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CODE OF FEDERAL REGULATIONS

Title 20
Employees' Benefits

Parts 1 to 399

Revised as of April 1, 2025

Containing a codification of documents
of general applicability and future effect

As of April 1, 2025

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Cite this Code: CFR

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Title 1 through Title 16.....as of January 1
Title 17 through Title 27.....as of April 1
Title 28 through Title 41.....as of July 1
Title 42 through Title 50.....as of October 1

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(b) The matter incorporated is adequately summarized in the preamble of the final rule and is available to the extent necessary to afford fairness and uniformity in the administrative process.

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OLIVER A. POTTS,
Director,
Office of the Federal Register
April 1, 2025

THIS TITLE

Title 20—EMPLOYEES' BENEFITS is composed of four volumes. The first volume, containing parts 1–399, includes current regulations issued by the Office of Workers' Compensation Programs, Department of Labor and the Railroad Retirement Board. The second volume, containing parts 400–499, includes all current regulations issued by the Social Security Administration. The third volume, containing parts 500 to 656, includes current regulations issued by the Employees' Compensation Appeals Board, and the Employment and Training Administration. The fourth volume, containing part 657 to End, includes the current regulations issued by the Office of Workers' Compensation Programs, the Benefits Review Board, the Office of the Assistant Secretary for Veterans' Employment and Training Service (all of the Department of Labor) and the Joint Board for the Enrollment of Actuaries. The contents of these volumes represent all current regulations codified under this title of the CFR as of April 1, 2025.

An index to chapter III appears in the second volume.

For this volume, Susannah C. Hurley was Chief Editor. The Code of Federal Regulations publication program is under the direction of John Hyrum Martinez, assisted by Stephen J. Frattini.

Title 20—Employees' Benefits

(This book contains parts 1 to 399)

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SUBCHAPTER A—ORGANIZATION AND PROCEDURES

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1.2 What functions are assigned to OWCP?
1.3 What rules are contained in this chapter?
1.4 Where are other rules concerning OWCP functions found?
1.5 When was the former Bureau of Employees' Compensation abolished?
1.6 How were many of OWCP's current functions administered in the past?

AUTHORITY: 5 U.S.C. 301, 8145 and 8149 (Reorganization Plan No. 6 of 1950, 15 FR 3174, 3 CFR, 1949–1953 Comp., p. 1004, 64 Stat. 1263); 42 U.S.C. 7384d and 7385s–10; E.O. 13179, 65 FR 77487, 3 CFR, 2000 Comp., p. 321; Secretary of Labor's Order No. 13–71, 36 FR 8155; Employment Standards Order No. 2–74, 39 FR 34722; Secretary of Labor's Order No. 10–2009, 74 FR 218.

SOURCE: 76 FR 37902, June 28, 2008, unless otherwise noted.

§ 1.1 Under what authority does the Office of Workers' Compensation Programs operate?

(a) The Assistant Secretary of Labor for Employment Standards, by authority vested in him by the Secretary of Labor in Secretary's Order No. 13–71 (36 FR 8755), established in the Employment Standards Administration (ESA) an Office of Workers' Compensation Programs (OWCP) by Employment Standards Order No. 2–74 (39 FR 34722). The Assistant Secretary subsequently designated as the head thereof a Director who, under the general supervision of the Assistant Secretary, administered the programs assigned to OWCP by the Assistant Secretary.

(b) Effective November 8, 2009, ESA was dissolved into its four component parts, including OWCP. Secretary of Labor's Order 10–2009 (74 FR 58834) cancelled or modified all prior orders and directives referencing ESA, devolved certain authorities and responsibilities of ESA to OWCP, and delegated authority to the Director, OWCP, to administer the programs now assigned directly to OWCP.

§ 1.2 What functions are assigned to OWCP?

The Secretary of Labor has delegated authority and assigned responsibility to the Director of OWCP for the Department of Labor's programs under the following statutes:

(a) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101 *et seq.*), except 5 U.S.C. 8149 as it pertains to the Employees' Compensation Appeals Board.

(b) The War Hazards Compensation Act, as amended (42 U.S.C. 1701 *et seq.*).

(c) The War Claims Act of 1948, as amended (50 U.S.C. App. 2003 *et seq.*).

(d) The Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (42 U.S.C. 7384 *et seq.*), except 42 U.S.C. 7385s–15 as it pertains to the Office of the Ombudsman, and activities, pursuant to Executive Order 13179 (''Providing Compensation to America's Nuclear Weapons Workers'') of December 7, 2000, assigned to the Secretary of Health and Human Services, the Secretary of Energy and the Attorney General.

(e) The Longshore and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 *et seq.*), except: 33 U.S.C. 919(d) with respect to administrative law judges in the Office of Administrative Law Judges; 33 U.S.C. 921(b) as it pertains to the Benefits Review Board; and activities, pursuant to 33 U.S.C. 941, assigned to the Assistant Secretary of Labor for Occupational Safety and Health.

(f) The Black Lung Benefits Act, as amended (30 U.S.C. 901 *et seq.*)., including 26 U.S.C. 9501, except: 33 U.S.C. 919(d) as incorporated by 30 U.S.C. 932(a), with respect to administrative law judges in the Office of Administrative Law Judges; and 33 U.S.C. 921(b) as incorporated by 30 U.S.C. 932(a), as it applies to the Benefits Review Board.

§ 1.3 What rules are contained in this chapter?

The rules in this chapter are those governing the OWCP functions under the Federal Employees' Compensation Act, the War Hazards Compensation

Act, the War Claims Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

§ 1.4 Where are other rules concerning OWCP functions found?

(a) The rules of OWCP governing its functions under the Longshore and Harbor Workers' Compensation Act and its extensions are set forth in subchapter A of chapter VI of this title.

(b) The rules of OWCP governing its functions under the Black Lung Benefits Act program are set forth in subchapter B of chapter VI of this title.

(c) The rules and regulations of the Employees' Compensation Appeals Board are set forth in chapter IV of this title.

(d) The rules and regulations of the Benefits Review Board are set forth in Chapter VII of this title.

§ 1.5 When was the former Bureau of Employees' Compensation abolished?

By Secretary of Labor's Order issued September 23, 1974 (39 FR 34723), issued concurrently with Employment Standards Order 2–74 (39 FR 34722), the Secretary revoked the prior Secretary's Order No. 18–67 (32 FR 12979), which had delegated authority and assigned responsibility for the various workers' compensation programs enumerated in §1.2, except the Black Lung Benefits Program and the Energy Employees Occupational Illness Compensation Program not then in existence, to the Director of the former Bureau of Employees' Compensation.

§ 1.6 How were many of OWCP's current functions administered in the past?

(a) Administration of the Federal Employees' Compensation Act and the Longshore and Harbor Workers' Compensation Act was initially vested in an independent establishment known as the U.S. Employees' Compensation Commission. By Reorganization Plan No. 2 of 1946 (3 CFR, 1943–1949 Comp., p. 1064; 60 Stat. 1095, effective July 16, 1946), the Commission was abolished and its functions were transferred to the Federal Security Agency to be performed by a newly created Bureau of Employees' Compensation within such Agency. By Reorganization Plan No. 19 of 1950 (15 FR 3178, 3 CFR, 1949–1954 Comp., page 1010, 64 Stat. 1271), said Bureau was transferred to the Department of Labor (DOL), and the authority formerly vested in the Administrator, Federal Security Agency, was vested in the Secretary of Labor. By Reorganization Plan No. 6 of 1950 (15 FR 3174, 3 CFR, 1949–1953 Comp., page 1004, 64 Stat. 1263), the Secretary of Labor was authorized to make from time to time such provisions as he shall deem appropriate, authorizing the performance of any of his functions by any other officer, agency, or employee of the DOL.

(b) In 1972, two separate organizational units were established within the Bureau: an Office of Workmen's Compensation Programs (37 FR 20533) and an Office of Federal Employees' Compensation (37 FR 22979). In 1974, these two units were abolished and one organizational unit, the Office of Workers' Compensation Programs, was established in lieu of the Bureau of Employees' Compensation (39 FR 34722).

SUBCHAPTER B—FEDERAL EMPLOYEES' COMPENSATION ACT

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AUTHORITY: 5 U.S.C. 301, 8102a, 8103, 8145 and 8149; 31 U.S.C. 3716 and 3717; Reorganization Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; Secretary of Labor's Order No. 10–2009, 74 FR 218; Pub. L. 117–263.

SOURCE: 76 FR 37903, June 28, 2011, unless otherwise noted.

Subpart A—General Provisions

INTRODUCTION

§ 10.0 What are the provisions of the FECA, in general?

The Federal Employees' Compensation Act (FECA) as amended (5 U.S.C. 8101 *et seq.*) provides for the payment of workers' compensation benefits to civilian officers and employees of all branches of the Government of the United States. The regulations in this part describe the rules for filing, processing, and paying claims for benefits under the FECA. Proceedings under the FECA are non-adversarial in nature.

(a) The FECA has been amended and extended a number of times to provide workers' compensation benefits to volunteers in the Civil Air Patrol (5 U.S.C. 8141), members of the Reserve Officers' Training Corps (5 U.S.C. 8140), Peace Corps Volunteers (5 U.S.C. 8142), Job Corps enrollees and Volunteers in Service to America (5 U.S.C. 8143), members of the National Teachers Corps (5 U.S.C. 8143a), certain student employees (5 U.S.C. 5351 and 8144), certain law enforcement officers not employed by the United States (5 U.S.C. 8191–8193), and various other classes of persons who provide or have provided services to the Government of the United States.

(b) The FECA provides for payment of several types of benefits, including compensation for wage loss, schedule awards, medical and related benefits, and vocational rehabilitation services for conditions resulting from injuries sustained in performance of duty while in service to the United States.

(c) The FECA also provides for payment of monetary compensation to specified survivors of an employee whose death resulted from a work-related injury and for payment of certain burial expenses subject to the provisions of 5 U.S.C. 8134.

(d) All types of benefits and conditions of eligibility listed in this section are subject to the provisions of the FECA and of this part. This section shall not be construed to modify or enlarge upon the provisions of the FECA.

§ 10.1 What rules govern the administration of the FECA and this chapter?

In accordance with 5 U.S.C. 8145 and Secretary's Order 5–96, the responsibility for administering the FECA, except for 5 U.S.C. 8149 as it pertains to the Employees' Compensation Appeals Board, has been delegated to the Director of the Office of Workers' Compensation Programs (OWCP). Except as otherwise provided by law, the Director, OWCP and his or her designees have

the exclusive authority to administer, interpret and enforce the provisions of the Act.

§ 10.2 What do these regulations contain?

This part 10 sets forth the regulations governing administration of all claims filed under the FECA, except to the extent specified in certain particular provisions. Its provisions are intended to assist persons seeking compensation benefits under the FECA, as well as personnel in the various Federal agencies and the Department of Labor who process claims filed under the FECA or who perform administrative functions with respect to the FECA. This part 10 applies to part 25 of this chapter except as modified by part 25. The various subparts of this part contain the following:

(a) *Subpart A.* The general statutory and administrative framework for processing claims under the FECA. It contains a statement of purpose and scope, together with definitions of terms, descriptions of basic forms, information about the disclosure of OWCP records, and a description of rights and penalties under the FECA, including convictions for fraud.

(b) *Subpart B.* The rules for filing notices of injury and claims for benefits under the FECA. It also addresses evidence and burden of proof, as well as the process of making decisions concerning eligibility for benefits.

(c) *Subpart C.* The rules governing claims for and payment of continuation of pay.

(d) *Subpart D.* The rules governing emergency and routine medical care, second opinion and referee medical examinations directed by OWCP, and medical reports and records in general. It also addresses the kinds of treatment which may be authorized and how medical bills are paid.

(e) *Subpart E.* The rules relating to the payment of monetary compensation benefits for disability, impairment and death. It includes the provisions for identifying and processing overpayments of compensation.

(f) *Subpart F.* The rules governing the payment of continuing compensation benefits. It includes provisions concerning the employee's and the employer's responsibilities in returning the employee to work. It also contains provisions governing reports of earnings and dependents, recurrences, and reduction and termination of compensation benefits.

(g) *Subpart G.* The rules governing the appeals of decisions under the FECA. It includes provisions relating to hearings, reconsiderations, and appeals before the Employees' Compensation Appeals Board.

(h) *Subpart H.* The rules concerning legal representation and for adjustment and recovery from a third party. It also contains provisions relevant to three groups of employees whose status requires special application of the provisions of the FECA: Federal grand and petit jurors, Peace Corps volunteers, and non- Federal law enforcement officers.

(i) *Subpart I.* Information for medical providers. It includes rules for medical reports, medical bills, and the OWCP medical fee schedule, as well as the provisions for exclusion of medical providers.

(j) *Subpart J.* Death Gratuity. The rules relating to the payment of the death gratuity benefit under 5 U.S.C. 8102a.

§ 10.3 Have the collection of information requirements of this part been approved by the Office of Management and Budget (OMB)?

The collection of information requirements in this part have been approved by OMB and assigned OMB control numbers 1240–0001, 1240–0007, 1240–0008, 1240–0009, 1240–0012, 1240–0013, 1240–0015, 1240–0016, 1240–0017, 1240–0018, 1240–0019, 1240–0022, 1240–0044, 1240–0045, 1240–0046, 1240–0047, 1240–0049, 1240–0050 and 1240–0051.

Definitions and Forms

§ 10.5 What definitions apply to the regulations in this subchapter?

Certain words and phrases found in this part are defined in this section or in the FECA. Some other words and phrases that are used only in limited situations are defined in the later subparts of the regulations in this subchapter.

(a) *Benefits* or *Compensation* in the regulations in this subchapter means

Compensation as defined by the FECA at 5 U.S.C. 8101(12), which is the money OWCP pays to or on behalf of a beneficiary from the Employees' Compensation Fund. The terms Benefits and Compensation include payments for lost wages, loss of wage-earning capacity, and permanent physical impairment. The terms Benefits and Compensation also include the money paid to beneficiaries for an employee's death, including both death benefits and any death gratuity benefit. These two terms also include any other amounts paid out of the Employees' Compensation Fund for such things as medical treatment, medical examinations conducted at the request of OWCP as part of the claims adjudication process, vocational rehabilitation services under 5 U.S.C. 8111, services of an attendant and funeral expenses under 5 U.S.C. 8134, but do not include continuation of pay as provided by 5 U.S.C. 8118.

(b) *Beneficiary* means an individual who is entitled to a benefit under the FECA and this part.

(c) *Claim* means a written assertion of an individual's entitlement to benefits under the FECA, submitted in a manner authorized by this part.

(d) *Claimant* means an individual whose claim has been filed.

(e) *Director* means the Director of OWCP or a person designated to carry out his or her functions.

(f) *Disability* means the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total.

(g) *Earnings from employment or self-employment* means:

(1) Gross earnings or wages before any deductions and includes the value of subsistence, quarters, reimbursed expenses and any other goods or services received in kind as remuneration; or

(2) A reasonable estimate of the cost to have someone else perform the duties of an individual who accepts no remuneration. Neither lack of profits, nor the characterization of the duties as a hobby, removes an unremunerated individual's responsibility to report the estimated cost to have someone else perform his or her duties.

(h) *Employee* means, but is not limited to, an individual who fits within one of the following listed groups:

(1) A civil officer or employee in any branch of the Government of the United States, including an officer or employee of an instrumentality wholly owned by the United States pursuant to 5 U.S.C. 8101(1)(A);

(2) An individual rendering personal service to the United States similar to the service of a civil officer or employee of the United States, without pay or for nominal pay, when a statute authorizes the acceptance or use of the service, or authorizes payment of travel or other expenses of the individual pursuant to 5 U.S.C. 8101(1)(B);

(3) An individual, other than an independent contractor or an individual employed by an independent contractor, employed on the Menominee Indian Reservation in Wisconsin in operations conducted under a statute relating to Tribal timber and logging operations on that reservation pursuant to 5 U.S.C. 8101(1)(C);

(4) An individual appointed to a position on the office staff of a former President under section 1(b) of the Act of August 25, 1958 (72 Stat. 838) pursuant to 5 U.S.C. 8101(1)(E); or

(5) An individual selected and serving as a Federal petit or grand juror pursuant to 5 U.S.C. 8101(1)(F).

(i) *Employer* or *Agency* means any civil agency or instrumentality of the United States Government, or any other organization, group or institution employing an individual defined as an ''employee'' by this section. These terms also refer to officers and employees of an employer having responsibility for the supervision, direction or control of employees of that employer as an ''immediate superior,'' and to other employees designated by the employer to carry out the functions vested in the employer under the FECA and this part, including officers or employees delegated responsibility by an employer for authorizing medical treatment for injured employees.

(j) *Entitlement* means entitlement to benefits as determined by OWCP under the FECA and the procedures described in this part.

(k) *FECA* means the Federal Employees' Compensation Act, as amended.

(l) *Hospital services* means services and supplies provided by hospitals within the scope of their practice as defined by State law.

(m) *Impairment* means any anatomic or functional abnormality or loss. A permanent impairment is any such abnormality or loss after maximum medical improvement has been achieved.

(n) *Knowingly* means with knowledge, consciously, willfully or intentionally.

(o) *Medical services* means services and supplies provided by or under the supervision of a physician. Reimbursable chiropractic services are limited to physical examinations (and related laboratory tests), x-rays performed to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation.

(p) *Medical support services* means services, drugs, supplies and appliances provided by a person other than a physician or hospital.

(q) *Occupational disease or illness* means a condition produced by the work environment over a period longer than a single workday or shift.

(r) *OWCP* means the Office of Workers' Compensation Programs.

(s) *Pay rate for compensation purposes* means the employee's pay, as determined under 5 U.S.C. 8114, at the time of injury, the time disability begins or the time compensable disability recurs if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the United States, whichever is greater, except as otherwise determined under 5 U.S.C. 8113 with respect to any period.

(t) *Physician* means an individual defined as such in 5 U.S.C. 8101(2), except during the period for which his or her license to practice medicine has been suspended or revoked by a State licensing or regulatory authority.

(u) *Qualified hospital* means any hospital licensed as such under State law which has not been excluded under the provisions of subpart I of this part. Except as otherwise provided by regulation, a qualified hospital shall be deemed to be designated or approved by OWCP.

(v) *Qualified physician* means any physician who has not been excluded under the provisions of subpart I of this part. Except as otherwise provided by regulation, a qualified physician shall be deemed to be designated or approved by OWCP.

(w) *Qualified provider of medical support services or supplies* means any person, other than a physician or a hospital, who provides services, drugs, supplies and appliances for which OWCP makes payment, who possesses any applicable licenses required under State law, and who has not been excluded under the provisions of subpart I of this part.

(x) *Recurrence of disability* means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations. A recurrence of disability does not apply when a light-duty assignment is withdrawn for reasons of misconduct, non-performance of job duties or other downsizing or where a loss of wage-earning capacity determination as provided by 5 U.S.C. 8115 is in place.

(y) *Recurrence of medical condition* means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a ''need for further medical treatment after release from treatment,'' nor is an examination without treatment.

(z) *Representative* means an individual or law firm properly authorized by a claimant in writing to act for the claimant in connection with a claim or proceeding under the FECA or this part.

(aa) *Student* means an individual defined at 5 U.S.C. 8101(17). Two terms

used in that particular definition are further defined as follows:

(1) *Additional type of educational or training institution* means a technical, trade, vocational, business or professional school accredited or licensed by the United States Government or a State Government or any political subdivision thereof providing courses of not less than three months duration, that prepares the individual for a livelihood in a trade, industry, vocation or profession.

(2) *Year beyond the high school level* means:

(i) The 12-month period beginning the month after the individual graduates from high school, provided he or she had indicated an intention to continue schooling within four months of high school graduation, and each successive 12-month period in which there is school attendance or the payment of compensation based on such attendance; or

(ii) If the individual has indicated that he or she will not continue schooling within four months of high school graduation, the 12-month period beginning with the month that the individual enters school to continue his or her education, and each successive 12-month period in which there is school attendance or the payment of compensation based on such attendance.

(bb) *Subluxation* means an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae which must be demonstrable on any x-ray film to an individual trained in the reading of x-rays.

(cc) *Surviving spouse* means the husband or wife living with or dependent for support upon a deceased employee at the time of his or her death, or living apart for reasonable cause or because of the deceased employee's desertion, unless otherwise defined under the FECA for the specific benefit such as the FECA death gratuity at 5 U.S.C. 8102a.

(dd) *Temporary aggravation of a pre-existing condition* means that factors of employment have directly caused that condition to be more severe for a limited period of time and have left no greater impairment than existed prior to the employment injury.

(ee) *Traumatic injury* means a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected.

§ 10.6 What special statutory definitions apply to dependents and survivors?

(a) 5 U.S.C. 8133 provides that certain benefits are payable to certain enumerated survivors of employees who have died from an injury sustained in the performance of duty.

(b) 5 U.S.C. 8148 also provides that certain other benefits may be payable to certain family members of employees who have been incarcerated due to a felony conviction.

(c) 5 U.S.C. 8110(b) further provides that any employee who is found to be eligible for a basic benefit shall be entitled to have such basic benefit augmented at a specified rate for certain persons who live in the beneficiary's household or who are dependent upon the beneficiary for support.

(d) 5 U.S.C. 8101, 8110, 8133, and 8148, which define the nature of such survivorship or dependency necessary to qualify a beneficiary for a survivor's benefit or an augmented benefit, apply to the provisions of this part but not to the death gratuity provided under subpart J.

(e) 5 U.S.C. 8102a provides the definitions for survivorship or dependency necessary to qualify as a beneficiary for a death gratuity benefit as well as allowing half the death gratuity benefit to be paid to alternate beneficiary.

§ 10.7 What forms are needed to process claims under the FECA?

(a) Notice of injury, claims and certain specified reports shall be made on forms prescribed by OWCP. Employers shall not modify these forms or use substitute forms. Employers are expected to maintain an adequate supply of the basic forms needed for the proper recording and reporting of injuries.

Form No.	Title
(1) CA–1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.
(2) CA–2	Notice of Occupational Disease and Claim for Compensation.
(3) CA–2a	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation.
(4) CA–3	Report of Work Status.
(5) CA–5	Claim for Compensation by Widow, Widower and/or Children.
(6) CA–5b	Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.
(7) CA–6	Official Superior's Report of Employee's Death.
(8) CA–7	Claim for Compensation Due to Traumatic Injury or Occupational Disease.
(9) CA–7a	Time Analysis Form.
(10) CA–7b	Leave Buy Back (LBB) Worksheet/Certification and Election.
(11) CA–16	Authorization of Examination and/or Treatment.
(12) CA–17	Duty Status Report.
(13) CA–20	Attending Physician's Report.
(14) CA–20a	Attending Physician's Supplemental Report.
(15) CA–40	Designation of a Recipient of the Federal Employees' Compensation Act Death Gratuity Payment under Section 1105 of Public Law 110–181 (Section 8102a).
(16) CA–41	Claim for Survivor Benefits Under the Federal Employees' Compensation Act Section 8102a Death Gratuity.
(17) CA–42	Official Notice of Employees' Death for Purposes of FECA Section 8102a Death Gratuity.
(18) CA–1108	Statement of Recovery Letter with Long Form.
(19) CA–1122	Statement of Recovery Letter with Short Form.

(b) Copies of the forms listed in this paragraph are available for public inspection at the Office of Workers' Compensation Programs, U.S. Department of Labor, Washington, DC 20210. They may also be obtained from district offices, employers (*i.e.*, safety and health offices, supervisors), and the Internet, at *http://www.dol.gov*.

INFORMATION IN PROGRAM RECORDS

§ 10.10 Are all documents relating to claims filed under the FECA considered confidential?

All records relating to claims for benefits, including copies of such records maintained by an employer, are considered confidential and may not be released, inspected, copied or otherwise disclosed except as provided in the Freedom of Information Act and the Privacy Act of 1974 or under the routine uses provided by DOL/GOVT–1 if such release is consistent with the purpose for which the record was created.

§ 10.11 Who maintains custody and control of FECA records?

All records relating to claims for benefits filed under the FECA, including any copies of such records maintained by an employing agency, are covered by the government-wide Privacy Act system of records entitled DOL/GOVT–1 (Office of Workers' Compensation Programs, Federal Employees' Compensation Act File). This system of records is maintained by and under the control of OWCP, and, as such, all records covered by DOL/GOVT–1 are official records of OWCP. The protection, release, inspection and copying of records covered by DOL/GOVT–1 shall be accomplished in accordance with the rules, guidelines and provisions of this part, as well as those contained in 29 CFR parts 70 and 71, and with the notice of the system of records and routine uses published in the FEDERAL REGISTER. All questions relating to access/disclosure, and/or amendment of FECA records maintained by OWCP or the employing agency, are to be resolved in accordance with this section.

§ 10.12 How may a FECA claimant or beneficiary obtain copies of protected records?

(a) A claimant seeking copies of his or her official FECA file should address a request to the District Director of the OWCP office having custody of the file. A claimant seeking copies of FECA-related documents in the custody of the employer should follow the procedures established by that agency.

(b) (1) While an employing agency may establish procedures that an injured employee or beneficiary should follow in requesting access to documents it maintains, any decision issued in response to such a request must comply with the rules and regulations of the Department of Labor which govern all other aspects of safeguarding these records.

(2) No employing agency has the authority to issue determinations with respect to requests for the correction

or amendment of records contained in or covered by DOL/GOVT–1. That authority is within the exclusive control of OWCP. Thus, any request for correction or amendment received by an employing agency must be referred to OWCP for review and decision.

(3) Any administrative appeal taken from a denial issued by the employing agency or OWCP shall be filed with the Solicitor of Labor in accordance with 29 CFR 71.7 and 71.9.

§ 10.13 What process is used by a person who wants to correct FECA-related documents?

Any request to amend a record covered by DOL/GOVT–1 should be directed to the district office having custody of the official file. No employer has the authority to issue determinations with regard to requests for the correction of records contained in or covered by DOL/GOVT–1. Any request for correction received by an employer must be referred to OWCP for review and decision.

RIGHTS AND PENALTIES

§ 10.15 May compensation rights be waived?

No employer or other person may require an employee or other claimant to enter into any agreement, either before or after an injury or death, to waive his or her right to claim compensation under the FECA. No waiver of compensation rights shall be valid.

§ 10.16 What criminal and civil penalties may be imposed in connection with a claim under the FECA?

(a) A number of statutory provisions make it a crime to file a false or fraudulent claim or statement with the Government in connection with a claim under the FECA, or to wrongfully impede a FECA claim. Included among these provisions are 18 U.S.C. 287, 1001, 1920, and 1922. Furthermore, a civil action to recover benefits paid erroneously under the FECA may be maintained under the False Claims Act, 31 U.S.C. 3729–3733. Enforcement of such provisions that may apply to claims under the FECA is within the jurisdiction of the Department of Justice.

(b) In addition, administrative proceedings may be initiated under the Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 U.S.C. 3801–12, to impose civil penalties and assessments against persons who make, submit, or present, or cause to be made, submitted or presented, false, fictitious or fraudulent claims or written statements to OWCP in connection with a claim under the FECA. The Department of Labor's regulations implementing the PFRCA are found at 29 CFR part 22.

§ 10.17 Is a beneficiary who defrauds the Government in connection with a claim for benefits still entitled to those benefits?

When a beneficiary either pleads guilty to or is found guilty on either Federal or State criminal charges of defrauding the Federal Government in connection with a claim for benefits, the beneficiary's entitlement to any further compensation benefits will terminate effective the date of conviction, which is the date of the verdict or, in the case of a plea bargain, the date the claimant made the plea in open court (not the date of sentencing or the date court papers were signed). The employing agency may, upon request, be required to provide the documentation needed for termination under this section. Termination of entitlement under this section is not affected by any subsequent change in or recurrence of the beneficiary's medical condition.

§ 10.18 Can a beneficiary who is incarcerated based on a felony conviction still receive benefits?

(a) Whenever a beneficiary is incarcerated in a State or Federal jail, prison, penal institution or other correctional facility due to a State or Federal felony conviction, he or she forfeits all rights to compensation benefits during the period of incarceration. A beneficiary's right to compensation benefits for the period of his or her incarceration is not restored after such incarceration ends, even though payment of compensation benefits may resume. A beneficiary has an affirmative duty to provide notice of any conviction and imprisonment. The employing agency shall provide OWCP any information or documentation they may have concerning such matters.

(b) If the beneficiary has eligible dependents, OWCP will pay compensation to such dependents at a reduced rate during the period of his or her incarceration, by applying the percentages of 5 U.S.C. 8133(a)(1) through (5) to the beneficiary's gross current entitlement rather than to the beneficiary's monthly pay.

(c) If OWCP's decision on entitlement is pending when the period of incarceration begins, and compensation is due for a period of time prior to such incarceration, payment for that period will only be made to the beneficiary following his or her release.

Subpart B—Filing Notices and Claims; Submitting Evidence

NOTICES AND CLAIMS FOR INJURY, DISEASE, AND DEATH—EMPLOYEE OR SURVIVOR'S ACTIONS

§ 10.100 How and when is a notice of traumatic injury filed?

(a) To claim benefits under the FECA, an employee who sustains a work-related traumatic injury must give notice of the injury in writing on Form CA–1, which may be obtained from the employer or from the Internet at *www.dol.gov* under forms. The employee must forward this notice to the employer. Another person, including the employer, may give notice of injury on the employee's behalf. The person submitting a notice shall include the Social Security Number (SSN) of the injured employee. All such notices should be submitted electronically wherever feasible to facilitate processing of such claims. All employers that currently do not have such capability should create such a method by December 31, 2012.

(b) For injuries sustained on or after September 7, 1974, a notice of injury must be filed within three years of the injury. (The form contains the necessary words of claim.) The requirements for filing notice are further described in 5 U.S.C. 8119. Also see § 10.205 concerning time requirements for filing claims for continuation of pay.

(1) If the claim is not filed within three years, compensation may still be allowed if notice of injury was given within 30 days or the employer had actual knowledge of the injury or death within 30 days after occurrence. This knowledge may consist of written records or verbal notification. An entry into an employee's medical record may also satisfy this requirement if it is sufficient to place the employer on notice of a possible work-related injury or disease.

(2) OWCP may excuse failure to comply with the three-year time requirement because of truly exceptional circumstances (for example, being held prisoner of war).

(3) The claimant may withdraw his or her claim (but not the notice of injury) by so requesting in writing to OWCP at any time before OWCP determines eligibility for benefits. Any continuation of pay (COP) granted to an employee after a claim is withdrawn must be charged to sick or annual leave, or considered an overpayment of pay consistent with 5 U.S.C. 5584, at the employee's option.

(c) However, in cases of latent disability, the time for filing claim does not begin to run until the employee has a compensable disability and is aware, or reasonably should have been aware, of the causal relationship between the disability and the employment (see 5 U.S.C. 8122(b)).

§ 10.101 How and when is a notice of occupational disease filed?

(a) To claim benefits under the FECA, an employee who has a disease which he or she believes to be work-related must give notice of the condition in writing on Form CA–2, which may be obtained from the employer or from the Internet at *www.dol.gov* under forms. The employee must forward this notice to the employer. Another person, including the employer, may do so on the employee's behalf. The person submitting a notice shall include the Social Security Number (SSN) of the injured employee. All such notices should be submitted electronically wherever feasible to facilitate processing of such claims. All employers that currently do not have such capability should create such a method by December 31, 2012. The claimant may withdraw his or her claim (but not the notice of occupational disease) by so requesting in writing to OWCP at any

time before OWCP determines eligibility for benefits.

(b) For occupational diseases sustained as a result of exposure to injurious work factors that occurs on or after September 7, 1974, a notice of occupational disease must be filed within three years of the onset of the condition. (The form contains the necessary words of claim.) The requirements for timely filing are described in §10.100(b)(1) through (3).

(c) However, in cases of latent disability, the time for filing claim does not begin to run until the employee has a compensable disability and is aware, or reasonably should have been aware, of the causal relationship between the disability and the employment (see 5 U.S.C. 8122(b)).

§ 10.102 How and when is a claim for wage loss compensation filed?

(a) Form CA–7 is used to claim compensation for periods of disability not covered by COP.

(1) An employee who is disabled with loss of pay for more than three calendar days due to an injury, or someone acting on his or her behalf, must file Form CA–7 before compensation can be paid.

(2) The employee shall complete the front of Form CA–7 and submit the form to the employer for completion and transmission to OWCP. The form should be completed as soon as possible, but no more than 14 calendar days after the date pay stops due to the injury or disease. All such notices should be submitted electronically wherever feasible to facilitate processing of such claims. All employers that currently do not have such capability should create such a method by December 31, 2012.

(3) The requirements for filing claims are further described in 5 U.S.C. 8121.

(b) Form CA–7 is also used to claim compensation for additional periods of disability following the initial injury.

(1) It is the employee's responsibility to submit Form CA–7. Without receipt of such claim, OWCP has no knowledge of continuing wage loss. Therefore, while disability continues, the employee should submit a claim on Form CA–7 each two weeks until otherwise instructed by OWCP.

(2) The employee shall complete the front of Form CA–7 and submit the form to the employer for completion and transmission to OWCP.

(3) The employee is responsible for submitting, or arranging for the submittal of, medical evidence to OWCP which establishes both that disability continues and that the disability is due to the work-related injury. Form CA–20a is submitted with Form CA–7 for this purpose.

§ 10.103 How and when is a claim for permanent impairment filed?

Form CA–7 is used to claim compensation for impairment to a body part covered under the schedule established by 5 U.S.C. 8107. All such notices should be submitted electronically wherever feasible to facilitate processing of such claims. All employers that currently do not have such capability should create such a method by December 31, 2012. If Form CA–7 has already been filed to claim disability compensation, an employee may file a claim for such impairment by sending a letter to OWCP which specifies the nature of the benefit claimed. OWCP may create a form specifically for schedule award claims; if that form is created, only that form may be used to file a claim under 5 U.S.C. 8107.

§ 10.104 How and when is a claim for recurrence filed?

(a) A recurrence should be reported on Form CA–2a if that recurrence causes the employee to lose time from work and incur a wage loss, or if the employee experiences a renewed need for treatment after previously being released from care. However, a notice of recurrence should not be filed when a new injury, new occupational disease, or new event contributing to an already-existing occupational disease has occurred. In these instances, the employee should file Form CA–1 or CA–2.

(b) The employee has the burden of establishing by the weight of reliable, probative and substantial evidence that the recurrence of disability is causally related to the original injury.

(1) The employee must include a detailed factual statement as described on Form CA–2a. The employer may

submit comments concerning the employee's statement.

(2) The employee should arrange for the submittal of a detailed medical report from the attending physician as described on Form CA–2a. The employee should also submit, or arrange for the submittal of, similar medical reports for any examination and/or treatment received after returning to work following the original injury.

(c) A claim for recurrence of disability is not available where OWCP has issued a loss of wage-earning capacity determination. Under that circumstance, the only method for claiming additional wage loss compensation is through a request to modify that determination. However, OWCP is not precluded from adjudicating a limited period of disability following the issuance of a loss of wage-earning capacity decision, such as where an employee has a demonstrated need for surgery.

§ 10.105 How and when is a notice of death and claim for benefits filed?

(a) If an employee dies from a work-related traumatic injury or an occupational disease, any survivor may file a claim for death benefits using Form CA–5 or CA–5b, which may be obtained from the employer or from the Internet at *www.dol.gov* under forms. The survivor must provide this notice in writing and forward it to the employer. Another person, including the employer, may do so on the survivor's behalf. The survivor may also submit the completed Form CA–5 or CA–5b directly to OWCP. The survivor shall disclose the SSNs of all survivors on whose behalf claim for benefits is made in addition to the SSN of the deceased employee. All such notices should be submitted electronically wherever feasible to facilitate processing of such claims. All employers that currently do not have such capability should create such a method by December 31, 2012. The survivor may withdraw his or her claim (but not the notice of death) by so requesting in writing to OWCP at any time before OWCP determines eligibility for benefits.

(b) For deaths that occur on or after September 7, 1974, a notice of death must be filed within three years of the death. The form contains the necessary words of claim. The requirements for timely filing are described in §10.100(b)(1) through (3).

(c) However, in cases of death due to latent disability, the time for filing the claim does not begin to run until the survivor is aware, or reasonably should have been aware, of the causal relationship between the death and the employment (see 5 U.S.C. 8122(b)).

(d) The filing of a notice of injury or occupational disease will satisfy the time requirements for a death claim based on the same injury or occupational disease. If an injured employee or someone acting on the employee's behalf does not file a claim before the employee's death, the right to claim compensation for disability other than medical expenses ceases and does not survive.

(e) A survivor must be alive to receive any payment; there is no vested right to such payment. A report as described in §10.414 of this part must be filed once each year to support continuing payments of compensation.

Notices and Claims for Injury, Disease, and Death—Employer's Actions

§ 10.110 What should the employer do when an employee files a notice of traumatic injury or occupational disease?

(a) The employer shall complete the agency portion of Form CA–1 (for traumatic injury) or CA–2 (for occupational disease) no more than 10 working days after receipt of notice from the employee. The employer shall also complete the Receipt of Notice and give it to the employee, along with copies of both sides of Form CA–1 or Form CA–2.

(b) The employer must complete and transmit the form to OWCP within 10 working days after receipt of notice from the employee if the injury or disease will likely result in:

(1) A medical charge against OWCP;

(2) Disability for work beyond the day or shift of injury;

(3) The need for more than two appointments for medical examination and/or treatment on separate days, leading to time loss from work;

(4) Future disability;

(5) Permanent impairment; or

(6) Continuation of pay pursuant to 5 U.S.C. 8118.

(c) The employer should not wait for submittal of supporting evidence before sending the form to OWCP.

(d) If none of the conditions in paragraph (b) of this section applies, the Form CA–1 or CA–2 shall be retained as a permanent record in the Employee Medical Folder in accordance with the guidelines established by the Office of Personnel Management.

§ 10.111 What should the employer do when an employee files an initial claim for compensation due to disability or permanent impairment?

(a) Except for employees covered by paragraph (d) of this section, when an employee is disabled by a work-related injury and loses pay for more than three calendar days, or has a permanent impairment or serious disfigurement as described in 5 U.S.C. 8107, the employer shall furnish the employee with Form CA–7 for the purpose of claiming compensation.

(b) If the employee is receiving continuation of pay (COP), the employer should give Form CA–7 to the employee by the 30th day of the COP period and submit the form to OWCP by the 40th day of the COP period. If the employee has not returned the form to the employer by the 40th day of the COP period, the employer should ask him or her to submit it as soon as possible.

(c) Upon receipt of Form CA–7 from the employee, or someone acting on his or her behalf, the employer shall complete the appropriate portions of the form. As soon as possible, but no more than five working days after receipt from the employee, the employer shall forward the completed Form CA–7 and any accompanying medical report to OWCP.

(d) Postal Service employees are not entitled to compensation or continuation of pay for the waiting period, the first three days of disability. Such employees may use annual leave, sick leave or leave without pay during that period; however, if the disability exceeds 14 days, the employee may have their sick leave or annual leave reinstated or receive pay for the time spent on leave without pay. This waiting period does not apply to the provision of medical care, and days of time loss for medical treatment only with no work-related disability do not count as part of the waiting period. A Postal Service employee seeking wage loss compensation for this period should utilize Form CA–7 to claim such benefits.

§ 10.112 What should the employer do when an employee files a claim for continuing compensation due to disability?

(a) If the employee continues in a leave-without-pay status due to a work-related injury after the period of compensation initially claimed on Form CA–7, the employer shall furnish the employee with another Form CA–7 for the purpose of claiming continuing compensation.

(b) Upon receipt of Form CA–7 from the employee, or someone acting on his or her behalf, the employer shall complete the appropriate portions of the form. As soon as possible, but no more than five working days after receipt from the employee, the employer shall forward the completed Form CA–7 and any accompanying medical report to OWCP.

§ 10.113 What should the employer do when an employee dies from a work-related injury or disease?

(a) The employer shall immediately report a death due to a work-related traumatic injury or occupational disease to OWCP by telephone, telegram, or facsimile (fax). No more than 10 working days after notification of the death, the employer shall complete and send Form CA–6 to OWCP.

(b) When possible, the employer shall furnish a Form CA–5 or CA–5b to all persons likely to be entitled to compensation for death of an employee. The employer should also supply information about completing and filing the form.

(c) The employer shall promptly transmit Form CA–5 or CA–5b to OWCP. The employer shall also promptly transmit to OWCP any other claim or paper submitted which appears to claim compensation on account of death.

EVIDENCE AND BURDEN OF PROOF

§ 10.115 What evidence is needed to establish a claim?

Forms CA–1, CA–2, CA–5 and CA–5b describe the basic evidence required. OWCP may send a request for additional evidence to the claimant and to his or her representative, if any; however the burden of proof still remains with the claimant. Evidence should be submitted in writing. The evidence submitted must be reliable, probative and substantial. Each claim for compensation must meet five requirements before OWCP can accept it. These requirements, which the employee must establish to meet his or her burden of proof, are as follows:

(a) The claim was filed within the time limits specified by the FECA;

(b) The injured person was, at the time of injury, an employee of the United States as defined in 5 U.S.C. 8101(1) and §10.5(h) of this part;

(c) The fact that an injury, disease or death occurred;

(d) The injury, disease or death occurred while the employee was in the performance of duty; and

(e) The medical condition for which compensation or medical benefits is claimed is causally related to the claimed injury, disease or death. Neither the fact that the condition manifests itself during a period of Federal employment, nor the belief of the claimant that factors of employment caused or aggravated the condition, is sufficient in itself to establish causal relationship.

(f) In all claims, the claimant is responsible for submitting, or arranging for submittal of, a medical report from the attending physician. For wage loss benefits, the claimant must also submit medical evidence showing that the condition claimed is disabling. The rules for submitting medical reports are found in §§10.330 through 10.333.

§ 10.116 What additional evidence is needed in cases based on occupational disease?

(a) The employee must submit the specific detailed information described on Form CA–2 and should submit any checklist (Form CA–35, A–H) provided by the employer. OWCP has developed these checklists to address particular occupational diseases. The medical report should also include the information specified on the checklist for the particular disease claimed.

(b) The employer should submit the specific detailed information described on Form CA–2 and on any checklist pertaining to the claimed disease.

§ 10.117 What happens if, in any claim, the employer contests any of the facts as stated by the claimant?

(a) An employer who has reason to disagree with any aspect of the claimant's report shall submit a statement to OWCP that specifically describes the factual allegation or argument with which it disagrees and provide evidence or argument to support its position. The employer may include supporting documents such as witness statements, medical reports or records, or any other relevant information.

(b) Any such statement shall be submitted to OWCP with the notice of traumatic injury or death, or within 30 calendar days from the date notice of occupational disease or death is received from the claimant. If the employer does not submit a written explanation to support the disagreement, OWCP may accept the claimant's report of injury as established. The employer may not use a disagreement with an aspect of the claimant's report to delay forwarding the claim to OWCP or to compel or induce the claimant to change or withdraw the claim.

§ 10.118 Does the employer participate in the claims process in any other way?

(a) The employer is responsible for submitting to OWCP all relevant and probative factual and medical evidence in its possession, or which it may acquire through investigation or other means. Such evidence may be submitted at any time.

(b) The employer may ascertain the events surrounding an injury and the extent of disability where it appears that an employee who alleges total disability may be performing other work, or may be engaging in activities which would indicate less than total disability. This authority is in addition to that given in §10.118(a). However, the

provisions of the Privacy Act apply to any endeavor by the employer to ascertain the facts of the case (see §§10.10 and 10.11).

(c) The employer does not have the right, except as provided in subpart C of this part, to actively participate in the claims adjudication process.

§ 10.119 What action will OWCP take with respect to information submitted by the employer?

OWCP will consider all evidence submitted appropriately, and OWCP will inform the employee, the employee's representative, if any, and the employer of any action taken. Where an employer contests a claim within 30 days of the initial submittal and the claim is later approved, OWCP will notify the employer of the rationale for approving the claim.

§ 10.120 May a claimant submit additional evidence?

A claimant or a person acting on his or her behalf may submit to OWCP at any time any other evidence relevant to the claim.

§ 10.121 What happens if OWCP needs more evidence from the claimant?

If the claimant submits factual evidence, medical evidence, or both, but OWCP determines that this evidence is not sufficient to meet the burden of proof, OWCP will inform the claimant of the additional evidence needed. The claimant will be allowed at least 60 days to submit the evidence required. OWCP is not required to notify the claimant a second time if the evidence submitted in response to OWCP's first request for additional evidence is not sufficient to meet the burden of proof.

[88 FR 975, Jan. 6, 2023]

DECISIONS ON ENTITLEMENT TO BENEFITS

§ 10.125 How does OWCP determine entitlement to benefits?

(a) In reaching any decision with respect to FECA coverage or entitlement, OWCP considers the claim presented by the claimant, the report by the employer, and the results of such investigation as OWCP may deem necessary.

(b) OWCP claims staff apply the law, the regulations, and its procedures to the facts as reported or obtained upon investigation. They also apply decisions of the Employees' Compensation Appeals Board and administrative decisions of OWCP as set forth in FECA Program Memoranda.

§ 10.126 What does the decision contain?

The decision shall contain findings of fact and a statement of reasons. It is accompanied by information about the claimant's appeal rights, which may include the right to a hearing, a reconsideration, and/or a review by the Employees' Compensation Appeals Board. (See subpart G of this part.)

§ 10.127 To whom is the decision sent?

A copy of the decision shall be mailed to the employee's last known address. If the employee has a designated representative before OWCP, a copy of the decision will also be mailed to the representative. A copy of the decision will also be sent to the employer.

Subpart C—Continuation of Pay

§ 10.200 What is continuation of pay?

(a) For most employees who sustain a traumatic injury, the FECA provides that the employer must continue the employee's regular pay during any periods of resulting disability, up to a maximum of 45 calendar days. This is called continuation of pay, or COP. The employer, not OWCP, pays COP. Unlike wage loss benefits, COP is subject to taxes and all other payroll deductions that are made from regular income.

(b) The employer must continue the pay of an employee, except for Postal Service employees pursuant to 5 U.S.C. 8117 and as provided below in paragraph (c) of this section, who is eligible for COP, and may not require the employee to use his or her own sick or annual leave, unless the provisions of §10.200(c), §10.220, or §10.222 apply. However, while continuing the employee's pay, the employer may controvert the employee's COP entitlement pending a final determination by OWCP. OWCP has the exclusive authority to

determine questions of entitlement and all other issues relating to COP.

(c) Postal Service employees are not entitled to continuation of pay for the first 3 days of temporary disability and may use annual, sick or leave without pay during that period, except that if the disability exceeds 14 days or is followed by permanent disability, the Postal Service employee may have that leave restored.

(d) The FECA excludes certain persons from eligibility for COP. COP cannot be authorized for members of these excluded groups, which include but are not limited to: persons rendering personal service to the United States similar to the service of a civil officer or employee of the United States, without pay or for nominal pay; volunteers (for instance, in the Civil Air Patrol and Peace Corps); Job Corps and Youth Conservation Corps enrollees; individuals in work- study programs, and grand or petit jurors (unless otherwise Federal employees).

ELIGIBILITY FOR COP

§ 10.205 What conditions must be met to receive COP?

(a) To be eligible for COP, a person must:

(1) Have a ''traumatic injury'' as defined at §10.5(ee) which is job-related and the cause of the disability, and/or the cause of lost time due to the need for medical examination and treatment;

(2) File Form CA–1 within 30 days of the date of the injury (but if that form is not available, using another form would not alone preclude receipt); and

(3) Begin losing time from work due to the traumatic injury within 45 days of the injury.

(b) OWCP may find that the employee is not entitled to COP for other reasons consistent with the statute (see §10.220).

§ 10.206 May an employee who uses leave after an injury later decide to use COP instead?

On Form CA–1, an employee may elect to use accumulated sick or annual leave, or leave advanced by the agency, instead of electing COP. The employee can change the election between leave and COP for prospective periods at any point while eligibility for COP remains. The employee may also change the election for past periods and request COP in lieu of leave already taken for the same period. In either situation, the following provisions apply:

(a) The request must be made to the employer within one year of the date the leave was used or the date of the written approval of the claim by OWCP (if written approval is issued), whichever is later.

(b) Where the employee is otherwise eligible, the agency shall restore leave taken in lieu of any of the 45 COP days. Where any of the 45 COP days remain unused, the agency shall continue pay prospectively.

(c) The use of leave may not be used to delay or extend the 45-day COP period or to otherwise affect the time limitation as provided by 5 U.S.C. 8117. Therefore, any leave used during the period of eligibility counts towards the 45-day maximum entitlement to COP.

§ 10.207 May an employee who returns to work, then stops work again due to the effects of the injury, receive COP?

If the employee recovers from disability and returns to work, then becomes disabled again and stops work, the employer shall pay any of the 45 days of entitlement to COP not used during the initial period of disability where:

(a) The employee completes Form CA–2a and elects to receive regular pay;

(b) OWCP did not deny the original claim for disability;

(c) The disability recurs and the employee stops work within 45 days of the time the employee first returned to work following the initial period of disability; and

(d) Pay has not been continued for the entire 45 days.

RESPONSIBILITIES

§ 10.210 What are the employee's responsibilities in COP cases?

An employee who sustains a traumatic injury which he or she considers disabling, or someone authorized to act on his or her behalf, must take the following actions to ensure continuing

eligibility for COP. The employee must:

(a) Complete and submit Form CA–1 to the employing agency as soon as possible, but no later than 30 days from the date the traumatic injury occurred.

(b) Ensure that medical evidence supporting disability resulting from the claimed traumatic injury, including a statement as to when the employee can return to his or her date of injury job, is provided to the employer within 10 calendar days after filing the claim for COP.

(c) Ensure that relevant medical evidence is submitted to OWCP, and cooperate with OWCP in developing the claim.

(d) Ensure that the treating physician specifies work limitations and provides them to the employer and/or representatives of OWCP.

(e) Provide to the treating physician a description of any specific alternative positions offered the employee, and ensure that the treating physician responds promptly to the employer and/or OWCP, with an opinion as to whether and how soon the employee could perform that or any other specific position.

§ 10.211 What are the employer's responsibilities in COP cases?

Once the employer learns of a traumatic injury sustained by an employee, it shall:

(a) Provide a Form CA–1 and Form CA–16 to authorize medical care in accordance with § 10.300. Failure to do so may mean that OWCP will not uphold any termination of COP by the employer.

(b) Advise the employee of the right to receive COP, and the need to elect among COP, annual or sick leave or leave without pay, for any period of disability.

(c) Inform the employee of any decision to controvert COP and/or terminate pay, and the basis for doing so.

(d) Complete Form CA–1 and transmit it, along with all other available pertinent information, (including the basis for any controversion), to OWCP within 10 working days after receiving the completed form from the employee.

CALCULATION OF COP

§ 10.215 How does OWCP compute the number of days of COP used?

COP is payable for a maximum of 45 calendar days, and every day used is counted toward this maximum. The following rules apply:

(a) Time lost on the day or shift of the injury does not count toward COP. (Instead, the agency must keep the employee in a pay status for that period);

(b) The first COP day is the first day disability begins following the date of injury (providing it is within the 45 days following the date of injury), except where the injury occurs before the beginning of the work day or shift, in which case the date of injury is charged to COP;

(c) Any part of a day or shift (except for the day of the injury) counts as a full day toward the 45 calendar day total;

(d) Regular days off are included if COP has been used on the regular work days immediately preceding or following the regular day(s) off, and medical evidence supports disability; and

(e) Leave used during a period when COP is otherwise payable is counted toward the 45-day COP maximum as if the employee had been in a COP status.

(f) For employees with part-time or intermittent schedules, all calendar days on which medical evidence indicates disability are counted as COP days, regardless of whether the employee was or would have been scheduled to work on those days. The rate at which COP is paid for these employees is calculated according to § 10.216(b).

§ 10.216 How is the pay rate for COP calculated?

The employer shall calculate COP using the period of time and the weekly pay rate.

(a) The pay rate for COP purposes is equal to the employee's regular ''weekly'' pay (the average of the weekly pay over the preceding 52 weeks).

(1) The pay rate excludes overtime pay, but includes other applicable extra pay except to the extent prohibited by law.

(2) Changes in pay or salary (for example, promotion, demotion, within-

grade increases, termination of a temporary detail, *etc.*) which would have otherwise occurred during the 45-day period are to be reflected in the weekly pay determination.

(b) The weekly pay for COP purposes is determined according to the following formulas:

(1) For full or part-time workers (permanent or temporary) who work the same number of hours each week of the year (or of the appointment), the weekly pay rate is the hourly pay rate (A) in effect on the date of injury multiplied by (×) the number of hours worked each week (B): A × B = Weekly Pay Rate.

(2) For part-time workers (permanent or temporary) who do not work the same number of hours each week, but who do work each week of the year (or period of appointment), the weekly pay rate is an average of the weekly earnings, established by dividing (÷) the total earnings (excluding overtime) from the year immediately preceding the injury (A) by the number of weeks (or partial weeks) worked in that year (B): A ÷ B = Weekly Pay Rate.

(3) For intermittent and seasonal workers, whether permanent or temporary, who do not work either the same number of hours or every week of the year (or period of appointment), the weekly pay rate is the average weekly earnings established by dividing (÷) the total earnings during the full 12-month period immediately preceding the date of injury (excluding overtime) (A), by the number of weeks (or partial weeks) worked during that year (B) (that is, A ÷ B); or 150 times the average daily wage earned in the employment during the days employed within the full year immediately preceding the date of injury divided by 52 weeks, whichever is greater.

§ 10.217 Is COP charged if the employee continues to work, but in a different job that pays less?

If the employee cannot perform the duties of his or her regular position, but instead works in another job with different duties with no loss in pay, then COP is not chargeable. COP must be paid and the days counted against the 45 days authorized by law whenever an actual reduction of pay results from the injury, including a reduction of pay for the employee's normal administrative workweek that results from a change or diminution in his or her duties following an injury. However, this does not include a reduction of pay that is due solely to an employer being prohibited by law from paying extra pay to an employee for work he or she does not actually perform.

CONTROVERSION AND TERMINATION OF COP

§ 10.220 When is an employer not required to pay COP?

An employer shall continue the regular pay of an eligible employee without a break in time for up to 45 calendar days, except when, and only when:

(a) The disability was not caused by a traumatic injury;

(b) The employee is not a citizen of the United States or Canada;

(c) No written claim was filed within 30 days from the date of injury;

(d) The injury was not reported until after employment has been terminated;

(e) The injury occurred off the employing agency's premises and was otherwise not within the performance of official duties;

(f) The injury was caused by the employee's willful misconduct, intent to injure or kill himself or herself or another person, or was proximately caused by intoxication by alcohol or illegal drugs; or

(g) Work did not stop until more than 45 days following the injury.

§ 10.221 How is a claim for COP controverted?

When the employer stops an employee's pay for one of the reasons cited in § 10.220, the employer must controvert the claim for COP on Form CA–1, explaining in detail the basis for the refusal. The final determination on entitlement to COP always rests with OWCP.

§ 10.222 When may an employer terminate COP which has already begun?

(a) Where the employer has continued the pay of the employee, it may be stopped only when at least one of the following circumstances is present:

(1) Medical evidence which on its face supports disability due to a work-related injury is not received within 10 calendar days after the claim is submitted (unless the employer's own investigation shows disability to exist). Where the medical evidence is later provided, however, COP shall be reinstated retroactive to the date of termination;

(2) The medical evidence from the treating physician shows that the employee is not disabled from his or her regular position;

(3) Medical evidence from the treating physician shows that the employee is not totally disabled, and the employee refuses a written offer of a suitable alternative position which is approved by the attending physician. If OWCP later determines that the position was not suitable, OWCP will direct the employer to grant the employee COP retroactive to the termination date.

(4) The employee returns to work with no loss of pay;

(5) The employee's period of employment expires or employment is otherwise terminated (as established prior to the date of injury);

(6) OWCP directs the employer to stop COP; and/or

(7) COP has been paid for 45 calendar days.

(b) An employer may not interrupt or stop COP to which the employee is otherwise entitled because of a disciplinary action, unless a preliminary notice was issued to the employee before the date of injury and the action becomes final or otherwise takes effect during the COP period.

(c) An employer cannot otherwise stop COP unless it does so for one of the reasons found in this section or §10.220. Where an employer stops COP, it must file a controversion with OWCP, setting forth the basis on which it terminated COP, no later than the effective date of the termination.

§ 10.223 Are there other circumstances under which OWCP will not authorize payment of COP?

When OWCP finds that an employee or his or her representative refuses or obstructs a medical examination required by OWCP, the right to COP is suspended until the refusal or obstruction ceases. COP already paid or payable for the period of suspension is forfeited. If already paid, the COP may be charged to annual or sick leave or considered an overpayment of pay consistent with 5 U.S.C. 5584.

§ 10.224 What happens if OWCP finds that the employee is not entitled to COP after it has been paid?

Where OWCP finds that the employee is not entitled to COP after it has been paid, the employee may chose to have the time charged to annual or sick leave, or considered an overpayment of pay under 5 U.S.C. 5584. The employer must correct any deficiencies in COP as directed by OWCP.

Subpart D—Medical and Related Benefits

EMERGENCY MEDICAL CARE

§ 10.300 What are the basic rules for authorizing emergency medical care?

(a) When an employee sustains a work-related traumatic injury that requires medical examination, medical treatment, or both, the employer shall authorize such examination and/or treatment by issuing a Form CA–16. This form may be used for occupational disease or illness only if the employer has obtained prior permission from OWCP.

(b) The employer shall issue Form CA–16 within four hours of the claimed injury. If the employer gives verbal authorization for such care, he or she should issue a Form CA–16 within 48 hours. The employer is not required to issue a Form CA–16 more than one week after the occurrence of the claimed injury. The employer may not authorize examination or medical or other treatment in any case that OWCP has disallowed.

(c) Form CA–16 must contain the full name and address of the qualified physician or qualified medical facility authorized to provide service. The authorizing official must sign and date the form and must state his or her title. Form CA–16 authorizes treatment

for 60 days from the date of injury, unless OWCP terminates the authorization sooner.

(d) The employer should advise the employee of the right to his or her initial choice of physician. The employer shall allow the employee to select a qualified physician, after advising him or her of those physicians excluded under subpart I of this part. The physician may be in private practice, including a health maintenance organization (HMO), or employed by a Federal agency such as the Department of the Army, Navy, Air Force, or Veterans Affairs. Any qualified physician may provide initial treatment of a work-related injury in an emergency. See also §10.825(b).

§10.301 May the physician designated on Form CA–16 refer the employee to another medical specialist or medical facility?

The physician designated on Form CA–16 may refer the employee for further examination, testing, or medical care. OWCP will pay this physician or facility's bill on the authority of Form CA–16. The employer should not issue a second Form CA–16.

§10.302 Should the employer authorize medical care if he or she doubts that the injury occurred, or that it is work-related?

If the employer doubts that the injury occurred, or that it is work-related, he or she should authorize medical care by completing Form CA–16 and checking block 6B of the form. If the medical and factual evidence sent to OWCP shows that the condition treated is not work-related, OWCP will notify the employee, the employer, and the physician or hospital that OWCP will not authorize payment for any further treatment.

§10.303 Should the employer use a Form CA–16 to authorize medical testing when an employee is exposed to a workplace hazard just once?

(a) Simple exposure to a workplace hazard, such as an infectious agent, does not constitute a work-related injury entitling an employee to medical treatment under the FECA. The employer therefore should not use a Form CA–16 to authorize medical testing for an employee who has merely been exposed to a workplace hazard, unless the employee has sustained an identifiable injury or medical condition as a result of that exposure. OWCP will authorize preventive treatment only under certain well-defined circumstances (see §10.313).

(b) Employers may be required under other statutes or regulations to provide their employees with medical testing and/or other services in situations described in paragraph (a) of this section. For example, regulations issued by the Occupational Safety and Health Administration at 29 CFR chapter XVII require employers to provide their employees with medical consultations and/or examinations when they either exhibit symptoms consistent with exposure to a workplace hazard, or when an identifiable event such as a spill, leak or explosion occurs and results in the likelihood of exposure to a workplace hazard. In addition, 5 U.S.C. 7901 authorizes employers to establish health programs whose staff can perform tests for workplace hazards, counsel employees for exposure or feared exposure to such hazards, and provide health care screening and other associated services.

§10.304 Are there any exceptions to these procedures for obtaining medical care?

In cases involving emergencies or unusual circumstances, OWCP may authorize treatment in a manner other than as stated in this subpart.

Medical Treatment and Related Issues

§10.310 What are the basic rules for obtaining medical care?

(a) The employee is entitled to receive all medical services, appliances or supplies which a qualified physician prescribes or recommends and which OWCP considers necessary to treat the work-related injury. Billing for these services is described in subpart I of this part. The employee need not be disabled to receive such treatment. If there is any doubt as to whether a specific service, appliance or supply is necessary to treat the work-related injury, the employee should consult

OWCP prior to obtaining it through the automated authorization process described in §10.800. OWCP may also utilize the services of a field nurse to facilitate and coordinate medical care for the employee. OWCP may contract with a specific provider or providers to supply such services or appliances, including durable medical equipment and prescribed medications.

(b) Any qualified physician or qualified hospital may provide such services, appliances and supplies. Non-physician providers such as physicians' assistants, nurse practitioners and physical therapists may also provide authorized services for injured employees to the extent allowed by applicable Federal and State law.

(c) Where OWCP has not contracted for the provision of appliances or supplies, only a supplier of durable medical equipment that is registered in Medicare's Durable Medical Equipment, Prosthetics, Orthotics and Supplies Accreditation process may furnish such appliances and supplies. OWCP may apply a test of cost-effectiveness to appliances and supplies, may offset the cost of prior rental payments against a future purchase price, and may provide refurbished appliances where appropriate.

§ 10.311 What are the special rules for the services of chiropractors?

(a) The services of chiropractors that may be reimbursed are limited by the FECA to treatment to correct a spinal subluxation. The costs of physical and related laboratory tests performed by or required by a chiropractor to diagnose such a subluxation are also payable.

(b) In accordance with 5 U.S.C. 8101(3), a diagnosis of spinal ''subluxation as demonstrated by X-ray to exist'' must appear in the chiropractor's report before OWCP can consider payment of a chiropractor's bill.

(c) A chiropractor may interpret his or her x-rays to the same extent as any other physician. To be given any weight, the medical report must state that x-rays support the finding of spinal subluxation. OWCP will not necessarily require submittal of the x-ray, or a report of the x-ray, but the report must be available for submittal on request.

(d) A chiropractor may also provide services in the nature of physical therapy under the direction of, and as prescribed by, a qualified physician.

§ 10.312 What are the special rules for the services of clinical psychologists?

A clinical psychologist may serve as a physician only within the scope of his or her practice as defined by State law. Therefore, a clinical psychologist may not serve as a physician for conditions that include a physical component unless the applicable State law allows clinical psychologists to treat physical conditions. A clinical psychologist may also perform testing, evaluation and other services under the direction of a qualified physician.

§ 10.313 Will OWCP pay for preventive treatment?

The FECA does not authorize payment for preventive measures such as vaccines and inoculations, and in general, preventive treatment may be a responsibility of the employing agency under the provisions of 5 U.S.C. 7901 (see §10.303). However, OWCP can authorize treatment for the following conditions, even though such treatment is designed, in part, to prevent further injury:

(a) Complications of preventive measures which are provided or sponsored by the agency, such as an adverse reaction to prophylactic immunization.

(b) Actual or probable exposure to a known contaminant due to an injury, thereby requiring disease-specific measures against infection. Examples include the provision of tetanus antitoxin or booster toxoid injections for puncture wounds; administration of rabies vaccine for a bite from a rabid or potentially rabid animal; or appropriate measures where exposure to human immunodeficiency virus (HIV) has occurred.

(c) Conversion of tuberculin reaction from negative to positive following exposure to tuberculosis in the performance of duty. In this situation, the appropriate therapy may be authorized.

(d) Where injury to one eye has resulted in loss of vision, periodic examination of the uninjured eye to detect possible sympathetic involvement of the uninjured eye at an early stage.

§ 10.314 Will OWCP pay for the services of an attendant?

Yes, OWCP will pay for the services of an attendant where the need for such services has been medically documented. In the exercise of the discretion afforded by 5 U.S.C. 8111(a), the Director has determined that, except where attendant service payments were being made prior to January 4, 1999, direct payments to the claimant to cover such services will no longer be made. Rather, the cost of providing attendant services will be paid under section 8103 of the Act, and medical bills for these services will be considered under §10.801, so long as the personal care services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly trained individual, subject to requirements specified by OWCP. By paying for the services under section 8103, OWCP can better determine whether the services provided are necessary, and what type of provider is most qualified to provide adequate care to meet the needs of the injured employee. In addition, a system requiring the personal care provider to submit a bill to OWCP, where the amount billed will be subject to OWCP's fee schedule, will result in greater fiscal accountability.

§ 10.315 Will OWCP pay for transportation to obtain medical treatment?

(a) The employee is entitled to reimbursement of reasonable and necessary expenses, including transportation needed to obtain authorized medical services, appliances or supplies. To determine what is a reasonable distance to travel, OWCP will consider the availability of services, the employee's condition, and the means of transportation. Generally, a roundtrip distance of up to 100 miles is considered a reasonable distance to travel. Travel should be undertaken by the shortest route, and if practical, by public conveyance. If the medical evidence shows that the employee is unable to use these means of transportation, OWCP may authorize travel by taxi or special conveyance.

(b) For non-emergency medical treatment, if roundtrip travel of more than 100 miles is contemplated, or air transportation or overnight accommodations will be needed, the employee must submit a written request to OWCP for prior authorization with information describing the circumstances and necessity for such travel expenses. OWCP will approve the request if it determines that the travel expenses are reasonable and necessary, and are incident to obtaining authorized medical services, appliances or supplies. Requests for travel expenses that are often approved include those resulting from referrals to a specialist for further medical treatment, and those involving air transportation of an employee who lives in a remote geographical area with limited local medical services.

(c) If a claimant disagrees with the decision of OWCP that requested travel expenses are either not reasonable or necessary, or are not incident to obtaining authorized medical services or supplies, he or she may utilize the appeals process described in subpart G of this part.

(d) The standard form designated for medical travel refund requests is Form OWCP–957 and must be used to seek reimbursement under this section. This form can be obtained from OWCP.

§ 10.316 After selecting a treating physician, may an employee choose to be treated by another physician instead?

(a) When the physician originally selected to provide treatment for a work-related injury refers the employee to a specialist for further medical care, the employee need not consult OWCP for approval. In all other instances, however, the employee must submit a written request to OWCP with his or her reasons for desiring a change of physician.

(b) OWCP will approve the request if it determines that the reasons submitted are sufficient. Requests that are often approved include those for transfer of care from a general practitioner

to a physician who specializes in treating conditions like the work-related one, or the need for a new physician when an employee has moved. The employer may not authorize a change of physicians.

DIRECTED MEDICAL EXAMINATIONS

§ 10.320 Can OWCP require an employee to be examined by another physician?

OWCP sometimes needs a second opinion from a medical specialist. The employee must submit to examination by a qualified physician as often and at such times and places as OWCP considers reasonably necessary. The employee may have a qualified physician, paid by him or her, present at such examination. However, the employee is not entitled to have anyone else present at the examination unless there is rationalized medical evidence that establishes that someone else is needed in the room or OWCP decides that exceptional circumstances exist. Where an employee requires an accommodation, such as where a hearing-impaired employee needs an interpreter, the presence of an interpreter will be allowed. Also, OWCP may send a case file for second opinion review where actual examination is not needed, or where the employee is deceased.

§ 10.321 What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?

(a) If one medical opinion holds more probative value, OWCP will base its determination of entitlement on that medical conclusion (see § 10.502). A difference in medical opinion sufficient to be considered a conflict occurs when two reports of virtually equal weight and rationale reach opposing conclusions (see *James P. Roberts*, 31 ECAB 1010 (1980)).

(b) If a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser or consultant, OWCP shall appoint a third physician to make an examination (see § 10.502). This is called a referee or impartial examination. OWCP will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case. The employee is not entitled to have anyone present at the examination unless OWCP decides that exceptional circumstances exist. For example, where a hearing-impaired employee needs an interpreter, the presence of an interpreter would be allowed. Also, a case file may be sent for referee or impartial medical review where there is no need for an actual examination, or where the employee is deceased.

§ 10.322 Who pays for second opinion and referee examinations?

OWCP will pay second opinion and referee medical specialists directly. OWCP will reimburse the employee all necessary and reasonable expenses incident to such an examination, including transportation costs and actual wages lost for the time needed to submit to an examination required by OWCP.

§ 10.323 What are the penalties for failing to report for or obstructing a second opinion or referee examination?

(a) If an employee refuses to submit to or in any way obstructs an examination required by OWCP, including testing such as functional capacity determinations conducted in connection with an OWCP-directed medical examination, his or her right to compensation under the FECA is suspended under 5 U.S.C. 8123(d) until such refusal or obstruction stops. The action of the employee's representative is considered to be the action of the employee for purposes of this section. The employee will forfeit compensation otherwise paid or payable under the FECA for the period of the refusal or obstruction, and any compensation already paid for that period will be declared an overpayment and will be subject to recovery pursuant to 5 U.S.C. 8129.

(b) If the employee does not report for an OWCP-directed examination or in any way obstructs this examination, he or she may provide an explanation to OWCP within 14 days. If this explanation does not establish good cause for the employee's actions, entitlement to compensation will be suspended in accordance with 5 U.S.C. 8123(d). Should the employee subsequently

agree to attend the examination or cease the obstruction (as expressed in writing or by telephone documented on Form CA–110), OWCP will restore any periodic benefits to which the employee is entitled when the employee actually reports for and cooperates with the examination. Payment is retroactive to the date the employee agreed to attend or cease obstruction of the examination.

§ 10.324 May an employer require an employee to undergo a physical examination in connection with a work-related injury?

The employer may have authority independent of the FECA to require the employee to undergo a medical examination to determine whether he or she meets the medical requirements of the position held or can perform the duties of that position. Nothing in the FECA or in this part affects such authority. However, no agency-required examination or related activity shall interfere with the employee's initial choice of physician or the provision of any authorized examination or treatment, including the issuance of Form CA–16.

MEDICAL REPORTS

§ 10.330 What are the requirements for medical reports?

In all cases reported to OWCP, a medical report from the attending physician is required. This report should include:

(a) Dates of examination and treatment;

(b) History given by the employee;

(c) Physical findings;

(d) Results of diagnostic tests;

(e) Diagnosis;

(f) Course of treatment;

(g) A description of any other conditions found but not due to the claimed injury;

(h) The treatment given or recommended for the claimed injury;

(i) The physician's opinion, with medical reasons, as to causal relationship between the diagnosed condition(s) and the factors or conditions of the employment;

(j) The extent of disability affecting the employee's ability to work due to the injury;

(k) The prognosis for recovery; and

(l) All other material findings.

§ 10.331 How and when should the medical report be submitted?

(a) Form CA–16 may be used for the initial medical report; Form CA–20 may be used for the initial report and for subsequent reports; and Form CA–20a may be used where continued compensation is claimed. Use of medical report forms is not required, however. The report may also be made in narrative form on the physician's letterhead stationery. The report should bear the physician's signature or signature stamp. OWCP may require an original signature on the report.

(b) The report shall be submitted directly to OWCP as soon as possible after medical examination or treatment is received, either by the employee or the physician. (See also § 10.210.) The employer may request a copy of the report from OWCP. The employer should use Form CA–17 to obtain interim reports concerning the duty status of an employee with a disabling injury.

§ 10.332 What additional medical information will OWCP require to support continuing payment of benefits?

In all cases of serious injury or disease, especially those requiring hospital treatment or prolonged care, OWCP will request detailed narrative reports from the attending physician at periodic intervals. The physician will be asked to describe continuing medical treatment for the condition accepted by OWCP, a prognosis, a description of work limitations, if any, and the physician's opinion as to the continuing causal relationship between the employee's condition and factors of his or her Federal employment.

§ 10.333 What additional medical information will OWCP require to support a claim for a schedule award?

To support a claim for a schedule award, a medical report must contain accurate measurements of the function of the organ or member, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment* as described in § 10.404. These measurements may include: The

actual degree of loss of active or passive motion or deformity; the amount of atrophy; the decrease, if any, in strength; the disturbance of sensation; pain due to nerve impairment; the diagnosis of the condition; and functional impairment ratings.

MEDICAL BILLS

§ 10.335 How are medical bills submitted?

Usually, medical providers submit bills directly to OWCP or to a bill processing agent designated by OWCP. The rules for submitting and paying bills are stated in subpart I of this part. An employee claiming reimbursement of medical expenses should submit an itemized bill as described in § 10.802.

§ 10.336 What are the time frames for submitting bills?

To be considered for payment, bills must be submitted by the end of the calendar year after the year when the expense was incurred, or by the end of the calendar year after the year when OWCP first accepted the claim as compensable, whichever is later.

§ 10.337 If an employee is only partially reimbursed for a medical expense, must the provider refund the balance of the amount paid to the employee?

(a) The OWCP fee schedule sets maximum limits on the amounts payable for many services (see § 10.805). The employee may be only partially reimbursed for medical expenses because the amount he or she paid to the medical provider for a service exceeds the maximum allowable charge set by the OWCP fee schedule.

(b) If this happens, OWCP shall advise the employee of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider may request reconsideration of the fee determination as set forth in §§ 10.812 and 10.813.

(c) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may make reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

Subpart E—Compensation and Related Benefits

COMPENSATION FOR DISABILITY AND IMPAIRMENT

§ 10.400 What is total disability?

(a) Permanent total disability is presumed to result from the loss of use of both hands, both arms, both feet, or both legs, or the loss of sight of both eyes. 5 U.S.C. 8105(b). However, the presumption of permanent total disability as a result of such loss may be rebutted by evidence to the contrary, such as evidence of continued ability to work and to earn wages despite the loss.

(b) Temporary total disability is defined as the inability to return to the position held at the time of injury or earn equivalent wages, or to perform other gainful employment, due to the work-related injury. Except as presumed under paragraph (a) of this section, an employee's disability status is always considered temporary pending return to work.

§ 10.401 When and how is compensation for total disability paid?

(a) Compensation is payable when an employee starts to lose pay if the injury causes permanent disability or if pay loss continues for more than 14 calendar days. Otherwise, compensation is payable on the fourth day after pay stops pursuant to 5 U.S.C. 8117(a). Compensation may not be paid while an injured employee is in a continuation of pay status or receives pay for leave or, for Postal Service employees, for the first three days of temporary disability as described in 5 U.S.C. 8117(b) and § 10.200(c), except for medical or vocational rehabilitation benefits.

(b) Compensation for total disability is payable at the rate of 66⅔ percent of the pay rate if the employee has no dependents, or 75 percent of the pay rate if the employee has at least one dependent. (''Dependents'' are defined at 5 U.S.C. 8110(a).)

§ 10.402 What is partial disability?

An injured employee who cannot return to the position held at the time of injury (or earn equivalent wages) due to the work-related injury, but who is not totally disabled for all gainful employment, is considered to be partially disabled.

§ 10.403 When and how is compensation for partial disability paid?

(a) 5 U.S.C. 8115 outlines how compensation for partial disability is determined. If the employee has actual earnings which fairly and reasonably represent his or her wage-earning capacity, those earnings will form the basis for payment of compensation for partial disability. (See §§ 10.500 through 10.521 concerning return to work.) If the employee's actual earnings do not fairly and reasonably represent his or her wage-earning capacity, or if the employee has no actual earnings, OWCP uses the factors stated in 5 U.S.C. 8115 to select a position which represents his or her wage-earning capacity, which include the nature of the injury, the degree of physical impairment, the usual employment, the age of the employee, the employee's qualifications for other employment and the availability of suitable employment. However, OWCP will not secure employment for the employee in the position selected for establishing a wage-earning capacity.

(b) Compensation for partial disability is payable as a percentage of the difference between the employee's pay rate for compensation purposes and the employee's wage-earning capacity. The percentage is 66⅔ percent of this difference if the employee has no dependents, or 75 percent of this difference if the employee has at least one dependent.

(c) The formula which OWCP uses to compute the compensation payable for partial disability employs the following terms: Pay rate for compensation purposes, which is defined in § 10.5(s) of this part; current pay rate, which means the salary or wages for the job held at the time of injury at the time of the determination; and earnings, which means the employee's actual earnings, or the salary or pay rate of the position selected by OWCP as representing the employee's wage-earning capacity.

(d) The employee's wage-earning capacity in terms of percentage is computed by dividing the employee's earnings by the current pay rate. The comparison of earnings and ''current'' pay rate for the job held at the time of injury need not be made as of the beginning of partial disability. OWCP may use any convenient date for making the comparison as long as both wage rates are in effect on the date used for comparison.

(e) The employee's wage-earning capacity in terms of dollars is computed by first multiplying the pay rate for compensation purposes by the percentage of wage-earning capacity. The resulting dollar amount is then subtracted from the pay rate for compensation purposes to obtain the employee's loss of wage-earning capacity.

§ 10.404 When and how is compensation for a schedule impairment paid?

Compensation is provided for specified periods of time for the permanent loss or loss of use of certain members, organs and functions of the body. Such loss or loss of use is known as permanent impairment. Compensation for proportionate periods of time is payable for partial loss or loss of use of each member, organ or function. 5 U.S.C. 8107(b)(19). OWCP evaluates the degree of impairment to schedule members, organs and functions as defined in 5 U.S.C. 8107 according to the standards set forth in the specified (by OWCP) edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*.

(a) 5 U.S.C. 8107(c) provides compensation for loss to the following list of schedule members:

Member	Weeks
Arm	312
Leg	288
Hand	244
Foot	205
Eye	160
Thumb	75
First Finger lost	46
Great toe	38
Second finger	30
Third finger	25
Toe other than great toe	16
Fourth finger	15
Hearing, one ear	52

Member	Weeks
Hearing, both ears	200

(b) Pursuant to the authority provided by 5 U.S.C. 8107(c)(22), the Secretary has added the following organs to the compensation schedule for injuries that were sustained on or after September 7, 1974, except that a schedule award for the skin may be paid for injuries on or after September 11, 2001:

Member	Weeks
Breast (one)	52
Kidney (one)	156
Larynx	160
Lung (one)	156
Penis	205
Testicle (one)	52
Tongue	160
Ovary (one)	52
Uterus/cervix and vulva/vagina	205
Skin	205

(c) Compensation for schedule awards is payable at 66⅔ percent of the employee's pay, or 75 percent of the pay when the employee has at least one dependent.

(d) The period of compensation payable under 5 U.S.C. 8107(c) shall be reduced by the period of compensation paid or payable under the schedule for an earlier injury if:

(1) Compensation in both cases is for impairment of the same member or function or different parts of the same member or function, or for disfigurement; and

(2) OWCP finds that compensation payable for the later impairment in whole or in part would duplicate the compensation payable for the pre-existing impairment.

(e) Compensation not to exceed $3,500 may be paid for serious disfigurement of the face, head or neck which is likely to handicap a person in securing or maintaining employment. Under 5 U.S.C. 8107(21), a disfigurement award may be paid concurrently with schedule awards.

§ 10.405 Who is considered a dependent in a claim based on disability or impairment?

(a) Dependents include a wife or husband; an unmarried child under 18 years of age; an unmarried child over 18 who is incapable of self-support; a student, until he or she reaches 23 years of age or completes four years of school beyond the high school level; or a wholly dependent parent.

(b) Augmented compensation payable for an unmarried child, which would otherwise terminate when the child reached the age of 18, may be continued while the child is a student as defined in 5 U.S.C. 8101(17).

§ 10.406 What are the maximum and minimum rates of compensation in disability cases?

(a) Compensation for total or partial disability may not exceed 75 percent of the basic monthly pay of the highest step of grade 15 of the General Schedule. (Basic monthly pay does not include locality adjustments.) However, this limit does not apply to disability sustained in the performance of duty which was due to an assault which occurred during an attempted assassination of a Federal official described under 18 U.S.C. 351(a) or 1751(a).

(b) Compensation for total disability may not be less than 75 percent of the basic monthly pay of the first step of grade 2 of the General Schedule or actual pay, whichever is less. (Basic monthly pay does not include locality adjustments.)

COMPENSATION FOR DEATH

§ 10.410 Who is entitled to compensation in case of death, and what are the rates of compensation payable in death cases?

(a) Pursuant to 5 U.S.C. 8133, benefits may be paid to eligible dependents of an employee whose death results from an injury sustained in the performance of duty. This benefit is separate and distinct from a death gratuity benefit under 5 U.S.C. 8102a and subpart J of this part.

(b) If there is no child entitled to compensation, the employee's surviving spouse will receive compensation equal to 50 percent of the employee's monthly pay until death or remarriage before reaching age 55. Upon remarriage, the surviving spouse will be paid a lump sum equal to 24 times the monthly compensation payment (excluding compensation payable on account of another individual) to which

the surviving spouse was entitled immediately before the remarriage. If remarriage occurs at age 55 or older, the lump-sum payment will not be paid and compensation will continue until death.

(c) If there is a child entitled to compensation, the compensation for the surviving spouse will equal 45 percent of the employee's monthly pay plus 15 percent for each child, but the total percentage may not exceed 75 percent.

(d) If there is a child entitled to compensation and no surviving spouse, compensation for one child will equal 40 percent of the employee's monthly pay. Fifteen percent will be awarded for each additional child, not to exceed 75 percent, the total amount to be shared equally among all children.

(e) If there is no child or surviving spouse entitled to compensation, the parents will receive compensation equal to 25 percent of the employee's monthly pay if one parent was wholly dependent on the employee at the time of death and the other was not dependent to any extent, or 20 percent each if both were wholly dependent on the employee, or a proportionate amount in the discretion of the Director if one or both were partially dependent on the employee. If there is a child or surviving spouse entitled to compensation, the parents will receive so much of the compensation described in the preceding sentence as, when added to the total percentages payable to the surviving spouse and children, will not exceed a total of 75 percent of the employee's monthly pay.

(f) If there is no child, surviving spouse or dependent parent entitled to compensation, the brothers, sisters, grandparents and grandchildren will receive compensation equal to 20 percent of the employee's monthly pay to such dependent if one was wholly dependent on the employee at the time of death; or 30 percent if more than one was wholly dependent, divided among such dependents equally; or 10 percent if no one was wholly dependent but one or more was partly dependent, divided among such dependents equally. If there is a child, surviving spouse or dependent parent entitled to compensation, the brothers, sisters, grandparents and grandchildren will receive so much of the compensation described in the preceding sentence as, when added to the total percentages payable to the children, surviving spouse and dependent parents, will not exceed a total of 75 percent of the employee's monthly pay.

(g) A child, brother, sister or grandchild may be entitled to receive death benefits until death, marriage, or reaching age 18. Regarding entitlement after reaching age 18, refer to § 10.417.

§ 10.411 What are the maximum and minimum rates of compensation in death cases?

(a) Compensation for death may not exceed the employee's pay or 75 percent of the basic monthly pay of the highest step of grade 15 of the General Schedule, except that compensation may exceed the employee's basic monthly pay if such excess is created by authorized cost-of-living increases. (Basic monthly pay does not include locality adjustments.) However, the maximum limit does not apply when the death occurred during an assassination of a Federal official described under 18 U.S.C. 351(a) or 18 U.S.C. 1751(a).

(b) Compensation for death is computed on a minimum pay rate equal to the basic monthly pay of an employee at the first step of grade 2 of the General Schedule. (Basic monthly pay does not include locality adjustments.)

§ 10.412 Will OWCP pay the costs of burial and transportation of the remains?

In a case accepted for death benefits, OWCP will pay up to $800 for funeral and burial expenses. When an employee's home is within the United States and the employee dies outside the United States, or away from home or the official duty station, an additional amount may be paid for transporting the remains to the employee's home as set forth in 5 U.S.C. 8134. An additional amount of $200 is paid to the personal representative of the decedent for reimbursement of the costs of terminating the decedent's status as an employee of the United States in accordance with 5 U.S.C. 8133.

§ 10.413 May a schedule award be paid after an employee's death?

For a schedule award to be paid following the death of an employee, the employee must have filed a valid claim specifically for a schedule award prior to death; in addition, the employee must have died from a cause other than the injury before the end of the period specified in the schedule. The balance of the schedule award may be paid to an employee's survivors pursuant to the proportions and order of precedence described in 5 U.S.C. 8109.

§ 10.414 What reports of dependents are needed in death cases?

If a beneficiary is receiving compensation benefits on account of an employee's death, OWCP will ask him or her to complete a report once each year on Form CA–12. The report requires the beneficiary to note changes in marital status and dependents. If the beneficiary fails to submit the form (or an equivalent written statement) within 30 days of the date of request, OWCP shall suspend compensation until the requested form or equivalent written statement is received. The suspension will include compensation payable for or on behalf of another person (for example, compensation payable to a widow on behalf of a child). When the form or statement is received, compensation will be reinstated at the appropriate rate retroactive to the date of suspension, provided the beneficiary is entitled to such compensation.

§ 10.415 What must a beneficiary do if the number of beneficiaries decreases?

The circumstances under which compensation on account of death shall be terminated are described in 5 U.S.C. 8133(b). A beneficiary in a claim for death benefits should promptly notify OWCP of any event which would affect his or her entitlement to continued compensation. The terms ''marriage'' and ''remarriage'' include common-law marriage as recognized and defined by State law in the State where the beneficiary resides. If a beneficiary, or someone acting on his or her behalf, receives a check or electronic payment which includes payment of compensation for any period after the date when entitlement ended, he or she must promptly return such funds to OWCP.

§ 10.416 How does a change in the number of beneficiaries affect the amount of compensation paid to the other beneficiaries?

If compensation to a beneficiary is terminated, the amount of compensation payable to one or more of the remaining beneficiaries may be reapportioned. Similarly, the birth of a posthumous child may result in a reapportionment of the amount of compensation payable to other beneficiaries. The parent, or someone acting on the child's behalf, shall promptly notify OWCP of the birth and submit a copy of the birth certificate.

§ 10.417 What reports are needed when compensation payments continue for children over age 18?

(a) Compensation payable on behalf of a child, brother, sister, or grandchild, which would otherwise end when the person reaches 18 years of age, shall be continued if and for so long as he or she is not married and is either a student as defined in 5 U.S.C. 8101(17), or physically or mentally incapable of self-support.

(b) At least once each year, OWCP will ask a beneficiary receiving compensation based on the student status of a dependent to provide proof of continuing entitlement to such compensation, including certification of school enrollment. The beneficiary is required to report any changes to student status in the interim.

(c) Likewise, at least once each year unless otherwise provided in paragraph (d) of this section, OWCP will ask a beneficiary or legal guardian receiving compensation based on a dependent's physical or mental inability to support himself or herself to submit a medical report verifying that the dependent's medical condition persists and that it continues to preclude self-support. If there is a change in that condition, the beneficiary or legal guardian is required to immediately report that change to OWCP.

(d) In the case of a dependent incapable of self support due to that dependent's physical or mental disability where the status of that dependent is

unlikely to change, a beneficiary or legal guardian may establish the permanency of that condition by submitting a well rationalized medical report which describes that condition and the ongoing prognosis of that condition. If the permanency of that condition is established by such a report, OWCP will not seek further information regarding that condition; however, if there is a change in that condition, the beneficiary or legal guardian is required to immediately report that change to OWCP.

ADJUSTMENTS TO COMPENSATION

§ 10.420 How are cost-of-living adjustments applied?

(a) In cases of disability, a beneficiary is eligible for cost-of-living adjustments under 5 U.S.C. 8146a where injury-related disability began more than one year prior to the date the cost-of-living adjustment took effect. The employee's use of continuation of pay as provided by 5 U.S.C. 8118, or of sick or annual leave, during any part of the period of disability does not affect the computation of the one-year period.

(b) Where an injury does not result in disability but compensation is payable for permanent impairment of a covered member, organ or function of the body, a beneficiary is eligible for cost-of-living adjustments under 5 U.S.C. 8146a where the award for such impairment began more than one year prior to the date the cost-of-living adjustment took effect.

(c) In cases of recurrence of disability, where the pay rate for compensation purposes is the pay rate at the time disability recurs, a beneficiary is eligible for cost-of-living adjustments under 5 U.S.C. 8146a where the effective date of that pay rate began more than one year prior to the date the cost-of-living adjustment took effect.

(d) In cases of death, entitlement to cost-of-living adjustments under 5 U.S.C. 8146a begins with the first such adjustment occurring more than one year after the date of death. However, if the death was preceded by a period of injury-related disability, compensation payable to the survivors will be increased by the same percentages as the cost-of-living adjustments paid or payable to the deceased employee for the period of disability, as well as by subsequent cost-of-living adjustments to which the survivors would otherwise be entitled.

§ 10.421 May a beneficiary receive other kinds of payments from the Federal Government concurrently with compensation?

(a) 5 U.S.C. 8116(a) provides that a beneficiary may not receive wage-loss compensation concurrently with a Federal retirement or survivor annuity. The beneficiary must elect the benefit that he or she wishes to receive, and the election, once made, is revocable.

(b) An employee may receive compensation concurrently with military retired pay, retirement pay, retainer pay or equivalent pay for service in the Armed Forces or other uniformed services.

(c) An employee may not receive compensation for total disability concurrently with severance pay or separation pay. However, an employee may concurrently receive compensation for partial disability or permanent impairment to a schedule member, organ or function with severance pay or separation pay.

(d) Pursuant to 5 U.S.C. 8116(d), a beneficiary may receive compensation under the FECA for either the death or disability of an employee concurrently with benefits under title II of the Social Security Act on account of the age or death of such employee. However, this provision of the FECA also requires OWCP to reduce the amount of any such compensation by the amount of any Social Security Act benefits that are attributable to the Federal service of the employee.

(e) To determine the employee's entitlement to compensation, OWCP may require an employee to submit an affidavit or statement as to the receipt of any Federally funded or Federally assisted benefits. If an employee fails to submit such affidavit or statement within 30 days of the date of the request, his or her right to compensation shall be suspended until such time as the requested affidavit or statement is received. At that time compensation

will be reinstated retroactive to the date of suspension provided the employee is entitled to such compensation.

§ 10.422 May compensation payments be issued in a lump sum?

(a) In exercise of the discretion afforded under 5 U.S.C. 8135(a), OWCP has determined that lump-sum payments will not be made to persons entitled to wage-loss benefits (that is, those payable under 5 U.S.C. 8105 and 8106). Therefore, when OWCP receives requests for lump-sum payments for wage-loss benefits, OWCP will not exercise further discretion in the matter. This determination is based on several factors, including:

(1) The purpose of the FECA, which is to replace lost wages;

(2) The prudence of providing wage-loss benefits on a regular, recurring basis; and

(3) The high cost of the long-term borrowing that is needed to pay out large lump sums.

(b) However, a lump-sum payment may be made to an employee entitled to a schedule award under 5 U.S.C. 8107 where OWCP determines that such a payment is in the employee's best interest. Lump-sum payments of schedule awards generally will be considered in the employee's best interest only where the employee does not rely upon compensation payments as a substitute for lost wages (that is, the employee is working or is receiving annuity payments). An employee possesses no absolute right to a lump-sum payment of benefits payable under 5 U.S.C. 8107.

(c) Lump-sum payments to surviving spouses are addressed in 5 U.S.C. 8135(b); payments to beneficiaries under 5 U.S.C. 8137 payable as a lump sum pursuant to 5 U.S.C. 8135 are addressed in part 25 of this title.

§ 10.423 May compensation payments be assigned to, or attached by, creditors?

(a) As a general rule, compensation and claims for compensation are exempt from the claims of private creditors. Further, any attempt by a FECA beneficiary to assign his or her claim is null and void. However, pursuant to provisions of the Social Security Act, 42 U.S.C. 659, and regulations issued by the Office of Personnel Management (OPM) at 5 CFR part 581, FECA benefits, including survivor's benefits, may be garnished to collect overdue alimony and child support payments.

(b) Garnishment for child support and alimony may be requested by providing a copy of the State agency or court order to the district office handling the FECA claim.

§ 10.424 May someone other than the beneficiary be designated to receive compensation payments?

A beneficiary may be incapable of managing or directing the management of his or her benefits because of a mental or physical disability, or because of legal incompetence, or because he or she is under 18 years of age. In this situation, absent the appointment of a guardian or other party to manage the financial affairs of the claimant by a court or administrative body authorized to do so, OWCP in its sole discretion may approve a person to serve as the representative payee for funds due the beneficiary. Where a guardian or other party has been appointed by a court or administrative body authorized to do so to manage the financial affairs of the claimant, OWCP will recognize that individual as the representative payee.

§ 10.425 May compensation be claimed for periods of restorable leave?

The employee may claim compensation for periods of annual and sick leave which are restorable in accordance with the rules of the employing agency. Forms CA–7a and CA–7b are used for this purpose. Leave donated to an employee by an employing agency leave bank is not restorable leave.

OVERPAYMENTS

§ 10.430 How does OWCP notify an individual of a payment made?

(a) In addition to providing narrative descriptions to recipients of benefits paid or payable, OWCP includes on each periodic check a clear indication of the period for which payment is being made. A form is sent to the recipient with each supplemental check which states the date and amount of the payment and the period for which

payment is being made. For payments sent by electronic funds transfer (EFT), a notification of the date and amount of payment appears on the statement from the recipient's financial institution.

(b) By these means, OWCP puts the recipient on notice that a payment was made and the amount of the payment. If the amount received differs from the amount indicated on the written notice or bank statement, the recipient is responsible for notifying OWCP of the difference. Absent affirmative evidence to the contrary, the beneficiary will be presumed to have received the notice of payment, whether mailed or transmitted electronically. For EFT payments, OWCP is entitled to presume receipt and acceptance of that payment once a recipient has had an opportunity to receive a statement from their financial institution.

§ 10.431 What does OWCP do when an overpayment is identified?

Before seeking to recover an overpayment or adjust benefits, OWCP will advise the beneficiary in writing that:

(a) The overpayment exists, and the amount of overpayment;

(b) A preliminary finding shows either that the individual was or was not at fault in the creation of the overpayment;

(c) He or she has the right to inspect and copy Government records relating to the overpayment; and

(d) He or she has the right to present evidence which challenges the fact or amount of the overpayment, and/or challenges the preliminary finding that he or she was at fault in the creation of the overpayment. He or she may also request that recovery of the overpayment be waived.

§ 10.432 How can an individual present evidence to OWCP in response to a preliminary notice of an overpayment?

The individual may present this evidence to OWCP in writing or at a prerecoupment hearing. The evidence must be presented or the hearing requested within 30 days of the date of the written notice of overpayment. Failure to request the hearing within this 30-day time period shall constitute a waiver of that right.

§ 10.433 Under what circumstances can OWCP waive recovery of an overpayment?

(a) OWCP may consider waiving an overpayment only if the individual to whom it was made was not at fault in accepting or creating the overpayment. Each recipient of compensation benefits is responsible for taking all reasonable measures to ensure that payments he or she receives from OWCP are proper. The recipient must show good faith and exercise a high degree of care in regard to receipt of their benefits. Such care includes reporting events which may affect entitlement to or the amount of benefits, including reviewing their accounts and related statements (including electronic statements and records from their financial institutions involving EFT payments). A recipient who has done any of the following will be found to be at fault with respect to creating an overpayment:

(1) Made an incorrect statement as to a material fact which he or she knew or should have known to be incorrect; or

(2) Failed to provide information which he or she knew or should have known to be material; or

(3) Accepted a payment which the recipient knew or should have known to be incorrect. (This provision applies only to the overpaid individual.)

(b) Whether or not OWCP determines that an individual was at fault with respect to the creation of an overpayment depends on the circumstances surrounding the overpayment. The degree of care expected may vary with the complexity of those circumstances and the individual's capacity to realize that he or she is being overpaid.

§ 10.434 If OWCP finds that the recipient of an overpayment was not at fault, what criteria are used to decide whether to waive recovery of it?

If OWCP finds that the recipient of an overpayment was not at fault, repayment will still be required unless:

(a) Adjustment or recovery of the overpayment would defeat the purpose of the FECA (see § 10.436), or

(b) Adjustment or recovery of the overpayment would be against equity and good conscience (see § 10.437).

§ 10.435 Is an individual responsible for an overpayment that resulted from an error made by OWCP or another Government agency?

(a) The fact that OWCP may have erred in making the overpayment, or that the overpayment may have resulted from an error by another Government agency, does not by itself relieve the individual who received the overpayment from liability for repayment if the individual also was at fault in accepting the overpayment.

(b) However, OWCP may find that the individual was not at fault if failure to report an event affecting compensation benefits, or acceptance of an incorrect payment, occurred because:

(1) The individual relied on misinformation given in writing by OWCP (or by another Government agency which he or she had reason to believe was connected with the administration of benefits) as to the interpretation of a pertinent provision of the FECA or its regulations; or

(2) OWCP erred in calculating cost-of-living increases, schedule award length and/or percentage of impairment, or loss of wage-earning capacity.

§ 10.436 Under what circumstances would recovery of an overpayment defeat the purpose of the FECA?

Recovery of an overpayment will defeat the purpose of the FECA if such recovery would cause hardship to a currently or formerly entitled beneficiary because:

(a) The beneficiary from whom OWCP seeks recovery needs substantially all of his or her current income (including compensation benefits) to meet current ordinary and necessary living expenses; and

(b) The beneficiary's assets do not exceed a specified amount as determined by OWCP from data furnished by the Bureau of Labor Statistics. A higher amount is specified for a beneficiary with one or more dependents.

§ 10.437 Under what circumstances would recovery of an overpayment be against equity and good conscience?

(a) Recovery of an overpayment is considered to be against equity and good conscience when any individual who received an overpayment would experience severe financial hardship in attempting to repay the debt.

(b) Recovery of an overpayment is also considered to be against equity and good conscience when any individual, in reliance on such payments or on notice that such payments would be made, gives up a valuable right or changes his or her position for the worse. In making such a decision, OWCP does not consider the individual's current ability to repay the overpayment.

(1) To establish that a valuable right has been relinquished, it must be shown that the right was in fact valuable, that it cannot be regained, and that the action was based chiefly or solely in reliance on the payments or on the notice of payment. Donations to charitable causes or gratuitous transfers of funds to other individuals are not considered relinquishments of valuable rights.

(2) To establish that an individual's position has changed for the worse, it must be shown that the decision made would not otherwise have been made but for the receipt of benefits, and that this decision resulted in a loss.

§ 10.438 Can OWCP require the individual who received the overpayment to submit additional financial information?

(a) The individual who received the overpayment is responsible for providing information about income, expenses and assets as specified by OWCP. This information is needed to determine whether or not recovery of an overpayment would defeat the purpose of the FECA, or be against equity and good conscience. This information will also be used to determine the repayment schedule, if necessary.

(b) Failure to submit the requested information within 30 days of the request shall result in denial of waiver, and no further request for waiver shall

be considered until the requested information is furnished.

§ 10.439 What is addressed at a pre-recoupment hearing?

At a pre-recoupment hearing, the OWCP representative will consider all issues in the claim on which a formal decision has been issued. Such a hearing will thus fulfill OWCP's obligation to provide pre-recoupment rights and a hearing under 5 U.S.C. 8124(b). Pre-recoupment hearings shall be conducted in exactly the same manner as provided in § 10.615 through § 10.622.

§ 10.440 How does OWCP communicate its final decision concerning recovery of an overpayment, and what appeal right accompanies it?

(a) OWCP will send a copy of the final decision to the individual from whom recovery is sought; his or her representative, if any; and the employing agency.

(b) The only review of a final decision concerning an overpayment is to the Employees' Compensation Appeals Board. The provisions of 5 U.S.C. 8124(b) (concerning hearings) and 5 U.S.C. 8128(a) (concerning reconsiderations) do not apply to such a decision. The pendency of an appeal with ECAB has no effect on the finality of the order being appealed; in the event ECAB reverses the final overpayment decision, any monies collected will be restored to the beneficiary.

§ 10.441 How are overpayments collected?

(a) When an overpayment has been made to an individual who is entitled to further payments, the individual shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. If no refund is made, OWCP shall decrease later payments of compensation, taking into account the probable extent of future payments, the rate of compensation, the financial circumstances of the individual, and any other relevant factors, so as to minimize any hardship. Should the individual die before collection has been completed, collection shall be made by decreasing later payments, if any, payable under the FECA with respect to the individual's death. If no further benefits are payable with respect to the individual's death, OWCP may also file a claim with the estate of the individual or seek repayment of the overpayment through other means including referral of the debt to the Treasury Department.

(b) When an overpayment has been made to an individual who is not entitled to further payments, the individual shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. The overpayment is subject to the provisions of the Federal Claims Collection Act of 1966 (as amended) and may be reported to the Internal Revenue Service as income. If the individual fails to make such refund, OWCP may recover the same through any available means, including offset of salary, annuity benefits, or other Federal payments, including tax refunds as authorized by the Tax Refund Offset Program, or referral of the debt to a collection agency or to the Department of Justice.

Subpart F—Continuing Benefits

RULES AND EVIDENCE

§ 10.500 What are the basic rules governing continuing receipt of compensation benefits and return to work?

(a) Benefits are available only while the effects of a work-related condition continue. Compensation for wage loss due to disability is available only for any periods during which an employee's work-related medical condition prevents him or her from earning the wages earned before the work-related injury. For example, an employee is not entitled to compensation for any wage-loss claimed on a CA–7 to the extent that evidence contemporaneous with the period claimed on a CA–7 establishes that an employee had medical work restrictions in place; that light duty within those work restrictions was available; and that the employee was previously notified in writing that such duty was available. Similarly, an employee receiving continuing periodic payments for disability was not prevented from earning

the wages earned before the work-related injury if the evidence establishes that the employing agency had offered, in accordance with OWCP procedures, a temporary light duty assignment within the employee's work restrictions. (The penalty provision of 5 U.S.C. 8106(c)(2) will not be imposed on such assignments under this paragraph.)

(b) Each disabled employee is obligated to perform such work as he or she can. OWCP's goal is to return each disabled employee to work as soon as he or she is medically able. In determining what work qualifies under 5 U.S.C. 8115 for determining the wage-earning capacity for a particular disabled employee, OWCP considers all relevant factors, including the employee's current physical limitations, whether the work is available within the employee's demonstrated commuting area and the employee's qualifications to perform such work.

(c) A disabled employee who refuses to seek or accept suitable employment within the meaning of 5 U.S.C. 8106(c)(2) is not entitled to compensation.

(d) Payment of medical benefits is available for all treatment necessary due to a work-related medical condition.

§ 10.501 What medical evidence is necessary to support continuing receipt of compensation benefits?

(a) The employee is responsible for providing sufficient medical evidence to justify payment of any compensation sought.

(1) To support payment of continuing compensation where an employee has been found entitled to periodic benefits, narrative medical evidence must be submitted whenever OWCP requests it but ordinarily not less than once a year and with any filing of a form CA–1032. It must contain a physician's rationalized opinion as to whether the specific period of alleged disability is causally related to the employee's accepted injury or illness.

(2) For those employees with more serious conditions not likely to improve and for employees over the age of 65, OWCP may require less frequent documentation, but ordinarily not less than once every three years.

(3) The physician's opinion must be based on the facts of the case and the complete medical background of the employee, must be one of reasonable medical certainty and must include objective findings in support of its conclusions. Subjective complaints of pain are not sufficient, in and of themselves, to support payment of continuing compensation. Likewise, medical limitations based solely on the fear of a possible future injury are also not sufficient to support payment of continuing compensation. See §10.330 for a fuller discussion of medical evidence.

(b) OWCP may require any kind of non-invasive testing to determine the employee's functional capacity. Failure to undergo such testing will result in a suspension of benefits. In addition, OWCP may direct the employee to undergo a second opinion or referee examination in any case it deems appropriate (see §§10.320 and 10.321).

§ 10.502 How does OWCP evaluate evidence in support of continuing receipt of compensation benefits?

In considering the medical and factual evidence, OWCP will weigh the probative value of the attending physician's report, any second opinion physician's report, any other medical reports, or any other evidence in the file. If OWCP determines that the medical evidence supporting one conclusion is more consistent, logical, and well-reasoned than evidence supporting a contrary conclusion, OWCP will use the conclusion that is supported by the weight of the medical evidence as the basis for awarding or denying further benefits. If medical reports that are equally well-reasoned support inconsistent determinations of an issue under consideration, OWCP will direct the employee to undergo a third, impartial referee examination to resolve the issue, which will be given special weight in determining the issue.

§ 10.503 Under what circumstances may OWCP reduce or terminate compensation benefits?

Once OWCP has advised the employee that it has accepted a claim and has either approved continuation of pay or paid medical benefits or compensation,

benefits will not be terminated or reduced unless the weight of the evidence establishes that:

(a) The disability for which compensation was paid has ceased;

(b) The disabling condition is no longer causally related to the employment;

(c) The employee is only partially disabled;

(d) The employee has returned to work;

(e) The beneficiary was convicted of fraud in connection with a claim under the FECA, or the beneficiary was incarcerated based on any felony conviction; or

(f) OWCP's initial decision was in error.

RETURN TO WORK—EMPLOYER'S RESPONSIBILITIES

§ 10.505 What actions must the employer take?

Upon authorizing medical care, the employer should advise the employee in writing as soon as possible of his or her obligation to return to work under § 10.210 and as defined in this subpart. The term ''return to work'' as used in this subpart is not limited to returning to work at the employee's normal worksite or usual position, but may include returning to work at other locations and in other positions. In general, the employer should make all reasonable efforts to place the employee in his or her former or an equivalent position, in accordance with 5 U.S.C. 8151(b)(2), if the employee has fully recovered after one year. The Office of Personnel Management (not OWCP) administers this provision.

(a) Where the employer has specific alternative positions available for partially disabled employees, the employer should advise the employee in writing of the specific duties and physical requirements of those positions.

(b) Where the employer has no specific alternative positions available for an employee who can perform restricted or limited duties, the employer should advise the employee of any accommodations the agency can make to accommodate the employee's limitations due to the injury.

§ 10.506 May the employer monitor the employee's medical care?

The employer may monitor the employee's medical progress and duty status by obtaining periodic medical reports. Form CA–17 is usually adequate for this purpose. To aid in returning an injured employee to suitable employment, the employer may also contact the employee's physician in writing concerning the work limitations imposed by the effects of the injury and possible job assignments. (However, the employer shall not contact the physician by telephone or through personal visit.) When such contact is made, the employer shall send a copy of any such correspondence to OWCP and the employee, as well as a copy of the physician's response when received. The employer may also contact the employee at reasonable intervals to request periodic medical reports addressing his or her ability to return to work.

§ 10.507 How should the employer make an offer of suitable work?

Where the attending physician or OWCP notifies the employer in writing that the employee is partially disabled (that is, the employee can perform some work but not return to the position held at date of injury), the employer should act as follows:

(a) If the employee can perform in a specific alternative position available in the agency, and the employer has advised the employee in writing of the specific duties and physical requirements, the employer shall notify the employee in writing immediately of the date of availability.

(b) If the employee can perform restricted or limited duties, the employer should determine whether such duties are available or whether an existing job can be modified. If so, the employer shall advise the employee in writing of the duties, their physical requirements and availability.

(c) The employer must make any job offer in writing. However, the employer may make a job offer verbally as long as it provides the job offer to the employee in writing within two business days of the verbal job offer.

(d) The offer must include a description of the duties of the position, the physical requirements of those duties,

and the date by which the employee is either to return to work or notify the employer of his or her decision to accept or refuse the job offer. The employer must send a complete copy of any job offer to OWCP when it is sent to the employee.

§ 10.508 May relocation expenses be paid for an employee who would need to move to accept an offer of reemployment?

If possible, the employer should offer suitable reemployment in the location where the employee currently resides. If this is not practical, the employer may offer suitable reemployment at the employee's former duty station or other location. Where the distance between the location of the offered job and the location where the employee currently resides is at least 50 miles, OWCP may pay such relocation expenses as are considered reasonable and necessary if the employee has been terminated from the agency's employment rolls and would incur relocation expenses by accepting the offered reemployment. OWCP may also pay such relocation expenses when the new employer is other than a Federal employer. OWCP will notify the employee that relocation expenses are payable if it makes a finding that the job is suitable. To determine whether a relocation expense is reasonable and necessary, OWCP shall use as a guide the Federal travel regulations for permanent changes of duty station.

§ 10.509 If an employee's light duty job is eliminated due to downsizing, what is the effect on compensation?

In general, an employee will not be considered to have experienced a compensable recurrence of disability as defined in §10.5(x) merely because his or her employer has eliminated the employee's light-duty position in a reduction-in-force or some other form of downsizing. When this occurs, OWCP will determine the employee's wage-earning capacity based on his or her actual earnings in such light-duty position if this determination is appropriate on the basis that such earnings fairly and reasonably represent the employee's wage-earning capacity and such a determination has not already been made and the employing agency has stated, in writing, that no other employment is available.

§ 10.510 When may a light duty job form the basis of a loss of wage-earning capacity determination?

A light-duty position that fairly and reasonably represents an employee's ability to earn wages may form the basis of a loss of wage-earning capacity determination if that light duty position is a classified position to which the injured employee has been formally reassigned. The position must conform to the established physical limitations of the injured employee; the employer must have a written position description outlining the duties and physical requirements; and the position must correlate to the type of appointment held by the injured employee at the time of injury. If these circumstances are present, a determination may be made that the position constitutes ''regular'' Federal employment. In the absence of a ''light-duty position'' as described in this paragraph, OWCP will assume that the employee was instead engaged in non-competitive, makeshift or odd lot employment which does not represent the employee's wage-earning capacity, *i.e.,* work of the type provided to injured employees who cannot otherwise be employed by the Federal Government or in any well-known branch of the general labor market.

§ 10.511 How may a loss of wage-earning capacity determination be modified?

If OWCP issues a formal loss of wage-earning capacity determination, including a finding of no loss of wage-earning capacity, that determination and rate of compensation, if applicable, remains in place until that determination is modified by OWCP. Modification of such a determination is only warranted where the party seeking the modification establishes either that there is a material change in the nature and extent of the injury-related condition, the employee has been retrained or otherwise vocationally rehabilitated, or the original determination was erroneous. However, OWCP is not precluded from adjudicating a limited period of disability following the

issuance of a loss of wage-earning capacity decision, such as where an employee has a demonstrated need for surgery.

RETURN TO WORK—EMPLOYEE'S RESPONSIBILITIES

§ 10.515 What actions must the employee take with respect to returning to work?

(a) If an employee can resume regular Federal employment, he or she must do so. No further compensation for wage loss is payable once the employee has recovered from the work-related injury to the extent that he or she can perform the duties of the position held at the time of injury, or earn equivalent wages.

(b) If an employee cannot return to the job held at the time of injury due to partial disability from the effects of the work-related injury, but has recovered enough to perform some type of work, he or she must seek work. In the alternative, the employee must accept suitable work offered to him or her. This work may be with the original employer or through job placement efforts made by or on behalf of OWCP.

(c) If the employer has advised an employee in writing that specific alternative positions exist within the agency, the employee shall provide the description and physical requirements of such alternate positions to the attending physician and ask whether and when he or she will be able to perform such duties.

(d) If the employer has advised an employee that it is willing to accommodate his or her work limitations, the employee shall so advise the attending physician and ask him or her to specify the limitations imposed by the injury. The employee is responsible for advising the employer immediately of these limitations.

(e) From time to time, OWCP may require the employee to report his or her efforts to obtain suitable employment, whether with the Federal Government, State and local Governments, or in the private sector.

§ 10.516 How will an employee know if OWCP considers a job to be suitable?

OWCP shall advise the employee that it has found the offered work to be suitable and afford the employee 30 days to accept the job or present any reasons to counter OWCP's finding of suitability. If the employee presents such reasons, and OWCP determines that the reasons are unacceptable, it will notify the employee of that determination and that he or she has 15 days in which to accept the offered work without penalty. At that point in time, OWCP's notification need not state the reasons for finding that the employee's reasons are not acceptable.

§ 10.517 What are the penalties for refusing to accept a suitable job offer?

(a) 5 U.S.C. 8106(c) provides that a partially disabled employee who refuses to seek suitable work, or refuses to or neglects to work after suitable work is offered to or arranged for him or her, is not entitled to compensation. An employee who refuses or neglects to work after suitable work has been offered or secured for him or her has the burden to show that this refusal or failure to work was reasonable or justified.

(b) After providing the two notices described in § 10.516, OWCP will terminate the employee's entitlement to further compensation under 5 U.S.C. 8105, 8106, and 8107 on all claims where the injury occurred prior to the termination decision, as provided by 5 U.S.C. 8106(c)(2). However, the employee remains entitled to medical benefits as provided by 5 U.S.C. 8103.

§ 10.518 Does OWCP provide services to help employees return to work?

OWCP may, in its discretion, provide vocational rehabilitation services as authorized by 5 U.S.C. 8104. Vocational rehabilitation services may include vocational evaluation, testing, training, and placement services with either the original employer or a new employer, when the injured employee cannot return to the job held at the time of injury. These services also include functional capacity evaluations, which help

to tailor individual rehabilitation programs to employees' physical reconditioning and behavioral modification needs, and help employees to meet the demands of current or potential jobs.

§ 10.519 What action will OWCP take if an employee refuses to undergo vocational rehabilitation?

Under 5 U.S.C. 8104(a), OWCP may direct a permanently disabled employee to undergo vocational rehabilitation. To ensure that vocational rehabilitation services are available to all who might be entitled to benefit from them, an injured employee who has a loss of wage-earning capacity shall be presumed to be ''permanently disabled,'' for purposes of this section only, unless and until the employee proves that the disability is not permanent. If an employee without good cause fails or refuses to apply for, undergo, participate in, or continue to participate in a vocational rehabilitation effort when so directed, OWCP will act as follows:

(a) Where a suitable job has been identified, OWCP will reduce the employee's future monetary compensation based on the amount which would likely have been his or her wage-earning capacity had he or she undergone vocational rehabilitation. OWCP will determine this amount in accordance with the job identified through the vocational rehabilitation planning process, which includes meetings with the OWCP nurse and the employer. The reduction will remain in effect until such time as the employee acts in good faith to comply with the direction of OWCP.

(b) Where a suitable job has not been identified, because the failure or refusal occurred in the early but necessary stages of a vocational rehabilitation effort (that is, interviews, testing, counseling, functional capacity evaluations, and work evaluations), OWCP cannot determine what would have been the employee's wage-earning capacity.

(c) Under the circumstances identified in paragraph (b) of this section, in the absence of evidence to the contrary, OWCP will assume that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity, and OWCP will reduce the employee's monetary compensation accordingly (that is, to zero). This reduction will remain in effect until such time as the employee acts in good faith to comply with the direction of OWCP.

§ 10.520 How does OWCP determine compensation after an employee completes a vocational rehabilitation program?

After completion of a vocational rehabilitation program, OWCP may adjust compensation to reflect the injured worker's wage-earning capacity. Actual earnings will be used if they fairly and reasonably reflect the earning capacity. The position determined to be the goal of a training plan is assumed to represent the employee's earning capacity if it is suitable and performed in sufficient numbers so as to be reasonably available, whether or not the employee is placed in such a position.

§ 10.521 If an employee elects to receive retirement benefits instead of FECA benefits, what effect may such an election have on that employee's entitlement to FECA compensation?

Where an employee is undergoing vocational rehabilitation, or where OWCP is attempting to otherwise place that employee in a suitable job, and that employee elects to receive retirement benefits from the Office of Personnel Management instead of benefits under the FECA, the OWCP may proceed with a loss of wage-earning capacity determination which may reduce FECA entitlement as long as the determination is based on the evidence of record at the time of such election.

Reports of Earnings From Employment and Self-Employment

§ 10.525 What information must the employee report?

(a) An employee who is receiving compensation for partial or total disability must advise OWCP immediately of any return to work, either part-time or full-time. An employee must report all outside employment, including any concurrent dissimilar employment held at the time of injury, even if the injury did not result in any lost time in that position. In addition, an employee who

is receiving compensation for partial or total disability will periodically be required to submit a report of earnings from employment or self-employment, either part-time or full-time. (See §10.5(g) for a definition of ''earnings.'')

(b) The employee must report even those earnings which do not seem likely to affect his or her level of benefits. Many kinds of income, though not all, will result in reduction of compensation benefits. While earning income will not necessarily result in a reduction of compensation, failure to report income may result in forfeiture of all benefits paid during the reporting period.

§10.526 Must the employee report volunteer activities?

An employee who is receiving compensation for partial or total disability is periodically required to report volunteer activity or any other kind of activity which shows that the employee is no longer totally disabled for work. The fact that the employee did not receive any salary for this work is not a basis for failing to report this activity; instead the employee must report the cost if any to have someone else do the work or activity.

§10.527 Does OWCP verify reports of earnings?

To make proper determinations of an employee's entitlement to benefits, OWCP may verify the earnings reported by the employee through a variety of means, including but not limited to computer matches with the Office of Personnel Management and inquiries to the Social Security Administration. Also, OWCP may perform computer matches with records of State agencies, including but not limited to workers' compensation administrations, to determine whether private employers are paying workers' compensation insurance premiums for recipients of benefits under the FECA.

§10.528 What action will OWCP take if the employee fails to file a report of activity indicating an ability to work?

OWCP periodically requires each employee who is receiving compensation benefits to complete an affidavit as to any work, or activity indicating an ability to work, which the employee has performed for the prior 15 months. If an employee who is required to file such a report fails to do so within 30 days of the date of the request, his or her right to compensation for wage loss under 5 U.S.C. 8105 or 8106 is suspended until OWCP receives the requested report. At that time, OWCP will reinstate compensation retroactive to the date of suspension if the employee remains entitled to compensation.

§10.529 What action will OWCP take if the employee files an incomplete report?

(a) If an employee knowingly omits or understates any earnings or work activity in making a report, he or she shall forfeit the right to compensation with respect to any period for which the report was required. A false or evasive statement, omission, concealment, or misrepresentation with respect to employment activity or earnings in a report may also subject an employee to criminal prosecution.

(b) Where the right to compensation is forfeited, OWCP shall recover any compensation already paid for the period of forfeiture pursuant to 5 U.S.C. 8129 and other relevant statutes.

Reports of Dependents

§10.535 How are dependents defined, and what information must the employee report?

(a) Dependents in disability cases are defined in §10.405. While the employee has one or more dependents, the employee's basic compensation for wage loss or for permanent impairment shall be augmented as provided in 5 U.S.C. 8110. (The rules for death claims are found in §10.414.)

(b) An employee who is receiving augmented compensation on account of dependents must advise OWCP immediately of any change in the number or status of dependents. The employee should also promptly refund to OWCP any amounts received on account of augmented compensation after the right to receive augmented compensation has ceased. Any difference between actual entitlement and the amount already paid beyond the date entitlement ended is an overpayment

of compensation and may be recovered pursuant to 5 U.S.C. 8129 and other relevant statutes.

(c) An employee who is receiving augmented compensation shall be periodically required to submit a statement as to any dependents, or to submit supporting documents such as birth or marriage certificates or court orders, to determine if he or she is still entitled to augmented compensation.

§ 10.536 What is the penalty for failing to submit a report of dependents?

If an employee fails to submit a requested statement or supporting document within 30 days of the date of the request, OWCP will suspend his or her right to augmented compensation until OWCP receives the requested statement or supporting document. At that time, OWCP will reinstate augmented compensation retroactive to the date of suspension, provided that the employee is entitled to receive augmented compensation.

§ 10.537 What reports are needed when compensation payments continue for children over age 18?

(a) Compensation payable on behalf of a child that would otherwise end when the child reaches 18 years of age will continue if and for so long as he or she is not married and is either a student as defined in 5 U.S.C. 8101(17), or physically or mentally incapable of self-support.

(b) At least once each year, OWCP will ask an employee who receives compensation based on the student status of a child to provide proof of continuing entitlement to such compensation, including certification of school enrollment. The employee is required to report any changes to student status in the interim as soon as they occur.

(c) Likewise, at least once each year, OWCP will ask an employee who receives compensation based on a child's physical or mental inability to support himself or herself, and who is not covered by §10.417(d) of this part, to submit a medical report verifying that the child's medical condition persists and that it continues to preclude self- support. The employee is required to report any changes to that status in the interim.

(d) If an employee fails to submit proof within 30 days of the date of the request, OWCP will suspend the employee's right to compensation until the requested information is received. At that time OWCP will reinstate compensation retroactive to the date of suspension, provided the employee is entitled to such compensation.

Reduction and Termination of Compensation

§ 10.540 When and how is compensation reduced or terminated?

(a) Except as provided in paragraphs (c), (d), and (e) of this section, where the evidence establishes that compensation should be either reduced or terminated, OWCP will provide the beneficiary with written notice of the proposed action and give him or her 30 days to submit relevant evidence or argument to support entitlement to continued payment of compensation.

(b) Notice provided under this section will include a description of the reasons for the proposed action and a copy of the specific evidence upon which OWCP is basing its determination. Payment of compensation will continue until any evidence or argument submitted has been reviewed and an appropriate decision has been issued, or until 30 days have elapsed if no additional evidence or argument is submitted.

(c) OWCP will not provide such written notice when the beneficiary has no reasonable basis to expect that payment of compensation will continue. For example, when a claim has been made for a specific period of time and that specific period expires, no written notice will be given.

(d) Written notice will also not be given when a beneficiary dies, when OWCP either reduces or terminates compensation upon an employee's return to work, when OWCP terminates only medical benefits after a physician indicates that further medical treatment is not necessary or has ended, or when OWCP denies payment for a particular medical expense.

(e) OWCP will also not provide such written notice when compensation is terminated, suspended or forfeited due to one of the following: A beneficiary's

conviction for fraud in connection with a claim under the FECA; a beneficiary's incarceration based on any felony conviction; an employee's failure to report earnings from employment or self-employment; an employee's failure or refusal to either continue performing suitable work or to accept an offer of suitable work; or an employee's refusal to undergo or obstruction of a directed medical examination or treatment for substance abuse.

§ 10.541 What action will OWCP take after issuing written notice of its intention to reduce or terminate compensation?

(a) If the beneficiary submits evidence or argument prior to the issuance of the decision, OWCP will evaluate it in light of the proposed action and undertake such further development as it may deem appropriate, if any. Evidence or argument which is repetitious, cumulative, or irrelevant will not require any further development. If the beneficiary does not respond within 30 days of the written notice, OWCP will issue a decision consistent with its prior notice. OWCP will not grant any request for an extension of this 30-day period.

(b) Evidence or argument which refutes the evidence upon which the proposed action was based will result in the continued payment of compensation. If the beneficiary submits evidence or argument which fails to refute the evidence upon which the proposed action was based but which requires further development, OWCP will not provide the beneficiary with another notice of its proposed action upon completion of such development. Once any further development of the evidence is completed, OWCP will either continue payment or issue a decision consistent with its prior notice.

Subpart G—Appeals Process

§ 10.600 How can final decisions of OWCP be reviewed?

There are three methods for reviewing a formal decision of the OWCP (§§ 10.125 through 10.127 discuss how decisions are made). These methods are: reconsideration by the district office; a hearing before an OWCP hearing representative; and appeal to the Employees' Compensation Appeals Board (ECAB). For each method there are time limitations and other restrictions which may apply, and not all options are available for all decisions, so the employee should consult the requirements set forth below. Further rules governing appeals to the ECAB are found at part 501 of this title.

RECONSIDERATIONS AND REVIEWS BY THE DIRECTOR

§ 10.605 What is reconsideration?

The FECA provides that the Director may review an award for or against compensation upon application by an employee (or his or her representative) who receives an adverse decision. The employee shall exercise this right through a request to the district office. The request, along with the supporting statements and evidence, is called the ''application for reconsideration.''

§ 10.606 How does a claimant request reconsideration?

(a) An employee (or representative) seeking reconsideration should send the application for reconsideration to the address as instructed by OWCP in the final decision.

(b) The application for reconsideration, including all supporting documents, must:

(1) Be submitted in writing;

(2) Be signed and dated by the claimant or the authorized representative; and

(3) Set forth arguments and contain evidence that either:

(i) Shows that OWCP erroneously applied or interpreted a specific point of law;

(ii) Advances a relevant legal argument not previously considered by OWCP; or

(iii) Constitutes relevant and pertinent new evidence not previously considered by OWCP.

§ 10.607 What is the time limit for requesting reconsideration?

(a) An application for reconsideration must be received by OWCP within one year of the date of the OWCP decision for which review is sought.

(b) OWCP will consider an untimely application for reconsideration only if the application demonstrates clear evidence of error on the part of OWCP in its most recent merit decision. The application must establish, on its face, that such decision was erroneous.

(c) The year in which a claimant has to timely request reconsideration shall not include any period subsequent to an OWCP decision for which the claimant can establish through probative medical evidence that he or she is unable to communicate in any way and that his or her testimony is necessary in order to obtain modification of the decision.

§ 10.608 How does OWCP decide whether to grant or deny the request for reconsideration?

(a) A timely request for reconsideration may be granted if OWCP determines that the employee has presented evidence and/or argument that meets at least one of the standards described in § 10.606(b)(3). If reconsideration is granted, the case is reopened and the case is reviewed on its merits (see § 10.609).

(b) Where the request is timely but fails to meet at least one of the standards described in § 10.606(b)(3), or where the request is untimely and fails to present any clear evidence of error, OWCP will deny the application for reconsideration without reopening the case for a review on the merits. A decision denying an application for reconsideration cannot be the subject of another application for reconsideration. The only review for this type of nonmerit decision is an appeal to the ECAB (see § 10.625), and OWCP will not entertain a request for reconsideration or a hearing on this decision denying reconsideration.

§ 10.609 How does OWCP decide whether new evidence requires modification of the prior decision?

When application for reconsideration is granted, OWCP will review the decision for which reconsideration is sought on the merits and determine whether the new evidence or argument requires modification of the prior decision.

(a) After OWCP decides to grant reconsideration, but before undertaking the review, OWCP will send a copy of the reconsideration application to the employer, which will have 20 days from the date sent to comment or submit relevant documents. OWCP will provide any such comments to the employee, who will have 20 days from the date the comments are sent to him or her within which to comment. If no comments are received from the employer, OWCP will proceed with the merit review of the case. Where a reconsideration request pertains only to a medical issue (such as disability or a schedule award) not requiring comment from the employing agency, the employing agency will be notified that a request for reconsideration has been received, but OWCP is not required to wait 20 days for comment before reaching a determination, except when that claimant is deployed in an area of armed conflict.

(b) A claims examiner who did not participate in making the contested decision will conduct the merit review of the claim. When all evidence has been reviewed, OWCP will issue a new merit decision, based on all the evidence in the record. A copy of the decision will be provided to the agency.

(c) An employee dissatisfied with this new merit decision may again request reconsideration under this subpart or appeal to the ECAB. An employee may not request a hearing on this decision.

§ 10.610 What is a review by the Director?

The FECA specifies that an award for or against payment of compensation may be reviewed at any time on the Director's own motion. Such review may be made without regard to whether there is new evidence or information. If the Director determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director (at any time and on the basis of existing evidence) may modify, rescind, decrease or increase compensation previously awarded, or award compensation previously denied. A review on the Director's own motion is not subject to

a request or petition and none shall be entertained.

(a) The decision whether or not to review an award under this section is solely within the discretion of the Director. The Director's exercise of this discretion is not subject to review by the ECAB, nor can it be the subject of a reconsideration or hearing request.

(b) Where the Director reviews an award on his or her own motion, any resulting decision is subject as appropriate to reconsideration, a hearing and/or appeal to the ECAB. Jurisdiction on review or on appeal to ECAB is limited to a review of the merits of the resulting decision. The Director's determination to review the award is not reviewable.

HEARINGS

§ 10.615 What is a hearing?

A hearing is a review of an adverse decision by a hearing representative. Initially, the claimant can choose between two formats: An oral hearing or a review of the written record. At the discretion of the hearing representative, an oral hearing may be conducted by telephone, teleconference, videoconference or other electronic means. In addition to the evidence of record, the employee may submit new evidence to the hearing representative.

§ 10.616 How does a claimant obtain a hearing?

(a) A claimant, injured on or after July 4, 1966, who has received a final adverse decision by the district office may obtain a hearing by writing to the address specified in the decision. The hearing request must be sent within 30 days (as determined by postmark or other carrier's date marking) of the date of the decision for which a hearing is sought. The claimant must not have previously submitted a reconsideration request (whether or not it was granted) on the same decision.

(b) OWCP will schedule an oral hearing and determine whether the oral hearing will be conducted in person, including whether the in person hearing will be by teleconference, videoconference or other electronic means. The claimant can request a change in the format from a hearing to a review of the written record by making a written request to the Branch of Hearings and Review. OWCP will grant a request received by the Branch of Hearings and Review within 30 days of: the date OWCP acknowledges the initial hearing request, or the date OWCP issues a notice setting a date for an oral hearing, in cases where the initial request was for, or was treated as a request for, an oral hearing. A request received after those dates will be subject to OWCP's discretion. The decision to grant or deny a change of format from a hearing to a review of the written record is not reviewable.

§ 10.617 How is an oral hearing conducted?

(a) The hearing representative retains complete discretion to set the time, place and method of the hearing, including the amount of time allotted for the hearing, considering the issues to be resolved. Any requests for reasonable accommodation by individuals with disabilities should be made through the procedure described in the initial acknowledgement letter.

(b) Unless otherwise directed in writing by the claimant, the hearing representative will mail a notice of the time, place and method of the oral hearing to the claimant and any representative at least 30 days before the scheduled date. The employer will also be mailed a notice at least 30 days before the scheduled date.

(c) The hearing is an informal process, and the hearing representative is not bound by common law or statutory rules of evidence, by technical or formal rules of procedure or by section 5 of the Administrative Procedure Act, but the hearing representative may conduct the hearing in such manner as to best ascertain the rights of the claimant. During the hearing process, the claimant may state his or her arguments and present new written evidence in support of the claim. Hearings are limited to one hour; this limitation may be extended in the discretion of the hearing representative.

(d) Testimony at oral hearings, including those conducted by teleconference, videoconference or other electronic means, is recorded, then transcribed and placed in the record. Oral

testimony shall be made under oath. The transcript of the hearing is the official record of the hearing.

(e) OWCP will furnish a transcript of the oral hearing to the claimant and the employer, who have 20 days from the date it is sent to comment. The employer shall send any comments to OWCP and the claimant, who will have 20 more days from the date of the agency's certificate of service to comment.

(f) The hearing remains open for the submittal of additional evidence until 30 days after the hearing is held, unless the hearing representative, in his or her sole discretion, grants an extension. Only one such extension may be granted. A copy of the decision will be mailed to the claimant's last known address, to any representative, and to the employer.

(g) The hearing representative determines the conduct of the oral hearing and may terminate the hearing at any time he or she determines that all relevant evidence has been obtained, or because of misbehavior on the part of the claimant and/or representative.

(h) Pursuant to 5 U.S.C. 8126, if an individual disobeys or resists a lawful order or process in proceedings under this part, or misbehaves during a hearing or in a manner so as to obstruct the hearing, OWCP may certify the facts to the appropriate U.S. District Court, which may, if the evidence warrants, punish the individual in the same manner and to the same extent as for a contempt committed before the court, or commit the individual on the same conditions as if the forbidden act had occurred with reference to the process of or in the presence of the court.

§ 10.618 How is a review of the written record conducted?

(a) The hearing representative will review the official record and any additional evidence submitted by the claimant and by the agency. The hearing representative may also conduct whatever investigation is deemed necessary. New evidence and arguments are to be submitted at any time up to the time specified by OWCP, but they should be submitted as soon as possible to avoid delaying the hearing process.

(b) The claimant should submit, with his or her application for review, all evidence or argument that he or she wants to present to the hearing representative. If the claimant chooses to change the request from an oral hearing to a review of the written record, the claimant should submit all evidence or argument at that time. A copy of all pertinent material will be sent to the employer, which will have 20 days from the date it is sent to comment. (Medical evidence is not considered ''pertinent'' for review and comment by the agency, and it will therefore not be furnished to the agency. OWCP has sole responsibility for evaluating medical evidence.) The employer shall send any comments to OWCP and the claimant, who will have 20 more days from the date of the agency's certificate of service to comment.

§ 10.619 May subpoenas be issued for witnesses and documents?

A claimant may request a subpoena, but the decision to grant or deny such a request is within the discretion of the hearing representative. The hearing representative may issue subpoenas for the attendance and testimony of witnesses, and for the production of books, records, correspondence, papers or other relevant documents. Subpoenas are issued for documents only if they are relevant and cannot be obtained by other means, and for witnesses only where oral testimony is the best way to ascertain the facts.

(a) A claimant may request a subpoena only as part of the hearings process, and no subpoena will be issued under any other part of the claims process. To request a subpoena, the requestor must:

(1) Submit the request in writing and send it to the hearing representative as early as possible but no later than 60 days (as evidenced by postmark, electronic marker or other objective date mark) after the date of the original hearing request.

(2) Explain in the original request for a subpoena why the testimony or evidence is directly relevant to the issues at hand, and a subpoena is the best method or opportunity to obtain such evidence because there are no other means by which the documents or testimony could have been obtained.

(b) No subpoena will be issued for attendance of employees of OWCP acting in their official capacities as decision-makers or policy administrators. For hearings taking the form of a review of the written record, no subpoena for the appearance of witnesses will be considered.

(c) The hearing representative issues the subpoena under his or her own name. It may be served in person or by certified mail, return receipt requested (or equivalent service from a commercial carrier), addressed to the person to be served at his or her last known principal place of business or residence. A decision to deny a subpoena can only be appealed as part of an appeal of any adverse decision which results from the hearing.

§ 10.620 Who pays the costs associated with subpoenas?

(a) Witnesses who are not employees or former employees of the Federal Government shall be paid the same fees and mileage as paid for like services in the District Court of the United States where the subpoena is returnable, except that expert witnesses shall be paid a fee not to exceed the local customary fee for such services.

(b) Where OWCP asked that the witness submit evidence into the case record or asked that the witness attend, OWCP shall pay the fees and mileage. Where the claimant requested the subpoena, and where the witness submitted evidence into the record at the request of the claimant, the claimant shall pay the fees and mileage.

§ 10.621 What is the employer's role when an oral hearing has been requested?

(a) The employer may send one (or more, if deemed appropriate by the hearing representative) representative(s) to observe the proceeding, but the agency representative cannot give testimony or argument or otherwise participate in the hearing, except where the claimant or the hearing representative specifically asks the agency representative to testify.

(b) The hearing representative may deny a request by the claimant that the agency representative testify where the claimant cannot show that the testimony would be relevant or where the agency representative does not have the appropriate level of knowledge to provide such evidence at the hearing. The employer may also comment on the hearing transcript, as described in § 10.617(e).

§ 10.622 May a claimant or representative withdraw a request for or postpone a hearing?

(a) The claimant and/or representative may withdraw the hearing request at any time up to and including the day the hearing is held, or the decision issued. Withdrawing the hearing request means the record is returned to the jurisdiction of the district office and no further requests for a hearing on the underlying decision will be considered.

(b) OWCP will entertain any reasonable request for scheduling the oral hearing, including whether to participate by teleconference, videoconference or other electronic means, but such requests should be made at the time of the original application for hearing. Scheduling (including format) is at the sole discretion of the hearing representative, and is not reviewable.

(c) Once the oral hearing is scheduled and OWCP has mailed appropriate written notice to the claimant and representative, OWCP will, upon submission of proper written documentation of unavoidable serious scheduling conflicts (such as court-ordered appearances/trials, jury duty or previously scheduled outpatient procedures), entertain requests from a claimant or his representative for rescheduling as long as the hearing can be rescheduled on the same monthly docket, generally no more than 7 days after the originally scheduled time. When a request to postpone a scheduled hearing under this subsection cannot be accommodated on the docket, no further opportunity for an oral hearing will be provided. Instead, the hearing will take the form of a review of the written record and a decision issued accordingly.

(d) Where the claimant or representative is hospitalized for a non-elective reason or where the death of the claimant's or representative's parent,

spouse, child or other immediate family prevents attendance at the hearing, OWCP will, upon submission of proper documentation, grant a postponement beyond one monthly docket.

(e) Decisions regarding rescheduling under paragraphs (b) through (d) of this section are within the sole discretion of the hearing representative and are not reviewable.

(f) A claimant who fails to appear at a scheduled hearing may request in writing within 10 days after the date set for the hearing that another hearing be scheduled. Where good cause for failure to appear is shown, another hearing will be scheduled and conducted by teleconference. The failure of the claimant to request another hearing within 10 days, or the failure of the claimant to appear at the second scheduled hearing without good cause shown, shall constitute abandonment of the request for a hearing. Where good cause is shown for failure to appear at the second scheduled hearing, review of the matter will proceed as a review of the written record.

REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB)

§ 10.625 What kinds of decisions may be appealed?

Only final decisions of OWCP may be appealed to the ECAB. However, certain types of final decisions, described in this part as not subject to further review, cannot be appealed to the ECAB. Decisions that are not appealable to the ECAB include: Decisions concerning the amounts payable for medical services, decisions concerning exclusion and reinstatement of medical providers, decisions by the Director to review an award on his or her own motion, and denials of subpoenas independent of the appeal of the underlying decision. In appeals before the ECAB, attorneys from the Office of the Solicitor of Labor shall represent OWCP.

§ 10.626 Who has jurisdiction of cases on appeal to the ECAB?

While a case is on appeal to the ECAB, OWCP has no jurisdiction over the claim with respect to issues which directly relate to the issue or issues on appeal. The OWCP continues to administer the claim and retains jurisdiction over issues unrelated to the issue or issues on appeal and issues which arise after the appeal as a result of ongoing administration of the case. Such issues would include, for example, the ability to terminate benefits where an individual returns to work while an appeal is pending at the ECAB. ECAB's rules of procedure are found at part 501 of this title.

Subpart H—Special Provisions

REPRESENTATION

§ 10.700 May a claimant designate a representative?

(a) The claims process under the FECA is informal. Unlike many workers' compensation laws, the employer is not a party to the claim, and OWCP acts as an impartial evaluator of the evidence. Nevertheless, a claimant may appoint one individual to represent his or her interests, but the appointment must be in writing.

(b) There can be only one representative at any one time, so after one representative has been properly appointed, OWCP will not recognize another individual as representative until the claimant withdraws the authorization of the first individual. In addition, OWCP will recognize only certain types of individuals (see §10.701); however if the representative is an attorney, OWCP may communicate with any member of that attorney's recognized law firm.

(c) A properly appointed representative who is recognized by OWCP may make a request or give direction to OWCP regarding the claims process, including a hearing. This authority includes presenting or eliciting evidence, making arguments on facts or the law, and obtaining information from the case file, to the same extent as the claimant.

§ 10.701 Who may serve as a representative?

A claimant may authorize any individual to represent him or her in regard to a claim under the FECA, unless that individual's service as a representative would violate any applicable provision of law (such as 18 U.S.C. 205 and

208). A Federal employee may act as a representative only:

(a) On behalf of immediate family members, defined as a spouse, children, parents, and siblings of the representative, provided no fee or gratuity is charged; or

(b) While acting as a union representative, defined as any officially sanctioned union official, and no fee or gratuity is charged.

§ 10.702 How are fees for services paid?

(a) A representative may charge the claimant a fee and other costs associated with the representation before OWCP. The claimant is solely responsible for paying the fee and other charges. The claimant will not be reimbursed by OWCP, nor is OWCP in any way liable for the amount of the fee. Contingency fees are not allowed in any form.

(b) Administrative costs (mailing, copying, messenger services, travel and the like, but not including secretarial services, paralegal and other activities) need not be approved before the representative collects them. Before any fee for services can be collected, however, the fee must be approved by the Secretary.

§ 10.703 How are fee applications approved?

(a) *Fee application.* The representative must submit the fee application to OWCP for services rendered before OWCP. (Representative services before ECAB must be approved by ECAB under 20 CFR part 501.) The application submitted to OWCP shall contain the following:

(1) An itemized statement showing the representative's hourly rate, the number of hours worked and specifically identifying the work performed and a total amount charged for the representation (excluding administrative costs).

(2) A statement of agreement or disagreement with the amount charged, signed by the claimant. The statement must also acknowledge that the claimant is aware that he or she must pay the fees and that OWCP is not responsible for paying the fee or other costs.

(b) *Approval where there is no dispute.* Where a fee application that describes the services rendered in accordance with paragraph (a)(1) of this section is accompanied by a signed statement indicating the claimant's agreement with the fee as described in paragraph (a)(2) of this section, the application is deemed approved except that no contingency fee arrangement may be considered deemed approved through this process.

(c) *Disputed requests.* (1) Where the claimant disagrees with the amount of the fee, as indicated in the statement accompanying the submittal, OWCP will evaluate the objection and decide whether or not to approve the request. OWCP will provide a copy of the request to the claimant and ask him or her to submit any further information in support of the objection within 15 days from the date the request is forwarded. After that period has passed, OWCP will evaluate the information received to determine whether the amount of the fee is substantially in excess of the value of services received by looking at the following factors:

(i) Usefulness of the representative's services;

(ii) The nature and complexity of the claim;

(iii) The actual time spent on development and presentation of the claim; and

(iv) Customary local charges for services for a representative of similar background and experience.

(2) Where the claimant disputes the representative's request and files an objection with OWCP, an appealable decision will be issued.

§ 10.704 What penalties apply to representatives who collect a fee without approval?

Representatives who collect a fee without proper approval from OWCP may be charged with a misdemeanor under 18 U.S.C. 292.

THIRD PARTY LIABILITY

§ 10.705 When must an employee or other FECA beneficiary take action against a third party?

(a) If an injury or death for which benefits are payable under the FECA is

caused, wholly or partially, by someone other than a Federal employee acting within the scope of his or her employment, the claimant can be required to take action against that third party.

(b) The Office of the Solicitor of Labor (SOL) is hereby delegated authority to administer the subrogation aspects of certain FECA claims for OWCP. Either OWCP or SOL can require a FECA beneficiary to assign his or her claim for damages to the United States or to prosecute the claim in his or her own name. All information regarding subrogation claims administered by SOL should be submitted to Chief, Subrogation Unit, U.S. Department of Labor, Office of the Solicitor, 200 Constitution Avenue, NW., Room S4325, Washington, DC 20210.

§ 10.706 How will a beneficiary know if OWCP or SOL has determined that action against a third party is required?

When OWCP determines that an employee or other FECA beneficiary must take action against a third party, it will notify the employee or beneficiary in writing. If the case is transferred to SOL, a second notification may be issued.

§ 10.707 What must a FECA beneficiary who is required to take action against a third party do to satisfy the requirement that the claim be "prosecuted"?

At a minimum, a FECA beneficiary must do the following:

(a) Seek damages for the injury or death from the third party, either through an attorney or on his or her own behalf;

(b) Either initiate a lawsuit within the appropriate statute of limitations period or obtain a written release of this obligation from OWCP or SOL unless recovery is possible through a negotiated settlement prior to filing suit;

(c) Refuse to settle or dismiss the case for any amount less than the amount necessary to repay OWCP's refundable disbursements, as defined in §10.714, without receiving permission from OWCP or SOL;

(d) Provide periodic status updates and other relevant information in response to requests from OWCP or SOL;

(e) Submit detailed information about the amount recovered and the costs of the suit on a ''Statement of Recovery'' form approved by OMB;

(f) Submit information regarding the names of all plaintiffs to the suit or settlement and their relationship to the injured employee, if not the same as the FECA beneficiary;

(g) If any portion of the settlement or judgment was paid to more than one individual, advise whether it was indicated in the settlement or judgment the amount each individual is to receive, and if so, the percentage of the total award;

(h) Advise whether any portion of the settlement or judgment was paid in more than one capacity, such as a joint payment to a husband and wife for personal injury and loss of consortium or a payment to a spouse representing both loss of consortium and wrongful death; and

(i) Pay any required refund.

§ 10.708 Can a FECA beneficiary who refuses to comply with a request to assign a claim to the United States or to prosecute the claim in his or her own name be penalized?

When a FECA beneficiary refuses a request to either assign a claim or prosecute a claim in his or her own name, OWCP may determine that he or she has forfeited his or her right to all past or future compensation for the injury with respect to which the request is made. Alternatively, OWCP may also suspend the FECA beneficiary's compensation payments until he or she complies with the request.

§ 10.709 What happens if a beneficiary directed by OWCP or SOL to take action against a third party does not believe that a claim can be successfully prosecuted at a reasonable cost?

If a beneficiary consults an attorney and is informed that a suit for damages against a third party for the injury or death for which benefits are payable is unlikely to prevail or that the costs of such a suit are not justified by the potential recovery, he or she should request that OWCP or SOL release him or her from the obligation to proceed. This request should be in writing and

provide evidence of the attorney's opinion. If OWCP or SOL agrees, the beneficiary will not be required to take further action against the third party.

§ 10.710 Under what circumstances must a recovery of money or other property in connection with an injury or death for which benefits are payable under the FECA be reported to OWCP or SOL?

Any person who has filed a FECA claim that has been accepted by OWCP (whether or not compensation has been paid), or who has received FECA benefits in connection with a claim filed by another, is required to notify OWCP or SOL of the receipt of money or other property as a result of a settlement or judgment in connection with the circumstances of that claim. This includes an injured employee, and in the case of a claim involving the death of an employee, a spouse, children or other dependents entitled to receive survivor's benefits. OWCP or SOL should be notified in writing within 30 days of the receipt of such money or other property or the acceptance of the FECA claim, whichever occurs later.

§ 10.711 How is the amount of the recovery of the FECA beneficiary determined?

(a) When a FECA beneficiary is entitled to receive money as a result of a judgment entered in a lawsuit or settlement of a lawsuit or any other settlement or recovery from a responsible third party, the entire amount of the award is reported as the gross recovery. To determine the amount of the recovery of the FECA beneficiary, deductions are made for the portion representing damage to real or personal property, the portion representing loss of consortium, the portion representing wrongful death and the portion representing a survival action. To make deductions for loss of consortium, wrongful death and survival action, it must be established that:

(1) These claims were asserted in the suit (or if there was no suit that these claims were included in the settlement or recovery); and

(2) That such claims are permissible under the state law where the action was brought.

(b) OWCP or SOL will determine the appropriate percentage of the total judgment or settlement that will be allocated for loss of consortium, wrongful death action and survival action. FECA beneficiaries may accept OWCP's or SOL's determination or demonstrate good cause in writing for a different allocation. Whether to accept a specific allocation is at the discretion of OWCP or SOL, even where it has been incorporated into the settlement agreement. OWCP or SOL will not determine the appropriate percentage to be allocated for loss of consortium, wrongful death action and survival action if a judge or jury specifies the percentage to be awarded of a contested verdict attributable to each of several plaintiffs; in such case, OWCP or SOL will accept that percentage allocation.

(c) The amount of the recovery of the FECA beneficiary will be determined as followed:

(1) If a settlement or judgment is paid to or for one individual, the recovery is the gross recovery less the portion representing damage to real or personal property. The portion representing damage to real or personal property must be established in writing and approved by OWCP or SOL.

(2) In any case involving an injury to an employee where a judgment or settlement is paid to or on behalf of more than one individual, the recovery is the gross recovery less the portion representing damage to real or personal property and less the portion representing loss of consortium. OWCP or SOL will allocate up to 25% for a spouse and up to 5% for each child not to exceed 15% for all children for loss of consortium.

(3) In any case involving the death of an employee, where both wrongful death and survival actions have been asserted, separate statements of recovery are completed for the deceased employee and the surviving FECA beneficiaries. For the deceased employee, the recovery is the gross recovery less the portion representing damage to real or personal property, less the portion representing loss of consortium, less the portion representing the

wrongful death action. For the surviving spouse and children, the recovery is the gross recovery less the portion representing damage to real or personal property, less the portion representing loss of consortium, less the portion representing the survival action. OWCP or SOL will allocate the total judgment or settlement as follows:

(i) For loss of consortium, OWCP or SOL will allocate up to 15% for a spouse and up to 5% for each child not to exceed 10% for all children;

(ii) For the wrongful death action, OWCP or SOL will allocate 65% of the remainder after subtraction of the amounts attributed to loss of consortium;

(iii) For the survival action, OWCP or SOL will allocate 35% percent of the remainder after subtraction of the amounts attributed to loss of consortium.

(d) In any case involving an injury to an employee where a judgment or settlement is paid to or on behalf of more than one individual and in any case involving the death of an employee, court costs will be attributed using the same percentages as was used for loss of consortium, wrongful death action and survival action. Attorney fees will be determined using the same percentage that was used for the gross recovery. These calculations are used only for the purpose of determining the amount of the refund and if applicable the surplus.

§ 10.712 How much of any settlement or judgment must be paid to the United States?

The statute permits a FECA beneficiary to retain, as a minimum, one-fifth of the net amount of money or property remaining after a reasonable attorney's fee and the costs of litigation have been deducted from the third-party recovery. The United States shares in the attorney fees by allowing the beneficiary to retain, at the time of distribution, an amount equivalent to a reasonable attorney's fee proportionate to the refund due the United States. After the refund owed to the United States is calculated, the FECA beneficiary retains any surplus remaining, and this amount is credited, dollar for dollar, against future compensation including wage-loss compensation, schedule award benefits and medical benefits for the same injury, as defined in § 10.719. OWCP will resume the payment of compensation only after the FECA beneficiary has been awarded compensation which exceeds the amount of the surplus.

(a) The refund to the United States is calculated as follows, using the Statement of Recovery form approved by OMB:

(1) Determine the amount of the recovery of the FECA beneficiary as set forth in § 10.711 as follows:

(i) Set out the gross recovery which is the entire amount of the award;

(ii) Subtract the amount of award representing damage to real or personal property approved by OWCP or SOL (Subtotal A);

(iii) Multiply Subtotal A by the appropriate percentage in § 10.711(c), or if it is a contested verdict by the percentage allocated by the judge or jury, and subtract this amount from Subtotal A (Subtotal B);

(iv) If both a wrongful death action and survival action have been asserted, multiply Subtotal B by 65% to determine the amount allocated to the wrongful death case and multiply Subtotal B by 35% to determine the amount allocated to the survival action, or if it is a contested verdict, by the percentage allocated by the judge or jury. Separate Statements of Recovery must be completed for each cause of action. For the wrongful death action use the result of Subtotal B times 65% for Subtotal C and for the survival action use the result of Subtotal B times 35% for Subtotal C. If both a wrongful death and survival have not been asserted the amount in Subtotal B is used for Subtotal C;

(v) Subtotal C is the amount of recovery of the FECA beneficiary;

(2) Subtract the amount of attorney's fees actually paid, but not more than the maximum amount of attorney's fees considered by OWCP or SOL to be reasonable, from Subtotal C. This is calculated by first determining the attorney fee percentage which is determined by dividing the gross recovery into the amount of attorney's fees actually paid, but the attorney's fee

amount must not be more than the maximum amount of attorney's fees considered to be reasonable by OWCP or SOL and must be approved by OWCP or SOL. Subtotal C is multiplied by the fee percentage and this amount is subtracted from Subtotal C (Subtotal D);

(3) Subtract the costs of litigation, as allowed by OWCP or SOL from Subtotal D (Subtotal E). If loss of consortium and/or wrongful death and survival actions are claimed, the costs of litigation are reduced first by the percentage used for loss of consortium and then by the percentage used for wrongful death or survival action as set forth in § 10.711;

(4) Multiply Subtotal E by 20% and subtract this amount from Subtotal E (Subtotal F);

(5) Compare Subtotal F and the refundable disbursements as defined in § 10.714. Subtotal G is the lower of the two amounts;

(6) Multiply Subtotal G by the percentage used for attorney's fees in paragraph (a)(2), to determine the Government's allowance for attorney's fees, and subtract this amount from Subtotal G. This is the amount of the refund.

(b) The credit against future benefits (also referred to as the surplus) is calculated as follows:

(1) If Subtotal F, as calculated according to paragraph (a)(4) of this section, is less than the refundable disbursements, as defined in § 10.714, there is no credit to be applied against future benefits (but the remainder of the unused disbursements must be applied to any future recovery for the same injury);

(2) If Subtotal F is greater than the refundable disbursements, the credit against future benefits (or surplus) amount is determined by subtracting the refundable disbursements from Subtotal F.

(c) Examples of how these calculations are made follows:

(1) In this example, a Federal employee sues another party for causing injuries for which the employee has received $22,000 in benefits under the FECA, subject to refund. The suit is settled and the injured employee receives $100,000, all of which was for his injury. The injured worker paid attorney's fees of $25,000 and costs for the litigation of $3,000.

(i) Gross Recovery	$100,000.00
(ii) Amount of Property Damage	$0.00
(iii) Subtotal A (Line a minus Line b)	$100,000.00
(iv) Amount Allocated for Loss of Consortium 0% of Line c	$0.00
(v) Subtotal B (Line c minus Line d)	$100,000.00
(vi) Amount Allocated for Wrongful Death 0% of Line e	$0.00
(vii) Amount Allocated for Survival Action 0% of Line e	$0.00
(viii) Subtotal C—If Wrongful Death use Line f, if survival action use Line g, otherwise use Subtotal B	$100,000.00
(ix) Attorney's Fees 25% (Line h × .25)	$25,000.00
(x) Subtotal D (Line h minus Line i)	$75,000.00
(xi) Court costs	$3,000.00
(xii) Subtotal E (Line j minus Line k)	$72,000.00
(xiii) One-fifth of Subtotal E (Line l × .20)	$14,400.00
(xiv) Subtotal F (Line l minus Line m)	$57,600.00
(xv) Refundable Disbursements	$22,000.00
(xvi) Subtotal G (lower of Subtotal F or refundable disbursements)	$22,000.00
(xvii) Government's allowance for attorney's fees (attorney's fees percentage used to determine Subtotal D multiplied by Subtotal G)	$5,500.00
(xviii) Refund to the United States (Line p minus Line q)	$16,500.00
(xix) Credit against future benefits (If Subtotal F greater than refundable disbursements, Line n minus Line o)	$35,600.00

(2) In this example, a Federal employee who is married sues another party for causing injuries as a result of car accident where she was driving her personally owned vehicle on approved travel and the employee received $75,000 in disbursements. The suit includes a claim for loss of consortium which is permitted under the state law

and for damage to her vehicle (documented at $50,000.00). A joint settlement is reached where the injured employee and her spouse receive $250,000 for all their claims. Attorney's fees were $83,325 and there were $25,000 in approved court costs.

(i) Gross Recovery	$250,000.00
(ii) Amount of Property Damage	$50,000.00
(iii) Subtotal A (Line a minus Line b)	$200,000.00
(iv) Amount Allocated for Loss of Consortium (25% of Line c)	$50,000.00
(v) Subtotal B (Line c minus Line d)	$150,000.00
(vi) Amount Allocated for Wrongful Death 0% of Line e	$0.00
(vii) Amount Allocated for Survival Action 0% of Line e	$0.00
(viii) Subtotal C—If Wrongful Death Use Line f, if survival action use Line g, otherwise use Subtotal B	$150,000.00
(ix) Attorney's Fees 33.33% (line h × .3333)	$49,995.00
(x) Subtotal D (Line h minus Line i)	$100,005.00
(xi) Court costs are reduced by the amount allocated for the loss of consortium (in this example, $25,000 − ($25,000 × .25))	$18,750.00
(xii) Subtotal E (line j minus Line k)	$81,255.00
(xiii) One-fifth of Subtotal E (Line l × .20)	$16,251.00
(xiv) Subtotal F (Line l minus Line m)	$65,004.00
(xv) Refundable Disbursements	$75,000.00
(xvi) Subtotal G (lower of Subtotal F or refundable disbursements)	$65,004.00
(xvii) Government's allowance for attorney's fees (attorney's fees percentage used to determine Subtotal D multiplied by subtotal G)	$21,665.83
(xviii) Refund to the United States (Line p minus Line q)	$43,338.17
(xix) Credit against future benefits (If Subtotal F is greater than refundable disbursements, Line n minus Line o)	$0.00

(3) In this example, a Federal employee who is married with two minor children is killed in the performance of duty. A suit for wrongful death and survival is filed which includes claims for loss of consortium all of which is permitted under state law. A joint settlement is reached for all claims and all parties in the amount of $1,000,000. There were court costs of $48,000 and attorney's fees of $300,000. Two Statements of Recovery are completed: One for the wrongful death claim and the other for the survival action. Disbursements in this case were $30,000 for the deceased employee and $100,000 for the surviving spouse and children.

(i) For the wrongful death claim the calculation is as follows:

(A) Gross Recovery	$1,000.000.00
(B) Amount of Property Damage	$0.00
(C) Subtotal A (Line a minus Line b)	$1,000,000.00
(D) Amount Allocated for Loss of Consortium (25% (15% for spouse, 5% for each child) of Line c)	$250,000.00
(E) Subtotal B (Line c minus Line d)	$750,000.00
(F) Amount Allocated for Wrongful Death 65% of Line e	$487,500.00
(G) Amount Allocated for Survival Action 35% of Line e	$262,500.00
(H) Subtotal C—If Wrongful Death Use Line f, if survival action use Line g, otherwise use Subtotal B	$487,500.00
(I) Attorney's Fees 30% (Line h × .30)	$146,250.00
(J) Subtotal D (Line h minus Line i)	$341,250.00
(K) Court costs are reduced by the amount allocated for the loss of consortium (in this example, .25 × $48,000 = 12,000) and then by the amount allocated for survivor action, [(48,000 − 12,000) × .35 = 12,600], [48,000 − 12,000 − 12,600])	$23,400.00
(L) Subtotal E (Line j minus Line k)	$317,850.00
(M) One-fifth of Subtotal E (Line l × .20)	$63,570.00
(N) Subtotal F (Line l minus Line m)	$254,280.00
(O) Refundable Disbursements	$100,000.00
(P) Subtotal G (lower of Subtotal F or refundable disbursements)	$100,000.00
(Q) Government's allowance for attorney's fees (attorney's fees percentage used to determine Subtotal D multiplied by subtotal G)	$30,000.00

(R) Refund to the United States (Line p minus Line q)	$70,000.00
(S) Credit against future benefits (If Subtotal F is greater than refundable disbursements, Line n minus Line o)	$154,280.00

(ii) For the survival claim the calculation is as follows:

(A) Gross Recovery	$1,000.000.00
(B) Amount of Property Damage	$0.00
(C) Subtotal A (Line a minus Line b)	$1,000,000.00
(D) Amount Allocated for Loss of Consortium (25% (15% for spouse, 5% for each child) of Line c)	$250,000.00
(E) Subtotal B (Line c minus Line d)	$750,000.00
(F) Amount Allocated for Wrongful Death 65% of Line e	$487,500.00
(G) Amount Allocated for Survival Action 35% of Line e	$262,500.00
(H) Subtotal C—If Wrongful Death Use Line f, if survival action use Line g, otherwise use Subtotal B	$262,500.00
(I) Attorney's Fees 30% (line h × .30)	$78,750.00
(J) Subtotal D (Line h minus Line i)	$183,750.00
(K) Court costs are reduced by the amount allocated for the loss of consortium (in this example, .25 × $48,000 = 12,000) and then by the amount allocated for wrongful death, [(48,000 − 12,000) × .65 = 23,400], [48,000 − 12,000 − 23,400])	$12,600.00
(L) Subtotal E (Line j minus Line k)	$171,150.00
(M) One-fifth of Subtotal E (Line l × .20)	$34,230.00
(N) Subtotal F (Line l minus Line m)	$136,920.00
(O) Refundable Disbursements	$30,000.00
(P) Subtotal G (lower of Subtotal F or refundable disbursements)	$30,000.00
(Q) Government's allowance for attorney's fees (attorney's fees percentage used to determine Subtotal D multiplied by subtotal G)	$9,000.00
(R) Refund to the United States (Line p minus Line q)	$21,000.00
(S) Credit against future benefits (If Subtotal F is greater than refundable disbursements, Line n minus Line o)	$106,920.00

§ 10.713 How is a structured settlement (that is, a settlement providing for receipt of funds over a specified period of time) treated for purposes of reporting the gross recovery?

In this situation, the gross recovery to be reported is the present value of the right to receive all of the payments included in the structured settlement, allocated in the case of multiple recipients in the same manner as single payment recoveries.

§ 10.714 What amounts are included in the refundable disbursements?

The refundable disbursements of a specific claim consist of the total money paid by OWCP from the Employees' Compensation Fund with respect to that claim to or on behalf of a FECA beneficiary including charges for field nurses, vocational rehabilitation, and second opinion and referee physicians, less charges for any medical file review (*i.e.*, the physician does not examine the employee) done at the request of OWCP. Charges for medical examinations also may be subtracted if the FECA beneficiary establishes that the examinations were required to be made available to the employee under a statute other than the FECA by the employing agency or at the employing agency's cost. Requests for disbursements can be made to SOL or OWCP.

§ 10.715 Is a beneficiary required to pay interest on the amount of the refund due to the United States?

If the refund due to the United States is not submitted within 30 days of receiving a request for payment from SOL or OWCP, interest shall accrue on the refund due to the United States from the date of the request. The rate of interest assessed shall be the rate of the current value of funds to the United States Treasury as published in the FEDERAL REGISTER (as of the date the request for payment is sent). Waiver of the collection of interest shall be

in accordance with the provisions of the Department of Labor regulations on Federal Claims Collection governing waiver of interest, 29 CFR 20.61.

§ 10.716 If the required refund is not paid within 30 days of the request for repayment, can it be collected from payments due under the FECA?

If the required refund is not paid within 30 days of the request for payment, OWCP can, in its discretion, collect the refund by withholding all or part of any payments currently payable to the beneficiary under the FECA with respect to any injury. The waiver provisions of §§ 10.432 through 10.440 do not apply to such determinations.

§ 10.717 Is a settlement or judgment received as a result of allegations of medical malpractice in treating an injury covered by the FECA a gross recovery that must be reported to OWCP or SOL?

Since an injury caused by medical malpractice in treating an injury covered by the FECA is also an injury covered under the FECA, any recovery in a suit alleging such an injury is treated as a gross recovery that must be reported to OWCP or SOL.

§ 10.718 Are payments to a beneficiary as a result of an insurance policy which the beneficiary has purchased a gross recovery that must be reported to OWCP or SOL?

Since payments received by a FECA beneficiary pursuant to an insurance policy purchased by someone other than a liable third party are not payments in satisfaction of liability for causing an injury covered by the FECA, they are not considered a gross recovery covered by section 8132 that requires filing a Statement of Recovery and paying any required refund.

§ 10.719 If a settlement or judgment is received for more than one wound or medical condition, can the refundable disbursements paid on a single FECA claim be attributed to different conditions for purposes of calculating the refund or credit owed to the United States?

(a) All wounds, diseases or other medical conditions accepted by OWCP in connection with a single claim are treated as the same injury for the purpose of computing any required refund and any credit against future benefits in connection with the receipt of a recovery from a third party, except that an injury caused by medical malpractice in treating an injury covered under the FECA will be treated as a separate injury for purposes of section 8132.

(b) If an injury covered under the FECA is caused under circumstances creating a legal liability in more than one person, other than the United States, to pay damages, OWCP or SOL will determine whether recoveries received from one or more third parties should be attributed to separate conditions for which compensation is payable in connection with a single FECA claim. If such an attribution is both practicable and equitable, as determined by OWCP or SOL, in its discretion, the conditions will be treated as separate injuries for purposes of calculating the refund and credit owed to the United States under section 8132.

FEDERAL GRAND AND PETIT JURORS

§ 10.725 When is a Federal grand or petit juror covered under the FECA?

(a) Federal grand and petit jurors are covered under the FECA when they are in performance of duty as a juror, which includes that time when a juror is:

(1) In attendance at court pursuant to a summons;

(2) In deliberation;

(3) Sequestered by order of a judge; or

(4) At a site, by order of the court, for the taking of a view.

(b) A juror is not considered to be in the performance of duty while traveling to or from home in connection with the activities enumerated in paragraphs (a) (1) through (4) of this section.

§ 10.726 When does a juror's entitlement to disability compensation begin?

Pursuant to 28 U.S.C. 1877, entitlement to disability compensation does not commence until the day after the date of termination of service as a juror.

§ 10.727 What is the pay rate of jurors for compensation purposes?

For the purpose of computing compensation payable for disability or death, a juror is deemed to receive pay at the minimum rate for Grade GS–2 of the General Schedule unless his or her actual pay as an ''employee'' of the United States while serving on court leave is higher, in which case the pay rate for compensation purposes is determined in accordance with 5 U.S.C. 8114.

PEACE CORPS VOLUNTEERS

§ 10.730 What are the conditions of coverage for Peace Corps volunteers and volunteer leaders injured while serving outside the United States?

(a) Any injury sustained by a volunteer or volunteer leader while he or she is located abroad is deemed proximately caused by Peace Corps employment and will be found by OWCP to have been sustained in the performance of duty, and any illness contracted while that volunteer is located abroad will be found by OWCP to be proximately caused by the employment unless the evidence establishes:

(1) The injury or illness was caused by the claimant's willful misconduct, intent to bring about the injury or death of self or another, or was proximately caused by the intoxication by alcohol or illegal drugs of the injured claimant; or

(2) The illness is shown to have preexisted the period of service abroad; or

(3) The injury or illness claimed is a manifestation of symptoms of, or consequent to, a pre-existing congenital defect or abnormality.

(b) If the OWCP finds that the evidence indicates that the injury or illness may not have been sustained in the performance of duty due to the circumstances enumerated in paragraph (a)(2) and (3) of this section, the claimant may still prove his claim by the submittal of substantial and probative evidence that such injury or illness was sustained in the performance of duty with the Peace Corps.

(c) If an injury or illness, or episode thereof, comes within one of the exceptions described in paragraph (a)(2) or (3) of this section, the claimant may nonetheless be entitled to compensation. This will be so provided he or she meets the burden of proving by the submittal of substantial, probative and rationalized medical evidence that the illness or injury was proximately caused by factors or conditions of Peace Corps service, or that it was materially aggravated, accelerated or precipitated by factors of Peace Corps service; if the injury or illness was temporarily aggravated by factors of Peace Corps service, disability compensation is payable for the period of such aggravation.

§ 10.731 What is the pay rate of Peace Corps volunteers and volunteer leaders for compensation purposes?

The pay rate for these claimants is defined as the pay rate in effect on the date following separation, provided that the rate equals or exceeds the pay rate on the date of injury. It is defined in accordance with 5 U.S.C. 8142(a), not 8101(4).

NON-FEDERAL LAW ENFORCEMENT OFFICERS

§ 10.735 When is a non-Federal law enforcement officer (LEO) covered under the FECA?

(a) A law enforcement officer (officer) includes an employee of a State or local Government, the Governments of U.S. possessions and territories, or an employee of the United States pensioned or pensionable under sections 521–535 of Title 4, D.C. Code, whose functions include the activities listed in 5 U.S.C. 8191.

(b) Benefits are available to officers who are not ''employees'' under 5 U.S.C. 8101, and who are determined in the discretion of OWCP to have been engaged in the activities listed in 5 U.S.C. 8191 with respect to the enforcement of crimes against the United States. Individuals who only perform administrative functions in support of officers are not considered officers.

(c) Except as provided by 5 U.S.C. 8191 and 8192 and elsewhere in this part, the provisions of the FECA and of subparts A, B, and D through I of this part apply to officers.

§ 10.736 What are the time limits for filing a LEO claim?

OWCP must receive a claim for benefits under 5 U.S.C. 8191 within five years after the injury or death. This five-year limitation is not subject to waiver. The tolling provisions of 5 U.S.C. 8122(d) do not apply to these claims.

§ 10.737 How is a LEO claim filed, and who can file a LEO claim?

A claim for injury or occupational disease should be filed on Form CA–721; a death claim should be filed on Form CA–722. All claims should be submitted to the officer's employer for completion and forwarding to OWCP. A claim may be filed by the officer, the officer's survivor, or any person or association authorized to act on behalf of an officer or an officer's survivors.

§ 10.738 Under what circumstances are benefits payable in LEO claims?

(a) Benefits are payable when an officer is injured while apprehending, or attempting to apprehend, an individual for the commission of a Federal crime. However, either an actual Federal crime must be in progress or have been committed, or objective evidence (of which the officer is aware at the time of injury) must exist that a potential Federal crime was in progress or had already been committed. The actual or potential Federal crime must be an integral part of the criminal activity toward which the officer's actions are directed. The fact that an injury to an officer is related in some way to the commission of a Federal crime does not necessarily bring the injury within the coverage of the FECA. The FECA is not intended to cover officers who are merely enforcing local laws.

(b) For benefits to be payable when an officer is injured preventing, or attempting to prevent, a Federal crime, there must be objective evidence that a Federal crime is about to be committed. An officer's belief, unsupported by objective evidence, that he or she is acting to prevent the commission of a Federal crime will not result in coverage. Moreover, the officer's subjective intent, as measured by all available evidence (including the officer's own statements and testimony, if available), must have been directed toward the prevention of a Federal crime. In this context, an officer's own statements and testimony are relevant to, but do not control, the determination of coverage.

§ 10.739 What kind of objective evidence of a potential Federal crime must exist for coverage to be extended?

Based on the facts available at the time of the event, the officer must have an awareness of sufficient information which would lead a reasonable officer, under the circumstances, to conclude that a Federal crime was in progress, or was about to occur. This awareness need not extend to the precise particulars of the crime (the section of Title 18, United States Code, for example), but there must be sufficient evidence that the officer was in fact engaged in actual or attempted apprehension of a Federal criminal or prevention of a Federal crime.

§ 10.740 In what situations will OWCP automatically presume that a law enforcement officer is covered by the FECA?

(a) Where an officer is detailed by a competent State or local authority to assist a Federal law enforcement authority in the protection of the President of the United States, or any other person actually provided or entitled to U.S. Secret Service protection, coverage will be extended.

(b) Coverage for officers of the U.S. Park Police and those officers of the Uniformed Division of the U.S. Secret Service who participate in the District of Columbia Retirement System is adjudicated under the principles set forth in paragraph (a) of this section, and does not extend to numerous tangential activities of law enforcement (for example, reporting to work, changing clothes). However, officers of the Non-Uniformed Division of the U.S. Secret Service who participate in the District of Columbia Retirement System are covered under the FECA during the performance of all official duties.

§ 10.741 How are benefits calculated in LEO claims?

(a) Except for continuation of pay, eligible officers and survivors are entitled to the same benefits as if the officer had been an employee under 5 U.S.C. 8101. However, such benefits may be reduced or adjusted as OWCP in its discretion may deem appropriate to reflect comparable benefits which the officer or survivor received or would have been entitled to receive by virtue of the officer's employment.

(b) For the purpose of this section, a comparable benefit includes any benefit that the officer or survivor is entitled to receive because of the officer's employment, including pension and disability funds, State workers' compensation payments, Public Safety Officers' Benefits Act payments, and State and local lump-sum payments. Health benefits coverage and proceeds of life insurance policies purchased by the employer are not considered to be comparable benefits.

(c) The FECA provides that, where an officer receives comparable benefits, compensation benefits are to be reduced proportionally in a manner that reflects the relative percentage contribution of the officer and the officer's employer to the fund which is the source of the comparable benefit. Where the source of the comparable benefit is a retirement or other system which is not fully funded, the calculation of the amount of the reduction will be based on a per capita comparison between the contribution by the employer and the contribution by all covered officers during the year prior to the officer's injury or death.

(d) The non-receipt of compensation during a period where a dual benefit (such as a lump-sum payment on the death of an officer) is being offset against compensation entitlement does not result in an adjustment of the respective benefit percentages of remaining beneficiaries because of a cessation of compensation under 5 U.S.C. 8133(c).

Subpart I—Information for Medical Providers

MEDICAL RECORDS AND BILLS

§ 10.800 How do providers enroll with OWCP for authorizations and billing?

(a) All providers must enroll with OWCP or its designated bill processing agent (hereinafter OWCP in this subpart) to have access to the automated authorization system and to submit medical bills to OWCP. To enroll, the provider must complete and submit a Form OWCP–1168 to the appropriate location noted on that form. By completing and submitting this form, providers certify that they satisfy all applicable Federal and State licensure and regulatory requirements that apply to their specific provider or supplier type. The provider must maintain documentary evidence indicating that it satisfies those requirements. The provider is also required to notify OWCP immediately if any information provided to OWCP in the enrollment process changes. Agency medical officers, private physicians and hospitals are also required to keep records of all cases treated by them under the FECA so they can supply OWCP with a history of the injury, a description of the nature and extent of injury, the results of any diagnostic studies performed, the nature of the treatment rendered and the degree of any impairment and/or disability arising from the injury.

(b) Where a medical provider intends to bill for a procedure where prior authorization is required, that provider must request such authorization from OWCP.

(c) After enrollment, a provider must submit all medical bills to OWCP through its bill processing portal and include the Provider Number/ID obtained through enrollment or other identifying number required by OWCP.

§ 10.801 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to injured employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 10.800.

OWCP may withhold payment for services until such report or evidence is provided. The physician or provider shall itemize the charges on Form OWCP–1500 or CMS–1500 (for professional services or medicinal drugs dispensed in the office), Form OWCP–04 or UB–04 (for hospitals), an electronic or paper-based bill that includes required data elements (for pharmacies) or other form as warranted and accepted by OWCP, and submit the form promptly to OWCP.

(b) The provider shall identify each service performed using the Physician's Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC), or the Revenue Center Code (RCC) with a brief narrative description; OWCP has discretion to determine which of these codes may be utilized in the billing process. The Director also has the authority to create and supply specific procedure codes that will be used by OWCP to better describe and allow specific payments for special services. These OWCP-created codes will be issued to providers by OWCP as appropriate and may only be used as authorized by OWCP. For example, a physician conducting a referee or second opinion examination under 5 U.S.C. 8123 will be furnished an OWCP-created code; a provider may not use such an OWCP-created code for other types of medical examinations or services. Where no appropriate code is submitted to identify the services performed, the bill will be returned to the provider and/or denied.

(c) For professional charges billed on Form OWCP–1500 or CMS–1500, the provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the ''International Classification of Disease, 9th Edition, Clinical Modification'' (ICD–9–CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment or monthly, if treatment for the work-related condition is necessary for more than 30 days.

(1) (i) Hospitals shall submit charges for inpatient medical and surgical treatment or supplies promptly to OWCP on Form OWCP–04 or UB–04.

(ii) For outpatient billing, the provider shall identify each service performed, using Revenue Center Codes (RCCs) and HCPCS/CPT codes as warranted. The charge for each individual service, or the total charge for all identical services, should also appear on the form. OWCP may adopt an Outpatient Prospective Payment System (OWCP OPPS) (as developed and implemented by the Center for Medicare and Medicaid services (CMS) for Medicare, while modifying the allowable costs under Medicare to account for deductibles and other additional costs which are covered by FECA). Once adopted, hospital providers shall submit outpatient hospital bills on the current version of the Universal Billing Form (UB) and use HCPCS codes and other coding schemes in accordance with the OWCP OPPS.

(2) Pharmacies shall itemize charges for prescription medications, appliances, or supplies on electronic or paper-based bills and submit them promptly to OWCP. Bills for prescription medications must include the NDC assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider's billhead stationery and submit them promptly to OWCP. Such charges shall be subject to any applicable OWCP fee schedule.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which reimbursement is sought was performed as described, necessary, appropriate and properly billed in accordance with accepted industry standards. For example, accepted industry standards preclude upcoding billed services for extended medical appointments when the employee actually had a brief routine appointment, or charging for the services of a professional when a paraprofessional or aide performed the service; industry standards prohibit unbundling services to charge separately for services that should be billed as a single charge. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart

concerning the rendering of treatment and/or the process for seeking reimbursement for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: Be itemized on the Health Insurance Claim Form (for physicians) or the OWCP–04 (for hospitals); contain the signature or signature stamp of the provider; and identify the procedures using HCPCS/CPT codes, RCCs, or NDCs. Otherwise, OWCP may deny the bill, and the provider must correct and resubmit the bill.

§ 10.802 How should an employee prepare and submit requests for reimbursement for medical expenses, transportation costs, loss of wages, and incidental expenses?

(a) If an employee has paid bills for medical, surgical or dental services, supplies or appliances due to an injury sustained in the performance of duty and seeks reimbursement for those expenses, he or she may submit a request for reimbursement on Form OWCP–915, together with an itemized bill on Form OWCP–1500, CMS–1500, OWCP–04 or UB–04 prepared by the provider and a medical report as provided in §10.800, to OWCP.

(1) The provider of such service shall state each diagnosed condition and furnish the applicable ICD–9–CM code, or as revised, and identify each service performed using the applicable HCPCS/CPT code, with a brief narrative description of the service performed, or, where no code is applicable, a detailed description of that service. If no code or description is received, OWCP will deny the reimbursement request and correction and resubmission will be required.

(2) The reimbursement request must be accompanied by evidence that the provider received payment for the service from the employee and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a signed statement by the provider, a mechanical stamp or other device showing receipt of payment, a copy of the employee's canceled check (both front and back) or a copy of the employee's credit card receipt or a form indicating a balance of zero to the provider.

(b) If services were provided by a hospital, pharmacy or nursing home, the employee should submit the bill in accordance with the provisions of §10.801(a). Any request for reimbursement must be accompanied by evidence, as described in paragraph (a) of this section, that the provider received payment for the service from the employee and a statement of the amount paid.

(c) OWCP may waive the requirements of paragraphs (a) and (b) of this section if extensive delays in the filing or the adjudication of a claim make it unusually difficult for the employee to obtain the required information.

(d) OWCP will not accept copies of bills for reimbursement unless they bear the signature of the provider, with evidence of payment. Payment for medical and surgical treatment, appliances or supplies shall in general be no greater than the maximum allowable charge for such service determined by the Director, as set forth in §10.805.

(e) An employee will be only partially reimbursed for a medical expense if the amount he or she paid to a provider for the service exceeds the maximum allowable charge set by the Director's schedule. If this happens, OWCP shall advise the employee of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider may request reconsideration of the fee determination as set forth in §10.812.

(f) If the provider fails to make appropriate refund to the employee, or to credit the employee's account, within 60 days after the employee requests a refund of any excess amount, or the date of a subsequent reconsideration decision which continues to disallow all or a portion of the appealed amount, the provider shall be subject to exclusion procedures as provided by §10.815.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain

such refund or credit to OWCP. OWCP may make reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

(h) If an employee seeks reimbursement for transportation costs, loss of wages or incidental expenses related to medical treatment under this part, that employee may submit such reimbursement request on the Medical Travel Refund Request OWCP–957 form to OWCP along with all proof of payment. Requests for reimbursement for lost wages under this subsection must include an official statement from the employing agency indicating the amount of wage loss.

§ 10.803 What are the time limitations on OWCP's payment of bills?

OWCP will pay providers and reimburse employees promptly for all bills received on an approved form and in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the end of the calendar year in which the claim was first accepted as compensable by OWCP, whichever is later.

MEDICAL FEE SCHEDULE

§ 10.805 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services, devices and supplies furnished by physicians, hospitals, and other providers for work-related injuries shall not exceed a maximum allowable charge for such service as determined by the Director, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing home for employees admitted to that nursing home prior to August 29, 2011, but does apply to all charges for services provided by a nursing home where the employee was admitted to that nursing home after that date. The schedule does apply to charges for treatment furnished in a nursing home by a physician or other medical professional at any time.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

§ 10.806 How are the maximum fees defined?

For professional medical services, the Director shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of Relative Value Units (RVU) to procedures identified by Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an assignment of Geographic Practice Cost Index (GPCI) values which represent the relative work, practice expenses and malpractice expenses relative to other localities throughout the country; and a monetary value assignment (conversion factor) for one unit of value for each coded service.

§ 10.807 How are payments for particular services calculated?

Payment for a procedure, service or device identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the Relative Value Units (RVU) values for that procedure by the Geographic Practice Cost Index (GPCI) values for services in that area and by the conversion factor to arrive at a dollar amount assigned to one unit in that category of service.

(a) The ''locality'' which serves as a basis for the determination of cost is defined by the Office of Management and Budget Metropolitan Statistical Areas. The Director shall base the determination of the relative per capita cost of medical care in a locality using information about enrollment and medical cost per county, provided by the Centers for Medicare and Medicaid Services (CMS).

(b) The Director shall assign the RVUs published by CMS to all services

for which CMS has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, the Director may develop and assign any RVUs that he or she considers appropriate. The geographic adjustment factor shall be that designated by GPCI for Metropolitan Statistical Areas as devised for CMS and as updated or revised by CMS from time to time. The Director will devise conversion factors for each category of service as appropriate using OWCP's processing experience and internal data.

(c) For example, if the RVUs for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (MP), and the conversion factor assigned to one unit in that category of service (surgery) is $61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding GPCI values for the locality times the conversion factor. If the GPCI values for the locality are 0.988(W), 0.948 (PE), and 1.174 (MP), then the maximum payment calculation is:

$[(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \times \$61.20$

$[2.45 + 3.44 + .56] \times \$61.20$

$6.45 \times \$61.20 = \$394.74$

§ 10.808 Does the fee schedule apply to every kind of procedure?

Where the time, effort and skill required to perform a particular procedure vary widely from one occasion to the next, the Director may choose not to assign a relative value to that procedure. In this case the allowable charge for the procedure will be set individually based on consideration of a detailed medical report and other evidence. At its discretion, OWCP may set fees without regard to schedule limits for specially authorized consultant examinations, for examinations performed under 5 U.S.C. 8123, and for other specially authorized services.

§ 10.809 How are payments for medicinal drugs determined?

Payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price, or as otherwise specified by OWCP, of the medication by the quantity or amount provided, plus a dispensing fee. OWCP may, in its discretion, contract for or require the use of specific providers for certain medications.

(a) All prescription medications identified by National Drug Code (NDC) will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers, or by other method designated by OWCP. The Director will establish the dispensing fee, which will not be affected by the location or type of provider dispensing the medication.

(b) The NDCs, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

(c) With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available.

§ 10.810 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Inpatient Prospective Payment System (IPPS) devised by CMS (42 CFR parts 412, 413, 424, 485, and 489). Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All inpatient hospital discharges will be classified according to the DRGs prescribed by the CMS in the form of the DRG Grouper software program. Each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by CMS in the form of their PPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location (MSA) of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio,

and other factors used by CMS to determine the specific rate for a hospital discharge under their PPS. The Director may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from CMS' IPPS on consideration of detailed medical reports and other evidence.

(4) The Director shall review the predetermined hospital rates at least once a year, and may adjust any or all components when he or she deems it necessary or appropriate.

(b) The Director shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when he or she deems it necessary or appropriate.

§ 10.811 When and how are fees reduced?

(a) OWCP accepts a provider's designation of the code used to identify a billed procedure or service if the code is consistent with the medical and other evidence, and will pay no more than the maximum allowable fee for that procedure. If the code is not consistent with the medical evidence or where no code is supplied, the bill will be returned to the provider for correction and resubmission.

(b) If the charge submitted for a service supplied to an injured employee exceeds the maximum amount determined to be reasonable according to the schedule, OWCP shall pay the amount allowed by the schedule for that service and shall notify the provider in writing that payment was reduced for that service in accordance with the schedule. OWCP shall also notify the provider of the method for requesting reconsideration of the balance of the charge.

§ 10.812 If OWCP reduces a fee, may a provider request reconsideration of the reduction?

(a) A physician or other provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set by the Director may, within 30 days, request reconsideration of the fee determination.

(1) The provider should make such a request to the OWCP district office with jurisdiction over the employee's claim. The request must be accompanied by documentary evidence that the procedure performed was incorrectly identified by the original code, that the presence of a severe or concomitant medical condition made treatment especially difficult, or that the provider possessed unusual qualifications. In itself, board-certification in a specialty is not sufficient evidence of unusual qualifications to justify an exception. These are the only three circumstances which will justify reevaluation of the paid amount.

(2) A list of OWCP district offices and their respective areas of jurisdiction is available upon request from the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210, or from the Internet at *http://www.dol.gov./owcp.* Within 30 days of receiving the request for reconsideration, the OWCP district office shall respond in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted.

(b) If the OWCP district office issues a decision which continues to disallow a contested amount, the provider may apply to the Regional Director of the region with jurisdiction over the OWCP district office. The application must be filed within 30 days of the date of such decision, and it may be accompanied by additional evidence. Within 60 days of receipt of such application, the Regional Director shall issue a decision in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted. This decision shall be final, and shall not be subject to further review.

§ 10.813 If OWCP reduces a fee, may a provider bill the claimant for the balance?

A provider whose fee for service is partially paid by OWCP as a result of the application of its fee schedule or other tests for reasonableness in accordance with this part shall not request reimbursement from the employee for additional amounts.

(a) Where a provider's fee for a particular service or procedure is lower to the general public than as provided by the schedule of maximum allowable

charges, the provider shall bill at the lower rate. A fee for a particular service or procedure which is higher than the provider's fee to the general public for that same service or procedure will be considered a charge ''substantially in excess of such provider's customary charges'' for the purposes of §10.815(d).

(b) A provider whose fee for service is partially paid by OWCP as the result of the application of the schedule of maximum allowable charges and who collects or attempts to collect from the employee, either directly or through a collection agent, any amount in excess of the charge allowed by OWCP, and who does not cease such action or make appropriate refund to the employee within 60 days of the date of the decision of OWCP, shall be subject to the exclusion procedures provided by §10.815(h).

EXCLUSION OF PROVIDERS

§10.815 What are the grounds for excluding a provider from payment under the FECA?

A physician, hospital, or provider of medical services, appliances or supplies shall be excluded from payment under the FECA if such physician, hospital or provider has:

(a) Been convicted under any criminal statute of fraudulent activities in connection with any Federal or State program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies;

(b) Been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any Federal or State program referred to in paragraph (a) of this section;

(c) Knowingly made, or caused to be made, any false statement or misrepresentation of a material fact in connection with a determination of the right to reimbursement under the FECA, or in connection with a request for payment;

(d) Submitted, or caused to be submitted, three or more bills or requests for payment within a twelve-month period under this subpart containing charges which OWCP finds to be substantially in excess of such provider's customary charges, unless OWCP finds there is good cause for the bills or requests containing such charges;

(e) Knowingly failed to timely reimburse employees for treatment, services or supplies furnished under this subpart and paid for by OWCP;

(f) Failed, neglected or refused on three or more occasions during a 12-month period to submit full and accurate medical reports, or to respond to requests by OWCP for additional reports or information, as required by the FECA and §10.800;

(g) Knowingly furnished treatment, services or supplies which are substantially in excess of the employee's needs, or of a quality which fails to meet professionally recognized standards; or

(h) Collected or attempted to collect from the employee, either directly or through a collection agent, an amount in excess of the charge allowed by OWCP for the procedure performed, and has failed or refused to make appropriate refund to the employee, or to cease such collection attempts, within 60 days of the date of the decision of OWCP.

(i) Failed to inform OWCP of any change in their provider status as required in section 10.800 of this title.

(j) Engaged in conduct related to care of an employee's FECA covered injury that OWCP finds to be misleading, deceptive or unfair.

§10.816 What will cause OWCP to automatically exclude a physician or other provider of medical services and supplies?

(a) OWCP shall automatically exclude a physician, hospital, or provider of medical services or supplies who has been convicted of a crime described in §10.815(a), or has been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any program as described in §10.815(b).

(b) The exclusion applies to participating in the program and to seeking payment under the FECA for services performed after the date of the entry of the judgment of conviction or order of exclusion, suspension or resignation, as the case may be, by the court or agency concerned. Proof of the conviction, exclusion, suspension or resignation

may consist of a copy thereof authenticated by the seal of the court or agency concerned.

(c) A provider may be excluded on a voluntary basis at any time.

§ 10.817 How are OWCP's exclusion procedures initiated?

(a) Upon receipt of information indicating that a physician, hospital or provider of medical services or supplies (hereinafter the provider) has or may have engaged in activities enumerated in §10.815(c) through (j) OWCP will forward that information to the Department of Labor's Office of Inspector General (DOL OIG) for its consideration. If the information was provided directly to DOL OIG, DOL OIG will notify OWCP of its receipt and implement the appropriate action within its authority, unless such notification will or may compromise the identity of confidential sources, or compromise or prejudice an ongoing or potential criminal investigation.

(b) DOL OIG will conduct such action as it deems necessary, and, when appropriate, provide a written report as described in paragraph (c) of this section to OWCP. OWCP will then determine whether to initiate procedures to exclude the provider from participation in the FECA program. If DOL OIG determines not to take any further action, it will promptly notify OWCP.

(c) If DOL OIG discovers reasonable cause to believe that violations of §10.815 have occurred, it shall, when appropriate, prepare a written report, *i.e.*, investigative memorandum, and forward that report along with supporting evidence to OWCP. The report shall be in the form of a single memorandum in narrative form with attachments.

(1) The report should contain all of the following elements:

(i) A brief description and explanation of the subject provider or providers;

(ii) A concise statement of the DOL OIG's findings upon which exclusion may be based;

(iii) A summary of the events that make up the DOL OIG's findings;

(iv) A discussion of the documentation supporting the DOL OIG's findings;

(v) A discussion of any other information that may have bearing upon the exclusion process; and

(vi) The supporting documentary evidence including any expert opinion rendered in the case.

(2) The attachments to the report should be provided in a manner that they may be easily referenced from the report.

§ 10.818 How is a provider notified of OWCP's intent to exclude him or her?

Following receipt of the investigative report, OWCP will determine if there exists a reasonable basis to exclude the provider or providers. If OWCP determines that such a basis exists, OWCP shall initiate the exclusion process by sending the provider a letter, by certified mail and with return receipt requested (or equivalent service from a commercial carrier), which shall contain the following:

(a) A concise statement of the grounds upon which exclusion shall be based;

(b) A summary of the information, with supporting documentation, upon which OWCP has relied in reaching an initial decision that exclusion proceedings should begin;

(c) An invitation to the provider to:

(1) Resign voluntarily from eligibility for providing services under this part without admitting or denying the allegations presented in the letter; or

(2) Request a decision on exclusion based upon the existing record and any additional documentary information the provider may wish to furnish;

(d) A notice of the provider's right, in the event of an adverse ruling by the deciding official, to request a formal hearing before an administrative law judge;

(e) A notice that should the provider fail to answer (as described in §10.819) the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider without conducting any further proceedings; and

(f) The address to where the answer from the provider should be sent.

§ 10.819 What requirements must the provider's answer and OWCP's decision meet?

(a) The provider's answer shall be in writing and shall include an answer to OWCP's invitation to resign voluntarily. If the provider does not offer to resign, he or she shall request that a determination be made upon the existing record and any additional information provided.

(b) Should the provider fail to answer the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider.

(c) The provider may inspect or request copies of information in the record at any time prior to the deciding official's decision by making such request to OWCP within 20 days of receipt of the letter of intent.

(d) Any response from the provider will be forwarded to DOL OIG, which shall have 30 days to answer the provider's response. That answer will be forwarded to the provider, who shall then have 15 days to reply.

(e) The deciding official shall be the Regional Director in the region in which the provider is located unless otherwise specified by the Director of the Division of Federal Employees' Compensation.

(f) The deciding official shall issue his or her decision in writing, and shall send a copy of the decision to the provider by certified mail, return receipt requested (or equivalent service from a commercial carrier). The decision shall advise the provider of his or her right to request, within 30 days of the date of an adverse decision, a formal hearing before an administrative law judge under the procedures set forth in §§ 10.820 through 10.823. The filing of a request for a hearing within the time specified shall stay the effectiveness of the decision to exclude.

§ 10.820 How can an excluded provider request a hearing?

A request for a hearing shall be sent to the deciding official and shall contain:

(a) A concise notice of the issues on which the provider desires to give evidence at the hearing;

(b) Any request for the presentation of oral argument or evidence; and

(c) Any request for a certification of questions concerning professional medical standards, medical ethics or medical regulation for an advisory opinion from a competent recognized professional organization or Federal, State or local regulatory body.

§ 10.821 How are hearings assigned and scheduled?

(a) If the deciding official receives a timely request for hearing, the OWCP representative shall refer the matter to the Chief Administrative Law Judge of the Department of Labor, who shall assign it for an expedited hearing. The administrative law judge assigned to the matter shall consider the request for hearing, act on all requests therein, and issue a Notice of Hearing and Hearing Schedule for the conduct of the hearing. A copy of the hearing notice shall be served on the provider by certified mail, return receipt requested. The Notice of Hearing and Hearing Schedule shall include:

(1) A ruling on each item raised in the request for hearing;

(2) A schedule for the prompt disposition of all preliminary matters, including requests for the certification of questions to advisory bodies; and

(3) A scheduled hearing date not less than 30 days after the date the schedule is issued, and not less than 15 days after the scheduled conclusion of preliminary matters, provided that the specific time and place of the hearing may be set on 10 days' notice.

(b) The provider is entitled to be heard on any matter placed in issue by his or her response to the Notice of Intent to Exclude, and may designate ''all issues'' for purposes of hearing. However, a specific designation of issues is required if the provider wishes to interpose affirmative defenses, or request the issuance of subpoenas or the certification of questions for an advisory opinion.

§ 10.822 How are subpoenas or advisory opinions obtained?

(a) The provider may apply to the administrative law judge for the issuance of subpoenas upon a showing of good cause therefor.

(b) A certification of a request for an advisory opinion concerning professional medical standards, medical ethics or medical regulation to a competent recognized or professional organization or Federal, State or local regulatory agency may be made:

(1) As to an issue properly designated by the provider, in the sound discretion of the administrative law judge, provided that the request will not unduly delay the proceedings;

(2) By OWCP on its own motion either before or after the institution of proceedings, and the results thereof shall be made available to the provider at the time that proceedings are instituted or, if after the proceedings are instituted, within a reasonable time after receipt. The opinion, if rendered by the organization or agency, is advisory only and not binding on the administrative law judge.

§ 10.823 How will the administrative law judge conduct the hearing and issue the recommended decision?

(a) To the extent appropriate, proceedings before the administrative law judge shall be governed by 29 CFR part 18.

(b) The administrative law judge shall receive such relevant evidence as may be adduced at the hearing. Parties to the hearing are the provider and OWCP. Evidence shall be presented under oath, orally or in the form of written statements. The administrative law judge shall consider the Notice and Response, including all pertinent documents accompanying them, and may also consider any evidence which refers to the provider or to any claim with respect to which the provider has provided medical services, hospital services, or medical services and supplies, and such other evidence as the administrative law judge may determine to be necessary or useful in evaluating the matter.

(c) All hearings shall be recorded and the original of the complete transcript shall become a permanent part of the official record of the proceedings.

(d) Pursuant to 5 U.S.C. 8126 and 29 CFR part 18, the administrative law judge may issue subpoenas, administer oaths, and examine witnesses with respect to the proceedings.

(e) At the conclusion of the hearing, the administrative law judge shall issue a recommended decision and cause it to be served on all parties to the proceeding, their representatives and the Director of OWCP.

§ 10.824 How does the recommended decision become final?

(a) Within 30 days from the date the recommended decision is issued, each party may state, in writing, whether the party objects to the recommended decision. This written statement should be filed with the Director of OWCP.

(b) For purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the Director, the statement will be considered to be ''filed'' on the date that the provider mails it to the Director, as determined by postmark or the date that such written statement is actually received by the Director, whichever is earlier.

(c) Written statements objecting to the recommended decision may be filed upon one or more of the following grounds:

(1) A finding or conclusion of material fact is not supported by substantial evidence;

(2) A necessary legal conclusion is erroneous;

(3) The decision is contrary to law or to the duly promulgated rules or decisions of the Director;

(4) A substantial question of law, policy, or discretion is involved; or

(5) A prejudicial error of procedure was committed.

(d) Each issue shall be separately numbered and plainly and concisely stated, and shall be supported by detailed citations to the record when assignments of error are based on the record, and by statutes, regulations or principal authorities relied upon. Except for good cause shown, no assignment of error by any party shall rely on any question of fact or law upon which the administrative law judge had not been afforded an opportunity to pass.

(e) If a written statement of objection is filed within the allotted period of time, the Director will review the objection. The Director will forward

the written objection to the DOL OIG, which will have 14 calendar days from that date to respond. Any response from DOL OIG will be forwarded to the provider, which will have 14 calendar days from that date to reply.

(f) The Director of OWCP will consider the recommended decision, the written record and any response or reply received and will then issue a written, final decision either upholding or reversing the exclusion.

(g) If no written statement of objection is filed within the allotted period of time, the Director of OWCP will issue a written, final decision accepting the recommendation of the administrative law judge.

(h) The decision of the Director of OWCP shall be final with respect to the provider's participation in the program, and shall not be subject to further review by any court or agency.

§ 10.825 What are the effects of exclusion?

(a) OWCP may give notice of the exclusion of a physician, hospital or provider of medical services or supplies:

(1) All OWCP district offices;

(2) All Federal employers;

(3) The CMS;

(4) The State or local authority responsible for licensing or certifying the excluded party.

(b) Notwithstanding any exclusion of a physician, hospital, or provider of medical services or supplies under this subpart, OWCP shall not refuse an employee reimbursement for any otherwise reimbursable medical treatment, service or supply if:

(1) Such treatment, service or supply was rendered in an emergency by an excluded physician; or

(2) The employee could not reasonably have been expected to have known of such exclusion.

(c) An employee who is notified that his or her attending physician has been excluded shall have a new right to select a qualified physician.

§ 10.826 How can an excluded provider be reinstated?

(a) If a physician, hospital, or provider of medical services or supplies has been automatically excluded pursuant to § 10.816, the provider excluded will automatically be reinstated upon notice to OWCP that the conviction or exclusion which formed the basis of the automatic exclusion has been reversed or withdrawn. However, an automatic reinstatement shall not preclude OWCP from instituting exclusion proceedings based upon the underlying facts of the matter.

(b) A physician, hospital, or provider of medical services or supplies excluded from participation as a result of an order issued pursuant to this subpart may apply for reinstatement one year after the entry of the order of exclusion, unless the order expressly provides for a shorter period. An application for reinstatement shall be addressed to the Director for Federal Employees' Compensation, and shall contain a concise statement of the basis for the application. The application should be accompanied by supporting documents and affidavits.

(c) A request for reinstatement may be accompanied by a request for an oral presentation. Oral presentations will be allowed only in unusual circumstances where it will materially aid the decision process.

(d) The Director of OWCP shall order reinstatement only in instances where such reinstatement is clearly consistent with the goal of this subpart to protect the FECA program against fraud and abuse. To satisfy this requirement the provider must provide reasonable assurances that the basis for the exclusion will not be repeated.

Subpart J—Death Gratuity

§ 10.900 What is the death gratuity under this subpart?

(a) The death gratuity authorized by 5 U.S.C. 8102a and payable pursuant to the provisions of this subpart is a payment to a claimant who is an eligible survivor (as defined in §§ 10.906 and 10.907) or a designated alternate beneficiary (as defined in §§ 10.908 and 10.909) of an employee who dies of injuries incurred in connection with the employee's service with an Armed Force in a contingency operation. This payment was authorized by section 1105 of Public Law 110–181 (2008). For the purposes of this subchapter, the term ''Armed

Force'' means the Army, Navy, Air Force, Marine Corps, and Coast Guard.

(b) This death gratuity payment is a FECA benefit, as defined by §10.5(a) of this part. All the provisions and definitions in this part apply to claims for payment under this subpart unless otherwise specified.

§ 10.901 Which employees are covered under this subpart?

For purposes of this subpart, the term ''employee'' means all employees defined in 5 U.S.C. 8101 and §10.5 of this part and all non-appropriated fund instrumentality employees as defined in 10 U.S.C. 1587(a)(1).

§ 10.902 Does every employee's death due to injuries incurred in connection with his or her service with an Armed Force in a contingency operation qualify for the death gratuity?

Yes. All such deaths that occur on or after January 28, 2008 (the date of enactment of Public Law 110–181 (2008)) qualify for the death gratuity administered by this subpart.

§ 10.903 Is the death gratuity payment applicable retroactively?

An employee's death qualifies for the death gratuity if the employee died on or after October 7, 2001, and before January 28, 2008, if the death was a result of injuries incurred in connection with the employee's service with an Armed Force in the theater of operations of Operation Enduring Freedom or Operation Iraqi Freedom.

§ 10.904 Does a death as a result of occupational disease qualify for payment of the death gratuity?

Yes—throughout this subpart, the word ''injury'' is defined as it is in 5 U.S.C. 8101(5), which includes a disease proximately caused by employment. If an employee's death results from an occupational disease incurred in connection with the employee's service in a contingency operation, the death qualifies for payment of the death gratuity under this subpart.

§ 10.905 If an employee incurs a covered injury in connection with his or her service with an Armed Force in a contingency operation but does not die of the injury until years later, does the death qualify for payment of the death gratuity?

Yes—as long as the employee's death is a result of injuries incurred in connection with the employee's service with an Armed Force in a contingency operation, the death qualifies for the death gratuity of this subpart regardless of how long after the injury the employee's death occurs.

§ 10.906 What special statutory definitions apply to survivors under this subpart?

For the purposes of paying the death gratuity to eligible survivors under this subpart, OWCP will use the following definitions:

(a) ''Surviving spouse'' means the person who was legally married to the deceased employee at the time of his or her death.

(b) ''Children'' means, without regard to age or marital status, the deceased employee's natural children and adopted children. It also includes any stepchildren who were a part of the decedent's household at the time of death.

(1) A stepchild will be considered part of the decedent's household if the decedent and the stepchild share the same principal place of abode in the year prior to the decedent's death. The decedent and stepchild will be considered as part of the same household notwithstanding temporary absences due to special circumstances such as illness, education, business travel, vacation travel, military service, or a written custody agreement under which the stepchild is absent from the employee's household for less than 180 days of the year.

(2) A natural child who is an illegitimate child of a male decedent is included in the definition of ''children'' under this subpart if:

(i) The child has been acknowledged in writing signed by the decedent;

(ii) The child has been judicially determined, before the decedent's death, to be his child;

(iii) The child has been otherwise proved, by evidence satisfactory to the

employing agency, to be the decedent's child; or

(iv) The decedent had been judicially ordered to contribute to the child's support.

(c) ''Parent'' or ''parents'' mean the deceased employee's natural father and mother or father and mother through adoption. It also includes persons who stood in loco parentis to the decedent for a period of not less than one year at any time before the decedent became an employee.

(1) A person stood in loco parentis when the person assumed the status of parent toward the deceased employee. (Any person who takes a child of another into his or her home and treats the child as a member of his or her family, providing parental supervision, support, and education as if the child were his or her own child, will be considered to stand in loco parentis.)

(2) Only one father and one mother, or their counterparts in loco parentis, may be recognized in any case.

(3) Preference will be given to those who exercised a parental relationship on the date, or most nearly before the date, on which the decedent became an employee.

(d) ''Brother'' and ''sister'' mean any person, without regard to age or marital status, who is a natural brother or sister of the decedent, a half-brother or half-sister, or a brother or sister through adoption. Step-brothers or step-sisters of the decedent are not considered a ''brother'' or a ''sister.''

§ 10.907 What order of precedence will OWCP use to determine which survivors are entitled to receive the death gratuity payment under this subpart?

If OWCP determines that an employee's death qualifies for the death gratuity, the FECA provides that the death gratuity payment will be disbursed to the living survivor(s) highest on the following list:

(a) The employee's surviving spouse.

(b) The employee's children, in equal shares.

(c) The employee's parents, brothers, and sisters, or any combination of them, if designated by the employee pursuant to the designation procedures in § 10.909.

(d) The employee's parents, in equal shares.

(e) The employee's brothers and sisters, in equal shares.

§ 10.908 Can an employee designate alternate beneficiaries to receive a portion of the death gratuity payment?

An employee may designate another person or persons to receive not more than 50 percent of the death gratuity payment pursuant to the designation procedures in § 10.909. Only living persons, rather than trusts, corporations or other legal entities, may be designated under this subsection. The balance of the death gratuity will be paid according to the order of precedence described in § 10.907.

§ 10.909 How does an employee designate a variation in the order or percentage of gratuity payable to survivors and how does the employee designate alternate beneficiaries?

(a) Form CA–40 must be used to make a variation in the order or percentages of survivors under § 10.907 and/or to make an alternate beneficiary designation under § 10.908. A designation may be made at any time before the employee's death, regardless of the time of injury. The form will not be valid unless it is signed by the employee and received and signed prior to the death of the employee by the supervisor of the employee or by another official of the employing agency authorized to do so.

(b) Alternatively, any paper executed prior to the effective date of this regulation that specifies an alternate beneficiary of the death gratuity payment will serve as a valid designation if it is in writing, completed before the employee's death, signed by the employee, and signed prior to the death of the employee by the supervisor of the employee or by another official of the employing agency authorized to do so.

(c) If an employee makes a survivor designation under § 10.907(c), but does not designate the portions to be received by each designated survivor, the death gratuity will be disbursed to the survivors in equal shares.

(d) An alternate beneficiary designation made under § 10.908 must indicate

the percentage of the death gratuity, in 10 percent increments up to the maximum of 50 percent, that the designated person(s) will receive. No more than five alternate beneficiaries may be designated. If the designation fails to indicate the percentage to be paid to an alternate beneficiary, the designation to that person will be invalid.

§ 10.910 What if a person entitled to a portion of the death gratuity payment dies after the death of the covered employee but before receiving his or her portion of the death gratuity?

(a) If a person entitled to all or a portion of the death gratuity due to the order of precedence for survivors in § 10.907 dies after the death of the covered employee but before the person receives the death gratuity, the portion will be paid to the living survivors otherwise eligible according to the order of precedence prescribed in that subsection.

(b) If a survivor designated under the survivor designation provision in § 10.907(c) dies after the death of the covered employee but before receiving his or her portion of the death gratuity, the survivor's designated portion will be paid to the next living survivors according to the order of precedence.

(c) If a person designated as an alternate beneficiary under § 10.908 dies after the death of the covered employee but before the person receives his or her designated portion of the death gratuity, the designation to that person will have no effect. The portion designated to that person will be paid according to the order of precedence prescribed in § 10.907.

(d) If there are no living survivors or alternate beneficiaries, the death gratuity will not be paid.

§ 10.911 How is the death gratuity payment process initiated?

(a) Either the employing agency or a living claimant (survivor or alternate beneficiary) may initiate the death gratuity payment process. If the death gratuity payment process is initiated by the employing agency notifying OWCP of the employee's death, each claimant must file a claim with OWCP in order to receive payment of the death gratuity. The legal representative or guardian of any minor child may file on the child's behalf. Alternatively, if a claimant initiates the death gratuity payment process by filing a claim, the employing agency must complete a death notification form and submit it to OWCP. Other claimants must also file a claim for their portion of the death gratuity.

(b) The employing agency must notify OWCP immediately upon learning of an employee's death that may be eligible for benefits under this subpart, by submitting form CA–42 to OWCP. The agency must also submit to OWCP any designation forms completed by the employee, and the agency must provide as much information as possible about any living survivors or alternate beneficiaries of which the agency is aware.

(1) OWCP will then contact any living survivor(s) or alternate beneficiary(ies) it is able to identify.

(2) OWCP will furnish claim form CA–41 to any identified survivor(s) or alternate beneficiary(ies) and OWCP will provide information to them explaining how to file a claim for the death gratuity.

(c) Alternatively, any claimant may file a claim for death gratuity benefits with OWCP. Form CA–41 may be used for this purpose. The claimant will be required to provide any information that he or she has regarding any other beneficiaries who may be entitled to the death gratuity payment. The claimant must disclose, in addition to the Social Security number (SSN) of the deceased employee, the SSNs (if known) and all known contact information of all other possible claimants who may be eligible to receive the death gratuity payment. The claimant must also identify, if known, the agency that employed the deceased employee when he or she incurred the injury that caused his or her death. OWCP will then contact the employing agency and notify the agency that it must complete and submit form CA–42 for the employee. OWCP will also contact any other living survivor(s) or alternate beneficiary(ies) it is able to identify, furnish to them claim form CA–41, and provide information explaining how to file a claim for the death gratuity.

(d) If a claimant submits a claim for the death gratuity to an employing

agency, the agency must promptly transmit the claim to OWCP. This includes both claim forms CA–41 and any other claim or paper submitted which appears to claim compensation on account of the employee's death.

§ 10.912 What is required to establish a claim for the death gratuity payment?

Claim form CA–41 describes the basic requirements. Much of the required information will be provided by the employing agency when it completes notification form CA–42. However, the claimant bears the burden of proof to ensure that OWCP has the evidence needed to establish the claim. OWCP may send any request for additional evidence to the claimant and to his or her representative, if any. Evidence should be submitted in writing. The evidence submitted must be reliable, probative, and substantial. Each claim for the death gratuity must establish the following before OWCP can pay the gratuity:

(a) That the claim was filed within the time limits specified by the FECA, as prescribed in 5 U.S.C. 8122 and this part. Timeliness is based on the date that the claimant filed the claim for the death gratuity under §10.911, not the date the employing agency submitted form CA–42. As procedures for accepting and paying retroactive claims were not available prior to the publication of the interim final rule, the applicable statute of limitations began to run for a retroactive payment under this subpart on August 18, 2009.

(b) That the injured person, at the time he or she incurred the injury or disease, was an employee of the United States as defined in 5 U.S.C. 8101(1) and §10.5(h) of this part, or a non-appropriated fund instrumentality employee, as defined in 10 U.S.C. 1587(a)(1).

(c) That the injury or disease occurred and that the employee's death was causally related to that injury or disease. The death certificate of the employee must be provided. Often, the employing agency will provide the death certificate and any needed medical documentation. OWCP may request from the claimant any additional documentation that may be needed to establish the claim.

(d) That the employee incurred the injury or disease in connection with the employee's service with an Armed Force in a contingency operation. This will be determined from evidence provided by the employing agency or otherwise obtained by OWCP and from any evidence provided by the claimant.

(1) Section 8102a defines ''contingency operation'' to include humanitarian operations, peacekeeping operations, and similar operations. (''Similar operations'' will be determined by OWCP.)

(i) A ''contingency operation'' is defined by 10 U.S.C. 101(a)(13) as a military operation that—

(A) Is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or

(B) Results in the call or order to, or retention on, active duty of members of the uniformed services under section 688, 12301(a), 12302, 12304, 12305, or 12406 of Title 10, chapter 15 of Title 10, or any other provision of law during a war or during a national emergency declared by the President or Congress.

(ii) A ''humanitarian or peacekeeping operation'' is defined by 10 U.S.C. 2302(8) as a military operation in support of the provision of humanitarian or foreign disaster assistance or in support of a peacekeeping operation under chapter VI or VII of the Charter of the United Nations. The term does not include routine training, force rotation, or stationing.

(iii) ''Humanitarian assistance'' is defined by 10 U.S.C. 401(e) to mean medical, surgical, dental, and veterinary care provided in areas of a country that are rural or are underserved by medical, surgical, dental, and veterinary professionals, respectively, including education, training, and technical assistance related to the care provided; construction of rudimentary surface transportation systems; well drilling and construction of basic sanitation facilities; rudimentary construction and repair of public facilities.

(2) A contingency operation may take place within the United States or abroad. However, operations of the National Guard are only considered ''contingency operations'' for purposes of this subpart when the President, Secretary of the Army, or Secretary of the Air Force calls the members of the National Guard into service. A ''contingency operation'' does not include operations of the National Guard when called into service by a Governor of a State.

(3) To show that the injury or disease was incurred ''in connection with'' the employee's service with an Armed Force in a contingency operation, the claim must show that the employee incurred the injury or disease while in the performance of duty as that phrase is defined for the purposes of otherwise awarding benefits under FECA.

(4)(i) When the contingency operation occurs outside of the United States, OWCP will find that an employee's injury or disease was incurred ''in connection with'' the employee's service with an Armed Force in a contingency operation if the employee incurred the injury or disease while performing assignments in the same region as the operation, unless there is conclusive evidence that the employee's service was not supporting the Armed Force's operation.

(ii) Economic or social development projects, including service on Provincial Reconstruction Teams, undertaken by covered employees in regions where an Armed Force is engaged in a contingency operation will be considered to be supporting the Armed Force's operation.

(5) To show that an employee's injury or disease was incurred ''in connection with'' the employee's service with an Armed Force in a contingency operation, the claimant will be required to establish that the employee's service was supporting the Armed Force's operation. The death gratuity does not cover Federal employees who are performing service within the United States that is not supporting activity being performed by an Armed Force.

(e) The claimant must establish his or her relationship to the deceased employee so that OWCP can determine whether the claimant is the survivor entitled to receive the death gratuity payment according to the order of precedence prescribed in §10.907.

§ 10.913 In what situations will OWCP consider that an employee incurred injury in connection with his or her service with an Armed Force in a contingency operation?

(a) OWCP will consider that an employee incurred injury in connection with service with an Armed Force in a contingency operation if:

(1) The employee incurred injury while serving under the direction or supervision of an official of an Armed Force conducting a contingency operation; or

(2) The employee incurred injury while riding with members of an Armed Force in a vehicle or other conveyance deployed to further an Armed Force's objectives in a contingency operation.

(b) An employee may incur injury in connection with service with an Armed Force in a contingency operation in situations other than those listed above. Additional situations will be determined by OWCP on a case-by-case basis.

§ 10.914 What are the responsibilities of the employing agency in the death gratuity payment process?

Because some of the information needed to establish a claim under this subpart will not be readily available to the claimants, the employing agency of the deceased employee has significant responsibilities in the death gratuity claim process. These responsibilities are as follows:

(a) The agency must completely fill out form CA–42 immediately upon learning of an employee's death that may be eligible for benefits under this subpart. The agency must complete form CA–42 as promptly as possible if notified by OWCP that a survivor filed a claim based on the employee's death. The agency should provide as much information as possible regarding the circumstances of the employee's injury and his or her assigned duties at the time of the injury, so that OWCP can determine whether the injury was incurred in the performance of duty and whether the employee was performing service in connection with an Armed

Force in a contingency operation at the time.

(b) The employing agency must promptly transmit any form CA–41s received from claimants to OWCP. The employer must also promptly transmit to OWCP any other claim or paper submitted that appears to claim compensation on account of the employee's death.

(c) The employing agency must maintain any designations completed by the employee and signed by a representative of the agency in the employee's official personnel file or a related system of records. The agency must forward any such forms to OWCP if the agency submits form CA–42 notifying OWCP of the employee's death. The agency must also forward any other paper signed by the employee and employing agency that appears to make designations of the death gratuity.

(d) If requested by OWCP, the employing agency must determine whether a survivor, who is claiming the death gratuity based on his or her status as an illegitimate child of a deceased male employee, has offered satisfactory evidence to show that he or she is in fact the employee's child.

(e) The employing agency must notify OWCP of any other death gratuity payments under any other law of the United States for which the employee's death qualifies. The employing agency also must notify OWCP of any other death gratuity payments that have been paid based on the employee's death.

(f) Non-appropriated fund instrumentalities must fulfill the same requirements under this subpart as any other employing agency.

§ 10.915 What are the responsibilities of OWCP in the death gratuity payment process?

(a) If the death gratuity payment process is initiated by the employing agency's submission of form CA–42, OWCP will identify living potential claimants. OWCP will make a reasonable effort to provide claim form CA–41s to any known potential claimants and provide instructions on how to file a claim for the death gratuity payment.

(b) If the death gratuity payment process is initiated by a claimant's submission of a claim, OWCP will contact the employing agency and prompt it to submit form CA–42. OWCP will then review the information provided by both the claim and form CA–42, and OWCP will attempt to identify all living survivors or alternate beneficiaries who may be eligible for payment of the gratuity.

(c) If OWCP determines that the evidence is not sufficient to meet the claimant's burden of proof, OWCP will notify the claimant of the additional evidence needed. The claimant will be allowed at least 30 days to submit the additional evidence required. OWCP may also request additional information from the employing agency.

(d) OWCP will review the information provided by the claimant and information provided by the employing agency to determine whether the claim satisfies all the requirements listed in § 10.912.

(e) OWCP will calculate the amount of the death gratuity payment and pay the beneficiaries as soon as possible after accepting the claim.

§ 10.916 How is the amount of the death gratuity calculated?

The death gratuity payment under this subpart equals $100,000 minus the amount of any death gratuity payments that have been paid under any other law of the United States based on the same death. A death gratuity payment is a payment in the nature of a gift, beyond reimbursement for death and funeral expenses, relocation costs, or other similar death benefits. Only other death gratuity payments will reduce the amount of the death gratuity provided in this subpart. For this reason, death benefits provided to the same employee's survivors such as those under 5 U.S.C. 8133 as well as benefits paid under 5 U.S.C. 8134 are not death gratuity payments, and therefore have no effect on the amount of the death gratuity provided under this subpart.

(a) A payment provided under section 413 of the Foreign Service Act of 1980 (22 U.S.C. 3973), is a death gratuity payment, and if a deceased employee's survivors received that payment for the

employee's death, the amount of the death gratuity paid to the survivors under this subpart would be reduced by the amount of the Foreign Service Act death gratuity. Other death gratuities that would affect the calculation of the amount payable include but are not limited to: the gratuity provision in section 1603 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (Pub. L. 109–234, June 15, 2006); the $10,000 death gratuity to the personal representative of civilian employees, at Title VI, Section 651 of the Omnibus Consolidated Appropriations Act of 1996 (Pub. L. 104–208, September 30, 1996); the death gratuity for members of the Armed Forces or any employee of the Department of Defense dying outside the United States while assigned to intelligence duties, at 10 U.S.C. 1489; and the death gratuity for employees of the Central Intelligence Agency, at 50 U.S.C. 403k.

(b) The amount of the death gratuity under this section will be calculated before it is disbursed to the employee's survivors or alternate beneficiaries, by taking into account any death gratuities paid by the time of disbursement. Therefore, any designations made by the employee under §10.909 are only applicable to the amount of the death gratuity as described in paragraph (a) of this section. The following examples are intended to provide guidance in this administration of this subpart.

(1) *Example One.* An employee's survivors are entitled to the Foreign Service Act death gratuity; the employee's spouse received payment in the amount of $80,000 under that Act. A death gratuity is also payable under FECA; the amount of the FECA death gratuity that is payable is a total of $20,000. That employee, using Form CA–40 had designated 50% of the death gratuity under this subpart to be paid to his neighbor John Smith who is still living. So, 50% of the death gratuity will be paid to his spouse and the remaining 50% of the death gratuity paid under this subpart would be paid to John Smith. This means the surviving spouse will receive $10,000 and John Smith will receive $10,000.

(2) *Example Two.* Employee dies in circumstances that would qualify her for payment of the gratuity under this subpart; her agency has paid the $10,000 death gratuity pursuant to Public Law 104–208. The employee had not completed any designation form. The FECA death gratuity is reduced by the $10,000 death gratuity and employee's spouse receives $90,000.

(3) *Example Three.* An employee of the Foreign Service whose annual salary is $75,000 dies in circumstances that would qualify for payment of both the Foreign Service Act death gratuity and the death gratuity under this subpart. Before his death, the employee designated that 40% of the death gratuity under this subpart be paid to his cousin Jane Smith, pursuant to the alternate beneficiary designation provision at §10.908 and that 10% be paid to his uncle John Doe who has since died. At the time of his death, the employee had no surviving spouse, children, parents, or siblings. Therefore, the Foreign Service Act death gratuity will not be paid, because no eligible survivors according to the Foreign Service Act provision exist. The death gratuity under this subpart would equal $100,000, because no other death gratuity has been paid, and Jane would receive $40,000 according to the employee's designation. As John Doe is deceased, no death gratuity may be paid pursuant to the designation of a share of the death gratuity to him.

PART 25—COMPENSATION FOR DISABILITY AND DEATH OF NON-CITIZEN FEDERAL EMPLOYEES OUTSIDE THE UNITED STATES

Subpart A—General Provisions

Sec.

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AUTHORITY: 5 U.S.C. 301, 8137, 8145 and 8149; 1946 Reorganization Plan No. 2, sec. 3, 3 CFR 1943–1948 Comp., p. 1064; 60 Stat. 1095; Reorganization Plan No. 19 of 1950, sec. 1, 3 CFR 1943–1953 Comp., p. 1010; 64 Stat. 1271; Secretary of Labor's Order No. 10–2009, 74 FR 218.

SOURCE: 76 FR 37947, June 28, 2011, unless otherwise noted.

Subpart A—General Provisions

§ 25.1 How are claims of Federal employees who are neither citizens nor residents adjudicated?

This part describes how OWCP pays compensation under the FECA to employees of the United States who are neither citizens nor residents of the United States, any territory or Canada, as well as to any dependents of such employees. It has been determined that the compensation provided under the FECA is substantially disproportionate to the compensation for disability or death which is payable in similar cases under local law, regulation, custom or otherwise, in areas outside the United States, any territory or Canada and therefore a special schedule should apply to such cases This special schedule applies to any non-citizen non-resident Federal employee who is neither hired nor employed in the United States, Canada or in a possession or territory of the United States. Therefore, with respect to the claims of such employees whose injury (or injury resulting in death) has occurred subsequent to August 29, 2011, or may occur, the regulations in this part shall apply.

§ 25.2 In general, what is the Director's policy regarding such claims?

(a) Pursuant to 5 U.S.C. 8137(a)(2), a special schedule is established by subpart B of this part that applies to any non-citizen non-resident Federal employee who is neither hired nor employed in the United States, Canada or in a possession or territory of the United States (hereinafter non-citizen non-resident employees). The special schedule in subpart B of this part is subject to the exceptions set forth in paragraph (b) of this section. The special schedule set forth in subpart B of this part applies to claims of such employees whose injury (or injury resulting in death) occurred on or after August 29, 2011.

(b) This special schedule of compensation established by subpart B of this part shall apply to non-citizen non-resident employees outside of the United States unless:

(1) The injured employee receives compensation pursuant to a specific separate agreement between the United States and another government (or similar compensation from another sovereign government);

(2) The employee receives compensation pursuant to the special schedule under subpart C for the particular locality, or for a class of employees in that particular locality; or

(3) The employee otherwise establishes entitlement to compensation under local law pursuant to § 25.100(e).

(c) Compensation in all cases of such employees paid and closed prior to August 29, 2011 shall be deemed compromised and paid under 5 U.S.C. 8137. In all other cases, compensation may be adjusted to conform with the regulations in this part, or the beneficiary may by compromise or agreement with the Director have compensation continued on the basis of a previous adjustment of the claim.

(d) Compensation received by beneficiaries pursuant to 5 U.S.C. 8137 and the special schedule set forth in subpart B or as otherwise specified in paragraph (b) of this section is the exclusive measure of compensation in cases of injury (or death from injury)

to non-citizen non-resident employees of the United States as specified in paragraph (a) of this section.

(e) Compensation for disability and death of non-citizen non-resident employees outside the United States under this part shall in no event exceed that generally payable under the FECA.

§ 25.3 What is the authority to settle and pay such claims?

In addition to the authority to receive, process and pay claims, when delegated such representative or agency receiving delegation of authority shall, in respect to cases adjudicated under this part, and when so authorized by the Director, have authority to make lump-sum awards (in the manner prescribed by 5 U.S.C. 8135) whenever such authorized representative shall deem such settlement to be for the best interest of the United States, and to compromise and pay claims for any benefits provided for under this part, including claims in which there is a dispute as to questions of fact or law. The Director shall, in instructions to the particular representative concerned, establish such procedures in respect to action under this section as he or she may deem necessary, and may specify the scope of any administrative review of such action.

§ 25.4 What type of evidence is required to establish a claim under this part?

Claims of non-citizen non-resident employees of the United States as specified in §25.2(a), if otherwise compensable, shall be approved only upon evidence of the following nature without regard to the date of injury or death for which the claim is made:

(a) Appropriate certification by the Federal employing establishment; or

(b) An armed service's casualty or medical record; or

(c) Verification of the employment and casualty by Department of Defense personnel; or

(d) Recommendation of an armed service's ''Claim Service'' based on investigations conducted by it.

§ 25.5 How does OWCP adjudicate claims of non-citizen residents of possessions or territories?

An employee who is a bona fide permanent resident of any United States possession, territory, commonwealth, or trust territory will receive the full benefits of the FECA, as amended, except that the application of the minimum benefit provisions provided therein shall be governed by the restrictions set forth in 5 U.S.C. 8138.

Subpart B—The Special Schedule of Compensation

§ 25.100 What general provisions does OWCP apply to the Special Schedule?

(a) The definitions of terms in the FECA, as amended, shall apply to terms used in this subpart.

(b) The provisions of the FECA, unless modified by this subpart or otherwise inapplicable, shall be applied whenever possible in the application of this subpart.

(c) The provisions of the regulations for the administration of the FECA, as amended or supplemented from time to time by instructions applicable to this subpart, shall apply in the administration of compensation under this subpart, whenever they can reasonably be applied.

§ 25.101 How is compensation for disability paid?

Compensation for disability shall be paid to the non-citizen non-resident employee as follows:

(a) *Temporary total disability*. Where the injured employee is disabled and unable to earn wages equivalent to those earned at the time of injury for a period of time less than two years, the employee shall receive 50 percent of the monthly pay during the period of such disability.

(b) *Temporary partial disability*. Where the injured employee is disabled and unable to earn equivalent wages to those earned at the time of injury, but who is not totally disabled for work, the injured employee shall receive during the period of disability, that proportion of compensation for temporary total disability, as determined under paragraph (a) of this section, which is

equal in percentage to the degree or percentage of physical impairment caused by the disability.

(c) *Permanent total disability.* Where it is found that the injured employee is disabled and will be or has been unable to earn equivalent wages to those earned at the time of injury for greater than two years, the employee is deemed permanently disabled. Such employee shall receive a lump sum settlement based on compensation equaling 50 percent of the monthly pay or a percentage proportionate to the extent of disability. The lump sum award shall be made by the manner prescribed by 5 U.S.C. 8135.

(d) *Permanent partial disability.* Where there is permanent disability (impairment) involving the loss, or loss of use, of a member or function of the body, the injured employee is entitled to schedule compensation at 50 percent of the monthly pay to be paid in a lump sum according to 5 U.S.C. 8135, for the following losses and periods:

(1) Arm lost: 312 weeks' compensation.

(2) Leg lost: 288 weeks' compensation.

(3) Hand lost: 244 weeks' compensation.

(4) Foot lost: 205 weeks' compensation.

(5) Eye lost: 160 weeks' compensation.

(6) Thumb lost: 75 weeks' compensation.

(7) First finger lost: 46 weeks' compensation.

(8) Great toe lost: 38 weeks' compensation.

(9) Second finger lost: 30 weeks' compensation.

(10) Third finger lost: 25 weeks' compensation.

(11) Toe, other than great toe, lost: 16 weeks' compensation.

(12) Fourth finger lost: 15 weeks' compensation.

(13) Loss of hearing: One ear, 52 weeks' compensation; both ears, 200 weeks' compensation.

(14) Breast (one) lost: 52 weeks' compensation.

(15) Kidney (one) lost: 156 weeks' compensation.

(16) Larynx lost: 160 weeks' compensation.

(17) Lung (one) lost: 156 weeks' compensation.

(18) Penis lost: 205 weeks' compensation.

(19) Testicle (one) lost: 52 weeks' compensation.

(20) Tongue lost: 160 weeks' compensation.

(21) Ovary (one) lost: 52 weeks' compensation.

(22) Uterus/cervix and vulva/vagina lost: 205 weeks' compensation.

(23) Skin: 205 weeks' compensation.

(24) Phalanges: Compensation for loss of more than one phalanx of a digit shall be the same as for the loss of the entire digit. Compensation for loss of the first phalanx shall be one-half of the compensation for the loss of the entire digit.

(25) Amputated arm or leg: Compensation for an arm or a leg, if amputated at or above the elbow or the knee, shall be the same as for the loss of the arm or leg; but, if amputated between the elbow and the wrist, or between the knee and the ankle, the compensation shall be the same as for the loss of the hand or the foot.

(26) Binocular vision or percent of vision: Compensation for loss of binocular vision, or for 80 percent or more of the vision of an eye shall be the same as for the loss of the eye.

(27) Two or more digits: Compensation for loss of two or more digits, one or more phalanges of two or more digits of a hand or foot may be proportioned to the loss of use of the hand or foot occasioned thereby, but shall not exceed the compensation for the loss of a hand or a foot.

(28) Total loss of use: Compensation for a permanent total loss of use of a member shall be the same as for loss of the member.

(29) Partial loss or partial loss of use: Compensation for permanent partial loss or loss of use of a member may be for proportionate loss of use of the member.

(30) Consecutive awards: In any case in which there occurs a loss or loss of use of more than one member or parts of more than one member set forth in paragraph (d) of this section, but not amounting to permanent total disability, the award of compensation shall be for the loss or loss of use of each such member or part thereof, which awards shall run consecutively.

(31) Other cases: In all other cases within this class of disability the compensation during the continuance of disability shall be that proportion of compensation for permanent total disability, as determined under paragraph (c) of this section, which is equal in percentage to the degree or percentage of physical impairment caused by the disability.

(32) Compensation under paragraph (d) of this section for permanent partial disability shall be in addition to any compensation for temporary total or temporary partial disability under this section, and awards for temporary total, temporary partial, and permanent partial disability shall run consecutively.

(e) In the event a beneficiary covered under subpart B can demonstrate that the amount payable under the special schedule would result in a payment that would be demonstrably less than the amount payable under the law of his home country, the Director retains the discretion to pay that amount of compensation under 5 U.S.C. 8137(a)(2)(A), not to exceed the amount payable under FECA. To request benefits under this paragraph, the beneficiary must submit the following:

(1) Translated copies of the applicable local statute as well as any regulations, policies and procedures the beneficiary avers are applicable; and

(2) A translated copy of an opinion rendered by an attorney licensed in that jurisdiction or an advisory opinion from a court or administrative tribunal that explains the benefits payable to the beneficiary.

§ 25.102 How is compensation for death of a non-citizen non-resident employee paid?

If the disability causes death, the compensation shall be payable in the amount and to or for the benefit of the following persons:

(a) To the undertaker or person entitled to reimbursement, reasonable funeral expenses not exceeding $800.

(b) To the surviving spouse, if there is no child, 30 percent of the monthly pay until his or her death or remarriage subject to the lump sum provisions of 5 U.S.C. 8135.

(c) To the surviving spouse, if there is a child, the compensation payable under paragraph (b) of this section, and in addition thereto 10 percent of the monthly wage for each child, not to exceed a total of 50 percent of the monthly pay for such surviving spouse and children subject to the lump sum provisions of 5 U.S.C. 8135. If a child has a guardian other than the surviving spouse, the compensation payable on account of such child shall be paid to such guardian. The compensation entitlement of any child shall cease when he or she dies, marries or reaches the age of 18 years, or if over such age and incapable of self-support, becomes capable of self-support.

(d) To the children, if there is no surviving spouse, 25 percent of the monthly pay for one child and 10 percent thereof for each additional child, not to exceed a total of 50 percent of the monthly pay thereof, divided among such children share and share alike subject to the lump sum provisions of 5 U.S.C. 8135. The compensation entitlement of each child shall cease when he or she dies, marries or reaches the age of 18, or if over such age and incapable of self-support, becomes capable of self-support. The compensation of a child under legal age shall be paid to its guardian, if there is one, otherwise to the person having the custody or care of such child, for such child, as the Director in his or her discretion shall determine.

(e) To the parents, if one is wholly dependent for support upon the deceased employee at the time of his or her death and the other is not dependent to any extent, 20 percent of the monthly pay; if both are wholly dependent, 10 percent thereof to each; if one is or both are partly dependent, a proportionate amount in the discretion of the Director. The compensation to a parent or parents in the percentages specified shall be paid if there is no surviving spouse or child, but if there is a surviving spouse or child, there shall be paid so much of such percentages for a parent or parents as, when added to the total of the percentages of the surviving spouse and children, will not exceed a total of 50 percent of the

monthly pay. These payments are subject to the lump sum provision of 5 U.S.C. 8135.

(f) To the brothers, sisters, grandparents and grandchildren, if one is wholly dependent upon the deceased employee for support at the time of his or her death, 20 percent of the monthly pay to such dependent; if more than one are wholly dependent, 30 percent of such pay, divided among such dependents share and share alike; if there is no one of them wholly dependent, but one or more are partly dependent, 10 percent of such pay divided among such dependents share and share alike. The compensation to such beneficiaries shall be paid if there is no surviving spouse, child or dependent parent. If there is a surviving spouse, child or dependent parent, there shall be paid so much of the above percentages as, when added to the total of the percentages payable to the surviving spouse, children and dependent parents, will not exceed a total of 50 percent of such pay. These payments are subject to the lump sum provision of 5 U.S.C. 8135.

(g) The compensation entitlement of each beneficiary under paragraphs (e) and (f) of this section shall be paid until he or she, if a parent or grandparent, dies, marries or ceases to be dependent, or, if a brother, sister or grandchild, dies, marries or reaches the age of 18 years, or if over such age and incapable of self-support, becomes capable of self-support. The compensation of a brother, sister or grandchild under legal age shall be paid to his or her guardian, if there is one, otherwise to the person having the custody or care of such person, for such person, as the Director in his or her discretion shall determine.

(h) Upon the cessation of any person's compensation for death under this subpart, the compensation of any remaining person entitled to continuing compensation in the same case shall remain the same so that the continuing compensation shall be at the same rate each person previously received.

(i) In cases where there are two or more classes of persons entitled to compensation for death under this subpart, and the apportionment of such compensation as provided in this section would result in injustice, the Director may in his or her discretion modify the apportionments to meet the requirements of the case.

(j) Compensation for death shall be paid where practicable in a lump sum pursuant to section 8135.

(k) In the event a beneficiary eligible for death benefits covered under subpart B can demonstrate that the amount payable under the special schedule would result in a payment that would be demonstrably less than the amount payable under the law of his home country, the Director retains the discretion to pay that amount of compensation under 5 U.S.C. 8137(a)(2)(A), not to exceed the amount payable under FECA. To request benefits under this paragraph, the beneficiary must submit the following:

(1) Translated copies of the applicable local statute as well as any regulations, policies and procedures the beneficiary asserts are applicable; and

(2) A translated copy of an opinion rendered by an attorney licensed in that jurisdiction or an advisory opinion from a court or administrative tribunal that explains the benefits payable to the beneficiary.

(l) A FECA death gratuity of $65,000 may be payable for the death of a non-citizen non-resident employee should the death be a result of injury incurred in connection with service with an Armed Force in a contingency operation as set forth in subpart J of part 10.

Subpart C—Extensions of the Special Schedule of Compensation

§ 25.200 How is the Special Schedule applied for employees in the Republic of the Philippines?

(a) *Modified special schedule of compensation.* Except for injury or death of direct-hire employees of the U.S. Military Forces covered by the Philippine Medical Care Program and the Employees' Compensation Program pursuant to the agreement signed by the United States and the Republic of the Philippines on March 10, 1982 who are also members of the Philippine Social Security System, the special schedule of compensation established in subpart B

of this part shall apply, with the modifications or additions specified in paragraphs (b) through (k) of this section, in the Republic of the Philippines, to injury or death occurring on or after July 1, 1968, with the following limitations:

(1) *Temporary disability.* Benefits for payments accruing on and after July 1, 1969, for injuries causing temporary disability and which occurred on and after July 1, 1968, shall be payable at the rates in the special schedule as modified in this section.

(2) *Permanent disability and death.* Benefits for injuries occurring on and after July 1, 1968, which cause permanent disability or death, shall be payable at the rates specified in the special schedule as modified in this section for all awards not paid in full before July 1, 1969, and any award paid in full prior to July 1, 1969: Provided, that application for adjustment is made, and the adjustment will result in additional benefits of at least $10. In the case of injuries or death occurring on or after December 8, 1941 and prior to July 1, 1968, the special schedule as modified in this section may be applied to prospective awards for permanent disability or death, provided that the monthly and aggregate maximum provisions in effect at the time of injury or death shall prevail. These maxima are $50 and $4,000, respectively.

(b) *Death benefits.* 400 weeks' compensation at two-thirds of the weekly wage rate, shared equally by the eligible survivors in the same class.

(c) *Death beneficiaries.* Benefits are payable to the survivors in the following order of priority (all beneficiaries in the highest applicable classes are entitled to share equally):

(1) Surviving spouse and unmarried children under 18, or over 18 and totally incapable of self-support.

(2) Dependent parents.

(3) Dependent grandparents.

(4) Dependent grandchildren, brothers and sisters who are unmarried and under 18, or over 18 and totally incapable of self-support.

(d) *Burial allowance.* 14 weeks' wages or $400, whichever is less, payable to the eligible survivor(s), regardless of the actual expense. If there is no eligible survivor, actual burial expenses may be paid or reimbursed, in an amount not to exceed what would be paid to an eligible survivor.

(e) *Permanent total disability.* 400 weeks' compensation at two-thirds of the weekly wage rate.

(f) *Permanent partial disability.* Where applicable, the compensation provided in § 25.100(c)(1) through (19) subject to an aggregate limitation of 400 weeks' compensation. In all other cases, provided for permanent total disability that proportion of the compensation (paragraph (e) of this section) which is equivalent to the degree or percentage of physical impairment caused by the disability.

(g) *Temporary partial disability.* Two-thirds of the weekly loss of wage-earning capacity.

(h) *Compensation period for temporary disability.* Compensation for temporary disability is payable for a maximum period of 80 weeks.

(i) *Maximum compensation.* The total aggregate compensation payable in any case, for injury or death or both, shall not exceed $8,000, exclusive of medical costs and burial allowance. The weekly rate of compensation for disability or death shall not exceed $35.

(j) *Method of payment.* Only compensation for temporary disability shall be payable periodically. Compensation for permanent disability and death shall be payable in full at the time the extent of entitlement is established.

(k) *Exceptions.* The Director in his or her discretion may make exceptions to the regulations in this section by:

(1) Reapportioning death benefits, for the sake of equity.

(2) Excluding from consideration potential death beneficiaries who are not available to receive payment.

(3) Paying compensation for permanent disability or death on a periodic basis, where this method of payment is considered to be in the best interest of the beneficiary.

§ 25.201 How is the Special Schedule applied for employees in Australia?

(a) The special schedule of compensation established by subpart B of this part shall apply in Australia with the modifications or additions specified in

paragraph (b) of this section, as of December 8, 1941, in all cases of injury (or death from injury) which occurred between December 8, 1941 and December 31, 1961, inclusive, and shall be applied retrospectively in all such cases of injury (or death from injury). Compensation in all such cases pending as of July 15, 1946, shall be readjusted accordingly, with credit taken in the amount of compensation paid prior to such date. Refund of compensation shall not be required if the amount of compensation paid in any such case, otherwise than through fraud, misrepresentation or mistake, and prior to July 15, 1946, exceeds the amount provided for under this paragraph, and such case shall be deemed compromised and paid under 5 U.S.C. 8137.

(b) The total aggregate compensation payable in any case under paragraph (a) of this section, for injury or death or both, shall not exceed the sum of $4,000, exclusive of medical costs. The maximum monthly rate of compensation in any such case shall not exceed the sum of $50.

(c) The benefit amounts payable under the provisions of the Commonwealth Employees' Compensation Act of 1930–1964, Australia, shall apply as of January 1, 1962, in Australia, as the exclusive measure of compensation in cases of injury (or death from injury) according on and after January 1, 1962, and shall be applied retrospectively in all such cases, occurring on and after such date: Provided, that the compensation payable under the provisions of this paragraph shall in no event exceed that payable under the FECA.

§ 25.202 How is the Special Schedule applied for Japanese seamen?

(a) *General.* The special schedule of compensation established by subpart B of this part shall apply as of November 1, 1971, with the modifications or additions specified in paragraphs (b) through (i) of this section, to injuries sustained outside the continental United States or Canada by direct-hire Japanese seamen who are neither citizens nor residents of the United States or Canada and who are employed by the Military Sealift Command in Japan.

(b) *Temporary total disability.* Weekly compensation shall be paid at 75 percent of the weekly wage rate.

(c) *Temporary partial disability.* Weekly compensation shall be paid at 75 percent of the weekly loss of wage-earning capacity.

(d) *Permanent total disability.* Compensation shall be paid in a lump sum equivalent to 360 weeks' wages.

(e) *Permanent partial disability.* (1) The provisions of § 25.101 of this part shall apply to the types of permanent partial disability listed in paragraphs (d)(1) through (13) and (d)(24) through (29) of that section: Provided that weekly compensation shall be paid at 75 percent of the weekly wage rate and that the number of weeks allowed for specified losses shall be changed as follows:

(i) Arm lost: 312 weeks.
(ii) Leg lost: 288 weeks.
(iii) Hand lost: 244 weeks.
(iv) Foot lost: 205 weeks.
(v) Eye lost: 160 weeks.
(vi) Thumb lost: 75 weeks.
(vii) First finger lost: 46 weeks.
(viii) Second finger lost: 30 weeks.
(ix) Third finger lost: 25 weeks.
(x) Fourth finger lost: 15 weeks.
(xi) Great toe lost: 38 weeks.
(xii) Toe, other than great toe lost: 16 weeks.

(2) In all other cases, that proportion of the compensation provided for permanent total disability in paragraph (d) of this section which is equivalent to the degree or percentage of physical impairment caused by the injury.

(f) *Death.* If there are two or more eligible survivors, compensation equivalent to 360 weeks' wages shall be paid to the survivors, share and share alike. If there is only one eligible survivor, compensation equivalent to 300 weeks' wages shall be paid. The following survivors are eligible for death benefits:

(1) Spouse who lived with or was dependent upon the employee.

(2) Unmarried children under 21 who lived with or were dependent upon the employee.

(3) Adult children who were dependent upon the employee by reason of physical or mental disability.

(4) Dependent parents, grandparents and grandchildren.

(g) *Burial allowance.* $1,000 payable to the eligible survivor(s), regardless of

actual expenses. If there are no eligible survivors, actual expenses may be paid or reimbursed, up to $1,000.

(h) *Method of payment.* Only compensation for temporary disability shall be payable periodically, as entitlement accrues. Compensation for permanent disability and death shall be payable in a lump sum.

(i) *Maxima.* In all cases, the maximum weekly benefit shall be $130. Also, except in cases of permanent total disability and death, the aggregate maximum compensation payable for any injury shall be $51,000. This amount will be adjusted annually on March 1 in accordance with the percentage amount determined by the cost of living adjustment under 5 U.S.C. 8146a.

(j) *Prior injury.* In cases where injury or death occurred prior to November 1, 1971, benefits will be paid in accordance with regulations promulgated, contained in 20 CFR parts 1–399, edition revised as of January 1, 1971.

§ 25.203 How is the Special Schedule applied to non-resident aliens in the Territory of Guam?

The special schedule of compensation established by subpart B of this part shall apply to an injury or death occurring on or after August 29, 2011 in the Territory of Guam to non-resident alien employees recruited in foreign countries for employment by the military departments in the Territory of Guam. This schedule shall not apply to any employee who becomes a bona fide permanent resident as such claims will be decided in accordance with § 25.5.

SUBCHAPTER C—ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT OF 2000

PART 30—CLAIMS FOR COMPENSATION UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT OF 2000, AS AMENDED

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AUTHORITY: 5 U.S.C. 301; 31 U.S.C. 3716 and 3717; 42 U.S.C. 7384d, 7384t, 7384u and 7385s–10; Executive Order 13179, 65 FR 77487, 3 CFR, 2000 Comp., p. 321; Secretary of Labor's Order No. 10–2009, 74 FR 58834.

SOURCE: 71 FR 78534, Dec. 29, 2006, unless otherwise noted.

Subpart A—General Provisions

INTRODUCTION

§ 30.0 What are the provisions of EEOICPA, in general?

Part B of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or Act), 42 U.S.C. 7384 *et seq.*, provides for the payment of compensation benefits to covered Part B employees and, where applicable, survivors of such employees, of the United States Department of Energy (DOE), its predecessor agencies and certain of its contractors and subcontractors. Part B also provides for the payment of supplemental compensation benefits to other covered Part B employees who have already been found eligible for benefits under section 5 of the Radiation Exposure Compensation Act, as amended (RECA), 42 U.S.C. 2210 note, and where applicable, survivors of such persons. Part E of the Act provides for the payment of compensation benefits to covered Part E employees and, where applicable, survivors of such employees. The regulations in this part describe the rules governing filing, processing, and paying claims for benefits under both Part B and Part E of EEOICPA.

(a) Part B of EEOICPA provides for the payment of either lump-sum monetary compensation for the disability of a covered Part B employee due to an occupational illness or for monitoring

for beryllium sensitivity, as well as for medical and related benefits for such illness. Part B also provides for the payment of monetary compensation for the disability of a covered Part B employee to specified survivors if the employee is deceased at the time of payment.

(b) Part E of EEOICPA provides for the payment of monetary compensation for the established wage-loss and/or impairment of a covered Part E employee due to a covered illness, and for medical and related benefits for such covered illness. Part E also provides for the payment of monetary compensation for the death (and established wage-loss, where applicable) of a covered Part E employee to specified survivors if the covered Part E employee is deceased at the time of payment.

(c) All types of benefits and conditions of eligibility listed in this section are subject to the provisions of EEOICPA and this part.

§ 30.1 What rules govern the administration of EEOICPA and this chapter?

In accordance with EEOICPA, Executive Order 13179 and Secretary's Order No. 10–2009, the primary responsibility for administering the Act, except for those activities assigned to the Secretary of Health and Human Services (HHS), the Secretary of Energy and the Attorney General, has been delegated to the Director of the Office of Workers' Compensation Programs (OWCP). Except as otherwise provided by law, the Director of OWCP and his or her designees have the exclusive authority to administer, interpret and enforce the provisions of the Act.

[84 FR 3046, Feb. 8, 2019]

§ 30.2 In general, how have the tasks associated with the administration of EEOICPA claims process been assigned?

(a) In E.O. 13179, the President assigned the tasks associated with administration of the EEOICPA claims process among the Secretaries of Labor, HHS and Energy, and the Attorney General. In light of the fact that the Secretary of Labor has been assigned primary responsibility for administering EEOICPA, almost the entire claims process is within the exclusive control of OWCP. This means that all claimants file their claims with OWCP, and OWCP is responsible for granting or denying compensation under the Act (see §§ 30.100 through 30.102). OWCP also provides assistance to claimants and potential claimants by providing information regarding eligibility and other program requirements, including information on completing claim forms and the types and availability of medical testing and diagnostic services related to occupational illnesses under Part B of the Act and covered illnesses under Part E of the Act. In addition, OWCP provides an administrative review process for claimants who disagree with its recommended and final adverse decisions on claims of entitlement (see §§ 30.300 through 30.320).

(b) However, HHS has exclusive control of the portion of the claims process under which it provides reconstructed doses for certain radiogenic cancer claims (see § 30.115), which it delegated to the National Institute for Occupational Safety and Health (NIOSH) in 42 CFR part 82. HHS also has exclusive control of the process for designating classes of employees to be added to the Special Exposure Cohort under Part B of the Act, and has promulgated regulations governing that process at 42 CFR part 83. Finally, HHS has promulgated regulations at 42 CFR part 81 that set out guidelines that OWCP follows when it assesses the compensability of an employee's radiogenic cancer (see § 30.213). DOE and DOJ must, among other things, notify potential claimants and submit evidence that OWCP deems necessary for its adjudication of claims under EEOICPA (see §§ 30.105, 30.112, 30.206, 30.212 and 30.221).

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3046, Feb. 8, 2019]

§ 30.3 What do these regulations contain?

This part 30 sets forth the regulations governing administration of all claims that are filed with OWCP, except to the extent specified in certain provisions. Its provisions are intended to assist persons seeking benefits under EEOICPA, as well as personnel in the

various federal agencies and DOL who process claims filed under EEOICPA or who perform administrative functions with respect to EEOICPA. The various subparts of this part contain the following:

(a) *Subpart A.* The general statutory and administrative framework for processing claims under both Parts B and E of EEOICPA. It contains a statement of purpose and scope, together with definitions of terms, information regarding the disclosure of OWCP records, and a description of rights and penalties involving EEOICPA claims, including convictions for fraud.

(b) *Subpart B.* The rules for filing claims for entitlement under EEOICPA. It also addresses general standards regarding necessary evidence and the burden of proof, descriptions of basic forms and special procedures for certain cancer claims.

(c) *Subpart C.* The eligibility criteria for occupational illnesses and covered illnesses compensable under Parts B and E of EEOICPA, respectively.

(d) *Subpart D.* The rules governing the adjudication process leading to recommended and final decisions on claims for entitlement filed under Parts B and E of EEOICPA. It also describes the hearing and reopening processes.

(e) *Subpart E.* The rules governing medical care, second opinion and referee medical examinations and impairment evaluations directed by OWCP as part of its adjudication of entitlement, and medical reports and records in general. It also addresses the kinds of medical treatment that may be authorized and how medical bills are paid.

(f) *Subpart F.* The rules relating to the payment of monetary compensation available under Parts B and E of EEOICPA. It includes provisions on medical monitoring for beryllium sensitivity, on the identification, processing and recovery of overpayments of compensation, and on the maximum aggregate amount of compensation payable under Part E.

(g) *Subpart G.* The rules concerning the representation of claimants in connection with the administrative adjudication of claims before OWCP, subrogation of the United States, the effect of tort suits against beryllium vendors and atomic weapons employers, and the coordination of benefits under Part E of EEOICPA with state workers' compensation benefits for the same covered illness.

(h) *Subpart H.* Information for medical providers. It includes rules for medical reports, medical bills, and the OWCP medical fee schedule, as well as the provisions for exclusion of medical providers.

(i) *Subpart I.* The rules relating to the adjudication of alleged periods of wage-loss of covered Part E employees. It also includes provisions on the use by OWCP of Social Security Administration earnings information and certain medical evidence to establish compensable wage-loss.

(j) *Subpart J.* The rules relating to the adjudication of alleged permanent impairment due to the exposure of covered Part E employees to toxic substances. It includes provisions relating to the medical evaluation of ratable impairments, the rating of progressive conditions, and qualifications of physicians.

DEFINITIONS

§ 30.5 What are the definitions used in this part?

(a) *Act* or *EEOICPA* means the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (42 U.S.C. 7384 *et seq.*).

(b) *Atomic weapon* means any device utilizing atomic energy, exclusive of the means for transporting or propelling the device (where such means is a separable and divisible part of the device), the principle purpose of which is for use as, or for development of, a weapon, a weapon prototype, or a weapon test device.

(c) *Atomic weapons employee* means:

(1) An individual employed by an atomic weapons employer during a period when the employer was processing or producing, for the use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; or

(2)(i) An individual employed at a facility that NIOSH reported had a potential for significant residual contamination outside of the period described in paragraph (c)(1) of this section;

(ii) By the atomic weapons employer that owned the facility referred to in paragraph (c)(2)(i) of this section, or a subsequent owner or operator of such facility; and

(iii) During a period reported by NIOSH, in its report dated October 2003 and titled ''Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities,'' or any update to that report, to have a potential for significant residual radioactive contamination.

(d) *Atomic weapons employer* means any entity, other than the United States, that:

(1) Processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; and

(2) Is designated by the Secretary of Energy as an atomic weapons employer for purposes of the compensation program.

(e) *Atomic weapons employer facility* means any facility, owned by an atomic weapons employer, that:

(1) Is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling; and

(2) Is designated as such in the list periodically published in the FEDERAL REGISTER by DOE.

(f) *Attorney General* means the Attorney General of the United States or the United States Department of Justice (DOJ).

(g) *Benefit* or *Compensation* means the money the Department pays to or on behalf of either a covered Part B employee under Part B, or a covered Part E employee under Part E, from the Energy Employees Occupational Illness Compensation Fund. However, the term ''compensation'' used in section 7385f(b) of EEOICPA (restricting entitlement to only one payment of compensation under Part B) means only the payments specified in section 7384s(a)(1) and in section 7384u(a). Except as used in section 7385f(b), these two terms also include any other amounts paid out of the Fund for such things as medical treatment, monitoring, examinations, services, appliances and supplies as well as for transportation and expenses incident to the securing of such medical treatment, monitoring, examinations, services, appliances, and supplies.

(h) *Beryllium sensitization or sensitivity* means that the individual has either:

(1) An abnormal beryllium lymphocyte proliferation test (LPT) performed on either blood or lung lavage cells; or

(2) Three borderline beryllium LPTs performed on blood cells over a period of 3 years.

(i) *Beryllium vendor* means the specific corporations and named predecessor corporations listed in section 7384l(6) of the Act and any other entities designated as such by DOE on December 27, 2002.

(j) *Beryllium vendor facility* means a facility owned and operated by a beryllium vendor.

(k) *Chronic silicosis* means a non-malignant lung disease if:

(1) The initial occupational exposure to silica dust preceded the onset of silicosis by at least 10 years; and

(2) A written diagnosis of silicosis is made by a licensed physician and is accompanied by:

(i) A chest radiograph, interpreted by an individual certified by NIOSH as a B reader, classifying the existence of pneumoconioses of category 1/0 or higher; or

(ii) Results from a computer assisted tomograph or other imaging technique that are consistent with silicosis; or

(iii) Lung biopsy findings consistent with silicosis.

(l) *Claim* means a written assertion to OWCP of an individual's entitlement to benefits under EEOICPA, submitted in a manner authorized by this part.

(m) *Claimant* means the individual who is alleged to satisfy the criteria for compensation under the Act.

(n) *Compensation fund* or *fund* means the fund established on the books of the Treasury for payment of benefits and compensation under the Act.

(o) *Contemporaneous record* means any document created at or around the time of the event that is recorded in the document.

(p) *Covered beryllium illness* means any of the following:

(1) Beryllium sensitivity as established by either:

(i) An abnormal beryllium LPT performed on either blood or lung lavage cells; or

(ii) Three borderline beryllium LPTs performed on blood cells over a period of 3 years.

(2) Established chronic beryllium disease (see § 30.207(c)).

(3) Any injury, illness, impairment, or disability sustained as a consequence of a covered beryllium illness referred to in paragraphs (o)(1) or (2) of this section.

(q) *Covered Part E employee* means, under Part E of the Act, a Department of Energy contractor employee or a RECA section 5 uranium worker who has been determined by OWCP to have contracted a covered illness (see paragraph (r) of this section) through exposure at a Department of Energy facility or a RECA section 5 facility, as appropriate.

(r) *Covered Part B employee* means, under Part B of the Act, a covered beryllium employee (see § 30.205), a covered employee with cancer (see § 30.210(a)), a covered employee with chronic silicosis (see § 30.220), or a covered uranium employee (see paragraph (s) of this section).

(s) *Covered illness* means, under Part E of the Act relating to exposures at a DOE facility or a RECA section 5 facility, an illness or death resulting from exposure to a toxic substance.

(t) *Covered uranium employee* means, under Part B of the Act, an individual who has been determined by DOJ to be entitled to an award under section 5 of RECA, whether or not the individual was the employee or the deceased employee's survivor.

(u) *Current or former employee as defined in 5 U.S.C. 8101(1)* as used in § 30.205(a)(1) means an individual who fits within one of the following listed groups:

(1) A civil officer or employee in any branch of the Government of the United States, including an officer or employee of an instrumentality wholly owned by the United States;

(2) An individual rendering personal service to the United States similar to the service of a civil officer or employee of the United States, without pay or for nominal pay, when a statute authorizes the acceptance or use of the service, or authorizes payment of travel or other expenses of the individual;

(3) An individual, other than an independent contractor or individual employed by an independent contractor, employed on the Menominee Indian Reservation in Wisconsin in operations conducted under a statute relating to tribal timber and logging operations on that reservation;

(4) An individual appointed to a position on the office staff of a former President; or

(5) An individual selected and serving as a Federal petit or grand juror.

(v) *Department* means the United States Department of Labor (DOL).

(w) *Department of Energy* or *DOE* includes the predecessor agencies of DOE back to the establishment of the Manhattan Engineer District on August 13, 1942.

(x) *Department of Energy contractor employee* means any of the following:

(1) An individual who is or was in residence at a DOE facility as a researcher for one or more periods aggregating at least 24 months.

(2) An individual who is or was employed at a DOE facility by:

(i) An entity that contracted with the DOE to provide management and operating, management and integration, or environmental remediation at the facility;

(ii) A contractor or subcontractor that provided services, including construction and maintenance, at the facility; or

(iii) A civilian employee of a state or Federal government agency if the agency employing that individual is found to have entered into a contract with DOE for the provision of one or more services it was not statutorily obligated to perform, and DOE compensated the agency for those services. The delivery or removal of goods from the premises of a DOE facility does not constitute a service for the purposes of

determining a worker's coverage under this paragraph (x).

(y)(1) *Department of Energy facility* means, as determined by the Director of OWCP, any building, structure, or premise, including the grounds upon which such building, structure, or premise is located:

(i) In which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by E.O. 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and

(ii) With regard to which the DOE has or had:

(A) A proprietary interest; or

(B) Entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services.

(2) DOL has adopted the determinations of the Department of Energy regarding Department of Energy facilities that were contained in the list of facilities published in the FEDERAL REGISTER on August 23, 2004 (69 FR 51825). DOL will periodically update this list as it deems appropriate in its sole discretion by publishing a revised list of Department of Energy facilities in the FEDERAL REGISTER.

(z) *Disability* means, for purposes of determining entitlement to payment of Part B benefits under section 7384s(a)(1) of the Act, having been determined by OWCP to have or have had established chronic beryllium disease, cancer, or chronic silicosis.

(aa) *Eligible surviving beneficiary* means any individual who is entitled under sections 7384s(e), 7384u(e), or 7385s–3(c) and (d) of the Act to receive a payment on behalf of a deceased covered Part B employee or a deceased covered Part E employee.

(bb) *Employee* means either a current or former employee.

(cc) *Occupational illness* means, under Part B of the Act, a covered beryllium illness, cancer sustained in the performance of duty as defined in §30.210(a), specified cancer, chronic silicosis, or an illness for which DOJ has awarded compensation under section 5 of RECA.

(dd) *OWCP* means the Office of Workers' Compensation Programs, United States Department of Labor. One of the four divisions of OWCP is the Division of Energy Employees Occupational Illness Compensation.

(ee) *Physician* includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners, within the scope of their practice as defined by state law. Physician assistants and nurse practitioners are excluded from this definition. The services of chiropractors that may be reimbursed are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

(ff) *Qualified physician* means any physician who has not been excluded under the provisions of subpart H of this part. Except as otherwise provided by regulation, a qualified physician shall be deemed to be designated or approved by OWCP.

(gg) *Specified cancer* means:

(1) Leukemia (other than chronic lymphocytic leukemia) provided that the onset of the disease was at least 2 years after first exposure;

(2) Lung cancer (other than in situ lung cancer that is discovered during or after a post-mortem exam);

(3) Bone cancer;

(4) Renal cancers; or

(5) The following diseases, provided onset was at least 5 years after first exposure:

(i) Multiple myeloma;

(ii) Lymphomas (other than Hodgkin's disease); and

(iii) Primary cancer of the:

(A) Thyroid;

(B) Male or female breast;

(C) Esophagus;

(D) Stomach;

(E) Pharynx;

(F) Small intestine;

(G) Pancreas;

(H) Bile ducts;

(I) Gall bladder;

(J) Salivary gland;

(K) Urinary bladder;

(L) Brain;

(M) Colon;

(N) Ovary; or

(O) Liver (except if cirrhosis or hepatitis B is indicated).

(6) The specified diseases designated in this section mean the physiological condition or conditions that are recognized by the National Cancer Institute under those names or nomenclature, or under any previously accepted or commonly used names or nomenclature.

(hh) *Survivor* means:

(1) For claims under Part B of the Act, and subject to paragraph (gg)(3) of this section, a surviving spouse, child, parent, grandchild and grandparent of a deceased covered Part B employee.

(2) For claims under Part E of the Act, and subject to paragraph (gg)(3) of this section, a surviving spouse and child of a deceased covered Part E employee.

(3) Those individuals listed in paragraphs (gg)(1) and (gg)(2) of this section do not include any individuals not living as of the time OWCP makes a lump-sum payment or payments to an eligible surviving beneficiary or beneficiaries.

(ii) *Time of injury* is defined as follows:

(1) For an employee's claim, this term means:

(i) In regard to a claim arising out of exposure to beryllium or silica, the last date on which a covered Part B employee was exposed to such substance in the performance of duty in accordance with sections 7384n(a) or 7384r(c) of the Act;

(ii) In regard to a claim arising out of exposure to radiation under Part B, the last date on which a covered Part B employee was exposed to radiation in the performance of duty in accordance with section 7384n(b) of the Act or, in the case of a member of the Special Exposure Cohort, the last date on which the member of the Special Exposure Cohort was employed at the Department of Energy facility or the atomic weapons employer facility at which the member was exposed to radiation; or

(iii) In regard to a claim arising out of exposure to a toxic substance, the last date on which a covered Part E employee was employed at the Department of Energy facility or RECA section 5 facility, as appropriate, at which the exposure took place.

(2) For a survivor's claim, the date of the employee's death is the time of injury.

(jj) *Time of payment* or *payment* means the date that a paper check issued by the Department of the Treasury was received by the payee or by someone who was legally able to act for the payee, or the date the Department of the Treasury made an Electronic Funds Transfer to the payee's financial institution.

(kk) *Toxic substance* means any material that has the potential to cause illness or death because of its radioactive, chemical, or biological nature.

(ll) *Workday* means a single workshift whether or not it occurred on more than one calendar day.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3046, Feb. 8, 2019; 89 FR 57731, July 16, 2024]

INFORMATION IN PROGRAM RECORDS

§ 30.10 Are all OWCP records relating to claims filed under EEOICPA considered confidential?

All OWCP records relating to claims for benefits under EEOICPA are considered confidential and may not be released, inspected, copied or otherwise disclosed except as provided in the Freedom of Information Act and the Privacy Act of 1974.

§ 30.11 Who maintains custody and control of claim records?

All OWCP records relating to claims for benefits filed under the Act are covered by the Privacy Act system of records entitled DOL/ESA–49 (Office of Workers' Compensation Programs, Energy Employees Occupational Illness Compensation Program Act File). This system of records is maintained by and under the control of OWCP, and, as such, all records covered by DOL/ESA–49 are official records of OWCP. The protection, release, inspection and copying of records covered by DOL/ESA–49 shall be accomplished in accordance with the rules, guidelines and provisions of this part, as well as those contained in 29 CFR parts 70 and 71, and with the notice of the system of records and routine uses published in the FEDERAL REGISTER. All questions relating to access, disclosure, and/or amendment of claims records maintained by OWCP are to be resolved in accordance with this section.

§ 30.12 What process is used by a person who wants to obtain copies of or amend EEOICPA claim records?

(a) A claimant seeking copies of his or her official EEOICPA file should address a request to the District Director of the OWCP district office having custody of the file.

(b) Any request to amend a record covered by DOL/ESA–49 should be directed to the district office having custody of the official file.

(c) Any administrative appeal taken from a denial issued by OWCP under this section shall be filed with the Solicitor of Labor in accordance with 29 CFR 71.7 and 71.9.

RIGHTS AND PENALTIES

§ 30.15 May EEOICPA benefits be assigned, transferred or garnished?

(a) Pursuant to section 7385f(a) of the Act, no claim for EEOICPA benefits may be assigned or transferred.

(b) Provisions of the Social Security Act (42 U.S.C. 659) and regulations issued by the Office of Personnel Management at 5 CFR part 581 permit the garnishment of payments of EEOICPA monetary benefits to collect overdue alimony and child support. A request to garnish a payment for either of these purposes should be submitted to the district office that is handling the EEOICPA claim, and must be accompanied by a copy of the pertinent state agency or court order.

§ 30.16 What penalties may be imposed in connection with a claim under the Act?

(a) Other statutory provisions make it a crime to file a false or fraudulent claim or statement with the federal government in connection with a claim under the Act. Included among these provisions is 18 U.S.C. 1001. Enforcement of criminal provisions that may apply to claims under the Act is within the jurisdiction of the Department of Justice.

(b) In addition, administrative proceedings may be initiated under the Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 U.S.C. 3801 *et seq.*, to impose civil penalties and assessments against persons or entities who make, submit or present, or cause to be made, submitted or presented, false, fictitious or fraudulent claims or written statements to OWCP in connection with a claim under EEOICPA. The Department's regulations implementing PFCRA are found at 29 CFR part 22.

§ 30.17 Is a beneficiary who defrauds the government in connection with a claim for EEOICPA benefits still entitled to those benefits?

When a beneficiary either pleads guilty to or is found guilty on either federal or state criminal charges of defrauding the federal or a state government in connection with a claim for benefits under the Act or any other federal or state workers' compensation law, the beneficiary forfeits (effective the date either the guilty plea is accepted or a verdict of guilty is returned after trial) any entitlement to any further benefits for any injury, illness or death covered by this part for which the time of injury was on or before the date of such guilty plea or verdict. Any subsequent change in or recurrence of the beneficiary's medical condition does not affect termination of entitlement under this section.

Subpart B—Filing Claims; Evidence and Burden of Proof; Special Procedures for Certain Cancer Claims

FILING CLAIMS FOR BENEFITS UNDER EEOICPA

§ 30.100 In general, how does an employee file an initial claim for benefits?

(a) To claim benefits under EEOICPA, an employee must file a claim in writing with OWCP. Form EE–1 should be used for this purpose, but any written communication that requests benefits under EEOICPA will be considered a claim. It will, however, be necessary for an employee to submit a Form EE–1 for OWCP to fully develop the claim. Copies of Form EE–1 may be obtained from OWCP or on the internet at *http://www.dol.gov/owcp/energy/index.htm*. The employee must sign the written claim that is filed with OWCP, but another person may present the claim to OWCP on the employee's behalf.

(b) The employee may choose, at his or her own option, to file for benefits for only certain conditions that are potentially compensable under the Act (*e.g.*, the employee may not want to claim for an occupational illness or a covered illness for which a payment has been received that would necessitate an offset of EEOICPA benefits under the provisions of § 30.505(b) of these regulations). The employee may withdraw his or her claim by so requesting in writing to OWCP at any time before OWCP determines his or her eligibility for benefits.

(c) Except as provided in paragraph (d) of this section, a claim is considered to be ''filed'' on the date that the employee mails his or her claim to OWCP, as determined by postmark or other carrier's date marking, or on the date that the claim is received by OWCP, whichever is the earliest determinable date. However, in no event will a claim under Part B of EEOICPA be considered to be ''filed'' earlier than July 31, 2001, nor will a claim under Part E of EEOICPA be considered to be ''filed'' earlier than October 30, 2000.

(1) The employee shall affirm that the information provided on the Form EE–1 is true, and must inform OWCP of any subsequent changes to that information.

(2) Except for a covered uranium employee filing a claim under Part B of the Act, the employee is responsible for submitting with his or her claim, or arranging for the submission of, medical evidence to OWCP that establishes that he or she sustained an occupational illness and/or a covered illness. This required medical evidence is described in § 30.114 and does not refer to mere recitations of symptoms the employee experienced that the employee believes indicate that he or she sustained an occupational illness or a covered illness.

(d) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be ''filed'' on the date that the employee mailed his or her claim to DOE, as determined by postmark or other carrier's date marking, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be ''filed'' earlier than October 30, 2000.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3047, Feb. 8, 2019]

§ 30.101 In general, how is a survivor's claim filed?

(a) A survivor of an employee must file a claim for compensation in writing with OWCP. Form EE–2 should be used for this purpose, but any written communication that requests survivor benefits under the Act will be considered a claim. It will, however, be necessary for a survivor to submit a Form EE–2 for OWCP to fully develop the claim. Copies of Form EE–2 may be obtained from OWCP or on the internet at *http://www.dol.gov/owcp/energy/index.htm*. The survivor must sign the written claim that is filed with OWCP, but another person may present the claim to OWCP on the survivor's behalf. Although only one survivor needs to file a claim under this section to initiate the development process, OWCP will distribute any monetary benefits payable on the claim among all eligible surviving beneficiaries who have filed claims with OWCP.

(b) A survivor may choose, at his or her own option, to file for benefits for only certain conditions that are potentially compensable under the Act (*e.g.*, the survivor may not want to claim for an occupational illness or a covered illness for which a payment has been received that would necessitate an offset of EEOICPA benefits under the provisions of § 30.505(b) of these regulations). The survivor may withdraw his or her claim by so requesting in writing to OWCP at any time before OWCP determines his or her eligibility for benefits.

(c) A survivor must be alive to receive any payment under EEOICPA; there is no vested right to such payment.

(d) Except as provided in paragraph (e) of this section, a survivor's claim is considered to be ''filed'' on the date that the survivor mails his or her claim to OWCP, as determined by postmark or other carrier's date marking, or the date that the claim is received

by OWCP, whichever is the earliest determinable date. However, in no event will a survivor's claim under Part B of the Act be considered to be ''filed'' earlier than July 31, 2001, nor will a survivor's claim under Part E of the Act be considered to be ''filed'' earlier than October 30, 2000.

(1) The survivor shall affirm that the information provided on the Form EE–2 is true, and must inform OWCP of any subsequent changes to that information.

(2) Except for the survivor of a covered uranium employee claiming under Part B of the Act, the survivor is responsible for submitting, or arranging for the submission of, evidence to OWCP that establishes that the employee upon whom the survivor's claim is based was eligible for such benefits, including medical evidence that establishes that the employee sustained an occupational illness or a covered illness. This required medical evidence is described in § 30.114 and does not refer to mere recitations by the survivor of symptoms the employee experienced that the survivor believes indicate that the employee sustained an occupational illness or a covered illness.

(e) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be ''filed'' on the date that the survivor mailed his or her claim to DOE, as determined by postmark or other carrier's date marking, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be ''filed'' earlier than October 30, 2000.

(f) A spouse or a child of a deceased DOE contractor employee or RECA section 5 uranium worker, who is not a covered spouse or covered child under Part E, may submit a written request to OWCP for a determination of whether that deceased DOE contractor employee or RECA section 5 uranium worker contracted a covered illness under section 7385s–4(d) of EEOICPA.

(1) Any such request submitted pursuant to paragraph (f) of this section will not be considered a survivor's claim for benefits under Part E of the Act.

(2) As part of its consideration of any request submitted pursuant to paragraph (f) of this section, OWCP will apply the eligibility criteria in subpart C of this part. However, the adjudicatory procedures contained in subpart D of this part will not apply to OWCP's consideration of such a request, and OWCP's response to the request will not constitute a final agency decision on entitlement to any benefits under EEOICPA.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3047, Feb. 8, 2019]

§ 30.102 In general, how does an employee file a claim for additional impairment or wage-loss under Part E of EEOICPA?

(a) An employee previously awarded impairment benefits by OWCP may file a claim for additional impairment benefits. Such claim must be based on an increase in the employee's impairment rating attributable to the covered illness or illnesses from the impairment rating that formed the basis for the last award of such benefits by OWCP. OWCP will only adjudicate claims for such an increased rating that are filed at least two years from the date of the last award of impairment benefits. However, OWCP will not wait two years before it will adjudicate a claim for additional impairment that is based on an allegation that the employee sustained a new covered illness.

(b) An employee previously awarded wage-loss benefits by OWCP may be eligible for additional wage-loss benefits for periods of wage-loss that were not addressed in a prior claim only if the employee had not reached his or her Social Security retirement age at the time of the prior award. OWCP will adjudicate claims filed on a yearly basis in connection with each succeeding calendar year for which qualifying wage-loss under Part E is alleged, as well as claims that aggregate calendar years for which qualifying wage-loss is alleged.

(c) Employees should use Form EE–10 to claim for additional impairment or wage-loss benefits under Part E of EEOICPA.

(1) The employee, or the person filing the claim on behalf of the employee, shall affirm that the information provided on Form EE–10 is true, and must inform OWCP of any subsequent changes to that information.

(2) The employee is responsible for submitting with any claim filed under this section, or arranging for the submission of, factual and medical evidence establishing that he or she experienced another calendar year of qualifying wage-loss, and/or medical evidence establishing that he or she has an increased minimum impairment rating, as appropriate.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3047, Feb. 8, 2019]

§ 30.103 How does a claimant make sure that OWCP has the evidence necessary to process the claim?

(a) Claims and certain required submissions should be made on forms prescribed by OWCP. Persons submitting forms shall not modify these forms or use substitute forms.

Form No.	Title
(1) EE–1 ..	Claim for Benefits Under the Energy Employees Occupational Illness Compensation Program Act.
(2) EE–2 ..	Claim for Survivor Benefits Under the Energy Employees Occupational Illness Compensation Program Act.
(3) EE–3 ..	Employment History for a Claim Under the Energy Employees Occupational Illness Compensation Program Act.
(4) EE–4 ..	Employment History Affidavit for a Claim Under the Energy Employees Occupational Illness Compensation Program Act.

(b) Copies of the forms listed in this section are available for public inspection at the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210. They may also be obtained from OWCP district offices and on the internet at *http://www.dol.gov/owcp/energy/index.htm*.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3047, Feb. 8, 2019]

VERIFICATION OF ALLEGED EMPLOYMENT

§ 30.105 What must DOE do after an employee or survivor files a claim?

(a) After it receives a claim for benefits described in § 30.100 or § 30.101, OWCP may request that DOE verify the employment history provided by the claimant. Upon receipt of such a request, DOE will complete Form EE–5 as soon as possible and transmit the completed form to OWCP. On this form, DOE will certify either that it concurs with the employment history provided by the claimant, that it disagrees with such history, or that it can neither concur nor disagree after making a reasonable search of its records and also making a reasonable effort to locate pertinent records not already in its possession.

(b) Claims for additional impairment or wage-loss benefits under Part E of the Act described in § 30.102 will not require any verification of employment by DOE, since OWCP will have made any required findings on this particular issue when it adjudicated the employee's initial claim for benefits.

§ 30.106 Can OWCP request employment verification from other sources?

(a) For most claims filed under EEOICPA, DOE has access to sufficient factual information to enable it to fulfill its obligations described in § 30.105(a). However, in instances where it lacks such information, DOE may arrange for other entities to provide OWCP with the information necessary to verify an employment history submitted as part of a claim. These other entities may consist of either current or former DOE contractors and subcontractors, atomic weapons employers, beryllium vendors, or other entities with access to relevant employment information.

(b) On its own initiative, OWCP may also arrange for entities other than DOE to perform the employment verification duties described in § 30.105(a).

EVIDENCE AND BURDEN OF PROOF

§ 30.110 Who is entitled to compensation under the Act?

(a) Under Part B of EEOICPA, compensation is payable to the following covered Part B employees, or their survivors:

(1) A ''covered beryllium employee'' (as described in § 30.205(a)) with a covered beryllium illness (as defined in § 30.5(p)) who was exposed to beryllium

in the performance of duty (in accordance with § 30.206).

(2) A ''covered Part B employee with cancer'' (as described in § 30.210(a)).

(3) A ''covered Part B employee with chronic silicosis'' (as described in § 30.220).

(4) A ''covered uranium employee'' (as defined in § 30.5(t)).

(b) Under Part E of EEOICPA, compensation is payable to a ''covered Part E employee'' (as defined in § 30.5(q)), or his or her survivors.

(c) Any claim that does not meet all of the criteria for at least one of these categories, as set forth in the regulations in this part, must be denied.

(d) All claims for benefits under the Act must comply with the claims procedures and requirements set forth in subpart B of this part before any payment can be made from the Fund.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3047, Feb. 8, 2019]

§ 30.111 What is the claimant's responsibility with respect to burden of proof, production of documents, presumptions, and affidavits?

(a) Except where otherwise provided in the Act and these regulations, the claimant bears the burden of proving by a preponderance of the evidence the existence of each and every criterion necessary to establish eligibility under any compensable claim category set forth in § 30.110. Proof by a preponderance of the evidence means that it is more likely than not that the proposition to be proved is true. Subject to the exceptions expressly provided in the Act and the regulations in this part, the claimant also bears the burden of providing to OWCP all written medical documentation, contemporaneous records, or other records and documents necessary to establish any and all criteria for benefits set forth in these regulations.

(b) In the event that the claim lacks required information or supporting documentation, OWCP will notify the claimant of the deficiencies and provide him or her an opportunity for correction of the deficiencies.

(c) Written affidavits or declarations, subject to penalty for perjury, by the employee, survivor or any other person, will be accepted as evidence of employment history and survivor relationship for purposes of establishing eligibility and may be relied on in determining whether a claim meets the requirements of the Act for benefits if, and only if, such person attests that due diligence was used to obtain records in support of the claim, but that no records exist.

(d) A claimant will not be entitled to any presumption otherwise provided for in these regulations if substantial evidence exists that rebuts the existence of the fact that is the subject of the presumption. Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. When such evidence exists, the claimant shall be notified and afforded the opportunity to submit additional written medical documentation or records.

§ 30.112 What kind of evidence is needed to establish covered employment and how will that evidence be evaluated?

(a) Evidence of covered employment may include: employment records; pay stubs; tax returns; Social Security records; and written affidavits or declarations, subject to penalty of perjury, by the employee, survivor or any other person. However, no one document is required to establish covered employment and a claimant is not required to submit all of the evidence listed above. A claimant may submit other evidence not listed above to establish covered employment. To be acceptable as evidence, all documents and records must be legible. OWCP will accept photocopies, certified copies, and original documents and records.

(b) Pursuant to §§ 30.105 and/or 30.106, DOE or another entity verifying alleged employment shall certify that it concurs with the employment information provided by the claimant, that it disagrees with the information provided by the claimant, or, after a reasonable search of its records and a reasonable effort to locate pertinent records not already in its possession, it can neither concur nor disagree with the information provided by the claimant.

(1) If DOE or another entity certifies that it concurs with the employment

information provided by the claimant, then the criterion for covered employment will be established.

(2) If DOE or another entity certifies that it disagrees with the information provided by the claimant or that after a reasonable search of its records and a reasonable effort to locate pertinent records not already in its possession it can neither concur nor disagree with the information provided by the claimant, OWCP will evaluate the evidence submitted by the claimant to determine whether the claimant has established covered employment by a preponderance of the evidence. OWCP may request additional evidence from the claimant to demonstrate that the claimant has met the criterion for covered employment. Nothing in this section shall be construed to limit OWCP's ability to require additional documentation.

(3) If the only evidence of covered employment submitted by the claimant is a written affidavit or declaration subject to penalty of perjury by the employee, survivor or any other person, and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under § 30.111.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3048, Feb. 8, 2019]

§ 30.113 What are the requirements for written medical documentation, contemporaneous records, and other records or documents?

(a) All written medical documentation, contemporaneous records, and other records or documents submitted by an employee or his or her survivor to prove any criteria provided for in these regulations must be legible. OWCP will accept photocopies, certified copies, and original documents and records.

(b) To establish eligibility, the employee or his or her survivor may be required to provide, where appropriate, additional contemporaneous records to the extent they exist or an authorization to release additional contemporaneous records or a statement by the custodian(s) of the record(s) certifying that the requested record(s) no longer exist. Nothing in this section shall be construed to limit OWCP's ability to require additional documentation.

(c) If a claimant submits a certified statement, by a person with knowledge of the facts, that the medical records containing a diagnosis and date of diagnosis of a covered medical condition no longer exist, then OWCP may consider other evidence to establish a diagnosis and date of diagnosis of a covered medical condition. However, OWCP will evaluate the probative value of such other evidence to determine whether it is sufficient proof of a covered medical condition.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3048, Feb. 8, 2019]

§ 30.114 What kind of evidence is needed to establish a compensable medical condition and how will that evidence be evaluated?

(a) Evidence of a compensable medical condition may include: a physician's report, laboratory reports, hospital records, death certificates, x-rays, magnetic resonance images or reports, computer axial tomography or other imaging reports, lymphocyte proliferation testings, beryllium patch tests, pulmonary function or exercise testing results, pathology reports including biopsy results and other medical records. A claimant is not required to submit all of the evidence listed in this paragraph. A claimant may submit other evidence that is not listed in this paragraph to establish a compensable medical condition. Nothing in this section shall be construed to limit OWCP's ability to require additional documentation.

(b) The medical evidence submitted will be used to establish the diagnosis and the date of diagnosis of the compensable medical condition.

(1) For covered beryllium illnesses under Part B of EEOICPA, additional medical evidence, as set forth in § 30.207, is required to establish a beryllium illness.

(2) For chronic silicosis under Part B of EEOICPA, additional medical evidence, as set forth in §30.222, is required to establish chronic silicosis.

(3) For covered illnesses under Part E of EEOICPA, additional medical evidence, as set forth in §30.232, is required to establish a covered illness.

(i) For impairment benefits under Part E of EEOICPA, additional medical evidence, as set forth in §30.901, is required to establish an impairment that is the result of a covered illness referred to in §30.900.

(ii) For wage-loss benefits under Part E of EEOICPA, additional medical evidence, as set forth in §30.806, is required to establish wage-loss that is the result of a covered illness referred to in §30.800.

(4) For consequential injuries, illnesses, impairments or diseases, the claimant must also submit a physician's fully rationalized medical report showing a causal relationship between the resulting injury, illness, impairment or disease and the compensable medical condition.

(c) OWCP will evaluate the medical evidence in accordance with recognized and accepted diagnostic criteria used by physicians to determine whether the claimant has established the medical condition for which compensation is sought in accordance with the requirements of the Act.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3048, Feb. 8, 2019]

SPECIAL PROCEDURES FOR CERTAIN RADIOGENIC CANCER CLAIMS

§ 30.115 For those radiogenic cancer claims that do not seek benefits under Part B of the Act pursuant to the Special Exposure Cohort provisions, what will OWCP do once it determines that an employee contracted cancer?

(a) Other than claims seeking benefits under Part E of the Act that have previously been accepted under section 7384u of the Act or claims previously accepted under Part B pursuant to the Special Exposure Cohort provisions, OWCP will forward the claim package (including, but not limited to, Forms EE–1, EE–2, EE–3, EE–4 and EE–5, as appropriate) to NIOSH for dose reconstruction. At that point in time, development of the claim by OWCP may be suspended.

(1) This package will include OWCP's initial findings in regard to the diagnosis and date of diagnosis of the employee, as well as any employment history compiled by OWCP (including information such as dates and locations worked, and job titles). The package, however, will not constitute either a recommended or final decision by OWCP on the claim.

(2) NIOSH will then reconstruct the radiation dose of the employee and provide the claimant and OWCP with the final dose reconstruction report. The final dose reconstruction record will be delivered to OWCP with the final dose reconstruction report and to the claimant upon request.

(b) Following its receipt of the final dose reconstruction report from NIOSH, OWCP will resume its adjudication of the cancer claim and consider whether the claimant has met the eligibility criteria set forth in subpart C of this part. However, during the period before it receives a reconstructed dose from NIOSH, OWCP may continue to develop other aspects of a claim, to the extent that it deems such development to be appropriate.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3048, Feb. 8, 2019]

Subpart C—Eligibility Criteria

GENERAL PROVISIONS

§ 30.200 What is the scope of this subpart?

The regulations in this subpart describe the criteria for eligibility for benefits for claims under Part B of EEOICPA relating to covered beryllium illness under sections 7384l, 7384n, 7384s and 7384t of the Act; for cancer under sections 7384l, 7384n, 7384q and 7384t of the Act; for chronic silicosis under sections 7384l, 7384r, 7384s and 7384t of the Act; and for claims relating to covered uranium employees under sections 7384t and 7384u of the Act. These regulations also describe the criteria for eligibility for benefits for claims under Part E of EEOICPA relating to covered illnesses under sections 7385s–4 and 7385s–5 of the Act. This subpart describes the type and extent of

evidence that will be necessary to establish the criteria for eligibility for compensation for these illnesses.

ELIGIBILITY CRITERIA FOR CLAIMS RELATING TO COVERED BERYLLIUM ILLNESS UNDER PART B OF EEOICPA

§ 30.205 What are the criteria for eligibility for benefits relating to beryllium illnesses covered under Part B of EEOICPA?

To establish eligibility for benefits under this section, the claimant must establish the criteria set forth in both paragraphs (a) and (b) of this section:

(a) The employee is a covered beryllium employee only if the criteria in paragraphs (a)(1) and (a)(3) of this section, or (a)(2) and (a)(3) of this section, are established:

(1) The employee is a ''current or former employee as defined in 5 U.S.C. 8101(1)'' (see §30.5(u)) who may have been exposed to beryllium at a DOE facility or at a facility owned, operated or occupied by a beryllium vendor; or

(2) The employee is a current or former civilian employee of:

(i) Any entity that contracted with the DOE to provide management and operation, management and integration, or environmental remediation of a DOE facility; or

(ii) Any contractor or subcontractor that provided services, including construction and maintenance, at such a facility; or

(iii) A beryllium vendor, or of a contractor or subcontractor of a beryllium vendor, during a period when the vendor was engaged in activities related to the production or processing of beryllium for sale to, or use by, the DOE, including periods during which environmental remediation of a vendor's facility was undertaken pursuant to a contract between the vendor and DOE; and

(3) The civilian employee was exposed to beryllium in the performance of duty by establishing that he or she was, during a period when beryllium dust, particles, or vapor may have been present at such a facility:

(i) Employed at a DOE facility (as defined in §30.5(y)); or

(ii) Present at a DOE facility, or at a facility owned, operated, or occupied by a beryllium vendor, because of his or her employment by the United States, a beryllium vendor, a contractor or subcontractor of a beryllium vendor, or a contractor or subcontractor of the DOE. Under this paragraph, exposure to beryllium in the performance of duty can be established whether or not the beryllium that may have been present at such facility was produced or processed for sale to, or use by, DOE.

(b) The employee has one of the following:

(1) Beryllium sensitivity as established by either:

(i) An abnormal beryllium LPT performed on either blood or lung lavage cells; or

(ii) Three borderline beryllium LPTs performed on blood cells over a period of 3 years.

(2) Established chronic beryllium disease.

(3) Any injury, illness, impairment, or disability sustained as a consequence of the conditions specified in paragraphs (b)(1) and (2) of this section.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3048, Feb. 8, 2019; 89 FR 57731, July 16, 2024]

§ 30.206 How does a claimant prove that the employee was a "covered beryllium employee" exposed to beryllium dust, particles or vapor in the performance of duty?

(a) Proof of employment or physical presence at a DOE facility, or a beryllium vendor facility as defined in §30.5(j), because of employment by the United States, a beryllium vendor, or a contractor or subcontractor of a beryllium vendor during a period when beryllium dust, particles or vapor may have been present at such facility, may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was employed or present at a covered facility and the time period of such employment or presence.

(b) If the evidence shows that exposure occurred while the employee was employed or present at a facility during a time frame that is outside the relevant time frame indicated for that facility, OWCP may request that DOE provide additional information on the facility. OWCP will determine whether

the evidence of record supports enlarging the relevant time frame for that facility.

(c) If the evidence shows that exposure occurred while the employee was employed or present at a facility that would have to be designated by DOE as a beryllium vendor under section 7384m of the Act to be a covered facility, and that the facility has not been so designated, OWCP will deny the claim on the ground that the facility is not a covered facility.

(d) Records from the following sources may be considered as evidence for purposes of establishing employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created by any vendor, processor, or producer of beryllium or related products designated as a beryllium vendor by the DOE in accordance with section 7384m of the Act.

(3) Records or documents created as a by product of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3048, Feb. 8, 2019]

§ 30.207 How does a claimant prove a diagnosis of a beryllium disease covered under Part B?

(a) Written medical documentation is required in all cases to prove that the employee developed a covered beryllium illness. Proof that the employee developed a covered beryllium illness must be made by using the procedures outlined in paragraph (b), (c), (d) or (e) of this section.

(b) Beryllium sensitivity or sensitization is established with either:

(1) An abnormal beryllium LPT performed on either blood or lung lavage cells; or

(2) Three borderline beryllium LPTs performed on blood cells over a period of 3 years.

(c) Chronic beryllium disease is established in the following manner:

(1) For diagnoses on or after January 1, 1993, beryllium sensitivity (as established in accordance with paragraph (b) of this section), together with lung pathology consistent with chronic beryllium disease, including the following:

(i) A lung biopsy showing granulomas or a lymphocytic process consistent with chronic beryllium disease;

(ii) A computerized axial tomography scan showing changes consistent with chronic beryllium disease; or

(iii) Pulmonary function or exercise testing showing pulmonary deficits consistent with chronic beryllium disease.

(2) For diagnoses before January 1, 1993, the presence of the following:

(i) Occupational or environmental history, or epidemiologic evidence of beryllium exposure; and

(ii) Any three of the following criteria:

(A) Characteristic chest radiographic (or computed tomography (CT)) abnormalities.

(B) Restrictive or obstructive lung physiology testing or diffusing lung capacity defect.

(C) Lung pathology consistent with chronic beryllium disease.

(D) Clinical course consistent with a chronic respiratory disorder.

(E) Immunologic tests showing beryllium sensitivity (skin patch test or beryllium blood test preferred).

(d) OWCP will use the criteria in either paragraph (c)(1) or (2) of this section to establish that the employee developed chronic beryllium disease as follows:

(1) If the earliest dated medical evidence shows that the employee was either treated for, tested positive for, or diagnosed with a chronic respiratory disorder before January 1, 1993, the criteria set forth in paragraph (c)(2) of this section may be used;

(2) If the earliest dated medical evidence shows that the employee was either treated for, tested positive for, or diagnosed with a chronic respiratory disorder on or after January 1, 1993, the criteria set forth in paragraph (c)(1) of this section must be used; and

(3) If the employee was treated for a chronic respiratory disorder before

January 1, 1993 and medical evidence verifies that such treatment was performed before January 1, 1993, but the medical evidence is dated on or after January 1, 1993, the criteria set forth in paragraph (c)(2) of this section may be used.

(e) An injury, illness, impairment or disability sustained as a consequence of beryllium sensitivity or established chronic beryllium disease must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disability and the beryllium sensitivity or established chronic beryllium disease. Neither the fact that the injury, illness, impairment or disability manifests itself after a diagnosis of beryllium sensitivity or established chronic beryllium disease, nor the belief of the claimant that the injury, illness, impairment or disability was caused by the beryllium sensitivity or established chronic beryllium disease, is sufficient in itself to prove a causal relationship.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3048, Feb. 8, 2019; 89 FR 57731, July 16, 2024]

ELIGIBILITY CRITERIA FOR CLAIMS RELATING TO RADIOGENIC CANCER UNDER PARTS B AND E OF EEOICPA

§ 30.210 What are the criteria for eligibility for benefits relating to radiogenic cancer?

(a) To establish eligibility for benefits for radiogenic cancer under Part B of EEOICPA, an employee or his or her survivor must show that:

(1) The employee has been diagnosed with one of the forms of cancer specified in § 30.5(gg); and

(i) Is a member of the Special Exposure Cohort (as described in § 30.214(a) of this subpart) who, as a civilian DOE employee or civilian DOE contractor employee, contracted the specified cancer after beginning employment at a DOE facility; or

(ii) Is a member of the Special Exposure Cohort (as described in § 30.214(a) of this subpart) who, as a civilian atomic weapons employee, contracted the specified cancer after beginning employment at an atomic weapons employer facility (as defined in § 30.5(e)); or

(2) The employee has been diagnosed with cancer; and

(i)(A) Is/was a civilian DOE employee who contracted that cancer after beginning employment at a DOE facility; or

(B) Is/was a civilian DOE contractor employee who contracted that cancer after beginning employment at a DOE facility; or

(C) Is/was a civilian atomic weapons employee who contracted that cancer after beginning employment at an atomic weapons employer facility; and

(ii) The cancer was at least as likely as not related to the employment at the DOE facility or atomic weapons employer facility; or

(3) The employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the accepted cancer.

(b)(1) To establish eligibility for benefits for radiogenic cancer under Part E of EEOICPA, an employee or his or her survivor must show that:

(i) The employee has been diagnosed with cancer; and

(A) Is/was a civilian DOE contractor employee or a civilian RECA section 5 uranium worker who contracted that cancer after beginning employment at a DOE facility or a RECA section 5 facility; and

(B) The cancer was at least as likely as not related to exposure to a toxic substance of a radioactive nature at a DOE facility or a RECA section 5 facility; and

(C) It is at least as likely as not that the exposure to such toxic substance(s) was related to employment at a DOE facility or a RECA section 5 facility; or

(ii) The employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the accepted cancer.

(2) Eligibility for benefits for radiogenic cancer under Part E in a claim that has previously been accepted under Part B pursuant to the Special Exposure Cohort provisions is described in § 30.230(a) of these regulations.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3049, Feb. 8, 2019; 86 FR 46778, Aug. 20, 2021]

§ 30.211 How does a claimant establish that the employee has or had contracted cancer?

A claimant establishes that the employee has or had contracted a specified cancer (as defined in § 30.5(gg)) or other cancer with medical evidence that sets forth an explicit diagnosis of cancer and the date on which that diagnosis was first made.

[84 FR 3049, Feb. 8, 2019]

§ 30.212 How does a claimant establish that the employee contracted cancer after beginning employment at a DOE facility, an atomic weapons employer facility or a RECA section 5 facility?

(a) Proof of employment by the DOE or a DOE contractor at a DOE facility, or by an atomic weapons employer at an atomic weapons employer facility, or at a RECA section 5 facility, may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment.

(b)(1) Except as provided in paragraph (b)(2) of this section, if the evidence shows that exposure occurred while the employee was employed at a facility during a time frame that is outside the relevant period indicated for that facility, OWCP may request that DOE provide additional information on the facility. OWCP will determine whether the evidence of record supports enlarging the relevant period for that facility.

(2) OWCP may choose not to request that DOE provide additional information on an atomic weapons employer facility that NIOSH reported had a potential for significant residual radiation contamination in its report dated October 2003 and titled ''Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities,'' or any update to that report, if the evidence referred to in paragraph (a) of this section establishes that the employee was employed at that facility during a period when NIOSH reported that it had a potential for significant residual radiation contamination.

(c) If the evidence shows that exposure occurred while the employee was employed by an employer that would have to be designated by DOE as an atomic weapons employer under section 7384l(4) of the Act to be a covered employer, and that the employer has not been so designated, OWCP will deny the claim on the ground that the employer is not a covered atomic weapons employer.

(d) Records from the following sources may be considered as evidence for purposes of establishing employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

§ 30.213 How does a claimant establish that the radiogenic cancer was at least as likely as not related to employment at the DOE facility, the atomic weapons employer facility, or the RECA section 5 facility?

(a) HHS, with the advice of the Advisory Board on Radiation and Worker Health, has issued regulatory guidelines at 42 CFR part 81 that OWCP uses to determine whether radiogenic cancers claimed under Parts B and E were at least as likely as not related to employment at a DOE facility, an atomic weapons employer facility, or a RECA section 5 facility. Persons should consult HHS's regulations for information regarding the factual evidence that will be considered by OWCP, in addition to the employee's final dose reconstruction report that will be provided to OWCP by NIOSH, in making this particular factual determination.

(b) HHS's regulations satisfy the legal requirements in section 7384n(c) of the Act, which also sets out OWCP's obligation to use them in its adjudication of claims for radiogenic cancer

filed under Part B of the Act, and provide the factual basis for OWCP to determine if the ''probability of causation'' (PoC) that an employee's cancer was sustained in the performance of duty is 50% or greater (*i.e.*, it is ''at least as likely as not'' causally related to employment), as required under section 7384n(b).

(c) OWCP also uses HHS's regulations when it makes the determination required by section 7385s–4(c)(1)(A) of the Act, since those regulations provide the factual basis for OWCP to determine if ''it is at least as likely as not'' that exposure to radiation at a DOE facility or RECA section 5 facility, as appropriate, was a significant factor in aggravating, contributing to, or causing the employee's radiogenic cancer claimed under Part E. For cancer claims under Part E, if the PoC is less than 50% and the claimant alleges that the employee was exposed to additional toxic substances, OWCP will determine if the claim is otherwise compensable pursuant to § 30.230(d) of this part.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3049, Feb. 8, 2019]

§ 30.214 How does a claimant establish that the employee is a member of the Special Exposure Cohort?

(a) For purposes of establishing eligibility as a member of the Special Exposure Cohort (SEC) under § 30.210(a)(1), the employee must have been a DOE employee, a DOE contractor employee, or an atomic weapons employee who meets any of the following requirements:

(1) The employee was so employed for a number of workdays aggregating at least 250 workdays before February 1, 1992, at a gaseous diffusion plant located in Paducah, Kentucky; Portsmouth, Ohio; or Oak Ridge, Tennessee; and during such employment:

(i) Was monitored through the use of dosimetry badges for exposure at the plant of the external parts of the employee's body to radiation; or

(ii) Worked in a job that had exposures comparable to a job that is or was monitored through the use of dosimetry badges.

(2) The employee was so employed before January 1, 1974, by DOE or a DOE contractor or subcontractor on Amchitka Island, Alaska, and was exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests.

(3) The employee is a member of a group or class of employees subsequently designated as additional members of the SEC by HHS.

(b) For purposes of satisfying the 250 workday requirement of paragraph (a)(1) of this section, the claimant may aggregate the days of service at more than one gaseous diffusion plant.

(c) Proof of employment by the DOE or a DOE contractor, or an atomic weapons employer, for the requisite time periods set forth in paragraph (a) of this section, may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment. If the evidence shows that exposure occurred while the employee was employed by an employer that would have to be designated by DOE as an atomic weapons employer under section 7384l(4) of the Act to be a covered employer, and that the employer has not been so designated, OWCP will deny the claim on the ground that the employer is not a covered atomic weapons employer.

(d) Records from the following sources may be considered as evidence for purposes of establishing employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

§ 30.215 How does a claimant establish that the employee has sustained an injury, illness, impairment or disease as a consequence of a diagnosed cancer?

An injury, illness, impairment or disease sustained as a consequence of a diagnosed cancer covered by the provisions of § 30.210 must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the cancer. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a cancer, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the cancer, is sufficient in itself to prove a causal relationship.

ELIGIBILITY CRITERIA FOR CLAIMS RELATING TO CHRONIC SILICOSIS UNDER PART B OF EEOICPA

§ 30.220 What are the criteria for eligibility for benefits relating to chronic silicosis?

To establish eligibility for benefits for chronic silicosis under Part B of EEOICPA, an employee or his or her survivor must show that:

(a) The employee is a civilian DOE employee, or a civilian DOE contractor employee, who was present for a number of workdays aggregating at least 250 workdays during the mining of tunnels at a DOE facility (as defined in § 30.5(y)) located in Nevada or Alaska for tests or experiments related to an atomic weapon, and has been diagnosed with chronic silicosis (as defined in § 30.5(k)); or

(b) The employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the accepted chronic silicosis.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3049, Feb. 8, 2019]

§ 30.221 How does a claimant prove exposure to silica in the performance of duty?

(a) Proof of the employee's employment and presence for the requisite days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an atomic weapon may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and present at these sites and the time period(s) of such employment and presence.

(b) If the evidence shows that exposure occurred while the employee was employed and present at a facility during a time frame that is outside the relevant time frame indicated for that facility, OWCP may request that DOE provide additional information on the facility. OWCP will determine whether the evidence of record supports enlarging the relevant time frame for that facility.

(c) Records from the following sources may be considered as evidence for purposes of establishing proof of employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

(d) For purposes of satisfying the 250 workday requirement of § 30.220(a), the claimant may aggregate the days of service at more than one qualifying site.

§ 30.222 How does a claimant establish that the employee has been diagnosed with chronic silicosis or has sustained a consequential injury, illness, impairment or disease?

(a) A written diagnosis of the employee's chronic silicosis (as defined in § 30.5(k)) shall be made by a licensed physician and accompanied by one of the following:

(1) A chest radiograph, interpreted by an individual certified by NIOSH as a B reader, classifying the existence of pneumoconioses of category 1/0 or higher; or

(2) Results from a computer assisted tomograph or other imaging technique that are consistent with silicosis; or

(3) Lung biopsy findings consistent with silicosis.

(b) An injury, illness, impairment or disease sustained as a consequence of accepted chronic silicosis covered by the provisions of § 30.220(a) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the accepted chronic silicosis. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of accepted chronic silicosis, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the accepted chronic silicosis, is sufficient in itself to prove a causal relationship.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3049, Feb. 8, 2019]

ELIGIBILITY CRITERIA FOR CERTAIN URANIUM EMPLOYEES UNDER PART B OF EEOICPA

§ 30.225 What are the criteria for eligibility for benefits under Part B of EEOICPA for certain uranium employees?

In order to be eligible for benefits under this section, the claimant must establish the criteria set forth in either paragraph (a) or paragraph (b) of this section:

(a) The Attorney General has determined that the claimant is a covered uranium employee who is entitled to payment of $100,000 as compensation due under section 5 of RECA for a claim made under that statute (there is, however, no requirement that the claimant or surviving eligible beneficiary has actually received payment pursuant to RECA). If a deceased employee's survivor(s) has been determined to be entitled to such an award, his or her survivor(s), if any, will only be entitled to EEOICPA compensation in accordance with section 7384u(e) of the Act.

(b) The covered uranium employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the medical condition for which he or she was determined to be entitled to payment of $100,000 as compensation due under section 5 of RECA.

§ 30.226 How does a claimant establish that a covered uranium employee has sustained a consequential injury, illness, impairment or disease?

An injury, illness, impairment or disease sustained as a consequence of a medical condition covered by the provisions of § 30.225(a) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the accepted medical condition. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a medical condition covered by the provisions of § 30.225(a), nor the belief of the claimant that the injury, illness, impairment or disease was caused by such a condition, is sufficient in itself to prove a causal relationship.

ELIGIBILITY CRITERIA FOR OTHER CLAIMS UNDER PART E OF EEOICPA

§ 30.230 What are the criteria necessary to establish that an employee contracted a covered illness under Part E of EEOICPA?

To establish that an employee contracted a covered illness under Part E of the Act, the employee, or his or her survivor, must show one of the following:

(a) That OWCP has determined under Part B of EEOICPA that the employee is a DOE contractor employee as defined in § 30.5(x), and that he or she has been awarded compensation under that Part of the Act for an occupational illness;

(b) That the Attorney General has determined that the employee is entitled to payment of $100,000 as compensation due under section 5 of RECA for a claim made under that statute (however, if a deceased employee's survivor has been determined to be entitled to such an award, his or her survivor(s), if any, will only be entitled to benefits under Part E of EEOICPA in accordance with section 7385s–3 of the Act);

(c) That the Secretary of Energy has accepted a positive determination of a Physicians Panel that the employee sustained an illness or died due to exposure to a toxic substance at a DOE facility under former section 7385o of

EEOICPA, or that the Secretary of Energy has found significant evidence contrary to a negative determination of a Physicians Panel; or

(d)(1) That the employee is a civilian DOE contractor employee as defined in §30.5(x), or a civilian who was employed in a uranium mine or mill located in Colorado, New Mexico, Arizona, Wyoming, South Dakota, Washington, Utah, Idaho, North Dakota, Oregon or Texas at any time during the period from January 1, 1942 through December 31, 1971, or was employed in the transport of uranium ore or vanadium-uranium ore from such a mine or mill during that same period, and that he or she:

(i) Has been diagnosed with an illness; and

(ii) That it is at least as likely as not that exposure to a toxic substance at a Department of Energy facility or at a RECA section 5 facility, as appropriate, was a significant factor in aggravating, contributing to, or causing the illness; and

(iii) That it is at least as likely as not that the exposure to such toxic substance was related to employment at a Department of Energy facility or a RECA section 5 facility, as appropriate.

(2) In making the determination under paragraph (d)(1)(ii) of this section, OWCP will consider:

(i) The nature, frequency and duration of exposure of the covered employee to the substance alleged to be toxic;

(ii) Evidence of the carcinogenic or pathogenic properties of the alleged toxic substance to which the employee was exposed;

(iii) An opinion of a qualified physician with expertise in treating, diagnosing or researching the illness claimed to be caused or aggravated by the alleged exposure; and

(iv) Any other evidence that OWCP determines to have demonstrated relevance to the relation between a particular toxic substance and the claimed illness.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3049, Feb. 8, 2019]

§30.231 How does a claimant prove employment-related exposure to a toxic substance at a DOE facility or a RECA section 5 facility?

To establish employment-related exposure to a toxic substance at a Department of Energy facility or RECA section 5 facility as required by §30.230(d), an employee, or his or her survivor(s), must prove that the employee was employed at such facility and that he or she was exposed to a toxic substance in the course of that employment.

(a) Proof of employment may be established by any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment. If the only evidence of covered employment submitted by the claimant is a written affidavit or declaration subject to penalty of perjury by the employee, survivor or any other person, and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under §30.111.

(b) For claimants who have established proof of employment, proof of exposure to a toxic substance may be established by the submission of any appropriate document or information that is evidence that such substance was present at the facility where the employee was employed and that the employee came into contact with such substance. Information from the following sources may be considered as probative factual evidence for purposes of establishing an employee's exposure to a toxic substance at a DOE facility or a RECA section 5 facility:

(1) To the extent practicable and appropriate, from DOE, a DOE-sponsored Former Worker Program, or an entity that acted as a contractor or subcontractor to DOE;

(2) OWCP's Site Exposure Matrices; or

(3) Any other entity deemed by OWCP to be a reliable source of information necessary to establish that the employee was exposed to a toxic substance at a DOE facility or RECA section 5 facility.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3049, Feb. 8, 2019]

§ 30.232 How does a claimant establish that the employee has been diagnosed with a covered illness, or sustained an injury, illness, impairment or disease as a consequence of a covered illness?

(a) To establish that the employee has been diagnosed with a covered illness as required by § 30.230(d), the employee, or his or her survivor(s), must provide the following:

(1) Written medical evidence containing a physician's diagnosis of the employee's covered illness (as that term is defined in § 30.5(s)), and the physician's reasoning for his or her opinion regarding causation; and

(2) Any other evidence OWCP may deem necessary to show that the employee has or had an illness that resulted from an exposure to a toxic substance while working at either a DOE facility or a RECA section 5 facility.

(b) An injury, illness, impairment or disease sustained as a consequence of a covered illness (as defined in § 30.5(s)) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the covered illness. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a covered illness, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the covered illness, is sufficient in itself to prove a causal relationship.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3049, Feb. 8, 2019]

Subpart D—Adjudicatory Process

GENERAL PROVISIONS

§ 30.300 What administrative process will OWCP use to decide claims for entitlement, and how can claimants obtain judicial review of final decisions on their claims?

OWCP district offices will issue recommended decisions with respect to most claims for entitlement under Part B and/or Part E of EEOICPA that are filed pursuant to the regulations set forth in subpart B of this part. In circumstances where a claim is made for more than one benefit available under Part B and/or Part E of the Act, OWCP may issue a recommended decision on only part of that particular claim in order to adjudicate that portion of the claim as quickly as possible. Should this occur, OWCP will issue one or more recommended decisions on the deferred portions of the claim when the adjudication of those portions is completed. All recommended decisions granting and/or denying claims for entitlement under Part B and/or Part E of the Act will be forwarded to the Final Adjudication Branch (FAB). Claimants will be given an opportunity to object to all or part of the recommended decision before the FAB. The FAB will consider objections filed by a claimant and conduct a hearing, if requested to do so by the claimant, before issuing a final decision on the claim for entitlement. Claimants may request judicial review of a final decision of FAB by filing an action in Federal district court.

[84 FR 3050, Feb. 8, 2019]

§ 30.301 May subpoenas be issued for witnesses and documents in connection with a claim under Part B of EEOICPA?

(a) In connection with the adjudication of a claim under Part B of EEOICPA, an OWCP district office and/or a FAB reviewer may, at their own initiative, issue subpoenas for the attendance and testimony of witnesses, and for the production of books, electronic records, correspondence, papers or other relevant documents. Subpoenas will only be issued for documents if they are relevant and cannot

be obtained by other means, and for witnesses only where oral testimony is the best way to ascertain the facts.

(b) A claimant may also request a subpoena in connection with his or her claim under Part B of the Act, but such request may only be made to a FAB reviewer. No subpoenas will be issued at the request of the claimant under any other portion of the claims process. The decision to grant or deny such request is within the discretion of the FAB reviewer. To request a subpoena under this section, the requestor must:

(1) Submit the request in writing and send it to the FAB reviewer as early as possible, but no later than 30 days (as evidenced by postmark or other carrier's date marking) after the date of the original hearing request;

(2) Explain why the testimony or evidence is directly relevant and material to the issues in the case; and

(3) Establish that a subpoena is the best method or opportunity to obtain such evidence because there are no other means by which the documents or testimony could have been obtained.

(c) No subpoena will be issued for attendance of employees or contractors of OWCP or NIOSH acting in their official capacities as decision-makers or policy administrators. For hearings taking the form of a review of the written record, no subpoena for the appearance of witnesses will be considered.

(d) The FAB reviewer will issue the subpoena under his or her own name. It may be served in person or by certified mail, return receipt requested, addressed to the person to be served at his or her last known principal place of business or residence. A decision to deny a subpoena requested by a claimant can only be challenged as part of a request for reconsideration of any adverse decision of the FAB which results from the hearing.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3050, Feb. 8, 2019]

§ 30.302 Who pays the costs associated with subpoenas?

(a) Witnesses who are not employees or former employees of the federal government shall be paid the same fees and mileage as paid for like services in the District Court of the United States where the subpoena is returnable, except that expert witnesses shall be paid a fee not to exceed the local customary fee for such services.

(b) Where OWCP asked that the witness submit evidence into the case record or asked that the witness attend, OWCP shall pay the fees and mileage. Where the claimant asked for the subpoena, and where the witness submitted evidence into the record at the request of the claimant, the claimant shall pay the fees and mileage.

§ 30.303 What information may OWCP request in connection with a claim under Part E of EEOICPA?

At any time during the course of development of a claim for benefits under Part E, OWCP may determine that it needs relevant information to adjudicate the claim. When this occurs, and at the request of OWCP, DOE and/or any contractor who employed a Department of Energy contractor employee must provide to OWCP information or documents in response to the request in connection with a claim under Part E of EEOICPA.

(a) The party to whom the request is made must respond to OWCP within 90 days of the request with either:

(1) The requested information or documents; or

(2) A sworn statement that a good faith search for the requested information or documents was conducted, and that the information or documents could not be located.

(b) DOE and/or the DOE contractor who employed a Department of Energy contractor employee must query third parties under its control to acquire the requested information or documents.

(c) In providing the requested information or documents, DOE and/or the DOE contractor who employed a DOE contractor employee must preserve the current organization of the requested information or documents, and must provide such description and indexing of the requested information or documents as OWCP considers appropriate to facilitate their use by OWCP.

(d) Information or document requests may include, but are not limited to, requests for records, files and other data, whether paper, electronic, imaged or otherwise, developed, acquired or

maintained by DOE or the DOE contractor who employed a DOE contractor employee. Such information or documents may include records, files and data on facility industrial hygiene, employment of individuals or groups, exposure and medical records, and claims applications.

RECOMMENDED DECISIONS ON CLAIMS

§ 30.305 How does OWCP determine entitlement to EEOICPA compensation?

(a) In reaching a recommended decision with respect to EEOICPA compensation, OWCP considers the claim presented by the claimant, the factual and medical evidence of record, the dose reconstruction report prepared by NIOSH (if any), any report submitted by DOE and the results of such investigation as OWCP may deem necessary.

(b) The OWCP claims staff applies the law, the regulations and its procedures when it evaluates the medical evidence and the facts as reported or obtained upon investigation.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3050, Feb. 8, 2019]

§ 30.306 What does the recommended decision include?

The recommended decision shall include a discussion of the district office's findings of fact and conclusions of law in support of the recommendation. The recommended decision may recommend acceptance or rejection of the claim in its entirety, or of a portion of the claim presented. It is accompanied by a notice of the claimant's right to file objections with, and request a hearing before, the FAB.

[84 FR 3050, Feb. 8, 2019]

§ 30.307 Can one recommended decision address the entitlement of multiple claimants?

(a) When multiple individuals have filed survivor claims under Part B and/or Part E of EEOICPA relating to the same deceased employee, the entitlement of all of those individuals shall be determined in the same recommended decision, except as described in paragraph (b) of this section.

(b) If another individual subsequently files a survivor claim for the same award, the recommended decision on that claim will not address the entitlement of the earlier claimants if the district office recommended that the later survivor claim be denied.

[84 FR 3050, Feb. 8, 2019]

§ 30.308 To whom is the recommended decision sent?

(a) A copy of the recommended decision will be mailed to the claimant's last known address and to the claimant's designated representative before OWCP, if any. Notification to either the claimant or the representative will be considered notification to both parties.

(b) At the same time it issues a recommended decision on a claim, the OWCP district office will forward the record of such claim to the FAB. Any new evidence submitted to the district office following the issuance of the recommended decision will also be forwarded to the FAB for consideration.

[71 FR 78534, Dec. 29, 2006. Redesignated at 84 FR 3050, Feb. 8, 2019]

HEARINGS AND FINAL DECISIONS ON CLAIMS

§ 30.310 What must the claimant do if he or she objects to the recommended decision or wants to request a hearing?

(a) Within 60 days from the date the recommended decision is issued, the claimant must state, in writing, whether he or she objects to any of the findings of fact and/or conclusions of law discussed in such decision, including NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), and whether a hearing is desired. This written statement should be filed with the FAB at the address indicated in the notice accompanying the recommended decision.

(b) For purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the FAB, the statement will be considered to be ''filed'' on the date that the claimant mails it to the FAB, as determined by postmark or other carrier's date marking, or on the date that such written

statement is actually received, whichever is the earliest determinable date.

[84 FR 3050, Feb. 8, 2019]

§ 30.311 What happens if the claimant does not object to the recommended decision or request a hearing within 60 days?

(a) If the claimant does not file a written statement that objects to the recommended decision and/or requests a hearing within the period of time allotted in § 30.310, the FAB may issue a final decision accepting the recommendation of the district office as provided in § 30.316.

(b) If the recommended decision accepts all or part of a claim for compensation, the FAB may issue a final decision at any time after receiving written notice from the claimant that he or she waives any objection to all or part of the recommended decision.

§ 30.312 What will the FAB do if the claimant objects to the recommended decision but does not request a hearing?

If the claimant files a written statement that objects to the recommended decision within the period of time allotted in § 30.310 but does not request a hearing, the FAB will consider any objections by means of a review of the written record. If the claimant only objects to part of the recommended decision, the FAB may issue a final decision accepting the remaining part of the recommendation of the district office without first reviewing the written record (see § 30.316).

§ 30.313 How is a review of the written record conducted?

(a) The FAB reviewer will consider the written record forwarded by the district office and any additional evidence and/or argument submitted by the claimant. The reviewer may also conduct whatever investigation is deemed necessary.

(b) The claimant should submit, with his or her written statement that objects to the recommended decision, all evidence or argument that he or she wants to present to the reviewer. However, evidence or argument may be submitted at any time up to the date specified by the reviewer for the submission of such evidence or argument.

(c) Any objection that is not presented to the FAB reviewer, including any objection to NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3050, Feb. 8, 2019]

§ 30.314 How is a hearing conducted?

(a) The FAB reviewer retains complete discretion to set the time and place of the hearing, including the amount of time allotted for the hearing, considering the issues to be resolved. At the discretion of the reviewer, the hearing may be conducted by telephone, teleconference, videoconference or other electronic means. As part of the hearing process, the FAB reviewer will consider the written record forwarded by the district office and any additional evidence and/or argument submitted by the claimant. The reviewer may also conduct whatever investigation is deemed necessary.

(1) The FAB reviewer will try to set the hearing at a place that is within commuting distance of the claimant's residence, but will not be able to do so in all cases. Therefore, for reasons of economy, the claimant may be required to travel a roundtrip distance of up to 200 miles to attend the hearing.

(2) In unusual circumstances, the FAB reviewer may set a place for the hearing that is more than 200 miles roundtrip from the claimant's residence. However, in that situation, OWCP will reimburse the claimant for reasonable and necessary travel expenses incurred to attend the hearing if he or she submits a written reimbursement request that documents such expenses.

(b) The FAB reviewer will mail a notice of the time and place of the hearing to the claimant and any representative at least 30 days before the scheduled hearing date. The FAB reviewer may mail a hearing notice less than 30 days prior to the hearing if the claimant and/or representative waives the above 30-day notice period in writing. If the claimant only objects to part of

the recommended decision, the FAB reviewer may issue a final decision accepting the remaining part of the recommendation of the district office without first holding a hearing (see § 30.316). Any objection that is not presented to the FAB reviewer, including any objection to NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

(c) The hearing is an informal process, and the reviewer is not bound by common law or statutory rules of evidence, or by technical or formal rules of procedure. The reviewer may conduct the hearing in such manner as to best ascertain the rights of the claimant. During the hearing process, the claimant may state his or her arguments and present new written evidence and/or testimony in support of the claim.

(d) Testimony at hearings is recorded, then transcribed and placed in the record. Oral testimony shall be made under oath.

(e) The FAB reviewer will furnish a transcript of the hearing to the claimant, who has 20 days from the date it is sent to submit any comments to the reviewer.

(f) The claimant will have 30 days after the hearing is held to submit additional evidence or argument, unless the reviewer, in his or her sole discretion, grants an extension. Only one such extension may be granted.

(g) The reviewer determines the conduct of the hearing and may terminate the hearing at any time he or she determines that all relevant evidence has been obtained, or because of misbehavior on the part of the claimant and/or representative at or near the place of the oral presentation.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3050, Feb. 8, 2019]

§ 30.315 May a claimant postpone a hearing?

(a) The FAB will entertain any reasonable request for scheduling the time and place of the hearing, but such requests should be made at the time that the hearing is requested. Scheduling is at the discretion of the FAB, and is not reviewable. In most instances, once the hearing has been scheduled and appropriate written notice has been mailed, it cannot be postponed at the claimant's request for any reason except those stated in paragraph (b) of this section, unless the FAB reviewer can reschedule the hearing on the same docket (that is, during the same hearing trip). If a request to postpone a scheduled hearing does not meet one of the tests of paragraph (b) of this section and cannot be accommodated on the same docket, or if the claimant and/or representative cancels or fails to attend a scheduled hearing, no further opportunity for a hearing will be provided. Instead, the FAB will consider the claimant's objections by means of a review of the written record. In the alternative, a teleconference may be substituted for the hearing at the discretion of the reviewer.

(b) Where the claimant or the representative appointed by the claimant in accordance with § 30.600 of this part has a medical reason that prevents attendance at the hearing, or where the death or illness of the claimant's parent, spouse, or child prevents the claimant from attending the hearing as scheduled, a postponement may be granted in the discretion of the FAB if the claimant or the representative provides at least 24 hours notice and a reasonable explanation supporting his or her inability to attend the scheduled hearing.

(c) At any time after requesting a hearing, the claimant can request a change to a review of the written record by making a written request to the FAB. Once such a change is made, no further opportunity for a hearing will be provided.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3051, Feb. 8, 2019]

§ 30.316 How does the FAB issue a final decision on a claim?

(a) If the claimant does not file a written statement that objects to the recommended decision and/or requests a hearing within the period of time allotted in § 30.310, or if the claimant waives any objections to all or part of the recommended decision, the FAB may issue a final decision accepting

the recommendation of the district office, either in whole or in part (see §§ 30.311, 30.312 and 30.314(b)).

(b) If the claimant objects to all or part of the recommended decision, the FAB reviewer will issue a final decision on the claim after either the hearing or the review of the written record, and after completing such further development of the case as he or she may deem necessary.

(c) Any recommended decision (or part thereof) that is pending either a hearing or a review of the written record for more than one year from the date the FAB received the written statement described in § 30.310(a), or the date the Director reopened the claim for issuance of a new final decision pursuant to § 30.320(a), shall be considered a final decision of the FAB on the one-year anniversary of such date. Any recommended decision described in § 30.311 that is pending at the FAB for more than one year from the date that the period of time described in § 30.310 expired shall be considered a final decision of the FAB on the one-year anniversary of such date.

(d) The decision of the FAB, whether issued pursuant to paragraph (a), (b) or (c) of this section, shall be final upon the date of issuance of such decision, unless a timely request for reconsideration under § 30.319 has been filed.

(e) A copy of the final decision of the FAB will be mailed to the claimant's last known address and to the claimant's designated representative before OWCP, if any. Notification to either the claimant or the representative will be considered notification to both parties.

§ 30.317 Can the FAB request a further response from the claimant or return a claim to the district office?

At any time before the issuance of its final decision, the FAB may request that the claimant submit additional evidence or argument, or return the claim to the district office for further development and/or issuance of a newly recommended decision without issuing a final decision, whether or not requested to do so by the claimant.

§ 30.318 How will FAB consider objections to NIOSH's reconstruction of a radiation dose, or to OWCP's calculation of the recommended probability of causation, in a Part B claim for radiogenic cancer?

(a) If the claimant objects to NIOSH's reconstruction of the radiation dose to which the employee was exposed, either in writing or at the oral hearing, the FAB reviewer has the discretion to consult with NIOSH as part of his or her consideration of any objection. However, the HHS dose reconstruction regulation, which provides guidance for the technical methods developed and used by NIOSH to provide a reasonable estimate of the radiation dose received by an employee, is binding on FAB. Should this consultation take place, the FAB reviewer will properly document it in the case. Whether or not NIOSH is consulted, and as provided for in § 30.317, the FAB reviewer may decide to return the case to the district office for referral to NIOSH for such further action as may be appropriate.

(b) If the claimant objects to OWCP's calculation of the recommended probability of causation in a Part B radiogenic cancer claim, the FAB reviewer has the discretion to consider if OWCP used incorrect factual information when it performed this calculation. However, the statute requires that OWCP use a particular methodology, established by regulations issued by HHS at 42 CFR part 81, when it calculates the recommended probability of causation.

[84 FR 3051, Feb. 8, 2019]

§ 30.319 May a claimant request reconsideration of a final decision of the FAB?

(a) A claimant may request reconsideration of a final decision of the FAB by filing a written request with the FAB within 30 days from the date of issuance of such decision. If a timely request for reconsideration is made, the decision in question will no longer be considered ''final'' under § 30.316(d).

(b) For purposes of determining whether the written request referred to in paragraph (a) of this section has been timely filed with the FAB, the request will be considered to be ''filed''

on the date that the claimant mails it to the FAB, as determined by postmark or other carrier's date marking, or on the date that such written request is actually received, whichever is the earliest determinable date.

(c) A hearing is not available as part of the reconsideration process. If the FAB grants the request for reconsideration, it will consider the written record of the claim again and issue a new final decision on the claim. A new final decision that is issued after the FAB grants a request for reconsideration will be ''final'' upon the date of issuance of such new decision.

(1) Instead of issuing a new final decision after granting a request for reconsideration, the FAB may return the claim to the district office for further development as provided in § 30.317.

(2) If the FAB denies the request for reconsideration, the FAB decision that formed the basis for the request will be considered ''final'' upon the date the request is denied, and no further requests for reconsideration of that particular final decision of the FAB will be entertained.

(d) A claimant may not seek judicial review of a decision on his or her claim under EEOICPA until OWCP's decision on the claim is final pursuant to either § 30.316(d) (for claims in which no request for reconsideration was filed with the FAB) or paragraph (c) of this section (for claims in which a request for reconsideration was filed with the FAB).

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3051, Feb. 8, 2019]

REOPENING CLAIMS

§ 30.320 Can a claim be reopened after the FAB has issued a final decision?

(a) At any time after the FAB has issued a final decision pursuant to § 30.316, and without regard to whether new evidence or information is presented or obtained, the Director for Energy Employees Occupational Illness Compensation may reopen a claim and return it to the FAB for issuance of a new final decision, or to the district office for such further development as may be necessary, to be followed by a new recommended decision. The Director may also vacate any other type of decision issued by the FAB.

(b) At any time after the FAB has issued a final decision pursuant to § 30.316, a claimant may file a written request that the Director for Energy Employees Occupational Illness Compensation reopen his or her claim, provided that the claimant also submits new evidence of a diagnosed medical condition, covered employment, or exposure to a toxic substance. A written request to reopen a claim may also be supported by identifying either a change in the PoC guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort. If the Director concludes that the evidence submitted or matter identified in support of the claimant's request is material to the claim, the Director will reopen the claim and return it to the district office for such further development as may be necessary, to be followed by a new recommended decision.

(c) The decision whether or not to reopen a claim under this section is solely within the discretion of the Director for Energy Employees Occupational Illness Compensation and is not reviewable. If the Director reopens a claim pursuant to paragraphs (a) or (b) of this section and returns it to the district office, the resulting new recommended decision will be subject to the adjudicatory process described in this subpart. However, neither the district office nor the FAB can consider any objection concerning the Director's decision to reopen a claim under this section.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3051, Feb. 8, 2019]

Subpart E—Medical and Related Benefits

MEDICAL TREATMENT AND RELATED ISSUES

§ 30.400 What are the basic rules for obtaining medical treatment?

(a) A covered Part B employee or a covered Part E employee who fits into at least one of the compensable claim categories described in subpart C of this part is entitled to receive all medical services, appliances or supplies

that a qualified physician prescribes or recommends and that OWCP considers necessary to treat his or her occupational illness or covered illness, retroactive to the date the claim for benefits for that occupational illness or covered illness under Part B or Part E of EEOICPA was filed. The employee need not be disabled to receive such treatment. If there is any doubt as to whether a specific service, appliance or supply is necessary to treat the occupational illness or covered illness, the employee should consult OWCP prior to obtaining it through the automated authorization process described in §30.700. In situations where the occupational illness or covered illness is a secondary cancer, such treatment may include treatment of the underlying primary cancer when it is medically necessary or related to treatment of the secondary cancer; however, payment for medical treatment of the underlying primary cancer under these circumstances does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of EEOICPA.

(b) If a claimant disagrees with the decision of OWCP that medical benefits provided under paragraph (a) of this section are not necessary to treat an occupational illness or covered illness, he or she may choose to utilize the adjudicatory process described in subpart D of this part.

(c) Any qualified physician may provide medical services, appliances and supplies to the covered Part B employee or the covered Part E employee. A hospital or a provider of medical services or supplies may furnish appropriate services, drugs, supplies and appliances, so long as such provider possesses all applicable licenses required under State law and has not been excluded from participation in the program under subpart H of this part. OWCP may apply a test of cost-effectiveness when it decides if appliances and supplies are necessary to treat an occupational illness or covered illness, may offset the cost of prior rental payments against a future purchase price, and may provide refurbished appliances where appropriate. Also, OWCP may authorize payment for durable medical equipment and modifications to a home or vehicle, to the extent that OWCP deems it necessary and reasonable. With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available. OWCP may contract with a specific provider or providers to supply non-physician medical services or supplies.

(d) In circumstances when a covered employee dies after filing a claim but before such claim is accepted, OWCP will pay for medical treatment for all accepted illnesses, retroactive to the date that the employee filed the claim, if the deceased employee's survivor(s) files a claim that is accepted under Part B and/or Part E of EEOICPA. If this occurs, OWCP shall only pay either the provider(s) or the employee's estate for medical treatment that the employee obtained after filing his or her claim.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3051, Feb. 8, 2019]

§30.401 What are the special rules for the services of chiropractors?

(a) The services of chiropractors that may be reimbursed by OWCP are limited to treatment to correct a spinal subluxation. The costs of physical and related laboratory tests performed by or required by a chiropractor to diagnose such a subluxation are also payable.

(b) A diagnosis of spinal subluxation as demonstrated by x-ray to exist must appear in the chiropractor's report before OWCP can consider payment of a chiropractor's bill.

(c) A chiropractor may interpret his or her x-rays to the same extent as any other physician. To be given any weight, the medical report must state that x-rays support the finding of spinal subluxation. OWCP will not necessarily require submission of the x-ray, or a report of the x-ray, but the report must be available for submission on request.

(d) A chiropractor may also provide services in the nature of physical therapy under the direction of a qualified physician.

§ 30.402 What are the special rules for the services of clinical psychologists?

A clinical psychologist may serve as a physician within the scope of his or her practice as defined by state law. Therefore, a clinical psychologist may not serve as a physician for conditions that include a physical component unless the applicable state law allows clinical psychologists to treat physical conditions. A clinical psychologist may also perform testing, evaluation, and other services under the direction of a qualified physician.

§ 30.403 Will OWCP pay for home health care, nursing home, and assisted living services?

(a) OWCP will authorize and pay for home health care claimed under section 7384t of the Act, whether or not such care constitutes skilled nursing care, so long as the care has been determined to be medically necessary. OWCP will pay for approved periods of care by a registered nurse, licensed practical nurse, home health aide or similarly trained individual, subject to the pre-authorization requirements described in paragraph (c) of this section.

(b) OWCP will also authorize and pay for periods of nursing home and assisted living services claimed under section 7384t of the Act, so long as such services have been determined to be medically necessary, subject to the pre-authorization requirements described in paragraph (c) of this section.

(c) To file an initial claim for home health care, nursing home, or assisted living services, the beneficiary must submit Form EE–17A to OWCP and identify his or her treating physician. OWCP then provides the treating physician with Form EE–17B, which asks the physician to submit a letter of medical necessity and verify that a timely face-to-face physical examination of the beneficiary took place. This particular pre-authorization process must be followed only for the initial claim for home health care, nursing home, and assisted living services; any subsequent request for pre-authorization must satisfy OWCP's usual medical necessity requirements. If a claimant disagrees with the decision of OWCP that the claimed services are not medically necessary, he or she may utilize the adjudicatory process described in subpart D of this part.

[84 FR 3052, Feb. 8, 2019]

§ 30.404 Will OWCP pay for transportation to obtain medical treatment?

(a) The employee is entitled to reimbursement for reasonable and necessary expenses, including transportation, incident to obtaining authorized medical services, appliances or supplies. To determine what is a reasonable distance to travel, OWCP will consider the availability of services, the employee's condition, and the means of transportation. Generally, a roundtrip distance of up to 200 miles is considered a reasonable distance to travel.

(b) If travel of more than 200 miles is contemplated, or air transportation or overnight accommodations will be needed, the employee must submit a written request to OWCP for prior authorization with information describing the circumstances and necessity for such travel expenses. OWCP will approve the request if it determines that the travel expenses are reasonable and necessary, and are incident to obtaining authorized medical services, appliances or supplies. Requests for travel expenses that are often approved include those resulting from referrals to a specialist for further medical treatment, and those involving air transportation of an employee who lives in a remote geographical area with limited local medical services.

(c) If a claimant disagrees with the decision of OWCP that requested travel expenses are either not reasonable or necessary, or are not incident to obtaining authorized medical services, appliances or supplies, he or she may utilize the adjudicatory process described in subpart D of this part.

(d) The standard form designated for medical travel refund requests is Form OWCP–957 and must be used to seek reimbursement under this section. This form can be obtained from OWCP.

§ 30.405 After selecting a treating physician, may an employee choose to be treated by another physician instead?

(a) OWCP will provide the employee with an opportunity to designate a treating physician when it accepts the claim. When the physician originally selected to provide treatment for an occupational illness or a covered illness refers the employee to a specialist for further medical care, the employee need not consult OWCP for approval. In all other instances, however, the employee must submit a written request to OWCP with his or her reasons for desiring a change of physician.

(b) OWCP will approve the request if it determines that the reasons submitted are credible and supported by probative factual and/or medical evidence, as appropriate. Requests that are often approved include those for transfer of care from a general practitioner to a physician who specializes in treating the occupational illnesses or covered illnesses covered by EEOICPA, or the need for a new physician when an employee has moved.

(c) OWCP may deny a requested change of physician if it determines that the reasons submitted are not both credible and supported by probative evidence. If a claimant disagrees with such an informal denial, he or she may utilize the adjudicatory process described in subpart D of this part.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3052, Feb. 8, 2019]

§ 30.406 Are there any exceptions to these procedures for obtaining medical care?

In cases involving emergencies or unusual circumstances, OWCP may authorize treatment in a manner other than as stated in this subpart.

DIRECTED MEDICAL EXAMINATIONS

§ 30.410 Can OWCP require an employee to be examined by another physician?

(a) OWCP sometimes needs a second opinion from a medical specialist. The employee must submit to examination by a qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP as often and at such times and places as OWCP considers reasonably necessary. Also, OWCP may send a case file for second opinion review to a qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP where an actual examination is not needed, or where the employee is deceased.

(b) If the initial examination is disrupted by someone accompanying the employee, OWCP will schedule another examination with a different qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP. The employee will not be entitled to have anyone else present at the subsequent examination unless OWCP decides that exceptional circumstances exist. For example, where a hearing-impaired employee needs an interpreter, the presence of an interpreter would be allowed.

(c) OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a second opinion examination.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3052, Feb. 8, 2019]

§ 30.411 What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?

(a) If one medical opinion holds more probative value than the other, OWCP will base its determination of coverage on the medical opinion with the greatest probative value. A difference in medical opinion sufficient to be considered a conflict only occurs when two reports of virtually equal weight and rationale reach opposing conclusions.

(b) If a conflict exists between the medical opinion of the employee's physician and the medical opinion of a second opinion physician, an OWCP medical adviser or consultant, or a physician submitting an impairment evaluation that meets the criteria set out in § 30.905 of this part, OWCP shall appoint a third physician who conforms to the standards regarding conflicts of interest adopted by OWCP to make an examination or an impairment evaluation. This is called a referee examination or a referee impairment evaluation. OWCP will select a physician who

is qualified in the appropriate specialty and who has had no prior connection with the case. Also, a case file may be sent to a physician who conforms to the standards regarding conflicts of interest adopted by OWCP for a referee medical review where there is no need for an actual examination, or where the employee is deceased.

(c) If the initial referee examination or referee impairment evaluation is disrupted by someone accompanying the employee, OWCP will schedule another examination or impairment evaluation with a different qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP. The employee will not be entitled to have anyone else present at the subsequent referee examination or referee impairment evaluation unless OWCP decides that exceptional circumstances exist. For example, where a hearing-impaired employee needs an interpreter, the presence of an interpreter would be allowed.

(d) OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a referee medical examination.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3052, Feb. 8, 2019]

§ 30.412 Who pays for second opinion and referee examinations?

OWCP will pay second opinion and referee medical specialists directly. OWCP will also reimburse the employee for all necessary and reasonable expenses incident to such an examination, including transportation costs and actual wages the employee lost for the time needed to submit to an examination required by OWCP.

MEDICAL REPORTS

§ 30.415 What are the requirements for medical reports?

In general, medical reports from the employee's attending physician should include the following:

(a) Dates of examination and treatment;

(b) History given by the employee;

(c) Physical findings;

(d) Results of diagnostic tests;

(e) Diagnosis;

(f) Course of treatment;

(g) A description of any other conditions found due to the claimed occupational illness or covered illness;

(h) The treatment given or recommended for the claimed occupational illness or covered illness; and

(i) All other material findings.

§ 30.416 How and when should medical reports be submitted?

(a) The initial medical report (and any subsequent reports) should be made in narrative form on the physician's letterhead stationery. The physician should use the Form EE–7 as a guide for the preparation of his or her initial medical report in support of a claim under Part B and/or Part E of EEOICPA. The report should bear the physician's handwritten or electronic signature. OWCP may require an original signature on the report.

(b) The report shall be submitted directly to OWCP as soon as possible after medical examination or treatment is received, either by the employee or the physician.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3052, Feb. 8, 2019]

§ 30.417 What additional medical information may OWCP require to support continuing payment of benefits?

In all cases requiring hospital treatment or prolonged care, OWCP will request detailed narrative reports from the attending physician at periodic intervals. The physician will be asked to describe continuing medical treatment for the occupational illness or covered illness accepted by OWCP, a prognosis, and the physician's opinion as to the continuing causal relationship between the need for additional treatment and the occupational illness or covered illness.

MEDICAL BILLS

§ 30.420 How should medical bills and reimbursement requests be submitted?

Usually, medical providers submit their bills directly for processing. The rules for submitting and processing provider bills and reimbursement requests are stated in subpart H of this

part. An employee requesting reimbursement for out-of-pocket medical expenses must submit a Form OWCP–915 and meet the requirements described in § 30.702.

§ 30.421 What are the time frames for submitting bills and reimbursement requests?

To be considered for payment, bills and reimbursement requests must be submitted by the end of the calendar year after the year when the expense was incurred, or by the end of the calendar year after the year when OWCP first accepted the claim as compensable under subpart D of this part, whichever is later.

§ 30.422 If an employee is only partially reimbursed for a medical expense, must the provider refund the balance of the amount paid to the employee?

(a) The OWCP fee schedule sets maximum limits on the amounts payable for many services. The employee may be only partially reimbursed for out-of-pocket medical expenses because the amount he or she paid to the medical provider for a service exceeds the maximum allowable charge set by the OWCP fee schedule.

(b) If this happens, the employee will be advised of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid that exceeds the maximum allowable charge. The provider that the employee paid, but not the employee, may request reconsideration of the fee determination as set forth in § 30.712.

(c) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge that OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may authorize reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

Subpart F—Survivors; Payments and Offsets; Overpayments

SURVIVORS

§ 30.500 What special statutory definitions apply to survivors under EEOICPA?

(a) For the purposes of paying compensation to survivors under both Parts B and E of EEOICPA, OWCP will use the following definitions:

(1) *Surviving spouse* means the wife or husband of a deceased covered Part B employee or deceased covered Part E employee who was married to that individual for the 365 consecutive days immediately prior to the death of that individual.

(2) *Child* of a deceased covered Part B employee or deceased covered Part E employee means only a biological child, a stepchild or an adopted child of that individual.

(b) For the purposes of paying compensation to survivors only under Part B of EEOICPA, OWCP will use the following additional definitions:

(1) *Parent* includes fathers and mothers of a deceased covered Part B employee through adoption.

(2) *Grandchild* means a child of a child of a deceased covered Part B employee.

(3) *Grandparent* means a parent of a parent of a deceased covered Part B employee.

(c) For the purposes of paying compensation to survivors under Part E of EEOICPA, OWCP will use the following additional definitions:

(1) *Covered child* means a child that is, as of the date of the deceased covered Part E employee's death, either under the age of 18 years, or under the age of 23 years and a full-time student who was continuously enrolled in one or more educational institutions since attaining the age of 18 years, or any age and incapable of self-support. A child's marital status or dependency on the covered employee for support is irrelevant to his or her eligibility for benefits as a covered child under Part E.

(2) *Incapable of self-support* means that the child must have been physically and/or mentally incapable of

self-support at the time of the covered employee's death.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3052, Feb. 8, 2019]

§ 30.501 What order of precedence will OWCP use to determine which survivors are entitled to receive compensation under EEOICPA?

(a) Under Part B of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part B employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as follows, subject to the qualifications set forth in § 30.5(hh)(3):

(1) If there is a surviving spouse, the compensation shall be paid to that individual.

(2) If there is no surviving spouse, the compensation shall be paid in equal shares to all children of the deceased covered Part B employee.

(3) If there is no surviving spouse and no children, the compensation shall be paid in equal shares to the parents of the deceased covered Part B employee.

(4) If there is no surviving spouse, no children and no parents, the compensation shall be paid in equal shares to all grandchildren of the deceased covered Part B employee.

(5) If there is no surviving spouse, no children, no parents and no grandchildren, the compensation shall be paid in equal shares to the grandparents of the deceased covered Part B employee.

(6) Notwithstanding paragraphs (a)(1) through (a)(5) of this section, if there is a surviving spouse and at least one child of the deceased covered Part B employee who is a minor at the time of payment and who is not a recognized natural child or adopted child of such surviving spouse, half of the compensation shall be paid to the surviving spouse, and the other half of the compensation shall be paid in equal shares to each child of the deceased covered Part B employee who is a minor at the time of payment.

(b) Under Part E of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part E employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as follows, subject to the qualifications set forth in § 30.5(hh)(3):

(1) If there is a surviving spouse, the compensation shall be paid to that individual.

(2) If there is no surviving spouse, the compensation shall be paid in equal shares to all ''covered'' children of the deceased covered Part E employee.

(3) Notwithstanding paragraphs (b)(1) and (b)(2) of this section, if there is a surviving spouse and at least one ''covered'' child of the deceased covered Part E employee who is living at the time of payment and who is not a recognized natural child or adopted child of such surviving spouse, then half of such payment shall be made to such surviving spouse, and the other half of such payment shall be made in equal shares to each ''covered'' child of the employee who is living at the time of payment.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3052, Feb. 8, 2019]

§ 30.502 When is entitlement for survivors determined for purposes of EEOICPA?

Entitlement to any lump-sum payment for survivors under the EEOICPA, other than for ''covered'' children under Part E, will be determined as of the time OWCP makes such a payment. As noted in § 30.500(c)(1), a child of a deceased Part E employee will only qualify as a ''covered'' child of that individual if he or she satisfied one of the additional statutory criteria for a ''covered'' child as of the date of the deceased Part E employee's death.

[84 FR 3053, Feb. 8, 2019]

PAYMENT OF CLAIMS AND OFFSET FOR CERTAIN PAYMENTS

§ 30.505 What procedures will OWCP follow before it pays any compensation?

(a) In cases involving the approval of a claim, whether in whole or in part, OWCP shall take all necessary steps to determine the amount of any offset or coordination of EEOICPA benefits before paying any benefits, and to verify the identity of the covered Part B employee, the covered Part E employee,

or the eligible surviving beneficiary or beneficiaries. To perform these tasks, OWCP may conduct any investigation, require any claimant to provide or execute any affidavit, record or document, or authorize the release of any information as OWCP deems necessary to ensure that the compensation payment is made in the correct amount and to the correct person or persons. OWCP shall also require every claimant under Part B of the Act to execute and provide any necessary affidavit described in § 30.620 of these regulations. Should a claimant fail or refuse to execute an affidavit or release of information, or fail or refuse to provide a requested document or record or to provide access to information, such failure or refusal may be deemed to be a rejection of the payment, unless the claimant does not have and cannot obtain the legal authority to provide, release, or authorize access to the required information, records, or documents.

(b) To determine the amount of any offset, OWCP shall require the covered Part B employee, covered Part E employee or each eligible surviving beneficiary filing a claim under this part to execute and provide an affidavit (or declaration made under oath on Form EE–1 or EE–2) reporting the amount of any payment made pursuant to a final judgment or settlement in litigation seeking damages. Even if someone other than the covered Part B employee or the covered Part E employee receives a payment pursuant to a final judgment or settlement in litigation seeking damages (*e.g.*, the surviving spouse of a deceased covered Part B employee or a deceased covered Part E employee), the receipt of any such payment must be reported.

(1) For the purposes of this paragraph (b) only, ''litigation seeking damages'' refers to any request or demand for money (other than for workers' compensation) by the covered Part B employee or the covered Part E employee, or by another individual if the covered Part B employee or the covered Part E employee is deceased, made or sought in a civil action or in anticipation of the filing of a civil action, for injuries incurred on account of an exposure for which compensation is payable under EEOICPA. This term does not also include any request or demand for money made or sought pursuant to a life insurance or health insurance contract, or any request or demand for money made or sought by an individual other than the covered Part B employee or the covered Part E employee in that individual's own right (*e.g.*, a spouse's claim for loss of consortium), or any request or demand for money made or sought by the covered Part B employee or the covered Part E employee (or the estate of a deceased covered Part B employee or deceased covered Part E employee) not for injuries incurred on account of an exposure for which compensation is payable under the EEOICPA (*e.g.*, a covered Part B employee's or a covered Part E employee's claim for damage to real or personal property).

(2) If a payment has been made pursuant to a final judgment or settlement in litigation seeking damages, OWCP shall subtract a portion of the dollar amount of such payment from the benefit payments to be made under EEOICPA. OWCP will calculate the amount to be subtracted from the benefit payments in the following manner:

(i) OWCP will first determine the value of the payment made pursuant to either a final judgment or settlement in litigation seeking damages by adding the dollar amount of any monetary damages (excluding contingent awards) and any medical expenses for treatment provided on or after the date the covered Part B employee or the covered Part E employee filed a claim for EEOICPA benefits that were paid for under the final judgment or settlement. In the event that these payments include a ''structured'' settlement (where a party makes an initial cash payment and also arranges, usually through the purchase of an annuity, for payments in the future), OWCP will usually accept the cost of the annuity to the purchaser as the dollar amount of the right to receive the future payments.

(ii) OWCP will then make certain deductions from the above dollar amount to arrive at the dollar amount to be subtracted from any unpaid EEOICPA benefits. Allowable deductions consist of attorney's fees OWCP deems reasonable, and itemized costs of suit (out-of-

pocket expenditures not part of the normal overhead of a law firm's operation like filing fees, travel expenses, witness fees, and court reporter costs for transcripts) provided that adequate supporting documentation is submitted to OWCP.

(iii) The EEOICPA benefits that will be reduced will consist of any unpaid lump-sum payments payable in the future and medical benefits payable in the future. In those cases where it has not yet paid EEOICPA benefits, OWCP will reduce such benefits on a dollar-for-dollar basis, beginning with the lump-sum payments first. If the amount to be subtracted exceeds the lump-sum payments, OWCP will reduce ongoing EEOICPA medical benefits payable in the future by the amount of any remaining surplus. This means that OWCP will apply the amount it would otherwise pay to reimburse the covered Part B employee or the covered Part E employee for any ongoing EEOICPA medical treatment to the remaining surplus until it is absorbed. In addition to this reduction of ongoing EEOICPA medical benefits, OWCP will not be the first payer for any medical expenses that are the responsibility of another party (who will instead be the first payer) as part of a final judgment or settlement in litigation seeking damages.

(3) The above reduction of EEOICPA benefits will not occur if an EEOICPA claimant had his or her award under section 5 of RECA reduced by the full amount of the payment made pursuant to a final judgment or settlement in litigation seeking damages. It will also not occur if an EEOICPA claimant's prior payment of EEOICPA benefits, or his or her workers' compensation benefits, were offset to reflect the full amount of the payment made pursuant to a final judgment or settlement in litigation seeking damages. However, if the prior reduction or offset of the above benefits did not reflect the full amount of the payment made pursuant to a final judgment or settlement in litigation seeking damages, OWCP will reduce currently payable EEOICPA benefits by the amount of any surplus final judgment or settlement payment that remains.

(c) Except as provided in § 30.506(b) of these regulations, when OWCP has verified the identity of every claimant who is entitled to the compensation payment, or to a share of the compensation payment, and has determined the correct amount of the payment or the share of the payment, OWCP shall notify every claimant, every duly appointed guardian or conservator of a claimant, or every person with power of attorney for a claimant, and require such person or persons to complete a Form EN–20 providing payment information. Such form shall be signed and returned to OWCP within sixty days of the date of the form or within such greater period as may be allowed by OWCP. Failure to sign and return the form within the required time may be deemed to be a rejection of the payment. If the claimant dies before the payment is received, the person who receives the payment shall return it to OWCP for redetermination of the correct disbursement of the payment. No payment shall be made until OWCP has made a determination concerning the survivors related to a respective claim for benefits.

(d) The total amount of compensation (other than medical benefits) under Part E that can be paid to all claimants as a result of the exposure of a covered Part E employee shall not be more than $250,000 in any circumstances.

§ 30.506 To whom and in what manner will OWCP pay compensation?

(a) Except with respect to claims under Part B of the Act for beryllium sensitivity, payment shall be made to the covered Part B employee or the covered Part E employee, to the duly appointed guardian or conservator of that individual, or to the person with power of attorney for that individual, unless the covered Part B employee or covered Part E employee is deceased at the time of the payment. In all cases involving a deceased covered Part B employee or deceased covered Part E employee, payment shall be made to the eligible surviving beneficiary or beneficiaries, to the duly appointed guardian or conservator of the eligible surviving beneficiary or beneficiaries,

or to every person with power of attorney for an eligible surviving beneficiary, in accordance with the terms and conditions specified in sections 7384s(e), 7384u(e), and 7385s–3(c) and (d) of EEOICPA.

(b) Under Part B of the Act, compensation for any consequential injury, illness, impairment or disease is limited to payment of medical benefits for that injury, illness, impairment or disease. Under Part E of the Act, compensation for any consequential injury, illness, impairment or disease consists of medical benefits for that injury, illness, impairment or disease, as well as any additional monetary benefits that are consistent with the terms of § 30.505(d).

(c) Rejected compensation payments, or shares of compensation payments, shall not be distributed to other eligible surviving beneficiaries, but shall be returned to the Fund.

(d) No covered Part B employee may receive more than one lump-sum payment under Part B of EEOICPA for any occupational illnesses he or she contracted. However, any individual, including a covered Part B employee who has received a lump-sum payment for his or her own occupational illness or illnesses, may receive one lump-sum payment for each deceased covered Part B employee for whom he or she qualifies as an eligible surviving beneficiary under Part B of the Act.

§ 30.507 What compensation will be provided to covered Part B employees who only establish beryllium sensitivity under Part B of EEOICPA?

The establishment of beryllium sensitivity does not entitle a covered Part B employee, or the eligible surviving beneficiary or beneficiaries of a deceased covered Part B employee, to any lump-sum payment provided for under Part B. Instead, a covered Part B employee whose sole accepted occupational illness is beryllium sensitivity shall receive beryllium sensitivity monitoring, as well as medical benefits for the treatment of this occupational illness in accordance with § 30.400 of these regulations.

§ 30.508 What is beryllium sensitivity monitoring?

Beryllium sensitivity monitoring shall consist of medical examinations to confirm and monitor the extent and nature of a covered Part B employee's beryllium sensitivity. Monitoring shall also include regular medical examinations, with diagnostic testing, to determine if the covered Part B employee has established chronic beryllium disease.

§ 30.509 Under what circumstances may a survivor claiming under Part E of the Act choose to receive the benefits that would otherwise be payable to a covered Part E employee who is deceased?

(a) If a covered Part E employee dies after filing a claim but before monetary benefits are paid under Part E of the Act, and his or her death is from a cause other than a covered illness, his or her survivor can choose to receive either the survivor benefits payable on account of the death of that covered Part E employee, or the monetary benefits that would otherwise have been payable to the covered Part E employee.

(b) For the purposes of this section only, a death ''from a cause other than a covered illness'' refers only to a death that was *solely* caused by a non-covered illness or illnesses. Therefore, the choice referred to in paragraph (a) of this section will not be available if a covered illness contributed to the death of the covered Part E employee in any manner. In those instances, survivor benefits will still be payable to the claimant, but he or she cannot choose to receive the monetary benefits that would have otherwise been payable to the deceased covered Part E employee in lieu of survivor benefits.

(c) OWCP only makes impairment determinations based on rationalized medical evidence in the case file that is sufficiently detailed and meets the various requirements for the many different types of impairment determinations possible under the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA's *Guides*). Therefore, OWCP will only make an impairment determination for a deceased covered Part E employee

pursuant to this section if the medical evidence of record is sufficient to satisfy the pertinent requirements in the AMA's *Guides* and subpart J of this part.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3053, Feb. 8, 2019]

OVERPAYMENTS

§ 30.510 How does OWCP notify an individual of a payment made on a claim?

(a) In addition to providing narrative descriptions to recipients of benefits paid or payable, OWCP includes on each check a clear indication of the reason the payment is being made. For payments sent by electronic funds transfer, a notification of the date and amount of payment appears on the statement from the recipient's financial institution.

(b) By these means, OWCP puts the recipient on notice that a payment was made and the amount of the payment. If the amount received differs from the amount indicated on the written notice or bank statement, the recipient is responsible for notifying OWCP of the difference. Absent affirmative evidence to the contrary, the recipient will be presumed to have received the notice of payment, whether mailed or transmitted electronically.

§ 30.511 What is an "overpayment" for purposes of EEOICPA?

An ''overpayment'' is any amount of compensation paid under sections 7384s, 7384t, 7384u, 7385s–2 or 7385s–3 of the EEOICPA to a recipient that constitutes, as of the time OWCP makes such payment:

(a) Payment where no amount is payable under this part; or

(b) Payment in excess of the correct amount determined by OWCP.

§ 30.512 What does OWCP do when an overpayment is identified?

Before seeking to recover an overpayment or adjust benefits, OWCP will advise the recipient of the overpayment in writing that:

(a) The overpayment exists, and the amount of overpayment;

(b) A preliminary finding shows either that the recipient was or was not at fault in the creation of the overpayment;

(c) He or she has the right to inspect and copy OWCP records relating to the overpayment; and

(d) He or she has the right to present written evidence which challenges the fact or amount of the overpayment, and/or challenges the preliminary finding that he or she was at fault in the creation of the overpayment. He or she may also request that recovery of the overpayment be waived. Any submission of evidence or request that recovery of the overpayment be waived must be presented to OWCP within 30 days of the date of the written notice of overpayment.

§ 30.513 Under what circumstances may OWCP waive recovery of an overpayment?

(a) OWCP may consider waiving recovery of an overpayment only if the recipient was not at fault in accepting or creating the overpayment. Recipients of benefits paid under EEOICPA are responsible for taking all reasonable measures to ensure that payments received from OWCP are proper. The recipient must show good faith and exercise a high degree of care in reporting events which may affect entitlement to or the amount of benefits. A recipient who has done any of the following will be found to be at fault with respect to creating an overpayment:

(1) Made an incorrect statement as to a material fact which he or she knew or should have known to be incorrect; or

(2) Failed to provide information which he or she knew or should have known to be material; or

(3) Accepted a payment which he or she knew or should have known to be incorrect. (This provision applies only to the overpaid individual.)

(b) Whether or not OWCP determines that a recipient was at fault with respect to the creation of an overpayment depends on the circumstances surrounding the overpayment. The degree of care expected may vary with the complexity of those circumstances and the recipient's capacity to realize that he or she is being overpaid.

§ 30.514 If OWCP finds that the recipient of an overpayment was not at fault, what criteria are used to decide whether to waive recovery of it?

If OWCP finds that the recipient of an overpayment was not at fault, repayment will still be required unless:

(a) Adjustment or recovery of the overpayment would defeat the purpose of the Act (see § 30.516); or

(b) Adjustment or recovery of the overpayment would be against equity and good conscience (see § 30.517).

§ 30.515 Is a recipient responsible for an overpayment that resulted from an error made by OWCP?

(a) The fact that OWCP may have erred in making the overpayment does not by itself relieve the recipient of the overpayment from liability for repayment if the recipient also was at fault in accepting the overpayment.

(b) However, OWCP may find that the recipient was not at fault if failure to report an event affecting compensation benefits, or acceptance of an incorrect payment, occurred because:

(1) The recipient relied on misinformation given in writing by OWCP regarding the interpretation of a pertinent provision or EEOICPA of this part; or

(2) OWCP erred in calculating either the percentage of impairment or wage-loss under Part E of EEOICPA.

§ 30.516 Under what circumstances would recovery of an overpayment defeat the purpose of the Act?

Recovery of an overpayment will defeat the purpose of the Act if such recovery would cause hardship to the recipient because:

(a) The recipient from whom OWCP seeks recovery needs substantially all of his or her current income to meet current ordinary and necessary living expenses; and

(b) The recipient's assets do not exceed two months' expenditures as determined by OWCP using the Bureau of Labor Statistics Consumer Expenditure Survey tables.

§ 30.517 Under what circumstances would recovery of an overpayment be against equity and good conscience?

(a) Recovery of an overpayment is considered to be against equity and good conscience when the recipient would experience severe financial hardship in attempting to repay the debt.

(b) Recovery of an overpayment is also considered to be against equity and good conscience when the recipient, in reliance on such payments or on notice that such payments would be made, gives up a valuable right or changes his or her position for the worse. In making such a decision, OWCP does not consider the recipient's current ability to repay the overpayment.

(1) To establish that a valuable right has been relinquished, it must be shown that the right was in fact valuable, that it cannot be regained, and that the action was based chiefly or solely in reliance on the payments or on the notice of payment. Gratuitous transfers of funds to other individuals are not considered relinquishments of valuable rights.

(2) To establish that a recipient's position has changed for the worse, it must be shown that the decision made would not otherwise have been made but for the receipt of benefits, and that this decision resulted in a loss.

§ 30.518 Can OWCP require the recipient of the overpayment to submit additional financial information?

(a) The recipient of the overpayment is responsible for providing information about income, expenses and assets as specified by OWCP. This information is needed to determine whether or not recovery of an overpayment would defeat the purpose of the Act, or would be against equity and good conscience. This information will also be used to determine the repayment schedule, if necessary.

(b) Failure to submit this requested information within 30 days of the request shall result in denial of waiver, and no further request for waiver shall be considered until the requested information is furnished.

§ 30.519 How does OWCP communicate its final decision concerning recovery of an overpayment?

(a) After considering any written documentation or argument submitted to OWCP within the 30-day period set out in § 30.512(d), OWCP will issue a final decision on the overpayment. OWCP will send a copy of the final decision to the individual from whom recovery is sought and his or her representative, if any.

(b) The provisions of subpart D of this part do not apply to any decision regarding the recovery of an overpayment.

§ 30.520 How are overpayments collected?

(a) When an overpayment has been made to a recipient who is entitled to further payments, the recipient shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. If no refund is made, OWCP shall recover the overpayment by reducing any further lump-sum payments due currently or in the future, taking into account the financial circumstances of the recipient, and any other relevant factors, so as to minimize any hardship. Should the recipient die before collection has been completed, further collection shall be made by decreasing later payments, if any, payable under EEOICPA with respect to the underlying occupational illness or covered illness.

(b) When an overpayment has been made to a recipient and OWCP is unable to recover the overpayment by reducing compensation due currently, the recipient shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. The overpayment is subject to the provisions of the Federal Claims Collection Act of 1966, as amended (31 U.S.C. 3701 *et seq.*), and may be reported to the Internal Revenue Service as income. If the recipient fails to make such refund, OWCP may recover the overpayment through any available means, including offset of salary, annuity benefits, or other Federal payments, including tax refunds as authorized by the Tax Refund Offset Program, or referral of the debt to a collection agency or to the Department of Justice.

Subpart G—Special Provisions

REPRESENTATION

§ 30.600 May a claimant designate a representative?

(a) The claims process under this part is informal, and OWCP acts as an impartial evaluator of the evidence. A claimant need not be represented to file a claim or receive a payment. Nevertheless, a claimant may appoint one individual to represent his or her interests, but the appointment must be in writing.

(b) There can be only one representative at any one time, so after one representative has been properly appointed, OWCP will not recognize another individual as a representative until the claimant withdraws the authorization of the first individual. In addition, OWCP will recognize only certain types of individuals (see § 30.601). For the purposes of paragraph (b) of this section, a ''representative'' does not include a person who only has a power of attorney to act on behalf of a claimant.

(c) A properly appointed representative who is recognized by OWCP may make a request or give direction to OWCP regarding the claims process, including a hearing. This authority includes presenting or eliciting evidence, making arguments on facts or the law, and obtaining information from the case file, to the same extent as the claimant.

(1) Any notice requirement contained in this part or EEOICPA is fully satisfied if served on the representative, and has the same force and effect as if sent to the claimant.

(2) A representative does not have authority to sign the Form EE–1 (described in § 30.100(a)) or the Form EE–2 (described in § 30.101(a)) for his or her client. A representative also does not have authority to sign the Form EN–20 (described in § 30.505(c)) for his or her client

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3053, Feb. 8, 2019]

§ 30.601 Who may serve as a representative?

A claimant may authorize any individual to represent him or her in regard to a claim under EEOICPA, unless that individual's service as a representative would violate any applicable provision of law (such as 18 U.S.C. 205 and 208) or the standards regarding conflicts of interest adopted by OWCP. Under those standards, authorized representatives are prohibited from having private, non-representational financial interests with respect to their client's EEOICPA claims. This does not include their fee for serving as a representative. A Federal employee may act as a representative only:

(a) On behalf of immediate family members, defined as a spouse, children, parents, and siblings of the representative, provided no fee or gratuity is charged; or

(b) While acting as a union representative, defined as any officially sanctioned union official, and no fee or gratuity is charged.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3053, Feb. 8, 2019]

§ 30.602 Who is responsible for paying the representative's fee?

A representative may charge the claimant a fee for services and for costs associated with the representation before OWCP. The claimant is solely responsible for paying the fee and other costs. OWCP will not reimburse the claimant, nor is it in any way liable for the amount of the fee and costs.

§ 30.603 Are there any limitations on what the representative may charge the claimant for his or her services?

(a) Notwithstanding any contract, the representative may not receive, for services rendered in connection with a claim pending before OWCP, more than the percentages of the lump-sum payment made to the claimant set out in paragraph (b) of this section, exclusive of costs and expenses.

(b) The percentages referred to in paragraph (a) of this section are:

(1) 2 percent for the filing of an initial claim with OWCP, provided that the representative was retained prior to the filing of the initial claim; plus

(2) 10 percent of the difference between the lump-sum payment made to the claimant and the amount proposed in the recommended decision with respect to objections to a recommended decision.

(c)(1) Any representative who violates this section shall be fined not more than $5,000.

(2) The authority to prosecute violations of this limitation lies with the Department of Justice.

(d) The fee limitations described in this section shall not apply with respect to representative services that are rendered in connection with a petition filed with a U.S. District Court seeking review of an OWCP decision that is final pursuant to § 30.316(d), or with respect to any subsequent appeal in such a proceeding.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3053, Feb. 8, 2019]

THIRD PARTY LIABILITY

§ 30.605 What rights does the United States have upon payment of compensation under EEOICPA?

If an occupational illness or covered illness for which compensation is payable under EEOICPA is caused, wholly or partially, by someone other than a federal employee acting within the scope of his or her employment, a DOE contractor or subcontractor, a beryllium vendor, an atomic weapons employer or a RECA section 5 mine or mill, the United States is subrogated for the full amount of any payment of compensation under EEOICPA to any right or claim that the individual to whom the payment was made may have against any person or entity on account of such occupational illness or covered illness.

§ 30.606 Under what circumstances must a recovery of money or other property in connection with an illness for which benefits are payable under EEOICPA be reported to OWCP?

Any person who has filed an EEOICPA claim that has been accepted by OWCP (whether or not compensation has been paid), or who has received EEOICPA benefits in connection with a claim filed by another, is required to notify OWCP of the receipt of

money or other property as a result of a settlement or judgment in connection with the circumstances of that claim.

§ 30.607 How is a structured settlement (that is, a settlement providing for receipt of funds over a specified period of time) treated for purposes of reporting the recovery?

In this situation, the recovery to be reported is the present value of the right to receive all of the payments included in the structured settlement, allocated in the case of multiple recipients in the same manner as single payment recoveries.

§ 30.608 How does the United States calculate the amount to which it is subrogated?

The subrogated amount of a specific claim consists of the total money paid by OWCP from the Energy Employees Occupational Illness Compensation Fund with respect to that claim to or on behalf of a covered Part B employee, a covered Part E employee or an eligible surviving beneficiary, less charges for any medical file review (*i.e.*, the physician did not examine the employee) done at the request of OWCP. Charges for medical examinations also may be subtracted if the covered Part B employee, covered Part E employee or an eligible surviving beneficiary establishes that the examinations were required to be made available to the covered Part B employee or covered Part E employee under a statute other than EEOICPA.

§ 30.609 Is a settlement or judgment received as a result of allegations of medical malpractice in treating an illness covered by EEOICPA a recovery that must be reported to OWCP?

Since an injury caused by medical malpractice in treating an occupational illness or covered illness compensable under EEOICPA is also covered under EEOICPA, any recovery in a suit alleging such an injury is treated as a recovery that must be reported to OWCP.

§ 30.610 Are payments to a covered Part B employee, a covered Part E employee or an eligible surviving beneficiary as a result of an insurance policy which the employee or eligible surviving beneficiary has purchased a recovery that must be reported to OWCP?

Since payments received by a covered Part B employee, a covered Part E employee or an eligible surviving beneficiary pursuant to an insurance policy purchased by someone other than a liable third party are not payments in satisfaction of liability for causing an occupational illness or covered illness compensable under the Act, they are not considered a recovery that must be reported to OWCP.

§ 30.611 If a settlement or judgment is received for more than one medical condition, can the amount paid on a single EEOICPA claim be attributed to different conditions for purposes of calculating the amount to which the United States is subrogated?

(a) All medical conditions accepted by OWCP in connection with a single claim are treated as the same illness for the purpose of computing the amount which the United States is entitled to offset in connection with the receipt of a recovery from a third party, except that an injury caused by medical malpractice in treating an illness covered under EEOICPA will be treated as a separate injury.

(b) If an illness covered under EEOICPA is caused under circumstances creating a legal liability in more than one person, other than the United States, a DOE contractor or subcontractor, a beryllium vendor or an atomic weapons employer, to pay damages, OWCP will determine whether recoveries received from one or more third parties should be attributed to separate conditions for which compensation is payable in connection with a single EEOICPA claim. If such an attribution is both practicable and equitable, as determined by OWCP, in its discretion, the conditions will be treated as separate injuries for purposes of calculating the amount to which the United States is subrogated.

EFFECT OF TORT SUITS AGAINST BERYLLIUM VENDORS AND ATOMIC WEAPONS EMPLOYERS

§ 30.615 What type of tort suits filed against beryllium vendors or atomic weapons employers may disqualify certain claimants from receiving benefits under Part B of EEOICPA?

(a) A tort suit (other than an administrative or judicial proceeding for workers' compensation) that includes a claim arising out of a covered Part B employee's employment-related exposure to beryllium or radiation, filed against a beryllium vendor or an atomic weapons employer, by a covered Part B employee or an eligible surviving beneficiary or beneficiaries of a deceased covered Part B employee, will disqualify that otherwise eligible individual or individuals from receiving benefits under Part B of EEOICPA unless such claim is terminated in accordance with the requirements of §§ 30.616 through 30.619 of these regulations.

(b) The term ''claim arising out of a covered Part B employee's employment-related exposure to beryllium or radiation'' used in paragraph (a) of this section includes a claim that is derivative of a covered Part B employee's employment-related exposure to beryllium or radiation, such as a claim for loss of consortium raised by a covered Part B employee's spouse.

(c) If all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation are terminated in accordance with the requirements of §§ 30.616 through 30.619 of these regulations, proceeding with the remaining portion of the tort suit filed against a beryllium vendor or an atomic weapons employer will not disqualify an otherwise eligible individual or individuals from receiving benefits under Part B of EEOICPA.

§ 30.616 What happens if this type of tort suit was filed prior to October 30, 2000?

(a) If a tort suit described in § 30.615 was filed prior to October 30, 2000, the claimant or claimants will not be disqualified from receiving any EEOICPA benefits to which they may be found entitled if the tort suit was terminated in any manner prior to December 28, 2001.

(b) If a tort suit described in § 30.615 was filed prior to October 30, 2000 and was pending as of December 28, 2001, the claimant or claimants will be disqualified from receiving any benefits under Part B of EEOICPA unless they dismissed all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation that were included in the tort suit prior to December 31, 2003.

§ 30.617 What happens if this type of tort suit was filed during the period from October 30, 2000 through December 28, 2001?

(a) If a tort suit described in § 30.615 was filed during the period from October 30, 2000 through December 28, 2001, the claimant or claimants will be disqualified from receiving any benefits under Part B of EEOICPA unless they dismiss all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation that are included in the tort suit on or before the last permissible date described in paragraph (b) of this section.

(b) The last permissible date is the later of:

(1) April 30, 2003; or

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, ''the date the claimant or claimants first became aware'' will be deemed to be the date they received either a reconstructed dose from NIOSH, or a diagnosis of a covered beryllium illness, as applicable.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3053, Feb. 8, 2019]

§ 30.618 What happens if this type of tort suit was filed after December 28, 2001?

(a) If a tort suit described in § 30.615 was filed after December 28, 2001, the claimant or claimants will be disqualified from receiving any benefits under

Part B of EEOICPA if a judgment is entered against them.

(b) If a tort suit described in § 30.615 was filed after December 28, 2001 and a judgment has not yet been entered against the claimant or claimants, they will also be disqualified from receiving any benefits under Part B of EEOICPA unless, prior to entry of any judgment, they dismiss all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation that are included in the tort suit on or before the last permissible date described in paragraph (c) of this section.

(c) The last permissible date is the later of:

(1) April 30, 2003; or

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, ''the date the claimant or claimants first became aware'' will be deemed to be the date they received either a reconstructed dose from NIOSH, or a diagnosis of a covered beryllium illness, as applicable.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3053, Feb. 8, 2019]

§ 30.619 Do all the parties to this type of tort suit have to take these actions?

The type of tort suits described in § 30.615 may be filed by more than one individual, each with a different cause of action. For example, a tort suit may be filed against a beryllium vendor by both a covered Part B employee and his or her spouse, with the covered Part B employee claiming for chronic beryllium disease and the spouse claiming for loss of consortium due to the covered Part B employee's exposure to beryllium. However, since the spouse of a living covered Part B employee could not be an eligible surviving beneficiary under Part B of EEOICPA, the spouse would not have to comply with the termination requirements of §§ 30.616 through 30.618. A similar result would occur if a tort suit were filed by both the spouse of a deceased covered Part B employee and other family members (such as children of the deceased covered part B employee). In this case, the spouse would be the only eligible surviving beneficiary of the deceased covered Part B employee under Part B of the EEOICPA because the other family members could not be eligible for benefits while he or she was alive. As a result, the spouse would be the only party to the tort suit who would have to comply with the termination requirements of §§ 30.616 through 30.618.

§ 30.620 How will OWCP ascertain whether a claimant filed this type of tort suit and if he or she has been disqualified from receiving any benefits under Part B of EEOICPA?

Prior to authorizing payment on a claim under Part B of EEOICPA, OWCP will require each claimant to execute and provide an affidavit stating if he or she filed a tort suit (other than an administrative or judicial proceeding for workers' compensation) against either a beryllium vendor or an atomic weapons employer that included a claim arising out of a covered Part B employee's employment-related exposure to beryllium or radiation, and if so, the current status of such tort suit. OWCP may also require the submission of any supporting evidence necessary to confirm the particulars of any affidavit provided under this section.

Coordination of Part E Benefits With State Workers' Compensation Benefits

§ 30.625 What does "coordination of benefits" mean under Part E of EEOICPA?

In general, ''coordination of benefits'' under Part E of the Act occurs when compensation to be received under Part E is reduced by OWCP, pursuant to section 7385s–11 of EEOICPA, to reflect certain benefits the beneficiary receives under a state workers' compensation program for the same covered illness.

§ 30.626 How will OWCP coordinate compensation payable under Part E of EEOICPA with benefits from state workers' compensation programs?

(a) OWCP will reduce the compensation payable under Part E by the amount of benefits the claimant receives from a state workers' compensation program by reason of the same covered illness, after deducting the reasonable costs to the claimant of obtaining those benefits.

(b) To determine the amount of any reduction of EEOICPA compensation, OWCP shall require the covered Part E employee or each eligible surviving beneficiary filing a claim under Part E to execute and provide affidavits reporting the amount of any benefit received pursuant to a claim filed in a state workers' compensation program for the same covered illness.

(c) If a covered Part E employee or a survivor of such employee receives benefits through a state workers' compensation program pursuant to a claim for the same covered illness, OWCP shall reduce a portion of the dollar amount of such state workers' benefit from the compensation payable under Part E. OWCP will calculate the net amount of the state workers' compensation benefit amount to be subtracted from the compensation payment under Part E in the following manner:

(1) OWCP will first determine the dollar value of the benefits received by that individual from a state workers' compensation program by including all benefits, other than medical and vocational rehabilitation benefits, received for the same covered illness or injury sustained as a consequence of a covered illness.

(2) OWCP will then make certain deductions from the above dollar benefit received under a state workers' compensation program to arrive at the dollar amount that will be subtracted from any compensation payable under Part E of EEOICPA.

(i) Allowable deductions consist of reasonable costs in obtaining state workers' compensation benefits incurred by that individual, including but not limited to attorney's fees OWCP deems reasonable and itemized costs of suit (out-of-pocket expenditures not part of the normal overhead of a law firm's operation like filing, travel expenses, witness fees, and court reporter costs for transcripts), provided that adequate supporting documentation is submitted to OWCP for its consideration.

(ii) The EEOICPA benefits that will be reduced will consist of any unpaid monetary payments payable in the future and medical benefits payable in the future. In those cases where it has not yet paid EEOICPA benefits under Part E, OWCP will reduce such benefits on a dollar-for-dollar basis, beginning with the current monetary payments first. If the amount to be subtracted exceeds the monetary payments currently payable, OWCP will reduce ongoing EEOICPA medical benefits payable in the future by the amount of any remaining surplus. This means that OWCP will apply the amount it would otherwise pay to reimburse the covered Part E employee for any ongoing EEOICPA medical treatment to the remaining surplus until it is absorbed (or until further monetary benefits become payable that are sufficient to absorb the surplus).

(3) The above coordination of benefits will not occur if the beneficiary under a state workers' compensation program receives state workers' compensation benefits for both a covered and a noncovered illness arising out of and in the course of the same work-related incident.

§ 30.627 Under what circumstances will OWCP waive the statutory requirement to coordinate these benefits?

A waiver to the requirement to coordinate Part E benefits with benefits paid under a state workers' compensation program may be granted if OWCP determines that the administrative costs and burdens of coordinating benefits in a particular case or class of cases justifies the waiver. This decision is exclusively within the discretion of OWCP.

Subpart H—Information for Medical Providers

MEDICAL RECORDS AND BILLS

§ 30.700 In general, what responsibilities do providers have with respect to enrolling with OWCP, seeking authorization to provide services, billing, and retaining medical records?

(a) All providers must enroll with OWCP or its designated bill processing agent (hereinafter OWCP in this subpart) to have access to the automated authorization system and to submit medical bills to OWCP. To enroll, the provider must complete and submit a Form OWCP–1168 to the appropriate location noted on that form. By completing and submitting this form, providers certify that they satisfy all applicable Federal and state licensure and regulatory requirements that apply to their specific provider or supplier type. The provider must maintain documentary evidence indicating that it satisfies those requirements. The provider is also required to notify OWCP immediately if any information provided to OWCP in the enrollment process changes. Federal government medical officers, private physicians and hospitals are also required to keep records of all cases treated by them under EEOICPA so they can supply OWCP with a history of the claimed occupational illness or covered illness, a description of the nature and extent of the claimed occupational illness or covered illness, the results of any diagnostic studies performed and the nature of the treatment rendered. This requirement terminates after a provider has supplied OWCP with the above-noted information, and otherwise terminates ten years after the record was created.

(b) Where a medical provider intends to bill for a procedure where prior authorization is required, authorization must be requested from OWCP.

(c) After enrollment, a provider must submit all medical bills to OWCP through its bill processing portal and include the Provider Number/ID obtained through enrollment or other identifying number required by OWCP.

[84 FR 3053, Feb. 8, 2019]

§ 30.701 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 30.700. OWCP may withhold payment for services until such report or evidence is provided. The physician or provider shall itemize the charges on Form OWCP–1500 or CMS–1500 (for professional charges or medicinal drugs dispensed in the office), Form OWCP–04 or UB–04 (for hospitals), an electronic or paper-based bill that includes required data elements (for pharmacies) or other form as warranted, and submit the form or bill promptly to OWCP.

(b) The provider shall identify each service performed using the Physician's Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC) number, or the Revenue Center Code (RCC), with a brief narrative description. OWCP has discretion to determine which of these codes may be utilized in the billing process. OWCP also has the authority to create and supply specific procedure codes that will be used by OWCP to better describe and allow specific payments for special services. These OWCP-created codes will be issued to providers by OWCP as appropriate and may only be used as authorized by OWCP. For example, a physician conducting a referee or second opinion examination as described in §§ 30.410 through 30.412 will be furnished an OWCP-created code. A provider may not use an OWCP-created code for other types of medical examinations or services. When no code is submitted to identify the services performed, the bill will be returned to the provider and/or denied.

(c) For professional charges billed on Form OWCP–1500 or CMS–1500, the provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the ''International Classification of Disease, 9th Edition, Clinical Modification'' (ICD–9–CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment

or monthly, if treatment for the occupational illness or covered illness is necessary for more than 30 days.

(1)(i) Hospitals shall submit charges for both inpatient and outpatient medical and surgical treatment or supplies promptly to OWCP on Form OWCP–04 or UB–04.

(ii) OWCP may adopt a Home Health Prospective Payment System (HHPPS), as developed and implemented by the Centers for Medicare and Medicaid Services (CMS) within HHS for Medicare, while modifying the allowable costs under Medicare to account for deductibles and other additional costs that are covered by EEOICPA. If adopted, home health care providers will be required to submit bills on Form OWCP–04 or UB–04 and to use Health Insurance Prospective Payment System codes and other coding schemes.

(2) Pharmacies shall itemize charges for prescription medications, appliances or supplies on electronic or paper-based bills and submit them promptly to OWCP. Bills for prescription medications must include all required data elements, including the NDC number assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider's billhead stationery and submit them promptly to OWCP. Such charges shall be subject to any applicable OWCP fee schedule.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which payment is sought was performed as described and was necessary, appropriate and properly billed in accordance with accepted industry standards. For example, accepted industry standards preclude upcoding billed services for extended medical appointments when the employee actually had a brief routine appointment, or charging for the services of a professional when a paraprofessional or aide performed the service. Also, industry standards prohibit unbundling services to charge separately for services that should be billed as a single charge. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart concerning the rendering of treatment and/or the process for seeking payment for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: Be itemized on Form OWCP–1500 or CMS–1500 (for physicians), Form OWCP–04 or UB–04 (for hospitals), or an electronic or paper-based bill that includes required data elements (for pharmacies); contain the handwritten or electronic signature of the provider when required; and identify the procedures using HCPCS/CPT codes, RCCs or NDC numbers. Otherwise, OWCP may deny the bill, and the provider must correct and resubmit the bill. The decision of OWCP whether to pay a provider's bill is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

[84 FR 3053, Feb. 8, 2019]

§ 30.702 How should an employee prepare and submit requests for reimbursement for medical expenses, transportation costs, loss of wages, and incidental expenses?

(a) If an employee has paid bills for medical, surgical or other services, supplies or appliances provided by a professional due to an occupational illness or a covered illness, he or she must submit a request for reimbursement on Form OWCP–915, together with an itemized bill on Form OWCP–1500 or CMS–1500 prepared by the provider, or Form OWCP–04 or UB–04 prepared by the provider, and a medical report as provided in § 30.700, to OWCP for consideration.

(1) The provider of such service shall state each diagnosed condition and furnish the applicable ICD–9–CM code, or as revised, and identify each service performed using the applicable HCPCS/CPT code, with a brief narrative description of the service performed, or, where no code is applicable, a detailed description of that service. If no code or description is received, OWCP will deny the reimbursement request, and correction and resubmission will be required.

(2) The reimbursement request must be accompanied by evidence that the provider received payment for the service from the employee and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a signed statement by the provider, a mechanical stamp or other device showing receipt of payment, a copy of the employee's canceled check (both front and back), a copy of the employee's credit card receipt or a provider billing form indicating a zero balance due.

(b) If a pharmacy or nursing home provided services for which the employee paid, the employee must also use Form OWCP–915 to request reimbursement and should submit the request in accordance with the provisions of § 30.701(a). Any such request for reimbursement must be accompanied by evidence, as described in paragraph (a)(2) of this section, that the provider received payment for the service from the employee and a statement of the amount paid.

(c) OWCP may waive the requirements of paragraphs (a) and (b) of this section if extensive delays in the filing or the adjudication of a claim make it unusually difficult for the employee to obtain the required information.

(d) Copies of bills submitted for reimbursement must bear the handwritten or electronic signature of the provider when required, with evidence of payment. Payment for medical and surgical treatment, appliances or supplies shall in general be no greater than the maximum allowable charge for such service determined by OWCP, as set forth in § 30.705. OWCP will issue a letter decision on whether to reimburse an employee for out-of-pocket medical expenses, and the amount of any reimbursement. A claimant who disagrees with OWCP's letter decision may request a formal recommended decision and utilize the adjudicatory process described in subpart D of this part.

(e) An employee will be only partially reimbursed for a medical expense if the amount he or she paid to a provider for the service exceeds the maximum allowable charge set by OWCP's schedule. If this happens, OWCP shall advise the employee of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider that the employee paid, but not the employee, may request reconsideration of the fee determination as set forth in § 30.712.

(f) If the provider fails to make appropriate refund to the employee, or to credit the employee's account, within 60 days after the employee requests a refund of any excess amount, or the date of a subsequent reconsideration decision which continues to disallow all or a portion of the disputed amount, OWCP will initiate exclusion procedures as provided by § 30.715.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may authorize reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

[84 FR 3053, Feb. 8, 2019]

§ 30.703 What are the time limitations on OWCP's payment of bills?

OWCP will pay providers and reimburse employees promptly for all bills received on an approved form and in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the end of the calendar year in which the claim was first accepted as compensable by OWCP, whichever is later.

Medical Fee Schedule

§ 30.705 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services, devices and supplies furnished by physicians, hospitals and other providers for occupational illnesses or covered illnesses shall not exceed a maximum allowable charge for

such service as determined by OWCP, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing homes, but it does apply to charges for treatment furnished in a nursing home by a physician or other medical professional. In the future, OWCP may also decide to implement a fee schedule for services provided in nursing homes.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

[84 FR 3055, Feb. 8, 2019]

§ 30.706 How are the maximum fees for professional medical services defined?

For professional medical services, OWCP shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of a Relative Value Unit (RVU) to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an assignment of Geographic Practice Cost Index (GPCI) values which represent the relative work, practice expenses and malpractice expenses relative to other localities throughout the country; and a monetary value assignment (conversion factor) for one unit of value for each coded service.

[84 FR 3055, Feb. 8, 2019]

§ 30.707 How are payments to providers calculated?

Payment for a procedure, service or device identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the RVU values for that procedure by the GPCI values for services in that area and by the conversion factor to arrive at a dollar amount assigned to one unit in that category of service.

(a) The ''locality'' which serves as a basis for the determination of cost is defined by the Bureau of Census Metropolitan Statistical Areas. OWCP shall base the determination of the relative per capita cost of medical care in a locality using information about enrollment and medical cost per county, provided by CMS.

(b) OWCP shall assign the RVUs published by CMS to all services for which CMS has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, OWCP may develop and assign any RVUs it considers appropriate. The geographic adjustment factor shall be that designated by GPCI values for Metropolitan Statistical Areas as devised for CMS and as updated or revised by CMS from time to time. OWCP will devise conversion factors for each category of service as appropriate using OWCP's processing experience and internal data.

(c) For example, if the RVUs for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (M), and the conversion factor assigned to one unit in that category of service (surgery) is $61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding GPCI values for the locality times the conversion factor. If the GPCI values for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$$[(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \times \$61.20$$

$$[2.45 + 3.44 + .56] \times \$61.20$$

$$6.45 \times \$61.20 = \$394.74$$

[84 FR 3055, Feb. 8, 2019]

§ 30.708 Does the fee schedule apply to every kind of procedure?

Where the time, effort and skill required to perform a particular procedure vary widely from one occasion to the next, OWCP may choose not to assign a relative value to that procedure. In this case the allowable charge for the procedure will be set individually based on consideration of a detailed medical report and other evidence. At

its discretion, OWCP may set fees without regard to schedule limits for specially authorized consultant examinations, for directed medical examinations, and for other specially authorized services.

§ 30.709 How are payments for medicinal drugs determined?

Unless otherwise specified by OWCP, payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee. OWCP may, in its discretion, contract for or require the use of specific providers for certain medications.

(a) All prescription medications identified by NDC number will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. OWCP will establish the dispensing fee, which will not be affected by the location or type of provider dispensing the medication.

(b) The NDC numbers, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

(c) With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available.

[84 FR 3055, Feb. 8, 2019]

§ 30.710 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Inpatient Prospective Payment System (IPPS) devised by CMS. Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All inpatient hospital discharges will be classified according to the DRGs prescribed by CMS in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by CMS in the form of their IPPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by CMS to determine the specific rate for a hospital discharge under their IPPS. OWCP may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from CMS's IPPS on consideration of detailed medical reports and other evidence.

(4) OWCP shall review the pre-determined hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

(b) OWCP shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when OWCP deems it necessary or appropriate.

[84 FR 3055, Feb. 8, 2019]

§ 30.711 How are payments for outpatient medical services determined?

(a) OWCP will pay for outpatient medical services according to Ambulatory Payment Classifications (APC) based on the Outpatient Prospective Payment System devised by CMS.

(b) All outpatient medical services will be classified according to the APC prescribed by CMS for that service in the form of the Outpatient Prospective Payment System Grouper software program. Each payment is derived by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor to arrive at a national unadjusted payment rate for the APC. The labor portion of the national unadjusted payment rate is further adjusted by the hospital wage index for the area where payment is being made.

(c) If a payable service has no assigned APC, the payment will be derived from the OWCP Medical Fee Schedule.

(d) OWCP shall review the pre-determined outpatient hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

[84 FR 3056, Feb. 8, 2019]

§ 30.712 When and how are fees reduced?

(a) OWCP shall accept a provider's designation of the code to identify a billed procedure or service if the code is consistent with medical reports and other evidence, and will pay no more than the maximum allowable fee for that procedure. If the code is not consistent with the medical and other evidence or where no code is supplied, the bill will be returned to the provider for correction and resubmission.

(b) If the charge submitted for a service supplied to an employee exceeds the maximum amount determined to be reasonable according to the schedule, OWCP shall pay the amount allowed by the schedule for that service and shall notify the provider in writing that payment was reduced for that service in accordance with the schedule. OWCP shall also notify the provider of the method for requesting reconsideration of the balance of the charge. The decision of OWCP to pay less than the charged amount is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

[84 FR 3056, Feb. 8, 2019]

§ 30.713 If OWCP reduces a fee, may a provider request reconsideration of the reduction?

(a) A physician or other provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set by OWCP may, within 30 days, request reconsideration of the fee determination.

(1) The provider should make such a request to the district office with jurisdiction over the employee's claim. The request must be accompanied by documentary evidence that the procedure performed was either incorrectly identified by the original code, that the presence of a severe or concomitant medical condition made treatment especially difficult, or that the provider possessed unusual qualifications. In itself, board certification in a specialty is not sufficient evidence of unusual qualifications to justify a charge in excess of the maximum allowable amount set by OWCP. These are the only three circumstances that will justify re-evaluation of the paid amount.

(2) A list of district offices and their respective areas of jurisdiction is available upon request from the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210, or at *http://www.dol.gov/owcp/energy/index.htm.* Within 30 days of receiving the request for reconsideration, the district office shall respond in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted.

(b) If the district office issues a decision that continues to disallow a contested amount, the provider may apply to the Regional Director of the region with jurisdiction over the district office. The application must be filed within 30 days of the date of such decision, and it may be accompanied by additional evidence. Within 60 days of receipt of such application, the Regional Director shall issue a decision in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted. This decision is final, and shall not be subject to further review.

[84 FR 3056, Feb. 8, 2019]

§ 30.714 If OWCP reduces a fee, may a provider bill the employee for the balance?

A provider whose fee for service is partially paid by OWCP as a result of the application of its fee schedule or other tests for reasonableness in accordance with this part shall not request payment from the employee for the unpaid amount of the provider's bill.

(a) Where a provider's fee for a particular service or procedure is lower to the general public than as provided by the schedule of maximum allowable charges, the provider shall bill at the

lower rate. A fee for a particular service or procedure which is higher than the provider's fee to the general public for that same service or procedure will be considered a charge ''substantially in excess of such provider's customary charges'' for the purposes of § 30.715(d).

(b) A provider whose fee for service is partially paid by OWCP as the result of the application of the schedule of maximum allowable charges and who collects or attempts to collect from the employee, either directly or through a collection agent, any amount in excess of the charge allowed by OWCP, and who does not cease such action or make appropriate refund to the employee within 60 days of the date of the decision of OWCP, shall be subject to the exclusion procedures provided by § 30.715(h).

[71 FR 78534, Dec. 29, 2006. Redesignated at 84 FR 3056, Feb. 8, 2019]

EXCLUSION OF PROVIDERS

§ 30.715 What are the grounds for excluding a provider from payment under this part?

A physician, hospital, or provider of medical services or supplies shall be excluded from payment under this part if such physician, hospital or provider has:

(a) Been convicted under any criminal statute of fraudulent activities in connection with any Federal or state program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies;

(b) Been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any Federal or state program referred to in paragraph (a) of this section;

(c) Knowingly made, or caused to be made, any false statement or misrepresentation of a material fact in connection with a determination of the right to reimbursement under this part, or in connection with a request for payment;

(d) Submitted, or caused to be submitted, three or more bills or requests for payment within a 12-month period under this subpart containing charges which OWCP finds to be substantially in excess of such provider's customary charges, unless OWCP finds there is good cause for the bills or requests containing such charges;

(e) Knowingly failed to timely reimburse employees for treatment, services or supplies furnished under this subpart and paid for by OWCP;

(f) Failed, neglected or refused on three or more occasions during a 12-month period to submit full and accurate medical reports, or to respond to requests by OWCP for additional reports or information, as required by § 30.700;

(g) Knowingly furnished treatment, services or supplies which are substantially in excess of the employee's needs, or of a quality which fails to meet professionally recognized standards;

(h) Collected or attempted to collect from the employee, either directly or through a collection agent, an amount in excess of the charge allowed by OWCP for the procedure performed, and has failed or refused to make appropriate refund to the employee, or to cease such collection attempts, within 60 days of the date of the decision of OWCP;

(i) Failed to inform OWCP of any change in their provider status as required in § 30.700; or

(j) Engaged in conduct related to care of an employee's occupational illness or covered illness that OWCP finds to be misleading, deceptive or unfair.

[84 FR 3056, Feb. 8, 2019]

§ 30.716 What will cause OWCP to automatically exclude a physician or other provider of medical services and supplies?

(a) OWCP shall automatically exclude a physician, hospital, or provider of medical services or supplies who:

(1) Has been convicted of a crime described in § 30.715(a); or

(2) Has been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any federal or state program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies.

(b) The exclusion applies to participating in the program and to seeking payment under this part for services performed after the date of the entry of the judgment of conviction or order of

exclusion, suspension or resignation, as the case may be, by the court or agency concerned. Proof of the conviction, exclusion, suspension or resignation may consist of a copy thereof authenticated by the seal of the court or agency concerned.

(c) A provider may be excluded on a voluntary basis at any time.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3057, Feb. 8, 2019]

§ 30.717 When are OWCP's exclusion procedures initiated?

(a) Upon receipt of information indicating that a physician, hospital or provider of medical services or supplies (hereinafter the provider) has or may have engaged in activities enumerated in paragraphs (c) through (j) of § 30.715, OWCP will forward that information to the Department of Labor's Office of Inspector General (DOL OIG) for its consideration. If the information was provided directly to DOL OIG, DOL OIG will notify OWCP of its receipt and implement the appropriate action within its authority, unless such notification will or may compromise the identity of confidential sources, or compromise or prejudice an ongoing or potential criminal investigation.

(b) DOL OIG will conduct such action as it deems necessary, and, when appropriate, provide a written report as described in paragraph (c) of this section to OWCP. OWCP will then determine whether to initiate procedures to exclude the provider from participation in the EEOICPA program. If DOL OIG determines not to take any further action, it will promptly notify OWCP of such determination.

(c) If DOL OIG discovers reasonable cause to believe that violations of § 30.715 have occurred, it shall, when appropriate, prepare a written report, *i.e.*, investigative memorandum, and forward the report along with supporting evidence to OWCP. The report shall be in the form of a single memorandum in narrative form with attachments.

(1) The report should contain all of the following elements:

(i) A brief description and explanation of the subject provider or providers;

(ii) A concise statement of the DOL OIG's findings upon which exclusion may be based;

(iii) A summary of the events that make up the DOL OIG's findings;

(iv) A discussion of the documentation supporting DOL OIG's findings;

(v) A discussion of any other information that may have bearing upon the exclusion process; and

(vi) The supporting documentary evidence including any expert opinion rendered in the case.

(2) The attachments to the report should be provided in a manner that they may be easily referenced from the report.

[84 FR 3057, Feb. 8, 2019]

§ 30.718 How is a provider notified of OWCP's intent to exclude him or her?

Following receipt of the investigative report, OWCP will determine if there exists a reasonable basis to exclude the provider or providers. If OWCP determines that such a basis exists, OWCP shall initiate the exclusion process by sending the provider a letter, by certified mail and with return receipt requested (or equivalent services from a commercial carrier), which shall contain the following:

(a) A concise statement of the grounds upon which exclusion shall be based;

(b) A summary of the information, with supporting documentation, upon which OWCP has relied in reaching an initial decision that exclusion proceedings should begin;

(c) An invitation to the provider to:

(1) Resign voluntarily from participation in the EEOICPA program without admitting or denying the allegations presented in the letter; or

(2) Request a decision on exclusion based upon the existing record and any additional documentary information the provider may wish to furnish;

(d) A notice of the provider's right, in the event of an adverse ruling by the deciding official, to request a formal hearing before an administrative law judge;

(e) A notice that should the provider fail to respond (as described in § 30.719) the letter of intent within 60 days of receipt, the deciding official may deem

the allegations made therein to be true and may order exclusion of the provider without conducting any further proceedings; and

(f) The address to where the response from the provider should be sent.

[84 FR 3057, Feb. 8, 2019]

§ 30.719 What requirements must the provider's response and OWCP's decision meet?

(a) The provider's response shall be in writing and shall include an answer to OWCP's invitation to resign voluntarily. If the provider does not offer to resign, he or she shall request that a determination be made upon the existing record and any additional information provided.

(b) Should the provider fail to respond to the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider.

(c) The provider may inspect or request copies of information in the record at any time prior to the deciding official's decision by making such request to OWCP within 20 days of receipt of the letter of intent.

(d) OWCP shall have 30 days to answer the provider's response. That answer will be forwarded to the provider, who shall then have 15 days to reply. Any response from the provider may be forwarded to DOL OIG, should OWCP deem it appropriate, to obtain additional information which may be relevant to the provider's response.

(e) The deciding official shall be the Regional Director in the region in which the provider is located unless otherwise specified by the Director for Energy Employees Occupational Illness Compensation.

(f) The deciding official shall issue his or her decision in writing, and shall send a copy of the decision to the provider by certified mail, return receipt requested (or equivalent service from a commercial carrier). The decision shall advise the provider of his or her right to request, within 30 days of the date of the adverse decision, a formal hearing before an administrative law judge under the procedures set forth in § 30.720. The filing of a request for a hearing within the time specified shall stay the effectiveness of the decision to exclude.

[84 FR 3057, Feb. 8, 2019]

§ 30.720 How can an excluded provider request a hearing?

A request for a hearing shall be sent to the deciding official and shall contain:

(a) A concise notice of the issues on which the provider desires to give evidence at the hearing;

(b) Any request for the presentation of oral argument or evidence; and

(c) Any request for a certification of questions concerning professional medical standards, medical ethics or medical regulation for an advisory opinion from a competent recognized professional organization or Federal, state or local regulatory body.

[84 FR 3057, Feb. 8, 2019]

§ 30.721 How are hearings assigned and scheduled?

(a) If the deciding official receives a timely request for hearing, he or she shall refer the matter to the Chief Administrative Law Judge of the Department of Labor, who shall assign it for an expedited hearing. The administrative law judge assigned to the matter shall consider the request for hearing, act on all requests therein, and issue a Notice of Hearing and schedule for the conduct of the hearing. A copy of the hearing notice shall be served on the provider by certified mail, return receipt requested. The Notice of Hearing and schedule shall include:

(1) A ruling on each item raised in the request for hearing;

(2) A schedule for the prompt disposition of all preliminary matters, including requests for the certification of questions to advisory bodies; and

(3) A scheduled hearing date not less than 30 days after the date the schedule is issued, and not less than 15 days after the scheduled conclusion of preliminary matters, provided that the specific time and place of the hearing may be set on 10 days' notice.

(b) The provider is entitled to be heard on any matter placed in issue by his or her response to the notice of intent to exclude, and may designate ''all

issues'' for purposes of hearing. However, a specific designation of issues is required if the provider wishes to interpose affirmative defenses, or request the certification of questions for an advisory opinion.

[84 FR 3057, Feb. 8, 2019]

§ 30.722 How are subpoenas or advisory opinions obtained?

(a) In exclusion proceedings involving medical services provided under Part B of the Act only, the provider may apply to the administrative law judge for the issuance of subpoenas upon a showing of good cause therefore.

(b) A certification of a request for an advisory opinion concerning professional medical standards, medical ethics or medical regulation to a competent recognized or professional organization or federal, state or local regulatory agency may be made:

(1) As to an issue properly designated by the provider, in the sound discretion of the administrative law judge, provided that the request will not unduly delay the proceedings;

(2) By OWCP on its own motion either before or after the institution of proceedings, and the results thereof shall be made available to the provider at the time that proceedings are instituted or, if after the proceedings are instituted, within a reasonable time after receipt. The opinion, if rendered by the organization or agency, is advisory only and not binding on the administrative law judge.

§ 30.723 How will the administrative law judge conduct the hearing and issue the recommended decision?

(a) To the extent appropriate, proceedings before the administrative law judge shall be governed by 29 CFR part 18.

(b) The administrative law judge shall receive such relevant evidence as may be adduced at the hearing. Parties to the hearing are the provider and OWCP. Evidence shall be presented under oath, orally or in the form of written statements. The administrative law judge shall consider the notice and response, including all pertinent documents accompanying them, and may also consider any evidence which refers to the provider or to any claim with respect to which the provider has provided medical services, hospital services, or medical services and supplies, and such other evidence as the administrative law judge may determine to be necessary or useful in evaluating the matter.

(c) All hearings shall be recorded and the original of the complete transcript shall become a permanent part of the official record of the proceedings.

(d) In conjunction with the hearing, the administrative law judge may:

(1) Administer oaths; and

(2) Examine witnesses.

(e) At the conclusion of the hearing, the administrative law judge shall issue a written decision and cause it to be served on all parties to the proceeding, their representatives and OWCP.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3058, Feb. 8, 2019]

§ 30.724 How does a recommended decision become final?

(a) Within 30 days from the date the recommended decision is issued, the provider may state, in writing, any objections to the recommended decision. This written statement should be filed with the Director for Energy Employees Occupational Illness Compensation.

(b) For the purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the Director for Energy Employees Occupational Illness Compensation, the statement will be considered to be ''filed'' on the date that the provider mails it to the Director, as determined by postmark or other carrier's date marking, or the date that such written statement is actually received by the Director, whichever is earlier.

(c) Written statements objecting to the recommended decision may be filed upon one or more of the following grounds:

(1) A finding or conclusion of material fact is not supported by substantial evidence;

(2) A necessary legal conclusion is erroneous;

(3) The decision is contrary to law or to the duly promulgated rules or decisions of the Director;

(4) A substantial question of law, policy, or discretion is involved; or

(5) A prejudicial error of procedure was committed.

(d) Each issue shall be separately numbered and plainly and concisely stated, and shall be supported by detailed citations to the record when assignments of error are based on the record, and by statutes, regulations or principal authorities relied upon. Except for good cause shown, no assignment of error by the provider shall rely on any question of fact or law upon which the administrative law judge had not been afforded an opportunity to pass.

(e) If a written statement of objection is filed within the allotted period of time, the Director for Energy Employees Occupational Illness Compensation will review the objection. The Director will forward the written objection to DOL OIG, which will have 14 calendar days from that date to respond. Any response from DOL OIG will be forwarded to the provider, which will have 14 calendar days from that date to reply.

(f) The Director for Energy Employees Occupational Illness Compensation will consider the recommended decision, the written record and any response or reply received and will then issue a written, final decision either upholding or reversing the exclusion.

(g) If no written statement of objection is filed within the allotted period of time, the Director for Energy Employees Occupational Illness Compensation will issue a written, final decision accepting the recommendation of the administrative law judge.

(h) The decision of the Director for Energy Employees Occupational Illness Compensation shall be final with respect to the provider's participation in the program, and shall not be subject to further review.

[84 FR 3058, Feb. 8, 2019]

§ 30.725 What are the effects of non-automatic exclusion?

(a) OWCP shall give notice of the exclusion of a physician, hospital or provider of medical services or supplies to:

(1) All OWCP district offices;

(2) CMS;

(3) All employees who are known to have had treatment, services or supplies from the excluded provider within the six-month period immediately preceding the order of exclusion; and

(4) The state or local authority responsible for licensing or certifying the excluded provider.

(b) Notwithstanding any exclusion of a physician, hospital, or provider of medical services or supplies under this subpart, OWCP shall not refuse an employee reimbursement for any otherwise reimbursable medical treatment, service or supply if:

(1) Such treatment, service or supply was rendered in an emergency by an excluded physician; or

(2) The employee could not reasonably have been expected to know of such exclusion.

(c) An employee who is notified that his or her attending physician has been excluded shall have a new right to select a qualified physician.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3059, Feb. 8, 2019]

§ 30.726 How can an excluded provider be reinstated?

(a) If a physician, hospital, or provider of medical services or supplies has been automatically excluded pursuant to § 30.716, the provider excluded will automatically be reinstated upon notice to OWCP that the conviction or exclusion which formed the basis of the automatic exclusion has been reversed or withdrawn. However, an automatic reinstatement shall not preclude OWCP from instituting exclusion proceedings based upon the underlying facts of the matter.

(b) A physician, hospital, or provider of medical services or supplies excluded from participation as a result of an order issued pursuant to this subpart may apply for reinstatement one year after the entry of the order of exclusion, unless the order expressly provides for a shorter period. An application for reinstatement shall be addressed to the Director for Energy Employees Occupational Illness Compensation, and shall contain a concise statement of the basis for the application. The application should be accompanied by supporting documents and affidavits.

(c) A request for reinstatement may be accompanied by a request for oral presentation. Oral presentations will be allowed only in unusual circumstances where it will materially aid the decision process.

(d) The Director for Energy Employees Occupational Illness Compensation shall order reinstatement only in instances where such reinstatement is clearly consistent with the goal of this subpart to protect the EEOICPA program against fraud and abuse. To satisfy this requirement the provider must provide reasonable assurances that the basis for the exclusion will not be repeated.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3059, Feb. 8, 2019]

Subpart I—Wage-Loss Determinations Under Part E of EEOICPA

GENERAL PROVISIONS

§ 30.800 What types of wage-loss are compensable under Part E of EEOICPA?

Years of wage-loss occurring prior to normal retirement age that are the result of a covered illness contracted by a covered Part E employee through work-related exposure to a toxic substance at a Department of Energy facility or a RECA section 5 facility, as appropriate, may be compensable under Part E of the Act. Whether years of wage-loss are compensable depends on determinations with respect to:

(a) The average annual wage of the employee as determined by OWCP in accordance with § 30.810;

(b) The percentage of his or her average annual wage that the employee was able to earn during the calendar year(s) in question as determined by OWCP in accordance with § 30.811; and

(c) Whether the employee's inability to earn at least as much as his or her average annual wage was due to a covered illness as defined in § 30.5(s).

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3059, Feb. 8, 2019]

§ 30.801 What special definitions does OWCP use in connection with Part E wage-loss determinations?

For the purposes of paying compensation based on wage-loss under Part E of the Act, OWCP will apply the following definitions:

(a) *Average annual wage* means 12 times the average monthly wage of a covered Part E employee for the 36 months preceding the month during which he or she first experienced wage-loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility (referred to as the ''trigger month''), excluding any months during which the employee was unemployed. Because being ''retired'' is not equivalent to being ''unemployed,'' months during which an employee had no wages because he or she was retired will not be excluded from this calculation.

(b) *Normal retirement age* means the age at which a covered Part E employee first became eligible for unreduced retirement benefits under the Old-Age, Survivors and Disability Insurance (OASDI) provisions of the Social Security Act. In general, persons born during or before 1937 are eligible for unreduced OASDI retirement benefits at age 65, and that age increases in monthly increments until it reaches 67, which is the age at which persons born during or after 1960 become eligible for unreduced OASDI retirement benefits.

(c) *Month during which the employee was unemployed* means any month during which the covered Part E employee had $250 (in constant 2013 dollars) or less in wages unless the month is one during which the employee was retired.

(d) *Quarter* means the three-month period January through March, April through June, July through September, or October through December.

(e) *Quarter during which the employee was unemployed* means any quarter during which the covered Part E employee had $750 (in constant 2013 dollars) or less in wages unless the quarter is one during which the employee was retired.

(f) *Trigger month* means the calendar month during which the employee first experienced a loss in wages due to exposure to a toxic substance at a DOE facility or RECA section 5 facility.

(g) *Wages* mean all monetary payments that the covered Part E employee earns from his or her regular employment or services that are taxed as income by the Internal Revenue Service. Salaries, overtime compensation, sick leave, vacation leave, tips, and bonuses received for employment services are considered wages under this subpart. However, capital gains, IRA distributions, pensions, annuities, unemployment compensation, state workers' compensation benefits, medical retirement benefits, and Social Security benefits are not considered wages.

(h) *Year of wage-loss* means a calendar year during which the covered Part E employee's earnings were less than his or her average annual wage, after such earnings have been adjusted using the Consumer Price Index for All Urban Consumers (CPI–U), as produced by the Bureau of Labor Statistics, to reflect their value in the year during which the employee first experienced wage-loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3059, Feb. 8, 2019]

EVIDENCE OF WAGE-LOSS

§ 30.805 What are the criteria for eligibility for wage-loss benefits under Part E?

(a) In addition to satisfying the general eligibility requirements applicable to all Part E claims, a claimant seeking benefits for calendar years of qualifying wage-loss has the burden of proof to establish each of the following criteria:

(1) He or she held a job at which he or she earned wages;

(2) He or she experienced a loss in those wages in a particular month (referred to as the ''trigger month'' in this section);

(3) The wage-loss in the trigger month was caused by the covered Part E employee's covered illness, *i.e.,* that he or she would have continued to earn wages in the trigger month from that employment *but for the covered illness;*

(4) His or her average annual wage;

(5) His or her normal retirement age and the calendar year in which he or she would reach that age;

(6) Beginning with the calendar year of the trigger month, the percentage of the average annual wage that was earned in each calendar year up to and including the retirement year;

(7) The number of those calendar years in which the covered illness caused the covered Part E employee to earn 50% or less of his or her average annual wage; and

(8) The number of those calendar years in which the covered illness caused him or her to earn more than 50% but not more than 75% of his or her average annual wage.

(b) OWCP will discontinue development of a request for wage-loss benefits, during which the claimant must meet his or her burden of proof to establish each of the criteria listed in paragraph (a) of this section, at any point when the claimant is unable to meet such burden and proceed to issue a recommended decision to deny the request.

[84 FR 3059, Feb. 8, 2019]

§ 30.806 What kind of medical evidence must the claimant submit to prove that he or she lost wages due to a covered illness?

OWCP requires the submission of rationalized medical evidence of sufficient probative value to convince the fact-finder that the covered Part E employee experienced a loss in wages in his or her trigger month due to a covered illness, *i.e.,* medical evidence based on a physician's fully explained and reasoned decision (see § 30.805(a)(3)). A loss in wages in the trigger month due solely to non-covered illness matters, such as a reduction in force or voluntary retirement, is not proof of compensable wage-loss under Part E.

[84 FR 3059, Feb. 8, 2019]

§ 30.807 What factual evidence does OWCP use to determine a covered Part E employee's average annual wage?

(a) OWCP may rely on annual or quarterly wage information reported to the Social Security Administration to establish a covered Part E employee's

presumed average annual wage (see §30.810) and the duration and extent of any years of wage-loss that are compensable under Part E of the Act (see §30.811). OWCP may also rely on other probative evidence of a covered Part E employee's wages, and may ask the claimant for additional evidence needed to make this determination, if necessary. For the purposes of making these two types of determinations, OWCP will consider all monetary payments that the covered Part E employee received as wages (see §30.801(g)).

(b) A claimant who disagrees with the evidence OWCP has obtained under paragraph (a) of this section and alleges a different average annual wage for the covered Part E employee, or that there was a greater duration or extent of wage-loss, may submit records that were produced in the ordinary course of business due to the employee's employment to rebut that evidence, to the extent that such records are determined to be authentic by OWCP. The average annual wage and/or wage-loss of the covered Part E employee will then be determined by OWCP in the exercise of its discretion.

[84 FR 3059, Feb. 8, 2019]

DETERMINATIONS OF AVERAGE ANNUAL WAGE AND PERCENTAGES OF LOSS

§30.810 How will OWCP calculate the average annual wage of a covered Part E employee?

To calculate the average annual wage of a covered Part E employee as defined in §30.801(a), OWCP will:

(a) Aggregate the wages for the 36 months that preceded the trigger month, excluding any month during which the employee was unemployed;

(b) Add any additional wages earned by the employee during those same months as evidenced by records described in §30.807;

(c) Divide the sum of paragraphs (a) and (b) of this section by 36, less the number of months during which the employee was unemployed; and

(d) Multiply this figure by 12 to calculate the covered Part E employee's average annual wage.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3060, Feb. 8, 2019]

§30.811 How will OWCP calculate the duration and extent of a covered Part E employee's initial period of compensable wage-loss?

(a) To determine the initial calendar years of wage-loss, OWCP will use the evidence it receives under §§30.805 through 30.807 to compare the calendar-year wages for the covered Part E employee, as adjusted, with the average annual wage determined under §30.810 for each calendar year beginning with the calendar year that includes the trigger month, and concluding with the last calendar year of wage-loss prior to the submission of the claim or the calendar year in which the employee reached normal retirement age (as defined in §30.801(b)), whichever occurred first.

(b) OWCP will then aggregate separately the number of calendar years of wage-loss in which the employee's wages, as adjusted, did not exceed 50 percent of the average annual wage determined under §30.810, and the number of calendar years of wage-loss in which the employee's wages, as adjusted, exceeded 50 percent of such average annual wage, but did not exceed 75 percent of such average annual wage.

(c) For each calendar year of wage-loss determined under paragraph (c) of this section during which the employee's wages did not exceed 50 percent of his or her average annual wage, OWCP will pay the employee $15,000 as compensation for wage-loss. For each calendar year of wage-loss determined under paragraph (c) of this section during which the employee's calendar-year wages exceeded 50 percent of his or her average annual wage but did not exceed 75 percent of such average annual wage, OWCP will pay the employee $10,000 as compensation for wage-loss.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3060, Feb. 8, 2019]

§30.812 May a covered Part E employee claim for subsequent periods of compensable wage-loss?

A covered Part E employee previously awarded compensation for wage-loss under §30.811 may file for additional compensation for wage-loss suffered by the employee during periods subsequent to a period for which a wage-loss claim for the employee has

already been adjudicated by OWCP. However, no compensation for wage-loss shall be awarded for any period following the year during which the covered Part E employee attained normal retirement age for purposes of the Social Security Act as described in § 30.801(b).

SPECIAL RULES FOR CERTAIN SURVIVOR CLAIMS UNDER PART E OF EEOICPA

§ 30.815 Are there special rules that OWCP will use to determine the extent of a deceased covered Part E employee's compensable wage-loss?

(a) For purposes of adjudicating a claim of a survivor of a deceased covered Part E employee only, OWCP will presume that such employee experienced wage-loss for each calendar year subsequent to the calendar year of his or her death through and including the calendar year in which the employee would have reached normal retirement age under the Social Security Act. During these particular calendar years, OWCP will also presume that the deceased covered Part E employee's subsequent calendar-year wages did not exceed 50 percent of his or her average annual wage as determined under § 30.810.

(b) Except as provided in paragraph (a) of this section, OWCP will calculate the wage-loss of a deceased covered Part E employee in conformance with the provisions of §§ 30.800 through 30.811.

(c) If OWCP determines that a deceased covered Part E employee had an aggregate of not less than ten calendar years of adjusted earnings that did not exceed 50 percent of his or her average annual earnings, it will pay the eligible surviving beneficiary(s) additional compensation (the basic survivor award payable under section 7385s–3(a)(1) is $125,000) in the amount of $25,000 pursuant to section 7385s–3(a)(2) of the Act. In the alternative, if OWCP determines that the aggregate number of such years is not less than 20 years, it will pay the eligible surviving beneficiary(s) additional compensation in the amount of $50,000 pursuant to section 7385s–3(a)(3).

Subpart J—Impairment Benefits Under Part E of EEOICPA

GENERAL PROVISIONS

§ 30.900 Who can receive impairment benefits under Part E?

In order to receive impairment benefits under Part E, the employee must show that:

(a) He or she is a covered Part E employee who has been determined to have contracted a covered illness through exposure to a toxic substance at a DOE facility or a RECA section 5 facility, as appropriate, pursuant to either §§ 30.210 through 30.215 or §§ 30.230 through 30.232 of these regulations; and

(b) He or she has been determined to have an impairment, pursuant to the regulations set out in this subpart, that is the result of the covered illness referred to in paragraph (a) of this section.

§ 30.901 How does OWCP determine the extent of an employee's impairment that is due to a covered illness contracted through exposure to a toxic substance at a DOE facility or a RECA section 5 facility, as appropriate?

(a) OWCP will determine the amount of impairment benefits to which an employee is entitled based on one or more impairment evaluations submitted by physicians. An impairment evaluation shall contain the physician's opinion on the extent of whole person impairment of all organs and body functions of the employee that are compromised or otherwise affected by the employee's covered illness or illnesses, which shall be referred to as an ''impairment rating.''

(b) In making impairment benefit determinations, OWCP will only consider medical reports from physicians who are certified by the relevant medical board and who satisfy any additional criteria determined by OWCP to be necessary to qualify to perform impairment evaluations under Part E, including any specific training and experience related to particular conditions and other objective factors.

(c) OWCP will establish criteria based upon objective factors such as training and certification that must be

met by physicians preparing impairment evaluations in order for an impairment evaluation to be considered in determining an impairment award. Such criteria shall be made available to claimants and the public by OWCP.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3060, Feb. 8, 2019]

§ 30.902 How will OWCP calculate the amount of the award of impairment benefits that is payable under Part E?

(a) OWCP will multiply the percentage points of the impairment rating by $2,500 to calculate the amount of the award.

(b) An employee's impairment rating may be comprised of multiple impairments of organs and body functions due to multiple covered illnesses. If an impairment award is payable based on a whole person impairment rating in which at least one of the impairments is subject to a reduction under §§ 30.505(b) and/or 30.626, OWCP will reduce the impairment award proportionately.

[84 FR 3060, Feb. 8, 2019]

MEDICAL EVIDENCE OF IMPAIRMENT

§ 30.905 How may an impairment evaluation be obtained?

(a) Except as provided in paragraph (b) of this section, OWCP may request that an employee undergo an evaluation of his or her permanent impairment that specifies the percentage points that are the result of the employee's covered illness or illnesses. To be of any probative value, such evaluation must be performed by a physician who meets the criteria OWCP has identified for physicians performing impairment evaluations for the pertinent covered illness or illnesses in accordance with the AMA's *Guides*.

(b) In lieu of submitting an evaluation requested by OWCP under paragraph (a) of this section, an employee may obtain an impairment evaluation at his own initiative and submit it to OWCP for consideration. Such an evaluation will be deemed to have sufficient probative value to be considered in the adjudication of impairment benefits by OWCP only if:

(1) The evaluation was performed by a physician who meets the criteria identified by OWCP for the covered illness or illnesses in question;

(2) The evaluation was performed no more than one year before the date that it was received by OWCP; and

(3) The evaluation conforms to all applicable requirements set out in this part.

§ 30.906 Who will pay for an impairment evaluation?

(a) OWCP will pay for one impairment evaluation obtained by an employee if it meets the criteria set out in § 30.905(b), unless it was performed by a physician prior to the date that the claim for Part E benefits is filed, or obtained for a claim in which OWCP finds that the employee did not contract a covered illness. At its discretion, OWCP may direct that the employee undergo additional evaluations. OWCP will pay for any such additional evaluations and will reimburse the employee for any reasonable and necessary costs incident to the evaluations, as described in §§ 30.404 and 30.412 of this part.

(b) Except for one impairment evaluation obtained pursuant to § 30.905(b) and meeting the criteria set out in § 30.905(b)(1), (2) and (3), the employee must pay for any impairment evaluations not directed by OWCP.

§ 30.907 Can an impairment evaluation obtained by OWCP be challenged prior to issuance of the recommended decision?

(a) An employee may submit arguments challenging an impairment evaluation, and/or additional medical evidence of impairment, before the district office issues a recommended decision on his or her claim. However, the district office will not consider an additional impairment evaluation, even if it differs from the impairment evaluation obtained under § 30.905 or § 30.906, if it does not meet the criteria listed in § 30.905(b)(1), (2) and (3).

(b) If the district office obtains an additional impairment evaluation that differs from the impairment evaluation obtained under § 30.905 or § 30.906, the district office will base its recommended determinations regarding

impairment upon the evidence it considers to have the greatest probative value, after evaluating all relevant evidence of impairment in the record, including evidence from directed impairment evaluations and referee impairment evaluations, if any, that it deems necessary pursuant to §§ 30.410 and 30.411 of this part.

§ 30.908 How will the FAB evaluate new medical evidence submitted to challenge the impairment determination in the recommended decision?

(a) If an employee submits an additional impairment evaluation that differs from the impairment evaluation relied upon by the district office, the FAB will not consider the additional impairment evaluation if it does not meet the criteria listed in § 30.905(b)(1), (2) and (3).

(b) The employee shall bear the burden of proving that the additional impairment evaluation submitted is more probative than the evaluation relied upon by the district office to determine the employee's recommended impairment rating.

(c) If an employee submits an additional impairment evaluation that differs from the impairment evaluation relied upon by the district office, the FAB will review all relevant evidence of impairment in the record, and will base its determinations regarding impairment upon the evidence it considers to be most probative. The FAB will determine the impairment rating after it has evaluated all relevant evidence and argument in the record.

[71 FR 78534, Dec. 29, 2006, as amended at 84 FR 3060, Feb. 8, 2019]

RATABLE IMPAIRMENTS

§ 30.910 Will an impairment that cannot be assigned a numerical percentage using the AMA's Guides be included in the impairment rating?

(a) An impairment of an organ or body function that cannot be assigned a numerical impairment percentage using the AMA's *Guides* will not be included in the employee's impairment rating.

(b) A mental impairment that does not originate from a documented physical dysfunction of the nervous system, and cannot be assigned a numerical percentage using the AMA's *Guides*, will not be included in the impairment rating for the employee. Mental impairments that are due to documented physical dysfunctions of the nervous system can be assigned numerical percentages using the AMA's *Guides* and will be included in the rating.

§ 30.911 Does maximum medical improvement always have to be reached for an impairment to be included in the impairment rating?

(a) An impairment that is the result of a covered illness will be included in the employee's impairment rating determined by OWCP under § 30.901 only if OWCP concludes that the impairment has reached maximum medical improvement, which means that it is well-stabilized and unlikely to improve substantially with or without medical treatment.

(b) Notwithstanding paragraph (a) of this section, if OWCP finds that an employee's covered illness is in the terminal stages, based upon probative medical evidence, an impairment that results from such covered illness will be included in the impairment rating for the employee even if it has not reached maximum medical improvement.

§ 30.912 Can a covered Part E employee receive benefits for additional impairment following an award of such benefits by OWCP?

A covered Part E employee previously awarded impairment benefits by OWCP may file a claim for additional impairment benefits. Such claim must be based on an increase in the impairment rating that is the result of the covered illness or illnesses from the impairment rating that formed the basis for the last award of such benefits by OWCP. OWCP will only adjudicate claims for such an increased rating that are filed at least two years from the date of the last award of impairment benefits. However, OWCP will not wait two years before it will adjudicate a claim for additional impairment that is based on an allegation that the employee sustained a new covered illness.

SUBCHAPTERS D–E [RESERVED]

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AUTHORITY: 1950 Reorg. Plan No. 19, sec. 1, 3 CFR, 1949–1953 Comp., p. 1010, 64 Stat. 1271; 5 U.S.C. 8145, 8149; 42 U.S.C. 1704, 1706; Secretary's Order 7–87, 52 FR 48466; Employment Standards Order 78–1, 43 FR 51469.

SOURCE: 53 FR 3679, Feb. 8, 1988, unless otherwise noted.

Subpart A—General Provisions

§ 61.1 Statutory provisions

(a) The War Hazards Compensation Act, as amended (42 U.S.C. 1701 *et seq.*) provides for reimbursement of workers' compensation benefits paid under the Defense Base Act (42 U.S.C. 1651 *et seq.*), or under other workers' compensation laws as described in §61.100(a), for injury or death causally related to a war-risk hazard.

(b) If no benefits are payable under the Defense Base Act or other applicable workers' compensation law, compensation is paid to the employee or survivors for the war-risk injury or death of—

(1) Any person subject to workers' compensation coverage under the Defense Base Act;

(2) Any person engaged by the United States under a contract for his or her personal services outside the continental United States;

(3) Any person subject to workers' compensation coverage under the Nonappropriated Fund Instrumentalities Act (5 U.S.C. 8171 *et seq.*);

(4) Any person engaged for personal services outside the continental United States under a contract approved and financed by the United States under the Mutual Security Act of 1954, as

amended (other than title II of chapter II unless the Secretary of Labor, upon the recommendation of the head of any department or other agency of the U.S. Government, determines a contract financed under a successor provision of any successor Act should be covered by this subchapter), except that in cases where the United States is not a formal party to contracts approved and financed under the Mutual Security Act of 1954, as amended, the Secretary, upon the recommendation of the head of any department or agency of the United States, may waive the application of the Act; or

(5) Any person engaged for personal services outside the continental United States by an American employer providing welfare or similar services for the benefit of the Armed Forces under appropriate authorization by the Secretary of Defense.

(c) The Act also provides for payment of detention benefits to an employee specified in paragraph (a) of this section who—

(1) If found to be missing from his or her place of employment under circumstances supporting a reasonable inference that the absence is due to the belligerent action of a hostile force or person;

(2) Is known to have been taken by a hostile force or person as a prisoner or hostage; or

(3) Is not returned to his or her home or to the place of employment due to the failure of the United States or its contractor to furnish transportation.

§ 61.2 Administration of the Act and this chapter.

(a) Pursuant to 42 U.S.C. 1706, Secretary of Labor's Order 6–84, (49 FR 32473), and Employment Standards Order 78–1, (43 FR 51469), the responsibility for administration of the Act has been delegated to the Director, Office of Workers' Compensation Programs.

(b) In administering the provisions of the Act, the Director may enter into agreements or cooperative working arrangements with other agencies of the United States or of any State (including the District of Columbia, Puerto Rico, and the Virgin Islands) or political subdivisions thereof, and with other public agencies and private persons, agencies, or institutions within and outside the United States. The Director may also contract with insurance carriers for the use of their service facilities to process claims filed under the Act

§ 61.3 Purpose and scope of this part.

(a) This part 61 sets forth the rules applicable to the filing, processing, and payment of claims for reimbursement and workers' compensation benefits under the provisions of the War Hazards Compensation Act, as amended. The provisions of this part are intended to afford guidance and assistance to any person, insurance carrier, self-insured employer, or compensation fund seeking benefits under the Act, as well as to personnel within the Department of Labor who administer the Act.

(b) Subpart A describes the statutory and administrative framework within which claims under the Act are processed, contains a statement of purpose and scope, and defines terms used in the administration of the Act.

(c) Subpart B describes the procedure by which an insurance carrier, self-insured employer, or compensation fund shall file a claim for reimbursement under section 104 of the Act, and describes the procedures for processing a claim for reimbursement and transferring a case for direct payment by the Department of Labor.

(d) Subpart C contains the rules governing the filing and processing of a claim for injury, disability or death benefits under section 101(a) of the Act.

(e) Subpart D contains provisions relating to claims for detention benefits under section 101(b) of the Act.

(f) Subpart E contains miscellaneous provisions concerning disclosure of program information, approval of claims for legal services, and assignment of claim.

§ 61.4 Definitions and use of terms.

For the purpose of this part—

(a) *The Act* means the War Hazards Compensation Act, 42 U.S.C. 1701 *et seq.*, as amended.

(b) *Office* or *OWCP* means the Office of Workers' Compensation Programs, Employment Standards Administration, United States Department of Labor.

(c) *Contractor with the United States* includes any contractor, subcontractor or subordinate subcontractor.

(d) *Carrier* means any payer of benefits for which reimbursement is requested under the Act, and includes insurance carriers, self-insured employers and compensation funds.

(e) *War-risk hazard* means any hazard arising during a war in which the United States is engaged; during an armed conflict in which the United States is engaged, whether or not war has been declared; or during a war or armed conflict between military forces of any origin, occurring within any country in which a person covered by the Act is serving; from—

(1) The discharge of any missile (including liquids and gas) or the use of any weapon, explosive, or other noxious thing by a hostile force or person or in combating an attack or an imagined attack by a hostile force or person;

(2) Action of a hostile force or person, including rebellion or insurrection against the United States or any of its allies;

(3) The discharge or explosion of munitions intended for use in connection with a war or armed conflict with a hostile force or person (except with respect to employees of a manufacturer, processor, or transporter of munitions during the manufacture, processing, or transporting of munitions, or while stored on the premises of the manufacturer, processor, or transporter);

(4) The collision of vessels in convoy or the operation of vessels or aircraft without running lights or without other customary peacetime aids to navigation; or

(5) The operation of vessels or aircraft in a zone of hostilities or engaged in war activities.

(f) *Hostile force or person* means any nation, any subject of a foreign nation, or any other person serving a foreign nation—

(1) Engaged in a war against the United States or any of its allies;

(2) Engaged in armed conflict, whether or not war has been declared, against the United States or any of its allies; or

(3) Engaged in a war or armed conflict between military forces of any origin in any country in which a person covered by the Act is serving.

(g) *Allies* means any nation with which the United States is engaged in a common military effort or with which the United States has entered into a common defensive military alliance.

(h) *War activities* includes activities directly relating to military operations.

(i) *Continental United States* means the States and the District of Columbia.

(j) *Injury* means injury resulting from a war-risk hazard, as defined in this section, whether or not such injury occurred in the course of the person's employment, and includes any disease proximately resulting from a war-risk hazard.

(k) *Death* means death resulting from an injury, as defined in this section.

(l) The terms *compensation*, *physician*, and *medical*, *surgical*, *and hospital services and supplies* when used in subparts D and E are construed and applied as defined in the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*).

(m) The terms *disability*, *wages*, *child*, *grandchild*, *brother*, *sister*, *parent*, *widow*, *widower*, *student*, *adoption* or *adopted* are construed and applied as defined in the Longshore and Harbor Workers' Compensation Act, as amended (35 U.S.C. 901 *et seq.*).

Subpart B—Reimbursement of Carriers

§ 61.100 General reimbursement provisions.

(a) The Office shall reimburse any carrier that pays benefits under the Defense Base Act or other applicable workers' compensation law due to the injury, disability or death of any person specified in § 61.1(a), if the injury or death for which the benefits are paid arose from a war-risk hazard. The amount to be reimbursed includes disability and death payments, funeral and burial expenses, medical expenses, and the reasonable and necessary claims expense incurred in processing the request.

(b) The Office shall not provide reimbursement in any case in which an additional premium for war-risk hazard was charged, or in which the carrier has been reimbursed, paid, or compensated for the loss for which reimbursement is requested.

(c) Reimbursement under this section with respect to benefits shall be limited to the amounts which will discharge the liability of the carrier under the applicable workers' compensation law.

§ 61.101 Filing a request for reimbursement.

(a) A carrier or employer may file a request for reimbursement. The request shall be submitted to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013–7117;

(b) Each request for reimbursement shall include documentation itemizing the payments for which reimbursement is claimed. The documentation shall be sufficient to establish the purpose of the payment, the name of the payee, the date(s) for which payment was made, and the amount of the payment. Copies of any medical reports and bills related to medical examination or treatment for which reimbursement is claimed shall also be submitted. If the carrier cannot provide copies of the payment drafts or receipts, the Office may accept a certified listing of payments which includes payee name, description of services rendered, date of services rendered, amount paid, date paid check or draft number, and signature of certifier.

(c) When filing an initial request for reimbursement under the Act, the carrier shall submit copies of all available documents related to the workers' compensation case, including—

(1) Notice and claim forms;

(2) Statements of the employee or employer;

(3) Medical reports;

(4) Compensation orders; and

(5) Proof of liability (e.g., insurance policy or other documentation).

§ 61.102 Disposition of reimbursement requests.

(a) If the Office finds that insufficient or inadequate information has been submitted with the claim, the carrier shall be asked to submit further information. Failure to supply the requested information may result in disallowance of items not adequately supported as properly reimbursable.

(b) The Office shall not withhold payment of an approved part of a reimbursement request because of denial of another part of the reimbursement request.

(c) The Office shall regard awards, decisions and approved settlement agreements under the Defense Base Act or other applicable workers' compensation law, that have become final, as establishing prima facie, the right of the beneficiary to the payment awarded or provided for.

(d) The Office shall advise the carrier of the amount approved for reimbursement. If the reimbursement request has been denied in whole or in part, the Office shall provide the carrier an explanation of the action taken and the reasons for the action. A carrier within the United States may file objections with the Associate Director for Federal Employees' Compensation to the disallowance or reduction of a claim within 60 days of the Office's decision. A carrier outside the United States has six months within which to file objections with the Associate Director. The Office may consider objections filed beyond the time limits under unusual circumstances or when reasonable cause has been shown for the delay. A determination by the Office is final.

(e) In determining whether a claim is reimbursable, the Office shall hold the carrier to the same degree of care and prudence as any individual or corporation in the protection of its interests or the handling of its affairs would be expected to exercise under similar circumstances. A part or an item of a claim may be disapproved if the Office finds that the carrier—

(1) Failed to take advantage of any right accruing by assignment or subrogation (except against the United States, directly or indirectly, its employees, or members of its armed forces) due to the liability of a third

party, unless the financial condition of the third party or the facts and circumstances surrounding the liability justify the failure;

(2) Failed to take reasonable measures to contest, reduce, or terminate its liability by appropriate available procedure under workers' compensation law or otherwise; or

(3) Failed to make reasonable and adequate investigation or injury as to the right of any person to any benefit or payment; or

(4) Failed to avoid augmentation of liability by reason of delay in recognizing or discharging a compensation claimant's right to benefits.

§ 61.103 Examination of records of carrier.

Whenever it is deemed necessary, the Office may request submission of case records or may inspect the records and accounts of a carrier for the purpose of verifying any allegation, fact or payment stated in the claim. The carrier shall furnish the records and permit or authorize their inspection as requested. The right of inspection shall also relate to records and data necessary for the determination of whether any premium or other charge was made with respect to the reimbursement claimed.

§ 61.104 Reimbursement of claims expense.

(a) A carrier may claim reimbursement for reasonable and necessary claims expense incurred in connection with a case for which reimbursement is claimed under the Act. Reimbursement may be claimed for allocated and unallocated claims expense.

(b) The term ''allocated claims expense'' includes payments made for reasonable attorneys' fees, court and litigation costs, expenses of witnesses and expert testimony, examinations, autopsies and other items of expense that were reasonably incurred in determining liability under the Defense Base Act or other workers' compensation law. Allocated claims expense must be itemized and documented as described in § 61.101.

(c) The term ''unallocated claims expense'' means costs that are incurred in processing a claim, but cannot be specifically itemized or documented. A carrier may receive reimbursement of unallocated claims expense in an amount of to 15% of the sum of the reimbursable payments made under the Defense Base Act or other workers' compensation law. If this method of computing unallocated claims expense would not result in reimbursement of reasonable and necessary claims expense, the Office may, in its discretion, determine an amount that fairly represents the expenses incurred.

(d) The Office shall not consider as a claims expense any general administrative costs, general office maintenance costs, rent, insurance, taxes, or other similar general expenses. Nor shall expenses incurred in establishing or documenting entitlement to reimbursement under the Act be considered.

§ 61.105 Direct payment of benefits.

(a) The Office may pay benefits, as they accrue, directly to any entitled beneficiary in lieu of reimbursement of a carrier.

(b) The Office will not accept a case for direct payment until the right of the person or persons entitled to benefits has been established and the Office finds that the carrier would be entitled to reimbursement for continuing benefits.

(c) The Office will not accept a case for direct payment until the rate of compensation or benefit and the period of payment have become relatively fixed and known. The Office may accept a case for direct payment before this condition has been satisfied, if the Office determines that direct payment is advisable due to the circumstances in that particular case.

(d) In cases transferred to the Office for direct payment, medical care for the effects of a war-risk injury may be furnished in a manner consistent with the regulations governing the furnishing of medical care under the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, *et seq.*).

(e) The transfer of a case to the Office for direct payment does not affect the hearing or adjudicatory rights of a beneficiary or carrier as established under the Defense Base Act or other applicable workers' compensation law.

(f) The Office may retransfer any case to a carrier either for the purpose

of completion of adjudicatory processes or for continuation of payment of benefits.

Subpart C—Compensation for Injury, Disability or Death

§ 61.200 Entitlement to benefits.

(a) Compensation under section 101(a) of the Act is payable for injury or death due to a war-risk hazard of an employee listed in § 61.1(a), whether or not the person was engaged in the course of his or her employment at the time of the injury.

(b) Compensation under this subpart is paid under the provisions of the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*), except that the determination of beneficiaries and the computation of compensation are made in accordance with sections 6, 8, 9, and 10 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901 *et seq.*).

(c) The Office may not approve a claim for compensation if any of the following conditions are met:

(1) The employee resides at or in the vicinity of the place of employment, does not live there solely due to the exigencies of the employment, and is injured outside the course of the employment.

(2) The claim is filed due to the injury or death of a prisoner of war detained or utilized by the United States.

(3) The person seeking benefits recovers or receives workers' compensation benefits from any other source for the same injury or death.

(4) The person seeking benefits is a national of a foreign country and is entitled to compensation benefits from that or any other foreign country on account of the same injury or death.

(5) The employee is convicted in a court of competent jurisdiction of any subversive act against the United States or any of its allies.

§ 61.201 Filing of notice and claim.

An employee or his or her survivors may file a claim under section 101(a) of the Act only after a determination has been made that no benefits are payable under the Defense Base Act administered by the Office's Division of Longshore and Harbor Workers' Compensation, Notice and claim may be filed on standard Longshore or Federal Employees' Compensation Act forms. The claimant shall submit notice and claim, along with any supporting documentation, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013–7117.

§ 61.202 Time limitations for filing notice and claim.

The time limitation provisions found in 5 U.S.C. 8119 apply to the filing of claims under section 101(a) of the War Hazards Compensation Act. The Office may waive the time limitations if it finds that circumstances beyond the claimant's control prevented the filing of a timely claim.

§ 61.203 Limitations on and deductions from benefits.

(a) Compensation payable for injury, disability or death may not exceed the maximum limitations specified in section 6(b) of the Longshore and Harbor Workers' Compensation Act, as amended.

(b) In determining benefits for disability or death, the Office shall not apply the minimum limits found in sections 6(b) and 9(e) of the Longshore and Harbor Workers' Compensation Act.

(c) Compensation for death or permanent disability payable to persons who are not citizens of the United States and who are not residents of the United States or Canada is in the same amount as provided for residents, except that dependents in a foreign country are limited to the employee's spouse and children, or if there be no spouse or children, to the employee's father or mother whom the employee supported, either wholly or in part, for the period of one year immediately prior to the date of the injury. The Office may discharge its liability for all future payments of compensation to a noncitizen/nonresident by paying a limp sum representing one-half the commuted value of all future compensation as determined by the Office.

(d) If any employee or beneficiary receives or claims wages, payments in lieu of wages, or insurance benefits for

disability or loss of life (other than workers' compensation benefits), and the cost of these payments is provided in whole or in part by the United States, the Office shall credit the amount of the benefits against any payments to which the person is entitled under the Act. The Office shall apply credit only where the wages, payments, or benefits received are items for which the contractor is entitled to reimbursement from the United States, or where they are otherwise reimbursable by the United States.

(e) If an employee who is receiving workers' compensation benefits on account of a prior accident or disease sustains an injury compensable under the Act, the employee is not entitled to any benefits under the Act during the period covered by other workers' compensation benefits unless the injury from a war-risk hazard increases the employee's disability. If the war-risk injury increases the disability, compensation under the Act is payable only for the amount of the increase in disability. This provision is applicable only to disability resulting jointly from two unrelated causes, namely, (1) prior industrial accident or disease, and (2) injury from a war-risk hazard.

(f) Compensation for disability under this subchapter, with the exception of allowances for scheduled losses of members or functions of the body, may not be paid for the same period of time during which benefits for detention under this subchapter are paid or accrued.

§ 61.204 Furnishing of medical treatment.

All medical services, appliances, drugs and supplies which in the opinion of the Office are necessary for the treatment of an injury coming within the purview of section 101(a) of the Act shall be furnished to the same extent, and wherever practicable in the same manner and under the same regulations, as are prescribed for the furnishing of medical treatment under the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*).

§ 61.205 Burial expense.

(a) When the death of a person listed in §61.1(a) results from an injury caused by a war-risk hazard, the Office shall pay reasonable burial expenses up to the amount specified in section 9 of the Longshore and Harbor Workers' Compensation Act. If any part of the burial expense has been paid by any other agency of the United States, or by any person under obligation to discharge burial expenses, the amount so paid shall be deducted from the burial expense payable by the Office. Payment will be made directly (1) to the undertaker, (2) to the estate of the deceased if the estate is obligated to make payment, or (3) to any person who has paid such burial expenses and is entitled to such reimbursement.

(b) If the employee's home is within the United States and death occurs away from the employee's home or outside the United States, the Office may pay an additional sum for transporting the remains to the home.

§ 61.206 Reports by employees and dependents.

The Office may require a claimant to submit reports of facts materially affecting the claimant's entitlement to compensation under the Act. These may include reports of recurrence or termination of disability, of employment and earnings, or of a change in the marital or dependency status of a beneficiary.

Subpart D—Detention Benefits

§ 61.300 Payment of detention benefits.

(a) The Office shall pay detention benefits to any person listed in §61.1(a) who is detained by a hostile force or person, or who is not returned to his or her home or to the place of employment by reason of the failure of the United States or its contractor to furnish transportation. Benefits are payable for periods of absence on and subsequent to January 1, 1942, regardless of whether the employee was actually engaged in the course of his or her employment at the time of capture or disappearance.

(b) For the purposes of paying benefits for detention, the employee is considered as totally disabled until the time that the employee is returned to his or her home, to the place of employment, or to the jurisdiction of the

United States. The Office shall credit the compensation benefits to the employee's account, to be paid to the employee for the period of the absence or until the employee's death is in fact established or can be legally presumed to have occurred. A part of the compensation accruing to the employee may be disbursed during the period of absence to the employee's dependents.

(c) During the period of absence of any employee detained by a hostile force or person, detention benefits shall be credited to the employee's account at one hundred percent of his or her average weekly wages. The average weekly wages may not exceed the average weekly wages paid to civilian employees of the United States performing the same or most similar employment in that geographic area. If there are eligible dependents, the Office may pay to these dependents seventy percent of the credited benefits.

(d) The Office may not pay detention benefits under any of the following conditions:

(1) The employee resides at or in the vicinity of the place of employment, does not live there solely due to the exigencies of the employment, and is detained under circumstances outside the course of the employment.

(2) The person detained is a prisoner of war detained or utilized by the United States.

(3) Workers' compensation benefits from any other source or other payments from the United States are paid for the same period of absence or detention.

(4) The person seeking detention benefits is a national of a foreign country and is entitled to compensation benefits from that or any other foreign country on account of the same absence or detention.

(5) The employee has been convicted in a court of competent jurisdiction of any subversive act against the United States or any of its allies.

§ 61.301 Filing a claim for detention benefits.

(a) A claim for detention benefits shall contain the following information: Name, address, and occupation of the missing employee; name, address and relation to the employee of any dependent making claim; name and address of the employer; contract number under which employed; date, place and circumstances of capture or detention; date, place and circumstances of release (if applicable). The employer shall provide information about the circumstances of the detention and the employee's payrate at the time of capture. Dependents making claim for detention benefits may be required to submit all evidence available to them concerning the employment status of the missing person and the circumstances surrounding his or her absence.

(b) A claim filed by a dependent or by the employee upon his or her release should be sent with any supporting documentation to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013–7117.

§ 61.302 Time limitations for filing a claim for detention benefits.

The time limitation provisions found in the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*) apply to the filing of claims for detention benefits. The Office may waive the time limitations if it finds that circumstances beyond the claimant's control prevented the filing of a timely claim.

§ 61.303 Determination of detention status.

A determination that an employee has been detained by a hostile force or person may be made on the basis that the employee has disappeared under circumstances that make detention appear probable. In making the determination, the Office will consider the information and the conclusion of the Department or agency of the United States having knowledge of the circumstances surrounding the absence of the employee as prima facie evidence of the employee's status. The presumptive status of total disability of the missing person shall continue during the period of the absence, or until death is in fact established or can be legally presumed to have occurred.

§ 61.304 Limitations on and deductions from detention benefits.

(a) In determining benefits for detention, the Office shall not apply the minimum limits found in sections 6(b) and 9(e) of the Longshore and Harbor Workers' Compensation Act.

(b) If any employee or dependent receives or claims wages, payments in lieu of wages, or insurance benefits for the period of detention, and the cost of the wages, payments or benefits is provided in whole or in part by the United States, the Office shall credit the amount of the benefits against any detention payments to which the person is entitled under the Act. The Office shall apply credit only where the wages, payments, or benefits received are items for which the contractor is entitled to reimbursement from the United States, or where they are otherwise reimbursable by the United States.

§ 61.305 Responsibilities of dependents receiving detention benefits.

A dependent having knowledge of a change of status of a missing employee shall promptly inform the Office of the change. The Office must be advised immediately by the dependent if the employee is returned home or to the place of his or her employment, or is able to be returned to the jurisdiction of the United States.

§ 61.306 Transportation of persons released from detention and return of employees.

(a) The Office may furnish the cost of transporting an employee from the point of the employee's release from detention to his or her home, the place of employment, or other place within the jurisdiction of the United States. The Office shall not pay for transportation if the employee is furnished the transportation under any agreement with his or her employer or under any other provision of law.

(b) The Office may furnish the cost of transportation under circumstances not involving detention, if the furnishing of transportation is an obligation of the United States or its contractor, and the United States or its contractor fails to return the employee to his or her home or to the place of employment.

§ 61.307 Transportation of recovered bodies of missing persons.

If an employee dies while in detention and the body is later recovered, the Office may provide the cost of transporting the body to the home of the deceased or to any place designated by the employee's next of kin, near relative, or legal representative.

Subpart E—Miscellaneous Provisions

§ 61.400 Custody of records relating to claims under the War Hazards Compensation Act.

All records, medical and other reports, statements of witnesses and other papers filed with the Office with respect to the disability, death, or detention of any person coming within the purview of the Act, are the official records of the Office and are not records of the agency, establishment, Government department, employer, or individual making or having the care or use of such records.

§ 61.401 Confidentiality of records.

Records of the Office pertaining to injury, death, or detention are confidential, and are exempt from disclosure to the public under section 552(b)(6) of title 5, U.S. Code. No official or employee of the United States who has investigated or secured statements from witnesses and others pertaining to any case within the purview of the Act, or any person having the care or use of such records, shall disclose information from or pertaining to such records to any person, except in accordance with applicable regulations (see 29 CFR part 70a).

§ 61.402 Protection, release, inspection and copying of records.

The protection, release, inspection and copying of the records shall be accomplished in accordance with the rules, guidelines and provisions contained in 29 CFR parts 70 and 70a and the annual notice of systems of records and routine uses as published in the FEDERAL REGISTER.

§ 61.403 Approval of claims for legal and other services.

(a) No claim for legal services or for any other services rendered in respect to a claim or award for compensation under the Act to or on account of any person shall be valid unless approved by the Office. Any such claim approved by the Office shall, in the manner and to the extent fixed by the Office, be paid out of the compensation payable to the claimant.

(b) The Office shall not recognize a contract for a stipulated fee or for a fee on a contingent basis. No fee for services shall be approved except upon application supported by a sufficient statement of the extent and character of the necessary work done on behalf of the claimant. Except where the claimant was advised that the representation would be rendered on a gratuitous basis, the fee approved shall be reasonably commensurate with the actual necessary work performed by the representative, and with due regard to the capacity in which the representative appeared, the amount of compensation involved, and the circumstances of the claimant.

§ 61.404 Assignments; creditors.

The right of any person to benefits under the Act is not transferable of assignable at law or in equity except to the United States, and none of the moneys paid or payable (except money paid as reimbursement for funeral expenses), or rights existing under the Act are subject to execution, levy, attachment, garnishment, or other legal process or to the operation of any bankruptcy or insolvency law.

SUBCHAPTER G—COMPENSATION FOR INJURY, DISABILITY OR DEATH OF CIVILIAN AMERICAN CITIZENS INCURRED WHILE DETAINED BY OR IN HIDING FROM THE IMPERIAL JAPANESE GOVERNMENT

PART 71—GENERAL PROVISIONS

Sec.
71.1 General administrative provisions.
71.2 Computation of benefits.
71.3 Deductions from benefits.
71.4 Limitation upon benefits.
71.5 Payment of benefits.
71.6 Notice of injury or death.
71.7 Claim filing, processing, adjudication and time limits.

AUTHORITY: Sec. 32, 39 Stat. 749, as amended, sec. 106, 56 Stat. 1033, as amended, sec. 5, 62 Stat. 1242, as amended; 5 U.S.C. 8145, 8149, 42 U.S.C. 1706, 50 U.S.C. App., 2004.

SOURCE: 16 FR 2933, Apr. 4, 1951, unless otherwise noted.

§ 71.1 General administrative provisions.

(a) Section 5(f) of the War Claims Act of 1948 (act of July 3, 1948; Pub. L. 896, 80th Cong., 62 Stat. 1240) makes provision for the payment of benefits with respect to the injury, disability or death resulting from injury of any civilian American citizen occurring while he was held by or in hiding from the Imperial Japanese Government to the same extent as if such civilian American citizen were an employee within the purview of the act of December 2, 1942 (Pub. L. 784, 77th Cong., 56 Stat. 1028, 42 U.S.C. 1701, *et seq.*). Under section 5(f) of the said War Claims Act of 1948, the rights of individuals to benefits payable under this subchapter shall accrue from and after December 7, 1941, subject, however, to all of the provisions of said act and the regulations in this subchapter.

(b) The regulations in part 61 of subchapter F of this chapter governing the administration of the benefits provided under titles I and II of the said act of December 2, 1942, as amended, shall, insofar as they are applicable and are not inconsistent with any of the provisions of this subchapter, govern the administration of the benefits payable under this subchapter. Provisions of such regulations relating to benefits for detention by the enemy, reimbursement to an employer or insurance carrier, and limitations on benefits in cases where workmen's compensation is payable are not applicable to the benefits provided in this subchapter nor are they within the purview of this subchapter. The provisions of sections 101(b), 104 and 105 of such act of December 2, 1942, and the various provisions of part 61 of this chapter relating to such provisions, accordingly, are not applicable to the payment of benefits under this subchapter.

(c) All rights or benefits under this subchapter which are determinable with reference to other provisions of law other than the said War Claims Act of 1948, shall be determined with reference to such provisions as they existed and were in force on January 3, 1948.

(d) As used in this subchapter:

(1) The term ''Bureau'' means the Bureau of Employees' Compensation, U.S. Department of Labor.

(2) The term ''civilian American citizen'' means any person who, being then a citizen of the United States, was captured by the Imperial Japanese Government on or after December 7, 1941, at Midway, Guam, Wake Island, the Philippine Islands, or any Territory or possession of the United States attacked or invaded by such government or while in transit to or from any such place, or who went into hiding at any such place in order to avoid capture or internment by such government; except (i) a person who at any time voluntarily gave aid to, collaborated with, or in any manner served such government, or (ii) a person who at the time of his capture or entrance into hiding was within the purview of the Federal Employees' Compensation Act of September 7, 1918, as amended and extended, or the said act of December 2, 1942, as amended, or the Missing Persons Act of March 7, 1942 (56 Stat. 143), as amended, or who was a regularly appointed, enrolled, enlisted, or

inducted member of any military or naval force.

(3) The terms ''held by the Imperial Japanese Government'' or ''captured by the Imperial Japanese Government'' mean a holding of such person as a prisoner, internee, hostage or in any other capacity.

(4) The terms ''compensation'', ''physician'' and ''medical, surgical and hospital services and supplies'' shall be construed and applied as defined in the Federal Employees' Compensation Act of September 7, 1916, as amended.

(5) The term ''benefit'' is construed as synonymous with the term ''compensation''.

(6) The terms ''disability'', ''wages'', ''child'', ''grandchild'', ''brother'', ''sister'', ''parent'', ''widow'', ''widower'', ''adoption'' or ''adopted'' shall be construed and applied as defined in the Longshoremen's and Harbor Workers' Compensation Act, as amended.

§ 71.2 Computation of benefits.

(a) For the purpose of determining the benefits under this subchapter, the average weekly wage of any such civilian American citizen, whether employed, self-employed, or not employed, shall be deemed to have been $37.50. The provisions of this subchapter are applicable and benefits are payable whether or not such civilian American citizen was employed. Monthly compensation in cases involving partial disability shall be determined by the percentage which the degree of partial disability bears to total disability, and shall not be determined with respect to the extent of loss of wage-earning capacity.

(b) Notwithstanding any of the provisions of part 61 of this chapter, total maximum aggregate compensation for disability payable under this subchapter is limited to $7,500 in case of injury and $7,500 in case of death, such sum being exclusive of medical costs and funeral and burial expenses.

§ 71.3 Deductions from benefits.

If a civilian American citizen or his dependents receives or has received from the United States any payments on account of the same injury or death, or from his employer in the form of wages or payments in lieu of wages, or in any form of support or compensation (including workmen's compensation) in respect to the same objects, the benefits under this subchapter shall be diminished in the case of an injured person by the amount of payments such injured person received on account of the same injury or disability, or in the case of dependents, by the amount of payments such dependents of the deceased civilian American citizen received on account of the same death, as the case may be.

§ 71.4 Limitation upon benefits.

No person, except a widow or a child, shall be entitled to benefits under this subchapter for disability with respect to himself and to death benefits on account of the death of another.

§ 71.5 Payment of benefits.

(a) Benefits under this subchapter payable for disability or death shall be paid only to the person entitled thereto, or to his legal or natural guardian if he has one, and shall not upon death of the person so entitled survive for the benefit of his estate or any other person.

(b) The benefit of a minor or an incompetent person who has no natural or legal guardian may, in the discretion of the Bureau be paid in whole or in such part as the Bureau may determine, for and on behalf of such minor or incompetent directly to the person or institution caring for, supporting or having custody of such minor or incompetent.

(c) In any case in which benefits are payable under this subchapter to any person who is prevented from accepting such benefits by the rules, regulations or customs of the church or the religious order or organization of which he is a member, such benefits will be paid, upon the request of such person, to such church or to such religious order or organization.

§ 71.6 Notice of injury or death.

Notwithstanding any of the provisions in part 61 of this chapter, no notice or report of injury or death shall be required for claims filed under this subchapter.

§ 71.7 Claim filing, processing, adjudication and time limits.

(a) Claims for injury, disability or death benefits payable under section 5(f) of the said War Claims Act of 1948, originating in the United States or in its Territories or possessions, shall be filed by mailing to the Bureau of Employees' Compensation, United States Department of Labor, Washington, DC 20211. All claims originating in the Philippine Islands may be filed by mailing to the Bureau of Employees' Compensation, United States Department of Labor, Manila, P.I. All claims will be finally processed and adjudicated by the Bureau at its principal office in Washington, DC.

(b) The limitation provisions for the filing of claims for disability or death benefits, as prescribed by applicable provisions of statute, shall not begin to run earlier than July 3, 1948.

PARTS 72–199 [RESERVED]

CHAPTER II—RAILROAD RETIREMENT BOARD

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SUBCHAPTER A—GENERAL ADMINISTRATION

PART 200—GENERAL ADMINISTRATION

Sec.

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AUTHORITY: 45 U.S.C. 231f(b)(5) and 45 U.S.C. 362;

Section 200.4 also issued under 5 U.S.C. 552;

Section 200.5 also issued under 5 U.S.C. 552a;

Section 200.6 also issued under 5 U.S.C. 552b; and

Section 200.7 also issued under 31 U.S.C. 3717.

§ 200.1 Designation of central and field organization.

(a) *Introduction.* (1) The Railroad Retirement Board (hereinafter referenced as the ''Board'') is an independent agency in the executive branch of the Federal Government and is administered by three members appointed by the President, with the advice and consent of the Senate. By law, one member is appointed upon recommendations made by railroad labor organizations, one upon recommendations of railroad employers, and the third member, the Chairman, is in effect independent of employees and employers and represents the public interest. The terms of office are five years and are arranged so as to expire in different calendar years.

(2) The primary function of the Board is the determination and payment of benefits under the retirement-survivor and unemployment-sickness programs. To this end, the Board must maintain lifetime earnings records for covered employees, a network of field offices to assist railroad personnel and their dependents in filing claims for benefits, and examiners to adjudicate the claims.

(3) The Board administers the Railroad Retirement Act and the Railroad Unemployment Insurance Act. The Railroad Retirement Tax Act, which imposes employment taxes to fund the railroad retirement system, is administered by the Internal Revenue Service of the U.S. Department of Treasury. The Board also participates in the administration of the Federal Medicare health insurance program.

(4) The headquarters of the Board is in Chicago, Illinois, at 844 North Rush Street. The Board maintains numerous district offices across the country in localities easily accessible to large numbers of railroad workers.

(b) *Internal organization.* (1) Reporting directly to the Board Members is the seven member Executive Committee. The Executive Committee is comprised of the General Counsel, the Director of Administration, the Director of Programs, the Chief Financial Officer, the Chief Information Officer, and the Director of Field Service. The Chief Actuary is a non-voting member. The Board members will designate a member of the Executive Committee as Senior Executive Officer.

(2) The Executive Committee is responsible for the day to day operations of the agency. The Senior Executive Officer is responsible for the direction and oversight of the Executive Committee. The General Counsel is responsible for advising the Board Members on major issues, interpreting the Acts and regulations administered by the Board, drafting and analyzing legislation, representing the Board in litigation and administrative forums and planning, directing, and coordinating the work of the Office of General Counsel, the Office of Secretary to the

Board, the Bureau of Hearings and Appeals, and the Office of Legislative Affairs through their respective directors. The Director of Programs is responsible for managing, coordinating, and controlling the program operations of the agency which carry out provisions of the Railroad Retirement and Railroad Unemployment Insurance Acts. The Director of Administration is responsible for managing, coordinating and controlling certain administrative operations of the Board including the Division of Acquisition Management, the Bureau of Human Resources, the Office of Public Affairs, and the Division of Real Property Management. The Chief Financial Officer is responsible for the financial management of the agency, and the Chief Information Officer is responsible for coordinating the agency's information resources management program. The Chief Actuary is responsible for the actuarial program of the Board, and for maintaining statistical and financial information. The Director of Field Services is responsible for the oversight of the agency's nationwide field offices.

(3) The Office of Equal Employment Opportunity is responsible for equal employment opportunity and affirmative employment programs.

(c) *Office of Inspector General.* The Railroad Retirement Solvency Act of 1983 established the Office of Inspector General within the Board to be governed by the Inspector General Act of 1978. As structured, the Inspector General reports directly to the Chairman. The Office of Inspector General is responsible for policy direction and conduct of audit, inspection, and investigation activities relating to program and operations of the Board; and maintaining liaison with other law enforcement agencies, the Department of Justice, and United States Attorneys on all matters relating to the detection and prevention of fraud and abuse. The Inspector General reports semi-annually to the Congress through the Chairman concerning fraud, abuses, other serious problems, and deficiencies of agency programs and operations; recommends corrective action; and, reports on progress made in implementing these actions.

[52 FR 11010, Apr. 6, 1987, as amended at 67 FR 5723, Feb. 7, 2002; 80 FR 13763, Mar. 17, 2015; 84 FR 28726, June 20, 2019]

§ 200.2 The general course and method by which the Board's functions are channeled and determined.

(a) *Retirement and death benefits.* (1) Retirement and death benefits must be applied for by filing application therefor. (For details as to application, see parts 210 and 237 of this chapter). The Bureau of Retirement Claims considers the application and the evidence and information submitted with it. Wage and service records maintained by the Board are checked and if necessary, further evidence is obtained from the employee, the employer, fellow employees, public records and any other person or source available. The Bureau makes initial decisions on the following matters:

(i) Applications for benefits;

(ii) Requests for the withdrawal of an application;

(iii) Requests for a change in an annuity beginning date;

(iv) The termination of an annuity;

(v) The modification of the amount of an annuity or lump sum;

(vi) Requests for the reinstatement of an annuity which had been terminated or modified;

(vii) The existence of an erroneous payment;

(viii) The eligibility of an individual for a supplemental annuity or the amount of such supplemental annuity.

(ix) Whether representative payments shall serve the interests of an individual by reason of his incapacity to manage his annuity payments; and

(x) Who shall be appointed or continued as representative payee on behalf of an annuitant.

(2) A claimant dissatisfied with the Bureau's decision may, upon filing notice within one year from the date the decision is mailed to the claimant, appeal to the Bureau of Hearings and Appeals. *Provided, however,* That (i) an individual under age 16 shall not have the right to appeal a finding of incapacity to manage his annuity payments, but shall have the right to contest on appeal that he is, in fact, under age 16;

(ii) an individual who has been adjudged legally incompetent shall not have the right to appeal a finding of incapacity to manage his annuity payments, but shall have the right to contest on appeal the fact of his having been adjudged legally incompetent; and (iii) an individual shall not have the right to appeal a denial of his application to serve as representative payee on behalf of an annuitant. There he may have an oral hearing before a hearings officer of which a stenographic record is made, submit additional evidence, be represented, and present written and oral argument. If dissatisfied with the decision of the hearings officer, the claimant may appeal to the Board itself. This appeal must be made on a prescribed form within four months of the date a copy of the hearings officer's decision was mailed to him. If new evidence is received, the Board may remand the case to the hearings officer for investigation and recommendation concerning the new evidence. (For details on appeals procedure, see part 260 of this chapter.) A claimant, after he has unsuccessfully appealed to the Board itself and has thus exhausted all administrative remedies within the Board, may obtain a review of a final decision of the Board by filing a petition for review, within one year after the entry of the decision on the records of the Board and its communication to the claimant, in the U.S. Court of Appeals for the circuit in which the claimant resides, or in the U.S. Court of Appeals for the Seventh Circuit, or in the U.S. Court of Appeals for the District of Columbia Circuit.

(b) *Unemployment, sickness, and maternity benefits.* (1) Claims for unemployment benefits are handled by a comprehensive organization set up in the field. Under agreements between the Railroad Retirement Board and covered employers, the employers select employees of theirs to act as unemployment claims agents. These agents perform their services, specified in the agreement, in accordance with instructions issued by the Board but under general supervision and control of the employer. In accordance with the agreements, employers are reimbursed for such services at the rate of 50 cents for each claim taken by an unemployment claims agent and transmitted to the Board. There are some 13,000 such contract claims agents. An unemployed person who wishes to file a claim for unemployment benefits need only consult his recent railroad employer to be directed to the unemployment claims agent with whom he may file his claim.

(2) When an employee makes his first claim in any benefit year, he identifies himself and fills out an application for unemployment benefits (UI–1), an application for employment service (Form ES–1), and a pay rate report (Form UI 1a) to be used in determining the rate at which benefits may be paid. The employee is given an informational booklet UB–4 and an Unemployment Bulletin No. UB–3 informing him of his responsibilities and explaining the statements to which he is required to certify and to which he does certify when he registers for benefits. When the applications and pay rate report are completed, the unemployment claims agent sends them to the nearest field office of the Board. That office inspects the applications to detect errors and omissions and to note items requiring investigation. The office also attempts to verify the employee's statement about his pay rate unless the unemployment claims agent has already done so. The application for unemployment benefits and the pay rate report are then sent to the appropriate regional office of the Board. The application for employment service is retained in the field office for use in referring the claimant to suitable job openings. On the basis of the information furnished on the application for unemployment benefits, the regional office determines whether the applicant is a qualified employee (that is, whether he earned $500 or more from covered employment in the base year). The applicant is notified by letter if he is found to be not qualified.

(3) In addition to the application forms and pay rate report, the claimant executes a registration and claim for unemployment insurance benefits (Form UI–3). In substance, registration consists of his appearing before an unemployment claims agent during the agent's working hours and signing his name on the registration and claim form for the days he wishes to claim as

days of unemployment. Registration for any day must be made on the day or not later than the sixth calendar day thereafter, except that, if such calendar day is not a business day, the claimant may make his registration on the next following business day. In other words, a claimant must ordinarily appear for registration at seven-day intervals. Under certain circumstances, such as illness, employment, looking for employment, etc., an employee may make a delayed registration for any day for which he is unable to register within the time limit mentioned above. The unemployment claims agent sends the claim to the nearest field office where it is inspected with a view to calling the claimant in for interview or referral to job openings, detecting errors and omissions, and noting items requiring investigation. The claim is then forwarded to the regional office.

(4) Claims for sickness benefits are handled by the field organization of the Board. An employee need not register in person for sickness benefits but claims for such benefits must be made on the forms prescribed by the Board and executed by the individual claiming benefits except that, if the Board is satisfied that an employee is so sick or injured that he cannot sign forms, the Board may accept forms executed by someone else in his behalf. Forms used in connection with claims for sickness benefits may be obtained from a railroad employer, a railway labor organization, or any Board office. An application for sickness benefits (Form SI–1a) and the required statement of sickness (Form SI–1b) may be mailed to any office of the Board (see part 335 of this chapter). It is important that a statement of sickness be filed promptly, for no day can be considered as a day of sickness unless a statement of sickness with respect to such day is filed at an office of the Board within ten days. The application and statement of sickness are forwarded to a regional office where they are examined. If it appears that the employee is entitled to benefits, the regional office will send him a claim form covering a 14-day registration period, and a pay rate report (Form SI–1d). The employee completes the forms, indicating on the claim form the days during the period he claims as days of sickness and returns both forms to the regional office to which the claim form is preaddressed. When additional medical information is needed, a form for supplemental doctor's statement is sent to the employee. This should be filled out by a doctor and returned to the Board.

(5) Maternity benefits must be applied for on a form prescribed by the Board. A statement of maternity sickness, executed by a person authorized to execute statements of sickness (see part 335 of this chapter), is required also. The necessary forms may be obtained from a railroad employer, a railway labor organization, or any Board office. An application for maternity benefits (Form SI–101) and the statement of maternity sickness (Form SI–104) may be filed in person or by mail with any Board office. It is important that the statement of maternity sickness be filed promptly since no day can be considered as a day of sickness in a maternity period unless a statement of maternity sickness with respect to the day is filed at an office of the Board within ten days. As in the case of claims for sickness benefits, the forms are forwarded to a regional office. Claim forms are mailed to the claimant and are pre-addressed for return to the regional office.

(6) Whether benefits are payable to a claimant and, if so, the amount of benefits payable, is determined with respect to claims for unemployment, sickness, and maternity benefits, by the regional office. The names and addresses of claimants to whom benefits are found payable, and the amounts payable to them, are certified to the local disbursing office of the Treasury Department which mails the benefit checks to the claimants. If a claim is denied in whole or in part, an explanation is given to the claimant by letter.

(7) The rate at which benefits are payable is determined from the claimant's railroad wages earned in a base year period or from his daily pay rate for his last railroad employment in the base year period, whichever will result in the higher benefit rate. His daily benefit rate will be at least 60 per centum of his daily pay rate for his last

railroad employment in the base year period, but not exceeding $10.20.

(8) Any qualified employee whose claim for benefits under the Railroad Unemployment Insurance Act has been denied in whole or in part may, within one year from the date such denial is communicated to him, appeal from the initial determination, and such appeal will be heard before an impartial hearings officer. An unsuccessful claimant in an appeal before such hearings officer may appeal to the Board. (For further details of appeals procedure by claimants for benefits and for appeals procedure by employers, see parts 319 and 320 of this chapter.)

Any claimant, or any railway labor organization organized in accordance with the provisions of the Railway Labor Act, of which the claimant is a member, or any other party aggrieved by a final decision pursuant to the Railroad Unemployment Insurance Act, may, only after all administrative remedies within the Board will have been availed of and exhausted, obtain a review of such final decision of the Board by filing a petition for review within 90 days after the mailing of notice of such decision to the claimant or other party, or within such further time as the Board may allow, in the United States court of appeals for the circuit in which the claimant or other party resides or will have had his principal place of business or principal executive office, or in the United States Court of Appeals for the Seventh Circuit, or in the United States Court of Appeals for the District of Columbia Circuit.

(c) *Current compensation and service records.* Current compensation and service records are maintained by the Bureau of Research and Employment Accounts. These records are obtained from reports made periodically on either a quarterly or annual basis by employers and employee representatives. General instructions in this regard may be found in part 250 of this chapter. Special instructions to employers and employee representatives are issued from time to time by the Director of Research and Employment Accounts.

(d) *Collection of contributions.* The Office of Budget and Fiscal Operations acts as the collecting agency of the Board in receiving contributions due under the Railroad Unemployment Insurance Act. Contributions are, with some few exceptions, due quarterly and with the payment, the employer must file a report, Form DC–1, Employers Quarterly or Annual Report of Contributions under the Railroad Unemployment Insurance Act. (For further details see part 345 of this chapter.)

(e) *Employment service.* Employers needing workers may avail themselves of the Board's employment service by making requests of any field office for referrals, in writing, on forms provided by the Board, or by telephone.

[15 FR 6752, Oct. 6, 1950, as amended at 21 FR 4808, June 29, 1956; Board Order 62–115, 27 FR 9254, Sept. 19, 1962; Board Order 67–67, 32 FR 9064, June 27, 1967; 41 FR 22557, June 4, 1976. Redesignated at 52 FR 11010, Apr. 6, 1987, as amended at 55 FR 26430, June 28, 1990]

§ 200.3 Obtaining forms from the Railroad Retirement Board.

Forms used by the Board, including applications for benefits and informational publications, may be obtained from the Board's headquarters at 844 Rush Street, Chicago, Illinois 60611, and from local Board offices.

[63 FR 17326, Apr. 9, 1998]

§ 200.4 Availability of information to public.

(a) The following materials (more particularly described in paragraph (d) of this section), with identifying details deleted pursuant to paragraph (b) of this section, are available for public inspection and copying:

(1) All final opinions (including concurring and dissenting opinions), and all orders made in the adjudication of cases, which have precedential effect;

(2) All statements of policy and interpretations which have been adopted by the Board, or by anyone under authority delegated by the Board, which have not been published in the FEDERAL REGISTER;

(3) Administrative staff manuals and instructions to staff that affect any member of the public; and

(4) Copies of all records, regardless of form or format—

(i) That have been released to any person under paragraph (f) of this section; and

(ii) That because of the nature of their subject matter, the RRB determines have become or are likely to become the subject of subsequent requests for substantially the same records, or that have been requested 3 or more times.

(b) The identifying details to be deleted shall include, but not be limited to, names and identifying numbers of employees and other individuals as needed to comply with sections 12(d) and (n) of the Railroad Unemployment Insurance Act, section 7(b)(3) of the Railroad Retirement Act, and § 200.8 of this part, or to prevent a clearly unwarranted invasion of personal privacy.

(c) The RRB shall maintain a current index of the materials referred to in paragraph (a) of this section which will have been issued, adopted, or promulgated subsequent to July 4, 1967. This index shall be available for public inspection in an electronic format at RRB.gov. Copies of the index or any portion thereof may be obtained for a fee equivalent to the costs of reproduction by submitting a written request therefor. Such request should comply with the form for requests as described in paragraph (h) of this section to the General Counsel, Railroad Retirement Board, Room 836, 844 N. Rush Street, Chicago, Illinois 60611–1275.

(d) The materials and indexes thereto shall be kept, and made available to the public upon request in an electronic format, in the bureaus and offices of the RRB that produce or utilize the materials. The following materials currently in use shall, as long as they are in effect as precedents and instructions, be made available in offices of the Board at 844 N. Rush Street, Chicago, Illinois 60611–1275:

(1) In the Office of Programs/Operations: The Retirement Claims Manual, RCM Circulars, Special Services Manual, Policy Decisions, Procedural Memoranda containing information on the adjudication of claims not contained in the Retirement Claims Manual or in RCM Circulars, Field Operating Manual (Parts I and VI), FOM Circulars and Memoranda, the Occupational Disability Rating Schedule, Adjudication Instruction Manual, memorandum instructions on adjudication, and circular letters of instruction to railroad officials.

(2) In the Office of Programs/Policy and Systems: The Instructions to Employers, and Circular Letters to Employers.

(3) In the Office of General Counsel: Legal Opinions.

(4) In the Office of the Secretary to the Board: Decisions and rulings of the Board.

(5) Field offices shall also make available to the extent practicable such of these materials and indexes as are furnished them in the ordinary course of business.

(e) The copies of manuals and instructions made available for public copying and inspection shall not include:

(1) Confidential statements, standards, and instructions which do not affect the public, and

(2) Instructions not affecting the public (such as those relating solely to processing and procedure, to management, or to personnel) which it is feasible to separate from instructions that do affect the public.

(f) With the exception of records specifically excluded from disclosure by section 552(b) of title 5, United States Code, or other applicable statute, any records of or in the custody of this agency, other than those made available under paragraphs (a), (c), and (d) of this section, shall, upon receipt of a written request reasonably describing them, promptly be made available to the person requesting them.

(g) The RRB may charge the person of persons making a request for records under paragraph (f) of this section a fee in an amount not to exceed the costs actually incurred in complying with the request and not to exceed the cost of processing a check for payment. Depending on the category into which the request falls, a fee may be assessed for the cost of search for documents, reviewing documents to determine whether any portion of any located documents is permitted to be withheld, and duplicating documents.

(1) *Fee schedule.* To the extent that the following are chargeable, they are

chargeable according to the following schedule:

(i) The charge for making a manual search for records shall be the salary rate, including benefits, for a GS–7, step 5 Federal employee;

(ii) The charge for reviewing documents to determine whether any portion of any located document is permitted to be withheld shall be the salary rate, including benefits, for a GS–13, step 5 Federal employee;

(iii) The charge for making photocopies of any size document shall be $.10 per copy per page:

(iv) The charge for computer-generated listings or labels shall include the direct cost to the RRB of analysis and programming, where required, plus the cost of computer operations to produce the listing or labels. The maximum computer search charge shall be $2,250.00 per hour ($37.50 per minute). Search time shall not include the time expended in analysis or programming where these operations are required.

(v) There shall be no charge for transmitting documents by regular post. The charge for all other methods of transmitting documents shall be the actual cost of transmittal.

(2) *Categories of requesters.* For the purpose of assessing fees, requesters shall be classified into one of the following five groups:

(i) *Commercial use requesters.* Commercial use requesters are requesters who seek information for a use or purpose that furthers the commercial, trade, or profit interests of the requester or the person on whose behalf the request is made. For such requesters, the RRB will fully charge for the cost of searching, reviewing and copying and shall not consider a request for waiver or reduction of fees based upon an assertion that disclosure would be in the public interest; however, the RRB will not charge a fee if the total cost for searching, reviewing, and copying is less than $10.00.

(ii) *Educational and non-commercial scientific institution requesters.* Educational requesters are educational institutions which operate a program or programs of scholarly research. They may be a preschool, a public or private elementary or secondary school, an institution of graduate higher education, an institution of undergraduate higher education, an institution of professional education, or an institution of vocational education. Non-commercial scientific requesters are institutions that are not operated on a ''commercial'' basis and which are operated solely for the purpose of conducting scientific research the results of which are not intended to promote any particular product or industry. To be eligible for inclusion in this category, requesters must show that the request is being made under the auspices of a qualifying institution and that the records are not sought for a commercial use, but are sought in furtherance of scholarly (if the request is from an educational institution) or scientific (if the request is from a non-commercial scientific institution) research. For requesters in this category, the RRB shall charge for the cost of reproduction alone, excluding the first 100 pages, for which no charge will be made. If after excluding the cost of the first 100 pages of reproduction, there remain costs to be assessed, the RRB will not charge for such costs is such costs total less than $10.00. If the cost is $10.00 or more, the RRB may waive the charge or reduce it if it determines that disclosure of the information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester. To be eligible for free search time, these requesters must reasonably describe the records sought.

(iii) *Requesters who are representatives of the news media.* The term ''representative of the news media'' refers to any person or entity that actively gathers information of potential interest to a segment of the public, uses its editorial skills to turn the raw materials into a distinct work, and distributes that work to an audience. The term ''news'' means information that is about current events or that would be of current interest to the public. Examples of news media entities include television or radio stations that broadcast ''news'' to the public at large and publishers of periodicals that disseminate ''news'' and make their products available through a variety of means to

the general public, including news organizations that disseminate solely on the internet. A request for records supporting the news-dissemination function of the requester shall not be considered to be for a commercial use. ''Freelance'' journalists who demonstrate a solid basis for expecting publication through a news media entity shall be considered as a representative of the news media. A publishing contract would provide the clearest evidence that publication is expected; however, the RRB will also consider a requester's past publication record in making this determination. If, after excluding the cost of the first 100 pages of reproduction, there remain costs to be assessed, the RRB will not charge for such costs if such costs total less than $10.00. If the cost is $10.00 or more, the RRB may waive the charge or reduce it if it determines that disclosure is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester. To be eligible for free search time, these requesters must reasonably describe the record sought.

(iv) *Requests by subjects of records in Privacy Act Systems of Records.* Requests from subject individuals for records about themselves filed in any of the RRB's Privacy Act Systems of records will continue to be treated under the fee provisions of the Privacy Act of 1984 which permit assessing fees only for reproduction.

(v) *All other requesters.* For requesters who do not fall within the purview of paragraph (g)(2)(i), (ii), (iii), or (iv) of this section, the RRB will charge the full direct cost of searching for and reproducing records that are responsive to the request. The RRB will not charge for such costs to be assessed if the total is less than $10.00. If the total is $10.00 or more, the RRB may waive the charge or reduce it if it determines that disclosure of the information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester. Requesters may seek a waiver of fees by submitting a written application demonstrating how disclosure of the requested information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.

(3) *Charges for unsuccessful searches.* Where search time is chargeable, the RRB may assess charges for time spent searching, even if the RRB fails to locate the records, or if located, the records are determined to be exempt from disclosure. If the RRB estimates that search charges are likely to exceed $25.00 it will notify the requester of the estimated amount of fees, unless the requester has agreed in advance to pay fees as high as those anticipated. Such notice will offer the requester the opportunity to confer with agency personnel with the object of reformulating the request to meet his or here needs at a lower cost.

(4) *Aggregating requests.* When the RRB reasonably believes that a requester or group of requesters acting in concert is attempting to break a request into a series of requests for the purpose of evading the assessment of fees, the RRB will aggregate any such requests and charge accordingly. One element the RRB will consider in determining whether a belief would be reasonable is the time period in which the requests have been.

(5) *Advance payments.* (i) The RRB estimates or determines that the allowable charges payment unless:

(A) The RRB estimates or determines that the allowable charges that a requester may be required to pay are likely to exceed $250.00, in which case the RRB will notify the requester of the likely cost and obtain satisfactory assurance of full payment where the requester has a history of prompt payment of FOIA fees, or require an advance payment of an amount up to the full estimated charges in the case of requesters with no history of payment; or

(B) A requester has previously failed to pay a fee charged in a timely fashion (i.e., within 30 days of the date of the billing), in which case the RRB may require the requester to pay the full

amount owed plus any applicable interest as provided below of demonstrate that he has, in fact, paid the fee, and to make an advance payment of the full amount of the estimated fee before the agency begins to process a new request or a pending request from that requester.

(ii) When the RRB acts under paragraph (g)(5)(i) of this section, the administrative time limits prescribed in subsection (a)(6) of the Freedom of Information Act (5 U.S.C. 552(a)(6)) (i.e., 10 working days from receipt of initial requests and 20 working days from receipt of appeals from initial denials, plus permissible extensions of these time limits) will begin only after the RRB has received the fee payments described in said paragraph (g)(5)(i) of this section.

(6) *Charging interest.* Interest may be charged to any requester who fails to pay fees charged within 30 days of the date of billing. Interest will be assessed beginning on the 31st day following the day on which the bill for fees was sent. Interest will be the rate prescribed in section 3717 of title 31 of the U.S. Code Annotated and will accrue from the date of the billing.

(7) *Collection of fees due.* Whenever it is appropriate in the judgment of the RRB in order to encourage repayment of fees billed in accordance with these regulations, the RRB will use the procedures authorized by the Debt Collection Act of 1982 (Pub. L. 97–365), including disclosure to consumer reporting agencies and use of collection agencies.

(8) *Restriction on charging fees.* If the RRB fails to comply with the FOIA's time limits in which to respond to a request, it may not charge search fees, or, in the instances of requests from requesters described in paragraphs (g)(2)(ii) and (iii) of this section, may not charge reproduction fees except as described in paragraphs (g)(8)(i) and (ii) of this section.

(i) If the RRB has determined that unusual circumstances as defined by the FOIA apply and the agency provided timely written notice to the requester in accordance with the FOIA, a failure to comply with the time limit shall be excused for an additional 10 days.

(ii) If the RRB has determined that unusual circumstances as defined by the FOIA apply, and more than 5,000 pages are necessary to respond to the request, the agency may charge search fees, or, in the case of requesters described in paragraphs (g)(2)(ii) and (iii) of this section, may charge duplication fees if the following steps are taken. The agency must have provided timely written notice of unusual circumstances to the requester in accordance with the FOIA and the agency must have discussed with the requester via written mail, email, or telephone (or made not less than three good-faith attempts to do so) how the requester could effectively limit the scope of the request in accordance with 5 U.S.C. 552(a)(6)(B)(ii). If the exception in this paragraph (g)(8)(ii) is satisfied, the component may charge all applicable fees incurred in the processing of the request.

(9) *Other statutes specifically providing for fees.* The fee schedule of this section does not apply to fees charged under any statute that specifically requires an agency to set and collect fees for particular types of records. In instances where records responsive to a request are subject to a statutorily-based fee schedule program, the agency must inform the requester of the contact information of that program.

(h) Any person or organization requesting records pursuant to this section shall submit such request in writing to the General Counsel, Railroad Retirement Board, Room 836, 844 N. Rush Street, Chicago, Illinois 60611–2092. All such requests should be clearly and prominently identified as requests for information under the Freedom of Information Act. If submitted by mail or otherwise submitted in an envelope or other cover, requests should be clearly and prominently identified as such on the envelope or cover. Requests may also be submitted by e-mail, to EFOIA *https://secure.rrb.gov/efoia/.*

(i) *Timing of responses to requests.* The RRB ordinarily will respond to requests according to their order of receipt. In instances involving misdirected requests that are required to be rerouted, the response time shall commence on the date that the request

is received by the office that is designated to receive requests, but in any event not later than 10 working days after the request is first received by any office that is designated by these regulations to receive requests.

(1) *Unusual circumstances.* Whenever the RRB cannot meet the statutory time limit for processing a request because of ''unusual circumstances,'' as defined in the FOIA, and the RRB extends the time limit on that basis, the RRB shall, before expiration of the 20-day period to respond, notify the requester in writing of the unusual circumstances involved and of the date by which the RRB estimates processing of the request will be completed. Where the extension exceeds 10 working days, the RRB shall, as described by the FOIA, provide the requester with an opportunity to modify the request or arrange an alternative time period for processing the original or modified request. The RRB shall make available its designated FOIA Public Liaison for this purpose. The RRB shall also alert requesters to the availability of the Office of Government Information Services (OGIS) to provide dispute resolution services.

(2) *Expedited processing.* (i) The RRB shall process requests and appeals on an expedited basis whenever it is determined that they involve:

(A) Circumstances in which the lack of expedited processing could reasonably be expected to pose an imminent threat to the life or physical safety of an individual; or

(B) An urgency to inform the public about an actual or alleged Federal Government activity, if made by a person who is primarily engaged in disseminating information.

(ii) A request for expedited processing may be made at any time. Requests based on paragraphs (i)(2)(i)(A) and (B) of this section must be submitted to the General Counsel, Railroad Retirement Board, Room 836, 844 N Rush Street, Chicago, Illinois 60611–1275.

(iii) A requester who seeks expedited processing must submit a statement, certified to be true and correct, explaining in detail the basis for making the request for expedited processing. For example, under paragraph (i)(2)(i)(B) of this section, a requester who is not a full-time member of the news media must establish that the requester is a person whose primary professional activity or occupation is information dissemination, though it need not be the requester's sole occupation. Such a requester also must establish a particular urgency to inform the public about the government activity involved in the request—one that extends beyond the public's right to know about government activity generally. The existence of numerous articles published on a given subject can be helpful in establishing the requirement that there be an ''urgency to inform'' the public on the topic. As a matter of administrative discretion, an agency may waive the formal certification requirement.

(iv) The RRB shall notify the requester within 10 calendar days of the receipt of a request for expedited processing of its decision whether to grant or deny expedited processing. If expedited processing is granted, the request will be given priority and will be processed as soon as practicable. If a request for expedited processing is denied, the RRB will act on any appeal of that decision expeditiously.

(j) The General Counsel, or any other individual specifically authorized to act on behalf of the General Counsel, shall have the authority to grant or deny a request for information submitted under this section. The General Counsel or such authorized representative shall, within 20 working days following the receipt of a request, except as provided in paragraph (k)(1) of this section, make a determination granting or denying the request and notify the requester of his or her decision, and if a denial, the reasons therefor. The requester shall be further advised that a total or partial denial may be appealed to the Board as provided in paragraph (k) of this section. Additionally, any grant shall contain a statement notifying the requester of the assistance available from the RRB's FOIA Public Liaison, and any denial shall contain a statement notifying the requester of the assistance available from the RRB's FOIA Public Liaison and the dispute resolution services offered by the National Archives and

Records Administration's (NARA's) Office of Government Information Services (OGIS).

(k) In cases where a request for information is denied, in whole or in part, by the General Counsel or his or her authorized representative, the party who originally made the request may appeal such determination to the Board by filing a written appeal with the Secretary of the Board within 90 working days following receipt of the notice of denial. The Board shall render a decision on an appeal within 20 working days following receipt of the appeal except as provided in paragraph (k)(1) of this section. The requester shall promptly be notified of the Board's decision and, in cases where the denial is upheld, of the provisions for judicial review of such final administrative decisions.

(1) In unusual circumstances, as enumerated in section 552(a)(6)(B) of title 5, United States Code, the time restrictions of paragraphs (j) and (k) of this section may be extended in the aggregate by no more than 10 days by notice to the requester of such extension, the reasons therefor, and the date on which a determination is expected to be dispatched.

(2) For purposes of paragraphs (j) and (k) of this section, a request shall be received by the General Counsel of the RRB when it arrives at the RRB's headquarters. *Provided, however,* That when the estimated fee to be assessed for a given request exceeds $30.00, such request shall be deemed not to have been received by the General Counsel until the requester is advised of the estimated cost and agrees to bear it. *Provided further,* That a request which does not fully comply with all the provisions of paragraph (h) of this section shall be deemed to have been received by the General Counsel on the day it actually reaches his or her office.

(l) Any person in the employ of the Railroad Retirement Board who receives a request for any information, document or record of this agency, or in the custody thereof, shall advise the requester to address such request to the General Counsel. If the request received is in writing, it shall be immediately referred for action to the General Counsel.

(m) The General Counsel shall maintain records of:

(1) The total amount of fees collected by this agency pursuant to this section;

(2) The number of initial denials of requests for records made pursuant to this section and the reason for each;

(3) The number of appeals from such denials and the result of each appeal, together with the reason(s) for the action upon each appeal that results in a denial of information;

(4) The name(s) and title(s) or position(s) of each person responsible for each initial denial of records requested and the number of instances of action on a request for information for each such person;

(5) The results of each proceeding conducted pursuant to section 552(a)(4)(F) of title 5 U.S. Code, including a report of any disciplinary action against an official or employee who was determined to be primarily responsible for improperly withholding records, or an explanation of why disciplinary action was not taken;

(6) Every rule made by this agency affecting or in implementation of section 552 of title 5 U.S. Code;

(7) The fee schedule for copies of records and documents requested pursuant to this regulation; and

(8) All other information which indicates efforts to administer fully the letter and spirit of section 552 of title 5 U.S. Code.

(n) The RRB shall, prior to February 1 of each year, prepare and submit a report to the Attorney General of the United States covering each of the categories of records maintained in accordance with the foregoing for the preceding fiscal year.

(o) *Special procedures for handling requests for business information.* (1) The Freedom of Information Act exempts from mandatory disclosure matters that are ''trade secrets and commercial or financial information obtained from a person and privileged or confidential * * *.'' The Board maintains records that may include information within this exception and to protect the rights of submitters of business information with respect to the confidentiality of such information, all requests for records or information contained in

contract bids, contract proposals, contracts, and similar business information documents shall be handled in accordance with the procedures established by this paragraph.

(2) When the General Counsel or an individual authorized to grant or deny requests under the Freedom of Information Act receives a request for business information, the General Counsel or other individual shall promptly provide the person who submitted the information to the RRB with written notice that a request for the information has been made. The notice shall specify what record or information has been requested and shall inform the business submitter that the submitter may, within ten working days after the date of the notice, file a written objection to disclosure of the information or portions of the information. The written objection to disclosure shall be addressed to the individual whose name appears in the notification and shall specify the portion or portions of the information that the submitter believes should not be disclosed and state the grounds or bases for objecting to disclosure of such portion or portions. No written notice to the business submitter shall be required under this subparagraph if it is readily determined that the information will not be disclosed or that the information has lawfully been published or otherwise made available to the public.

(3) In determining whether to grant or deny the request for the business information, the official or entity making the determination shall carefully consider any objection to disclosure made by the submitter of the information in question.

(4) If a determination is made to disclose information with respect to which the business submitter has filed an objection to disclosure, the official or entity making the determination shall, no later than ten working days prior to the date on which disclosure of the information will be made, provide the submitter with written notice of the determination to disclose. The written notice shall state the reasons why the submitter's grounds for objecting to disclosure were rejected and inform the submitter of the date on which the information is to be disclosed.

(5) The RRB shall promptly notify the business submitter of any suit commenced under the Freedom of Information Act to compel disclosure of information which he or she submitted to the RRB.

(p) *Custom tailored information services; Fees charged.* This paragraph (p) and paragraph (q) of this section set forth the policy of the Railroad Retirement Board with respect to the assessment of a fee for providing custom tailored information where requested. Except as provided in paragraphs (p)(4)(vii) and (q) of this section, a fee shall be charged for providing custom tailored information.

(1) *Definition: Custom tailored information.* Custom tailored information is information not otherwise required to be disclosed under this part but which can be created or extracted and manipulated, reformatted, or otherwise prepared to the specifications of the requester from existing records. For example, the RRB needs to program computers to provide data in a particular format or to compile selected items from records, provide statistical data, ratios, proportions, percentages, etc. If this data is not already compiled and available, the end product would be the result of custom tailored information services.

(2) *Providing custom tailored information.* The RRB is not required to provide custom tailored information. It will do so only when the appropriate fees have been paid as provided in paragraph (p)(4) of this section and when the request for such information will not divert staff and equipment from the RRB's primary responsibilities.

(3) *Requesting custom tailored information.* Information may be requested in person, by telephone, or by mail. Any request should reasonably describe the information wanted and may be sent to the General Counsel, Railroad Retirement Board, Room 836, 844 N. Rush Street, Chicago, Illinois 60611–1275.

(4) *Fee schedule.* Requests for custom tailored information are chargeable according to the following schedule:

(i) *Manual searching for records.* Full cost of the time of the employees who perform the service, even if records

cannot be found, management and supervisory costs, plus the full costs of any machine time and materials the employee uses. Consulting and other indirect costs will be assessed as appropriate.

(ii) *Photocopying or reproducing records on magnetic tapes or computer diskettes.* The charge for making photocopies of any size document shall be $.10 per copy per page. The charge for reproducing records on magnetic tapes or computer diskettes is the full cost of the operator's time plus the full cost of the machine time and the materials used.

(iii) *Use of electronic data processing equipment to obtain records.* Full cost for the service, including computer search time and computer runs and printouts, and the time of computer programmers and operators and of other employees.

(iv) *Certification or authentication.* Full cost of certification and authentication.

(v) *Providing other special services.* Full cost of the time of the employee who performs the service, management and supervisory costs, plus the full costs of any machine time and materials the employee uses. Consulting and other indirect costs will be assessed as appropriate.

(vi) *Special forwarding arrangements.* Full cost of special arrangements for forwarding material requested.

(vii) *Statutory supersession.* Where a Federal statute prohibits the assessment of a charge for a service or addresses an aspect of that charge, the statute shall take precedence over this paragraph (p).

(q) *Assessment of a fee with respect to the provision of custom tailored information where the identification of the beneficiary is obscure and where provision of the information can be seen as benefiting the public generally.* When the identification of a specific beneficiary with respect to the provision of custom tailored information is obscure, the service can be considered primarily as benefiting broadly the general public, and the estimated cost of providing the information is less than $1,000.00, the General Counsel shall determine whether or not a fee is to be charged. In any such case where the cost is $1,000.00 or more, the request shall be referred by the Director of Administration to the three-member Board for a determination whether or not a fee is to be assessed.

[Board Order 6784, 32 FR 9651, Sept. 4, 1967. Redesignated at 52 FR 11010, Apr. 6, 1987]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 200.4, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 200.5 Protection of privacy of records maintained on individuals.

(a) *Purpose and scope.* The purpose of this section is to establish specific procedures necessary for compliance with the Privacy Act of 1974 (Pub. L. 93–579). These regulations apply to all record systems containing information of a personal or private nature maintained by the Railroad Retirement Board that are indexed and retrieved by personal identifier.

(b) *Definitions*—(1) *Individual.* The term ''individual'' pertains to a natural person who is a citizen of the United States or an alien lawfully admitted for permanent residence and not to a company or corporation.

(2) *System of records.* For the purposes of this section, the term ''system of records'' pertains to only those records that can be retrieved by an individual identifier.

(3) *Railroad Retirement Board.* For purposes of this section, the term ''Railroad Retirement Board'' refers to the United States Railroad Retirement Board, an independent agency in the executive branch of the United States Government.

(4) *Board.* For purposes of this section the term ''Board'' refers to the three member governing body of the United States Railroad Retirement Board.

(c) *Procedure for requesting the existence of personally identifiable records in a record system.* An individual can determine if a particular record system maintained by the Railroad Retirement Board contains any record pertaining to him by submitting a written request for such information to the system manager of that record system as described in the annual notice published in the FEDERAL REGISTER. A current copy of the system notices, published in accordance with paragraph (i)

of this section, is available for inspection at all regional and district offices of the Board. If necessary, Board personnel will aid requesters in determining what system(s) of records they wish to review and will forward any requests for information to the appropriate system manager. Also, requests for personal information may be submitted either by mail or in person to the system manager at the headquarters of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. Prior to responding to a request for information under this subsection, the system manager shall require the individual requesting such information to provide identifying data, such as his full name, date of birth, and social security number. The system manager shall respond to a request under this subsection within a reasonable time by stating that a record on the individual either is or is not contained in the system.

(d) *Disclosure of requested information to individuals.* (1) Upon request, an individual shall be granted access to records pertaining to himself, other than medical records and records compiled in anticipation of a civil or criminal action or proceeding against him, which are indexed by individual identifier in a particular system of records. Requests for access must be in writing and should be addressed to the system manager of that record system as described in the annual notice published in the FEDERAL REGISTER. Requests under this subsection may be submitted either by mail or in person at the headquarters offices of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611.

(2) The system manager shall, within ten working days following the date on which the request is received in his office, render a decision either granting or denying access and shall promptly notify the individual of his decision. If the request is denied, the notification shall inform the individual of his right to appeal the denial to the Board. An individual whose request for access under this subsection has been denied by the system manager may appeal that determination to the Board by filing a written appeal with the Secretary of the Board, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611 within twenty working days following receipt of the notice of denial. The Board shall render a decision on an appeal within thirty working days following the date on which the appeal is received in the office of the Secretary of the Board. The individual shall promptly be notified of the Board's decision.

(3) In cases where an individual has been granted access to his records, the system manager shall, prior to releasing such records, require the individual to produce identifying data such as his name, date of birth, and social security number.

(4) Disclosure to an individual of his record may be made by providing him, upon written request therefor, a copy of the record or portion thereof which he reasonably describes in his request.

(5) An individual, and if such individual so desires, one other person of his choosing, may review and have a copy made of his record (in a form comprehensible to him) during regular business hours at the location described as the repository of the record system containing such records in the annual notice published in the FEDERAL REGISTER or at such other location convenient to the individual as specified by the system manager. If an individual is accompanied by another person, the system manager may require written authorizations for disclosure in the presence of the other person from the individual before any record or portion thereof is released.

(e) *Special procedures—medical records.* (1) An individual concerning whom the Railroad Retirement Board maintains medical records in a system of records shall, upon written request, be permitted to review such medical records or be furnished copies of such records if the system manager of the system containing the requested records determines that disclosure of the records or any portion thereof would not be harmful to the individual's mental or physical health.

(2) If, upon review of the medical records requested, the system manager determines that disclosure of such records or any portion thereof might be harmful to the individual's mental or

physical health, he shall inform the individual that copies of the records may be furnished to a physician of the individual's own choosing. If the individual should select a physician to conduct such a review and direct the Board to permit the physician to review the records, the system manger shall promptly forward copies of the records in question to that physician. The system manger shall inform the physician that the records are being provided to him or her for the purpose of making an independent determination as to whether release or the records directly to the individual who has requested them might be harmful to that individual. The physician shall be informed that if, in his or her opinion, direct disclosure of the records would not be harmful to the individual's mental or physical health, he or she may then provide the copies to the individual. The physician shall further be informed that should he or she determine that disclosure of the records in question might be harmful to the individual, such records shall not be disclosed and should be returned to the Board, but the physician may summarize and discuss the contents of the records with the individual.

(3) The special procedure established by paragraph (e) of this section to permit an individual access to medical records pertaining to himself or herself shall not be construed as authorizing the individual to direct the Board to disclose such medical records to any third parties, other than to a physician in accordance with paragraph (e)(2) of this section. Medical records shall not be disclosed by the Board to any entities or persons other than the individual to whom the record pertains or his or her authorized physician regardless of consent, except as permissible under paragraphs (j)(1)(i), (iii), and (viii) of this section and as provided under paragraph (e)(4) of this section.

(4) Notwithstanding the provisions of paragraphs (e)(1), (2) and (3) of this section and of paragraph (d) of this section, if a determination made with respect to an individual's claim for benefits under the Railroad Retirement Act of the Railroad Unemployment Insurance Act is based in whole or in part on medical records, disclosure of or access to such medical records shall be granted to such individual or to such individual's representative when such records are requested for the purpose of contesting such determination either administratively of judicially.

(5) The procedures for access to medical records set forth in paragraph (e) of this section shall not apply with respect to requests for access to an individual's disability decision sheet or similar adjudicatory documents, access to which is governed solely by paragraph (d) of this section.

(f) *General exemptions*—(1) *Systems of records subject to investigatory material exemption under 5 U.S.C. 552a(j)(2).* RRB–43, Investigation Files, a system containing information concerning alleged violations of law, regulation, or rule pertinent to the administration of programs by the RRB or alleging misconduct or conflict of interest on the part of RRB employees in the discharge of their official duties.

(2) *Scope of exemption.* (i) The system of records identified in this paragraph is maintained by the Office of Investigations (OI) of the Office of Inspector General (OIG), a component of the Board which performs as its principal function activities pertaining to the enforcement of criminal laws. Authority for the criminal law enforcement activities of the OIG's OI is the Inspector General Act of 1978, 5 U.S.C. App.

(ii) Applicable information in the system of records described in this paragraph is exempt from subsections (c)(3) and (4) (Accounting of Certain Disclosures), (d) (Access to Records), (e)(1), (2), (3), (4)(G), (H), and (I), (5), and (8), (Agency Requirements), (f) (Agency Rules) and (g) (Civil Remedies) of 5 U.S.C. 552a.

(iii) To the extent that information in this system of records does not fall within the scope of this general exemption under 5 U.S.C. 552(j)(2) for any reason, the specific exemption under 5 U.S.C. 552(k)(2) is claimed for such information. (See paragraph (g) of this section.)

(3) *Reasons for exemptions.* The system of records described in this section is exempt for one or more of the following reasons:

(i) 5 U.S.C. 552a(c)(3) requires an agency to make available to the individual named in the records, at his or her request, an accounting of each disclosure of records. This accounting must state the date, nature, and purpose of each disclosure of a record and the name and address of the recipient. Accounting of each disclosure would alert the subjects of an investigation to the existence of the investigation and the fact that they are subjects of an investigation. The release of such information to the subjects of an investigation would provide them with significant information concerning the nature of the investigation, and could seriously impede or compromise the investigation and lead to the improper influencing of witnesses, the destruction of evidence, or the fabrication of testimony.

(ii) 5 U.S.C. 552a(c)(4) requires an agency to inform any person or other agency about any correction or notation of dispute made by the agency in accordance with subsection (d) of the Act. Since the RRB is claiming that this system of records is exempt from subsection (d) of the Act, concerning access to records, this section is inapplicable and is exempted to the extent that this system of records is exempted from subsection (d) of the Act.

(iii) 5 U.S.C. 552a(d) requires an agency to permit an individual to gain access to records pertaining to him or her, to request amendment of such records, to request a review of an agency decision not to amend such records, and to contest the information contained in such records. Granting access to records in this system of records could inform the subject of the investigation of an actual or potential criminal violation of the existence of that investigation, of the nature and scope of the information and evidence obtained as to his or her activities, of the identity of confidential sources, witnesses, and law enforcement personnel, and could provide information to enable the subject to avoid detection or apprehension. Granting access to such information could seriously impede or compromise an investigation, lead to the improper influencing of witnesses, the destruction of evidence, or the fabrication of testimony, and disclose investigative techniques and procedures.

(iv) 5 U.S.C. 552a(e)(1) requires each agency to maintain in its records only such information about an individual as is relevant and necessary to accomplish a purpose required by statute or executive order of the President. The application of this provision could impair investigations and law enforcement, because it is not always possible to detect the relevance or necessity of specific information in the early stages of an investigation. Relevance and necessity are often questions of judgment and timing, and it is only after the information is evaluated that the relevance and necessity of such information can be established.

(v) 5 U.S.C. 552a(e)(2) requires an agency to collect information to the greatest extent practicable directly from the subject individual when the information may result in adverse determinations about an individual's rights, benefits, and privileges under Federal programs. The application of this provision could impair investigations and law enforcement by alerting the subject of an investigation of the existence of the investigation, enabling the subject to avoid detection or apprehension, to influence witnesses improperly, to destroy evidence, or to fabricate testimony. Moreover, in certain circumstances the subject of an investigation cannot be required to provide information to investigators, and information must be collected from other sources. Furthermore, it is often necessary to collect information from sources other than the subject of the investigation to verify the accuracy of the evidence collected.

(vi) 5 U.S.C. 552a(e)(3) requires an agency to inform each person whom it asks to supply information, on a form that can be retained by the person, of the authority under which the information is sought and whether disclosure is mandatory or voluntary; of the principal purposes for which the information is intended to be used; of the routine uses which may be made of the information; and of the effects on the person, if any, of not providing all or any part of the requested information. The application of this provision could provide the subject of an investigation

with substantial information about the nature of that investigation.

(vii) 5 U.S.C. 552a(e)(4)(G) and (H) require an agency to publish a FEDERAL REGISTER notice concerning its procedures for notifying an individual at his request if the system of records contains a record pertaining to him or her, how he or she can gain access to such a record, and how he or she can contest its contents. Since the RRB is claiming that the system of records is exempt from subsection (f) of the Act, concerning agency rules, and subsection (d) of the Act, concerning access to records, these requirements are inapplicable and are exempted to the extent that these systems of records are exempted from subsections (f) and (d) of the Act. Although the RRB is claiming exemption from these requirements, RRB has published such a notice concerning its notification, access, and contest procedures because, under certain circumstances, RRB might decide it is appropriate for an individual to have access to all or a portion of his or her records in this system of records.

(viii) 5 U.S.C. 552a(e)(4)(I) requires an agency to publish in the FEDERAL REGISTER notice concerning the categories of sources or records in the system of records. Exemption from this provision is necessary to protect the confidentiality of the sources of information, to protect the privacy of confidential sources and witnesses, and to avoid the disclosure of investigative techniques and procedures. Although RRB is claiming exemption from this requirement, RRB has published such a notice in broad generic terms in the belief that this is all subsection (e)(4)(I) of the Act requires.

(ix) 5 U.S.C. 552a(e)(5) requires an agency to maintain its records with such accuracy, relevance, timeliness, and completeness as is reasonably necessary to assure fairness to the individual in making any determination about the individual. Since the Act defines ''maintain'' to include the collection of information, complying with this provision would prevent the collection of any data not shown to be accurate, relevant, timely, and complete at the moment it is collected. In collecting information for criminal law enforcement purposes, it is not possible to determine in advance what information is accurate, relevant, timely, and complete. Facts are first gathered and then placed into a logical order to prove or disprove objectively the criminal behavior of an individual. Material which may seem unrelated, irrelevant, or incomplete when collected may take on added meaning or significance as the investigation progresses. The restrictions of this provision could interfere with the preparation of a complete investigative report, thereby impending effective law enforcement.

(x) 5 U.S.C. 552a(e)(8) requires an agency to make reasonable efforts to serve notice on an individual when any record on such individual is made available to any person under compulsory legal process when such process becomes a matter of public record. Complying with this provision could prematurely reveal an ongoing criminal investigation to the subject of the investigation.

(xi) 5 U.S.C. 552a(f)(1) requires an agency to promulgate rules which shall establish procedures whereby an individual can be notified in response to his or her request if any system of records named by the individual contains a record pertaining to him or her. The application of this provision could impede or compromise an investigation or prosecution if the subject of an investigation was able to use such rules to learn of the existence of an investigation before it could be completed. In addition, mere notice of the fact of an investigation could inform the subject or others that their activities are under or may become the subject of an investigation and could enable the subjects to avoid detection or apprehension, to influence witnesses improperly, to destroy evidence, or to fabricate testimony. Since the RRB is claiming that these systems of records are exempt from subsection (d) of the Act, concerning access to records, the requirements of subsections (f)(2) through (5) of the Act, concerning agency rules for obtaining access to such records, are inapplicable and are exempted to the extent that this system of records is exempted from subsection (d) of the Act. Although RRB is

claiming exemption from the requirements of subsection (f) of the Act, RRB has promulgated rules which establish Agency procedures because, under certain circumstances, it might be appropriate for an individual to have access to all or a portion of his or her records in this system of records. These procedures are described elsewhere in this part.

(xii) 5 U.S.C. 552a(g) provides for civil remedies if an agency fails to comply with the requirements concerning access to records under subsections (d)(1) and (3) of the Act; maintenance of records under subsection (e)(5) of the Act; and any rule promulgated thereunder, in such a way as to have an adverse effect on an individual. Since the RRB is claiming that this system of records is exempt from subsections (c)(3) and (4), (d), (e)(1), (2), (3), (4)(G), (H), and (I), (5), and (8), and (f) of the Act, the provisions of subsection (g) of the Act are inapplicable and are exempted to the extent that this system or records is exempted from those subsections of the Act.

(g) *Specific exemptions*—(1) *Systems of records subject to investigatory material exemption under 5 U.S.C. 552a(k)(2).* RRB–43, Investigation Files, a system containing information concerning alleged violations of law, regulation, or rule pertinent to the administration of programs by the RRB or alleging misconduct or conflict of interest on the part of RRB employees in the discharge of their official duties.

(2) *Privacy Act provisions from which exempt.* The system of records described in this paragraph is exempt from subsections (c)(3) (Accounting of Certain Disclosures), (d) (Access to Records), (e)(1), 4G, H, and I (Agency Requirements), and (f) (Agency Rules) of 5 U.S.C. 552a.

(3) *Reasons for exemptions.* The system of records described in this section is exempt for one or more of the following reasons:

(i) To prevent the subject of the investigations from frustrating the investigatory process.

(ii) To protect investigatory material compiled for law enforcement purposes.

(iii) To fulfill commitments made to protect the confidentiality of sources and to maintain access to necessary sources of information.

(iv) To prevent interference with law enforcement proceedings.

(h) *Request for amendment of a record.* (1) An individual may request that a record pertaining to himself be amended by submitting a written request for such amendment to the system manager as described in the annual notice published in the FEDERAL REGISTER. Requests under this subsection may be made either by mail or in person at the headquarters offices of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. Such a request should include a statement of the information in the record which the individual believes is incorrect, a statement of any information not in the record which the individual believes would correct the record, if included, and a statement of any evidence which substantiates the individual's belief concerning the inaccuracy of the information presently contained in the record.

(2) Prior to rendering a determination in response to a request under this subsection, the system manager shall require that the individual provide identifying data such as his name, date of birth, and social security number.

(3) The system manager responsible for the system of records which contains the challenged record shall acknowledge receipt of the request in writing within ten working days following the date on which the request for amendment was received in his office and shall promptly render a decision either granting or denying the request.

(i) If the system manager grants the individual's request to amend his record, the system manager shall amend the record accordingly, advise the individual in writing that the requested amendment has been made and where an accounting of disclosures has been made, advise all previous recipients of the record to whom disclosure of such record was made and accounted for of the fact that the amendment was made and the substance of the amendment.

(ii) If the system manager denies the individual's request to amend his

record, the system manager shall inform the individual that the request has been denied in whole or in part, the reason for the denial and the procedure regarding the individual's right to appeal the denial to the Board.

(i) *Appeal of initial adverse determination on amendment.* (1) An individual, whose request for amendment of a record pertaining to him is denied, may appeal that determination to the Board by filing a written appeal with the Secretary of the Board, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. The written notice of appeal should include a statement of the information in the record which the individual believes is correct, a statement of any information not in the record which the individual believes would correct the record, if included, and a statement of any evidence which substantiates the individual's belief concerning the inaccuracy of the information presently contained in the record.

(2) The Board shall consider the appeal and render a final decision thereon within thirty working days following the date on which the appeal is received in the office of the Secretary of the Board. An extension of the thirty day response period is permitted for a good cause upon notification of such to the requester.

(3) If, upon consideration of the appeal, the Board upholds the denial, the appellant shall be so informed in writing. The appellant shall be advised that he may file a concise statement with the Board setting forth his reasons for disagreeing with the Board's decision and the procedures to be followed in filing such a statement of disagreement. The individual shall also be informed of his right to judicial review as provided under section 552a(g)(1)(A) of title 5 of the United States Code. If disclosure has or will be made of a record containing information about which an individual has filed a statement of disagreement, that contested information will be annotated and a copy of the statement of disagreement will be provided to past and future recipients of the information along with which the Board may include a statement of its reasons for not amending the record in question.

(4) If, upon consideration of the appeal, the Board reverses the denial, the Board shall amend the record, advise the appellant in writing that such amendment has been made, and where an accounting of disclosures has been made, advise all previous recipients of the record to whom disclosure of such was made and accounted for, of the fact that the amendment was made and the substance of the amendment.

(j) *Disclosure of record to person other than the individual to whom it pertains.* (1) Records collected and maintained by the Railroad Retirement Board in the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act which contain information of a personal or private nature shall not be disclosed to any person or to another agency without the express written consent of the individual to whom the record pertains. Such written consent shall not be required if the disclosure is not otherwise prohibited by law or regulation and is:

(i) To officers or employees of the Railroad Retirement Board who, in the performance of their official duties, have a need for the record;

(ii) Required under section 552 of title 5 of the U.S. Code;

(iii) For a routine use of such record as published in the annual notice in the FEDERAL REGISTER;

(iv) To the Bureau of the Census for uses pursuant to the provisions of title 13 of the United States Code;

(v) To a recipient who has provided the Board with advance written assurance that the record will be used solely as a statistical or research record, and the record is to be transferred in a form that is not individually identifiable;

(vi) To the National Archives of the United States as a record which has sufficient historical or other value to warrant its continued preservation by the U.S. Government or for evaluation by the administrator of General Services or his designee to determine whether the record has such value;

(vii) To another agency or to an instrumentality of any governmental jurisidiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if

the head of the agency or instrumentality has made a written request to the agency which maintains the record specifying the particular portion desired and the law enforcement activity for which the record is sought;

(viii) To a person pursuant to a showing of compelling circumstances affecting the health or safety of an individual if, upon such disclosure, notification is transmitted to the last known address of such individual;

(ix) To either House of Congress, or, to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee;

(x) To the Comptroller General, or any of his authorized representatives, in the course of the performance of the duties of the General Accounting Office; or

(xi) Pursuant to the order of a court of competent jurisdiction.

(2) The Railroad Retirement Board shall maintain an accounting of all disclosures of records made under paragraph (h)(1) of this section, except those made under paragraphs (h)(1)(i) and (ii) of this section. This accounting will include:

(i) Date of disclosure;

(ii) Specific subject matter of disclosure;

(iii) Purpose of disclosure; and

(iv) Name and address of the person or agency to whom the information has been released.

The Railroad Retirement Board shall maintain the accounting for five years or the life of the system of records, whichever is longer, and make such accounting, with the exception of disclosures made under paragraph (h)(1)(vii) of this section, available to the individual to whom the record pertains upon his request. If, subsequent to disclosure of a record for which disclosure an accounting has been made pursuant to this subsection, an amendment is made to that record or an individual has filed a statement of disagreement concerning that record, the person or agency to whom such disclosure was made shall be notified of the amendment or statement of disagreement.

(k) *Annual notice of systems of records.* The Railroad Retirement Board shall publish in the FEDERAL REGISTER on an annual basis a listing of the various systems of records which it maintains by individual identifier. That notice shall provide the following for each system:

(1) The name and location of the system;

(2) The categories of individuals on whom records are maintained in the system;

(3) The routine uses of the system;

(4) The methods of storage, disposal, retention, access controls and retrievability of the system;

(5) The title and business address of the individual who is responsible for the system;

(6) The procedure whereby an individual can be notified at his request whether or not the system contains a record pertaining to him;

(7) The procedure whereby the individual can be notified at his request how he can gain access to any record pertaining to him which is contained in the system;

(8) How the individual can contest the contents of such a record; and

(9) The categories of sources of records in the system.

(l) *Collection of information and maintenance of records.* With respect to each system of records indexed by individual identifer which is maintained by the Railroad Retirement Board, the Railroad Retirement Board shall:

(1) Maintain in each system only such information about an individual as is relevant and necessary in accomplishing the purposes for which the system is kept;

(2) To the greatest extent practicable, collect information directly from the individual when that information may result in an adverse determination about such individual's rights, benefits or privileges under programs administered by the Railroad Retirement Board;

(3) Inform each individual who is asked to supply information:

(i) The authority under which the solicitation of such information is carried out;

(ii) Whether disclosure of the requested information is mandatory or voluntary and any penalties for failure to furnish such information;

(iii) The principal purposes for which the information will be used;

(iv) The routine uses and transfers of such information; and

(v) The possible effects on such individual if he fails to provide the requested information.

(4) Maintain all records which are used by the Railroad Retirement Board in making any determination about any individual with such accuracy, relevance, timeliness and completeness as is reasonably necessary to assure fairness to the individual in the determination;

(5) Prior to disseminating any record about an individual to any person other than an agency, unless the dissemination is made pursuant to paragraph (h)(1)(ii) of this section, make reasonable efforts to assure that such records are accurate, complete, timely and relevant for purposes of the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act;

(6) Maintain no record describing how any individual exercises rights guaranteed by the First Amendment unless expressly authorized by statute or by the individual to whom the record pertains or unless pertinent to and within the scope of an authorized law enforcement activity;

(7) Make reasonable efforts to serve notice on an individual when any record on such individual is made available to any person under compulsory legal process when such process becomes a matter of public record; and

(8) At least thirty days prior to publication of information under paragraph (i) of this section, publish in the FEDERAL REGISTER notice of any new use or intended use of the information in the system and provide an opportunity for interested persons to submit written data, views or arguments to the Railroad Retirement Board.

(m) *Fees.* The Railroad Retirement Board may assess a fee for copies of any records furnished to an individual under paragraph (d) of this section. The fees for copies shall be $.10 per copy per page, not to exceed the actual cost of reproduction, and should be paid to the Director of Budget and Fiscal Operations for deposit to the Railroad Retirement Account. If payment is made by check, the check should be payable to the order of the Railroad Retirement Board. Any fee of less than $10 may be waived by the system manager if he determines that it is in the public interest to do so.

(n) *Government contractors.* When the Railroad Retirement Board provides by a contract or by a subcontract subject to its approval for the operation by or on behalf of the Railroad Retirement Board of a system of records to accomplish an agency function, the Railroad Retirement Board shall, consistent with its authority, cause the requirements of section 552a of title 5 of the United States Code to be applied to such system. In each such contract or subcontract for the operation of a system of records, entered into on or after September 27, 1975, the Railroad Retirement Board shall cause to be included a provision stating that the contractors or subcontractors and their employees shall be considered employees of the Railroad Retirement Board for purposes of the civil and criminal penalties provided in sections (g) and (i) of the Privacy Act of 1974 (5 U.S.C. 552a (g) and (i)).

(o) *Mailing lists.* The Railroad Retirement Board shall neither sell nor rent information containing any individual's name or address, unless authorized by statute.

(p) *Disclosure of social security account numbers.* Whenever an individual is requested by the Railroad Retirement Board to disclose his social security account number he shall be informed as to whether such disclosure is mandatory or voluntary. If disclosure of the individual's social security account number is mandatory, he shall be informed of the statutory authority requiring such disclosure.

[41 FR 20580, May 19, 1976, as amended at 43 FR 17468, Apr. 25, 1978; 50 FR 27222, July 2, 1985. Redesignated at 52 FR 11010, Apr. 6, 1987, as amended at 53 FR 3198, Feb. 4, 1988; 54 FR 43055, Oct. 20, 1989]

§ 200.6 Open meetings.

(a) *Definitions*—(1) *Meeting.* For purposes of this section, the term ''meeting'' shall mean the deliberations of at least two of the three members of the Railroad Retirement Board, which deliberations determine or result in the

joint conduct or disposition of official agency business. The term ''meeting'' shall not include:

(i) Deliberations of the Board members concerning the closure of a meeting, the withholding of any information with respect to a meeting, the scheduling of a meeting, the establishment of the agenda of a meeting, or any change in the scheduling, agenda, or the open or closed status of a meeting; or

(ii) Consideration by the Board members of agency business circulated to them individually in writing for disposition by notation.

(2) *Public announcement.* For purposes of this section the term ''public announcement'' shall mean the posting of the notice of a scheduled meeting as required by this section on a bulletin board available to the public on the first floor of the Board's headquarters building located at 844 Rush Street, Chicago, Illinois 60611.

(b)(1) The members of the Board shall not jointly conduct or dispose of agency business except in accordance with the procedures and requirements established by this section. *Provided, however*, That nothing in this section shall be construed so as to prohibit the Board from disposing of routine or administrative matters by sequential, notational voting.

(2) Where agency business is disposed of by notational voting as provided in paragraph (b)(1) of this section, the minutes of the next succeeding Board meeting shall reflect such action.

(3) Every portion of every meeting of the Board at which agency business is conducted or disposed of shall be open to public observation, except as provided in paragraph (c) of this section.

(c)(1) Except as provided in this section, every portion of every meeting of the Board shall be open to the public. A meeting or a portion of a meeting may be closed where (i) the Board properly determines that the subject matter of the meeting or portion thereof is such as to make it likely that disclosure of matters falling within one or more of the exceptions set out in paragraph (c)(3) of this section would result, and (ii) the Board determines that the public interest would not require that the meeting or portion thereof be open to the public.

(2) The requirements of paragraphs (d) and (e) of this section shall not apply to information pertaining to a meeting which would otherwise be required to be disclosed to the public under this section where the Board properly determines that the disclosure of the information is likely to disclose matters within the exceptions listed in paragraph (c)(3) of this section, and that the public interest would not require that the matters, even though excepted, should be disclosed.

(3) The Board may close a meeting or a portion thereof and may withhold information concerning the meeting or portion thereof, including the explanation of closure, the description of the subject matter of the meeting, and the list of individuals expected to attend, which otherwise would be required to be made public under paragraphs (d) and (e) of this section, where it has determined, as provided in paragraphs (c)(1) and (2) of this section, where it has determined, as provided in paragraphs (c)(1) and (2) of this section, that the public interest would not otherwise require that the meeting or portion thereof be open or that the information be made public, and that the meeting, or portion thereof, or the disclosure of the information is likely to:

(i) Disclose matters that are (A) specifically authorized under criteria established by Executive Order to be kept secret in the interests of national defense or foreign policy and (B) in fact properly classified pursuant to such executive order;

(ii) Relate solely to the internal personnel rules and practices of the Board;

(iii) Disclose matters exempted from disclosure under 45 U.S.C. 362(d) and 362(n) and 45 U.S.C. 231f(b)(3) or disclose matters specifically exempted from disclosure by any other statute (other than 5 U.S.C 552), *Provided*, That such other statute either requires that the matters be withheld from the public in such a manner as to afford no discretion on the issue or establishes particular criteria for withholding or refers to particular types of matters to be withheld;

(iv) Disclose trade secrets and commercial or financial information obtained from a person and privileged or confidential;

(v) Involve accusing any person of a crime, or formally censuring any person;

(vi) Disclose information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(vii) Disclose investigatory records compiled for law enforcement purposes, or information which if written would be contained in such records, but only to the extent that the production of such records or information would

(A) Interfere with law enforcement proceedings,

(B) Deprive a person of a right to a fair trial or an impartial adjudication,

(C) Constitute an unwarranted invasion of personal privacy,

(D) Disclose the identity of a confidential source and, in the case of a record compiled by a criminal law enforcement authority in the course of a criminal investigation, or by an agency conducting a lawful national security intelligence investigation, confidential information furnished only by the confidential source,

(E) Disclose investigative techniques and procedures, or

(F) Endanger the life or physical safety of law enforcement personnel;

(viii) Disclose information the premature disclosure of which would be likely to significantly frustrate implementation of a proposed Board action, except that this paragraph shall not apply in any instance where the Board has already disclosed to the public the content or nature of its proposed action, or where the Board is required by law to make such disclosure on its own initiative prior to taking final agency action on such proposal; or

(ix) Specifically concern the agency's issuance of a subpoena, or the agency's participation in a civil action or proceeding, an action in a foreign court or international tribunal, or an arbitration, or the initiation, conduct, or disposition by the agency of a particular case of formal agency adjudication pursuant to the authority granted in 45 U.S.C. 231f and 45 U.S.C. 365.

(d)(1) Any action by the Board to close a meeting or a portion thereof, or to withhold any information pertaining to such meeting or portion thereof, shall be taken only upon the vote of at least two members of the Board that the meeting or portion thereof be closed or information withheld for one or more of the reasons set forth in paragraph (c)(3) of this section. A single vote may be taken with respect to a series of meetings, to close the meetings or portions thereof or to withhold information pertaining to such meetings, where the meetings or portions thereof involve the same subject matter and are scheduled within 30 calendar days after the date of the initial meeting in the series.

(2) The vote of each member of the Board participating in the vote on closure of a meeting or portion thereof shall be recorded. Vote by proxy shall not be allowed.

(3) A person whose interests might be directly affected by a meeting or portion thereof which otherwise would be open may request that the meeting or portion thereof which concerns such person's interests be closed under paragraphs (c)(3)(v), (vi), or (vii) of this section. The request should be directed to The Secretary, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611, and must be received no later than the beginning of the meeting to which it applies. Upon receipt of such a request the Board shall vote by recorded vote on the question as to whether the meeting or portion thereof should be closed.

(4) Within one day following a vote taken under paragraphs (d)(2) and (3) of this section, a copy of such vote showing the vote of each member shall be available for public inspection and copying in the office of the Secretary of the Board, located in the Board's headquarters office.

(5) If a meeting or portion thereof is closed in accordance with an action under paragraphs (d)(2) or (3) of this section, the Board shall, within one day following the vote, except to the extent such information is exempt from disclosure under paragraph (c) of this section, make available for inspection and copying in the office of the

Secretary of the Board a written explanation of the Board's action and a list of the persons expected to attend and their affiliations.

(e)(1) Except as to those meetings or portions of meetings scheduled as provided in paragraphs (d)(2) and (3) of this section, the Board shall for each meeting make public announcement at least one week prior thereto of the time, place and subject matter of the meeting, whether the meeting is to be open or closed to the public, and the name and telephone number of an official of the Railroad Retirement Board designated by the Board to respond to any requests from the public pertaining to the meeting.

(2) The requirement contained in paragraph (e)(1) of this section that the Board give one week advance notice of each meeting shall not apply where the Board determines by majority vote, which vote shall be recorded, that agency business requires that a meeting be scheduled at an earlier date. If a meeting is scheduled less than one week in the future, as provided in this paragraph, the Board shall make a public announcement at the earliest practicable time of the time, place and subject matter of the meeting and whether the meeting is to be open or closed to the public.

(3) The Board may change the time and place of a previously scheduled and announced meeting, but such change must be announced to the public at the earliest practicable time. The Board may change the subject matter, or its determination to open or close a meeting or portion thereof, of a previously scheduled and announced meeting only if (i) a majority of the Board determines by recorded vote that agency business requires the change and that no earlier public announcement of the change was possible, and (ii) the Board makes a public announcement of the change and the vote of each member thereon at the earliest practicable time.

(4) Immediately following each public announcement required by this subsection, the Board shall submit for publication in the FEDERAL REGISTER notice of the time, place, and subject matter of the meeting, whether the meeting is to be open or closed, any changes in such items from a previous announcement, and the name and telephone number of the Railroad Retirement Board official designated by the Board to respond to requests concerning the announced meeting.

(f)(1) Whenever the Board should determine to close a meeting or a portion of a meeting under any of the exemptions contained in paragraph (c)(3) of this section, the General Counsel of the Railroad Retirement Board shall, prior to the meeting, certify in writing that in his or her opinion the meeting or portion thereof may be closed to the public and shall state the applicable exemptions which permit closure. The Board shall maintain a copy of the General Counsel's certification and a copy of the statement of the presiding officer of the meeting setting forth the time and place of the meeting and a list of the persons present, other than those present merely as spectators.

(2) In the event that a meeting or any portion of a meeting is closed to the public, a complete transcript or recording shall be made of the meeting or portion thereof closed; *Provided, however,* That if the meeting or portion thereof is closed under paragraph (c)(3)(ix) of this section, a set of minutes may be made of the closed meeting or portion of a meeting in lieu of a complete transcript or recording thereof. If a set of minutes is the method chosen to record the proceedings of a meeting or portion thereof closed under paragraph (c)(3)(ix) of this section, such minutes shall fully and clearly describe the matters discussed. The minutes shall also fully reflect any actions taken by the Board, set forth a statement of the reasons for such actions, summarize each of the views expressed concerning such actions, identify any documents considered in connection with such agency actions, and show the vote of the Board and each of its members on such actions.

(3) The transcript, recording, or minutes of each meeting or portion thereof closed to the public shall be available for public inspection or listening in the office of the Secretary of the Board, 844 Rush Street, Chicago, Illinois 60611, no later than two weeks following the meeting. There shall be expunged or erased from the transcript, recording,

or minutes of each meeting which is made available to the public any items of discussion or testimony when it has been determined that they contain information which may be withheld under paragraph (c) of this section, and that the public interest would not require disclosure. The determination as to what items of discussion or testimony shall be expunged or erased from the copies of the transcript, recording, or minutes available to the public shall be made by the Secretary of the Board with the approval of the Board.

(4) Copies of transcripts, minutes, or transcriptions of recordings maintained by the Board as provided in paragraph (e)(3) of this section shall be provided to members of the public who request such copies, at the actual cost of duplicating or transcription. Requests for copies of transcripts, minutes or transcriptions of recordings should be in writing, addressed to the Secretary of the Board, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611, and should clearly indicate the date of the meeting or meetings for which such copies are requested. If the requester desires a copy of only a portion or portions of the transcript, minutes, or transcription of a specified meeting, the request should specify which portion or portions are desired.

(5) The Board shall maintain the complete transcript, recording, or minutes required to be made under paragraph (e)(2) of this section for a period of at least two years after the meeting, or for at least one year after the conclusion of any agency proceeding with respect to which the meeting or portion of the meeting was held, whichever occurs later.

(g) Nothing in this section shall expand or limit the rights of any person under 5 U.S.C. 552, and 20 CFR 200.3, except that the exemptions contained in paragraph (c) of this section shall govern in the case of any request under 5 U.S.C. 552 and 20 CFR 200.3 to copy, inspect, or obtain copies of transcripts, recordings, or minutes described in paragraph (f) of this section. Nothing in this section shall limit the rights of any individual under 5 U.S.C. 552a and 20 CFR 200.4 to gain access to any record which would be available to such individual under those provisions.

[42 FR 15312, Mar. 21, 1977, as amended at 42 FR 22865, Nov. 11, 1977. Redesignated at 52 FR 11010, Apr. 6, 1987]

§ 200.7 Assessment or waiver of interest, penalties, and administrative costs with respect to collection of certain debts.

(a) *Purpose.* The Debt Collection Act of 1982 requires the Board to charge interest on claims for money owed the Board, to assess penalties on delinquent debts, and to assess charges to cover the costs of processing claims for delinquent debts. The Act permits, and in certain cases requires, an agency to waive the collection of interest, penalties and charges under circumstances which comply with standards enunciated jointly by the Comptroller General and the Attorney General. Those standards are contained in 4 CFR 102.13. This section contains the circumstances under which the Board may either assess or waive interest, penalties, and administrative costs which arise from benefit or annuity overpayments made under any of the Acts which the Board administers.

(b)(1) Simple interest shall be assessed once a month on the unpaid principal of a debt.

(2) Interest shall accrue from the date on which notice of the debt and demand for repayment with interest is first mailed or hand-delivered to the debtor, or in the case of a debt which is subject to section 10(c) of the Railroad Retirement Act or section 2(d) of the Railroad Unemployment Insurance Act, interest shall accrue from the date that a denial of waiver of recovery is mailed or hand-delivered to the debtor or, if waiver has not been requested, upon the expiration of the time within which to request waiver, except as otherwise specified in this section.

(3) In the case of a lien for reimbursement of sickness benefits pursuant to part 341 of this chapter, interest on the amount of the lien shall accrue from the date of settlement or the entry of final judgment.

(4) The rate of interest assessed shall be the rate of the current value of funds to the U.S. Treasury (i.e., the Treasury tax and loan account rate) as

prescribed and published in the FEDERAL REGISTER and the Treasury Financial Manual Bulletins annually or quarterly, in accordance with 31 U.S.C. 3717.

(5) The rate of interest as initially assessed shall remain fixed for the duration of the indebtedness, except that where a debtor has defaulted on a repayment agreement and seeks to enter into a new agreement, a new interest rate may be assessed.

(c)(1) A penalty charge of 6 percent per year shall be assessed on any debt that is delinquent for more than 90 days.

(2) The penalty charge shall accrue from the date on which the debt became delinquent.

(3) A debt is delinquent if it has not been paid in full by the 30th day after the date on which the initial demand letter was first mailed or hand-delivered, or, if the debt is being repaid under an installment payment agreement, at any time after the debtor fails to satisfy his or her obligation for payment thereunder.

(4) In the case of a lien for reimbursement of sickness benefits pursuant to part 341 of this chapter, the amount of the lien is delinquent if it has not been paid in full by the 30th day after the date of settlement or entry of final judgment.

(d)(1) Charges shall be assessed against the debtor for administrative costs incurred as a result of processing and handling the debt because it became delinquent.

(2) Administrative costs include costs incurred in obtaining a credit report and in using a private debt collector.

(e) When a debt is paid in partial or installment payments, amounts received shall be applied first to outstanding penalty and administrative cost charges, second to accrued interest, and third to outstanding principal. Where a debtor is in default under an installment repayment agreement, uncollected interest, penalties and administrative cost charges which have accrued under the agreement shall be added to the principal to be paid under any new installment repayment agreement entered into between the Board and the debtor.

(f) *Exemptions.* The assessment of interest, penalties, and administrative costs under this section does not apply to debts under sections 2(f) and 8(g) of the Railroad Unemployment Insurance Act (45 U.S.C. 352(f) and 358(g)).

(g)(1) The Board shall waive the collection of interest under the following circumstances:

(i) When the debt is paid within thirty days after the date on which notice of the debt was mailed or personally delivered to the debtor,

(ii) When, in any case where a decision with respect to waiver of recovery of an overpayment must be made:

(A) The debt is paid within thirty days after the end of the period within which the debtor may request waiver of recovery, if no request for waiver is received within the prescribed time period; or

(B) The debt is paid within thirty days after the date on which notice was mailed to the debtor that his or her request for waiver of recovery has been wholly or partially denied if the debtor requested waiver of recovery within the prescribed time limit; however, regardless of when the debt is paid, no interest may be charged for any period prior to the end of the period within which the debtor may request waiver of recovery or, if such request is made, for any period prior to the date on which notice was mailed to the debtor that his or her request for waiver of recovery has been wholly or partially denied;

(iii) When, in the situations described in paragraphs (g)(1)(i) and (ii) of this section, the debt is paid within any extension of the thirty-day period granted by the Board;

(iv) With respect to any portion of the debt which is paid within the time limits described in paragraphs (g)(1)(i), (g)(1)(ii), or (g)(1)(iii) of this section; or

(v) In regard to any debt the recovery of which is waived.

(2) The Board may waive the collection of interest, penalties and administrative costs in whole or in part in the following circumstances:

(i) Where, in the judgment of the Board, collecting interest, penalty and administrative costs would be against equity and good conscience; or

(ii) Where, in the judgment of the Board, collecting interest, penalty and administrative costs would not be in the best interest of the United States.

(h)(1) In making determinations as to when the collection of interest, penalty and administrative costs is against equity and good conscience the Board will consider evidence on the following factors:

(i) The fault of the overpaid individual in causing the underlying overpayment; and

(ii) Whether the overpaid individual in reliance on the incorrect payment relinquished a valuable right or changed his or her position for the worse.

(2) In rendering a determination as to when the collection of interest, penalties and administrative costs is not in the best interest of the United States the Board will consider the following factors:

(i) Whether the collection of interest, penalties and administrative costs would result in the debt never being repaid; and

(ii) Whether the collection of interest, penalties and administrative costs would cause undue hardship.

(i) The Board shall waive the collection of interest, penalties, and administrative costs in any case where the debt to be recovered is being recovered by full or partial withholding of a current annuity payable under the Railroad Retirement Act and the debt was not incurred through fraud.

[52 FR 41559, Oct. 29, 1987, as amended at 59 FR 15049, Mar. 31, 1994; 67 FR 5723, Feb. 7, 2002]

§ 200.8 Disclosure of information obtained in the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act.

(a) *Purpose and scope.* The purpose of this section is to establish specific procedures necessary for compliance with section 12(d) of the Railroad Unemployment Insurance Act, which is incorporated into the Railroad Retirement Act by section 7(b)(3) of that Act. Except as otherwise indicated in this section, these regulations apply to all information obtained by the Railroad Retirement Board in connection with the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act.

(b) *Definitions—Agency.* The term *agency* refers to the Railroad Retirement Board, an independent agency in the executive branch of the United States Government.

Applicant. The term *applicant* means a person who signs an application for an annuity or lump-sum payment or unemployment benefits or sickness benefits for himself or herself or for some other person.

Beneficiary. The term *beneficiary* refers to an individual to whom a benefit is payable under either the Railroad Retirement Act or the Railroad Unemployment Insurance Act.

Board. The term *Board* refers to the three-member governing body of the Railroad Retirement Board.

Document. The term *document* includes correspondence, applications, claims, reports, records, memoranda and any other materials or data used, prepared, received or transmitted to, from, by or for the agency in connection with the administration of the Railroad Retirement Act or the Railroad Unemployment Insurance Act.

Information. The term *information* means any non-medical document or data which is obtained by the agency in the administration of the Railroad Retirement Act and/or the Railroad Unemployment Insurance Act. *Information* does not include the fact of entitlement to or the amount of a benefit under either of these Acts. Medical records are subject to the disclosure provisions set out in § 200.5(e) of this part.

Testify and testimony. The terms *testify* and *testimony* include both in-person oral statements before a court or a legislative or administrative body and statements made in the form of depositions, interrogatories, declarations, affidavits or other means of formal participation in such proceedings.

(c) *General rule.* Except as otherwise authorized by this section, information shall not be produced, disclosed, delivered or open to inspection in any manner revealing the identity of an employee, applicant or beneficiary unless the Board or its authorized designee finds that such production, disclosure,

delivery, or inspection is clearly in furtherance of the interest of the employee, applicant or beneficiary or of the estate of such employee, applicant, or beneficiary. Where no such finding is made, no information shall be released except in accordance with the provisions of § 200.5 of this part, unless release of such information is required by a law determined to supersede this general rule. In addition, regardless of whether or not such finding can be made, information which is compiled in anticipation of a civil or criminal action or proceeding against an applicant or beneficiary may not be released under this general rule.

(d) *Subpoenas—statement of policy and general rule.* (1) It is the policy of the Board to provide information, data, and records to non-Federal litigants to the same extent and in the same manner that they are available to the general public. The availability of Board employees to testify before state and local courts and administrative and legislative bodies, as well as in Federal court and administrative proceedings which involve non-Federal litigants, concerning information acquired in the course of performing their official duties or because of the employee's official capacity, is governed by the Board's policy of maintaining strict impartiality with respect to private litigants and minimizing the disruption of an employee's official duties. Thus, the Board may refuse to make an employee available for testimony under this paragraph or paragraph (e) or (f) of this section if it determines that the information sought is available other than through testimony and where making such employee available would cause disruption of agency operations. However, this paragraph does not apply to any civil or criminal proceeding where the United States, the Railroad Retirement Board, or any other Federal agency is a party; to Congressional requests or subpoenas for testimony; to consultative services and technical assistance provided by the Board or the agency in carrying out its normal program activities; to employees serving as expert witnesses in connection with professional and consultative services rendered as approved outside activities (in cases where employees are providing such outside services, they must state for the record that the testimony represents their own views and does not necessarily represent the official position of the agency); or to employees making appearances in their private capacity in legal or administrative proceedings that do not relate to the official business of the agency (such as cases arising out of traffic accidents, crimes, domestic relations, etc.) and not involving professional and consultative services as described above.

(2) No officer, agent, or employee of the agency is authorized to accept or receive service of subpoenas, summons, or other judicial process addressed to the Board or to the agency except as the Board may from time to time delegate such authority by power of attorney. The Board has issued such power of attorney to the Deputy General Counsel of the agency and to no one else.

(3) In the event the production, disclosure, or delivery of any information is called for on behalf of the United States or the agency, such information shall be produced, disclosed, or delivered only upon and pursuant to the advice of the Deputy General Counsel.

(4) When any member, officer, agent, or employee of the agency is served with a subpoena to produce, disclose, deliver, or furnish any information, he or she shall immediately notify the Deputy General Counsel of the fact of the service of such subpoena. Unless otherwise ordered by the Deputy General Counsel or his or her designee, he or she shall appear in response to the subpoena and respectfully decline to produce, disclose, deliver, or furnish the information, basing such refusal upon the authority of this section.

(e) *Subpoena duces tecum.* (1) When any document is sought from the agency by a subpoena duces tecum or other judicial order issued to the agency by a court of competent jurisdiction in a proceeding wherein such document is relevant, a copy of such document, certified by the Secretary to the Board to be a true copy, may be produced, disclosed, or delivered by the agency if, in

the judgment of the Board or its designee, such production is clearly in furtherance of the interest of the employee, applicant, or beneficiary to whom the document pertains, or is clearly in furtherance of the interest of the estate of such employee, applicant, or beneficiary, and such document does not consist of or include a report of medical information.

(2) When the production, diclosure, or delivery of any document described in paragraph (e)(1) of this section would not be permitted under the standards therein set forth, no member, officer, agent, or employee of the agency shall make any disclosure of or testify with respect to such document.

(f) *Requests for voluntary testimony.* All requests for testimony by a Board employee in his or her official capacity must be in writing and directed to the Deputy General Counsel. They shall state the nature of the requested testimony, why the information is not available by any other means, and the reasons, if any, why the testimony would be in the interest of the Board or the Federal government.

(g) *Authorized release of information.* Subject to the limitation expressed in paragraph (h) of this section, disclosure of documents and information is hereby authorized, in such manner as the Board may by instructions prescribe, in the following cases:

(1) To any employer, employee, applicant, or prospective applicant for an annuity or death benefit under the Railroad Retirement Act of 1974, or his or her duly authorized representative, as to matters directly concerning such employer, employee, applicant, or prospective applicant in connection with the administration of such Act.

(2) To any employer, employee, applicant or prospective applicant for benefits under the Railroad Unemployment Insurance Act, or his or her duly authorized representative, as to matters directly concerning such employer, employee, applicant, or prospective applicant in connection with the administration of such Act.

(3) To any officer or employee of the United States lawfully charged with the administration of the Railroad Retirement Tax Act, the Social Security Act, or acts or executive orders administered by the Department of Veterans Affairs, and for the purpose of the administration of those Acts only.

(4) To any applicant or prospective applicant for death benefits or accrued annuities under the Railroad Retirement Act, or to his or her duly authorized representative, as to the amount payable as such death benefits or accrued annuities, and the name of the person or persons determined by the agency to be the beneficiary, or beneficiaries, thereof, if such applicant or prospective applicant purports to have a valid reason for believing himself or herself to be, in whole or in part, the beneficiary thereof.

(5) To any officer or employee of the United States lawfully charged with the administration of any Federal law concerning taxes imposed with respect to amounts payable under the Railroad Retirement Act of 1974 and the Railroad Unemployment Insurance Act and the name of the person or persons to whom such amount was payable.

(6) To any officer or employee of any state of the United States lawfully charged with the administration of any law of such state concerning unemployment compensation, as to the amounts payable to payees or beneficiaries under the Railroad Retirement Act of 1974 and the Railroad Unemployment Insurance Act.

(7) To any court of competent jurisdiction in which proceedings are pending which relate to the care of the person or estate of an incompetent individual, as to amounts payable under the Railroad Retirement Act to such incompetent individual, but only for the purpose of such proceedings.

(8) To parties involved in litigation, including an action with respect to child support, alimony, or marital property, the amount of any actual or estimated benefit payable under the Railroad Retirement Act or the Railroad Unemployment Insurance Act, where such amount or estimated amount is relevant to that litigation.

(9) To any employer, as to the monthly amount of any retirement annuity under the Railroad Retirement Act of 1974 or benefit under the Railroad Unemployment Insurance Act to which a present or former employee of that employer is entitled.

(10) To any governmental welfare agency, information about the receipt of benefits and eligibility for benefits.

(11) To any law enforcement agency, information necessary to investigate or prosecute criminal activity in connection with claims for benefits under the Railroad Retirement Act, Railroad Unemployment Insurance Act, or any other Act the Board may be authorized to administer.

(12) To any consular official, other than a consular officer of a country to which United States Treasury checks and warrants may not be sent, acting in behalf of a compatriot who has claimed benefits under the Railroad Retirement Act or Railroad Unemployment Insurance Act, information that is pertinent to the claim and that the applicant himself could have upon his or her own request.

(h) No document and no information acquired solely by reason of any agreement, arrangement, contract, or request by or on behalf of the agency, relating to the gathering, preparation, receipt or transmittal of documents or information to, from or for the agency, which is by virtue of such agreement, arrangement, contract, or request in the possession of any person other than an employee of the agency, shall be produced, reproduced, or duplicated, disclosed or delivered by any person to any other person or tribunal (other than the agency or an employee thereof, or the person to whom the document or information pertains), whether in response to a subpoena or otherwise, except with the consent of the Board or its designee. Any person, upon receipt of any request, subpoena, or order calling for the production, disclosure, or delivery of such document or information shall notify the Board or its designee of the request, subpoena, or order and shall take no further action except upon advice of the Board or its designee. Unless consent of the Board or its designee is given, the person shall respectfully decline to comply with the request, subpoena or order.

(i) Notwithstanding any other provision of this section, no disclosure of information may be made by the Board or any member, officer, agent, or employee of the agency, if the disclosure of such information is prohibited by law.

(j) The Deputy General Counsel or his designee will request the assistance of the Department of Justice where necessary to represent the interests of the agency and its employees under this section.

[54 FR 43055, Oct. 20, 1989, as amended at 56 FR 50247, Oct. 4, 1991; 63 FR 2141, Jan. 14, 1998]

§ 200.9 Selection of members of Actuarial Advisory Committee.

(a) *Introduction.* Under section 15(f) of the Railroad Retirement Act of 1974 (45 U.S.C. 231n(f)), the Board is directed to select two actuaries to serve on an Actuarial Advisory Committee. This section describes how the two actuaries are selected.

(b) *Carrier actuary.* One member of the Actuarial Advisory Committee shall be selected by recommendations made by ''carrier representatives.'' ''Carrier representatives,'' as used in this section, shall mean any organization formed jointly by the express companies, sleeping-car companies and carriers by railroad subject to the Interstate Commerce Act which own or control more than 50 percent of the total railroad mileage within the United States.

(c) *Railway labor actuary.* The other member of the Actuarial Advisory Committee to be selected by the Board shall be recommended by ''representatives of employees.'' ''Representatives of employees,'' as used in this section, shall mean any organization or body formed jointly by a majority of railway labor organizations organized in accordance with the provisions of the Railway Labor Act, as amended, or any individual or committee authorized by a majority of such railway labor organizations to make such recommendation.

[54 FR 43056, Oct. 20, 1989]

§ 200.10 Representatives of applicant or beneficiaries.

(a) *Power of attorney.* An applicant or a beneficiary shall not be required to hire, retain or utilize the services of an attorney, agent, or other representative in any claim filed with the Board.

In the event an applicant or beneficiary desires to be represented by another person, he or she shall file with the Board prior to the time of such representation a power of attorney signed by such applicant or beneficiary and naming such other person as the person authorized to represent the applicant or beneficiary with respect to matters in connection with his or her claim. However, the Board may recognize one of the following persons as the duly authorized representative of the applicant or beneficiary without requiring such power of attorney when it appears that such recognition is in the interest of the applicant or beneficiary:

(1) A Member of Congress;

(2) A person designated by the railway labor organization of which the applicant or beneficiary is a member to act on behalf of members of that organization on such matters; or

(3) An attorney who, in the absence of information to the contrary, declares that he or she is representing the applicant or beneficiary.

(b) *Payment of claim.* The Board will not certify payment of any awarded claim to or through any person other than the applicant or beneficiary for the reason that a power of attorney for such person to represent such applicant or beneficiary has been filed.

[54 FR 43057, Oct. 20, 1989]

SUBCHAPTER B—REGULATIONS UNDER THE RAILROAD RETIREMENT ACT

PART 201—DEFINITIONS

AUTHORITY: Secs. 1, 10, 50 Stat. 307, as amended, 314, as amended; 45 U.S.C. 228a, 228j.

§ 201.1 Words and phrases.

For the purposes of the regulations in this chapter, except where the language or context indicates otherwise:

(a) *Act*. The term ''act,'' or ''1937 act'' means the Railroad Retirement Act of 1937 (50 Stat. 307; 45 U.S.C. chapter 9). The term ''1935 act,'' means the Railroad Retirement Act of 1935 (49 Stat. 967; 45 U.S.C. chapter 9).

(b) *Employer*. The term ''employer'' means an employer as defined in the act and part 202 of this chapter.

(c) *Employee*. The term ''employee'' means an employee as defined in the act and part 203 of this chapter.

(d) *Service*. The term ''service'' means service as defined in the act and part 220 of this chapter.

(e) *Compensation*. The term ''compensation'' means compensation as defined in the act and part 222 of this chapter.

(f) *Board*. The term ''Board'' means the Railroad Retirement Board.

(g) *Company*. The term ''company'' means a partnership, association, joint stock company, corporation, or institution.

(h) *United States*. The term ''United States'' where used in a geographical sense means the States and the District of Columbia.

(i) *Carrier*. The term ''carrier'' means an express company, sleeping-car company, or carrier by railroad, subject to part I of the Interstate Commerce Act (24 Stat. 379; 49 U.S.C. chapter 1).

(j) *Person*. The term ''person'' includes an individual, trust, estate, partnership, association, joint stock company, company, corporation, and institution.

(k) *General Committee*. The term ''General Committee'' as used in section 1 of the Railroad Retirement Act of 1937 (50 Stat. 307; 45 U.S.C., Sup., 228a) is construed to include any subordinate unit of a national railway labor organization, defined as an employer in the 1937 act, regardless of the title or designation of such unit, which, under the constitution and bylaws of the organization of which it is a unit, is properly authorized to and does represent that organization on all of a particular railroad or on a substantial portion thereof (such as on that portion of a railroad under the jurisdiction of the general manager) in negotiating with the management of that railroad with respect to the wages and working conditions of the employees represented by such organization.

(l) *Local lodges and divisions; local lodge or division*. The term ''local lodges and divisions'' and the term ''local lodge or division'' as used in section 1(a) and 1(b), respectively, of the 1937 act, shall be construed to include any subordinate unit of a national railway labor organization defined as an ''employer'' under the 1937 act, which unit functions in the same manner as, or similar to ''local lodges'' as that term is ordinarily used, irrespective of the designation of such unit by its national organization.

[4 FR 1477, Apr. 7, 1939, as amended by Board Order 40–367, 5 FR 2717, Aug. 1, 1940; Board Order 59–190, 24 FR 9083, Nov. 7, 1959]

PART 202—EMPLOYERS UNDER THE ACT

Sec.

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AUTHORITY: Secs. 1, 10, 50 Stat. 307, as amended, 314, as amended; 45 U.S.C. 228a, 228j, unless otherwise noted.

SOURCE: 4 FR 1478, Apr. 7, 1939, unless otherwise noted.

§ 202.1 Statutory provisions.

The term ''employer'' means any carrier (as defined in subsection 1(m) of this section), and any company which is directly or indirectly owned or controlled by one or more such carriers or under common control therewith, and which operates any equipment or facility or performs any service (except trucking service, casual service, and the casual operation of equipment or facilities) in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, and any receiver, trustee, or other individual or body, judicial or otherwise, when in the possession of the property or operating all or any part of the business of any such employer: *Provided, however*, That the term ''employer'' shall not include any street, interurban, or suburban electric railway, unless such railway is operating as a part of a general steam-railroad system of transportation, but shall not exclude any part of the general steam-railroad system now or hereafter operated by any other motive power. The Interstate Commerce Commission is hereby authorized and directed upon request of the Board, or upon complaint of any party interested, to determine after hearing whether any line operated by electric power falls within the terms of this proviso. The term ''employer'' shall also include railroad associations, traffic associations, tariff bureaus, demurrage bureaus, weighing and inspection bureaus, collection agencies and other associations, bureaus, agencies, or organizations controlled and maintained wholly or principally by two or more employers as hereinbefore defined and engaged in the performance of services in connection with or incidental to railroad transportation; and railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, as amended, and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitution and by-laws of such organizations. (Sec. 1 (a), 50 Stat. 307; 45 U. S. C. 228a (a))

The term ''employer'' shall not include any company by reason of its being engaged in the mining of coal, the supplying of coal to an employer where delivery is not beyond the mine tipple, and the operation of equipment or facilities therefore, or in any of such activities. (54 Stat. 785; 45 U.S.C. 228a (a))

[4 FR 1478, Apr. 7, 1939, as amended by Board Order 41–526, 7 FR 96, Jan. 6, 1942]

§ 202.2 Company or person principally engaged in carrier business.

Any company or person principally engaged in carrier business is an employer.

§ 202.3 Company or person principally engaged in non-carrier business.

(a) With respect to any company or person principally engaged in business other than carrier business, but which, in addition to such principal business, engages in some carrier business, the Board will require submission of information pertaining to the history and all operations of such company or person with a view to determining whether some identifiable and separable enterprise conducted by the person or company is to be considered to be the employer. The determination will be made in the light of considerations such as the following:

(1) The primary purpose of the company or person on and since the date it was established;

(2) The functional dominance or subservience of its carrier business in relation to its non-carrier business;

(3) The amount of its carrier business and the ratio of such business to its entire business;

(4) Whether its carrier business is a separate and distinct enterprise.

(b) In the event that the employer is found to be an aggregate of persons or legal entities or less than the whole of a legal entity or a person operating in only one of several capacities, then the unit or units competent to assume legal obligations shall be responsible for the discharge of the duties of the employer.

§ 202.4 Control.

A company or person is controlled by one or more carriers, whenever there exists in one or more such carriers the right or power by any means, method or circumstance, irrespective of stock ownership to direct, either directly or indirectly, the policies and business of such a company or person and in any case in which a carrier is in fact exercising direction of the policies and business of such a company or person.

§ 202.5 Company or person under common control.

A company or person is under common control with a carrier, whenever the control (as the term is used in § 202.4) of such company or person is in the same person, persons, or company as that by which such carrier is controlled.

§ 202.6 Casual service and the casual operation of equipment or facilities.

The service rendered or the operation of equipment or facilities by a controlled company or person in connection with the transportation of passengers or property by railroad is ''casual'' whenever such service or operation is so irregular or infrequent as to afford no substantial basis for an inference that such service or operation will be repeated, or whenever such service or operation is insubstantial.

§ 202.7 Service or operation in connection with railroad transportation.

The service rendered or the operation of equipment or facilities by persons or companies owned or controlled by or under common control with a carrier is in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, if such service or operation is reasonably directly related, functionally or economically, to the performance of obligations which a company or person or companies or persons have undertaken as a common carrier by railroad, or to the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad.

§ 202.8 Controlled company or person principally engaged in service or operation in connection with railroad transportation.

Any company or person owned or controlled by one or more carriers or under common control therewith, whose principal business is the operation of equipment or facilities or the performance of service (other than trucking service) in connection with the transportation of passengers or property by railroad, shall be an employer.

§ 202.9 Controlled company or person not principally engaged in service or operation in connection with railroad transportation.

(a) With respect to any company or person owned or controlled by one or more carriers or under common control therewith, performing a service or operating equipment in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, but which is principally engaged in some other business, the Board will require the submission of information pertaining to the history and all operations of such company or person with a view to determining whether it is an employer or whether some identifiable and separable enterprise conducted by the person or company is to be considered to be the employer, and will make a determination in the light of considerations such as the following:

(1) The primary purpose of the company or person on and since the date it was established;

(2) The functional dominance or subservience of its business which constitutes a service or operation of equipment or facilities in connection with the transportation of passengers or property by railroad in relation to its other business;

(3) The amount of its business which constitutes a service or operation of equipment or facilities in connection with the transportation of passengers or property by railroad and the ratio of such business to its entire business;

(4) Whether such service or operation is a separate and distinct enterprise;

(5) Whether such service or operation is more than casual, as that term is defined in § 202.6.

(b) In the event that the employer is found to be an aggregate of persons or legal entities or less than the whole of a legal entity or a person operating in only one of several capacities, then the unit or units competent to assume legal obligations shall be responsible for the discharge of the duties of the employer.

§ 202.10 Commencement of employer status of receiver or trustee, etc.

A receiver, trustee, or other individual or body, judicial or otherwise, in the possession of the property or operating all or any part of the business of a carrier, or of a company or person owned or controlled by or under common control with such a carrier, which operates any equipment or facility or performs any service in connection with the transportation of passengers or property by railroad, shall be deemed to be an employer beginning as of whichever of the following three dates is the earliest:

(a) The date that it takes possession of such property; or

(b) The first date on which it has authority to operate all or any part of the business of such a carrier, company or person; or

(c) The date that it begins operating without appointment or authorization all or any part of the business of such a carrier, company or person;

Provided, however, That the receiver, trustee, or other individual or body, judicial or otherwise, shall be an employer only with respect to such individuals as would be employees if the preceding employer had continued in the possession of the property or the operation of the business.

§ 202.11 Termination of employer status.

The employer status of any company or person shall terminate whenever such company or person loses any of the characteristics essential to the existence of an employer status.

[Board Order 41–85, 6 FR 1210, Mar. 1, 1941]

§ 202.12 Evidence of termination of employer status.

(a) In determining whether a cessation of an essential characteristic, such as control or service in connection with railroad transportation, has occurred, consideration will be given only to those events or actions which evidence a final or complete cessation. Mere temporary periods of inactivity or failure to exercise functions or to operate equipment or facilities will not necessarily result in a loss of employer status.

(b) The actual date of cessation of employer status shall be the date upon which final or complete cessation of an essential employer characteristic occurs. The following indicate but do not delimit the type of evidence that will be considered in determining the actual date of cessation of an employer status: stoppage of business or operations; the cancellation of tariffs, concurrences, or powers of attorney filed with the Interstate Commerce Commission; the effective date of a certificate permitting abandonment; the effective date of a pertinent judicial action such as the discharge of a receiver, trustee, or other judicial officer, or an order approving sale of equipment or machinery; the sale, transfer, or lease of property, equipment, or machinery essential to the continuance of an employer function or to control by a carrier employer; public or private notices of contemplated or scheduled abandonment or cessation of operations; termination of contract; discharge of last employee; date upon which the right of a railway labor organization to participate in the selection of labor members of the National Railroad Adjustment Board ceases or is denied; and date on which an employer, if a labor organization, ceases to represent or is denied the right to represent crafts or classes of employees in the railroad industry, or to promote the interests of employees in the railroad industry.

(c) In the absence of evidence to the contrary the employer status of an existing company or person shall be presumed to continue, and in accordance with § 250.1(b) of this chapter it is the

duty of each employer promptly to notify the Board of any change in operations affecting such company's status as an employer.

[Board Order 41–85, 6 FR 1210, Mar. 1, 1941]

§ 202.13 Electric railways.

(a) The Deputy General Counsel will require the submission of information pertaining to the history and operations of an electric railway with a view to determining whether it is an employer and will inquire into and make his recommendations upon the following considerations:

(1) Whether the electric railway is more than a street, suburban or interurban electric railway; or

(2) Whether it is operating as a part of a general steam-railroad system of transportation; or

(3) Whether it is part of the national transportation system.

(b) If in the opinion of the Deputy General Counsel an electric railway has the characteristic set forth in either paragraphs (a)(1), (2), or (a)(3) of this section, he will conclude that it is an employer under the act and if the operator concurs in such opinion, the decision will be made final by the Board. If the operator does not concur in the conclusion reached the question will be submitted to the Interstate Commerce Commission for determination.

(45 U.S.C. 231f(b)(5))

[4 FR 1478, Apr. 7, 1939, as amended at 48 FR 51448, Nov. 9, 1983]

§ 202.14 Service incidental to railroad transportation.

An organization, association, bureau or agency is performing a service in connection with or incidental to railroad transportation whenever it is engaged in the performance of functions which would normally be performed by the constituent employers in the absence of such organization, association, bureau, or agency.

§ 202.15 Railway labor organizations.

Railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, as amended, and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitution and bylaws of such organizations, shall be employers within the meaning of the act.

(a) An organization doing business on or after June 21, 1934, which establishes, in accordance with paragraph (a)(1), (2), or (3) of this section a right, under section 3 ''First'' (a) of the Railway Labor Act, as amended (48 Stat. 1189; 45 U.S.C. 153 ''First'' (a)), to participate in the selection of labor members of the National Railroad Adjustment Board, will be presumed, in the absence of clear and convincing evidence to the contrary, to be, from and after the date on which such right is thus established, a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended. Such an organization can establish that it is an employer by establishing, in accordance with paragraph (b) of this section, that, as a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended, it is a ''railway'' organization. An organization, doing business on or after June 21, 1934, which has not established such a right of participation, will be presumed not to be a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended, and such presumption can be rebutted only by clear and convincing evidence satisfactory to the Board showing that the reasons for the organization's failure to establish such a right have no relation to its being a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended. Only after such presumption has thus been rebutted will further evidence as to whether the organization is an employer be considered. (The establishment or nonestablishment of such a right of participation will not raise any presumption as to whether an organization is, or is not, a ''railway'' organization. The existence of this qualification shall be determined in accordance with paragraph (b) of this section.) An

organization will have established such a right of participation if:

(1) It has in fact participated in the selection of labor members of the National Railroad Adjustment Board and has continued to participate in such selection; or

(2) It has been found, under section 3 ''First'' (f) of the Railway Labor Act, as amended (48 Stat. 1190; 45 U.S.C. 153 ''First'' (f)), to be qualified to participate in the selection of labor members of the National Railroad Adjustment Board; or

(3) It is recognized by all organizations, qualified under paragraphs (a)(1) or (2) of this section, as having the right to participate in the selection of labor members of the National Railroad Adjustment Board.

(b) The question as to whether a labor organization, national in scope, and organized in accordance with the provisions of the Railway Labor Act, as amended, is, as such a national labor organization, a ''railway'' labor organization, will be determined by the Board on the basis of considerations such as the following:

(1) The extent to which it is, and has been recognized as, representative of crafts or classes of employees in the railroad industry.

(2) The extent to which its purposes and business are and have been to promote the interests of employees in the railroad industry.

(c) A labor organization which ceased doing business before June 21, 1934, will have been an employer if its characteristics were substantially the same as those of labor organizations, doing business on or after June 21, 1934, which are established as employers in accordance with paragraphs (a) and (b) of this section.

(d) An organization which establishes, to the satisfaction of the Board, that it is a labor organization, as defined in paragraph (e) of this section, and that is composed of labor organizations which are established as employers in accordance with paragraphs (a), (b), and (c) of this section, is thereby established as being an employer.

(e) For the purposes of the regulations in this chapter, a labor organization is an organization whose business is to promote the interests of employees in their capacity as employees, either directly or through their organizations.

PART 203—EMPLOYEES UNDER THE ACT

Sec.

203.1 Statutory provisions.
203.2 General definition of employee.
203.3 When an individual is performing service for an employer.
203.4 When service is compensated.
203.5 Service outside the United States.
203.6 Age, citizenship, and other factors.
203.7 Local lodge employee.

AUTHORITY: Secs. 1, 10, 50 Stat. 307, as amended, 314 as amended; 45 U.S.C. 228a, 228j, unless otherwise noted.

SOURCE: 12 FR 1133, Feb. 19, 1947, unless otherwise noted.

§ 203.1 Statutory provisions.

The term ''employee'' means (1) any individual in the service of one or more employers for compensation, (2) any individual who is in the employment relation to one or more employers, and (3) an employee representative. The term ''employee'' shall include an employee of a local lodge or division defined as an employer in sub-section (a) only if he was in the service of or in the employment relation to a carrier on or after the enactment date. The term ''employee representative'' means any officer or official representative of a railway labor organization other than a labor organization included in the term ''employer'' as defined in section 1(a) who before or after the enactment date was in the service of an employer as defined in section 1(a) and who is duly authorized and designated to represent employees in accordance with the Railway Labor Act, as amended, and any individual who is regularly assigned to or regularly employed by such officer or official representative in connection with the duties of his office.

The term ''employee'' shall not include any individual while such individual is engaged in the physical operations consisting of the mining of coal, the preparation of coal, the handling (other than movement by rail with standard railroad locomotives) of coal

not beyond the mine tipple, or the loading of coal at the tipple.

An individual is in the service of an employer whether his service is rendered within or without the United States if (i) he is subject to the continuing authority of the employer to supervise and direct the manner of rendition of his service, or he is rendering professional or technical services and is integrated into the staff of the employer, or he is rendering, on the property used in the employer's operations, other personal services the rendition of which is integrated into the employer's operations, and (ii) he renders such service for compensation, or a method of computing the monthly compensation for such service is provided in section 3(c): *Provided*, *however*, That an individual shall be deemed to be in the service of an employer, other than a local lodge or division or a general committee of a railway-labor-organization employer, not conducting the principal part of its business in the United States only when he is rendering service to it in the United States; and an individual shall be deemed to be in the service of such a local lodge or division only if (1) all, or substantially all, the individuals constituting its membership are employees of an employer conducting the principal part of its business in the United States; or (2) the headquarters of such local lodge or division is located in the United States; and an individual shall be deemed to be in the service of such a general committee only if (1) he is representing a local lodge or division described in clauses (1) or (2) immediately above; or (2) all, or substantially all, the individuals represented by it are employees of an employer conducting the principal part of its business in the United States; or (3) he acts in the capacity of a general chairman or an assistant general chairman of a general committee which represents individuals rendering service in the United States to an employer, but in such case if his office or headquarters is not located in the United States and the individuals represented by such general committee are employees of an employer not conducting the principal part of its business in the United States, only such proportion of the remuneration for such service shall be regarded as compensation as the proportion which the mileage in the United States under the jurisdiction of such general committee bears to the total mileage under its jurisdiction, unless such mileage formula is inapplicable in which case the Board may prescribe such other formula as it finds to be equitable, and if the application of such mileage formula, or such other formula as the Board may prescribe, would result in the compensation of the individual being less than 10 per centum of his remuneration for such service no part of such remuneration shall be regarded as compensation: *Provided further*, That an individual not a citizen or resident of the United States shall not be deemed to be in the service of an employer when rendering service outside the United States to an employer who is required under the laws applicable in the place where the service is rendered to employ therein, in whole or in part, citizens or residents thereof; and the laws applicable on August 29, 1935, in the place where the service is rendered shall be deemed to have been applicable there at all times prior to that date.

§ 203.2 General definition of employee.

An individual shall be an employee whenever (a) he is engaged in performing compensated service for an employer or (b) he is in an employment relation to an employer, or (c) he is an employee representative, or (d) he is an officer of an employer.

§ 203.3 When an individual is performing service for an employer.

(a) The legal relationship of employer and employee is defined by the act. Thus, an individual is performing service for an employer if:

(1) He is subject to the right of an employer, directly or through another, to supervise and direct the manner in which his services are rendered; or

(2) In rendering professional or technical services he is integrated into the staff of the employer; or

(3) He is rendering personal services on the property used in the operations of the employer and the services are integrated into those operations.

(b) The provisions in paragraph (a) of this section are controlling irrespective of whether the service is performed on a part-time basis, and, with respect to paragraph (a)(1) of this section, irrespective of whether the right to supervise and direct is exercised.

§ 203.4 When service is compensated.

Service shall be ''compensated'' if it is performed for compensation, as that term is defined in part 222 of this chapter: *Provided, however,* That service prior to September 1941 of a station employee whose duties consisted of or included the carrying of passengers' hand baggage and otherwise assisting passengers at passenger stations shall be considered compensated service although the individual's remuneration was, in whole or in part, in the form of tips. (For the effect of compensation of less than $3.00 per month earned after December 31, 1936, for service to a local lodge or division of a railway-labor-organization employer, see part 222 of this chapter.)

(Sec. 3, 50 Stat. 310, as amended; 45 U.S.C. 228c)

§ 203.5 Service outside the United States.

(a) An individual shall not be an employee by reason of rendition of service to an employer other than a local lodge or division, or a general committee of a railway-labor-organization employer, not conducting the principal part of its business in the United States except while engaged in performing service for it in the United States.

(b) An individual shall not be an employee by reason of rendition of service to a local lodge or division, unless:

(1) All, or substantially all the individuals constituting the membership of such local lodge or division are employees of an employer conducting the principal part of its business in the United States; or

(2) The headquarters of such local lodge or division is located in the United States.

(c) An individual shall not be an employee by reason of rendition of service to a general committee of a railway-labor-organization employer, unless:

(1) Such individual is representing a local lodge or division, all or substantially all of whose members are employees of an employer conducting the principal part of its business in the United States, or the headquarters of such local lodge or division is located in the United States; or

(2) All or substantially all the individuals represented by such a general committee are employees of an employer conducting the principal part of its business in the United States; or

(3) Such an individual acts in the capacity of a general chairman or an assistant general chairman of a general committee which represents individuals rendering service in the United States to an employer; *Provided, however,* That if the office or headquarters of such general chairman or assistant general chairman is not located within the United States he will not be an employee unless 10 percent or more of his remuneration for service as general chairman or assistant general chairman is creditable as compensation, the creditable compensation to be computed according to the proportion which the mileage in the United States under the jurisdiction of such general committee bears to the total mileage under its jurisdiction, or according to a formula to be prescribed by the Board if the mileage formula is inapplicable.

§ 203.6 Age, citizenship, and other factors.

The age, citizenship, or residence of an individual, or his designation as other than an ''employee'' shall not be controlling in determining whether or not such individual is an employee within the meaning of the act, except that an individual not a citizen or resident of the United States shall not be deemed to be in the service of an employer when rendering service outside the United States to an employer who is required by the laws of the place where the service is performed to employ, in whole or in part, citizens or residents thereof and the laws in force therein on August 29, 1935, shall be deemed to have been in force at all times prior to that date.

[Board Order 55–89, 20 FR 3706, May 27, 1955]

§ 203.7 Local lodge employee.

An individual who, prior to January 1, 1937, shall have rendered service to a

local lodge or division of a railway labor organization included as an employer under section 1(a) of the act, shall be an employee with respect to such service to such local lodge or division only if he was on August 29, 1935, in the service of or in an employment relation to an employer which was a carrier. An individual who, subsequent to December 31, 1936, shall have rendered service to a local lodge or division of a railway labor organization included as an employer under section 1(a) of the act, shall be an employee with respect to such service to such local lodge or division only with respect to such service as was preceded by service, or an employment relation, on or after August 29, 1935, to an employer which was a carrier. (For the effect of compensation less than $3.00 per month earned after December 31, 1936, for service to a local lodge or division of a railway-labor-organization employer, see part 222 of this chapter.)

PART 204—EMPLOYMENT RELATION

Sec.

204.1 Introduction.
204.2 Employment relation—determination by the Board.
204.3 Employment relation—prior service.
204.4 Conditions which preclude an employment relation.
204.5 Employment relation—deemed service.
204.6 Employment relation—pay for time lost.
204.7 Employment relation—service to a local lodge or division of a railway labor organization.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 54 FR 5224, Feb. 2, 1989, unless otherwise noted.

§ 204.1 Introduction.

In order for an individual to receive credit under the Railroad Retirement Act (Act) for railroad service prior to 1937, he or she must establish that he or she was actively working for an employer under the Act on August 29, 1935, or was in an employment relation to an emp]oyer on that date. Section 204.3 of this part defines employment relation for purposes of establishing prior service. It is also necessary to establish an employment relation to an employer for any month in which an individual wishes to receive a deemed service month, as provided for in § 210.3 of this chapter, and to receive credit for pay for time lost as provided for in § 211.3 of this chapter. This part defines employment relation for these purposes. See §§ 204.5 and 204.6. In addition, in order for an individual to have his or her service to a local lodge or division of a railway labor organization considered as creditable service under the Act, he or she must establish that he or she was working for a railroad or in an employment relation to a railroad on or after August 29, 1935, and that such employment or employment relation preceded his or her service to the local lodge or division. Section 204.7 defines employment relation for this purpose.

§ 204.2 Employment relation—determination by the Board.

The existence or non-existence of an employment relation, as defined in this part, is a conclusion which must be reached by the Board or its authorized officers or employees upon the basis of the evidence before the agency. The employer and the employee are the principal sources of evidence with respect to a determination whether an employment relation existed, but the Board will not be bound by the mere conclusion of the employer or the employee that the employee had or did not have an employment relation.

§ 204.3 Employment relation—prior service.

An individual shall have an employment relation to an employer on August 29, 1935, for purposes of crediting service prior to January 1, 1937, if:

(a) He or she was in the service of an employer on that date; or

(b) He or she was on that date on 1eave of absence expressly granted by the employer or by a duly authorized representative of such employer, but only if such leave of absence was established to the satisfaction of the Board before July 1947; or

(c) He or she was in the service of an employer after that date and before January 1946, in each of six calendar months, whether or not consecutive; or

(d) Before that date he or she did not retire and was not retired or discharged from the service of the last

employer by whom he or she was employed, but solely by reason of a physical or mental disability he or she ceased before August 29, 1935, to be in the service of such employer and thereafter remained continuously disabled until he or she attained age sixty-five or until August 1945; or

(e) Solely for the reason stated in paragraph (c) of this section an employer by whom he or she was employed before August 29, 1935, did not on or after August 29, 1935, and before August 1945, call him or her to return to service, or if he or she were called to return to service he or she for such reason was unable to render service in six calendar months as provided in paragraph (b) of this section; or

(f) He or she was on August 29, 1935, absent from the service of an employer by reason of a discharge which, within one year after the effective date thereof, was protested to an appropriate labor representative or to the employer, as wrongful, and which was followed within ten years of the effective date thereof by his or her reinstatement in good faith to his or her former service with all his or her seniority rights.

§ 204.4 Conditions which preclude an employment relation.

(a) An individual shall not have been on August 29, 1935, an employee by reason of an employment relation if, during the last payroll period in which he or she rendered service to an employer prior to that date, such service was rendered outside of the United States to an employer not conducting the principal part of its business in the United States.

(b) An individual may not acquire an employment relation solely by virtue of service to a local lodge or division of a railway labor organization.

§ 204.5 Employment relation—deemed service.

For the purpose of crediting deemed service months as provided in § 210.3(b) of this chapter, an individual must have maintained an employment relation to one or more employers in the month or months to be deemed. For that purpose an employment relation exists with respect to any month in which an individual, although not in the active service of an employer, is on furlough subject to recall by an employer, is on a bona fide leave of absence, has not been retired or discharged but was by reason of continuous disability unable to return to service, or was not in active service because of a discharge later determined to be wrongful. However, an employment relation with respect to an employer ceases after an individual has resigned or relinquished his or her rights to return to the service of that employer or after the individual becomes entitled to receive an annuity under the Railroad Retirement Act.

§ 204.6 Employment relation—pay for time lost.

For the purpose of crediting pay for time lost as provided in § 211.3 of this chapter, an individual must have maintained an employment relation to one or more employers in the month or months to be credited with pay for time lost. For that purpose an employment relation exists with respect to any month in which an individual, although not in the active service of an employer, is on furlough subject to recall by an employer, is on a bona fide leave of absence, has not been retired or discharged but was by reason of continuous disability unable to return to service, or was not in active service because of a discharge later determined to be wrongful. However, an employment relation with respect to an employer ceases after an individual has resigned or relinquished his or her rights to return to the service of that employer.

§ 204.7 Employment relation—service to a local lodge or division of a railway labor organization.

Service by an individual to a local lodge or division of a railway labor organization shall be creditable under the Railroad Retirement Act only if, prior to such service, and on or after August 29, 1935, such individual performed compensated service for a carrier employer under part 202 of this chapter or was in an employment relation to such a carrier employer under the rules set forth in § 204.3 of this part.

PART 205—EMPLOYEE REPRESENTATIVE

Sec.
205.1 Introduction.
205.2 Definition of employee representative.
205.3 Factors considered in determining employee representative status.
205.4 Claiming status as an employee representative.
205.5 Reports of an employee representative.
205.6 Service of an employee representative.
205.7 Termination of employee representative status.

AUTHORITY: 45 U.S.C. 231, 45 U.S.C. 231f, 45 U.S.C. 231h.

SOURCE: 53 FR 39255, Oct. 6, 1988, unless otherwise noted.

§ 205.1 Introduction.

This part sets out the various factors considered in determining an individual's status as an employee representative under section 1(b)(1) of the Railroad Retirement Act, and discusses the procedure for reporting and crediting of compensation and service as an employee representative under that Act. An employee representative is considered to be a covered employee under the provisions of the Railroad Retirement Act.

§ 205.2 Definition of employee representative.

(a) An individual shall be an employee representative within the meaning of the Railroad Retirement Act if he or she is an officer or official representative of a railway labor organization, other than a labor organization included in the term ''employer'' within the meaning of part 202 of these regulations, who before or after August 29, 1935, was in the service of an ''employer'' within the meaning of part 202 of these regulations and who is duly authorized and designated to represent employees in accordance with the Railway Labor Act, as amended.

(b) An individual is also considered to be an employee representative within the meaning of the Act if he or she is regularly assigned to or regularly employed by an individual described in paragraph (a) of this section in connection with the duties of the office of employee representative of said individual.

(c) *Example:* A is employed by railroad R as a carman. He is also employed as recording secretary for the local chapter of union U, which has been recognized as the collective bargaining representative of the carmen of R. Although U represents some railroad employees, it is not a railway labor organization as described in part 202 of these regulations. A is an employee representative. His service for U is treated as employee service under the Railroad Retirement Act.

§ 205.3 Factors considered in determining employee representative status.

The following factors, among others, are considered by the Board in determining an individual's status as an employee representative:

(a) The name of the last railroad or other employer under the Act by which the individual was employed, and the period of employment;

(b) The present official name of the organization by which the individual is employed, as well as any other name(s) under which that organization operated previously;

(c) The date on which the organization was founded;

(d) The title of the position held by the individual within the organization, and the duties of said position;

(e) The method by which the individual, or the person to whom he or she is regularly assigned or by whom he or she is regularly employed, was authorized to represent members of the organization in negotiating with their employers, the date on which the individual was so authorized, and the time period covered by said authorization;

(f) The purpose or business of the organization as reflected by its constitution and by-laws;

(g) The extent to which the organization is, and has been recognized as, representative of crafts or classes of employees in the railroad industry;

(h) The extent to which the purposes and businesses of the organization are and have been to promote the interests of employees in the railroad industry as indicated by:

(1) The specific employee group(s) represented; and

(2) The proportion of members that are employed by railroad employers in relation to those members that are employed by non-railroad employers;

(i) Whether the organization has been certified by the National Mediation Board as a representative of any class of employees of any company;

(j) If the organization has not been certified as representative of any class of employees, the manner and method by which the organization determined that it was the duly authorized representative of such employees;

(k) Whether the organization participates or is authorized to participate in the selection of labor members of the National Railroad Adjustment Board; and

(l) Whether the organization was assisted by any carrier by railroad, express company, or sleeping car company, directly or indirectly, in its formation, in influencing employees to join the organization, financially, or in the collection of dues, fees, assessments, or any contributions payable to the organization.

§ 205.4 Claiming status as an employee representative.

An individual who claims status as an employee representative shall file a report in accordance with § 209.10 of this chapter.

(Approved by the Office of Management and Budget under control number 3220–0014)

§ 205.5 Reports of an employee representative.

An annual report of creditable compensation shall be made by an employee representative in accordance with § 209.10 of this chapter.

(Approved by the Office of Management and Budget under control number 3220–0014)

§ 205.6 Service of an employee representative.

Service rendered as an employee representative is creditable in the same manner and to the same extent as though the organization by which the employee representative was employed were an employer under the Railroad Retirement Act. (Creditable railroad service is discussed under part 210 of the Board's regulations.)

§ 205.7 Termination of employee representative status.

The employee representative status of any individual shall terminate whenever the individual or the organization by whom he or she is employed loses any of the characteristics essential to the existence of employee representative status.

PART 206—ACCOUNT BENEFITS RATIO

Sec.

206.1 Definitions.
206.2 Computations.

AUTHORITY: 45 U.S.C. 231f(b)(5); 45 U.S.C. 231u(a).

SOURCE: 68 FR 51153, Aug. 26, 2003, unless otherwise noted.

§ 206.1 Definitions.

Except as otherwise expressly noted, as used in this part—

Account benefits ratio means the amount determined by the Railroad Retirement Board by dividing the fair market value of the assets in the Railroad Retirement Account and the National Railroad Retirement Investment Trust (and for years prior to 2002, the Social Security Equivalent Benefit Account) as of the close of each fiscal year by the total benefits and administrative expenses paid from those accounts during the fiscal year.

Administrative expenses paid means the amount of the cash transfers from the Railroad Retirement Account to the agency's single administrative fund. Also included in this term is the amount of the cash transfers from the Railroad Retirement Account to the Limitation on the Office of Inspector General and the administrative expenses paid by the National Railroad Retirement Investment Trust.

Assets means the market value of cash and investments in the Railroad Retirement Account and the National Railroad Retirement Investment Trust (and for years before 2002, the Social Security Equivalent Benefit Account).

Average account benefits ratio means for any calendar year, the average of the account benefits ratio for the 10 most recent fiscal years ending before

such calendar year. If the amount computed is not a multiple of 0.1, such amount shall be increased to the next highest 0.1.

Total benefits paid means the total amount of benefits paid from the Railroad Retirement Account and the National Railroad Retirement Investment Trust in a fiscal year minus any benefit overpayments actually recovered during that fiscal year.

§ 206.2 Computation.

(a) On or before November 1, 2003, the Railroad Retirement Board shall:

(1) Compute the account benefits ratios for each of the most recent 10 preceding fiscal years; and

(2) Certify the account benefits ratio for each such fiscal year to the Secretary of the Treasury.

(b) On or before November 1 of each year after 2003, the Railroad Retirement Board shall:

(1) Compute the account benefits ratio for the fiscal year ending in such year; and

(2) Certify the account benefits ratio for such fiscal year to the Secretary of the Treasury.

(c) No later than May 1 of each year, beginning 2003, the Board shall compute its projection of the account benefits ratio and the average account benefits ratios for each of the next succeeding 5 fiscal years.

PART 209—RAILROAD EMPLOYERS' REPORTS AND RESPONSIBILITIES

Sec.

209.1 General.
209.2 Duty to furnish information and records.
209.3 Social security number required.
209.4 Method of filing.
209.5 Information regarding change in status.
209.6 Employers' notice of death of employees.
209.7 Employers' supplemental reports of service.
209.8 Employers' annual reports of creditable service and compensation.
209.9 Employers' adjustment reports.
209.10 Terminated employers' reports.
209.11 Employee representatives' reports.
209.12 Certificates of service months and compensation.
209.13 Employers' gross earnings reports.
209.14 Report of separation allowances subject to tier II taxation.
209.15 Compensation reportable when paid.
209.16 Disposal of payroll records.
209.17 Use of payroll records as returns of compensation.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 49 FR 46729, Nov. 28, 1984, unless otherwise noted.

§ 209.1 General.

Benefits under the Railroad Retirement Act are based in part upon an individual's years of service and amount of compensation credited to the individual under the Act. It is the duty of the Board to gather, keep and compile such records and data as may be necessary to assure proper administration of the Act. This part sets forth the types of reports employers are required to make to the Board and states the penalties that the Board may impose upon employers and employees who fail or refuse to make required reports.

§ 209.2 Duty to furnish information and records.

In the administration of the Railroad Retirement Act of 1974, the Board may require any employer or employee to furnish or submit any information, records, contracts, documents, reports or other materials within their possession or control, that, in the judgment of the Board, may have any bearing upon:

(a) The employer status of any individual, person or company,

(b) The employee or pension status of any individual,

(c) The amount and creditability of service and compensation, or

(d) Any other matter arising which involves the administration of the Railroad Retirement Act. Any person who knowingly fails or refuses to make any report or furnish any information required by the Board, may be punished by a fine of not more than $10,000 or by imprisonment not exceeding one year, or both.

(Approved by the Office of Management and Budget under control number 3220–0089)

[49 FR 46729, Nov. 2, 1984, as amended at 52 FR 11016, Apr. 6, 1987]

§ 209.3 Social security number required.

Each employer shall furnish to the Board a social security number for each employee for whom any report is submitted to the Board. Employers are encouraged to validate any social security number provided under this section.

(Approved by the Office of Management and Budget under control number 3220–0008)

[63 FR 32613, June 15, 1998]

§ 209.4 Method of filing.

Any report or information required to be furnished under this part shall be prepared in accordance with instructions of the Board and shall be filed with the Board electronically, which includes the use of magnetic tape, computer diskette, electronic data interchange, or on such form as prescribed by the Board. If not filed electronically, reports shall be transmitted by facsimile or mailed directly to the Board. Any report which includes, or should include, information for 250 or more employees must be filed electronically, as described in this section.

[63 FR 32613, June 15, 1998]

§ 209.5 Information regarding change in status.

It is the duty of each employer to promptly notify the Board of:

(a) Any change in the employer's operations, ownership or control of the employer which affects its status as an employer under the Railroad Retirement Act and the Railroad Unemployment Insurance Act;

(b) Any change in the ownership or control by the employer in any company which may affect the status of the company as an employer under the Railroad Retirement Act or Railroad Unemployment Insurance Act; and

(c) The gain of ownership or control by the employer of any company which may give that company status as an employer under the Railroad Retirement Act and Railroad Unemployment Insurance Act. The notice must fully advise the Board of the type of change in ownership, the date of the change, the number of employees affected by the change and any other information pertinent to the change.

[49 FR 46729, Nov. 28, 1984. Redesignated at 63 FR 32613, June 15, 1998]

§ 209.6 Employers' notice of death of employees.

Each employer shall notify the Board immediately of the death of an employee who, prior to the employee's death, performed compensated service which has not been reported to the Board.

(Approved by the Office of Management and Budget under control number 3220–0005)

[63 FR 32613, June 15, 1998]

§ 209.7 Employers' supplemental reports of service.

Each employer shall furnish the Board a report of the current year service of each employee who ceases work for the purpose of retiring under the provisions of the Railroad Retirement Act.

(Approved by the Office of Management and Budget under control number 3220–0005)

[63 FR 32613, June 15, 1998]

§ 209.8 Employers' annual reports of creditable service and compensation.

Each year, on or before the last day of February, each employer is required to make an annual report of the creditable service and compensation (including a report that there is no compensation or service to report) of employees who performed compensated service in the preceding calendar year. The annual report shall include service and compensation previously furnished in supplemental reports and notices of death.

(Approved by the Office of Management and Budget under control number 3220–0008)

[63 FR 32613, June 15, 1998]

§ 209.9 Employers' adjustment reports.

(a) The Board may request employers to submit adjustments to correct employee accounts when:

(1) Errors are detected in processing employers' annual report;

(2) An employee shows that the amount of service or compensation reported by the employer to the employee's account was not correct; or

(3) An employee shows that he or she should have been credited with service and compensation for a period for which the employer reported no service and compensation.

(b) Employers may submit adjustment reports to:

(1) Correct service and compensation previously reported; and

(2) Report service and compensation that was omitted from a previous report.

(c) Employers submitting adjustment reports covering pay for time lost as an employee shall report this compensation as provided for in § 211.3 of this chapter. Adjustment reports may be submitted to the Board each month.

(Approved by the Office of Management and Budget under control number 3220–0008)

[49 FR 46729, Nov. 28, 1984. Redesignated and amended at 63 FR 32613, June 15, 1998]

§ 209.10 Terminated employers' reports.

When an employer's status as an employer is terminated, a final report of creditable service and compensation shall be made. The final report shall be submitted to the Board on or before the last day of the month following the final month for which there was compensated service. The report shall be completed as prescribed in § 209.8(a) of this part and shall be marked Final Compensation Report.

(Approved by the Office of Management and Budget under control number 3220–0008)

[49 FR 46729, Nov. 28, 1984. Redesignated and amended at 63 FR 32613, June 15, 1998]

§ 209.11 Employee representatives' reports.

An individual claiming status as an employee representative shall describe his or her duties as an employee representative on the form prescribed by the Board. The Board shall determine whether the individual claiming to be an employee representative meets the requirements for such a status. If the individual is determined to be an employee representative, he or she is required to make an annual report of creditable compensation as provided for in § 209.8 of this part. If an employee representative's status is terminated, the last report of service and compensation shall be marked Final Compensation Report.

(Approved by the Office of Management and Budget under control number 3220–0014)

[63 FR 32613, June 15, 1998]

§ 209.12 Certificates of service months and compensation.

(a) Each year the Board shall provide each employee who performed compensated service in the preceding calendar year a certificate of service months and compensation. This certificate is the employee's record of the service and compensation credited to his or her account at the Board. An employee who for any reason does not receive a certificate may obtain one from the nearest Board district office or may write the Board for one.

(b) By April 1 of each year each employer shall provide the Board the current address of each employee for whom it had reported compensation. This requirement shall not apply in the case of an employee for whom the employer had previously provided an address.

(Approved by the Office of Management and Budget under control number 3220–0194)

[63 FR 32613, June 15, 1998]

§ 209.13 Employers' gross earnings reports.

(a) Each employer is required to report the gross earnings of a one-percent sample group of railroad employees. The gross earnings sample is based on the earnings of employees whose social security numbers end with the digits 30. This report is used to determine:

(1) Tax and benefit amounts involved in the Financial Interchange with the Social Security Administration and the Health Care Financing Administration; and

(2) Estimated tax income accruing to the railroad retirement system in future periods.

(b) Employers shall submit reports annually for employees in the gross earnings sample. Such reports shall include the employee's gross annual

earnings, which includes all compensation taxable under the hospital insurance portion of the tier I tax rate. Employers with 5,000 or more employees shall provide a monthly or quarterly breakdown of the year's earnings. Employers with fewer than 5,000 employees may submit an annual amount only, although a monthly or quarterly breakdown is preferable. Gross earnings are to be counted for the same time period as used in determining the employer's annual report of creditable compensation. The reports are to be prepared in accordance with prescribed instructions and filed in accordance with § 209.4 of this part.

(Approved by the Office of Management and Budget under control number 3220–0132)

[49 FR 46729, Nov. 28, 1984, as amended at 55 FR 26430, June 28, 1990; 57 FR 4365, Feb. 5, 1992; 59 FR 2292, Jan. 14, 1994. Redesignated and amended at 63 FR 32613, 32614, June 15, 1998]

§ 209.14 Report of separation allowances subject to tier II taxation.

For any employee who is paid a separation payment, the employer must file a report of the amount of the payment. This report shall be submitted to the Board on or before the last day of the month following the end of the calendar quarter in which payment is made. The report is to be prepared in accordance with prescribed instructions and filed in accordance with § 209.4 of this part.

(Approved by the Office of Management and Budget under control number 3220–0173)

[63 FR 32614, June 15, 1998]

§ 209.15 Compensation reportable when paid.

(a) *General.* In preparing a report required under this part, an employer may report compensation in the report required for the year in which the compensation was paid even though such compensation was earned by the employee in a previous year. If compensation is reported with respect to the year in which it was paid, it shall be credited by the Board to the employee in such year unless within the four year period provided in § 211.15 of this chapter the employee requests that such compensation be credited to the year in which it was earned. If the employee makes such a request, and the Board determines that the compensation should be credited to the year in which it was earned, the reporting employer must file an adjustment report as required by § 209.9 of this part which reports such compensation in the year in which it was earned. The employee may revoke his or her request anytime prior to the filing of the adjustment report. Upon the Board's receipt of the adjustment report, the request becomes irrevocable.

(b) *Pay for time lost.* Compensation which is pay for time lost, as provided in § 211.3 of this chapter, shall be reported with respect to the period in which the time and compensation were lost. For example, if an employee is off work because of an on-the-job injury for a period of months in a given year and in a later year receives a payment from his or her employer to compensate for wages lost during the period of absence, the employer must, by way of adjustment provided for in § 209.9 of this part, report the compensation with respect to the year in which the time and compensation were lost.

(c) *Separation allowance or severance pay.* A separation allowance or severance payment shall be reported in accordance with § 209.14 of this part.

(d) *Miscellaneous pay.* Miscellaneous pay, as defined in § 211.11 of this chapter, shall be reported in the year paid and reported on the annual report of compensation as provided for in § 209.8 of this part.

(e) *Vacation pay.* Vacation pay may be reported in accordance with this section except that any payments made in the year following the year in which the employee resigns or is discharged shall be reported by way of adjustment under § 209.9 of this part as paid in the year of resignation or discharge.

[58 FR 45250, Aug. 27, 1993, as amended at 63 FR 32614, June 15, 1998]

§ 209.16 Disposal of payroll records.

Employers may dispose of payroll records for periods subsequent to 1936, *provided that* the payroll records are more than five years old and that there is no dispute pending pertaining to the

compensation reported for the period of those records.

[61 FR 31395, June 20, 1996]

§ 209.17 Use of payroll records as returns of compensation.

Payroll records of employers which have permanently ceased operations may be accepted in lieu of prescribed reports *provided that* there is no official of the employer available to prepare and certify to the accuracy of such reports and, *provided further that* any employer and employee tax liability incurred under the Railroad Retirement Tax Act has been discharged.

[61 FR 31395, June 20, 1996]

PART 210—CREDITABLE RAILROAD SERVICE

Sec.
210.1 General.
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210.4 Year of service.
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AUTHORITY: 45 U.S.C. 231f.

§ 210.1 General.

An individual's entitlement to benefits and the amount of benefits payable under the Railroad Retirement Act are determined based, in part, on the individual's years of service. This part defines what the term service means under the Railroad Retirement Act and sets forth what types of service are creditable under that Act.

[49 FR 46731, Nov. 28, 1984]

§ 210.2 Definition of service.

Service means a period of time for which an employee receives payment from a railroad employer for the performance of work; or a period of time for which an employee receives compensation which is paid for time lost as an employee; or a period of time credited to an employee for creditable military service as defined in part 212 of this chapter. Service shall also include deemed months of service as provided under § 210.3(b) of this chapter and any month in which an employee is credited with compensation under § 211.12 of this chapter based on benefits paid under title VII of the Regional Rail Reorganization Act of 1973.

[53 FR 17182, May 16, 1988]

§ 210.3 Month of service.

(a) *Reported.* A reported month of service is any calendar month or any part of a calendar month for which an employee receives compensation for services performed for an employer; or receives pay for time lost as an employee; or is credited with compensation for a period of creditable military service; or is credited with compensation under § 211.12 of this chapter based on benefits paid under title VII of the Regional Rail Reorganization Act of 1973.

(b) *Deemed.* A deemed month of service is any additional month of service credited to an employee subject to paragraphs (b)(1) and (2) of this section.

(1) An employee who is credited with less than twelve reported months of service for a calendar year after 1984 may be ''deemed'' to have performed service for compensation in additional months, not to exceed twelve, providing:

(i) The employee's compensation for the calendar year in question exceeds an amont calculated by multiplying the number of reported months credited for that year by an amount equal to one-twelfth of the current annual maximum for non-tier I components as defined in § 211.15 of this chapter; and

(ii) The employee maintains an employment relation to one or more employers or serves as an employee representative in the month or months to be deemed. For purposes of this section, employment relation has the same meaning as defined in part 204 of this chapter, disregarding the restrictions involving the establishment of such a relationship as of August 29, 1935. Employee representative has the same meaning as defined in part 205 of this chapter.

(2) Employees satisfying the conditions in both paragraphs (b)(1)(i) and (b)(1)(ii) of this section shall have their months of service for a calendar year calculated using the following formula:

$$\text{Months of service} = \frac{\text{Employee's creditable non-tier I compensation}}{\text{Maximum annual creditable non-tier I compensation} \div 12}$$

The quotient obtained using this formula equals the employee's total months of service, reported and deemed, for the calendar year. Any fraction or remainder in the quotient is credited as an additional month of service.

(3) *Examples.* The provisions of paragraphs (b)(1) and (2) of this section may be illustrated by the following examples.

Example (1): Employee B worked in the railroad industry in 1985 and was credited with nine reported months of service (January through September) and non-tier I compensation of $20,000. The 1985 annual maximum for non-tier I compensation is $29,700. B maintained an employment relation in the three months he was not employed in 1985. The following computations are necessary to determine if B has sufficient non-tier I compensation to be credited with deemed months of service.

(1) Enter the annual maximum for non-tier I compensation for the calendar year $29,700
(2) Divide line (1) by 12
$29,700 ÷ 12 ..... $2,475
(3) Enter the employee's reported months of service for the calendar year 9
(4) Multiply line (2) by line (3) $2,475 × 9 ..... $22,275
(5) Enter the employee's non-tier I compensation for the calendar year $20,000
(6) Subtract line (4) from line (5). Enter the result (but not less than zero). This is the employee's excess non-tier I compensation for the calendar year.
$20,000 − $22,275 0

a. If line (6) is zero, the employee does not have sufficient non-tier I compensation to be credited with deemed months of service.

b. If line (6) is greater than zero, the employee has sufficient non-tier I compensation to be credited with deemed months of service.

Since the amount on line (6) is zero, employee B does not have enough non-tier I compensation to be credited with deemed months of service. B is credited with only nine reported months of service for the year.

Example (2): Assume the same facts as in example (1), except that employee B was credited with non-tier I compensation of $25,000 for 1985. The following computations are necessary to determine if B has sufficient non-tier I compensation to be credited with deemed months of service.

(1) Enter the annual maximum for non-tier I compensation for the calendar year $29,700
(2) Divide line (1) by 12
$29,700 ÷ 12 ..... $2,475
(3) Enter the employee's reported months of service for the calendar year 9
(4) Multiply line (2) by line (3) $2,475 × 9 ..... $22,275
(5) Enter the employee's non-tier I compensation for the calendar year $25,000
(6) Subtract line (4) from line (5). Enter the result (but not less than zero). This is the employee's excess non-tier I compensation for the calendar year.
$25,000 − $22,275 ..... $2,725

a. If line (6) is zero, the employee does not have sufficient non-tier I compensation to be credited with deemed months of service.

b. If line (6) is greater than zero, the employee has sufficient non-tier I compensation to be credited with deemed months of service.

Since the amount on line (6) is greater than zero, employee B has enought non-tier I compensation to be credited with deemed months of service. B now satisfies all the requirements for deeming, therefore his months of service for the calendar year are calculated using the formula in § 210.3(b)(2).

$$\text{Months of service} = \frac{\text{Employee's creditable non-tier I compensation}}{\text{Maximum annual creditable non-tier I compensation} \div 12}$$

$$\text{(1)} \quad \text{Months of service} = \frac{\$25{,}000}{\$29{,}700 \div 12} \text{ or } \$25{,}000 \div \$2{,}475$$

$$(2)\quad \text{Months of service} = \frac{\$25{,}000}{\$2{,}475} \text{ or } \$25{,}000 \div \$2{,}475$$

(3) Months of service = 25,000 ÷ 2,475 or 10.10

(4) Round the result in line (3) to the next higher whole number. This is the employee's total months of service for the calendar year.

10.10 becomes 11

Employee B is credited with 11 months of service for 1985; nine reported months (January through September) and two deemed months (October and November).

[53 FR 17182, May 16, 1988]

§ 210.4 Year of service.

(a) A year of service is twelve months of reported or deemed service, consecutive or not consecutive. A fraction of a year of service is taken at its actual value.

(b) The term years of service means the total number of years an employee is credited with service as defined in § 210.2 of this part.

[49 FR 46731, Nov. 28, 1984, as amended at 53 FR 17183, May 16, 1988]

§ 210.5 Creditability of service.

(a) *Service before January 1, 1937.* (1) Service performed before January 1, 1937, is called prior service. Prior service is creditable under the Railroad Retirement Act if the employee had an employment relation with a railroad employer on August 29, 1935. Prior service may be combined with creditable service performed after December 31, 1936, to make the employee's total years of service equal, but not exceed, 30 years (360 months).

(2) An employee is considered to have an employment relation on August 29, 1935, if:

(i) The employee was on that date in active railroad service for an employer; or

(ii) The employee was on that date on a leave of absence expressly granted by the employer or the employer's authorized representative, but only if such leave of absence was established to the satisfaction of the Board before July 1947; or

(iii) The employee had 6 months of active railroad service for an employer during the period August 29, 1935, through December 31, 1945; or

(iv) The employee was not in the service of an employer by reason of a mental or physical disability from which the employee was continuously disabled until the employee attained age 65 or until August 1945; or

(v) Solely for the reason stated in paragraph (a)(2)(iv) of this section the employee was not recalled to active service before August 1945; or

(vi) If the employee was recalled, the employee was unable to perform 6 months of service during the period August 29, 1935, through December 31, 1945, solely for the reason stated in paragraph (a)(2)(iv) of this section.

(b) *Service after December 31, 1936.* All service performed after December 31, 1936, is creditable. If an employee has service both before January 1, 1937, and after December 31, 1936, all service after December 31, 1936, is credited first; if this service totals less than 30 years (360 months), then the service before January 1, 1937, is included but only up to the amount sufficient to make the total years of service equal 30. Where the years of service include only part of the service performed before January 1, 1937, the part included is taken in reverse order beginning with the last calendar month of the service.

(c) *Service after December 31, 1936, to a local lodge or division.* Services performed for a local lodge or division of a railway labor organization is creditable if the employee is credited with compensation as defined in § 211.2 of this chapter.

(d) *Service based on time lost.* Any month or any part of a month during which an employee performed no active service but received pay for time lost as an employee is counted as a month of service. Service for time lost as an employee shall be credited as provided for in § 211.3 of this chapter.

(e) *Place of performance of service.* (1) Service performed for an employer who

conducts the principal part of its business with the United States is creditable. However, service performed for an employer who conducts the principal part of its business outside the United States is creditable only when the service is performed in the United States. If an employer, other than a local lodge or division or a general committee of a railway labor organization, does not conduct the principal part of its business within the United States, the service performed outside the United States for that employer is not creditable.

(2) Service performed outside the United States by an employee who is not a citizen or resident of the United States is not creditable if the employer is required under the laws of that place to hire, in whole or in part, only citizens or residents of that place.

(f) *Service as employee representative.* Service performed as an employee representative is creditable in the same manner and to the same extent as service performed for an employer.

(g) *Service performed after the beginning date of an annuity.* Service performed after the beginning date of an annuity shall be used in the annuity recomputation.

[49 FR 46731, Nov. 28, 1984, as amended at 53 FR 17184, May 16, 1988]

§ 210.6 Service credited for creditable military service.

Any calendar month in which an employee performed creditable military service, as defined in part 212 of this chapter, shall be counted as a month of service and shall be included in the employee's years of service, as provided for in § 210.5, provided that the employee has not previously been credited with reported or deemed service for an employer for the same month(s).

[53 FR 17184, May 16, 1988]

§ 210.7 Verification of service claimed.

Service claimed by an employee, which is not credited in the records of the Board, must be verified to the satisfaction of the Board before it may be credited. Verification of the Service claimed shall be as follows:

(a) Service claimed will be verified from the payroll or other detailed records of the employer.

(b) If the payroll or other detailed records are incomplete or missing, the service claimed and not established by these records will be verified from the personnel records of the employer.

(c) If the payroll, personnel and detailed records are incomplete or missing, the service claimed and not established by these records will be verified from any other books and records of the employer.

(d) If the employer's records do not establish the service claimed, the employee may submit affidavits and other evidence in support of the service claimed in either of the following instances:

(1) When there are no employer records available to show whether or not the service claimed was performed; or

(2) When there are employer records available which do not verify the service claimed and do not establish that the service claimed was not performed.

(e) When service is verified as to over-all dates, but is not supported in detail by employer records, and when there are no employer records showing in detail absences from service, a deduction shall be made to cover an average amount of the absences. The deduction shall be the absences shown by the applicant or 5 percent of the total period in question, whichever is greater. However, where the employee submits detailed records of the service claimed, properly identified and established as having been made at the time the employee performed the service for which detailed records of the employer are not available, full credit may be allowed for the service as may be verified from the records. Also, the employee may be permitted to establish in any other manner satisfactory to the Board the actual amount of his or her absences.

(f) For the purpose of verifying service before 1937, employers shall preserve through 1986, in accessible form, the original records of the service and compensation.

(g) For the purpose of verifying service after 1936, employers shall preserve in accessible form the original records

of service and compensation for a period of five calendar years after the due date of the report.

(Approved by the Office of Management and Budget under control numbers 3220–0003 and 3220–0008)

[49 FR 46731, Nov. 28, 1984, as amended at 52 FR 11016, Apr. 6, 1987]

PART 211—CREDITABLE RAILROAD COMPENSATION

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AUTHORITY: 45 U.S.C. 231f.

SOURCE: 49 FR 46732, Nov. 28, 1984, unless otherwise noted.

§ 211.1 General.

Benefits under the Railroad Retirement Act are based in part on the individual's years of service and amount of compensation credited to the individual under the Act. This part defines what the term compensation means and sets forth the criteria applied in determining what payments are creditable as compensation under the Railroad Retirement Act.

§ 211.2 Definition of compensation.

(a) The term compensation means any form of payment made to an individual for services rendered as an employee for an employer; services performed as an employee representative; and any separation or subsistence allowance paid under any benefit schedule provided in conformance with title VII of the Regional Rail Reorganization Act of 1973 and any termination allowance paid under section 702 of that Act. Compensation may be paid as money, a commodity, a service or a privilege. However, if an employee is to be paid in any form other than money, the employer and employee must agree before the service is performed upon the following:

(1) The value of the commodity, service or privilege; and

(2) That the amount agreed upon to be paid may be paid in the form of the commodity, service or privilege.

(b) Compensation includes, but is not limited to, the following:

(1) Salary, wages and bonuses;

(2) Pay for time lost as an employee;

(3) Cash tips of $20 or more received in a calendar month;

(4) Vacation pay;

(5) Military pay as determined in § 211.7 of this part;

(6) Displacement allowances as provided for in § 211.8 of this part;

(7) Dismissal allowances as provided for in § 211.9 of this part;

(8) Separation allowances as provided for in § 211.10 of this part;

(9) Miscellaneous pay as provided for in § 211.11 of this part;

(10) Payments made under title VII of the Regional Rail Reorganization Act of 1973 as provided for in § 211.12 of this part.

(11) Payments paid to an employee or employee representative which are subject to tax under section 3201(a) or 3211(a) of the Internal Revenue Code of 1954 are creditable as compensation under the Railroad Retirement Act for purposes of computation of benefits under sections 3(a)(1), 3(f)(3), 4(a)(1) and 4(f)(1).

(12) Voluntary payments of any tax by an employer, without deducting such tax from the employee's salary.

(13) Payments made by an employer with respect to a deceased employee except as provided for in § 211.13 of this part.

(c) Compensation does not include:

(1) Tips, except as provided in paragraph (b)(3) of this section;

(2) Payments for services performed by a nonresident alien for the period the individual is temporarily present in the United States as a nonimmigrant

under subparagraph (F) or (J) of section 1101(a)(15) of title 8, U.S.C. and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be;

(3) Remuneration paid in certain cases, as described below, for services performed for a local lodge or division of a railway labor organization.

(i) Remuneration for services rendered for a local lodge or division of a railway labor organization which was earned after 1936 and prior to April 1, 1940, shall not be creditable as compensation in a month unless taxes with respect to such remuneration were paid under the Railroad Retirement Tax Act prior to July 1, 1940.

(ii) Remuneration for services rendered for a local lodge or division of a railway labor organization which was earned after March 31, 1940, and prior to January 1, 1975, shall not be creditable as compensation in a month if the amount of such remuneration earned in the month is less than $3.00.

(iii) Remuneration for services rendered for a local lodge or division of a railway labor organization which was earned after December 31, 1974, shall not be creditable as compensation in a month if the amount of such remuneration earned in the month is less than $25.00.

(4) Payments for service as a delegate to a national or international convention of a railway-labor-organization employer if the individual rendering the service has not previously rendered service, other than as a delegate, which may be included in the individual's years of service;

(5) Except as provided in § 211.2(b)(11), the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of the employee's dependents under a plan or system established by an employer which makes provisions for employees generally (or for employees generally and their dependents), or for a class or classes of employees (or for a class or classes of employees and their dependents), on account of sickness or accident disability, or medical, or hospitalization expenses in connection with sickness or accident disability; and

(6) Any amount paid specifically—either as an advance, as reimbursement or allowance—for traveling or other bona fide and necessary expenses incurred, or reasonably expected to be incurred in the business of the employer, provided the payment is identified by the employer either by a separate payment or by specifically indicating the separate amounts where both wages and expense reimbursement or allowance are combined in a single payment.

[49 FR 46732, Nov. 28, 1984, as amended at 53 FR 17184, May 16, 1988; 58 FR 45251, Aug. 27, 1993]

§ 211.3 Compensation paid for time lost.

(a) A payment made to an employee for a period during which the employee was absent from the active service of the employer is considered to be pay for time lost and is, therefore, creditable compensation. Pay for time lost as an employee includes:

(1) Pay received for a certain period of time due to personal injury, or

(2) Pay received for loss of earnings for a certain period of time, resulting from the employee being placed in a position or occupation paying less money. In reporting compensation which represents pay for time lost, employers shall allocate the amount paid to the employee to the month(s) in which the time was actually lost. The entire amount of any payment made to an employee for personal injury is considered pay for time lost unless, at the time of payment, the employer states that a particular amount of the payment was for reasons other than pay for time lost.

(b) Where pay for time lost is allocated to the month(s) in which the time was actually lost, the Board will accept the allocation made by the parties involved if it relates to the employee's normal monthly pay. A reasonable relationship to an employee's normal monthly pay is ordinarily no less than ten times the employee's daily pay rate.

§ 211.4 Vacation pay.

Payments made to an employee with respect to vacation or holidays shall be

considered creditable compensation whether or not the employee takes the vacation or holiday.

[58 FR 45251, Aug. 27, 1993]

§ 211.5 Employee representative compensation.

All payments made by a railway labor organization to an individual who is an employee representative as a result of the position or office he occupies with such organization are creditable as compensation, including payments made for services not connected with the representation of employees, except that payments in excess of the annual maximum amount will not be credited.

[53 FR 17184, May 16, 1988]

§ 211.6 Compensation based on waiver or refund of organization dues.

A waiver or refund or organization dues which was based solely on consideration for membership in the organization is considered creditable compensation if there is proof that the waiver or refund was intended to be, and was accepted as, a dismissal of an obligation of the organization to compensate the employee for services rendered.

[53 FR 17184, May 16, 1988]

§ 211.7 Compensation credited for creditable military service.

In determining the creditable compensation of an employee, the following amounts shall be credited for each month of military service, provided the employee's combined monthly railroad and military compensation does not exceed the maximum creditable amount:

(a) $160 for each calendar month before 1968;

(b) $260 for each calendar month after 1967 and before 1975;

(c) For years after 1974, the actual military earnings reported as wages under the Social Security Act.

[53 FR 17184, May 16, 1988]

§ 211.8 Displacement allowance.

An allowance paid to an employee because he has been displaced to a lower paying position is creditable compensation.

[58 FR 45251, Aug. 27, 1993]

§ 211.9 Dismissal allowance.

Dismissal allowances paid to an employee under a protective labor agreement that covers the amounts paid for specific periods of time are creditable as compensation under the Railroad Retirement Act, provided the employee has not severed his or her employee-employer relationship.

[53 FR 17184, May 16, 1988, as amended at 58 FR 45251, Aug. 27, 1993]

§ 211.10 Separation allowance or severance pay.

Separation or severance payments are creditable compensation except that no part of such payment shall be considered creditable compensation to any period after the employee has severed his or her employer-employee relationship except as provided for in § 211.11 of this part.

[58 FR 45251, Aug. 27, 1993]

§ 211.11 Miscellaneous pay.

Any payment made to an employee by an employer which is excluded from compensation under the Railroad Retirement Act, but which is subject to taxes under the Railroad Retirement Tax Act, shall be considered compensation for purposes of this part but only for the limited purpose of computing the portion of the annuity computed under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act (commonly called the tier I component).

[58 FR 45251, Aug. 27, 1993]

§ 211.12 Compensation credited for title VII benefits.

Payments made to an employee under title VII of the Regional Rail Reorganization Act of 1973 are creditable as compensation only for the month in which the employee first filed an application for benefits under that Act. The compensation to be credited cannot exceed the monthly creditable amounts defined in § 211.13(a) of this part for compensation earned prior to 1985 or the annual creditable amount defined

in § 211.13(b) of this part for compensation earned after 1984.

[53 FR 17185, May 16, 1988]

§ 211.13 Payments made after death.

Payments made by an employer with respect to a deceased employee but paid after the calendar year of the employee's death to the employee's survivors or estate are not creditable compensation.

[58 FR 45251, Aug. 27, 1993]

§ 211.14 Maximum creditable compensation.

Maximum creditable compensation for calendar years after 1984 is the maximum annual taxable wage base defined in section 3231(e)(2)(B) of the Internal Revenue Code of 1986. In November of each calendar year the Director of Research and Employment Accounts shall notify each employer of the amount of maximum creditable compensation applicable to the following calendar year.

[58 FR 45251, Aug. 27, 1993]

§ 211.15 Verification of compensation claimed.

Compensation claimed by an employee, which is not credited in the records of the Board, must be verified to the satisfaction of the Board before it may be credited. An employee's claim to compensation not credited shall be processed as follows:

(a) If the compensation claimed is in excess of the maximum creditable amounts defined in § 211.13 of this part, the Director of the Bureau of Research and Employment Accounts shall inform the employee that the compensation claimed is not creditable.

(b) If the compensation is claimed within four years from the date the compensation was required to be reported to the Board as prescribed in § 209.6 of this chapter, the Director of Research and Employment Accounts shall contact the employer requesting a review of their records, and if the employee's claim is correct, the employer will submit an adjustment crediting the employee with the compensation claimed. If the employer states that the employee's claim is incorrect, the employee will be requested to submit check stubs to show railroad retirement taxes withheld from the compensation claimed. Upon receipt of the check stubs, the proof will be sent to the employer along with a request for the employer to submit an adjustment crediting the employee with the compensation claimed.

[49 FR 46732, Nov. 28, 1984, as amended at 53 FR 17185, May 16, 1988. Redesignated at 58 FR 45251, Aug. 27, 1993]

§ 211.16 Finality of records of compensation.

(a) *Time limit for corrections to records of compensation.* The Board's record of the compensation reported as paid to an employee for a given period shall be conclusive as to amount, or if no compensation was reported for such period, then as to the employee's having received no compensation for such period, unless the error in the amount of compensation or the failure to make return of the compensation is called to the attention of the Board within four years after the date on which the compensation was required to be reported to the Board as provided for in § 209.6 of this chapter.

(b) *Correction after 4 years.* (1) The Board may correct a report of compensation after the time limit set forth in paragraph (a) of this section where the compensation was posted or not posted as the result of fraud on the part of the employer.

(2) Subject to paragraph (c) of this section, the Board may correct a report of compensation after the time limit set forth in paragraph (a) of this section for one of the following reasons:

(i) Where the compensation was posted for the wrong person or the wrong period;

(ii) Where the earnings were erroneously reported to the Social Security Administration in the good faith belief by the employer or employee that such earnings were not covered under the Railroad Retirement Act and there is a final decision of the Board under part 259 of this chapter that such employer or employee was covered under the Railroad Retirement Act during the period in which the earnings were paid;

(iii) Where a determination pertaining to the coverage under the Railroad Retirement Act of an individual,

partnership, or company as an employer, is retroactive; or

(iv) Where a record of compensation could not otherwise be corrected under this part and where in the judgment of the three-member Board that heads the Railroad Retirement Board failure to make a correction would be inequitable.

(c) *Limitation on crediting service.* (1) Except as provided in paragraph (b)(1) of this section, no employee may be credited with service months or tier II compensation beyond the four year period referred to in paragraph (a) of this section unless the employee establishes to the satisfaction of the Board that all employment taxes imposed by sections 3201, 3211, and 3221 of title 26 of the Internal Revenue Code have been paid with respect to the compensation and service.

(2) The limitation on the creditability of service months and tier II compensation in paragraph (c)(1) of this section shall not affect the creditability, for purposes of computing the tier I component of a railroad retirement annuity, of compensation payments with respect to which taxes have been paid under either the Railroad Retirement Tax Act or the Federal Insurance Contributions Act.

[62 FR 3790, Jan. 27, 1997]

PART 212—MILITARY SERVICE

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AUTHORITY: 45 U.S.C. 231f.

SOURCE: 49 FR 46734, Nov. 28, 1984, unless otherwise noted.

§ 212.1 General.

In determining an individual's entitlement and amount of benefits under the Railroad Retirement Act, an individual's military service creditable under the Railroad Retirement Act is used. This part defines military service as used under this Act and sets forth the criteria to determine the creditability of military service.

§ 212.2 Military service defined.

Military service is the performance of active service by an individual in the armed forces of the United States. An individual is considered to be in active military service when commissioned or enrolled in the land, naval or air forces of the United States until resignation or discharge therefrom. The service of an individual in any reserve component of the land, naval or air forces of the United States, during any period in which ordered to active duty, even though less than thirty days, is also considered active service. However, service in the Army Specialist Corps and the Merchant Marine is not creditable under the Railroad Retirement Act.

§ 212.3 Crediting of military service.

In determining an individual's entitlement to an annuity and the amount of annuity to be paid under the Railroad Retirement Act, a calendar month or part of a calendar month during which the individual was in the active military service of the United States in a war service period, or period of national emergency, as determined in §212.4 of this part, may be included in the individual's years of service. Military service is credited as though the individual had performed service for a railroad employer as provided for in part 210 of this chapter, provided that the individual is credited with railroad service in the year of or the year before entrance into active military service. Compensation for creditable military service shall be credited as provided for in §211.7 of this chapter.

§ 212.4 Periods of creditable military service.

In order for military service to be considered to be creditable under the Railroad Retirement Act, it must have been performed during one of the following periods:

(a) April 21, 1898, through August 13, 1898—Spanish American War;

(b) February 4, 1899, through April 27, 1902—Philippine Insurrection;

(c) May 9, 1916, through February 5, 1917—Mexican Border Disturbances;

(d) April 6, 1917, through November 11, 1918—World War I;

(e) September 8, 1939, through June 14, 1948—National Emergency and World War II. Individuals required to continue in service after this period may be credited with the service if:

(1) They were in military service on December 31, 1946, or

(2) They were required to remain in military service involuntarily after December 31, 1946;

(f) June 15, 1948, through December 15, 1950. This service is creditable if:

(1) Entered into involuntarily; or

(2) Entered into voluntarily, but only if:

(i) The individual who seeks credit for this service performs service as an employee for an employer as defined in part 202 of this chapter either in the year of his or her release from active military service or in the year following such release, and;

(ii) The individual does not engage in any employment not covered by part 203 between his or her release from active military service and his or her commencement of service for an employer.

(g) December 16, 1950, through September 14, 1978—National Emergency.

[49 FR 46734, Nov. 28, 1984, as amended at 55 FR 20454, May 17, 1990]

§ 212.5 Verification of military service.

Military service may be verified by the following proof:

(a) The original certificate of discharge or release to inactive duty from a branch of the armed forces that shows the beginning and ending dates of the individual's active military service; or a certified copy of the original certificate made by the Federal, State, county or municipal agency or department in which the original certificate is recorded; or

(b) A certificate from a branch of the armed forces that shows the beginning and ending dates of the individual's active military service; or

(c) A photocopy of the document described in paragraph (a) or (b) of this section.

§ 212.6 Board's determination for use of military service.

(a) Military service may be creditable under both the Railroad Retirement and Social Security Acts, but there are provisions under those Acts to prevent duplicate use of the service. The Railroad Retirement Board will determine whether an employee's military service should be used as railroad service or as Social Security service. The Board's determination is intended to be to the employee's advantage; however, if the employee does not agree with the Board's determination for use of the employee's military service, the employee may request that it be changed.

(b) Generally, it is to the employee's advantage for the employee's military service to be creditable as railroad service where any of the following conditions may be met with the use of the employee's military service as railroad service:

(1) It gives the employee 10 years of service (120 months), which is the minimum needed to qualify for an annuity based on age and service or total disability, as provided for in part 216, subpart B; or

(2) It gives the employee 20 years of service (240 months), which is the minimum needed to qualify for an occupational disability annuity, as provided for in § 216.6 of this chapter; or

(3) It gives the employee 25 years of service (300 months), which is the minimum needed to qualify for a supplemental annuity, as provided for in part 216, subpart C; or

(4) It gives the employee 30 years of service (360 months), which would allow the employee to retire at age 60 with a full annuity and will also provide a full annuity to a qualified spouse at age 60, as provided for in part 216, subparts B and D; or

(5) It gives the employee sufficient railroad service to entitle the employee to vested dual benefit payments, as provided for in part 216, subpart H.

(c) In certain cases it may be to the employee's advantage for the employee's military service to be credited under the Social Security Act. This is generally true under the following conditions:

(1) Crediting the military service under the Social Security Act would entitle the employee and any eligible children to social security benefits, since direct benefits are not payable to

children of retired employees under the Railroad Retirement Act; or

(2) Crediting the military service under the Social Security Act would entitle employee to vested dual benefit payments.

PART 216—ELIGIBILITY FOR AN ANNUITY

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AUTHORITY: 45 U.S.C. 231f.

SOURCE: 56 FR 28692, June 24, 1991, unless otherwise noted.

Subpart A—General

§ 216.1 Introduction.

This part explains when an individual is eligible for a monthly annuity under the Railroad Retirement Act. An individual eligible for an annuity as described in this part may become entitled to an annuity only in such amount as set forth in parts 225 through 229 of this chapter

(a) *Regular annuity*. A regular monthly annuity is provided for:

(1) An employee who retires because of age or disability;

(2) An employee's spouse or divorced spouse; or

(3) The widow, widower, child, parent, remarried widow or widower, or surviving divorced spouse of an employee.

(b) *Supplemental annuity*. An employee who retires because of age or disability may also be entitled to a supplemental annuity.

§ 216.2 Definitions.

Except as otherwise expressly noted, as used in this part—

Age means an individual's age on the day preceding the anniversary date of his or her birth.

Annuity means a payment due an entitled individual for a calendar month and made to him or her on the first day of the following month.

Apply means to sign a form or statement that the Railroad Retirement Board accepts as an application for benefits under the rules set out in part 217 of this chapter.

Attainment of age means that an individual attains a given age on the first moment of the day preceding the anniversary date of his or her birth corresponding to such numerical age.

Board means the Railroad Retirement Board.

Claimant means an individual who files an annuity application or for whom an annuity application is filed.

Eligible means that an individual meets all the requirements for payment of an annuity but has not yet applied for one.

Employee means an individual who is or has been in the service of an employer as here defined.

Employer means a company, individual, or other entity determined to be a covered employer under the Railroad Retirement Act as provided by part 202 of this chapter.

Entitled means that an individual has applied for and has established his or her rights to benefits.

Railroad Retirement Act means the Railroad Retirement Act of 1974, as amended.

Re-entitled annuity means an annuity to which an individual becomes entitled after an earlier-awarded annuity has been terminated. A re-entitled annuity is usually awarded on the basis of different factors of eligibility from the initial annuity, and may be awarded without the filing of another application.

Retirement age means, with respect to an employee who attains age 62 before January 1, 2000 (age 60 in the case of a widow(er), remarried widow(er) or surviving divorced spouse) age 65. For an employee who attains age 62 (or age 60 in the case of a widow(er), remarried widow(er), or surviving divorced spouse) after December 31, 1999, retirement age means the age provided for in section 216(1) of the Social Security Act.

Social Security Act means the Social Security Act as amended.

Tier I benefit means the benefit component calculated using Social Security Act formulas and based upon earnings covered under both the Railroad Retirement Act and the Social Security Act.

Tier II benefit means the benefit component calculated under a formula found in the Railroad Retirement Act and based only upon earnings and service in the railroad industry.

Year of service means 12 calendar months, consecutive or otherwise, of service creditable to an employee as described in part 210 of this chapter.

§ 216.3 Other regulations related to this part.

This part is related to a number of other parts. Part 217 of this chapter describes how to apply for an annuity. Part 218 indicates when annuities begin and when they terminate. Part 219 sets out what evidence is necessary to prove

eligibility. Where eligibility for an annuity is based upon a family relationship to an employee (for example, a widow's annuity), the definition of such family relationship may be found in part 222 of this chapter. Part 225 of this chapter describes the computation of the primary insurance amount.

Subpart B—Current Connection With the Railroad Industry

§ 216.11 General.

A current connection with the railroad industry is required to qualify for certain types of railroad retirement benefits. The existence of a current connection is clear in most cases where entitlement or death immediately follows continuous years of railroad employment. However, there are cases in which the employee did not work for a railroad employer for a period of time before entitlement or death. In these situations, special tests are applied to determine whether the employee can be considered to have a current connection with the railroad industry for the purpose of determining his or her eligibility for an annuity or other benefits.

§ 216.12 When current connection is required.

(a) A current connection is required to qualify an individual for the following types of railroad retirement benefits:

(1) An employee occupational disability annuity as described in subpart D of this part;

(2) A supplemental annuity as described in subpart E of this part;

(3) An employee vested dual benefit in certain cases;

(4) A survivor annuity as described in subparts G, H, and I of this part; and

(5) A lump-sum death payment as described in part 234 of this chapter.

(b) A current connection which was established when an employee's annuity began is effective for:

(1) Any annuity under this part for which the employee later becomes eligible; and

(2) Any survivor annuity under this part or a lump-sum death payment under part 234 of this chapter.

§ 216.13 Regular current connection test.

An employee has a current connection with the railroad industry if he or she meets one of the following requirements:

(a) The employee has creditable railroad service in at least 12 of the 30 consecutive months immediately preceding the earlier of:

(1) The month his or her annuity begins; or

(2) The month he or she dies.

(b) The employee has creditable railroad service in at least 12 months in a period of 30 consecutive months and does not work in any regular non-railroad employment in the interval between the month the 30-month period ends and the earlier of:

(1) The month his or her annuity begins; or

(2) The month he or she dies.

§ 216.14 Regular non-railroad employment that will not break a current connection.

Regular non-railroad employment will not break an employee's current connection if it is performed during the 30-month period described in § 216.13(b), in or after the month the annuity begins, or in the month the employee dies.

§ 216.15 Special current connection test.

(a) *For survivor annuities.* An employee who does not have a current connection under the regular test has a current connection only to qualify an individual for a survivor annuity if:

(1) The employee would not be fully or currently insured under section 214 of the Social Security Act if his or her railroad compensation after 1936 were treated as social security earnings;

(2) The employee has no quarters of coverage as defined in section 213 of the Social Security Act; or

(3) The employee received a pension or a retirement annuity that began before 1948 based on at least 114 months of service.

(b) *For survivor and supplemental annuities.* An employee who does not have a current connection under the regular test has a current connection in order

to pay a supplemental or survivor annuity if he or she meets all of the following requirements:

(1) Has been credited with at least 25 years of railroad service;

(2) Stopped working in the railroad industry ''involuntarily and without fault'' on or after October 1, 1975, or was on furlough, leave of absence or absent for injury on that date;

(3) Did not decline an offer of employment in the same ''class or craft'' as his or her most recent railroad service; and

(4) Was alive on October 1, 1981.

(c) *''Involuntarily and without fault'' defined.* An employee is considered to have stopped railroad employment involuntarily and without fault if:

(1) The employee loses his or her job;

(2) The employee could not, through the exercise of seniority rights, remain in railroad service in the same class or craft as his or her most recent railroad service, regardless of the location where that service would be performed; and

(3) The employee did not lose his or her job because of poor job performance, misconduct, medical reasons or other action or inaction on the part of the employee.

(d) *Effect of separation allowance.* An employee who accepts a separation allowance and in so doing relinquishes his or her seniority rights to railroad employment is deemed to have voluntarily terminated his or her railroad service. However, if the employee stopped railroad employment involuntarily and without fault, as defined in paragraph (c) of this section, receipt of a separation allowance will not affect a current connection under paragraph (b) of this section.

(e) *''Class or craft'' defined.* The terms''class or craft,'' as used in this section, have the same meaning as they do generally in the railroad industry.

(f) *For supplemental annuities only.* An additional special current connection test is required for an individual who was receiving a disability annuity which terminated due to the individual's recovery from disability. If the individual becomes entitled to a new annuity, a new current connection test based on the new annuity beginning date must be made. This test is made using the rules contained in §§ 216.13 and 216.17.

§ 216.16 What is regular non-railroad employment.

(a) Regular non-railroad employment is full or part-time employment for pay.

(b) Regular non-railroad employment does not include any of the following:

(1) Self-employment;

(2) Temporary work provided as relief by an agency of a Federal, State, or local government;

(3) Service inside or outside the United States for an employer under the Railroad Retirement Act, even if the employer does not conduct the main part of its business in the United States;

(4) Involuntary military service not creditable under the Railroad Retirement Act;

(5) Employment with the following agencies of the United States Government:

(i) Department of Transportation;

(ii) Interstate Commerce Commission;

(iii) National Mediation Board;

(iv) Railroad Retirement Board;

(v) National Transportation Safety Board; or

(vi) Surface Transportation Board.

(6) Employment entered into after early retirement by an employee who is receiving an annuity under Conrail's voluntary annuity program. This program is provided under the Staggers Rail Act of 1980 (Pub. L. 96–448); or

(7) Employment with the Alaska Railroad so long as it is an instrumentality of the State of Alaska.

[56 FR 28692, June 24, 1991, as amended at 62 FR 11324, Mar. 12, 1997]

§ 216.17 What amount of regular non-railroad employment will break a current connection.

The amount of regular non-railroad employment needed to break a current connection depends on when the applicable 30-month period ends (see § 216.13 of this part), as follows:

(a) If the 30-month period ends in the calendar year before or in the same calendar year as the annuity begins or the

month the employee dies, the current connection is broken if the employee:

(1) Works in each month in the interval after the end of the 30-month period and before the earlier of the month the annuity begins or the employee dies; or

(2) Works and earns at least $200 in wages in any 3 months within the interval described in paragraph (a)(1) of this section.

(b) If the 30-month period ends more than a year before the calendar year in which the annuity begins or the employee dies, the current connection is broken if the employee:

(1) Works in any 2 consecutive years wholly or partially within the interval after the end of the 30-month period and before the month the annuity begins or the employee dies, whichever is earlier; and

(2) Earns at least $1,000 in wages in any year wholly or partially within the interval described in paragraph (b)(1) of this section (but not counting earnings during the 30-month period and after the annuity beginning date), even if that year is not one of the 2 consecutive years described in paragraph (b)(1) of this section.

Subpart C—Railroad and Last Non-Railroad Employment

§ 216.21 General.

To be eligible for an employee, a spouse, or a divorced spouse annuity, the Railroad Retirement Act requires that an applicant must stop work for pay performed as an employee for a railroad employer. In addition, no employee, spouse or divorced spouse annuity may be paid for any month in which the employee, spouse or divorced spouse annuitant works for pay for any railroad employer after the date his or her annuity began. No annuity may be paid to a widow or widower, surviving divorced spouse, remarried widow or widower, child, or parent for any month such individual works for pay for a railroad employer.

§ 216.22 Work as an employee which affects payment.

(a) *Work for a railroad employer.* Work for pay as an employee of a railroad employer always prevents payment of an annuity.

(b) *Work for last non-railroad employer.* Work for pay in the service of the last non-railroad employer by whom an individual is employed will reduce the amount of the tier II benefit of the employee, spouse and supplemental annuity as provided in part 230 of this chapter. An individual's last non-railroad employer is:

(1) Any non-railroad employer from whom the individual last resigned (in point of time) in order to receive an annuity; and

(2) Any additional non-railroad employer from whom the individual resigned in order to have an annuity become payable. Employment which an individual stops within 6 months of the date on which the individual files for an annuity will be presumed in the absence of evidence to the contrary to be service from which the individual resigned in order to receive an annuity.

(c) *Corporate officers.* An officer of a corporation will be considered to be an employee of the corporation. A director of a corporation acting solely in his or her capacity as such director is not an employee of the corporation.

§ 216.23 Work which does not affect eligibility.

An individual may engage in any of the following without adversely affecting his or her annuity:

(a) *Work for a railway labor organization.* An individual may work for a local lodge or division of a railway labor organization if the pay is under $25 a month, unless the work performed is solely for the purpose of collecting insurance premiums.

(b) *Work without pay.* Work performed for any person or entity for which no pay is received, or where the pay merely constitutes reimbursement for out-of-pocket expenses, or where the amount received consists only of free will donations and there is no agreement that such donation shall constitute remuneration for services, does not affect entitlement to an annuity.

(c) *Self-employment.* Self-employment is work performed in an individual's own business, trade or profession as an independent contractor, rather than as an employee. An individual is not self-employed if the business is incorporated. The designation or description

of the relationship between the individual and another person as anything other than that of an employer and employee is immaterial. If the Board determines that an employer-employee relationship exists, the fact that the employee is designated as a partner, coadventurer, agent, independent contractor, or the like will be disregarded. An individual determined to be an employee of a railroad employer pursuant to part 203 of this chapter is not self-employed. Whether an individual performing services is an employee depends upon the degree to which the recipient of services controls the individual's work. Control is determined in accordance with general legal principles delineating an employer-employee relationship. Among the factors considered are:

(1) *Instructions.* An individual required to comply with instructions about when, where, and how to work is ordinarily an employee. Instructions may be oral or in the form of manuals or written procedures which show how the desired result is to be accomplished. An individual who ordinarily works without receiving instructions because he or she is highly skilled or knowledgeable may nevertheless be an employee if the employer has a right to instruct the individual in performance of the work.

(2) *Training.* Training provided an individual by an employer indicates that the employer wants the work to be performed in a particular method or manner, especially if the training is given periodically or at frequent intervals. An individual may be trained by an experienced employee working with him or her, by correspondence, by required attendance at meetings, or by other methods.

(3) *Integration into the employer's business.* Integration of an individual's services into the business operations of an employer generally shows that the individual is subject to direction and control. When the success or continuation of a business depends to an appreciable degree upon the performance of certain services, the individuals who perform those services must necessarily be subject to a certain amount of control by the owner of the business.

(4) *Services rendered personally.* A requirement that an individual personally work for the employer indicates that the employer is interested in the methods as well as the results, and that the employer intends to control the result by controlling who does the work.

(5) *Hiring, supervising, and payment of assistants.* An employer generally hires, supervises, and pays assistants. An individual who hires, supervises, and pays other workers at the direction of the employer may be an employee acting as a representative of the employer. However, if an individual hires, supervises, and pays his or her own assistants pursuant to a contract under which the individual agrees to provide materials and labor and under which the individual is responsible only for the attainment of a result, this factor indicates an independent contractor status.

(6) *Continuing work relationship.* A work relationship between an individual and an employer which continues over time indicates that the individual is an employee. A relationship may continue if the individual works at frequently recurring, though somewhat irregular intervals, either on call of the employer or when work is available.

(7) *Set hours of work.* A requirement that an individual work for an employer during a specified period of the day, week, month or year, or for a specified number of hours daily indicates that the individual is an employee. An individual whose occupation renders fixed hours impractical may be an employee if required by the employer to work at certain times.

(8) *Full time required.* A requirement that an individual devote full time to the employer's business indicates that the individual is an employee. What full time means may vary with the intent of the parties, the nature of the occupation, and customs in the locality. Full-time work may be required indirectly even though not specified in writing or orally. An individual required to produce a minimum volume of business for an employer may be compelled to devote full time to producing the work. Prohibiting work for

any other employer may require an individual to work full time to earn a living However, part-time work performed on a regular basis, or on call of the employer, or when work is available, may also render an individual an employee.

(9) *Working on employer's premises.* Working on the employer's premises may indicate that an individual is an employee where by nature the work could be done elsewhere, because the employer's place of business is physically within the employer's direction and supervision. Desk space, telephone, and stenographic services provided by an employer place the worker within the employer's direction and supervision unless the worker has the option not to use these facilities. Work done off the employer's premises does not by itself indicate that the worker is not an employee because some occupations require that work be performed away from the premises of the employer. Control over the place of work is indicated when the person or persons for whom the services are performed have the right to compel the worker to travel a designated route, to canvass a territory within a certain time, or to work at specific places as required.

(10) *Order or sequence set.* Performing tasks in the order or sequence set by the employer indicates that the worker is an employee. Often, because of the nature of an occupation, the person or persons for whom the services are performed do not set the order of the services or set the order infrequently. It is sufficient to show control, however, if such person or persons retain the right to do so.

(11) *Oral or written reports.* Regular oral or written reports submitted to the employer indicate that the worker is an employee, compelled to account to the employer for his or her actions.

(12) *Payment by hour, week, month.* Payment at a fixed rate per hour, week, or month indicates that an individual is an employee. Payment by commission with a guaranteed minimum salary, or by a drawing account at stated intervals with no requirement to repay amounts which exceed the individual's earnings, also indicates that an individual is an employee. Payment in a lump sum for a completed job indicates that an individual is self-employed. The lump sum may be computed by the number of hours required to do the job at a fixed hourly rate, or by weekly or monthly installments toward a lump sum agreed upon in advance as the total cost. Payment made on a straight commission basis generally indicates that the worker is an independent contractor.

(13) *Payment of business and/or traveling expenses.* Payment by the employer of expenses which an individual incurs in connection with the employer's business indicates that the individual is an employee.

(14) *Furnishing of tools and materials.* The fact that the person or persons for whom the services are performed furnish significant tools, materials, and other equipment tends to show the existence of an employer-employee relationship.

(15) *Investment in facilities.* If the worker invests in facilities which are used by the worker in performing services and which are not typically maintained by employees, such as an office rented by the worker from a party unrelated to the worker or to the employer, this factor tends to indicate that the worker is an independent contractor. On the other hand, if all facilities necessary to the work which an individual performs are furnished without charge by the employer, this factor indicates the existence of an employer-employee relationship. Facilities include equipment or premises necessary for the work, other than items such as tools, instruments, and clothing which may be commonly provided by an employee in a particular trade.

(16) *Realization of profit or loss.* An individual not in a position to realize a profit or suffer a loss as a result of work performed for an employer is an employee. An individual has an opportunity for profit or loss if he or she:

(i) Hires, directs, and pays assistants;

(ii) Has his or her own office, equipment, materials, or other facilities for doing the work;

(iii) Has continuing and recurring liabilities or obligations, and success or failure depends on the relation of receipts to expenditures; or

(iv) Agrees to perform specific jobs for prices agreed upon in advance and

pays expenses incurred in connection with the work.

(17) *Working for more than one firm at a time.* If a worker performs more than *de minimis* services for a number of unrelated persons or firms at the same time, this factor generally indicates that the worker is an independent contractor. However, a worker who performs services for more than one person may be an employee of each of the persons, especially where such persons are part of the same service arrangement.

(18) *Making service available to the general public.* The fact that an individual makes his or her services available to the general public on a regular and consistent basis rather than to one employer indicates that the individual is self-employed rather than an employee of any one firm. An individual may make services available to the public by working from his or her own office with assistants, from his or her own home, by holding business licenses, by a listing in a business directory, or by advertising.

(19) *Employer's right to discharge.* The right to discharge a worker is a factor which indicates that the worker is an employee and the person who possesses the right is an employer. An employer exercises control through the threat of dismissal, which causes the worker to obey the employer's instructions. An employer's right to discharge exists even if it is restricted due to a collective bargaining agreement. An employer ordinarily cannot end a relationship without incurring liability with a self-employed individual who meets contract specifications.

(20) *Employee's right to terminate.* The fact that an individual has the right to end his or her relationship with an employer at any time without incurring liability for work to be performed indicates that the individual is an employee. A self-employed individual is legally obligated to satisfactorily complete a specific job.

§ 216.24 Relinquishment of rights to return to work.

(a) *What return to work rights must be given up.* Before an individual may receive an annuity based on age, he or she must give up any seniority or other rights to return to work for any railroad employer.

(b) *When right to return to work is ended.* An individual's right to return to work for a railroad employer is ended whenever any of the following events occur:

(1) The employer reports to the Board that the individual no longer has the right;

(2) The individual or an authorized agent of that individual gives the employer an oral or written notice of the individual's wish to give up that right and:

(i) The individual certifies to the Board that the right has been given up;

(ii) The Board notifies the employer of the individual's certification; and

(iii) The employer either confirms the individual's right has been given up or fails to reply within 10 days following the day the Board mailed the notice to the employer;

(3) An event occurs which under the established rules or practices of the employer automatically ends that right;

(4) The employer or the individual or both take an action which clearly and positively ends that right;

(5) The individual never had that right and permanently stops working;

(6) The Board gives up that right for the individual, having been authorized to do so by the individual;

(7) The individual dies; or

(8) The individual signs a statement that he or she gives up all rights to return to work in order to receive a separation allowance or severance pay.

(The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 3220–0016)

Subpart D—Employee Annuity

§ 216.30 General.

The Railroad Retirement Act provides annuities for employees who have reached a specified age and have been credited with a specified number of years of service. The Act also provides annuities for employees who become disabled. In addition, to be eligible for an annuity an employee must comply with the work restrictions outlined in subpart C of this part.

§ 216.31 Who is eligible for an age annuity.

The Railroad Retirement Act provides annuities based on the employee's age for employees who have been credited with at least 10 years of railroad service.

(a) *Annuities based on 10 years of service.* An employee with 10 years of railroad service but less than 30 years of service is eligible for an annuity if he or she:

(1) Has attained retirement age; or

(2) Has attained age 62 (the annuity cannot begin prior to the first full month during which the employee is age 62) but is less than retirement age. All components of the annuity are reduced for each month the employee is under retirement age when the annuity begins.

(b) *Annuities based on 30 years of service.* An employee who has been credited with 30 years of railroad service is eligible for an annuity at age 60 (the annuity cannot begin prior to the first full month the employee is age 60). The Tier I component of the annuity is reduced if the employee meets the following conditions:

(1) The employee annuity begins before the month in which the employee is age 62; and either

(2) He or she had not attained age 60, prior to July 1, 1984; or

(3) He or she had not completed 30 years of railroad service prior to July 1, 1984.

(c) *Change from employee disability to age annuity.* A disability annuity paid to an employee through the end of the month before the month in which the employee attains retirement age is converted to an age annuity beginning with the month in which he or she attains retirement age.

§ 216.32 Who is eligible for a disability annuity.

The Railroad Retirement Act provides two types of disability annuities for employees who have been credited with at least 10 years of railroad service. An employee may receive an annuity if his or her disability prevents work in his or her regular railroad occupation. An employee who cannot be considered for a disability based on ability to work in his or her regular railroad occupation may receive an annuity if his or her disability prevents work in any regular employment.

(a) *Disability for work in regular railroad occupation.* An employee disabled for work in his or her regular occupation, as defined in part 220 of this chapter, is eligible for a disability annuity if he or she:

(1) Has not attained retirement age; and

(2) Has a current connection with the railroad industry; and has either:

(3) Completed 20 years of service; or

(4) Completed 10 years of service and is at least 60 years old.

(b) *Disabled for work in any regular employment.* An employee disabled for work in any regular employment, as defined in part 220 of this chapter, is eligible for a disability annuity if he or she:

(1) Is under retirement age; and

(2) Has completed 10 years of service.

§ 216.33 What is required for payment of an age or disability annuity.

In addition to the eligibility requirements listed above, an employee may be required to meet other conditions before payment of his or her annuity may begin.

(a) To receive payment of an employee annuity based on age, an eligible employee must:

(1) Apply to be entitled to an annuity; and

(2) Give up the right to return to service with his or her last railroad employer.

(b) If a disability annuity is converted to an age annuity when the annuitant attains retirement age, the age annuity cannot be paid until the employee gives up the right to return to work as described in subpart C of this part. The employee may authorize the Board to relinquish any such right on his or her behalf at the time when he or she applies for the disability annuity.

(c) To receive payment of an employee annuity based on disability, and eligible employee must apply to be entitled to an annuity.

(d) When requested, the employee must submit evidence to support his or

her application, such as proof of age or evidence of disability.

(The information collection requirements contained in this section were approved by the Office of Management and Budget under control number 3220–0002)

Subpart E—Supplemental Annuity

§ 216.40 General.

An employee with a current connection with the railroad industry at the time of retirement may qualify for a supplemental annuity in addition to the regular employee annuity. Supplemental annuities are paid from a separate account funded by employer taxes in addition to those assessed for regular annuities. The Board reduces a supplemental annuity if the employee receives a private pension based on contributions from a railroad employer.

§ 216.41 Who is entitled to a supplemental annuity.

An employee is entitled to a supplemental annuity if he or she:

(a) Has been credited with railroad service in at least one month before October 1981;

(b) Is entitled to the payment of an employee annuity awarded after June 30, 1966;

(c) Has a current connection with the railroad industry when the employee annuity begins;

(d) Has given up the right to return to work as shown in subpart C of this part; and either

(e) Is age 65 or older and has completed 25 years of service; or

(f) Is age 60 or older and under age 65, has completed 30 years of service, and is awarded an annuity on or after July 1, 1974.

§ 216.42 How a private railroad pension affects a supplemental annuity.

(a) *What is a private railroad pension.* The Board determines whether a pension established by a railroad employer is a private pension that will cause a reduction in the employee's supplemental annuity. A private pension for purposes of this subpart is a plan that:

(1) Is a written plan or arrangement which is communicated to the employees to whom it applies;

(2) Is established and maintained by an employer for a defined group of employees; and

(3) Provides for the payment of definitely determinable benefits to employees over a period of years, usually for life, after retirement or disability. Such a plan is sometimes referred to as a defined benefit plan.

(b) *Defined contribution plan.* A plan under which the employer is obligated to make fixed contributions to the plan regardless of profits (sometimes known as a money purchase plan) is a private pension plan. A plan under which the employer's contributions are discretionary is not a private pension plan under this section.

(c) *Other than retirement benefits.* A plan which provides benefits not customarily considered retirement benefits (such as unemployment benefits, sickness or hospitalization benefits) is not a private pension plan under this section.

(d) *Effective date of private railroad pension for supplemental annuity purposes.* A private pension reduces a supplemental annuity payment effective on the first day of the month after the month the Board determines that it is a private pension as defined in paragraph (a) of this section.

(e) *Effect of private railroad pension.* A supplemental annuity is reduced by the amount of any private pension the employee is receiving which is attributable to an employer's contributions, less any amount by which the private pension is reduced because of the supplemental annuity. The supplemental annuity is not reduced for the amount of a private pension attributable to the employee's contributions. The Board will determine the amount of a private pension for any month which is attributable to the employee's contributions.

§ 216.43 Effect of a supplemental annuity on other benefits.

(a) *Employee annuity.* A supplemental annuity that begins after December 31, 1974, does not affect the payment of a regular employee annuity. A supplemental annuity beginning prior to 1975 causes a reduction in the employee annuity as provided by section 3(j) of the Railroad Retirement Act of 1937.

(b) *Spouse or survivor annuity.* The payment of a supplemental annuity does not affect the amount of a spouse or survivor annuity.

(c) *Residual lump-sum.* The amount of a supplemental annuity is not deducted from the gross residual lump-sum benefit. See part 234 of this chapter for an explanation of the residual lump-sum benefit.

Subpart F—Spouse and Divorced Spouse Annuities

§ 216.50 General.

The Railroad Retirement Act provides annuities for the spouse, and divorced spouse, of an employee who is entitled to an employee annuity. A spouse may receive an annuity based on age, or on having a child of the employee in his or her care. A divorced spouse may only receive an annuity based on age. No spouse or divorced spouse annuity may be paid based upon disability.

§ 216.51 Who is eligible for a spouse annuity.

(a) To be eligible for an annuity, a spouse must:

(1) Be the husband or wife, as defined in part 222 of this chapter, of an employee who is entitled to an annuity described under subpart D of this part; and

(2) Stop working for any railroad employer.

(b) Where the employee's annuity began before January 1, 1975, the employee has completed less than 30 years of railroad service, and is age 65 or older, the spouse must be:

(1) Age 65 or older;

(2) Less than age 65 and have in his or her care a disabled child or minor child (a child under 18 years old if the spouse claimant is a wife, or under 16 years old if the spouse claimant is a husband) of the employee; or

(3) Age 62 or older but under age 65. In such case, all annuity components are reduced for each month the spouse is under age 65 at the time the annuity begins.

(c) Where the employee's annuity begins after December 31, 1974, the employee has completed 10 years but less than 30 years of railroad service, and has attained age 62, the spouse must be:

(1) Retirement age or older;

(2) Less than retirement age and have in his or her care a disabled child or a minor child (a child under 18 years old if the spouse claimant is a wife, or under 16 years old if the spouse claimant is a husband) of the employee; or

(3) Age 62 or older but under retirement age. In such case, all annuity components are reduced for each month the spouse is under retirement age at the time the annuity begins.

(d) Where the employee's annuity began after June 30, 1974, the employee has completed 30 years of railroad service, and is age 60 or older, the spouse must be:

(1) Age 60 or older;

(2) Less than age 60 and have in his or her care a disabled child or a minor child (a child under 18 years old if the spouse claimant is a wife, or under 16 years old if the spouse claimant is a husband) of the employee; or

(3) Age 60 but less than retirement age. In such case, the tier I component is reduced if the following conditions are met:

(i) The employee was under age 62 at the time his or her annuity began;

(ii) The employee annuity began after June 30, 1984;

(iii) The employee was under age 60 on June 30, 1984 or completed 30 years of railroad service after June 30, 1984; and

(iv) The spouse annuity begins after June 30, 1984.

§ 216.52 Who is eligible for an annuity as a divorced spouse.

To be eligible for a divorced spouse annuity, the employee annuitant must be at least age 62 and the divorced spouse (see § 222.22 of this chapter) must:

(a) Be the divorced wife or husband of an employee;

(b) Stop work for a railroad employer;

(c) Not be entitled to an old-age or disability benefit under the Social Security Act based on a primary insurance amount that is equal to or greater than one-half of the employee's tier I primary insurance amount; and either

(d) Have attained retirement age; or

(e) Have attained age 62 but be under retirement age. The annuity is reduced for each month the spouse is under retirement age at the time the annuity begins.

§ 216.53 What is required for payment.

An eligible spouse or divorced spouse must:

(a) Apply to be entitled to an annuity; and

(b) Give up the right to return to work for a railroad employer.

(Approved by the Office of Management and Budget under control number 3220–0016 and 3220–0042)

§ 216.54 Who is an employee's wife or husband.

An employee's wife or husband is an individual who—

(a) Is married to the employee; and

(b) Has been married to the employee for at least one year immediately before the date the spouse applied for annuity;

(c) Is the natural parent of the employee's child;

(d) Was entitled to an annuity as a widow(er), a parent, or a disabled child under this part in the month before he or she married the employee; or

(e) Could have been entitled to a benefit listed in paragraph (d) of this section, if the spouse had applied and been old enough in the month before he or she married the employee.

Subpart G—Widow(er), Surviving Divorced Spouse, and Remarried Widow(er) Annuities

§ 216.60 General.

The Railroad Retirement Act provides annuities for the widow(er), surviving divorced spouse, or remarried widow(er) of an employee. The deceased employee must have completed 10 years of railroad service and have had a current connection with the railroad industry at the time of his or her death. A widow(er), surviving divorced spouse, or remarried widow(er) may receive an annuity based on age, on disability, or on having a child of the employee in his or her care.

§ 216.61 Who is eligible for an annuity as a widow(er).

(a) A widow(er) of an employee who has completed 10 years of railroad service and had a current connection with the railroad industry at death is eligible for an annuity if he or she:

(1) Has not remarried; and either

(2) Has attained retirement age;

(3) Is at least 50 but less than 60 years of age and became disabled as defined in part 220 of this chapter before the end of the period described in § 216.68 (this results in a reduced annuity);

(4) Is less than retirement age but has in his or her care a child who either is under age 18 (16 with respect to the tier I component) or is disabled and who is entitled to an annuity under subpart H of this part; or

(5) Is at least 60 years of age but has not attained retirement age. (In this case, all components of the annuity are reduced for each month the widow(er) is age 62 or over but under retirement age when the annuity begins. For each month the widow(er) is at least age 60 but under age 62, all components of the annuity are reduced as if the widow(er) were age 62).

§ 216.62 Who is eligible for an annuity as a surviving divorced spouse.

(a) A surviving divorced spouse of an employee who completed 10 years of railroad service and had a current connection with the railroad industry at death, is eligible for an annuity if he or she:

(1) Is unmarried;

(2) Is not entitled to an old-age benefit under the Social Security Act that is equal to or higher than the surviving divorced spouse's annuity before any reduction for age; and either

(3) Has attained retirement age;

(4) Is at least 50 years of age but less than retirement age and is disabled as defined in part 220 of this chapter before the end of the period described in § 216.68 (this results in a reduced annuity.);

(5) Is less than retirement age but has in his or her care a child who either is under age 16 or is disabled and who is entitled to an annuity under subpart H of this part; or

(6) Is at least 60 years of age but has not attained retirement age. In this

case, the annuity is reduced for each month the surviving spouse is under retirement age when the annuity begins.

(b) A disabled surviving spouse's annuity is converted to an annuity based on age beginning the month he or she becomes 60 years old. The annuity rate does not change.

(c) If a surviving divorced spouse marries after attaining age 60 (or age 50 if he or she is a disabled surviving divorced spouse), such marriage shall be deemed not to have occurred.

§ 216.63 Who is eligible for an annuity as a remarried widow(er).

(a) A widow(er) of an employee who completed 10 years of railroad service and had a current connection with the railroad industry at death is eligible for an annuity as a remarried widow(er) if he or she:

(1) Remarried either:

(i) After having attained age 60 (after age 50 if disabled); or

(ii) Before age 60 but the marriage terminated;

(2) Is not entitled to an old-age benefit under the Social Security Act that is equal to or higher than the full amount of the remarried widow(er)'s annuity before any reduction for age; and

(3) Has attained retirement age;

(4) Is at least 50 but less than 60 years of age and is disabled as defined in part 220 of this chapter before the end of the period described in § 216.68 (this results in a reduced annuity);

(5) Has not attained retirement age but has in his or her care a child who either is under age 16 or is disabled, and who is entitled to an annuity under subpart H of this part; or

(6) Is at least age 60 but has not attained retirement age. (In this case, the annuity is reduced for each month the remarried widow(er) is under retirement age when the annuity begins.)

(b) An individual entitled to a widow(er)'s annuity may be entitled to an annuity as a remarried widow(er) if he or she:

(1) Remarries after having attained age 60 (after age 50 if he or she has been determined to be disabled prior to his or her remarriage) and is not a surviving divorced spouse; or

(2) Is entitled to an annuity based upon having a child of the employee in his or her care and marries an individual entitled to a retirement, disability, widow(er)'s, mother's, father's, parent's, or disabled child's benefit under the Railroad Retirement Act or Social Security Act.

§ 216.64 What is required for payment.

An eligible widow(er), surviving divorced spouse, or remarried widow(er) must:

(a) Apply to be entitled for an annuity; and

(b) Submit evidence requested by the Board to support his or her application.

(Approved by the Office of Management and Budget under control number 3220–0030)

§ 216.65 Who is an employee's widow(er).

An individual who was married to the employee at the employee's death is the deceased employee's widow(er) if he or she:

(a) Was married to the employee for at least 9 months before the day the employee died;

(b) Is the natural parent of the employee's child;

(c) Was married to the employee when either the employee or the widow(er) adopted the other's child, or they both legally adopted a child who was then under 18 years old;

(d) Was married to the employee less than 9 months before the employee died but, at the time of marriage, the employee was reasonably expected to live for 9 months; and

(1) The employee's death was accidental;

(2) The employee died in the line of duty while he or she was serving active duty as a member of armed forces of the United States; or

(3) The surviving spouse was previously married to the employee for at least 9 months;

(e) Was entitled in the month before the month of marriage to either:

(1) A benefit under section 202 of the Social Security Act as a widow, widower, spouse (divorced spouse, surviving divorced spouse), father, mother, parent, or disabled child; or

(2) An annuity under the Railroad Retirement Act as a widow, widower,

divorced spouse, or surviving divorced spouse, parent or disabled child; or

(f) Could have been entitled to a benefit listed in paragraph (e) of this section, if the widow(er) had applied and been old enough to qualify therefor in the month before the month of marriage.

§ 216.66 Who is an employee's surviving divorced spouse.

An individual who was married to the employee is the deceased employee's surviving divorced spouse if he or she:

(a) Was married to the employee for a period of at least 10 years immediately before the date the divorce became final, and applies for an annuity based on age or disability; or

(b) Applies for an annuity based on having a ''child in care'' and either:

(1) Is the natural parent of the employee's child;

(2) Was married to the employee at the time the employee or the surviving divorced spouse adopted the other's child who was then under 18 years old; or

(3) Was married to the employee at the time they adopted a child who was then under 18 years old.

§ 216.67 "Child in care."

(a) *Railroad Retirement Act.* Part 222 of this chapter sets forth what is required to establish that a child is in an individual's care for purposes of the Railroad Retirement Act. This definition is used to establish eligibility for the tier II component of a female spouse or widow(er) annuity under that Act. Under this definition a child must be under age 18 or under a disability before any benefit is payable based upon having the child in care.

(b) *Social Security Act.* In order to establish eligibility for the tier I components of a spouse or widow(er) annuity, and eligibility for a surviving divorced spouse annuity based upon having a child of the employee in care, the definition of ''child in care'' found in the Social Security Act is used. Under this definition, a child must be under age 16 or under a disability.

§ 216.68 Disability period for widow(er), surviving divorced spouse, or remarried widow(er).

A widow(er), surviving divorced spouse, or remarried widow(er) who has a disability as defined in part 220 of this chapter is eligible for an annuity only if the disability began before the end of a period which:

(a) Begins in the later of:

(1) The month in which the employee died;

(2) The last month for which the widow(er) or surviving divorced spouse was entitled to an annuity for having the employee's child in care; or

(3) The last month for which the widow(er) or surviving divorced spouse was entitled to a previous annuity based on disability; and

(b) Ends with the earlier of:

(1) The month before the month in which the widow(er) or surviving divorced spouse or remarried widow(er) become 60 years old; or

(2) The last day of the last month of a 7-year period (84 consecutive months) following the month in which the period began.

Subpart H—Child's Annuity

§ 216.70 General.

The Railroad Retirement Act provides an annuity for the child of a deceased employee but not for the child of a living employee. The Act does provide that the child of a living employee can establish another individual's eligibility for a spouse annuity or cause an increase in the annuities of an employee and spouse. The eligibility requirements described in this subpart also apply for the following purposes, except as otherwise indicated in this part:

(a) To establish annuity eligibility for a spouse under subpart F of this part if he or she has the employee's eligible child in care;

(b) To establish annuity eligibility for a widow(er), or surviving divorce spouse or remarried widow(er) under subpart G of this part if he or she has the employee's child in care; or

(c) To provide an increase in the employee's annuity under the Social Security Overall Minimum Guaranty (see

part 229) by including the eligible child.

§ 216.71 Who is eligible for a child's annuity.

An individual is eligible for a child's annuity if the individual:

(a) Is a child of an employee who has completed 10 years of railroad service and had a current connection with the railroad industry when he or she died;

(b) Is not married at the time the application is filed;

(c) Is dependent upon the employee as defined in part 222 of this chapter; and

(d) Meets one of the following at the time the application is filed:

(1) Is under age 18; or

(2) Is age 18 or older and either:

(i) Is disabled as defined in part 220 of this chapter before attaining age 22 (the disability must continue through the time of application for benefits);

(ii) Is under age 19 and is a full-time student as defined in § 216.74 of this part; or

(iii) Becomes age 19 in a month in which he or she is a full-time student and has not completed the requirement for, or received a diploma or certificate from, a secondary school.

§ 216.72 What is required for payment of a child's annuity.

An eligible child of a deceased employee is entitled to an annuity upon applying therefor and submitting any evidence requested by the Board.

(Approved by the Office of Management and Budget under control number 3220–0030)

§ 216.73 Who may be re-entitled to a child's annuity.

If an individual's entitlement to a child's annuity has ended, the individual may be re-entitled if he or she has not married and he or she applies to be re-entitled. The re-entitlement may begin with:

(a) The first month in which the individual is a full-time student if he or she is under age 19, or is age 19 and has not completed requirements for, or received a diploma or certificate from, a secondary school;

(b) The first month the individual is disabled, if the disability began before he or she attained age 22 and continues through the time of application for benefits; or

(c) The first month in which the individual is under a disability that began before the last day of a 7-year period (84 consecutive months) following the month in which the previous child's annuity ended, or the individual was no longer included as a disabled child in a railroad retirement annuity paid under the Social Security Overall Minimum Annuity (see part 229).

§ 216.74 When a child is a full-time elementary or secondary school student.

(a) A child is a full-time elementary or secondary school student if he or she meets all of the following conditions:

(1) The child is in full-time attendance at an elementary or secondary school; or

(2) The child is instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which the child resides; or

(3) The child is in an independent study elementary or a secondary education program administered by the local school, district, or jurisdiction, which is in accordance with the law of the State or other jurisdiction in which he or she resides.

(b) The child is in full-time attendance in a day or evening non-correspondence course of at least 13 weeks duration and he or she is carrying a subject load that is considered full-time for day students under the institution's standards and practices. If he or she is in a home schooling program as described in paragraph (a)(2) of this section, he or she must be carrying a subject load that is considered full-time for day students under the standards and practices set by the State or other jurisdiction in which the student resides.

(c) To be considered in full-time attendance, scheduled attendance must be at the rate of at least 20 hours per week unless one of the exceptions in paragraphs (c) (1) and (2) of this section applies. If the student is in an independent study program as described in paragraph (a)(3) of this section, the number of hours spent in school attendance is determined by combining

the number of hours of attendance at a school facility with the agreed upon number of hours spent in independent study. The student may still be considered in full-time attendance if the scheduled rate of attendance is below 20 hours per week if the Board finds that:

(1) The school attended does not schedule at least 20 hours per week and going to that particular school is the student's only reasonable alternative; or

(2) The student's medical condition prevents him or her from having scheduled attendance of at least 20 hours per week. To prove that the student's medical condition prevents him or her from scheduling 20 hours per week, the Board may request that the student provide appropriate medical evidence or a statement from the school; or

(3) The student is not attending classes, but is graduating in that month and classes ended the month before.

(d) An individual is not a full-time student if, while attending an elementary or secondary school, he or she is paid compensation by an employer who has requested or required that the individual attend the school. An individual is not a full time student while he or she is confined in a penal institution or correctional facility because he or she committed a felony after October 19, 1980.

(e) A student who reaches age 19 but has not completed the requirements for a secondary school diploma or certificate and who is a full-time elementary or secondary student, as defined in paragraph (a) of this section, will continue to be eligible for benefits until the first day of the first month following the end of the quarter or semester in which he or she is then enrolled, or if the school is not operated on a quarter or semester system, the earlier of:

(1) The first day of the month following completion of the course(s) in which he or she was enrolled when age 19 was reached; or

(2) The first day of the third month following the month in which he or she reached age 19.

[63 FR 17326, Apr. 9, 1998]

§ 216.75 When a child is a full-time student during a period of non-attendance.

A student who has been in full-time attendance at an elementary or secondary school is considered a full-time student during a period of non-attendance (include part-time attendance) if:

(a) The period of non-attendance is 4 consecutive months or less;

(b) The student shows to the satisfaction of the Board that he or she intends to return, or the student does return, to full-time attendance at the end of the period; and

(c) The student has not been expelled or suspended from the school.

Subpart I—Parent's Annuity

§ 216.80 General.

The Railroad Retirement Act provides an annuity for the surviving parent of a deceased employee. The deceased employee must have completed 10 years of railroad service and have had a current connection with the railroad industry at the time of his or her death. A parent may only receive an annuity based on age.

§ 216.81 Who is eligible for a parent's annuity.

(a) Where the employee is not survived by a widow(er), or child who is or ever could be entitled to an annuity as described by subpart G or H of this part, a parent of the deceased employee is eligible for both the tier I and tier II components of an annuity if he or she:

(1) Is age 60 or older;

(2) Has not married since the employee died;

(3) Received one-half of his or her support (as defined in part 222 of this chapter) from the employee at the time the employee died; and

(4) Files proof of support as provided for in paragraphs (b)(4) and (b)(5) of this section.

(b) Where the employee is survived by a widow(er), or child who is or ever could be entitled to an annuity as described by subpart G or H of this part, a parent of the deceased employee is eligible for an annuity consisting of the tier I component alone if he or she:

(1) Is age 60 or older;

(2) Has not married since the employee died;

(3) Is not in receipt of an old age benefit under the Social Security Act equal to or exceeding the amount of the parent's tier I annuity amount before it is reduced for the family maximum but after the sole survivor minimum is considered;

(4) Received at least one-half of his or her support (as defined in part 222 of this chapter) from the employee either:

(i) When the employee died, or

(ii) At the beginning of the period of disability if the employee has a period of disability (as explained in part 220 of this chapter) which did not end before death; and

(5) Files proof of support with the Board within 2 years after either:

(i) The month in which the employee filed an application for a period of disability if support is to be established as of the beginning of the period of disability; or

(ii) The date of the employee's death if support is to be established at that point.

(c) The Board may accept proof of support filed after the 2-year period for reasons which constitute good cause to do so as that term is defined in part 219 of this chapter.

§ 216.82 What is required for payment.

An eligible parent must file an application and submit the evidence requested by the Board to be entitled to an annuity.

(Approved by the Office of Management and Budget under control number 3220–0030)

Subpart J—Eligibility for More Than One Annuity

§ 216.90 General.

An individual may meet the eligibility provisions for more than one annuity described in this part. The Railroad Retirement Act generally requires that the total amount of annuities otherwise independently payable to one individual must be reduced if that individual is entitled to multiple annuities. Entitlement as a survivor includes entitlement as a widow(er), surviving divorced spouse, remarried widow(er), child, or parent.

§ 216.91 Entitlement as an employee and spouse, divorced spouse, or survivor.

(a) *General.* If an individual is entitled to an annuity as a spouse, divorced spouse or survivor, and is also entitled to an employee annuity, then the spouse, divorced spouse or survivor annuity must be reduced by the amount of the employee annuity. However, this reduction does not apply (except as provided in paragraph (b) of this section) if the spouse, divorced spouse or survivor or the individual upon whose earnings record the spouse, divorced spouse or survivor annuity is based worked for a railroad employer or as an employee representative before January 1, 1975.

(b) *Tier I reduction.* If an individual is entitled to an annuity as a spouse, divorced spouse or survivor, and is also entitled to an employee annuity, then the tier I component of the spouse, divorced spouse or survivor annuity must be reduced by the amount of the tier I component of the employee annuity. Where the spouse or survivor is entitled to a tier II component, then a portion of this reduction may be restored in the computation of this component.

§ 216.92 Entitlement as a spouse or divorced spouse and as a survivor.

If an individual is entitled to both a spouse or divorced spouse and survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she can receive the smaller annuity rather than the larger annuity.

§ 216.93 Entitlement to more than one survivor annuity.

If an individual is entitled to more than one survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she can receive the smaller annuity rather than the larger annuity.

§ 216.94 Entitlement to more than one divorced spouse annuity.

If an individual is entitled to more than one annuity as a divorced spouse, only the larger annuity will be paid. However, if the individual so chooses, he or she can receive the smaller annuity rather than the larger annuity.

PART 217—APPLICATION FOR ANNUITY OR LUMP SUM

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AUTHORITY: 45 U.S.C. 231d and 45 U.S.C. 231f.

SOURCE: 47 FR 7647, Feb. 22, 1982, unless otherwise noted.

Subpart A—General

§ 217.1 Introduction.

This part prescribes how to apply for an annuity or lump-sum payment under this chapter. It contains the rules for the filing and cancellation of an application and the period of time the application is in effect. Eligibility requirements for an annuity and for a lump-sum payment are found respectively in parts 216 and 234 of this chapter.

[54 FR 13363, Apr. 3, 1989]

§ 217.2 Definitions.

The following definitions are used in this part:

Applicant means a person who signs an application for an annuity or lump sum for himself or herself or for some other person.

Application refers only to a form described in § 217.6.

Apply or *file* means to sign a form or statement that the Railroad Retirement Board accepts as an application.

Award means to process a form to make a payment. An annuity is awarded on the date the payment form is processed.

Claimant means a person who files for an annuity or lump sum for himself or herself or the person for whom an application is filed.

§ 217.3 Need to file an application.

In addition to meeting other requirements, a person must file an application to become entitled to an annuity or lump sum. Filing an application will—

(a) Permit a formal decision on whether the person is entitled to an annuity or lump sum;

(b) Protect a person's entitlement to an annuity for as many as 12 months before the application is filed; and

(c) Provide the right to appeal if the person is dissatisfied with the decision (see part 260 of this chapter).

(Approved by the Office of Management and Budget under control numbers 3220–0030, 3220–0031 and 3220–0042)

[47 FR 7647, Feb. 22, 1982, as amended at 52 FR 11017, Apr. 6, 1987]

Subpart B—Applications

§ 217.5 When an application is a claim for an annuity or lump sum.

An application is a claim for an annuity or lump sum if it meets all of the following conditions:

(a) It is on an application form completed and filed with the Board as described in § 217.6;

(b) It is signed by the claimant or by someone described in § 217.17 who can sign the application for the claimant;

(c) It is filed with the Board on or before the date of death of the claimant. (See § 217.10 for limited exceptions.)

(Approved by the Office of Management and Budget under control number 3220–0002)

[47 FR 7647, Feb. 22, 1982, as amended at 52 FR 11017, Apr. 6, 1987]

§ 217.6 What is an application filed with the Board.

(a) *General.* An application filed with the Board is generally one that is filed on a form set up by the Board for that purpose. See part 200 of this chapter for a list of application forms.

(b) *Claim filed with the Social Security Administration.* An application filed for benefits under title II of the Social Security Act on one of the forms set up by the Social Security Administration for that purpose (except an application for a disability insurance benefit that terminated before the employee completed his or her 120th month of creditable railroad service) is also considered an application for an annuity or lump sum if it is filed as shown in § 217.7.

(c) *Claim filed with the Veterans Administration.* An application filed with the Veterans Administration on one of its forms for survivor benefits under section 3005 of title 38, United States Code, is also considered an application for a survivor annuity.

§ 217.7 Claim filed with the Social Security Administration.

(a) *Claim is for life benefits.* An application for life benefits under title II of the Social Security Act is an application for an annuity if the conditions either in paragraphs (a)(1), (2), and (3) or in paragraph (a)(4) of this section are met:

(1) The application was filed because the applicant did not know he or she was eligible for an annuity under the Railroad Retirement Act. The Board must have or receive evidence indicating why the applicant thought that he or she lacked eligibility for an annuity.

(2) The claimant would have been entitled to and would currently be entitled to an annuity under subpart B or D of part 216 of this chapter if the applicant had applied for the annuity on the date the social security application was filed.

(3) The applicant asks the Board in a written statement to consider the application for social security benefits as an application for an employee or spouse annuity.

(4) The application was filed because the employee had less than 10 years of creditable railroad service, and having established entitlement to social security benefits and continued working in railroad service, subsequently acquired 10 years of railroad service.

(b) *Claim is for death benefits.* An application for death benefits under title II of the Social Security Act is an application for an annuity or lump sum if—

(1) The application is filed based on the death of an employee and the Board has jurisdiction for the payment of survivor benefits based on the compensation record of the deceased employee; and

(2) The claimant is eligible for an annuity or a lump-sum death payment on the date the application is filed.

§ 217.8 When one application satisfies the filing requirement for other benefits.

An annuity application filed with the Board is generally considered as an application for other benefits to which a person is or may be eligible. Therefore a claimant does not need to file another application to be entitled to any of the following types of benefits:

(a) An employee age annuity if—

(1) The employee's application for a disability annuity is denied and the employee is eligible for the age annuity on the date the application is filed; or

(2) The employee is entitled to a disability annuity in the month before the month he or she is 65 years old.

(b) An employee disability annuity if an application for an age annuity is denied and the employee is eligible for the disability annuity on the date the application is filed.

(c) An accrued employee or supplemental annuity, or a residual lump sum, if a claimant is eligible for one of these payments when he or she files an

application for a survivor annuity or lump-sum payment under this chapter.

(d) A widow(er)'s annuity if the widow(er) was entitled to a spouse annuity in the month before the month the employee died.

(e) A widow(er)'s annuity if the widow(er) was included in the computation of the employee's annuity under the social security overall minimum provision of the Railroad Retirement Act in the month before the month the employee died.

(f) A child's annuity if the spouse of the employee had the child ''in care'' and was entitled to a spouse annuity in the month before the month the employee died.

(g) A child's annuity or child's full-time student annuity if the child of the employee was included in the computation of the employee's annuity under the social security overall minimum provision of the Railroad Retirement Act in the month before the month the employee died.

(h) A widow(er)'s annuity based on age if the widow(er) was entitled to a widow(er)'s annuity based on disability in the month before the month in which he or she attains age 60.

(i) A widow(er)'s annuity based on age or disability if a widow(er), who was receiving an annuity because he or she had the employee's child ''in care'', is eligible for an age or disability annuity when he or she no longer has an eligible child ''in care''.

(j) A spouse annuity based on age if a spouse, who was receiving an annuity because he or she had the employee's child ''in care'', is eligible for an unreduced age annuity when he or she no longer has an eligible child ''in care''.

(k) A widow(er)'s annuity based upon having the employee's child ''in care'' if during the time the widow(er) is entitled to an annuity based on disability, he or she has ''in care'' a child of the deceased employee.

(l) A divorced spouse annuity if the divorced spouse was entitled to a spouse annuity reduced for age in the month before the month of the effective date of the final decree of divorce.

(m) A divorced spouse annuity if the spouse claimant has remarried the employee during the six-month retroactive period of the spouse annuity application.

(n) A divorced spouse annuity if the divorced spouse was entitled to a spouse annuity not reduced for age in the month before the month of the effective date of the final decree of divorce and would also be entitled to a divorced spouse annuity not reduced for age.

(o) A surviving divorced spouse annuity if the surviving divorced spouse was entitled to a divorced spouse annuity in the month before the month the employee died.

(p) A remarried widow(er)'s annuity if the remarried widow(er) was entitled to a widow(er)'s annuity in the month before the month of remarriage.

(q) A remarried widow(er)'s annuity or a surviving divorced spouse annuity based on age or disability if the remarried widow(er) or surviving divorced spouse, who was receiving an annuity because he or she had the employee's child ''in care'', is eligible for an age or disability annuity when he or she no longer has an eligible child ''in care''.

(r) A remarried widow(er)'s annuity or a surviving divorced spouse annuity based on age if the remarried widow(er) or the surviving divorced spouse was entitled to an annuity based on the disability in the month before the month in which he or she attains age 65.

(s) A remarried widow(er)'s annuity or a surviving divorced spouse annuity based on age if the remarried widow(er) or surviving divorced spouse, who was receiving an annuity based on disability, is 60 years old or older when he or she recovers from the disability.

(t) A benefit under title II of the Social Security Act unless the applicant restricts the application only to an annuity payable under the Railroad Retirement Act.

(u) An accrued annuity due at the death of a spouse or divorced spouse if the claimant is entitled to an employee annuity on the same claim number.

(v) A full-time student's annuity if the student was entitled to a child's annuity in the month before the month the child attained age 18.

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13363, Apr. 3, 1989; 60 FR 21982, May 4, 1995; 66 FR 27454, May 17, 2001]

§ 217.9 Effective period of application.

(a) *When effective period ends.* The effective period of an application ends on the date of the notice of an initial decision denying the claim. If a timely appeal is made (see part 260 of this chapter) the effective period of the application ends on the date of the notice of the decision of the referee, on the date of the notice of the final decision of the Board, or when court review of the denial has been completed. After the effective period of an application ends, the person must file a new application for any annuity or lump sum to which the claimant believes he or she is eligible.

(b) *Application filed before claimant is eligible*—(1) *General rule.* Except as shown in paragraph (b)(2) and paragraph (b)(3) of this section, an application for an annuity must be denied if it is filed with the Board more than three months before the date an annuity can begin.

(2) *Application for disability annuity.* If the Board determines that a claimant for a disability annuity is disabled under part 220 of this chapter, beginning with a date after the application is filed and before a final decision is made, the application is treated as though it were filed on the date the claimant became disabled. The claimant may be an employee, widow(er), surviving divorced spouse, remarried widow(er), or surviving child.

(3) *Application for spouse annuity filed simultaneously with employee disability annuity application.* When the qualifying employee's annuity application effective period is determined by the preceding paragraph (b)(2) of this section, a spouse who meets all eligibility requirements may file an annuity application on the same date as the employee claimant. The spouse application will be treated as though it were filed on the later of the actual filing date or the employee's annuity beginning date.

(c) *Application filed after the claimant is eligible*—(1) *Application for lump-sum death payment.* An application for a lump-sum death payment under part 234 of this chapter must be filed within two years after the death of the employee. This period may be extended under the Soldiers' and Sailors' Civil Relief Act of 1940, or when the applicant can prove ''good cause'' under § 217.11 of this chapter for not filing within the time limit.

(2) *Application for annuity unpaid at death.* An application for an annuity due but unpaid at death under part 234 of this chapter must be filed within two years after the death of the person entitled to the annuity. This period may be extended under the Soldiers' and Sailors' Civil Relief Act of 1940, or when the applicant can prove ''good cause'' under § 217.11 of this chapter for not filing within the time limit.

(3) *Application for residual lump sum.* An application for a residual lump sum under part 234 of this chapter may be filed at any time after the death of the employee.

(4) *Application for a period of disability.* In order to be entitled to a period of disability under part 220 of this chapter, an employee must apply while he or she is disabled under part 220 or not later than 12 months after the month in which the period of disability ends except that an employee who is unable to apply within the 12-month period after the period of disability ends because his or her physical condition limited his or her activities to the extent that he or she could not complete and sign an application or because he or she was mentally incompetent, may apply no later than 36 months after the period of disability ends.

(Approved by the Office of Management and Budget under control number 3220–0002)

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13363, Apr. 3, 1989; 67 FR 42714, June 25, 2002]

§ 217.10 Application filed after death.

(a) A survivor eligible for an annuity or lump sum under this chapter may file an application to establish a period of disability if the employee dies before filing an application for a disability annuity. A period of disability is defined in part 220 of this chapter. The application must be filed within three months after the month the employee died.

(b) A person who could receive payment for the estate of a person who paid the burial expenses of the deceased employee may file an application if the person who paid the burial

expenses dies before applying for the lump-sum death payment under part 234 of this chapter. The application must be filed within the two-year period shown in § 217.9 (c)(1).

(c) A widow(er) or surviving divorced spouse may file an application for a spouse or divorced spouse annuity after the death of the employee if the widower(er) or surviving divorced spouse was eligible for a spouse or divorced spouse annuity in any month before the month the employee died. The spouse or divorced spouse annuity is payable from the beginning date set forth in part 218 of this chapter.

(Approved by the Office of Management and Budget under control numbers 3220–0031 and 3220–0032)

[47 FR 7647, Feb. 22, 1982, as amended at 52 FR 11017, Apr. 6, 1987; 54 FR 13364, Apr. 3, 1989]

§ 217.11 "Good cause" for delay in filing application.

(a) An applicant has ''good cause'' for a delay in the filing of an application for a lump-sum death payment or an annuity unpaid at death, as shown in § 217.9(c)(1) and (2), if the delay was due to—

(1) Circumstances beyond the applicant's control, such as extended illiness, mental or physical incapacity, or communication difficulties; or

(2) Incorrect or incomplete information furnished by the Board; or

(3) Efforts by the applicant to secure evidence without realizing that evidence could be submitted after filing an application; or

(4) Unusual or unavoidable circumstances which show that the applicant could not reasonably be expected to have been aware of the need to file an application within the set time limit.

(b) An applicant does not have good cause for a delay in filing if he or she was informed of the need to file within the set time limit but neglected to do so or decided not to file.

Subpart C—Filing An Application

§ 217.15 Where to file.

(a) *Applicant in U.S. or Canada.* An applicant who lives in the United States or Canada may file an application at any Board office in person or by mail. An applicant may also give the application to any Board field employee who is authorized to receive it at a place other than a Board office.

(b) *Application outside U.S.* An applicant who lives outside the United States or Canada may file an application at any United States Foreign Service office. An applicant may also send the application to an office of the Board.

§ 217.16 Filing date.

An application filed in a manner and form acceptable to the Board is officially filed with the Board on the earliest of the following dates:

(a) On the date it is received at a Board office.

(b) On the date it is delivered to a field employee of the Board as described in § 217.15.

(c) On the date it is received at any office of the U.S. Foreign Service.

(d) On the date the application was mailed, as shown by the postmark, if using the date it is received will result in the loss or reduction of benefits.

(e) On the date the Social Security Administration considers the application filed, if it is filed with the Social Security Administration or the Veterans Administration.

§ 217.17 What is an acceptable signature.

An application may be signed according to the following rules:

(a) A claimant who is 18 years old or older, competent (able to handle his or her own affairs), and physically able to sign the application, must sign in his or her own handwriting, except as provided in paragraph (e) or paragraph (f) of this section. A parent or a person standing in place of a parent must sign the application for a child who is not yet 18 years old, except as shown in paragraph (d) of this section.

(b) A claimant who is unable to write must make his or her mark. A Board representative or two other persons must sign as witnesses to a signature by mark.

(c) A claimant's representative, as described in part 266 of this chapter,

must sign the application if the claimant is incompetent (unable to handle his or her own affairs).

(d) A claimant who is a child between the ages of 16 and 18, is competent, as defined in paragraph (a) of this section, has no court appointed representative, and is not in the care of any person, may sign the application.

(e) If it is necessary to protect a claimant from losing benefits and there is good cause for the claimant not personally signing the application, the Board may accept an application signed by someone other than a person described in paragraphs (a), (b), (c), and (d) of this section. A person who signs an application for someone else will be required to provide evidence of his or her authority to sign the application for the person claiming benefits under the following rules:

(1) If the person who signs is a court-appointed representative, he or she must submit a certificate issued by the court showing authority to act for the claimant.

(2) If the person who signs is not a court-appointed representative, he or she must submit a statement describing his or her relationship to the claimant. The statement must also describe the extent to which the person is responsible for the care of the claimant.

(3) If the person who signs is the manager or principal officer of an institution which is responsible for the care of the claimant, he or she must submit a statement indicating the person's position of responsibility at the institution.

(4) The Board may, at any time, in its sole discretion require additional evidence to establish the authority of a person to sign an application for someone else.

(f) An acceptable signature may include:

(1) A handwritten signature that complies with the rules set out in paragraphs (a), (b), (c), (d), or (e) of this section; or

(2) In the case of an application being taken and processed in the Railroad Retirement Board's automated claims system, an electronic signature, which shall consist of a personal identification number (PIN) assigned by the Railroad Retirement Board as described in the application instructions; or

(3) An alternative signature or signature proxy acceptable to the Railroad Retirement Board. An example of an alternative signature is attestation, which refers to the action taken by a Railroad Retirement Board (RRB) employee of confirming and annotating RRB records of the applicant's intent to file or complete an application or related form, the applicant's affirmation under penalty of perjury that the information provided is correct, and the applicant's agreement to sign the application or related form.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0030, 3220–0031 and 3220–0042)

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13364, Apr. 3, 1989; 76 FR 60373, Sept. 29, 2011]

§ 217.18 When application is not acceptable.

(a) *Not properly signed.* The Board will ask the applicant to prepare a corrected application if—

(1) The original application was signed by someone other than the claimant or a person described in § 217.17; or

(2) The signature has been changed; or

(3) The signature is not readable or does not appear to be authentic.

(b) *Incomplete or not readable.* The Board will ask the applicant to prepare a supplemental application with certain items completed if—

(1) Any entries on the application are not readable or appear to be incorrect; or

(2) An important part of the application was not completed.

(c) *Obtaining corrected application.* If an application is not properly signed, the applicant must prepare a new application with a corrected signature. If the Board receives the corrected application within 30 days after the applicant is asked to prepare it, the Board will use the filing date of the original application to pay benefits. If the Board receives the corrected application more than 30 days after the notice to the applicant, the Board will use the

filing date of the corrected application to pay benefits.

§ 217.19 Representative of the claimant selected after application is filed.

(a) *Before benefits awarded.* If the Board selects a representative for an incompetent claimant (see part 266 of this chapter) after an application is filed but before the benefit is awarded, a new benefit application must be filed by the representative. However, benefits will be paid using the filing date of the original benefit application.

(b) *After benefits awarded.* If the Board selects a representative after a monthly annuity was awarded to another person, the representative must apply as a substitute payee on a form specifically designed for that purpose. A new annuity application is not required.

§ 217.20 When a written statement is used to establish the filing date.

(a) *Statement filed with the Board.* A written statement indicating an intent to file a claim for an annuity or lump sum, filed with the Board as provided in §§ 217.15 and 217.16, can establish the filing date of an application. A form set up by the Board to obtain information about persons who may be eligible for an annuity or lump sum in a particular case is not by itself considered a written statement for the purpose of this section. The Board will use the filing date of the written statement if all of the following requirements are met:

(1) The statement gives a person's clear and positive intent to claim an annuity or lump sum for himself or herself or for some other person.

(2) The claimant or a person described in § 217.17 signs the statement.

(3) The person who signed the statement files an application with the Board on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application.

(4) The claimant is alive when the application is filed except as provided in § 217.10.

(b) *Statement filed with the Social Security Administration.* A written statement filed with the Social Security Administration can be used to establish the filing date of an application if, assuming the statement were an application, the conditions under § 217.7 are met and—

(1) The statement gives a clear and positive intent to claim benefits under title II of the Social Security Act;

(2) The claimant or a person described in § 217.17 signs the statement;

(3) The statement is sent to the Board by the Social Security Administration;

(4) The person who signed the statement files an application with the Board on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application; and

(5) The claimant is alive when the application is filed except as provided in § 217.10.

(c) *Telephone contact with the Board.* If an individual telephones a Board office and advises a Board employee that he or she intends to file an application but cannot do so before the end of the month, the Board employee will prepare and sign a written statement which may be used to establish the filing date of an application if all of the following requirements are met:

(1) The inquirer expresses a clear and positive intent to claim benefits for himself or herself or for some other person;

(2) The prescribed application cannot be filed by the end of the current month;

(3) The inquirer is either the potential claimant or the person who will file an application as representative payee therefor;

(4) The inquiry is received by an office of the Board no more than 3 months before eligibility exists;

(5) It appears that a loss of benefits might otherwise result;

(6) The telephone inquirer files an application with the Board on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application; and

(7) The claimant is alive when the application is filed, except as provided in § 217.10 of the part.

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13364, Apr. 3, 1989]

§ 217.21 Deterred from filing.

A person who telephones or visits a Board office stating that he or she wishes to file for an annuity or lump sum, but puts off filing because of an action or lack of action by an employee of the Board, can establish a filing date based on that oral notice if the following conditions are met:

(a) There is evidence which establishes that the employee of the Board failed to—

(1) Tell the person that it was necessary to file an application on the proper form; or

(2) Tell the person that a written statement could protect the filing date; or

(3) Give the person the proper application form; or

(4) Correctly inform the person of his or her eligibility.

(b) The person files an application on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application.

(c) The claimant is alive when the application is filed except as provided in § 217.10.

Subpart D—Cancellation of Application

§ 217.25 Who may cancel an application.

An application may be cancelled by the claimant or a person described in § 217.17. If the claimant is deceased, the person who is or could be eligible for any annuity accrual under part 234 of this chapter may cancel the application for the annuity.

§ 217.26 How to cancel an application.

An application may be cancelled under the following conditions:

(a) *Before an annuity is awarded.* The application may be cancelled if—

(1) The applicant files a written request with the Board at a place described in § 217.15 asking that the application be cancelled or stating that he or she wants to withdraw the application;

(2) The claimant is alive on the date the written request is filed or the claimant is deceased and the rights of no person other than the person requesting the cancellation will be adversely affected; and

(3) The applicant files the written request on or before the date the annuity is awarded.

(b) *After an annuity is awarded.* The application may be cancelled if—

(1) The conditions in paragraph (a)(1) and (2) of this section are met;

(2) Any other person who would lose benefits because of the cancellation consents to the cancellation in writing; and

(3) All annuity payments already made based on the application being cancelled are repaid or will be recovered.

§ 217.27 Effect of cancellation.

When a person cancels an application the effect is the same as though an application was never filed. When an employee cancels his or her application, any application filed by the employee's spouse is also cancelled. However, a request to cancel a survivor's application will cancel only the application of the survivor named in the written request. A person who cancels an application may reapply by filing a new application under this part.

Subpart E—Denial of Application

§ 217.30 Reasons for denial of application.

The Board will deny each application filed by or for an employee, spouse or survivor for one or more of the following reasons:

(a) The claimant does not meet the eligibility requirements for an annuity or lump sum under this chapter.

(b) The applicant does not submit the evidence required under this chapter to establish eligibility for an annuity or lump sum.

(c) The applicant files an application more than three months before the date on which the eligible person's benefit can begin except if the application is for an employee disability annuity or for a spouse annuity filed simultaneously with the employee's disability annuity application.

[47 FR 7647, Feb. 22, 1982, as amended at 67 FR 42714, June 25, 2002]

§ 217.31 Applicant's right to appeal denial.

Each applicant is given the right to appeal the denial of his or her application if he or she does not agree with the Board's decision. The appeals process is explained in part 260 of this chapter.

PART 218—ANNUITY BEGINNING AND ENDING DATES

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AUTHORITY: 45 U.S.C. 231f(b)(5).

SOURCE: 54 FR 30725, July 24, 1989, unless otherwise noted.

Subpart A—General

§ 218.1 Introduction.

This part tells when a person's entitlement to a monthly railroad retirement annuity begins and ends. Ordinarily, an annuity begins on the earliest date permitted under the Railroad Retirement Act (Act). This part also tells when and how a person may select a later beginning date. Included is an explanation of how work and certain types of special payments affect the beginning date of an employee or spouse annuity.

§ 218.2 Definitions.

As used in this part:

Applicant means a person who signs an application for an annuity for himself, herself or for some other person.

Application means a form described in part 217 of this chapter.

Award means to process a form to make a payment.

Claimant means the person for whom an annuity application is filed.

Filing date means the date on which an application or written statement is filed with the Board.

Tier I benefit means the benefit calculated using the Social Security formulas and is based upon earnings, both in and outside the railroad industry.

Tier II benefit means the benefit calculated under a formula found in the Act and is based only upon railroad earnings.

§ 218.3 When an employee disappears.

(a) *General.* If an employee who is entitled to an annuity disappears, the employee annuity ends on the last day of the month before the month of the disappearance.

(b) *Employee has a current connection.* (1) The Board may pay survivor benefits from the month of the employee's disappearance if both of the following

conditions are met at the time of the disappearance:

(i) The employee has a current connection with the railroad industry as defined in part 216 of this chapter, and

(ii) The employee's spouse is entitled, or would have been entitled if he or she had filed an application, to a spouse annuity in the month that the employee disappeared.

(2) If the employee is later found to have been alive during any month for which a survivor annuity was paid, the amount of any incorrect payment must be recovered under the rules of part 255, Erroneous Payments, of this chapter. The incorrect payment is the amount of any survivor benefits which were paid minus any spouse benefits which were paid minus any spouse benefits that would have been paid.

(c) *Employee has no current connection.* If the employee does not have a current connection and the employee's spouse is entitled to an annuity in the month of the employee's disappearance, the spouse annuity will continue to be paid until one of the following events occurs:

(1) The employee's death is established.

(2) The spouse annuity ends for another reason.

Subpart B—When an Annuity Begins

§ 218.5 General rules.

(a) An annuity begins either on the earliest date permitted by law, or on a specific date chosen by the applicant. If the applicant chooses a specific date, that date must not be before the earliest date permitted by law.

(b) An annuity may not begin on the thirty-first day of a month, unless the claimant would lose benefits if the annuity begins on the first day of the following month. No annuity is payable for the thirty-first day of any month.

§ 218.6 How to choose an annuity beginning date.

(a) *When application is filed.* The applicant may choose an annuity beginning date by—

(1) Naming the month, day and year in an application accepted by the Board; or

(2) Including with the application a signed statement which tells the date (month, day and year) when the annuity should begin.

(b) *After application is filed.* After an application is filed, the claimant may choose an annuity beginning date by submitting a signed statement which tells the month, day and year when the annuity should begin.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0030 and 3220–0042)

§ 218.7 When chosen annuity beginning date is more than three months after filing date.

If the applicant for any type of annuity other than a disability annuity, or a spouse annuity based upon the disabled applicant's compensation, chooses an annuity beginning date in a month which is more than three months after the date the application is filed, the Board will deny the application as explained in part 217 of this chapter. The applicant must file a new application no earlier than three months before the month he or she wants the annuity to begin.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0030 and 3220–0042)

§ 218.8 When an individual may change the annuity beginning date.

(a) *Before annuity is awarded.* A claimant may change the annuity beginning date if—

(1) The claimant requests the change in a signed statement; and

(2) The statement is received by the Board on or before the date of the claimant's death.

(b) *After annuity is awarded.* An award can be reopened to change the annuity beginning date to a later date if—

(1) The annuitant requests the change in a signed statement;

(2) The statement is received by the Board on or before the date of the annuitant's death;

(3) The annuitant shows that it is to his or her advantage to have a later annuity beginning date; and

(4) All payments made for the period before the later annuity beginning date are recovered by cash refund or setoff.

§ 218.9 When an employee annuity begins.

(a) *Full-age annuity*—employee has completed 10 years but less than 30 years of service. An employee full-age annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the month in which the claimant attains full retirement age; or

(3) The first day of the sixth month before the month in which the application is filed.

(b) *Reduced-age annuity*—employee has completed 10 years but less than 30 years of service. An employee reduced-age annuity begins on the later of either the date chosen by the applicant, or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the first full month in which the claimant is age 62; or

(3) The first day of the month in which the application is filed if the claimant does not have a spouse (or divorced spouse) who would be entitled to a retroactive unreduced spouse (or divorced spouse) annuity. If the claimant has such a spouse (or divorced spouse) the claimant's annuity can begin on the first day of the month in which the spouse (or divorced spouse) annuity begins.

(c) *Disability annuity.* An employee disability annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the twelfth month before the month in which the application is filed;

(3) The first day of the sixth month after the month of disability onset; or

(4) The first day of the month of disability onset if the claimant was previously entitled to an employee disability annuity which ended within five years of the current disability onset month.

(d) *Annuity based on at least 30 years of service.* An employee annuity based on at least 30 years of service begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the first full month in which the claimant is age 60 and will accept a reduced annuity;

(3) The first day of the month in which the claimant attains age 62; or

(4) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.10 When a supplemental annuity begins.

An employee supplemental annuity begins on the latest of—

(a) The beginning date of the employee age or disability annuity;

(b) The first day of the month in which the employee meets the age and years of service requirements as shown in part 216 of this chapter; or

(c) The first day of the twelfth month before the month in which the employee disability annuitant under age 65 gives up the right to return to work as explained in part 216 of this chapter.

§ 218.11 When a spouse annuity begins.

(a) A spouse annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules.* The earliest date permitted by law is the latest of—

(i) The day after the day the claimant last worked for a railroad employer;

(ii) The beginning date of the employee annuity;

(iii) The first day of the month in which the claimant meets the marriage

requirement as shown in part 216 of this chapter; or

(iv) The first day of the month in which the employee annuitant meets the age requirement to qualify the claimant as shown in part 216 of this chapter.

(2) *Full-age annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant meets the age requirement as shown in part 216 of this chapter; or

(iii) The first day of the sixth month before the month in which the application is filed.

(3) *''Child in care'' annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant becomes eligible for a spouse annuity based on having a ''child in care'' as shown in part 216 of this chapter; or

(iii) The first day of the sixth month before the month in which the application is filed.

(4) *Reduced-age annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the first full month in which the spouse is age 62 if the employee has less than 30 years of service;

(iii) The first day of the month in which the spouse is age 60, if the employee has at least 30 years of service;

(iv) The first day of the sixth month before the month in which the application is filed; or

(v) The first day of the month in which the application is filed if beginning the annuity in an earlier month would increase the age reduction factor applied to the annuity.

§ 218.12 When a divorced spouse annuity begins.

(a) A divorced spouse annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules*. The earliest date permitted by law is the latest of—

(i) The day after the day the claimant last worked for a railroad employer;

(ii) The beginning date of the employee annuity;

(iii) The first day of the first full month in which the employee annuitant is age 62 if the employee has not been granted a period of disability;

(iv) The first day of the month in which the employee annuitant attains age 62 if the employee has been granted a period of disability; or

(v) The first day of the month in which the final decree of divorce is effective.

(2) *Full-age annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains full retirement age;

(iii) The first day of the twelfth month before the month in which the application is filed if the employee is a disability annuitant or has been granted a period of disability; or

(iv) The first day of the sixth full month before the month in which the application is filed if the employee is not entitled to a disability annuity or a period of disability.

(3) *Reduced-age annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the first full month the claimant is age 62 if the application is filed in or before that month; or

(iii) The first day of the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.13 When a widow(er) annuity begins.

(a) A widow(er) annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *Full-age annuity*. The earliest date permitted by law is the latest of—

(i) The first day of the month in which the employee dies;

(ii) The first day of the month in which the claimant attains full retirement age; or

(iii) The first day of the sixth month before the month in which the application is filed.

(2) *Reduced-age annuity*—(i) *Widow(er) age 60 through age 62.* The earliest date permitted by law is the latest of—

(A) The first day of the month in which the employee dies;

(B) The first day of the month in which the claimant attains age 60; or

(C) The first day of the sixth month before the month in which the application is filed.

(ii) *Widow(er) over age 62 but under full retirement age.* The earliest date permitted by law is the latest of—

(A) The first day of the month in which the employee dies;

(B) The first day of the month in which the claimant attains age 62 and one month; or

(C) The first day of the month in which the application is filed.

(3) *Disability annuity.* The earliest date permitted by law is the latest of—

(i) The first day of the month in which the employee dies;

(ii) The first day of the month in which the claimant attains age 50;

(iii) The first day of the twelfth month before the month in which the application is filed; or

(iv) The first day of the sixth month after the month of disability onset.

(4) *''Child in care'' annuity.* The earliest date permitted by law is the latest of—

(i) The first day of the month in which the employee dies;

(ii) The first day of the month in which the claimant becomes eligible for a widow(er) annuity based on having a ''child in care'' as explained in part 216 of this chapter; or

(iii) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.14 When a child annuity begins.

(a) A child annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules.* The earliest date permitted by law is the later of—

(i) The first day of the month in which the employee dies; or

(ii) The first day of the month in which the claimant becomes eligible for a child annuity as explained in part 216 of this chapter.

(2) *Child age annuity.* The earliest date permitted by law is the later of—

(i) The month shown in paragraph (b)(1) of this section; or

(ii) The first day of the sixth month before the month in which the application is filed.

(3) *Child annuity based on full-time school attendance.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the sixth month before the month in which the application is filed;

(iii) The first day of the month in which the claimant is in full-time school attendance at an elementary or secondary educational institution; or

(iv) The first day of the month in which the claimant attains age 18.

(4) *Child disability annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the sixth month before the month in which the application is filed;

(iii) The first day of the month in which the claimant meets the definition of disability as explained in part 220; or

(iv) The first day of the month in which the claimant attains age 18.

§ 218.15 When a parent annuity begins.

A parent annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(a) The first day of the month in which the employee dies;

(b) The first day of the month in which the claimant attains age 60; or

(c) The first day of the sixth month before the month in which the application is filed.

§ 218.16 When a surviving divorced spouse annuity begins.

(a) A surviving divorced spouse annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules.* The earliest date permitted by law is the later of—

(i) The first day of the month in which the employee dies; or

(ii) The first day of the month in which the claimant becomes eligible for a surviving divorced spouse annuity as shown in part 216 of this chapter.

(2) *Full-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains full retirement age; or

(iii) The first day of the sixth month before the month in which the application is filed.

(3) *Reduced age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 60; or

(iii) The first day of the month in which the application is filed or the first day of the month preceding the month in which the application is filed if the employee died in that preceding month.

(4) *Disability annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 50;

(iii) The first day of the twelfth month before the month in which the application is filed; or

(iv) The first day of the sixth month after the month of disability onset.

(5) *''Child in care'' annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section; or

(ii) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.17 When a remarried widow(er) annuity begins.

(a) A remarried widow(er) annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules.* The earliest date permitted by law is the later of—

(i) The first day of the month in which the employee dies; or

(ii) The first day of the month in which the claimant becomes eligible for a remarried widow(er) annuity as shown in part 216 of this chapter.

(2) *Full-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains full retirement age; or

(iii) The first day of the sixth month before the month in which the application is filed.

(3) *Reduced-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 60: or

(iii) The first day of the month in which the application is filed or the first day of the month preceding the month in which the application is filed if the employee died in that preceding month.

(4) *Disability annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 50;

(iii) The first day of the twelfth month before the month in which the application is filed; or

(iv) The first day of the sixth month after the month of disability onset.

(5) *''Child in care'' annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section; or

(ii) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

Subpart C—How Work and Special Payments Affect an Employee, Spouse, or Divorced Spouse Annuity Beginning Date

§ 218.25 Introduction.

The rules in this subpart apply only to an employee, spouse, divorced spouse, and supplemental annuity. They do not apply to any type of survivor annuity.

§ 218.26 Work started after annuity beginning date.

(a) *General.* An annuity can begin only after an employee, spouse, or divorced spouse stops any work for a railroad employer. However, if the employee, spouse or divorced spouse starts work after an ''intent to retire'' is established, that work will have no effect on the annuity beginning date. However, an annuity cannot be paid for any month the employee, spouse or divorced spouse returns to work for a railroad employer.

(b) *Intent to retire*—(1) *Disability annuity.* An ''intent to retire'' is established to pay a disability annuity when—

(i) The employee files for a disability annuity; or

(ii) The employee gives up all rights to return to work for a railroad employee before starting any new work.

(2) *Age annuity.* An ''intent to retire'' is established to pay an employee age, spouse or divorced spouse annuity when the employee, spouse or divorced spouse gives up all rights to return to work for a railroad employer before starting any new work.

§ 218.27 Vacation pay.

(a) *From railroad employer.* Vacation pay may be credited to the vacation period due the employee or to the last day of actual work for the railroad employer. If the vacation pay is credited to the vacation period, the annuity can begin no earlier than the day after the vacation period ends. (Part 211 of this chapter discusses how vacation pay is credited as compensation.)

(b) *From non-railroad employer.* Vacation pay will not affect the annuity beginning date.

§ 218.28 Sick pay.

(a) *From railroad employer.* If the employee is carried on the payroll while sick, the annuity can begin no earlier than the day after the last day of sick pay. However, sick pay is not considered compensation and does not affect the annuity beginning date if it is a payment described in § 211.2(c)(6) of these regulations.

(b) *From non-railroad employer.* Sick pay will not affect the annuity beginning date.

§ 218.29 Pay for time lost.

Pay for time lost because of personal injury must be credited to an actual period of time lost. The annuity can begin no earlier than the day after that period ends.

§ 218.30 Separation, displacement or dismissal allowance.

(a) *General.* When an employee receives a separation, displacement or dismissal allowance from a railroad employer, the annuity beginning date depends on whether the payments are a separation allowance as described in paragraph (b) of this section, or monthly compensation payments as described in paragraph (c) of this section. (Part 211 of this chapter discusses how a separation, displacement or dismissal alowance is credited as compensation.)

(b) *Separation allowance.* When an employee accepts a separation allowance, the employee gives up his or her job rights. Regardless of whether a separation allowance is paid in a lump sum or in installments, the annuity can begin as early as the day after the day the separation allowance is credited.

(c) *Monthly compensation payments.* An employee who receives monthly compensation payments keeps his or her job rights while the payments are being made. The annuity cannot begin until after the end of the period for which payments are made.

Subpart D—When an Annuity Ends

§ 218.35 When an employee age annuity ends.

An employee annuity based on age ends with the last day of the month before the month in which the employee dies.

§ 218.36 When an employee disability annuity ends.

(a) *Ending date.* An employee annuity based on disability ends with the earliest of—

(1) The last day of the month before the month in which the employee dies;

(2) The last day of the second month following the month in which the employee's disability ends; or

(3) The last day of the month before the month in which the employee attains full retirement age (the disability annuity is changed to an age annuity).

(b) *Effect of ended disability annuity on eligibility for a later annuity.* The ending of a disability annuity will not affect an employee's rights to receive any annuity to which he or she later becomes entitled. When a disability annuity ends before an employee attains full retirement age, any additional railroad service the employee has after the disability annuity ends can be credited as if no annuity had previously been paid.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.37 When a supplemental annuity ends.

A supplemental annuity ends when the employee age or disability annuity ends.

§ 218.38 When a spouse annuity ends.

(a) *General rules.* A spouse annuity ends with the earliest of—

(1) The last day of the month before the month in which the spouse dies;

(2) The last day of the month before the month in which the employee dies or the employee's entitlement to an annuity ends;

(3) The last day of the month before the month in which the spouse's marriage to the empoyee is ended by absolute divorce, annulment, or other judicial action (the spouse may be entitled to a divorced spouse annuity as explained in part 216 of this chapter); or

(4) The month shown in paragraphs (b) and (d) of this section.

(b) *Annuity entitlement based on ''child in care.''* A spouse annuity based on having a ''child in care'' ends as shown in this paragraph if he or she is not also eligible for a full-age spouse annuity as explained in part 216 of this chapter. However, see also paragraph (c) of this section. If the spouse is eligible for a full-age spouse annuity when he or she is no longer entitled on the basis of a child, his or her annuity is changed to a spouse annuity based on age. A spouse annuity based on having a ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraphs (a) and (d) of this section;

(2) The last day of the month before the month in which the child is no longer in the spouse's care, as explained in part 216 of this chapter;

(3) The last day of the month before the month in which the child attains age 18 and is not disabled;

(4) The last day of the month before the month in which the child marries;

(5) The last day of the month before the month in which the child dies; or

(6) The last day of the second month after the month in which the child's disability ends, if the child is over age 18.

(c) *Tier I benefit entitlement based on ''child in care.''* The tier I benefit of a spouse entitled because he or she has a ''child in care'' and is not otherwise entitled to a tier I benefit based on age, ends with the earliest of—

(1) The last day of the month shown in paragraphs (a) and (d) of this section;

(2) The last day of the month before the month in which the child is no longer in the spouse's care as explained in part 216 of this chapter;

(3) The last day of the month before the month in which the child attains age 16 and is not disabled;

(4) The last day of the month before the month in which the child marries;

(5) The last day of the month before the month in which the child dies; or

(6) The last day of the second month after the month in which the child's disability ends, if the child is over age 16.

(d) *Entitlement based on deemed marriage.* If the spouse entitlement is based on a deemed valid marriage, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraphs (a) and (b) of this section;

(2) The last day of the month before the month in which the deemed spouse enters a valid marriage with someone other than the employee; or

(3) The last day of the month before the month in which the Board approves an award to someone else as the employee's legal spouse.

§ 218.39 When a divorced spouse annuity ends.

A divorced spouse annuity ends with the earliest of the last day of the month before the month in which the—

(a) Divorced spouse dies;

(b) Employee's entitlement to an annuity ends;

(c) Divorced spouse marries;

(d) Employee dies; or

(e) Divorced spouse becomes entitled to a retirement or disability insurance benefit under the Social Security Act based on a primary insurance amount which equals or exceeds the amount of the full divorced spouse annuity before reduction for age.

§ 218.40 When a widow(er) annuity ends.

(a) *Entitlement based on age.* When a widow(er)'s annuity is based on age, the annuity ends with the earliest of the last day of the month before the month in which—

(1) The widow(er) dies;

(2) The widow(er) remarries (the widow(er) may be entitled to benefits as a remarried widow(er) as explained in part 216 of this chapter);

(3) The widow(er) becomes entitled to another survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity; or

(4) The Board approves an award to someone else as the employee's legal widow(er) if entitlement is based on a deemed valid marriage.

(b) *Disabled widow(er).* If entitlement is based on the widow(er)'s disability, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the second month following the month in which the disability ends; or

(3) The last day of the month before the month in which the widow(er) attains age 60 (the disability annuitant then becomes entitled to an annuity based upon age).

(c) *Annuity entitlement based on ''child in care.''* A widow(er) annuity based on having a ''child in care'' ends as shown in this paragraph if he or she is not eligible for a widow(er) annuity based on age as explained in part 216 of this chapter. However, see also paragraph (d) of this section. If the widow(er) is eligible for a widow(er) annuity based on age, when he or she is no longer entitled on the basis of having a ''child in care,'' his or her annuity is changed to a widow(er) annuity based on age. A widow(er) annuity based on having a ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the widow(er)'s care as explained in part 216 of this chapter (in this case entitlement to the annuity does not terminate, but no annuity is payable while the child is no longer in care);

(3) The last day of the month before the month in which the child attains age 18 and is not disabled;

(4) The last day of the month before the month in which the widow(er) attains full retirement age (the ''child in care'' annuity is changed to an age annuity);

(5) The last day of the month before the month in which the child marries;

(6) The last day of the month before the month in which the child dies; or

(7) The last day of the second month after the month in which the child's disability ends, if the child is over age 18.

(d) *Tier I benefit entitlement based on child in care.* The tier I benefit of a widow(er), entitled because he or she has a ''child in care'' and is not otherwise entitled to a tier I benefit based on age, ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the widow(er)'s care as explained in part 216 of this chapter;

(3) The last day of the month before the month in which the child attains age 16 and is not disabled;

(4) The last day of the month before the month in which the child marries;

(5) The last day of the month before the month in which the child dies; or

(6) The last day of the second month after the month in which the child's disability ends, if the child is over age 16.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.41 When a child annuity ends.

A child annuity ends with the earliest of—

(a) The last day of the month before the month in which the child marries;

(b) The last day of the month before the month in which the child dies;

(c) The last day of the month before the month in which the child attains age 18 if the child is not eligible for an annuity as a disabled or student child;

(d) The last day of the last month in which the child is considered a full-time student, as defined in part 216 of this chapter, if the child is a full-time student age 18 through 19; or

(e) The last day of the second month after the month in which the child's disability ends, if the child is over age 18.

§ 218.42 When a parent annuity ends.

(a) *Tier I.* The tier I benefit of a parent annuity ends with the earliest of the last day of the month before the month in which the parent—

(1) Dies;

(2) Becomes entitled to an old age benefit under the Social Security Act that is equal to or larger than the tier I benefit of the parent annuity before any reduction for the family maximum, unless he or she is also entitled to a tier II benefit (reduction for the family maximum is discussed in part 228 of this chapter);

(3) Becomes entitled to another survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity; or

(4) Remarries after the employee's death, unless he or she marries a person who is entitled to Social Security or Railroad Retirement Act benefits as a divorced spouse, widow, widower, mother, father, parent, or disabled child.

(b) *Tier II.* The tier II benefit of a parent annuity ends with the earliest of the last day of the month before the month in which the parent—

(1) Dies;

(2) Remarries after the employee's death; or

(3) Becomes entitled to another survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity.

§ 218.43 When a surviving divorced spouse annuity ends.

(a) *Entitlement based on age.* When the surviving divorced spouse annuity is based on age, the annuity ends with the earliest of the last day of the month before the month in which the surviving divorced spouse—

(1) Dies;

(2) Becomes entitled to an old age benefit under the Social Security Act that is equal to or larger than the amount of the full surviving divorced spouse annuity before reduction for age; or

(3) Becomes entitled to a spouse or survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity.

(b) *Entitlement based on disability.* When the surviving divorced spouse annuity is based on disability, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the second month following the month in which the disability ends; or

(3) The last day of the month before the month in which the surviving divorced spouse attains full retirement age (the disability annuitant then becomes entitled based upon age).

(c) *Entitlement based on ''child in care.''* When the surviving divorced spouse annuity is based on having a ''child in care'' as explained in part 216 of this chapter, the annuity ends as shown in this paragraph unless he or she is at least age 60 and was married

to the employee for at least 10 years. In that case, the surviving divorced spouse annuity based on having a child in care is changed to an annuity based on age. If the surviving divorced spouse is not entitled to an annuity based on age, the surviving divorced spouse annuity based on ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the surviving divorced spouse's care, as explained in part 216 of this chapter (in this case entitlement to the annuity does not terminate, but no annuity is payable while the child is no longer in care);

(3) The last day of the month before the month in which the child attains age 16, unless the child is disabled;

(4) The last day of the month before the month in which the surviving divorced spouse remarries unless the marriage is to an individual entitled to a retirement, disability, widow(er)'s, father's/mother's, parent's or child's disability benefit under the Railroad Retirement Act or Social Security Act;

(5) The last day of the second month after the month in which the child's disability ends, if the child is over age 16; or

(6) The last day of the month before the month in which the surviving divorced spouse attains full retirement age (the annuitant then becomes entitled to an annuity based upon age).

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.44 When a remarried widow(er) annuity ends.

(a) *Entitlement based on age.* When the remarried widow(er) annuity is based on age, the annuity ends with the earliest of the last day of the month before the month in which the remarried widow(er)—

(1) Dies;

(2) Becomes entitled to an old age benefit under the Social Security Act that is equal to or larger than the amount of the full remarried widow(er) annuity before reduction for age or the family maximum (see part 228 of this chapter); or

(3) Becomes entitled to a spouse or survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity.

(b) *Entitlement based on disability.* When the remarried widow(er) annuity is based on disability, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the second month following the month in which the disability ends; or

(3) The last day of the month before the month in which the remarried widow(er) attains full retirement age (the disability annuitant then becomes entitled to an annuity based upon age).

(c) *Entitlement based on ''child in care.''* When the remarried widow(er) annuity is based on having a ''child in care,'' as explained in part 216 of this chapter, the annuity ends as shown in this paragraph unless the remarried widow(er) is at least age 60. In that case, the remarried widow(er) annuity based on having a ''child in care'' is changed to an annuity based on age. If the remarried widow(er) is not entitled to an annuity based on age, the remarried widow(er) annuity based on having a ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the remarried widow(er)'s care, as explained in part 216 of this chapter (in this case entitlement to the annuity does not terminate but no annuity is payable while the child is no longer in care);

(3) The last day of the month before the month in which the child attains age 16, unless the child is disabled;

(4) The last day of the month before the month in which the remarried widow(er) remarries unless the marriage is to an individual entitled to a retirement, disability, widow(er)'s, father's/mother's, parent's or child's disability benefit under the Railroad Retirement Act or Social Security Act;

(5) The last day of the second month after the month in which the child's disability ends, if the child is over age 16; or

(6) The last day of the month before the month in which the remarried widow attains full retirement age (the annuitant then becomes entitled to an annuity based upon age).

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

PART 219—EVIDENCE REQUIRED FOR PAYMENT

Subpart A—General Evidence Requirements

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Subpart A—General Evidence Requirements

§ 219.1 Introduction.

As described in parts 216 (Eligibility for an Annuity), 234 (Lump-Sum Payments), and 222 (Family Relationships), certain requirements must be met before benefits may be paid under the Railroad Retirement Act. This part contains the basic rules for evidence that is required to support a claimant's claim for monthly or lump-sum benefit payments under the Railroad Retirement Act. Part 219 describes when evidence is required and what types of documents can be used as evidence. Part 222 defines and explains family relationships for which evidence requirements are stated in part 219. Special evidence requirements for disability annuities are found in part 220 of this chapter.

§ 219.2 Definitions.

As used in this subpart—

Annuity means a recurring payment due an entitled person for a calendar month and made to him or her on the first day of the following month.

Apply means to sign a form or statement that the Board accepts as an application.

Claimant means the person who files an application for an annuity or lump-sum payment for himself, herself, or some other person.

Benefit means any employee annuity, spouse annuity, survivor annuity, or lump-sum payment under the Railroad Retirement Act.

Convincing evidence means one or more pieces of evidence that proves to the satisfaction of the Board that an individual meets a requirement for eligibility for benefits. See § 219.7 for guides the Board uses in deciding whether evidence is convincing.

Eligible means that a person meets all of the requirements for payment of benefits but has not yet applied therefor.

Entitled means that a person has applied for and has proved his or her right to payment of benefits.

Evidence means any record or document or testimony that helps to show whether a person is eligible for benefits. It may also be used to establish whether the person is still entitled to benefits.

Representative means a person who acts on behalf of a claimant in regard to his or her claim for benefits from the Board and in the presentation of evidence to support the claim.

§ 219.3 When evidence is required.

(a) *To prove initial eligibility.* The Board will ask for evidence to prove a claimant is eligible for benefits when he or she applies for benefits. Usually the Board will ask the claimant to furnish specific kinds of evidence or information by a certain date to prove initial eligibility for benefits. If evidence or information is not received by that date, the Board may decide that the claimant is not eligible for benefits and will deny his or her application.

(b) *To prove continued entitlement.* After a claimant establishes entitlement to an annuity, the Board may ask that annuitant to produce by a certain date information or evidence needed to decide whether he or she may continue to receive an annuity or whether the annuity should be reduced or stopped. If the information is not received by the date specified, the Board may decide that the person is no longer entitled to benefits or that his or her annuity should be stopped or reduced.

§ 219.4 Who is responsible for furnishing evidence.

(a) *Claimant or representative responsible.* When evidence is required to prove a person's eligibility for or right to continue to receive annuity or lump-sum payments, that claimant or his or her representative is responsible for obtaining and submitting the evidence to the Board.

(b) *What to do when required evidence will be delayed.* When the required evidence cannot be furnished within the specified time, the claimant or representative who was asked to furnish the evidence or information should notify the Board and explain why there will be a delay. If the delay is caused by illness, failure to receive the information from another source, or a similar situation, the claimant will be allowed a reasonable time to secure the evidence or information. If the information is not received within a reasonable time as determined by the Board, the claimant or representative who was asked to furnish the evidence or information will be notified of the effect that his or her failure to furnish the evidence or information will have on the claimant's eligibility to receive or continue to receive payments.

§ 219.5 Where and how to provide evidence.

(a) *When Board office is accessible.* A claimant or representative should give his or her evidence to an employee of the Railroad Retirement Board office where he or she files the application. An employee of the Board will tell the claimant or representative what is needed and how to get it.

(b) *When Board office is not accessible.* A claimant who lives in an area where there is no Board office or who is unable to travel to a Board office may send evidence to the Board office nearest to where the claimant lives. A claimant who lives outside the United

States may take evidence to the American embassy or consulate or other Foreign Service Office nearest to where he or she lives or send it to the headquarters of the Board.

§ 219.6 Records as evidence.

(a) *General.* If a claimant or an annuitant provides an original document or record as evidence to prove eligibility or continued entitlement to payments, where possible, a Board employee will make a photocopy or transcript of these original documents or records and return the original documents to the person who furnished them. A claimant may also submit certified copies of original records as described in paragraph (c) of this section. The Board may also accept uncertified copies as described in paragraph (d) of this section.

(b) *Foreign-language documents.* If the evidence submitted is a foreign-language document, the Board may require that the record be translated. An acceptable translation includes, but is not limited to, a translation certified by a United States consular official or employee of the Department of State authorized to certify evidence, or by an employee of the Board or the Social Security Administration.

(c) *Certified copies of original records.* The Board will accept copies of original records or extracts from records if they are certified as true and exact copies of the original by—

(1) The official custodian of the record;

(2) A Veterans Administration employee, if the evidence was given to that agency to obtain veterans benefits;

(3) A Social Security Administration employee, if the evidence was given to that agency to obtain social security benefits;

(4) A United States Consular Officer, an employee of the Department of State, or an employee of the Immigration and Naturalization Service authorized to certify evidence received outside the United States; or

(5) An employee of a state agency or state welfare office authorized to certify copies of original records in the agency's or office's files.

(d) *Uncertified copies and facsimiles.* In lieu of certified paper copies of records or extracts from such official sources as listed in paragraph (c) of this section, the Board will accept facsimile copies of such records or extracts when the official custodian of such records transmits the facsimile directly to an office of the Board and the source of the transmittal is clearly identified on the facsimile.

[54 FR 31942, Aug. 3, 1989, as amended at 65 FR 19829, Apr. 13, 2000]

§ 219.7 How the Board decides what is convincing evidence.

When the Board receives evidence, a Board representative examines it to see if it is convincing evidence. If it is, no other evidence is needed. In deciding whether the evidence is convincing, the Board representative decides whether—

(a) The information contained in the evidence was given by a person in a position to know the facts;

(b) There was any reason to give false information when the evidence was created;

(c) The information contained in the evidence was given under oath, or in the presence of witnesses, or with the knowledge that there was a penalty for giving false information;

(d) The evidence was created at the time the event took place or shortly after;

(e) The evidence has been altered or has any erasures on it; and

(f) The information contained in the evidence agrees with other available evidence, including existing Board records.

§ 219.8 Preferred evidence and other evidence.

(a) *Preferred evidence.* When a claimant submits the type of evidence shown as preferred in subparts B and C of this part, the Board will generally find it is convincing evidence. This means that unless there is information in the Board's records that raises a doubt about the evidence, other evidence to prove the same fact will not be needed.

(b) *Other evidence.* If preferred evidence is not available, the Board will consider any other evidence a claimant

furnishes. If the other evidence consists of several different records or documents which all show the same information, the Board may determine that it is convincing evidence even though it is not preferred evidence. If the other evidence is not convincing by itself, the claimant will be asked to submit additional evidence. If the additional evidence shows the same information all the evidence considered together may be convincing evidence.

(c) *Board decision.* When the Board has convincing evidence of the facts that must be proven, or when it is clear that the evidence provided does not prove the necessary facts, the Board will make a formal decision about the applicant's rights to benefits.

§ 219.9 Evidence, information, and records filed with the Board.

The Railroad Retirement Act provides criminal penalties for any persons who misrepresent the facts or make false statements to obtain payments for themselves or someone else. All evidence and documents given to the Board are kept confidential and are not disclosed to anyone but the person who submitted them, except under the rules described in part 200 of this chapter.

Subpart B—Evidence of Age and Death

§ 219.20 When evidence of age is required.

(a) Evidence of age is required when an employee applies for an annuity under the Railroad Retirement Act or for Medicare coverage under title XVIII of the Social Security Act.

(b) Evidence of age is also required from a person who applies for a spouse's or divorced spouse's, widow's, widower's, surviving divorced spouse's, parent's, or child's annuity under the Railroad Retirement Act, or for Medicare coverage under title XVIII of the Social Security Act.

§ 219.21 Types of evidence to prove age.

(a) *Preferred evidence.* The best type of evidence to prove a claimant's age is—

(1) A birth certificate recorded before age 5;

(2) A church record of birth or baptism recorded before age 5; or

(3) Notification of registration of birth made before age 5.

(b) *Other evidence of age.* If an individual cannot obtain preferred evidence of age, he or she will be asked to submit other convincing evidence to prove age. The other evidence may be one or more of the following records, with the records of highest value listed first:

(1) Hospital birth record or certificate.

(2) Physician's or midwife's birth record.

(3) Bible or other family record.

(4) Naturalization record.

(5) Military record.

(6) Immigration record.

(7) Passport.

(8) Selective service registration record.

(9) Census record.

(10) School record.

(11) Vaccination record.

(12) Insurance record.

(13) Labor union or fraternal record.

(14) Employer's record.

(15) Marriage record.

(16) A statement signed by the individual giving the reason why he or she cannot obtain other convincing evidence of age and the sworn statements of two other persons who have personal knowledge of the age that the individual is trying to prove.

(Approved by the Office of Management and Budget under control number 3220–0106)

§ 219.22 When evidence of death is required.

(a) *When evidence of the employee's death is required.* Evidence to prove the employee's death is always required for payment of any type of survivor annuity or lump-sum payment based on the deceased employee's record. See parts 216 and 234 for types of survivor payments.

(b) *When evidence to prove death of other persons is required.* Evidence to prove the death of persons other than the empoyee is required when—

(1) A claimant, who is eligible for survivor benefits, dies after the employee;

(2) A residual lump sum (see part 234 of this chapter) is payable and a person whom the employee named to receive all or part of this payment dies before the employee, or such person dies after the employee but before receiving his or her share of the benefit; or

(3) There is reasonable doubt of the death of—

(i) Any person who, if alive, has priority over the applicant;

(ii) Any spouse whose death is alleged to have ended a previous marriage, if a later marriage in question cannot be presumed valid under state law; or

(iii) Any person the termination of whose entitlement would increase payments to other entitled persons.

§ 219.23 Evidence to prove death.

(a) *Preferred evidence of death.* The best evidence of a person's death is—

(1) A certified copy of or extract from the public record of death, or verdict of the coroner's jury of the state or community where death occurred; or a certificate or statement of death issued by a local registrar or public health official;

(2) A signed statement of the funeral director, attending physician, or official of an institution where death occurred;

(3) A certified copy of, or extract from, an official report or finding of death made by an agency or department of the United States or of a state; or

(4) If death occurred outside the United States, an official report of death by a United States Consul or other authorized employee of the State Department, or a certified copy of the public record of death in a foreign country.

(b) *Other evidence of death.* If the preferred evidence of death cannot be obtained, the individual who must furnish evidence of death will be asked to explain the reason therefor and to submit other convincing evidence, such as sworn statements of at least two persons who have personal knowledge of the death. These persons must be able to swear to the date, time, place, and cause of death.

(Approved by the Office of Management and Budget under control number 3220–0077)

§ 219.24 Evidence of presumed death.

When a person cannot be proven dead but evidence of death is needed, the Board may presume he or she died at a certain time if the Board receives the following evidence:

(a) A certified copy of, or extract from, an official report or finding by an agency or department of the United States that a missing person is presumed to be dead as stated in Federal law (5 U.S.C. 5565). Unless other evidence is submitted showing an actual date of death, the Board will use the date on which the person was reported missing as the date of death.

(b) Signed statements by those in a position to know that facts and other records which show that the person has been absent from his or her residence for no apparent reason and has not been heard from for at least 7 years. If there is no evidence available that that person continued in life after the date of disappearance, the Board will use as the date of death the date the person disappeared.

(c) When a person has been missing for less than 7 years but may be presumed dead due to drowning or common disaster (fire, accident, etc.), signed statements from the applicant and individuals who know the circumstances surrounding the occurrence leading to the person's disappearance. The best evidence is statements from individuals who witnessed the occurrence or saw the missing person at the scene of the occurrence shortly before it happened.

Subpart C—Evidence of Relationship

§ 219.30 When evidence of marriage is required.

(a) *When an application is filed for benefits.* Documentary evidence of marriage is required when an individual files for a monthly annuity, lump-sum death payment, residual lump sum, or Medicare coverage, as the wife, husband, widow, widower, divorced spouse or surviving divorced spouse, or stepparent of the employee. A claimant may also be required to submit evidence of another person's marriage

when that person's marriage is necessary to determine the applicant's entitlement to benefits under the Railroad Retirement Act.

(b) *State law.* In deciding whether the marriage to the employee is valid or not, in a case where the employee is living, the Board will follow the law of the state where the employee had a permanent home when the applicant filed an application; in a case where the employee is dead, the Board will follow the law of the state where the employee had a permanent home when he or she died.

(c) *Types of evidence.* What evidence will be required depends on whether the employee's marriage was a ceremonial marriage, a common-law marriage, or a marriage that can be deemed to be valid.

§ 219.31 Evidence of a valid ceremonial marriage.

(a) *Preferred evidence.* Preferred evidence of a ceremonial marriage is—

(1) A copy of the public record of the marriage, certified by the custodian of the record or by a Board employee;

(2) A copy of a church record of the marriage certified by the custodian of the record or by a Board employee; or

(3) The original certificate of marriage.

(b) *Other evidence of a ceremonial marriage.* If preferred evidence of a ceremonial marriage cannot be obtained, the applicant must state the reason therefor in writing and submit either—

(1) A sworn statement of the clergyman or official who performed the marriage ceremony; or

(2) Other convincing evidence, such as the sworn statements of at least two persons who have direct knowledge of the marriage, preferably eyewitnesses to the marriage ceremony.

(Approved by the Office of Management and Budget under control number 3220–0140)

§ 219.32 Evidence of a common-law marriage.

(a) *Preferred evidence.* Evidence of a common-law marriage must give the reasons why the informant believes that a marriage exists. If the information described in this paragraph is not furnished on a form provided by the Board, it must be submitted in the form of a sworn statement. Preferred evidence of a common-law marriage is one of the following:

(1) If both the husband and wife are alive, each shall sign a statement and get signed statements from one blood relative of each. The statement of another individual may be submitted for each statement the husband or wife is unable to get from a relative. Each signed statement should show—

(i) That the husband and wife believed they were married;

(ii) The basis for this belief; and

(iii) That the husband and wife have presented themselves to the public as husband and wife.

(2) If either the husband or wife is dead, the surviving spouse shall furnish a signed statement and signed statements from two blood relatives of the dead spouse. The surviving spouse's statement should show that he or she and the dead spouse believed themselves to be married, the basis for this belief, and that they presented themselves to the public as husband and wife. The statements from relatives of the dead spouse should support the surviving spouse's statement.

(3) If both husband and wife are dead, the applicant shall get a signed statement from one blood relative of each dead spouse. Each statement should show that the husband and wife believed themselves to be married, the basis for this belief, and that they presented themselves to the public as husband and wife.

(4) Statements by relatives and other individuals described in paragraphs (a)(1), (2) and (3) of this section are not required when—

(i) The husband and wife entered into a ceremonial marriage which was void because of a legal impediment to the marriage;

(ii) After the impediment was removed, the husband and wife continued to live together as man and wife until the employee filed an application or one of them died; and

(iii) A valid common-law marriage was established, under the law of the State in which they lived, by their continuing to live together as man and wife.

(b) *Other evidence of common-law marriage.* When preferred evidence of a

common-law marriage cannot be obtained, the claimant will be asked to explain the reason therefor and to furnish other convincing evidence of the marriage.

(Approved by the Office of Management and Budget under control number 3220–0021)

§ 219.33 Evidence of a deemed valid marriage.

(a) *Preferred evidence.* Preferred evidence of a deemed valid marriage is—

(1) Evidence of a ceremonial marriage as described in § 219.31;

(2) If both the employee and spouse are alive, the spouse's signed statement that he or she went through the ceremony in good faith and his or her reasons for believing the marriage was valid; or if the employee is dead, the widow or widower's signed statement to that effect;

(3) If required to remove a reasonable doubt, the signed statements of other persons who have information about what the parties knew about any previous marriage or other facts showing whether the parties went through the marriage ceremony in good faith; and

(4) Evidence that the parties were living in the same household when the employee applied for payments; or, if the employee is dead, when he or she died. See § 219.51 for the evidence required to demonstrate living in the same household.

(b) *Other evidence of a deemed valid marriage.* If preferred evidence of a deemed valid marriage cannot be obtained, the claimant must explain the reason therefor and submit other convincing evidence of the marriage.

(Approved by the Office of Management and Budget under control number 3220–0140)

§ 219.34 When evidence that a marriage has ended is required.

Evidence of how a previous marriage ended may be required to determine whether a later marriage is valid. If a widow or widower remarried after the employee's death and that marriage was annulled, evidence of the annulment is required. If the claimant is a divorced spouse or surviving divorced spouse, evidence to prove a final or absolute divorce from the employee may be required.

§ 219.35 Evidence that a marriage has ended.

(a) *Preferred evidence.* Preferred evidence that a marriage has ended is—

(1) A certified copy of the decree of divorce or annulment; or

(2) Evidence of the death (See § 219.23) of a party to the marriage.

(b) *Other evidence that a marriage has ended.* If preferred evidence that the marriage has ended cannot be obtained, the claimant must explain the reason therefor and submit other convincing evidence that the marriage has ended.

(Approved by the Office of Management and Budget under control numbers 3220–0021 and 3220–0140)

§ 219.36 When evidence of a parent or child relationship is required.

(a) *When parent or child applies.* A person who applies for a parent's or child's annuity or for Medicare coverage is required to submit evidence of his or her relationship to the deceased employee.

(b) *When individual with child in care applies.* An individual who applies for an annuity because he or she has a child of the employee in care is required to submit evidence of the child's relationship to the employee.

(c) *Evidence required depends on relationship.* The evidence the Board will require depends on whether the person is the employee's natural child, adopted child, stepchild, grandchild, or stepgrandchild; or whether the person is the employee's natural parent or adopting parent.

§ 219.37 Evidence of natural parent or child relationship.

(a) *Preferred evidence.* If the claimant is the natural parent of the employee, preferred evidence of the ralationship is a copy of the employee's public or religious birth record. If the claimant is the natural child of the employee, preferred evidence of the relationship is a copy of the child's public or religious birth record.

(b) *Other evidence of parent or child relationship.* (1) When preferred evidence of a parent or child relationship cannot be obtained, the Board may ask the applicant for evidence of the employee's

marriage or of the marriage of the employee's parents if that is needed to remove any reasonable doubt of the relationship.

(2) To show that a person is the child of the employee, the person may be asked for evidence that he or she would be able to inherit the employee's personal property under the law of the state where the employee died or had a permanent home.

(3) In some instances the Board may ask for a signed statement from the employee that a person is his or her natural child, or for a copy of a court order showing that the person has been declared to be the child of the employee, or for a copy of a court order requiring the employee to contribute to the person's support because the person is his or her child, or for any other supporting evidence which may be required in order to establish that the person is the child of the employee.

§ 219.38 Evidence of stepparent or stepchild relationship.

If the claimant is a stepparent or stepchild of the employee, the Board will ask for the evidence described in § 219.37 or § 219.39 which shows the person's natural or adoptive relationship to the employee's husband, wife, widow, or widower. The Board will also ask for evidence of the husband's, wife's, widow's or widower's marriage to the employee (See §§ 219.30–219.33).

§ 219.39 Evidence of relationship by legal adoption—parent or child.

(a) *Preferred evidence.* Preferred evidence of legal adoption is—

(1) A copy of the decree or order of adoption, certified by the custodian of the record;

(2) A photocopy of the decree or order of adoption; or

(3) If the widow or widower adopted the child after the employee's death, the evidence described in paragraph (a)(1) or (2) of this section; the widow's or widower's statement as to whether the child was living in the same household with the employee when the employee died (see §§ 219.50 and 219.51); what support, if any, the child was getting from another person or organization; and if the widow or widower had a deemed valid marriage with the employee, evidence of that marriage (see § 219.33).

(b) *Other evidence of legal adoption.* In some states the record of adoption proceedings is sealed and cannot be obtained without a court order. In this event, the Board will accept as proof of adoption an official notice received by the adopting parents at the time of adoption that the adoption has been completed or a birth certificate issued as a result of the adoption proceeding.

§ 219.40 Evidence of relationship by equitable adoption—child.

(a) *Preferred evidence.* If the claimant is a person who claims to be the equitably adopted child of the employee (or of the employee's wife, widow, widower, or husband), as defined in part 222 of this chapter, the Board will ask for evidence of the agreement to adopt if it is in writing. The Board will also ask for written statements from the child's natural parents as well as adopting parents concerning the child's relationship to the adopting parents.

(b) *Other evidence.* If the agreement to adopt was not in writing, the Board will require other convincing evidence about the child's relationship to the adopting parents.

(Approved by the Office of Management and Budget under control number 3220–0040)

§ 219.41 Evidence of relationship of grandchild or stepgrandchild.

If the child is the grandchild or stepgrandchild of the employee, the Board will require the kind of evidence described in §§ 219.36–219.38 that shows that child's relationship to his or her parents and his or her parents' relationship to the employee.

§ 219.42 When evidence of child's dependency is required.

Evidence of a child's dependency on the employee is required when—

(a) The employee is receiving an annuity that can be increased under the social security overall minimum (see part 229 of this chapter) by including a child, grandchild or a spouse who has a child in his or her care;

(b) A wife under age 65 applies for a full spouse annuity because she has a child or a grandchild of the employee in her care; or

(c) A child or someone in behalf of a child applies for a child's annuity based on the deceased employee's record.

§ 219.43 Evidence of child's dependency.

(a) *When the dependency requirement must be met.* Usually the dependency requirement must be met at one of the times shown in part 222 of this chapter.

(b) *Natural or adopted.* If the child is the employee's natural or adopted child, the Board may ask for the following evidence:

(1) A signed statement by someone who knows the facts that confirms that the child is the natural or adopted child.

(2) If the child was adopted by someone else while the employee was alive but the adoption was annulled, the Board may require a certified copy of the annulment decree or other convincing evidence of the annulment.

(3) A signed statement by someone having personal knowledge of the circumstances showing when and where the child lived with the employee and when and why they may have lived apart; and showing what contributions the employee made to the child's support and how the contributions were made.

(c) *Stepchild.* If the child is the employee's stepchild, the Board may ask for the following evidence;

(1) A signed statement by someone having personal knowledge of the circumstances showing when and where the child lived with the employee and when and why they may have lived apart.

(2) A signed statement by someone having personal knowledge of the circumstances showing what contributions the employee made to the child's support, the child's ordinary living costs and the income and support the child received from any other source during the relevant time as required by § 222.55 of this chapter.

(d) *Grandchild or stepgrandchild.* If the child is the employee's grandchild or stepgrandchild, the Board will require the evidence described in paragraph (c) of this section. The Board will also require evidence of the employee's death or disability.

(Approved by the Office of Management and Budget under control number 3220–0099)

§ 219.44 Evidence of relationship of a person other than a parent or child.

(a) *Claimants other than child or parent.* When any person other than a child or parent applies for benefits due because of the employee's death or because of the death of a beneficiary, the Board may ask the claimant for evidence of relationship.

(b) *Evidence required.* The type of evidence required is dependent upon the amount payable and the claimant's relationship to the deceased employee or beneficiary.

(c) *More than one eligible and claimants agree on relationship.* If there is more than one person eligible for benefits, and all eligible persons agree on the relationship of each other eligible person, only one of the persons will be asked to furnish proof of relationship. For example, if brothers and sisters of a deceased employee file applications for the residual lump sum or annuity payments due but unpaid at death, only one of them need file proof of relationship if their applications indicate that there is no dispute as to who are the brothers and sisters of the employee.

Subpart D—Other Evidence Requirements

§ 219.50 When evidence of "living with" is required.

Evidence of ''living with'' (see part 222 of this chapter on Family Relationships) is required when—

(a) The employee's spouse applies for a spouse's annuity as a deemed spouse; or

(b) The employee's legal widow or widower applies for a lump-sum death payment, annuity payments due the employee but unpaid at death, or a residual lump-sum death payment on the basis of that relationship, or the employee's deemed widow or widower applies for a widow's or widower's annuity.

§ 219.51 Evidence to prove "living with".

The following evidence may be required:

(a) If the employee is alive, both the employee and his or her spouse must sign a statement that they are living together in the same household when the spouse applies for a spouse's annuity as a deemed spouse.

(b) If the employee is dead, the widow or widower must sign a statement showing whether he or she was living together in the same household with the employee when the employee died.

(c) If the employee and spouse, widow or widower were temporarily living apart, a signed statement is required explaining where each was living, how long the separation lasted, and the reason for separation. If more evidence is required to remove any reasonable doubt about the temporary nature of the separation, the Board may ask for sworn statements of other persons having personal knowledge of the facts or for other convincing evidence.

(d) If the employee and spouse, widow, or widower were not living in the same household, the Board may ask for evidence that the employee was contributing to or under court order to contribute to the support of his or her spouse, widow, or widower. Evidence of contributions or a certified copy of the order for support may be requested. The court order for support must be in effect on the day the spouse applies for a spouse's annuity or, if the employee is dead, the day of the employee's death. This type of evidence does not apply for purposes of establishing a deemed valid marriage. (See part 222 of this chapter.) A deemed spouse, widow, or widower must furnish evidence as described in paragraphs (a) and (b) of this section.

(Approved by the Office of Management and Budget under control number 3220–0030)

§ 219.52 When evidence of having a child in care is required.

A person who applies for a spouse's, widow's or widower's, or surviving divorced spouse's annuity on the basis of caring for a child, or for an increase under the social security overall minimum guaranty provision based on caring for a child, is required to furnish evidence that he or she has in care an eligible child of the employee as described in part 222 of this chapter. What evidence the Board will require depends upon whether the child is living with the applicant or with someone else.

§ 219.53 Evidence of having a child in care.

(a) *Preferred evidence of having a child in care.* Preferred evidence of having a child in care is—

(1) If the child is living with the applicant, the claimant's signed statement showing that the child is living with him or her.

(2) If the child is living with someone else—

(i) The claimant's signed statement showing with whom the child is living and why. The claimant must also show when the child last lived with him or her, how long the separation will last, and what care and contributions he or she provides for the child; and

(ii) The signed statement of the person with whom the child is living showing what care the claimant provides and the sources and amounts of support received by the child. If the child is in an institution, an official thereof should sign the statement. A copy of any court order or written agreement showing who has custody of the child should be provided to the Board.

(b) *Other evidence.* If the preferred evidence described in paragraph (a) of this section cannot be obtained, the Board will require other convincing evidence that the applicant has the child in care.

(Approved by the Office of Management and Budget under control numbers 3220–0030 and 3220–0042)

§ 219.54 When evidence of school attendance is required.

If a child age 18 applies for payments as a student, the Board will require evidence that the child is attending elementary or secondary school. After the child has started his or her school attendance, the Board may also ask for evidence that he or she is continuing to attend school full time. To be acceptable to the Board, the child must submit the evidence of school attendance

within 90 days of the date the evidence is requested by the Board.

§ 219.55 Evidence of school attendance for child age 18.

The child will be asked to submit (on a form furnished by the Board or other form acceptable to the Board) the following evidence:

(a) A signed statement that he or she is attending school full-time and is not being paid by an employer to attend school; and

(b) A statement from an official of the school verifying that the child is attending school full-time. The Board may also accept as evidence a letter of acceptance from the school, receipted bill, or other evidence showing that the child has enrolled or been accepted at that school or is continuing in full-time attendance.

(Approved by the Office of Management and Budget under control numbers 3220–0030, 3220–0083, and 3220–0123)

§ 219.56 When evidence of a parent's support is required.

If a person applies for a parent's annuity, the Board will require evidence to show that the parent received at least one-half of his or her support from the employee in the one-year period before—

(a) The employee died; or

(b) The beginning of a period of disability if the employee had a period of disability which did not end before his or her death.

§ 219.57 Evidence of a parent's support.

(a) The Board will require the parent's signed statement showing his or her income, any other sources of support, the amount from each source and his or her expenses during the one-year period.

(b) The Board may also ask the parent for signed statements from other people who know the facts about his or her sources of support.

(c) If the statements described in paragraphs (a) and (b) of this section cannot be obtained, the Board will require other convincing evidence that the parent is receiving one-half of his or her support from the employee.

(Approved by the Office of Management and Budget under control number 3220–0099)

§ 219.58 When evidence regarding payment of burial expenses is required.

If a person applies for the lump-sum death payment because he or she is responsible for paying the funeral home or burial expenses of the employee or because he or she has paid some or all of these expenses, the Board will require evidence of such payment.

§ 219.59 Evidence of responsibility for or payment of burial expenses.

The Board will ask for the following evidence:

(a) The claimant's signed statement showing—

(1) That he or she accepted responsibility for the funeral home expenses or paid some or all of these expenses or other burial expenses; or the name and address of the person who accepted responsibility for or paid these expenses;

(2) Total funeral home expenses and, if necessary, the total of other burial expenses; and if someone else paid part of the expenses, that person's name, address, and the amount he or she paid;

(3) The amount of cash or property the applicant expects to receive as repayment for any burial expenses he or she paid; and whether anyone has applied for any burial allowance from the Veterans Administration or other governmental agency for these expenses; and

(4) If the claimant is an owner or official of a funeral home, a signed statement from anyone, other than employee of the home, who helped make the burial arrangements showing whether he or she accepted responsibility for paying the burial expenses.

(b) Unless the claimant is an owner or official of a funeral home, a signed statement from the owner or official of the funeral home which handled the deceased employee's funeral and, if necessary, from those who supplied other burial goods or services which shows—

(1) The name and address of everyone who accepted responsibility for or paid any part of the burial expenses; and

(2) Information which the owner or official of the funeral home and, if necessary, any other supplier has about the expenses and payments described in paragraphs (a)(2) and (a)(3) of this section.

(Approved by the Office of Management and Budget under control number 3220–0031)

§ 219.60 When evidence of the employee's permanent home is required.

The Board may ask for evidence to prove where the employee had a permanent home at the time of filing an application or, if earlier, at the time the employee died if—

(a) The claimant is applying for payments as the employee's wife, husband, widow, widower, parent, or child; and

(b) The claimant's relationship to the employee depends upon the laws of the state where the employee had his or her permanent home when his or her wife or husband applied for an annuity or when the employee died.

§ 219.61 Evidence of where the employee had a permanent home.

The Board will ask for the following evidence to establish the employee's permanent home:

(a) The claimant's signed statement showing what the employee considered to be his or her permanent home.

(b) If the statement in paragraph (a) of this section or other evidence raises a reasonable doubt in establishing the employee's permanent home, evidence of where the employee paid personal property taxes, real estate taxes, or income taxes; or evidence where the employee voted; or other convincing evidence.

§ 219.62 When evidence of "good cause" is required.

The principle of ''good cause'', as defined in part 217 of this chapter, is applied by the Board in determining whether to allow an application which is submitted more than two years after the employee's death as acceptable for the lump-sum death payment or for an annuity unpaid at death, or to accept the proof of support required for entitlement to a parent's annuity if such proof is filed more than two years after the employee's death.

§ 219.63 What evidence is required to establish "good cause".

The Board will ask for the following evidence of ''good cause'':

(a) The claimant's signed statement explaining why he or she did not file the application for lump-sum death payment or annuity unpaid at death or the parent's proof of support within the specified two-year period.

(b) If the statement in paragraph (a) of this section or other evidence raises a reasonable doubt as to whether there was good cause, other convincing evidence to establish ''good cause''.

§ 219.64 When evidence may be required for other reasons.

(a) The Board will require evidence of the appointment of a legal representative when—

(1) The employee's estate is entitled to a lump-sum death payment, annuity unpaid at death, or residual lump sum, and an executor or administrator has been appointed for the estate; or

(2) A minor child or incompetent is entitled to an annuity or lump-sum payment and a guardian, trustee, committee, or conservator has been appointed to act in his or her behalf.

(b) The Board will require evidence of an annuitant's earnings when the information that he or she furnished the Board does not agree with the earnings data furnished by the Social Security Administration or secured from other sources, and the annuitant maintains that the earnings data from the Social Security Administration or from other sources is not correct.

(c) The Board will require evidence to establish the amounts paid as a public service pension, public disability benefit, or worker's compensation to an employee, spouse, widow, or widower when the pension, public disability benefit, or worker's compensation affects the amount of his or her annuity.

(d) The Board will require evidence to reconcile discrepancies between the information furnished by the claimant and information already in the records of the Board, the Social Security Administration, or other public agencies. Such discrepancies may be differences in name, date or place of birth, periods

of employment, or other identifying data.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0136, and 3220–0154)

§ 219.65 Other types of evidence that may be required.

(a) The Board may ask for a statement from an employer listing the annuitant's earnings by months and explaining any payments made to the annuitant when he or she was not working.

(b) The Board may ask for copies of award notices from a public agency showing the amounts of periodic payments and the period covered by each payment.

(c) The Board may ask for a statement from the applicant explaining discrepancies and may ask for sworn statements from persons who have personal knowledge of the facts or for any other convincing evidence.

(d) The Board may ask for proof of the court appointment of a legal representative, such as:

(1) Certified copy of letters of appointment;

(2) ''Short'' certificate;

(3) Certified copy of order of appointment; or

(4) Any official document issued by the clerk or other proper official of the appointing court.

PART 220—DETERMINING DISABILITY

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APPENDIX 1 TO PART 220 [RESERVED]
APPENDIX 2 TO PART 220—MEDICAL-VOCATIONAL GUIDELINES
APPENDIX 3 TO PART 220—RAILROAD RETIREMENT BOARD OCCUPATIONAL DISABILITY STANDARDS

AUTHORITY: 45 U.S.C. 231a; 45 U.S.C. 231f.

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Subpart A—General

§ 220.1 Introduction of part.

(a) This part explains how disability determinations are made by the Railroad Retirement Board. In some determinations of disability entitlement, as described below, the Board makes the decision of disability under the Railroad Retirement Act based on the regulations set out in this part. However, in certain other determinations of disability entitlement (as also described below) the Board has the authority to decide whether the claimant is disabled as that term is defined in the Social Security Act and the regulations of the Social Security Administration.

(b) In order for a claimant to become entitled to a railroad retirement annuity based on disability for his or her regular railroad occupation, or to become entitled to a railroad retirement annuity based on disability for any regular employment as an employee, widow(er), or child, he or she must be disabled as those terms are defined in the Railroad Retirement Act. In order for a claimant to become entitled to a period of disability, to early Medicare coverage based on disability, to benefits under the social security overall minimum, or to a disability annuity as a surviving divorced spouse or remarried widow(er), the claimant must be found disabled as that term is defined in the Social Security Act.

§ 220.2 The basis for the Board's disability decision.

(a) The Board makes disability decisions for claims of disability under the Railroad Retirement Act. These decisions are based either on the rules contained in the Board's regulations in this part or the rules contained in the regulations of the Social Security Administration, whichever is controlling.

(b) A disability decision is made only if the claimant meets other basic eligibility requirements for the specific disability benefit for which he or she is applying. For example, a claimant for an occupational disability annuity must first meet the eligibility requirements for that annuity, as explained in part 216 of this chapter, in order for the Board to make a disability decision.

§ 220.3 Determinations by other organizations and agencies.

Determinations of the Social Security Administration or any other governmental or non-governmental agency about whether or not a claimant is disabled under the laws, regulations or standards administered by that agency shall be considered by the Board but are not binding on the Board.

Subpart B—General Definitions of Terms Used in This Part

§ 220.5 Definitions as used in this part.

Act means the Railroad Retirement Act of 1974.

Application refers only to a form described in part 217 of this chapter.

Board means the Railroad Retirement Board.

Claimant means the person for whom an application for an annuity, period of disability or Medicare coverage is filed.

Eligible means that a person would meet all the requirements for payment of an annuity but has not yet applied.

Employee is defined in part 203 of this title.

Entitled means that a person has applied and has proven his or her right to have the annuity, period of disability, or Medicare coverage begin.

Medical source refers to both a treating source and a source of record.

Review physician means a medical doctor either employed by or under contract to the Board who upon request reviews medical evidence and provides medical advice.

Social security overall minimum refers to the provision of the Railroad Retirement Act which guarantees that the total monthly annuities payable to an

employee and his or her family will not be less than the total monthly amount which would be payable under the Social Security Act if the employee's railroad service were credited as employment under the Social Security Act.

Source of record means a hospital, clinic or other source that has provided a claimant with medical treatment or evaluation, as well as a physician or psychologist who has treated or evaluated a claimant but does not have an ongoing relationship with him or her.

Treating source means the claimant's own physician or psychologist who has provided the claimant with medical treatment or evaluation and who has an ongoing treatment relationship with him or her.

Subpart C—Disability Under the Railroad Retirement Act for Work in an Employee's Regular Railroad Occupation

§ 220.10 Disability for work in an employee's regular railroad occupation.

(a) In order to receive an occupational disability annuity an eligible employee must be found by the Board to be disabled for work in his or her regular railroad occupation because of a permanent physical or mental impairment. In this subpart the Board describes in general terms how it evaluates a claim for an occupational disability annuity. In accordance with section 2(a)(2) of the Railroad Retirement Act this subpart was developed with the cooperation of employers and employees. This subpart is supplemented by an Occupational Disability Claims Manual (Manual)[1] which was also developed with the cooperation of employers and employees.

(b) In accordance with section 2(a)(2) of the Railroad Retirement Act, the Board shall select two physicians, one from recommendations made by representatives of employers and one from recommendations made by representatives of employees. These individuals shall comprise the Occupational Disability Advisory Committee (Committee). This Committee shall periodically review, as necessary, this subpart and the Manual and make recommendations to the Board with respect to amendments to this subpart or to the Manual. The Board shall confer with the Committee before it amends either this subpart or the Manual.

[63 FR 7541, Feb. 13, 1998]

§ 220.11 Definitions as used in this subpart.

Functional capacity test means one of a number of tests which provide objective measures of a claimant's maximal work ability and includes functional capacity evaluations which provide a systematic comprehensive assessment of a claimant's overall strength, mobility, endurance and capacity to perform physically demanding tasks, such as standing, walking, lifting, crouching, stooping or bending, climbing or kneeling.

Independent Case Evaluation (ICE) means the process for evaluating claims not covered by appendix 3 of this part.

Permanent physical or mental impairment means a physical or mental impairment or combination of impairments that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.

Regular railroad occupation means an employee's railroad occupation in which he or she has engaged in service for hire in more calendar months than the calendar months in which he or she has been engaged in service for hire in any other occupation during the last preceding five calendar years, whether or not consecutive; or has engaged in service for hire in not less than one-half of all of the months in which he or she has been engaged in service for hire during the last preceding 15 consecutive calendar years. If an employee last worked as an officer or employee of a railway labor organization and if continuance in such employment is no longer available to him or her, the ''regular occupation'' shall be the position to which the employee holds seniority rights or the position which he or she left to work for a railway labor organization.

[1] The Manual may be obtained from the Board's headquarters at 844 North Rush Street, Chicago, IL 60611.

Residual functional capacity has the same meaning as found in § 220.120.

[63 FR 7541, Feb. 13, 1998]

§ 220.12 Evidence considered.

The regulations explaining the employee's responsibility to provide evidence of disability, the kind of evidence, what medical evidence consists of, and the consequences of refusing or failing to provide evidence or to have a medical examination are found in § 220.45 through § 220.48. The regulations explaining when the employee may be requested to report for a consultative examination are found in § 220.50 and § 220.51. The regulations explaining how the Board evaluates conclusions by physicians concerning the employee's disability, how the Board evaluates the employee's symptoms, what medical findings consist of, and the need to follow prescribed treatment are found in § 220.112 through § 220.115.

[56 FR 12980, Mar. 28, 1991. Redesignated at 63 FR 7541, Feb. 13, 1998]

§ 220.13 Establishment of permanent disability for work in regular railroad occupation.

The Board will presume that a claimant who is not allowed to continue working for medical reasons by his employer has been found, under standards contained in this subpart, disabled unless the Board finds that no person could reasonably conclude on the basis of evidence presented that the claimant can no longer perform his or her regular railroad occupation for medical reasons. (See § 220.21 if the claimant is not currently disabled, but was previously occupationally disabled for a specified period of time in the past). The Board uses the following evaluation process in determining disability for work in the regular occupation:

(a) The Board evaluates the employee's medically documented physical and mental impairment(s) to determine if the employee is medically disabled. In order to be found medically disabled, the employee's impairments must be severe enough to prevent a person from doing any substantial gainful activity. The Board makes this determination based on the guidelines set out in § 220.100(b)(3). If the Board finds that an employee has an impairment which is medically disabling, it will find the employee disabled for work in his or her regular occupation without considering the duties of his or her regular occupation.

(b) If the Board finds that the claimant does not have an impairment described in paragraph (a) of this section, it will—

(1) Determine the employee's regular railroad occupation, as defined in § 220.11, based upon the employee's own description of his or her job;

(2) Evaluate whether the claimant is disabled as follows:

(i) The Board first determines whether the employee's regular railroad occupation is an occupation covered under appendix 3 of this part. Second, the Board will determine whether the employee's claimed impairment(s) is covered under appendix 3 of this part. If claimant's regular railroad occupation or impairment(s) is not covered under appendix 3 of this part, then the Board will determine if the employee is disabled under ICE as set forth in paragraph (b)(2)(iv) of this section.

(ii)(A) If the Board determines that, in accordance with paragraph (b)(2)(i) of this section, appendix 3 of this part applies, then the Board will confirm the existence of the employee's impairment(s) using—

(*1*) The ''highly recommended'' and ''recommended'' tests set forth in appendix 3 of this part that relate to the body part affected by the claimant's impairment(s); or

(*2*) By using valid diagnostic tests accepted by the medical community as described in § 220.27.

(B) If the employee's impairment(s) cannot be confirmed because there are significant differences in objective tests such as imaging study, electrocardiograms or other test results, and these differences cannot be readily resolved, the Board will determine if the employee is disabled under ICE as set forth in paragraph (b)(2)(iv) of this section. However, if the employee's impairment(s) cannot be confirmed, and there are no significant differences in objective medical tests which cannot be readily resolved, then the employee will be found not disabled.

(iii) Once the impairment(s) is confirmed, as provided for in paragraph (b)(2)(ii) of this section, the Board will apply appendix 3 of this part. If appendix 3 of this part dictates a ''D'' (disabled) finding, the Board will find the claimant disabled.

(iv) If the Board does not find the employee disabled using the standards in appendix 3 of this part, then the Board will determine if the employee is disabled using ICE. To evaluate a claim under ICE the Board will use the following steps:

(A) *Step 1.* The Board will determine if the medical evidence is complete. Under this step the Board may request the claimant to take additional medical tests such as a functional capacity test or other consultative examinations;

(B) *Step 2.* If the employee's impairment(s) has not been confirmed, as provided for in paragraph (b)(2)(ii)(A)(*2*) of this section, the Board will next confirm the employee's impairment(s), as described in paragraph (b)(2)(ii)(A)(*2*) of this section;

(C) *Step 3.* The Board will determine whether the opinions among the physicians regarding medical findings are consistent, by reviewing the employee's medical history, physical and mental examination findings, laboratory or other test results, and other information provided by the employee or obtained by the Board. If such records reveal that there are significant differences in the medical findings, significant differences in opinions concerning the residual functional capacity evaluations among treating physicians, or significant differences between the results of functional capacity evaluations and residual functional capacity examinations, then the Board may request additional evidence from treating physicians, additional consultative examinations and/or residual functional capacity tests to resolve the inconsistencies;

(D) *Step 4.* When the Board determines that there is concordance of medical findings, then the Board will assess the quality of the evidence in accordance with § 220.112, which describes the weight to be given to the opinions of various physicians, and § 220.114, which describes how the Board evaluates symptoms such as pain. The Board will also assess the weight of evidence by utilizing § 220.14, which outlines factors to be used in determining the weight to be attributed to certain types of evidence. If, after assessment, the Board determines that there is no substantial objective evidence of an impairment, the Board will determine that the employee is not disabled;

(E) *Step 5.* Next, the Board determines the physical and mental demands of the employee's regular railroad occupation. In determining the job demands of the employee's regular railroad occupation, the Board will not only consider the employee's own description of his or her regular railroad occupation, but shall also consider the employer's description of the physical requirements and environmental factors relating to the employee's regular railroad occupation, as provided by the employer on the appropriate form set forth in appendix 3 of this part, and consult other sources such as the Dictionary of Occupational Titles and the job descriptions of occupations found in the Occupational Disability Claims Manual, as provided for in § 220.10;

(F) *Step 6.* Based upon the assessment of the evidence in paragraph (b)(2)(iv)(D) of this section, the Board shall determine the employee's residual functional capacity. The Board will then compare the job demands of the employee's regular railroad occupation, as determined in paragraph (b)(2)(iv)(E) of this section. If the demands of the employee's regular railroad occupation exceed the employee's residual functional capacity, then the Board will find the employee disabled. If the demands do not exceed the employee's residual functional capacity, then the Board will find the employee not disabled.

[56 FR 12980, Mar. 28, 1991, as amended at 63 FR 7541, Feb. 13, 1998; 74 FR 63600, Dec. 4, 2009]

§ 220.14 Weighing of evidence.

(a) *Factors which support greater weight.* Evidence will generally be given more weight if it meets one or more of the following criteria:

(1) The residual functional capacity evaluation is based upon functional objective tests with high validity and reliability;

(2) The medical evidence shows multiple impairments which have a cumulative effect on the employee's residual functional capacity;

(3) Symptoms associated with limitations are consistent with objective findings;

(4) There exists an adequate trial of therapies with good compliance, but poor outcome;

(5) There exists consistent history of conditions between treating physicians and other health care providers.

(b) *Factors which support lesser weight.* Evidence will generally be given lesser weight if it meets one or more of the following criteria:

(1) There is an inconsistency between the diagnoses of the treating physicians;

(2) There is inconsistency between reports of pain and functional impact;

(3) There is inconsistency between subjective symptoms and physical examination findings;

(4) There is evidence of poor compliance with treatment regimen, keeping appointments, or cooperating with treatment;

(5) There is evidence of exam findings which is indicative of exaggerated or potential malingering response;

(6) The evidence consists of objective findings of exams that have poor reliability or validity;

(7) The evidence consists of imaging findings which are nonspecific and largely present in the general population;

(8) The evidence consists of a residual functional capacity evaluation which is supported by limited objective data without consideration for functional capacity testing.

[63 FR 7542, Feb. 13, 1998]

§ 220.15 Effects of work on occupational disability.

(a) *Disability onset when the employee works despite impairment.* An employee who has stopped work in his or her regular occupation due to a permanent physical or mental impairment(s) may make an effort to return to work in his or her regular occupation. If the employee is subsequently forced to stop that work after a short time because of his or her impairment(s), the Board will generally consider that work as an unsuccessful work attempt. In this situation, the Board may determine that the employee became disabled for work in his or her regular occupation before the last date the employee worked in his or her regular occupation. No annuity will be payable, however, until after the last date worked.

(b) *Occupational disability annuitant work restrictions.* The restrictions which apply to an annuitant who is disabled for work in his or her regular occupation are found in §§ 220.160 through 220.164.

§ 220.16 Responsibility to notify the Board of events which affect disability.

If the annuitant is entitled to a disability annuity because he or she is disabled for work in his or her regular occupation, the annuitant should promptly tell the Board if—

(a) His or her impairment(s) improves;

(b) He or she returns to any type of work;

(c) He or she increases the amount of work; or

(d) His or her earnings increase.

§ 220.17 Recovery from disability for work in the regular occupation.

(a) *General.* Disability for work in the regular occupation will end if—

(1) There is medical improvement in the annuitant's impairment(s) to the extent that the annuitant is able to perform the duties of his or her regular occupation; or

(2) The annuitant demonstrates the ability to perform the duties of his or her regular occupation. The Board provides a trial work period before terminating a disability annuity because of the annuitant's return to work.

(b) *Definition of the trial work period.* The trial work period is a period during which the annuitant may test his or her ability to work and still be considered occupationally disabled. It begins and ends as described in paragraph (e) of this section. During this period, the annuitant may perform ''services'' (see paragraph (c) of this section) in as

many as 9 months, but these months do not have to be consecutive. The Board will not consider those services as showing that the annuitant's occupational disability has ended until the annuitant has performed services in at least 9 months. However, after the trial work period has ended, the Board will consider the work the annuitant did during the trial work period in determining whether the annuitant's occupational disability has ended at any time after the trial work period.

(c) *What the Board means by services in an occupational disability case.* When used in this section, ''services'' means any activity which, even though it may not be substantial gainful activity as defined in § 220.141, is—

(1) Done by a person in employment or self-employment for pay or profit, or is the kind normally done for pay or profit; and

(2) The activity is a return to the same duties of the annuitant's regular occupation or the activity so closely approximates the duties of the regular occupation as to demonstrate the ability to perform those duties.

(d) *Limitations on the number of trial work periods.* The annuitant may have only one trial work period during each period in which he or she is occupationally disabled.

(e) *When the trial work period begins and ends.* (1) The trial work period begins with whichever of the following calendar months is the latest—

(i) The annuity beginning date;

(ii) The month after the end of the appropriate waiting period; or

(iii) The month the application for disability is filed.

(2) The trial work period ends with the close of whichever of the following calendar months is the earlier—

(i) The ninth month (whether or not the months have been consecutive) in which the annuitant performed services; or

(ii) The month in which new evidence, other than evidence relating to any work the annuitant did during the trial work period, shows that the annuitant is not disabled, even though the annuitant has not worked a full nine months. The Board may find that the annuitant's disability has ended at any time during the trial work period if the medical or other evidence shows that the annuitant is no longer disabled.

§ 220.18 The reentitlement period.

(a) *General.* The reentitlement period is an additional period after the nine months of trial work during which the annuitant may continue to test his or her ability to work if the annuitant has a disabling impairment.

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of nine months of trial work but cannot begin earlier than December 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which the annuitant's impairment(s) no longer exists or is not medically disabling; or

(2) The last day of the 36th month following the end of the annuitant's trial work period.

(c) *When the annuitant is not entitled to a reentitlement period.* The annuitant is not entitled to a reentitlement period if—

(1) The annuitant is not entitled to a trial work period; or

(2) The annuitant's disability ended before the annuitant completed nine months of trial work in that period in which he or she was disabled.

§ 220.19 Payment of the disability annuity during the trial work period and the reentitlement period.

(a) The employee who is entitled to an occupational disability annuity will not be paid an annuity for each month in the trial work period or reentitlement period in which he or she—

(1) Works for an employer covered by the Railroad Retirement Act (see § 220.160); or

(2) Earns more than $400 (after deduction of impairment-related work expenses) in employment or self-employment (see §§ 220.161 and 220.164). See § 220.145 for the definition of impairment-related work expenses.

(b) If the employee's occupational disability annuity is stopped because of work during the trial work period or reentitlement period, and the employee discontinues that work before the end of either period, the disability annuity

may be started again without a new application and a new determination of disability.

§ 220.20 Notice that an annuitant is no longer disabled.

The regulation explaining the Board's responsibilities in notifying the annuitant, and the annuitant's rights when the disability annuity is stopped is found in § 220.183.

§ 220.21 Initial evaluation of a previous occupational disability.

(a) In some cases, the Board may determine that a claimant is not currently disabled for work in his or her regular occupation but was previously disabled for a specified period of time in the past. This can occur when—

(1) The disability application was filed before the claimant's occupational disability ended, but the Board did not make the initial determination of occupational disability until after the claimant's disability ended; or

(2) The disability application was filed after the claimant's occupational disability ended but no later than the 12th month after the month the disability ended.

(b) When evaluating a claim for a previous occupational disability, the Board follows the steps in § 220.13 to determine whether an occupational disability existed, and follows the steps in §§ 220.16 and 220.17 to determine when the occupational disability ended.

Example 1: The claimant sustained multiple fractures to his left leg in an automobile accident which occurred on June 16, 1982. For a period of 18 months following the accident the claimant underwent 2 surgical procedures which restored the functional use of his leg. After a recovery period following the last surgery, the claimant returned to his regular railroad job on February 1, 1984. The claimant, although fully recovered medically and regularly employed, filed an application on December 3, 1984 for a determination of occupational disability for the period June 16, 1982 through January 31, 1984. The Board reviewed his claim in January 1985 and determined that he was occupationally disabled for the prior period which began on June 16, 1982 and continued through January 31, 1984. A disability annuity is payable to the employee only for the period December 1, 1983 through January 31, 1984. An annuity may not begin any earlier than the 1st day of the 12th month before the month in which the application was filed. (See part 218 of this chapter for the rules on when an annuity may begin).

Example 2: The claimant is occupationally disabled using the same medical facts disclosed above, beginning June 16, 1982 (the date of the automobile accident). The claimant files an application for an occupational disability annuity, dated December 1, 1983. However, as of February 1, 1984, and before the Board makes a disability determination, the claimant returns to his regular railroad job and is no longer considered occupationally disabled. The Board reviews the claimant's application in May of 1984 and finds him occupationally disabled for the period June 16, 1982 through January 31, 1984. A disability annuity is payable to the employee from December 1, 1982 through January 31, 1984. (See part 218 of this chapter for the rules on when an annuity may begin).

Subpart D—Disability Under the Railroad Retirement Act for Any Regular Employment

§ 220.25 General.

The definition and discussion of disability for any regular employment are found in §§ 220.26 through 220.184.

§ 220.26 Disability for any regular employment, defined.

An employee, widow(er), or child is disabled for any regular employment if he or she is unable to do any substantial gainful activity because of a medically determinable physical or mental impairment which meets the duration requirement defined in § 220.28. In the case of a widow(er), the permanent physical or mental impairment must have prevented work in any regular employment before the end of a specific period (see § 220.30). In the case of a child, the permanent physical or mental impairment must have prevented work in any regular employment since before age 22. To meet this definition of disability, a claimant must have a severe impairment, which makes him or her unable to do any previous work or other substantial gainful activity which exists in the national economy. To determine whether a claimant is able to do any other work, the Board considers a claimant's residual functional capacity, age, education and work experience. See § 220.100 for

the process by which the Board evaluates disability for any regular employment. This process applies to employees, widow(er)s, or children who apply for annuities based on disability for any regular employment. This process does not apply to surviving divorced spouses or remarried widow(er)s who apply for annuities based on disability.

§ 220.27 What is needed to show an impairment.

A physical or mental impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the claimant's statement of symptoms. (See § 220.113 for further information about what is meant by symptoms, signs, and laboratory findings.) (See also § 220.112 for the effect of a medical opinion about whether or not a claimant is disabled.)

§ 220.28 How long the impairment must last.

Unless the claimant's impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. This is known as the duration requirement.

§ 220.29 Work that is considered substantial gainful activity.

Work is considered to be substantial gainful activity if it—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done or is intended to be done for pay or profit. (See § 220.141 for a detailed explanation of what is substantial gainful activity.)

§ 220.30 Special period required for eligibility of widow(er)s.

In order to be found disabled for any regular employment, a widow(er) must have a permanent physical or mental impairment which prevented work in any regular employment since before the end of a specific period as defined in part 216 of this chapter.

Subpart E—Disability Determinations Governed by the Regulations of the Social Security Administration

§ 220.35 Introduction.

In addition to its authority to decide whether a claimant is disabled under the Railroad Retirement Act, the Board has authority in certain instances to decide whether a claimant is disabled as that term is defined in the Social Security Act. In making these decisions the Board must apply the regulations of the Social Security Administration in the same manner as does the Secretary of Health and Human Services in making disability decisions under the Social Security Act. Regulations of the Social Security Administration concerning disability are found at part 404, subpart P of this title.

§ 220.36 Period of disability.

(a) *General.* In order to receive an annuity based upon a disability, an employee must be found disabled under the Railroad Retirement Act. If an employee is found disabled under the Railroad Retirement Act, the Board will determine whether he is disabled under the Social Security Act to qualify for a period of disability as defined in that Act.

(b) *Period of disability*—(1) *Definition and effect.* A period of disability is a continuous period of time during which an employee is disabled as that term is defined in § 404.1505 of this title. A period of disability established by the Board—

(i) Preserves the disabled employee's earnings record as it is when the period begins;

(ii) Protects the insured status required for entitlement to social security overall minimum;

(iii) May cause an increase in the rate of an employee, spouse, or survivor annuity; or

(iv) May permit a disabled employee to receive Medicare benefits in addition to an annuity under the Railroad Retirement Act.

(2) *Effect on benefits.* The establishment of a period of disability for the employee will never cause a denial or

reduction in benefits under the Railroad Retirement Act or Social Security Act, but it will always be used to establish Medicare entitlement before age 65.

(3) *Who may establish a period of disability.* The Railroad Retirement Board or the Social Security Administration may establish a period of disability. However, the decision of one agency is not binding upon the other agency.

(4) *When the Board may establish a period of disability.* The Board has independent authority to decide whether or not to establish a period of disability for any employee who was awarded an annuity under the Railroad Retirement Act, or who—

(i) Has applied for a disability annuity; and

(ii) Has at least 10 years of railroad service.

(5) *When an employee is entitled to a period of disability.* An employee is entitled to a period of disability if he or she meets the following requirements:

(i) The employee is disabled under the Social Security Act, as described in § 404.1505 of this title.

(ii) The employee is insured for a period of disability under § 404.130 of this title based on combined railroad and social security earnings.

(iii) The employee files an application as shown in subparagraph (b)(6) of this section.

(iv) At least 5 consecutive months elapse from the month in which the period of disability begins and before the month in which it would end.

(6) *Application for a period of disability.* (i) An application for an employee disability annuity under the Railroad Retirement Act or an employee disability benefit under the Social Security Act is also an application for a period of disability.

(ii) An employee who is receiving an age annuity or who was previously denied a period of disability must file a separate application for a period of disability.

(iii) In order to be entitled to a period of disability, an employee must apply while he or she is disabled or not later than 12 months after the month in which the period of disability ends.

(iv) An employee who is unable to apply within the 12-month period after the period of disability ends because his or her physical condition limited his or her activities to the extent that he or she could not complete and sign an application or because he or she was mentally incompetent, may apply no later than 36 months after the period of disability ends.

(v) A period of disability can also be established on the basis of an application filed within 3 months after the month a disabled employee died.

(c) *Social security overall minimum.* The social security overall minimum provision of the Railroad Retirement Act guarantees that the total monthly annuities payable to an employee and his or her family will not be less than the total monthly benefit which would be payable under the Social Security Act if the employee's railroad service were credited as employment under the Social Security Act.

(The information collection requirements contained in paragraph (b)(6) were approved by the Office of Management and Budget under control number 3220–0002)

§ 220.37 When a child's disability determination is governed by the regulations of the Social Security Administration.

(a) In order to receive an annuity based upon disability, a child of a deceased employee must be found disabled under the Railroad Retirement Act. However, in addition to this determination, the child must be found disabled under the Social Security Act in order to qualify for Medicare based upon disability.

(b) Although the child of a living employee may not receive an annuity under the Railroad Retirement Act, he or she, if found disabled under the Social Security Act, may qualify for the following:

(1) Inclusion as a disabled child in the employee's annuity rate under the social security overall minimum.

(2) Entitlement to Medicare based upon disability.

§ 220.38 When a widow(er)'s disability determination is governed by the regulations of the Social Security Administration.

In order to receive an annuity based upon disability, a widow(er) must be

found disabled under the Railroad Retirement Act. However, in addition to this determination, the widow(er) must be found disabled under the Social Security Act in order to qualify for early Medicare based upon disability.

§ 220.39 Disability determination for a surviving divorced spouse or remarried widow(er).

A surviving divorced spouse or a remarried widow(er) must be found disabled under the Social Security Act in order to qualify for both an annuity under the Railroad Retirement Act and early Medicare based upon disability. Disability determinations for surviving divorced spouses and remarried widow(er)s are governed by the applicable regulations of the Social Security Administration, found at § 404.1577 of this title.

Subpart F—Evidence of Disability

§ 220.45 Providing evidence of disability.

(a) *General.* You are responsible for providing all evidence of the claimed disability and the effect of the disability on your ability to work. You must inform the Board about or submit all evidence known to you that relates to the claimed disability. This duty is ongoing and requires you to disclose any additional related evidence about which you become aware. This duty applies at each level of the administrative review process, including the appeals level, if the evidence relates to the period on or before the date of the hearings officer's decision. The Board will assist you, when necessary, in obtaining the required evidence. At its discretion, the Board will arrange for an examination by a consultant at the expense of the Board as explained in §§ 220.50 and 220.51.

(b) *Kind of evidence.* (1) You must provide medical evidence proving that you have an impairment(s) and how severe it is during the time you claim to be disabled. The Board will consider only impairment(s) you claim to have or about which the Board receives evidence. Before deciding that you are not disabled, the Board will develop a complete medical history (*i.e.*, evidence from the records of your medical sources) covering at least the preceding 12 months, unless you say that your disability began less than 12 months before you filed an application. The Board will make every reasonable effort to help you in getting medical reports from your own medical sources when you give the Board permission to request them. Every reasonable effort means that the Board will make an initial request and, after 20 days, one follow-up request to your medical source to obtain the medical evidence necessary to make a determination before the Board evaluates medical evidence obtained from another source on a consultative basis. The medical source will have 10 days from the follow-up request to reply (unless experience indicates that a longer period is advisable in a particular case). In order to expedite processing, the Board may order a consultative exam from a non-treating source while awaiting receipt of medical source evidence. If the Board asks you to do so, you must contact the medical sources to help us get the medical reports.

(2) *Exceptions.* Notwithstanding paragraph (a) of this section, evidence does not include:

(i) Oral or written communications between you and your representative that are subject to the attorney-client privilege, unless you voluntarily disclose the communications to us; or

(ii) Your representative's analysis of your claim, unless you or your representative voluntarily disclose it to us. Your representative's ''analysis of your claim'' means information that is subject to the attorney work product doctrine, but it does not include medical evidence, medical source opinions, or any other factual matter that we may consider in determining whether or not you are entitled to benefits (see paragraph (b)(2)(iv) of this section).

(iii) The provisions of paragraph (b)(2)(i) of this section apply to communications between you and your non-attorney representative only if the communications would be subject to the attorney-client privilege if your non-attorney representative were an attorney. The provisions of paragraph (b)(2)(ii) of this section apply to the

analysis of your claim by your non-attorney representative only if the analysis of your claim would be subject to the attorney work product doctrine if your non-attorney representative were an attorney.

(iv) The attorney-client privilege generally protects confidential communications between an attorney and the attorney's client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney's analysis, theories, mental impressions, and notes. In the context of your disability claim, neither the attorney-client privilege nor the attorney work product doctrine allows you to withhold factual information, medical source opinions, or other medical evidence that we may consider in determining whether or not you are entitled to benefits. For example, if you tell your representative about the medical sources you have seen, your representative cannot refuse to disclose the identity of those medical sources to us based on the attorney-client privilege. As another example, if your representative asks a medical source to complete an opinion form related to your impairment(s), symptoms, or limitations, your representative cannot withhold the completed opinion form from us based on the attorney work product doctrine. The attorney work product doctrine would not protect the source's opinions on the completed form, regardless of whether or not your representative used the form in an analysis of your claim or made handwritten notes on the face of the report.

(c) *Your responsibility.* You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. When you submit evidence received from another source, you must submit that evidence in its entirety, unless you previously submitted the same evidence to us or we instruct you otherwise. The Board may also ask you to provide evidence about:

(1) Your age;

(2) Your education and training;

(3) Your work experience;

(4) Your daily activities both before and after the date you say that you became disabled;

(5) Your efforts to work; and

(6) Any other evidence showing how your impairment(s) affects your ability to work. (In §§ 220.125 through 220.134, we discuss in more detail the evidence the Board needs when it considers vocational factors.)

[89 FR 78238, Sept. 25, 2024]

§ 220.46 Medical evidence.

(a) *Acceptable medical sources.* The Board needs reports about the claimant's impairment(s) from acceptable medical sources. Acceptable medical sources are—

(1) Licensed physicians (medical or osteopathic doctors);

(2) Licensed or certified psychologists at the independent practice level;

(3) Licensed or certified school psychologists, or other licensed or certified individuals with another title who perform the same function as a school psychologist in a school setting (for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only);

(4) Licensed optometrists (for impairments of visual disorders, or for the measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices);

(5) Licensed podiatrists (for impairments of the foot only, or foot and ankle only, depending on the scope of practice in the State in which the podiatrist practices);

(6) Qualified speech-language pathologists (for speech or language impairments only.) For this source, *qualified* means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which the speech-language pathologist practices, or hold a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association;

(7) Licensed audiologists (for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only);

(8) Licensed Advanced Practice Registered Nurses or other licensed advance practice nurses with another

title (for impairments within the individual's licensed scope of practice only);

(9) Licensed Physician Assistants/Physician Associates (for impairments within the individual's licensed scope of practice); or

(10) Persons authorized to furnish a copy or summary of the records of a medical facility. Generally, the copy or summary should be certified as accurate by the custodian or by any authorized employee of the Railroad Retirement Board, Social Security Administration, Department of Veterans Affairs, or State agency.

(b) *Other medical sources.* Individuals who are licensed as healthcare workers by a State and are working within the scope of practice permitted under State or Federal law, other than acceptable medical sources identified in paragraph (a) of this section, are other medical sources. Examples include licensed clinical social workers, naturopaths, and chiropractors. The Board will accept and consider evidence from other medical sources about the claimant's impairment(s) and the effect on the claimant's ability to work, but the presence of a medically determinable physical or mental impairment must be established with objective medical evidence from an acceptable medical source as defined in paragraph (a) of this section.

(c) *Medical reports.* Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed, with response to treatment and prognosis; and

(6)(i) Statements about what the claimant can still do despite his or her impairment(s) based on the medical source's findings on factors in paragraphs (c)(1) through (5) of this section (except in disability claims for remarried widow's and surviving divorced spouses). (See § 220.112).

(ii) Statements about what the claimant can still do (based on the medical source's findings on factors in paragraphs (c)(1) through (5) of this section) should describe—

(A) The medical source's opinion about the claimant's ability, despite his or her impairment(s), to do work-related activities such as sitting, standing, moving about, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(B) In cases of mental impairment(s), the medical source's opinion about the claimant's ability to reason or make occupational, personal, or social adjustments. (See § 220.112).

(d) *Completeness.* The medical evidence, including the clinical and laboratory findings, must be complete and detailed enough for the Board to determine whether the claimant is disabled. Specifically, it must allow the Board to determine—

(1) The nature and limiting effects of the claimant's impairment(s) for any period in question;

(2) The probable duration of the claimant's impairment(s); and

(3) The claimant's residual functional capacity to do work-related physical and mental activities.

(e) *Evidence from treating medical sources.* A statement by or the opinion of the claimant's treating medical source will not determine whether the claimant is disabled. However, the medical evidence provided by a treating medical source will be considered by the Board in making a disability decision. A treating medical source is a medical source to whom the claimant has been going for treatment on a continuing basis. The claimant may have more than one treating medical source. The Board may use consulting physicians or other medical consultants for specialized examinations or tests, to obtain more complete evidence, and to resolve any conflicts. A consulting physician is a doctor (often a specialist) to whom the claimant is referred for an examination once or on a limited basis. (See § 220.50 for an explanation of when the Board may request a consultative examination.)

(f) *Information from non-medical sources.* Information from other sources may also help the Board understand

how an impairment affects the claimant's ability to work. Other sources include—

(1) Public and private social welfare agency personnel;

(2) Family members, caregivers, friends, and neighbors of the claimant;

(3) Educational personnel such as teachers, counselors, and daycare center workers;

(4) Railroad and nonrailroad employers; and,

(5) The claimants themselves.

(Approved by the Office of Management and Budget under control number 3220–0038)

[56 FR 12980, Mar. 28, 1991, as amended at 90 FR 4627, Jan. 16, 2025]

§ 220.47 Purchase of existing medical evidence.

The Board needs specific medical evidence to determine whether a claimant is disabled. The claimant is responsible for providing that evidence. However, at its discretion, the Board will pay the reasonable cost to obtain medical evidence that it needs and requests from physicians not employed by the Federal government and other non-Federal providers of medical services.

§ 220.48 If the claimant fails to submit medical or other evidence.

The Board may request a claimant to submit medical or other evidence. If the claimant does not submit that evidence, the Board will make a decision on other evidence which is either already available in the claimant's case or which the Board may develop from other sources, including reports of consultative examinations.

Subpart G—Consultative Examinations

§ 220.50 Consultative examinations at the Board's expense.

A consultative examination is a physical or mental examination or test purchased for a claimant at the Board's request and expense. If the claimant's medical sources cannot provide sufficient medical evidence about the claimant's impairment(s) in order to enable the Board to determine whether the claimant is disabled, the Board may ask the claimant to have one or more consultative examinations or tests. The decision to purchase a consultative examination will be made on an individual case basis in accordance with the provisions of §§ 220.53 through 220.56. Selection of the source for the examination will be consistent with the provisions of § 220.64 (Program Integrity).

(Approved by the Office of Management and Budget under control number 3220–0124)

§ 220.51 Notice of the examination.

If the Board arranges for an examination or test, the claimant will be provided with reasonable notice of the date, time, and place of the examination or test and the name of the person who will do it. The Board will also give the examiner any necessary background information about the claimant's impairment(s).

§ 220.52 Failure to appear at a consultative examination.

(a) *General.* The Board may find that the claimant is not disabled if he or she does not have good reason for failing or refusing to take part in a consultative examination or test which was arranged by the Board. If the individual is already receiving an annuity and does not have a good reason for failing or refusing to take part in a consultative examination or test which the Board arranged, the Board may determine that the individual's disability has stopped because of his or her failure or refusal. The claimant for whom an examination or test has been scheduled should notify the Board as soon as possible before the scheduled date of the examination or test if he or she has any reason why he or she cannot go to the examination or test. If the Board finds that the claimant has a good reason for failure to appear, another examination or test will be scheduled.

(b) *Examples of good reasons for failure to appear.* Some examples of good reasons for not going to a scheduled examination or test include—

(1) Illness on the date of the scheduled examination or test;

(2) Failure to receive notice or timely notice of an examination or test;

(3) Receipt of incorrect or incomplete information about the examination or test; or

(4) A death or serious illness in the claimant's immediate family.

(c) *Objections by a claimant's physician.* The Board should be notified immediately if the claimant is advised by his or her treating physician not to take an examination or test. In some cases, the Board may be able to secure the information which is needed in another way or the treating physician may agree to another type of examination for the same purpose.

§ 220.53 When the Board will purchase a consultative examination and how it will be used.

(a)(1) *General.* The decision to purchase a consultative examination for a claimant will be made after full consideration is given to whether the additional information needed (e.g., clinical findings, laboratory tests, diagnosis, and prognosis, etc.) is readily available from the records of the claimant's medical sources. Upon filing an application for a disability annuity, a claimant will be required to obtain from his or her medical source(s) information regarding the claimed impairments. The Board will seek clarification from a medical source who has provided a report when that report contains a conflict or ambiguity, or does not contain all necessary information or when the information supplied is not based on objective evidence. The Board will not, however, seek clarification from a medical source when it is clear that the source either cannot or will not provide the necessary findings, or cannot reconcile a conflict or ambiguity in the findings provided from the source's records. Therefore, before purchasing a consultative examination, the Board will consider not only existing medical reports, but also the background report containing the claimant's allegations and information about the claimant's vocational background, as well as other pertinent evidence in his or her file.

(2) When the Board purchases a consultative examination, we will use the report from the consultative examination to try to resolve a conflict or ambiguity if one exists. The Board will do this by comparing the persuasiveness and value of the evidence. The Board will also use a consultative examination to secure needed medical evidence the file does not contain such as clinical findings, laboratory tests, a diagnosis or prognosis necessary for decision.

(b) *Situations requiring a consultative examination.* A consultative examination may be purchased when the evidence as a whole, both medical and non-medical, is not sufficient to support a decision on the claim. In addition, other situations, such as one or more of the following, will normally require a consultative examination (these situations are not all-inclusive):

(1) The specific additional evidence needed for adjudication has been pinpointed and high probability exists for obtaining it through purchase.

(2) The additional evidence needed is not contained in the records of the claimant's treating sources.

(3) Evidence that may be needed from the claimant's treating or other medical sources cannot be obtained for reasons beyond his or her control, such as death or noncooperation of the medical source.

(4) Highly technical or specialized medical evidence which is needed is not available from the claimant's treating sources.

(5) A conflict, inconsistency, ambiguity or insufficiency in the evidence must be resolved.

(6) There is an indication of a change in the claimant's condition that is likely to affect his or her ability to function, but current severity is not documented.

(7) Information provided by any source appears not to be supported by objective evidence.

§ 220.54 When the Board will not purchase a consultative examination.

A consultative examination will not be purchased in the following situations (these situations are not all-inclusive):

(a) In disabled widow(er) benefit claims, when the alleged month of disability is after the end of the 7-year period specified in § 216.38 and there is no possibility of establishing an earlier onset, or when the 7-year period expired in the past and all the medical

evidence in the claimant's file establishes that he or she was not disabled on or before the expiration date.

(b) When any issues about the actual performance of substantial gainful activity have not been resolved.

(c) In childhood disability claims, when it is determined that the claimant's alleged childhood disability did not begin before the month of attainment of age 22. In this situation, the claimant could not be entitled to benefits as a disabled child unless found disabled before age 22.

(d) When, on the basis of the claimant's allegations and all available medical reports in his or her case file, it is apparent that he or she does not have an impairment which will have more than a minimal effect on his or her capacity to work.

(e) Childhood disability claims filed concurrently with the employee's claim and entitlement cannot be established for the employee.

(f) Survivors childhood disability claims where entitlement is precluded based on non-disability factors.

§ 220.55 Purchase of consultative examinations at the reconsideration level.

(a) When a claimant requests a review of the Board's initial determination at the reconsideration level of review, consultative medical examinations will be obtained when needed, but not routinely. A consultative examination will not, if possible, be performed by the same physician or psychologist used in the initial claim.

(b) Where the evidence tends to substantiate an affirmation of the initial denial but the claimant states that the treating physician or psychologist considers him or her to be disabled, the Board will assist the claimant in securing medical reports or records from the treating physician.

§ 220.56 Securing medical evidence at the hearings officer hearing level.

(a) Where there is a conflict in the medical evidence at the hearing level of review before a hearings officer, the hearings officer will try to resolve it by comparing the persuasiveness and value of the conflicting evidence. The hearings officer's reasoning will be explained in the decision rationale. Where such resolution is not possible, the hearings officer will secure additional medical evidence (e.g., clinical findings, laboratory test, diagnosis, prognosis, etc.) to resolve the conflict. Even in the absence of a conflict, the hearings officer will also secure additional medical evidence when the file does not contain findings, laboratory tests, a diagnosis, or a prognosis necessary for a decision.

(b) Before requesting a consultative examination, the hearings officer will ascertain whether the information is available as a result of a recent examination by any of the claimant's medical sources. If it is, the hearings officer will request the evidence from that medical practitioner. If contact with the medical source is not productive for any reason, or if there is no recent examination by a medical source, the hearings officer will obtain a consultative examination.

§ 220.57 Types of purchased examinations and selection of sources.

(a) *Additional evidence needed for disability determination.* The types of examinations and tests the Board will purchase depends upon the additional evidence needed for the disability determination. The Board will purchase only the specific evidence needed. For example, if special tests (such as X-rays, blood studies, or EKG) will furnish the additional evidence needed for the disability determination, a more comprehensive medical examination will not be authorized.

(b) *The physician or psychologist selected to do the examination or test must be qualified.* The physician's or psychologist's qualifications must indicate that the physician or psychologist is currently licensed in the State and has the training and experience to perform the type of examination or test requested. The physician or psychologist may use support staff to help perform the examination. Any such support staff must meet appropriate licensing or certification requirements of the State. See also § 220.64.

(c) *Use of video teleconferencing technology.* Video teleconferencing technology (VTT) may be used for a psychological or a psychiatric consultative examination provided that the following requirements are met:

(1) The examining physician or psychologist is currently state-licensed in the state in which the provider practices;

(2) The examining physician or psychologist has the training and experience to perform the type of examination requested;

(3) The examining physician or psychologist has access to video teleconferencing technology;

(4) The examining physician or psychologist is permitted to perform the exam in accordance with state licensing laws and regulations;

(5) The protocol for the examination does not require physical contact;

(6) The claimant has the right to refuse a VTT examination without penalty; and

(7) The VTT examination complies with all requirements in this subpart governing consultative examinations.

[56 FR 12980, Mar. 28, 1991, as amended at 87 FR 27513, May 9, 2022]

§ 220.58 Objections to the designated physician or psychologist.

A claimant or his or her representative may object to his or her being examined by a designated physician or psychologist. If there is a good reason for the objection, the Board will schedule the examination with another physician or psychologist. A good reason may be where the consultative examination physician or psychologist had previously represented an interest adverse to the claimant. For example, the physician or psychologist may have represented the claimant's employer in a worker's compensation case or may have been involved in an insurance claim or legal action adverse to the claimant. Other things the Board will consider are: language barrier, office location of consultative examination physician or psychologist (2nd floor, no elevator, etc.), travel restrictions, and examination by the physician or psychologist in connection with a previous unfavorable determination. If the objection is because a physician or psychologist allegedly ''lacks objectivity'' (in general, but not in relation to the claimant personally) the Board will review the allegations. To avoid a delay in processing the claimant's claim, the consultative examination in such a case will be changed to another physician or psychologist while a review is being conducted. Any objection to use of the substitute physician or psychologist will be handled in the same manner. However, if the Board or the Social Security Administration had previously conducted such a review and found that the reports of the consultative physician or psychologist in question conform to the Board's guidelines, then the Board will not change the claimant's examination.

§ 220.59 Requesting examination by a specific physician, psychologist or institution—hearings officer hearing level.

In an unusual case, a hearings officer may have reason to request an examination by a particular physician, psychologist or institution. Some examples include the following:

(a) Conflicts in the existing medical evidence require resolution by a recognized authority in a particular specialty:

(b) The impairment requires hospitalization for diagnostic purposes; or

(c) The claimant's treating physician or psychologist is in the best position to submit a meaningful report.

§ 220.60 Diagnostic surgical procedures.

The Board will not order diagnostic surgical procedures such as myelograms and arteriograms for the evaluation of disability under the Board's disability program. In addition, the Board will not order procedures such as cardiac catheterization and surgical biopsy. However, if any of these procedures have been performed as part of a workup by the claimant's treating physician or other medical source, the results may be secured and used to help evaluate an impairment(s)'s severity.

§ 220.61 Informing the examining physician or psychologist of examination scheduling, report content and signature requirements.

Consulting physicians or psychologists will be fully informed at the time the Board contacts them of the following obligations:

(a) *General.* In scheduling full consultative examinations, sufficient time should be allowed to permit the examining physician to take a case history and perform the examination (including any needed tests).

(b) *Report content.* The reported results of the claimant's medical history, examination, pertinent requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help the Board determine the nature, severity, duration of the impairment, and residual functional capacity. Pertinent points in the claimant's medical history, such as a description of chest pain, will reflect the claimant's statements of his or her symptoms, not simply the physician's or psychologist's statements or conclusions. The examining physician's or psychologist's report of the consultative examination will include the objective medical facts.

(c) *Elements of a complete examination.* A complete examination is one which involves all the elements of a standard examination in the applicable medical specialty. When a complete examination is involved, the report will include the following elements:

(1) The claimant's major or chief complaint(s).

(2) A detailed description, within the area of speciality of the examination, of the history of the claimant's major complaint(s).

(3) A description, and disposition, of pertinent ''positive,'' as well as ''negative,'' detailed findings based on the history, examination and laboratory test(s) related to the major complaint(s) and any other abnormalities reported or found during examination or laboratory testing.

(4) The results of laboratory and other tests (*e.g.,* x-rays) performed according to the requirements stated in the Board's directions to the examining physician or psychologist.

(5) The diagnosis and prognosis for the claimant's impairment(s).

(6) A statement as to what the claimant can still do despite his or her impairment(s) (except in disability claims for remarried widows and widowers, and surviving divorced spouses). This statement must describe the consultative physician's or psychologist's opinion concerning the claimant's ability, despite his or her impairment(s), to do basic work activities such as sitting, standing, lifting, carrying, handling objects, hearing, speaking, and traveling: and, in cases of mental impairment(s), the consultative physician's or psychologist's opinion as to the claimant's ability to reason or make occupational, personal, or social adjustments.

(7) When less than a complete examination is required (for example, a specific test or study is needed), not every element is required.

(d) *Signature requirements.* All consultative examination reports will be personally reviewed and signed by the physician or psychologist who actually performed the examination. This attests to the fact that the physician or psychologist doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory test results.

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63600, Dec. 4, 2009]

§ 220.62 Reviewing reports of consultative examinations.

(a) The Board will review the report of the consultative examination to determine whether the specific information requested has been furnished. The Board will consider these factors in reviewing the report:

(1) Whether the report provides evidence which serves as an adequate basis for decision-making in terms of the impairment it assesses.

(2) Whether the report is internally consistent. Whether all the diseases, impairments and complaints described in the history are adequately assessed and reported in the physical findings. Whether the conclusions correlate the findings from the claimant's medical history, physical examination and laboratory tests and explain all abnormalities.

(3) Whether the report is consistent with the other information available to the Board within the specialty of the examination requested. Whether the report fails to mention an important or relevant complaint within the speciality that is noted on other evidence in the file (e.g., blindness in one eye, amputations, flail limbs or claw hands, etc.).

(4) Whether the report is properly signed.

(b) If the report is inadequate or incomplete, the Board will contact the examining consultative physician or psychologist, give an explanation of the Board's evidentiary needs, and ask that the physician or psychologist furnish the missing information or prepare a revised report.

(c) Where the examination discloses new diagnostic information or test results which are significant to the claimant's treatment, the Board will consider referral of the consultative examination report to the claimant's treating physician or psychologist.

(d) The Board will take steps to ensure that consultative examinations are scheduled only with medical sources who have the equipment required to provide an adequate assessment and record of the level of severity of the claimant's alleged impairments.

§ 220.63 Conflict of interest.

All implications of possible conflict of interest between Board medical consultants and their medical practices will be avoided. Board review physicians or psychologists will not perform consultative examinations for the Board's disability programs without prior approval. In addition, they will not acquire or maintain, directly or indirectly, including any member of their families, any financial interest in a medical partnership or similar relationship in which consultative examinations are provided. Sometimes one of the Board's review physicians or psychologists will have prior knowledge of a case (e.g., the claimant was a patient). Where this is so, the physician or psychologist will not participate in the review or determination of the case. This does not preclude the physician or psychologist from submitting medical evidence based on prior treatment or examination of the claimant.

§ 220.64 Program integrity.

The Board will not use in its program any individual or entity who is excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; who has been convicted, under Federal or State law, in connection with the delivery of health care services, of fraud, theft, embezzlement, breach of fiduciary responsibility or financial abuse; who has been convicted under Federal or State law of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; whose license to provide health care services is revoked or suspended by any State licensing authority for reasons bearing on professional competence, professional conduct, or financial integrity; who has surrendered such a license while formal disciplinary proceedings involving professional conduct were pending; or who has had a civil monetary assessment or penalty imposed on such individual or entity for any activity described in this section or as a result of formal disciplinary proceedings. Also see §§ 220.53 and 220.57(b).

Subpart H—Evaluation of Disability

§ 220.100 Evaluation of disability for any regular employment.

(a) *General.* The Board uses a set evaluation process, explained in paragraph (b) of this section, to determine whether a claimant is disabled for any regular employment. This evaluation process applies to employees, widow(er)s, and children who have applied for annuities under the Railroad Retirement Act based on disability for any regular employment. Regular employment means substantial gainful activity as that term is defined in § 220.141.

(b) *Steps in evaluating disability.* A set order is followed to determine whether disability exists. The duration requirement, as described in § 220.28, must be met for a claimant to be found disabled. The Board reviews any current work activity, the severity of the claimant's impairment(s), the claimant's residual functional capacity, and the claimant's age, education, and work experience. If the Board finds that the claimant is disabled or is not disabled at any step in the process, the Board does not review further. (See § 220.105 if the claimant is not currently disabled but was previously disabled for a specified period of time in the past.) The steps are as follows:

(1) *Claimant is working.* If the claimant is working, and the work is substantial gainful activity, the Board will find that he or she is not disabled regardless of his or her impairments, age, education, or work experience. If the claimant is not performing substantial gainful activity, the Board will follow paragraph (2) of this section.

(2) *Impairment(s) not severe.* If the claimant does not have an impairment or combination of impairments which significantly limit his or her physical or mental ability to do basic work activities, the Board will find that the claimant is not disabled without consideration of age, education, or work experience. If the claimant has an impairment or combination of impairments which significantly limit his or her ability to do basic work activities, the Board will follow paragraph (3) of this section. (See § 220.102(b) for a definition of basic work activities.)

(3) *Impairment(s) is medically disabling.* If the claimant has an impairment or a combination of impairments which meets the duration requirement and which the Board finds is medically disabling, the Board will find the claimant disabled without considering his or her age, education or work experience. In determining whether an impairment or combination of impairments is medically disabling, the Board will consider factors such as the nature and limiting effects of the impairment(s); the effects of the treatment the claimant has undergone, is undergoing, and/or will continue to undergo; the prognosis for the claimant; medical records furnished in support of the claimant's claim; whether the severity of the impairment(s) would fall within any of the impairments included in the Listing of Impairments as issued by the Social Security Administration and as amended from time to time (20 CFR part 404, subpart P, appendix 1); or whether the impairment(s) meet such other criteria which the agency by administrative ruling of general applicability has determined to be medically disabling.

(4) *Impairment(s) must prevent past relevant work.* If the claimant's impairment or combination of impairments is not medically disabling, the Board will then review the claimant's residual functional capacity (*see* § 220.120) and the physical and mental demands of past relevant work (see § 220.130). If the Board determines that the claimant is still able to do his or her past relevant work, the Board will find that he or she is not disabled. If the claimant is unable to do his or her past relevant work, the Board will follow paragraph (b)(5) of this section.

(5) *Impairment(s) must prevent any other work.* (i) If the claimant is unable to do his or her past relevant work because of his or her impairment or combination of impairments, the Board will review the claimant's residual functional capacity and his or her age, education and work experience to determine if the claimant is able to do any other work. If the claimant cannot do other work, the Board will find him or her disabled. If the claimant can do

other work, the Board will find the claimant not disabled.

(ii) If the claimant has only a marginal education (see § 220.129) and long work experience (i.e., 35 years or more) in which he or she only did arduous unskilled physical labor, and the claimant can no longer do this kind of work, the Board will use a different rule (see § 220.127) to determine disability.

(c) Once a claimant has been found eligible to receive a disability annuity, the Board follows a somewhat different order of evaluation to determine whether the claimant's eligibility continues as explained in § 220.180.

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63600, Dec. 4, 2009]

§ 220.101 Evaluation of mental impairments.

(a) *General.* The steps outlined in § 220.100 apply to the evaluation of physical and mental impairments. In addition, in evaluating the severity of a mental impairment(s), the Board will follow a special procedure at each administrative level of review. Following this procedure will assist the Board in—

(1) Identifying additional evidence necessary for the determination of impairment severity;

(2) Considering and evaluating aspects of the mental impairment(s) relevant to the claimant's ability to work; and

(3) Organizing and presenting the findings in a clear, concise, and consistent manner.

(b) *Use of the procedure to record pertinent findings and rate the degree of functional loss.* (1) This procedure requires the Board to record the pertinent signs, symptoms, findings, functional limitations, and effects of treatment contained in the claimant's case record. This will assist the Board in determining if a mental impairment(s) exists. Whether or not a mental impairment(s) exists is decided in the same way the question of a physical impairment is decided, i.e., the evidence must be carefully reviewed and conclusions supported by it. The mental status examination and psychiatric history will ordinarily provide the needed information. (See § 220.27 for further information about what is needed to show an impairment.)

(2) If the Board determines that a mental impairment(s) exists, this procedure then requires the Board to indicate whether certain medical findings which have been found especially relevant to the ability to work are present or absent.

(3) The procedure then requires the Board to rate the degree of functional loss resulting from the impairment(s). Four areas of function considered by the Board as essential to work have been identified, and the degree of functional loss in those areas must be rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform those work-related functions.

For the first two areas (activities of daily living and social functioning), the rating is done based upon the following five-point scale; none, slight, moderate, marked, and extreme. For the third area (concentration, persistence, or pace), the following five-point scale is used: never, seldom, often, frequent, and constant. For the fourth area (deterioration or decompensation in work or work-like settings), the following four-point scale is used: never, once or twice, repeated (three or more), and continual. The last two points for each of these scales represent a degree of limitation which is incompatible with the ability to perform the work-related function.

(c) *Use of the procedure to evaluate mental impairments.* Following the rating of the degree of functional loss resulting from the impairment(s), the Board then determines the severity of the mental impairment(s).

(1) If the four areas considered by the Board as essential to work have been rated to indicate a degree of limitation as ''none'' or ''slight'' in the first and second area, ''never'' or ''seldom'' in the third area, and ''never'' in the fourth area, the Board can generally conclude that the impairment(s) is not severe, unless the evidence otherwise indicates that there is significant limitation of the claimant's mental ability to do basic work activities (see § 220.102).

(2) If the claimant's mental impairment(s) is severe, the Board must then

determine if it is medically disabling using the Board's prior conclusions based on this procedure (i.e., the presence of certain medical findings considered by the Board as especially relevant to a claimant's ability to work and the Board's rating of functional loss resulting from the mental impairment(s)).

(3) If the claimant has a severe impairment(s), but the impairment(s) is not medically disabling, the Board will then do a residual functional capacity assessment for those claimants (employees, widow(er)s, and children) whose applications are based on disability for any regular employment under the Railroad Retirement Act.

(4) At all adjudicative levels, the Board will, in each case, incorporate the pertinent findings and conclusions based on this procedure in its decision rationale. The Board's rationale must show the significant history, including examination, laboratory findings, and functional limitations that the Board considered in reaching conclusions about the severity of the mental impairment(s).

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63600, Dec. 4, 2009]

§ 220.102 Non-severe impairment(s), defined.

(a) *Non-severe impairment(s).* An impairment or combination of impairments is not severe if it does not significantly limit the claimant's physical or mental ability to do basic work activities.

(b) *Basic work activities.* Basic work activities means the ability and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

§ 220.103 Two or more unrelated impairments—initial claims.

(a) *Unrelated severe impairments.* Two or more unrelated severe impairments cannot be combined to meet the 12-month duration test. If the claimant has a severe impairment(s) and then develops another unrelated severe impairment(s) but neither one is expected to last for 12 months, he or she cannot be found disabled even though the 2 impairments in combination last for 12 months.

(b) *Concurrent impairments.* If the claimant has 2 or more concurrent impairments which, when considered in combination, are severe, the board must also determine whether the combined effect of the impairments can be expected to continue to be severe for 12 months. If 1 or more of the claimant's impairments improves or is expected to improve within 12 months, so that the combined effect of the claimant's impairments is no longer severe, he or she will be found to not meet the 12-month duration test.

§ 220.104 Multiple impairments.

To determine whether the claimant's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligiblity under the law, the combined effect of all of the claimant's impairments are considered regardless of whether any such impairment, if considered separately, would be of sufficient severity. If a medically severe combination of impairments is found, it will be considered throughout the disability evaluation process. If a medically severe combination of impairments is not found, the claimant will be determined to be not disabled.

§ 220.105 Initial evaluation of a previous disability.

(a) In some cases, the Board may determine that a claimant is not currently disabled but was previously disabled for a specified period of time in the past. This can occur when—

(1) The disability application was filed before the claimant's disability ended but the Board did not make the initial determination of disability

until after the claimant's disability ended; or

(2) The disability application was filed after the claimant's disability ended but no later than the 12th month after the month the disability ended.

(b) When evaluating a claim for a previous disability, the Board follows the steps in § 220.100 to determine whether a disability existed, and follows the steps in § 220.180 to determine when the disability ended.

Example 1. The claimant sustained multiple fractures to his left leg in an automobile accident which occurred on June 16, 1982. For a period of 18 months following the accident the claimant underwent 2 surgical procedures which restored the functional use of his leg. After a recovery period following the last surgery, the claimant returned to work on February 1, 1984.

The claimant, although fully recovered medically and regularly employed, filed an application on December 3, 1984 for a determination of disability for the period June 16, 1982 through January 31, 1984. The Board reviewed his claim in January 1985 and determined that he was disabled for the prior period which began June 16, 1982 and continued through January 31, 1984. A disability annuity is payable to the employee only for the period December 1, 1983 through January 31, 1984.

An annuity may not begin any earlier than the 1st of the 12th month before the month in which the application was filed (See part 218 of this chapter for the rules on when an annuity may begin).

Example 2: The claimant is disabled using the same medical facts disclosed above, beginning June 16, 1982 (the date of the automobile accident). The claimant files an application for a disability annuity, dated December 1, 1983. However, as of February 1, 1984, and before the Board makes a disability determination, the claimant returns to full-time work and is no longer considered disabled. The Board reviews the claimant's application in May 1984 and finds him disabled for the period June 16, 1982 through January 31, 1984. A disability annuity is payable to the employee from December 1, 1982 through January 31, 1984. (See part 218 of this chapter for the rules on when an annuity may begin).

Subpart I—Medical Considerations

§ 220.110 Medically disabled.

(a) ''*Medically disabled.*'' The term ''medically disabled ''refers to disability based solely on impairment(s) which are considered to be so medically severe as to prevent a person from doing any substantial gainful activity. The Board will base its decision about whether the claimant's impairment(s) is medically disabling on medical evidence only, without consideration of the claimant's residual functional capacity, age, education or work experience. The Board will also consider the medical opinion given by one or more physicians employed or engaged by the Board or the Social Security Administration to make medical judgments. The medical evidence used to establish a diagnosis or confirm the existence of an impairment, and to establish the severity of the impairment includes medical findings consisting of signs, symptoms and laboratory findings. The medical findings must be based on medically acceptable clinical and laboratory diagnostic techniques. If the claimant has more than one impairment, but none of the impairments, by themselves, is medically disabling, the Board will review the signs, symptoms, and laboratory findings of all of the impairments to determine whether the combination of impairments is medically disabling. In general, impairments that the Board considers to be medically disabling are:

(1) Permanent;

(2) Expected to result in death; or

(3) Have a specific length of duration.

(b) *Diagnosis of impairments.* A diagnosis of a particular impairment is not sufficient for a finding of medical disability, unless the diagnosis is supported by medical findings that are based on medically acceptable clinical and laboratory techniques.

(c) *Addiction to alcohol or drugs.* If a claimant has a condition diagnosed as addiction to alcohol or drugs, this condition will not, by itself, be a basis for determining whether the claimant is, or is not, disabled. As with any other medical condition, the Board will decide whether the claimant is disabled based on symptoms, signs, and laboratory findings.

[74 FR 63601, Dec. 4, 2009]

§ 220.111 [Reserved]

§ 220.112 Conclusions by physicians concerning the claimant's disability.

(a) *General.* Under the statute, the Board is responsible for making the decision about whether a claimant meets the statutory definition of disability. A claimant can only be found disabled if he or she is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 220.28). A claimant's impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (See § 220.27). The decision as to whether a claimant is disabled may involve more than medical considerations and the Board may have to consider such factors as age, education and past work experience. Such vocational factors are not within the expertise of medical sources.

(b) *Medical opinions that are conclusive.* A medical opinion by a treating source will be conclusive as to the medical issues of the nature and severity of a claimant's impairment(s) where the Board finds that (1) it is fully supported by medically acceptable clinical and laboratory diagnostic techniques and (2) it is not inconsistent with the other substantial medical evidence of record. A medical opinion that is not fully supported will not be conclusive.

(c) *Medical opinions that are not fully supported.* If an opinion by a treating source(s) is not fully supported, the Board will make every reasonable effort (i.e., an initial request and, after 20 days, one follow-up request) to obtain from the claimant's treating source(s) the relevant evidence that supports the medical opinion(s) before the Board makes a determination as to whether a claimant is disabled.

Example: In a case involving an organic mental disorder caused by trauma to the head, a consultative physician, upon interview with the claimant, found only mild disorientation as to time and place. The claimant's treating physician reports that the claimant, as the result of his impairment, has severe disorientation as to time and place. The treating physician supplies office notes which follow the course of the claimant's illness from the date of injury to the present. These notes indicate that the claimant's condition is such that he has some ''good days'' on which he appears to be unimpaired, but generally support the treating physician's opinion that the claimant is severely impaired. In this case the treating physician's opinion will be given some weight over that of the consultative physician.

(d) *Inconsistent medical opinions.* Where the Board finds that the opinion of a treating source regarding medical issues is inconsistent with the evidence of record, including opinions of other sources that are supported by medically acceptable clinical and laboratory diagnostic techniques, the Board must resolve the inconsistency. If necessary to resolve the inconsistency, the Board will secure additional independent evidence and/or further interpretation or explanation from the treating source(s) and/or the consultative physician or psychologist. The Board's determination will be based on all the evidence in the case record, including the opinions of the medical sources. In resolving an inconsistency, the Board will give some extra weight to the treating source's supported opinion(s) which interprets the medical findings about the nature and severity of the impairment(s).

Example: In a case involving arthritis of the shoulder, where the X-rays confirm bone destruction, the examinations indicate minimal swelling and inflammation, but the treating source supplies evidence of greater restriction in the range of motion than found by the consultative physician, the Board will ask the treating source for further interpretation of the range of motion studies. If the treating source supplies a reasonable explanation. e.g., that the individual's condition is subject to periods of aggravation, the treating source's explanation will be given some extra weight over that of the consultative physician.

(e) *Medical opinions that will not be considered conclusive nor given extra weight.* The Board will not consider as conclusive nor give extra weight to medical opinions which are not in accord with the statutory or regulatory

standards for establishing disability. Thus, opinions that the individual's impairments are medically disabling where the medical findings which are the basis for that conclusion would not support an impairment so severe as to preclude any substantial gainful activity will not be conclusive nor given extra weight. Likewise, an opinion(s) as to the individual's residual functional capacity which is not in accord with regulatory requirements set forth in §§ 220.120 and 220.121 will not be conclusive nor given extra weight.

Example 1: A medical opinion states that a claimant is disabled based on blindness, but findings show functional visual accuity in the better eye, after best correction, of 20/100. That medical opinion would not be conclusive or given extra weight.

Example 2: A medical opinion that the individual is limited to light work when the evidence shows that he or she can lift a maximum of 50 pounds and lift 25 pounds frequently will not be considered as conclusive nor given extra weight. This is because the individual's exertional capacity exceeds the criteria set forth in the regulations for light work.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 60291, Oct. 22, 2003; 74 FR 63601, Dec. 4, 2009]

§ 220.113 Symptoms, signs, and laboratory findings.

Medical findings consist of symptoms, signs, and laboratory findings:

(a) *Symptoms* are the claimant's own description of his or her physical or mental impairment(s). The claimant's statements alone are not enough to establish that there is a physical or mental impairment(s).

(b) *Signs* are anatomical, physiological, or psychological abnormalities which can be observed, apart from the claimant's own statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

(c) *Laboratory findings* are anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.) x-rays, and psychological tests.

§ 220.114 Evaluation of symptoms, including pain.

(a) *General.* In determining whether the claimant is disabled, the Board considers all of the claimant's symptoms, including pain, and the extent to which the claimant's symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. By objective medical evidence, the Board means medical signs and laboratory findings as defined in §§ 220.113(b) and (c) of this part. By other evidence, the Board means the kinds of evidence described in §§ 220.45 and 220.46 of this part. These include statements or reports from the claimant, the claimant's treating or examining physician or psychologist, and others about the claimant's medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how the claimant's impairment(s) and any related symptoms affect the claimant's ability to work. The Board will consider all of the claimant's statements about his or her symptoms, such as pain, and any description by the claimant, the claimant's physician, or psychologist, or other persons about how the symptoms affect the claimant's activities of daily living and ability to work. However, statements alone about the claimant's pain or other symptoms will not establish that the claimant is disabled; there must be medical signs and laboratory findings which show that the claimant has a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of the claimant's pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that the claimant is disabled. In evaluating the intensity and

persistence of the claimant's symptoms, including pain, the Board will consider all of the available evidence, including the claimant's medical history, the medical signs and laboratory findings and statements about how the claimant's symptoms affect the claimant. (Section 220.112(b) of this part explains how the Board considers opinions of the claimant's treating source and other medical opinions on the existence and severity of the claimant's symptoms, such as pain.) The Board will then determine the extent to which the claimant's alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how the claimant's symptoms affect the claimant's ability to work.

(b) *Need for medically determinable impairment that could reasonably be expected to produce symptoms, such as pain.* The claimant's symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect the claimant's ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. The finding that the claimant's impairment(s) could reasonably be expected to produce the claimant's pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of the claimant's symptoms. The Board will develop evidence regarding the possibility of a medically determinable mental impairment when the Board has information to suggest that such an impairment exists, and the claimant alleges pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

(c) *Evaluating the intensity and persistence of symptoms, such as pain, and determining the extent to which the claimant's symptoms limit his or her capacity for work*—(1) *General.* When the medical signs or laboratory findings show that the claimant has a medically determinable impairment(s) that could reasonably be expected to produce the claimant's symptoms, such as pain, the Board must then evaluate the intensity and persistence of the claimant's symptoms so that it can determine how the claimant's symptoms limit the claimant's capacity for work. In evaluating the intensity and persistence of the claimant's symptoms, the Board considers all of the available evidence, including the claimant's medical history, the medical signs and laboratory findings, and statements from the claimant, the claimant's treating or examining physician or psychologist, or other persons about how the claimant's symptoms affect the claimant. The Board also considers the medical opinions of the claimant's treating source and other medical opinions as explained in § 220.112 of this part. Paragraphs (c)(2) through (c)(4) of this section explain further how the Board evaluates the intensity and persistence of the claimant's symptoms and how it determines the extent to which the claimant's symptoms limit the claimant's capacity for work, when the medical signs or laboratory findings show that the claimant has a medically determinable impairment(s) that could reasonably be expected to produce the claimant's symptoms, such as pain.

(2) *Consideration of objective medical evidence.* Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist the Board in making reasonable conclusions about the intensity and persistence of the claimant's symptoms and the effect those symptoms, such as pain, may have on the claimant's ability to work. The Board must always attempt to obtain objective medical evidence and, when it is obtained, the Board will consider it in reaching a

conclusion as to whether the claimant is disabled. However, the Board will not reject the claimant's statements about the intensity and persistence of the claimant's pain or other symptoms or about the effect the claimant's symptoms have on the claimant's ability to work solely because the available objective medical evidence does not substantiate the claimant's statements.

(3) *Consideration of other evidence.* Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, the Board will carefully consider any other information the claimant may submit about his or her symptoms. The information that the claimant, the claimant's treating or examining physician or psychologist, or other persons provide about the claimant's pain or other symptoms (*e.g.*, what may precipitate or aggravate the claimant's symptoms, what medications, treatments or other methods he or she uses to alleviate them, and how the symptoms may affect the claimant's pattern of daily living) is also an important indicator of the intensity and persistence of the claimant's symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which the claimant, his or her treating or examining physician or psychologist, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether the claimant is disabled. The Board will consider all of the evidence presented, including information about the claimant's prior work record, the claimant's statements about his or her symptoms, evidence submitted by the claimant's treating, examining or consulting physician or psychologist, and observations by Board employees and other persons. Section 220.112 of this part explains in detail how the Board considers and weighs treating source and other medical opinions about the nature and severity of the claimant's impairment(s) and any related symptoms, such as pain. Factors relevant to the claimant's symptoms, such as pain, which the Board will consider include:

(i) The claimant's daily activities;

(ii) The location, duration, frequency, and intensity of the claimant's pain or other symptoms;

(iii) Precipitating and aggravating factors;

(iv) The type, dosage, effectiveness, and side effects of any medication the claimant takes or has taken to alleviate the claimant's pain or other symptoms;

(v) Treatment, other than medication, the claimant receives or has received for relief of pain or other symptoms;

(vi) Any measures the claimant uses or has used to relieve pain or other symptoms (*e.g.*, lying flat on the claimant's back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and

(vii) Other factors concerning the claimant's functional limitations and restrictions due to pain or other symptoms.

(4) *How the Board determines the extent to which symptoms, such as pain, affect the claimant's capacity to perform basic work activities.* In determining the extent to which the claimant's symptoms, such as pain, affect the claimant's capacity to perform basic work activities, the Board considers all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. The Board will consider the claimant's statements about the intensity, persistence, and limiting effects of the claimant's symptoms, and the Board will evaluate the claimant's statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether the claimant is disabled. The Board will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between the claimant's statements and the rest of the evidence, including the claimant's medical history, the medical signs and laboratory findings, and statements by the claimant's treating or examining physician or psychologist or other persons about how the claimant's symptoms affect the claimant. The claimant's symptoms, including

pain, will be determined to diminish the claimant's capacity for basic work activities to the extent that the claimant's alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) *Consideration of symptoms in the disability determination process.* The Board follows a set order of steps to determine whether the claimant is disabled. If the claimant is not doing substantial gainful activity, the Board considers the claimant's symptoms, such as pain, to evaluate whether the claimant has a severe physical or mental impairment(s), and at each of the remaining steps in the process. Section 220.100 explains this process in detail. The Board also considers the claimant's symptoms, such as pain, at the appropriate steps in the Board's review when the Board considers whether the claimant's disability continues. Subpart O of this part explains the procedure the Board follows in reviewing whether the claimant's disability continues.

(1) *Need to establish a severe medically determinable impairment(s).* The claimant's symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether the claimant's impairment or combination of impairment(s) is severe. (*See* § 220.100(b)(2) of this part).

(2) *Decision of whether impairment(s) is medically disabling.* The Board will not substitute the claimant's allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of the claimant's impairment(s) to that of being medically disabling. If the symptoms, signs, and laboratory findings of the claimant's impairment(s) are found by the Board to be so severe as to prevent any substantial gainful activity, the Board will find the claimant disabled. If it does not, the Board will consider the impact of the claimant's symptoms on the claimant's residual functional capacity. (*See* paragraph (d)(3) of this section.)

(3) *Impact of symptoms (including pain) on residual functional capacity.* If the claimant has a medically determinable severe physical or mental impairment(s), but the claimant's impairment(s) is not medically disabling, the Board will consider the impact of the claimant's impairment(s) and any related symptoms, including pain, on the claimant's residual functional capacity. (*See* § 220.120 of this part.)

[68 FR 60291, Oct. 22, 2003, as amended at 74 FR 63601, Dec. 4, 2009]

§ 220.115 Need to follow prescribed treatment.

(a) *What treatment the claimant must follow.* In order to get a disability annuity, the claimant must follow treatment prescribed by his or her physician if this treatment can restore the claimant's ability to work.

(b) *When the claimant does not follow prescribed treatment.* If the claimant does not follow the prescribed treatment without a good reason, the Board will find him or her not disabled or, if the claimant is already receiving a disability annuity, the Board will stop paying the annuity.

(c) *Acceptable reasons for failure to follow prescribed treatment.* The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of the claimant's religion.

(2) The prescribed treatment would be cataract surgery for one eye, when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through surgery.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its magnitude (e.g., open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for the claimant.

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

Subpart J—Residual Functional Capacity

§ 220.120 The claimant's residual functional capacity.

(a) *General.* The claimant's impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what the claimant can do in a work setting. The claimant's residual functional capacity is what the claimant can still do despite the claimant's limitations. If the claimant has more than one impairment, the Board will consider all of the claimant's impairment(s) of which the Board is aware. The Board will consider the claimant's ability to meet certain demands of jobs, such as physical demands, mental demands, sensory requirements, and other functions, as described in paragraphs (b), (c), and (d) of this section. Residual functional capacity is an assessment based upon all of the relevant evidence. It may include descriptions (even the claimant's own) of limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment of the claimant's medical condition. Observations by the claimant's treating or examining physicians or psychologists, the claimant's family, neighbors, friends, or other persons, of the claimant's limitations, in addition to those observations usually made during formal medical examinations, may also be used. These descriptions and observations, when used, must be considered along with the claimant's medical records to enable us to decide to what extent the claimant's impairment(s) keeps the claimant from performing particular work activities. This assessment of the claimant's remaining capacity for work is not a decision on whether the claimant is disabled, but is used as the basis for determining the particular types of work the claimant may be able to do despite the claimant's impairment(s). Then, using the guidelines in §§ 220.125 and 220.134 of this part the claimant's vocational background is considered along with the claimant's residual functional capacity in arriving at a disability determination or decision. In deciding whether the claimant's disability continues or ends, the residual functional capacity assessment may also be used to determine whether any medical improvement the claimant has experienced is related to the claimant's ability to work as discussed in § 220.178 of this part.

(b) *Physical abilities.* When the Board assesses the claimant's physical abilities, the Board first assesses the nature and extent of the claimant's physical limitations and then determines the claimant's residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce the claimant's ability to do past work and other work.

(c) *Mental abilities.* When the Board assesses the claimant's mental abilities, the Board first assesses the nature and extent of the claimant's mental limitations and restrictions and then determines the claimant's residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce the claimant's ability to do past work and other work.

(d) *Other abilities affected by impairment(s).* Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If the claimant has this type of impairment(s), the Board considers any resulting limitations and restrictions which may reduce the claimant's ability to do past work and other work in deciding the claimant's residual functional capacity.

(e) *Total limiting effects.* When the claimant has a severe impairment(s), but the claimant's symptoms, signs,

and laboratory findings are not medically disabling, the Board will consider the limiting effects of all of the claimant's impairment(s), even those that are not severe, in determining the claimant's residual functional capacity. Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of the claimant's impairment(s) and any related symptoms, the Board will consider all of the medical and non-medical evidence, including the information described in § 220.114 of this part.

[68 FR 60293, Oct. 22, 2003, as amended at 74 FR 63601, Dec. 4, 2009]

§ 220.121 Responsibility for assessing and determining residual functional capacity.

(a) For cases at the initial or reconsideration level, the responsibility for determining residual functional capacity rests with the bureau of retirement claims. This assessment is based on all the evidence the Board has, including any statements regarding what the claimant can still do that have been provided by treating or examining physicians, consultative physicians, or any other physician designated by the Board. In any case where there is evidence which indicates the existence of a mental impairment, the bureau of retirement claims will not make a residual functional capacity determination without making every reasonable effort to ensure that a qualified psychiatrist or psychologist has provided a medical review of the case.

(b) For cases at the hearing level or the three-member-Board review level, the responsibility for deciding residual functional capacity rests with the hearings officer or the three-member Board, respectively.

Subpart K—Vocational Considerations

§ 220.125 When vocational background is considered.

(a) *General.* The Board will consider vocational factors when the claimant is applying for—

(1) An employee annuity based on disability for any regular employment; (See § 220.45(b))

(2) Widow(er) disability annuity; or

(3) Child's disability annuity based on disability before age 22.

(b) *Disability determinations in which vocational factors must be considered along with medical evidence.* When the Board cannot decide whether the claimant is disabled on medical evidence alone, the Board must use other evidence.

(1) The Board will use information from the claimant about his or her age, education, and work experience.

(2) The Board will consider the doctors' reports, and hospital records, as well as the claimant's own statements and other evidence to determine a claimant's residual functional capacity and how it affects the work the claimant can do. Sometimes, to do this, the Board will need to ask the claimant to have special examinations or tests. (See § 220.50.)

(3) If the Board finds that the claimant can no longer do the work he or she has done in the past, the Board will determine whether the claimant can do other work (jobs) which exist in significant numbers in the national economy.

§ 220.126 Relationship of ability to do work and residual functional capacity.

(a) If the claimant can do his or her previous work (his or her usual work or other applicable past work), the Board will determine he or she is not disabled.

(b) If the residual functional capacity is not enough for the claimant to do any of his or her previous work, the Board must still decide if the claimant can do any other work. To determine whether the claimant can do other work, the Board will consider the claimant's residual functional capacity, and his or her age, education, and work experience. Any work (jobs) that

the claimant can do must exist in significant numbers in the national economy (either in the region where he or she lives or in several regions of the country).

§ 220.127 When the only work experience is arduous unskilled physical labor.

(a) *Arduous work.* Arduous work is primarily physical work requiring a high level of strength or endurance. The Board will consider the claimant unable to do lighter work and therefore, disabled if he or she has—

(1) A marginal education (see § 220.129);

(2) Work experience of 35 years or more during which he or she did arduous unskilled physical labor; and

(3) A severe impairment which no longer allows him or her to do arduous unskilled physical labor.

(b) *Exceptions.* The Board may consider the claimant not disabled if—

(1) The claimant is working or has worked despite his or her impairment(s) (except where work is sporadic or not medically advisable); or

(2) Evidence shows that the claimant has training or past work experience which enables him or her to do substantial gainful activity in another occupation with his or her impairment, either full-time or on reasonably regular part-time basis.

Example: B is a 60-year-old miner with a 4th grade education who has a life-long history of arduous physical labor. B says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a combination of impairments and establishes that these impairments prevent B from performing his usual work or any other type of arduous physical labor. His vocational background does not show that he has skills or capabilities needed to do lighter work which would be readily transferable to another work setting. Under these circumstances, the Board will find that B is disabled.

§ 220.128 Age as a vocational factor.

(a) *General.* (1) *Age* refers to how old the claimaint is (chronological age) and the extent to which his or her age affects his or her ability to—

(i) Adapt to a new work situation; and

(ii) Do work in competition with others.

(2) In determining disability, the Board does not consider age alone. The Board must also consider the claimant's residual functional capacity, education, and work experience. If the claimant is unemployed because of his or her age and can still do a significant number of jobs which exist in the national economy, the Board will find that he or she is not disabled. Appendix 2 of this part explains in detail how the Board considers age as a vocational factor. However, the Board does not apply these age categories mechanically in a borderline situation.

(b) *Younger person.* If the claimant is under age 50, the Board generally does not consider that his or her age will seriously affect the ability to adapt to a new work situation. In some circumstances, the Board considers age 45 a handicap in adapting to a new work setting (see Rule 201.17 in appendix 2 of this part).

(c) *Person approaching advanced age.* If the claimant is closely approaching advanced age (50–54), the Board considers that the claimant's age, along with a severe impairment and limited work experience, may seriously affect the claimant's ability to adjust to a significant number of jobs in the national economy.

(d) *Person of advanced age.* The Board considers that advanced age (55 or over) is the point at which age significantly affects the claimant's ability to do substantial gainful activity.

(1) If the claimant is severly impaired and of advanced age, and he or she cannot do medium work (see § 220.132), the claimant may not be able to work unless he or she has skills that can be used in less demanding jobs which exist in significant numbers in the national economy.

(2) If the claimant is close to retirement age (60–64) and has a severe impairment, the Board will not consider him or her able to adjust to sedentary or light work unless the claimant has skills which are highly marketable.

§ 220.129 Education as a vocational factor.

(a) *General.* ''Education'' is primarily used to mean formal schooling or other

training which contributes to the claimant's ability to meet vocational requirements, for example, reasoning ability, communication skills, and arithmetical ability. If the claimant does not have formal schooling, this does not necessarily mean that the claimant is uneducated or lacks these abilities. Past work experience and the kinds of responsibilities the claimant had when he or she was working may show that he or she has intellectual abilities, although the claimant may have little formal education. A claimant's daily activities, hobbies, or the results of testing may also show that the claimant has significant intellectual ability that can be used to work.

(b) *How the Board evaluates the claimant's education.* The importance of the claimant's educational background may depend upon how much time has passed between the completion of the claimant's formal education and the beginning of the claimant's physical or mental impairment(s) and what the claimant has done with his or her education in a work or other setting. Formal education completed many years before the claimant's impairment(s) began, or unused skills and knowledge that were a part of the claimant's formal education, may no longer be useful or meaningful in terms of ability to work. Therefore, the numerical grade level that the claimant completed in school may not represent his or her actual educational abilities. These educational abilities may be higher or lower than the numerical grade level that the claimant completed. However, if there is no other evidence to contradict it, the Board uses the claimant's numerical grade level to determine the claimant's educational abilities. The term ''education'' also includes how well the claimant is able to communicate in English since this ability is often acquired or improved by education. In evaluating the claimant's educational level, the Board uses the following categories:

(1) *Illiteracy.* Illiteracy means the inability to read or write. The Board will consider the claimant illiterate if he or she cannot read or write a simple message such as instructions or inventory lists even though the claimant can sign his or her name. Generally, the illiterate claimant has had little or no formal schooling.

(2) *Marginal education.* Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. Generally, this means a 6th grade or less level of education.

(3) *Limited education.* Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex duties needed in semi-skilled or skilled jobs. Generally, a limited education is a 7th grade through 11th grade level of education.

(4) *High school education and above.* High school and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. The claimant with this level of education is generally considered able to do semi-skilled through skilled work.

(5) *Inability to communicate in English.* Since the ability to speak, read, and understand English is generally learned or increased at school, the Board may consider this an educational factor. Because English is the dominant language of the country, it may be difficult for the claimant who does not speak and understand English to do a job, regardless of the amount of education he or she may have in another language. The claimant's ability to speak, read and understand English will be considered when the Board evaluates what work, if any, he or she can do.

(6) *Information about the claimant's education.* The Board will ask the claimant how long he or she attended school and whether he or she can speak, understand, read and write in English, and do at least simple calculations in arithmetic. The Board will also consider information about how much formal or informal education the claimant received from his or her previous work, community projects, hobbies and any other activities which might help him or her to work.

§ 220.130 Work experience as a vocational factor.

(a) *General. Work experience* means skills and abilities the claimant has acquired through work he or she has done which show the type of work he or she may be expected to do. Work the claimant has already been able to do shows the kind of work that he or she may be expected to do. The Board considers that the claimant's work experience is relevant and applies when it was done within the last 15 years, lasted long enough for him or her to learn to do it, and was substantial gainful activity. This work experience is called ''past relevant work.'' The Board does not usually consider that work the claimant did 15 years or more before the time the Board is deciding whether he or she is disabled (or when the disability insured status requirement was last met, if earlier) applies. A gradual change occurs in most jobs so that after 15 years, it is no longer realistic to expect that skills and abilities acquired in a job done then continue to apply. The 15-year guide is intended to insure that remote work experience is not currently applied. If the claimant has no work experience or worked only ''off-and-on'' or for brief periods of time during the 15-year period, the Board generally considers that these do not apply. If the claimant has acquired skills through his or her past work, the Board considers the claimant to have these work skills unless he or she cannot use them in other skilled or semi-skilled work that he or she can do. If the claimant cannot use his or her skills in other skilled or semi-skilled work, the Board will consider his or her work background the same as unskilled. However, even if the claimant has no work experience, the Board may consider that the claimant is able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

(b) *Information about the claimant's work.* (1) Sometimes the Board will need information about the claimant's past work to make a disability determination. The Board may request work information from—

(i) The claimant; and

(ii) The claimant's employer or other person who knows about the claimant's work (member of family or co-worker) with the claimant's permission.

(2) The Board will ask for the following information about all the jobs the claimant has had in the last 15 years:

(i) The dates the claimant worked.

(ii) All the duties the claimant did.

(iii) Any tools, machinery, and equipment the claimant used.

(iv) The amount of walking, standing, sitting, lifting and carrying the claimant did during the work day, as well as any other physical and mental duties of the job.

(3) If all the claimant's work in the past 15 years has been arduous and unskilled, and the claimant has very little education, the Board will ask the claimant to tell about all of his or her work from the time he or she first began working. (See § 220.45(b).)

§ 220.131 Work which exists in the national economy.

(a) *General.* The Board considers that work exists in the national economy when it exists in significant numbers either in the region where the claimant lives or in several other regions of the country. It does not matter whether—

(1) Work exits in the immediate area in which the claimant lives,

(2) A specific job vacancy exists for the claimant; or

(3) The claimant would be hired if the claimant applied for work.

(b) *How the Board determines the existence of work.* Work exists in the national economy when there are a significant number of jobs (in one or more occupations) having requirements which the claimant is able to meet with his or her physical or mental ability and vocational qualifications. Isolated jobs that exist in very limited numbers in relatively few locations outside the region where the claimant lives are not considered ''work which exists in the national economy.'' The Board will not deny the claimant a disability annuity on the basis of the existence of these kinds of jobs. The Board will determine that the claimant is disabled if the work he or she can do does not exist in the national economy. If the work the claimant can do does exist in the national economy, the

Board will determine that the claimant is not disabled.

(c) *Inability to obtain work.* The Board will determine that the claimant is not disabled if he or she has the residual functional capacity and vocational abilities to do work which exists in the national economy but the claimant remains unemployed because of—

(1) His or her inability to get work;

(2) Lack of work in his or her local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which the claimant has worked;

(5) Cyclical economic conditions;

(6) No job openings for the claimant;

(7) The claimant not actually being hired to do work he or she could otherwise do; or

(8) The claimant not wishing to do a particular type of work.

(d) *Administrative notice of job data.* The following sources are used when the Board determines that unskilled, sedentary, light and medium jobs exist in the national economy:

(1) *Dictionary of Occupational Titles*, published by the Department of Labor.

(2) *County Business Patterns*, published by the Bureau of the Census.

(3) *Census Reports*, also published by the Bureau of the Census.

(4) *Occupational Analyses*, prepared for the Social Security Administration by various State employment agencies.

(5) *Occupational Outlook Handbook*, published by the Bureau of Labor Statistics.

(e) *Use of vocational experts and other specialists.* If the issue in determining whether the claimant is disabled is whether his or her work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, the Board may use the services of a vocational expert or other specialist. The Board will decide whether to use a vocational expert or other specialist.

§ 220.132 Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, jobs are classified as ''sedentary'', ''light'', ''medium'', ''heavy'', and ''very heavy.'' These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. In making disability determinations the Board uses the following definitions:

(a) *Sedentary work.* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and the other sedentary criteria are met.

(b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, the claimant must have the ability to do substantially all of these activities. If the claimant can do light work, the Board determines that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexerity or inability to sit for long periods of time.

(c) *Medium work.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If the claimant can do medium work, the Board determines that he or she can also do sedentary and light work.

(d) *Heavy work.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If the claimant can do heavy work, the Board determines that he or she can also do medium, light, and sedentary work.

(e) *Very heavy work.* Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If the claimant can

do very heavy work, the Board determines that he or she can also do heavy, medium, light and sedentary work.

§ 220.133 Skill requirements.

(a) *General.* To evaluate skills and to help determine the existence in the national economy of work the claimant is able to do, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, the Board uses materials published by the Department of Labor.

(b) *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time (30 days). The job may or may not require considerable strength. A job is considered unskilled if the claimant can usually learn to do the job in 30 days, and little job training and judgment are needed. The claimant does not gain work skills by doing unskilled jobs. For example, jobs are considered unskilled if primary work duties are—

(1) Handling;

(2) Feeding;

(3) Offbearing (placing or removing materials from machines which are automatic or operated by others); or

(4) Machine tending.

(c) *Semi-skilled work.* Semi-skilled work is work which needs some skills but does not require doing the more complex work duties. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hand or feet must be moved quickly to do repetitive tasks. Semi-skilled jobs may require—

(1) Alertness and close attention to watching machine processes;

(2) Inspecting, testing, or otherwise looking for irregularities;

(3) Tending or guarding equipment, property, materials, or persons against loss, damage, or injury; or

(4) Other types of activities which are similarly less complex than skilled work but more complex than unskilled work.

(d) *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled jobs may require—

(1) Laying out work;

(2) Estimating quality;

(3) Determining suitability and needed quantities of materials;

(4) Making precise measurements;

(5) Reading blueprints or other specifications;

(6) Making necessary computations or mechanical adjustments to control or regulate work; or

(7) Dealing with people, facts, figures or abstract ideas at a high level of complexity.

(e) *Skills that can be used in other work (transferability)*—(1) *What the Board means by transferable skills.* The Board considers the claimant to have skills that can be used in other jobs, when the skilled or semi-skilled work activities the claimant did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

(2) *How the Board determines skills that can be transferred to other jobs.* Transferability is most probable and meaningful among jobs in which—

(i) The same or a lesser degree of skill is required;

(ii) The same or similar tools and machines are used; and

(iii) The same or similar raw materials, products, processes, or services are involved.

(3) *Degrees of transferability.* There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, they are considered not transferable.

§ 220.134 Medical-vocational guidelines in appendix 2 of this part.

(a) The Dictionary of Occupational Titles includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 of this part

provides rules using this data reflecting major functional and vocational patterns.

(b) The Board applies that rules in appendix 2 of this part in cases where a claimant is not doing substantial gainful activity and is prevented by a severe impairment(s) from doing vocationally relevant past work.

(c) The rules in appendix 2 of this part do not cover all possible variations of factors. The Board does not apply these rules if one of the findings of fact about the claimant's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, the Board gives full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, the Board uses that rule to decide whether that claimant is disabled.

§ 220.135 Exertional and nonexertional limitations.

(a) *General.* The claimant's impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit the claimant's ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of both. Limitations are classified as exertional if they affect the claimant's ability to meet the strength demands of jobs. The classification of a limitation as exertional is related to the United States Department of Labor's classification of jobs by various exertional levels (sedentary, light, medium, heavy, and very heavy) in terms of the strength demands for sitting, standing, walking, lifting, carrying, pushing, and pulling. Sections 220.132 and 220.134 of this part explain how the Board uses the classification of jobs by exertional levels (strength demands) which is contained in the Dictionary of Occupational Titles published by the Department of Labor, to determine the exertional requirements of work which exists in the national economy. Limitations or restrictions which affect the claimant's ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing or pulling, are considered nonexertional. Sections 220.100(b)(5) and 220.180(h) of this part explain that if the claimant can no longer do the claimant's past relevant work because of a severe medically determinable impairment(s), the Board must determine whether the claimant's impairment(s), when considered along with the claimant's age, education, and work experience, prevents the claimant from doing any other work which exists in the national economy in order to decide whether the claimant is disabled or continues to be disabled. Paragraphs (b), (c), and (d) of this section explain how the Board applies the medical-vocational guidelines in appendix 2 of this part in making this determination, depending on whether the limitations or restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, are exertional, nonexertional, or a combination of both.

(b) *Exertional limitations.* When the limitations and restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, affect only the claimant's ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), the Board considers that the claimant has only exertional limitations. When the claimant's impairment(s) and related symptoms only impose exertional limitations and the claimant's specific vocational profile is listed in a rule contained in appendix 2 of this part, the Board will directly apply that rule to decide whether the claimant is disabled.

(c) *Nonexertional limitations.* (1) When the limitations and restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, affect only the claimant's ability to meet the demands of jobs other than the strength demands, the Board considers that the claimant has only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) Difficulty functioning because the claimant is nervous, anxious, or depressed;

(ii) Difficulty maintaining attention or concentration;

(iii) Difficulty understanding or remembering detailed instructions;

(iv) Difficulty in seeing or hearing;

(v) Difficulty tolerating some physical feature(s) of certain work settings, *e.g.*, the claimant cannot tolerate dust or fumes; or

(vi) Difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If the claimant's impairment(s) and related symptoms, such as pain, only affect the claimant's ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in appendix 2 of this part.

(d) *Combined exertional and nonexertional limitations.* When the limitations and restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, affect the claimant's ability to meet both the strength and demands of jobs other than the strength demands, the Board considers that the claimant has a combination of exertional and nonexertional limitations or restrictions. If the claimant's impairment(s) and related symptoms, such as pain, affect the claimant's ability to meet both the strength and demands of jobs other than the strength demands, the Board will not directly apply the rules in appendix 2 unless there is a rule that directs a conclusion that the claimant is disabled based upon the claimant's strength limitations; otherwise the rules provide a framework to guide the Board's decision.

[68 FR 60294, Oct. 22, 2003]

Subpart L—Substantial Gainful Activity

§ 220.140 General.

The work that a claimant has done during any period in which the claimant believes he or she is disabled may show that the claimant is able to do work at the substantial gainful activity level. If the claimant is able to engage in substantial gainful activity, the Board will find that the claimant is not disabled for any regular employment under the Railroad Retirement Act. Even if the work the claimant has done was not substantial gainful activity, it may show that the claimant is able to do more work than he or she actually did. The Board will consider all of the medical and vocational evidence in the claimant's file to decide whether or not the claimant has the ability to engage in substantial gainful activity.

§ 220.141 Substantial gainful activity, defined.

Substantial gainful activity is work activity that is both substantial and gainful.

(a) *Substantial work activity.* Substantial work activity is work activity that involves doing significant physical or mental activities. The claimant's work may be substantial even if it is done on a part-time basis or if the claimant does less, gets paid less, or has less responsibility than when the claimant worked before.

(b) *Gainful work activity.* Gainful work activity is work activity that the claimant does for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

(c) *Some other activities.* Generally, the Board does not consider activities like taking care of one's self, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

§ 220.142 General information about work activity.

(a) *The nature of the claimant's work.* If the claimant's duties require use of the claimant's experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that the claimant has the ability to work at the substantial gainful activity level.

(b) *How well the claimant performs.* The Board considers how well the claimant does his or her work when the

Board determines whether or not the claimant is doing substantial gainful activity. If the claimant does his or her work satisfactorily, this may show that the claimant is working at the substantial gainful activity level. If the claimant is unable, because of his or her impairments, to do ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work, this may show that the claimant is not working at the substantial gainful activity level. If the claimant is doing work that involves minimal duties that make little or no demands on the claimant and that are of little or no use to the claimant's railroad or non-railroad employer, or to the operation of a business if the claimant is self-employed, this does not show that the claimant is working at the substantial gainful activity level.

(c) *If the claimant's work is done under special conditions.* Even though the work the claimant is doing takes into account his or her impairment, such as work done in a sheltered workshop or as a patient in a hospital, it may still show that the claimant has the necessary skills and ability to work at the substantial gainful activity level.

(d) *If the claimant is self-employed.* Supervisory, managerial, advisory or other significant personal services that the claimant performs as a self-employed person may show that the claimant is able to do substantial gainful activity.

(e) *Time spent in work.* While the time the claimant spends in work is important, the Board will not decide whether or not the claimant is doing substantial gainful activity only on that basis. The Board will still evaluate the work to decide whether it is substantial and gainful regardless of whether the claimant spends more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

§ 220.143 Evaluation guides for an employed claimant.

(a) *General.* The Board uses several guides to decide whether the work the claimant has done shows that he or she is able to do substantial gainful activity.

(1) *The claimant's earnings may show the claimant has done substantial gainful activity.* The amount of the claimant's earnings from work the claimant has done may show that he or she has engaged in substantial gainful activity. Generally, if the claimant worked for substantial earnings, this will show that he or she is able to do substantial gainful activity. On the other hand, the fact that the claimant's earnings are not substantial will not necessarily show that the claimant is not able to do substantial gainful activity. The Board will generally consider work that the claimant is forced to stop after a short time because of his or her impairment(s) as an unsuccessful work attempt and the claimant's earnings from that work will not show that the claimant is able to do substantial gainful activity.

(2) *The Board considers only the amount the claimant earns.* The Board does not consider any income not directly related to the claimant's productivity when the Board decides whether the claimant has done substantial gainful activity. If the claimant's earnings are subsidized, the amount of the subsidy is not counted when the Board determines whether or not the claimant's work is substantial gainful activity. Thus, where work is done under special conditions, the Board only considers the part of the claimant's pay which the claimant actually ''earns.'' For example, where a handicapped person does simple tasks under close and continuous supervision, the Board would not determine that the person worked at the substantial gainful activity level only on the basis of the amount of pay. A railroad or non-railroad employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If the claimant's work is subsidized and the claimant's railroad and non-railroad employer does not set the amount of the subsidy or does not adequately explain how the subsidy was figured, the Board will investigate to see how much the claimant's work is worth.

(3) *If the claimant is working in a sheltered or special environment.* If the

claimant is working in a sheltered workshop, the claimant may or may not be earning the amounts he or she is being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that the claimant is not earning all he or she is being paid. Since persons in military service being treated for a severe impairment usually continue to receive full pay, the Board evaluates work activity in a therapy program or while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of the work, rather than on the actual amount of the earnings.

(b) *Earnings guidelines*—(1) *General.* If the claimant is employed, the Board first considers the criteria in paragraph (a) of this section and § 220.145, and then the guides in paragraphs (b)(2), (3), (4), (5), and (6) of this section.

(2) *Earnings that will ordinarily show that the claimant has engaged in substantial gainful activity.* The Board will consider that the earnings from the employed claimant (including earnings from sheltered work, see paragraph (b)(4) of this section) show that the claimant engaged in substantial gainful activity if:

(i) *Before January 1, 2001*, the earnings averaged more than the amount(s) in Table 1 of this section for the time(s) in which the claimant worked.

(ii) *Beginning January 1, 2001*, the earnings are more than an amount determined for each calendar year to be the larger of:

(A) The amount for the previous year, or

(B) The amount established by the Social Security Administration to constitute substantial gainful activity for such year.

TABLE 1—AMOUNTS INDICATING SUBSTANTIAL GAINFUL ACTIVITY PERFORMED

For months	Monthly earnings averaged more than
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
January 1990–June 1999	500
July 1999–December 2000	700

(3) *Earnings that will ordinarily show that the claimant has not engaged in substantial gainful activity.* Beginning January 1, 2001, if the claimant's earnings are equal to or less than the amount(s) determined under paragraph (b)(2)(ii) of this section for the year(s) in which the claimant works, the Board will generally consider that the earnings from the claimant's work as an employee will show the claimant has not engaged in substantial gainful activity. Before January 1, 2001, if the claimant's earnings were less than the amount(s) in Table 2 of this section for the year(s) in which the claimant worked, the Board will generally consider that the earnings from the claimant's work as an employee will show that the claimant has not engaged in substantial gainful activity.

TABLE 2—AMOUNTS INDICATING SUBSTANTIAL GAINFUL ACTIVITY NOT PERFORMED

For months	Monthly earnings averaged less than
In calendar years before 1976	$130
In calendar year 1976	150
In calendar year 1977	160
In calendar year 1978	170
In calendar year 1979	180
In calendar years 1980–1989	190
In calendar years 1990–2000	300

(4) *If the claimant worked in a sheltered workshop.* Before January 1, 2001 if the claimant worked in a sheltered workshop or a comparable facility especially set up for severely impaired persons, the Board will ordinarily consider that the claimant's earnings from this work show that the claimant has engaged in substantial gainful activity if the claimant's earnings average more than the amounts in Table 1 of this section. Average monthly earnings from a sheltered workshop or a comparable facility that are equal to or less than those indicated in Table 1 of this section will ordinarily show that the claimant has not engaged in substantial gainful activity without the need to consider the other information, as described in paragraph (b)(6) of this section, regardless of whether they are more or less than those indicated in paragraph (b)(3) of this section. When the claimant's earnings from a sheltered workshop or comparable facility are equal to or less than those amounts indicated in Table 1 of this section, the Board will consider the provisions of paragraph (b)(6) of this section only if there is evidence that the claimant may have done substantial gainful activity. For work performed in a sheltered workshop or comparable facility beginning January 1, 2001, the rules of paragraph (b)(2), (3), and (6) apply the same as they do to any other work done by an employee.

(5) *If there is evidence showing that the claimant may have done substantial gainful activity.* If there is evidence showing that the claimant may have done substantial gainful activity, the Board will apply the criteria in paragraph (b)(6) of this section regarding comparability and value of services.

(6) *Earnings that are not high enough to ordinarily show that the claimant engaged in substantial gainful activity.* (i) Before January 1, 2001, if the claimant's average monthly earnings were between the amounts shown in paragraphs (b)(2) and (3) of this section, the Board will generally consider other information in addition to the claimant's earnings (see paragraph (b)(6)(iii) of this section). This rule generally applies to employees who did not work in a sheltered workshop or a comparable facility, although the Board may apply it to some people who work in sheltered workshops or comparable facilities (see paragraph (b)(4) of this section).

(ii) Beginning January 1, 2001, if the claimant's average monthly earnings are equal to or less than the amounts determined under paragraph (b)(2) of this section, the Board will generally not consider other information in addition to the claimant's earnings unless there is evidence indicating that the claimant may be engaging in substantial gainful activity or that the claimant is in a position to defer or suppress his or her earnings.

(iii) Examples of other information the Board may consider include, whether—

(A) The claimant's work is comparable to that of unimpaired people in the claimant's community who are doing the same or similar occupations as their means of livelihood, taking into account the time, energy, skill, and responsibility involved in the work, and

(B) The claimant's work, although significantly less than that done by unimpaired people, is clearly worth the amounts shown in paragraph (b)(2) of this section, according to pay scales in the claimant's community.

[56 FR 12980, Mar. 28, 1991, as amended at 64 FR 62976, Nov. 18, 1999; 72 FR 21101, Apr. 30, 2007]

§ 220.144 Evaluation guides for a self-employed claimant.

(a) *If the claimant is a self-employed claimant.* The Board will consider the claimant's activities and their value to the claimant's business to decide whether the claimant has engaged in substantial gainful activity if the claimant is self-employed. The Board will not consider the claimant's income alone since the amount of income the claimant actually receives may depend upon a number of different factors like capital investment, profit sharing agreements, etc. The Board will generally consider work that the claimant is forced to stop after a short time because of his or her impairment(s) as an unsuccessful work attempt and the claimant's income from that work will not show that the claimant is able to do substantial gainful activity. The

Board will evaluate the claimant's work activity on the value to the business of the claimant's services regardless of whether the claimant receives an immediate income for his or her services. The Board considers that the claimant has engaged in substantial gainful activity if—

(1) The claimant's work activity, in terms of factors such as hours, skills, energy output, efficency, duties, and responsibilities, is comparable to that of unimpaired persons in the claimant's community who are in the same or similar businesses as their means of livelihood;

(2) The claimant's work activity, although not comparable to that of unimpaired persons, is clearly worth the amount shown in § 220.143(b)(2) when considered in terms of its value to the business, or when compared to the salary that an owner would pay to an employed person to do the work the claimant is doing; or

(3) The claimant renders services that are significant to the operation of the business and receives a substantial income from the business.

(b) *What the Board means by significant services*—(1) *Claimants who are not farm landlords.* If the claimant is not a farm landlord and the claimant operates a business entirely by himself or herself, any services that the claimant renders are significant to the business. If the claimant's business involves the services of more than one person, the Board will consider the claimant to be rendering significant services if he or she contributes more than half the total time required for the management of the business or he or she renders management services for more than 45 hours a month regardless of the total management time required by the business.

(2) *Claimants who are farm landlords*—(i) *General.* If the claimant is a farm landlord, that is, the claimant rents farm land to another, the Board will consider the claimant to be rendering significant services if the claimant materially participates in the production or the management of the production of the things raised on the rented farm. If the claimant was given social security earnings credits because he or she materially participated in the activities of the farm and he or she continues these same activities, the Board will consider the claimant to be rendering significant services.

(ii) *Material participation.* (A) The claimant will have established that he or she is materially participating if he or she—

(*1*) Furnishes a large portion of the machinery, tools, and livestock used in the production of the things raised on the rented farm; or

(*2*) Furnishes or advances monies or assumes financial responsibility for a substantial part of the expense involved in the production of the things raised on the rented farm.

(B) The claimant will have presented strong evidence that he or she is materially participating if he or she periodically—

(*1*) Advise or consults with the other person who under the rental agreement produces the things raised on the rented farm; and

(*2*) Inspects the production activities on the land.

(iii) *Production.* The term ''production'' refers to the physical work performed and the expenses incurred in producing the things raised on the farm. It includes activities like the actual work of planting, cultivating, and harvesting of crops, and the furnishing of machinery, implements, seed, and livestock.

(iv) *Management of the production.* The term ''management of the production'' refers to services performed in making managerial decisions about the production of the crop, such as when to plant, cultivate, dust, spray or harvest. It includes advising and consulting, making inspections, and making decisions on matters, such as rotation of crops, the type of crops to be grown, the type of livestock to be raised, and the type of machinery and implements to be furnished.

(c) *What the Board means by substantial income.* After the claimant's normal business expenses are deducted from the claimant's gross income to determine net income, the Board will deduct the reasonable value of any unpaid help, any soil bank payments that were included as farm income, and impairment-related work expenses described in § 220.145 that have not been deducted

in determining the claimant's net earnings from self-employment. The Board will consider the resulting amount of income from the business to be substantial if—

(1) It averages more than the amounts described in § 220.143(b)(2); or

(2) It averages less than the amounts described in § 220.143(b)(2) but the livelihood which the claimant gets from the business is either comparable to what it was before the claimant became severely impaired or is comparable to that of unimpaired self-employed persons in the claimant's community who are in the same or similar businesses as their means of livelihood.

§ 220.145 Impairment-related work expenses.

(a) *General.* When the Board figures the claimant's earnings in deciding if the claimant has done substantial gainful activity, the Board will subtract the reasonable costs to the claimant of certain items and services which, because of his or her impairment(s), the claimant needs and uses to enable him or her to work. The costs are deductible even though the claimant also needs or uses the items and services to carry out daily living functions unrelated to his or her work. Paragraph (b) of this section explains the conditions for deducting work expenses. Paragraph (c) of this section describes the expenses the Board will deduct. Paragraph (d) of this section explains when expenses may be deducted. Paragraph (e) of this section describes how expenses may be allocated. Paragraph (f) of this section explains the limitations on deducting expenses. Paragraph (g) of this section explains the Board's verification procedures.

(b) *Conditions for deducting impairment-related work expenses.* The Board will deduct impairment-related work expenses if—

(1) The claimant is otherwise disabled as defined in § 220.26;

(2) The severity of the claimant's impairment(s) requires the claimant to purchase (or rent) certain items and services in order to work;

(3) The claimant pays the cost of the item or service. No deduction will be allowed to the extent that payment has been or will be made by another source. No deduction will be allowed to the extent that the claimant has been, could be, or will be reimbursed for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if the claimant purchases crutches for $80 but the claimant was, could be, or will be reimbursed $64 by some agency, plan, or program, the Board will deduct only $16;

(4) The claimant pays for the item or service in a month he or she is working (in accordance with paragraph (d) of this section); and

(5) The claimant's payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

(c) *What expenses may be deducted*—(1) *Payments for attendant care services.* (i) If because of the claimant's impairment(s) the claimant needs assistance in traveling to and from work, or while at work the claimant needs assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments the claimant makes for those services may be deducted.

(ii) If because of the claimant's impairment(s) the claimant needs assistance with personal functions (e.g., dressing, administering medications) at home in preparation for going to and assistance in returning from work, the payments the claimant makes for those services may be deducted.

(iii)(A) The Board will deduct payments the claimant makes to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

(B) The Board considers a family member to be anyone who is related to the claimant by blood, marriage or adoption, whether or not that person lives with the claimant.

(iv) If only part of the claimant's payment to a person is for services that come under the provisions of paragraph (c)(1) of this section, the Board will only deduct that part of the payment which is attributable to those services. For example, an attendant

gets the claimant ready for work and helps the claimant in returning from work, which takes about 2 hours a day. The rest of the attendant's 8-hour day is spent cleaning the claimant's house and doing the claimant's laundry, etc. The Board would only deduct one-fourth of the attendant's daily wages as an impairment-related work expense.

(2) *Payment for medical devices.* If the claimant's impairment(s) requires that the claimant utilize medical devices in order to work, the payments the claimant makes for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment which can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(3) *Payments for prosthetic devices.* If the claimant's impairment(s) requires that the claimant utilize a prosthetic device in order to work, the payments the claimant makes for that device can be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

(4) *Payments for equipment*—(i) *Work-related equipment.* If the claimant's impairment(s) requires that the claimant utilize special equipment in order to do his or her job, the payments the claimant makes for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, vision aids, sensory aids for the blind, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

(ii) *Residential modifications.* If the claimant's impairment(s) requires that the claimant make modifications to his or her residence, the location of the claimant's place of work will determine if the cost of these modifications will be deducted. If the claimant is employed away from home, only the cost of changes made outside of the claimant's home to permit the claimant to get to his or her means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of the claimant's home will not be deducted. If the claimant works at home, the costs of modifying the inside of the claimant's home in order to create a working space to accommodate the claimant's impairment(s) will be deducted to the extent that the changes pertain specifically to the space in which the claimant works. Examples of such changes are the enlargement of a doorway leading into the workspace or modification of the workspace to accommodate problems in dexterity. However, if the claimant is self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) *Non-medical appliances and equipment.* Expenses for appliances and equipment which the claimant does not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is for the control of the claimant's disabling impairment(s), thus enabling the claimant to work. To be considered essential, the item must be of such a nature that if it were not available to the claimant there would be an immediate adverse impact on the claimant's ability to function in his or her work activity. In this situation, the expense is deductible whether the item is used at home or in the working place. An example would be the need for an electric air cleaner by a person with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If an exercycle is prescribed and used as necessary treatment to enable the claimant to work, the Board will deduct payments the claimant makes toward its cost.

(5) *Payments for drugs and medical services.* (i) If the claimant must use drugs or medical services (including diagnostic procedures) to control his or her impairment(s), the payments the claimant makes for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of the claimant's impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are anti-convulsant drugs to control epilepsy or anticonvulsant blood level monitoring; antidepressant medication for mental impairments; medication used to allay the side effects of certain treatments; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal impairments; electroencephalograms and brain scans related to a disabling epileptic impairment; tests to determine the efficacy of medication on a diabetic condition; and immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) The Board will only deduct the costs of drugs or services that are directly related to the claimant's impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

(6) *Payments for similar items and services*—(i) *General.* If the claimant is required to utilize items and services not specified in paragraphs (c)(1) through (5) of this section, but which are directly related to his or her impairment(s) and which the claimant needs to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, the purchase and maintenance of a dog guide which the claimant needs to work, and transportation.

(ii) *Medical supplies and services not described above.* The Board will deduct payments the claimant makes for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. The Board will also deduct payments the claimant makes for physical therapy which the claimant requires because of his or her impairment(s) and which the claimant needs in order to work.

(iii) *Payments for transportation costs.* The Board will deduct transportation costs in these situations:

(A) The claimant's impairment(s) requires that in order to get to work the claimant needs a vehicle that has structural or operational modifications. The modifications must be critical to the claimant's operation or use of the vehicle and directly related to the claimant's impairment(s). The Board will deduct the cost of the modifications, but not the cost of the vehicle. The Board will also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs.

(B) The claimant's impairment(s) requires the claimant to use driver assistance, taxicabs or other hired vehicles in order to work. The Board will deduct amounts paid to the driver and, if the claimant's own vehicle is used, the Board will also deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(C) The claimant's impairment(s) prevents the claimant from taking available public transportation to and from work and the claimant must drive his or her (unmodified) vehicle to work. If the Board can verify through the claimant's physician or other sources that the need to drive is caused by the claimant's impairment(s) (and not due to the unavailability of public transportation), the Board will deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(7) *Payments for installing, maintaining, and repairing deductible items.* If the device, equipment, appliance, etc., that

the claimant utilizes qualifies as a deductible item as described in paragraphs (c)(2), (3), (4) and (6) of this section, the costs directly related to installing, maintaining and repairing these items are also deductible. (The costs which are associated with modifications to a vehicle are deductible. Except for a mileage allowance, as provided for in paragraph (c)(6)(iii)(A) of this section, the costs which are associated with the vehicle itself are not deductible.)

(d) *When expenses may be deducted*—(1) *Effective date.* To be deductible, an expense must be incurred after November 30, 1980. An expense may be considered incurred after that date if it is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

(2) *Payments for services.* A payment the claimant makes for services may be deducted if the services are received while the claimant is working and the payment is made in a month the claimant is working. The Board considers the claimant to be working even though he or she must leave work temporarily to receive the services.

(3) *Payments for items.* A payment the claimant makes toward the cost of a deductible item (regardless of when it is acquired) may be deducted if payment is made in a month claimant is working. See paragraph (e)(4) of this section when purchases are made in anticipation of work.

(e) *How expenses are allocated*—(1) *Recurring expenses.* The claimant may pay for services on a regular periodic basis, or the claimant may purchase an item on credit and pay for it in regular periodic installments or the claimant may rent an item. If so, each payment the claimant makes for the services and each payment the claimant makes toward the purchase or rental (including interest) is deductible in the month it is made.

Example: B starts work in October 1981 at which time she purchases a medical device at a cost of $4,800 plus interest charges of $720. Her monthly payments begin in October. She earns and receives $400 a month. The term of the installment contract is 48 months. No downpayment is made. The monthly allowable deduction for the item would be $115 ($5,520 divided by 48) for each month of work during the 48 months.

(2) *Non-recurring expenses.* Part or all of the claimant's expenses may not be recurring. For example, the claimant may make a one-time payment in full for an item or service or make a downpayment. If the claimant is working when he or she makes the payment, the Board will either deduct the entire amount in the month the claimant pays it or allocate the amount over a 12-consecutive-month period beginning with the month of payment, whichever the claimant selects.

Example: A begins working in October 1981 and earns $525 a month. In the same month, he purchases and pays for a deductible item at a cost of $250. In this situation the Board could allow a $250 deduction for October 1981, reducing A's earnings below the substantial gainful activity level for that month.

If A's earnings had been $15 above the substantial gainful activity earnings amount, A probably would select the option of projecting the $250 payment over the 12-month period, October 1981–September 1982, giving A an allowable deduction of $20.83 a month for each month of work during that period. This deduction would reduce A's earnings below the substantial gainful activity level for 12 months.

(3) *Allocating downpayments.* If the claimant makes a downpayment, the Board will, if the claimant chooses, make a separate calculation for the downpayment in order to provide for uniform monthly deductions. In these situations the Board will determine the total payment that the claimant will make over a 12-consecutive-month period beginning with the month of the downpayment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period if the claimant's regular monthly payments will extend over a period of less than 12 months.

Example 1. C starts working in October 1981, at which time he purchases special equipment at a cost of $4,800, paying $1,200 down. The balance of $3,600, plus interest of $540, is to be repaid in 36 installments of $115 a month beginning November 1981. C earns $500 a month. He chooses to have the downpayment allocated. In this situation the Board would allow a deduction of $205.42 a month for each month of work during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of

$115 for each month of work during the remaining installment period.

Explanation:	
Downpayment in October 1981	$1,200
Monthly payments:	
November 1981 through September 1982	1,265
	12 / $2,465 = 205.42

Example 2. D, while working, buys a deductible item in July 1981, paying $1,450 down. However, his first monthly payment of $125 is not due until September 1981. D chooses to have the downpayment allocated. In this situation, the Board would allow a deduction of $225 a month for each month of work during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of $125 for each month of work.

Explanation:	
Downpayment in July 1981	$1,450
Monthly payments:	
September 1981 through June 1982	1,250
	12 / $2,700 = $225

(4) *Payments made in anticipation of work.* A payment made toward the cost of a deductible item that the claimant made in any of the 11 months preceding the month he or she started working will be taken into account in determining the claimant's impairment-related work expenses. When an item is paid for in full during the 11 months preceding the month the claiment started working, the payment will be allocated over the 12-consecutive-month period beginning with the month of the payment. However, the only portion of the payment which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of $600, the deductible amount would be $450 ($600 divided by 12, multiplied by 9). Installment payments (including a downpayment) that the claimant made for a particular item during the 11 months preceding the month he or she started working will be totalled and considered to have been made in the month of the claimant's first payment for that item within this 11-month period. The sum of these payments will be allocated over the 12-consecutive-month period beginning with the month of the claimant's first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for in 3 monthly installments of $200 each, the total payment of $600 will be considered to have been made in the month of the first payment, that is, 3 months before the month work began. The deductible amount would be $450 ($600 divided by 12, multiplied by 9). The amount, as determined by these formulas, will then be considered to have been paid in the first month of work. The Board will deduct either this entire amount in the first month of work or allocate it over a 12-consecutive-month period, beginning with the first month of work, whichever the claimant selects. In the above examples, the claimant would have the choice of having the entire $450 deducted in the first month of work or having $37.50 a month ($450 divided by 12) deducted for each month that he or she works over a 12-consecutive-month period, beginning with the first month of work. To be deductible, the payments must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, non-medical appliances and vehicle modifications. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for the purpose of this paragraph.

(f) *Limits on deductions.* (1) The Board will deduct the actual amounts the claimant pays towards his or her impairment-related work expenses unless the amounts are unreasonable. With respect to durable medical equipment, prosthetic devices, medical services, and similar medically-related items and services, the Board will apply the prevailing charges under Medicare (Part B of the title XVIII, Health Insurance for the Aged and Disabled) to the extent that this information is

readily available. Where the Medicare guides are used, the Board will consider the amount that the claimant pays to be reasonable if it is no more than the prevailing charge for the same item or service under the Medicare guidelines. If the amount the claimant actually pays is more than the prevailing charge for the same item under the Medicare guidelines, the Board will deduct from the claimant's earnings the amount the claimant paid to the extent he or she establishes that the amount is consistent with the standard or normal charge for the same or similar item or service in his or her community. For items and services that are not listed in the Medicare guidelines, and for items and services that are listed in the Medicare guidelines but for which such guides cannot be used because the information is not readily available, the Board will consider the amount the claimant pays to be reasonable if it does not exceed the standard or normal charge for the same or similar item or service in the claimant's community.

(2) Impairment-related work expenses are not deducted in computing the claimant's earnings for purposes of determining whether the claimant's work was ''services'' as described in § 220.170.

(3) The decision as to whether the claimant performed substantial gainful activity in a case involving impairment-related work expenses for items or services necessary for the claimant to work generally will be based upon the claimant's ''earnings'' and not on the value of ''services'' the claimant rendered. (See §§ 220.143 (b)(6)(i) and (ii), and 220.144(a)). This is not necessarily so, however, if the claimant is in a position to control or manipulate his or her earnings.

(4) No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent that the claimant has been, could be, or will be reimbursed for payments he or she made. (See paragraph (b)(3) of this section.)

(5) The provisions described in the foregoing paragraphs in this section are effective with respect to expenses incurred on or after December 1, 1980, although expenses incurred after November 1980, as a result of contractual or other arrangements entered into before December 1980, are deductible. For months before December 1980, the Board will deduct impairment-related work expenses from the claimant's earnings only to the extent they exceeded the normal work-related expenses the claimant would have had if the claimant did not have his or her impairment(s). The Board will not deduct expenses, however, for those things with the claimant needed even when he or she was not working.

(g) *Verification.* The Board will verify the claimant's need for items or services for which deductions are claimed, and the amount of the charges for those items or services. The claimant will also be asked to provide proof that he or she paid for the items or services.

Subpart M—Disability Annuity Earnings Restrictions

§ 220.160 How work for a railroad employer affects a disability annuity.

A disability annuity is not payable and the annuity must be returned for any month in which the disabled annuitant works for an employer as defined in part 202 of this chapter.

§ 220.161 How work affects an employee disability annuity.

In addition to the condition in § 220.160, the employee's disability annuity is not payable and the employee must return the annuity payment for any month in which the employee earns more than $400 (after deduction of impairment-related work expenses) in employment or self-employment of any kind. Any annuity amounts withheld because the annuitant earned over $400 in a month may be paid after the end of the year, as shown in § 220.164. The $400 monthly limit no longer applies when the employee attains retirement age and the disability annuity is converted to a full age annuity. See § 220.145 for the definition of impairment-related work expenses.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 39010, July 1, 2003]

§ 220.162 Earnings report.

(a) *General.* Any annuitant receiving an annuity based on disability must report to the Board any work and earnings as described in §§ 220.160 and 220.161. The report may be a written or oral statement by the annuitant, or a person acting for the annuitant, made or sent to a representative of the Board. The report should include the name and address of the railroad or non-railroad employer, a description of the work and the amount of gross wages (before deductions) or the net income from self-employment (earnings after deducting business expenses).

(b) *Employee reports.* In addition to the requirement described in (a), a report of earnings over $400 a month must be made before the employee accepts a disability annuity (the annuity payment is issued and not returned) for the second month after the first month in which earnings are over $400. Along with the report, the employee must return the annuity payment for any month in which he or she earns over $400.

§ 220.163 Employee penalty deductions.

If the employee earns over $400 in a month and does not report it within the time limit shown in § 220.162(b), a penalty is imposed. The penalty deduction for the first failure to report equals the annuity amount for the first month in which the employee earned over $400. The deduction for a second or later failure to report equals the annuity amount for each month in which the employee earned over $400 and failed to report it on time.

§ 220.164 Employee end-of-year adjustment.

(a) *General.* After the end of a year, the employee whose annuity was withheld for earnings over $400 in a month receives a form on which to report his or her earnings for the year.

(b) *Earnings are less than $5000.* If the employee's yearly earnings are less than $5000, all annuity payments and penalties withheld during the year because of earnings over $4800 are paid.

(c) *Earnings are $5000 or more.* (1) If the employee's yearly earnings are $5000 or more, the annuity payments are adjusted so that the employee does not have more than one regular deduction for every $400 of earnings over $4800. The last $200 or more of earnings over $4800 is treated as if it were $400. If the annuity rate changes during the year, any annuities due at the end of the year are paid first for months in which the annuity rate is higher. Penalty deductions may also apply as described in paragraph (c)(2) of this section.

(2) If the employee's yearly earnings are $5000 or more and the employee failed to report monthly earnings over $400 within the time limit described in § 220.162(b), penalty deductions will also apply. If it is the employee's first failure to report, the penalty deduction is equal to one month's annuity. If it is the employee's second or later failure to report, the penalty deduction equals the annuity amount for each month in which the employee earned over $400 and failed to report it on time.

(d) This section is illustrated by the following examples:

Example 1: Employee is awarded a disability annuity based upon his inability to engage in his regular railroad occupation effective January 1, 1989. During that year, he works April through October, for which he receives $785 per month. He does not report these earnings to the Board until January of the following year. The employee is considered to have earned $5600 ($7 \times \$785 = \$5495$, which is rounded up to the nearest $400). He forfeits three months of annuities:

$$\left(\frac{\$5600 - \$4800}{\$400}\right) = \begin{array}{c}\text{2 plus 1 month annuity}\\ \text{penalty for failure}\\ \text{to report}\end{array}$$

Example 2: The same employee in the following year also works April through October, for which he receives $785 per month. This time he reports the earnings on October 31. This year he forfeits 6 months of annuity payments, 2 due to earnings, computed as above, and 4 more due to penalty deductions for failure to report earnings over $400 for the months April through July. There are no penalty deductions with respect to the months August, September, and October, since the employee reported these earnings prior to accepting an annuity for the second month after the month of earnings in excess of $400.

Subpart N—Trial Work Period and Reentitlement Period for Annuitants Disabled for Any Regular Employment

§ 220.170 The trial work period.

(a) *Definition of the trial work period.* The trial work period is a period during which the annuitant may test his or her ability to work and still be considered disabled. The trial work period begins and ends as described in paragraph (e) of this section. During this period, the annuitant may perform ''services'' (see paragraph (b) of this section) in as many as 9 months, but these months do not have to be consecutive. The Board will not consider those services as showing that the annuitant's disability has ended until the annuitant has performed services in at least 9 months. However, after the trial work period has ended, the Board will consider the work the annuitant did during the trial work period in determining whether the annuitant's disability has ended at any time after the trial work period.

(b) *What the Board means by services.* When used in this section, services means any activity (whether legal or illegal), even though it is not substantial gainful activity, which is done in employment or self-employment for pay or profit, or is the kind normally done for pay or profit. We generally do not consider work done without remuneration to be services if it is done merely as therapy or training, or if it is work usually done in a daily routine around the house, or in self-care.

(1) *If the claimant is an employee.* The Board will consider the claimant's work as an employee to be services if:

(i) Before January 1, 2002, the claimant's earnings in a month were more than the amount(s) indicated in Table 1 of this section for the year(s) in which the claimant worked.

(ii) *Beginning January 1, 2002,* the claimant's earnings in a month are more than an amount determined for each calendar year to be the larger of:

(A) Such amount for the previous year, or

(B) The amount established by the Social Security Administration for such year as constituting the amount of monthly earnings used to determine whether a person has performed services for counting trial work period months.

(2) *If the claimant is self-employed.* The Board will consider the claimant's activities as a self-employed person to be services if:

(i) *Before January 1, 2002,* the claimant's net earnings in a month were more than the amount(s) indicated in Table 2 of this section for the year(s) in which the claimant worked, or the hours the claimant worked in the business in a month are more than the number of hours per month indicated in Table 2 for the years in which the claimant worked.

(ii) *Beginning January 1, 2002,* the claimant worked more than 80 hours a month in the business, or the claimant's net earnings in a month are more than an amount determined for each calendar year to be the larger of:

(A) Such amount for the previous year, or

(B) The amount established by the Social Security Administration for such year as constituting the amount of monthly earnings used to determine whether a person has performed services for counting trial work period months.

TABLE 1—FOR NON SELF-EMPLOYED

For months	You earn more than
In calendar years before 1979	$50
In calendar years 1979–1989	75
In calendar years 1990–2000	200
In calendar year 2001	530

TABLE 2—FOR THE SELF-EMPLOYED

For months	Your net earnings are more than	Or you work in the business more than (hours)
In calendar years before 1979	$50	15
In calendar years 1979–1989	75	15
In calendar years 1990–2000	200	40
In calendar year 2001	530	80

(c) *Limitations on the number of trial work periods.* The annuitant may have only one trial work period during each period in which he or she is disabled for any regular employment as defined in § 220.26.

(d) *Who is and is not entitled to a trial work period.* (1) Generally, the annuitant is entitled to a trial work period

if he or she is entitled to an annuity based on disability.

(2) An annuitant is not entitled to a trial work period if he or she is in a second period of disability for which he or she did not have to complete a waiting period before qualifying for a disability annuity.

(e) *Payment of the disability annuity during the trial work period.* (1) The disability annuity of an employee, child, or widow(er) who is disabled for any regular employment will not be paid for any month in the trial work period in which the annuitant works for an employer covered by the Railroad Retirement Act (see § 220.160).

(2) The disability annuity of an employee who is disabled for any regular employment will not be paid for any month in this period in which the employee annuitant earns more than $400 in employment or self-employment (see §§ 220.161 and 220.164).

(3) If the disability annuity for an employee, child, or widow(er) who is disabled for any regular employment is stopped because of work during the trial work period, and the disability annuitant discontinues that work before the end of the trial work period, the disability annuity may be started again without a new application and a new determination of disability.

(f) *When the trial work period begins and ends.* (1) The trial work period begins with whichever of the following calendar months is the later—

(i) The annuity beginning date;

(ii) The month after the end of the appropriate waiting period; or

(iii) The month the application for disability is filed.

(2) The trial work period ends with the close of whichever of the following calendar months is the earlier—

(i) The 9th month (whether or not the months have been consecutive) in which the annuitant performed services; or

(ii) The month in which new evidence, other than evidence relating to any work the annuitant did during the trial work period, shows that the annuitant is not disabled, even though he or she has not worked a full 9 months. The Board may find that the annuitant's disability has ended at any time during the trial work period if the medical or other evidence shows that the annuitant is no longer disabled.

[56 FR 12980, Mar. 28, 1991, as amended at 72 FR 21102, Apr. 30, 2007]

§ 220.171 The reentitlement period.

(a) *General.* (1) The reentitlement period is an additional period after the 9 months of trial work during which the annuitant may continue to test his or her ability to work if he or she has a disabling impairment(s).

(2) The disability annuity of an employee, child, or widow(er) who is disabled for any regular employment will not be paid for—

(i) Any month, after the 3rd month, in this period in which the annuitant does substantial gainful activity; or

(ii) Any month in this period in which the annuitant works for an employer covered by the Railroad Retirement Act (see § 220.160).

(3) The disability annuity of an employee who is disabled for any regular employment will not be paid for any month in this period in which the employee annuitant earns more than $400 in employment or self-employment (see §§ 220.161 and 220.164).

(4) If the disability annuity of an employee, child or widow(er) who is disabled for any regular employment is stopped because of work during the trial work period or reentitlement period, and the disability annuitant discontinues that work before the end of either period, the disability annuity may be started again without a new application or a new determination of disability.

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of nine months of trial work but cannot begin earlier than December 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which the annuitant's impairment(s) no longer exists or is not medically disabling; or

(2) The last day of the 36th month following the end of the annuitant's trial work period.

(c) *When the annuitant is not entitled to a reentitlement period.* The annuitant is not entitled to a reentitlement period if—

(1) He or she is not entitled to a trial work period; or

(2) His or her disability ended before the annuitant completed nine months of trial work in that period in which he or she was disabled.

Subpart O—Continuing or Stopping Disability Due to Substantial Gainful Activity or Medical Improvement

§ 220.175 Responsibility to notify the Board of events which affect disability.

If the annuitant is entitled to a disability annuity because he or she is disabled for any regular employment, the annuitant should promptly tell the Board if—

(a) His or her impairment(s) improves;

(b) He or she returns to work;

(c) He or she increases the amount of work; or

(d) His or her earnings increase.

§ 220.176 When disability continues or ends.

There is a statutory requirement that, if an annuitant is entitled to a disability annuity, the annuitant's continued entitlement to such an annuity must be reviewed periodically until the employee or child annuitant reaches full retirement age and the widow(er) annuitant reaches age 60. When the annuitant is entitled to a disability annuity as a disabled employee, disabled widow(er) or as a person disabled since childhood, there are a number of factors to be considered in deciding whether his or her disability continues. The Board must first consider whether the annuitant has worked and, by doing so, demonstrated the ability to engage in substantial gainful activity. If so, the disability will end. If the annuitant has not demonstrated the ability to engage in substantial gainful activity, then the Board must determine if there has been any medical improvement in the annuitant's impairment(s) and, if so, whether this medical improvement is related to the annuitant's ability to work. If an impairment(s) has not medically improved, the Board must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to ability to work has not occurred and no exception applies, the disability will continue. Even the medical improvement related to ability to work has occurred or an exception applies (see § 220.179 for exceptions), in most cases the Board must also show that the annuitant is currently able to engage in substantial gainful activity before it can find that the annuitant is no longer disabled.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 39010, July 1, 2003]

§ 220.177 Terms and definitions.

There are several terms and definitions which are important to know in order to understand how the Board reviews whether a disability for any regular employment continues:

(a) *Medical improvement.* Medical improvement is any decrease in the medical severity of an impairment(s) which was present at the time of the most recent favorable medical decision that the annuitant was disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on a comparison of prior and current medical evidence showing changes (improvement) in the symptoms, signs or laboratory findings associated with the impairment(s).

Example 1: The claimant was awarded a disability annuity due to a herniated disc. At the time of the Board's prior decision granting the claimant an annuity he had had a laminectomy.

Postoperatively, a myelogram still shows evidence of a persistant deficit in his lumbar spine. He had pain in his back, and pain and a burning sensation in his right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in his back and leg. When the Board reviewed the annuitant's claim to determine whether his disability should be continued, his treating physician reported that he had seen the annuitant regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. The annuitant's doctor further reported a moderately decreased range of motion in the annuitant's back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has not occurred because there

has been no decrease in the severity of the annuitant's back impairment as shown by changes in symptoms, signs or laboratory findings.

Example 2: The claimant was awarded a disability annuity due to rheumatoid arthritis. At the time, laboratory findings were positive for this impairment. The claimant's doctor reported persistent swelling and tenderness of the claimant's fingers and wrists and that he complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, the annuitant's impairment has responded favorably to therapy so that for the last year his fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of the annuitant's impairment as documented by the current symptoms and signs reported by his physician. Although the annuitant's impairment is subject to temporary remission and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. The Board would then determine if this medical improvement is related to the annuitant's ability to work.

(b) *Medical improvement not related to ability to do work.* Medical improvement is not related to the annuitant's ability to work if there has been a decrease in the severity of the impairment(s) (as defined in paragraph (a) of this section) present at the time of the most recent favorable medical decision, but no increase in that annuitant's functional capacity to do basic work activities as defined in paragraph (d) of this section. If there has been any medical improvement in an annuitant's impairment(s), but it is not related to the annuitant's ability to do work and none of the exceptions applies, the annuity will be continued.

Example: An annuitant was 65 inches tall and weighed 246 pounds at the time his disability was established. He had venous insufficiency and persistent edema in his legs. At the time, the annuitant's ability to do basic work activities was affected because he was able to sit for 6 hours, but was able to stand or walk only occasionally. At the time of the Board's continuing disability review, the annuitant had undergone a vein stripping operation. He now weighed 220 pounds and had intermittent edema. He is still able to sit for 6 hours at a time and to stand or walk only occasionally although he reports less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by his weight loss and the improvement in his edema. This medical improvement is not related to his ability to work, however, because his functional capacity to do basic work activities (i.e., the ability to sit, stand and walk) has not increased.

(c) *Medical improvement that is related to ability to do work.* Medical improvement is related to an annuitant's ability to work if there has been a decrease in the severity (as defined in paragraph (a) of this section) of the impairment(s) present at the time of the most recent favorable medical decision and an increase in the annuitant's functional capacity to do basic work activities as discussed in paragraph (d) of this section. A determination that medical improvement related to an annuitant's ability to do work has occurred does not, necessarily, mean that such annuitant's disability will be found to have ended unless it is also shown that the annuitant is currently able to engage in substantial gainful activity as discussed in paragraph (e) of this section.

Example 1: The annuitant has a back impairment and has had a laminectomy to relieve the nerve root impingement and weakness in his left leg. At the time of the Board's prior decision, basic work activities were affected because he was able to stand less than 6 hours, and sit no more than ½ hour at a time. The annuitant had a successful fusion operation on his back about 1 year before the Board's review of his entitlement. At the time of the Board's review, the weakness in his leg has decreased. The annuitant's functional capacity to perform basic work activities now is unimpaired because he now has no limitation on his ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of his impairment as demonstrated by the decreased weakness in his leg. This medical improvement is related to his ability to work because there has also been an increase in his functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on his ability to sit, walk, or stand. Whether or not his disability is found to have ended, however, will depend on the Board's determination as to whether he can currently engage in substantial gainful activity.

Example 2: The annuitant was injured in an automobile accident receiving a compound fracture to his right femur and a fractured pelvis. When he applied for disability annuity 10 months after the accident his doctor reported that neither fracture had yet

achieved solid union based on his clinical examination. X-rays supported this finding. The annuitant's doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of the Board's review 6 months later, solid union had occurred and the annuitant had been returned to full weight-bearing for over a month. His doctor reported this and the fact that his prior fractures no longer placed any limitation on his ability to walk, stand, and lift, and, that in fact, he could return to full-time work if he so desired.

Medical improvement has occurred because there has been a decrease in the severity of the annuitant's impairments as shown by x-ray and clinical evidence of solid union and his return to full weight-bearing. This medical improvement is related to his ability to work because these findings no longer support an impairment of the severity of the impairment on which the finding that he was medically disabled was based (see § 220.178(c)(1)). Whether or not the annuitant's disability is found to have ended will depend on the Board's determination as to whether he can currently engage in substantial gainful activity.

(d) *Functional capacity to do basic work activities.* (1) Under the law, disability is defined, in part, as the inability to do any regular employment by reason of a physical or mental impairment(s). ''Regular employment'' is defined in this part as ''substantial gainful activity.'' In determining whether the annuitant is disabled under the law, the Board will measure, therefore, how and to what extent the annuitant's impairment(s) has affected his or her ability to do work. The Board does this by looking at how the annuitant's functional capacity for doing basic work activities has been affected. Basic work activities means the abilities and aptitudes necessary to do most jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and non-exertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes in a work setting and dealing with both supervisors and fellow workers. The annuitant who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment(s) will result in some limitation to the functional capacity to do one or more of these basic work activities. Diabetes, for example, can result in circulatory problems which could limit the length of time the annuitant could stand or walk and can result in damage to his or her eyes as well, so that the annuitant also had limited vision. What the annuitant can still do, despite his or her impairment(s), is called his or her residual functional capacity. How the residual functional capacity is assessed is discussed in more detail in § 220.120. Unless an impairment is so severe that it is deemed to prevent the annuitant from doing substantial gainful activity (*i.e.,* the impairment(s) is medically disabling), it is this residual functional capacity that is used to determine whether the annuitant can still do his or her past work or, in conjunction with his or her age, education and work experience, do any other work.

(2) A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the annuitant can stand or walk for longer periods. When new evidence showing a change in medical findings establishes that both medical improvement has occurred and the annuitant's functional capacity to perform basic work activities, or residual functional capacity, has increased, the Board will find that medical improvement which is related to the annuitant's ability to do work has occurred. A residual functional capacity assessment is also used to determine whether an annuitant can engage in substantial gainful activity and, thus, whether he or she continues to be disabled (see paragraph (e) of this section).

(3) Many impairment-related factors must be considered in assessing an annuitant's functional capacity for basic work activities. Age is one key factor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits

become irreversible over time and that maximum exercise performance diminishes with age. Other changes related to sustained periods of inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the cardiac and respiratory systems which limit the exertional range.

(4) Studies have also shown that the longer the annuitant is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if the annuitant is age 50 or over and had been receiving a disability annuity for a considerable period of time, the Board will consider this factor along with his or her age in assessing the residual functional capacity. This will ensure that the disadvantages resulting from inactivity and the aging process during a longer period of disability will be considered. In some instances where available evidence does not resolve what the annuitant can or cannot do on a sustained basis, the Board may provide special work evaluations or other appropriate testing.

(e) *Ability to engage in substantial gainful activity.* In most instances, the Board must show that the annuitant is able to engage in substantial gainful activity before stopping his or her annuity. When doing this, the Board will consider all of the annuitant's current impairments not just that impairment(s) present at the time of the most recent favorable determination. If the Board cannot determine that the annuitant is still disabled based on medical considerations alone (as discussed in §§ 220.110 through 220.115), it will use the new symptoms, signs and laboratory findings to make an objective assessment of functional capacity to do basic work activities (or residual functional capacity) and will consider vocational factors. See §§ 220.120 through 220.134.

(f) *Evidence and basis for the Board's decision.* The Board's decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that the annuitant had previously been determined to be disabled. The Board will consider all of the evidence the annuitant submits. An annuitant must give the Board reports from his or her physician, psychologist, or others who have treated or evaluated him or her, as well as any other evidence that will help the board determine if he or she is still disabled (see § 220.45). The annuitant must have a good reason for not giving the Board this information or the Board may find that his or her disability has ended (see § 220.178(b)(2)). If the Board asks the annuitant, he or she must contact his or her medical sources to help the Board get the medical reports. The Board will make every reasonable effort to help the annuitant in getting medical reports when he or she gives the Board permission to request them from his or her physician, psychologist, or other medical sources, Every reasonable effort means that the Board will make an initial request and, after 20 days, one follow-up request to the annuitant's medical source to obtain the medical evidence necessary to make a determination before the Board evaluates medical evidence obtained from another source on a consultative basis. The medical source will have 10 days from the follow-up to reply (unless experience indicates that a longer period is advisable in a particular case). In some instances the Board may order a consultative examination while awaiting receipt of medical source evidence. Before deciding that an annuitant's disability has ended, the Board will develop a complete medical history covering at least the preceding 12 months (See § 220.45(b)). A consultative examination may be purchased when the Board needs additional evidence to determine whether or not an annuitant's disability continues. As a result, the Board may ask the annuitant, upon the Board request and reasonable notice, to undergo consultative examinations and tests to help the Board determine whether the annuitant is still disabled (see § 220.50). The Board will decide

whether or not to purchase a consultative examination in accordance with the standards in §§ 220.53 through 220.54.

(g) *Point of comparison.* For purposes of determining whether medical improvement has occurred, the Board will compare the current medical severity of that impairment(s), which was present at the time of the most recent favorable medical decision that the annuitant was disabled or continued to be disabled, to the medical severity of that impairment(s) at that time. If medical improvement has occurred, the Board will compare the annuitant's current functional capacity to do basic work activities (i.e., his or her residual functional capacity) based on this previously existing impairment(s) with the annuitant's prior residual functional capacity in order to determine whether the medical improvement is related to his or her ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether the annuitant was disabled or continued to be disabled which became final.

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63601, Dec. 4, 2009]

§ 220.178 Determining medical improvement and its relationship to the annuitant's ability to do work.

(a) *General.* Paragraphs (a), (b), and (c) of § 220.177 discuss what is meant by medical improvement, medical improvement not related to the ability to work and medical improvement that is related to the ability to work. How the Board will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed in paragraphs (b) and (c) of this section.

(b) *Determining if medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, the Board then must determine if it is related to the annuitant's ability to do work. In § 220.177(d) the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect the annuitant's residual functional capacity is explained. In determining whether medical improvement that has occurred is related to the annuitant's ability to do work, the Board will assess the annuitant's residual functional capacity (in accordance with § 220.177(d)) based on the current severity of the impairment(s) which was present at that annuitant's last favorable medical decision. The annuitant's new residual functional capacity will then be compared to the annuitant's residual functional capcity at the time of the Board's most recent favorable medical decision. Unless an increase in the current residual functional capacity is based on changes in the signs, symptoms, or laboratory findings, any medical improvement that has occurred will not be considered to be related to the annuitant's ability to do work.

(c) *Additional factors and considerations.* The Board will also apply the following in its determinations of medical improvement and its relationship to the annuitant's ability to do work:

(1) *Previous impairment was medically disabling.* If the Board's most recent favorable decision was based on the fact that the annuitant's impairment(s) at that time was medically disabling, an assessment of his or her residual functional capacity would not have been made. If medical improvement has occurred and the current severity of the prior impairment(s) is no longer medically disabling based on the standard (*see* § 220.100(b)(3)) applied at the time of that decision, the Board will find that the medical improvement was related to the annuitant's ability to work. If the medical findings support impairment(s) that is currently so severe as to be medically disabling, the annuitant is deemed, in the absence of evidence to the contrary, to be unable to engage in substantial gainful activity. If there has been medical improvement to the degree that the impairment(s) is not currently medically disabling, then there has been medical improvement related to the annuitant's ability to work. The Board must, of course, also establish that the annuitant can currently engage in gainful activity before finding that his or her disability has ended.

(2) *Prior residual functional capacity assessment made.* The residual functional capacity assessment used in making the most recent favorable medical decision will be compared to the residual functional capacity assessment based on current evidence in order to determine if an annuitant's functional capacity for basic work activities has increased. There will be no attempt made to reassess the prior residual functional capacity.

(3) *Prior residual functional capacity assessment should have been made, but was not.* If the most recent favorable medical decision should have contained an assessment of the annuitant's residual functional capacity (i.e., his or her impairment(s) was not medically disabling) but does not, either because this assessment is missing from the annuitant's file or because it was not done, the Board will reconstruct the residual functional capacity. This reconstructed residual functional capacity will accurately and objectively assess the annuitant's functional capacity to do basic work activities. The Board will assign the maximum functional capacity consistent with an allowance.

Example: The annuitant was previously found to be disabled on the basis that while his impairment was not medically disabling, it did prevent him from doing his past or any other work. The prior adjudicator did not, however, include a residual functional capacity assessment in the rationale of that decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, i.e., medical improvement, has occurred, the residual functional capacity based on the current level of severity of the annuitant's impairment will have to be compared with his residual functional capacity based on its prior severity in order to determine if the medical improvement is related to his ability to do work. In order to make this comparison, the Board will review the prior evidence and make an objective assessment of the annuitant's residual functional capacity at the time of its most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

(4) *Impairment subject to temporary remission.* In some cases the evidence shows that the annuitant's impairment(s) are subject to temporary remission. In assessing whether medical improvement has occurred in annuitants with this type of impairment(s), the Board will be careful to consider the longitudinal history of the impairment(s), including the occurrence of prior remission, and prospects for future worsenings. Improvement in such impairment(s) that is only temporary, i.e., less than 1 year, will not warrant a finding of medical improvement.

(5) *Prior file cannot be located.* If the prior file cannot be located, the Board will first determine whether the annuitant is able to now engage in substantial gainful activity based on all of his or her current impairments. (In this way, the Board will be able to determine that his or her disability continues at the earliest point without addressing the often lengthy process of reconstructing prior evidence.) If the annuitant cannot engage in substantial gainful activity currently, his or her disability will continue unless one of the second group of exceptions applies (see § 220.179(b)).

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63602, Dec. 4, 2009]

§ 220.179 Exceptions to medical improvement.

(a) *First group of exceptions to medical improvement.* The law provides for certain limited situations when the annuitant's disability can be found to have ended even though medical improvement has not occurred, if he or she can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that the annuitant is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the annuitant should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, the Board must also show that, taking all of the annuitant's current impairment(s) into account, not just those that existed at the time of the Board's most recent favorable medical decision, the annuitant is now able to engage in substantial gainful activity before his or her disability can be found to have ended. As part of the review process, the annuitant will be asked about any medical or vocational therapy that he or she has received or

is receiving. Those answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that the annuitant is the beneficiary of advances in medical or vocational therapy or technology (related to his or her ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased the annuitant's ability to do basic work activities. The Board will apply this exception when substantial evidence shows that the annuitant has been the beneficiary of services which reflect these advances and they have favorably affected the severity of his or her impairment(s) or ability to do basic work activities. This decision will be based on new medical evidence and a new residual functional capacity assessment. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that the annuitant has undergone vocational therapy (related to his or her ability to work).* Vocational therapy (related to the annuitant's ability to work) may include, but is not limited to, additional education, training, or work experience that improves his or her ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. If, at the time of the Board's review the annuitant has not completed vocational therapy which could affect the continuance of his or her disability, the Board will review such annuitant's claim upon completion of the therapy.

Example 1: The annuitant was found to be disabled because the limitations imposed on him by his impairment(s) allowed him to only do work that was at a sedentary level of exertion. The annuitant's prior work experience was work that required a medium level of exertion with no acquired skills that could be transferred to sedentary work. His age, education, and past work experience at the time did not qualify him for work that was below this medium level of exertion. The annuitant enrolled in and completed a specialized training course which qualifies him for a job in data processing as a computer programmer in the period since he was awarded a disability annuity. On review of his claim, current evidence shows that there is no medical improvement and that he can still do only sedentary work. As the work of a computer programmer is sedentary in nature, he is now able to engage in substantial gainful activity when his new skills are considered.

Example 2: The annuitant was previously entitled to a disability annuity because the medical evidence and assessment of his residual functional capacity showed he could only do light work. His prior work was considered to be of a heavy exertional level with no acquired skills that could be transferred to light work. His age, education, and past work experience did not qualify him for work that was below the heavy level of exertion. The current evidence and residual functional capacity show there has been no medical improvement and that he can still do only light work. Since he was originally entitled to a disability annuity, his vocational rehabilitation agency enrolled him in and he successfully completed a trade school course so that he is now qualified to do small appliance repair. This work is light in nature, so when his new skills are considered, he is now able to engage in substantial gainful activity even though there has been no change in his residual functional capacity.

(3) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the annuitant's impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that the annuitant's impairment(s) is not as severe as was determined at the time of the Board's most recent favorable medical decision, such evidence may serve as a basis for finding that the annuitant can engage in substantial gainful activity and is no longer disabled. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of the Board's most recent favorable medical decision.

(i) *How the Board will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to the Board's attention by several methods. In reviewing cases, the Board often becomes aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, the Board develops listings of new techniques and when they become generally available.

(ii) *How the annuitant will know which methods are new or improved techniques and when they become generally available.* The Board will let annuitants know which methods it considers to be new or improved techniques and when they become available.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of the annuitant's last favorable medical decision. Current evidence shows that the annuitant's impairment, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all his current impairments into account, the annuitant is now able to engage in substantial gainful activity, this exception would be used to find that he is no longer disabled even if medical improvement has not occurred.

(4) *Substantial evidence demonstrates that any prior disability decision was in error.* The Board will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to an annuity based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in file such as pulmonary function study values was misread or an adjudicative standard such as a medical/vocational rule in appendix 2 of this part was misapplied).

Example 1: The annuitant was granted a disability annuity when it was determined that his epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. As history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of his seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether the annuitant was still considered to be disabled would be based on whether he could currently engage in substantial gainful activity.

Example 2: The annuitant's prior award of a disability annuity was based on vocational rule 201.14 in appendix 2 of this part. This rule applies to a person age 50–54 who has at least a high school education, whose previous work was entirely at semiskilled level, and who can do only sedentary work. On review it is found that at the time of the prior determination the annuitant was actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of his claim and the prior decision is found to have been in error. Continuation of his disability would depend on a finding of his current inability to engage in substantial gainful activity.

(ii) At the time of the prior evaluation, required and material evidence of the severity of the annuitant's impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: The annuitant was found disabled on the basis of chronic obstructive pulmonary disease. The severity of his impairment was documented primarily by pulmonary function testing results. The evidence showed that he could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that the annuitant's impairment does not limit his ability to perform basic work activities in any way. Error is found based on the fact that required material evidence, which was originally missing, now becomes available and shows that if it had been available at the time of the prior

determination, disability would not have been found.

(iii) Substantial evidence which is new evidence relating to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the disability would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: The annuitant was previously found entitled to a disability annuity on the basis of diabetes mellitus which the prior adjudicator believed was medically disabling. The prior record shows that the annuitant has ''brittle'' diabetes for which he was taking insulin. The annuitant's urine was 3 + for sugar, and he alleged occasional hypoglycemic attacks caused by exertion. His doctor felt the diabetes was never really controlled because he was not following his diet or taking his medication regularly. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that the annuitant's impairment clearly is not medically disabling. Error cannot be found because it would represent a substitution of current judgment for that of the prior adjudicator that the annuitant's impairment was medically disabling. The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision are met.

(5) *The annuitant is currently engaging in substantial gainful activity.* If the annuitant is currently engaging in substantial gainful activity, before the Board determines whether he or she is no longer disabled because of his or her work activity, the Board will consider whether he or she is entitled to a trial work period as set out in § 220.170. The Board will find that the annuitant's disability has ended in the month in which he or she demonstrated the ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether the annuitant continues to have a disabling impairment(s) for purposes of deciding his or her eligibility for a reentitlement period.

(b) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that the annuitant is no longer disabled. In these situations the decision will be made without a determination that the annuitant has medically improved or can engage in substantial gainful activity.

(1) *A prior determination was fraudulently obtained.* If the Board finds that any prior favorable determination was obtained by fraud, it may find that the annuitant is not disabled. In addition, the Board may reopen the claim.

(2) *Failure to cooperate with the Board.* If there is a question about whether the annuitant continues to be disabled and the Board requests that he or she submit medical or other evidence or go for a physical or mental examination by a certain date, the Board will find that the annuitant's disability has ended if he or she fails (without good cause) to do what is requested. The month in which the annuitant's disability ends will be the first month in which he or she failed to do what was requested.

(3) *Inability of the Board to locate the annuitant.* If there is question about whether the annuitant continues to be disabled and the Board is unable to find him or her to resolve the question, the Board will suspend annuity payments. If, after a suitable investigation, the Board is still unable to locate the annuitant, the Board will determine that the annuitant's disability has ended. The month such annuitant's disability ends will be the first month in which the question arose and the annuitant could not be found.

(4) *Failure of the annuitant to follow prescribed treatment which would be expected to restore the ability to engage in substantial gainful activity.* If treatment has been prescribed for the annuitant which would be expected to restore his or her ability to work, he or she must follow that treatment in order to be paid a disability annuity. If the annuitant is not following that treatment and he or she does not have good cause for failing to follow the treatment, the

Board will find that his or her disability has ended. The month such annuitant's disability ends will be the first month in which he or she failed to follow the prescribed treatment.

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63602, Dec. 4, 2009]

§ 220.180 Determining continuation or cessation of disability.

Evaluation steps. To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop a disability annuity are made objectively, neutrally and are fully documented, the Board will follow specific steps in reviewing the question of whether an annuitant's disability continues. The Board's review may cease and the disability may be continued at any point if the Board determines that there is sufficient evidence to find that the annuitant is still unable to engage in substantial gainful activity. The steps are—

(a) Is the annuitant engaging in substantial gainful activity? If he or she is (and any applicable trial work period has been completed), the Board will find disability to have ended (see § 220.179(a)(5));

(b) If the annuitant is not engaging in substantial gainful activity, does he or she have an impairment or combination of impairments which is medically disabling? If the annuitant's impairment(s) is medically disabling, his or her disability will be found to continue;

(c) If the annuitant's impairment(s) is not medically disabling, has there been medical improvement as defined in § 220.177(a)? If there has been medical improvement as shown by a decrease in medical severity, see step (d). If there has been no decrease in medical severity, then there has been no medical improvement; (See step (e));

(d) If there has been medical improvement, the Board must determine whether it is related to the annuitant's ability to do work in accordance with paragraphs (a) through (d) of § 220.177, (i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination). If medical improvement is not related to the annuitant's ability to do work, see step (e). If medical improvement is related to the annuitant's ability to do work, see step (f);

(e) If the Board found at step (c) that there has been no medical improvement or if it found at step (d) that the medical improvement is not related to the annuitant's ability to work, the Board considers whether any of the exceptions in § 220.178 apply. If none of them apply, disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (f). If an exception from the second group of exceptions to medical improvement applies, disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process;

(f) If medical improvement is shown to be related to the annuitant's ability to do work or if one of the first group of exceptions to medical improvement applies, the Board will determine whether all of the annuitant's current impairments in combination are severe. This determination will consider all current impairments and the impact of the combination of those impairments on the ability to function. If the residual functional capacity assessment in step (d) above shows significant limitation of ability to do basic work activities, see step (g). When the evidence shows that all current impairments in combination do not significantly limit physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature, and the annuitant will no longer be consider to be disabled;

(g) If the annuitant's impairment(s) is severe, the Board will assess his or her current ability to engage in substantial gainful activity. That is, the Board will assess the annuitant's residual functional capacity based on all of his or her current impairments and consider whether he or she can still do work that was done in the past. If he or she can do such work, disability will be found to have ended; and

(h) If the annuitant is not able to do work he or she has done in the past,

the Board will consider one final step. Given the residual functional capacity assessment and considering the annuitant's age, education and past work experience, can he or she do other work? If the annuitant can do other work, disability will be found to have ended. If he or she cannot do other work, disability will be found to continue.

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63603, Dec. 4, 2009]

§ 220.181 The month in which the Board will find that the annuitant is no longer disabled.

If the evidence shows that the annuitant is no longer disabled, the Board will find that his or her disability ended in the earliest of the following months—

(a) The month the Board mails the annuitant a notice saying that the Board finds that he or she is no longer disabled based on evidence showing:

(1) There has been medical improvement in the annuitant's impairments related to the ability to work and the annuitant has the capacity to engage in substantial gainful work under the rules set out in §§ 220.177 and 220.178; or

(2) There has been no medical improvement in the annuitant's impairments related to the ability to work but the annuitant has the capacity to engage in substantial gainful work and one of the exceptions to medical improvement set out in § 220.179(a)(1), (2), (3) or (4) applies.

(b) The month in which the annuitant demonstrated his or her ability to engage in substantial gainful activity (following completion of a trial work period);

(c) The month in which the annuitant actually does substantical gainful activity where such annuitant is not entitled to a trial work period;

(d) The month in which the annuitant returns to full-time work, with no significant medical restrictions and acknowledges that medical improvement has occurred, and the Board expected the annuitant's impairment(s) to improve;

(e) The first month in which the annuitant failed without good cause to do what the Board asked, when the rule set out in paragraph (b)(2) of § 220.179 applies;

(f) The first month in which the question of continuing disability arose and the Board could not locate the annuitant after a suitable investigation (see § 220.179(b)(3));

(g) The first month in which the annuitant failed without good cause to follow prescribed treatment, when the rule set out in paragraph (b)(4) of § 220.179 applies; or

(h) The first month the annuitant was told by his or her physician that he or she could return to work provided there is no substantial conflict between the physician's and the annuitant's statements regarding that annuitant's awareness of his or her capacity for work and the earlier date is supported by the medical evidence.

(i) The month the evidence shows that the annuitant is no longer disabled under the rules set out in §§ 220.177 through 220.180, and he or she was disabled only for a specified period of time in the past as discussed in § 220.21 or § 220.105;

[56 FR 12980, Mar. 28, 1991, as amended at 74 FR 63603, Dec. 4, 2009]

§ 220.182 Before a disability annuity is stopped.

Before the Board stops a disability annuity, it will give the annuitant a chance to explain why it should not do so.

§ 220.183 Notice that the annuitant is not disabled.

(a) *General.* If the Board determines that the annuitant does not meet the disability requirements of the law, the disability annuity will generally stop. Except in the circumstance described in paragraph (d) of this section, the Board will give the annuitant advance written notice when the Board has determined that he or she is not now disabled.

(b) *What the advance written notice will tell the annuitant.* The advance written notice will provide—

(1) A summary of the information the Board has and an explanation of why the Board believes the annuitant is no longer disabled. If it is because of medical reasons, the notice will tell the annuitant what the medical information

in his or her file shows. If it is because of the annuitant's work activity, the notice will tell the annuitant what information the Board has about the work he or she is doing or has done, and why this work shows that he or she is not disabled. If it is because of the annuitant's failure to give the Board information the Board needs or failure to do what the Board asks, the notice will tell the annuitant what information the Board needs and why, or what the annuitant has to do and why;

(2) The date the disability annuity will stop;

(3) An opportunity for the annuitant to submit evidence within a specified period to support continuance of disability before the decision becomes final; and

(4) An explanation of the annuitant's rights to reconsideration and appeal after the decision becomes final.

(c) *What the annuitant should do if he or she receives an advance written notice.* If the annuitant agrees with the advance written notice, he or she does not need to take any action. If the annuitant desires further information or disagrees with what the Board has told him or her, the annuitant should immediately write or visit a Board office. If the annuitant believes he or she is now disabled, the annuitant should tell the Board why. The annuitant may give the Board any additional or new information, including reports from doctors, hospitals, railroad or non-railroad employers, or others that he or she believes the Board should have. The annuitant should send these as soon as possible to a Board office.

(d) *When the Board will not give the annuitant advance written notice.* The Board will not give the annuitant advance written notice when the Board determines that he or she is not now disabled if the Board recently told the annuitant that—

(1) The information the Board has shows that he or she is not disabled;

(2) The Board was gathering more information; and

(3) The disability annuity would stop.

§ 220.184 If the annuitant becomes disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which the last impairment(s) ends, the Board will find that disability is continuing. The impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep the annuitant from doing substantial gainful activity, or severe enough so that he or she is still disabled.

§ 220.185 The Board may conduct a review to find out whether the annuitant continues to be disabled.

After the Board finds that the annuitant is disabled, the Board must evaluate the annuitant's impairment(s) from time to time to determine if the annuitant is still eligible for disability cash benefits. The Board calls this evaluation a continuing disability review. The Board may begin a continuing disability review for any number of reasons including the annuitant's failure to follow the provisions of the Railroad Retirement Act or these regulations. When the Board begins such a review, the Board will notify the annuitant that the Board is reviewing the annuitant's eligibility for disability benefits, why the Board is reviewing the annuitant's eligibility, that in medical reviews the medical improvement review standard will apply, that the Board's review could result in the termination of the annuitant's benefits, and that the annuitant has the right to submit medical and other evidence for the Board's consideration during the continuing disability review. In doing a medical review the Board will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that the annuitant is no longer under a disability. If this review shows that the Board should stop payment of cash benefits, the Board will notify the annuitant in writing and give the annuitant an opportunity to appeal. In § 220.186 the Board describes those events that may prompt it to review whether the annuitant continues to be disabled.

§ 220.186 When and how often the Board will conduct a continuing disability review.

(a) *General.* The Board conducts continuing disability reviews to determine whether or not the annuitant continues

to meet the disability requirements of the law. Payment of cash benefits or a period of disability ends if the medical or other evidence shows that the annuitant is not disabled under the standards set out in section 2 of the Railroad Retirement Act or section 223(f) of the Social Security Act.

(b) *When the Board will conduct a continuing disability review.* A continuing disability review will be started if—

(1) The annuitant has been scheduled for a medical improvement expected diary review;

(2) The annuitant has been scheduled for a periodic review in accordance with the provisions of paragraph (d) of this section;

(3) The Board needs a current medical or other report to see if the annuitant's disability continues. (This could happen when, for example, an advance in medical technology, such as improved treatment for Alzheimer's disease or a change in vocational therapy or technology raises a disability issue.);

(4) The annuitant returns to work and successfully completes a period of trial work;

(5) Substantial earnings are reported to the annuitant's wage record;

(6) The annuitant tells the Board that he or she has recovered from his or her disability or that he or she has returned to work;

(7) A State Vocational Rehabilitation Agency tells the Board that—

(i) The services have been completed; or

(ii) The annuitant is now working; or

(iii) The annuitant is able to work;

(8) Someone in a position to know of the annuitant's physical or mental condition tells the Board that the annuitant is not disabled, that the annuitant in not following prescribed treatment, that the annuitant has returned to work, or that the annuitant is failing to follow the provisions of the Social Security Act, the Railroad Retirement Act, or these regulations, and it appears that the report could be substantially correct; or

(9) Evidence the Board receives raises a question as to whether the annuitant's disability continues.

(c) *Definitions.* As used in this section—

Medical improvement expected diary—refers to a case which is scheduled for review at a later date because the individual's impairment(s) is expected to improve. Generally, the diary period is set for not less than 6 months or for not more than 18 months. Examples of cases likely to be scheduled for a medical improvement excepted diary are fractures and cases in which corrective surgery is planned and recovery can be anticipated. The term ''medical improvement expected diary'' also includes a case which is scheduled for a review at a later date because the individual is undergoing vocational therapy, training or an educational program which may improve his or her ability to work so that the disability requirement of the law is no longer met. Generally, the diary period will be the length of the training, therapy, or program of education.

Permanent impairment medical improvement not expected—refers to a case in which any medical improvement in the person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability program to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity. The interaction of the individual's age, impairment consequences and lack of recent attachment to the labor market may also be considered in determining whether an impairment is permanent. Improvement which is considered temporary under § 220.178(c)(3), will not be considered in deciding if an impairment is permanent. Examples of permanent impairments are as follows and are not intended to be all inclusive:

(1) Parkinsonian syndrome with significant rigidity, brady kinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

(2) Amyotrophic lateral sclerosis, based on documentation of a clinically appropriate medical history, neurological findings consistent with the diagnosis of ALS, and the results of any

electrophysiological and neuroimaging testing.

(3) Diffuse pulmonary fibrosis in an individual age 55 or older which reduces FEV1 to 1.45 to 2.05 (L, BTPS) or less depending on the individual's height.

(4) Amputation of leg at hip.

Nonpermanent impairment refers to a case in which any medical improvement in the person's impairment(s) is possible. This means an impairment for which improvement cannot be predicted based on current experience and the facts of the particular case but which is not at the level of severity of an impairment that is considered permanent. Examples of nonpermanent impairments are: regional enteritis, hyperthyroidism, and chronic ulcerative colitis.

(d) *Frequency of review.* If an annuitant's impairment is expected to improve, generally the Board will review the annuitant's continuing eligibility for disability benefits at intervals from 6 months to 18 months following the Board's most recent decision. The Board's notice to the annuitant about the review of the annuitant's case will tell the annuitant more precisely when the review will be conducted. If the annuitant's disability is not considered permanent but is such that any medical improvement in the annuitant's impairment(s) cannot be accurately predicted, the Board will review the annuitant's continuing eligibility for disability benefits at least once every 3 years. If no medical improvement is expected in the annuitant's impairment(s), the Board will not routinely review the annuitant's continuing eligibility. Regardless of the annuitant's classification, the Board will conduct an immediate continuing disability review if a question of continuing disability is raised pursuant to paragraph (b) of this section.

(e) *Change in classification of impairment.* If the evidence developed during a continuing disability review demonstrates that the annuitant's impairment has improved, is expected to improve, or has worsened since the last review, the Board may reclassify the annuitant's impairment to reflect this change in severity. A change in the classification of the annuitant's impairment will change the frequency with which the Board will review the case. The Board may also reclassify certain impairments because of improved tests, treatment, and other technical advances concerning those impairments.

(f) *Review after administrative appeal.* If the annuitant was found eligible to receive or to continue to receive disability benefits on the basis of a decision by a hearings officer, the three-member Board or a Federal court, the agency will not conduct a continuing disability review earlier than 3 years after that decision unless the annuitant's case should be scheduled for a medical improvement expected or vocational reexamination diary review or a question of continuing disability is raised pursuant to paragraph (b) of this section.

(g) *Waiver of timeframes.* All cases involving a nonpermanent impairment will be reviewed by the Board at least once every 3 years unless the Board determines that the requirements should be waived to ensure that only the appropriate number of cases are reviewed. The appropriate number of cases to be reviewed is to be based on such considerations as the backlog of pending reviews, the projected number of new applications, and projected staffing levels. Therefore, an annuitant's continuing disability review may be delayed longer than 3 years following the Board's original decision or other review under certain circumstances. Such a delay would be based on the Board's need to ensure that backlogs, and new disability claims workloads are accomplished within available medical and other resources and that such reviews are done carefully and accurately.

[56 FR 12980, Mar. 28, 1991, as amended at 65 FR 20372, Apr. 17, 2000; 74 FR 63603, Dec. 4, 2009]

§ 220.187 If the annuitant's medical recovery was expected and the annuitant returned to work.

If the annuitant's impairment was expected to improve and the annuitant returned to full-time work with no significant medical limitations and acknowledges that medical improvement has occurred, the Board may find that

the annuitant's disability ended in the month he or she returned to work. Unless there is evidence showing that the annuitant's disability has not ended, the Board will use the medical and other evidence already in the annuitant's file and the fact that he or she has returned to full-time work without significant limitations to determine that the annuitant is no longer disabled. (If the annuitant's impairment is not expected to improve, the Board will not ordinarily review his or her claim until the end of the trial work period, as described in § 220.170.)

Example: Evidence obtained during the processing of the annuitant's claim showed that the annuitant had an impairment that was expected to improve about 18 months after the annuitant's disability began. The Board, therefore, told the annuitant that his or her claim would be reviewed again at that time. However, before the time arrived for the annuitant's scheduled medical reexamination, the annuitant told the Board that he or she had returned to work and the annuitant's impairment had improved. The Board investigated immediately and found that, in the 16th month after the annuitant's began, the annuitant returned to full-time work without any significant medical restrictions. Therefore, the Board would find that the annuitant's disability ended in the first month the annuitant returned to full-time work.

APPENDIX 1 TO PART 220 [RESERVED]

APPENDIX 2 TO PART 220—MEDICAL-VOCATIONAL GUIDELINES

Sec.

200.00 Introduction.
201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).
202.00 Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).
203.00 Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).
204.00 Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).

200.00 *Introduction.* (a) The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical considerations alone, where an individual with a severe medically determinable physical or mental impairment(s) is not engaging in substantial gainful activity and the individual's impairment(s) prevents the performance of his or her vocationally relevant past work. They also reflect the analysis of the various vocational factors (i.e., age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. However, each of these findings of fact is subject to rebuttal and the individual may present evidence to refute such findings. Where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not disabled. In any instance where a rule does not apply, full consideration must be given to all of the relevant facts of the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations.

(b) The existence of jobs in the national economy is reflected in the ''Decisions'' shown in the rules; i.e., in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy) as supported by the ''Dictionary of Occupational Titles'' and the ''Occupational Outlook Handbook,'' published by the Department of Labor; the ''County Business Patterns'' and ''Census Surveys'' published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies. Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. However, the existence of such jobs for individuals whose remaining functional capacity or other factors do not coincide with the criteria of a rule must be further considered in terms of what kinds of jobs or types of work may be either additionally indicated or precluded.

(c) In the application of the rules, the individual's residual functional capacity (*i.e.,* the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs), age, education, and work experience must first be determined. When assessing the person's residual functional capacity, the Board

considers his or her symptoms (such as pain), signs, and laboratory findings together with other evidence the Board obtains.

(d) The correct disability decision (i.e., on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile. If an individual's specific profile is not listed within this appendix 2, a conclusion of disabled or not disabled is not directed. Thus, for example, an individual's ability to engage in substantial gainful work where his or her residual functional capacity falls between the ranges of work indicated in the rules (e.g., the individual who can perform more than light but less than medium work), is decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in this appendix 2. These rules represent various combinations of exertional capabilities, age, education and work experience and also provide an overall structure for evaluation of those cases in which the judgments as to each factor do not coincide with those of any specific rule. Thus, when the necessary judgments have been made as to each factor and it is found that no specific rule applies, the rules still provide guidance for decisionmaking, such as in cases involving combinations of impairments. For example, if strength limitations resulting from an individual's impairment(s) considered with the judgments made as to the individual's age, education and work experience correspond to (or closely approximate) the factors of a particular rule, the adjudicator then has a frame of reference for considering the jobs or types of work precluded by other, nonexertional impairments in terms of numbers of jobs remaining for a particular individual.

(e) Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental, sensory, or skin impairments. In addition, some impairments may result solely in postural and manipulative limitations or environmental restrictions. Environmental restrictions are those restrictions which result in inability to tolerate some physical feature(s) of work settings that occur in certain industries or types of work, e.g., an inability to tolerate dust or fumes.

(1) In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in this appendix 2. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments.

(2) However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

201.00 *Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).* (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

(b) These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity.

(c) Vocational adjustment to sedentary work may be expected where the individual has special skills or experience relevant to sedentary work or where age and basic educational competences provide sufficient occupational mobility to adapt to the major segment of unskilled sedentary work. Inability to engage in substantial gainful activity would be indicated where an individual who is restricted to sedentary work because of a severe medically determinable impairment lacks special skills or experience relevant to sedentary work, lacks educational qualifications relevant to most sedentary work (e.g., has a limited education or less) and the individual's age, though not necessarily advanced, is a factor which significantly limits vocational adaptability.

(d) The adversity of functional restrictions to sedentary work at advanced age (55 and over) for individuals with no relevant past work or who can no longer perform vocationally relevant past work and have no transferable skills, warrants a finding of disabled in the absence of the rare situation where the individual has recently completed education which provides a basis for direct entry into skilled sedentary work. Advanced age and a history of unskilled work or no work experience would ordinarily offset any vocational advantages that might accrue by reason of any remote past education, whether it is more or less than limited education.

(e) The presence of acquired skills that are readily transferable to a significant range of skilled work within an individual's residual functional capacity would ordinarily warrant a finding of ability to engage in substantial gainful activity regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) In order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) Individuals approaching advanced age (age 50–54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. When such individuals have no past work experience or can no longer perform vocationally relevant past work and have no transferable skills, a finding of disabled ordinarily obtains. However, recently completed education which provides for direct entry into sedentary work will preclude such a finding. For this age group, even a high school education or more (ordinarily completed in the remote past) would have little impact for effecting a vocational adjustment unless relevant work experience reflects use of such education.

(h) The term ''younger individual'' is used to denote an individual age 18 through 49. For those within this group who are age 45–49, age is a less positive factor than for those who are age 18–44. Accordingly, for such individuals; (1) who are restricted to sedentary work, (2) who are unskilled or have no transferable skills, (3) who have no relevant past work or who can no longer perform vocationally relevant past work, and (4) who are either illiterate or unable to communicate in the English language, a finding of disabled is warranted. On the other hand, age is a more positive factor for those who are under age 45 and is usually not a significant factor in limiting such an individual's ability to make a vocational adjustment, even an adjustment to unskilled sedentary work, and even where the individual is illiterate or unable to communicate in English. However, a finding of disabled is not precluded for those individuals under age 45 who do not meet all of the criteria of a specific rule and who do not have the ability to perform a full range of sedentary work. The following examples are illustrative: Example 1: An individual under age 45 with a high school education can no longer do past work and is restricted to unskilled sedentary jobs because of a severe medically determinable cardiovascular impairment (which does not meet or equal the listings in appendix 1). A permanent injury of the right hand limits the individual to sedentary jobs which do not require bilateral manual dexterity. None of the rules in appendix 2 are applicable to this particular set of facts, because this individual cannot perform the full range of work defined as sedentary. Since the inability to perform jobs requiring bilateral manual dexterity significantly compromises the only range of work for which the individual is otherwise qualified (i.e., sedentary), a finding of disabled would be appropriate. Example 2: An illiterate 41 year old individual with mild mental retardation (IQ of 78) is restricted to unskilled sedentary work and cannot perform vocationally relevant past work, which had consisted of unskilled agricultural field work; his or her particular characteristics do not specifically meet any of the rules in appendix 2, because this individual cannot perform the full range of work defined as sedentary. In light of the adverse factors which further narrow the range of sedentary work for which this individual is qualified, a finding of disabled is appropriate.

(i) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. Thus, the functional capability for a full range of sedentary work represents sufficient numbers of jobs to indicate substantial vocational scope for those individuals age 18–44 even if they are illiterate or unable to communicate in English.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
201.01	Advanced age	Limited or less	Unskilled or none	Disabled.
201.02	do	do	Skilled or semiskilled—skills not transferable [1].	Do.
201.03	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
201.04	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
201.05	do	High school graduate or more—provides for direct entry into skilled work [2].	do	Not disabled.
201.06	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Disabled.
201.07	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
201.08	do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Do.
201.09	Closely approaching advanced age.	Limited or less	Unskilled or none	Disabled.
201.10	do	do	Skilled or semiskilled—skills not transferable.	Do.
201.11	do	do	Skilled or semiskilled—skills transferable.	Not disabled.
201.12	do	High school graduate or more—does not provide for direct entry into skilled work [3].	Unskilled or none	Disabled.
201.13	do	High school graduate or more—provides for direct entry into skilled work [3].	do	Not disabled.
201.14	do	High school graduate or more—does not provide for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Disabled.
201.15	do	do	Skilled or semiskilled—skills transferable.	Not disabled.
201.16	do	High school graduate or more—provides for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Do.
201.17	Younger individual age 45–49.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
201.18	do	Limited or less—at least literate and able to communicate in English.	do	Not disabled.
201.19	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
201.20	do	do	Skilled or semiskilled—skills transferable.	Do.
201.21	do	High school graduate or more	Skilled or semiskilled—skills not transferable.	Do.
201.22	do	do	Skilled or semiskilled—skills transferable.	Do.
201.23	Younger individual age 18–44.	Illiterate or unable to communicate in English.	Unskilled or none	Do. [4]
201.24	do	Limited or less—at least literate and able to communicate in English.	do	Do. [4]
201.25	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do. [4]
201.26	do	do	Skilled or semiskilled—skills transferable.	Do. [4]
201.27	do	High school graduate or more	Unskilled or none	Do. [4]
201.28	do	do	Skilled or semiskilled—skills not transferable.	Do. [4]

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
201.29	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]

[1] See 201.00(f).
[2] See 201.00(d).
[3] See 201.00(g).
[4] See 201.00(h).

202.00 *Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.

(b) The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competences for unskilled work.

(c) However, for individuals of advanced age who can no longer perform vocationally relevant past work and who have a history of unskilled work experience, or who have only skills that are not readily transferable to a significant range of semi-skilled or skilled work that is within the individual's functional capacity, or who have no work experience, the limitations in vocational adaptability represented by functional restriction to light work warrant a finding of disabled. Ordinarily, even a high school education or more which was completed in the remote past will have little positive impact on effecting a vocational adjustment unless relevant work experience reflects use of such education.

(d) Where the same factors in paragraph (c) of this section regarding education and work experience are present, but where age, though not advanced, is a factor which significantly limits vocational adaptability (i.e., closely approaching advanced age, 50–54) and an individual's vocational scope is further significantly limited by illiteracy or inability to communicate in English, a finding of disabled is warranted.

(e) The presence of acquired skills that are readily transferable to a significant range of semi-skilled or skilled work within an individual's residual functional capacity would ordinarily warrant a finding of not disabled regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) For a finding of transferability of skills to light work for individuals of advanced age who are closely approaching retirement age (age 60–64), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly, the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. The capability for light work, which includes the ability to do sedentary work, represents the capability for substantial numbers of such jobs. This, in turn, represents substantial vocational scope for younger individuals (age 18–49) even if illiterate or unable to communicate in English.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
202.01	Advanced age	Limited or less	Unskilled or none	Disabled.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
202.02	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.03	.....do	.....do	Skilled or semiskilled—skills transferable [1].	Not disabled.
202.04	.....do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
202.05	.....do	High school graduate or more—provides for direct entry into skilled work [2].	.....do	Not disabled.
202.06	.....do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Disabled.
202.07	.....do	.....do	Skilled or semiskilled—skills transferable [2].	Not disabled.
202.08	.....do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Do.
202.09	Closely approaching advanced age.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
202.10	.....do	Limited or less—At least literate and able to communicate in English.	.....do	Not disabled.
202.11	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.12	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.13	.....do	High school graduate or more	Unskilled or none	Do.
202.14	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.15	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.16	Younger individual	Illiterate or unable to communicate in English.	Unskilled or none	Do.
202.17	.....do	Limited or less—At least literate and able to communicate in English.	.....do	Do.
202.18	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.19	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.20	.....do	High school graduate or more	Unskilled or none	Do.
202.21	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.22	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.

[1] See 202.00(f).
[2] See 202.00(c).

203.00 *Maximum sustained work capability limited to medium work as a result of severe medically determinable impair- ment(s).* (a) The functional capacity to perform medium work includes the functional capacity to perform sedentary, light, and medium work. Approximately 2,500 separate sedentary, light, and medium occupations can be identified, each occupation representing numerous jobs in the national economy which do not require skills or previous experience and which can be performed after a short demonstration or within 30 days.

(b) The functional capacity to perform medium work represents such substantial work capability at even the unskilled level that a finding of disabled is ordinarily not warranted in cases where a severely impaired individual retains the functional capacity to perform medium work. Even the adversity of advanced age (55 or over) and a work history of unskilled work may be offset by the substantial work capability represented by the functional capacity to perform medium work. However, an individual with a marginal education and long work experience (i.e., 35 years or more) limited to the performance of arduous unskilled labor, who is not working and is no longer able to perform this labor because of a severe impairment(s),

may still be found disabled even though the individual is able to do medium work.

(c) However, the absence of any relevant work experience becomes a more significant adversity for individuals of advanced age (55 and over). Accordingly, this factor, in combination with a limited education or less, militates against making a vocational adjustment to even this substantial range of work and a finding of disabled is appropriate. Further, for individuals closely approaching retirement age (60–64) with a work history of unskilled work and with marginal education or less, a finding of disabled is appropriate.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
203.01	Closely approaching retirement age.	Marginal or none	Unskilled or none	Disabled.
203.02	do	Limited or less	None	Do.
203.03	do	Limited	Unskilled	Not disabled.
203.04	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
203.05	do	do	Skilled or semiskilled—skills transferable.	Do.
203.06	do	High school graduate or more	Unskilled or none	Do.
203.07	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.08	do	do	Skilled or semiskilled—skills transferable.	Do.
203.09	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.10	Advanced age	Limited or less	None	Disabled.
203.11	do	do	Unskilled	Not disabled.
203.12	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.13	do	do	Skilled or semiskilled—skills transferable.	Do.
203.14	do	High school graduate or more	Unskilled or none	Do.
203.15	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.16	do	do	Skilled or semiskilled—skills transferable.	Do.
203.17	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.18	Closely approaching advanced age.	Limited or less	Unskilled or none	Do.
203.19	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.20	do	do	Skilled or semiskilled—skills transferable.	Do.
203.21	do	High school graduate or more	Unskilled or none	Do.
203.22	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.23	do	do	Skilled or semiskilled—skills transferable.	Do.
203.24	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.25	Younger individual	Limited or less	Unskilled or none	Do.
203.26	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.27	do	do	Skilled or semiskilled—skills transferable.	Do.
203.28	do	High school graduate or more	Unskilled or none	Do.
203.29	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.30	do	do	Skilled or semiskilled—skills transferable.	Do.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
203.31	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

204.00 *Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).* The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work—either of which would have already provided a basis for a decision of ''not disabled''. Environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 60294, Oct. 22, 2003]

APPENDIX 3 TO PART 220—RAILROAD RETIREMENT BOARD OCCUPATIONAL DISABILITY STANDARDS

1. INTRODUCTION

1.01 The Board uses this appendix to adjudicate the occupational disability claims of employees with medical conditions and job titles covered by the Tables in this appendix. The Tables are divided into ''Body Parts'', with each Body Part further divided by job title. Under each job title there is a list of impairments and tests with accompanying test results which establish a finding of ''D'' (disabled). The use of these Tables is a three-step process. In the first step we determine whether the employee's regular railroad occupation is covered by the Tables; next we establish the existence of an impairment covered by the Tables; finally, we reach a disability determination. If we do not find an employee disabled under these Tables, the employee may still be found disabled using Independent Case Evaluation (ICE), as explained in subpart C of this part.

1.02 The Cancer Tables are treated in a different way than other body systems. Different types of cancer and their treatments have different functional impacts. In the Cancer Tables the impact of the impairment is seen as being significant or not significant. Therefore, these tables contain an ''S'' (significant) which is equivalent to a ''D'' rating. A detailed explanation of how to use those tables is in that section. The steps to use the remaining Tables are explained below:

2. CONFIRMING THE IMPAIRMENT

2.01 Once we determine that the employee's regular railroad occupation is covered by the Job Titles in the Tables, we must determine the existence of an impairment covered by the Tables. This is done through the use of Confirmatory Tests. These tests can include information from medical records, surgical or operative reports, or specific diagnostic test results. Confirmatory Tests are listed in the initial section regarding each Body Part covered in the Tables. If an impairment cannot be confirmed because of inconsistent medical information, ICE may be required.

2.02 There are two types of Confirmatory Tests as follows.

2.03 ''Highly Recommended'' Tests—The designation of a confirmatory test as being ''highly recommended'' means that the test is almost always performed to confirm the existence of the impairment. For many conditions, only one ''highly recommended'' test finding is suggested to confirm the impairment. However, there may be times when that test is not available or is negative, but other more detailed testing confirms the impairment.

2.04 *Example A:* To confirm the condition of pulmonary hypertension, the Tables under Body Part C., Cardiac, designate as ''highly recommended'': an electrocardiogram which indicates definite right ventricular hypertrophy. However, the impairment may also be confirmed by insertion of a Swan-Ganz catheter into the pulmonary artery and the pulmonary artery pressure measured directly.

2.05 There may be some conditions for which several ''highly recommended'' tests are suggested to confirm an impairment. In these circumstances, we will use all ''highly

recommended'' tests to establish the existence of the impairment.

2.06 *Example B:* Under Body Part E., Lumbar Sacral Spine, three highly recommended medical findings are identified for the diagnosis of chronic back pain, not otherwise specified. These findings include:

A. A history of back pain under medical treatment for at least one year, and

B. A history of back pain unresponsive to therapy for at least one year, and

C. A history of back pain with functional limitations for at least one year.

2.07 All three of these criteria must be satisfied to confirm the existence of chronic back pain.

2.08 Sometimes the employee may have undergone detailed testing which is as reliable as one of the ''highly recommended'' tests listed in the Tables. In cases where an impairment has not been confirmed by one of the designated ''highly recommended'' tests, the impairment may still be confirmed by ''recommended'' tests (see below) or by evidence acceptable under section 220.27 of this part.

2.09 Recommended Tests—The designation of a confirmatory test as ''recommended'' means that the test need not be performed, or be positive, to confirm the impairment. However, a positive test provides significant support for confirming the impairment. If there are no ''highly recommended'' tests for confirming the impairment, at least one of the ''recommended'' tests should be positive.

2.10 There are two categories of recommended tests which are described below.

A. *Imaging studies*—These studies can include MRI, CAT scan, myelogram, or plain film x-rays. For conditions where several of these imaging studies are identified as ''recommended'' tests, at least one of the test results should be positive and meet the confirmatory test criteria. For some conditions, such as degenerative disc condition, there are several equivalent imaging methods to confirm a diagnosis.

B. *Other tests*—This category of tests refers to non-imaging studies.

2.11 If there are no ''highly recommended'' confirmatory tests designated to confirm an impairment and the ''recommended'' confirmatory tests only include non-imaging procedures, at least one of these tests should be positive to confirm the impairment. The greater the number of tests that are positive, the greater the confidence that the correct diagnosis has been established.

2.12 *Example:* Under Body Part C., Cardiac, the diagnostic confirmatory tests for ventricular ectopy, a cardiac arrhythmia, include the following ''recommended'' tests:

A. Medical record review, i.e., a review of the claimant's medical records, or

B. Holter monitoring, or

C. Provocative testing producing a definite arrhythmia.

2.13 In this situation, only one of the ''recommended'' confirmatory tests need be positive to confirm the impairment. However, the more tests that are positive, the stronger the support for the diagnosis.

2.14 In no circumstance will the Board require that an invasive test be performed to confirm an impairment. Several of the Confirmatory Tests which are described in the Tables are invasive and it is not the intention of the Board to suggest that these be performed. The inclusion of invasive tests in the Tables Confirmatory Tests section is intended to help the Board evaluate the significance of findings from such tests that may have already been performed and which are part of the submitted medical record.

2.15 If an employee's impairment(s) cannot be confirmed by use of the confirmatory tests listed in the Tables, it still may be confirmed by medical evidence described in section 220.27 of this part. However, if a claimant's impairment(s) cannot be confirmed through use of the Tables or under section 220.27, and the medical evidence is complete and in concordance, the claimant will be found not disabled.

3. Disability Determination

3.01 Once the Board determines that the employee's regular railroad occupation is covered by one of the Job Titles in the Tables and that his or her alleged impairment fits into a Body Part covered by the Tables and can be confirmed, we examine the results of any of the disability tests listed under the impairment. If the results from any of these tests indicate a ''D'' finding, the employee is found disabled. If none of the test results indicate a ''D'' finding, then the employee's claim is evaluated using ICE.

3.02 *Example:* A trainman has angina as confirmed by the recommended tests under Body Part A: Cardiac—Angina. An echocardiogram shows that he has poor ejection fraction ≤35%. The employee is rated disabled. If none of the results of the listed disability tests match the results required for a ''D'' finding, then the employee's claim is evaluated under ICE.

Tables

A. Cancer
B. Endocrine
C. Cardiac
D. Respiratory
E. Lumbar Sacral Spine
F. Cervical Spine
G. Shoulder and Elbow
H. Hand and Arm
I. Hip
J. Knee
K. Ankle and Foot

A. CANCER

Cancer

Cancer conditions can be viewed as belonging to one of three categories.

Category 1: Significant impact on functional capacity or anticipated life span.

Category 2: Intermediate impact on functional capacity; large individual variability.

Category 3: No significant impact on functional capacity or expected life span.

The factors that are considered in developing these categories include the following:

Type of Cancer

The functional impact of different malignancies varies tremendously and each malignancy has to be considered on an individual basis.

Magnitude of Disease

The disability standards are based upon the magnitude or extent of disease. The extent of disease affects both anticipated life span and the functional capacity or work ability of the individual. Localized cancer including cancer ''in situ'' can frequently be completely cured and not have an impact on functional capacity or life span. In contrast, many cancers that have distant or significant regional spread generally have a poor prognosis. The magnitude or extent of disease is classified into three categories: local, regional and distant.

The criteria which are used to classify a cancer into one of the three categories are based upon the distillation of several staging methods into a single system [Miller, et al. (1992). Cancer Statistics Review, 1973–1989; NIH Publication No. 92–2789].

Effects of Treatment

Although some types of cancer may be potentially curable with radical surgery and/or radiation therapy, the treatment regimen may result in a significant impairment that could affect functional capacity and ability to work. For example, a person with a laryngeal tumor which had spread regionally could be cured by a complete laryngectomy and radiotherapy. However, this treatment could result in a loss of speech and significantly impair the individual's communicative skills or ability to use certain types of respiratory protective equipment.

Prognosis

Some cancers may have minimal impact on a person's functional capacity, but have a very poor prognosis with respect to life expectancy. For example, an individual with early stage brain cancer may be minimally impaired, but have a poor prognosis and minimal potential for surviving longer than two years. Five and two year survival data are presented in the Cancer Disability Guideline Table which follows.

The Cancer Disability Guideline Table provides information concerning the probability of survival for five years for local, regional, and distant disease for each type of malignancy. In addition, two-year survival data are also presented for all disease stages. The five-year survival data are based upon data collected from population-based registries in Connecticut, New Mexico, Utah, Hawaii, Atlanta, Detroit, Seattle and the San Francisco and East Bay area between 1983 and 1987 (Miller, 1992). The two-year data are from a cohort study initially diagnosed in 1988.

Assessment

The malignancies are classified as disabling (Category 1), potentially disabling (Category 2) and non-disabling (Category 3). Category 2 conditions must be evaluated with respect to how the worker's tumor affects the worker's ability to perform the job and an assessment of his life span.

Information concerning the potential impact of the malignancy on a worker's ability to perform a job is identified in the Functional Impact column in the table. All railroad occupations in the Tables are considered together. Functional impacts are classified as significant if the treatment or sequelae from treatment including radiotherapy, chemotherapy and/or surgery is likely to impair the worker from performing the job. If the treatment results in a significant impairment of another organ system, the individual should be evaluated for disability associated with impairment of that body part. For example, a person undergoing an amputation for a bone malignancy would have to be evaluated for an amputation of that body part. For many cancers, it is difficult to make generalizations regarding the level of impairment that will occur after the person has initiated or completed treatment. Nonsignificant impacts include those that are unlikely to have any effect on the individual's work capacity.

Cancer type	2-year[1]	5-year[1]	Disability status[2]	Functional impact[3]
Brain:				
Local		26	1	S
Regional		27.9	1	S
Distant		23.6	1	S

Cancer type	2-year[1]	5-year[1]	Disability status[2]	Functional impact[3]
Female Breast:				
Regional		71.1	2	S
Distant		17.8	1	S
Colon:				
Local		91	2	S
Regional		60.1	2	S
Distant		6	1	S
Rectal:				
Local		84.5	2	S
Regional		50.7	2	S
Distant		5.3	1	S
Esophagus:				
Local		18.5	1	S
Regional		5.2	1	S
Distant		1.8	1	S
Hodgkin's Disease:[4]				
Stage 1		90–95	3	S
Stage 2		86	2	S
Stage 3		<80	2	S
Stage 4		<80	1	S
Kidney/Renal Pelvis:				
Local		85.4	3	S
Regional		56.3	2	S
Distant		9	1	S
Larynx:				
Local		84.2	2	S
Regional		52.5	2	S
Distant		24	1	S
Acute Lymphocytic Leukemia:				
All		51.1	2	S
Chronic Lymphocytic Leukemia:				
All		66.2	2	S
Acute Myelogenous Leukemia:				
All		9.7	1	S
Chronic Myelogenous Leukemia:				
All		21.7	1	S
Liver/Intrahepatic Bile Duct:				
Local		15.1	1	S
Regional		5.8	1	S
Distant		1.9	1	S
Lung/Bronchus:[5]				
Local		45.6	2	S
Regional		13.1	1	S
Distant		1.3	1	S
Melanomas of Skin:				
Regional		53.6	2	S
Distant		12.8	1	S
Oral Cavity/Pharyngeal:				
Local		76.2	2	S
Regional		40.9	2	S
Distant		18.7	1	S
Pancreas:				
Local		6.1	1	S
Regional		3.7	1	S
Distant		1.4	1	S
Prostate:				
Local		91	3	S
Regional		80.4	2	S
Distant		28	1	S
Stomach:				
Local		55.4	1	S
Regional		17.3	1	S
Distant		2.1	1	S
Testicular:				
Distant		65.5	1	S
Thyroid:				
Regional		93.1	3	S
Distant		47.2	1	S
Bladder:				
Regional		46	2	S
Distant		9.1	1	S

[1]Source of 2 and 5 year survival data: Miller BA et al. Cancer Statistics Review 1973–1989. NIH Publication No. 92–2789.
[2]Disability Status:

Category 1: Significant impact on functional capacity or life span.
Category 2: Intermediate impact.
Category 3: No significant impact on functional capacity or life span.
[3]Functional Impacts:
(S) Significant—significant potential for the effects of treatment (radiotheraphy, chemotherapy. surgery) to affect functional capacity.
[4]Hodgkin's disease data presented for each stage derived from American Cancer Society. American Cancer Society Textbook reference for unstaged cancer is derived from Cancer Statistics Review (See 3). In addition to other data, see: American Cancer Society Textbook of Clinical Oncology. Eds: Holleb AI, Fink DJ, Murphy GP, Atlanta: American Cancer Society, Inc. 1991.)
[5]Small cell carcinoma is classified as a 1.

B. Endocrine

Confirmatory test	Minimum result	Requirements
BODY PART: ENDOCRINE CONFIRMATORY TESTS		
Diabetes, requiring insulin (IDDM):		
Medical record review	Confirmation of condition and need for insulin use.	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: ENDOCRINE JOB TITLE: ENGINEER		
Diabetes, requiring insulin (IDDM):		
Medical record review	Confirmation of condition and need for insulin use.	D

C. Cardiac

Confirmatory test	Minimum result	Requirements
BODY PART: CARDIAC CONFIRMATORY TESTS		
Angina:		
Medical record review	Confirmed history of ischemia including copies of electrocardiogram.	Recommended.
Stress test	Definite ischemia on exercise test	Recommended.
Thallium study	Definite ischemia with exercise	Recommended.
Aortic valve disease:		
Cardiac catheterization	Proven and significant	Recommended.
Echocardiogram	Significant valve disease	Recommended.
Coronary artery disease:		
Medical record review	Documented ischemia with electrocardiogram confirmation.	Recommended.
Medical record review	Documented myocardial infarction	Recommended.
Stress test	Positive	Recommended.
Thallium study	Definite ischemia with exercise	Recommended.
Angiography	Definite occlusion (>60%) of one vessel	Recommended.
Cardiomyopathy:		
Echocardiogram	Proven ejection fraction ≤35%	Recommended.
Catheterization	Poor global function and not coronary artery disease.	Recommended.
Hypertension:		
Medical record review	Documentation of hypertension for one year.	Highly recommended.
Medical record review	Definite diagnosis by cardiologist or internist.	Highly recommended.
Medical record review	Confirmation of medication use	Highly recommended.
Arrhythmia: heart block:		
Medical record review	Proven episode with electrocardiogram confirmation.	Recommended.
Electrocardiogram	Documentation of arrhythmia	Recommended.
Mitral valve disease:		
Cardiac catheterization	Significant valve disease	Recommended.
Echocardiogram	Significant valve disease	Recommended.
Pericardial disease:		
Medical record review	Confirmed by cardiologist or internist	Highly recommended.
Pulmonary hypertension:		
Physical examination	Increased pulmonic sound or pulmonary ejection murmur by cardiologist or internist.	Recommended.

C. Cardiac—Continued

Confirmatory test	Minimum result	Requirements
Electrocardiogram	Definite right ventricular hypertension	Highly recommended.
Ventricular ectopy:		
Medical record review	Definite episode within one year	Recommended.
Holter monitoring	Definite arrhythmia	Recommended.
Provocative testing	Positive response	Recommended.
Arrhythmia: supraventricular tachycardia:		
Medical record review	Definite episode within one year	Recommended.
Holter monitoring	Definite arrhythmia	Recommended.
Post heart transplant:		
Medical record review	Documented	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: CARDIAC JOB TITLE: TRAINMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤7 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤ 7 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤ 7 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥5 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D

Disability test	Test result	Disability classification
BODY PART: CARDIAC JOB TITLE: ENGINEER		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: DISPATCHER		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D

Disability test	Test result	Disability classification
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: CARMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤ 5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤ 5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D

Disability test	Test result	Disability classification
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: SIGNALMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤7 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infractions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤7 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤7 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥5 mm Hg	D
Cardiac catherization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D

Disability test	Test result	Disability classification
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: TRACKMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤7 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by a cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤7 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤7 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥5 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: MACHINIST		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D

Disability test	Test result	Disability classification
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: SHOP LABORER		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg.	
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D

Disability test	Test result	Disability classification
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: SALES REPRESENTATIVE		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic >120 and systolic >160, 50% of the time and evidence of end organ damage (blood creatinine >2; urinary protein >½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D

Disability test	Test result	Disability classification
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: GENERAL OFFICE CLERK		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Arrhythmia: heart block:		
Holter	Documented asystole length >1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D

D. Respiratory

Confirmatory test	Minimum result	Requirements
BODY PART: RESPIRATORY CONFIRMATORY TESTS		
Asthma:		
Spirometry	FEV1/FVC ratio diminished	Recommended.
Spirometry	>15% change with administration of bronchodilator.	Recommended.
Methacholine challenge test	Positive: FEV1 decrease >20% at (PC ≤8 mg/ml).	Recommended
Bronchiectasis:		
Medical record review	Chronic cough and sputum	Recommended.
Chest X-ray	Bronchiectasis demonstrated	Recommended.
Chest CAT scan	Bronchiectasis demonstrated	Recommended.
Chronic bronchitis:		
Medical record review	Frequent cough—2 years duration	Highly recommended.

D. Respiratory—Continued

Confirmatory test	Minimum result	Requirements
Chronic obstructive pulmonary disease:		
Spirometry	FEV1/FVC ratio below 65% when stable	Highly recommended.
Spirometry	FEV1 below 75% of predicted when stable	Highly recommended.
Cor pulmonale:		
Electrocardiogram	Definite right ventricular hypertrophy	Recommended.
Echocardiogram	Definite right ventricular hypertrophy	Recommended.
Pulmonary fibrosis:		
Lung biopsy	Diffuse fibrosis	Recommended.
Chest CAT scan	More than minimal fibrosis	Recommended.
Lung resection:		
Medical record review	At least one lobe resected	Highly recommended.
Pneumothorax:		
Medical record review	Required hospitalization with chest tube drainage.	Highly recommended.
Restrictive lung disease:		
Chest X-ray	Restrictive lung changes	Recommended.
DLCO	Abnormal	Highly recommended.
Chest CAT scan	Restrictive lung changes	Recommended.
Spirometry	FVC <75% predicted	Highly recommended.
Silicosis:		
Medical record review	Occupational exposure for at least 1 year	Highly recommended.
Tuberculosis:		
Chest X-ray	Evidence of changes consistent with tuberculosis infection.	Recommended.
Culture	Positive	Recommended.

Disability test	Test result	Disability classification
BODY PART: RESPIRATORY JOB TITLE: TRAINMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	
Bronchiectasis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D

Disability test	Test result	Disability classification
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	efinite positive right ventricular hypertrophy	D
Silicosis:		
Resting ABG	PCO2 arterial >50 mm Hg If stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: CARMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D

Disability test	Test result	Disability classification
BODY PART: RESPIRATORY JOB TITLE: SIGNALMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting AGB	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: TRACKMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D

Disability test	Test result	Disability classification
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: MACHINIST		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting AGB	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D

Disability test	Test result	Disability classification
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: SHOP LABORER		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop >5 torr at maximum exercise	D

Disability test	Test result	Disability classification
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial >50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D

E. Lumbar Sacral Spine

Confirmatory test	Minimum result	Requirements
BODY PART: LS SPINE CONFIRMATORY TESTS		
Ankylosing spondylitis:		
X-ray-lumbar sacral spine	Sacroilitis	Highly recommended.
HLA B27 (blood test)	Positive HLA B27 (90% case)	Recommended.
Backache, unspecified:		
Medical record review	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Chronic back pain, not otherwise specified:.		
Medical record review	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Cauda equina syndrome with bowel or bladder dysfunction:.		
Magnetic resonance imaging	Neural impingement of spinal nerves below L1.	Recommended.
Computerized tomography	Neural impingement of spinal nerves below L1.	Recommended.
Cystometrogram	Impaired bladder function	Recommended.
Rectal examination	Diminished rectal sphincter tone	Recommended.
Myelogram	Neural impingement of spinal nerves below L1.	Recommended.
Degeneration of lumbar disc:		
X-ray lumbar sacral spine	Significant degenerative disc changes	Recommended.
Computerized tomography	Significant degenerative disc changes	Recommended.
Magnetic resonance imaging	Significant degenerative disc changes	Recommended.
Myelogram	Significant degenerative disc changes	Recommended.
Displacement of lumbar disc:.		
X-ray-lumbar sacral spine	Significant degenerative disc changes	Recommended.
Computerized tomography	Significant degenerative disc changes	Recommended.
Magnetic resonance imaging	Significant degenerative disc changes	Recommended.
Myelogram	Significant degenerative disc changes	Recommended.
Fracture: vertebral body:.		
Magnetic resonance imaging	Fracture vertebral body	Recommended.
Computerized tomography	Fracture vertebral body	Recommended.
X-ray-lumbar sacral spine	Fracture vertebral body	ommended.
Fracture: posterior element with spinal canal displacement:		
Magnetic resonance imaging	Fracture posterior spinal element with displacement of spinal canal.	Recommended.
Computerized tomography	Fracture posterior spinal element with displacement of spinal canal.	Recommended.
X-ray-lumbar sacral spine	Fracture posterior spinal element with displacement of spinal canal.	Recommended.
Fracture: posterior spinal element with no displacement:.		
X-ray-lumbar sacral spine	Fracture posterior spinal element	Recommended.
Magnetic resonance imaging	Fracture posterior spinal element	Recommended.
Computerized tomography	Fracture posterior spinal element	Recommended.
Fracture: spinous process:		
X-ray-lumbar sacral spine	Spinous process fracture	Recommended.

E. Lumbar Sacral Spine—Continued

Confirmatory test	Minimum result	Requirements
Magnetic resonance imaging	Spinous process fracture	Recommended.
Computerized tomography	Spinous process fracture	Recommended.
Fracture: Transverse process:		
Lumbar sacral spine	Transverse process fracture	Recommended.
Magnetic resonance imaging	Transverse process fracture	Recommended.
Computerized tomography	Transverse process fracture	Recommended.
Intervertebral disc disorder:		
X-ray-lumbar sacral spine	Significant disc degeneration	Recommended.
Magnetic resonance imaging	Significant disc degeneration	Recommended.
Computerized tomography	Significant disc degeneration	Recommended.
Myelogram	Significant disc degeneration	Recommended.
Lumbago:		
Medical record review: lumbar	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Lumbosacral neuritis:		
Magnetic resonance imaging	Evidence of neural compression	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical history	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of neural compression	Recommended.
Lumbar spinal stenosis:		
Computerized tomography	Significant narrowing: spinal cord canal or intervertebral foramen.	Recommended.
Magnetic resonance imaging	Significant narrowing: spinal cord canal or intervertebral foramen.	Recommended.
Myelogram	Significant narrowing: spinal cord canal or intervertebral foramen.	Recommended.
Mechanical complication of internal orthopedic device:		
Medical record review	Documentation of failure of implant following surgical procedure.	Highly recommended.
Osteomalacia:		
X-ray-lumbar sacral spine	Evidence of significant osteomalacia	Recommended.
Magnetic resonance imaging	Evidence of significant osteomalacia	Recommended.
Computerized tomography	Evidence of significant osteomalacia	Recommended.
Osteomyelitis, chronic-lumbar:		
X-ray-lumbar sacral spine	Evidence of chronic infection	Recommended.
Magnetic resonance imaging	Evidence of chronic infection	Recommended.
Computerized tomography	Evidence of chronic infection	Recommended.
Osteoporosis:		
Computerized tomography	Significant bone density loss	Recommended.
Dual photon absorptiometry	Significant bone density loss	Recommended.
X-ray-lumbar sacral spine	Significant bone density loss	Recommended.
Post laminectomy syndrome with radiculopathy:		
Medical record review: lumbar	Documented surgical history of laminectomy.	Highly recommended.
Magnetic resonance imaging	Evidence of laminectomy	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical record review: lumbar	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of laminectomy	Recommended.
Myelogram	Evidence of laminectomy	Recommended.
Radiculopathy:		
Magnetic resonance imaging	Evidence of neural compression	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.

E. Lumbar Sacral Spine—Continued

Confirmatory test	Minimum result	Requirements
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical record review: lumbar	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of neural compression	Recommended.
Myelogram	Evidence of neural compression	Recommended.
Sciatica:		
Magnetic resonance imaging	Evidence of neural compression	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical history	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of neural compression	Recommended.
Myelogram	Evidence of neural compression	Recommended.
Strains and sprains, unspecified:		
Medical record review	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Medical record review	Documented history of strain and/or sprain	Highly recommended.
Spondylolisthesis grade 1:		
X-ray-lumbar sacral spine	1–25% slippage	Recommended.
Computerized tomography	1–25% slippage	Recommended.
Magnetic resonance imaging	1–25% slippage	Recommended.
Spondylolisthesis grade 2:		
X-ray-lumbar sacral spine	26–50% slippage	Recommended.
Computerized tomography	26–50% slippage	Recommended.
Magnetic resonance imaging	26–50% slippage	Recommended.
Spondylolisthesis grade 3:		
X-ray-lumbar sacral spine	51–75% slippage	Recommended.
Computerized tomography	51–75% slippage	Recommended.
Magnetic resonance imaging	51–75% slippage	Recommended.
Spondylolisthesis grade 4:		
X-ray-lumbar sacral spine	Complete slippage	Recommended.
Computerized tomography	Complete slippage	Recommended.
Magnetic resonance imaging	Complete slippage	Recommended.
Spondylolisthesis-acquired:		
X-ray-lumbar sacral spine	Slippage	Recommended.
Computerized tomography	Slippage	Recommended.
Magnetic resonance imaging	Slippage	Recommended.
Spondylolsis:		
X-ray-lumbar sacral spine	Defect—pars interarticularis	Recommended.
Computerized tomography	Defect—pars interarticularis	Recommended.
Magnetic resonance imaging	Defect—pars interarticularis	Recommended.
Sprains and strains, sacral:		
Medical record review: lumbar	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back with functional limitations for at least 1 year.	Highly recommended.
Medical record review: lumbar	Documented history of strain and/or sprain	Highly recommended.
Sprains and strains, sacroiliac:		
Medical record review: lumbar	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Medical record review: lumbar	Documented history of strain and/or sprain	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: LS SPINE JOB TITLE: TRAINMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves < L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves < L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D

Disability test	Test result	Disability classification
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis—acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
BODY PART: LS SPINE JOB TITLE: ENGINEER		
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
BODY PART: LS SPINE JOB TITLE: CARMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D

Disability test	Test result	Disability classification
Cystometrogram	Impaired bladder function	D
Myeolgram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D

Disability test	Test result	Disability classification
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminshed by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminshed by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminshed by 50%	D
BODY PART: LS SPINE JOB TITLE: SIGNALMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifing capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
BODY PART: LS SPINE JOB TITLE: TRACKMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifing capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physcial examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vetebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	

BODY PART: LS SPINE
JOB TITLE: MACHINIST

Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D

Disability test	Test result	Disability classification
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D

Disability test	Test result	Disability classification
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade I:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
BODY PART: LS SPINE JOB TITLE: SHOP LABORER		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumber disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

F. Cervical Spine

Confirmatory test	Minimum result	Requirements
BODY PART: CE SPINE CONFIRMATORY TESTS		
Cervical disc disease with myelopathy:		
Physical examination: cervical	Evidence of myelopathy	Highly recommended.
Myelogram	Evidence of neurogenic compression	Recommended.
Computerized axial tomography	Evidence of neurogenic compression	Recommended.
Magnetic resonance imaging	Evidence of neurogenic compression	Recommended.
Chronic herniated disc:		
X-ray: cervical spine	Evidence of significant disc degeneration	Recommended.
Myelogram	Evidence of significant disc degeneration	Recommended.
Computerized axial tomography	Evidence of significant disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of significant disc degeneration	Recommended.
Cervical spondylolysis:		
X-ray: cervical spine	Evidence of significant disc degeneration	Recommended.
Computerized axial tomography	Evidence of significant disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of significant disc degeneration	Recommended.
Cervical intervertebral disc degeneration:		
X-ray: cervical spine	Evidence of significant disc degeneration	Recommended.
Myelogram	Evidence of significant disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of significant disc degeneration	Recommended.
Fracture: posterior element with spinal canal displacement:		
X-ray: cervical spine	Fractured posterior element with canal displacement.	Recommended.
Computerized axial tomography	Fractured posterior element with canal displacement.	Recommended.
Magnetic resonance imaging	Fractured posterior element with canal displacement.	Recommended.
Fracture: transverse, spinous or posterior process:		
X-ray: cervical spine	Fracture of relevant part	Recommended.
Computerized axial tomography	Fracture of relevant part	Recommended.
Magnetic resonance imaging	Fracture of relevant part	Recommended.
Osteoarthritis, cervical:		
X-ray: cervical spine	Evidence of extensive disc degeneration	Recommended.
Computerized axial tomography	Evidence of extensive disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of extensive disc degeneration	Recommended.
Post laminectomy syndrome:		
Medical records: cervical	Confirmed surgical history	Highly recommended.
Medical records: cervical	Continued pain post-surgery	Highly recommended.
Radiculopathy:		
Medical records: cervical	History of radicular pain	Highly recommended.
Physical examination: arm	Loss of reflexes in affected dermatomes	Recommended.
Physical examination: arm	Evidence of atrophy >2 cm	Recommended.
Electromyography	Definite denervation in muscle of affected nerve root.	Recommended.
Myelogram	Evidence of neurogenic compression	Recommended.
Magnetic resonance imaging	Compression of spinal nerves	Recommended.
Computerized axial tomography	Compression of spinal nerves	Recommended.
Rheumatoid arthritis, cervical:		
Rheumatoid factor (blood test)	Titer of rheumatoid factor	Recommended.
X-ray: cervical spine	Rheumatoid changes of spine	Highly recommended.
Medical records review: cervical	Confirmation by rheumatologist or internist	Highly recommended.
Spondylogenic compression of spinal cord:		
Physical examination: cervical	Evidence of myelopathy	Highly recommended.
Computerized axial tomography	Evidence of neurogenic compression	Recommended.
Magnetic resonance imaging	Evidence of neurogenic compression	Recommended.
Myelogram	Evidence of neurogenic compression	Recommended.

Disability test	Test result	Disability classification
BODY PART: CE SPINE JOB TITLE: TRAINMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	

Disability test	Test result	Disability classification
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: ENGINEER		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination:	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: DISPATCHER		
Cervical disc disease with myelopathy:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Spondylogenic compression of spinal cord:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D

Disability test	Test result	Disability classification
BODY PART: CE SPINE JOB TITLE: CARMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART; CE SPINE JOB TITLE: SIGNALMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: TRACKMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D

Disability test	Test result	Disability classification
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondyloysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: MACHINIST		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: SHOP LABORER		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D

Disability test	Test result	Disability classification
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: SALES REPRESENTATIVE		
Cervical disc disease with myelopathy:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Spondylogenic compression of spinal cord:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
BODY PART: CE SPINE JOB TITLE: GENERAL OFFICE CLERK		
Cervical disc disease with myelopathy:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Spondylogenic compression of spinal cord:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D

G. Shoulder and Elbow

Confirmatory test	Minimum result	Requirements.
BODY PART: SHOULDER AND ELBOW CONFIRMATORY TESTS		
Arthritis, acromioclavicular:		
X-ray: shoulder	Significant degenerative changes of joint	Recommended.
Computerized tomography	Significant degenerative changes of joint	Recommended.
Magnetic resonance imaging	Significant degenerative changes of joint	Recommended.
Arthritis, glenohumeral:		
X-ray: shoulder	Significant degenerative changes of joint	Recommended.
Computerized tomography	Significant degenerative changes of joint	Recommended.
Magnetic resonance imaging	Significant degenerative changes of joint	Recommended.
Rotator cuff tear:		
Computerized tomography	Tear of rotator cuff	Recommended.
Magnetic resonance imaging	Tear of rotator cuff	Recommended.
Medical diagnosis leading to a permanent functional limitation of the elbow:		
Medical record review	Condition with permanent functional limitation.	Highly recommended.
X-ray: elbow	Imaging confirmation of functional diagnosis.	Recommended.
Magnetic resonance imaging	Imaging confirmation of functional diagnosis.	Recommended.

Disability test	Test result	Disability classification
BODY PART: SHOULDER AND ELBOW JOB TITLE: TRAINMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	>40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: ENGINEER		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of moiton	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	>40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: CARMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	>40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: SIGNALMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	>40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: TRACKMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D

Disability test	Test result	Disability classification
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	>40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: MACHINIST		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	>40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: SHOP LABORER		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	>40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D

H. Hand and Arm

Confirmatory test	Minimum result	Requirements
BODY PART: HAND AND ARM CONFIRMATORY TESTS		
Carpal tunnel syndrome:		
Medical record review	Pain, paresthesia and weakness in distribution median nerve.	Highly recommended.
Nerve conduction testing	Definite median nerve conduction slowing at wrist.	Highly recommended.
Electromyography	Denervation in severe cases	Recommended.
Fracture: wrist:		
X-ray: wrist	Evidence of fracture	Highly recommended.
Hand: permanent functional limitation:		
Medical record review	Documentation of medical condition for permanent limitation.	Highly recommended.
Physical examination	Definite reproducible evidence of limitation	Highly recommended.
Imaging study (e.g. X-ray, CAT, MRI)	Positive confirmation of underlying condition.	Highly recommended.
Rheumatoid arthritis: hand:		
Rheumatoid factor	Titer of rheumatoid factor	Recommended.
Medical record review	History of objective findings including serological studies.	Highly recommended.
X-ray: hand	Characteristic rheumatoid changes	Highly recommended.
Tenosynovitis:		
Medical record review	History of chronic tenosynovitis and objective findings.	Highly recommended.
Physical examination	Definite evidence of tenosynovitis	Highly recommended.
Thumb: Permanent functional limitation:		
Medical record review	Documentation of medical condition for permanent limitation.	Highly recommended.
Physical examination	Definite reproducible evidence of limitation	Highly recommended.
Imaging study (X-ray, CAT, MRI)	Positive confirmation of underlying condition.	Highly recommended.

H. Hand and Arm—Continued

Confirmatory test	Minimum result	Requirements
Wrist: Permanent functional limitation:		
Medical record review	Documentation of medical condition for permanent limitation.	Highly recommended.
Physical examination	Definite reproducible evidence of limitation	Highly recommended.
Imaging study (e.g. X-ray, CAT, MRI)	Positive confirmation of underlying condition.	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: HAND AND ARM JOB TITLE: TRAINMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE ENGINEER		
Fracture, wrist:		
Physical examination—range of motion	Extension-limit to 30 degrees	D
Physical examination—range of motion	Flexion-limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: DISPATCHER		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D

Disability test	Test result	Disability classification
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: CARMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb:	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP of PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: SIGNALMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: TRACKMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D

Disability test	Test result	Disability classification
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: MACHINIST		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: SHOP LABORER		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: SALES REPRESENTATIVE		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D

Disability test	Test result	Disability classification
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: GENERAL OFFICE CLERK		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degree extension	D
Ankylosis: degree from neutral	<40 degree flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: >20 degrees from neutral	D

I. Hip

Confirmatory test	Minimum result	Requirements
BODY PART: HIP CONFIRMATORY TESTS		
Ankylosis, hip:		
X-ray: hip	Extreme joint destruction	Highly Recommended.
Physical examination—range of motion	No mobility	Highly Recommended.
Osteoarthritis, hip:		
X-ray: hip	<4 mm joint space, or other positive evidence.	Recommended.
Magnetic resonance imaging	<4 mm joint space, or other positive evidence.	Recommended.
Computerized axial tomography	<4 mm joint space, or other positive evidence.	Recommended.
Osteomyelitis, hip:		
X-ray: hip	Evidence of chronic infection	Recommended.
Computerized axial tomography	Evidence of chronic infection	Recommended.
Paget's disease:		
X-ray: hip	Osteolytic or blastic lesions	Highly Recommended.
Alkaline phosphatase	Increased up to 50 times	Highly Recommended.
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip	Recommended.
Medical record review	Documentation of prior hip replacement	Recommended.

Disability test	Test result	Disability classification
BODY PART: HIP JOB TITLE: TRAINMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or >flexion	D
Physical examination—range of motion	Ankylosis internal rotation >5 degrees	D
Physical examination—range of motion	Ankylosis external rotation >10 degrees	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Ankylosis in abduction >5 degrees	D
Physical examination—range of motion	Ankylosis in adduction >5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: ENGINEER		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or >flexion	D
Physical examination—range of motion	Ankylosis internal rotation >5 degrees	D
Physical examination—range of motion	Ankylosis external rotation >10 degrees	D
Physical examination—range of motion	Ankylosis in abduction >5 degrees	D
Physical examination—range of motion	Ankylosis in adduction >5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Signficant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: CARMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or >flexion	D
Physical examination—range of motion	Ankylosis internal rotation >5 degrees	D
Physical examination—range of motion	Ankylosis external rotation >10 degrees	D
Physical examination—range of motion	Ankylosis in abduction >5 degrees	D
Physical examination—range of motion	Ankylosis in adduction >5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D

Disability test	Test result	Disability classification
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: SIGNALMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or >flexion	D
Physical examination—range of motion	Ankylosis internal rotation >5 degrees	D
Physical examination—range of motion	Ankylosis external rotation >10 degrees	D
Physical examination—range of motion	Ankylosis in abduction >5 degrees	D
Physical examination—range of motion	Ankylosis in adduction >5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: TRACKMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or >flexion	D
Physical examination—range of motion	Ankylosis internal rotation >5 degrees	D
Physical examination—range of motion	Ankylosis external rotation >10 degrees	D
Physical examination—range of motion	Ankylosis in abduction >5 degrees	D
Physical examination—range of motion	Ankylosis in adduction >5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: MACHINIST		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or >flexion	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Ankylosis internal rotation >5 degrees	D
Physical examination—range of motion	Ankylosis external rotation >10 degrees	D
Physical examination—range of motion	Ankylosis in abduction >5 degrees	D
Physical examination—range of motion	Ankylosis in adduction >5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abudction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: SHOP LABORER		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees of >flexion	D
Physical examination—range of motion	Ankylosis internal rotation >5 degrees	D
Physical examination—range of motion	Ankylosis external rotation >10 degrees	D
Physical examination—range of motion	Ankylosis in abduction >5 degrees	D
Physical examination—range of motion	Ankylosis in adduction >5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray; hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D

J. Knee

Confirmatory test	Minimum result	Requirements
BODY PART: KNEE CONFIRMATORY TESTS		
Arthritis: knee:		
X-ray: knee	Evidence of significant degenerative changes.	Recommended.
Collateral ligament tear with laxity:		
Physical examination: knee	Evidence of ligamentous laxity	Highly Recommended.
Magnetic resonance imaging	Evidence of ligamentous tear	Recommended.
Cruciate and collateral ligament tear with laxity:		
Magnetic resonance imaging	Tear of both ligaments	Recommended.
Physical examination	Evidence of ligamentous laxity	Highly Recommended.
Medical record review	Documentation of tear by arthroscopy	Recommended.

J. Knee—Continued

Confirmatory test	Minimum result	Requirements
Cruciate ligament tear with laxity:		
Physical examination: knee	Evidence of ligamentous laxity	Highly Recommended.
Magnetic resonance imaging	Evidence of cruciate tear	Recommended.
Medical record review	Documentation of tear by arthroscopy	Recommended.
Intercondylar fracture:		
X-ray: knee	Evidence of fracture	Highly Recommended.
Osteomyelitis: knee:		
Medical record review	Documented history of osteomyelitis requiring treatment.	Highly Recommended.
X-ray: knee	Evidence of chronic infection	Recommended.
Computerized tomography	Evidence of chronic infection	Recommended.
Magnetic resonance imaging	Evidence of chronic infection	Recommended.
Osteonecrosis:		
X-ray: knee	Necrosis of femoral condyle or tibial plateau.	Recommended.
Computerized tomography	Necrosis of femoral condyle or tibial plateau.	Recommended.
Magnetic resonance imaging	Necrosis of femoral condyle or tibial plateau.	Recommended.
Patellofemoral arthritis:		
X-ray: knee	Evidence of arthritis	Recommended.
Magnetic resonance imaging	Evidence of arthritis	Recommended.
Physical examination	Crepitation with movement	Highly Recommended.
Patellar fracture nonunion with displacement:		
X-ray: knee	Nonunion and displacement	Recommended.
Magnetic resonance imaging	Nonunion and displacement	Recommended.
Computerized tomography	Nonunion and displacement	Recommended.
Plateau fracture:		
X-ray: knee	Evidence of fracture	Recommended.
Computerized tomography	Evidence of fracture	Recommended.
Magnetic resonance imaging	Evidence of fracture	Recommended.
Meniscectomy—medial or lateral:		
Medical record review	History of surgery	Highly Recommended.
Patellectomy:		
Physical examination: knee	Absent patella	Highly Recommended.
Patellar—subluxation—recurrent:		
Medical record review	History of recurrent subluxation	Highly Recommended.
Supracondylar fracture:		
X-ray: knee	Evidence of fracture	Recommended.
Magnetic resonance imaging	Evidence of fracture	Recommended.
Computerized tomography	Evidence of fracture	Recommended.
Total knee replacement:		
X-ray: knee	Presence of replacement knee	Recommended.
Medical record review	Documented surgical history	Recommended.
Tibial shaft fracture:		
X-ray: leg	Fracture of shaft	Recommended.
Magnetic resonance imaging	Evidence of fracture	Recommended.
Computerized tomography	Evidence of fracture	Recommended.

Disability test	Test result	Disability classification
BODY PART: KNEE JOB TITLE: TRAINMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or >degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D

Disability test	Test result	Disability classification
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Intercondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
X-ray knee	Nonunion and >3 mm displacement	D
Plateau fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Supracondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Post fracture angulation	>20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: ENGINEER		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Intercondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
X-ray knee	Nonunion and >3 mm displacement	D
Plateau fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Supracondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Post fracture angulation	>20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: CARMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D

Disability test	Test result	Disability classification
Intercondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
X-ray knee	Nonunion and >3 mm displacement	D
Plateau fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Supracondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Post fracture angulation	>20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: SIGNALMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Intercondylar fracture:		
Post fracture angulation	>20 degrees angulation	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
X-ray knee	Nonunion and >3 mm displacement	D
Plateau fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Supracondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Post fracture angulation	>20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: TRACKMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Intercondylar fracture:		
Post fracture angulation	>20 degree angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
X-ray knee	Nonunion and >3 mm displacement	D
Plateau fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Supracondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Post fracture angulation	>20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: MACHINIST		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Intercondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D

Disability test	Test result	Disability classification
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
X-ray knee	Nonunion and >3 mm displacement	D
Plateau fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Supracondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Post fracture angulation	>20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: SHOP LABORER		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Intercondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patellofemoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
X-ray knee	Nonunion and >3 mm displacement	D
Plateau fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Supracondylar fracture:		
Post fracture angulation	>20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or > degrees)	D
Post fracture angulation	>20 degrees malalignment	D

K. Ankle and Foot

Confirmatory test	Minimum result	Requirements
BODY PART: ANKLE AND FOOT CONFIRMATORY TESTS		
Ankle fracture:		
Medical record review	Documented history of ankle fracture	Recommended.
X-ray: ankle	Ankle fracture	Highly recommended.
Ankylosis, ankle:		
X-ray: ankle	Extensive joint destruction	Highly recommended.
Physical examination	No mobility	Highly recommended.
Arthritis, subtalar joint:		
X-ray: ankle	Evidence of significant arthritis: subtalar joint.	Highly recommended.
Arthritis, talonavicular joint:		
X-ray: ankle	Significant arthritis: talonavicular joint	Highly recommended.
Achilles tendon rupture:		
Medical record review	Documentation of achilles tendon rupture	Highly recommended.
Physical examination	Rupture of achilles tendon	Highly recommended.
Arthritis, ankle:		
X-ray: ankle	Significant arthritis	Highly recommended.
Hindfoot fracture:		
X-ray: foot and ankle	Documentation of fracture	Highly recommended.
Rheumatoid arthritis, foot:		
Medical History	Documented history of condition	Highly recommended.
X-ray: foot	Significant arthritis	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: ANKLE AND FOOT JOB TITLE: TRAINMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity >15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation >15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity >15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability, <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture, 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability, <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture, 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot)	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: ENGINEER		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity >15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or > dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation >15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity >15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot)	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: DISPATCHER		
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot)	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: CARMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity >15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or > dorisiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylois in int or ext malrotation >15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	0
Physical examination	Varus deformity >15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D

Disability test	Test result	Disability classification
Physical examination	Varus angulation >20 degrees (hindfoot)	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare—up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: SIGNALMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity >15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or > dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation >15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity >15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot)	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: TRACKMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination—range of motion	Varus deformity >15 degrees	D
Physical examination—range of motion	Plantar flexion capability ≤5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or > dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation >15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: angle—talonavicular joint	Talonavicular joint space 0 mm	D

Disability test	Test result	Disability classification
Physical examination	Varus deformity >15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot)	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: MACHINIST		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity >15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or > dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation >15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity >15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot)	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: SHOP LABORER		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity >15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or > dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Ankylosis in int or ext malrotation >15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity >15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot) ...	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D

Disability test	Test result	Disability classification
BODY PART: ANKLE AND FOOT JOB TITLE: SALES REPRESENTATIVES		
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity >15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation >20 degrees (hindfoot) ...	D
Physical examination	Valgus angulation >20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D

JOB INFORMATION FORMS

Form Approved
OMB No. 3220-0193

JOB INFORMATION FORM

RRB Claim Number
Employee's Name
Date Released
Regular Railroad Occupation*
Location
Date Last Worked

* The regular railroad occupation is: 1) the occupation in which the employee has been engaged for more calendar months than any other occupation during the last preceding 5 calendar years, whether consecutive or not; or 2) the occupation which the employee has been in service for not less than one-half of all months in which the employee has been engaged in service during the last 15 consecutive calendar years; or 3) if an employee last worked as an officer or employee of a railway labor organization and if that employment is no longer available, the regular occupation shall be the position to which the employee holds seniority rights or the position left to work for the railway labor organization.

The above-named railroad employee has applied for an occupational disability benefit under section 2(a)(iv) of the Railroad Retirement Act. Railroad Retirement Board (RRB) regulation 20 CFR 220.13 (b)(2) provides that railroad employers may furnish pertinent information concerning the job duties the employee is required to perform. If you wish to provide job duty information on the above-named employee, it must be received by the RRB no later than _____.

EMPLOYER INFORMATION

The attached list of job duties indicate those duties generally performed by the employee.

Please provide any additional information on the duties the employee performed over the last 5 years, or 15 years if appropriate.

This information can be entered in the Remarks section or attached to this form.

G-251a(12-97)

Job information should be sent to:

U.S. RAILROAD RETIREMENT BOARD
844 NORTH RUSH STREET
CHICAGO, ILLINOIS 60611-2092
ATTENTION: DISABILITY PROGRAMS SECTION

or a facsimile may be sent to (312)751-7167.

Employer Certification - The information contained in this report is correct to the best of my knowledge and belief.

NAME _____ SIGNATURE _____
(Please Print)
TITLE _____ DATE ____/____/____
(Please Print)
TELEPHONE NO (____) _____

Remarks:

Paperwork Reduction Act Notice

Section 7 (b)(6) of the Railroad Retirement Act (RRA) allows the Railroad Retirement Board (RRB) to collect this information. While you are not required to respond, the information you provide will be used by the RRB in determining an applicant's eligibility for an occupational disability under the RRA.

We estimate that this form takes an average of 20 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. *Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number.* If you wish, send comments regarding the accuracy of our estimate or any other aspects of this form, including suggestions for reducing the completion time to: Chief of Information Management, Railroad Retirement Board, 844 North Rush Street, Chicago, IL 60611-2092 and to the Office of Management and Budget, Paperwork Reduction Project (3220-0193), Washington DC 20503. Please do **not** return this form to either of these addresses.

G-251a (12-97)

Form Approved
OMB No. 3220-0193

JOB INFORMATION FORM

RRB Claim Number
Employee's Name
Date Released
Regular Railroad Occupation*
Location
Date Last Worked

* The regular railroad occupation is: 1) the occupation in which the employee has been engaged for more calendar months than any other occupation during the last preceding five calendar years, whether consecutive or not; or 2) the occupation which the employee has been in service for not less than one-half of all months in which the employee has been engaged in service during the last 15 consecutive calendar years; or 3) if an employee last worked as an officer or employee of a railway labor organization and if that employment is no longer available, the regular occupation shall be the position to which the employee holds seniority rights or the position left to work for the railway labor organization.

The above-named railroad employee has applied for an occupational disability benefit under section 2(a)(iv) of the Railroad Retirement Act. Railroad Retirement Board (RRB) regulation 20 CFR 220.13 (b)(2) provides that railroad employers may furnish pertinent information concerning the job duties the employee is required to perform. If you wish to provide job duty information on the above-named employee, it must be received by the RRB no later than _____.

EMPLOYER INFORMATION

You may wish to provide the RRB with job duty information. If so, the job information that is needed for a disability decision should include a full description of the basic duties to perform the occupation listed. For example, list the types of machinery, tools and/or equipment used, technical knowledge or skills involved, and number of people supervised. Also include the types of physical activities involved in a typical 8 hour work day, such as how many hours of walking, standing or sitting, what items are lifted and carried and how much these items weigh, and how often bending, crouching, kneeling, reaching and climbing are performed. If exposure to environmental hazards, such as working at heights or around dangerous machinery, in extreme temperatures or excessive noise are present, also list these.

G-251b(12-97)

This information can be entered in the Remarks section or attached to this form.

Job information should be sent to:

U.S. RAILROAD RETIREMENT BOARD
844 NORTH RUSH STREET
CHICAGO, ILLINOIS 60611-2092
ATTENTION: DISABILITY PROGRAMS SECTION

or a facsimile may be sent to (312)751-7167.

Employer Certification - The information contained in this report is correct to the best of my knowledge and belief.

NAME _____ SIGNATURE _____
(Please Print)
TITLE _____ DATE ____/____/____
(Please Print)
TELEPHONE NO (____)_____

Remarks:

Paperwork Reduction Act Notice

Section 7 (b)(6) of the Railroad Retirement Act (RRA) allows the Railroad Retirement Board (RRB) to collect this information. While you are not required to respond, the information you provide will be used by the RRB in determining an applicant's eligibility for an occupational disability under the RRA.

We estimate that this form takes an average of 20 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. *Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number.* If you wish, send comments regarding the accuracy of our estimate or any other aspects of this form, including suggestions for reducing the completion time to: Chief of Information Management, Railroad Retirement Board, 844 North Rush Street, Chicago, IL 60611-2092 and to the Office of Management and Budget, Paperwork Reduction Project (3220-0193), Washington DC 20503. Please do **not** return this form to either of these addresses.

G-251b (12-97)

[63 FR 7543, Feb. 13, 1998]

PART 221—JURISDICTION DETERMINATIONS

Sec.
221.1 Introduction.
221.2 Railroad Retirement Board jurisdiction.
221.3 Social Security Administration jurisdiction.
221.4 When a jurisdiction decision may be reversed.

AUTHORITY: Sec. 7(b)(1), Pub. L. 94–547 (45 U.S.C. 231f(b)(1)).

SOURCE: 47 FR 7656, Feb. 22, 1982, unless otherwise noted.

§ 221.1 Introduction.

This part explains the factors involved in deciding whether the Social

Security Administration or the Railroad Retirement Board will pay benefits to a railroad employee, and his or her eligible family members, both before and after the employee's death. The agency that has jurisdiction over the payment of benefits also has jurisdiction of the applicant's medicare coverage (see part 270 of this chapter). The Board is responsible for making this decision.

§ 221.2 Railroad Retirement Board jurisdiction.

(a) *Life cases.* The Board has jurisdiction to pay monthly benefits to each living employee who has completed at least ten years (120 months) of creditable service under the Railroad Retirement Act, and to his or her eligible spouse. Creditable service is described in part 220 of this chapter.

(b) *Death cases.* The Board has jurisdiction to pay monthly benefits or lump-sum death benefits to eligible survivors of a deceased employee, when the deceased employee has at least ten years (120 months) of service that is creditable under the Railroad Retirement Act and a current connection as described in part 216 of this chapter. Lump-sum death benefits are described in part 234 of this chapter. The Board also has jurisdiction to pay any residual benefits that may become payable at the death of an employee. Residual benefits are described in part 234 of this chapter. The Board retains jurisdiction to pay any residual that may be payable even after jurisdiction has been transferred to the Social Security Administration as described in § 221.3.

§ 221.3 Social Security Administration jurisdiction.

The Board transfers jurisdiction (railroad service and compensation credits earned by the employee which the Social Security Administration considers in determining benefits payable) to the Social Security Administration when—

(a) *Life and death cases.* A living or deceased employee has less than 120 months of service that is creditable under the Railroad Retirement Act; or

(b) *Death cases.* A deceased employee has at least 120 months of service that is creditable under the Railroad Retirement Act (see part 220 of this chapter) but does not have a current connection with the railroad industry as described in part 216 of this chapter.

§ 221.4 When a jurisdiction decision may be reversed.

The Board may reverse a jurisdiction decision whenever evidence is received by the Board indicating that the original decision was incorrect.

PART 222—FAMILY RELATIONSHIPS

Subpart A—General

Sec.

222.1 Introduction.
222.2 Definitions.
222.3 Other regulations related to this part.
222.4 Homicide of employee.

Subpart B—Relationship as Wife, Husband, or Widow(er)

222.10 When determinations of relationship as wife, husband, widow or widower of employee are made.
222.11 Determination of marriage relationship.
222.12 Ceremonial marriage relationship.
222.13 Common-law marriage relationship.
222.14 Deemed marriage relationship.
222.15 When spouse is living with employee.
222.16 When spouse is living in the same household with employee.
222.17 ''Child in care'' when child of the employee is living with the claimant.
222.18 ''Child in care'' when child of the employee is not living with the claimant.

Subpart C—Relationship as Divorced Spouse, Surviving Divorced Spouse, or Remarried Widow(er)

222.20 When determination of relationship as divorced spouse, surviving divorced spouse, or remarried widow(er) is made.
222.21 When marriage is terminated by final divorce.
222.22 Relationship as divorced spouse.
222.23 Relationship as surviving divorced spouse.
222.24 Relationship as remarried widow(er).

Subpart D—Relationship as Child

222.30 When determinations of relationship as child are made.
222.31 Relationship as child for annuity and lump-sum payment purposes.
222.32 Relationship as a natural child.
222.33 Relationship resulting from legal adoption.

222.34 Relationship resulting from equitable adoption.
222.35 Relationship as stepchild.
222.36 Relationship as grandchild or stepgrandchild.

Subpart E—Relationship as Parent, Grandchild, Brother or Sister

222.40 When determinations of relationship are made for parent, grandchild, brother or sister.
222.41 Determination of relationship and support for parent.
222.42 When employee is contributing to support.
222.43 How the one-half support determination is made.
222.44 Other relationship determinations for lump-sum payments.

Subpart F—Child Support and Dependency

222.50 When child dependency determinations are made.
222.51 When a natural child is dependent.
222.52 When a legally adopted child is dependent—general.
222.53 When a legally adopted child is dependent—child adopted after entitlement.
222.54 [Reserved]
222.55 When a stepchild is dependent.
222.56 When a grandchild or stepgrandchild is dependent.
222.57 When an equitably adopted child is dependent.
222.58 When a child is living with an employee.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 54 FR 42949, Oct. 19, 1989, unless otherwise noted.

Subpart A—General

§ 222.1 Introduction.

This part sets forth and describes the family relationships that may make a claimant eligible for an annuity or lump-sum payment under the Railroad Retirement Act and furnishes the basic rules for determining when those relationships exist. Such relationships may result from a current or terminated marriage or through birth, death or adoption. Other relevant relationships are having a child in care, dependency or lack of it, contributing to support, living in the same household, and being under court order to contribute to support.

§ 222.2 Definitions.

As used in this part—

Annuity means a payment under the Railroad Retirement Act due to an entitlement claimant for a calendar month and made to him or her on the first day of the following month.

Apply means to sign a form or statement that the Railroad Retirement Board accepts as an application for an annuity or lump-sum payment under the rules set out in part 217 of this chapter.

Child has differing definitions for annuity and lump-sum payment purposes. See § 222.31.

Claimant means a person who files an application for an annuity or lump-sum payment or for whom an application is filed.

Eligible means that a person would meet all the requirements for payment of an annuity or lump-sum payment as of a given date but has not yet applied therefor.

Employee means an employee as defined in part 203 of this chapter.

Final divorce means a divorce that completely dissolves a marriage and restores the parties to the status of single persons; it is also referred to as an absolute divorce.

Finally divorced person means a person whose marriage has been terminated or dissolved by a final divorce.

Legal impediment means that there was a defect in the procedures followed in a marriage ceremony or that a previous marriage of the employee or spouse had not ended at the time of the ceremony.

Lump-sum payment means any of the following payments under the Railroad Retirement Act: lump-sum death payment, residual lump-sum, annuities due but unpaid at death, or lump-sum refund payment (see part 234 of this chapter).

Marriage means the social and legal relationship of husband and wife for family relationship purposes, as well as the act by which the married state is effected.

Permanent home means the employee's true and fixed home (legal domicile); it is the place to which the employee intends to return whenever he or she is absent therefrom.

Relationship means a family connection by blood, marriage, or adoption between the employee and another person who is a claimant.

Spouse means the husband or wife of the employee.

State law means the law of the State in which the employee has his or her permanent home or, in the case of a deceased employee, the law of the State in which the employee had his or her permanent home at the time of his or her death. If the employee's permanent home is not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa, the laws of the District of Columbia are applied.

§ 222.3 Other regulations related to this part.

This part is related to a number of other parts of this chapter:

Part 216 describes when a person is eligible for an annuity under the Railroad Retirement Act.

Part 217 describes how to apply for an annuity or for lump-sum payments.

Part 218 sets forth the beginning and ending dates of annuities.

Part 219 sets out what evidence is necessary to prove eligibility and the relationships described in this part.

Part 220 describes when a person is eligible for a disability annuity under the Railroad Retirement Act or a period of disability under the Social Security Act.

Part 225 explains how primary insurance amounts (PIA's) are computed.

Part 226 outlines the computation of employee and spouse annuities.

Part 228 describes how survivor annuities are computed.

Part 229 describes when and how an employee and spouse annuity may be increased under the social security overall minimum provision.

Part 234 describes lump-sum payments under the Railroad Retirement Act.

§ 222.4 Homicide of employee.

No person convicted of the felonious and intentional homicide of an employee can be entitled to an annuity or lump-sum payment based on the employee's earnings record (service and compensation). Further, the convicted person is considered not to exist in deciding the rights of other persons to annuity or lump-sum payments. A minor may be denied a survivor annuity or lump-sum payment on the earnings record of a parent if the minor was convicted of intentionally causing the parent's death by an act which would be considered a felony if committed by an adult.

Subpart B—Relationship as Wife, Husband, or Widow(er)

§ 222.10 When determinations of relationship as wife, husband, widow or widower of employee are made.

(a) The claimant's relationship as the wife or husband of an employee is determined when the claimant applies for an annuity, or when there is a claim which would include a husband or wife in the computation of the social security overall minimum provision, or when a claim is filed for a lump-sum payment. If a deemed marriage (see § 222.14) is to be determined, the husband, wife, or widow(er) must also be found to be or to have been living in the same household as the employee (see § 222.16).

(b) The claimant's relationship as the widow(er) of an employee is determined as of the date on which the employee died. If the claimant applied for a lump-sum payment as the widow(er) of the employee, one of the following determinations is made:

(1) Whether the widow(er) was living in the same household as the employee, as defined in § 222.16 of this part, at the time of the employee's death, if the claimant is applying for the 1974 Act lump-sum death payment.

(2) Whether the widow(er) was living with the employee, as defined in § 222.15 of this part, at the time of the employee's death, if the claimant is applying for the 1937 Act lump-sum death payment, annuities due but unpaid at death, the residual lump-sum payment, or a lump-sum refund payment.

(c) In order for a claimant who has applied for a monthly survivor annuity to establish a deemed marriage, the claimant must have been living in the same household as the employee at the time of the employee's death (see § 222.16).

(d) If the husband, wife, widow(er), remarried widow(er), or surviving divorced spouse of the employee is a claimant for a monthly annuity on a basis other than age or disability, a child-in-care determination is required (see §§ 222.17 and 222.18).

§ 222.11 Determination of marriage relationship.

A claimant will be considered to be the husband, wife, or widow(er) of an employee if the law of the State in which the employee has or had a permanent home would recognize that the claimant and employee were validly married, or if a deemed marriage is established.

(a) Generally, State courts will find that a claimant and employee were validly married if—

(1) The employee and claimant were married in a civil or religious ceremony (see § 222.12) or

(2) The employee and claimant live together in a common-law marriage relationship which is recognized under applicable State law (see § 222.13), and no impediment to the marriage existed at the time it took place.

(b) A deemed marriage relationship may be established as described in § 222.14.

§ 222.12 Ceremonial marriage relationship.

A valid ceremonial marriage is one which would be recognized as valid by the courts of the State in which the marriage ceremony took place. Generally, State law provides various procedures which must be followed, such as designation of who may perform the marriage ceremony, what licenses or witnesses are required, and similar rules. A ceremonial marriage may be a civil or religious ceremony, or a ceremony which follows tribal customs, Chinese customs, or similar traditional procedures.

§ 222.13 Common-law marriage relationship.

Under the laws of some States, a common-law marriage is one which is not solemnized in a formal ceremony, but is generally evidenced by a consummated agreement to marry between two persons legally capable of making a marriage contract, followed by cohabitation. The laws of the various States which recognize common-law marriage delineate specific factors which must be present in order to establish a valid common-law marriage in those States.

§ 222.14 Deemed marriage relationship.

If a ceremonial or common-law marriage relationship cannot be established under State law, a claimant may still be found to have the relationship as spouse of an employee based upon a deemed marriage. A claimant is deemed to be the wife, husband, or widow(er) of the employee if the person's marriage to the employee would have been valid under State law except for a legal impediment, and all of the following requirements are met:

(a) The claimant married the employee in a civil or religious ceremony.

(b) The claimant went through the marriage ceremony in good faith. Good faith means that at the time of the ceremony the claimant did not know that a legal impediment existed, or if the claimant did know, he or she thought that it would not prevent a valid marriage.

(c) The claimant was living in the same household as the employee (see § 222.16) when he or she applied for the spouse annuity or when the employee died.

[54 FR 42949, Oct. 19, 1989, as amended at 65 FR 20726, Apr. 18, 2000]

§ 222.15 When spouse is living with employee.

A spouse, or widow(er) is living with the employee if—

(a) He or she and the employee are living in the same household; or

(b) The employee is contributing to the support of the spouse or widow(er); or

(c) The employee is under court order to contribute to the support of the spouse or widow(er).

§ 222.16 When spouse is living in the same household with employee.

(a) Living in the same household means that the employee and spouse customarily live together as a married couple in the same residence.

(b) The employee and spouse are also considered members of the same household when they live apart but expect to resume or continue living together after a temporary separation.

(c) If the employee and spouse were separated solely for medical reasons, the Board will consider them ''living in the same household'' even if the separation was likely to be permanent.

§ 222.17 "Child in care" when child of the employee is living with the claimant.

''Child in care'' means a child who has been living with the claimant for at least 30 consecutive days unless—

(a) The child is in active military service;

(b) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older and is not disabled;

(c) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older with a mental disability and the claimant does not exercise parental control and responsibility; or

(d) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older with a physical disability, but it is not necessary for the claimant to perform personal services for the child.

(e) Parental control and responsibility for the care and welfare of the child means that the parent supervises the child's activities and makes important decisions about the child's needs either alone or with another person. Personal services are services such as dressing, feeding and managing money which the child cannot do alone because of a disability.

§ 222.18 "Child in care" when child of the employee is not living with the claimant.

(a) *When child is in care.* A child living apart from a claimant is in that claimant's care if—

(1) The child lives apart or is expected to live apart from the claimant for not more than six months; or

(2) The child is under 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities), the claimant supervises the child's activities and makes important decisions about his or her needs, and one of the following circumstances applies:

(i) The child is living apart because of attendance at school but generally spends a vacation of at least 30 consecutive days with the claimant each year, and, if the claimant and the child's other parent are separated, the school must look to the claimant for decisions about the child's welfare.

(ii) The child is living apart because of the claimant's employment but the claimant makes regular and substantial contributions to the child's support. ''Contributing to support'' is defined in § 222.42.

(iii) The child is living apart because of the child's or the claimant's physical disability; or

(3) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older and is mentally disabled and the claimant supervises the child's activities, makes important decisions about the child's needs, and helps in the child's upbringing and development.

(b) *When child is not in care.* A child living apart from a claimant is not in the claimant's care if—

(1) The child is in active military service; or

(2) The child is living with his or her other parent; or

(3) A court order removed the child from the claimant's custody and control; or

(4) The claimant gave the right to custody and control of the child to someone else; or

(5) The claimant is mentally disabled.

Subpart C—Relationship as Divorced Spouse, Surviving Divorced Spouse, or Remarried Widow(er)

§ 222.20 When determination of relationship as divorced spouse, surviving divorced spouse, or remarried widow(er) is made.

(a) *Divorced spouse.* The claimant's relationship as the divorced spouse of an employee is determined when the purported divorced spouse applies for an annuity, or when there is a claim which would include a divorced spouse in the computation of the social security overall minimum provision. Such a determination is also made when a spouse annuitant age 62 or over secures a final divorce from the employee after 10 years of marriage.

(b) *Surviving divorced spouse.* The claimant's relationship as the surviving divorced spouse of an employee is determined when the purported surviving divorced spouse applies for an annuity on the basis of age, disability, or having a child in care. Such a determination is also made when there is a divorced spouse annuitant and the employee dies.

(c) *Remarried widow(er).* The claimant's relationship as a remarried widow(er) of an employee is determined when the purported remarried widow(er) applies for an annuity. Such a determination is also made when a widow(er) who is receiving an annuity remarries after age 60, or when a widow(er) who is receiving a disability annuity remarries after age 50.

§ 222.21 When marriage is terminated by final divorce.

A final divorce, often referred to as an absolute divorce, completely dissolves the marriage relationship and restores the parties to the status of single persons. A legal separation, qualified or preliminary divorce, divorce from bed and board, interlocutory decree of divorce, or similar court order is not considered a final divorce for family relationship and benefit entitlement purposes.

§ 222.22 Relationship as divorced spouse.

A claimant will be considered to be the divorced spouse of an employee if—

(a) His or her marriage to the employee has been terminated by a final divorce; and

(b) He or she is not married (if the claimant remarried after the divorce from the employee, the later marriage has been terminated by death, final divorce, or annulment); and

(c) He or she had been validly married to the employee, as set forth in § 222.11, for a period of 10 years immediately before the date the divorce became final. The claimant meets this requirement even if the claimant and employee were divorced within the ten-year period, provided that the claimant and employee were remarried no later than the calendar year immediately following the year in which the divorce took place.

§ 222.23 Relationship as surviving divorced spouse.

A claimant will be considered to be the surviving divorced spouse of a deceased employee if the conditions in either paragraph (a) or (b) of this section are met:

(a) *Age or disability.* The claimant applied for an annuity on the basis of age or disability, and the conditions set forth in § 222.22 are met.

(b) *Child in care.* The claimant applied for an annuity on the basis of having a child in care, and—

(1) His or her marriage to the employee has been terminated by a final divorce; and

(2) He or she is not married (if the claimant remarried after the divorce from the employee, the later marriage has been terminated by death, final divorce, or annulment); and

(3) He or she either—

(i) Was the natural parent of the employee's child; or

(ii) Had been married to the employee when either the employee or the claimant legally adopted the other's child or when they both legally adopted a child who was then under 18 years of age.

§ 222.24 Relationship as remarried widow(er).

(a) *New eligibility.* A claimant will have the relationship of a remarried widow(er) if he or she is the widow(er), as discussed in § 222.11, of an employee and the claimant—

(1) Remarried after attaining age 60, or remarried after attaining age 50 and after the date on which he or she became disabled; or

(2) Remarried before attaining age 60, but is now unmarried, or remarried before attaining age 50 or before the date on which he or she became disabled, but is now unmarried.

(b) *Reentitlement.* A claimant will have the relationship of a remarried widow(er) if he or she remarries after his or her entitlement to an annuity as a widow(er) has been established, and the claimant—

(1) Remarries after attaining age 60, or remarries after attaining age 50 and after the date on which he or she became disabled; or

(2) Is entitled to an annuity based upon having a child of the employee in care and remarries, but this marriage is to a person who is entitled to a retirement, disability, widow(er)'s, mother's, father's, parent's, or disabled child's benefit under the Railroad Retirement Act or Social Security Act.

Subpart D—Relationship as Child

§ 222.30 When determinations of relationship as child are made.

(a) Determinations will be made regarding a person's relationship as the child of the employee and that person's dependency on the employee (see subpart F of this part) when—

(1) The wife or husband of an employee applies for a spouse's annuity based on having the employee's child in care; or

(2) The employee's annuity can be increased under the social security overall minimum provision based on the child; or

(3) The employee dies and the claimant applies for a child's annuity.

(b) A determination will be made regarding a claimant's relationship as the child of the employee when the claimant applies for a share of a lump-sum payment as a child.

§ 222.31 Relationship as child for annuity and lump-sum payment purposes.

(a) *Annuity claimant.* When there are claimants under paragraph (a)(1), (a)(2), or (a)(3) of § 222.30, a person will be considered the child of the employee when that person is—

(1) The natural or legally adopted child of the employee (see § 222.33); or

(2) The stepchild of the employee; or

(3) The grandchild or step-grandchild of the employee or spouse; or

(4) The equitably adopted child of the employee.

(b) *Lump-sum payment claimant.* A claimant for a lump-sum payment must be one of the following in order to be considered the child of the employee:

(1) The natural child of the employee;

(2) A child legally adopted by the employee (this does not include any child adopted by the employee's widow or widower after the employee's death); or

(3) The equitably adopted child of the employee. For procedures on how a determination of the person's relationship to the employee is made, see §§ 222.32–222.33.

[65 FR 20726, Apr. 18, 2000]

§ 222.32 Relationship as a natural child.

A claimant will be considered the natural child of the employee for both annuity and lump-sum payment purposes if one of the following sets of conditions is met:

(a) *State inheritance law.* Under relevant state inheritance law, the claimant could inherit a share of the employee's personal estate as the employee's natural child if the employee were to die without leaving a will as described in paragraph (e) of this section;

(b) *Natural child.* The claimant is the employee's natural son or daughter, and the employee and the claimant's mother or father went through a marriage ceremony which would have been valid except for a legal impediment;

(c) *By order of law.* The claimant's natural mother or father has not married the employee, but—

(1) The employee has acknowledged in writing that the claimant is his or her son or daughter; or

(2) A court has decreed that the employee is the mother or father of the claimant; or

(3) A court has ordered the employee to contribute to the claimant's support because the claimant is the employee's son or daughter; and,

(4) Such acknowledgment, court decree, or court order was made not less than one year before the employee became entitled to an annuity, or in the case of a disability annuitant prior to his or her most recent period of disability, or in case the employee is deceased, prior to his or her death. The written acknowledgment, court decree, or court order will be considered to have occurred on the first day of the month in which it actually occurred.

(d) Other evidence of relationship. The claimant's natural mother or father has not married the employee, but—

(1) The claimant has submitted evidence acceptable in the judgment of the Board, other than that discussed in paragraph (c) of this section, that the employee is his or her natural mother or father; and

(2) The employee was living with the claimant or contributing to the claimant's support, as discussed in §§ 222.58 and 222.42 of this part, when—

(i) The spouse applied for an annuity based on having the employee's child in care; or

(ii) The employee's annuity could have been increased under the social security overall minimum provision; or

(iii) The employee died, if the claimant is applying for a child's annuity or lump-sum payment.

(e) *Use of state laws*—(1) *General*. To determine whether a claimant is the natural child of the employee, the state inheritance laws regarding whether the claimant could inherit a child's share of the employee's personal property if he or she were to die intestate will apply. If such laws would permit the claimant to inherit the employee's personal property, the claimant will be considered the child of the employee. The state inheritance laws where the employee was domiciled when he or she died will apply. If the employee's domicile was not in one of the 50 states, the Commonwealth of Puerto Rico, the Virgin slands, Guam, American Samoa, or the Northern Mariana Islands, the laws of the District of Columbia will apply.

(2) *Standards*. The Board will not apply any state inheritance law requirement that an action to establish paternity must have been commenced within a specific time period, measured from the employee's death or the child's birth, or that an action to establish paternity must have been commenced or completed before the employee's death. If state laws on inheritance require a court to determine paternity, the Board will not require such a determination, but the Board will decide paternity using the standard of proof that the state court would apply as the basis for making such a determination.

(3) *Employee is living*. If the employee is living, the Board will apply the state law where the employee is domiciled which was in effect when the annuity may first be increased under the social security overall minimum (see part 229 of this chapter). If under a version of state law in effect at that time, a person does not qualify as a child of the employee, the Board will look to all versions of state law in effect from when the employee's annuity may first have been increased until the Board makes a final decision, and will apply the version of state law most favorable to the employee.

(4) *Employee is deceased*. The Board will apply the state law where the employee was domiciled when he or she died. The Board will apply the version of state law in effect at the time of the final decision on the application for benefits. If under that version of state law the claimant does not qualify as the child of the employee, the Board will apply the state law in effect when the employee died, or any version of state law in effect from the month of potential entitlement to benefits until a final determination on the application. The Board will apply the version most beneficial to the claimant. The following rules determine the law in effect as of the employee's death:

(i) Any law enacted after the employee's death, if that law would have retroactive application to the employee's date of death, will apply; or

(ii) Any law that supersedes a law declared unconstitutional, that was considered constitutional on the employee's date of death, will apply.

[65 FR 20726, Apr. 18, 2000]

§ 222.33 Relationship resulting from legal adoption.

(a) *Adopted by employee.* A claimant will be considered to be the child of the employee for both annuity and lump-sum payment purposes if the employee legally adopted the claimant in accordance with applicable State law. Legal adoption differs from equitable adoption in that in the case of legal adoption formal adoption proceedings have been completed in accordance with applicable State law and such proceedings are not defective.

(b) *Adopted by widow or widower.* A claimant who is legally adopted by the widow or widower of the employee after the employee's death will be considered to be the child of the employee for annuity but not for lump-sum payment purposes if—

(1) Either the claimant is adopted by the widow or widower within two years after the date on which the employee died, or the employee commenced proceedings to legally adopt the claimant before the employee's death; and

(2) The claimant was living in the employee's household at the time of the employee's death; and

(3) The claimant was not receiving regular support contributions from any other person other than the employee or spouse at the time of the employee's death.

(c) The adoption laws of the state or foreign country where the adoption took place, not the state inheritance laws, will determine whether the claimant is the employee's adopted child.

[54 FR 42949, Oct. 19, 1989, as amended at 65 FR 20727, Apr. 18, 2000]

§ 222.34 Relationship resulting from equitable adoption.

In many States, where a legal adoption proceeding was defective under State law or where a contemplated legal adoption was not completed, a claimant may be considered to be an equitably adopted child. A claimant will have the relationship of an equitably adopted child for annuity and lump-sum payment purposes if, in addition to meeting the other requirements of this part—

(a) The employee had agreed to adopt the claimant; and

(b) The natural parents or the person legally responsible for the care of the claimant agreed to the adoption; and

(c) The employee and the claimant lived together as parent and child; and

(d) The agreement to adopt is recognized under applicable State law such that, if the employee were to die without leaving a will, the claimant could inherit a share of the employee's personal estate as the child of the employee.

§ 222.35 Relationship as stepchild.

A claimant will be considered to have the relationship of stepchild of an employee, and will be considered a child for annuity but not for lump-sum benefit purposes if—

(a) The claimant's natural or adoptive parent married the employee after the claimant's birth; and

(b) The marriage between the employee and the claimant's parent is a valid marriage under applicable State law (see §§ 222.12 and 222.13), or would be valid except for a legal impediment; and

(c) The employee and the claimant's parent were married at least one year before the date—

(1) On which the spouse applies for an annuity based on having the employee's child in care; or

(2) On which the employee's annuity can be increased under the social security overall minimum provision; or

(d) The employee and the claimant's parent were married at least nine months before the date on which the employee died if the claimant is applying for a child's annuity; or if the employee and the claimant's parent were married less than nine months, the employee was reasonably expected to live for nine months, and—

(1) The employee's death was accidental; or

(2) The employee died in the line of duty as a member of the armed forces of the United States; or

(3) The widow(er) was previously married to the employee for at least nine months.

§ 222.36 Relationship as grandchild or stepgrandchild.

A claimant will have the relationship of grandchild or stepgrandchild of an employee, or the grandchild or stepgrandchild of an employee's spouse, and be considered a child for annuity purposes if the requirements in both paragraph (a) and either paragraph (b) or (c) of this section are met.

(a) The claimant is the natural child, adopted child, or stepchild of a child of an employee, or of a child of the employee's spouse as defined in this subpart;

(b) The claimant's natural or adoptive parents are deceased or are disabled, as defined in section 223(d) of the Social Security Act, in the month in which—

(1) The employee, who is entitled to an age and service or disability annuity, under the Railroad Retirement Act, would also be entitled to an age benefit under section 202(a) of the Social Security Act or a disability benefit under section 223 of the Social Security Act, if his or her railroad compensation were considered wages under that Act; or

(2) The employee dies; or

(3) The employee's period of disability begins, if the employee has a period of disability which continues until he or she could be entitled to a social security benefit as described in paragraph (b)(1) of this section or until he or she dies.

(c) The claimant was legally adopted in the United States by the employee's widow(er) after the employee's death, and the claimant's natural or adoptive parent or stepparent was not living in the employee's household and making regular contributions to the claimant's support at the time the employee died.

NOTE: A grandchild or stepgrandchild does not have the relationship of ''child'' for lump-sum payment purposes (see § 222.44).

Subpart E—Relationship as Parent, Grandchild, Brother or Sister

§ 222.40 When determinations of relationship are made for parent, grandchild, brother or sister.

(a) *Parent.* The claimant's relationship as a parent of the employee is determined when the claimant applies for an annuity or for lump-sum payments.

(b) *Grandchild.* The claimant's relationship as a grandchild, rather than as a child, of the employee is determined when the claimant applies for lump-sum payments.

(c) *Brother or sister.* The claimant's relationship as a brother or sister of the employee is determined when the claimant applies for lump-sum payments.

§ 222.41 Determination of relationship and support for parent.

(a) *Annuity claimant.* For purposes of applying for an annuity, a claimant is considered the employee's parent when the claimant—

(1) Is the natural mother or father of the employee, and is considered the employee's parent under the law of the State in which the employee had a permanent home when the employee died; or

(2) Is a person who legally adopted the employee before the employee became 16 years old; or

(3) Is a stepparent who married the employee's natural or adoptive parent before the employee became 16 years old (the marriage must be valid under the law of the State in which the employee had a permanent home when the employee died); and

(4) Was receiving at least one-half support from the employee (see §§ 222.42 and 222.43 of this part) either when the employee died or at the beginning of the period of disability, if the employee had a period of disability.

(b) *Lump-sum payment claimant.* For purposes of applying for lump-sum payments, a claimant is considered the employee's parent when he or she—

(1) Is the natural mother or father of the employee, and is considered the employee's parent under applicable State law; or

(2) Legally adopted the employee, if thereby recognized as a parent under applicable State law; but

(3) The claimant need not have received one-half support from the employee.

§ 222.42 When employee is contributing to support.

(a) An employee is contributing to the support of a person if the employee gives cash, goods, or services to help support such person. Support includes food, clothing, housing, routine medical care, and other ordinary and necessary living expenses. The value of any goods which the employee contributes shall be based upon the replacement cost of those goods at the time they are contributed. If the employee provides services that would otherwise require monetary payment, the cash value of the employee's services may be considered a contribution to support.

(b) The employee is contributing to the support of a person if that person receives an allotment, allowance, or benefit based upon the employee's military pay, veteran's pension or compensation, social security earnings, or railroad compensation.

(c) Contributions must be made regularly and must be large enough to meet an important part of the person's ordinary and necessary living expenses. If the employee provides only occasional gifts or donations for special purposes, they will not be considered contributions for support. Although the employee's contributions must be made on a regular basis, temporary interruptions caused by circumstances beyond the employee's control, such as illness or unemployment, will be disregarded unless during these interruptions someone else assumes responsibility for support of the person on a regular basis.

§ 222.43 How the one-half support determination is made.

(a) *Amount of contributions.* The employee provides one-half support to a person if the employee makes regular contributions to that person's support, and the amount of the contributions is equal to or in excess of one-half of the person's ordinary and necessary living expenses. Ordinary and necessary living expenses are the costs for food, clothing, housing, routine medical care, and similar necessities. A contribution may be in cash, goods, or services (see § 222.42 of this part). For example, an employee pays rent and utilities amounting to $6,000 per year on an apartment in which his mother resides. In addition, the employee's mother receives $3,600 per year in social security benefits which she uses to pay for her food, clothing and medical care. The mother's total necessary living expenses are $9,600 ($6,000 + $3,600). Since the employee contributes $6,000 toward these expenses, he is contributing in excess of one-half of his mother's support.

(b) *Reasonable period of time.* The employee is not providing at least one-half of a person's support unless the employee has made contributions for a reasonable period of time. Ordinarily, the Board will consider a reasonable period of time to be the 12-month period immediately preceding the time when the one-half support requirement must be satisfied. However, if the employee provided one-half or more of the person's support for at least 3 months of the 12-month period, and was forced to stop or reduce contributions because of circumstances beyond his or her control, such as illness or unemployment, and no one else took over responsibility for providing at least one-half of the person's support on a permanent basis, three months shall be considered a reasonable period of time.

§ 222.44 Other relationship determinations for lump-sum payments.

Other claimants will be considered to have the relationships to the employee shown below for lump-sum payment purposes:

(a) *Grandchildren.* A grandchild is a separate class of beneficiary to be considered for lump-sum payments and is not a child of the employee; he or she is a child of the employee's son or daughter as determined under State law. A stepgrandchild is not included in this class of beneficiary.

(b) *Brother or Sister.* ''Brother'' or ''Sister'' means a full brother or sister or a half brother or half sister, but not a stepbrother or stepsister.

Subpart F—Child Support and Dependency

§ 222.50 When child dependency determinations are made.

(a) *Dependency determination.* One of the requirements for a child's annuity or for increasing an employee or spouse annuity under the social security overall minimum provision on the basis of the presence of a child in the family group is that the child be dependent upon the employee. The dependency requirements and the time when they must be met are explained in §§ 222.51 through 222.57.

(b) *Related determinations.* To prove a child's dependency, an applicant may be asked to show that at a specific time the child lived with the employee, that the child received contributions for his or her support from the employee, or that the employee provided at least one-half of the child's support. The terms ''living with'', ''contributing to support'', and ''one-half support'' are defined in §§ 222.58, 222.42, an 222.43. These determinations are required when—

(1) A natural child or legally adopted child of the employee is adopted by someone else; or

(2) The child claimant is the stepchild, grandchild, or equitably adopted child of the employee.

§ 222.51 When a natural child is dependent.

The employee's natural child, as defined in § 222.32, is considered to be dependent upon the employee. However, if the child is legally adopted by someone else during the employee's lifetime and, after the adoption, a child's annuity or other annuity or annuity increase is applied for on the basis of the employee's earnings record and the relationship of the child to the employee, the child will be considered dependent upon the employee (the natural parent) only if he or she was either living with the employee or the employee was contributing to the child's support when either:

(a) A spouse's annuity begins; or

(b) The employee's annuity can be increased under the social security overall minimum provision; or

(c) The employee dies; or

(d) If the employee had a period of disability which lasted until he or she could have become entitled to an age or disability benefit under the Social Security Act (treating the employee's railroad compensation as wages under that Act), at the beginning of the period of disability or at the time the employee could have become entitled to the benefit.

§ 222.52 When a legally adopted child is dependent—general.

(a) *During employee's lifetime.* If the employee adopts a child before he or she could become entitled to a social security benefit (treating his or her railroad compensation as wages under that Act), the child is considered dependent upon the employee. If the employee adopts a child, unless the child is his natural child or stepchild, after he or she could become entitled to an old age or disability benefit under the Social Security Act (treating his or her railroad compensation as wages under that Act), the child is considered dependent on the employee only if the requirements of § 222.53 are met.

(b) *After employee's death.* If the surviving spouse of an employee adopted a child after the employee's death, the child is considered dependent on the employee if either—

(1) The employee began proceedings to adopt the child prior to his or her death, or the surviving spouse adopted the child within two years after the employee's death; and

(2) The child was living in the employee's household at the time of the employee's death; and

(3) The child was not receiving regular contributions from any person, including any public or private welfare organization, other than the employee or spouse at the time of the employee's death.

§ 222.53 When a legally adopted child is dependent—child adopted after entitlement.

A child who is not the employee's natural child or stepchild, and who is adopted by the employee after the employee could become entitled to an old age or disability benefit under the Social Security Act (treating his or her railroad compensation as wages under

that Act), is considered dependent on the employee during the employee's lifetime only if—

(a) The child had not attained age 18 when adoption proceedings were commenced, and the child's adoption was issued by a court of competent jurisdiction within the United States; or

(b) The child had attained age 18 before adoption proceedings were commenced, the child's adoption was issued by a court of competent jurisdiction within the United States, and the child was living with or receiving at least one-half of the child's support from the employee for the year immediately preceding the month in which the adoption was issued.

[89 FR 47461, June 3, 2024]

§ 222.54 [Reserved]

§ 222.55 When a stepchild is dependent.

An employee's stepchild, as described in § 222.35, is considered dependent on the employee if the stepchild receiving at least one-half of his or her support from the employee at one of the times shown in § 222.51.

[54 FR 42949, Oct. 19, 1989, as amended at 62 FR 47138, Sept. 8, 1997]

§ 222.56 When a grandchild or stepgrandchild is dependent.

An employee's grandchild or stepgrandchild, as described in § 222.36, is considered dependent on the employee if the requirements in both paragraphs (a) and (b), or paragraph (c) of this section are met:

(a) The grandchild or stepgrandchild was living with the employee before the grandchild or stepgrandchild attained age 18.

(b) The grandchild or stepgrandchild is living with the employee in the United States and receives at least one-half of his or her support from the employee for the year before the month in which—

(1) The employee could become entitled to an age and service or disability annuity under the Social Security Act (treating his or her railroad compensation as wages under that Act); or

(2) The employee dies; or

(3) The employee becomes entitled to a period of disability that lasts until he or she could become entitled to a social security benefit as described above or until he or she dies.

(c) In the case of a grandchild or stepgrandchild born within the one-year period referred to in paragraph (b) of this section, at the close of such period the child must have been living with and receiving at least one-half of his or her support from the employee for substantially all of the period that began on the date the grandchild or stepgrandchild was born. ''Substantially all'' is defined in § 222.53.

§ 222.57 When an equitably adopted child is dependent.

An employee's equitably adopted child, as defined in § 222.34, is considered dependent upon the employee if the employee was either living with or contributing to the support of the child at the time of his or her death. If the equitable adoption is found to have occurred after the employee could have become entitled to an old age or disability benefit under the Social Security Act (treating his or her railroad compensation as wages under that Act), the child is not considered dependent on the employee during the employee's lifetime. If the equitable adoption took place before such time, the child is dependent on the employee if the employee was living with or contributing to the support of the child at one of the times shown in § 222.51.

§ 222.58 When a child is living with an employee.

A child is living with the employee if the child normally lives in the same household with the employee and the employee has parental control and authority over the child's activities. The child is considered to be ''living with'' the employee while they are living apart if they expect to live together again after a temporary separation. A temporary separation may include the employee's absence because of working away from home or hospitalization. However, the employee must have parental control and authority over the child during the period of temporary separation. A child who is in active military service or in prison is not ''living with'' the employee, since the

employee does not have parental control over the child.

PART 225—PRIMARY INSURANCE AMOUNT DETERMINATIONS

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Subpart A—General

§ 225.1 Introduction.

This part discusses Primary Insurance Amount, which is referred to as PIA throughout this part, and which is an important element in the calculation of any retirement or survivor annuity. There are a number of PIA computations based on different periods, amounts, and types of earnings. However, the formulas for computing any PIA are prescribed in section 215 of the Social Security Act and are described in detail in the regulations of the Social Security Administration (20 CFR part 404, subpart C). This part discusses PIA computation formulas and relates them to the PIA's which the Board uses. Descriptions of the majority of PIA's used in computing retirement or survivor annuities under the Railroad Retirement Act are contained in this part. Explanations are included of when delayed retirement credits and cost-of-living increases can be added to the PIA's used by the Board. This part also explains when and how a PIA is recomputed or adjusted. Since these regulations are intended to address annuities currently being awarded, certain PIA's, not used in the computation of

annuities awarded after August 13, 1981, are not included in these regulations. Parts 226, 228 and 229 of this chapter explain how PIA's are used in actual annuity computations.

§ 225.2 Definitions.

As used in this part:

Average Indexed Monthly Earnings means the result of dividing the total of the indexed earnings through the indexing year and the nonindexed earnings after the indexing year in the benefit computation years by the number of months in the benefit computation years. The indexing year for the Average Indexed Monthly Earnings PIA is the second year before the employee's eligibility year. Indexing of an employee's yearly earnings serves to put the earnings in proportion to the earnings level of all workers for the corresponding years, and to express the earnings in terms of a more recent dollar value. Indexed earnings are determined under section 215(b)(1) of the Social Security Act. The Average Indexed Monthly Earnings formula PIA is based on the Average Indexed Monthly Earnings amount.

Average Monthly Earnings means the average determined by dividing the acutal earnings used in computing the PIA by the total months in the benefit computation years. The Average Monthly Earnings is determined under section 215(b)(4) of the Social Security Act. The Average Monthly Earnings formula PIA is based on the Average Monthly Earnings amount.

Base Years means the years after 1950 (or 1936, if applicable) and up to the year in which the employee dies or is entitled to an annuity based on retirement or disability. When the employee's death occurs before he or she reaches retirement age as defined in section 216(l) of the Social Security Act, the Base Years include the year of the employee's death. Base Years are defined in sections 215(b)(2)(B)(ii) and 215(d) of the Social Security Act.

Benefit Computation Years means the years with the highest earnings used in computing the Average Indexed Monthly Earnings or Average Monthly Earnings. The number of Benefit Computation Years is determined in accordance with section 215(b)(2)(B)(i) of the Social Security Act and is based on the employee's age or when the employee becomes disabled or dies.

Compensation means *railroad compensation* which is the amount of creditable railroad earnings under the Railroad Retirement Act, as explained in part 211 of this chapter.

Earnings means *compensation* creditable under the Railroad Retirement Act (other than compensation attributable to years of service prior to 1937) or ''wages'' creditable under the Social Security Act or both.

Eligible means that a person meets the necessary requirements and could qualify for payment if a valid application were filed.

Eligibility Year means the earliest of: the employee's year of attainment of age 62; The year of disability onset; or the year of death. The Eligibility Year determines the formula used to compute a Primary Insurance Amount. Eligibility Year is defined in section 215(a) of the Social Security Act.

Employee means any person who is working or has worked for a railroad employer who is eligible for a retirement annuity or on whose account a survivor is eligible for a survivor annuity, as explained in part 216 of this chapter. For a detailed discussion of Employees under the Railroad Retirement Act, see part 203 of this chapter.

Entitled means that a person meets the necessary requirements, files a valid application and establishes his or her right to payment.

Indexed Earnings means the employee's yearly earnings for the years after 1950 that have been adjusted to put the earnings in proportion to the earnings level of all workers for each of those years and to express the earnings in terms of a more recent dollar amount.

Primary Insurance Amount (PIA) means the result obtained by applying one of three formulas in the Social Security Act to the employee's earnings as prescribed under that Act. A PIA can be based on the Average Indexed Monthly Earnings formula, the Average Monthly Earnings formula or, in the case of the Special Minimum PIA, on a special formula based on years of coverage. Averaging earnings and PIA formulas are prescribed in section 215 of the Social Security Act.

Social Security Act means the Social Security Act as amended from time to time, unless the Act as in effect on a particular date is specified.

Wages means creditable wages or self-employment under sections 209 or 211, respectively, of the Social Security Act.

Year of service means 12 months of railroad service credited in accordance with part 210 of this chapter.

Years of coverage means years after 1936 as defined in section 215(a)(1)(C)(ii) of the Social Security Act in which the employee had earnings over certain specified amounts. Years of Coverage is primarily a factor in determining the Special Minimum formula PIA amount.

[54 FR 12903, Mar. 29, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 225.3 PIA computation formulas.

(a) *General.* PIA's are generally computed under one of two normal formulas determined by the employee's eligibility year. In addition, there is a special PIA formula, based on an employee's years of coverage, that is used when it produces a PIA that is higher than the PIA computed under the appropriate PIA formula. The two most common PIA formulas are the Average Indexed Monthly Earnings PIA formula and the Average Monthly Earnings PIA formula. The special PIA formula is called the Special Minimum PIA formula.

(b) *Average Indexed Monthly Earnings PIA formula.* When the employee's eligibility year is after 1978, the Tier I PIA, Overall Minimum PIA, Survivor Tier I PIA, Employee's Retirement Insurance Benefit PIA and Residual Lump-Sum PIA are computed under the Average Indexed Monthly Earnings PIA formula.

(c) *Average Monthly Earnings PIA formula.* The Average Monthly Earnings PIA formula is used to compute a PIA for one of two reasons: either the employee's eligibility year is before 1979 or the type of PIA requires that it always be computed under the Average Monthly Earnings PIA formula.

(1) *Use of Average Monthly Earnings PIA formula based on the employee's eligibility year.* The Average Monthly Earnings PIA formula is used in computing the Tier I PIA, the Overall Minimum PIA, the Employee Fictional Retirement Insurance Benefit PIA and the Residual Lump-Sum PIA when the employee's eligibility year is before 1979.

(2) *Types of PIA's always computed using the Average Monthly Earnings PIA formula.* The following PIA's used by the Board are determined under the Social Security Act as in effect on December 31, 1974, and are always computed using the Average Monthly Earnings PIA formula.

(i) Combined Earnings Dual Benefit PIA described in § 225.12.

(ii) Social Security Earnings Dual Benefit PIA described in § 225.13.

(iii) Railroad Earnings Dual Benefit PIA described in § 225.14.

(iv) Combined Earnings PIA described in § 225.23.

(v) Social Security Earnings PIA described in § 225.24.

(vi) Railroad Earnings PIA described in § 225.25.

(d) *Special Minimum PIA formula.* The Special Minimum PIA formula is based on the employee's years of coverage. The Special Minimum PIA formula usually applies when the employee had consistently low earnings during his or her working lifetime. The Special Minimum PIA formula is used when it is higher than the PIA calculated under the applicable Average Indexed Monthly Earnings formula or the Average Monthly Earnings formula.

§ 225.4 Limitation on amount of earnings used to compute a PIA.

Certain PIA's used by the Board are based on a combination of compensation and wages, while other PIA's used by the Board are based solely on either compensation or wages. For purposes of crediting earnings when computing any PIA, compensation is always treated as wages. Regardless of whether a PIA is based on a combination of compensation and wages or exclusively on either compensation or wages, the total earnings for each year used in computing a PIA cannot be higher than the maximum social security earnings creditable in that year under sections 209(a) and 211(b) of the Social Security Act. The various PIA's used by the

Board are described in subparts B and C of this part.

Subpart B—PIA's Used in Computing Employee, Spouse and Divorced Spouse Annuities

§ 225.10 General.

This subpart contains information about the PIA's that can be used in computing most employee, spouse and divorced spouse annuities. The Tier I PIA is used in computing the tier I component of an employee, spouse or divorced spouse annuity. The Combined Earnings Dual Benefit PIA, Social Security Earnings Dual Benefit PIA and Railroad Earnings Dual Benefit PIA are used in computing an employee's vested dual benefit component and a corresponding tier II component offset when entitlement to a vested dual benefit exists. Retirement annuity computations are discussed in part 226 of this chapter. The Overall Minimum PIA is used in computing the overall minimum guaranty formula rate as discussed in part 229 of this chapter.

§ 225.11 Tier I PIA.

(a) *General.* The Tier I PIA is used in computing an employee, spouse or divorced spouse tier I amount. Except for the cases described in paragraphs (b) through (d) of this section, a Tier I PIA is determined under sections 215 and 223 of the Social Security Act. Railroad and Social Security earnings are included in the calculation of a Tier I PIA.

(b) *Employee attains age 60 and/or acquires 30 years of service after June 30, 1984.* When an employee is entitled to an age and service annuity before the month of attaining age 62, as explained in part 216 of this chapter, the following Railroad Retirement Act rules apply in addition to those in § 225.11(a) in computing the Tier I PIA.

(1) Four months before the first full month the employee is age 62, the Average Indexed Monthly Earnings is determined as if the employee's eligibility year were the year the annuity began.

(2) The benefit computation years used in computing the Tier I PIA are based on the date of the employee's actual attainment of age 62.

(3) The Tier I PIA is adjusted when the employee reaches age 62 to use the year in which the employee attains age 62 as the eligibility year.

(4) Cost-of-living increases and recomputations apply after the employee attains age 62.

(c) *Employee attains age 60 and acquires 30 years of service before July 1, 1984.* For purposes of determining the benefit computation years to be used in computing the Tier I PIA for an employee who is age 60 through 64, and who both has 30 years of service and attains age 60 prior to July 1, 1984, the employee is considered to be age 65 when the age and service annuity begins. For purposes of computing the Average Indexed Monthly Earnings, the eligibility year is the year the annuity begins or age 62, if earlier. Cost-of-living increases are paid from the year the annuity begins. Recomputations are paid after the employee actually attain age 62.

(d) *Disability annuity.* When an employee is entitled to a disability annuity, as explained in subpart B of part 216 of this chapter, the following Railroad Retirement Act rule applies in addition to those in § 225.11(a) in computing the Tier I PIA. The Tier I PIA is computed as if the employee were 62 years old on the date, as determined by the Board, of onset of disability, if the employee is under age 62 on that date.

§ 225.12 Combined Earnings Dual Benefit PIA.

(a) *General.* The Combined Earnings Dual Benefit PIA is used in computing the employee vested dual benefit when the employee meets certain eligibility requirements as described in part 216 of this chapter. The Combined Earnings Dual Benefit PIA is also used in computing the employee's tier II annuity component when the employee becomes entitled to a vested dual benefit. This PIA is determined under section 215 of the Social Security Act as in effect on December 31, 1974. Railroad and social security earnings after 1950 (or after 1936, if applicable) and through December 31, 1974, or the last year of railroad service before 1974 are included in the calculation of this PIA.

(b) *Employee insured on own wage record on December 31, 1974.* Railroad

and social security earnings after 1950 (or after 1936, if a higher PIA would result) and through 1974 are used in computing the Combined Earnings Dual Benefit PIA if the employee—

(1) Had at least 25 years of railroad service before January 1, 1975; or

(2) Had at least 10 years of railroad service as of December 31, 1974, and worked in the railroad industry anytime during calendar year 1974; or

(3) Had at least 10 years of railroad service as of December 31, 1974, and had a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

(c) *Employee insured on own wage record in last year of railroad service.* Railroad and social security earnings after 1950 (or after 1936, if a higher PIA would result) and through December 31 of the year before 1974 in which the employee last worked in railroad service are used in computing the Combined Earnings Dual Benefit PIA if the employee—

(1) Had at least 10 but less than 25 years of railroad service through December 31, 1974; and

(2) Did not work in the railroad industry during 1974; and

(3) Did not have a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

§ 225.13 Social Security Earnings Dual Benefit PIA.

(a) *General.* The Social Security Earnings Dual Benefit PIA is used in computing the employee vested dual benefit when the employee meets certain eligibility requirements as described in part 216 of this chapter. The Social Security Dual Benefit PIA is also used in computing the employee's tier II annuity component when the employee becomes entitled to a vested dual benefit. This PIA is determined under section 215 of the Social Security Act as in effect on December 31, 1974. Social security earnings after 1950 (or after 1936, if applicable) and through December 31, 1974, or the last year of railroad service before 1974 are included in the calculation of this PIA.

(b) *Employee insured on own wage record on December 31, 1974.* Social security earnings after 1950 (or after 1936, if a higher PIA would result) and through 1974 are used in computing the Social Security Earnings Dual Benefit PIA if the employee—

(1) Had at least 25 years of railroad service before January 1, 1975; or

(2) Had at least 10 years of railroad service as of December 31, 1974, and worked in the railroad industry anytime during calendar year 1974; or

(3) Had at least 10 years of railroad service as of December 31, 1974, and has a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

(c) *Employee insured on own wage record in last year of railroad service.* Social security earnings after 1950 (or after 1936, if a higher PIA would result) and through December 31 of the year before 1974 in which the employee last worked in the railroad industry are used in computing the Social Security Earnings Dual Benefit PIA if the employee—

(1) Had at least 10 but less than 25 years of railroad service through December 31, 1974; and

(2) Did not work in the railroad industry during 1974; and

(3) Did not have a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

§ 225.14 Railroad Earnings Dual Benefit PIA.

(a) *General.* The Railroad Earnings Dual Benefit PIA is used in computing the employee vested dual benefit when the employee meets certain eligibility requirements as described in part 216 of this chapter. The Railroad Earnings Dual Benefit PIA is also used in computing the employee's tier II annuity component when the employee becomes entitled to a vested dual benefit. This PIA is determined under section 215 of the Social Security Act as in effect on December 31, 1974. Railroad earnings after 1950 (or after 1936, if applicable) and through December 31, 1974, or the last year of railroad service

before 1974 are included in the calculation of this PIA.

(b) *Employee insured on own wage record on December 31, 1974.* Railroad earnings after 1950 (or after 1936, if a higher PIA would result) and through 1974 are used in computing the Railroad Earnings Dual Benefit PIA if the employee—

(1) Had at least 25 years of railroad service before January 1, 1975; or

(2) Had at least 10 years of railroad service as of December 31, 1974, and worked in the railroad industry anytime during calendar year 1974; or

(3) Had at least 10 years of railroad service as of December 31, 1974, and had a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

(c) *Employee insured on own wage record in last year of railroad service.* Railroad earnings after 1950 (or after 1936, if a higher PIA would result) and through December 31 of the year before 1974 in which the employee last worked in railroad service are used in computing the Railroad Earnings Dual Benefit PIA if the employee—

(1) Had at least 10 but less than 25 years of railroad service through December 31, 1974; and

(2) Did not work in the railroad industry during 1974; and

(3) Did not have a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

§ 225.15 Overall Minimum PIA.

The Overall Minimum PIA is considered when the employee would be eligible for an old age insurance benefit or a disability insurance benefit under section 202 or 223 of the Social Security Act based on combined railroad and social security earnings. The Overall Minimum PIA is used in computing the social security overall minimum guaranty amount. The overall minimum guaranty rate annuity formula is discussed in part 229 of this chapter. The Overall Minimum PIA is determined under the rules in sections 215 and 223 of the Social Security Act. Railroad and social security earnings are included in the calculation of the Overall Minimum PIA. The Overall Minimum PIA is used to determine the amount which is treated as a social security benefit for the purpose of taxation pursuant to section 86(d) of the Internal Revenue Code of 1986.

Subpart C—PIA's Used in Computing Survivor Annuities and the Amount of the Residual Lump-Sum Payable

§ 225.20 General.

The Survivor Tier I PIA and the Employee RIB PIA are used in computing the tier I component of a survivor annuity. The Combined Earnings PIA, Social Security Earnings PIA and Railroad Earnings PIA may be used in computing a vested dual benefit offset in the survivor tier II component when the survivor tier II is based on a percentage of the employee annuity tier II. In addition, these three PIA's are identical to those dual benefit PIA's used in computing an employee retirement annuity, as described in subpart B of this part, when the employee died after being entitled to an annuity. Survivor annuity computations are discussed in part 228 of this chapter. The Residual Lump-Sum PIA (RLS PIA) is used in computing the amount of the residual lump-sum payable when retirement annuity payments were made, as explained in part 234 of this chapter.

§ 225.21 Survivor Tier I PIA.

The Survivor Tier I PIA is used in computing the tier I component of a survivor annuity. This PIA is determined in accordance with section 215 of the Social Security Act using the deceased employee's combined railroad and social security earnings after 1950 (or after 1936 if a higher PIA would result) through the date of the employee's death.

§ 225.22 Employee RIB PIA used in survivor annuities.

The Employee Retirement Insurance Benefit PIA (Employee RIB PIA) is used to compute the employee RIB amount when the employee had received a retirement annuity which was reduced for early retirement. As explained in part 228 of this chapter, the

employee RIB amount may be used in the survivor tier I component. This PIA is computed in accordance with section 215 of the Social Security Act using the deceased employee's combined railroad and social security earnings. The Employee RIB PIA is the same as the Survivor Tier I PIA when the employee had no earnings in the year of death. Earnings in the year of death are used in the recomputed PIA beginning January 1 of the year after the employee's death. (See subpart F of this part for a discussion of PIA recomputations.)

§ 225.23 Combined Earnings PIA used in survivor annuities.

The Combined Earnings PIA used in survivor annuities may be used in computing the tier II component when the survivor tier II is based on a percentage of the employee annuity tier II and the employee had been or would be, if he or she were still alive, entitled to a vested dual benefit. If the employee received a retirement annuity before death, this PIA is identical to the retirement Combined Earnings Dual Benefit PIA described in subpart B of this part. If a retirement annuity was not paid before the employee's death, the PIA is determined as if the employee were 65 years old in the month of his or her death. The Combined Earnings PIA used in survivor annuities is determined in accordance with section 215 of the Social Security Act as in effect on December 31, 1974. It is computed using the deceased employee's combined railroad and social security earnings after 1950 (or after 1936 if a higher PIA would result) through December 31, 1974.

§ 225.24 SS Earnings PIA used in survivor annuities.

The Social Security Earnings PIA (SS Earnings PIA) used in survivor annuities may be used in computing the tier II component when the survivor tier II is based on a percentage of the employee annuity tier II and the employee had been or would be, if he or she were still alive, entitled to a vested dual benefit. If the employee received a retirement annuity before death, this PIA is identical to the retirement SS Earnings Dual Benefit PIA described in subpart B of this part. If a retirement annuity was not paid before the employee's death, the PIA is determined as if the employee were 65 years old in the month of his or her death. The SS Earnings PIA used in survivor annuities is determined in accordance with section 215 of the Social Security Act as in effect on December 31, 1974. It is computed using the deceased employee's social security earnings after 1950 (or after 1936, if a higher PIA would result) through December 31, 1974.

§ 225.25 RR Earnings PIA used in survivor annuities.

The Railroad Earnings PIA (RR Earnings PIA) used in survivor annuities may be used in computing the tier II component when the survivor tier II is based on a percentage of the employee annuity tier II and the employee had been or would be, if he or she were still alive, entitled to a vested dual benefit. If the employee received a retirement annuity before death, this PIA is identical to the retirement RR Earnings Dual Benefit PIA described in subpart B of this part. If a retirement annuity was not paid before the employee's death, the PIA is determined as if the employee were 65 years old in the month of his or her death. The RR Earnings PIA used in survivor annuities is determined in accordance with section 215 of the Social Security Act as in effect on December 31, 1974. It is computed using the deceased employee's railroad earnings after 1950 (or after 1936, if a higher PIA would result) through December 31, 1974.

§ 225.26 Residual Lump-Sum PIA.

The Residual Lump-Sum PIA (RLS PIA) is used to compute the regular retirement annuity amounts to be deducted from the gross residual lump-sum amount in determining the amount of the residual lump-sum payable, as explained in part 234 of this chapter. The RLS PIA is determined in accordance with section 215 of the Social Security Act using the employee's railroad compensation after 1950 (or after 1936, if a higher PIA would result) as if it were social security earnings. The RLS PIA is computed just like the retirement Tier I PIA described in subpart B of this part, except that social

security earnings are not used to compute the RLS PIA.

Subpart D—Delayed Retirement Credits

§ 225.30 General.

(a) A delayed retirement credit (DRC) is a percentage increase in a PIA. An employee who would have an insured status in accordance with section 214(a) of the Social Security Act based on combined railroad and social security earnings can earn DRC's. A DRC can be earned by the employee for each month, in or after the month of attaining full retirment age and before the month of attaining age 70 (72 before 1984), in which the employee does not receive either—

(1) An annuity because the employee did not apply for an annuity; or

(2) The tier I and vested dual benefit work deduction annuity components or the social security overall minimum annuity rate because they are not paid since the employee works and has earnings in excess of the exempt amount. (The tier I and vested dual benefit work deduction annuity components, the social security overall minimum annuity rate and the exempt amount are described in parts 226, 229 and 230 of this chapter, respectively.)

(b) Any credit earned by the employee also extends to the employee's widow(er), remarried widow(er) or surviving divorced spouse when he or she receives a survivor annuity that is based on age or disability.

(c) Credit earned by the employee does not extend to the employee's spouse or divorced spouse.

[54 FR 12903, Mar. 29, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 225.31 PIA's to which DRC's are added.

(a) DRC's can be added to the following PIA's when used in computing the following benefits:

(1) Tier I PIA used in computing a retirement employee annuity.

(2) Overall Minimum PIA used in computing a retirement employee annuity.

(3) Survivor Tier I PIA used in computing a widow(er), remarried widow(er) or surviving divorced spouse annuity based on age or disability.

(4) Employee RIB PIA used in computing a widow(er), remarried widow(er) or surviving divorced spouse annuity based on age or disability.

(5) RLS PIA used in computing the amount of the residual lump-sum payable (as explained in part 234 of this chapter).

§ 225.32 DRC's and the Special Minimum PIA.

Delayed retirement credits cannot be added to the Special Minimum PIA. Delayed retirement credits can only be added to the regular PIA's used in computing the benefits outlined in § 225.31.

§ 225.33 Months for which DRC's are due.

(a) A DRC is due for each month after 1970 in which the employee is—

(1) Full retirement age or older and under age 70 (72 before 1984); and

(2) Fully insured under section 214(a) of the Social Security Act based on combined railroad and social security earnings; and either—

(i) Is not entitled to an annuity because he or she did not apply for an annuity; or

(ii) Is entitled to an annuity but has the full amount of the tier I and vested dual benefit work deduction component (described in part 226 of this chapter) or the social security overall minimum rate (described in part 229 of this chapter) withheld because of earnings in excess of the exempt amount (as explained in part 230 of this chapter).

(b) The months for which credit is due need not be consecutive.

[54 FR 12903, Mar. 29, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 225.34 How the amount of the DRC is figured.

(a) The amount of the DRC depends on—

(1) The year the employee reaches full retirement age; and

(2) The number of months for which the credit is due, as explained in § 225.33.

(b) The percent given in paragraph (b)(1), (2), or (3) of this section is multiplied by the PIA; that product is then multiplied by the number of months

for which credit is due and rounded to the next lowest multiple of $0.10, if the answer is not already a multiple of $0.10. The result is the DRC which is added to the PIA.

(1) *Employee attained age 65 before 1982.* The DRC equals one-twelfth of one percent of the PIA times the number of months after 1970 in which the employee is age 65 or older and for which credit is due.

(2) *Employee attains age 65 after 1981 and before 1990.* The DRC equals one-fourth of one percent of the PIA times the number of months in which the employee is age 65 or older and for which credit is due.

(3) Employee attains age 65 in 1990 and before 2003.

(i) The rate of the DRC (one-fourth of one percent) is increased by one-twenty-fourth of one percent in each even year through 2002. Therefore, depending on when the employee attains age 65, the DRC percent will be as follows:

Year employee attains age 65	Delayed retirement credit percent
1990	7/24 of 1%.
1991	Do.
1992	1/3 of 1%.
1993	Do.
1994	3/8 of 1%.
1995	Do.
1996	5/12 of 1%.
1997	Do.
1998	11/24 of 1%.
1999	Do.
2000	1/2 of 1%.
2001	Do.
2002	13/24 of 1%.

(ii) The delayed retirement credit equals the appropriate percent of the PIA times the number of months in which the employee is age 65 or older and for which credit is due.

(4) Employee attains full retirement age in 2003 or later. The rate of the DRC (one-fourth of one percent) is increased by one-twenty-fourth of one percent in each even year through 2008. Therefore, depending on when the employee attains full retirement age, the DRC percent will be as follows:

Year employee attains full retirement age	Delayed retirement credit percent
2003	13/24 of 1%.
2004	7/12 of 1%.
2005	Do.
2006	5/8 of 1%.
2007	Do.
2008 and later	2/3 of 1%.

(c) *Example:* Mr. Jones was qualified for a full age and service annuity when he reached age 65 in January 1985, but decided not to apply for an annuity because he was still working. Mr. Jones stopped working on December 31, 1985, and applied for his annuity to begin January 1, 1986. Based on his earnings, his PIA was $350.50. Since Mr. Jones did not receive an annuity for the 12 months from the month in which he became 65 (January 1985) until the month following the month he stopped working (January 1986), he is due credit for each of those 12 months. The total amount of his DRC's is calculated as follows:

Percent		PIA		No. of months		Unrounded result		Total amount of DRC's
.25%	X	350.50	X	12	=	10.51	=	$10.50

Mr. Jones' PIA increase for DRC's is $361.00 (350.50 + 10.50).

[54 FR 12903, Mar. 29, 1989; 54 FR 21203, May 17, 1989, as amended at 68 FR 39010, July 1, 2003; 68 FR 43515, Aug. 1, 2003]

§ 225.35 When a PIA used in computing a retirement annuity can be increased for DRC's.

Delayed retirement credits earned at different times are added to the PIA used in computing a retirement annuity as follows:

DRC's earned for month in	Are added to PIA
Years before the year the employee annuity begins.	On the date the annuity begins.
Year the annuity begins	On January 1 of the year after the annuity begins.
Years after the annuity begins, and before the year the employee attains age 70 (72 before 1984).	On January 1 of the year after the credits are earned.

DRC's earned for month in	Are added to PIA
Year the employee attains age 70 (72 before 1984).	In the month age 70 (or 72) is attained.

§ 225.36 Effect of DRC's on survivor annuities.

(a) *Widow(er), remarried widow(er) or surviving divorced spouse.* Delayed retirement credits that the employee earned are used in computing the tier I component of a widow(er), remarried widow(er) or surviving divorced spouse annuity. All DRC's, including credits earned in the year of death, can be used in computing the widow(er) or surviving divorced spouse annuity beginning with the month of death. Delayed retirement credits for months up to, but not including, the month of death are used.

(b) *Other survivor annuities.* Delayed retirement credits cannot be used in computing any other survivor annuity based on the deceased employee's record.

Subpart E—Cost-of-Living Increases

§ 225.40 General.

A cost-of-living increase is an automatic increase in a PIA provided under section 215(i) of the Social Security Act. The Social Security Administration determines the percentage amount of any cost-of-living increase paid by the Board.

§ 225.41 How a cost-of-living increase is determined and applied.

Depending on the condition of the social security trust funds, the increase can be based on rises in either the consumer price index as published by the Department of Labor or the average wage index which is the average of the annual total wages used for computing a PIA. The increase is payable when the appropriate index for the third calendar quarter of one year shows an increase of at least three percent over the same index for the third calendar quarter of the previous year (or the last calendar quarter within which a legislated general benefit increase became effective). No increase is payable for the calendar year that immediately follows a year in which a legislated general benefit increase was effective. The increase amount is determined by multiplying the PIA by the percentage increase in the appropriate quarter of a previous year.

§ 225.42 Notice of the percentage amount of a cost-of-living increase.

The percentage amount of the cost-of-living increase is published in the FEDERAL REGISTER by the Secretary of Health and Human Services within 45 days of the end of the measuring period used in finding the increase.

§ 225.43 PIA's subject to cost-of-living increases.

The Retirement Tier I, Overall Minimum, Survivor Tier I, Employee RIB and RLS PIA's are adjusted for cost-of-living increases. The remaining PIA's described in subparts B and C of this part are frozen at the amounts determined under the Social Security Act as in effect on December 31, 1974.

§ 225.44 When a cost-of-living increase is payable.

A cost-of-living increase is payable beginning with December of the year for which the increase is due. The increase is paid in the January payment.

Subpart F—Recomputing PIA's

§ 225.50 General.

After an annuitant begins receiving an annuity, the PIA's may be recomputed as explained in § 225.52. Most recomputations result in an increase in the PIA. The Board pays a recomputed PIA when an increase of at least $1 results. Most recomputations are processed automatically and require no action by the annuitant.

§ 225.51 PIA's that are subject to recomputation.

The following PIA's are subject to recomputation—

(a) Tier I PIA;

(b) Survivor Tier I PIA;

(c) Overall Minimum PIA;

(d) Employee RIB PIA; and

(e) Residual Lump-Sum PIA.

§ 225.52 Reasons for recomputing a PIA.

There are three major reasons for recomputing a PIA:

(a) Recomputation to consider additional earnings.

(b) Recomputation when an employee is eligible for periodic pension payments based on other than railroad or social security earnings.

(c) Recomputation to use a new or different PIA formula, as provided in section 215(f) of the Social Security Act.

§ 225.53 Recomputation to consider additional earnings.

(a) *Additional earnings that cause a recomputation*—(1) *Earnings not included in earlier computation or recomputation.* The most common reason for recomputing a PIA is to include earnings that were not used previously, as described in paragraphs (a)(2) through (a)(4) of this section. The inclusion of these earnings may result in a revised Average Monthly Earnings or revised Average Indexed Monthly Earnings amount and, consequently, cause recomputation of the PIA.

(2) *Earnings in the year an employee becomes entitled to an age annuity or becomes disabled.* Earnings in the year an employee becomes entitled to an age annuity or becomes disabled are not used in the initial computation of the PIA. However, the Board does consider those earnings in a recomputation of the PIA and begins paying the higher benefits at the time described in paragraph (b) of this section.

(3) *Earnings not reported in time to use them in the computation of the PIA.* Because of the way reports of earnings are made, the earnings an employee has in the year before he or she becomes entitled to an annuity, becomes disabled, or dies, might not be reported in time to use them in computing the PIA. The Board recomputes the PIA with the new earnings information and begins paying annuitants the higher benefits based on the additional earnings at the time described in paragraph (b) of this section.

(4) *Earnings after entitlement that are used in a recomputation.* Earnings for a year after an employee becomes entitled to an annuity are used in a recomputation of a PIA when the earnings are higher than those for a year used in the previous PIA computation.

(b) *Effective date of recomputation to consider additional earnings.* A PIA that is recomputed to include additional earnings becomes payable at the latest of the following times:

(1) Date the annuity begins.

(2) January of the year following the year an employee receiving an age annuity attains age 62.

(3) January of the year following the year an employee becomes disabled.

(4) January of the year following the year in which the earnings are earned.

Example: Mr. Jones, a railroad employee, becomes entitled to an age annuity in June 1986, at the age of 62. Although Mr. Jones has earnings of $23,000 in the first five months of 1986, those earnings cannot be used in the initial computation of the Tier I PIA. However, effective with January 1, 1987, the Tier I PIA is recomputed to include the earnings for 1986.

§ 225.54 Recomputation when an employee is eligible for periodic pension payments based on other than railroad or social security earnings.

(a) *Description.* This recomputation serves as a reduction in the PIA for entitlement to a periodic pension based, in part or in whole, on earnings after 1956 not covered under either the Social Security Act or the Railroad Retirement Act. A recomputation for a periodic pension is made in accordance with sections 215(a)(7) and 215(f)(9) of the Social Security Act. A recomputation affecting the Retirement Tier I, Overall Minimum, or Residual Lump-Sum PIA is required when all the following conditions exist—

(1) The employee has less than 30 years of coverage as defined in section 215(a) of the Social Security Act. The years of coverage include railroad and social security earnings;

(2) The employee becomes eligible for an annuity after 1985; and

(3) The employee becomes eligible for the periodic pension payments after 1985 based, in part or in whole, on earnings after 1956 not covered under either the Social Security Act or the Railroad Retirement Act.

(b) *Effective date of recomputation.* The Retirement Tier I, Overall Minimum or Residual Lump-Sum PIA is recomputed

when the employee becomes eligible for a periodic pension payment based on other than railroad or social security earnings. However, payment of the recomputed PIA is effective with the month in which the employee becomes entitled to the periodic pension.

§ 225.55 Recomputation to use a new or different PIA formula.

(a) *Description*—(1) *New computation formula.* If a new formula for computing or recomputing PIA's is enacted into law and the annuitant is eligible for the recomputation, the Board will recompute the PIA under the new formula.

(2) *Recomputation under different formula.* In some cases, a PIA may be recomputed under a computation formula different from the formula used in the computation (or earlier recomputation) of the PIA. The annuitant must be eligible for a computation or recomputation under the different formula.

(b) *Effective date of recomputation*—(1) *New computation formula.* A PIA recomputed under a newly enacted formula is effective with the month as directed in the legislation that establishes the new formula. The new PIA formula applies when it produces a PIA that is higher than the amount on which the existing annuity is based.

(2) *Different computation formula.* A PIA recomputed under a different formula is effective with the first month that the different formula produces a PIA that is higher than the PIA on which the existing annuity is based.

§ 225.56 Automatic recomputation.

Periodically, the Board reviews the earnings record of every retired, disabled and recently deceased employee to see if a recomputation of the PIA is necessary. When a recomputation is called for due to a change in the reported railroad or social security earnings, the Board processes it automatically. Increased benefits resulting from a recomputation are paid from the earliest month that the recomputation is effective. The annuitant does not have to request a recomputation to consider additional earnings, although the annuitant may request a recomputation before the automatic recomputation is processed. However, the effective date of the recomputation is the same, whether the recomputation is done automatically or at the request of the annuitant.

§ 225.57 Requesting a recomputation.

An annuitant who meets the conditions for a recomputation may request that his or her PIA be recomputed sooner than it would be recomputed automatically. Providing inclusion of the additional earnings increases the PIA, the Board will recompute the PIA from the earliest permissible date as described in this part.

§ 225.58 Waiver of recomputation.

If the employee or the employee's family are disadvantaged in any way by a recomputation of a PIA to consider additional earnings, a request can be made to waive or give up the right to the recomputation. Such a request must be in writing and be made by every entitled family member. A request for waiver of a recomputation applies only to that recomputation for which the request is made.

Subpart G—Adjusting PIA's

§ 225.60 Adjustment at age 62 when employee is entitled to an annuity based on 30 years of railroad service.

(a) *Description.* The Tier I PIA of an employee who is entitled to an age annuity based on 30 years of railroad service is adjusted when the employee reaches age 62. The Average Indexed Monthly Earnings on which the PIA is based is adjusted by using the year in which the employee attains age 62 as the eligibility year. This adjustment applies to any employee who attained age 60 or acquired 30 years of railroad service after June 30, 1984. The adjustment affects the tier I of the employee and spouse annuity.

(b) *Effective date of adjustment.* A PIA adjustment based on the employee's attainment of age 62 is effective with the first full month in which the employee is age 62. For purposes of a spouse age annuity tier I, the adjusted PIA is used beginning with the first full month both the employee and spouse are age 62.

PART 226—COMPUTING EMPLOYEE, SPOUSE, AND DIVORCED SPOUSE ANNUITIES

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Subpart A—General

§ 226.1 Introduction.

This part explains how employee, spouse, and divorced spouse annuities are computed. It describes how to determine the years of railroad service and average monthly compensation used in computing the employee annuity rate. The railroad retirement family maximum, cost-of-living increases, and the recomputation of an annuity to include additional railroad earnings are also explained in this part.

§ 226.2 Definitions.

Except as otherwise expressly noted, as used in this part—

Annuity means a payment due an entitled individual for a calendar month and payable to him or her on the first day of the following month.

Eligible means that an individual meets all the requirements for payment of an annuity but has not yet applied for one.

Employee means an individual who is or has been in the service of an employer as defined in part 202 of this chapter.

Entitled means that an individual has applied for and has established his or her rights to benefits.

Railroad Retirement Act means the Railroad Retirement Act of 1974, as amended.

Retirement age means, with respect to an employee, spouse or divorced spouse who attains age 62 before January 1, 2000, age 65. For an employee, spouse or divorced spouse who attains age 62 after December 31, 1999, retirement age means the age provided for in section 216(l) of the Social Security Act.

Social Security Act means the Social Security Act as amended.

§ 226.3 Other regulations related to this part.

This part is closely related to part 216 of this chapter, which describes

when an employee, spouse, or divorced spouse is eligible for an annuity, part 225 of this chapter, which explains the primary insurance amounts (PIA's) used in computing the employee, spouse and divorced spouse annuity rates, and part 229 of this chapter, which describes when and how employee and spouse annuities can be increased under the social security overall minimum. The creditable service and compensation used in determining the years of service and average monthly compensation are explained in parts 210 and 211 of this chapter. The beginning and ending dates of annuities are explained in part 218 of this chapter.

Subpart B—Computing an Employee Annuity

§ 226.10 Employee tier I.

Tier I of an employee annuity is an amount similar to the social security benefit the employee would receive based on combined railroad and social security earnings. The tier I benefit is computed as follows:

(a) A tier I PIA is computed based on combined railroad and social security earnings, as shown in § 225.11 of this chapter. This PIA is adjusted for any delayed retirement credits or cost-of-living increases, as shown in subparts D and E of part 225 of this chapter, and is reduced for receipt of a pension based upon non-covered service in accordance with section 215(a)(7) of the Social Security Act. The tier I of a disability annuity may also be adjusted for other benefits based on disability, as shown in §§ 226.70–226.74 of this part. Except in the case of an employee who retires at age 60 with 30 years of service, if the result is not a multiple of $1, it is rounded to the next lower multiple of $1. In the case of an employee who retires with an age reduced annuity based upon 30 years of service (see § 216.31 of this chapter) the tier I is not rounded until all reductions have been made.

(b) If the employee is entitled to a reduced age annuity (see § 216.31 of this chapter), the rate from paragraph (a) of this section is multiplied by a fraction for each month the employee is under retirement age on the annuity beginning date. The result is subtracted from the rate in paragraph (a) of this section. At present the fraction is 5/9 of 1% (or 1/180). If the employee retires before age 62 with at least 30 years of service, the employee is deemed age 62 for age reduction purposes and a 20% reduction is applied. This reduction remains in effect until the first full month throughout which the employee is age 62, at which time the tier I is recomputed to reflect interim increases in the national wage levels and the age reduction factor is recomputed, if necessary, in accordance with this paragraph.

(c) The amount from paragraph (a) or (b) of this section is reduced by the amount of any monthly benefit payable to the employee under title II of the Social Security Act, including any social security benefit payable under a totalization agreement between the Social Security Administration and another country. The social security benefit used to reduce the tier I may be an age or disability benefit on the employee's own earnings record, a benefit based on the earnings record of another person, or the total of two types of benefits. The amount of the social security benefit used to reduce tier I is before any deduction for excess earnings. It is after any reduction for other benefits based on disability. The result cannot be less than zero.

(d) The tier I is subject to automatic annual increases as provided for in subpart E of part 225 of this chapter.

Example: An employee born on November 3, 1919, becomes entitled to an age annuity effective October 1, 1982. Retirement age for individuals born in 1919 is age 65. He has less than 30 years of service. His tier I PIA Is $712.60, which is rounded down to $712. Since the employee is 25 months under age 65 when his annuity begins, $712 is multiplied by 25/180 (1/180 for each month under age 65), to produce an age reduction of $98.89, and a tier I rate after age reduction of $613.11. The employee is also entitled to a social security benefit of $190 a month. The employee's final tier I rate is $423.11.

§ 226.11 Employee tier II.

The tier II of an employee annuity is based only on railroad service. For annuities awarded after September 1981, the tier II benefit is computed as follows:

(a) The product obtained by multiplying the employee's creditable years of service by the average monthly compensation, determined as shown in subpart E of this part, is multiplied by seven-tenths of 1 percent (.007).

(b) If the employee is entitled to a vested dual benefit (see § 226.12 of this part), the result from paragraph (a) of this section is reduced by 25 percent of the vested dual benefit amount. This reduction is made before reduction of the tier II benefit for age. The result cannot be less than zero.

(c) If the railroad retirement family maximum applies, as shown in §§ 226.50–226.52 of this part, the amount from paragraph (a) or (b) of this section is reduced by the smaller of—

(1) The difference between the total railroad retirement maximum reduction amount and the reductions in the spouse and supplemental annuities; or

(2) The total tier II amount from paragraph (a) or (b) of this section.

(d) If the employee is entitled to a reduced age annuity (see § 216.31 of this chapter), the rate from paragraph (a) through (c) of this section is reduced in the same manner as the tier I as provided for in § 226.10 of this part. In the case of an employee with 30 years of service who is entitled to a reduced age annuity (see § 216.31 of this chapter), the age reduction only applies to the tier I component; no age reduction applies to the tier II component.

(e) The total tier II amount (paragraphs (a) through (d) of this section), is increased by 32.5 percent of the percentage increase in the cost-of-living increase to the tier I annuity component. Each cost-of-living increase is paid only to an employee whose annuity begins on or before the effective date of the increase. The increases are effective on the same date as any cost-of-living increase to the tier I annuity component.

§ 226.12 Employee vested dual benefit.

(a) *General.* An employee vested dual benefit is payable, in addition to tiers I and II, to an employee who meets one of the following requirements:

(1) *Employee worked in the railroad industry in 1974.* An employee who worked for a railroad in 1974 and retired after 1974 is considered vested if on December 31, 1974, he or she had both 10 years of railroad service and sufficient quarters of coverage under the Social Security Act to qualify for a social security benefit. An employee qualified on this basis is eligible for vested dual benefit amounts computed on his or her railroad and social security credits through December 31, 1974.

(2) *Employee who did not work for a railroad in 1974.* An employee who did not work in the railroad industry in 1974, but who had 25 or more years of railroad service before 1975 or a current connection with the railroad industry on December 31, 1974, as defined in part 216 of this chapter, or a current connection when he or she retired, is also considered vested under the same conditions as an employee who had worked in the railroad industry in 1974.

(3) *An employee who completed 10 years or more years of railroad service (but less than 25) before 1975 but left the industry before 1975 and did not have a current connection on December 31, 1974 or when he or she retired.* Such an employee is considered vested only if he or she had sufficient social security quarters of coverage to qualify for a social security retirement benefit as of the end of the year prior to 1975 in which he or she left the railroad industry. The vested dual benefit amount is based only on credits acquired through the last year of pre-1975 railroad service instead of through December 31, 1974.

(b) *Computation.* The employee vested dual benefit is computed as follows:

(1) The combined earnings dual benefit PIA is subtracted from the total of the railroad earnings dual benefit PIA and the social security earnings dual benefit PIA (see part 225 of this chapter for an explanation of these PIA's).

(2) The result from paragraph (b)(1) of this section is adjusted for any applicable cost-of-living increase, as shown in § 226.13 of this part.

(3) If the employee is entitled to a reduced age annuity (see § 216.1 of this chapter), the rate from paragraph (b)(2) of this section is reduced in the same manner as the tier I as provided for in § 226.10 of this part. In the case of an employee with 30 years of service who is entitled to an annuity reduced for age, the age reduction applies only to

the tier I component; no age reduction applies to the vested dual benefit.

(4) The vested dual benefit payable in a given year may also be reduced for insufficient funding as shown in part 233 of this chapter.

Example: An employee born on November 3, 1919, becomes entitled to an annuity including a vested dual benefit on October 1, 1982. His combined earnings dual benefit PIA is $254.90, his railroad earnings dual benefit PIA is $93.80, and his social security earnings dual benefit PIA is $244.70. The vested dual benefit before cost-of-living increase is $83.60 ($93.80 + $244.70 −$254.90 = $83.60). A cost-of-living increase of $67.72 (81 percent of $83.60. See § 226.13 of this part) results in a vested dual benefit of $151.32. Retirement age for a person born in 1919 is age 65. Since the employee is 25 months under age 65 when the annuity begins, $151.32 is multiplied by 25/180, to produce an age reduction of $21.02 and a vested dual benefit rate after age reduction of $130.30.

§ 226.13 Cost-of-living increase in employee vested dual benefit.

If the employee's annuity begins June 1, 1975 or later, a cost-of-living increase is added to the total vested dual benefit amount. This increase is based on the cost-of-living increases in social security benefits during the period from January 1, 1975, to the earlier of the date the employee's annuity begins or January 1, 1982. The increases are effective on June 1 of each year through 1981. The percentage increase for annuities that begin June 1, 1981, or later is 81 percent.

§ 226.14 Employee regular annuity rate.

The regular annuity rate payable to the employee is the total of the employee tier I, tier II, and vested dual benefit amounts, from §§ 226.10–226.12.

§ 226.15 Deductions from employee regular annuity rate.

The employee annuity as computed under this subpart may be reduced by premiums required for supplemental medicare coverage, income tax withholding, recovery of debts due the Federal government, garnishment pursuant to part 350 of the chapter and property awards as provided for in part 295 of this chapter.

§ 226.16 Supplemental annuity.

A supplemental annuity is payable in addition to tiers I and II and the vested dual benefit to an employee who meets the requirements of § 216.41 of this chapter. The supplemental annuity is equal to $23 plus $4 for each full year of service, over 25 years of service, up to a maximum of $43. The supplemental annuity may be reduced by the railroad retirement family maximum as shown in §§ 226.50–226.52 of this part, or for the receipt of a private pension benefit as explained in part 227 of this chapter.

Subpart C—Computing a Spouse or Divorced Spouse Annuity

§ 226.30 Spouse or divorced spouse tier I.

(a) *General.* The tier I of a spouse or divorced spouse annuity is an amount similar to the social security benefit the spouse or divorced spouse would receive based on the employee's combined railroad and social security earnings. In the case of an employee who retires before age 62 with 30 years of service, the spouse tier I is simply 50% of the employee tier I until the first month throughout which both the employee and spouse are age 62 at which time the tier I is an amount similar to the social security benefit on the employee's combined railroad and social security earnings.

(b) *Reduction for other disability benefits.* The spouse or divorced spouse tier I may be adjusted for other disability benefits received by a disabled employee, as shown in §§ 226.70–226.74 of this part.

(c) *Reduction for government pension.* The amount in paragraphs (a) or (b) of this section is reduced (but not below zero) by the amount of any government pension payable on the spouse's or divorced spouse's earnings record, as described in § 226.31 of this part.

(d) *Rounding.* The last tier I rate from paragraph (a), (b) or (c) of this section, if not a multiple of $1, is rounded to the next lower multiple of $1. However, in cases in which the spouse is in receipt of an age reduced 60/30 annuity or in which the employee with 30 years of service began a disability annuity July 1, 1984, or later,

the spouse tier I is not rounded until all reductions have been made. See § 226.10(a).

(e) *Age reduction.* If the spouse or divorced spouse is entitled to a reduced age annuity (see §§ 216.51 and 216.52 of this chapter), the rounded tier I rate from paragraph (d) of this section is multiplied by a fraction for each month the spouse or divorced spouse is under retirement age on the date the annuity begins. The result is subtracted from the rate from paragraph (d) of this section. At present the fraction is 25/36 of 1% (or 1/144). In the case of an employee with 30 years of service who is awarded a disability annuity on July 1, 1984, or later, where the spouse does not have a child of the employee under age 18 in care, the spouse tier I is reduced for each month the spouse is under retirement age on the date the spouse annuity begins. If the spouse is age 60 or 61, he or she is deemed to be age 62 for purposes of the age reduction. The age reduction is applied before reduction for a government pension.

(f) *Reduction for social security benefit.* The previous tier I rate, from paragraph (d) or (e) of this section, is reduced by the amount of any monthly benefit payable to the spouse or divorced spouse under title II of the Social Security Act. The social security benefit used to reduce tier I may be an age or disability benefit on the spouse's or divorced spouse's own earnings record, a benefit based on the earnings record of another person, or the total of two types of benefits. The result cannot be less than zero.

(g) *Reduction for employee annuity.* If the spouse or divorced spouse is entitled to an employee annuity on his or her own wage record, the spouse or divorced spouse tier I is reduced for the spouse's own employee annuity as follows:

(1) *Spouse.* If either the employee or the spouse had some railroad service before 1975, the previous tier I rate from paragraphs (d) through (f) of this section, whichever applies, is reduced (but not below zero) by the spouse's own employee tier I rate, as computed under § 226.10 of this part. If both the employee and spouse began railroad service after 1974, the spouse's total annuity rate, as shown in § 226.33, is reduced (but not below zero) by the spouse's own employee total annuity rate, as shown in § 226.14. These reductions are effective from the later of the date the employee or spouse annuity begins.

(2) *Divorced spouse.* The previous tier I rate from paragraphs (d) through (f) of this section, whichever applies, is reduced (but not below zero) by the divorced spouse's own employee total annuity rate as shown in § 226.14.

Example: The computation of the spouse tier I may be illustrated as follows: A railroad employee's wife who was born on September 16, 1920, becomes entitled to a spouse annuity on October 1, 1982. She is also entitled to a social security benefit of $190 a month effective October 1, 1982. Her husband's employee tier I PIA is $712.60. The spouse tier I is $356.30 (50 percent of $712.60). This is rounded down to $356. Since she is 35 months under age 65, the present retirement age when the annuity begins, $356 is multiplied by 35/144, to produce an age reduction of $86.53 and a tier I rate after age reduction of $269.47. Her final tier I rate effective October 1, 1982, after reduction for social security benefits, is $79.47 ($269.47 − $190.00).

§ 226.31 Reduction for public pension.

(a) The tier I annuity component of a spouse/divorced spouse annuity, as described in the preceding sections of this part, is reduced if the spouse/divorced spouse is in receipt of a public pension.

(b) *When reduction is required.* Unless the spouse or divorced spouse annuity meets one of the exceptions in paragraph (d) of this section, the tier I annuity component is reduced each month the annuitant is receiving a monthly pension from a Federal, state, or local government agency (government pension), but excluding a pension paid by a government of a foreign country, for which he or she was employed in work not covered by social security on the last day of such employment. For purposes of this section, Federal government employees are not considered to be covered by social security if they are covered for Medicare but are not otherwise covered by social security.

(c) *Payment in a lump sum.* If the government pension is not paid monthly or is paid in a lump-sum payment, the Board will determine how much the

pension would be if it were paid monthly and then reduce the monthly railroad retirement annuity accordingly. The number of years covered by a lump-sum payment and thus the period when the annuity will be reduced, will generally be clear from the pension plan. If one of the alternatives to a lump-sum payment is a life annuity, and the amount of the monthly benefit for the life annuity can be determined, the reduction will be based on that monthly benefit amount. Where the period or the equivalent monthly pension benefit is not clear, it may be necessary for the Board to determine the reduction period on an individual basis.

(d) *Exceptions.* The reduction does not apply:

(1) If the annuitant is receiving a government pension based on employment for an interstate instrumentality; or

(2) If the annuitant receives or is eligible to receive a government pension for one or more months in the period December 1977 through November 1982 and he or she meets the requirements for social security benefits that were applied in January 1977 (even though he or she did not actually claim such benefits nor become entitled to such benefits until a later month). The January 1977 requirements are, for a man, a one-half support test (see paragraph (e) of this section), and, for a woman claiming benefits as a divorced spouse, marriage for at least 20 years to the insured worker. A person is considered eligible for a government pension for any month in which he or she meets all the requirements for payment except that he or she is working or has not applied; or

(3) If the annuitant was receiving or eligible (as defined in paragraph (d)(2) of this section) to receive a government pension for one or more months before July 1983, and he or she meets the one-half support test (see paragraph (e) of this section). If the annuitant meets the exception in this paragraph but he or she does not meet the exception in paragraph (d)(2) of this section, December 1982 is the earliest month for which the reduction will not affect his benefits; or

(4) If the annuitant has been eligible for a government pension in a given month except for a requirement which delayed eligibility for such pension until the month following the month in which all other requirements were met, the Board will consider the annuitant to be eligible in that given month for the purpose of meeting one of the exceptions in paragraphs (d)(2) and (d)(3) of this section. If the annuitant meets an exception solely because of this paragraph, his or her benefits will be unreduced for months after November 1984 only.

(e) *The one-half support test.* For a man to meet the January 1977 requirement as provided in the exception in paragraph (d)(2) of this section and for a man or a woman to meet the exception in paragraph (d)(3) of this section, he or she must meet a one-half support test. One-half support is defined in part 222 of this chapter. One-half support must be met at one of the following times:

(1) If the employee upon whose compensation the spouse or divorced spouse annuity is based had a period of disability, as defined in part 220 of this chapter, which did not end before he or she became entitled to an age and service or disability annuity, the spouse/divorced spouse annuitant must have been receiving at least one-half support from the employee either—

(i) At the beginning of the employee's period of disability; or

(ii) At the time the employee became entitled to an age and service or disability annuity.

(2) If the employee upon whose compensation the spouse or divorced spouse annuity is based did not have a period of disability, as defined in part 220 of this chapter, at the time of his or her entitlement, the spouse or divorced spouse annuitant must have been receiving at least one-half support from the employee at the time the employee became entitled to an age and service or disability annuity.

(f) *Amount of reduction.* (1) If the spouse/divorced spouse annuitant becomes eligible for a government pension after June 1983, the Board will reduce (to zero, if necessary) the tier I annuity component by two-thirds of the amount of the monthly pension. If the amount of the reduction is not a

multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(2) If the spouse/divorced spouse annuitant became eligible for a government pension before July 1983 and he or she did not meet one of the exceptions in paragraph (d) of this section, the Board will reduce (to zero, if necessary) the tier I component by the full amount of the pension for months before December 1984 and by two-thirds the amount of his or her monthly pension for months after November 1984. If the amount of the reduction is not a multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(g) *Reduction not applicable.* This reduction is not applied to claimants who both filed and were entitled to a spouse benefit prior to December 1977.

§ 226.32 Spouse tier II.

The spouse tier II benefit is computed as follows:

(a) The employee's tier II amount as computed under § 226.11 of this part, after any reduction for entitlement to a vested dual benefit but before reduction for the railroad retirement family maximum, is multiplied by 45 percent. The spouse tier II is recomputed if the employee's tier II rate is reduced for entitlement to a vested dual benefit after the beginning date of the spouse annuity.

(b) If tier I of a spouse annuity is reduced for the spouse's employee annuity, as provided for in § 226.30(g) of this part, the reduction is restored in tier II. The restored amount is payable on the effective date of the spouse or the employee tier I benefit, whichever is later. The previous tier II rate is increased by the restored amount, which is determined as follows:

(1) *Initial restored amount.* The restored amount is the amount by which the spouse tier I was reduced by reason of receipt of an employee annuity on the date the restored amount is first payable. The restored amount is only payable if either the employee or spouse had railroad service prior to 1975.

(2) *Recomputation of restored amount.* The restored amount is recomputed if the spouse becomes entitled to a government pension, a social security benefit, or a different type of social security benefit after the date the initial restored amount is effective. The recomputed amount is the amount by which the spouse tier I is reduced by reason of receipt of an employee annuity on the effective date of the entitlement to a government pension or social security benefit.

(3) *Cost-of-living increase in restored amount.* If an initial or recomputed restored amount is effective before the effective date of the cost-of-living increase shown in paragraph (e) of this section, the restored amount is multiplied by the percentage increase that applies. The result is added to the restored amount on the effective date of the increase for each year that the increase is payable.

(c) If the employee's tier II has been reduced pursuant to section 3(g)(2) of the Railroad Retirement Act (takeback provision) the spouse tier II is reduced by one half of the ''takeback'' in the employee tier II.

(d) If the railroad retirement family maximum applies, as shown in §§ 226.50–226.52 of this part, the spouse tier II rate, as determined in paragraphs (a) through (c) of this section, is reduced by the smaller of—

(1) The total railroad retirement maximum reduction amount; or

(2) The previous spouse tier II rate.

(e) The tier II rate, from paragraphs (a) through (d) of this section, is increased by the same percentage as the employee tier II increase described in § 226.11(e) of this part.

(f) If the spouse is entitled to a reduced age annuity (see § 216.51 of this chapter), the tier II rate, as determined in paragraphs (a) through (e) of this section is reduced in the same manner as the tier I as provided for in § 226.30(e) of this part.

Example: An employee's tier II rate is $329.63 effective October 17, 1981. The spouse rate is $148.33 (45 percent × $329.63) effective October 17, 1981. This is increased to $151.89 effective June 1, 1982, by a cost-of-living increase of 2.4 percent. The spouse is 35 months under age 65, the present retirement age, when the annuity begins. The $151.89 rate is multiplied by $^{35}/_{144}$ to produce an age reduction of $36.92. This is subtracted from $151.89 to produce a final rate of $114.97.

§ 226.33 Spouse regular annuity rate.

The final tier I and tier II rates, from §§ 226.30 and 226.32, are added together to obtain the total spouse regular annuity rate.

§ 226.34 Divorced spouse regular annuity rate.

The regular annuity rate of a divorced spouse is equal to his or her tier I amount. The divorced spouse is not entitled to a tier II benefit.

§ 226.35 Deductions from regular annuity rate.

The regular annuity rate of the spouse and divorced spouse annuity may be reduced by premiums required for supplemental medicare coverage, income tax withholding (spouse annuity only), recovery of debts due the Federal government, and garnishment pursuant to part 350 of this chapter.

Subpart D—Railroad Retirement Family Maximum

§ 226.50 General.

There is a monthly ceiling on total family benefits which limits the amount of certain portions of the employee and spouse annuity. This railroad retirement family maximum amount varies according to the employee's earnings in the ten-year period that ends with the year in which his or her annuity begins. If the employee and spouse annuity amounts described in § 226.52 of this part are higher than the maximum from § 226.51 of this part, first the spouse tier II, then the supplemental annuity and, finally, the employee tier II are reduced until the total annuity amount is equal to the maximum or until the spouse tier II and the employee supplemental annuity and tier II have been reduced to zero, whichever comes first. The reduction for the railroad retirement family maximum is first computed from the date the employee's annuity begins. It is recomputed if the employee's tier II rate is reduced for entitlement to a vested dual benefit. It is also recomputed if a workers' compensation or other disability benefit begins or ends, or the employee's tier I benefit or supplemental annuity begins after the beginning date of the regular employee annuity. Finally, it is recomputed if a spouse who was entitled to an annuity divorces the employee or the spouse annuity entitlement ends.

§ 226.51 Maximum monthly amount.

The railroad retirement family maximum is equal to an employee's ''final average monthly compensation'' (FAMC) up to ½ of 1/12 of the annual maximum tier I earnings as shown in part 224 of this chapter in the year the annuity begins plus 80 percent of so much of his or her FAMC as exceeds ½ of 1/12 of the tier I maximum in the year the annuity begins. For this purpose, the FAMC is determined by dividing the individual's total earnings up to the tier II earnings limit as shown in part 211 of this chapter for the two highest-earnings years out of the last 10 calendar years, including the year of retirement, by 24. The railroad retirement maximum cannot be more than the FAMC and cannot be less than $1,200.

Example: An employee's annuity begins on December 2, 1982. He has yearly earnings that exceed the tier II annual maximum of $24,300 in 1982 and $22,200 in 1981. The FAMC is the sum of the tier II maximum for 1981 and 1982 divided by 24 ($24,300 + $22,200 ÷ 24) or $1,937.50. The maximum which may be credited to a month for tier I in 1982 is $2,700. The family maximum is $1,350 (½ of 1/12 of the annual tier I maximum) plus $470 (80% of the difference between $1,937.50 and $1,350) or $1,820.

§ 226.52 Total annuity subject to maximum.

The total annuity amount which is compared to the maximum monthly amount to determine if a reduction for the railroad retirement family maximum applies is determined by adding together the amounts in paragraphs (a) and (b) of this section. A hypothetical spouse annuity amount is included from the beginning date of the employee annuity if the spouse is not entitled to an annuity at the time the maximum calculation is made.

(a) *Employee annuity amounts.* The following amounts are added together—

(1) The employee tier I amount, effective on the date the employee's tier I benefit begins or, if later, on the date a

reduction for other disability benefits begins or ends, as shown in § 226.71 of this part. This amount is before any reduction for age or social security benefits but after including any delayed retirement credits, after any reduction for other disability benefits, and after rounding; and

(2) The employee tier II rate before reduction for the railroad retirement family maximum, effective on the employee's annuity beginning date and, if later, on the date the tier II is first reduced for a vested dual benefit, as shown in § 226.11 of this part; and

(3) The initial supplemental annuity rate effective on the date the supplemental annuity begins, before any reduction for a private pension, as shown in part 227 of this chapter.

(b) *Spouse annuity amounts.* The following amounts are added together—

(1) The spouse tier I amount, which is or would be effective on the date the employee's annuity or tier I benefit begins, as shown in § 226.30. This amount is before any reduction for other disability benefits, age, or social security benefits, but after any reduction for a government pension or employee annuity; and

(2) The spouse tier II rate which is or would be effective on the employee's annuity beginning date, the date the employee's tier I benefit begins, or the date the employee's tier II rate is reduced for a vested dual benefit, as shown in § 226.11. This rate includes the restored amount but does not include any cost-of-living increase in the tier II original rate or restored amount. It is the rate before reduction for the railroad retirement family maximum or age minus any cost-of-living increases.

Subpart E—Years of Service and Average Monthly Compensation

§ 226.60 General.

The years of service and average monthly compensation used in computing an employee's tier II annuity rate are based on the employee's creditable railroad service and compensation as described in parts 210 and 211 of this chapter. In computing the average monthly compensation, the compensation for each year cannot be higher than twelve times the tier II monthly maximum creditable for that year, as described in part 211 of this chapter.

§ 226.61 Use of military service.

(a) *Claim for use of military service.* An employee is deemed to have filed a claim for the use of military service and earnings as service and compensation under the Railroad Retirement Act if—

(1) The employee indicates on the annuity application or another signed statement that he or she has military service;

(2) The employee does not specifically request that the military service be credited as wages under the Social Security Act;

(3) The military service is creditable under the Railroad Retirement Act, as shown in part 212 of this chapter; and

(4) Using the military service as railroad service and compensation would be to the employee's advantage (the employee and his or her family would receive higher total benefits than if the military service were credited under the Social Security Act).

(b) *Effective date for use of military service.* Military service can be used as service and compensation under the Railroad Retirement Act starting with the date the annuity begins but no earlier than twelve months before the employee files an application or statement showing that he or she has military service.

§ 226.62 Computing average monthly compensation.

The employee's average monthly compensation is computed by first determining the employee's highest 60 months of railroad compensation (disregarding compensation in excess of the maximum creditable tier II compensation for that year). The total of the highest 60 months is then divided by 60 to determine the average monthly compensation.

§ 226.63 Determining monthly compensation.

(a) *Based on yearly compensation.* If Board records do not show monthly compensation for a year, the monthly compensation is determined by dividing the total compensation reported for the year by the number of months of

service credited to the employee for that year.

(b) *For employee with government employment and no railroad service for 60-month period before annuity begins*—(1) *General.* The compensation used in determining the average monthly compensation (AMC) is indexed for an employee who has not worked in the railroad industry for the 60-month period before the month the employee's annuity begins and whose major employment during that period was for a government agency listed in § 216.16 of this chapter. The compensation is indexed by multiplying it by the quotient obtained by dividing the average annual wage for the indexing year by the average annual wage for the year being indexed. If the month for which compensation is being indexed is before 1951, the average annual wage for 1951 is used.

(2) *Indexing year defined.* The indexing year is the second year before the year in which the annuity begins.

Subpart F—Reduction for Workers' Compensation and Disability Benefits Under a Federal, State, or Local Law or Plan

§ 226.70 General.

For any month an employee disability annuitant is entitled to workers' compensation or a public disability benefit, the tier I benefit of the spouse or divorced spouse is reduced due to receipt of such benefits. (If both spouse and divorced spouse annuities are payable, the reduction amount is divided and applied in equal amounts to both the spouse and divorced spouse tier I benefits.) The employee tier I is reduced by the difference between the total reduction amount, described in § 226.71 of this part, and the reduction in the spouse and divorced spouse tier I benefits.

§ 226.71 Initial reduction.

(a) *When reduction is effective.* A reduction for other disability benefits begins with the first month the employee is receiving both a disability annuity and workers' compensation or a public disability benefit. The reduction ends with the month before the month in which the employee becomes 65 years old or with the month in which the workers compensation or public disability benefit ends.

(b) *Amount of reduction.* The reduction for other disability benefits equals the difference between—

(1) The total tier I rates of the employee, spouse, and divorced spouse, before any reductions (age, public pension, social security benefits, etc.) plus the monthly amount of the workers' compensation of public disability benefit; and

(2) The higher of—

(i) Eighty percent of the employee's average current earnings, as defined in this section; or

(ii) The total tier I rates, as described in paragraph (b)(1) of this section.

Example 1: Harold is entitled to a monthly disability annuity with a tier I component of $507 and a monthly public disability benefit of $410 from the state. Eighty percent of Harold's average current earnings is $800. Because this amount is higher than Harold's tier I component, to determine the reduction for other disability benefits the Board subtracts this amount ($800) from the total of Harold's tier I component ($507) and public disability benefit ($410) which results in a reduction amount of $117 ($917–$800). This leaves Harold with a reduced tier I amount of $390 ($507–$117).

Example 2: Tom is entitled to a disability annuity with a tier I component of $560. His wife and divorced wife are both entitled to annuities with tier I components of $280 each. Total benefits are $1,120. Tom is receiving a monthly workers' compensation benefit of $500 from the state. Eighty percent of Tom's average current earnings is $820. Because the total benefit ($1,120) is higher than Tom's average current earnings, to determine the reduction for other disability benefits the Board subtracts this amount from $1,620 ($1,120 plus $500) which results in a reduction amount of $500. This means that the tier I of the spouse and divorced spouse annuity are each reduced by $250.

(c) *Average current earnings, defined.* An employee's ''average current earnings'' is the highest of—

(1) The average monthly wage (AMW) used to compute the tier I AMW PIA. (The earnings are not indexed, even if the tier I PIA which is being paid is based on average indexed monthly earnings. See part 225 of this chapter.); or

(2) One-sixtieth of the employee's total earnings covered under either the

Social Security or Railroad Retirement Acts (including earnings that exceed the maximum earnings used in computing social security benefits) for the five consecutive years after 1950 in which the employee had the highest earnings. The result, if not a multiple of $1, is rounded to the next lower multiple of $1; or

(3) One-twelfth of the employee's total earnings covered under either the Social Security or Railroad Retirement Acts (including earnings that exceed the maximum earnings used in computing social security benefits) for the year of highest earnings in the period which includes the year in which the employee became disabled and the five preceding years. The result, if not a multiple of $1, is rounded to the next lower multiple of $1.

§ 226.72 Benefits that do not cause a reduction.

The tier I is not reduced for the following types of benefits:

(a) A benefit paid under a law or plan that provided, on February 18, 1981, for reducing the benefit for entitlement to a disability insurance benefit under the Social Security Act.

(b) A Federal disability benefit based on service for other than a state or local government, if all or part of that service is covered under the Social Security Act.

(c) A disability benefit paid by the Federal government or a state or local government based on state or local employment, if all or substantially all of that employment is covered under the Social Security Act. ''Substantially all'' means 85 percent or more of the employment.

(d) A benefit paid by the Veteran's Administration.

(e) Private disability benefits.

(f) Amounts paid under the Federal Employers' Liability Act (FELA).

(g) Benefits based on need, such as welfare benefits or supplemental security income.

§ 226.73 Changes in reduction amount.

The reduction amount is not changed when a tier I benefit increases because of a recomputation or a general adjustment in annuity rates, such as a cost-of-living increase. However, the reduction amount may change for the following reasons:

(a) *A spouse or divorced spouse becomes entitled to a tier I benefit after the effective date of the reduction.* The reduction amount is recomputed as if the spouse or divorced spouse were entitled to a tier I benefit on the date the reduction first applied. The new reduction amount applies beginning with the date the spouse or divorced spouse tier I benefit begins.

Example: An employee became entitled to an annuity with a tier I component of $500 on May 1, 1991. He was also receiving a state disability benefit of $300 a month based on employment not covered under the Social Security Act. On June 1, 1991, the employee's tier I increased to $520.70. On October 1, 1991, the employee's wife becomes entitled to an annuity with a tier I benefit of $260.00. The tier I amount ($250) that would have been payable to the wife on May 1, 1991 (assuming she had been eligible for a benefit at that time) is used to determine the reduction for other disability benefits beginning October 1, 1991.

(b) *The tier I benefit of a spouse or divorced spouse annuity ends after the effective date of the reduction.* The new reduction amount is computed using the tier I rate to which the employee was entitled when the reduction first applied. The new reduction amount applies beginning with the month after the month in which the spouse or divorced spouse tier I benefit ends.

(c) The average current earnings are redetermined, as shown in § 226.74.

(d) *The amount of the other disability benefit changes.* The reduction amount is recomputed to use the new benefit rate beginning with the date on which the new rate is payable. Any increases in the tier I amounts which were effective after the reduction first applied are not included in computing the new reduction amount.

Example: The employee's tier I benefit is $500 on May 1, 1991, when the annuity is first reduced for other disability benefits. The tier I increases to $520 effective June 1, 1991. When the amount of the disability benefit changes on October 1, 1991, $500, not $520, is used as the employee tier I amount in recomputing the reduction amount.

§ 226.74 Redetermination of reduction.

(a) *General.* The average current earnings are redetermined in the second year after the year the reduction

for other disability benefits was first applied and every third year after that. The redetermined amount is used only if it results in a lower reduction amount. The new reduction amount is effective with January of the year after the redetermination is made.

(b) *Redetermined average current earnings.* The average current earnings are redetermined by multiplying the initial average current earnings amount by—

(1) The average of the total wages (including wages that exceed the maximum used in computing social security benefits) of all persons for whom wages were reported to the Secretary of the Treasury for the year before the year of redetermination, divided by the average of the total wages reported to the Secretary of the Treasury for 1977 or, if later, the year before the year for which the reduction was first computed. If the result is not a multiple of $1, it is rounded to the next lower multiple of $1; or

(2) If the reduction was first computed before 1978, the average of all taxable wages reported to the Secretary of Health and Human Services for the first quarter of 1977, divided by the average of all taxable wages reported to the Secretary of Health and Human Services for the first quarter of the year before the year for which the reduction was first computed. If the result is not a multiple of $1, it is rounded to the next lower multiple of $1.

Subpart G—Recomputation To Include Additional Railroad Service and Compensation

§ 226.90 When recomputation applies.

An employee's annuity may be recomputed to include additional railroad service and compensation and social security wages which the employee earns after the beginning date of the employee annuity. The annuity is recomputed only if the recomputation increases the annuity rate by more than $1 a month or results in a lump-sum payment of more than $5. Before a recomputed rate can be paid, the employee must stop working in the railroad industry. A recomputed tier I component is payable beginning with January 1 of the year after the year in which the wages or compensation are earned or (provided the employee is age 62 or disabled), in the case of railroad compensation, in the year after the employee stops working in the railroad industry. A recomputed tier II component is payable from the date the annuity is reinstated after the employee has ceased railroad work.

§ 226.91 How an employee annuity rate is recomputed.

(a) *Tier I.* A recomputation is made if any social security wages or railroad compensation for a year in which the employee returned to work are higher than the earnings for a year included in the previous computation of the tier I PIA, as shown in part 225 of this chapter. The higher earnings are used instead of the lower earnings for the earlier year to determine the average monthly wage or average indexed monthly earnings. Part 225 of this chapter describes how a PIA is recomputed.

(b) *Tier II.* The additional service is added to the years of service previously used in computing the tier II rate. The additional compensation is used to recompute the average monthly compensation, if the compensation for a month in which the employee returned to railroad service is higher than the compensation for a month used in the previous computation of the average monthly compensation. The higher monthly compensation is used instead of the lower compensation for a previous month to determine the new average monthly compensation as shown in § 226.62 of this part. The increased years of service and average monthly compensation are used in computing a new tier II rate, as shown in § 226.11 of this part.

Example: An employee receiving an annuity which began on January 1, 1992, returns to railroad service for 10 months in 1992 and 2 months in 1993. He stops work on February 20, 1993. He has earnings of $34,500.00 in 1992 and $5,200.00 in 1993. His tier II rate effective January 1, 1992, was based on 26 years (312 months) of service and an average monthly compensation of $2,995 ($179,700 ÷ 60). The additional 12 months of service increases the year of service used in computing the tier II rate to 27 (312 months + 12 months = 324 months ÷ 12 = 27). The 1992 earnings of $34,500.00 are used instead of 1987 earnings of

$32,700.00. The 1993 earnings are not used because they are lower than the earnings for previous months used in computing the average monthly compensation. The additional $1,800.00 in earnings increases the average monthly compensation to $3,025 ($179,100 + $1,800.00 = $181,500.00 ÷ 60). The initial tier II amount is increased from $545.09 (26 × $2,995 × .007) to $571.73 (27 × $3,025 × .007), effective with the date of annuity reinstatement, March 1, 1993.

§ 226.92 Effect of recomputation on spouse and divorced spouse annuity.

The annuity of a spouse or divorced spouse is recomputed to use the employee's recomputed tier I PIA and tier II rate, if the recomputation results in a lump-sum payment of more than $5 or an increase in the spouse or divorced spouse annuity rate of more than $1 a month. The spouse or divorced spouse annuity rate is recomputed beginning with the same date the employee's annuity rate is recomputed.

PART 227—COMPUTING SUPPLEMENTAL ANNUITIES

Sec.

227.1 Introduction.
227.2 Initial supplemental annuity rate.
227.3 Reduction for railroad retirement family maximum.
227.4 Reduction for employer pension.
227.5 Employer tax credits.

AUTHORITY: 45 U.S.C. 231f(b)(5).

SOURCE: 50 FR 11502, Mar. 22, 1985, unless otherwise noted.

§ 227.1 Introduction.

This part explains how to compute a supplemental annuity. A supplemental annuity is payable to an employee who meets the requirements in § 216.12 of this chapter.

§ 227.2 Initial supplemental annuity rate.

The supplemental annuity rate, before reduction for the railroad retirement family maximum or any private pension, is $23 for an employee's first 25 years of service plus $4 for each added year of service up to 30 years. The highest supplemental annuity rate is $43 for an employee with 30 or more years of service.

§ 227.3 Reduction for railroad retirement family maximum.

If the railroad retirement family maximum applies, and the reduction amount is higher than the spouse tier II rate, as shown in part 226 of this chapter, the initial supplemental annuity rate from § 227.2 is reduced by the smaller of—

(a) The difference between the total railroad retirement maximum reduction amount and the reduction in the spouse annuity; or

(b) The total supplemental annuity rate from § 227.2.

[50 FR 11502, Mar. 22, 1985, as amended at 54 FR 12903, Mar. 29, 1989]

§ 227.4 Reduction for employer pension.

(a) *General.* The supplemental annuity for each month is reduced by the amount of any private pension the employee is receiving for that month based on the contributions of a railroad employer. This reduction is applied to the supplemental annuity amount after any reduction for railroad retirement family maximum. Private pension is explained in § 216.14 of this chapter.

(b) *Private pension reduced for supplemental annuity.* If the employer reduces the private pension for the employee's entitlement to the supplemental annuity, the reduced pension amount is subtracted from the supplemental annuity. However, the reduction in the supplemental annuity can be no greater than the difference between the supplemental annuity amount, after any reduction for railroad retirement family maximum, and the amount the private pension is reduced for the supplemental annuity. This guarantees that the sum of the reduced supplemental annuity and the reduced employer pension is not less than the amount of the full employer pension.

Example: The full employer pension is $80. This is reduced by $35 because of the employee's entitlement to a supplemental annuity. The initial supplemental annuity rate is $43.

Full employer pension	$80
Reduction for supplemental annuity	−35
Reduced pension amount	45
Supplemental annuity	43
Reduced pension amount	−45

	0
Guarantee amount:	
Supplemental annuity	43
Reduction in private pension	−35
	8
Supplemental annuity	43
Reduction in private pension	−8
Reduced supplemental annuity	35

The reduced supplemental annuity amount is $35. This amount plus the reduced employer pension of $45 equals $80, the full amount of the employer pension.

(c) *Part of private pension based on employee contributions.* If the employer pension is based on both employer and employee contributions, a special formula is used to determine the amount to be subtracted from the supplemental annuity. The Board first computes the pension amount the employee's contributions could have purchased from a private insurance company. That amount is subtracted from the total employer pension. The result is the pension amount used to reduce the supplemental annuity.

§ 227.5 Employer tax credits.

Employers are entitled to tax credits if they pay non-negotiated pensions to former employees whose supplemental annuities are reduced because of the pensions. Non-negotiated pensions are paid under pension plans that are not established by collective bargaining agreements. The tax credits for each month equal the sum of the reductions for employer pensions in the supplemental annuities of all former employees for that month. The Board sends a report of total tax credits to each employer after the end of each calendar quarter. The credits are applied to the man-hour supplemental annuity tax the employer pays the Internal Revenue Service under section 3221 of the Railroad Retirement Tax Act.

PART 228—COMPUTATION OF SURVIVOR ANNUITIES

Subpart A—General

Sec.

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228.2 Tier I and tier II annuity components.

Subpart B—The Tier I Annuity Component

228.10 Computation of the tier I annuity component for a widow(er), disabled widow(er), remarried widow(er), and a surviving divorced spouse.
228.11 Computation of the tier I annuity component of a widow(er) with a child in care, remarried widow(er) with a child in care, or a surviving divorced spouse with a child in care.
228.12 Computation of the tier I annuity component of a child's insurance annuity.
228.13 Computation of the tier I annuity component of a parent's insurance annuity.
228.14 Family maximum.
228.15 Reduction for age.
228.16 Adjustments in the age reduction factor (ARF).
228.17 Adjustments to the widow(er)'s, disabled widow(er)'s, surviving divorced spouse's, and remarried widow(er)'s tier I annuity amount.
228.18 Reduction for public pension.
228.19 Reduction for a social security benefit.
228.20 Reduction for an employee annuity.
228.21 Entitlement as a spouse or divorced spouse and as a survivor.
228.22 Entitlement to more than one survivor annuity.
228.23 Priority of reductions.
228.40 Cost of living increase applicable to the tier I annuity component.

Subpart C—The Tier II Annuity Component

228.50 Tier II annuity component widow(er), child, or parent.
228.51 Takeback amount.
228.52 Restored amount.
228.53 Spouse minimum guarantee.
228.60 Cost-of-living increase.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 60 FR 16368, Mar. 30, 1995, unless otherwise noted.

Subpart A—General

§ 228.1 Introduction.

(a) *What does this part include?* This part includes the computation of a widow(er)'s, disabled widow(er)'s, remarried widow(er)'s, surviving divorced spouse's, parent's, and child's insurance annuity under the Railroad Retirement Act. This part describes the two annuity components or tiers which are included in these annuities. The tier I annuity component, which may be payable in all of the above annuities, is described in subpart B of this

part. Subpart C of this part describes the tier II annuity component which is only applicable to the widow(er)'s, disabled widow(er)'s, parent's, and child's annuity.

(b) *Other relevant parts.* (1) Part 225, Primary Insurance Amount Determinations, describes the various types of primary insurance amounts which form the basis of the computation of the tier I annuity component described in this part.

(2) Part 216, Eligibility for an Annuity, describes the eligibility requirements for receipt of the annuity computations described in this part.

§ 228.2 Tier I and tier II annuity components.

(a) *Tier I annuity component.* The Tier I annuity component is generally the amount that would have been payable under the Social Security Act if all of the employee's earnings after 1936 under both the railroad retirement system and the social security system had been creditable under the Social Security Act.

(b) *Tier II annuity component.* The tier II annuity component is the portion of the survivor's annuity which is based on an employee's railroad earnings only. The tier II component of an annuity described in this part is a specified percentage of the employee's actual or anticipated tier II annuity component.

Subpart B—The Tier I Annuity Component

§ 228.10 Computation of the tier I annuity component for a widow(er), disabled widow(er), remarried widow(er), and a surviving divorced spouse.

The tier I annuity component for these beneficiaries is generally based on the survivor tier I Primary Insurance Amount (PIA). The survivor tier I PIA is determined in accordance with section 215 of the Social Security Act using the deceased employee's combined railroad and social security earnings after 1950 (or after 1936 if a higher PIA would result) up to the maximum creditable amounts through the year of the employee's death. See part 225 of this chapter. This amount may be further adjusted for certain reductions or deductions as described in §§ 228.15–228.20 of this part and is subject to the family maximum. See § 228.14 of this part.

§ 228.11 Computation of the tier I annuity component of a widow(er) with a child in care, remarried widow(er) with a child in care, or a surviving divorced spouse with a child in care.

The tier I annuity component of a widow(er), remarried widow(er), or a surviving divorced spouse with a child of the employee in his or her care is 75 percent of the PIA computed under § 228.10 of this part. The amount may be adjusted for certain reductions and deductions described in §§ 228.15–228.20 of this part and is subject to the family maximum. See § 228.14 of this part.

§ 228.12 Computation of the tier I annuity component of a child's insurance annuity.

The tier I annuity component of a child's insurance annuity is 75 percent of the PIA computed under § 228.10 of this part. The amount may be adjusted for the family maximum. See § 228.14 of this part.

§ 228.13 Computation of the tier I annuity component of a parent's insurance annuity.

The tier I annuity component of a parent's insurance annuity is dependent on whether one or two parents are entitled.

(a) *One parent entitled.* A parent's tier I annuity component is equal to 82½ percent of the PIA computed under § 228.10 of this part.

(b) *More than one parent entitled.* A parent's tier I annuity component is equal to 75 percent of the PIA computed under § 228.10 of this part.

(c) The amounts computed under paragraph (a) or (b) of this section may be adjusted for the family maximum. See § 228.14 of this part.

§ 228.14 Family maximum.

(a) *Family maximum defined.* Under the Social Security Act, the amount of total monthly benefits that can be paid for any month on one person's earnings record is limited. This limited amount is called the family maximum. The

family maximum is based on the survivor tier I PIA (see part 225 of this chapter). Generally, if three or more persons are entitled to benefits, their benefits will be adjusted for the family maximum.

(b) *Computation of the family maximum*—(1) *The employee attains age 62, has a period of disability or dies prior to 1979.* The maximum is the amount appearing in column V of the applicable table published each year by the Secretary of Health and Human Services on the line on which appears in column IV the primary insurance amount of the insured individual whose compensation is the basis for the benefits payable. Where the total of the survivor benefits exceeds the maximum, the total tier I benefits for each month after 1964 are reduced to the amount appearing in column V. Each survivor's benefit is proportionately reduced, based on the percentage of the PIA used to compute the survivor benefits. However, when any of the persons entitled to benefits on the insured individual's compensation would, except for the limitation described in §404.353(b) of title 20 (dealing with the entitlement to more than one child's benefit), be entitled to a child's annuity on the basis of the compensation of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—

(i) The sum of the maximum amounts of benefits payable on the basis of the compensation of all such insured individuals, or

(ii) The last figure in column V of the applicable table published each year by the Secretary of Health and Human Services. The ''applicable table'' refers to the table which is effective for the month the benefit is payable.

(2) *The employee attains age 62, has a period of disability or dies in 1979.* The maximum is computed as follows:

(i) 150 percent of the first $230 of the individual's primary insurance amount, plus

(ii) 272 percent of the primary insurance amount over $230 but not over $332, plus

(iii) 134 percent of the primary insurance amount over $332 but not over $433, plus

(iv) 175 percent of the primary insurance amount over $433.

If the total of this computation is not a multiple of $0.10, it will be rounded to the next lower multiple of $0.10.

(3) *The employee attains age 62, or has a period of disability or dies after 1979.* The maximum is computed as in paragraph (b)(2) of this section. However, the dollar amounts shown there will be updated each year after 1979 as average earnings rise. This updating is done by first dividing the average of the total wages for the second year before the individual dies or becomes eligible, by the average of the total wages for 1977. The result of that computation is then multiplied by each dollar amount in the formula in paragraph (b)(2) of this section. Each updated dollar amount will be rounded to the nearer dollar, if the amount is an exact multiple of $0.50 (but not of $1), it will be rounded to the next higher $1. Before November 2 of each calendar year after 1978, the Secretary of Health and Human Services will publish in the FEDERAL REGISTER the formula and updated dollar amounts to be used for determining the monthly maximum for the following year.

(c) *Special minimum PIA.* Regardless of the method used to compute the primary insurance amount, if the special minimum primary insurance amount described in §404.261 to this title is higher, then the family maximum will be based upon the special minimum primary insurance amount.

§ 228.15 Reduction for age.

(a) *Widow(er), surviving divorced spouse, or remarried widow(er).* The tier I annuity component is reduced 19/40 of 1 percent multiplied by the number of months before the annuitant attains full retirement age (presently age 65) effective with the annuity beginning date for widow(ers) born before 1/2/40. (For widow(ers) born after 1/1/40, see section 216(l) of the Social Security Act.)

(b) *Disabled widow(er), disabled surviving divorced spouse, or disabled remarried widow(er).* The tier I annuity component is reduced for a maximum of 60 months even though the annuity may begin at age 50.

§ 228.16 Adjustments in the age reduction factor (ARF).

Upon the attainment of retirement age, the previously-computed age reduction factor is adjusted to remove those months for which a full annuity was not paid even though the individual was entitled.

§ 228.17 Adjustments to the widow(er)'s, disabled widow(er)'s, surviving divorced spouse's, and remarried widow(er)'s tier I annuity amount.

(a) If the employee died before attaining age 62 and after 1978 and the widow(er), disabled widow(er), remarried widow(er), or surviving divorced spouse is first eligible after 1984, the Board will compute the tier I annuity amount as if the employee had not died but had reached age 62 in the second year after the indexing year (see § 225.2 of this chapter); *provided*, *however*, that if the employee was entitled to a primary insurance amount based on average monthly wages this section is not applicable. The indexing year is never earlier than the second year before the year of the employee's death. Except for this limitation it is the earlier of__

(1) The year the employee attained age 60, or would have attained age 60 had the employee lived, and

(2) The second year before the year in which the widow(er), remarried widow(er), or surviving divorced spouse becomes eligible for such an annuity, has attained age 60, or is age 50–59 and disabled.

(b) The tier I annuity component is increased if the employee's annuity was increased or would have been increased based on delayed retirement credits (see § 225.36 of this chapter).

(c) The tier I annuity component is reduced if the employee had been entitled to an age reduced annuity, including an annuity based on 30 years of service, which is reduced for age because it began before the employee attained age 62. In this instance, the widow(er)'s, remarried widow(er)'s, or surviving divorced spouse's tier I annuity component after applying any reduction for age is further reduced to the larger of amount the employee would have received as a tier I annuity component if still alive or 82½ percent of his or her primary insurance amount.

§ 228.18 Reduction for public pension.

(a) The tier I annuity component of a widow(er), remarried widow(er), surviving divorced spouse, or disabled widow(er) annuity, as described in the preceding sections of this part, is reduced if the survivor is in receipt of a public pension.

(b) *When reduction is required.* Unless the survivor annuitant meets one of the exceptions in paragraph (d) of this section, the tier I annuity component is reduced each month the survivor annuitant is receiving a monthly pension from a Federal, State, or local government agency (Government pension) for which he or she was employed in work not covered by social security on the last day of such employment. For purposes of this section, Federal government employees are not considered to be covered by social security if they are covered for Medicare but are not otherwise covered by social security, or if they are covered under social security solely by an election to become subject to the Federal Employees and Retirement System made after December 31, 1987, and have not worked 60 months under that system.

(c) *Payment in a lump sum.* If the Government pension is not paid monthly or is paid in a lump-sum payment, the Board will determine how much the pension would be if it were paid monthly. If one of the alternatives to a lump-sum payment is a life annuity, and the amount of the monthly benefit for the life annuity can be determined, the reduction will be based on that monthly benefit amount. Where the period for the equivalent monthly pension benefit is not clear, it may be necessary for the Board to determine the reduction period on an individual case basis.

(d) *Exceptions.* The reduction does not apply:

(1) If the survivor is receiving a Government pension based on employment for an interstate instrumentality; or

(2) If the survivor receives or is eligible to receive a Government pension for one or more months in the period December 1977 through November 1982 and he or she meets the requirements for social security benefits that were

applied in January 1977, assuming the employee's earnings had been covered under that Act (even though he or she did not actually claim such benefits or become entitled for such benefits until a later month). The January 1977 requirements are, for a man, a one-half support test (see paragraph (e) of this section), and, for a woman claiming benefits as a surviving divorced spouse, marriage for at least 20 years to the insured worker. A person is considered eligible for a Government pension for any month in which he or she meets all the requirements for payment except that he or she is working or has not applied; or

(3) If a survivor annuitant was receiving or eligible (as defined in paragraph (d)(2) of this section) to receive a Government pension for one or more months before July 1983, and he or she meets the one-half support test (see paragraph (e) of this section). If a survivor annuitant meets the exception in this paragraph but he or she does not meet the exception in paragraph (d)(2) of this section, December 1982 is the earliest month for which the reduction will not affect his benefits; or

(4) If a survivor annuitant was eligible for a Government pension in a given month except for a requirement which delayed eligibility for such pension until the month following the month in which all other requirements were met, the Board will consider the annuitant to be eligible in that given month for the purpose of meeting one of the exceptions in paragraphs (d)(2) and (3) of this section. If an annuitant meets an exception solely because of this paragraph, his or her benefits will be unreduced for months after November 1984 only.

(e) *The one-half support test.* For a man to meet the January 1977 requirement as provided in the exception in paragraph (d)(2) of this section and for a man or a woman to meet the exception in paragraph (d)(3) of this section, he or she must meet a one-half support test. One-half support is defined in part 222 of this chapter. One-half support must be met at one of the following times:

(1) If the employee upon whose compensation the survivor annuity is based had a period of disability which did not end before he or she became entitled to an age and service or disability annuity, or died, the survivor annuitant must have been receiving at least one-half support from the employee—

(i) At the beginning of his or her period of disability; or

(ii) At the time he or she became entitled to an age and service or disability annuity; or

(iii) At the time of his or her death.

(2) If the employee upon whose compensation the survivor annuity is based did not have a period of disability at the time of his or her entitlement or death, the survivor annuitant must have been receiving at least one-half support from the employee—

(i) At the time he or she became entitled to an age and service annuity or disability annuity; or

(ii) At the time of his or her death.

(f) *Amount of reduction.* (1) If a survivor annuitant becomes eligible for a Government pension after June 1983, the Board will reduce (but not below zero) the tier I annuity component by two-thirds of the amount of the monthly pension. If the amount of the reduction is not a multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(2) If a survivor annuitant became eligible for a Government pension before July 1983 and he or she did not meet one of the exceptions in paragraph (d) of this section, the Board will reduce (but not below zero) the tier I component by the full amount of the pension for months before December 1984 and by two-thirds the amount of his or her monthly pension for months after November 1984. If the amount of the reduction is not a multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(g) *Reduction not applicable.* This reduction is not applied to claimants who both filed and were entitled to benefits prior to December 1977.

§ 228.19 Reduction for a social security benefit.

The tier I annuity component is reduced for the amount of any social security benefit to which the survivor annuitant is entitled.

§ 228.20 Reduction for an employee annuity.

(a) *General.* If an individual is entitled to an annuity as a survivor, and is also entitled to an employee annuity, then the survivor annuity must be reduced by the amount of the employee annuity. However, this reduction does not apply (except as provided in paragraph (b) of this section) if the survivor or the individual upon whose earnings record the survivor annuity is based worked for a railroad employer or as an employee representative before January 1, 1975.

(b) *Tier I reduction.* If an individual is entitled to an annuity as a survivor, then the tier I component of the survivor annuity must be reduced by the amount of the tier I component of the employee annuity after reduction for age. Where the survivor is entitled to a tier II component and either the survivor or the employee had railroad earnings before 1975, a portion of this reduction may be restored in the computation of the tier II component (see § 228.52 of this part).

§ 228.21 Entitlement as a spouse or divorced spouse and as a survivor.

If an individual is entitled to both a spouse or divorced spouse and survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she may receive the smaller annuity rather than the larger annuity.

§ 228.22 Entitlement to more than one survivor annuity.

If an individual is entitled to more than one survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she may receive the smaller annuity rather than the larger annuity.

§ 228.23 Priority of reductions.

The tier I component of the survivor annuity is first reduced by the family maximum, if applicable, then any applicable age reduction, then by any public pension offset, then by any social security benefit payable, then by the tier I component of any employee annuity payable to the survivor annuitant.

§ 228.40 Cost of living increase applicable to the tier I annuity component.

The tier I annuity component of a survivor annuity is increased at the same time and by the same percentage as the increase provided for under section 215(i) of the Social Security Act. The amount of the increase is published in the FEDERAL REGISTER annually. The cost-of-living increase is payable beginning with the benefit for the month of December of the year for which the increase is due. The increase is paid in the January payment.

Subpart C—The Tier II Annuity Component

§ 228.50 Tier II annuity component widow(er), child, or parent.

(a) *General.* The tier II annuity component is an additional amount payable to a widow(er), disabled widow(er), child, or parent, but not to a surviving divorced spouse or remarried widow(er), and a parent as provided in paragraph (b)(2) of this section, based on the railroad employee's earnings in the railroad industry. Unlike the tier I annuity component it is not reduced for any other social insurance benefit except a railroad retirement annuity. See §§ 228.20–228.23 of this part.

(b) *Amount of the tier II annuity component (1981 amendment)*—(1) *Widow(er) or disabled widow(er).* The amount of a widow(er)'s or disabled widow(er)'s tier II annuity component is 50 percent of the amount of the employee's tier II which would have been payable in the month in which the widow became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time.

(2) *Parent.* The amount of a parent's tier II annuity component is 35 percent of the amount of the employee's tier II annuity component which would have been payable in the month in which the parent became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time. However, if another survivor is entitled, or potentially entitled, to a tier II annuity component, the parent tier II annuity component is zero.

(3) *Child.* The amount of each child's tier II annuity component is 15 percent of the employee's tier II annuity component which would have been payable in the month in which the child became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time.

(c) *Minimum tier II survivor annuity components.* If the total tier II annuity components payable to survivors is less than 35 percent of the employee's tier II annuity component which would have been payable in the month the survivors became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time, the individual tier II annuity components computed in paragraph (b) of this section shall be increased proportionally so that the total of all such tier II annuity components equals 35 percent of the employee's tier II annuity component.

(d) *Maximum tier II annuity components.* If the total tier II survivor annuity components payable to survivors exceeds 80 percent of the employee's tier II annuity component which would have been payable in the month the survivors became entitled had the employee been alive and entitled to an annuity under the Railroad Retirement Act at that time, the individual tier II annuity components computed in paragraph (b) of this section shall be reduced proportionally so that the total of all such tier II annuity components totals no more than 80 percent of the employee's tier II annuity component.

(e) *Age reduction.* The tier II annuity component of a widow(er) or disabled widow(er) is subject to reduction by the same age reduction factor as is applicable to the tier I annuity component. See § 228.15 of this part.

§ 228.51 Takeback amount.

(a) The 1983 amendments to the Railroad Retirement Act provided that a portion of the cost-of-living increases payable on the tier I annuity component be offset from the amount of the tier II annuity. This amount is the takeback amount. The amount of the takeback and its application depends on the employee and survivor's annuity beginning dates.

(b)(1) The tier II takeback amount for survivors whose annuity beginning date is January 1, 1984 or later is usually the amount of the employee's takeback amount. That amount is equal to 5 percent of the employee's primary insurance amount, less all applicable reductions (net tier I), on November 1, 1983. However, if the employee's annuity was reduced for a social security benefit but the survivor's annuity is not, the takeback amount is the amount the employee's annuity would have been reduced for the takeback if the employee's annuity had not been reduced for a social security benefit. If the employee's annuity had not been tiered or was being paid under the overall minimum, the Board will compute the amount of the tier II takeback that would have been applicable to the employee's annuity.

(2) The tier II takeback amount for survivors whose annuity beginning date is before January 1, 1984 is equal to 5 percent of the survivor's net tier I annuity component, before deduction on account of work, on November 1, 1983.

(3) The tier II takeback will be applied in accord with the above paragraphs in any case where the employee died or retired before January 1, 1984. If the employee died or retires after December 31, 1983, or the employee never retired and dies after December 31, 1993, no takeback will be applied to the survivor's annuity.

(c) No takeback is applied if the survivor tier II annuity amount before the takeback is applied is $10.00 or less and cost-of-living increases have not increased the tier II annuity amount to more than $10.00 (the takeback may never reduce the tier II to an amount less than $10.00).

§ 228.52 Restored amount.

(a) *General.* A restored amount is added to the tier II annuity component of a widow(er)'s annuity whose annuity is reduced for receipt of an employee annuity under the Railroad Retirement Act provided either the employee or the widow(er) had ten years of creditable railroad service prior to January 1, 1975.

(b) *Amount.* The amount of the tier II restored amount for a widow(er) is the

difference between the amount payable as a widow(er) under the Railroad Retirement Act of 1937 as increased by all annual social security cost-of-living percentage increases from January 1, 1975, until the later of the annuity beginning date of either the employee's annuity or the widow(er)'s annuity and the amount payable to the widow(er) under the Railroad Retirement Act of 1974 under the rules set forth in this part.

(c) *Widower.* In order to qualify for an annuity under the 1937 Act and thus for a restored amount, a widower must have been dependent on his spouse for at least 50 percent of his support in the year prior to her death or at the time the spouse's annuity began.

§ 228.53 Spouse minimum guarantee.

The Railroad Retirement Act provides that a spouse should receive no less as a widow(er) than he or she received as a spouse. However, if the widow(er) becomes entitled to a social security benefit, thus reducing his or her annuity, the spouse minimum guarantee is payable only to the extent that it guarantees the amount that the widow(er) would have received as a spouse had he or she been entitled to a social security benefit in the month preceding the employee's death in an amount equal to the amount of the social security benefit payable at the time the widow(er) first became entitled to the social security benefit.

§ 228.60 Cost-of-living increase.

The tier II annuity component of a survivor annuity under the Railroad Retirement Act is increased by 32.5 percent of the percentage increase under section 215(i) of the Social Security Act at the same time that any such increase is payable. The amount of the increase is published in the FEDERAL REGISTER annually. The cost-of-living is payable beginning with the benefit payable for the month of December of the year for which the increase is due. The increase is paid in the January payment. In addition, in determining the amount of the tier II component at the time the survivor annuity begins, all cost-of-living increases that were applied or would have been applied after the employee's annuity beginning date or death and prior to the surviving annuity beginning date are taken into consideration.

PART 229—SOCIAL SECURITY OVERALL MINIMUM GUARANTEE

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Subpart A—General

§ 229.1 Introduction.

This part explains when an annuity can be increased under the social security overall minimum guarantee, also sometimes referred to as the ''special guaranty'', and how the increased amount is determined. Deductions and reductions in the overall minimum rate are explained.

§ 229.2 Definitions.

The following definitions are used in this part:

Annuity means a payment under the Railroad Retirement Act due and payable to an entitled claimant for a calendar month and made to him or her on the first day of the following month. The recipient of an annuity is called an annuitant.

Average Indexed Monthly Earnings or AIME means the average of the employee's monthly creditable earnings in both railroad and social security covered employment in the years used in computing the Primary Insurance Amount, after the earnings are adjusted or ''indexed''. The indexing is a means of expressing prior years earnings in terms of their current dollar value. It is based on increases in the average wages of all wage earners from 1951 although the second year before the year the worker dies or becomes eligible for benefits.

Contribution and benefit base means the maximum earnings used in computing a social security benefit under section 230 of the Social Security Act.

1974 Act means the Railroad Retirement Act approved October 16, 1974, including all amendments.

Railroad formula rate means the amount computed in accord with the regular railroad computations (sections 3(a), 3(b) and 3(h) of the Railroad Retirement Act).

Retirement age means age 65, with respect to an employee or spouse who attains age 62 before January 1, 2000 (age 60 in the case of a widow(er), remarried widow(er) or surviving divorced spouse). For an employee or spouse who attains age 62 (or age 60 in the case of a widow(er), remarried widow(er), or surviving divorced spouse) after December 31, 1999, retirement age means the age provided for in section 216(l) of the Social Security Act.

§ 229.3 Other regulations related to this part.

This part is related to a number of other parts of this chapter (listed numerically):

Part 216 describes when a person is eligible for an annuity under the Railroad Retirement Act.

Part 217 describes how to apply for an annuity or for lump-sum payments.

Part 218 sets forth the beginning and ending dates of annuities.

Part 219 sets out what evidence is necessary to prove eligibility and the relationships described in this part.

Part 220 describes when a person is eligible for a disability annuity under the Railroad Retirement Act or a period of disability under the Social Security Act.

Part 222 describes the family relationships which may cause an annuity to be increased under this part.

Part 225 explains how Primary Insurance Amounts (PIA's) are computed.

§ 229.4 Applying for the overall minimum.

The Board may require an annuitant to provide information regarding his or her family and regarding his or her earnings from employment and self-employment in order to determine whether the claimant or annuitant qualifies for the overall minimum.

(Approved by the Office of Management and Budget under control number 3220–0083)

Subpart B—Social Security Overall Minimum Guarantee Defined

§ 229.10 What the social security overall minimum guarantee is.

The social security overall minimum guarantee is the amount of total family benefits which would be paid under the Social Security Act if the employee's railroad service had been covered by that Act. A 100 percent overall minimum benefit may be paid, as described in § 229.11. A 100 percent overall minimum based on age (age O/M) may be payable when the employee is 62 years old. The age O/M is reduced for age for months in which the O/M is payable before the employee attains retirement age. An overall minimum may also be payable before age 62 based on an employee's disability (DIB O/M). The DIB O/M is not reduced for age.

§ 229.11 100 percent overall minimum.

Section 3(f)(3) of the 1974 Act guarantees that the total annuities payable to the employee and spouse, including the vested dual benefits but not including a supplemental annuity, will not be less than 100 percent of the total family benefits payable under the Social Security Act if the employee's railroad service after 1936 were credited as social security earnings. Subpart F describes how the 100 percent overall minimum rate is computed.

Subpart C—Eligibility for Increase Under the Overall Minimum

§ 229.20 When an employee is eligible for an increase under the overall minimum.

(a) *Overall minimum based on age.* An employee annuity can be increased under the age O/M if all the following conditions are met:

(1) The employee is entitled to an age or disability annuity as shown in part 216 of this chapter.

(2) The employee is at least 62 years old throughout the whole month. The O/M is reduced for each month it is payable before the month the employee attains retirement age.

(3) The employee is fully insured under section 214 or 227 of the Social Security Act based on railroad and social security earnings.

(b) *Overall minimum based on disability.* An employee annuity can be increased under the DIB O/M if the employee is under retirement age, and

(1) Is entitled to an age or disability annuity; and

(2) Is disabled under § 404.1505 of this title; and

(3) Is insured for a disability benefit under § 404.130 of this title based upon combined railroad and social security earnings.

(c) *Spouse with child in care or spouse retirement age or older.* If the employee has not attained the age required to qualify the spouse for a spouse annuity but the employee meets the conditions of paragraph (a) or (b) of this section, the employee annuity can be increased under the overall minimum if:

(1) The employee and spouse complete the required statements concerning the family and earnings as provided for in § 229.4 of this part; and

(2) The spouse meets the marriage requirements as provided for in part 222 of this chapter; and

(3) The spouse has an eligible child in care, or the spouse is retirement age or older.

(d) *Spouse election.* If the employee has not attained the age required to quality the spouse for a spouse annuity but the employee meets the conditions of paragraph (a) or (b) of this section, the employee annuity can be increased under the overall minimum if:

(1) The employee and spouse complete the required statements concerning the family and earnings as provided for in § 229.4 of this part; and

(2) The spouse meets the marriage requirements as provided for in part 222 of this chapter; and

(3) The spouse is between age 62 and retirement age and does not have a child in care; and

(4) The spouse files an election to be included.

§ 229.21 When a spouse is eligible for an increase under the overall minimum.

Normally, only the employee annuity receives the amount of the overall minimum increase. However, a spouse annuity may be increased under the O/M in cases in which the O/M benefit amount exceeds the total amount of the employee and spouse annuity.

§ 229.22 Beginning date of increase under overall minimum.

(a) *Employee age O/M.* An increase under the overall minimum in an employee annuity based on age can be paid beginning with the later of:

(1) The first day of the first full month throughout which the employee is age 62; or

(2) The beginning date of the employee's age or disability annuity; or

(3) The first month of the quarter in which the employee becomes insured under section 214 or 227 of the Social Security Act based on railroad and social security earnings; or

(4) The month the employee attains retirement age, if a DIB O/M was paid in the previous month. A DIB O/M is changed to an age O/M in the month the employee attains retirement age.

(b) *Employee DIB O/M.* An increase under the overall minimum in an employee annuity based on disability can be paid beginning with the later of—

(1) The beginning date of the employee's disability annuity; or

(2) The month after the month in which the disability waiting period described in § 404.315(d) of this title ends; or

(3) If no disability waiting period is required, the first month in which the employee is disabled and is insured for a disability benefit under § 404.130 of this title.

(c) *Spouse.* An increase in a spouse annuity under the overall minimum can be paid on the later of:

(1) The date the increase in the employee's annuity is paid; or

(2) The date the spouse is both eligible under the O/M and entitled to a spouse annuity.

Subpart D—Family Members Included in Overall Minimum Computation

§ 229.30 Who can be included in the computation of an annuity under the overall minimum.

(a) *Spouse.* In order to be included as a spouse in the computation of the overall minimum rate, a person must be the employee's wife or husband, as defined in part 222 of this chapter, as of the date described in § 229.31 of this part. The spouse must also be 62 years or older throughout the whole month in which he or she is first included or have the employee's child who is under 16 years old or disabled (before attaining age 22) in his or her care. If a spouse is 62 years old or older and under retirement age, and does not have an eligible child in his or her care, the spouse will be included only if he or she requests the payment of a reduced spouse annuity.

(b) *Child.* In order to be included as a child in the computation of the overall minimum, a person must meet the following requirements as of the date described in § 229.32 of this part. The person must be:

(1) The employee's child as defined in part 222 of this chapter; and

(2) Dependent on the employee, as shown in part 222 of this chapter; and

(3) Not married; and either

(4) Under 18 years old, or 18 years old to 19 years old and a full-time student, as defined in part 216 of this chapter, or 18 years old or older and disabled for any regular employment (see part 220 of this chapter) before attaining age 22.

(c) *Divorced spouse.* In order to be included as a divorced spouse in the computation of the overall minimum, a person must be eligible for a benefit as a divorced spouse under the Railroad Retirement Act as of the date described in § 229.33 of this part.

§ 229.31 When a spouse can be included in the computation of the overall minimum rate.

(a) A spouse who is married to the employee when the employee's application is filed can be included in the computation of the overall minimum rate beginning in the later of the month in which:

(1) The employee first is eligible for an increase in his or her annuity under the overall minimum, as shown in § 229.22 of this part; or

(2) The spouse first becomes eligible to be included under the overall minimum, as shown in § 229.30 of this part.

(b) A spouse who marries the employee after the employee application is filed can be included in the overall minimum computation in the month in which he or she becomes eligible, as shown in § 229.30 of this part, if the overall minimum rate is already payable in the previous month. If the railroad formula rate is payable in the month before the spouse becomes eligible, the spouse can be included in the overall minimum computation in the later of the month in which:

(1) The employee first is eligible for an increase in his or her annuity rate under the overall minimum, as shown in § 229.22; or

(2) The spouse annuity begins.

§ 229.32 When a child can be included in the computation of the overall minimum rate.

A child who meets the requirements of § 229.30(b) of this part can be included in the computation of the overall minimum rate in the month in which:

(a) The employee first is eligible for an increase in his or her annuity rate under the overall minimum, as shown in § 229.22 of this part; or

(b) In the case of a child born or adopted by the employee after the employee's annuity beginning date, such child can be included only when the overall minimum rate is already payable in the month before the month in which the child is born, or adopted except where:

(1) The child is born or adopted prior to the employee's attaining age 62 or becoming eligible for a period of disability (see § 220.36 of this chapter); or

(2) The child who is adopted after the employee's annuity beginning date meets the dependency requirements set forth in § 222.53 of this chapter.

(c) In the case of a child who has attained age 18 and has become re-entitled as a full-time student or disabled child, as described in § 229.30 of this part, such child can only be included when the overall minimum rate is already payable in the month before the month the child becomes re-entitled.

§ 229.33 When a divorced spouse can be included in the computation of the overall minimum rate.

A divorced spouse annuitant can be included in the computation of the overall minimum rate in the later of the month in which:

(1) The employee first is eligible for an increase in his or her annuity rate under the overall minimum, as shown in § 229.22; or

(2) The divorced spouse annuity begins.

Subpart E—When Entitlement Under the Overall Minimum Ends

§ 229.40 When an annuity increase under the overall minimum ends.

(a) *Employee Age O/M.* An increase in an employee's annuity under the overall minimum based on age ends with the month before the month in which the employee dies. If a disability annuity is increased under the overall minimum based on age rather than disability, and the employee is under retirement age, the increase ends with

the second month after the month the disability ends as shown in part 220 of this chapter.

(b) *Employee DIB O/M.* An increase in an employee's annuity under the overall minimum based on disability ends with the earlier of:

(1) The month before the month in which the employee dies; or

(2) The month before the month the employee attains retirement age (the DIB O/M is changed to an age O/M); or

(3) The second month after the month the disability ends, as explained in part 220 of this chapter.

(c) *Spouse.* An increase in a spouse annuity under the overall minimum ends when the increase in the employee annuity ends, as shown in paragraphs (a) and (b) of this section, when the spouse can no longer be included in computing the annuity rate under the overall minimum as shown in § 229.41 of this part, or when the spouse annuity ends as shown in part 218 of this chapter.

§ 229.41 When a spouse can no longer be included in computing an annuity rate under the overall minimum.

A spouse's inclusion in the computation of the overall minimum rate ends the earlier of:

(a) The month before the month in which the spouse dies; or

(b) The month before the month in which the spouse's marriage to the employee legally terminates; or

(c) If the spouse has an eligible child in care, the earlier of the month before the month in which the child leaves the spouse's care, attains age 16 and is not disabled, or, if disabled, recovers from being disabled; or

(d) The month before the month the employee dies.

§ 229.42 When a child can no longer be included in computing an annuity rate under the overall minimum.

A child's inclusion in the computation of the overall minimum rate ends the earlier of:

(a) The month before the month in which the child dies; or

(b) The month before the month in which the child marries; or

(c) The month before the month the child becomes 18 years old, unless the child is disabled or a full-time student, as shown in part 216 of this chapter; or

(d) The second month after the month the child's disability ends, if the child is 18 years old or older, and not a full-time student; or

(e) The month in which a student child's annuity would end, as shown in part 218 of this chapter, if the child is 18 years old or older, a full-time student in an elementary or secondary school, and not disabled; or

(f) The month before the month the child becomes entitled to an overall minimum benefit or child's annuity on another earning record, if including the child on the other earnings record would result in higher monthly benefits; or

(g) In the case of a stepchild of the employee, the month after the month in which the divorce between the stepparent and the natural parent becomes final.

[58 FR 53397, Oct. 15, 1993, as amended at 62 FR 47138, Sept. 8, 1997]

§ 229.43 When a divorced spouse can no longer be included in computing an annuity under the overall minimum.

A divorced spouse's inclusion in the computation of the overall minimum rate ends the earlier of:

(a) The month before the month in which the divorced spouse dies; or

(b) The month before the month the employee dies; or

(c) The month before the month in which the divorced spouse remarries; or

(d) The month before the month in which the divorced spouse becomes entitled to a retirement or disability benefit under the Social Security Act based upon a primary insurance amount which is equal to or exceeds the divorced spouse annuity before reduction for age.

Subpart F—Computation of the Overall Minimum Rate

§ 229.45 Employee benefit.

The original employee 100 percent overall minimum amount, before adjustment for age, other family members, or other benefits, is the Overall Minimum PIA, as described in part 225

of this chapter. This is the PIA which would be used under the Social Security Act if the employee's railroad service had been covered under that Act instead of the Railroad Retirement Act. The Overall Minimum PIA may be recomputed for additional earnings and adjusted for cost-of-living increases. Delayed retirement credits are added to the Overall Minimum PIA as shown in part 225, subpart D of this chapter.

§ 229.46 Spouse or divorced spouse benefit.

If a spouse or divorced spouse is included in the computation of the overall minimum, a benefit of 50 percent times the Overall Minimum PIA is computed. In the case of a spouse, the benefit may be adjusted for the family maximum, age, or other benefits. In the case of a divorced spouse, the benefit may be adjusted only for age or other benefits.

§ 229.47 Child's benefit.

If a child is included in the computation of the overall minimum, a child's benefit of 50 percent times the Overall Minimum PIA is computed. This amount may be adjusted for the family maximum or other benefits.

§ 229.48 Family maximum.

(a) *Family maximum defined.* Under the Social Security Act, the amount of monthly benefits that can be paid for any month on one person's earnings record is limited. This limited amount is called the family maximum. The family maximum used to adjust the social security overall minimum rate is based on the employee's Overall Minimum PIA. The divorced spouse overall minimum is never reduced because of the family maximum.

(b) *Computation of the family maximum*—(1) *The employee attains retirement age prior to 1979.* The maximum is the amount appearing in column V of the applicable table published each year by the Secretary of Health and Human Services on the line on which appears in column IV the primary insurance amount of the insured individual whose compensation is the basis for the benefits payable. Where the maximum is exceeded, the total tier I benefits for each month after 1964 are reduced to the amount appearing in column V. However, when any of the persons entitled to benefits on the insured individual's compensation would, except for the limitation described in § 404.353(b) of title 20 (dealing with the entitlement to more than one child's benefit), be entitled to a child's annuity on the basis of the compensation of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of:

(i) The sum of the maximum amounts of benefits payable on the basis of the compensation of all such insured individuals, or

(ii) The last figure in column V of the applicable table published each year by the Secretary of Health and Human Services. The ''applicable'' table refers to the table which is effective for the month the benefit is payable.

(2) *The employee attains retirement age in 1979.* (i) The maximum is computed as follows:

(A) 150 percent of the first $230 of the individual's primary insurance amount, plus

(B) 272 percent of the primary insurance amount over $230 but not over $332, plus

(C) 134 percent of the primary insurance amount over $332 but not over $433, plus

(D) 175 percent of the primary insurance amount over $433.

(ii) If the total of this computation is not a multiple of $0.10, it will be rounded to the next lower multiple of $0.10.

(3) *The employee attains retirement age after 1979.* The maximum is computed as in paragraph (b)(2) of this section. However, the dollar amount shown there will be updated each year as average earnings rise. This updating is done by first dividing the average of the total wages (see 20 CFR 404.203(m)) for the second year before the individual dies or becomes eligible, by the average of the total wages for 1977. The result of that computation is then multiplied by each dollar amount in the formula in paragraph (b)(2) of this section. Each updated dollar amount will be rounded to the nearer dollar, if the amount is an exact multiple of $0.50 (but not of $1), it will be rounded to the next higher $1. Before November 2 of

each calendar year after 1978, the Secretary of Health and Human Services will publish in the FEDERAL REGISTER the formula and updated dollar amounts to be used for determining the monthly maximum for the following year.

(c) *Disability family maximum.* If an employee's first month of entitlement to the DIB O/M is July 1980 or later, the family maximum is 85 percent of the employee's Average Indexed Monthly Earnings but not less than the employee's Overall Minimum PIA, and no more than 150 percent of the employee's Overall Minimum PIA.

(d) *Reduction for family maximum.* The spouse's and child(ren)'s share of the Overall Minimum PIA are reduced if the total benefits are higher than the family maximum amount. These auxiliary shares are adjusted so that they each receive a proportionate share of the family maximum amount over and above the employee benefit. This adjustment is before adjustment for age or other benefits. The spouse and child(ren)'s benefits are computed as follows:

(1) The Overall Minimum PIA is subtracted from the family maximum amount.

(2) The result from paragraph (d)(1) of this section is divided by the total number of auxiliary beneficiaries (spouse and children).

(3) If the amount of each benefit from paragraph (d)(2) of this section is not a multiple of $0.10, it is rounded to the next lower multiple of $0.10. After determining the beneficiary's share (the amount after reduction for other benefits) the amount is rounded to the next lowest multiple of $1.00, if it is not already a multiple of $1.00.

(e) *Combined family maximum.* If a child is eligible to be included in the computation of the overall minimum on more than one railroad retirement annuity, a combined family maximum may apply, if it results in higher annuity rates. The combined family maximum is the smaller of:

(1) The sum of the individual family maximums on each earnings record; or

(2) 1.75 times the highest primary insurance amount possible in a year using average indexed monthly earnings equal to one-twelfth of the contribution and benefit base for that year. Average indexed monthly earnings and contribution and benefit base are explained in § 229.2 of this part.

(f) This section may be illustrated by the following examples:

(1) An employee, age 62, applies for an age and service annuity under the Railroad Retirement Act (RRA). His annuity rate is $700. The employee has a son who was disabled for all regular employment prior to his attaining age 18. The RRA does not provide an annuity for a disabled child of a living employee. If the employee had been covered under the Social Security Act he would have received a benefit of $500 (the Overall Minimum PIA) and his child would have received a benefit of $250 (50 percent of $500), which produces a total family benefit of $750. The family maximum is $804.90. Under the O/M guarantee, the employee would receive $750 since it is higher than his annuity rate of $700. Since $750 is less than the family maximum computed for this employee, there is no reduction for the family maximum.

(2) It is determined that a disabled employee is entitled to a DIB O/M computed as follows:

Overall Minimum PIA	$ 600.00
Spouse (50% × 600)	300.00
Child (50% × 600)	300.00
	1200.00

However, the employee's family maximum is $900 (150 percent of $600). Consequently, the DIB O/M will be paid as follows:

Employee	$ 600.00
Spouse	150.00
Child	150.00
	900.00

§ 229.49 Adjustment of benefits under family maximum for change in family group.

(a) *Increase in family group.* If an overall minimum rate is adjusted for the family maximum and an additional family member can be included, the benefits payable to previous auxiliary beneficiaries (spouse and children) are reduced to provide a share for the new family member. The difference between the Overall Minimum PIA (see § 225.15 of this part) and the family maximum

amount is divided by the increased number of auxiliary beneficiaries. If the amount of each benefit is not a multiple of $0.10, it is rounded to the next lower multiple of $0.10. After determining a beneficiary's share (the amount after reduction for other benefits) the amount is rounded to the next lowest multiple of $1.00, if it is not already a multiple of $1.00.

(b) *Decrease in family group.* If an overall minimum rate is adjusted for the family maximum and there is a decrease in the number of eligible family members, the benefits for the remaining auxiliary beneficiaries (spouse and children) are increased. If the family maximum still applies, the difference between the Overall Minimum PIA and the family maximum amount is divided by the number of remaining auxiliary beneficiaries. If the amount of each benefit is not a multiple of $0.10, it is rounded to the next lower multiple of $0.10. After determining the beneficiary's share (the amount after reduction for other benefits) the amount is rounded to the next lowest multiple of $1.00, if it is not already a multiple of $1.00.

(c) *Effective date of rate change.* The overall minimum rate changes described in paragraphs (a) and (b) of this section are effective the month in which the number of auxiliary beneficiaries changes.

§ 229.50 Age reduction in employee or spouse benefit.

(a) *When age reduction applies.* The employee overall minimum benefit is reduced for each month the employee is under retirement age on the date the employee becomes eligible for an increase under the overall minimum, as shown in § 229.22 of this part, unless the employee has a period of disability and § 229.52 of this part does not apply, in which case no age reduction is applied. The spouse overall minimum benefit is reduced for each month a spouse, who is not a spouse with the employee's child under 16 years old or disabled before attaining age 22 in his or her care, is under retirement age on the date the spouse is eligible for an increase under the overall minimum (see § 229.21 of this part). If a spouse's overall minimum benefit is reduced for age and he or she later begins caring for an eligible child, no age reduction will apply for the months the child is in his or her care.

(b) *Employee age reduction.* The Overall Minimum PIA plus any delayed retirement credits is reduced by 1/180 for each month the employee is under retirement age on the date the employee becomes eligible for the overall minimum. When the PIA amount is increased, the amount of the increase is reduced by 1/180 for the same number of months used to determine the initial age reduction.

(c) *Spouse age reduction.* The amount of the spouse overall minimum benefit, after any adjustment for the family maximum, is reduced by 1/144 for each month the spouse is under retirement age on the date when he or she becomes eligible under the overall minimum. When the spouse benefit increases, the amount of the increase is reduced by 1/144 for the same number of months used to compute the initial age reduction.

(d) *Age reduction after 1999.* Beginning in the year 2000 the amount of age reduction shall be as specified in paragraphs (b) and (c) of this section for the first 36 months of the reduction period, as defined in paragraph (e) of this section, and 1/240 for any additional months included in such period.

(e) *Reduction period defined.* The reduction period is the number of months beginning with the first month for which the O/M is payable and ending with the month before the month the beneficiary attains retirement age.

§ 229.51 Adjustment of age reduction.

(a) *General.* If an age reduced employee or spouse overall minimum benefit is not paid for certain months before the employee or spouse attains retirement age, or the employee becomes entitled to a DIB O/M, the age reduction may be adjusted to drop the months for which no payment was made or the overall minimum rate was not reduced for age.

(b) *Employee adjusted age reduction.* The following months are deducted from the months used to determine the age reduction in the Overall Minimum PIA amount, effective the month in

which the employee attains retirement age or becomes entitled to a DIB O/M:

(1) Months in which the increase under the overall minimum is completely or partially deducted because of the employee's excess earnings; and

(2) Months in which the employee is entitled to a DIB O/M as well as a reduced O/M.

(c) *Spouse adjusted age reduction.* The following months are deducted from the months used to determine the age reduction in the spouse overall minimum benefit, effective the month in which the spouse attains retirement age:

(1) Months in which the spouse O/M benefit is completely or partially deducted because of the employee's or spouse's excess earnings:

(2) Months after entitlement to a spouse O/M benefit ends for any reason;

(3) Months in which a spouse has in her care the employee's child who is under 16 years old or disabled before age 22;

(4) Months in which a DIB O/M benefit is not payable because the employee refused rehabilitation service (see § 229.81 of this part).

§ 229.52 Age reduction when a reduced age O/M is effective before DIB O/M.

If an employee received a reduced age O/M before the effective date of a DIB O/M, the PIA amount for the DIB O/M is reduced as if the employee had attained retirement age on the effective date of the DIB O/M.

§ 229.53 Reduction for social security benefits on employee's wage record.

The total annuity rate under the overall minimum is reduced, but not below zero, by the total amount of the social security benefits being paid to all family members on the employee's wage record.

§ 229.54 Reduction for social security benefit paid to employee on another person's earnings record.

The employee PIA amount under the overall minimum, after any age reduction, is reduced, but not below zero, by the amount of any social security benefit being paid to the employee on another person's earnings record.

§ 229.55 Reduction for spouse social security benefit.

A spouse benefit under the overall minimum, after any adjustment for the family maximum and for age, is reduced, but not below zero, by the amount of any social security benefit being paid to the spouse on other than the employee's earnings record. If the social security benefit is equal to or higher than the spouse overall minimum benefit and the family maximum applies, the overall minimum rate is recomputed so that the spouse is not included, if it would result in a higher overall minimum rate.

§ 229.56 Reduction for child's social security benefit.

A child's benefit under the overall minimum, after any adjustment for the family maximum, is reduced, but not below zero, by the amount of any social security benefit being paid to the child on other than the employee's earnings record. If the social security benefit is equal to or higher than the child's overall minimum benefit and the family maximum applies, the overall minimum rate is recomputed so that the child is not included, if it would result in a higher overall minimum rate.

§ 229.57 Reduction in spouse overall minimum benefit for employee annuity.

If an annuitant is entitled to both an employee annuity on his or her own earnings record and a spouse annuity on a different earnings record, the total overall minimum rates on both earnings records must be higher than the total railroad formula rates for the overall minimum to apply. The spouse overall minimum benefit amount, after adjustment for the family maximum and for age, is reduced by the employee-only overall minimum rate on the spouse's own earnings record (the employee benefit adjusted for age and social security benefits) plus the amount of any social security benefit payable to the spouse on other than the empoyee's earnings record.

§ 229.58 Rounding of overall minimum amounts.

The overall minimum amount for each beneficiary which is not a multiple of $0.10 is rounded to the next lower multiple of $0.10. After reducing each beneficiary's share for other benefits, if the result is not a multiple of $1.00 it is rounded to the next lower multiple of $1.00.

Subpart G—Reduction for Worker's Compensation or Disability Benefits Under a Federal, State, or Local Law or Plan

§ 229.65 Initial reduction.

(a) *When reduction is effective.* A benefit computed under the overall minimum based on disability (DIB O/M) is reduced (not below zero) for any month the employee is under retirement age and is entitled to worker's compensation or disability benefits under a Federal, State, or local law or plan (public disability benefit). The reduction is effective with the month the employee is entitled to worker's compensation or a public disability benefit.

(b) *When reduction is not made.* A reduction for worker's compensation is not made if the law or plan under which the worker's compensation or public disability benefit is paid provides for the reduction of the benefit provided due to entitlement to a social security disability benefit, and so provided on February 18, 1981.

(c) *Amount of reduction.* The reduction in the DIB O/M for worker's compensation or public disability benefit equals the difference between:

(1) The sum of the monthly DIB O/M rate, including benefits for all family members (subject to the family maximum), plus the monthly worker's compensation or public disability benefit; and

(2) The higher of 80 percent of the employee's average current earnings before becoming disabled or the monthly DIB O/M rate (before reduction for worker's compensation or public disability benefit).

(d) *Average current earnings, defined.* Beginning January 1, 1979, an employee's average current earnings for purposes of this section are the highest of:

(1) The average monthly wage (see § 225.2 of this chapter) used to compute the DIB O/M under the Social Security Act rules which were in effect before 1979; or

(2) One-sixtieth of the employee's total earnings from employment or self-employment under either the Social Security or Railroad Retirement Acts (including earnings that exceed the maximum used in computing social security benefits) for the 5 consecutive years after 1950 in which the earnings were the highest; or

(3) One-twelfth of the employee's total earnings from employment or self-employment under either the Social Security or Railroad Retirement Acts (including earnings that exceed the maximum used in computing social security benefits) for the year of highest earnings in the period from 5 years before through the year in which the employee became disabled. The result is rounded to the next lower multiple of $1.00.

§ 229.66 Changes in reduction amount.

(a) *Change in DIB O/M.* The amount of the worker's compensation or public disability benefit reduction does not change when there is an increase in the DIB O/M rate because of an amendment or cost of living increase. However, the reduction amount does change if there is a change in the family members included in the DIB O/M. When the number of family members changes and the DIB O/M is still payable, the amount of the reduction is recomputed using the DIB O/M rate, including the changed family group, as if the new family composition had existed when the worker's compensation or public disability benefit reduction first applied. However, this new reduction is not effective until the date of the change of the family group. The worker's compensation or public disability benefit and average current earnings are the same as those used before the change in the family group.

(b) *Change in amount of worker's compensation/public disability benefit.* The amount of the reduction for worker's compensation or public disability benefit changes when there is a change in

the amount of the worker's compensation or public disability benefit. If the worker's compensation or public disability benefit increases, the change in the reduction amount is effective with the month of the increase. If the worker's compensation or public disability benefit decreases, the change in the reduction amount is effective with the month of the decrease, no matter when the notice of the decrease is received.

§ 229.67 Redetermination of reduction.

(a) *General.* All cases reduced for worker's compensation or public disability benefit are recomputed in the second year after the year the reduction was first applied and every third year after that. The redetermined rate is effective with January of the year after the year the redetermination is made. The redetermined reduction is used only if it provides an annuity rate that is higher than the previous annuity rate.

(b) *Redetermined average current earnings.* The average current earnings amount used in redetermining a worker's compensation or public disability benefit reduction is determined by multiplying the initial average current earnings amount by:

(1) The average total wages (including wages that exceed the maximum used in computing social security benefits) of all persons for whom wages were reported to the Secretary of the Treasury for the year before the year or redetermination, divided by the average total wages for 1977 or, if later, the year before the year the reduction was first computed. If the result is not a multiple of $1.00, it is rounded to the next lower multiple of $1.00; or

(2) If the reduction was first computed before 1978, the average taxable wages reported to the Secretary of Health and Human Services for the first quarter of 1977, divided by the average taxable wages for the first quarter of the year before the year the reduction was first computed. If the result is not a multiple of $1.00, it is rounded to the next lower multiple of $1.00.

§ 229.68 Reduction of DIB O/M.

A reduction for entitlement to worker's compensation or a public disability benefit is applied after the DIB O/M is reduced for age and the family maximum. The spouse and child O/M benefits are first reduced proportionately. The employee O/M benefit is decreased by any remaining reduction amount.

Subpart H—Miscellaneous Deductions and Reductions

§ 229.80 Earnings restrictions.

The O/M may be reduced due to earnings from employment or self-employment in the same manner as a social security benefit. These restrictions on earnings are found at subpart E of part 404 of this chapter. Earnings can never reduce an employee's benefit below the railroad formula rate less the amount that those benefits would be reduced by earnings.

§ 229.81 Refusal to accept vocational rehabilitation.

The DIB O/M is not payable for any month in which the disabled employee refuses, without good reason, to accept vocational rehabilitation services available under an approved state program. A disabled child's benefit under the O/M is not payable for any month in which the child refuses, without good reason, to accept such vocational rehabilitation services, unless the child is a full-time student.

§ 229.82 Failure to have child in care.

(a) *General.* The full amount of the spouse overall minimum benefit is not payable for any month a spouse, who is included in the overall minimum because he or she has a child in his or her care, is under retirement age and is no longer caring for an eligible child. However, if the spouse is at least 62 years old, a reduced spouse annuity or a reduced overall minimum benefit is payable if the spouse has stated that he or she will accept a reduced benefit.

(b) *Report required.* When the overall minimum, which includes a benefit for a spouse who has the employee's child in his or her care, is payable, both the employee and spouse are responsible for reporting when the child leaves the spouse's care. The report is due before the benefits are paid for the second month after the first month in which

the child is no longer in the spouse's care.

(c) *Penalty for failure to report.* If the employee or spouse does not report the fact that a spouse included in the overall minimum no longer has an eligible child in his or her care within the time limit shown in paragraph (b) of this section, a penalty is deducted from the overall minimum amount, unless there is a good reason for the person's failure to report. The penalty deduction for the first failure to make a timely report equals the amount of the overall minimum increase for the first month in which a report should have been made. The deduction for the second failure to make a timely report is twice the amount of the overall minimum increase for the first month in which a report should have been made. The deduction for the third and later failures to make a timely report is three times the amount of the overall minimum increase for the first month in which a report should have been made or, if less, the overall minimum increase times the number of months for which a timely report was not made.

§ 229.83 Deportation.

The age DIB O/M is not payable for any month after the month the Board receives notice that the employee has been deported for a reason shown in section 202(h) of the Social Security Act. This restriction no longer applies if the employee is later legally admitted to the United States for permanent residence.

§ 229.84 Conviction for subversive activities.

If a person is convicted of subversive activities (under chapter 37, 105, or 115 of title 18 of the U.S. Code or section 4, 112, or 113 of the Internal Security Act of 1950, as amended), the court may order that earnings in the year of the conviction and previous years are to be disregarded in determining whether the person is entitled to social security benefits. These earnings would also be ignored in determining entitlement to the age or DIB O/M.

§ 229.85 Substantial gainful activity by blind employee or child.

A blind employee or child who is 55 years old or older is entitled to an O/M benefit based on disability while he or she is working in substantial gainful activity that does not require skills or ability used in his or her previous work. However, the DIB O/M or child's O/M benefit is not payable for any month in which the employee or child works in any type of substantial gainful activity which requires skills or abilities comparable to those of any gainful activity in which he or she has previously engaged with some regularity and over a substantial period of time.

Subpart I—Payment of Overall Minimum Rate

§ 229.90 Proportionate shares of overall minimum.

When both the employee and the spouse are entitled to annuities and the overall minimum rate is higher than the railroad formula rate, the overall minimum amount must be divided between the employee and spouse. The employee receives two-thirds of the total O/M rate. The spouse receives one-third of the total O/M rate.

§ 229.91 Payment of the overall minimum for part of a month.

(a) *Employee annuity payable for part of a month.* If an employee annuity begins after the first day of the month, the O/M amount payable for the partial month is 1/30 of the monthly rate times the number of days in the partial month.

(b) *Spouse annuity payable for part of a month*—(1) *Spouse not included in O/M before beginning date of spouse annuity and O/M applies as of the spouse annuity beginning date.* If a spouse annuity begins after the first day of a month, and the spouse is not includable in the O/M before the beginning date of the spouse annuity, and the O/M rate paid to the family group, including the spouse, as of the spouse annuity beginning date exceeds the amounts payable using the benefit formulas under the Railroad Retirement Act, the amount payable to the spouse for the partial month is 1/30

of the spouse's share of the O/M rate times the number of days in the month beginning with the spouse's annuity beginning date. In such a case, if the employee annuity is payable from the first day of the month, the amount payable to the employee is:

(i) One-thirtieth of the higher of the railroad formula or the O/M rate, without the spouse included, times the number of days in the month before the spouse annuity begins, plus

(ii) One-thirtieth of the employee's share of the O/M rate, with the spouse included, times the number of days in the month beginning with the spouse's annuity beginning date.

(2) *Spouse included in O/M before beginning date of spouse annuity and the O/M continues to apply.* If a spouse annuity begins after the first day of a month, and the spouse is includable in the O/M before the beginning date of the spouse annuity, and the O/M rate paid to the family group, including the spouse, as of the spouse annuity beginning date continues to exceed the amounts payable using the benefit formulas under the Railroad Retirement Act, the amount payable to the spouse for the partial month is 1/30 of the spouse's share of the O/M rate times the number of days in the month beginning with the spouse's annuity beginning date. In such a case, if the employee annuity is payable from the first of the month, the amount payable to the employee is:

(i) One-thirtieth of the O/M rate, with the spouse included, times the number of days in the month before the spouse annuity begins; plus

(ii) One-thirtieth of the employee's share of the O/M rate, with the spouse included, times the number of days in the month beginning with the spouse's annuity beginning date.

(3) *O/M rate applies before beginning date of spouse annuity and the railroad formula applies as of the spouse annuity beginning date.* If a spouse annuity begins after the first day of a month and the O/M rate applies to the family group, with or without the spouse included, before the beginning date of the spouse annuity, and the O/M rate paid to the family group, including the spouse, as of the spouse annuity beginning date is less than the amounts payable using the formulas under the Railroad Retirement Act, the amount payable to the spouse for the partial month is 1/30 of the spouse's railroad formula rate times the number of days in the month beginning with the spouse's annuity beginning date. In such a case, if the employee annuity is payable from the first day of the month, the amount payable to the employee is:

(i) One-thirtieth of the O/M times the number of days in the month before the spouse annuity begins; plus

(ii) One-thirtieth of the employee's railroad formula rate times the number of days in the month beginning with the spouse's annuity beginning date.

PART 230—MONTHS ANNUITIES NOT PAYABLE BY REASON OF WORK

Sec.

230.1 Statutory provisions.
230.2 Loss of annuity for month in which compensated service is rendered.
230.5 Exception concerning service to a local lodge or division.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: Board Order 60–2, 25 FR 593, Jan. 23, 1960, unless otherwise noted. Redesignated at 47 FR 7656, Feb. 22, 1982.

§ 230.1 Statutory provisions.

No annuity shall be paid with respect to any month in which an individual in receipt of any annuity hereunder shall render compensated service to an employer or to the last person by whom he was employed prior to the date on which the annuity began to accrue. Individuals receiving annuities shall report to the Board immediately all such compensated service. No annuity under paragraph 4 or 5 of subsection (a) of this section shall be paid to an individual with respect to any month in which the individual is under age sixty-five and is paid more than $100 in earnings from employment or self-employment of any form: *Provided*, That for purposes of this paragraph, if a payment in any one calendar month is for accruals in more than one calendar month, such payment shall be deemed to have been paid in each of the months in which accrued to the extent accrued in such month. Any such individual under the age of sixty-five shall report to the Board any such payment of earnings for such employment or self-employment before receipt and acceptance of an annuity for the second month following the month of such

payment. A deduction shall be imposed, with respect to any such individual who fails to make such report, in the annuity or annuities otherwise due the individual, in an amount equal to the amount of the annuity for each month in which he is paid such earnings in such employment or self-employment, except that the first deduction imposed pursuant to this sentence shall in no case exceed an amount equal to the amount of the annuity otherwise due for the first month with respect to which the deduction is imposed. If pursuant to the third sentence of this subsection an annuity was not paid to an individual with respect to one or more months in any calendar year, and it is subsequently established that the total amount of such individual's earnings during such year as determined in accordance with that sentence (but exclusive of earnings for services described in the first sentence of this subsection) did not exceed $1,200, the annuity with respect to such month or months, and any deduction imposed by reason of the failure to report earnings for such month or months under the fifth sentence of this subsection, shall then be payable. If the total amount of such individual's earnings during such year (exclusive of earnings for services described in the first sentence of this subsection) is in excess of $1,200, the number of months in such year with respect to which an annuity is not payable by reason of such third and fifth sentences shall not exceed one month for each $100 of such excess, treating the last $50 or more of such excess as $100; and if the amount of the annuity has changed during such year, any payments of annuity which become payable solely by reason of the limitation contained in this sentence shall be made first with respect to the month or months for which the annuity is larger. (Section 2(d) of the act.)

§ 230.2 Loss of annuity for month in which compensated service is rendered.

If an individual in receipt of an annuity renders compensated service, he shall not be paid an annuity with respect to any month in which such service is rendered to:

(a) An employer;

(b) Any person whether or not an employer by whom he was most recently employed when his annuity begins to accrue;

(c) Any person with whom he held, at the time the annuity begins to accrue, any rights to return to service;

(d) Any person with whom he ceased service in order to have his annuity begin to accrue.

[Board Order 60–2, 25 FR 593, Jan. 23, 1960; 25 FR 1074, Feb. 6, 1960. Redesignated at 47 FR 7656, Feb. 22, 1982]

§ 230.5 Exception concerning service to a local lodge or division.

In determining whether an annuity is subject to the provisions of this part the Board shall disregard any compensated service rendered after December 31, 1936, to a local lodge or division of a railway-labor-organization employer if the compensation for such service is required to be disregarded under the provisions of § 222.3(f) of this chapter.

[Board Order 40–742, 6 FR 298, Jan. 14, 1941. Redesignated at 47 FR 7656, Feb. 22, 1982]

PART 233—REDUCTION IN THE WINDFALL BENEFIT ANNUITY COMPONENT

Sec.

233.1 When reduction must be made.
233.2 Computation of reduction.
233.3 Reduction of retroactive and other similar payments.
233.4 Reconsideration of the reduction computation.

AUTHORITY: Sec. 1122(c), Pub. L. 97–35, 95 Stat. 638 (45 U.S.C. 231f).

SOURCE: 46 FR 50786, Oct. 15, 1981, unless otherwise noted.

§ 233.1 When reduction must be made.

On or before August 31 of each fiscal year, the Board shall, in accordance with this section, determine the amount of the reduction, if any that will have to be made in the following fiscal year in the amount of the windfall benefit components of persons entitled to such benefit components under the Railroad Retirement Act. A reduction must be made where it is determined that the balance in the Dual Benefits Payments Account, comprised of such funds as will be available for the payment of windfall benefits in the following fiscal year including the enacted or estimated appropriation to the Account for the next succeeding fiscal year, disregarding any interest which may be earned by the moneys in the

Account during the next fiscal year, is less than the estimate of the amount of the windfall benefits that would be payable under the Railroad Retirement Act during such fiscal year if no reduction were to be applicable. The amount of the windfall benefit as determined by the Board and paid to a person under this section shall constitute full and complete payment of the person's windfall component and there shall be no further liability on the part of the Board, the U.S. Government, or any other person or entity for the amount of any reduction imposed.

§ 233.2 Computation of reduction.

The amount of the reduction to be made in the windfall benefit components of annuities shall be determined in the following manner: the balance in the Dual Benefits Payments Account as determined under § 233.1 shall be divided by the amount of the estimated windfall benefits that would be payable for the fiscal year as determined under § 233.1 to obtain a percentage. This percentage of the unreduced windfall benefit component shall be the amount of that component to which persons are entitled under the Railroad Retirement Act. In no event, however, shall the amount of the windfall benefit exceed the amount that would be payable under the Railroad Retirement Act without regard to this section.

§ 233.3 Reduction of retroactive and other similar payments.

If a person is entitled to a retroactive payment for a month or months in an earlier fiscal year, the reduction factor as imposed with respect to the windfall component of the person's annuity, including that portion attributable to an earlier fiscal year, shall be the reduction factor applicable in the year of payment: *Provided*, *however*, That if the application of the payment year reduction factor would result in a larger payment than would the application of the earlier year reduction factor, the earlier year reduction factor shall be applied. The reduction factor imposed in the case of a replacement payment shall be that reduction factor which was applicable to the original payment. The term ''replacement payment'' means a payment made to a beneficiary to replace a check which was issued to the beneficiary in an earlier month, but which was not negotiated, and ''replacement payment'' also means a payment made to the beneficiary for an earlier month in which his or her annuity was not paid for some reason such as lack of a current address.

§ 233.4 Reconsideration of the reduction computation.

The Board shall periodically, but at least quarterly, examine the determinations and calculations made under §§ 233.1 and 233.2, in view of changes which may occur in the estimates used. If, as a result of this examination, the Board determines that the balance in the Dual Benefits Payments Account will be insufficient to pay benefits from that Account for the balance of the fiscal year at the established rate, the Board shall establish a new rate of reduction to be applied to benefits to be paid for the remaining months so that the balance in the Dual Benefits Payments Account will be sufficient to pay benefits for the remainder of the fiscal year. If, as a result of this examination, the Board finds that the balance in the Account is greater than would be required to pay benefits at the then applicable reduction percentage for the remainder of the fiscal year, the Board may, at its discretion, decrease the reduction percentage with respect to benefits to be paid for the remaining months.

PART 234—LUMP-SUM PAYMENTS

Subpart A—General

Sec.

234.1 Introduction.
234.2 Definitions.

Subpart B—Lump-Sum Death Payment

234.10 General.
234.11 1974 Act lump-sum death payment.
234.12 1937 Act lump-sum death payment.
234.13 Payment to a funeral home.
234.14 Payment to an equitably entitled person.
234.15 When an employee's estate is entitled.
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234.17 When an equitably entitled person's estate is payable.

234.18 Payment of a deferred lump-sum to a widow(er).
234.19 Effect of payment on future entitlement.
234.20 Computation of the employee's 1937 Act LSDP basic amount.
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Subpart C—Annuities Due but Unpaid at Death

234.30 General.
234.31 Regular employee retirement and supplemental annuities.
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Subpart D—Residual Lump-Sum Payment

234.40 General.
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234.42 How the employee may designate beneficiaries.
234.43 Payment to designated beneficiaries.
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234.45 Payment to the employee's estate.
234.46 Amount of the RLS payable.
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234.48 Computation of the gross RLS amount.

Subpart E—Lump-Sum Refund Payment

234.50 General.
234.51 Persons to whom a lump-sum refund payment is payable.
234.52 Effect of payment on other benefits.
234.53 Computation of the lump-sum refund payment.

Subpart F—Tier II Separation Allowance Lump-Sum Payment

234.55 General.
234.56 Persons to whom a separation allowance lump-sum payment is payable.
234.57 Effect of payment on other benefits.
234.58 Computation of the separation allowance lump-sum payment.

Subpart G—Miscellaneous

234.60 Escheat.
234.61 Assignment of interest by an eligible person.
234.62 Effect of conviction of a felony on entitlement.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 51 FR 3036, Jan. 23, 1986, unless otherwise noted.

Subpart A—General

§ 234.1 Introduction.

This part contains information about the various lump-sum payments payable under sections 6(a)(1) through 6(d)(2) of the 1974 Act.

§ 234.2 Definitions.

As used in this part:

Applicant means the person who signs an application for an annuity or lump-sum for himself, herself or for some other person.

Apply means to sign a form or statement that the Board accepts as an application.

Burial expenses means expenses in connection with the actual burial or other disposition of the remains of the deceased employee.

Eligible means a person meets all the requirements for payment of an annuity or a lump-sum, but has not yet applied.

Employee means any person who is working or has worked for a railroad employer.

Entitled means a person who meets all the requirements for an annuity or a lump-sum, and has applied.

Equitably entitled person means the person whose funds were used to pay the burial expenses of a deceased employee.

Lump-sum means any non-recurring payment due because of an employee's or beneficiary's death.

Person means an individual, partnership, trust estate, association, corporation, government unit, or estate of a deceased individual.

Reimbursable burial expenses means that part of the burial expenses not previously reimbursed by another Federal agency.

Subpart B—Lump-Sum Death Payment

§ 234.10 General.

A lump-sum death payment (LSDP) is payable when an employee with ten or more years of railroad service and a current connection with the railroad industry dies and is not survived by an individual who is eligible for a monthly annuity in the month the employee

died. The amount of the LSDP and the priority for payment depend upon when the employee acquired his or her 120th month of railroad service. If the employee acquired the 120th month of railroad service after 1974, a 1974 Act lump-sum death payment is payable to the employee's widow(er). If the employee acquired the 120th month of railroad service before 1975, a 1937 Act lump-sum death payment is payable to the employee's widow(er), the funeral home or the payer of the employee's burial expenses. An application for an LSDP must be filed within two years after the employee's death.

(Approved by the Office of Management and Budget under control number 3220–0031)

[51 FR 3036, Jan. 23, 1986, as amended at 52 FR 11017, Apr. 6, 1987]

§ 234.11 1974 Act lump-sum death payment.

(a) The total amount of the 1974 Act LSDP is payable to the employee's widow(er), if she or he was ''living in the same household'' as the employee at the time of the employee's death. (Refer to § 234.21 for an explanation of ''living in the same household.'')

(b) The amount of the 1974 Act LSDP is equal to three times the amount of the PIA, as determined by section 215 of the Social Security Act, or $255.00, whichever is less.

§ 234.12 1937 Act lump-sum death payment.

(a) The 1937 Act LSDP is payable in the following order and amounts:

(1) The employee's ''living with'' widow(er) is paid the total amount of the LSDP. (Refer to § 234.21 for an explanation of ''living with.'')

(2) A funeral home, which has unpaid expenses, is paid the amount of the unpaid expenses or the total amount of the LSDP, whichever is less.

(3) An equitably entitled person is paid the total amount of the LSDP or a proportionate share of the LSDP, depending upon the amount of burial expenses he or she paid.

(b) The 1937 Act LSDP is equal to ten times the basic amount. (Refer to § 234.20 for an explanation of the computation of the employee's basic amount.)

§ 234.13 Payment to a funeral home.

The 1937 Act LSDP is paid to a funeral home under the following conditions:

(a) A person who has assumed responsibility for all or part of the burial expenses files an application authorizing payment to the funeral home. Usually, the Board considers the person who makes the arrangements with the funeral home or makes a voluntary payment to the funeral home to be the person who has assumed responsibility for the burial expenses.

(b) An official of the funeral home with unpaid expenses files an application on behalf of the funeral home after 90 days have elapsed from the date of the employee's death, if during that 90-day period no one has assumed responsibility for the payment of the burial expenses.

(Approved by the Office of Management and Budget under control number 3220–0031)

§ 234.14 Payment to an equitably entitled person.

(a) An equitably entitled person's funds used to pay burial expenses may consist of:

(1) The individual's own money;

(2) Money in a joint account with the employee or another individual;

(3) Money paid to an individual who was named beneficiary to receive the money;

(4) A promissory note; or

(5) Money which several people placed into a pooled fund.

(b) Payment is made to equitably entitled persons in the following order:

(1) The person who paid the funeral home expenses;

(2) The person who paid the grave opening and closing expenses;

(3) The person who provided the burial plot; and

(4) The person who paid any type of expenses not listed in paragraphs (b)(1) through (3) of this section.

§ 234.15 When an employee's estate is entitled.

(a) The employee's estate is considered an equitably entitled person if the funds used to pay burial expenses consisted of:

(1) Money in the employee's single-ownership bank account;

(2) Money paid directly to the funeral home by the employee before death;

(3) Money paid by the employee under a contract, plan, system or general practice where no beneficiary was named to receive the money;

(4) Money found among the employee's effects;

(5) Unpaid salary due the employee by the employee's employer;

(6) Money obtained by selling the employee's real or personal property; or

(7) Money from a trust fund.

(b) If the employee's estate is the equitably entitled person, the Board will pay the LSDP to the legal representative of the employee's estate. When no legal representative of the employee's estate has been or is expected to be appointed, the Board will pay the LSDP according to state statutory procedures applicable when no formal probate or administration occurs.

§ 234.16 When a widow(er) is eligible as an equitably entitled person.

When a widow(er) files for an LSDP and the ''living with'' requirement (described in § 234.21) is not met, the widow(er) could be paid as an equitably entitled person.

§ 234.17 When an equitably entitled person's estate is payable.

When an equitably entitled person dies before negotiating the LSDP check, that person's share is payable to his or her estate.

§ 234.18 Payment of a deferred lump-sum to a widow(er).

In certain cases, a deferred LSDP may be payable to the employee's widow(er), even if someone may be entitled to a monthly annuity in the month of the employee's death. A deferred LSDP is the difference between the amount of the LSDP and the total of the monthly survivor annuities paid during the 12-month period which begins in the month of the employee's death.

§ 234.19 Effect of payment on future entitlement.

Payment of an LSDP does not affect the entitlement of survivors to monthly annuities at a later date.

§ 234.20 Computation of the employee's 1937 Act LSDP basic amount.

(a) Definition of terms used in this section:

Average monthly remuneration (AMR) means the amount obtained by adding together the creditable compensation and wages earned by the employee after 1936 and before the LSDP closing date and dividing that sum by three times the number of calendar quarters in that period. (Refer to part 211 of this chapter for a definition of creditable compensation and section 209 of the Social Security Act for a definition of creditable wages.)

Closing date means whichever of the following produce the highest AMR:

(1) The first day of the calendar year in which the employee both attained age 65 and was completely insured;

(2) The first day of the calendar year in which the employee died; or

(3) The first day of the calendar year following the year in which the employee died;

(4) However, if paragraphs (a)(1) through (3) of this definition do not occur before January 1, 1975, the closing date is January 1, 1975.

(b) *LSDP basic amount formula.* The basic amount is computed using the following formula:

(1) Determine 52.4% of the AMR up to and including $75.00;

(2) Determine 12.8% of the AMR exceeding $75.00;

(3) Determine 1% of the sum of paragraphs (b)(1) and (2) of this section;

(4) Multiply the result of paragraph (b)(3) of this section by the number of years after 1936 through 1974 in which the employee earned $200 or more;

(5) Add the results of paragraphs (b)(1), (2) and (3) of this section. If the resulting basic amount is less than $18.14, increase it to $18.14.

§ 234.21 Definitions of "living with" and "living in the same household."

(a) *Living with.* A widow(er) is considered ''living with'' the employee at the time of the employee's death, if one of the following conditions applies:

(1) The employee and spouse were members of the same household;

(2) The spouse was receiving regular contributions for support from the employee; or

(3) The employee was under court order to contribute to the spouse's support.

(b)(1) *Living in the same household.* An employee and spouse were ''living in the same household'' if they lived together as a married couple in the same residence. However, an employee and spouse, who were temporarily living apart, will be considered ''living in the same household'' if there was intent to share the same residence had the employee not died. The Board will usually assume that a married couple was living apart temporarily, if the separation was caused by circumstances beyond their control, for example, ill health, financial difficulties, service with the Armed Forces, or confinement in a curative, custodial, or penal institution.

(2) If the employee and spouse were separated solely for medical reasons, the Board will consider them ''living in the same household,'' even if the separation was likely to be permanent.

Subpart C—Annuities Due but Unpaid at Death

§ 234.30 General.

When an applicant or an annuitant dies before being paid any annuities that may be due, the total of those annuities become payable to certain survivors in a lump-sum. Refer to § 234.31 through § 234.34 for information about when and to whom each type of unpaid annuity is payable. An application for an unpaid annuity must be filed within two years after the death of the person originally entitled to the annuity.

(Approved by the Office of Management and Budget under control numbers 3220–0031 and 3220–0032 and 3220–0042)

[51 FR 3036, Jan. 23, 1986, as amended at 52 FR 11017, Apr. 6, 1987]

§ 234.31 Regular employee retirement and supplemental annuities.

A regular employee retirement annuity or a supplemental annuity which is unpaid at the death of the employee is payable in the following order and amounts:

(a) A surviving spouse, who was ''living with'' (see § 234.21) the employee at the time of the employee's death, receives the full amount of the unpaid annuity.

(b) Each person who paid the employee's burial expenses receives a share of the unpaid annuities in the same proportion that he or she paid the burial expenses, but only to the extent that he or she is not reimbursed by the LSDP. If a payer of the employee's burial expenses dies before negotiating his or her check, that payment becomes payable to his or her estate.

(c) Surviving children of the employee receive equal shares.

(d) Surviving grandchildren of the employee receive equal shares.

(e) Surviving parents of the employee each receive equal shares.

(f) Surviving brothers and sisters of the employee receive equal shares. Half blood brothers and sisters share equally with full blood brothers and sisters.

§ 234.32 Spouse or divorced spouse annuities.

A spouse annuity or divorced spouse annuity which is unpaid at the death of the spouse or divorced spouse is paid in the following order and amounts:

(a) The employee receives the full amount.

(b) If the employee died before negotiating the check in payment of the unpaid annuities, the unpaid spouse annuity or divorced spouse annuity is paid in the same order and amounts as described in § 234.31 (b) through (f).

§ 234.33 Survivor annuities.

Any survivor annuity which is unpaid at the death of the survivor is paid in the same order and amounts as described in § 234.31(a) and § 234.31(c) through § 234.31(f).

§ 234.34 When an entitled relative of the employee dies before receiving payment of a due but unpaid annuity.

If a person, who is entitled to unpaid annuities based upon his or her relationship to the employee, dies before negotiating the check in payment of the unpaid annuities, the amount to which he or she was entitled becomes payable to other relatives of the employee in the same degree of relationship. If no relatives in that degree of

relationship survive, the amount becomes payable to relatives in the next degree of relationship.

Subpart D—Residual Lump-Sum Payment

§ 234.40 General.

The residual lump-sum (RLS) is the means by which railroad employees and their survivors are guaranteed to receive at least as much in benefits as the employee paid in railroad retirement taxes during the years 1937 through 1974. An RLS payment can be made only if it appears that no other benefits based at least in part on railroad service will be payable under either the Railroad Retirement Act or Social Security Act in the future. The residual is reduced for any retirement benefits that were paid on the basis of the employee's railroad service, and for any survivor benefits based on the employee's earnings already paid by either the Board or the Social Security Administration. A widow(er) or dependent parent can, before attaining age 60, elect to waive future rights to monthly benefits based on the employee's railroad service in order to receive the RLS.

§ 234.41 Persons to whom an RLS is payable.

After the death of an employee, the RLS is payable, in the following order, to: beneficiaries designated by the employee; surviving relatives of the employee in order provided by law (see § 234.44); or the employee's estate.

§ 234.42 How the employee may designate beneficiaries.

The employee may designate one or more persons as beneficiaries of the RLS on a form available at any Board office. The employee may specify the share that each beneficiary is to receive. Also, the employee may designate alternate beneficiaries in the event that all primary beneficiaries die before the RLS becomes payable.

(Approved by the Office of Management and Budget under Control No. 3220–0031)

§ 234.43 Payment to designated beneficiaries.

(a) *How designated beneficiaries are paid.* Primary beneficiaries are paid the RLS to the exclusion of alternate beneficiaries. If a designated beneficiary dies before the date on which the RLS becomes payable, his or her share of the RLS becomes payable to any other designated beneficiaries. If an entitled designated beneficiary dies before negotiating the RLS check, that share is payable to his or her estate.

(b) *Amount designated beneficiaries are paid.* If the employee specified the share that each beneficiary is to receive, payment is made in the proportion specified. Otherwise, if there is more than one designated beneficiary, each is paid an equal share of the RLS.

§ 234.44 Payment to surviving relatives.

(a) *How surviving relatives are paid.* If the employee either did not designate a beneficiary or was not survived by a designated beneficiary, the RLS is payable to surviving relatives of the employee in the following order of relationship to the employee:

(1) Widow(er) who was ''living with'' the employee at the time of the employee's death (see § 234.21 for a definition of ''living with'');

(2) Child;

(3) Grandchild;

(4) Parent;

(5) Brother or sister, including half blood brother or sister.

(b) *Amount surviving relatives are paid.* If more than one relative in an equal degree of relationship survives the employee, each one is paid an equal share of the RLS. If an entitled relative of the employee dies before negotiating the RLS check, that share becomes payable to other surviving relatives of the employee in the same degree of relationship. If no relatives in that degree of relationship survive, relatives in the next degree of relationship are payable.

§ 234.45 Payment to the employee's estate.

(a) *When the employee's estate is paid.* If no designated beneficiaries or relatives survive the employee when the RLS becomes payable, the employee's

estate may be paid the RLS. Employees may also designate their estates to receive all or a share of the RLS as beneficiaries.

(b) *How the employee's estate is paid.* If a legal representative of the employee's estate has been appointed and has not been discharged, the Board will pay the RLS to the legal representative. When no legal representative of the employee's estate has been or is expected to be appointed, or the estate of the deceased employee has been closed and reopening is not expected, the Board will pay the RLS according to state statutory procedures applicable when no formal probate or administration occurs.

§ 234.46 Amount of the RLS payable.

The gross RLS amount is equal to certain percentages of the employee's creditable compensation, including military service, as described in § 234.48. (Creditable compensation and military service are discussed in parts 211 and 212 of this chapter, respectively.) The amount of the RLS payable is equal to the gross RLS minus the sum of all retirement benefits that have been paid on the basis of the employee's railroad service and all survivor benefits based on the employee's earnings previously paid by either the Board or the Social Security Administration.

§ 234.47 Election of the RLS by a widow(er) or parent.

(a) An RLS cannot be paid if it appears that there are immediate or future monthly survivor benefits payable to anyone other than a widow(er) or parent. A widow(er) or parent can elect to have the RLS paid in lieu of future monthly benefits based on the employee's railroad earnings under either the Railroad Retirement Act or Social Security Act.

(b) *When an election must be filed.* An election to have the RLS paid must be filed before the widow(er) or parent attains age 60 if he or she would be entitled to benefits under the Railroad Retirement Act, or before the age of eligibility if he or she would be entitled to future benefits under the Social Security Act instead of the Railroad Retirement Act.

(c) *Filing an election.* An election to have the RLS paid must be made on the certification provided by the Board for that purpose, and must contain an irrevocable election to have the RLS paid in lieu of all benefits based on the employee's railroad service to which the widow(er) or parent might otherwise become entitled. Once the RLS check is negotiated, the election cannot be revoked.

§ 234.48 Computation of the gross RLS amount.

The amount of the gross RLS is equal to the percentages of the employee's creditable compensation shown in Table I. However, compensation may only be credited up to the maximum amounts shown in Table II.

(a) *Percentages of the employee's creditable compensation and the periods to which those percentages apply:*

TABLE I

Percent	Period
4	Jan. 1, 1937 through December 1946.
7	Jan. 1, 1947 through December 1958.
7.5	Jan. 1, 1959 through December 1961.
8	Jan. 1, 1962 through December 1965.
8.1	Jan. 1, 1966 through December 1966.
8.65	Jan. 1, 1967 through December 1967.
8.8	Jan. 1, 1968 through December 1968.
9.45	Jan. 1, 1969 through December 1970.
9.85	Jan. 1, 1971 through December 1972.
10.1	Jan. 1, 1973 through September 1973.
5.35	Oct. 1, 1973 through December 1973.
5.45	Jan. 1, 1974 through December 1974.

(b) *Maximum compensation which may be credited per month:*

TABLE II

Compensation per Month	Period
$300	Jan. 1, 1937 through June 1954.
$350	July 1, 1954 through May 1959.
$400	June 1, 1959 through October 1963.
$450	Nov. 1, 1963 through December 1965.
$550	Jan. 1, 1966 through December 1967.
$650	Jan. 1, 1968 through December 1971.
$750	Jan. 1, 1972 through December 1972.
$900	Jan. 1, 1973 through December 1973.
$1,100	Jan. 1, 1974 through December 1974.

Subpart E—Lump-Sum Refund Payment

§ 234.50 General.

Under the 1974 Act, railroad employees with 10 or more years of railroad

service, who are not entitled to a vested dual benefit payment, may be eligible for a lump-sum refund payment if they had concurrent railroad and social security earnings within the period 1951 through 1974. The combined earnings from the railroad retirement and social security systems in any of those years must exceed the maximums given in § 234.53. The lump-sum refund is payable to either the employee or the employee's survivors.

§ 234.51 Persons to whom a lump-sum refund payment is payable.

Employees receive their lump-sum refund payment from the Board, without applying for it, at the time their regular annuity is awarded. If an employee dies without receiving payment of a regular annuity, the lump-sum refund payment is payable to the employee's survivors in the same order of priority as shown for the RLS in § 234.44.

§ 234.52 Effect of payment on other benefits.

The lump-sum refund payment is deductible from the RLS; however, it has no effect on the payment of other benefits.

§ 234.53 Computation of the lump-sum refund payment.

(a) The lump-sum refund payment is calculated as follows:

(1) Combine the railroad employee's creditable earnings, including military service, under the Social Security Act and Railroad Retirement Act for each of the years 1951 through 1974;

(2) Determine the amount of the employee's creditable earnings in excess of the amounts for each year shown in the chart in paragraph (b) of this section;

(3) Multiply the results of paragraph (a)(2) of this section by the percentage shown in the chart in paragraph (b) of this section; and

(4) Add the results of paragraph (a)(3) of this section. The total is the amount of the lump-sum refund payment.

(b) *Chart for calculation of lump-sum refund payment.*

Year	Amount	Percentage
1951–53	$3,600	1.5
1954–56	4,200	2.0
1957–58	4,200	2.25
1959	4,800	2.5
1960–61	4,800	3.0
1962	4,800	3.125
1963–65	5,400	3.625
1966	6,600	4.2
1967	6,600	4.4
1968	7,800	3.3
1969–70	7,800	4.2
1971	7,800	4.6
1972	9,000	4.6
1973	10,800	4.85
1974	13,200	4.95

Subpart F—Tier II Separation Allowance Lump-Sum Payment

SOURCE: 56 FR 1573, Jan. 16, 1991, unless otherwise noted.

§ 234.55 General.

Under the Railroad Retirement Act certain railroad employees who have received separation or severance payments may be entitled to a lump-sum payment if tier II railroad retirement taxes were deducted from these payments. This part sets forth the conditions for entitlement to the lump-sum payment and explains how the payment is computed.

§ 234.56 Persons to whom a separation allowance lump-sum payment is payable.

(a) An employee who has completed 10 years of service at the time of his or her retirement or death and who has received on or after January 1, 1985, a separation allowance or severance payment (see § 210.11 of this chapter) which would have been used to increase his or her tier II benefit, except for the fact that he or she was neither in an employment relation to one or more employers as defined in part 204 of this chapter nor an employee representative (see part 205 of this chapter), shall be entitled to a lump sum in the amount provided for in § 234.58.

(b) If an employee, otherwise eligible for the lump sum provided for in this section, dies before he or she becomes entitled to a regular annuity or before he or she receives payment of the lump sum, the lump sum is payable to the employee's widow or widower who will not have died before receiving payment. If the employee is not survived

by a widow or widower who will not have died before receiving payment, the lump sum is payable to the employee's survivors in the same order of priority as shown for the residual lump-sum (RLS) in § 234.44.

§ 234.57 Effect of payment on other benefits.

The tier II separation allowance lump-sum payment has no effect on the payment of other benefits.

§ 234.58 Computation of the separation allowance lump-sum payment.

The separation allowance lump-sum payment is calculated as follows:

(a) Determine the amount of the compensation due to the receipt of separation or severance pay that could not be considered in the computation of tier II;

(b) Multiply this amount by the rate or rates of tax imposed by section 3201(b) of the Internal Revenue Code of 1954 or 1986 on the compensation (tier II tax); and

(c) The product is the amount of the separation allowance lump-sum payment.

Example: In January of 1988 an employee with 10 years of railroad service relinquished his seniority rights in order to receive a separation allowance of $20,000, thereby severing his employment relation. This was the only creditable railroad compensation earned by the employee in 1988. Both the employer and employee would have paid their share of railroad retirement taxes on this amount. With respect to the employee tier II tax, the tax rate for 1988 was 4.9% under section 3201(b) of the Internal Revenue Code of 1986. Although the full $20,000 was creditable under the Railroad Retirement Act for tier I benefit computation purposes, only one month's compensation, $2,800, one-twelfth of the annual tier II earnings base of $33,600 for 1988, was creditable for tier II benefit purposes. This is because section 3(i)(4) of the Railroad Retirement Act does not permit crediting of compensation for tier II computation purposes after the employment relation has been severed. Under the lump-sum provision discussed above, the employee in this example would, upon award of his employee annuity, receive a payment of $842.80 ($20,000 minus $2,800, the amount of separation allowance that was creditable, or $17,200 times 4.9%).

Subpart G—Miscellaneous

SOURCE: 51 FR 3036, Jan. 23, 1986, unless otherwise noted. Redesignated at 56 FR 1573, Jan. 16, 1991.

§ 234.60 Escheat.

Any payment under this part which would be payable to any state, political subdivision of a state, the U.S. government or a foreign government because of the lack of a legal heir, shall remain in the Railroad Retirement Account.

§ 234.61 Assignment of interest by an eligible person.

(a) Any person who is eligible to receive a share of a lump-sum payment may assign his or her share to another eligible applicant, provided the share is not more than $500.

(b) If an LSDP or accrued annuity is payable, the request that a share be assigned must be received at a Board office no later than two years after the death of the employee or the originally entitled person.

(Approved by the Office of Management and Budget under control number 3220–0031)

§ 234.62 Effect of conviction of a felony on entitlement.

A person who has been convicted of a felony or an act in the nature of a felony of intentionally causing the employee's death shall not be entitled to any benefits under the Railroad Retirement Act. If a charge of felony is pending against an applicant for a lump-sum payment, the Board will make no payment until the applicant submits proof that the charge has been withdrawn, that no further action will be taken on the charge, or that he or she has been cleared of the charge.

PART 235—PAYMENT OF SOCIAL SECURITY BENEFITS BY THE RAILROAD RETIREMENT BOARD

Sec.

235.1 Basis and purpose.
235.2 Other regulations related to this part.
235.3 Who is paid social security benefits by the Board.
235.4 How the Board pays social security benefits.

AUTHORITY: 42 U.S.C. 405(i), 45 U.S.C. 231f.

SOURCE: 54 FR 5225, Feb. 2, 1989, unless otherwise noted.

§ 235.1 Basis and purpose.

Effective January 1, 1975, the Railroad Retirement Act of 1974 (Act) requires the Railroad Retirement Board (Board) to provide for the payment of monthly social security benefit payments on behalf of the Social Security Administration to certain individuals as described in § 235.3 of this part. However, any such individual who was receiving benefits from the Social Security Administration prior to January 1, 1975, will continue to receive benefits from that agency unless he or she becomes eligible for a different type of social security benefit after that date and files a new application with the Social Security Administration for that benefit. Benefits under the new entitlement will be paid by the Board. The Act provides an offset in the railroad retirement benefits of individuals who are also eligible for social security benefits. Because the Board is required to make this offset, the payment of social security benefits by the Board is authorized for the purpose of convenience in the administration of the Act.

§ 235.2 Other regulations related to this part.

This part is related to a number of other parts in this chapter:

(a) Part 216 describes when a person is eligible for an annuity under the Railroad Retirement Act.

(b) Part 222 defines family relationships (for example, who is the wife or widow of an employee) for use when it is necessary to establish such a relationship in order to receive a benefit under the Railroad Retirement Act.

§ 235.3 Who is paid social security benefits by the Board.

The following individuals, if entitled to social security benefits, are paid such benefits by the Board:

(a) A railroad employee who has been credited with at least 120 months of railroad service (or at least 60 months of railroad service, all of which accrue after December 31, 1995);

(b) A wife or husband of a railroad employee who has been credited with at least 120 months of railroad service (or at least 60 months of railroad service, all of which accrue after December 31, 1995);

(c) A divorced wife or husband of a railroad employee who has been credited with at least 120 months of railroad service (or at least 60 months of railroad service, all of which accrue after December 31, 1995);

(d) A survivor of a railroad employee, including a surviving divorced spouse, remarried widow(er), surviving divorced mother or father, who is entitled, or upon application would be entitled, to an annuity under the Railroad Retirement Act; and

(e) Any other person entitled to benefits under title II of the Social Security Act based on the social security wages of a railroad employee who has been credited with at least 120 months of railroad service (or at least 60 months of railroad service, all of which accrue after December 31, 1995), except survivors of a railroad employee when the Social Security Administration has jurisdiction for survivor benefits. See part 221 of this chapter.

[54 FR 5225, Feb. 2, 1989, as amended at 89 FR 47463, June 3, 2024]

§ 235.4 How the Board pays social security benefits.

(a) When an individual described in § 235.3 of this part is determined by the Social Security Administration to be entitled to social security benefits, the Social Security Administration certifies such benefits to the Board for payment by the Board. Once social security entitlement is certified to the Board, the Board then certifies the amount of the social security benefit to the Department of the Treasury for payment and makes any necessary adjustments in the individual's railroad retirement benefit.

(b) The Board has no authority with respect to the adjudication of the benefit to be paid under the Social Security Act. Entitlement to and the computation of such benefits is a matter solely within the jurisdiction of the Social Security Administration.

PARTS 236–240 [RESERVED]

PART 243—TRANSFER, ASSIGNMENT, OR WAIVER OF PAYMENTS

Sec.
243.1 Prohibition against garnishment.
243.2 Legal process for the enforcement of child support and alimony obligations.
243.3 Payments pursuant to court decree or court-approved property settlement.
243.4 Taxation of benefits.
243.5 Assignment of a portion of an annuity paid under the social security overall minimum provision.
243.6 Waiver of annuity payments.

AUTHORITY: 45 U.S.C. 231f(b)(5).

SOURCE: 53 FR 35806, Sept. 15, 1988, unless otherwise noted.

§ 243.1 Prohibition against garnishment.

Except as hereinafter provided in this part, no benefits paid under the Railroad Retirement Act are assignable or subject to any tax or to garnishment, attachment, or other legal process (including any order issued by any court in connection with a bankruptcy proceeding), nor shall any payment be anticipated.

§ 243.2 Legal process for the enforcement of child support and alimony obligations.

Benefits paid by the Board are subject to legal process brought for the enforcement of legal obligations to provide child support or to make alimony payments, as provided in part 350 of this chapter.

§ 243.3 Payments pursuant to court decree or court-approved property settlement.

Certain annuity components are subject to division pursuant to a court decree or to a court-approved property settlement incident to any such decree, as provided in part 295 of this chapter.

§ 243.4 Taxation of benefits.

(a) Annuities paid by the Board are subject to Federal income tax in accord with the Internal Revenue Code. The annuity portion equivalent to the amount of the benefit that the person would have actually received under the Social Security Act if railroad service had been creditable under that Act is treated for Federal income tax purposes the same way as a social security benefit. Annuity payments computed under the social security overall minimum provision contained in section 3(f)(3) of the Railroad Retirement Act (see § 243.5 of this part) are also treated as social security benefits for Federal income tax purposes. Railroad retirement annuity amounts exceeding social security equivalent payments, vested dual benefits, and supplemental annuities are taxed in the same manner as benefits provided under an employer plan which meets the requirements of section 401(a) of the Internal Revenue Code.

(b) Pursuant to section 14 of the Railroad Retirement Act, no annuity or supplemental annuity, in whole or in part, is subject to any tax by any state or any political subdivision thereof.

§ 243.5 Assignment of a portion of an annuity paid under the social security overall minimum provision.

Section 3(f)(3) of the Railroad Retirement Act, the social security overall minimum provision, guarantees that an annuitant will receive, in combined benefits under the Railroad Retirement and Social Security Acts, not less than the amount which would have been paid to the employee and to members of his or her family under the Social Security Act if the employee's railroad service had been creditable under that Act. An annuitant whose annuity is computed under that provision may assign all or any portion of that annuity to any of the members of his or her family who are or who could be included in the computation of the annuity. Any assignment issued pursuant to this section will terminate:

(a) When revoked by the annuitant by notification to the Board; or

(b) When the annuity is no longer computed under the social security overall minimum provision.

§ 243.6 Waiver of annuity payments.

(a) Any individual who has been awarded an annuity under the Railroad Retirement Act shall have the right to waive such annuity in whole or in part by filing with the Board a statement to that effect signed by him or her.

(b) Such a waiver shall be effective as of the date specified in the waiver

statement, except that if an annuity has been awarded, a waiver shall not be effective before the first day of the month after the month in which the waiver form is received at an office of the Board and shall not be effective as to any annuity payment which has already been made or which cannot be prevented.

(c) For the period during which a waiver is in effect, no payment of the amount of the annuity waived can ever be made to any person. A waiver of an annuity shall not, however, have any effect on the amount of a spouse's annuity otherwise payable or on a lump sum under section 6(c) of the Act otherwise due, nor shall it serve to make an individual eligible for a lump-sum death benefit under section 6(b) of the Act or any insurance benefit under the Social Security Act on the basis of the wages of the same deceased employee.

(d) A waiver once made shall continue in effect until the annuitant requests in writing that it be terminated.

PART 250 [RESERVED]

PART 255—RECOVERY OF OVERPAYMENTS

Sec.

255.1 Introduction.
255.2 Overpayments.
255.3 When overpayments are to be recovered.
255.4 Persons from whom overpayments may be recovered.
255.5 Recovery by cash payment.
255.6 Recovery by setoff.
255.7 Recovery by deduction in computation of death benefit.
255.8 Recovery by adjustment in connection with subsequent payments.
255.9 Individual enrolled under supplementary medical insurance plan.
255.10 Waiver of recovery.
255.11 Fault.
255.12 When recovery is contrary to the purpose of the Railroad Retirement Act.
255.13 When recovery is against equity or good conscience.
255.14 Waiver not available when recovery can be made from accrual of social security benefits.
255.15 Waiver to an estate.
255.16 Administrative relief from recovery.
255.17 Recovery of overpayments from a representative payee.
255.18 Compromise of overpayments.
255.19 Suspension or termination of the collection of overpayments.

AUTHORITY: 45 U.S.C. 231f(b)(5); 45 U.S.C. 231i.

SOURCE: 62 FR 64163, Dec. 4, 1997, unless otherwise noted.

§ 255.1 Introduction.

Section 10 of the Railroad Retirement Act provides for the recovery of an overpayment of benefits to an individual. This part explains when an overpayment must be recovered, from whom an overpayment may be recovered, and when recovery of the overpayment may be waived or administrative relief from recovery granted, and circumstances under which the overpayment may be compromised, or circumstances under which recovery of the overpayment may be suspended or terminated.

§ 255.2 Overpayments.

An overpayment, within the meaning of this part, is made in any case in which an individual receives a payment under the Railroad Retirement Act, all or part of which payment he or she is not entitled to receive.

§ 255.3 When overpayments are to be recovered.

Overpayments shall be recovered in all cases except those in which recovery is waived under § 255.10 of this part or administrative relief from recovery is granted under § 255.16 of this part, or where the overpayment is compromised or recovery is terminated or suspended under § 255.18 or § 255.19 of this part.

§ 255.4 Persons from whom overpayments may be recovered.

(a) *Overpaid individual.* The Board may recover an overpayment from the individual to whom the overpayment has been made by any method permitted by this part, or by the Federal Claims Collection Standards (4 CFR chapter 2) (Example 1 of this section). If the overpaid individual dies before recovery is completed, then recovery may be effected by recovery from the estate or the heirs of such individual.

(b) *Other than overpaid individual.* The Board may recover an overpayment from a person other than the overpaid individual if such person is receiving

benefits based upon the same record of compensation as the overpaid individual under a statute administered by the Board. In such a case, the Board will ordinarily recover the overpayment by setoff against such benefits as are provided for in § 255.6 of this part (Example 2 of this section). However, the Board may ask for a cash refund of the overpayment.

(c) *Individual not in the same household.* Recovery under paragraph (b) of this section may be made from an individual who was not living in the same household, as defined in part 216 of this chapter, as the overpaid individual at the time of the overpayment, if the individual from whom recovery is to be made either was aware that benefits were being paid incorrectly or benefitted from the overpayment. (Example 3 of this section).

(d) *Examples.* This section may be illustrated by the following examples:

Example (1). An employee receiving a disability annuity returns to work without notifying the Board. The Board discovers that the employee is working and determines that the employee has recovered from his disability and has been overpaid. The Board requests that the employee repay the overpayment by cash refund either in one lump sum or in installment payments. If the employee refuses, the Board may refer the debt to a collection agency or the Department of Justice for civil suit or may collect the debt in any other manner permitted by law.

Example (2). The employee in Example 1 agrees to refund the overpayment by cash installment payments. However, the employee dies before repaying the total amount of the overpayment. At his death the employee's widow, who was living with the employee at the time the overpayment was incurred, becomes entitled to a widow's annuity. The Board may recover the remainder of the overpayment from any benefits due the widow.

Example (3). C, a child of a deceased employee by his first marriage, is receiving a disability annuity on the employee's record of compensation. W, the employee's second wife, is receiving a widow's annuity on the employee's record of compensation. C lives with his mother, the employee's first wife. C marries without notifying the Board. Marriage terminates a child's annuity. W is not aware of C's marriage. Upon discovery of C's marriage, the Board demands that C refund the overpaid annuities; C refuses. Even though W is receiving an annuity based upon the same record of compensation as that of C, the Board will not recover the overpayment from W because she is not in the same household as C, was not aware of the incorrect benefits paid, and did not benefit from them.

§ 255.5 Recovery by cash payment.

The Board shall have the right to require that an overpayment to an individual be immediately and fully repaid in cash by that individual. However, if the Board determines that the individual is financially unable to pay the amount of the indebtedness in a lump sum, payment may be accepted in regular installments in accordance with the Federal Claims Collection Standards, found in 4 CFR chapter 2. These standards provide that whenever possible installment payments should be sufficient in amounts and frequency to liquidate the debt in not more than 3 years.

§ 255.6 Recovery by setoff.

An overpayment may be recovered by setoff from any subsequent payment determined to be payable under any statute administered by the Board to the individual who received the overpayment. An overpayment may be recovered from someone other than the overpaid individual by setoff from a subsequent payment determined to be payable to that other individual on the basis of the same record of compensation as that of the overpaid individual.

§ 255.7 Recovery by deduction in computation of death benefit.

In computing the residual lump sum provided for in part 234, subpart D, of this chapter, the Board shall include in the benefits to be deducted from the applicable percentages of the aggregate compensation provided for in that part all overpayments, whether waived under § 255.10 of this part or otherwise not recovered, that were paid to the employee or to his or her spouse or to his or her survivors with respect to the employee's employment.

§ 255.8 Recovery by adjustment in connection with subsequent payments.

(a) Recovery of an overpayment may be made by permanently reducing the amount of any annuity payable to the individual or individuals from whom

recovery is sought. This method of recovery is called an actuarial adjustment of the annuity. The Board cannot require any individual to take an actuarial adjustment in order to recover an overpayment nor is an actuarial adjustment available as a matter of right. An actuarial adjustment becomes effective and the debt is considered recovered when, in the case of an individual paid by electronic funds transfer, the first annuity payment reflecting the annuity rate after actuarial adjustment is deposited to the account of the overpaid individual, or, in the case of an individual paid by check, the first annuity check reflecting the annuity rate after actuarial adjustment is negotiated.

Example. An annuitant agrees to recovery of a $5,000 overpayment by actuarial adjustment. However, the annuitant dies before negotiating the first annuity check reflecting the actuarially-reduced rate. The $5,000 is not considered recovered. If the annuitant had negotiated the check before he died, the $5,000 would be considered fully recovered.

(b) In calculating any adjustment under this section, beginning with the first day of January after the tables and long-term or ultimate interest rate go into effect under section 15(g) of the Railroad Retirement Act (the triennial evaluation), the Board shall use those tables and long-term or ultimate interest rate.

[63 FR 29548, June 1, 1998]

§ 255.9 Individual enrolled under supplementary medical insurance plan.

Where recovery of the overpayment is by setoff as provided for in § 255.6 of this part, and where recovery of the overpayment by such means will be accomplished within a period of 5 months, and the individual from whom recovery is sought is an enrollee under Part B of Title XVIII of the Social Security Act (Supplementary Medical Insurance Benefits for the Aged and Disabled), an amount of such individual's monthly benefit which is equal to his or her obligation for supplementary medical insurance premiums will be applied toward payment of such premiums, and the balance of the monthly benefit will be applied toward recovery of the overpayment.

§ 255.10 Waiver of recovery.

There shall be no recovery from any person in any case where more than the correct amount of annuities or other benefits has been paid to an individual or where payment has been made to an individual not entitled thereto if in the judgment of the Board:

(a) The overpaid individual is without fault, and

(b) Recovery would be contrary to the purpose of the Railroad Retirement Act or would be against equity or good conscience.

§ 255.11 Fault.

(a) Before recovery of an overpayment may be waived, it must be determined that the overpaid individual was without fault in causing the overpayment. If recovery is sought from other than the overpaid individual but the overpaid individual was not without fault, then waiver is not available. However, see § 255.16 of this part for provisions as to when administrative relief from recovery may be granted in such circumstances.

(b) Fault means a defect of judgment or conduct arising from inattention or bad faith. Judgment or conduct is defective when it deviates from a standard of reasonable care taken to comply with the entitlement provisions of this chapter. Conduct includes both action and inaction. Unlike fraud, fault does not require a deliberate intent to deceive.

(c) Whether an individual is at fault in causing an overpayment generally depends on all circumstances surrounding the overpayment. Among the factors the Board will consider are: the ability of the overpaid individual to understand the reporting requirements of the Railroad Retirement Act or to realize that he or she is being overpaid (*e.g.*, age, education, comprehension, physical and mental condition); the particular cause of non-entitlement to benefits; and the number of instances in which the individual may have made erroneous statements.

(d)(1) Circumstances in which the Board will find an individual at fault include but are not limited to:

(i) Failure to furnish to the Railroad Retirement Board information which

the individual knew or should have known to be material;

(ii) An incorrect statement made by the individual which he or she knew or should have known was incorrect (including furnishing an opinion or conclusion when asked for facts); and

(iii) Failure to return a payment which the individual knew or should have known was incorrect.

(2) Where any of the circumstances listed in paragraph (d)(1) are found to have occurred, the individual shall be presumed to be not without fault. This presumption may be rebutted, but the burden of presenting evidence to rebut the presumption is on the individual.

(3) For purposes of paragraph (d)(1)(i), furnishing information to the Social Security Administration or any other agency shall not be considered to constitute furnishing information to the Railroad Retirement Board.

(4) For purposes of this section, an error on the part of the agency shall not extinguish fault on the part of the individual.

(e) Circumstances in which the Board will find an individual not at fault include but are not limited to:

(1) The overpayment is the result of Board error of which the overpaid individual was not aware and could not reasonably have been expected to be aware (Example 1 of this section).

(2) The overpayment is the result of an adjustment to the overpaid individual's annuity because of entitlement of another individual to an annuity on the same record of compensation as that of the overpaid individual (Example 2 of this section).

(3) The overpayment is the result of the Board's continuing to pay an individual after he or she has notified the Board of an event which caused or should have caused a reduction in his or her benefit; provided that continued payment of the unreduced benefit led the individual to believe in good faith that he or she was entitled to the payments subsequently received.

(f) The application of this section may be illustrated by the following examples:

Example (1). The Board makes a mathematical error in the computation of an employee's annuity, thus giving the employee a higher rate than he or she is entitled to but which is sufficiently close to the estimated rate given the employee at the time he or she applied for the annuity that the employee believed, in good faith, that the amount was correct. The employee is not at fault in causing the overpayment in this case. The overpayment may be waived if the requirements of § 255.12 or § 255.13 of this part are met.

Example (2). The widow and four minor children of a railroad employee are receiving benefits from the Board under the family maximum. Another minor child not living in the same household as the above individuals is also determined to be the child of the deceased employee. The widow was not aware of the existence of this child. An award of benefits to this child causes a reduction in benefits to the other individuals under the family maximum benefit provision of the Social Security Act. Because of normal administrative delay this reduction does not take place for a period of 2 months after its effective date. The widow and her children are without fault with respect to this overpayment. The overpayment may be waived if the requirements of § 255.12 or § 255.13 of this part are met.

§ 255.12 When recovery is contrary to the purpose of the Railroad Retirement Act.

(a) The purpose of the Railroad Retirement Act is to pay retirement and survivor annuities and other benefits to eligible beneficiaries. It is contrary to the purpose of the Act for an overpayment to be recovered from income and resources which the individual requires to meet ordinary and necessary living expenses. If either income or resources, or a combination thereof, are sufficient to meet such expenses, recovery of an overpayment is not contrary to the purpose of the Act.

(b) For purposes of this section, income includes any funds which may reasonably be considered available for the individual's use, regardless of source, including inheritance prospects. Income to the individual's spouse or dependents is available to the individual if the spouse or dependent lived with the individual at the time waiver is considered. Types of income include but are not limited to:

(1) Government benefits, such as Black Lung, Social Security, Workers' Compensation, and Unemployment Compensation benefits;

(2) Wages and self-employment income;

(3) Regular incoming payments, such as rent or pensions; and

(4) Investment income.

(c) For purposes of this section, resources may include:

(1) Liquid assets, such as cash on hand, the value of stocks, bonds, savings accounts, mutual funds and the like;

(2) Non-liquid assets (except an individual's primary residence) at their fair market value; and

(3) Accumulated, unpaid Federal benefits.

(4) For purposes of paragraphs (c)(1) and (2) of this section, assets concealed or improperly transferred on and after the date of notification of the overpayment, other than cash expended to meet ordinary and necessary living expenses, shall be included.

(d) Whether an individual has sufficient income and resources to meet ordinary and necessary living expenses depends not only on the amount of his or her income and resources, but also on whether the expenses are ordinary and necessary. While the level of expenses which is ordinary and necessary may vary among individuals, it must be held at a level reasonable for an individual who is living on a fixed income. The Board will consider the discretionary nature of an expense in determining whether it is reasonable. Ordinary and necessary living expenses include:

(1) Fixed living expenses such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (*e.g.*, life, accident, and health insurance), taxes, installment payments, etc.;

(2) Medical, hospital, and other similar expenses;

(3) Expenses for the support of others for whom the individual is legally responsible; and

(4) Miscellaneous expenses (*e.g.*, newspapers, haircuts).

(e) Where recovery of the full amount of an overpayment would be made from income and resources required to meet ordinary and necessary living expenses, but recovery of a lesser amount would leave income or resources sufficient to meet such expenses, recovery of the lesser amount is not contrary to the purpose of the Act.

(f) This section may be illustrated by the following examples:

Example (1). A remarried widow, W, is overpaid $6000 due to receipt of benefits on the wage records of both her late husbands. It has been determined that she is without fault. Her financial disclosure statement reveals monthly income greater than monthly expenses, and assets of $12,000, $10,000 of which is in cash. She claims to be saving these funds for future medical expenses, because she has a progressive disease. While it is not necessarily contrary to the purposes of the Act to recover the overpayment in these circumstances, the legitimate medical expenses associated with the disease must be considered.

Example (2). A disability annuitant, D, is overpaid $33,000 because of simultaneous entitlement to workers' compensation payments. He is determined to be without fault. He claims he has assumed financial responsibility for his adult child and her children. A claimed expense for which the annuitant has no legal obligation to pay does not make recovery contrary to the purposes of the Act.

§ 255.13 When recovery is against equity or good conscience.

(a) Recovery is considered to be against equity or good conscience if a person, in reliance on payments made to him or her or on notice that payment would be made, relinquished a significant and valuable right (Example 1 of this section) or changed his or her position to his or her substantial detriment (Example 2 of this section).

(b) An individual's ability to repay an overpayment is not material to a finding that recovery would be against equity or good conscience but is relevant with respect to the credibility of a claim of detrimental reliance under paragraph (a) of this section.

(c) This section may be illustrated by the following examples:

Example (1). After being informed by the Board that he had been credited with sufficient years of railroad service to retire at age 60, an employee quit his railroad job and applied for benefits under the Railroad Retirement Act. He receives benefits for six months when it is discovered that he had insufficient railroad service to retire at age 60 and was not entitled to the benefits he received. His annuity was terminated. Because the employee gave up his seniority rights when he quit his railroad job, he cannot get his job back. It is determined that the employee was not at fault in causing the overpayments. In this situation recovery of the overpayment would be against equity or

good conscience because the overpaid individual gave up a valuable right.

Example (2). A widow, having been awarded annuities for herself and her daughter, entered her daughter in a private school. The widow did not have substantial assets and her income, apart from the annuities she received in the amounts payable, would not have been sufficient for her to have undertaken the obligation to send her daughter to private school. In order to pay for the schooling she took out a loan and used the monthly annuities to pay interest and principal on the loan. After the widow and her daughter had received payments for almost a year, the deceased employee was found not to have been insured under the Railroad Retirement Act. Therefore, all payments to the widow and child were erroneous and the annuities were terminated. It is determined that the widow was not at fault in causing the overpayment. Having incurred a financial obligation (the school loan) toward which the benefits had been applied, the widow was in a worse position financially than if she and her daughter had never been entitled to benefits. In this situation, the recovery of the overpayment would be against equity or good conscience.

§ 255.14 Waiver not available when recovery can be made from accrual of social security benefits.

Where the overpayment is the result of a reduction of benefits payable under the Railroad Retirement Act due to the overpaid individual's entitlement to social security benefits and recovery of such overpayment may be made by offset against an accrual of social security benefits, it shall not be considered to be against equity or good conscience or contrary to the purpose of the Railroad Retirement Act to recover the overpayment by offset against the accrual. Consequently, in such a case recovery of an overpayment is not subject to waiver consideration.

§ 255.15 Waiver to an estate.

It shall never be considered contrary to the purpose of the Railroad Retirement Act to recover an overpayment from the estate of an overpaid individual.

§ 255.16 Administrative relief from recovery.

(a) Where the Board seeks to recover an overpayment from someone other than the overpaid individual, as provided for in § 255.4 of this part, and where waiver of recovery, as provided for in § 255.10 of this part, is not available because the overpaid individual was at fault as defined in § 255.11 of this part, the Board may forego recovery of the overpayment where the individual from whom recovery is sought was not at fault in causing the overpayment and where recovery is contrary to the purpose of the Railroad Retirement Act as defined in § 255.12 of this part.

(b) Application of administrative relief from recovery with respect to a given person from whom recovery may be made shall have no effect on the authority of the Board to recover the overpayment from anyone else from whom recovery may be sought.

(c) This section may be illustrated by the following examples:

Example (1): An employee, through his own fault, causes an overpayment in his annuity. The employee dies before the overpayment can be recovered from him and he leaves no estate. A widow's annuity is payable on the employee's compensation record. The widow was not at fault in causing the overpayment. The Board may recover the remainder of the overpayment by setoff against the widow's annuity. However, it may forego recovery under this section if such recovery would be contrary to the purpose of the Railroad Retirement Act as defined in § 255.12 of this part. Since this is not a waiver of the overpayment, the Board is free to recover the overpayment from the widow at a later date, for example, if an accrual of benefits should become payable, or if it determines that such recovery would not be against the purpose of the Railroad Retirement Act.

Example (2): A representative payee for a retarded child, through her own fault, causes an overpayment in the child's annuity. The overpaid amounts were used for the benefit of the child. The representative payee dies before the overpayment can be recovered from her and she leaves no estate. The Board may not waive the remainder of the overpayment with respect to the child since for purposes of waiver the representative payee is considered the overpaid individual (see § 255.17 of this part) and the overpaid individual was at fault. However, if the child was not at fault in causing the overpayment and recovery would be contrary to the purpose of the Railroad Retirement Act as defined in § 255.12 of this part, then the Board may forego recovery of the overpayment from the child's annuity under this section.

§ 255.17 Recovery of overpayments from a representative payee.

(a) *Joint liability.* In general, if an overpayment is made to an individual receiving benefits as a representative payee (see part 266 of this chapter) the Board may recover the overpayment from either the representative payee or the beneficiary, or both. If the beneficiary is currently receiving benefits, either in his or her own right or through a representative payee, the Board will generally propose to recover the overpayment by setoff against those benefits as provided for in § 255.6 of this part. If the beneficiary is not currently receiving benefits but the representative payee is receiving benefits, then the Board will generally propose to recover the overpayment by setoff against those benefits.

(b) *Waiver of overpayments.* For purposes of § 255.10 of this part (Waiver of recovery), if it is determined that the representative payee was at fault in causing the overpayment there may be no waiver of the overpayment either as to the representative payee or the beneficiary. However, if the beneficiary was not at fault in causing the overpayment he or she may be eligible for administrative relief from recovery under § 255.16 of this part.

(c) This section may be illustrated by the following examples:

Example (1). M is receiving a child's annuity as a representative payee for her disabled son, S. With M's knowledge S marries. Although both M and S know that marriage terminates the child's annuity, neither of them informs the Board of this event. Both M and S are liable for any overpayment caused. Waiver is not available since M would be considered at fault in causing the overpayment. Administrative relief from recovery is not available to S since he would also be considered at fault.

Example (2). R is a representative payee for B, who resides in a skilled-care facility. R is found to be at fault in causing an overpayment of benefits to B. The Board may recover the overpayment from either R or B. Waiver is not available because R was at fault in causing the overpayment. However, if B was not at fault in causing the overpayment he or she may be entitled to administrative relief from recovery under § 255.16 of this part.

§ 255.18 Compromise of overpayments.

(a) This section sets forth the principal standards which the Board applies in exercising its authority under 31 U.S.C. 3711 to compromise an overpayment. In addition, the Board may compromise an overpayment under the Federal Claims Collection Standards set forth in 4 CFR part 103.

(b) An overpayment may be compromised only if it is in the best interest of the agency. Circumstances and factors to be considered are:

(1) The overpayment cannot be collected because of the overpaid individual's inability to pay the full amount of the overpayment within a reasonable time;

(2) The overpaid individual refuses to pay the overpayment in full and it appears that enforced collection procedures will take an inordinate amount of time or that the cost of collecting does not justify the enforced collection of the full amount; or

(3) There is doubt that the Board could prove its case in court for the full amount claimed because of a bona fide dispute as to the facts or because of the legal issues involved.

§ 255.19 Suspension or termination of the collection of overpayments.

This section sets forth the principal standards which the Board applies in approving the suspension or termination of the collection of an overpayment. In addition the Board may suspend or terminate collection under the Federal Claims Collection Standards set forth in 4 CFR part 104.

(a) Collection action on a Board claim may be suspended temporarily when the debtor cannot be located and there is reason to believe future collection action may be productive or collection may be effected by offset in the near future.

(b) Collection action may be terminated when:

(1) The debtor is unable to make any substantial payment;

(2) The debtor cannot be located and offset is too remote to justify retention of the claim;

(3) The cost of collection action will exceed the amount recoverable; or

(4) The claim is legally without merit or cannot be substantiated by the evidence.

PART 258—HEARINGS BEFORE THE BOARD OR DESIGNATED EXAMINERS

Sec.

258.1 Hearings.
258.2 Witnesses.
258.3 Application for witnesses.
258.4 Service of subpoenas.
258.5 Exhibits.
258.6 Procedure when examiner appointed.
258.7 Board decisions and opinions and dissenting opinions.

AUTHORITY: Sec. 10, 50 Stat. 314, as amended; 45 U.S.C. 228j, unless otherwise noted.

SOURCE: 43 FR 56888, Dec. 5, 1978, unless otherwise noted.

§ 258.1 Hearings.

(a) To such extent as may be necessary to determine (1) the employee status of any individual or group of individuals, (2) the employer status of any person, and (3) any other matter arising out of or necessary for the administration of the Railroad Unemployment Insurance Act and the Railroad Retirement Acts of 1935, 1937, and 1974, other than those matters specifically provided for in parts 260 and 320 of this chapter, the Board may itself or through one of its members or a designated examiner, conduct hearings, require and compel the attendance of witnesses and the production of records and documents, administer oaths, take testimony, make all pertinent investigations and findings of fact, and render decisions upon such findings.

(b) Where the Board determines that an oral hearing is necessary to the determination of a matter before it, the Board shall notify all parties to the proceeding that a hearing will be conducted, and, if the hearing is to be before a single Board member or a designated examiner, the notice shall identify the member or examiner authorized to conduct the hearing. The Board or the person authorized to conduct the hearing shall fix a time and place for the holding of the hearing and shall notify all parties thereof.

§ 258.2 Witnesses.

(a) In any hearing held pursuant to the provisions of this part, witnesses may be compelled to appear, give testimony, and produce records and documents.

(b) Designation by the Board of any person as an examiner to preside at and conduct such hearings shall constitute a delegation of authority to such examiner to require and compel the attendance of witnesses and the production of records and documents, to administer oaths, and to take testimony.

§ 258.3 Application for witnesses.

(a) Any person or persons conducting a hearing pursuant to the provisions of this part or part 260 of this chapter may, upon such person's or persons' own motion or upon application of any party to such hearing, issue a subpoena for a witness or witnesses. An application for a subpoena shall be by affidavit filed with the person or persons conducting the hearing within such period of time as will permit service and return of a subpoena prior to the date set for the hearing at which the witness is to appear, but in no case shall such application be filed later than 10 days prior to the date of hearing. The application shall set forth:

(1) The name and address of the witness;

(2) The title of the matter to be heard, i.e., names of parties;

(3) The issue to which the testimony of the witness will be directed;

(4) The substance of the testimony which such witness is expected to give or the facts to which such witness will testify; and

(5) The specific books, papers or documents which are requested, if a subpoena duces tecum is applied for.

(b) In addition to the above, the party filing such application shall, at the time of filing, deposit therewith a sum of money sufficient to cover the fees and transportation allowance of the witness, or, in lieu thereof, shall state in the application that satisfactory arrangements have been made with the witness for the direct payment of his or her fees and transportation allowance and any other allowable expense.

§ 258.4 Service of subpoenas.

Service of subpoenas issued under § 258.3 may be made by any individual designated by the Board. Such individual shall deliver a copy of the subpoena to the person or persons named therein, and shall at that time tender to that person or persons the fees for one day's attendance and the transportation allowance authorized by law; *Provided, however,* That if the witness or witnesses be summoned to appear upon motion of the person or persons designated to conduct the hearing, no fees or transportation allowance need be tendered. Fees and transportation allowances shall be in the same amount as is allowed to witnesses in the courts of the United States. The person serving the subpoena shall make certification of the manner and time of service on the original subpoena and shall file such original subpoena with the person or persons by whom it was issued.

§ 258.5 Exhibits.

Copies of all exhibits admitted in evidence at any hearing held pursuant to the provisions of this part shall be furnished by the party offering the same to all other parties participating in the proceedings.

§ 258.6 Procedure when examiner appointed.

(a) Where an examiner has been designated by the Board under this part to conduct a hearing with respect to a matter before it, the examiner shall preside at the hearing and shall cause all testimony to be recorded. The examiner shall, as soon as practicable following the conclusion of the hearing, mail to each party at the address stated in his or her appearance a free transcript of the record of the proceedings had before the examiner. Thereafter, the examiner shall give all parties participating in the hearing the opportunity to present argument upon both law and facts. Upon conclusion of the proceedings before him or her, the examiner shall prepare a report which, together with the record of the proceedings before him or her, shall be submitted to the Board. The report shall set forth the examiner's findings of fact, conclusions of law, and recommendations as to decision. The report may also contain such discussion of the question raised, both legal and factual, as the examiner may desire to present to the Board. A copy of the examiner's report shall be served by the examiner upon each party participating in the hearing by mailing such copy to each such party at the address stated in his or her appearance. Each party shall, within 30 days after the date of mailing to him or her of the examiner's report, file with the Board and serve upon other parties by mailing to their addresses as stated in their appearances such exceptions in writing as he or she desires to make to the examiner's findings of fact and conclusions of law. Each exception shall specifically designate the particular findings of fact or conclusions of law to which objection is taken, and shall set forth in detail the grounds for the objection. General exceptions and exceptions not specifically directed to particular findings of fact or conclusions of law will not be considered by the Board. Exceptions to findings of fact shall make specific reference by page numbers to those portions of the record upon which reliance is placed.

(b) Each party shall have 10 days after receipt of exceptions taken by other parties in which to file with the Board replies to those exceptions. Replies to exceptions to findings of fact shall make specific reference by page number to those portions of the record upon which reliance is placed.

(c) The Board may, upon the application of a party and for cause shown, extend the time for filing and serving of exceptions or filing of replies thereto. The Board will render its decision upon the record, the examiner's report, and such exceptions and replies thereto as are made.

(d) The examiner's report shall be advisory only and the Board may, in any case, exercise its right to reject or adopt the examiner's report in whole or in part or adopt such report with modifications. Findings of fact to which no exceptions are taken will, subject only to the power of the Board upon its own consideration to reject or modify, be presumed to be correct.

(e) The decision of the Board shall be communicated to the parties participating in the hearing within 30 days of the date upon which the decision of the Board is entered upon its records.

§ 258.7 Board decisions and opinions and dissenting opinions.

The following shall apply to all decisions of the Board except decisions relating to matters of internal administration:

A decision made by at least two members of the Board shall constitute the decision of the Board. The decision of the Board shall be stated in a written opinion filed in the record of the proceedings. A dissenting opinion may be stated by a member of the Board who disagrees with the decision of the Board and any such dissenting opinion shall also be filed in the record of the proceedings.

PART 259—INITIAL DETERMINATIONS AND APPEALS FROM INITIAL DETERMINATIONS WITH RESPECT TO EMPLOYER STATUS AND EMPLOYEE STATUS

Sec.

259.1 Initial determinations with respect to employer and employee status.
259.2 Parties to determinations with respect to employer and employee status.
259.3 Reconsideration of initial determinations with respect to employer or employee status.
259.4 Authority to conduct investigations.
259.5 Appeals from decisions of the Board.
259.6 Finality of determinations issued under this part.

AUTHORITY: 45 U.S.C. 231f; 45 U.S.C. 362(l).

SOURCE: 43 FR 56889, Dec. 5, 1978, unless otherwise noted.

§ 259.1 Initial determinations with respect to employer and employee status.

(a) All requests for a determination with respect to employer or employee status shall be filed with the Secretary to the Board.

(b) The General Counsel of the Railroad Retirement Board or his or her designee shall make the initial investigations with respect to:

(1) The status of any person as an employer under the Railroad Retirement Act and the Railroad Unemployment Insurance Act and the rules and regulations issued thereunder; and

(2) The status of any individual or group of individuals as an employee or employees of an employer covered under the Railroad Retirement Act and the Railroad Unemployment Insurance Act.

(c) Upon completion of this investigation the General Counsel, or his or her designee, shall submit to the Board the results of the investigation together with a recommendation concerning the coverage determination. The Board shall make the initial determination with respect to the status of any person as an employer or as an employee under the Railroad Retirement Act and Railroad Unemployment Insurance Act. The Secretary to the Board shall promptly notify the party or parties, as defined in § 259.2 of this part, and other interested persons or entities of the Board's determination.

[57 FR 4366, Feb. 5, 1992]

§ 259.2 Parties to determinations with respect to employer and employee status.

(a) With respect to any determination under this part concerning the status of a person as an employer under the Railroad Retirement Act and the Railroad Unemployment Insurance Act, that person shall be a party to such determination and may submit written briefs or argument, as well as any documentary evidence pertinent to the matter at issue, to the decision maker to be considered in the rendition of a determination. The employees of such person may submit written briefs or argument with respect to such determination, but shall not be parties thereto.

(b) With respect to any determination under this part concerning the status of an individual or group of individuals as an employee or employees of an employer covered by the Railroad Retirement Act and the Railroad Unemployment Insurance Act, the employer alleged to be the employer of the individual or group of individuals and the individual or group of individuals shall each be considered a party to such determination and may submit

written briefs or argument, and documentary evidence pertinent to the matter at issue, to the decision maker to be considered in the rendition of a determination.

§ 259.3 Reconsideration of initial determinations with respect to employer or employee status.

(a) A party to an initial decision issued under § 259.1 shall have the right to request reconsideration of that decision. A request for reconsideration shall be in writing and must be filed with the Secretary to the Board within one year following the date on which the initial determination was issued. Where a request for reconsideration has been timely filed, the Secretary to the Board shall notify all other parties to the initial determination of such request. The party who requested reconsideration and any other party shall have the right to submit briefs or written argument, as well as any documentary evidence pertinent to the issue under consideration. The General Counsel or his or her designee shall review the material furnished all parties and shall submit it to the Board with a recommendation as to the determination upon reconsideration. The Board shall then issue a determination with respect to the request for reconsideration. The Secretary to the Board shall promptly notify all parties and other interested persons or entities of the determination upon reconsideration.

(b) A party who claims to be aggrieved by an initial decision of the Board but who fails to timely request reconsideration under this section shall forfeit any further right to appeal under this part.

[57 FR 4366, Feb. 5, 1992]

§ 259.4 Authority to conduct investigations.

In performing his or her responsibilities under § 259.1 or § 259.3, the General Counsel or his or her designee shall have the authority and the power to conduct any investigations he deems necessary. In addition, the General Counsel or his or her designee shall have the power to compel, by subpoena, any person, company, corporation, or other entity to produce any records or other documents pertinent to the matter under consideration.

(45 U.S.C. 231f(b)(5))

[43 FR 56889, Dec. 5, 1978, as amended at 48 FR 51447, Nov. 9, 1983; 57 FR 4366, Feb. 5, 1992]

§ 259.5 Appeals from decisions of the Board.

A party who claims to be aggrieved by a decision of the Board under this part may obtain review of such decision by filing a petition for review in the United States court of appeals for the circuit in which the party resides or has its principal place of business or principal executive office, in the United States Court of Appeals for the Seventh Circuit, or in the United States Court of Appeals for the District of Columbia. The petition for review must be filed within 90 days following the date on which the notice of the Board's decision was mailed to that party.

[43 FR 56889, Dec. 5, 1978. Redesignated at 57 FR 4366, Feb. 5, 1992]

§ 259.6 Finality of determinations issued under this part.

Any determination rendered by the Board at the initial or reconsideration stages shall be considered a final determination and shall be binding with respect to all parties unless reversed on reconsideration or upon judicial review. A final determination may be reopened at the request of a party who was, or could have been, a party to the final determination when the party alleges that the law or the facts upon which the final determination was based have changed sufficiently to warrant a contrary determination. Such a request shall be submitted to the Secretary to the Board, who shall consider such request as a request for an initial determination under § 259.1.

[57 FR 4366, Feb. 5, 1992]

PART 260—REQUESTS FOR RECONSIDERATION AND APPEALS WITHIN THE BOARD

Sec.

260.1 Initial decisions.
260.2 Initial decisions on the amount of service and compensation credited to an employee.

260.3 Request for reconsideration of initial decision.
260.4 Request for waiver of recovery of an overpayment and/or for reconsideration of an initial erroneous payment decision.
260.5 Appeal from a reconsideration decision.
260.6 Time limits for issuing a hearing decision.
260.7 Time limits for issuing a decision when a hearing is not held.
260.8 Pre-hearing case review.
260.9 Final appeal from a decision of the hearings officer.
260.10 Determination of date of filing.

AUTHORITY: 45 U.S.C. 231f; 45 U.S.C. 231g; 45 U.S.C. 355.

SOURCE: 47 FR 36809, Aug. 24, 1982, unless otherwise noted.

§ 260.1 Initial decisions.

(a) *General.* Claims for benefits shall be adjudicated and initial decisions made by the Board concerning:

(1) Applications for benefits under the Railroad Retirement Act;

(2) The withdrawal of an application;

(3) A change in an annuity beginning date;

(4) The termination of an annuity;

(5) The modification of the amount of an annuity or lump-sum benefit;

(6) The reinstatement of an annuity which had been terminated or modified;

(7) The existence of an erroneous payment;

(8) The recovery of the amount of an erroneous payment;

(9) The eligibility of an individual for a supplemental annuity or the amount of such supplemental annuity;

(10) Whether representative payment shall serve the best interests of an annuitant as a result of that individual's incapacity to manage his annuity payments; and

(11) Who shall be designated or continued as representative payee on behalf of an annuitant.

(b) *Adjudication of claim and the issuance of initial decision.* Adjudication of a claim and the issuance of an initial decision shall be in accordance with instructions issued by the Board and shall be made upon the basis of evidence submitted by the claimant and evidence otherwise available.

(c) *Recovery of erroneous payment.* A decision to recover the amount of an erroneous payment under paragraph (a)(8) of this section by suspension or reduction of a monthly benefit payable by the Board shall not be made prior to a date 30 calendar days after the date on which notice of the erroneous payment decision is sent to the beneficiary or payee of the benefit as provided in § 260.1(d)(6).

(d) *Notice of initial decision.* (1) In all cases except those described in paragraph (d)(2) through (4) and (6) of this section, written notice of an initial decision shall be mailed by the Board to the claimant, annuitant or payee of an annuity at the individual's last known address within 30 calendar days after such decision is made. Such notice shall inform the claimant, annuitant or payee of an annuity of the reason(s) for the decision and such individual's right to reconsideration of such initial decision as provided in § 260.3.

(2) No notice of an initial decision by the Board shall be required when the death of an annuitant causes the entitlement to an annuity to cease.

(3) When an initial decision is made that an annuitant's entitlement to a disability has ended, written notice of the decision shall be mailed to the annuitant or payee of an annuity at the annuitant's or payee's last known address. Such notice shall inform the annuitant or payee of an annuity:

(i) Of the date on which the recovery from disability is found to have occurred;

(ii) Of the reason(s) supporting such a finding of recovery;

(iii) That entitlement to the annuity ends on the last day of the second month after the month in which disability ends as described in § 220.181;

(iv) That the Board will stop payment of the annuitant's disability annuity with the last day of the second month following the month in which disability ends as described in § 220.181, or the last day of the first month following the month in which the notice provided by this paragraph is sent by the Board, whichever date is later:

(v) That any annuity payments received after entitlement has ended will have to be repaid unless waiver of recovery is appropriate;

(vi) That prior to the termination date of the annuity the annuitant or payee of an annuity may submit to the

Board any information in writing which the annuitant or payee desires to be considered by the Board in its review;

(vii) That if no information in writing is received by the Board before the termination date the annuity will be terminated as scheduled on that date; and

(viii) That the annuitant or payee has the right to reconsideration of such decision as provided in § 260.3.

(4) When an initial decision would result in the termination of an annuity for which there are competing claims or as a result of the receipt by the Board of information from a source other than the annuitant or payee of an annuity, written notice of the proposed decision shall be mailed to the annuitant or payee of an annuity at such annuitant's or payee's last known address. Such notice shall inform the annuitant or payee of an annuity:

(i) Of the reason(s) for the annuity termination;

(ii) That the annuitant or payee has 30 calendar days from the date of the notice to submit to the Board any information in writing which such annuitant or payee desires to be considered by the Board in its review;

(iii) That payment of the annuity will either cease or a decision to continue payment of such annuity shall be made after the Board has considered any information in writing which may be submitted to the Board within 30 calendar days from the date of the notice;

(iv) That if no information in writing is received within 30 calendar days from the date of the notice, payment of the annuity will cease at the end of that 30-day period; and

(v) That the annuitant or payee has the right to reconsideration of such decision as provided in § 260.3.

(5) Whenever the Board receives any significant information in writing from an annuitant or payee of an annuity as a result of mailing the notice described in paragraph (d)(4) of this section, the Board shall forward a copy of such information to each of the individuals who has filed a competing claim for such annuity informing them that:

(i) The annuity will either be terminated at the specified time or a decision to continue payment of the annuity will be made by the Board; and

(ii) They may respond to such information and their response will be considered by the Board provided that it is received by the Board within a reasonable time. When the Board decision in such case is to continue payment of the annuity, the Board shall send notice of such initial decision to each of the competing claimants in accordance with paragraph (d)(1) of this section.

(6) When an initial decision that an erroneous payment has been made to a beneficiary is made under paragraph (a)(7) of this section, written notice of that decision shall be mailed to the beneficiary or payee of the benefit at such beneficiary's or payee's last known address within 30 calendar days after such decision is made. Such notice shall inform the beneficiary or payee:

(i) Of the reason(s) for the decision;

(ii) Of the methods by which recovery may be made;

(iii) Of the possibility of waiver of recovery of the erroneous payment;

(iv) Of the conditions which must be met before waiver of recovery could be granted;

(v) That the beneficiary may request waiver of recovery of the erroneous payment and/or reconsideration of the erroneous payment decision as provided in § 260.4; and

(vi) Of the possibility of an oral hearing with respect to the issues of waiver of recovery and reconsideration of the erroneous payment decision.

[47 FR 36809, Aug. 24, 1982, as amended at 55 FR 39146, Sept. 25, 1990; 56 FR 13040, Mar. 28, 1991; 67 FR 77153, Dec. 17, 2002]

§ 260.2 Initial decisions on the amount of service and compensation credited to an employee.

Within 30 days after receipt of a timely request by an employee for amendment with respect to the number of service months and amount of compensation credited to the employee by the Board under the Railroad Retirement Act and the Railroad Unemployment Insurance Act, the Board shall appoint a qualified employee to make a determination with respect to such matter. The employee appointed by the Board shall promptly render a decision.

Written notice of such decision shall be communicated to the employee within 30 days after such decision is made. Such decision shall include notification of the employee's right to reconsideration of the initial decision as provided in § 260.3. For purposes of this section, a timely request to amend an employee's record of service months and compensation maintained under the Railroad Retirement Act shall be filed within four years after the date on which the report of service months and compensation was required to be made to the Board by the employee's employer. See § 211.16 of this chapter.

[67 FR 77153, Dec. 17, 2002]

§ 260.3 Request for reconsideration of initial decision.

(a) *Right to file request for reconsideration.* Every claimant shall have the right to file a request for reconsideration of an initial decision described in § 260.1(a) or in § 260.2. *Provided, however,* That:

(1) An individual under age 18 shall not have the right to reconsideration of a finding of incapacity to manage his or her annuity payments, but shall have the right to contest the finding that he or she is, in fact, under age 18;

(2) An individual who has been adjudged legally incompetent shall not have the right to reconsideration of a finding of incapacity to manage his or her annuity payments, but shall have the right to contest the fact of his or her having been adjudged legally incompetent; and

(3) An individual shall not have the right to reconsideration of a denial of his or her application to serve as representative payee on behalf of an annuitant. Such request for reconsideration shall be filed and disposed of in the manner prescribed in this section, except that a request for reconsideration of an initial erroneous payment decision under § 260.1(a)(7) shall be filed and disposed of in the manner prescribed in § 260.4.

(b) *Written request for reconsideration.* A written request for reconsideration may be filed with any office of the Board within 60 days from the date on which notice of the initial decision is mailed to the claimant. The claimant shall state the basis for the reconsideration request and provide any additional evidence which is available. No hearing will be provided.

(c) *Right to further review of initial decision.* The right to further review of an initial decision shall be forfeited unless a written request for reconsideration is filed within the time period prescribed in this section or good cause is shown by the claimant for failing to file a timely request for reconsideration.

(d) *Timely request for reconsideration.* In determining whether the claimant has good cause for failure to file a timely request for reconsideration the bureau director shall consider the circumstances which kept the claimant from filing the request on time and if any action by the Board misled the claimant. Examples of circumstances where good cause may exist include, but are not limited to:

(1) A serious illness which prevented the claimant from contacting the Board in person, in writing, or through a friend, relative or other person;

(2) A death or serious illness in the claimant's immediate family which prevented him or her from filing;

(3) The destruction of important and relevant records;

(4) A failure to be notified of a decision;

(5) An unusual or unavoidable circumstance existed which demonstrates that the claimant would not have known of the need to file timely or which prevented the claimant from filing in a timely manner; or

(6) The claimant thought that his or her representative had requested reconsideration.

(e) *Impartial review.* The reconsideration of the initial decision shall be conducted by a person who shall not have any interest in the parties or in the outcome of the proceedings, shall not have directly participated in the initial decision which has been requested to be reconsidered and shall not have any other interest in the matter which might prevent a fair and impartial decision.

(f) *Timely review.* The Board shall make every effort to issue a decision upon reconsideration and send a copy of the decision to the claimant within 60 days of the date that the decision for reconsideration is filed.

(g) *Right to appeal adverse decision.* If the reconsideration decision is adverse to the claimant, annuitant or payee, he or she shall be notifed of his or her right to appeal the decision to the Bureau of Hearings and Appeals, as provided in § 260.5.

[47 FR 36809, Aug. 24, 1982, as amended at 48 FR 51448, Nov. 9, 1983; 55 FR 39146, Sept. 25, 1990; 67 FR 77153, Dec. 17, 2002]

§ 260.4 Request for waiver of recovery of an overpayment and/or for reconsideration of an initial erroneous payment decision.

(a) *General.* A beneficiary who has been determined to have received an erroneous payment under § 260.1(a)(7) shall have the right, upon the filing of a timely request in accordance with the requirements of this section, to request waiver of recovery of the erroneous payment and/or reconsideration of the erroneous payment decision. The beneficiary shall have the right to an informal oral hearing on the issue of waiver of recovery and/or reconsideration of the erroneous payment decision, before an employee of the Board designated to conduct such a hearing, prior to commencement of recovery by suspension or reduction of a monthly benefit.

(b) *Request for waiver of recovery and/or reconsideration of an erroneous payment decision and for a personal conference.* A request for reconsideration of an erroneous payment decision must be filed in accordance with § 260.3(b) of this part. A request for waiver of recovery of an overpayment decision and for a personal conference under this section shall be in writing and addressed to the field office of the Board set forth in the initial decision letter or to the Debt Recovery Manager and shall be filed within 60 calendar days from the date on which notice of the overpayment decision was sent to the beneficiary. The beneficiary shall state in the request whether he or she elects to have a personal conference. If the beneficiary does not elect to have a personal conference with respect to his or her request for waiver of recovery or for reconsideration of the overpayment decision, he or she may, along with the request, submit any evidence and argument which he or she would like to present in support of his or her case.

(c) *Right to further review of an initial overpayment decision.* The right to further review of an initial overpayment decision shall be forfeited unless a written request for reconsideration is filed within the time period prescribed in § 260.3(b) of this part (60 days) or good cause, as defined in section 260.3(d) of this part, is shown by the beneficiary for failing to file a timely request for reconsideration. Nothing in this section shall be taken to mean that waiver of recovery will not be considered in these cases where the request for waiver is not filed within 60 days, but action to recover the erroneous payment will not be deferred if such a request is not filed within 60 days. Any amounts recovered prior to the date on which the request for waiver as permitted under the preceding sentence is filed shall not be waived under part 255 of this chapter.

(d) *Delay in commencement of recovery of erroneous payment.* Where a timely request for waiver or reconsideration is filed as provided in this section, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such request for waiver or reconsideration has been made and notice thereof mailed to the claimant.

(e) *Impartial review.* Upon receipt of a timely request for personal conference under this section, the Board shall promptly arrange for the selection of a Board employee to conduct a personal conference in the case. The employee designated to conduct the personal conference under this section shall not have had any prior involvement with the initial erroneous payment decision and shall conduct the personal conference in a fair and impartial manner. The employee designated to conduct the personal conference under this section shall promptly schedule a time and place for the personal conference and promptly notify the beneficiary of such. If the beneficiary agrees, the personal conference may be conducted by telephone.

(f) *Personal conference.* The beneficiary shall upon request have the opportunity to review, prior to the personal conference, his or her claim folder and all documents pertinent to the issues raised. A personal conference conducted under this section shall be informal. At the personal conference the beneficiary shall be afforded the following rights:

(1) To present his or her case orally and to submit evidence, whether through witnesses or documents;

(2) To cross-examine adverse witnesses who appear at the personal conference; and

(3) To be represented by counsel or other person.

(g) *Preparation of recommended decision.* Upon completion of the personal conference the employee who conducts the personal conference shall prepare a summary of the case including a statement of the facts, the employee's findings of fact and law, and a recommended decision.

(h) *Timely review.* The Board shall make every effort to render a decision with respect to the beneficiary's request for reconsideration of the initial erroneous payment determination and/or waiver of recovery and notify the beneficiary of that decision within 60 days of the date that the request for reconsideration and/or waiver is filed or the date that the summary of the case is received from the employee who conducts the personal conference, whichever is later.

(i) *Right to appeal adverse decision.* If the Board renders a decision adverse to the beneficiary, he or she may appeal the decision to the Bureau of Hearings and Appeals, as provided in § 260.5 of this part.

(j) *Repayment is not a bar to requesting waiver and/or reconsideration.* The fact that a beneficiary may have notified the Board with respect to the method by which he or she could choose to have the recovery made, or the fact that such beneficiary may have actually tendered to the Board a portion or all of the amount of the erroneous payment, shall in no way operate to prejudice his or her right to request reconsideration of the initial erroneous payment determination or to request waiver of recovery.

[47 FR 36809, Aug. 24, 1982, as amended at 55 FR 39146, Sept. 25, 1990; 67 FR 77153, Dec. 17, 2002]

§ 260.5 Appeal from a reconsideration decision.

(a) *General.* Every claimant shall have a right to appeal to the Bureau of Hearings and Appeals from any reconsideration decision with which he or she disagrees.

(b) *Appeal from a reconsideration decision.* Appeal from a reconsideration decision shall be made by filing the form prescribed by the Board for such purpose. Such appeal must be filed with the Bureau of Hearings and Appeals within 60 days from the date upon which notice of the reconsideration decision is mailed to the claimant. Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's right to appeal, provided that the claimant files the appeal form within the later of the 60-day period following the date of the reconsideration decision, or the 30-day period following the date of the letter sending the form to the claimant.

(c) *Right to review of a reconsideration decision.* The right to review of a reconsideration decision shall be forfeited unless an appeal is filed in the manner and within the time prescribed in this section. However, when a claimant fails to file an appeal with the Bureau of Hearings and Appeals within the time prescribed in this section, the hearings officer may waive this requirement of timeliness. Such waiver shall only occur in cases where the claimant has made a showing of good cause for failure to file a timely appeal. Good cause for failure to file a timely appeal will be determined by a hearings officer in the manner prescribed in § 260.3(d) of this part.

(d) *Delay in the commencement of recovery of erroneous payment.* Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the Bureau of Hearings and Appeals, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a

decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

(e) *Impartial review.* Within 30 days after the claimant has filed a proper appeal, the Director of Hearings and Appeals shall appoint a hearings officer to act on the appeal. The Director of Hearings and Appeals may, if the Bureau of Hearings and Appeals' caseload dictates, appoint a qualified Board employee, other than a hearings officer assigned to the Bureau of Hearings and Appeals, to act as a hearings officer with respect to a case. Such hearings officer shall not have any interest in the parties or in the outcome of the proceedings, shall not have directly participated in the initial decision or the reconsideration decision from which the appeal is made, and shall not have any other interest in the matter which might prevent a fair and impartial decision.

(f) *Power of hearings officer to conduct hearings.* In the development of appeals, the hearings officer shall have the power to hold hearings, require and compel the attendance of witnesses by subpoena or otherwise in accordance with the procedures set forth in part 258 of this chapter, administer oaths, rule on motions, take testimony, and make all necessary investigations.

(g) *Evidence presented in support of appeal.* (1) The appellant, or his or her representative, shall be afforded full opportunity to present testimony, or written evidence or exhibits upon any controversial question of fact; to examine and cross-examine witnesses; and to present argument in support of the appeal.

(2) The formal rules of evidence shall not apply; however, the hearings officer may exclude evidence which he or she finds is irrelevant or repetitious. Any evidence excluded by the hearings officer shall be described and that description made part of the record.

(3) If, in the judgment of the hearings officer, evidence not offered by the appellant is available and is relevant and material to the merits of the claim, the hearings officer may obtain such evidence upon his or her own initiative. If new evidence is obtained after an oral hearing, other than evidence submitted by the appellant or his or her representative, the hearings officer shall provide the appellant or his or her representative with a copy of such evidence. In such event, the appellant shall have 30 days to submit rebuttal evidence or argument or to request a supplemental hearing to confront and challenge such new evidence. The appellant may move for an extension of time to submit rebuttal evidence or argument and the hearings officer may grant the motion upon a showing of good cause.

(h) *Submission of written argument in lieu of oral hearings.* Where the hearings officer finds that no factual issues are presented by an appeal, and the only issues raised by the appellant are issues concerning the application or interpretation of law, the appellant or his or her representative shall be afforded full opportunity to submit written argument in support of the claim but no oral hearing shall be held.

(i) *Conduct of an oral hearing.* (1) In any case in which an oral hearing is to be held, the hearings officer shall schedule a time and place for the conduct of the hearing. At the discretion of the hearings officer, any hearing required under this part may be held in person, by telephone conference call, or by video teleconferencing as described in § 260.5(1). The hearing shall not be open to the public. The hearings officer shall promptly notify by mail the party or parties to the proceeding as to the time and place for the hearing. The notice shall include a statement of the specific issues involved in the case. The hearings officer shall make every effort to hold the hearing within 150 days after the date the appeal is filed.

(2) If the appellant objects to the time or place of the hearing, he or she must notify the hearings officer no later than 5 calendar days before the time set for the hearing. The appellant must state the reason for his or her objection. If at all possible, the request should be in writing. The hearings officer will change the time or place of the hearing if he or she finds there is good cause to do so.

(3) The hearings officer shall rule on any objection timely filed by a party under paragraph (i) of this section and

shall notify the party of his or her ruling thereon. The hearings officer may for good cause shown, or upon his or her own motion, reschedule the time and/or place of the hearing. If an individual objects to having a hearing by video teleconferencing, the hearings officer will find the individual's wish not to appear by video teleconferencing to be a good reason for changing the time or place of the scheduled hearing and will reschedule the hearing for a time or place where either a telephone conference call or an in person hearing will be held. The hearings officer may also limit or expand the issues to be resolved at the hearing.

(4) If neither a party nor his or her representative appears at the time and place scheduled for the hearing, that party shall be deemed to have waived his or her right to an oral hearing unless said party either filed with the hearings officer a notice of objection showing good cause why the hearing should have been rescheduled, which notice was timely filed but not ruled upon, or, within 10 days following the date on which the hearing was scheduled, said party files with the hearings officer a motion to reschedule the hearing showing good cause why neither the party nor his or her representative appeared at the hearing and further showing good cause as to why said party failed to file at the prescribed time any notice of objection to the time and place of the hearing.

(5) If the hearings officer finds either that a notice of objection was timely filed showing good cause to reschedule the hearing, or that the party has within 10 days following the date of the hearing filed a motion showing good cause for failure to appear and to file a notice of objection, the hearings officer shall reschedule the hearing. If the hearings officer finds that the hearing shall not be rescheduled, he or she shall so notify the party in writing.

(j) *Record of evidence considered.* The hearings officer will make a record of the material evidence. The record will include the applications, written statements, reports, and other documents that were used in making the determination under review and any other additional evidence the appellant or any other party to the hearing presents in writing. If a hearing was held in the appeal, the tape recording of the hearing will be part of the record while the appeal is pending. The hearings officer's decision will be based on the record. The entire record at any time during the pendency of the appeal shall be available for examination by the appellant or by his or her duly authorized representative.

(k) *Extension of time to submit evidence.* Except where the hearings officer has determined that additional evidence not offered by the appellant at or prior to the hearing is available, the record shall be closed as of the conclusion of the hearing. The appellant may request an extension of time to submit evidence and the hearings officer will grant the request upon a showing of good cause for failure to have submitted the evidence earlier. The extension shall be for a period not exceeding 30 days.

(l) *Hearing by telephone or video teleconferencing.* As stated in paragraph (i)(1) of this section, at the discretion of the hearings officer, any hearing required under this part may be conducted in person, by telephone conference call, or by video teleconferencing. The hearings officer may determine the hearing should be conducted by telephone conference call or video teleconferencing if use of these methods would be more efficient than conducting an in person hearing and the hearings officer does not determine that there is a circumstance in the particular case preventing the use of these methodologies to conduct the hearing.

(The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 3220-0007)

[67 FR 77154, Dec. 17, 2002, as amended at 71 FR 55283, Sept. 22, 2006]

§ 260.6 Time limits for issuing a hearing decision.

(a) *General.* The hearings officer shall make every effort to issue a decision within 45 days after the hearing is held.

(b) *Submission of additional evidence.* If the hearings officer requests additional evidence, he or she shall do so within 30 days after the hearing is held and he or she shall make every effort to issue the hearing decision within 45 days after

the additional evidence is received and the period for comment has ended. If the claimant wishes to submit additional evidence or written statements of fact or law, the hearings officer shall make every effort to issue the hearing decision within 45 days after the written statements are received or the additional evidence is received and the period for comment has ended.

(c) *Supplemental hearing.* If on the basis of additional evidence the hearings officer decides a supplemental hearing is necessary, the supplemental hearing will be held within 30 days after the receipt of the additional evidence and the hearings officer shall make every effort to issue a decision within 30 days after the supplemental hearing is held.

(d) *Reassignment of case to another hearings officer.* If, after a hearing has been held, it is necessary to reassign a case to another hearings officer due to the unavailability of the original hearings officer (e.g., resignation, retirement, illness), the case will be promptly reassigned. The new hearings officer shall make every effort to issue a hearing decision within 30 days after the reassignment.

§ 260.7 Time limits for issuing a decision when a hearing is not held.

If a claimant waives his or her right to appear at a hearing and the hearings officer does not schedule the case for hearing, or the evidence in the record supports a favorable decision without a hearing, or a hearing is not required pursuant to § 260.5(g), the hearings officer shall make every effort to issue a decision within 90 days from the date the appeal is filed: *Provided, however,* that if the hearings officer requests additional evidence it shall be requested within 45 days of the filing of the appeal and the hearings officer shall make every effort to issue a decision within 30 days after the additional evidence is received and the appellant comments on the evidence, or if no comment is received after the close of the comment period.

§ 260.8 Pre-hearing case review.

(a) *General.* The hearings officer assigned to a case may, prior to an oral hearing, upon his or her own motion, refer the case back to the office of the Board which issued the initial decision for the purpose of reconsideration of that decision, where the hearings officer finds that:

(1) Additional evidence pertinent to the resolution of the issues on appeal was submitted by the appellant at the time the appeal was filed, or subsequent thereto; or

(2) Additional evidence pertinent to the resolution of the issues on appeal is available and should be procured; or

(3) There is some other indication in the record that the initial decision may be revised in a manner favorable to the appellant.

(b) *Referral of case for further review by initial adjudicating unit.* Where the hearings officer finds that referral of a case back to the office which issued the initial decision for the purpose of reconsideration of that decision would be warranted, the hearings officer shall give that office the reason for such referral, together with specific directions as to the handling of the case on reconsideration.

(c) *Reconsideration of case by initial adjudicating unit.* The office to which a case is referred shall promptly undertake any additional development required, and shall make a determination as to whether the initial determination may be revised in whole or in part in a manner favorable to the appellant. Upon issuance of its determination, the office in question shall return the case along with a copy of its decision to the hearings officer.

(d) *Revision of initial decision in whole or in part.* Where the office to which a case is referred determines to revise its initial decision in whole or in part, that office shall notify the appellant of such determination. If the revised determination is wholly favorable to the appellant, he or she shall be notified that the appeal to the Bureau of Hearings and Appeals will be dismissed by the hearings officer assigned to the case. If the revised decision is partially favorable to the appellant, the notice shall inform the appellant that the hearings officer will proceed with the portion of the appellant's case not revised in his or her favor, unless the appellant should request dismissal of the appeal.

(e) *Timely conduct of oral hearing.* The fact that a case on appeal has been referred back to the office which issued the initial decision in the case shall not delay the conduct of a hearing scheduled with respect to the appeal, unless the appellant agrees to a delay. If it appears that the office to which a case has been referred will not have completed its reconsideration of the case prior to the date of a scheduled hearing on an appeal and the appellant has not agreed to a delay in the conduct of the hearing, the hearings officer shall proceed with the hearing and the handling of the case as though the case had not been referred back to the office.

[47 FR 36809, Aug. 24, 1982, as amended at 67 FR 77155, Dec. 17, 2002]

§ 260.9 Final appeal from a decision of the hearings officer.

(a) *General.* Every appellant shall have a right to a final appeal to the Railroad Retirement Board from any decision of a hearings officer by which he or she claims to be aggrieved.

(b) *Appeal from decision of hearings officer.* Final appeal from a decision of a hearings officer shall be made by the execution and filing of the final appeal form prescribed by the Board. Such appeal must be filed with the Board within 60 days from the date upon which notice of the decision of the hearings officer is mailed to the appellant at the last address furnished by him or her. Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's right to appeal, *Provided that* the claimant files the appeal form within the later of the 60-day period following the date of the hearing officer's decision, or the 30-day period following the date of the letter sending the form to the claimant.

(c) *Timely filing.* The right to further review of a decision of a hearings officer shall be forfeited unless formal final appeal is filed in the manner and within the time prescribed in § 260.9(b). However, when a claimant fails to file an appeal before the Board within the time prescribed in this section, the Board may waive this requirement if, along with the final appeal form, the appellant in writing requests an extension of time. The request for an extension of time must give the reasons why the final appeal form was not filed within the time limit prescribed in this section. If in the judgment of the Board the reasons given establish that the appellant had good cause for not filing the final appeal form within the time prescribed, the Board will consider the appeal to have been filed in a timely manner. The Board will use the standards found in § 260.3(d) of this chapter in determining if good cause exists.

(d) *Delay in the commencement of recovery of erroneous payment.* Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the three-member Board, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

(e) *Submission of additional evidence.* Upon final appeal to the Board, the appellant shall not have the right to submit additional evidence. However, the Board may grant a request to submit new evidence where new and material evidence is available that, despite due diligence, was not available before the decision of the hearings officer was issued. The Board may also obtain new evidence on its own motion. Upon admission of new evidence, the Board, at its discretion, may:

(1) Vacate the decision of the hearings officer and remand the case to the Bureau of Hearings and Appeals for issuance of a new decision. The decision of the hearings officer on remand may be appealed to the Board in the manner described in paragraph (b) of this section; or

(2) Return the case to the hearings officer for further consideration with direction to submit a recommended decision to the Board.

(f) *Decision of the Board.* The decision of the Board shall be made upon the record of evidence developed by the hearings officer and any additional evidence admitted pursuant to paragraph (e) of this section. The appellant may submit additional argument in writing with the appeal to the Board. The appellant shall have no right to an oral

presentation before the Board except where the Board so permits. Such presentation shall be limited in form, subject matter, length, and time as the Board may indicate to the appellant.

(g) *Issuance of decision.* The Board shall make every effort to issue a decision within 90 days after the later of:

(1) The date the final appeal is filed;

(2) The date new or better evidence is obtained in accordance with § 260.9(d) and the appellant has commented on it;

(3) The date new or better evidence is obtained in accordance with § 260.9(d) and after the close of the comment period;

(4) The date further argument submitted in accordance with § 260.9(e) is received; or

(5) The date the record is returned to the Board following referral back to the hearings officer.

(h) *Review of decisions rendered prior to appeal to Board.* The Board may, on its own motion, review or cause to be reviewed any decision issued by a subordinate official or employee under this part.

(The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 3220–0007)

[47 FR 36809, Aug. 24, 1982, as amended at 50 FR 19523, May 9, 1985; 52 FR 11017, Apr. 6, 1987; 67 FR 77155, Dec. 17, 2002; 68 FR 6820, Feb. 11, 2003]

§ 260.10 Determination of date of filing.

(a) *General rule.* Except as otherwise provided in paragraph (b) of this section, for purposes of this part, a document or form is filed on the day it is received by an office of the Board or by an employee of the Board who is authorized to receive it at a place other than one of the Board's offices.

(b) *Other dates of filing.* The Board will also accept as the date of filing the date a document or form is mailed to the Board by the United States mail, if using the date the Board receives it would result in the loss or lessening of rights. The date shown by a U.S. postmark will be used as the date of mailing. If the postmark is unreadable, or there is no postmark, the Board will consider other evidence of when the document or form was mailed to the Board.

[67 FR 77156, Dec. 17, 2002]

PART 261—ADMINISTRATIVE FINALITY

Sec.
261.1 Reopening and revising decisions.
261.2 Conditions for reopening.
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261.11 Discretion of the three-member Board to reopen or not to reopen a final decision.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 62 FR 45713, Aug. 29, 1997, unless otherwise noted.

§ 261.1 Reopening and revising decisions.

(a) This part sets forth the Board's rules governing finality of decisions. After the expiration of the time limits for review as set forth in part 260 of this chapter, decisions of the agency may be reopened and revised under the conditions described in this part, by the bureau, office, or entity that made the earlier decision or by a bureau, office, or other entity at a higher level, which has the claim properly before it.

(b) A *final decision* as that term is used in this part means any decision of the type listed in § 260.1 of this chapter where the time limits for review as set forth in part 260 of this chapter or in the Railroad Retirement Act have expired.

(c) *Reopening* a final decision under this part means a conscious determination on the part of the agency to reconsider an otherwise final decision for purposes of revising that decision.

(d) *New and material evidence* as that phrase is used in this part means evidence that may reasonably be expected to affect a final decision, which was unavailable to the agency at the time the

decision was made, and which the claimant could not reasonably have been expected to have submitted at that time.

§ 261.2 Conditions for reopening.

A final decision may be reopened:

(a) Within 12 months of the date of the notice of such decision, for any reason;

(b) Within four years of the date of the notice of such decision, if there is new and material evidence or there was adjudicative error not consistent with the evidence of record at the time of adjudication; or

(c) At any time if:

(1) The decision was obtained by fraud or similar fault;

(2) Another person files a claim on the same record of compensation and allowance of the claim adversely affects the first claim;

(3) A person previously determined to be dead on whose earnings record a survivor annuity is based is found to be alive;

(4) A claim was denied because of the absence of proof of death of the employee, and the death is later established:

(i) By reason of an unexplained absence from his or her residence for a period of 7 years; or

(ii) By location or identification of his or her body;

(5) The Social Security Administration has awarded duplicate benefits on the same record of compensation;

(6) The decision was that the claimant did not have an insured status, and compensation has been credited to the employee's record of compensation in accordance with part 211 of this chapter:

(i) To enter items transferred by the Social Security Administration which were credited under the Social Security Act when they should have been credited to the employee's railroad retirement compensation record; or

(ii) To correct an error made in the allocation of earnings to an individual which, if properly allocated, would have given him or her an insured status at the time of the decision and the evidence of these earnings was in the possession of the Railroad Retirement Board or the Social Security Administration at the time of the decision;

(7) The decision is wholly or partially unfavorable to a party, but only to correct clerical error or an error that appears on the face of the evidence that was considered when the determination or decision was made;

(8) The decision found the claimant entitled to an annuity or to a lump sum payment based on the earnings record of a deceased person, and it is later established that:

(i) The claimant was convicted of a felony or an act in the nature of a felony for intentionally causing that person's death; or

(ii) If the claimant was subject to the juvenile justice system, he or she was found by a court of competent jurisdiction to have intentionally caused that person's death by committing an act which, if committed by an adult, would have been considered a felony or an act in the nature of a felony;

(9) The claimant shows that it is to his or her advantage to select a later annuity beginning date and refunds, by cash payment or setoff, past payments applying to the period prior to the later beginning date, subject, however, to the provisions of subpart D of part 217 and § 218.9 of this chapter;

(10) The decision is incorrect because of a failure to apply a reduction, or the proper reduction, to the tier I component of an annuity, but the Board shall apply the reduction only for the months following the month the Board first takes corrective action.

(d) Revision of the amount or payment of a separation allowance lump sum amount pursuant to section 6(e) of the Railroad Retirement Act is limited to 60 days from the date of notification of the award of the separation allowance lump sum payment.

§ 261.3 Change of legal interpretation or administrative ruling.

A change of legal interpretation or administrative ruling upon which a decision is based does not render a decision erroneous and does not provide a basis for reopening.

§ 261.4 Decisions which shall not be reopened.

The following decisions shall not be reopened:

(a) An award of an annuity beginning date to an applicant later found to have been in compensated service to an employer under part 202 of this chapter on that annuity beginning date and who is found not to be at fault in causing the erroneous award; provided, however, that this exception shall not operate to permit payment of benefits for any month in which the claimant is found to be engaged in compensated service.

(b) An award of an annuity based on a subsequently discovered erroneous crediting of months of service and compensation to a claimant where:

(1) The loss of such months of service and compensation will cause the applicant to lose his or her eligibility for an annuity previously awarded;

(2) The erroneously credited months of service do not exceed six months; and

(3) The annuitant is found not to be at fault in causing the erroneous crediting.

(c) An erroneous award of an annuity where the error is no greater than one dollar per month per annuity affected.

(d) An erroneous award of a lump sum or accrued annuity payment where the error is no greater than $25.00.

§ 261.5 Late completion of timely investigation.

(a) A decision may be revised after the applicable time period in § 261.2(a) or § 261.2(b) of this part expires if the Railroad Retirement Board begins an investigation into whether to revise the decision before the applicable time period expires and the agency diligently pursues the investigation to the conclusion. The investigation may be based on a request by a claimant or on action by the Railroad Retirement Board.

(b) *Diligently pursued* for purposes of this section means that in view of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if the investigation is concluded and, if necessary, the decision is revised within 6 months from the date the investigation began.

(c) If the investigation is not diligently pursued to its conclusion, the decision will be revised if a revision is applicable and if it is favorable to the claimant. It will not be revised if it would be unfavorable to the claimant.

§ 261.6 Notice of revised decision.

(a) When a decision is revised, notice of the revision will be mailed to the parties to the decision at their last known address. The notice will state the basis for the revised decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a hearings officer or the three-member Board proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, all parties will be notified in writing of the proposed action. If a revised decision is issued by a hearings officer, any party may request that it be reviewed by the three-member Board, or the three-member Board may review the decision on its own initiative.

§ 261.7 Effect of revised decision.

A revised decision is binding unless:

(a) The revised decision is reconsidered or appealed in accord with part 260 of this chapter;

(b) The three-member Board reviews the revised decision; or

(c) The revised decision is further revised consistent with this part.

§ 261.8 Time and place to request review of a revised decision.

A party to a revised decision may request, as appropriate, further review of the decision in accordance with the rules set forth in part 260 of this chapter.

§ 261.9 Finality of findings when later claim is filed on same earnings record.

If two claims for benefits are filed on the same record of compensation, findings of fact made in a decision in the first claim may be revised in determining or deciding the second claim, even though the time limit for revising

the findings made in the first claim has passed. However, a finding in connection with a claim that a person was fully or currently insured at the time of filing an application, at the time of death, or any other pertinent time, may be revised only under the conditions stated in § 261.2 of this part.

§ 261.10 Increase in future benefits where time period for reopening has expired.

If, after the time period for reopening under § 261.2(b) of this part has expired, new evidence is furnished showing a different date of birth or new evidence is furnished which would cause a correction in a record of compensation as provided for in part 211 of this chapter and, as a result of the new evidence, increased benefits would be payable, the Board will pay increased benefits, but only for the months following the month the new evidence is received.

§ 261.11 Discretion of the three-member Board to reopen or not to reopen a final decision.

In any case in which the three-member Board may deem proper, the Board may direct that any decision, which is otherwise subject to reopening under this part, shall not be reopened or direct that any decision, which is otherwise not subject to reopening under this part, shall be reopened.

PART 262 [RESERVED]

PART 266—REPRESENTATIVE PAYMENT

Sec.

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AUTHORITY: 45 U.S.C. 231k and 231f.

SOURCE: 59 FR 3992, Jan. 28, 1994, unless otherwise noted.

§ 266.1 Introduction.

(a) *Explanation of representative payment.* This part explains the principles and procedures that the Board follows in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds which he or she receives on behalf of an annuitant. A representative payee may be either a person or an organization selected by the Board to receive benefits on behalf of an annuitant. A representative payee will be selected if the Board believes that the interest of an annuitant will be served by representative payment rather than direct payment of benefits. Generally, the Board will appoint a representative payee if it determines that the annuitant is not able to manage or direct the management of benefit payments in his or her interest.

(b) *Statutory authority.* Section 12 of the Railroad Retirement Act provides that every annuitant and claimant shall be conclusively presumed to have been competent until the date on which the Board receives a notice in writing that a legal guardian or other person legally vested with the care of the person or estate of an incompetent or a minor has been appointed: Provided, however, That despite receiving such notice, the Board may, if it finds the interests of such annuitant or claimant to be served thereby, recognize actions by, conduct transactions with, and make payments to such annuitant or claimant.

(c) *Policy used to determine whether to make representative payment.* (1) In accordance with section 12 of the Railroad Retirement Act, the Board's policy is that every annuitant has the right to manage his or her own benefits. However, some annuitants due to mental or physical condition or due to their youth may be unable to do so. If the Board determines that the interests of an annuitant would be better served if benefit payments were certified to another person as representative payee, the Board will appoint a representative payee in accordance with the procedures set forth in this part. The Board may appoint a representative payee even if the annuitant is a legally competent individual. If the annuitant is a legally incompetent individual, the Board may appoint the legal guardian or some other person as a representative payee.

(2) If payment is being made directly to an annuitant and a question arises concerning his or her ability to manage or direct the management of benefit payments, the Board may, if the annuitant is 18 years old or older and has not been adjudged legally incompetent, continue to pay the annuitant until the Board makes a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

§ 266.2 Recognition by the Board of a person to act in behalf of another.

(a) Regardless of the receipt of written notice of the appointment of a guardian or other person legally vested with the care of the person or estate of an incompetent or a minor who is receiving or claiming benefits or to whom any right or privilege is extended under the law, the Board may, in its discretion, validly recognize actions by and conduct transactions with others acting on behalf of the individual found by the Board to be a minor or to be unable to manage his or her affairs, if the Board finds such actions or transactions to be in the best interest of such individual.

(b) In the absence of a written notice of the appointment of a guardian or other person legally vested with the care of the person or estate of an incompetent or minor, the Board shall, except where special circumstances appear, recognize a person to act on behalf of an individual under the following circumstances:

(1) When the individual has been adjudged mentally incompetent by a court having jurisdiction to do so;

(2) When the individual has been committed to a mental institution by a court having jurisdiction to do so;

(3) When the individual is an inmate of a mental institution;

(4) When the individual is less than 16 years of age; or

(5) When the individual is between 16 and 18 years of age and is in the care of another person and does not have the capacity to act on his or her own behalf.

§ 266.3 Information considered in determining whether to make representative payments.

In determining whether to make representative payment, the Board may consider the following information:

(a) *Evidence of legal guardianship.* Evidence of the appointment of a legal guardian or other person legally vested with the care of the person or estate of an incompetent or a minor shall be a certified copy of the court's determination.

(b) *Medical evidence.* The Board may use medical evidence, when such is available, to help determine whether an annuitant is capable of managing or directing the management of benefit payments. For example, a statement by a physician or other medical professional based upon his or her recent examination of the annuitant and his or her knowledge of the annuitant's present condition will be used in the Board's determination, if it includes information concerning the nature of the annuitant's illness, the annuitant's chances for recovery and the opinion of the physician or other medical professional as to whether the annuitant is able to manage or direct the management of benefit payments.

(c) *Other evidence.* The Board may also consider statements of relatives, friends, and other people in a position to know and observe the annuitant, which contain information helpful to

the Board in deciding whether the annuitant is able to manage or direct the management of benefit payments.

§ 266.4 Information considered in selecting a representative payee.

In selecting a representative payee, the Board tries to select the person, agency, organization or institution that will best serve the interest of the annuitant. In making this selection, the Board may consider such factors as the following:

(a) The relationship of the person to the annuitant, including the type of relationship, *e.g.*, family or legal guardianship; degree of relationship, if the person is a family member; and the length of association, if a non-family member;

(b) The amount of interest that the person shows in the annuitant, including the contributions the person makes to the welfare of the annuitant and the contacts and frequency of such contacts with the annuitant;

(c) Any legal authority the person, agency, organization or institution has to act on behalf of the annuitant;

(d) Whether the potential payee has custody of the annuitant;

(e) Whether the potential payee is in a position to know of and look after the needs of the annuitant;

(f) Verification of the social security account number, name, address, telephone number, place of employment, and main source of income if applicable, accepted as part of any person's application for designation as a representative payee, unless such person's identification has already been established to the satisfaction of the Board;

(g) Whether an applicant for designation as a representative payee has ever been convicted of a felony or misdemeanor under the statutes administered by the Board or the Social Security Act, or convicted of a felony under any other Federal or State law; and

(h) Whether the services of such person as representative payee have previously been terminated, suspended, or declined by the Board or the Social Security Administration for:

(1) Misuse of the benefits of the annuitant for whom they were intended;

(2) Failure to comply with any provision of or regulation under the Railroad Retirement Act or the Social Security Act; or

(3) Failure to meet the requirements of this part.

(i) Whether the potential payee is a creditor of the annuitant. A creditor who provides goods and services to the annuitant ordinarily may not serve as a representative payee unless such appointment poses no substantial conflict of interest and unless the creditor is:

(1) A relative who resides with the annuitant;

(2) A legal guardian or legal representative of the annuitant; or

(3) A licensed or certified care facility (or owner, administrator or employee thereof) where there annuitant resides.

§ 266.5 Order of preference in selecting a representative payee.

As a guide in selecting a representative payee, categories of preferred payees have been established. These preferences are flexible. The primary concern of the Board is to select the payee who will best serve the annuitant's interest. The preferences are:

(a) For annuitants 18 years old or older, the preference is:

(1) A legal guardian, spouse, or other relative who has custody of the annuitant or who demonstrates strong concern for the personal welfare of the annuitant;

(2) A friend who has custody of the annuitant or demonstrates strong concern for the personal welfare of the annuitant;

(3) A public or nonprofit agency or institution having custody of the annuitant;

(4) A private institution operated for profit and licensed under State law, which has custody of the annuitant; and

(5) Persons other than those listed above who are qualified to carry out the responsibilities of a representative payee and who are able and willing to serve as a payee for an annuitant; *e.g.*, members of community groups or organizations who volunteer to serve as representative payee for an annuitant.

(b) For annuitants under age 18, the preference is:

(1) A natural or adoptive parent who has custody of the annuitant, or a legal guardian;

(2) A natural or adoptive parent who does not have custody of the annuitant, but is contributing toward the annuitant's support and is demonstrating strong concern for the annuitant's well-being;

(3) A relative or stepparent who has custody of the annuitant;

(4) A natural or adoptive parent who does not have custody of the annuitant and is not contributing toward his or her support but is demonstrating strong concern for the annuitant's well-being;

(5) A relative who does not have custody of the annuitant but is contributing toward the annuitant's support and is demonstrating concern for the annuitant's well-being;

(6) A relative or close friend who does not have custody of the annuitant but is demonstrating concern for the annuitant's well-being; and

(7) An authorized social agency or custodial institution.

§ 266.6 Information to be submitted by a representative payee-applicant; face-to-face interview.

Before the Board selects a representative payee, the Board may request the payee-applicant to provide information concerning the factors listed in § 266.4 of this part. An employee of the Board may also conduct a face-to-face interview with the payee-applicant.

(Approved by the Office of Management and Budget under control number 3220–0052)

§ 266.7 Accountability of a representative payee.

(a) A representative payee is accountable for the use of benefits. The Board will require periodic written reports from representative payees. The Board may also, at the Board's option, verify how a representative payee used benefit payments. A representative payee must keep records of what was done with all benefit payments in order to make accounting reports. The Board may ask the following questions:

(1) The amount of benefit payments on hand at the beginning of the accounting period;

(2) How the benefit payments were used;

(3) How much of the benefit payments were saved and how the savings were invested;

(4) Where the annuitant lived during the accounting period;

(5) The amount of the annuitant's income from other sources during the accounting period. The Board may ask for information about other funds to enable the Board to evaluate the use of benefit payments; and

(6) Whether the representative payee has been convicted of a felony or misdemeanor offense under the statutes administered by the Board or by the Social Security Administration within the past 15 years or whether any such charges are pending.

(b) An individual to whom payments are certified as representative payee on behalf of an annuitant shall submit a written report in such form and at such times as the Board may require, accounting for the payments certified to him or her on behalf of the annuitant. If, however, such payee is a court-appointed fiduciary and, as such, is required to make an annual accounting to the court, a true copy of each such account filed with the court may be submitted in lieu of the accounting form prescribed by the Board. If any representative payee fails to submit the required accounting within a reasonable period of time after it is requested, no further payments shall be made to him or her on behalf of the annuitant unless for good cause shown, the default of the representative payee is excused by the Board, and the required accounting is thereafter submitted.

(c) At any time after the Board has selected a representative payee, the Board may ask such payee to submit information showing a continuing relationship to the annuitant and a continuing responsibility for the care of the annuitant. If the representative payee does not give the Board the requested information within a reasonable period of time, the Board may stop paying such payee unless the Board determines that the payee had a good reason for not complying with the Board's request, and the Board receives the information requested.

(d) Where, pursuant to paragraph (b) or (c) of this section, the Board suspends payments, such suspension shall not exceed a period of 30 days; thereafter, the payments will be made to the annuitant except where the annuitant is an unemancipated minor under age 18 or where in the Board's judgment the interests of the annuitant would not be served by releasing payment to the annuitant.

(Approved by the Office of Management and Budget under control numbers 3220–0052 and 3220–0151)

§ 266.8 Advance notice of the determination to make representative payment.

(a) As a general rule, whenever the Board intends to make representative payment and to name a representative payee, the Board will notify the annuitant or, in the case of an unemancipated minor under age 18, or an individual who is legally incompetent, the individual acting on his or her behalf of the Board's proposed actions. Such notice will tell the person that the Board plans to name a representative payee and who that payee will be. The notice will also ask the person to contact the Board within 15 days of the date of the notice if he or she objects to either proposed action. If he or she objects to either proposed action, the objecting party may—

(1) Review the evidence upon which the proposed actions will be based; and

(2) Submit any additional evidence regarding the proposed actions.

(b) If the objecting party objects to the proposed actions, the Board will review its proposed determinations and consider any additional information provided. The Board will then issue a decision on whether to appoint a representative payee and who that payee will be. If the objecting party is dissatisfied with either determination, he or she may request a reconsideration under part 260 of this chapter.

(c) If the objecting party does not file a timely objection to the proposed actions, the Board will issue a decision on whether to appoint a representative payee and who that payee will be. If the objecting party is dissatisfied with either determination, he or she may request a reconsideration under part 260 of this chapter.

(d) A request for reconsideration or an appeal from a determination under this section under part 260 of this chapter shall not prevent the Board from making payments to a representative payee during the pendency of such reconsideration or appeal.

(e) The Board's failure or refusal to select an individual as representative payee or the Board's termination of representative payee status with respect to an individual is not subject to a request for reconsideration or an appeal under part 260 of this chapter by such individual.

§ 266.9 Responsibilities of a representative payee.

(a) A representative payee shall, subject to review by the Board and to such requirements as it may from time-to-time prescribe, apply the payments made to him or her on behalf of the annuitant only for the use and benefit of such annuitant, and in a manner and for purposes which are in the annuitant's best interests.

(b) A representative payee shall notify the Board of any event that will affect the amount of benefits the annuitant receives or the right of the annuitant to receive benefits.

(c) A representative payee shall notify the Board of any change in his or her circumstances that would affect performance of the payee responsibilities.

§ 266.10 Use of benefit payments.

(a) *Current maintenance.* Payments made to an individual as representative payee on behalf of an annuitant shall be considered as having been applied for the use and benefit of the annuitant when they are used for the annuitant's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care, and personal comfort items.

Example: An aged annuitant is entitled to a monthly railroad retirement benefit of $800. His son, who is his representative payee, disburses his benefits in the following manner:

Rent and utilities	$500
Medical	50
Food	80
Clothing(coat)	90
Savings	60

Miscellaneous 20

The above expenditures would represent proper disbursements on behalf of the annuitant.

(b) *Institutional care.* If an annuitant is receiving care in a Federal, state, or private institution because of mental or physical incapacity, current maintenance includes the customary charges made by the institution in providing care and maintenance, as well as expenditures for those items which will aid in the annuitant's recovery or release from the institution or expenses for personal needs which will improve the annuitant's conditions while in the institution.

(c) *Support of legal dependents.* If the current maintenance needs of the annuitant are met, the representative payee may use part of the payments for the support of the annuitant's legally dependent spouse, child, and/or parent.

(d) *Claims of creditors.* Where a debt arose prior to the first month for which benefits are certified to a representative payee, the representative payee may satisfy such debt out of present benefit payments only if the current and reasonably foreseeable needs of the annuitant are met.

Example: A retroactive railroad retirement annuity check in the amount of $2,100, representing benefits due for November 1989 through January 1990, was issued on behalf of the annuitant to the annuitant's daughter, who is the representative payee. The check was certified in February 1990. The nursing home, where the annuitant resides, is owed money for maintenance expenses the annuitant incurred prior to February 1990.

If the accrual is not required for the annuitant's current maintenance and the annuitant had no foreseeable needs which would require large disbursements, the expenditure of the accrual or part thereof for the past due maintenance charges would be consistent with the Board's guidelines.

§ 266.11 Conservation and investment of benefit payments.

(a) *General.* If benefit payments made to a representative payee are not needed for the annuitant's current maintenance or reasonably foreseeable needs or the support of legal dependents or to pay creditors in accordance with § 266.10, they shall be conserved or invested on behalf of the annuitant. Such funds must be invested in accordance with the rules applicable to investment of trust estates by trustees. Any investment must show clearly that the representative payee holds the property in trust for the annuitant.

(b) *Preferred investments.* Preferred investments for excess funds are deposits in an interest or dividend paying account in a bank, trust company, credit union, or savings and loan association which is insured under either Federal or State law, direct obligations of the United States Government or obligations for which both principal and interest are guaranteed unconditionally by the United States Government. The account must be in a form which shows clearly that the representative payee has only a fiduciary, and not a personal, interest in the funds. If the payee is the legally appointed guardian or fiduciary of the annuitant, the account may be established to indicate this relationship. If the payee is not the legally appointed guardian or fiduciary, the accounts may be established as follows:

(1) For U.S. Savings Bonds—

(Name of annuitant)

(Social Security Number), for whom

(Name of payee)

is representative payee for Railroad Retirement benefits;

(2) For interest or dividend paying accounts—

(Name of annuitant) by

(Name of payee), representative payee.

(c) *Interest and dividend payments.* The interest and dividends which result from an investment are the property of the annuitant and may not be considered to be the property of the representative payee.

(d) *Prohibition against commingling.* The representative payee shall not commingle his or her personal funds with the representative payments. A representative payee may consolidate and maintain an annuitant's funds in an account with other annuitants if he or she maintains a separate, accurate

and complete accounting of each annuitant's funds under his or her control.

§ 266.12 Effect of matters or actions submitted or taken by legal guardian, etc.

All matters and actions in connection with an annuity submitted or taken by the guardian or other person legally vested with the care of the person or estate of an incompetent or a minor shall be considered by the Board in the same manner and with the same effect as though such matters or actions had been submitted or taken by the ward, if the ward had capacity to act in his or her own behalf; *Provided, however*, That the Board may, if it deems it necessary, require the guardian or other person legally vested with the care of the person or estate of an incompetent or a minor to submit a certified copy of an order from the court of appointment authorizing some particular action which the guardian or other person legally vested with the care of the person or estate desires to take in connection with the application.

§ 266.13 When a new representative payee will be selected.

When the Board learns that the interests of the annuitant are not served by continuing payment to the present representative payee or that the present representative payee is no longer able to carry out the payee responsibilities, the Board will undertake to find a new representative payee. The Board will select a new representative payee if the Board finds a preferred payee or if the present payee—

(a) Has not used the benefit payments on the annuitant's behalf in accordance with the guidelines in this part;

(b) Has not carried out the other responsibilities described in this part;

(c) Dies;

(d) No longer wishes to be representative payee;

(e) Is unable to manage the benefit payments; or

(f) Fails to cooperate, within a reasonable time, in providing evidence, accounting, or other information which the Board requests.

§ 266.14 When representative payment will be stopped.

If an annuitant receiving representative payment shows the Board that he or she is mentally and physically able to manage or direct the management of benefit payments, the Board will make direct payment to the annuitant. Information which the annuitant may give to the Board to support his or her request for direct payment include the following:

(a) A physician's statement regarding the annuitant's condition, or a statement by a medical officer of the institution where the annuitant is or was confined, showing that the annuitant is able to manage or direct the management of his or her funds;

(b) A certified copy of a court order restoring the annuitant's rights in a case where an annuitant was adjudged legally incompetent; or

(c) Other evidence which establishes the annuitant's ability to manage or direct the management of benefits.

§ 266.15 Transfer of accumulated benefit payments.

A representative payee who has conserved or invested funds from railroad retirement payments made to him or her on behalf of an annuitant shall, upon direction of the Board, transfer any such funds (including interest or dividends earned from investment of such funds) to a successor representative payee appointed by the Board, or, at the option of the Board, shall transfer such funds, including interest, to the Board for payment to a successor payee or to the annuitant.

PART 295—PAYMENTS PURSUANT TO COURT DECREE OR COURT-APPROVED PROPERTY SETTLEMENT

Sec.

295.1 Introduction.
295.2 Definitions.
295.3 Documentation and service.
295.4 Review of documentation.
295.5 Limitations.
295.6 Disclosure of information.
295.7 Miscellaneous.

AUTHORITY: 45 U.S.C. 231f; 45 U.S.C. 231m.

SOURCE: 51 FR 12845, Apr. 16, 1986, unless otherwise noted.

§ 295.1 Introduction.

(a) *Purpose.* This part implements section 419 of Public Law 98–76 (97 Stat. 438), which amended section 14 of the Railroad Retirement Act to provide that, with respect to annuity amounts payable for months beginning with September 1983, the Board must comply with a court decree of divorce, annulment or legal separation, or with the terms of any court-approved property settlement incident to any such decree, which characterizes specified benefits as property subject to distribution. This part also implements section 1003 of Public Law 109–280 (120 Stat. 1053), which amended section 5 of the Railroad Retirement Act to allow the payment of an employee's tier II benefit component awarded to a former spouse as part of a property distribution incident to a decree of divorce, annulment, or legal separation to continue after the employee's death. Garnishment of benefits for alimony or child support is dealt with in part 350 of this chapter.

(b) *Benefits subject to this part.* Only the following benefits or portions of benefits under the Railroad Retirement Act are subject to this part:

(1) Employee annuity net tier II benefit component as provided under section 3(b) of the Railroad Retirement Act;

(2) Employee annuity vested dual benefit component as provided under section 3(h) of the Act;

(3) Employee annuity increase as provided under section 3(f) of the Act; and

(4) Supplemental annuities as provided under section 2(b) of the Act.

[51 FR 12845, Apr. 16, 1986, as amended at 73 FR 47045, Aug. 13, 2008]

§ 295.2 Definitions.

As used in this part—

Act means the Railroad Retirement Act.

Court means any court of competent jurisdiction of any state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands; any court of the United States (as defined in section 451 of title 28 of the United States Code) having competent jurisdiction; any Indian court as defined by section 1301 of title 25 of the United States Code; or any court of competent jurisdiction of a foreign country with which the United States has an agreement requiring the United States to honor any court order of such country.

Court decree means a final decree of divorce, dissolution, annulment, or legal separation issued by a court (including a final decree or order modifying the terms of a previously issued decree of divorce, dissolution, annulment, or legal separation), which is issued in accordance with the laws of the jurisdiction of that court and which provides for the division of property.

Division of property means any transfer of property or its value by an individual to his or her spouse or former spouse in compliance with any community property settlement, equitable distribution of property, or other distribution of property between spouses or former spouses, which is intended as a present and complete settlement of the property rights of the parties.

Employee means an individual who is or was formerly an employee as defined by part 203 of this chapter.

Final decree means a decree from which no appeal may be taken or from which no appeal has been taken within the time allowed for taking such appeals under the laws applicable to such appeals, or a decree from which timely appeal has been taken and such appeal has been finally decided under the laws applicable to such appeals.

Former spouse means the former husband or wife of an employee who, on or before the date of a court order, was married to the employee and that marriage has ended by final decree of divorce, dissolution, or annulment.

Property settlement means an agreement between the parties to a suit for divorce, dissolution, annulment or legal separation in which they expressly agree to a division of their property rights, and which is incorporated in the final decree; is filed with the court in connection with a suit for divorce, dissolution, annulment or legal separation; or is otherwise presented to the court in a suit in accordance with the law of the jurisdiction.

An agreement assigning or transferring property between spouses is not within the purview of this part unless it is subsequently approved by a court in connection with a suit for divorce, dissolution, annulment or legal separation.

Spouse means the husband or wife of an employee who, on or before the date of a court order, was married to the employee and that marriage has not ended by final decree of divorce, dissolution, or annulment.

[51 FR 12845, Apr. 16, 1986, as amended at 73 FR 47045, Aug. 13, 2008]

§ 295.3 Documentation and service.

(a) *Court decree or property settlement.* The Board will honor a court decree or a property settlement which meets the following criteria:

(1) The court decree or property settlement must provide that the spouse or former spouse is awarded payments from railroad retirement annuities payable to the railroad employee.

(2) The court decree or property settlement must specify an amount to be paid to the spouse or former spouse.

(3) The court decree or property settlement must obligate the Board to make payments directly to the spouse or former spouse.

(4) The court decree or property settlement must clearly identify both the employee and the spouse or former spouse to whom payments are to be made.

(5) The court decree or property settlement submitted to the Board must be a recently certified copy of the document filed with the court. Where the award is made in an order modifying and earlier court decree, copies of both the original decree and the subsequent order must be furnished. In the case of a court-approved property settlement, both the settlement and any decree or order incorporating or approving the settlement must be provided.

(b) *Date of decree.* While only benefits payable for months after August, 1983 are subject to this part, the date the decree is entered or the property settlement is approved may precede September 1, 1983. A subsequent modification of a decree which was entered or a property settlement which was approved prior to September 1, 1983 must be in accord which the law of the jurisdiction in which the original decree was entered or the property settlement was approved.

(c) *Supporting documentation.* The spouse or former spouse shall submit such additional documentation as the Board shall require, including but not limited to:

(1) Identifying information concerning the employee such as social security number, railroad retirement claim number, full name, date of birth, and current address.

(2) Identifying information concerning the spouse or former spouse such as social security number, full name, and current address.

(3) A statement that—

(i) No condition of the law of the jurisdiction in which the decree was entered or the property settlement approved and no condition contained in the decree or agreement which requires termination of payment has occurred;

(ii) If any such condition does occur, the spouse or former spouse will immediately notify the Board; and

(iii) The spouse or former spouse agrees to repay any erroneous payment arising from occurrence of any such condition.

(d) *Delivery.* Any court decree or property settlement must be delivered by certified or registered mail, return receipt requested, or by personal service, to the General Counsel of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. Where the decree or property settlement is delivered to any other office of the Board, it shall not be considered delivered until the date it is received by the General Counsel. Where the decree or property settlement was furnished to any office of the Board prior to September 1, 1983, delivery is not accomplished until a copy is received by the General Counsel subsequent to August 30, 1983.

(Approved by the Office of Management and Budget under control number 3220–0042)

[51 FR 12845, Apr. 16, 1986, as amended at 73 FR 47046, Aug. 13, 2008]

§ 295.4 Review of documentation.

(a) *Regularity.* The General Counsel or his or her designee shall review the court decree or property settlement to determine that it complies with both

the law of the jurisdiction, and with Federal law and these regulations.

(b) *Amount.* Ambiguities in the amount to be paid the spouse or former spouse shall be resolved in accord with expressed indications of the court's intent, except that:

(1) Where the amount is expressed in terms of a dollar figure:

(i) If the figure exceeds the total benefits which may be allocated under this part, the excess will be disregarded, provided that any future increase in the benefits subject to this part will be prospectively applied to the excess effective with the date of the benefit increase.

(ii) If the figure is less than the total benefits which may be allocated under this part, only the amount specified will be paid.

(2) Where the amount is expressed as a fraction, percentage, or ratio:

(i) The amount specified shall be applied only against benefits subject to this part, irrespective of the wording of the decree or property settlement.

(ii) When the amount is expressed in terms of a fraction or ratio referring to the length of railroad service, years shall be converted into the equivalent months. If the length of railroad service specified in the decree or property settlement exceeds the number of creditable service months used by the Board to determine the employee's years of service for calculating an annuity, the actual number used by the Board shall be substituted. If the decree understates the actual number of creditable railroad service months, the number of years or months set forth in the decree or property settlement will be used.

(3) An amount may be expressed in any other fashion only to the extent to which it may be readily ascertained from records maintained by the Board in the regular course of administration of the Act.

(4) Unless the order expressly provides otherwise, the Board will deduct the amount specified by the order from any annuity paid to the employee, whether the employee has retired based on age or on disability.

(c) *Notification.* The General Counsel or his or her designee shall make reasonable effort to notify the spouse or former spouse and the employee of a determination that the decree or property settlement does or does not qualify as a decree or property settlement which will be honored pursuant to this part. This notice will be mailed to the most recent address of each party or representative of each party as shown in the Board's records pertaining to the employee. A copy of the decree or property settlement will be provided to the employee with this notice. The notice must state:

(1) The rationale for a determination that the decree or property settlement does not comply with this part; or

(2) The dollar amount or proportion of benefits which will be paid to the spouse or former spouse.

(d) *Withholding after notification.* (1) Where the General Counsel or his or her designee has notified the spouse or former spouse that a decree or property settlement will be honored under this part, but where the employee is not then entitled to any benefits subject to division under this part, the Director of Retirement Benefits will notate the Board's records to reflect both the amount of benefits awarded to the spouse or former spouse pursuant to the decree or property settlement and his or her current address. Where the employee is currently entitled to benefits subject to this part, and the spouse or former spouse has furnished all additional documentation required, the Director of Retirement Benefits will take action to withhold from the employee's monthly benefit the amount stated in the General Counsel's notice under paragraph (c) of this section that the Board will honor the decree or property settlement.

(2) Where the employee was not entitled to benefits subject to this part at the time of the notice by the General Counsel that the Board will honor the decree or property settlement, but the employee becomes so entitled at a later time, the Board will attempt to contact the spouse or former spouse at the most recent address shown in the Board's records pertaining to the employee. The notice will inform the spouse or former spouse that an annuity has been awarded, that the spouse or former spouse may, upon submission of all required documentation, receive

a portion of the annuity, and that the spouse or former spouse should contact the Board within three months from the date of the notice. The Director of Retirement Benefits will initiate withholding of the amount awarded to the spouse or former spouse from the employee's monthly benefit, and will continue to withhold this amount for three successive months; provided, that an initial annuity payment for a retroactive period shall count as one monthly benefit payment. If after the third month's payment has been withheld the Board has received no response from the spouse or former spouse, the amount withheld from the employee's benefit shall be paid to the employee, and the Board take no further action regarding the decree until the spouse or former spouse contacts the Board.

(3) Benefits withheld from the employee may not be paid to a spouse or former spouse until the spouse or former spouse has furnished all supporting documentation required pursuant to §295.3 of this part. The Board shall allow a reasonable time, not to exceed three months from the date of the initial response from the spouse or former spouse, for the submission of all required documentation. If the documentation is not furnished within the time allowed, payment of the amounts withheld shall be made to the employee.

(4) Any payments made to the employee subsequent to the three-month notice period specified in paragraphs (d)(2) and (3) of this section, and prior to receipt of a response or required documentation from the spouse or former spouse, shall be considered properly paid to the employee and the Board shall have no further liability to the spouse or former spouse with respect to such amounts.

[51 FR 12845, Apr. 16, 1986, as amended at 73 FR 47046, Aug. 13, 2008]

§295.5 Limitations.

(a) *Employee benefit entitlement.* Payments will be made to a spouse or former spouse under this part only if the employee has been awarded an annuity under the Railroad Retirement Act. Payments to a spouse or former spouse shall be made only for months and from such amounts with respect to which an annuity is payable to the employee, and, except as provided in paragraph (f)(4) of this section, shall be suspended or terminated for any month in which the annuity of the employee is suspended or terminated. No arrearage accrues to the spouse or former spouse with respect to any month for which the annuity of the employee is suspended or reduced as required under the Act.

(b) *Minimum amount.* The amount of payment to a spouse or former spouse may not be less than one dollar per month.

(c) *Prospective payment.* Payment to a spouse or former spouse may accrue no earlier than the later of the date of delivery, pursuant to §295.3 of this part, of a court decree or property settlement which will be honored under this part, or from October 1, 1983. The amount to be paid the spouse or former spouse under this part will not be increased to satisfy an arrearage due from the employee.

(d) *Payees.* Payment of an amount awarded to a spouse or former spouse by a court decree or property settlement will be made only to the spouse or former spouse except where the Board determines that another person shall be recognized to act on behalf of the spouse or former spouse as provided by part 266 of this chapter, relating to incompetence. Payment will not be made to the heirs, legatees, creditors or assignees of a spouse or former spouse, except that where an amount is payable to a spouse or former spouse pursuant to this part, but is unpaid at the death of that spouse or former spouse, the unpaid amount may be paid in accordance with §234.31 of this chapter, pertaining to employee annuities unpaid at death.

(e) *Net amount of benefits.* Notwithstanding the terms of the decree or property settlement, the amount of benefits payable to the employee which are subject to this part shall not include:

(1) Amounts deducted to satisfy a debt due the United States, including any amount withheld to recover erroneous payments under the Railroad Retirement Act, Railroad Unemployment Insurance Act, or any other acts administered by the Board; and

(2) Benefits which are waived pursuant to § 243.6 of this chapter.

(f) *Termination.* Except as provided in paragraph (f)(4) of this section payments to a spouse or former spouse terminate on the earlier of—

(1) The date on which the employee annuity terminates;

(2) The date required by the court decree or property settlement or the law of the jurisdiction in which the court decree or property settlement was entered; or

(3) The last day of the month before the month in which the spouse or former spouse dies.

(4) If the employee dies on or after August 17, 2007, a former spouse who is receiving a portion of the employee's annuity pursuant to a court decree or property settlement compliant with this part may continue to receive a portion of the employee's tier II benefit component unless the court decree or property settlement requires such payment to terminate upon the death of the employee.

(g) *Priority.* In the event that the General Counsel receives more than one decree or property settlement from competing parties, benefits shall be available to satisfy the decrees or property settlements on a first come, first served basis governed by the date of receipt by the General Counsel. Conflicting decrees or property settlements received on the same day shall be accorded priority based upon the earliest date upon which the decree or property settlement became final.

[51 FR 12845, Apr. 16, 1986, as amended at 53 FR 35807, Sept. 15, 1988; 62 FR 67724, Dec. 30, 1997; 73 FR 47046, Aug. 13, 2008; 86 FR 30493, July 1, 2021]

§ 295.6 Disclosure of information.

(a) *Immunity from process.* The provision for the payment of benefits under this part pursuant to a court decree or property settlement shall not be construed to be a waiver of the sovereign immunity of the Railroad Retirement Board as an agency of the U.S. Government. The Board may not be joined in a suit for divorce, dissolution, annulment or legal separation, or otherwise subjected to the jurisdiction of any state court. Subpoenas, notices of joinder, interrogatories, orders for production of documents, and like state process issued in connection with a suit for divorce, dissolution, annulment or legal separation will be treated as requests for disclosure of information under this section.

(b) *Request for information.* A response to a request for information to be used in connection with a suit for divorce, dissolution, annulment or legal separation may be made by the General Counsel or his or her designee, by the Director of Retirement Benefits, or by a contact representative of the Board's field service.

(c) *Information available.* In the absence of a signed authorization from the employee, a spouse or former spouse who is a party to a suit for divorce, dissolution, annulment or legal separation, or his or her legal representative, may be furnished the amount of benefits the employee is currently receiving. If the employee is not currently entitled to benefits, the Board may furnish the amount of any estimated benefit to which the employee would be entitled if he or she were of retirement age at the time of the request, as reflected by the records of the Board, to the extent it is possible for the Board to compute such amount. The Board shall not be required to furnish the present value of future benefits, the amount of benefits payable at a future date, or any other computations based on statistics or procedures not maintained by the Board in the normal course of administration of the Act.

(d) *Certification.* A letter or statement prepared by a Board official in the regular course of duty from the official records of the Board, which refers to the authority of this section and bears his or her signature, shall be a sufficient response for purposes of discharging the responsibilities of the Board under this section. A certification in accordance with this section may be considered a public document for purposes of admissibility as evidence of present or potential benefits under the Act for use in a divorce, dissolution, annulment or legal separation proceeding.

[51 FR 12845, Apr. 16, 1986, as amended at 73 FR 47046, Aug. 13, 2008]

§ 295.7 Miscellaneous.

(a) *Disbursement cycle.* In honoring and complying with a court decree or property settlement, the Board shall not be required to disrupt its normal disbursement cycle, despite any special schedule of accrual or payment of amounts due the spouse or former spouse set forth in the decree or settlement. A decree or settlement received too late to be honored during the disbursement cycle in which it was received shall be honored with respect to the next payment due the employee.

(b) *Liability for payments.* Neither the Board nor any of its employees shall be liable with respect to any payment made to any individual from moneys due from or payable by the Board pursuant to a court decree or property settlement regular on its face, if such payment is made in accordance with this part.

(c) *Liability for disclosures.* No employee of the Board whose duties include responding to requirements contained in this part shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by such employee in connection with the performance of the employee's duties in making such response.

(d) *Applicable law.* For purposes of a proceeding under this part, the Board will apply the law of the jurisdiction in which the court decree or property settlement was issued unless it comes to the attention of the Board that the state of issuance has no contact with the plaintiff or defendant in the action; in which case, the Board may, in its sole discretion, apply the law of any jurisdiction with significant interest in the matter.

(e) *Erroneous payments.* (1) If a spouse or former spouse receives a payment pursuant to this part from an employee's benefit, and the Board later determines that the employee was not entitled to all or part of those benefits for any month, the amount of the employee's benefits which was paid to the spouse or former spouse in excess of the amount which was actually payable shall be an erroneous payment to the spouse or former spouse within the meaning of section 10 of the Railroad Retirement Act.

(2) Where all documentation required by this part is in the Board's records pertaining to the employee prior to the time the employee annuity is awarded, but where the Board due to clerical oversight fails to withhold the amount awarded by the court order, then the Board shall begin deduction from the employee annuity with the month the error is discovered, and shall pay the amount which should have been withheld pursuant to this part to the spouse or former spouse. The amount paid to the spouse or former spouse representing months for which the amount under the order was not timely withheld shall be an erroneous payment to the employee within the meaning of section 10 of the Railroad Retirement Act. This section shall not apply where the Board has attempted to contact the spouse or former spouse at the time the employee annuity is awarded pursuant to § 295.4(d).

[51 FR 12845, Apr. 16, 1986, as amended at 73 FR 47046, Aug. 13, 2008]

SUBCHAPTER C—REGULATIONS UNDER THE RAILROAD UNEMPLOYMENT INSURANCE ACT

PART 300—DEFINITIONS

AUTHORITY: Sec. 12, 52 Stat. 1107, as amended; 45 U.S.C. 362. Interprets or applies sec. 1, 52 Stat. 1094, as amended; 45 U.S.C. 351.

§ 300.1 Words and phrases.

For the purposes of the regulations in this part, except where the language or context indicates otherwise:

(a) The term ''act'' means the Railroad Unemployment Insurance act.

(b) The term ''employer'' means an employer as defined in the act and part 201 of this chapter.

(c) The term ''Board'' means the Railroad Retirement Board.

(d) The term ''person'' includes an individual, trust, estate, partnership, association, joint stock company, company, corporation, and institution.

(e) The term ''United States'', when used in a geographical sense, means the States and the District of Columbia.

(f) The term ''State'' means any of the States or the District of Columbia.

(g) The term ''employment'' means service performed as an employee.

(h) The term ''local lodges and divisions'' and the term ''local lodge or division'' as used in section 1(a) and 1(d), respectively, of the act, shall be construed to include any subordinate unit of a national railway labor organization defined as an ''employer'' under the act, which unit functions in the same manner as, or similar to ''local lodges'' as that term is ordinarily used, irrespective of the designation of such unit by its national organization.

[Board Order 40–368 and Board Order 40–385, 5 FR 2717, Aug. 1, 1940, as amended by Board Order 68–72, 33 FR 11114, Aug. 6, 1968]

PART 301—EMPLOYERS UNDER THE ACT

Sec.

301.1 Statutory provisions.
301.4 Who are employers.

AUTHORITY: 45 U.S.C. 362(1).

§ 301.1 Statutory provisions.

(a) The term ''employer'' means any carrier (as defined in subsection (b) of this section), and any company which is directly or indirectly owned or controlled by one or more such carriers or under common control therewith, and which operates any equipment or facility or performs any service (except trucking service, casual service, and the casual operation of equipment or facilities) in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, and any receiver, trustee, or other individual or body, judicial or otherwise, when in the possession of the property or operating all or any part of the business of any such employer: *Provided, however,* That the term ''employer'' shall not include any street, interurban, or suburban electric railway, unless such railway is operating as a part of a general steam-railroad system of transportation, but shall not exclude any part of the general steam-railroad system of transportation now or hereafter operated by any other motive power. The Interstate Commerce Commission is hereby authorized and directed upon request of the Board, or upon complaint of any party interested, to determine after hearing whether any line operated by electric power falls within the terms of this proviso. The term ''employer'' shall also include railroad associations, traffic associations, tariff bureaus, demurrage bureaus, weighing and inspection bureaus, collection agencies, and other associations, bureaus, agencies, or organizations controlled and maintained wholly or principally by two or more employers as hereinbefore defined and engaged in the performance of services in connection with or incidental to railroad transportation; and railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitution and bylaws of such organizations.

The term ''employer'' shall not include any company by reason of its being engaged in the mining of coal, the supplying of coal to an employer where delivery is not beyond the mine tipple, and the operation of equipment or facilities therefor, or in any of such activities. * * *

(b) The term ''carrier'' means an express company, sleeping-car company, or carrier

by railroad, subject to part I of the Interstate Commerce Act.

[Board Order 40–368, 5 FR 2718, Aug. 1, 1940, as amended by Board Order 41–526, 7 FR 97, Jan. 6, 1942]

§ 301.4 Who are employers.

The provisions of § 201.1(k) and the provisions of §§ 202.2 through 202.15 of this chapter shall be applicable to the determination of who are employers under the Railroad Unemployment Insurance Act to the same extent and in the same manner as they are applicable to the determination of who are employers under the Railroad Retirement Act of 1937.

[Board Order 40–368, 5 FR 2718, Aug. 1, 1940]

PART 302—QUALIFIED EMPLOYEE

Sec.
302.1 Introduction.
302.2 Definitions.
302.3 Qualifying conditions.
302.4 Nonqualifying earnings or payments.
302.5 Accelerated benefit year.
302.6 Publication requirements.
302.7 Establishing base year service and compensation.

AUTHORITY: 45 U.S.C. 362(1).

SOURCE: 56 FR 6966, Feb. 21, 1991, unless otherwise noted.

§ 302.1 Introduction.

This part sets forth the base year service and compensation required of an employee to qualify for benefits under the Railroad Unemployment Insurance Act with respect to a benefit year. Under the Act, only employees who satisfy the qualifying conditions of section 3 of the Act may be paid benefits. No provision is made for payment of dependents benefits for an employee's spouse or children. A qualified employee who claims benefits must demonstrate that he or she is eligible for benefits in accordance with the other provisions of the Act and this chapter. However, a qualified employee who is disqualified under any of the provisions of section 4 of the Act does not forfeit his or her status as a qualified employee.

§ 302.2 Definitions.

Base year. The term ''base year'' means the completed calendar year immediately preceding the beginning of the benefit year.

Benefit year. The term ''benefit year'' means the 12-month period beginning July 1 of any year and ending June 30 of the next year. If a registration period begins in June and ends in July, the benefit year ending date is deemed to be the last day of such registration period. If an employee is eligible for payment of extended benefits, the benefit year ending date for such employee will be June 30, or the last day of his or her extended benefit period, whichever date is later.

Compensation. The term ''compensation'' means generally any form of earnings or money remuneration earned on the basis of railroad employment during any month, excluding any amount in excess of the monthly compensation base for that month and also excluding payments of the character described in § 302.4 of this part.

Monthly compensation base. The term ''monthly compensation base'' means the greater of $600, or the amount calculated using the following formula:

$$\mathrm{MCB} = 600\left(1 + \frac{\mathrm{A} - 37{,}800}{56{,}700}\right)$$

For the purpose of this formula, ''MCB'' is the dollar amount of the monthly compensation base, and ''A'' is the amount of the Tier I tax base under section 3231(e)(2) of the Internal Revenue Code for the calendar year for which the monthly compensation base is being computed. If the dollar amount computed under this formula is not a multiple of $5, it shall be rounded to the nearest multiple of $5. If the dollar amount computed is equidistant between two multiples of $5, it shall be rounded up the nearest multiple of $5.

Registration period. With respect to unemployment benefits, the term ''registration period'' has the meaning given in § 325.1(c) of this chapter. With respect to sickness benefits, the term ''registration period'' has the meaning given in § 335.1(d) of this chapter.

[56 FR 6966, Feb. 21, 1991; 56 FR 10302, Mar. 11, 1991]

§ 302.3 Qualifying conditions.

(a) *Basic requirements.* To qualify for benefits with respect to a benefit year, an employee:

(1) Must have earned compensation in an amount equal to at least 2.5 times the amount of the monthly compensation base during his or her base year; and

(2) If such employee has earned no compensation prior to such base year, he or she must have earned compensation in at least five months during his or her base year.

(b) *Deemed service months disregarded.* For purposes of paragraph (a) of this section, service months deemed under § 210.3 of this chapter shall be disregarded.

§ 302.4 Nonqualifying earnings or payments.

The following types of earnings or payments do not count as compensation for the purpose of determining whether an employee has satisfied the base year qualifying conditions:

(a) Compensation earned as an employee representative, as defined in part 205 of this chapter, or as an employee of a local lodge or division of a railway labor organization;

(b) Tips;

(c) Payments under nongovernmental plans for unemployment, maternity or sickness insurance;

(d) Personal injury settlements or judgments, unless a portion thereof represents pay for time lost;

(e) Wages from employment that is subject to the Federal Unemployment Tax Act;

(f) Earnings from self-employment or investments;

(g) Pay for military service;

(h) Remuneration for service which is performed by a nonresident alien individual for the period he or she is temporarily present in the United States as a nonimmigrant under subparagraph (F) or (J) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be; and

(i) Any payment that is not subject to contributions under section 8 of the Railroad Unemployment Insurance Act.

[56 FR 6966, Feb. 21, 1991; 56 FR 10302, Mar. 11, 1991]

§ 302.5 Accelerated benefit year.

(a) *Eligibility conditions.* An employee who is not a qualified employee with respect to the benefit year in effect at the time of his or her application for benefits may be eligible for an ''accelerated'' benefit year if he or she meets all of the following conditions.

(1) The employee has 10 or more years of service, as defined in part 210 of this chapter, prior to the beginning of his or her current period of unemployment or sickness;

(2) The employee has satisfied the qualifying conditions as defined in § 302.3 of this part with respect to the next succeeding benefit year;

(3) The employee's current period of unemployment or sickness includes at least 14 consecutive days of unemployment or 14 consecutive days of sickness; and

(4)(i) If the applicant is claiming unemployment benefits, he or she did not voluntarily leave work without good cause or did not voluntarily retire, or

(ii) If the applicant is claiming sickness benefits, he or she has not attained age 65 or has not voluntarily retired.

(b) *Beginning date of benefit year.* An accelerated benefit year begins on the first day of the month during which the employee's period of 14 consecutive days of unemployment or 14 consecutive days of sickness begins. Thus, for example, if an eligible employee has 14 consecutive days of unemployment from May 29–June 11, his or her benefit year beginning date is May 1, that is, he or she does not have to wait until July 1 to begin receiving benefits. If such employee also had a claim for the period May 15 to May 28, such claim may then be compensable or may serve as the waiting period even though the claim did not consist of 14 days of unemployment. His or her benefit year ends June 30 of the following year.

(c) *Effect of attaining age 65.* If a benefit year begins early for the purpose of paying sickness benefits and the employee attains age 65 before July 1 of

the general benefit year, sickness benefits may not be paid for any day from the day on which the employee attained age 65 up to and including June 30, but unemployment benefits may be paid in this interim period if the employee is otherwise eligible. Sickness benefits may be paid for days of sickness beginning July 1 or later. If a benefit year begins early for the purpose of paying unemployment benefits, attainment of age 65 will have no effect on the employee's rights to sickness benefits, other than extended sickness benefits, in the accelerated benefit year. An employee is deemed to attain age 65 on the day before his or her sixty-fifth birthday.

§ 302.6 Publication requirements.

(a) *Publication of base year compensation requirement.* On or before December 1 of each year, the Railroad Retirement Board will compute the amount of base year compensation that an employee must have during the following calendar year in order to be a qualified employee on the basis of such compensation. Within 10 days of such computation, the Board will publish a notice in the FEDERAL REGISTER of the amount so computed and will notify each employer of that amount. Information as to such qualifying amount may also be obtained from any district or regional office of the Railroad Retirement Board or from the Bureau of Unemployment and Sickness Insurance.

(b) *Notices.* The Board will provide employers with notices of their employees' rights to benefits under the Railroad Unemployment Insurance Act. The Board will arrange with employers to post such notices in such numbers and in such places as may be necessary to ensure that they will be seen by the greatest number of employees.

§ 302.7 Establishing base year service and compensation.

(a) *Employer reports.* In determining whether an applicant for benefits is a qualified employee, the Board will rely initially upon reports of base year service and compensation provided by employers in accordance with part 209 of this chapter.

(b) *No employer report located.* If the Board cannot locate the employer's report of base year service and compensation for an applicant, the applicant will be afforded an opportunity, by completing the form prescribed by the Board, to provide such other statement, information, evidence or documentation to establish his or her status as a qualified employee. An employee's claim for credit for service or compensation that is not shown in the Board's records of service and compensation shall be verified in accordance with §§ 210.7 and 211.14 of this chapter.

(c) *Employer fails to report.* When an employer has failed or refuses to file a report under part 209 of this chapter, an employee may establish his or her base year service and compensation by submitting:

(1) Statements, under oath or otherwise, signed by an official or duly authorized employee of a Federal or State governmental agency, based upon reports to the agency by the employer; or

(2) Statements, under oath or otherwise, signed by an officer or a duly authorized employee of the employer, or if not so signed, on forms prepared by the employer.

(Approved by the Office of Management and Budget under control numbers 3220–0025 and 3220–0070)

PART 319—PROCEDURE FOR DETERMINING LIABILITY FOR CONTRIBUTIONS OR REPAYMENTS OF BENEFITS

Sec.

319.1 Statutory provisions.
319.2 Procedure for determining entitlement to benefits awarded where employer status is denied, and for determining liability for contributions.

AUTHORITY: Sec. 12, 52 Stat. 1107, as amended; 45 U.S.C. 362.

§ 319.1 Statutory provisions.

* * * In any case in which benefits are awarded to a claimant in whole or in part upon the basis of pay earned in the service of a person or company found by the Board to be an employer as defined in this Act but which denies that it is such an employer, such benefits awarded on such basis shall be

paid to such claimant subject to a right of recovery of such benefits. The Board shall thereupon designate one of its officers or employees to receive evidence and to report to the Board on whether such benefits should be repaid. The Board may also designate one of its officers or employees to receive evidence and report to the Board whether or not any person or company is entitled to a refund of contributions or should be required to pay contributions under this Act, regardless of whether or not any claims for benefits will have been filed upon the basis of service in the employ of such person or company, and shall follow such procedure if contributions are assessed and payment is refused or payment is made and a refund claimed upon the basis that such person or company is or will not have been liable for such contributions. In any such case the Board or the person so designated shall, by publication or otherwise, notify all parties properly interested of their right to participate in the proceeding and, if a hearing is to be held, of the time and place of the hearing. At the request of any party properly interested the Board shall provide for a hearing, and may provide for a hearing on its own motion. The Board shall prescribe regulations governing the proceedings provided for in this paragraph and for decisions upon such proceedings.

Final decision of the Board in the cases provided for in the preceding two paragraphs shall be communicated to the claimant and to the other interested parties within fifteen days after it is made. Any properly interested party notified, as hereinabove provided, of his right to participate in the proceedings may obtain a review of any such decision by which he claims to be aggrieved or the determination of any issue therein in the manner provided in subsection (f) of this section with respect to the review of the Board's decisions upon claims for benefits and subject to all provisions of law applicable to the review of such decisions. Subject only to such review, the decision of the Board upon all issues determined in such decision shall be final and conclusive for all purposes and shall conclusively establish all rights and obligations, arising under this Act, of every party notified as hereinabove provided of his right to participate in the proceedings.

Any issue determinable pursuant to this subsection and subsection (f) of this section shall not be determined in any manner other than pursuant to this subsection and subsection (f). (Section 5(c), Railroad Unemployment Insurance Act.)

In any proceeding other than a court proceeding, the rules of evidence prevailing in courts of law or equity shall not be controlling, but a full and complete record shall be kept of all proceedings and testimony, and the Board's final determination, together with its findings of fact and conclusions of law in connection therewith, shall be communicated to the parties within fifteen days after the date of such final determinations.

(Section 5(e), Railroad Unemployment Insurance Act.)

Any claimant, or any railway labor organization organized in accordance with the provisions of the Railway Labor Act, of which claimant is a member, or any other party aggrieved by a final decision under subsection (c) of this section, may, only after all administrative remedies within the Board will have been availed of and exhausted, obtain a review of any final decision of the Board by filing a petition for review within ninety days after the mailing of notice of such decision to the claimant or other party, or within such further time as the Board may allow, in the United States court of appeals for the circuit in which the claimant or other party resides or will have had his principal place of business or principal executive office, or in the United States Court of Appeals for the Seventh Circuit or in the Court of Appeals for the District of Columbia. * * * (Section 5(f), Railroad Unemployment Insurance Act.)

[Board Order 58–142, 23 FR 9089, Nov. 22, 1958]

§ 319.2 Procedure for determining entitlement to benefits awarded where employer status is denied, and for determining liability for contributions.

(a) The Board may designate one of its officers or employees as examiner to receive evidence and report to the Board (1) whether or not a claimant should repay benefits awarded in whole or in part upon the basis of pay earned in the service of a person or company found by the Board to be an employer as defined in the Railroad Unemployment Insurance Act, but which denies that it is such an employer, or (2) whether or not any person or company is entitled to a refund of contributions or should be required to pay contributions under the Act. Such procedure shall be followed if contributions are assessed and payment is refused or payment is made and a refund claimed upon the basis that such person or company is or will not have been liable for such contributions. The examiner shall have power to hold hearings, require and compel the attendance of witnesses, administer oaths, take testimony, and make all necessary investigations. At the request of any party properly interested, the Board shall

provide for a hearing before such examiner, and may provide for a hearing on its own motion. The examiner shall, by publication or otherwise, notify all parties properly interested of their right to participate in the proceeding and if a hearing is to be held, of the time and place of the hearing.

(b) All evidence and argument presented by any party, and all evidence developed by the examiner, shall be preserved and shall constitute a part of the record. All oral evidence presented at any hearing, and all oral argument, shall be reduced to writing. The record at any time shall be available for examination by any properly interested party or his representative.

(c) Upon the completion of any proceeding, the examiner shall upon the basis of the entire record, render a report to the Board as soon as practicable, and within five days after the making thereof shall send a copy of the report to each party appearing in the proceeding by mailing such copy to him at the address stated in his appearance. Such report shall contain a statement of (1) the issue or issues raised, (2) the evidence submitted, (3) findings of fact, (4) conclusions of law, and (5) a recommended determination.

(d) Any party to the proceeding may, within twenty days after the mailing to him of a copy of the examiner's report, file with the Board, and serve upon other parties by mailing to their addresses as stated in their appearances, such exceptions in writing as he desires to make to the examiner's findings of fact and conclusions of law. Each exception shall specifically designate the particular finding of fact or conclusion of law to which exception is taken, and shall set forth in detail the grounds of the exception. General exceptions and exceptions not specifically directed to particular findings of fact or conclusions of law will not be considered. Each party shall have ten days after the receipt of exceptions taken by other parties in which to file with the Board replies to the exceptions. The Board may, upon the application of any party and for cause shown, extend the time for filing and serving of exceptions or filing of replies thereto. The examiner's report shall be advisory but shall be presumed to be correct. Findings of fact to which no exceptions are taken will, subject only to the power of the Board to reject or modify, stand confirmed.

(e) The Board will render its decision upon the record and upon the basis of the examiner's report and such exceptions and replies thereto as are made. Further argument will not be permitted except upon a showing by any party that he has arguments to present which for valid reasons he was unable to present at an earlier stage, and in cases in which the Board requests further elaboration of arguments. In such cases, the further argument shall be submitted orally or in writing, as the Board may indicate in each case, and shall be subject to such restrictions as to form, subject matter, length, and time as the Board may indicate. The decision of the Board will be communicated to all parties to the proceeding within fifteen days after it has been made by mailing a copy of the decision to each such party at the address furnished by him.

(f) The decision of the Board, with respect to all issues determined therein, shall be final and conclusive for all purposes, and shall conclusively establish all rights and obligations, arising under any act administered by the Board, of every person notified of his right to participate in the proceeding.

(g) Any properly interested party notified of his right to participate in the proceeding may, as provided in section 5(c) of the Railroad Unemployment Insurance Act, and in accordance with the provisions of section 5(f) of the Act, obtain judicial review of a final decision of the Board, under this section, by which he claims to be aggrieved, by filing a petition for review in the proper court within ninety days after the mailing to him of notice of such decision, or within such further time as the Board may allow. Such petition for review must be filed in the U.S. Court of Appeals for the circuit in which the party resides or will have had his principal place of business or principal executive office, or in the U.S. Court of Appeals for the Seventh Circuit or in the Court of Appeals for the District of Columbia.

(h) Insofar as applicable and not inconsistent with the preceding provisions of this section, the provisions of §§ 250.7 to 250.16 of this chapter shall be followed in any proceeding under this section.

[Board Order 58–142, 23 FR 9089, Nov. 22, 1958]

PART 320—INITIAL DETERMINATIONS UNDER THE RAILROAD UNEMPLOYMENT INSURANCE ACT AND REVIEWS OF AND APPEALS FROM SUCH DETERMINATIONS

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AUTHORITY: 45 U.S.C. 355 and 362(1).

SOURCE: Board Order 58–142, 23 FR 9090, Nov. 22, 1958, unless otherwise noted.

§ 320.1 Introduction.

This part explains which units of the Board are authorized to make initial determinations with respect to entitlement to benefits under the Railroad Unemployment Insurance Act and waiver of recovery of overpayments under that Act. This part explains how notice of such determinations is to be communicated to the claimant and to his or her base-year employer(s) and how these determinations may be appealed.

[56 FR 65679, Dec. 18, 1991]

§ 320.2 Definitions.

As used in this part—

Base-year employer means the railroad employer(s) for whom a claimant worked and earned compensation creditable under the Railroad Unemployment Insurance Act during the base year. The base year is the calendar year immediately preceding the benefit year for which a claim is being filed. A benefit year is generally the period July 1 through the following June 30.

Party means the claimant, the base-year employer(s), or any person so designated under this part.

[56 FR 65679, Dec. 18, 1991]

§ 320.5 Initial determinations.

An initial determination shall be made with respect to each claim for unemployment or sickness benefits by the appropriate adjudicating office as provided by § 320.6 of this part. Prior to making an initial determination the Board shall provide the claimant's base-year employer(s) and most recent employer if different with notice that a claim has been filed and that the employer(s) has an opportunity to submit information which may be pertinent to the adjudication of the claim. The adjudicating office shall make its determination on the basis of the claimant's application and claim and any relevant information or evidence including any information received from the base-year employer(s). A determination allowing payment of an initial claim shall not establish a presumption that benefits for subsequent claims in the same period of unemployment or sickness are also payable. The Director of Policy and Systems shall issue instructions with respect to the adjudication of claims and initial determination on such claims. If it is found that only part of the benefits claimed may initially be paid, a partial payment shall be made prior to a final decision on the whole claim.

[56 FR 65679, Dec. 18, 1991, as amended at 77156, Dec. 17, 2002]

§ 320.6 Adjudicating office.

(a) The term ''adjudicating office'' means any subordinate office of the Board which is authorized to make initial determinations and reconsideration decisions with respect to claims for benefits. The following paragraphs state which offices of the Board are adjudicating offices and define their authority to make determinations or decisions.

(b) *Field offices.* Field offices are authorized to make initial determinations on the following issues relating to eligibility for unemployment or sickness benefits, as the case may be:

(1) Availability for work;

(2) Voluntary leaving of work, with or without good cause;

(3) Failure to accept work or apply for work or failure to report to an employment office;

(4) Timely registration for unemployment benefits under § 325.2 of this chapter and timely filing of claims for sickness benefits under § 335.4(c) of this chapter;

(5) Receipt of remuneration for claimed days of unemployment or sickness, as the case may be;

(6) Mileage or work restrictions and stand-by or lay-over rules;

(7) Whether the claimant's unemployment is due to a strike.

(8) Whether a claimant's earnings attributable to days in a period for which he or she has registered for unemployment benefits exceed the amount of the applicable monthly compensation base.

(c) *Field Service-Headquarters.* Field Service-Headquarters staff are authorized to make determinations on any of the issues listed in paragraph (b) of this section. In addition, Field Service–Headquarters staff are authorized to make initial determinations on the following issues:

(1) Erroneous payment of benefits, including fraud;

(2) Applicability of the disqualification in section 4(a–2)(iii) of the Railroad Unemployment Insurance Act if the claimant's unemployment results from a strike against a non-railroad employer by which he is employed;

(3) Determination of the amount of the Board's claim for reimbursement from pay for time lost payments under section 2(f) of the Railroad Unemployment Insurance Act or damages for personal injury under section 12(o) of the Railroad Unemployment Insurance Act.

(d) *Director of Operations.* The Director of Operations is authorized to make determinations on all issues of eligibility for unemployment and sickness benefits as set forth in paragraphs (b) and (c) of this section, and on any other issue not reserved to the Director of Policy and Systems by paragraph (e) of this section.

(e) *Director of Policy and Systems.* The Director of Policy and Systems shall adjudicate:

(1) The applicability of the disqualification in section 4(a–2)(iii) of the Railroad Unemployment Insurance Act if the claimant's unemployment results from a strike against a railroad employer by which he or she is employed; and

(2) Whether a plan submitted by an employer or other person or company qualifies as a nongovernmental plan for unemployment or sickness insurance, within the meaning of part 323 of this chapter.

(f) *Debt Recovery Manager.* The Debt Recovery Manager shall adjudicate:

(1) All requests for waiver of recovery of an erroneous payment made under the Railroad Unemployment Insurance Act; and

(2) Offers of compromise of debts arising out of the benefit provisions of the Railroad Unemployment Insurance Act.

[53 FR 2486, Jan. 28, 1988, as amended at 60 FR 28534, June 1, 1995; 67 FR 77156, Dec. 17, 2002; 80 FR 13764, Mar. 17, 2015]

§ 320.8 Notice of initial determination.

(a) *Benefits payable.* If benefits are payable for a claim, no special notice of the award will be issued to the claimant. A notice of the award will be sent to the base-year employer(s). The amount of benefits due will be certified to the United States Treasury Department for payment.

(b) *Benefits not payable.* If an initial determination results in denial of a claim, either in whole or in part, the adjudicating office shall issue a notice of the denial within 15 days of the date that it makes its determination. The notice shall explain the basis for the

denial of benefits and shall set forth what steps the claimant can take to contest the denial.

(c) *Communication of notice of denial.* When the adjudicating office mails the denial notice to the claimant's address of record, it shall be considered that notice of the denial has been communicated to the claimant on the date of mailing such notice. If the adjudicating office has been notified that a claimant has an attorney or other representative helping him or her with the claim, a copy of the denial notice shall be sent to the attorney or such other representative.

[53 FR 2486, Jan. 28, 1988, as amended at 56 FR 65679, Dec. 18, 1991]

§ 320.9 Notice of erroneous benefit payment.

(a) *Content of notice.* When an adjudicating office determines that benefits were paid erroneously, that office shall issue to the claimant a notice of the amount of the erroneous payment and the basis for the determination. The notice shall include a statement telling the claimant of his or her right to request reconsideration of the determination, of the provisions for waiver and of his or her right to request waiver.

(b) *Communication of notice of erroneous payment.* When the adjudicating office mails the erroneous payment notice to the claimant's address of record, it shall be considered that notice of the erroneous payment has been communicated to the claimant on the date of mailing such notice. If the adjudicating office has been notified that a claimant has an attorney or other representative helping him or her with the claim, a copy of the erroneous payment notice shall be sent to the attorney or such other representative.

[53 FR 2486, Jan. 28, 1988]

§ 320.10 Reconsideration of initial determination.

(a) *Request.* A claimant shall have the right to request reconsideration of an initial determination under § 320.5 of this part which denies in whole or in part his or her claim for benefits. A claimant shall have the right to request reconsideration of a notice of overpayment under § 320.9 of this part. The base-year employer(s) shall have the right to request reconsideration of an initial determination under § 320.5 of this part which awards in whole or in part a claimant's claim for benefits. A reconsideration request shall be made in writing and addressed to the adjudicating office that issued the initial determination and must be received by the adjudicating office no later than 60 days from the date of the notice of the initial decision. A railroad employer may fulfill the written request requirement by using an electronic system that has been approved by the agency in the manner prescribed by the agency.

(b) *Review of evidence.* Upon request, the party requesting reconsideration shall have an opportunity to review all evidence and documents that pertain to the initial determination. The Board shall made all reasonable efforts to protect the identity of the source of adverse evidence.

(c) *Notice of decision.* The adjudicating office shall, as soon as possible, render a decision on the request for reconsideration. If a decision rendered by a district office, as the adjudicating office, sustains the initial determination, either in whole or in part, the decision shall be referred to the appropriate Field Service-Headquarters staff for review prior to issuance. The party who requested reconsideration shall be notified, in writing, of the decision on reconsideration no later than 15 days from the date of the decision or, where the Field Service-Headquarters staff has conducted a review of the decision, within 7 days following the completion of the review. If the decision results in denial of benefits, the claimant shall be notified of the right to appeal as provided in § 320.12 of this part. If the decision results in payment of benefits, the base-year employer(s) shall be notified of the right to appeal as provided in § 320.12 of this part.

(d) *Right to further review of initial determination.* The right to further review of a determination made under § 320.5 or § 320.9 of this part shall be forfeited unless a written request for reconsideration is filed within the time period prescribed in this section or good cause

is shown by the party requesting reconsideration for failing to file a timely request for reconsideration. A railroad employer may fulfill the written request requirement by using an electronic system approved by the agency in the manner prescribed by the agency.

(e) *Timely request for reconsideration.* In determining whether either the claimant or the base-year employer(s) has good cause for failure to file a timely request for reconsideration, the adjudicating office shall consider the circumstances which kept either the claimant or the base-year employer(s) from filing the request on time and whether any action by the Board misled either of them. Examples of circumstances where good cause may exist include, but are not limited to:

(1) A serious illness which prevented the claimant from contacting the Board in person, in writing, or through a friend, relative or other person;

(2) A death or serious illness in the claimant's immediate family which prevented him or her from filing.

(3) The destruction of important and relevant records;

(4) A failure to be notified of a decision;

(5) The existence of an unusual or unavoidable circumstance which demonstrates that either the claimant or the base-year employer(s) would not have known of the need to file timely or which prevented either of them from filing in a timely manner; or

(6) The claimant thought that his or her representative had requested reconsideration.

[56 FR 65679, Dec. 18, 1991, as amended at 67 FR 77156, Dec. 17, 2002; 71 FR 53004, Sept. 8, 2006; 80 FR 13764, Mar. 17, 2015]

§ 320.11 Request for waiver of recovery.

(a) *Time limitation.* The claimant shall have 60 days from the date of the notification of the erroneous payment determination in which to file a request for waiver, except that where an erroneous payment is not subject to waiver in accordance with §340.10(e) of this chapter, waiver may not be requested and recovery will not be stayed. Such requests shall be made in writing and be filed by mail or in person at any Board office. The claimant shall, along with the request, submit any evidence and argument which he or she would like to present in support of his or her case. A request solely for reconsideration of an overpayment shall not be considered a request for waiver under this section but shall be treated as a request for reconsideration under §320.10 of this part.

(b) *Recovery action.* Where a claimant has made a timely request for waiver of recovery, no action will be taken to recover the erroneous payment by setoff against current benefits prior to a decision on such request; *provided however,* That the Board may, prior to a decision, withhold the amount of the erroneous payment from benefit payments under any of the following circumstances:

(1) The claimant admits he or she was at fault in causing the overpayment;

(2) The claimant is found to have committed fraud;

(3) The claimant authorizes recovery by setoff or agrees to repayment; or

(4) The amount of erroneous payment is not subject to waiver or provided for in §340.10(e) of this chapter.

(c) *Review of evidence.* Upon request, the claimant shall have an opportunity to review all evidence and documents that pertain to the erroneous payment determination.

(d) *Decision.* The Debt Recovery Manager shall make a decision on the claimant's request for waiver of recovery and shall notify the claimant accordingly. The decision of the Manager shall include the basis of the decision, setting forth his or her reasons for the decision including the impact, if any, of any evidence submitted by the base-year or last employer. If the Manager decides that waiver of recovery is not appropriate, the adjudicating office shall wait 15 days from the date of the notification of the waiver decision before taking any action to recover the erroneous payment. If the Manager decides that recovery should be waived, any amount of the erroneous payment so waived but previously recovered by setoff shall be refunded to the claimant.

(e) *Appeal.* If the Debt Recovery Manager decides that waiver of recovery is

not appropriate, the claimant shall have the right to appeal such decision as provided under § 320.12 of this part.

(f) *Requests made after 60 days.* Nothing in this section shall be taken to mean that waiver of recovery will not be considered in those cases where the request for waiver is not filed within 60 days, but action to recover the erroneous payment will not be deferred if such request is not filed within 60 days, and any amount of the erroneous payment recovered prior to the date on which the request is filed shall not be subject to waiver under part 340 of this chapter. Further, it shall not be considered that a claimant prejudices his or her request for waiver by tendering all or a portion of an erroneous payment or by selecting a particular method of repaying the debt. However, no waiver consideration shall be given to a debt which is settled by compromise.

(g) *Evidence provided by base-year employer(s) and most recent employer, if different.* In making a decision under paragraph (d) of this section, the Debt Recovery Manager shall consider all evidence of record including any evidence submitted by the claimant's base-year employer(s) and the most recent employer, if different. Where a claimant has requested waiver the Manager shall notify his or her base-year employer(s) and the most recent employer, if different, of the right to submit, within 30 days, any information which may be pertinent to the waiver decision.

[56 FR 65680, Dec. 18, 1991, as amended at 67 FR 77156, Dec. 17, 2002]

§ 320.12 Appeal to the Bureau of Hearings and Appeals.

(a) Any party aggrieved by a decision under § 320.10 of this part or a claimant aggrieved by a decision under § 320.11 of this part may appeal such decision to the Bureau of Hearings and Appeals. Such an appeal shall be made by filing the form prescribed by the Board for such purpose. The appeal must be filed with the Bureau of Hearings and Appeals within 60 days from the date upon which notice of the decision on reconsideration or waiver of recovery was mailed to either a claimant or the base year employer(s). Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's or base-year employer's right to appeal, *Provided that* the claimant or base-year employer files the appeal form within the later of the 60-day period from the date of the reconsideration decision, or the 30-day period following the date of the Board's letter sending the appeal form to the claimant or base-year employer.

(b) If no appeal is filed within the time limits specified in paragraph (a) of this section, the decision of the adjudicating office under §§ 320.10 or 320.11 of this part shall be considered final and no further review of such decision shall be available unless the hearings officer finds that there was good cause for the failure to file a timely appeal as described in § 320.10 of this part.

(c) Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the Bureau of Hearings and Appeals, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

[67 FR 77157, Dec. 17, 2002]

§ 320.18 Hearings officer.

Within a reasonable time after a party has filed a properly executed appeal, the Director of Hearings and Appeals shall appoint a hearings officer to act in the appeal. Such hearings officer shall not have any interest in the parties or in the outcome of the proceeding, shall not have directly participated in the initial determination from which the appeal is made, and shall not have any other interest in the matter which might prevent a fair and impartial hearing. In any case in which employee status or creditability of compensation is an issue, the hearings officer shall receive evidence and report to the Board thereon with recommendations. In all other cases, the hearings officer shall consider and decide the appeal; in each such case where the hearings officer determines that an issue of fact exists, the parties shall have the right to a hearing.

[56 FR 65680, Dec. 18, 1991]

§ 320.19 Election to participate.

(a) *Claimant files an appeal.* Where the claimant has filed an appeal under § 320.12 of this part the hearings officer shall notify the claimant's base-year employer(s) that such an appeal has been filed and shall provide the base-year employer with a statement of issues on appeal. The hearings officer shall inform the base-year employer(s) that such employer(s) shall have a right to be present at any hearing which is to be held under this part and the right to submit evidence with respect to the issues on appeal. Within 30 days of the date of such notice a base-year employer shall provide the hearings officer with a statement in writing which summarizes the evidence which such employer intends to present with respect to the issues on appeal, which indicates whether the employer wishes to be present at any hearing which may be held, and which designates who will represent the employer with respect to the appeal. An employer who fails to respond in the time prescribed shall be barred from further participation in the appeal and shall forfeit any further right to review as provided for in this part.

(b) *Base-year employer files an appeal.* Where a base-year employer files an appeal under § 320.12 of this part, the hearings officer shall notify the claimant that such an appeal has been filed and shall provide the claimant with a statement of issues on appeal. The hearings officer shall inform the claimant that he or she or a duly authorized representative shall have a right to be present at any hearing which is to be held under this part and the right to submit evidence with respect to the issues on appeal. Within 30 days of the date of such notice the claimant shall file with the hearings officer an election to participate in the appeal. A claimant who fails to file an election in the time prescribed shall be barred from further participation in the appeal and shall forfeit any right of review as provided for in this part.

[56 FR 65680, Dec. 18, 1991]

§ 320.20 Powers of hearings officer.

In the development of an appeal, the hearings officer shall have the power to hold hearings, require and compel the attendance of witnesses, administer oaths, take testimony, and make all necessary investigations.

§ 320.22 Notice of hearing.

(a) *Notification of parties.* At the discretion of the hearings officer, any hearing required under this part may be held in person, by telephone conference call, or by video teleconferencing as described in § 320.25(d). The hearings officer shall promptly notify the party or parties to the proceeding by mail as to said time and place for the hearing. The notice shall include a statement of the specific issues involved in the case. The hearings officer shall make every effort to hold the hearing within 150 days after the date the appeal is filed.

(b) *Notice of objection.* A party to the proceeding may object to the time and place of the hearing, or as to the stated issues to be resolved, by filing a written notice of objection with the hearings officer. The notice of objection shall clearly set forth the matter objected to and the reasons for such objection, and, if the matter objected to is the time and place of the hearing, said notice shall further state that party's choice as to the time and place for the hearing. Said notice of objection shall be filed at the earliest practicable time, but in no event shall said notice be filed later than five business days prior to the scheduled date of the hearing.

(c) *Ruling on objection.* The hearings officer shall rule on any objection timely filed by a party under this section and shall notify the party of his or her ruling thereon. The hearings officer may for good cause shown, or upon his or her own motion, reschedule the time and/or place of the hearing. If an individual objects to having a hearing by video teleconferencing, the hearings officer will find the individual's wish not to appear by video teleconferencing to be a good reason for changing the time or place of the scheduled hearing and will reschedule the hearing for a time or place where a telephone conference call or an in person hearing will be held. The hearings officer also may limit or expand the issues to be resolved at the hearing.

(d) *Failure to appear or to file objection.* If neither a party nor his or her representative appears at the time and place scheduled for the hearing, that party shall be deemed to have waived his or her right to an oral hearing unless said party either filed with the hearings officer a notice of objection showing good cause why the hearing should have been rescheduled, which notice was timely filed but not ruled upon, or, within 10 days following the date on which the hearing was scheduled, said party files with the hearings officer a motion to reschedule the hearing showing good cause why neither the party nor his or her representative appeared at the hearing and further showing good cause as to why said party failed to file at the prescribed time any notice of objection to the time and place of the hearing.

(e) *Rescheduling the hearing.* If the hearings officer finds either that a notice of objection was timely filed showing good cause to reschedule the hearing, or that the party has within 10 days following the date of the hearing filed a motion showing good cause for failure to appear and to file a notice of objection, the hearings officer shall reschedule the hearing. If the hearings officer finds that the hearing shall not be rescheduled, he or she shall so notify the party in writing.

[53 FR 2488, Jan. 28, 1988, as amended at 71 FR 55283, Sept. 22, 2006]

§ 320.25 Hearing of appeal.

(a) *Manner of conducting hearing.* The hearing shall be informal, fair, and impartial, and shall be conducted in such manner as to ascertain the substantial rights of the parties. The hearing shall not be open to the public.

(b) *Evidence presented in support of appeal.* (1) Any party, or his or her representative, shall be afforded full opportunity to present evidence upon any controversial question of fact, orally or in writing or by means of exhibits; to examine and cross-examine witnesses; and to present argument in support of the appeal.

(2) The formal rules of evidence shall not apply; however, the hearings officer may exclude evidence which he or she finds is irrelevant or repetitious. Any evidence excluded by the hearings officer shall be described and that description made part of the record.

(3) If, in the judgment of the hearings officer, evidence not offered is available and is relevant and material to the merits of the claim, the hearings officer may obtain such evidence upon his or her own initiative. If new evidence is obtained after an oral hearing, other than evidence submitted by a party or his representative, the hearings officer shall provide the parties or their representatives with a copy of such evidence. In such event, any party shall have 30 days to submit rebuttal evidence or argument or to request a supplemental hearing to confront and challenge such new evidence. Any party may move for an extension of time to submit rebuttal evidence or argument and the hearings officer may grant the motion upon a showing of good cause.

(c) *Where no oral hearing required.* Where the hearings officer finds that no factual issues are presented by an appeal, and the only issues raised by the parties are issues concerning the application or interpretation of law, the parties or their representatives shall be afforded full opportunity to submit written argument in support of their position but no oral hearing shall be held.

(d) *Hearing by telephone or video teleconferencing.* As stated in § 320.22(a), at the discretion of the hearings officer, any hearing required under this part may be conducted in person, by telephone conference call, or by video teleconferencing. The hearings officer may determine the hearing should be conducted by telephone conference call or video teleconferencing if use of these methods would be more efficient than conducting an in person hearing and the hearings officer does not determine that there is a circumstance in the particular case preventing the use of these methodologies to conduct the hearing.

[Board Order 58–142, 23 FR 9090, Nov. 22, 1958, as amended at 56 FR 65681, Dec. 18, 1991; 67 FR 77157, Dec. 17, 2002; 71 FR 55284, Sept. 22, 2006]

§ 320.28 Record of evidence considered.

The hearings officer will make a record of the material evidence. The

record will include the applications, written statements, reports, and other documents that were used in making the determination under review and any other additional evidence the appellant or any other party to the hearing presents in writing. If a hearing was held in the appeal, the tape recording of the hearing will be part of the record while the appeal is pending. The hearings officer's decision will be based on the record. The entire record at any time during the pendency of the appeal shall be available for examination by any party or by his or her duly authorized representative.

[67 FR 77157, Dec. 17, 2002]

§ 320.30 Decision or report of hearings officer.

As soon as practicable after the completion of the record, the hearings officer shall render his decision, or submit his report to the Board, as may be appropriate in the case. The decision or report shall be based on the record and shall be in writing. Such decision shall contain a brief statement of (a) the issue or issues raised, (b) the evidence submitted, (c) findings of fact, (d) the decision made, and (e) the reasons therefor. Such report shall contain a statement of (1) the issue or issues raised, (2) the evidence submitted, (3) findings of fact, (4) conclusions of law, (5) recommendations as to the decision to be made by the Board, and (6) such discussion of the foregoing as the hearings officer may desire to present to the Board. Within 15 days after rendition of the decision or submission of the report, a copy of the decision or report shall be mailed to each party at the last address of record. In the case of a report, a copy of the transcript of the hearing, if any was held, shall also be mailed to each party.

[Board Order 66–84, 31 FR 10181, July 28, 1966, as amended at 56 FR 65681, Dec. 18, 1991]

§ 320.32 Effect of decision of hearings officer.

A decision of the hearings officer, subject to review as hereinafter provided, shall be binding upon any adjudicating office and upon all parties;

(a) With respect to the initial determination involved, and

(b) With respect to other initial determinations, irrespective of whether they have been appealed, which involved the same parties and which were based upon the same issue or issues determined in the decision of the hearings officer.

[56 FR 65681, Dec. 18, 1991]

§ 320.35 Review of decision of hearings officer on motion of Board.

The Board may, on its own motion, review a decision of the hearings officer on the basis of the evidence previously submitted in the case, and may designate any employee of the Board to take additional evidence and to report his findings to the Board.

§ 320.38 Appeal to Board from decision of hearings officer.

Any claimant aggrieved by a decision of the hearings officer and any base-year employer(s) whose employee was awarded benefits, who participated in the appeal before the hearings officer, may appeal to the Board for review of the decision.

[56 FR 65681, Dec. 18, 1991]

§ 320.39 Execution and filing of appeal to Board from decision of hearings officer.

(a) An appeal to the Board from the decision of a hearings officer shall be filed on the form provided by the Board and shall be executed in accordance with the instructions on the form. Such appeal shall be filed within 60 days from the date upon which notice of the decision of the hearings officer was mailed to the parties. The right to further review of a decision of a hearings officer shall be forfeited unless formal final appeal is filed in the manner and within the time prescribed in this section. Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's right to appeal, *Provided that* the claimant files the appeal form within the later of the 60-day period following the date of the hearing officer's decision, or the 30-day period following the date of the letter sending the appeal form to the claimant. However, when a party fails to file an appeal before the Board within the time

prescribed in this section, the Board may waive this requirement if along with the final appeal, the party in writing requests an extension of time. The request for an extension of time must give the reasons why the final appeal form was not filed within the time limit prescribed in this section. If in the judgment of the Board the reasons given establish that the party has good cause for not filing the final appeal form within the time limit prescribed, the Board will consider the appeal to have been filed in a timely manner. The Board will use the standards found in § 320.10(e) of this part in determining if good cause exists.

(b) Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the three-member Board, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

[67 FR 77157, Dec. 17, 2002; 68 FR 6820, Feb. 11, 2003]

§ 320.40 Procedure before the Board on appeal from a decision of a hearings officer.

Upon the filing of an appeal to the Board from a decision of a hearings officer, the Secretary to the Board shall notify all parties to the decision of the hearings officer that an appeal has been filed. The parties shall not have the right to submit additional evidence, except that:

(a) The Board may permit the submission of additional evidence upon a showing by a party that he or she has additional evidence to present which, for valid reasons, he or she was unable to present at an earlier stage;

(b) The Board may request the submission of additional evidence; and

(c) The Board may designate any employee of the Board to take additional evidence and to report his or her findings to the Board. Any such additional evidence shall be submitted in such manner as the Board may indicate and shall be included in the record.

(d) Any party may submit additional argument in writing with the appeal to the Board. No party shall have the right to an oral presentation before the Board except where the Board so permits. Such presentation may be limited in form, subject matter, length, and time as the Board may indicate to the parties.

[56 FR 65681, Dec. 18, 1991, as amended at 67 FR 77158, Dec. 17, 2002]

§ 320.41 Procedure before Board after submission of report by hearings officer.

(a) After submission to the Board of a hearings officer's report, in an appeal involving employee status or the creditability of compensation, any party to the proceeding may, within twenty days after the mailing to him of a copy of the report, file with the Board and serve upon other parties by mailing to their last addresses of record such exceptions in writing as he desires to make to the hearings officer's findings of fact and conclusions of law. Each exception shall specifically designate the particular finding of fact or conclusion of law to which exception is taken, and shall set forth in detail the grounds of the exception. General exceptions and exceptions not specifically directed to particular findings of fact or conclusions of law will not be considered. Each party shall have ten days after the receipt of exceptions taken by other parties in which to file with the Board replies to the exceptions. The Board may, upon the application of any party and for cause shown, extend the time for filing and serving of exceptions or filing of replies thereto. The hearings officer's report shall be advisory but shall be presumed to be correct. Findings of fact to which no exceptions are taken will, subject only to the power of the Board to reject or modify, stand confirmed.

(b) Further argument will not be permitted except upon a showing by any party that he has arguments to present which for valid reasons he was unable to present at an earlier stage, and in cases in which the Board requests further elaboration of arguments. In such cases, the further argument shall be submitted orally or in writing, as the Board may indicate in each case, and shall be subject to such restrictions as

to form, subject matter, length, and time as the Board may indicate.

§ 320.42 Decision of Board.

The decision of the Board, whether on an appeal to the Board from a decision of a hearings officer, or after submission of a report by a hearings officer, shall be made upon the basis of the record established in accordance with the foregoing sections. Notice of such decision, together with the Board's findings of fact and conclusions of law in connection therewith, shall, within 15 days from the date on which the decision is made, be mailed to the parties at the latest addresses furnished by them. Subject only to judicial review in accordance with § 320.45, the decision of the Board shall be final and conclusive for all purposes:

(a) With respect to the initial determination involved, and

(b) With respect to other initial determinations, irrespective of whether they have been appealed, which involve the same parties and which were based on the same issue or issues determined in the decision of the Board. In a case in which there has been a hearings officer's report, in an appeal involving employee status or the creditability of compensation, the decision of the Board on all issues determined in such decision shall be final and conclusively establish all rights and obligations, arising under the Act, of every party notified as hereinabove provided of his or her right to participate in the proceedings.

[Board Order 66–84, 31 FR 10181, July 28, 1966, as amended at 56 FR 65681, Dec. 18, 1991]

§ 320.45 Judicial review.

Upon being notified of a decision of the Board made (a) upon review, on the Board's own motion, of a decision of a hearings officer, or (b) upon an appeal to the Board, an aggrieved party may obtain judicial review of such final decision, by filing a petition for review within ninety days after the date on which notice of such decision was mailed to him, or within such further time as the Board may allow, in the U.S. Court of Appeals for the circuit in which the party resides or will have had his principal place of business or principal executive office, or in the U.S. Court of Appeals for the Seventh Circuit or in the Court of Appeals for the District of Columbia.

[Board Order 58–142, 23 FR 9090, Nov. 22, 1958, as amended at 56 FR 65682, Dec. 18, 1991]

§ 320.48 Representatives of parties.

In the event a party to any proceeding within the Board, under the preceding regulations in this part, desires to be represented by another person, he shall file with the Board prior to the time of such representation a power of attorney signed by him and naming such other person as the person authorized to represent him: *Provided, however*, That without requiring such power of attorney the Board may recognize as the duly authorized representative of the claimant the person designated by the claimant's railway labor organization to act in behalf of members of that organization on such matters whenever such representative acts or appears for such claimant.

§ 320.49 Determination of date of filing.

(a) *General rule.* Except as otherwise provided in paragraph (b) of this section, for purposes of this part, a document or form is filed on the day it is received by an office of the Board or by an employee of the Board who is authorized to receive it at a place other than one of the Board's offices.

(b) *Other dates of filing.* The Board will also accept as the date of filing the date a document or form is mailed to the Board by the United States mail, if using the date the Board receives it would result in the loss or lessening of rights. The date shown by a U.S. postmark will be used as the date of mailing. If the postmark is unreadable, or there is no postmark, the Board will consider other evidence of when the document or form was mailed to the Board.

(c) *Use of electronic mail.* By agreement between a base-year employer and the Board, any document required to be filed with the Board or any notice required to be sent to the employer may be transmitted by electronic mail.

[67 FR 77158, Dec. 17, 2002]

PART 321—ELECTRONIC FILING OF APPLICATIONS AND CLAIMS FOR BENEFITS UNDER THE RAILROAD UNEMPLOYMENT INSURANCE ACT

Sec.
321.1 Filing applications electronically.
321.2 Filing claims for benefits electronically.

AUTHORITY: 45 U.S.C. 355 and 362(l).

SOURCE: 69 FR 32260, June 9, 2004, unless otherwise noted.

§ 321.1 Filing applications electronically.

(a) *Electronic filing.* An application for benefits under the Railroad Unemployment Insurance Act may be filed electronically through the Board's Internet Web site, *http://www.rrb.gov,* utilizing a User ID and a PIN/Password.

(b) *Adjudication of applications filed electronically.* An application filed electronically shall be adjudicated in accordance with the procedures set forth in this part.

(c) *Date of filing.* The date of filing for an application filed electronically shall be the date that the electronic filing of the application is accepted by the Board's electronic system. If an attempt to file an application through the Board's electronic system is unsuccessful and is rejected by that system, the claimant must submit another application. If the subsequent application, filed either electronically or on paper, is received by the Board within 30 days from the date of the notification that the initial filing attempt was rejected, the Board will establish the filing date of the subsequent application as the date the rejected application was attempted to be filed.

§ 321.2 Filing claims for benefits electronically.

(a) *Electronic filing.* A claim for benefits under the Railroad Unemployment Insurance Act may be filed electronically through the Board's Internet Web site, *http://www.rrb.gov,* utilizing a User ID and a PIN/Password.

(b) *Adjudication of claims filed electronically.* A claim for benefits under the Railroad Unemployment Insurance Act filed electronically shall be adjudicated in accordance with the procedures set forth in this part.

(c) *Date of filing.* The date of filing for a claim for benefits under the Railroad Unemployment Insurance Act filed electronically shall be the date that the electronic filing of the claim is accepted by the Board's electronic system. If an attempt to file a claim for benefits under the Railroad Unemployment Insurance Act is unsuccessful and is rejected by the Board's electronic system, the claimant must submit another claim for benefits. If the subsequent claim for benefits, either filed electronically or on paper, is received by the Board within 30 days from the date of the notification that the initial filing was rejected, the Board will establish the filing date of the subsequent claim as the date the rejected claim was attempted to be filed.

PART 322—REMUNERATION

Sec.
322.1 Introduction.
322.2 General definition of remuneration.
322.3 Determining the days with respect to which remuneration is payable or accrues.
322.4 Consideration of evidence.
322.5 Payments under vacation agreements.
322.6 Pay for time lost.
322.7 Dismissal, coordination, and separation allowances.
322.8 Miscellaneous income.
322.9 Subsidiary remuneration.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: Board Order 59–73, 24 FR 2487, Mar. 31, 1959, unless otherwise noted.

§ 322.1 Introduction.

The Railroad Unemployment Insurance Act provides benefits for a qualified employee's days of unemployment or days of sickness, as defined in section 1(k) of the Act. Under that section, no day can be a day of unemployment or a day of sickness for any employee if ''remuneration'' is payable or accrues to the employee for such day. In computing the amount of benefits payable to an employee for days of unemployment or days of sickness in any registration period, or in determining whether the employee has satisfied the waiting period requirement, the Board will not count any day with respect to

which remuneration is payable or accrues to the employee. Section 322.2 defines the term ''remuneration'' and explains what types of payments to employees constitute remuneration.

[65 FR 14459, Mar. 17, 2000]

§ 322.2 General definition of remuneration.

(a) *Remuneration.* (1) Remuneration includes pay for services for hire, pay for time lost as defined in § 322.6, and other earned income payable or accruing with respect to any day. Income is ''earned'' if it is payable or accrues in consideration of services and if such services were in turn rendered in consideration of the income payable or accruing.

(2) Remuneration includes income in the form of a commodity, service, or privilege if, before the performance of the service for which it is payment, the parties have agreed upon the value of such commodity, service, or privilege, and that such part of the amount agreed upon to be paid may be paid in the form of such commodity, service, or privilege.

(3) Remuneration for a working day that includes a part of two consecutive calendar days is deemed to have been earned on the first of such two days.

(b) *Subsidiary remuneration.* For the purpose of this part, remuneration does not include subsidiary remuneration, as defined in § 322.9. Subsidiary remuneration for any day does not prevent such day from being a day of unemployment or a day of sickness, except as explained in § 322.9.

(c) *Supplemental unemployment or sickness benefits.* The term remuneration does not include money payments received by an employee pursuant to any nongovernmental plan for unemployment or sickness insurance, as defined in part 323 of this chapter. Employer payments of sick pay to an employee are remuneration, except when payment is made pursuant to a nongovernmental plan for sickness insurance.

[65 FR 14459, Mar. 17, 2000]

§ 322.3 Determining the days with respect to which remuneration is payable or accrues.

(a) *Payable or accrues.* In determining whether remuneration is ''payable'' or ''accrues'' to an employee with respect to a claimed day or days, consideration shall be given to such factors as

(1) The intention of the parties with respect to the remuneration as indicated in employment contracts, in any expressed or implied agreements between the parties, and by the actions of the parties;

(2) Any evidence, such as vouchers or agreement of the parties, relating the remuneration to a particular period of time or indicating that the remuneration accrued or became payable without reference to any particular period of time;

(3) The measure by which the amount of remuneration was determined;

(4) Whether the amount of the remuneration is proportionate to the length of time needed to render the service for which it is payment;

(5) Whether the service for which the remuneration accrues is required to be rendered on any particular day or particular days; and

(6) Whether a specified amount of the remuneration is contingent upon a result accomplished on a particular day or particular days.

(b) *Layover days.* Remuneration shall not be regarded as payable or accruing to an employee with respect to his or her ''layover'' days between regular assignments in train and engine service solely because they are termed ''layover'' days. But no such ''layover'' day may be considered as a day of unemployment or sickness. See § 332.6 of this chapter.

(c) *Guaranteed earnings.* A payment under a plan which guarantees an amount of earnings or mileage in a specified period is remuneration with respect to each day in the specified period.

(d) *Equivalent of full-time work.* An employee who works fewer than five days each week under a compressed work schedule that provides the equivalent of full-time employment does not earn remuneration with respect to his or her additional rest days resulting

from such work schedule, but such employee will not be considered to be available for work on such rest days. See § 327.10(d) of this chapter.

[Board Order 59–73, 24 FR 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.4 Consideration of evidence.

(a) *Initial proof.* A claimant's certification that he or she did not work on any day claimed and did not receive income such as vacation pay or pay for time lost for any such day shall constitute sufficient evidence for an initial finding that no remuneration is payable or has accrued to him or her with respect to such day, unless a base year employer reports that he or she worked on days claimed or received payments that constitute remuneration as defined in this part, or unless there is other conflicting evidence.

(b) *Investigation.* When there is a question as to whether or not remuneration is payable or has accrued to a claimant with respect to a claimed day or days, investigation shall be made with a view to obtaining information sufficient for a finding.

(Approved by the Office of Management and Budget under control number 3220–0049)

[Board Order 59–73, 24 FR 2487, Mar. 31, 1959, as amended at 52 FR 11017, Apr. 6, 1987; 65 FR 14460, Mar. 17, 2000]

§ 322.5 Payments under vacation agreements.

(a) *General.* In ascertaining the accrual of remuneration under a vacation agreement, consideration shall be given to the applicable agreements and practices, the interpretations of such agreements and practices developed by the parties, and the actions of the parties pursuant thereto. When there is information that an employee has received or is to receive payment under a vacation agreement, such payment shall, in the absence of evidence to the contrary, be considered to be remuneration with respect to the days to which the payment is assigned.

(b) *Vacation pay.* If an employee takes a vacation in accordance with a vacation agreement, the payment for such vacation shall constitute remuneration with respect to the days in the vacation period for which the payment is made. An employee shall be regarded as taking a vacation when, in accordance with the applicable agreements and practices (1) he is absent from work during a scheduled or assigned vacation period; (2) he is required to take his vacation with pay while he is on furlough; or (3) he chooses to take his vacation with pay while he is unemployed or absent from work due to illness or other personal circumstances.

(c) *Pay in lieu of vacation.* If a payment in lieu of vacation is made to an employee under a vacation agreement such payment shall not constitute remuneration with respect to any particular day or days. A payment under a vacation agreement shall be regarded as in lieu of vacation if:

(1) The payment is made at the end of the vacation year to an employee who did not take his vacation during such year; or

(2) The payment is made after the employee's death, or after he ceased service for the purpose of receiving an annuity, and the payment is credited to the employee's last day of service; or

(3) It is otherwise established that the parties intended the payment to be in lieu of vacation, without reference to any particular period.

[Board Order 59–73, 24 FR 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.6 Pay for time lost.

(a) *Definition.* The term ''pay for time lost'' means any payment made to an employee with respect to an identifiable period of time during which the employee was absent from the active service of the person or company making the payment, including absence on account of personal injury. The entire amount paid to an employee who was absent on account of personal injury is pay for time lost if such amount includes pay for time lost, unless at the time of payment the parties, by agreement, specify a different amount as the amount of the pay for time lost and the period of time covered by such pay. The amount allocated to time lost is remuneration for every day in the period of time lost. The amount of a payment for personal injury that is apportioned to factors other than time lost

is, nevertheless, a portion of ''damages'' for the purposes of part 341 of this chapter.

(b) *Employment relationship required.* Pay for time lost shall not be deemed to have been earned on any day after the day of the employee's resignation or other termination of his employment relationship.

(c) *Initial evidence.* A report that an employee has received or is to receive pay for time lost shall, in the absence of evidence to the contrary, be considered sufficient for a finding that remuneration is payable with respect to each day in the period to which the pay is assigned.

[Board Order 59–73, 24 FR 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.7 Dismissal, coordination, and separation allowances.

(a) *Coordination or dismissal allowance.* Coordination or dismissal allowances are payments made to an employee who has been furloughed for a specified period of time during which he or she continues in an employment relationship and remains subject to call. Such pay is remuneration with respect to each day in the month or other period for which it is payable. The employer shall be held liable to the Board for any benefits paid to the employee and found recoverable under section 2(f) of the Railroad Unemployment Insurance Act by reason of the payment of any such allowances or other pay for the same days for which the Board paid benefits.

(b) *Separation allowance.* A separation allowance or severance payment made to an employee who voluntarily or involuntarily terminates his or her employment relationship is not remuneration with respect to any day after the employment relationship is severed. An employee who is paid a separation allowance, whether in a lump sum or in installments, is disqualified by section 4(a–1)(iii) of the Railroad Unemployment Insurance Act from receiving unemployment or sickness benefits for the period of time approximating the length of time it would have taken the employee to earn, at his or her ''straight'' time rate of pay, the amount of the separation allowance if he or she had continued working in the job from which he or she separated.

[65 FR 14460, Mar. 17, 2000]

§ 322.8 Miscellaneous income.

(a) *Income from self-employment.* In determining whether income from self-employment is remuneration with respect to a particular day or particular days, consideration shall be given to whether, and to what extent, (1) such income can be related to services performed on the day or days and (2) the expenses of the self-employment can be attributed to the day or days. Income from services performed by an individual on a farm which he owns or rents, or in his own mercantile establishment, ordinarily is not remuneration with respect to any day.

(b) *Income from investment.* Income in the form of interest, dividends, and other returns on invested capital which is not coupled with the rendition of personal services shall not be regarded as remuneration.

(c) *Commissions on sales.* Commissions on sales shall be regarded as remuneration with respect to the day or days on which sales are made.

(d) *Payments for service as a public official.* In determining whether income for service as a public official is remuneration and, if so, the particular day or days with respect to which such remuneration is payable or accrues, consideration shall be given to such factors as—

(1) The amount of the income;

(2) The terms and conditions of payment;

(3) The character and extent of the services rendered;

(4) The importance, prestige, and responsibilities attached to the position;

(5) The day or days on which services, or readiness to perform services, are required; and

(6) The provisions of the applicable statutes.

(e) *Payments to local lodge officials.* A payment by a local lodge of a labor organization to an employee for services as a local lodge official shall be regarded as subsidiary remuneration if such payment does not exceed an average of $15 a day for the period with respect to which it is payable or accrues, unless there is information that the

work from which the payment is derived does not require substantially less than full time as determined by generally prevailing standards, or is not susceptible of performance at such times and under such circumstances as not to be inconsistent with the holding of normal full-time employment in another occupation.

(f) *Public relief payments.* Public relief payments made in consideration of need shall not be regarded as remuneration.

[Board Order 59–73, 24 FR 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.9 Subsidiary remuneration.

(a) *Definition.* The term ''subsidiary remuneration'' means remuneration not in excess of an average of $15 per day for the period with respect to which it is payable or accrues, if

(1) The work from which the remuneration derives requires substantially less than full time as determined by generally prevailing standards; and

(2) The work is susceptible of performance at such times and under such circumstances as not to be inconsistent with the holding of normal full-time employment in another occupation.

(b) *Exception.* If a claimant's remuneration is ''compensation'' as defined in part 302 of this chapter, such remuneration is not subsidiary unless the claimant had base year compensation from a different position or occupation of not less than two and one-half times the monthly compensation base for months in the base year in which he or she received the remuneration. Compensation in excess of an average of $15 per day is remuneration for the days for which it is payable or accrues.

(c) *Period for which remuneration is payable or accrues.* The ''period'' of time used in determining whether remuneration averages more than $15 per day depends on the terms and conditions of the employment and the rate of payment for the work. If the claimant is paid a monthly salary, the ''month'' is the period with respect to which the pay must average not more than $15 per day. The average is the monthly salary divided by 30. If the claimant is paid a weekly salary, the amount of the salary is divided by seven. If the claimant is paid by the hour or the day, the ''period'' is the day. Where payment is made by the hour or the day, the pay is not added up and then averaged out over the week or the month. For example, earnings of $20 on one day and $10 on another day do not average out to $15 per day so as to permit both days to be considered as days of unemployment or days of sickness.

(d) *Substantially less than full time.* The phrase ''substantially less than full time'' means employment of not more than four hours per day.

(e) *Compatibility with full time employment.* Work is considered to be susceptible of performance at such times and under such circumstances as not to be inconsistent with the holding of normal full-time employment in another position or occupation if it is a form of secondary employment that a claimant has done or could do at his or her own convenience while performing the duties of his or her railroad job.

(f) *Determinations.* The Board shall make a determination whether remuneration is subsidiary by applying the standards in this section to the facts of each case. Earnings that average more than $15 per day are not subsidiary remuneration under any circumstances. Also, earnings of any amount that are included in a claimant's qualifying base year compensation are not subsidiary remuneration. Even if earnings do not exceed an average of $15 per day, they may still not be subsidiary remuneration if the claimant worked more than four hours per day or if the work had to be performed at such times and under such circumstances as to be inconsistent with the holding of normal full-time work in his or her regular railroad work. If the evidence does not establish that the earnings are subsidiary remuneration, the question whether they are remuneration for particular days will then be considered.

(g) *Examples.* The following examples illustrate this section.

(1) A claimant receives a salary of $350 per month for serving as secretary-treasurer of the local lodge of his union. He performs a variety of duties at his own convenience while holding down a full-time railroad job in his craft. The average payment per day is not more than $15 and is, therefore, subsidiary remuneration.

(2) A claimant worked three hours per day, at $5 per hour, in the family insurance business. He was marked up for work as an extra board trainman and worked whenever he was called. When called, he skipped work in the family insurance business. His insurance earnings of $15 per day were subsidiary remuneration.

(3) While unemployed from her railroad job, a claimant took a job as a school bus driver. She worked from 7 a.m. to 9 a.m., and 2:30 p.m. to 5:30 p.m. Her regular railroad job was a daytime job from 8 a.m. to 4:30 p.m. Her pay as a school bus driver was not subsidiary remuneration because the job was not compatible with the holding of full time work in her regular railroad occupation.

[65 FR 14460, Mar. 17, 2000]

PART 323—NONGOVERNMENTAL PLANS FOR UNEMPLOYMENT OR SICKNESS INSURANCE

Sec.

323.1 Introduction.
323.2 Definition of nongovernmental plan for unemployment or sickness insurance.
323.3 Standards for Board approval of a nongovernmental plan.
323.4 Guidelines for content of a nongovernmental plan.
323.5 Submitting proposed plan for Board approval.
323.6 Treatment of benefit payments under a nongovernmental plan for purposes of contributions.
323.7 Effective date.

AUTHORITY: 45 U.S.C. 362(1).

SOURCE: 56 FR 26328, June 7, 1991, unless otherwise noted.

§ 323.1 Introduction.

(a) This part defines the phrase *nongovernmental plan for unemployment or sickness insurance* and sets forth the procedure by which an employer may obtain a determination by the Railroad Retirement Board as to whether a particular plan that such employer maintains for its employees qualifies as a nongovernmental plan. In general, any payment by an employer to an employee for services rendered as an employee will be considered to be *remuneration* within the meaning of section 1(j) of the Railroad Unemployment Insurance Act and part 322 of this chapter. This includes employer payments that relate to an employee's loss of earnings during a period of time when the employee is unemployed or sick, including sickness resulting from injury. The exception is when an employer pays an employee a benefit pursuant to the provisions of a nongovernmental plan for unemployment or sickness insurance established by an employer for the benefit of its employees. Benefit payments under such plans are not remuneration and do not affect an employee's eligibility for unemployment or sickness benefits under the Railroad Unemployment Insurance Act.

(b) This part does not have any general applicability to private insurance contracts under which an insurance company, pursuant to a policy of insurance maintained by or for an employee, pays medical or hospital expenses or other cash benefits to or in behalf of an employee. Nor does this part apply to any private plan for relief of unemployment established by a party other than an employer such as, for example, a plan established by a labor union under which it undertakes to pay benefits to striking members of the union out of a strike insurance fund. Insurance policy benefits and strike unemployment benefits, although paid under plans that are nongovernmental in nature, are not considered remuneration for services under the general definition of *remuneration*. See part 322 of this chapter.

§ 323.2 Definition of nongovernmental plan for unemployment or sickness insurance.

A nongovernmental plan for unemployment or sickness insurance is a benefit plan, program or policy that is in the nature of insurance and is designed and established by an employer for the purpose of supplementing the benefits that an employee of such employer may receive under the Railroad Unemployment Insurance Act during a period of unemployment or sickness. A nongovernmental plan may be established by labor-management agreement or by unilateral employer action. Payments under such plans are referred to

as supplemental unemployment benefits (SUB pay) or supplemental sickness benefits, rather than as wages, salary or pay for time lost, because their inherent nature is to supplement benefit payments under the Railroad Unemployment Insurance Act rather than to replace or duplicate such payments.

§ 323.3 Standards for Board approval of a nongovernmental plan.

An unemployment or sickness benefit plan qualifies as a nongovernmental plan if it conforms to the following standards:

(a) The plan is in writing and has been published or otherwise communicated to covered employees prior to the inception of the plan;

(b) Benefits under the plan are payable only to employees who are involuntarily laid off or separated from the service of the employer or who are absent from work on account of illness or injury;

(c) Payment of benefits under the plan is conditioned upon a covered employee's meeting the eligibility conditions governing payment of benefits under the Railroad Unemployment Insurance Act. However, a plan will not be disqualified merely because it:

(1) Provides benefits during any waiting period required under the Railroad Unemployment Insurance Act, or

(2) Provides benefits after an employee has exhausted rights to benefits under the Railroad Unemployment Insurance Act, or

(3) Provides benefits during a period when the employee is not a ''qualified employee'', within the meaning of part 302 of this chapter;

(d) Payment of benefits under the plan is coordinated with benefit payments to which the employee may be entitled under the Railroad Unemployment Insurance Act. In general, plan benefit payments will be considered coordinated with Railroad Unemployment Insurance Act benefit payments when computation of the plan benefits takes Railroad Unemployment Insurance Act benefit entitlement into consideration in such a way as to make it clear that the plan is supplementing Railroad Unemployment Insurance Act benefit payments for days of unemployment or days of sickness. For example, a plan that provides for payment of a specified daily benefit amount is considered coordinated with Railroad Unemployment Insurance Act benefit payments if the plan provides that the daily benefit amount otherwise payable to the employee is reduced by the amount of benefits that the employee received or could receive under the Railroad Unemployment Insurance Act for the same day if the employee had met all the eligibility criteria for such benefit. Similarly, there is acceptable coordination if the plan simply provides for payment of an amount as an ''add-on'' benefit to the amount of Railroad Unemployment Insurance Act benefits paid or payable. On the other hand, a plan that allows payment so as to compensate an employee for railroad or non-railroad earnings that are lower in amount than what the employee would get under the plan if he or she were not employed is not considered coordinated with benefit payments under the Railroad Unemployment Insurance Act because an employer payment made under such circumstances supplements earnings rather than benefit payments under the Railroad Unemployment Insurance Act. No Railroad Unemployment Insurance Act benefits are payable to an employee who is earning remuneration from railroad or non-railroad employment. Employer payments that make up for low earnings are pay for time lost and therefore are *compensation* and *remuneration*;

(e) The plan confers upon covered employees an enforceable right to the benefits under the plan. The plan may not commit to management discretion any decision as to whether such employee will actually be paid the benefits to which he is entitled under the plan or the amount to be paid;

(f) The plan may not provide benefits to a covered employee in an amount that, when added to his or her Railroad Unemployment Insurance Act benefits, is greater than the wages of salary that would have been paid if the employee were employed; and

(g) The plan incorporates the features set forth in § 323.4 of this part and has been approved by the Board's Director of Unemployment and Sickness

Insurance as a nongovernmental plan for unemployment or sickness insurance.

§ 323.4 Guidelines for content of a nongovernmental plan.

At a minimum, a nongovernmental plan for unemployment or sickness insurance should contain the following features:

(a) The title of the plan (e.g., Supplemental Unemployment Benefit Plan or Supplemental Sickness Benefit Plan);

(b) A statement of purpose, such as the following:

> There is hereby established a nongovernmental plan for (unemployment insurance) (sickness insurance) [specify which one] within the meaning of section 1(j) of the Railroad Unemployment Insurance Act. The purpose of this plan is to supplement the benefits that an eligible employee may receive under that Act and not to replace or duplicate such benefits. Payments under this plan are designed as one of the benefits of employment with [name of employer] and are not intended as pay for time lost or any other form of remuneration for services rendered as an employee;

(c) A statement as to which class or craft of employees, or other specified group of employees, is covered by the plan;

(d) The criteria governing a particular covered employee's eligibility for supplemental benefits under the plan;

(e) The dollar amount of supplemental benefits payable on a periodic basis to an eligible employee, the duration of supplemental benefits, how such benefits will be computed, and the conditions under which an employee will be disqualified or benefit payments reduced or terminated; and

(f) The identity of the plan administrator and the procedure by which a covered employee may claim supplemental benefits under the plan, including forms to be filed (if any), how to file, the time limit for filing, and how an employee may appeal from a denial of supplemental benefits.

§ 323.5 Submitting proposed plan for Board approval.

An employer shall submit each proposed plan, or a proposed revision to an existing plan, to the Director of Unemployment and Sickness Insurance, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. The Director shall determine whether the plan or revision conforms to this part. Approval shall be effective as of the effective date of the plan. If not approved, the Director will advise the employer in which particular respects the proposed plan or revision does not conform to this part.

§ 323.6 Treatment of benefit payments under a nongovernmental plan for purposes of contributions.

Benefit payments under nongovernmental plans approved by the Board under this part are not *compensation* as defined in section 1(i) of the Railroad Unemployment Insurance Act, and therefore they are not subject to contribution under part 345 of this chapter.

§ 323.7 Effective date.

(a) This part shall not apply to a plan approved by the Director of Unemployment and Sickness Insurance prior to the effective date of this part. However, it shall apply to any proposed revision to such plan.

(b) Any plan in effect on the effective date of this part that has not been approved by the Director of Unemployment and Sickness Insurance shall be considered a proposed plan for purposes of § 323.5.

PART 325—REGISTRATION FOR RAILROAD UNEMPLOYMENT BENEFITS

Sec.
325.1 General.
325.2 Procedure for registering for unemployment benefits.
325.3 Application for unemployment benefits and employment service.
325.4 Claim for unemployment benefits.
325.5 Death of employee.
325.6 Verification procedures.

AUTHORITY: 45 U.S.C. 362(i) and 362(l).

SOURCE: 54 FR 24551, June 8, 1989, unless otherwise noted.

§ 325.1 General.

(a) *Day of unemployment.* A ''day of unemployment'' is a calendar day on which an employee, although ready and willing to work, is unemployed, and on

which no remuneration is payable and for which the employee has registered, as required by this part. The amount of compensable days of unemployment shall be computed in accordance with this section.

(b) *Registration period.* Except for registration periods in extended unemployment benefit periods, a ''registration period'' means a period of 14 consecutive days beginning with the first day for which an employee registers following:

(1) His or her last day of work, or

(2) The last day of the employee's last preceding registration period, and with respect to which the employee properly files a claim for benefits on such form and in such manner as the Board prescribes.

(c) *General waiting period.* Benefits are payable to any qualified employee for each day of unemployment in excess of seven during his or her first registration period in a period of continuing unemployment if such period of continuing unemployment is his or her initial period of continuing unemployment beginning in the benefit year, and then for each day of unemployment in excess of four during any subsequent registration period within the same period of continuing unemployment. A strike waiting period, described in paragraph (d) of this section, will satisfy a general waiting period with respect to a benefit year.

(d) *Strike waiting period.* If a qualified employee has a period of continuing unemployment that includes days of unemployment due to a stoppage of work because of a strike in the establishment, premises, or enterprise at which he or she was last employed, no benefits are payable for his or her first 14 days of unemployment due to such stoppage of work. For subsequent days of unemployment due to the same stoppage of work, benefits are payable for days of unemployment in excess of four in each subsequent registration period within the period of continuing unemployment. If such period of continuing unemployment ends because the employee has exhausted his or her benefits as provided for under part 336 of this chapter, but the stoppage of work continues, benefits are payable for days of unemployment in excess of seven in the employee's first registration period in a new period of continuing unemployment based upon the same stoppage of work and for days of unemployment in excess of four in subsequent registration periods in the same period of continuing unemployment.

(e) *Period of continuing unemployment.* A ''period of continuing unemployment'' means a single registration period that includes more than four days of unemployment or a series of consecutive periods each of which includes more than four days of unemployment, or a series of successive registration periods, each of which includes more than four days of unemployment, if each succeeding registration period begins within 15 days after the last day of the immediately preceding registration period. An employee's period of continuing unemployment ends on the last day of a benefit year in which he or she exhausts rights to unemployment benefits as provided for in part 336 of this chapter.

(f) *Computation of compensable days—*(1) *Example 1.* An employee has an initial period of continuing unemployment from June 14 through July 25 and is unemployed on all days in that period. The employee's first registration period covers June 14 to June 27, and his subsequent registration periods cover June 28 to July 11 and July 12 to July 25. Under paragraph (c) of this section, a one-week waiting period applies to his first registration period and the employee is therefore paid benefits for days of unemployment in excess of seven in that period. The employee is then paid benefits for days of unemployment in excess of four in each of the two ensuing registration periods. [Note: if this employee's period of continuing unemployment had been the result of a strike in the establishment, premises, or enterprise at which the employee was last employed, then under paragraph (d) of this section, no benefits would be payable for the period June 14 to June 27, and benefits would then be payable for days of unemployment in excess of four in each of the ensuing registration periods.]

(2) *Example 2.* Same facts as in example 1, but the employee is unemployed again beginning August 18. Since August 18 is more than 15 days after July

25, the end of his last registration period, the employee begins a new period of continuing unemployment. The employee's first registration period in the new period of continuing unemployment covers August 18 to August 31. The employee is paid benefits for days of unemployment in excess of seven in that registration period because that period is the employee's first registration period in a new period of continuing unemployment commencing in the benefit year beginning July 1, and he or she did not previously have a waiting period in any registration period earlier in that benefit year. The employee's next registration period covers September 1 to September 14, and the employee returned to work on September 12. In that registration period, the employee has 11 days of unemployment and is therefore paid benefits for days of unemployment in excess of four.

(3) *Example 3.* Same facts as in examples 1 and 2, but the employee then has a new period of continuing unemployment beginning November 1 in the same benefit year. November 1 to November 14 is the employee's first registration period in that period of continuing unemployment. The employee is paid benefits for days of unemployment in excess of four in that registration period and for days of unemployment in excess of four in any subsequent registration period in the same benefit year because earlier in the benefit year the employee had a registration period, August 18 to August 31, in which he or she satisfied the waiting period.

(g) *Remuneration exceeds base year compensation.* (1) No benefits are payable to any otherwise eligible employee for any day of unemployment in a registration period where the total amount of remuneration, as defined in part 322 of this chapter, payable to the employee during a registration period exceeds the amount of the base year monthly compensation base. For this purpose an employee is considered to have received the amount he would have earned except for the fact that he declined suitable work available to him or her during the registration period.

(2) Days of unemployment which are not compensable by virtue of paragraph (g)(1) of this section shall nevertheless be counted as days of unemployment for purposes of determining whether the general waiting period, as described in paragraph (c) of this section, has been satisfied, and for purposes of determining a period of continuing unemployment.

(h) *Pay for time lost.* An employee may claim unemployment benefits in accordance with this part even though he or she is also pursuing a claim for pay for time lost or other remuneration. If such pay is awarded to the employee with respect to any day for which the Board has paid him or her unemployment benefits, the Board will recover the amount of unemployment benefits that was paid for any day or days for which he or she was awarded pay for time lost. See part 322 of this chapter. It is the employee's responsibility to tell the Board that he or she has filed or intends to file a claim for time lost.

[54 FR 24551, June 8, 1989, as amended at 65 FR 19647, Apr. 12, 2000]

§ 325.2 Procedure for registering for unemployment benefits.

(a) *Registering as unemployed.* To claim unemployment benefits for any day, an employee must register as unemployed by doing the following:

(1) Apply for unemployment benefits and employment service in accordance with § 325.3;

(2) File a claim in accordance with § 325.4; and

(3) Provide any other information that the Board needs to properly adjudicate his or her right to unemployment benefits.

(b) *No benefits payable without registration.* No unemployment benefits shall be paid to any otherwise qualified employee with respect to any day claimed as a day of unemployment, and no waiting period credit shall be allowed, until such time as the employee has complied with the requirements of paragraph (a) of this section.

(c) *When a registration period may begin.* When registering for unemployment benefits, an employee may claim benefits for any calendar day on which he or she is unemployed and believes himself or herself to be eligible for benefits. A registration period may begin

as early as the first calendar day on which an employee is unemployed following his or her last day of work even though such first calendar day would have been a rest day if the employee had not become unemployed. However, a registration period may not begin with any calendar day with respect to which an employee has received or will receive remuneration.

Example 1. An employee whose rest days are Saturday and Sunday is laid off on Friday, September 2, after working his regular shift on that day. His first 14-day registration period could start as early as Saturday, September 3. A registration period starting on September 3 would end on September 16. If he continues to be unemployed, his next registration period could begin September 17 and end September 30, and so forth.

Example 2. An employee whose rest days are Saturday and Sunday is laid off on Friday, September 2, but he decides to take two weeks' vacation pay covering days through Friday, September 16. Because he will have received remuneration for days through September 16, his claim for unemployment benefits could begin on Saturday, September 17, if he continues to be unemployed after his vacation ends.

Example 3. An employee whose rest days are Saturday and Sunday is laid off on Monday, September 5, after working his regular shift on that day. His first 14-day registration period could begin on Tuesday, September 6, the first day on which he was unemployed following his last day of work.

(Approved by the Office of Management and Budget under control number 3220–0166)

§ 325.3 Application for unemployment benefits and employment service.

(a) *Requirement.* An unemployed employee who wishes to claim unemployment benefits shall apply for such benefits by completing the form prescribed by the Board for that purpose. Such form shall also constitute an application for employment service. An application will be required at the beginning of each period of unemployment in a benefit year unless:

(1) The employee filed an application for an initial period of unemployment in a benefit year and has a subsequent period of unemployment within the same benefit year; or

(2) The employee had filed an application for benefits for a period of unemployment that began in the preceding benefit year and the period of unemployment continued into the next ensuing benefit year.

In either of these circumstances, the initial application will be treated as an application for days in the subsequent period of unemployment or as an application for days in the next ensuing benefit year, as the case may be.

(b) *Purpose of application.* An application for unemployment benefits and employment service is a document that serves three purposes. First, it identifies an employee who has become unemployed and wishes to begin receiving unemployment benefits. Second, it assists the Board in determining whether the applicant is a qualified employee and if so, whether any of the information reported on the application affects his or her eligibility for payment of benefits. Third, it assists the Board in placing the employee in any suitable employment that may be available.

(c) *Time for filing application.* An employee may deliver or mail his or her application to any Board office, but such application must be received at a Board office within 30 calendar days of the first day that the employee intends to claim as a day of unemployment. For example, if an employee becomes unemployed on October 31 and intends to claim unemployment benefits for days starting November 1, the application must reach a Board office no later than November 30. If the application is received December 1, the employee may not be paid unemployment benefits for November 1 as such day would not be considered as a ''day of unemployment''. If an employee returns to work and then becomes unemployed again within the same benefit year, he or she is not required to file a new application for benefits and employment service but need only contact the nearest Board office to obtain a claim form and file such form as described in § 325.4.

(d) *Extension of time for filing.* Notwithstanding paragraph (c) of this section, the Board will consider an application for unemployment benefits as timely filed if:

(1) The employee can show that he or she made a reasonable effort to file the form on time but was prevented from doing so by circumstances beyond his or her control; provided, however, that

lack of diligence, forgetfulness or lack of knowledge of the time limit for applying shall not be considered to be a circumstance beyond the employee's control; and

(2) The employee files an application within one year of the day or days that he or she claims as a day or days of unemployment.

§ 325.4 Claim for unemployment benefits.

(a) *Requirement.* After an unemployed employee has applied for unemployment benefits in accordance with § 325.3, he or she shall claim a day as a day of unemployment by registering with respect to such day. Registration shall be made on the claim form provided by the Board to the employee.

(b) *Claim.* A claim for unemployment benefits shall cover a period of 14 consecutive calendar days. Each such 14-day period shall be a registration period. An employee shall provide the information called for by the claim form and shall file his or her claim in accordance with paragraph (c) of this section.

(c) *Time for filing.* A claim for unemployment benefits shall be filed at any Board office no later than 15 calendar days after the last day of the claim period, as defined in paragraph (b) of this section, or 15 calendar days after the date on which the claim form was mailed to the employee, whichever is later. In determining whether the time for filing the claim may be extended, the standards set forth in § 325.3(d) shall be applied. None of the days included in a claim that is not timely filed shall be considered a day of unemployment.

(d) *Claim for new period of unemployment.* An employee who has complied with the application requirement under § 325.3 with respect to a period of unemployment in a benefit year, and who again becomes unemployed in the same benefit year, need not file a new application but may initiate a claim for benefits for days in such subsequent period by calling or visiting the nearest district office of the Board to request a claim form. Such request shall be made no later than 30 calendar days after the first day for which the employee wishes to claim benefits. Upon receipt of a request under this paragraph, the district office shall provide the employee with a claim form which shall show the beginning and ending dates of the registration period covered by the claim form, with the first day shown on the claim form being no earlier than the 30th day before the date on which the employee requested the claim form, unless the delay may be excused by applying the standards set forth in § 325.3(d).

(e) *Delayed claims.* If an employee makes an initial application and claim for benefits in accordance with this part but does not continue to file ongoing claims because he or she receives an initial determination denying his or her application or claim for benefits and if, upon review, the denial is reversed by an appeals referee or other authorized reviewing official, the employee shall have 30 days from the date of the notice of the reversal in which to file a claim or claims for benefits for the days that he or she would have claimed as days of unemployment but for the initial determination denying benefits. The appeals referee or other reviewing official, as appropriate, shall notify the employee of the 30-day time limit imposed by this paragraph. An employee whose claim for benefits has been denied may continue to claim any additional day or days for which he or she believes that he or she is eligible for benefits.

(f) *Claim required for waiting period.* The requirement to file a claim for unemployment benefits includes a requirement to file a claim for the noncompensable waiting period described in § 325.1(d), except that the Director of Unemployment and Sickness Insurance may waive such requirement in connection with unemployment resulting from a work stoppage or other labor dispute.

(g) *Withdrawal of claim.* An employee may withdraw his or her claim for unemployment benefits by submitting a written statement to that effect and by repaying any benefits paid on the claim, unless the employee's claim was intentionally false or fraudulent.

[54 FR 24551, June 8, 1989, as amended at 58 FR 45841, Aug. 31, 1993]

§ 325.5 Death of employee.

If an employee dies before filing one or more of the required forms, the form or forms may be filed by or in behalf of the person or persons to whom benefits would be payable pursuant to section 2(g) of the Act. Such form or forms shall be filed within the time prescribed in § 325.3. Under these circumstances, the word ''employee'', as used in this part, shall include the individual or individuals by or in behalf of whom the form is filed.

§ 325.6 Verification procedures.

The Board's procedures for adjudicating and processing applications and claims for unemployment benefits filed pursuant to this part will include both pre-payment and post-payment procedures for verifying the validity of such applications and claims. Such procedures shall be designed with a view to obtaining substantial evidence as to the days of unemployment of the employees who register in accordance with this part. The verification procedures shall include, but are not limited to:

(a) Pre-payment contacts with railroad employers, utilizing data processing techniques to the extent feasible so as not to delay unduly the payment of valid claims; and

(b) Computer matching programs with state agencies or other entities that may have relevant data concerning non-railroad employment and benefit payments under state unemployment compensation laws.

PART 327—AVAILABLE FOR WORK

Sec.
327.1 Introduction.
327.5 Meaning of ''available for work''.
327.10 Consideration of availability.
327.15 Reasonable efforts to obtain work.

AUTHORITY: 45 U.S.C. 362(i), 362(l).

§ 327.1 Introduction.

The Railroad Unemployment Insurance Act provides for the payment of unemployment benefits to qualified railroad employees for days of unemployment. Under section 1(k) of the Act, an unemployed employee must be ''available for work'' as a condition of eligibility for unemployment benefits for any day claimed as a day of unemployment. This part defines the phrase ''available for work'' and explains how the Board will apply that phrase to claims for unemployment benefits.

[55 FR 1811, Jan. 19, 1990]

§ 327.5 Meaning of "available for work".

(a) *General definition.* A claimant for unemployment benefits is available for work if he is willing and ready to work.

(b) *Willing to work.* A claimant is willing to work if he is willing to accept and perform for hire such work as is reasonably appropriate to his circumstances in view of factors such as:

(1) The current practices recognized by management and labor with respect to such work;

(2) The degree of risk involved to the claimant's health, safety, and morals;

(3) His physical fitness and prior training;

(4) His experience and prior earnings;

(5) His length of unemployment and prospects for obtaining work; and

(6) The distance of the work from his residence and from his most recent work.

(c) *Ready to work.* A claimant is ready to work if he:

(1) Is in a position to receive notice of work which he is willing to accept and perform, and

(2) Is prepared to be present with the customary equipment at the location of such work within the time usually allotted.

(d) *Deemed available for work.* During the period extending from March 1, 2020 until December 31, 2020, a claimant will be deemed to be available for work during any period for which he or she is subject to a state or local order related to the public health emergency declared effective March 1, 2020 preventing him or her from reporting to work.

[Board Order 53–296, 18 FR 8157, Dec. 12, 1953, as amended at 85 FR 19386, Apr. 7, 2020]

§ 327.10 Consideration of availability.

(a) *Initial proof.* A claimant who registers for unemployment benefits in accordance with the provisions of part 325

of this chapter shall, absent any evidence to the contrary, initially be considered available for work. Evidence that a claimant may not be available for work shall include any evidence provided by the claimant's base year employer(s) pursuant to section 5(b) of the Railroad Unemployment Insurance Act.

(b) *Information indicating unavailability.* If the office of the Board which is adjudicating a claimant's claims for benefits receives information indicating that the claimant may not be available for work, he shall be required to submit evidence of his availability for work, and no benefits shall thereafter be paid with respect to any day in the period of the claimant's unemployment unless sufficient evidence of the claimant's availability for work on such day is presented.

(c) *Employee who has retired voluntarily.* An employee who has retired voluntarily shall be presumed not to be eligible for unemployment benefits. An employee shall be regarded as having retired voluntarily if his not being in the active service of his employer is due to an agreement between his labor organization and his employer requiring retirement upon attaining a certain age.

(d) *Equivalent of full-time work.* (1) A claimant who is continuously employed from week to week under a work schedule that provides the equivalent of full-time employment shall not be considered available for work with respect to any rest day or other non-work day within a 14-day registration period.

(2) The application of paragraph (d) may be illustrated by the following examples:

Example (1): A claimant's regular work schedule requires him or her to work five nine-hour days one week followed by three nine-hour days and one eight-hour day in the next week. The claimant has five non-work days within this two-week period. The claimant is not considered available for work on those non-work days.

Example (2): On Monday an employee who has been working a shift which has Saturdays and Sundays off changes to a shift which normally has Wednesdays and Thursdays off. As a consequence, the employee has six non-work days within a 14-day period. The employee is not considered available for work with respect to any of the six non-work days.

Example (3): An employee regularly receives remuneration for 40 hours per week by working 10 hours on each of four days per week, thus giving him or her six rest days in a 14-day period. The employee will not be considered available for work on the rest days.

(e) *Attendance in school or training course.* (1) A claimant who has voluntarily left work to enroll as a student in an educational institution shall be presumed not to be available for work. For the purpose of this provision, leaving work is considered voluntary when the claimant on his or her own initiative left work that he or she could have continued to perform but for the claimant's decision to attend school. In all other cases, this presumption shall not apply, but eligibility shall instead be determined on the basis of the facts of each case. In each such case, the claimant shall be given an opportunity to establish that he or she remains ready and willing to engage in full-time employment for hire, notwithstanding his or her school attendance. If a claimant is enrolled in a vocational training program at a trade or technical school, he or she shall be considered available for work if his or her current prospects for work are poor and the vocational training can reasonably be expected to increase his or her prospects for obtaining new employment.

(2) *Examples.* The application of paragraph (e) may be illustrated by the following examples:

Example (1): An individual is laid off by his or her railroad employer. Instead of looking for other employment, the individual decides to enter college in order to become a teacher. He or she is enrolled as a full-time day student. The individual is not available for work.

Example (2): An employee is furloughed by his or her railroad employer and will not likely be able to return to railroad work. After making a reasonable effort to obtain work and finding none, the individual enrolls in a six-month course of training, which upon completion would permit him or her to obtain an entry level job in the data processing industry. The individual is considered available for work while training for the data processing job.

(f) *Failure to work in anticipation of maximum mileage.* (1) An employee in

train and engine service who voluntarily lays off work in anticipation of reaching the maximum mileage or earnings permitted under an agreement with his or her employer shall not be considered available for work.

(2) *Example.* Halfway through the month an engineer has worked in train service covering 2,000 miles. By agreement with his or her employer he or she may not operate a train in excess of 3,000 miles per month. In order to allow engineers with less seniority to perform service, the engineer lays off work for five days. The engineer is not considered available for work on those days.

(g) *Confinement.* A claimant who is confined in a penal institution or is in the custody of a Federal, State or local governmental unit or official thereof shall not be considered available for work. An individual shall not be considered in the custody of a governmental unit or official thereof if he or she has been released on bail and is awaiting trial or he or she has been placed on probation or parole. However, an individual who has been released from custody by a governmental unit or official thereof under a program that permits leave from custody of a short duration, after which he or she must return to custody, shall not be considered available for work on those days on which he or she is on furlough from confinement.

(h) *Missed turns in pool service.* A train and engine service employee assigned to pool service shall not be considered as ready to work, within the meaning of §327.5(c) of this part, with respect to any day on which such employee would have worked if he or she had not missed his or her turn in pool service employment.

[Board Order 53–296, 18 FR 8157, Dec. 12, 1953, as amended by Board Order 55–30, 20 FR 1015, Feb. 17, 1955; 55 FR 1811, Jan. 19, 1990]

§327.15 Reasonable efforts to obtain work.

(a) *Requirement.* A claimant may be required at any time to show, as evidence of willingness to work, that he is making reasonable efforts to obtain work which he professes to be willing to accept and perform, unless he has good prospects of obtaining such work or his circumstances are such that any efforts to obtain work other than by making application for employment service pursuant to §325.3 of this chapter would be fruitless to the claimant.

(b) *Failure to comply with requirement.* When the office of the Board which is adjudicating claims for benefits has information that the claimant has failed to comply with the requirements set forth in paragraph (a) of this section, no benefits shall be paid with respect to any days in the period of the claimant's unemployment unless sufficient evidence of the claimant's availability for work on such days is presented.

(c) *What constitutes reasonable efforts.* A claimant shall be considered as making reasonable efforts to obtain work when he takes such steps toward obtaining work as are appropriate to his circumstances. In determining what steps are appropriate to a claimant's circumstances, consideration shall be given to actions such as:

(1) Registering with a union hiring or placement facility;

(2) Applying for employment with former employers;

(3) Making application with employers including individuals and companies not covered by the act, who may reasonably be expected to have openings in work suitable for him;

(4) Responding to appropriate ''want ads'' for work which appears suitable for him;

(5) Actively prosecuting his claim for reinstatement in his former work;

(6) Any other action reasonably directed toward obtaining work.

[Board Order 53–296, 18 FR 8157, Dec. 12, 1953, as amended at 55 FR 1812, Jan. 19, 1990]

PART 330—DETERMINATION OF DAILY BENEFIT RATES

Sec.

330.1 Introduction.
330.2 Computation of daily benefit rate.
330.3 Daily rate of compensation.
330.4 Last railroad employment in the base year.
330.5 Procedure for obtaining and using information about daily rate of compensation.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: 56 FR 28702, June 24, 1991, unless otherwise noted.

§ 330.1 Introduction.

The Railroad Unemployment Insurance Act provides for the payment of benefits, at a specified daily benefit rate, to any qualified employee for his or her days of unemployment or days of sickness, subject to a maximum amount per day. The ''daily benefit rate'' for an employee is the amount of benefits that he or she may receive for each compensable day of unemployment or sickness in any registration period in a period of continuing unemployment or sickness.

[65 FR 19648, Apr. 12, 2000]

§ 330.2 Computation of daily benefit rate.

(a) *Basic formula.* A qualified employee's daily benefit rate for a given benefit year, as defined in part 302 of this chapter, is an amount equal to 60 percent of the employee's daily rate of compensation for his or her last railroad employment in the applicable base year, but such rate will not exceed the maximum amount set forth in paragraph (b) of this section nor will it be less than $12.70 per day.

(b) *Maximum daily benefit rate.* The maximum daily benefit rate is the product of the monthly compensation base, as computed under part 302 of this chapter, for the base year immediately preceding the beginning of the benefit year, multiplied by five percent. If the maximum daily benefit rate so computed is not a multiple of $1.00, the Board will round it down to the nearest multiple of $1.00.

(c) *When increase effective.* Whenever the annual application of the formula in paragraph (b) of this section triggers an increase in the maximum daily benefit rate, such increase will apply to days of unemployment or days of sickness in registration periods beginning after June 30 of the calendar year immediately following the base year referred to in paragraph (b) of this section.

(d) *Notice.* Whenever the annual application of the formula in paragraph (b) of this section triggers an increase in the maximum daily benefit rate, or if the annual application of the formula does not trigger an increase, the Board will publish a notice in the FEDERAL REGISTER explaining how it computed the maximum daily benefit rate for the year. The Board will also notify each employer of the maximum amount of the daily benefit rate. The Board will make the computation as soon as it has computed the amount of the monthly compensation base under part 302 of this chapter and will publish notice as soon as possible thereafter, but in no event later than June 1 of each year. Information as to the current amount of the maximum daily benefit rate will also be available in any Board district or regional office.

(e) *Sources of information.* In determining an employee's daily rate of compensation for the purpose of computing his or her daily benefit rate, the Board will rely on information furnished by the employee and his or her last employer in the base year. An employee's earnings from employment not covered by the Railroad Unemployment Insurance Act are not considered in computing his or her daily benefit rate.

[56 FR 28702, June 24, 1991, as amended at 65 FR 19648, Apr. 12, 2000]

§ 330.3 Daily rate of compensation.

(a) *Definition.* An employee's daily rate of compensation is his or her straight-time rate of pay, including any cost-of-living allowance provided in any applicable working agreement. It does not include any overtime pay, penalty payment, or other special allowance except as hereinafter provided. An employer's or employee's report of the daily rate of compensation shall, in the absence of information to the contrary, and subject to the considerations set forth in this section and §§ 330.4 and 330.5, be considered to show the daily rate of compensation of the employee by or for whom the report has been furnished. Where a rate other than a daily rate is reported, the Board will convert it to a daily rate.

(b) *Hourly, weekly or monthly rate.* An hourly rate shall be converted to a daily rate by multiplying such hourly rate by the number of hours constituting a working day for the employee's occupation or class of service. A weekly or monthly rate shall be converted to a daily rate by dividing such rate by the number of working days

constituting the work week or work month, as the case may be, for the employee's occupation or class of service.

(c) *Mileage rate.* When a collective bargaining agreement provides for payment of compensation on a mileage basis, the employee's daily rate of compensation is his or her rate of pay for the number of miles constituting a basic day, including any allowance, as prescribed by the agreement, that is added to his or her basic rate of pay for the number of miles constituting a basic day.

(d) *Piece rate or tonnage rate.* Where a piece rate or tonnage rate is reported, the daily rate of compensation shall be determined by computing the employee's average earnings per day for the days on which he or she worked substantially full time (excluding any overtime pay or penalty rates) at such piece rate or tonnage rate during the last two pay periods in which he or she engaged in such work in the base year.

(e) *Commissions or percentage of sales.* Where the compensation reported consists of or includes commissions or percentages of sales, the daily rate of such commissions or percentage of sales shall be determined by computing the employee's average net commissions or percentage earnings (excluding any amounts he or she received to compensate him or her for expenses) per day for the days in the last two pay periods in which he or she worked on a commission or percentage basis in the base year.

(f) *International service.* In the case of an employee who, on his last day of employment in the base year, worked partly outside the United States and partly in the United States for an employer not conducting the principal part of its business in the United States, the employee's daily rate of compensation shall be determined in the same manner as it would if all his service on that day had been rendered in the United States.

§ 330.4 Last railroad employment in the base year.

The phrase ''last railroad employment in the applicable base year,'' as used in § 330.2(a) of this part, means generally the employee's last ''service performed as an employee,'' within the meaning of section 1(g) of the Railroad Unemployment Insurance Act. If an employee did not actually perform any service as an employee in the applicable base year (the calendar year preceding a benefit year) but did receive qualifying compensation such as vacation pay or pay for time lost for days in such base year, the Board will consider that his or her last railroad employment in the base year was the employment on which the qualifying compensation was based. The daily rate of such compensation shall be deemed to be the employee's daily rate of compensation for purposes of this part. If an employee's last railroad employment in the base year was casual or temporary work and was performed while on furlough from other base year railroad employment, the Board will disregard the daily rate of compensation paid for the casual or temporary work if such rate of compensation produces a daily benefit rate lower than the daily benefit rate based on the daily rate of compensation for the employment from which the employee was furloughed.

§ 330.5 Procedure for obtaining and using information about daily rate of compensation.

(a) *Information furnished by employers.* Every employer, as defined in part 301 of this chapter, shall furnish information to the Board with respect to the daily rate of compensation of each employee for his or her last employment in the applicable base year. The employer shall make such report when it files its annual report of compensation in accordance with part 209 of this chapter and shall use the form prescribed by the Board for that purpose. If an employee's last daily rate of compensation in the base year is $99.99 or more, the employer may report such rate as $99.99 instead of the employee's actual last daily rate of compensation. In the absence of evidence to the contrary or a challenge by the employee, the daily rate of compensation provided by an employer under this section shall be used to compute a qualified employee's daily benefit rate. If an employer fails to report the last daily rate of compensation for a qualified employee who has applied for benefits

or if an employee challenges the daily rate reported by an employer, the procedure in paragraphs (b) and (c) of this section will apply.

(b) *Information furnished by employee.* The Board will afford an employee an opportunity to establish his or her last daily rate of compensation if the base year employer did not report a rate for the employee on its annual report of compensation or if the employee challenges the accuracy of the rate reported by the employer. Unless deemed unreasonable, a daily rate of compensation reported by an employee under this paragraph will be used provisionally to compute his or her daily benefit rate, but such rate will be verified in accordance with paragraph (c) of this section. In any case in which the employee's report is deemed unreasonable and no employer report has been provided, the employee's report shall be disregarded, and the Board will seek to verify the employee's last daily pay rate in accordance with paragraph (c) of this section. Pending receipt of such verification, the employee's daily benefit rate shall be set at $12.70. When an unverified and uncorrected pay rate has been verified or corrected, appropriate redetermination of the daily benefit rate shall be made, and such redetermined benefit rate shall be applied to all the employee's days of unemployment or sickness in the benefit year.

(c) *Employer verification.* Whenever an employee has established a daily rate of compensation under paragraph (b) of this section, the Board will request the employee's base year employer to verify such rate within 30 days. If such verification is not received within 30 days, the employee's daily rate of compensation may be based upon other evidence gathered by the Board if such evidence is reasonable in light of compensation rates reported for other employees of the base year employer in the same occupation or class of service as the employer or in light of previous compensation rates reported by the base year employer for its employees. A daily benefit rate established under this paragraph may not exceed the maximum daily benefit rate established under this part.

(d) *Protest.* An employee who is dissatisfied with the daily benefit rate computed under this part may contest such computation in accordance with part 320 of this chapter.

(Approved by the Office of Management and Budget under control numbers 3220–0007, 3220–0008 and 3220–0097)

PART 332—MILEAGE OR WORK RESTRICTIONS AND STAND-BY OR LAY-OVER RULES

Sec.
332.1 Statutory provisions.
332.2 General considerations.
332.3 Mileage and work restrictions.
332.4 Restrictions in extra service.
332.5 Equivalent of full-time work.
332.6 Standing by for and laying over between regularly assigned trips or tours of duty.
332.7 Consideration of evidence.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: Board Order 59–95, 24 FR 3372, Apr. 30, 1959, unless otherwise noted.

§ 332.1 Statutory provisions.

* * * (1) a day of unemployment with respect to any employee, means a calendar day on which he is able to work and is available for work and with respect to which * * * no remuneration is payable or accrues to him * * * and (2) a ''day of sickness'', with respect to any employee, means a calendar day on which because of any physical, mental, psychological, or nervous injury, illness, sickness, or disease he is not able to work, or, with respect to a female employee, a calendar day on which, because of pregnancy, miscarriage, or the birth of a child, (i) she is unable to work or (ii) working would be injurious to her health, and with respect to which * * * no remuneration is payable or accrues to him * * * *Provided, further,* That any calendar day on which no remuneration is payable to or accrues to an employee solely because of the application to him of mileage or work restrictions agreed upon in schedule agreements between employers and employees or solely because he is standing by for or laying over between regularly assigned trips or tours of duty shall not be considered either a day of unemployment or a day of sickness. (Section 1(k), Railroad Unemployment Insurance Act)

[Board Order 68–72, 33 FR 11115, Aug. 6, 1968]

§ 332.2 General considerations.

(a) *Classes of service covered.* Conditions under which remuneration with respect to a day may not be payable to

or accrue to an employee solely because of the application to him of a mileage or work restriction exist in train-and-engine service, yard service, dining-car service, sleeping-car service, and other Pullman-car service, and similar service, and express service on trains. In the determination of a claim for benefits of an employee in any other service, the employee's lack of remuneration with respect to any claimed day shall be presumed not to be due solely to the application of a mileage or work restriction. Conditions under which remuneration with respect to a day may not be payable to or accrue to an employee solely because he is standing by for or laying over between regularly assigned trips or tours of duty exist in train-and-engine service, dining-car service, sleeping-car service, and other Pullman-car service, and similar service, and express service on trains. In the determination of a claim for benefits of an employee in any other service, the employee's lack of remuneration with respect to any claimed day shall be presumed not to be due solely to his standing by for or laying over between regularly assigned trips or tours of duty.

(b) *Sickness claims.* An employee who, in connection with a claim to a day as a day of sickness, is held to be not able to work because of any physical, mental, psychological, or nervous injury, illness, sickness, or disease shall not be considered to lack remuneration with respect to such day solely because of the application to him of mileage or work restrictions or solely because he is standing by for or laying over between regularly assigned trips or tours of duty. Nor shall a female employee be considered to lack remuneration with respect to a day solely because of the application to her of mileage or work restrictions or solely because she is standing by for or laying over between regularly assigned trips or tours of duty if the day is one on which, because of pregnancy, miscarriage, or the birth of a child, (1) she is unable to work or (2) working would be injurious to her health.

[Board Order 59–95, 24 FR 3372, Apr. 30, 1959, as amended at 26 FR 8593, Sept. 14, 1961; Board Order 68–72, 33 FR 11115, Aug. 6, 1968]

§ 332.3 Mileage and work restrictions.

Subject to the provisions of § 332.2(b), a day shall not be considered as a day of unemployment or as a day of sickness with respect to an employee if no remuneration is payable or accrues to him solely because of the application to him of a mileage or work restriction agreed upon in a written agreement between his employer and employees of his employer, or authorized pursuant to such written agreement. Provisions of agreements setting overtime or other premium rates of pay shall not be regarded as work restrictions. Mileage or work restrictions shall be considered as applicable to an employee with respect to any day on which he is out of service because of having reached or exceeded the maximum mileage, earnings, or hours of work prescribed in such an agreement, or authorized pursuant to such an agreement. Performance of other work by an employee while he is out of service because of having reached or exceeded the maximum mileage, earnings, or hours of work shall not serve to make the mileage or work restriction inapplicable to him.

§ 332.4 Restrictions in extra service.

Mileage or work restrictions shall be considered to exist in rotating extra board, pool, or chain gang service when there is in effect an arrangement between the employer and its employees for increasing or decreasing the number of employees in such service according to the amount of work available. When the arrangement is such that an employee in extra board, pool, or chain gang service gets the equivalent of full-time work, his lack of remuneration on any non-work day shall, subject to the provisions of § 332.2(b), be considered as due solely to the application to him of a mileage or work restriction.

§ 332.5 Equivalent of full-time work.

An employee who has the equivalent of full-time work with respect to service on days within a registration period is not eligible for unemployment benefits for any non-work days within such registration period. In determining whether an employee has the equivalent of full-time work, the Board will

consider the provisions of labor-management agreements that prescribe the number of miles or hours of credit constituting a basic work day, week, or month in the employee's occupation or service. The Board will consider that an employee had the equivalent of full-time work if the number of miles or hours credited to the employee for service in the registration period is at least 10 times the number of miles or hours constituting a basic day in the employee's occupation or service. For this purpose, any miles or hours of credit not earned because the employee missed his or her turn and any penalty miles assessed to the employee shall be added to the miles or hours of credit actually earned on the basis of service on days within the registration period.

[55 FR 1813, Jan. 19, 1990]

§ 332.6 Standing by for and laying over between regularly assigned trips or tours of duty.

Subject to the provisions of § 332.2(b), a day shall not be considered as a day of unemployment or as a day of sickness with respect to an employee if no remuneration is payable or accrues to him solely because he is standing by for or laying over between regularly assigned trips or tours of duty. Only employees who hold regular assignments may be regarded as standing by for or laying over between regularly assigned trips or tours of duty. In determining whether an employee has a regular assignment, consideration shall be given to whether the trips or tours of duty have definite starting times; whether there are a definite number of trips or tours of duty, either periodically or for the whole duration of the assignment; and whether there is a definite route of each trip or definite duration of each tour of duty. An employee who is separated from a regular assignment shall not be regarded as standing by for or laying over between regularly assigned trips or tours of duty. An employee shall be deemed separated from a regular assignment when he is suspended or discharged from service or displaced by a senior employee or held out of service for investigation or discipline, or when his regular assignment is abolished or discontinued.

§ 332.7 Consideration of evidence.

An employee shall be requested to furnish such information as to any mileage or work restrictions or as to lay-over or stand-by status as may be necessary for the determination of his claim. An employee's statement in connection with his claim that he was not out of service because of a lay-over or stand-by rule or because of a mileage or work restriction shall, in the absence of evidence to the contrary, be accepted as sufficient for a finding on that point. An employee's report of the number of miles or hours' credit earned in rotating extra board, pool, or chain gang service shall, in the absence of evidence to the contrary, be accepted as correct for purposes of determining whether he had the equivalent of full-time work during the period covered by his claim. When it appears clear that an employee in rotating extra board, pool, or chain gang service who fails to report the number of miles or hours' credit earned on days in the period covered by his claim form was not employed on enough days to have had the equivalent of full-time work in the period, no additional information as to mileage or work restrictions shall be deemed necessary for the determination of his claim.

PART 335—SICKNESS BENEFITS

Sec.

335.1 General.
335.2 Manner of claiming sickness benefits.
335.3 Execution of statement of sickness and supplemental doctor's statement.
335.4 Filing statement of sickness and claim for sickness benefits.
335.5 Death of employee.
335.6 Payment of sickness benefits.

AUTHORITY: 45 U.S.C. 362(i) and 362(l).

SOURCE: 54 FR 43057, Oct. 20, 1989, unless otherwise noted.

§ 335.1 General.

(a) *Statutory basis.* The Railroad Unemployment Insurance Act provides for the payment of sickness benefits to a qualified railroad employee for days of sickness within a period of continuing sickness. To establish basic eligibility for sickness benefits, a qualified employee must have at least four consecutive days of sickness with respect to

each period of continuing sickness. The terms ''day of sickness'' and ''period of continuing sickness'' as used in this part, are defined in sections 1(k) and 2(a) of the Act, respectively, and paragraphs (b) and (c) of this section. As evidence of days of sickness based upon illness or injury or upon pregnancy, miscarriage or childbirth, section 1(k) requires an employee to file a statement of sickness. Other information that is required to identify an employee's days of sickness is obtained by means of an application for sickness benefits at the beginning of each period of continuing sickness and by means of a claim for sickness benefits which is filed for each registration period within a period of continuing sickness. The term ''registration period'', generally refers to a period of 14 consecutive days and is defined in paragraph (d) of this section.

(b) *Day of sickness.* The term ''day of sickness'' means, in general, any calendar day, including days that would normally be rest days, on which an employee is not able to work because of any physical or mental illness or injury. With respect to a female employee, a ''day of sickness'' also includes any calendar day on which she is not able to work, or working would be injurious to her health, because of pregnancy, miscarriage or childbirth.

(c) *Period of continuing sickness.* (1) The term ''period of continuing sickness'' refers to a period of time when an employee is not able to work on account of illness, injury, sickness or disease, including inability caused by pregnancy, miscarriage or childbirth. An employee has a period of continuing sickness under either of these circumstances:

(i) He or she has any number of ''consecutive'' days of sickness based on one or more infirmities; or

(ii) He or she has any number of ''successive'' days of sickness based on a single infirmity and there is no interruption of more than 90 ''consecutive'' days which are not days of sickness.

(2) Days of sickness are ''consecutive'' when they occur one after another continuously and without interruption by any day that is not a day of sickness. Days of sickness are ''successive'' when one or more days of sickness follow any day of sickness with an interval of one or more days that are not days of sickness.

Example: An employee is sick for 11 ''consecutive'' days from October 1 through October 11, meaning that each day in the period October 1 through October 11 is a day of sickness and there is no day in that period that is not a day of sickness. If the employee also had days of sickness on October 16, 17, 18, 21 and 22, those five days are considered ''successive'' days of sickness.

(3) A period of continuing sickness with respect to any employee begins with the first day of a number of consecutive days of sickness or with the first day of a number of successive days of sickness attributable to a single cause with no interval of more than 90 days that are not days of sickness. In the example given in paragraph (c)(2) of this section, October 1 begins a period of continuing sickness. The days October 16, 17, 18, 21, and 22 are in the period of continuing sickness beginning October 1, and benefits are payable for them, provided that the employee's inability to work on those five days is due to one or more of the same infirmities that caused the employee to be unable to work on the days from October 1 through October 11. Otherwise, October 16 begins another period of continuing sickness.

(4) A period of continuing sickness ends when either of these circumstances occurs:

(i) 91 consecutive days have elapsed none of which is a day of sickness resulting from the infirmity that was the basis for the preceding days of sickness; or

(ii) One or more days that are not days of sickness have elapsed and a statement of sickness is filed with respect to a day of sickness based on an infirmity other than any infirmity causing inability on the preceding days of sickness. The end of a benefit year, generally the 12-month period beginning July 1 of any year and ending June 30 of the next year (see 45 U.S.C. 351(m)), does not end a period of continuing sickness. In the example in paragraph (c)(2) of this section, if the inability to work on October 16 was not due to an infirmity or infirmities that

caused the inability to work on October 11, then a period of continuing sickness ends on October 11. A new application and statement of sickness would be required in order for the employee to be paid sickness benefits for days beginning October 16. See §335.2 of this part.

(5) A period of continuing sickness can be interrupted, provided that:

(i) The interruption is for not more than 90 consecutive days; and

(ii) The days of sickness after the interruption are due to one or more of the same causes as the days of sickness before the interruption. A period of continuing sickness can be interrupted any number of times so long as each interruption is not more than 90 days and the days of sickness are all due to the same cause. If a period of continuing sickness is caused by more than one infirmity, any one of the infirmities can be considered as the single continuing cause that will permit the interruption of the period of continuing sickness for not more than 90 days without ending it.

(d) *Registration period.* The term ''registration period'' means, with respect to any employee, the period which begins with the first day with respect to which a statement of sickness for a period of continuing sickness is filed in his or her behalf in accordance with this part, or the first such day after the end of a registration period which will have begun with a day with respect to which a statement of sickness for a period of continuing sickness was filed in his or her behalf, and ends with whichever is the earlier of:

(1) The thirteenth day thereafter; or

(2) The day immediately preceding the day with respect to which a statement of sickness for a new period of continuing sickness is filed in his or her behalf. However, each of the successive 14-day periods in an extended sickness benefit period shall constitute a registration period.

(e) *Liability for infirmity.* When sickness benefits are paid to an employee on the basis of an infirmity for which he or she recovers a personal injury settlement or judgment, the Board shall receive reimbursement for the sickness benefits in accordance with part 341 of this chapter.

§ 335.2 Manner of claiming sickness benefits.

(a) *Forms required for claiming benefits.* To claim sickness benefits for a period of inability to work due to an illness or injury, or in the case of a female employee, pregnancy, miscarriage, or childbirth, an employee must file the following forms:

(1) An application for sickness benefits at the beginning of each period of continuing sickness;

(2) A statement of sickness to accompany the employee's application;

(3) A claim for sickness benefits for each 14-day registration period during the employee's period of continuing sickness; and

(4) A supplemental doctor's statement, if the adjudicating office requests additional proof of the employee's inability to work.

(b) *Mailing or delivering the forms.* The forms required by paragraph (a) of this section may be mailed or delivered to any Board office. If the Board is satisfied that the employee is too sick or injured to execute the required forms, the Board may accept forms executed by someone in the employee's behalf. Instructions for completing and filing the forms are printed on the forms themselves.

(Approved by the Office of Management and Budget under control numbers 3220–0034, 3220–0039 and 3220–0045)

§ 335.3 Execution of statement of sickness and supplemental doctor's statement.

(a) *Who may execute.* A statement of sickness and any required supplemental doctor's statement shall be executed by any of the following individuals:

(1) A licensed medical doctor;

(2) A licensed dentist if the infirmity relates to the teeth or gums;

(3) A licensed podiatrist or chiropodist if the infirmity relates to the feet or toes;

(4) A licensed chiropractor;

(5) A clinical psychologist;

(6) A certified nurse mid-wife;

(7) The superintendent or other supervisory official of a hospital, clinic, or group health association, or similar organization, in which all examinations and treatment are conducted

under the supervision of licensed medical doctors or under the supervision of licensed chiropractors, and in which medical records are maintained for each patient;

(8) A physician assistant-certified (PAC);

(9) An accredited Christian Science Practitioner;

(10) A substance-abuse professional as defined in 49 CFR part 40.3, if the infirmity involves alcohol or controlled substances-related disorders; or

(11) A nurse practitioner.

(b) *Use of Board form or other form.* The statement of sickness and supplemental doctor's statement referred to in paragraph (a) of this section shall be completed on the forms prescribed by the Board, except that other standardized medical forms may be substituted if they provide the same information as that called for by the Board's forms.

[54 FR 43057, Oct. 20, 1989, as amended at 60 FR 40073, Aug. 7, 1995; 62 FR 44408, Aug. 21, 1997; 65 FR 66499, Nov. 6, 2000]

§ 335.4 Filing statement of sickness and claim for sickness benefits.

(a) *General requirement.* Except as provided in paragraph (e) of this section, statements of sickness and claims for sickness benefits must be filed within the time limits specified by this section. Failure to comply with the time restrictions on filing claims will result in a denial of benefits for days for which timely statements and claims are not filed, as such days would not be considered days of sickness.

(b) *Statement of sickness.* An employee shall file a statement of sickness within ten calendar days of the first day that he or she wishes to claim as a day of sickness. For example, if an employee wishes to claim sickness benefits for days starting November 1, the statement of sickness should reach the Board no later than November 10. If the statement of sickness is received November 11, the employee cannot be paid sickness benefits for November 1. Such day would not be considered as a ''day of sickness'', unless the form may be considered as timely filed under paragraph (d)(3), (4) or (5) of this section.

(c) *Claim for sickness benefits.* An employee shall file a claim for sickness benefits within 30 days after the ending date shown on the claim form, or within 30 days after the date on which the Board mails the claim form to the employee, whichever date is later. Failure to comply with this provision shall bar the payment of sickness benefits with respect to any day included within the calendar period covered by the claim form.

Example: If a form for claiming sickness benefits is mailed to an employee on July 13, for the period from July 1 to July 14, the employee must file the claim within 30 days after July 14 [on or before August 13], to be paid benefits for the period July 1 to July 14. If the claim form was not mailed to the employee until July 16, the claim must be filed within 30 days after July 16 [on or before August 15].

(d) *When form considered timely filed.* The Board will consider a statement of sickness or a claim for sickness benefits as timely filed if:

(1) The statement or form was received in a Board office within the prescribed time; or

(2) The statement or form was mailed to a Board office in accordance with instructions printed on the form and was received at such office; or

(3) The employee made a reasonable effort to file the statement of sickness or claim form within the prescribed time but was prevented from doing so by circumstances beyond his or her control, and such statement or claim was received at a Board office within a reasonable time following the removal of the circumstances that prevented the employee from filing the form. The phrase ''circumstances beyond his or her control'' shall not include an employee's forgetfulness or lack of knowledge of the sickness benefit program or the time limit for filing for sickness benefits or any other lack of diligence by the employee. For the purposes of this provision, if a statement of sickness is not received within the prescribed time but is received within 30 days of the first day that an employee intends to claim as a day of sickness, the Board will consider that the employee made a reasonable effort to file the statement within the prescribed time, unless it is clear on the basis of affirmative evidence that the delay was not the result of circumstances beyond the employee's control; or

(4) The employee mistakenly registered for unemployment benefits when he or she should have applied for sickness benefits for the day or days claimed and the appropriate statement of sickness was then received at an office of the Board within a reasonable time after unemployment benefits were denied; or

(5) Notwithstanding the foregoing, any claim that is not filed within two years of the day or days claimed shall not be considered as timely filed, and such day or days shall not be considered as days of sickness.

(e) *Days for which no statement of sickness deemed filed.* A statement of sickness shall not be deemed to be filed with respect to any day in a benefit year in which the employee is not a qualified employee as defined in section 3 of the Railroad Unemployment Insurance Act or has exhausted his or her rights to sickness benefits under the Act. See part 336 of this chapter.

[54 FR 43057, Oct. 20, 1989, as amended at 57 FR 807, Jan. 9, 1992; 60 FR 40073, Aug. 7, 1995]

§ 335.5 Death of employee.

If an employee dies before filing one or more of the required forms, the form or forms may be filed by or in behalf of the person or persons to whom benefits would be payable pursuant to section 2(g) of the Railroad Unemployment Insurance Act. Such form or forms shall be filed within the time prescribed in § 335.4 of this part. Under these circumstances, the word ''employee'' as used in § 335.4(b) of this part and as used in § 335.4(d)(3) of this part shall include the individual or individuals by or in behalf of whom the form is filed. The order of distribution for benefits due but unpaid as of the date of an employee's death is the same as the order of distribution for annuities unpaid at death under the Railroad Retirement Act and may be found at § 234.31 of this title.

§ 335.6 Payment of sickness benefits.

(a) *General rule.* Except as provided in this section, benefits are payable to any qualified employee for each day of sickness after the fourth consecutive day of sickness in a period of continuing sickness, as defined in § 335.1(c), but excluding four days of sickness in any registration period in such period of continuing sickness.

(b) *Waiting period.* Benefits are payable to any qualified employee for each day of sickness in excess of seven during his or her first registration period in a period of continuing sickness if such period of continuing sickness is his or her initial period of continuing sickness beginning in the benefit year. For this purpose, the first registration period in a period of continuing sickness is the registration period that first begins with four consecutive days of sickness and includes more than four days of sickness. For the purpose of computing benefits under this section, a period of continuing sickness ends on the last day of a benefit year in which the employee exhausts rights to sickness benefits as provided for under part 336 of this chapter.

(c) *Computation of compensable days—* (1) *Example 1.* An employee has an initial period of continuing sickness from June 14 through July 25, and all days in that period are days of sickness. The employee's first registration period covers June 14 to June 27, and his or her subsequent registration period covers June 28 to July 11, and July 12 to July 25. In the one-week waiting period the employee is paid benefits for days of sickness in excess of seven. In each of the two ensuing registration periods the employee is paid benefits for days of sickness in excess of four.

(2) *Example 2.* Same facts as in Example 1, but the employee later has a new period of continuing sickness based upon a different illness or impairment beginning September 17. The employee's first registration period in his or her new period of continuing sickness covers September 17 to September 30. The employee is paid benefits for days of sickness in excess of seven in that 14-day period because that period is his or her first registration period in a new period of continuing sickness commencing in the benefit year beginning July 1, and he or she did not previously have a waiting period in any registration period earlier in the benefit year.

(3) *Example 3.* Same facts as in examples 1 and 2, but the employee then has a new period of continuing sickness beginning January 1 in the same benefit year. January 1 to January 14 is the

employee's first registration period in that period of continuing sickness. The employee is paid benefits for days of sickness in excess of four in that registration period because earlier in the benefit year he or she had a registration period, September 17 to September 30, in which he or she satisfied the initial seven-day waiting period.

(d) *Amount payable.* The gross amount of sickness benefits for any registration period in a period of continuing sickness shall be computed by multiplying the number of compensable days of sickness in such registration period by the employee's daily benefit rate, as computed under part 330 of this chapter.

[65 FR 19649, Apr. 12, 2000]

PART 336—DURATION OF NORMAL AND EXTENDED BENEFITS

Subpart A—Normal Benefits

Sec.
336.1 Introduction.
336.2 Duration of normal unemployment benefits.
336.3 Duration of normal sickness benefits.
336.4 Base year compensation.
336.5 Notice to employee.

Subpart B—Extended Benefits

336.10 Eligibility.
336.11 Exhaustion of rights to normal unemployment benefits.
336.12 Exhaustion of rights to normal sickness benefits.
336.13 Years of service requirement.
336.14 Extended benefit period.
336.15 How to claim extended benefits.
336.16 Notice to employee.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: 59 FR 3996, Jan. 28, 1994, unless otherwise noted.

Subpart A—Normal Benefits

§ 336.1 Introduction.

(a) *General.* This subpart explains how long a qualified employee may receive normal unemployment or sickness benefits under the Railroad Unemployment Insurance Act during a benefit year. Under section 2(c) of that Act, normal unemployment benefits are payable for up to 130 days of unemployment within a benefit year, or in an amount equal to the amount of the employee's ''base year compensation'', whichever is less. A similar limitation applies to the payment of sickness benefits. An employee who exhausts his or her normal unemployment or sickness benefits may be eligible for payment of extended unemployment or extended sickness benefits under the conditions set forth in subpart B of this part.

(b) *Definitions.* The terms ''benefit year'', ''base year'', and ''compensation'' are defined in part 302 of this chapter. The term ''registration period'' is defined in parts 325 and 335 of this chapter. For the purposes of this subpart, and as explained in § 336.4 of this part, an employee's ''base year compensation'' may include compensation in excess of the monthly compensation base (as defined in part 302 of this chapter) even though such excess may not be counted for the purpose of determining whether such employee is a ''qualified employee'' within the meaning of part 302.

(c) *Recovery of benefits.* When unemployment or sickness benefits are recovered by the Board for one or more days, the Board will disregard those days in determining whether the employee has exhausted normal unemployment or sickness benefits with respect to the applicable benefit year.

§ 336.2 Duration of normal unemployment benefits.

(a) *130 compensable day limitation.* A qualified employee who has satisfied the waiting period for a benefit year may receive benefits for a maximum of 130 days of unemployment within such benefit year, subject to the limitation on payment explained in paragraph (b) of this section. In any registration period beginning after the end of the waiting period and before the beginning of the next ensuing benefit year, benefits are payable for days of unemployment in excess of four, but the aggregate number of compensable days may not exceed 130 for the benefit year. An employee who is unemployed on all days during a registration period could have a maximum of 10 compensable days of unemployment in such registration period. The amount of benefits for each compensable day of unemployment is the amount of the daily

benefit rate computed for such employee pursuant to part 330 of this chapter.

(b) *Base year compensation limit.* Notwithstanding the provisions of paragraph (a) of this section, the Board will not pay unemployment benefits to a qualified employee, with respect to his or her days of unemployment within a benefit year, in an amount greater than the amount of his or her base year compensation, as computed under § 336.4 of this part.

(c) *Unemployment due to a strike.* The limitations set forth in paragraphs (a) and (b) of this section also apply to an employee whose unemployment is due to a stoppage of work because of a strike in the establishment, premises, or enterprise at which he was last employed. But no unemployment benefits are payable for the employee's first 14 days of unemployment due to such stoppage of work.

§ 336.3 Duration of normal sickness benefits.

The duration of normal sickness benefits is the same as the duration of normal unemployment benefits, as set forth in § 336.2 of this part. A qualified employee who has satisfied the benefit year waiting period and is otherwise eligible for sickness benefits may receive benefits for a maximum of 130 days of sickness within a benefit year, but the amount paid as sickness benefits may not exceed the amount of the employee's base year compensation, as computed under § 336.4 of this part.

§ 336.4 Base year compensation.

(a) *Formula.* For the purposes of this part, an employee's base year compensation includes any compensation in excess of the monthly compensation base (as defined in part 302 of this chapter) for any month in the applicable base year but shall not include any amount that exceeds the value of ''X'' in the following formula: X = $775(A/$600). In this formula, ''A'' is the dollar amount of the monthly compensation base with respect to months in such base year. For example, if an employee had railroad earnings of $1,500 per month in each of three months in base year 1990, the employee's base year compensation for purposes of part 302 of this chapter would be $2,235 (three times the monthly compensation base of $745 per month for months in 1990). But the employee's base year compensation for purposes of computing maximum normal unemployment (or sickness) benefits under this subpart would be $2,886 (three times $962), and his or her normal unemployment (or sickness) benefits would not be considered exhausted until he or she is paid unemployment (or sickness) benefits in an amount equal to $2,886. In this example, $962 is the amount computed as the value of ''X'' in the above formula when ''A'' is equal to $745.

(b) *Employer's duty to report.* The base year employer(s) of an employee shall provide information as to the amount of an employee's monthly compensation in excess of the monthly compensation base, as defined in part 302 of this chapter, unless the amount of the employee's compensation at the monthly compensation base limit, as already reported to the Board, is equal to or greater than an amount equal to 130 times the daily benefit rate applicable to the employee's days of unemployment or days of sickness.

(Approved by the Office of Management and Budget under control number 3220–0070)

§ 336.5 Notice to employee.

The Board will notify an employee when it appears that his or her right to normal unemployment or normal sickness benefits will be exhausted. Such notice will include information about the availability of extended benefits under subpart B of this part if the employee has completed 10 years of railroad service and the availability of normal benefits for the next ensuing benefit year if the employee is not eligible for extended benefits.

Subpart B—Extended Benefits

§ 336.10 Eligibility.

(a) Except as provided in paragraph (b) of this section, an employee may receive extended unemployment or extended sickness benefits under this part if he or she:

(1) Has exhausted normal unemployment or normal sickness benefits (as

the case may be) under subpart A of this part;

(2) Has completed 10 years of railroad service, as set forth in §336.13 of this part; and

(3) Continues to have days of unemployment or days of sickness, as the case may be.

(b) An employee is not eligible for extended sickness benefits if he or she has voluntarily retired or has attained age 65. In the case of claims for unemployment benefits, an employee is not eligible for extended unemployment benefits if he or she has voluntarily left work without good cause or has voluntarily retired.

§ 336.11 Exhaustion of rights to normal unemployment benefits.

For the purposes of this part, the Board considers that an employee has exhausted his or her current rights to normal benefits for days of unemployment if:

(a) The employee received unemployment benefits for 130 days of unemployment in the benefit year; or

(b) The employee received unemployment benefits in the benefit year equal to the amount of his or her base year compensation; or

(c) At the end of a normal benefit year during which the employee was qualified for benefits, he or she received less than the maximum unemployment benefits for the benefit year and he or she is not qualified for benefits in the next succeeding benefit year.

§ 336.12 Exhaustion of rights to normal sickness benefits.

For the purposes of this part, the Board considers that an employee has exhausted his or her current rights to normal benefits for days of sickness if:

(a) The employee received sickness benefits for 130 days of sickness in the benefit year; or

(b) The employee received sickness benefits in the benefit year equal to the amount of his or her base year compensation; or

(c) At the end of the normal benefit year during which the employee was qualified for benefits, he or she received less than the maximum sickness benefits for the benefit year and he or she is not qualified for benefits in the next succeeding benefit year.

§ 336.13 Years of service requirement.

(a) *Eligibility.* For the purposes of this part, an employee is not eligible for extended unemployment or sickness benefits if he or she does not have at least 10 years of railroad service. An employee who has 120 service months, as defined in part 210 of this chapter, whether or not consecutive, is considered to have 10 years of railroad service.

(b) *Initial determination.* The Board will determine whether an employee has 10 years of railroad service on the basis of reports filed by employers pursuant to part 209 of this chapter. The number of years of service shown in the Board's records will be accepted as correct for the purposes of this part, unless the employee claims credit for more service than that shown in the Board's records and such additional service is verified, subject to part 211 of this chapter.

(c) *Effective date.* An employee acquires ten years of railroad service as of the first day with respect to which creditable compensation is attributable in his 120th month of service.

[65 FR 19649, Apr. 12, 2000]

§ 336.14 Extended benefit period.

(a) *Defined.* An extended benefit period consists of seven consecutive 14-day registration periods.

(b) *Beginning date.* In the case of unemployment benefits, an extended benefit period begins with the first day of unemployment after the day on which the employee exhausts his or her rights to normal unemployment benefits. In the case of sickness benefits, the beginning date is the first day of sickness after the employee exhausts normal sickness benefits. Such first day of unemployment or first day of sickness must be within the same benefit year with respect to which the employee exhausted normal unemployment or normal sickness benefits, as the case may be. However, no extended benefit period may begin on any day of unemployment or sickness prior to the date on which the employee acquired 10 years of railroad service.

(c) *Ending date.* An employee's extended benefit period ends on the 97th day after it began. If an employee attains age 65 during an extended sickness benefit period, such extended benefit period will terminate on the day next preceding the date on which the employee attains age 65, except that it may continue for the purpose of paying benefits for his or her days of unemployment, if any, during such extended period. If an extended sickness benefit period terminates because the employee has attained age 65, and if at that point the employee has rights to normal sickness benefits, the employee will be paid normal sickness benefits if he or she is otherwise entitled to payment thereof.

(d) *Maximum number of compensable days.* Extended benefits may be paid for a maximum of 65 days of unemployment (or 65 days of sickness, as the case may be) within an employee's extended benefit period.

[59 FR 3996, Jan. 28, 1994, as amended at 65 FR 19649, Apr. 12, 2000]

§ 336.15 How to claim extended benefits.

An employee who has 10 or more years of railroad service who exhausts his or her rights to normal unemployment or normal sickness benefits and who wishes to claim extended unemployment or extended sickness benefits may do so by claiming benefits on the forms provided by the Board pursuant to parts 325 or 335 of this chapter. The claim forms provided for this purpose are the same as those provided for claiming normal benefits. No special application for extended benefits is required, and no waiting period applies to the payment of extended benefits.

§ 336.16 Notice to employee.

Upon determining that an employee is eligible for a period of extended unemployment or sickness benefits, the Board will notify the employee of the beginning and ending dates of such extended benefit period.

PART 337 [RESERVED]

PART 340—RECOVERY OF BENEFITS

Sec.

340.1 Statutory provisions.
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340.16 Debt collection.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: Board Order 27–22, 32 FR 3341, Feb. 28, 1967, unless otherwise noted.

§ 340.1 Statutory provisions.

(a) Section 2(d) of the Railroad Unemployment Insurance Act provides that:

If the Board finds that at any time more than the correct amount of benefits has been paid to any individual under this Act or a payment has been made to an individual not entitled thereto (including payments made prior to July 1, 1940) recovery by adjustments in subsequent payments to which such individual is entitled under this Act or any other Act administered by the Board may, except as otherwise provided in this subsection, be made under regulations prescribed by the Board. If such individual dies before recovery is completed, recovery may be made by setoff or adjustments, under regulations prescribed by the Board, in subsequent payments due, under this Act or any other Act administered by the Board to the estate, designee, next of kin, legal representative, or surviving spouse of such individual, with respect to the employment of such individual.

Adjustments under this subsection may be made either by deductions from subsequent payments or, with respect to payments which are to be made during a lifetime or lifetimes, by subtracting the total amount of benefits paid in excess of the proper amount from the actuarial value, as determined by

the Board, of such payments to be made during a lifetime or lifetimes and recertifying such payments on the basis of the reduced actuarial value. In the latter case recovery shall be deemed to have been completed upon such recertification.

There shall be no recovery in any case in which more than the correct amount of benefits has been paid to an individual or payment has been made to an individual not entitled thereto (including payments made prior to July 1, 1940) who, in the judgment of the Board, is without fault when, in the judgment of the Board, recovery would be contrary to the purpose of this Act or would be against equity or good conscience.

No certifying or disbursing officer shall be held liable for any amount certified or paid by him in good faith to any person where the recovery of such amount is waived under the third paragraph of this subsection or has been begun but cannot be completed under the first paragraph of this subsection.

(b) Section 2(f) of the Act provides, in part, that:

If (i) benefits are paid to any employee with respect to unemployment or sickness in any registration period, and it is later determined that remuneration is payable to such employee with respect to any period which includes days in such registration period which had been determined to be days of unemployment or sickness, and (ii) the person or company from which such remuneration is payable has, before payment thereof, notice of the payment of benefits upon the basis of days of unemployment or sickness included in such period, the remuneration so payable shall not be reduced by reason of such benefits but the remuneration so payable, to the extent to which benefits were paid upon the basis of days which had been determined to be days of unemployment or sickness and which are included in the period for which such remuneration is payable, shall be held to be a special fund in trust for the Board. * * *

(c) Section 4(a–1) of the Act provides, in part, that:

There shall not be considered as a day of unemployment or as a day of sickness, with respect to any employee— * * *

(ii) Any day in any period with respect to which the Board finds that he is receiving or will have received annuity payments or pensions under the Railroad Retirement Act of 1935 or the Railroad Retirement Act of 1937, or insurance benefits under title II of the Social Security Act, or unemployment, maternity, or sickness benefits under an unemployment, maternity, or sickness compensation law other than this Act, or any other social insurance payments under any law: *Provided*, That if an employee receives or is held entitled to receive any such payments, other than unemployment, maternity, or sickness payments, with respect to any period which include days of unemployment or sickness in a registration period, after benefits under this Act for such registration period will have been paid, the amount by which such benefits under this Act will have been increased by including such days as days of unemployment or as days of sickness shall be recoverable by the Board: *Provided further*, That, if that part of any such payment or payments, other than unemployment, maternity, or sickness payments, which is apportionable to such days of unemployment or days of sickness is less in amount than the benefits under this Act which, but for this paragraph, would be payable and not recoverable with respect to such days of unemployment or days of sickness, the preceding provisions of this paragraph shall not apply but such benefits under this Act for such days of unemployment or days of sickness shall be diminished or recoverable in the amount of such part of such other payment or payments;

(d) Section 12(o) of the Act provides that:

Benefits payable to an employee with respect to days of sickness shall be payable regardless of the liability of any person to pay damages for such infirmity. The Board shall be entitled to reimbursement from any sum or damages paid or payable to such employee or other person through suit, compromise, settlement, judgment, or otherwise on account of any liability (other than a liability under a health, sickness, accident, or similar insurance policy) based upon such infirmity, to the extent that it will have paid or will pay benefits for days of sickness resulting from such infirmity. Upon notice to the person against whom such right or claim exists or is asserted, the Board shall have a lien upon such right or claim, any judgment obtained thereunder, and any sum or damages paid under such right or claim, to the extent of the amount to which the Board is entitled by way of reimbursement.

(e) Section 3, Pub. L. 89–508, 80 Stat. 308, provides that:

(a) The head of an agency or his designee, pursuant to regulations prescribed by him and in conformity with such standards as may be promulgated jointly by the Attorney General and the Comptroller General, shall attempt collection of all claims of the United States for money or property arising out of the activities of, or referred to, his agency.

(b) With respect to such claims of the United States that have not been referred to another agency, including the General Accounting Office, for further collection action

and that do not exceed $20,000, exclusive of interest, the head of an agency or his designee, pursuant to regulations prescribed by him and in conformity with such standards as may be promulgated jointly by the Attorney General and the Comptroller General, may (1) compromise any such claim, or (2) cause collection action on any such claim to be terminated or suspended where it appears that no person liable on the claim has the present or prospective financial ability to pay any significant sum thereon or that the cost of collecting the claim is likely to exceed the amount of recovery. The Comptroller General or his designee shall have the foregoing authority with respect to claims referred to the General Accounting Office by another agency for further collection action. The head of an agency or his designee shall not exercise the foregoing authority with respect to a claim as to which there is an indication of fraud, the presentation of a false claim, or misrepresentation on the part of the debtor or any other party having an interest in the claim, or a claim based in whole or in part on conduct in violation of the antitrust laws; nor shall the head of an agency, other than the Comptroller General of the United States, have authority to compromise a claim that arises from an exception made by the General Accounting Office in the account of an accountable officer.

(c) A compromise effected pursuant to authority conferred by subsection (b) of this section shall be final and conclusive on the debtor and on all officials, agencies, and courts of the United States, except if procured by fraud, misrepresentation, the presentation of a false claim, or mutual mistake of fact. No accountable officer shall be liable for any amount paid or for the value of property lost, damaged, or destroyed, where the recovery of such amount or value may not be had because of a compromise with a person primarily responsible under subsection (b).

§ 340.2 Amount recoverable.

For purposes of this part, an ''amount recoverable'' is an amount of unemployment, sickness, or maternity benefits paid under the Railroad Unemployment Insurance Act which is:

(a) Determined to have been paid erroneously;

(b) Recoverable under section 2(f) of the Act because remuneration is found to be payable with respect to a period which includes days which had been determined to be days of unemployment or sickness;

(c) Recoverable under section 4(a–1)(ii) of the Act because of the employee's having received or been held entitled to receive annuity payments under the Railroad Retirement Act, insurance benefits under title II of the Social Security Act, unemployment, sickness or maternity benefits under any law other than the Railroad Unemployment Insurance Act, or any other social insurance payments under any law; or

(d) Recoverable under section 12(o) of the Act by virtue of the Board's right to reimbursement from any sum or damages payable through suit, compromise, settlement, judgment, or otherwise on account of liability based upon an infirmity, to the extent that it will have paid or will pay benefits for days of sickness resulting from that infirmity.

§ 340.3 When amounts recoverable to be recovered.

Amounts recoverable shall be recovered in all cases except those in which recovery is waived under § 340.10 or a compromise is approved under § 340.13.

§ 340.4 Methods of recovery of amounts recoverable.

An amount recoverable may be recovered by any one or a combination of the methods described in §§ 340.5, 340.6, 340.7, and 340.8.

§ 340.5 Recovery by cash payment.

The Board shall have the right to require that amounts recoverable be immediately and fully repaid in cash and any debtor shall have the absolute right to repay such amount recoverable in this manner. However if the debtor is financially unable to pay the indebtedness in a lump sum, payment may be accepted in regular installments. The amount and frequency of such installment payments should bear a reasonable relation to the size of the debt and the debtor's ability to pay. Whenever possible installment payments should be sufficient in amounts and frequency to liquidate the debt in not more than three years.

§ 340.6 Recovery by setoff.

An amount recoverable may be recovered by setoff against any subsequent payments to which the individual from whom the amount is recoverable is entitled under the Railroad Unemployment Insurance Act, the

Railroad Retirement Act, or any other Act administered by the Board, or, in the case of that individual's death, from any payments due under those Acts to his or her estate, designee, next of kin, legal representative, or surviving spouse. In any case in which full recovery is not effected by setoff, the balance due may be recovered by one or more of the other methods described in this part. If the individual dies before recovery is completed, such recovery shall be made from his estate or heirs.

[53 FR 2489, Jan. 28, 1988]

§ 340.7 Deduction in computation of death benefit.

In computing the residual lump sum provided for in part 234, subpart D, of this chapter, the Board shall include in the benefits to be deducted from the gross residual all amounts recoverable under this part, but not recovered, including amounts where recovery was waived, that were paid to the individual or paid to others as benefits accrued to the individual but not paid at death.

[57 FR 1379, Jan. 14, 1992]

§ 340.8 Recovery by adjustment in connection with subsequent payments under the Railroad Retirement Act.

Recovery under this part may be made by permanently reducing the amount of any annuity payable to the overpaid individual (or an individual receiving an annuity based upon the same compensation record as that of the overpaid individual) under the Railroad Retirement Act. This method of recovery is called an actuarial adjustment of the annuity. The Board cannot require any individual to take an actuarial adjustment in order to recover an overpayment nor is an actuarial adjustment available as a matter of right. An actuarial adjustment does not become effective until the overpaid individual negotiates the first annuity check which reflects the annuity rate after actuarial adjustment.

Example: An individual agrees to recovery of a $5,000 overpayment made to him by actuarial adjustment to an annuity awarded him under the Railroad Retirement Act. However, he dies before negotiating the first annuity check reflecting his actuarially reduced rate. The $5,000 is not considered recovered.

[57 FR 1379, Jan. 14, 1992]

§ 340.9 Effect of adjustment in connection with subsequent payments.

Adjustment by the method described in § 340.8 shall constitute recovery of the amount recoverable.

§ 340.10 Waiver of recovery of erroneous payments.

(a) *When waiver of recovery may be applied.* Section 2(d) of the Act provides that there shall be no recovery in any case where more than the correct amount of benefits has been paid to an individual or where payment has been made to an individual not entitled to benefits if, in the judgment of the Board:

(1) The individual is without fault; and

(2) Recovery would be contrary to the purpose of the Act or would be against equity or good conscience.

(b) *Fault.* (1) Fault means a defect of judgment or conduct arising from inattention or bad faith. Judgment or conduct is defective when it deviates from a prudent standard of care taken to comply wih the entitlement provisions of the Act. Conduct includes both action and inaction. Unlike fraud, fault does not require a deliberate intent to deceive.

(2) Whether an individual is at fault in causing erroneous payments generally depends on all circumstances surrounding the erroneous payments. Among the factors the Board will consider are: the ability of the overpaid individual to understand the reporting requirements of the Act or to realize that he or she is being overpaid (*e.g.*, age, comprehension, memory, physical and mental condition); the particular cause of benefit non-entitlement; and the number of claims on which the individual made erroneous statements.

(3) Circumstances in which the Board will find an individual at fault include but are not limited to:

(i) Failure to furnish information which the individual knew or should have known was material;

(ii) An incorrect statement made by the individual which he or she knew or

should have known was incorrect (including furnishing an opinion or conclusion when asked for facts);

(iii) Failure to return a payment which the individual knew or should have known was incorrect.

(c) *When recovery defeats the purpose of the Railroad Unemployment Insurance Act.* (1) The purpose of the Railroad Unemployment Insurance Act is to furnish some replacement for an individual's railroad earnings lost because of days of sickness or unemployment. The purpose of the Act is defeated when an erroneous payment is recovered from income and resources which the individual requires to meet ordinary and necessary living expenses. If either income or resources are sufficient to meet expenses, the purpose of the Act is not defeated by recovery of an erroneous payment.

(2) For purposes of this section, income includes any funds which may reasonably be considered available for the individual's use, regardless of source. Income to the individual's spouse or dependents is available if the spouse or dependent lived with the individual at the time waiver is considered. Types of income include, but are not limited to:

(i) Government benefits such as Black Lung, Social Security, Workers' Compensation, and Unemployment Compensation benefits;

(ii) Wages and self-employment income;

(iii) Regular payments such as rent or pensions; and

(iv) Investment income.

(3) For purposes of this section, resources include, but are not limited to, liquid assets such as cash on hand, the value of stocks, bonds, savings accounts, mutual funds, any accrual benefit payable by the United States of America or any other source.

(4) Whether an individual has sufficient income and resources to meet ordinary and necessary living expenses depends not only on the amount of his or her income and resources, but also on whether the expenses are ''ordinary and necessary.'' While the level of expenses which is ''ordinary and necessary'' may vary between individuals, it must be held at a level reasonable for an individual who is temporarily unemployed or incapacitated due to sickness. The Board will consider the discretionary nature of an expense in determining whether it is reasonable. Ordinary and necessary living expenses include:

(i) Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (*e.g.*, life, accident, and health insurance), taxes, installment payments, etc.;

(ii) Medical, hospitalization, and other similar expenses;

(iii) Expenses for the support of others for whom the individual is legally responsible; and

(iv) Miscellaneous expenses (*e.g.*, newspapers, haircuts).

(5) Where recovery of the full amount of an erroneous payment would be made from income and resources required to meet ordinary and necessary living expenses, but recovery of a lesser amount would leave income or resources sufficient to meet expenses, recovery of the lesser amount does not defeat the purpose of the Act.

(d) *When recovery is against equity or good conscience.* Recovery is considered to be against equity or good conscience when a person, in reliance on such payments or on notice that such payment would be made, relinquished a valuable right or changed his or her position for the worse.

(e) *Recoveries not subject to waiver.* (1) Where an amount is recoverable pursuant to section 2(f) of the Act from remuneration payable to an employee by a person or company, or where a lien for reimbursement of sickness benefits has arisen pursuant to section 12(o) of the Act, and in either case recovery is sought from a person other than the employee, no right to waiver of recovery exists.

(2) Where the amount recoverable is equal to or less than 10 times the current maximum daily benefit rate under the Railroad Unemployment Insurance Act it shall not be considered contrary to the purpose of the Act or against equity or good conscience to recover such payment. Consequently, the amount recoverable is not subject to waiver under this part.

(3) Where the amount recoverable is the result of an overpayment of benefits payable under the Railroad Unemployment Insurance Act due to entitlement to annuities under the Railroad Retirement Act for the same days for which benefits were payable, and recovery of such overpayment may be made by offset against an accrual of the annuities, it shall not be considered contrary to the purpose of the Act or against equity or good conscience to recover the erroneous payment by offset against such accrual. Consequently, the amount recoverable is not subject to waiver under this part.

(4) Where there exists accumulated Federal benefits payable by any executive agency of the United States, any amount recoverable which is equal to or less than the accumulated Federal benefits is not subject to waiver. Any amount recoverable which is greater than the identified accumulated Federal benefits may be considered for waiver in accordance with the provisions of this part and part 320 of this chapter.

[53 FR 2489, Jan. 28, 1988, as amended at 57 FR 1379, Jan. 14, 1992]

§ 340.11 Waiver of methods of recovery.

The Board may waive any right to recover all or any part of an amount recoverable by any one or more methods without waiving the right to recover by some other method or methods if, in the judgment of the Board, the individual is without fault and if, in the judgment of the Board, recovery by the methods waived would be against equity and good conscience and recovery by such other methods would not be against equity and good conscience.

§ 340.12 Waiver not a matter of right.

A waiver under § 340.10 or § 340.11 is not a matter of right, but is at all times within the judgment of the Board.

§ 340.13 Compromise of amounts recoverable.

The Board or its designee may compromise an amount recoverable, provided such amount does not exceed $100,000, excluding interest, or such higher amount as the Attorney General may from time to time prescribe. Compromise of an amount recoverable may not be considered in any case in which there is an indication of fraud, the presentation of a false claim or misrepresentation on the part of the debtor or his representative. Compromise is at all times within the discretionary authority of the Board or its designee.

[Board Order 27–22, 32 FR 3341, Feb. 28, 1967, as amended at 62 FR 41271, Aug. 1, 1997]

§ 340.14 Factors due to be considered in a compromise.

The following indicate the character of reasons which will be considered in approving a compromise:

(a) The debtor's ability to repay the full amount within a reasonable time;

(b) The debtor's refusal to pay the claim in full and the Board's inability to effect collection in full within a reasonable time by other collection methods;

(c) Doubt concerning the Board's ability to prove its case in court for the full amount because of a bona fide dispute as to the facts or because of the legal issues involved;

(d) The cost of collecting the amount recoverable does not justify the enforced collection of the full amount.

§ 340.15 Suspension or termination of collection action.

Collection action on a Board claim may be suspended or terminated under the following conditions:

(a) Collection action on a Board claim may be suspended temporarily when the debtor cannot be located and there is reason to believe future collection action may be productive or collection may be effected by offset in the near future.

(b) Collection action may be terminated when:

(1) The debtor is unable to make any substantial payment;

(2) The debtor cannot be located and offset is too remote to justify retention of the claim;

(3) The cost of collection action will exceed the amount recoverable;

(4) The claim is legally without merit or cannot be substantiated by the evidence.

§ 340.16 Debt collection.

(a) The Associate Executive Director for Unemployment and Sickness Insurance shall take steps to collect all delinquent debts due the Board under the benefit provisions of the Act, except those that have been classed as uncollectible. Such steps shall commence not later than July 1, 1985 and shall include notice to each debtor of the time limit for paying the debt and the consequences of failure to pay on time.

(b) It shall be the duty of every employer or other person paying remuneration for time lost or any sum or damages for personal injury to remit the amount of reimbursement due the Board, if any, within 30 days of the date of the payment of remuneration or damages to an employee. Failure to remit the amount due within 30 days shall subject the employer or other person to interest and penalties, in addition to the principal amount due the Board.

[50 FR 36872, Sept. 10, 1985]

PART 341—STATUTORY LIEN WHERE SICKNESS BENEFITS PAID

Sec.

341.1 Lien.
341.2 Sum or damages paid or payable.
341.3 Notice of lien.
341.4 Information required to be furnished by the employee.
341.5 Amount of reimbursement.
341.6 Report of settlement or judgment.
341.7 Liability on Board's claim.
341.8 Termination of sickness benefits due to a settlement.
341.9 Board as a party; attorney's fee.

AUTHORITY: Sec. 323, Pub. L. 79–572, 60 Stat. 740, 741; 45 U.S.C. 362(o).

SOURCE: 49 FR 570, Jan. 5, 1984, unless otherwise noted.

§ 341.1 Lien.

After notice in accordance with this part, the Board shall have a lien upon any sum or damages paid or payable to an employee based upon an infirmity for which the employee received sickness benefits.

§ 341.2 Sum or damages paid or payable.

(a) The term ''sum or damages paid or payable'' means the amount of money that an employee recovers because of any claim of liability based upon his or her injury or illness.

(b) The term ''sum or damages paid or payable'' does not include:

(1) An amount specified in a settlement or award as payment for any loss of property, or the amount of a settlement or award specifically apportioned as pay for lost time.

(2) An amount paid as a result of a lawsuit based on wrongful death.

(3) Workers' compensation payments.

(4) ''No-Fault'' personal-injury protection benefits or any other benefits paid under a health, sickness, accident or similar insurance policy carried by an employee.

(5) Payments made to an employee under the terms of his or her insurance policy providing for payment of all amounts that the employee is legally entitled to recover for bodily injury from the owner or operator of an uninsured motor vehicle.

§ 341.3 Notice of lien.

(a) *Notice to alleged tortfeasor.* The Board shall mail a ''Notice of Lien'' to each person or company identified as liable or potentially liable for causing the employee's infirmity. The ''Notice of Lien'' will notify the person or company of the Board's right to reimbursement. The notice shall include:

(1) The employee's name, address and social security number;

(2) The date and place of the accident; and

(3) The employee's occupation, if injured on duty.

(b) *Notice to employee.* A notice regarding repayment of sickness benefits shall be sent to an employee who names a party other than a railroad as the alleged tortfeasor.

(c) *Notice of amount of lien.* The amount of the Board's lien shall be reported, upon request, to a railroad or other person or company that may be liable for paying damages, or to the employee, or to an attorney representing any of those parties. The amount of the lien shall be reported

whether or not the terms of a settlement have been agreed upon. When requested, a list showing the sickness benefits paid for each claim period may be furnished.

§ 341.4 Information required to be furnished by the employee.

(a) When applying for sickness benefits, an employee shall report the name and address of the person or company, if any, who is alleged to have caused his or her infirmity. The employee shall also provide whatever other details are reasonably needed so that the Board may establish its lien.

(b) The employee shall, upon request, tell the Board whether and from whom he or she has collected any damages for the infirmity.

(Approved by the Office of Management and Budget under control number 3220–0036)

[49 FR 570, Jan. 5, 1984, as amended at 52 FR 11018, Apr. 6, 1987]

§ 341.5 Amount of reimbursement.

(a) The Board shall receive as reimbursement the lesser of:

(1) The amount of sickness benefits paid to the employee for the infirmity for which he or she recovers any sum or damages; or

(2) The net amount of the sum or damages paid to the employee for the infirmity, after substracting the amount of the expenses listed in paragraph (b) of this section.

(b) The expenses that may be subtracted from the amount of damages recovered are:

(1) The medical and hospital expenses that the employee incurred because of his or her injury. These expenses are deductible even if they are paid under an insurance policy covering the employee or are covered by his or her membership in a medical or hospital plan or association. But such expenses are not deductible if they are not covered by insurance or by membership in a medical or hospital plan or association and are consequently paid by a railroad or other person directly to the doctor, clinic or hospital that provided the medical care or services.

(2) The cost of litigation. This includes both the amount of the fee to which the attorney and the employee have agreed and the other expenses that the employee incurred in the conduct of the litigation itself.

§ 341.6 Report of settlement or judgment.

(a) When a person or company makes a settlement or must satisfy a final judgment based on an injury for which the employee received sickness benefits, the person or company shall notify the Board of the settlement or final judgment. That notice shall be in writing and submitted within five days of the settlement or final judgment. A railroad employer may fulfill the written notice requirement by sending an electronic message in the manner prescribed by the agency. That notification shall contain:

(1) The amount of the settlement or final judgment;

(2) The date of the settlement or final judgment; and

(3) The amount withheld from the settlement or final judgment to satisfy the Board's lien.

(b) Payment of the amount due the Board shall be delivered to the Board within 30 days after the date of the settlement agreement or the entry of final judgment.

(c) If the damages payable are to be paid directly to the court to satisfy a final judgment, thus making it impossible for the person or company to remit the amount of reimbursement due the Board, the person or company shall immediately notify the Board of the situation.

[49 FR 570, Jan. 5, 1984, as amended at 71 FR 53005, Sept. 8, 2006]

§ 341.7 Liability on Board's claim.

(a) A person or company paying any sum or damages to an employee who has received sickness benefits from the Board shall, upon receipt of notice as provided in § 341.3(a), be liable to the Board for the amount of reimbursement computed under § 341.5. This liability may be relieved by either:

(1) Withholding the amount reimbursable to the Board from the sum or damages payable to the employee, and subsequently paying that amount to the Board; or

(2) Including the U.S. Railroad Retirement Board as a payee on the check or draft along with the employee and

any others who have an interest in the damages.

(b) If the person or company paying the damages does not protect the Board's lien or attempts to protect the Board's lien in some manner other than those described in paragraph (a) of this section, that person or company shall remain liable to the Board until the Board is reimbursed in full.

§ 341.8 Termination of sickness benefits due to a settlement.

(a) Sickness benefits payable to an eligible employee shall be paid without regard to whether any person or company may be liable for causing the employee's infirmity. However, the Board will terminate the payment of sickness benefits upon receipt of an oral or written report that a settlement or final judgment for the infirmity has been made. A railroad employer may file the required report by sending an electronic message in the manner prescribed by the agency.

(b) A report of settlement shall be made to the Sickness and Unemployment Benefits Section and shall include the information required in § 341.6. Where the report is an oral report, and the informant is neither the employee nor his or her representative, the informant shall be told that written confirmation containing the information called for by § 341.6 must be submitted to the Board within 5 days from the date of the oral report. A railroad employer may fulfill the written report requirement by sending an electronic message in the manner prescribed by the agency.

(c) If, in the case of an oral report, the written confirmation as described in paragraph (b) of this section is not received within five days, the Sickness and Unemployment Benefits Section shall take steps within five additional working days to verify whether there has been a settlement or final judgment. If there has been no settlement or final judgment, the payment of sickness benefits shall be reinstated.

(d) Within five days of the notification of a settlement or final judgment, the Board shall inform the employee of the report of the settlement or final judgment. The notice to the employee shall state how the employee may inform the Board that there has not been a settlement or final judgment. If the employee states that there has not been a settlement or final judgment, the adjudicating office shall, within 10 days after the receipt of such a statement, make a determination as to the employee's rights to future sickness benefits and shall notify him or her accordingly.

(e) An employee shall have the right to appeal from the determination of the amount of sickness benefits recoverable from the settlement or judgment.

An employee shall also have the right to appeal the termination of his or her sickness benefits after the report of a settlement or final judgment made in accordance with the procedures provided in paragraphs (b), (c) and (d) of this section. Such appeals shall be filed and processed in accordance with part 320 of these regulations.

[49 FR 570, Jan. 5, 1984, as amended at 71 FR 53005, Sept. 8, 2006]

§ 341.9 Board as a party; attorney's fee.

(a) The Board shall not participate in the prosecution of a personal-injury claim of an employee eligible for sickness benefits and shall neither encourage nor discourage such employee with respect to the pursuit of a claim for damages.

(b) The Board shall not be a party in any action for damages brought by an employee claiming sickness benefits under the Railroad Unemployment Insurance Act. The Board's right of reimbursement under section 12(o) of the Railroad Unemployment Insurance Act shall not be construed as giving the Board a right of subrogation or other cause of action for damages against an alleged tortfeasor. The Board shall intervene in such an action only when it is apparent that intervention may be required to protect its right of reimbursement.

(c) The Board shall not be liable for the payment of any attorney's fee or other expenses incurred in connection with such a claim for damages.

PART 344 [RESERVED]

PART 345—EMPLOYERS' CONTRIBUTIONS AND CONTRIBUTION REPORTS

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AUTHORITY: 45 U.S.C. 362(l).

SOURCE: 61 FR 20072, May 3, 1996, unless otherwise noted.

Subpart A—General Provisions and Definitions

§ 345.101 Requirement for contribution.

Every employer, as defined in part 301 of this chapter, shall pay to the Railroad Retirement Board a contribution with respect to the compensation paid to an employee in any calendar month for service by such employee (except for service to a local lodge or division of a railway labor organization). For the purposes of this part, the term ''compensation'' is defined in part 302 of this chapter. The compensation subject to contribution is the gross amount of compensation paid to an employee for service in any month, not to exceed the amount of the monthly compensation base (MCB), as defined in part 302 of this chapter. The amount of contribution payable by each employer is to be computed and paid pursuant to the provisions of this part.

§ 345.102 Multiple employer limitation.

(a) The contributions required by this part shall not apply to any amount of the aggregate compensation paid to such employee by all such employers in such calendar month which is in excess of the MCB; and

(b) Each employer (other than a subordinate unit of a national-railway-labor-organization employer) shall be liable for that portion of the contribution with respect to such compensation paid by all such employers which the compensation paid by the employer to such employee bears to the total compensation paid in such month by all such employers to such employee.

(c) In the event that the compensation paid by such employers to the employee in such month is less than the

MCB, each subordinate unit of a national-railway-labor-organization employer shall be liable for such portion of any additional contribution as the compensation paid by such employer to such employee in such month bears to the total compensation paid by all national-railway-labor-organization employers to such employee in such month.

§ 345.103 Rate of contribution.

(a) Each employer will have an experience-rated rate of contribution computed by the Board under the provisions of section 8(a)(1)(C) of the Railroad Unemployment Insurance Act. See subpart D of this part.

(b) Notwithstanding paragraph (a) of this section the rate of contribution applicable to an employer that first becomes subject to this part after December 31, 1989, will be computed by the Board in accordance with section 8(a)(1)(D) of the Railroad Unemployment Insurance Act. See subpart D of this part.

§ 345.104 Employees and employee representatives not liable.

The amount of contributions for which an employer is liable under this part shall not be deducted from an employee's compensation, and the Board will not recognize any agreement under which an employee assumes liability for such contributions. Employee representatives under part 205 of this chapter are not employees for purposes of the Railroad Unemployment Insurance Act and are not liable for payment of contributions under this part.

§ 345.105 Definitions.

(a) *Chief Financial Officer.* References in this part to the Board's Chief Financial Officer mean the Chief Financial Officer, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611. The Chief Financial Officer shall be responsible for assessing, collecting, and depositing contributions due from employers under this part.

(b) *Monthly compensation base.* For the purposes of this part, the monthly compensation base (MCB) is the maximum monthly amount of compensation per employee that is subject to contribution pursuant to this part. On or before December 1 of each year, the Board will compute the amount of the MCB in accordance with section 1(i) of the Railroad Unemployment Insurance Act and part 302 of this chapter, and will publish notice of the amount so computed in the FEDERAL REGISTER within 10 days after such computation has been made. Information as to the amount of the MCB should be requested from the Board's Chief Financial Officer.

(c) *Month defined.* (1) For the purposes of this part, if the date prescribed for filing a report or paying a contribution is the last day of a calendar month, each succeeding calendar month or fraction thereof during which the failure to file or pay the contribution continues shall constitute a month.

(2) If the date prescribed for filing the report or paying the contribution is a date other than the last day of a calendar month, the period that terminates with the date numerically corresponding thereto in the succeeding calendar month and each such successive period shall constitute a month. If, in the month of February, there is no date corresponding to the date prescribed for filing the report or paying, the period from such date in January through the last day of February shall constitute a month. Thus, if a report is due on January 30, the first month shall end on February 28 (or 29 if a leap year), and the succeeding months shall end on March 30, April 30, etc.

(3) If a report is not timely filed or a contribution is not timely paid, the fact that the date prescribed for filing the report or paying the contribution, or the corresponding date in any succeeding calendar month, falls on a Saturday, Sunday, or a legal holiday is immaterial in determining the number of months.

(d) *Reference to forms.* Any reference in this part to any prescribed reporting or other form of the Board includes a reference to any other form of the Board prescribed in substitution for such prescribed form.

(e) *Showing reasonable cause.* For purposes of this part if an employer exercised ordinary business care and prudence and was nevertheless unable to file the return within the prescribed

time, then the delay is due to reasonable cause. A failure to pay any amount due under this part within the prescribed time will be considered to be due to reasonable cause to the extent that the employer has made a satisfactory showing that he exercised ordinary business care and prudence in providing for payment but nevertheless was unable to pay on time.

Subpart B—Reporting and Collecting Contributions

§ 345.110 Reports of compensation of employees.

The provisions of part 209 of this chapter shall be applicable to the reporting of compensation under the Railroad Unemployment Insurance Act to the same extent and in the same manner as they are applicable to the reporting of compensation under the Railroad Retirement Act.

§ 345.111 Contribution reports.

(a) *General.* (1) Except as provided in paragraph (a)(2) of this section, every employer shall, for each calendar quarter of each year, prepare a contribution report, in duplicate, on Form DC–1. If the Form DC–1 is filed electronically, no duplicate submission is required.

(2) Contribution reports of employers who are required by State law to pay compensation on a weekly basis shall include with respect to such compensation all payroll weeks in which all or the major part of the compensation falls within the period for which the reports are required.

(b) *Compensation to be reported on Form DC–1.* Employers shall enter on the employer's quarterly contribution report, prior to any additions or subtractions, the amount of creditable compensation appearing on payrolls or other disbursement documents for the corresponding quarter as the amount of creditable compensation from which the contribution payable for that quarter is to be computed.

(Approved by the Office of Management and Budget under control number 3220–0012)

[67 FR 13567, Mar. 25, 2002]

§ 345.112 Final contribution reports.

Upon termination of employer status, as determined under part 301 of this chapter, the last contribution report of the employer shall be so indicated by checking the box on the Form DC–1 entitled ''Final Report''. Such contribution report shall be filed with the Board on or before the sixtieth day after the final date for which there is payable compensation with respect to which contribution is required. The period covered by each such contribution report shall be plainly written thereon, indicating the final date for which compensation is payable. There shall be executed as part of each such final contribution report a statement giving the address at which compensation records will be kept and the name of the person keeping the records.

(Approved by the Office of Management and Budget under control number 3220–0012)

§ 345.113 Execution of contribution reports.

(a) Each contribution report on Form DC–1 shall be signed by hand by:

(1) The individual, if the employer is an individual;

(2) The president, vice president, or other duly authorized officer, if the employer is a corporation; or

(3) A responsible and duly authorized member or officer having knowledge of its affairs if the employer is a partnership or other unincorporated organization.

(b) The Form DC–1 may be filed electronically through the Board's authorized agent. If filed electronically, no further authentication is required.

[67 FR 13567, Mar. 25, 2002]

§ 345.114 Prescribed forms for contribution reports.

Each employer's contribution report, together with any prescribed copies and supporting data, shall be filled out in accordance with the instructions and regulations applicable thereto. The prescribed forms may be obtained from or accessed by contacting the Board. An employer will not be excused from making a contribution report for the reason that no form has been furnished to such employer. Application should be made to the Board for the prescribed

forms in ample time to have the contribution report prepared, verified, and filed with the Board on or before the due date. Contribution reports that have not been so prepared will not be accepted and shall not be considered filed for purposes of §345.115 of this part. In case the prescribed form has not been obtained, a statement made by the employer disclosing the period covered and the amount of compensation with respect to which the contribution is required may be accepted as a tentative contribution report if accompanied by the amount of contribution due. If filed within the prescribed time, the statements so made will relieve the employer from liability for any penalty imposed under this part for the delinquent filing of the contribution report provided that the failure to file a contribution report on the prescribed form was due to reasonable cause and not due to willful neglect, *and provided further*, that within 30 days after receipt of the tentative report, such tentative report is supplemented by a contribution report made on the proper form.

(Approved by the Office of Management and Budget under control number 3220–0012)

[67 FR 13568, Mar. 25, 2002]

§345.115 Place and time for filing contribution reports.

Each employer shall file its contribution report with the Chief Financial Officer, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois, 60611–2092, or the Chief Financial Officer's designee. The employer's contribution report for each quarterly period shall be filed on or before the last day of the calendar month following the period for which it is made. If such last day falls on Saturday, Sunday, or a national legal holiday, the report may be filed on the next following business day. If mailed, reports must be postmarked on or before the date on which the report is required to be filed.

[67 FR 13568, Mar. 25, 2002]

§345.116 Payment of contributions.

(a) The contribution required to be reported on an employer's contribution report is due and payable to the Board without assessment or notice, at the time fixed for filing the contribution report as provided for in §345.115 of this part.

(b) An employer shall deposit the contributions required under this part in accord with instructions issued by the Railroad Retirement Board. At the direction of the Board, the Secretary of the Treasury shall credit such contributions to the Railroad Unemployment Insurance Account in accord with section 10 of the Railroad Unemployment Insurance Act and to the Railroad Unemployment Insurance Administration Fund in accord with section 11 of the Railroad Unemployment Insurance Act.

§345.117 When fractional part of cent may be disregarded.

In the payment of employers' contributions to the Board a fractional part of a cent shall be disregarded unless it amounts to one-half cent or more, in which case it shall be increased to one cent.

§345.118 Adjustments.

(a) *In general.* If more or less than the correct amount of an employer's contribution is paid with respect to any compensation, proper adjustments with respect to the contributions shall be made, without interest, in subsequent contribution payments by the same employer, as provided for in this section.

(b) *Compensation adjustment.* A compensation adjustment is the amount of any adjustment reported by an employer on Form BA–4. See part 209 of this chapter.

(c) *Adjustment of contributions.* (1) All adjustments of contributions based on compensation adjustments shall be accounted for by the employer on the contribution report for the same quarter in which the Form BA–4 reflecting the compensation adjustments is filed with the Board.

(2) If less than the correct amount of contributions is paid for any previous calendar quarter or calendar year because of an error that does not constitute a compensation adjustment as defined in paragraph (b) of this section, the employer shall adjust the error by—

(i) Reporting the additional contribution on the next report filed after discovery of the error; and

(ii) Paying the amount thereof to the Board at the time such report is filed.

(3) If more than the correct amount of contributions is paid for any previous calendar quarter or calendar year because of an error that does not constitute a compensation adjustment as defined in paragraph (b) of this section, the employer shall adjust the error by applying the excess payment as a credit against the contribution due on the next report filed after discovery of the error. However, if the overpayment cannot be adjusted because the employer is no longer required to file a report or because the overpayment to be adjusted exceeds the amount of contribution due on the employer's next report, the employer may file for a refund of the amount which cannot be adjusted as provided for in this section. If the overpayment is the result of an incorrect contribution rate as determined by the Board, the employer may file for a refund of the amount of overpayment or may take an adjustment as provided for in this section.

(d) *Limitations on adjustments.* No overpayment shall be adjusted under this section after the expiration of three years from the time the contribution report was required to be filed, or two years from the time the contribution was paid, whichever of such periods expires the later, or if no contribution report was filed, two years from the time the contribution was paid. Any underpayment not adjusted within the time limits as set forth in paragraph (c) of this section shall be adjusted on the employer's next contribution report or reported immediately on a supplemental return. Interest shall accrue on such underpayment as provided for in § 345.122 of this part from the time the adjustment should have been made under paragraph (c) of this section to date of payment. However, no underpayment shall be adjusted under this section after the receipt from the Board of formal notice and demand.

§ 345.119 Refunds.

(a) *In general.* If more than the correct amount of the employer's contribution is paid with respect to any compensation and the overpayment may not be adjusted in accordance with § 345.118 of this part, the amount of the overpayment shall be refunded in accordance with this section.

(b) *When permitted.* A claim for refund may be made only when the overpayment cannot be adjusted in accordance with the procedure set forth in § 345.118.

(c) *Form of claim.* A claim for refund shall be directed to the Chief Financial Officer and shall set forth all grounds in detail and all facts alleged in support of the claim, including the amount and date of each payment to the Board of the contribution to the Board, and the period covered by the contribution report on which such contribution was reported.

(d) *Claim by fiduciary.* If an executor, administrator, guardian, trustee, or receiver files a claim for refund, evidence to establish the legal authority of the fiduciary shall be annexed to the claim filed by such fiduciary under this section.

(e) *Time limit.* No refund shall be allowed after the expiration of three years from the time the contribution report was required to be filed or two years from the time the contribution was paid, whichever of such periods expires the later, or if no contribution report was filed, two years from the time the contribution was paid.

(f) *Interest.* Interest shall be payable on any contribution refunded at the overpayment rate provided for in section 6621 of the Internal Revenue Code of 1986 from the date of the overpayment to a date preceding the date of the refund check by not more than 30 days.

(g) *Refunds reduced by underpayments.* Any overpayment claimed or a refund under this section shall be reduced by the amount of any amount of any contributions previously assessed under § 345.120 of this part, which has not already been collected.

§ 345.120 Assessment and collection of contributions or underpayments of contributions.

(a) If any employer's contribution is not paid to the Board when due or is not paid in full when due, the Board

may, as the circumstances warrant, assess the contribution or the deficiency and any interest or penalty applicable under this part (whether or not the deficiency is adjustable as an underpayment under § 345.118 of this part).

(b) The amount of any such assessment will be collected in accordance with the applicable provisions of law. If any employer liable to pay any contribution neglects or refuses to pay the same within ten days after notice and demand, the Board may collect such contribution with such interest and other additional amounts as are required by law, by levy, by administrative offset as authorized by 31 U.S.C. 3716 and in accordance with the procedures set forth in part 367 of this chapter, or by a proceeding in court, but only if the levy is made or proceeding begun:

(1) Within 10 years after assessment of the contribution; or

(2) Prior to the expiration of any period, including extension thereof, for collection agreed upon by the Chief Financial Officer and the employer.

(c) All provisions of law, including penalties, applicable with respect to any tax imposed by the provisions of the Railroad Retirement Tax Act and the regulations thereunder, insofar as not inconsistent with the provisions in this part, shall be applicable with respect to the assessment and collection of contributions under this part.

§ 345.121 Jeopardy assessment.

(a) Whenever in the opinion of the Board it becomes necessary to protect the interests of the Government by effecting an immediate reporting and collection of an employer's contribution, the Board will assess the contribution whether or not the time otherwise prescribed by law for filing the contribution report and paying such contribution has expired, together with all penalties and interest thereon. Upon assessment, such contribution, and any penalty, and interest provided for under this part shall be immediately due and payable, and the Board shall thereupon issue immediately a notice and demand for payment of the contribution, penalty, and interest.

(b) The collection of the whole or any part of the amount of the jeopardy assessment may be stayed by filing with the Board a bond in an amount equal to the amount with respect to which the stay is desired, and with such sureties as the Board may deem necessary. Such bond shall be conditioned upon the payment of the amount (together with interest and any penalties thereon) the collection of which is stayed, at the time at which, but for the jeopardy assessment, such amount would be due. In lieu of surety or sureties the employer may deposit with the Board bonds or notes of the United States, or bonds or notes fully guaranteed by the United States as to principal and interest, having a par value not less than the amount of the bond required to be furnished, together with an agreement authorizing the Board in case of default to collect or sell such bonds or notes so deposited.

§ 345.122 Interest.

(a) *Rate.* If the employer's contribution is not paid to the Board when due and is not adjusted under § 345.118 of this part, interest accrues at the rate of 1 percent per month, or fraction of a month. Interest on past due contributions from the due date thereof until the date paid will be assessed after payment of the contributions, and notice and demand made upon the employer for payment thereof, in any case in which payment of the contribution is made before assessment under § 345.120.

(b) *Waiver of interest.* The Chief Financial Officer may waive, in whole or in part, any interest imposed by paragraph (a) of this section if in his or her judgment—

(1) There was a reasonable cause and not willful neglect for the late filing, late payment or underpayment, such as: the serious illness or death of an individual with the sole authority to execute the return and payment; fire, casualty, or natural disaster at the place where the railroad unemployment insurance records are kept; or reasons outside the employer's control, such as, the failure of the employer's bank to comply with the employer's filing and payment instructions;

(2) The amount of interest attributed to the delinquency is totally disproportionate to the period of the delay and the amount of contributions paid; and

(3) The employer's past record for timely compliance with railroad unemployment insurance reporting and payment requirements warrants such action considering such factors as the number and extent of delays associated with late reports, payments, and underpayments.

§ 345.123 Penalty for delinquent or false contribution reports.

(a) *Delinquent reports.* Unless waived under paragraph (b) of this section, the failure to file a contribution report on or before the due date shall cause a penalty to accrue of five percent of the amount of such contribution if the failure is for not more than one month, with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding 25 percent in the aggregate.

(b) *Waiver of penalty.* The Chief Financial Officer may waive all or a portion of the penalty imposed under paragraph (a) of this section consistent with the criteria applicable to waiver of interest as provided for in § 345.122(b) of this part.

(c) *Penalty on net amount.* For the purpose of paragraph (a) of this section the amount of contribution required to be shown on Form DC–1 shall be reduced by the amount of any part of the contribution that is paid on or before the date prescribed for the payment of the contribution and by the amount of any credit against the contribution that may be claimed upon the DC–1.

(d) *False reports.* If a fraudulent contribution report is made, a penalty equal to 50 percent of the amount of any underpayment shall be imposed on the employer.

§ 345.124 Right to appeal the amount of a contribution, interest, or penalty.

(a) Except as otherwise provided, an employer may seek administrative review of any determination with respect to any contribution, interest, or penalty made under this part by filing a request for reconsideration with the Chief Financial Officer within 30 days after the mailing of notice of such determination. An employer shall have a right to appeal to the Board from any reconsideration decision under this section by filing notice of appeal to the Secretary to the Board within 14 days after the mailing of the decision on reconsideration. Upon receipt of a notice of an appeal, the Board may designate one of its officers or employees to receive evidence and report to the Board under the procedures set forth in part 319 of this chapter. An appeal of the contribution rate is made under § 345.307 of this part.

(b) Any appeal filed under this part shall not relieve the employer from filing any reports or paying any contribution required under this part nor stay the collection thereof. Upon the request of an employer, the Board may relieve the employer of any obligation required under this part pending an appeal. Unless specifically provided by the Board, such relief shall not stay the accrual of interest on any disputed amount as provided for in § 345.122 of this part.

[67 FR 13568, Mar. 25, 2002]

§ 345.125 Records.

Every employer subject to the payment of contributions for any calendar quarter shall, with respect to each such quarter, keep such permanent records as are necessary to establish the total amount of compensation payable to its employees, for a period of at least five calendar years after the date the contribution report to which the compensation relates was required to be filed, or the date the contribution is paid, whichever is later. The record should be in such form as to contain the information required to be shown on the quarterly contribution report. All records required by the regulations in this part shall be kept at a safe and convenient location accessible to inspection by the Board or any of its officers or employees, or by the Inspector General of the Railroad Retirement Board. Such records shall be at all times open for inspection by such officers or employees.

(Approved by the Office of Management and Budget under control number 3220–0012)

§ 345.126 Liens.

If any employer, after demand, neglects or refuses to pay a contribution

required under this part, the amount of such contribution (including any interest, penalties, additional amount, or additions to such contribution, together with any costs that may accrue in addition thereto) shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belonging to such employer.

Subpart C—Individual Employer Records

§ 345.201 Individual employer record defined.

Effective January 1, 1990, the Board will establish and maintain a record, hereinafter known as an Individual Employer Record, for each employer subject to this part. As used in this subpart, ''Individual Employer Record'' means a record of each employer's benefit ratio; reserve ratio; 1-year compensation base; 3-year compensation base; unallocated charge; reserve balance; net cumulative contribution balance; and cumulative benefit balance. See § 345.302 of this part for a definition of these terms. Whenever a new employer begins paying compensation with respect to which contributions are payable under this part, the Board will establish and maintain an individual employer record for such employer.

§ 345.202 Consolidated employer records.

(a) *Establishing a consolidated employer record.* Two or more employers that are under common ownership or control may request the Board to consolidate their individual employer records into a joint individual employer record. Such joint individual employer record shall be treated as though it were a single employer record. A request for such consolidation shall be made to the Director of Policy and Systems, and such consolidation shall be effective commencing with the calendar year following the year of the request.

(b) *Discontinuance of a consolidated employer record.* Two or more employers that have established and maintained a consolidated employer record will be permitted to discontinue such consolidated record only if the individual employers agree to an allocation of the consolidated employer record and such allocation is approved by the Director of Policy and Systems. The discontinuance of the consolidated record shall be effective commencing with the calendar year following the year of the Director of Policy and Systems' approval.

[80 FR 13764, Mar. 17, 2015]

§ 345.203 Merger or combination of employers.

In the event of a merger or combination of two or more employers, or an employer and non-employer, the individual employer record of the employer surviving the merger (or any person that becomes an employer as the result of the merger or combination) shall consist of the combination of the individual employer records of the entities participating in the merger. Where the person surviving the merger is an existing employer under part 202 of this chapter, the individual employer record for the surviving employer will not be updated to reflect the combined record until the calendar year following the year of the Board's determination. Where the entity surviving the merger becomes an employer under part 202 of this chapter by virtue of the merger, the individual employer record shall consist of the combined record effective with its employer effective date.

[70 FR 42489, July 25, 2005]

§ 345.204 Sale or transfer of assets.

(a) In the event property of an employer is sold or transferred to another employer (or to a person that becomes an employer as the result of the sale or transfer) or is partitioned among two or more employers or persons, the individual employer record of such employer shall be prorated among the employer or employers that receive the property (including any person that becomes an employer by reason of such transaction or partition), in accordance with any agreement among the respective parties (including an agreement that there shall be no proration of the employer record). Such agreement shall be subject to the approval of the Board. Where the employer acquiring the assets is an existing employer under part 202 of this chapter,

that employer's individual employer record will take into consideration the acquired assets no earlier than the calendar year following the year of the Board's determination, unless an agreement among the respective parties provides otherwise. Where the employer acquiring the assets becomes an employer under part 202 of this chapter by virtue of such acquisition, the individual employer record for such employer shall consider the acquired assets as of such person's employer effective date, subject to any agreement between the respective parties and the provisions of paragraph (b) of this section.

(b) There shall be no transfer of the employer record where an employer abandons a line of track in accordance with the provisions of the Interstate Commerce Act and the applicable regulations thereunder, and a new entity, found by the Board to be an ''employer'' under part 301 of this chapter, is formed to operate or continue service over such line; the Board will assign to such entity a new-employer contribution rate in accordance with section 8(a)(1)(D) of the RUIA and § 345.304 of this part.

[61 FR 20072, May 3, 1996, as amended at 70 FR 42489, July 25, 2005]

§ 345.205 Reincorporation.

The cumulative benefit balance, net cumulative contribution balance, 1-year compensation base, and 3-year compensation base of an employer that reincorporates or otherwise alters its corporate identity in a transaction not involving a merger, consolidation, or unification will attach to the reincorporated or altered identity.

§ 345.206 Abandonment.

If an employer abandons property or discontinues service but continues to operate as an employer, the employer's individual employer record shall continue to be calculated as provided in this subpart without retroactive adjustment.

§ 345.207 Defunct employer.

If the Board determines that an employer has permanently ceased to pay compensation with respect to which contributions are payable under this part, the Board will, on the date of such determination, transfer the employer's net cumulative contribution balance as a subtraction from, and the cumulative benefit balance as an addition to, the system unallocated charge balance and will cancel all other accumulations of the employer. The Board's determination that an employer is defunct will be based on evidence indicating that the employer has ceased all operations as an employer and has terminated its status as an employer. In making its determination, the Board will consider evidence as described in part 202 of this chapter with respect to termination of employer status under the Railroad Retirement Act. Mere failure of an employer to pay contributions due under this part does not indicate that such employer is defunct.

§ 345.208 System records.

Effective January 1, 1990, the Board will establish and maintain records necessary to determine pooled charges, pooled credits, and unallocated charges for the experience rating system and will publish a notice with respect thereto no later than October 15 of each year. See § 345.302 of this part for the definition of these terms.

Subpart D—Contribution Rates

§ 345.301 Introduction.

(a) *General.* Effective January 1, 1993, each employer that is subject to this part will have an experience-rated rate of contribution computed as set forth in § 345.303 of this part. A transitional rate of contribution applies to each such employer for 1991 and 1992, in accordance with section 8(a)(1)(B) of the RUIA. An employer that first becomes subject to section 8 of the RUIA after December 31, 1989 will have a ''new-employer'' contribution rate as computed in § 345.304 of this part. An employer's experience-rated contribution rate will be not less than 0.65 percent nor more than 12.5 percent. Not later than October 15 of each year, the Board will notify each employer of its experience-rated contribution rate for the following calendar year.

(b) *Components of an experience-rated contribution rate.* An employer's experience-rated contribution rate for each

calendar year beginning with 1993 will be based upon the following charges:

(1) An allocated charge based upon the amount of benefits paid to employees of such employer; this charge is explained in subpart E of this part;

(2) An unallocated charge based upon a proportionate share of the system unallocated charge balance, the computation of which is explained in §345.302(p) of this part;

(3) A pooled charge, also referred to as risk-sharing, to cover the cost of benefit payments that are chargeable to a base year employer but are not captured by the contribution rate assigned to such employer because it is paying contributions at the maximum rate of contribution; the formula for computing the pooled charge is set forth in §345.302(j) of this part;

(4) A surcharge of 1.5, 2.5, or 3.5 percent, or a pooled credit, depending on the balance to the credit of the Account as of June 30 of a given year; and

(5) An addition of 0.65 percent to the rate of contribution to cover the expenses incurred by the Board in administering the RUIA.

(c) *Maximum rate of contribution.* Notwithstanding any provision of this part, an employer's contribution rate for any calendar year shall be limited to 12 percent, except when a surcharge of 3.5 percent is in effect with respect to that calendar year. If a 3.5 percent surcharge is in effect, the maximum contribution limit with respect to that calendar year is 12.5 percent. The surcharge rate for a calendar year will be 3.5 percent when the balance to the credit of the Account is less than zero. The Board will compute the surcharge rate in accordance with §345.302(n) of this part.

§345.302 Definition of terms and phrases used in experience-rating.

(a) *Account.* The Railroad Unemployment Insurance Account established by section 10 of the Railroad Unemployment Insurance Act (RUIA) and maintained by the Secretary of the Treasury in the unemployment trust fund established pursuant to section 904 of the Social Security Act. Benefits paid under the RUIA for an employee's days of unemployment or days of sickness are paid from this Account.

(b) *Benefit ratio.* This ratio is computed for each employer as of any given June 30 by dividing all benefits charged to the employer under subpart E of this part during the 12 calendar quarters ending on such June 30 by the employer's three-year compensation base as of such June 30, as computed under paragraph (q) of this section. The ratio is computed to four decimal places.

(c) *Benefits.* Benefits are money payments paid or payable by the Board to a qualified employee with respect to his or her days of unemployment or days of sickness, as provided by the RUIA.

(d) *Compensation.* This term has the meaning given in part 302 of this chapter.

(e) *Contributions.* Contributions are the money payments paid or payable by an employer subject to this part with respect to the compensation paid or payable to employees of such employer.

(f) *Cumulative benefit balance.* An employer's cumulative benefit balance as of any given June 30 is determined by adding:

(1) The net amount of the benefits charged to the employer under subpart E on or after January 1, 1990, and

(2) The cumulative amount of the employer's unallocated charges on and after January 1, 1990, as computed under paragraph (r) of this section.

(g) *Fund.* The Railroad Unemployment Insurance Administration Fund established by section 11 of the RUIA and maintained by the Secretary of the Treasury in the unemployment trust fund established pursuant to section 904 of the Social Security Act. The costs incurred by the Board in administering the RUIA are paid from the Fund.

(h) *Net cumulative contribution balance.* The Board will determine an employer's net cumulative contribution balance as of any given June 30, as follows:

(1) *Step 1.* Compute the sum of all contributions paid by the employer pursuant to this part after December 31, 1989; add that portion of the tax, if any, imposed under 26 U.S.C. 3321(a) that is attributable to the surtax rate under section 7106(b) of the Railroad

Unemployment Insurance and Retirement Improvement Act of 1988 (Pub. L. 100–647) and any repayment taxes paid by the employer pursuant to 26 U.S.C. 3321(a) after the outstanding balance of loans made under section 10(d) of the RUIA before October 1, 1985, plus interest, has been paid;

(2) *Step 2.* Subtract an amount equal to the amount of such contributions deposited, pursuant to section 8(i) of the RUIA, to the credit of the Fund; and

(3) *Step 3.* Add an amount equal to the aggregate amount by which such contributions were reduced in prior calendar years as a result of pooled credits, if any, under paragraph (k) of this section.

(i) *One-year compensation base.* An employer's one-year compensation base is the aggregate amount of compensation with respect to which the employer is liable for contributions under this part in the four calendar quarters ending on such June 30.

(j) *Pooled charge ratio.* The pooled charge ratio, when applicable, is a pro-rata increase in the rate of contribution assigned to each employer that is not already paying contributions at the maximum rate. A pooled charge will become applicable to each such employer during a calendar year when the Account loses income because one or more other employers are paying contributions at the maximum rate (12 or 12.5 percent) rather than at the higher experience-based rate that their benefit charges would otherwise require. The pooled charge ratio thus picks up the cost of benefits paid to employees of employers whose rate of contribution is capped at the maximum rate. The pooled charge ratio for a calendar year is the same for all employers whose rate is less than the maximum and is computed as follows:

(1) *Step 1.* For each employer paying contributions at the maximum contribution limit under § 345.301(c) of this part, compute the amount of contributions that such employer would have paid if its experience-based rate were applied to its one-year compensation base as of the preceding June 30 and by then deducting from such amount the amount derived by applying the maximum contribution rate to the same one-year compensation base. For the purposes of this computation, the experience-based rate is the rate computed for such employer under § 345.303 of this part.

(2) *Step 2.* After the amount is computed for each employer in accordance with Step 1 of this paragraph (j), add the amounts for all such employers. The aggregate amount so computed represents the amount of contributions not collected by the Account because of the maximum contribution limit.

(3) *Step 3.* For each employer whose experience-based rate of contribution, as computed at Step 3 of § 345.303(a) of this part, is less than zero, the percentage rate by which the employer's rate was raised in order to bring that rate to the minimum rate of zero is multiplied by the employer's 1-year compensation base. The total of the amounts so computed is subtracted from the aggregate amount computed in Step 2 of this paragraph (j).

(4) *Step 4.* Divide the net aggregate amount computed at Step 3 of this paragraph (j) by the system compensation base as of the preceding June 30, excluding from such base the one-year compensation base of each employer whose experience-based contribution rate, computed at Step 6 of § 345.303(a) of this part, exceeds the maximum contribution limit. The result is the pooled charge ratio for the current calendar year. This ratio is computed to four decimal places.

(k) *Pooled credit ratio.* Effective January 1, 1991, and on the first of each subsequent calendar year, the Board will reduce each employer's rate of contribution, as computed under § 345.303 of this part, by the amount of the pooled credit ratio, if any, applicable to such calendar year. This ratio is computed by reference to the accrual balance to the credit of the Account as of the preceding June 30. The Board will determine the amount of the pooled credit ratio, as follows:

(1) *Step 1.* First, the Board computes the accrual balance to the credit of the Account as of the close of business on the preceding June 30 in the same manner as under Step 1 of paragraph (n) of this section. There will be a pooled credit ratio for the calendar year if that balance is in excess of the greater

of $250 million or of the amount that bears the same ratio to $250 million as the system compensation base as of that June 30 bears to the system compensation base as of June 30, 1991, as computed in accordance with paragraph (o) of this section.

(2) *Step 2.* If there is such an excess amount, divide that excess amount by the system compensation base as of the June 30 preceding the calendar year. The result is the pooled credit ratio applicable to each employer for the calendar year involved in the computation. This ratio is computed to four decimal places.

(l) *Reserve balance.* An employer's reserve balance is computed as of any given June 30 by subtracting its cumulative benefit balance as of such June 30 from its net cumulative contribution balance as of such June 30. An employer's net cumulative benefit balance is computed under paragraph (f) of this section and its net cumulative contribution balance under paragraph (h) of this section. An employer's reserve balance may be either positive or negative, depending upon whether its net cumulative contribution balance exceeds its cumulative benefit balance.

(m) *Reserve ratio.* This ratio is computed for each employer as of any given June 30 by dividing its reserve balance as of June 30 by its one-year compensation base as of such June 30. An employer's reserve balance is computed under paragraph (l) of this section and its one-year compensation base under paragraph (i) of this section. This ratio is computed to four decimal places; it may be either a positive or negative figure, depending on whether the employer's reserve balance is a positive or negative figure.

(n) *Surcharge rate.* Effective January 1, 1991, and on the first of each subsequent calendar year, the Board will add to each employer's rate of contribution, as computed under § 345.303 of this part, a surcharge rate of 1.5, 2.5, or 3.5 percent if the accrual balance to the credit of the Account, as of the preceding June 30, falls within the range of balances set forth in Steps 1 and 2 of this paragraph (n). The Board will determine which surcharge rate, if any, is in effect for a calendar year by means of the following computation:

(1) *Step 1.* First, the Board computes the accrual balance to the credit of the Account as of the close of business on the preceding June 30. Such balance will include any amounts in the Account attributable to loans made under section 10(d) of the Act before October 1, 1985, but not the obligation of the Account to repay such loans with interest. For this purpose, the Account will be deemed to include any balance to the credit of the Fund that exceeds $6 million. The surcharge rate, as specified in Step 2 of this paragraph (n), will apply if that balance is less than the greater of $100 million or of the amount that bears the same ratio to $100 million as the system compensation base as of that June 30 bears to the system compensation base as of June 30, 1991, as computed in accordance with paragraph (o) of this section.

(2) *Step 2.* If the balance to the credit of the Account is less than the greater of the amounts referred to in the last sentence of Step 1 of this paragraph (n), but is equal to or more than the greater of $50 million or of the amount that bears the same ratio to $50 million as the system compensation base as of that June 30 bears to the system compensation base as of June 30, 1991, then the surcharge rate for the calendar year shall be 1.5 percent. If the balance to the credit of the Account is less than the greater of the amounts referred to in this Step 2, but greater than or equal to zero, then the surcharge rate for the calendar year shall be 2.5 percent. If the balance to the credit of the Account is less than zero, the surcharge rate for the calendar year shall be 3.5 percent.

(o) *System compensation base.* The system compensation base as of June 30 of each year is the total of the amounts of the one-year compensation bases of all base year employers, computed in accordance with paragraph (i) of this section. Not later than October 15 of each year, the Board will compute the amount of the system compensation base and will publish notice of such amount in the FEDERAL REGISTER as soon as practicable thereafter.

(p) *System unallocated charge balance.* This balance, as computed initially for the period January 1 through June 30, 1990 and updated as of June 30 of each

subsequent calendar year, represents the net amount of expenditures from, and income to, the Account that cannot be allocated as benefit charges, or adjustments, to the cumulative benefit balances of individual base year employers. The Board computes this balance, as of June 30 of each year, as follows:

(1) *Step 1.* Compute the aggregate amount of all interest paid by the Account on loans from the Railroad Retirement Account after September 30, 1985, pursuant to section 10(d) of the RUIA, during the 12-month period ending on June 30;

(2) *Step 2.* Add the amount of unemployment benefits paid by reason of strikes or work stoppages growing out of labor disputes and the cumulative benefit balance of any defunct employer;

(3) *Step 3.* Add the aggregate amount of any other benefit payment that is not chargeable to a base year employer pursuant to subpart E of this part and any other expenditure not chargeable to the Fund;

(4) *Step 4.* Subtract the aggregate amount of income to the Account received as a proportionate part of the earnings of the unemployment trust fund, computed in accordance with section 904(e) of the Social Security Act, and all income to the Account received as fines or penalties collected under the RUIA;

(5) *Step 5.* Subtract the aggregate amount of all transfers from the Fund to the Account pursuant to section 11(d) of the RUIA;

(6) *Step 6.* Subtract the aggregate amount of any other cash receipt to the Account that cannot be treated as an adjustment to the benefit charges of a base year employer;

(7) *Step 7.* Subtract the net cumulative contribution balance of any defunct employer, calculated as of the date on which the Board determines that such employer is defunct. After the Board has computed the amount of the system unallocated charge balance as of June 30 of each year, the Board will publish notice of such amount in the FEDERAL REGISTER on or before October 15 of such year.

(q) *Three-year compensation base.* An employer's three-year compensation base as of any given June 30 is the aggregate amount of compensation with respect to which the employer is liable for contributions under this part in the 12 calendar quarters ending on such June 30.

(r) *Unallocated charge.* An employer's unallocated charge as of any given June 30 is the amount that, as of such June 30, bears the same ratio to the system unallocated charge balance as the employer's 1-year compensation base bears to the system compensation base. The system unallocated charge balance is computed under paragraph (p) of this section and the system compensation base under paragraph (o) of this section.

§ 345.303 Computation of rate.

(a) With respect to compensation in a calendar year that begins after December 31, 1992, the Board will compute, by October 15, 1992, and by October 15 of each subsequent year, a contribution rate for each employer (other than a new employer) in accordance with the following 8-step process:

(1) *Step 1.* Compute the employer's *benefit ratio* as of the preceding June 30;

(2) *Step 2.* Compute the employer's *reserve ratio* as of the preceding June 30 and subtract it from the *benefit ratio;*

(3) *Step 3.* Subtract the *pooled credit ratio* (if any) for the calendar year;

(4) *Step 4.* Multiply the Step 3 result by 100, in order to obtain a percentage rate, and then round such rate to the nearest 100th of one percent. If the rate so computed is zero or less than zero, the percentage rate will be deemed zero at this point;

(5) *Step 5.* Add 0.65 (the administrative charge) to the percentage rate computed through Step 4.

(6) *Step 6.* Add the *surcharge rate* (if any) for the calendar year;

(7) *Step 7.* Add the *pooled charge ratio* (if any) for the calendar year, as computed to four decimal places and multiplied by 100;

(8) *Step 8.* If the rate computed through Step 7 is greater than 12 percent (or 12.5 percent if a surcharge of 3.5 percent is in effect for the calendar year), reduce the percentage rate so computed to 12 percent or 12.5 percent, if appropriate.

(b) The percentage rate computed under paragraph (a) of this section is the employer's rate of contribution for the calendar year in question.

(c)(1) Any computation that is to be made under this section on the basis of a 12-quarter period ending on a given June 30 shall be made on the basis of a period beginning on January 1, 1990, or on the first day of the first calendar quarter that begins after the date on which the employer first began to pay compensation subject to this part, or on July 1 of the third calendar year preceding that June 30, whichever date is later, and ending on that June 30.

(2) The amount computed under paragraph (c)(1) of this section shall be increased to an amount that bears the same ratio to the amount so computed as 12 bears to the number of calendar quarters on which the computation is based.

§ 345.304 New-employer contribution rates.

(a) An employer whose coverage under the RUIA becomes effective after December 31, 1989, is considered a ''new employer'' for the purposes of this part and will be assigned a contribution rate as computed under this section. The Board shall determine where an employer is a new employer and, if so, the effective date of its coverage under the RUIA and its rate of contribution with respect to compensation paid to employees on and after such effective date.

(b) *Initial contribution rate.* The rate of contribution with respect to compensation paid in calendar months before the end of the first full calendar year that the employer is subject to this section shall be the average contribution rate paid by all employers during the three calendar years preceding the calendar year before the calendar year in which the compensation is paid. The Board will compute the average contribution rate by dividing the aggregate contributions paid by all employers during those three calendar years by the aggregate compensation with respect to which such contributions were paid and by then multiplying the resulting ratio, as computed to four decimal points, by 100.

(c) *Second contribution rate.* The rate of contribution with respect to compensation paid in months in the second full calendar year shall be the smaller of the maximum contribution limit under the RUIA or the percentage rate computed as follows:

$$R = \frac{2(A2) + B}{3}$$

(d) *Third contribution rate.* The rate of contribution with respect to compensation paid in months in the third full calendar year shall be the smaller of the maximum contribution limit under the RUIA or the percentage rate computed as follows:

$$R = \frac{A3 + 2C}{3}$$

(e) *Subsequent calendar years.* The rate of contribution with respect to months after the third full calendar year shall be determined under § 345.303 of this part.

(f) *Meaning of symbols.* For the purpose of the formulas in paragraphs (c) and (d) of this section, ''R'' is the applicable contribution rate being computed; ''A2'' is the contribution rate that would have been determined under paragraph (b) of this section if the employer's second calendar year had been its first full calendar year; ''A3'' is the contribution rate that would have been determined under paragraph (b) of this section, if the employer's third calendar year had been such employer's first full calendar year; ''B'' is the contribution rate for the employer as determined under § 345.303 of this part for the employer's second full calendar year; and ''C'' is the contribution rate for the employer as determined under § 345.303 of this part for the employer's third full calendar year.

(g) *Special rule for certain computations.* For purposes of computing ''B'' and ''C'' in the formulas in this section, the percentage rate computed under § 345.303 shall not be reduced under Step 8 of that section; and any computations that, under § 345.303, are to be made on the basis of a 4-quarter or 12-quarter period ending on a given June 30 shall be made on the basis of a period commencing with the first day

of the first calendar quarter that begins after the date on which the employer first began paying compensation subject to this part and ending on that June 30, and the amount so computed shall be increased to an amount that bears the same ratio to the amount so computed as four or twelve, as appropriate, bears to the number of calendar quarters in the period on which the computation was based.

§ 345.305 Notification and proclamations.

(a) *Quarterly notifications to employers.* Not later than the last day of any calendar quarter that begins after March 31, 1990, the Board will notify each employer of its cumulative benefit balance and its net cumulative contribution balance as of the end of the preceding calendar quarter, as computed in accordance with § 345.302(f) and (h) of this part as of the last day of such preceding calendar quarter rather than as of a given June 30 if such last day is not a June 30.

(b) *Annual notifications to employers.* Not later than October 15, 1990, and October 15 of each year thereafter, the Board will notify each employer of its benefit ratio, reserve ratio, one-year compensation base, three-year compensation base, unallocated charge, and reserve balance as of the preceding June 30, as computed in accordance with this part, and of the contribution rate applicable to the employer for the following calendar year as computed under the applicable section of this part.

(c) *Proclamations.* Not later than October 15, 1990, and October 15 of each year thereafter, the Board shall proclaim—

(1) The balance to the credit of the Account as of the preceding June 30 for purposes of computing the pooled credit ratio and the surcharge rate of contribution;

(2) The balance of any advances to the Account under section 10(d) of the RUIA after September 30, 1985, that has not been repaid with interest as provided in such section as of September 30 of that year;

(3) The system compensation base as of that June 30;

(4) The system unallocated charge balance as of that June 30; and

(5) The pooled credit ratio, the pooled charge ratio, and the surcharge rate of contribution, if any, applicable in the following calendar year.

(d) *Publication and notice.* As soon as practical after the Board has determined and proclaimed the amounts specified in paragraph (c) of this section, the Board will publish notice of such amounts in the FEDERAL REGISTER. The notifications to employers under paragraphs (a) and (b) of this section will be sent to the employer official designated to receive them.

§ 345.306 Availability of information.

Upon request of an employer subject to this part, the Board will make available to such employer any information that is necessary to verify the accuracy of its rate of contribution, as determined by the Board, including information necessary to verify the accuracy of the data maintained by the Board in the employer's individual employer record.

§ 345.307 Rate protest.

(a) *Request for reconsideration.* An employer may appeal a determination of a contribution rate computed under this part by filing a request for reconsideration with the Director of Policy and Systems within 90 days after the date on which the Board notified the employer of its rate of contribution for the next ensuing calendar year. Within 45 days of the receipt of a request for reconsideration, the Director shall issue a decision on the protest.

(b) *Appeal to the Board.* An employer aggrieved by the decision of the Director of Policy and Systems under paragraph (a) of this section may appeal to the Board. Such appeal shall be filed with the Secretary to the Board within 30 days after the date on which the Director notified the employer of the decision on reconsideration. The Board may decide such appeal without a hearing or, in its discretion, may refer the matter to a hearings officer pursuant to part 319 of this chapter.

(c) *Decision of the Board final.* Subject to judicial review provided for in section 5(f) of the RUIA, the decision of the Board under paragraph (b) of this

section is final with respect to all issues determined therein.

(d) *Waiver of time limits.* A request for reconsideration or appeal under this section shall be forfeited if the request or appeal is not filed within the time prescribed, unless reasonable cause, as defined in this part, for failure to file timely is shown.

(e) *Rate pending review.* Pending review of the protested rate, the employer shall continue to pay contributions at such rate. Any adjustment in the contributions paid at such rate as the result of an appeal shall be in accordance with § 345.118 of this part.

(f) The amount of a contribution, interest, or penalty may be protested in accord with § 345.124 of this part.

[67 FR 13568, Mar. 25, 2002, as amended at 80 FR 13764, Mar. 17, 2015]

Subpart E—Benefit Charging

§ 345.401 General rule.

Effective January 1, 1990, all benefits paid to an employee for his or her days of unemployment or days of sickness will be charged to the base year employer of such employee, except as hereinafter provided in this part. The Board will make the charge by adding the gross amount of the benefits payable to an employee on the basis of a claim for benefits to that employee's base year employer's cumulative benefit balance. The benefit charge does not depend on whether the employee receiving the benefit payment is a current employee of the base year employer.

§ 345.402 Strikes or work stoppages.

If benefits are payable to an employee for days of unemployment resulting from a strike or work stoppage growing out of a labor dispute, the Board will charge the benefit payment to the system unallocated charge balance, not to the cumulative benefit balance of the employee's base year employer. For the purposes of this section, the phrase ''strike or work stoppage growing out of a labor dispute'' does not include an employee's protected refusal to work under section 212(b) of the Federal Railroad Safety Act of 1970 (45 U.S.C. 441(b)).

§ 345.403 Multiple base year employers.

(a) *General rules for benefit charging.* All benefits paid to an employee who had more than one base year employer shall be charged to the cumulative benefit balances of such employers, as follows:

(1) If the employer at the time of the claim is the same as the last employer in the base year, benefits will be charged in reverse chronological order, but the amount charged to each base year employer shall not exceed the amount of compensation paid by such employer to the employee in the base year;

(2) In all other cases, benefits will be charged in the same ratio as the compensation paid to such employee by the employer bears to the total of such compensation paid to such employee by all such employers in the base year; benefit charging in accordance with this method shall apply whether the base year employment was with successive employers or with concurrent employers.

(b) *Excess benefit payments.* If, in applying the rule in paragraph (a)(1) of this section, there remain benefit payments, in whole or in part, that cannot be charged to any base year employer, the amount of benefits paid in excess of those chargeable under paragraph (a)(1) shall be charged to the system unallocated charge balance.

(c) *Board records as basis for charging multiple base year employers.* Where an employee has more than one base year employer, the Board will use records compiled on the basis of employer reports filed under § 345.110 of this part for the purpose of determining whether the employer at the time of the claim for benefits is the last employer in the base year and for other purposes related to benefit charging under this subpart. If, in a particular case, such records do not contain all the data necessary to determine the charge, the Board will request the necessary data from the base year employers who may be liable for the charge.

§ 345.404 Adjustments.

(a) *Recovery of benefits charged to base year employer.* Where the Board recovers a benefit payment that it had previously charged, in whole or in part, to one or more base year employers, the Board will subtract the amount of the recovery from the cumulative benefit balances of the employers of the employee to whom such amount was paid as a benefit in proportion to the amount by which each such employer's cumulative benefit balance was increased as a result of the payment of the benefit.

(b) *Recovery of other benefit payments.* Where the Board recovers a benefit payment that was not charged, in whole or in part, to any base year employer, or was made before January 1, 1990, the Board will treat the amount of the recovery as a subtraction from the system unallocated charge balance.

(c) *Payment of interest or other debt collection-related charges.* The Board will not adjust a base year employer's cumulative benefit balance to reflect payment by a debtor of interest or other charges assessed by the Board under § 200.7 of this chapter with respect to the collection of a debt arising from a benefit payment charged to such employer and later found to be recoverable by the Board.

(d) *Limitations.* The Board will adjust a base year employer's cumulative benefit balance only when the Board actually recovers, by cash payment or setoff, a debt that represents a benefit payment that was charged, in whole or in part, to such employer. No adjustment shall be made—

(1) If the Board waives recovery of a debt in accordance with part 340 of this chapter, or

(2) If the Board finds that a debt is uncollectible, or

(3) To the extent of the amount not recovered by the Board by reason of a compromise settlement of a debt.

§ 345.405 Notices to base year employers.

(a) *Prepayment notification.* When the Board receives an employee's claim for unemployment or sickness benefits, the Board will give the employee's base year employer notice of the claim and an opportunity to provide information to the Board with respect to the employee's eligibility for benefits for the period of time covered by the claim.

(b) *Notice of claim determination.* After the base year employer has had an opportunity to provide information in accordance with the prepayment notification process described in paragraph (a) of this section, the office of the Board that is adjudicating the employee's claim for benefits will determine whether to pay or to deny benefits on the claim. Such office will send notice to the base year employer showing what determination was made on the claim. If benefits are found to be payable, the amount of the payment will be charged to the cumulative benefit balance of the base year employer in accordance with the provisions of this subpart. If the base year employer disagrees with the payment of benefits, it may request reconsideration in accordance with part 320 of this chapter.

(c) *Quarterly notice of benefit charges.* As soon as practical following the end of each calendar quarter, the Board will send to each employer a report of its cumulative benefit balance computed as of the end of such quarter. The computation of such balance will reflect the following:

(1) The total amount of unemployment and sickness benefit payments made after December 31, 1989, that have been charged to the employer as the base year employer of the employees who received the benefits; minus

(2) The total amount realized in recovery of such benefits; plus

(3) The total amount of the unallocated charges assigned to such base year employer after December 31, 1989; minus

(4) The total amount realized in recovery of such unallocated charges.

§ 345.406 Defunct employer.

Whenever the Board determines, pursuant to § 345.207 of this part, that an employer is defunct, the Board will add the amount of such employer's benefit charges, as shown in its cumulative benefit balance, to the system unallocated charge balance.

PART 346—RAILROAD HIRING

AUTHORITY: 45 U.S.C. 362(l).

§ 346.1 Central register.

(a) The Board shall maintain a central register of railroad employees with at least one year of service who have declared their current availability for rail industry employment. The register shall indicate which of those employees claims a first right of hire.

(b) The central register shall be subdivided by class and craft of prior employment and shall be updated periodically to reflect current employee availability.

(c) Upon request, listings of employees named in the central register and selected on the basis of job experience, location of residence, claimed hiring preference, last railroad employer or other available selection criteria will be furnished to railroads. Railroads may provide written notice of job vacancies to selected employees listed on the register. The railroad notice to the employees should contain job qualification requirements and application instructions. If the railroad requests, the Board shall notify the employees of the vacancy.

[53 FR 3201, Feb. 4, 1988]

PART 348—REPRESENTATIVE PAYMENT

Sec.
348.1 Introduction.
348.2 Recognition by the Board of a person to act in behalf of another.

AUTHORITY: 45 U.S.C. 355, 45 U.S.C. 231k.

SOURCE: 61 FR 42377, Aug. 15, 1996, unless otherwise noted.

§ 348.1 Introduction.

(a) *Explanation of representative payment.* This part explains the principles and procedures that the Board follows in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds which he or she receives on behalf of a claimant. A representative payee may be either a person or an organization selected by the Board to receive benefits on behalf of a claimant. A representative payee will be selected if the Board believes that the interest of a claimant will be served by representative payment rather than direct payment of benefits. Generally, the Board will appoint a representative payee if it determines that the claimant is not able to manage or direct the management of benefit payments in his or her interest.

(b) *Statutory authority.* Section 12 of the Railroad Retirement Act, which is also applicable to the Railroad Unemployment Insurance Act, provides that every claimant shall be conclusively presumed to have been competent until the date on which the Board receives a notice in writing that a legal guardian or other person legally vested with the care of the person or estate of an incompetent or a minor has been appointed: *Provided, however,* That despite receiving such notice, the Board may, if it finds the interests of such claimant to be served thereby, recognize actions by, conduct transactions with, and make payments to such claimant.

(c) *Policy used to determine whether to make representative payment.* (1) The Board's policy is that every claimant has the right to manage his or her own benefits. However, due to mental or physical condition some claimants may be unable to do so. If the Board determines that the interests of a claimant would be better served if benefit payments were certified to another person as representative payee, the Board will appoint a representative payee in accordance with the procedures set forth in this part. The Board may appoint a representative payee even if the claimant is a legally competent individual. If the claimant is a legally incompetent individual, the Board may appoint the legal guardian or some other person as a representative payee.

(2) If payment is being made directly to a claimant and a question arises concerning his or her ability to manage or direct the management of benefit

payments, the Board may, if the claimant has not been adjudged legally incompetent, continue to pay the claimant until the Board makes a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

§ 348.2 Recognition by the Board of a person to act in behalf of another.

The provisions of part 266 of this chapter shall be applicable to the appointment of a representative payee under this part to the same extent and in the same manner as they are applicable to the appointment of a representative payee under the Railroad Retirement Act.

PART 349—FINALITY OF DECISIONS REGARDING UNEMPLOYMENT AND SICKNESS INSURANCE BENEFITS

Sec.

349.1 Reopening and revising decisions.
349.2 Conditions for reopening.
349.3 Change of legal interpretation or administrative ruling.
349.4 Late completion of timely investigation.
349.5 Notice of revised decision.
349.6 Effect of revised decision.
349.7 Time and place to request a review and/or hearing on revised decision.
349.8 Discretion of the three-member Board to reopen or not to reopen a final decision.

AUTHORITY: 45 U.S.C. 355 and 362(l).

SOURCE: 65 FR 66499, Nov. 6, 2000, unless otherwise noted.

§ 349.1 Reopening and revising decisions.

(a) This part sets forth the Board's rules governing finality of decisions with respect to benefits under the Railroad Unemployment Insurance Act. After the expiration of the time limits for review as set forth in part 320 of this chapter, decisions may be reopened and revised only under the conditions described in this subpart, by the bureau, office or entity that made the earlier decision or by a bureau, office, or other entity at a higher level which has the claim properly before it. Whether a final decision is reopened or not reopened is solely within the discretion of the Board.

(b) A *final decision*, as that term is used in this part, means any decision under § 320.5 of this chapter where the time limit for review, as set forth in part 320 of this chapter or in the Railroad Unemployment Insurance Act, has expired.

(c) *Reopening* a final decision under this part means a conscious determination on the part of the agency to reconsider an otherwise final decision for purposes of revising that decision.

(d) *New and material evidence*, as that phrase is used in this part, means evidence which was unavailable to the agency at the time the decision was made, and which the claimant could not reasonably have been expected to have submitted at that time.

§ 349.2 Conditions for reopening.

A final decision may be reopened:

(a) Within 12 months of the date of the notice of such decision, for any reason;

(b) Within four years of the date of the notice of such decision:

(1) If there is new and material evidence; or

(2) If the decision was not reasonably consistent with the evidence of record at the time of adjudication.

(c) At any time if:

(1) The decision was obtained by fraud or similar fault;

(2) The decision was that the claimant was not a qualified employee, and he or she is now qualified because compensation was credited to the employee's record of compensation in accordance with part 211 of this chapter:

(i) To correct errors apparent on the face of the compensation record;

(ii) To enter items transferred by the Social Security Administration which were credited under the Social Security Act when they should have been credited to the employee's railroad retirement compensation record; or

(iii) To correct errors made in the allocation of earnings to individuals or periods which would have made him or her a qualified employee at the time of the decision if the earnings had been credited to his or her earnings record at that time;

(3) The decision is wholly or partially unfavorable to a claimant, but only to correct a clerical error or an error that appears on the face of the evidence that was considered when the decision was made.

§ 349.3 Change of legal interpretation or administrative ruling.

A change of legal interpretation or administrative ruling upon which a decision is based does not render a decision erroneous and does not provide a basis for reopening.

§ 349.4 Late completion of timely investigation.

(a) A decision may be revised after the applicable time period in §§ 349.2(a) or (b) expires if the Board begins an investigation into whether to revise the decision before the applicable time period expires and the agency diligently pursues the investigation to the conclusion. The investigation may be based on a request by a claimant or on action by the Board.

(b) *Diligently pursued* for purposes of this section means that in view of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if the investigation is concluded and, if necessary, the decision is revised within six months from the date the investigation began.

(c) If the investigation is not diligently pursued to its conclusion, the decision will be revised if a revision is applicable and if it is favorable to the claimant. It will not be revised if it would be unfavorable to the claimant.

§ 349.5 Notice of revised decision.

(a) When a decision is revised, notice of the revision will be mailed to the parties to the decision at their last known address. The notice will state the basis for the revised decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a hearings officer or the three-member Board proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, all parties will be notified in writing of the proposed action. If a revised decision is issued by a hearings officer, any party may request that it be reviewed by the three-member Board, or the three-member Board may review the decision on its own initiative.

§ 349.6 Effect of revised decision.

A revised decision is binding unless:

(a) The revised decision is being reconsidered or appealed in accord with part 320 of this chapter;

(b) The three-member Board reviews the revised decision; or

(c) The revised decision is further revised consistent with this part.

§ 349.7 Time and place to request a review and/or hearing on revised decision.

A party to a revised decision may request, as appropriate, further review of the decision in accordance with the rules set forth in part 320 of this chapter. Further review or a hearing will be held according to the rules set forth in part 320 of this chapter.

§ 349.8 Discretion of the three-member Board to reopen or not to reopen a final decision.

In any case in which the three-member Board may deem proper, the Board may direct that any decision, which is otherwise subject to reopening under this part, shall not be reopened or direct that any decision, which is otherwise not subject to reopening under this part, shall be reopened.

SUBCHAPTER D—GARNISHMENT OF BENEFITS

PART 350—GARNISHMENT OF BENEFITS PAID UNDER THE RAILROAD RETIREMENT ACT, THE RAILROAD UNEMPLOYMENT INSURANCE ACT, AND UNDER ANY OTHER ACT ADMINISTERED BY THE BOARD

Sec.
350.1 Authorization for garnishment of benefits paid by the Board.
350.2 Definitions.
350.3 Procedure.
350.4 Exemptions.
350.5 Miscellaneous.
350.6 Garnishment of payments after disbursement.

AUTHORITY: 15 U.S.C. 1673(b)(2); 42 U.S.C. 659; and 45 U.S.C. 231f(b)(5), 231m, 352(e), and 362(l).

§ 350.1 Authorization for garnishment of benefits paid by the Board.

(a) Annuities and accrued annuities payable under the Railroad Retirement Act, sickness and unemployment benefits payable under the Railroad Unemployment Insurance Act, and benefits payable under any other Act administered by the Board, are subject, in like manner and to the same extent as if the Board were a private person, to legal process brought for the enforcement of legal obligations to provide child support or to make alimony payments.

(b) Lump sums, other than accrued annuities, which are payable under the Railroad Retirement Act of 1974, such as those payable under sections 6(b)(1) and 6(c)(1) of that Act, are not subject to legal process as defined in this subchapter. However, an individual entitled to a benefit under section 6 of the Railroad Retirement Act of 1974 may assign the right to receive all or any part of that benefit.

(c) Except as authorized under paragraphs (a) and (b) of this section and part 295 of this chapter, no benefit paid by the Board shall be assignable or be subject to garnishment, attachment, or other legal process, nor shall the payment thereof be anticipated.

(d) In the absence of law to the contrary, it will be assumed that ''wages,'' ''earnings,'' and analogous terms referred to in relevant provisions of state law include payments made by a private person which are analogous to those paid by the Board.

[45 FR 28314, Apr. 29, 1980, as amended at 50 FR 12242, Mar. 28, 1985; 53 FR 35807, Sept. 15, 1988]

§ 350.2 Definitions.

(a) *Child support* means periodic payments of funds for the support and maintenance of a child or children; such term also includes attorney's fees, interest, and court costs, when and to the same extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accordance with applicable state law by a court of competent jurisdiction.

(b) *Alimony* means periodic payments of funds for the support and maintenance of a spouse or former spouse and, subject to and in accord with state law, includes but is not limited to, separate maintenance, alimony pendente lite, maintenance, and spousal support; such term also includes attorney's fees, interest, and court costs, when and to the extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accord with applicable State law by a court of competent jurisdiction. Alimony does not include any payment or transfer of property or of its value in compliance with any community property settlement, equitable distribution of property, or other division of property, nor does it include any payment to an estate.

(c) *Legal process* means any court order, summons, or other similar process, including administrative orders, in the nature of garnishment, which is directed to and the purpose of which is to compel the Board to make a payment from moneys which are otherwise payable to an individual, to another party in order to satisfy a legal obligation of such individual to provide child support or make alimony payments. For purposes of this subchapter, legal process additionally includes assignments in lieu of garnishment, but only where

grounds for the issuance of legal process in the nature of garnishment exist. Such assignments are revocable.

(d) *Legal obligation* means an obligation to pay alimony or child support which is enforceable under appropriate state law.

[45 FR 28314, Apr. 29, 1980, as amended at 53 FR 35807, Sept. 15, 1988]

§ 350.3 Procedure.

(a) Service of legal process brought for the enforcement of an individual's obligation to provide child support or make alimony payments shall be accomplished by certified or registered mail, return receipt requested, directed to the Deputy General Counsel of the Board, 844 Rush Street, Chicago, Illinois 60611, or by personal service upon the Deputy General Counsel.

(b) Where the Deputy General Counsel is effectively served with legal process relating to an individual's legal obligation to provide child support or to make alimony payments, he shall, as soon as possible and not later than 15 days after the date of effective service of such process, send written notice that such process has been so served, together with a copy thereof, to the individual whose moneys are affected thereby; and, if response to such process is required, shall respond within 30 days, or within such longer period as may be prescribed by state law, after the date effective service is made. These requirements do not apply in the case of an assignment in lieu of garnishment or an assignment of a portion, attributable to the existence of the annuitant's family members, of a railroad retirement annuity computed under the social security minimum guaranty provision of the Railroad Retirement Act.

(c) Included with the legal process issued to the Board should be the name of the individual against whom the legal obligation to provide child support or to make alimony payments is sought to be enforced and, if available, the individual's social security or railroad retirement number, the individual's address, and the type of benefit that the individual is receiving from the Board.

(d) Legal process which refers to a payment in terms of a percentage of some other amount must also refer to that payment in terms of a specific amount or amounts. In connection with any legal process which does not refer to a payment in terms of a specific amount or amounts, the Board may compute the amount or may comply with that portion of the legal process which specifies an amount or amounts and withhold compliance with the balance of the process pending clarification from the issuing court or from the party which procured that process.

[45 FR 28314, Apr. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 350.4 Exemptions.

(a) Unless a lower percentage or dollar amount limitation on garnishment is provided by applicable state or local law, the portion of any payment due to an individual which is subject to legal process to enforce any order for the support of any person shall not exceed 65 percent. Where the individual is supporting a spouse or dependent child, other than a spouse or child with respect to whose support that legal process is issued, the portion subject to legal process is reduced by 10 percent. Where the alimony or support arrearage is less than 12 weeks old, the portion subject to legal process is reduced by 5 percent. If a lower limitation is provided by applicable state or local law, then that lower limitation shall be applied.

(b) In the absence of some evidence to the contrary, it will be assumed that the defendant is not supporting a spouse or dependent child other than a spouse or child with respect to whose support the legal process is issued.

(c) In any case in which a recurring benefit payment is reduced, whether due to a recovery by the Board of an overpayment or for some other reason, below the rate at which it is ordinarily paid, any applicable exemptions shall be applied to the amount of the reduced benefit which is actually paid.

(d) For purposes of the applicability of exemptions, amounts deducted for medicare premiums must first be subtracted from the annuity amount.

[45 FR 28314, Apr. 29, 1980]

§ 350.5 Miscellaneous.

(a) The Board may not be required to vary its normal disbursement cycles in order to comply with legal process. However, legal process which is received too late to be honored during the disbursement cycle in which it is received may be honored to the extent that the legal process may, in compliance with this part, be satisfied from the next payment due to the obligor.

(b) Except as provided in these regulations, the Board may not be required in connection with proceedings under this part to forward documents which have been sent to the Board, to an individual, whether or not he is entitled to benefits paid by the Board, or to disclose information other than that relating to the type, amount (whether actual or estimated), and dates of payment of benefits paid by the Board to that individual.

(c) Neither the Board nor any of its employees shall be liable with respect to any payment made to any individual from moneys due from or payable by the Board pursuant to legal process regular on its face, if such payment is made in accordance with this part.

(d) No employee of the Board whose duties include responding to legal process pursuant to requirements contained in this part shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by such employee in connection with the performance of the employee's duties in responding to any such process.

(e) For purposes of a proceeding under this part, the Board will apply the law of the state in which the legal process is issued unless it comes to the attention of the Board that the state of issuance has no contact with the plaintiff or defendant in the action; in which case, the Board may, in its sole discretion, apply the law of any state with significant interest in the matter.

(f) No acknowledgement or response will be made to legal process which does not contain the mailing address to which acknowledgement may be made. No response to any legal process will be notarized or verified.

[45 FR 28314, Apr. 29, 1980, as amended at 50 FR 12242, Mar. 28, 1985]

§ 350.6. Garnishment of payments after disbursement.

Payments that are covered by 45 U.S.C. 231m or 45 U.S.C. 352(e) and that are made by direct deposit are subject to 31 CFR part 212, Garnishment of Accounts Containing Federal Benefit Payments. This section may be amended only by a rulemaking issued jointly by the Department of the Treasury and the agencies defined as a ''benefit agency'' in 31 CFR 212.3.

[76 FR 9961, Feb. 23, 2011]

SUBCHAPTER E—ADMINISTRATIVE REMEDIES FOR FRAUDULENT CLAIMS OR STATEMENTS

PART 355—REGULATIONS UNDER THE PROGRAM FRAUD CIVIL REMEDIES ACT OF 1986

Sec.

355.1 Basis and purpose.
355.2 Definitions.
355.3 Basis for civil penalties and assessments.
355.4 Investigation.
355.5 Review by the reviewing official.
355.6 Prerequisites for issuing a complaint.
355.7 Complaint.
355.8 Service of complaint.
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355.10 Default upon failure to file an answer.
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355.12 Notice of hearing.
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355.18 Authority of the ALJ.
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355.21 Discovery.
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355.26 Form, filing and service of papers.
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355.28 Motions.
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355.30 The hearing and burden of proof.
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355.32 Location of hearing.
355.33 Witnesses.
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355.36 Post-hearing briefs.
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355.42 Judicial review.
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355.44 Right to administrative offset.
355.45 Deposit in Treasury of United States.
355.46 Compromise or settlement.
355.47 Limitations.

AUTHORITY: 31 U.S.C. 3809.

SOURCE: 52 FR 47706, Dec. 16, 1987, unless otherwise noted.

§ 355.1 Basis and purpose.

(a) *Basis.* This part implements the Program Fraud Civil Remedies Act of 1986, Pub. L. 99–509, 6101–6104, 100 Stat. 1874 (Oct. 21, 1986), to be codified at 31 U.S.C. 3801–3812. 31 U.S.C. 3809 of the statute requires each authority head to promulgate regulations necessary to implement the provisions of the statute.

(b) *Purpose.* This part—

(1) Establishes administrative procedures for imposing civil penalties and assessments against persons who make, submit, or present, or cause to be made, submitted, or presented, false, fictitious, or fraudulent claims or written statements to authorities or to their agents, and

(2) Specifies the hearing and appeal rights of persons subject to allegations of liability for such penalties and assessments.

§ 355.2 Definitions.

ALJ means an Administrative Law Judge detailed to the authority pursuant to 5 U.S.C. 3344.

Authority means Railroad Retirement Board.

Authority head means the three-member Railroad Retirement Board.

Benefits means, except as the context otherwise requires, anything of value, including but not limited to any advantage, preference, privilege, license, permit, favorable decision, ruling, status, or loan guarantee.

Board means Railroad Retirement Board.

Claim means any request, demand, or submission—

(a) Made to the authority for property, services, or money (including money representing grants, loans, insurance, or benefits);

(b) Made to a recipient of property, services, or money from the authority or to a party to a contract with the authority—

(1) For property or services if the United States—

(i) Provided such property or services;

(ii) Provided any portion of the funds for the purchase of such property or services; or

(iii) Will reimburse such recipient or party for the purchase of such property or services; or

(2) For the payment of money (including money representing grants, loans, insurance, or benefits) if the United States—

(i) Provided any portion of the money requested or demanded; or

(ii) Will reimburse such recipient or party for any portion of the money paid on such request or demand; or

(c) Made to the authority which has the effect of decreasing an obligation to pay or account for property, services, or money.

Complaint means the administrative complaint served by the reviewing official on the defendant under § 355.7.

Defendant means any person alleged in a complaint under § 355.7 to be liable for a civil penalty or assessment under § 355.3.

Government means the U.S. Government.

Individual means a natural person.

Initial decision means the written decision of the ALJ required by § 355.10 or § 355.37, and includes a revised initial decision issued following a remand or a motion for reconsideration.

Investigating official means the Inspector General of the Railroad Retirement Board or an officer or employee of the Office of the Inspector General designated by the Inspector General and serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule.

Knows or has reason to know means that a person, with respect to a claim or statement—

(a) Has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

(b) Acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(c) Acts in reckless disregard of the truth or falsity of the claim or statement.

Makes, wherever it appears, shall include the terms presents, submits, and causes to be made, presented, or submitted. As the context requires, *making* or *made* shall likewise include the corresponding forms of such terms.

Person means any individual, partnership, corporation, association, private organization, state, political subdivision of a state, municipality, county, district, and Indian tribe, and includes the plural of that term.

Presiding officer means ALJ.

Representative means an attorney who is a member in good standing of the bar of any state, territory, or possession of the United States or of the District of Columbia.

Reviewing official means the General Counsel of the Board or his or her designee who is—

(a) Not subject to supervision by, or required to report to, the investigating official; and

(b) Not employed in the organizational unit of the authority in which the investigating official is employed; and

(c) Is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule.

Statement means any representation, certification, affirmation, document, record, or accounting or bookkeeping entry made—

(a)With respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

(b) With respect to (including relating to eligibility for)—

(1) A contract with, or a bid or proposal for a contract with; or

(2) A grant, loan, or benefit from the authority, or any state, political subdivision of a state, or other party, if the U.S. Government provides any portion of the money or property under such contract or for such grant, loan, or benefit, or if the Government will reimburse such state, political subdivision, or party for any portion of the money or property under such contract or for such grant, loan, or benefit.

§ 355.3 Basis for civil penalties and assessments.

(a) *Claims.* (1) Except as provided in paragraph (c) of this section, any person who makes a claim that the person knows or has reason to know—

(i) Is false, fictitious, or fraudulent;

(ii) Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

(iii) Includes or is supported by any written statement that—

(A) Omits a material fact;

(B) Is false, fictitious, or fraudulent as a result of such omission; and

(C) Is a statement in which the person making such statement has a duty to include such material fact; or

(iv) Is for payment for the provision of property or services which the person has not provided as claimed, shall be subject, in addition to any other remedy that may be prescribed by law, to a civil penalty of not more than $5,000 for each such claim. This penalty is subject to adjustment in accord with part 356 of this chapter.

(2) Each voucher, invoice, claim form, or other individual request or demand for property, services, or money constitutes a separate claim.

(3) A claim shall be considered made to an authority, recipient, or party when such claim is actually made to an agent, fiscal intermediary, or other entity, including any state or political subdivision thereof, acting for or on behalf of such authority, recipient, or party.

(4) Each claim for property, services, or money is subject to a civil penalty regardless of whether such property, services, or money is actually delivered or paid.

(5) If the Government has made any payment (including transferred property or provided services) on a claim, a person subject to a civil penalty under paragraph (a)(1) of this section shall also be subject to an assessment of not more than twice the amount of such claim or that portion thereof that is determined to be in violation of paragraph (a)(1) of this section. Such assessment shall be in lieu of damages sustained by the Government because of such claim. However, such assessment shall not be in lieu of any recovery of erroneous payments as authorized by section 10 of the Railroad Retirement Act or section 2(d) of the Railroad Unemployment Insurance Act.

(b) *Statements.* (1) Except as provided in paragraph (c) of this section, any person who makes a written statement that—

(i) The person knows or has reason to know—

(A) Asserts a material fact which is false, fictitious, or fraudulent; or

(B) Is false, fictitious, or fraudulent because it omits a material fact that the person making the statement has a duty to include in such statement; and

(ii) Contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, shall be subject, in addition to any other remedy that may be prescribed by law, to a civil penalty of not more than $5,000 for each such statement. This penalty is subject to adjustment in accord with part 356 of this chapter.

(2) Each written representation, certification, or affirmation constitutes a separate statement.

(3) A statement shall be considered made to an authority when such statement is actually made to an agent, fiscal intermediary, or other entity, including any state or political subdivision thereof, acting for or behalf of such authority.

(c)(1) In the case of any claim or statement made by any individual relating to any of the benefits listed in paragraph (c)(2) of this section received by such individual, such individual may be held liable for penalties and assessments under this section only if such claim or statement is made by such individual in making application for such benefits with respect to such individual's eligibility to receive such benefits.

(2) For purposes of this paragraph, the term ''benefits'' means any annuity or other benefit under the Railroad Retirement Act of 1974 which are intended for the personal use of the individual who receives the benefits or for a member of the individual's family.

(d) No proof of specific intent to defraud is required to establish liability under this section.

(e) In any case in which it is determined that more than one person is liable for making a claim or statement under this section, each such person may be held liable for a civil penalty under this section.

(f) In any case in which it is determined that more than one person is liable for making a claim under this section on which the Government has made payment (including transferred property or provided services), an assessment may be imposed against any such person or jointly and severally against any combination of such persons.

[52 FR 47706, Dec. 16, 1987, as amended at 62 FR 3791, Jan. 27, 1997]

§ 355.4 Investigation.

(a) If an investigating official concludes that a subpoena pursuant to the authority conferred by 31 U.S.C. 3804(a) is warranted—

(1) The subpoena so issued shall notify the person to whom it is addressed of the authority under which the subpoena is issued and shall identify the records or documents sought;

(2) He or she may designate a person to act on his behalf to receive the documents sought; and

(3) The person receiving such subpoena shall be required to tender to the investigating official or the person designated to receive the documents a certification that the documents sought have been produced, or that such documents are not available and the reasons therefor, or that such documents, suitably identified, have been withheld based upon the assertion of an identified privilege.

(b) If the investigating official concludes that an action under the Program Fraud Civil Remedies Act may be warranted, the investigating official shall submit a report containing the findings and conclusions of such investigation to the reviewing official.

(c) Nothing in this section shall preclude or limit an investigating official's discretion to refer allegations directly to the Department of Justice for suit under the False Claims Act or other civil relief, or to preclude or limit such official's discretion to defer or postpone a report or referral to avoid interference with a criminal investigation or prosecution.

(d) Nothing in this section modifies any responsibility of an investigating official to report violations of criminal law to the Attorney General.

§ 355.5 Review by the reviewing official.

(a) If, based on the report of the investigating official under § 355.4(b), the reviewing official determines that there is adequate evidence to believe that a person is liable under § 355.3 of this part, the reviewing official shall transmit to the Attorney General a written notice of the reviewing official's intention to issue a complaint under § 355.7.

(b) Such notice shall include—

(1) A statement of the reviewing official's reasons for issuing a complaint;

(2) A statement specifying the evidence that supports the allegations of liability;

(3) A description of the claims or statements upon which the allegations of liability are based;

(4) An estimate of the amount of money or the value of property, services, or other benefits requested or demanded in violation of § 355.3 this part;

(5) A statement of any exculpatory or mitigating circumstances that may relate to the claims or statements known by the reviewing official or the investigating official; and

(6) A statement that there is a reasonable prospect of collecting an appropriate amount of penalties and assessments. Such a statement may be based upon information then known or an absence of any information indicating that the person may be unable to pay such an amount.

§ 355.6 Prerequisites for issuing a complaint.

(a) The reviewing official may issue a complaint under § 355.7 only if—

(1) The Department of Justice approves the issuance of a complaint in a written statement described in 31 U.S.C. 3803(b)(1), and

(2) In the case of allegations of liability under § 355.3(a) with respect to a claim, the reviewing official determines that, with respect to such claim or a group of related claims submitted

at the same time such claim is submitted (as defined in paragraph (b) of this section), the amount of money or the value of property or services demanded or requested in violation of §355.3(a) does not exceed $150,000.

(b) For the purposes of this section, a related group of claims submitted at the same time shall include only those claims arising from the same transaction (*e.g.*, grant, loan, application, or contract) that are submitted simultaneously as part of a single request, demand, or submission.

(c) Nothing in this section shall be construed to limit the reviewing official's authority to join in a single complaint against a person, claims that are unrelated or were not submitted simultaneously, regardless of the amount of money or the value of property or services demanded or requested.

§ 355.7 Complaint.

(a) On or after the date the Department of Justice approves the issuance of a complaint in accordance with 31 U.S.C. 3803(b)(1), the reviewing official may serve a complaint on the defendant, as provided in §355.8.

(b) The complaint shall state—

(1) The allegations of liability against the defendant, including the statutory basis for liability, an identification of the claims or statements that are the basis for the alleged liability, and the reasons why liability allegedly arises from such claims or statements;

(2) The maximum amount of penalties and assessments for which the defendant may be held liable;

(3) Instructions for filing an answer to request a hearing, including a specific statement of the defendant's right to request a hearing by filing an answer and to be represented by a representative; and

(4) That failure to file and answer within 30 days of service of the complaint may result in the imposition of the maximum amount of penalties and assessments without right to appeal.

(c) At the same time the reviewing official serves the complaint, he or she shall serve the defendant with a copy of these regulations.

§ 355.8 Service of complaint.

(a) Service of a complaint must be made by certified or registered mail or by delivery in any manner authorized by Rule 4(d) of the Federal Rules of Civil Procedure.

(b) Proof of service, stating the name and address of the person on whom the complaint was served, and the manner and date of service, may be made by—

(1) Affidavit of the individual making service;

(2) An acknowledged U.S. Postal Service return receipt card; or

(3) Written acknowledgment of the defendant or his representative.

§ 355.9 Answer.

(a) The defendant may request a hearing by filing an answer with the reviewing official within 30 days of service of the complaint. An answer shall be deemed to be a request for hearing.

(b) In the answer, the defendant—

(1) Shall admit or deny each of the allegations of liability made in the complaint;

(2) Shall state any defense on which the defendant intends to rely;

(3) May state any reasons why the defendant contends that the penalties and assessments should be less than the statutory maximum; and

(4) Shall state the name, address, and telephone number of the person authorized by the defendant to act as defendant's representative, if any.

§ 355.10 Default upon failure to file an answer.

(a) If the defendant does not file an answer within the time prescribed in §355.9(a), the reviewing official may refer the complaint to the ALJ.

(b) Upon the referral of the complaint, the ALJ shall promptly serve on defendant in the manner prescribed in §355.8, a notice that an initial decision will be issued under this section.

(c) If the defendant has failed to answer the complaint, the ALJ shall assume the facts alleged in the complaint to be true and, if such facts establish liability under §355.3, the ALJ shall issue an initial decision imposing the maximum amount of penalties and assessments allowed under the statute.

(d) Except as otherwise provided in this section, by failing to file a timely answer, the defendant waives any right to further review of the penalties and assessments imposed under paragraph (c) of this section, and the initial decision shall become final and binding upon the parties 30 days after it is issued.

(e) If, before such an initial decision becomes final, the defendant files a motion with the ALJ seeking to reopen on the grounds that extraordinary circumstances prevented the defendant from filing an answer, the initial decision shall be stayed pending the ALJ's decision on the motion.

(f) If, on such motion, the defendant can demonstrate extraordinary circumstances excusing the failure to file a timely answer, the ALJ shall withdraw the initial decision in paragraph (c) of this section, if such a decision has been issued, and shall grant the defendant an opportunity to answer the complaint.

(g) A decision of the ALJ denying a defendant's motion under paragraph (e) of this section is not subject to reconsideration under § 355.38.

(h) The defendant may appeal to the authority head the decision denying a motion to reopen by filing a notice of appeal with the authority head within 15 days after the ALJ denies the motion. The timely filing of a notice of appeal shall stay the initial decision until the authority head decides the issue.

(i) If the defendant files a timely notice of appeal with the authority head, the ALJ shall forward the record of the proceeding to the authority head.

(j) The authority head shall decide expeditiously whether extraordinary circumstances excuse the defendant's failure to file a timely answer based solely on the record before the ALJ.

(k) If the authority head decides that extraordinary circumstances excused the defendant's failure to file a timely answer, the authority head shall remand the case to the ALJ with instructions to grant the defendant an opportunity to answer.

(l) If the authority head decides that the defendant's failure to file a timely answer is not excused, the authority head shall reinstate the initial decision of the ALJ, which shall become final and binding upon the parties 30 days after the authority head issues such decision.

§ 355.11 Referral of complaint and answer to the ALJ.

Upon receipt of an answer, the reviewing official shall file the complaint and answer with the ALJ.

§ 355.12 Notice of hearing.

(a) When the ALJ receives the complaint and answer, the ALJ shall promptly serve a notice of hearing upon the defendant in the manner prescribed by § 355.8. At the same time, the ALJ shall send a copy of such notice to the representative for the Government.

(b) Such notice shall include—

(1) The tentative time and place, and the nature of the hearing;

(2) The legal authority and jurisdiction under which the hearing is to be held;

(3) The matters of fact and law to be asserted;

(4) A description of the procedures for the conduct of the hearing;

(5) The name, address, and telephone number of the representative of the Government and of the defendant, if any; and

(6) Such other matters as the ALJ deems appropriate.

§ 355.13 Parties to the hearing.

(a) The parties to the hearing shall be the defendant and the authority.

(b) Pursuant to 31 U.S.C. 3730(c)(5), a private plaintiff under the False Claims Act may participate in these proceedings to the extent authorized by the provisions of that Act.

§ 355.14 Separation of functions.

(a) The investigating official, the reviewing official, and any employee or agent of the authority who takes part in investigating, preparing, or presenting a particular case may not, in such case or a factually related case—

(1) Participate in the hearing as the ALJ;

(2) Participate or advise in the initial decision or the review of the initial decision by the authority head, except as a witness or a representative in public proceedings; or

(3) Make the collection of penalties and assessments under 31 U.S.C. 3806.

(b) The ALJ shall not be responsible to, or subject to the supervision or direction of the investigating official or the reviewing official.

(c) Except as provided in paragraph (a) of this section, the representative for the Government may be employed anywhere in the authority, including in the offices of either the investigating official or the reviewing official.

§ 355.15 Ex parte contacts.

No party or person (except employees of the ALJ's office) shall communicate in any way with the ALJ on any matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

§ 355.16 Disqualification of reviewing official or ALJ.

(a) A reviewing official or ALJ in a particular case may disqualify himself or herself at any time.

(b) A party may file with the ALJ a motion for disqualification of a reviewing official or an ALJ. Such motion shall be accompanied by an affidavit alleging personal bias or other reason for disqualification.

(c) Such motion and affidavit shall be filed promptly upon the party's discovery of reasons requiring disqualification, or such objections shall be deemed waived.

(d) Such affidavit shall state specific facts that support the party's discovery of such facts. It shall be accompanied by a certificate of the representative of record that it is made in good faith.

(e) Upon the filing of such a motion and affidavit, the ALJ shall proceed no further in the case until he or she resolves the matter of disqualification in accordance with paragraph (f) of this section.

(f)(1) If the ALJ determines that a reviewing official is disqualified, the ALJ shall dismiss the complaint without prejudice.

(2) If the ALJ disqualifies himself or herself, the case shall be reassigned promptly to another ALJ.

(3) If the ALJ denies a motion to disqualify, the authority head may determine the matter only as part of his or her review of the initial decision upon appeal, if any.

§ 355.17 Rights of parties.

Except as otherwise limited by this part, all parties may—

(a) Be accompanied, represented, and advised by a representative;

(b) Participate in any conference held by the ALJ;

(c) Conduct discovery;

(d) Agree to stipulations of fact or law, which shall be made part of the record;

(e) Present evidence relevant to the issues at the hearing;

(f) Present and cross-examine witnesses;

(g) Present oral arguments at the hearing as permitted by the ALJ; and

(h) Submit written briefs and proposed findings of fact and conclusions of law after the hearing.

§ 355.18 Authority of the ALJ.

(a) The ALJ shall conduct a fair and impartial hearing, avoid delay, maintain order, and assure that a record of the proceeding is made.

(b) The ALJ has the authority to—

(1) Set and change the date, time, and place of the hearing upon reasonable notice to the parties;

(2) Continue or recess the hearing in whole or in part for a reasonable period of time;

(3) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding;

(4) Administer oaths and affirmations;

(5) Issue subpoenas requiring the attendance of witnesses and the production of documents at depositions or at hearings;

(6) Rule on motions and other procedural matters;

(7) Regulate the scope and timing of discovery;

(8) Regulate the course of the hearing and the conduct of representatives and parties;

(9) Examine witnesses;
(10) Receive, rule on, exclude, or limit evidence;
(11) Upon motion of a party, take official notice of facts;
(12) Upon motion of a party, decide cases, in whole or in part, by summary judgment where there is no disputed issue of material fact;
(13) Conduct any conference, argument, or hearing on motions in person or by telephone; and
(14) Exercise such other authority as is necessary to carry out the responsibilities of the ALJ under this part.
(c) The ALJ does not have the authority to decide upon the validity of Federal statutes or regulations.

§ 355.19 Prehearing conferences.

(a) The ALJ may schedule prehearing conferences as appropriate.
(b) Upon the motion of any party, the ALJ shall schedule at least one prehearing conference at a reasonable time in advance of the hearing.
(c) The ALJ may use prehearing conferences to discuss the following:
(1) Simplification of the issues;
(2) The necessity or desirability of amendments to the pleadings, including the need for a more definite statement;
(3) Stipulations, admissions of fact or as to the contents and authenticity of documents;
(4) Whether the parties can agree to submission of the case on a stipulated record;
(5) Whether a party chooses to waive appearance at an oral hearing and to submit only documentary evidence (subject to the objection of other parties) and written argument;
(6) Limitation of the number of witnesses;
(7) Scheduling dates for the exchange of witness lists and of proposed exhibits;
(8) Discovery;
(9) The time and place for the hearing; and
(10) Such other matters as may tend to expedite the fair and just disposition of the proceedings.
(d) The ALJ may issue an order containing all matters agreed upon by the parties or ordered by the ALJ at a prehearing conference.

§ 355.20 Disclosure of documents.

(a) Upon written request to the reviewing official, the defendant may review any relevant and material documents, transcripts, records, and other materials that relate to the allegations set out in the complaint and upon which the findings and conclusions of the investigating official under § 355.4(b) are based unless such documents are subject to a privilege under Federal law. Upon payment of fees for duplication, the defendant may obtain copies of such documents.
(b) Upon written request to the reviewing official, the defendant also may obtain a copy of all exculpatory information in the possession of the reviewing official or investigating official relating to the allegations in the complaint, even if it is contained in a document that would otherwise be privileged. If the document would otherwise be privileged, only that portion containing exculpatory information must be disclosed.
(c) The notice sent to the Attorney General from the reviewing official as described in § 355.5 is not discoverable under any circumstances.
(d) The defendant may file a motion to compel disclosure of the documents subject to the provisions of this section. Such a motion may only be filed with the ALJ following the filing of an answer pursuant to § 355.9.

§ 355.21 Discovery.

(a) The following types of discovery are authorized:
(1) Requests for production of documents for inspection and copying;
(2) Requests for admissions of the authenticity of any relevant document or of the truth of any relevant fact;
(3) Written interrogatories; and
(4) Depositions.
(b) For the purpose of this section and §§ 355.22 and 355.23, the term ''documents'' includes information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence. Nothing contained herein shall be interpreted to require the creation of a document.
(c) Unless mutually agreed to by the parties, discovery is available only as ordered by the ALJ. The ALJ shall regulate the timing of discovery.

(d) *Motions for discovery.* (1) A party seeking discovery may file a motion with the ALJ. Such a motion shall be accompanied by a copy of the requested discovery, or in the case of depositions, a summary of the scope of the proposed deposition.

(2) Within ten days of service, a party may file an opposition to the motion and/or a motion for protective order as provided in § 355.24.

(3) The ALJ may grant a motion for discovery only if he or she finds that the discovery sought—

(i) Is necessary for the expeditious, fair, and reasonable consideration of the issues;

(ii) Is not unduly costly or burdensome;

(iii) Will not unduly delay the proceeding; and

(iv) Does not seek privileged information.

(4) The burden of showing that discovery should be allowed is on the party seeking discovery.

(5) The ALJ may grant discovery subject to a protective order under § 355.24.

(e) *Depositions.* (1) If a motion for deposition is granted, the ALJ shall issue a subpoena for the deponent, which may require the deponent to produce documents. The subpoena shall specify the time and place at which the deposition will be held.

(2) The party seeking to depose shall serve the subpoena in the manner prescribed in § 355.8.

(3) The deponent may file with the ALJ a motion to quash the subpoena or a motion for a protective order within ten days of service.

(4) The party seeking to depose shall provide for the taking of a verbatim transcript of the deposition, which it shall make available to all other parties for inspection and copying.

(f) Each party shall bear its own costs of discovery.

§ 355.22 Exchange of witness lists, statements, and exhibits.

(a) At least 15 days before the hearing or at such other time as may be ordered by the ALJ, the parties shall exchange witness lists, copies of prior statements of proposed witnesses, and copies of proposed hearing exhibits, including copies of any written statements that the party intends to offer in lieu of live testimony in accordance with § 355.33(b). At the time the above documents are exchanged, any party that intends to rely on the transcript of deposition testimony in lieu of live testimony at the hearing, if permitted by the ALJ, shall provide each party with a copy of the specific pages of the transcript it intends to introduce into evidence.

(b) If a party objects, the ALJ shall not admit into evidence the testimony of any witness whose name does not appear on the witness list or any exhibit not provided to the opposing party as provided above unless the ALJ finds good cause for the failure or that there is no prejudice to the objecting party.

(c) Unless another party objects within the time set by the ALJ, documents exchanged in accordance with paragraph (a) of this section shall be deemed to be authentic for the purpose of admissibility at the hearing.

§ 355.23 Subpoenas for attendance at hearing.

(a) A party wishing to procure the appearance and testimony of any individual at the hearing may request that the ALJ issue a subpoena.

(b) A subpoena requiring the attendance and testimony of an individual may also require the individual to produce documents at the hearing.

(c) A party seeking a subpoena shall file a written request therefor not less than 15 days before the date fixed for the hearing unless otherwise allowed by the ALJ for good cause shown. Such request shall specify any documents to be produced and shall designate the witnesses and describe the address and location thereof with sufficient particularity to permit such witnesses to be found.

(d) The subpoena shall specify the time and place at which the witness is to appear and any documents the witness is to produce.

(e) The party seeking the subpoena shall serve it in the manner prescribed in § 355.8. A subpoena on a party or upon an individual under the control of a party may be served by first-class mail.

(f) A party or the individual to whom the subpoena is directed may file with

the ALJ a motion to quash the subpoena within ten days after service or on or before the time specified in the subpoena for compliance if it is less than ten days after service.

§ 355.24 Protective order.

(a) A party or a prospective witness or deponent may file a motion for a protective order with respect to discovery sought by an opposing party or with respect to the hearing, seeking to limit the availability or disclosure of evidence.

(b) In issuing a protective order, the ALJ may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense, including one or more of the following:

(1) That the discovery not be had;

(2) That the discovery may be had only on specified terms and conditions, including a designation of the time or place;

(3) That the discovery may be had only through a method of discovery other than that requested;

(4) That certain matters not be inquired into, or that the scope of discovery be limited to certain matters;

(5) That discovery be conducted with no one present except persons designated by the ALJ;

(6) That the contents of discovery or evidence be sealed;

(7) That a deposition after being sealed be opened only by order of the ALJ;

(8) That a trade secret or other confidential research, development, commercial information, or facts pertaining to any criminal investigation, proceeding, or other administrative investigation not be disclosed or be disclosed only in a designated way; or

(9) That the parties simultaneously file specified documents or information enclosed in sealed envelopes to be opened as directed by the ALJ.

§ 355.25 Fees.

The party requesting a subpoena shall pay the cost of the fees and mileage of any witness subpoenaed in the amounts that would be payable to a witness in a proceeding in U.S. District Court. A check for witness fees and mileage shall accompany the subpoena when served, except that when a subpoena is issued on behalf of the authority, a check for witness fees and mileage need not accompany the subpoena.

§ 355.26 Form, filing and service of papers.

(a) *Form.* (1) Documents filed with the ALJ shall include an original and two copies.

(2) Every pleading and paper filed in the proceeding shall contain a caption setting forth the title of the action, the case number assigned by the ALJ, and a designation of the paper (*e.g.*, motion to quash subpoena).

(3) Every pleading and paper shall be signed by, and shall contain the address and telephone number of the party or the person on whose behalf the paper was filed, or his or her representative.

(4) Papers are considered filed when they are mailed. Date of mailing may be established by a certificate from the party or its representative or by proof that the document was sent by certified or registered mail.

(b) *Service.* A party filing a document with the ALJ shall, at the time of filing, serve a copy of such document on every other party. Service upon any party of any document other than the complaint or notice of hearing shall be made by delivering or mailing a copy to the party's last known address. When a party is represented by a representative, service shall be made upon such representative in lieu of the actual party.

(c) *Proof of service.* A certificate of the individual serving the document by personal delivery or by mail, setting forth the manner of service, shall be proof of service.

§ 355.27 Computation of time.

(a) In computing any period of time under this part or in an order issued thereunder, the time begins with the day following the act, event, or default, and includes the last day of the period, unless it is a Saturday, Sunday, or legal holiday observed by the Federal government, in which event it includes the next business day.

(b) When the period of time allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays

observed by the Federal government shall be excluded from the computation.

(c) Where a document has been served or issued by mail, an additional five days will be added to the time permitted for any response.

§ 355.28 Motions.

(a) Any application to the ALJ for an order or ruling shall be by motion. Motions shall state the relief sought, the authority relied upon, and the facts alleged, and shall be filed with the ALJ and served on all other parties.

(b) Except for motions made during a prehearing conference or at the hearing, all motions shall be in writing. The ALJ may require that oral motions be reduced to writing.

(c) Within 15 days after a written motion is served, or such other time as may be fixed by the ALJ, any party may file a response to such motion.

(d) The ALJ may not grant a written motion before the time for filing responses thereto has expired, except upon consent of the parties or following a hearing on the motion, but may overrule or deny such motion without awaiting a response.

(e) The ALJ shall make a reasonable effort to dispose of all outstanding motions prior to the beginning of the hearing.

§ 355.29 Sanctions.

(a) The ALJ may sanction a person, including any party or representative for—

(1) Failing to comply with an order, rule, or procedure governing the proceeding;

(2) Failing to prosecute or defend an action; or

(3) Engaging in other misconduct that interferes with the speedy, orderly, or fair conduct of the hearing.

(b) Any such sanction, including but not limited to those listed in paragraphs (c), (d), (e) of this section, shall reasonably relate to the severity and nature of the failure or misconduct.

(c) When a party fails to comply with an order, including an order for taking a deposition, the production of evidence within the party's control, or a request for admission, the ALJ may—

(1) Draw an inference in favor of the requesting party with regard to the information sought;

(2) In the case of requests for admission, deem each matter of which an admission is requested to be admitted;

(3) Prohibit the party failing to comply with such order from introducing evidence concerning, or otherwise relying upon testimony relating to the information sought; and

(4) Strike any part of the pleadings or other submissions of the party failing to comply with such request.

(d) If a party fails to prosecute or defend an action under this part commenced by service of a notice of hearing, the ALJ may dismiss the action or may issue an initial decision imposing penalties and assessments.

(e) The ALJ may refuse to consider any motion, request, response, brief or other document which is not filed in a timely fashion.

§ 355.30 The hearing and burden of proof.

(a) The ALJ shall conduct a hearing on the record in order to determine whether the defendant is liable for a civil penalty or assessment under §355.3 and, if so, the appropriate amount of any such civil penalty or assessment considering any aggravating or mitigating factors.

(b) The authority shall prove defendant's liability and any aggravating factors by a preponderance of the evidence.

(c) The defendant shall prove any affirmative defenses and any mitigating factors by a preponderance of the evidence.

(d) The hearing shall be open to the public unless otherwise ordered by the ALJ for good cause shown.

§ 355.31 Determining the amount of penalties and assessments.

(a) In determining an appropriate amount of civil penalties and assessments, the ALJ and upon appeal, the authority head, should evaluate any circumstances that mitigate or aggravate the violation and should articulate in their opinions the reasons that support the penalties and assessments they impose. Because of the intangible

costs of fraud, the expense of investigating such conduct, and the need to deter others who might be similarly tempted, ordinarily double damages and a significant civil penalty should be imposed.

(b) Although not exhaustive, the following factors are among those that may influence the ALJ and the authority head in determining the amount of penalties and assessments to impose with respect to the misconduct (*i.e.*, the false, fictitious, or fraudulent claims or statements) charged in the complaint:

(1) The number of false, fictitious, or fraudulent claims or statements;

(2) The time period over which such claims or statements were made;

(3) The degree of the defendant's culpability with respect to the misconduct;

(4) The amount of money or the value of the property, services, or benefit falsely claimed;

(5) The value of the Government's actual loss as a result of the misconduct, including foreseeable consequential damages and the costs of investigation;

(6) The relationship of the amount imposed as civil penalties to the amount of the Government's loss;

(7) The potential or actual impact of the misconduct upon national defense, public health or safety, or public confidence in the management of Government programs and operations, including particularly the impact on the intended beneficiaries of such programs;

(8) Whether the defendant has engaged in a pattern of the same or similar misconduct;

(9) Whether the defendant attempted to conceal the misconduct;

(10) The degree to which the defendant has involved others in the misconduct or in concealing it;

(11) Where the misconduct of employees or agents is imputed to the defendant, the extent to which the defendant's practices fostered or attempted to preclude such misconduct;

(12) Whether the defendant cooperated in or obstructed an investigation of the misconduct;

(13) Whether the defendant assisted in identifying and prosecuting other wrongdoers;

(14) The complexity of the program or transaction, and the degree of the defendant's sophistication with respect to it, including the extent of the defendant's prior participation in the program or in similar transactions;

(15) Whether the defendant has been found, in any criminal, civil, or administrative proceeding to have engaged in similar misconduct or to have dealt dishonestly with the Government of the United States or of a state, directly or indirectly; and

(16) The need to deter the defendant and others from engaging in the same or similar misconduct.

(c) Nothing in this section shall be construed to limit the ALJ or the authority head from considering any other factors that in any given case may mitigate or aggravate the offense for which penalties and assessments are imposed.

§ 355.32 Location of hearing.

(a) The hearing may be held—

(1) In any judicial district of the United States in which the defendant resides or transacts business;

(2) In any judicial district of the United States in which the claim or statement in issue was made; or

(3) In such other place as may be agreed upon by the defendant and the ALJ.

(b) Each party shall have the opportunity to present argument with respect to the location of the hearing.

(c) The hearing shall be held at the place and at the time ordered by the ALJ.

§ 355.33 Witnesses.

(a) Except as provided in paragraph (b) of this section, testimony at the hearing shall be given orally by witnesses under oath or affirmation.

(b) At the discretion of the ALJ, testimony may be admitted in the form of a written statement or deposition. Any such written statement must be provided to all other parties along with the last known address of such witness, in a manner which allows sufficient time for other parties to subpoena such witness for cross-examination at the hearing. Prior written statements of witnesses proposed to testify at the hearing and deposition transcripts

shall be exchanged as provided in § 355.22(a).

(c) The ALJ shall exercise reasonable control over the mode and order of interrogating witnesses and presenting evidence so as to—

(1) Make the interrogation and presentation effective for the ascertainment of the truth.

(2) Avoid needless consumption of time, and

(3) Protect witnesses from harassment or undue embarrassment.

(d) The ALJ shall permit the parties to conduct such cross-examination as may be required for a full and true disclosure of the facts.

(e) At the discretion of the ALJ, a witness may be cross-examined on matters relevant to the proceeding without regard to the scope of his or her direct examination. To the extent permitted by the ALJ, cross-examination on matters outside the scope of direct examination shall be conducted in the manner of direct examination and may proceed by leading questions only if the witness is a hostile witness, an adverse party, or a witness identified with an adverse party.

(f) Upon motion of any party, the ALJ shall order witnesses excluded so that they cannot hear the testimony of other witnesses. This rule does not authorize exclusion of—

(1) A party who is an individual;

(2) In the case of a party that is not an individual, an officer or employee of the party designated by the party's representative; or

(3) An individual whose presence is shown by a party to be essential to the presentation of its case, including an individual employed by the Government engaged in assisting the representative for the Government.

§ 355.34 Evidence.

(a) The ALJ shall determine the admissibility of evidence.

(b) Except as provided herein, the ALJ shall not be bound by the Federal Rules of Evidence. However, the ALJ may apply the Federal Rules of Evidence where appropriate, *e.g.,* to exclude unreliable evidence.

(c) The ALJ shall exclude irrelevant and immaterial evidence.

(d) Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or by considerations of undue delay or needless presentation of cumulative evidence.

(e) Although relevant, evidence may be excluded if it is privileged under Federal law.

(f) Evidence concerning offers of compromise or settlement shall be inadmissible to the extent provided in Rule 408 of the Federal Rules of Evidence.

(g) The ALJ shall permit the parties to introduce rebuttal witnesses and evidence.

(h) All documents and other evidence offered or taken for the record shall be open to examination by all parties, unless otherwise ordered by the ALJ pursuant to § 355.24.

§ 355.35 The record.

(a) The hearing will be recorded and transcribed. Transcripts may be obtained following the hearing from the ALJ at a cost not to exceed the actual cost of duplication.

(b) The transcript of testimony, exhibits and other evidence admitted at the hearing, and all papers and requests filed in the proceeding constitute the record for the decision by the ALJ and the authority head.

(c) The record may be inspected and copied (upon payment of a reasonable fee) by anyone, unless otherwise ordered by the ALJ pursuant to § 355.24.

§ 355.36 Post-hearing briefs.

The ALJ may require the parties to file post-hearing briefs. In any event, any party may file a post-hearing brief. The ALJ shall fix the time for filing such briefs, not to exceed 60 days from the date the parties receive the transcript of the hearing or, if applicable, the stipulated record. Such briefs may be accompanied by proposed findings of fact and conclusions of law. The ALJ may permit the parties to file reply briefs.

§ 355.37 Initial decision.

(a) The ALJ shall issue an initial decision based only on the record, which

shall contain findings of fact, conclusions of law, and the amount of any penalties and assessments imposed.

(b) The findings of fact shall include a finding on each of the following issues:

(1) Whether the claims or statements identified in the complaint, or any portions thereof, violate § 355.3;

(2) If the person is liable for penalties or assessments, the appropriate amount of any such penalties or assessments considering any mitigating or aggravating factors that he or she finds in the case, such as those described in § 355.31.

(c) The ALJ shall promptly serve the initial decision on all parties within 90 days after the time for submission of post-hearing briefs and reply briefs (if permitted) has expired. The ALJ shall at the same time serve all defendants with a statement describing the right of any defendant determined to be liable for a civil penalty or assessment to file a motion for reconsideration with the ALJ or a notice of appeal with the authority head. If the ALJ fails to meet the deadline contained in this paragraph, he or she shall notify the parties of the reason for the delay and shall set a new deadline.

(d) Unless the initial decision of the ALJ is timely appealed to the authority head, or a motion for reconsideration of the initial decision is timely filed, the initial decision shall constitute the final decision of the authority head and shall be final and binding on the parties 30 days after it is issued by the ALJ.

§ 355.38 Reconsideration of initial decision.

(a) Except as provided in paragraph (d) of this section, any party may file a motion for reconsideration of the initial decision within 20 days of receipt of the initial decision. If service was made by mail, receipt will be presumed to be five days from the date of mailing in the absence of contrary proof.

(b) Every such motion must set forth the matters claimed to have been erroneously decided and the nature of the alleged errors. Such motion shall be accompanied by a supporting brief.

(c) Responses to such motions shall be allowed only upon request of the ALJ.

(d) No party may file a motion for reconsideration of an initial decision that has been revised in response to a previous motion for reconsideration.

(e) The ALJ may dispose of a motion for reconsideration by denying it or by issuing a revised initial decision.

(f) When a motion for reconsideration is made, the time periods for appeal to the authority head contained in this section, and for finality of the initial decision in § 355.36(d), shall begin on the date the ALJ issues the denial of the motion for reconsideration or a revised initial decision, as appropriate.

§ 355.39 Appeal to authority head.

(a) Any defendant who has filed a timely answer and who is determined in an initial decision to be liable for a civil penalty or assessment may appeal such decision to the authority head by filing a notice of appeal with the authority head in accordance with this section.

(b)(1) No notice of appeal may be filed until the time period for filing a motion for reconsideration under § 355.38 has expired.

(2) If a motion for reconsideration is timely filed, a notice of appeal must be filed within 30 days after the ALJ denies the motion or issues a revised initial decision, whichever applies.

(3) If no motion for reconsideration is timely filed, a notice of appeal must be filed within 30 days after the ALJ issues the initial decision.

(4) The authority head may extend the initial 30-day period for an additional 30 days if the defendant files with the authority head a request for an extension within the initial 30-day period and shows good cause.

(c) If the defendant files a timely notice of appeal with the authority head, the ALJ shall forward the record of the proceeding to the authority head.

(d) A notice of appeal shall be accompanied by a written brief specifying exceptions to the initial decision and reasons supporting the exceptions.

(e) The representative for the Government may file a brief in opposition

to exceptions within 30 days of receiving the notice of appeal and accompanying brief.

(f) There is no right to appear personally before the authority head.

(g) There is no right to appeal any interlocutory ruling by the ALJ.

(h) In reviewing the initial decision, the authority head shall not consider any objection that was not raised before the ALJ unless a demonstration is made of extraordinary circumstances causing the failure to raise the objection.

(i) If any party demonstrates to the satisfaction of the authority head that additional evidene not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the authority head shall remand the matter to the ALJ for consideration of such additional evidence.

(j) The authority head may affirm, reduce, reverse, compromise, remand, or settle any penalty or assessment, determined by the ALJ in any initial decision.

(k) The authority head shall promptly serve each party to the appeal with a copy of the decision of the authority head. At the same time the authority head shall serve the defendant with a statement describing the defendant's right to seek judicial review.

(l) Unless a petition for review is filed as provided in 31 U.S.C. 3805 after a defendant has exhausted all administrative remedies under this part and within 60 days after the date on which the authority head serves the defendant with a copy of the authority head's decision, a determination that a defendant is liable under § 355.3 is final and is not subject to judicial review.

§ 355.40 Stays ordered by the Department of Justice.

If at any time the Attorney General or an Assistant Attorney General designated by the Attorney General transmits to the authority head a written finding that continuation of the administrative process described in this part with respect to a claim or statement may adversely affect any pending or potential criminal or civil action related to such claim or statement, the authority head shall stay the process immediately. The authority head may order the process resumed only upon receipt of the written authorization of the Attorney General.

§ 355.41 Stay pending appeal.

(a) An initial decision is stayed automatically pending disposition of a motion for reconsideration or of an appeal to the authority head.

(b) No administrative stay is available following a final decision of the authority head.

§ 355.42 Judicial review.

Section 3805 of title 31 U.S. Code authorizes judicial review by an appropriate U.S. District Court of a final decision of the authority head imposing penalties or assessments under this part and specifies the procedures for such review.

§ 355.43 Collection of civil penalties and assessments.

Sections 3806 and 3808(b) of title 31 U.S. Code, authorize actions for collection of civil penalties and assessments imposed under this part and specify the procedures for such actions.

§ 355.44 Right to administrative offset.

The amount of any penalty or assessment which has become final, or for which a judgment has been entered under § 355.42 or § 355.43, or any amount agreed upon in a compromise or settlement under § 355.46, may be collected by administrative offset under 31 U.S.C. 3716, except that an administrative offset may not be made under this subsection against a refund of an overpayment of Federal taxes, then or later owing by the United States to the defendant.

§ 355.45 Deposit in Treasury of United States.

All amounts collected pursuant to this part shall be deposited as miscellaneous receipts in the Treasury of the United States, except as provided in 31 U.S.C. 3806(g).

§ 355.46 Compromise or settlement.

(a) Parties may make offers of compromise or settlement at any time.

(b) The reviewing official has the exclusive authority to compromise or

settle a case under this part at any time after the date on which the reviewing official is permitted to issue a complaint and before the date on which the ALJ issues an initial decision.

(c) The authority head has exclusive authority to compromise or settle a case under this part at any time after the date on which the ALJ issues an initial decision, except during the pendency of any review under § 355.42 or during the pendency of any action to collect penalties and assessments under § 355.43.

(d) The Attorney General has exclusive authority to compromise or settle a case under this part during the pendency of any review under § 355.42 or of any action to recover penalties and assessments under 31 U.S.C. 3806.

(e) The investigating official may recommend settlement terms to the reviewing official, the authority head, or the Attorney General, as appropriate. The reviewing official may recommend settlement terms to the authority head, or the Attorney General, as appropriate.

(f) Any compromise or settlement must be in writing.

§ 355.47 Limitations.

(a) The notice of hearing with respect to a claim or statement must be served in the manner specified in § 355.8 within 6 years after the date on which such claim or statement is made.

(b) If the defendant fails to file a timely answer, service of a notice under § 355.10(b) shall be deemed a notice of hearing for purposes of this section.

(c) The statute of limitations may be extended by agreement of the parties.

PART 356—CIVIL MONETARY PENALTY INFLATION ADJUSTMENT

Sec.

356.1 Introduction.
356.2 Penalties under the Program Fraud Civil Remedies Act of 1986.
356.3 False claims.

AUTHORITY: 28 U.S.C. 2461; 31 U.S.C. 3729, 3809.

SOURCE: 81 FR 26169, May 2, 2016, unless otherwise noted.

§ 356.1 Introduction.

(a) The Federal Civil Penalties Inflation Adjustment Act, as amended by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (28 U.S.C. 2461 note), requires that civil monetary penalties be adjusted on an annual basis by the percentage by which the Consumer Price Index for all Urban Consumers (CPI–U) for the month of October preceding the adjustment exceeds the CPI–U for the month of October of the calendar year prior to the October preceding the adjustment, with final amounts rounded to the nearest dollar. That Act also requires a one-time catch up adjustment in the amount of the percentage by which the CPI–U for October 2015 exceeds the CPI–U for the month of October of the calendar year during which the amount of civil monetary penalty was established or adjusted under a provision of law other than the Federal Civil Penalties Inflation Adjustment Act.

(b) Other than adjustments under the Federal Civil Penalties Inflation Adjustment Act, the Board last established or adjusted civil monetary penalties in 1986. The CPI–U increased by 215.628 percent between October 1986 and October 2015.

(c) Imposition of the increased civil monetary penalties are limited to actions occurring after the effective date of the increases.

(d) The amount of the one-time catch up adjustment may not exceed 150 percent of the penalty amount or range as of November 2, 2015. The ten percent cap on increases imposed by the Debt Collection Improvements Act of 1996 was eliminated in the 2015 amendments to the Federal Civil Penalties Inflation Adjustment Act, and is no longer applicable.

§ 356.2 Penalties under the Program Fraud Civil Remedies Act of 1986.

(a) For claims or statements made on or before October 23, 1996, the maximum penalty which may be assessed under part 355 of this chapter is $5,000.

(b) For claims or statements made after October 23, 1996, but before August 1, 2016, the maximum penalty which may be assessed under part 355 of this chapter is $5,500.

(c) For claims or statements made on or after August 1, 2016, but before January 1, 2017, the maximum penalty which may be assessed under part 355 of this chapter is $10,781.

(d) For claims or statements made on or after January 1, 2017, the maximum penalty which may be assessed under part 355 of this chapter is the larger of:

(1) The amount for the previous calendar year; or

(2) An amount adjusted for inflation, calculated by multiplying the amount for the previous calendar year by the percentage by which the CPI–U for the month of October preceding the current calendar year exceeds the CPI–U for the month of October of the calendar year two years prior to the current calendar year, adding that amount to the amount for the previous calendar year, and rounding the total to the nearest dollar.

(e) Notice of the maximum penalty which may be assessed under part 355 of this chapter for calendar years after 2016 will be published by the Board in the FEDERAL REGISTER on an annual basis on or before January 15 of each calendar year.

§ 356.3 False claims.

(a) For claims or statements made on or before October 23, 1996, the minimum penalty which may be assessed under 31 U.S.C. 3729 is $5,000 and the maximum penalty is $10,000.

(b) For claims or statements made after October 23, 1996, but before August 1, 2016, the minimum penalty which may be assessed under 31 U.S.C. 3729 is $5,500 and the maximum penalty is $11,000.

(c) For claims or statements made on or after August 1, 2016, but before January 1, 2017, the minimum penalty which may be assessed under 31 U.S.C. 3729 is $10,781 and the maximum penalty is $21,563.

(d) For claims or statements made on or after January 1, 2017, the minimum and maximum penalty amounts which may be assessed under 31 U.S.C. 3729 is the larger of:

(1) The amount for the previous calendar year; or

(2) An amount adjusted for inflation, calculated by multiplying the amount for the previous calendar year by the percentage by which the CPI–U for the month of October preceding the current calendar year exceeds the CPI–U for the month of October of the calendar year two years prior to the current calendar year, adding that amount to the amount for the previous calendar year, and rounding the total to the nearest dollar.

(e) Notice of the minimum and maximum penalty which may be assessed under 31 U.S.C. 3729 for calendar years after 2016 will be published by the Board in the FEDERAL REGISTER on an annual basis on or before January 15 of each calendar year.

SUBCHAPTER F—INTERNAL ADMINISTRATION, POLICY AND PROCEDURES

PART 360 [RESERVED]

PART 361—RECOVERY OF DEBTS OWED TO THE UNITED STATES GOVERNMENT BY GOVERNMENT EMPLOYEES

Sec.

361.1 Purpose.
361.2 Scope.
361.3 Definitions.
361.4 Determination of indebtedness.
361.5 Notice requirements before offset.
361.6 Requests for waiver or hearing.
361.7 Written decision following a hearing.
361.8 Limitations on notice and hearing requirements.
361.9 Exception to requirement that a hearing be offered.
361.10 Written agreement to repay debt as alternative to salary offset.
361.11 Procedures for salary offset: When deductions may begin.
361.12 Procedures for salary offset: Types of collection.
361.13 Procedures for salary offset: Methods of collection.
361.14 Procedures for salary offset: Imposition of interest, penalties and administrative costs.
361.15 Non-waiver of rights.
361.16 Refunds.
361.17 Coordination with other government agencies.

AUTHORITY: 5 U.S.C. 5514(b)(1).

SOURCE: 53 FR 45262, Nov. 9, 1988, unless otherwise noted.

§ 361.1 Purpose.

These regulations, which implement 5 U.S.C. 5514, provide the standards and procedures which the Board will utilize to collect debts owed to the United States from the current pay accounts of its employees, including the current pay accounts of employees who owe debts to agencies other than the Board.

§ 361.2 Scope.

(a) *Coverage.* This part applies to agencies and employees as defined by § 361.3 of this part.

(b) *Applicability.* This part and 5 U.S.C. 5514 apply in recovering certain debts by administrative offset, except where the employee consents to the recovery, from the current pay account of an employee. Because it is an administrative offset, debt collection procedures for salary offset which are not specified in 5 U.S.C. 5514 and these regulations shall be consistent with the provisions of the Federal Claims Collection Standards (FCCS).

(1) *Excluded debts or claims.* The procedures contained in this part do not apply to debts or claims arising under the Internal Revenue Code of 1954 as amended (26 U.S.C. 1, *et seq.*), the Social Security Act (42 U.S.C. 301, *et seq.*), or the tariff laws of the United States; or to any case where collection of a debt by salary offset is explicitly provided for or prohibited by another statute (*e.g.*, travel advances in 5 U.S.C. 5705 and employee training expenses in 5 U.S.C. 4108).

(2) *Waiver requests and claims to the U.S. General Accounting Office.* This part does not preclude an employee from requesting waiver of recovery of an overpayment under 5 U.S.C. 5584 or any other similar provision of law, or from questioning the amount of validity of a debt by submitting a subsequent claim to the U.S. General Accounting Office.

(3) *Compromise, suspension, or termination under the Federal Claims Collection Standards (4 CFR 101.1, et seq.).* Nothing in this part precludes the compromise, suspension or termination of collection actions where appropriate under the standards implementing 31 U.S.C. 3711, *et seq.* (4 CFR 101.1, *et seq.*).

§ 361.3 Definitions.

For purposes of this part, terms are defined as follows:

Agency means—

(a) An executive agency as defined by section 105 of title 5, United States Code; including the U.S. Postal Service and the U.S. Postal Rate Commission;

(b) A military department as defined in section 102 of title 5, United States Code;

(c) An agency or court in the judicial branch, including a court as defined in section 610 of title 28, United States

Court for the Northern Mariana Islands, and the Judicial Panel on Multidistrict Litigation;

(d) An agency of the legislative branch, including the U.S. Senate and the U.S. House of Representatives; and

(e) Other independent establishments that are entities of the Federal government.

Creditor agency means the agency to which the debt is owed.

Debt means an amount owed to the United States from sources which include loans insured or guaranteed by the United States and all other amounts due the United States from fees, leases, rents, royalties, services, sales of real or personal property, overpayments, fines, penalties, damages, interest, forfeitures (except those arising under the Uniform Code of Military Justice), and all other similar sources.

Delinquent debt means a debt which has not been paid by the date specified in the creditor agency's initial written notification, unless satisfactory arrangements for payment have been made by that date, or where, at any time thereafter, the employee fails to satisfy his or her obligations under a payment agreement with the creditor agency.

Disposable pay means that part of current basic pay, special pay, incentive pay, retired pay, retainer pay, or in the case of an employee not entitled to basic pay, other authorized pay, remaining after the deduction of any amount required by law to be withheld. Agencies must exclude deductions described in 5 CFR 581.104 (b) through (f) to determine disposable pay subject to salary offset.

Employee means a current employee of a Federal agency, including a current member of the Armed Forces or a Reserve of the Armed Forces (Reserves).

FCCS means the Federal Claims Collection Standards jointly published by the Department of Justice and the U.S. General Accounting Office at 4 CFR 101.1, *et seq*.

Paying agency means the Federal agency or branch of the Armed Forces or Reserves employing the individual and disbursing his or her current pay account.

Salary offset means an administrative offset to collect a debt under 5 U.S.C. 5514 by deduction(s) at one or more officially established pay intervals from the current pay account of an employee without his or her consent.

Waiver means the cancellation, remission, forgiveness, or non-recovery of a debt allegedly owed by an employee to an agency as permitted or required by 5 U.S.C. 5584, 5 U.S.C. 8346(b), 10 U.S.C. 2774, 32 U.S.C. 716, or any other similar law.

§ 361.4 Determination of indebtedness.

In determining that an employee is indebted, the Board will review the debt to make sure it is valid and past due.

§ 361.5 Notice requirements before offset.

The Board shall provide an employee written Notice of Intent to Offset Salary (Notice of Intent). The employee will be provided the notice at least thirty calendar days before the intended deduction is to begin. In addition, the notice must provide the following:

(a) That the Board has reviewed the records relating to the claim and has determined that a debt is owed, and the origin, nature, and amount of that debt;

(b) The Board's intention to collect the debt by means of deduction from the employee's current disposable pay account;

(c) The amount, frequency, approximate beginning date, and duration of the intended deductions;

(d) An explanation of the Board's requirements concerning interest, penalties, and administrative costs, and notification that such assessment must be made unless such payments are excused in accordance with the FCCS;

(e) Advice as to the employee's or his or her representative's right to inspect and copy or to be provided copies of government records relating to the debt;

(f) If not previously provided, notification of the opportunity (under terms agreeable to the Board) to establish a schedule for the voluntary repayment of the debt or to enter into a written agreement to establish a schedule for

repayment of the debt in lieu of offset. The agreement must be in writing, signed by both the employee and the Board, and documented in the Board's files (4 CFR 102.2(e));

(g) Advice that the Board will accept a repayment agreement which is reasonable in view of the financial condition of the employee at that time;

(h) If there is a statutory provision for waiver, cancellation, remission or forgiveness of the debt to be collected, advice that waiver may be requested within the period and by the procedure specified and explaining the conditions under which waiver, cancellation, remission or forgiveness is granted;

(i) Advice as to the employee's right to a hearing conducted by an official arranged by the Board (an administrative law judge, or alternatively, a hearing official not under the control of the head of the agency) on the Board's determination of the debt, the amount of the debt, and the percentage of disposable pay to be deducted each pay period if a petition is filed as prescribed by the Board;

(j) Advice that the timely filing of a petition for hearing or a request for waiver (if the waiver statute or regulations are not ''permissive'' in nature) will stay the commencement of collection proceedings;

(k) Advice that a final decision on the hearing (if one is requested) will be issued at the earliest practical date, but not later than sixty days after the filing of the petition requesting the hearing unless the employee requests and the hearing official grants a delay in the proceedings;

(l) Advice as to the method and time period for requesting a hearing as provided for in § 361.5 and for requesting waiver, if it is available;

(m) Advice that any knowingly false or frivolous statements, representations, or evidence may subject the employee to:

(1) Disciplinary procedures appropriate under chapter 75 of title 5, United States Code, part 752 of title 5, Code of Federal Regulations, or any other applicable statutes or regulations;

(2) Penalties under the False Claims Act, sections 3729–3731 of title 31, United States Code, or any other applicable statutory authority; or

(3) Criminal penalties under sections 286, 287, 1001, and 1002 of title 18, United States Code, or any other applicable statutory authority;

(n) Advice as to other rights and remedies available to the employee under statutes or regulations governing the program for which the collection is being made; and

(o) Advice that unless there are applicable contractual or statutory provisions to the contrary, amounts paid on or deducted for the debt which are later waived or found not owed to the United States will be promptly refunded to the employee. Such refunds will not bear interest unless required or permitted by law.

§ 361.6 Requests for waiver or hearing.

(a) A request for waiver or for a hearing must be made in writing and received by the Chief Financial Officer no later than thirty calendar days after the notice is sent to the employee. This time limit may, at the discretion of the Chief Financial Officer, be extended if the employee can show that the delay was caused by circumstances which were beyond the employee's control or because of the employee's failure to receive notice of the time limit. Any right to waiver or to a hearing is forfeited unless the time limits set forth in this paragraph are complied with.

(b) The employee's request for a hearing must be signed by the employee and fully identify and explain with reasonable specificity all the facts, evidence and witnesses, if any, which the employee believes support his or her position.

(c) A request for a hearing under this paragraph is not a request for waiver. A request for waiver must state the basis for the request for waiver and whether a hearing is requested. If no request for a hearing is contained in the waiver request, no hearing will be provided.

(d) A hearing, if requested, will be an informal proceeding conducted by an administrative law judge or hearing official not under the control of the Board. The employee, or his/her representative, and the Board will be

given full opportunity to present evidence, witnesses and argument.

§ 361.7 Written decision following a hearing.

Within thirty days after the hearing, the administrative law judge or hearing official shall issue a written decision stating the facts evidencing the nature and origin of the alleged debt; the amount and validity of the alleged debt; and the judge or hearing official's analysis, findings and conclusions with respect to the employee's position on liability for the debt and with respect to his or her eligibility for waiver. The decision of the administrative law judge or hearing official shall be the final agency decision.

§ 361.8 Limitations on notice and hearing requirements.

(a) The procedural requirements of this part are not applicable to collections which result from:

(1) An employee's election of coverage or of a change in coverage under a Federal benefits program which requires periodic deductions from pay and which cannot be placed into effect immediately because of normal processing delays; and

(2) Ministerial adjustments in pay rates or allowances which cannot be placed into effect immediately because of normal processing delays.

(b) *Limited procedures.* If the period of the normal processing delay for which the retroactive deduction must be recovered does not exceed four pay periods, the procedures provided in §§ 361.4 and 361.5 of this part shall not apply, but the Board shall in advance of the collection issue a general notice that:

(1) Because of the employee's election, future salary will be reduced to cover the period between the effective date of the election and the first regular withholding, and the employee may dispute the amount of the retroactive collection by notifying a specified office or official; or

(2) Due to a normal ministerial adjustment in pay or allowances which could not be placed into effect immediately, future salary will be reduced to cover any excess pay or allowances received by the employee, the employee may dispute the amount of the retroactive collection by notifying a specified office or official.

(c) *Limitation on exceptions.* The exceptions described in paragraphs (a) and (b) of this section shall not include a recovery required to be made for any reason other than normal processing delays in putting the change into effect, even if the period of time for which the amounts must be retroactively withheld is less than four pay periods. Further, if normal processing delays exceed four pay periods, then the full procedures prescribed under §§ 361.4 and 361.5 of this part shall be extended to the employee.

§ 361.9 Exception to requirement that a hearing be offered.

When an employee is overpaid due to the hours worked reported on the payroll exceeding the actual hours worked, no pre-offset hearing must be granted since in such cases there is no question regarding credibility and veracity. In these cases the Board will make its determination under this part based upon review of the written record.

§ 361.10 Written agreement to repay debt as alternative to salary offset.

(a) *Notification by employee.* The employee may propose, in response to a Notice of Intent, a written agreement to repay the debt as an alternative to salary offset. Any employee who wishes to do this must submit a proposed written agreement to repay the debt which is received by the Board within thirty calendar days of the date of the Notice of Intent.

(b) *Board's response.* In response to timely notice by the debtor as described in paragraph (a) of this section, the Board will notify the employee whether the employee's proposed written agreement for repayment is acceptable. It is within the Board's discretion to accept a repayment agreement instead of proceeding by offset. In making this determination, the Board will balance the agency's interest in collecting the debt against hardship to the employee. If the debt is delinquent and the employee has not disputed its existence or amount, the Board will accept a repayment agreement instead of offset only if the employee is able to establish that offset would result in

undue financial hardship or would be against equity and good conscience.

§ 361.11 Procedures for salary offset: When deductions may begin.

(a) Deductions to liquidate an employee's debt will be by the method and in the amount stated in the Notice of Intent to collect from the employee's current pay.

(b) If the employee filed a petition for hearing with the Board before the expiration of the period provided for in § 361.5, then deductions will begin after the hearing officer has provided the employee with a hearing and the hearing officer's final written decision is in favor of the Board.

(c) If an employee retires, resigns or his or her period of employment ends before collection of a debt is completed, offset shall be made from subsequent payments of any nature (*e.g.*, final salary payment, lump sum leave, etc.) due the employee from the Board to the extent necessary to liquidate the debt. If the debt cannot be liquidated by offset from any final payment due the employee from the Board, the Board shall liquidate the debt by administrative offset, pursuant to 31 U.S.C. 3716, from later payments of any kind which are due the employee from the United States.

§ 361.12 Procedures for salary offset: Types of collection.

A debt will be collected in a lump sum or in installments. Collection will be effected in one lump sum collection unless the employee is financially unable to pay in one lump sum, or if the amount of the debt exceeds 15 percent of disposable pay. In these cases, deduction will be by installments.

§ 361.13 Procedures for salary offset: Methods of collection.

(a) *General.* A debt will be collected by deductions at officially-established pay intervals from an employee's current pay account, unless the employee and the Board agree to alternative arrangements for repayment. The alternative arrangement must be in writing, signed by both the employee and the Board.

(b) *Installment deductions.* Installment deductions will be made over a period not greater than the anticipated period of employment. The size and frequency of installment deductions will bear a reasonable relation to the size of the debt and the employee's ability to pay. However, the amount deducted for any period will not exceed 15 percent of the disposable pay from which the deduction is made, unless the employee has agreed in writing to the deduction of a greater amount. If possible, the installment payment will be sufficient in size and frequency to liquidate the debt in three years. Installment payments of less than $25 per pay period or $50 a month will be accepted only in the most unusual circumstances.

(c) *Sources of deductions.* The Board will make deductions only from basic pay, special pay, incentive pay, retired pay, retainer pay, or in the case of an employee not entitled to basic pay, other authorized pay.

§ 361.14 Procedures for salary offset: Imposition of interest, penalties and administrative costs.

Interest will be charged in accordance with 4 CFR 102.13.

§ 361.15 Non-waiver of rights.

So long as there are no statutory or contractual provisions to the contrary, no employee involuntary payment (of all or a portion of a debt) collected under these regulations will be interpreted as a waiver of any rights that the employee may have under 5 U.S.C. 5514.

§ 361.16 Refunds.

The Board will refund promptly to the appropriate individual amounts offset under these regulations when:

(a) A debt is waived or otherwise found not owing the United States (unless expressly prohibited by statute or regulation); or

(b) The Board is directed by an administrative or judicial order to refund amounts deducted from the employee's current pay.

§ 361.17 Coordination with other government agencies.

(a) *Board is paying agency.* (1) If the Board receives a claim which meets the requirements of 5 CFR 550.1108 from another agency, deductions shall begin

prospectively at the next officially established pay interval. The employee will receive written notice that the Board has received a certified debt claim from a creditor agency. The notice will contain the amount of the debt and the date deductions from salary will commence and the amount of such deductions.

(2) If the Board receives a claim which does not meet the requirements of 5 CFR 550.1108, then the Board will return the claim to the creditor agency and inform the creditor agency that before any action is taken to collect the debt from the employee's current pay account, the procedures under 5 U.S.C. 5514 and 5 CFR part 550 must be followed and a claim which meets the requirements of 5 CFR 550.1108 must be received.

(b) *Board is creditor agency*. When the Board is owed a debt by an employee of another agency, the other agency shall not initiate the requested offset until the Board provides the agency with a written certification that the procedures under this part have been followed and the Board has provided the other agency with a claim which meets the requirement of 5 CFR 550.1108.

PART 362—EMPLOYEES' PERSONAL PROPERTY CLAIMS

Sec.

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362.2 Definitions.
362.3 Who may file a claim.
362.4 Delegation of authority.
362.5 Time limits for filing a claim.
362.6 Procedure for filing a claim.
362.7 Factors to be considered in settling a claim.
362.8 Investigation of a claim.
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AUTHORITY: Sec. 3(a), Pub. L. 88–558, 78 Stat. 767 (31 U.S.C. 241(b)(1)), unless otherwise noted.

SOURCE: 45 FR 57709, Aug. 29, 1980, unless otherwise noted.

§ 362.1 Purposes.

(a) This part prescribes regulations under the Military Personnel and Civilian Employees' Claims Act of 1964, as amended, for the settlement of a claim against the United States made by an officer or employee of the Railroad Retirement Board for damage to, or loss of, personal property incident to his service. In accordance with that Act, the possession of such property must be reasonable, useful, or proper under the circumstances.

(b) The Railroad Retirement Board is not an insurer of its officers' or employees' personal property and does not underwrite the damage or loss of such property that may be sustained by an officer or employee. Officers and employees of the Board are encouraged to carry private insurance to the maximum extent practicable to avoid large losses or losses which may not be recoverable from the Board. The procedures set forth in this section are designed to enable the claimant to obtain the maximum amount of otherwise unreimbursed or uninsured compensation for his loss or damage. Failure of the claimant to comply with these procedures may reduce or preclude payment of his claim under this part.

§ 362.2 Definitions.

As used in this part:

(a) *Act* means the Military Personnel and Civilian Employees' Claims Act of 1964, as amended (31 U.S.C. 240–243).

(b) *Article of extraordinary value* means an article which was purchased or which the employee values at a monetary amount which is in excess of the usual, regular or customary amount paid for an article which is capable of accomplishing the same purposes.

(c) *Benefit of the Board* means that the operations and service of the Board were assisted, facilitated or improved.

(d) *Board* means the Railroad Retirement Board.

(e) *Employee* means an officer or employee of the Board.

(f) *Settle* means consider, ascertain, adjust, determine and dispose of any claim, whether by full or partial allowance or by disallowance.

§ 362.3 Who may file a claim.

A claim may be filed by an employee, by his spouse in his name as authorized agent, or by any other authorized agent or legal representative of the employee. If the employee is dead, his (a) spouse, (b) child, (c) father or mother, or both, or (d) brother or sister, or both, may file the claim and be entitled to payment in that order of priority.

§ 362.4 Delegation of authority.

The Deputy General Counsel of the Board is authorized to settle any claim filed under this part.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.5 Time limits for filing a claim.

A claim under this part may be considered only if:

(a) The damage or loss occurred after August 31, 1964; and

(b) The claim is filed in writing within two years after the damage, loss or theft occurred or became known to the employee.

§ 362.6 Procedure for filing a claim.

(a) Railroad Retirement Board Form G–108, Employee Claim for Loss or Damage to Personal Property, is the prescribed form for filing claims pursuant to the regulations in this part and must be completed by the employee, the person acting on his behalf, or his survivor and forwarded directly to the General Counsel of the Board for processing. Railroad Retirement Board Form G–108 may be obtained from the Board's Bureau of Law.

(b) In addition to the information required to complete the form described § 362.6(a), the following information or data must be submitted with each claim:

(1) With respect to claims involving property which is stolen or lost, the purchase receipt, or if not available, statements from the employee estimating the value and what security measures or precautions were taken to protect the property;

(2) With respect to claims involving property which is damaged, an itemized repair estimate from an appropriate commercial source, or, if beyond repair, a statement from an appropriate commercial source or, if such a statement is not available, from the employee, indicating that the damaged property is beyond repair;

(3) With respect to claims involving property stated to be beyond repair in accordance with paragraph (b)(2) of this section, a statement from the employee estimating the value and the purchase receipt, if available;

(4) With respect to claims considered under § 362.10(b)(3), a statement by the employee's supervisor verifying that the supervisor required the employee to provide, or that the supervisor consented to having the employee provide, such property and that the provision of such personal property was in the interest of the Board;

(5) With respect to a claim filed by an agent or survivor of an employee, a power of attorney or other satisfactory evidence of authority to file the claim.

§ 362.7 Factors to be considered in settling a claim.

Claims are payable only for such types, quantities or amounts of tangible personal property as the Deputy General Counsel of the Board shall determine to be reasonable, useful, or proper under the circumstances existing at the time and place of the loss, theft or damage of the property. In determining what is reasonable, useful or proper the Deputy General Counsel will consider the type and quantity of property involved, the circumstances attending acquisition and use of the property, and whether possession or use by the employee at the time of loss, theft or damage was incident to the employee's service. What is reasonable, useful or proper is a question of fact to be determined by the Deputy General Counsel.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.8 Investigation of a claim.

The Deputy General Counsel or his designee may investigate the circumstances surrounding the theft, loss or damage of an employee's property.

In order to complete such investigation, the Deputy General Counsel or his designee may request the submission of information in addition to that described in § 362.7 of this part.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.9 Fraudulent claims.

Claims are not payable for items fraudulently claimed. When investigation discloses that an employee, an agent of the employee, or a survivor of the employee has intentionally misrepresented an item claimed, as to cost, condition, cost of repair or other significant information, the claim as to that item will be disallowed in its entirety even though some actual loss or damage may have been sustained. However, if the remainder of the claim is proper it will be paid as to other items. This section does not preclude appropriate prosecution and disciplinary action if warranted.

§ 362.10 Principal types of claims allowable.

(a) In general, a claim may be allowed only for tangible personal property of a type and quantity that was, from the Board's perspective, reasonable, useful, or proper for the employee to possess under the circumstances at the time of the loss or damage. Any questions in this regard are to be resolved by the Deputy General Counsel.

(b) Claims that will ordinarily be allowed include, but are not limited to, cases in which the loss or damage occurred:

(1) In a common or natural disaster;

(2) When the property was subjected to extraordinary risks in the performance of duty or efforts to save human life or property of the United States Government;

(3) When the property was used for the benefit of the Board at the direction, or with the consent, of a supervisor.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.11 Principal types of claims not allowable.

(a) Claims will be disallowed when:

(1) The personal property was lost, stolen or damaged prior to August 31, 1964;

(2) The loss or damage totals less than $5 or, to the extent of the excess, more than the maximum amount provided in section 241(b)(1) of title 31 of the U.S. Code;

(3) The loss or damage was caused, at least in part, by the negligence of the employee or his agent;

(4) The personal property was acquired, possessed or transported in violation of law or regulation;

(5) The personal property was brought into Board offices for temporary storage in anticipation of delivery to another person or removal to another location;

(6) The personal property lost or damaged was food-stuffs or furniture;

(b) Claims which will ordinarily not be allowed include, but are not limited to, claims for:

(1) Money or currency, except when lost in a common or natural disaster;

(2) Articles of extraordinary value;

(3) Articles being worn (unless allowable under § 362.10);

(4) Intangible property, such as bank books, checks, notes, stock certificates, money orders or travelers' checks;

(5) Property owned by the United States, unless the employee is financially responsible for it to another U.S. Government agency;

(6) Losses of insurers or subrogees and those losses recoverable from an insurer or carrier;

(7) Losses or damages sustained in quarters not assigned or otherwise provided in kind by the Board;

(8) Losses recoverable or recovered pursuant to contract;

(9) Loss or damage to any vehicle used for transportation or in transportation (unless allowable under § 362.10).

§ 362.12 Computation of amount of reimbursement.

(a) The amount awarded with regard to any item of personal property will not exceed its depreciated replacement cost at the time of loss. Unless proven to be otherwise, replacement cost will

be based on the price paid in cash for the property or, if not acquired by purchase or exchange, the value at the time of acquisition. The amount normally payable on property damaged beyond economical repair is found by determining its depreciated value immediately before it was damaged or lost, less any salvage value. If the cost of repair is less than the depreciated value of the property, then it is economically repairable, and the cost of repair is the amount payable.

(b) Depreciation in value of an item of personal property is determined by considering the type of article involved, its cost, condition when lost or damaged beyond economical repair, and the time elapsed between the date of acquisition and the date of accrual of the claim.

(c) Allowance for articles acquired by barter will not exceed the cost of the articles tendered in barter.

§ 362.13 Property recovered after payment of claim.

When previously lost or stolen property is recovered by the employee after allowance of a claim by the Board, the employee shall return the amount of reimbursement.

§ 362.14 Finality of settlement.

Notwithstanding any other provision of law, settlement of a claim under the Act and this part is final and conclusive.

§ 362.15 Agent's or attorney's fee.

Under the terms of the Act, no more than 10 percent of the amount paid in settlement of a claim submitted and settled under this part may be paid or delivered to or received by any agent or attorney on account of services rendered in connection with that claim, any contract to the contrary notwithstanding.

PART 363—GARNISHMENT OF REMUNERATION OF BOARD PERSONNEL

Sec.

363.1 Authorization for garnishment of remuneration for employment paid by the Board.
363.2 Definitions.
363.3 Procedure.
363.4 Exemptions.
363.5 Miscellaneous.

AUTHORITY: 15 U.S.C. 1673(b)(2); 42 U.S.C. 659, 661, and 662; and 45 U.S.C. 231f(b)(5) and 362(1).

SOURCE: 45 FR 28315, Apr. 29, 1980, unless otherwise noted.

§ 363.1 Authorization for garnishment of remuneration for employment paid by the Board.

(a) Remuneration for employment paid or payable by the Board is subject, in like manner and to the same extent as if the Board were a private person, to legal process brought for the enforcement of legal obligations to provide child support or to make alimony payments.

(b) Remuneration for employment includes compensation paid or payable for personal services, whether such compensation is denominated as wages, salary, commission, bonus, pay, or otherwise, and includes, but is not limited to, severance pay, sick pay, and incentive pay, but does not include awards for making suggestions.

(c) Remuneration for employment does not include:

(1) Amounts required by law to be deducted, including but not limited to Federal employment taxes and civil service retirement contributions;

(2) Amounts which are deducted as health insurance premiums;

(3) Amounts which are deducted as premiums for regular life insurance coverage; and

(4) Amounts which are properly withheld for Federal, state, or local income tax purposes, if the withholding of such amounts is authorized or required by law and if amounts withheld are not greater than would be the case if the individual concerned claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1954 may be permitted only when such individual presents evidence of a tax obligation which supports the additional withholding).

§ 363.2 Definitions.

(a) *Child support* means periodic payments of funds for the support and maintenance of a child or children;

such term also includes attorney's fees, interest, and court costs, when and to the same extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accordance with applicable state law by a court of competent jurisdiction.

(b) *Alimony* means periodic payments of funds for the support and maintenance of a spouse or former spouse and, subject to and in accord with state law, includes but is not limited to, separate maintenance, alimony pendente lite, maintenance, and spousal support; such term also includes attorney's fees, interest, and court costs, when and to the extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accord with applicable state law by a court of competent jurisdiction. Alimony does not include any payment or transfer of property or of its value in compliance with any community property settlement, equitable distribution of property, or other division of property, nor does it include any payment to an estate.

(c) *Legal process* means any court order, summons, or other similar process, including administrative orders, in the nature of garnishment, which is directed to and the purpose of which is to compel the Board to make a payment from moneys which are otherwise payable to an individual, to another party in order to satisfy a legal obligation of such individual to provide child support or make alimony payments. Legal process additionally includes assignments in lieu of garnishment, but only where grounds for the issuance of legal process in the nature of garnishment exist. Such assignments are revocable.

§ 363.3 Procedure.

(a) Service of legal process brought for the enforcement of a Board employee's obligation to provide child support or make alimony payments shall be accomplished by certified or registered mail, return receipt requested, directed to the Deputy General Counsel of the Board, 844 Rush Street, Chicago, Illinois 60611, or by personal service upon the Deputy General Counsel.

(b) Where the Deputy General Counsel is effectively served with legal process relating to a Board employee's legal obligation to provide child support or to make alimony payments, he shall, as soon as possible and not later than 15 days after the date of effective service of such process, send written notice that such process has been so served, together with a copy thereof, to the individual whose moneys are affected thereby; and, if response to such process is required, shall respond within 30 days, or within such longer period as may be prescribed by state law, after the date effective service is made. These requirements do not apply in the case of an assignment in lieu of garnishment.

[45 FR 28315, Apr. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 363.4 Exemptions.

(a) The portion of any payment due to a Board employee which is subject to legal process to enforce any order for the support of any person shall not exceed 65 percent. Where the individual is supporting a spouse or dependent child, other than a spouse or child with respect to whose support that legal process is issued, the portion subject to legal process is reduced by 10 percent. Where the alimony or support arrearage is less than 12 weeks old, the portion subject to legal process is reduced by 5 percent. If a lower limitation is provided by applicable state or local law, then that lower limitation shall be applied.

(b) In the absence of some evidence to the contrary, it will be assumed that the defendant is not supporting a spouse or dependent child other than a spouse or child with respect to whose support the legal process is issued.

§ 363.5 Miscellaneous.

(a) The Board may not be required to vary its normal disbursement cycles in order to comply with legal process.

(b) Except as provided in these regulations, the Board may not be required, in connection with proceedings under this part, to forward documents which have been sent to the Board, to an employee of the Board.

(c) Neither the Board nor any of its employees shall be liable with respect to any payment made to any individual from moneys due from or payable by the Board pursuant to legal process

regular on its face, if such payment is made in accordance with this part.

(d) No employee of the Board whose duties include responding to legal process pursuant to requirements contained in this part shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by such employee in connection with the performance of the employee's duties in responding to any such process.

(e) For purposes of a proceeding under this part the Board will apply the law of the state in which the legal process is issued unless it comes to the attention of the Board that the state of issuance has no contact with the plaintiff or defendant in the action; in which case, the Board may, in its sole discretion, apply the law of any state with significant interest in the matter.

PART 364—USE OF PENALTY MAIL TO ASSIST IN THE LOCATION AND RECOVERY OF MISSING CHILDREN

Sec.

364.1 Purpose.
364.2 Definitions.
364.3 Publication of missing children information in the Railroad Retirement Board's in-house publications.
364.4 Placement of missing children posters in Board field offices.
364.5 Further study of the use of penalty mail in the location and recovery of missing children.

AUTHORITY: 39 U.S.C. 3220(a)(2).

SOURCE: 52 FR 527, Jan. 7, 1987, unless otherwise noted.

§ 364.1 Purpose.

These regulations, which implement 39 U.S.C. 3220, provide the standards and guidelines for the use of Board penalty mail in the location and recovery of missing children.

§ 364.2 Definitions.

For purposes of this part, terms are defined as follows:

All-A-Board is the Board's in-house newspaper that is published on an irregular basis about six times a year.

Field office is a Board district office. These offices are located throughout the United States.

Penalty mail means the official mail of the Board that is used to carry out the Board's duties.

Shelf life means the amount of time the Board has to remove from circulation outdated missing children information. This is a three month period, commencing with the date notice is received by the National Center for Missing and Exploited Children that such information is no longer accurate.

§ 364.3 Publication of missing children information in the Railroad Retirement Board's in-house publications.

(a) *All-A-Board.* Information about missing children will appear in the All-A-Board. This publication will obtain the necessary information from the National Center for Missing and Exploited Children. The editorial staff of the All-A-Board shall determine the number of children described in each issue and where this information will appear in the publication.

(b) *Other in-house publications.* The Board may publish missing children information in other in-house publications as it deems appropriate. This determination will be made in accordance with the guidelines that appear in § 364.5.

§ 364.4 Placement of missing children posters in Board field offices.

(a) *Poster content.* The National Center for Missing and Exploited Children shall select the missing child and the pertinent information about that child, which may include a photograph of the child, that will appear on the poster. The Board will develop a standard format for these posters.

(b) *Transmission of posters to field offices.* The Board shall send the posters to its field offices in penalty mail. Those posters will be included in penalty mailings that are made in the normal course of the Board's operations.

(c) *Field office use of posters.* (1) Upon receipt of the poster, the field office will place it in the waiting room, if possible. Otherwise, the field office should put the poster in a place where it will be viewed by the public.

(2) The field office must remove and destroy the posters by the end of their shelf life. The field office also may remove posters that they believe have ceased to be of assistance in locating and recovering missing children.

§ 364.5 Further study of the use of penalty mail in the location and recovery of missing children.

(a) *Criteria.* The Board shall continue to study different alternatives for using penalty mail to assist in the location and recovery of missing children. In order to implement a proposal, it must:

(1) Be cost effective; and

(2) Fulfill the goal of aiding in the location and recovery of missing children.

(b) *Requirements.* In any program, the National Center for Missing and Exploited Children shall select the missing children and the information about these children, which may include a photograph, that will be used by the Board. Proposals must provide for the removal of this material before the end of its shelf life.

PART 365—ENFORCEMENT OF NONDISCRIMINATION ON THE BASIS OF HANDICAP IN PROGRAMS OR ACTIVITIES CONDUCTED BY THE RAILROAD RETIREMENT BOARD

Sec.

365.101 Purpose.
365.102 Application.
365.103 Definitions.
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365.150 Program accessibility: Existing facilities.
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365.160 Communications.
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365.170 Compliance procedures.
365.171–365.999 [Reserved]

AUTHORITY: 29 U.S.C. 794.

SOURCE: 53 FR 43434, Oct. 27, 1988, unless otherwise noted.

§ 365.101 Purpose.

The purpose of this part is to effectuate section 119 of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, which amended section 504 of the Rehabilitation Act of 1973 to prohibit discrimination on the basis of handicap in programs or activities conducted by Executive agencies or the United States Postal Service.

§ 365.102 Application.

This regulation (§§ 365.101 through 365.170) applies to all programs or activities conducted by the agency, except for programs or activities conducted outside the United States that do not involve individuals with handicaps in the United States.

§ 365.103 Definitions.

For purposes of this part, the term—

Agency means Railroad Retirement Board.

Assistant Attorney General means the Assistant Attorney General, Civil Rights Division, United States Department of Justice.

Auxiliary aids means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency. For example, auxiliary aids useful for persons with impaired vision include readers, brailled materials, audio recordings, and other similar services and devices. Auxiliary aids useful for persons with impaired hearing include telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf person (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Board means the three-member board, appointed pursuant to 45 U.S.C. 231f, which heads the agency.

Chief Executive Officer means the Chief Executive Officer of the Railroad Retirement Board. This individual is the chief operating officer of the agency.

Complete complaint means a written statement that contains the complainant's name and address and describes the agency's actions in sufficient detail to inform the agency of the nature and date of the alleged violation of section 504. It shall be signed by the complainant or by someone authorized to do so on his or her behalf. Complaints filed on behalf of classes or third parties shall describe or identify (by name, if possible) the alleged victims of discrimination.

Facility means all or any portion of buildings, structures, equipment, roads, walks, parking lots, rolling stock or other conveyances, or other real or personal property.

Individual with handicaps means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. As used in this definition, the phrase:

(1) *Physical or mental impairment* includes—

(i) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs: cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or

(ii) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term ''physical or mental impairment'' includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and drug addiction and alcoholism.

(2) *Major life activities* includes functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(3) *Has a record of such an impairment* means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(4) *Is regarded as having an impairment* means—

(i) Has a physical or mental impairment that does not substantially limit major life activities but is treated by the agency as constituting such a limitation;

(ii) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(iii) Has none of the impairments defined in paragraph (1) of this definition but is treated by the agency as having such an impairment.

Qualified individual with handicaps means—

(1) An individual with handicaps who meets the essential eligibility requirements for participation in, or receipt of benefits from, a program or activity.

(2) *Qualified handicapped person* as that term is defined for purposes of employment in 29 CFR 1613.702(f), which is made applicable to this part by § 365.140.

Section 504 means section 504 of the Rehabilitation Act of 1973 (Pub. L. 93–112, 87 Stat. 394 (29 U.S.C. 794)), as amended by the Rehabilitation Act Amendments of 1974 (Pub. L. 93–516, 88 Stat. 1617); the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 (Pub. L. 95–602, 92 Stat. 2955); the Rehabilitation Act Amendments of 1986, (Pub. L. 99–506, 100 Stat. 1810), and the Civil Rights Restoration Act of 1987 (Pub. L. 100–259, 102 Stat. 28 (1988)). As used in this part, section 504 applies only to programs or activities conducted by Executive agencies and not to federally assisted programs.

§§ 365.104–365.109 [Reserved]

§ 365.110 Self-evaluation.

(a) The agency shall, by December 27, 1989, evaluate its current policies and practices, and the effects thereof, that do not or may not meet the requirements of this part, and, to the extent modification of any such policies and practices is required, the agency shall proceed to make the necessary modifications.

(b) The agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps, to participate in the self-evaluation process by submitting comments (both oral and written).

(c) The agency shall, until at least three years following the completion of the self-evaluation, maintain on file and make available for public inspection:

(1) A description of areas examined and any problems identified, and

(2) A description of any modifications made.

§ 365.111 Notice.

The agency shall make available to employees, applicants, participants, beneficiaries, and other interested persons such information regarding the provisions of this part and its applicability to the programs or activities conducted by the agency, and make such information available to them in such manner as the agency head finds necessary to apprise such persons of the protections against discrimination assured them by section 504 and this part.

§§ 365.112–365.129 [Reserved]

§ 365.130 General prohibitions against discrimination.

(a) No qualified individual with handicaps shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity conducted by the agency.

(b)(1) The agency, in providing any aid, benefit, or service may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap—

(i) Deny a qualified individual with handicaps the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with handicaps an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with handicaps with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aid, benefits, or service to individuals with handicaps or to any class of individuals with handicaps than is provided to others unless such action is necessary to provide qualified individuals with handicaps with aid, benefits, or services that are as effective as those provided to others.

(v) Deny a qualified individual with handicaps the opportunity to participate as a member of planning or advisory boards; or

(vi) Otherwise limit a qualified individual with handicaps in the enjoyment of any right, privilege, advantage or opportunity enjoyed by others receiving benefits under any programs administered by the Board.

(2) The agency may not deny a qualified individual with handicaps the opportunity to participate in programs or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) The agency may not, directly or through contractual or other arrangements, utilize criteria or methods of administration the purposes or effect of which would:

(i) Subject qualified individuals with handicaps to discrimination on the basis of handicap;

(ii) Deny qualified individuals with handicap assistance in obtaining benefits under any program administered by the agency; or

(iii) Defeat or substantially impair accomplishment of the objectives of a program or activity with respect to individuals with handicaps.

(4) The agency may not, in determining the site or location of a facility, make selections the purpose or effect of which would:

(i) Exclude individuals with handicaps from, deny them the benefits of, or otherwise subject them to discrimination under any program or activity conducted by the agency; or

(ii) Defeat or substantially impair the accomplishment of the objectives

of a program or activity with respect to individuals with handicaps.

(5) The agency, in the selection of procurement contractors, may not use criteria that subject qualified individuals with handicaps to discrimination on the basis of handicap.

(c) The exclusion of nonhandicapped persons from the benefits of a program limited by Federal statute or Executive Order to individuals with handicaps or the exclusion of a specific class of individuals with handicaps from a program limited by Federal statute or Executive Order to a different class of individuals with handicaps is not prohibited by this part.

(d) The agency shall administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with handicaps.

§§ 365.131–365.139 [Reserved]

§ 365.140 Employment.

No qualified individual with handicaps shall, on the basis of handicap, be subjected to discrimination in employment under any program or activity conducted by the agency. The definitions, requirements and procedures of section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791), as established by the Equal Employment Opportunity Commission in 29 CFR part 1613, shall apply to employment in federally conducted programs or activities.

§§ 365.141–365.148 [Reserved]

§ 365.149 Program accessibility: Discrimination prohibited.

Except as otherwise provided in § 365.150, no qualified individual with handicaps shall, because the agency's facilities are inaccessible to or unusable by individuals with handicaps, be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any program or activity conducted by the agency.

§ 365.150 Program accessibility: Existing facilities.

(a) *General.* The agency shall operate each program or activity so that the program or activity when viewed in its entirety is readily accessible to and usable by individuals with handicaps. Although all facilities in which the agency operates, except for the headquarters building, are either owned or leased by and under the general control of the General Services Administration (GSA), the agency recognizes its obligation to request the GSA to make space reassignments or any structural changes which the agency determines are necessary to ensure program accessibility. This paragraph does not—

(1) Necessarily require the agency to make each of its existing facilities accessible to and usable by individuals with handicaps; or

(2) Require the agency to take or to recommend to the GSA any action that the agency can demonstrate would result in a fundamental alteration in the nature of a program or activity or result in undue financial and administrative burdens. In those circumstances where agency personnel believe that the proposed action would fundamentally alter the program or activity or would result in undue financial and administrative burdens, the agency has the burden of proving that compliance with § 365.150(a) would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the Chief Executive Officer after considering all agency resources available for use in the funding and operation of the conducted program or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action would result in such an alteration or such burdens, the agency shall take any other action that would not result in such an alteration or such burdens that would nevertheless ensure that individuals with handicaps receive the benefits and services of the program or activity.

(b) *Methods.* In general the agency will comply with this section by making home visits. The agency may also comply with the requirements of this section through such means as redesign of equipment, reassignment of services to accessible buildings, assignment of aids to beneficiaries, delivery of services at alternate accessible sites, alteration of existing facilities and construction of new facilities, use of accessible rolling stock, or any other methods that result in making its programs

or activities readily accessible to and usable by individuals with handicaps. The agency is not required to make or request the GSA to make structural changes in existing facilities where other methods are effective in achieving compliance with this section. The agency, in making or requesting space reassignments or alterations to existing buildings, shall ensure that accessibility requirements, to the extent compelled by the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151–4157), and any regulations implementing it are met. In choosing among available methods for meeting the requirements of this section, the agency shall give priority to those methods that offer programs and activities to qualified individuals with handicaps in the most integrated setting appropriate.

(c) *Time period for compliance.* The agency shall comply with the obligations established under this section by February 27, 1989, except that where structural changes in facilities are undertaken, the agency will make such changes or, where applicable, request the GSA to make such changes by December 27, 1991, but in any event as expeditiously as possible.

(d) *Transition plan.* In the event that structural changes to facilities will be undertaken to achieve program accessibility, the agency shall develop or, where applicable, request the GSA to develop, by June 27, 1989, a transition plan setting forth the steps necessary to complete such changes. The agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps, to participate in the development of the transition plan by submitting comments (both oral and written). A copy of the transition plan shall be made available for public inspection. The plan shall, at a minimum—

(1) Identify physical obstacles in the agency's facilities that limit the accessibility of its programs or activities to individuals with handicaps;

(2) Describe in detail the methods that will be used to make the facilities accessible;

(3) Specify the schedule for taking the steps necessary to achieve compliance with this section and, if the time period of the transition plan is longer than one year, identify steps that will be taken during each year of the transition period; and

(4) Indicate the official responsible for implementation of the plan.

§ 365.151 Program accessibility: New construction and alterations.

Each building or part of a building that is constructed or altered by, on behalf of, or for the use of the agency shall be designed, constructed, or altered so as to be readily accessible to and usable by individuals with handicaps. The definitions, requirements, and standards of the Architectural Barriers Act (42 U.S.C. 4151–4157), as established in 41 CFR 101–19.600 to 101–19.607, apply to buildings covered by this section.

§§ 365.152–365.159 [Reserved]

§ 365.160 Communications.

(a) The agency shall take appropriate steps to ensure effective communication with applicants, participants, personnel of other Federal entities, and members of the public.

(1) The agency shall furnish appropriate auxiliary aids where necessary to afford an individual with handicaps an equal opportunity to participate in, and enjoy the benefits of, a program or activity conducted by the agency.

(i) In determining what type of auxiliary aid is necessary, the agency shall give primary consideration to the requests of the individual with handicaps.

(ii) The agency need not provide individually prescribed devices, readers for personal use or study, or other devices of a personal nature.

(2) Where the agency communicates with applicants and beneficiaries by telephone, telecommunication devices for deaf persons (TDD's) or equally effective telecommunication systems shall be used to communicate with persons with impaired hearing.

(b) The agency shall take appropriate steps to provide individuals with handicaps with information as to the existence and location of accessible services, activities, and facilities and information regarding their section 504

rights under the agency's programs or activities.

(c) This section does not require the agency to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens. In those circumstances where agency personnel believe that the proposed action would fundamentally alter the program or activity or would result in undue financial and administrative burdens, the agency has the burden of proving that compliance with § 365.160 would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the Chief Executive Officer after considering all agency resources available for use in the funding and operation of the conducted program or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action required to comply with this section would result in such an alteration or such burdens, the agency shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that, to the maximum extent possible, individuals with handicaps receive the benefits and services of the program or activity.

§§ 365.161–365.169 [Reserved]

§ 365.170 Compliance procedures.

(a) Except as provided in paragraph (b) of this section, this section applies to all allegations of discrimination on the basis of handicap in programs or activities conducted by the agency;

(b) The agency shall process complaints alleging violations of section 504 with respect to employment according to the procedures established by the Equal Employment Opportunity Commission in 29 CFR part 1613 pursuant to section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791).

(c) Except with respect to complaints arising under § 365.170(b), responsibility for implementation and operation of this section shall be vested in the Chief Executive Officer.

(d) The Chief Executive Officer shall accept and investigate all complete complaints for which he or she has jurisdiction. All complete complaints must be filed within 90 days of the alleged act of discrimination. The Chief Executive Officer may extend this time period for good cause.

(e) If the Chief Executive Officer receives a complaint over which the agency does not have jurisdiction, he or she shall promptly notify the complainant and shall make reasonable efforts to refer the complaint to the appropriate government entity.

(f) The Chief Executive Officer shall notify the Architectural and Transportation Barriers Compliance Board upon receipt of any complaint alleging that a building or facility used by the agency that is subject to the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151–4157), is not readily accessible to and usable by individuals with handicaps.

(g) Within 120 days of the receipt of a complete complaint under § 365.170(d) for which the agency has jurisdiction, the Chief Executive Officer shall notify the complainant of the results of the investigation in a letter containing—

(1) Findings of fact and conclusions of law;

(2) A description of a remedy for each violation found; and

(3) A notice of the right to appeal.

(h) Appeals of the findings of fact and conclusions of law or remedies must be filed by the complainant within 45 days of receipt from the Chief Executive Officer of the letter required by § 365.170(g). The Chief Executive Officer may extend this time for good cause.

(i) Timely appeals shall be accepted and processed by the Board.

(j) The Board shall notify the complainant of the results of the appeal within 60 days of the receipt of the request. If the Board determines that it needs additional information from the complainant, it shall have 30 days from the date it receives the additional information to make its determination on the appeal.

(k) The time limits cited in paragraphs (g) and (j) of this section may be extended with the permission of the Assistant Attorney General.

(l) The agency may delegate its authority for conducting complaint investigations to other Federal agencies

except that the authority for making the final determination may not be delegated to another agency.

§§ 365.171–365.999 [Reserved]

PART 366—COLLECTION OF DEBTS BY FEDERAL TAX REFUND OFFSET

Sec.

366.1 Notification to Internal Revenue Service.
366.2 Past-due legally enforceable debt.
366.3 Reasonable attempt to notify.
366.4 Notification to debtor.
366.5 Consideration of evidence.
366.6 Change in notification to Internal Revenue Service.

AUTHORITY: 45 U.S.C. 231f(b)(5); 31 U.S.C. 3720A.

SOURCE: 54 FR 397, Jan. 6, 1989, unless otherwise noted.

§ 366.1 Notification to Internal Revenue Service.

Upon entering into an agreement with the Internal Revenue Service and the Financial Management Service with regard to its participation in the tax refund offset program, the Board may notify the Internal Revenue Service, pursuant to the terms of such agreement, of past-due legally enforceable debts owed to the Board that are to be collected by tax refund offset. The Board's notification to the Internal Revenue Service will be as prescribed by the Internal Revenue Service in regard to information included and format, and will be made by such dates as prescribed by the Internal Revenue Service. The Board will provide the Internal Revenue Service with a toll-free or collect telephone number which the Internal Revenue Service may furnish to debtors whose refunds have been offset for use in obtaining information from the Board concerning the offset.

[54 FR 397, Jan. 6, 1989, as amended at 60 FR 66073, Dec. 21, 1995]

§ 366.2 Past-due legally enforceable debt.

A past-due legally enforceable debt which may be referred to the Internal Revenue Service is a debt:

(a) Which arose under any statute administered by the Board or under any contract;

(b) Which is an obligation of a debtor who is a natural person or a business;

(c) Which, except in the case of a judgment debt, has been delinquent at least three months but not more than ten years at the time the offset is made;

(d) Which is at least $25.00;

(e) With respect to which the rights regarding reconsideration, waiver, and appeal, described in part 260 or 320 of this chapter or in other law, if applicable, have been exhausted;

(f) With respect to which either:

(1) The Board's records do not contain evidence that the debtor (or, if an individual, his or her spouse) has filed for bankruptcy under title 11 of the United States Code; or

(2) The Board can clearly establish at the time of the referral that the automatic stay under section 362 of the Bankruptcy Code has been lifted or is no longer in effect with respect to the debtor (or, if an individual, his or her spouse) and the debt was not discharged in the bankruptcy proceeding;

(g) Which cannot currently be collected pursuant to the salary offset provisions of 5 U.S.C. 5514(a)(1);

(h) Which is not eligible for administrative offset under 31 U.S.C. 3716(a) by reason of 31 U.S.C. 3716(c)(2), or cannot currently be collected by administrative offset under 31 U.S.C. 3716(a) by the Board against amounts payable to the debtor by the Board;

(i) Which cannot currently be collected by administrative offset under § 255.6 or § 340.6 of this chapter against amounts payable to the debtor under any statute administered by the Board;

(j) With respect to which the Board has notified, or has made a reasonable attempt to notify, the debtor that the debt is past due, and that unless the debtor repays the debt within 60 days, will be referred to the Internal Revenue Service for offset against any overpayment of tax; and

(k) With respect to which the Board has given the debtor at least 60 days from the date of the notification required in paragraph (j) of this section to present evidence that all or part of

the debt is not past due or legally enforceable, has considered evidence, if any, presented by such debtor, and has determined that an amount of such debt is past due and legally enforceable.

[54 FR 397, Jan. 6, 1989, as amended at 60 FR 66073, Dec. 21, 1995]

§ 366.3 Reasonable attempt to notify.

In order to constitute a reasonable attempt to notify the debtor the Board must have used a mailing address for the debtor obtained from the Internal Revenue Service pursuant to section 6103 (m)(2) or (m)(4) of the Internal Revenue Code within a period of one year preceding the attempt to notify the debtor, whether or not the Board has used any other address maintained by the Board for the debtor.

§ 366.4 Notification to debtor.

The notification provided by the Board to the debtor will inform the debtor how he or she may present evidence to the Board that all or part of the debt is not past due or legally enforceable.

§ 366.5 Consideration of evidence.

Evidence submitted by the debtor will be considered only by officials or employees of the Board and a determination that an amount of such debt is past-due and legally enforceable will be made only by such officials or employees.

§ 366.6 Change in notification to Internal Revenue Service.

If, after submitting to the Internal Revenue Service notification of liability for a debt, the Board:

(a) Determines that an error has been made with respect to the information contained in the notification,

(b) Receives a payment or credits a payment to the account of the debtor named in the notification that reduces the amount of the debt referred to the Internal Revenue Service for offset, or

(c) Receives notification that the debtor has filed for bankruptcy under title 11 of the United States Code or has been adjudicated bankrupt and the debt has been discharged, the Board will promptly notify the Internal Revenue Service. However, the Board will make no notification to the Internal Revenue Service to increase the amount of a debt owed by a debtor named in the Board's original notification to the Internal Revenue Service. If the amount of a debt is reduced after referral by the Board and offset by the Internal Revenue Service, the Board will refund to the debtor any excess amount and will promptly notify the Internal Revenue Service of any refund made by the Board.

[54 FR 397, Jan. 6, 1989, as amended at 60 FR 66073, Dec. 21, 1995]

PART 367—RECOVERY OF DEBTS OWED TO THE UNITED STATES GOVERNMENT BY ADMINISTRATIVE OFFSET

Sec.

367.1 Purpose and scope.
367.2 Past-due legally enforceable debt.
367.3 Board responsibilities.
367.4 Notification to another agency.
367.5 Notification to debtor.
367.6 Consideration of evidence.
367.7 Change in notification to another government agency.
367.8 Administrative offset against amounts payable from Civil Service Retirement and Disability Fund.

AUTHORITY: 45 U.S.C. 231f(b)(5); 31 U.S.C. 3716.

SOURCE: 56 FR 46375, Sept. 12, 1991, unless otherwise noted.

§ 367.1 Purpose and scope.

The regulations in this part establish procedures to implement the Debt Collection Act of 1982 (Pub. L. 97–365), as amended by the Debt Collection Improvement Act of 1996 (Pub. L. 104–134), 31 U.S.C. 3716. The statute authorizes the Board to collect a claim arising under an agency program by means of administrative offset, and requires the Board to refer nontax debts over 180 days delinquent to the Department of Treasury for administrative offset (the ''Treasury Offset Program''). No claim may be collected by such means if outstanding for more than 10 years after the Board's right to collection of the debt first accrued, unless facts material to the Government's right to collect the debt were not known and could not reasonably have been known by the official or officials of the government

who were charged with the responsibility to discover and collect such debts. This part specifies the agency procedures that will be followed by the Board for referral and collection by administrative offset.

[62 FR 19220, Apr. 21, 1997]

§ 367.2 Past-due legally enforceable debt.

A past-due legally enforceable debt which may be referred to another governmental agency for administrative offset is a debt:

(a) Which arose under any statute administered by the Board or under any contract; and with respect to debts referred to the Department of Treasury, is a nontax debt;

(b) Which is an obligation of a debtor who is a natural person or a business;

(c) Which, except in the case of a judgment debt, has been delinquent at least three months but not more than ten years at the time the offset is made;

(d) Which is at least $25.00;

(e) With respect to which the rights described in part 260 or 320 of this chapter or the applicable law regarding reconsideration, waiver, and appeal, if applicable, have been exhausted;

(f) With respect to which:

(1) The Board's records do not contain evidence that the debtor (or, if an individual, his or her spouse) has filed for bankruptcy under title 11 of the United States Code; or

(2) The Board can clearly establish at the time of the referral that the automatic stay under section 362 of the Bankruptcy Code has been lifted or is no longer in effect with respect to the debtor (or, if an individual, his or her spouse) and the debt was not discharged in the bankruptcy proceeding; or

(3) The Board's records do not contain evidence that foreclosure is pending on collateral securing the debt.

(g) Which cannot currently be collected pursuant to the salary offset provisions of 5 U.S.C. 5514(a)(1);

(h) Which cannot currently be collected by administrative offset under § 255.6 or § 340.6 of this chapter against amounts payable to the debtor under any statute administered by the Board;

(i) With respect to which the Board has notified, or has made a reasonable attempt to notify, the debtor that the debt is past due, and that unless the debtor repays the debt within 60 days, the debt will be referred to any other agency of the United States government for offset against any money owed the debtor by that agency; and

(j) With respect to which the Board has given the debtor at least 60 days from the date of the notification required in paragraph (i) of this section to present evidence that all or part of the debt is not past due or legally enforceable, has considered evidence, if any, presented by the debtor, and has determined that the amount of such debt is past due and legally enforceable; and

(k) Which has not been referred to the Department of Justice or which is not otherwise in litigation with the Board.

[56 FR 46375, Sept. 12, 1991, as amended at 60 FR 66073, Dec. 21, 1995; 62 FR 19220, Apr. 21, 1997]

§ 367.3 Board responsibilities.

(a) The Board may delegate to an employee or employees the responsibility for collecting any claims owed the Board by means of administrative offset, except that all nontax debts over 120 days delinquent shall be referred to the Department of Treasury for administrative offset through the Treasury Offset Program as required by 31 U.S.C. 3716;

(b) Except for mandatory referral of claims to the Department of Treasury or as otherwise directed by the Secretary of Treasury, before collecting a claim by means of administrative offset, the Board must ensure that administrative offset is feasible, allowable, and appropriate, and must notify the debtor of the Board's policies for collecting a claim by means of administrative offset.

(c) Except for mandatory referral of claims to the Department of Treasury or as otherwise directed by the Secretary of Treasury, whether collection by administrative offset is feasible is a determination to be made on a case-by-case basis, in the exercise of its sound discretion. The Board shall consider not only whether administrative offset

can be accomplished, both practically and legally, but also whether offset is best suited to further and protect all of the Government's interests. In appropriate circumstances, the Board may give due consideration to the debtor's financial condition, and is not required to use offset in every instance in which there is an available source of funds. The Board may also consider whether offset would substantially interfere with or defeat the purposes of the program authorizing the payments against which offset is contemplated.

(d) Before advising the debtor that the delinquent debt will be subject to administrative offset, the agency official responsible for administering the program under which the debt arose shall review the claim and determine that the debt is valid and overdue.

(e) Administrative offset shall be considered by the Board only after attempting to collect a claim under the statutes administered by the Board except that no claim under this Act that has been outstanding for more than 10 years after the Government's right to collect the debt first accrued may be collected by means of administrative offset, unless facts material to the right to collect the debt were not known and could not reasonably have been known by the official of the agency who was charged with the responsibility to discover and collect such debts.

[56 FR 46375, Sept. 12, 1991, as amended at 62 FR 19220, Apr. 21, 1997; 81 FR 30173, May 16, 2016]

§ 367.4 Notification to another agency.

When the Board refers a debt under this part to another agency forcollection by means of administrative offset, the Board shall provide a written certification to the other agency stating that the debtor owes the debt (including the amount) and that the provisions of this part have been fully complied with.

§ 367.5 Notification to debtor.

The notification provided by the Board to the debtor will inform the debtor how he or she may present evidence to the Board that all or part of the debt is not past due or legally enforceable.

§ 367.6 Consideration of evidence.

Evidence submitted by the debtor will be considered only by officials or employees of the Board, and a determination that all or a portion of such debt is past-due and legally enforceable will be made only by such officials or employees.

§ 367.7 Change in notification to another government agency.

If, after submitting notification of liability for a debt to another agency, the Board:

(a) Determines that an error has been made with respect to the information contained in the notification;

(b) Receives a payment or credits a payment to the account of the debtor named in the notification that reduces the amount of the debt referred to the other agency for offset; or

(c) Receives notification that the debtor has filed for bankruptcy under title 11 of the United States Code or has been adjudicated bankrupt and the debt has been discharged; the Board will promptly notify the other agency. If the amount of a debt is reduced after referral by the Board and offset by the other agency, the Board will refund to the debtor any excess amount and will promptly notify the other agency of any refund made by the Board. If the amount of debt has increased after referral by the Board but prior to offset by the other agency, then the Board will promptly notify the other agency of such increase.

[56 FR 46375, Sept. 12, 1991, as amended at 60 FR 66073, Dec. 21, 1995]

§ 367.8 Administrative offset against amounts payable from Civil Service Retirement and Disability Fund.

(a) The Board may request that moneys which are due and payable to a debtor from the Civil Service Retirement and Disability Fund be administratively offset in reasonable amounts in order to collect debts owed to the Board by the debtor. Such requests shall be made to the appropriate officials of the Office of Personnel Management in accordance with such regulations as may be prescribed by the Director of that Office.

(b) When making a request for administrative offset under paragraph (a)

of this section, the Board shall include a written certification that:

(1) The debtor owes the United States a debt, including the amount of the debt;

(2) The Board has complied with all applicable statutes, regulations, and procedures of the Office of Personnel Management; and

(3) The Board has complied with the requirements of the applicable provisions of the Federal Claims Collection Standards, the Railroad Retirement Act and the Railroad Unemployment Insurance Act including any required hearing or review.

(c) When the Board decides to request administrative offset under paragraph (a) of this section, it should make the request as soon as practical after completion of the applicable due process procedures in order that the Office of Personnel Management may identify and flag the debtor's account in anticipation of the time when the debtor becomes eligible and requests to receive payments from the Fund. This will satisfy any requirement that offset be initiated prior to expiration of the applicable statute of limitations. At such time as the debtor makes a claim for payments from the Fund, if at least a year has elapsed since the offset request was originally made, the debtor will be permitted to offer a satisfactory repayment plan in lieu of offset upon establishing that changed financial circumstances would render the offset unjust.

(d) In accordance with procedures established by the Office of Personnel Management, the Board may request an offset from the Civil Service Retirement and Disability Fund prior to completion of due process procedures.

(e) If the Board collects part or all of the debt by other means before deductions are made or completed pursuant to paragraph (a) of this section, the Board shall act promptly to modify or terminate its request for offset under paragraph (a) of this section.

PART 368—PROHIBITION OF CIGARETTE SALES TO MINORS

Sec.

368.1 Introduction.
368.2 Definitions.
368.3 Vending machines.
368.4 Concession stands.
368.5 Free tobacco samples.

AUTHORITY: Sec. 636, Pub. L. 104–52, 109 Stat. 507 (40 U.S.C. 486nt).

SOURCE: 61 FR 8214, Mar. 4, 1996, unless otherwise noted.

§ 368.1 Introduction.

This part implements Public Law 104–52, the ''Prohibition of Cigarette Sales to Minors in Federal Buildings and Lands Act,'' which prohibits the sale of tobacco products through vending machines and the distribution of free samples of tobacco products on Federal property.

§ 368.2 Definitions.

As used in this part—

Federal property includes any building and real property occupied and maintained by the Board.

Minor means an individual under the age of 18 years.

Tobacco product means cigarettes, cigars, little cigars, pipe tobacco, smokeless tobacco, snuff, and chewing tobacco.

§ 368.3 Vending machines.

The sale of tobacco products in vending machines is prohibited in or around Federal property occupied and maintained by the Railroad Retirement Board.

§ 368.4 Concession stands.

Tobacco products may be sold on property occupied and maintained by the Railroad Retirement Board only as authorized by the Railroad Retirement Board or the General Services Administration or other Federal agency. Concession stands may not sell tobacco products to minors.

§ 368.5 Free tobacco samples.

The distribution of free samples of tobacco products is prohibited in or around Federal property occupied and maintained by the Railroad Retirement Board.

PART 369—USE OF THE SEAL OF THE RAILROAD RETIREMENT BOARD

Sec.

369.1 Unofficial use of the seal of the Railroad Retirement Board.
369.2 Authority to grant written permission for use of the seal.
369.3 Procedures for obtaining permission to use the seal.
369.4 Inappropriate use of the seal.
369.5 Penalty for misuse of the seal.

AUTHORITY: 18 U.S.C. 701; 45 U.S.C. 231f.

SOURCE: 66 FR 29475, May 31, 2001, unless otherwise noted.

§ 369.1 Unofficial use of the seal of the Railroad Retirement Board.

Use of the seal of the Railroad Retirement Board for non-Agency business is prohibited unless permission for use of the seal has been obtained in accordance with this part.

§ 369.2 Authority to grant written permission for use of the seal.

The Board hereby delegates authority to grant written permission for the use of the seal of the Railroad Retirement Board to the Director of Administration.

§ 369.3 Procedures for obtaining permission to use the seal.

Requests for written permission to use the seal of the Railroad Retirement Board shall be in writing and shall be directed to the Director of Administration of the Railroad Retirement Board. The request should, at a minimum, contain the following information:

(a) Name and address of the requester.

(b) A description of the type of activity in which the requester is engaged or proposes to engage.

(c) A statement of whether the requester considers the proposed use or imitation to be commercial or non-commercial, and why.

(d) A brief description and illustration or sample of the proposed use, as well as a description of the product or service in connection with which it will be used. This description will provide sufficient detail to enable the Director of Administration to determine whether the intended use of the seal is consistent with the interests of the government.

(e) In the case of a non-commercial use, a description of the requesting organization's function and purpose shall be provided.

§ 369.4 Inappropriate use of the seal.

The Railroad Retirement Board shall not grant permission for use of the seal in those instances where use of the seal will give the unintended appearance of Agency endorsement or authentication. Situations where use of the seal of the Railroad Retirement Board would be inappropriate include, but are not limited to, the following examples:

(a) A consulting firm makes arrangements with a railroad to conduct a retirement planning seminar for its employees. Included in the material distributed to the seminar attendees is a booklet, prepared by the consulting firm, which displays the seal of the Railroad Retirement Board on the cover and contains information regarding benefits payable under the Railroad Retirement Act.

(b) A former employee of the Railroad Retirement Board owns a coffee and donut shop, frequented by present and past railroad workers. Many of the shop's customers know of the owner's prior employment with the Board and frequently ask him questions related to benefits payable under the Railroad Unemployment Insurance and Railroad Retirement Acts. The shop owner prepares and distributes to his customers a monthly flyer listing benefit questions presented to him during the month, as well as his answers to the questions. The flyer displays the seal of the Board.

(c) A retired railroad employee works part-time in a train hobby shop. The shop owner, at the former railroad worker's suggestion, develops and sells items such as coffee mugs and computer mouse pads with text relevant to benefits paid by the Railroad Retirement Board. The text is taken from publications issued by the Railroad Retirement Board. The merchandise also bears the seal of the Railroad Retirement Board.

§ 369.5 Penalty for misuse of the seal.

Unauthorized use of the seal of the Railroad Retirement Board may result in criminal prosecution under applicable law.

SUBCHAPTER G [RESERVED]

SUBCHAPTER H—EMERGENCY REGULATIONS

PART 375—PLAN OF OPERATION DURING A NATIONAL EMERGENCY

Sec.
375.1 Purpose.
375.2 National emergency and effective date.
375.3 Policy.
375.4 Mailing instructions.
375.5 Organization and functions of the Board, delegations of authority, and lines of succession.
375.6 Personnel, fiscal, and service functions.
375.7 Operating regulations.
375.8 Regulations for employers.

AUTHORITY: 45 U.S.C. 231f(b)(5), 362(l).

SOURCE: 29 FR 15864, Nov. 26, 1964, unless otherwise noted. Redesignated at 29 FR 16322, Dec. 5, 1964, and further redesignated at 45 FR 28314, Apr. 29, 1980.

§ 375.1 Purpose.

(a) The Railroad Retirement Board has adopted a plan to provide basic organization and methods of operation which may be needed to continue uninterrupted service during a period of national emergency as defined in § 375.2.

(b) The plan is published to inform all interested persons of the circumstances and ways in which the Board will organize and operate in a national emergency.

(c) For purposes of Government-wide uniformity, the procedures of the Board regarding payments during evacuation to employees and their dependents shall conform to those contained in subpart D of part 550 of the regulations of the Office of Personnel Management pertaining to ''Payments During Evacuation'' (5 CFR part 550, subpart D).

[29 FR 15864, Nov. 26, 1964, as amended at 64 FR 66381, Nov. 26, 1999]

§ 375.2 National emergency and effective date.

A period of national emergency shall be deemed to exist and the provisions of this part shall become effective only (a) after an attack upon the United States, or at a time specified by the authority of the President after such attack, and (b) by order of the Chair of the Board or his or her successor as set forth in § 375.5, or when it is no longer possible to communicate with such official at his or her designated station.

[29 FR 15864, Nov. 26, 1964, as amended at 64 FR 66381, Nov. 26, 1999]

§ 375.3 Policy.

To the greatest extent possible, payment of benefits shall be made and employment service functions shall be carried on through the period of a national emergency in strict conformance with the pertinent provisions of the Railroad Retirement Act, the Railroad Unemployment Insurance Act, and the regulations promulgated by the Board to administer those acts. Where the character of the national emergency is such as to prevent this, the stand-by regulations contained in this part shall obtain. It will be expected, however, that every effort shall be made to return to normal operating practices as quickly as possible thereafter.

§ 375.4 Mailing instructions.

In a national emergency as defined in § 375.2, all mail shall be directed to Board offices at their normal locations.

[40 FR 52844, Nov. 13, 1975]

§ 375.5 Organization and functions of the Board, delegations of authority, and lines of succession.

(a) During a national emergency, as defined in § 375.2, the respective functions and responsibilities of the Board shall be, to the extent possible, as set forth in the U.S. Government Manual, which is published annually by the Office of the Federal Register, and is available on the Internet at *http://www.nara.gov/fedreg/*, under *Other Publications*.

(b) The following delegation of authority is made to provide continuity in the event of a national emergency:

(1) The Chair of the Board shall act with full administrative authority for the Board.

(2) In the absence or incapacity of the Chair, the authority of the Chair to act

shall pass to the available successor highest on the following list:

Labor Member of the Board
Management Member of the Board
Director of Administration
Director of Programs
General Counsel
Chief Information Officer
Director of Supply and Service
Regional Directors in order of length of Board service.

(3) Except as may be determined otherwise by the Chair of the Board or his or her successor and as provided in §§ 375.6 and 375.7, the duties of each office head or regional director shall be discharged in his or her absence or incapacity during a national emergency by the available staff member next in line of succession. Each office head and each regional director shall designate and preposition the line of succession within his or her office or region. If no such designation has been made, such duties shall be assumed by the available subordinate who is highest in grade or, if there is more than one, in length of Board service.

(4) Emergency responsibility and authority under this section, once assumed, shall be relinquished on direction of the duly constituted higher authority acting under the provisions of paragraph (b)(2) of this section.

[Board Order 68–135, 29 FR 15864, Nov. 26, 1964. Redesignated at 29 FR 16322, Dec. 5, 1964, as amended by Board Order 71–26, 36 FR 4980, Mar. 16, 1971; Board Order 75–52, 40 FR 26673, June 25, 1975; 40 FR 52844, Nov. 13, 1975; 64 FR 66381, Nov. 26, 1999]

§ 375.6 Personnel, fiscal, and service functions.

(a) *Personnel.* In a national emergency as defined in § 375.2, when it is no longer possible for a regional director to communicate with the Chair or his or her successor as set forth in § 375.5, complete responsibility and authority for administration of the personnel function are delegated to such regional director for his or her respective geographic area.

(b) *Fiscal.* (1) In a national emergency, as defined in § 375.2, the Chair of the Board or his or her successor, as set forth in § 375.5, shall designate an individual to assume the responsibilities of the Chief Financial Officer in the event that he or she is unable to assume those responsibilities.

(2) In a national emergency, incumbents of the following positions are hereby authorized to appoint emergency certifying officers:

Director of Administration
Director of Programs
Chief Financial Officer
Regional Directors.

(i) The emergency certifying officers shall be empowered to certify:

(*a*)Benefit payments under the Railroad Retirement Act.

(*b*)Benefit payments under the Railroad Unemployment Insurance Act.

(*c*)Administrative expenses of the Railroad Retirement Board.

(ii) Emergency certifying officers shall be appointed under the authority delegated by this section when (*a*) normal channels for certifying payments have been rendered inoperable, and (*b*) clearance has been obtained from the ranking offical in line of sucession as set forth in § 375.5(b)(1) and (2) and under such instructions and conditions as he may prescribe.

(c) *Supply and service.* (1) In a national emergency, as defined in § 375.2, complete responsibility and authority for the procurement of needed supplies, equipment, space, communications, transportation, and repair services, are delegated to each regional director for his or her geographic area.

(2) Federal sources of supply and service, if available, shall be used.

(3) Any supplies, equipment, space, or services provided under this emergency delegation shall be documented to show what was provided, the amount procured, the cost thereof, and the source from which procured.

(4) As soon after the period of national emergency as conditions permit, the records required by paragraph (c)(3) of this section shall be transmitted to the Director of Supply and Service or his surviving successor.

[29 FR 15864, Nov. 26, 1964. Redesignated at 29 FR 16322, Dec. 5, 1964, as amended by Board Order 67–29, 32 FR 3975, Mar. 11, 1967; 34 FR 12490, July 31, 1969; Board Order 75–52, 40 FR 26674, June 25, 1975; 40 FR 52844, Nov. 13, 1975; 64 FR 66381, Nov. 26, 1999]

§ 375.7 Operating regulations.

(a) *Retirement claims.* (1) In a national emergency as defined in § 375.2, applications for and development and certification of claims for retirement, disability, and survivor benefits shall be to the extent possible, as set forth in subchapter B of this chapter, except that:

(i) Standards of evidence may be relaxed although legal requirements for entitlement to payments shall remain unchanged; in determining relationships, employment, birth, death, etc., consideration shall be given to whatever information is in the possession of applicants and beneficiaries or the Board office adjudicating a claim.

(ii) If prescribed forms are not available, any writing that contains substantially the necessary information shall be acceptable.

(iii) In a national emergency, that is when the headquarters office is inoperable, the development and certification of claims shall be assumed by the regional offices.

(2) To provide the necessary authority for a decentralized program as outlined in this paragraph (a), those authorities which have been delegated to the Director of Programs are hereby delegated to the regional directors or their surviving successors.

(b) *Unemployment and sickness claims.* (1) In a national emergency as defined in § 375.2, receipt, adjudication, and certification of claims for unemployment and sickness benefits shall be to the extent possible as set forth in subchapter C of this chapter, except that:

(i) Where the Board's wage records have been destroyed or are otherwise unavailable, the wage-record evidence in the possession of the claimant, or the employer's wage records will be acceptable in determining qualifications for benefits.

(ii) In the event normal record sources are destroyed or otherwise unavailable, other evidence of previous benefit payments shall be considered in determining the periods for which benefits are currently payable and the amounts.

(iii) In developing sickness benefit claims where medical evidence in the form of a doctor's statement is not available, an affidavit from the claimant or other person having knowledge of his sickness or injury shall be acceptable.

(iv) If prescribed forms are not available, any writing that contains substantially the necessary information shall be acceptable.

(v) Eligibility interviews, investigations, and checking procedures shall be curtailed.

(vi) If claims cannot be submitted to the processing offices in headquarters because of the national emergency, the development and certification of claims shall be assumed by district offices.

(2) To provide the necessary authority for a decentralized program as outlined in paragraph (b) of this section, the authorities which have been delegated to the Director of Programs and to the regional directors are hereby delegated to the district managers or to their surviving successors.

[29 FR 15864, Nov. 26, 1964. Redesignated at 29 FR 16322, Dec. 5, 1964, as amended by Board Order 75–52, 40 FR 26674, June 25, 1975; 64 FR 66381, Nov. 26, 1999]

§ 375.8 Regulations for employers.

(a) In a national emergency, as described in § 375.2, employers shall continue to follow, to the greatest extent possible, the requirements pertaining to employers in subchapters A, B, and C of this chapter.

(b) Where a national emergency, as described in § 375.2, prevents an employer from following any requirement imposed by paragraph (a) of this section, the employer shall comply with such requirement as soon as possible after the cessation of the national emergency.

(c) In a national emergency, as defined in § 375.2, all communications by employers shall be directed as set forth in § 375.4.

[64 FR 66382, Nov. 26, 1999]

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FINDING AIDS

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CODE OF FEDERAL REGULATIONS

Title 20
Employees' Benefits

Parts 400 to 499

Revised as of April 1, 2025

Containing a codification of documents
of general applicability and future effect

As of April 1, 2025

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Title 17 through Title 27.....as of April 1
Title 28 through Title 41.....as of July 1
Title 42 through Title 50.....as of October 1

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OLIVER A. POTTS,
Director,
Office of the Federal Register
April 1, 2025

THIS TITLE

Title 20—EMPLOYEES' BENEFITS is composed of four volumes. The first volume, containing parts 1–399, includes current regulations issued by the Office of Workers' Compensation Programs, Department of Labor and the Railroad Retirement Board. The second volume, containing parts 400–499, includes all current regulations issued by the Social Security Administration. The third volume, containing parts 500 to 656, includes current regulations issued by the Employees' Compensation Appeals Board, and the Employment and Training Administration. The fourth volume, containing part 657 to End, includes the current regulations issued by the Office of Workers' Compensation Programs, the Benefits Review Board, the Office of the Assistant Secretary for Veterans' Employment and Training Service (all of the Department of Labor) and the Joint Board for the Enrollment of Actuaries. The contents of these volumes represent all current regulations codified under this title of the CFR as of April 1, 2025.

An index to chapter III appears in the second volume.

For this volume, Cheryl E. Sirofchuck was Chief Editor. The Code of Federal Regulations publication program is under the direction of John Hyrum Martinez, assisted by Stephen J. Frattini.

Title 20—Employees' Benefits

(This book contains parts 400 to 499)

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PART 400 [RESERVED]

PART 401—PRIVACY AND DISCLOSURE OF OFFICIAL RECORDS AND INFORMATION

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APPENDIX A TO PART 401—EMPLOYEE STANDARDS OF CONDUCT

AUTHORITY: Secs. 205, 702(a)(5), 1106, and 1141 of the Social Security Act (42 U.S.C. 405, 902(a)(5), 1306, and 1320b–11); 5 U.S.C. 552 and 552a; 8 U.S.C. 1360; 26 U.S.C. 6103; 30 U.S.C. 923.

SOURCE: 62 FR 4143, Jan. 29, 1997, unless otherwise noted.

Subpart A—General

§ 401.5 Purpose of the regulations.

(a) *General.* The purpose of this part is to describe the Social Security Administration (SSA) policies and procedures for implementing the requirements of the Privacy Act of 1974, 5 U.S.C. 552a and section 1106 of the Social Security Act concerning disclosure of information about individuals, both with and without their consent. This part also complies with other applicable statutes.

(b) *Privacy.* This part implements the Privacy Act by establishing agency policies and procedures for the maintenance of records. This part also establishes agency policies and procedures under which you can ask us whether we maintain records about you or obtain access to your records. Additionally, this part establishes policies and procedures under which you may seek to have your record corrected or amended if you believe that your record is not accurate, timely, complete, or relevant.

(c) *Disclosure.* This part also sets out the general guidelines which we follow in deciding whether to make disclosures. However, we must examine the facts of each case separately to decide if we should disclose the information or keep it confidential.

§ 401.10 Applicability.

(a) *SSA.* All SSA employees and components are governed by this part. SSA employees governed by this part include all regular and special government employees of SSA; experts and consultants whose temporary (not in

excess of 1 year) or intermittent services have been procured by SSA by contract pursuant to 5 U.S.C. 3109; volunteers where acceptance of their services are authorized by law; those individuals performing gratuitous services as permitted under conditions prescribed by the Office of Personnel Management; and, participants in work-study or training programs.

(b) *Other entities.* This part also applies to advisory committees and councils within the meaning of the Federal Advisory Committee Act which provide advice to: Any official or component of SSA; or the President and for which SSA has been delegated responsibility for providing services.

§ 401.15 Limitations on scope.

The regulations in this part do not—

(a) Make available to an individual records which are not retrieved by that individual's name or other personal identifier.

(b) Make available to the general public records which are retrieved by an individual's name or other personal identifier or make available to the general public records which would otherwise not be available to the general public under the Freedom of Information Act, 5 U.S.C. 552, and part 402 of this title.

(c) Govern the maintenance or disclosure of, notification about or access to, records in the possession of SSA which are subject to the regulations of another agency, such as personnel records which are part of a system of records administered by the Office of Personnel Management.

(d) Apply to grantees, including State and local governments or subdivisions thereof, administering federally funded programs.

(e) Make available records compiled by SSA in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any subject individual or party to such litigation or proceedings shall be governed by applicable constitutional principles, rules of discovery, and applicable regulations of the agency.

§ 401.20 Scope.

(a) *Access.* Sections 401.30 through 401.95, which set out SSA's rules for implementing the Privacy Act, apply to records retrieved by an individual's name or personal identifier subject to the Privacy Act. The rules in §§ 401.30 through 401.95 also apply to information developed by medical sources for the Social Security program and shall not be accessed except as permitted by this part.

(b) *Disclosure*—(1) *Program records.* Regulations that apply to the disclosure of information about an individual contained in SSA's program records are set out in §§ 401.100 through 401.200 of this part. These regulations also apply to the disclosure of other Federal program information which SSA maintains. That information includes:

(i) Health insurance records which SSA maintains for the Health Care Financing Administration's (HCFA) programs under title XVIII of the Social Security Act. We will disclose these records to HCFA. HCFA may redisclose these records under the regulations applying to records in HCFA's custody;

(ii) Black lung benefit records which SSA maintains for the administration of the Federal Coal Mine Health and Safety Act; (However, this information is not covered by section 1106 of the Social Security Act.) and

(iii) Information retained by medical sources pertaining to a consultative examination performed for the Social Security program shall not be disclosed except as permitted by this part.

(2) *Nonprogram records.* Section 401.110 sets out rules applicable to the disclosure of nonprogram records, e.g., SSA's administrative and personnel records.

[62 FR 4143, Jan. 29, 1997, as amended at 65 FR 16812, Mar. 30, 2000; 72 FR 20939, Apr. 27, 2007]

§ 401.25 Terms defined.

Access means making a record available to a subject individual.

Act means the Social Security Act.

Agency means the Social Security Administration.

Commissioner means the Commissioner of Social Security.

Disclosure means making a record about an individual available to or releasing it to another party.

FOIA means the Freedom of Information Act.

Individual when used in connection with the Privacy Act or for disclosure of nonprogram records, means a living person who is a citizen of the United States or an alien lawfully admitted for permanent residence. It does not include persons such as sole proprietorships, partnerships, or corporations. A business firm which is identified by the name of one or more persons is not an individual. When used in connection with the rules governing program information, *individual* means a living natural person; this does not include corporations, partnerships, and unincorporated business or professional groups of two or more persons.

Information means information about an individual, and includes, but is not limited to, vital statistics; race, sex, or other physical characteristics; earnings information; professional fees paid to an individual and other financial information; benefit data or other claims information; the social security number, employer identification number, or other individual identifier; address; phone number; medical information, including psychological or psychiatric information or lay information used in a medical determination; and information about marital and family relationships and other personal relationships.

Maintain means to establish, collect, use, or disseminate when used in connection with the term *record*; and, to have control over or responsibility for a system of records when used in connection with the term *system of records*.

Notification means communication to an individual whether he is a subject individual. (*Subject individual* is defined further on in this section.)

Program information means personal information and records collected and compiled by SSA in order to discharge its responsibilities under titles I, II, IV part A, X, XI, XIV, XVI and XVIII of the Act and parts B and C of the Federal Coal Mine Health and Safety Act.

Record means any item, collection, or grouping of information about an individual that is maintained by SSA including, but not limited to, information such as an individual's education, financial transactions, medical history, and criminal or employment history that contains the individual's name, or an identifying number, symbol, or any other means by which an individual can be identified. When used in this part, record means only a record which is in a system of records.

Routine use means the disclosure of a record outside SSA, without the consent of the subject individual, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statutes other than the Freedom of Information Act, 5 U.S.C. 552. It does not include disclosures which the Privacy Act otherwise permits without the consent of the subject individual and without regard to whether they are compatible with the purpose for which the information is collected, such as disclosures to the Bureau of the Census, the General Accounting Office, or to Congress.

Social Security Administration (SSA) means (1) that Federal agency which has administrative responsibilities under titles, I, II, X, XI, XIV, XVI, and XVIII of the Act; and (2) units of State governments which make determinations under agreements made under sections 221 and 1633 of the Act.

Social Security program means any program or provision of law which SSA is responsible for administering, including the Freedom of Information Act and Privacy Act. This includes our responsibilities under parts B and C of the Federal Coal Mine Health and Safety Act.

Statistical record means a record maintained for statistical research or reporting purposes only and not maintained to make determinations about a particular subject individual.

Subject individual means the person to whom a record pertains.

System of records means a group of records under our control from which information about an individual is retrieved by the name of the individual or by an identifying number, symbol, or other identifying particular. Single records or groups of records which are not retrieved by a personal identifier are not part of a system of records. Papers maintained by individual Agency employees which are prepared, maintained, or discarded at the discretion of the employee and which are not subject

to the Federal Records Act, 44 U.S.C. 2901, are not part of a system of records; provided, that such personal papers are not used by the employee or the Agency to determine any rights, benefits, or privileges of individuals.

We and *our* mean the Social Security Administration.

Subpart B—The Privacy Act

§ 401.30 Privacy Act and other responsibilities.

(a) *Policy.* Our policy is to protect the privacy of individuals to the fullest extent possible while nonetheless permitting the exchange of records required to fulfill our administrative and program responsibilities, and responsibilities for disclosing records which the general public is entitled to have under the Freedom of Information Act, 5 U.S.C. 552, and 20 CFR part 402.

(b) *Maintenance of records.* We will maintain no record unless:

(1) It is relevant and necessary to accomplish an SSA function which is required to be accomplished by statute or Executive Order;

(2) We obtain the information in the record, as much as it is practicable, from the subject individual if we may use the record to determine an individual's rights, benefits or privileges under Federal programs;

(3) We inform the individual providing the record to us of the authority for our asking him or her to provide the record (including whether providing the record is mandatory or voluntary, the principal purpose for maintaining the record, the routine uses for the record, and what effect his or her refusal to provide the record may have on him or her). Further, the individual agrees to provide the record, if the individual is not required by statute or Executive Order to do so.

(c) *First Amendment rights.* We will keep no record which describes how an individual exercises rights guaranteed by the First Amendment unless we are expressly authorized:

(1) By statute,

(2) By the subject individual, or

(3) Unless pertinent to and within the scope of an authorized law enforcement activity.

(d) *Privacy Officer.* The Privacy Officer is an advisor to the Agency on all privacy policy and disclosure matters. The Privacy Officer coordinates the development and implementation of Agency privacy policies and related legal requirements to ensure Privacy Act compliance, and monitors the coordination, collection, maintenance, use and disclosure of personal information. The Privacy Officer also ensures the integration of privacy principles into information technology systems architecture and technical designs, and generally provides to Agency officials policy guidance and directives in carrying out the privacy and disclosure policy.

(e) *Senior Agency Official for Privacy.* The Senior Agency Official for Privacy assumes overall responsibility and accountability for ensuring the agency's implementation of information privacy protections as well as agency compliance with federal laws, regulations, and policies relating to the privacy of information, such as the Privacy Act. The compliance efforts also include reviewing information privacy procedures to ensure that they are comprehensive and up-to-date and, where additional or revised procedures may be called for, working with the relevant agency offices in the consideration, adoption, and implementation of such procedures. The official also ensures that agency employees and contractors receive appropriate training and education programs regarding the information privacy laws, regulations, polices and procedures governing the agency's handling of personal information. In addition to the compliance role, the official has a central policy-making role in the agency's development and evaluation of legislative, regulatory and other policy proposals which might implicate information privacy issues, including those relating to the collection, use, sharing, and disclosure of personal information.

(f) *Privacy Impact Assessment.* In our comprehensive Privacy Impact Assessment (PIA) review process, we incorporate the tenets of privacy law, SSA privacy regulations, and privacy policy directly into the development of certain Information Technology projects. Our review examines the risks and

ramifications of collecting, maintaining and disseminating information in identifiable form in an electronic information system and identifies and evaluates protections and alternate processes to reduce the risk of unauthorized disclosures. As we accomplish the PIA review, we ask systems personnel and program personnel to resolve questions on data needs and data protection prior to the development of the electronic system.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20939, Apr. 27, 2007]

§ 401.35 Your right to request records.

The Privacy Act gives you the right to direct access to most records about yourself that are in our systems of records. Exceptions to this Privacy Act right include—

(a) Special procedures for access to certain medical records (see 5 U.S.C. 552a(f)(3) and § 401.55);

(b) Unavailability of certain criminal law enforcement records (see 5 U.S.C. 552a(k), and § 401.85); and

(c) Unavailability of records compiled in reasonable anticipation of a court action or formal administrative proceeding.

NOTE TO § 401.35: The Freedom of Information Act (see 20 CFR part 402) allows you to request information from SSA whether or not it is in a system of records.

§ 401.40 How to get your own records.

(a) *Your right to notification and access.* Subject to the provisions governing medical records in § 401.55, you may ask for notification of or access to any record about yourself that is in an SSA system of records. If you are a minor, you may get information about yourself under the same rules as for an adult. Under the Privacy Act, if you are the parent or guardian of a minor, or the legal guardian of someone who has been declared legally incompetent, and you are acting on his or her behalf, you may ask for information about that individual. You may be accompanied by another individual of your choice when you request access to a record in person, *provided* that you affirmatively authorize the presence of such other individual during any discussion of a record to which you are requesting access.

(b) *Identifying the records.* At the time of your request, you must specify which systems of records you wish to have searched and the records to which you wish to have access. You may also request copies of all or any such records. Also, we may ask you to provide sufficient particulars to enable us to distinguish between records on individuals with the same name. The necessary particulars are set forth in the notices of systems of records which are published in the FEDERAL REGISTER.

(c) *Requesting notification or access.* To request notification of or access to a record, you may visit your local social security office or write to the manager of the SSA system of records. The name and address of the manager of the system is part of the notice of systems of records. Every local social security office keeps a copy of the FEDERAL REGISTER containing that notice. That office can also help you get access to your record. You do not need to use any special form to ask for a record about you in our files, but your request must give enough identifying information about the record you want to enable us to find your particular record. This identifying information should include the system of records in which the record is located and the name and social security number (or other identifier) under which the record is filed. We do not honor requests for all records, all information, or similar blanket requests. Before granting notification of or access to a record, we may, if you are making your request in person, require you to put your request in writing if you have not already done so.

§ 401.45 Verifying your identity.

(a) *When required.* Unless you are making a request for notification of or access to a record in person, and you are personally known to the SSA representative, you must verify your identity in accordance with paragraph (b) of this section if:

(1) You make a request for notification of a record and we determine that the mere notice of the existence of the record would be a clearly unwarranted invasion of privacy if disclosed to someone other than the subject individual; or,

(2) You make a request for access to a record which is not required to be disclosed to the general public under the Freedom of Information Act, 5 U.S.C. 552, and part 402 of this chapter.

(b) *Manner of verifying identity*—(1) *Request in person.* If you make a request to us in person, you must provide at least one piece of tangible identification such as a driver's license, passport, alien or voter registration card, or union card to verify your identity. If you do not have identification papers to verify your identity, you must certify in writing that you are the individual who you claim to be and that you understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense.

(2) *Request by telephone.* If you make a request by telephone, you must verify your identity by providing identifying particulars which parallel the record to which notification or access is being sought. If we determine that the particulars provided by telephone are insufficient, you will be required to submit your request in writing or in person. We will not accept telephone requests where an individual is requesting notification of or access to sensitive records such as medical records.

(3) *Electronic requests.* If you make a request by computer or other electronic means, e.g., over the Internet, we require you to verify your identity by using identity confirmation procedures that are commensurate with the sensitivity of the information that you are requesting. If we cannot confirm your identity using our identity confirmation procedures, we will not process the electronic request. When you cannot verify your identity through our procedures, we will require you to submit your request in writing.

(4) *Electronic disclosures.* When we collect or provide personally identifiable information over open networks such as the Internet, we use encryption in all of our automated online transaction systems to protect the confidentiality of the information. When we provide an online access option, such as a standard e-mail comment form on our Web site, and encryption is not being used, we alert you that personally identifiable information (such as your social security number) should not be included in your message.

(5) *Requests not made in person.* Except as provided in paragraphs (b)(2) of this section, if you do not make a request in person, you must submit a written request to SSA to verify your identify or you must certify in your request that you are the individual you claim to be. You must also sign a statement that you understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense.

(6) *Requests on behalf of another.* If you make a request on behalf of a minor or legal incompetent as authorized under § 401.40, you must verify your relationship to the minor or legal incompetent, in addition to verifying your own identity, by providing a copy of the minor's birth certificate, a court order, or other competent evidence of guardianship to SSA; except that you are not required to verify your relationship to the minor or legal incompetent when you are not required to verify your own identity or when evidence of your relationship to the minor or legal incompetent has been previously given to SSA.

(7) *Medical records—additional verification.* You need to further verify your identity if you are requesting notification of or access to sensitive records such as medical records. Any information for further verification must parallel the information in the record to which notification or access is being sought. Such further verification may include such particulars as the date or place of birth, names of parents, name of employer or the specific times the individual received medical treatment.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20939, Apr. 27, 2007]

§ 401.50 Granting notification of or access to a record.

(a) *General.* Subject to the provisions governing medical records in § 401.55 and the provisions governing exempt systems in § 401.85, upon receipt of your request for notification of or access to

a record and verification of your identity, we will review your request and grant notification or access to a record, if you are the subject of the record.

(b) *Our delay in responding.* If we determine that we will have to delay responding to your request because of the number of requests we are processing, a breakdown of equipment, shortage of personnel, storage of records in other locations, etc., we will so inform you and tell you when notification or access will be granted.

§ 401.55 Access to medical records.

(a) *General.* You have a right to access your medical records, including any psychological information that we maintain.

(b) *Medical records procedures*—(1) *Notification of or access to medical records.* (i) You may request notification of or access to a medical record pertaining to you. Unless you are a parent or guardian requesting notification of or access to a minor's medical record, you must make a request for a medical record in accordance with this section and the procedures in §§ 401.45 through 401.50 of this part.

(ii) When you request medical information about yourself, you must also name a representative in writing. The representative may be a physician, other health professional, or other responsible individual who will be willing to review the record and inform you of its contents. Following the discussion, you are entitled to your records. The representative does not have the discretion to withhold any part of your record. If you do not designate a representative, we may decline to release the requested information. In some cases, it may be possible to release medical information directly to you rather than to your representative.

(2) *Utilization of the designated representative.* You will be granted direct access to your medical record if we can determine that direct access is not likely to have an adverse effect on you. If we believe that we are not qualified to determine, or if we do determine, that direct access to you is likely to have an adverse effect, the record will be sent to the designated representative. We will inform you in writing that the record has been sent.

(c) *Medical records of minors*—(1) *Request by the minor.* You may request access to your own medical records in accordance with paragraph (b) of this section.

(2) *Requests on a minor's behalf; notification of or access to medical records to an individual on a minor's behalf.* (i) To protect the privacy of a minor, we will not give to a parent or guardian direct notification of or access to a minor's record, even though the parent or guardian who requests such notification or access is authorized to act on a minor's behalf as provided in § 401.75 of this part.

(ii) A parent or guardian must make all requests for notification of or access to a minor's medical record in accordance with this paragraph and the procedures in §§ 401.45 through 401.50 of this part. A parent or guardian must at the time he or she makes a request designate a family physician or other health professional (other than a family member) to whom the record, if any, will be sent. If the parent or guardian will not designate a representative, we will decline to release the requested information.

(iii) Where a medical record on the minor exists, we will in all cases send it to the physician or health professional designated by the parent or guardian. The representative will review the record, discuss its contents with the parent or legal guardian, then release the entire record to the parent or legal guardian. The representative does not have the discretion to withhold any part of the minor's record. We will respond in the following similar manner to the parent or guardian making the request: ''We have completed processing your request for notification of or access to _____'s (Name of minor) medical records. Please be informed that if any medical record was found pertaining to that individual, it has been sent to your designated physician or health professional.''

(iv) In each case where we send a minor's medical record to a physician or health professional, we will make reasonable efforts to inform the minor that we have given the record to the representative.

(3) *Requests on behalf of an incapacitated adult.* If you are the legal guardian of an adult who has been declared legally incompetent, you may receive his or her records directly.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20939, Apr. 27, 2007]

§ 401.60 Access to or notification of program records about more than one individual.

When information about more than one individual is in one record filed under your social security number, you may receive the information about you and the fact of entitlement and the amount of benefits payable to other persons based on your record. You may receive information about yourself or others, which is filed under someone else's social security number, if that information affects your entitlement to social security benefits or the amount of those benefits.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20940, Apr. 27, 2007]

§ 401.65 How to correct your record.

(a) *How to request a correction.* This section applies to all records kept by SSA (as described in § 401.5) except for records of earnings. (20 CFR 422.125 describes how to request correction of your earnings record.) You may request that your record be corrected or amended if you believe that the record is not accurate, timely, complete, relevant, or necessary to the administration of a social security program. To amend or correct your record, you should write to the manager identified in the notice of systems of records which is published in the FEDERAL REGISTER (see § 401.40(c) on how to locate this information). The staff at any social security office can help you prepare the request. You should submit any available evidence to support your request. Your request should indicate—

(1) The system of records from which the record is retrieved;

(2) The particular record which you want to correct or amend;

(3) Whether you want to add, delete or substitute information in the record; and

(4) Your reasons for believing that your record should be corrected or amended.

(b) *What we will not change.* You cannot use the correction process to alter, delete, or amend information which is part of a determination of fact or which is evidence received in the record of a claim in the administrative appeal process. Disagreements with these determinations are to be resolved through the SSA appeal process. (See subparts I and J of part 404, and subpart N of part 416, of this chapter.) For example, you cannot use the correction process to alter or delete a document showing a birth date used in deciding your social security claim. However, you may submit a statement on why you think certain information should be altered, deleted, or amended, and we will make this statement part of your file.

(c) *Acknowledgment of correction request.* We will acknowledge receipt of a correction request within 10 working days, unless we can review and process the request and give an initial determination of denial or compliance before that time.

(d) *Notice of error.* If the record is wrong, we will correct it promptly. If wrong information was disclosed from the record, we will tell all those of whom we are aware received that information that it was wrong and will give them the correct information. This will not be necessary if the change is not due to an error, e.g., a change of name or address.

(e) *Record found to be correct.* If the record is correct, we will inform you in writing of the reason why we refuse to amend your record and we will also inform you of your right to seek a review of the refusal and the name and address of the official to whom you should send your request for review.

(f) *Record of another government agency.* If you request us to correct or amend a record governed by the regulation of another government agency, e.g., Office of Personnel Management, Federal Bureau of Investigation, we will forward your request to such government agency for processing and we will inform you in writing of the referral.

§ 401.70 Appeals of refusals to correct records or refusals to allow access to records.

(a) *General.* This section describes how to appeal decisions we make under the Privacy Act concerning your request for correction of or access to your records, those of your minor child, or those of a person for whom you are the legal guardian. This section describes how to appeal decisions made by SSA under the Privacy Act concerning your request for correction of or access to your records, those of your minor child, or those of a person for whom you are the legal guardian. We generally handle a denial of your request for information about another person under the provisions of the Freedom of Information Act (see part 402 of this chapter). To appeal a decision under this section, your request must be in writing.

(b) *Appeal of refusal to correct or amend records.* If we deny your request to correct an SSA record, you may request a review of that decision. As discussed in §401.65(e), our letter denying your request will tell you to whom to write.

(1) We will review your request within 30 working days from the date of the receipt. However, for a good reason and with the approval of the Executive Director for the Office of Privacy and Disclosure, we may extend this time limit up to an additional 30 days. In that case, we will notify you about the delay, the reason for it and the date when the review is expected to be completed.

(2) If, after review, we determine that the record should be corrected, we will do so. However, if we refuse to amend the record as you requested, we will inform you that—

(i) Your request has been refused and the reason for the refusal;

(ii) The refusal is our final decision; and

(iii) You have a right to seek court review of our final decision.

(3) We will also inform you that you have a right to file a statement of disagreement with the decision. Your statement should include the reason you disagree. We will make your statement available to anyone to whom the record is subsequently disclosed, together with a statement of our reasons for refusing to amend the record. Also, we will provide a copy of your statement to individuals whom we are aware received the record previously.

(c) *Appeals after denial of access.* If, under the Privacy Act, we deny your request for access to your own record, those of your minor child or those of a person to whom you are the legal guardian, we will advise you in writing of the reason for that denial, the name and title or position of the person responsible for the decision and your right to appeal that decision. You may appeal the denial decision to the Office of the General Counsel, Office of Privacy and Disclosure, Social Security Administration, Attn: Executive Director, 6401 Security Boulevard, Baltimore, MD 21235, within 30 days after you receive notice denying all or part of your request, or, if later, within 30 days after you receive materials sent to you in partial compliance with your request.

(d) *Filing your appeal.* If you file an appeal, the Executive Director or his or her designee will review your request and any supporting information submitted and then send you a notice explaining the decision on your appeal. The time limit for making our decision after we receive your appeal is 30 working days. The Executive Director or his or her designee may extend this time limit up to 30 additional working days if one of the circumstances in 20 CFR 402.140 is met. We will notify you in writing of any extension, the reason for the extension and the date by which we will decide your appeal. The notice of the decision on your appeal will explain your right to have the matter reviewed in a Federal district court if you disagree with all or part of our decision.

[72 FR 20940, Apr. 27, 2007, as amended at 88 FR 1329, Jan. 10, 2023]

§ 401.75 Rights of parents or legal guardians.

For purposes of this part, a parent or guardian of any minor or the legal guardian of any individual who has been declared incompetent due to physical or mental incapacity or age by a court of competent jurisdiction is authorized to act on behalf of a minor or

incompetent individual. Except as provided in § 401.45, governing procedures for verifying an individual's identity, and § 401.55(c) governing special procedures for notification of or access to a minor's medical records, if you are authorized to act on behalf of a minor or legal incompetent, you will be viewed as if you were the individual or subject individual.

§ 401.80 Accounting for disclosures.

(a) We will maintain an accounting of all disclosures of a record for five years or for the life of the record, whichever is longer; *except that*, we will not make accounting for:

(1) Disclosures under paragraphs (a) and (b) of § 401.110; and,

(2) Disclosures of your record made with your written consent.

(b) The accounting will include:

(1) The date, nature, and purpose of each disclosure; and

(2) The name and address of the person or entity to whom the disclosure is made.

(c) You may request access to an accounting of disclosures of your record. You must request access to an accounting in accordance with the procedures in § 401.40. You will be granted access to an accounting of the disclosures of your record in accordance with the procedures of this part which govern access to the related record. We may, at our discretion, grant access to an accounting of a disclosure of a record made under paragraph (g) of § 401.110.

§ 401.85 Exempt systems.

(a) *General policy*. The Privacy Act permits certain types of specific systems of records to be exempt from some of its requirements. Our policy is to exercise authority to exempt systems of records only in compelling cases.

(b) *Specific systems of records exempted*. (1) Those systems of records listed in paragraph (b)(2) of this section are exempt from the following provisions of the Act and this part:

(i) 5 U.S.C. 552a(c)(3) and paragraph (c) of § 401.80 of this part which require that you be granted access to an accounting of disclosures of your record.

(ii) 5 U.S.C. 552a (d) (1) through (4) and (f) and §§ 401.35 through 401.75 relating to notification of or access to records and correction or amendment of records.

(iii) 5 U.S.C. 552a(e)(4) (G) and (H) which require that we include information about SSA procedures for notification, access, and correction or amendment of records in the notice for the systems of records.

(iv) 5 U.S.C. 552a(e)(3) and § 401.30 which require that if we ask you to provide a record to us, we must inform you of the authority for our asking you to provide the record (including whether providing the record is mandatory or voluntary, the principal purposes for maintaining the record, the routine uses for the record, and what effect your refusal to provide the record may have on you), and if you are not required by statute or Executive Order to provide the record, that you agree to provide the record. This exemption applies only to an investigatory record compiled by SSA for criminal law enforcement purposes in a system of records exempt under subsection (j)(2) of the Privacy Act to the extent that these requirements would prejudice the conduct of the investigation.

(2) The following systems of records are exempt from those provisions of the Privacy Act and this part listed in paragraph (b)(1) of this section:

(i) Pursuant to subsection (j)(2) of the Privacy Act, the Investigatory Material Compiled for Law Enforcement Purposes System, SSA.

(ii) Pursuant to subsection (k)(2) of the Privacy Act:

(A) The General Criminal Investigation Files, SSA;

(B) The Criminal Investigations File, SSA; and,

(C) The Program Integrity Case Files, SSA.

(D) Civil and Administrative Investigative Files of the Inspector General, SSA/OIG.

(E) Complaint Files and Log. SSA/OGC.

(F) Anti-Harassment & Hostile Work Environment Case Tracking and Records System, SSA.

(G) Social Security Administration Violence Evaluation and Reporting System, SSA.

(H) Anti-Fraud System, SSA.

(iii) Pursuant to subsection (k)(5) of the Privacy Act:

(A) Security and Suitability Files.

(B) [Reserved]

(iv) Pursuant to subsection (k)(6) of the Privacy Act, the Personnel Research and Merit Promotion Test Records, SSA/DCHR/OPE.

(c) *Notification of or access to records in exempt systems of records.* (1) Where a system of records is exempt as provided in paragraph (b) of this section, you may nonetheless request notification of or access to a record in that system. You should make requests for notification of or access to a record in an exempt system of records in accordance with the procedures of §§ 401.35 through 401.55.

(2) We will grant you notification of or access to a record in an exempt system but only to the extent such notification or access would not reveal the identity of a source who furnished the record to us under an express promise, and prior to September 27, 1975, an implied promise, that his or her identity would be held in confidence, if:

(i) The record is in a system of records which is exempt under subsection (k)(2) of the Privacy Act and you have been, as a result of the maintenance of the record, denied a right, privilege, or benefit to which you would otherwise be eligible; or,

(ii) The record is in a system of records which is exempt under subsection (k)(5) of the Privacy Act.

(3) If we do not grant you notification of or access to a record in a system of records exempt under subsections (k) (2) and (5) of the Privacy Act in accordance with this paragraph, we will inform you that the identity of a confidential source would be revealed if we granted you notification of or access to the record.

(d) *Discretionary actions by SSA.* Unless disclosure of a record to the general public is otherwise prohibited by law, we may at our discretion grant notification of or access to a record in a system of records which is exempt under paragraph (b) of this section. Discretionary notification of or access to a record in accordance with this paragraph will not be a precedent for discretionary notification of or access to a similar or related record and will not obligate us to exercise discretion to grant notification of or access to any other record in a system of records which is exempt under paragraph (b) of this section.

[62 FR 4143, Jan. 29, 1997, as amended at 82 FR 16510, Apr. 5, 2017; 83 FR 63416, Dec. 10, 2018; 84 FR 45901, Sept. 3, 2019; 87 FR 25141, Apr. 28, 2022]

§ 401.90 Contractors.

(a) All contracts which require a contractor to maintain, or on behalf of SSA to maintain, a system of records to accomplish an SSA function must contain a provision requiring the contractor to comply with the Privacy Act and this part.

(b) A contractor and any employee of such contractor will be considered employees of SSA only for the purposes of the criminal penalties of the Privacy Act, 5 U.S.C. 552a(i), and the employee standards of conduct (see appendix A of this part) where the contract contains a provision requiring the contractor to comply with the Privacy Act and this part.

(c) This section does not apply to systems of records maintained by a contractor as a result of his management discretion, e.g., the contractor's personnel records.

§ 401.95 Fees.

(a) *Policy.* Where applicable, we will charge fees for copying records in accordance with the schedule set forth in this section. We may only charge fees where you request that a copy be made of the record to which you are granted access. We will not charge a fee for searching a system of records, whether the search is manual, mechanical, or electronic. Where we must copy the record in order to provide access to the record (e.g., computer printout where no screen reading is available), we will provide the copy to you without cost. Where we make a medical record available to a representative designated by you or to a physician or health professional designated by a parent or guardian under § 401.55 of this part, we will not charge a fee.

(b) *Fee schedule.* Our Privacy Act fee schedule is as follows:

(1) Copying of records susceptible to photocopying—$.10 per page.

(2) Copying records not susceptible to photocopying (e.g., punch cards or magnetic tapes)—at actual cost to be determined on a case-by-case basis.

(3) We will not charge if the total amount of copying does not exceed $25.

(c) *Other fees.* We also follow §§ 402.155 through 402.165 of this chapter to determine the amount of fees, if any, we will charge for providing information under the FOIA and Privacy Act.

Subpart C—Disclosure of Official Records and Information

§ 401.100 Disclosure of records with the written consent of the subject of the record.

(a) *General.* Except as permitted by the Privacy Act and the regulations in this part, or when required by the FOIA, we will not disclose your records without your written consent.

(b) *Disclosure with written consent.* The written consent must clearly specify to whom the information may be disclosed, the information you want us to disclose (e.g., social security number, date and place of birth, monthly Social Security benefit amount, date of entitlement), and, where applicable, during which timeframe the information may be disclosed (e.g., during the school year, while the subject individual is out of the country, whenever the subject individual is receiving specific services).

(c) *Disclosure of the entire record.* We will not disclose your entire record. For example, we will not honor a blanket consent for all information in a system of records or any other record consisting of a variety of data elements. We will disclose only the information you specify in the consent. We will verify your identity and where applicable (e.g., where you consent to disclosure of a record to a specific individual), the identity of the individual to whom the record is to be disclosed.

(d) A parent or guardian of a minor is not authorized to give written consent to a disclosure of a minor's medical record. See § 401.55(c)(2) for the procedures for disclosure of or access to medical records of minors.

[72 FR 20940, Apr. 27, 2007]

§ 401.105 Disclosure of personal information without the consent of the subject of the record.

(a) SSA maintains two categories of records which contain personal information:

(1) Nonprogram records, primarily administrative and personnel records which contain information about SSA's activities as a government agency and employer, and

(2) Program records which contain information about SSA's clients that it keeps to administer benefit programs under Federal law.

(b) We apply different levels of confidentiality to disclosures of information in the categories in paragraphs (a)(1) and (2) of this section. For administrative and personnel records, the Privacy Act applies. To the extent that SSA has physical custody of personnel records maintained as part of the Office of Personnel Management's (OPM) Privacy Act government-wide systems of records, these records are subject to OPM's rules on access and disclosure at 5 CFR parts 293 and 297. For program records, we apply somewhat more strict confidentiality standards than those found in the Privacy Act. The reason for this difference in treatment is that our program records include information about a much greater number of persons than our administrative records, the information we must collect for program purposes is often very sensitive, and claimants are required by statute and regulation to provide us with the information in order to establish entitlement for benefits.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20940, Apr. 27, 2007]

§ 401.110 Disclosure of personal information in nonprogram records without the consent of the subject of the record.

The disclosures listed in this section may be made from our nonprogram records, e.g., administrative and personnel records, without your consent. Such disclosures are those:

(a) To officers and employees of SSA who have a need for the record in the performance of their duties. The SSA official who is responsible for the record may upon request of any officer or employee, or on his own initiative,

determine what constitutes legitimate need.

(b) Required to be disclosed under the Freedom of Information Act, 5 U.S.C. 552, and 20 CFR part 402.

(c) For a routine use as defined in § 401.25 of this part. Routine uses will be listed in any notice of a system of records. SSA publishes notices of systems of records, including all pertinent routine uses, in the FEDERAL REGISTER.

(d) To the Bureau of the Census for purposes of planning or carrying out a census or survey or related activity pursuant to the provisions of Title 13 U.S.C.

(e) To a recipient who has provided us with advance written assurance that the record will be used solely as a statistical research or reporting record; *Provided,* that, the record is transferred in a form that does not identify the subject individual.

(f) To the National Archives of the United States as a record which has sufficient historical or other value to warrant its continued preservation by the United States Government, or for evaluation by the Administrator of General Services or his designee to determine whether the record has such value.

(g) To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of such government agency or instrumentality has submitted a written request to us, specifying the record desired and the law enforcement activity for which the record is sought.

(h) To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last known address of the subject individual.

(i) To either House of Congress, or to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee.

(j) To the Comptroller General, or any of his authorized representatives, in the course of the performance of duties of the Government Accountability Office.

(k) Pursuant to the order of a court of competent jurisdiction.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20940, Apr. 27, 2007]

§ 401.115 Disclosure of personal information in program records without the consent of the subject of the record.

This section describes how various laws control the disclosure of personal information that we keep. We disclose information in the program records only when a legitimate need exists. For example, we disclose information to officers and employees of SSA who have a need for the record in the performance of their duties. We also must consider the laws identified below in the respective order when we disclose program information:

(a) Some laws require us to disclose information (§ 401.120); some laws require us to withhold information (§ 401.125). These laws control whenever they apply.

(b) If no law of this type applies in a given case, then we must look to FOIA principles. See § 401.130.

(c) When FOIA principles do not require disclosure, we may disclose information if both the Privacy Act and section 1106 of the Social Security Act permit the disclosure.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20940, Apr. 27, 2007]

§ 401.120 Disclosures required by law.

We disclose information when a law specifically requires it. The Social Security Act requires us to disclose information for certain program purposes. These include disclosures to the SSA Office of Inspector General, the Federal Parent Locator Service, and to States pursuant to an arrangement regarding use of the Blood Donor Locator Service. Also, there are other laws which require that we furnish other agencies information which they need for their programs. These agencies include the Department of Veterans Affairs for its benefit programs, U.S. Citizenship and Immigration Services to carry out its duties regarding aliens, the Railroad Retirement Board for its benefit programs, and to Federal, State and local

agencies administering Temporary Assistance for Needy Families, Medicaid, unemployment compensation, food stamps, and other programs.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20941, Apr. 27, 2007]

§ 401.125 Disclosures prohibited by law.

We do not disclose information when a law specifically prohibits it. The Internal Revenue Code generally prohibits us from disclosing tax return information which we receive to maintain individual earnings records. This includes, for example, amounts of wages and contributions from employers. Other laws restrict our disclosure of certain information about drug and alcohol abuse which we collect to determine eligibility for social security benefits.

§ 401.130 Freedom of Information Act.

The FOIA requires us to disclose any information in our records upon request from the public, unless one of several exemptions in the FOIA applies. When the FOIA requires disclosure (see part 402 of this chapter), the Privacy Act permits it. *The public* does not include Federal agencies, courts, or the Congress, but does include State agencies, individuals, corporations, and most other parties. The FOIA does not apply to requests that are not from *the public* (e.g., from a Federal agency). However, we apply FOIA principles to requests from these other sources for disclosure of program information.

§ 401.135 Other laws.

When the FOIA does not apply, we may not disclose any personal information unless both the Privacy Act and section 1106 of the Social Security Act permit the disclosure. Section 1106 of the Social Security Act requires that disclosures which may be made must be set out in statute or regulations; therefore, any disclosure permitted by this part is permitted by section 1106.

§ 401.140 General principles.

When no law specifically requiring or prohibiting disclosure applies to a question of whether to disclose information, we follow FOIA principles to resolve that question. We do this to insure uniform treatment in all situations. The FOIA principle which most often applies to SSA disclosure questions is whether the disclosure would result in a ''clearly unwarranted invasion of personal privacy.'' To decide whether a disclosure would be a clearly unwarranted invasion of personal privacy we consider—

(a) The sensitivity of the information (e.g., whether individuals would suffer harm or embarrassment as a result of the disclosure);

(b) The public interest in the disclosure;

(c) The rights and expectations of individuals to have their personal information kept confidential;

(d) The public's interest in maintaining general standards of confidentiality of personal information; and

(e) The existence of safeguards against unauthorized redisclosure or use.

§ 401.145 Safeguards against unauthorized redisclosure or use.

(a) The FOIA does not authorize us to impose any restrictions on how information is used after we disclose it under that law. In applying FOIA principles, we consider whether the information will be adequately safeguarded against improper use or redisclosure. We must consider all the ways in which the recipient might use the information and how likely the recipient is to redisclose the information to other parties. Thus, before we disclose personal information we may consider such factors as—

(1) Whether only those individuals who have a need to know the information will obtain it;

(2) Whether appropriate measures to safeguard the information to avoid unwarranted use or misuse will be taken; and

(3) Whether we would be permitted to conduct on-site inspections to see whether the safeguards are being met.

(b) We feel that there is a strong public interest in sharing information with other agencies with programs having the same or similar purposes, so we generally share information with those

agencies. However, since there is usually little or no public interest in disclosing information for disputes between two private parties or for other private or commercial purposes, we generally do not share information for these purposes.

§ 401.150 Compatible purposes.

(a) *General.* The Privacy Act allows us to disclose information maintained in a system of records without your consent to any other party if such disclosure is pursuant to a routine use published in the system's notice of system of records. A ''Routine use'' must be compatible with the purpose for which SSA collected the information.

(b) *Notice of routine use disclosures.* A list of permissible routine use disclosures is included in every system of records notice published in the FEDERAL REGISTER.

(c) *Determining compatibility*—(1) *Disclosure to carry out SSA programs.* We disclose information for published routine uses necessary to carry out SSA's programs.

(2) *Disclosure to carry out programs similar to SSA programs.* We may disclose information for the administration of other government programs. These disclosures are pursuant to published routine uses where the use is compatible with the purpose for which the information was collected. These programs generally meet the following conditions:

(i) The program is clearly identifiable as a Federal, State, or local government program.

(ii) The information requested concerns eligibility, benefit amounts, or other matters of benefit status in a Social Security program and is relevant to determining the same matters in the other program. For example, we disclose information to the Railroad Retirement Board for pension and unemployment compensation programs, to the Department of Veterans Affairs for its benefit programs, to worker's compensation programs, to State general assistance programs and to other income maintenance programs at all levels of government. We also disclose for health maintenance programs like Medicaid and Medicare.

(iii) The information will be used for appropriate epidemiological or similar research purposes.

[72 FR 20941, Apr. 27, 2007]

§ 401.155 Law enforcement purposes.

(a) *General.* The Privacy Act allows us to disclose information for law enforcement purposes under certain conditions. Much of the information in our files is especially sensitive or very personal. Furthermore, participation in social security programs is mandatory, so people cannot limit what information is given to us. Therefore, we generally disclose information for law enforcement purposes only in limited situations. The Privacy Act allows us to disclose information if the head of the law enforcement agency makes a written request giving enough information to show that the conditions in paragraphs (b) or (c) of this section are met, what information is needed, and why it is needed. Paragraphs (b) and (c) of this section discuss the disclosures we generally make for these purposes.

(b) *Serious crimes.* SSA may disclose information for criminal law enforcement purposes where a violent crime such as murder or kidnapping has been committed and the individual about whom the information is being sought has been indicted or convicted of that crime.

(c) *Criminal activity involving the social security program or another program with the same purposes.* We disclose information when necessary to investigate or prosecute fraud or other criminal activity involving the social security program. We may also disclose information for investigation or prosecution of criminal activity in other income-maintenance or health-maintenance programs (e.g., other governmental pension programs, unemployment compensation, general assistance, Medicare or Medicaid) if the information concerns eligibility, benefit amounts, or other matters of benefit status in a social security program and is relevant to determining the same matters in the other program.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20941, Apr. 27, 2007]

§ 401.160 Health or safety.

The Privacy Act allows us to disclose information in compelling circumstances where an individual's health or safety is affected. For example, if we learn that someone has been exposed to an excessive amount of radiation, we may notify that person and appropriate health officials. If we learn that someone has made a threat against someone else, we may notify that other person and law enforcement officials. When we make these disclosures, the Privacy Act requires us to send a notice of the disclosure to the last known address of the person whose record was disclosed.

§ 401.165 Statistical and research activities.

(a) *General.* Statistical and research activities often do not require information in a format that identifies specific individuals. Therefore, whenever possible, we release information for statistical or research purposes only in the form of aggregates or individual data that cannot be associated with a particular individual. The Privacy Act allows us to release records if there are safeguards that the record will be used solely as a statistical or research record and the individual cannot be identified from any information in the record.

(b) *Safeguards for disclosure with identifiers.* The Privacy Act also allows us to disclose data for statistical and research purposes in a form allowing individual identification, pursuant to published routine use, when the purpose is compatible with the purpose for which the record was collected. We will disclose personally identifiable information for statistical and research purposes if—

(1) We determine that the requestor needs the information in an identifiable form for a statistical or research activity, will use the information only for that purpose, and will protect individuals from unreasonable and unwanted contacts;

(2) The activity is designed to increase knowledge about present or alternative Social Security programs or other Federal or State income-maintenance or health-maintenance programs; or is used for research that is of importance to the Social Security program or the Social Security beneficiaries; or an epidemiological research project that relates to the Social Security program or beneficiaries; and

(3) The recipient will keep the information as a system of statistical records, will follow appropriate safeguards, and agrees to our on-site inspection of those safeguards so we can be sure the information is used or redisclosed only for statistical or research purposes. No redisclosure of the information may be made without SSA's approval.

(c) *Statistical record.* A statistical record is a record in a system of records which is maintained only for statistical and research purposes, and which is not used to make any determination about an individual. We maintain and use statistical records only for statistical and research purposes. We may disclose a statistical record if the conditions in paragraph (b) of this section are met.

(d) *Compiling of records.* Where a request for information for statistical and research purposes would require us to compile records, and doing that would be administratively burdensome to ongoing SSA operations, we may decline to furnish the information.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 20941, Apr. 27, 2007]

§ 401.170 Congress.

(a) We disclose information to either House of Congress. We also disclose information to any committee or subcommittee of either House, or to any joint committee of Congress or subcommittee of that committee, if the information is on a matter within the committee's or subcommittee's jurisdiction.

(b) We disclose to any member of Congress the information needed to respond to constituents' requests for information about themselves (including requests from parents of minors, or legal guardians). However, these disclosures are subject to the restrictions in §§ 401.35 through 401.60.

§ 401.175 Government Accountability Office.

We disclose information to the Government Accountability Office when that agency needs the information to carry out its duties.

[72 FR 20941, Apr. 27, 2007]

§ 401.180 Disclosure under court order or other legal process.

(a) *General.* The Privacy Act permits us to disclose information when we are ordered to do so by a court of competent jurisdiction. When information is used in a court proceeding, it usually becomes part of the public record of the proceeding and its confidentiality often cannot be protected in that record. Much of the information that we collect and maintain in our records on individuals is especially sensitive. Therefore, we follow the rules in paragraph (d) of this section in deciding whether we may disclose information in response to an order from a court of competent jurisdiction. When we disclose pursuant to an order from a court of competent jurisdiction, and the order is a matter of public record, the Privacy Act requires us to send a notice of the disclosure to the last known address of the person whose record was disclosed.

(b) *Court.* For purposes of this section, a court is an institution of the judicial branch of the U.S. Federal government consisting of one or more judges who seek to adjudicate disputes and administer justice. (See 404.2(c)(6) of this chapter). Entities not in the judicial branch of the Federal government are not courts for purposes of this section.

(c) *Court order.* For purposes of this section, a court order is any legal process which satisfies all of the following conditions:

(1) It is issued under the authority of a Federal court;

(2) A judge or a magistrate judge of that court signs it;

(3) It commands SSA to disclose information; and

(4) The court is a court of competent jurisdiction.

(d) *Court of competent jurisdiction.* It is the view of SSA that under the Privacy Act the Federal Government has not waived sovereign immunity, which precludes state court jurisdiction over a Federal agency or official. Therefore, SSA will not honor state court orders as a basis for disclosure. State court orders will be treated in accordance with the other provisions of this part.

(e) *Conditions for disclosure under a court order of competent jurisdiction.* We disclose information in compliance with an order of a court of competent jurisdiction if—

(1) another section of this part specifically allows such disclosure, or

(2) SSA, the Commissioner of Social Security, or any officer or employee of SSA in his or her official capacity is properly a party in the proceeding, or

(3) disclosure of the information is necessary to ensure that an individual who is accused of criminal activity receives due process of law in a criminal proceeding under the jurisdiction of the judicial branch of the Federal government.

(f) *In other circumstances.* We may disclose information to a court of competent jurisdiction in circumstances other than those stated in paragraph (e) of this section. We will make our decision regarding disclosure by balancing the needs of a court while preserving the confidentiality of information. For example, we may disclose information under a court order that restricts the use and redisclosure of the information by the participants in the proceeding; we may offer the information for inspection by the court *in camera* and under seal; or we may arrange for the court to exclude information identifying individuals from that portion of the record of the proceedings that is available to the public. We will make these determinations in accordance with § 401.140.

(g) *Other regulations on request for testimony, subpoenas and production of records in legal proceedings.* See 20 CFR part 403 of this chapter for additional rules covering disclosure of information and records governed by this part and requested in connection with legal proceedings.

[72 FR 20941, Apr. 27, 2007]

§ 401.185 Other specific recipients.

In addition to disclosures we make under the routine use provision, we also release information to—

(a) The Bureau of the Census for purposes of planning or carrying out a census, survey, or related activity; and

(b) The National Archives of the United States if the record has sufficient historical or other value to warrant its continued preservation by the United States Government. We also disclose a record to the Administrator of General Services for a determination of whether the record has such a value.

§ 401.190 Deceased persons.

We do not consider the disclosure of information about a deceased person to be a clearly unwarranted invasion of that person's privacy. However, in disclosing information about a deceased person, we follow the principles in § 401.115 to insure that the privacy rights of a living person are not violated.

§ 401.195 Situations not specified in this part.

If no other provision in this part specifically allows SSA to disclose information, the Commissioner or designee may disclose this information if not prohibited by Federal law. For example, the Commissioner or designee may disclose information necessary to respond to life threatening situations.

§ 401.200 Blood donor locator service.

(a) *General.* We will enter into arrangements with State agencies under which we will furnish to them at their request the last known personal mailing addresses (residence or post office box) of blood donors whose blood donations show that they are or may be infected with the human immunodeficiency virus which causes acquired immune deficiency syndrome. The State agency or other authorized person, as defined in paragraph (b) of this section, will then inform the donors that they may need medical care and treatment. The safeguards that must be used by authorized persons as a condition to receiving address information from the Blood Donor Locator Service are in paragraph (g) of this section, and the requirements for a request for address information are in paragraph (d) of this section.

(b) *Definitions. State* means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of Northern Marianas, and the Trust Territory of the Pacific Islands.

Authorized person means—

(1) Any agency of a State (or of a political subdivision of a State) which has duties or authority under State law relating to the public health or otherwise has the duty or authority under State law to regulate blood donations; and

(2) Any entity engaged in the acceptance of blood donations which is licensed or registered by the Food and Drug Administration in connection with the acceptance of such blood donations, and which provides for—

(i) The confidentiality of any address information received pursuant to the rules in this part and section 1141 of the Social Security Act and related blood donor records;

(ii) Blood donor notification procedures for individuals with respect to whom such information is requested and a finding has been made that they are or may be infected with the human immunodeficiency virus; and

(iii) Counseling services for such individuals who have been found to have such virus. New counseling programs are not required, and an entity may use existing counseling programs or referrals to provide these services.

Related blood donor records means any record, list, or compilation established in connection with a request for address information which indicates, directly or indirectly, the identity of any individual with respect to whom a request for address information has been made pursuant to the rules in this part.

(c) *Use of social security number for identification.* A State or an authorized person in the State may require a blood donor to furnish his or her social security number when donating blood. The number may then be used by an authorized person to identify and locate a donor whose blood donation indicates that he or she is or may be infected with the human immunodeficiency virus.

(d) *Request for address of blood donor.* An authorized person who has been unable to locate a blood donor at the address he or she may have given at the time of the blood donation may request assistance from the State agency which has arranged with us to participate in the Blood Donor Locator Service. The request to the Blood Donor Locator Service must—

(1) Be in writing;

(2) Be from a participating State agency either on its own behalf as an authorized person or on behalf of another authorized person;

(3) Indicate that the authorized person meets the confidentiality safeguards of paragraph (g) of this section; and

(4) Include the donor's name and social security number, the addresses at which the authorized person attempted without success to contact the donor, the date of the blood donation if available, a statement that the donor has tested positive for the human immunodeficiency virus according to the latest Food and Drug Administration standards or that the history of the subsequent use of the donated blood or blood products indicates that the donor has or may have the human immunodeficiency virus, and the name and address of the requesting blood donation facility.

(e) *SSA response to request for address.* After receiving a request that meets the requirements of paragraph (d) of this section, we will search our records for the donor's latest personal mailing address. If we do not find a current address, we will request that the Internal Revenue Service search its tax records and furnish us any personal mailing address information from its files, as required under section 6103(m)(6) of the Internal Revenue Code. After completing these searches, we will provide to the requesting State agency either the latest mailing address available for the donor or a response stating that we do not have this information. We will then destroy the records or delete all identifying donor information related to the request and maintain only the information that we will need to monitor the compliance of authorized persons with the confidentiality safeguards contained in paragraph (g) of this section.

(f) *SSA refusal to furnish address.* If we determine that an authorized person has not met the requirements of paragraphs (d) and (g) of this section, we will not furnish address information to the State agency. In that case, we will notify the State agency of our determination, explain the reasons for our determination, and explain that the State agency may request administrative review of our determination. The Commissioner of Social Security or a delegate of the Commissioner will conduct this review. The review will be based on the information of record and there will not be an opportunity for an oral hearing. A request for administrative review, which may be submitted only by a State agency, must be in writing. The State agency must send its request for administrative review to the Commissioner of Social Security, 6401 Security Boulevard, Baltimore, MD 21235, within 60 days after receiving our notice refusing to give the donor's address. The request for review must include supporting information or evidence that the requirements of the rules in this part have been met. If we do not furnish address information because an authorized person failed to comply with the confidentiality safeguards of paragraph (g) of this section, the State agency will have an opportunity to submit evidence that the authorized person is now in compliance. If we then determine, based on our review of the request for administrative review and the supporting evidence, that the authorized person meets the requirements of the rules in this part, we will respond to the address request as provided in paragraph (e) of this section. If we determine on administrative review that the requirements have not been met, we will notify the State agency in writing of our decision. We will make our determination within 30 days after receiving the request for administrative review, unless we notify the State agency within this 30-day time period that we will need additional time. Our determination on the request for administrative review will give the findings of fact, the reasons for the decision, and what actions the State agency should take to ensure

that it or the blood donation facility is in compliance with the rules in this part.

(g) *Safeguards to ensure confidentiality of blood donor records.* We will require assurance that authorized persons have established and continue to maintain adequate safeguards to protect the confidentiality of both address information received from the Blood Donor Locator Service and related blood donor records. The authorized person must, to the satisfaction of the Secretary—

(1) Establish and maintain a system for standardizing records which includes the reasons for requesting the addresses of blood donors, dates of the requests, and any disclosures of address information;

(2) Store blood donors' addresses received from the Blood Donor Locator Service and all related blood donor records in a secure area or place that is physically safe from access by persons other than those whose duties and responsibilities require access;

(3) Restrict access to these records to authorized employees and officials who need them to perform their official duties related to notifying blood donors who are or may be infected with the human immunodeficiency virus that they may need medical care and treatment;

(4) Advise all personnel who will have access to the records of the confidential nature of the information, the safeguards required to protect the information, and the civil and criminal sanctions for unauthorized use or disclosure of the information;

(5) Destroy the address information received from the Blood Donor Locator Service, as well as any records established in connection with the request which indicate directly or indirectly the identity of the individual, after notifying or attempting to notify the donor at the address obtained from the Blood Donor Locator Service; and

(6) Upon request, report to us the procedures established and utilized to ensure the confidentiality of address information and related blood donor records. We reserve the right to make onsite inspections to ensure that these procedures are adequate and are being followed and to request such information as we may need to ensure that the safeguards required in this section are being met.

(h) *Unauthorized disclosure.* Any official or employee of the Federal Government, a State, or a blood donation facility who discloses blood donor information, except as provided for in this section or under a provision of law, will be subject to the same criminal penalty as provided in section 7213(a) of the Internal Revenue Code of 1986 for the unauthorized disclosure of tax information.

APPENDIX A TO PART 401—EMPLOYEE STANDARDS OF CONDUCT

(a) *General.* All SSA employees are required to be aware of their responsibilities under the Privacy Act of 1974, 5 U.S.C. 552a. Regulations implementing the Privacy Act are set forth in this part. Instruction on the requirements of the Act and regulation shall be provided to all new employees of SSA. In addition, supervisors shall be responsible for assuring that employees who are working with systems of records or who undertake new duties which require the use of systems of records are informed of their responsibilities. Supervisors shall also be responsible for assuring that all employees who work with such systems of records are periodically reminded of the requirements of the Privacy Act and are advised of any new provisions or interpretations of the Act.

(b) *Penalties.* (1) All employees must guard against improper disclosure of records which are governed by the Privacy Act. Because of the serious consequences of improper invasions of personal privacy, employees may be subject to disciplinary action and criminal prosecution for knowing and willful violations of the Privacy Act and regulation. In addition, employees may also be subject to disciplinary action for unknowing or unwillful violations, where the employee had notice of the provisions of the Privacy Act and regulations and failed to inform himself or herself sufficiently or to conduct himself or herself in accordance with the requirements to avoid violations.

(2) SSA may be subjected to civil liability for the following actions undertaken by its employees:

(a) Making a determination under the Privacy Act and §§ 401.65 and 401.70 not to amend an individual's record in accordance with his or her request, or failing to make such review in conformity with those provisions;

(b) Refusing to comply with an individual's request for notification of or access to a record pertaining to him or her;

(c) Failing to maintain any record pertaining to any individual with such accuracy, relevance, timeliness, and completeness as is necessary to assure fairness in any determination relating to the qualifications, character, rights, or opportunities of, or benefits to the individual that may be made on the basis of such a record, and consequently makes a determination which is adverse to the individual; or

(d) Failing to comply with any other provision of the Act or any rule promulgated thereunder, in such a way as to have an adverse effect on an individual.

(3) An employee may be personally subject to criminal liability as set forth below and in 5 U.S.C. 552a (i):

(a) *Willful disclosure.* Any officer or employee of SSA, who by virtue of his employment or official position, has possession of, or access to, agency records which contain individually identifiable information the disclosure of which is prohibited by the Privacy Act or by rules or regulations established thereunder, and who, knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and may be fined not more than $5,000.

(b) *Notice requirements.* Any officer or employee of SSA who willfully maintains a system of records without meeting the notice requirements [of the Privacy Act] shall be guilty of a misdemeanor and may be fined not more than $5,000.

(c) *Rules governing employees not working with systems of records.* Employees whose duties do not involve working with systems of records will not generally disclose to any one, without specific authorization from their supervisors, records pertaining to employees or other individuals which by reason of their official duties are available to them. Notwithstanding the above, the following records concerning Federal employees are a matter of public record and no further authorization is necessary for disclosure:

(1) Name and title of individual.

(2) Grade classification or equivalent and annual rate of salary.

(3) Position description.

In addition, employees shall disclose records which are listed in SSA's Freedom of Information Regulation as being available to the public. Requests for other records will be referred to the responsible SSA Freedom of Information Officer. This does not preclude employees from discussing matters which are known to them personally, and without resort to a record, to official investigators of Federal agencies for official purposes such as suitability checks, Equal Employment Opportunity investigations, adverse action proceedings, grievance proceedings, etc.

(d) *Rules governing employees whose duties require use or reference to systems of records.* Employees whose official duties require that they refer to, maintain, service, or otherwise deal with systems of records (hereinafter referred to as ''Systems Employees'') are governed by the general provisions. In addition, extra precautions are required and systems employees are held to higher standards of conduct.

(1) Systems Employees shall:

(a) Be informed with respect to their responsibilities under the Privacy Act;

(b) Be alert to possible misuses of the system and report to their supervisors any potential or actual use of the system which they believe is not in compliance with the Privacy Act and regulation;

(c) Disclose records within SSA only to an employee who has a legitimate need to know the record in the course of his or her official duties;

(d) Maintain records as accurately as practicable.

(e) Consult with a supervisor prior to taking any action where they are in doubt whether such action is in conformance with the Act and regulation.

(2) Systems employees shall not:

(a) Disclose in any form records from a system of records except (1) with the consent or at the request of the subject individual; or (2) where its disclosure is permitted under § 401.110.

(b) Permit unauthorized individuals to be present in controlled areas. Any unauthorized individuals observed in controlled areas shall be reported to a supervisor or to the guard force.

(c) Knowingly or willfully take action which might subject SSA to civil liability.

(d) Make any arrangements for the design, development, or operation of any system of records without making reasonable effort to provide that the system can be maintained in accordance with the Act and regulation.

(e) *Contracting officers.* In addition to any applicable provisions set forth above, those employees whose official duties involve entering into contracts on behalf of SSA shall also be governed by the following provisions:

(1) *Contracts for design, or development of systems and equipment.* The contracting officer shall not enter into any contract for the design or development of a system of records, or for equipment to store, service or maintain a system of records unless the contracting officer has made reasonable effort to ensure that the product to be purchased is capable of being used without violation of the Privacy Act or the regulations in this part. He shall give special attention to provision of physical safeguards.

(2) *Contracts for the operation of systems of records.* The Contracting Officer, in conjunction with other officials whom he feels appropriate, shall review all proposed contracts providing for the operation of systems of records prior to execution of the contracts to

determine whether operation of the system of records is for the purpose of accomplishing a Department function. If it is determined that the operation of the system is to accomplish an SSA function, the contracting officer shall be responsible for including in the contract appropriate provisions to apply the provisions of the Privacy Act and regulation to the system, including prohibitions against improper release by the contractor, his employees, agents, or subcontractors.

(3) *Other service contracts.* Contracting officers entering into general service contracts shall be responsible for determining the appropriateness of including provisions in the contract to prevent potential misuse (inadvertent or otherwise) by employees, agents, or subcontractors of the contractor.

(f) *Rules governing SSA officials responsible for managing systems of records.* In addition to the requirements for Systems Employees, SSA officials responsible for managing systems of records as described in §401.40(c) (system managers) shall:

(1) Respond to all requests for notification of or access, disclosure, or amendment of records in a timely fashion in accordance with the Privacy Act and regulation;

(2) Make any amendment of records accurately and in a timely fashion;

(3) Inform all persons whom the accounting records show have received copies of the record prior to the amendments of the correction; and

(4) Associate any statement of disagreement with the disputed record, and

(a) Transmit a copy of the statement to all persons whom the accounting records show have received a copy of the disputed record, and

(b) Transmit that statement with any future disclosure.

[62 FR 4143, Jan. 29, 1997, as amended at 72 FR 69617, Dec. 10, 2007]

PART 402—AVAILABILITY OF INFORMATION AND RECORDS TO THE PUBLIC

Sec.

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SOURCE: 89 FR 102711, Dec. 18, 2024, unless otherwise noted.

§ 402.05 Scope and purpose of this part.

(a) The purpose of this part is to describe the Social Security Administration's (SSA) policies and procedures for implementing the requirements of the Freedom of Information Act (FOIA) 5 U.S.C. 552. The FOIA mandates disclosure to the public of Federal agency records unless specific exemptions apply. The FOIA also requires an agency to proactively disclose records and make certain records available for public inspection.

(b) The rules in this part describe how SSA makes records available to the public, including:

(1) What constitutes a proper request for records;
(2) How to make a FOIA request;
(3) Who has the authority to release and withhold records;
(4) What fees may be charged to process a request for records;
(5) The timing of determinations regarding release;
(6) The exemptions that permit the withholding of records;
(7) Requesters' right to seek assistance from the FOIA Public Liaison;
(8) Requesters' right to appeal the agency's FOIA determination;
(9) Requesters' right to seek assistance from the Office of Government Information Services and then go to court if they still disagree with our release determination; and
(10) The records available for public inspection.

(c) The rules in this part do not revoke, modify, or supersede SSA's regulations relating to disclosure of information in part 401 or 403 of this chapter.

§ 402.10 Definitions.

As used in this part:

Agency means the Social Security Administration (SSA). Agency may also refer to any executive department, military department, government corporation, government-controlled corporation, or other establishment in the executive branch of the Federal Government, or any independent regulatory agency. A private organization is not an agency even if it is performing work under contract with the Government or is receiving Federal financial assistance.

Chief FOIA Officer means a senior official of SSA who has an agency-wide responsibility for ensuring efficient and appropriate compliance with the FOIA, monitoring implementation of the FOIA throughout the agency, and making recommendations to the head of the agency to improve the agency's implementation of the FOIA. The Commissioner of SSA designated the General Counsel as the Chief FOIA Officer for SSA. The Chief FOIA Officer or the Chief FOIA Officer's designee is authorized to make final decisions in response to appeals of the FOIA Officer's determinations.

Commercial interest includes interests relating to business, trade, and profit. These interests could be present regardless of the identity of the requester (*e.g.*, individual, non-profit corporation, for-profit corporation). The interest of a representative of the news media in using the information for news dissemination purposes will not be considered a commercial interest.

Commercial use request is a request that asks for information for a use or a purpose that furthers a commercial, trade, or profit interest, which can include furthering those interests through litigation. An agency's decision to place a requester in the commercial use category will be made on a case-by-case basis based on the requester's intended use of the information. Agencies will notify requesters of their placement in this category.

Component means each separate office, division, commission, service, center, or administration within SSA that may maintain agency records subject to a request under the FOIA.

Duplication means the process of reproducing a copy of a record, or of the information contained in it, to the extent necessary to respond to a request. Copies include paper, electronic records, audiovisual materials, and other formats of agency records.

Educational institution is any school that operates a program of scholarly research. A requester in this fee category must show that the request is made in connection with their role at the educational institution. To qualify for this category, a requester must show that the FOIA request is authorized by, and is made under the auspices of or in connection with the requester's role at a qualifying institution and that the records are sought to further a scholarly research goal of the institution, and not for a commercial use or purpose, or for individual use or benefit. SSA may seek verification from the requester that the request is in furtherance of scholarly research and will advise requesters of their placement in this category.

Exemption means one of the nine exemptions to the mandatory disclosure of records permitted under section 552(b) of the FOIA.

Expedited processing means the process set forth in the FOIA that allows requesters to request faster processing of their FOIA request, if they meet specific criteria noted in § 402.65.

Fee category means one of the three categories established by the FOIA to determine whether a requester will be charged fees under FOIA for search, review, and duplication. The categories are: commercial use requests; scientific or educational institutions and news media requests; and all other requests.

Fee waiver means the waiver or reduction of fees if a requester is able to demonstrate the requirements set forth in § 402.85.

FOIA Library means an electronic location(s) that SSA uses to post records that are made available to the public without a specific request. SSA makes FOIA library records electronically available to the public through our website, *www.ssa.gov*, including at *www.ssa.gov/foia*. Posted records may include those provided under agency discretion and not required pursuant to FOIA.

FOIA Officer means an SSA official whom the Commissioner of Social Security delegated the authority to release or withhold records; to assess, waive, or reduce fees in response to FOIA requests; and to make all other determinations regarding the processing of a FOIA request. In this capacity, the FOIA Officer is authorized to request and receive responsive records that may be maintained by other agency components. Except for records subject to proactive disclosure pursuant to subsection (a)(2) of the FOIA, only the FOIA Officer has the authority to release or withhold records or to waive fees in response to a FOIA request.

FOIA Public Liaison means an agency official who reports to the agency Chief FOIA Officer and serves as a supervisory official to whom a requester can raise concerns about the service the requester received concerning the processing of the FOIA request. This individual is responsible for increasing transparency in the agency's FOIA business process, helping requesters understand the status of requests, and assisting in the resolution of disputes. The FOIA Public Liaison may be contacted via email to *FOIA.Public.Liaison@ssa.gov*.

FOIA request means a written request that meets the criteria in § 402.30.

Freedom of Information Act or *FOIA* means the law codified at 5 U.S.C. 552 that provides the public with the right to request agency records from the Federal executive branch agencies.

Non-commercial scientific institution means an institution that does not further the commercial, trade, or profit interests of any person or entity and is operated for the purpose of conducting scientific research whose results are not intended to promote any particular product or industry.

Numident refers to the ''Numerical Identification System,'' the SSA system that contains information available on an Application for a Social Security Card (Form SS–5). The Numident record contains the name of the applicant, place of birth, and other information.

OGC means the Office of the General Counsel.

Online FOIA portal means the electronic application that SSA uses to process FOIA requests. The public may also submit requests directly to SSA via the online FOIA portal.

OPD means the Office of Privacy and Disclosure.

Other requester means any individual or organization whose FOIA request does not qualify as a commercial-use request, representative of the news media request (including a request made by a freelance journalist), or an educational or non-commercial scientific institution request.

Production means the process of preparing the records for duplication, including the time spent in preparing the records for duplication (*i.e.*, materials used, records/database retrieval, employee and contractor time, as well as systems processing time).

Record(s) means any information maintained by an agency, regardless of format, that is made or received in connection with official agency business that is under the agency's control at the time of the FOIA request. Record(s) includes any information maintained for an agency by a third party.

(1) Record(s) does not include personal records of an employee, or other information in formally organized and officially designated SSA libraries and FOIA library, where such materials are available under the rules of the particular library.

(2) Record(s) includes information maintained by the State Disability Determination Services related to performing the disability determination function and medical source information pertaining to consultative examinations performed for the Social Security program when obtained by, created on behalf of, or otherwise, in the control of SSA.

Redact means delete or mark over.

Representative of the news media means any person or entity that gathers information of potential interest to a segment of the public, uses its editorial skills to turn raw materials into a distinct work, and distributes that work to an audience. The term ''news'' means information that is about current events or that would be of current interest to the public. Examples of news media entities include television or radio stations that broadcast news to the public at large and publishers of periodicals, including print and online publications that disseminate news and make their products available through a variety of means to the general public. We do not consider FOIA requests for records that support the news-dissemination function of the requester to be a commercial use. We consider ''freelance'' journalists who demonstrate a solid basis for expecting publication through a news media entity as working for that entity. A publishing contract provides the clearest evidence that a journalist expects publication; however, we also consider a requester's past publication record. We decide whether to grant a requester media status on a case-by-case basis,.

Request means asking for records, whether or not the requester refers specifically to the FOIA. Requests from Federal agencies, subpoenas, and court orders for documents are not included within this definition.

Review, unless otherwise specifically defined in this part, means examining records responsive to a request to determine whether any portions are exempt from disclosure. Review time includes processing a record for disclosure (*i.e.,* doing all that is necessary to prepare the record for disclosure), including redacting the record and marking the appropriate FOIA exemptions. It does not include the process of resolving general legal or policy issues regarding exemptions.

Search means the process of identifying, locating, and retrieving records responsive to a request, whether in hard copy or in electronic form or format, or by manual or automated/electronic means.

Special services means performing additional services outside of that required under the FOIA to respond to a request. Examples include using an overnight mail service to send the agency's response to a FOIA request.

SS–5 means an Application for a Social Security Card. It is used to request an original, different, or replacement Social Security Card.

SSA means the Social Security Administration.

Submitter means any person or entity that provides trade secrets or commercial or financial information to the agency, and includes individuals, corporations, other organizational entities, and state and foreign governments.

Tolling means temporarily stopping the running of a time limit. We may toll a FOIA request to seek clarification from the requester or to address fee issues, as further described in § 402.60(h).

Trade secrets and confidential commercial or financial information means trade secrets and confidential commercial or financial information that is obtained by the agency from a submitter, such that it may be protected from disclosure under Exemption 4 of the FOIA, 5 U.S.C. 552(b)(4).

§ 402.15 SSA's FOIA policy.

(a) *Presumption of openness.* SSA will withhold information only if we reasonably foresee that disclosure would harm an interest protected by a FOIA exemption or if disclosure is prohibited by law.

(b) *Authority to release and withhold records.* As described in § 402.50, the

agency's FOIA Officer, or the FOIA Officer's designee, has the authority to:

(1) Release or withhold records in response to initial requests;

(2) Grant or deny expedited processing; and

(3) Reduce or waive fees.

(c) *Records publicly available.* We make available for public inspection in an electronic format records that are final and have been requested and released three or more times and other specified records described in § 402.155. We do not make available for public inspection records that are not static, such as the Open Access Death Master File.

(d) *Required record production.* The FOIA does not require an agency to give opinions, conduct research, answer questions, or create records.

§ 402.20 Relationship between the FOIA and the Privacy Act of 1974.

(a) *Coverage.* The FOIA and the rules in this part apply to all SSA records. The Privacy Act, 5 U.S.C. 552a, applies to records that are about individuals, but only if the records are in a system of records.

(b) *Requesting your own records.* If you have filed a FOIA request and are an individual requesting your own records that are maintained in a system of records, or if you are a parent or legal guardian authorized to act under § 401.75 of this chapter who is seeking the records about a minor or individual who has been declared incompetent, your request may be handled under the Privacy Act. See § 401.40 of this chapter. If we handle your request under the Privacy Act, we will provide you with written notification with further processing instructions. Privacy Act requests are also processed under the FOIA, when appropriate, to give you the benefit of both statutes. You must verify your identity in accordance with our regulations. See § 401.45 of this chapter.

§ 402.25 Who can file a FOIA request?

Any person may submit a FOIA request to SSA. Under the FOIA, ''any person'' includes requests from individuals, corporations, State and local agencies, as well as foreign entities. Requests from Federal agencies and Federal or State courts are not covered by the FOIA.

§ 402.30 Requirements of a FOIA request.

(a) To be considered a FOIA request under this part, the following must occur:

(1) The request must be written (either by hand or electronically);

(2) The request must be submitted in accordance with § 402.35;

(3) The requester must provide the following required contact information: Requester's name, U.S. or foreign postal address, description of records sought, and fee willing to pay. While not required, we encourage requesters to provide us with their email address and phone number; and

(4) The request must clearly state and reasonably describe what SSA records are being requested in sufficient detail to enable OPD to locate them with a reasonable amount of effort. Broad, sweeping requests and vague requests are not reasonably described. When known, requests should identify the records sought by providing the name/title of the record, applicable date range, subject matter, offices or employees involved, and record type. If the request is for electronic communications, such as email records, the request may identify the names, position titles, or other identifying information about the agency employees involved, as well as the applicable timeframe. Absent sufficient details, the agency may be unable to search for or locate the records sought. The greater the date range, the longer it may take to process the request and the greater amount of fees that may be charged.

(b) Requests that do not meet the required criteria in paragraph (a) of this section are not considered proper FOIA requests.

§ 402.35 Where to submit a FOIA request.

(a) *Submission of requests.* Except as specified in paragraph (b) of this section, requesters must submit FOIA requests in writing to OPD through the following options:

(1) *Online FOIA portal:* Link available from the agency's *www.ssa.gov/foia*

website or the National FOIA Portal at *www.FOIA.gov*.

(2) *Email: FOIA.Public.Liaison@ssa.gov*.

(3) *Mail:* SSA Office of Privacy and Disclosure, ATTN: Freedom of Information Officer, 6401 Security Boulevard, Baltimore, MD 21235.

(b) *Requests for copies of Deceased Individual's Application for a Social Security Card (SS–5) or Numident record*. Requesters may use the Form SSA–711, *Request for a Deceased Individual's Social Security Record*, to request a copy of a deceased individual's original SS–5 or Numident record. When the Form SSA–711 is used, it may be submitted to the office listed on the form or as directed in paragraph (a) of this section.

§ 402.40 Requests for deceased individual's records.

(a) The agency will disclose the records concerning a deceased individual when we have acceptable proof of death unless Federal law or regulations prohibits the disclosure.

(b) Proof of death includes:

(1) A copy of a public record of death of the number holder;

(2) A statement of death by the funeral home director;

(3) A statement of death by the attending physician or the superintendent, physician, or intern of the institution where the person died;

(4) A copy of the coroner's report of death or the verdict of the coroner's jury;

(5) An obituary that we determine has sufficient identifying information; or

(6) Other certified record of death that we determine within our discretion is acceptable.

(c) If upon review of the provided proof of death, we cannot determine that the individual is deceased or we have questions about the authenticity of the proof, then the proof is not acceptable. When we do not have acceptable proof of death, we will treat the request in accordance with § 402.20(b), requests for information about a living person.

§ 402.45 Requests handled outside of the FOIA process.

When records outlined in paragraphs (a) through (d) of this section are requested from OPD, OPD will respond to the requester and provide information for requesting the records sought:

(a) To the extent a request asks for records that are currently publicly available, either from SSA or from another part of the Federal Government. See § 402.155.

(b) If the records sought are distributed by SSA as part of its regular program activity, for example, public information leaflets distributed by SSA. See §§ 402.155 through 402.165.

(c) If the records sought are earnings records covered by § 422.125 of this chapter.

(d) If a request does not meet the requirements of a FOIA request as defined in § 402.30. We will send written correspondence to the requester:

(1) Providing instructions for how to submit a proper FOIA request; or

(2) Asking for additional information to make the request a proper FOIA request.

§ 402.50 FOIA Officer's authority.

(a) *Release determination*. Only the Deputy Executive Director for OPD or their designee is authorized to make determinations about:

(1) Release or withholding of records;

(2) Expedited processing;

(3) Charging or waiver of fees; and

(4) Other matters relating to processing a request for records under this part.

(b) *Determination provided in writing*. The FOIA Officer's determination is provided in writing to the requester via emailed communication or, in the absence of the requester's email address, via U.S. postal mail. If the requester disagrees with the FOIA Officer's determination in response to items identified in paragraph (a) of this section, the requester may appeal the determination to the Executive Director for OPD, as described in § 402.105.

§ 402.55 Referrals and consultations.

(a) *Consultation and referral*. When reviewing records located by SSA in response to a request, SSA will determine whether another agency of the

Federal Government is better able to determine whether the record is exempt from disclosure under the FOIA. As to any such record, SSA will proceed in one of the following ways:

(1) *Referral of FOIA records in whole or in part to an outside agency.* We will notify the requester in writing when we opt to refer records in whole or in part to another agency for direct response from that agency, including the name(s) or the agency(s) to which the record was referred and that agency's FOIA contact information, unless notification would cause harm to an interest protected under the FOIA. In such instances, in order to avoid harm to an interest protected by an applicable exemption, we coordinate to seek the view of the originating agency.

(2) *Agency consultation.* If a request is for records that were created by, or provided to us by, another agency that is not subject to the FOIA, we may consult with that agency, as described in paragraph (b) of this section.

(b) *Consultation with another agency or entity.* If a request is for records that originated with SSA but contain information of interest to another agency or entity, we may consult with the other agency or entity prior to issuing our release determination to the requester.

§ 402.60 How does SSA process FOIA requests?

(a) *Acknowledgement.* (1) If we receive a FOIA request that will take longer than 10 working days to process, we will provide an acknowledgment. The acknowledgement email or letter restates the FOIA request and provides the requester with the request's tracking number.

(2) If we require clarification to process the FOIA request, we will contact the requester either via email, U.S. postal mail, or phone call. We attempt to contact requesters twice. If we do not receive a response to our clarification attempts within 30 calendar days from the date of our first contact to the requester, we will close the FOIA request due to insufficient information.

(b) *Perfected requests.* FOIA requests are considered ''perfected,'' *i.e.,* the 20-working day statutory time begins, when the request meets the requirements of the proper FOIA request listed in § 402.30. There may be times that we require more information from the requester after perfecting a request. The 20-working day period may be extended in unusual circumstances by written notice to the requester. See paragraph (d) of this section.

(c) *Multi-tracking procedures.* FOIA requests are categorized simple, complex, or expedited. Unless granted expedited processing, we process FOIA requests in each track according to a first-in, first-out basis.

(1) *Simple.* For most non-expedited requests, we make a determination about release of the record(s) requested within 20-working days.

(2) *Complex.* We will place into a complex processing queue any request that cannot be completed within 20-working days due to the complex nature of the request, including consultation with components that may maintain records subject to the request. We make good faith efforts to notify requesters in writing if it is necessary for us to take additional time to process a request and of the requester's right to seek dispute resolution services with the Office of Government Information Services. See § 402.100.

(3) *Expedited processing.* Unless granted expedited processing, we process FOIA requests according to a first-in, first-out basis. See § 402.65 for information on expedited processing.

(d) *Unusual circumstances.* (1) Unusual circumstances exist when there is a need to:

(i) Search for and collect records from SSA components or field locations that are separate from OPD;

(ii) Search for, collect, and review a voluminous number of records that are part of a single request; or

(iii) Consult with two or more SSA components or another agency having substantial interest in the request before releasing the records.

(2) Within the unusual circumstances letter to the requester, we will provide an estimated date that we will contact the requester with the applicable fee notice and/or further correspondence. We will notify the requester of the date by which we estimate completing the

request. We will also advise the requester that they may modify or narrow the scope of their request.

(3) When unusual circumstances exist, we will process the request under the complex track.

(e) *Aggregating requests.* We may aggregate requests in cases where it reasonably appears that multiple requests, submitted either by a requester or by a group of requesters acting in concert, constitute a single request, involving clearly related matters, which would otherwise involve unusual circumstances. In the event requests are aggregated, they will be treated as one request for estimating response time and calculating fees.

(f) *Fee notice.* FOIA requesters are issued a fee notice that informs them of the estimated search, review, and duplication time associated with processing their FOIA request. For more information on fees, see §§ 402.70 through 402.80.

(g) *Tolling.* (1) We may stop or toll the 20 working days in two circumstances:

(i) We may stop the clock once if we require additional information regarding the specifics of the request; and

(ii) We may stop the clock as many times as needed regarding fee assessments.

(2) The processing time will resume upon our receipt of the requester's response. There may be instances when we require multiple clarifications on a FOIA request. After the first request for clarification, any additional clarifications are performed without tolling the clock. If we do not receive a response to our clarification attempts within 30 calendar days from the date of our first contact to the requester, we will close the FOIA request.

(h) *Retrieving records.* We are required to furnish copies of records only when they are in our possession or we can retrieve them from storage. We will make reasonable efforts to search for records except when such efforts would significantly interfere with the operation of our automated information system(s). The Federal Government follows National Archives and Records Administration rules on record retention. Records are retained or destroyed under the guidelines of the Federal Records Act.

(i) *No records determinations.* We will search for records to satisfy a request using methods that can be reasonably expected to produce the requested records. Nevertheless, we may not be able to always find the records requested using the information provided by the requester, or they may not exist. If we advise that we have been unable to find the records despite a diligent search, the requester may appeal the no records determination to the Executive Director for OPD, as described in § 402.105.

(j) *Furnishing records.* We will furnish copies of records in whole or in-part, unless we reasonably foresee that disclosure would harm an interest protected by a FOIA exemption or if disclosure is prohibited by law. When information within a responsive record(s) is exempt from disclosure, the information is redacted and the applicable FOIA exemption(s) are noted within the redacted cell. We will make reasonable efforts to provide the records in the form or format requested if the record is readily reproducible in that form or format. We may provide individual records as we process them on a rolling basis, or we may release all responsive records once the request is completed. See § 402.95 for more information on SSA's release of records.

(k) *Directing a requester to another agency.* If a request is for records that are not SSA records for purposes of the FOIA, and we believe the records may be maintained by another agency, we may advise the requester to submit their request to that other agency. In such cases, we will provide the requester with the other agency's name in our response letter. Our recommendation that the requester submit their request to the other agency is not a guarantee the other agency will have or disclose the records requested.

(l) *Burdensome requests.* The FOIA requires an agency to provide the record in any form or format requested by the person if the record is readily reproducible by the agency in that form or format. We will not search or produce records in response to a FOIA request that we determine would be unduly

burdensome to process. FOIA requests are determined to be unreasonably burdensome when processing the FOIA request would significantly interfere with the ongoing operation of the agency's programs.

§ 402.65 Expedited processing.

(a) Expedited processing must be requested at the same time as the FOIA request. We provide expedited processing when the requester can demonstrate a ''compelling need'' for the requested information:

(1) When there is an imminent threat to the life or safety of a person;

(2) When the requester is primarily engaged in disseminating information, and shows an urgency to inform the public about actual or alleged government activities; or

(3) When the requester can show, in detail and to our satisfaction, that a prompt response is needed because the requester may be denied a legal right, benefit, or remedy without the requested information, and that it cannot be obtained elsewhere in a reasonable amount of time.

(b) A requester who seeks expedited processing must submit a statement, certified to be true and correct, explaining in detail the basis for making the request for expedited processing. We will notify the requester within 10 calendar days of receipt of the request for expedited processing of our decision to grant or deny expedited processing. Only the FOIA Officer may make the decision to grant or deny expedited processing. Requests granted expedited processing will be given priority and processed as soon as practicable. Requests that do not meet the ''compelling need'' criteria, will be processed normally. If we do not grant the request for expedited processing, the requester may appeal the denial to the Executive Director for OPD. In the appeal letter, the requester should explain why they believe their request demonstrates a ''compelling need,'' such as describing how the request meets the criteria in paragraphs (a)(1) through (3) of this section. The process described in § 402.105 will also apply to these appeals.

§ 402.70 Fees associated with processing FOIA requests.

(a) *Charging authorities*—(1) *Section 1106(c).* Section 1106(c) of the Social Security Act (42 U.S.C. 1306(c)) allows the agency to charge for FOIA requests that are not directly related to SSA's administration of the Social Security Act. See § 402.80 for information on the agency's authorization under section 1106(c) to charge requesters. Requesters may request a fee waiver, as described in § 402.85.

(2) *FOIA fee categories.* The FOIA establishes three fee categories of requesters, *i.e.*, commercial use, noncommercial scientific or educational institutions and representatives of the news media; and other requesters. The category of the requester determines the fees that may be charged; see § 402.75 for the FOIA fee schedule. Requesters may request a fee waiver, as described in § 402.85.

(b) *Hourly rate when charging under section 1106(c) and the FOIA fee categories.* (1) When we search for and review records, we charge an hourly rate, based in 15-minute increments, depending on the grade(s) of the employee(s) and/or contractors performing the search and review. The hourly rate is the same when charging under the FOIA fee provisions or section 1106(c) of the Social Security Act. SSA uses the current General Schedule (GS) salary table for the locality pay area of Washington-Baltimore-Arlington, DC-MD-VA-WV-PA. We use the following criteria to compute our hourly rates for search or review:

(i) When performed by employees at grade GS–1 through GS–8, SSA will charge an hourly rate based on the salary of a GS–5, step 7, employee;

(ii) When performed by a GS–9 through GS–14, SSA will charge an hourly rate based on the salary of a GS–12, step 4, employee; and

(iii) When performed by a GS–15 or above, SSA will charge an hourly rate based on the salary of a GS–15, step 7, employee.

(2) When work is performed by a contractor, we will charge an hourly rate based on the GS equivalent of the contractor's hourly pay rate. We compute the hourly rate by taking the current hourly rate for the specified grade and

adding 16 percent of that rate to cover benefits and rounding to the nearest whole dollar. These rates are adjusted as Federal salaries change. Federal salary rates are available from the Office of Personnel Management. When a search and review involves employees at more than one of these GS levels, we will charge the rate appropriate for each. We may charge a fee for search time even if we are unable to locate any responsive records or the records are exempt from disclosure.

§ 402.75 FOIA fee schedule.

(a) *Fee schedule category.* Requesters whom SSA charges under the FOIA fee schedule are subject to the following fees dependent upon their fee category:

(1) *Commercial.* Commercial use requesters are charged for search, review, and duplication.

(2) *Non-commercial educational or scientific institutions and representative of the news media.* Requesters that fit this category are charged for the duplication of documents. We will not charge requesters the copying costs for the first 100 pages of duplication.

(3) *Other.* If the FOIA request does not fall within a category described in paragraph (a)(1) or (2) of this section, we will charge for search and duplication; however, we will not charge for the first two hours of search time or for the duplication costs of the first 100 pages.

(b) *Certification.* If a requester asks for certification of the record(s) responsive to their FOIA request and OPD agrees to provide it, we will notify the requester of the appropriate certification fee via written correspondence.

(c) *Record(s) production and duplication*—(1) *Electronic records.* We will charge the actual costs for producing and duplicating the record and the time spent by the employees or contractors in production, duplication, or otherwise processing the FOIA request, at the rates given in § 402.70(c).

(2) *Photocopying standard size pages.* For noncommercial requesters, we will charge $0.10 per page after the first 100 pages, which are free. The FOIA Officer may charge lower fees for particular documents where:

(i) The document has already been printed in large numbers;

(ii) The program office determines that using existing stock to answer this request, and any other anticipated FOIA requests, will not interfere with program requirements; and

(iii) The FOIA Officer determines that the lower fee is adequate to recover the prorated share of the original printing costs.

(3) *Photocopying odd-size documents.* For photocopying documents, such as punch cards or blueprints, or duplicating other records, such as tapes, we will charge the actual costs of operating the machine, plus the actual cost of the materials used, plus charges for the time spent by the operator, at the rates given in § 402.70(c).

(d) *Cost of service less than cost of issuing a bill.* We will not charge a fee when the cost of the service is less than the cost of sending the requester a bill. However, where an individual, organization, or governmental unit makes multiple separate requests, we will total the costs incurred and bill the requester for the services rendered.

(e) *Fee waiver.* We may waive or reduce the fee if we find that waiver is in the public interest. See § 402.85 for fee waiver information.

§ 402.80 Charging under section 1106(c) of the Social Security Act.

Section 1106(c) of the Social Security Act permits the agency to charge the full cost to process requests for information for purposes not directly related to the administration of program(s) under the Social Security Act. This may be done notwithstanding the fee provisions in FOIA, the Privacy Act, or any other provision of law. In responding to FOIA requests for non-program purposes, we will charge the full cost (both direct and indirect costs) of our services, regardless of the requester's fee categorization, unless the cost of the service is less than the cost of issuing a bill as stated in paragraph (b) of this section.

(a) *Full costs.* The agency may charge full costs for processing records or information requests, including but not limited to:

(1) *Search.* We may charge for search time even if we are unable to locate any responsive records or the records

are exempt from disclosure. We will notify the requester in writing if the records estimated as responsive are determined unreasonably burdensome for the agency to process and/or the search would cause significant interference with the operation of SSA's automated information systems.

(2) *Review.* Review includes the reviews performed at any level (staff through executive), including but not limited to review by multiple people and offices.

(3) *Production and duplication of record(s).* We may charge the full cost of the systems' processing (*e.g.*, computer search time, computer processing database retrieval), materials used to produce and duplicate the requested record(s), and time spent by agency employee(s) and/or contractor(s) in production, duplication, or otherwise processing the FOIA request.

(4) *Certification.* We will charge the full costs for certification.

(5) *Employee's time.* The full cost of an employee's time includes fringe benefits and overhead costs, such as rent and utilities.

(6) *Forwarding/delivering materials.* If special arrangements for forwarding material are requested, we will charge the requester the full cost of this service (*e.g.*, if express mail or a commercial delivery service is requested). If no special forwarding arrangements are requested, we will charge the requester the full cost of the service, including the U.S. Postal Service cost.

(7) *Performing other special services.* If we agree to provide any special services requested, we will charge the full cost of the time of the employee(s) or contractor(s) who perform the service, plus the full cost of any systems processing time and materials that the employee or contractor uses.

(b) *Cost of service less than cost of issuing a bill.* We will not charge a fee when the cost of the service is less than the cost of sending the requester a bill. However, where an individual, organization, or governmental unit makes multiple separate requests, we will total the costs incurred and bill the requester for the services rendered.

(c) *Standard administrative fees for non-program information.* The information in this part does not revoke, modify, or supersede the schedule of standard administrative fees the agency charges for specified non-program information requests.

(d) *Non-program purpose.* Non-program purposes constitute any purpose that is not program related.

(1) We consider a request to be program related if:

(i) The information must be disclosed under the Social Security Act (Act); or

(ii) The information will be used for a purpose which is directly related to the administration of a program under the Act for which SSA has responsibility. In deciding whether this paragraph (d)(1)(ii) applies, the major criteria SSA considers is whether the information is:

(A) Needed to pursue a benefit under a program that SSA administers under the Act.

(B) Needed solely to verify the accuracy of information obtained in connection with a program that SSA administers under the Act.

(C) Needed in connection with an activity under SSA's purview which is authorized under the Act.

(D) Needed by an employer to carry out taxpaying responsibilities under the Federal Insurance Contributions Act or section 218 of the Act.

(2) We will consider each request on a case-by-case basis when the criteria in this paragraph (d) are not met but the requester claims a request is for a program-related purpose for another reason. We will not conclude a request is program-related solely because the records sought are about programs administered by SSA or are claimed to be of public interest.

(e) *Disagreement with program or non-program determination.* Only the FOIA Officer has the authority to make the program/non-program decision. If a requester disagrees with the FOIA Officer's non-program determination, they may appeal the decision to the Executive Director for OPD. In the appeal letter, the requester should explain why they believe the request meets the requirements in paragraph (c) of this section. The process described in § 402.105 will also apply to these appeals.

§ 402.85 Waiver of fees in the public interest.

A requester may request waiver or reduction of fees, whether charged under § 402.75 or § 402.80, if the release of the requested records is in the public interest. We will waive or reduce the fees we would otherwise charge if disclosure of the requested information:

(a) Is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government; and

(b) Is not primarily in the commercial interest of the requester.

(1) *Procedure for requesting a waiver or reduction.* A requester must make the request for a fee waiver or reduction in writing at the same time they make their request for records. The requester should explain with reasonable specificity why they believe a waiver or reduction is proper under the analysis in paragraphs (b)(2) and (3) of this section. Only the FOIA Officer may make the decision whether to waive, or reduce, the fees. If we do not completely grant the request for a waiver or reduction, the requester may appeal the denial to the Executive Director for OPD. In the appeal letter, the requester should explain why they believe the request meets the requirements in paragraphs (b)(2) and (3) of this section. The process prescribed in § 402.105 will also apply to these appeals.

(2) *Public interest.* We consider the factors below when analyzing whether disclosure is in the public interest:

(i) How the records pertain to the Federal Government's operations or activities;

(ii) Whether disclosure would reveal any meaningful information about Government operations or activities not already known to the public; and

(iii) Whether the contribution to public understanding of those operations or activities would be significant.

(iv) Regarding the above criteria, you must be reasonably specific in your waiver request as to the specific Government operation or activity and provide direct, clear (not remote or attenuated) connections to the meaningful information you seek. Generalized interest in government programs is not reasonably specific to grant waiver.

(3) *Not primarily in requester's commercial interest.* If the disclosure is determined to be in the public interest as described in paragraph (b)(2) of this section, we will then determine whether it also furthers the requester's commercial interest and, if so, whether this effect outweighs the advancement of that public interest. We consider the following factors when analyzing whether disclosure is not primarily in the requester's commercial interest:

(i) Would the disclosure further a commercial interest of the requester, or of someone on whose behalf the requester is acting?

(ii) If disclosure would further a commercial interest of the requester, would that effect outweigh the advancement of the public interest defined in paragraph (b)(2) of this section? Which effect is primary?

(4) *Burden on SSA to produce the record(s).* If the disclosure meets the requirements in paragraphs (b)(2) and (3) of this section, we reserve the right to charge a fee if special services are needed to provide the records.

(5) *Deciding between waiver and reduction.* If the disclosure meets the requirements in paragraphs (b)(2) and (3) of this section, we will normally waive fees. However, in some cases we may decide only to reduce the fees. For example, we may do this when disclosure of some but not all of the requested records meet the fee waiver criteria.

§ 402.90 Notification of fees and prepayment requirements.

Requesters must agree to pay the fee, whether charged under § 402.75 or § 402.80, before we will begin the search for record(s).

(a) *Cost estimate.* OPD will issue a fee notice to the requester for the processing of their request for records that includes an estimated fee based on the time we estimate it will take to process the record(s) requested. We issue fee notices via email or, when the requester does not provide an email address, via U.S. postal mail.

(b) *Advanced payment information required.* The requester must agree to pay the estimated fee provided within the fee notice and provide the agency with

payment information within 30 calendar days from the date of our fee notice. Payment information is required before OPD will begin the search for the requested record(s). Unless otherwise specified in the schedule of standard administrative fees the agency charges for specified non-program information requests, OPD will process payment when the request is closed, *i.e.*, when the FOIA Officer issues a decision on records release. If the payment information provided by the requester expires during the course of OPD's processing of the FOIA request, the requester must provide updated payment information. If updated payment information is not provided within 30 calendar days of our written request for the payment information, we reserve the right to administratively close the request.

(c) *Changes in estimated fee.* (1) If the time spent to search for records is more or less than the time estimated in the fee notice, OPD will issue the requester a revised fee notice after the responsive component(s) performs the records search and retrieval.

(2) If the record(s) provided to OPD for review are more or less than those from which OPD estimated search and review time, OPD will issue the requester a revised fee notice after the responsive component(s) perform the records search and retrieval.

(3) OPD will either dispose of the payment information or return the payment information to the requester when OPD issues the revised fee notice.

(4) The requester must agree to pay the revised fee before we will continue processing the request. If the requester disagrees with the revised fee, the requester may appeal to the Executive Director for OPD. Appeals will be processed as described in § 402.105.

(d) *Prompt payment.* We will administratively close the FOIA request if we do not receive a response or appeal within 30 calendar days from the date of the fee notice. ''Response'' includes:

(1) Requesting to narrow the scope of the request; or

(2) Providing payment in response to the fee notice. Appeals will be processed as described in § 402.105.

(e) *Methods of payment.* We accept payment by check or money order made payable to the Social Security Administration (SSA), as well as by credit card (MasterCard, Visa, Discover, American Express, or Diner's Club).

§ 402.95 Release of records.

(a) *Records previously released.* If we have released a record, or a part of a record, to others in the past, we will ordinarily release it to the requester, as well. However, we will not release it to a requester if a statute forbids this disclosure; an exemption applies that was not previously applicable; or if the previous release was unauthorized.

(b) *Withholding records.* Section 552(b) of the FOIA explains the nine exemptions under which we may withhold records requested under the FOIA. Within §§ 402.115 through 402.150, we describe the FOIA exemptions and explain how we apply them to disclosure determinations. In some cases, more than one exemption may apply to the same document. Section 552(b) of the FOIA, while providing nine exemptions from mandatory disclosure, does not itself provide any assurance of confidentiality by the agency.

(c) *FOIA library.* If the record(s) requested are already publicly available, either in our electronic FOIA library or elsewhere online, such as at *www.ssa.gov*, we will direct the requester to the publicly available record(s).

(d) *Poor copy.* If we cannot make a legible copy of a record to be released, we do not attempt to reconstruct it. Instead, we furnish the best copy possible and note its poor quality in our reply.

§ 402.100 FOIA Public Liaison and the Office of Government Information Services.

We notify requesters of their right to seek dispute resolution from the FOIA Public Liaison or the Office of Government Information Services (OGIS) within our fee notices, responses to determinations identified in § 402.50(a), and responses to appeals.

(a) *FOIA Public Liaison.* If requesters have questions about the response to their request or wish to seek dispute resolutions services within SSA, the requester may contact the FOIA Public

Liaison via email to *FOIA.Public.Liaison@ssa.gov*.

(b) *OGIS*. OGIS is an entity outside of SSA that offers mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. OGIS' contact information will be provided in any decision letter issued by the FOIA Officer and Executive Director for OPD.

§ 402.105 Appeals of the FOIA Officer's determination.

(a) *Appeal requirements*. If a requester disagrees with the FOIA Officer's determination in response to items specified in § 402.50(a), the requester may appeal the decision. The appeal must meet the following requirements:

(1) Be submitted in writing via the avenues identified in § 402.35(a);

(2) Be received, or in the case of electronic submissions, transmitted within 90 calendar days from the date of the determination the requester is appealing; and

(3) Explain what the requester is appealing and include additional information to support the appeal. The appeal should clearly identify the agency determination that is being appealed and the assigned request's tracking number. To facilitate handling when submitted via mail or fax, the requester should mark the appeal letter, or subject line of the electronic transmission, ''Freedom of Information Act Appeal.''

(b) *Acknowledgement*. If we receive an appeal that will take longer than 10 working days to process, we will provide an acknowledgment. The acknowledgement is provided via email or, when the requester does not provide an email address, via U.S. postal mail. The acknowledgement email or letter restates the FOIA appeal and provides the requester with the appeal's tracking number.

(c) *Processing timeframe*. FOIA appeals are categorized as either simple or complex, based on the designation of the initial request.

(1) *Simple*. Generally, we make a determination about release of the requested record(s) within 20-working days.

(2) *Complex*. Appeals of complex requests cannot be completed within 20-working days. During OPD's processing of the appeal, OPD will need to consult with appropriate SSA component(s), including legal counsel; therefore, we generally require more than 20-working days to issue a final decision on the appeal.

(d) *Final decision*. The Chief FOIA Officer delegated to the Executive Director for OPD the authority to make decisions on appeals of the FOIA Officer's determinations.

(1) The final decision is provided in writing to the requester via email or, in the absence of the requester's email address, via U.S. postal mail.

(2) The final decision letter will explain the basis of the decision (for example, the reasons why an exemption applies).

(e) *Disagreement with final decision*. If a requester disagrees with the final decision issued by the Executive Director for OPD, they may seek assistance from OGIS, as described in § 402.100. Requesters may also ask a U.S. District Court to review our final decision. See 5 U.S.C. 552(a)(4)(B).

§ 402.110 U.S. District Court action.

If the Executive Director for OPD or the Executive Director for OPD's designee, upon review, affirms the denial of the FOIA Officer's determination of items specified in § 402.50(a), requesters may ask a U.S. District Court to review that denial. See 5 U.S.C. 552(a)(4)(B).

§ 402.115 The FOIA Exemption 1: National defense and foreign policy.

Exemption 1 protects from disclosure information specifically authorized under criteria established by an Executive order to be kept secret in the interest of national defense or foreign policy and are in fact properly classified pursuant to such Executive order.

§ 402.120 The FOIA Exemption 2: Internal personnel rules and practices.

Exemption 2 authorizes our agency to withhold records that are related solely to the internal personnel rules and practices of an agency. For example, we may withhold personnel rules and practices dealing with employee relations or human resources.

§ 402.125 The FOIA Exemption 3: Records exempted by other statutes.

(a) *Required record release.* Exemption 3 authorizes our agency to withhold records if another statute specifically allows or requires us to withhold them. We may use another statute to justify withholding only if it prohibits disclosure or if it sets forth criteria to guide our decision on releasing or identifies particular types of material to be withheld.

(b) *Examples.* (1) We often use this exemption to withhold information regarding a worker's earnings which is tax return information under section 6103 of the Internal Revenue Code.

(2) We also use this exemption to withhold death information about decedents:

(i) When the date of death is within three calendar years from the current date, the requested information about the decedent is protected under section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113–67).

(ii) When the agency's source of death is the state, the requested information is protected under section 205(r) of the Social Security Act.

§ 402.130 The FOIA Exemption 4: Trade secrets and confidential commercial or financial information.

Submitters may designate information as trade secrets and confidential commercial or financial information at the time of submission or within a reasonable time thereafter. Submitters must use good faith efforts to designate, by appropriate markings, any portion of its submission that it considers to be protected from disclosure under the FOIA exemptions. These designations expire ten years after the due date of the submission unless the submitter requests a longer designation period.

(a) *Steps of submitters notice*—(1) *The submitter's notice.* When trade secrets or confidential commercial or financial information is requested under the FOIA, SSA will provide written submitter's notice if we have a reason to believe that information in the records could reasonably be disclosed under the FOIA. The submitter's notice will describe and include a copy of the trade secret or commercial or financial information requested or portions of records containing the information. In cases involving many submitters, SSA may post or publish a submitter's notice in a place or manner reasonably likely to inform the submitters of the proposed disclosure instead of sending individual notifications. The submitter's notice requirements of this section do not apply if:

(i) SSA determines the information is fully exempt under the FOIA, and therefore will not be disclosed;

(ii) The information has been previously published or made generally available; or

(iii) Disclosure of the information is required by statute other than the FOIA.

(2) *Submitter's opportunity to object to disclosure.* (i) Unless SSA grants an extension, the submitter must respond to the notice within five working days of SSA issuing the submitter's notice or the information may be released in accordance with these regulations and the FOIA. A submitter who fails to respond within five working days will be considered to have no objection to the disclosure of the information. SSA is not required to consider any information received after the date of any disclosure decision. Any information provided by a submitter under this subpart may itself be subject to disclosure under the FOIA.

(ii) If a submitter objects to disclosure, the submitter should provide SSA with a detailed written statement that specifies all grounds for withholding the particular information under any exemption of the FOIA. In order to rely on Exemption 4 as basis for non-disclosure, the submitter must explain why the information constitutes a trade secret or commercial or financial information that is confidential.

(iii) SSA will consider a submitter's timely made objections and specific grounds for nondisclosure in deciding whether to disclose the requested information.

(3) *Notice of intent to disclose.* Whenever SSA decides to disclose information over the objection of a submitter, SSA provides the following to the submitter:

(i) A Release Over Objection letter explaining the reasons why each of the submitter's disclosure objections did not meet the requirements for withholding under the FOIA.

(ii) A copy of the information as SSA intends to release it.

(iii) A statement of our intent to disclose the information five working days from the date on the Release Over Objection letter unless the submitter files an action in a U.S. District Court to prevent the release.

(b) *Notice of FOIA lawsuit.* When a submitter's notice is issued for a request that is the subject of a lawsuit, SSA notifies the submitter of the lawsuit within the notice.

(c) *Requester notification.* To the extent SSA expects substantial delays in the processing of FOIA requests due to the agency's communications with the submitter, we will notify the requester in writing via email, or when the requester's email is not provided, via U.S. postal mail.

§ 402.135 The FOIA Exemption 5: Internal documents.

This exemption covers inter-agency or intra-agency government documents that fall within an evidentiary privilege recognized in civil discovery. Such internal government communications may include an agency's communications with an outside consultant or other outside person, with a court, or with Congress, when those communications are for a purpose similar to the purpose of privileged intra-agency communications. Some of the most-commonly applicable privileges are described in the following paragraphs:

(a) *Deliberative process privilege.* This privilege protects the decision-making processes of government agencies. Information is protected under this privilege if it is predecisional and deliberative. The purpose of the privilege is to prevent injury to the quality of the agency decision-making process by encouraging open and frank internal discussions, by avoiding premature disclosure of decisions not yet adopted, and by avoiding the public confusion that might result from disclosing reasons that were not in fact the ultimate grounds for an agency's decision. Purely factual material in a deliberative document is within this privilege only if it is inextricably intertwined with the deliberative portions so that it cannot reasonably be segregated, if it would reveal the nature of the deliberative portions, or if its disclosure would in some other way make possible an intrusion into the decision-making process. We will release purely factual material in a deliberative document unless that material is otherwise exempt. The privilege continues to protect predecisional documents even after a decision is made; however, we will release predecisional deliberative communications that were created 25 years or more before the date on which the records are requested.

(b) *Attorney work product privilege.* This privilege protects records prepared by or for an attorney in anticipation of or for litigation. It includes documents prepared for purposes of administrative and court proceedings. This privilege extends to information directly prepared by an attorney, as well as materials prepared by non-attorneys working for an attorney.

(c) *Attorney-client communication privilege.* This privilege protects confidential communications between an attorney and the attorney's client where legal advice is sought or provided.

§ 402.140 The FOIA Exemption 6: Clearly unwarranted invasion of personal privacy.

We may withhold records about individuals if disclosure would constitute a clearly unwarranted invasion of their personal privacy.

(a) *Balancing test.* When we decide whether to release records that contain personal or private information about someone else, we weigh the foreseeable harm of invading a person's privacy against the public interest in disclosure. When we determine whether disclosure would be in the public interest, we will consider whether disclosure of the requested information would shed light on how a Government agency performs its statutory duties.

(b) *Agency employees.* To protect the safety of agency employees, we will not disclose information when the information sought is contact information and/or duty stations of one or more Federal employees if the disclosure would place

employee(s) at risk of injury or other harm.

(c) *Examples.* We generally withhold the personally identifiable information of individuals if we do not have the consent (consistent with § 401.100 of this chapter) of the number holder, including but not limited to the number holder's home address, age, Social Security number, claims file, and other personal information. If the information requested concerns agency employees, we will determine disclosure on a case-by-case basis. For example, our redaction of management officials' information may be treated differently depending on how the balancing test applies in a given circumstance.

§ 402.145 The FOIA Exemption 7: Law enforcement.

Exemption 7 authorizes our agency to withhold certain records that the government has compiled for law enforcement purposes. The records may apply to actual or potential violations of either criminal or civil laws or regulations. We can withhold these records only to the extent that releasing them would cause harm in at least one of the following situations:

(a) *Enforcement proceedings.* Pursuant to the FOIA Exemption 7(A) (5 U.S.C. 552(b)(7)(a)), we may withhold information whose release could reasonably be expected to interfere with prospective or ongoing law enforcement proceedings. Investigations of fraud and mismanagement, employee misconduct, and civil rights violations may fall into this category. In certain cases—such as when a fraud investigation is likely—we may refuse to confirm or deny the existence of records that relate to the violations in order not to disclose that an investigation is in progress, or may be conducted.

(b) *Fair trial or impartial adjudication.* Under the FOIA Exemption 7(B) (5 U.S.C. 552(b)(7)(b)), we may withhold records whose release would deprive a person of a fair trial or an impartial adjudication because of prejudicial publicity.

(c) *Personal privacy.* Under the FOIA Exemption 7(C) (5 U.S.C. 552(b)(7)(c)), we may withhold the personally identifiable information of individuals when the disclosure could reasonably be expected to constitute an unwarranted invasion of personal privacy. When a name surfaces in an investigation, that person is likely to be vulnerable to innuendo, rumor, harassment, and retaliation.

(d) *Confidential sources and information.* Pursuant to the FOIA Exemption 7(D) (5 U.S.C. 552(b)(7)(d)), we may withhold the identity of confidential sources, as well as the records obtained from the confidential sources in criminal investigations or by an agency conducting a lawful national security investigation. A confidential source may be an individual; a State, local, or foreign government agency; or any private organization. The exemption applies whether the source provides information under an express promise of confidentiality or under circumstances from which such an assurance could be reasonably inferred; however, inferred confidentiality is determined in a case-by-case analysis. Also protected from mandatory disclosure is any information which, if disclosed, could reasonably be expected to jeopardize the system of confidentiality that assures a flow of information from sources to investigatory agencies.

(e) *Techniques and procedures.* Under the FOIA Exemption 7(E) (5 U.S.C. 552(b)(7)(e)), we may withhold records that would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law. In some cases, it is not possible to describe even in general terms those techniques without disclosing the very material to be withheld.

(f) *Life and physical safety.* Under the FOIA Exemption 7(F) (5 U.S.C. 552(b)(7)(f)), we may withhold records whose disclosure could reasonably be expected to endanger the life or physical safety of any individual. This protection extends to threats and harassment, as well as to physical violence.

§ 402.150 The FOIA Exemptions 8 and 9: Records on financial institutions; records on wells.

Exemption 8 permits us to withhold records about regulation or supervision

of financial institutions. Exemption 9 permits the withholding of geological and geophysical information and data, including maps, concerning wells.

§ 402.155 Records available for public inspection.

(a) Under the FOIA, SSA is required to make available for public inspection in an electronic format:

(1) Final opinions made in the adjudication of cases;

(2) An agency's statements and interpretations of policy that have been adopted but are not published in the FEDERAL REGISTER;

(3) Administrative staff manuals and instructions that affect the public; and

(4) Copies of records, regardless of form or format, that an agency determines will likely become the subject of subsequent requests, as well as records that have been requested and released three or more times, unless said materials are published and copies are offered to sale.

(b) SSA will not use or cite instructional manuals issued to our employees, general statements of policy, and other materials which are used in processing claims as a precedent for an action against a person unless we have indexed the record and published it or made it available, or unless the person has timely notice of the record.

(c) Records that SSA makes available for public inspection in an electronic format may be accessed through *www.ssa.gov* free of charge. Such records include:

(1) Compilation of Social Security Laws and Regulations;

(2) SSA regulations under the retirement, survivors, disability, and supplemental security income programs, *i.e.*, 20 CFR parts 401, 402, 404, 416, and 422;

(3) Social Security Handbook;

(4) Social Security Rulings and Acquiescence Rulings;

(5) SSA's Public Programs Operations Manual System;

(6) SSA's Organizational Structure;

(7) State and Local Coverage Handbook for State Social Security Administrators; and

(8) SSA's Public Hearings, Appeals, and Litigation Law Manual.

§ 402.160 Where records are published.

(a) *Methods of publication.* Materials we are required to publish pursuant to the provisions of 5 U.S.C. 552(a)(1) and (a)(2), we publish in one of the following ways:

(1) By publication in the FEDERAL REGISTER of Social Security Administration regulations, and by their subsequent inclusion in the Code of Federal Regulations;

(2) By publication in the FEDERAL REGISTER of appropriate general notices;

(3) By other forms of publication, when incorporated by reference in the Code of Federal Regulations with the approval of the Director of the Federal Register;

(4) By publication in the ''Social Security Rulings'' of indexes of precedential social security orders and opinions issued in the adjudication of claims, statements of policy and interpretations that have been adopted but have not been published in the FEDERAL REGISTER; and

(5) By posting in the FOIA library.

(b) *Publication of rulings.* Although not required pursuant to 5 U.S.C. 552(a)(1) and (a)(2), we publish the following rulings in the FEDERAL REGISTER and by other forms of publication:

(1) We publish Social Security Rulings in the FEDERAL REGISTER under the authority of the Commissioner of Social Security. They are binding on all components of SSA. These rulings represent precedent final opinions and orders and statements of policy and interpretations that we have adopted.

(2) We publish Social Security Acquiescence Rulings in the FEDERAL REGISTER under the authority of the Commissioner of Social Security. They are binding on all components of SSA, except with respect to claims subject to the relitigation procedures established in 20 CFR 404.985(c) and 416.1485(c). For a description of Social Security Acquiescence Rulings, see 20 CFR 404.985(b) and 416.1485(b).

§ 402.165 Publications for sale through the Government Publishing Office.

The public may purchase publications containing information pertaining to the program, organization,

functions, and procedures of SSA from the electronic U.S. Government Bookstore maintained by the Government Publishing Office. The publications for sale include but are not limited to:

(a) Title 20, parts 400 through 499, of the Code of Federal Regulations;

(b) FEDERAL REGISTER issues; and

(c) Compilation of the Social Security Laws.

PART 403—TESTIMONY BY EMPLOYEES AND THE PRODUCTION OF RECORDS AND INFORMATION IN LEGAL PROCEEDINGS

Sec.

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AUTHORITY: Secs. 702(a)(5) and 1106 of the Act, (42 U.S.C. 902(a)(5) and 1306); 5 U.S.C. 301; 31 U.S.C. 9701.

SOURCE: 66 FR 2809, Jan. 12, 2001, unless otherwise noted.

§ 403.100 When can an SSA employee testify or produce information or records in legal proceedings?

An SSA employee can testify concerning any function of SSA or any information or record created or acquired by SSA as a result of the discharge of its official duties in any legal proceeding covered by this part only with the prior authorization of the Commissioner. An SSA employee can provide records or other information in a legal proceeding covered by this part only to the extent that doing so is consistent with 20 CFR parts 401 and 402. A request for both testimony and records or other information is considered two separate requests—one for testimony and one for records or other information. SSA maintains a policy of strict impartiality with respect to private litigants and seeks to minimize the disruption of official duties.

§ 403.105 What is the relationship between this part and 20 CFR parts 401 and 402?

(a) *General.* Disclosure of SSA's records and information contained in those records is governed by the regulations at 20 CFR parts 401 and 402. SSA employees will not disclose records or information in any legal proceeding covered by this part except as permitted by 20 CFR parts 401 and 402.

(b) *Requests for information or records that do not include testimony.* (1) If you do not request testimony, §§ 403.120–403.140 do not apply.

(2) If 20 CFR part 401 or 402 permits disclosure to you of any requested record or information, we will make every reasonable effort to provide the disclosable information or record to you on or before the date specified in your request.

(3) If neither 20 CFR part 401 nor 402 permits disclosure of information or a record you request, we will notify you as provided in § 403.145. We will also send you any notices required by part 401 or 402.

§ 403.110 What special definitions apply to this part?

The following definitions apply:

(a) *Application* means a written request for testimony that conforms to the requirements of § 403.120.

(b)(1) *Employee* includes—

(i) Any person employed in any capacity by SSA, currently or in the past;

(ii) Any person appointed by, or subject to the supervision, jurisdiction, or control of SSA, the Commissioner of Social Security, or any other SSA official, currently or in the past; and

(iii) Any person who is not described elsewhere in this definition but whose

disclosure of information is subject to the regulations at 20 CFR part 401, currently or in the past.

(2) For purposes of this paragraph (b), a person subject to SSA's jurisdiction or control includes any person hired as a contractor by SSA, any person performing services for SSA under an agreement (such as an officer or employee of a State agency involved in determining disability for SSA), and any consultant (including medical or vocational experts or medical services or consultative examination providers), contractor, or subcontractor of such person. Such a person would also include any person who has served or is serving in any advisory capacity, formal or informal.

(3) For purposes of this paragraph (b), a person employed by SSA in the past is considered an employee only when the matter about which the person would testify is one in which he or she was personally involved while at SSA; where the matter concerns official information that the employee acquired while working, such as sensitive or confidential agency information; where the person purports to speak for SSA; or where significant SSA resources would be required to prepare the person to testify. Such a person would not be considered an employee when the person will rely only on expertise or general knowledge he or she acquired while working at SSA.

(c) *Commissioner* means the Commissioner of Social Security or his or her designee(s).

(d) *Legal proceeding* includes any pretrial, trial, and post-trial stage of any existing or reasonably anticipated judicial or administrative action, hearing, investigation, or similar proceeding before a court, commission, board, agency, or other tribunal, authority or entity, foreign or domestic. *Legal proceeding* also includes any deposition or other pretrial proceeding, including a formal or informal request for testimony by an attorney or any other person.

(e) *Record* has the same meaning as ''record'' in 20 CFR 402.30.

(f) *Request* means any attempt to obtain the production, disclosure, or release of information, records, or the testimony of an SSA employee, including any order, subpoena, or other command issued in a legal proceeding as well as any informal or other attempt (by any method) by a party or a party's representative.

(g) *SSA* means the Social Security Administration.

(h) *Testimony* includes any sworn statement (oral or written), including (but not limited to)—

(1) Any statement provided through personal appearance; deposition; or recorded interview; or provided by telephone, television, or videotape;

(2) Any response during discovery or other similar proceedings that would involve more than the mere physical production of records; and

(3) Any declaration made under penalty of perjury or any affidavit.

(i) *We* or *our* means the Social Security Administration.

(j) *You* or *your* means an individual or entity that submits a request for records, information or testimony.

§ 403.115 When does this part apply?

(a) Except as specified in paragraph (b) of this section, this part applies to any request in connection with any legal proceeding for SSA records or other information or for testimony from SSA or its employees. This part applies to requests for testimony related to SSA's functions or to any information or record created or acquired by SSA as a result of the discharge of its official duties.

(b) This part does not apply to requests for testimony—

(1) In an SSA administrative proceeding;

(2) In a legal proceeding to which SSA is a party (''SSA'' here includes the Commissioner and any employee acting in his or her official capacity);

(3) From the United States Department of Justice;

(4) In a criminal proceeding in which the United States is a party;

(5) In a legal proceeding initiated by state or local authorities arising from an investigation or audit initiated by, or conducted in cooperation with, SSA's Office of the Inspector General;

(6) From either house of Congress;

(7) In a law enforcement proceeding related to threats or acts against SSA, its employees, or its operations (''SSA''

here includes the Commissioner and any employee acting in his or her official capacity); or

(8) Where Federal law or regulations expressly require a Federal employee to provide testimony.

§ 403.120 How do you request testimony?

(a) You must submit a written application for testimony of an SSA employee. Your application must-

(1) Describe in detail the nature and relevance of the testimony sought in the legal proceeding;

(2) Include a detailed explanation as to why you need the testimony, why you cannot obtain the information you need from an alternative source, and why providing it to you would be in SSA's interest; and

(3) Provide the date and time that you need the testimony and the place where SSA would present it.

(b) You must submit a complete application to SSA at least 30 days in advance of the date that you need the testimony. If your application is submitted fewer than 30 days before that date, you must provide, in addition to the requirements set out above, a detailed explanation as to why—

(1) You did not apply in a timely fashion; and

(2) It is in SSA's interest to review the untimely application.

(c) You must send your application for testimony to: Office of the General Counsel, Office of General Law, Social Security Administration, Attn: Touhy Officer, 6401 Security Boulevard, Baltimore, MD, 21235. If you are requesting testimony of an employee of the Office of the Inspector General, send your application to the address in § 403.125.

(d) The Commissioner has the sole discretion to waive any requirement in this section.

(e) If your application does not include each of the items required by paragraph (a) of this section, we may return it to you for additional information. Unless the Commissioner waives one or more requirements, we will not process an incomplete or untimely application.

[66 FR 2809, Jan. 12, 2001; 66 FR 14316, Mar. 12, 2001, as amended at 73 FR 26002, May 8, 2008; 74 FR 16327, Apr. 10, 2009; 79 FR 7577, Feb. 10, 2014; 88 FR 1329, Jan. 10, 2023]

§ 403.125 How will we handle requests for records, information, or testimony involving SSA's Office of the Inspector General?

A request for records or information of the Office of the Inspector General or the testimony of an employee of the Office of the Inspector General will be handled in accordance with the provisions of this part, except that the Inspector General or the Inspector General's designee will make those determinations that the Commissioner otherwise would make. Send your request for records or information pertaining to the Office of the Inspector General or your application for testimony of an employee of the Office of the Inspector General to: Office of the Inspector General, Social Security Administration, 6401 Security Boulevard, Room 3–ME–1, Baltimore, MD 21235. Requests may also be sent via email to *SSA.OIG.Touhy.Requests@ssa.gov*.

[66 FR 2809, Jan. 12, 2001, as amended at 88 FR 1329, Jan. 10, 2023]

§ 403.130 What factors may the Commissioner consider in determining whether SSA will grant your application for testimony?

In deciding whether to authorize the testimony of an SSA employee, the Commissioner will consider applicable law and factors relating to your need and the burden to SSA. The considerations include, but are not limited to, the following:

(a) *Risk of law violation or compromise of Government privilege.* (1) Would providing the testimony violate a statute (such as 26 U.S.C. 6103 or section 1106 of the Social Security Act, 42 U.S.C. 1306), Executive Order, or regulation (such as 20 CFR part 401)?

(2) Would providing the testimony put confidential, sensitive, or privileged information at risk?

(b) *Burden on SSA.* (1) Would granting the application unduly expend for private purposes the resources of the United States (including the time of

SSA employees needed for official duties)?

(2) Would the testimony be available in a less burdensome form or from another source?

(3) Would the testimony be limited to the purpose of the request?

(4) Did you previously request the same testimony in the same or a related proceeding?

(c) *Interests served by allowing testimony.* (1) Would providing the testimony serve SSA's interest?

(2) Would providing the testimony maintain SSA's policy of impartiality among private litigants?

(3) Is another government agency involved in the proceeding?

(4) Do you need the testimony to prevent fraud or similar misconduct?

(5) Would providing the testimony be necessary to prevent a miscarriage of justice or to preserve the rights of an accused individual to due process in a criminal proceeding?

§ 403.135 What happens to your application for testimony?

(a) If 20 CFR part 401 or 402 does not permit disclosure of information about which you seek testimony from an SSA employee, we will notify you under § 403.145.

(b) If 20 CFR part 401 or 402 permits disclosure of the information about which you seek testimony,

(1) The Commissioner makes the final decision on your application;

(2) All final decisions are in the sole discretion of the Commissioner; and

(3) We will notify you of the final decision on your application.

§ 403.140 If the Commissioner authorizes testimony, what will be the scope and form of that testimony?

The employee's testimony must be limited to matters that were specifically approved. We will provide testimony in the form that is least burdensome to SSA unless you provide sufficient information in your application for SSA to justify a different form. For example, we will provide an affidavit or declaration rather than a deposition and a deposition rather than trial testimony.

§ 403.145 What will SSA do if you have not satisfied the conditions in this part or in 20 CFR part 401 or 402?

(a) We will provide the following information, as appropriate, to you or the court or other tribunal conducting the legal proceeding if your request states that a response is due on a particular date and the conditions prescribed in this part, or the conditions for disclosure in 20 CFR part 401 or 402, are not satisfied or we anticipate that they will not be satisfied by that date:

(1) A statement that compliance with the request is not authorized under 20 CFR part 401 or 402, or is prohibited without the Commissioner's approval;

(2) The requirements for obtaining the approval of the Commissioner for testimony or for obtaining information, records, or testimony under 20 CFR part 401 or 402; and

(3) If the request complies with § 403.120, the estimated time necessary for a decision. We will make every reasonable effort to provide this information in writing on or before the date specified in your request.

(b) Generally, if a response to a request for information, records, or testimony is due before the conditions of this part or the conditions for disclosure in 20 CFR part 401 or 402 are met, no SSA employee will appear.

(c) SSA will seek the advice and assistance of the Department of Justice when appropriate.

§ 403.150 Is there a fee for our services?

(a) *General.* Unless the Commissioner grants a waiver, you must pay fees for our services in providing information, records, or testimony. You must pay the fees as prescribed by the Commissioner. In addition, the Commissioner may require that you pay the fees in advance as a condition of providing the information, records, or testimony. Make fees payable to the Social Security Administration by check or money order.

(b) *Records or information.* Unless the Commissioner grants a waiver, you must pay the fees for production of records or information prescribed in 20 CFR §§ 401.95 and 402.155 through 402.185, as appropriate.

(c) *Testimony.* Unless the Commissioner grants a waiver, you must pay fees calculated to reimburse the United States Government for the full cost of providing the testimony. Those costs include, but are not limited to—

(1) The salary or wages of the witness and related costs for the time necessary to prepare for and provide the testimony and any travel time, and

(2) Other travel costs.

(d) *Waiver or reduction of fees.* The Commissioner may waive or reduce fees for providing information, records, or testimony under this part. The rules in 20 CFR §402.185 apply in determining whether to waive fees for the production of records. In deciding whether to waive or reduce fees for testimony or for production of information that does not constitute a record, the Commissioner may consider other factors, including but not limited to—

(1) The ability of the party responsible for the application to pay the full amount of the chargeable fees;

(2) The public interest, as described in 20 CFR §402.185, affected by complying with the application;

(3) The need for the testimony or information in order to prevent a miscarriage of justice;

(4) The extent to which providing the testimony or information serves SSA's interest; and

(5) The burden on SSA's resources required to provide the information or testimony.

§ 403.155 Does SSA certify records?

We can certify the authenticity of copies of records we disclose pursuant to 20 CFR parts 401 and 402, and this part. We will provide this service only in response to your written request. If we certify, we will do so at the time of the disclosure and will not certify copies of records that have left our custody. A request for certified copies of records previously released is considered a new request for records. Fees for this certification are set forth in 20 CFR 402.165(e).

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Subpart A—Introduction, General Provisions and Definitions

AUTHORITY: Secs. 203, 205(a), 216(j), and 702(a)(5) of the Social Security Act (42 U.S.C. 403, 405(a), 416(j), and 902(a)(5)) and 48 U.S.C. 1801.

§ 404.1 Introduction.

The regulations in this part 404 (Regulations No. 4 of the Social Security Administration) relate to the provisions of title II of the Social Security Act as amended on August 28, 1950, and as further amended thereafter. The regulations in this part are divided into 22 subparts:

(a) Subpart A contains provisions relating to general definitions and use of terms.

(b) Subpart B relates to quarters of coverage and insured status requirements.

(c) Subpart C relates to the computation and recomputation of the primary insurance amount.

(d) Subpart D relates to the requirements for entitlement to monthly benefits and to the lump-sum death payment duration of entitlement and benefit rates.

(e) Subpart E contains provisions relating to the reduction and increase of insurance benefits and to deductions from benefits and lump-sum death payments.

(f) Subpart F relates to overpayments, underpayments, waiver of adjustment or recovery of overpayments and liability of certifying officers.

(g) Subpart G relates to filing of applications and other forms.

(h) Subpart H relates to evidentiary requirements for establishing an initial and continuing right to monthly benefits and for establishing a right to lump-sum death payment. (Evidentiary requirements relating to disability are contained in subpart P.)

(i) Subpart I relates to maintenance and revision of records of wages and self-employment income.

(j) Subpart J relates to initial determinations, the administrative review process, and reopening of determinations and decisions.

(k) Subpart K relates to employment, wages, self-employment and self-employment income.

(l) Subpart L is reserved.

(m) Subpart M relates to coverage of employees of State and local Governments.

(n) Subpart N relates to benefits in cases involving veterans.

(o) Subpart O relates to the interrelationship of the old-age, survivors and disability insurance program with the railroad retirement program.

(p) Subpart P relates to the determination of disability or blindness.

(q) Subpart Q relates to standards, requirements and procedures for States making determinations of disability for the Commissioner. It also sets out the Commissioner's responsibilities in carrying out the disability determination function.

(r) Subpart R relates to the provisions applicable to attorneys and other individuals who represent applicants in connection with claims for benefits.

(s) Subpart S relates to the payment of benefits to individuals who are entitled to benefits.

(t) Subpart T relates to the negotiation and administration of totalization agreements between the United States and foreign countries.

(u) Subpart U relates to the selection of a representative payee to receive benefits on behalf of a beneficiary and to the duties and responsibilities of a representative payee.

(v) Subpart V relates to payments to State vocational rehabilitative agencies for vocational rehabilitation services.

[26 FR 7054, Aug. 5, 1961; 26 FR 7760, Aug. 19, 1961, as amended at 27 FR 4513, May 11, 1962; 28 FR 14492, Dec. 31, 1963; 51 FR 11718, Apr. 7, 1986; 62 FR 38450, July 18, 1997; 83 FR 62456, Dec. 4, 2018]

§ 404.2 General definitions and use of terms.

(a) *Terms relating to the Act and regulations.* (1) *The Act* means the Social Security Act, as amended (42 U.S.C. Chapter 7).

(2) *Section* means a section of the regulations in part 404 of this chapter unless the context indicates otherwise.

(b) *Commissioner; Appeals Council; Administrative Law Judge; Administrative Appeals Judge defined*—(1) *Commissioner* means the Commissioner of Social Security.

(2) *Appeals Council* means the Appeals Council of the Office of Analytics, Review, and Oversight in the Social Security Administration or such member or members thereof as may be designated by the Chair of the Appeals Council.

(3) *Administrative Law Judge* means an Administrative Law Judge in the Office of Hearings Operations in the Social Security Administration.

(4) *Administrative Appeals Judge* means an Administrative Appeals Judge serving as a member of the Appeals Council.

(c) *Miscellaneous.* (1) *Certify,* when used in connection with the duty imposed on the Commissioner by section 205(i) of the act, means that action taken by the Administration in the form of a written statement addressed to the Managing Trustee, setting forth the name and address of the person to whom payment of a benefit or lump sum, or any part thereof, is to be made, the amount to be paid, and the time at which payment should be made.

(2) *Benefit* means an old-age insurance benefit, disability insurance benefit, wife's insurance benefit, husband's insurance benefit, child's insurance benefit, widow's insurance benefit, widower's insurance benefit, mother's insurance benefit, father's insurance benefit, or parent's insurance benefit under Title II of the Act. (Lump sums, which are death payments under title II of the Act, are excluded from the term benefit as defined in this part to permit greater clarity in the regulations.)

(3) *Lump sum* means a lump-sum death payment under title II of the act or any person's share of such a payment.

(4) *Attainment of age.* An individual attains a given age on the first moment of the day preceding the anniversary of his birth corresponding to such age.

(5) *State,* unless otherwise indicated, includes:

(i) The District of Columbia,

(ii) The Virgin Islands,

(iii) The Commonwealth of Puerto Rico effective January 1, 1951,

(iv) Guam and American Samoa, effective September 13, 1960, generally, and for purposes of sections 210(a) and 211 of the Act effective after 1960 with respect to service performed after 1960, and effective for taxable years beginning after 1960 with respect to crediting net earnings from self-employment and self-employment income,

(v) The Territories of Alaska and Hawaii prior to January 3, 1959, and August 21, 1959, respectively, when those territories acquired statehood, and

(vi) The Commonwealth of the Northern Mariana Islands (CNMI) effective January 1, 1987; Social Security coverage for affected temporary employees of the government of the CNMI is also effective on January 1, 1987, under section 210(a)(7)(E) of the Social Security Act. In addition, Social Security coverage for affected non-temporary employees of the government of the CNMI is effective on October 1, 2012, under section 210(a)(7)(C) of the Social Security Act.

(6) *United States,* when used in a geographical sense, includes, unless otherwise indicated:

(i) The States,

(ii) The Territories of Alaska and Hawaii prior to January 3, 1959, and August 21, 1959, respectively, when they acquired statehood,

(iii) The District of Columbia,

(iv) The Virgin Islands,

(v) The Commonwealth of Puerto Rico effective January 1, 1951, (vi) Guam and American Samoa, effective September 13, 1960, generally, and for purposes of sections 210(a) and 211 of the Act, effective after 1960 with respect to service performed after 1960, and effective for taxable years beginning after 1960 with respect to crediting net earnings from self-employment and self-employment income, and

(vii) The Commonwealth of the Northern Mariana Islands effective January 1, 1987.

(7) Masculine gender includes the feminine, unless otherwise indicated.

(8) The terms defined in sections 209, 210, and 211 of the act shall have the meanings therein assigned to them.

[26 FR 7055, Aug. 5, 1961; 26 FR 7760, Aug. 19, 1961, as amended at 28 FR 1037, Feb. 2, 1963; 28 FR 14492, Dec. 31, 1963; 29 FR 15509, Nov. 19, 1964; 41 FR 32886, Aug. 6, 1976; 51 FR 11718, Apr. 7, 1986; 61 FR 41330, Aug. 8, 1996; 62 FR 38450, July 18, 1997; 69 FR 51555, Aug. 20, 2004; 79 FR 33684, June 12, 2014; 83 FR 21708, May 10, 2018; 85 FR 73156, Nov. 16, 2020]

§ 404.3 General provisions.

(a) *Effect of cross references.* The cross references in the regulations in this part 404 to other portions of the regulations, when the word *see* is used, are made only for convenience and shall be given no legal effect.

(b) *Periods of limitation ending on nonwork days.* Pursuant to the provisions of section 216(j) of the act, effective September 13, 1960, where any provision of title II, or any provision of another law of the United States (other than the Internal Revenue Code of 1954) relating to or changing the effect of title II, or any regulation of the Commissioner issued under title II, provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday or Federal legal holiday or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive Order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees either by statute or Executive Order. For purposes of this paragraph, the day on which a period ends shall include the final day of any extended period where such extension is authorized by law or by the Commissioner pursuant to law. Such extension of any period of limitation does not apply to periods during which benefits may be paid for months prior to the month an application for such benefits is filed pursuant to § 404.621, or to periods during which an application for benefits may be accepted as such pursuant to § 404.620.

[26 FR 7055, Aug. 5, 1961, as amended at 29 FR 15509, Nov. 19, 1964; 51 FR 11718, Apr. 7, 1986; 61 FR 41330, Aug. 8, 1996; 62 FR 38450, July 18, 1997]

Subpart B—Insured Status and Quarters of Coverage

AUTHORITY: Secs. 205(a), 212, 213, 214, 216, 217, 223, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 412, 413, 414, 416, 417, 423, and 902(a)(5)).

SOURCE: 45 FR 25384, Apr. 15, 1980, unless otherwise noted.

GENERAL

§ 404.101 Introduction.

(a) *Insured status.* This subpart explains what we mean when we say that a person has insured status under the social security program. It also describes how a person may become fully insured, currently insured or insured for disability benefits. Your insured status is a basic factor in determining if you are entitled to old-age or disability insurance benefits or to a period of disability. It is also a basic factor in determining if dependents' or survivors' insurance benefits or a lump-sum death payment are payable based on your earnings record. If you are neither fully nor currently insured, no benefits are payable based on your earnings. (Subpart D of this part describes these benefits and the kind of insured status required for each.) In §§ 404.110 through 404.120 we tell how we determine if you are fully or currently insured. The rules for determining if you are insured for purposes of establishing a period of disability or becoming entitled to disability insurance benefits are in §§ 404.130 through 404.133. Whether you have the required insured status depends on the number of quarters of coverage (QCs) you have acquired.

(b) *QCs.* This subpart also sets out our rules on crediting you with QCs. QCs are used in determining insured

status. In general, you are credited with QCs based on the wages you are paid and the self-employment income you derive during certain periods. (See subpart K of this part for a definition of *wages* and *self-employment income*.) Our rules on how and when you acquire a QC are contained in §§ 404.140 through 404.146.

§ 404.102 Definitions.

For the purpose of this subpart—

Act means the Social Security Act, as amended.

Age means how many years old you are. You reach a particular age on the day before your birthday. For example, if your sixty-second birthday is on July 1, 1979, you became age 62 on June 30, 1979.

Quarter or *calendar quarter* means a period of three calendar months ending March 31, June 30, September 30, or December 31 of any year.

We, *our*, or *us* means the Social Security Administration.

You or *your* means the worker whose insured status is being considered.

FULLY INSURED STATUS

§ 404.110 How we determine fully insured status.

(a) *General.* We describe how we determine the number of quarters of coverage (QCs) you need to be fully insured in paragraphs (b), (c), and (d) of this section. The table in § 404.115 may be used to determine the number of QCs you need to be fully insured under paragraph (b) of this section. We consider certain World War II veterans to have died fully insured (see § 404.111). We also consider certain employees of private nonprofit organizations to be fully insured if they meet special requirements (see § 404.112).

(b) *How many QCs you need to be fully insured.* (1) You need at least 6 QCs but not more than 40 QCs to be fully insured. A person who died before 1951 with at least 6 QCs is fully insured.

(2) You are fully insured for old-age insurance benefits if you have one QC (whenever acquired) for each calendar year elapsing after 1950 or, if later, after the year in which you became age 21, and before the year you reach retirement age, that is, before—

(i) The year you become age 62, if you are a woman;

(ii) The year you become age 62, if you are a man who becomes age 62 after 1974;

(iii) The year 1975, if you are a man who became age 62 in 1973 or 1974; or

(iv) The year you became age 65, if you are a man who became age 62 before 1973.

(3) A person who is otherwise eligible for survivor's benefits and who files an application will be entitled to benefits based on your earnings if you die fully insured. You will be fully insured if you had one QC (whenever acquired) for each calendar year elapsing after 1950 or, if later, after the year you became age 21, and before the earlier of the following years:

(i) The year you die; or

(ii) The year you reach retirement age as shown in paragraph (b)(2) of this section.

(c) *How a period of disability affects the number of QCs you need.* In determining the number of elapsed years under paragraph (b) of this section, we do not count as an elapsed year any year which is wholly or partly in a period of disability we established for you. For example, if we established a period of disability for you from December 5, 1975 through January 31, 1977, the three years, 1975, 1976 and 1977, would not be counted as elapsed years.

(d) *How we credit QCs for fully insured status based on your total wages before 1951*—(1) *General.* For purposes of paragraph (b) of this section, we may use the following rules in crediting QCs based on your wages before 1951 instead of the rule in § 404.141(b)(1).

(i) We may consider you to have one QC for each $400 of your total wages before 1951, as defined in paragraph (d)(2) of this section, if you have at least 7 elapsed years as determined under paragraph (b)(2) or (b)(3) of this section; and the number of QCs determined under this paragraph plus the number of QCs credited to you for periods after 1950 make you fully insured.

(ii) If you file an application in June 1992 or later and you are not entitled to a benefit under section 227 of the Act in the month the application is made, we may consider you to have at least one QC before 1951 if you have $400 or more

total wages before 1951, as defined in paragraph (d)(2) of this section, provided that the number of QCs credited to you under this paragraph plus the number of QCs credited to you for periods after 1950 make you fully insured.

(2) *What are total wages before 1951.* For purposes of paragraph (d)(1) of this section, your total wages before 1951 include—

(i) Remuneration credited to you before 1951 on the records of the Secretary;

(ii) Wages considered paid to you before 1951 under section 217 of the Act (relating to benefits in case of veterans);

(iii) Compensation under the Railroad Retirement Act of 1937 before 1951 that can be credited to you under title II of the Social Security Act; and

(iv) Wages considered paid to you before 1951 under section 231 of the Act (relating to benefits in case of certain persons interned in the United States during World War II).

(e) *When your fully insured status begins.* You are fully insured as of the first day of the calendar quarter in which you acquire the last needed QC (see § 404.145).

[45 FR 25384, Apr. 15, 1980, as amended at 50 FR 36573, Sept. 9, 1985; 57 FR 23156, June 2, 1992; 83 FR 21708, May 10, 2018]

§ 404.111 When we consider a person fully insured based on World War II active military or naval service.

We consider that a person, who was not otherwise fully insured, died fully insured if—

(a) The person was in the active military or naval service of the United States during World War II;

(b) The person died within three years after separation from service and before July 27, 1954; and

(c) The conditions in § 404.1350 that permit us to consider the person fully insured are met.

(d) The provisions of this section do not apply to persons filing applications after May 31, 1992, unless a survivor is entitled to benefits under section 202 of the Act based on the primary insurance amount of the fully insured person for the month preceding the month in which the application is made.

[45 FR 25384, Apr. 15, 1980, as amended at 57 FR 23157, June 2, 1992]

§ 404.112 When we consider certain employees of private nonprofit organizations to be fully insured.

If you are age 55 or over on January 1, 1984, and are on that date an employee of an organization described in § 404.1025(a) which does not have in effect a waiver certificate under section 3121(k) of the Code on that date and whose employees are mandatorily covered as a result of section 102 of Pub. L. 98–21, we consider you to be fully insured if you meet the following requirements:

Your age on January 1, 1984 is—	QC's acquired after Dec. 31, 1983
60 or over	6
59 or over but less than age 60	8
58 or over but less than age 59	12
57 or over but less than age 58	16
55 or over but less than age 57	20

[50 FR 36573, Sept. 9, 1985]

§ 404.115 Table for determining the quarters of coverage you need to be fully insured.

(a) *General.* You may use the following table to determine the number of quarters of coverage (QCs) you need to be fully insured under § 404.110. Paragraphs (b) and (c) of this section tell you how to use this table.

Worker who reaches retirement age as described in § 404.110(b)(2)			Worker who dies before reaching retirement age as described in § 404.110(b)(2)		
Col. I—Date of birth	Col. II [1]		Col. III [2]—Year of death	Col. IV [3]	Col. V [4]—Age in year of death
	Men	Women			
Jan. 1, 1893 or earlier	6	6	[5] 1957	6	[6] 28
Jan. 2, 1893 to Jan. 1, 1894	7	6	1958	7	29
Jan. 2, 1894 to Jan. 1, 1895	8	6	1959	8	30
Jan. 2, 1895 to Jan. 1, 1896	9	6	1960	9	31
Jan. 2, 1896 to Jan. 1, 1897	10	7	1961	10	32
Jan. 2, 1897 to Jan. 1, 1898	11	8	1962	11	33

Worker who reaches retirement age as described in § 404.110(b)(2)			Worker who dies before reaching retirement age as described in § 404.110(b)(2)		
Col. I—Date of birth	Col. II [1]		Col. III [2]—Year of death	Col. IV [3]	Col. V [4]—Age in year of death
	Men	Women			
Jan. 2, 1898 to Jan. 1, 1899	12	9	1963	12	34
Jan. 2, 1899 to Jan. 1, 1900	13	10	1964	13	35
Jan. 2, 1900 to Jan. 1, 1901	14	11	1965	14	36
Jan. 2, 1901 to Jan. 1, 1902	15	12	1966	15	37
Jan. 2, 1902 to Jan. 1, 1903	16	13	1967	16	38
Jan. 2, 1903 to Jan. 1, 1904	17	14	1968	17	39
Jan. 2, 1904 to Jan. 1, 1905	18	15	1969	18	40
Jan. 2, 1905 to Jan. 1, 1906	19	16	1970	19	41
Jan. 2, 1906 to Jan. 1, 1907	20	17	1971	20	42
Jan. 2, 1907 to Jan. 1, 1908	21	18	1972	21	43
Jan. 2, 1908 to Jan. 1, 1909	22	19	1973	22	44
Jan. 2, 1909 to Jan. 1, 1910	23	20	1974	23	45
Jan. 2, 1910 to Jan. 1, 1911	24	21	1975	24	46
Jan. 2, 1911 to Jan. 1, 1912	24	22	1976	25	47
Jan. 2, 1912 to Jan. 1, 1913	24	23	1977	26	48
Jan. 2, 1913 to Jan. 1, 1914	24	24	1978	27	49
Jan. 2, 1914 to Jan. 1, 1915	25	25	1979	28	50
Jan. 2, 1915 to Jan. 1, 1916	26	26	1980	29	51
Jan. 2, 1916 to Jan. 1, 1917	27	27	1981	30	52
Jan. 2, 1917 to Jan. 1, 1918	28	28	1982	31	53
Jan. 2, 1918 to Jan. 1, 1919	29	29	1983	32	54
Jan. 2, 1919 to Jan. 1, 1920	30	30	1984	33	55
Jan. 2, 1920 to Jan. 1, 1921	31	31	1985	34	56
Jan. 2, 1921 to Jan. 1, 1922	32	32	1986	35	57
Jan. 2, 1922 to Jan. 1, 1923	33	33	1987	36	58
Jan. 2, 1923 to Jan. 1, 1924	34	34	1988	37	59
Jan. 2, 1924 to Jan. 1, 1925	35	35	1989	38	60
Jan. 2, 1925 to Jan. 1, 1926	36	36	1990	39	61
Jan. 2, 1926 to Jan. 1, 1927	37	37	[7] 1991	40	62
Jan. 2, 1927 to Jan. 1, 1928	38	38	.....	.....	.....
Jan. 2, 1928 to Jan. 1, 1929	39	39	.....	.....	.....
Jan. 2, 1929 or later	40	.....	.....	.....	

[1] Number of QCs required for fully insured status; living worker or worker who dies after reaching retirement age.
[2] Worker born before Jan. 2, 1930 who dies before reaching retirement age.
[3] Number of QCs required for fully insured status.
[4] Worker born Jan. 2, 1930 or later, who dies before reaching retirement age.
[5] Or earlier.
[6] Or younger.
[7] Or later.

(b) *Number of QCs you need.* The QCs you need for fully insured status are in column II opposite your date of birth in column I. If a worker dies before reaching retirement age as described in § 404.110(b)(2), the QCs needed for fully insured status are shown in column IV opposite—

(1) The year of death in column III, if the worker was born before January 2, 1930; or

(2) The age in the year of death in column V, if the worker was born after January 1, 1930.

(c) *How a period of disability affects the number of QCs you need.* If you had a period of disability established for you, it affects the number of QCs you need to be fully insured (see § 404.110(c)). For each year which is wholly or partly in a period of disability, subtract one QC from the number of QCs shown in the appropriate line and column of the table as explained in paragraph (b) of this section.

CURRENTLY INSURED STATUS

§ 404.120 How we determine currently insured status.

(a) *What the period is for determining currently insured status.* You are currently insured if you have at least 6 quarters of coverage (QCs) during the 13-quarter period ending with the quarter in which you—

(1) Die;

(2) Most recently became entitled to disability insurance benefits; or

(3) Became entitled to old-age insurance benefits.

(b) *What quarters are not counted as part of the 13-quarter period.* We do not count as part of the 13-quarter period

any quarter all or part of which is included in a period of disability established for you, except that the first and last quarters of the period of disability may be counted if they are QCs (see § 404.146(d)).

DISABILITY INSURED STATUS

§ 404.130 How we determine disability insured status.

(a) *General.* We have four different rules for determining if you are insured for purposes of establishing a period of disability or becoming entitled to disability insurance benefits. To have disability insured status, you must meet one of these rules and you must be fully insured (see § 404.132 which tells when the period ends for determining the number of quarters of coverage (QCs) you need to be fully insured).

(b) *Rule I—You must meet the 20/40 requirement.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You are fully insured; and

(2) You have at least 20 QCs in the 40-quarter period (see paragraph (f) of this section) ending with that quarter.

(c) *Rule II—You become disabled before age 31.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You have not become (or would not become) age 31;

(2) You are fully insured; and

(3) You have QCs in at least one-half of the quarters during the period ending with that quarter and beginning with the quarter after the quarter you became age 21; however—

(i) If the number of quarters during this period is an odd number, we reduce the number by one; and

(ii) If the period has less than 12 quarters, you must have at least 6 QCs in the 12-quarter period ending with that quarter.

(d) *Rule III—You had a period of disability before age 31.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You are disabled again at age 31 or later after having had a prior period of disability established which began before age 31 and for which you were only insured under paragraph (c) of this section; and

(2) You are fully insured and have QCs in at least one-half the calendar quarters in the period beginning with the quarter after the quarter you became age 21 and through the quarter in which the later period of disability begins, up to a maximum of 20 QCs out of 40 calendar quarters; however—

(i) If the number of quarters during this period is an odd number, we reduce the number by one;

(ii) If the period has less than 12 quarters, you must have at least 6 QCs in the 12-quarter period ending with that quarter; and

(iii) No monthly benefits may be paid or increased under Rule III before May 1983.

(e) *Rule IV—You are statutorily blind.* You are insured in a quarter for purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

(1) You are disabled by blindness as defined in § 404.1581; and

(2) You are fully insured.

(f) *How we determine the 40-quarter or other period.* In determining the 40-quarter period or other period in paragraph (b), (c), or (d) of this section, we do not count any quarter all or part of which is in a prior period of disability established for you, unless the quarter is the first or last quarter of this period and the quarter is a QC. However, we will count all the quarters in the prior period of disability established for you if by doing so you would be entitled to benefits or the amount of the benefit would be larger.

[49 FR 28547, July 13, 1984, as amended at 55 FR 7313, Mar. 1, 1990]

§ 404.131 When you must have disability insured status.

(a) *For a period of disability.* To establish a period of disability, you must have disability insured status in the quarter in which you become disabled or in a later quarter in which you are disabled.

(b) *For disability insurance benefits.* (1) To become entitled to disability insurance benefits, you must have disability insured status in the first full month that you are disabled as described in § 404.1501(a), or if later—

(i) The 17th month (if you have to serve a waiting period described in § 404.315(d)) before the month in which you file an application for disability insurance benefits; or

(ii) The 12th month (if you do not have to serve a waiting period) before the month in which you file an application for disability insurance benefits.

(2) If you do not have disability insured status in a month specified in paragraph (b)(1) of this section, you will be insured for disability insurance benefits beginning with the first month after that month in which you do meet the insured status requirement and you also meet all other requirements for disability insurance benefits described in § 404.315.

§ 404.132 How we determine fully insured status for a period of disability or disability insurance benefits.

In determining if you are fully insured for purposes of paragraph (b), (c), (d), or (e) of § 404.130 on disability insured status, we use the fully insured status requirements in § 404.110, but apply the following rules in determining when the period of elapsed years ends:

(a) If you are a woman, or a man born after January 1, 1913, the period of elapsed years in § 404.110(b) used in determining the number of quarters of coverage (QCs) you need to be fully insured ends as of the earlier of—

(1) The year you become age 62; or

(2) The year in which—

(i) Your period of disability begins;

(ii) Your waiting period begins (see § 404.315(d)); or

(iii) You become entitled to disability insurance benefits (if you do not have to serve a waiting period).

(b) If you are a man born before January 2, 1913, the period of elapsed years in § 404.110(b) used in determining the number of QCs you need to be fully insured ends as of the earlier of—

(1) The year 1975; or

(2) The year specified in paragraph (a)(2) of this section.

[45 FR 25384, Apr. 15, 1980, as amended at 49 FR 28547, July 13, 1984]

§ 404.133 When we give you quarters of coverage based on military service to establish a period of disability.

For purposes of establishing a period of disability only, we give you quarters of coverage (QCs) for your military service before 1957 (see subpart N of this part). We do this even though we may not use that military service for other purposes of title II of the Act because a periodic benefit is payable from another Federal agency based in whole or in part on the same period of military service.

QUARTERS OF COVERAGE

§ 404.140 What is a quarter of coverage.

(a) *General.* A quarter of coverage (QC) is the basic unit of social security coverage used in determining a worker's insured status. We credit you with QCs based on your earnings covered under social security.

(b) *How we credit QCs based on earnings before 1978 (General).* Before 1978, wages were generally reported on a quarterly basis and self-employment income was reported on an annual basis. For the most part, we credit QCs for calendar years before 1978 based on your quarterly earnings. For these years, as explained in § 404.141, we generally credit you with a QC for each calendar quarter in which you were paid at least $50 in wages or were credited with at least $100 of self-employment income. Section 404.142 tells how self-employment income derived in a taxable year beginning before 1978 is credited to specific calendar quarters for purposes of § 404.141.

(c) *How we credit QCs based on earnings after 1977 (General).* After 1977, both wages and self-employment income are generally reported on an annual basis. For calendar years after 1977, as explained in § 404.143, we generally credit you with a QC for each part of your total covered earnings in a calendar year that equals the amount required for a QC in that year. Section 404.143 also tells how the amount required for

a QC will be increased in the future as average wages increase. Section 404.144 tells how self-employment income derived in a taxable year beginning after 1977 is credited to specific calendar years for purposes of § 404.143.

(d) *When a QC is acquired and when a calendar quarter is not a QC (general).* Section 404.145 tells when a QC is acquired and § 404.146 tells when a calendar quarter cannot be a QC. These rules apply when we credit QCs under § 404.141 or § 404.143.

§ 404.141 How we credit quarters of coverage for calendar years before 1978.

(a) *General.* The rules in this section tell how we credit calendar quarters as quarters of coverage (QCs) for calendar years before 1978. We credit you with a QC for a calendar quarter based on the amount of wages you were paid and self-employment income you derived during certain periods. The rules in paragraphs (b), (c), and (d) of this section are subject to the limitations in § 404.146, which tells when a calendar quarter cannot be a QC.

(b) *How we credit QCs based on wages paid in, or self-employment income credited to, a calendar quarter.* We credit you with a QC for a calendar quarter in which—

(1) You were paid wages of $50 or more (see paragraph (c) of this section for an exception relating to wages paid for agricultural labor); or

(2) You were credited (under § 404.142) with self-employment income of $100 or more.

(c) *How we credit QCs based on wages paid for agricultural labor in a calendar year after 1954.* (1) We credit QCs based on wages for agricultural labor depending on the amount of wages paid during a calendar year for that work. If you were paid wages for agricultural labor in a calendar year after 1954 and before 1978, we credit you with QCs for calendar quarters in that year which are not otherwise QCs according to the following table.

If the wages paid to you in a calendar year for agricultural labor were	We credit you with	And assign: [1]
$400 or more	4 QCs	All.
At least $300 but less than $400.	3 QCs	Last 3.
At least $200 but less than $300.	2 QCs	Last 2.
At least $100 but less than $200.	1 QC	Last.
Less than $100	No QCs.	

[1] One QC to each of the following calendar quarters in that year.

(2) When we assign QCs to calendar quarters in a year as shown in the table in paragraph (c)(1) of this section, you might not meet (or might not meet as early in the year as otherwise possible) the requirements to be fully or currently insured, to be entitled to a computation or recomputation of your primary insurance amount, or to establish a period of disability. If this happens, we assign the QCs to different quarters in that year than those shown in the table if this assignment permits you to meet these requirements (or meet them earlier in the year). We can only reassign QCs for purposes of meeting these requirements.

(d) *How we credit QCs based on wages paid or self-employment income derived in a year.* (1) If you were paid wages in a calendar year after 1950 and before 1978 at least equal to the annual wage limitation in effect for that year as described in §§ 404.1047 and 404.1096, we credit you with a QC for each quarter in that calendar year. If you were paid at least $3,000 wages in a calendar year before 1951, we credit you with a QC for each quarter in that calendar year.

(2) If you derived self-employment income (or derived self-employment income and also were paid wages) during a taxable year beginning after 1950 and before 1978 at least equal to the self-employment income and wage limitation in effect for that year as described in § 404.1068(b), we credit you with a QC for each calendar quarter wholly or partly in that taxable year.

[45 FR 25384, Apr. 15, 1980; 45 FR 41931, June 23, 1980, as amended at 70 FR 14977, Mar. 24, 2005]

§ 404.142 How we credit self-employment income to calendar quarters for taxable years beginning before 1978.

In crediting quarters of coverage under § 404.141(b)(2), we credit any self-

employment income you derived during a taxable year that began before 1978 to calendar quarters as follows:

(a) If your taxable year was a calendar year, we credit your self-employment income equally to each quarter of that calendar year.

(b) If your taxable year was not a calendar year (that is, it began on a date other than January 1, or was less than a calendar year), we credit your self-employment income equally—

(1) To the calendar quarter in which your taxable year ended; and

(2) To each of the next three or fewer preceding quarters that were wholly or partly in your taxable year.

§ 404.143 How we credit quarters of coverage for calendar years after 1977.

(a) *Crediting quarters of coverage (QCs).* For calendar years after 1977, we credit you with a QC for each part of the total wages paid and self-employment income credited (under § 404.144) to you in a calendar year that equals the amount required for a QC in that year. For example, if the total of your wages and self-employment income for a calendar year is more than twice, but less than 3 times, the amount required for a QC in that year, we credit you with only 2 QCs for the year. The rules for crediting QCs in this section are subject to the limitations in § 404.146, which tells when a calendar quarter cannot be a QC. In addition, we cannot credit you with more than four QCs for any calendar year. The amount of wages and self-employment income that you must have for each QC is—

(1) $250 for calendar year 1978; and

(2) For each calendar year after 1978, an amount determined by the Commissioner for that year (on the basis of a formula in section 213(d)(2) of the Act which reflects national increases in average wages). The amount determined by the Commissioner is published in the FEDERAL REGISTER on or before November 1 of the preceding year and included in the appendix to this subpart.

(b) *Assigning QCs.* We assign a QC credited under paragraph (a) of this section to a specific calendar quarter in the calendar year only if the assignment is necessary to—

(1) Give you fully or currently insured status;

(2) Entitle you to a computation or recomputation of your primary insurance amount; or

(3) Permit you to establish a period of disability.

[45 FR 25834, Apr. 15, 1980, as amended at 62 FR 38450, July 18, 1997]

§ 404.144 How we credit self-employment income to calendar years for taxable years beginning after 1977.

In crediting quarters of coverage under § 404.143(a), we credit self-employment income you derived during a taxable year that begins after 1977 to calendar years as follows:

(a) If your taxable year is a calendar year or begins and ends within the same calendar year, we credit your self-employment income to that calendar year.

(b) If your taxable year begins in one calendar year and ends in the following calendar year, we allocate proportionately your self-employment income to the two calendar years on the basis of the number of months in each calendar year which are included completely within your taxable year. We consider the calendar month in which your taxable year ends as included completely within your taxable year.

Example: For the taxable year beginning May 15, 1978, and ending May 14, 1979, your self-employment income is $1200. We credit 7/12 ($700) of your self-employment income to calendar year 1978 and 5/12 ($500) of your self-employment income to calendar year 1979.

§ 404.145 When you acquire a quarter of coverage.

If we credit you with a quarter of coverage (QC) for a calendar quarter under paragraph (b), (c), or (d) of § 404.141 for calendar years before 1978 or assign it to a specific calendar quarter under paragraph (b) of § 404.143 for calendar years after 1977, you acquire the QC as of the first day of the calendar quarter.

§ 404.146 When a calendar quarter cannot be a quarter of coverage.

This section applies when we credit you with quarters of coverage (QCs) under § 404.141 for calendar years before 1978 and under § 404.143 for calendar

years after 1977. We cannot credit you with a QC for—

(a) A calendar quarter that has not begun;

(b) A calendar quarter that begins after the quarter of your death;

(c) A calendar quarter that has already been counted as a QC; or

(d) A calendar quarter that is included in a period of disability established for you, unless—

(1) The quarter is the first or the last quarter of this period; or

(2) The period of disability is not taken into consideration (see § 404.320(a)).

APPENDIX TO SUBPART B OF PART 404—QUARTER OF COVERAGE AMOUNTS FOR CALENDAR YEARS AFTER 1978

This appendix shows the amount determined by the Commissioner that is needed for a quarter of coverage for each year after 1978 as explained in § 404.143. We publish the amount as a Notice in the FEDERAL REGISTER on or before November 1 of the preceding year. The amounts determined by the Commissioner are as follows:

Calendar year	Amount needed
1979	$260
1980	290
1981	310
1982	340
1983	370
1984	390
1985	410
1986	440
1987	460
1988	470
1989	500
1990	520
1991	540
1992	570

[45 FR 25384, Apr. 15, 1980, as amended at 52 FR 8247, Mar. 17, 1987; 57 FR 44096, Sept. 24, 1992; 62 FR 38450, July 18, 1997]

Subpart C—Computing Primary Insurance Amounts

AUTHORITY: Secs. 202(a), 205(a), 215, and 702(a)(5) of the Social Security Act (42 U.S.C. 402(a), 405(a), 415, and 902(a)(5)).

SOURCE: 47 FR 30734, July 15, 1982, unless otherwise noted.

GENERAL

§ 404.201 What is included in this subpart?

In this subpart we describe how we compute your primary insurance amount (PIA), how and when we will recalculate or recompute your PIA to include credit for additional earnings, and how we automatically adjust your PIA to reflect changes in the cost of living.

(a) *What is my primary insurance amount?* Your primary insurance amount (PIA) is the basic figure we use to determine the monthly benefit amount payable to you and your family. For example, if you retire in the month you attain full retirement age (as defined in § 404.409) or if you become disabled, you will be entitled to a monthly benefit equal to your PIA. If you retire prior to full retirement age your monthly benefit will be reduced as explained in §§ 404.410–404.413. Benefits to other members of your family are a specified percentage of your PIA as explained in subpart D. Total benefits to your family are subject to a maximum as explained in § 404.403.

(b) *How is this subpart organized?* (1) In §§ 404.201 through 404.204, we explain some introductory matters.

(2) In §§ 404.210 through 404.213, we describe the average-indexed-monthly-earnings method we use to compute the primary insurance amount (PIA) for workers who attain age 62 (or become disabled or die before age 62) after 1978.

(3) In §§ 404.220 through 404.222, we describe the average-monthly-wage method we use to compute the PIA for workers who attain age 62 (or become disabled or die before age 62) before 1979.

(4) In §§ 404.230 through 404.233, we describe the guaranteed alternative method we use to compute the PIA for people who attain age 62 after 1978 but before 1984.

(5) In §§ 404.240 through 404.243, we describe the old-start method we use to compute the PIA for those who had all or substantially all of their social security covered earnings before 1951.

(6) In §§ 404.250 through 404.252, we describe special rules we use to compute the PIA for a worker who previously had a period of disability.

(7) In §§ 404.260 through 404.261, we describe how we compute the special minimum PIA for long-term, low-paid workers.

(8) In §§ 404.270 through 404.278, we describe how we automatically increase your PIA because of increases in the cost of living.

(9) In §§ 404.280 through 404.288, we describe how and when we will recompute your PIA to include additional earnings which were not used in the original computation.

(10) In § 404.290 we describe how and when we will recalculate your PIA.

(11) Appendices I–VII contain material such as figures and formulas that we use to compute PIAs.

[68 FR 4701, Jan. 30, 2003]

§ 404.202 Other regulations related to this subpart.

This subpart is related to several others. In subpart B of this part, we describe how you become insured for social security benefits as a result of your work in covered employment. In subpart D, we discuss the different kinds of social security benefits available—old-age and disability benefits for you and benefits for your dependents and survivors—the amount of the benefits, and the requirements you and your family must meet to qualify for them; your work status, your age, the size of your family, and other factors may affect the amount of the benefits for you and your family. Rules relating to deductions, reductions, and nonpayment of benefits we describe in subpart E. In subpart F of this part, we describe what we do when a recalculation or recomputation of your primary insurance amount (as described in this subpart) results in our finding that you and your family have been overpaid or underpaid. In subparts G and H of this part, we tell how to apply for benefits and what evidence is needed to establish entitlement to them. In subpart J of this part, we describe how benefits are paid. Then in subparts I, K, N, and O of this part, we discuss your earnings that are taxable and creditable for social security purposes (and how we keep records of them), and deemed military wage credits which may be used in finding your primary insurance amount.

§ 404.203 Definitions.

(a) *General definitions.* As used in this subpart—

Ad hoc increase in primary insurance amounts means an increase in primary insurance amounts enacted by the Congress and signed into law by the President.

Entitled means that a person has applied for benefits and has proven his or her right to them for a given period of time.

We, us, or *our* means the Social Security Administration.

You or *your* means the insured worker who has applied for benefits or a deceased insured worker on whose social security earnings record someone else has applied.

(b) *Other definitions.* To make it easier to find them, we have placed other definitions in the sections of this subpart in which they are used.

[47 FR 30734, July 15, 1982, as amended at 62 FR 38450, July 18, 1997]

§ 404.204 Methods of computing primary insurance amounts—general.

(a) *General.* We compute most workers' primary insurance amounts under one of two major methods. There are, in addition, several special methods of computing primary insurance amounts which we apply to some workers. Your primary insurance amount is the highest of all those computed under the methods for which you are eligible.

(b) *Major methods.* (1) If after 1978 you reach age 62, or become disabled or die before age 62, we compute your primary insurance amount under what we call the *average-indexed-monthly-earnings* method, which is described in §§ 404.210 through 404.212. The earliest of the three dates determines the computation method we use.

(2) If before 1979 you reached age 62, became disabled, or died, we compute your primary insurance amount under what we call the *average-monthly-wage* method, described in §§ 404.220 through 404.222.

(c) *Special methods.* (1) Your primary insurance amount, computed under any of the special methods for which you are eligible as described in this paragraph, may be substituted for your primary insurance amount computed

under either major method described in paragraph (b) of this section.

(2) If you reach age 62 during the period 1979–1983, your primary insurance amount is guaranteed to be the highest of—

(i) The primary insurance amount we compute for you under the average-indexed-monthly-earnings method;

(ii) The primary insurance amount we compute for you under the average-monthly-wage method, as modified by the rules described in §§ 404.230 through 404.233; or

(iii) The primary insurance amount computed under what we call the *old-start* method; as described in §§ 404.240 through 404.242.

(3) If you had all or substantially all of your social security earnings before 1951, we will also compute your primary insurance amount under what we call the *old-start* method.

(4) We compute your primary insurance amount under the rules in §§ 404.250 through 404.252, if—

(i) You were disabled and received social security disability insurance benefits sometime in your life;

(ii) Your disability insurance benefits were terminated because of your recovery or because you engaged in substantial gainful activity; and

(iii) You are, after 1978, re-entitled to disability insurance benefits, or entitled to old-age insurance benefits, or have died.

(5) In some situations, we use what we call a *special minimum* computation, described in §§ 404.260 through 404.261, to find your primary insurance amount. Computations under this method reflect long-term, low-wage attachment to covered work.

AVERAGE-INDEXED-MONTHLY-EARNINGS METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.210 Average-indexed-monthly-earnings method.

(a) *Who is eligible for this method.* If after 1978, you reach age 62, or become disabled or die before age 62, we will compute your primary insurance amount under the average-indexed-monthly-earnings method.

(b) *Steps in computing your primary insurance amount under the average-indexed-monthly-earnings method.* We follow these three major steps in computing your primary insurance amount:

(1) First, we find your *average indexed monthly earnings,* as described in § 404.211;

(2) Second, we find the *benefit formula* in effect for the year you reach age 62, or become disabled or die before age 62, as described in § 404.212; and

(3) Then, we apply that benefit formula to your average indexed monthly earnings to find your primary insurance amount, as described in § 404.212.

(4) Next, we apply any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that became effective in or after the year you reached age 62, unless you are receiving benefits based on the minimum primary insurance amount, in which case not all the increases may be applied, as described in § 404.277.

§ 404.211 Computing your average indexed monthly earnings.

(a) *General.* In this method, your social security earnings after 1950 are *indexed,* as described in paragraph (d) of this section, then averaged over the period of time you can reasonably have been expected to have worked in employment or self-employment covered by social security. (Your earnings before 1951 are not used in finding your average indexed monthly earnings.)

(b) *Which earnings may be used in computing your average indexed monthly earnings*—(1) *Earnings.* In computing your average indexed monthly earnings, we use wages, compensation, self-employment income, and deemed military wage credits (see §§ 404.1340 through 404.1343) that are creditable to you for social security purposes for years after 1950.

(2) *Computation base years.* We use your earnings in your *computation base years* in finding your average indexed monthly earnings. All years after 1950 up to (but not including) the year you become entitled to old-age or disability insurance benefits, and through the year you die if you had not been entitled to old-age or disability benefits, are computation base years for you. The year you become entitled to benefits and following years may be used as

computation base years in a recomputation if their use would result in a higher primary insurance amount. (See §§ 404.280 through 404.287.) However, years after the year you die may not be used as computation base years even if you have earnings credited to you in those years. Computation base years do not include years wholly within a period of disability unless your primary insurance amount would be higher by using the disability years. In such situations, we count all the years during the period of disability, even if you had no earnings in some of them.

(c) *Average of the total wages.* Before we compute your average indexed monthly earnings, we must first know the ''average of the total wages'' of all workers for each year from 1951 until the second year before you become eligible. The average of the total wages for years after 1950 are shown in appendix I. Corresponding figures for more recent years which have not yet been incorporated into this appendix are published in the FEDERAL REGISTER on or before November 1 of the succeeding year. ''Average of the total wages'' (or ''average wage'') means:

(1) For the years 1951 through 1977, four times the amount of average taxable wages that were reported to the Social Security Administration for the first calendar quarter of each year for social security tax purposes. For years prior to 1973, these average wages were determined from a sampling of these reports.

(2) For the years 1978 through 1990, all remuneration reported as wages on Form W-2 to the Internal Revenue Service for all employees for income tax purposes, divided by the number of wage earners. We adjusted those averages to make them comparable to the averages for 1951–1977. For years after 1977, the term includes remuneration for services not covered by social security and remuneration for covered employment in excess of that which is subject to FICA contributions.

(3) For years after 1990, all remuneration reported as wages on Form W-2 to the Internal Revenue Service for all employees for income tax purposes, including remuneration described in paragraph (c)(2) of this section, plus contributions to certain deferred compensation plans described in section 209(k) of the Social Security Act (also reported on Form W-2), divided by the number of wage earners. If both distributions from and contributions to any such deferred compensation plan are reported on Form W-2, we will include only the contributions in the calculation of the average of the total wages. We will adjust those averages to make them comparable to the averages for 1951–1990.

(d) *Indexing your earnings.* (1) The first step in indexing your social security earnings is to find the relationship (under paragraph (d)(2) of this section) between—

(i) The average wage of all workers in your computation base years; and

(ii) The average wage of all workers in your *indexing year.* As a general rule, your indexing year is the second year before the earliest of the year you reach age 62, or become disabled or die before age 62. However, your indexing year is determined under paragraph (d)(4) of this section if you die before age 62, your surviving spouse or surviving divorced spouse is first eligible for benefits after 1984, and the indexing year explained in paragraph (d)(4) results in a higher widow(er)'s benefit than results from determining the indexing year under the general rule.

(2) To find the relationship, we divide the average wages for your indexing year, in turn, by the average wages for each year beginning with 1951 and ending with your indexing year. We use the quotients found in these divisions to index your earnings as described in paragraph (d)(3) of this section.

(3) The second step in indexing your social security earnings is to multiply the actual year-by-year dollar amounts of your earnings (up to the maximum amounts creditable, as explained in §§ 404.1047 and 404.1096 of this part) by the quotients found in paragraph (d)(2) of this section for each of those years. We round the results to the nearer penny. (The quotient for your indexing year is 1.0; this means that your earnings in that year are used in their actual dollar amount; any earnings after your indexing year that may be used in computing your average indexed monthly earnings are also used in their actual dollar amount.)

Example: Ms. A reaches age 62 in July 1979. Her year-by-year social security earnings since 1950 are as follows:

Year	Earnings
1951	$3,200
1952	3,400
1953	3,300
1954	3,600
1955	3,700
1956	3,700
1957	4,000
1958	4,200
1959	4,400
1960	4,500
1961	2,800
1962	2,200
1963	0
1964	0
1965	3,700
1966	4,500
1967	5,400
1968	6,200
1969	6,900
1970	7,300
1971	7,500
1972	7,800
1973	8,200
1974	9,000
1975	9,900
1976	11,100
1977	9,900
1978	11,000

Step 1. The first step in indexing Ms. A's earnings is to find the relationship between the general wage level in Ms. A's indexing year (1977) and the general wage level in each of the years 1951–1976. We refer to appendix I for average wage figures, and perform the following computations:

Year	I. 1977 general wage level	II. Nationwide average of the total wages	III. Column I divided by column II equals relationship
1951	$9,779.44	$2,799.16	3.4937053
1952	9,779.44	2,973.32	3.2890641
1953	9,779.44	3,139.44	3.1150269
1954	9,779.44	3,155.64	3.0990354
1955	9,779.44	3,301.44	2.9621741
1956	9,779.44	3,532.36	2.7685287
1957	9,779.44	3,641.72	2.6853904
1958	9,779.44	3,673.80	2.6619413
1959	9,779.44	3,855.80	2.5362934
1960	9,779.44	4,007.12	2.4405159
1961	9,779.44	4,086.76	2.3929568
1962	9,779.44	4,291.40	2.2788461
1963	9,779.44	4,396.64	2.2242986
1964	9,779.44	4,576.32	2.1369659
1965	9,779.44	4,658.72	2.0991689
1966	9,779.44	4,938.36	1.9803012
1967	9,779.44	5,213.44	1.8758133
1968	9,779.44	5,571.76	1.7551797
1969	9,779.44	5,893.76	1.6592871
1970	9,779.44	6,186.24	1.5808375
1971	9,779.44	6,497.08	1.5052054
1972	9,779.44	7,133.80	1.3708599
1973	9,779.44	7,580.16	1.2901364
1974	9,779.44	8,030.76	1.2177478
1975	9,779.44	8,630.92	1.1330704
1976	9,779.44	9,226.48	1.0599318
1977	9,779.44	9,779.44	1.0000000

Step 2. After we have found these indexing quotients, we multiply Ms. A's actual year-by-year earnings by them to find her indexed earnings, as shown below:

Year	I. Actual earnings	II. Indexing quotient	III. Column I multiplied by column II equals indexed earnings
1951	$3,200	3.4937053	$11,179.86
1952	3,400	3.2890641	11,182.82
1953	3,300	3.1150269	10,279.59
1954	3,600	3.0990354	11,156.53
1955	3,700	2.9621741	10,960.04
1956	3,700	2.7685287	10,243.56
1957	4,000	2.6853904	10,741.56
1958	4,200	2.6619413	11,180.15
1959	4,400	2.5362934	11,159.69
1960	4,500	2.4405159	10,982.32
1961	2,800	2.3929568	6,700.28
1962	2,200	2.2788461	5,013.46
1963	0	2.2242986	0
1964	0	2.1369659	0
1965	3,700	2.0991689	7,766.92
1966	4,500	1.9803012	8,911.36
1967	5,400	1.8758133	10,129.39
1968	6,200	1.7551797	10,882.11
1969	6,900	1.6592871	11,449.08
1970	7,300	1.5808375	11,540.11
1971	7,500	1.5052054	11,289.04
1972	7,800	1.3708599	10,692.71
1973	8,200	1.2901364	10,579.12
1974	9,000	1.2177478	10,959.73
1975	9,900	1.1330704	11,217.40
1976	11,100	1.0599318	11,765.24
1977	9,900	1.0000000	9,900.00
1978	11,000	0	11,000.00

(4) We calculate your indexing year under this paragraph if you, the insured worker, die before reaching age 62, your surviving spouse or surviving divorced spouse is first eligible after 1984, and the indexing year calculated under this paragraph results in a higher widow(er)'s benefit than results from the indexing year calculated under the general rule explained in paragraph (d)(1)(ii). For purposes of this paragraph, the indexing year is never earlier than the second year before the year of your death. Except for this limitation, the indexing year is the earlier of—

(i) The year in which you, the insured worker, attained age 60, or would have attained age 60 if you had lived, and

(ii) The second year before the year in which the surviving spouse or the

surviving divorced spouse becomes eligible for widow(er)'s benefits, *i.e.*, has attained age 60, or is age 50–59 and disabled.

(e) *Number of years to be considered in finding your average indexed monthly earnings.* To find the number of years to be used in computing your average indexed monthly earnings—

(1) We count the years beginning with 1951, or (if later) the year you reach age 22, and ending with the earliest of the year before you reach age 62, become disabled, or die. Years wholly or partially within a period of disability (as defined in § 404.1501(b) of subpart P of this part) are not counted unless your primary insurance amount would be higher. In that case, we count all the years during the period of disability, even though you had no earnings in some of those years. These are your *elapsed years.* From your elapsed years, we then subtract up to 5 years, the exact number depending on the kind of benefits to which you are entitled. You cannot, under this procedure, have fewer than 2 benefit computation years.

(2) For computing old-age insurance benefits and survivors insurance benefits, we subtract 5 from the number of your elapsed years. See paragraphs (e)(3) and (4) of this section for the dropout as applied to disability benefits. This is the number of your *benefit computation years;* we use the same number of your computation base years (see paragraph (b)(2) of this section) in computing your average indexed monthly earnings. For benefit computation years, we use the years with the highest amounts of earnings after indexing. They may include earnings from years that were not indexed, and must include years of no earnings if you do not have sufficient years with earnings. You cannot have fewer than 2 benefit computation years.

(3) Where the worker is first entitled to disability insurance benefits (DIB) after June 1980, there is an exception to the usual 5 year dropout provision explained in paragraph (e)(2) of this section. (For entitlement before July 1980, we use the usual dropout.) We call this exception the *disability dropout.* We divide the elapsed years by 5 and disregard any fraction. The result, which may not exceed 5, is the number of dropout years. We subtract that number from the number of elapsed years to get the number of benefit computation years, which may not be fewer than 2. After the worker dies, the disability dropout no longer applies and we use the basic 5 dropout years to compute benefits for survivors. We continue to apply the disability dropout when a person becomes entitled to old-age insurance benefits (OAIB), unless his or her entitlement to DIB ended at least 12 months before he or she became eligible for OAIB. For first DIB entitlement before July 1980, we use the rule in paragraph (e)(2) of this section.

(4) For benefits payable after June 1981, the disability dropout might be increased by the *child care dropout.* If the number of disability dropout years is fewer than 3, we will drop out a benefit computation year for each benefit computation year that the worker meets the child care requirement and had no earnings, until the total of all dropout years is 3. The child care requirement for any year is that the worker must have been living with his or her child (or his or her spouse's child) substantially throughout any part of any calendar year that the child was alive and under age 3. In actual practice, no more than 2 child care years may be dropped, because of the combined effect of the number of elapsed years, 1-for-5 dropout years (if any), and the computation years required for the computation.

Example: Ms. M., born August 4, 1953, became entitled to disability insurance benefits (DIB) beginning in July 1980 based on a disability which began January 15, 1980. In computing the DIB, we determined that the elapsed years are 1975 through 1979, the number of dropout years is 1 (5 elapsed years divided by 5), and the number of computation years is 4. Since Ms. M. had no earnings in 1975 and 1976, we drop out 1975 and use her earnings for the years 1977 through 1979.

Ms. M. lived with her child, who was born in 1972, in all months of 1973 and 1974 and did not have any earnings in those years. We, therefore, recompute Ms. M.'s DIB beginning with July 1981 to give her the advantage of the child care dropout. To do this, we reduce the 4 computation years by 1 child care year to get 3 computation years. Because the child care dropout cannot be applied to computation years in which the worker had

earnings, we can drop only one of Ms. M.'s computation years, *i.e.*, 1976, in addition to the year 1975 which we dropped in the initial computation.

(i) *Living with* means that you and the child ordinarily live in the same home and you exercise, or have the right to exercise, parental control. See § 404.366(c) for a further explanation.

(ii) *Substantially throughout any part of any calendar year* means that any period you were not living with the child during a calendar year did not exceed 3 months. If the child was either born or attained age 3 during the calendar year, the period of absence in the year cannot have exceeded the smaller period of 3 months, or one-half the time after the child's birth or before the child attained age 3.

(iii) *Earnings* means wages for services rendered and net earnings from self-employment minus any net loss for a taxable year. See § 404.429 for a further explanation.

(f) *Your average indexed monthly earnings.* After we have indexed your earnings and found your benefit computation years, we compute your average indexed monthly earnings by—

(1) Totalling your indexed earnings in your benefit computation years;

(2) Dividing the total by the number of months in your benefit computation years; and

(3) Rounding the quotient to the next lower whole dollar. if not already a multiple of $1.

Example: From the example in paragraph (d) of this section, we see that Ms. A reaches age 62 in 1979. Her elapsed years are 1951–1978 (28 years). We subtract 5 from her 28 elapsed years to find that we must use 23 benefit computation years. This means that we will use her 23 highest computation base years to find her average indexed monthly earnings. We exclude the 5 years 1961–1965 and total her indexed earnings for the remaining years, *i.e.*, the benefit computation years (including her unindexed earnings in 1977 and 1978) and get $249,381.41. We then divide that amount by the 276 months in her 23 benefit computation years and find her average indexed monthly earnings to be $903.56, which is rounded down to $903.

[47 FR 30734, July 15, 1982; 47 FR 35479, Aug. 13, 1982, as amended at 48 FR 11695, Mar. 21, 1983; 51 FR 4482, Feb. 5, 1986; 57 FR 1381, Jan. 14, 1992]

§ 404.212 Computing your primary insurance amount from your average indexed monthly earnings.

(a) *General.* We compute your primary insurance amount under the average-indexed-monthly-earnings method by applying a *benefit formula* to your average indexed monthly earnings.

(b) *Benefit formula.* (1) We use the applicable benefit formula in appendix II for the year you reach age 62, become disabled, or die whichever occurs first. If you die before age 62, and your surviving spouse or surviving divorced spouse is first eligible after 1984, we may compute the primary insurance amount, for the purpose of paying benefits to your widow(er), as if you had not died but reached age 62 in the second year after the indexing year that we computed under the provisions of § 404.211(d)(4). We will not use this primary insurance amount for computing benefit amounts for your other survivors or for computing the maximum family benefits payable on your earnings record. Further, we will only use this primary insurance amount if it results in a higher widow(er)'s benefit than would result if we did not use this special computation.

(2) The dollar amounts in the benefit formula are automatically increased each year for persons who attain age 62, or who become disabled or die before age 62 in that year, by the same percentage as the increase in the average of the total wages (see appendix I).

(3) We will publish benefit formulas for years after 1979 in the FEDERAL REGISTER at the same time we publish the average of the total wage figures. We begin to use a new benefit formula as soon as it is applicable, even before we periodically update appendix II.

(4) We may use a modified formula, as explained in § 404.213, if you are entitled to a pension based on your employment which was not covered by Social Security.

(c) *Computing your primary insurance amount from the benefit formula.* We compute your primary insurance amount by applying the benefit formula to your average indexed monthly earnings and adding the results for each step of the formula. For computations using the benefit formulas in effect for 1979 through 1982, we round the

total amount to the next higher multiple of $0.10 if it is not a multiple of $0.10 and for computations using the benefit formulas effective for 1983 and later years, we round to the next lower multiple of $0.10. (See paragraph (e) of this section for a discussion of the minimum primary insurance amount.)

(d) *Adjustment of your primary insurance amount when entitlement to benefits occurs in a year after attainment of age 62, disability or death.* If you (or your survivors) do not become entitled to benefits in the same year you reach age 62, become disabled, or die before age 62, we compute your primary insurance amount by—

(1) Computing your average indexed monthly earnings as described in § 404.211;

(2) Applying to your average indexed monthly earnings the benefit formula for the year in which you reach age 62, or become disabled or die before age 62; and

(3) Applying to the primary insurance amount all automatic cost-of-living and *ad hoc* increases in primary insurance amounts that have gone into effect in or after the year you reached age 62, became disabled, or died before age 62. (See § 404.277 for special rules on minimum benefits, and appendix VI for a table of percentage increases in primary insurance amounts since December 1978. Increases in primary insurance amounts are published in the FEDERAL REGISTER and we periodically update appendix VI.)

(e) *Minimum primary insurance amount.* If you were eligible for benefits, or died without having been eligible, before 1982, your primary insurance amount computed under this method cannot be less than $122. This minimum benefit provision has been repealed effective with January 1982 for most workers and their families where the worker initially becomes eligible for benefits in that or a later month, or dies in January 1982 or a later month without having been eligible before January 1982. For members of a religious order who are required to take a vow of poverty, as explained in 20 CFR 404.1024, and which religious order elected Social Security coverage before December 29, 1981, the repeal is effective with January 1992 based on first eligibility or death in that month or later.

[47 FR 30734, July 15, 1982, as amended at 48 FR 46142, Oct. 11, 1983; 51 FR 4482, Feb. 5, 1986; 52 FR 47916, Dec. 17, 1987]

§ 404.213 Computation where you are eligible for a pension based on your noncovered employment.

(a) *When applicable.* Except as provided in paragraph (d) of this section, we will modify the formula prescribed in § 404.212 and in appendix II of this subpart in the following situations:

(1) You become eligible for old-age insurance benefits after 1985; or

(2) You become eligible for disability insurance benefits after 1985; and

(3) For the same months after 1985 that you are entitled to old-age or disability benefits, you are also entitled to a monthly pension(s) for which you first became eligible after 1985 based in whole or part on your earnings in employment which was not covered under Social Security. We consider you to first become eligible for a monthly pension in the first month for which you met all requirements for the pension except that you were working or had not yet applied. In determining whether you are eligible for a pension before 1986, we consider all applicable service used by the pension-paying agency. (Noncovered employment includes employment outside the United States which is not covered under the United States Social Security system. Pensions from noncovered employment outside the United States include both pensions from social insurance systems that base benefits on earnings but not on residence or citizenship, and those from private employers. However, for benefits payable for months prior to January 1995, we will not modify the computation of a totalization benefit (see §§ 404.1908 and 404.1918) as a result of your entitlement to another pension based on employment covered by a totalization agreement. Beginning January 1995, we will not modify the computation of a totalization benefit in any case (see § 404.213(e)(8)).

(b) *Amount of your monthly pension that we use.* For purposes of computing your primary insurance amount, we consider the amount of your monthly pension(s) (or the amount prorated on

a monthly basis) which is attributable to your noncovered work after 1956 that you are entitled to for the first month in which you are concurrently entitled to Social Security benefits. For applications filed before December 1988, we will use the month of earliest concurrent eligibility. In determining the amount of your monthly pension we will use, we will consider the following:

(1) If your pension is not paid on a monthly basis or is paid in a lump-sum, we will allocate it proportionately as if it were paid monthly. We will allocate this the same way we allocate lump-sum payments for a spouse or surviving spouse whose benefits are reduced because of entitlement to a Government pension. (See § 404.408a.)

(2) If your monthly pension is reduced to provide a survivor's benefit, we will use the unreduced amount.

(3) If the monthly pension amount which we will use in computing your primary insurance amount is not a multiple of $0.10, we will round it to the next lower multiple of $0.10.

(c) *How we compute your primary insurance amount.* When you become entitled to old-age or disability insurance benefits and to a monthly pension, we will compute your primary insurance amount under the average-indexed-monthly-earnings method (§ 404.212) as modified by paragraph (c) (1) and (2) of this section. Where applicable, we will also consider the 1977 simplified old-start method (§ 404.241) as modified by § 404.243 and a special minimum primary insurance amount as explained in §§ 404.260 and 404.261. We will use the highest result from these three methods as your primary insurance amount. We compute under the average-indexed-monthly-earnings method, and use the higher primary insurance amount resulting from the application of paragraphs (c) (1) and (2) of this section, as follows:

(1) The formula in appendix II, except that instead of the first percentage figure (*i.e.*, 90 percent), we use—

(i) 80 percent if you initially become eligible for old-age or disability insurance benefits in 1986;

(ii) 70 percent for initial eligibility in 1987;

(iii) 60 percent for initial eligibility in 1988;

(iv) 50 percent for initial eligibility in 1989;

(v) 40 percent for initial eligibility in 1990 and later years, or

(2) The formula in appendix II minus one-half the portion of your monthly pension which is due to noncovered work after 1956 and for which you were entitled in the first month you were entitled to both Social Security benefits and the monthly pension. If the monthly pension amount is not a multiple of $0.10, we will round to the next lower multiple of $0.10. To determine the portion of your pension which is due to noncovered work after 1956, we consider the total number of years of work used to compute your pension and the percentage of those years which are after 1956, and in which your employment was not covered. We take that percentage of your total pension as the amount which is due to your noncovered work after 1956.

(d) *Alternate computation.* (1) If you have more than 20 but less than 30 years of coverage as defined in the column headed ''Alternate Computation Under § 404.213(d)'' in appendix IV of this subpart, we will compute your primary insurance amount using the applicable percentage given below instead of the first percentage in appendix II of this subpart if the applicable percentage below is larger than the percentage specified in paragraph (c) of this section:

(i) For benefits payable for months before January 1989—

Years of coverage	Percent
29	80
28	70
27	60
26	50

(ii) For benefits payable for months after December 1988—

Years of coverage	Percent
29	85
28	80
27	75
26	70
25	65
24	60
23	55
22	50
21	45

(2) If you later earn additional year(s) of coverage, we will recompute your primary insurance amount, effective with January of the following year.

(e) *Exceptions.* The computations in paragraph (c) of this section do not apply in the following situations:

(1) Payments made under the Railroad Retirement Act are not considered to be a pension from noncovered employment for the purposes of this section. See subpart O of this part for a discussion of railroad retirement benefits.

(2) You were entitled before 1986 to disability insurance benefits in any of the 12 months before you reach age 62 or again become disabled. (See § 404.251 for the appropriate computation.)

(3) You were a Federal employee performing service on January 1, 1984 to which Social Security coverage was extended on that date solely by reason of the amendments made by section 101 of the Social Security Amendments of 1983.

(4) You were an employee of a nonprofit organization who was exempt from Social Security coverage on December 31, 1983 unless you were previously covered under a waiver certificate which was terminated prior to that date.

(5) You have 30 years of coverage as defined in the column headed ''Alternate Computation Under § 404.213(d)'' in appendix IV of this subpart.

(6) Your survivors are entitled to benefits on your record of earnings. (After your death, we will recompute the primary insurance amount to nullify the effect of any monthly pension, based in whole or in part on noncovered employment, to which you had been entitled.)

(7) For benefits payable for months after December 1994, payments by the social security system of a foreign country which are based on a totalization agreement between the United States and that country are not considered to be a pension from noncovered employment for purposes of this section. See subpart T of this part for a discussion of totalization agreements.

(8) For benefits payable for months after December 1994, the computations in paragraph (c) do not apply in the case of an individual whose entitlement to U.S. social security benefits results from a totalization agreement between the United States and a foreign country.

(9) For benefits payable for months after December 1994, you are eligible after 1985 for monthly periodic benefits based wholly on service as a member of a uniformed service, including inactive duty training.

(f) *Entitlement to a totalization benefit and a pension based on noncovered employment.* If, before January 1995, you are entitled to a totalization benefit and to a pension based on noncovered employment that is not covered by a totalization agreement, we count your coverage from a foreign country with which the United States (U.S.) has a totalization agreement and your U.S. coverage to determine if you meet the requirements for the modified computation in paragraph (d) of this section or the exception in paragraph (e)(5) of this section.

(1) Where the amount of your totalization benefit will be determined using a computation method that does not consider foreign earnings (see § 404.1918), we will find your total years of coverage by adding your—

(i) Years of coverage from the agreement country (quarters of coverage credited under § 404.1908 divided by four) and

(ii) Years of U.S. coverage as defined for the purpose of computing the special minimum primary insurance amount under § 404.261.

(2) Where the amount of your totalization benefit will be determined using a computation method that does consider foreign earnings, we will credit your foreign earnings to your U.S. earnings record and then find your total years of coverage using the method described in § 404.261.

[52 FR 47916, Dec. 17, 1987, as amended at 55 FR 21382, May 24, 1990; 57 FR 22429, May 28, 1992; 60 FR 17444, Apr. 6, 1995; 60 FR 56513, Nov. 9, 1995]

AVERAGE-MONTHLY-WAGE METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.220 Average-monthly-wage method.

(a) *Who is eligible for this method.* You must before 1979, reach age 62, become disabled or die to be eligible for us to compute your primary insurance amount under the average-monthly-wage method. Also, as explained in § 404.230, if you reach age 62 after 1978 but before 1984, you are eligible to have your primary insurance amount computed under a modified average-monthly-wage method if it is to your advantage. Being eligible for either the average-monthly-wage method or the modified average-monthly-wage method does not preclude your eligibility under the *old-start* method described in §§ 404.240 through 404.242.

(b) *Steps in computing your primary insurance amount under the average-monthly-wage method.* We follow these three major steps in computing your primary insurance amount under the average-monthly-wage method:

(1) First, we find your average monthly wage, as described in § 404.221;

(2) Second, we look at the *benefit table* in appendix III; and

(3) Then we find your primary insurance amount in the benefit table, as described in § 404.222.

(4) Finally, we apply any automatic cost-of-living or *ad hoc* increases that became effective in or after the year you reached age 62, or became disabled, or died before age 62, as explained in §§ 404.270 through 404.277.

§ 404.221 Computing your average monthly wage.

(a) *General.* Under the average-monthly-wage method, your social security earnings are averaged over the length of time you can reasonably have been expected to have worked under social security after 1950 (or after you reached age 21, if later).

(b) *Which of your earnings may be used in computing your average monthly wage.* (1) In computing your average monthly wage, we consider all the wages, compensation, self-employment income, and deemed military wage credits that are creditable to you for social security purposes. (The maximum amounts creditable are explained in §§ 404.1047 and 404.1096 of this part.)

(2) We use your earnings in your *computation base years* in computing your average monthly wage. All years after 1950 up to (but not including) the year you become entitled to old-age or disability insurance benefits, or through the year you die if you had not been entitled to old-age or disability benefits, are computation base years for you. Years after the year you die may not be used as computation base years even if you have earnings credited to you in them. However, years beginning with the year you become entitled to benefits may be used for benefits beginning with the following year if using them would give you a higher primary insurance amount. Years wholly within a period of disability are not computation base years unless your primary insurance amount would be higher if they were. In such situations, we count all the years during the period of disability, even if you had no earnings in some of them.

(c) *Number of years to be considered in computing your average monthly wage.* To find the number of years to be used in computing your average monthly wage—

(1) We count the years beginning with 1951 or (if later) the year you reached age 22 and ending with the year before you reached age 62, or became disabled, or died before age 62. Any part of a year—or years—in which you were disabled, as defined in § 404.1505, is not counted unless doing so would give you a higher average monthly wage. In that case, we count all the years during the period of disability, even if you had no earnings in some of those years. These are your *elapsed years.* (If you are a male and you reached age 62 before 1975, see paragraph (c)(2) of this section for the rules on finding your elapsed years.)

(2) If you are a male and you reached age 62 in—

(i) 1972 or earlier, we count the years beginning with 1951 and ending with the year before you reached age 65, or became disabled or died before age 65 to find your elapsed years;

(ii) 1973, we count the years beginning with 1951 and ending with the year

before you reached age 64, or became disabled or died before age 64 to find your elapsed years; or

(iii) 1974, we count the years beginning with 1951 and ending with the year before you reached age 63, became disabled, or died before age 63 to find your elapsed years.

(3) Then we subtract 5 from the number of your elapsed years. This is the number of your *benefit computation years*; we use the same number of your computation base years in computing your average monthly wage. For benefit computation years, we use the years with the highest amounts of earnings, but they may include years of no earnings. You cannot have fewer than 2 benefit computation years.

(d) *Your average monthly wage.* After we find your benefit computation years, we compute your average monthly wage by—

(1) Totalling your creditable earnings in your benefit computation years;

(2) Dividing the total by the number of months in your benefit computation years; and

(3) Rounding the quotient to the next lower whole dollar if not already a multiple of $1.

Example: Mr. B reaches age 62 and becomes entitled to old-age insurance benefits in August 1978. He had no social security earnings before 1951 and his year-by-year social security earnings after 1950 are as follows:

Year	Earnings
1951	$2,700
1952	2,700
1953	3,400
1954	3,100
1955	4,000
1956	4,100
1957	4,000
1958	4,200
1959	4,800
1960	4,800
1961	4,800
1962	4,800
1963	4,800
1964	1,500
1965	0
1966	0
1967	0
1968	3,100
1969	5,200
1970	7,100
1971	7,800
1972	8,600
1973	8,900
1974	9,700
1975	10,100
1976	10,800
1977	11,900

We first find Mr. B's elapsed years, which are the 27 years 1951–1977. We subtract 5 from his 27 elapsed years to find that we must use 22 benefit computation years in computing his average monthly wage. His computation base years are 1951–1977, which are the years after 1950 and prior to the year he became entitled. This means that we will use his 22 computation base years with the highest earnings to compute his average monthly wage. Thus, we exclude the years 1964–1967 and 1951.

We total his earnings in his benefit computation years and get $132,700. We then divide that amount by the 264 months in his 22 benefit computation years and find his average monthly wage to be $502.65, which is rounded down to $502.

(e) *''Deemed'' average monthly wage for certain deceased veterans of World War II.* Certain deceased veterans of World War II are ''deemed'' to have an average monthly wage of $160 (see §§ 404.1340 through 404.1343 of this part) unless their actual average monthly wage, as found in the method described in paragraphs (a) through (d) of this section is higher.

§ 404.222 Use of benefit table in finding your primary insurance amount from your average monthly wage.

(a) *General.* We find your primary insurance amount under the average-monthly-wage method in the benefit table in appendix III.

(b) *Finding your primary insurance amount from benefit table.* We find your average monthly wage in column III of the table. Your primary insurance amount appears on the same line in column IV (column II if you are entitled to benefits for any of the 12 months preceding the effective month in column IV). As explained in § 404.212(e), there is a minimum primary insurance amount of $122 payable for persons who became eligible or died after 1978 and before January 1982. There is also an alternative minimum of $121.80 (before the application of cost-of-living increases) for members of this group whose benefits were computed from the benefit table in effect in December 1978 on the basis of either the old-start computation method in §§ 404.240 through 404.242 or the guaranteed alternative computation method explained in §§ 404.230 through 404.233. However, as can be seen from the extended table in appendix III, the lowest

primary insurance amount under this method is now $1.70 for individuals for whom the minimum benefit has been repealed.

Example: In the example in § 404.221(d), we computed Mr. B's average monthly wage to be $502. We refer to the December 1978 benefit table in appendix III. Then we find his average monthly wage in column III of the table. Reading across, his primary insurance amount is on the same line in column IV and is $390.50. A 9.9 percent automatic cost-of-living benefit increase was effective for June 1979, increasing Mr. B's primary insurance amount to $429.20, as explained in §§ 404.270 through 404.277. Then, we increase the $429.20 by the 14.3 percent June 1980 cost-of-living benefit increase and get $490.60, and by the 11.2 percent June 1981 increase to get $545.60.

[47 FR 30734, July 15, 1982, as amended at 48 FR 46142, Oct. 11, 1983]

GUARANTEED ALTERNATIVE FOR PEOPLE REACHING AGE 62 AFTER 1978 BUT BEFORE 1984

§ 404.230 Guaranteed alternative.

(a) *General.* If you reach age 62 after 1978 but before 1984, we compute your primary insurance amount under a modified average-monthly-wage method as a *guaranteed alternative* to your primary insurance amount computed under the average-indexed-monthly-earnings method. We also compute your primary insurance amount under the old-start method (§§ 404.240 through 404.242) and under the special rules for a person who had a period of disability (§§ 404.250 through 404.252), if you are eligible. In §§ 404.231 through 404.233, we explain the average-monthly-wage method as the alternative to the average-indexed-monthly-earnings method.

(b) *Restrictions.* (1) To qualify for this guaranteed-alternative computation, you must have some creditable earnings before 1979.

(2) You or your survivors do not qualify for a guaranteed-alternative computation if you were eligible (you attained age 62, became disabled, or died before age 62) for social security benefits based on your own earnings at any time before 1979 unless—

(i) Those benefits were disability insurance benefits which were terminated because you recovered from your disability or you engaged in substantial gainful activity; and

(ii) You spent at least 12 months without being eligible for disability benefits again.

(3) This guaranteed alternative method applies only to old-age insurance benefits and to survivor benefits where the deceased worker reached the month of his or her 62nd birthday after 1978 but before 1984 and died after reaching age 62.

§ 404.231 Steps in computing your primary insurance amount under the guaranteed alternative—general.

If you reach age 62 after 1978 but before 1984, we follow three major steps in finding your guaranteed alternative:

(a) First, we compute your average monthly wage, as described in § 404.232;

(b) Second, we find the primary insurance amount that corresponds to your average monthly wage in the benefit table in appendix III.

(c) Then we apply any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that have become effective in or after the year you reached age 62.

§ 404.232 Computing your average monthly wage under the guaranteed alternative.

(a) *General.* With the exception described in paragraph (b) of this section, we follow the rules in § 404.221 to compute your average monthly wage.

(b) *Exception.* We do not use any year after the year you reach age 61 as a computation base year in computing your average monthly wage for purposes of the guaranteed alternative.

§ 404.233 Adjustment of your guaranteed alternative when you become entitled after age 62.

(a) If you do not become entitled to benefits at the time you reach age 62, we adjust the guaranteed alternative computed for you under § 404.232 as described in paragraph (b) of this section.

(b) To the primary insurance amount computed under the guaranteed alternative, we apply any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that go into effect in the year you reach age 62 and in years up through the year you become entitled to benefits. (See appendix VI for a list of the percentage increases in

primary insurance amounts since December 1978.)

Example: Mr. C reaches age 62 in January 1981 and becomes entitled to old-age insurance benefits in April 1981. He had no social security earnings before 1951 and his year-by-year social security earnings after 1950 are as follows:

Year	Earnings
1951	$3,600
1952	3,600
1953	3,600
1954	3,600
1955	4,200
1956	4,200
1957	4,200
1958	4,200
1959	4,800
1960	4,800
1961	4,800
1962	4,800
1963	4,800
1964	4,800
1965	4,800
1966	6,600
1967	6,600
1968	7,800
1969	7,800
1970	7,800
1971	7,800
1972	9,000
1973	10,800
1974	13,200
1975	14,100
1976	15,300
1977	16,500
1978	17,700
1979	22,900
1980	25,900
1981	29,700

Mr. C's elapsed years are the 30 years 1951 through 1980. We subtract 5 from his 30 elapsed years to find that we must use 25 benefit computation years in computing his average monthly wage. His computation base years are 1951 through 1980 which are years after 1950 up to the year he reached age 62. We will use his 25 computation base years with the highest earnings to compute his average monthly wage. Thus, we exclude the years 1951–1955. The year 1981 is not a base year for this computation.

We total his earnings in his benefit computation years and get $236,000. We then divide by the 300 months in his 25 benefit computation years, and find his average monthly wage to be $786.66 which is rounded down to $786.

The primary insurance amount in the benefit table in appendix III that corresponds to Mr. C's average monthly wage is $521.70. The 9.9 percent and 14.3 percent cost of living increase for 1979 and 1980, respectively, are not applicable because Mr. C reached age 62 in 1981.

The average indexed monthly earnings method described in §§ 404.210 through 404.212 considers all of the earnings after 1950, including 1981 earnings which, in Mr. C's case cannot be used in the guaranteed alternative method. Mr. C's primary insurance amount under the average indexed earnings method is $548.40. Therefore, his benefit is based upon the $548.40 primary insurance amount. As in the guaranteed alternative method, Mr. C is not entitled to the cost of living increases for years before the year he reaches age 62.

OLD-START METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.240 Old-start method—general.

If you had all or substantially all your social security earnings before 1951, your primary insurance amount computed under the ''1977 simplified old-start'' method may be higher than any other primary insurance amount computed for you under any other method for which you are eligible. As explained in § 404.242, if you reach age 62 after 1978, your primary insurance amount computed under the old-start method is used, for purposes of the guaranteed alternative described in § 404.230, if the old-start primary insurance amount is higher than the one found under the average-monthly-wage method. We may use a modified computation, as explained in § 404.243, if you are entitled to a pension based on your employment which was not covered by Social Security.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47917, Dec. 17, 1987]

§ 404.241 1977 simplified old-start method.

(a) *Who is qualified.* To qualify for the old-start computation, you must meet the conditions in paragraphs (a) (1), (2), or (3) of this section:

(1) You must—

(i) Have one ''quarter of coverage'' (see §§ 404.101 and 404.110 of this part) before 1951;

(ii) Have attained age 21 after 1936 and before 1950, or attained age 22 after 1950 and earned fewer than 6 quarters of coverage after 1950;

(iii) Have not had a period of disability which began before 1951, unless it can be disregarded, as explained in § 404.320 of this part; and,

(iv) Have attained age 62, become disabled, or died, after 1977.

(2)(i) You or your survivor becomes entitled to benefits for June 1992 or later;

(ii) You do not meet the conditions in paragraph (a)(1) of this section, and,

(iii) No person is entitled to benefits on your earnings record in the month before the month you or your survivor becomes entitled to benefits.

(3) A recomputation is first effective for June 1992 or later based on your earnings for 1992 or later.

(b) *Steps in old-start computation.* (1) First, we allocate your earnings during the period 1937–1950 as described in paragraph (c) of this section.

(2) Next, we compute your average monthly wage, as described in paragraph (d) of this section.

(3) Next, we apply the old-start formula to your average monthly wage, as described in paragraph (e)(1) of this section.

(4) Next, we apply certain increments to the amount computed in step (3), as described in paragraph (e)(2) of this section.

(5) Next, we find your primary insurance amount in the benefit table in appendix III, as described in paragraph (f)(1) of this section.

(6) Then, we apply automatic cost-of-living or *ad hoc* increases in primary insurance amounts to the primary insurance amount found in step (5), as described in paragraph (f)(2) of this section.

(c) *Finding your computation base years under the old-start method.* (1) Instead of using your actual year-by-year earnings before 1951, we find your computation base years for 1937–1950 (and the amount of earnings for each of them) by allocating your total 1937–1950 earnings among the years before 1951 under the following procedure:

(i) If you reached age 21 before 1950 and your total 1937–1950 earnings *are not* more than $3,000 times the number of years after the year you reached age 20 and before 1951 (a maximum of 14 years), we allocate your earnings equally among those years, and those years are your computation base years before 1951.

(ii) If you reached age 21 before 1950 and your total 1937–1950 earnings *are* more than $3,000 times the number of years after the year you reached age 20 and before 1951, we allocate your earnings at the rate of $3,000 per year for each year after you reached age 20 and before 1951 up to a maximum of 14 years. We credit any remainder in reverse order to years before age 21 in $3,000 increments and any amount left over of less than $3,000 to the year before the earliest year to which we credited $3,000. No more than $42,000 may be credited in this way and to no more than 14 years. Those years are your computation base years before 1951.

(iii) If you reached age 21 in 1950 or later and your total pre-1951 earnings are $3,000 or less, we credit the total to the year you reached age 20 and that year is your pre-1951 computation base year.

(iv) If you reached age 21 in 1950 or later and your total pre-1951 earnings are more than $3,000, we credit $3,000 to the year you reached age 20 and credit the remainder to earlier years (or year) in blocks of $3,000 in reverse order. We credit any remainder of less than $3,000 to the year before the earliest year to which we had credited $3,000. No more than $42,000 may be credited in this way and to no more than 14 years. Those years are your computation base years before 1951.

(v) If you die before 1951, we allocate your 1937–1950 earnings under paragraphs (c)(1) (i) through (iv), except that in determining the number of years, we will use the year of death instead of 1951. If you die before you attain age 21, the number of years in the period is equal to 1.

(vi) For purposes of paragraphs (c)(1) (i) through (v), if you had a period of disability which began before 1951, we will exclude the years wholly within a period of disability in determining the number of years.

(2)(i) All years after 1950 up to (but not including) the year you become entitled to old-age insurance or disability insurance benefits (or through the year you die if you had not become entitled to old-age or disability benefits) are also computation base years for you.

(ii) Years wholly within a period of disability are not computation base years unless your primary insurance amount would be higher if they were. In such situations, we count all the years during the period of disability,

even if you had no earnings in some of them.

Example: Ms. D reaches age 62 in June 1979. Her total 1937–1950 social security earnings are $40,000 and she had social security earnings of $7,100 in 1976 and $6,300 in 1977. Since she reaches age 62 after 1978, we first compute her primary insurance amount under the average-indexed-monthly-earnings method (§§ 404.210 through 404.212). As of June 1981, it is $170.50, which is the minimum primary insurance amount applicable, because her average indexed monthly earnings of $50 would yield only $56.50 under the benefit formula. Ms. D reached age 62 after 1978 but before 1984 and her guaranteed alternative under the average-monthly-wage method as of June 1981 is $170.30, which is the minimum primary insurance amount based on average monthly wages of $48. (These amounts include the 9.9, the 14.3, and the 11.2 percent cost-of-living increases effective June 1979, June 1980, and June 1981 respectively.)

Ms. D is also eligible for the old-start method. We first allocate $3,000 of her 1937–1950 earnings to each of her 13 computation base years starting with the year she reached age 21 (1938) and ending with 1950. The remaining $1,000 is credited to the year she reached age 20. Ms. D, then, has 42 computation base years (14 before 1951 and 28 after 1950).

(d) *Computing your average monthly wage under the old-start method.* (1) First, we count your elapsed years, which are the years beginning with 1937 (or the year you reach 22, if later) and ending with the year before you reach age 62, or become disabled or die before age 62. (See § 404.211(e)(1) for the rule on how we treat years wholly or partially within a period of disability.)

(2) Next, we subtract 5 from the number of your elapsed years, and this is the number of computation years we must use. We then choose this number of your computation base years in which you had the highest earnings. These years are your benefit computation years. You must have at least 2 benefit computation years.

(3) Then we compute your average monthly wage by dividing your total creditable earnings in your benefit computation years by the number of months in these years and rounding the quotient to the next lower dollar if not already a multiple of $1.

(e) *Old-start computation formula.* We use the following formula to compute your primary insurance benefit, which we will convert to your primary insurance amount:

(1) We take 40 percent of the first $50 of your average monthly wage, plus 10 percent of the next $200 of your average monthly wage up to a total average monthly wage of $250. (We do not use more than $250 of your average monthly wage.)

(2) We increase the amount found in paragraph (e)(1) of this section by 1 percent for each $1,650 in your pre-1951 earnings, disregarding any remainder less than $1,650. We always increase the amount by at least 4 of these 1 percent increments but may not increase it by more than 14 of them.

(f) *Finding your primary insurance amount under the old-start method.* (1) In column I of the benefit table in appendix III we locate the amount (the primary insurance benefit) computed in paragraph (e) of this section and find the corresponding primary insurance amount on the same line in column IV of the table.

(2) We increase that amount by any automatic cost-of-living or *ad hoc* increases in primary insurance amounts effective since the beginning of the year in which you reached age 62, or became disabled or died before age 62. (See §§ 404.270 through 404.277.)

Example: From the example in paragraph (c)(2) of this section, we see that Ms. D's elapsed years total 40 (number of years at ages 22 to 61, both inclusive). Her benefit computation years, therefore, must total 35. Since she has only 16 years of actual earnings, we must include 19 years of zero earnings in this old-start computation to reach the required 35 benefit computation years.

We next divide her total social security earnings ($53,400) by the 420 months in her benefit computation years and find her average monthly wage to be $127.

We apply the old-start computation formula to Ms. D's average monthly wage as follows: 40 percent of the first $50 of her average monthly wage ($20.00), plus 10 percent of the remaining $77 of her average monthly wage ($7.70), for a total of $27.70.

We then apply 14 1-percent increments to that amount, increasing it by $3.88 to $31.58. We find $31.58 in column I of the December 1978 benefit table in appendix III and find her primary insurance amount of $195.90 on the same line in column IV. We apply the 9.9 percent automatic cost-of-living increase effective for June 1979 to $195.90 and get an old-start primary insurance amount of $215.30 which we then increase to $246.10 to reflect

the 14.3 percent cost-of-living increase effective for June 1980, and to $273.70 to reflect the June 1981 increase. Since that primary insurance amount is higher than the $153.10 primary insurance amount computed under the average-monthly-wage method and the $153.30 primary insurance amount computed under the average-indexed-monthly-earnings method, we base Ms. D's benefits (and those of her family) on $215.30 (plus later cost-of-living increases), which is the highest primary insurance amount.

[47 FR 30734, July 15, 1982, as amended at 55 FR 21382, May 24, 1990; 57 FR 23157, June 2, 1992]

§ 404.242 Use of old-start primary insurance amount as guaranteed alternative.

If your primary insurance amount as computed under the old-start method is higher than your primary insurance amount computed under the average-monthly-wage method, your old-start primary insurance amount will serve as the guaranteed alternative to your primary insurance amount computed under the average-indexed-monthly-earnings method, as described in § 404.230. However, earnings that you have in or after the year you reach age 62, or become disabled or die before age 62 are not used in an old-start computation in this situation.

§ 404.243 Computation where you are eligible for a pension based on noncovered employment.

The provisions of § 404.213 are applicable to computations under the old-start method, except for paragraphs (c) (1) and (2) and (d) of that section. Your primary insurance amount will be whichever of the following two amounts is larger:

(a) One-half the primary insurance amount computed according to § 404.241 (before application of the cost of living amount); or

(b) The primary insurance amount computed according to § 404.241 (before application of the cost of living amount), minus one-half the portion of your monthly pension which is due to noncovered work after 1956 and for which you were eligible in the first month you became eligible for Social Security benefits. If the result is not a multiple of $0.10, we will round to the next lower multiple of $0.10. (See § 404.213 (b)(3) if you are not eligible for a monthly pension in the first month you are entitled to Social Security benefits.) To determine the portion of your pension which is due to noncovered work after 1956, we consider the total number of years of work used to compute your pension and the percentage of those years which are after 1956 and in which your employment was not covered. We take that percentage of your total pension as the amount which is due to your noncovered work after 1956.

[52 FR 47918, Dec. 17, 1987]

Special Computation Rules for People Who Had a Period of Disability

§ 404.250 Special computation rules for people who had a period of disability.

If you were disabled at some time in your life, received disability insurance benefits, and those benefits were terminated because you recovered from your disability or because you engaged in substantial gainful activity, special rules apply in computing your primary insurance amount when you become eligible after 1978 for old-age insurance benefits or if you become re-entitled to disability insurance benefits or die. (For purposes of §§ 404.250 through 404.252, we use the term *second entitlement* to refer to this situation.) There are two sets of rules:

(a) *Second entitlement within 12 months.* If 12 months or fewer pass between the last month for which you received a disability insurance benefit and your second entitlement, see the rules in § 404.251; and

(b) *Second entitlement after more than 12 months.* If more than 12 months pass between the last month for which you received a disability insurance benefit and your second entitlement, see the rules in § 404.252.

§ 404.251 Subsequent entitlement to benefits less than 12 months after entitlement to disability benefits ended.

(a) *Disability before 1979; second entitlement after 1978.* In this situation, we compute your second-entitlement primary insurance amount by selecting the highest of the following:

(1) The primary insurance amount to which you were entitled when you last received a benefit, increased by any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that took effect since then;

(2) The primary insurance amount resulting from a recomputation of your primary insurance amount, if one is possible; or

(3) The primary insurance amount computed for you as of the time of your second entitlement under any method for which you are qualified at that time, including the average-indexed-monthly-earnings method if the previous period of disability is disregarded.

(b) *Disability and second entitlement after 1978.* In this situation, we compute your second-entitlement primary insurance amount by selecting the highest of the following:

(1) The primary insurance amount to which you were entitled when you last received a benefit, increased by any automatic cost-of-living or *ad hoc* increases in primary insurance amount that took effect since then;

(2) The primary insurance amount resulting from a recomputation of your primary insurance amount, if one is possible (this recomputation may be under the average-indexed-monthly-earnings method only); or

(3) The primary insurance amount computed for you as of the time of your second entitlement under any method (including an old-start method) for which you are qualified at that time.

(c) *Disability before 1986; second entitlement after 1985.* When applying the rule in paragraph (b)(3) of this section, we must consider your receipt of a monthly pension based on noncovered employment. (See § 404.213). However, we will disregard your monthly pension if you were previously entitled to disability benefits before 1986 and in any of the 12 months before your second entitlement.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.252 Subsequent entitlement to benefits 12 months or more after entitlement to disability benefits ended.

In this situation, we compute your second-entitlement primary insurance amount by selecting the higher of the following:

(a) *New primary insurance amount.* The primary insurance amount computed as of the time of your second entitlement under any of the computation methods for which you qualify at the time of your second entitlement; or

(b) *Previous primary insurance amount.* The primary insurance amount to which you were entitled in the last month for which you were entitled to a disability insurance benefit.

SPECIAL MINIMUM PRIMARY INSURANCE AMOUNTS

§ 404.260 Special minimum primary insurance amounts.

Regardless of the method we use to compute your primary insurance amount, if the special minimum primary insurance amount described in § 404.261 is higher, then your benefits (and those of your dependents or survivors) will be based on the special minimum primary insurance amount. Special minimum primary insurance amounts are not based on a worker's average earnings, as are primary insurance amounts computed under other methods. Rather, the special minimum primary insurance amount is designed to provide higher benefits to people who worked for long periods in low-paid jobs covered by social security.

§ 404.261 Computing your special minimum primary insurance amount.

(a) *Years of coverage.* (1) The first step in computing your special minimum primary insurance amount is to find the number of your years of coverage, which is the sum of—

(i) The quotient found by dividing your total creditable social security earnings during the period 1937–1950 by $900, disregarding any fractional remainder; plus

(ii) The number of your computation base years after 1950 in which your social security earnings were at least the amounts shown in appendix IV.

(*Computation base years* mean the same here as in other computation methods discussed in this subpart.)

(2) You must have at least 11 years of coverage to qualify for a special minimum primary insurance amount computation. However, special minimum primary insurance amounts based on little more than 10 years of coverage are usually lower than the regular minimum benefit that was in effect before 1982 (see §§ 404.212(e) and 404.222(b) of this part). In any situation where your primary insurance amount computed under another method is higher, we use that higher amount.

(b) *Computing your special minimum primary insurance amount.* (1) First, we subtract 10 from your years of coverage and multiply the remainder (at least 1 and no more than 20) by $11.50;

(2) Then we increase the amount found in paragraph (b)(1) of this section by any automatic cost-of-living or *ad hoc* increases that have become effective since December 1978 to find your special minimum primary insurance amount. See appendix V for the applicable table, which includes the 9.9 percent cost-of-living increase that became effective June 1979, the 14.3 percent increase that became effective June 1980, and the 11.2 percent increase that became effective June 1981.

Example: Ms. F, who attained age 62 in January 1979, had $10,000 in total social security earnings before 1951 and her post-1950 earnings are as follows:

Year	Earnings
1951	$1,100
1952	950
1953	0
1954	1,000
1955	1,100
1956	1,200
1957	0
1958	1,300
1959	0
1960	1,300
1961	0
1962	1,400
1963	1,300
1964	0
1965	500
1966	700
1967	650
1968	900
1969	1,950
1970	2,100
1971	2,000
1972	1,500
1973	2,700
1974	2,100
1975	2,600
1976	3,850
1977	4,150
1978	0

Her primary insurance amount under the average-indexed-monthly-earnings method as of June 1981 is $240.40 (based on average indexed monthly earnings of $229). Her guaranteed-alternative primary insurance amount under the average-monthly-wage method as of June 1981 is $255.80 (based on average monthly wages of $131).

However, Ms. F has enough earnings before 1951 to allow her 11 years of coverage before 1951 ($10,000 ÷ $900 = 11, plus a remainder, which we drop). She has sufficient earnings in 1951–52, 1954–56, 1958, 1960, 1962–63, 1969–71, 1973, and 1976–77 to have a year of coverage for each of those years. She thus has 15 years of coverage after 1950 and a total of 26 years of coverage. We subtract 10 from her years of coverage, multiply the remainder (16) by $11.50 and get $184.00. We then apply the June 1979, June 1980, and June 1981 automatic cost-of-living increases (9.9 percent, 14.3 percent, and 11.2 percent, respectively) to that amount to find her special minimum primary insurance amount of $202.30 effective June 1979, $231.30 effective June 1980, and $257.30 effective June 1981. (See appendices V and VI.) Since her special minimum primary insurance amount is higher than the primary insurance amounts computed for her under the other methods described in this subpart for which she is eligible, her benefits (and those of her family) are based on the special minimum primary insurance amount.

[47 FR 30734, July 15, 1982, as amended at 48 FR 46143, Oct. 11, 1983]

COST-OF-LIVING INCREASES

§ 404.270 Cost-of-living increases.

Your primary insurance amount may be automatically increased each December so it keeps up with rises in the cost of living. These automatic increases also apply to other benefit amounts, as described in § 404.271.

[47 FR 30734, July 15, 1982, as amended at 51 FR 12603, Apr. 14, 1986]

§ 404.271 When automatic cost-of-living increases apply.

Besides increases in the primary insurance amounts of current beneficiaries, automatic cost-of-living increases also apply to—

(a) The special minimum primary insurance amounts (described in §§ 404.260

through 404.261) of current and future beneficiaries;

(b) The primary insurance amounts of people who after 1978 become eligible for benefits or die before becoming eligible (beginning with December of the year they become eligible or die), although certain limitations are placed on the automatic adjustment of the frozen minimum primary insurance amount (as described in § 404.277); and

(c) The *maximum family benefit amounts* in column V of the benefit table in appendix III.

[47 FR 30734, July 15, 1982, as amended at 51 FR 12603, Apr. 14, 1986; 83 FR 21708, May 10, 2018]

§ 404.272 Indexes we use to measure the rise in the cost-of-living.

(a) *The bases.* To measure increases in the cost-of-living for annual automatic increase purposes, we use either:

(1) The revised Consumer Price Index (CPI) for urban wage earners and clerical workers as published by the Department of Labor, or

(2) The average wage index (AWI), which is the average of the annual total wages that we use to index (*i.e.*, update) a worker's past earnings when we compute his or her primary insurance amount (§ 404.211(c)).

(b) *Effect of the OASDI fund ratio.* Which of these indexes we use to measure increases in the cost-of-living depends on the Old-Age, Survivors, and Disability Insurance (OASDI) fund ratio.

(c) *OASDI fund ratio for years after 1984.* For purposes of cost-of-living increases, the OASDI fund ratio is the ratio of the combined assets in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (see section 201 of the Social Security Act) on January 1 of a given year, to the estimated expenditures from the Funds in the same year. The January 1 balance consists of the assets (*i.e.*, government bonds and cash) in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, plus Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA) taxes transferred to these trust funds on January 1 of the given year, minus the outstanding amounts (principal and interest) owed to the Federal Hospital Insurance Trust Fund as a result of interfund loans. Estimated expenditures are amounts we expect to pay from the Old-Age and Survivors Insurance and the Disability Insurance Trust Funds during the year, including the net amount that we pay into the Railroad Retirement Account, but excluding principal repayments and interest payments to the Hospital Insurance Trust Fund and transfer payments between the Old-Age and Survivors Insurance and the Disability Insurance Trust Funds. The ratio as calculated under this rule is rounded to the nearest 0.1 percent.

(d) *Which index we use.* We use the CPI if the OASDI fund ratio is 15.0 percent or more for any year from 1984 through 1988, and if the ratio is 20.0 percent or more for any year after 1988. We use either the CPI or the AWI, depending on which has the lower percentage increase in the applicable measuring period (see § 404.274), if the OASDI fund ratio is less than 15.0 percent for any year from 1984 through 1988, and if the ratio is less than 20.0 percent for any year after 1988. For example, if the OASDI fund ratio for a year is 17.0 percent, the cost-of-living increase effective December of that year will be based on the CPI.

[51 FR 12603, Apr. 14, 1986]

§ 404.273 When are automatic cost-of-living increases effective?

We make automatic cost-of-living increases if the applicable index, either the CPI or the AWI, rises over a specified measuring period (*see* the rules on measuring periods in § 404.274). If the cost-of-living increase is to be based on an increase in the CPI, the increase is effective in December of the year in which the measuring period ends. If the increase is to be based on an increase in the AWI, the increase is effective in December of the year after the year in which the measuring period ends.

[69 FR 19925, Apr. 15, 2004]

§ 404.274 What are the measuring periods we use to calculate cost-of-living increases?

(a) *General.* Depending on the OASDI fund ratio, we measure the rise in one index or in both indexes during the applicable measuring period (described in paragraphs (b) and (c) of this section) to determine whether there will be an automatic cost-of-living increase and if so, its amount.

(b) *Measuring period based on the CPI*—(1) *When the period begins.* The measuring period we use for finding the amount of the CPI increase begins with the later of—

(i) Any calendar quarter in which an *ad hoc* benefit increase is effective; or

(ii) The third calendar quarter of any year in which the last automatic increase became effective.

(2) *When the period ends.* The measuring period ends with the third calendar quarter of the following year. If this measuring period ends in a year after the year in which an ad hoc increase was enacted or took effect, there can be no cost-of-living increase at that time. We will extend the measuring period to the third calendar quarter of the next year.

(c) *Measuring period based on the AWI*—(1) *When the period begins.* The measuring period we use for finding the amount of the AWI increase begins with the later of—

(i) The calendar year before the year in which an *ad hoc* benefit increase is effective; or

(ii) The calendar year before the year in which the last automatic increase became effective.

(2) *When the period ends.* The measuring period ends with the following year. If this measuring period ends in a year in which an *ad hoc* increase was enacted or took effect, there can be no cost-of-living increase at that time. We will extend the measuring period to the next calendar year.

[69 FR 19925, Apr. 15, 2004]

§ 404.275 How is an automatic cost-of-living increase calculated?

(a) *Increase based on the CPI.* We compute the average of the CPI for the quarters that begin and end the measuring period by adding the three monthly CPI figures, dividing the total by three, and rounding the result to the same number of decimal places as the published CPI figures. If the number of decimal places in the published CPI values differs between those used for the beginning and ending quarters, we use the number for the ending quarter. If the average for the ending quarter is higher than the average for the beginning quarter, we divide the average for the ending quarter by the average of the beginning quarter to determine the percentage increase in the CPI over the measuring period.

(b) *Increase based on the AWI.* If the AWI for the year that ends the measuring period is higher than the AWI for the year which begins the measuring period and all the other conditions for an AWI-based increase are met, we divide the higher AWI by the lower AWI to determine the percentage increase in the AWI.

(c) *Rounding rules.* We round the increase from the applicable paragraph (a) or (b) of this section to the nearest 0.1 percent by rounding 0.05 percent and above to the next higher 0.1 percent and otherwise rounding to the next lower 0.1 percent. For example, if the applicable index is the CPI and the increase in the CPI is 3.15 percent, we round the increase to 3.2 percent. We then apply this percentage increase to the amounts described in § 404.271 and round the resulting dollar amounts to the next lower multiple of $0.10 (if not already a multiple of $0.10).

(d) *Additional increase. See* § 404.278 for the additional increase that is possible.

[69 FR 19925, Apr. 15, 2004, as amended at 72 FR 2186, Jan. 18, 2007]

§ 404.276 Publication of notice of increase.

When we determine that an automatic cost-of-living increase is due, we publish in the FEDERAL REGISTER within 45 days of the end of the measuring period used in finding the amount of the increase—

(a) The fact that an increase is due;

(b) The amount of the increase;

(c) The increased special minimum primary insurance amounts; and

(d) The range of increased maximum family benefits that corresponds to the range of increased special minimum primary insurance amounts.

§ 404.277 When does the frozen minimum primary insurance amount increase because of cost-of-living adjustments?

(a) *What is the frozen minimum primary insurance amount (PIA)?* The frozen minimum is a minimum PIA for certain workers whose benefits are computed under the average-indexed-monthly-earnings method. Section 404.210(a) with § 404.212(e) explains when the frozen minimum applies.

(b) *When does the frozen minimum primary insurance amount (PIA) increase automatically?* The frozen minimum PIA increases automatically in every year in which you or your dependents or survivors are entitled to benefits and a cost-of-living increase applies.

(c) *When are automatic increases effective for old-age or disability benefits based on a frozen minimum primary insurance amount (PIA)?* Automatic cost-of-living increases apply to your frozen minimum PIA beginning with the earliest of:

(1) December of the year you become entitled to benefits and receive at least a partial benefit;

(2) December of the year you reach full retirement age (as defined in § 404.409) if you are entitled to benefits in or before the month you attain full retirement age, regardless of whether you receive at least a partial benefit; or

(3) December of the year you become entitled to benefits if that is after you attain full retirement age.

(d) *When are automatic increases effective for survivor benefits based on a frozen minimum primary insurance amount (PIA)?* (1) Automatic cost-of-living increases apply to the frozen minimum PIA used to determine survivor benefits in December of any year in which your child(ren), your surviving spouse caring for your child(ren), or your parent(s), are entitled to survivor benefits for at least one month.

(2) Automatic cost-of-living increases apply beginning with December of the earlier of:

(i) The year in which your surviving spouse or surviving divorced spouse (as defined in §§ 404.335 and 404.336) has attained full retirement age (as defined in § 404.409) and receives at least a partial benefit, or

(ii) The year in which your surviving spouse or surviving disabled spouse becomes entitled to benefits and receives at least a partial benefit.

(3) Automatic cost-of-living increases are not applied to the frozen minimum PIA in any year in which no survivor of yours is entitled to benefits on your social security record.

[68 FR 4702, Jan. 30, 2003]

§ 404.278 Additional cost-of-living increase.

(a) *General.* In addition to the cost-of-living increase explained in § 404.275 for a given year, we will further increase the amounts in § 404.271 if—

(1) The OASDI fund ratio is more than 32.0 percent in the given year in which a cost-of-living increase is due; and

(2) In any prior year, the cost-of-living increase was based on the AWI as the lower of the CPI and AWI.

(b) *Measuring period for the additional increase*—(1) To compute the additional increase for all individuals and for maximum benefits payable to a family, we begin with the year in which the insured individual became eligible for old-age or disability benefits to which he or she is currently entitled, or died before becoming eligible.

(2) *Ending.* The end of the measuring period is the year before the first year in which a cost-of-living increase is due based on the CPI and in which the OASDI fund ratio is more than 32.0 percent.

(c) *Compounded percentage benefit increase.* To compute the additional cost-of-living increase, we must first compute the compounded percentage benefit increase (CPBI) for both the cost-of-living increases that were actually paid during the measuring period and for the increases that would have been paid if the CPI had been the basis for all the increases.

(d) *Computing the CPBI.* The computation of the CPBI is as follows—

(1) Obtain the sum of (i) 1.000 and (ii) the actual cost-of-living increase percentage (expressed as a decimal) for each year in the measuring period;

(2) Multiply the resulting amount for the first year by that for the second year, then multiply that product by

the amount for the third year, and continue until the last amount has been multiplied by the product of the preceding amounts;

(3) Subtract 1 from the last product;

(4) Multiply the remaining product by 100. The result is what we call the *actual* CPBI.

(5) Substitute the cost-of-living increase percentage(s) that would have been used if the increase(s) had been based on the CPI (for some years, this will be the percentage that was used), and do the same computations as in paragraphs (d) (1) through (4) of this section. The result is what we call the *assumed* CPBI.

(e) *Computing the additional cost-of-living increase.* To compute the percentage increase, we—

(1) Subtract the actual CPBI from the assumed CPBI;

(2) Add 100 to the actual CPBI;

(3) Divide the answer from paragraph (e)(1) of this section by the answer from paragraph (e)(2) of this section, multiply the quotient by 100, and round to the nearest 0.1. The result is the additional increase percentage, which we apply to the appropriate amount described in § 404.271 after that amount has been increased under § 404.275 for a given year. If that increased amount is not a multiple of $0.10, we will decrease it to the next lower multiple of $0.10.

(f) *Restrictions on paying an additional cost-of-living increase.* We will pay the additional increase to the extent necessary to bring the benefits up to the level they would have been if they had been increased based on the CPI. However, we will pay the additional increase only to the extent payment will not cause the OASDI fund ratio to drop below 32.0 percent for the year after the year in which the increase is effective.

[51 FR 12604, Apr. 21, 1986, as amended at 69 FR 19925, Apr. 15, 2004; 83 FR 21708, May 10, 2018]

Recomputing Your Primary Insurance Amount

§ 404.280 Recomputations.

At times after you or your survivors become entitled to benefits, we will recompute your primary insurance amount. Usually we will recompute only if doing so will increase your primary insurance amount. However, we will also recompute your primary insurance amount if you first became eligible for old-age or disability insurance benefits after 1985, and later become entitled to a pension based on your noncovered employment, as explained in § 404.213. There is no limit on the number of times your primary insurance amount may be recomputed, and we do most recomputations automatically. In the following sections, we explain:

(a) Why a recomputation is made (§ 404.281),

(b) When a recomputation takes effect (§ 404.282),

(c) Methods of recomputing (§§ 404.283 and 404.284),

(d) Automatic recomputations (§ 404.285),

(e) Requesting a recomputation (§ 404.286),

(f) Waiving a recomputation (§ 404.287), and

(g) Recomputing when you are entitled to a pension based on noncovered employment (§ 404.288).

[52 FR 47918, Dec. 17, 1987]

§ 404.281 Why your primary insurance amount may be recomputed.

(a) *Earnings not included in earlier computation or recomputation.* The most common reason for recomputing your primary insurance amount is to include earnings of yours that were not used in the first computation or in an earlier recomputation, as described in paragraphs (c) through (e) of this section. These earnings will result in a revised average monthly wage or revised average indexed monthly earnings.

(b) *New computation method enacted.* If a new method of computing or recomputing primary insurance amounts is enacted into law and you are eligible to have your primary insurance amount recomputed under the new method, we will recompute it under the new method if doing so would increase your primary insurance amount.

(c) *Earnings in the year you reach age 62 or become disabled.* In the initial computation of your primary insurance amount, we do not use your earnings in the year you become entitled to old-

age insurance benefits or become disabled. However, we can use those earnings (called *lag earnings*) in a recomputation of your primary insurance amount. We recompute and begin paying you the higher benefits in the year after the year you become entitled to old-age benefits or become disabled.

(d) *Earnings not reported to us in time to use them in the computation of your primary insurance amount.* Because of the way reports of earnings are required to be submitted to us for years after 1977, the earnings you have in the year before you become entitled to old-age insurance benefits, or become disabled or in the year you die might not be reported to us in time to use them in computing your primary insurance amount. We recompute your primary insurance amount based on the new earnings information and begin paying you (or your survivors) the higher benefits based on the additional earnings, beginning with the month you became entitled or died.

(e) *Earnings after entitlement that are used in a recomputation.* Earnings that you have after you become entitled to benefits will be used in a recomputation of your primary insurance amount.

(f) *Entitlement to a monthly pension.* We will recompute your primary insurance amount if in a month after you became entitled to old-age or disability insurance benefits, you become entitled to a pension based on noncovered employment, as explained in § 404.213. Further, we will recompute your primary insurance amount after your death to disregard a monthly pension based on noncovered employment which affected your primary insurance amount.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.282 Effective date of recomputations.

Most recomputations are effective beginning with January of the calendar year after the year in which the additional earnings used in the recomputation were paid. However, a recomputation to include earnings in the year of death (whether or not paid before death) is effective for the month of death. Additionally if you first became eligible for old-age or disability insurance benefits after 1985 and you later also become entitled to a monthly pension based on noncovered employment, we will recompute your primary insurance amount under the rules in § 404.213; this recomputed Social Security benefit amount is effective for the first month you are entitled to the pension. Finally, if your primary insurance amount was affected by your entitlement to a pension, we will recompute the amount to disregard the pension, effective with the month of your death.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.283 Recomputation under method other than that used to find your primary insurance amount.

In some cases, we may recompute your primary insurance amount under a computation method different from the method used in the computation (or earlier recomputation) of your primary insurance amount, if you are eligible for a computation or recomputation under the different method.

§ 404.284 Recomputations for people who reach age 62, or become disabled, or die before age 62 after 1978.

(a) *General.* Years of your earnings after 1978 not used in the computation of your primary insurance amount (or in earlier recomputations) under the average-indexed-monthly-earnings method may be substituted for earlier years of your indexed earnings in a recomputation, but only under the average-indexed-monthly-earnings method. See § 404.288 for the rules on recomputing when you are entitled to a monthly pension based on noncovered employment.

(b) *Substituting actual dollar amounts in earnings for earlier years of indexed earnings.* When we recompute your primary insurance amount under the average-indexed-monthly earnings method, we use actual dollar amounts, *i.e.*, no indexing, for earnings not included in the initial computation or earlier recomputation. These later earnings are substituted for earlier years of indexed or actual earnings that are lower.

(c) *Benefit formula used in recomputation.* The formula that was used in the first computation of your primary insurance amount is also used in recomputations of your primary insurance amount.

(d) *Your recomputed primary insurance amount.* We recompute your primary insurance amount by applying the benefit formula to your average indexed monthly earnings as revised to include additional earnings. See § 404.281. We then increase the recomputed PIA by the amounts of any automatic cost-of-living or *ad hoc* increases in primary insurance amounts that have become effective since you reached age 62, or became disabled or died before age 62.

(e) *Minimum increase in primary insurance amounts.* Your primary insurance amount may not be recomputed unless doing so would increase it by at least $1.

Example 1. Ms. A, whose primary insurance amount we computed to be $432.40 in June 1979 in §§ 404.210 through 404.212 (based on average indexed monthly earnings of $903), had earnings of $11,000 in 1979 which were not used in the initial computation of her primary insurance amount. We may recompute her primary insurance amount effective for January 1980. In this recomputation, her 1979 earnings may be substituted in their actual dollar amount for the lowest year of her indexed earnings that was used in the initial computation. In Ms. A's case, we substitute the $11,000 for her 1966 indexed earnings of $8,911.36. Her total indexed earnings are now $251,470.05 and her new average indexed monthly earnings are $911. We apply to Ms. A's new average indexed monthly earnings the same benefit formula we used in the initial computation. Doing so produces an amount of $396.00. An automatic cost-of-living increase of 9.9 percent was effective in June 1979. We increase the $396.00 amount by 9.9 percent to find Ms. A's recomputed primary insurance amount of $435.30. Later we increased the primary insurance amount to $497.60 to reflect the 14.3 percent cost-of-living increase beginning June 1980 and to $553.40 to reflect the 11.2 percent cost-of-living increase beginning June 1981.

Example 2. Mr. B, whose primary insurance amount we computed to be $429.20 (based on average monthly wages of $502) in June 1978 in §§ 404.220 through 404.222, had earnings of $12,000 in 1978 which were not used in the initial computation of his primary insurance amount. We may recompute his primary insurance amount effective for January 1979. In this recomputation, his 1978 earnings are substituted for the lowest year of earnings used in the initial computation ($2,700 in 1952). Mr. B's total earnings are now $142,000 and his new average monthly wage is $537.

We next find Mr. B's new average monthly wage in column III of the December 1978 benefit table in appendix III. Reading across, we find his recomputed primary insurance amount on the same line in column IV, which is $407.70. We then apply the 9.9 percent, the 14.3 percent and the 11.2 percent automatic cost-of-living increases for June 1979, June 1980, and June 1981, respectively, to compute Mr. B's primary insurance amount of $569.60.

(f) *Guaranteed alternatives.* We may recompute your primary insurance amount by any of the following methods for which you qualify, if doing so would result in a higher amount than the one computed under the average-indexed-monthly-earnings method. Earnings in or after the year you reach age 62 cannot be used.

(1) If you reached age 62 after 1978 and before 1984, we may recompute to include earnings for years before the year you reached age 62 by using the guaranteed alternative (§ 404.231). We will increase the result by any cost-of-living or *ad hoc* increases in the primary insurance amounts that have become effective in and after the year you reached age 62.

(2) We will also recompute under the old-start guarantee (§ 404.242) and the prior-disability guarantee (§ 404.252) if you meet the requirements of either or both these methods.

[47 FR 30734, July 15, 1982, as amended at 52 FR 47918, Dec. 17, 1987]

§ 404.285 Recomputations performed automatically.

Each year, we examine the earnings record of every retired, disabled, and deceased worker to see if the worker's primary insurance amount may be recomputed under any of the methods we have described. When a recomputation is called for, we perform it automatically and begin paying the higher benefits based on your recomputed primary insurance amount for the earliest possible month that the recomputation can be effective. You do not have to request this service, although you may request a recomputation at an earlier

date than one would otherwise be performed (see § 404.286). Doing so, however, does not allow your increased primary insurance amount to be effective any sooner than it would be under an automatic recomputation. You may also waive a recomputation if one would disadvantage you or your family (see § 404.287).

§ 404.286 How to request an immediate recomputation.

You may request that your primary insurance amount be recomputed sooner than it would be recomputed automatically. To do so, you must make the request in writing to us and provide acceptable evidence of your earnings not included in the first computation or earlier recomputation of your primary insurance amount. If doing so will increase your primary insurance amount, we will recompute it. However, we cannot begin paying higher benefits on the recomputed primary insurance amount any sooner than we could under an automatic recomputation, *i.e.*, for January of the year following the year in which the earnings were paid or derived.

§ 404.287 Waiver of recomputation.

If you or your family would be disadvantaged in some way by a recomputation of your primary insurance amount, or you and every member of your family do not want your primary insurance amount to be recomputed for any other reason, you may waive (that is, give up your right to) a recomputation, but you must do so in writing. That you waive one recomputation, however, does not mean that you also waive future recomputations for which you might be eligible.

§ 404.288 Recomputing when you are entitled to a monthly pension based on noncovered employment.

(a) *After entitlement to old-age or disability insurance benefits.* If you first become eligible for old-age or disability insurance benefits after 1985 and you later become entitled to a monthly pension based on noncovered employment, we may recompute your primary insurance amount under the rules in § 404.213. When recomputing, we will use the amount of the pension to which you are entitled or deemed entitled in the first month that you are concurrently eligible for both the pension and old-age or disability insurance benefits. We will disregard the rule in § 404.284(e) that the recomputation must increase your primary insurance amount by at least $1.

(b) *Already entitled to benefits and to a pension based on noncovered employment.* If we have already computed or recomputed your primary insurance amount to take into account your monthly pension, we may later recompute for one of the reasons explained in § 404.281. We will recompute your primary insurance amount under the rules in §§ 404.213 and 404.284. Any increase resulting from the recomputation under the rules of § 404.284 will be added to the most recent primary insurance amount which we had computed to take into account your monthly pension.

(c) *After your death.* If one or more survivors are entitled to benefits after your death, we will recompute the primary insurance amount as though it had never been affected by your entitlement to a monthly pension based in whole or in part on noncovered employment.

[52 FR 47918, Dec. 17, 1987]

RECALCULATIONS OF PRIMARY INSURANCE AMOUNTS

§ 404.290 Recalculations.

(a) Your primary insurance amount may be ''recalculated'' in certain instances. When we recalculate your primary amount, we refigure it under the same method we used in the first computation by taking into account—

(1) Earnings (including compensation for railroad service) incorrectly included or excluded in the first computation;

(2) Special deemed earnings credits including credits for military service (see subpart N of this part) and for individuals interned during World War II (see subpart K of this part), not available at the time of the first computation;

(3) Correction of clerical or mathematical errors; or

(4) Other miscellaneous changes in status.

(b) Unlike recomputations, which may only serve to increase your primary insurance amount, recalculations may serve to either increase or reduce it.

APPENDIXES TO SUBPART C OF PART 404—NOTE

The following appendices contain data that are needed in computing primary insurance amounts. Appendix I contains *average of the total wages* figures, which we use to *index* a worker's earnings for purposes of computing his or her average indexed monthly earnings. Appendix II contains benefit formulas which we apply to a worker's average indexed monthly earnings to find his or her primary insurance amount. Appendix III contains the benefit table we use to find a worker's primary insurance amount from his or her average monthly wage. We use the figures in appendix IV to find your years of coverage for years after 1950 for purposes of your special minimum primary insurance amount. Appendix V contains the table for computing the special minimum primary insurance amount. Appendix VI is a table of the percentage increases in primary insurance amounts since 1978. Appendix VII is a table of the *old-law* contribution and benefit base that would have been effective under the Social Security Act without enactment of the 1977 amendments.

The figures in the appendices are by law automatically adjusted each year. We are required to announce the changes through timely publication in the FEDERAL REGISTER. The only exception to the requirement of publication in the FEDERAL REGISTER is the update of benefit amounts shown in appendix III. We update the benefit amounts for payment purposes but are not required by law to publish this extensive table in the FEDERAL REGISTER. We have not updated the table in appendix III, but the introductory paragraphs at appendix III explain how you can compute the current benefit amount.

When we publish the figures in the FEDERAL REGISTER, we do not change every one of these figures. Instead, we provide new ones for each year that passes. We continue to use the old ones for various computation purposes, as the regulations show. Most of the new figures for these appendices are required by law to be published by November 1 of each year. Notice of automatic cost-of-living increases in primary insurance amounts is required to be published within 45 days of the end of the applicable measuring period for the increase (see §§ 404.274 and 404.276). In effect, publication is required within 45 days of the end of the third calendar quarter of any year in which there is to be an automatic cost-of-living increase.

We begin to use the new data in computing primary insurance amounts as soon as required by law, even before we periodically update these appendices. If the data you need to find your primary insurance amount have not yet been included in the appendices, you may find the figures in the FEDERAL REGISTER on or about November 1.

[52 FR 8247, Mar. 17, 1987]

APPENDIX I TO SUBPART C OF PART 404—AVERAGE OF THE TOTAL WAGES FOR YEARS AFTER 1950

Explanation: We use these figures to index your social security earnings (as described in § 404.211) for purposes of computing your average indexed monthly earnings.

Calendar year	Average of the total wages
1951	$2,799.16
1952	2,973.32
1953	3,139.44
1954	3,155.64
1955	3,301.44
1956	3,532.36
1957	3,641.72
1958	3,673.80
1959	3,855.80
1960	4,007.12
1961	4,086.76
1962	4,291.40
1963	4,396.64
1964	4,576.32
1965	4,658.72
1966	4,938.36
1967	5,213.44
1968	5,571.76
1969	5,893.76
1970	6,186.24
1971	6,497.08
1972	7,133.80
1973	7,580.16
1974	8,030.76
1975	8,630.92
1976	9,226.48
1977	9,779.44
1978	10,556.03
1979	11,479.46
1980	12,513.46
1981	13,773.10
1982	14,531.34
1983	15,239.24
1984	16,135.07
1985	16,822.51
1986	17,321.82
1987	18,426.51
1988	19,334.04
1989	20,099.55
1990	21,027.98

[47 FR 30734, July 15, 1982, as amended at 52 FR 8247, Mar. 17, 1987; 57 FR 44096, Sept. 24, 1992]

APPENDIX II TO SUBPART C OF PART 404—BENEFIT FORMULAS USED WITH AVERAGE INDEXED MONTHLY EARNINGS

As explained in §404.212, we use one of the formulas below to compute your primary insurance amount from your average indexed monthly earnings (AIME). To select the appropriate formula, we find in the left-hand column the year after 1978 in which you reach age 62, or become disabled, or die before age 62. The benefit formula to be used in computing your primary insurance amount is on the same line in the right-hand columns. For example, if you reach age 62 or become disabled or die before age 62 in 1979, then we compute 90 percent of the first $180 of AIME, 32 percent of the next $905 of AIME, and 15 percent of AIME over $1,085. After we figure your amount for each step in the formula, we add the amounts. If the total is not already a multiple of $0.10, we round the total as follows:

(1) For computations using the benefit formulas in effect for 1979 through 1982, we round the total upward to the nearest $0.10, and

(2) For computations using the benefit formulas in effect for 1983 and later, we round the total downward to the nearest $0.10.

BENEFIT FORMULAS

Year you reach age 62 [1]	90 percent of the first—	plus 32 percent of the next—	plus 15 percent of AIME over—
1979	$180	$905	$1,085
1980	194	977	1,171
1981	211	1,063	1,274
1982	230	1,158	1,388
1983	254	1,274	1,528
1984	267	1,345	1,612
1985	280	1,411	1,691
1986	297	1,493	1,790
1987	310	1,556	1,866
1988	319	1,603	1,922
1989	339	1,705	2,044
1990	356	1,789	2,145
1991	370	1,860	2,230
1992	387	1,946	2,333

[1] Or become disabled or die before age 62.

[57 FR 44096, Sept. 24, 1992; 57 FR 45878, Oct. 5, 1992]

APPENDIX III TO SUBPART C OF PART 404—BENEFIT TABLE

This benefit table shows primary insurance amounts and maximum family benefits in effect in December 1978 based on cost-of-living increases which became effective for June 1978. (See §404.403 for information on maximum family benefits.) You will also be able to find primary insurance amounts for an individual whose entitlement began in the period June 1977 through May 1978.

The benefit table in effect in December 1978 had a minimum primary insurance amount of $121.80. As explained in §404.222(b), certain workers eligible, or who died without having been eligible, before 1982 had their benefit computed from this table. However, the minimum benefit provision was repealed for other workers by the 1981 amendments to the Act (the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35 as modified by Pub. L. 97–123). As a result, this benefit table includes a downward extension from the former minimum of $121.80 to the lowest primary insurance amount now possible. The extension is calculated as follows. For each single dollar of average monthly wage in the benefit table, the primary insurance amount shown for December 1978 is $121.80 multiplied by the ratio of that average monthly wage to $76. The upper limit of each primary insurance benefit range in column I of the table is $16.20 multiplied by the ratio of the average monthly wage in column III of the table to $76. The maximum family benefit is 150 percent of the corresponding primary insurance amount.

The repeal of the minimum benefit provision is effective with January 1982 for most workers and their families where the worker initially becomes eligible for benefits after 1981 or dies after 1981 without having been eligible before January 1982. For members of a religious order who are required to take a vow of poverty, as explained in 20 CFR 404.1024, and which religious order elected Social Security coverage before December 29, 1981, the repeal is effective with January 1992 based on first eligibility or death in that month or later.

To use this table, you must first compute the primary insurance benefit (column I) or the average monthly wage (column III), then move across the same line to either column II or column IV as appropriate. To determine increases in primary insurance amounts since December 1978 you should see appendix VI. Appendix VI tells you, by year, the percentage of the increases. In applying each cost-of-living increase to primary insurance amounts, we round the increased primary insurance amount to the next lower multiple of $0.10 if not already a multiple of $0.10. (For cost-of-living increases which are effective before June 1982, we round to the next higher multiple of $0.10.)

EXTENDED DECEMBER 1978 TABLE OF BENEFITS EFFECTIVE JANUARY 1982

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective January 1982: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
	0.42		2	1	1.70	2.60
0.43	.63		3	2	3.30	5.00
.64	.85		4	3	4.90	7.40
.86	1.06		5	4	6.50	9.80
1.07	1.27		6	5	8.10	12.20
1.28	1.49		7	6	9.70	14.60
1.50	1.70		8	7	11.30	17.00
1.71	1.91		9	8	12.90	19.40
1.92	2.13		10	9	14.50	21.80
2.14	2.34		11	10	16.10	24.20
2.35	2.55		12	11	17.70	26.60
2.56	2.77		13	12	19.30	29.00
2.78	2.98		14	13	20.90	31.40
2.99	3.19		15	14	22.50	33.80
3.20	3.41		16	15	24.10	36.20
3.42	3.62		17	16	25.70	38.60
3.63	3.83		18	17	27.30	41.00
3.84	4.05		19	18	28.90	43.40
4.06	4.26		20	19	30.50	45.80
4.27	4.47		21	20	32.10	48.20
4.48	4.68		22	21	33.70	50.60
4.69	4.90		23	22	35.30	53.00
4.91	5.11		24	23	36.90	55.40
5.12	5.32		25	24	38.50	57.80
5.33	5.54		26	25	40.10	60.20
5.55	5.75		27	26	41.70	62.60
5.76	5.96		28	27	43.30	65.00
5.97	6.18		29	28	44.90	67.40
6.19	6.39		30	29	46.50	69.80
6.40	6.60		31	30	48.10	72.20
6.61	6.82		32	31	49.70	74.60
6.83	7.03		33	32	51.30	77.00
7.04	7.24		34	33	52.90	79.40
7.25	7.46		35	34	54.50	81.80
7.47	7.67		36	35	56.10	84.20
7.68	7.88		37	36	57.70	86.60
7.89	8.10		38	37	59.30	89.00
8.11	8.31		39	38	60.90	91.40
8.32	8.52		40	39	62.60	93.90
8.53	8.73		41	40	64.20	96.30
8.74	8.95		42	41	65.80	98.70
8.96	9.16		43	42	67.40	101.10
9.17	9.37		44	43	69.00	103.50
9.38	9.59		45	44	70.60	105.90
9.60	9.80		46	45	72.20	108.30
9.81	10.01		47	46	73.80	110.70
10.02	10.23		48	47	75.40	113.10
10.24	10.44		49	48	77.00	115.50
10.45	10.65		50	49	78.60	117.90
10.66	10.87		51	50	80.20	120.30
10.88	11.08		52	51	81.80	122.70
11.09	11.29		53	52	83.40	125.10
11.30	11.51		54	53	85.00	127.50
11.52	11.72		55	54	86.60	129.90
11.73	11.93		56	55	88.20	132.30
11.94	12.15		57	56	89.80	134.70
12.16	12.36		58	57	91.40	137.10
12.37	12.57		59	58	93.00	139.50
12.58	12.78		60	59	94.60	141.90
12.79	13.00		61	60	96.20	144.30
13.01	13.21		62	61	97.80	146.70
13.22	13.42		63	62	99.40	149.10
				63	101.00	151.50

EXTENDED DECEMBER 1978 TABLE OF BENEFITS EFFECTIVE JANUARY 1982—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective January 1982: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
13.43	13.64		64	64	102.60	153.90
13.65	13.85		65	65	104.20	156.30
13.86	14.06		66	66	105.80	158.70
14.07	14.28		67	67	107.40	161.10
14.29	14.49		68	68	109.00	163.50
14.50	14.70		69	69	110.60	165.90
14.71	14.92		70	70	112.20	168.30
14.93	15.13		71	71	113.80	170.70
15.14	15.34		72	72	115.40	173.10
15.35	15.56		73	73	117.00	175.50
15.57	15.77		74	74	118.60	177.90
15.78	15.98		75	75	120.20	180.30
15.99	16.20		76	76	121.80	182.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
	16.20	114.30		76	121.80	182.70
16.21	16.84	116.10	77	78	123.70	185.60
16.85	17.60	118.80	79	80	126.60	189.90
17.61	18.40	121.00	81	81	128.90	193.50
18.41	19.24	123.00	82	83	131.20	196.80
19.25	20.00	125.80	84	85	134.00	201.00
20.01	20.64	128.10	86	87	136.50	204.80
20.65	21.28	130.10	88	89	138.60	207.90
21.29	21.88	132.70	90	90	141.40	212.10
21.89	22.28	135.00	91	92	143.80	215.70
22.29	22.68	137.20	93	94	146.20	219.20
22.59	23.08	139.40	95	96	148.50	222.80
23.09	23.44	142.00	97	97	151.30	227.00
23.45	23.76	144.30	98	99	153.70	230.60
23.77	24.20	147.10	100	101	156.70	235.10
24.21	24.60	149.20	102	102	158.90	238.50
24.61	25.00	151.70	103	104	161.60	242.40
25.01	25.48	154.50	105	106	164.60	246.90
25.49	25.92	157.00	107	107	167.30	251.00
25.93	26.40	159.40	108	109	169.80	254.80
26.41	26.94	161.90	110	113	172.50	258.80
26.95	27.46	164.20	114	118	174.90	262.40
27.47	28.00	166.70	119	122	177.60	266.50
28.01	28.68	169.30	123	127	180.40	270.60
28.69	29.25	171.80	128	132	183.00	274.60
29.26	29.68	174.10	133	136	185.50	278.30
29.69	30.36	176.50	137	141	188.00	282.10
30.37	30.92	179.10	142	146	190.80	286.20
30.93	31.36	181.70	147	150	193.60	290.40
31.37	32.00	183.90	151	155	195.90	293.90
32.01	32.60	186.50	156	160	198.70	298.10
32.61	33.20	189.00	161	164	201.30	302.00
33.21	33.88	191.40	165	169	203.90	305.90
33.89	34.50	194.00	170	174	206.70	310.10
34.51	35.00	196.30	175	178	209.10	313.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
35.01	35.80	198.90	179	183	211.90	318.00
35.81	36.40	201.30	184	188	214.40	321.70
36.41	37.08	203.90	189	193	217.20	326.00
37.09	37.60	206.40	194	197	219.90	329.90
37.61	38.20	208.80	198	202	222.40	333.60
38.21	39.12	211.50	203	207	225.30	338.00
39.13	39.68	214.00	208	211	228.00	342.00
39.69	40.33	216.00	212	216	230.10	345.20
40.34	41.12	218.70	217	221	233.00	349.50
41.13	41.76	221.20	222	225	235.60	353.40
41.77	42.44	223.90	226	230	238.50	357.80
42.45	43.20	226.30	231	235	241.10	361.70
43.21	43.76	229.10	236	239	244.00	366.10
43.77	44.44	231.20	240	244	246.30	371.10
44.45	44.88	233.50	245	249	248.70	378.80
44.89	45.60	236.40	250	253	251.80	384.90
		238.70	254	258	254.30	392.50
		240.80	259	263	256.50	400.00
		243.70	264	267	259.60	206.00
		246.10	268	272	262.10	413.70
		248.70	273	277	264.90	421.20
		251.00	278	281	267.40	427.20
		253.50	282	286	270.00	434.90
		256.20	287	291	272.90	442.60
		258.30	292	295	275.10	448.50
		261.10	296	300	278.10	456.10
		263.50	301	305	280.70	463.80
		265.80	306	309	283.10	469.80
		268.50	310	314	286.00	477.40
		270.70	315	319	288.30	485.10
		273.20	320	323	291.00	491.10
		275.80	324	328	293.80	498.70
		278.10	329	333	296.20	506.20
		281.00	334	337	299.30	512.50
		283.00	338	342	301.40	519.90
		285.60	343	347	304.20	527.50
		288.30	348	351	307.10	533.60
		290.50	352	356	309.40	541.20
		293.30	357	361	312.40	548.80
		295.60	362	365	314.90	554.90
		297.90	366	370	317.30	562.50
		300.60	371	375	320.20	569.90
		303.10	376	379	322.90	576.30
		305.70	380	384	325.60	583.90
		307.90	385	389	328.00	591.30
		310.30	390	393	330.50	597.40
		313.00	394	398	333.40	605.10
		315.40	399	403	336.00	612.70
		318.20	404	407	338.90	618.60
		320.20	408	412	341.10	626.30
		322.50	413	417	343.50	633.80
		324.80	418	421	346.00	639.90
		327.40	422	426	348.70	647.50
		329.60	427	431	351.10	655.10
		331.60	432	436	353.20	662.70
		334.40	437	440	356.20	665.70
		336.50	441	445	358.40	669.70
		338.70	446	450	360.80	673.40
		341.30	451	454	363.50	676.30
		343.50	455	459	365.90	680.10
		345.80	460	464	368.30	683.80
		347.90	465	468	370.60	687.10
		350.70	469	473	373.50	690.80

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		352.60	474	478	375.60	694.60
		354.90	479	482	378.00	697.70
		357.40	483	487	380.70	701.60
		359.70	488	492	383.10	705.40
		361.90	493	496	385.50	708.40
		364.50	497	501	388.20	712.10
		366.60	502	506	390.50	715.80
		368.90	507	510	392.90	719.00
		371.10	511	515	395.30	722.80
		373.70	516	520	398.00	726.70
		375.80	521	524	400.30	729.50
		378.10	525	529	402.70	733.40
		380.80	530	534	405.60	737.10
		382.80	535	538	407.70	740.20
		385.10	539	543	410.20	744.10
		387.60	544	548	412.80	747.80
		389.90	549	553	415.30	751.60
		392.10	554	556	417.60	753.90
		393.90	557	560	419.60	756.90
		396.10	561	563	421.90	759.30
		398.20	564	567	424.10	762.30
		400.40	568	570	426.50	764.50
		402.30	571	574	428.50	767.50
		404.40	575	577	430.70	769.90
		406.20	578	581	432.70	772.80
		408.40	582	584	435.00	775.20
		410.20	585	588	436.90	778.20
		412.60	589	591	439.50	780.50
		414.60	592	595	441.60	783.50
		416.70	596	598	443.80	785.60
		418.70	599	602	446.00	788.90
		420.70	603	605	448.10	791.10
		422.80	606	609	450.30	794.00
		424.90	610	612	452.60	796.50
		426.90	613	616	454.70	799.50
		428.90	617	620	456.80	802.50
		431.00	621	623	459.10	804.80
		433.00	624	627	461.20	807.90
		435.10	628	630	463.40	810.70
		437.10	631	634	465.60	814.70
		439.20	635	637	467.80	818.50
		441.40	638	641	470.10	822.40
		443.20	642	644	472.10	826.10
		445.40	645	648	474.40	830.10
		447.40	649	652	476.50	833.70
		448.60	653	656	477.80	836.10
		449.90	657	660	479.20	838.40
		451.50	661	665	480.90	841.50
		453.10	666	670	482.60	844.50
		454.80	671	675	484.40	847.40
		456.40	676	680	486.10	850.50
		458.00	681	685	487.80	853.50
		459.80	686	690	489.70	856.40
		461.20	691	695	491.20	859.60
		462.80	696	700	492.90	862.60
		464.50	701	705	494.70	865.60
		466.10	706	710	496.40	868.60
		467.70	711	715	498.20	871.50
		469.40	716	720	500.00	874.60
		471.00	721	725	501.70	877.60
		472.60	726	730	503.40	880.70
		474.20	731	735	505.10	883.80
		475.90	736	740	506.90	886.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		477.40	741	745	508.50	889.90
		478.90	746	750	510.10	892.70
		480.40	751	755	511.70	896.40
		481.80	756	760	513.20	897.80
		483.20	761	765	514.70	900.40
		484.50	766	770	516.00	903.00
		485.80	771	775	517.40	905.40
		487.20	776	780	518.90	907.90
		488.60	781	785	520.40	910.40
		489.80	786	790	521.70	912.90
		491.10	791	795	523.10	915.40
		492.50	796	800	524.60	918.00
		494.00	801	805	526.20	920.50
		495.30	806	810	527.50	923.00
		496.70	811	815	529.00	925.60
		498.00	816	820	530.40	928.00
		499.40	821	825	531.90	930.60
		500.70	826	830	533.30	933.10
		502.00	831	835	534.70	935.70
		503.30	836	840	536.10	938.10
		504.70	841	845	537.60	940.80
		506.00	846	850	538.90	943.00
		507.50	851	855	540.50	945.70
		508.80	856	860	541.90	948.10
		510.20	861	865	543.40	950.70
		511.50	866	870	544.80	953.20
		512.90	871	875	546.30	955.70
		514.10	876	880	547.60	958.20
		515.50	881	885	549.10	960.80
		516.80	886	890	550.40	963.20
		518.20	891	895	551.90	966.00
		519.60	896	900	553.40	968.30
		521.00	901	905	554.90	970.90
		522.30	906	910	556.30	973.50
		523.70	911	915	557.80	976.00
		525.10	916	920	559.30	978.30
		526.30	921	925	560.60	961.00
		527.60	926	930	561.90	983.40
		529.00	931	935	563.40	985.90
		530.40	936	940	564.90	988.50
		531.70	941	945	566.30	991.00
		533.00	946	950	567.70	993.50
		534.50	951	955	569.30	996.10
		535.90	956	960	570.80	998.60
		537.30	961	965	572.30	1,001.00
		538.40	966	970	573.40	1,003.60
		539.80	971	975	574.90	1,006.20
		541.20	976	980	576.40	1,008.50
		542.60	981	985	577.90	1,011.10
		543.80	986	990	579.20	1,013.60
		545.20	991	995	580.70	1,016.20
		546.60	996	1,000	582.20	1,018.60
		547.80	1,001	1,005	583.50	1,020.70
		548.90	1,006	1,010	584.60	1,023.20
		550.20	1,011	1,015	586.00	1,025.30
		551.50	1,016	1,020	587.40	1,027.80
		552.60	1,021	1,025	588.60	1,029.90
		553.80	1,026	1,030	589.80	1,032.20
		555.10	1,031	1,035	591.20	1,034.50
		556.20	1,036	1,040	592.40	1,036.70
		557.50	1,041	1,045	593.80	1,039.10
		558.80	1,046	1,050	595.20	1,041.30
		559.80	1,051	1,055	596.20	1,043.40

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		561.10	1,056	1,060	597.60	1,045.90
		562.40	1,061	1,065	599.00	1,048.00
		563.60	1,066	1,070	600.30	1,050.50
		564.80	1,071	1,075	601.60	1,052.60
		566.00	1,076	1,080	602.80	1,054.90
		567.30	1,081	1,085	604.20	1,057.10
		568.40	1,086	1,090	605.40	1,059.40
		569.70	1,091	1,095	606.80	1,061.70
		571.00	1,096	1,100	608.20	1,064.00
		572.00	1,101	1,105	609.20	1,066.10
		573.30	1,106	1,110	610.60	1.068.50
		574.60	1,111	1,115	612.00	1,070.70
		575.70	1,116	1,120	613.20	1,073.10
		577.00	1,121	1,125	614.60	1,075.30
		578.20	1,126	1,130	615.80	1,077.60
		579.40	1,131	1,135	617.10	1,079.70
		580.60	1,136	1,140	618.40	1,082.20
		581.90	1,141	1,145	619.80	1,084.40
		583.10	1,146	1,150	621.10	1,086.70
		584.20	1,151	1,555	622.20	1,088.80
		585.50	1,156	1,160	623.60	1,091.10
		586.70	1,161	1,165	624.90	1,093.40
		587.90	1,166	1,170	626.20	1,095.80
		589.20	1,171	1,175	627.50	1,098.00
		590.30	1,176	1,180	628.70	1,100.20
		591.40	1,181	1,185	629.90	1,102.20
		592.60	1,186	1,190	631.20	1,104.30
		593.70	1,191	1,195	632.30	1,106.50
		594.80	1,196	1,200	633.50	1,108.60
		595.90	1,201	1,205	634.70	1,110.60
		597.10	1,206	1,210	636.00	1,112.90
		598.20	1,211	1,215	637.10	1,114.90
		599.30	1,216	1,220	638.30	1,117.00
		600.40	1,221	1,225	639.50	1,119.00
		601.60	1,226	1,230	640.80	1,121.20
		602.70	1,231	1,235	641.90	1,123.30
		603.80	1,236	1,240	643.10	1,125.40
		605.00	1,241	1,245	644.40	1,127.50
		606.10	1,246	1,250	645.50	1,129.60
		607.20	1,251	1,255	646.70	1,131.60
		608.30	1,256	1,260	647.90	1,133.80
		609.50	1,261	1,265	649.20	1,135.90
		610.60	1,266	1,270	650.30	1,138.00
		611.70	1,271	1,275	651.50	1,140.00
		612.80	1,276	1,280	652.70	1,142.20
		613.80	1,281	1,285	653.70	1,144.10
		614.80	1,286	1,290	654.90	1,146.10
		616.00	1,291	1,295	656.10	1,148.00
		617.00	1,296	1,300	657.20	1,150.00
		618.10	1,301	1,305	658.30	1,152.00
		619.10	1,306	1,310	659.40	1,154.00
		620.20	1,311	1,315	660.60	1,155.90
		621.30	1,316	1,320	661.70	1,157.90
		622.30	1,321	1,325	662.80	1,159.80
		623.40	1,326	1,330	664.00	1,161.90
		624.40	1,331	1,335	665.00	1,163.80
		625.50	1,336	1,340	666.20	1,165.80
		626.60	1,341	1,345	667.40	1,167.70
		627.60	1,346	1,350	668.40	1,169.70
		628.70	1,351	1,355	669.60	1,171.70
		629.70	1,356	1,360	670.70	1,173.70
		630.80	1,361	1,365	671.90	1,175.60
		631.80	1,366	1,370	672.90	1,177.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		632.90	1,371	1,375	674.10	1,179.60
		633.90	1,376	1,380	675.20	1,181.60
		634.90	1,381	1,385	676.20	1,183.40
		635.90	1,386	1,390	677.30	1,185.30
		636.90	1,391	1,395	678.30	1,187.10
		637.90	1,396	1,400	679.40	1,189.00
		638.90	1,401	1,405	680.50	1,190.80
		639.90	1,406	1,410	681.50	1,192.70
		640.90	1,411	1,415	682.60	1,194.60
		641.90	1,416	1,420	683.70	1,196.50
		642.90	1,421	1,425	685.70	1,198.30
		643.90	1,426	1,430	684.80	1,200.20
		644.90	1,431	1,435	686.90	1,202.00
		645.90	1,436	1,440	687.90	1,203.90
		646.90	1,441	1,445	689.00	1,205.70
		647.90	1,446	1,450	690.10	1,207.70
		648.90	1,451	1,455	691.10	1,209.50
		649.90	1,456	1,460	692.20	1,211.40
		650.90	1,461	1,465	693.30	1,213.20
		651.90	1,466	1,470	694.30	1,215.10
		652.90	1,471	1,475	695.40	1,216.90

[47 FR 30734, July 15, 1982; 47 FR 35479, Aug. 16, 1982, as amended at 48 FR 46143, Oct. 11, 1983; 48 FR 50076, Oct. 31, 1983]

APPENDIX IV TO SUBPART C OF PART 404—EARNINGS NEEDED FOR A YEAR OF COVERAGE AFTER 1950

MINIMUM SOCIAL SECURITY EARNINGS TO QUALIFY FOR A YEAR OF COVERAGE AFTER 1950 FOR PURPOSES OF THE—

Year	Special minimum primary insurance amount	Benefit computations described in section 404.213(d)[2]
1951–1954	$900	$900
1955–1958	1,050	1,050
1959–1965	1,200	1,200
1966–1967	1,650	1,650
1968–1971	1,950	1,950
1972	2,250	2,250
1973	2,700	2,700
1974	3,300	3,300
1975	3,525	3,525
1976	3,825	3,825
1977	4,125	4,125
1978	4,425	4,425
1979	4,725	4,725
1980	5,100	5,100
1981	5,550	5,550
1982	6,075	6,075
1983	6,675	6,675
1984	7,050	7,050
1985	7,425	7,425
1986	7,875	7,875

MINIMUM SOCIAL SECURITY EARNINGS TO QUALIFY FOR A YEAR OF COVERAGE AFTER 1950 FOR PURPOSES OF THE——Continued

Year	Special minimum primary insurance amount	Benefit computations described in section 404.213(d)[2]
1987	8,175	8,175
1988	8,400	8,400
1989	8,925	8,925
1990	9,525	9,525
1991	5,940	9,900
1992	6,210	10,350

[2] Applies only to certain individuals with pensions from noncovered employment.

NOTE: For 1951–78, the amounts shown are 25 percent of the contribution and benefit base (the contribution and benefit base is the same as the annual wage limitation as shown in § 404.1047) in effect. For years after 1978, however, the amounts are 25 percent of what the contribution and benefit base would have been if the 1977 Social Security Amendments had not been enacted, except, for special minimum benefit purposes, the applicable percentage is 15 percent for years after 1990.

[57 FR 44096, Sept. 24, 1992]

APPENDIX V TO SUBPART C OF PART 404—COMPUTING THE SPECIAL MINIMUM PRIMARY INSURANCE AMOUNT AND RELATED MAXIMUM FAMILY BENEFITS

These tables are based on section 215(a)(1)(C)(i) of the Social Security Act, as amended. They include the percent cost-of-living increase shown in appendix VI for each effective date.

JUNE 1979

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$12.70	$19.10
12	25.30	38.00
13	38.00	57.00
14	50.60	75.90
15	63.20	94.90
16	75.90	113.90
17	88.50	132.80
18	101.20	151.80
19	113.80	170.70
20	126.40	189.60
21	139.10	208.70
22	151.70	227.60
23	164.40	246.60
24	177.00	265.50
25	189.60	284.50
26	202.30	303.50
27	214.90	322.40
28	227.50	341.30
29	240.20	360.30
30	252.80	379.20

JUNE 1980

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$14.60	$21.90
12	29.00	43.50
13	43.50	65.30
14	57.90	86.90
15	72.30	108.50
16	86.80	130.20
17	101.20	151.80
18	115.70	173.60
19	130.10	195.20
20	144.50	216.80
21	159.00	238.60
22	173.40	260.20
23	188.00	282.00
24	202.40	303.60
25	216.80	325.20
26	231.30	347.00
27	245.70	368.60
28	260.10	390.20
29	274.60	411.90
30	289.00	433.50

JUNE 1981

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefits
11	$16.30	$24.50

JUNE 1981—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefits
12	32.30	48.50
13	48.40	72.70
14	64.40	96.70
15	80.40	120.70
16	96.60	144.90
17	112.60	168.90
18	128.70	193.10
19	144.70	217.10
20	160.70	241.10
21	176.90	265.40
22	192.90	289.40
23	209.10	313.70
24	225.10	337.70
25	241.10	361.70
26	257.30	386.00
27	273.30	410.00
28	289.30	434.00
29	305.40	458.10
30	321.40	482.10

JUNE 1982

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$17.50	$26.30
12	34.60	52.00
13	51.90	78.00
14	69.10	103.80
15	86.30	129.60
16	103.70	155.60
17	120.90	181.30
18	138.20	207.30
19	155.40	233.10
20	172.50	258.90
21	189.90	285.00
22	207.10	310.80
23	224.50	336.90
24	241.70	362.60
25	258.90	388.40
26	276.30	414.50
27	293.50	440.30
28	310.70	466.10
29	327.90	491.90
30	345.10	517.70

DECEMBER 1983

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$18.10	$27.20
12	35.80	53.80
13	53.70	80.70
14	71.50	107.40
15	89.30	134.10
16	107.30	161.00
17	125.10	187.60
18	143.00	214.50
19	160.80	241.20
20	178.50	267.90
21	196.50	294.90
22	214.30	321.60
23	232.30	348.60
24	250.10	375.20
25	267.90	401.90
26	285.90	429.00

DECEMBER 1983—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
27	303.70	455.70
28	321.50	482.40
29	339.30	509.10
30	357.10	535.80

DECEMBER 1984

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$18.70	$28.10
12	37.00	55.60
13	55.50	83.50
14	74.00	111.10
15	92.40	138.70
16	111.00	166.60
17	129.40	194.10
18	148.00	222.00
19	166.40	249.60
20	184.70	277.20
21	203.30	305.20
22	221.80	332.80
23	240.40	360.80
24	258.80	388.30
25	277.20	415.90
26	295.90	444.00
27	314.30	471.60
28	332.70	499.20
29	351.10	526.90
30	369.50	554.50

DECEMBER 1985

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$19.20	$28.90
12	38.10	57.30
13	57.20	86.00
14	76.20	114.50
15	95.20	142.90
16	114.40	171.70
17	133.40	200.10
18	152.50	228.80
19	171.50	257.30
20	190.40	285.70
21	209.60	314.60
22	228.60	343.10
23	247.80	371.90
24	266.80	400.30
25	285.70	428.70
26	305.00	457.70
27	324.00	486.20
28	343.00	514.60
29	361.90	543.20
30	380.90	571.60

DECEMBER 1986

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$19.40	$29.20
12	38.50	58.00
13	57.90	87.10
14	77.10	115.90

DECEMBER 1986—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
15	96.40	144.70
16	115.80	173.90
17	135.10	202.70
18	154.40	231.70
19	173.70	260.60
20	192.80	289.40
21	212.30	318.60
22	231.50	347.50
23	251.00	376.70
24	270.20	405.50
25	289.40	434.20
26	308.90	463.60
27	328.20	492.50
28	347.40	521.20
29	366.60	550.20
30	385.80	579.00

DECEMBER 1987

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$20.20	$30.40
12	40.10	60.40
13	60.30	90.70
14	80.30	120.70
15	100.40	150.70
16	120.60	181.20
17	140.70	211.20
18	160.80	241.40
19	180.90	271.50
20	200.80	301.50
21	221.20	331.90
22	241.20	362.00
23	261.50	392.50
24	281.50	422.50
25	301.50	452.40
26	321.80	483.00
27	341.90	513.10
28	361.90	543.00
29	381.90	573.30
30	402.00	603.30

DECEMBER 1988

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$21.00	$31.60
12	41.70	62.80
13	62.70	94.30
14	83.50	125.50
15	104.40	156.70
16	125.40	188.40
17	146.30	219.60
18	167.20	251.00
19	188.10	282.30
20	208.80	313.50
21	230.00	345.10
22	250.80	376.40
23	271.90	408.20
24	292.70	439.40
25	313.50	470.40
26	334.60	502.30
27	355.50	533.60
28	376.30	564.70
29	397.10	596.20

DECEMBER 1988—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
30	418.00	627.40

DECEMBER 1989

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$21.90	$33.00
12	43.60	65.70
13	65.60	98.70
14	87.40	131.30
15	109.30	164.00
16	131.20	197.20
17	153.10	229.90
18	175.00	262.70
19	196.90	295.50
20	218.60	328.20
21	240.80	361.30
22	262.50	394.00
23	284.60	427.30
24	306.40	460.00
25	328.20	492.50
26	350.30	525.90
27	372.20	558.60
28	393.90	591.20
29	415.70	624.20
30	437.60	656.80

DECEMBER 1990

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$23.00	$34.70
12	45.90	69.20
13	69.10	104.00
14	92.10	138.30
15	115.20	172.80
16	138.20	207.80
17	161.30	242.30
18	184.40	276.80
19	207.50	311.40
20	230.40	345.90
21	253.80	380.80
22	276.60	415.20
23	299.90	450.30
24	322.90	484.80
25	345.90	519.00
26	369.20	554.20
27	392.20	588.70
28	415.10	623.10
29	438.10	657.90
30	461.20	692.20

DECEMBER 1991

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$23.80	$35.90
12	47.50	71.70
13	71.60	107.80
14	95.50	143.40
15	119.40	179.10
16	143.30	215.40
17	167.20	251.20

DECEMBER 1991—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
18	191.20	287.00
19	215.10	322.90
20	238.90	358.60
21	263.10	394.80
22	286.80	430.50
23	310.90	466.90
24	334.80	502.70
25	358.60	538.20
26	382.80	574.70
27	406.70	610.40
28	430.40	646.10
29	454.30	682.20
30	478.20	717.80

NOTE: The amounts shown in the above table for years of coverage less than 19 are not payable for June 1981 through December 1981 because the corresponding values shown in column II are less than the $135.70 minimum primary insurance amount payable for that period. For months after December 1981, a special minimum primary insurance amount of $128.70 will be payable.

[47 FR 30734, July 15, 1982, as amended at 52 FR 8248, Mar. 17, 1987; 57 FR 44097, Sept. 24, 1992; 57 FR 45878, Oct. 5, 1992]

APPENDIX VI TO SUBPART C OF PART 404—PERCENTAGE OF AUTOMATIC INCREASES IN PRIMARY INSURANCE AMOUNTS SINCE 1978

Effective date	Percentage increase
06/79	9.9
06/80	14.3
06/81	11.2
06/82	7.4
12/83	3.5
12/84	3.5
12/85	3.1
12/86	1.3
12/87	4.2
12/88	4.0
12/89	4.7
12/90	5.4
12/91	3.7

[57 FR 44097, Sept. 24, 1992]

APPENDIX VII TO SUBPART C OF PART 404—''OLD-LAW'' CONTRIBUTION AND BENEFIT BASE

Explanation: We use these figures to determine the earnings needed for a year of coverage for years after 1978 (see § 404.261 and appendix IV). This is the contribution and benefit base that would have been effective under the Social Security Act without the enactment of the 1977 amendments.

Year	Amount
1979	$18,900
1980	20,400
1981	22,200
1982	24,300

Year	Amount
1983	26,700
1984	28,200
1985	29,700
1986	31,500
1987	32,700
1988	33,600
1989	35,700
1990	38,100
1991	39,600
1992	41,400

[52 FR 8248, Mar. 17, 1987, as amended at 57 FR 44097, Sept. 24, 1992; 57 FR 45878, Oct. 5, 1992]

Subpart D—Old-Age, Disability, Dependents' and Survivors' Insurance Benefits; Period of Disability

AUTHORITY: Secs. 202, 203(a) and (b), 205(a), 216, 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 403(a) and (b), 405(a), 416, 423, 425, and 902(a)(5)).

SOURCE: 44 FR 34481, June 15, 1979, unless otherwise noted.

GENERAL

§ 404.301 Introduction.

This subpart sets out what requirements you must meet to qualify for social security benefits, how your benefit amounts are figured, when your right to benefits begins and ends, and how family relationships are determined. These benefits are provided by title II of the Social Security Act. They include—

(a) *For workers,* old-age and disability benefits and benefit protection during periods of disability;

(b) *For a worker's dependents,* benefits for a worker's wife, divorced wife, husband, divorced husband, and child; and

(c) *For a worker's survivors,* benefits for a worker's widow, widower, divorced wife, child, and parent, and a lump-sum death payment.

[44 FR 34481, June 15, 1979, as amended at 83 FR 21708, May 10, 2018]

§ 404.302 Other regulations related to this subpart.

This subpart is related to several others. Subpart H sets out what evidence you need to prove you qualify for benefits. Subpart P describes what is needed to prove you are disabled. Subpart E describes when your benefits may be reduced or stopped for a time. Subpart G describes the need for and the effect of an application for benefits. Part 410 describes when you may qualify for black lung benefits. Part 416 describes when you may qualify for supplemental security income. Also 42 CFR part 405 describes when you may qualify for hospital and medical insurance if you are aged, disabled, or have chronic kidney disease.

§ 404.303 Definitions.

As used in this subpart:

Apply means to sign a form or statement that the Social Security Administration accepts as an application for benefits under the rules set out in subpart G.

Eligible means that a person would meet all the requirements for entitlement to benefits for a period of time but has not yet applied.

Entitled means that a person has applied and has proven his or her right to benefits for a period of time.

Insured person or *the insured* means someone who has enough earnings under social security to permit payment of benefits on his or her earnings record. The requirements for becoming insured are described in subpart B.

Permanent home means the true and fixed home (legal domicile) of a person. It is the place to which a person intends to return whenever he or she is absent.

Primary insurance amount means an amount that is determined from the average monthly earnings creditable to the insured person. This term and the manner in which it is computed are explained in subpart C.

We or *Us* means the Social Security Administration.

You means the person who has applied for benefits or the person for whom someone else has applied.

§ 404.304 What are the general rules on benefit amounts?

This subpart describes how we determine the highest monthly benefit amount you ordinarily could qualify for under each type of benefit. However, the highest monthly benefit amount you could qualify for may not be the amount you will be paid. In a

particular month, your benefit amount may be reduced or not paid at all. Under some circumstances, your benefit amount may be increased. The most common reasons for a change in your benefit amount are listed below.

(a) *Age.* Sections 404.410 through 404.413 explain how your old-age, wife's or husband's, or widow's or widower's benefits may be reduced if you choose to receive them before you attain full retirement age (as defined in § 404.409).

(b) *Earnings.* Sections 404.415 through 404.418 explain how deductions will be made from your benefits if your earnings or the insured person's earnings go over certain limits.

(c) *Overpayments and underpayments.* Your benefits may be increased or decreased to make up for any previous overpayment or underpayment made on the insured person's record. For more information about this, see subpart F of this part.

(d) *Family maximum.* Sections 404.403 through 404.406 explain that there is a maximum amount payable on each insured person's earnings record. If you are entitled to benefits as the insured's dependent or survivor, your benefits may be reduced to keep total benefits payable to the insured's family within these limits.

(e) *Government pension offset.* If you are entitled to wife's, husband's, widow's, widower's, mother's, or father's benefits and receive a Government pension for work that was not covered under Social Security, your monthly benefits may be reduced because of that pension. For more information about this, see § 404.408a, which covers reductions for Government pensions.

(f) *Rounding.* After all other deductions or reductions, we reduce any monthly benefit that is not a multiple of $1 to the next lower multiple of $1.

[68 FR 4702, Jan. 30, 2003, as amended at 83 FR 21708, May 10, 2018]

§ 404.305 When you may not be entitled to benefits.

In addition to the situations described in § 404.304 when you may not receive a benefit payment, there are special circumstances when you may not be entitled to benefits. These circumstances are—

(a) *Waiver of benefits.* If you have waived benefits and been granted a tax exemption on religious grounds as described in §§ 404.1039 and 404.1075, no one may become entitled to any benefits or payments on your earnings record and you may not be entitled to benefits on anyone else's earnings record; and

(b) *Person's death caused by an intentional act.* You may not become entitled to or continue to receive any survivor's benefits or payments on the earnings record of any person, or receive any underpayment due a person, if you were convicted of a felony or an act in the nature of a felony of intentionally causing that person's death. If you were subject to the juvenile justice system, you may not become entitled to or continue to receive survivor's benefits or payments on the earnings record of any person, or receive any underpayment due a person, if you were found by a court of competent jurisdiction to have intentionally caused that person's death by committing an act which, if committed by an adult, would have been considered a felony or an act in the nature of a felony.

[44 FR 34481, June 15, 1979, as amended at 47 FR 42098, Sept. 24, 1982; 52 FR 19136, May 21, 1987, 52 FR 21410, June 5, 1987; 58 FR 64888, Dec. 10, 1993]

OLD-AGE AND DISABILITY BENEFITS

§ 404.310 When am I entitled to old-age benefits?

We will find you entitled to old-age benefits if you meet the following three conditions:

(a) You are at least 62 years old;

(b) You have enough social security earnings to be fully insured as defined in §§ 404.110 through 404.115; and

(c) You apply; or you are entitled to disability benefits up to the month you attain full retirement age (as defined in § 404.409). When you attain full retirement age, your disability benefits automatically become old-age benefits.

[68 FR 4702, Jan. 30, 2003]

§ 404.311 When does my entitlement to old-age benefits begin and end?

(a) We will find you entitled to old-age benefits beginning with:

(1) If you have attained full retirement age (as defined in § 404.409), the

first month covered by your application *in* which you meet all requirements for entitlement; or

(2) If you have attained age 62, but have not attained full retirement age (as defined in § 404.409), the first month covered by your application *throughout* which you meet all requirements for entitlement.

(b) We will find your entitlement to old-age benefits ends with the month before the month you die.

[68 FR 4702, Jan. 30, 2003]

§ 404.312 How is my old-age benefit amount calculated?

(a) If your old-age benefits begin in the month you attain full retirement age (as defined in § 404.409), your monthly benefit is equal to the primary insurance amount (as explained in subpart C of this part).

(b) If your old-age benefits begin after the month you attain full retirement age, your monthly benefit is your primary insurance amount plus an increase for retiring after full retirement age. See § 404.313 for a description of these increases.

(c) If your old-age benefits begin before the month you attain full retirement age, your monthly benefit amount is the primary insurance amount minus a reduction for each month you are entitled before you attain full retirement age. These reductions are described in §§ 404.410 through 404.413.

[68 FR 4702, Jan. 30, 2003]

§ 404.313 What are delayed retirement credits and how do they increase my old-age benefit amount?

(a) *What are delayed retirement credits and how do I earn them?* Delayed retirement credits (DRCs) are credits we use to increase the amount of your old-age benefit amount. You may earn a credit for each month during the period beginning with the month you attain full retirement age (as defined in § 404.409) and ending with the month you attain age 70 (72 before 1984). You earn a credit for each month for which you are fully insured and eligible but do not receive an old-age benefit either because you do not apply for benefits or because you elect to voluntarily suspend your benefits to earn DRCs. Even if you were entitled to old-age benefits before full retirement age you may still earn DRCs for months during the period from full retirement age to age 70, if you voluntarily elect to suspend those benefits. If we have determined that you are entitled to benefits, you may voluntarily suspend benefits for any month beginning with the month after the month in which you voluntarily request that we suspend your benefits. If you apply for benefits, and we have not made a determination that you are entitled to benefits, you may voluntarily have your benefits suspended for any month for which you have not received a payment.

(b) *How is the amount of the increase because of delayed retirement credits computed?*—(1) *Computation of the increase amount.* The amount of the increase depends on your date of birth and the number of credits you earn. We total the number of credits (which need not be consecutive) and multiply that number by the applicable percentage from paragraph (b)(2) of this section. We then multiply the result by your benefit amount and round the answer to the next lower multiple of 10 cents (if the answer is not already a multiple of 10 cents). We add the result to your benefit amount. If a supplementary medical insurance premium is involved it is then deducted. The result is rounded to the next lower multiple of $1 (if the answer is not already a multiple of $1).

(2) *Credit percentages.* The applicable credit amount for each month of delayed retirement can be found in the table below.

If your date of birth is:	The credit for each month you delay retirement is:
Before 1/2/1917	1/12 of 1%
1/2/1917—1/1/1925	1/4 of 1%
1/2/1925—1/1/1927	7/24 of 1%
1/2/1927—1/1/1929	1/3 of 1%
1/2/1929—1/1/1931	3/8 of 1%
1/2/1931—1/1/1933	5/12 of 1%
1/2/1933—1/1/1935	11/24 of 1%
1/2/1935—1/1/1937	1/2 of 1%
1/2/1937—1/1/1939	13/24 of 1%
1/2/1939—1/1/1941	7/12 of 1%
1/2/1941—1/1/1943	5/8 of 1%
After 1/1/1943	2/3 of 1%

Example: Alan was qualified for old-age benefits when he reached age 65 on January 15, 1998. He decided not to apply for old-age

benefits immediately because he was still working. When he became age 66 in January 1999, he stopped working and applied for benefits beginning with that month. Based on his earnings, his primary insurance amount was $782.60. However, because he did not receive benefits immediately upon attainment of full retirement age (65), he is due an increase based on his delayed retirement credits. He earned 12 credits, one for each month from January 1998 through December 1998. Based on his date of birth of 1/15/1933 he is entitled to a credit of 11/24 of one percent for each month of delayed retirement. 12 credits multiplied by 11/24 of one percent equals a credit of 5.5 percent. 5.5% of the primary insurance amount of $782.60 is $43.04 which is rounded to $43.00, the next lower multiple of 10 cents. $43.00 is added to the primary insurance amount, $782.60. The result, $825.60 is the monthly benefit amount. If a supplementary medical insurance premium is involved it is then deducted. The result is rounded to the next lower multiple of $1 (if the answer is not already a multiple of $1).

(c) *When is the increase because of delayed retirement credits effective?*—(1) *Credits earned after entitlement and before the year of attainment of age 70.* If you are entitled to benefits, we examine our records after the end of each calendar year to determine whether you have earned delayed retirement credits during the previous year for months when you were at or over full retirement age and you were fully insured and eligible for benefits but did not receive them. Any increase in your benefit amount is effective beginning with January of the year after the year the credits were earned.

(2) *Credits earned after entitlement in the year of attainment of age 70.* If you are entitled to benefits in the month you attain age 70, we examine our records to determine if you earned any additional delayed retirement credits during the calendar year in which you attained age 70. Any increase in your benefit amount is effective beginning with the month you attained age 70.

(3) *Credits earned prior to entitlement.* If you are full retirement age or older and eligible for old-age benefits but do not apply for benefits, your delayed retirement credits for months from the month of attainment of full retirement age through the end of the year prior to the year of filing will be included in the computation of your initial benefit amount. Credits earned in the year you attain age 70 will be added in the month you attain age 70.

(d) *How do delayed retirement credits affect the special minimum primary insurance amount?* We do not add delayed retirement credits to your old-age benefit if your benefit is based on the special minimum primary insurance amount described in § 404.260. We add the delayed retirement credits only to your old-age benefit based on your regular primary insurance amount, *i.e.* as computed under one of the other provisions of subpart C of this part. If your benefit based on the regular primary insurance amount plus your delayed retirement credits is higher than the benefit based on your special minimum primary insurance amount, we will pay the higher amount to you. However, if the special minimum primary insurance amount is higher than the regular primary insurance amount without the delayed retirement credits, we will use the special minimum primary insurance amount to determine the family maximum and the benefits of others entitled on your earnings record.

(e) *What is the effect of my delayed retirement credits on the benefit amount of others entitled on my earnings record?*—(1) *Surviving spouse or surviving divorced spouse.* If you earn delayed retirement credits during your lifetime, we will compute benefits for your surviving spouse or surviving divorced spouse based on your regular primary insurance amount plus the amount of those delayed retirement credits. All delayed retirement credits, including any earned during the year of death, can be used in computing the benefit amount for your surviving spouse or surviving divorced spouse beginning with the month of your death. We compute delayed retirement credits up to but not including the month of death.

(2) *Other family member.* We do not use your delayed retirement credits to increase the benefits of other family members entitled on your earnings record.

(3) *Family maximum.* We add delayed retirement credits to your benefit after we compute the family maximum. However, we add delayed retirement credits to your surviving spouse's or

surviving divorced spouse's benefit before we reduce for the family maximum.

[68 FR 4703, Jan. 30, 2003, as amended at 75 FR 76259, Dec. 8, 2010]

§ 404.315 Who is entitled to disability benefits?

(a) *General.* You are entitled to disability benefits while disabled before attaining full retirement age as defined in § 404.409 if—

(1) You have enough social security earnings to be *insured for disability*, as described in § 404.130;

(2) You apply;

(3) You have a disability, as defined in § 404.1505, or you are not disabled, but you had a disability that ended within the 12-month period before the month you applied; and

(4) You have been disabled for 5 full consecutive months or no waiting period is required. The 5-month waiting period begins with a month in which you were both insured for disability and disabled. Your waiting period can begin no earlier than the 17th month before the month you apply—no matter how long you were disabled before then. No waiting period is required if:

(i) You were previously entitled to disability benefits or to a period of disability under § 404.320 any time within 5 years of the month you again became disabled; or

(ii) You have been medically determined to have amyotrophic lateral sclerosis, and we approved your application for disability insurance benefits on or after July 23, 2020.

(b) *Prohibition against reentitlement to disability benefits if drug addiction or alcoholism is a contributing factor material to the determination of disability.* You cannot be entitled to a period of disability payments if drug addiction or alcoholism is a contributing factor material to the determination of disability and your earlier entitlement to disability benefits on the same basis terminated after you received benefits for 36 months during which treatment was available.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21930, May 16, 1983; 51 FR 10616, Mar. 28, 1986; 51 FR 16166, May 1, 1986; 53 FR 43681, Oct. 28, 1988; 57 FR 30119, July 8, 1992; 60 FR 8145, Feb. 10, 1995; 68 FR 4704, Jan. 30, 2003; 86 FR 48021, Aug. 27, 2021]

§ 404.316 When entitlement to disability benefits begins and ends.

(a) You are entitled to disability benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement. If a waiting period is required, your benefits cannot begin earlier than the first month following that period.

(b) Your entitlement to disability benefits ends with the earliest of these months:

(1) The month before the month of your death;

(2) The month before the month you attain full retirement age as defined in § 404.409 (at full retirement age your disability benefits will be automatically changed to old-age benefits);

(3) The second month after the month in which your disability ends as provided in § 404.1594(b)(1), unless continued subject to paragraph (c); or (4) subject to the provisions of paragraph (d) of this section, the month before your termination month (§ 404.325).

(c)(1) Your benefits, and those of your dependents, may be continued after your impairment is no longer disabling if—

(i) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 404.327(a) and (b);

(ii) You began participating in the program before the date your disability ended; and

(iii) We have determined under § 404.328 that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(2) We generally will stop your benefits with the earliest of these months—

(i) The month in which you complete the program; or

(ii) The month in which you stop participating in the program for any reason (see §404.327(b) for what we mean by ''participating'' in the program); or

(iii) The month in which we determine under §404.328 that your continuing participation in the program will no longer increase the likelihood that you will not have to return to the disability benefit rolls.

Exception to paragraph (c): In no case will we stop your benefits with a month earlier than the second month after the month your disability ends, provided that you meet all other requirements for entitlement to and payment of benefits through such month.

(d) If, after November 1980, you have a disabling impairment (§404.1511), you will be paid benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§404.1592a) following the end of your trial work period (§404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefit.) You will also be paid benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, you cannot be paid benefits for any months in which you do substantial gainful activity.

(e) If drug addiction or alcoholism is a contributing factor material to the determination of disability as described in §404.1535, you may receive disability benefits on that basis for no more than 36 months regardless of the number of entitlement periods you may have. Not included in these 36 months are months in which treatment for your drug addiction or alcoholism is not available, months before March 1995, and months for which your benefit payments were suspended for any reason. Benefits to your dependents may continue after the 36 months of benefits if, but for the operation of this paragraph, you would otherwise be entitled to benefits based on disability. The 36-month limit is no longer effective for benefits for months beginning after September 2004.

(f) If drug addiction or alcoholism is a contributing factor material to the determination of disability as described in §404.1535 and your disability benefits are suspended for 12 consecutive months because of your failure to comply with treatment requirements, your disability benefits will be terminated effective the first month after such 12-month period. Benefits to your dependents may continue after the 12-month period if, but for the operation of this paragraph, you would otherwise be entitled to benefits based on disability.

[44 FR 34481, June 15, 1979, as amended at 47 FR 31542, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 49 FR 22270, May 29, 1984; 51 FR 17617, May 14, 1986; 60 FR 8145, Feb. 10, 1995; 68 FR 4704, Jan. 30, 2003; 70 FR 36505, June 24, 2005]

§ 404.317 How is the amount of my disability benefit calculated?

Your monthly benefit is equal to the primary insurance amount (PIA). This amount is computed under the rules in subpart C of this part as if it was an old-age benefit, and as if you were 62 years of age at the beginning of the 5-month waiting period mentioned in §404.315(a). If the 5-month waiting period is not required because of your previous entitlement, your PIA is figured as if you were 62 years old when you become entitled to benefits this time. If the 5-month waiting period is not required because you have been medically determined to have amyotrophic lateral sclerosis (see §404.315), your PIA is figured as if you were 62 years old when you become entitled to benefits. Your monthly benefit amount may be reduced if you receive workers' compensation or public disability payments before you attain full retirement age (as defined in §404.409) (see §404.408). Your benefits may also be reduced if you were entitled to other retirement-age benefits before you attained full retirement age (as defined in §404.409).

[68 FR 4704, Jan. 30, 2003, as amended at 81 FR 10033, Apr. 4, 2016; 86 FR 48021, Aug. 27, 2021]

§ 404.320 Who is entitled to a period of disability.

(a) *General.* A period of disability is a continuous period of time during which you are disabled. If you become disabled, you may apply to have our records show how long your disability lasts. You may do this even if you do not qualify for disability benefits. If we establish a period of disability for you, the months in that period of time will not be counted in figuring your average earnings. If benefits payable on your earnings record would be denied or reduced because of a period of disability, the period of disability will not be taken into consideration.

(b) *Who is entitled.* You are entitled to a period of disability if you meet all the following conditions:

(1) You have or had a disability as defined in § 404.1505.

(2) You are *insured for disability*, as defined in § 404.130 in the calendar quarter in which you became disabled, or in a later calendar quarter in which you were disabled.

(3) You file an application while disabled, or no later than 12 months after the month in which your period of disability ended. If you were unable to apply within the 12-month period after your period of disability ended because of a physical or mental condition as described in § 404.322, you may apply not more than 36 months after the month your disability ended.

(4) At least 5 consecutive months go by from the month in which your period of disability begins and before the month in which it would end.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21930, May 16, 1983; 51 FR 10616, Mar. 28, 1986]

§ 404.321 When a period of disability begins and ends.

(a) *When a period of disability begins.* Your period of disability begins on the day your disability begins if you are insured for disability on that day. If you are not insured for disability on that day, your period of disability will begin on the first day of the first calendar quarter after your disability began in which you become insured for disability. Your period of disability may not begin after you have attained full retirement age as defined in § 404.409.

(b) *When disability ended before December 1, 1980.* Your period of disability ends on the last day of the month before the month in which you become 65 years old or, if earlier, the last day of the second month following the month in which your disability ended.

(c) *When disability ends after November 1980.* Your period of disability ends with the close of whichever of the following is the earliest—

(1) The month before the month in which you attain full retirement age as defined in § 404.409.

(2) The month immediately preceding your termination month (§ 404.325); or

(3) If you perform substantial gainful activity during the reentitlement period described in § 404.1592a, the last month for which you received benefits.

(d) *When drug addiction or alcoholism is a contributing factor material to the determination of disability.* (1) Your entitlement to receive disability benefit payments ends the month following the month in which, regardless of the number of entitlement periods you may have had based on disability where drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535)—

(i) You have received a total of 36 months of disability benefits. Not included in these 36 months are months in which treatment for your drug addiction or alcoholism is not available, months before March 1995, and months for which your benefits were suspended for any reason; or

(ii) Your benefits have been suspended for 12 consecutive months because of your failure to comply with treatment requirements.

(2) For purposes other than payment of your disability benefits, your period of disability continues until the termination month as explained in § 404.325.

[49 FR 22271, May 29, 1984, as amended at 60 FR 8145, Feb. 10, 1995; 65 FR 42782, July 11, 2000; 68 FR 4704, Jan. 30, 2003]

§ 404.322 When you may apply for a period of disability after a delay due to a physical or mental condition.

If because of a physical or mental condition you did not apply for a period of disability within 12 months after your period of disability ended,

you may apply not more than 36 months after the month in which your disability ended. Your failure to apply within the 12-month time period will be considered due to a physical or mental condition if during this time—

(a) Your physical condition limited your activities to such an extent that you could not complete and sign an application; or

(b) You were mentally incompetent.

§ 404.325 The termination month.

If you do not have a disabling impairment, your termination month is the third month following the month in which your impairment is not disabling even if it occurs during the trial work period or the reentitlement period. If you continue to have a disabling impairment and complete 9 months of trial work, your termination month will be the third month following the earliest month you perform substantial gainful activity or are determined able to perform substantial gainful activity; however, in no event will the termination month under these circumstances be earlier than the first month after the end of the reentitlement period described in § 404.1592a.

Example 1: You complete your trial work period in December 1999. You then work at the substantial gainful activity level and continue to do so throughout the 36 months following completion of your trial work period and thereafter. Your termination month will be January 2003, which is the first month in which you performed substantial gainful activity after the end of your 36-month reentitlement period. This is because, for individuals who have disabling impairments (see § 404.1511) and who work, the termination month cannot occur before the first month after the end of the 36-month reentitlement period.

Example 2: You complete your trial work period in December 1999, but you do not do work showing your ability to do substantial gainful activity during your trial work period or throughout your 36-month reentitlement period. In April 2003, 4 months after your reentitlement period ends, you become employed at work that we determine is substantial gainful activity, considering all of our rules in §§ 404.1574 and 404.1574a. Your termination month will be July 2003; that is, the third month after the earliest month you performed substantial gainful activity.

[65 FR 42782, July 11, 2000]

RULES RELATING TO CONTINUATION OF BENEFITS AFTER YOUR IMPAIRMENT IS NO LONGER DISABLING

SOURCE: 70 FR 36505, June 24, 2005, unless otherwise noted.

§ 404.327 When you are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services.

(a) *What is an appropriate program of vocational rehabilitation services, employment services, or other support services?* An appropriate program of vocational rehabilitation services, employment services, or other support services means—

(1) A program that is carried out under an individual work plan with an employment network under the Ticket to Work and Self-Sufficiency Program under part 411 of this chapter;

(2) A program that is carried out under an individualized plan for employment with—

(i) A State vocational rehabilitation agency (*i.e.*, a State agency administering or supervising the administration of a State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720–751) under 34 CFR part 361; or

(ii) An organization administering a Vocational Rehabilitation Services Project for American Indians with Disabilities authorized under section 121 of part C of title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 741);

(3) A program of vocational rehabilitation services, employment services, or other support services that is carried out under a similar, individualized written employment plan with—

(i) An agency of the Federal Government (for example, the Department of Veterans Affairs);

(ii) A one-stop delivery system or specialized one-stop center described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)); or

(iii) Another provider of services approved by us; providers we may approve include, but are not limited to—

(A) A public or private organization with expertise in the delivery or coordination of vocational rehabilitation services, employment services, or other support services; or

(B) A public, private or parochial school that provides or coordinates a program of vocational rehabilitation services, employment services, or other support services carried out under an individualized program or plan;

(4) An individualized education program developed under policies and procedures approved by the Secretary of Education for assistance to States for the education of individuals with disabilities under the Individuals with Disabilities Education Act, as amended (20 U.S.C. 1400 *et seq.*); you must be age 18 through age 21 for this provision to apply.

(b) *When are you participating in the program?* (1) You are participating in a program described in paragraph (a)(1), (a)(2), or (a)(3) of this section when you are taking part in the activities and services outlined in your individual work plan, your individualized plan for employment, or your similar individualized written employment plan, as appropriate.

(2) If you are a student age 18 through 21 receiving services under an individualized education program described in paragraph (a)(4) of this section, you are participating in your program when you are taking part in the activities and services outlined in your program or plan.

(3) You are participating in your program under paragraph (b)(1) or (2) of this section during temporary interruptions in your program. For an interruption to be considered temporary, you must resume taking part in the activities and services outlined in your plan or program, as appropriate, no more than three months after the month the interruption occurred.

§ 404.328 When your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(a) We will determine that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls if your completion of or your continuation in the program will provide you with—

(1) Work experience (see § 404.1565) so that you would more likely be able to do past relevant work (see § 404.1560(b)), despite a possible future reduction in your residual functional capacity (see § 404.1545); or

(2) Education (see § 404.1564) and/or skilled or semi-skilled work experience (see § 404.1568) so that you would more likely be able to adjust to other work that exists in the national economy (see § 404.1560(c)), despite a possible future reduction in your residual functional capacity (see § 404.1545).

(b) If you are a student age 18 through age 21 participating in an individualized education program described in § 404.327(a)(4), we will find that your completion of or continuation in the program will increase the likelihood that you will not have to return to the disability benefit rolls.

(c) If you are receiving transition services after having completed an individualized education program as described in paragraph (b) of this section, we will determine that the transition services will increase the likelihood that you will not have to return to the disability benefit rolls if they meet the requirements in § 404.328(a).

Benefits for Spouses and Divorced Spouses

§ 404.330 Who is entitled to wife's or husband's benefits.

You are entitled to benefits as the wife or husband of an insured person who is entitled to old-age or disability benefits if—

(a) You are the insured's wife or husband based upon a relationship described in §§ 404.345 through 404.346 and one of the following conditions is met:

(1) Your relationship to the insured as a wife or husband has lasted at least 1 year. (You will be considered to meet the 1-year duration requirement throughout the month in which the first anniversary of the marriage occurs.)

(2) You and the insured are the natural parents of a child; or

(3) In the month before you married the insured you were entitled to, or if you had applied and been old enough you could have been entitled to, any of

these benefits or payments: Wife's, husband's, widow's, widower's, or parent's benefits; disabled child's benefits; or annuity payments under the Railroad Retirement Act for widows, widowers, parents, or children 18 years old or older;

(b) You apply;

(c) You are age 62 or older throughout a month and you meet all other conditions of entitlement, or you are the insured's wife or husband and have *in your care* (as defined in §§ 404.348 through 404.349), throughout a month in which all other conditions of entitlement are met, a child who is entitled to child's benefits on the insured's earnings record and the child is either under age 16 or disabled; and

(d) You are not entitled to an old-age or disability benefit based upon a primary insurance amount that is equal to or larger than the full wife's or husband's benefit.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 45 FR 68932, Oct. 17, 1980; 48 FR 21926, May 16, 1983]

§ 404.331 Who is entitled to wife's or husband's benefits as a divorced spouse.

You are entitled to wife's or husband's benefits as the divorced wife or divorced husband of an insured person who is entitled to old-age or disability benefits if you meet the requirements of paragraphs (a) through (e). You are entitled to these benefits even though the insured person is not yet entitled to benefits, if the insured person is at least age 62 and if you meet the requirements of paragraphs (a) through (f). The requirements are that—

(a) You are the insured's divorced wife or divorced husband and—

(1) You were validly married to the insured under State law as described in § 404.345 or you were deemed to be validly married as described in § 404.346; and

(2) You were married to the insured for at least 10 years immediately before your divorce became final;

(b) You apply;

(c) You are not married. (For purposes of meeting this requirement, you will be considered not to be married throughout the month in which the divorce occurred);

(d) You are age 62 or older throughout a month in which all other conditions of entitlement are met; and

(e) You are not entitled to an old-age or disability benefit based upon a primary insurance amount that is equal to or larger than the full wife's or husband's benefit.

(f) You have been divorced from the insured person for at least 2 years.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21926, May 16, 1983; 51 FR 11911, Apr. 8, 1986; 58 FR 64891, Dec. 10, 1993]

§ 404.332 When wife's and husband's benefits begin and end.

(a) You are entitled to wife's or husband's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement under § 404.330 or § 404.331. However, if you are entitled as a divorced spouse before the insured person becomes entitled, your benefits cannot begin before January 1985 based on an application filed no earlier than that month.

(b) Your entitlement to benefits ends with the month before the month in which one of the following events first occurs:

(1) You become entitled to an old-age or disability benefit based upon a primary insurance amount that is equal to or larger than the full wife's or husband's benefit.

(2) You are the wife or husband and are divorced from the insured person unless you meet the requirements for benefits as a divorced wife or divorced husband as described in § 404.331.

(3) You are the divorced wife or divorced husband and you marry someone, other than the insured who is entitled to old-age benefits, unless that other person is someone entitled to benefits as a wife, husband, widow, widower, father, mother, parent or disabled child. Your benefits will end if you remarry the insured who is not yet entitled to old-age benefits.

(4) If you are under age 62, there is no longer a child of the insured who is under age 16 or disabled and entitled to child's benefits on the insured's earnings record. (See paragraph (c) of this section if you were entitled to wife's or husband's benefits for August 1981 on the basis of having a child in care.) (If

you no longer have in your care a child who is under age 16 or disabled and entitled to child's benefits on the insured's earnings record, your benefits may be subject to deductions as provided in § 404.421.)

(5) The insured person dies or is no longer entitled to old age or disability benefits. Exception: Your benefits will continue if the insured person was entitled to disability benefits based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of his or her disability (as described in § 404.1535), the insured person's benefits ended after 36 months of benefits (see § 404.316(e)) or 12 consecutive months of suspension for noncompliance with treatment (see § 404.316(f)), and but for the operation of these provisions, the insured person would remain entitled to benefits based on disability.

(6) If your benefits are based upon a deemed valid marriage and you have not divorced the insured, you marry someone other than the insured.

(7) You die.

(8) You became entitled as the divorced wife or the divorced husband before the insured person became entitled, but he or she is no longer insured.

(c) If you were entitled to wife's or husband's benefits for August 1981 on the basis of having a child in care, your entitlement will continue until September 1983, until the child reaches 18 (unless disabled) or is otherwise no longer entitled to child's benefits, or until one of the events described in paragraph (b) (1), (2), (3), (5), (6) or (7) of this section occurs, whichever is earliest.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21926, May 16, 1983; 49 FR 24115, June 12, 1984; 51 FR 11911, Apr. 8, 1986; 58 FR 64891, Dec. 10, 1993; 60 FR 8145, Feb. 10, 1995; 64 FR 14608, Mar. 26, 1999]

§ 404.333 Wife's and husband's benefit amounts.

Your wife's or husband's monthly benefit is equal to one-half the insured person's primary insurance amount. If you are entitled as a divorced wife or as a divorced husband before the insured person becomes entitled, we will compute the primary insurance amount as if he or she became entitled to old-age benefits in the first month you are entitled as a divorced wife or as a divorced husband. The amount of your monthly benefit may change as explained in § 404.304.

[51 FR 11912, Apr. 8, 1986]

§ 404.335 How do I become entitled to widow's or widower's benefits?

We will find you entitled to benefits as the widow or widower of a person who died fully insured if you meet the requirements in paragraphs (a) through (e) of this section:

(a) You are the insured's widow or widower based upon a relationship described in §§ 404.345 through 404.346, and you meet one of the conditions in paragraphs (a)(1) through (4) of this section:

(1) Your relationship to the insured as a wife or husband lasted for at least 9 months immediately before the insured died.

(2) Your relationship to the insured as a wife or husband did not last 9 months before the insured died, but you meet one of the conditions in paragraphs (a)(2)(i) through (iv) of this section.

(i) At the time of your marriage the insured was reasonably expected to live for 9 months, and the death of the insured was accidental. The death is accidental if it was caused by an event that the insured did not expect, if it was the result of bodily injuries received from violent and external causes, and if, as a direct result of these injuries, death occurred not later than 3 months after the day on which the bodily injuries were received. An intentional and voluntary suicide will not be considered an accidental death.

(ii) At the time of your marriage the insured was reasonably expected to live for 9 months, and the death of the insured occurred in the line of duty while he or she was serving on active duty as a member of the uniformed services as defined in § 404.1019.

(iii) At the time of your marriage the insured was reasonably expected to live for 9 months, and you had been previously married to the insured for at least 9 months.

(iv) The insured had been married prior to his or her marriage to you and the prior spouse was institutionalized during the marriage to the insured due

to mental incompetence or similar incapacity. During the period of the prior spouse's institutionalization, the insured, as determined based on evidence satisfactory to the Agency, would have divorced the prior spouse and married you, but the insured did not do so because the divorce would have been unlawful, by reason of the institutionalization, under the laws of the State in which the insured was domiciled at the time. Additionally, the prior spouse must have remained institutionalized up to the time of his or her death and the insured must have married you within 60 days after the prior spouse's death.

(3) You and the insured were the natural parents of a child; or you were married to the insured when either of you adopted the other's child or when both of you adopted a child who was then under 18 years old.

(4) In the month before you married the insured, you were entitled to or, if you had applied and had been old enough, could have been entitled to any of these benefits or payments: widow's, widower's, father's (based on the record of a fully insured individual), mother's (based on the record of a fully insured individual), wife's, husband's, parent's, or disabled child's benefits; or annuity payments under the Railroad Retirement Act for widows, widowers, parents, or children age 18 or older.

(b) You apply, except that you need not apply again if you meet one of the conditions in paragraphs (b)(1) through (4) of this section:

(1) You are entitled to wife's or husband's benefits for the month before the month in which the insured dies and you have attained full retirement age (as defined in § 404.409) or you are not entitled to either old-age or disability benefits.

(2) You are entitled to mother's or father's benefits for the month before the month in which you attained full retirement age (as defined in § 404.409).

(3) You are entitled to wife's or husband's benefits and to either old-age or disability benefits in the month before the month of the insured's death, you are under full retirement age (as defined in § 404.409) in the month of death, and you have filed a Certificate of Election in which you elect to receive reduced widow's or widower's benefits.

(4) You applied in 1990 for widow's or widower's benefits based on disability and you meet both of the conditions in paragraphs (b)(4)(i) and (ii) of this section:

(i) You were entitled to disability insurance benefits for December 1990, or eligible for supplemental security income or federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, for January 1991.

(ii) You were found not disabled for any month based on the definition of disability in §§ 404.1577 and 404.1578, as in effect prior to January 1991, but would have been entitled if the standard in § 404.1505(a) had applied. (This exception to the requirement for filing an application is effective only with respect to benefits payable for months after December 1990.)

(c) You are at least 60 years old; or you are at least 50 years old and have a disability as defined in § 404.1505 and you meet all of the conditions in paragraphs (c)(1) through (4) of this section:

(1) Your disability started not later than 7 years after the insured died or 7 years after you were last entitled to mother's or father's benefits or to widow's or widower's benefits based upon a disability, whichever occurred last.

(2) Your disability continued during a waiting period of 5 full consecutive months, unless months beginning with the first month of eligibility for supplemental security income or federally administered State supplementary payments are counted, as explained in the Exception in paragraph (c)(3) of this section. The waiting period may begin no earlier than the 17th month before you applied; the fifth month before the insured died; or if you were previously entitled to mother's, father's, widow's, or widower's benefits, the 5th month before your entitlement to benefits ended. If you were previously entitled to widow's or widower's benefits based upon a disability, no waiting period is required.

(3) Exception: For monthly benefits payable for months after December 1990, if you were or have been eligible for supplemental security income or

federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, your disability need not have continued through a separate, full 5-month waiting period before you may begin receiving benefits. We will include as months of the 5-month waiting period the months in a period beginning with the first month you received supplemental security income or a federally administered State supplementary payment and continuing through all succeeding months, regardless of whether the months in the period coincide with the months in which your waiting period would have occurred, or whether you continued to be eligible for supplemental security income or a federally administered State supplementary payment after the period began, or whether you met the nondisability requirements for entitlement to widow's or widower's benefits. However, we will not pay you benefits under this provision for any month prior to January 1991.

(4) You have not previously received 36 months of payments based on disability when drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), regardless of the number of entitlement periods you may have had, or your current application for widow's or widower's benefits is not based on a disability where drug addiction or alcoholism is a contributing factor material to the determination of disability.

(d) You are not entitled to an old-age benefit that is equal to or larger than the insured person's primary insurance amount.

(e) You are unmarried, unless for benefits for months after 1983 you meet one of the conditions in paragraphs (e)(1) through (3) of this section:

(1) You remarried after you became 60 years old.

(2) You are now age 60 or older and you meet both of the conditions in paragraphs (e)(2)(i) and (ii) of this section:

(i) You remarried after attaining age 50 but before attaining age 60.

(ii) At the time of the remarriage, you were entitled to widow's or widower's benefits as a disabled widow or widower.

(3) You are now at least age 50, but not yet age 60 and you meet both of the conditions in paragraphs (e)(3)(i) and (ii) of this section:

(i) You remarried after attaining age 50.

(ii) You met the disability requirements in paragraph (c) of this section at the time of your remarriage (*i.e.*, your disability began within the specified time and before your remarriage).

[68 FR 4704, Jan. 30, 2003, as amended at 70 FR 61365, Oct. 24, 2005]

§ 404.336 How do I become entitled to widow's or widower's benefits as a surviving divorced spouse?

We will find you entitled to widow's or widower's benefits as the surviving divorced wife or the surviving divorced husband of a person who died fully insured if you meet the requirements in paragraphs (a) through (e) of this section:

(a) You are the insured's surviving divorced wife or surviving divorced husband and you meet both of the conditions in paragraphs (a)(1) and (2) of this section:

(1) You were validly married to the insured under State law as described in § 404.345 or are deemed to have been validly married as described in § 404.346.

(2) You were married to the insured for at least 10 years immediately before your divorce became final.

(b) You apply, except that you need not apply again if you meet one of the conditions in paragraphs (b)(1) through (4) of this section:

(1) You are entitled to wife's or husband's benefits for the month before the month in which the insured dies and you have attained full retirement age (as defined in § 404.409) or you are not entitled to old-age or disability benefits.

(2) You are entitled to mother's or father's benefits for the month before the month in which you attain full retirement age (as defined in § 404.409).

(3) You are entitled to wife's or husband's benefits and to either old-age or disability benefits in the month before the month of the insured's death, you have not attained full retirement age (as defined in § 404.409) in the month of

death, and you have filed a Certificate of Election in which you elect to receive reduced widow's or widower's benefits.

(4) You applied in 1990 for widow's or widower's benefits based on disability, and you meet the requirements in both paragraphs (b)(4)(i) and (ii) of this section:

(i) You were entitled to disability insurance benefits for December 1990 or eligible for supplemental security income or federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, for January 1991.

(ii) You were found not disabled for any month based on the definition of disability in §§ 404.1577 and 404.1578, as in effect prior to January 1991, but would have been entitled if the standard in § 404.1505(a) had applied. (This exception to the requirement for filing an application is effective only with respect to benefits payable for months after December 1990.)

(c) You are at least 60 years old; or you are at least 50 years old and have a disability as defined in § 404.1505 and you meet all of the conditions in paragraphs (c)(1) through (4) of this section:

(1) Your disability started not later than 7 years after the insured died or 7 years after you were last entitled to mother's or father's benefits or to widow's or widower's benefits based upon a disability, whichever occurred last.

(2) Your disability continued during a waiting period of 5 full consecutive months, unless months beginning with the first month of eligibility for supplemental security income or federally administered State supplementary payments are counted, as explained in the Exception in paragraph (c)(3) of this section. This waiting period may begin no earlier than the 17th month before you applied; the fifth month before the insured died; or if you were previously entitled to mother's, father's, widow's, or widower's benefits, the 5th month before your previous entitlement to benefits ended. If you were previously entitled to widow's or widower's benefits based upon a disability, no waiting period is required.

(3) Exception: For monthly benefits payable for months after December 1990, if you were or have been eligible for supplemental security income or federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, your disability does not have to have continued through a separate, full 5-month waiting period before you may begin receiving benefits. We will include as months of the 5-month waiting period the months in a period beginning with the first month you received supplemental security income or a federally administered State supplementary payment and continuing through all succeeding months, regardless of whether the months in the period coincide with the months in which your waiting period would have occurred, or whether you continued to be eligible for supplemental security income or a federally administered State supplementary payment after the period began, or whether you met the nondisability requirements for entitlement to widow's or widower's benefits. However, we will not pay you benefits under this provision for any month prior to January 1991.

(4) You have not previously received 36 months of payments based on disability when drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), regardless of the number of entitlement periods you may have had, or your current application for widow's or widower's benefits is not based on a disability where drug addiction or alcoholism is a contributing factor material to the determination of disability.

(d) You are not entitled to an old-age benefit that is equal to or larger than the insured person's primary insurance amount.

(e) You are unmarried, unless for benefits for months after 1983 you meet one of the conditions in paragraphs (e)(1) through (3) of this section:

(1) You remarried after you became 60 years old.

(2) You are now age 60 or older and you meet both of the conditions in paragraphs (e)(2)(i) and (ii) of this section:

(i) You remarried after attaining age 50 but before attaining age 60.

(ii) At the time of the remarriage, you were entitled to widow's or widower's benefits as a disabled widow or widower.

(3) You are now at least age 50 but not yet age 60 and you meet both of the conditions in paragraphs (e)(3)(i) and (ii) of this section:

(i) You remarried after attaining age 50.

(ii) You met the disability requirements in paragraph (c) of this section at the time of your remarriage (*i.e.*, your disability began within the specified time and before your remarriage).

[68 FR 4705, Jan. 30, 2003, as amended at 71 FR 24814, Apr. 27, 2006]

§ 404.337 When does my entitlement to widow's and widower's benefits start and end?

(a) We will find you entitled to widow's or widower's benefits under § 404.335 or § 404.336 beginning with the first month covered by your application in which you meet all other requirements for entitlement.

(b) We will end your entitlement to widow's or widower's benefits at the earliest of the following times:

(1) The month before the month in which you become entitled to an old-age benefit that is equal to or larger than the insured's primary insurance amount.

(2) The second month after the month your disability ends or, where disability ends on or after December 1, 1980, the month before your termination month (§ 404.325). However your payments are subject to the provisions of paragraphs (c) and (d) of this section.

NOTE: You may remain eligible for payment of benefits if you attained full retirement age (as defined in § 404.409) before your termination month and you meet the other requirements for widow's or widower's benefits.

(3) If drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.1535, the month after the 12th consecutive month of suspension for noncompliance with treatment or after 36 months of benefits on that basis when treatment is available regardless of the number of entitlement periods you may have had, unless you are otherwise disabled without regard to drug addiction or alcoholism.

(4) The month before the month in which you die.

(c)(1) Your benefits may be continued after your impairment is no longer disabling if—

(i) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 404.327(a) and (b);

(ii) You began participating in the program before the date your disability ended; and

(iii) We have determined under § 404.328 that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(2) We generally will stop your benefits with the earliest of these months—

(i) The month in which you complete the program; or

(ii) The month in which you stop participating in the program for any reason (see § 404.327(b) for what we mean by ''participating'' in the program); or

(iii) The month in which we determine under § 404.328 that your continuing participation in the program will no longer increase the likelihood that you will not have to return to the disability benefit rolls.

Exception to paragraph (c): In no case will we stop your benefits with a month earlier than the second month after the month your disability ends, provided that you meet all other requirements for entitlement to and payment of benefits through such month.

(d) If, after November 1980, you have a disabling impairment (§ 404.1511), we will pay you benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§ 404.1592a) following the end of your trial work period (§ 404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefits.) We will also pay you benefits for the first month after the trial work

period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, we cannot pay you benefits for any months in which you do substantial gainful activity.

[68 FR 4706, Jan. 30, 2003, as amended at 70 FR 36506, June 24, 2005]

§ 404.338 Widow's and widower's benefits amounts.

(a) Your monthly benefit is equal to the insured person's primary insurance amount. If the insured person dies before reaching age 62 and you are first eligible after 1984, we may compute a special primary insurance amount to determine the amount of the monthly benefit (see § 404.212(b)).

(b) We may increase your monthly benefit amount if the insured person delays filing for benefits or requests voluntary suspension of benefits, and thereby earns delayed retirement credit (see § 404.313), and/or works before the year 2000 after reaching full retirement age (as defined in § 404.409(a)). The amount of your monthly benefit may change as explained in § 404.304.

(c) Your monthly benefit will be reduced if the insured person chooses to receive old-age benefits before reaching full retirement age. If so, your benefit will be reduced to the amount the insured person would be receiving if alive, or 82½ percent of his or her primary insurance amount, whichever is larger.

[70 FR 28811, May 19, 2005]

§ 404.339 How do I become entitled to mother's or father's benefits as a surviving spouse?

You may be entitled as the widow or widower to mother's or father's benefits on the earnings record of someone who was fully or currently insured when he or she died. You are entitled to these benefits if—

(a) You are the widow or widower of the insured and meet the conditions described in § 404.335(a);

(b) You apply for these benefits; or you were entitled to wife's benefits for the month before the insured died;

(c) You are unmarried;

(d) You are not entitled to widow's or widower's benefits, or to an old-age benefit that is equal to or larger than the full mother's or father's benefit; and

(e) You have *in your care* the insured's child who is entitled to child's benefits and he or she is under 16 years old or is disabled. Sections 404.348 and 404.349 describe when a child is *in your care*.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 73 FR 40967, July 17, 2008]

§ 404.340 How do I become entitled to mother's or father's benefits as a surviving divorced spouse?

You may be entitled to mother's or father's benefits as the surviving divorced wife or the surviving divorced husband on the earnings record of someone who was fully or currently insured when she or he died. You are entitled to these benefits if—

(a) You were validly married to the insured under State law as described in § 404.345 or you were deemed to be validly married as described in § 404.346 but the marriage ended in a final divorce and—

(1) You are the mother or father of the insured's child; or

(2) You were married to the insured when either of you adopted the other's child or when both of you adopted a child and the child was then under 18 years old;

(b) You apply for these benefits; or you were entitled to wife's or husband's benefits for the month before the insured died;

(c) You are unmarried;

(d) You are not entitled to widow's or widower's benefits, or to an old-age benefit that is equal to or larger than the full mother's or father's benefit; and

(e) You have *in your care* the insured's child who is under age 16 or disabled, is your natural or adopted child, and is entitled to child's benefits on the insured person's record. Sections

404.348 and 404.349 describe when a child is *in your care*.

[44 FR 34481, June 15, 1979, as amended at 45 FR 68932, Oct. 17, 1980; 48 FR 21927, May 16, 1983; 58 FR 64891, Dec. 10, 1993; 73 FR 40967, July 17, 2008]

§ 404.341 When mother's and father's benefits begin and end.

(a) You are entitled to mother's or father's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement.

(b) Your entitlement to benefits ends with the month before the month in which one of the following events first occurs:

(1) You become entitled to a widow's or widower's benefit or to an old-age benefit that is equal to or larger than the full mother's or father's benefit.

(2) There is no longer a child of the insured who is under age 16 or disabled and entitled to a child's benefit on the insured's earnings record. (See paragraph (c) of this section if you were entitled to mother's or father's benefits for August 1981.) (If you no longer have in your care a child who is under age 16 or disabled and entitled to child's benefits on the insured's earnings record, your benefits may be subject to deductions as provided in § 404.421.)

(3) You remarry. Your benefits will not end, however, if you marry someone entitled to old-age, disability, wife's, husband's, widow's, widower's, father's, mother's, parent's or disabled child's benefits.

(4) You die.

(c) If you were entitled to spouse's benefits on the basis of having a child in care, or to mother's or father's benefits for August 1981, your entitlement will continue until September 1983, until the child reaches 18 (unless disabled) or is otherwise no longer entitled to child's benefits, or until one of the events described in paragraph (b)(1), (3), or (4) of this section occurs, whichever is earliest.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 49 FR 24115, June 12, 1984; 58 FR 64891, Dec. 10, 1993; 64 FR 14608, Mar. 26, 1999]

§ 404.342 Mother's and father's benefit amounts.

Your mother's or father's monthly benefit is equal to 75 percent of the insured person's primary insurance amount. The amount of your monthly benefit may change as explained in § 404.304.

§ 404.344 Your relationship by marriage to the insured.

You may be eligible for benefits if you are related to the insured person as a wife, husband, widow, or widower. To decide your relationship to the insured, we look first to State laws. The State laws that we use are discussed in § 404.345. If your relationship cannot be established under State law, you may still be eligible for benefits if your relationship as the insured's wife, husband, widow, or widower is based upon a *deemed valid marriage* as described in § 404.346.

§ 404.345 Your relationship as wife, husband, widow, or widower under State law.

To decide your relationship as the insured's wife or husband, we look to the laws of the State where the insured had a permanent home when you applied for wife's or husband's benefits. To decide your relationship as the insured's widow or widower, we look to the laws of the State where the insured had a permanent home when he or she died. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa, we look to the laws of the District of Columbia. For a definition of permanent home, see § 404.303. If you and the insured were validly married under State law at the time you apply for wife's or husband's benefits or at the time the insured died if you apply for widow's, widower's, mother's, or father's benefits, the relationship requirement will be met. The relationship requirement will also be met if under State law you would be able to inherit a wife's, husband's, widow's, or widower's share of the insured's personal property if he or she were to die without leaving a will.

§ 404.346 Your relationship as wife, husband, widow, or widower based upon a deemed valid marriage.

(a) *General.* If your relationship as the insured's wife, husband, widow, or widower cannot be established under State law as explained in § 404.345, you may be eligible for benefits based upon a deemed valid marriage. You will be deemed to be the wife, husband, widow, or widower of the insured if, in good faith, you went through a marriage ceremony with the insured that would have resulted in a valid marriage except for a legal impediment. A legal impediment includes only an impediment which results because a previous marriage had not ended at the time of the ceremony or because there was a defect in the procedure followed in connection with the intended marriage. For example, a defect in the procedure may be found where a marriage was performed through a religious ceremony in a country that requires a civil ceremony for a valid marriage. Good faith means that at the time of the ceremony you did not know that a legal impediment existed, or if you did know, you thought that it would not prevent a valid marriage.

(b) *Entitlement based upon a deemed valid marriage.* To be entitled to benefits as a wife, husband, widow or widower as the result of a deemed valid marriage, you and the insured must have been living in the same household (see § 404.347) at the time the insured died or, if the insured is living, at the time you apply for benefits. However, a marriage that had been deemed valid, shall continue to be deemed valid if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of death of the insured individual.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21927, May 16, 1983; 58 FR 64892, Dec. 10, 1993]

§ 404.347 "Living in the same household" defined.

Living in the same household means that you and the insured customarily lived together as husband and wife in the same residence. You may be considered to be living in the same household although one of you is temporarily absent from the residence. An absence will be considered temporary if:

(a) It was due to service in the U.S. Armed Forces;

(b) It was 6 months or less and neither you nor the insured were outside of the United States during this time and the absence was due to business, employment, or confinement in a hospital, nursing home, other medical institution, or a penal institution;

(c) It was for an extended separation, regardless of the duration, due to the confinement of either you or the insured in a hospital, nursing home, or other medical institution, if the evidence indicates that you were separated solely for medical reasons and you otherwise would have resided together; or

(d) It was based on other circumstances, and it is shown that you and the insured reasonably could have expected to live together in the near future.

[61 FR 41330, Aug. 8, 1996]

§ 404.348 When is a child living with me in my care?

A child who has been living with you for at least 30 days is *in your care* unless—

(a) The child is in active military service;

(b) The child is 16 years old or older and not disabled;

(c) The child is 16 years old or older with a mental disability, but you do not actively supervise his or her activities and you do not make important decisions about his or her needs, either alone or with help from your spouse; or

(d) The child is 16 years old or older with a physical disability, but it is not necessary for you to perform personal services for him or her. Personal services are services such as dressing, feeding, and managing money that the child cannot do alone because of a disability.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 73 FR 40967, July 17, 2008]

§ 404.349 When is a child living apart from me in my care?

(a) *In your care.* A child living apart from you is in your care if—

(1) The child lived apart from you for not more than 6 months, or the child's current absence from you is not expected to last over 6 months;

(2) The child is under 16 years old, you supervise his or her activities and make important decisions about his or her needs, and one of the following circumstances exist:

(i) The child is living apart because of school but spends at least 30 days vacation with you each year unless some event makes having the vacation unreasonable; and if you and the child's other parent are separated, the school looks to you for decisions about the child's welfare;

(ii) The child is living apart because of your employment but you make regular and substantial contributions to his or her support; see § 404.366(a) for a definition of *contributions for support*;

(iii) The child is living apart because of a physical disability that the child has or that you have; or

(3) The child is 16 years old or older, is mentally disabled, and you supervise his or her activities, make important decisions about his or her needs, and help in his or her upbringing and development.

(b) *Not in your care.* A child living apart from you is not in your care if—

(1) The child is in active military service;

(2) The child is living with his or her other parent;

(3) The child is removed from your custody and control by a court order;

(4) The child is 16 years old or older, is mentally competent, and either has been living apart from you for 6 months or more or begins living apart from you and is expected to be away for more than 6 months;

(5) You gave your right to have custody and control of the child to someone else; or

(6) You are mentally disabled.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

CHILD'S BENEFITS

§ 404.350 Who is entitled to child's benefits?

(a) *General.* You are entitled to child's benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died if—

(1) You are the insured person's child, based upon a relationship described in §§ 404.355 through 404.359;

(2) You are dependent on the insured, as defined in §§ 404.360 through 404.365;

(3) You apply;

(4) You are unmarried; and

(5) You are under age 18; you are 18 years old or older and have a disability that began before you became 22 years old; or you are 18 years or older and qualify for benefits as a full-time student as described in § 404.367.

(b) *Entitlement preclusion for certain disabled children.* If you are a disabled child as referred to in paragraph (a)(5) of this section, and your disability was based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535) and your benefits ended after your receipt of 36 months of benefits, you will not be entitled to benefits based on disability for any month following such 36 months regardless of the number of entitlement periods you have had if, in such following months, drug addiction or alcoholism is a contributing factor material to the later determination of disability (as described in § 404.1535).

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 60 FR 8146, Feb. 10, 1995; 61 FR 38363, July 24, 1996]

§ 404.351 Who may be reentitled to child's benefits?

If your entitlement to child's benefits has ended, you may be reentitled on the same earnings record if you have not married and if you apply for reentitlement. Your reentitlement may begin with—

(a) The first month in which you qualify as a full-time student. (See § 404.367.)

(b) The first month in which you are disabled, if your disability began before you became 22 years old.

(c) The first month you are under a disability that began before the end of the 84th month following the month in which your benefits had ended because an earlier disability had ended; or

(d) With respect to benefits payable for months beginning October 2004, you

can be reentitled to childhood disability benefits at anytime if your prior entitlement terminated because you ceased to be under a disability due to the performance of substantial gainful activity and you meet the other requirements for reentitlement. The 84-month time limit in paragraph (c) in this section continues to apply if your previous entitlement to childhood disability benefits terminated because of medical improvement.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 61 FR 38363, July 24, 1996; 71 FR 66865, Nov. 17, 2006]

§ 404.352 When does my entitlement to child's benefits begin and end?

(a) We will find your entitlement to child's benefits begins at the following times:

(1) If the insured is deceased, with the first month covered by your application in which you meet all other requirements for entitlement.

(2) If the insured is living and your first month of entitlement is September 1981 or later, with the first month covered by your application throughout which you meet all other requirements for entitlement.

(3) If the insured is living and your first month of entitlement is before September 1981, with the first month covered by your application in which you meet all other requirements for entitlement.

(b) We will find your entitlement to child's benefits ends at the earliest of the following times:

(1) With the month before the month in which you become 18 years old, if you are not disabled or a full-time student.

(2) With the second month following the month in which your disability ends, if you become 18 years old and you are disabled. If your disability ends on or after December 1, 1980, your entitlement to child's benefits continues, subject to the provisions of paragraphs (c) and (d) of this section, until the month before your termination month (§ 404.325).

(3) With the last month you are a full-time student or, if earlier, with the month before the month you become age 19, if you become 18 years old and you qualify as a full-time student who is not disabled. If you become age 19 in a month in which you have not completed the requirements for, or received, a diploma or equivalent certificate from an elementary or secondary school and you are required to enroll for each quarter or semester, we will find your entitlement ended with the month in which the quarter or semester in which you are enrolled ends. If the school you are attending does not have a quarter or semester system which requires reenrollment, we will find your entitlement to benefits ended with the month you complete the course or, if earlier, the first day of the third month following the month in which you become 19 years old.

(4) With the month before the month you marry. We will not find your benefits ended, however, if you are age 18 or older, disabled, and you marry a person entitled to child's benefits based on disability or person entitled to old-age, divorced wife's, divorced husband's, widow's, widower's, mother's, father's, parent's, or disability benefits.

(5) With the month before the month the insured's entitlement to old-age or disability benefits ends for a reason other than death or the attainment of full retirement age (as defined in § 404.409). Exception: We will continue your benefits if the insured person was entitled to disability benefits based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of his or her disability (as described in § 404.1535), the insured person's benefits ended after 36 months of payment (see § 404.316(e)) or 12 consecutive months of suspension for noncompliance with treatment (see § 404.316(f)), and the insured person remains disabled.

(6) With the month before the month you die.

(7) With the month in which the divorce between your parent (including an adoptive parent) and the insured stepparent becomes final if you are entitled to benefits as a stepchild and the marriage between your parent (including an adoptive parent) and the insured stepparent ends in divorce.

(c) If you are entitled to benefits as a disabled child age 18 or over and your disability is based on a finding that drug addiction or alcoholism was a

contributing factor material to the determination of disability (as described in § 404.1535), we will find your entitlement to benefits ended under the following conditions:

(1) If your benefits have been suspended for a period of 12 consecutive months for failure to comply with treatment, with the month following the 12 months unless you are otherwise disabled without regard to drug addiction or alcoholism (see § 404.470(c)).

(2) If you have received 36 months of benefits on that basis when treatment is available, regardless of the number of entitlement periods you may have had, with the month following such 36-month payment period unless you are otherwise disabled without regard to drug addiction or alcoholism.

(d)(1) Your benefits may be continued after your impairment is no longer disabling if—

(i) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 404.327(a) and (b);

(ii) You began participating in the program before the date your disability ended; and

(iii) We have determined under § 404.328 that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(2) We generally will stop your benefits with the earliest of these months—

(i) The month in which you complete the program; or

(ii) The month in which you stop participating in the program for any reason (see § 404.327(b) for what we mean by ''participating'' in the program); or

(iii) The month in which we determine under § 404.328 that your continuing participation in the program will no longer increase the likelihood that you will not have to return to the disability benefit rolls.

Exception to paragraph (d): In no case will we stop your benefits with a month earlier than the second month after the month your disability ends, provided that you meet all other requirements for entitlement to and payment of benefits through such month.

(e) If, after November 1980, you have a disabling impairment (§ 404.1511), we will pay you benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§ 404.1592a) following the end of your trial work period (§ 404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefits during that period.) We will also pay you benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, we cannot pay you benefits for any months in which you do substantial gainful activity.

[68 FR 4707, Jan. 30, 2003, as amended at 70 FR 36506, June 24, 2005; 75 FR 52621, Aug. 27, 2010]

§ 404.353 Child's benefit amounts.

(a) *General.* Your child's monthly benefit is equal to one-half of the insured person's primary insurance amount if he or she is alive and three-fourths of the primary insurance amount if he or she has died. The amount of your monthly benefit may change as explained in § 404.304.

(b) *Entitlement to more than one benefit.* If you are entitled to a child's benefit on more than one person's earnings record, you will ordinarily receive only the benefit payable on the record with the highest primary insurance amount. If your benefit before any reduction would be larger on an earnings record with a lower primary insurance amount and no other person entitled to benefits on any earnings record would receive a smaller benefit as a result of your receiving benefits on the record with the lower primary insurance amount, you will receive benefits on that record. See § 404.407(d) for a further explanation. If you are entitled to

a child's benefit and to other dependent's or survivor's benefits, you can receive only the highest of the benefits.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 48 FR 21928, May 16, 1983; 51 FR 12606, Apr. 14, 1986; 61 FR 38363, July 24, 1996]

§ 404.354 Your relationship to the insured.

You may be related to the insured person in one of several ways and be entitled to benefits as his or her child, *i.e.*, as a natural child, legally adopted child, stepchild, grandchild, stepgrandchild, or equitably adopted child. For details on how we determine your relationship to the insured person, see §§ 404.355 through 404.359.

[63 FR 57593, Oct. 28, 1998]

§ 404.355 Who is the insured's natural child?

(a) *Eligibility as a natural child.* You may be eligible for benefits as the insured's natural child if any of the following conditions is met:

(1) You could inherit the insured's personal property as his or her natural child under State inheritance laws, as described in paragraph (b) of this section.

(2) You are the insured's natural child and the insured and your mother or father went through a ceremony which would have resulted in a valid marriage between them except for a ''legal impediment'' as described in § 404.346(a).

(3) You are the insured's natural child and your mother or father has not married the insured, but the insured has either acknowledged in writing that you are his or her child, been decreed by a court to be your father or mother, or been ordered by a court to contribute to your support because you are his or her child. If the insured is deceased, the acknowledgment, court decree, or court order must have been made or issued before his or her death. To determine whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a), the written acknowledgment, court decree, or court order will be considered to have occurred on the first day of the month in which it actually occurred.

(4) Your mother or father has not married the insured but you have evidence other than the evidence described in paragraph (a)(3) of this section to show that the insured is your natural father or mother. Additionally, you must have evidence to show that the insured was either living with you or contributing to your support at the time you applied for benefits. If the insured is not alive at the time of your application, you must have evidence to show that the insured was either living with you or contributing to your support when he or she died. See § 404.366 for an explanation of the terms ''living with'' and ''contributions for support.''

(b) *Use of State Laws*—(1) *General.* To decide whether you have inheritance rights as the natural child of the insured, we use the law on inheritance rights that the State courts would use to decide whether you could inherit a child's share of the insured's personal property if the insured were to die without leaving a will. If the insured is living, we look to the laws of the State where the insured has his or her permanent home when you apply for benefits. If the insured is deceased, we look to the laws of the State where the insured had his or her permanent home when he or she died. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, we will look to the laws of the District of Columbia. For a definition of permanent home, see § 404.303. For a further discussion of the State laws we use to determine whether you qualify as the insured's natural child, see paragraphs (b)(3) and (b)(4) of this section. If these laws would permit you to inherit the insured's personal property as his or her child, we will consider you the child of the insured.

(2) *Standards.* We will not apply any State inheritance law requirement that an action to establish paternity must be taken within a specified period of time measured from the worker's death or the child's birth, or that an action to establish paternity must have been started or completed before the worker's death. If applicable State inheritance law requires a court determination of paternity, we will not require

that you obtain such a determination but will decide your paternity by using the standard of proof that the State court would use as the basis for a determination of paternity.

(3) *Insured is living.* If the insured is living, we apply the law of the State where the insured has his or her permanent home when you file your application for benefits. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we look at all versions of State law that were in effect from the first month for which you could be entitled to benefits up until the time of our final decision and apply the version of State law that is most beneficial to you.

(4) *Insured is deceased.* If the insured is deceased, we apply the law of the State where the insured had his or her permanent home when he or she died. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we will apply the version of State law that was in effect at the time the insured died, or any version of State law in effect from the first month for which you could be entitled to benefits up until our final decision on your application. We will apply whichever version is most beneficial to you. We use the following rules to determine the law in effect as of the date of death:

(i) If a State inheritance law enacted after the insured's death indicates that the law would be retroactive to the time of death, we will apply that law; or

(ii) If the inheritance law in effect at the time of the insured's death was later declared unconstitutional, we will apply the State law which superseded the unconstitutional law.

[63 FR 57593, Oct. 28, 1998]

§ 404.356 Who is the insured's legally adopted child?

You may be eligible for benefits as the insured's child if you were legally adopted by the insured. If you were legally adopted after the insured's death by his or her surviving spouse you may also be considered the insured's legally adopted child. We apply the adoption laws of the State or foreign country where the adoption took place, not the State inheritance laws described in § 404.355, to determine whether you are the insured's legally adopted child.

[44 FR 34481, June 15, 1979, as amended at 63 FR 57594, Oct. 28, 1998]

§ 404.357 Who is the insured's stepchild?

You may be eligible for benefits as the insured's stepchild if, after your birth, your natural or adopting parent married the insured. You also may be eligible as a stepchild if you were conceived prior to the marriage of your natural parent to the insured but were born after the marriage and the insured is not your natural parent. The marriage between the insured and your parent must be a valid marriage under State law or a marriage which would be valid except for a *legal impediment* described in § 404.346(a). If the insured is alive when you apply, you must have been his or her stepchild for at least 1 year immediately preceding the day you apply. For purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), you will be considered to meet the one year duration requirement throughout the month in which the anniversary of the marriage occurs. If the insured is not alive when you apply, you must have been his or her stepchild for at least 9 months immediately preceding the day the insured died. This 9-month requirement will not have to be met if the marriage between the insured and your parent lasted less than 9 months under one of the conditions described in § 404.335(a)(2)(i)–(iii).

[48 FR 21928, May 16, 1983, as amended at 64 FR 14608, Mar. 26, 1999; 70 FR 61365, Oct. 24, 2005]

§ 404.358 Who is the insured's grandchild or stepgrandchild?

(a) *Grandchild and stepgrandchild defined.* You may be eligible for benefits as the insured's grandchild or stepgrandchild if you are the natural child, adopted child, or stepchild of a person who is the insured's child as defined in §§ 404.355 through 404.357, or

§ 404.359. Additionally, for you to be eligible as a grandchild or stepgrandchild, your natural or adoptive parents must have been either deceased or under a disability, as defined in § 404.1501(a), at the time your grandparent or stepgrandparent became entitled to old-age or disability benefits or died; or if your grandparent or stepgrandparent had a period of disability that continued until he or she became entitled to benefits or died, at the time the period of disability began. If your parent is deceased, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), your parent will be considered to be deceased as of the first day of the month of death.

(b) *Legally adopted grandchild or stepgrandchild.* If you are the insured's grandchild or stepgrandchild and you are legally adopted by the insured or by the insured's surviving spouse after his or her death, you are considered an adopted child and the dependency requirements of § 404.362 must be met.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21928, May 16, 1983]

§ 404.359 Who is the insured's equitably adopted child?

You may be eligible for benefits as an equitably adopted child if the insured had agreed to adopt you as his or her child but the adoption did not occur. The agreement to adopt you must be one that would be recognized under State law so that you would be able to inherit a child's share of the insured's personal property if he or she were to die without leaving a will. The agreement must be in whatever form, and you must meet whatever requirements for performance under the agreement, that State law directs. If you apply for child's benefits after the insured's death, the law of the State where the insured had his or her permanent home at the time of his or her death will be followed. If you apply for child's benefits during the insured's life, the law of the State where the insured has his or her permanent home at the time or your application will be followed.

§ 404.360 When a child is dependent upon the insured person.

One of the requirements for entitlement to child's benefits is that you be dependent upon the insured. The evidence you need to prove your dependency is determined by how you are related to the insured. To prove your dependency you may be asked to show that at a specific time you lived with the insured, that you received contributions for your support from the insured, or that the insured provided at least one-half of your support. These dependency requirements, and the time at which they must be met, are explained in §§ 404.361 through 404.365. The terms *living with*, *contributions for support*, and *one-half support* are defined in § 404.366.

§ 404.361 When a natural child is dependent.

(a) *Dependency of natural child.* If you are the insured's natural child, as defined in § 404.355, you are considered dependent upon him or her, except as stated in paragraph (b) of this section.

(b) *Dependency of natural child legally adopted by someone other than the insured.* (1) Except as indicated in paragraph (b)(2) of this section, if you are legally adopted by someone other than the insured (your natural parent) during the insured's lifetime, you are considered dependent upon the insured only if the insured was either living with you or contributing to your support at one of the following times:

(i) When you applied;

(ii) When the insured died; or

(iii) If the insured had a period of disability that lasted until he or she became entitled to disability or old-age benefits or died, at the beginning of the period of disability or at the time he or she became entitled to disability or old-age benefits.

(2) You are considered dependent upon the insured (your natural parent) if:

(i) You were adopted by someone other than the insured after you applied for child's benefits; or

(ii) The insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits or died, and you are adopted by someone other than the insured

after the beginning of that period of disability.

[64 FR 14608, Mar. 26, 1999]

§ 404.362 When a legally adopted child is dependent.

(a) *General.* If you were legally adopted by the insured before he or she became entitled to old-age or disability benefits, you are considered dependent upon him or her. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits during the life of the insured, you must meet the dependency requirements stated in paragraph (b) of this section. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits after the death of the insured, you are considered dependent upon him or her. If you were adopted after the insured's death by his or her surviving spouse, you may be considered dependent upon the insured only under the conditions described in paragraph (c) of this section.

(b) *Adoption by the insured after he or she became entitled to benefits*—(1) *General.* If you are legally adopted by the insured after he or she became entitled to benefits and you are not the insured's natural child or stepchild, you are considered dependent on the insured during his or her lifetime only if—

(i) You had not attained age 18 when adoption proceedings were started, and your adoption was issued by a court of competent jurisdiction within the United States; or

(ii) You had attained age 18 before adoption proceedings were started; your adoption was issued by a court of competent jurisdiction within the United States; and you were living with or receiving at least one-half of your support from the insured for the year immediately preceding the month in which your adoption was issued.

(2) *Natural child and stepchild.* If you were legally adopted by the insured after he or she became entitled to benefits and you are the insured's natural child or stepchild, you are considered dependent upon the insured.

(c) *Adoption by the insured's surviving spouse*—(1) *General.* If you are legally adopted by the insured's surviving spouse after the insured's death, you are considered dependent upon the insured as of the date of his or her death if—

(i) You were either living with or receiving at least one-half of your support from the insured at the time of his or her death; and,

(ii) The insured had started adoption proceedings before he or she died; or if the insured had not started the adoption proceedings before he or she died, his or her surviving spouse began and completed the adoption within 2 years of the insured's death.

(2) *Grandchild or stepgrandchild adopted by the insured's surviving spouse.* If you are the grandchild or stepgrandchild of the insured and any time after the death of the insured you are legally adopted by the insured's surviving spouse, you are considered the dependent child of the insured as of the date of his or her death if—

(i) Your adoption took place in the United States;

(ii) At the time of the insured's death, your natural, adopting or stepparent was not living in the insured's household and making regular contributions toward your support; and

(iii) You meet the dependency requirements stated in § 404.364.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 56 FR 24000, May 28, 1991; 57 FR 3938, Feb. 3, 1992]

§ 404.363 When is a stepchild dependent?

If you are the insured's stepchild, as defined in § 404.357, we consider you dependent on him or her if you were receiving at least one-half of your support from him or her at one of these times—

(a) When you applied;

(b) When the insured died; or

(c) If the insured had a period of disability that lasted until his or her death or entitlement to disability or old-age benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

[44 FR 34481, June 15, 1979, as amended at 75 FR 52621, Aug. 27, 2010]

§ 404.364 When is a grandchild or stepgrandchild dependent?

If you are the insured's grandchild or stepgrandchild, as defined in § 404.358(a), you are considered dependent upon the insured if—

(a) You began living with the insured before you became 18 years old; and

(b) You were living with the insured in the United States and receiving at least one-half of your support from him or her for the year before he or she became entitled to old-age or disability benefits or died; or if the insured had a period of disability that lasted until he or she became entitled to benefits or died, for the year immediately before the month in which the period of disability began. If you were born during the 1-year period, the insured must have lived with you and provided at least one-half of your support for *substantially all* of the period that begins on the date of your birth. Paragraph (c) of this section explains when the *substantially all* requirement is met.

(c) The ''substantially all'' requirement will be met if, at one of the times described in paragraph (b) of this section, the insured was living with you and providing at least one-half of your support, and any period during which he or she was not living with you and providing one-half of your support did not exceed the lesser of 3 months or one-half of the period beginning with the month of your birth.

[44 FR 34481, June 15, 1979, as amended at 73 FR 40967, July 17, 2008]

§ 404.365 When an equitably adopted child is dependent.

If you are the insured's equitably adopted child, as defined in § 404.359, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at the time of his or her death. If your equitable adoption is found to have occurred after the insured became entitled to old-age or disability benefits, your dependency cannot be established during the insured's life. If your equitable adoption is found to have occurred before the insured became entitled to old-age or disability benefits, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at one of these times—

(a) When you applied; or

(b) If the insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

§ 404.366 "Contributions for support," "one-half support," and "living with" the insured defined—determining first month of entitlement.

To be eligible for child's or parent's benefits, and in certain Government pension offset cases, you must be dependent upon the insured person at a particular time or be assumed dependent upon him or her. What it means to be a dependent child is explained in §§ 404.360 through 404.365; what it means to be a dependent parent is explained in § 404.370(f); and the Government pension offset is explained in § 404.408a. Your dependency upon the insured person may be based upon whether at a specified time you were receiving *contributions for your support* or *one-half of your support* from the insured person, or whether you were *living with* him or her. These terms are defined in paragraphs (a) through (c) of this section.

(a) *Contributions for support.* The insured makes a contribution for your support if the following conditions are met:

(1) The insured gives some of his or her own cash or goods to help support you. Support includes food, shelter, routine medical care, and other ordinary and customary items needed for your maintenance. The value of any goods the insured contributes is the same as the cost of the goods when he or she gave them for your support. If the insured provides services for you that would otherwise have to be paid for, the cash value of his or her services may be considered a contribution for your support. An example of this would be work the insured does to repair your home. The insured person is making a contribution for your support if you receive an allotment, allowance, or benefit based upon his or her military pay, veterans' pension or compensation, or social security earnings.

(2) Contributions must be made regularly and must be large enough to meet an important part of your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. If the insured person only provides gifts or donations once in a while for special purposes, they will not be considered contributions for your support. Although the insured's contributions must be made on a regular basis, temporary interruptions caused by circumstances beyond the insured person's control, such as illness or unemployment, will be disregarded unless during this interruption someone else takes over responsibility for supporting you on a permanent basis.

(b) *One-half support.* The insured person provides one-half of your support if he or she makes regular contributions for your ordinary living costs; the amount of these contributions equals or exceeds one-half of your ordinary living costs; and any income (from sources other than the insured person) you have available for support purposes is one-half or less of your ordinary living costs. We will consider any income which is available to you for your support whether or not that income is actually used for your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. A contribution may be in cash, goods, or services. The insured is not providing at least one-half of your support unless he or she has done so for a reasonable period of time. Ordinarily we consider a reasonable period to be the 12-month period immediately preceding the time when the one-half support requirement must be met under the rules in §§ 404.362(c)(1) and 404.363 (for child's benefits), in § 404.370(f) (for parent's benefits) and in § 404.408a(c) (for benefits where the Government pension offset may be applied). A shorter period will be considered reasonable under the following circumstances:

(1) At some point within the 12-month period, the insured either begins or stops providing at least one-half of your support on a permanent basis and this is a change in the way you had been supported up to then. In these circumstances, the time from the change up to the end of the 12-month period will be considered a reasonable period, unless paragraph (b)(2) of this section applies. The change in your source of support must be permanent and not temporary. Changes caused by seasonal employment or customary visits to the insured's home are considered temporary.

(2) The insured provided one-half or more of your support for at least 3 months of the 12-month period, but was forced to stop or reduce contributions because of circumstances beyond his or her control, such as illness or unemployment, and no one else took over the responsibility for providing at least one-half of your support on a permanent basis. Any support you received from a public assistance program is not considered as a taking over of responsibility for your support by someone else. Under these circumstances, a reasonable period is that part of the 12-month period before the insured was forced to reduce or stop providing at least one-half of your support.

(c) *''Living with'' the insured.* You are living with the insured if you ordinarily live in the same home with the insured and he or she is exercising, or has the right to exercise, parental control and authority over your activities. You are living with the insured during temporary separations if you and the insured expect to live together in the same place after the separation. Temporary separations may include the insured's absence because of active military service or imprisonment if he or she still exercises parental control and authority. However, you are not considered to be living with the insured if you are in active military service or in prison. If *living with* is used to establish dependency for your eligibility to child's benefits and the date your application is filed is used for establishing the point for determining dependency, you must have been living with the insured throughout the month your application is filed in order to be entitled to benefits for that month.

(d) *Determining first month of entitlement.* In evaluating whether dependency is established under paragraph

(a), (b), or (c) of this section, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), we will not use the temporary separation or temporary interruption rules.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21928, May 16, 1983; 52 FR 26955, July 17, 1987; 64 FR 14608, Mar. 26, 1999]

§ 404.367 When you are a "full-time elementary or secondary school student".

You may be eligible for child's benefits if you are a full-time elementary or secondary school student. For the purposes of determining whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a)(2)(i), if you are entitled as a student on the basis of attendance at an elementary or secondary school, you will be considered to be in full-time attendance for a month during any part of which you are in full-time attendance. You are a full-time elementary or secondary school student if you meet all the following conditions:

(a) You attend a school which provides elementary or secondary education as determined under the law of the State or other jurisdiction in which it is located. Participation in the following programs also meets the requirements of this paragraph:

(1) You are instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which you reside; or

(2) You are in an independent study elementary or secondary education program in accordance with the law of the State or other jurisdiction in which you reside which is administered by the local school or school district/jurisdiction.

(b) You are in full-time attendance in a day or evening noncorrespondence course of at least 13 weeks duration and you are carrying a subject load which is considered full-time for day students under the institution's standards and practices. If you are in a home schooling program as described in paragraph (a)(1) of this section, you must be carrying a subject load which is considered full-time for day students under standards and practices set by the State or other jurisdiction in which you reside;

(c) To be considered in full-time attendance, your scheduled attendance must be at the rate of at least 20 hours per week unless one of the exceptions in paragraphs (c) (1) and (2) of this section applies. If you are in an independent study program as described in paragraph (a)(2) of this section, your number of hours spent in school attendance are determined by combining the number of hours of attendance at a school facility with the agreed upon number of hours spent in independent study. You may still be considered in full-time attendance if your scheduled rate of attendance is below 20 hours per week if we find that:

(1) The school attended does not schedule at least 20 hours per week and going to that particular school is your only reasonable alternative; or

(2) Your medical condition prevents you from having scheduled attendance of at least 20 hours per week. To prove that your medical condition prevents you from scheduling 20 hours per week, we may request that you provide appropriate medical evidence or a statement from the school.

(d) You are not being paid while attending the school by an employer who has requested or required that you attend the school;

(e) You are in grade 12 or below; and

(f) You are not subject to the provisions in § 404.468 for nonpayment of benefits to certain prisoners and certain other inmates of publicly funded institutions.

[48 FR 21928, May 16, 1983, as amended at 48 FR 55452, Dec. 13, 1983; 56 FR 35999, July 30, 1991; 61 FR 38363, July 24, 1996]

§ 404.368 When you are considered a full-time student during a period of nonattendance.

If you are a full-time student, your eligibility may continue during a period of nonattendance (including part-time attendance) if all the following conditions are met:

(a) The period of nonattendance is 4 consecutive months or less;

(b) You show us that you intend to resume your studies as a full-time student at the end of the period or at the end of the period you are a full-time student; and

(c) The period of nonattendance is not due to your expulsion or suspension from the school.

[48 FR 21929, May 16, 1983]

PARENT'S BENEFITS

§ 404.370 Who is entitled to parent's benefits?

You may be entitled to parent's benefits on the earnings record of someone who has died and was fully insured. You are entitled to these benefits if all the following conditions are met:

(a) You are related to the insured person as his or her parent in one of the ways described in § 404.374.

(b) You are at least 62 years old.

(c) You have not married since the insured person died.

(d) You apply.

(e) You are not entitled to an old-age benefit equal to or larger than the parent's benefit amount.

(f) You were receiving at least one-half of your support from the insured at the time he or she died, or at the beginning of any period of disability he or she had that continued up to death. See § 404.366(b) for a definition of *one-half support*. If you were receiving one-half of your support from the insured at the time of the insured's death, you must give us proof of this support within 2 years of the insured's death. If you were receiving one-half of your support from the insured at the time his or her period of disability began, you must give us proof of this support within 2 years of the month in which the insured filed his or her application for the period of disability. You must file the evidence of support even though you may not be eligible for parent's benefits until a later time. There are two exceptions to the 2-year filing requirement:

(1) If there is a good cause for failure to provide proof of support within the 2-year period, we will consider the proof you give us as though it were provided within the 2-year period. Good cause does not exist if you were informed of the need to provide the proof within the 2-year period and you neglected to do so or did not intend to do so. Good cause will be found to exist if you did not provide the proof within the time limit due to—

(i) Circumstances beyond your control, such as extended illness, mental or physical incapacity, or a language barrier;

(ii) Incorrect or incomplete information we furnished you;

(iii) Your efforts to get proof of the support without realizing that you could submit the proof after you gave us some other evidence of that support; or

(iv) Unusual or unavoidable circumstances that show you could not reasonably be expected to know of the 2-year time limit.

(2) The Soldiers' and Sailors' Civil Relief Act of 1940 provides for extending the filing time.

§ 404.371 When parent's benefits begin and end.

(a) You are entitled to parent's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement.

(b) Your entitlement to benefits ends with the month before the month in which one of the following events first occurs:

(1) You become entitled to an old-age benefit equal to or larger than the parent's benefit.

(2) You marry, unless your marriage is to someone entitled to wife's, husband's, widow's, widower's, mother's, father's, parent's or disabled child's benefits. If you marry a person entitled to these benefits, the marriage does not affect your benefits.

(3) You die.

[44 FR 34481, June 15, 1979, as amended at 49 FR 24116, June 12, 1984]

§ 404.373 Parent's benefit amounts.

Your parent's monthly benefit before any reduction that may be made as explained in § 404.304, is figured in one of the following ways:

(a) *One parent entitled.* Your parent's monthly benefit is equal to 82½ percent of the insured person's primary insurance amount if you are the only parent

entitled to benefits on his or her earnings record.

(b) *More than one parent entitled.* Your parent's monthly benefit is equal to 75 percent of the insured person's primary insurance amount if there is another parent entitled to benefits on his or her earnings record.

§ 404.374 Parent's relationship to the insured.

You may be eligible for benefits as the insured person's parent if—

(a) You are the mother or father of the insured and would be considered his or her parent under the laws of the State where the insured had a permanent home when he or she died;

(b) You are the adoptive parent of the insured and legally adopted him or her before the insured person became 16 years old; or

(c) You are the stepparent of the insured and you married the insured's parent or adoptive parent before the insured became 16 years old. The marriage must be valid under the laws of the State where the insured had his or her permanent home when he or she died. See § 404.303 for a definition of *permanent home.*

§§ 404.380–404.384 [Reserved]

LUMP-SUM DEATH PAYMENT

§ 404.390 General.

If a person is fully or currently insured when he or she dies, a lump-sum death payment of $255 may be paid to the widow or widower of the deceased if he or she was living in the same household with the deceased at the time of his or her death. If the insured is not survived by a widow(er) who meets this requirement, all or part of the $255 payment may be made to someone else as described in § 404.392.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21929, May 16, 1983; 61 FR 41330, Aug. 8, 1996]

§ 404.391 Who is entitled to the lump-sum death payment as a widow or widower who was living in the same household?

You are entitled to the lump-sum death payment as a widow or widower who was living in the same household if—

(a) You are the widow or widower of the deceased insured individual based upon a relationship described in § 404.345 or § 404.346;

(b) You apply for this payment within two years after the date of the insured's death. You need not apply again if, in the month prior to the death of the insured, you were entitled to wife's or husband's benefits on his or her earnings record; and

(c) You were living in the same household with the insured at the time of his or her death. The term *living in the same household* is defined in § 404.347.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21929, May 16, 1983]

§ 404.392 Who is entitled to the lump-sum death payment when there is no widow(er) who was living in the same household?

(a) *General.* If the insured individual is not survived by a widow(er) who meets the requirements of § 404.391, the lump-sum death payment shall be paid as follows:

(1) To a person who is entitled (or would have been entitled had a timely application been filed) to widow's or widower's benefits (as described in § 404.335) or mother's or father's benefits (as described in § 404.339) on the work record of the deceased worker for the month of that worker's death; or

(2) If no person described in (1) survives, in equal shares to each person who is entitled (or would have been entitled had a timely application been filed) to child's benefits (as described in § 404.350) on the work record of the deceased worker for the month of that worker's death.

(b) *Application requirement.* A person who meets the requirements of paragraph (a)(1) of this section need not apply to receive the lump-sum death payment if, for the month prior to the death of the insured, that person was entitled to wife's or husband's benefits on the insured's earnings record. Otherwise, an application must be filed within 2 years of the insured's death.

[48 FR 21929, May 16, 1983; 61 FR 41330, Aug. 8, 1996]

Subpart E—Deductions; Reductions; and Nonpayments of Benefits

AUTHORITY: Secs. 202, 203, 204(a) and (e), 205(a) and (c), 216(l), 222(c), 223(e), 224, 225, 702(a)(5), and 1129A of the Social Security Act (42 U.S.C. 402, 403, 404(a) and (e), 405(a) and (c), 416(l), 422(c), 423(e), 424a, 425, 902(a)(5), and 1320a–8a); 48 U.S.C. 1801.

SOURCE: 32 FR 19159, Dec. 20, 1967, unless otherwise noted.

§ 404.401 Deduction, reduction, and nonpayment of monthly benefits or lump-sum death payments.

Under certain conditions, the amount of a monthly insurance benefit or the lump-sum death payment as calculated under the pertinent provisions of sections 202 and 203 of the Act (including reduction for age under section 202(q) of a monthly benefit) must be increased or decreased to determine the amount to be actually paid to a beneficiary. Increases in the amount of a monthly benefit or lump-sum death payment are based upon recomputation and recalculations of the primary insurance amount (see subpart C of this part). A decrease in the amount of a monthly benefit or lump-sum death payment is required in the following instances:

(a) *Reductions.* A reduction of a person's monthly benefit is required where:

(1) The total amount of the monthly benefits payable on an earnings record exceeds the maximum that may be paid (see § 404.403);

(2) An application for monthly benefits is effective for a month during a retroactive period, and the maximum has already been paid for that month or would be exceeded if such benefit were paid for that month (see § 404.406);

(3) An individual is entitled to old-age or disability insurance benefits in addition to any other monthly benefit (see § 404.407);

(4) An individual under full retirement age (see § 404.409) is concurrently entitled to disability insurance benefits and to certain public disability benefits (see § 404.408);

(5) An individual is entitled in a month to a widow's or widower's insurance benefit that is reduced under section 202 (e)(4) or (f)(5) of the Act and to any other monthly insurance benefit other than an old-age insurance benefit (see § 404.407(b)); or

(6) An individual is entitled in a month to old-age, disability, wife's, husband's, widow's, or widower's insurance benefit and reduction is required under section 202(q) of the Act (see § 404.410).

(b) *Deductions.* A deduction from a monthly benefit or a lump-sum death payment may be required because of:

(1) An individual's earnings or work (see §§ 404.415 and 404.417);

(2) Failure of certain beneficiaries receiving wife's or mother's insurance benefits to have a child in her care (see § 404.421);

(3) The earnings or work of an old-age insurance beneficiary where a wife, husband, or child is also entitled to benefits (see §§ 404.415 and 404.417);

(4) Failure to report within the prescribed period either certain work outside the United States or not having the care of a child (see § 404.451);

(5) Failure to report within the prescribed period earnings from work in employment or self-employment (*see* § 404.453); or

(6) Certain taxes which were neither deducted from the wages of maritime employees nor paid to the Federal Government (see § 404.457).

(c) *Adjustments.* We may adjust your benefits to correct errors in payments under title II of the Act. We may also adjust your benefits if you received more than the correct amount due under titles VIII or XVI of the Act. For the title II rules on adjustment to your benefits, see subpart F of this part. For the rules on adjusting your benefits to recover title VIII overpayments, see § 408.930 of this chapter. For the rules on adjusting your benefits to recover title XVI overpayments, see § 416.572 of this chapter.

(d) *Nonpayments.* Nonpayment of monthly benefits may be required because:

(1) The individual is an alien who has been outside the United States for more than 6 months (see § 404.460);

(2) The individual on whose earnings record entitlement is based has been deported (see § 404.464);

(3) The individual is engaged in substantial gainful activity while entitled to disability insurance benefits based on ''statutory blindness'' (see § 404.467); or

(4) The individual has not provided satisfactory proof that he or she has a Social Security number or has not properly applied for a Social Security number (see § 404.469).

(e) *Recalculation.* A reduction by recalculation of a benefit amount may be prescribed because an individual has been convicted of certain offenses (see § 404.465) or because the primary insurance amount is recalculated (see subpart C of this part).

(f) *Suspensions.* Suspension of monthly benefits may be required pursuant to section 203(h)(3) of the Act (the Social Security Administration has information indicating that work deductions may reasonably be expected for the year), or pursuant to section 225 of the Act (the Social Security Administration has information indicating a beneficiary is no longer disabled).

[40 FR 30813, July 23, 1975, as amended at 48 FR 37016, Aug. 16, 1983; 56 FR 41789, Aug. 23, 1991; 65 FR 16813, Mar. 30, 2000; 66 FR 38906, July 26, 2001; 68 FR 40122, July 7, 2003; 69 FR 25955, May 10, 2004; 81 FR 19033, Apr. 4, 2016; 83 FR 21708, May 10, 2018]

§ 404.401a When we do not pay benefits because of a disability beneficiary's work activity.

If you are receiving benefits because you are disabled or blind as defined in title II of the Social Security Act, we will stop your monthly benefits even though you have a disabling impairment (§ 404.1511), if you engage in substantial gainful activity during the reentitlement period (§ 404.1592a) following completion of the trial work period (§ 404.1592). You will, however, be paid benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity in those two months. If anyone else is receiving monthly benefits based on your earnings record, that individual will not be paid benefits for any month for which you cannot be paid benefits during the reentitlement period. Except as provided in § 404.471, earnings from work activity during a trial work period will not stop your benefits.

[49 FR 22271, May 29, 1984, as amended at 58 FR 64883, Dec. 10, 1993; 71 FR 66865, Nov. 17, 2006]

§ 404.402 Interrelationship of deductions, reductions, adjustments, and nonpayment of benefits.

(a) *Deductions, reductions, adjustment.* Deductions because of earnings or work (*see* §§ 404.415 and 404.417); failure to have a child ''in his or her care'' (*see* § 404.421); as a penalty for failure to timely report noncovered work outside the United States, failure to report that he or she no longer has a child ''in his or her care,'' or failure to timely report earnings (*see* §§ 404.451 and 404.453); because of unpaid maritime taxes (*see* § 404.457); or nonpayments because of drug addiction and alcoholism to individuals other than an insured individual who are entitled to benefits on the insured individual's earnings record are made:

(1) Before making any reductions because of the *maximum* (see § 404.403),

(2) Before applying the benefit *rounding* provisions (see § 404.304(f)), and,

(3) Except for deductions imposed as a penalty (see §§ 404.451 and 404.453), before making any adjustment necessary because an error has been made in the payment of benefits (see subpart F). However, for purposes of charging excess earnings for taxable years beginning after December 1960 or ending after June 1961, see paragraph (b) of this section and § 404.437 for reductions that apply before such charging.

(b) *Reductions, nonpayments.* (1) Reduction because of the *maximum* (see § 404.403) is made:

(i) Before reduction because of simultaneous entitlement to old-age or disability insurance benefits and to other benefits (see § 404.407);

(ii) Before reduction in benefits for age (see §§ 404.410 through 404.413);

(iii) Before adjustment necessary because an error has been made in the payment of benefits (see subpart F of this part);

(iv) Before reduction because of entitlement to certain public disability benefits provided under Federal, State, or local laws or plans (see § 404.408);

(v) Before nonpayment of an individual's benefits because he is an alien living outside the United States for 6 months (see § 404.460), or because of deportation (see § 404.464);

(vi) Before the redetermination of the amount of benefit payable to an individual who has been convicted of certain offenses (see § 404.465); and

(vii) Before suspension of benefits due to earnings (see § 404.456), for benefits payable or paid for months after December 1995 to a non-working auxiliary or survivor who resides in a different household than the working auxiliary or survivor whose benefits are suspended.

(2) Reduction of benefits because of entitlement to certain public disability benefits (*see* § 404.408) is made before deduction under section 203 of the Act relating to work (*see* §§ 404.415, 404.417, 404.451, and 404.453) and failure to have care of a child (*see* §§ 404.421 and 404.451).

(3) Reduction of the benefit of a spouse who is receiving a Government pension (see § 404.408(a)) is made after the withholding of payments as listed in paragraph (d)(1) of this section and after reduction because of receipt of certain public disability benefits (paragraph (b)(2) of this section).

(c) *Alien outside the United States; deportation nonpayment—deduction.* If an individual is subject to nonpayment of a benefit for a month under § 404.460 or § 404.464, no deduction is made from his benefit for that month under § 404.415, § 404.417, or § 404.421, and no deduction is made because of that individual's work from the benefit of any person entitled or deemed entitled to benefits under § 404.420, on his earnings record, for that month.

(d) *Order of priority—deductions and other withholding provisions.* Deductions and other withholding provisions are applied in accordance with the following order of priority:

(1) Current nonpayments under §§ 404.460, 404.464, 404.465, 404.467, and 404.469;

(2) Current reductions under § 404.408;

(3) Current reductions under § 404.408a;

(4) Current deductions under §§ 404.417 and 404.421;

(5) Current withholding of benefits under § 404.456;

(6) Unpaid maritime tax deductions (§ 404.457);

(7) Withholdings to recover overpayments (see subpart F of this part);

(8) Penalty deductions under §§ 404.451 and 404.453.

[40 FR 30813, July 23, 1975, as amended at 44 FR 29047, May 18, 1979; 48 FR 37016, Aug. 16, 1983; 48 FR 46148, Oct. 11, 1983; 56 FR 41789, Aug. 23, 1991; 60 FR 8146, Feb. 10, 1995; 68 FR 15659, Apr. 1, 2003; 68 FR 40122, July 7, 2003]

§ 404.403 Reduction where total monthly benefits exceed maximum family benefits payable.

(a) *General.* (1) The Social Security Act limits the amount of monthly benefits that can be paid for any month based on the earnings of an insured individual. If the total benefits to which all persons are entitled on one earnings record exceed a maximum amount prescribed by law, then those benefits must be reduced so that they do not exceed that maximum.

(2) The method of determining the total benefits payable (the *family maximum*) depends on when the insured individual died or became eligible, whichever is earlier. For purposes of this section, the year in which the insured individual becomes eligible refers generally to the year in which the individual attains age 62 or becomes disabled. However, where eligibility or death is in 1979 or later, the year of death, attainment of age 62, or beginning of current disability does not control if the insured individual was entitled to a disability benefit within the 12 month period preceding current eligibility or death. Instead the year in which the individual became eligible for the former disability insurance benefit is the year of eligibility.

(3) The benefits of an individual entitled as a divorced spouse or surviving divorced spouse will not be reduced pursuant to this section. The benefits of all other individuals entitled on the same record will be determined under this section as if no such divorced spouse or surviving divorced spouse were entitled to benefits.

(4) In any case where more than one individual is entitled to benefits as the spouse or surviving spouse of a worker

for the same month, and at least one of those individuals is entitled based on a marriage not valid under State law (see §§ 404.345 and 404.346), the benefits of the individual whose entitlement is based on a valid marriage under State law will not be reduced pursuant to this section. The benefits of all other individuals entitled on the same record (unless excluded by paragraph (a)(3) of this section) will be determined under this section as if such validly married individual were not entitled to benefits.

(5) When a person entitled on a worker's earnings record is also entitled to benefits on another earnings record, we consider only the amount of benefits actually due or payable on the worker's record to the dually-entitled person when determining how much to reduce total monthly benefits payable on the worker's earnings record because of the maximum. We do not include, in total benefits payable, any amount not paid because of that person's entitlement on another earnings record (see § 404.407). The effect of this provision is to permit payment of up to the full maximum benefits to other beneficiaries who are not subject to a deduction or reduction. (See § 404.402 for other situations where we apply deductions or reductions before reducing total benefits for the maximum.)

Example 1: A wage earner, his wife and child are entitled to benefits. The wage earner's primary insurance amount is $600.00. His maximum is $900.00. Due to the maximum limit, the monthly benefits for the wife and child must be reduced to $150.00 each. Their original benefit rates are $300.00 each.

Maximum—$900.00
Subtract primary insurance amount—$600.00
Amount available for wife and child—$300.00
Divide by 2—$150.00 each for wife and child

The wife is also entitled to benefits on her own record of $120.00 monthly. This reduces her wife's benefit to $30.00. The following table illustrates this calculation.

Wife's benefit, reduced for maximum—$150.00
Subtract reduction due to dual entitlement—$120.00
Wife's benefit—$30.00

In computing the total benefits payable on the record, we disregard the $120.00 we cannot pay the wife. This allows us to increase the amount payable to the child to $270.00. The table below shows the steps in our calculation.

Amount available under maximum—$300.00
Subtract amount due wife after reduction due to entitlement to her own benefit—$30.00
Child's benefit—$270.00

Example 2: A wage earner, his wife and 2 children are entitled to benefits. The wage earner's primary insurance amount is $1,250.00. His maximum is $2,180.00. Due to the maximum limit, the monthly benefits for the wife and children must be reduced to $310.00 each. Their original rates (50 percent of the worker's benefit) are $625.00 each. The following shows the calculation.

Maximum—$2,180.00
Subtract primary insurance amount—$1,250.00
Amount available for wife and children—$930.00
Divide by 3—$310 each for wife and children

The children are also entitled to benefits on their own records. Child one is entitled to $390.00 monthly and child two is entitled to $280.00 monthly. This causes a reduction in the benefit to child one to 0.00 and the benefit to child two to $30.00. Again, the following illustrates the calculation.

Benefit payable to child 1 reduced for maximum—$310.00
Subtract reduction due to dual entitlement—$390.00
Benefit payable to child 1—$0.00
Benefit payable to child 2, reduced for maximum—$310.00
Subtract reduction for dual entitlement—$280.00
Benefit payable to child 2—$30.00

In computing the total benefits payable on the record, we consider only the benefits actually paid to the children, or $30. This allows payment of an additional amount to the wife, increasing her benefit to $625.00. This is how the calculation works.

Amount available under maximum for wife and children—$930.00
Subtract amount due children after reduction due to entitlement to their own benefits—$30.00
Amount available for wife—$900.00
Amount payable to wife (original benefit)—$625.00

Example 3: A wage earner, his wife and 4 children are entitled to benefits. The wage earner's primary insurance amount is $1,250.00. His maximum is $2,180.00. Due to the maximum limit, the monthly benefits for the wife and children must be reduced to $186.00 each. Their original rates are $625.00 each. This is how the calculation works.

Maximum—$2,180.00
Subtract primary insurance amount—$1,250.00
Amount available for wife and children—$930.00
Divide by 5—$186.00 each for wife and four children

Two children are also entitled to benefits on their own records. Child one is entitled to $390.00 monthly and child two is entitled to $280.00 monthly. This causes a reduction in the benefit to child one to $0.00 and the benefit to child two to $0.00. This calculation is as follows.

Benefit to child 1, reduced for maximum—$186.00
Subtract reduction due to dual entitlement—$390.00
Benefit payable to child 1—$0.00
Benefit to child 2, reduced for maximum—$186.00
Subtract reduction for dual entitlement—$280.00
Benefit payable to child two—$0.00

In computing the total benefits payable on the record, we disregard the $372.00 we cannot pay the children. This allows payment of an additional amount to the wife, and the two remaining children as follows:

Amount available under maximum for wife and children—$930.00
Subtract amount due child one and child two after reduction due to entitlement to their own benefits—$0.00
Amount available for wife and the other two children—$930.00
Amount payable to the wife and each of the remaining two children—$310.00

(b) *Eligibility or death before 1979.* Where more than one individual is entitled to monthly benefits for the same month on the same earnings record, a reduction in the total benefits payable for that month may be required (except in cases involving a *saving clause*—see § 404.405) if the maximum family benefit is exceeded. The maximum is exceeded if the total of the monthly benefits exceeds the amount appearing in column V of the applicable table in section 215(a) of the Act on the line on which appears in column IV the primary insurance amount of the insured individual whose earnings record is the basis for the benefits payable. Where the maximum is exceeded, the total benefits for each month after 1964 are reduced to the amount appearing in column V. However, when any of the persons entitled to benefits on the insured individual's earnings would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the basis of the earnings record of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—

(1) The sum of the maximum amounts of benefits payable on the basis of the earnings records of all such insured individuals, or

(2) The last figure in column V of the applicable table in (or deemed to be in) section 215(a) of the Act. The *applicable* table refers to the table which is effective for the month the benefit is payable.

(c) *Eligible for old-age insurance benefits or dies in 1979.* If an insured individual becomes eligible for old-age insurance benefits or dies in 1979, the monthly maximum is as follows—

(1) 150 percent of the first $230 of the individual's primary insurance amount, plus

(2) 272 percent of the primary insurance amount over $230 but not over $332, plus

(3) 134 percent of the primary insurance amount over $332 but not over $433, plus

(4) 175 percent of the primary insurance amount over $433.

If the total of this computation is not a multiple of $0.10, it will be rounded to the next lower multiple of $0.10.

(d) *Eligible for old-age insurance benefits or dies after 1979.* (1) If an insured individual becomes eligible for old-age insurance benefits or dies after 1979, the monthly maximum is computed as in paragraph (c) of this section. However, the dollar amounts shown there will be updated each year as average earnings rise. This updating is done by first dividing the average of the total wages (see § 404.203(m)) for the second year before the individual dies or becomes eligible, by the average of the total wages for 1977. The result of that computation is then multiplied by each dollar amount in the formula in paragraph (c) of this section. Each updated dollar amount will be rounded to the nearer dollar; if the amount is an exact multiple of $0.50 (but not of $1), it will be rounded to the next higher $1.

(2) Before November 2 of each calendar year after 1978, the Commissioner will publish in the FEDERAL REGISTER the formula and updated dollar amounts to be used for determining the monthly maximum for the following year.

(d–1) *Entitled to disability insurance benefits after June 1980.* If you first become eligible for old-age or disability insurance benefits after 1978 and first entitled to disability insurance benefits after June 1980, we compute the monthly family maximum under a formula which is different from that in paragraphs (c) and (d) of this section. The computation under the new formula is as follows:

(1) We take 85 percent of your average indexed monthly earnings and compare that figure with your primary insurance amount (see § 404.212 of this part). We work with the larger of these two amounts.

(2) We take 150 percent of your primary insurance amount.

(3) We compare the results of paragraphs (d–1) (1) and (2) of this section. The smaller amount is the monthly family maximum. As a result of this rule, the entitled spouse and children of some workers will not be paid any benefits because the family maximum does not exceed the primary insurance amount.

(e) *Person entitled on more than one record during years after 1978 and before 1984.* (1) If any of the persons entitled to monthly benefits on the earnings record of an insured individual would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the earnings record of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—(i) the sum of the maximum amounts of benefits payable on the earnings records of all the insured individuals, or (ii) 1.75 times the highest primary insurance amount possible for that month based on the average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year.

(2) If benefits are payable on the earnings of more than one individual and the primary insurance amount of one of the insured individuals was computed under the provisions in effect before 1979 and the primary insurance amount of the others was computed under the provisions in effect after 1978, the maximum monthly benefits cannot be more than the amount computed under paragraph (e)(1) of this section.

(f) *Person entitled on more than one record for years after 1983.* (1) If any person for whom paragraphs (c) and (d) would apply is entitled to monthly benefits on the earnings record of an insured individual would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the earnings record of one or more other insured individuals, the total benefits payable to all persons on the earnings record of any of those insured individuals may not be reduced to less than the smaller of:

(i) The sum of the maximum amounts of benefits payable on the earnings records of all the insured individuals, or

(ii) 1.75 times the highest primary insurance amount possible for January 1983, or if later, January of the year that the person becomes entitled or reentitled on more than one record.

This highest primary insurance amount possible for that year will be based on the average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year. Thereafter, the total monthly benefits payable to persons on the earnings record of those insured individuals will then be increased only when monthly benefits are increased because of cost-of-living adjustments (see § 404.270ff).

(2) If benefits are payable on the earnings of more than one individual and the primary insurance amount of one of the insured individuals was computed under the provisions in effect before 1979 and the primary insurance amount of the other was computed under the provisions in effect after 1978, the maximum monthly benefits cannot be more than the amount computed under paragraph (f)(1) of this section.

(g) *Person previously entitled to disability insurance benefits.* If an insured individual who was previously entitled to disability insurance benefits becomes entitled to a ''second entitlement'' as defined in § 404.250, or dies, after 1995, and the insured individual's primary insurance amount is determined under §§ 404.251(a)(1), 404.251(b)(1), or 404.252(b), the monthly

maximum during the second entitlement is determined under the following rules:

(1) If the primary insurance amount is determined under §§ 404.251(a)(1) or 404.251(b)(1), the monthly maximum equals the maximum in the last month of the insured individual's earlier entitlement to disability benefits, increased by any cost-of-living or ad hoc increases since then.

(2) If the primary insurance amount is determined under § 404.252(b), the monthly maximum equals the maximum in the last month of the insured individual's earlier entitlement to disability benefits.

(3) Notwithstanding paragraphs (g)(1) and (g)(2) of this section, if the second entitlement is due to the insured individual's retirement or death, and the monthly maximum in the last month of the insured individual's earlier entitlement to disability benefits was computed under paragraph (d–1) of this section, the monthly maximum is equal to the maximum that would have been determined for the last month of such earlier entitlement if computed without regard for paragraph (d–1) of this section.

[45 FR 1611, Jan. 8, 1980, as amended at 46 FR 25601, May 8, 1981; 48 FR 46148, Oct. 11, 1983; 51 FR 12606, Apr. 14, 1986; 58 FR 64892, Dec. 10, 1993; 62 FR 38450, July 18, 1997; 64 FR 17101, Apr. 8, 1999; 64 FR 57775, Oct. 27, 1999; 65 FR 16813, Mar. 30, 2000]

§ 404.404 How reduction for maximum affects insured individual and other persons entitled on his earnings record.

If a reduction of monthly benefits is required under the provisions of § 404.403, the monthly benefit amount of each of the persons entitled to a monthly benefits on the same earnings record (with the exception of the individual entitled to old-age or disability insurance benefits) is proportionately reduced so that the total benefits that can be paid in 1 month (including an amount equal to the primary insurance amount of the old-age or disability insurance beneficiary, when applicable) does not exceed the maximum family benefit (except as provided in § 404.405 where various savings clause provisions are described).

§ 404.405 Situations where total benefits can exceed maximum because of "savings clause."

The following provisions are *savings clauses* and describe exceptions to the rules concerning the maximum amount payable on an individual's earnings record in a month as described in § 404.403. The effect of a *savings clause* is to avoid lowering benefit amounts or to guarantee minimum increases to certain persons entitled on the earnings record of the insured individual when a statutory change has been made that would otherwise disadvantage them. The reduction described in § 404.403 does not apply in the following instances:

(a)–(m) [Reserved]

(n) *Months after August 1972.* The reduction described in § 404.403(a) shall not apply to benefits for months after August 1972 where two or more persons were entitled to benefits for August 1972 based upon the filing of an application in August 1972 or earlier and the total of such benefits was subject to reduction for the maximum under § 404.403 (or would have been subject to such reduction except for this paragraph) for January 1971. In such a case, maximum family benefits on the insured individual's earnings record for any month after August 1972 may not be less than the larger of:

(1) The maximum family benefits for such month determined under the applicable table in section 215(a) of the Act (the *applicable* table in section 215(a) is that table which is effective for the month the benefit is payable or in the case of a lump-sum payment, the month the individual died); or

(2) The total obtained by multiplying each benefit for August 1972 after reduction for the maximum but before deduction or reduction for age, by 120 percent and raising each such increased amount, if it is not a multiple of 10 cents, to the next higher multiple of 10 cents.

(o) *Months after December 1972.* The reduction described in § 404.403 shall not apply to benefits for months after December 1972 in the following cases:

(1) In the case of a redetermination of widow's or widower's benefits, the reduction described in § 404.403 shall not apply if:

(i) Two or more persons were entitled to benefits for December 1972 on the earnings records of a deceased individual and at least one such person is entitled to benefits as the deceased individual's widow or widower for December 1972 and for January 1973; and

(ii) The total of benefits to which all persons are entitled for January 1973 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each person referred to in paragraph (o)(1)(i) of this section for months after December 1972 shall be no less than the amount it would have been if the widow's or widower's benefit had not been redetermined under the Social Security Amendments of 1972.

(2) In the case of entitlement to child's benefits based upon disability which began between ages 18 and 22 the reduction described in § 404.403 shall not apply if:

(i) One or more persons were entitled to benefits on the insured individual's earnings record for December 1972 based upon an application filed in that month or earlier; and

(ii) One or more persons not included in paragraph (o)(2)(i) of this section are entitled to child's benefits on that earnings record for January 1973 based upon disability which began in the period from ages 18 to 22; and

(iii) The total benefits to which all persons are entitled on that record for January 1973 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each person referred to in paragraph (o)(2)(i) of this section for months after December 1972 shall be no less than the amount it would have been if the person entitled to child's benefits based upon disability in the period from ages 18 to 22 were not so entitled.

(3) In the case of entitlement of certain surviving divorced mothers, the reduction described in § 404.403 shall not apply if:

(i) One or more persons were entitled to benefits on the insured individual's earnings record for December 1972 based upon an application filed in December 1972 or earlier; and

(ii) One or more persons not included in paragraph (o)(3)(i) of this section are entitled to benefits on that earnings record as a surviving divorced mother for a month after December 1972; and

(iii) The total of benefits to which all persons are entitled on that record for any month after December 1972 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each such person referred to in paragraph (o)(3)(i) of this section for months after December 1972 in which any person referred to in paragraph (o)(3)(ii) of this section is entitled shall be no less than it would have been if the person(s) referred to in paragraph (o)(3)(ii) of this section had not become entitled to benefits.

(p) *Months after December 1973.* The reduction described in § 404.403 shall not apply to benefits for months after December 1973 where two or more persons were entitled to monthly benefits for January 1971 or earlier based upon applications filed in January 1971 or earlier, and the total of such benefits was subject to reduction for the maximum under § 404.403 for January 1971 or earlier. In such a case, maximum family benefits payable on the insured individual's earnings record for any month after January 1971 may not be less than the larger of:

(1) The maximum family benefit for such month shown in the applicable table in section 215(a) of the Act (the *applicable* table in section 215(a) of the Act is that table which is effective for the month the benefit is payable or in the case of a lump-sum payment, the month the individual died); or

(2) The largest amount which has been determined payable for any month for persons entitled to benefits on the insured individual's earnings records; or

(3) In the case of persons entitled to benefits on the insured individual's earnings record for the month immediately preceding the month of a general benefit or cost-of-living increase after September 1972, an amount equal to the sum of the benefit amount for each person (excluding any part of an old-age insurance benefit increased because of delayed retirement under the provisions of § 404.305(a) for the month

immediately before the month of increase in the primary insurance amount (after reduction for the family maximum but before deductions or reductions for age) multiplied by the percentage of increase. Any such increased amount, if it is not a multiple of $0.10, will be raised to the next higher multiple of $0.10 for months before June 1982 and reduced to the next lower multiple of $0.10 for months after May 1982.

(q) *Months after May 1978.* The *family maximum* for months after May 1978 is figured for all beneficiaries just as it would have been if none of them had gotten a benefit increase because of the retirement credit if:

(1) One or more persons were entitled (without the reduction required by § 404.406) to monthly benefits for May 1978 on the wages and self-employment income of a deceased wage earner;

(2) The benefit for June 1978 of at least one of those persons is increased by reason of a delayed retirement credit (see § 404.330(b)(4) or § 404.333(b)(4)); and

(3) The total amount of monthly benefits to which all those persons are entitled is reduced because of the maximum or would be so reduced except for certain restrictions (see § 404.403 and § 404.402(a)).

[32 FR 19159, Dec. 20, 1967, as amended at 40 FR 30814, July 23, 1975; 43 FR 8132, Feb. 28, 1978; 43 FR 29277, July 7, 1978; 48 FR 46148, Oct. 11, 1983]

§ 404.406 Reduction for maximum because of retroactive effect of application for monthly benefits.

Under the provisions described in § 404.403, beginning with the month in which a person files an application and becomes entitled to benefits on an insured individual's earnings record, the benefit rate of other persons entitled on the same earnings record (aside from the individual on whose earnings record entitlement is based) are adjusted downward, if necessary, so that the maximum benefits payable on one earnings record will not be exceeded. An application may also be effective (retroactively) for benefits for months before the month of filing (see § 404.603). For any month before the month of filing, however, benefits that have been previously certified by the Administration for payment to other persons (on the same earnings record) are not changed. Rather, the benefit payment of the person filing the application in the later month is reduced for each month of the retroactive period to the extent that may be necessary, so that no earlier payment to some other person is made erroneous. This means that for each month of the retroactive period the amount payable to the person filing the later application is the difference, if any, between (a) the total amount of benefits actually certified for payment to other persons for that month, and (b) the maximum amount of benefits payable for that month to all persons, including the person filing later.

[32 FR 19159, Dec. 20, 1967, as amended at 64 FR 14608, Mar. 26, 1999]

§ 404.407 Reduction because of entitlement to other benefits.

(a) *Entitlement to old-age or disability insurance benefit and other monthly benefit.* If an individual is entitled to an old-age insurance benefit or disability insurance benefit for any month after August 1958 and to any other monthly benefit payable under the provisions of title II of the Act (see subpart D of this part) for the same month, such other benefit for the month, after any reduction under section 202(q) of the Act because of entitlement to such benefit for months before retirement age and any reduction under section 203(a) of the Act, is reduced (but not below zero) by an amount equal to such old-age insurance benefit (after reduction under section 202(q) of the Act) or such disability insurance benefit, as the case may be.

(b) *Entitlement to widow's or widower's benefit and other monthly benefit.* If an individual is entitled for any month after August 1965 to a widow's or widower's insurance benefit under the provisions of section 202 (e)(4) or (f)(5) of the Act and to any other monthly benefit payable under the provisions of title II of the Act (see subpart D) for the same month, except an old-age insurance benefit, such other insurance

benefit for that month, after any reduction under paragraph (a) of this section, any reduction for age under section 202(q) of the Act, and any reduction under the provisions described in section 203(a) of the Act, shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under paragraph (a) of this section or section 203(a) of the Act.

(c) *Entitlement to old-age insurance benefit and disability insurance benefit.* Any individual who is entitled for any month after August 1965 to both an old-age insurance benefit and a disability insurance benefit shall be entitled to only the larger of such benefits for such month, except that where the individual so elects, he or she shall instead be entitled to only the smaller of such benefits for such month. Only a person defined in § 404.612 (a), (c), or (d) may make the above described election.

(d) *Child's insurance benefits.* A child may, for any month, be simultaneously entitled to a child's insurance benefit on more than one individual's earnings if all the conditions for entitlement described in § 404.350 are met with respect to each claim. Where a child is simultaneously entitled to child's insurance benefits on more than one earnings record, the general rule is that the child will be paid an amount which is based on the record having the highest primary insurance amount. However, the child will be paid a higher amount which is based on the earnings record having a lower primary insurance amount if no other beneficiary entitled on any record would receive a lower benefit because the child is paid on the record with the lower primary insurance amount. (See § 404.353(b).)

(e) *Entitlement to more than one benefit where not all benefits are child's insurance benefits and no benefit is an old-age or disability insurance benefit.* If an individual (other than an individual to whom section 202 (e)(4) or (f)(5) of the Act applies) is entitled for any month to more than one monthly benefit payable under the provisions of this subpart, none of which is an old-age or disability insurance benefit and all of which are not child's insurance benefits, only the greater of the monthly benefits to which he would (but for the provisions of this paragraph) otherwise be entitled is payable for such month. For months after August 1965, an individual who is entitled for any month to more than one widow's or widower's insurance benefit to which section 202 (e)(4) or (f)(5) of the Act applies is entitled to only one such benefit for such month, such benefit to be the largest of such benefits.

[32 FR 19159, Dec. 20, 1967, as amended at 51 FR 12606, Apr. 14, 1986; 54 FR 5603, Feb. 6, 1989]

§ 404.408 Reduction of benefits based on disability on account of receipt of certain other disability benefits provided under Federal, State, or local laws or plans.

(a) *When reduction required.* Under section 224 of the Act, a disability insurance benefit to which an individual is entitled under section 223 of the Act for a month (and any monthly benefit for the same month payable to others under section 202 on the basis of the same earnings record) is reduced (except as provided in paragraph (b) of this section) by an amount determined under paragraph (c) of this section if:

(1) The individual first became entitled to disability insurance benefits after 1965 but before September 1981 based on a period of disability that began after June 1, 1965, and before March 1981, and

(i) The individual entitled to the disability insurance benefit is also entitled to periodic benefits under a workers' compensation law or plan of the United States or a State for that month for a total or partial disability (whether or not permanent), and

(ii) The Commissioner has, in a month before that month, received a notice of the entitlement, and

(iii) The individual has not attained age 62, or

(2) The individual first became entitled to disability insurance benefits after August 1981 based on a disability that began after February 1981, and

(i) The individual entitled to the disability insurance benefit is also, for that month, concurrently entitled to a periodic benefit (including workers' compensation or any other payments

based on a work relationship) on account of a total or partial disability (whether or not permanent) under a law or plan of the United States, a State, a political subdivision, or an instrumentality of two or more of these entities, and

(ii) The individual has not attained full retirement age as defined in § 404.409.

(b) *When reduction not made.* (1) The reduction of a benefit otherwise required by paragraph (a)(1) of this section is not made if the workers' compensation law or plan under which the periodic benefit is payable provides for the reduction of such periodic benefit when anyone is entitled to a benefit under title II of the Act on the basis of the earnings record of an individual entitled to a disability insurance benefit under section 223 of the Act.

(2) The reduction of a benefit otherwise required by paragraph (a)(2) of this section is not to be made if:

(i) The law or plan under which the periodic public disability benefit is payable provides for the reduction of that benefit when anyone is entitled to a benefit under title II of the Act on the basis of the earnings record of an individual entitled to a disability insurance benefit under section 223 of the Act and that law or plan so provided on February 18, 1981. (The reduction required by paragraph (a)(2) of this section will not be affected by public disability reduction provisions not actually in effect on this date or by changes made after February 18, 1981, to provisions that were in effect on this date providing for the reduction of benefits previously not subject to a reduction); or

(ii) The benefit is a Veterans Administration benefit, a public disability benefit (except workers' compensation) payable to a public employee based on employment covered under Social Security, a public benefit based on need, or a wholly private pension or private insurance benefit.

(c) *Amount of reduction*—(1) *General.* The total of benefits payable for a month under sections 223 and 202 of the Act to which paragraph (a) of this section applies is reduced monthly (but not below zero) by the amount by which the sum of the monthly disability insurance benefits payable on the disabled individual's earnings record and the other public disability benefits payable for that month exceeds the higher of:

(i) Eighty percent of his *average current earnings,* as defined in paragraph (c)(3) of this section, or

(ii) The total of such individual's disability insurance benefit for such month and all other benefits payable for such month based on such individual's earnings record, prior to reduction under this section.

(2) *Limitation on reduction.* In no case may the total of monthly benefits payable for a month to the disabled worker and to the persons entitled to benefits for such month on his earnings record be less than:

(i) The total of the benefits payable (after reduction under paragraph (a) of this section) to such beneficiaries for the first month for which reduction under this section is made, and

(ii) Any increase in such benefits which is made effective for months after the first month for which reduction under this section is made.

(3) *Average current earnings defined.* (i) Beginning January 1, 1979, for purposes of this section, an individual's *average current earnings* is the largest of either paragraph (c)(3)(i) (*a*), (*b*) or (*c*) of this section (after reducing the amount to the next lower multiple of $1 when the amount is not a multiple of $1):

(A) The average monthly wage (determined under section 215(b) of the Act as in effect prior to January 1979) used for purposes of computing the individual's disability insurance benefit under section 223 of the Act;

(B) One-sixtieth of the total of the individual's wages and earnings from self-employment, without the limitations under sections 209(a) and 211(b)(1) of the Act (see paragraph (c)(3)(ii) of this section), for the 5 consecutive calendar years after 1950 for which the wages and earnings from self-employment were highest; or

(C) One-twelfth of the total of the individual's wages and earnings from self-employment, without the limitations under sections 209(a) and 211(b)(1) of the Act (see paragraph (c)(3)(ii) of this section), for the calendar year in which the individual had the highest

wages and earnings from self-employment during the period consisting of the calendar year in which the individual became disabled and the 5 years immediately preceding that year. Any amount so computed which is not a multiple of $1 is reduced to the next lower multiple of $1.

(ii) *Method of determining calendar year earnings in excess of the limitations under sections 209(a) and 211(b)(1) of the Act.* For the purposes of paragraph (c)(3)(i) of this section, the extent by which the wages or earnings from self-employment of an individual exceed the maximum amount of earnings creditable under sections 209(a) and 211(b)(1) of the Act in any calendar year after 1950 and before 1978 will ordinarily be estimated on the basis of the earnings information available in the records of Administration. (See subpart I of this part.) If an individual provides satisfactory evidence of his actual earnings in any year, the extent, if any, by which his earnings exceed the limitations under sections 209(a) and 211(b)(1) of the Act shall be determined by the use of such evidence instead of by the use of estimates.

(4) *Reentitlement to disability insurance benefits.* If an individual's entitlement to disability insurance benefits terminates and such individual again becomes entitled to disability insurance benefits, the amount of the reduction is again computed based on the figures specified in this paragraph (c) applicable to the subsequent entitlement.

(5) *Computing disability insurance benefits.* When reduction is required, the total monthly Social Security disability insurance benefits payable after reduction can be more easily computed by subtracting the monthly amount of the other public disability benefit from the higher of paragraph (c)(1) (i) or (ii). This is the method employed in the examples used in this section.

(d) *Items not counted for reduction.* Amounts paid or incurred, or to be incurred, by the individual for medical, legal, or related expenses in connection with the claim for public disability payments (see § 404.408 (a) and (b)) or the injury or occupational disease on which the public disability award or settlement agreement is based, are excluded in computing the reduction under paragraph (a) of this section to the extent they are consonant with the applicable Federal, State, or local law or plan and reflect either the actual amount of expenses already incurred or a reasonable estimate, given the circumstances in the individual's case, of future expenses. Any expenses not established by evidence required by the Administration or not reflecting a reasonable estimate of the individual's actual future expenses will not be excluded. These medical, legal, or related expenses may be evidenced by the public disability award, compromise agreement, a court order, or by other evidence as the Administration may require. This other evidence may consist of:

(1) A detailed statement by the individual's attorney, physician, or the employer's insurance carrier; or

(2) Bills, receipts, or canceled checks; or

(3) Other clear and convincing evidence indicating the amount of expenses; or

(4) Any combination of the foregoing evidence from which the amount of expenses may be determinable.

(e) *Certification by individual concerning eligibility for public disability benefits.* Where it appears that an individual may be eligible for a public disability benefit which would give rise to a reduction under paragraph (a) of this section, the individual may be required, as a condition of certification for payment of any benefit under section 223 of the Act to any individual for any month, and of any benefit under section 202 of the Act for any month based on such individual's earnings record, to furnish evidence as requested by the Administration and to certify as to:

(1) Whether he or she has filed or intends to file any claim for a public disability benefit, and

(2) If he or she has so filed, whether there has been a decision on the claim. The Commissioner may rely, in the absence of evidence to the contrary, upon a certification that he or she has not filed and does not intend to file such a claim, or that he or she has filed and no decision has been made, in certifying any benefit for payment pursuant to section 205(i) of the Act.

(f) *Verification of eligibility or entitlement to a public disability benefit under paragraph (a).* Section 224 of the Act requires the head of any Federal agency to furnish the Commissioner information from the Federal agency's records which is needed to determine the reduction amount, if any, or verify other information to carry out the provisions of this section. The Commissioner is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plan of public disability benefits in order to obtain information that may be required to carry out the provisions of this section.

(g) *Public disability benefit payable on other than a monthly basis.* Where public disability benefits are paid periodically but not monthly, or in a lump sum as a commutation of or a substitute for periodic benefits, such as a compromise and release settlement, the reduction under this section is made at the time or times and in the amounts that the Administration determines will approximate as nearly as practicable the reduction required under paragraph (a) of this section.

(h) *Priorities.* (1) For an explanation of when a reduction is made under this section where other reductions, deductions, etc., are involved, see § 404.402.

(2) Whenever a reduction in the total of benefits for any month based on an individual's earnings record is made under paragraph (a) of this section, each benefit, except the disability insurance benefit, is first proportionately decreased. Any excess reduction over the sum of all the benefits, other than the disability insurance benefit, is then applied to the disability insurance benefit.

Example 1: Effective September 1981, Harold is entitled to a monthly disability primary insurance amount of $507.90 and a monthly public disability benefit of $410.00 from the State. Eighty percent of Harold's average current earnings is $800.00. Because this amount ($800.00) is higher than Harold's disability insurance benefit ($507.90), we subtract Harold's monthly public disability benefit ($410.00) from eighty percent of his average current earnings ($800.00). This leaves Harold a reduced monthly disability benefit of $390.00.

Example 2: In September 1981, Tom is entitled to a monthly disability primary insurance amount of $559.30. His wife and two children are also entitled to monthly benefits of $93.20 each. The total family benefit is $838.90. Tom is also receiving a monthly workers' compensation benefit of $500.00 from the State. Eighty percent of Tom's average current earnings is $820.10. Because the total family benefit ($838.90) is higher than 80 percent of the average current earnings ($820.10), we subtract the monthly workers' compensation benefit ($500.00) from the total family benefit ($838.90), leaving $338.90 payable. This means the monthly benefits to Tom's wife and children are reduced to zero, and Tom's monthly disability benefit is reduced to $338.90.

(i) *Effect of changes in family composition.* The addition or subtraction in the number of beneficiaries in a family may cause the family benefit to become, or cease to be, the applicable limit for reduction purposes under this section. When the family composition changes, the amount of the reduction is recalculated as though the new number of beneficiaries were entitled for the first month the reduction was imposed. If the applicable limit both before and after the change is 80 percent of the average current earnings and the limitation on maximum family benefits is in effect both before and after the change, the amount payable remains the same and is simply redistributed among the beneficiaries entitled on the same earnings record.

Example 1: Frank is receiving $500.00 a month under the provisions of a State workers' compensation law. He had a prior period of disability which terminated in June 1978. In September 1981, Frank applies for a second period of disability and is awarded monthly disability insurance benefits with a primary insurance amount of $370.20. His child, Doug, qualifies for benefits of $135.10 a month on Frank's earnings record. The total family benefits is $505.30 monthly.

Frank's average monthly wage (as used to compute the primary insurance amount) is $400.00; eighty percent of his average current earnings (computed by using the 5 consecutive years in which his earnings were highest) is $428.80 (80% of $536.00); eighty percent of Frank's average current earnings (computed by using the 1 calendar year in which his earnings were highest) is $509.60 (80% of $637.00). The highest value for 80 percent of average current earnings is therefore $509.60 (80%). Since this is higher than the total family benefit ($505.30), the $509.60 is the applicable limit in determining the amount of the reduction (or offset). The amount payable after the reduction is—

80% of Frank's average current earnings ...	$509.60
Frank's monthly workers' compensation benefit	−500.00
Monthly benefit payable to Frank	9.60

No monthly benefits are payable to Doug because the reduction is applied to Doug's benefit first. In December 1981, another child, Mike, becomes entitled on Frank's earnings record. The monthly benefit to each child before reduction is now $109.10, the amount payable when there are two beneficiaries in addition to the wage earner. Thus, the total family benefit becomes $588.40. Because this is now higher than $509.60 (80% of Frank's average current earnings), $588.40 becomes the applicable limit in determining the amount of reduction. The amount payable after the increase in the total family benefit is—

The new total family benefit	$588.40
Frank's monthly workers' compensation rate	−500.00
Monthly benefit payable to Frank	88.40

No monthly benefits are payable to either child because the reduction (or offset) is applied to the family benefits first.

Example 2: Jack became entitled to disability insurance benefits in December 1973 (12/73), with a primary insurance amount (PIA) of $220.40. He was also receiving a workers' compensation benefit. An offset was imposed against the disability insurance benefit. By June 1977 (6/77), Jack's PIA had increased to $298.00 because of several statutory benefit increases. In December 1977 (12/77), his wife, Helen, attained age 65 and filed for unreduced wife's benefits. (She was not entitled to a benefit on her own earnings record.) This benefit was terminated in May 1978 (5/78), at her death. Helen's benefit was computed back to 12/73 as though she were entitled in the first month that offset was imposed against Jack. Since there were no other beneficiaries entitled and Helen's entire monthly benefit amount is subject to offset, the benefit payable to her for 12/77 through April 1978 (4/78), would be $38.80. This gives Helen the protected statutory benefit increases since 12/73. The table below shows how Helen's benefit was computed beginning with the first month offset was imposed.

Month of entitlement/ statutory increase	Jack's PIA	Helen's benefit prior to offset	Helen's statutory increase
December 1973	$220.40	$110.20	.....
March 1974	236.00	118.00	$7.80
June 1974	244.80	122.40	+ 4.40
June 1975	264.40	132.20	+ 9.80
June 1976	281.40	140.70	+ 8.50
June 1977	298.00	149.00	+ 8.30
December 1977 through April 1978[1]	.....	.....	38.80

[1] Monthly benefit payable to Helen.

(j) *Effect of social security disability insurance benefit increases.* Any increase in benefits due to a recomputation or a statutory increase in benefit rates is not subject to the reduction for public disability benefits under paragraph (a) and does not change the amount to be deducted from the family benefit. The increase is simply added to what amount, if any, is payable. If a new beneficiary becomes entitled to monthly benefits on the same earnings record after the increase, the amount of the reduction is redistributed among the new beneficiaries entitled under section 202 of the Act and deducted from their current benefit rate.

Example: In March 1981, Chuck became entitled to disability insurance benefits with a primary insurance amount of $362.40 a month. He has a wife and two children who are each entitled to a monthly benefit of $60.40. Chuck is receiving monthly disability compensation from a worker's compensation plan of $410.00. Eighty percent of his average current earnings is $800.00. Because this is higher than the total family benefit ($543.60), $800.00 is the applicable limit in computing the amount of reduction. The amount of monthly benefits payable after the reduction is—

Applicable limit	$800.00
Chuck's monthly disability compensation	−410.00
Total amount payable to Chuck and the family after reduction	$390.00
Amount payable to Chuck	−362.40
Total amount payable to the family	$27.60
$9.20 payable to each family member equals	$27.60
.....	3

In June 1981, the disability benefit rates were raised to reflect an increase in the cost-of-living. Chuck is now entitled to $403.00 a month and each family member is entitled to $67.20 a month (an increase of $6.80 to each family member). The monthly amounts payable after the cost-of-living increase are now $403.00 to Chuck and $16.00 to each family member ($9.20 plus the $6.80 increase).

In September 1981, another child becomes entitled to benefits based on Chuck's earnings record. The monthly amount payable to the family (excluding Chuck) must now be divided by 4:

$6.90 payable to each family member equals	$27.60
	4

The June 1981 cost-of-living increase is added to determine the amount payable. Chuck continues to receive $403.00 monthly. Each family member receives a cost-of-living increase of $5.10. Thus, the amount payable to each is $12.00 in September 1981 ($6.90 plus the $5.10 increase). (See Example 2 under (i).)

(k) *Effect of changes in the amount of the public disability benefit.* Any change in the amount of the public disability benefit received will result in a recalculation of the reduction under paragraph (a) and, potentially, an adjustment in the amount of such reduction. If the reduction is made under paragraph (a)(1) of this section, any increased reduction will be imposed effective with the month after the month the Commissioner received notice of the increase in the public disability benefit (it should be noted that only workers' compensation can cause this reduction). Adjustments due to a decrease in the amount of the public disability benefit will be effective with the actual date the decreased amount was effective. If the reduction is made under paragraph (a)(2) of this section, any increase or decrease in the reduction will be imposed effective with the actual date of entitlement to the new amount of the public disability benefit.

Example: In September 1981, based on a disability which began March 12, 1981, Theresa became entitled to Social Security disability insurance benefits with a primary insurance amount of $445.70 a month. She had previously been entitled to Social Security disability insurance benefits from March 1967 through July 1969. She is receiving a temporary total workers' compensation payment of $227.50 a month. Eighty percent of her average current earnings is $610.50. The amount of monthly disability insurance benefit payable after reduction is—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment	−227.50
Total amount payable to Theresa after reduction	383.00

On November 15, 1981, the Commissioner was notified that Theresa's workers' compensation rate was increased to $303.30 a month effective October 1, 1981. This increase reflected a cost-of-living adjustment granted to all workers' compensation recipients in her State. The reduction to her monthly disability insurance benefit is recomputed to take this increase into account—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment beginning October 1, 1981	−303.30
Total new amount payable to Theresa beginning October 1981 after recalculation of the reduction	$307.20

Effective January, 1, 1982, Theresa's workers' compensation payment is decreased to $280.10 a month when she begins to receive a permanent partial payment. The reduction to her monthly disability insurance benefit is again recalculated to reflect her decreased workers' compensation amount—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment beginning January 1, 1982	−280.10
Total new amount payable to Theresa beginning January 1982 after recalculation of the reduction	$330.40

If, in the above example, Theresa had become entitled to disability insurance benefits in August 1981, the increased reduction to her benefit, due to the October 1, 1981 increase in her workers' compensation payment, would have been imposed beginning with December 1981, the month after the month she notified the Social Security Administration of the increase. The later decrease in her workers' compensation payment would still affect her disability insurance benefit beginning with January 1982.

(l) *Redetermination of benefits*—(1) *General.* In the second calendar year after the year in which reduction under this section in the total of an individual's benefits under section 223 of the Act and any benefits under section 202 of the Act based on his or her wages and self-employment income is first required (in a continuous period of months), and in each third year thereafter, the amount of those benefits which are still subject to reduction under this section are redetermined, provided this redetermination does not result in any decrease in the total amount of benefits payable under title II of the Act on the basis of the workers' wages and self-employment income. The redetermined benefit is effective with the January following the year in which the redetermination is made.

(2) *Average current earnings.* In making the redetermination required by paragraph (l)(1) of this section, the individual's average current earnings (as

defined in paragraph (c)(3) of this section) is deemed to be the product of his average current earnings as initially determined under paragraph (c)(3) of this section and:

(i) The ratio of the average of the total wages (as defined in § 404.1049) of all persons for whom wages were reported to the Secretary of the Treasury or his delegate for the calendar year before the year in which the redetermination is made, to the average of the total wages of all person reported to the Secretary of the Treasury or his delegate for calendar year 1977 or, if later, the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability); and

(ii) In any case in which the reduction was first computed before 1978, the ratio of the average of the taxable wages reported to the Commissioner of Social Security for the first calendar quarter of 1977 to the average of the taxable wages reported to the Commissioner of Social Security for the first calendar quarter of the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability). Any amount determined under the preceding two sentences which is not a multiple of $1 is reduced to the next lower multiple of $1.

(3) *Effect of redetermination.* Where the applicable limit on total benefits previously used was 80 percent of the average current earnings, a redetermination under this paragraph may cause an increase in the amount of benefits payable. Also, where the limit previously used was the total family benefit, the redetermination may cause the average current earnings to exceed the total family benefit and thus become the new applicable limit. If for some other reason (such as a statutory increase or recomputation) the benefit has already been increased to a level which equals or exceeds the benefit resulting from a redetermination under this paragraph, no additional increase is made. A redetermination is designed to bring benefits into line with current wage levels when no other change in payments has done so.

Example: In October 1978, Alice became entitled to disability insurance benefits with a primary insurance amount of $505.10. Her two children were also entitled to monthly benefits of $189.40 each. Alice was also entitled to monthly disability compensation benefits of $667.30 from the State. Eighty percent of Alice's average current earnings is $1340.80, and that amount is the applicable limit. The amount of monthly benefits payable after the reduction is—

Applicable limit	$1,340.80
Alice's State disability compensation benefit	−667.30
Total benefits payable to Alice and both children after reduction	$673.50
Alice's disability insurance benefit	−505.10
Payable to the children	$168.40
$84.20 payable to each child after reduction equals	$168.40

2

In June 1979 and June 1980, cost-of-living increases in Social Security benefits raise Alice's benefit by $50.10 (to $555.20) and $79.40 (to $634.60) respectively. The children's benefits (before reduction) are each raised by $18.80 (to $208.20) and $29.80 (to $238.00). These increases in Social Security benefits are not subject to the reduction (*i.e.*, offset).

In 1980, Alice's average current earnings are redetermined as required by law. The offset is recalculated, and if the amount payable to the family is higher than the current amount payable to the family, that higher amount becomes payable the following January (*i.e.*, January 1981). The current amount payable to the family after the reduction is recalculated—

Alice's 1978 benefit after reduction	$505.10
Alice's cost-of-living increase in June 1979	+ 50.10
Alice's cost-of-living increase in June 1980	+ 79.40
One child's 1978 benefit after reduction	+ 84.20
That child's cost-of-living increase in June 1979	+ 18.70
That child's cost-of-living increase in June 1980	+ 29.70
The other child's 1978 benefit after reduction	+ 84.20
The other child's cost-of-living increase in June 1979	+ 18.70
The other child's cost-of-living increase in June 1980	+ 29.70
Total amount payable to the family after reduction in January 1981	899.80

The amount payable to the family after reduction is then recalculated using the redetermined average current earnings—

Average current earnings before redetermination	$1,676.00
Redetermination ratio effective for January 1981	× 1.174
Redetermined average current earnings	$1,967.00
	× 80%
80% of the redetermined average current earnings	$1,573.60

Alice's State disability compensation benefit	−667.30
Total benefits payable to the family after offset	$906.30

We then compare the total amount currently being paid to the family ($899.80) to the total amount payable after the redetermination ($906.30). In this example, the redetermination yields a higher amount and, therefore, becomes payable the following January (*i.e.*, January 1981). Additional computations are required to determine the amount that will be paid to each family member—

Total benefits payable to the family using the redetermined average current earnings	$906.30
Total cost-of-living increases to both children	−96.80
Balance payable	809.50
Alice's current benefit amount before reduction	−634.60
Payable to the children	174.90
Total cost-of-living increases to both children	+ 96.80
Total payable to children after reduction	271.70
$135.90 (rounded from $135.85) payable to each child equals	$271.70

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[32 FR 19159, Dec. 20, 1967; 33 FR 3060, Feb. 16, 1968, as amended at 37 FR 3425, Feb. 16, 1972; 48 FR 37017, Aug. 16, 1983; 48 FR 38814, Aug. 26, 1983; 62 FR 38450, July 18, 1997; 81 FR 19033, Apr. 4, 2016]

§ 404.408a Reduction where spouse is receiving a Government pension.

(a) *General*—(1) *Terms used in this section.* (i) *Government pension* means any monthly periodic benefit (or equivalent) you receive that is based on your Federal, State, or local government employment.

(ii) *Noncovered employment* means Federal, State, or local government employment that Social Security did not cover and for which you did not pay Social Security taxes. For the purposes of this section, we consider your Federal, State, or local government employment to be noncovered employment if you pay only Medicare taxes.

(iii) *Spouse's benefits* are Social Security benefits you receive as a wife, husband, widow(er), mother, father, divorced spouse, or surviving divorced spouse.

(2) *When reduction is required.* We will reduce your spouse's benefit for each month that you receive a government pension based on noncovered employment, unless one of the exceptions in paragraph (b) of this section applies. When we consider whether you receive a government pension based on noncovered employment, we consider the entire month to be a month covered by Social Security if you worked for a Federal, State, or local government employer in a position covered by Social Security for at least 1 day in that month and there was no noncovered employment that month under the same pension plan.

(b) *Exceptions.* The reduction does not apply:

(1) If you are receiving a Government pension based on employment for an interstate instrumentality.

(2) If you received or are eligible to receive a Government pension for one or more months in the period December 1977 through November 1982 and you meet the requirements for Social Security benefits that were applied in January 1977, even though you don't claim benefits, and you don't actually meet the requirements for receiving benefits until a later month. The January 1977 requirements are, for a man, a one-half support test (see paragraph (c) of this section), and, for a woman claiming benefits as a divorced spouse, marriage for at least 20 years to the insured worker. You are considered eligible for a Government pension for any month in which you meet all the requirements for payment except that you are working or have not applied.

(3) If you were receiving or were eligible (as defined in paragraph (b)(2) of this section) to receive a Government pension for one or more months before July 1983, and you meet the dependency test of one-half support that was applied to claimants for husband's and widower's benefits in 1977, even though you don't claim benefits, and you don't actually meet the requirements for receiving benefits until a later month. If you meet the exception in this paragraph but you do not meet the exception in paragraph (b)(2), December 1982 is the earliest month for which the reduction will not affect your benefits.

(4) If you would have been eligible for a pension in a given month except for a requirement which delayed eligibility

for such pension until the month following the month in which all other requirements were met, we will consider you to be eligible in that given month for the purpose of meeting one of the exceptions in paragraphs (b) (2) and (3) of this section. If you meet an exception solely because of this provision, your benefits will be unreduced for months after November 1984 only.

(5) If, with respect to monthly benefits payable for months after December 1994, you are receiving a Government pension based wholly upon service as a member of a uniformed service, regardless of whether on active or inactive duty and whether covered by social security. However, if the earnings on the last day of employment as a military reservist were not covered, January 1995 is the earliest month for which the reduction will not affect your benefits.

(6) If you are receiving a government pension and the last 60 months of your government employment were covered by both Social Security and the pension plan that provides your government pension.

(i) If the last day of your government employment was after June 30, 2004 and on or before March 2, 2009, we will apply a transitional rule to reduce the last 60-month requirement under the following conditions:

(A) You worked 60 months in Federal, State, or local government employment covered by Social Security before March 2, 2004, and you worked at least 1 month of covered government employment after March 2, 2004, or

(B) You worked fewer than 60 months in government employment covered by Social Security on or before March 2, 2004 and you worked the remaining number of months needed to total 60 months after March 2, 2004. The months that you worked before or after March 2, 2004 do not have to be consecutive.

(ii) We will always reduce your monthly spouse's benefit if you receive a government pension based on noncovered employment and you later go back to work for a Federal, State, or local government, unless:

(A) Your final 60 months of Federal, State, or local government employment were covered by Social Security; and

(B) Both your earlier and later Federal, State, or local government employment were under the same pension plan.

(7) If you are a former Federal employee and you receive a government pension based on work that included at least 60 months in employment covered by Social Security in the period beginning January 1, 1988 and ending with the first month you became entitled to spouse's benefits, whether or not the 60 months are consecutive), and:

(i) You worked in the Civil Service Retirement System (CSRS), but switched after 1987 to either the Federal Employees Retirement System (FERS) or the Foreign Service Pension System; or

(ii) You worked in the legislative branch and left CSRS after 1987 or received a lump sum payment from CSRS or another retirement system after 1987.

(8) You were a State or local government employee, or a Federal employee who worked in the CSRS but switched to the FERS before 1988, your last day of service was in covered employment, and

(i) You filed for spouse's benefits before April 1, 2004 and became entitled to benefits based on that filing, or

(ii) Your last day of service was before July 1, 2004,

(c) The *one-half support test.* For a man to meet the January 1977 requirement as provided in the exception in paragraph (b)(2) and for a man or a woman to meet the exception in paragraph (b)(3) of this section, he or she must meet a one-half support test. One-half support is defined in § 404.366 of this part. One-half support must be met at one of the following times:

(1) If the insured person had a period of disability which did not end before he or she became entitled to old-age or disability insurance benefits, or died, you must have been receiving at least one-half support from the insured either—

(i) At the beginning of his or her period of disability;

(ii) At the time he or she became entitled to old-age or disability insurance benefits; or

(iii) If deceased, at the time of his or her death.

(2) If the insured did not have a period of disability at the time of his or her entitlement or death, you must have been receiving at least one-half support from the insured either—

(i) At the time he or she became entitled to old-age insurance benefits; or

(ii) If deceased, at the time of his or her death.

(d) *Amount and priority of reduction—* (1) *Post-June 1983 government pensions.* (i) If you became eligible for a government pension after June 1983, and you do not meet one of the exceptions in paragraph (b) of this section, we will reduce (to zero, if necessary) your monthly Social Security spouse's benefits by two-thirds of the amount of your government pension.

(ii) If you earned part of your pension based on employment other than Federal, State, or local government employment, we will only use the part of your pension earned in government employment to compute the GPO.

(iii) If the reduction is not a multiple of 10 cents, we will round it to the next higher multiple of 10 cents.

(2) *Pre-July 1983 government pensions.* (i) If you became eligible for a government pension before July 1983, and do not meet one of the exceptions in paragraph (b) of this section, we will reduce (to zero, if necessary) your monthly Social Security spouse's benefits as follows:

(A) By the full amount of your pension for months before December 1984; and

(B) By two-thirds the amount of your monthly pension for months after November 1984.

(ii) If the reduction is not a multiple of 10 cents, we will round it to the next higher multiple of 10 cents.

(3) *Reductions for age and simultaneous entitlement.* We will reduce your spouse's benefit, if necessary, for age and for simultaneous entitlement to other Social Security benefits before we reduce it because you are receiving a government pension. In addition, this reduction follows the order of priority stated in § 404.402(b).

(4) *Reduction not a multiple of $1.00.* If the monthly benefit payable to you after the required reduction(s) is not a multiple of $1.00, we will reduce it to the next lower multiple of $1.00 as required by § 404.304(f).

(5) *Lump sum payments.* If the government pension is not paid monthly or is paid in a lump sum, we will allocate the pension on a basis equivalent to a monthly benefit and then reduce the monthly Social Security benefit accordingly.

(i) We will generally obtain information about the number of years covered by a lump-sum payment from the pension plan.

(ii) If one of the alternatives to a lump-sum payment is a life annuity, and we can determine the amount of the monthly annuity, we will base the reduction on that monthly amount.

(iii) If the period or the equivalent monthly pension benefit is not clear, we may determine the reduction period and the equivalent monthly benefit on an individual basis.

(e) *When effective.* This reduction was put into the Social Security Act by the Social Security Amendments of 1977. It only applies to applications for benefits filed in or after December 1977 and only to benefits for December 1977 and later.

[49 FR 41245, Oct. 22, 1984; 50 FR 20902, May 21, 1985, as amended at 51 FR 23052, June 25, 1986; 60 FR 56513, Nov. 9, 1995; 80 FR 34050, June 15, 2015]

§ 404.408b Reduction of retroactive monthly social security benefits where supplemental security income (SSI) payments were received for the same period.

(a) *When reduction is required.* We will reduce your retroactive social security benefits if—

(1) You are entitled to monthly social security benefits for a month or months before the first month in which those benefits are paid; and

(2) SSI payments (including federally administered State supplementary payments) which were made to you for the same month or months would have been reduced or not made if your social security benefits had been paid when regularly due instead of retroactively.

(b) *Amount of reduction.* Your retroactive monthly social security benefits will be reduced by the amount of the

SSI payments (including federally administered State supplementary payments) that would not have been paid to you, if you had received your monthly social security benefits when they were regularly due instead of retroactively.

(c) *Benefits subject to reduction.* The reduction described in this section applies only to monthly social security benefits. Social security benefits which we pay to you for any month after you have begun receiving recurring monthly social security benefits, and for which you did not have to file a new application, are not subject to reduction. The lump-sum death payment, which is not a monthly benefit, is not subject to reduction.

(d) *Refiguring the amount of the reduction.* We will refigure the amount of the reduction if there are subsequent changes affecting your claim which relate to the reduction period described in paragraph (a) of this section. Refiguring is generally required where there is a change in your month of entitlement or the amount of your social security benefits or SSI payments (including federally administered State supplementary payments) for the reduction period.

(e) *Reimbursement of reduced retroactive monthly social security benefits.* The amount of the reduction will be—

(1) First used to reimburse the States for the amount of any federally administered State supplementary payments that would not have been made to you if the monthly social security benefits had been paid when regularly due instead of retroactively; and

(2) The remainder, if any, shall be covered into the general fund of the U.S. Treasury for the amount of SSI benefits that would not have been paid to you if the monthly social security benefits had been paid to you when regularly due instead of retroactively.

[47 FR 4988, Feb. 3, 1982]

§ 404.409 What is full retirement age?

Full retirement age is the age at which you may receive unreduced old-age, wife's, husband's, widow's, or widower's benefits. Full retirement age has been 65 but is being gradually raised to age 67 beginning with people born after January 1, 1938. See § 404.102 regarding determination of age.

(a) *What is my full retirement age for old-age benefits or wife's or husband's benefits?* You may receive unreduced old-age, wife's, or husband's benefits beginning with the month you attain the age shown.

If your birth date is:	Full retirement age is:
Before 1/2/1938	65 years.
1/2/1938—1/1/1939	65 years and 2 months.
1/2/1939—1/1/1940	65 years and 4 months.
1/2/1940—1/1/1941	65 years and 6 months.
1/2/1941—1/1/1942	65 years and 8 months.
1/2/1942—1/1/1943	65 years and 10 months.
1/2/1943—1/1/1955	66 years.
1/2/1955—1/1/1956	66 years and 2 months.
1/2/1956—1/1/1957	66 years and 4 months.
1/2/1957—1/1/1958	66 years and 6 months.
1/2/1958—1/1/1959	66 years and 8 months.
1/2/1959—1/1/1960	66 years and 10 months.
1/2/1960 and later	67 years.

(b) *What is my full retirement age for widow's or widower's benefits?* You may receive unreduced widow's or widower's benefits beginning with the month you attain the age shown.

If your birth date is:	Full retirement age is:
Before 1/2/1912	62 years.
1/2/1912—1/1/1940	65 years.
1/2/1940—1/1/1941	65 years and 2 months.
1/2/1941—1/1/1942	65 years and 4 months.
1/2/1942—1/1/1943	65 years and 6 months.
1/2/1943—1/1/1944	65 years and 8 months.
1/2/1944—1/1/1945	65 years and 10 months.
1/2/1945—1/1/1957	66 years.
1/2/1957—1/1/1958	66 years and 2 months.
1/2/1958—1/1/1959	66 years and 4 months.
1/2/1959—1/1/1960	66 years and 6 months.
1/2/1960—1/1/1961	66 years and 8 months.
1/2/1961—1/1/1962	66 years and 10 months.
1/2/1962 and later	67 years.

(c) *Can I still retire before full retirement age?* You may still elect early retirement. You may receive old-age, wife's or husband's benefits at age 62. You may receive widow's or widower's benefits at age 60. Those benefits will be reduced as explained in § 404.410.

[68 FR 4707, Jan. 30, 2003]

§ 404.410 How does SSA reduce my benefits when my entitlement begins before full retirement age?

Generally your old-age, wife's, husband's, widow's, or widower's benefits are reduced if entitlement begins before the month you attain full retirement age (as defined in § 404.409). However, your benefits as a wife or husband are not reduced for any month in which

you have in your care a child of the worker on whose earnings record you are entitled. The child must be entitled to child's benefits. Your benefits as a widow or widower are not reduced below the benefit amount you would receive as a mother or father for any month in which you have in your care a child of the worker on whose record you are entitled. The child must be entitled to child's benefits. Subject to §§ 404.411 through 404.413, reductions in benefits are made in the amounts described.

(a) *How does SSA reduce my old-age benefits?* The reduction in your primary insurance amount is based on the number of months of entitlement prior to the month you attain full retirement age. The reduction is 5/9 of 1 percent for each of the first 36 months and 5/12 of 1 percent for each month in excess of 36.

Example: Alex's full retirement age for unreduced benefits is 65 years and 8 months. She elects to begin receiving benefits at age 62. Her primary insurance amount of $980.50 must be reduced because of her entitlement to benefits 44 months prior to full retirement age. The reduction is 36 months at 5/9 of 1 percent and 8 months at 5/12 of 1 percent.

$980.50 \times 36 \times 5/9 \times .01 = \$196.10$
$980.50 \times 8 \times 5/12 \times .01 = \$\ 32.68$

The two added together equal a total reduction of $228.78. This amount is rounded to $228.80 (the next higher multiple of 10 cents) and deducted from the primary insurance amount. The resulting $751.70 is the monthly benefit payable.

(b) *How does SSA reduce my wife's or husband's benefits?* Your wife's or husband's benefits before any reduction (see §§ 404.304 and 404.333) are reduced first (if necessary) for the family maximum under § 404.403. They are then reduced based on the number of months of entitlement prior to the month you attain full retirement age. This does not include any month in which you have a child of the worker on whose earnings record you are entitled in your care. The child must be entitled to child benefits. The reduction is 25/36 of 1 percent for each of the first 36 months and 5/12 of 1 percent for each month in excess of 36.

Example: Sam is entitled to old-age benefits. His spouse Ashley elects to begin receiving wife's benefits at age 63. Her full retirement age for unreduced benefits is 65 and 4 months. Her benefit will be reduced for 28 months of entitlement prior to full retirement age. If her unreduced benefit is $412.40 the reduction will be $\$412.40 \times 28 \times 25/36 \times .01$. The resulting $80.18 is rounded to $80.20 (the next higher multiple of 10 cents) and subtracted from $412.40 to determine the monthly benefit amount of $332.20.

(c) *How does SSA reduce my widow's or widower's benefits?* Your entitlement to widow's or widower's benefits may begin at age 60 based on age or at age 50 based on disability. Refer to § 404.335 for more information on the requirements for entitlement. Both types are reduced if entitlement begins prior to attainment of full retirement age (as defined in § 404.409).

(1) *Widow's or widower's benefits based on age.* Your widow's or widower's unreduced benefit amount (the worker's primary insurance amount after any reduction for the family maximum under § 404.403), is reduced or further reduced based on the number of months of entitlement prior to the month you attain full retirement age. This does not include any month in which you have in your care a child of the worker on whose earnings record you are entitled. The child must be entitled to child's benefits. The number of months of entitlement prior to full retirement age is multiplied by .285 and then divided by the number of months in the period beginning with the month of attainment of age 60 and ending with the month immediately before the month of attainment of full retirement age.

Example: Ms. Bogle is entitled to an unreduced widow benefit of $785.70 beginning at age 64. Her full retirement age for unreduced old-age benefits is 65 years and 4 months. She will receive benefits for 16 months prior to attainment of full retirement age. The number of months in the period from age 60 through full retirement age of 65 and 4 months is 64. The reduction in her benefit is $\$785.70 \times 16 \times .285$ divided by 64 or $55.98. $55.98 is rounded to the next higher multiple of 10 cents ($56.00) and subtracted from $785.70. The result is a monthly benefit of $729.70.

(2) *Widow's or widower's benefits based on disability.* (i) For months after December 1983, your widow's or widower's benefits are not reduced for months of entitlement prior to age 60. You are deemed to be age 60 in your month of entitlement to disabled widow's or widower's benefits and your benefits are

reduced only under paragraph (c)(1) of this section.

(ii) For months from January 1973 through December 1983, benefits as a disabled widow or widower were reduced under paragraph (c)(1) of this section. The benefits were then subject to an additional reduction of 43/240 of one percent for each month of entitlement prior to age 60 based on disability.

(3) *Widow's or widower's benefits prior to 1973.* For months prior to January 1973 benefits as a widow or widower were reduced only for months of entitlement prior to age 62. The reduction was 5/9 of one percent for each month of entitlement from the month of attainment of age 60 through the month prior to the month of attainment of age 62. There was an additional reduction of 43/198 of one percent for each month of entitlement prior to age 60 based on disability.

(d) *If my benefits are reduced under this section does SSA ever change the reduction?* The reduction computed under paragraphs (a), (b) or (c) of this section may later be adjusted to eliminate reduction for certain months of entitlement prior to full retirement age as provided in § 404.412. For special provisions on reducing benefits for months prior to full retirement age involving entitlement to two or more benefits, see § 404.411.

(e) *Are my widow's or widower's benefits affected if the deceased worker was entitled to old-age benefits?* If the deceased individual was entitled to old-age benefits, see § 404.338 for special rules that may affect your reduced widow's or widower's benefits.

[68 FR 4708, Jan. 30, 2003]

§ 404.411 How are benefits reduced for age when a person is entitled to two or more benefits?

(a) *What is the general rule?* Except as specifically provided in this section, benefits of an individual entitled to more than one benefit will be reduced for months of entitlement before full retirement age (as defined in § 404.409) according to the provisions of § 404.410. Such age reductions are made before any reduction under the provisions of § 404.407.

(b) *How is my disability benefit reduced after entitlement to an old-age benefit or widow's or widower's benefit?* A person's disability benefit is reduced following entitlement to an old-age or widow's or widower's benefit (or following the month in which all conditions for entitlement to the widow's or widower's benefit are met except that the individual is entitled to an old-age benefit which equals or exceeds the primary insurance amount on which the widow's or widower's benefit is based) in accordance with the following provisions:

(1) *Individuals born January 2, 1928, or later whose disability began January 1, 1990, or later.* When an individual is entitled to a disability benefit for a month after the month in which she or he becomes entitled to an old-age benefit which is reduced for age under § 404.410, the disability benefit is reduced by the amount by which the old-age benefit would be reduced under § 404.410 if she or he attained full retirement age in the first month of the most recent period of entitlement to the disability benefit.

(2) *Individuals born January 2, 1928, or later whose disability began before January 1, 1990, and, all individuals born before January 2, 1928, regardless of when their disability began*—(i) *First entitled to disability in or after the month of attainment of age 62.* When an individual is first entitled to a disability benefit in or after the month in which she or he attains age 62 and for which she or he is first entitled to a widow's or widower's benefit (or would be so entitled except for entitlement to an equal or higher old-age benefit) before full retirement age, the disability benefit is reduced by the larger of:

(A) The amount the disability benefit would have been reduced under paragraph (b)(1) of this section; or

(B) The amount equal to the sum of the amount the widow's or widower's benefit would have been reduced under the provisions of § 404.410 if full retirement age for unreduced benefits were age 62 plus the amount by which the disability benefit would have been reduced under paragraph (b)(1) of this section if the benefit were equal to the excess of such benefit over the amount of the widow's or widower's benefit

(without consideration of this paragraph).

(ii) *First entitled to disability before age 62.* When a person is first entitled to a disability benefit for a month before the month in which she or he attains age 62 and she or he is also entitled to a widow's or widower's benefit (or would be so entitled except for entitlement to an equal or higher old-age benefit), the disability benefit is reduced as if the widow or widower attained full retirement age in the first month of her or his most recent period of entitlement to the disability benefits.

(c) *How is my old-age benefit reduced after entitlement to a widow's or widower's benefit?*—(1) *Individual born after January 1, 1928.* The old-age benefit is reduced in accordance with § 404.410(a). There is no further reduction.

(2) *Individual born before January 2, 1928.* The old-age benefit is reduced if, in the first month of entitlement, she or he is also entitled to a widow's or widower's benefit to which she or he was first entitled for a month before attainment of full retirement age or if, before attainment of full retirement age, she or he met all conditions for entitlement to widow's or widower's benefits in or before the first month for which she or he was entitled to old-age benefits except that the old-age benefit equals or exceeds the primary insurance amount on which the widow's or widower's benefit would be based. Under these circumstances, the old-age benefit is reduced by the larger of the following:

(i) The amount by which the old-age benefit would be reduced under the regular age reduction provisions of § 404.410; or

(ii) An amount equal to the sum of:

(A) The amount by which the widow's or widower's benefit would be reduced under § 404.410 for months prior to age 62; and

(B) The amount by which the old-age benefit would be reduced under § 404.410 if it were equal to the excess of the individual's primary insurance amount over the widow's or widower's benefit before any reduction for age (but after any reduction for the family maximum under § 404.403).

(d) *How is my wife's or husband's benefit reduced when I am entitled to a reduced old-age benefit in the same month?* When a person is first entitled to a wife's or husband's benefit in or after the month of attainment of age 62, that benefit is reduced if, in the first month of entitlement, she or he is also entitled to an old-age benefit (but is not entitled to a disability benefit) to which she or he was first entitled before attainment of full retirement age. Under these circumstances, the wife's or husband's benefit is reduced by the sum of:

(1) The amount by which the old-age benefit would be reduced under the provisions of § 404.410; and

(2) The amount by which the spouse benefit would be reduced under the provisions of § 404.410 if it were equal to the excess of such benefit (before any reduction for age but after reduction for the family maximum under § 404.403) over the individual's own primary insurance amount.

(e) *How is my wife's or husband's or widow's or widower's benefit reduced when I am entitled to a reduced disability benefit in the same month?* When a person is first entitled to a spouse or widow's or widower's benefit in or after the month of attainment of age 62 (or in the case of widow's or widower's benefits, age 50) that benefit is reduced if, in the first month of entitlement to that benefit, he or she is also entitled to a reduced disability benefit. Under these circumstances, the wife's or husband's or widow's or widower's benefit is reduced by the sum of:

(1) The amount (if any) by which the disability benefit is reduced under paragraph (b)(1) of this section, and

(2) The amount by which the wife's or husband's or widow's or widower's benefit would be reduced under § 404.410 if it were equal to the excess of such benefit (before any reduction for age but after reduction for the family maximum under § 404.403) over the disability benefit (before any reduction under paragraph (b) of this section).

[68 FR 4709, Jan. 30, 2003]

§ 404.412 After my benefits are reduced for age when and how will adjustments to that reduction be made?

(a) *When may adjustment be necessary?* The following months are not counted

for purposes of reducing benefits in accordance with § 404.410;

(1) Months subject to deduction under § 404.415 or § 404.417;

(2) In the case of a wife's or husband's benefit, any month in which she or he had a child of the insured individual in her or his care and for which the child was entitled to child's benefits;

(3) In the case of a wife's or husband's benefit, any month for which entitlement to such benefits is precluded because the insured person's disability ceased (and, as a result, the insured individual's entitlement to disability benefits ended);

(4) In the case of a widow's or widower's benefit, any month in which she or he had in her or his care a child of the deceased insured individual and for which the child was entitled to child's benefits;

(5) In the case of a widow's or widower's benefit, any month before attainment of full retirement age for which she or he was not entitled to such benefits;

(6) In the case of an old-age benefit, any month for which the individual was entitled to disability benefits.

(b) *When is the adjustment made?* We make automatic adjustments in benefits to exclude the months of entitlement described in paragraphs (a)(1) through (6) of this section from consideration when determining the amount by which such benefits are reduced. Each year we examine beneficiary records to identify when an individual has attained full retirement age and one or more months described in paragraphs (a)(1) through (6) of this section occurred prior to such age during the period of entitlement to benefits reduced for age. Increases in benefit amounts based upon this adjustment are effective with the month of attainment of full retirement age. In the case of widow's or widower's benefits, this adjustment is made in the month of attainment of age 62 as well as the month of attainment of full retirement age.

[68 FR 4710, Jan. 30, 2003, as amended at 68 FR 40122, July 7, 2003]

§ 404.413 After my benefits are reduced for age what happens if there is an increase in my primary insurance amount?

(a) *What is the general rule on reduction of increases?* After an individual's benefits are reduced for age under §§ 404.410 through 404.411, the primary insurance amount on which such benefits are based may subsequently be increased because of a recomputation, a general benefit increase pursuant to an amendment of the Act, or increases based upon a rise in the cost-of-living under section 215(i) of the Social Security Act. When the primary insurance amount increases the monthly benefit amount also increases.

(b) *How are subsequent increases in the primary insurance amount reduced after 1977?* After 1977, when an individual's benefits have been reduced for age and the benefit is increased due to an increase in the primary insurance amount, the amount of the increase to which the individual is entitled is proportionately reduced as provided in paragraph (c) of this section. The method of reduction is determined by whether entitlement to reduced benefits began before 1978 or after 1977. When an individual is entitled to more than one benefit which is reduced for age, the rules for reducing the benefit increases apply to each reduced benefit.

(c) *How is the reduction computed for increases after 1977?*—(1) *Entitlement to reduced benefits after 1977.* If an individual becomes entitled after 1977 to a benefit reduced for age, and the primary insurance amount on which the reduced benefit is based is increased, the amount of the increase payable to the individual is reduced by the same percentage as we use to reduce the benefit in the month of initial entitlement. Where the reduced benefit of an individual has been adjusted at full retirement age (age 62 and full retirement age for widows or widowers), any increase to which the individual becomes entitled thereafter is reduced by the adjusted percentage.

(2) *Entitlement to reduced benefits before 1978.* For an individual, who became entitled to a benefit reduced for age before 1978, whose benefit may be increased as a result of an increase in

the primary insurance amount after 1977, we increase the amount of the benefit by the same percentage as the increase in the primary insurance amount.

(d) *How was the reduction computed for increases prior to 1978?* When the individual's primary insurance amount increased, the amount of the increase was reduced separately under §§ 404.410 and 404.411. The separate reduction was based on the number of months from the effective date of the increase through the month of attainment of age 65. This reduced increase amount was then added to the reduced benefit that was in effect in the month before the effective date of the increase. The result was the new monthly benefit amount.

[68 FR 4710, Jan. 30, 2003]

§ 404.415 Deductions because of excess earnings.

(a) *Deductions because of insured individual's earnings.* Under the annual earnings test, we will reduce your monthly benefits (except disability insurance benefits based on the beneficiary's disability) by the amount of your excess earnings (as described in § 404.434), for each month in a taxable year (calendar year or fiscal year) in which you are under full retirement age (as defined in § 404.409(a)).

(b) *Deductions from husband's, wife's, and child's benefits because of excess earnings of the insured individual.* We will reduce husband's, wife's, and child's insurance benefits payable (or deemed payable—see § 404.420) on the insured individual's earnings record because of the excess earnings of the insured individual. However, beginning with January 1985, we will not reduce the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years.

(c) *Deductions because of excess earnings of beneficiary other than the insured.* If benefits are payable to you (or deemed payable—see § 404.420) on the earnings record of an insured individual and you have excess earnings (as described in § 404.430) charged to a month, we will reduce only your benefits for that month under the annual earnings test. Child's insurance benefits payable by reason of being disabled will be evaluated using Substantial Gainful Activity guidelines (as described in § 404.1574 or § 404.1575). This deduction equals the amount of the excess earnings. (See § 404.434 for charging of excess earnings where both the insured individual and you, a beneficiary, have excess earnings.)

[70 FR 28811, May 19, 2005]

§ 404.417 Deductions because of noncovered remunerative activity outside the United States; 45 hour and 7-day work test.

(a) *Deductions because of individual's activity*—(1) *Prior to May 1983.* For months prior to May 1983, a 7-day work test applies in a month before benefit deductions are made for noncovered remunerative activity outside the United States. A deduction is made from any monthly benefit (except disability insurance benefits, child's insurance benefits based on the child's disability, or widow's or widower's insurance benefits based on the widow's or widower's disability) payable to an individual for each month in a taxable year beginning after December 1954 in which the beneficiary, while under age 72 (age 70 after December 1982), engages in noncovered remunerative activity (see § 404.418) outside the United States on 7 or more different calendar days. The deduction is for an amount equal to the benefit payable to the individual for that month.

(2) *From May 1983 on.* Effective May 1983, a 45-hour work test applies before a benefit deduction is made for the non-covered remunerative activity performed outside the United States in a month by the type of beneficiary described in paragraph (a)(1) of this section.

(b) *Deductions from benefits because of the earnings or work of an insured individual*—(1) *Prior to September 1984.* Where the insured individual entitled to old-age benefits works on 7 or more days in a month prior to September 1984 while under age 72 (age 70 after December 1982), a deduction is made for that month from any:

(i) Wife's, husband's, or child's insurance benefit payable on the insured individual's earnings record; and

(ii) Mother's, father's, or child's insurance benefit based on child's disability, which under § 404.420 is deemed payable on the insured individual's earnings record because of the beneficiary's marriage to the insured individual.

(2) *From September 1984 on.* Effective September 1984, a benefit deduction is made for a month from the benefits described in paragraph (b)(1) of this section only if the insured individual, while under age 70, has worked in excess of 45 hours in that month.

(3) *Amount of deduction.* The amount of the deduction required by this paragraph (b) is equal to the wife's, husband's or child's benefit.

(4) *From January 1985 on.* Effective January 1985, no deduction will be made from the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years.

[49 FR 24117, June 12, 1984, as amended at 51 FR 11912, Apr. 21, 1986; 52 FR 26145, July 13, 1987]

§ 404.418 "Noncovered remunerative activity outside the United States," defined.

An individual is engaged in noncovered remunerative activity outside the United States for purposes of deductions described in § 404.417 if:

(a) He performs services outside the United States as an employee and the services do not constitute employment as defined in subpart K of this part and, for taxable years ending after 1955, the services are not performed in the active military or naval service of the United States; or

(b) He carries on a trade or business outside the United States (other than the performance of services as an employee) the net income or loss of which is not includable in computing his net earnings from self-employment (as defined in § 404.1050) for a taxable year and would not be excluded from net earnings from self-employment (see § 404.1052) if the trade or business were carried on in the United States. When used in the preceding sentence with respect to a trade or business, the term *United States* does not include the Commonwealth of Puerto Rico, the Virgin Islands and, with respect to taxable years beginning after 1960, Guam or American Samoa, in the case of an alien who is not a resident of the United States (including the Commonwealth of Puerto Rico, the Virgin Islands and, with respect to taxable years beginning after 1960, Guam and American Samoa), and the term *trade or business* shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954.

§ 404.420 Persons deemed entitled to benefits based on an individual's earnings record.

For purposes of imposing deductions under the annual earnings test (see § 404.415) and the foreign work test (see § 404.417), a person who is married to an old-age insurance beneficiary and who is entitled to a mother's or father's insurance benefit or a child's insurance benefit based on the child's disability (and all these benefits are based on the earnings record of some third person) is deemed entitled to such benefit based on the earnings record of the old-age insurance beneficiary to whom he or she is married. This section is effective for months in any taxable year of the old-age insurance beneficiary that begins after August 1958.

[49 FR 24117, June 12, 1984]

§ 404.421 How are deductions made when a beneficiary fails to have a child in his or her care?

Deductions for failure to have a child in care (as defined in subpart D of this part) are made as follows:

(a) *Wife's or husband's benefit.* A deduction is made from the wife's or husband's benefits to which he or she is entitled for any month if he or she is under full retirement age and does not have in his or her care a child of the insured entitled to child's benefits. However, a deduction is not made for any month in which he or she is age 62 or over, but under full retirement age, and there is in effect a certificate of election for him or her to receive actuarially reduced wife's or husband's benefits for such month (see subpart D of this part).

(b) *Mother's or father's benefits*—(1) *Widow or widower.* A deduction is made from the mother's or father's benefits to which he or she is entitled as the

widow or widower (see subpart D of this part) of the deceased individual upon whose earnings such benefit is based, for any month in which he or she does not have in his or her care a child who is entitled to child's benefits based on the earnings of the deceased insured individual.

(2) *Surviving divorced mother or father.* A deduction is made from the mother's or father's benefits to which he or she is entitled as the surviving divorced mother or father (see subpart D of this part) of the deceased individual upon whose earnings record such benefit is based, for any month in which she or he does not have in care a child of the deceased individual who is her or his son, daughter, or legally adopted child and who is entitled to child's benefits based on the earnings of the deceased insured individual.

(c) *Amount to be deducted.* The amount deducted from the benefits, as described in paragraphs (a) and (b) of this section, is equal to the amount of the benefits which is otherwise payable for the month in which she or he does not have a child in his or her care.

(d) *When a child is considered not entitled to benefits.* For purposes of paragraphs (a) and (b) of this section, a person is considered not entitled to child's benefits for any month in which she or he is age 18 or over and is entitled to child's benefits because she or he is a full-time student at an educational institution. This paragraph applies to benefits for months after December 1964.

[68 FR 4710, Jan. 30, 2003, as amended at 68 FR 40122, July 7, 2003]

§ 404.423 Manner of making deductions.

Deductions provided for in §§ 404.415, 404.417, and 404.421 (as modified in § 404.458) are made by withholding benefits (in whole or in part, depending upon the amount to be withheld) for each month in which an event causing a deduction occurred. If the amount to be deducted is not withheld from the benefits payable in the month in which the event causing the deduction occurred, such amount constitutes a *deduction overpayment* and is subject to adjustment or recovery in accordance with the provisions of subpart F of this part.

[32 FR 19159, Dec. 20, 1967, as amended at 68 FR 40122, July 7, 2003]

§ 404.424 Total amount of deductions where more than one deduction event occurs in a month.

If more than one of the deduction events specified in §§ 404.415, 404.417, and 404.421 occurred in any 1 month, each of which would occasion a deduction equal to the benefit for such month, only an amount equal to such benefit is deducted.

§ 404.425 Total amount of deductions where deduction events occur in more than 1 month.

If a deduction event described in §§ 404.415, 404.417, and 404.421 occurs in more than 1 month, the total amount deducted from an individual's benefits is equal to the sum of the deductions for all months in which any such event occurred.

[68 FR 40122, July 7, 2003]

§ 404.428 Earnings in a taxable year.

(a) When we apply the annual earnings test to your earnings as a beneficiary under this subpart (see § 404.415), we count all of your earnings (as defined in § 404.429) for all months of your taxable year even though you may not be entitled to benefits during all months of that year. (See § 404.430 for the rule that applies to the earnings of a beneficiary who attains full retirement age (as described in § 404.409(a))).

(b) Your taxable year is presumed to be a calendar year until you show to our satisfaction that you have a different taxable year. If you are self-employed, your taxable year is a calendar year unless you have a different taxable year for the purposes of subtitle A of the Internal Revenue Code of 1986. In either case, the number of months in a taxable year is not affected by:

(1) The date a claim for Social Security benefits is filed;

(2) Attainment of any particular age;

(3) Marriage or the termination of marriage; or

(4) Adoption.

(c) The month of death is counted as a month of the deceased beneficiary's taxable year in determining whether

the beneficiary had excess earnings for the year under § 404.430. For beneficiaries who die after November 10, 1988, we use twelve as the number of months to determine whether the beneficiary had excess earnings for the year under § 404.430.

(d) Wages, as defined in § 404.429(c), are charged as earnings for the months and year in which you rendered the services. Net earnings or net losses from self-employment count as earnings or losses in the year for which such earnings or losses are reportable for Federal income tax purposes.

[70 FR 28811, May 19, 2005]

§ 404.429 Earnings; defined.

(a) *General.* The term ''earnings'' as used in this subpart (other than as a part of the phrase ''net earnings from self-employment'') includes the sum of your wages for services rendered in a taxable year, plus your net earnings from self-employment for the taxable year, minus any net loss from self-employment for the same taxable year.

(b) *Net earnings or net loss from self-employment.* Your net earnings or net loss from self-employment are determined under the provisions in subpart K of this part, except that:

(1) In this section, the following occupations are included in the definition of ''trade or business'' (although they may be excluded in subpart K):

(i) The performance of the functions of a public office;

(ii) The performance of a service of a duly ordained, commissioned, or licensed minister of a church in the exercise of his or her ministry or by a member of a religious order in the exercise of duties required by the order;

(iii) The performance of service by an individual in the exercise of his or her profession as a Christian Science practitioner;

(iv) The performance by an individual in the exercise of his or her profession as a doctor of medicine, lawyer, dentist, osteopath, veterinarian, chiropractor, naturopath, or optometrist.

(2) For the sole purpose of the earnings test under this subpart:

(i) If you reach full retirement age, as defined in § 404.409(a), on or before the last day of your taxable year, you will have excluded from your gross earnings from self-employment, your royalties attributable to a copyright or patent obtained before the taxable year in which you reach full retirement age; and

(ii) If you are entitled to insurance benefits under title II of the Act, other than disability insurance benefits or child's insurance benefits payable by reason of being disabled, we will exclude from gross earnings any self-employment income you received in a year after your initial year of entitlement that is not attributable to services you performed after the first month you became entitled to benefits. In this section, services means any significant work activity you performed in the operation or management of a trade, profession, or business which can be related to the income received. If a part of the income you receive in a year is not related to any significant services you performed after the month of initial entitlement, only that part of your income may be excluded from gross earnings for deduction purposes. We count the balance of the income for deduction purposes. Your royalties or other self-employment income is presumed countable for purposes of the earnings test until it is shown to our satisfaction that such income may be excluded under this section.

(3) We do not count as significant services:

(i) Actions you take after the initial month of entitlement to sell a crop or product if it was completely produced in or before the month of entitlement. This rule does not apply to income you receive from a trade or business of buying and selling products produced or made by others; for example, a grain broker.

(ii) Your activities to protect an investment in a currently operating business or activities that are too irregular, occasional, or minor to be considered as having a bearing on the income you receive, such as—

(A) Hiring an agent, manager, or other employee to operate the business;

(B) Signing contracts where your signature is required, so long as the major contract negotiations were handled by others in running the business for you;

(C) Looking over the company's financial records to assess the effectiveness of those agents, managers, or employees in running the business for you;

(D) Personally contacting an old and valued customer solely for the purpose of maintaining good will when such contact has a minimal effect on the ongoing operation of the trade or business; or

(E) Occasionally filling in for an agent, manager, or other employee or partner in an emergency.

(4) In figuring your net earnings or net loss from self-employment, we count all net income or net loss even though:

(i) You did not perform personal services in carrying on the trade or business;

(ii) The net profit was less than $400;

(iii) The net profit was in excess of the maximum amount creditable to your earnings record; or

(iv) The net profit was not reportable for social security tax purposes.

(5) Your net earnings from self-employment is the excess of gross income over the allowable business deductions (allowed under the Internal Revenue Code). Net loss from self-employment is the excess of business deductions (that are allowed under the Internal Revenue Code) over gross income. You cannot deduct, from wages or net earnings from self-employment, expenses in connection with the production of income excluded from gross income under paragraph (b)(2)(ii) of this section.

(c) *Wages.* Wages include the gross amount of your wages rather than the net amount paid after deductions by your employer for items such as taxes and insurance. Wages are defined in subpart K of this part, except that we also include the following types of wages that are excluded in subpart K:

(1) Remuneration in excess of the amounts in the annual wage limitation table in § 404.1047;

(2) Wages of less than the amount stipulated in section § 404.1057 that you receive in a calendar year for domestic service in the private home of your employer, or service not in the course of your employer's trade or business;

(3) Payments for agricultural labor excluded under § 404.1055;

(4) Remuneration, cash and non-cash, for service as a home worker even though the cash remuneration you received is less than the amount stipulated in § 404.1058(a) in a calendar year;

(5) Services performed outside the United States in the Armed Forces of the United States.

(d) *Presumptions concerning wages.* For purposes of this section, when reports received by us show that you received wages (as defined in paragraph (c) of this section) during a taxable year, it is presumed that they were paid to you for services rendered in that year unless you present evidence to our satisfaction that the wages were paid for services you rendered in another taxable year. If a report of wages shows your wages for a calendar year, your taxable year is presumed to be a calendar year for purposes of this section unless you present evidence to our satisfaction that your taxable year is not a calendar year.

[70 FR 28812, May 19, 2005]

§ 404.430 Monthly and annual exempt amounts defined; excess earnings defined.

(a) *Monthly and annual exempt amounts.* (1) The earnings test monthly and annual exempt amounts are the amounts of wages and self-employment income which you, as a Social Security beneficiary, may earn in any month or year without part or all of your monthly benefit being deducted because of excess earnings. The monthly exempt amount, (which is 1/12 of the annual exempt amount), applies only in a beneficiary's grace year or years. (See § 404.435(a) and (b)). The annual exempt amount applies to the earnings of each non-grace taxable year prior to the year of full retirement age, as defined in § 404.409(a). A larger ''annual'' exempt amount applies to the total earnings of the months in the taxable year that precedes the month in which you attain full retirement age. The full annual exempt amount applies to the earnings of these pre-full retirement age months, even though they are earned in less than a year. For beneficiaries using a fiscal year as a taxable

year, the exempt amounts applicable at the end of the fiscal year apply.

(2) We determine the monthly exempt amounts for each year by a method that depends on the type of exempt amount. In each case, the exempt amount so determined must be greater than or equal to the corresponding exempt amount in effect for months in the taxable year in which the exempt amount determination is being made.

(i) To calculate the lower exempt amount (the one applicable before the calendar year of attaining full retirement age) for any year after 1994, we multiply $670 (the lower exempt amount for 1994) by the ratio of the national average wage index for the second prior year to that index for 1992. If the amount so calculated is not a multiple of $10, we round it to the nearest multiple of $10 (*i.e.*, if the amount ends in $5 or more, we round up, otherwise we round down). The annual exempt amount is then 12 times the rounded monthly exempt amount.

(ii) The higher exempt amount (the one applicable in months of the year of attaining full retirement age (as defined in section 404.409(a)) that precede such attainment) was set by legislation (Public Law 104–121) for years 1996–2002. To calculate the higher exempt amount for any year after 2002, we multiply $2,500 (the higher exempt amount for 2002) by the ratio of the national average wage index for the second prior year to that index for 2000. We round the result as described in paragraph (a)(2)(i) of this section for the lower exempt amount.

(iii) The following are the annual and monthly exempt amounts for taxable years 2000 through 2005.

Year	For years through taxable year preceding year of reaching full retirement age		Months of taxable year prior to month of full of retirement age	
	Reduction: $1 for every $2 over the exempt amount		Reduction: $1 for every $3 over the exempt amount	
	Annual	Monthly	Annual	Monthly
2000	$10,080	$840	$17,000	$1,417
2001	10,680	890	25,000	2,084
2002	11,280	940	30,000	2,500
2003	11,520	960	30,720	2,560
2004	11,640	970	31,080	2,590
2005	12,000	1,000	31,800	2,650

(b) *Method of determining excess earnings for years after December 1999.* If you have not yet reached your year of full retirement age, your excess earnings for a taxable year are 50 percent of your earnings (as described in § 404.429) that are above the exempt amount. After December 31, 1999, in the taxable year in which you will reach full retirement age (as defined in § 404.409(a)), the annual (and monthly, if applicable) earnings limit applies to the earnings of the months prior to the month in which you reach full retirement age. Excess earnings are 33⅓ percent of the earnings above the annual exempt amount. Your earnings after reaching the month of full retirement age are not subject to the earnings test.

[70 FR 28813, May 19, 2005]

§ 404.434 Excess earnings; method of charging.

(a) *Months charged.* If you have not yet reached your year of full retirement age, and if your estimated earnings for a year result in estimated excess earnings (as described in § 404.430), we will charge these excess earnings to your full benefit each month from the beginning of the year, until all of the estimated excess earnings have been charged. Excess earnings, however, are not charged to any month described in §§ 404.435 and 404.436.

(b) *Amount of excess earnings charged*—(1) *Insured individual's excess earnings.* For each $1 of your excess earnings we will decrease by $1 the benefits to which you and all others are entitled (or deemed entitled—see § 404.420) on your earnings record. (See § 404.439 where the excess earnings for a

month are less than the total benefits payable for that month.) (See 404.415(b) for the effect on divorced wife's and divorced husband's benefits.)

(2) *Excess earnings of beneficiary other than insured individual.* We will charge a beneficiary, other than the insured, $1 for each $1 of the beneficiary's excess earnings (see § 404.437). These excess earnings, however, are charged only against that beneficiary's own benefits.

(3) *You, the insured individual, and a person entitled (or deemed entitled) on your earnings record both have excess earnings.* If both you and a person entitled (or deemed entitled) on your earnings record have excess earnings (as described in § 404.430), your excess earnings are charged first against the total family benefits payable (or deemed payable) on your earnings record, as described in paragraph (b)(1) of this section. Next, the excess earnings of a person entitled on your earnings record are charged against his or her own benefits remaining after part of your excess earnings have been charged against his/her benefits (because of the reduction in the total family benefits payable). See § 404.441 for an example of this process and the manner in which partial monthly benefits are apportioned.

(c) *Earnings test applicability.* Public Law 106–182 eliminated the Social Security earnings test, beginning with the month in which a person attains full retirement age (as defined in § 404.409(a)), for taxable years after 1999. In the year that you reach full retirement age, the annual earnings test amount is applied to the earnings amounts of the months that precede your month of full retirement age. (See § 404.430). The reduction rate for these months is $1 of benefits for every $3 you earned above the earnings limit in these months. The earnings threshold amount will be increased in conjunction with increases in average wages.

[70 FR 28813, May 19, 2005]

§ 404.435 Excess earnings; months to which excess earnings can or cannot be charged; grace year defined.

(a) *Monthly benefits payable.* We will not reduce your benefits on account of excess earnings for any month in which you, the beneficiary—

(1) Were not entitled to a monthly benefit;

(2) Were considered not entitled to benefits (due to non-covered work outside the United States or no child in care, as described in § 404.436);

(3) Were at full retirement age (as described in § 404.409(a));

(4) Were entitled to payment of a disability insurance benefit as defined in § 404.315; (see §§ 404.1592 and 404.1592a(b) which describes the work test if you are entitled to disability benefits);

(5) Are age 18 or over and entitled to a child's insurance benefit based on disability;

(6) Are entitled to a widow's or widower's insurance benefit based on disability; or

(7) Had a non-service month in your grace year (see paragraph (b) of this section). A non-service month is any month in which you, while entitled to retirement or survivors benefits:

(i) Do not work in self-employment (see paragraphs (c) and (d) of this section);

(ii) Do not perform services for wages greater than the monthly exempt amount set for that month (see paragraph (e) of this section and § 404.430); and

(iii) Do not work in non-covered remunerative activity on 7 or more days in a month while outside the United States. A non-service month occurs even if there are no excess earnings in the year.

(b) *Grace year defined.* (1) A beneficiary's initial grace year is the first taxable year in which the beneficiary has a non-service month (see paragraph (a)(7) of this section) in or after the month in which the beneficiary is entitled to a retirement, auxiliary, or survivor's benefit.

(2) A beneficiary may have another grace year each time his or her entitlement to one type of benefit ends and, after a break in entitlement of at least one month, the beneficiary becomes entitled to a different type of retirement or survivors benefit. The new grace year would then be the taxable year in which the first non-service month occurs after the break in entitlement.

(3) For purposes of determining whether a given year is a beneficiary's grace year, we will not count as a non-service month, a month that occurred while the beneficiary was entitled to disability benefits under section 223 of the Social Security Act or as a disabled widow, widower, or child under section 202.

(4) A beneficiary entitled to child's benefits, to spouse's benefits before age 62 (entitled only by reason of having a child in his or her care), or to mother's or father's benefits is entitled to a termination grace year in any year the beneficiary's entitlement to these types of benefits terminates. This provision does not apply if the termination is because of death or if the beneficiary is entitled to a Social Security benefit for the month following the month in which the entitlement ended. The beneficiary is entitled to a termination grace year in addition to any other grace year(s) available to him or her.

Example 1: Don, age 62, will retire from his regular job in April of next year. Although he will have earned $15,000 for January-April of that year and plans to work part time, he will not earn over the monthly exempt amount after April. Don's taxable year is the calendar year. Since next year will be the first year in which he has a non-service month while entitled to benefits, it will be his grace year and he will be entitled to the monthly earnings test for that year only. He will receive benefits for all months in which he does not earn over the monthly exempt amount (May-December) even though his earnings have substantially exceeded the annual exempt amount. However, in the years that follow, up to the year of full retirement age, only the annual earnings test will be applied if he has earnings that exceed the annual exempt amount, regardless of his monthly earnings amounts.

Example 2: Marion was entitled to mother's insurance benefits from 1998 because she had a child in her care. Because she had a non-service month in 1998, 1998 was her initial grace year. Marion's child turned 16 in May 2000, and the child's benefits terminated in April 2000. Marion's entitlement to mother's benefits also terminated in April 2000. Since Marion's entitlement did not terminate by reason of her death and she was not entitled to another type of Social Security benefit in the month after her entitlement to a mother's benefit ended, she is entitled to a termination grace year for 2000, the year in which her entitlement to mother's insurance benefits terminated. She applied for and became entitled to widow's insurance benefits effective February 2001. Because there was a break in entitlement to benefits of at least one month before entitlement to another type of benefit, 2001 will be a subsequent grace year if Marion has a non-service month in 2001.

(c) *You worked in self-employment.* You are considered to have worked in self-employment in any month in which you performed substantial services (see § 404.446) in the operation of a trade or business (or in a combination of trades and businesses if there are more than one), as an owner or partner even though you had no earnings or net earnings resulting from your services during the month.

(d) *Presumption regarding work in self-employment.* You are presumed to have worked in self-employment in each month of your taxable year until you show to our satisfaction that in a particular month you did not perform substantial services (see § 404.446(c)) in any trades and businesses from which you derived your annual net income or loss (see § 404.429).

(e) *Presumption regarding services for wages.* You are presumed to have performed services in any month for wages (as defined in § 404.429) of more than the applicable monthly exempt amount in each month of the year, until you show to our satisfaction that you did not perform services for wages in that month that exceeded the monthly exempt amount.

[70 FR 28814, May 19, 2005]

§ 404.436 Excess earnings; months to which excess earnings cannot be charged because individual is deemed not entitled to benefits.

Under the annual earnings test, excess earnings (as described in § 404.430) are not charged to any month in which an individual is deemed not entitled to a benefit. A beneficiary (*i.e.*, the insured individual or any person entitled or deemed entitled on the individual's earnings record) is deemed not entitled to a benefit for a month if he is subject to a deduction for that month because of:

(a) Engaging in noncovered remunerative activity outside the United States (as described in §§ 404.417 and 404.418); or

(b) Failure to have a child in his or her care (as described in § 404.421).

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 9429, Apr. 16, 1973; 38 FR 17716, July 3, 1973; 43 FR 8133, Feb. 28, 1978; 68 FR 40123, July 7, 2003]

§ 404.437 Excess earnings; benefit rate subject to deductions because of excess earnings.

We will further reduce your benefits (other than a disability insurance benefit) because of your excess earnings (see § 404.430), after your benefits may have been reduced because of the following:

(a) The family maximum (see §§ 404.403 and 404.404), which applies to entitled beneficiaries remaining after exclusion of beneficiaries deemed not entitled under § 404.436 (due to a deduction for engaging in non-covered remunerative activity outside the United States or failure to have a child in one's care);

(b) Your entitlement to benefits (see § 404.410) for months before you reach full retirement age (see § 404.409(a)) (this applies only to old-age, wife's, widow's, widower's or husband's benefits);

(c) Your receipt of benefits on your own earnings record, which reduces (see § 404.407) your entitlement (or deemed entitlement; see § 404.420) to benefits on another individual's earnings record; and

(d) Your entitlement to benefits payable (or deemed payable) to you based on the earnings record of an individual entitled to a disability insurance benefit because of that individual's entitlement to workers' compensation (see § 404.408).

[70 FR 28814, May 19, 2005]

§ 404.439 Partial monthly benefits; excess earnings of the individual charged against his benefits and the benefits of persons entitled (or deemed entitled) to benefits on his earnings record.

Deductions are made against the total family benefits where the excess earnings (as described in § 404.430) of an individual entitled to old-age insurance benefits are charged to a month and require deductions in an amount less than the total family benefits payable on his earnings record for that month (including the amount of a mother's or child's insurance benefit payable to a spouse who is deemed entitled on the individual's earnings record—see § 404.420). The difference between the total benefits payable and the deductions made under the annual earnings test for such month is paid (if otherwise payable under title II of the Act) to each person in the proportion that the benefit to which each is entitled (before the application of the reductions described in § 404.403 for the family maximum, § 404.407 for entitlement to more than one type of benefit, and section 202(q) of the Act for entitlement to benefits before retirement age) and before the application of § 404.304(f) to round to the next lower dollar bears to the total of the benefits to which all of them are entitled, except that the total amount payable to any such person may not exceed the benefits which would have been payable to that person if none of the insured individual's excess earnings had been charged to that month.

Example: A is entitled to an old-age insurance benefit of $165 and his wife is entitled to $82.50 before rounding, making a total of $247.50. After A's excess earnings have been charged to the appropriate months, there remains a partial benefit of $200 payable for October, which is apportioned as follows:

	Original benefit	Fraction of original	Benefit[1]
A	$165	2/3	$133
Wife	82.50	1/3	66
Total	247.50		199

[1] After deductions for excess earnings and after rounding per § 404.304(f).

[38 FR 9429, Apr. 16, 1973, as amended at 38 FR 17717, July 3, 1973; 43 FR 8133, Feb. 28, 1978; 48 FR 46149, Oct. 11, 1983]

§ 404.440 Partial monthly benefits; prorated share of partial payment exceeds the benefit before deduction for excess earnings.

Where, under the apportionment described in § 404.439, a person's prorated share of the partial benefit exceeds the benefit rate to which he was entitled before excess earnings of the insured individual were charged, such person's share of the partial benefit is reduced to the amount he would have been paid

had there been no deduction for excess earnings (see example). The remainder of the partial benefit is then paid to other persons eligible to receive benefits in the proportion that the benefit of each such other person bears to the total of the benefits to which all such other persons are entitled (before reduction for the family maximum). Thus, if only two beneficiaries are involved, payment is made to one as if no deduction had been imposed; and the balance of the partial benefit is paid to the other. If three or more beneficiaries are involved, however, reapportionment of the excess of the beneficiary's share of the partial benefit over the amount he would have been paid without the deduction is made in proportion to his original entitlement rate (before reduction for the family maximum). If the excess amount involved at any point totals less than $1, it is not reapportioned; instead, each beneficiary is paid on the basis of the last calculation.

Example: Family maximum is $150. Insured individual's excess earnings charged to the month are $25. The remaining $125 is prorated as partial payment.

	Original benefit	Fraction of original total benefit	Benefit after deductions for excess earnings but before reduction for family maximum	Benefit reduced for maximum but without deductions for excess earnings	Benefit payable after both deductions and reductions (and rounded)
Insured Individual	$100	2/5	50	100.00	75
Wife	50	1/5	25	16.60	16
Child	50	1/5	25	16.60	16
Child	50	1/5	25	16.60	16

[32 FR 19159, Dec. 20, 1967, as amended at 48 FR 46149, Oct. 11, 1983]

§ 404.441 Partial monthly benefits; insured individual and another person entitled (or deemed entitled) on the same earnings record both have excess earnings.

Where both the insured individual and another person entitled (or deemed entitled) on the same earnings record have excess earnings (as described in § 404.430), their excess earnings are charged, and their partial monthly benefit is apportioned, as follows:

Example: M and his wife are initially entitled to combined total benefits of $264 per month based on M's old-age insurance benefit of $176. For the taxable year in question, M's excess earnings were $1,599 and his wife's excess earnings were $265. Both were under age 65. M had wages of more than $340 in all months of the year except February, while his wife had wages of more than $340 in all months of the year. After M's excess earnings have been charged to the appropriate months (all months through July except February), there remains a partial benefit payment for August of $249, which is allocated to M and his wife in the ratio that the original benefit of each bears to the sum of their original benefits: $166 and $83. His wife's excess earnings are charged against her full benefit for February ($88), her partial benefit for August ($83), her full benefit for September, and from $6 of her October benefit, leaving an $82 benefit payable to her for that month.

[48 FR 46149, Oct. 11, 1983]

§ 404.446 Definition of "substantial services" and "services."

(a) *General.* In general, the substantial services test will be applicable only in a grace year (including a termination grace year) as defined in § 404.435(c)(1). It is a test of whether, in view of all the services rendered by the individual and the surrounding circumstances, the individual reasonably can be considered retired in the month in question. In determining whether an individual has or has not performed substantial services in any month, the following factors are considered:

(1) The amount of time the individual devoted to all trades and businesses;

(2) The nature of the services rendered by the individual;

(3) The extent and nature of the activity performed by the individual before he allegedly retired as compared with that performed thereafter;

(4) The presence or absence of an adequately qualified paid manager, partner, or family member who manages the business;

(5) The type of business establishment involved;

(6) The amount of capital invested in the trade or business; and

(7) The seasonal nature of the trade or business.

(b) *Individual engaged in more than one trade or business.* When an individual, in any month, performs services in more than one trade or business, his services in all trades or businesses are considered together in determining whether he performed substantial services in self-employment in such month.

(c) *Evidentiary requirements.* An individual who alleges that he did not render substantial services in any month, or months, shall submit detailed information about the operation of the trades or businesses, including the individual's activities in connection therewith. When requested to do so by the Administration, the individual shall also submit such additional statements, information, and other evidence as the Administration may consider necessary for a proper determination of whether the individual rendered substantial services in self-employment. Failure of the individual to submit the requested statements, information, and other evidence is a sufficient basis for a determination that the individual rendered substantial services in self-employment during the period in question.

[32 FR 19159, Dec. 20, 1967, as amended at 47 FR 46691, Oct. 20, 1982]

§ 404.447 Evaluation of factors involved in substantial services test.

In determining whether an individual's services are substantial, consideration is given to the following factors:

(a) *Amount of time devoted to trades or businesses.* Consideration is first given to the amount of time the self-employed individual devotes to all trades or businesses, the net income or loss of which is includable in computing his earnings as defined in § 404.429. For the purposes of this paragraph, the time devoted to a trade or business includes all the time spent by the individual in any activity, whether physical or mental, at the place of business or elsewhere in furtherance of such trade or business. This includes the time spent in advising and planning the operation of the business, making business contacts, attending meetings, and preparing and maintaining the facilities and records of the business. All time spent at the place of business which cannot reasonably be considered unrelated to business activities is considered time devoted to the trade or business. In considering the weight to be given to the time devoted to trades or businesses the following rules are applied:

(1) *Forty-five hours or less in a month devoted to trade or business.* Where the individual establishes that the time devoted to his trades and businesses during a calendar month was not more than 45 hours, the individual's services in that month are not considered substantial unless other factors (see paragraphs (b), (c), and (d) of this section) make such a finding unreasonable. For example, an individual who worked only 15 hours in a month might nevertheless be found to have rendered substantial services if he was managing a sizable business or engaging in a highly skilled occupation. However, the services of less than 15 hours rendered in all trades and businesses during a calendar month are not substantial.

(2) *More than 45 hours in a month devoted to trades and businesses.* Where an individual devotes more than 45 hours to all trades and businesses during a calendar month, it will be found that the individual's services are substantial unless it is established that the individual could reasonably be considered retired in the month and, therefore, that such services were not, in fact, substantial.

(b) *Nature of services rendered.* Consideration is also given to the nature of the services rendered by the individual in any case where a finding that the individual was retired would be unreasonable if based on time alone (see paragraph (a) of this section). The more highly skilled and valuable his services in self-employment are, the more likely the individual rendering such services could not reasonably be considered retired. The performance of services regularly also tends to show that the individual has not retired. Services are considered in relation to the technical and management needs of

the business in which they are rendered. Thus, skilled services of a managerial or technical nature may be so important to the conduct of a sizable business that such services would be substantial even though the time required to render the services is considerably less than 45 hours.

(c) *Comparison of services rendered before and after retirement.* Where consideration of the amount of time devoted to a trade or business (see paragraph (a) of this section) and the nature of services rendered (see paragraph (b) of this section) is not sufficient to establish whether an individual's services were substantial, consideration is given to the extent and nature of the services rendered by the individual before his *retirement*, as compared with the services performed during the period in question. A significant reduction in the amount or importance of services rendered in the business tends to show that the individual is retired; absence of such reduction tends to show that the individual is not retired.

(d) *Setting in which services performed.* Where consideration of the factors described in paragraphs (a), (b), and (c) of this section is not sufficient to establish that an individual's services in self-employment were or were not substantial, all other factors are considered. The presence or absence of a capable manager, the kind and size of the business, the amount of capital invested and whether the business is seasonal, as well as any other pertinent factors, are considered in determining whether the individual's services are such that he can reasonably be considered retired.

§ 404.450 Required reports of work outside the United States or failure to have care of a child.

(a) *Beneficiary engaged in noncovered remunerative activity; report by beneficiary.* Any individual entitled to a benefit which is subject to a deduction in that month because of noncovered remunerative activity outside the United States (see § 404.417) shall report the occurrence of such an event to the Social Security Administration before the receipt and acceptance of a benefit for the second month following the month in which such event occurred.

(b) *Beneficiary receiving wife's, husband's, mother's or father's insurance benefits does not have care of a child; report by beneficiary.* Any person receiving wife's, husband's, mother's, or father's insurance benefits which are subject to a deduction (as described in § 404.421) because he or she did not have a child in his or her care shall report the occurrence of such an event to the Social Security Administration before the receipt and acceptance of a benefit for the second month following the month in which the deduction event occurred.

(c) *Report required by person receiving benefits on behalf of another.* Where a person is receiving benefits on behalf of a beneficiary (see subpart U of this part) it is his duty to make the report to the Administration required by paragraph (a) or (b) of this section, on behalf of the beneficiary.

(d) *Report; content and form.* A report required under the provisions of this section shall be filed with the Social Security Administration. (See § 404.614 of this part for procedures concerning place of filing and date of receipt of such a report.) The report should be made on a form prescribed by the Administration and in accordance with instructions, printed thereon or attached thereto, as prescribed by the Administration. Prescribed forms may be obtained at any office of the Administration. If the prescribed form is not used, the report should be properly identified (e.g., show the name and social security claim number of the beneficiary about whom the report is made), describe the events being reported, tell when the events occurred, furnish any other pertinent data (e.g., who has care of the children), and be properly authenticated (e.g., bear the signature and address of the beneficiary making the report or the person reporting on his behalf). The report should contain all the information needed for a proper determination of whether a deduction applies and, if it does, the period for which such deductions should be made.

[32 FR 19159, Dec. 20, 1967, as amended at 49 FR 24117, June 12, 1984; 51 FR 10616, Mar. 28, 1986; 65 FR 16813, Mar. 30, 2000]

§ 404.451 Penalty deductions for failure to report within prescribed time limit noncovered remunerative activity outside the United States or not having care of a child.

(a) *Penalty for failure to report.* If an individual (or the person receiving benefits on his behalf) fails to comply with the reporting obligations of § 404.450 within the time specified in § 404.450 and it is found that good cause for such failure does not exist (see § 404.454), a penalty deduction is made from the individual's benefits in addition to the deduction described in § 404.417 (relating to noncovered remunerative activity outside the United States) or § 404.421 (relating to failure to have care of a child).

(b) *Determining amount of penalty deduction.* The amount of the penalty deduction for failure to report noncovered remunerative activity outside the United States or not having care of a child within the prescribed time is determined as follows:

(1) *First failure to make timely report.* The penalty deduction for the first failure to make a timely report is an amount equal to the individual's benefit or benefits for the first month for which the deduction event was not reported timely.

(2) *Second failure to make timely report.* The penalty deduction for the second failure to make a timely report is an amount equal to twice the amount of the individual's benefit or benefits for the first month for which the deduction event in the second failure period was not reported timely.

(3) *Subsequent failures to make timely reports.* The penalty deduction for the third or subsequent failure to file a timely report is an amount equal to three times the amount of the individual's benefit or benefits for the first month for which the deduction event in the third failure period was not reported timely.

(c) *Determining whether a failure to file a timely report is first, second, third, or subsequent failure*—(1) *Failure period.* A failure period runs from the date of one delinquent report (but initially starting with the date of entitlement to monthly benefits) to the date of the next succeeding delinquent report, excluding the date of the earlier report and including the date of the later report. The failure period includes each month for which succeeding delinquent report, excluding a report becomes overdue during a failure period, but it does not include any month for which a report is not yet overdue on the ending date of such period. If *good cause* (see § 404.454) is found for the entire period, the period is not regarded as a failure period.

(2) *First failure.* When no penalty deduction under paragraph (b) of this section has previously been imposed against the beneficiary for failure to report noncovered remunerative activity outside the United States or for failure to report not having care of a child, the earliest month in the first failure period for which a report is delinquent and for which *good cause* (see § 404.454) for failure to make the required report is not found is considered to be the first failure.

(3) *Second failure.* After one penalty deduction under paragraph (b) of this section has been imposed against the beneficiary, the first month for which a report is delinquent in the second failure period is considered to be the second failure.

(4) *Third and subsequent failures.* After a second penalty deduction under paragraph (b) of this section has been imposed against the beneficiary, the first month for which a report is delinquent in the third failure period is considered to be the third failure. Subsequent failures will be determined in the same manner.

Example: M became entitled in January 1966 to mother's benefits; these benefits are not payable for any month in which the mother does not have a child in her care. M accepted benefits for each month from January 1966 through June 1967. In July 1967 she reported that she had not had a child in her care in January 1967. As she was not eligible for a benefit for any month in which she did not have a child in her care, M's July 1967 benefit was withheld to recover the overpayment she had received for January 1967, and the next payment she received was for August 1967. No penalty was imposed for her failure to make a timely report of the deduction event that occurred in January 1967 because it was determined that *good cause* existed.

In March 1968 M reported that she had not had a child in her care in September or October 1967; however, she had accepted benefit

payments for each month from August 1967 through February 1968. Her benefits for March and April 1968 were withheld to recover the overpayment for September and October 1967. Also, it was determined that *good cause* was not present for M's failure to make a timely report of the deduction event that had occurred in September 1967. A penalty equal to her benefit for September 1967 was deducted from M's May 1968 payment since this was her *first failure* to report not having a child in her care. Payments to her then were continued.

On November 4, 1968, it was learned that M had not had a child in her care in November 1967 or in June, July, or August 1968 although she had accepted benefits for June through October 1968. Consequently, M's benefits for November 1968 through February 1969 were withheld to recover the 4 months' overpayment she received for months in which she did not have a child in her care. In addition, it was determined that *good cause* was not present for M's failure to report the deduction events, and a penalty was imposed equal to twice the amount of M's benefit for the month of June 1968. This was M's *second failure* to report not having a child in her care. No further penalty applied for November 1967 because that month was included in M's *first-failure* period.

(5) *Penalty deductions imposed under § 404.453 not considered.* A failure to make a timely report of earnings as required by § 404.452 for which a penalty deduction is imposed under § 404.453 is not counted as a failure to report in determining the first or subsequent failure to report noncovered remunerative activity outside the United States or not having care of a child.

(d) *Limitation on amount of penalty deduction.* Notwithstanding the provisions described in paragraph (b) of this section, the amount of the penalty deduction imposed for failure to make a timely report of noncovered remunerative activity outside the United States or for failure to report not having care of a child may not exceed the number of months in that failure period for which the individual received and accepted a benefit and for which a deduction is imposed by reason of his noncovered remunerative activity outside the United States or failure to have care of a child. (See § 404.458 for other limitations on the amount of the penalty deduction.)

[38 FR 3596, Feb. 8, 1973, as amended at 38 FR 9430, Apr. 16, 1973]

§ 404.452 Reports to Social Security Administration of earnings; wages; net earnings from self-employment.

(a) *Reporting requirements and conditions under which a report of earnings, that is, wages and/or net earnings from self-employment, is required.* (1) If you have not reached full retirement age (see § 404.409(a)) and you are entitled to a monthly benefit, other than only a disability insurance benefit, you are required to report to us the total amount of your earnings (as defined in § 404.429) for each taxable year. This report will enable SSA to pay you accurate benefits and avoid both overpayments and underpayments.

(2) If your wages and/or net earnings from self-employment in any month(s) of the year are below the allowable amount (see §§ 404.446 and 404.447), your report should include this information in order to establish your grace year (see § 404.435) and possible eligibility for benefits for those months.

(3) Your report to us for a taxable year should be filed on or before the 15th day of the fourth month following the close of the taxable year; for example, April 15 when the beneficiary's taxable year is a calendar year. An income tax return or form W-2, filed timely with the Internal Revenue Service, may serve as the report required to be filed under the provisions of this section, where the income tax return or form W-2 shows the same wages and/or net earnings from self-employment that must be reported to us. Although we may accept W-2 information and special payment information from employers, you still have primary responsibility for making sure that the earnings we use for deduction purposes are correct. If there is a valid reason for a delay, we may grant you an extension of up to 4 months to file this report.

(4) You are not required to report to us if:

(i) You reached full retirement age before the first month of your entitlement to benefits; or

(ii) Your benefit payments were suspended under the provisions described in § 404.456 for all months of a taxable year before the year of full retirement age, or for all months prior to your full retirement age in the full retirement age year, unless you are entitled to

benefits as an auxiliary or survivor and your benefits are reduced for any month in the taxable year because of earnings and there is another person entitled to auxiliary or survivor's benefits on the same record, but living in a different household.

(b) *Report required by person receiving benefits on behalf of another.* When you receive benefits as a representative payee on behalf of a beneficiary (see subpart U of this part), it is your duty to report any earnings of the beneficiary to us.

(c) *Information required.* If you are the beneficiary, your report should show your name, address, Social Security number, the taxable year for which the report is made, and the total amount of your wages and/or net earnings from self employment during the taxable year. If you are a representative payee, your report should show the name, address, and Social Security number of the beneficiary, the taxable year for which the report is made, and the total earnings of the beneficiary, as well as your name, address, and Social Security number.

(d) *Requirement to furnish requested information.* You, the beneficiary (or the person reporting on his/her behalf) are required to furnish any other information about earnings and services that we request for the purpose of determining the correct amount of benefits payable for a taxable year (see § 404.455).

(e) *Extension of time for filing report—*(1) *Request for extension to file report.* Your request for an extension of time, or the request of your authorized agent, must be in writing and must be filed at a Social Security Administration office before your report is due. Your request must include the date, your name, the Social Security number of the beneficiary, the name and Social Security number of the person filing the request if other than the beneficiary, the year for which your report is due, the amount of additional time requested, the reason why you require this extension (see § 404.454), and your signature.

(2) *Evidence that extension of time has been granted.* If you do not receive written approval of an extension of time for making your report of earnings, it will be presumed that no extension of time was granted. In such case, if you do not file on time, you will need to establish that you had good cause (§ 404.454) for filing your report after the normal due date.

[70 FR 28815, May 19, 2005]

§ 404.453 Penalty deductions for failure to report earnings timely.

(a) *Penalty for failure to report earnings; general.* Penalty deductions are imposed against an individual's benefits, in addition to the deductions required because of his excess earnings (see § 404.415), if:

(1) He fails to make a timely report of his earnings as specified in § 404.452 for a taxable year beginning after 1954;

(2) It is found that good cause for failure to report earnings timely (see § 404.454) does not exist;

(3) A deduction is imposed because of his earnings (see § 404.415) for that year; and

(4) He received and accepted any payment of benefits for that year.

(b) *Determining amount of penalty deduction.* The amount of the penalty deduction for failure to report earnings for a taxable year within the prescribed time is determined as follows:

(1) *First failure to file timely report.* The penalty deduction for the first failure to file a timely report is an amount equal to the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during the taxable year, except that with respect to any deductions imposed on or after January 2, 1968, if the amount of the deduction imposed for the taxable year is less than the benefit or benefits for the last month of the taxable year for which he was entitled to a benefit under section 202 of the Act, the penalty deduction is an amount equal to the amount of the deduction imposed but not less than $10.

(2) *Second failure to file timely report.* The penalty deduction for the second failure to file a timely report is an amount equal to twice the amount of the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during such taxable year.

(3) *Subsequent failures to file timely reports.* The penalty deduction for the

third or subsequent failure to file a timely report is an amount equal to three times the amount of the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during such taxable year.

(c) *Determining whether a failure to file a timely report is first, second, or subsequent failure*—(1) *No prior failure.* Where no penalty deduction under this section has previously been imposed against the beneficiary for failure to make a timely report of his earnings, all taxable years (and this may include 2 or more years) for which a report of earnings is overdue as of the date the first delinquent report is made are included in the first failure. The latest of such years for which *good cause* for failure to make the required report (see § 404.454) is not found is considered the first failure to file a timely report.

Example: X became entitled to benefits in 1964 and had reportable earnings for 1964, 1965, and 1966. He did not make his annual reports for those years until July 1967. At that time it was found that 1966 was the only year for which he has good cause for not making a timely report of his earnings. Since all taxable years for which a report is overdue as of the date of the first delinquent report are included in the first failure period, it was found that his first failure to make a timely report was for 1965. The penalty is equal to his December 1965 benefit rate. If good cause had also been found for both 1965 and 1964, then X would have *no prior failure* within the meaning of this subsection.

(2) *Second and subsequent failures.* After one penalty deduction under paragraph (b) of this section has been imposed against an individual, each taxable year for which a timely report of earnings is not made (and the count commences with reports of earnings which become delinquent after the date the first delinquent report described in paragraph (c)(1) of this section was made), and for which *good cause* for failure to make the required report is not found, is considered separately in determining whether the failure is the second or subsequent failure to report timely.

Example: Y incurred a penalty deduction for not making his 1963 annual report until July 1964. In August 1966 it was found that he had not made a timely report of either his 1964 or 1965 earnings, and good cause was not present with respect to either year. The penalty for 1964 is equal to twice his benefit rate for December 1964. The penalty for 1965 is equal to three times his benefit rate for December 1965.

(3) *Penalty deduction imposed under § 404.451 not considered.* A failure to make a report as required by § 404.450, for which a penalty deduction is imposed under § 404.451, is not counted as a failure to report in determining, under this section, whether a failure to report earnings or wages is the first or subsequent failure to report.

(d) *Limitation on amount of penalty deduction.* Notwithstanding the provisions described in paragraph (b) of this section, the amount of the penalty deduction imposed for failure to file a timely report of earnings for a taxable year may not exceed the number of months in that year for which the individual received and accepted a benefit and for which deductions are imposed by reason of his earnings for such year. (See § 404.458 for other limitations on the amount of the penalty deduction.)

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 3597, Feb. 8, 1973; 38 FR 9431, Apr. 16, 1973]

§ 404.454 Good cause for failure to make required reports.

(a) *General.* The failure of an individual to make a timely report under the provisions described in §§ 404.450 and 404.452 will not result in a penalty deduction if the individual establishes to the satisfaction of the Administration that his failure to file a timely report was due to good cause. Before making any penalty determination as described in §§ 404.451 and 404.453, the individual shall be advised of the penalty and good cause provisions and afforded an opportunity to establish good cause for failure to report timely. The failure of the individual to submit evidence to establish good cause within a specified time may be considered a sufficient basis for a finding that good cause does not exist (see § 404.705). In determining whether good cause for failure to report timely has been established by the individual, consideration is given to whether the failure to report within the proper time limit was the result of untoward circumstances, misleading action of the Social Security Administration, confusion as to

the requirements of the Act resulting from amendments to the Act or other legislation, or any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have. For example, *good cause* may be found where failure to file a timely report was caused by:

(1) Serious illness of the individual, or death or serious illness in his immediate family;

(2) Inability of the individual to obtain, within the time required to file the report, earnings information from his employer because of death or serious illness of the employer or one in the employer's immediate family; or unavoidable absence of his employer; or destruction by fire or other damage of the employer's business records;

(3) Destruction by fire, or other damage, of the individual's business records;

(4) Transmittal of the required report within the time required to file the report, in good faith to another Government agency even though the report does not reach the Administration until after the period for reporting has expired;

(5) Unawareness of the statutory provision that an annual report of earnings is required for the taxable year in which the individual attained age 72 provided his earnings for such year exceeded the applicable amount, e.g., $1,680 for a 12-month taxable year ending after December 1967;

(6) Failure on the part of the Administration to furnish forms in sufficient time for an individual to complete and file the report on or before the date it was due, provided the individual made a timely request to the Administration for the forms;

(7) Belief that an extension of time for filing income tax returns granted by the Internal Revenue Service was also applicable to the annual report to be made to the Social Security Administration;

(8) Reliance upon a written report to the Social Security Administration made by, or on behalf of, the beneficiary before the close of the taxable year, if such report contained sufficient information about the beneficiary's earnings or work, to require suspension of his benefits (see § 404.456) and the report was not subsequently refuted or rescinded; or

(9) Failure of the individual to understand reporting responsibilities due to his or her physical, mental, educational, or linguistic limitation(s).

(b) *Notice of determination.* In every case in which it is determined that a penalty deduction should be imposed, the individual shall be advised of the penalty determination and of his reconsideration rights. If it is found that good cause for failure to file a timely report does not exist, the notice will include an explanation of the basis for this finding; the notice will also explain the right to partial adjustment of the overpayment, in accordance with the provisions of § 404.502(c).

(c) *Good cause for subsequent failure.* Where circumstances are similar and an individual fails on more than one occasion to make a timely report, good cause normally will not be found for the second or subsequent violation.

[38 FR 3597, Feb. 8, 1973, as amended at 43 FR 8133, Feb. 28, 1978; 59 FR 1634, Jan. 12, 1994]

§ 404.455 Request by Social Security Administration for reports of earnings and estimated earnings; effect of failure to comply with request.

(a) *Request by Social Security Administration for report during taxable year; effect of failure to comply.* The Social Security Administration may, during the course of a taxable year, request a beneficiary to estimate his or her earnings (as defined in § 404.429) for the current taxable year and for the next taxable year, and to furnish any other information about his or her earnings that the Social Security Administration may specify. If a beneficiary fails to comply with a request for an estimate of earnings for a taxable year, the beneficiary's failure, in itself, constitutes justification under section 203(h) of the Act for a determination that it may reasonably be expected that the beneficiary will have deductions imposed under the provisions described in § 404.415, due to his or her earnings for that taxable year. Furthermore, the failure of the beneficiary to comply with a request for an estimate of earnings for a taxable year will, in itself, constitute justification for the Social

Security Administration to use the preceding taxable year's estimate of earnings (or, if available, reported earnings) to suspend payment of benefits for the current or next taxable year.

(b) *Request by Social Security Administration for report after close of taxable year; failure to comply.* After the close of his or her taxable year, the Social Security Administration may request a beneficiary to furnish a report of his or her earnings for the closed taxable year and to furnish any other information about his or her earnings for that year that the Social Security Administration may specify. If he or she fails to comply with this request, this failure shall, in itself, constitute justification under section 203(h) of the Act for a determination that the beneficiary's benefits are subject to deductions as described in § 404.415 for each month in the taxable year (or only for the months thereof specified by the Social Security Administration).

[56 FR 11373, Mar. 18, 1991]

§ 404.456 Current suspension of benefits because an individual works or engages in self-employment.

(a) *Circumstances under which benefit payments may be suspended.* If, on the basis of information obtained by or submitted to the Administration, it is determined that an individual entitled to monthly benefits for any taxable year may reasonably be expected to have deductions imposed against his benefits (as described in § 404.415) by reason of his earnings for such year, the Administration may, before the close of the taxable year, suspend all or part, as the Administration may specify, of the benefits payable to the individual and to all other persons entitled (or deemed entitled—see § 404.420) to benefits on the basis of the individual's earnings record.

(b) *Duration of suspension.* The suspension described in paragraph (a) of this section shall remain in effect with respect to the benefits for each month until the Administration has determined whether or not any deduction under § 404.415 applies for such month.

(c) *When suspension of benefits becomes final.* For taxable years beginning after August 1958, if benefit payments were suspended (as described in paragraph (a) of this section) for all months of entitlement in an individual's taxable year, no benefit payment for any month in that year may be made after the expiration of the period of 3 years, 3 months, and 15 days following the close of the individual's taxable year unless, within that period, the individual, or any person entitled to benefits based on his earnings record, files with the Administration information showing that a benefit for a month is payable to the individual. Subject to the limitations of this paragraph, a determination about deductions may be reopened under the circumstances described in § 404.907.

[32 FR 19159, Dec. 20, 1967, as amended at 65 FR 16813, Mar. 30, 2000]

§ 404.457 Deductions where taxes neither deducted from wages of certain maritime employees nor paid.

(a) *When deduction is required.* A deduction is required where:

(1) An individual performed services after September 1941 and before the termination of Title I of the First War Powers Act, 1941, on or in connection with any vessel as an officer or crew member; and

(2) The services were performed in the employ of the United States and employment was through the War Shipping Administration or, for services performed before February 11, 1942, through the United States Maritime Commission; and

(3) The services, under the provisions of § 404.1041 of this part, constituted employment for the purposes of title II of the Social Security Act; and

(4) The taxes imposed (by section 1400 of the Internal Revenue Code of 1939, as amended) with respect to such services were neither deducted from the individual's wages nor paid by the employer.

(b) *Amount of deduction.* The deduction required by paragraph (a) of this section is an amount equal to 1 percent of the wages with respect to which the taxes described in paragraph (a)(4) of this section were neither deducted nor paid by the employer.

(c) *How deduction is made.* The deduction required by paragraph (a) of this section is made by withholding an

amount as determined under paragraph (b) of this section from any monthly benefit or lump-sum death payment based on the earnings record of the individual who performed the services described in paragraph (a) of this section.

[32 FR 19159, Dec. 20, 1967, as amended at 65 FR 16813, Mar. 30, 2000]

§ 404.458 Limiting deductions where total family benefits payable would not be affected or would be only partly affected.

Notwithstanding the provisions described in §§ 404.415, 404.417, 404.421, 404.451, and 404.453 about the amount of the deduction to be imposed for a month, no such deduction is imposed for a month when the benefits payable for that month to all persons entitled to benefits on the same earnings record and living in the same household remain equal to the maximum benefits payable to them on that earnings record. Where making such deductions and increasing the benefits to others in the household (for the month in which the deduction event occurred) would give members of the household less than the *maximum* (as determined under § 404.404) payable to them, the amount of deduction imposed is reduced to the difference between the maximum amount of benefits payable to them and the total amount which would have been paid if the benefits of members of the household not subject to deductions were increased for that month. The individual subject to the deduction for such month may be paid the difference between the deduction so reduced and his benefit as adjusted under § 404.403 (without application of § 404.402(a)). All other persons in the household are paid, for such month, their benefits as adjusted under § 404.403 without application of § 404.402(a).

[47 FR 43673, Oct. 4, 1982, as amended at 68 FR 15659, Apr. 1, 2003; 68 FR 40123, July 7, 2003]

§ 404.459 Penalty for making false or misleading statements or withholding information.

(a) *Why would SSA penalize me?* You will be subject to a penalty if:

(1) You make, or cause to be made, a statement or representation of a material fact, for use in determining any initial or continuing right to, or the amount of, monthly insurance benefits under title II or benefits or payments under title XVI, that you know or should know is false or misleading; or

(2) You make a statement or representation of a material fact for use as described in paragraph (a)(1) of this section with knowing disregard for the truth; or

(3) You omit from a statement or representation made for use as described in paragraph (a)(1) of this section, or otherwise withhold disclosure (for example, fail to come forward to notify us) of, a fact which you know or should know is material to the determination of any initial or continuing right to, or the amount of, monthly insurance benefits under title II or benefits or payments under title XVI, if you know, or should know, that the statement or representation with such omission is false or misleading or that the withholding of such disclosure is misleading.

(b) *What is the penalty?* The penalty is nonpayment of benefits under title II that we would otherwise pay you and ineligibility for cash benefits under title XVI (including State supplementary payments made by SSA according to § 416.2005).

(c) *How long will the penalty last?* The penalty will last—

(1) Six consecutive months the first time we penalize you;

(2) Twelve consecutive months the second time we penalize you; and

(3) Twenty-four consecutive months the third or subsequent time we penalize you.

(d) *Will this penalty affect any of my other government benefits?* If we penalize you, the penalty will apply only to your eligibility for benefits under titles II and XVI (including State supplementary payments made by us according to § 416.2005). The penalty will not affect—

(1) Your eligibility for benefits that you would otherwise be eligible for under titles XVIII and XIX but for the imposition of the penalty; and

(2) The eligibility or amount of benefits payable under titles II or XVI to another person. For example, another person (such as your spouse or child) may be entitled to benefits under title

II based on your earnings record. Benefits would still be payable to that person to the extent that you would be receiving such benefits but for the imposition of the penalty. As another example, if you are receiving title II benefits that are limited under the family maximum provision (§ 404.403) and we stop your benefits because we impose a penalty on you, we will not increase the benefits of other family members who are limited by the family maximum provision simply because you are not receiving benefits because of the penalty.

(e) *How will SSA make its decision to penalize me?* In order to impose a penalty on you, we must find that you knowingly (knew or should have known or acted with knowing disregard for the truth) made a false or misleading statement or omitted or failed to report a material fact if you knew, or should have known, that the omission or failure to disclose was misleading. We will base our decision to penalize you on the evidence and the reasonable inferences that can be drawn from that evidence, not on speculation or suspicion. Our decision to penalize you will be documented with the basis and rationale for that decision. In determining whether you knowingly made a false or misleading statement or omitted or failed to report a material fact so as to justify imposition of the penalty, we will consider all evidence in the record, including any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time. In determining whether you acted knowingly, we will also consider the significance of the false or misleading statement or omission or failure to disclose in terms of its likely impact on your benefits.

(f) *What should I do if I disagree with SSA's initial determination to penalize me?* If you disagree with our initial determination to impose a penalty, you have the right to request reconsideration of the penalty decision as explained in § 404.907. We will give you a chance to present your case, including the opportunity for a face-to-face conference. If you request reconsideration of our initial determination to penalize you, you have the choice of a case review, informal conference, or formal conference, as described in § 416.1413(a) through (c). If you disagree with our reconsidered determination you have the right to follow the normal administrative and judicial review process by requesting a hearing before an administrative law judge, Appeals Council review and Federal court review, as explained in § 404.900.

(g) *When will the penalty period begin and end?* Subject to the additional limitations noted in paragraphs (g)(1) and (g)(2) of this section, the penalty period will begin the first day of the month for which you would otherwise receive payment of benefits under title II or title XVI were it not for imposition of the penalty. Once a sanction begins, it will run continuously even if payments are intermittent. If more than one penalty has been imposed, but they have not yet run, the penalties will not run concurrently.

(1) If you do not request reconsideration of our initial determination to penalize you, the penalty period will begin no earlier than the first day of the second month following the month in which the time limit for requesting reconsideration ends. The penalty period will end on the last day of the final month of the penalty period. For example, if the time period for requesting reconsideration ends on January 10, a 6-month period of nonpayment begins on March 1 if you would otherwise be eligible to receive benefits for that month, and ends on August 31.

(2) If you request reconsideration of our initial determination to penalize you and the reconsidered determination does not change our original decision to penalize you, the penalty period will begin no earlier than the first day of the second month following the month we notify you of our reconsidered determination. The penalty period will end on the last day of the final month of the penalty period. For example, if we notify you of our reconsidered determination on August 31, 2001, and you are not otherwise eligible for payment of benefits at that time, but would again be eligible to receive payment of benefits on October 1, 2003, a 6-month period of nonpayment would

begin on October 1, 2003 and end on March 31, 2004.

[65 FR 42285, July 10, 2000, as amended at 71 FR 61407, Oct. 18, 2006]

§ 404.460 Nonpayment of monthly benefits to aliens outside the United States.

(a) *Nonpayment of monthly benefits to aliens outside the United States more than 6 months.* Except as described in paragraph (b) and subject to the limitations in paragraph (c) of this section after December 1956 no monthly benefit may be paid to any individual who is not a citizen or national of the United States, for any month after the sixth consecutive calendar month during all of which he is outside the United States, and before the first calendar month for all of which he is in the United States after such absence.

(1) For nonpayment of benefits under this section, it is necessary that the beneficiary be an alien, and while an alien, be outside the United States for more than six full consecutive calendar months. In determining whether, at the time of a beneficiary's initial entitlement to benefits, he or she has been outside the United States for a period exceeding six full consecutive calendar months, not more than the six calendar months immediately preceding the month of initial entitlement may be considered. For the purposes of this section, *outside the United States* means outside the territorial boundaries of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands of the United States, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(2) Effective with 6-month periods beginning after January 2, 1968, after an alien has been outside the United States for any period of 30 consecutive days, he is deemed to be outside the United States continuously until he has returned to the United States and remained in the United States for a period of 30 consecutive days.

(3) Payments which have been discontinued pursuant to the provisions of this section will not be resumed until the alien beneficiary has been in the United States for a full calendar month. A full calendar month includes 24 hours of each day of the calendar month.

(4) Nonpayment of benefits to an individual under this section does not cause nonpayment of benefits to other persons receiving benefits based on the individual's earnings record.

Example: R, an alien, leaves the United States on August 15, 1967, and returns on February 1, 1968. He leaves again on February 15, 1968, and does not return until May 15, 1968, when he spends 1 day in the United States. He has been receiving monthly benefits since July 1967.

R's first 6-month period of absence begins September 1, 1967. Since this period begins before January 2, 1968, his visit (Feb. 1, 1968, to Feb. 15, 1968) to the United States for less than 30 consecutive days is sufficient to break this 6-month period.

R's second 6-month period of absence begins March 1, 1968. Since this period begins after January 2, 1968, and he was outside the United States for 30 consecutive days, he must return and spend 30 consecutive days in the United States prior to September 1, 1968, to prevent nonpayment of benefits beginning September 1968. If R fails to return to the United States for 30 consecutive days prior to September 1, 1968, payments will be discontinued and will not be resumed until R spends at least 1 full calendar month in the United States.

(b) *When nonpayment provisions do not apply.* The provisions described in paragraph (a) of this section do not apply, subject to the limitations in paragraph (c) of this section, to a benefit for any month if:

(1) The individual was, or upon application would have been, entitled to a monthly benefit for December 1956, based upon the same earnings record; or

(2)(i) The individual upon whose earnings the benefit is based, before that month, has resided in the United States for a period or periods aggregating 10 years or more or has earned not less than 40 quarters of coverage;

(ii) Except that, effective with July 1968, § 404.460(b)(2)(i) does not apply if:

(A) The beneficiary is a citizen of a country with a social insurance or pension system meeting the conditions described in paragraphs (b)(7)(i), (ii), and (iii) of this section but does not meet the condition described in paragraph (b)(7)(iv) of this section; or

(B) The beneficiary is a citizen of a country with no social insurance or

pension system of general application and at any time within 5 years before January 1968 (or the first month after December 1967 in which benefits are subject to suspension pursuant to paragraph (a) of this section) such beneficiary was residing in a country to which payments were withheld by the Treasury Department pursuant to Vol. II, 31 U.S.C. 3329. *See* § 404.460(c).

(iii) For purposes of this subparagraph a period of residence begins with the day the insured individual arrives in the United States with the intention of establishing at least a temporary home here; it continues so long as he maintains an attachment to an abode in the United States, accompanied by actual physical presence in the United States for a significant part of the period; and ends with the day of departure from the United States with the intention to reside elsewhere; or

(3) The individual is outside the United States while in the active military or naval service of the United States; or

(4) The individual on whose earnings the benefit is based died before that month and:

(i) Death occurred while the individual was on active duty or inactive duty training as a member of a uniformed service, or

(ii) Death occurred after the individual was discharged or released from a period of active duty or inactive duty training as a member of a uniformed service, and the Administrator of Veterans' Affairs determines, and certifies to the Commissioner, that the discharge or release was under conditions other than dishonorable and that death was as a result of a disease or injury incurred or aggravated in line of duty while on active duty or inactive duty training; or

(5) The individual on whose earnings record the benefit is based worked in service covered by the Railroad Retirement Act, and such work is treated as employment covered by the Social Security Act under the provisions described in subpart O of this part; or

(6) The nonpayment of monthly benefits under the provisions described in paragraph (a) of this section would be contrary to a treaty obligation of the United States in effect on August 1, 1956 (see § 404.463(b)); or

(7) The individual is a citizen of a foreign country that the Commissioner determines has in effect a social insurance or pension system (see § 404.463) which meets all of the following conditions:

(i) Such system pays periodic benefits or the actuarial equivalent thereof; and

(ii) The system is of general application; and

(iii) Benefits are paid in this system on account of old age, retirement, or death; and

(iv) Individuals who are citizens of the United States but not citizens of the foreign country and who qualify for such benefits are permitted to receive benefits without restriction or qualification, at their full rate, or the actuarial equivalent thereof, while outside of the foreign country and without regard to the duration of their absence therefrom.

(c) *Nonpayment of monthly benefits to aliens residing in certain countries*—(1) *Benefits for months after June 1968.* Notwithstanding the provisions of paragraphs (a) and (b) of this section, we cannot pay monthly benefits for any month after June 1968 to anyone not a citizen or national of the United States for any month while residing in a country to which payments are being withheld by the Treasury Department pursuant to Vol. II, 31 U.S.C. 3329.

(2) *Benefits for months before July 1968.* If a person who is not a United States citizen or national is entitled to receive benefits under title II of the Social Security Act, and was residing in a country where the Treasury Department withheld benefits on June 30, 1968 pursuant to Vol. II, 31 U.S.C. 3329, benefits cannot be paid. However, if the Treasury Department subsequently removes that restriction, a person who is not a United States citizen or national may be able to be paid benefits to which they were entitled for months prior to July 1968. Benefits cannot be paid,—

(i) To any person other than such individual, or, if such individual dies before such benefits can be paid, to any person other than an individual who was entitled for the month in which

the deceased individual died (with the application of section 202(j)(1) of the Social Security Act) to a monthly benefit under title II of such Act on the basis of the same wages and self-employment income as such deceased individual; or

(ii) In excess of an amount equal to the amount of the last 12 months' benefits that would have been payable to such individual.

(3) *List of countries under Treasury Department alien payment restriction.* The Treasury Department is currently withholding payments to persons residing in the following countries pursuant to Vol. II, 31 U.S.C. 3329. We will publish future additions to or deletions from the list of countries in the FEDERAL REGISTER: Cuba, North Korea.

(d) *Nonpayment of monthly benefits to certain aliens entitled to benefits on a worker's earnings record.* An individual who after December 31, 1984 becomes eligible for benefits on the earnings record of a worker for the first time, is an alien, has been outside the United States for more than 6 consecutive months, and is qualified to receive a monthly benefit by reason of the provisions of paragraphs (b)(2), (b)(3), (b)(5), or (b)(7) of this section, must also meet a U.S. residence requirement described in this section to receive benefits:

(1) An alien entitled to benefits as a child of a living or deceased worker—

(i) Must have resided in the U.S. for 5 or more years as the child of the parent on whose earnings record entitlement is based; or

(ii) The parent on whose earnings record the child is entitled and the other parent, if any, must each have either resided in the United States for 5 or more years or died while residing in the U.S.

(2) An alien who meets the requirements for child's benefits based on paragraph (d)(1) of this section above, whose status as a child is based on an adoptive relationship with the living or deceased worker, must also—

(i) Have been adopted within the United States by the worker on whose earnings record the child's entitlement is based; and

(ii) Have lived in the United States with, and received one-half support from, the worker for a period, beginning prior to the child's attainment of age 18, of

(A) At least one year immediately before the month in which the worker became eligible for old-age benefits or disability benefits or died (whichever occurred first), or

(B) If the worker had a period of disability which continued until the worker's entitlement to old-age or disability benefits or death, at least one year immediately before the month in which that period of disability began.

(3) An alien entitled to benefits as a spouse, surviving spouse, divorced spouse, surviving divorced spouse, or surviving divorced mother or father must have resided in the United States for 5 or more years while in a spousal relationship with the person on whose earnings record the entitlement is based. The spousal relationship over the required period can be that of wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, or a combination of two or more of these categories.

(4) An alien who is entitled to parent's benefits must have resided in the United States for 5 or more years as a parent of the person on whose earnings record the entitlement is based.

(5) Individuals eligible for benefits before January 1, 1985 (including those eligible for one category of benefits on a particular worker's earnings record after December 31, 1984, but also eligible for a different category of benefits on the same worker's earnings record before January 1, 1985), will not have to meet the residency requirement.

(6) Definitions applicable to paragraph (d) of this section are as follows:

Eligible for benefits means that an individual satisfies the criteria described in subpart D of this part for benefits at a particular time except that the person need not have applied for those benefits at that time.

Other parent for purposes of paragraph (d)(1)(ii) of this section means any other living parent who is of the opposite sex of the worker and who is the adoptive parent by whom the child was adopted before the child attained age 16 and who is or was the spouse of the person on whose earnings record

the child is entitled; or the natural mother or natural father of the child; or the step-parent of the child by a marriage, contracted before the child attained age 16, to the natural or adopting parent on whose earnings record the child is entitled. (Note: Based on this definition, a child may have more than one living *other parent*. However, the child's benefit will be payable for a month if in that month he or she has one *other parent* who had resided in the U.S. for at least 5 years.)

Resided in the United States for satisfying the residency requirement means presence in the United States with the intention of establishing at least a temporary home. A period of residence begins upon arrival in the United States with that intention and continues so long as an attachment to an abode in the United States is maintained, accompanied by actual physical presence in the United States for a significant part of the period, and ending the day of departure from the United States with the intention to reside elsewhere. The period need not have been continuous and the requirement is satisfied if the periods of U.S. residence added together give a total of 5 full years.

(7) The provisions described in paragraph (d) of this section shall not apply if the beneficiary is a citizen or resident of a country with which the United States has a totalization agreement in force, except to the extent provided by that agreement.

[32 FR 19159, Dec. 20, 1967, as amended at 34 FR 13366, Aug. 19, 1969; 52 FR 8249, Mar. 17, 1987; 52 FR 26145, July 13, 1987; 60 FR 17445, Apr. 6, 1995; 62 FR 38450, July 18, 1997; 69 FR 51555, Aug. 20, 2004; 74 FR 48856, Sept. 25, 2009; 83 FR 21709, May 10, 2018]

§ 404.461 Nonpayment of lump sum after death of alien outside United States for more than 6 months.

Where an individual dies outside the United States after January 1957 and no monthly benefit was or could have been paid to him for the month preceding the month in which he died because of the provisions described in § 404.460, no lump-sum death payment may be made upon the basis of the individual's earnings record.

§ 404.462 Nonpayment of hospital and medical insurance benefits of alien outside United States for more than 6 months.

No payments may be made under part A (hospital insurance benefits) of title XVIII for items or services furnished to an individual in any month for which the prohibition described in § 404.460 against payment of benefits to an individual outside the United States for more than six full consecutive calendar months is applicable (or would be if he were entitled to any such benefits). Also, no payments may be made under part B (supplementary medical insurance benefits) of title XVIII for expenses incurred by an individual during any month the individual is not paid a monthly benefit by reason of the provisions described in § 404.460 or for which no monthly benefit would be paid if he were otherwise entitled thereto.

§ 404.463 Nonpayment of benefits of aliens outside the United States; "foreign social insurance system," and "treaty obligation" exceptions defined.

(a) *Foreign social insurance system exception.* The following criteria are used to evaluate the social insurance or pension system of a foreign country to determine whether the exception described in § 404.460(b) to the alien nonpayment provisions applies:

(1) *Social insurance or pension system.* A *social insurance system* means a governmental plan which pays benefits as an earned right, on the basis either of contributions or work in employment covered under the plan, without regard to the financial need of the beneficiary. However, a plan of this type may still be regarded as a *social insurance system* though it may provide, in a subordinate fashion, for a supplemental payment based on need. A *pension system* means a governmental plan which pays benefits based on residence or age, or a private employer's plan for which the government has set up uniform standards for coverage, contributions, eligibility, and benefit amounts provided that, in both of these types of plans, the financial need of the beneficiary is not a consideration.

(2) *In effect.* The social insurance or pension system of the foreign country must be *in effect.* This means that the foreign social insurance or pension system is in full operation with regard to taxes (or contributions) and benefits, or is in operation with regard to taxes (or contributions), and provision is made for payments to begin immediately upon the expiration of the period provided in the law for acquiring earliest eligibility. It is not *in effect* if the law leaves the beginning of operation to executive or other administrative action; nor is it in effect if the law has been temporarily suspended.

(3) *General application.* The term *of general application* means that the social insurance or pension system (or combination of systems) covers a substantial portion of the paid labor force in industry and commerce, taking into consideration the industrial classification and size of the paid labor force and the population of the country, as well as occupational, size of employer, and geographical limitations on coverage.

(4) *Periodic benefit or actuarial equivalent.* The term *periodic benefit* means a benefit payable at stated regular intervals of time such as weekly, biweekly, or monthly. *Actuarial equivalent* of a periodic benefit means the commutation of the value of the periodic benefit into a lump-sum payment, taking life expectancy and interest into account.

(5) *Benefits payable on account of old age, retirement, or death.* The requirement that benefits be payable *on account of old age, retirement, or death,* is satisfied if the foreign social insurance plan or system includes provision for payment of benefits to aged or retired persons and to dependents and survivors of covered workers. The requirement is also met where the system pays benefits based only on old age or retirement. The requirement is not met where the only benefits payable are workmen's compensation payments, cash sickness payments, unemployment compensation payments, or maternity insurance benefits.

(6) *System under which U.S. citizens who qualify may receive payment while outside the foreign country.* The foreign social insurance or pension system must permit payments to qualified U.S. citizens while outside such foreign country, regardless of the duration of their absence therefrom and must make the payments without restriction or qualification to these U.S. citizens at full rate, or at the full actuarial value. The foreign system is considered to pay benefits at the full rate if the U.S. citizen receives the full benefit rate in effect for qualified beneficiaries at the time of his award, whether he is then inside or outside the paying country; and he continues to receive the same benefit amount so long as he remains outside that country, even though he may not receive any increases going into effect after his award provided that in those other countries in which such increases are denied to beneficiaries, they are denied to all beneficiaries including nationals of the paying country.

(7) *List of countries which meet the social insurance or pension system exception in section 202(t)(2) of the act.* The following countries have been found to have in effect a social insurance or pension system which meets the requirements of section 202(t)(2) of the Act. Unless otherwise specified, each country meets such requirements effective January 1957. The effect of these findings is that beneficiaries who are citizens of such countries and not citizens of the United States may be paid benefits regardless of the duration of their absence from the United States unless for months beginning after June 1968 they are residing in a country to which payments to individuals are being withheld by the Treasury Department pursuant to the first section of the Act of October 9, 1940 (31 U.S.C. 123). Further additions to or deletions from the list of countries will be published in the FEDERAL REGISTER.

Antigua and Barbuda (effective November 1981)
Argentina (effective July 1968)
Austria (except from January 1958 through June 1961)
Bahamas, Commonwealth of the (effective October 1974)
Barbados (effective July 1968)
Belgium (effective July 1968)
Belize (effective September 1981)
Bolivia
Brazil
Burkina Faso, Republic of (formerly Upper Volta)
Canada (effective January 1966)
Chile

Colombia (effective January 1967)
Costa Rica (effective May 1962)
Cyprus (effective October 1964)
Czechoslovakia (effective July 1968)
Denmark (effective April 1964)
Dominica (effective November 1978)
Dominican Republic (effective November 1984)
Ecuador
El Salvador (effective January 1969)
Finland (effective May 1968)
France (effective June 1968)
Gabon (effective June 1964)
Grenada (effective April 1983)
Guatemala (effective October 1978)
Guyana (effective September 1969)
Iceland (effective December 1980)
Ivory Coast
Jamaica (effective July 1968)
Liechtenstein (effective July 1968)
Luxembourg
Malta (effective September 1964)
Mexico (effective March 1968)
Monaco
Netherlands (effective July 1968)
Nicaragua (effective May 1986)
Norway (effective June 1968)
Panama
Peru (effective February 1969)
Philippines (effective June 1960)
Poland (effective March 1957)
Portugal (effective May 1968)
San Marino (effective January 1965)
Spain (effective May 1966)
St. Christopher and Nevis (effective September 1983)
St. Lucia (effective August 1984)
Sweden (effective July 1966)
Switzerland (effective July 1968)
Trinidad and Tobago (effective July 1975)
Trust Territory of the Pacific Islands (Micronesia) (effective July 1976)
Turkey
United Kingdom
Western Samoa (effective August 1972)
Yugoslavia
Zaire (effective July 1961) (formerly Congo (Kinshasa))

(b) *The ''treaty obligation'' exception.* It is determined that the Treaties of Friendship, Commerce, and Navigation now in force between the United States and the Federal Republic of Germany, Greece, the Republic of Ireland, Israel, Italy, and Japan, respectively, create treaty obligations precluding the application of § 404.460(a) to citizens of such countries; and that the Treaty of Friendship, Commerce, and Navigation now in force between the United States and the Kingdom of the Netherlands creates treaty obligations precluding the application of § 404.460(a) to citizens of that country with respect to monthly survivors benefits only. There is no treaty obligation that would preclude the application of § 404.460(a) to citizens of any country other than those listed above.

[32 FR 19159, Dec. 20, 1967, as amended at 43 FR 2628, Jan. 18, 1978; 52 FR 8249, Mar. 17, 1987]

§ 404.464 How does deportation or removal from the United States affect the receipt of benefits?

(a) *Old-age or disability insurance benefits.* (1) You cannot receive an old-age or disability benefit for any month that occurs after the month we receive notice from the Secretary of Homeland Security or the Attorney General of the United States that you were:

(i) Deported under the provisions of section 241(a) of the Immigration and Nationality Act (INA) that were in effect before April 1, 1997, unless your deportation was under:

(A) Paragraph (1)(C) of that section; or

(B) Paragraph (1)(E) of that section and we received notice of your deportation under this paragraph before March 3, 2004;

(ii) Removed as deportable under the provisions of section 237(a) of the INA as in effect beginning April 1, 1997, unless your removal was under:

(A) Paragraph (1)(C) of that section; or

(B) Paragraph (1)(E) of that section and we received notice of your removal under this paragraph before March 3, 2004; or

(iii) Removed as inadmissible under the provisions of section 212(a)(6)(A) of the INA as in effect beginning April 1, 1997.

(2) Benefits that cannot be paid to you because of your deportation or removal under paragraph (a)(1) of this section may again be payable for any month subsequent to your deportation or removal that you are lawfully admitted to the United States for permanent residence. You are considered lawfully admitted for permanent residence as of the month you enter the United States with permission to reside here permanently.

(b) *Dependents or survivors benefits.* If an insured person on whose record you are entitled cannot be paid (or could

not have been paid while still alive) an old-age or disability benefit for a month(s) because of his or her deportation or removal under paragraph (a)(1) of this section, you cannot be paid a dependent or survivor benefit on the insured person's record for that month(s) unless:

(1) You are a U.S citizen; or

(2) You were present in the United States for the entire month. (This means you were not absent from the United States for any period during the month, no matter how short.)

(c) *Lump sum death payment.* A lump sum death payment cannot be paid on the record of a person who died:

(1) In or after the month we receive from the Secretary of Homeland Security or the Attorney General of the United States notice of his or her deportation or removal under the provisions of the INA specified in paragraph (a)(1) of this section (excluding the exceptions under paragraphs (a)(1)(i)(A) and (B) and (ii)(A) and (B) of this section); and

(2) Before the month in which the deceased person was thereafter lawfully admitted to the United States for permanent residence.

[70 FR 16411, Mar. 31, 2005]

§ 404.465 Conviction for subversive activities; effect on monthly benefits and entitlement to hospital insurance benefits.

(a) *Effect of conviction.* Where an individual is convicted of any offense (committed after August 1, 1956) under chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 U.S.C., or under section 4, 112, or 113 of the Internal Security Act of 1950, as amended, the court, in addition to all other penalties provided by law, may order that, in determining whether any monthly benefit is payable to the individual for the month in which he is convicted or for any month thereafter, and in determining whether the individual is entitled to hospital insurance benefits under part A of title XVIII for any such month, and in determining the amount of the benefit for that month, the following are not to be taken into account:

(1) Any wages paid to such individual, or to any other individual, in the calendar quarter in which such conviction occurred or in any prior calendar quarter, and

(2) Any net earnings from self-employment derived by the individual, or any other individual, during the taxable year in which the conviction occurred or during any prior taxable year.

(b) *Recalculation of benefit.* When notified by the Attorney General that the additional penalty as described in paragraph (a) of this section has been imposed against any individual entitled to benefits under section 202 or section 223 of the Act (see subpart D), the Administration, for the purposes of determining the individual's entitlement to such benefits as of the month in which convicted and the amount of the benefit, will exclude the applicable wages and net earnings in accordance with the order of the court.

(c) *Effect of pardon.* In the event that an individual, with respect to whom the additional penalty as described in paragraph (a) of this section has been imposed, is granted a pardon of the offense by the President of the United States, such penalty is not applied in determining such individual's entitlement to benefits, and the amount of such benefit, for any month beginning after the date on which the pardon is granted.

§ 404.466 Conviction for subversive activities; effect on enrollment for supplementary medical insurance benefits.

An individual may not enroll under part B (supplementary medical insurance benefits) of title XVIII if he has been convicted of any offense described in § 404.465.

§ 404.467 Nonpayment of benefits; individual entitled to disability insurance benefits or childhood disability benefits based on statutory blindness is engaging in substantial gainful activity.

(a) *Disability insurance benefits.* An individual who has attained age 55 and who meets the definition of disability for disability insurance benefits purposes based on *statutory blindness,* as defined in § 404.1581, may be entitled to

disability insurance benefits for months in which he is engaged in certain types of substantial gainful activity. No payment, however, may be made to the individual or to beneficiaries entitled to benefits on his earnings record for any month in which such individual engages in any type of substantial gainful activity.

(b) *Childhood disability benefits.* An individual who has attained age 55 and who meets the definition of disability prescribed in §404.1583 for childhood disability benefits on the basis of statutory blindness may be entitled to childhood disability benefits for months in which he engages in certain types of substantial gainful activity. However, no payment may be made to such individual for any month after December 1972 in which such individual engages in substantial gainful activity.

[39 FR 43715, Dec. 18, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§ 404.468 Nonpayment of benefits to prisoners.

(a) *General.* No monthly benefits will be paid to any individual for any month any part of which the individual is confined in a jail, prison, or other penal institution or correctional facility for conviction of a felony. This rule applies to disability benefits (§404.315) and child's benefits based on disability (§404.350) effective with benefits payable for months beginning on or after October 1, 1980. For all other monthly benefits, this rule is effective with benefits payable for months beginning on or after May 1, 1983. However, it applies only to the prisoner; benefit payments to any other person who is entitled on the basis of the prisoner's wages and self-employment income are payable as though the prisoner were receiving benefits.

(b) *Felonious offenses.* An offense will be considered a felony if—

(1) It is a felony under applicable law: or

(2) In a jurisdiction which does not classify any crime as a felony, it is an offense punishable by death or imprisonment for a term exceeding one year.

(c) *Confinement.* In general, a jail, prison, or other penal institution or correctional facility is a facility which is under the control and jurisdiction of the agency in charge of the penal system or in which convicted criminals can be incarcerated. Confinement in such a facility continues as long as the individual is under a sentence of confinement and has not been released due to parole or pardon. An individual is considered confined even though he or she is temporarily or intermittently outside of that facility (e.g., on work release, attending school, or hospitalized).

(d) *Vocational rehabilitation exception.* The nonpayment provision of paragraph (a) of this section does not apply if a prisoner who is entitled to benefits on the basis of disability is actively and satisfactorily participating in a rehabilitation program which has been specifically approved for the individual by court of law. In addition, the Commissioner must determine that the program is expected to result in the individual being able to do substantial gainful activity upon release and within a reasonable time. No benefits will be paid to the prisoner for any month prior to the approval of the program.

[49 FR 48182, Dec. 11, 1984, as amended at 62 FR 38450, July 18, 1997]

§ 404.469 Nonpayment of benefits where individual has not furnished or applied for a Social Security number.

No monthly benefits will be paid to an entitled individual unless he or she either furnishes to the Social Security Administration (SSA) satisfactory proof of his or her Social Security number, or, if the individual has not been assigned a number, he or she makes a proper application for a number (see §422.103). An individual submits satisfactory proof of his or her Social Security number by furnishing to SSA the number and sufficient additional information that can be used to determine whether that Social Security number or another number has been assigned to the individual. Sufficient additional information may include the entitled individual's date and place of birth, mother's maiden name, and father's name. If the individual does not know his or her Social Security number, SSA will use this additional information to determine the Social Security number, if any, that it

assigned to the individual. This rule applies to individuals who become entitled to benefits beginning on or after June 1, 1989.

[56 FR 41789, Aug. 23, 1991]

§ 404.470 Nonpayment of disability benefits due to noncompliance with rules regarding treatment for drug addiction or alcoholism.

(a) *Suspension of monthly benefits.* (1) For an individual entitled to benefits based on a disability (§ 404.1505) and for whom drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), monthly benefits will be suspended beginning with the first month after we notify the individual in writing that he or she has been determined not to be in compliance with the treatment requirements for such individuals (§ 404.1536).

(2) This rule applies to all individuals entitled to disability benefits (§ 404.315), widow(er)'s benefits (§ 404.335), and child's benefits based on a disability (§ 404.350) effective with benefits paid in months beginning on or after March 1, 1995.

(3) Benefit payments to any other person who is entitled on the basis of a disabled wage earner's entitlement to disability benefits are payable as though the disabled wage earner were receiving benefits.

(b) *Resumption of monthly benefits.* The payment of benefits may be resumed only after an individual demonstrates and maintains compliance with appropriate treatment requirements for:

(1) 2 consecutive months for the first determination of noncompliance;

(2) 3 consecutive months for the second determination of noncompliance; and

(3) 6 consecutive months for the third and all subsequent determinations of noncompliance.

(c) *Termination of benefits.* (1) A suspension of benefit payments due to noncompliance with the treatment requirements for 12 consecutive months will result in termination of benefits effective with the first month following the 12th month of suspension of benefits.

(2) Benefit payments to any other person who is entitled on the basis of a disabled wage earner's entitlement to disability benefits are payable as though the disabled wage earner were receiving benefits.

[60 FR 8146, Feb. 10, 1995]

§ 404.471 Nonpayment of disability benefits for trial work period service months upon a conviction of fraudulently concealing work activity.

(a) *Nonpayment of benefits during the trial work period.* Beginning with work activity performed in March 2004 and thereafter, if you are convicted by a Federal court of fraudulently concealing your work activity and the concealment of the work activity occurred while you were in a trial work period, monthly disability benefits under title II of the Social Security Act are not payable for months in which you performed services during that trial work period prior to the conviction (see § 404.1592 for a definition of a trial work period and services). Benefits already received for months of work activity in the trial work period prior to the conviction and in the same period of disability during which the fraudulently concealed work activity occurred, will be considered an overpayment on the record.

(b) *Concealment of work activity.* You can be found to be fraudulently concealing work activity if—

(1) You provide false information to us concerning the amount of earnings you received or are receiving for a particular period;

(2) You received or are receiving disability benefits while engaging in work activity under another identity (this would include working under another social security number or a forged social security number); or

(3) You take other actions to conceal work activity with the intent of fraudulently obtaining benefits in excess of amounts that are due.

[71 FR 66866, Nov. 17, 2006]

§ 404.480 Paying benefits in installments: Drug addiction or alcoholism.

(a) *General.* For disabled beneficiaries who receive benefit payments through

a representative payee because drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), certain amounts due the beneficiary for a past period will be paid in installments. The amounts subject to payment in installments include:

(1) Benefits due but unpaid which accrued prior to the month payment was effectuated;

(2) Benefits due but unpaid which accrued during a period of suspension for which the beneficiary was subsequently determined to have been eligible; and

(3) Any adjustment to benefits which results in an accrual of unpaid benefits.

(b) *Installment formula.* Except as provided in paragraph (c) of this section, the amount of the installment payment in any month is limited so that the sum of (1) the amount due for a past period (and payable under paragraph (a) of this section) paid in such month and (2) the amount of any benefit due for the preceding month under such entitlement which is payable in such month, does not exceed two times the amount of the beneficiary's benefit payment for the preceding month. In counting the amount of the beneficiary's benefit payment for the previous month, no reductions or deductions under this title are taken into account.

(c) *Exception to installment limitation.* An exception to the installment payment limitation in paragraph (b) of this section can be granted for the first month in which a beneficiary accrues benefit amounts subject to payment in installments if the beneficiary has unpaid housing expenses which result in a high risk of homelessness for the beneficiary. In that case, the benefit payment may be increased by the amount of the unpaid housing expenses so long as that increase does not exceed the amount of benefits which accrued during the most recent period of nonpayment. We consider a person to be at risk of homelessness if continued nonpayment of the outstanding housing expenses is likely to result in the person losing his or her place to live or if past nonpayment of housing expenses has resulted in the person having no appropriate personal place to live. In determining whether this exception applies, we will ask for evidence of outstanding housing expenses that shows that the person is likely to lose or has already lost his or her place to live. For purposes of this section, homelessness is the state of not being under the control of any public institution and having no appropriate personal place to live. Housing expenses include charges for all items required to maintain shelter (for example, mortgage payments, rent, heating fuel, and electricity).

(d) *Payment through a representative payee.* If the beneficiary does not have a representative payee, payment of amounts subject to installments cannot be made until a representative payee is selected.

(e) *Underpaid beneficiary no longer entitled.* In the case of a beneficiary who is no longer currently entitled to monthly payments, but to whom amounts defined in paragraph (a) of this section are still owing, we will treat such beneficiary's monthly benefit for the last month of entitlement as the beneficiary's benefit for the preceding month and continue to make installment payments of such benefits through a representative payee.

(f) *Beneficiary currently not receiving Social Security benefits because of suspension for noncompliance with treatment.* If a beneficiary is currently not receiving benefits because his or her benefits have been suspended for noncompliance with treatment (as defined in § 404.1536), the payment of amounts under paragraph (a) of this section will stop until the beneficiary has demonstrated compliance with treatment as described in § 404.470 and will again commence with the first month the beneficiary begins to receive benefit payments.

(g) *Underpaid beneficiary deceased.* Upon the death of a beneficiary, any remaining unpaid amounts as defined in paragraph (a) of this section will be treated as underpayments in accordance with § 404.503(b).

[60 FR 8146, Feb. 10, 1995]

Subpart F—Overpayments, Underpayments, Waiver of Adjustment or Recovery of Overpayments, and Liability of a Certifying Officer

AUTHORITY: Secs. 204, 205(a), 702(a)(5), and 1147 of the Social Security Act (42 U.S.C. 404, 405(a), 902(a)(5), and 1320b–17); 31 U.S.C. 3711; 31 U.S.C. 3716; 31 U.S.C. 3720A.

§ 404.501 General applicability of section 204 of the Act.

(a) *In general.* Section 204 of the Act provides for adjustment as set forth in §§ 404.502 and 404.503, in cases where an individual has received more or less than the correct payment due under title II of the Act. As used in this subpart, the term *overpayment* includes a payment in excess of the amount due under title II of the Act, a payment resulting from the failure to impose deductions or to suspend or reduce benefits under sections 203, 222(b), 224, and 228(c), and (d), and (e) of the Act (see subpart E of this part), a payment pursuant to section 205(n) of the Act in an amount in excess of the amount to which the individual is entitled under section 202 or 223 of the Act, a payment resulting from the failure to terminate benefits, and a payment where no amount is payable under title II of the Act. The term *pandemic period* as used throughout this subpart for the purposes of the waiver authority in § 404.506(b) refers exclusively to the period of time beginning on March 1, 2020, and ending on September 30, 2020. The term *underpayment* as used in this subpart refers only to monthly insurance benefits and includes nonpayment where some amount of such benefits was payable. An underpayment may be in the form of an accrued unpaid benefit amount for which no check has been drawn or in the form of an unnegotiated check payable to a deceased individual. The provisions for adjustment also apply in cases where through error:

(1) A reduction required under section 202(j)(1), 202(k)(3), 203(a), or 205(n) of the Act is not made, or

(2) An increase or decrease required under section 202(d)(2), or 215 (f) or (g) of the Act is not made, or

(3) A deduction required under section 203(b) (as may be modified by the provisions of section 203(h)), 203(c), 203(d), 203(i), 222(b), or 223(a)(1)(D) of the Act or section 907 of the Social Security Amendments of 1939 is not made, or

(4) A suspension required under section 202(n) or 202(t) of the Act is not made, or

(5) A reduction under section 202(q) of the Act is not made, or

(6) A reduction, increase, deduction, or suspension is made which is either more or less than required, or

(7) A payment in excess of the amount due under title XVIII of the Act was made to or on behalf of an individual (see 42 CFR 405.350 through 405.351) entitled to benefits under title II of the Act, or

(8) A payment of past due benefits is made to an individual and such payment had not been reduced by the amount of attorney's fees payable directly to an attorney under section 206 of the Act (see § 404.977).

(9) A reduction under § 404.408b is made which is either more or less than required.

(b) *Payments made on the basis of an erroneous report of death.* Any monthly benefit or lump sum paid under title II of the Act on the basis of an erroneous report by the Department of Defense of the death of an individual in the line of duty while such individual was a member of the uniformed services (as defined in section 210(m) of the Act) on active duty (as defined in section 210(l) of the Act) is deemed a correct payment for any month prior to the month such Department notifies the Administration that such individual is alive.

(c) *Payments made by direct deposit to a financial institution.* When a payment in excess of the amount due under title II of the Act is made by direct deposit to a financial institution to or on behalf of an individual who has died, and the financial institution credits the payment to a joint account of the deceased individual and another person who was entitled to a monthly benefit on the basis of the same earnings record as the deceased individual for the month before the month in which the deceased individual died, the amount of the payment in excess of the

correct amount will be an overpayment to the other person.

[34 FR 14887, Sept. 27, 1969, as amended at 44 FR 34942, June 18, 1979; 47 FR 4988, Feb. 3, 1982; 48 FR 46149, Oct. 11, 1983; 55 FR 7313, Mar. 1, 1990; 85 FR 52914, Aug. 27, 2020]

§ 404.502 Overpayments.

Upon determination that an overpayment has been made, adjustments will be made against monthly benefits and lump sums as follows:

(a) *Individual overpaid is living.* (1) If the individual to whom an overpayment was made is at the time of a determination of such overpayment entitled to a monthly benefit or a lump sum under title II of the Act, or at any time thereafter becomes so entitled, no benefit for any month and no lump sum is payable to such individual, except as provided in paragraphs (c) and (d) of this section, until an amount equal to the amount of the overpayment has been withheld or refunded. Such adjustments will be made against any monthly benefit or lump sum under title II of the Act to which such individual is entitled whether payable on the basis of such individual's earnings or the earnings of another individual.

(2) If any other individual is entitled to benefits for any month on the basis of the same earnings as the overpaid individual, except as adjustment is to be effected pursuant to paragraphs (c) and (d) of this section by withholding a part of the monthly benefit of either the overpaid individual or any other individual entitled to benefits on the basis of the same earnings, no benefit for any month will be paid on such earnings to such other individual until an amount equal to the amount of the overpayment has been withheld or refunded.

(3) If a representative payee receives a payment on behalf of a beneficiary after that beneficiary dies, the representative payee or his estate is solely liable for repaying the overpayment. If the representative payee is entitled to a monthly benefit or a lump sum under title II of the Act at the time we determine that an overpayment exists or at any time thereafter, except as provided in paragraphs (c) and (d) of this section, we will not pay the monthly benefits or the lump sum to the representative payee until the amount of the overpayment has been repaid. We will make such adjustments against any monthly benefit or lump sum under title II of the Act to which the representative payee is entitled whether payable on the basis of such representative payee's earnings or the earnings of another individual.

(b) *Individual overpaid dies before adjustment.* If an overpaid individual dies before adjustment is completed under the provisions of paragraph (a) of this section, no lump sum and no subsequent monthly benefit will be paid on the basis of earnings which were the basis of the overpayment to such deceased individual until full recovery of the overpayment has been effected, except as provided in paragraphs (c) and (d) of this section or under § 404.515. Such recovery may be effected through:

(1) Payment by the estate of the deceased overpaid individual,

(2) Withholding of amounts due the estate of such individual under title II of the Act,

(3) Withholding a lump sum or monthly benefits due any other individual on the basis of the same earnings which were the basis of the overpayment to the deceased overpaid individual, or

(4) Any combination of the amount above.

(5) The methods in paragraphs (b)(1) and (b)(2) of this section for overpayments owed by a representative payee for payments made after the beneficiary's death. We will not recover such overpayments from any person other than the individual who was representative payee or his estate, but we may recover these overpayments from such other person under § 404.503(b).

(c) *Adjustment by withholding part of a monthly benefit.* (1) Where it is determined that withholding the full amount each month would *defeat the purpose of title II, i.e.*, deprive the person of income required for ordinary and necessary living expenses (see § 404.508), adjustment under paragraphs (a) and (b) of this section may be effected by withholding an amount of not less than $10 of the monthly benefit payable to an individual.

(2) Adjustment as provided by this paragraph will not be available if the overpayment was caused by the individual's intentional false statement or representation, or willful concealment of, or deliberate failure to furnish, material information. In such cases, recovery of the overpayment will be accomplished as provided in paragraph (a) of this section.

(d) *Individual overpaid enrolled under supplementary insurance plan.* Notwithstanding the provisions of paragraphs (a), (b), and (c) of this section, if the individual liable for the overpayment is an enrollee under part B of title XVIII of the Act and the overpayment was not caused by such individual's intentional false statement or representation, or willful concealment of, or deliberate failure to furnish, material information, an amount of such individual's monthly benefit which is equal to his obligation for supplementary medical insurance premiums will be applied toward payment of such premiums, and the balance of the monthly benefit will be applied toward recovery of the overpayment. Further adjustment with respect to such balance may be made if the enrollee so requests and meets the conditions of paragraph (c) of this section.

[35 FR 5943, Apr. 10, 1970, as amended at 44 FR 20653, Apr. 6, 1979; 73 FR 65542, Nov. 4, 2008]

§ 404.502a Notice of right to waiver consideration.

Whenever an initial determination is made that more than the correct amount of payment has been made, and we seek adjustment or recovery of the overpayment, the individual from whom we are seeking adjustment or recovery is immediately notified. The notice includes:

(a) The overpayment amount and how and when it occurred;

(b) A request for full, immediate refund, unless the overpayment can be withheld from the next month's benefit;

(c) The proposed adjustment of benefits if refund is not received within 30 days after the date of the notice and adjustment of benefits is available;

(d) An explanation of the availability of a different rate of withholding when full withholding is proposed, installment payments when refund is requested and adjustment is not currently available, and/or cross-program recovery when refund is requested and the individual is receiving another type of payment from SSA (language about cross-program recovery is not included in notices sent to individuals in jurisdictions where this recovery option is not available);

(e) An explanation of the right to request waiver of adjustment or recovery and the automatic scheduling of a file review and pre-recoupment hearing (commonly referred to as a personal conference) if a request for waiver cannot be approved after initial paper review;

(f) An explanation of the right to request reconsideration of the fact and/or amount of the overpayment determination;

(g) Instructions about the availability of forms for requesting reconsideration and waiver;

(h) An explanation that if the individual does not request waiver or reconsideration within 30 days of the date of the overpayment notice, adjustment or recovery of the overpayment will begin;

(i) A statement that an SSA office will help the individual complete and submit forms for appeal or waiver requests; and

(j) A statement that the individual receiving the notice should notify SSA promptly if reconsideration, waiver, a lesser rate of withholding, repayment by installments or cross-program adjustment is wanted.

[61 FR 56131, Oct. 31, 1996]

§ 404.503 Underpayments.

Underpayments will be adjusted as follows:

(a) *Individual underpaid is living.* If an individual to whom an underpayment is due is living, the amount of such underpayment will be paid to such individual either in a single payment (if he is not entitled to a monthly benefit or a lump-sum death payment) or by increasing one or more monthly benefits or a lump-sum death payment to which such individual is or becomes entitled. However, if we determine that the individual to whom an underpayment is

due also received an overpayment as defined in § 404.501(a) for a different period, we will apply any underpayment due the individual to reduce that overpayment, unless we have waived recovery of the overpayment under the provisions of §§ 404.506 through 404.512.

(b) *Individual dies before adjustment of underpayment.* If an individual who has been underpaid dies before receiving payment or negotiating a check or checks representing such payment, we first apply any amounts due the deceased individual against any overpayments as defined in § 404.501(a) owed by the deceased individual, unless we have waived recovery of such overpayment under the provisions of §§ 404.506 through 404.512. We then will distribute any remaining underpayment to the living person (or persons) in the highest order of priority as follows:

(1) The deceased individual's surviving spouse as defined in section 216(c), (g), or (h) of the Act who was either:

(i) Living in the same household (as defined in § 404.347) with the deceased individual at the time of such individual's death, or

(ii) Entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died.

(2) The child or children of the deceased individual (as defined in section 216 (e) or (h) of the Act) entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died (if more than one such child, in equal shares to each such child).

(3) The parent or parents of the deceased individual, entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died (if more than one such parent, in equal shares to each such parent). For this purpose, the definition of ''parent'' in § 404.374 includes the parent(s) of any deceased individual who was entitled to benefits under title II of the Act.

(4) The surviving spouse of the deceased individual (as defined in section 216(c), (g), or (h) of the Act) who does not qualify under paragraph (b)(1) of this section.

(5) The child or children of the deceased individual (as defined in section 216 (e) or (h) of the Act) who do not qualify under paragraph (b)(2) of this section (if more than one such child, in equal shares to each such child).

(6) The parent or parents of the deceased individual, who do not qualify under paragraph (b)(3) of this section (if more than one such parent, in equal shares to each such parent). For this purpose, the definition of ''parent'' in § 404.374 includes the parent(s) of any deceased individual who was entitled to benefits under title II of the Act.

(7) The legal representative of the estate of the deceased individual as defined in paragraph (d) of this section.

(c) In the event that a person who is otherwise qualified to receive an underpayment under the provisions of paragraph (b) of this section, dies before receiving payment or before negotiating the check or checks representing such payment, his share of the underpayment will be divided among the remaining living person(s) in the same order of priority. In the event that there is (are) no other such person(s), the underpayment will be paid to the living person(s) in the next lower order of priority under paragraph (b) of this section.

(d) *Definition of legal representative.* The term *legal representative*, for the purpose of qualifying to receive an underpayment, generally means the administrator or executor of the estate of the deceased individual. However, it may also include an individual, institution or organization acting on behalf of an unadministered estate, provided that such person can give the Administration good acquittance (as defined in paragraph (e) of this section). The following persons may qualify as legal representative for the purposes of this subpart, provided they can give the Administration good acquittance:

(1) A person who qualifies under a State's *small estate* statute,

(2) A person resident in a foreign country who, under the laws and customs of that country, has the right to receive assets of the estate,

(3) A public administrator, or

(4) A person who has the authority, under applicable law, to collect the assets of the estate of the deceased individual.

(e) *Definition of ''good acquittance.''* A person is considered to give the Administration *good acquittance* when payment to that person will release the Administration from further liability for such payment.

[34 FR 14487, Sept. 27, 1969, as amended at 35 FR 14129, Sept. 5, 1970; 55 FR 7313, Mar. 1, 1990; 60 FR 17445, Apr. 6, 1995; 73 FR 65543, Nov. 4, 2008]

§ 404.504 Relation to provisions for reductions and increases.

The amount of an overpayment or underpayment is the difference between the amount paid to the beneficiary and the amount of the payment to which the beneficiary was actually entitled. Such payment, for example, would be equal to the difference between the amount of a benefit in fact paid to the beneficiary and the amount of such benefit as reduced under section 202(j)(1), 202(k)(3), 203(a), or 224(a), or as increased under section 202(d)(2), 202(m), or 215 (f) and (g). In effecting an adjustment with respect to an overpayment, no amount can be considered as having been withheld from a particular benefit which is in excess of the amount of such benefit as so decreased.

[34 FR 14888, Sept. 27, 1969]

§ 404.505 Relationship to provisions requiring deductions.

Adjustments required by any of the provisions in this subpart F are made in addition to, but after, any deductions required by section 202(t), 203(b), 203(c), 203(d), and 222(b) of the Act, or section 907 of the Social Security Act Amendments of 1939, and before any deductions required by section 203(g) or 203(h)(2) of the Act.

[34 FR 14888, Sept. 27, 1969]

§ 404.506 When waiver may be applied and how to process the request.

(a) Section 204(b) of the Act provides that there shall be no adjustment or recovery in any case where an overpayment under title II has been made to an individual who is without fault if adjustment or recovery would either defeat the purpose of title II of the Act, or be against equity and good conscience.

(b) We will apply the procedures in this paragraph (b) when an individual requests waiver of all or part of a qualifying overpayment.

(1) For purposes of this paragraph (b), a qualifying overpayment is one that accrued during the *pandemic period* (see § 404.501(a)) because of the actions that we took in response to the COVID–19 national public health emergency, including the suspension of certain of our manual workloads that would have processed actions identifying and stopping certain overpayments.

(2) Notwithstanding any other provision of this subpart, we will presume that an individual who requests waiver of a qualifying overpayment is without fault in causing the overpayment (see § 404.507) unless we determine that the qualifying overpayment made to a beneficiary or a representative payee was the result of fraud or similar fault or involved misuse of benefits by a representative payee (see § 404.2041).

(3) If we determine under paragraph (b)(2) of this section that an individual or a representative payee is without fault in causing a qualifying overpayment we will also determine that recovery of the qualifying overpayment would be against equity and good conscience. For purposes of this paragraph (b)(3) only, ''against equity and good conscience'' is not limited to the meaning used in § 404.509 but means a broad concept of fairness that takes into account all of the facts and circumstances of the case.

(4) If we determine that a primary beneficiary is not without fault with respect to a qualifying overpayment under paragraph (b)(2) of this section, because it was caused by fraud or similar fault or because of representative payee misuse, we may still find that any auxiliary beneficiaries on the primary beneficiary's record are eligible for waiver of recovery of the qualifying overpayment under this paragraph (b). If an auxiliary beneficiary requests waiver of a qualifying overpayment in accordance with this paragraph (b), we will waive recovery of the overpayment if the auxiliary beneficiary meets all of the requirements of this paragraph (b).

(5) The provisions of this paragraph (b) will apply to a qualifying overpayment identified by December 31, 2020.

(c) If an individual requests waiver of adjustment or recovery of a title II overpayment within 30 days after receiving a notice of overpayment that contains the information in §404.502a, no adjustment or recovery action will be taken until after the initial waiver determination is made. If the individual requests waiver more than 30 days after receiving the notice of overpayment, SSA will stop any adjustment or recovery actions until after the initial waiver determination is made.

(d) When waiver is requested, the individual gives SSA information to support his/her contention that he/she is without fault in causing the overpayment (see §404.507) and that adjustment or recovery would either defeat the purpose of title II of the Act (see §404.508) or be against equity and good conscience (see §404.509). That information, along with supporting documentation, is reviewed to determine if waiver can be approved. If waiver cannot be approved after this review, the individual is notified in writing and given the dates, times and place of the file review and personal conference; the procedure for reviewing the claims file prior to the personal conference; the procedure for seeking a change in the scheduled dates, times, and/or place; and all other information necessary to fully inform the individual about the personal conference. The file review is always scheduled at least 5 days before the personal conference. We will offer to the individual the option of conducting the personal conference face-to-face at a place we designate, by telephone, or by video teleconference. The notice will advise the individual of the date and time of the personal conference.

(e) At the file review, the individual and the individual's representative have the right to review the claims file and applicable law and regulations with the decisionmaker or another SSA representative who is prepared to answer questions. We will provide copies of material related to the overpayment and/or waiver from the claims file or pertinent sections of the law or regulations that are requested by the individual or the individual's representative.

(f) At the personal conference, the individual is given the opportunity to:

(1) Appear personally, testify, cross-examine any witnesses, and make arguments;

(2) Be represented by an attorney or other representative (see §404.1700), although the individual must be present at the conference; and

(3) Submit documents for consideration by the decisionmaker.

(g) At the personal conference, the decisionmaker:

(1) Tells the individual that the decisionmaker was not previously involved in the issue under review, that the waiver decision is solely the decisionmaker's, and that the waiver decision is based only on the evidence or information presented or reviewed at the conference;

(2) Ascertains the role and identity of everyone present;

(3) Indicates whether or not the individual reviewed the claims file;

(4) Explains the provisions of law and regulations applicable to the issue;

(5) Briefly summarizes the evidence already in file which will be considered;

(6) Ascertains from the individual whether the information presented is correct and whether he/she fully understands it;

(7) Allows the individual and the individual's representative, if any, to present the individual's case;

(8) Secures updated financial information and verification, if necessary;

(9) Allows each witness to present information and allows the individual and the individual's representative to question each witness;

(10) Ascertains whether there is any further evidence to be presented;

(11) Reminds the individual of any evidence promised by the individual which has not been presented;

(12) Lets the individual and the individual's representative, if any, present any proposed summary or closing statement;

(13) Explains that a decision will be made and the individual will be notified in writing; and

(14) Explains repayment options and further appeal rights in the event the decision is adverse to the individual.

(h) SSA issues a written decision to the individual (and his/her representative, if any) specifying the findings of fact and conclusions in support of the decision to approve or deny waiver and advising of the individual's right to appeal the decision. If waiver is denied, adjustment or recovery of the overpayment begins even if the individual appeals.

(i) If it appears that the waiver cannot be approved, and the individual declines a personal conference or fails to appear for a second scheduled personal conference, a decision regarding the waiver will be made based on the written evidence of record. Reconsideration is then the next step in the appeals process (but see § 404.930(a)(7)).

[61 FR 56131, Oct. 31, 1996, as amended at 73 FR 1973, Jan. 11, 2008; 85 FR 52914, Aug. 27, 2020]

§ 404.507 Fault.

Fault as used in *without fault* (see § 404.506 and 42 CFR 405.355) applies only to the individual. Although the Administration may have been at fault in making the overpayment, that fact does not relieve the overpaid individual or any other individual from whom the Administration seeks to recover the overpayment from liability for repayment if such individual is not without fault. In determining whether an individual is at fault, the Social Security Administration will consider all pertinent circumstances, including the individual's age and intelligence, and any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual has. Notwithstanding any other provision of this subpart, we will not determine any overpaid individual to be at fault in causing a qualifying overpayment (see § 404.506(b)(1)) unless we determine that the qualifying overpayment made to a beneficiary or a representative payee during the pandemic period (see § 404.501) was the result of fraud or similar fault or involved misuse of benefits by a representative payee (see § 404.2041). What constitutes fault (except for *deduction overpayments*—see § 404.510) on the part of the overpaid individual or on the part of any other individual from whom the Administration seeks to recover the overpayment depends upon whether the facts show that the incorrect payment to the individual or to a provider of services or other person, or an incorrect payment made under section 1814(e) of the Act, resulted from:

(a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or

(b) Failure to furnish information which he knew or should have known to be material; or

(c) With respect to the overpaid individual only, acceptance of a payment which he either knew or could have been expected to know was incorrect.

[34 FR 14888, Sept. 27, 1969; 34 FR 15646, Oct. 9, 1969, as amended at 44 FR 34942, June 18, 1979; 59 FR 1634, Jan. 12, 1994; 85 FR 52914, Aug. 27, 2020]

§ 404.508 Defeat the purpose of Title II.

(a) *General. Defeat the purpose of title II,* for purposes of this subpart, means defeat the purpose of benefits under this title, *i.e.*, to deprive a person of income required for ordinary and necessary living expenses. This depends upon whether the person has an income or financial resources sufficient for more than ordinary and necessary needs, or is dependent upon all of his current benefits for such needs. An individual's ordinary and necessary expenses include:

(1) Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (e.g., life, accident, and health insurance including premiums for supplementary medical insurance benefits under title XVIII), taxes, installment payments, etc.;

(2) Medical, hospitalization, and other similar expenses;

(3) Expenses for the support of others for whom the individual is legally responsible; and

(4) Other miscellaneous expenses which may reasonably be considered as part of the individual's standard of living.

(b) *When adjustment or recovery will defeat the purpose of title II.* Adjustment or recovery will defeat the purposes of

title II in (but is not limited to) situations where the person from whom recovery is sought needs substantially all of his current income (including social security monthly benefits) to meet current ordinary and necessary living expenses.

[32 FR 18026, Dec. 16, 1967, as amended at 34 FR 14888, Sept. 27, 1969]

§ 404.509 Against equity and good conscience; defined.

(a) Recovery of an overpayment is *against equity and good conscience* (under title II and title XVIII) if an individual—

(1) Changed his or her position for the worse (Example 1) or relinquished a valuable right (Example 2) because of reliance upon a notice that a payment would be made or because of the overpayment itself; or

(2) Was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment (Examples 3 and 4).

(b) The individual's financial circumstances are not material to a finding of *against equity and good conscience*.

Example 1. A widow, having been awarded benefits for herself and daughter, entered her daughter in private school because the monthly benefits made this possible. After the widow and her daughter received payments for almost a year, the deceased worker was found to be not insured and all payments to the widow and child were incorrect. The widow has no other funds with which to pay the daughter's private school expenses. Having entered the daughter in private school and thus incurred a financial obligation toward which the benefits had been applied, she was in a worse position financially than if she and her daughter had never been entitled to benefits. In this situation, the recovery of the payments would be *against equity and good conscience.*

Example 2. After being awarded old-age insurance benefits, an individual resigned from employment on the assumption he would receive regular monthly benefit payments. It was discovered 3 years later that (due to a Social Security Administration error) his award was erroneous because he did not have the required insured status. Due to his age, the individual was unable to get his job back and could not get any other employment. In this situation, recovery of the overpayments would be *against equity and good conscience* because the individual gave up a valuable right.

Example 3. M divorced K and married L. M died a few years later. When K files for benefits as a surviving divorced wife, she learns that L had been overpaid $3,200 on M's earnings record. Because K and L are both entitled to benefits on M's record of earnings and we could not recover the overpayment from L, we sought recovery from K. K was living in a separate household from L at the time of the overpayment and did not receive the overpayment. K requests waiver of recovery of the $3,200 overpayment from benefits due her as a surviving divorced wife of M. In this situation, it would be *against equity and good conscience* to recover the overpayment from K.

Example 4. G filed for and was awarded benefits. His daughter, T, also filed for student benefits on G's earnings record. Since T was an independent, full-time student living in another State, she filed for benefits on her own behalf. Later, after T received 12 monthly benefits, the school reported that T had been a full-time student only 2 months and had withdrawn from school. Since T was overpaid 10 monthly benefits, she was requested to return the overpayment to SSA. T did not return the overpayment and further attempts to collect the overpayment were unsuccessful. G was asked to repay the overpayment because he was receiving benefits on the same earnings record. G requested waiver. To support his waiver request G established that he was not at fault in causing the overpayment because he did not know that T was receiving benefits. Since G is without fault and, in addition, meets the requirements of not living in the same household at the time of the overpayment and did not receive the overpayment, it would be *against equity and good conscience* to recover the overpayment from G.

[53 FR 25483, July 7, 1988]

§ 404.510 When an individual is "without fault" in a deduction overpayment.

In determining whether an individual is ''without fault'' with respect to a deduction overpayment, the Social Security Administration will consider all pertinent circumstances, including the individual's age and intelligence, and any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual has. Except as provided in § 404.511 or elsewhere in this subpart F, situations in which an individual will be considered to be ''without fault'' with respect to a deduction overpayment include, but are not limited to, those that are described in this

section. An individual will be considered ''without fault'' in accepting a payment which is incorrect because he/she failed to report an event specified in sections 203 (b) and (c) of the Act, or an event specified in section 203(d) of the Act as in effect for monthly benefits for months after December 1960, or because a deduction is required under section 203 (b), (c), (d), or section 222(b) of the Act, or payments were not withheld as required by section 202(t) or section 228 of the Act, if it is shown that such failure to report or acceptance of the overpayment was due to one of the following circumstances:

(a) Reasonable belief that only his net cash earnings (*take-home* pay) are included in determining the annual earnings limitation or the monthly earnings limitation under section 203(f) of the Act.

(b) Reliance upon erroneous information from an official source within the Social Security Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under title II of the Act) with respect to the interpretation of a pertinent provision of the Social Security Act or regulations pertaining thereto. For example, this circumstance could occur where the individual is misinformed by such source as to the interpretation of a provision in the Act or regulations relating to deductions, or relating to the effect of residence of an alien outside the United States for more than 6 months.

(c) The beneficiary's death caused the earnings limit applicable to his earnings for purposes of deduction and the charging of excess earnings to be reduced below $1,680 for a taxable year ending after 1967.

(d) [Reserved]

(e) Reasonable belief that in determining, for deduction purposes, his earnings from employment and/or net earnings from self-employment in the taxable year in which he became entitled to benefits, earnings in such year prior to such entitlement would be excluded. However, this provision does not apply if his earnings in the taxable year, beginning with the first month of entitlement, exceeded the earnings limitation amount for such year.

(f) Unawareness that his earnings were in excess of the earnings limitation applicable to the imposition of deductions and the charging of excess earnings or that he should have reported such excess where these earnings were greater than anticipated because of:

(1) Retroactive increases in pay, including back-pay awards;

(2) Work at a higher pay rate than realized;

(3) Failure of the employer of an individual unable to keep accurate records to restrict the amount of earnings or the number of hours worked in accordance with a previous agreement with such individual;

(4) The occurrence of five Saturdays (or other work days, e.g., five Mondays) in a month and the earnings for the services on the fifth Saturday or other work day caused the deductions.

(g) The continued issuance of benefit checks to him after he sent notice to the Administration of the event which caused or should have caused the deductions provided that such continued issuance of checks led him to believe in good faith that he was entitled to checks subsequently received.

(h) Lack of knowledge that bonuses, vacation pay, or similar payments, constitute earnings for purposes of the annual earnings limitation.

(i) [Reserved]

(j) Reasonable belief that earnings in excess of the earnings limitation amount for the taxable year would subject him to deductions only for months beginning with the first month in which his earnings exceeded the earnings limitation amount. However, this provision is applicable only if he reported timely to the Administration during the taxable year when his earnings reached the applicable limitation amount for such year.

(k) Lack of knowledge by a wife, husband, or child entitled to wife's, husband's, or child's insurance benefits, as the case may be, that the individual entitled to old-age insurance benefits on the same earnings record has incurred or would incur deductions because of a violation of the annual earnings or 7–day foreign work test, whichever is applicable, provided the wife, husband, or child is not living with

such old-age insurance beneficiary and did not know and had no reason to know that such beneficiary's earnings activity or the income derived therefrom has caused or would cause such deductions.

(l) Reasonable belief, with respect to earnings activity for months after December 1982, that net earnings from self-employment after attainment of age 70 (age 72 for months after December 1972 and before January 1983) in the taxable year in which such age was attained would not cause deductions (see § 404.430(a)) with respect to benefits payable for months in that taxable year prior to the attainment of such age.

(m) Reasonable belief by an individual entitled to child's, wife's, husband's, widow's, widower's, mother's, or parent's insurance benefits that earnings from employment and/or net earnings from self-employment after the termination of entitlement (other than termination by reason of entitlement to an old-age insurance benefit) in the taxable year in which the termination event occurred would not cause deductions with respect to benefits payable for months in that taxable year prior to the month in which the termination event occurred.

(n) Failure to understand the deduction provisions of the Act or the occurrence of unusual or unavoidable circumstances the nature of which clearly shows that the individual was unaware of a violation of such deduction provisions.

[27 FR 1162, Feb. 8, 1962, as amended at 28 FR 14492, Dec. 31, 1963; 34 FR 14888, Sept. 27, 1969; 36 FR 23361, Dec. 9, 1971; 43 FR 31318, July 21, 1978; 44 FR 20653, Apr. 6, 1979; 59 FR 1634, Jan. 12, 1994; 60 FR 17445, Apr. 6, 1995]

§ 404.510a When an individual is "without fault" in an entitlement overpayment.

A benefit payment under title II or title XVIII of the Act to or on behalf of an individual who fails to meet one or more requirements for entitlement to such payment or a benefit payment exceeding the amount to which he is entitled, constitutes an entitlement overpayment. Where an individual or other person on behalf of an individual accepts such overpayment because of reliance on erroneous information from an official source within the Social Security Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under title II or title XVIII of the Act) with respect to the interpretation of a pertinent provision of the Social Security Act or regulations pertaining thereto, or where an individual or other person on behalf of an individual is overpaid as a result of the adjustment upward (under the family maximum provision in section 203 of the Act) of the benefits of such individual at the time of the proper termination of one or more beneficiaries on the same social security record and the subsequent reduction of the benefits of such individual caused by the reentitlement of the terminated beneficiary(ies) pursuant to a change in a provision of the law, such individual, in accepting such overpayment, will be deemed to be *without fault*. For purposes of this section *governmental agency* includes intermediaries and carriers under contract pursuant to sections 1816 and 1842 of the Act.

[39 FR 43716, Dec. 18, 1974]

§ 404.511 When an individual is at "fault" in a deduction overpayment.

(a) *Degree of care.* An individual will not be *without fault* if the Administration has evidence in its possession which shows either a lack of good faith or failure to exercise a high degree of care in determining whether circumstances which may cause deductions from his benefits should be brought to the attention of the Administration by an immediate report or by return of a benefit check. The high degree of care expected of an individual may vary with the complexity of the circumstances giving rise to the overpayment and the capacity of the particular payee to realize that he is being overpaid. Accordingly, variances in the personal circumstances and situations of individual payees are to be considered in determining whether the necessary degree of care has been exercised by an individual to warrant a finding that he was without fault in accepting a *deduction overpayment*.

(b) *Subsequent deduction overpayments.* The Social Security Administration generally will not find an individual to be without fault where, after having been exonerated for a ''deduction overpayment'' and after having been advised of the correct interpretation of the deduction provision, the individual incurs another ''deduction overpayment'' under the same circumstances as the first overpayment. However, in determining whether the individual is without fault, the Social Security Administration will consider all of the pertinent circumstances surrounding the prior and subsequent ''deduction overpayments,'' including any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which the individual may have.

[16 FR 13054, Dec. 28, 1951, as amended at 59 FR 1634, Jan. 12, 1994]

§ 404.512 When adjustment or recovery of an overpayment will be waived.

(a) *Adjustment or recovery deemed ''against equity and good conscience.''* In the situations described in §§ 404.510(a), (b), and (c), and 404.510a, adjustment or recovery will be waived since it will be deemed such adjustment or recovery is *against equity and good conscience.* Adjustment or recovery will also be deemed *against equity and good conscience* in the situation described in § 404.510(e), but only as to a month in which the individual's earnings from wages do not exceed the total monthly benefits affected for that month.

(b) *Adjustment or recovery considered to defeat the purpose of title II* or be *against equity and good conscience* under certain circumstances. In the situation described in § 404.510(e) (except in the case of an individual whose monthly earnings from wages in employment do not exceed the total monthly benefits affected for a particular month), and in the situations described in § 404.510 (f) through (n), adjustment or recovery shall be waived only where the evidence establishes that adjustment or recovery would work a financial hardship (see § 404.508) or would otherwise be inequitable (see § 404.509).

[27 FR 1163, Feb. 8, 1962, as amended at 35 FR 6321, Apr. 18, 1970; 36 FR 23361, Dec. 9, 1971]

§ 404.513 Liability of a certifying officer.

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any individual.

(a) Where adjustment or recovery of such amount is waived under section 204(b) of the Act; or

(b) Where adjustment under section 204(a) of the Act is not completed prior to the death of all individuals against whose benefits or lump sums deductions are authorized; or

(c) Where a claim for recovery of an overpayment is compromised or collection or adjustment action is suspended or terminated pursuant to the Federal Claims Collection Act of 1966 (31 U.S.C. 951–953) (see § 404.515).

[34 FR 14889, Sept. 27, 1969]

§ 404.515 Collection and compromise of claims for overpayment.

(a) *General effect of the Debt Collection Improvement Act of 1996.* Claims by the Administration against an individual for recovery of overpayments under title II or title XVIII (not including title XVIII overpayments for which refund is requested from providers, physicians, or other suppliers of services) of the Act, not exceeding the sum of $100,000 or any higher amount authorized by the Attorney General, exclusive of interest, may be compromised, or collection suspended or terminated where such individual or his estate does not have the present or prospective ability to pay the full amount of the claim within a reasonable time (see paragraph (c) of this section) or the cost of collection is likely to exceed the amount of recovery (see paragraph (d) of this section) except as provided under paragraph (b) of this section.

(b) *When there will be no compromise, suspension or termination of collection of a claim for overpayment*—(1) *Overpaid individual alive.* In any case where the overpaid individual is alive, a claim for overpayment will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such individual or on the part of any

other party having an interest in the claim.

(2) *Overpaid individual deceased.* In any case where the overpaid individual is deceased (i) a claim for overpayment in excess of $5,000 will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud; the filing of a false claim, or misrepresentation on the part of such deceased individual, and (ii) a claim for overpayment regardless of the amount will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication that any person other than the deceased overpaid individual had a part in the fraudulent action which resulted in the overpayment.

(c) *Inability to pay claim for recovery of overpayment.* In determining whether the overpaid individual is unable to pay a claim for recovery of an overpayment under title II or title XVIII of the Act, the Administration will consider such individual's age, health, present and potential income (including inheritance prospects), assets (e.g., real property, savings account), possible concealment or improper transfer of assets, and assets or income of such individual which may be available in enforced collection proceedings. The Administration will also consider exemptions available to such individual under the pertinent State or Federal law in such proceedings. In the event the overpaid individual is deceased, the Administration will consider the available assets of the estate, taking into account any liens or superior claims against the estate.

(d) *Cost of collection or litigative probabilities.* Where the probable costs of recovering an overpayment under title II or title XVIII of the Act would not justify enforced collection proceedings for the full amount of the claim or there is doubt concerning the Administration's ability to establish its claim as well as the time which it will take to effect such collection, a compromise or settlement for less than the full amount will be considered.

(e) *Amount of compromise.* The amount to be accepted in compromise of a claim for overpayment under title II or title XVIII of the Act shall bear a reasonable relationship to the amount which can be recovered by enforced collection proceedings giving due consideration to the exemptions available to the overpaid individual under State or Federal law and the time which such collection will take.

(f) *Payment.* Payment of the amount which the Administration has agreed to accept as a compromise in full settlement of a claim for recovery of an overpayment under title II or title XVIII of the Act must be made within the time and in the manner set by the Administration. A claim for such recovery of the overpayment shall not be considered compromised or settled until the full payment of the compromised amount has been made within the time and manner set by the Administration. Failure of the overpaid individual or his estate to make such payment as provided shall result in reinstatement of the full amount of the overpayment less any amounts paid prior to such default.

[34 FR 14889, Sept. 27, 1969; 34 FR 15413, Oct. 3, 1969, as amended at 79 FR 33684, June 12, 2014]

§ 404.520 Referral of overpayments to the Department of the Treasury for tax refund offset—General.

(a) The standards we will apply and the procedures we will follow before requesting the Department of the Treasury to offset income tax refunds due taxpayers who have an outstanding overpayment are set forth in §§ 404.520 through 404.526. These standards and procedures are authorized by 31 U.S.C. 3720A and are implemented through Department of the Treasury regulations at 31 CFR 285.2.

(b) We will use the Department of the Treasury tax refund offset procedure to collect overpayments that are certain in amount, past due and legally enforceable, and eligible for tax refund offset under regulations issued by the Department of the Treasury. We will use these procedures to collect overpayments only from persons who are not currently entitled to monthly Social Security benefits under title II of the Act. We will refer overpayments to

the Department of the Treasury for offset against Federal tax refunds regardless of the length of time the debts have been outstanding.

[62 FR 64277, Dec. 5, 1997, as amended at 76 FR 65108, Oct. 20, 2011]

§ 404.521 Notice to overpaid persons.

Before we request the collection of an overpayment by reduction of Federal and State income tax refunds, we will send a written notice of intent to the overpaid person. In our notice of intent to collect an overpayment through tax refund offset, we will state:

(a) The amount of the overpayment; and

(b) That we will collect the overpayment by requesting that the Department of the Treasury reduce any amounts payable to the overpaid person as refunds of Federal and State income taxes by an amount equal to the amount of the overpayment unless, within 60 calendar days from the date of our notice, the overpaid person:

(1) Repays the overpayment in full; or

(2) Provides evidence to us at the address given in our notice that the overpayment is not past due or legally enforceable; or

(3) Asks us to waive collection of the overpayment under section 204(b) of the Act.

(c) The conditions under which we will waive recovery of an overpayment under section 204(b) of the Act;

(d) That we will review any evidence presented that the overpayment is not past due or not legally enforceable;

(e) That the overpaid person has the right to inspect and copy our records related to the overpayment as determined by us and will be informed as to where and when the inspection and copying can be done after we receive notice from the overpaid person that inspection and copying are requested.

[56 FR 52468, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997; 76 FR 65108, Oct. 20, 2011]

§ 404.522 Review within SSA that an overpayment is past due and legally enforceable.

(a) *Notification by overpaid individual.* An overpaid individual who receives a notice as described in § 404.521 has the right to present evidence that all or part of the overpayment is not past due or not legally enforceable. To exercise this right, the individual must notify us and present evidence regarding the overpayment within 60 calendar days from the date of our notice.

(b) *Submission of evidence.* The overpaid individual may submit evidence showing that all or part of the debt is not past due or not legally enforceable as provided in paragraph (a) of this section. Failure to submit the notification and evidence within 60 calendar days will result in referral of the overpayment to the Department of the Treasury, unless the overpaid individual, within this 60-day time period, has asked us to waive collection of the overpayment under section 204(b) of the Act and we have not yet determined whether we can grant the waiver request. If the overpaid individual asks us to waive collection of the overpayment, we may ask that evidence to support the request be submitted to us.

(c) *Review of the evidence.* After a timely submission of evidence by the overpaid individual, we will consider all available evidence related to the overpayment. If the overpaid individual has not requested a waiver we will make findings based on a review of the written record, unless we determine that the question of indebtedness cannot be resolved by a review of the documentary evidence. If the overpaid individual has asked us to make a waiver determination and our records do not show that after an oral hearing we had previously determined that he was at ''fault'' in accepting the overpayment, we will not deny the waiver request without first scheduling an oral hearing.

[56 FR 52469, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997]

§ 404.523 Findings by SSA.

(a) Following the hearing or a review of the record, we will issue written findings which include supporting rationale for the findings. Issuance of these findings concerning whether the overpayment or part of the overpayment is past due and legally enforceable is the final Agency action with respect to the past-due status and enforceability of the overpayment. If we

make a determination that a waiver request cannot be granted, we will issue a written notice of this determination in accordance with the regulations in subpart J of this part. Our referral of the overpayment to the Department of the Treasury will not be suspended under § 404.525 pending any further administrative review of the waiver request that the individual may seek.

(b) Copies of the findings described in paragraph (a) of this section will be distributed to the overpaid individual and the overpaid individual's attorney or other representative, if any.

(c) If the findings referred to in paragraph (a) of this section affirm that all or part of the overpayment is past due and legally enforceable and, if waiver is requested, we determine that the request cannot be granted, we will refer the overpayment to the Department of the Treasury. No referral will be made to the Department of the Treasury if, based on our review of the overpayment, we reverse our prior finding that the overpayment is past due and legally enforceable or, upon consideration of a waiver request, we determine that waiver of our collection of the overpayment is appropriate.

[56 FR 52469, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997]

§ 404.524 Review of our records related to the overpayment.

(a) *Notification by the overpaid individual.* An overpaid individual who intends to inspect or copy our records related to the overpayment as determined by us must notify us stating his or her intention to inspect or copy.

(b) *Our response.* In response to a notification by the overpaid individual as described in paragraph (a) of this section, we will notify the overpaid individual of the location and time when the overpaid individual may inspect or copy our records related to the overpayment. We may also, at our discretion, mail copies of the overpayment-related records to the overpaid individual.

[56 FR 52469, Oct. 21, 1991]

§ 404.525 Suspension of offset.

If, within 60 days of the date of the notice described in § 404.521, the overpaid individual notifies us that he or she is exercising a right described in § 404.522(a) and submits evidence pursuant to § 404.522(b) or requests a waiver under § 404.506, we will suspend any notice to the Department of the Treasury until we have issued written findings that affirm that an overpayment is past due and legally enforceable and, if applicable, make a determination that a waiver request cannot be granted.

[56 FR 52469, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997]

§ 404.526 Tax refund insufficient to cover amount of overpayment.

If a tax refund for a given taxable year is insufficient to recover an overpayment completely, the case will remain with the Department of the Treasury for offset, assuming that all criteria for offset continue to be met.

[62 FR 64278, Dec. 5, 1997]

§ 404.527 Additional methods for recovery of title II benefit overpayments.

(a) *General.* In addition to the methods specified in §§ 404.502 and 404.520, an overpayment under title II of the Act is also subject to recovery under the rules in subparts D and E of part 422 of this chapter. Subpart D of part 422 of this chapter applies only under the following conditions:

(1) The overpayment occurred after the individual has attained age 18;

(2) The overpaid individual is no longer entitled to benefits under title II of the Act; and

(3) Pursuant to paragraph (b) of this section, we have determined that the overpayment is otherwise unrecoverable under section 204 of the Act.

(b) *When an overpayment is considered to be otherwise unrecoverable.* An overpayment under title II of the Act is considered to be otherwise unrecoverable under section 204 of the Act if all of the following conditions are met:

(1) Our billing system sequence has been completed (*i.e.*, we have sent the individual an initial notice of the overpayment, a reminder notice, and a past-due notice) or collection activity has been suspended or terminated in accordance with the Federal Claims Collection Standards in 31 CFR 903.2 or 903.3.

(2) We have not entered into an installment payment arrangement with the overpaid individual or, if we have entered into such an arrangement, the overpaid individual has failed to make any payment for two consecutive months.

(3) The overpaid individual has not requested waiver pursuant to § 404.506 or § 404.522 or, after a review conducted pursuant to those sections, we have determined that we will not waive collection of the overpayment.

(4) The overpaid individual has not requested reconsideration of the initial overpayment determination pursuant to §§ 404.907 and 404.909 or, after a review conducted pursuant to § 404.913, we have affirmed, in whole or in part, the initial overpayment determination.

(5) The overpayment cannot be recovered pursuant to § 404.502 by adjustment of benefits payable to any individual other than the overpaid individual. For purposes of this paragraph, an overpayment will be deemed to be unrecoverable from any individual who was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment.

[62 FR 64278, Dec. 5, 1997, as amended at 68 FR 74183, Dec. 23, 2003]

§ 404.530 Are title VIII and title XVI benefits subject to adjustment to recover title II overpayments?

(a) *Definitions*—(1) *Cross-program recovery*. Cross-program recovery is the process that we will use to collect title II overpayments from benefits payable to you under title VIII and title XVI of the Act.

(2) *Benefits payable*. For purposes of this section, benefits payable means the amount of title VIII or title XVI benefits you actually would receive. For title VIII benefits, it includes your monthly benefit and any past-due benefits after any reduction by the amount of income for the month as described in §§ 408.505 through 408.515 of this chapter. For title XVI benefits, it includes your monthly benefit and any past-due benefits as described in § 416.420 of this chapter.

(b) *When may we collect title II overpayments using cross-program recovery?* We may use cross-program recovery to collect a title II overpayment you owe when benefits are payable to you under title VIII, title XVI, or both.

[70 FR 15, Jan. 3, 2005]

§ 404.535 How much will we withhold from your title VIII and title XVI benefits to recover a title II overpayment?

(a) If past-due benefits are payable to you, we will withhold the lesser of the entire overpayment balance or the entire amount of past-due benefits.

(b)(1) We will collect the overpayment from current monthly benefits due in a month under title VIII and title XVI by withholding the lesser of the amount of the entire overpayment balance or:

(i) 10 percent of the monthly title VIII benefits payable for that month and

(ii) in the case of title XVI benefits, an amount no greater than the lesser of the benefit payable for that month or an amount equal to 10 percent of your income for that month (including such monthly benefit but excluding payments under title II when recovery is also made from title II benefits and excluding income excluded pursuant to §§ 416.1112 and 416.1124 of this chapter).

(2) Paragraph (b)(1) of this section does not apply if:

(i) You request and we approve a different rate of withholding, or

(ii) You or your spouse willfully misrepresented or concealed material information in connection with the overpayment.

(c) In determining whether to grant your request that we withhold less than the amount described in paragraph (b)(1) of this section, we will use the criteria applied under § 404.508 to similar requests about withholding from title II benefits.

(d) If you or your spouse willfully misrepresented or concealed material information in connection with the overpayment, we will collect the overpayment by withholding the lesser of the overpayment balance or the entire amount of title VIII and title XVI benefits payable to you. We will not collect at a lesser rate. (See § 416.571 of this chapter for what we mean by concealment of material information.)

[70 FR 15, Jan. 3, 2005]

§ 404.540 Will you receive notice of our intention to apply cross-program recovery?

Before we collect an overpayment from you using cross-program recovery, we will send you a written notice that tells you the following information:

(a) We have determined that you owe a specific overpayment balance that can be collected by cross-program recovery;

(b) We will withhold a specific amount from the title VIII or title XVI benefits (see § 404.535);

(c) You may ask us to review this determination that you still owe this overpayment balance;

(d) You may request that we withhold a different amount from your current monthly benefits (the notice will not include this information if § 404.535(d) applies); and

(e) You may ask us to waive collection of this overpayment balance.

[70 FR 15, Jan. 3, 2005]

§ 404.545 When will we begin cross-program recovery from current monthly benefits?

(a) We will begin collecting the overpayment balance from your title VIII or title XVI current monthly benefits or payments by cross-program recovery no sooner than 30 calendar days after the date of the notice described in § 404.540. If within that 30-day period you pay us the full overpayment balance stated in the notice, we will not begin cross-program recovery.

(b) If within that 30-day period you ask us to review our determination that you still owe us this overpayment balance, we will not begin cross-program recovery from your current monthly benefits before we review the matter and notify you of our decision in writing.

(c) If within that 30-day period you ask us to withhold a different amount than the amount stated in the notice, we will not begin cross-program recovery from your current monthly benefits until we determine the amount we will withhold. This paragraph does not apply when § 404.535(d) applies.

(d) If within that 30-day period you ask us to waive recovery of the overpayment balance, we will not begin cross-program recovery from your current monthly benefits before we review the matter and notify you of our decision in writing. See §§ 404.506 through 404.512.

[70 FR 15, Jan. 3, 2005]

Subpart G—Filing of Applications and Other Forms

AUTHORITY: Secs. 202(i), (j), (o), (p), and (r), 205(a), 216(i)(2), 223(b), 228(a), and 702(a)(5) of the Social Security Act (42 U.S.C. 402(i), (j), (o), (p), and (r), 405(a), 416(i)(2), 423(b), 428(a), and 902(a)(5)).

SOURCE: 44 FR 37209, June 26, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.601 Introduction.

This subpart contains the Social Security Administration's rules for filing a claim for old-age, disability, dependents', and survivors' insurance benefits as described in subpart D of part 404. It tells what an application is, who may sign it, where and when it must be signed and filed, the period of time it is in effect and how it may be withdrawn. This subpart also explains when a written statement, request, or notice will be considered filed. Since the application form and procedures for filing a claim under this subpart are the same as those used to establish entitlement to Medicare benefits under 42 CFR part 405, persons who wish to become entitled to Medicare benefits should refer to the provisions of this subpart. Requirements concerning applications for the black lung benefits program are contained in part 410. Requirements concerning applications for the supplemental security income program are contained in part 416. Part 422 contains the requirements for applying for a social security number.

§ 404.602 Definitions.

For the purpose of this subpart—

Applicant means the person who files an application for benefits for himself or herself or for someone else. A person who files for himself or herself is both the *applicant* and the *claimant*.

Application refers only to an application on a form described in § 404.611.

Benefits means any old-age, disability, dependents', and survivors' insurance benefits described in subpart D, including a period of disability.

Claimant means the person who files an application for benefits for himself or herself or the person for whom an application is filed.

We, *us*, or *our* means the Social Security Administration (SSA).

You or *your* means, as appropriate, the person who applies for benefits, the person for whom an application is filed, or the person who may consider applying for benefits.

§ 404.603 You must file an application to receive benefits.

In addition to meeting other requirements, you must file an application to become entitled to benefits. If you believe you may be entitled to benefits, you should file an application. Filing an application will—

(a) Permit a formal decision to be made on your entitlement to benefits;

(b) Protect your entitlement to any benefits that may be payable for as many as 6 months or 12 months (depending on the type of benefit, as explained in § 404.621) before the application was filed; and

(c) Give you the right to appeal if you are dissatisfied with the decision.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47444, Sept. 28, 1981]

APPLICATIONS

§ 404.610 What makes an application a claim for benefits?

We will consider your application a claim for benefits if it generally meets all of the following conditions:

(a) You must file on a prescribed form, as stated in § 404.611. *See* § 422.505(a) of this chapter for the types of prescribed applications you can file.

(b) You must complete and file the application with us as stated in §§ 404.611 and 404.614.

(c) You, or someone described in § 404.612 who may sign an application for you, must sign the application.

(d) You must be alive at the time you file (unless one of the limited exceptions in § 404.615 applies).

[69 FR 498, Jan. 6, 2004]

§ 404.611 How do I file an application for Social Security benefits?

(a) *General rule.* You must apply for benefits on an application that we prescribe. *See* § 422.505(a) of this chapter for the types of applications we will accept. *See* § 404.614 for places where you can file your application for benefits.

(b) *What if I file a claim with the Railroad Retirement Board (RRB)?* If you file an application with the RRB on one of its forms for an annuity under section 2 of the Railroad Retirement Act, as amended, we will consider this an application for title II Social Security benefits, which you may be entitled to, unless you tell us otherwise.

(c) *What if I file a claim with the Department of Veterans Affairs (DVA)?* If you file an application with the DVA on one of its forms for survivors' dependency and indemnity compensation (*see* section 3005 of title 38 U.S.C.), we will consider this an application for Social Security survivors' benefits, except for the lump sum death payment.

[69 FR 498, Jan. 6, 2004]

§ 404.612 Who may sign an application.

We will determine who may sign an application according to the following rules:

(a) A claimant who is 18 years old or over, mentally competent, and physically able to do so, must sign his or her own application. If the claim is for child's benefits for a person who is not yet 22 years old, the application may be signed by a parent or a person standing in place of the parent.

(b) A claimant who is between 16 and 18 years old may sign his or her own application if he or she is mentally competent, has no court appointed representative, and is not in the care of any person.

(c) If the claimant is under age 18, or mentally incompetent, or physically unable to sign, the application may be signed by a court appointed representative or a person who is responsible for the care of the claimant, including a relative. If the claimant is in the care of an institution, the manager or principal officer of the institution may sign the application.

(d) If a person who could receive disability benefits or who could have a period of disability established dies before filing, an application for disability benefits or for a period of disability may be signed by a person who would be qualified to receive any benefits due the deceased.

(e) If a written statement showing an intent to claim benefits is filed with us, but the person for whom the benefits are claimed dies before an application is filed, an application may be filed as explained in § 404.630(d).

(f) If a person who could receive benefits on the basis of a ''deemed'' filing date of an application under § 404.633 (b)(1)(i) or (b)(2)(i) dies before an application for the benefits is filed, the application may be signed by a person who would be qualified to receive any benefits due the deceased person as explained in § 404.633 (b)(1)(ii) and (b)(2)(ii).

(g) If it is necessary to protect a claimant from losing benefits and there is good cause for the claimant not signing the application, we may accept an application signed by some one other than a person described in this section.

Example: Mr. Smith comes to a social security office a few days before the end of a month to file an application for old-age benefits for his neighbor, Mr. Jones. Mr. Jones, a 63 year old widower, just suffered a heart attack and is in the hospital. He asked Mr. Smith to file the application for him. We will accept an application signed by Mr. Smith since it would not be possible to have Mr. Jones sign and file the application until the next calendar month and a loss of one month's benefits would result.

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994; 61 FR 41330, Aug. 8, 1996]

§ 404.613 Evidence of authority to sign an application for another.

(a) A person who signs an application for someone else will be required to provide evidence of his or her authority to sign the application for the person claiming benefits under the following rules:

(1) If the person who signs is a court appointed representative, he or she must submit a certificate issued by the court showing authority to act for the claimant.

(2) If the person who signs is not a court appointed representative, he or she must submit a statement describing his or her relationship to the claimant. The statement must also describe the extent to which the person is responsible for the care of the claimant. This latter information will not be requested if the application is signed by a parent for a child with whom he or she is living.

(3) If the person who signs is the manager or principal officer of an institution which is responsible for the care of the claimant, he or she must submit a statement indicating the person's position of responsibility at the institution.

(b) We may, at any time, require additional evidence to establish the authority of a person to sign an application for someone else.

§ 404.614 When an application or other form is considered filed.

(a) *General rule.* Except as otherwise provided in paragraph (b) of this section and in §§ 404.630 through 404.633 which relate to the filing date of an application, an application for benefits, or a written statement, request, or notice is filed on the day it is received by an SSA employee at one of our offices or by an SSA employee who is authorized to receive it at a place other than one of our offices.

(b) *Other places and dates of filing.* We will also accept as the date of filing—

(1) The date an application for benefits, or a written statement, request or notice is received by any office of the U.S. Foreign Service or by the Veterans Administration Regional Office in the Philippines;

(2) The date an application for benefits or a written statement, request or notice is mailed to us by the U.S. mail, if using the date we receive it would result in the loss or lessening of rights. The date shown by a U.S. postmark will be used as the date of mailing. If the postmark is unreadable, or there is no postmark, we will consider other evidence of when you mailed it to us; or

(3) The date an application for benefits is filed with the Railroad Retirement Board or the Veterans Administration. See § 404.611 (b) and (c) for an

explanation of when an application for benefits filed with the Railroad Retirement Board or the Veterans Administration is considered an application for social security benefits.

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994]

§ 404.615 Claimant must be alive when an application is filed.

A claimant must be alive at the time an application is filed. There are the following exceptions to this general rule:

(a) If a disabled person dies before filing an application for disability benefits or a period of disability, a person who would be qualified to receive any benefits due the deceased may file an application. The application must be filed within 3 months after the month in which the disabled person died.

(b) If a written statement showing an intent to claim benefits is filed with us, but the person for whom the benefits are claimed dies before an application is filed, an application may be filed as explained in § 404.630(d).

(c) If a person who could receive benefits on the basis of a ''deemed'' filing date of an application under § 404.633 (b)(1)(i) or (b)(2)(i) dies before an application for the benefits is filed, the application may be signed by a person who would be qualified to receive any benefits due the deceased person as explained in § 404.633 (b)(1)(ii) and (b)(2)(ii).

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994; 61 FR 41330, Aug. 8, 1996]

§ 404.617 Pilot program for photographic identification of disability benefit applicants in designated geographic areas.

(a) To be eligible for Social Security disability insurance benefits in the designated pilot geographic areas during the time period of the pilot, you or a person acting on your behalf must give SSA permission to take your photograph and make this photograph a part of the claims folder. You must give us this permission when you apply for benefits and/or when we ask for it at a later time. Failure to cooperate will result in denial of benefits. We will permit an exception to the photograph requirement when an individual has a sincere religious objection. This pilot will be in effect for a six-month period after these final rules become effective.

(b) *Designated pilot geographic areas means:*

(1) All SSA field offices in the State of South Carolina.

(2) The Augusta, Georgia SSA field office.

(3) All SSA field offices in the State of Kansas.

(4) Selected SSA field offices located in New York City.

[68 FR 23194, May 1, 2003]

Effective Filing Period of Application

§ 404.620 Filing before the first month you meet the requirements for benefits.

(a) *General rule.* If you file an application for benefits before the first month you meet all the other requirements for entitlement, the application will remain in effect until we make a final determination on your application unless there is an administrative law judge hearing decision on your application. If there is an administrative law judge hearing decision, your application will remain in effect until the administrative law judge hearing decision is issued.

(1) If you meet all the requirements for entitlement while your application is in effect, we may pay you benefits from the first month that you meet all the requirements.

(2) If you first meet all the requirements for entitlement after the period for which your application was in effect, you must file a new application for benefits. In this case, we may pay you benefits only from the first month that you meet all the requirements based on the new application.

(b) [Reserved]

[44 FR 37209, June 26, 1979, as amended at 52 FR 4003, Feb. 9, 1987; 83 FR 21709, May 10, 2018]

§ 404.621 What happens if I file after the first month I meet the requirements for benefits?

(a) *Filing for disability benefits and for old-age, survivors', or dependents' benefits.* (1) If you file an application for

disability benefits, widow's or widower's benefits based on disability, or wife's, husband's, or child's benefits based on the earnings record of a person entitled to disability benefits, after the first month you could have been entitled to them, you may receive benefits for up to 12 months immediately before the month in which your application is filed. Your benefits may begin with the first month in this 12-month period in which you meet all the requirements for entitlement. Your entitlement, however, to wife's or husband's benefits under this rule is limited by paragraph (a)(3) of this section.

(2) If you file an application for old-age benefits, widow's or widower's benefits not based on disability, wife's, husband's, or child's benefits based on the earnings record of a person not entitled to disability benefits, or mother's, father's, or parent's benefits, after the first month you could have been entitled to them, you may receive benefits for up to 6 months immediately before the month in which your application is filed. Your benefits may begin with the first month in this 6-month period in which you meet all the requirements for entitlement. Your entitlement, however, to old-age, wife's, husband's, widow's, or widower's benefits under this rule is limited by paragraph (a)(3) of this section.

(3) If the effect of the payment of benefits for a month before the month you file would be to reduce your benefits because of your age, you cannot be entitled to old-age, wife's, husband's, widow's, or widower's benefits for any month before the month in which your application is filed, unless you meet one of the conditions in paragraph (a)(4) of this section. (An explanation of the reduction that occurs because of age if you are entitled to these benefits for a month before you reach full retirement age, as defined in § 404.409, is in § 404.410.) An example follows that assumes you do not meet any of the conditions in paragraph (a)(4) of this section.

Example: You will attain full retirement age in March 2003. If you apply for old-age benefits in March, you cannot be entitled to benefits in the 6-month period before March because the payment of benefits for any of these months would result in your benefits being reduced for age. If you do not file your application until June 2003, you may be entitled to benefits for the month of March, April and May because the payment of benefits for these months would not result in your benefits being reduced for age. You will not, however, receive benefits for the 3 months before March.

(4) The limitation in paragraph (a)(3) of this section on your entitlement to old-age, wife's, husband's, widow's, or widower's benefits for months before you file an application does not apply if:

(i) You are a widow, widower, surviving divorced wife, or surviving divorced husband who is disabled and could be entitled to retroactive benefits for any month before age 60. If you could not be entitled before age 60, the limitation will prevent payment of benefits to you for past months, but it will not affect the month you become entitled to hospital insurance benefits.

(ii) You are a widow, widower, or surviving divorced spouse of the insured person who died in the month before you applied and you were at least age 60 in the month of death of the insured person on whose earnings record you are claiming benefits. In this case, you can be entitled beginning with the month the insured person died if you choose and if you file your application on or after July 1, 1983.

(b) *Filing for lump-sum death payment.* An application for a lump-sum death payment must be filed within 2 years after the death of the person on whose earnings record the claim is filed. There are two exceptions to the 2-year filing requirement:

(1) If there is a good cause for failure to file within the 2-year period, we will consider your application as though it were filed within the 2-year period. Good cause does not exist if you were informed of the need to file an application within the 2-year period and you neglected to do so or did not desire to make a claim. Good cause will be found to exist if you did not file within the time limit due to—

(i) Circumstances beyond your control, such as extended illness, mental or physical incapacity, or a language barrier;

(ii) Incorrect or incomplete information we furnished you;

(iii) Your efforts to get evidence to support your claim without realizing that you could submit the evidence after filing an application; or

(iv) Unusual or unavoidable circumstances which show that you could not reasonably be expected to know of the time limit.

(2) The Soldiers' and Sailors' Civil Relief Act of 1940 provides for extending the filing time.

(c) *Filing for a period of disability.* You must file an application for a period of disability while you are disabled or no later than 12 months after the month in which your period of disability ended. If you were unable to apply within the 12-month time period because of a physical or mental condition, you may apply not more than 36 months after your disability ended. The general rule we use to decide whether your failure to file was due to a physical or mental condition is stated in § 404.322.

(d) *Filing after death of person eligible for disability benefits or period of disability.* If you file for disability benefits or a period of disability for another person who died before filing an application and you would qualify under § 404.503(b) to receive any benefits due the deceased, you must file an application no later than the end of the third month following the month in which the disabled person died.

[68 FR 4711, Jan. 30, 2003, as amended at 83 FR 21709, May 10, 2018]

§ 404.622 Limiting an application.

Your application may entitle you to benefits for up to 6 months or 12 months (depending on the type of benefit, as explained in § 404.621) before the month in which it is filed. You may limit the number of months of your entitlement in the 6-month or 12-month period. You may state this choice any time before a decision is made on your claim by indicating, in writing, the month you want your benefits to begin. You may change the first month of entitlement in this 6-month or 12-month period after a decision has been made on your claim under the following conditions:

(a) You file the request in writing.

(b) If you are filing for the claimant, he or she is alive when the request is filed.

(c) If any other person who is entitled to benefits would lose some or all of those benefits because of the change, that person, or the person who filed for him or her, consents in writing.

(d) Any benefit payments that would become improper as a result of the change in entitlement month are repaid, or we are satisfied that they will be repaid.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47445, Sept. 28, 1981]

§ 404.623 Am I required to file for all benefits if I am eligible for old-age and husband's or wife's benefits?

(a) *Presumed filing for husband's or wife's benefits.* If you file an application for old-age benefits, you are presumed to have filed an application for husband's or wife's benefits in the first month of your entitlement to old-age benefits, if—

(1) Your old-age benefits are reduced for age because you choose to receive them before you reach full retirement age (as defined in § 404.409); and

(2) You are eligible for either a husband's or a wife's benefit for the first month of your entitlement to old-age benefits.

(b) *Presumed filing for old-age benefits.* If you file an application for a husband's or a wife's benefit, you are presumed to have filed an application for old-age benefits in the first month of your entitlement to husband's or wife's benefits if—

(1) Your husband's or wife's benefits are reduced for age because you choose to receive them before you reach full retirement age (as defined in § 404.409); and

(2) You are eligible for old-age benefits for the first month of your entitlement to husband's or wife's benefits.

(c) *Exception.* Paragraph (b) of this section does not apply if you are also entitled to disability benefits in the first month of your entitlement to husband's or wife's benefits. In this event, you are presumed to have filed for old-age benefits only if your disability benefits end before you reach full retirement age (as defined in § 404.409).

[68 FR 4712, Jan. 30, 2003]

FILING DATE BASED ON WRITTEN STATEMENT

§ 404.630 Use of date of written statement as filing date.

If a written statement, such as a letter, indicating your intent to claim benefits either for yourself or for another person is filed with us under the rules stated in § 404.614, we will use the filing date of the written statement as the filing date of the application, if all of the following requirements are met:

(a) The statement indicates an intent to claim benefits.

(b) The statement is signed by the claimant, the claimant's spouse, or a person described in § 404.612. If the claimant, the claimant's spouse, or a person described in § 404.612 telephones us and advises us of his or her intent to file a claim but cannot file an application before the end of the month, we will prepare and sign a written statement if it is necessary to prevent the loss of benefits. If the claimant, the claimant's spouse, or a person described in § 404.612 contacts us through the Internet by completing and transmitting the Personal Identification Information data on the Internet Social Security Benefit Application to us, we will use the date of the transmission as the filing date if it is necessary to prevent the loss of benefits.

(c) The claimant files an application with us on an application form as described in § 404.611, or one is filed for the claimant by a person described in § 404.612, within 6 months after the date of a notice we will send advising of the need to file an application. We will send the notice to the claimant. However, if it is clear from the information we receive that the claimant is a minor or is mentally incompetent, we will send the notice to the person who submitted the written statement.

(d) The claimant is alive when the application is filed; or if the claimant has died after the written statement was filed, an application is filed—

(1) By or for a person who would be eligible to receive benefits on the deceased's earnings record;

(2) By a person acting for the deceased's estate; or

(3) If the statement was filed with a hospital under § 404.632, by the hospital if—

(i) No person described in paragraph (d) (1) or (2) of this section can be located; or

(ii) A person described in paragraphs (d) (1) or (2) of this section is located but refuses or fails to file the application unless the refusal or failure to file is because it would be harmful to the deceased person or the deceased's estate.

[44 FR 37209, June 26, 1979, as amended at 71 FR 24814, Apr. 27, 2006]

§ 404.631 Statements filed with the Railroad Retirement Board.

A written statement filed with the Railroad Retirement Board will be considered a written statement filed with us under the rules in § 404.630 if—

(a) The statement indicates an intent to claim any payments under the Railroad Retirement Act;

(b) It bears the signature of the person filing the statement;

(c) No application is filed with the Railroad Retirement Board on one of its forms. If an application has been filed, we will use the date of filing of that application as determined by the Railroad Retirement Board (see § 404.614(b)(3)); and

(d) The statement is sent to us by the Railroad Retirement Board.

§ 404.632 Statements filed with a hospital.

A statement (generally a hospital admission form) filed with a hospital may serve as a written statement under § 404.630 if the requirements of this section are met. The statement will be considered filed with us as of the date it was filed with the hospital and will serve to protect entitlement to benefits. A statement filed with a hospital by you or some other person for you requesting or indicating an intent to claim benefits will be considered a written statement filed with us and § 404.630 will apply to it if—

(a) You are a patient in the hospital;

(b) The hospital provides services covered by hospital insurance under the Medicare program;

(c) An application has not already been filed; and

(d) The statement is sent to us.

DEEMED FILING DATE BASED ON MISINFORMATION

§ 404.633 Deemed filing date in a case of misinformation.

(a) *General.* You may have considered applying for monthly benefits for yourself or for another person, and you may have contacted us in writing, by telephone or in person to inquire about filing an application for these benefits. It is possible that in responding to your inquiry, we may have given you misinformation about your eligibility for such benefits, or the eligibility of the person on whose behalf you were considering applying for benefits, which caused you not to file an application at that time. If this happened, and later an application for such benefits is filed with us, we may establish an earlier filing date under this section.

Example 1: Mrs. Smith, a widow of an insured individual, contacts a Social Security office when she reaches age 60 to inquire about applying for widow's insurance benefits. She is told by an SSA employee that she must be age 62 to be eligible for these benefits. This information, which was incorrect, causes Mrs. Smith not to file an application for benefits. When Mrs. Smith reaches age 62, she again contacts a Social Security office to ask about filing for widow's insurance benefits and learns that she could have received the benefits at age 60. She files an application for these benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date based on the misinformation which she received from an SSA employee when she was age 60.

Example 2: Ms. Hill, a 22-year-old, is forced to stop work because of illness. When she contacts a Social Security office to inquire about applying for disability insurance benefits, she is told by an SSA employee that she must have 20 quarters of coverage out of the last 40 calendar quarters to be insured for disability insurance benefits. The employee fails to consider the special rules for insured status for persons who become disabled before age 31 and, consequently, tells Ms. Hill that she is not insured because she only has 16 quarters of coverage. The misinformation causes Ms. Hill not to file an application for disability insurance benefits. Because of her illness, she is unable to return to work. A year later, Ms. Hill reads an article that indicates that there are special rules for insured status for young workers who become disabled. She again contacts a Social Security office to inquire about benefits based on disability and learns that she was misinformed earlier about her insured status. She files an application for disability insurance benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date based on the misinformation provided to her earlier.

(b) *Deemed filing date of an application based on misinformation.* Subject to the requirements and conditions in paragraphs (c) through (g) of this section, we may establish a deemed filing date of an application for monthly benefits under the following provisions.

(1)(i) If we determine that you failed to apply for monthly benefits for yourself because we gave you misinformation about your eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which you met all of the requirements for entitlement to such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for you under paragraph (b)(1)(i) of this section, you or a person described in § 404.612 must file an application for such benefits. If you die before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if an application for the benefits is filed with us by a person who would be qualified to receive any benefits due you.

(2)(i) If you had authority under § 404.612 to sign an application for benefits for another person, and we determine that you failed to apply for monthly benefits for that person because we gave you misinformation about that person's eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which the person met all of the requirements for entitlement to such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for the person under paragraph (b)(2)(i) of this section, you, such person, or another person described in § 404.612 must file an application for such benefits. If the person referred to in paragraph (b)(2)(i) of this section dies before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if an application for the benefits is filed with us by a person who would be qualified to receive any benefits due the deceased person.

(c) *Requirements concerning the misinformation.* We apply the following requirements for purposes of paragraph (b) of this section.

(1) The misinformation must have been provided to you by one of our employees while he or she was acting in his or her official capacity as our employee. For purposes of this section, an employee includes an officer of SSA.

(2) Misinformation is information which we consider to be incorrect, misleading, or incomplete in view of the facts which you gave to the employee, or of which the employee was aware or should have been aware, regarding your particular circumstances, or the particular circumstances of the person referred to in paragraph (b)(2)(i) of this section. In addition, for us to find that the information you received was incomplete, the employee must have failed to provide you with the appropriate, additional information which he or she would be required to provide in carrying out his or her official duties.

(3) The misinformation may have been provided to you orally or in writing.

(4) The misinformation must have been provided to you in response to a specific request by you to us for information about your eligibility for benefits or the eligibility for benefits of the person referred to in paragraph (b)(2)(i) of this section for which you were considering filing an application.

(d) *Evidence that misinformation was provided.* We will consider the following evidence in making a determination under paragraph (b) of this section.

(1) *Preferred evidence.* Preferred evidence is written evidence which relates directly to your inquiry about your eligibility for benefits or the eligibility of another person and which shows that we gave you misinformation which caused you not to file an application. Preferred evidence includes, but is not limited to, the following—

(i) A notice, letter or other document which was issued by us and addressed to you; or

(ii) Our record of your telephone call, letter or in-person contact.

(2) *Other evidence.* In the absence of preferred evidence, we will consider other evidence, including your statements about the alleged misinformation, to determine whether we gave you misinformation which caused you not to file an application. We will not find that we gave you misinformation, however, based solely on your statements. Other evidence which you provide or which we obtain must support your statements. Evidence which we will consider includes, but is not limited to, the following—

(i) Your statements about the alleged misinformation, including statements about—

(A) The date and time of the alleged contact(s);

(B) How the contact was made, e.g., by telephone or in person;

(C) The reason(s) the contact was made;

(D) Who gave the misinformation; and

(E) The questions you asked and the facts you gave us, and the questions we asked and the information we gave you, at the time of the contact;

(ii) Statements from others who were present when you were given the alleged misinformation, e.g., a neighbor who accompanied you to our office;

(iii) If you can identify the employee or the employee can recall your inquiry about benefits—

(A) Statements from the employee concerning the alleged contact, including statements about the questions you asked, the facts you gave, the questions the employee asked, and the information provided to you at the time of the alleged contact; and

(B) Our assessment of the likelihood that the employee provided the alleged misinformation;

(iv) An evaluation of the credibility and the validity of your allegations in conjunction with other relevant information; and

(v) Any other information regarding your alleged contact.

(e) *Information which does not constitute satisfactory proof that misinformation was given.* Certain kinds of information will not be considered satisfactory proof that we gave you misinformation which caused you not to file an application. Examples of such information include—

(1) General informational pamphlets that we issue to provide basic program information;

(2) The Personal Earnings and Benefit Estimate Statement that is based on an individual's reported and projected earnings and is an estimate which can be requested at any time;

(3) General information which we review or prepare but which is disseminated by the media, e.g., radio, television, magazines, and newspapers; and

(4) Information provided by other governmental agencies, e.g., the Department of Veterans Affairs, the Department of Defense, State unemployment agencies, and State and local governments.

(f) *Claim for benefits based on misinformation.* You may make a claim for benefits based on misinformation at any time. Your claim must contain information that will enable us to determine if we did provide misinformation to you about your eligibility for benefits, or the eligibility of a person on whose behalf you were considering applying for benefits, which caused you not to file an application for the benefits. Specifically, your claim must be in writing and it must explain what information was provided; how, when and where it was provided and by whom; and why the information caused you not to file an application. If you give us this information, we will make a determination on such a claim for benefits if all of the following conditions are also met.

(1) An application for the benefits described in paragraph (b)(1)(i) or (b)(2)(i) of this section is filed with us by someone described in paragraph (b)(1)(ii) or (b)(2)(ii) of this section, as appropriate. The application must be filed after the alleged misinformation was provided. This application may be—

(i) An application on which we have made a previous final determination or decision awarding the benefits, but only if the claimant continues to be entitled to benefits based on that application;

(ii) An application on which we have made a previous final determination or decision denying the benefits, but only if such determination or decision is reopened under § 404.988; or

(iii) A new application on which we have not made a final determination or decision.

(2) The establishment of a deemed filing date of an application for benefits based on misinformation could result in the claimant becoming entitled to benefits or to additional benefits.

(3) We have not made a previous final determination or decision to which you were a party on a claim for benefits based on alleged misinformation involving the same facts and issues. This provision does not apply, however, if the final determination or decision may be reopened under § 404.988.

(g) *Effective date.* This section applies only to misinformation which we provided after December 1982. In addition, this section is effective only for benefits payable for months after December 1982.

[59 FR 44924, Aug. 31, 1994]

WITHDRAWAL OF APPLICATION

§ 404.640 Withdrawal of an application.

(a) *Request for withdrawal filed before a determination is made.* An application may be withdrawn before we make a determination on it if—

(1) A written request for withdrawal is filed at a place described in § 404.614 by the claimant or a person who may sign an application for the claimant under § 404.612; and

(2) The claimant is alive at the time the request is filed.

(b) *Request for withdrawal filed after a determination is made.* An application may be withdrawn after we make a determination on it if—

(1) The conditions in paragraph (a) of this section are met;

(2) Any other person whose entitlement would be rendered erroneous because of the withdrawal consents in writing to it. Written consent for the person may be given by someone who could sign an application for him or her under § 404.612; and

(3) All benefits already paid based on the application being withdrawn are repaid or we are satisfied that they will be repaid.

(4) *Old age benefits.* An old age benefit application may be withdrawn if, in addition to the requirements of this section—

(i) The request for withdrawal is filed within 12 months of the first month of entitlement; and

(ii) The claimant has not previously withdrawn an application for old age benefits.

(c) *Request for withdrawal filed after the claimant's death.* An application may be withdrawn after the claimant's death, regardless of whether we have made a determination on it, if—

(1) The claimant's application was for old-age benefits that would be reduced because of his or her age;

(2) The claimant died before we certified his or her benefit entitlement to the Treasury Department for payment;

(3) A written request for withdrawal is filed at a place described in § 404.614 by or for the person eligible for widow's or widower's benefits based on the claimant's earnings; and

(4) The conditions in paragraphs (b)(2) and (3) of this section are met.

(d) *Effect of withdrawal.* If we approve a request to withdraw an application, the application will be considered as though it was never filed. If we disapprove a request for withdrawal, the application is treated as though the request was never filed.

[44 FR 37209, June 26, 1979, as amended at 48 FR 21931, May 16, 1983; 51 FR 37720, Oct. 24, 1986; 75 FR 76259, Dec. 8, 2010]

§ 404.641 Cancellation of a request to withdraw.

A request to withdraw an application may be cancelled and the application reinstated if—

(a) A written request for cancellation is filed at a place described in § 404.614 by the claimant or someone who may sign an application for the claimant under § 404.612;

(b) The claimant is alive at the time the request for cancellation is filed; and

(c) For a cancellation request received after we have approved the withdrawal, the request is filed no later than 60 days after the date of the notice of approval.

Subpart H—Evidence

AUTHORITY: 42 U.S.C. 405(a), 902(a)(5), and 1320e–3.

GENERAL

§ 404.701 Introduction.

This subpart contains the Social Security Administration's basic rules about what evidence is needed when a person claims old-age, disability, dependents' and survivors' insurance benefits as described in subpart D. In addition, there are special evidence requirements for disability benefits. These are contained in subpart P. Evidence of a person's earnings under social security is described in subpart I. Evidence needed to obtain a social security number card is described in part 422. Evidence requirements for the supplemental security income program are contained in part 416.

§ 404.702 Definitions.

As used in this subpart:

Apply means to sign a form or statement that the Social Security Administration accepts as an application for benefits under the rules set out in subpart G.

Benefits means any old-age, disability, dependents' and survivors' insurance benefits described in subpart D, including a period of disability.

Convincing evidence means one or more pieces of evidence that prove you meet a requirement for eligibility. See § 404.708 for the guides we use in deciding whether evidence is convincing.

Eligible means that a person would meet all the requirements for entitlement to benefits for a period of time but has not yet applied.

Entitled means that a person has applied and has proven his or her right to benefits for a period of time.

Evidence means any record, document, or signed statement that helps to show whether you are eligible for benefits or whether you are still entitled to benefits.

Insured person means someone who has enough earnings under social security to permit the payment of benefits on his or her earnings record. He or she is *fully insured*, *transitionally insured*, *currently insured*, or *insured for disability* as defined in subpart B.

Participating payroll data provider means a payroll data provider that has established an information exchange with us to provide wage and employment information.

Payroll data provider means payroll providers, wage verification companies, and other commercial or non-commercial entities that collect and maintain information regarding employment and wages.

We or *Us* refers to the Social Security Administration.

You refers to the person who has applied for benefits, or the person for whom someone else has applied.

[43 FR 24795, June 7, 1978, as amended at 89 FR 107258, Dec. 31, 2024]

§ 404.703 When evidence is needed.

(a) *Evidence.* When you apply for benefits, we will ask for evidence that you are eligible for them. After you become entitled to benefits, we may ask for evidence showing whether you continue to be entitled to benefits; or evidence showing whether your benefit payments should be reduced or stopped. See § 404.401 for a list showing when benefit payments must be reduced or stopped.

(b) *Authorization to obtain data from a payroll data provider.* (1) We will ask you for a written authorization to obtain information about you from a payroll data provider whenever we determine the information is needed in connection with a determination of initial or ongoing entitlement to benefits.

(2) When we ask for your authorization, we will explain the authorization's scope and duration.

(i) We will explain to you that we will use the information obtained from a payroll data provider when it is needed in connection with a determination of initial or ongoing entitlement to title II benefits based on disability, or for eligibility or the amount of benefits under the Supplemental Security Income program of title XVI of the Social Security Act, and to prevent improper payments. We will explain to you that we may also use the authorization to obtain wage and employment information from a payroll data provider for claims associated with the claim filed, such as a claim for benefits by a spouse or child. We will also explain that we may use and disclose your information consistent with applicable Federal law (see, *e.g.*, part 401 of this chapter) and any privacy notices we provide to you.

(ii) We will also inform you that your authorization will remain effective until the earliest of one of the following occurrences:

(A) You revoke your authorization in writing (see § 404.1588(b)(4));

(B) We have terminated all entitlement for benefits, you have no other claims or appeals pending under this title, and the period for appealing the determination or decision terminating entitlement has lapsed; or

(C) There has been an adverse determination or decision on your claim, you have no other claims or appeals pending under this title, and the period for appealing the adverse determination or decision has lapsed.

[89 FR 107258, Dec. 31, 2024]

§ 404.704 Your responsibility for giving evidence.

When evidence is needed to prove your eligibility or your right to continue to receive benefit payments, you will be responsible for obtaining and giving the evidence to us. We will be glad to advise you what is needed and how to get it and we will consider any evidence you give us. If your evidence is a foreign-language record or document, we can have it translated for you. Evidence given to us will be kept confidential and not disclosed to anyone but you except under the rules set out in part 401. You should also be aware that Section 208 of the Social Security Act provides criminal penalties for misrepresenting the facts or for making false statements to obtain social security benefits for yourself or someone else.

§ 404.705 Failure to give requested evidence.

Generally, you will be asked to give us by a certain date specific kinds of evidence or information to prove you are eligible for benefits. If we do not receive the evidence or information by that date, we may decide you are not eligible for benefits. If you are already receiving benefits, you may be asked to give us by a certain date information needed to decide whether you continue to be entitled to benefits or whether your benefits should be stopped or reduced. If you do not give us the requested information by the date given, we may decide that you are no longer entitled to benefits or that your benefits should be stopped or reduced. You should let us know if you are unable to give us the requested evidence within the specified time and explain why there will be a delay. If this delay is due to illness, failure to receive timely evidence you have asked for from another source, or a similar circumstance, you will be given additional time to give us the evidence.

§ 404.706 Where to give evidence.

Evidence should be given to the people at a Social Security Administration office. In the Philippines evidence should be given to the people at the Veterans Administration Regional Office. Elsewhere outside the United States, evidence should be given to the people at a United States Foreign Service Office.

§ 404.707 Original records or copies as evidence.

(a) *General.* To prove your eligibility or continuing entitlement to benefits, you may be asked to show us an original document or record. These original records or documents will be returned to you after we have photocopied them. We will also accept copies of original records that are properly certified and some uncertified birth notifications. These types of records are described below in this section.

(b) *Certified copies of original records.* You may give us copies of original records or extracts from records if they are certified as true and exact copies by—

(1) The official custodian of the record;

(2) A Social Security Administration employee authorized to certify copies;

(3) A Veterans Administration employee if the evidence was given to that agency to obtain veteran's benefits;

(4) A U.S. Consular Officer or employee of the Department of State authorized to certify evidence received outside the United States; or

(5) An employee of a State Agency or State Welfare Office authorized to certify copies of original records in the agency's or office's files.

(c) *Uncertified copies of original records.* You may give us an uncertified photocopy of a birth registration notification as evidence where it is the practice of the local birth registrar to issue them in this way.

§ 404.708 How we decide what is enough evidence.

When you give us evidence, we examine it to see if it is convincing evidence. If it is, no other evidence is needed. In deciding if evidence is convincing, we consider whether—

(a) Information contained in the evidence was given by a person in a position to know the facts;

(b) There was any reason to give false information when the evidence was created;

(c) Information contained in the evidence was given under oath, or with witnesses present, or with the knowledge there was a penalty for giving false information;

(d) The evidence was created at the time the event took place or shortly thereafter;

(e) The evidence has been altered or has any erasures on it; and

(f) Information contained in the evidence agrees with other available evidence, including our records.

§ 404.709 Preferred evidence and other evidence.

If you give us the type of evidence we have shown as *preferred* in the following sections of this subpart, we will generally find it is convincing evidence. This means that unless we have information in our records that raises

a doubt about the evidence, other evidence of the same fact will not be needed. If preferred evidence is not available, we will consider any other evidence you give us. If this other evidence is several different records or documents which all show the same information, we may decide it is convincing evidence even though it is not *preferred* evidence. If the other evidence is not convincing by itself, we will ask for additional evidence. If this additional evidence shows the same information, all the evidence considered together may be convincing. When we have convincing evidence of the facts that must be proven or it is clear that the evidence provided does not prove the necessary facts, we will make a formal decision about your benefit rights.

EVIDENCE OF AGE, MARRIAGE, AND DEATH

§ 404.715 When evidence of age is needed.

(a) If you apply for benefits, we will ask for evidence of age which shows your date of birth unless you are applying for—

(1) A lump-sum death payment;

(2) A wife's benefit and you have the insured person's child in your care;

(3) A mother's or father's benefit; or

(4) A disability benefit (or for a period of disability) and neither your eligibility nor benefit amount depends upon your age.

(b) If you apply for wife's benefits while under age 62 or if you apply for a mother's or father's benefit, you will be asked for evidence of the date of birth of the insured person's children in your care.

(c) If you apply for benefits on the earnings record of a deceased person, you may be asked for evidence of his or her age if this is needed to decide whether he or she was insured at the time of death or what benefit amount is payable to you.

§ 404.716 Type of evidence of age to be given.

(a) *Preferred evidence.* The best evidence of your age, if you can obtain it, is either: a birth certificate or hospital birth record recorded before age 5; or a religious record which shows your date of birth and was recorded before age 5.

(b) *Other evidence of age.* If you cannot obtain the preferred evidence of your age, you will be asked for other convincing evidence that shows your date of birth or age at a certain time such as: an original family bible or family record; school records; census records; a statement signed by the physician or midwife who was present at your birth; insurance policies; a marriage record; a passport; an employment record; a delayed birth certificate, your child's birth certificate; or an immigration or naturalization record.

§ 404.720 Evidence of a person's death.

(a) *When evidence of death is required.* If you apply for benefits on the record of a deceased person, we will ask for evidence of the date and place of his or her death. We may also ask for evidence of another person's death if this is needed to prove you are eligible for benefits.

(b) *Preferred evidence of death.* The best evidence of a person's death is—

(1) A certified copy or extract from the public record of death, coroner's report of death, or verdict of a coroner's jury; or a certificate by the custodian of the public record of death;

(2) A statement of the funeral director, attending physician, intern of the institution where death occurred;

(3) A certified copy of, or extract from an official report or finding of death made by an agency or department of the United States; or

(4) If death occurred outside the United States, an official report of death by a United States Consul or other employee of the State Department; or a copy of the public record of death in the foreign country.

(c) *Other evidence of death.* If you cannot obtain the preferred evidence of a person's death, you will be asked to explain why and to give us other convincing evidence such as: the signed statements of two or more people with personal knowledge of the death, giving the place, date, and cause of death.

§ 404.721 Evidence to presume a person is dead.

If you cannot prove the person is dead but evidence of death is needed, we will presume he or she died at a certain time if you give us the following evidence:

(a) A certified copy of, or extract from, an official report or finding by an agency or department of the United States that a missing person is *presumed to be* dead as set out in Federal law (5 U.S.C. 5565). Unless we have other evidence showing an actual date of death, we will use the date he or she was reported missing as the date of death.

(b) Signed statements by those in a position to know and other records which show that the person has been absent from his or her residence and has not been heard from for at least 7 years. If the presumption of death is not rebutted pursuant to § 404.722, we will use as the person's date of death either the date he or she left home, the date ending the 7 year period, or some other date depending upon what the evidence shows is the most likely date of death.

(c) If you are applying for benefits as the insured person's grandchild or stepgrandchild but the evidence does not identify a parent, we will presume the parent died in the first month in which the insured person became entitled to benefits.

[43 FR 24795, June 7, 1978, as amended at 60 FR 19164, Apr. 17, 1995]

§ 404.722 Rebuttal of a presumption of death.

A presumption of death made based on § 404.721(b) can be rebutted by evidence that establishes that the person is still alive or explains the individual's absence in a manner consistent with continued life rather than death.

Example 1: Evidence in a claim for surviving child's benefits showed that the worker had wages posted to his earnings record in the year following the disappearance. It was established that the wages belonged to the worker and were for work done after his ''disappearance.'' In this situation, the presumption of death is rebutted by evidence (wages belonging to the worker) that the person is still alive after the disappearance.

Example 2: Evidence shows that the worker left the family home shortly after a woman, whom he had been seeing, also disappeared, and that the worker phoned his wife several days after the disappearance to state he intended to begin a new life in California. In this situation the presumption of death is rebutted because the evidence explains the worker's absence in a manner consistent with continued life.

[60 FR 19165, Apr. 17, 1995]

§ 404.723 When evidence of marriage is required.

If you apply for benefits as the insured person's husband or wife, widow or widower, divorced wife or divorced husband, we will ask for evidence of the marriage and where and when it took place. We may also ask for this evidence if you apply for child's benefits or for the lump-sum death payment as the widow or widower. If you are a widow, widower, or divorced wife who remarried after your marriage to the insured person ended, we may also ask for evidence of the remarriage. You may be asked for evidence of someone else's marriage if this is necessary to prove your marriage to the insured person was valid. In deciding whether the marriage to the insured person is valid or not, we will follow the law of the State where the insured person had his or her permanent home when you applied or, if earlier, when he or she died—see § 404.770. What evidence we will ask for depends upon whether the insured person's marriage was a ceremonial marriage, a common-law marriage, or a marriage we will deem to be valid.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

§ 404.725 Evidence of a valid ceremonial marriage.

(a) *General.* A valid *ceremonial marriage* is one that follows procedures set by law in the State or foreign country where it takes place. These procedures cover who may perform the marriage ceremony, what licenses or witnesses are needed, and similar rules. A ceremonial marriage can be one that follows certain tribal Indian custom, Chinese custom, or similar traditional procedures. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a ceremonial marriage is—

(1) If you are applying for wife's or husband's benefits, signed statements from you and the insured about when and where the marriage took place. If you are applying for the lump-sum death payment as the widow or widower, your signed statement about when and where the marriage took place; or

(2) If you are applying for any other benefits or there is evidence causing some doubt about whether there was a ceremonial marriage: a copy of the public record of marriage or a certified statement as to the marriage; a copy of the religious record of marriage or a certified statement as to what the record shows; or the original marriage certificate.

(c) *Other evidence of a ceremonial marriage.* If preferred evidence of a ceremonial marriage cannot be obtained, we will ask you to explain why and to give us a signed statement of the clergyman or official who held the marriage ceremony, or other convincing evidence of the marriage.

§ 404.726 Evidence of common-law marriage.

(a) *General.* A *common-law marriage* is one considered valid under certain State laws even though there was no formal ceremony. It is a marriage between two persons free to marry, who consider themselves married, live together as man and wife, and, in some States, meet certain other requirements. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a common-law marriage is—

(1) If both the husband and wife are alive, their signed statements and those of two blood relatives;

(2) If either the husband or wife is dead, the signed statements of the one who is alive and those of two blood relatives of the deceased person; or

(3) If both the husband and wife are dead, the signed statements of one blood relative of each;

NOTE: All signed statements should show why the signer believes there was a marriage between the two persons. If a written statement cannot be gotten from a blood relative, one from another person can be used instead.

(c) *Other evidence of common-law marriage.* If you cannot get preferred evidence of a common-law marriage, we will ask you to explain why and to give us other convincing evidence of the marriage. We may not ask you for statements from a blood relative or other person if we believe other evidence presented to us proves the common-law marriage.

§ 404.727 Evidence of a deemed valid marriage.

(a) *General.* A *deemed valid marriage* is a ceremonial marriage we consider valid even though the correct procedures set by State law were not strictly followed or a former marriage had not yet ended. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a deemed valid marriage is—

(1) Evidence of the ceremonial marriage as described in § 404.725(b)(2);

(2) If the insured person is alive, his or her signed statement that the other party to the marriage went through the ceremony in good faith and his or her reasons for believing the marriage was valid or believing the other party thought it was valid;

(3) The other party's signed statement that he or she went through the marriage ceremony in good faith and his or her reasons for believing it was valid;

(4) If needed to remove a reasonable doubt, the signed statements of others who might have information about what the other party knew about any previous marriage or other facts showing whether he or she went through the marriage in good faith; and

(5) Evidence the parties to the marriage were living in the same household when you applied for benefits or, if earlier, when the insured person died (see § 404.760).

(c) *Other evidence of a deemed valid marriage.* If you cannot obtain preferred evidence of a deemed valid marriage, we will ask you to explain why and to give us other convincing evidence of the marriage.

§ 404.728 Evidence a marriage has ended.

(a) *When evidence is needed that a marriage has ended.* If you apply for benefits as the insured person's divorced wife or divorced husband, you will be asked for evidence of your divorce. If you are the insured person's widow or divorced wife who had remarried but that husband died, we will ask you for evidence of his death. We may ask for evidence that a previous marriage you or the insured person had was ended before you married each other if this is needed to show the latter marriage was valid. If you apply for benefits as an unmarried person and you had a marriage which was annulled, we will ask for evidence of the annulment. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence a marriage has ended is—

(1) A certified copy of the decree of divorce or annulment; or

(2) Evidence the person you married has died (see § 404.720).

(c) *Other evidence a marriage has ended.* If you cannot obtain preferred evidence the marriage has ended, we will ask you to explain why and to give us other convincing evidence the marriage has ended.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

EVIDENCE FOR CHILD'S AND PARENT'S BENEFITS

§ 404.730 When evidence of a parent or child relationship is needed.

If you apply for parent's or child's benefits, we will ask for evidence showing your relationship to the insured person. What evidence we will ask for depends on whether you are the insured person's natural parent or child; or whether you are the stepparent, stepchild, grandchild, stepgrandchild, adopting parent or adopted child.

§ 404.731 Evidence you are a natural parent or child.

If you are the natural parent of the insured person, we will ask for a copy of his or her public or religious birth record made before age 5. If you are the natural child of the insured person, we will ask for a copy of your public or religious birth record made before age 5. In either case, if this record shows the same last name for the insured and the parent or child, we will accept it as convincing evidence of the relationship. However, if other evidence raises some doubt about this record or if the record cannot be gotten, we will ask for other evidence of the relationship. We may also ask for evidence of marriage of the insured person or of his or her parent if this is needed to remove any reasonable doubt about the relationship. To show you are the child of the insured person, you may be asked for evidence you would be able to inherit his or her personal property under State law where he or she had a permanent home (see § 404.770). In addition, we may ask for the insured persons signed statement that you are his or her natural child, or for a copy of any court order showing the insured has been declared to be your natural parent or any court order requiring the insured to contribute to you support because you are his or her son or daughter.

§ 404.732 Evidence you are a stepparent or stepchild.

If you are the stepparent or stepchild of the insured person, we will ask for the evidence described in § 404.731 or § 404.733 that which shows your natural or adoptive relationship to the insured person's husband, wife, widow, or widower. We will also ask for evidence of the husband's, wife's, widow's, or widower's marriage to the insured person—see § 404.725.

§ 404.733 Evidence you are the legally adopting parent or legally adopted child.

If you are the adopting parent or adopted child, we will ask for the following evidence:

(a) A copy of the birth certificate made following the adoption; or if this cannot be gotten, other evidence of the adoption; and, if needed, evidence of the date of adoption;

(b) If the widow or widower adopted the child after the insured person died, the evidence described in paragraph (a) of this section; your written statement whether the insured person was living in the same household with the child

when he or she died (see § 404.760); what support the child was getting from any other person or organization; and if the widow or widower had a deemed valid marriage with the insured person, evidence of that marriage—see § 404.727;

(c) If you are the insured's stepchild, grandchild, or stepgrandchild as well as his or her adopted child, we may also ask you for evidence to show how you were related to the insured before the adoption.

§ 404.734 Evidence you are an equitably adopted child.

In many States, the law will treat someone as a child of another if he or she agreed to adopt the child, the natural parents or the person caring for the child were parties to the agreement, he or she and the child then lived together as parent and child, and certain other requirements are met. If you are a child who had this kind or relationship to the insured person (or to the insured person's wife, widow, or husband), we will ask for evidence of the agreement if it is in writing. If it is not in writing or cannot be gotten, other evidence may be accepted. Also, the following evidence will be asked for: Written statements of your natural parents and the adopting parents and other evidence of the child's relationship to the adopting parents.

§ 404.735 Evidence you are the grandchild or stepgrandchild.

If you are the grandchild or stepgrandchild of the insured person, we will ask you for the kind of evidence described in §§ 404.731 through 404.733 that shows your relationship to your parent and your parent's relationship to the insured.

§ 404.736 Evidence of a child's dependency.

(a) *When evidence of a child's dependency is needed.* If you apply for child's benefit's we may ask for evidence you were the insured person's dependent at a specific time—usually the time you applied or the time the insured died or became disabled. What evidence we ask for depends upon how you are related to the insured person.

(b) *Natural or adopted child.* If you are the insured person's natural or adopted child, we may ask for the following evidence:

(1) A signed statement by someone who knows the facts that confirms this relationship and which shows whether you were legally adopted by someone other than the insured. If you were adopted by someone else while the insured person was alive, but the adoption was annulled, we may ask for a certified copy of the annulment decree or other convincing evidence of the annulment.

(2) A signed statement by someone in a position to know showing when and where you lived with the insured and when and why you may have lived apart; and showing what contributions the insured made to your support and when and how they were made.

(c) *Stepchild.* If you are the insured person's stepchild, we will ask for the following evidence:

(1) A signed statement by someone in a position to know—showing when and where you lived with the insured and when and why you may have lived apart.

(2) A signed statement by someone in a position to know showing you received at least one-half of your support from the insured for the one-year period ending at one of the times mentioned in paragraph (a) of this section; and the income end support you had in this period from any other source.

(d) *Grandchild or Stepgrandchild.* If you are the insured person's grandchild or stepgrandchild, we will ask for evidence described in paragraph (c) of this section showing that you were living together with the insured and receiving one-half of your support from him or her for the year before the insured became entitled to benefits or to a period of disability, or died. We will also ask for evidence of your parent's death or disability.

§ 404.745 Evidence of school attendance for child age 18 or older.

If you apply for child's benefits as a student age 18 or over, we may ask for evidence you are attending school. We may also ask for evidence from the school you attend showing your status at the school. We will ask for the following evidence:

(a) Your signed statement that you are attending school full-time and are not being paid by an employer to attend school.

(b) If you apply before the school year has started and the school is not a high school, a letter of acceptance from the school, receipted bill, or other evidence showing you have enrolled or been accepted at that school.

§ 404.750 Evidence of a parent's support.

If you apply for parent's benefits, we will ask you for evidence to show that you received at least one-half of your support from the insured person in the one-year period before he or she died or became disabled. We may also ask others who know the facts for a signed statement about your sources of support. We will ask you for the following evidence:

(a) The parent's signed statement showing his or her income, any other sources of support, and the amount from each source over the one-year period.

(b) If the statement described in paragraph (a) of this section cannot be obtained, other convincing evidence that the parent received one-half of his or her support from the insured person.

OTHER EVIDENCE REQUIREMENTS

§ 404.760 Evidence of living in the same household with insured person.

If you apply for the lump-sum death payment as the insured person's widow or widower, or for wife's, husband's, widow's, or widower's benefits based upon a deemed valid marriage as described in § 404.727, we will ask for evidence you and the insured were living together in the same household when he or she died; or if the insured is alive, when you applied for benefits. We will ask for the following as evidence of this:

(a) If the insured person is living, his or her signed statement and yours showing whether you were living together when you applied for benefits.

(b) If the insured person is dead, your signed statement showing whether you were living together when he or she died.

(c) If you and the insured person were temporarily living apart, a signed statement explaining where each was living, how long the separation lasted, and why you were separated. If needed to remove any reasonable doubts about this, we may ask for the signed statements of others in a position to know, or for other convincing evidence you and the insured were living together in the same household.

§ 404.762 What is acceptable evidence of having a child in my care?

What evidence we will ask for depends upon whether the child is living with you or with someone else. You will be asked to give the following evidence:

(a) If the child is living with you, your signed statement showing that the child is living with you.

(b) If the child is living with someone else—

(1) Your signed statement showing with whom he or she is living and why he or she is living with someone else. We will also ask when he or she last lived with you and how long this separation will last, and what care and contributions you provide for the child;

(2) The signed statement of the one with whom the child is living showing what care you provide and the sources and amounts of support received for the child. If the child is in an institution, an official there should sign the statement. These statements are preferred evidence. If there is a court order or written agreement showing who has custody of the child, you may be asked to give us a copy; and

(3) If you cannot get the preferred evidence described in paragraph (b)(2) of this section, we will ask for other convincing evidence that the child is in your care.

[43 FR 24795, June 7, 1978, as amended at 73 FR 40967, July 17, 2008]

§ 404.770 Evidence of where the insured person had a permanent home.

(a) *When evidence of the insured's permanent home is needed.* We may ask for evidence of where the insured person's permanent home was at the time you applied or, if earlier, the time he or she died if—

(1) You apply for benefits as the insured's wife, husband, widow, widower, parent or child; and

(2) Your relationship to the insured depends upon the State law that would be followed in the place where the insured had his or her permanent home when you applied for benefits or when he or she died.

(b) *What evidence is needed.* We will ask for the following evidence of the insured person's permanent home:

(1) Your signed statement showing where the insured considered his permanent home to be.

(2) If the statement in paragraph (b)(1) of this section or other evidence we have raises a reasonable doubt about where the insured's permanent home was, evidence of where he or she paid personal, property, or income taxes, or voted; or other convincing evidence of where his or her permanent home was.

§ 404.780 Evidence of "good cause" for exceeding time limits on accepting proof of support or application for a lump-sum death payment.

(a) *When evidence of good cause* is needed. We may ask for evidence that you had *good cause* (as defined in § 404.370(f)) for not giving us sooner proof of the support you received from the insured as his or her parent. We may also ask for evidence that you had *good cause* (as defined in § 404.621(b)) for not applying sooner for the lump-sum death payment. You may be asked for evidence of *good cause* for these delays if—

(1) You are the insured person's parent giving us proof of support more than 2 years after he or she died, or became disabled; or

(2) You are applying for the lump-sum death payment more than 2 years after the insured died.

(b) *What evidence of good cause* is needed. We will ask for the following evidence of good cause:

(1) Your signed statement explaining why you did not give us the proof of support or the application for lump-sum death payment within the specified 2 year period.

(2) If the statement in paragraph (b)(1) of the section or other evidence raises a reasonable doubt whether there was good cause, other convincing evidence of this.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

Subpart I—Records of Earnings

AUTHORITY: Secs. 205(a), (c)(1), (c)(2)(A), (c)(4), (c)(5), (c)(6), and (p), 702(a)(5), and 1143 of the Social Security Act (42 U.S.C. 405(a), (c)(1), (c)(2)(A), (c)(4), (c)(5), (c)(6), and (p), 902(a)(5), and 1320b–13).

SOURCE: 44 FR 38454, July 2, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.801 Introduction.

The Social Security Administration (SSA) keeps a record of the earnings of all persons who work in employment or self-employment covered under social security. We use these earnings records to determine entitlement to and the amount of benefits that may be payable based on a person's earnings under the retirement, survivors', disability and health insurance program. This subpart tells what is evidence of earnings, how you can find out what the record of your earnings shows, and how and under what circumstances the record of your earnings may be changed to correct errors.

§ 404.802 Definitions.

For the purpose of this subpart—

Earnings means wages and self-employment income earned by a person based on work covered by social security. (See subpart K for the rules about what constitutes wages and self-employment income for benefit purposes.)

Period means a taxable year when referring to self-employment income. When referring to wages it means a calendar quarter if the wages were reported or should have been reported quarterly by your employer or a calendar year if the wages were reported or should have been reported annually by your employer.

Record of earnings, *earnings record*, or *record* means SSA's records of the amounts of wages paid to you and the amounts of self-employment income you received, the periods in which the wages were paid and the self-employment income was received, and the

quarters of coverage which you earned based on these earnings.

Survivor means your spouse, divorced wife, child, or parent, who survives you. *Survivor* also includes your surviving divorced wife who may be entitled to benefits as a surviving divorced mother.

Tax return means, as appropriate, a tax return of wages or a tax return of self-employment income (including information returns and other written statements filed with the Commissioner of Internal Revenue under chapter 2 or 21 of the Internal Revenue Code of 1954, as amended).

Time limit means a period of time 3 years, 3 months, and 15 days after any year in which you received earnings. The period may be extended by the Soldiers and Sailors Relief Act of 1940 because of your military service or the military service of certain relatives who survive you (50 U.S.C. App. 501 and following sections). Where the time limit ends on a Federal nonwork day, we will extend it to the next Federal work day.

Wage report means a statement filed by a State under section 218 of the Social Security Act or related regulations. This statement includes wage amounts for which a State is billed and wage amounts for which credits or refunds are made to a State according to an agreement under section 218 of the Act.

We, us, or *our* means the Social Security Administration (SSA).

Year means a calendar year when referring to wages and a taxable year when referring to self-employment income.

You or *your* means any person for whom we maintain a record of earnings.

§ 404.803 Conclusiveness of the record of your earnings.

(a) *Generally.* For social security purposes, SSA records are evidence of the amounts of your earnings and the periods in which they were received.

(b) *Before time limit ends.* Before the time limit ends for a year, SSA records are evidence, but not conclusive evidence, of the amounts and periods of your earnings in that year.

(c) *After time limit ends.* After the time limit ends for a year—

(1) If SSA records show an entry of self-employment income or wages for an employer for a period in that year, our records are conclusive evidence of your self-employment income in that year or the wages paid to you by that employer and the periods in which they were received unless one of the exceptions in § 404.822 applies;

(2) If SSA records show no entry of wages for an employer for a period in that year, our records are conclusive evidence that no wages were paid to you by that employer in that period unless one of the exceptions in § 404.822 applies; and

(3) If SSA records show no entry of self-employment income for that year, our records are conclusive evidence that you did not receive self-employment income in that year unless the exception in § 404.822(b)(2) (i) or (iii) applies.

OBTAINING EARNINGS INFORMATION

§ 404.810 How to obtain a statement of earnings and a benefit estimate statement.

(a) *Right to a statement of earnings and a benefit estimate.* You or your legal representative or, after your death, your survivor or the legal representative of your estate may obtain a statement of your earnings as shown on our records at the time of the request. If you have a social security number and have wages or net earnings from self-employment, you may also request and receive an earnings statement that will include an estimate of the monthly old-age, disability, dependents', and survivors' insurance benefits potentially payable on your earnings record, together with a description of the benefits payable under the medicare program. You may request these statements by writing, calling, or visiting a social security office.

(b) *Contents of request.* When you request a statement of your earnings, we will ask you to complete a prescribed form, giving us your name, social security number, date of birth, and sex. You, your authorized representative or, after your death, your survivor or the legal representative of your estate will be asked to sign and date the form. If

you are requesting an estimate of the monthly benefits potentially payable on your earnings record, we will also ask you to give us the amount of your earnings for the last year, an estimate of your earnings for the current year, an estimate of your earnings for future years before your planned retirement, and the age at which you plan to retire, so that we can give you a more realistic estimate of the benefits that may be payable on your record. A request for a statement of earnings and a benefit estimate not made on the prescribed form will be accepted if the request is in writing, is signed and dated by the appropriate individual noted above, and contains all the information that is requested on the prescribed form.

[57 FR 54918, Nov. 23, 1992]

§ 404.811 The statement of earnings and benefit estimates you requested.

(a) *General.* After receiving a request for a statement of earnings and the information we need to comply with the request, we will provide you or your authorized representative a statement of the earnings we have credited to your record at the time of your request. With the statement of earnings, we will include estimates of the benefits potentially payable on your record, unless you do not have the required credits (quarters of coverage) for any kind of benefit(s). (However, see paragraph (b)(3) of this section regarding the possibility of our estimating up to eight additional credits on your record.) If we do not provide a statement of earnings and an estimate of all the benefits potentially payable, or any other information you requested, we will explain why.

(b) *Contents of statement of earnings and benefit estimates.* The statement of your earnings and benefit estimates will contain the following information:

(1) Your social security taxed earnings as shown by our records as of the date of your request;

(2) An estimate of the social security and medicare hospital insurance taxes paid on your earnings (although we do not maintain such tax information);

(3) The number of credits, *i.e.*, quarters of coverage, not exceeding 40, you have for both social security and medicare hospital insurance purposes, and the number you need to be eligible for social security and also for medicare hospital insurance coverage. If you do not already have the required credits (quarters of coverage) to be eligible to receive social security benefits and medicare hospital insurance coverage, we may include up to eight additional estimated credits (four per year) based on the earnings you told us you had for last year and this year that we have not yet entered on your record;

(4) A statement as to whether you meet the credits (quarters of coverage) requirements, as described in subpart B of this part, for each type of social security benefit when we prepare the benefit estimates, and also whether you are eligible for medicare hospital insurance coverage;

(5) Estimates of the monthly retirement (old-age), disability, dependents' and survivors' insurance benefits potentially payable on your record if you meet the credits (quarters of coverage) requirements. The benefit estimates we send you will be based partly on your stated earnings for last year (if not yet on your record), your estimate of your earnings for the current year and for future years before you plan to retire, and on the age at which you plan to retire. The estimate will include the retirement (old-age) insurance benefits you could receive at age 62 (or your current age if you are already over age 62), at full retirement age (currently age 65 to 67, depending on your year of birth) or at your current age if you are already over full retirement age, and at age 70;

(6) A description of the coverage under the medicare program;

(7) A reminder of your right to request a correction of your earnings record; and

(8) A remark that an annually updated statement is available on request.

[61 FR 18076, Apr. 24, 1996]

§ 404.812 Statement of earnings and benefit estimates sent without request.

(a) *Who will be sent a statement.* Unless one of the conditions in paragraph (b) of this section applies to you, we

will send you, without request, a statement of earnings and benefit estimates if:

(1) You have a social security account number;

(2) You have wages or net earnings from self-employment on your social security record;

(3) You have attained age 25 or older, as explained in paragraph (c)(3) of this section; and

(4) We can determine your current mailing address.

(b) *Who will not be sent a statement.* We will not send you an unrequested statement if any of the following conditions apply:

(1) You do not meet one or more of the conditions of paragraph (a) of this section;

(2) Our records contain a notation of your death;

(3) You are entitled to benefits under title II of the Act;

(4) We have already sent you a statement, based on your request, in the fiscal year we selected you to receive an unrequested statement;

(5) We cannot obtain your address (see paragraph (c)(2) of this section); or

(6) We are correcting your social security earnings record when we select you to receive a statement of earnings and benefit estimates.

(c) *The selection and mailing process.* Subject to the provisions of paragraphs (a) and (b) of this section, we will use the following process for sending statements without requests:

(1) *Selection.* We will use our records of assigned social security account numbers to identify individuals to whom we will send statements.

(2) *Addresses.* If you are living in one of the 50 States or the District of Columbia, our current procedure is to get your address from individual taxpayer files of the Internal Revenue Service, as authorized by section 6103(m)(7) of the Internal Revenue Code (26 U.S.C. 6103(m)(7)). If you live in Puerto Rico, the Virgin Islands, or Guam, we will get your address from the taxpayer records of the place in which you live.

(3) *Age.* If you have attained age 60 on or before September 30, 1995, we will send you a statement by that date. If you attain age 60 on or after October 1, 1995 but no later than September 30, 1999, we will send you a statement in the fiscal year in which you attain age 60, or in an earlier year as resources allow. Also, we will inform you that an annually updated statement is available on request. Beginning October 1, 1999, we will send you a statement each year in which you are age 25 or older.

(4) *Ineligible.* If we do not send you a statement because one or more conditions in paragraph (b) of this section apply when you are selected, we will send a statement in the first appropriate fiscal year thereafter in which you do qualify.

(5) *Undeliverable.* If the statement we send you is returned by the Post Office as undeliverable, we will not remail it.

(d) *Contents of statement of earnings and benefit estimates.* To prepare your statement and estimate your benefits, we will use the earnings in our records. If there are earnings recorded for you in either of the two years before the year in which you are selected to get a statement, we will use the later of these earnings as your earnings for the current year and future years when we estimate your benefits. In addition, if you do not already have the required credits (quarters of coverage) to be eligible to receive benefits, we will use that last recorded earnings amount to estimate up to eight additional credits (four per year) for last year and the current year if they are not yet entered on your record. If there are no earnings entered on your record in either of the two years preceding the year of selection, we will not estimate current and future earnings or additional credits for you. Your earnings and benefit estimates statement will contain the following information:

(1) Your social security taxed earnings as shown by our records as of the date we select you to receive a statement;

(2) An estimate of the social security and medicare hospital insurance taxes paid on your earnings (although we do not maintain such tax information);

(3) The number of credits, *i.e.*, quarters of coverage, not exceeding 40 (as described in paragraph (d) of this section), that you have for both social security and medicare hospital insurance purposes, and the number you need to be eligible for social security benefits

and also for medicare hospital insurance coverage;

(4) A statement as to whether you meet the credit (quarters of coverage) requirements, as described in subpart B of this part, for each type of social security benefit when we prepare the benefit estimates, and also whether you are eligible for medicare hospital insurance coverage;

(5) Estimates of the monthly retirement (old-age), disability, dependents' and survivors' insurance benefits potentially payable on your record if you meet the credits (quarters of coverage) requirements. If you are age 50 or older, the estimates will include the retirement (old-age) insurance benefits you could receive at age 62 (or your current age if you are already over age 62), at full retirement age (currently age 65 to 67, depending on your year of birth) or at your current age if you are already over full retirement age, and at age 70. If you are under age 50, instead of estimates, we may provide a general description of the benefits (including auxiliary benefits) that are available upon retirement;

(6) A description of the coverage provided under the medicare program;

(7) A reminder of your right to request a correction of your earnings record; and

(8) A remark that an annually updated statement is available on request.

[61 FR 18077, Apr. 24, 1996]

CORRECTING THE EARNINGS RECORD

§ 404.820 Filing a request for correction of the record of your earnings.

(a) *When to file a request for correction.* You or your survivor must file a request for correction of the record of your earnings within the time limit for the year being questioned unless one of the exceptions in § 404.822 applies.

(b) *Contents of a request.* (1) A request for correction of an earnings record must be in writing and must state that the record is incorrect.

(2) A request must be signed by you or your survivor or by a person who may sign an application for benefits for you or for your survivor as described in § 404.612.

(3) A request should state the period being questioned.

(4) A request should describe, or have attached to it, any available evidence which shows that the record of earnings is incorrect.

(c) *Where to file a request.* A request may be filed with an SSA employee at one of our offices or with an SSA employee who is authorized to receive a request at a place other than one of our offices. A request may be filed with the Veterans Administration Regional Office in the Philippines or with any U.S. Foreign Service Office.

(d) *When a request is considered filed.* A request is considered filed on the day it is received by any of our offices, by an authorized SSA employee, by the Veterans Administration Regional Office in the Philippines, or by any U.S. Foreign Service Office. If using the date we receive a mailed request disadvantages the requester, we will use the date the request was mailed to us as shown by a U.S. postmark. If the postmark is unreadable or there is no postmark, we will consider other evidence of the date when the request was mailed.

(e) *Withdrawal of a request for correction.* A request for correction of SSA records of your earnings may be withdrawn as described in § 404.640.

(f) *Cancellation of a request to withdraw.* A request to withdraw a request for correction of SSA records of your earnings may be cancelled as described in § 404.641.

(g) *Determinations on requests.* When we receive a request described in this section, we will make a determination to grant or deny the request. If we deny the request, this determination may be appealed under the provisions of subpart J of this part.

§ 404.821 Correction of the record of your earnings before the time limit ends.

Before the time limit ends for any year, we will correct the record of your earnings for that year for any reason if satisfactory evidence shows SSA records are incorrect. We may correct the record as the result of a request filed under § 404.820 or we may correct it on our own.

§ 404.822 Correction of the record of your earnings after the time limit ends.

(a) *Generally*. After the time limit for any year ends, we may correct the record of your earnings for that year if satisfactory evidence shows SSA records are incorrect and any of the circumstances in paragraphs (b) through (e) of this section applies.

(b) *Correcting SSA records to agree with tax returns*. We will correct SSA records to agree with a tax return of wages or self-employment income to the extent that the amount of earnings shown in the return is correct.

(1) *Tax returns of wages*. We may correct the earnings record to agree with a tax return of wages or with a wage report of a State.

(2) *Tax returns of self-employment income*—(i) *Return filed before the time limit ended*. We may correct the earnings record to agree with a tax return of self-employment income filed before the end of the time limit.

(ii) *Return filed after time limit ended*. We may remove or reduce, but not increase, the amount of self-employment income entered on the earnings record to agree with a tax return of self-employment income filed after the time limit ends.

(iii) *Self-employment income entered in place of erroneously entered wages*. We may enter self-employment income for any year up to an amount erroneously entered in SSA records as wages but which was later removed from the records. However, we may enter self-employment income under this paragraph only if—

(A) An amended tax return is filed before the time limit ends for the year in which the erroneously entered wages were removed; or

(B) Net earnings from self-employment, which are not already entered in the record of your earnings, were included in a tax return filed before the end of the time limit for the year in which the erroneously entered wages were removed.

(c) *Written request for correction or application for benefits filed before the time limit ends*—(1) *Written request for correction*. We may correct an earnings record if you or your survivor files a request for correction before the time limit for that year ends. The request must state that the earnings record for that year is incorrect. However, we may not correct the record under this paragraph after our determination on the request becomes final.

(2) *Application for benefits*. We may correct an earnings record if an application is filed for monthly benefits or for a lump-sum death payment before the time limit for that year ends. However, we may not correct the record under this paragraph after our determination on the application becomes final.

(3) See subpart J for the rules on the finality of determinations.

(d) *Transfer of wages to or from the Railroad Retirement Board*—(1) *Wages erroneously reported*. We may transfer to or from the records of the Railroad Retirement Board earnings which were erroneously reported to us or to the Railroad Retirement Board.

(2) *Earnings certified by Railroad Retirement Board*. We may enter earnings for railroad work under subpart O if the earnings are certified by the Railroad Retirement Board.

(e) *Other circumstances permitting correction*—(1) *Investigation started before time limit ends*. We may correct an earnings record if the correction is made as the result of an investigation started before, but completed after the time limit ends. An investigation is started when we take an affirmative step leading to a decision on a question about the earnings record, for example, an investigation is started when one SSA unit asks another unit to obtain additional information or evidence. We will remove or reduce earnings on the record under this paragraph only if we carried out the investigation as promptly as circumstances permitted.

(2) *Error apparent on face of records*. We may correct an earnings record to correct errors, such as mechanical or clerical errors, which can be identified and corrected without going beyond any of the pertinent SSA records.

(3) *Fraud*. We may change any entry which was entered on the earnings record as the result of fraud.

(4) *Entries for wrong person or period*. We may correct errors in SSA records resulting from earnings being entered for the wrong person or period.

(5) *Less than correct wages on SSA records.* We may enter wages paid to you by an employer for a period if no part of those wages or less than the correct amount of those wages is entered on SSA records.

(6) *Wage payments under a statute.* We may enter and allocate wages awarded to you for a period as the result of a determination or agreement approved by a court or administrative agency that enforces Federal or State statutes protecting your right to employment or wages.

[44 FR 38454, July 2, 1979, as amended at 57 FR 21600, May 21, 1992]

§ 404.823 Correction of the record of your earnings for work in the employ of the United States.

We may correct the record of your earnings to remove, reduce, or enter earnings for work in the employ of the United States only if—

(a) Correction is permitted under § 404.821 or § 404.822; and

(b) Any necessary determinations concerning the amount of remuneration paid for your work and the periods for which such remuneration was paid have been made as shown by—

(1) A tax return filed under section 3122 of the Internal Revenue Code (26 U.S.C. 3122); or

(2) A certification by the head of the Federal agency or instrumentality of which you have been an employee or his or her agent. A Federal instrumentality for these purposes includes a nonappropriated fund activity of the armed forces or Coast Guard.

[44 FR 38454, July 2, 1979, as amended at 55 FR 24891, June 19, 1990]

NOTICE OF REMOVAL OR REDUCTION OF AN ENTRY OF EARNINGS

§ 404.830 Notice of removal or reduction of your wages.

If we remove or reduce an amount of wages entered on the record of your earnings, we will notify you of this correction if we previously notified you of the amount of your wages for the period involved. We will notify your survivor if we previously notified you or your survivor of the amount of your earnings for the period involved.

§ 404.831 Notice of removal or reduction of your self-employment income.

If we remove or reduce an amount of self-employment income entered on the record of your earnings, we will notify you of this correction. We will notify your survivor if we previously notified you or your survivor of the amount of your earnings for the period involved.

Subpart J—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

AUTHORITY: Secs. 201(j), 204(f), 205(a)–(b), (d)–(h), and (j), 221, 223(i), 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(j), 404(f), 405(a)–(b), (d)–(h), and (j), 421, 423(i), 425, and 902(a)(5)); sec. 5, Pub. L. 97–455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)–(e), and 15, Pub. L. 98–460, 98 Stat. 1802 (42 U.S.C. 421 note); sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

§ 404.900 Introduction.

(a) *Explanation of the administrative review process.* This subpart explains the procedures we follow in determining your rights under title II of the Social Security Act. The regulations describe the process of administrative review and explain your right to judicial review after you have taken all the necessary administrative steps. These procedures apply also to persons claiming certain benefits under title XVIII of the Act (Medicare); see 42 CFR 405.904(a)(1). The administrative review process consists of several steps, which usually must be requested within certain time periods and in the following order:

(1) *Initial determination.* This is a determination we make about your entitlement or your continuing entitlement to benefits or about any other matter, as discussed in § 404.902, that gives you a right to further review.

(2) *Reconsideration.* If you are dissatisfied with an initial determination, you may ask us to reconsider it.

(3) *Hearing before an administrative law judge.* If you are dissatisfied with the reconsideration determination, you

may request a hearing before an administrative law judge.

(4) *Appeals Council review.* If you are dissatisfied with the decision of the administrative law judge, you may request that the Appeals Council review the decision.

(5) *Federal court review.* When you have completed the steps of the administrative review process listed in paragraphs (a)(1) through (a)(4) of this section, we will have made our final decision. If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court.

(6) *Expedited appeals process.* At some time after your initial determination has been reviewed, if you have no dispute with our findings of fact and our application and interpretation of the controlling laws, but you believe that a part of the law is unconstitutional, you may use the expedited appeals process. This process permits you to go directly to a Federal district court so that the constitutional issue may be resolved.

(b) *Nature of the administrative review process.* In making a determination or decision in your case, we conduct the administrative review process in an informal, non-adversarial manner. Subject to certain timeframes at the hearing level (see § 404.935) and the limitations on Appeals Council consideration of additional evidence (see § 404.970), we will consider at each step of the review process any information you present as well as all the information in our records. If you are dissatisfied with our decision in the review process, but do not take the next step within the stated time period, you will lose your right to further administrative review and your right to judicial review, unless you can show us that there was good cause for your failure to make a timely request for review.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 300, Jan. 3, 1986; 51 FR 8808, Mar. 14, 1986; 52 FR 4004, Feb. 9, 1987; 78 FR 57259, Sept. 18, 2013; 80 FR 14835, Mar. 20, 2015; 81 FR 90992, Dec. 16, 2016]

§ 404.901 Definitions.

As used in this subpart:

Date you receive notice means 5 days after the date on the notice, unless you show us that you did not receive it within the 5-day period.

Decision means the decision made by an administrative law judge or the Appeals Council.

Determination means the initial determination or the reconsidered determination.

Preponderance of the evidence means such relevant evidence that as a whole shows that the existence of the fact to be proven is more likely than not.

Remand means to return a case for further review.

Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.

Vacate means to set aside a previous action.

Waive means to give up a right knowingly and voluntarily.

We, us, or *our* refers to the Social Security Administration.

You or *your* refers to any person claiming a right under the old age, disability, dependents' or survivors' benefits program.

[45 FR 52081, Aug. 5, 1980, as amended at 73 FR 76943, Dec. 18, 2008]

§ 404.902 Administrative actions that are initial determinations.

Initial determinations are the determinations we make that are subject to administrative and judicial review. We will base our initial determination on the preponderance of the evidence. We will state the important facts and give the reasons for our conclusions in the initial determination. In the old age, survivors' and disability insurance programs, initial determinations include, but are not limited to, determinations about—

(a) Your entitlement or your continuing entitlement to benefits;

(b) Your reentitlement to benefits;

(c) The amount of your benefit;

(d) A recomputation of your benefit;

(e) A reduction in your disability benefits because you also receive benefits under a workmen's compensation law;

(f) A deduction from your benefits on account of work;

(g) [Reserved]

(h) Termination of your benefits;

(i) Penalty deductions imposed because you failed to report certain events;

(j) Any overpayment or underpayment of your benefits;

(k) Whether an overpayment of benefits must be repaid to us;

(l) How an underpayment of benefits due a deceased person will be paid;

(m) The establishment or termination of a period of disability;

(n) A revision of your earnings record;

(o) Whether the payment of your benefits will be made, on your behalf, to a representative payee;

(p) Your drug addiction or alcoholism;

(q) Who will act as your payee if we determine that representative payment will be made;

(r) An offset of your benefits under § 404.408b because you previously received supplemental security income payments for the same period;

(s) Whether your completion of, or continuation for a specified period of time in, an appropriate program of vocational rehabilitation services, employment services, or other support services will increase the likelihood that you will not have to return to the disability benefit rolls, and thus, whether your benefits may be continued even though you are not disabled;

(t) Nonpayment of your benefits under § 404.468 because of your confinement in a jail, prison, or other penal institution or correctional facility for conviction of a felony;

(u) Whether or not you have a disabling impairment(s) as defined in § 404.1511;

(v) Nonpayment of your benefits under § 404.469 because you have not furnished us satisfactory proof of your Social Security number, or, if a Social Security number has not been assigned to you, you have not filed a proper application for one;

(w) A claim for benefits under § 404.633 based on alleged misinformation; and

(x) Whether we were negligent in investigating or monitoring or failing to investigate or monitor your representative payee, which resulted in the misuse of benefits by your representative payee.

[45 FR 52081, Aug. 5, 1980, as amended at 47 FR 4988, Feb. 3, 1982; 47 FR 31543, July 21, 1982; 49 FR 22272, May 29, 1984; 50 FR 20902, May 21, 1985; 56 FR 41790, Aug. 23, 1991; 59 FR 44925, Aug. 31, 1994; 60 FR 8147, Feb. 10, 1995; 68 FR 40123, July 7, 2003; 69 FR 60232, Oct. 7, 2004; 70 FR 36507, June 24, 2005; 73 FR 76943, Dec. 18, 2008]

§ 404.903 Administrative actions that are not initial determinations.

Administrative actions that are not initial determinations may be reviewed by us, but they are not subject to the administrative review process provided by this subpart, and they are not subject to judicial review. These actions include, but are not limited to, an action—

(a) Suspending benefits pending an investigation and determination of any factual issue relating to a deduction on account of work;

(b) Suspending benefits pending an investigation to determine if your disability has ceased;

(c) Denying a request to be made a representative payee;

(d) Certifying two or more family members for joint payment of benefits;

(e) Withholding less than the full amount of your monthly benefit to recover an overpayment;

(f) Determining the fee that may be charged or received by a person who has represented you in connection with a proceeding before us;

(g) Refusing to recognize, disqualifying, or suspending a person from acting as your representative in a proceeding before us (see §§ 404.1705 and 404.1745);

(h) Compromising, suspending or terminating collection of an overpayment under the Federal Claims Collection Act;

(i) Extending or not extending the time to file a report of earnings;

(j) Denying your request to extend the time period for requesting review of a determination or a decision;

(k) Denying your request to use the expedited appeals process;

(l) Denying your request to reopen a determination or a decision;

(m) Withholding temporarily benefits based on a wage earner's estimate of

earnings to avoid creating an overpayment;

(n) Determining whether (and the amount of) travel expenses incurred are reimbursable in connection with proceedings before us;

(o) Denying your request to readjudicate your claim and apply an Acquiescence Ruling;

(p) Findings on whether we can collect an overpayment by using the Federal income tax refund offset procedure (see § 404.523);

(q) Determining whether an organization may collect a fee from you for expenses it incurred in serving as your representative payee (see § 404.2040a);

(r) Declining under § 404.633(f) to make a determination on a claim for benefits based on alleged misinformation because one or more of the conditions specified in § 404.633(f) are not met;

(s) The assignment of a monthly payment day (see § 404.1807);

(t) Determining whether we will refer information about your overpayment to a consumer reporting agency (see §§ 404.527 and 422.305 of this chapter);

(u) Determining whether we will refer your overpayment to the Department of the Treasury for collection by offset against Federal payments due you (see §§ 404.527 and 422.310 of this chapter);

(v) Determining whether we will order your employer to withhold from your disposable pay to collect an overpayment you received under title II of the Social Security Act (see part 422, subpart E, of this chapter);

(w) Determining whether provisional benefits are payable, the amount of the provisional benefits, and when provisional benefits terminate (see § 404.1592e);

(x) Determining whether to select your claim for the quick disability determination process under § 404.1619;

(y) The removal of your claim from the quick disability determination process under § 404.1619;

(z) Starting or discontinuing a continuing disability review;

(aa) Issuing a receipt in response to your report of a change in your work activity; and

(bb) Determining whether a non-attorney representative is eligible to receive direct fee payment as described in § 404.1717 of this part.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 8808, Mar. 14, 1986; 55 FR 1018, Jan. 11, 1990; 56 FR 52469, Oct. 21, 1991; 57 FR 23057, June 1, 1992; 59 FR 44925, Aug. 31, 1994; 62 FR 6120, Feb. 11, 1997; 62 FR 64278, Dec. 5, 1997; 68 FR 74183, Dec. 23, 2003; 70 FR 57142, Sept. 30, 2005; 71 FR 16443, Mar. 31, 2006; 71 FR 66853, 66866, Nov. 17, 2006; 72 FR 51177, Sept. 6, 2007; 76 FR 45192, July 28, 2011; 76 FR 80245, Dec. 23, 2011; 80 FR 400, Jan. 6, 2015]

§ 404.904 Notice of the initial determination.

We will mail a written notice of our initial determination to you at your last known address. The written notice will explain in simple and clear language what we have determined and the reasons for and the effect of our determination. If our determination involves a determination of disability that is in whole or in part unfavorable to you, our written notice also will contain in understandable language a statement of the case setting forth the evidence on which our determination is based. The notice also will inform you of your right to reconsideration. We will not mail a notice if the beneficiary's entitlement to benefits has ended because of his or her death.

[72 FR 51177, Sept. 6, 2007]

§ 404.905 Effect of an initial determination.

An initial determination is binding unless you request a reconsideration within the stated time period, or we revise the initial determination.

[51 FR 300, Jan. 3, 1986]

§ 404.906 Testing modifications to the disability determination procedures.

(a) *Applicability and scope.* Notwithstanding any other provision in this part or part 422 of this chapter, we are establishing the procedures set out in this section to test modifications to our disability determination process. These modifications will enable us to test, either individually or in one or more combinations, the effect of: having disability claim managers assume primary responsibility for processing an application for disability benefits; providing persons who have applied for

benefits based on disability with the opportunity for an interview with a decisionmaker when the decisionmaker finds that the evidence in the file is insufficient to make a fully favorable determination or requires an initial determination denying the claim; having a single decisionmaker make the initial determination with assistance from medical consultants, where appropriate; and eliminating the reconsideration step in the administrative review process and having a claimant who is dissatisfied with the initial determination request a hearing before an administrative law judge. The model procedures we test will be designed to provide us with information regarding the effect of these procedural modifications and enable us to decide whether and to what degree the disability determination process would be improved if they were implemented on a national level.

(b) *Procedures for cases included in the tests.* Prior to commencing each test or group of tests in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe which model or combinations of models we intend to test, where the specific test site(s) will be, and the duration of the test(s). The individuals who participate in the test(s) will be randomly assigned to a test group in each site where the tests are conducted. Paragraphs (b) (1) through (4) of this section lists descriptions of each model.

(1) In the disability claim manager model, when you file an application for benefits based on disability, a disability claim manager will assume primary responsibility for the processing of your claim. The disability claim manager will be the focal point for your contacts with us during the claims intake process and until an initial determination on your claim is made. The disability claim manager will explain the disability programs to you, including the definition of disability and how we determine whether you meet all the requirements for benefits based on disability. The disability claim manager will explain what you will be asked to do throughout the claims process and how you can obtain information or assistance through him or her. The disability claim manager will also provide you with information regarding your right to representation, and he or she will provide you with appropriate referral sources for representation. The disability claim manager may be either a State agency employee or a Federal employee. In some instances, the disability claim manager may be assisted by other individuals.

(2) In the single decisionmaker model, the decisionmaker will make the disability determination and may also determine whether the other conditions for entitlement to benefits based on disability are met. The decisionmaker will make the disability determination after any appropriate consultation with a medical or psychological consultant. The medical or psychological consultant will not be required to sign the disability determination forms we use to have the State agency certify the determination of disability to us (see § 404.1615). However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see § 404.1617). In some instances the decisionmaker may be the disability claim manager described in paragraph (b)(1) of this section. When the decisionmaker is a State agency employee, a team of individuals that includes a Federal employee will determine whether the other conditions for entitlement to benefits are met.

(3) In the predecision interview model, if the decisionmaker(s) finds that the evidence in your file is insufficient to make a fully favorable determination or requires an initial determination denying your claim, a predecision notice will be mailed to you. The notice will tell you that, before the decisionmaker(s) makes an initial determination about whether you are disabled, you may request a predecision interview with the decisionmaker(s). The notice will also tell you that you may submit additional evidence. You must request a

predecision interview within 10 days after the date you receive the predecision notice. You must also submit any additional evidence within 10 days after you receive the predecision notice. If you request a predecision interview, the decisionmaker(s) will conduct the predecision interview in person, by videoconference, or by telephone as the decisionmaker(s) determines is appropriate under the circumstances. If you make a late request for a predecision interview, or submit additional evidence late, but show in writing that you had good cause under the standards in §404.911 for missing the deadline, the decisionmaker(s) will extend the deadline. If you do not request the predecision interview, or if you do not appear for a scheduled predecision interview and do not submit additional evidence, or if you do not respond to our attempts to communicate with you, the decisionmaker(s) will make an initial determination based upon the evidence in your file. If you identify additional evidence during the predecision interview, which was previously not available, the decisionmaker(s) will advise you to submit the evidence. If you are unable to do so, the decisionmaker(s) may assist you in obtaining it. The decisionmaker(s) also will advise you of the specific timeframes you have for submitting any additional evidence identified during the predecision interview. If you have no treating source(s) (see §404.1502), or your treating source(s) is unable or unwilling to provide the necessary evidence, or there is a conflict in the evidence that cannot be resolved through evidence from your treating source(s), the decisionmaker(s) may arrange a consultative examination or resolve conflicts according to existing procedures (see §404.1519a). If you attend the predecision interview, or do not attend the predecision interview but you submit additional evidence, the decisionmaker(s) will make an initial determination based on the evidence in your file, including the additional evidence you submit or the evidence obtained as a result of the predecision notice or interview, or both.

(4) In the reconsideration elimination model, we will modify the disability determination process by eliminating the reconsideration step of the administrative review process. If you receive an initial determination on your claim for benefits based on disability, and you are dissatisfied with the determination, we will notify you that you may request a hearing before an administrative law judge.

[60 FR 20026, Apr. 24, 1995, as amended at 73 FR 2415, Jan. 15, 2008; 76 FR 24806, May 3, 2011; 82 FR 5863, Jan. 18, 2017]

RECONSIDERATION

§ 404.907 Reconsideration—general.

If you are dissatisfied with the initial determination, reconsideration is the first step in the administrative review process that we provide, except that we provide the opportunity for a hearing before an administrative law judge as the first step for those situations described in §§404.930 (a)(6) and (a)(7), where you appeal an initial determination denying your request for waiver of adjustment or recovery of an overpayment (see §404.506). If you are dissatisfied with our reconsidered determination, you may request a hearing before an administrative law judge.

[61 FR 56132, Oct. 31, 1996]

§ 404.908 Parties to a reconsideration.

(a) *Who may request a reconsideration.* If you are dissatisfied with the initial determination, you may request that we reconsider it. In addition, a person who shows in writing that his or her rights may be adversely affected by the initial determination may request a reconsideration.

(b) *Who are parties to a reconsideration.* After a request for the reconsideration, you and any person who shows in writing that his or her rights are adversely affected by the initial determination will be parties to the reconsideration.

§ 404.909 How to request reconsideration.

(a) We shall reconsider an initial determination if you or any other party to the reconsideration files a written request—

(1) Within 60 days after the date you receive notice of the initial determination (or within the extended time period if we extend the time as provided in paragraph (b) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry.

(b) *Extension of time to request a reconsideration.* If you want a reconsideration of the initial determination but do not request one in time, you may ask us for more time to request a reconsideration. Your request for an extension of time must be in writing and must give the reasons why the request for reconsideration was not filed within the stated time period. If you show us that you had good cause for missing the deadline, we will extend the time period. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.911 Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you had good cause for missing a deadline to request review we consider—

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeal Council review or filed a civil suit.

(6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.

(7) You did not receive notice of the determination or decision.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.

[45 FR 52081, Aug. 5, 1980, as amended at 59 FR 1634, Jan. 12, 1994]

§ 404.913 Reconsideration procedures.

(a) *Case review.* With the exception of the type of case described in paragraph (b) of this section, the reconsideration process consists of a case review. Under a case review procedure, we will give you and the other parties to the reconsideration an opportunity to present additional evidence to us. The official who reviews your case will then make a reconsidered determination based on all of this evidence.

(b) *Disability hearing.* If you have been receiving benefits based on disability and you request reconsideration of an initial or revised determination that, based on medical factors, you are not now disabled, we will give you and the other parties to the reconsideration an opportunity for a disability hearing. (See §§ 404.914 through 404.918.)

[51 FR 300, Jan. 3, 1986]

§ 404.914 Disability hearing—general.

(a) *Availability*. We will provide you with an opportunity for a disability hearing if:

(1) You have been receiving benefits based on a medical impairment that renders you disabled;

(2) We have made an initial or revised determination based on medical factors that you are not now disabled because your impairment:

(i) Has ceased;

(ii) Did not exist; or

(iii) Is no longer disabling; and

(3) You make a timely request for reconsideration of the initial or revised determination.

(b) *Scope*. The disability hearing will address only the initial or revised determination, based on medical factors, that you are not now disabled. Any other issues which arise in connection with your request for reconsideration will be reviewed in accordance with the reconsideration procedures described in § 404.913(a).

(c) *Time and place*—(1) *General*. Either the State agency or the Associate Commissioner for Disability Determinations or his or her delegate, as appropriate, will set the time and place of your disability hearing. We will send you a notice of the time and place of your disability hearing at least 20 days before the date of the hearing. You may be expected to travel to your disability hearing. (See §§ 404.999a–404.999d regarding reimbursement for travel expenses.)

(2) *Change of time or place*. If you are unable to travel or have some other reason why you cannot attend your disability hearing at the scheduled time or place, you should request at the earliest possible date that the time or place of your hearing be changed. We will change the time or place if there is good cause for doing so under the standards in § 404.936 (c) and (d).

(d) *Combined issues*. If a disability hearing is available to you under paragraph (a) of this section, and you file a new application for benefits while your request for reconsideration is still pending, we may combine the issues on both claims for the purpose of the disability hearing and issue a combined initial/reconsidered determination which is binding with respect to the common issues on both claims.

(e) *Definition*. For purposes of the provisions regarding disability hearings (§§ 404.914 through 404.918) *we*, *us* or *our* means the Social Security Administration or the State agency.

[51 FR 300, Jan. 3, 1986, as amended at 51 FR 8808, Mar. 14, 1986; 71 FR 10427, Mar. 1, 2006]

§ 404.915 Disability hearing—disability hearing officers.

(a) *General*. Your disability hearing will be conducted by a disability hearing officer who was not involved in making the determination you are appealing. The disability hearing officer will be an experienced disability examiner, regardless of whether he or she is appointed by a State agency or by the Associate Commissioner for Disability Determinations or his or her delegate, as described in paragraphs (b) and (c) of this section.

(b) *State agency hearing officers*—(1) *Appointment of State agency hearing officers*. If a State agency made the initial or revised determination that you are appealing, the disability hearing officer who conducts your disability hearing may be appointed by a State agency. If the disability hearing officer is appointed by a State agency, that individual will be employed by an adjudicatory unit of the State agency other than the adjudicatory unit which made the determination you are appealing.

(2) *State agency* defined. For purposes of this subpart, *State agency* means the adjudicatory component in the State which issues disability determinations.

(c) *Federal hearing officers*. The disability hearing officer who conducts your disability hearing will be appointed by the Associate Commissioner for Disability Determinations or his or her delegate if:

(1) A component of our office other than a State agency made the determination you are appealing; or

(2) The State agency does not appoint a disability hearing officer to conduct your disability hearing under paragraph (b) of this section.

[51 FR 301, Jan. 3, 1986, as amended at 71 FR 10428, Mar. 1, 2006]

§ 404.916 Disability hearing—procedures.

(a) *General.* The disability hearing will enable you to introduce evidence and present your views to a disability hearing officer if you are dissatisfied with an initial or revised initial determination, based on medical factors, that you are not now disabled as described in § 404.914(a)(2).

(b) *Your procedural rights.* We will advise you that you have the following procedural rights in connection with the disability hearing process:

(1) You may request that we assist you in obtaining pertinent evidence for your disability hearing and, if necessary, that we issue a subpoena to compel the production of certain evidence or testimony. We will follow subpoena procedures similar to those described in § 404.950(d) for the administrative law judge hearing process;

(2) You may have a representative at the hearing appointed under subpart R of this part, or you may represent yourself;

(3) You or your representative may review the evidence in your case file, either on the date of your hearing or at an earlier time at your request, and present additional evidence;

(4) You may present witnesses and question any witnesses at the hearing;

(5) You may waive your right to appear at the hearing. If you do not appear at the hearing, the disability hearing officer will prepare and issue a written reconsidered determination based on the information in your case file.

(c) *Case preparation.* After you request reconsideration, your case file will be reviewed and prepared for the hearing. This review will be conducted in the component of our office (including a State agency) that made the initial or revised determination, by personnel who were not involved in making the initial or revised determination. Any new evidence you submit in connection with your request for reconsideration will be included in this review. If necessary, further development of the evidence, including arrangements for medical examinations, will be undertaken by this component. After the case file is prepared for the hearing, it will be forwarded by this component to the disability hearing officer for a hearing. If necessary, the case file may be sent back to this component at any time prior to the issuance of the reconsidered determination for additional development. Under paragraph (d) of this section, this component has the authority to issue a favorable reconsidered determination at any time in its development process.

(d) *Favorable reconsideration determination without a hearing.* If all the evidence in your case file supports a finding that you are now disabled, either the component that prepares your case for hearing under paragraph (c) or the disability hearing officer will issue a written favorable reconsideration determination, even if a disability hearing has not yet been held.

(e) *Opportunity to submit additional evidence after the hearing.* At your request, the disability hearing officer may allow up to 15 days after your disability hearing for receipt of evidence which is not available at the hearing, if:

(1) The disability hearing officer determines that the evidence has a direct bearing on the outcome of the hearing; and

(2) The evidence could not have been obtained before the hearing.

(f) *Opportunity to review and comment on evidence obtained or developed by us after the hearing.* If, for any reason, additional evidence is obtained or developed by us after your disability hearing, and all evidence taken together can be used to support a reconsidered determination that is unfavorable to you with regard to the medical factors of eligibility, we will notify you, in writing, and give you an opportunity to review and comment on the additional evidence. You will be given 10 days from the date you receive our notice to submit your comments (in writing or, in appropriate cases, by telephone), unless there is good cause for granting you additional time, as illustrated by the examples in § 404.911(b). Your comments will be considered before a reconsidered determination is issued. If you believe that it is necessary to have further opportunity for a hearing with respect to the additional evidence, a

supplementary hearing may be scheduled at your request. Otherwise, we will ask for your written comments on the additional evidence, or, in appropriate cases, for your telephone comments.

[51 FR 301, Jan. 3, 1986]

§ 404.917 Disability hearing—disability hearing officer's reconsidered determination.

(a) *General.* The disability hearing officer who conducts your disability hearing will prepare and will also issue a written reconsidered determination, unless:

(1) The disability hearing officer sends the case back for additional development by the component that prepared the case for the hearing, and that component issues a favorable determination, as permitted by § 404.916(c);

(2) It is determined that you are engaging in substantial gainful activity and that you are therefore not disabled; or

(3) The reconsidered determination prepared by the disability hearing officer is reviewed under § 404.918.

(b) *Content.* The disability hearing officer's reconsidered determination will give the findings of fact and the reasons for the reconsidered determination. The disability hearing officer must base the reconsidered determination on the preponderance of the evidence offered at the disability hearing or otherwise included in your case file.

(c) *Notice.* We will mail you and the other parties a notice of reconsidered determination in accordance with § 404.922.

(d) *Effect.* The disability hearing officer's reconsidered determination, or, if it is changed under § 404.918, the reconsidered determination that is issued by the Associate Commissioner for Disability Determinations or his or her delegate, is binding in accordance with § 404.921, subject to the exceptions specified in that section.

[51 FR 302, Jan. 3, 1986, as amended at 71 FR 10428, Mar. 1, 2006; 73 FR 76943, Dec. 18, 2008]

§ 404.918 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.

(a) *General.* The Associate Commissioner for Disability Determinations or his or her delegate may select a sample of disability hearing officers' reconsidered determinations, before they are issued, and review any such case to determine its correctness on any grounds he or she deems appropriate. The Associate Commissioner or his or her delegate shall review any case within the sample if:

(1) There appears to be an abuse of discretion by the hearing officer;

(2) There is an error of law; or

(3) The action, findings or conclusions of the disability hearing officer are not supported by substantial evidence.

NOTE TO PARAGRAPH (a): If the review indicates that the reconsidered determination prepared by the disability hearing officer is correct, it will be dated and issued immediately upon completion of the review. If the reconsidered determination prepared by the disability hearing officer is found by the Associate Commissioner or his or her delegate to be deficient, it will be changed as described in paragraph (b) of this section.

(b) *Methods of correcting deficiencies in the disability hearing officer's reconsidered determination.* If the reconsidered determination prepared by the disability hearing officer is found by the Associate Commissioner for Disability Determinations or his or her delegate to be deficient, the Associate Commissioner or his or her delegate will take appropriate action to assure that the deficiency is corrected before a reconsidered determination is issued. The action taken by the Associate Commissioner or his or her delegate will take one of two forms:

(1) The Associate Commissioner or his or her delegate may return the case file either to the component responsible for preparing the case for hearing or to the disability hearing officer, for appropriate further action; or

(2) The Associate Commissioner or his or her delegate may issue a written reconsidered determination which corrects the deficiency.

(c) *Further action on your case if it is sent back by the Associate Commissioner*

for Disability Determinations or his or her delegate either to the component that prepared your case for hearing or to the disability hearing officer. If the Associate Commissioner for Disability Determinations or his or her delegate sends your case back either to the component responsible for preparing the case for hearing or to the disability hearing officer for appropriate further action, as provided in paragraph (b)(1) of this section, any additional proceedings in your case will be governed by the disability hearing procedures described in § 404.916(f) or if your case is returned to the disability hearing officer and an unfavorable determination is indicated, a supplementary hearing may be scheduled for you before a reconsidered determination is reached in your case.

(d) *Opportunity to comment before the Associate Commissioner for Disability Determinations or his or her delegate issues a reconsidered determination that is unfavorable to you*. If the Associate Commissioner for Disability Determinations or his or her delegate proposes to issue a reconsidered determination as described in paragraph (b)(2) of this section, and that reconsidered determination is unfavorable to you, he or she will send you a copy of the proposed reconsidered determination with an explanation of the reasons for it, and will give you an opportunity to submit written comments before it is issued. At your request, you will also be given an opportunity to inspect the pertinent materials in your case file, including the reconsidered determination prepared by the disability hearing officer, before submitting your comments. You will be given 10 days from the date you receive the Associate Commissioner's notice of proposed action to submit your written comments, unless additional time is necessary to provide access to the pertinent file materials or there is good cause for providing more time, as illustrated by the examples in § 404.911(b). The Associate Commissioner or his or her delegate will consider your comments before taking any further action on your case.

[71 FR 10428, Mar. 1, 2006]

§ 404.919 Notice of another person's request for reconsideration.

If any other person files a request for reconsideration of the initial determination in your case, we shall notify you at your last known address before we reconsider the initial determination. We shall also give you an opportunity to present any evidence you think helpful to the reconsidered determination.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

§ 404.920 Reconsidered determination.

After you or another person requests a reconsideration, we will review the evidence we considered in making the initial determination and any other evidence we receive. We will make our determination based on the preponderance of the evidence.

[73 FR 76943, Dec. 18, 2008]

§ 404.921 Effect of a reconsidered determination.

The reconsidered determination is binding unless—

(a) You or any other party to the reconsideration requests a hearing before an administrative law judge within the stated time period and a decision is made;

(b) The expedited appeals process is used; or

(c) The reconsidered determination is revised.

[51 FR 302, Jan. 3, 1986]

§ 404.922 Notice of a reconsidered determination.

We shall mail a written notice of the reconsidered determination to the parties at their last known address. We shall state the specific reasons for the determination and tell you and any other parties of the right to a hearing. If it is appropriate, we will also tell you and any other parties how to use the expedited appeals process.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

EXPEDITED APPEALS PROCESS

§ 404.923 Expedited appeals process—general.

By using the expedited appeals process you may go directly to a Federal district court without first completing the administrative review process that is generally required before the court will hear your case.

§ 404.924 When the expedited appeals process may be used.

You may use the expedited appeals process if all of the following requirements are met:

(a) We have made an initial and a reconsidered determination; an administrative law judge has made a hearing decision; or Appeals Council review has been requested, but a final decision has not been issued.

(b) You are a party to the reconsidered determination or the hearing decision.

(c) You have submitted a written request for the expedited appeals process.

(d) You have claimed, and we agree, that the only factor preventing a favorable determination or decision is a provision in the law that you believe is unconstitutional.

(e) If you are not the only party, all parties to the determination or decision agree to request the expedited appeals process.

§ 404.925 How to request expedited appeals process.

(a) *Time of filing request.* You may request the expedited appeals process—

(1) Within 60 days after the date you receive notice of the reconsidered determination (or within the extended time period if we extend the time as provided in paragraph (c) of this section);

(2) At any time after you have filed a timely request for a hearing but before you receive notice of the administrative law judge's decision;

(3) Within 60 days after the date you receive a notice of the administrative law judge's decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (c) of this section); or

(4) At any time after you have filed a timely request for Appeals Council review, but before you receive notice of the Appeals Council's action.

(b) *Place of filing request.* You may file a written request for the expedited appeals process at one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry.

(c) *Extension of time to request expedited appeals process.* If you want to use the expedited appeals process but do not request it within the stated time period, you may ask for more time to submit your request. Your request for an extension of time must be in writing and must give the reasons why the request for the expedited appeals process was not filed within the stated time period. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.926 Agreement in expedited appeals process.

If you meet all the requirements necessary for the use of the expedited appeals process, our authorized representative shall prepare an agreement. The agreement must be signed by you, by every other party to the determination or decision and by our authorized representative. The agreement must provide that—

(a) The facts in your claim are not in dispute;

(b) The sole issue in dispute is whether a provision of the Act that applies to your case is unconstitutional;

(c) Except for your belief that a provision of the Act is unconstitutional, you agree with our interpretation of the law;

(d) If the provision of the Act that you believe is unconstitutional were not applied to your case, your claim would be allowed; and

(e) Our determination or the decision is final for the purpose of seeking judicial review.

§ 404.927 Effect of expedited appeals process agreement.

After an expedited appeals process agreement is signed, you will not need to complete the remaining steps of the

administrative review process. Instead, you may file an action in a Federal district court within 60 days after the date you receive notice (a signed copy of the agreement will be mailed to you and will constitute notice) that the agreement has been signed by our authorized representative.

[45 FR 52081, Aug. 5, 1980, as amended at 49 FR 46369, Nov. 26, 1984]

§ 404.928 Expedited appeals process request that does not result in agreement.

If you do not meet all of the requirements necessary to use the expedited appeals process, we shall tell you that your request to use this process is denied and that your request will be considered as a request for a hearing or Appeals Council review, whichever is appropriate.

Hearing Before an Administrative Law Judge

§ 404.929 Hearing before an administrative law judge—general.

If you are dissatisfied with one of the determinations or decisions listed in § 404.930, you may request a hearing. Subject to § 404.956, the Deputy Commissioner for Hearings Operations, or their delegate, will appoint an administrative law judge to conduct the hearing. If circumstances warrant, the Deputy Commissioner for Hearings Operations, or their delegate, may assign your case to another administrative law judge. We will schedule you to appear by audio, agency video, online video, or in person as set forth in § 404.936. Audio means telephone or similar audio-based technology in a private location you choose. Agency video means video, with audio functionality, using our equipment in one of our offices. Online video means video, with audio functionality, using a personal electronic device in a private location you choose. When we determine your manner of appearance, we consider the factors described in § 404.936(c)(1)(i) through (ii). You may submit new evidence (subject to the provisions of § 404.935), examine the evidence used in making the determination or decision under review, and present and question witnesses. The administrative law judge who conducts the hearing may ask you questions. The administrative law judge will issue a decision based on the preponderance of the evidence in the hearing record. If you waive your right to appear at the hearing, the administrative law judge will make a decision based on the preponderance of the evidence that is in the file and, subject to the provisions of § 404.935, any new evidence that may have been submitted for consideration.

[89 FR 68360, Aug. 26, 2024]

§ 404.930 Availability of a hearing before an administrative law judge.

(a) You or another party may request a hearing before an administrative law judge if we have made—

(1) A reconsidered determination;

(2) A revised determination of an initial determination, unless the revised determination concerns the issue of whether, based on medical factors, you are disabled;

(3) A reconsideration of a revised initial determination concerning the issue of whether, based on medical factors, you are disabled;

(4) A revised reconsidered determination;

(5) A revised decision based on evidence not included in the record on which the prior decision was based;

(6) An initial determination denying waiver of adjustment or recovery of an overpayment based on a personal conference (see § 404.506); or

(7) An initial determination denying waiver of adjustment or recovery of an overpayment based on a review of the written evidence of record (see § 404.506), and the determination was made concurrent with, or subsequent to, our reconsideration determination regarding the underlying overpayment but before an administrative law judge holds a hearing.

(b) We will hold a hearing only if you or another party to the hearing file a written request for a hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 61 FR 56132, Oct. 31, 1996; 73 FR 2415, Jan. 15, 2008; 76 FR 24806, May 3, 2011]

§ 404.932 Parties to a hearing before an administrative law judge.

(a) *Who may request a hearing.* You may request a hearing if a hearing is available under § 404.930. In addition, a person who shows in writing that his or her rights may be adversely affected by the decision may request a hearing.

(b) *Who are parties to a hearing.* After a request for a hearing is made, you, the other parties to the initial, reconsidered, or revised determination, and any other person who shows in writing that his or her rights may be adversely affected by the hearing, are parties to the hearing. In addition, any other person may be made a party to the hearing if his or her rights may be adversely affected by the decision, and we notify the person to appear at the hearing or to present evidence supporting his or her interest.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 75 FR 39160, July 8, 2010]

§ 404.933 How to request a hearing before an administrative law judge.

(a) *Written request.* You may request a hearing by filing a written request. You should include in your request—

(1) The name and social security number of the wage earner;

(2) The reasons you disagree with the previous determination or decision;

(3) A statement of additional evidence to be submitted and the date you will submit it; and

(4) The name and address of any designated representative.

(b) *When and where to file.* The request must be filed—

(1) Within 60 days after the date you receive notice of the previous determination or decision (or within the extended time period if we extend the time as provided in paragraph (c) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board for persons having 10 or more years of service in the railroad industry.

(c) *Extension of time to request a hearing.* If you have a right to a hearing but do not request one in time, you may ask for more time to make your request. The request for an extension of time must be in writing and it must give the reasons why the request for a hearing was not filed within the stated time period. You may file your request for an extension of time at one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.935 Submitting written evidence to an administrative law judge.

(a) When you submit your request for hearing, you should also submit information or evidence as required by § 404.1512 or any summary of the evidence to the administrative law judge. Each party must make every effort to ensure that the administrative law judge receives all of the evidence and must inform us about or submit any written evidence, as required in § 404.1512, no later than 5 business days before the date of the scheduled hearing. If you do not comply with this requirement, the administrative law judge may decline to consider or obtain the evidence, unless the circumstances described in paragraph (b) of this section apply.

(b) If you have evidence required under § 404.1512 but you have missed the deadline described in paragraph (a) of this section, the administrative law judge will accept the evidence if he or she has not yet issued a decision and you did not inform us about or submit the evidence before the deadline because:

(1) Our action misled you;

(2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier; or

(3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:

(i) You were seriously ill, and your illness prevented you from contacting us in person, in writing, or through a friend, relative, or other person;

(ii) There was a death or serious illness in your immediate family;

(iii) Important records were destroyed or damaged by fire or other accidental cause; or

(iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing.

[81 FR 90993, Dec. 16, 2016]

§ 404.936 Time, place, and manner of appearance for a hearing before an administrative law judge.

(a) *General.* We set the time and manner(s) of appearance for any hearing. We will set the place of a hearing when we schedule you and any other parties to the hearing to appear in person or by agency video. We may change the time, manner(s) of appearance, or place, if it is necessary. After sending you reasonable notice of the proposed action, the administrative law judge may adjourn or postpone the hearing or reopen it to receive additional evidence any time before the administrative law judge notifies you of a hearing decision.

(b) *Place of hearing.* If we set the place of the hearing, it can be in the 50 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands. The ''place'' of the hearing is the hearing office or other site(s) at which you and any other parties to the hearing are located when you make your appearance(s) before the administrative law judge by agency video or in person. A party to a hearing may only appear from the geographic areas, noted in this subsection, in which we hold hearings.

(c) *Determining manner of appearance to schedule.* We will schedule you or any other party to the hearing to appear by audio, agency video, online video, or in person. We may schedule you to appear by online video only if you agree to appear in that manner.

(1) When we determine your manner of appearance at the hearing, we consider the following factors:

(i) Which manner of appearance would be the most efficient for conducting the hearing; and

(ii) Any facts in your particular case that provide a good reason to schedule your appearance by audio, agency video, online video, or in person.

(2) We will generally direct any person we call as a witness, other than you or any other party to the hearing, to appear by audio, by agency video, or by online video. Witnesses include medical experts and vocational experts. Witnesses you call will appear at the hearing pursuant to § 404.950(e). If they are unable to appear with you in the same manner as you, we will generally direct them to appear by agency video or by audio. We will consider directing witnesses to appear in person only when:

(i) A witness is unable to appear by other available manners of appearance;

(ii) We determine that an alternate manner of appearance would be less efficient than conducting the appearance in person; or

(iii) We find that there are facts in your particular case that provide a good reason to schedule this individual's appearance in person.

(3) We follow the procedures set forth in § 404.937 to ensure the safety of the public and our employees in our hearing process.

(d) *Objecting to appearing by audio, by agency video, or both.* Prior to scheduling your hearing, we will notify you that we may schedule you to appear by audio or by agency video, or, if you agree, by online video. If you object to appearing by audio, by agency video, or both, you must notify us in writing within 30 days after the date you receive the notice. If you only object to appearing by audio, we may schedule you to appear in person, by agency video, or, if you agree, by online video. Similarly, if you only object to appearing by agency video, we may schedule you to appear in person, by audio, or, if you agree, by online video. If you object to appearing by both audio and agency video, and your residence does not change while your request for hearing is pending, we will schedule you to appear before the administrative law judge in person or, if you agree, by online video.

(1) If you notify us that you object to appearing by audio, by agency video, or both, more than 30 days after the date you receive our notice, we will extend the time period if you show you had

good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 404.911.

(2) Notwithstanding any objections you may have to appearing by audio and subject to paragraph (d)(3) of this section, we will schedule you or any other party to the hearing to appear by audio when we cannot schedule you to appear by agency video or by online video and extraordinary circumstances prevent you from appearing in person. For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(3) Notwithstanding any objections you may have to appearing by audio, if you are incarcerated and an appearance by agency video and online video is not available, we will schedule you to appear by audio, unless we find that there are facts in your particular case that provide a good reason to schedule you to appear in person, if allowed by the place of confinement, or by agency video, online video, or in person upon your release. For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(4) Notwithstanding any objections you may have to appearing by audio, by agency video, or both, if you change your residence while your request for hearing is pending, we will determine how you will appear, including by audio or by agency video, as provided in paragraph (c) of this section. For us to consider your change of residence when we schedule your hearing, you must submit evidence verifying your new residence. For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(5) Notwithstanding any objection you may have to appearing by audio, we will schedule you or any other party to the hearing to appear by audio in the circumstances provided in § 404.937(b)(2)(ii) and (c). For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(e) *Time period to agree to an appearance by online video.* Prior to scheduling your hearing, we will notify you that we may schedule you to appear by online video if you agree to appear in that manner. To agree to appear by online video, you must notify us in writing within 30 days after the date you receive the notice. If you notify us that you agree to appearing by online video more than 30 days after the date you receive our notice, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 404.911. You may withdraw your agreement any time before the start of your hearing.

(f) *Objecting to the time or place of the hearing.* (1) If you wish to object to the time or place of the hearing, you must:

(i) Notify us in writing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or 30 days after receiving notice of the hearing, whichever is earlier; and

(ii) State the reason(s) for your objection and state the time or place you want the hearing to be held. If the administrative law judge finds you have good cause, as determined under paragraph (e) of this section, we will change the time or place of the hearing.

(2) If you notify us that you object to the time or place of hearing less than 5 days before the date set for the hearing or, if earlier, more than 30 days after receiving notice of the hearing, we will consider this objection only if you show you had good cause for missing the deadline. To determine whether good cause exists for missing this deadline, we use the standards explained in § 404.911.

(g) *Good cause for changing the time or place.* The administrative law judge will determine whether good cause exists for changing the time or place of your scheduled hearing. If the administrative law judge finds that good cause exists, we will set the time or place of the new hearing. A finding that good cause exists to reschedule the time or place of your hearing will generally not change the assignment of the administrative law judge or how you or another party will appear at the hearing, unless we determine a change will promote efficiency in our hearing process.

(1) The administrative law judge will find good cause to change the time or place of your hearing if he or she determines that, based on the evidence:

(i) A serious physical or mental condition or incapacitating injury makes it impossible for you or your representative to travel to the hearing, or a death in the family occurs; or

(ii) Severe weather conditions make it impossible for you or your representative to travel to the hearing.

(2) In determining whether good cause exists in circumstances other than those set out in paragraph (f)(1) of this section, the administrative law judge will consider your reason(s) for requesting the change, the facts supporting it, and the impact of the proposed change on the efficient administration of the hearing process. Factors affecting the impact of the change include, but are not limited to, the effect on the processing of other scheduled hearings, delays that might occur in rescheduling your hearing, and whether we previously granted you any changes in the time or place of your hearing. Examples of such other circumstances that you might give for requesting a change in the time or place of the hearing include, but are not limited to, the following:

(i) You unsuccessfully attempted to obtain a representative and need additional time to secure representation;

(ii) Your representative was appointed within 30 days of the scheduled hearing and needs additional time to prepare for the hearing;

(iii) Your representative has a prior commitment to be in court or at another administrative hearing on the date scheduled for the hearing;

(iv) A witness who will testify to facts material to your case would be unavailable to attend the scheduled hearing and the evidence cannot be otherwise obtained;

(v) Transportation is not readily available for you to travel to the hearing; or

(vi) You are unrepresented, and you are unable to respond to the notice of hearing because of any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

[84 FR 69305, Dec. 18, 2019, as amended at 89 FR 68360, Aug. 26, 2024]

§ 404.937 Protecting the safety of the public and our employees in our hearing process.

(a) Notwithstanding any other provision in this part or part 422 of this chapter, we are establishing the procedures set out in this section to ensure the safety of the public and our employees in our hearing process.

(b)(1) At the request of any hearing office employee, the Hearing Office Chief Administrative Law Judge will determine, after consultation with the presiding administrative law judge, whether a claimant or other individual poses a reasonable threat to the safety of our employees or other participants in the hearing. The Hearing Office Chief Administrative Law Judge will find that a claimant or other individual poses a threat to the safety of our employees or other participants in the hearing when he or she determines that the individual has made a threat and there is a reasonable likelihood that the claimant or other individual could act on the threat or when evidence suggests that a claimant or other individual poses a threat. In making a finding under this paragraph, the Hearing Office Chief Administrative Law Judge will consider all relevant evidence, including any information we have in the claimant's record and any information we have regarding the claimant's or other individual's past conduct.

(2) If the Hearing Office Chief Administrative Law Judge determines that the claimant or other individual poses a reasonable threat to the safety of our employees or other participants in the hearing, the Hearing Office Chief Administrative Law Judge will either:

(i) Require the presence of a security guard at the hearing; or

(ii) Require that the hearing be conducted by audio, notwithstanding any objection to appearing by audio, or, if the claimant agrees, by online video.

(c) If we have banned a claimant from any of our facilities, we will provide the claimant with the opportunity for a hearing that will be conducted by

audio, notwithstanding any objection to appearing by audio, or, if the claimant agrees, by online video.

(d) The actions of the Hearing Office Chief Administrative Law Judge taken under this section are final and not subject to further review.

(e) For audio appearances under this section, we will call you or any other party to the hearing using your or their telephone number(s).

[76 FR 13508, Mar. 14, 2011, as amended at 77 FR 10658, Feb. 23, 2012; 89 FR 68361, Aug. 26, 2024]

§ 404.938 Notice of a hearing before an administrative law judge.

(a) *Issuing the notice.* After we set the time and place of the hearing, we will mail notice of the hearing to you at your last known address, or give the notice to you by personal service, unless you have indicated in writing that you do not wish to receive this notice. We will mail or serve the notice at least 75 days before the date of the hearing.

(b) *Notice information.* The notice of hearing will tell you:

(1) The specific issues to be decided in your case;

(2) That you may designate a person to represent you during the proceedings;

(3) How to request that we change the time or place of your hearing;

(4) That your hearing may be dismissed if neither you nor the person you designate to act as your representative appears at your scheduled hearing without good reason under § 404.957;

(5) The time and manner(s) in which you, or any other party or witness, will appear. If we schedule you to appear in person or by agency video, as set forth in § 404.936, the notice of hearing will tell you the place of the hearing.

(6) That you must make every effort to inform us about or submit all written evidence that is not already in the record no later than 5 business days before the date of the scheduled hearing, unless you show that your circumstances meet the conditions described in § 404.935(b); and

(7) Any other information about the scheduling and conduct of your hearing.

(c) *Acknowledging the notice of hearing.* The notice of hearing will ask you to return a form to let us know that you received the notice. If you or your representative do not acknowledge receipt of the notice of hearing, we will attempt to contact you for an explanation. If you tell us that you did not receive the notice of hearing, an amended notice will be sent to you by certified mail.

(d) *Amended notice of hearing or notice of supplemental hearing.* If we need to send you an amended notice of hearing, we will mail or serve the notice at least 20 days before the date of the hearing. Similarly, if we schedule a supplemental hearing, after the initial hearing was continued by the assigned administrative law judge, we will mail or serve a notice of hearing at least 20 days before the date of the hearing.

[68 FR 5219, Feb. 3, 2003, as amended at 75 FR 39160, July 8, 2010; 78 FR 29627, May 21, 2013; 79 FR 35932, June 25, 2014; 81 FR 90993, Dec. 16, 2016; 84 FR 69306, Dec. 18, 2019; 89 FR 68362, Aug. 26, 2024]

§ 404.939 Objections to the issues.

If you object to the issues to be decided at the hearing, you must notify the administrative law judge in writing at the earliest possible opportunity, but no later than 5 business days before the date set for the hearing, unless you show that your circumstances meet the conditions described in § 404.935(b). You must state the reason(s) for your objection(s). The administrative law judge will make a decision on your objection(s) either at the hearing or in writing before the hearing.

[81 FR 90993, Dec. 16, 2016]

§ 404.940 Disqualification of the administrative law judge.

An administrative law judge shall not conduct a hearing if he or she is prejudiced or partial with respect to any party or has any interest in the matter pending for decision. If you object to the administrative law judge who will conduct the hearing, you must notify the administrative law judge at your earliest opportunity. The administrative law judge shall consider

your objections and shall decide whether to proceed with the hearing or withdraw. If he or she withdraws, the Associate Commissioner for Hearings and Appeals, or his or her delegate, will appoint another administrative law judge to conduct the hearing. If the administrative law judge does not withdraw, you may, after the hearing, present your objections to the Appeals Council as reasons why the hearing decision should be revised or a new hearing held before another administrative law judge.

§ 404.941 Prehearing case review.

(a) *General.* After a hearing is requested but before it is held, we may, for the purposes of a prehearing case review, forward the case to the component of our office (including a State agency) that issued the determination being reviewed. That component will decide whether it should revise the determination based on the preponderance of the evidence. A revised determination may be fully or partially favorable to you. A prehearing case review will not delay the scheduling of a hearing unless you agree to continue the review and delay the hearing. If the prehearing case review is not completed before the date of the hearing, the case will be sent to the administrative law judge unless a favorable revised determination is in process or you and the other parties to the hearing agree in writing to delay the hearing until the review is completed.

(b) *When a prehearing case review may be conducted.* We may conduct a prehearing case review if—

(1) Additional evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulation; or

(4) There is an error in the file or some other indication that the prior determination may be revised.

(c) *Notice of a prehearing revised determination.* If we revise the determination in a prehearing case review, we will mail a written notice of the revised determination to all parties at their last known addresses. We will state the basis for the revised determination and advise all parties of the effect of the revised determination on the request for a hearing.

(d) *Effect of a fully favorable revised determination.* If the revised determination is fully favorable to you, we will tell you in the notice that an administrative law judge will dismiss the request for a hearing. We will also tell you that you or another party to the hearing may request that the administrative law judge vacate the dismissal and reinstate the request for a hearing if you or another party to the hearing disagrees with the revised determination for any reason. If you wish to make this request, you must do so in writing and send it to us within 60 days of the date you receive notice of the dismissal. If the request is timely, an administrative law judge will vacate the dismissal, reinstate the request for hearing, and offer you and all parties an opportunity for a hearing. The administrative law judge will extend the time limit if you show that you had good cause for missing the deadline. The administrative law judge will use the standards in § 404.911 to determine whether you had good cause.

(e) *Effect of a partially favorable revised determination.* If the revised determination is partially favorable to you, we will tell you in the notice what was not favorable. We will also tell you that an administrative law judge will hold the hearing you requested unless you and all other parties to the hearing agree in writing to dismiss the request for a hearing. An administrative law judge will dismiss the request for a hearing if we receive the written statement(s) agreeing to dismiss the request for a hearing before an administrative law judge mails a notice of his or her hearing decision.

[45 FR 52081, Aug. 5, 1980, as amended at 73 FR 76943, Dec. 18, 2008; 75 FR 33168, June 11, 2010; 76 FR 65369, Oct. 21, 2011]

§ 404.942 Prehearing proceedings and decisions by attorney advisors.

(a) *General.* After a hearing is requested but before it is held, an attorney advisor may conduct prehearing proceedings as set out in paragraph (c) of this section. If after the completion of these proceedings we can make a decision that is fully favorable to you

and all other parties based on the preponderance of the evidence, an attorney advisor, instead of an administrative law judge, may issue the decision. The conduct of the prehearing proceedings by the attorney advisor will not delay the scheduling of a hearing. If the prehearing proceedings are not completed before the date of the hearing, the case will be sent to the administrative law judge unless a fully favorable decision is in process or you and all other parties to the hearing agree in writing to delay the hearing until the proceedings are completed.

(b) *When prehearing proceedings may be conducted by an attorney advisor.* An attorney advisor may conduct prehearing proceedings if you have filed a claim for benefits based on disability and—

(1) New and material evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulations; or

(4) There is an error in the file or some other indication that a fully favorable decision may be issued.

(c) *Nature of the prehearing proceedings that may be conducted by an attorney advisor.* As part of the prehearing proceedings, the attorney advisor, in addition to reviewing the existing record, may—

(1) Request additional evidence that may be relevant to the claim, including medical evidence; and

(2) If necessary to clarify the record for the purpose of determining if a fully favorable decision is warranted, schedule a conference with the parties.

(d) *Notice of a decision by an attorney advisor.* If an attorney advisor issues a fully favorable decision under this section, we will mail a written notice of the decision to all parties at their last known addresses. We will state the basis for the decision and advise all parties that they may request that an administrative law judge reinstate the request for a hearing if they disagree with the decision for any reason. Any party who wants to make this request must do so in writing and send it to us within 60 days of the date he or she receives notice of the decision. The administrative law judge will extend the time limit if the requestor shows good cause for missing the deadline. The administrative law judge will use the standards in § 404.911 to determine whether there is good cause. If the request is timely, an administrative law judge will reinstate the request for a hearing and offer all parties an opportunity for a hearing.

(e) *Effect of an attorney advisor's decision.* An attorney advisor's decision under this section is binding unless—

(1) You or another party to the hearing submits a timely request that an administrative law judge reinstate the request for a hearing under paragraph (d) of this section;

(2) The Appeals Council reviews the decision on its own motion pursuant to § 404.969 as explained in paragraph (f)(3) of this section; or

(3) The decision of the attorney advisor is revised under the procedures explained in § 404.987.

(f) *Ancillary provisions.* For the purposes of the procedures authorized by this section, the regulations of part 404 shall apply to—

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§ 404.1513a, 404.1520a, 404.1526, and 404.1546.

(2) Define the term ''decision'' to include a decision made by an attorney advisor, as well as the decisions identified in § 404.901; and

(3) Make the decision of an attorney advisor under paragraph (d) of this section subject to review by the Appeals Council if the Appeals Council decides to review the decision of the attorney advisor anytime within 60 days after the date of the decision under § 404.969.

[60 FR 34131, June 30, 1995, as amended at 63 FR 35516, June 30, 1998; 64 FR 13678, Mar. 22, 1999; 64 FR 51893, Sept. 27, 1999; 72 FR 44765, Aug. 9, 2007; 73 FR 76944, Dec. 18, 2008; 74 FR 33328, July 13, 2009; 76 FR 18384, Apr. 4, 2011; 76 FR 65370, Oct. 21, 2011; 78 FR 45460, July 29, 2013; 80 FR 31991, June 5, 2015; 82 FR 5863, Jan. 18, 2017; 83 FR 712, Jan. 8, 2018; 83 FR 40453, Aug. 15, 2018]

§ 404.943 Responsibilities of the adjudication officer.

(a)(1) *General.* Under the procedures set out in this section we will test

modifications to the procedures we follow when you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether you are under a disability as defined in § 404.1505 is at issue. These modifications will enable us to test the effect of having an adjudication officer be your primary point of contact after you file a hearing request and before you have a hearing with an administrative law judge. The tests may be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under § 404.906. The adjudication officer, working with you and your representative, if any, will identify issues in dispute, develop evidence, conduct informal conferences, and conduct any other prehearing proceeding as may be necessary. The adjudication officer has the authority to make a decision fully favorable to you if the evidence so warrants. If the adjudication officer does not make a decision on your claim, your hearing request will be assigned to an administrative law judge for further proceedings.

(2) *Procedures for cases included in the tests.* Prior to commencing tests of the adjudication officer position in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe where the specific test site(s) will be and the duration of the test(s). We will also state whether the tests of the adjudication officer position in each site will be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under § 404.906. The individuals who participate in the test(s) will be assigned randomly to a test group in each site where the tests are conducted.

(b)(1) *Prehearing procedures conducted by an Adjudication Officer.* When you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether you are under a disability as defined in § 404.1505 is at issue, the adjudication officer will conduct an interview with you. The interview may take place in person, by telephone, or by videoconference, as the adjudication officer determines is appropriate under the circumstances of your case. If you file a request for an extension of time to request a hearing in accordance with § 404.933(c), the adjudication officer may develop information on, and may decide where the adjudication officer issues a fully favorable decision to you that you had good cause for missing the deadline for requesting a hearing. To determine whether you had good cause for missing the deadline, the adjudication officer will use the standards contained in § 404.911.

(2) *Representation.* The adjudication officer will provide you with information regarding the hearing process, including your right to representation. As may be appropriate, the adjudication officer will provide you with referral sources for representation, and give you copies of necessary documents to facilitate the appointment of a representative. If you have a representative, the adjudication officer will conduct an informal conference with the representative, in person or by telephone, to identify the issues in dispute and prepare proposed written agreements for the approval of the administrative law judge regarding those issues which are not in dispute and those issues proposed for the hearing. If you decide to proceed without representation, the adjudication officer may hold an informal conference with you. If you obtain representation after the adjudication officer has concluded that your case is ready for a hearing, the administrative law judge will return your case to the adjudication officer who will conduct an informal conference with you and your representative.

(3) *Evidence.* You, or your representative, may submit, or may be asked to obtain and submit, additional evidence to the adjudication officer. As the adjudication officer determines is appropriate under the circumstances of your case, the adjudication officer may refer the claim for further medical or vocational evidence.

(4) *Referral for a hearing.* The adjudication officer will refer the claim to the administrative law judge for further proceedings when the development

of evidence is complete, and you or your representative agree that a hearing is ready to be held. If you or your representative are unable to agree with the adjudication officer that the development of evidence is complete, the adjudication officer will note your disagreement and refer the claim to the administrative law judge for further proceedings. At this point, the administrative law judge conducts all further hearing proceedings, including scheduling and holding a hearing (§ 404.936), considering any additional evidence or arguments submitted (§§ 404.935, 404.944, 404.949, 404.950), and issuing a decision or dismissal of your request for a hearing, as may be appropriate (§§ 404.948, 404.953, 404.957). In addition, if the administrative law judge determines on or before the date of your hearing that the development of evidence is not complete, the administrative law judge may return the claim to the adjudication officer to complete the development of the evidence and for such other action as necessary.

(c)(1) *Fully favorable decisions issued by an adjudication officer.* If, after a hearing is requested but before it is held, the adjudication officer decides that the evidence in your case warrants a decision which is fully favorable to you, the adjudication officer may issue such a decision. For purposes of the tests authorized under this section, the adjudication officer's decision shall be considered to be a decision as defined in § 404.901. If the adjudication officer issues a decision under this section, it will be in writing and will give the findings of fact and the reasons for the decision. The adjudication officer will evaluate the issues relevant to determining whether or not you are disabled in accordance with the provisions of the Social Security Act, the rules in this part and part 422 of this chapter and applicable Social Security Rulings. For cases in which the adjudication officer issues a decision, he or she may determine your residual functional capacity in the same manner that an administrative law judge is authorized to do so in § 404.1546. The adjudication officer may also evaluate the severity of your mental impairments in the same manner that an administrative law judge is authorized to do so under § 404.1520a. The adjudication officer's decision will be based on the evidence which is included in the record and, subject to paragraph (c)(2) of this section, will complete the actions that will be taken on your request for hearing. A copy of the decision will be mailed to all parties at their last known address. We will tell you in the notice that the administrative law judge will not hold a hearing unless a party to the hearing requests that the hearing proceed. A request to proceed with the hearing must be made in writing within 30 days after the date the notice of the decision of the adjudication officer is mailed.

(2) *Effect of a decision by an adjudication officer.* A decision by an adjudication officer which is fully favorable to you under this section, and notification thereof, completes the administrative action on your request for hearing and is binding on all parties to the hearing and not subject to further review, unless—

(i) You or another party requests that the hearing continue, as provided in paragraph (c)(1) of this section;

(ii) The Appeals Council decides to review the decision on its own motion under the authority provided in § 404.969;

(iii) The decision is revised under the procedures explained in §§ 404.987 through 404.989; or

(iv) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 404.984.

(3) *Fee for a representative's services.* The adjudication officer may authorize a fee for your representative's services if the adjudication officer makes a decision on your claim that is fully favorable to you, and you are represented. The actions of, and any fee authorization made by, the adjudication officer with respect to representation will be made in accordance with the provisions of subpart R of this part.

(d) *Who may be an adjudication officer.* The adjudication officer described in this section may be an employee of the Social Security Administration or a State agency that makes disability determinations for us.

[60 FR 47475, Sept. 13, 1995, as amended at 75 FR 33168, June 11, 2010]

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

§ 404.944 Administrative law judge hearing procedures—general.

A hearing is open to the parties and to other persons the administrative law judge considers necessary and proper. At the hearing, the administrative law judge looks fully into the issues, questions you and the other witnesses, and, subject to the provisions of § 404.935, accepts as evidence any documents that are material to the issues; may stop the hearing temporarily and continue it at a later date if the administrative law judge finds that there is material evidence missing at the hearing or one or more variables outside of our control, such as audio quality or video quality, materially affects the hearing; and may reopen the hearing at any time before the administrative law judge mails a notice of the decision in order to receive new and material evidence. For purposes of this section, materially affects means prevents the hearing from proceeding. The administrative law judge may decide when the evidence will be presented and when the issues will be discussed.

[89 FR 68362, Aug. 26, 2024]

§ 404.946 Issues before an administrative law judge.

(a) *General.* The issues before the administrative law judge include all the issues brought out in the initial, reconsidered or revised determination that were not decided entirely in your favor. However, if evidence presented before or during the hearing causes the administrative law judge to question a fully favorable determination, he or she will notify you and will consider it an issue at the hearing.

(b) *New issues*—(1) *General.* The administrative law judge may consider a new issue at the hearing if he or she notifies you and all the parties about the new issue any time after receiving the hearing request and before mailing notice of the hearing decision. The administrative law judge or any party may raise a new issue; an issue may be raised even though it arose after the request for a hearing and even though it has not been considered in an initial or reconsidered determination. However, it may not be raised if it involves a claim that is within the jurisdiction of a State agency under a Federal-State agreement concerning the determination of disability.

(2) *Notice of a new issue.* The administrative law judge shall notify you and any other party if he or she will consider any new issue. Notice of the time and place of the hearing on any new issues will be given in the manner described in § 404.938, unless you have indicated in writing that you do not wish to receive the notice.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.948 Deciding a case without an oral hearing before an administrative law judge.

(a) *Decision fully favorable.* If the evidence in the hearing record supports a finding in favor of you and all the parties on every issue, the administrative law judge may issue a hearing decision based on a preponderance of the evidence without holding an oral hearing. The notice of the decision will state that you have the right to an oral hearing and to examine the evidence on which the administrative law judge based the decision.

(b) *Parties do not wish to appear.* (1) The administrative law judge may decide a case on the record and not conduct an oral hearing if—

(i) You and all the parties indicate in writing that you do not wish to appear before the administrative law judge at an oral hearing; or

(ii) You live outside the United States, you do not inform us that you wish to appear, and there are no other parties who wish to appear.

(2) When an oral hearing is not held, the administrative law judge shall make a record of the material evidence. The record will include the applications, written statements, certificates, reports, affidavits, and other documents that were used in making the determination under review and any additional evidence you or any other party to the hearing present in writing. The decision of the administrative law judge must be based on this record.

(c) *Case remanded for a revised determination.* (1) The administrative law judge may remand a case to the appropriate component of our office for a revised determination if there is reason to believe that the revised determination would be fully favorable to you. This could happen if the administrative law judge receives new and material evidence or if there is a change in the law that permits the favorable determination.

(2) Unless you request the remand, the administrative law judge shall notify you that your case has been remanded and tell you that if you object, you must notify him or her of your objections within 10 days of the date the case is remanded or we will assume that you agree to the remand. If you object to the remand, the administrative law judge will consider the objection and rule on it in writing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 73 FR 76944, Dec. 18, 2008; 75 FR 33168, June 11, 2010; 76 FR 65370, Oct. 21, 2011]

§ 404.949 Presenting written statements and oral arguments.

You or a person you designate to act as your representative may appear before the administrative law judge to state your case, present a written summary of your case, or enter written statements about the facts and law material to your case in the record. If presenting written statements prior to hearing, you must provide a copy of your written statements for each party no later than 5 business days before the date set for the hearing, unless you show that your circumstances meet the conditions described in § 404.935(b).

[81 FR 90993, Dec. 16, 2016

§ 404.950 Presenting evidence at a hearing before an administrative law judge.

(a) *The right to appear and present evidence.* Any party to a hearing has a right to appear before the administrative law judge, in the manner set forth in § 404.936, to present evidence and to state their position. A party may also make their appearance by means of a designated representative, who may make their appearance in the manner set forth in § 404.936.

(b) *Waiver of the right to appear.* You may send the administrative law judge a waiver or a written statement indicating that you do not wish to appear at the hearing. You may withdraw this waiver any time before a notice of the hearing decision is mailed to you. Even if all of the parties waive their right to appear at a hearing, we may notify them of a time and a place for an oral hearing, if the administrative law judge believes that a personal appearance and testimony by you or any other party is necessary to decide the case.

(c) *Admissible evidence.* Subject to the provisions of § 404.935, the administrative law judge may receive any evidence at the hearing that he or she believes is material to the issues, even though the evidence would not be admissible in court under the rules of evidence used by the court.

(d) *Subpoenas.* (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.

(2) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the administrative law judge or at one of our offices at least 10 business days before the hearing date, unless you show that your circumstances meet the conditions described in § 404.935(b). The written request must give the names of the witnesses or documents to be produced; describe the address or location of the witnesses or documents with sufficient detail to find them; state the important facts that the witness or document is expected to prove; and indicate why these facts could not be proven without issuing a subpoena.

(3) We will pay the cost of issuing the subpoena.

(4) We will pay subpoenaed witnesses the same fees and mileage they would receive if they had been subpoenaed by a Federal district court.

(e) *Witnesses at a hearing.* Witnesses you call may appear at a hearing with you in the same manner in which you are scheduled to appear. If they are unable to appear with you in the same manner as you, they may appear as prescribed in § 404.936(c)(2). Witnesses called by the administrative law judge will appear in the manner prescribed in § 404.936(c)(2). They will testify under oath or affirmation unless the administrative law judge finds an important reason to excuse them from taking an oath or affirmation. The administrative law judge may ask the witness any questions material to the issues and will allow the parties or their designated representatives to do so.

(f) *Collateral estoppel—issues previously decided.* An issue at your hearing may be a fact that has already been decided in one of our previous determinations or decisions in a claim involving the same parties, but arising under a different title of the Act or under the Federal Coal Mine Health and Safety Act. If this happens, the administrative law judge will not consider the issue again, but will accept the factual finding made in the previous determination or decision unless there are reasons to believe that it was wrong.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 68 FR 5219, Feb. 3, 2003; 75 FR 39160, July 8, 2010; 78 FR 29627, May 21, 2013; 81 FR 90993, Dec. 16, 2016; 84 FR 69306, Dec. 18, 2019; 89 FR 68362, Aug. 26, 2024]

§ 404.951 Official record.

(a) *Hearing recording.* All hearings will be recorded. The hearing recording will be prepared as a typed copy of the proceedings if—

(1) The case is sent to the Appeals Council without a decision or with a recommended decision by the administrative law judge;

(2) You seek judicial review of your case by filing an action in a Federal district court within the stated time period, unless we request the court to remand the case; or

(3) An administrative law judge or the Appeals Council asks for a written record of the proceedings.

(b) *Contents of the official record.* All evidence upon which the administrative law judge relies for the decision must be contained in the record, either directly or by appropriate reference. The official record will include the applications, written statements, certificates, reports, affidavits, medical records, and other documents that were used in making the decision under review and any additional evidence or written statements that the administrative law judge admits into the record under §§ 404.929 and 404.935. All exhibits introduced as evidence must be marked for identification and incorporated into the record. The official record of your claim will contain all of the marked exhibits and a verbatim recording of all testimony offered at the hearing. It also will include any prior initial determinations or decisions on your claim.

[81 FR 90994, Dec. 16, 2016

§ 404.952 Consolidated hearing before an administrative law judge.

(a) *General.* (1) A consolidated hearing may be held if—

(i) You have requested a hearing to decide your benefit rights under title II of the Act and you have also requested a hearing to decide your rights under another law we administer; and

(ii) One or more of the issues to be considered at the hearing you requested are the same issues that are involved in another claim you have pending before us.

(2) If the administrative law judge decides to hold the hearing on both claims, he or she decides both claims, even if we have not yet made an initial or reconsidered determination on the other claim.

(b) *Record, evidence, and decision.* There will be a single record at a consolidated hearing. This means that the evidence introduced in one case becomes evidence in the other(s). The administrative law judge may make either a separate or consolidated decision.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.953 The decision of an administrative law judge.

(a) *General.* The administrative law judge shall issue a written decision that gives the findings of fact and the

reasons for the decision. The administrative law judge must base the decision on the preponderance of the evidence offered at the hearing or otherwise included in the record. The administrative law judge shall mail a copy of the decision to all the parties at their last known address. The Appeals Council may also receive a copy of the decision.

(b) *Fully favorable oral decision entered into the record at the hearing.* The administrative law judge may enter a fully favorable oral decision based on the preponderance of the evidence into the record of the hearing proceedings. If the administrative law judge enters a fully favorable oral decision into the record of the hearing proceedings, the administrative law judge may issue a written decision that incorporates the oral decision by reference. The administrative law judge may use this procedure only in those categories of cases that we identify in advance. The administrative law judge may only use this procedure in those cases where the administrative law judge determines that no changes are required in the findings of fact or the reasons for the decision as stated at the hearing. If a fully favorable decision is entered into the record at the hearing, the administrative law judge will also include in the record, as an exhibit entered into the record at the hearing, a document that sets forth the key data, findings of fact, and narrative rationale for the decision. If the decision incorporates by reference the findings and the reasons stated in an oral decision at the hearing, the parties shall also be provided, upon written request, a record of the oral decision.

(c) *Recommended decision.* Although an administrative law judge will usually make a decision, the administrative law judge may send the case to the Appeals Council with a recommended decision based on a preponderance of the evidence when appropriate. The administrative law judge will mail a copy of the recommended decision to the parties at their last known addresses and send the recommended decision to the Appeals Council.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 54 FR 37792, Sept. 13, 1989; 69 FR 61597, Oct. 20, 2004; 73 FR 76944, Dec. 18, 2008; 75 FR 33168, June 11, 2010]

§ 404.955 The effect of a hearing decision.

The decision of the administrative law judge is binding on all parties to the hearing unless—

(a) You or another party request a review of the decision by the Appeals Council within the stated time period, and the Appeals Council reviews your case;

(b) You or another party requests a review of the decision by the Appeals Council within the stated time period, the Appeals Council denies your request for review, and you seek judicial review of your case by filing an action in a Federal district court;

(c) The Appeals Council decides on its own motion to review the decision under the procedures in § 404.969;

(d) The decision is revised by an administrative law judge or the Appeals Council under the procedures explained in § 404.987;

(e) The expedited appeals process is used;

(f) The decision is a recommended decision directed to the Appeals Council; or

(g) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 404.984.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 54 FR 37792, Sept. 13, 1989; 85 FR 73157, Nov. 16, 2020]

§ 404.956 Removal of a hearing request(s) to the Appeals Council.

(a) *Removal.* The Appeals Council may assume responsibility for a hearing request(s) pending at the hearing level of the administrative review process.

(b) *Notice.* We will mail a notice to all parties at their last known address telling them that the Appeals Council has assumed responsibility for the case(s).

(c) *Procedures applied.* If the Appeals Council assumes responsibility for a hearing request(s), it shall conduct all

proceedings in accordance with the rules set forth in §§ 404.929 through 404.961, as applicable.

(d) *Appeals Council review.* If the Appeals Council assumes responsibility for your hearing request under this section and you or any other party is dissatisfied with the hearing decision or with the dismissal of a hearing request, you may request that the Appeals Council review that action following the procedures in §§ 404.967 through 404.982. The Appeals Council may also decide on its own motion to review the action that was taken in your case under § 404.969. The administrative appeals judge who conducted a hearing, issued a hearing decision in your case, or dismissed your hearing request will not participate in any action associated with your request for Appeals Council review of that case.

(e) *Ancillary provisions.* For the purposes of the procedures authorized by this section, the regulations of part 404 shall apply to authorize a member of the Appeals Council to exercise the functions performed by an administrative law judge under subpart J of part 404.

[85 FR 73157, Nov. 16, 2020]

§ 404.957 Dismissal of a request for a hearing before an administrative law judge.

An administrative law judge may dismiss a request for a hearing under any of the following conditions:

(a) At any time before notice of the hearing decision is mailed, you or the party or parties that requested the hearing ask to withdraw the request. This request may be submitted in writing to the administrative law judge or made orally at the hearing.

(b)(1)(i) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and you have been notified before the time set for the hearing that your request for hearing may be dismissed without further notice if you did not appear at the time and place of hearing, and good cause has not been found by the administrative law judge for your failure to appear; or

(ii) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and within 10 days after the administrative law judge mails you a notice asking why you did not appear, you do not give a good reason for the failure to appear.

(2) In determining good cause or good reason under this paragraph, we will consider any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

(c) The administrative law judge decides that there is cause to dismiss a hearing request entirely or to refuse to consider any one or more of the issues because—

(1) The doctrine of *res judicata* applies in that we have made a previous determination or decision under this subpart about your rights on the same facts and on the same issue or issues, and this previous determination or decision has become final by either administrative or judicial action;

(2) The person requesting a hearing has no right to it under § 404.930;

(3) You did not request a hearing within the stated time period and we have not extended the time for requesting a hearing under § 404.933(c); or

(4) You die, there are no other parties, and we have no information to show that another person may be adversely affected by the determination that was to be reviewed at the hearing. However, dismissal of the hearing request will be vacated if, within 60 days after the date of the dismissal, another person submits a written request for a hearing on the claim and shows that he or she may be adversely affected by the determination that was to be reviewed at the hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 50 FR 21438, May 24, 1985; 51 FR 303, Jan. 3, 1986; 59 FR 1634, Jan. 12, 1994]

§ 404.958 Notice of dismissal of a request for a hearing before an administrative law judge.

We shall mail a written notice of the dismissal of the hearing request to all parties at their last known address. The notice will state that there is a right to request that the Appeals Council vacate the dismissal action.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.959 Effect of dismissal of a request for a hearing before an administrative law judge.

The dismissal of a request for a hearing is binding, unless it is vacated by an administrative law judge or the Appeals Council.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.960 Vacating a dismissal of a request for a hearing before an administrative law judge.

(a) Except as provided in paragraph (b) of this section, an administrative law judge or the Appeals Council may vacate a dismissal of a request for a hearing if you request that we vacate the dismissal. If you or another party wish to make this request, you must do so within 60 days of the date you receive notice of the dismissal, and you must state why our dismissal of your request for a hearing was erroneous. The administrative law judge or Appeals Council will inform you in writing of the action taken on your request. The Appeals Council may also vacate a dismissal of a request for a hearing on its own motion. If the Appeals Council decides to vacate a dismissal on its own motion, it will do so within 60 days of the date we mail the notice of dismissal and will inform you in writing that it vacated the dismissal.

(b) If you wish to proceed with a hearing after you received a fully favorable revised determination under the prehearing case review process in § 404.941, you must follow the procedures in § 404.941(d) to request that an administrative law judge vacate his or her order dismissing your request for a hearing.

[76 FR 65370, Oct. 21, 2011]

§ 404.961 Prehearing and posthearing conferences.

The administrative law judge may decide on his or her own, or at the request of any party to the hearing, to hold a prehearing or posthearing conference to facilitate the hearing or the hearing decision. The administrative law judge shall tell the parties of the time, place and purpose of the conference at least seven days before the conference date, unless the parties have indicated in writing that they do not wish to receive a written notice of the conference. At the conference, the administrative law judge may consider matters in addition to those stated in the notice, if the parties consent in writing. A record of the conference will be made. The administrative law judge shall issue an order stating all agreements and actions resulting from the conference. If the parties do not object, the agreements and actions become part of the hearing record and are binding on all parties.

§ 404.965 [Reserved]

APPEALS COUNCIL REVIEW

§ 404.966 [Reserved]

§ 404.967 Appeals Council review—general.

If you or any other party is dissatisfied with the hearing decision or with the dismissal of a hearing request, you may request that the Appeals Council review that action. The Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or remand the case to an administrative law judge. The Appeals Council shall notify the parties at their last known address of the action it takes.

§ 404.968 How to request Appeals Council review.

(a) *Time and place to request Appeals Council review.* You may request Appeals Council review by filing a written request. You should submit any evidence you wish to have considered by the Appeals Council with your request for review, and the Appeals Council will consider the evidence in accordance with § 404.970. You may file your request—

(1) Within 60 days after the date you receive notice of the hearing decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (b) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or

more years of service in the railroad industry.

(b) *Extension of time to request review.* You or any party to a hearing decision may ask that the time for filing a request for the review be extended. The request for an extension of time must be in writing. It must be filed with the Appeals Council, and it must give the reasons why the request for review was not filed within the stated time period. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

[45 FR 52081, Aug. 5, 1980, as amended at 81 FR 90993, Dec. 16, 2016]

§ 404.969 Appeals Council initiates review.

(a) *General.* Anytime within 60 days after the date of a decision or dismissal that is subject to review under this section, the Appeals Council may decide on its own motion to review the action that was taken in your case. We may refer your case to the Appeals Council for it to consider reviewing under this authority.

(b) *Identification of cases.* We will identify a case for referral to the Appeals Council for possible review under its own-motion authority before we effectuate a decision in the case. We will identify cases for referral to the Appeals Council through random and selective sampling techniques, which we may use in association with examination of the cases identified by sampling. We will also identify cases for referral to the Appeals Council through the evaluation of cases we conduct in order to effectuate decisions.

(1) *Random and selective sampling and case examinations.* We may use random and selective sampling to identify cases involving any type of action (*i.e.*, fully or partially favorable decisions, unfavorable decisions, or dismissals) and any type of benefits (*i.e.*, benefits based on disability and benefits not based on disability). We will use selective sampling to identify cases that exhibit problematic issues or fact patterns that increase the likelihood of error. Neither our random sampling procedures nor our selective sampling procedures will identify cases based on the identity of the decisionmaker or the identity of the office issuing the decision. We may examine cases that have been identified through random or selective sampling to refine the identification of cases that may meet the criteria for review by the Appeals Council.

(2) *Identification as a result of the effectuation process.* We may refer a case requiring effectuation to the Appeals Council if, in the view of the effectuating component, the decision cannot be effectuated because it contains a clerical error affecting the outcome of the claim; the decision is clearly inconsistent with the Social Security Act, the regulations, or a published ruling; or the decision is unclear regarding a matter that affects the claim's outcome.

(c) *Referral of cases.* We will make referrals that occur as the result of a case examination or the effectuation process in writing. The written referral based on the results of such a case examination or the effectuation process will state the referring component's reasons for believing that the Appeals Council should review the case on its own motion. Referrals that result from selective sampling without a case examination may be accompanied by a written statement identifying the issue(s) or fact pattern that caused the referral. Referrals that result from random sampling without a case examination will only identify the case as a random sample case.

(d) *Appeals Council's action.* If the Appeals Council decides to review a decision or dismissal on its own motion, it will mail a notice of review to all the parties as provided in § 404.973. The Appeals Council will include with that notice a copy of any written referral it has received under paragraph (c) of this section. The Appeals Council's decision to review a case is established by its issuance of the notice of review. If it is unable to decide within the applicable 60-day period whether to review a decision or dismissal, the Appeals Council may consider the case to determine if the decision or dismissal should be reopened pursuant to §§ 404.987 and 404.988. If the Appeals Council decides to review a decision on its own motion or to reopen a decision as provided in

§§ 404.987 and 404.988, the notice of review or the notice of reopening issued by the Appeals Council will advise, where appropriate, that interim benefits will be payable if a final decision has not been issued within 110 days after the date of the decision that is reviewed or reopened, and that any interim benefits paid will not be considered overpayments unless the benefits are fraudulently obtained.

[63 FR 36570, July 7, 1998, as amended at 75 FR 33168, June 11, 2010]

§ 404.970 Cases the Appeals Council will review.

(a) The Appeals Council will review a case at a party's request or on its own motion if—

(1) There appears to be an abuse of discretion by the administrative law judge or administrative appeals judge who heard the case;

(2) There is an error of law;

(3) The action, findings or conclusions in the hearing decision or dismissal order are not supported by substantial evidence;

(4) There is a broad policy or procedural issue that may affect the general public interest; or

(5) Subject to paragraph (b) of this section, the Appeals Council receives additional evidence that is new, material, and relates to the period on or before the date of the hearing decision, and there is a reasonable probability that the additional evidence would change the outcome of the decision.

(b) The Appeals Council will only consider additional evidence under paragraph (a)(5) of this section if you show good cause for not informing us about or submitting the evidence as described in § 404.935 because:

(1) Our action misled you;

(2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier; or

(3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:

(i) You were seriously ill, and your illness prevented you from contacting us in person, in writing, or through a friend, relative, or other person;

(ii) There was a death or serious illness in your immediate family;

(iii) Important records were destroyed or damaged by fire or other accidental cause;

(iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing; or

(v) You received a hearing level decision on the record and the Appeals Council reviewed your decision.

(c) If you submit additional evidence that does not relate to the period on or before the date of the administrative law judge hearing decision as required in paragraph (a)(5) of this section, or the Appeals Council does not find you had good cause for missing the deadline to submit the evidence in § 404.935, the Appeals Council will send you a notice that explains why it did not accept the additional evidence and advises you of your right to file a new application. The notice will also advise you that if you file a new application within 6 months after the date of the Appeals Council's notice, your request for review will constitute a written statement indicating an intent to claim benefits under § 404.630. If you file a new application within 6 months of the Appeals Council's notice, we will use the date you requested Appeals Council review as the filing date for your new application.

[81 FR 90994, Dec. 16, 2016, as amended at 85 FR 73157, Nov. 16, 2020]

§ 404.971 Dismissal by Appeals Council.

The Appeals Council will dismiss your request for review if you did not file your request within the stated period of time and the time for filing has not been extended. The Appeals Council may also dismiss any proceedings before it if—

(a) You and any other party to the proceedings files a written request for dismissal; or

(b) You or any other party to the proceedings dies and the record clearly shows that dismissal will not adversely affect any other person who wishes to continue the action.

§ 404.972 Effect of dismissal of request for Appeals Council review.

The dismissal of a request for Appeals Council review is binding and not subject to further review.

§ 404.973 Notice of Appeals Council review.

When the Appeals Council decides to review a case, it shall mail a prior notice to all parties at their last known address stating the reasons for the review and the issues to be considered. However, when the Appeals Council plans to issue a decision that is fully favorable to all parties, plans to remand the case for further proceedings, or plans to issue a decision that is favorable in part and remand the remaining issues for further proceedings, it may send the notice of Appeals Council review to all parties with the decision or remand order.

[85 FR 73157, Nov. 16, 2020]

§ 404.974 Obtaining evidence from Appeals Council.

You may request and receive copies or a statement of the documents or other written evidence upon which the hearing decision or dismissal was based and a copy or summary of the transcript of oral evidence. However, you will be asked to pay the costs of providing these copies unless there is a good reason why you should not pay.

§ 404.975 Filing briefs with the Appeals Council.

Upon request, the Appeals Council shall give you and all other parties a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case. A copy of each brief or statement should be filed for each party.

§ 404.976 Procedures before the Appeals Council.

(a) *Limitation of issues.* The Appeals Council may limit the issues it considers if it notifies you and the other parties of the issues it will review.

(b) *Evidence the Appeals Council will exhibit.* The Appeals Council will evaluate all additional evidence it receives, but will only mark as an exhibit and make part of the official record additional evidence that it determines meets the requirements of § 404.970(a)(5) and (b). If we need to file a certified administrative record in Federal court, we will include in that record all additional evidence the Appeals Council received during the administrative review process, including additional evidence that the Appeals Council received but did not exhibit or make part of the official record.

(c) *Oral argument.* You may request to appear before the Appeals Council to present oral argument in support of your request for review. The Appeals Council will grant your request if it decides that your case raises an important question of law or policy or that oral argument would help to reach a proper decision. If your request to appear is granted, the Appeals Council will tell you the time and place of the oral argument at least 10 business days before the scheduled date. The Appeals Council will determine whether your appearance will be by audio, agency video, online video, or in person as set forth in § 404.936. The Appeals Council will determine whether any other person relevant to the proceeding will appear by audio, agency video, online video, or in person as set forth in § 404.936(c)(2).

[81 FR 90994, Dec. 16, 2016, as amended at 84 FR 69306, Dec. 18, 2019; 85 FR 73157, Nov. 16, 2020; 89 FR 68362, Aug. 26, 2024]

§ 404.977 Case remanded by Appeals Council.

(a) *When the Appeals Council may remand a case.* The Appeals Council may remand a case to an administrative law judge so that he or she may hold a hearing and issue a decision or a recommended decision. The Appeals Council may also remand a case in which additional evidence is needed or additional action by the administrative law judge is required.

(b) *Action by administrative law judge on remand.* The administrative law judge shall take any action that is ordered by the Appeals Council and may take any additional action that is not inconsistent with the Appeals Council's remand order.

(c) *Notice when case is returned with a recommended decision.* When the administrative law judge sends a case to the

Appeals Council with a recommended decision, a notice is mailed to the parties at their last known address. The notice tells them that the case has been sent to the Appeals Council, explains the rules for filing briefs or other written statements with the Appeals Council, and includes a copy of the recommended decision.

(d) *Filing briefs with and obtaining evidence from the Appeals Council.* (1) You may file briefs or other written statements about the facts and law relevant to your case with the Appeals Council within 20 days of the date that the recommended decision is mailed to you. Any party may ask the Appeals Council for additional time to file briefs or statements. The Appeals Council will extend this period, as appropriate, if you show that you had good cause for missing the deadline.

(2) All other rules for filing briefs with and obtaining evidence from the Appeals Council follow the procedures explained in this subpart.

(e) *Procedures before the Appeals Council.* (1) The Appeals Council, after receiving a recommended decision, will conduct its proceedings and issue its decision according to the procedures explain in this subpart.

(2) If the Appeals Council believes that more evidence is required, it may again remand the case to an administrative law judge for further inquiry into the issues, rehearing, receipt of evidence, and another decision or recommended decision. However, if the Appeals Council decides that it can get the additional evidence more quickly, it will take appropriate action.

§ 404.979 Decision of Appeals Council.

After it has reviewed all the evidence in the administrative law judge hearing record and any additional evidence received, subject to the limitations on Appeals Council consideration of additional evidence in § 404.970, the Appeals Council will make a decision or remand the case to an administrative law judge. The Appeals Council may affirm, modify or reverse the administrative law judge hearing decision or it may adopt, modify or reject a recommended decision. If the Appeals Council issues its own decision, it will base its decision on the preponderance of the evidence. A copy of the Appeals Council's decision will be mailed to the parties at their last known address.

[52 FR 4004, Feb. 9, 1987, as amended at 73 FR 76944, Dec. 18, 2008; 81 FR 90994, Dec. 16, 2016]

§ 404.981 Effect of Appeals Council's decision or denial of review.

The Appeals Council may deny a party's request for review or it may decide to review a case and make a decision. The Appeals Council's decision, or the decision of the administrative law judge if the request for review is denied, is binding unless you or another party file an action in Federal district court, or the decision is revised. You may file an action in a Federal district court within 60 days after the date you receive notice of the Appeals Council's action.

§ 404.982 Extension of time to file action in Federal district court.

Any party to the Appeals Council's decision or denial of review, or to an expedited appeals process agreement, may request that the time for filing an action in a Federal district court be extended. The request must be in writing and it must give the reasons why the action was not filed within the stated time period. The request must be filed with the Appeals Council, or if it concerns an expedited appeals process agreement, with one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

COURT REMAND CASES

§ 404.983 Case remanded by a Federal court.

(a) *General rule.* When a Federal court remands a case to the Commissioner for further consideration, the Appeals Council, acting on behalf of the Commissioner, may make a decision following the provisions in paragraph (b) or (c) of this section, dismiss the proceedings, except as provided in paragraph (d) of this section, or remand the case to an administrative law judge following the provisions in paragraph (e) of this section with instructions to

take action and issue a decision or return the case to the Appeals Council with a recommended decision. Any issues relating to the claim(s) may be considered by the Appeals Council or administrative law judge whether or not they were raised in the administrative proceedings leading to the final decision in the case.

(b) *Appeals Council decision without a hearing.* If the Appeals Council assumes responsibility under paragraph (a) of this section for issuing a decision without a hearing, it will follow the procedures explained in §§ 404.973 and 404.979.

(c) *Administrative appeals judge decision after holding a hearing.* If the Appeals Council assumes responsibility for issuing a decision and a hearing is necessary to complete adjudication of the claim(s), an administrative appeals judge will hold a hearing using the procedures set forth in §§ 404.929 through 404.961, as applicable.

(d) *Appeals Council dismissal.* After a Federal court remands a case to the Commissioner for further consideration, the Appeals Council may dismiss the proceedings before it for any reason that an administrative law judge may dismiss a request for a hearing under § 404.957. The Appeals Council will not dismiss the proceedings in a claim where we are otherwise required by law or a judicial order to file the Commissioner's additional and modified findings of fact and decision with a court.

(e) *Appeals Council remand.* If the Appeals Council remands a case under paragraph (a) of this section, it will follow the procedures explained in § 404.977.

[85 FR 73157, Nov. 16, 2020]

§ 404.984 Appeals Council review of hearing decision in a case remanded by a Federal court.

(a) *General.* In accordance with § 404.983, when a case is remanded by a Federal court for further consideration and the Appeals Council remands the case to an administrative law judge, or an administrative appeals judge issues a decision pursuant to § 404.983(c), the decision of the administrative law judge or administrative appeals judge will become the final decision of the Commissioner after remand on your case unless the Appeals Council assumes jurisdiction of the case. The Appeals Council may assume jurisdiction, using the standard set forth in § 404.970, based on written exceptions to the decision which you file with the Appeals Council or based on its authority pursuant to paragraph (c) of this section. If the Appeals Council assumes jurisdiction of the case, it will not dismiss the request for a hearing where we are otherwise required by law or a judicial order to file the Commissioner's additional and modified findings of fact and decision with a court.

(b) *You file exceptions disagreeing with the hearing decision.* (1) If you disagree with the hearing decision, in whole or in part, you may file exceptions to the decision with the Appeals Council. Exceptions may be filed by submitting a written statement to the Appeals Council setting forth your reasons for disagreeing with the decision of the administrative law judge or administrative appeals judge. The exceptions must be filed within 30 days of the date you receive the hearing decision or an extension of time in which to submit exceptions must be requested in writing within the 30-day period. A timely request for a 30-day extension will be granted by the Appeals Council. A request for an extension of more than 30 days should include a statement of reasons as to why you need the additional time.

(2) If written exceptions are timely filed, the Appeals Council will consider your reasons for disagreeing with the hearing decision and all the issues presented by your case. If the Appeals Council concludes that there is no reason to change the hearing decision, it will issue a notice to you addressing your exceptions and explaining why no change in the hearing decision is warranted. In this instance, the hearing decision is the final decision of the Commissioner after remand.

(3) When you file written exceptions to the hearing decision, the Appeals Council may assume jurisdiction at any time, even after the 60-day time period which applies when you do not file exceptions. If the Appeals Council assumes jurisdiction of your case, any issues relating to your claim may be considered by the Appeals Council whether or not they were raised in the

administrative proceedings leading to the final decision in your case or subsequently considered by the administrative law judge or administrative appeals judge in the administrative proceedings following the court's remand order. The Appeals Council will either make a new, independent decision pursuant to § 404.983(b) or § 404.983(c), based on a preponderance of the evidence in the record that will be the final decision of the Commissioner after remand, dismiss the request for a hearing, or remand the case to an administrative law judge for further proceedings, including a new decision.

(c) *Appeals Council assumes jurisdiction without exceptions being filed.* Any time within 60 days after the date of the hearing decision, the Appeals Council may decide to assume jurisdiction of your case even though no written exceptions have been filed. Notice of this action will be mailed to all parties at their last known address. You will be provided with the opportunity to file briefs or other written statements with the Appeals Council about the facts and law relevant to your case. After the Appeals Council receives the briefs or other written statements, or the time allowed (usually 30 days) for submitting them has expired, the Appeals Council will either make a new, independent decision pursuant to § 404.983(b) or § 404.983(c), based on a preponderance of the evidence in the record that will be the final decision of the Commissioner after remand, dismiss the request for a hearing, or remand the case to an administrative law judge for further proceedings, including a new decision.

(d) *Exceptions are not filed and the Appeals Council does not otherwise assume jurisdiction.* If no exceptions are filed and the Appeals Council does not assume jurisdiction of your case, the decision of the administrative law judge or administrative appeals judge becomes the final decision of the Commissioner after remand.

[85 FR 73185, Nov. 16, 2020]

§ 404.985 Application of circuit court law.

The procedures which follow apply to administrative determinations or decisions on claims involving the application of circuit court law.

(a) *General.* We will apply a holding in a United States Court of Appeals decision that we determine conflicts with our interpretation of a provision of the Social Security Act or regulations unless the Government seeks further judicial review of that decision or we relitigate the issue presented in the decision in accordance with paragraphs (c) and (d) of this section. We will apply the holding to claims at all levels of the administrative review process within the applicable circuit unless the holding, by its nature, applies only at certain levels of adjudication.

(b) *Issuance of an Acquiescence Ruling.* When we determine that a United States Court of Appeals holding conflicts with our interpretation of a provision of the Social Security Act or regulations and the Government does not seek further judicial review or is unsuccessful on further review, we will issue a Social Security Acquiescence Ruling. The Acquiescence Ruling will describe the administrative case and the court decision, identify the issue(s) involved, and explain how we will apply the holding, including, as necessary, how the holding relates to other decisions within the applicable circuit. These Acquiescence Rulings will generally be effective on the date of their publication in the FEDERAL REGISTER and will apply to all determinations and decisions made on or after that date unless an Acquiescence Ruling is rescinded as stated in paragraph (e) of this section. The process we will use when issuing an Acquiescence Ruling follows:

(1) We will release an Acquiescence Ruling for publication in the FEDERAL REGISTER for any precedential circuit court decision that we determine contains a holding that conflicts with our interpretation of a provision of the Social Security Act or regulations no later than 120 days from the receipt of the court's decision. This timeframe will not apply when we decide to seek further judicial review of the circuit court decision or when coordination with the Department of Justice and/or other Federal agencies makes this timeframe no longer feasible.

(2) If we make a determination or decision on your claim between the date of a circuit court decision and the date we publish an Acquiescence Ruling, you may request application of the published Acquiescence Ruling to the prior determination or decision. You must demonstrate that application of the Acquiescence Ruling could change the prior determination or decision in your case. You may demonstrate this by submitting a statement that cites the Acquiescence Ruling or the holding or portion of a circuit court decision which could change the prior determination or decision in your case. If you can so demonstrate, we will readjudicate the claim in accordance with the Acquiescence Ruling at the level at which it was last adjudicated. Any readjudication will be limited to consideration of the issue(s) covered by the Acquiescence Ruling and any new determination or decision on readjudication will be subject to administrative and judicial review in accordance with this subpart. Our denial of a request for readjudication will not be subject to further administrative or judicial review. If you file a request for readjudication within the 60-day appeal period and we deny that request, we shall extend the time to file an appeal on the merits of the claim to 60 days after the date that we deny the request for readjudication.

(3) After we receive a precedential circuit court decision and determine that an Acquiescence Ruling may be required, we will begin to identify those claims that are pending before us within the circuit and that might be subject to readjudication if an Acquiescence Ruling is subsequently issued. When an Acquiescence Ruling is published, we will send a notice to those individuals whose cases we have identified which may be affected by the Acquiescence Ruling. The notice will provide information about the Acquiescence Ruling and the right to request readjudication under that Acquiescence Ruling, as described in paragraph (b)(2) of this section. It is not necessary for an individual to receive a notice in order to request application of an Acquiescence Ruling to his or her claim, as described in paragraph (b)(2) of this section.

(c) *Relitigation of court's holding after publication of an Acquiescence Ruling.* After we have published an Acquiescence Ruling to reflect a holding of a United States Court of Appeals on an issue, we may decide under certain conditions to relitigate that issue within the same circuit. We may relitigate only when the conditions specified in paragraphs (c)(2) and (3) of this section are met, and, in general, one of the events specified in paragraph (c)(1) of this section occurs.

(1) Activating events:

(i) An action by both Houses of Congress indicates that a circuit court decision on which an Acquiescence Ruling was based was decided inconsistently with congressional intent, such as may be expressed in a joint resolution, an appropriations restriction, or enactment of legislation which affects a closely analogous body of law;

(ii) A statement in a majority opinion of the same circuit indicates that the court might no longer follow its previous decision if a particular issue were presented again;

(iii) Subsequent circuit court precedent in other circuits supports our interpretation of the Social Security Act or regulations on the issue(s) in question; or

(iv) A subsequent Supreme Court decision presents a reasonable legal basis for questioning a circuit court holding upon which we base an Acquiescence Ruling.

(2) The General Counsel of the Social Security Administration, after consulting with the Department of Justice, concurs that relitigation of an issue and application of our interpretation of the Social Security Act or regulations to selected claims in the administrative review process within the circuit would be appropriate.

(3) We publish a notice in the FEDERAL REGISTER that we intend to relitigate an Acquiescence Ruling issue and that we will apply our interpretation of the Social Security Act or regulations within the circuit to claims in the administrative review process selected for relitigation. The notice will explain why we made this decision.

(d) *Notice of relitigation.* When we decide to relitigate an issue, we will provide a notice explaining our action to

all affected claimants. In adjudicating claims subject to relitigation, decisionmakers throughout the SSA administrative review process will apply our interpretation of the Social Security Act and regulations, but will also state in written determinations or decisions how the claims would have been decided under the circuit standard. Claims not subject to relitigation will continue to be decided under the Acquiescence Ruling in accordance with the circuit standard. So that affected claimants can be readily identified and any subsequent decision of the circuit court or the Supreme Court can be implemented quickly and efficiently, we will maintain a listing of all claimants who receive this notice and will provide them with the relief ordered by the court.

(e) *Rescission of an Acquiescence Ruling*. We will rescind as obsolete an Acquiescence Ruling and apply our interpretation of the Social Security Act or regulations by publishing a notice in the FEDERAL REGISTER when any of the following events occurs:

(1) The Supreme Court overrules or limits a circuit court holding that was the basis of an Acquiescence Ruling;

(2) A circuit court overrules or limits itself on an issue that was the basis of an Acquiescence Ruling;

(3) A Federal law is enacted that removes the basis for the holding in a decision of a circuit court that was the subject of an Acquiescence Ruling; or

(4) We subsequently clarify, modify or revoke the regulation or ruling that was the subject of a circuit court holding that we determined conflicts with our interpretation of the Social Security Act or regulations, or we subsequently publish a new regulation(s) addressing an issue(s) not previously included in our regulations when that issue(s) was the subject of a circuit court holding that conflicted with our interpretation of the Social Security Act or regulations and that holding was not compelled by the statute or Constitution.

[63 FR 24932, May 6, 1998]

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

§ 404.987 Reopening and revising determinations and decisions.

(a) *General*. Generally, if you are dissatisfied with a determination or decision made in the administrative review process, but do not request further review within the stated time period, you lose your right to further review and that determination or decision becomes final. However, a determination or a decision made in your case which is otherwise final and binding may be reopened and revised by us.

(b) *Procedure for reopening and revision*. We may reopen a final determination or decision on our own initiative, or you may ask that a final determination or a decision to which you were a party be reopened. In either instance, if we reopen the determination or decision, we may revise that determination or decision. The conditions under which we may reopen a previous determination or decision, either on our own initiative or at your request, are explained in § 404.988.

[59 FR 8535, Feb. 23, 1994]

§ 404.988 Conditions for reopening.

A determination, revised determination, decision, or revised decision may be reopened—

(a) Within 12 months of the date of the notice of the initial determination, for any reason;

(b) Within four years of the date of the notice of the initial determination if we find good cause, as defined in § 404.989, to reopen the case; or

(c) At any time if—

(1) It was obtained by fraud or similar fault (see § 416.1488(c) of this chapter for factors which we take into account in determining fraud or similar fault);

(2) Another person files a claim on the same earnings record and allowance of the claim adversely affects your claim;

(3) A person previously determined to be dead, and on whose earnings record your entitlement is based, is later found to be alive;

(4) Your claim was denied because you did not prove that a person died, and the death is later established—

(i) By a presumption of death under § 404.721(b); or

(ii) By location or identification of his or her body;

(5) The Railroad Retirement Board has awarded duplicate benefits on the same earnings record;

(6) It either—

(i) Denies the person on whose earnings record your claim is based gratuitous wage credits for military or naval service because another Federal agency (other than the Veterans Administration) has erroneously certified that it has awarded benefits based on the service; or

(ii) Credits the earnings record of the person on which your claim is based with gratuitous wage credits and another Federal agency (other than the Veterans Administration) certifies that it has awarded a benefit based on the period of service for which the wage credits were granted;

(7) It finds that the claimant did not have insured status, but earnings were later credited to his or her earnings record to correct errors apparent on the face of the earnings record (section 205(c)(5)(C) of the Act), to enter items transferred by the Railroad Retirement Board, which were credited under the Railroad Retirement Act when they should have been credited to the claimant's Social Security earnings record (section 205(c)(5)(D) of the Act), or to correct errors made in the allocation of wages or self-employment income to individuals or periods (section 205(c)(5)(G) of the Act), which would have given him or her insured status at the time of the determination or decision if the earnings had been credited to his or her earnings record at that time, and the evidence of these earnings was in our possession or the possession of the Railroad Retirement Board at the time of the determination or decision;

(8) It is fully or partially unfavorable to a party, but only to correct clerical error or an error that appears on the face of the evidence that was considered when the determination or decision was made;

(9) It finds that you are entitled to monthly benefits or to a lump sum death payment based on the earnings of a deceased person, and it is later established that:

(i) You were convicted of a felony or an act in the nature of a felony for intentionally causing that person's death; or

(ii) If you were subject to the juvenile justice system, you were found by a court of competent jurisdiction to have intentionally caused that person's death by committing an act which, if committed by an adult, would have been considered a felony or an act in the nature of a felony;

(10) It either—

(i) Denies the person on whose earnings record your claim is based deemed wages for internment during World War II because of an erroneous finding that a benefit based upon the internment has been determined by an agency of the United States to be payable under another Federal law or under a system established by that agency; or

(ii) Awards the person on whose earnings record your claim is based deemed wages for internment during World War II and a benefit based upon the internment is determined by an agency of the United States to be payable under another Federal law or under a system established by that agency; or

(11) It is incorrect because—

(i) You were convicted of a crime that affected your right to receive benefits or your entitlement to a period of disability; or

(ii) Your conviction of a crime that affected your right to receive benefits or your entitlement to a period of disability is overturned.

[45 FR 52081, Aug. 5, 1980, as amended at 49 FR 46369, Nov. 26, 1984; 51 FR 18313, May 19, 1986; 59 FR 1635, Jan. 12, 1994; 60 FR 19165, Apr. 17, 1995; 75 FR 33168, June 11, 2010]

§ 404.989 Good cause for reopening.

(a) We will find that there is good cause to reopen a determination or decision if—

(1) New and material evidence is furnished;

(2) A clerical error in the computation or recomputation of benefits was made; or

(3) The evidence that was considered in making the determination or decision clearly shows on its face that an error was made.

(b) We will not find good cause to reopen your case if the only reason for reopening is a change of legal interpretation or administrative ruling upon which the determination or decision was made.

§ 404.990 Finality of determinations and decisions on revision of an earnings record.

A determination or a decision on a revision of an earnings record may be reopened only within the time period and under the conditions provided in section 205(c) (4) or (5) of the Act, or within 60 days after the date you receive notice of the determination or decision, whichever is later.

§ 404.991 Finality of determinations and decisions to suspend benefit payments for entire taxable year because of earnings.

A determination or decision to suspend benefit payments for an entire taxable year because of earnings may be reopened only within the time period and under the conditions provided in section 203(h)(1)(B) of the Act.

§ 404.991a Late completion of timely investigation.

We may revise a determination or decision after the applicable time period in § 404.988(a) or § 404.988(b) expires if we begin an investigation into whether to revise the determination or decision before the applicable time period expires. We may begin the investigation either based on a request by you or by an action on our part. The investigation is a process of gathering facts after a determination or decision has been reopened to determine if a revision of the determination or decision is applicable.

(a) If we have diligently pursued the investigation to its conclusion, we may revise the determination or decision. The revision may be favorable or unfavorable to you. ''Diligently pursued'' means that in light of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if we conclude the investigation and if necessary, revise the determination or decision within 6 months from the date we began the investigation.

(b) If we have not diligently pursued the investigation to its conclusion, we will revise the determination or decision if a revision is applicable and if it will be favorable to you. We will not revise the determination or decision if it will be unfavorable to you.

[49 FR 46369, Nov. 26, 1984; 49 FR 48036, Dec. 10, 1984]

§ 404.992 Notice of revised determination or decision.

(a) When a determination or decision is revised, notice of the revision will be mailed to the parties at their last known address. The notice will state the basis for the revised determination or decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a reconsidered determination that you are disabled, based on medical factors, is reopened for the purpose of being revised, you will be notified, in writing, of the proposed revision and of your right to request that a disability hearing be held before a revised reconsidered determination is issued. If a revised reconsidered determination is issued, you may request a hearing before an administrative law judge.

(c) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based on evidence not included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action and of your right to request that a hearing be held before any further action is taken. If a revised decision is issued by an administrative law judge, you and any other party may request that it be reviewed by the Appeals Council, or the Appeals Council may review the decision on its own initiative.

(d) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action. If a revised decision is issued by an administrative law

judge, you and any other party may request that it be reviewed by the Appeals Council, or the Appeals Council may review the decision on its own initiative.

[51 FR 303, Jan. 3, 1986]

§ 404.993 Effect of revised determination or decision.

A revised determination or decision is binding unless—

(a) You or another party to the revised determination file a written request for reconsideration or a hearing before an administrative law judge, as appropriate;

(b) You or another party to the revised decision file, as appropriate, a request for review by the Appeals Council or a hearing before an administrative law judge;

(c) The Appeals Council reviews the revised decision; or

(d) The revised determination or decision is further revised.

[51 FR 303, Jan. 3, 1986]

§ 404.994 Time and place to request a hearing on revised determination or decision.

You or another party to a revised determination or decision may request, as appropriate, further review or a hearing on the revision by filing a request in writing at one of our offices within 60 days after the date you receive notice of the revision. Further review or a hearing will be held on the revision according to the rules of this subpart.

§ 404.995 Finality of findings when later claim is filed on same earnings record.

If two claims for benefits are filed on the same earnings records, findings of fact made in a determination on the first claim may be revised in determining or deciding the second claim, even though the time limit for revising the findings made in the first claim has passed. However, a finding in connection with a claim that a person was fully or currently insured at the time of filing an application, at the time of death, or any other pertinent time, may be revised only under the conditions stated in § 404.988.

§ 404.996 Increase in future benefits where time period for reopening expires.

If, after the time period for reopening under § 404.988(b) has ended, new evidence is furnished showing a different date of birth or additional earnings for you (or for the person on whose earnings record your claim was based) which would otherwise increase the amount of your benefits, we will make the increase (subject to the limitations provided in section 205(c) (4) and (5) of the Act) but only for benefits payable after the time we received the new evidence. (If the new evidence we receive would lead to a decrease in your benefits, we will take no action if we cannot reopen under § 404.988.)

[49 FR 46369, Nov. 26, 1984]

PAYMENT OF CERTAIN TRAVEL EXPENSES

§ 404.999a Payment of certain travel expenses—general.

When you file a claim for Social Security benefits, you may incur certain travel expenses in pursuing your claim. Sections 404.999b–404.999d explain who may be reimbursed for travel expenses, the types of travel expenses that are reimbursable, and when and how to claim reimbursement. Generally, the agency that requests you to travel will be the agency that reimburses you. No later than when it notifies you of the examination or hearing described in § 404.999b(a), that agency will give you information about the right to travel reimbursement, the right to advance payment and how to request it, the rules on means of travel and unusual travel costs, and the need to submit receipts.

[51 FR 8808, Mar. 14, 1986]

§ 404.999b Who may be reimbursed.

(a) The following individuals may be reimbursed for certain travel expenses—

(1) You, when you attend medical examinations upon request in connection with disability determinations; these are medical examinations requested by the State agency or by us when additional medical evidence is necessary to make a disability determination (also

referred to as consultative examinations, see § 404.1517);

(2) You, your representative (see § 404.1705 (a) and (b)), and all unsubpoenaed witnesses we or the State agency determines to be reasonably necessary who attend disability hearings; and

(3) You, your representative, and all unsubpoenaed witnesses we determine to be reasonably necessary who attend hearings on any claim for benefits before an administrative law judge.

(b) Sections 404.999a through 404.999d do not apply to subpoenaed witnesses. They are reimbursed under §§ 404.950(d) and 404.916(b)(1).

[51 FR 8808, Mar. 14, 1986]

§ 404.999c What travel expenses are reimbursable.

Reimbursable travel expenses include the ordinary expenses of public or private transportation as well as unusual costs due to special circumstances.

(a) Reimbursement for ordinary travel expenses is limited—

(1) To the cost of travel by the most economical and expeditious means of transportation available and appropriate to the individual's condition of health as determined by the State agency or by us, considering the available means in the following order—

(i) Common carrier (air, rail, or bus);

(ii) Privately owned vehicles;

(iii) Commercially rented vehicles and other special conveyances;

(2) If air travel is necessary, to the coach fare for air travel between the specified travel points involved unless first-class air travel is authorized in advance by the State agency or by the Secretary in instances when—

(i) Space is not available in less-than-first-class accommodations on any scheduled flights in time to accomplish the purpose of the travel;

(ii) First-class accommodations are necessary because you, your representative, or reasonably necessary witness is so handicapped or otherwise impaired that other accommodations are not practical and the impairment is substantiated by competent medical authority;

(iii) Less-than-first-class accommodations on foreign carriers do not provide adequate sanitation or health standards; or

(iv) The use of first-class accommodations would result in an overall savings to the government based on economic considerations, such as the avoidance of additional subsistence costs that would be incurred while awaiting availability of less-than-first-class accommodations.

(b) Unusual travel costs may be reimbursed but must be authorized in advance and in writing by us or the appropriate State official, as applicable, unless they are unexpected or unavoidable; we or the State agency must determine their reasonableness and necessity and must approve them before payment can be made. Unusual expenses that may be covered in connection with travel include, but are not limited to—

(1) Ambulance services;

(2) Attendant services;

(3) Meals;

(4) Lodging; and

(5) Taxicabs.

(c) If we reimburse you for travel, we apply the rules in §§ 404.999b through 404.999d and the same rates and conditions of payment that govern travel expenses for Federal employees as authorized under 41 CFR chapter 301. If a State agency reimburses you, the reimbursement rates shall be determined by the rules in §§ 404.999b through 404.999d and that agency's rules and regulations and may differ from one agency to another and also may differ from the Federal reimbursement rates.

(1) When public transportation is used, reimbursement will be made for the actual costs incurred, subject to the restrictions in paragraph (a)(2) of this section on reimbursement for first-class air travel.

(2) When travel is by a privately owned vehicle, reimbursement will be made at the current Federal or State mileage rate specified for that geographic location plus the actual costs of tolls and parking, if travel by a privately owned vehicle is determined appropriate under paragraph (a)(1) of this section. Otherwise, the amount of reimbursement for travel by privately owned vehicle cannot exceed the total cost of the most economical public transportation available for travel between the same two points. *Total cost* includes the cost for all the authorized

travelers who travel in the same privately owned vehicle. Advance approval of travel by privately owned vehicle is not required (but could give you assurance of its approval).

(3) Sometimes your health condition dictates a mode of transportation different from the most economical and expeditious. In order for your health to require a mode of transportation other than common carrier or passenger car, you must be so handicapped or otherwise impaired as to require special transportation arrangements and the conditions must be substantiated by competent medical authority.

(d) For travel to a hearing—

(1) Reimbursement is limited to travel within the U.S. For this purpose, the U.S. includes the U.S. as defined in § 404.2(c)(6) and the Northern Mariana Islands.

(2) We or the State agency will reimburse you, your representative, or an unsubpoenaed witness only if the distance from the person's residence or office (whichever he or she travels from) to the hearing site exceeds 75 miles.

(3) For travel expenses incurred on or after April 1, 1991, the amount of reimbursement under this section for travel by your representative to attend a disability hearing or a hearing before an administrative law judge shall not exceed the maximum amount allowable under this section for travel to the hearing site from any point within the geographic area of the office having jurisdiction over the hearing.

(i) The geographic area of the office having jurisdiction over the hearing means, as appropriate—

(A) The designated geographic service area of the State agency adjudicatory unit having responsibility for providing the disability hearing;

(B) If a Federal disability hearing officer holds the disability hearing, the geographic area of the State (which includes a State as defined in § 404.2(c)(5) and also includes the Northern Mariana Islands) in which the claimant resides or, if the claimant is not a resident of a State, in which the hearing officer holds the disability hearing; or

(C) The designated geographic service area of the Office of Hearings Operations hearing office having responsibility for providing the hearing.

(ii) We or the State agency determine the maximum amount allowable for travel by a representative based on the distance to the hearing site from the farthest point within the appropriate geographic area. In determining the maximum amount allowable for travel between these two points, we or the State agency apply the rules in paragraphs (a) through (c) of this section and the limitations in paragraph (d) (1) and (4) of this section. If the distance between these two points does not exceed 75 miles, we or the State agency will not reimburse any of your representative's travel expenses.

(4) If a change in the location of the hearing is made at your request from the location we or the State agency selected to one farther from your residence or office, neither your additional travel expenses nor the additional travel expenses of your representative and witnesses will be reimbursed.

[51 FR 8808, Mar. 14, 1986, as amended at 59 FR 8532, Feb. 23, 1994; 85 FR 73158, Nov. 16, 2020]

§ 404.999d When and how to claim reimbursement.

(a)(1) Generally, you will be reimbursed for your expenses after your trip. However, travel advances may be authorized if you request prepayment and show that the requested advance is reasonable and necessary.

(2) You must submit to us or the State agency, as appropriate, an itemized list of what you spent and supporting receipts to be reimbursed.

(3) Arrangements for special means of transportation and related unusual costs may be made only if we or the State agency authorizes the costs in writing in advance of travel, unless the costs are unexpected or unavoidable. If they are unexpected or unavoidable we or the State agency must determine their reasonableness and necessity and must approve them before payment may be made.

(4) If you receive prepayment, you must, within 20 days after your trip, provide to us or the State agency, as appropriate, an itemized list of your actual travel costs and submit supporting receipts. We or the State agency will require you to pay back any balance of the advanced amount that

exceeds any approved travel expenses within 20 days after you are notified of the amount of that balance. (State agencies may have their own time limits in place of the 20-day periods in the preceding two sentences.)

(b) You may claim reimbursable travel expenses incurred by your representative for which you have been billed by your representative, except that if your representative makes a claim for them to us or the State, he or she will be reimbursed directly.

(Approved by the Office of Management and Budget under control number 0960–0434)

[51 FR 8809, Mar. 14, 1986, as amended at 51 FR 44983, Dec. 16, 1986]

Subpart K—Employment, Wages, Self-Employment, and Self-Employment Income

AUTHORITY: Secs. 202(v), 205(a), 209, 210, 211, 229(a), 230, 231, and 702(a)(5) of the Social Security Act (42 U.S.C. 402(v), 405(a), 409, 410, 411, 429(a), 430, 431, and 902(a)(5)) and 48 U.S.C.1801.

SOURCE: 45 FR 20075, Mar. 27, 1980, unless otherwise noted.

§ 404.1001 Introduction.

(a)(1) In general, your social security benefits are based on your earnings that are on our records. (Subpart I of this part explains how we keep earnings records.) Basically, you receive credit only for earnings that are covered for social security purposes. The earnings are covered only if your work is covered. If you are an employee, your employer files a report of your covered earnings. If you are self-employed, you file a report of your covered earnings. Some work is covered by social security and some work is not. Also, some earnings are covered by social security and some are not. It is important that you are aware of what kinds of work and earnings are covered so that you will know whether your earnings should be on our records.

(2) If you are an employee, your covered work is called *employment*. This subpart explains our rules on the kinds of work that are covered as *employment* and the kinds that are not. We also explain who is an employee.

(3) If your work is *employment*, your covered earnings are called *wages*. This subpart explains our rules on the kinds of earnings that are covered as *wages* and the kinds that are not.

(4) If you work for yourself, you are self-employed. The subpart explains our rules on the kinds of self-employment that are covered and the kinds that are not.

(5) If you are self-employed, your covered earnings are called *self-employment income* which is based on your *net earnings from self-employment* during a taxable year. This subpart explains our rules on the kinds of earnings that are covered as *net earnings from self-employment* and the kinds that are not. We also explain how to figure your *net earnings from self-employment* and determine your *self-employment income* which is the amount that goes on our records.

(b) We include basically only the rules that apply to current work or that the law requires us to publish as regulations. We generally do not include rules that are seldom used or do not apply to current work because of changes in the law.

(c) The Social Security Act and the Internal Revenue Code (Code) have similar provisions on coverage of your earnings because the one law specifies the earnings for which you will receive credit for benefit purposes and the other the earnings on which you must pay social security taxes. Because the Code (title 26 U.S.C.) has some provisions that are not in the Act but which may affect you, you may need to refer to the Code or the Internal Revenue Service regulations (title 26 of the Code of Federal Regulations) to get complete information about your social security coverage.

(d) The rules are organized in the following manner:

(1) Sections 404.1003 through 404.1010 include the rules on employment. We discuss what we mean by employment, what work is covered as employment for social security purposes, and describe the kinds of workers who are considered employees.

(2) In §§ 404.1012 through 404.1038 we discuss various types of work that are not covered as employment for social security purposes.

(3) The rules on wages are found in §§ 404.1041 through 404.1059. We describe what is meant by the term *wages*, discuss the various types of pay that count as wages, and state when the pay counts for Social Security purposes. We include explanations of agriculture labor, domestic services, service not in the course of the employer's business, and home worker services under *wages* because special standards apply to these services.

(4) Our rules on self-employment and self-employment income are found in §§ 404.1065 through 404.1096. We discuss what we mean by self-employment, what we mean by a trade or business, what types of activities are considered self-employment, how to determine self-employment income, and how net earnings from self-employment are figured.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990; 61 FR 38365, July 24, 1996]

§ 404.1002 Definitions.

(a) *General definitions.* As used in this subpart—

The *Act* means the Social Security Act, as amended.

The *Code* means the Internal Revenue Code of 1954, as amended.

We, *our*, or *us* means the Social Security Administration.

You or *your* means any person whose earnings from employment or self-employment are included or excluded under social security.

(b) *Other definitions.* For ease of reference, we have placed other definitions in the sections of this subpart in which they are used.

EMPLOYMENT

§ 404.1003 Employment.

Employment means, generally, any service covered by social security performed by an employee for his or her employer. The rules on who is an employee and who is an employer are contained in §§ 404.1005 through 404.1010. Section 404.1004 states the general rule on the kinds of work covered as employment. Exceptions to the general rule are contained in §§ 404.1012 through 404.1038 which explain the kinds of work excluded from employment. All of these rules apply to current work unless otherwise indicated.

[45 FR 20075, Mar. 27, 1980, as amended at 61 FR 38365, July 24, 1996]

§ 404.1004 What work is covered as employment?

(a) *General requirements of employment.* Unless otherwise excluded from coverage under §§ 404.1012 through 404.1038, the work you perform as an employee for your employer is covered as employment under social security if one of the following situations applies:

(1) You perform the work within the United States (whether or not you or your employer are a citizen or resident of the United States).

(2) You perform the work outside the United States and you are a citizen or resident of the United States working for—

(i) An American employer; or

(ii) A foreign affiliate of an American employer that has in effect an agreement covering your work under section 3121(l) of the Code.

(3) You perform the work on or in connection with an American vessel or American aircraft and the conditions in paragraphs (a)(3) (i) and (ii) are met. Your citizenship or residence does not matter. The citizenship or residence of your employer matters only if it affects whether the vessel is an American vessel.

(i) You enter into the contract of employment within the United States or the vessel or aircraft touches at a port or airport within the United States during the performance of your contract of employment on the vessel or aircraft.

(ii) You are employed on and in connection with the vessel or aircraft when outside the United States.

(4) Your work is designated as employment or recognized as equivalent to employment under a totalization agreement. (See § 404.1913. An agreement may exempt work from coverage as well as extend coverage to work.)

(5) Your work performed after December 31, 1994, is in the employ of an international organization pursuant to a transfer from a Federal agency under section 3582 of title 5 of the United States Code and both the following are met:

(i) Immediately before the transfer, your work for the Federal agency was covered employment; and

(ii) You would be entitled, upon separation from the international organization and proper application, to reemployment with the Federal agency under section 3582.

(b) *Explanation of terms used in this section*—(1) *American employer* means—

(i) The United States or any of its instrumentalities;

(ii) A State, a political subdivision of a State, or an instrumentality of any one or more States or political subdivisions of a State;

(iii) An individual who is a resident of the United States;

(iv) A partnership, if at least two-thirds of the partners are residents of the United States;

(v) A trust, if all of the trustees are residents of the United States; or

(vi) A corporation organized under the laws of the United States or of any State.

(2) *American aircraft* means an aircraft registered under the laws of the United States.

(3) *American vessel* means a vessel documented or numbered under the laws of the United States. It also includes a vessel neither documented nor numbered under the laws of the United States, nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States, or corporations organized under the laws of the United States or of any State.

(4) *Citizen of the United States* includes a citizen of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa or the Commonwealth of the Northern Mariana Islands.

(5) *Foreign affiliate* refers to a foreign affiliate as defined in section 3121(l)(6) of the Code.

(6) *On and in connection with* refers to the performance of work on a vessel or aircraft which concerns the vessel or aircraft. Examples of this kind of work are the services performed on a vessel by employees as officers or crew members, or as employees of concessionaires, of the vessel.

(7) *On or in connection with* refers to work performed on the vessel or aircraft and to work which concerns the vessel or aircraft but not actually performed on it. For example, shore services in connection with repairing, loading, unloading, or provisioning a vessel performed by employees as officers or crew members, or as employees of concessionaires, of the vessel are included, since this work concerns the vessel though not performed on it.

(8) *State* refers to the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(9) *United States* when used in a geographical sense means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36573, Sept. 9, 1985; 55 FR 51687, Dec. 17, 1990; 61 FR 38365, July 24, 1996; 69 FR 51555, Aug. 20, 2004]

§ 404.1005 Who is an employee.

You must be an employee for your work to be covered as employment for social security purposes. You are an employee if you are—

(a) A corporation officer as described in § 404.1006;

(b) A common-law employee as described in § 404.1007 (unless you are, after December 31, 1982, a qualified real estate agent or direct seller as described in § 404.1069); or

(c) An agent-driver or commission-driver, a full-time life insurance salesman, a home worker, or a traveling or city salesman as described in § 404.1008.

[45 FR 20075, Mar. 27, 1980, as amended at 48 FR 40515, Sept. 8, 1983]

§ 404.1006 Corporation officer.

If you are an officer of a corporation, you are an employee of the corporation if you are paid or you are entitled to be paid for holding office or performing services. However, if you are a director of a corporation, we consider you to be self-employed when you work as a director.

§ 404.1007 Common-law employee.

(a) *General.* The common-law rules on employer-employee status are the basic test for determining whether you and the person or firm you work for have the relationship of employee and employer. Even though you are considered self-employed under the common-law rules, you may still be an employee for social security purposes under § 404.1006 (relating to corporation officers) or § 404.1008 (relating to workers in four specific jobs). In general, you are a common-law employee if the person you work for may tell you what to do and how, when, and where to do it. The person or firm you work for does not have to give these orders, but needs only the right to do so. Whether or not you are a common-law employee is not always clear. Several aspects of your job arrangement are considered in determining whether you are an employee or are self-employed under the common-law rules.

(b) *Factors that show employee status.* Some aspects of a job arrangement that may show you are an employee are as follows:

(1) The person you work for may fire you.

(2) The person you work for furnishes you with tools or equipment and a place to work.

(3) You receive training from the person you work for or are required to follow that person's instructions.

(4) You must do the work yourself.

(5) You do not hire, supervise, or pay assistants (unless you are employed as a foreman, manager, or supervisor).

(6) The person you work for sets your hours of work, requires you to work full-time, or restricts you from doing work for others.

(7) The person you work for pays your business or traveling expenses.

(8) You are paid by the hour, week or month.

(c) *Factors that show self-employed status.* Some aspects of a job arrangement or business venture that may show you are self-employed are as follows:

(1) You make a profit or suffer a loss.

(2) You are hired to complete a certain job and if you quit before the job is completed you may be liable for damages.

(3) You work for a number of persons or firms at the same time.

(4) You advertise to the general public that you are available to perform services.

(5) You pay your own expenses and have your own equipment and work place.

(d) *Questions about your status.* If there is a question about whether you are working as an employee or are self-employed, we or the Internal Revenue Service will make a determination after examining all of the facts of your case.

§ 404.1008 Agent-driver or commission-driver, full-time life insurance salesman, home worker, or traveling or city salesman.

(a) *General.* In addition to common-law employees and corporation officers, we consider workers in the four types of jobs described in paragraphs (b) through (e) of this section to be employees if their services are performed under the following conditions:

(1) Under the work arrangement the worker is expected to do substantially all of the work personally.

(2) The worker must not have a substantial investment in the facilities used to do the work. Facilities include such things as a place to work, storage space, equipment, machinery and office furniture. However, facilities do not include tools, equipment or clothing of the kind usually provided by employees nor transportation such as a car or truck.

(3) The work must be performed as part of a continuing work relationship between the worker and the person for whom the work is done. The work performed must not be a single transaction. Part-time and regular seasonal work may be performed as part of a continuing work relationship.

(b) *Agent-driver or commission-driver.* This is a driver hired by another person to distribute meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services. We consider you an agent-driver or commission-driver if you are paid a commission based on your sales or the difference between the price you charge your customers and the amount you

pay for the goods or services. It makes no difference whether you drive your own truck or the company's truck or whether you solicit the customers you serve.

(c) *Full-time life insurance salesman.* A full-time life insurance salesman's main activity is selling life insurance or annuity contracts, or both, mostly for one life insurance company. If you are a full-time life insurance salesman, you are probably provided office space, stenographic help, telephone, forms, rate books and advertising materials by the company or general agent, without cost to you.

(d) *Home worker.* A home worker is a person who works away from the place of business of the person he or she works for, usually at home. If you are a home worker and you work according to the instructions of the person you work for, on material or goods furnished by that person, and are required to return the finished product to that person (or another person whom he or she designates), you are an employee.

(e) *Traveling or city salesman.* The main activity of a traveling or city salesman is taking orders for merchandise for another person or firm. The salesman gets orders from wholesalers, retailers, contractors, or operators of hotels, restaurants or other firms whose main business is furnishing food or lodging or both. The salesman sells merchandise to others for resale or for use in their own business. We consider you a traveling or city salesman if most of your work is done for a single person or firm even though you have incidental sideline sales activities. However, you are not an employee under this paragraph as to those sideline sales. If you take orders for a number of persons or firms as a *multiple line* salesman, you are not a traveling or city salesman.

§ 404.1009 Who is an employer.

A person is an employer if he or she employs at least one employee. Sometimes it is not clear who a worker's employer is, since the employer does not always pay the worker's wages. When there is a question about who the employer is, we use the common-law rules to identify the employer (see § 404.1007).

§ 404.1010 Farm crew leader as employer.

A farm crew leader furnishes workers to do agricultural labor for another person, usually a farm operator. If the crew leader pays the workers (the money can be the crew leader's or the farm operator's), the crew leader is deemed to be the employer of the workers and is self-employed. However, the crew leader is not deemed the employer of the workers if there is a written agreement between the crew leader and the farm operator naming the crew leader as an employee. If the crew leader does not have this agreement and does not pay the workers, we use the common-law rules to determine the crew leader's status.

WORK EXCLUDED FROM EMPLOYMENT

§ 404.1012 Work excluded from employment.

Certain kinds of work performed by an employee are excluded from employment. They are described in §§ 404.1014 through 404.1038 and are exceptions to the general rule in § 404.1004 on the kinds of work that are covered as employment. In general, if the work performed by an employee is excluded from employment, the work is not covered under social security. However, certain kinds of work performed by an employee, even though excluded from employment, are covered as self-employment for social security purposes. In addition, if part of the work performed by an employee for the same employer is included as employment and part is excluded from employment, all the work may be included or all may be excluded as described in § 404.1013.

[45 FR 20075, Mar. 27, 1980, as amended at 61 FR 38365, July 24, 1996]

§ 404.1013 Included-excluded rule.

(a) If part of your work for an employer during a pay period is covered as employment and part excluded, all of your work during that period is considered covered if at least one-half of your time in the pay period is in covered work. If you spend most of your time in a pay period doing work that is excluded, all of your work in that period is excluded.

(b) A *pay period* is the period for which your employer ordinarily pays you. It cannot be more than 31 consecutive days. If the actual period is not always the same, your usual pay period will be used for applying the included-excluded rule.

(c) The included-excluded rule does not apply and your covered work will be counted if—

(1) Part of your work is covered by the Railroad Retirement Tax Act and part by the Social Security Act; or

(2) You have no usual *pay period* of 31 consecutive days or less, or you have separate pay periods for covered and excluded work.

§ 404.1014 Domestic service by a student for a local college club, fraternity or sorority.

(a) *General.* If you are a student and do work of a household nature in or about the club rooms or house of a local college club or local chapter of a college fraternity or sorority, and are enrolled and regularly attending classes at a school, college, or university, your work is not covered as employment.

(b) *Explanation of terms*—(1) *Work of a household nature* means the type of work done by cooks, waiters, butlers, maids, janitors, laundresses, furnacemen, handymen, gardeners, housekeepers and housemothers.

(2) A *local college club or local chapter of a college fraternity or sorority* does not include an alumni club or chapter. Also, if the club rooms or house are used mostly for supplying board or lodging to students or nonstudents as a business, the work done is not excluded by this section.

§ 404.1015 Family services.

(a) *General.* If you work as an employee of a relative, the work is excluded from employment if—

(1) You work while under age 18 in the employ of your parent;

(2) You do nonbusiness work (see § 404.1058(a)(3) for an explanation of nonbusiness work) or perform domestic service (as described in § 404.1057(b)) as an employee of your parent while under age 21;

(3) You do nonbusiness work as an employee of your son, daughter, or spouse; or

(4) You perform domestic service in the private home of your son, daughter or spouse as an employee of that son, daughter or spouse unless—

(i) The son or daughter has a child (either natural, adopted or stepchild) living in the home who is under age 18 or, if older, has a mental or physical condition that requires the personal care and supervision of an adult for at least four continuous weeks in the calendar quarter in which the work is done; and

(ii) The son or daughter is a widower or widow, or is divorced and has not remarried, or has a spouse living in the home who, because of a physical or mental condition, is incapable of taking care of the child and the condition is present for at least four continuous weeks in the calendar quarter in which the work is done.

(b) *Family work for other than sole proprietor.* Work for a corporation is not excluded under this section, and work for a partnership is not excluded unless the required family relationship exists between the employee and each of the partners.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59913, Dec. 17, 1992]

§ 404.1016 Foreign agricultural workers.

Farm work done by foreign workers lawfully admitted to the United States on a temporary basis to do farm work is not covered as employment. The excluded work includes any services connected with farm operations.

§ 404.1017 Sharefarmers.

(a) If you are a sharefarmer, your services are not covered as employment, but as self-employment.

(b) You are a sharefarmer if you have an arrangement with the owner or tenant of the land and the arrangement provides for all of the following:

(1) You will produce agricultural or horticultural commodities on the land.

(2) The commodities you produce or the income from their sale will be divided between you and the person with whom you have the agreement.

(3) The amount of your share depends on the amount of commodities you produce.

(c) If under your agreement you are to receive a specific rate of pay, a fixed sum of money or a specific amount of the commodities not based on your production, you are not a sharefarmer for social security purposes.

§ 404.1018 Work by civilians for the United States Government or its instrumentalities—wages paid after 1983.

(a) *General.* If you are a civilian employee of the United States Government or an instrumentality of the United States, your employer will determine the amount of remuneration paid for your work and the periods in or for which such remuneration was paid. We will determine whether your employment is covered under Social Security, the periods of such covered employment, and whether remuneration paid for your work constitutes wages for purposes of Social Security. To make these determinations we will consider the date of your appointment to Federal service, your previous Federal employing agencies and positions (if any), whether you were covered under Social Security or a Federal civilian retirement system, and whether you made a timely election to join a retirement system established by the Federal Employees' Retirement System Act of 1986 or the Foreign Service Pension System Act of 1986. Using this information and the following rules, we will determine that your service is covered unless—

(1) The service would have been excluded if the rules in effect in January 1983 had remained in effect; and

(i) You have been continuously performing such service since December 31, 1983; or

(ii) You are receiving an annuity from the Civil Service Retirement and Disability Fund or benefits for service as an employee under another retirement system established by a law of the United States and in effect on December 31, 1983, for employees of the Federal Government other than a system for members of the uniformed services.

(2) The service is under the provisions of 28 U.S.C. 294, relating to the assignment of retired Federal justices and judges to active duty.

(b) *Covered services*—(1) *Federal officials.* Any service for which you received remuneration after 1983 is covered if performed—

(i) As the President or the Vice President of the United States;

(ii) In a position placed in the Executive Schedule under 5 U.S.C. 5312 through 5317;

(iii) As a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service;

(iv) In a position to which you are appointed by the President, or his designee, or the Vice President under 3 U.S.C. 105(a)(1), 106(a)(1), or 107(a)(1) or (b)(1) if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule;

(v) As the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court, including the district court of a territory, a judge of the United States Claims Court, a judge of the United States Court of International Trade, a judge of the United States Tax Court, a United States magistrate, or a referee in bankruptcy or United States bankruptcy judge; or

(vi) As a Member, Delegate, or Resident Commissioner of or to the Congress.

(2) *Legislative Branch Employees.* Service you perform for the legislative branch of the Federal Government for which you are paid remuneration after 1983 is generally covered by Social Security if such service is not covered by the Civil Service Retirement System or by another retirement system established by a law of the United States and in effect on December 31, 1983, for employees of the Federal Government other than a system for members of the uniformed services.

(3) *Election to become subject to the Federal Employees' Retirement System or the Foreign Service Pension System.* Your service is covered if:

(i) You timely elect after June 30, 1987, under either the Federal Employees' Retirement System Act or the

Central Intelligence Agency Retirement Act, to become subject to the Federal Employees Retirement System provided in 5 U.S.C. 8401 through 8479; or

(ii) You timely elect after June 30, 1987, to become subject to the Foreign Service Pension System provided in 22 U.S.C. 4071 through 4071(k).

(4) *Subsequent Federal civilian service.* If you perform Federal civilian service on or after November 10, 1988, which is described in paragraph (b)(1), (b)(2), or (b)(3) of this section you will continue to be covered for any subsequent Federal Civilian Service not excluded under paragraph (c) of this section.

(c) *Excluded Service.* Notwithstanding § 404.1018a and this section, your service is not covered if performed—

(1) In a penal institution of the United States as an inmate thereof;

(2) As an employee included under 5 U.S.C. 5351(2) relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government, other than as a medical or dental intern or a medical or dental resident in training;

(3) As an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency; or

(4) Under any other statutory provisions that would require exclusion for reasons other than being in the employ of the Federal Government or an instrumentality of such.

(d) *Work as a Peace Corps Volunteer.* Work performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, 22 U.S.C. 2501 through 2523, is covered as employment.

(e) *Work as Job Corps Enrollee.* Work performed as an enrollee in the Job Corps is considered to be performed in the employ of the United States.

(f) *Work by Volunteer in Service to America.* Work performed and training received as a Volunteer in Service to America is considered to be performed in the employ of the United States if the volunteer is enrolled for a period of service of at least 1 year. If the enrollment is for less than 1 year, we use the common-law rules in § 404.1007 to determine the volunteer's status.

(g) *Work for international organizations.* Work performed for an international organization by an employee who was transferred from a Federal agency is generally covered as employment if, immediately before the transfer, the employee's services for the Federal agency were covered. (See §§ 404.1004(a)(5) and 404.1034(c).)

(h) *Meaning of ''continuously performing''*—(1) *Absence of less than 366 days.* You are considered to be continuously performing service described in paragraph (a)(1)(i) of this section if you return to the performance of such service after being separated from such service for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983.

(2) *Other absences.* You are considered to be continuously performing service described in paragraph (a)(1)(i) of this section regardless of the length of separation or whether the period of separation began before, on, or after December 31, 1983, if you—

(i) Return to the performance of such service after being detailed or transferred from such service to an international organization as described under 5 U.S.C. 3343 or under 5 U.S.C. 3581;

(ii) Are reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute of Taiwan as provided under 22 U.S.C. 3310;

(iii) Return to the performance of such service after performing service as a member of a uniformed service including service in the National Guard and temporary service in the Coast Guard Reserve and after exercising restoration or reemployment rights as provided under 38 U.S.C. chapter 43; or

(iv) Return to the performance of such service after employment by a tribal organization to which section 105(e)(2) of the Indian Self-Determination Act applies.

[53 FR 38944, Oct. 4, 1988; 53 FR 44551, Nov. 3, 1988, as amended at 55 FR 24891, June 19, 1990; 61 FR 38365, July 24, 1996; 79 FR 33684, June 12, 2014]

§ 404.1018a Work by civilians for the United States Government or its instrumentalities—remuneration paid prior to 1984.

(a) *General—remuneration paid prior to 1984.* If you worked as a civilian employee of the United States Government or an instrumentality of the United States, your work was excluded from employment if that work was covered by a retirement system established by law. Your work for an instrumentality that was exempt from Social Security tax was also excluded. Certain other work for the United States or an instrumentality of the United States was specifically excluded and is described in this section.

(b) *Work covered by a retirement system—remuneration paid prior to 1984.* Work you did as an employee of the United States or an instrumentality of the United States was excluded from employment if the work was covered by a retirement system established by a law of the United States. If you had a choice as to whether your work was covered by the retirement system, the work was not covered by that system until you chose that coverage. In order for the exclusion to apply, the work you did, rather than the position you held, must have been covered by the retirement system.

(c) *Work that was specifically excluded—remuneration paid prior to 1984.* Work performed by an employee of the United States or an instrumentality of the United States was excluded if it was done—

(1) As the President or Vice President of the United States;

(2) As a Member of the United States Congress, a Delegate to Congress, or a Resident Commissioner;

(3) In the legislative branch of the United States Government;

(4) By a student nurse, student dietitian, student physical therapist or student occupational therapist who was assigned or attached to a Federal hospital, clinic, or medical or dental laboratory;

(5) By a person designated as a student employee with the approval of the Office of Personnel Management who was assigned or attached primarily for training purposes to a Federal hospital, clinic, or medical or dental laboratory, other than a medical or dental intern or resident in training;

(6) By an employee who served on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) By a person to whom the Civil Service Retirement Act did not apply because the person's services were subject to another retirement system established by a law of the United States or by the instrumentality of the United States for which the work was done, other than the retirement system established by the Tennessee Valley Authority under the plan approved by the Secretary of Health, Education, and Welfare on December 28, 1956; or

(8) By an inmate of a penal institution of the United States, if the work was done in the penal institution.

(d) *Work for instrumentalities of the United States exempt from employer tax—remuneration paid prior to 1984.* (1) Work performed by an employee of an instrumentality of the United States was excluded if—

(i) The instrumentality was exempt from the employer tax imposed by section 3111 of the Code or by section 1410 of the Internal Revenue Code of 1939; and

(ii) The exemption was authorized by another law specifically referring to these sections.

(2) Work performed by an employee of an instrumentality of the United States was excluded if the instrumentality was not on December 31, 1950, subject to the employer tax imposed by section 1410 of the Internal Revenue Code of 1939 and the work was covered by a retirement system established by the instrumentality, unless—

(i) The work was for a corporation wholly owned by the United States;

(ii) The work was for a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Credit Union, a Federal land bank, a Federal intermediate credit bank, a bank for cooperatives, or a Federal Home Loan Bank;

(iii) The work was for a State, county, or community committee under the Agriculture Marketing Service and the Commodity Stabilization Service, formerly the Production and Marketing Administration; or

(iv) The work was by a civilian, who was not paid from funds appropriated by the Congress, in activities conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense or Secretary of Transportation at installations intended for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Defense Department or the Coast Guard, such as—

(A) Army and Air Force Exchange Service;

(B) Army and Air Force Motion Picture Service;

(C) Coast Guard Exchanges;

(D) Navy Ship's Service Stores; and

(E) Marine Corps Post Exchanges.

(3) For purposes of paragraph (d)(2) of this section, if an employee has a choice as to whether his or her work was covered by a retirement system, the work was not covered by that system until he or she chose that coverage. The work done, rather than the position held, must have been covered by the retirement system.

(e) *Work as a Peace Corps Volunteer—remuneration paid prior to 1984.* Work performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, 22 U.S.C. 2501 through 2523, was covered as employment.

(f) *Work as Job Corps Enrollee—remuneration paid prior to 1984.* Work performed as an enrollee in the Job Corps was considered to be performed in the employ of the United States.

(g) *Work by Volunteer in Service to America—remuneration paid prior to 1984.* Work performed and training received as a Volunteer in Service to America was considered to be performed in the employ of the United States if the volunteer was enrolled for a period of service of at least one year. If the enrollment was for less than one year, we used the common-law rules in § 404.1007 to determine the volunteer's status.

[53 FR 38945, Oct. 4, 1988]

§ 404.1018b Medicare qualified government employment.

(a) *General.* The work of a Federal, State, or local government employee not otherwise subject to Social Security coverage may constitute Medicare qualified government employment. Medicare qualified government employment means any service which in all ways meets the definition of ''employment'' for title II purposes of the Social Security Act, except for the fact that the service was performed by a Federal, State or local government employee. This employment is used solely in determining eligibility for protection under part A of title XVIII of the Social Security Act (Hospital Insurance) and for coverage under the Medicare program for end-stage renal disease.

(b) *Federal employment.* If, beginning with remuneration paid after 1982, your service as a Federal employee is not otherwise covered employment under the Social Security Act, it is Medicare qualified government employment unless excluded under § 404.1018(c).

(c) *State and local government employment.* If, beginning with service performed after March 31, 1986, your service as an employee of a State or political subdivision (as defined in § 404.1202(b)), Guam, American Samoa, the District of Columbia, or the Northern Mariana Islands is excluded from covered employment solely because of section 210(a)(7) of the Social Security Act which pertains to employees of State and local governments (note §§ 404.1020 through 404.1022), it is Medicare qualified government employment except as provided in paragraphs (c) (1) and (2) of this section.

(1) An individual's service shall not be treated as employment if performed—

(i) By an individual employed by a State or political subdivision for the purpose of relieving that individual from unemployment;

(ii) In a hospital, home, or other institution by a patient or inmate thereof as an employee of a State, political subdivision, or of the District of Columbia;

(iii) By an individual, as an employee of a State, political subdivision or the District of Columbia serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) By an individual as an employee included under 5 U.S.C. 5351(2) (relating to certain interns, student nurses, and other student employees of hospitals of

the District of Columbia government), other than as a medical or dental intern or a medical or dental resident in training; or

(v) By an election official or election worker paid less than $100 in a calendar year for such service prior to 1995, or less than $1,000 for service performed in any calendar year after 1994 and before 2000, or, for service performed in any calendar year after 1999, less than the $1,000 base amount, as adjusted pursuant to section 218(c)(8)(B) of the Social Security Act to reflect changes in wages in the economy. We will publish this adjustment of the $1,000 base amount in the FEDERAL REGISTER on or before November 1 preceding the year for which the adjustment is made.

(2) An individual's service performed for an employer shall not be treated as employment if—

(i) The service would be excluded from coverage under section 210(a)(7) of the Social Security Act which pertains to employees of State and local governments;

(ii) The service is performed by an individual who—

(A) Was performing substantial and regular service for remuneration for that employer before April 1, 1986;

(B) Was a bona fide employee of that employer on March 31, 1986; and

(C) Did not enter into the employment relationship with that employer for purposes of meeting the requirements of paragraphs (c)(2)(ii) (A) and (B) of this section; and

(iii) After March 31, 1986, but prior to the service being performed, the employment relationship with that employer had not been terminated.

[57 FR 59913, Dec. 17, 1992, as amended at 61 FR 38366, July 24, 1996]

§ 404.1019 Work as a member of a uniformed service of the United States.

(a) Your work as a member of a uniformed service of the United States is covered under Social Security (unless creditable under the Railroad Retirement Act), if—

(1) On or after January 1, 1957, the work is service on active duty or active duty for training but not including service performed while on leave without pay; or

(2) On or after January 1, 1988, the work is service on inactive duty training.

(b) You are a *member of a uniformed service* if—

(1) You are appointed, enlisted, or inducted into (or a retired member of)—

(i) One of the armed services (Army, Navy, Air Force, Marine Corps, or Coast Guard); or

(ii) A component of one of the armed services, including any reserve component as defined in Veterans' Benefits, 38 U.S.C. 101 (except the Coast Guard Reserve as a temporary member);

(2) You are a commissioned officer (including a retired commissioned officer) of the National Oceanic and Atmospheric Administration or the Regular or Reserve Corps of the Public Health Service;

(3) You are a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(4) You are a cadet at the United States Military, Coast Guard, or Air Force Academy, or a midshipman at the United States Naval Academy;

(5) You are a member of the Reserve Officers Training Corps, the Naval Reserve Officers Training Corps, or the Air Force Reserve Officers Training Corps, when ordered to annual training duty for 14 days or more including periods of authorized travel to and from that duty; or

(6) You are selected for active military or naval training under the Military Selective Service Act or are provisionally accepted for active duty in the military or naval service and you are ordered or directed to a place for final acceptance or entry upon active duty and are on the way to or from, or at, that place.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59913, Dec. 17, 1992]

§ 404.1020 Work for States and their political subdivisions and instrumentalities.

(a) *General.* If you work as an employee of a State, a political subdivision of a State, or any wholly owned instrumentality of one or more of these, your work is excluded from employment unless—

(1) The work is covered under an agreement under section 218 of the Act (see subpart M of this part); or

(2) The work is *covered transportation service* as defined in section 210(k) of the Act (see paragraph (c) of this section).

(3) You perform services after July 1, 1991, as an employee of a State (other than the District of Columbia, Guam, the Commonwealth of the Northern Mariana Islands, or American Samoa), a political subdivision of a State, or any wholly owned instrumentality of one or more of the foregoing and you are not a member of a retirement system of such State, political subdivision, or instrumentality. Retirement system has the meaning given that term in section 218(b)(4) of the Act, except as provided in regulations prescribed by the Secretary of the Treasury. This paragraph does not apply to services performed—

(i) As an employee employed to relieve you from unemployment;

(ii) In a hospital, home, or other institution where you are a patient or inmate thereof;

(iii) As an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) As an election official or election worker if the remuneration paid in a calendar year for such service prior to 1995 is less than $100, or less than $1000 for service performed in any calendar year after 1994 and before 2000, or, for service performed in any calendar year after 1999, less than the $1000 base amount, as adjusted pursuant to section 218(c)(8)(B) of the Social Security Act to reflect changes in wages in the economy. We will publish this adjustment of the $1000 base amount in the FEDERAL REGISTER on or before November 1 preceding the year for which the adjustment is made.

(v) As an employee in a position compensated solely on a fee basis which is treated, pursuant to section 211(c)(2)(E) of the Act, as a trade or business for purposes of inclusion of the fees in net earnings from self-employment; or

(4) The work is covered under § 404.1021 or § 404.1022.

(b) *Medicare qualified government employment.* Notwithstanding the provisions of paragraph (a) of this section, your work may be covered as Medicare qualified government employment (see § 404.1018b(c) of this subpart).

(c) *Covered transportation service*—(1) *Work for a public transportation system.* If you work for a public transportation system of a State or political subdivision of a State, your work may be covered transportation service if all or part of the system was acquired from private ownership. You must work as an employee of the State or political subdivision in connection with its operation of a public transportation system for your work to be covered transportation service. This paragraph sets out additional conditions that must be met for your work to be covered transportation service. If you work for a public transportation system but your work is not covered transportation service, your work may be covered for social security purposes under an agreement under section 218 of the Act (see subpart M of this part).

(2) *Transportation system acquired in whole or in part after 1936 and before 1951.* All work after 1950 for a public transportation system is covered transportation service if—

(i) Any part of the transportation system was acquired from private ownership after 1936 and before 1951; and

(ii) No general retirement system covering substantially all work in connection with the operation of the transportation system and guaranteed by the State constitution was in effect on December 31, 1950.

(3) *Transportation system operated on December 31, 1950, no part of which was acquired after 1936 and before 1951.* If no part of a transportation system operated by a State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and before 1951, work for that public transportation system is not covered transportation service unless performed under conditions described in paragraph (b)(4) of this section.

(4) *Addition after 1950 to existing transportation system.* Work for a public transportation system part of which was acquired from private ownership after 1950 as an addition to an existing transportation system is covered transportation service beginning with the first day of the third calendar quarter

following the calendar quarter in which the addition was acquired if—

(i) The work is performed by an employee who—

(A) Worked in employment in connection with the operation of the addition before the addition was acquired by the State or political subdivision; and

(B) Became an employee of the State or political subdivision in connection with and at the time of its acquisition of the addition;

(ii) On that first day, work performed by that employee is—

(A) Not covered by a general retirement system; or

(B) Covered by a general retirement system which contains special provisions that apply only to employees described in paragraph (c)(4)(i)(B) of this section;

(iii) The existing transportation system was operated by the State or political subdivision on December 31, 1950; and

(iv) Work for the existing transportation system was not covered transportation service because—

(A) No part of the system was acquired from private ownership after 1936 and before 1951; or

(B) The general retirement system described in paragraph (c)(2)(ii) of this section was in effect on December 31, 1950.

(5) *Transportation system acquired after 1950.* All work for a public transportation system is covered transportation service if—

(i) The transportation system was not operated by the State or political subdivision before 1951;

(ii) All or part of the transportation system was first acquired from private ownership after 1950; and

(iii) At the time the State or political subdivision first acquired any part of its transportation system from private ownership, it did not have a general retirement system covering substantially all work performed in connection with the operation of the transportation system.

(6) *Definitions.* (i) The term *general retirement system* means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision of a State for employees of the State, the political subdivision, or both. The term does not include a fund or system which covers only work performed in positions connected with the operation of the public transportation system.

(ii) A transportation system (or part of a system) is considered to have been acquired from private ownership by a State or political subdivision if—

(A) Before the acquisition, work performed by employees in connection with the operation of the system (or an acquired part) constituted employment under the Act; and

(B) Some of these employees became employees of the State or political subdivision in connection with and at the time of the acquisition.

(iii) The term *political subdivision* includes an instrumentality of a State, of one or more political subdivisions of a State, or of a State and one or more of its political subdivisions.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59910, 59914, Dec. 17, 1992; 61 FR 38366, July 24, 1996; 69 FR 51556, Aug. 20, 2004]

§ 404.1021 Work for the District of Columbia.

If you work as an employee of the District of Columbia or a wholly owned instrumentality of the District of Columbia, your work is covered as employment unless—

(a) Your work is covered by a retirement system established by a law of the United States; or

(b) You are—

(1) A patient or inmate of a hospital or penal institution and your work is for that hospital or institution;

(2) A student employee (a student nurse, dietitian, or physical or occupational therapist, but not a medical or dental intern or resident in training) of a District of Columbia hospital, clinic, or medical or dental laboratory;

(3) An employee serving temporarily in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(4) A member of a board, committee, or council of the District of Columbia paid on a per diem, meeting, or other fee basis.

(c) *Medicare qualified government employment.* If your work is not covered

under Social Security, it may be covered as Medicare qualified government employment (see § 404.1018b(c) of this subpart).

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59914, Dec. 17, 1992]

§ 404.1022 American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands.

(a) *Work in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands.* Work in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands for a private employer is covered as employment the same as in the 50 States. Work done by a resident of the Republic of the Philippines working in Guam on a temporary basis as a nonimmigrant alien admitted to Guam under section 101(a)(15)(H)(ii) of the Immigration and Nationality Act is excluded from coverage regardless of the employer.

(b) *Work for American Samoa or a political subdivision or wholly owned instrumentality of American Samoa.* Work as an officer or employee (including a member of the legislature) of the government of American Samoa, its political subdivisions, or any wholly owned instrumentality of any one or more of these, is covered as employment (unless the work is covered by a retirement system established by a law of the United States). The officer or employee is not considered as an employee of the United States, an agency of the United States, or an instrumentality of the United States, for purposes of title II of the Act. We consider any pay for this work to have been paid by the government of American Samoa, or the political subdivision or the wholly owned instrumentality of American Samoa.

(c) *Work for Guam, the Commonwealth of the Northern Mariana Islands (CNMI), or a political subdivision or wholly owned instrumentality of Guam or the CNMI.* Work as an officer or employee (including a member of the legislature) of the government of the CNMI, its political subdivisions, or any wholly owned instrumentality of any one or more of these, is covered as employment beginning October 1, 2012. Work as an officer or employee (including a member of the legislature) of the government of Guam, its political subdivisions, or any wholly owned instrumentality of any one or more of these, is excluded from coverage as employment. However, the exclusion does not apply to employees classified as temporary or intermittent unless the work is—

(1) Covered by a retirement system established by a law of Guam or the CNMI;

(2) Done by an elected official;

(3) Done by a member of the legislature; or

(4) Done in a hospital or penal institution by a patient or inmate of the hospital or penal institution.

(d) *Medicare qualified government employment.* If your work is not covered under Social Security, it may be covered as Medicare qualified government employment (see § 404.1018b(c) of this subpart).

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59914, Dec. 17, 1992; 69 FR 51556, Aug. 20, 2004; 79 FR 33684, June 12, 2014]

§ 404.1023 Ministers of churches and members of religious orders.

(a) *General.* If you are a duly ordained, commissioned, or licensed minister of a church, the work you do in the exercise of your ministry is excluded from employment. However, it is treated as self-employment for social security purposes. If you are a member of a religious order who has not taken a vow of poverty, the same rule applies to the work you do in the exercise of your duties required by that order. If you are a member of a religious order who has taken a vow of poverty, the work you do in the exercise of duties required by the order (the work may be done for the order or for another employer) is covered as employment only if the order or autonomous subdivision of the order to which you belong has filed an effective election of coverage. The election is made under section 3121(r) of the Code. For the rules on self-employment coverage of ministers and members of religious orders who have not taken vows of poverty, see § 404.1071.

(b) *What is an ordained, commissioned, or licensed minister.* The terms *ordained, commissioned, or licensed* describe the procedures followed by recognized churches or church denominations to

vest ministerial status upon qualified individuals. If a church or church denomination has an ordination procedure, the commissioning or licensing of a person as a minister may not make him or her a commissioned or licensed minister for purposes of this subpart. Where there is an ordination procedure, the commissioning or licensing must be recognized as having the same effect as ordination and the person must be fully qualified to exercise all of the ecclesiastical duties of the church or church denomination.

(c) *When is work by a minister in the exercise of the ministry.* (1) A minister is working in the exercise of the ministry when he or she is—

(i) Ministering sacerdotal functions or conducting religious worship (other than as described in paragraph (d)(2) of this section); or

(ii) Working in the control, conduct, and maintenance of a religious organization (including an integral agency of a religious organization) under the authority of a religious body constituting a church or church denomination.

(2) The following rules are used to decide whether a minister's work is in the exercise of the ministry:

(i) Whether the work is the conduct of religious worship or the ministration of sacerdotal functions depends on the tenets and practices of the religious body which is his or her church or church denomination.

(ii) Work in the control, conduct, and maintenance relates to directing, managing, or promoting the activities of the religious organization. Any religious organization is considered to be under the authority of a religious body constituting a church or church denomination if it is organized and dedicated to carrying out the tenets and principles of a faith according to either the requirements or sanctions governing the creation of institutions of the faith.

The term *religious organization* has the same meaning and application as is given to the term for income tax purposes under the Code.

(iii) If a minister is working in the conduct of religious worship or the ministration of sacerdotal functions, the work is in the exercise of the ministry whether or not it is performed for a religious organization. (See paragraph (d)(2) of this section for an exception to this rule.)

Example: M, a duly ordained minister, is engaged to work as chaplain at a privately owned university. M spends his entire time working as chaplain. This includes the conduct of religious worship, offering spiritual counsel to the university students, and teaching a class in religion. M is working in the exercise of the ministry.

(iv) If a minister is working for an organization which is operated as an integral agency of a religious organization under the authority of a religious body constituting a church or church denomination, all work by the minister in the conduct of religious worship, in the ministration of sacerdotal functions, or in the control, conduct, and maintenance of the organization is in the exercise of the ministry.

Example: M, a duly ordained minister, is engaged by the N Religious Board as director of one of its departments. M performs no other service. The N Religious Board is an integral agency of O, a religious organization operating under the authority of a religious body constituting a church denomination. M is working in the exercise of the ministry.

(v) If a minister, under an assignment or designation by a religious body constituting a church, works for an organization which is neither a religious organization nor operated as an integral agency of a religious organization, all service performed by him or her, even though the service may not involve the conduct of religious worship or the ministration of sacerdotal functions, is in the exercise of the ministry.

Example: M, a duly ordained minister, is assigned by X, the religious body constituting M's church, to perform advisory service to Y company in connection with the publication of a book dealing with the history of M's church denomination. Y is neither a religious organization nor operated as an integral agency of a religious organization. M performs no other service for X or Y. M is working in the exercise of the ministry.

(vi) If a minister is working for an organization which is neither a religious organization nor operated as an integral agency of a religious organization and the work is not performed under an assignment or designation by ecclesiastical superiors, then only the work

done by the minister in the conduct of religious worship or the ministration of sacerdotal functions is in the exercise of the ministry. (See paragraph (d)(2) of this section for an exception to this rule.)

Example: M, a duly ordained minister, is engaged by N University to teach history and mathematics. M does no other work for N although from time to time M performs marriages and conducts funerals for relatives and friends. N University is neither a religious organization nor operated as an integral agency of a religious organization. M is not working for N under an assignment by his ecclesiastical superiors. The work performed by M for N University is not in the exercise of the ministry. However, service performed by M in performing marriages and conducting funerals is in the exercise of the ministry.

(d) *When is work by a minister not in the exercise of the ministry.* (1) Work performed by a duly ordained, commissioned, or licensed minister of a church which is not in the exercise of the ministry is not excluded from employment.

(2) Work performed by a duly ordained, commissioned, or licensed minister of a church as an employee of the United States, or a State, territory, or possession of the United States, or the District of Columbia, or a foreign government, or a political subdivision of any of these, is not in the exercise of the ministry, even though the work may involve the ministration of sacerdotal functions or the conduct of religious worship. For example, we consider service performed as a chaplain in the Armed Forces of the United States to be work performed by a commissioned officer and not by a minister in the exercise of the ministry. Also, service performed by an employee of a State as a chaplain in a State prison is considered to be performed by a civil servant of the State and not by a minister in the exercise of the ministry.

(e) *Work in the exercise of duties required by a religious order.* Work performed by a member of a religious order in the exercise of duties required by the order includes all duties required of the member of the order. The nature or extent of the work is immaterial so long as it is service which the member is directed or required to perform by the member's ecclesiastical superiors.

§ 404.1024 Election of coverage by religious orders.

A religious order whose members are required to take a vow of poverty, or any autonomous subdivision of that religious order, may elect to have social security coverage extended to the work performed by its members in the exercise of duties required by that order or subdivision. The rules on the election of coverage by these religious orders are described in 26 CFR 31.3121(r). The rules on determining the wages of members of religious orders for which an election of coverage has been made are described in § 404.1046.

§ 404.1025 Work for religious, charitable, educational, or certain other organizations exempt from income tax.

(a) *After 1983.* Work done after 1983 by an employee in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) of the Code which is exempt from income tax under section 501(a) of the Code is covered as employment unless the work is for a church or church-controlled organization that has elected to have services performed by its employees excluded (see § 404.1026). (See § 404.1059(b) for special wage rule.)

(b) *Before 1984.* Work described in paragraph (a) of this section which was done before 1984 is excluded from employment. However, the exclusion does not apply to work done during the period for which a form SS–15, Certificate Waiving Exemption From Taxes Under the Federal Insurance Contributions Act, was filed (or was deemed to have been filed) with the Internal Revenue Service.

[50 FR 36573, Sept. 9, 1985]

§ 404.1026 Work for a church or qualified church-controlled organization.

(a) *General.* If you work for a church or qualified church-controlled organization, as described in this section, your employer may elect to have your services excluded from employment. You would then be considered to be self-employed and special conditions would apply to you. See § 404.1068(f) for those special conditions. The employer's election of the exclusion must be

made with the Internal Revenue Service in accordance with Internal Revenue Service procedures and must state that the church or church-controlled organization is opposed for religious reasons to the payment of Social Security employment taxes. The exclusion applies to current and future employees. If you work in an unrelated trade or business (within the meaning of section 513(a) of the Code) of the church or church-controlled organization, the exclusion does not apply to your services.

(b) *What is a church.* For purposes of this section the term *church* means a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

(c) *What is a qualified church-controlled organization.* For purposes of this section the term *qualified church-controlled organization* means any church-controlled organization exempt from income tax under section 501(c)(3) of the Code but does *not* include an organization which:

(1) Offers goods, services, or facilities for sale to the general public, other than on an incidental basis, or for other than a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(2) Normally receives more than 25 percent of its support from either governmental sources or receipts from admissions, sales of merchandise, performance of services or furnishing of facilities other than in an unrelated trade or business, or both.

[50 FR 36573, Sept. 9, 1985, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1027 Railroad work.

We exclude from employment any work you do as an employee or employee representative as described in the Railroad Retirement Tax Act. However, railroad compensation can be counted for social security purposes under the conditions described in subpart O of this part.

§ 404.1028 Student working for a school, college, or university.

(a) For purposes of this section, a *school, college, or university* has its usual accepted meaning. It does not, however, include any school, college, or university that is an instrumentality or integral part of a State or a political subdivision of a State for which work can only be covered by an agreement under section 218 of the Act. (See subpart M of this part.)

(b) If you are a student, any work you do as an employee of a school, college or university is excluded from employment, if you are enrolled in and regularly attending classes at that school, college, or university. The exclusion also applies to work you do for a private nonprofit auxiliary organization of the school, college, or university if it is organized and operated exclusively for the benefit of, to perform functions of, or to carry out the purposes of the school, college, or university. The organization must be operated, supervised, or controlled by, or in connection with, the school, college, or university.

(c) Whether you are a student for purposes of this section depends on your relationship with your employer. If your main purpose is pursuing a course of study rather than earning a livelihood, we consider you to be a student and your work is not considered employment.

§ 404.1029 Student nurses.

If you are a student nurse, your work for a hospital or nurses training school is excluded from employment if you are enrolled and regularly attending classes in a nurses training school which is chartered or approved under State law.

§ 404.1030 Delivery and distribution or sale of newspapers, shopping news, and magazines.

(a) *If you are under age 18.* Work you do before you reach age 18 delivering or distributing newspapers or shopping news is excluded from employment. This does not include delivery or distribution to some point for further delivery or distribution by someone else. If you make house-to-house delivery or sale of newspapers or shopping news

(including handbills and similar kinds of advertising material), your work is not covered while you are under age 18. Related work such as assembling newspapers is also excluded.

(b) *If you are any age.* No matter how old you are, work you do in connection with and at the time of the sale of newspapers or magazines to consumers is excluded from employment if there is an arrangement under which—

(1) You are to sell the newspapers or magazines at a fixed price; and

(2) Your pay is the difference between the fixed selling price and the amount you are charged for the newspapers or magazines (whether or not you are guaranteed a minimum amount of compensation or receive credit for unsold newspapers or magazines).

(c) *If you are age 18 or older.* If you have attained age 18, you are self-employed if you work under the arrangement described in paragraph (b) of this section. See § 404.1068(b).

§ 404.1031 Fishing.

(a) If you work on a boat engaged in catching fish or other forms of aquatic animal life, your work is not employment if you have an arrangement with the owner or operator of the boat which provides for all of the following:

(1) You do not receive any cash pay (other than as provided in paragraph (a)(2) of this section).

(2) You receive a share of the catch or a share of the proceeds from the sale of the catch.

(3) The amount of your share depends on the size of the catch.

(4) The operating crew of the boat (or each boat from which you receive a share if the fishing operation involves more than one boat) is normally made up of fewer than 10 individuals.

(b) Work excluded from employment under this section is considered to be self-employment (§ 404.1068(e)).

§ 404.1032 Work for a foreign government.

If you work as an employee of a foreign government in any capacity, your work is excluded from employment. If you are a citizen of the United States and work in the United States as an employee of a foreign government, you are considered to be self-employed (§ 404.1068(d)).

§ 404.1033 Work for a wholly owned instrumentality of a foreign government.

(a) If you work as an employee of an instrumentality of a foreign government, your work is excluded from employment if—

(1) The instrumentality is wholly owned by the foreign government;

(2) Your work is similar to work performed in foreign countries by employees of the United States Government or its instrumentalities; and

(3) The Secretary of State certifies to the Secretary of the Treasury that the foreign government grants an equivalent exemption for services performed in the foreign country by employees of the United States Government or its instrumentalities.

(b) Your work will not be excluded under this section if any of the conditions in paragraph (a) of this section are not met.

(c) If you are a citizen of the United States and work in the United States as an employee of an instrumentality of a foreign government and the conditions in paragraph (a) of this section are met, you are considered to be self-employed (§ 404.1068(d)).

§ 404.1034 Work for an international organization.

(a) If you work as an employee of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act (59 Stat. 669), your work is excluded from employment except as described in paragraphs (b) and (c) of this section. The organization must meet the following conditions:

(1) It must be a public international organization in which the United States participates under a treaty or authority of an act of Congress authorizing, or making an appropriation for, participation.

(2) It must be designated by executive order to be entitled to enjoy the privileges, exemptions, and immunities provided in the International Organizations Immunities Act.

(3) The designation must be in effect, and all conditions and limitations in the designation must be met.

(b) Your work will not be excluded under this section if any of the conditions in paragraph (a) of this section are not met.

(c) Your work performed after December 31, 1994 will not be excluded under this section if you perform service in the employ of an international organization pursuant to a transfer from a Federal agency under section 3582 of title 5 of the United States Code and

(1) Immediately before such transfer you performed service with a Federal agency which was covered as employment; and

(2) You would be entitled, upon separation from the international organization and proper application, to reemployment with the Federal agency under section 3582.

(d) If you are a citizen of the United States and work in the United States as an employee of an international organization that meets the conditions in paragraph (a) of this section and you are not subject to coverage based on paragraph (c) of this section, you are considered to be self-employed (§ 404.1068(d)).

[45 FR 20075, Mar. 27, 1980, as amended at 61 FR 38366, July 24, 1996]

§ 404.1035 Work for a communist organization.

If you work as an employee of an organization which is registered, or which is required by a final order of the Subversive Activities Control Board to register under the Internal Security Act of 1950 as a communist action, communist-front, or communist-infiltrated organization, your work is excluded from employment. The exclusion is effective with the calendar year in which the organization is registered or the final order is in effect.

§ 404.1036 Certain nonresident aliens.

(a) *Foreign students.* (1) Foreign students (nonimmigrant aliens) may be temporarily in the United States under subparagraph (F) of section 101(a)(15) of the Immigration and Nationality Act to attend a school or other recognized place of study approved by the Attorney General. On-campus work or work under permission granted by the Immigration and Naturalization Service which is done by these students is excluded from employment. Other work done by these foreign students is not excluded from employment under this section.

(2) Foreign students (nonimmigrant aliens) may be temporarily in the United States under subparagraph (M) of section 101(a)(15) of the Immigration and Nationality Act to pursue a vocational or nonacademic technical education approved by the Attorney General. Work done by these students to carry out the purpose for which they were admitted is excluded from employment. Other work done by these foreign students is not excluded from employment under this section.

(b) *Exchange visitors.* (1) Exchange visitors (nonimmigrant aliens) may be temporarily in the United States under subparagraph (J) of section 101(a)(15) of the Immigration and Nationality Act to participate in exchange visitor programs designated by the Director of the United States Information Agency. Work done by these exchange visitors to carry out the purpose for which they were admitted and for which permission has been granted by the sponsor, is excluded from employment. Other work done by these exchange visitors is not excluded from employment under this section.

(2) Exchange visitors (nonimmigrant aliens) may be temporarily in the United States under subparagraph (Q) of section 101(a)(15) of the Immigration and Nationality Act to participate in an international cultural exchange program approved by the Attorney General. Effective October 1, 1994, work done by these exchange visitors to carry out the purpose for which they were admitted is excluded from employment. Other work done by these exchange visitors is not excluded from employment under this section.

(c) *Spouse and children.* Work done by a foreign student's or exchange visitor's alien spouse or minor child who is also temporarily in the United States under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act is not excluded from employment under this section

unless that spouse or child and the work that is done meets the conditions of paragraph (a) or (b) of this section.

[61 FR 38366, July 24, 1996]

§ 404.1037 Work on or in connection with a non-American vessel or aircraft.

If you work as an employee within the United States on or in connection with (as explained in § 404.1004(b)(8)) a vessel or aircraft that is not an American vessel (as defined in § 404.1004(b)(3)) or American aircraft (as defined in § 404.1004(b)(2)), your work is excluded from employment if—

(a) You are not a citizen of the United States or your employer is not an American employer (as defined in § 404.1004(b)(1)); and

(b) You are employed on and in connection with (as explained in § 404.1004(b)(7)) the vessel or aircraft when outside the United States.

§ 404.1038 Domestic employees under age 18.

Domestic services you perform in a private home of your employer are excluded from employment, regardless of the amount earned, in any year in which you are under age 18 if domestic service is not your principal occupation. The exclusion applies to the entire year if you are under age 18 in any part of the year. See § 404.1057.

[61 FR 38366, July 24, 1996]

Exemption From Social Security by Reason of Religious Belief

§ 404.1039 Employers (including partnerships) and employees who are both members of certain religious groups opposed to insurance.

(a) You and your employer (or, if the employer is a partnership, each of its partners) may file applications with the Internal Revenue Service for exemption from your respective shares of the Federal Insurance Contributions Act taxes on your wages paid by that employer if you and your employer (or, if the employer is a partnership, each of its partners)—

(1) Are members of a recognized religious sect or division of the sect; and

(2) Adhere to the tenets or teachings of the sect or division of the sect and for that reason are conscientiously opposed to receiving benefits from any private or public insurance that—

(i) Makes payment in the event of death, disability, old-age, or retirement; or

(ii) Makes payment for the cost of, or provides services for, medical care including the benefits of any insurance system established by the Act.

(b) Both your application and your employer's application (or, if your employer is a partnership, each partner's application) must be filed with and approved by the Internal Revenue Service pursuant to section 3127 of the Internal Revenue Code. An application must contain or be accompanied by the applicant's waiver of all benefits and payments under title II and part A of title XVIII of the Act. See § 404.305 for the effect of the filing of the waiver and the granting of the exemption.

(c) Regardless of whether the applicant meets all these conditions, the application will not be approved unless we find that—

(1) The sect or division of the sect has established tenets or teachings which cause the applicant to be conscientiously opposed to the types of insurance benefits described in paragraph (a)(2) of this section; and

(2) For a substantial period of time it has been the practice for members of the sect or division of the sect to make provision for their dependent members that is reasonable in view of their general level of living; and

(3) The sect or division of the sect has been in existence continuously since December 31, 1950.

(d) An application for exemption will be approved by the Internal Revenue Service only if no benefit or payment under title II or part A of title XVIII of the Act became payable (or, but for section 203 or section 222(b) of the Act, would have become payable) to the applicant at or before the time of the filing of the application for exemption.

(e) The tax exemption ceases to be effective with respect to wages paid beginning with the calendar quarter in which either the employer (or if the employer is a partnership, any of its partners) or the employee involved does not meet the requirements of

paragraph (a) of this section or the religious sect or division of the sect is found by us to no longer meet the requirements of paragraph (c) of this section. If the tax exemption ceases to be effective, the waiver of the right to receive Social Security and Medicare Part A benefits will also no longer be effective. Benefits may be payable based upon the wages of the individual, whose exempt status was terminated, for and after the calendar year following the calendar year in which the event occurred upon which the cessation of the exemption is based. Benefits may be payable based upon the self-employment income of the individual whose exempt status was terminated for and after the taxable year in which the event occurred upon which the cessation of the exemption is based.

[58 FR 64889, Dec. 10, 1993]

WAGES

§ 404.1041 Wages.

(a) The term *wages* means remuneration paid to you as an employee for employment unless specifically excluded. Wages are counted in determining your entitlement to retirement, survivors', and disability insurance benefits.

(b) If you are paid wages, it is not important what they are called. Salaries, fees, bonuses and commissions on sales or on insurance premiums are wages if they are remuneration paid for employment.

(c) The way in which you are paid is unimportant. Wages may be paid on the basis of piecework or a percentage of the profits. Wages may be paid on an hourly, daily, weekly, monthly, or yearly basis. (See § 404.1056 for special rules for agricultural labor.)

(d) Your wages can be in any form. You can be paid in cash or something other than cash, for example, in goods or clothing. (See paragraphs (e) and (f) of this section for kinds of employment where cash payments alone are considered wages and § 404.1043(b) concerning the value of meals and lodging as wages.) If your employer pays you cash for your meals and lodging on a regular basis as part of your employment, these payments may be considered wages. Payments other than cash may be counted as wages on the basis of the fair value of the items when paid.

(e) In certain kinds of employment, cash payments alone count as wages. These types of employment are agricultural labor, domestic services, and services not in the course of the employer's trade or business.

(f) To count as wages, payments for services performed by home workers who are employees as described in § 404.1008(d) must be in cash and must amount to $100 or more in a calendar year. Once this cash pay test is met, all remuneration paid, whether in cash or kind, is also wages.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1042 Wages when paid and received.

(a) *In general.* Wages are received by an employee at the time they are paid by the employer to the employee. Wages are paid by an employer at the time that they are actually or constructively paid unless they are deemed to be paid later (as described in paragraph (c)(3) of this section).

(b) *Constructive payment.* Wages are constructively paid when they are credited to the account of, or set aside for, an employee so that they may be drawn upon by the employee at any time although not then actually received. To be a payment—

(1) The wages must be credited to or set aside for the employee and must be made available without restriction so that they may be drawn upon at any time; or

(2) The employer must intend to pay or to set aside or credit, and have the ability to pay wages when due to the employee, and failure of the employer to credit or set aside the wages is due to clerical error or mistake in the mechanics of payment, and because of the clerical error or mistake the wages are not actually available at that time.

(c) *Deemed payment.* (1) The first $100 of cash paid, either actually or constructively, by an employer to an employee in a calendar year is considered paid at the time that the amount of the cash payment totals $100 for the year in the case of pay for—

(i) Work not in the course of the employer's trade or business (non-business work);

(ii) Work by certain home workers; and

(iii) Work for an organization exempt from income tax under section 501 of the Code.

(2) We also apply this rule to domestic work in a private home of the employer, except see § 404.1057(a)(1) for the applicable dollar amount.

(3) Cash of less than $150 that an employer pays to an employee in a calendar year, either actually or constructively, for agricultural labor is considered paid at the earliest of—

(i) The time in the calendar year that the employee's pay totals $150; or

(ii) The 20th day of the calendar year on which the employee works for cash pay computed on a time basis.

(4) If an employer pays cash to an employee for two or more of the kinds of work referred to in paragraph (c)(1) of this section, we apply the provisions of this paragraph to the pay for each kind of work.

(d) *Employee tax deductions.* We consider employee tax deductions under section 3101 of the Code to be part of the employee's wages and consider them to be paid at the time of the deduction. We consider other deductions from wages to be wages paid at the time of the deduction. It is immaterial that the deductions are required or permitted by an act of Congress or the law of any State.

(e) *Tips.* (1) Tips received by an employee in the course of employment, that are considered to be *wages,* are deemed to be paid at the time the employee reports the tips to the employer in a written statement as provided under section 6053(a) of the Code. Tips that are not reported are deemed to be paid to the employee at the time they are received by the employee.

(2) We consider tips to be received in the course of employment whether they are received by the employee from the employer or from another person. Only tips employees receive and keep for themselves are considered to be the employees' pay. If employees split tips, each employee who receives part of the tip receives tips in the course of employment.

(f) *Payments under nonqualified deferred compensation plans.* Amounts that an employee is entitled to receive under nonqualified deferred compensation plans (plans that do not qualify for special tax treatment under the Code) are creditable as wages for Social Security purposes at the later of the following times:

(1) When the services are performed; or

(2) When there is no longer a substantial risk of forfeiture (as defined in section 83 of the Code) of the employee's rights to the deferred compensation.

Any amounts taken into account as wages by this paragraph (and the income attributable thereto) will not thereafter be treated as wages for Social Security purposes.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990; 61 FR 38366, July 24, 1996]

§ 404.1043 Facilities or privileges—meals and lodging.

(a) *Excluding the value of employer provided facilities or privileges from employee gross income prior to January 1, 1985.* (1) Generally, the facilities or privileges that an employer furnished an employee prior to January 1, 1985 are not wages if the facilities or privileges—

(i) Were of relatively small value; and

(ii) Were offered or furnished by the employer merely as a means of promoting the health, good will, contentment, or efficiency of the employees.

(2) The term *facilities or privileges* for the period prior to January 1, 1985 is intended to include such items as entertainment, medical services, and so-called *courtesy* discounts on purchases.

(b) *Meals and lodging.* The value of the meals and lodging furnished to an employee by an employer for reasons of the employer's convenience is not wages if—

(1) The meals are provided at the employer's place of business; and

(2) The employee, in the case of lodging, is required to accept lodging on the employer's business premises as a condition of employment.

[52 FR 29662, Aug. 11, 1987]

§ 404.1044 Vacation pay.

We consider your salary while on vacation, or a *vacation allowance* paid by your employer, to be wages.

§ 404.1045 Employee expenses.

Amounts that your employer pays you specifically—either as advances or reimbursements—for traveling or for other ordinary and necessary expenses incurred, or reasonably expected to be incurred, in your employer's business are not wages. The employer must identify these travel and other expenses either by making a separate payment or by specifically stating the separate amounts if both wages and expense allowances are combined in a single payment.

§ 404.1046 Pay for work by certain members of religious orders.

(a) If you are a member of a religious order who has taken a vow of poverty (§ 404.1023), and the order has elected Social Security coverage under section 3121(r) of the Code, your wages are figured in a special way. Your wages, for Social Security purposes, are the fair market value of any board, lodging, clothing, and other items of value furnished to you by the order, or furnished to the order on your behalf by another organization or person under an agreement with the order. See paragraph (b) of this section if you perform services for a third party. The order must report at least $100 a month for each active member. If the fair market value of items furnished to all members of a religious order does not vary significantly, the order may consider all members to have a uniform wage.

(b) If you perform services for a third party, the following rules apply:

(1) If you perform services for another agency of the supervising church or an associated institution, any amounts paid based on such services, whether paid directly to you or to the order, do not count on wages. Only wages figured under (a) above, are counted.

(2) If you perform services in a secular setting as an employee of a third party not affiliated or associated with the supervising church or an associated institution, any amounts paid based on such services, whether paid directly to you or to the order, count as wages paid to you by the third party. These wages are in addition to any wages counted under paragraph (a) of this section.

[55 FR 7309, Mar. 1, 1990; 55 FR 17530, Apr. 25, 1990]

§ 404.1047 Annual wage limitation.

Payments made by an employer to you as an employee in a calendar year that are more than the annual wage limitation are not wages. The annual wage limitation is:

Calendar year	Wage limitation
1951–54	$3,600
1955–58	4,200
1959–65	4,800
1966–67	6,600
1968–71	7,800
1972	9,000
1973	10,800
1974	13,200
1975	14,100
1976	15,300
1977	16,500
1978	17,700
1979	22,900
1980	25,900
1981	29,700
1982	32,400
1983	35,700
1984	37,800
1985	39,600
1986	42,000
1987	43,800
1988	45,000
1989	48,000
1990	51,300
1991	53,400
1992	55,500

[52 FR 8249, Mar. 17, 1987, as amended at 57 FR 44098, Sept. 24, 1992]

§ 404.1048 Contribution and benefit base after 1992.

(a) *General.* The contribution and benefit base after 1992 is figured under the formula described in paragraph (b) of this section in any calendar year in which there is an automatic cost-of-living increase in old-age, survivors, and disability insurance benefits. For purposes of this section, the calendar year in which the contribution and benefit base is figured is called the determination year. The base figured in the determination year applies to wages paid after (and taxable years beginning after) the determination year.

(b) *Formula for figuring the contribution and benefit base.* For wages paid

after (and taxable years beginning after) the determination year, the contribution and benefit base is the larger of—

(1) The contribution and benefit base in effect for the determination year; or

(2) The amount determined by—

(i) Multiplying the contribution and benefit base in effect for the determination year by the ratio of—

(A) The average of the total wages (as described in paragraph (c) of this section) reported to the Secretary of the Treasury for the calendar year before the determination year to

(B) The average of the total wages reported to the Secretary of the Treasury for the calendar year before the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination under this section resulting in an increase of the base was made; and

(ii) Rounding the result of the multiplication, if not a multiple of $300, to—

(A) The nearest multiple of $300; or

(B) The next higher multiple of $300 if the result is a multiple of $150.

(c) *Average of the total wages.* The average of the total wages means the amount equal to all remuneration reported as wages on Form W-2 to the Internal Revenue Service for all employees for income tax purposes plus contributions to certain deferred compensation plans described in section 209(k) of the Social Security Act (also reported on Form W-2), divided by the number of wage earners. If both distributions from and contributions to any such deferred compensation plan are reported on Form W-2, we will include only the contributions in the calculation of the average of the total wages. The reported remuneration and deferred compensation contributions include earnings from work not covered under social security and earnings from work covered under social security that are more than the annual wage limitation described in § 404.1047.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990; 57 FR 1382, Jan. 14, 1992]

§ 404.1049 Payments under an employer plan or system.

(a) Payments to, or on behalf of, you or any of your dependents under your employer's plan or system are excluded from wages if made because of your or your dependents'—

(1) Medical or hospitalization expenses connected with sickness or accident disability; or

(2) Death, except that the exclusion does not apply to payments for group-term life insurance to the extent that the payments are includible in the gross income of the employee under the Internal Revenue Code of 1986, effective with respect to group-term life insurance coverage in effect after 1987 for employees whose employment, for the employer (or successor of that employer) providing the insurance coverage, does not end prior to 1989. Such payments are wages, however, if they are for coverage for an employee who was separated from employment prior to January 1, 1989, if the payments are for any period for which the employee is reemployed by the employer (or successor of that employer) after the date of separation.

(b) Payments to you or your dependents under your employer's plan at or after the termination of your employment relationship because of your death or retirement for disability are excluded from wages.

(c) Payments made after 1983 to you or your dependents under your employer's plan at or after the termination of your employment relationship because of retirement after reaching an age specified in the plan or in a pension plan of the employer are not excluded from wages unless—

(1) The payments are to or from a trust or annuity plan of your employer as described in § 404.1052; or

(2) An agreement to retire was in effect on March 24, 1983, between you and your employer and the payments made after 1983 under a nonqualified deferred compensation plan (see § 404.1042(f)) are based on services performed for your employer before 1984.

(d) The plan or system established by the employer must provide for the employees generally or for a class or classes of employees. The plan or system may also provide for these employees' dependents. Payments under a plan or system established only for your dependents are not excluded from wages. The plan or system established

by the employer can provide for payments on account of one or more of the items in paragraphs (a) and (b) of this section.

(e) For purposes of this section, your dependents include your husband or wife, children, and any other members of your immediate family.

(f) It does not make any difference that the benefit payments are considered in arriving at the amount of your pay or are required by the employment agreement.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 1832, Jan. 14, 1985; 55 FR 7310, Mar. 1, 1990; 55 FR 17530, Apr. 25, 1990]

§ 404.1050 Retirement payments.

Payments made after 1983 to you (including any amount paid by an employer for insurance or annuities) on account of your retirement for age are not excluded from wages unless—

(a) The payments are to or from a trust or annuity plan of your employer as described in § 404.1052; or

(b) The payments satisfy the requirements described in § 404.1049(c)(2).

[55 FR 7310, Mar. 1, 1990]

§ 404.1051 Payments on account of sickness or accident disability, or related medical or hospitalization expenses.

(a) We do not include as wages any payment that an employer makes to you, or on your behalf, on account of your sickness or accident disability, or related medical or hospitalization expenses, if the payment is made more than 6 consecutive calendar months following the last calendar month in which you worked for that employer. Payments made during the 6 consecutive months are included as wages.

(b) The exclusion in paragraph (a) of this section also applies to any such payment made by a third party (such as an insurance company). However, if you contributed to your employer's sick pay plan, that portion of the third party payments attributable to your contribution is not wages.

(c) Payments of medical or hospitalization expenses connected with sickness or accident disability are excluded from wages beginning with the first payment only if made under a plan or system of your employer as explained in § 404.1049(a)(1).

(d) Payments under a worker's compensation law are not wages.

[55 FR 7310, Mar. 1, 1990]

§ 404.1052 Payments from or to certain tax-exempt trusts or payments under or into certain annuity plans.

(a) We do not include as wages any payment made—

(1) Into a tax-exempt trust or annuity plan by your employer on behalf of you or your beneficiary; or

(2) From a tax-exempt trust or under an annuity plan to, or on behalf of, you or your beneficiary.

(b) The trust must be exempt from tax under sections 401 and 501(a) of the Code, and the annuity plan must be a plan described in section 403(a) of the Code when payment is made.

(c) The exclusion does not apply to payments to an employee of the trust for work done as an employee of the trust.

[55 FR 7310, Mar. 1, 1990]

§ 404.1053 "Qualified benefits" under a cafeteria plan.

We do not include as wages any *qualified benefits* under a cafeteria plan as described in section 125 of the Code if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received. This includes any *qualified benefit* made to you, or on your behalf, pursuant to a salary reduction agreement between you and your employer. The Internal Revenue Service decides whether any plan is a cafeteria plan under section 125 of the Code and whether any benefit under the plan is a *qualified benefit*.

[55 FR 7310, Mar. 1, 1990]

§ 404.1054 Payments by an employer of employee's tax or employee's contribution under State law.

(a) We exclude as wages any payment by an employer (described in paragraph (b) of this section) that is not deducted from the employee's salary (or for which reimbursement is not made by the employee) of either—

(1) The tax imposed by section 3101 of the Code (employee's share of *Social Security tax*); or

(2) Any payment required from an employee under a State unemployment compensation law.

(b) The payments described in paragraph (a) of this section are not included as wages only if they are made by an employer on behalf of an employee employed in—

(1) Domestic service in the private home of the employer; or

(2) Agricultural labor.

[55 FR 7310, Mar. 1, 1990]

§ 404.1055 Payments for agricultural labor.

(a) *When cash payments are not wages.* We do not include as wages your cash payments in a calendar year after 1987 from an employer for agricultural labor (see § 404.1056) if your employer's total expenditures for agricultural labor are less than $2500 in that year and your employer paid you less than $150 cash remuneration in that year for your agricultural labor.

(b) *Exclusions for noncash payments and payments for seasonal agricultural labor.* (1) Noncash payments for agricultural labor are not wages.

(2) Your cash payments in a calendar year from an employer for agricultural labor are not wages, irrespective of your employer's total annual expenditures for agricultural labor, if you are a hand harvest laborer (*i.e.*, seasonal agricultural labor), and—

(i) Your employer paid you less than $150 in that year;

(ii) You are paid on a piece rate basis in an operation which has been, and is customarily and generally recognized in the region of employment as paying on a piece rate basis;

(iii) You commute daily from your permanent residence to the farm on which you are so employed; and,

(iv) You were employed in agriculture less than 13 weeks during the previous calendar year.

Example: In 1988, A (not a hand harvest laborer) performs agricultural labor for X for cash pay of $144 in the year. X's total agricultural labor expenditures for 1988 are $2,450. Neither the $150 cash-pay test nor the $2,500 expenditures test is met. Therefore, X's payments to A are not wages.

(c) *When cash-pay is creditable as wages.* (1) If you receive cash pay from an employer for services which are agricultural labor and for services which are not agricultural labor, we count only the amounts paid for agricultural labor in determining whether cash payments equal or exceed $150. If the amounts paid are less than $150, we count only those amounts paid for agricultural labor in determining if the $2500 expenditure test is met.

Example: Employer X operates a store and also operates a farm. Employee A, who regularly works in the store, works on X's farm when additional help is required for the farm activities. In calendar year 1988, X pays A $140 cash for agricultural labor performed in that year, and $2,260 for work in connection with the operation of the store. Additionally, X's total expenditures for agricultural labor in 1988 were $2,010. Since the cash payments by X to A in the calendar year 1988 for agricultural labor are less than $150, and total agricultural labor expenditures were under $2,500, the $140 paid by X to A for agricultural labor is not wages. The $2,260 paid for work in the store is wages.

(2) The amount of cash pay for agricultural labor that is creditable to an individual is based on cash paid in a calendar year rather than on amounts earned during a calendar year.

(3) If you receive cash pay for agricultural labor in any one calendar year from more than one employer, we apply the $150 cash-pay test and $2,500 total expenditures test to each employer.

(d) *Application of the $150 cash-pay and 20-day tests prior to 1988.* (1) For the time period prior to 1988, we apply either the $150 a year cash-pay test or the 20-day test. Cash payments are wages if you receive $150 or more from an employer for agricultural labor or under the 20-day test if you perform agricultural labor for which cash pay is computed on a time basis on 20 or more days during a calendar year. For purposes of the 20-day test, the amount of the cash pay is immaterial, and it is immaterial whether you also receive payments other than cash or payments that are not computed on a time basis. If cash paid to you for agricultural labor is computed on a time basis, the payments are not wages unless they

are paid in a calendar year in which either the 20-day test or the $150 cash-pay test is met.

(2) [Reserved]

[57 FR 59914, Dec. 17, 1992, as amended at 61 FR 38367, July 24, 1996; 70 FR 41955, July 21, 2005]

§ 404.1056 Explanation of agricultural labor.

(a) *What is agricultural labor.* (1) If you work on a farm as an employee of any person, you are doing agricultural labor if your work has to do with—

(i) Cultivating the soil;

(ii) Raising, shearing, feeding, caring for, training or managing livestock, bees, poultry, fur-bearing animals or wildlife; or

(iii) Raising or harvesting any other agricultural or horticultural commodity.

(2) If you work on a farm as an employee of any person in connection with the production or harvesting of maple sap, the raising or harvesting of mushrooms, or the hatching of poultry, you are doing agricultural labor. If you work in the processing of maple sap into maple syrup or maple sugar you are not doing agricultural labor even though you work on a farm. Work in a mushroom cave or poultry hatchery is agricultural labor only if the cave or hatchery is operated as part of a farm.

(3) If you work as an employee of the owner, tenant, or other operator of a farm, you are doing agricultural labor if most of your work is done on a farm and is involved with—

(i) The operation, management, conservation, improvement, or maintenance of the farm or its tools or equipment (this may include work by carpenters, painters, mechanics, farm supervisors, irrigation engineers, bookkeepers, and other skilled or semi-skilled workers); or

(ii) Salvaging timber or clearing the land of brush and other debris left by a hurricane.

(4) You are doing agricultural labor no matter for whom or where you work, if your work involves—

(i) Cotton ginning;

(ii) Operating or maintaining ditches, canals, reservoirs, or waterways, if they are used only for supplying and storing water for farm purposes and are not owned or operated for profit; or

(iii) Producing or harvesting crude gum (oleoresin) from living trees or processing the crude gum into gum spirits of turpentine and gum resin (if the processing is done by the original producer).

(5) Your work as an employee in the handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage, to a market or to a carrier for transportation to market, of any agricultural or horticultural commodity is agricultural labor if—

(i) You work for a farm operator or a group of farm operators (other than a cooperative organization);

(ii) Your work involves the commodity in its raw or unmanufactured state; and

(iii) The operator produced most of the commodity you work with during the period for which you are paid, or if you work for a group of operators, all of the commodity you work with during the pay period is produced by that group.

(6) If you do nonbusiness work, it is agricultural labor if you do the work on a farm operated for a profit. A farm is not operated for profit if the employer primarily uses it as a residence or for personal or family recreation or pleasure. (See § 404.1058(a) for an explanation of nonbusiness work.)

(7) The term *farm operator* means an owner, tenant, or other person, in possession of and operating a farm.

(8) Work is not *agricultural labor* if it is done in the employ of a cooperative organization, which includes corporations, joint-stock companies, and associations treated as corporations under the Code. Any unincorporated group of operators is considered to be a cooperative organization if more than 20 operators are in the group at any time during the calendar year in which the work is done.

(9) Processing work which changes the commodity from its raw or natural state is not agricultural labor. An example of this is the extraction of juices from fruits or vegetables. However, work in the cutting and drying of fruits or vegetables does not change

the commodity from its raw or natural state and can be agricultural labor.

(10) The term *commodity* means a single agricultural or horticultural product. For example, all apples are a commodity, while apples and oranges are two commodities.

(11) Work connected with the commercial canning or freezing of a commodity is not agricultural labor nor is work done after the delivery of the commodity to a terminal market for distribution for consumption.

(b) *What is a farm.* For purposes of social security coverage, *farm* includes a stock, dairy, poultry, fruit, fur-bearing animal, or truck farm, plantation, ranch, nursery, range or orchard. A farm also includes a greenhouse or other similar structure used mostly for raising agricultural or horticultural products. A greenhouse or other similar structure used mostly for other purposes such as display, storage, making wreaths and bouquets is not a farm.

[45 FR 20075, Mar. 27, 1980. Redesignated at 55 FR 7310, Mar. 1, 1990, as amended at 61 FR 38367, July 24, 1996; 70 FR 41955, July 21, 2005]

§ 404.1057 Domestic service in the employer's home.

(a) *Payments for domestic service*—(1) *The applicable dollar threshold.* We do not include as wages cash payments that an employer makes to you in any calendar year for domestic service in the employer's private home if the cash pay in that calendar year is less than the applicable dollar threshold. The threshold per employer is $1000 in calendar year 1995. In calendar years after 1995, this amount will be subject to adjustment in $100 increments based on the formula in section 215(a)(1)(B)(i) of the Act to reflect changes in wages in the economy. Non-cash payments for domestic service are not counted as wages.

(2) *How evaluation is made.* We apply the applicable dollar threshold described in paragraph (a)(1) of this section based on when the payments are made to you rather than when the pay is earned. To count toward the applicable dollar threshold, payment must be made to you in cash (including checks or other forms of money). We apply the applicable dollar threshold only to services performed as a domestic employee. If an employer pays you for performing other work, the cash pay for the nondomestic work does not count toward the applicable dollar threshold domestic service pay required for the remuneration to count as wages.

(3) *More than one domestic employer.* The applicable dollar threshold as explained in paragraph (a)(1) of this section applies to each employer when you perform domestic services for more than one employer in a calendar year. The wages paid by more than one employer for domestic services may not be combined to decide whether you have been paid the applicable dollar threshold or more in a calendar year. The standard applies to each employee when an employer has two or more domestic employees during a calendar year.

(4) *Rounding dollar amounts for reporting.* For social security purposes, an employer has an option in the way he or she reports cash wages paid for domestic service in his or her private home. The employer may report the actual wages paid or may round the wages to the nearest dollar. For purposes of rounding to the nearest dollar the cents are disregarded unless it amounts to one-half dollar or more, in which case it will be raised to $1. If an employer uses this method to report a cash payment to you for domestic services in his or her private home in a calendar year, he or she must use the same method to report payments to other employees in that year for similar services.

(b) *What is domestic service.* Domestic service is work of a household nature done by you in or about a private home of the employer. A private home is a fixed place of residence of a person or family. A separate dwelling unit maintained by a person in an apartment house, hotel, or other similar establishment may be a private home. If a house is used primarily for supplying board or lodging to the public as a business enterprise, it is not a private home. In general, services of a household nature in or about a private home include services performed by cooks, waiters, butlers, housekeepers, governesses, maids, valets, baby sitters, janitors, laundresses, furnacemen, caretakers,

handymen, gardeners, footmen, grooms, and chauffeurs of automobiles for family use. Pay for these services does not come under this provision unless the services are performed in or about a private home of the employer. Pay for services not of a household nature, such as services performed as a private secretary, tutor, or librarian, even though performed in the employer's home, does not come under this provision.

[45 FR 20075, Mar. 27, 1980; 45 FR 25060, Apr. 14, 1980. Redesignated at 55 FR 7310, Mar. 1, 1990, as amended at 61 FR 38367, July 24, 1996]

§ 404.1058 Special situations.

(a) *Payments for service not in course of employer's trade or business (nonbusiness work) and payments to certain home workers*—(1) *The $100 standard.* We do not include as wages cash pay of less than $100 paid to you in a calendar year by an employer for services not in the course of the employer's trade or business (nonbusiness work) and for services as a home worker as described in § 404.1008(d).

(2) *How evaluation is made.* (i) We apply the $100 standard for a calendar year based on when the payments are made to you rather than when the pay is earned. To count toward the $100 amount, payment must be in cash (including checks or other forms of money). The $100 standard applies to each employer when you perform services not in the course of the employer's trade or business or as a homeworker for two or more employers.

(ii) If the employer has two or more employees, the standard applies to each employee. In applying the $100 standard, we disregard cash payments for any other type of services you perform for the employer.

(iii) The noncash payments an employer pays you for services not in the course of the employer's trade or business are not wages even if the employer has paid you cash wages of $100 or more in the calendar year for services of that type.

(iv) Amounts paid to you as a home worker as described in § 404.1008(d) are not wages unless you are paid $100 or more in cash in a calendar year. If you meet this test, any noncash payments you receive for your services also count as wages.

(v) Amounts paid to you as a home worker in a common-law employment relationship (see § 404.1007) count as wages regardless of amount or whether paid in cash or kind.

(3) *Definitions.* The term *services not in the course of the employer's trade or business* (also called nonbusiness work) means services that do not promote or advance the trade or business of the employer. Services performed for a corporation do not come within this definition. A homeworker is described in § 404.1008(c).

(b) *Nonprofit, income-tax exempt organizations*—(1) *The $100 standard.* We do not include as wages payments of less than $100 in a calendar year made by an employer that is an organization exempt from income tax under section 501 of the Code.

(2) *How evaluation is made.* We apply the $100 standard for a calendar year based on when the payments are made to you rather than when the pay is earned. To figure the $100 amount, both cash and noncash payments are counted. The $100 standard applies to each employer where you render services for two or more nonprofit, income-tax exempt organizations during a calendar year. The $100 standard also applies to each of you where a nonprofit, income-tax exempt organization has two or more employees. In applying the standard, the tax-exempt status of the employer and not the nature or place of your services is controlling.

(c) *Payments to members of the uniformed services*—(1) *The standard.* We include as the wages of a member of the uniformed services—

(i) Basic pay, as explained in paragraph (c)(3) of this section, for performing the services described in paragraph (a)(1) of § 404.1019 of this subpart; or

(ii) Compensation, as explained in paragraph (c)(4) of this section, for performing the services described in paragraph (a)(2) of § 404.1019 of this subpart.

(2) *Wages deemed paid.* These following provisions apply to members of the uniformed services who perform services as described in paragraph (a)(1) of § 404.1019 of this subpart.

(i) After 1977, a member of the uniformed services is considered to have been paid additional wages of $100 for each $300 of basic pay paid to the individual in a calendar year. The amount of additional wages deemed paid cannot be more than $1,200 for any calendar year. No wages may be deemed paid for units of basic pay which are less than $300.

(ii) Before 1978, a member of the uniformed services is considered to have been paid additional wages of $300 for each calendar quarter after 1956 in which the individual is paid any amount of basic pay.

(3) *Basic pay. Basic pay* means the monthly pay prescribed by 37 U.S.C. 203 (Pay and Allowances for the Uniformed Services) for a member of the uniformed services on active duty or on active duty for training.

(4) *Compensation.* ''Compensation'' refers to the remuneration received for services as a member of a uniformed service, based on regulations issued by the Secretary concerned (as defined in 37 U.S.C. 101(5) under 37 U.S.C. 206(a), where such member is not entitled to the basic pay (as defined by paragraph (3) of this section).

(d) *Payments to volunteers and volunteer leaders in the Peace Corps.* If you are a *volunteer* or *volunteer leader* under the provisions of the Peace Corps Act (22 U.S.C. 2501ff), payments for your services are wages with the exception of amounts in excess of the amounts certified as payable under section 5(*c*) or 6(*l*) of the Peace Corps Act. Amounts certified under those sections are considered to have been paid to the individual at the time the service is performed. See § 404.1018(*e*) on coverage of these services.

(e) *Moving expenses.* We do not include as wages amounts paid to, or on behalf of, an employee for moving expenses if it is reasonable to believe that a similar deduction is allowable under section 217 of the Code.

(f) *Payments by employer to survivor or estate of former employee.* We do not include as wages any payment by an employer to a survivor or the estate of a former employee after the calendar year in which the employee died.

(g) *Payments to an employee who is entitled to disability insurance benefits.* We do not include as wages any payments made by an employer to an employee if at the time such payment is made—

(1) The employee is entitled to disability insurance benefits under the Act;

(2) The employee's entitlement to such benefits began before the calendar year in which the employer's payment is made; and

(3) The employee performed no work for the employer in the period in which the payments were paid by such employer (regardless of whether the employee worked in the period the payments were earned).

(h) *Tips.* (1) We include as wages tips received by an employee if—

(i) The tips are paid in cash; and

(ii) The tips amount to $20 or more and are received in the course of employment by an employee in a calendar month.

(2) Cash tips include checks and other forms of money. Tips received in a form other than cash, such as passes, tickets, or other goods are not wages. If an employee works for more than one employer in a calendar month, we apply the $20 tip test to work done for each employer.

(i) *Payments by employer under group legal services plan.* We do not include as wages any contribution, payment, or service, provided by an employer under a qualified group legal services plan which is excludable from the gross income of an employee, or the employee's spouse or dependents, under section 120 of the Code.

[45 FR 20075, Mar. 27, 1980, as amended at 52 FR 29662, Aug. 11, 1987. Redesignated and amended at 55 FR 7310, Mar. 1, 1990; 57 FR 59914, Dec. 17, 1992]

§ 404.1059 Deemed wages for certain individuals interned during World War II.

(a) *In general.* Persons who were interned during any period of time from December 7, 1941, through December 31, 1946, by the United States Government at a place operated by the Government within the United States for the internment of United States citizens of Japanese ancestry are deemed to have been paid wages (in addition to wages actually paid) as provided in paragraph (c) of this section during any period

after attaining age 18 while interned. This provision is effective for determining entitlement to, and the amount of, any monthly benefit for months after December 1972, for determining entitlement to, and the amount of, any lump-sum death payment in the case of a death after December 1972, and for establishing a period of disability.

(b) *Information needed to process deemed wages.* Unless we have already made a determination on deemed wages for a period of internment of an individual, any person applying for a monthly benefit, a recalculation of benefits by reason of this section, or a lump-sum death payment, must submit certain information before the benefit or payment may be computed on the basis of deemed wages. This information is—

(1) The place where the individual worked before internment;

(2) The highest hourly wage before internment;

(3) The place and date of internment;

(4) Date of birth (if not previously furnished);

(5) Whether or not another Federal benefit is being received based wholly or in part upon the period of internment; and

(6) In the case of a woman, her maiden name.

(c) *Amount of deemed wages.* The amount of wages which may be deemed is determined as follows:

(1) *Employed prior to internment.* If the individual was employed before being interned, the deemed wages are the greater of—

(i) The highest actual hourly rate of pay received for any employment before internment, multiplied by 40 for each full week during the period of internment; or

(ii) The Federal minimum hourly rate in effect for the period of internment, multiplied by 40 for each full week during that period.

(2) *Self-employed or not employed prior to internment.* If the individual was self-employed or was not employed before the period of internment, the deemed wages are the Federal minimum hourly rate in effect for that period, multiplied by 40 for each full week during the period.

(d) *When wages are not deemed.* Wages are not deemed under this section—

(1) For any period before the quarter in which the individual attained age 18; or

(2) If a larger benefit is payable without the deemed wages; or

(3) If a benefit based in whole or in part upon internment is determined by any agency of the United States to be payable under any other law of the United States or under a system set up by that agency. However, this exception does not apply in cases where the failure to receive deemed wages reduces the primary insurance amount by 50 cents or less.

(e) *Certification of internment.* The certification concerning the internment is made by the Archivist of the United States or his or her representative. After the internment has been verified, wages are deemed to have been paid to the internee.

[45 FR 20075, Mar. 27, 1980, as amended at 52 FR 29662, Aug. 11, 1987. Redesignated at 55 FR 7310, Mar. 1, 1990]

§ 404.1060 [Reserved]

SELF-EMPLOYMENT

§ 404.1065 Self-employment coverage.

For an individual to have self-employment coverage under social security, the individual must be engaged in a trade or business and have net earnings from self-employment that can be counted as self-employment income for social security purposes. The rules explaining whether you are engaged in a trade or business are in §§ 404.1066 through 404.1077. What are net earnings from self-employment is discussed in §§ 404.1080 through 404.1095. Section 404.1096 describes the net earnings from self-employment that are counted as self-employment income for social security purposes. See § 404.1913 for the effect of a totalization agreement on self-employment coverage. An agreement may exempt an activity from coverage as well as extend coverage to an activity.

[50 FR 36574, Sept. 9, 1985]

§ 404.1066 Trade or business in general.

For you to be covered as a self-employed person for social security purposes, you must be engaged in a trade or business. You can carry on a trade or business as an individual or as a member of a partnership. With some exceptions, the term *trade or business* has the same meaning as it does when used in section 162 of the Code.

§ 404.1068 Employees who are considered self-employed.

(a) *General.* Although we generally exclude services performed by employees from the definition of trade or business, certain types of services are considered a trade or business even though performed by employees. If you perform any of the services described in paragraphs (b) through (f) of this section, you are self-employed for social security purposes. Certain other services described in § 404.1071 (relating to ministers and members of religious orders) and § 404.1073 (relating to certain public officers) may be considered a trade or business even though performed by employees.

(b) *Newspaper vendors.* If you have attained age 18 and perform services as a newspaper vendor that are described in § 404.1030(b), you are engaged in a trade or business.

(c) *Sharefarmers.* If you perform services as a sharefarmer that are described in § 404.1017, you are engaged in a trade or business.

(d) *Employees of a foreign government, an instrumentality wholly owned by a foreign government, or an international organization.* If you are a United States citizen and perform the services that are described in § 404.1032, § 404.1033(a), or § 404.1034(a), you are engaged in a trade or business if the services are performed in the United States and are not covered as employment based upon § 404.1034(c).

(e) *Certain fishermen.* If you perform services as a fisherman that are described in § 404.1031, you are engaged in a trade or business.

(f) *Employees of a church or church-controlled organization that has elected to exclude employees from coverage as employment.* If you perform services that are excluded from employment as described in § 404.1026, you are engaged in a trade or business. Special rules apply to your earnings from those services which are known as church employee income. If you are paid $100 or more in a taxable year by an employer who has elected to have its employees excluded, those earnings are self-employment income (see § 404.1096(c)(1)). In figuring your church employee income you may not reduce that income by any deductions attributable to your work. Your church employee income and deductions may not be taken into account in determining the amount of other net earnings from self-employment. Effective for taxable years beginning on or after January 1, 1990, your church employee income is exempt from self-employment tax under the conditions set forth for members of certain religious groups (see § 404.1075).

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985; 58 FR 64889, Dec. 10, 1993; 61 FR 38367, July 24, 1996]

§ 404.1069 Real estate agents and direct sellers.

(a) *Trade or business.* If you perform services after 1982 as a qualified real estate agent or as a direct seller, as defined in section 3508 of the Code, you are considered to be engaging in a trade or business.

(b) *Who is a qualified real estate agent.* You are a qualified real estate agent as defined in section 3508 of the Code if you are a salesperson and—

(1) You are a licensed real estate agent;

(2) Substantially all of the earnings (whether or not paid in cash) for the services you perform as a real estate agent are directly related to sales or other output (including the performance of services) rather than to the number of hours worked; and

(3) Your services are performed under a written contract between yourself and the person for whom the services are performed which provides you will not be treated as an employee with respect to these services for Federal tax purposes.

(c) *Who is a direct seller.* You are a direct seller as defined in section 3508 of the Code if—

(1) You are engaged in the trade or business of selling (or soliciting the sale of) consumer products—

(i) To any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis which the Secretary of the Treasury prescribes by regulations, for resale (by the buyer or any other person) in the home or in other than a permanent retail establishment; or

(ii) In the home or in other than a permanent retail establishment; and

(2) Substantially all of your earnings (whether or not paid in cash) for the performance of these services are directly related to sales or other output (including the performance of services) rather than to the number of hours worked; and

(3) Your services are performed under a written contract between yourself and the person for whom the services are performed which provides you will not be treated as an employee with respect to these services for Federal tax purposes.

[48 FR 40515, Sept. 8, 1983]

§ 404.1070 Christian Science practitioners.

If you are a Christian Science practitioner, the services you perform in the exercise of your profession are a trade or business unless you were granted an exemption from coverage under section 1402(e) of the Code, and you did not revoke such exemption in accordance with section 1704(b) of the Tax Reform Act of 1986. An exemption cannot be granted if you filed a valid waiver certificate under the provisions that apply to taxable years ending before 1968.

[55 FR 7311, Mar. 1, 1990]

§ 404.1071 Ministers and members of religious orders.

(a) If you are a duly ordained, commissioned, or licensed minister of a church, or a member of a religious order who has not taken a vow of poverty, the services you perform in the exercise of your ministry or in the exercise of duties required by the order (§ 404.1023(c) and (e)) are a trade or business unless you filed for and were granted an exemption from coverage under section 1402(e) of the Code, and you did not revoke such exemption in accordance with the Social Security Amendments of 1977, section 1704(b) of the Tax Reform Act of 1986, or section 403 of the Ticket to Work and Work Incentives Improvement Act of 1999. An exemption cannot be granted if you filed a valid waiver certificate under the provisions of section 1402(e) that apply to taxable years ending before 1968.

(b) If you are a member of a religious order and have taken a vow of poverty, the services you perform in the exercise of your duties required by the order may be covered as employment. (See § 404.1023 (a) and (e)).

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7311, Mar. 1, 1990; 69 FR 51556, Aug. 20, 2004]

§ 404.1073 Public office.

(a) *General.* The performance of the functions of a public office is not a trade or business except under the circumstances explained in paragraph (b) of this section. If you are an officer of a State or political subdivision, you are considered as employee of the State or political subdivision.

(b) *State and local governmental employees paid by fees*—(1) *Voluntary coverage under section 218 of the Act.* The services of employees of States and political subdivisions, including those in positions paid solely on a fee-basis, may be covered as employment by a Federal-State agreement under section 218 of the Act (see subpart M of this part). States, when entering into these agreements, have the option of excluding under the agreement coverage of services in positions paid solely by fees. If you occupy a position paid solely on a fee-basis and the State has not covered your services under section 218 of the Act, you are considered to be engaged in a trade or business.

(2) *Mandatory old-age, survivors, disability, and hospital insurance coverage.* Beginning with services performed after July 1, 1991, Social Security coverage (old-age, survivors, disability, and hospital insurance) is mandatory, with certain exceptions, for services performed by employees of a State, a political subdivision of a State, or of a wholly owned instrumentality of one or more of the foregoing, if the employees are not members of a retirement

system of the State, political subdivision, or instrumentality. Among the exclusions from such mandatory coverage is service performed by an employee in a position compensated solely on a fee-basis which is treated pursuant to section 211(c)(2)(E) of the Act as a trade or business for purposes of inclusion of such fees in the net earnings from self-employment.

(3) If you are a notary public, you are not a public officer even though you perform a public function. Your services as a notary public are not covered for social security purposes.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59910, Dec. 17, 1992]

§ 404.1074 Farm crew leader who is self-employed.

If you are a farm crew leader and are deemed the employer of the workers as described in § 404.1010, we consider you to be engaged in a trade or business. This includes services performed in furnishing workers to perform agricultural labor for others, as well as services performed as a member of the crew.

§ 404.1075 Members of certain religious groups opposed to insurance.

(a) You may file an application with the Internal Revenue Service for exemption from social security self-employment tax if—

(1) You are a member of a recognized religious sect or division of the sect; and

(2) You adhere to the tenets or teachings of the sect or division of the sect and for this reason are conscientiously opposed to receiving benefits from any private or public insurance that—

(i) Makes payments in the event of death, disability, old age, or retirement; or

(ii) Makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Act).

(b) Your application must be filed under the rules described in 26 CFR 1.1402(h). An application must contain or be accompanied by the applicant's waiver of all benefits and payments under title II and part A of title XVIII of the Act. See § 404.305 for the effect of the filing of the waiver and the granting of the exemption.

(c) Regardless of whether you meet all these conditions, your application for exemption will not be approved unless we find that—

(1) The sect or division of the sect has established tenets or teachings which cause you to be conscientiously opposed to the types of insurance benefits described in paragraph (a)(2) of this section;

(2) For a substantial period of time it has been the practice for members of the sect or division of the sect to make provision for their dependent members which is reasonable in view of their general level of living; and

(3) The sect or division of the sect has been in existence continuously since December 31, 1950.

(d) Your application for exemption will be approved by the Internal Revenue Service only if no benefit or other payment under title II or part A of title XVIII of the Act became payable or, but for section 203 or section 222(b) of the Act, would have become payable, to you or on your behalf at or before the time of the filing of your application for exemption.

(e) The tax exemption ceases to be effective for any taxable year ending after the time you do not meet the requirements of paragraph (a) of this section or after the time we find the religious sect or division of the sect of which you are a member no longer meets the requirements of paragraph (c) of this section. If your tax exemption ceases to be effective, your waiver of the right to receive Social Security and Medicare part A benefits will also no longer be effective. Benefits may be payable based upon your wages for and after the calendar year following the calendar year in which the event occurred upon which the cessation of the exemption is based. Benefits may be payable based upon your self-employment income for and after the taxable year in which the event occurred upon which the cessation of the exemption is based.

[45 FR 20075, Mar. 27, 1980, as amended at 58 FR 64890, Dec. 10, 1993]

§ 404.1077 Individuals under railroad retirement system.

If you are an employee or employee representative as defined in section 3231 (b) and (c) of the Code, your work is not a trade or business. Your services are covered under the railroad retirement system.

SELF-EMPLOYMENT INCOME

§ 404.1080 Net earnings from self-employment.

(a) *Definition of net earnings from self-employment.* If you are self-employed, you must first determine the amount of your net earnings from self-employment before figuring the amount of your earnings that count for social security purposes. Some of your earnings may not be included as net earnings from self-employment even though they are taxable for income tax purposes. If you are an employee but we consider you to be self-employed for social security purposes, you must figure your earnings as though you were actually self-employed unless you work for a church or church-controlled organization that has exempted its employees (see § 404.1068(f)). Subject to the special rules in §§ 404.1081 through 404.1095, the term *net earnings from self-employment* means—

(1) Your gross income, as figured under subtitle A of the Code, from any trade or business you carried on, less deductions attributed to your trade or business that are allowed by that subtitle; plus

(2) Your distributive share of income (or loss) from a trade or business carried on by a partnership of which you are a member, as described in paragraph (b) of this section.

(b) *Income or loss from a partnership.* (1) Your distributive share (whether or not actually distributed) of the income or loss from any trade or business carried on by a partnership of which you are a member, other than as a limited partner, is determined under section 704 of the Code.

(2) If you are a limited partner, your distributive share is included in your net earnings from self-employment if—

(i) The amount is payable to you for services you render to or on behalf of the partnerships; and

(ii) It is a guaranteed payment described in section 707(c) of the Code.

(3) You are a *limited partner* if your financial liability for the obligations of the partnership is limited to the amount of your financial investment in the partnership. Generally, you will not have to perform services in the operation of, or participate in the control of, the business carried on by the partnership for the taxable year involved.

(c) *Reporting methods.* Your gross income from a trade or business includes the gross income you received (under the cash method) or that accrued to you (under the accrual method) from the trade or business in the taxable year. It is immaterial that the income may be attributable in whole or in part to services you rendered or other acts you performed in a prior taxable year.

(d) *What is a taxable year.* (1) The term *taxable year* means—

(i) Your annual accounting period on which you regularly figure your income in keeping your books; or

(ii) A short period resulting from your death before the end of your annual accounting period or from a change of your annual accounting period.

(2) The term *annual accounting period* means—

(i) A calendar year, consisting of 12 months ending on December 31; or

(ii) A fiscal year, consisting of—

(A) 12 months ending on the last day of any month other than December; or

(B) A period, if elected under section 441 of the Code, that varies from 52 to 53 weeks and always ends on the same day of the week that occurs last in a calendar month or nearest to the last day of the calendar month.

(3) Your taxable year for figuring self-employment income is the same as your taxable year for the purposes of subtitle A of the Code. Your taxable year is a calendar year if—

(i) You keep no books;

(ii) You have no annual accounting period; or

(iii) You have an annual accounting period that differs from the definition of fiscal year as described in paragraph (d)(2)(ii) of this section.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§ 404.1081 General rules for figuring net earnings from self-employment.

(a) *Determining net earnings.* (1) In determining your gross income and the deductions attributable to your trade or business for the purpose of determining your net earnings from self-employment, the provisions that apply to the taxes imposed by sections 1 and 3 of the Code are used.

(2) If you use the accrual method of accounting to figure your taxable income from a trade or business, you must use the same method in determining your net earnings from self-employment.

(3) If you are engaged in a trade or business of selling property on the installment plan and elect, under the provisions of section 453 of the Code, to use the installment method of accounting in figuring your income, you must use the installment method in determining your net earnings from self-employment.

(4) Any income which can be excluded from gross income under any provision of subtitle A of the Code cannot be counted in determining your net earnings from self-employment, unless—

(i) You are a resident of Puerto Rico (see § 404.1089);

(ii) You are a minister or member of a religious order (see § 404.1091);

(iii) You are a United States citizen or resident engaged in a trade or business outside the United States (see § 404.1092); or

(iv) You are a citizen of, or have income from sources within, certain possessions of the United States (see § 404.1093).

(b) *Trade or business carried on.* You must carry on the trade or business either personally or through agents or employees. Income from a trade or business carried on by an estate or trust is not included in determining the net earnings from self-employment of the individual beneficiaries of the estate or trust.

(c) *Aggregate net earnings.* If you are engaged in more than one trade or business, your net earnings from self-employment consist of the total of the net income and losses of all the trades or businesses you carry on. A loss in one trade or business you carry on offsets the income from another trade or business.

(d) *Partnerships.* When you have net earnings from self-employment from a partnership as described in § 404.1080 (a) and (b), those net earnings are combined with your other net earnings from self-employment in determining your total net earnings from self-employment for the taxable year.

(e) *Different taxable years.* If you are a partner and your taxable year is different from that of the partnership, you must include, in figuring your net earnings from self-employment, your distributive share of the income or loss of the partnership for its taxable year ending with or within your taxable year. For the special rule in case of the termination of a partner's taxable year as a result of death, see § 404.1087.

(f) *Meaning of partnerships.* A partnership for social security purposes is one that is recognized as a partnership for income tax purposes. For income tax purposes, the term *partnership* includes not only a partnership as known under common law, but also a syndicate, group, pool, joint venture, or other unincorporated organization that carries on any trade or business, financial operation, or venture, and which is not a trust, estate, or a corporation.

(g) *Proprietorship taxed as domestic corporation.* If you are a proprietor of an unincorporated business enterprise and have elected to be taxed as a domestic corporation, you must figure your net earnings from self-employment without regard to the election you have made.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§ 404.1082 Rentals from real estate; material participation.

(a) *In general.* Your rentals from real estate and from personal property leased with the real estate (including rentals paid in crop shares) and the deductions attributable to the rentals are excluded in figuring your net earnings from self-employment, unless you receive the rentals in the course of a trade or business as a real estate dealer. If you are an owner or lessee of

land, rentals paid in crop shares include income you get under an agreement with another person if the arrangement provides for the following:

(1) The other person will produce agricultural or horticultural commodities on the land.

(2) The commodities produced, or the income from their sale, will be divided between you and the other person.

(3) The amount of your share depends on the amount of the commodities produced.

(b) *Real estate dealers.* (1) You are a real estate dealer if you are engaged in the business of selling real estate to customers for profit.

(2) If you merely hold real estate for investment or speculation and receive rental income from it, you are not considered a real estate dealer.

(3) If you are a real estate dealer, but also hold real estate for investment or speculation in addition to real estate you hold for sale to customers, only the rental income from the real estate held for sale to customers and the deductions attributable to it are included in determining your net earnings from self-employment. The rental income from real estate you hold for investment or speculation and the deductions attributable to it are not counted in figuring your net earnings from self-employment.

(c) *Special rule for farm rental income*—(1) *In general.* If you own or lease land, any income you derive from it is included in figuring your net earnings from self-employment if—

(i) The income results from an arrangement between you and another person which provides for the other person to produce agricultural or horticultural commodities on the land that you own or lease and for you to materially participate in the production or the management of the production of the agricultural or horticultural commodities; and

(ii) You actually do materially participate.

(2) *Nature of arrangement.* (i) The arrangement between you and the other person may be either oral or written. It must provide that the other person will produce one or more agricultural or horticultural commodities and that you will materially participate in the production or the management of the production of the commodities.

(ii) The term *production,* refers to the physical work performed and the expenses incurred in producing a commodity. It includes activities like the actual work of planting, cultivating, and harvesting crops, and the furnishing of machinery, implements, seed, and livestock.

(iii) The term *management of the production,* refers to services performed in making managerial decisions about the production of the crop, such as when to plant, cultivate, dust, spray, or harvest, and includes advising and consulting, making inspections, and making decisions on matters, such as rotation of crops, the type of crops to be grown, the type of livestock to be raised, and the type of machinery and implements to be furnished.

(3) *Material participation.* (i) If you show that you periodically advise or consult with the other person, who under the rental arrangement produces the agricultural or horticultural commodities, and also show that you periodically inspect the production activities on the land, you will have presented strong evidence that you are materially participating.

(ii) If you also show that you furnish a large portion of the machinery, tools, and livestock used in the production of the commodities, or that you furnish or advance monies, or assume financial responsibility, for a substantial part of the expense involved in the production of the commodities, you will have established that you are materially participating.

(4) *Employees or agents.* We consider any farm rental arrangement entered into by your employee or agent and another person to be an arrangement entered into by you. However, we do not consider the services of an employee or agent as your services in determining the extent to which you have participated in the production or management of production of a commodity.

(5) *Examples.*

Example 1. After the death of her husband, Ms. A rents her farm, together with its machinery and equipment, to B for one-half of the proceeds from the commodities produced on the farm by B. It is agreed that B will live

in the tenant house on the farm and be responsible for the overall operation of the farm, such as planting, cultivating, and harvesting the field crops, caring for the orchard and harvesting the fruit and caring for the livestock and poultry. It also is agreed that Ms. A will continue to live in the farm residence and help B operate the farm. Under the agreement it is expected that Ms. A will regularly operate and clean the cream separator and feed the poultry flock and collect the eggs. When possible she will assist B in such work as spraying the fruit trees, penning livestock, culling the poultry, and controlling weeds. She will also assist in preparing the meals when B engages seasonal workers. The agreement between Ms. A and B clearly provides that she will materially participate in the overall production operations to be conducted on her farm by B. In actual practice, Ms. A regularly performs those services. The regularly performed services are material to the production of an agricultural commodity, and the services performed are material to the production operations to which they relate. The furnishing of a substantial portion of the farm machinery and equipment also supports the conclusion that Ms. A has materially participated. Accordingly, the rental income Ms. A receives from her farm should be included in her net earnings from self-employment.

Example 2. G owns a fully-equipped farm which he rents to H under an arrangement which provides that G will materially participate in the management of the production of crops raised on the farm under the arrangement. G lives in town about 5 miles from the farm. About twice a month he visits the farm and looks over the buildings and equipment. G may occasionally, in an emergency, discuss with H some phase of a crop production activity. In effect, H has complete charge of the management of farming operations regardless of the understanding between him and G. Although G pays one-half of the cost of the seed and fertilizer and is charged for the cost of materials purchased by H to make all necessary repairs, G's activities are not material in the crop production activities. Accordingly, G's income from the crops is not included in net earnings from self-employment.

(d) *Rental income from living quarters*—(1) *No services provided for occupants.* Payments you receive for renting living quarters in a private residence, duplex, or multiple-housing unit are generally rental income from real estate. Except in the case of real estate dealers, these payments are excluded in determining net earnings from self-employment, even if the payments are in part attributable to personal property furnished under the lease.

(2) *Services provided for occupants.* (i) Payments you receive for renting living quarters where services are also provided to the occupant, as in hotels, boarding houses, or apartment houses furnishing hotel services, or in tourist camps or tourist homes, are included in determining your net earnings from self-employment. Any payments you receive for the use of space in parking lots, warehouses, or storage garages are also included in determining your net earnings from self-employment.

(ii) Generally, we consider services to be provided to the occupant if they are primarily for the occupant's convenience and are other than those usually provided in connection with the rental of rooms or other space for occupancy only. We consider the supplying of maid service to be a service provided to the occupant. However, we do not consider the furnishing of heat and light, the cleaning of public entrances, exits, stairways, and lobbies and the collection of trash, as services provided to the occupant.

Example: A owns a building containing four apartments. During the taxable year, A received $1,400 from apartments numbered 1 and 2, which are rented without services provided to the occupants, and $3,600 from apartments numbered 3 and 4, which are rented with services provided. A's fixed expenses for the four apartments are $1,200 during the taxable year. In addition, A has $500 of expenses attributable to the services provided to the occupants of apartments 3 and 4. In determining his net earnings from self-employment, A includes the $3,600 received from apartments 3 and 4, and the expenses of $1,100 ($500 plus one-half of $1,200) attributable to them. The rentals and expenses attributable to apartments 1 and 2 are excluded. Therefore, A has $2,500 of net earnings from self-employment from the building for the taxable year.

(e) *Treatment of business income which includes rentals from real estate.* If an individual or a partnership is engaged in a trade or business other than real estate, and part of the income is rentals from real estate, only that part of the income which is not rentals and the expenses attributable to that portion are included in determining net earnings from self-employment.

§ 404.1083 Dividends and interest.

(a) The dividends you receive on shares of stock are excluded in determining your net earnings from self-employment, unless you are a dealer in stocks and securities and receive the dividends in the course of your trade or business.

(b) The interest you receive on a bond, debenture, note, certificate, or other evidence of indebtedness issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision) is excluded in determining your net earnings from self-employment, unless you are a dealer in stocks and securities and receive the interest in the course of your trade or business.

(c) If you hold stocks or securities for investment or speculation purposes, any dividends and interest you receive that are excludable under paragraphs (a) and (b) of this section are excluded in determining your net earnings from self-employment, whether or not you are a dealer in stocks and securities.

(d) A dealer in stocks or securities is a merchant with an established place of business who is regularly engaged in the business of purchasing stocks or securities and reselling them to customers. The dealer, as a merchant, buys stocks or securities and sells them to customers with a view to making a profit. Persons who buy and sell or hold stocks or securities for investment or speculation, regardless of whether the buying or selling constitutes a trade or business, are not dealers in stocks or securities.

[45 FR 20075, Mar. 25, 1980; 45 FR 25060, Apr. 14, 1980]

§ 404.1084 Gain or loss from disposition of property; capital assets; timber, coal, and iron ore; involuntary conversion.

(a) If you are engaged in a trade or business, you must, in determining your net earnings from self-employment, exclude any gain or loss—

(1) That is considered a gain or loss from the sale or exchange of a capital asset;

(2) From the cutting of timber or from the disposal of timber or coal, even if held primarily for sale to customers, if section 631 of the Code applies to the gain or loss;

(3) From the disposal of iron ore mined in the United States, even if held primarily for sale to customers, if section 631 of the Code applies to the gain or loss; and

(4) From the sale, exchange, involuntary conversion, or other disposition of property that is not—

(i) Stock in trade or other property of a kind which would properly be included in inventory if on hand at the close of the taxable year; or

(ii) Property held primarily for sale to customers in the ordinary course of a trade or business;

(b) For purposes of paragraph (a)(4) of this section, it is immaterial whether a gain or loss is treated as a capital gain or as an ordinary gain or loss for purposes other than determining earnings from self-employment.

(c) For purposes of paragraph (a)(4) of this section—

(1) The term *involuntary conversion* means a compulsory or unintended change of property into other property or money as a result of such things as destruction, theft or seizure; and

(2) The term *other disposition* includes destruction or loss by fire, theft, storm, shipwreck, or other casualty, even though there is no change of the property into other property or money.

Example: During the taxable year 1976, A, who owns a grocery store, had a net profit of $1,500 from the sale of groceries and a gain of $350 from the sale of a refrigerator case. During the same year, he had a loss of $2,000 as a result of damage by fire to the store building. In figuring taxable income for income tax purposes, all of these items are considered. In determining net earnings from self-employment, however, only the $1,500 of profit derived from the sale of groceries is included. The $350 gain and the $2,000 loss are excluded.

§ 404.1085 Net operating loss deduction.

When determining your net earnings from self-employment, you disregard the deduction provided by section 172 of the Code that relates to net operating losses sustained in years other than the taxable year.

§ 404.1086 Community income.

If community property laws apply to income that an individual derives from a trade or business (other than a trade or business carried on by a partnership), the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the spouse carrying on such trade or business or, if such trade or business is jointly operated, treated as the gross income and deductions of each spouse on the basis of his or her respective distributive share of the gross income and deductions.

[70 FR 41955, July 21, 2005]

§ 404.1087 Figuring partner's net earnings from self-employment for taxable year which ends as a result of death.

(a) *General.* In the case of a deceased partner whose taxable year ends because of death, the deceased partner's net earnings from self-employment includes the amount of his or her distributive share of partnership ordinary income or loss for the partnership's taxable year that is attributable to an interest in the partnership through the month of death.

(b) *Computation.* (1) The deceased partner's distributive share of partnership ordinary income or loss for the partnership taxable year in which death occurred is determined by applying the rules contained in paragraphs (d) and (f) of § 404.1081.

(2) The portion of the distributive share to be included in the deceased partner's net earnings from self-employment for his or her last taxable year is determined by treating the ordinary income or loss constituting the distributive share as having been realized or sustained ratably over the partnership taxable year during which the deceased partner had an interest in the partnership and during which the deceased partner's estate, or any other person succeeding by reason of the death to rights to his partnership interest, held an interest in the partnership.

(c) *Deceased partner's distributive share.* A deceased partner's distributive share includes the distributive share of the estate or of any other person succeeding to the interest of a deceased partner. It does not include any share attributable to a partnership interest that was not held by the deceased partner at the time of death. If a deceased partner's estate should acquire an interest in a partnership in addition to the interest to which it succeeded upon the death of the deceased partner, the amount of the distributive share attributable to the additional interest acquired by the estate is not included in computing the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year.

(d) *Options available to farmers.* In determining the applicability of the optional method of figuring net earnings from self-employment to a member of a farm partnership it is necessary to determine the partner's distributive share of partnership gross income or distributive share of income described in section 702(a)(8) of the Code.

§ 404.1088 Retirement payment to retired partners.

(a) *In general.* If you are a retired partner, in figuring your net earnings from self-employment you must exclude payments made to you on a periodic basis by a partnership on account of your retirement and which are to continue until your death. This exclusion applies only if the payments are made under a written plan which meets the requirements set out in 26 CFR 1.1402(a)–(17) and the conditions in paragraph (b) of this section are met. The necessary requirements and conditions must be met throughout the entire partnership's taxable year for the payments to be excluded so that either all or none of the payments are excluded.

(b) *Other conditions.* You must have been paid your full share of the partnership's capital before the close of the partnership's taxable year in which retirement payments are made. Also, no member of the partnership can have any financial obligations to you (in his or her capacity as a partner) except to make the retirement payments. Lastly, you cannot perform any services for the partnership in the partnership's taxable year which falls wholly or partially in your taxable year in which you receive the retirement payments.

Example: D, a partner in the DEF partnership, retired from the partnership as of December 31, 1976. The taxable year of both D and the partnership is the calendar year. During the partnership's taxable year ending December 31, 1977, D rendered no service to any trade or business carried on by the partnership. On or before December 31, 1977, all obligations (other than retirement payments under the plan) from the other partners to D were liquidated, and D's share of the capital of the partnership was paid to him. Retirement payments received by D under the partnership's plan in his taxable year ending December 31, 1977, are excluded in determining net earnings from self-employment (if any) for that taxable year.

§ 404.1089 Figuring net earnings for residents and nonresidents of Puerto Rico.

(a) *Residents.* If you are a resident of Puerto Rico, whether or not you are an alien, a citizen of the United States, or a citizen of Puerto Rico, you must figure your net earnings from self-employment in the same manner as would a citizen of the United States residing in the United States. In figuring your net earnings from self-employment you must include your income from sources in Puerto Rico even though you are a resident of Puerto Rico during the entire taxable year.

(b) *Nonresidents.* A citizen of Puerto Rico, who is also a citizen of the United States and who is not a resident of Puerto Rico must figure net earnings from self-employment in the same manner as other citizens of the United States.

§ 404.1090 Personal exemption deduction.

The deduction provided by section 151 of the Code, relating to personal exemptions, is excluded in determining net earnings from self-employment.

§ 404.1091 Figuring net earnings for ministers and members of religious orders.

(a) *General.* If you are a duly ordained, commissioned, or licensed minister of a church or a member of a religious order who has not taken a vow of poverty, we consider you to be engaged in a trade or business under the conditions described in § 404.1071 with regard to services described in § 404.1023 (c) and (e). In figuring your net earnings from self-employment from performing these services, you must include certain income (described in paragraphs (b) and (c) of this section) that may be excluded from your gross income for income tax purposes.

(b) *Housing and meals.* You must include in figuring your net earnings from self-employment the rental value of a home furnished to you and any rental allowance paid to you as payment for services performed in the exercise of your ministry or in the exercise of duties required by your order even though the rental value or rental allowance may be excluded from gross income by section 107 of the Code. Also, the value of any meals or lodging furnished to you in connection with the performance of these services is included in figuring your net earnings from self-employment even though their value is excluded from gross income by section 119 of the Code.

(c) *Housing allowance when included in retirement pay.* You must exclude any parsonage or housing allowance included in your retirement pay or any other retirement benefit received after retirement pursuant to a church plan as defined in section 414(e) of the Internal Revenue Code when computing your net earnings from self-employment. For example, if a minister retires from Church A and the rental value of a parsonage or any other allowance is included in his/her retirement pay, the parsonage allowance must be excluded when determining net earnings from self-employment. However, if this same retired minister goes to work for Church B and is paid a parsonage allowance by Church B, this new income must be included when computing net earnings from self-employment.

(d) *Services outside the United States.* If you are a citizen or resident of the United States performing services outside the United States which are in the exercise of your ministry or in the exercise of duties required by your order, your net earnings from self-employment from the performance of these services are figured as described in paragraph (b) of this section. However, they are figured without regard to the exclusions from gross income provided

in sections 911 and 931 of the Code relating to earned income from services performed outside the United States and from sources within possessions of the United States.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985; 70 FR 41955, July 21, 2005]

§ 404.1092 Figuring net earnings for U.S. citizens or residents living outside the United States.

(a) *Taxable years beginning after December 31, 1983.* If you are a citizen or resident of the United States and are engaged in a trade or business outside the United States, your net earnings from self-employment are figured without regard to the exclusion from gross income provided by section 911 (a)(1) of the Code.

(b) *Taxable years beginning after December 31, 1981, and before January 1, 1984.* If you are a citizen of the United States and were engaged in a trade or business outside the United States, your net earnings from self-employment are figured without regard to the exclusion from gross income provided by section 911(a)(1) of the Code unless you are a resident of a foreign country or countries for an uninterrupted period which includes an entire taxable year.

[50 FR 36574, Sept. 9, 1985]

§ 404.1093 Possession of the United States.

In using the exclusions from gross income provided under section 931 of the Code (relating to income from sources within possessions of the United States) and section 932 of the Code (relating to citizens of possessions of the United States) for purposes of figuring your net earnings from self-employment, the term *possession of the United States* shall be deemed not to include the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, or American Samoa.

[45 FR 20075, Mar. 27, 1980, as amended at 69 FR 51556, Aug. 20, 2004]

§ 404.1094 Options available for figuring net earnings from self-employment.

(a) *General.* If you have income from a trade or business in certain situations, you have options for figuring your net earnings from self-employment. The options available to you depend on whether you have income from an agricultural trade or business or a non-agricultural trade or business. For a definition of agricultural trade or business see § 404.1095.

(b) *Agricultural trade or business.* The net earnings from self-employment you derive from an agricultural trade or business may, at your option, be figured as follows:

(1) *Gross income of $2,400 or less.* If your gross income is $2,400 or less you may, at your option, report 66⅔ percent of the gross income as net earnings from self-employment instead of your actual net earnings from your business.

(2) *Gross income of more than $2,400.* If your gross income is more than $2,400 and your actual net earnings from your business are less than $1,600 you may, at your option, report $1,600 as net earnings from self-employment instead of your actual net earnings. If your actual net earnings are $1,600 or more you cannot use the optional method.

(3) *Two or more agricultural trades or businesses.* If you carry on more than one agricultural trade or business as a sole proprietor or as a partner, you must combine your gross income and net income from each trade or business to find out whether you may use the optional method of figuring net earnings.

(c) *Non-agricultural trade or business.* (1) The net earnings from self-employment you derive from a non-agricultural trade or business may be reported under an optional method if you are self-employed on a regular basis (as defined in paragraph (c)(4) of this section). You cannot use the optional method of reporting for more than 5 taxable years, and you cannot report less than your actual net earnings from self-employment.

(2) *Computation.* If your actual net earnings from self-employment are less than $1,600 and less than 66⅔ percent of your gross income, you may, at your

option, report 66⅔ percent of your gross income (but not more than $1,600) as your net earnings from self-employment.

Example: A operates a grocery store and files income tax returns on a calendar year basis. A meets the *self-employed on a regular basis* requirement because actual net earnings from self-employment were $400 or more in 1976 and in 1977. Gross income and net profit from operating the grocery store in 1978 through 1980 are as follows:

	1978	1979	1980
Gross income	$2,800	$1,200	$1,000
Net profit	300	400	800

For the year 1978, A may report as annual net earnings from self-employment either—

(i) None. (Actual net earnings from self-employment are less than $400); or

(ii) $1,600. (Non-agricultural option, 66⅔ percent of $2,800, but not to exceed the $1,600 maximum.)

For the year 1979, A may report as annual net earnings from self-employment either—

(i) $400. (Actual net earnings from self-employment); or

(ii) $800. (Non-agricultural option, 66⅔ percent of $1,200.)

For the year 1980, A must report $800, the actual net earnings from self-employment. The non-agricultural option is not available because A's actual net earnings are not less than 66⅔ percent of the gross income.

(3) *Figuring net earnings from both non-agricultural and agricultural self-employment.* If you are self-employed on a regular basis, you may use the non-agricultural optional method of reporting when you have both non-agricultural and agricultural trades or businesses. However, in order to use this method, your actual net earnings from non-agricultural self-employment combined with your actual net earnings from agricultural self-employment, or your optional net earnings from agricultural self-employment, must be less than $1,600, and the net non-agricultural earnings must be less than 66⅔ percent of your gross non-agricultural income. If you qualify for using both the non-agricultural and agricultural option, you may report less than your actual total net earnings, but not less than your actual net earnings from non-agricultural self-employment alone. If you elect to use both options in a given taxable year, the combined maximum reportable net earnings from self-employment may not exceed $1,600.

Example: C was regularly self-employed. She derived actual net earnings from self-employment of $400 or more in 1975 and in 1976. Her gross income and net profit from operating both a grocery store and a farm in 1978 are:

GROCERY STORE	
Gross income	$1,000
Net profit	800
FARM	
Gross income	$2,600
Net profit	400

For the year 1978, C may report $1,200 (actual net earnings from self-employment from both businesses), or $2,400 ($1,600 agricultural option (66⅔ percent of $2,600 farm gross income not to exceed $1,600) and $800 grocery store profit). C cannot use the non-agricultural option for 1978 because her actual grocery store net exceeds 66⅔ percent of her grocery store gross income.

(4) *Self-employed on a regular basis.* For any taxable year beginning after 1972, we consider you to be self-employed on a regular basis, or to be a member of a partnership on a regular basis, if, in at least 2 of the 3 taxable years immediately before that taxable year, you had actual net earnings from self-employment of not less than $400 from agricultural and non-agricultural trades or businesses (including your distributive share of the net income or loss from any partnership of which you are a member).

(d) *Members of partnerships.* If you are a member of a partnership you may use the optional method of reporting. Your gross income is your distributive share of the partnership's gross income (after all guaranteed payments to which section 707(c) of the Code applies have been deducted), plus your own guaranteed payment.

(e) *Computing gross income.* For purposes of this section gross income means—

(1) Under the cash method of computing, the gross receipts from the trade or business reduced by the cost or other basis of property that was purchased and sold, minus any income that is excluded in computing net earnings from self-employment; or

(2) Under the accrual method of computing, the gross income minus any income that is excluded in figuring net earnings from self-employment.

(f) *Exercise of option.* For each taxable year for which you are eligible to use the optional method and elect to use that method, you must figure your net earnings from self-employment in that manner on your tax return for that year. If you wish to change your method of reporting after your tax return is filed, you may change it by filing an amended tax return with the Internal Revenue Service or by filing with us Form 2190, Change in Method of Computing Net Earnings from Self-Employment.

§ 404.1095 Agricultural trade or business.

(a) An agricultural trade or business is one in which, if the trade or business were carried on entirely by employees, the major portion of the services would be agricultural labor (§ 404.1057).

(b)(1) If the services are partly agricultural and partly non-agricultural, the time devoted to the performance of each type of service is the test used to determine whether the major portion of the services is agricultural labor.

(2) If more than half of the time spent in performing all the services is spent in performing services that are agricultural labor, the trade or business is agricultural.

(3) If half or less of the time spent in performing all the services is spent in performing services that are agricultural labor, the trade or business is not agricultural. The time spent in performing the services is figured by adding the time spent in the trade or business during the taxable year by every individual (including the individual carrying on the trade or business and the members of that individual's family).

(c) We do not apply the rules in this section if the non-agricultural services are performed in connection with a trade or business separate and distinct from the agricultural trade or business. A roadside automobile service station on a farm is a trade or business separate and distinct from the agricultural trade or business, and the gross income from the service station, less the deductions attributable to it, is to be considered in determining net earnings from self-employment.

(d) We consider a sharefarmer (see § 404.1068(c)) or a materially participating owner or tenant (see § 404.1082(c)) to be engaged in an agricultural trade or business. We use the rules in this section to determine whether a farm crew leader who is self-employed (see § 404.1074) is engaged in an agricultural trade or business.

§ 404.1096 Self-employment income.

(a) *General.* Self-employment income is the amount of your net earnings from self-employment that is subject to social security tax and counted for social security benefit purposes. The term *self-employment income* means the net earnings from self-employment you derive in a taxable year, except as described in paragraphs (b), (c) and (d) of this section.

(b) *Maximum self-employment income.* (1) The term *self-employment income* does not include that part of your net earnings from self-employment that exceeds (or that part of your net earnings from self-employment which, when added to the wages you received in that taxable year, exceeds)—

Taxable year	Amount
Ending before 1955	$3,600
Ending in 1955 through 1958	4,200
Ending in 1959 through 1965	4,800
Ending in 1966 and 1967	6,600
Ending after 1967 and beginning before 1972	7,800
Beginning in 1972	9,000
Beginning in 1973	10,800
Beginning in 1974	13,200
Beginning in 1975	14,100
Beginning in 1976	15,300
Beginning in 1977	16,500
Beginning in 1978	17,700
Beginning in 1979	22,900
Beginning in 1980	25,900
Beginning in 1981	29,700
Beginning in 1982	32,400
Beginning in 1983	35,700
Beginning in 1984	37,800
Beginning in 1985	39,600
Beginning in 1986	42,000
Beginning in 1987	43,800
Beginning in 1988	45,000
Beginning in 1989	48,000
Beginning in 1990	51,300
Beginning in 1991	53,400
Beginning in 1992	55,500

(2) For the purpose of this paragraph the term *wages* includes remuneration paid to an employee for services covered by an agreement entered into under section 218 of the Act, or an agreement entered into under section 3121(l) of the Code, which would be

wages under section 209 of Act if the services were considered employment under section 210(a) of the Act.

(c) *Minimum net earnings from self employment.* (1) Self-employment income does not include your net earnings from self-employment when the amount of those earnings for the taxable year is less than $400. If you have only $300 of net earnings from self-employment for the taxable year you would not have any self-employment income. (Special rules apply if you are paid $100 or more and work for a church or church-controlled organization that has exempted its employees (see § 404.1068(f)).)

(2) If you have net earnings from self-employment of $400 or more for the taxable year you may have less than $400 of creditable self-employment income. This occurs where your net earnings from self-employment is $400 or more for a taxable year and the amount of your net earnings from self-employment plus the amount of the wages paid to you during that taxable year exceed the maximum creditable earnings for a year. For example, if you had net earnings from self-employment of $1,000 for 1978, and were also paid wages of $17,500 during 1978, your creditable self-employment income for 1978 would be $200.

(d) *Nonresident aliens.* A nonresident alien has self-employment income only if coverage is provided under a totalization agreement [see § 404.1913]. We do not consider an individual who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, or American Samoa to be a nonresident alien.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36575, Sept. 9, 1985; 52 FR 8250, Mar. 17, 1987; 57 FR 44098, Sept. 24, 1992; 69 FR 51556, Aug. 20, 2004]

Subpart L [Reserved]

Subpart M—Coverage of Employees of State and Local Governments

AUTHORITY: Secs. 205, 210, 218, and 702(a)(5) of the Social Security Act (42 U.S.C. 405, 410, 418, and 902(a)(5)); sec. 12110, Pub. L. 99–272, 100 Stat. 287 (42 U.S.C. 418 note); sec. 9002, Pub. L. 99–509, 100 Stat. 1970.

SOURCE: 53 FR 32976, Aug. 29, 1988, unless otherwise noted.

GENERAL

§ 404.1200 General.

(a) *Coverage under section 218 of the Act.* Under section 218 of the Social Security Act (the Act) a State may ask the Commissioner of Social Security to enter into an agreement to extend Federal old-age, survivors, disability and hospital insurance coverage to groups of employees of the State and its political subdivisions. The Commissioner shall enter into such an agreement. State and local government employees, after being covered under an agreement, have the same benefit rights and responsibilities as other employees who are mandatorily covered under the programs. For payments due on wages paid before 1987, the State assumes full financial and reporting responsibility for all groups covered under its agreement. The agreement may not be terminated in its entirety or with respect to any coverage group under that agreement. For payments due on wages paid in the year 1987 and years later, section 9002 of Pub. L. 99–509 amends section 218 of the Act by transferring responsibility for collecting contributions due and receiving wage reports from the Social Security Administration (SSA) to the Internal Revenue Service (IRS). Sections of the regulations wholly or partly affected by this amendment to the Act are appended with the phrase ''—for wages paid prior to 1987.''

(b) *Mandatory old-age, survivors, disability, and hospital insurance coverage.* Under section 210(a)(7)(F) of the Act, mandatory old-age, survivors, disability, and hospital insurance coverage is extended to certain services performed after July 1, 1991, by individuals who are employees of a State (other than the District of Columbia, Guam, the Commonwealth of the Northern Mariana Islands, or American Samoa), a political subdivision of the State, or any wholly owned instrumentality of one or more of the foregoing, and who are not members of the employer's retirement system. Certain

services are excluded from such mandatory coverage (see § 404.1020(a)(3).

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992; 62 FR 38450, July 18, 1997; 69 FR 51556, Aug. 20, 2004]

§ 404.1201 Scope of this subpart regarding coverage and wage reports and adjustments.

This subpart contains the rules of SSA about:

(a) Coverage under section 218 of the Act—

(1) How a State enters into and modifies an agreement; and

(2) What groups of employees a State can cover by agreement.

(b) Contributions, wage reports, and adjustments—for wages paid prior to 1987—

(1) How a State must identify covered employees and what records it must keep on those employees;

(2) Periodic reviews of the source records kept on covered employees;

(3) How and when a State must report wages and pay contributions;

(4) What the State's liability for contributions is and how SSA figures the amount of those contributions;

(5) What happens if a State fails to pay its contributions timely;

(6) How errors in reports and contribution payments are corrected;

(7) How overpayments of contributions are credited or refunded;

(8) How assessments are made if contributions are underpaid; and

(9) How a State can obtain administrative or judicial review of a decision on a credit, refund, or assessment.

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992; 65 FR 16813, Mar. 30, 2000]

§ 404.1202 Definitions.

(a) Terms which have special meaning in this subpart are described in this section. Where necessary, further explanation is included in the section where the term is used.

(b) *Coverage terms:*

Agreement—The agreement between the Commissioner of Social Security and the State containing the conditions under which retirement, survivors, disability and hospital insurance coverage is provided for State and local government employees.

Coverage—The extension of Social Security protection (retirement, survivors, disability, and hospital insurance) by agreement between the Commissioner of Social Security and a State to employees of the State and its political subdivisions or by agreement between the Commissioner of Social Security and an interstate instrumentality to employees of the interstate instrumentality.

Coverage group—The grouping by which employees are covered under an agreement.

Employee—An employee as defined in section 210(j) of the Act. Usually, the common-law control test is used in determining whether an employer-employee relationship exists. The term also includes an officer of a State or political subdivision.

Governmental function—The traditional functions of government: legislative, executive, and judicial.

Interstate instrumentality—An independent legal entity organized by two or more States to carry out one or more functions. For Social Security coverage purposes under section 218 of the Act, an interstate instrumentality is treated, to the extent practicable, as a ''State.''

Modification—A change to the agreement between the Commissioner of Social Security and a State which provides coverage of the services of employees not previously covered or which alters the agreement in some other respect.

Political subdivision—A separate legal entity of a State which usually has specific governmental functions. The term ordinarily includes a county, city, town, village, or school district, and in many States, a sanitation, utility, reclamation, drainage, flood control, or similar district. A political subdivision includes an instrumentality of a State, one or more political subdivisions of a State, or a State and one or more of its political subdivisions.

Proprietary function—A business engaged in by a State or political subdivision such as a public amusement park or public parking lot.

Retirement system—A pension, annuity, retirement, or similar fund or system established by a State or political subdivision.

SSA—The Social Security Administration.

State—Includes the fifty States, Puerto Rico, and the Virgin Islands. It does not include the District of Columbia, Guam, the Commonwealth of the Northern Mariana Islands, or American Samoa. ''State'' also refers to an interstate instrumentality where applicable.

We—The Social Security Administration.

(c) *Contributions, wage reporting, and adjustment terms—for wages paid prior to 1987:*

Allowance of a credit or refund—The written notice to a State of the determination by SSA of the amount owed to the State by SSA, the period involved, and the basis for the determination.

Assessment—The written notice to a State of the determination by SSA of the amount (contributions or accrued interest) owed to SSA by the State, the period involved, and the basis for the determination.

Contributions—Payments made under an agreement which the State deposits in a Federal Reserve bank. The amounts are based on the wages paid to employees whose services are covered under an agreement. These amounts are equal to the taxes imposed under the Internal Revenue Code on employers and employees in private employment.

Contribution return—Form used to identify and account for all contributions actions.

Disallowance of a State's claim for credit or refund—The written notice to a State of the determination by SSA that the State's claim for credit or refund is denied, the period involved, and the basis for the determination.

Overpayment—A payment of more than the correct amount of contributions or interest.

Underpayment—A payment of less than the correct amount of contributions or interest.

Wage reports—Forms used to identify employees who were paid wages for covered employment and the amounts of those wages paid. This includes corrective reports.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38450, July 18, 1997; 69 FR 51556, Aug. 20, 2004]

§ 404.1203 Evidence—for wages paid prior to 1987.

(a) *State's responsibility for submitting evidence.* The State, under the provisions of the agreement, is responsible for accurately reporting the wages paid employees for services covered by the agreement and for paying the correct amount of contributions due on those wages. This responsibility includes submitting evidence to verify the accuracy of the reports and payments.

(b) *Failure to submit requested evidence.* The State is required to submit information timely to SSA. If we request additional evidence to verify the accuracy of reports and payments, we specify when that evidence must be submitted. If we do not receive the evidence timely, and the State provides no satisfactory explanation for its failure to submit the evidence timely, we may proceed, if appropriate, on the basis of the information we have. Proceeding on the basis of the information we have permits us to credit the wage records of employees properly, where possible, while continuing to work with the State to resolve remaining discrepancies.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1204 Designating officials to act on behalf of the State.

(a) Each State which enters into an agreement shall designate the official or officials authorized to act on the State's behalf in administering the agreement. Each State shall inform SSA of the name, title, and address of the designated official(s) and the extent of each official's authority. For example, a State may indicate that the State official is authorized:

(1) To enter into an agreement and execute modifications to the agreement; and

(2) To carry out the ministerial duties necessary to administer the agreement.

For wages paid prior to 1987:

(3) To enter into agreements to extend or re-extend the time limit for assessment or credit;

(4) To make arrangements in connection with onsite reviews; and

(5) To request administrative review of an assessment, an allowance of a credit or refund, or a disallowance of a credit or refund.

(b) Each State shall inform SSA timely of changes in designated officials or changes in their authority.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

WHAT GROUPS OF EMPLOYEES MAY BE COVERED

§ 404.1205 Absolute coverage groups.

(a) *General.* An absolute coverage group is a permanent grouping of employees, e.g., all the employees of a city or town. It is a coverage group for coverage and reporting purposes. When used for coverage purposes, the term refers to groups of employees whose positions are not under a retirement system. An absolute coverage group may include positions which were formerly under a retirement system and, at the State's option, employees who are in positions under a retirement system but who are ineligible (see § 404.1208) to become members of that system.

(b) *What an absolute coverage group consists of.* An absolute coverage group consists of one of the following employee groups:

(1) State employees performing services in connection with the State's governmental functions;

(2) State employees performing services in connection with a single proprietary function of the State;

(3) Employees of a State's political subdivision performing services in connection with that subdivision's governmental functions;

(4) Employees of a State's political subdivision performing services in connection with a single proprietary function of the subdivision;

(5) Civilian employees of a State's National Guard units; and

(6) Individuals employed under an agreement between a State and the U.S. Department of Agriculture as agricultural products inspectors.

(c) *Designated coverage groups.* A State may provide coverage for designated (*i.e.*, selected) absolute coverage groups of the State or a political subdivision. When coverage is extended to these designated groups, the State must specifically identify each group as a designated absolute coverage group and furnish the effective date of coverage and any optional exclusion(s) for each group. Where a State has provided coverage to designated absolute coverage groups, the State may, by modifying its agreement, extend that coverage to any absolute coverage group in the State.

§ 404.1206 Retirement system coverage groups.

(a) *General.* Section 218(d) of the Act authorizes coverage of services of employees in positions under a retirement system. For purposes of obtaining coverage, a system may be considered a separate retirement system authorized by sections 218(d)(6) (A) or (B) or 218(l) of the Act. Under these sections of the Act a State may designate the positions of any one of the following groupings of employees as a separate retirement system:

(1) The entire system;

(2) The employees of the State under the system;

(3) The employees of each political subdivision in the State under the system;

(4) The employees of the State and the employees of any one or more of the State's political subdivisions;

(5) The employees of any combination of the State's political subdivisions;

(6) The employees of each institution of higher learning, including junior colleges and teachers colleges;

(7) The employees of a hospital which is an integral part of a political subdivision; or

(8) The employees in police officers' positions or firefighters' positions, or both.

If State law requires a State or political subdivision to have a retirement system, it is considered established even though no action has been taken to establish the system.

(b) *Retirement system coverage groups.* A retirement system coverage group is a grouping of employees in positions under a retirement system. Employees in positions under the system have voted for coverage for the system by referendum and a State has provided coverage by agreement or modification of its agreement. It is not a permanent grouping. It exists only for referendum and coverage purposes and is not a separate group for reporting purposes. Once coverage has been obtained, the retirement system coverage group becomes part of one of the absolute coverage groups described in § 404.1205(b).

(c) *What a retirement system coverage group consists of.* A retirement system coverage group consists of:

(1) Current employees—all employees whose services are not already covered by the agreement, who are in positions covered by the same retirement system on the date an agreement or modification of the agreement is made applicable to the system;

(2) Future employees—all employees in positions brought under the system after an agreement or modification of the agreement is signed; and

(3) Other employees—all employees in positions which had been under the retirement system but which were not under the retirement system when the group was covered (including ineligibles who had been optionally excluded from coverage under section 218(c)(3)(B) of the Act).

(d) *Referendum procedures.* Prior to signing the agreement or modification, the governor or an official of the State named by the governor (for an interstate instrumentality, its chief executive officer) must certify to the Commissioner that:

(1) All eligible employees were given at least 90 days' notice of the referendum;

(2) All eligible employees were given an opportunity to vote in the referendum;

(3) Only eligible employees were permitted to vote in the referendum;

(4) Voting was by secret written ballot on the question of whether service in positions covered by the retirement system should be included under an agreement;

(5) The referendum was conducted under the supervision of the governor or agency or individual named by him; and

(6) A majority of the retirement system's eligible employees voted for coverage under an agreement.

The State has two years from the date of a favorable referendum to enter into an agreement or modification extending coverage to the retirement system coverage group. If the referendum is unfavorable, another referendum cannot be held until at least one year after that unfavorable referendum.

(e) *Who is covered.* If a majority of the eligible employees in a retirement system vote for coverage, all employees in positions in that retirement system become covered.

(f) *Coverage of employees in positions under more than one retirement system.* (1) If an employee occupies two or more positions each of which is under a different retirement system, the employee's coverage in each position depends upon the coverage extended to each position under each system.

(2) If an employee is in a single position which is under more than one retirement system (because the employee's occupancy of that position permits her or him to become a member of more than one retirement system), the employee is covered when the retirement system coverage group including her or his position is covered under an agreement unless (A) he or she is not a member of the retirement system being covered and (B) he or she is a member of a retirement system which has not been covered. This rule also applies to the coverage of services in police officers' and firefighters' positions in States and interstate instrumentalities as discussed in § 404.1212(c).

[53 FR 32976, Aug. 29, 1988, as amended at 61 FR 38367, July 24, 1996; 62 FR 38451, July 18, 1997]

§ 404.1207 Divided retirement system coverage groups.

(a) *General.* Under section 218(d)(6)(C) of the Act certain States and under

section 218(g)(2) of the Act all interstate instrumentalities may divide a retirement system based on whether the employees in positions under that system want coverage. The States having this authority are Alaska, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin.

(b) *Divided retirement system coverage group.* A divided retirement system coverage group is a grouping under a retirement system of positions of members of the system who voted for coverage and positions of individuals who become members of the system (the ''yes'' group), and positions of members of the system who did not elect coverage (the ''no'' group) and ineligible employees (see § 404.1208). For purposes of this section for groups covered after 1959, the term ''member'' also includes individuals who have an option to become members of the retirement system but have not done so. The position of a member in the ''no'' group can be covered if, within two years after the agreement or modification extending coverage to the ''yes'' group is executed, the State provides an opportunity to transfer the position to the covered ''yes'' group and the individual occupying the position makes a written request for the transfer. The members of the ''no'' group can also be covered if, by referendum, a majority of them vote for coverage. If the majority votes for coverage, all positions of the members of the ''no'' group become covered. There is no further subdivision of the ''no'' group into those who voted for and those who voted against coverage. If the State requests, the ineligibles in the ''no'' group may become part of the ''yes'' group and have their services covered.

(c) *Referendum procedures.* To divide a retirement system, the State must conduct a referendum among the system's employees. If the system is to be divided, the governor or an individual named by him must certify to the Secretary that:

(1) The referendum was held by written ballot on the question of whether members of a retirement system wish coverage under an agreement;

(2) All members of the retirement system at the time the vote was held had the opportunity to vote;

(3) All members of the system on the date the notice of the referendum was issued were given at least 90 days' notice regarding the referendum;

(4) The referendum was conducted under the supervision of the governor or agency or person designated by him; and

(5) The retirement system was divided into two parts, one composed of positions of members of the system who voted for coverage and the other composed of the remaining positions under the retirement system.

After the referendum the State may include those members who chose coverage under its agreement as a retirement system coverage group. The State has two years from the date of the referendum to enter into an agreement or modification extending coverage to that group.

[53 FR 32976, Aug. 29, 1988, as amended at 70 FR 41956, July 21, 2005]

§ 404.1208 Ineligible employees.

(a) *Definition.* An ineligible is an employee who, on first occupying a position under a retirement system, is not eligible for membership in that system because of a personal disqualification like age, physical condition, or length of service.

(b) *Coverage of ineligible employees.* A State may, in its agreement or any modification to the agreement, provide coverage for the services of ineligible employees in one of three ways:

(1) As part of or as an addition to an absolute coverage group;

(2) As part of a retirement system coverage group covering all positions under the retirement system; or

(3) As part of or as an addition to a retirement system coverage group composed of those members in positions in a retirement system who chose coverage.

§ 404.1209 Mandatorily excluded services.

Some services are mandatorily excluded from coverage under a State's agreement. They are:

(a) Services of employees who are hired to relieve them from unemployment;

(b) Services performed in an institution by a patient or inmate of the institution;

(c) Transportation service subject to the Federal Insurance Contributions Act;

(d) Certain emergency services in case of fire, storm, snow, volcano, earthquake, flood or other similar emergency; and

(e) Services other than agricultural labor or student services which would be excluded from coverage if performed for a private employer.

(f) Services covered under section 210(a)(7)(F) of the Act. (See § 404.1200(b).)

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992]

§ 404.1210 Optionally excluded services.

Certain services and positions may, if the State requests it, be excluded from coverage. These exclusions may be applied on a statewide basis or selectively by coverage groups. They are:

(a) Services in any class or classes of elective positions;

(b) Services in any class or classes of part-time positions;

(c) Services in any class or classes of positions where the pay is on a fee basis;

(d) Any agricultural labor or student services which would also be excluded if performed for a private employer; and

(e) For modifications executed after 1994, services performed by election officials or election workers if the payments for those services in a calendar year are less than $1000 for calendar years after 1994 and before 2000, or, for calendar years after 1999, are less than the $1000 base amount as adjusted pursuant to section 218(c)(8)(B) of the Act to reflect changes in wages in the economy. We will publish this adjustment of the $1000 base amount in the FEDERAL REGISTER on or before November 1 preceding the year for which the adjustment is made.

[53 FR 32976, Aug. 29, 1988, as amended at 61 FR 38367, July 24, 1996]

§ 404.1211 Interstate instrumentalities.

For Social Security coverage purposes under section 218 of the Act, interstate instrumentalities are treated, to the extent practicable, as States, that is:

(a) They must be legally authorized to enter into an agreement with the Commissioner;

(b) They are subject to the same rules that are applied to the States;

(c) They may divide retirement systems and cover only the positions of members who want coverage; and

(d) They may provide coverage for firefighters and police officers in positions under a retirement system.

[53 FR 32976, Aug. 29, 1988, as amended at 61 FR 38368, July 24, 1996; 62 FR 38451, July 18, 1997]

§ 404.1212 Police officers and firefighters.

(a) *General.* For Social Security coverage purposes under section 218 of the Act, a police officer's or firefighter's position is any position so classified under State statutes or court decisions. Generally, these positions are in the organized police and fire departments of incorporated cities, towns, and villages. In most States, a police officer is a member of the ''police'' which is an organized civil force for maintaining order, preventing and detecting crimes, and enforcing laws. The terms ''police officer'' and ''firefighter'' do not include services in positions which, although connected with police and firefighting functions, are not police officer or firefighter positions.

(b) *Providing coverage.* A State may provide coverage of:

(1) Police officers' and firefighters' positions not under a retirement system as part of an absolute coverage group; or

(2) Police officers' or firefighters' positions, or both, as part of a retirement system coverage group.

(c) *Police officers and firefighters in positions under a retirement system.* All States and interstate instrumentalities may provide coverage for employees in police officers' or firefighters' positions, or both, which are under a retirement system by following the majority vote referendum procedures in

§ 404.1206(d). In addition, all interstate instrumentalities and the States listed in § 404.1207 may use the desire for coverage procedures described in § 404.1207.

[61 FR 38368, July 24, 1996]

HOW COVERAGE UNDER AGREEMENTS IS OBTAINED AND CONTINUES

§ 404.1214 Agreement for coverage.

(a) *General.* A State may enter into a written agreement with the Commissioner to provide for Social Security coverage for its employees or the employees of one or more of its political subdivisions. An interstate instrumentality may enter into a similar agreement for its employees. These agreements cover employees in groups of positions or by types of services rather than the individual employees.

(b) *Procedures.* A State or interstate instrumentality may request coverage by submitting to SSA a proposed written agreement for the desired coverage.

(c) *Authority to enter into an agreement for coverage*—(1) *Federal law.* Section 218(a) of the Act requires the Commissioner to enter into an agreement, at the request of the State, to extend Social Security coverage to the State's employees or those of its political subdivisions. Section 218(g) authorizes the Commissioner to enter into an agreement, at the request of an interstate instrumentality, to extend Social Security coverage to the employees of the interstate instrumentality.

(2) *State law.* State law must authorize a State or an interstate instrumentality to enter into an agreement with the Commissioner for Social Security coverage.

(d) *Provisions of the agreement.* The agreement must include:

(1) A description of the specific services to be covered and excluded;

(2) The State's promise to pay, to the Secretary of the Treasury, contributions equal to the sum of the taxes which would be required under the Federal Insurance Contributions Act from employers and employees if the employment were in the private sector;

(3) The State's promise to comply with the regulations the Commissioner prescribes for carrying out the provisions of section 218 of the Act; and

(4) Identification of the political subdivisions, coverage groups, or services being covered and the services that are excluded.

The agreement must be signed by the authorized State or interstate instrumentality official and the Commissioner or his or her designee.

(e) *Effective date.* The agreement must specify an effective date of coverage. However, the effective date cannot be earlier than the last day of the sixth calendar year preceding the year in which the agreement is mailed or delivered by other means to the Commissioner. The agreement is effective after the effective date.

(f) *Applicability of agreement.* The agreement establishes the continuing relationship between the Commissioner and the State or interstate instrumentality except as it is modified (see §§ 404.1215–404.1217).

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997; 66 FR 28836, May 25, 2001]

§ 404.1215 Modification of agreement.

(a) *General.* A State or interstate instrumentality may modify in writing its agreement, for example, to:

(1) Exclude, in limited situations, employee services or positions previously covered;

(2) Include additional coverage groups; or

(3) Include as covered services:

(i) Services of covered employees for additional retroactive periods of time; and

(ii) Services previously excluded from coverage.

(b) *Controlling date for retroactive coverage.* A State may specify in the modification a date to make all individuals in the coverage group who were in an employment relationship on that date eligible for retroactive coverage. This date is known as the controlling date for retroactive coverage. It can be no earlier than the date the modification is mailed or otherwise delivered to the Commissioner nor can it be later than the date the modification is signed by the Commissioner. If the State does not designate a controlling date, the

date the modification is signed by the Commissioner is the controlling date.

(c) *Conditions for modification.* The provisions of section 218 of the Act which apply to the original agreement also apply to a modification to the agreement.

(d) *Effective date.* Generally, a modification must specify an effective date of coverage. However, the effective date cannot be earlier than the last day of the sixth calendar year preceding the year in which the modification is mailed or delivered by other means to the Commissioner. The modification is effective after the effective date.

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[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997; 66 FR 28836, May 25, 2001]

§ 404.1216 Modification of agreement to correct an error.

(a) *General.* If an agreement or modification contains an error, the State may correct the error by a subsequent modification to the agreement. For example, the agreement or modification incorrectly lists a covered service as an optionally excluded service or shows an improper effective date of coverage. In correcting this type of error, which affects the extent of coverage, the State must submit a modification along with evidence to establish that the error occurred. However, a modification is not needed to correct minor typographical or clerical errors. For example, an agreement or modification incorrectly lists School District No. 12 as School District No. 13. This type of error can be corrected based on a written request from the appropriate official of the State or interstate instrumentality.

(b) *Correction of errors involving erroneous reporting to the IRS—for wages paid prior to 1987.* Where a State or political subdivision makes reports and payments to the Internal Revenue Service under the provisions of the Federal Insurance Contributions Act which apply to employees in private employment in the mistaken belief that this action would provide coverage for its employees, the State may provide the desired coverage for those same periods of time by a subsequent modification to its agreement. If State law permits, the State may make that coverage effective with the first day of the first period for which the erroneous reports and payments were made. (In this instance, the limitation on retroactive coverage described in § 404.1215(d) is not applicable.) Where the State does not want to provide such retroactive coverage or is not permitted to do so by State law, the State may provide the coverage for the affected coverage group as of a specified date (§ 404.1215(b)). The coverage would then apply to the services performed by individuals as members of the coverage group

(1) Who were employees on that date, and

(2) Whose wages were erroneously reported to IRS, and

(3) For whom a refund of FICA taxes has not been obtained at the time the Commissioner.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997; 66 FR 28836, May 25, 2001]

§ 404.1217 Continuation of coverage.

The coverage of State and local government employees continues as follows:

(a) *Absolute coverage group.* Generally, the services of an employee covered as a part of an absolute coverage group (see § 404.1205) continue to be covered indefinitely. A position covered as a part of an absolute coverage group continues to be covered even if the position later comes under a retirement system. This includes policemen's and firemen's positions which are covered with an absolute coverage group.

(b) *Retirement system coverage group.* Generally, the services of employees in positions covered as a part of a retirement system coverage group continue to be covered indefinitely. For a retirement system coverage group made up of members who chose coverage, a position continues to be covered until it is removed from the retirement system and is no longer occupied by a member who chose coverage or by a new member of the system. Coverage is not terminated because the positions are later covered under additional retirement

systems or removed from coverage under a retirement system, or because the retirement system is abolished with respect to the positions. However, if the retirement system has been abolished, newly created or reclassified positions or positions in a newly created political subdivision cannot be covered as a part of the retirement system coverage group. If the retirement system is not abolished, a newly created or reclassified position is a part of the coverage group if the position would have been a part of the group had it existed earlier. If the retirement system coverage group is made up of members who chose coverage, the newly created or reclassified position is a part of the coverage group if it is occupied by a member who chose coverage or by a new member.

§ 404.1218 Resumption of coverage.

Before April 20, 1983, an agreement could be terminated in its entirety or with respect to one or more coverage groups designated by the State. Coverage of any coverage group which has been previously terminated may be resumed by a modification to the agreement.

§ 404.1219 Dissolution of political subdivision.

If a political subdivision whose employees are covered under the agreement is legally dissolved, the State shall give us satisfactory evidence of its dissolution or nonexistence. The evidence must establish that the entity is not merely inactive or dormant, but that it no longer legally exists. We will notify the State whether the evidence is satisfactory.

How To Identify Covered Employees

§ 404.1220 Identification numbers.

(a) *State and local governments.* When a State submits a modification to its agreement under section 218 of the Act, which extends coverage to periods prior to 1987, SSA will assign a special identification number to each political subdivision included in that modification. SSA will send the State a Form SSA–214–CD, ''Notice of Identifying Number,'' to inform the State of the special identification number(s). The special number will be used for reporting the pre-1987 wages to SSA. The special number will also be assigned to an interstate instrumentality if pre-1987 coverage is obtained and SSA will send a Form SSA–214–CD to the interstate instrumentality to notify it of the number assigned.

(b) *Coverage group number for coverage groups.* If a State's agreement provides coverage for a State or a political subdivision based on designated proprietary or governmental functions, the State shall furnish a list of those groups. The list shall identify each designated function and the title and business address of the official responsible for filing each designated group's wage report. SSA assigns a coverage group number to each designated group based on the information furnished in the list.

(c) *Unit numbers for payroll record units.* SSA assigns, at a State's request, unit numbers to payroll record units within a State or political subdivision. When a State requests separate payroll record unit numbers, it must furnish the following:

(1) The name of each payroll record unit for the coverage group; and

(2) The title and business address of the official responsible for each payroll unit.

(d) *Unit numbers where contribution amounts are limited—for wages paid prior to 1987.* An agreement, or modification of an agreement, may provide for the computation of contributions as prescribed in § 404.1256 for some employees of a political subdivision. In this situation, SSA assigns special unit numbers to the political subdivision to identify those employees. SSA does not assign a special unit number to a political subdivision in which the contributions for all employees are computed as prescribed in § 404.1256.

(e) *Use.* For wages paid prior to 1987, the employer shall show the appropriate SSA-issued identifying number,

including any coverage group or payroll record unit number, on records, reports, returns, and claims to report wages, adjustments, and contributions.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 60 FR 42433, Aug. 16, 1995; 64 FR 33016, June 21, 1999; 66 FR 28836, May 25, 2001]

WHAT RECORDS OF COVERAGE MUST BE KEPT

§ 404.1225 Records—for wages paid prior to 1987.

(a) *Who keeps the records.* Every State which enters into an agreement shall keep, or require the political subdivisions whose employees are included under its agreement to keep, accurate records of all remuneration (whether in cash or in a medium other than cash) paid to employees performing services covered by that agreement. These records shall show for each employee:

(1) The employee's name, address, and Social Security number;

(2) The total amount of remuneration (including any amount withheld as contributions or for any other reason) and the date the remuneration was paid and the period of services covered by the payment;

(3) The amount of remuneration which constitutes wages (see § 404.1041 for wages and §§ 404.1047–404.1059 for exclusions from wages); and

(4) The amount of the employee's contribution, if any, withheld or collected, and if collected at a time other than the time such payment was made, the date collected. If the total remuneration (paragraph (a)(2) of this section) and the amount which is subject to contribution (paragraph (a)(3) of this section) are not equal, the reason shall be stated.

The State shall keep copies of all returns, reports, schedules, and statements required by this subpart, copies of claims for refund or credit, and copies of documents about each adjustment made under § 404.1265 or § 404.1271 as part of its records. These records may be maintained by the State or, for employees of a political subdivision, by the political subdivision. Each State shall use forms and systems of accounting as will enable the Commissioner to determine whether the contributions for which the State is liable are correctly figured and paid.

(b) *Place and period of time for keeping records.* All records required by this section shall:

(1) Be kept at one or more convenient and safe locations accessible to reviewing personnel (see § 404.1232(a));

(2) Be available for inspection by reviewing personnel at any time; and

(3) Be maintained for at least four years from the date of the event recorded. (This four-year requirement applies regardless of whether, in the meantime, the employing entity has been legally dissolved or, before April 20, 1983, the agreement was terminated in its entirety or in part.)

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997; 66 FR 28836, May 25, 2001]

REVIEW OF COMPLIANCE BY STATE WITH ITS AGREEMENT

§ 404.1230 Onsite review program.

To ensure that the services of employees covered by a State's agreement are reported and that those employees receive Social Security credit for their covered earnings, we periodically review the source records upon which a State's contribution returns and wage reports are based. These reviews are designed:

(a) To measure the effectiveness of the State's systems for ensuring that all wages for those employees covered by its agreement are reported and Social Security contributions on those wages are paid;

(b) To detect any misunderstanding of coverage or reporting errors and to advise the State of the corrective action it must take; and

(c) To find ways to improve a State's recordkeeping and reporting operations for the mutual benefit of the State and SSA.

§ 404.1231 Scope of review.

The onsite review focuses on four areas:

(a) State's controls and recordkeeping—to assess a State's systems

for assuring timely receipt, correctness, and completeness of wage reports and contribution returns;

(b) Instruction, education, and guidance a State provides local reporting officials—to assess a State's systems for assuring on a continuing basis that all reporting officials and their staffs have the necessary instructions, guidelines, and training to meet the State's coverage, reporting and recordkeeping requirements;

(c) Compliance by reporting officials—to assess a State's systems for assuring that the reporting officials in the State have adequate recordkeeping procedures, are properly applying the appropriate provisions of the State's agreement, and are complying with reporting requirements; and

(d) Quality control with prompt corrective action—to assess a State's systems for assuring that its reports and those of its political subdivisions are correct, for identifying the causes and extent of any deficiencies, and for promptly correcting these deficiencies.

§ 404.1232 Conduct of review.

(a) Generally, SSA staff personnel conduct the onsite review. Occasionally, members of the Office of the Inspector General may conduct or participate in the review.

(b) The review is done when considered necessary by SSA or, if practicable, in response to a State's specific request for a review.

(c) All pertinent source records prepared by the State or its political subdivisions are reviewed, on site, to verify the wage reports and contribution returns. We may review with the appropriate employees in a subdivision those source records and how the information is gathered, processed, and maintained. We notify the State's Social Security Administrator when we plan to make the review and request her or him to make the necessary arrangements.

(d) The review is a cooperative effort between SSA and the States to improve the methods for reporting and maintaining wage data to carry out the provisions of the agreement.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1234 Reports of review's findings.

We provide the State Social Security Administrator with reports of the review's findings. These reports may contain coverage questions which need development and resolution and reporting errors or omissions for the State to correct promptly. These reports may also recommend actions the State can take to improve its information gathering, recordkeeping, and wage reporting systems, and those of its political subdivisions.

How To Report Wages and Contributions—for Wages Paid Prior to 1987

§ 404.1237 Wage reports and contribution returns—general—for wages paid prior to 1987.

(a) *Wage reports.* Each State shall report each year the wages paid each covered employee during that year. With the wage report the State shall also identify, as prescribed by SSA, each political subdivision by its assigned identification number and, where appropriate, any coverage group or payroll record unit number assigned.

(b) *Wage reports of remuneration for agricultural labor.* A State may exclude from its agreement any services of employees the remuneration for which is not wages under section 209(h)(2) of the Act. Section 209(h)(2) excludes as wages the cash remuneration an employer pays employees for agricultural labor which is less than $150 in a calendar year, or, if the employee performs the agricultural labor for the employer on less than 20 days during a calendar year, the cash remuneration computed on a time basis. If a State does exclude the services and the individual meets the cash-pay or 20-day test described in § 404.1056, the State shall identify on the wage report and on any adjustment report each individual performing agricultural labor and the amount paid to her or him.

(c) *Contribution returns.* The State shall forward the contribution return as set out in § 404.1249(b). It shall make contribution payments under § 404.1262.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1239 Wage reports for employees performing services in more than one coverage group—for wages paid prior to 1987.

(a) *Employee of State in more than one coverage group.* If a State employee is in more than one coverage group, the State shall report the employee's total wages, up to the annual wage limitations in § 404.1047, as though the wages were paid by only one of the coverage groups.

(b) *Employee of political subdivision in more than one coverage group.* If an employee of a political subdivision is in more than one coverage group, the State shall report the employee's total wages, up to the annual wage limitations in § 404.1047, as though the wages were paid by only one of the coverage groups.

(c) *Employee of State and one or more political subdivisions.* If an individual performs covered services as an employee of the State and an employee of one or more political subdivisions and the State agreement does not provide for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, the State and each political subdivision shall report the amount of covered wages it paid the employee up to the annual wage limitations in § 404.1047.

(d) *Employee of more than one political subdivision.* If an individual performs covered services as an employee of more than one political subdivision and the State agreement does not provide for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, each political subdivision shall report the covered wages it paid the employee up to the annual wage limitations in § 404.1047.

(e) *Employee performing covered services for more than one political entity where section 218(e)(2) of the Act is applicable.* If an agreement provides for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, the reporting officials compute the total amount of wages paid the employee by two or more political subdivisions of a State, or a State and one or more of its political subdivisions, which were subject to section 218(e)(2) of the Act. The State reports the amount of wages paid up to the annual wage limitations in § 404.1047. The employee is treated as having only one employer. If the employee also had wages not subject to section 218(e)(2) of the Act, the State shall report those wages separately.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1242 Back pay.

(a) *Back pay defined.* Back pay is pay received in one period of time which would have been paid in a prior period of time except for a wrongful or improper action taken by an employer. It includes pay made under Federal or State laws intended to create an employment relationship (including situations where there is unlawful refusal to hire) or to protect an employee's right to wages.

(b) *Back pay under a statute.* Back pay under a statute is a payment by an employer following an award, determination or agreement approved or sanctioned by a court or administrative agency responsible for enforcing a Federal or State statute protecting an employee's right to employment or wages. Examples of these statutes are:

(1) National Labor Relations Act or a State labor relations act;

(2) Federal or State laws providing reemployment rights to veterans;

(3) State minimum wage laws; and

(4) Civil Rights Act of 1964.

Payments based on legislation comparable to and having a similar effect as those listed in this paragraph may also qualify as having been made under a statute. Back pay under a statute, excluding penalties, is wages if paid for covered employment. It is allocated to the periods of time in which it should have been paid if the employer had not violated the statute. For backpay awards affecting periods prior to 1987, a State must fill a wage report and pay the contributions due for all periods involved in the back pay award under the rules applicable to those periods.

(c) *Back pay not under a statute.* Where the employer and the employee agree on the amount payable without

any award, determination or agreement approved or sanctioned by a court or administrative agency, the payment is not made under a statute. This back pay cannot be allocated to prior periods of time but must be reported by the employer for the period in which it is paid.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1243 Use of reporting forms—for wages paid prior to 1987.

(a) *Submitting wage reports.* In the form and manner required by SSA, a State shall submit an annual report of the covered wages the State and its political subdivisions paid their employees. Any supplemental, adjustment, or correctional wage report filed is considered a part of the State's wage report.

(b) *Correction of errors.* If a State fails to report or incorrectly reports an employee's wages on its wage report, the State shall submit a corrective report as required by SSA.

(c) *Reporting on magnetic tape or other media.* After approval by SSA, a State may substitute magnetic tape or other media for any form required for submitting a report or reporting information.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1247 When to report wages—for wages paid prior to 1987.

A State shall report wages for the calendar year in which they were actually paid. If the wages were constructively paid in a prior calendar year, the wages shall be reported for the prior year (see § 404.1042(b) regarding constructive payment of wages).

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1249 When and where to make deposits of contributions and to file contribution returns and wage reports—for wages paid prior to 1987.

(a) *Deposits of contributions.* The State shall pay contributions in the manner required in § 404.1262. (For failure to make deposits when due see § 404.1265.) The contribution payment is considered made when received by the appropriate Federal Reserve bank or branch (see § 404.1262). Except as provided in paragraphs (b) (2) and (3) and paragraph (c) of this section, contributions are due and payable as follows:

(1) *For wages paid before July 1, 1980.* Contribution payments for wages paid in a calendar quarter are due on the 15th day of the second month following the end of the calendar quarter during which the wages were paid.

(2) *For wages paid beginning July 1, 1980, and before January 1984.* Contribution payments for wages paid in a calendar month are due within the thirty day period following the last day of that month.

(3) *For wages paid after December 1983 and prior to 1987.* Contribution payments for wages paid in the first half of a calendar month are due on the last day of that month. Contribution payments for wages paid in the second half of that calendar month are due on the fifteenth day of the next month. (For purposes of this section, the first half of a calendar month is the first 15 days of that month and the second half is the remainder of that month.)

(b) *Contribution returns and wage reports*—(1) *Where to be filed.* The State shall file the original copies of all contribution returns, wage reports, and adjustment reports with the SSA.

(2) *When to be filed*—(i) *For years prior to execution of agreement or modification.* If an agreement or modification provides for the coverage of employees for periods prior to 1987, the State shall pay contributions due and shall file wage reports with SSA for these periods within 90 days after the date of the notice that the Commissioner has signed the agreement or modification.

(ii) *For year of execution of agreement or modification.* If the agreement or modification provides for the coverage of employees for the year of execution of the agreement or modification, the

State may, within 90 days after the date of the notice that the Commissioner has signed the agreement or modification, submit a single contribution return and pay all contributions due for the following periods:

(A) The month in which the agreement or modification was signed;

(B) Any prior months in that year; and

(C) Any subsequent months before January 1984 (half-months after December 1983) whose contribution return and payment due date is within this 90 day period. The State shall file wage reports for that year by February 28 of the year following the date of execution or within 90 days of the date of the notice, whichever is later.

(iii) *For years after execution of agreement or modification.* Except as described in paragraph (b)(2)(ii) of this section, when the State pays its contributions under paragraph (a) of this section, it shall also file a contribution return. The State shall file the wage report for any calendar year after the year of execution of the agreement or modification by February 28 of the following calendar year.

(iv) For good cause shown, and upon written request by a State, the Commissioner may allow additional time for filing the reports and paying the related contributions described in paragraphs (b)(2)(i) and (b)(2)(ii) of this section.

(3) *Due date is on a weekend, legal holiday or Federal nonworkday.* If the last day for filing the wage report falls on a weekend, legal holiday or Federal nonworkday, the State may file the wage report on the next Federal workday. If the due date for paying contributions for the wages paid in a period (as specified in paragraph (a) of this section) falls on a weekend, legal holiday or Federal nonworkday, the State shall pay the contributions and shall file the contribution return no later than—

(i) The preceding Federal workday for wages paid in July 1980 through December 1983;

(ii) The next Federal workday for wages paid before July 1980 or after December 1983.

(4) *Submitting reports and payments.* When submitting the contribution returns or wage reports the State shall release them in time to reach SSA by the due date. When submitting contribution payments as described in § 404.1262, the State shall release the payments in time to reach the appropriate Federal Reserve bank or branch by the due date. In determining when to release any returns, reports, or payments the State shall provide sufficient time for them to timely reach their destination under the method of submission used, e.g., mail or electronic transfer of funds.

(c) *Payments by third party on account of sickness or accident disability.* Where a third party makes a payment to an employee on account of sickness or accident disability which constitutes wages for services covered under a State agreement, the wages will be considered, for purposes of the deposits required under this section, to have been paid to the employee on the date on which the employer receives notice from the third party of the amount of the payment. No interest will be assessed for failure to make a timely deposit of contributions due on such wages for which a deposit was made after December 1981 and before July 1982, to the extent that the failure to make the deposit timely is due to reasonable cause and not willful neglect.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997; 66 FR 28836, May 25, 2001]

§ 404.1251 Final reports—for wages paid prior to 1987.

If a political subdivision is legally dissolved, the State shall file a final report on that entity. The report shall include each coverage group whose existence ceases with that of the entity. It shall:

(a) Be marked ''final report'';

(b) Cover the period during which final payment of wages subject to the agreement is made; and

(c) Indicate the last date wages were paid.

With the final report, the State shall submit a statement showing the title and business address of the State official responsible for keeping the State's records and of each State and local official responsible for keeping the records for each coverage group whose existence is ended. The State shall also

identify, as prescribed by SSA, each political subdivision by its assigned number and, where applicable, any coverage group or payroll record unit number assigned.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

WHAT IS A STATE'S LIABILITY FOR CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§ 404.1255 State's liability for contributions—for wages paid prior to 1987.

A State's liability for contributions equals the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954, if the services of the employees covered by the State's agreement were employment as defined in section 3121 of the Code. The State's liability begins when those covered services are performed, for which wages are actually or constructively paid to those individuals, including wages paid in a form other than cash (see § 404.1041(d)). If an agreement is effective retroactively, the State's liability for contributions on wages paid during the retroactive period begins with the date of execution of the agreement or applicable modification. Where coverage of a coverage group has been terminated, the State is liable for contributions on wages paid for covered services even if the wages are paid after the effective date of termination of coverage.

§ 404.1256 Limitation on State's liability for contributions for multiple employment situations—for wages paid prior to 1987.

(a) *Limitation due to multiple employment.* Where an individual in any calendar year performs covered services as an employee of a State and as an employee of one or more political subdivisions of the State, or as an employee of more than one political subdivision; and the State provides all the funds for payment of the amounts which are equivalent to the taxes imposed on the employer under FICA on that individual's remuneration for those services; and no political subdivision reimburses the State for paying those amounts; the State's agreement or modification of an agreement may provide that the State's liability for the contributions on that individual's remuneration shall be computed as though the individual had performed services in employment for only one political subdivision. The State may then total the individual's covered wages from all these governmental employers and compute the contributions based on that total subject to the wage limitations in § 404.1047.

(b) *Identification of employees in multiple employment.* An agreement or modification of an agreement providing for the computation of contributions as described in paragraph (a) of this section shall identify the class or classes of employees to whose wages this method of computing contributions applies. For example, the State may provide that such computation shall apply to the wages paid to all individuals for services performed in positions covered by a particular retirement system, or to the wages paid to all individuals who are members of any two or more coverage groups designated in an agreement or modification. The State shall promptly notify SSA if the conditions in paragraph (a) of this section are no longer met by any class or classes of employees identified in an agreement or modification. In its notification, the State shall identify each class of employees and the date on which the conditions ceased to be met.

(c) *Effective date.* In the agreement or modification, the State shall provide that the computation of contributions shall apply to wages paid after the effective date stated in the agreement or modification. That date may be the last day of any calendar year; however, it may be no earlier than January 1 of the year in which the agreement or modification is submitted to SSA.

FIGURING THE AMOUNT OF THE STATE'S CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§ 404.1260 Amount of contributions—for wages paid prior to 1987.

The State's contributions are equal to the product of the applicable contribution rate (which is equivalent to

both the tax rates imposed under sections 3101 and 3111 of the Internal Revenue Code) times the amount of wages actually or constructively paid for covered services each year (subject to the wage limitations in § 404.1047) to the employee.

§ 404.1262 Manner of payment of contributions by State—for wages paid prior to 1987.

When paying its contributions, the State shall deposit its payment at the specific Federal Reserve bank or branch designated by SSA.

§ 404.1263 When fractional part of a cent may be disregarded—for wages paid prior to 1987.

In paying contributions to a Federal Reserve bank or branch, a State may disregard a fractional part of a cent unless it amounts to one-half cent or more, in which case it shall be increased to one cent. Fractional parts of a cent shall be used in computing the total of contributions.

IF A STATE FAILS TO MAKE TIMELY PAYMENTS—FOR WAGES PAID PRIOR TO 1987

§ 404.1265 Addition of interest to contributions—for wages paid prior to 1987.

(a) *Contributions not paid timely.* If a State fails to pay its contributions to the appropriate Federal Reserve bank or branch (see § 404.1262), when due under § 404.1249(a), we add interest on the unpaid amount of the contributions beginning with the date the payment was due, except as described in paragraphs (b) and (c) of this section. Interest, if charged, begins with the due date even if it is a weekend, legal holiday or Federal nonwork day. Interest is added at the rate prescribed in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

(b) *Method of making adjustment.* (1) If a State shall file a contribution return and shall accompany such return with payment of contributions due and payable as reported on such return in accordance with § 404.1249 but the amount of the contributions reported and paid is less than the correct amount of contributions due and payable and the underpayment of contributions is attributable to an error in computing the contributions (other than an error in applying the rate of contributions in effect at the time the wages were paid), the State shall adjust the underpayment by reporting the additional amount due by reason of such underpayment either as an adjustment of total contributions due with the first wage report filed after notification of the underpayment by the Social Security Administration, or as a single adjustment of total contributions due with any contribution return filed prior to the filing of such wage report.

(2) If an underpayment of contributions is due to an underreporting of or a failure to report one or more employees:

(i) Where the underreporting or failure to report has been ascertained by the State, the State may cause an adjustment by filing a report within 30 days after ascertainment of the error by the State;

(ii) Where the underreporting or failure to report has been ascertained by the Social Security Administration, a notification of underpayment shall be forwarded to the State, and the State may cause an adjustment of the underpayment by returning to the Social Security Administration, within 30 days from the date of the notification, a copy of the notification of underpayment and the State's corrected report. The report shall show the amount of wages, if any, erroneously reported for the reporting period and the correct amount of wages that should have been reported and the identification number of the State or the political subdivision for each employee who was omitted or erroneously reported. The filing to correct an underreporting of or a failure to report one or more employees' wages shall not constitute an adjustment under this section unless the wages were erroneously omitted or erroneously reported.

(c) *Payment.* The amount of each underpayment adjusted in accordance with this section shall be paid to the Federal Reserve Bank, or branch thereof, serving the district in which the State is located, without interest, at the time of reporting the adjustment; except that where any amounts due with respect to such an adjustment had

been paid in error to IRS and a refund thereof timely requested from, or instituted by, IRS, the amount of underpayment adjusted in accordance with this section, plus any interest paid by IRS on the amount of such underpayment, shall be paid to the Federal Reserve Bank, or branch thereof, serving the district in which the State is located, at the time of reporting the adjustment or within 30 days after the date of issuance by IRS of the refund of the erroneous payments, whichever is later. Except as provided in the preceding sentence of this paragraph, if an adjustment is reported pursuant to paragraph (b) of this section, but the amount thereof is not paid when due, interest thereafter accrues.

(d) *Verifying contributions paid against reported wages.* We check the computation of contributions to verify that a State has paid the correct amount of contributions on the wages it reports for a calendar year (see § 404.1249(b)(2)). If we determine that a State paid less than the amount of contributions due for that year, we add interest to the amount of the underpayment. We would add interest beginning with the date the unpaid contributions were initially due to the date those contributions are paid. However, if the total amount of the underpayment is 5 percent or less than 5 percent of the contributions due for a calendar year based upon the State's wage report and the State deposits the underpaid amount within 30 days after the date of our notification to the State of the amount due, the State may request that the interest on the underpaid amount be waived for good cause. This request must be made within 30 days of our notification to the State of the amount due. Such requests will be evaluated on an individual basis. The evaluation will include, but not be limited to, consideration of such factors as the circumstances causing the late payment, the State's past record of late payments and the amount involved.

Examples (1) The records of a political subdivision for the month of June are destroyed by fire. The State makes an estimated deposit of contributions for the month of June for that political subdivision and deposits contributions for the month of June for all other political subdivisions based on actual records. At the time SSA verifies contributions paid against reported wages, we discover that the State has paid only 97 percent of its total liability for the year. Within 30 days after we notify it of the amount due, the State asks that we waive the interest on the unpaid amount and the State deposits the unpaid amount. In this situation, we would waive the interest on the unpaid contributions.

(2) We would waive interest if:

(i) Some of the political subdivisions made small arithmetical errors in preparing their reports of wages,

(ii) After verification of the contributions paid against reported wages, SSA discovers that minimal additional contributions are due,

(iii) Within 30 days of our notice to the State regarding this underpayment the State, which usually makes its deposits timely, pays the amount due, and

(iv) Within that same 30 day period the State requests that we waive the interest due.

(3) We would not waive interest where a State frequently has problems depositing its contributions timely. Reasons given for the delays are, e.g., the computer was down, the 5 p.m. mail pickup was missed, one of the school district reports was misplaced. If requested we would not waive interest on this State's late payment of contributions based upon its past record of late payments and because of the circumstances cited.

(e) *Due date is on a weekend, legal holiday or Federal nonworkday.* If the last day of the 30-day periods specified in paragraphs (b) and (d) of this section is on a weekend, legal holiday or Federal nonworkday, the State shall make the required deposit or request for waiver of payment of interest on the next Federal workday.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1267 Failure to make timely payments—for wages paid prior to 1987.

If a State does not pay its contributions when due, the Commissioner has the authority under section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509 to deduct the amounts of the unpaid contributions plus interest at the rate prescribed from any amounts certified by her or him to the Secretary of the Treasury

for payments to the State under any other provision of the Social Security Act. The Commissioner notifies the Secretary of the Treasury of the amounts deducted and requests that the amount be credited to the Trust Funds. Amounts deducted are considered paid to the State under the other provision of the Social Security Act.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

HOW ERRORS IN REPORTS AND CONTRIBUTIONS ARE ADJUSTED—FOR WAGES PAID PRIOR TO 1987

§ 404.1270 Adjustments in general—for wages paid prior to 1987.

States have the opportunity to adjust errors in the payment of contributions. A State but not its political subdivisions is authorized to adjust errors in the underpayment of contributions. Similarly, the State shall file all claims for credits or refunds and SSA makes the credits and refunds only to the State. Generally, we do not refund contributions in cash to a State unless the State is not expected to have future liability for contributions under section 218 of the Act.

§ 404.1271 Adjustment of overpayment of contributions—for wages paid prior to 1987.

(a) *General.* If a State pays more than the correct amount of contributions, the State shall adjust the overpayment with the next contribution return filed on which the amount owed equals or exceeds the amount of the overpayment.

(b) *Overpayment due to overreporting of wages*—(1) *Report to file.* If the overpayment is due to the State's reporting more than the correct amount of wages paid to one or more employees during a reporting period and the overpayment is not adjusted under paragraph (a) of this section, the State shall file a report on the appropriate form showing:

(i) The corrected wage data as prescribed by SSA; and

(ii) The reason why the original reporting was incorrect.

(2) *Refund or credit of overpayment where section 218(e)(2) of the Act not applicable.* If:

(i) The State collected contributions from employees in excess of the amount of taxes that would have been required under section 3101 of the Internal Revenue Code; and

(ii) The State paid to the Secretary of the Treasury those contributions plus a matching amount in excess of the taxes which would have been required from an employer under section 3111 of the Code; and

(iii) The services of the employees in question would have constituted employment under section 3121(b) of the Code; and

(iv) Section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509 does not apply (see § 404.1256(a)), then the State shall adjust the overpaid contributions under paragraph (b)(1) of this section. With its adjustment the State, where appropriate, shall include on the prescribed form a statement that the employees from whom the excess contributions were collected have not received nor expect to receive a refund of excess contributions under section 6413(c) of the Internal Revenue Code of 1954 (see § 404.1275(b)). Generally, if the State does not include this statement with its adjustment request, we only refund or credit the State for up to one-half of the overpaid amount.

(c) *Refund or credit of overpayment where section 218(e)(2) of the Act applicable*—(1) *General.* If—

(i) The overreporting of the amount of wages paid to one or more employees during a reporting period(s) is due to a computation of contributions under § 404.1256 for a year or years prior to the year in which the agreement or modification providing for the computation is entered into, or

(ii) The overreporting is due to a failure to compute § 404.1256,

the State shall adjust the overpayment under paragraph (b)(1) of this section. An overpayment due to overreported wages which does not result from the computation of contributions or a failure to compute contributions under § 404.1256 shall also be adjusted by the State under paragraph (b)(1) of this section. If the adjustment of the overpayment results in an underreporting of wages for any employee by the State or any political subdivision, the State

shall include with the report adjusting the overpayment a report adjusting each underreporting. If the adjustment of the overpayment does not result in an underreporting of wages for any employee by the State or any political subdivision, the State shall include with the report adjusting the overpayment a statement that the adjustment of the overpayment does not result in any underreporting.

(2) *Amount of refund or credit.* If the State collects excess contributions from employees, the State's claim for refund or credit is limited to the overpaid amounts. (See § 404.1275 relating to adjustment of employee contributions.) If—

(i) The State collected the correct amount of contributions from employees based on the amount of wages reported and the Forms W-2 issued to the employees show only the amount of contributions actually collected, but the amount of wages reported is being adjusted downward, or

(ii) The State collects excess contributions from employees but Forms W-2 have not been issued for an amount of wages which is being adjusted downward, the State may claim a refund or credit for the overpaid amounts. Where the State's claim for refund or credit is for the total overpaid amount, the adjustment report shall include a statement that excess contributions have not been collected from employees, or, where excess contributions have been collected, that Forms W-2 have not been issued and that, when issued, they will show the correct amount of employee contributions.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1272 Refund or recomputation of overpayments which are not adjustable—for wages paid prior to 1987.

(a) *General.* If a State pays more than the correct amount of contributions or interest to the appropriate Federal Reserve bank or branch (see § 404.1262), and no adjustment in the amount of reported wages is necessary, that State may file a claim for refund or recomputation of the overpayment.

(b) *Form of claim.* No special form is required to make a claim for a refund or recomputation. If a credit is taken under § 404.1271, a claim is not required.

(c) *Proof of representative capacity.* If a report or return is made by an authorized official of the State who ceases to act in an official capacity and a claim for a refund is made by a successor official, the successor official must submit with the claim written evidence showing that he or she has the authority to make a claim for and receive a refund of any contributions paid by the former official. The written evidence is not necessary if the successor official has previously filed one or more reports or returns which contain her or his signature and official title.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1275 Adjustment of employee contributions—for wages paid prior to 1987.

The amount of contributions a State deducts from an employee's remuneration for covered services, or any correction of that amount, is a matter between the employee and the State or political subdivision. The State shall show any correction of an employee's contribution on statements it furnishes the employee under § 404.1225 of this part. Where the State issues an employee a Form W-2 and then submits an overpayment adjustment but claims less than the total overpaid amount as a refund or credit, the State shall not correct the previously issued Form W-2 to reflect that adjustment.

[53 FR 32976, Aug. 29, 1988, as amended at 65 FR 16813, Mar. 30, 2000]

§ 404.1276 Reports and payments erroneously made to Internal Revenue Service-transfer of funds—for wages paid prior to 1987.

(a) *General.* In some instances, State or local governmental entities not covered under an agreement make reports and pay contributions to IRS under the Federal Insurance Contributions Act (FICA) procedures applicable to private employers in the mistaken belief that this provides Social Security coverage under section 218 of the Act for their

employees. In other instances, entities which are covered under an agreement erroneously report to IRS, or a State or local government employee reports other employees to IRS or reports to IRS as a self-employed individual. Where these reports and payments are erroneously made to IRS, the State may correct the error and obtain coverage under its agreement as described in paragraphs (b) through (f) of this section.

(b) *Political subdivision not included in the State agreement.* We notify the State that if it desires coverage, it may be provided by either a regular modification or an error modification, depending on the circumstances (§§ 404.1215 and 404.1216). In most cases, the State may obtain coverage by a regular modification. If a regular modification cannot be used (e.g., State law does not permit the retroactive effective date which would be desired), the State may use an error modification. The effective date of either modification depends on the facts of the situation being corrected.

(c) *Political subdivision included in the agreement.* If a political subdivision included in the agreement erroneously makes reports and payments under FICA procedures, the State must correct the reportings for periods not barred by the statute of limitations. If the covered entity reported both under the agreement and under FICA procedures, we notify IRS and make necessary corrections in the earnings records. We also advise the State that the entity which reported under FICA procedures should request a refund of payments erroneously made to IRS.

(d) *State and local government employees erroneously reported as employees of individual or as self-employed*—(1) *Covered entity.* If employees of a covered entity are erroneously reported as employees of an individual or as self-employed, we advise the State that the individual who made the reports should request a refund from IRS for periods not barred by the statute of limitations. We require the State to file correctional reports and returns for any periods open under the State and local statute of limitations.

(2) *Noncovered entity.* We advise the State that the individual who made the reports should request a refund from IRS for the periods not barred by the statute of limitations. If the State wishes to provide coverage, it must submit a modification as discussed in paragraph (b) of this section. If the State does not wish to provide coverage, we void the reports. Amounts reported for periods barred by the statute of limitations remain on the earnings records.

(e) *Filing wage reports and paying contributions.* Generally, the entity or individual that makes the erroneous reports and payments requests the refund from IRS for periods not barred by the statute of limitations. The State files the necessary reports with SSA and pays any contributions due. The reports shall conform to the coverage provided by the agreement to the extent permitted by the statute of limitations. The due date for these reports depends on whether original reports or adjustment reports are involved. Reports and contribution returns for the entire retroactive period of coverage provided by a regular or error modification are due 90 days after the date of execution of the modification. The time limitations for issuing assessments and credits or refunds extend from this due date. Thus, SSA may issue assessments or credits or refunds for periods barred to refund by IRS. The State may request that reports and payments for the IRS barred periods be considered made under the agreement as described in paragraph (f) of this section.

(f) *Use of transfer procedure.* In limited situations, the State may request that reports and payments the State or a political subdivision (but not an individual) erroneously made under FICA procedures and which have been posted to the employee's earnings record be considered made under the State's agreement. We use a transfer procedure to do this. The transfer procedure may be used only where

(1) The periods are open to assessment under the State and local statute of limitations;

(2) The erroneous reports to be transferred are posted to SSA's records;

(3) The periods are barred to refund under the IRS statute of limitations; and

(4) A refund is not obtained from IRS by the reporting entity.

HOW OVERPAYMENTS OF CONTRIBUTIONS ARE CREDITED OR REFUNDED—FOR WAGES PAID PRIOR TO 1987

§ 404.1280 Allowance of credits or refunds—for wages paid prior to 1987.

If a State pays more than the amount of contributions due under an agreement, SSA may allow the State, subject to the time limitations in § 404.1282 and the exceptions to the time limitations in § 404.1283, a credit or refund of the overpayment.

§ 404.1281 Credits or refunds for periods of time during which no liability exists—for wages paid prior to 1987.

If a State pays contributions for any period of time for which contributions are not due, but the State is liable for contributions for another period, we credit the amount paid against the amount of contributions for which the State is liable. We refund any balance to the State.

§ 404.1282 Time limitations on credits or refunds—for wages paid prior to 1987.

(a) *General.* To get a credit or refund, a State must file a claim for a credit or refund of the overpaid amount with the Commissioner before the applicable time limitation expires. The State's claim for credit or refund is considered filed with the Commissioner when it is delivered or mailed to the Commissioner. Where the time limitation ends on a weekend, legal holiday or Federal nonworkday, we consider a claim timely filed if it is filed on the next Federal workday.

(b) *Time limitation.* Subject to the exceptions in § 404.1283, a State must file a claim for credit or refund of an overpayment before the end of the latest of the following time periods:

(1) 3 years, 3 months, and 15 days after the year in which the wages in question were paid or alleged to have been paid; or

(2) 3 years after the due date of the payment which included the overpayment; or

(3) 2 years after the overpayment was made to the Secretary of the Treasury.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1283 Exceptions to the time limitations on credits or refunds—for wages paid prior to 1987.

(a)(1) *Extension by agreement.* The applicable time period described in § 404.1282 for filing a claim for credit for, or refund of, an overpayment may, before the expiration of such period, be extended for no more than 6 months by written agreement between the State and the Commissioner. The agreement must involve and identify a known issue or reporting error. It must also identify the periods involved, the time limitation which is being extended and the date to which it is being extended, and the coverage group(s) and position(s) or individual(s) to which the agreement applies. The extension of the period of limitation shall not become effective until the agreement is signed by the appropriate State official and the Commissioner. (See § 404.3(c) for the applicable rule where periods of limitation expire on nonwork days.) A claim for credit or refund filed by the State before the extended time limit ends shall be considered to have been filed within the time period limitation specified in section 218(r)(1) of the Act as it read prior to the enactment of Pub. L. 99–509. (See § 404.1282.)

(2) *Reextension.* An extension agreement provided for in paragraph (a)(1) of this section may be reextended by written agreement between the State and the Commissioner for no more than 6 months at a time beyond the expiration of the prior extension or reextension agreement, and only if one of the following conditions is met:

(i) Litigation (including intrastate litigation) or a review under §§ 404.1290 or 404.1297 involving wage reports or corrections on the same issue is pending; or

(ii) The State is actively pursuing corrections of a known error which require additional time to complete; or

(iii) The Social Security Administration is developing a coverage or wage issue which was being considered before the statute of limitations expired

and additional time is needed to make a determination; or

(iv) The Social Security Administration has not issued to the State a final audit statement on the State's wage or correction reports; or

(v) There is pending Federal legislation which may substantially affect the issue in question, or the issue has national implications.

(b) *Deletion of wage entry on employee's earnings record.* If the Commissioner, under section 205(c)(5) (A), (B), or (E) of the Act, deletes a wage entry on an individual's earnings record, a claim for credit or refund of the overpayment resulting from the deletion is considered filed within the applicable time limitations in § 404.1282 if

(1) The State files the claim before the Commissioner's decision regarding the deletion of the wage entry from the individual's earnings record becomes final or

(2) The State files a claim regarding the deletion of the wage entry from the individual's earnings record which entry is erroneous because of fraud.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1284 Offsetting underpayments against overpayments—for wages paid prior to 1987.

(a) *State fails to make adjustment for allowance of credit.* If SSA notifies a State that a credit is due the State, and the State does not make the adjustment for the allowance of the credit, SSA offsets the credit against any contributions or interest due. Before making the offset, SSA will give the State an opportunity to make the adjustment.

(b) *State fails to make adjustment for underpayment of contributions or interest due.* If SSA notifies a State that contributions or interest are due, and the State does not pay the contributions or interest, SSA offsets the contributions or interest due against any credit due the State. Before making the offset, SSA will give the State an opportunity to pay the underpayment or interest due.

How Assessments for Underpayments of Contributions Are Made—for Wages Paid Prior to 1987

§ 404.1285 Assessments of amounts due—for wages paid prior to 1987.

(a) A State is liable for any amount due (which includes contributions or interest) under an agreement until the Commissioner is satisfied that the amount has been paid to the Secretary of the Treasury. If the Commissioner is not satisfied that a State has paid the amount due, the Commissioner issues an assessment for the amount due subject to the time limitations in § 404.1286 and the exceptions to the time limitations in §§ 404.1287 and 404.1289. If detailed wage information is not available, the assessment is issued based on the following:

(1) The largest number of individuals whose services are known to be covered under the agreement is used for computation purposes;

(2) The individuals are assumed to have maximum creditable earnings each year;

(3) The earnings are considered wages for covered services; and

(4) The amount computed is increased by twenty percent to insure that all covered wages are included in the assessment.

(b) If the State pays the amount assessed and the assessed amount is later determined to be more than the amount actually due, we issue a refund or credit to that State for the excess amount. When the assessment is issued within the applicable time limitation, there is no time limit on collecting the amount due. An assessment is issued on the date that it is mailed or otherwise delivered to the State.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1286 Time limitations on assessments—for wages paid prior to 1987.

(a) Subject to the exceptions to the time limitations in §§ 404.1287 and 404.1289, a State is not liable for an amount due under an agreement unless the Commissioner makes an assessment for that amount before the later of the following periods ends:

(1) Three years, 3 months, and 15 days after the year in which the wages, upon which the amount is due, were paid; or

(2) Three years after the date the amount became due.

(b) Where the time limitation ends on a weekend, legal holiday or Federal nonworkday, an assessment is considered timely if the Commissioner makes the assessment on the next Federal workday.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1287 Exceptions to the time limitations on assessments—for wages paid prior to 1987.

(a)(1) *Extension by agreement.* The applicable time period described in § 404.1286 for assessment of an amount due may, before the expiration of such period, be extended for no more than 6 months by written agreement between the State and the Commissioner. The agreement must involve and identify a known issue or reporting error. It must also identify the periods involved, the time limitation which is being extended and the date to which it is being extended, and the coverage group(s) and position(s) or individual(s) to which the agreement applies. The extension of the period of limitation shall not become effective until the agreement is signed by the appropriate State official and the Commissioner. (See § 404.3(c) for the applicable rule where periods of limitation expire on nonwork days.) An assessment made by the Commissioner before the extended time limit ends shall be considered to have been made within the time period limitation specified in section 218(q)(2) of the Act as it read prior to the enactment of Pub. L. 99–509. (See § 404.1286.)

(2) *Reextension.* An extension agreement provided for in paragraph (a)(1) of this section may be reextended by written agreement between the State and the Commissioner for no more than 6 months at a time beyond the expiration of the prior extension or reextension agreement, and only if one of the following conditions is met:

(i) Litigation (including intrastate litigation) or a review under § 404.1290 or § 404.1297 involving wage reports or corrections on the same issue is pending; or

(ii) The State is actively pursuing corrections of a known error which require additional time to complete; or

(iii) The Social Security Administration is developing a coverage or wage issue which was being considered before the statute of limitations expired and additional time is needed to make a determination; or

(iv) The Social Security Administration has not issued to the State a final audit statement on the State's wage or correction reports; or

(v) There is pending Federal legislation which may substantially affect the issue in question, or the issue has national implications.

(b) *The 365-day period.* If a State files a report before the applicable time limitation in § 404.1286 (or any extension under paragraph (a) of this section) ends and makes no payment or pays less than the correct amount due, the Commissioner may assess the State for the amount due after the applicable time limitation has ended. However, the Commissioner must make the assessment no later than the 365th day after the day the State makes payment to the Secretary of the Treasury. The Commissioner can only make this assessment on the wages paid to the reported individuals for the reported periods. The Commissioner, in making this assessment, credits the amount paid by the State on these individuals' wages for those reported periods.

(c) *Revision of employee's earnings record.* If, under section 205(c)(5) (A) or (B) of the Act, the Commissioner credits wages to an individual's earnings record, the Commissioner may make an assessment for any amount due on those wages before the Commissioner's decision on revising the individual's earnings record becomes final. (Sections 404.822(c) (1) and (2) describe the time limits for revising an earnings record where an individual has applied for monthly benefits or a lump-sum death payment or requested that we correct his earnings record.)

(d) *Overpayment of contributions on wages of employee having other wages in a period barred to assessment.* If the Commissioner allows a State a credit or refund of an overpayment for wages paid or alleged to have been paid an individual in a calendar year but the

facts upon which the allowance is based establish that contributions are due on other wages paid that individual in that year which are barred to assessment, we may make an assessment notwithstanding the periods of limitation in § 404.1286. The assessment, however, must be made before or at the time we notify the State of the allowance of the credit or refund. In this situation, the Commissioner reduces the amount of the State's credit or refund by the assessed amount and notifies the State accordingly. For purposes of this paragraph, the assessment shall only include contributions and not interest as provided for in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

Example: The State files an adjustment report timely to correct an error in the amount reported as wages for an employee. The correction reduces the employee's wages for the year to less than the maximum amount creditable. The employee has other earnings in the same year which were not reported because of the previously reported maximum amounts. The applicable time limitation for assessing contributions on wages for the year has expired before the credit was allowed. The Commissioner may assess for the underpaid contributions but no later than the date of the notice to the State that its claim for a credit had been allowed.

(e) *Evasion of payment.* The Commissioner may make an assessment of an amount due at any time where the State's failure to pay the amount due results from the fraudulent attempt of an officer or employee of the State or political subdivision to defeat or evade payment of that amount.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1289 Payment after expiration of time limitation for assessment—for wages paid prior to 1987.

The Commissioner accepts wage reports filed by a State even though the applicable time limitation described in § 404.1286 (or as the time limitation is extended under § 404.1287) has expired, provided:

(a) The State pays to the Secretary of the Treasury the amount due on the wages paid to employees performing services in the coverage group in the calendar years for which the wage reports are being made; and

(b) The State agrees in writing with the Secretary to extend the time limitation for all employees in the coverage group in the calendar years for which the wage reports are being made.

In this situation, the time period for assessment is extended until the Commissioner notifies the State that the wage reports are accepted. Where the State pays the amount due within the time period as extended under this section, the amount shall not include interest as provided for in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

SECRETARY'S REVIEW OF DECISIONS ON CREDITS, REFUNDS, OR ASSESSMENTS—FOR WAGES PAID PRIOR TO 1987

§ 404.1290 Review of decisions by the Secretary—for wages paid prior to 1987.

What decisions will be reviewed. A State, under section 218(s) of the Act as it read prior to the enactment of Pub. L. 99–509, may request review of an assessment of an amount due from the State, an allowance to the State of a credit or refund of an overpayment, or a disallowance of the State's claim for credit or refund of an overpayment. The Commissioner may review regardless of whether the amount assessed has been paid or whether the credit or refund has been accepted by the State. Prior to the Commissioner's review, however, an assessment, allowance or disallowance may be reconsidered under §§ 404.1291 through 404.1293.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1291 Reconsideration—for wages paid prior to 1987.

After the State requests review of the assessment or allowance or disallowance of a credit or refund, and prior to the Commissioner's review, that decision may be reconsidered, and affirmed, modified, or reversed. We notify the State of the reconsidered determination and the basis for it. The State may request the Commissioner to review this reconsidered determination under § 404.1294(b). In limited situations, SSA and the State may agree

that the reconsideration process should be waived, e.g., where major policy is at issue.

§ 404.1292 How to request review—for wages paid prior to 1987.

(a) *Form of request.* No particular form of request is required. However, a written request for review must:

(1) Identify the assessment, allowance or disallowance being questioned;

(2) Describe the specific issue on which the review is requested;

(3) Contain any additional information or argument relevant to that issue; and

(4) Be signed by an official authorized to request the review on behalf of the State.

(b) *Submitting additional material.* A State has 90 days from the date it requests review to submit additional evidence it wishes considered during the review process. The time limit for submitting additional evidence may be extended upon written request of the State and for good cause shown.

(Approved by the Office of Management and Budget under control number 0960–0425)

[53 FR 32976, Aug. 29, 1988, as amended at 66 FR 28836, May 25, 2001]

§ 404.1293 Time for filing request for review—for wages paid prior to 1987.

(a) *Time for filing.* The State must file its request for review within 90 days after the date of the notice of assessment, allowance, or disallowance. Usually, the date of the request for review is considered the filing date. Where the 90-day period ends on a weekend, legal holiday or Federal nonworkday, a request filed on the next Federal workday is considered as timely filed.

(b) *Extension of time.* For good cause shown, and upon written application by a State filed prior to the expiration of the time for filing a request for review, additional time for filing the request may be allowed.

§ 404.1294 Notification to State after reconsideration—for wages paid prior to 1987.

(a) The State will be notified in writing of the reconsidered determination on the assessment, allowance, or disallowance, and the basis for the determination.

(b) If the State does not agree with the reconsidered determination, it has 90 days from the date of notice of the reconsidered determination to request the Commissioner to review that determination. The rules on what the request should contain and the time for filing the request are the same as in §§ 404.1292 and 404.1293.

§ 404.1295 Commissioner's review—for wages paid prior to 1987.

Upon request by the State, the Commissioner will review the reconsidered determination (or the assessment, allowance or disallowance as initially issued if reconsideration is waived under § 404.1291). If necessary, the Commissioner may request the State to furnish additional evidence. Based upon the evidence considered in connection with the assessment, allowance or disallowance and any additional evidence submitted by the State or otherwise obtained by the Commissioner, the Commissioner affirms, modifies, or reverses the assessment, allowance or disallowance.

§ 404.1296 Commissioner's notification to the State—for wages paid prior to 1987.

The Commissioner notifies the State in writing of the decision on the assessment, allowance, or disallowance, and the basis for the decision.

How a State May Seek Court Review of Commissioner's Decision—for Wages Paid Prior to 1987

§ 404.1297 Review by court—for wages paid prior to 1987.

(a) *Who can file civil action in court.* A State may file a civil action under section 218(t) of the Act as it read prior to the enactment of Pub. L. 99–509 requesting a district court of the United States to review any decision the Commissioner makes under section 218(s) of the Act as it read prior to the enactment of Pub. L. 99–509 concerning the assessment of an amount due, the allowance of a credit or refund, or the disallowance of a claim for credit or refund.

(b) *Where the civil action must be filed.* A State must file the civil action in

the district court of the United States for the judicial district in which the State's capital is located. If the civil action is brought by an interstate instrumentality, it must file the civil action in the district court of the United States for the judicial district in which the instrumentality's principal office is located. The district court's judgment is final except that it is subject to review in the same manner as judgments of the court in other civil actions.

(c) *No interest on credit or refund of overpayment.* SSA has no authority to pay interest to a State after final judgment of a court involving a credit or refund of an overpayment made under section 218 of the Act.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1298 Time for filing civil action—for wages paid prior to 1987.

(a) *Time for filing.* The State must file the civil action for a redetermination of the correctness of the assessment, allowance or disallowance within 2 years from the date the Commissioner mails to the State the notice of the decision under § 404.1296. Where the 2-year period ends on a Saturday, Sunday, legal holiday or Federal nonwork day, an action filed on the next Federal workday is considered timely filed.

(b) *Extension of time for filing.* The Commissioner, for good cause shown, may upon written application by a State filed prior to the end of the two-year period, extend the time for filing the civil action.

§ 404.1299 Final judgments—for wages paid prior to 1987.

(a) *Overpayments.* Payment of amounts due to a State required as the result of a final judgment of the court shall be adjusted under §§ 404.1271 and 404.1272.

(b) *Underpayments.* Wage reports and contribution returns required as the result of a final judgment of the court shall be filed under §§ 404.1237–404.1251. We will assess interest under § 404.1265 where, based upon a final judgment of the court, contributions are due from a State because the amount of contributions assessed was not paid by the State or the State had used an allowance of a credit or refund of an overpayment.

Subpart N—Wage Credits for Veterans and Members of the Uniformed Services

AUTHORITY: Secs. 205 (a) and (p), 210 (l) and (m), 215(h), 217, 229, and 702(a)(5) of the Social Security Act (42 U.S.C. 405 (a) and (p), 410 (l) and (m), 415(h), 417, 429, and 902(a)(5)).

SOURCE: 45 FR 16464, Mar. 14, 1980, unless otherwise noted.

GENERAL

§ 404.1301 Introduction.

(a) The Social Security Act (Act), under section 217, provides for noncontributory wage credits to veterans who served in the active military or naval service of the United States from September 16, 1940, through December 31, 1956. These individuals are considered World War II or post-World War II veterans. The Act also provides for noncontributory wage credits to certain individuals who served in the active military or naval service of an allied country during World War II. These individuals are considered World War II veterans. In addition, certain individuals get wage credits, under section 229 of the Act, for service as members of the uniformed services on active duty or active duty for training beginning in 1957 when that service was first covered for social security purposes on a contributory basis through 2001. These individuals are considered members of the uniformed services.

(b) World War II or post-World War II veterans receive wage credits based on the length of active military or naval service, type of separation from service and, in some cases, whether the veteran is receiving another Federal benefit. However, a member of a uniformed service receives wage credits regardless of length of service, type of separation, or receipt of another Federal benefit.

(c) The Social Security Administration (SSA) uses these wage credits, along with any covered wages or self-employment income of the veteran or member of a uniformed service, to determine entitlement to, and the amount of, benefits and the lump-sum death payment that may be paid to

them, their dependents or survivors under the old-age, survivors', and disability insurance programs. These wage credits can also be used by the veteran or member of the uniformed service to meet the insured status and quarters of coverage requirements for a period of disability.

(d) This subpart tells how veterans or members of the uniformed services obtain wage credits, what evidence of service SSA requires, how SSA uses the wage credits, and how the wage credits are affected by payment of other benefits.

(e) This subpart explains that certain World War II veterans who die are considered (deemed) fully insured. This gives those veterans' survivors the same benefit rights as if the veterans were actually fully insured when they died.

(f) The rules are organized in the following manner:

(1) Sections 404.1310 through 404.1313 contain the rules on World War II veterans. We discuss who may qualify as a World War II veteran, how we determine whether the 90-day active service requirement for a World War II veteran is met, what we consider to be World War II active military or naval service, and what we do not consider to be World War II active military or naval service.

(2) Sections 404.1320 through 404.1323 contain the rules on post-World War II veterans. We discuss who may qualify as a post-World War II veteran, how we determine whether the 90-day active service requirement for a post-World War II veteran is met, what we consider to be post-World War II active military or naval service, and what we do not consider to be post-World War II active military or naval service.

(3) In § 404.1325 we discuss what is a *separation under conditions other than dishonorable*. The law requires that a World War II or post-World War II veteran's separation from active military or naval service be other than dishonorable for the veteran to get wage credits.

(4) Section 404.1330 contains the rules on members of the uniformed services. We discuss who may qualify as a member of a uniformed service.

(5) In §§ 404.1340 through 404.1343, we discuss the amount of wage credits for veterans and members of the uniformed services, situations which may limit the use of wage credits for World War II and post-World War II veterans, and situations in which the limits do not apply.

(6) Sections 404.1350 through 404.1352 contain the rules on deemed insured status for World War II veterans. We discuss when deemed insured status applies, the amount of wage credits used for deemed insured World War II veterans, how the wage credits affect survivors' social security benefits, and when deemed insured status does not apply.

(7) Sections 404.1360 through 404.1363 contain the rules on the effect of other benefits on the payment of social security benefits and lump-sum death payments based on wage credits for veterans. We discuss what happens when we learn of a determination that a Veterans Administration pension or compensation is payable or that a Federal benefit is payable before or after we determine entitlement to a monthly benefit or lump-sum death payment based on the death of the veteran.

(8) Sections 404.1370 and 404.1371 contain the rules on what we accept as evidence of a World War II and post-World War II veteran's active military or naval service, including date and type of separation, and what we accept as evidence of entitlement to wage credits for membership in a uniformed service during the years 1957 through 1967.

[45 FR 16464, Mar. 14, 1980, as amended at 70 FR 11865, Mar. 10, 2005]

§ 404.1302 Definitions.

As used in this subpart—

Act means the Social Security Act, as amended.

Active duty means periods of time an individual is on full-time duty in the active military or naval service after 1956 and includes active duty for training after 1956.

Active service means periods of time prior to 1957 an individual was on full-time duty in the active military or naval service. It does not include totaling periods of active duty for training purposes before 1957 which are less than 90 days.

Allied country means a country at war on September 16, 1940, with a country with which the United States was at war during the World War II period. Each of the following countries is considered an allied country: Australia, Belgium, Canada, Czechoslovakia, Denmark, France, India, Luxembourg, the Netherlands, New Zealand, Norway, Poland, Union of South Africa, and the United Kingdom.

Domiciled in the United States means an individual has a true, fixed, and permanent home in the United States to which the individual intends to return whenever he or she is absent.

Federal benefit means a benefit which is payable by another Federal agency (other than the Veterans Administration) or an instrumentality owned entirely by the United States under any law of the United States or under a program or pension system set up by the agency or instrumentality.

Post-World War II period means the time period July 25, 1947, through December 31, 1956.

Reserve component means Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve, Coast Guard Reserve, National Guard of the United States or Air National Guard of the United States.

Resided in the United States means an individual had a place where he or she lived, whether permanently or temporarily, in the United States and was bodily present in that place.

Survivor means you are a parent, widow, divorced wife, widower, or child of a deceased veteran or member of a uniformed service.

United States means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Veteran means an individual who served in the active military or naval service of the United States and was discharged or released from that service under conditions other than dishonorable. For a more detailed definition of the World War II veteran and a post-World War II veteran, see §§ 404.1310 and 404.1320.

Wage credit means a dollar amount we add to the earnings record of a veteran of the World War II or the post-World War II period. It is also a dollar amount we add to the earnings record of a member of a uniformed service who was on active duty from 1957 through 2001. The amount is set out in the Act and is added for each month, calendar quarter, or calendar year of service as required by law.

We, us, or *our* means the Social Security Administration.

World War II period means the time period September 16, 1940, through July 24, 1947.

You or *your* means a veteran, a veteran's survivor or a member of a uniformed service applying for or entitled to a social security benefit or a lump-sum death payment.

[45 FR 16464, Mar. 14, 1980, as amended at 70 FR 11865, Mar. 10, 2005]

WORLD WAR II VETERANS

§ 404.1310 Who is a World War II veteran.

You are a World War II veteran if you were in the active service of the United States during the World War II period and, if no longer in active service, you were separated from that service under conditions other than dishonorable after at least 90 days of active service. The 90-day active service requirement is discussed in § 404.1311.

§ 404.1311 Ninety-day active service requirement for World War II veterans.

(a) The 90 days of active service required for World War II veterans do not have to be consecutive if the 90 days were in the World War II period. The 90-day requirement cannot be met by totaling the periods of active duty for training purposes which were less than 90 days.

(b) If, however, all of the 90 days of active service required for World War II veterans were not in the World War II period, the 90 days must (only in those circumstances) be consecutive if the 90 days began before September 16, 1940, and ended on or after that date, or began before July 25, 1947, and ended on or after that date.

(c) The 90 days of active service is not required if the World War II veteran died in service or was separated from service under conditions other

than dishonorable because of a disability or injury which began or worsened while performing service duties.

§ 404.1312 World War II service included.

Your service was in the active service of the United States during the World War II period if you were in the—

(a) Army, Navy, Marine Corps, or Coast Guard, or any part of them;

(b) Commissioned corps of the United States Public Health Service and were—

(1) On active commissioned service during the period beginning September 16, 1940, through July 28, 1945, and the active service was done while on detail to the Army, Navy, Marine Corps, or Coast Guard; or

(2) On active commissioned service during the period beginning July 29, 1945, through July 24, 1947, regardless of whether on detail to the Army, Navy, Marine Corps, or Coast Guard;

(c) Commissioned corps of the United States Coast and Geodetic Survey and were—

(1) During the World War II period—

(i) Transferred to active service with the Army, Navy, Marine Corps, or Coast Guard; or

(ii) Assigned to active service on military projects in areas determined by the Secretary of Defense to be areas of immediate military hazard; or

(2) On active service in the Philippine Islands on December 7, 1941; or

(3) On active service during the period beginning July 29, 1945, through July 24, 1947;

(d) Philippine Scouts and performed active service during the World War II period under the direct supervision of recognized military authority;

(e) Active service of an allied country during the World War II period and—

(1) Had entered into that active service before December 9, 1941;

(2) Were a citizen of the United States throughout that period of active service or lost your United States citizenship solely because of your entrance into that service;

(3) Had resided in the United States for a total of four years during the five-year period ending on the day you entered that active service; and

(4) Were domiciled in the United States on that day; or

(f) Women's Army Auxiliary Corps, during the period May 14, 1942, through September 29, 1943, and performed active service with the Army, Navy, Marine Corps, or Coast Guard after September 29, 1943.

§ 404.1313 World War II service excluded.

Your service was not in the active service of the United States during the World War II period if, for example, you were in the—

(a) Women's Army Auxiliary Corps, except as described in § 404.1312(f);

(b) Coast Guard Auxiliary;

(c) Coast Guard Reserve (Temporary) unless you served on active full-time service with military pay and allowances;

(d) Civil Air Patrol; or

(e) Civilian Auxiliary to the Military Police.

POST-WORLD WAR II VETERANS

§ 404.1320 Who is a post-World War II veteran.

You are a post-World War II veteran if you were in the active service of the United States during the post-World War II period and, if no longer in active service, you were separated from the service under conditions other than dishonorable after at least 90 days of active service. The 90-day active service requirement is discussed in § 404.1321.

§ 404.1321 Ninety-day active service requirement for post-World War II veterans.

(a) The 90 days of active service required for post-World War II veterans do not have to be consecutive if the 90 days were in the post-World War II period. The 90-day requirement cannot be met by totaling the periods of active duty for training purposes before 1957 which were less than 90 days.

(b) If, however, all of the 90 days of active service required for post-World War II veterans were not in the post-World War II period, the 90 days must (only in those circumstances) be consecutive if the 90 days began before July 25, 1947, and ended on or after that

date, or began before January 1, 1957, and ended on or after that date.

(c) The 90 days of active service is not required if the post-World War II veteran died in service or was separated from service under conditions other than dishonorable because of a disability or injury which began or worsened while performing service duties.

§ 404.1322 Post-World War II service included.

Your service was in the active service of the United States during the post-World War II period if you were in the—

(a) Air Force, Army, Navy, Marine Corps, Coast Guard, or any part of them;

(b) Commissioned corps of the United States Public Health Service and were on active service during that period;

(c) Commissioned corps of the United States Coast and Geodetic Survey and were on active service during that period; or

(d) Philippine Scouts and performed active service during the post-World War II period under the direct supervision of recognized military authority.

§ 404.1323 Post-World War II service excluded.

Your service was not in the active service of the United States during the post-World War II period if, for example, you were in the—

(a) Coast Guard Auxiliary;

(b) Coast Guard Reserve (Temporary) unless you served on active full-time service with military pay and allowances;

(c) Civil Air Patrol; or

(d) Civilian Auxiliary to the Military Police.

SEPARATION FROM ACTIVE SERVICE

§ 404.1325 Separation from active service under conditions other than dishonorable.

Separation from active service under conditions other than dishonorable means any discharge or release from the active service except—

(a) A discharge or release for desertion, absence without leave, or fraudulent entry;

(b) A dishonorable or bad conduct discharge issued by a general court martial of the Army, Navy, Air Force, Marine Corps, or Coast Guard of the United States, or by the active service of an allied country during the World War II period;

(c) A dishonorable discharge issued by the United States Public Health Service or the United States Coast and Geodetic Survey;

(d) A resignation by an officer for the good of the service;

(e) A discharge or release because the individual was a conscientious objector; or

(f) A discharge or release because the individual was convicted by a civil court for treason, sabotage, espionage, murder, rape, arson, burglary, robbery, kidnapping, assault with intent to kill, assault with a deadly weapon, or because of an attempt to commit any of these crimes.

[45 FR 16464, Mar. 14, 1980; 45 FR 22023, Apr. 3, 1980]

MEMBERS OF THE UNIFORMED SERVICES

§ 404.1330 Who is a member of a uniformed service.

A member of a uniformed service is an individual who served on active duty after 1956. You are a member of a uniformed service if you—

(a) Are appointed, enlisted, or inducted into—

(1) The Air Force, Army, Navy, Coast Guard, or Marine Corps; or

(2) A reserve component of the uniformed services in paragraph (a)(1) of this section (except the Coast Guard Reserve as a temporary member);

(b) Served in the Army or Air Force under call or conscription;

(c) Are a commissioned officer of the National Oceanic and Atmospheric Administration or its predecessors, the Environmental Science Services Administration and the Coast and Geodetic Survey;

(d) Are a commissioned officer of the Regular or Reserve Corps of the Public Health Service;

(e) Are a retired member of any of the above services;

(f) Are a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(g) Are a cadet at the United States Military Academy, Air Force Academy, or Coast Guard Academy, or a midshipman at the United States Naval Academy; or

(h) Are a member of the Reserve Officers Training Corps of the Army, Navy or Air Force, when ordered to annual training duty for at least 14 days and while performing official travel to and from that duty.

AMOUNTS OF WAGE CREDITS AND LIMITS ON THEIR USE

§ 404.1340 Wage credits for World War II and post-World War II veterans.

In determining your entitlement to, and the amount of, your monthly benefit or lump-sum death payment based on your active service during the World War II period or the post-World War II period, and for establishing a period of disability as discussed in §§ 404.132 and 404.133, we add the (deemed) amount of $160 for each month during a part of which you were in the active service as described in § 404.1312 or § 404.1322. For example, if you were in active service from October 11, 1942, through August 10, 1943, we add the (deemed) amount of $160 for October 1942 and August 1943 as well as November 1942 through July 1943. The amount of wage credits that are added in a calendar year cannot cause the total amount credited to your earnings record to exceed the annual earnings limitation explained in §§ 404.1047 and 404.1096(b).

§ 404.1341 Wage credits for a member of a uniformed service.

(a) *General.* In determining your entitlement to, and the amount of your monthly benefit (or lump sum death payment) based on your wages while on active duty as a member of the uniformed service from 1957 through 2001, and for establishing a period of disability as discussed in § 404.132, we add wage credits to the wages paid you as a member of that service. The amount of the wage credits, the applicable time periods, the wage credit amount limits, and the requirement of a minimum period of active duty service for granting these wage credits, are discussed in paragraphs (b), (c), and (d) of this section.

(b) *Amount of wage credits.* The amount of wage credits added is—

(1) $100 for each $300 in wages paid to you for your service in each calendar year from 1978 through 2001; and

(2) $300 for each calendar quarter in 1957 through 1977, regardless of the amount of wages actually paid you during that quarter for your service.

(c) *Limits on wage credits.* The amount of these wage credits cannot exceed—

(1) $1200 for any calendar year, or

(2) An amount which when added to other earnings causes the total earnings for the year to exceed the annual earnings limitation explained in §§ 404.1047 and 404.1096(b).

(d) *Minimum active-duty service requirement.* (1) If you enlisted for the first time in a regular component of the Armed Forces on or after September 8, 1980, you must complete the shorter of 24 months of continuous active duty or the full period that you were called to active duty to receive these wage credits, unless:

(i) You are discharged or released from active duty for the convenience of the government in accordance with section 1171 of title 10 U.S.C. or because of hardship as specified in section 1173 of title 10 U.S.C.;

(ii) You are discharged or released from active duty for a disability incurred or aggravated in line of duty;

(iii) You are entitled to compensation for service-connected disability or death under chapter 11 of title 38 U.S.C.;

(iv) You die during your period of enlistment; or

(v) You were discharged prior to October 14, 1982, and your discharge was—

(A) Under chapter 61 of title 10 U.S.C.; or

(B) Because of a disability which resulted from an injury or disease incurred in or aggravated during your enlistment which was not the result of your intentional misconduct and did not occur during a period of unauthorized absence.

(2) If you entered on active duty as a member of the uniformed services as defined in § 404.1330 *on or after* October 14, 1982, having neither previously completed a period of 24 months' active duty nor been discharged or released from this period of active duty under

section 1171, title 10 U.S.C. (*i.e.*, convenience of the government), you must complete the shorter of 24 months of continuous active duty or the full period you were called or ordered to active duty to receive these wage credits, unless:

(i) You are discharged or released from active duty for the convenience of the government in accordance with section 1171 of title 10 U.S.C. or because of hardship as specified in section 1173 of title 10 U.S.C.;

(ii) You are discharged or released from active duty for a disability incurred or aggravated in line of duty;

(iii) You are entitled to compensation for service-connected disability or death under chapter 11 of title 38 U.S.C.; or

(iv) You die during your period of active service.

[45 FR 16464, Mar. 14, 1980, as amended at 52 FR 29663, Aug. 11, 1987; 70 FR 11865, Mar. 10, 2005]

§ 404.1342 Limits on granting World War II and post-World War II wage credits.

(a) You get wage credits for World War II or post-World War II active service only if the use of the wage credits results in entitlement to a monthly benefit, a higher monthly benefit, or a lump-sum death payment.

(b) You may get wage credits for active service in July 1947 for either the World War II period or the post-World War II period but not for both. If your active service is before and on or after July 25, 1947, we add the $160 wage credit to the period which is most advantageous to you.

(c) You do not get wage credits for the World War II period if another Federal benefit (other than one payable by the Veterans Administration) is determined by a Federal agency or an instrumentality owned entirely by the United States to be payable to you, even though the Federal benefit is not actually paid or is paid and then terminated, based in part on your active service during the World War II period except as explained in § 404.1343.

(d) You do not get wage credits for the post-World War II period if another Federal benefit (other than one payable by the Veterans Administration) is determined by a Federal agency or an instrumentality owned entirely by the United States to be payable to you, even though the Federal benefit is not actually paid or is paid and then terminated, based in part on your active service during the post-World War II period except as explained in § 404.1343.

§ 404.1343 When the limits on granting World War II and post-World War II wage credits do not apply.

The limits on granting wage credits described in § 404.1342 (c) and (d) do not apply—

(a) If the wage credits are used solely to meet the insured status and quarters of coverage requirements for a period of disability as described in §§ 404.132 and 404.133;

(b) If you are the surviving spouse or child of a veteran of the World War II period or post-World War II period and you are entitled under the Civil Service Retirement Act of 1930 to a survivor's annuity based on the veteran's active service and—

(1) You give up your right to receive the survivor's annuity;

(2) A benefit under the Civil Service Retirement Act of 1930 based on the veteran's active service was not payable to the veteran; and

(3) Another Federal benefit is not payable to the veteran or his or her survivors except as described in paragraph (c) of this section; or

(c) For the years 1951 through 1956, if another Federal benefit is payable by the Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, or the Public Health Service based on post-World War II active service but only if the veteran was also paid wages as a member of a uniformed service after 1956.

[45 FR 16464, Mar. 14, 1980, as amended at 49 FR 24118, June 12, 1984]

DEEMED INSURED STATUS FOR WORLD II VETERANS

§ 404.1350 Deemed insured status.

(a) *When deemed insured status applies.* If you are the survivor of a World War II veteran, we consider the veteran to have died fully insured as discussed in § 404.111 and we include wage credits in

determining your monthly benefit or lump-sum death payment if—

(1) The veteran was separated from active service of the United States before July 27, 1951; and

(2) The veteran died within 3 years after separation from active service and before July 27, 1954.

(b) *Amount of credit given for deemed insured World War II veterans.* (1) When we compute a survivor's benefit or lump-sum death payment, we give credit for—

(i) $200 (for increment year purposes) for each calendar year in which the veteran had at least 30 days of active service beginning September 16, 1940, through 1950; and

(ii) An average monthly wage of $160.

(2) If the World War II veteran was fully or currently insured without the wage credits, we add increment years (years after 1936 and prior to 1951 in which the veteran had at least $200 in creditable earnings) to the increment years based on the veteran's wages.

§ 404.1351 When deemed insured status does not apply.

As a survivor of a World War II veteran, you cannot get a monthly benefit or lump-sum death payment based on the veteran's deemed insured status as explained in § 404.1350 if—

(a) Your monthly benefit or lump-sum death payment is larger without using the wage credits;

(b) The Veterans Administration has determined that a pension or compensation is payable to you based on the veteran's death;

(c) The veteran died while in the active service of the United States;

(d) The veteran was first separated from active service after July 26, 1951;

(e) The veteran died after July 26, 1954; or

(f) The veteran's only service during the World War II period was by enlistment in the Philippine Scouts as authorized by the Armed Forces Voluntary Recruitment Act of 1945 (Pub. L. 190 of the 79th Congress).

§ 404.1352 Benefits and payments based on deemed insured status.

(a) *Our determination.* We determine your monthly benefit or lump-sum death payment under the deemed insured status provisions in §§ 404.1350 and 404.1351 regardless of whether the Veterans Administration has determined that any pension or compensation is payable to you.

(b) *Certification for payment.* If we determine that you can be paid a monthly benefit or lump-sum death payment, we certify these benefits for payment. However, the amount of your monthly benefit or lump-sum death payment may be changed if we are informed by the Veterans Administration that a pension or compensation is payable because of the veteran's death as explained in § 404.1360.

(c) *Payments not considered as pension or compensation.* We do not consider as pension or compensation—

(1) National Service Life Insurance payments;

(2) United States Government Life Insurance payments; or

(3) Burial allowance payments made by the Veterans Administration.

Effect of Other Benefits on Payment of Social Security Benefits and Payments

§ 404.1360 Veterans Administration pension or compensation payable.

(a) *Before we determine and certify payment.* If we are informed by the Veterans Administration that a pension or compensation is payable to you before we determine and certify payment of benefits based on deemed insured status, we compute your monthly benefit or lump-sum death payment based on the death of the World War II veteran without using the wage credits discussed in § 404.1350.

(b) *After we determine and certify payment.* If we are informed by the Veterans Administration that a pension or compensation is payable to you after we determine and certify payment of benefits based on deemed insured status, we—

(1) Stop payment of your benefits or recompute the amount of any further benefits that can be paid to you; and

(2) Determine whether you were erroneously paid and the amount of any erroneous payment.

§ 404.1361 Federal benefit payable other than by Veterans Administration.

(a) *Before we determine and certify payment.* If we are informed by another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service before we determine and certify your monthly benefit or lump-sum death payment, we compute your monthly benefit or lump-sum death payment without using the wage credits discussed in § 404.1340.

(b) *After we determine and certify payment.* If we are informed by another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service after we determine and certify payment, we—

(1) Stop payment of your benefits or recompute the amount of any further benefits that can be paid to you; and

(2) Determine whether you were erroneously paid and the amount of any erroneous payment.

§ 404.1362 Treatment of social security benefits or payments where Veterans Administration pension or compensation payable.

(a) *Before we receive notice from the Veterans Administration.* If we certify your monthly benefit or a lump-sum death payment as determined under the deemed insured status provisions in § 404.1350 before we receive notice from the Veterans Administration that a pension or compensation is payable to you, our payments to you are erroneous only to the extent that they exceed the amount of the accrued pension of compensation payable.

(b) *After we receive notice from the Veterans Administration.* If we certify your monthly benefit or lump-sum death payment as determined under the deemed insured status provisions in § 404.1350 after we receive notice from the Veterans Administration that a pension or compensation is payable to you, our payments to you are erroneous whether or not they exceed the amount of the accrued pension or compensation payable.

§ 404.1363 Treatment of social security benefits or payments where Federal benefit payable other than by Veterans Administration.

If we certify your monthly benefit or lump-sum death payment based on World War II or post-World War II wage credits after we receive notice from another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service, our payments to you are erroneous to the extent the payments are based on the World War II or post-World War II wage credits. The payments are erroneous beginning with the first month you are eligible for the Federal benefit.

Evidence of Active Service and Membership in a Uniformed Service

§ 404.1370 Evidence of active service and separation from active service.

(a) *General.* When you file an application for a monthly benefit or lump-sum death payment based on the active service of a World War II or post-World War II veteran, you must submit evidence of—

(1) Your entitlement as required by subpart H of this part or other evidence that may be expressly required;

(2) The veteran's period in active service of the United States; and

(3) The veteran's type of separation from active service of the United States.

(b) *Evidence we accept.* We accept as proof of a veteran's active service and separation from active service—

(1) An original certificate of discharge, or an original certificate of service, from the appropriate military service, from the United States Public Health Service, or from the United States Coast and Geodetic Survey;

(2) A certified copy of the original certificate of discharge or service made by the State, county, city agency or department in which the original certificate is recorded;

(3) A certification from the appropriate military service, United States Public Health Service, or United States Coast and Geodetic Survey showing the veteran's period of active service and type of separation;

(4) A certification from a local selective service board showing the veteran's period of active service and type of separation; or

(5) Other evidence that proves the veteran's period of active service and type of separation.

§ 404.1371 Evidence of membership in a uniformed service during the years 1957 through 1967.

(a) *General.* When you file an application for a monthly benefit or lump-sum death payment based on the services of a member of a uniformed service during the years 1957 through 1967, you should submit evidence identifying the member's uniformed service and showing the period(s) he or she was on active duty during those years.

(b) *Evidence we accept.* The evidence we will accept includes any official correspondence showing the member's status as an active service member during the appropriate period, a certification of service by the uniformed service, official earnings statements, copies of the member's Form W-2, and military orders, for the appropriate period.

Subpart O—Interrelationship of Old-Age, Survivors and Disability Insurance Program With the Railroad Retirement Program

AUTHORITY: Secs. 202(l), 205(a), (c)(5)(D), (i), and (o), 210 (a)(9) and (l)(4), 211(c)(3), and 702(a)(5) of the Social Security Act (42 U.S.C. 402(l), 405(a), (c)(5)(D), (i), and (o), 410 (a)(9) and (l)(4), 411(c)(3), and 902(a)(5)).

CROSS REFERENCE: For regulations under the Railroad Retirement Act, see chapter II of this title.

§ 404.1401 What is the interrelationship between the Railroad Retirement Act and the Old-Age, Survivors and Disability Insurance Program of the Social Security Act?

(a) *Background.* The Railroad Retirement Act provides a system of benefits for railroad employees, their dependents and survivors, and is integrated with the Social Security Act to provide a coordinated system of retirement, survivor, dependent and disability benefits payable on the basis of an individual's work in the railroad industry and in employment and self-employment covered by the Social Security Act. With respect to the coordination between the two programs, the Railroad Retirement Act distinguishes between ''career'' or ''vested'' railroad workers and those individuals who may be considered ''casual'' or ''non-vested'' railroad workers based on the total amount of railroad service credited to the worker, as explained in paragraph (b) of this section. The Railroad Retirement Board transfers to the Social Security Administration (SSA) the compensation records of workers who at the time of retirement, onset of disability or death, are non-vested and meet certain other requirements. Any compensation paid to non-vested workers for service after 1936 becomes wages under the Social Security Act (to the extent they do not exceed the annual wage limitations described in § 404.1047). Any benefits payable to non-vested workers, their dependents, and their survivors, are computed on the basis of the combined compensation and social security covered earnings creditable to the workers' records. Once a railroad worker meets the vesting requirements, the record of the worker's railroad service and compensation generally may not be used for benefit purposes under the Social Security Act, but under certain circumstances may be transferred after the worker's death to SSA for use in determining social security benefit entitlement for the railroad worker's survivors (*see* § 404.1407). Under certain circumstances (*see* § 404.1413), certification of benefits payable under the provisions of the Social Security Act will be made to the Railroad Retirement Board. The Railroad Retirement Board will certify such benefits to the Secretary of the Treasury.

(b) *Who is a vested railroad worker?* You are a vested railroad worker if you have:

(1) Ten years or more of service in the railroad industry, or

(2) Effective January 1, 2002, you have at least 5 years of service in the railroad industry, all of which accrue after December 31, 1995.

(c) *Definition of years of service.* As used in paragraph (b) of this section, the term *years of service* has the same meaning as assigned to it by section 1(f) of the Railroad Retirement Act of 1974, as amended, (45 U.S.C. 231(f)).

[69 FR 5692, Feb. 6, 2004]

§ 404.1402 When are railroad industry services by a non-vested worker covered under Social Security?

If you are a non-vested worker, we (the Social Security Administration) will consider your services in the railroad industry to be ''employment'' as defined in section 210 of the Social Security Act for the following purposes:

(a) To determine entitlement to, or the amount of, any monthly benefits or lump-sum death payment on the basis of your wages and self-employment income;

(b) To determine entitlement to, or the amount of, any survivor monthly benefit or any lump-sum death payment on the basis of your wages and self-employment income provided you did not have a ''current connection'' with the railroad industry, as defined in section 1(o) of the Railroad Retirement Act of 1974, as amended, (45 U.S.C. 231(o)), at the time of your death; (in such cases, survivor benefits are not payable under the Railroad Retirement Act);

(c) To determine entitlement to a period of disability (*see* subpart B of this part) on the basis of your wages and self-employment income; or

(d) To apply the provisions of section 203 of the Social Security Act concerning deductions from benefits under the annual earnings test (*see* subpart E of this part).

[69 FR 5693, Feb. 6, 2004]

§ 404.1404 Effective date of coverage of railroad services under the act.

Coverage under the act of services performed after 1936 by an individual in the railroad industry is effective as follows:

(a) The provisions of paragraphs (a) and (b) of § 404.1402 insofar as they relate to survivor monthly benefits are effective for months after December 1946 and insofar as they relate to lump-sum death payments are effective with respect to deaths after 1946;

(b) The provisions of paragraph (a) of § 404.1402 insofar as they relate to old-age insurance benefits or monthly benefits of dependents of old-age insurance beneficiaries are effective November 1, 1951; insofar as they relate to disability insurance benefits are effective for months after June 1957; and insofar as they relate to monthly benefits for dependents of disability insurance beneficiaries are effective for months after August 1958;

(c) The provisions of paragraph (c) of § 404.1402 are effective for benefits for months after June 1955; and

(d) The provisions of paragraph (d) of § 404.1402 are effective November 1, 1951.

[25 FR 5182, June 10, 1960]

§ 404.1405 If you have been considered a non-vested worker, what are the situations when your railroad industry work will not be covered under Social Security?

(a) *Awards by the Railroad Retirement Board prior to October 30, 1951.* The provisions of § 404.1402(a) shall not apply with respect to the wages and self-employment income of an individual if, prior to October 30, 1951, the Railroad Retirement Board has awarded under the Railroad Retirement Act a retirement annuity to such individual or a survivor annuity with respect to the death of such individual and such retirement or survivor annuity, as the case may be, was payable at the time an application for benefits is filed under the Social Security Act on the basis of the wages and self-employment income of such individual. A pension payable under section 6 of the Railroad Retirement Act of 1937 as in effect prior to the Railroad Retirement Act of 1974, or an annuity paid in a lump sum equal to its commuted value under section 3(i) of the Railroad Retirement Act in effect prior to the Social Security Act of October 30, 1951, is not a ''retirement or survivor annuity'' for the purpose of this paragraph.

(b) *You continue to work in the railroad industry after establishing entitlement to old-age insurance benefits under section*

202(a) of the Social Security Act. If your service in the railroad industry is used to establish your entitlement to, or to determine the amount of, your old-age insurance benefits under section 202(a) of the Social Security Act, but you become vested after the effective date of your benefits, your railroad service will no longer be deemed to be in ''employment'' as defined in section 210 of the Act. Your benefits and any benefits payable to your spouse or child under section 202(b), (c), or (d) of the Act will be terminated with the month preceding the month in which you become a vested worker. However, if you remain insured (*see* subpart B of this part) without the use of your railroad compensation, your benefits will instead be recalculated without using your railroad compensation. The recalculated benefits will be payable beginning with the month in which you become a vested worker. Any monthly benefits paid prior to the month you become a vested worker are deemed to be correct payments.

[18 FR 8694, Dec. 24, 1953, as amended at 25 FR 5182, June 10, 1960; 42 FR 18273, Apr. 6, 1977; 69 FR 5693, Feb. 6, 2004]

§ 404.1406 Eligibility to railroad retirement benefits as a bar to payment of social security benefits.

Notwithstanding the fact that, pursuant to the preceding provisions of this subpart, services rendered by an individual in the railroad industry are in employment, no lump-sum death payment or survivor monthly benefits shall be paid (except as provided in § 404.1407) under the regulations in this part on the basis of such individual's wages and self-employment income if any person, upon filing application therefor, would be entitled to an annuity under section 2 of the Railroad Retirement Act of 1974 or a lump-sum payment under section 6(b) of such Act with respect to the death of that individual; or for periods prior to 1975, would have been entitled to an annuity under section 5 or a lump-sum payment under section 5(f)(1) of the Railroad Retirement Act of 1937 with respect to the death of that individual.

[42 FR 18273, Apr. 6, 1977]

§ 404.1407 When railroad retirement benefits do not bar payment of social security benefits.

The provisions of § 404.1406 shall not operate if:

(a) The survivor is, or upon filing application would be, entitled to a monthly benefit with respect to the death of an insured individual for a month prior to January 1947, if such monthly benefit is greater in amount than the survivor annuity payable to such survivor after 1946 under the Railroad Retirement Act; or

(b) The residual lump-sum payment provided by section 6(c) of the Railroad Retirement Act of 1974 (or section 5(f)(2) of the Railroad Retirement Act of 1937 prior to the 1974 Act) with respect to the death of an insured individual is paid by the Railroad Retirement Board pursuant to an irrevocable election filed with the Board by the widow, widower, or parent of such individual to waive all future annuities or benefits based on the combined record of earnings and compensation to which such widow, widower or parent might become entitled, but only to the extent that widow's, widower's or parent's benefits may be payable under the regulations of this part to such widow, widower or parent, as the case may be, solely on the basis of the wages and self-employment income of such deceased individual and without regard to any compensation which may be treated as wages pursuant to § 404.1408.

[42 FR 18273, Apr. 6, 1977]

§ 404.1408 Compensation to be treated as wages.

(a) *General*. Where pursuant to the preceding provisions of this subpart, services rendered by an individual in the railroad industry are considered to be employment as defined in section 210 of the Social Security Act (see § 404.1027 of this part). Thus, any compensation (as defined in section 1(h) of the Railroad Retirement Act of 1974 or prior to the 1974 Act, section 1(h) of the Railroad Retirement Act of 1937) received by such individual for such services shall constitute wages, provided that the provisions of § 404.1406 do not operate to bar the payments of benefits under title II of the Social Security Act.

(b) *Military service exception.* An exception to paragraph (a) of this section applies to any compensation attributable as having been paid during any month on account of military service creditable under section 1 of the Railroad Retirement Act of 1974 (or section 4 of the Railroad Retirement Act of 1937 prior to the 1974 Act). Such compensation shall not constitute wages for purposes of title II of the Social Security Act if, based on such services, wages are deemed to have been paid to such individual during such month under the provisions described in §§ 404.1350 through 404.1352 of this part.

[65 FR 16813, Mar. 30, 2000]

§ 404.1409 Purposes of using compensation.

Compensation which is treated as wages under § 404.1408 shall be used, together with wages (see subpart K of this part) and self-employment income (see subpart K of this part), for purposes of:

(a) Determining an individual's insured status for monthly benefits or the lump-sum death payment (see subpart B of this part);

(b) Computing such individual's primary insurance amount (see subpart C of this part);

(c) Determining an individual's entitlement to the establishment of a period of disability (see subpart B of this part for disability insured status requirements); and

(d) Applying the deduction provisions of section 203 of the act (see subpart E of this part).

[25 FR 5183, June 10, 1960]

§ 404.1410 Presumption on basis of certified compensation record.

(a) *Years prior to 1975.* Where the Railroad Retirement Board certifies to SSA a report of record of compensation, such compensation is treated as wages under § 404.1408. For periods of service which do not identify the months or quarters in which such compensation was paid, the sum of the compensation quarters of coverage (see § 404.1412) will be presumed, in the absence of evidence to the contrary, to represent an equivalent number of quarters of coverage (see § 404.101). No more than four quarters of coverage shall be credited to an individual in a single calendar year.

(b) *Years after 1974.* Compensation paid in a calendar year will, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee will have been in railroad service. (For years prior to 1975, see § 404.1412.)

(c) *Allocation of compensation to months of service.* If by means of the presumptions in this section an individual does not have an insured status (see subpart B of this part) on the basis of quarters of coverage with which he is credited, or a deceased individual's primary insurance amount (see § 404.201) may be affected because he attained age 22 after 1936, the Administration may request the Railroad Retirement Board to furnish a report of the months in which such individual rendered service for compensation which is treated as wages under § 404.1408 if it appears the identification of such months may result in an insured status or if it will affect such primary insurance amount.

(d) *Effect of self-employment income and maximum earnings.* However, if such individual also had self-employment income for a taxable year and the sum of such income and wages (including compensation which is treated as wages under § 404.1408) paid to or received by him during such taxable year equals the following amounts, each calendar quarter any part of which falls in such taxable year, shall be a quarter of coverage:

(1) After 1950 and prior to 1955, equals $3,600 of remuneration;

(2) After 1954 and prior to 1959, equals $4,200 of remuneration;

(3) After 1958 and prior to 1966, equals $4,800 of remuneration;

(4) After 1965 and prior to 1968, equals $6,600 of remuneration;

(5) After 1967 and beginning prior to 1972, equals $7,800 of remuneration (including a fiscal year which began in 1971 and ended in 1972);

(6) Beginning after 1971 and prior to 1973, equals $9,000 of remuneration;

(7) Beginning after 1972 and prior to 1974, equals $10,800 of remuneration;

(8) Beginning after 1973 and prior to 1975, equals $13,200 of remuneration;

(9) Beginning after 1974 and prior to 1976, equals $14,100 of remuneration;

(10) Beginning after 1975 and prior to 1977, equals $15,300 of remuneration; or

(11) Beginning after 1976, and amount equal to the contribution and benefit base as determined under section 230 of the Social Security Act which is effective for such calendar year.

This subsection is an exception to the rule in paragraph (a) of this section concerning a presumption applicable to conversion of railroad compensation into quarters of coverage for years prior to 1975.

[42 FR 18273, Apr. 6, 1977, as amended at 65 FR 16814, Mar. 30, 2000]

§ 404.1412 Compensation quarters of coverage.

As used in this subpart, a compensation quarter of coverage is any quarter of coverage computed with respect to compensation paid to an individual for railroad employment after 1936 and prior to 1975 in accordance with the provisions for determining such quarters of coverage as contained in section 5(l)(4) of the Railroad Retirement Act of 1937. (For years beginning 1975, see § 404.1410(b)).

[42 FR 18274, Apr. 6, 1977]

§ 404.1413 When will we certify payment to the Railroad Retirement Board (RRB)?

(a) *When we will certify payment to RRB.* If we find that you are entitled to any payment under title II of the Social Security Act, we will certify payment to the Railroad Retirement Board if you meet any of the following requirements:

(1) You are a vested worker; or

(2) You are the wife or husband of a vested worker; or

(3) You are the survivor of a vested worker and you are entitled, or could upon application be entitled to, an annuity under section 2 of the Railroad Retirement Act of 1974, as amended, (45 U.S.C. 231(a)); or

(4) You are entitled to benefits under section 202 of the Social Security Act on the basis of the wages and self-employment income of a vested worker (unless you are the survivor of a vested worker who did not have a current connection, as defined in section 1(o) of the Railroad Retirement Act of 1974, as amended, (45 U.S.C. 231(o)) with the railroad industry at the time of his or her death).

(b) *What information does certification include?* The certification we make to the Railroad Retirement Board for individuals entitled to any payment(s) under title II will include your name, address, payment amount(s), and the date the payment(s) should begin.

(c) *Applicability limitations.* The applicability limitations in paragraphs (a)(1) through (4) of this section affect claimants who first become entitled to benefits under title II of the Social Security Act after 1974. (*See* also § 404.1810.)

[69 FR 5693, Feb. 6, 2004]

Subpart P—Determining Disability and Blindness

AUTHORITY: 42 U.S.C. 402, 405(a)–(b) and (d)–(h), 416(i), 421(a) and (h)–(j), 422(c), 423, 425, 902(a)(5), and 1320e–3; sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

SOURCE: 45 FR 55584, Aug. 20, 1980, unless otherwise noted.

GENERAL

§ 404.1501 Scope of subpart.

In order for you to become entitled to any benefits based upon disability or blindness or to have a period of disability established, you must be disabled or blind as defined in title II of the Social Security Act. This subpart explains how we determine whether you are disabled or blind. We discuss a *period of disability* in subpart D of this part. We have organized the rules in the following way.

(a) We define general terms, then discuss who makes our disability determinations and state that disability determinations made under other programs are not binding on our determinations.

(b) We explain the term *disability* and note some of the major factors that are considered in determining whether you are disabled in §§ 404.1505 through 404.1510.

(c) Sections 404.1512 through 404.1518 contain our rules on evidence. We explain your responsibilities for submitting evidence of your impairment, state what we consider to be acceptable sources of medical evidence, and describe what information should be included in medical reports.

(d) Our general rules on evaluating disability if you are filing a new application are stated in §§ 404.1520 through 404.1523. We describe the steps that we go through and the order in which they are considered.

(e) Our rules on medical considerations are found in §§ 404.1525 through 404.1530. We explain in these rules—

(1) The purpose of the Listing of Impairments found in appendix 1 of this subpart and how to use it;

(2) What we mean by the term *medical equivalence* and how we determine medical equivalence;

(3) The effect of a conclusion by your physician that you are disabled;

(4) What we mean by symptoms, signs, and laboratory findings;

(5) How we evaluate pain and other symptoms; and

(6) The effect on your benefits if you fail to follow treatment that is expected to restore your ability to work, and how we apply the rule.

(f) In §§ 404.1545 through 404.1546 we explain what we mean by the term *residual functional capacity*, state when an assessment of residual functional capacity is required, and who may make it.

(g) Our rules on vocational considerations are in §§ 404.1560 through 404.1569a. We explain in these rules—

(1) When we must consider vocational factors along with the medical evidence;

(2) How we use our residual functional capacity assessment to determine if you can still do your past relevant work or other work;

(3) How we consider the vocational factors of age, education, and work experience;

(4) What we mean by ''work which exists in the national economy'';

(5) How we consider the exertional, nonexertional, and skill requirements of work, and when we will consider the limitations or restrictions that result from your impairment(s) and related symptoms to be exertional, nonexertional, or a combination of both; and

(6) How we use the Medical-Vocational Guidelines in appendix 2 of this subpart.

(h) Our rules on substantial gainful activity are found in §§ 404.1571 through 404.1574. These explain what we mean by substantial gainful activity and how we evaluate your work activity.

(i) In §§ 404.1577, 404.1578, and 404.1579, we explain the special rules covering disability for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991, and in §§ 404.1581 through 404.1587 we discuss disability due to blindness.

(j) Our rules on when disability continues and stops are contained in § 404.1579 and §§ 404.1588 through 404.1598. We explain what your responsibilities are in telling us of any events that may cause a change in your disability status, when you may have a trial work period, and when we will review to see if you are still disabled. We also explain how we consider the issue of medical improvement (and the exceptions to medical improvement) in deciding whether you are still disabled.

[45 FR 55584, Aug. 20, 1980, as amended at 50 FR 50126, Dec. 6, 1985; 56 FR 57941, Nov. 14, 1991; 57 FR 30120, July 8, 1992; 68 FR 51161, Aug. 26, 2003]

§ 404.1502 Definitions for this subpart.

As used in the subpart—

(a) *Acceptable medical source* means a medical source who is a:

(1) Licensed physician (medical or osteopathic doctor);

(2) Licensed psychologist, which includes:

(i) A licensed or certified psychologist at the independent practice level; or

(ii) A licensed or certified school psychologist, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields

only, depending on the scope of practice in the State in which the optometrist practices;

(4) Licensed podiatrist for impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle;

(5) Qualified speech-language pathologist for speech or language impairments only. For this source, *qualified* means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association;

(6) Licensed audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only (with respect to claims filed (see § 404.614) on or after March 27, 2017);

(7) Licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title, for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017); or

(8) Licensed Physician Assistant for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 404.614) on or after March 27, 2017).

(b) *Commissioner* means the Commissioner of Social Security or his or her authorized designee.

(c) *Laboratory findings* means one or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.

(d) *Medical source* means an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or an individual who is certified by a State as a speech-language pathologist or a school psychologist and acting within the scope of practice permitted under State or Federal law.

(e) *Nonmedical source* means a source of evidence who is not a medical source. This includes, but is not limited to:

(1) You;

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Family members, caregivers, friends, neighbors, employers, and clergy.

(f) *Objective medical evidence* means signs, laboratory findings, or both.

(g) *Signs* means one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception, and must also be shown by observable facts that can be medically described and evaluated.

(h) *State agency* means an agency of a State designated by that State to carry out the disability or blindness determination function.

(i) *Symptoms* means your own description of your physical or mental impairment.

(j) *We* or *us* means, as appropriate, either the Social Security Administration or the State agency making the disability or blindness determination.

(k) *You* or *your* means, as appropriate, the person who applies for benefits or for a period of disability, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

[82 FR 5864, Jan. 18, 2017; 82 FR 15132, Mar. 27, 2017]

DETERMINATIONS

§ 404.1503 Who makes disability and blindness determinations.

(a) *State agencies.* State agencies make disability and blindness determinations for the Commissioner for most persons living in the State. State agencies make these disability and blindness determinations under regulations containing performance standards and other administrative requirements relating to the disability and blindness determination function. States have the option of turning the function over to the Federal Government if they no longer want to make disability determinations. Also, the Commissioner may take the function away from any State which has substantially failed to make disability and blindness determinations in accordance with these regulations. Subpart Q of this part contains the rules the States must follow in making disability and blindness determinations.

(b) *Social Security Administration.* The Social Security Administration will make disability and blindness determinations for—

(1) Any person living in a State which is not making for the Commissioner any disability and blindness determinations or which is not making those determinations for the class of claimants to which that person belongs; and

(2) Any person living outside the United States.

(c) *What determinations are authorized.* The Commissioner has authorized the State agencies and the Social Security Administration to make determinations about—

(1) Whether you are disabled or blind;

(2) The date your disability or blindness began; and

(3) The date your disability or blindness stopped.

(d) *Review of State Agency determinations.* On review of a State agency determination or redetermination of disability or blindness we may find that—

(1) You are, or are not, disabled or blind, regardless of what the State agency found;

(2) Your disability or blindness began earlier or later than the date found by the State agency; and

(3) Your disability or blindness stopped earlier or later than the date found by the State agency.

[46 FR 29204, May 29, 1981, as amended at 52 FR 33926, Sept. 9, 1987; 62 FR 38451, July 18, 1997; 65 FR 34957, June 1, 2000; 71 FR 16443, Mar. 31, 2006; 72 FR 51177, Sept. 6, 2007; 82 FR 5864, Jan. 18, 2017]

§ 404.1503a Program integrity.

We will not use in our program any individual or entity, except to provide existing medical evidence, who is currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; whose license to provide health care services is currently revoked or suspended by any State licensing authority pursuant to adequate due process procedures for reasons bearing on professional competence, professional conduct, or financial integrity; or who, until a final determination is made, has surrendered such a license while formal disciplinary proceedings involving professional conduct are pending. By individual or entity we mean a medical or psychological consultant, consultative examination provider, or diagnostic test facility. Also see §§ 404.1519 and 404.1519g(b).

[56 FR 36954, Aug. 1, 1991]

§ 404.1503b Evidence from excluded medical sources of evidence.

(a) *General.* We will not consider evidence from the following medical sources excluded under section 223(d)(5)(C)(i) of the Social Security Act (Act), as amended, unless we find good cause under paragraph (b) of this section:

(1) Any medical source that has been convicted of a felony under section 208 or under section 1632 of the Act;

(2) Any medical source that has been excluded from participation in any Federal health care program under section 1128 of the Act; or

(3) Any medical source that has received a final decision imposing a civil monetary penalty or assessment, or both, for submitting false evidence under section 1129 of the Act.

(b) *Good cause.* We may find good cause to consider evidence from an excluded medical source of evidence under section 223(d)(5)(C)(i) of the Act, as amended, if:

(1) The evidence from the medical source consists of evidence of treatment that occurred before the date the source was convicted of a felony under section 208 or under section 1632 of the Act;

(2) The evidence from the medical source consists of evidence of treatment that occurred during a period in which the source was not excluded from participation in any Federal health care program under section 1128 of the Act;

(3) The evidence from the medical source consists of evidence of treatment that occurred before the date the source received a final decision imposing a civil monetary penalty or assessment, or both, for submitting false evidence under section 1129 of the Act;

(4) The sole basis for the medical source's exclusion under section 223(d)(5)(C)(i) of the Act, as amended, is that the source cannot participate in any Federal health care program under section 1128 of the Act, but the Office of Inspector General of the Department of Health and Human Services granted a waiver of the section 1128 exclusion; or

(5) The evidence is a laboratory finding about a physical impairment and there is no indication that the finding is unreliable.

(c) *Reporting requirements for excluded medical sources of evidence.* Excluded medical sources of evidence (as described in paragraph (a) of this section) must inform us in writing that they are excluded under section 223(d)(5)(C)(i) of the Act, as amended, each time they submit evidence related to a claim for initial or continuing benefits under titles II or XVI of the Act. This reporting requirement applies to evidence that excluded medical sources of evidence submit to us either directly or through a representative, claimant, or other individual or entity.

(1) Excluded medical sources of evidence must provide a written statement, which contains the following information:

(i) A heading stating: ''WRITTEN STATEMENT REGARDING SECTION 223(d)(5)(C) OF THE SOCIAL SECURITY ACT—DO NOT REMOVE''

(ii) The name and title of the medical source;

(iii) The applicable excluding event(s) stated in paragraph (a)(1)-(a)(3) of this section;

(iv) The date of the medical source's felony conviction under sections 208 or 1632 of the Act, if applicable;

(v) The date of the imposition of a civil monetary penalty or assessment, or both, for the submission of false evidence, under section 1129 of the Act, if applicable; and

(vi) The basis, effective date, anticipated length of the exclusion, and whether the Office of the Inspector General of the Department of Health and Human Services waived the exclusion, if the excluding event was the medical source's exclusion from participation in any Federal health care program under section 1128 of the Act.

(2) The written statement provided by an excluded medical source of evidence may not be removed by any individual or entity prior to submitting evidence to us.

(3) We may request that the excluded medical source of evidence provide us with additional information or clarify any information submitted that bears on the medical source's exclusion(s) under section 223(d)(5)(C)(i) of the Act, as amended.

[81 FR 65540, Sept. 22, 2016]

§ 404.1504 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers— make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not

our decision about whether you are disabled or blind under our rules. Therefore, in claims filed (see § 404.614) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim in accordance with § 404.1513(a)(1) through (4).

[82 FR 5864, Jan. 18, 2017]

DEFINITION OF DISABILITY

§ 404.1505 Basic definition of disability.

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (*see* § 404.1560(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1, we will assess your residual functional capacity as provided in §§ 404.1520(e) and 404.1545. (*See* §§ 404.1520(g)(2) and 404.1562 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (*See* § 404.1520(h) for an exception to this rule.) We will use this definition of disability if you are applying for a period of disability, or disability insurance benefits as a disabled worker, or child's insurance benefits based on disability before age 22 or, with respect to disability benefits payable for months after December 1990, as a widow, widower, or surviving divorced spouse.

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§ 404.1581 through 404.1587. There are also different rules for determining disability for widows, widowers, and surviving divorced spouses for monthly benefits for months prior to January 1991. We discuss these rules in §§ 404.1577, 404.1578, and 404.1579.

[45 FR 55584, Aug. 20, 1980, as amended at 51 FR 10616, Mar. 28, 1986; 57 FR 30120, July 8, 1992; 68 FR 51161, Aug. 26, 2003; 77 FR 43494, July 25, 2012]

§ 404.1506 When we will not consider your impairment.

(a) *Permanent exclusion of felony-related impairment.* In determining whether you are under a disability, we will not consider any physical or mental impairment, or any increase in severity (aggravation) of a preexisting impairment, which arises in connection with your commission of a felony after October 19, 1980, if you are subsequently convicted of this crime. Your subsequent conviction will invalidate any prior determination establishing disability if that determination was based upon any impairment, or aggravation, which we must exclude under this rule.

(b) *Limited use of impairment arising in prison.* In determining whether you are under a disability for purposes of benefit payments, we will not consider any physical or mental impairment, or any increase in severity (aggravation) of a preexisting impairment, which arises in connection with your confinement in a jail, prison, or other penal institution or correctional facility for conviction of a felony committed after October 19, 1980. The exclusion of the impairment, or aggravation, applies in determining disability for benefits payable for any month during which you are confined. This rule does not preclude the establishment of a period of disability based upon the impairment or aggravation. You may become entitled to benefits upon release from prison provided that you apply and are under a disability at the time.

(c) *Felonious offenses.* We will consider an offense a felony if—

(1) It is a felony under applicable law; or

(2) In a jurisdiction which does not classify any crime as a felony, it is an offense punishable by death or imprisonment for a term exceeding one year.

(d) *Confinement.* In general, a jail, prison, or other penal institution or correctional facility is a facility which is under the control and jurisdiction of the agency in charge of the penal system or in which convicted criminals can be incarcerated. Confinement in such a facility continues as long as you are under a sentence of confinement and have not been released due to parole or pardon. You are considered confined even though you are temporarily or intermittently outside of the facility (e.g., on work release, attending school, or hospitalized).

[48 FR 5714, Feb. 8, 1983]

§ 404.1508 [Reserved]

§ 404.1509 How long the impairment must last.

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

§ 404.1510 Meaning of substantial gainful activity.

Substantial gainful activity means work that—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done (or intended) for pay or profit.

(See § 404.1572 for further details about what we mean by substantial gainful activity.)

§ 404.1511 Definition of a disabling impairment.

(a) *Disabled workers, persons disabled since childhood and, for months after December 1990, disabled widows, widowers, and surviving divorced spouses.* If you are entitled to disability cash benefits as a disabled worker, or to child's insurance benefits, or, for monthly benefits payable after December 1990, to widow's, widower's, or surviving divorced spouse's monthly benefits, a disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of this subpart or which, when considered with your age, education, and work experience, would result in a finding that you are disabled under § 404.1594. In determining whether you have a disabling impairment, earnings are not considered.

(b) *Disabled widows, widowers, and surviving divorced spouses, for monthly benefits for months prior to January 1991.* If you have been entitled to disability benefits as a disabled widow, widower, or surviving divorced spouse and we must decide whether you had a disabling impairment for any time prior to January 1991, a disabling impairment is an impairment (or combination of impairments) which, of itself, was so severe that it met or equaled a set of criteria in the Listing of Impairments in appendix 1 of this subpart, or results in a finding that you were disabled under § 404.1579. In determining whether you had a disabling impairment, earnings are not considered.

[57 FR 30120, July 8, 1992]

EVIDENCE

§ 404.1512 Responsibility for evidence.

(a) *Your responsibility*—(1) *General.* In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (*see* § 404.1513). This duty is ongoing and requires you to disclose any additional related evidence about which you become aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge hearing decision. We will consider only impairment(s) you say you have or about which we receive evidence. When you submit evidence received from another source, you must submit that evidence in its entirety, unless you previously submitted the same evidence to us or we instruct you otherwise. If we ask you, you must inform us about:

(i) Your medical source(s);

(ii) Your age;
(iii) Your education and training;
(iv) Your work experience;
(v) Your daily activities both before and after the date you say that you became disabled;
(vi) Your efforts to work; and
(vii) Any other factors showing how your impairment(s) affects your ability to work. In §§ 404.1560 through 404.1569, we discuss in more detail the evidence we need when we consider vocational factors.

(2) *Completeness.* The evidence in your case record must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(i) The nature and severity of your impairment(s) for any period in question;

(ii) Whether the duration requirement described in § 404.1509 is met; and

(iii) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in § 404.1520(e) or (f)(1) apply.

(b) *Our responsibility*—(1) *Development.* Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical evidence from your own medical sources and entities that maintain your medical sources' evidence when you give us permission to request the reports.

(i) *Every reasonable effort* means that we will make an initial request for evidence from your medical source or entity that maintains your medical source's evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one follow-up request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source's evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) *Complete medical history* means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier. If applicable, we will develop your complete medical history for the 12-month period prior to the month you were last insured for disability insurance benefits (see § 404.130), the month ending the 7-year period you may have to establish your disability and you are applying for widow's or widower's benefits based on disability (see § 404.335(c)(1)), or the month you attain age 22 and you are applying for child's benefits based on disability (see § 404.350).

(2) *Obtaining a consultative examination.* We may ask you to attend one or more consultative examinations at our expense. See §§ 404.1517 through 404.1519t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. We may order a consultative examination while awaiting receipt of medical source evidence in some instances, such as when we know a source is not productive, is uncooperative, or is unable to provide certain tests or procedures. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

(3) *Other work.* In order to determine under § 404.1520(g) that you are able to adjust to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§ 404.1560 through 404.1569a), given your residual functional capacity (which we have already assessed, as described in § 404.1520(e)), age, education, and work experience.

[82 FR 5864, Jan. 18, 2017]

§ 404.1513 Categories of evidence.

(a) *What we mean by evidence.* Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§ 404.1520b, 404.1520c (or under § 404.1527 for claims filed (see § 404.614) before March 27, 2017). We evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

(1) *Objective medical evidence.* Objective medical evidence is medical signs, laboratory findings, or both, as defined in § 404.1502(f).

(2) *Medical opinion.* A medical opinion is a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the following abilities: (For claims filed (see § 404.614) before March 27, 2017, see § 404.1527(a) for the definition of medical opinion.)

(i) Your ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching);

(ii) Your ability to perform mental demands of work activities, such as understanding; remembering; maintaining concentration, persistence, or pace; carrying out instructions; or responding appropriately to supervision, coworkers, or work pressures in a work setting;

(iii) Your ability to perform other demands of work, such as seeing, hearing, or using other senses; and

(iv) Your ability to adapt to environmental conditions, such as temperature extremes or fumes.

(3) *Other medical evidence.* Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairments, your medical history, clinical findings, diagnosis, treatment prescribed with response, or prognosis. (For claims filed (see § 404.614) before March 27, 2017, *other medical evidence* does not include a diagnosis, prognosis, or a statement that reflects a judgment(s) about the nature and severity of your impairment(s)).

(4) *Evidence from nonmedical sources.* Evidence from nonmedical sources is any information or statement(s) from a nonmedical source (including you) about any issue in your claim. We may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms we receive and our administrative records.

(5) *Prior administrative medical finding.* A prior administrative medical finding is a finding, other than the ultimate determination about whether you are disabled, about a medical issue made by our Federal and State agency medical and psychological consultants at a prior level of review (see § 404.900) in your current claim based on their review of the evidence in your case record, such as:

(i) The existence and severity of your impairment(s);

(ii) The existence and severity of your symptoms;

(iii) Statements about whether your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(iv) Your residual functional capacity;

(v) Whether your impairment(s) meets the duration requirement; and

(vi) How failure to follow prescribed treatment (see § 404.1530) and drug addiction and alcoholism (see § 404.1535) relate to your claim.

(b) *Exceptions for privileged communications.*

(1) The privileged communications listed in paragraphs (b)(1)(i) and (b)(1)(ii) of this section are not evidence, and we will neither consider nor provide any analysis about them in your determination or decision. This exception for privileged communications applies equally whether your representative is an attorney or a non-attorney.

(i) Oral or written communications between you and your representative that are subject to the attorney-client privilege, unless you voluntarily disclose the communication to us.

(ii) Your representative's analysis of your claim, unless he or she voluntarily discloses it to us. This analysis means information that is subject to the attorney work product doctrine, but it does not include medical evidence, medical opinions, or any other factual matter that we may consider in determining whether or not you are entitled to benefits (see paragraph (b)(2) of this section).

(2) The attorney-client privilege generally protects confidential communications between an attorney and his or her client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney's analyses, theories, mental impressions, and notes. In the context of your disability claim, neither the attorney-client privilege nor the attorney work product doctrine allow you to withhold factual information, medical opinions, or other medical evidence that we may consider in determining whether or not you are entitled to benefits. For example, if you tell your representative about the medical sources you have seen, your representative cannot refuse to disclose the identity of those medical sources to us based on the attorney-client privilege. As another example, if your representative asks a medical source to complete an opinion form related to your impairment(s), symptoms, or limitations, your representative cannot withhold the completed opinion form from us based on the attorney work product doctrine. The attorney work product doctrine would not protect the source's opinions on the completed form, regardless of whether or not your representative used the form in his or her analysis of your claim or made handwritten notes on the face of the report.

[82 FR 5865, Jan. 18, 2017; 82 FR 15132, Mar. 27, 2017]

§ 404.1513a Evidence from our Federal or State agency medical or psychological consultants.

The following rules apply to our Federal or State agency medical or psychological consultants that we consult in connection with administrative law judge hearings and Appeals Council reviews:

(a) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide medical evidence to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see § 404.1615(c)). The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 404.1615(c)(1), he or she will consider the evidence in your case record and make administrative findings about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative medical findings are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made. See § 404.1513(a)(5).

(2) When a State agency disability examiner makes the initial determination alone as provided in § 404.1615(c)(3), he or she may obtain medical evidence from a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§ 404.1520b, 404.1520c, and 404.1527.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in § 404.1615(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and reconsideration levels, about one or more of the medical issues listed in

paragraph (a)(1)(i) of this section under §§ 404.1520b, 404.1520c, and 404.1527.

(b) Administrative law judges are responsible for reviewing the evidence and making administrative findings of fact and conclusions of law. They will consider prior administrative medical findings and medical evidence from our Federal or State agency medical or psychological consultants as follows:

(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§ 404.1520b, 404.1520c, and 404.1527, as appropriate, because our Federal or State agency medical or psychological consultants are highly qualified and experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§ 404.1520b, 404.1520c, and 404.1527, as appropriate.

(c) When the Appeals Council makes a decision, it will consider prior administrative medical findings according to the same rules for considering prior administrative medical findings as administrative law judges follow under paragraph (b) of this section.

[82 FR 5866, Jan 18, 2017]

§ 404.1514 When we will purchase existing evidence.

We need specific medical evidence to determine whether you are disabled or blind. You are responsible for providing that evidence. However, we will pay physicians not employed by the Federal government and other non-Federal providers of medical services for the reasonable cost of providing us with existing medical evidence that we need and ask for after November 30, 1980.

[46 FR 45757, Sept. 15, 1981]

§ 404.1515 Where and how to submit evidence.

You may give us evidence about your impairment at any of our offices or at the office of any State agency authorized to make disability determinations. You may also give evidence to one of our employees authorized to accept evidence at another place. For more information about this, see subpart H of this part.

§ 404.1516 If you fail to submit medical and other evidence.

If you do not give us the medical and other evidence that we need and request, we will have to make a decision based on information available in your case. We will not excuse you from giving us evidence because you have religious or personal reasons against medical examinations, tests, or treatment.

§ 404.1517 Consultative examination at our expense.

If your medical sources cannot or will not give us sufficient medical evidence about your impairment for us to determine whether you are disabled or blind, we may ask you to have one or more physical or mental examinations or tests. We will pay for these examinations. However, we will not pay for any medical examination arranged by you or your representative without our advance approval. If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person or facility who will do it. We will also give the examiner any necessary background information about your condition.

[56 FR 36956, Aug. 1, 1991]

§ 404.1518 If you do not appear at a consultative examination.

(a) *General.* If you are applying for benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arrange for you to get information we need to determine your disability or blindness, we may find that you are not disabled or blind. If you are already receiving benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arranged for you, we may determine that your disability or blindness has stopped because of your failure or refusal. Therefore, if you have any reason why you cannot go for the scheduled appointment, you should tell us about this as soon as possible before the examination date. If

you have a good reason, we will schedule another examination. We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have a good reason for failing to attend a consultative examination.

(b) *Examples of good reasons for failure to appear.* Some examples of what we consider good reasons for not going to a scheduled examination include—

(1) Illness on the date of the scheduled examination or test;

(2) Not receiving timely notice of the scheduled examination or test, or receiving no notice at all;

(3) Being furnished incorrect or incomplete information, or being given incorrect information about the physician involved or the time or place of the examination or test, or;

(4) Having had death or serious illness occur in your immediate family.

(c) *Objections by your medical source(s).* If any of your medical sources tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your medical source(s) may agree to another type of examination for the same purpose.

[45 FR 55584, Aug. 20, 1980, as amended at 59 FR 1635, Jan. 12, 1994; 82 FR 5866, Jan. 18, 2017]

STANDARDS TO BE USED IN DETERMINING WHEN A CONSULTATIVE EXAMINATION WILL BE OBTAINED IN CONNECTION WITH DISABILITY DETERMINATIONS

§ 404.1519 The consultative examination.

A consultative examination is a physical or mental examination or test purchased for you at our request and expense from a treating source or another medical source, including a pediatrician when appropriate. The decision to purchase a consultative examination will be made on an individual case basis in accordance with the provisions of §§ 404.1519a through 404.1519f. Selection of the source for the examination will be consistent with the provisions of § 404.1503a and §§ 404.1519g through 404.1519j. The rules and procedures for requesting consultative examinations set forth in §§ 404.1519a and 404.1519b are applicable at the reconsideration and hearing levels of review, as well as the initial level of determination.

[56 FR 36956, Aug. 1, 1991, as amended at 65 FR 11875, Mar. 7, 2000]

§ 404.1519a When we will purchase a consultative examination and how we will use it.

(a) *General.* If we cannot get the information we need from your medical sources, we may decide to purchase a consultative examination. See § 404.1512 for the procedures we will follow to obtain evidence from your medical sources and § 404.1520b for how we consider evidence. Before purchasing a consultative examination, we will consider not only existing medical reports, but also the disability interview form containing your allegations as well as other pertinent evidence in your file.

(b) *Situations that may require a consultative examination.* We may purchase a consultative examination to try to resolve an inconsistency in the evidence, or when the evidence as a whole is insufficient to allow us to make a determination or decision on your claim. Some examples of when we might purchase a consultative examination to secure needed medical evidence, such as clinical findings, laboratory tests, a diagnosis, or prognosis, include but are not limited to:

(1) The additional evidence needed is not contained in the records of your medical sources;

(2) The evidence that may have been available from your treating or other medical sources cannot be obtained for reasons beyond your control, such as death or noncooperation of a medical source;

(3) Highly technical or specialized medical evidence that we need is not available from your treating or other medical sources; or

(4) There is an indication of a change in your condition that is likely to affect your ability to work, but the current severity of your impairment is not established.

[56 FR 36956, Aug. 1, 1991, as amended at 77 FR 10655, Feb. 23, 2012]

§ 404.1519b When we will not purchase a consultative examination.

We will not purchase a consultative examination in situations including, but not limited to, the following situations:

(a) In period of disability and disability insurance benefit claims, when you do not meet the insured status requirement in the calendar quarter you allege you became disabled or later and there is no possibility of establishing an earlier onset;

(b) In claims for widow's or widower's benefits based on disability, when your alleged month of disability is after the end of the 7-year period specified in § 404.335(c)(1) and there is no possibility of establishing an earlier onset date, or when the 7-year period expired in the past and there is no possibility of establishing an onset date prior to the date the 7-year period expired;

(c) In disability insurance benefit claims, when your insured status expired in the past and there is no possibility of establishing an onset date prior to the date your insured status expired;

(d) When any issues about your actual performance of substantial gainful activity or gainful activity have not been resolved;

(e) In claims for child's benefits based on disability, when it is determined that your alleged disability did not begin before the month you attained age 22, and there is no possibility of establishing an onset date earlier than the month in which you attained age 22;

(f) In claims for child's benefits based on disability that are filed concurrently with the insured individual's claim and entitlement cannot be established for the insured individual;

(g) In claims for child's benefits based on disability where entitlement is precluded based on other nondisability factors.

[56 FR 36956, Aug. 1, 1991]

Standards for the Type of Referral and for Report Content

§ 404.1519f Type of purchased examinations.

We will purchase only the specific examinations and tests we need to make a determination in your claim. For example, we will not authorize a comprehensive medical examination when the only evidence we need is a special test, such as an X-ray, blood studies, or an electrocardiogram.

[56 FR 36956, Aug. 1, 1991]

§ 404.1519g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own medical source or another medical source. If you are a child, the medical source we choose may be a pediatrician.

(b) By ''qualified,'' we mean that the medical source must be currently licensed in the State and have the training and experience to perform the type of examination or test we will request; the medical source must not be barred from participation in our programs under the provisions of § 404.1503a. The medical source must also have the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

(c) The medical source we choose may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse) must meet appropriate licensing or certification requirements of the State. See § 404.1503a.

[56 FR 36957, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000; 82 FR 5866, Jan. 18, 2017]

§ 404.1519h Your medical source.

When, in our judgment, your medical source is qualified, equipped, and willing to perform the additional examination or test(s) for the fee schedule payment, and generally furnishes complete and timely reports, your medical source will be the preferred source for the purchased examination or test(s).

[82 FR 5866, Jan. 18, 2017]

§ 404.1519i Other sources for consultative examinations.

We will use a different medical source than your medical source for a

purchased examination or test in situations including, but not limited to, the following:

(a) Your medical source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your medical source;

(c) You prefer a source other than your medical source and have a good reason for your preference;

(d) We know from prior experience that your medical source may not be a productive source, such as when he or she has consistently failed to provide complete or timely reports; or

(e) Your medical source is not a qualified medical source as defined in § 404.1519g.

[82 FR 5866, Jan. 18, 2017]

§ 404.1519j Objections to the medical source designated to perform the consultative examination.

You or your representative may object to your being examined by a medical source we have designated to perform a consultative examination. If there is a good reason for the objection, we will schedule the examination with another medical source. A good reason may be that the medical source we designated had previously represented an interest adverse to you. For example, the medical source may have represented your employer in a workers' compensation case or may have been involved in an insurance claim or legal action adverse to you. Other things we will consider include: The presence of a language barrier, the medical source's office location (e.g., 2nd floor, no elevator), travel restrictions, and whether the medical source had examined you in connection with a previous disability determination or decision that was unfavorable to you. If your objection is that a medical source allegedly ''lacks objectivity'' in general, but not in relation to you personally, we will review the allegations. See § 404.1519s. To avoid a delay in processing your claim, the consultative examination in your case will be changed to another medical source while a review is being conducted. We will handle any objection to use of the substitute medical source in the same manner. However, if we had previously conducted such a review and found that the reports of the medical source in question conformed to our guidelines, we will not change your examination.

[65 FR 11876, Mar. 7, 2000]

§ 404.1519k Purchase of medical examinations, laboratory tests, and other services.

We may purchase medical examinations, including psychiatric and psychological examinations, X-rays and laboratory tests (including specialized tests, such as pulmonary function studies, electrocardiograms, and stress tests) from a medical source.

(a) The rate of payment for purchasing medical or other services necessary to make determinations of disability may not exceed the highest rate paid by Federal or public agencies in the State for the same or similar types of service. *See* §§ 404.1624 and 404.1626 of this part.

(b) If a physician's bill or a request for payment for a physician's services includes a charge for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the test was personally performed or supervised by the physician who submitted the bill (or for whose services the request for payment was made) or by another physician with whom that physician shares his or her practice, the payment will be based on the physician's usual and customary charge for the test or the rates of payment which the State uses for purchasing such services, whichever is the lesser amount.

(2) If the bill or request for payment indicates that the test was performed by an independent laboratory, the amount of reimbursement will not exceed the billed cost of the independent laboratory or the rate of payment which the State uses for purchasing such services, whichever is the lesser amount. A nominal payment may be made to the physician for collecting, handling and shipping a specimen to the laboratory if the physician bills for

such a service. The total reimbursement may not exceed the rate of payment which the State uses for purchasing such services.

(c) The State will assure that it can support the rate of payment it uses. The State shall also be responsible for monitoring and overseeing the rate of payment it uses to ensure compliance with paragraphs (a) and (b) of this section.

[56 FR 36957, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000; 71 FR 16444, Mar. 31, 2006; 76 FR 24806, May 3, 2011]

§ 404.1519m Diagnostic tests or procedures.

We will request the results of any diagnostic tests or procedures that have been performed as part of a workup by your treating source or other medical source and will use the results to help us evaluate impairment severity or prognosis. However, we will not order diagnostic tests or procedures that involve significant risk to you, such as myelograms, arteriograms, or cardiac catheterizations for the evaluation of disability under the Social Security program. A State agency medical consultant must approve the ordering of any diagnostic test or procedure when there is a chance it may involve significant risk. The responsibility for deciding whether to perform the examination rests with the medical source designated to perform the consultative examination.

[56 FR 36957, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000; 71 FR 16444, Mar. 31, 2006; 76 FR 24806, May 3, 2011]

§ 404.1519n Informing the medical source of examination scheduling, report content, and signature requirements.

The medical sources who perform consultative examinations will have a good understanding of our disability programs and their evidentiary requirements. They will be made fully aware of their responsibilities and obligations regarding confidentiality as described in § 401.105(e). We will fully inform medical sources who perform consultative examinations at the time we first contact them, and at subsequent appropriate intervals, of the following obligations:

(a) *Scheduling.* In scheduling full consultative examinations, sufficient time should be allowed to permit the medical source to take a case history and perform the examination, including any needed tests. The following minimum scheduling intervals (*i.e.*, time set aside for the individual, not the actual duration of the consultative examination) should be used.

(1) Comprehensive general medical examination—at least 30 minutes;

(2) Comprehensive musculoskeletal or neurological examination—at least 20 minutes;

(3) Comprehensive psychiatric examination—at least 40 minutes;

(4) Psychological examination—at least 60 minutes (Additional time may be required depending on types of psychological tests administered); and

(5) All others—at least 30 minutes, or in accordance with accepted medical practices.

We recognize that actual practice will dictate that some examinations may require longer scheduling intervals depending on the circumstances in a particular situation. We also recognize that these minimum intervals may have to be adjusted to allow for those claimants who do not attend their scheduled examination. The purpose of these minimum scheduling timeframes is to ensure that such examinations are complete and that sufficient time is made available to obtain the information needed to make an accurate determination in your case. State agencies will monitor the scheduling of examinations (through their normal consultative examination oversight activities) to ensure that any overscheduling is avoided, as overscheduling may lead to examinations that are not thorough.

(b) *Report content.* The reported results of your medical history, examination, requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the

results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help us determine the nature, severity, and duration of the impairment, and residual functional capacity. The report should reflect your statement of your symptoms, not simply the medical source's statements or conclusions. The medical source's report of the consultative examination should include the objective medical facts as well as observations and opinions.

(c) *Elements of a complete consultative examination.* A complete consultative examination is one which involves all the elements of a standard examination in the applicable medical specialty. When the report of a complete consultative examination is involved, the report should include the following elements:

(1) Your major or chief complaint(s);

(2) A detailed description, within the area of specialty of the examination, of the history of your major complaint(s);

(3) A description, and disposition, of pertinent ''positive'' and ''negative'' detailed findings based on the history, examination and laboratory tests related to the major complaint(s), and any other abnormalities or lack thereof reported or found during examination or laboratory testing;

(4) The results of laboratory and other tests (e.g., X-rays) performed according to the requirements stated in the Listing of Impairments (see appendix 1 of this subpart P);

(5) The diagnosis and prognosis for your impairment(s);

(6) *A medical opinion.* Although we will ordinarily request a medical opinion as part of the consultative examination process, the absence of a medical opinion in a consultative examination report will not make the report incomplete. See § 404.1513(a)(3); and

(7) In addition, the medical source will consider, and provide some explanation or comment on, your major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions will represent the information provided by the medical source who signs the report.

(d) *When a complete consultative examination is not required.* When the evidence we need does not require a complete consultative examination (for example, we need only a specific laboratory test result to complete the record), we may not require a report containing all of the elements in paragraph (c).

(e) *Signature requirements.* All consultative examination reports will be personally reviewed and signed by the medical source who actually performed the examination. This attests to the fact that the medical source doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory test results. The signature of the medical source on a report annotated ''not proofed'' or ''dictated but not read'' is not acceptable. A rubber stamp signature of a medical source or the medical source's signature entered by any other person is not acceptable.

[56 FR 36958, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000; 82 FR 5866, Jan. 18, 2017]

§ 404.1519o When a properly signed consultative examination report has not been received.

If a consultative examination report is received unsigned or improperly signed we will take the following action.

(a) *When we will make determinations and decisions without a properly signed report.* We will make a determination or decision in the circumstances specified in paragraphs (a)(1) and (a)(2) of this section without waiting for a properly signed consultative examination report. After we have made the determination or decision, we will obtain a properly signed report and include it in the file unless the medical source who performed the original consultative examination has died:

(1) Continuous period of disability allowance with an onset date as alleged or earlier than alleged; or

(2) Continuance of disability.

(b) *When we will not make determinations and decisions without a properly signed report.* We will not use an unsigned or improperly signed consultative examination report to make the determinations or decisions specified in paragraphs (b)(1), (b)(2), (b)(3), and (b)(4) of this section. When we need a properly signed consultative examination report to make these determinations or decisions, we must obtain such a report. If the signature of the medical source who performed the original examination cannot be obtained because the medical source is out of the country for an extended period of time, or on an extended vacation, seriously ill, deceased, or for any other reason, the consultative examination will be rescheduled with another medical source:

(1) Denial; or

(2) Cessation; or

(3) Allowance of a period of disability which has ended; or

(4) Allowance with an onset date later than alleged.

[56 FR 36958, Aug. 1, 1991, as amended at 65 FR 11877, Mar. 7, 2000]

§ 404.1519p Reviewing reports of consultative examinations.

(a) We will review the report of the consultative examination to determine whether the specific information requested has been furnished. We will consider the following factors in reviewing the report:

(1) Whether the report provides evidence which serves as an adequate basis for decisionmaking in terms of the impairment it assesses;

(2) Whether the report is internally consistent; Whether all the diseases, impairments and complaints described in the history are adequately assessed and reported in the clinical findings; Whether the conclusions correlate the findings from your medical history, clinical examination and laboratory tests and explain all abnormalities;

(3) Whether the report is consistent with the other information available to us within the specialty of the examination requested; Whether the report fails to mention an important or relevant complaint within that specialty that is noted in other evidence in the file (e.g., your blindness in one eye, amputations, pain, alcoholism, depression);

(4) Whether this is an adequate report of examination as compared to standards set out in the course of a medical education; and

(5) Whether the report is properly signed.

(b) If the report is inadequate or incomplete, we will contact the medical source who performed the consultative examination, give an explanation of our evidentiary needs, and ask that the medical source furnish the missing information or prepare a revised report.

(c) With your permission, or when the examination discloses new diagnostic information or test results that reveal a potentially life-threatening situation, we will refer the consultative examination report to your treating source. When we refer the consultative examination report to your treating source without your permission, we will notify you that we have done so.

(d) We will perform ongoing special management studies on the quality of consultative examinations purchased from major medical sources and the appropriateness of the examinations authorized.

(e) We will take steps to ensure that consultative examinations are scheduled only with medical sources who have access to the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

[56 FR 36959, Aug. 1, 1991, as amended at 65 FR 11877, Mar. 7, 2000]

§ 404.1519q Conflict of interest.

All implications of possible conflict of interest between medical or psychological consultants and their medical or psychological practices will be avoided. Such consultants are not only those physicians and psychologists who work for us directly but are also those who do review and adjudication work in the State agencies. Physicians and psychologists who work for us directly as employees or under contract will not work concurrently for a State agency. Physicians and psychologists

who do review work for us will not perform consultative examinations for us without our prior approval. In such situations, the physician or psychologist will disassociate himself or herself from further involvement in the case and will not participate in the evaluation, decision, or appeal actions. In addition, neither they, nor any member of their families, will acquire or maintain, either directly or indirectly, any financial interest in a medical partnership, corporation, or similar relationship in which consultative examinations are provided. Sometimes physicians and psychologists who do review work for us will have prior knowledge of a case; for example, when the claimant was a patient. Where this is so, the physician or psychologist will not participate in the review or determination of the case. This does not preclude the physician or psychologist from submitting medical evidence based on treatment or examination of the claimant.

[56 FR 36959, Aug. 1, 1991]

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

§ 404.1519s Authorizing and monitoring the consultative examination.

(a) Day-to-day responsibility for the consultative examination process rests with the State agencies that make disability determinations for us.

(b) The State agency will maintain a good working relationship with the medical community in order to recruit sufficient numbers of physicians and other providers of medical services to ensure ready availability of consultative examination providers.

(c) Consistent with Federal and State laws, the State agency administrator will work to achieve appropriate rates of payment for purchased medical services.

(d) Each State agency will be responsible for comprehensive oversight management of its consultative examination program, with special emphasis on key providers.

(e) A key consultative examination provider is a provider that meets at least one of the following conditions:

(1) Any consultative examination provider with an estimated annual billing to the disability programs we administer of at least $150,000; or

(2) Any consultative examination provider with a practice directed primarily towards evaluation examinations rather than the treatment of patients; or

(3) Any consultative examination provider that does not meet the above criteria, but is one of the top five consultative examination providers in the State by dollar volume, as evidenced by prior year data.

(f) State agencies have flexibility in managing their consultative examination programs, but at a minimum will provide:

(1) An ongoing active recruitment program for consultative examination providers;

(2) A process for orientation, training, and review of new consultative examination providers, with respect to SSA's program requirements involving consultative examination report content and not with respect to medical techniques;

(3) Procedures for control of scheduling consultative examinations;

(4) Procedures to ensure that close attention is given to specific evaluation issues involved in each case;

(5) Procedures to ensure that only required examinations and tests are authorized in accordance with the standards set forth in this subpart;

(6) Procedures for providing medical or supervisory approval for the authorization or purchase of consultative examinations and for additional tests or studies requested by consulting medical sources. This includes physician approval for the ordering of any diagnostic test or procedure where the question of significant risk to the claimant/beneficiary might be raised. See § 404.1519m.

(7) Procedures for the ongoing review of consultative examination results to ensure compliance with written guidelines;

(8) Procedures to encourage active participation by physicians in the consultative examination oversight program;

(9) Procedures for handling complaints;

(10) Procedures for evaluating claimant reactions to key providers; and

(11) A program of systematic, onsite reviews of key providers that will include annual onsite reviews of such providers when claimants are present for examinations. This provision does not contemplate that such reviews will involve participation in the actual examinations but, rather, offer an opportunity to talk with claimants at the provider's site before and after the examination and to review the provider's overall operation.

(g) The State agencies will cooperate with us when we conduct monitoring activities in connection with their oversight management of their consultative examination programs.

[56 FR 36959, Aug. 1, 1991, as amended at 65 FR 11877, Mar. 7, 2000; 71 FR 16444, Mar. 31, 2006; 75 FR 32846, June 10, 2010; 76 FR 24806, May 3, 2011]

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

§ 404.1519t Consultative examination oversight.

(a) We will ensure that referrals for consultative examinations and purchases of consultative examinations are made in accordance with our policies. We will also monitor both the referral processes and the product of the consultative examinations obtained. This monitoring may include reviews by independent medical specialists under direct contract with SSA.

(b) Through our regional offices, we will undertake periodic comprehensive reviews of each State agency to evaluate each State's management of the consultative examination process. The review will involve visits to key providers, with State staff participating, including a program physician when the visit will deal with medical techniques or judgment, or factors that go to the core of medical professionalism.

(c) We will also perform ongoing special management studies of the quality of consultative examinations purchased from key providers and other sources and the appropriateness of the examinations authorized.

[56 FR 36960, Aug. 1, 1991]

EVALUATION OF DISABILITY

§ 404.1520 Evaluation of disability in general.

(a) *General*—(1) *Purpose of this section.* This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 404.1505.

(2) *Applicability of these rules.* These rules apply to you if you file an application for a period of disability or disability insurance benefits (or both) or for child's insurance benefits based on disability. They also apply if you file an application for widow's or widower's benefits based on disability for months after December 1990. (*See* § 404.1505(a).)

(3) *Evidence considered.* We will consider all evidence in your case record when we make a determination or decision whether you are disabled. See § 404.1520b.

(4) *The five-step sequential evaluation process.* The sequential evaluation process is a series of five ''steps'' that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (*See* paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (*See* paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (*See* paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (*See* paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and § 404.1560(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and § 404.1560(c).

(5) *When you are already receiving disability benefits.* If you are already receiving disability benefits, we will use a different sequential evaluation process to decide whether you continue to be disabled. We explain this process in § 404.1594(f).

(b) *If you are working.* If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. However, it is possible for you to have a period of disability for a time in the past even though you do not now have a severe impairment.

(d) *When your impairment(s) meets or equals a listed impairment in appendix 1.* If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) *When your impairment(s) does not meet or equal a listed impairment.* If your impairment(s) does not meet or equal a listed impairment, we will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record, as explained in § 404.1545. (See paragraph (g)(2) of this section and § 404.1562 for an exception to this rule.) We use our residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work (paragraph (f) of this section) and at the fifth step of the sequential evaluation process (if the evaluation proceeds to this step) to determine if you can adjust to other work (paragraph (g) of this section).

(f) *Your impairment(s) must prevent you from doing your past relevant work.* If we cannot make a determination or decision at the first three steps of the sequential evaluation process, we will compare our residual functional capacity assessment, which we made under paragraph (e) of this section, with the physical and mental demands of your past relevant work. See paragraph (h) of this section and § 404.1560(b). If you can still do this kind of work, we will find that you are not disabled.

(g) *Your impairment(s) must prevent you from making an adjustment to any other work.* (1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (See § 404.1560(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.

(2) We use different rules if you meet one of the two special medical-vocational profiles described in § 404.1562. If you meet one of those profiles, we will find that you cannot make an adjustment to other work, and that you are disabled.

(h) *Expedited process.* If we do not find you disabled at the third step, and we do not have sufficient evidence about your past relevant work to make a finding at the fourth step, we may proceed to the fifth step of the sequential evaluation process. If we find that you can adjust to other work based solely on your age, education, and the same residual functional capacity assessment we made under paragraph (e) of this section, we will find that you are not disabled and will not make a finding about whether you can do your past relevant work at the fourth step. If we find that you may be unable to adjust to other work or if § 404.1562 may apply, we will assess your claim at the fourth step and make a finding about whether you can perform your past relevant work. See paragraph (g) of this section and § 404.1560(c).

[50 FR 8727, Mar. 5, 1985; 50 FR 19164, May 7, 1985, as amended at 56 FR 36960, Aug. 1, 1991; 65 FR 80308, Dec. 21, 2000; 68 FR 51161, Aug. 26, 2003; 77 FR 10655, Feb. 23, 2012; 77 FR 43494, July 25, 2012]

§ 404.1520a Evaluation of mental impairments.

(a) *General.* The steps outlined in § 404.1520 apply to the evaluation of physical and mental impairments. In addition, when we evaluate the severity of mental impairments for adults (persons age 18 and over) and in persons under age 18 when Part A of the Listing of Impairments is used, we must follow a special technique at each level in the administrative review process. We describe this special technique in paragraphs (b) through (e) of this section. Using the technique helps us:

(1) Identify the need for additional evidence to determine impairment severity;

(2) Consider and evaluate functional consequences of the mental disorder(s) relevant to your ability to work; and

(3) Organize and present our findings in a clear, concise, and consistent manner.

(b) *Use of the technique.* (1) Under the special technique, we must first evaluate your pertinent symptoms, signs, and laboratory findings to determine whether you have a medically determinable mental impairment(s). See § 404.1521 for more information about what is needed to show a medically determinable impairment. If we determine that you have a medically determinable mental impairment(s), we must specify the symptoms, signs, and laboratory findings that substantiate the presence of the impairment(s) and document our findings in accordance with paragraph (e) of this section.

(2) We must then rate the degree of functional limitation resulting from the impairment(s) in accordance with paragraph (c) of this section and record our findings as set out in paragraph (e) of this section.

(c) *Rating the degree of functional limitation.* (1) Assessment of functional limitations is a complex and highly individualized process that requires us to consider multiple issues and all relevant evidence to obtain a longitudinal picture of your overall degree of functional limitation. We will consider all relevant and available clinical signs and laboratory findings, the effects of your symptoms, and how your functioning may be affected by factors including, but not limited to, chronic mental disorders, structured settings, medication, and other treatment.

(2) We will rate the degree of your functional limitation based on the extent to which your impairment(s) interferes with your ability to function independently, appropriately, effectively, and on a sustained basis. Thus, we will consider such factors as the quality and level of your overall functional performance, any episodic limitations, the amount of supervision or assistance you require, and the settings in which you are able to function. See 12.00C through 12.00H of the Listing of Impairments in appendix 1 to this subpart for more information about the factors we consider when we rate the degree of your functional limitation.

(3) We have identified four broad functional areas in which we will rate the degree of your functional limitation: Understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. See 12.00E of the Listing of Impairments in appendix 1 to this subpart.

(4) When we rate your degree of limitation in these areas (understand, remember, or apply information; interact

with others; concentrate, persist, or maintain pace; and adapt or manage oneself), we will use the following five-point scale: None, mild, moderate, marked, and extreme. The last point on the scale represents a degree of limitation that is incompatible with the ability to do any gainful activity.

(d) *Use of the technique to evaluate mental impairments.* After we rate the degree of functional limitation resulting from your impairment(s), we will determine the severity of your mental impairment(s).

(1) If we rate the degrees of your limitation as ''none'' or ''mild,'' we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see § 404.1522).

(2) If your mental impairment(s) is severe, we will then determine if it meets or is equivalent in severity to a listed mental disorder. We do this by comparing the medical findings about your impairment(s) and the rating of the degree of functional limitation to the criteria of the appropriate listed mental disorder. We will record the presence or absence of the criteria and the rating of the degree of functional limitation on a standard document at the initial and reconsideration levels of the administrative review process, or in the decision at the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision). See paragraph (e) of this section.

(3) If we find that you have a severe mental impairment(s) that neither meets nor is equivalent in severity to any listing, we will then assess your residual functional capacity.

(e) *Documenting application of the technique.* At the initial and reconsideration levels of the administrative review process, we will complete a standard document to record how we applied the technique. At the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision), we will document application of the technique in the decision. The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 404.1615(c)(1) of this part, the State agency medical or psychological consultant has overall responsibility for assessing medical severity. A State agency disability examiner may assist in preparing the standard document. However, our medical or psychological consultant must review and sign the document to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence.

(2) When a State agency disability examiner makes the determination alone as provided in § 404.1615(c)(3), the State agency disability examiner has overall responsibility for assessing medical severity and for completing and signing the standard document.

(3) When a disability hearing officer makes a reconsideration determination as provided in § 404.1615(c)(4), the determination must document application of the technique, incorporating the disability hearing officer's pertinent findings and conclusions based on this technique.

(4) At the administrative law judge hearing and Appeals Council levels, the written decision must incorporate the pertinent findings and conclusions based on the technique. The decision must show the significant history, including examination and laboratory findings, and the functional limitations that were considered in reaching a conclusion about the severity of the mental impairment(s). The decision must include a specific finding as to the degree of limitation in each of the functional areas described in paragraph (c) of this section.

(5) If the administrative law judge requires the services of a medical expert to assist in applying the technique but such services are unavailable, the administrative law judge may return the case to the State agency or the appropriate Federal component, using the rules in § 404.941 of this part, for completion of the standard document. If, after reviewing the case file and completing the standard document, the State agency or Federal component

concludes that a determination favorable to you is warranted, it will process the case using the rules found in § 404.941(d) or (e) of this part. If, after reviewing the case file and completing the standard document, the State agency or Federal component concludes that a determination favorable to you is not warranted, it will send the completed standard document and the case to the administrative law judge for further proceedings and a decision.

[65 FR 50774, Aug. 21, 2000; 65 FR 60584, Oct. 12, 2000, as amended at 71 FR 16444, Mar. 31, 2006; 75 FR 62680, Oct. 13, 2010; 76 FR 24806, May 3, 2011; 81 FR 66160, Sept. 26, 2016; 82 FR 5867. Jan. 18, 2017]

§ 404.1520b How we consider evidence.

After we review all of the evidence relevant to your claim, we make findings about what the evidence shows.

(a) *Complete and consistent evidence.* If all of the evidence we receive, including all medical opinion(s), is consistent and there is sufficient evidence for us to determine whether you are disabled, we will make our determination or decision based on that evidence.

(b) *Incomplete or inconsistent evidence.* In some situations, we may not be able to make our determination or decision because the evidence in your case record is insufficient or inconsistent. We consider evidence to be insufficient when it does not contain all the information we need to make our determination or decision. We consider evidence to be inconsistent when it conflicts with other evidence, contains an internal conflict, is ambiguous, or when the medical evidence does not appear to be based on medically acceptable clinical or laboratory diagnostic techniques. If the evidence in your case record is insufficient or inconsistent, we may need to take the additional actions in paragraphs (b)(1) through (4) of this section.

(1) If any of the evidence in your case record, including any medical opinion(s) and prior administrative medical findings, is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after considering the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i) through (b)(2)(iv) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical evidence over the telephone, we will send the telephone report to the source for review, signature, and return;

(ii) We may request additional existing evidence;

(iii) We may ask you to undergo a consultative examination at our expense (see §§ 404.1517 through 404.1519t); or

(iv) We may ask you or others for more information.

(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have.

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see § 404.614) on or after March 27, 2017. Because the evidence listed in paragraphs (c)(1) through (c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under § 404.1520c:

(1) *Decisions by other governmental agencies and nongovernmental entities.* See § 404.1504.

(2) *Disability examiner findings.* Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) *Statements on issues reserved to the Commissioner.* The statements listed in paragraphs (c)(3)(i) through (c)(3)(viii) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not you have a severe impairment(s);

(iii) Statements about whether or not your impairment(s) meets the duration requirement (see § 404.1509);

(iv) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(v) Statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see § 404.1545);

(vi) Statements about whether or not your residual functional capacity prevents you from doing past relevant work (see § 404.1560);

(vii) Statements that you do or do not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and

(viii) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see § 404.1594).

[82 FR 5867, Jan. 18, 2017]

§ 404.1520c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017.

For claims filed (see § 404.614) on or after March 27, 2017, the rules in this section apply. For claims filed before March 27, 2017, the rules in § 404.1527 apply.

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) *How we articulate our consideration of medical opinions and prior administrative medical findings.* We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are as follows:

(1) *Source-level articulation.* Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate

how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

(2) *Most important factors.* The factors of supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) are the most important factors we consider when we determine how persuasive we find a medical source's medical opinions or prior administrative medical findings to be. Therefore, we will explain how we considered the supportability and consistency factors for a medical source's medical opinions or prior administrative medical findings in your determination or decision. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (c)(5) of this section, as appropriate, when we articulate how we consider medical opinions and prior administrative medical findings in your case record.

(3) *Equally persuasive medical opinions or prior administrative medical findings about the same issue.* When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(c) *Factors.* We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:

(1) *Supportability.* The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) *Consistency.* The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

(3) *Relationship with the claimant.* This factor combines consideration of the issues in paragraphs (c)(3)(i) through (v) of this section.

(i) *Length of the treatment relationship.* The length of time a medical source has treated you may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(ii) *Frequency of examinations.* The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) *Purpose of the treatment relationship.* The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(iv) *Extent of the treatment relationship.* The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) *Examining relationship.* A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(4) *Specialization.* The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.

(5) *Other factors.* We will consider other factors that tend to support or

contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program's policies and evidentiary requirements. When we consider a medical source's familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

(d) *Evidence from nonmedical sources.* We are not required to articulate how we considered evidence from nonmedical sources using the requirements in paragraphs (a)–(c) in this section.

[82 FR 5867, Jan. 18, 2017]

§ 404.1521 Establishing that you have a medically determinable impairment(s).

If you are not doing substantial gainful activity, we will then determine whether you have a medically determinable physical or mental impairment(s) (see § 404.1520(a)(4)(ii)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be established by objective medical evidence from an acceptable medical source. We will not use your statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an impairment(s). After we establish that you have a medically determinable impairment(s), then we determine whether your impairment(s) is severe.

[82 FR 5868, Jan. 18, 2017]

§ 404.1522 What we mean by an impairment(s) that is not severe.

(a) *Non-severe impairment(s).* An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) *Basic work activities.* When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

[82 FR 5869, Jan. 18, 2017]

§ 404.1523 Multiple impairments.

(a) *Unrelated severe impairments.* We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) *Concurrent impairments.* If you have two or more concurrent impairments that, when considered in combination, are severe, we must determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

(c) *Combined effect.* In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, we will consider the combined

impact of the impairments throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see § 404.1520).

[82 FR 5869, Jan. 18, 2017]

MEDICAL CONSIDERATIONS

§ 404.1525 Listing of Impairments in appendix 1.

(a) *What is the purpose of the Listing of Impairments?* The Listing of Impairments (the listings) is in appendix 1 of this subpart. It describes for each of the major body systems impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience.

(b) *How is appendix 1 organized?* There are two parts in appendix 1:

(1) *Part A* contains criteria that apply to individuals age 18 and over. We may also use part A for individuals who are under age 18 if the disease processes have a similar effect on adults and children.

(2) *Part B* contains criteria that apply only to individuals who are under age 18; we never use the listings in part B to evaluate individuals who are age 18 or older. In evaluating disability for a person under age 18, we use part B first. If the criteria in part B do not apply, we may use the criteria in part A when those criteria give appropriate consideration to the effects of the impairment(s) in children. To the extent possible, we number the provisions in part B to maintain a relationship with their counterparts in part A.

(c) *How do we use the listings?* (1) Most body system sections in parts A and B of appendix 1 are in two parts: an introduction, followed by the specific listings.

(2) The introduction to each body system contains information relevant to the use of the listings in that body system; for example, examples of common impairments in the body system and definitions used in the listings for that body system. We may also include specific criteria for establishing a diagnosis, confirming the existence of an impairment, or establishing that your impairment(s) satisfies the criteria of a particular listing in the body system. Even if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in § 404.1521.

(3) In most cases, the specific listings follow the introduction in each body system, after the heading, *Category of Impairments.* Within each listing, we specify the objective medical and other findings needed to satisfy the criteria of that listing. We will find that your impairment(s) meets the requirements of a listing when it satisfies all of the criteria of that listing, including any relevant criteria in the introduction, and meets the duration requirement (see § 404.1509).

(4) Most of the listed impairments are permanent or expected to result in death. For some listings, we state a specific period of time for which your impairment(s) will meet the listing. For all others, the evidence must show that your impairment(s) has lasted or can be expected to last for a continuous period of at least 12 months.

(5) If your impairment(s) does not meet the criteria of a listing, it can medically equal the criteria of a listing. We explain our rules for medical equivalence in § 404.1526. We use the listings only to find that you are disabled or still disabled. If your impairment(s) does not meet or medically equal the criteria of a listing, we may find that you are disabled or still disabled at a later step in the sequential evaluation process.

(d) *Can your impairment(s) meet a listing based only on a diagnosis?* No. Your impairment(s) cannot meet the criteria of a listing based only on a diagnosis. To meet the requirements of a listing, you must have a medically determinable impairment(s) that satisfies all of the criteria in the listing.

(e) *How do we consider your symptoms when we determine whether your impairment(s) meets a listing?* Some listed impairments include symptoms, such as pain, as criteria. Section 404.1529(d)(2)

explains how we consider your symptoms when your symptoms are included as criteria in a listing.

[71 FR 10428, Mar. 1, 2006, as amended at 76 FR 19696, Apr. 8, 2011; 82 FR 5868, Jan. 18, 2017]

§ 404.1526 Medical equivalence.

(a) *What is medical equivalence?* Your impairment(s) is medically equivalent to a listed impairment in appendix 1 if it is at least equal in severity and duration to the criteria of any listed impairment.

(b) *How do we determine medical equivalence?* We can find medical equivalence in three ways.

(1)(i) If you have an impairment that is described in appendix 1, but —

(A) You do not exhibit one or more of the findings specified in the particular listing, or

(B) You exhibit all of the findings, but one or more of the findings is not as severe as specified in the particular listing,

(ii) We will find that your impairment is medically equivalent to that listing if you have other findings related to your impairment that are at least of equal medical significance to the required criteria.

(2) If you have an impairment(s) that is not described in appendix 1, we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is medically equivalent to the analogous listing.

(3) If you have a combination of impairments, no one of which meets a listing (see § 404.1525(c)(3)), we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairments are at least of equal medical significance to those of a listed impairment, we will find that your combination of impairments is medically equivalent to that listing.

(4) Section 404.1529(d)(3) explains how we consider your symptoms, such as pain, when we make findings about medical equivalence.

(c) *What evidence do we consider when we determine if your impairment(s) medically equals a listing?* When we determine if your impairment medically equals a listing, we consider all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. We do not consider your vocational factors of age, education, and work experience (see, for example, § 404.1560(c)(1)). We also consider the opinion given by one or more medical or psychological consultants designated by the Commissioner. (See § 404.1616.)

(d) *Who is a designated medical or psychological consultant?* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. See § 404.1616 for the necessary qualifications for medical consultants and psychological consultants.

(e) *Who is responsible for determining medical equivalence?*

(1) In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 404.1616 of this part) has the overall responsibility for determining medical equivalence.

(2) For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 404.918 of this part, with the Associate Commissioner for Disability Policy or his or her delegate.

(3) For cases at the administrative law judge or Appeals Council level, the responsibility for deciding medical

equivalence rests with the administrative law judge or Appeals Council.

[45 FR 55584, Aug. 20, 1980, as amended at 52 FR 33926, Sept. 9, 1987; 62 FR 38451, July 18, 1997; 65 FR 34957, June 1, 2000; 71 FR 10429, Mar. 1, 2006; 71 FR 16445, Mar. 31, 2006; 71 FR 57415, Sept. 29, 2006; 76 FR 24807, May 3, 2011; 82 FR 5869, Jan. 18, 2017; 82 FR 15132, Mar. 27, 2017]

§ 404.1527 Evaluating opinion evidence for claims filed before March 27, 2017.

For claims filed (see § 404.614) before March 27, 2017, the rules in this section apply. For claims filed on or after March 27, 2017, the rules in § 404.1520c apply.

(a) *Definitions.*

(1) *Medical opinions.* Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(2) *Treating source.* Treating source means your own acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment or evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

(b) *How we consider medical opinions.* In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See § 404.1520b.

(c) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's medical opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship.* Generally, we give more weight to the medical opinion of a source who has examined you than to the medical opinion of a medical source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's medical opinion.

(i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source,

the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the medical source's medical opinion more weight than we would give it if it were from a nontreating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her medical opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's medical opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support a medical opinion, particularly medical signs and laboratory findings, the more weight we will give that medical opinion. The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their medical opinions will depend on the degree to which they provide supporting explanations for their medical opinions. We will evaluate the degree to which these medical opinions consider all of the pertinent evidence in your claim, including medical opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent a medical opinion is with the record as a whole, the more weight we will give to that medical opinion.

(5) *Specialization.* We generally give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.

(6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the medical opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that a medical source has, regardless of the source of that understanding, and the extent to which a medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.*, that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are ''disabled'' or ''unable to work'' does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility

for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) *Evidence from our Federal or State agency medical or psychological consultants.* The rules in § 404.1513a apply except that when an administrative law judge gives controlling weight to a treating source's medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

(1) *Consideration.* Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an acceptable medical source if he or she has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation.* The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

[82 FR 5869, Jan. 18, 2017; 82 FR 15132, Mar. 27, 2017]

§ 404.1528 [Reserved]

§ 404.1529 How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how

your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

(b) *Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain.* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect your ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. In cases decided by a State agency (except in disability hearings under §§ 404.914 through 404.918 of this part and in fully favorable determinations made by State agency disability examiners alone under § 404.1615(c)(3) of this part), a State agency medical or psychological consultant or other medical or psychological consultant designated by the Commissioner directly participates in determining whether your medically determinable impairment(s) could reasonably be expected to produce your alleged symptoms. In the disability hearing process, a medical or psychological consultant may provide an advisory assessment to assist a disability hearing officer in determining whether your impairment(s) could reasonably be expected to produce your alleged symptoms. At the administrative law judge hearing or Appeals Council level of the administrative review process, the adjudicator(s) may ask for and consider the opinion of a medical or psychological expert concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. The finding that your impairment(s) could reasonably be expected to produce your pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of your symptoms. We will develop evidence regarding the possibility of a medically determinable mental impairment when we have information to suggest that such an impairment exists, and you allege pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work*—(1) *General.* When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work. In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence from your medical sources and nonmedical sources about how your symptoms affect you. We also consider the medical opinions as explained in § 404.1520c. Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work, when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain.

(2) *Consideration of objective medical evidence.* Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of your symptoms and the effect those symptoms, such as pain, may have on your ability to work. We must always attempt to obtain objective

medical evidence and, when it is obtained, we will consider it in reaching a conclusion as to whether you are disabled. However, we will not reject your statements about the intensity and persistence of your pain or other symptoms or about the effect your symptoms have on your ability to work solely because the available objective medical evidence does not substantiate your statements.

(3) *Consideration of other evidence.* Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. Section 404.1520c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

(i) Your daily activities;

(ii) The location, duration, frequency, and intensity of your pain or other symptoms;

(iii) Precipitating and aggravating factors;

(iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate your pain or other symptoms;

(v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;

(vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and

(vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms.

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities.* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities, we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. We will consider your statements about the intensity, persistence, and limiting effects of your symptoms, and we will evaluate your statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether you are disabled. We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you. Your symptoms, including pain, will be determined to diminish your capacity for basic work activities to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) *Consideration of symptoms in the disability determination process.* We follow a set order of steps to determine whether you are disabled. If you are not doing substantial gainful activity, we consider your symptoms, such as pain, to evaluate whether you have a severe physical or mental impairment(s), and at each of the remaining steps in the process. Sections 404.1520

and 404.1520a explain this process in detail. We also consider your symptoms, such as pain, at the appropriate steps in our review when we consider whether your disability continues. Sections 404.1579 and 404.1594 explain the procedure we follow in reviewing whether your disability continues.

(1) *Need to establish a severe medically determinable impairment(s).* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether your impairment or combination of impairment(s) is severe. (See § 404.1520(c).)

(2) *Decision whether the Listing of Impairments is met.* Some listed impairments include symptoms usually associated with those impairments as criteria. Generally, when a symptom is one of the criteria in a listing, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence, or limiting effects of the symptom as long as all other findings required by the specific listing are present.

(3) *Decision whether the Listing of Impairments is medically equaled.* If your impairment is not the same as a listed impairment, we must determine whether your impairment(s) is medically equivalent to a listed impairment. Section 404.1526 explains how we make this determination. Under § 404.1526(b), we will consider medical equivalence based on all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. In considering whether your symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether your symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute your allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of your impairment(s) to that of a listed impairment. If the symptoms, signs, and laboratory findings of your impairment(s) are equivalent in severity to those of a listed impairment, we will find you disabled. If it does not, we will consider the impact of your symptoms on your residual functional capacity. (See paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity.* If you have a medically determinable severe physical or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in appendix 1 of this subpart, we will consider the impact of your impairment(s) and any related symptoms, including pain, on your residual functional capacity. (See § 404.1545.)

[56 FR 57941, Nov. 14, 1991, as amended at 62 FR 38451, July 18, 1997; 71 FR 10429, Mar. 1, 2006; 71 FR 16445, Mar. 31, 2006; 75 FR 62681, Oct. 13, 2010; 76 FR 24807, May 3, 2011; 82 FR 5871, Jan. 18, 2017]

§ 404.1530 Need to follow prescribed treatment.

(a) *What treatment you must follow.* In order to get benefits, you must follow treatment prescribed by your medical source(s) if this treatment is expected to restore your ability to work.

(b) *When you do not follow prescribed treatment.* If you do not follow the prescribed treatment without a good reason, we will not find you disabled or, if you are already receiving benefits, we will stop paying you benefits.

(c) *Acceptable reasons for failure to follow prescribed treatment.* We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have an acceptable reason for failure to follow prescribed treatment. The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of your religion.

(2) The prescribed treatment would be cataract surgery for one eye, when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through treatment.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its magnitude (e.g., open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for you; or

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

[45 FR 55584, Aug. 20, 1980, as amended at 59 FR 1635, Jan. 12, 1994; 82 FR 5871, Jan. 18, 2017]

§ 404.1535 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

[60 FR 8147, Feb. 10, 1995]

§ 404.1536 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) If we determine that you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), you must avail yourself of appropriate treatment for your drug addiction or alcoholism at an institution or facility approved by us when this treatment is available and make progress in your treatment. Generally, you are not expected to pay for this treatment. You will not be paid benefits for any month after the month we have notified you in writing that—

(1) You did not comply with the terms, conditions and requirements of the treatment which has been made available to you; or

(2) You did not avail yourself of the treatment after you had been notified that it is available to you.

(b) If your benefits are suspended for failure to comply with treatment requirements, your benefits can be reinstated in accordance with the rules in § 404.470.

[60 FR 8147, Feb. 10, 1995]

§ 404.1537 What we mean by appropriate treatment.

By appropriate treatment, we mean treatment for drug addiction or alcoholism that serves the needs of the individual in the least restrictive setting possible consistent with your treatment plan. These settings range from outpatient counseling services through a variety of residential treatment settings including acute detoxification, short-term intensive residential treatment, long-term therapeutic residential treatment, and long-term recovery houses. Appropriate treatment is determined with the involvement of a State licensed or certified addiction professional on the basis of a detailed assessment of the individual's presenting symptomatology, psychosocial profile, and other relevant factors. This assessment may lead to a determination that more than one treatment modality is appropriate for the individual. The treatment will be provided or overseen by an approved institution or facility.

This treatment may include (but is not limited to)—

(a) Medical examination and medical management;

(b) Detoxification;

(c) Medication management to include substitution therapy (e.g., methadone);

(d) Psychiatric, psychological, psychosocial, vocational, or other substance abuse counseling in a residential or outpatient treatment setting; or

(e) Relapse prevention.

[60 FR 8148, Feb. 10, 1995]

§ 404.1538 What we mean by approved institutions or facilities.

Institutions or facilities that we may approve include—

(a) An institution or facility that furnishes medically recognized treatment for drug addiction or alcoholism in conformity with applicable Federal or State laws and regulations;

(b) An institution or facility used by or licensed by an appropriate State agency which is authorized to refer persons for treatment of drug addiction or alcoholism;

(c) State licensed or certified care providers;

(d) Programs accredited by the Commission on Accreditation for Rehabilitation Facilities (CARF) and/or the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) for the treatment of drug addiction or alcoholism;

(e) Medicare or Medicaid certified care providers; or

(f) Nationally recognized self-help drug addiction or alcoholism recovery programs (e.g., Alcoholics Anonymous or Narcotics Anonymous) when participation in these programs is specifically prescribed by a treatment professional at an institution or facility described in paragraphs (a) through (e) of this section as part of an individual's treatment plan.

[60 FR 8148, Feb. 10, 1995]

§ 404.1539 How we consider whether treatment is available.

Our determination about whether treatment is available to you for your drug addiction or your alcoholism will depend upon—

(a) The capacity of an approved institution or facility to admit you for appropriate treatment;

(b) The location of the approved institution or facility, or the place where treatment, services or resources could be provided to you;

(c) The availability and cost of transportation for you to the place of treatment;

(d) Your general health, including your ability to travel and capacity to understand and follow the prescribed treatment;

(e) Your particular condition and circumstances; and

(f) The treatment that is prescribed for your drug addiction or alcoholism.

[60 FR 8148, Feb. 10, 1995]

§ 404.1540 Evaluating compliance with the treatment requirements.

(a) *General.* Generally, we will consider information from the treatment institution or facility to evaluate your compliance with your treatment plan. The treatment institution or facility will:

(1) Monitor your attendance at and participation in treatment sessions;

(2) Provide reports of the results of any clinical testing (such as, hematological or urinalysis studies for individuals with drug addiction and hematological studies and breath analysis for individuals with alcoholism) when such tests are likely to yield important information;

(3) Provide observational reports from the treatment professionals familiar with your individual case (subject to verification and Federal confidentiality requirements); or

(4) Provide their assessment or views on your noncompliance with treatment requirements.

(b) *Measuring progress.* Generally, we will consider information from the treatment institution or facility to evaluate your progress in completing your treatment plan. Examples of milestones for measuring your progress with the treatment which has been prescribed for your drug addiction or alcoholism may include (but are not limited to)—

(1) Abstinence from drug or alcohol use (initial progress may include significant reduction in use);

(2) Consistent attendance at and participation in treatment sessions;

(3) Improved social functioning and levels of gainful activity;

(4) Participation in vocational rehabilitation activities; or

(5) Avoidance of criminal activity.

[60 FR 8148, Feb. 10, 1995]

§ 404.1541 Establishment and use of referral and monitoring agencies.

We will contract with one or more agencies in each of the States, Puerto Rico and the District of Columbia to provide services to individuals whose disabilities are based on a determination that drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535) and to submit information to us which we will use to make decisions about these individuals' benefits. These agencies will be known as referral and monitoring agencies. Their duties and responsibilities include (but are not limited to)—

(a) Identifying appropriate treatment placements for individuals we refer to them;

(b) Referring these individuals for treatment;

(c) Monitoring the compliance and progress with the appropriate treatment of these individuals; and

(d) Promptly reporting to us any individual's failure to comply with treatment requirements as well as failure to achieve progress through the treatment.

[60 FR 8148, Feb. 10, 1995]

RESIDUAL FUNCTIONAL CAPACITY

§ 404.1545 Your residual functional capacity.

(a) *General*—(1) *Residual functional capacity assessment.* Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is the most you can still do despite your limitations. We will assess your residual functional capacity based on all the relevant evidence in your case record. (*See* §§ 404.1512(d) through (e).)

(2) *If you have more than one impairment.* We will consider all of your medically determinable impairments of which we are aware, including your medically determinable impairments that are not ''severe,'' as explained in §§ 404.1520(c), 404.1521, and 404.1523, when we assess your residual functional capacity. (See paragraph (e) of this section.)

(3) *Evidence we use to assess your residual functional capacity.* We will assess your residual functional capacity based on all of the relevant medical and other evidence. In general, you are responsible for providing the evidence we will use to make a finding about your residual functional capacity. (*See* § 404.1512(c).) However, before we make a determination that you are not disabled, we are responsible for developing your complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help you get medical reports from your own medical sources. (*See* §§ 404.1512(d) through (f).) We will consider any statements about what you can still do that have been provided by medical sources, whether or not they are based on formal medical examinations. (*See* § 404.1513.) We will also consider descriptions and observations of your limitations from your impairment(s), including limitations that result from your symptoms, such as pain, provided by you, your family, neighbors, friends, or other persons. (*See* paragraph (e) of this section and § 404.1529.)

(4) *What we will consider in assessing residual functional capacity.* When we assess your residual functional capacity, we will consider your ability to meet the physical, mental, sensory, and other requirements of work, as described in paragraphs (b), (c), and (d) of this section.

(5) *How we will use our residual functional capacity assessment.* (i) We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work. (*See* §§ 404.1520(f) and 404.1560(b).)

(ii) If we find that you cannot do your past relevant work, you do not have any past relevant work, or if we use the procedures in § 404.1520(h) and § 404.1562 does not apply, we will use the

same assessment of your residual functional capacity at step five of the sequential evaluation process to decide if you can adjust to any other work that exists in the national economy. (*See* §§ 404.1520(g) and 404.1566.) At this step, we will not use our assessment of your residual functional capacity alone to decide if you are disabled. We will use the guidelines in §§ 404.1560 through 404.1569a, and consider our residual functional capacity assessment together with the information about your vocational background to make our disability determination or decision. For our rules on residual functional capacity assessment in deciding whether your disability continues or ends, *see* § 404.1594.

(b) *Physical abilities.* When we assess your physical abilities, we first assess the nature and extent of your physical limitations and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce your ability to do past work and other work.

(c) *Mental abilities.* When we assess your mental abilities, we first assess the nature and extent of your mental limitations and restrictions and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce your ability to do past work and other work.

(d) *Other abilities affected by impairment(s).* Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If you have this type of impairment(s), we consider any resulting limitations and restrictions which may reduce your ability to do past work and other work in deciding your residual functional capacity.

(e) *Total limiting effects.* When you have a severe impairment(s), but your symptoms, signs, and laboratory findings do not meet or equal those of a listed impairment in appendix 1 of this subpart, we will consider the limiting effects of all your impairment(s), even those that are not severe, in determining your residual functional capacity. Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of your impairment(s) and any related symptoms, we will consider all of the medical and nonmedical evidence, including the information described in § 404.1529(c).

[56 FR 57943, Nov. 14, 1991, as amended at 68 FR 51162, Aug. 26, 2003; 77 FR 10656, Feb. 23, 2012; 77 FR 43494, July 25, 2012]

§ 404.1546 Responsibility for assessing your residual functional capacity.

(a) *Responsibility for assessing residual functional capacity at the State agency.* When a State agency medical or psychological consultant and a State agency disability examiner make the disability determination as provided in § 404.1615(c)(1) of this part, a State agency medical or psychological consultant(s) is responsible for assessing your residual functional capacity. When a State agency disability examiner makes a disability determination alone as provided in § 404.1615(c)(3), the disability examiner is responsible for assessing your residual functional capacity.

(b) *Responsibility for assessing residual functional capacity in the disability hearings process.* If your case involves a disability hearing under § 404.914, a disability hearing officer is responsible for assessing your residual functional capacity. However, if the disability hearing officer's reconsidered determination is changed under § 404.918, the Associate Commissioner for the Office of Disability Determinations or his or her delegate is responsible for assessing your residual functional capacity.

(c) *Responsibility for assessing residual functional capacity at the administrative law judge hearing or Appeals Council level.* If your case is at the administrative law judge hearing level or at the Appeals Council review level, the administrative law judge or the administrative appeals judge at the Appeals Council (when the Appeals Council makes a decision) is responsible for assessing your residual functional capacity.

[68 FR 51162, Aug. 26, 2003, as amended at 71 FR 16445, Mar. 31, 2006; 75 FR 62681, Oct. 13, 2010; 76 FR 24807, May 3, 2011]

VOCATIONAL CONSIDERATIONS

§ 404.1560 When we will consider your vocational background.

(a) *General.* If you are applying for a period of disability, or disability insurance benefits as a disabled worker, or child's insurance benefits based on disability which began before age 22, or widow's or widower's benefits based on disability for months after December 1990, and we cannot decide whether you are disabled at one of the first three steps of the sequential evaluation process (*see* § 404.1520), we will consider your residual functional capacity together with your vocational background, as discussed in paragraphs (b) and (c) of this section.

(b) *Past relevant work.* We will first compare our assessment of your residual functional capacity with the physical and mental demands of your past relevant work. See § 404.1520(h) for an exception to this rule.

(1) *Definition of past relevant work*—(i) *What is past relevant work.* Past relevant work is work that you have done within the past five years that was substantial gainful activity and that lasted long enough for you to learn to do it (see § 404.1565(a)). We will not consider work to be past relevant work if you started and stopped it in fewer than 30 calendar days (see paragraph (b)(1)(ii) of this section).

(ii) *30 calendar days.* When we consider past relevant work and work experience (see § 404.1565), 30 calendar days means a period of 30 consecutive days, including weekends, starting from the first day of work. When we consider whether work lasted 30 calendar days, we generally do not consider the total number of hours or days worked during that period, or whether the work was full-time or part-time. The 30 calendar days requirement is separate from the consideration of substantial gainful activity or whether you worked long enough to learn how to do the work, although the work performed during the 30 calendar days may count toward the time needed for you to learn to do the work. The 30 calendar days requirement also applies if you were self-employed or an independent contractor; we will consider whether you were engaged in the same type of work for 30 calendar days, even if individual work assignments or contracts each lasted fewer than 30 calendar days.

(2) *Determining whether you can do your past relevant work.* We will ask you for information about work you have done in the past. We may also ask other people who know about your work. (*See* § 404.1565(b).) We may use the services of vocational experts or vocational specialists, or other resources, such as the ''Dictionary of Occupational Titles'' and its companion volumes and supplements, published by the Department of Labor, to obtain evidence we need to help us determine whether you can do your past relevant work, given your residual functional capacity. A vocational expert or specialist may offer relevant evidence within his or her expertise or knowledge concerning the physical and mental demands of a claimant's past relevant work, either as the claimant actually performed it or as generally performed in the national economy. Such evidence may be helpful in supplementing or evaluating the accuracy of the claimant's description of

his past work. In addition, a vocational expert or specialist may offer expert opinion testimony in response to a hypothetical question about whether a person with the physical and mental limitations imposed by the claimant's medical impairment(s) can meet the demands of the claimant's previous work, either as the claimant actually performed it or as generally performed in the national economy.

(3) *If you can do your past relevant work.* If we find that you have the residual functional capacity to do your past relevant work, we will determine that you can still do your past work and are not disabled. We will not consider your vocational factors of age, education, and work experience or whether your past relevant work exists in significant numbers in the national economy.

(c) *Other work.* (1) If we find that your residual functional capacity does not enable you to do any of your past relevant work or if we use the procedures in §404.1520(h), we will use the same residual functional capacity assessment when we decide if you can adjust to any other work. We will look at your ability to adjust to other work by considering your residual functional capacity and the vocational factors of age, education, and work experience, as appropriate in your case. (*See* §404.1520(h) for an exception to this rule.) Any other work (jobs) that you can adjust to must exist in significant numbers in the national economy (either in the region where you live or in several regions in the country).

(2) In order to support a finding that you are not disabled at this fifth step of the sequential evaluation process, we are responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that you can do, given your residual functional capacity and vocational factors. We are not responsible for providing additional evidence about your residual functional capacity because we will use the same residual functional capacity assessment that we used to determine if you can do your past relevant work.

[68 FR 51163, Aug. 26, 2003, as amended at 77 FR 43494, July 25, 2012; 89 FR 27667, Apr. 18, 2024]

§404.1562 Medical-vocational profiles showing an inability to make an adjustment to other work.

(a) *If you have done only arduous unskilled physical labor.* If you have no more than a marginal education (*see* §404.1564) and work experience of 35 years or more during which you did only arduous unskilled physical labor, and you are not working and are no longer able to do this kind of work because of a severe impairment(s) (*see* §§404.1520(c), 404.1521, and 404.1523), we will consider you unable to do lighter work, and therefore, disabled.

Example to paragraph (a): B is a 58-year-old miner's helper with a fourth grade education who has a lifelong history of unskilled arduous physical labor. B says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a ''severe'' combination of impairments that prevents B from performing his past relevant work. Under these circumstances, we will find that B is disabled.

(b) *If you are at least 55 years old, have no more than a limited education, and have no past relevant work experience.* If you have a severe, medically determinable impairment(s) (*see* §§404.1520(c), 404.1521, and 404.1523), are of advanced age (age 55 or older, *see* §404.1563), have a limited education or less (*see* §404.1564), and have no past relevant work experience (*see* §404.1565), we will find you disabled. If the evidence shows that you meet this profile, we will not need to assess your residual functional capacity or consider the rules in appendix 2 to this subpart.

[68 FR 51163, Aug. 26, 2003]

§404.1563 Your age as a vocational factor.

(a) *General.* ''Age'' means your chronological age. When we decide whether you are disabled under §404.1520(g)(1), we will consider your chronological age in combination with your residual functional capacity, education, and work experience. We will not consider your ability to adjust to other work on the basis of your age alone. In determining the extent to which age affects a person's ability to adjust to other work, we consider advancing age to be an increasingly limiting factor in the

person's ability to make such an adjustment, as we explain in paragraphs (c) through (e) of this section. If you are unemployed but you still have the ability to adjust to other work, we will find that you are not disabled. In paragraphs (b) through (e) of this section and in appendix 2 to this subpart, we explain in more detail how we consider your age as a vocational factor.

(b) *How we apply the age categories.* When we make a finding about your ability to do other work under § 404.1520(f)(1), we will use the age categories in paragraphs (c) through (e) of this section. We will use each of the age categories that applies to you during the period for which we must determine if you are disabled. We will not apply the age categories mechanically in a borderline situation. If you are within a few days to a few months of reaching an older age category, and using the older age category would result in a determination or decision that you are disabled, we will consider whether to use the older age category after evaluating the overall impact of all the factors of your case.

(c) *Younger person.* If you are a younger person (under age 50), we generally do not consider that your age will seriously affect your ability to adjust to other work. However, in some circumstances, we consider that persons age 45–49 are more limited in their ability to adjust to other work than persons who have not attained age 45. See Rule 201.17 in appendix 2.

(d) *Person closely approaching advanced age.* If you are closely approaching advanced age (age 50–54), we will consider that your age along with a severe impairment(s) and limited work experience may seriously affect your ability to adjust to other work.

(e) *Person of advanced age.* We consider that at advanced age (age 55 or older), age significantly affects a person's ability to adjust to other work. We have special rules for persons of advanced age and for persons in this category who are closely approaching retirement age (age 60 or older). See § 404.1568(d)(4).

(f) *Information about your age.* We will usually not ask you to prove your age. However, if we need to know your exact age to determine whether you get disability benefits or if the amount of your benefit will be affected, we will ask you for evidence of your age.

[45 FR 55584, Aug. 20, 1980, as amended at 65 FR 18000, Apr. 6, 2000; 68 FR 51163, Aug. 26, 2003; 73 FR 64196, Oct. 29, 2008]

§ 404.1564 Your education as a vocational factor.

(a) *General. Education* is primarily used to mean formal schooling or other training which contributes to your ability to meet vocational requirements, for example, reasoning ability, communication skills, and arithmetical ability. However, if you do not have formal schooling, this does not necessarily mean that you are uneducated or lack these abilities. Past work experience and the kinds of responsibilities you had when you were working may show that you have intellectual abilities, although you may have little formal education. Your daily activities, hobbies, or the results of testing may also show that you have significant intellectual ability that can be used to work.

(b) *How we evaluate your education.* The importance of your educational background may depend upon how much time has passed between the completion of your formal education and the beginning of your physical or mental impairment(s) and by what you have done with your education in a work or other setting. Formal education that you completed many years before your impairment began, or unused skills and knowledge that were a part of your formal education, may no longer be useful or meaningful in terms of your ability to work. Therefore, the numerical grade level that you completed in school may not represent your actual educational abilities. These may be higher or lower. However, if there is no other evidence to contradict it, we will use your numerical grade level to determine your educational abilities. In evaluating your educational level, we use the following categories:

(1) *Illiteracy.* Illiteracy means the inability to read or write. We consider someone illiterate if the person cannot read or write a simple message such as instructions or inventory lists even though the person can sign his or her

name. Generally, an illiterate person has had little or no formal schooling.

(2) *Marginal education.* Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. We generally consider that formal schooling at a 6th grade level or less is a marginal education.

(3) *Limited education.* Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs. We generally consider that a 7th grade through the 11th grade level of formal education is a limited education.

(4) *High school education and above.* High school education and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. We generally consider that someone with these educational abilities can do semi-skilled through skilled work.

(c) *Information about your education.* We will ask you how long you attended school, and whether you are able to understand, read, and write, and do at least simple arithmetic calculations. We will also consider other information about how much formal or informal education you may have had through your previous work, community projects, hobbies, and any other activities which might help you to work.

[45 FR 55584, Aug. 20, 1980, as amended at 85 FR 10602, Feb. 25, 2020]

§ 404.1565 Your work experience as a vocational factor.

(a) *General. Work experience* means skills and abilities you have acquired through work you have done which show the type of work you may be expected to do. Work you have already been able to do shows the kind of work that you may be expected to do. We consider that your work experience applies when it was done within the last five years, lasted long enough for you to learn to do it, and was substantial gainful activity. We do not usually consider that work you did more than five years before the time we are deciding whether you are disabled (or when the disability insured status requirement was last met, if earlier) applies. A gradual change occurs in most jobs so that after five years it is no longer realistic to expect that skills and abilities acquired in a job done then continue to apply. If you have no work experience or you did work that started and stopped in a period of fewer than 30 calendar days (see § 404.1560(b)(1)(ii)) during the five-year period, we generally consider that these do not apply. If you have acquired skills through your past work, we consider you to have these work skills unless you cannot use them in other skilled or semi-skilled work that you can now do. If you cannot use your skills in other skilled or semi-skilled work, we will consider your work background the same as unskilled. However, even if you have no work experience, we may consider that you are able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

(b) *Information about your work.* Under certain circumstances, we will ask you about the work you have done in the past. If you cannot give us all of the information we need, we may try, with your permission, to get it from your employer or other person who knows about your work, such as a member of your family or a co-worker. When we need to consider your work experience to decide whether you are able to do work that is different from what you have done in the past, we will ask you to tell us about all of the jobs you have had in the last five years. You must tell us the dates you worked, all of the duties you did, and any tools, machinery, and equipment you used. We will need to know about the amount of walking, standing, sitting, lifting and carrying you did during the workday, as well as any other physical or mental duties of your job. If all of your work in the past five years has been arduous and unskilled, and you have very little education, we will ask you to tell us about all of your work from the time you first began working. This information could help you to get disability benefits.

[89 FR 27667, Apr. 18, 2024]

§ 404.1566 Work which exists in the national economy.

(a) *General.* We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether—

(1) Work exists in the immediate area in which you live;

(2) A specific job vacancy exists for you; or

(3) You would be hired if you applied for work.

(b) *How we determine the existence of work.* Work exists in the national economy when there is a significant number of jobs (in one or more occupations) having requirements which you are able to meet with your physical or mental abilities and vocational qualifications. Isolated jobs that exist only in very limited numbers in relatively few locations outside of the region where you live are not considered ''work which exists in the national economy''. We will not deny you disability benefits on the basis of the existence of these kinds of jobs. If work that you can do does not exist in the national economy, we will determine that you are disabled. However, if work that you can do does exist in the national economy, we will determine that you are not disabled.

(c) *Inability to obtain work.* We will determine that you are not disabled if your residual functional capacity and vocational abilities make it possible for you to do work which exists in the national economy, but you remain unemployed because of—

(1) Your inability to get work;

(2) Lack of work in your local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which you have worked;

(5) Cyclical economic conditions;

(6) No job openings for you;

(7) You would not actually be hired to do work you could otherwise do; or

(8) You do not wish to do a particular type of work.

(d) *Administrative notice of job data.* When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of—

(1) *Dictionary of Occupational Titles,* published by the Department of Labor;

(2) *County Business Patterns,* published by the Bureau of the Census;

(3) *Census Reports,* also published by the Bureau of the Census;

(4) *Occupational Analyses,* prepared for the Social Security Administration by various State employment agencies; and

(5) *Occupational Outlook Handbook,* published by the Bureau of Labor Statistics.

(e) *Use of vocational experts and other specialists.* If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist. We will decide whether to use a vocational expert or other specialist.

§ 404.1567 Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, we classify jobs as *sedentary, light, medium, heavy,* and *very heavy.* These terms have the same meaning as they have in the *Dictionary of Occupational Titles,* published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

(a) *Sedentary work.* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be

very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

(c) *Medium work.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

(d) *Heavy work.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

(e) *Very heavy work.* Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light and sedentary work.

§ 404.1568 Skill requirements.

In order to evaluate your skills and to help determine the existence in the national economy of work you are able to do, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, we use materials published by the Department of Labor. When we make disability determinations under this subpart, we use the following definitions:

(a) *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding and offbearing (that is, placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled jobs.

(b) *Semi-skilled work.* Semi-skilled work is work which needs some skills but does not require doing the more complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

(c) *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

(d) *Skills that can be used in other work (transferability).*—(1) *What we mean by transferable skills.* We consider you to have skills that can be used in other jobs, when the skilled or semi-skilled work activities you did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

(2) *How we determine skills that can be transferred to other jobs.* Transferability is most probable and meaningful among jobs in which—

(i) The same or a lesser degree of skill is required;

(ii) The same or similar tools and machines are used; and

(iii) The same or similar raw materials, products, processes, or services are involved.

(3) *Degrees of transferability.* There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, we consider that they are not transferable.

(4) *Transferability of skills for persons of advanced age.* If you are of advanced age (age 55 or older), and you have a severe impairment(s) that limits you to *sedentary* or *light work,* we will find that you cannot make an adjustment to other work unless you have skills that you can transfer to other skilled or semiskilled work (or you have recently completed education which provides for direct entry into skilled work) that you can do despite your impairment(s). We will decide if you have transferable skills as follows. If you are of advanced age and you have a severe impairment(s) that limits you to no more than *sedentary* work, we will find that you have skills that are transferable to skilled or semiskilled sedentary work only if the sedentary work is so similar to your previous work that you would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See § 404.1567(a) and § 201.00(f) of appendix 2.) If you are of advanced age but have not attained age 60, and you have a severe impairment(s) that limits you to no more than *light* work, we will apply the rules in paragraphs (d)(1) through (d)(3) of this section to decide if you have skills that are transferable to skilled or semiskilled light work (see § 404.1567(b)). If you are *closely approaching retirement age* (age 60 or older) and you have a severe impairment(s) that limits you to no more than *light* work, we will find that you have skills that are transferable to skilled or semiskilled light work only if the light work is so similar to your previous work that you would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See § 404.1567(b) and Rule 202.00(f) of appendix 2 to this subpart.)

[45 FR 55584, Aug. 20, 1980, as amended at 65 FR 18000, Apr. 6, 2000; 73 FR 64197, Oct. 29, 2008]

§ 404.1569 Listing of Medical-Vocational Guidelines in appendix 2.

The Dictionary of Occupational Titles includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 provides rules using this data reflecting major functional and vocational patterns. We apply these rules in cases where a person is not doing substantial gainful activity and is prevented by a severe medically determinable impairment from doing vocationally relevant past work. (*See* § 404.1520(h) for an exception to this rule.) The rules in appendix 2 do not cover all possible variations of factors. Also, as we explain in § 200.00 of appendix 2, we do not apply these rules if one of the findings of fact about the person's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, we give full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, we use that rule to decide whether a person is disabled.

[45 FR 55584, Aug. 20, 1980, as amended at 77 FR 43494, July 25, 2012]

§ 404.1569a Exertional and nonexertional limitations.

(a) *General.* Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of both. Limitations are classified as exertional if they affect your ability to meet the

strength demands of jobs. The classification of a limitation as exertional is related to the United States Department of Labor's classification of jobs by various exertional levels (sedentary, light, medium, heavy, and very heavy) in terms of the strength demands for sitting, standing, walking, lifting, carrying, pushing, and pulling. Sections 404.1567 and 404.1569 explain how we use the classification of jobs by exertional levels (strength demands) which is contained in the Dictionary of Occupational Titles published by the Department of Labor, to determine the exertional requirements of work which exists in the national economy. Limitations or restrictions which affect your ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing or pulling, are considered nonexertional. When we decide whether you can do your past relevant work (*see* §§ 404.1520(f) and 404.1594(f)(7)), we will compare our assessment of your residual functional capacity with the demands of your past relevant work. If you cannot do your past relevant work, we will use the same residual functional capacity assessment along with your age, education, and work experience to decide if you can adjust to any other work which exists in the national economy. (*See* §§ 404.1520(g) and 404.1594(f)(8).) Paragraphs (b), (c), and (d) of this section explain how we apply the medical-vocational guidelines in appendix 2 of this subpart in making this determination, depending on whether the limitations or restrictions imposed by your impairment(s) and related symptoms, such as pain, are exertional, nonexertional, or a combination of both.

(b) *Exertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. When your impairment(s) and related symptoms only impose exertional limitations and your specific vocational profile is listed in a rule contained in appendix 2 of this subpart, we will directly apply that rule to decide whether you are disabled.

(c) *Nonexertional limitations.* (1) When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) You have difficulty functioning because you are nervous, anxious, or depressed;

(ii) You have difficulty maintaining attention or concentrating;

(iii) You have difficulty understanding or remembering detailed instructions;

(iv) You have difficulty in seeing or hearing;

(v) You have difficulty tolerating some physical feature(s) of certain work settings, e.g., you cannot tolerate dust or fumes; or

(vi) You have difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in appendix 2.

(d) *Combined exertional and nonexertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we consider that you have a combination of exertional and nonexertional limitations or restrictions. If your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands,

we will not directly apply the rules in appendix 2 unless there is a rule that directs a conclusion that you are disabled based upon your strength limitations; otherwise the rules provide a framework to guide our decision.

[56 FR 57943, Nov. 14, 1991, as amended at 68 FR 51163, Aug. 26, 2003]

SUBSTANTIAL GAINFUL ACTIVITY

§ 404.1571 General.

The work, without regard to legality, that you have done during any period in which you believe you are disabled may show that you are able to work at the substantial gainful activity level. If you are able to engage in substantial gainful activity, we will find that you are not disabled. (We explain the rules for persons who are statutorily blind in § 404.1584.) Even if the work you have done was not substantial gainful activity, it may show that you are able to do more work than you actually did. We will consider all of the medical and vocational evidence in your file to decide whether or not you have the ability to engage in substantial gainful activity.

[45 FR 55584, Aug. 20, 1980, as amended at 65 FR 42783, July 11, 2000]

§ 404.1572 What we mean by substantial gainful activity.

Substantial gainful activity is work activity that is both substantial and gainful:

(a) *Substantial work activity.* Substantial work activity is work activity that involves doing significant physical or mental activities. Your work may be substantial even if it is done on a part-time basis or if you do less, get paid less, or have less responsibility than when you worked before.

(b) *Gainful work activity.* Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

(c) *Some other activities.* Generally, we do not consider activities like taking care of yourself, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

§ 404.1573 General information about work activity.

(a) *The nature of your work.* If your duties require use of your experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that you have the ability to work at the substantial gainful activity level.

(b) *How well you perform.* We consider how well you do your work when we determine whether or not you are doing substantial gainful activity. If you do your work satisfactorily, this may show that you are working at the substantial gainful activity level. If you are unable, because of your impairments, to do ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work, this may show that you are not working at the substantial gainful activity level. If you are doing work that involves minimal duties that make little or no demands on you and that are of little or no use to your employer, or to the operation of a business if you are self-employed, this does not show that you are working at the substantial gainful activity level.

(c) *If your work is done under special conditions.* The work you are doing may be done under special conditions that take into account your impairment, such as work done in a sheltered workshop or as a patient in a hospital. If your work is done under special conditions, we may find that it does not show that you have the ability to do substantial gainful activity. Also, if you are forced to stop or reduce your work because of the removal of special conditions that were related to your impairment and essential to your work, we may find that your work does not show that you are able to do substantial gainful activity. However, work done under special conditions may show that you have the necessary skills and ability to work at the substantial gainful activity level. Examples of the special conditions that may relate to your impairment include, but are not limited to, situations in which—

(1) You required and received special assistance from other employees in performing your work;

(2) You were allowed to work irregular hours or take frequent rest periods;

(3) You were provided with special equipment or were assigned work especially suited to your impairment;

(4) You were able to work only because of specially arranged circumstances, for example, other persons helped you prepare for or get to and from your work;

(5) You were permitted to work at a lower standard of productivity or efficiency than other employees; or

(6) You were given the opportunity to work despite your impairment because of family relationship, past association with your employer, or your employer's concern for your welfare.

(d) *If you are self-employed.* Supervisory, managerial, advisory or other significant personal services that you perform as a self-employed individual may show that you are able to do substantial gainful activity.

(e) *Time spent in work.* While the time you spend in work is important, we will not decide whether or not you are doing substantial gainful activity only on that basis. We will still evaluate the work to decide whether it is substantial and gainful regardless of whether you spend more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

[45 FR 55584, Aug. 20, 1980, as amended at 65 FR 42783, July 11, 2000]

§ 404.1574 Evaluation guides if you are an employee.

(a) We use several guides to decide whether the work you have done shows that you are able to do substantial gainful activity. If you are working or have worked as an employee, we will use the provisions in paragraphs (a) through (d) of this section that are relevant to your work activity. We will use these provisions whenever they are appropriate, whether in connection with your application for disability benefits (when we make an initial determination on your application and throughout any appeals you may request), after you have become entitled to a period of disability or to disability benefits, or both.

(1) *Your earnings may show you have done substantial gainful activity.* Generally, in evaluating your work activity for substantial gainful activity purposes, our primary consideration will be the earnings you derive from the work activity. We will use your earnings to determine whether you have done substantial gainful activity unless we have information from you, your employer, or others that shows that we should not count all of your earnings. The amount of your earnings from work you have done (regardless of whether it is unsheltered or sheltered work) may show that you have engaged in substantial gainful activity. Generally, if you worked for substantial earnings, we will find that you are able to do substantial gainful activity. However, the fact that your earnings were not substantial will not necessarily show that you are not able to do substantial gainful activity. We generally consider work that you are forced to stop or to reduce below the substantial gainful activity level after a short time because of your impairment to be an unsuccessful work attempt. Your earnings from an unsuccessful work attempt will not show that you are able to do substantial gainful activity. We will use the criteria in paragraph (c) of this section to determine if the work you did was an unsuccessful work attempt.

(2) *We consider only the amounts you earn.* When we decide whether your earnings show that you have done substantial gainful activity, we do not consider any income that is not directly related to your productivity. When your earnings exceed the reasonable value of the work you perform, we consider only that part of your pay which you actually earn. If your earnings are being subsidized, we do not consider the amount of the subsidy when we determine if your earnings show that you have done substantial gainful activity. We consider your work to be subsidized if the true value of your work, when compared with the same or similar work done by unimpaired persons, is less than the actual amount of earnings paid to you for your work. For example, when a person with a serious impairment does simple

tasks under close and continuous supervision, our determination of whether that person has done substantial gainful activity will not be based only on the amount of the wages paid. We will first determine whether the person received a subsidy; that is, we will determine whether the person was being paid more than the reasonable value of the actual services performed. We will then subtract the value of the subsidy from the person's gross earnings to determine the earnings we will use to determine if he or she has done substantial gainful activity.

(3) *If you are working in a sheltered or special environment.* If you are working in a sheltered workshop, you may or may not be earning the amounts you are being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that you are not earning all you are being paid. Since persons in military service being treated for severe impairments usually continue to receive full pay, we evaluate work activity in a therapy program or while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of the work, rather than on the actual amount of the earnings.

(b) *Earnings guidelines*—(1) *General.* If you are an employee, we first consider the criteria in paragraph (a) of this section and § 404.1576, and then the guides in paragraphs (b)(2) and (3) of this section. When we review your earnings to determine if you have been performing substantial gainful activity, we will subtract the value of any subsidized earnings (see paragraph (a)(2) of this section) and the reasonable cost of any impairment-related work expenses from your gross earnings (see § 404.1576). The resulting amount is the amount we use to determine if you have done substantial gainful activity. We will generally average your earnings for comparison with the earnings guidelines in paragraphs (b)(2) and (3) of this section. See § 404.1574a for our rules on averaging earnings.

(2) *Earnings that will ordinarily show that you have engaged in substantial gainful activity.* We will consider that your earnings from your work activity as an employee (including earnings from work in a sheltered workshop or a comparable facility especially set up for severely impaired persons) show that you engaged in substantial gainful activity if:

(i) *Before January 1, 2001,* they averaged more than the amount(s) in Table 1 of this section for the time(s) in which you worked.

(ii) *Beginning January 1,* 2001, and each year thereafter, they average more than the larger of:

(A) The amount for the previous year, or

(B) An amount adjusted for national wage growth, calculated by multiplying $700 by the ratio of the national average wage index for the year 2 calendar years before the year for which the amount is being calculated to the national average wage index for the year 1998. We will then round the resulting amount to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

TABLE 1

For months:	Your monthly earnings averaged more than:
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
January 1990–June 1999	500
July 1999–December 2000	700

(3) *Earnings that will ordinarily show that you have not engaged in substantial gainful activity*—(i) *General.* If your average monthly earnings are equal to or less than the amount(s) determined under paragraph (b)(2) of this section for the year(s) in which you work, we will generally consider that the earnings from your work as an employee (including earnings from work in a sheltered workshop or comparable facility) will show that you have not engaged in substantial gainful activity. We will generally not consider other information in addition to your earnings except in the circumstances described in paragraph (b)(3)(ii) of this section.

(ii) *When we will consider other information in addition to your earnings.* We will generally consider other information in addition to your earnings if there is evidence indicating that you may be engaging in substantial gainful activity or that you are in a position to control when earnings are paid to you or the amount of wages paid to you (for example, if you are working for a small corporation owned by a relative). (See paragraph (b)(3)(iii) of this section for when we do not apply this rule.) Examples of other information we may consider include, whether—

(A) Your work is comparable to that of unimpaired people in your community who are doing the same or similar occupations as their means of livelihood, taking into account the time, energy, skill, and responsibility involved in the work; and

(B) Your work, although significantly less than that done by unimpaired people, is clearly worth the amounts shown in paragraph (b)(2) of this section, according to pay scales in your community.

(iii) *Special rule for considering earnings alone when evaluating the work you do after you have received social security disability benefits for at least 24 months.* Notwithstanding paragraph (b)(3)(ii) of this section, we will not consider other information in addition to your earnings to evaluate the work you are doing or have done if—

(A) At the time you do the work, you are entitled to social security disability benefits and you have received such benefits for at least 24 months (see paragraph (b)(3)(iv) of this section); and

(B) We are evaluating that work to consider whether you have engaged in substantial gainful activity or demonstrated the ability to engage in substantial gainful activity for the purpose of determining whether your disability has ceased because of your work activity (see §§ 404.1592a(a)(1) and (3)(ii) and 404.1594(d)(5) and (f)(1)).

(iv) *When we consider you to have received social security disability benefits for at least 24 months.* For purposes of paragraph (b)(3)(iii) of this section, social security disability benefits means disability insurance benefits for a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability. We consider you to have received such benefits for at least 24 months beginning with the first day of the first month following the 24th month for which you actually received social security disability benefits that you were due or constructively received such benefits. The 24 months do not have to be consecutive. We will consider you to have constructively received a benefit for a month for purposes of the 24-month requirement if you were otherwise due a social security disability benefit for that month and your monthly benefit was withheld to recover an overpayment. Any months for which you were entitled to benefits but for which you did not actually or constructively receive a benefit payment will not be counted for the 24-month requirement. If you also receive supplemental security income payments based on disability or blindness under title XVI of the Social Security Act, months for which you received only supplemental security income payments will not be counted for the 24-month requirement.

(c) *The unsuccessful work attempt*—(1) *General.* Ordinarily, work you have done will not show that you are able to do substantial gainful activity if, after you worked for a period of 6 months or less, your impairment forced you to stop working or to reduce the amount of work you do so that your earnings from such work fall below the substantial gainful activity earnings level in paragraph (b)(2) of this section, and you meet the conditions described in paragraphs (c)(2), (3), and (4) of this section. We will use the provisions of this paragraph when we make an initial determination on your application for disability benefits and throughout any appeal you may request. Except as set forth in § 404.1592a(a), we will also apply the provisions of this paragraph if you are already entitled to disability benefits, when you work and we consider whether the work you are doing is substantial gainful activity or demonstrates the ability to do substantial gainful activity.

(2) *Event that must precede an unsuccessful work attempt.* There must be a significant break in the continuity of

your work before we will consider that you began a work attempt that later proved unsuccessful. You must have stopped working or reduced your work and earnings below the substantial gainful activity earnings level because of your impairment or because of the removal of special conditions that were essential to the further performance of your work. We explain what we mean by special conditions in § 404.1573(c). We will consider your prior work to be ''discontinued'' for a significant period if you were out of work at least 30 consecutive days. We will also consider your prior work to be ''discontinued'' if, because of your impairment, you were forced to change to another type of work or another employer.

(3) *If you worked 6 months or less.* We will consider work of 6 months or less to be an unsuccessful work attempt if you stopped working or you reduced your work and earnings below the substantial gainful activity earnings level because of your impairment or because of the removal of special conditions that took into account your impairment and permitted you to work.

(4) *If you worked more than 6 months.* We will not consider work you performed at the substantial gainful activity earnings level for more than 6 months to be an unsuccessful work attempt regardless of why it ended or was reduced below the substantial gainful activity earnings level.

(d) *Work activity in certain volunteer programs.* If you work as a volunteer in certain programs administered by the Federal government under the Domestic Volunteer Service Act of 1973 or the Small Business Act, we will not count any payments you receive from these programs as earnings when we determine whether you are engaging in substantial gainful activity. These payments may include a minimal stipend, payments for supportive services such as housing, supplies and equipment, an expense allowance, or reimbursement of out-of-pocket expenses. We will also disregard the services you perform as a volunteer in applying any of the substantial gainful activity tests discussed in paragraph (b)(6) of this section. This exclusion from the substantial gainful activity provisions will apply only if you are a volunteer in a program explicitly mentioned in the Domestic Volunteer Service Act of 1973 or the Small Business Act. Programs explicitly mentioned in those Acts include Volunteers in Service to America, University Year for ACTION, Special Volunteer Programs, Retired Senior Volunteer Program, Foster Grandparent Program, Service Corps of Retired Executives, and Active Corps of Executives. We will not exclude under this paragraph, volunteer work you perform in other programs or any nonvolunteer work you may perform, including nonvolunteer work under one of the specified programs. For civilians in certain government-sponsored job training and employment programs, we evaluate the work activity on a case-by-case basis under the substantial gainful activity earnings test. In programs such as these, subsidies often occur. We will subtract the value of any subsidy and use the remainder to determine if you have done substantial gainful activity. See paragraphs (a)(2)-(3) of this section.

(e) *Work activity as a member or consultant of an advisory committee established under the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2.* If you are serving as a member or consultant of an advisory committee, board, commission, council, or similar group established under FACA, we will not count any payments you receive from serving on such committees as earnings when we determine whether you are engaging in substantial gainful activity. These payments may include compensation, travel expenses, and special assistance. We also will exclude the services you perform as a member or consultant of an advisory committee established under FACA in applying any of the substantial gainful activity tests discussed in paragraph (b)(6) of this section. This exclusion from the substantial gainful activity provisions will apply only if you are a member or consultant of an advisory committee specifically authorized by statute, or by the President, or determined as a matter of formal record by the head of a federal government agency. This exclusion from the substantial gainful activity provisions will not apply if your service as a member or consultant of an advisory committee is part of your duties or is required as an employee of

any governmental or non-governmental organization, agency, or business.

[46 FR 4869, Jan. 19, 1981, as amended at 48 FR 21936, May 16, 1983; 49 FR 22272, May 29, 1984; 54 FR 53605, Dec. 29, 1989; 64 FR 18570, Apr. 15, 1999; 64 FR 22903, Apr. 28, 1999; 65 FR 42783, July 11, 2000; 65 FR 82910, Dec. 29, 2000; 71 FR 3219, Jan. 20, 2006; 71 FR 66853, Nov. 17, 2006; 81 FR 71369, Oct. 17, 2016]

§ 404.1574a When and how we will average your earnings.

(a) If your work as an employee or as a self-employed person was continuous without significant change in work patterns or earnings, and there has been no change in the substantial gainful activity earnings levels, we will average your earnings over the entire period of work requiring evaluation to determine if you have done substantial gainful activity. See § 404.1592a for information on the reentitlement period.

(b) If you work over a period of time during which the substantial gainful activity earnings levels change, we will average your earnings separately for each period in which a different substantial gainful activity earnings level applies.

(c) If there is a significant change in your work pattern or earnings during the period of work requiring evaluation, we will average your earnings over each separate period of work to determine if any of your work efforts were substantial gainful activity.

(d) We will not average your earnings in determining whether benefits should be paid for any month(s) during or after the reentitlement period that occurs after the month disability has been determined to have ceased because of the performance of substantial gainful activity. See § 404.1592a for information on the reentitlement period. The following examples illustrate what we mean by a significant change in the work pattern of an employee and when we will average and will not average earnings.

Example 1: Mrs. H. began receiving disability insurance benefits in March 1993. In January 1995 she began selling magazines by telephone solicitation, expending a minimum of time, for which she received $225 monthly. As a result, Mrs. H. used up her trial work period during the months of January 1995 through September 1995. After the trial work period ended, we determined that Mrs. H. had not engaged in substantial gainful activity during her trial work period. Her reentitlement period began October 1995. In December 1995, Mrs. H. discontinued her telephone solicitation work to take a course in secretarial skills. In January 1997, she began work as a part-time temporary secretary in a banking firm. Mrs. H. worked 20 hours a week, without any subsidy or impairment-related work expenses, at beginner rates. She earned $285 per month in January 1997 and February 1997. In March 1997 she had increased her secretarial skills to journeyman level and was assigned as a part-time private secretary to one of the vice presidents of the banking firm. Mrs. H.'s earnings increased to $525 per month effective March 1997. We determined that Mrs. H. was engaging in substantial gainful activity beginning March 1997 and that her disability ceased that month, the first month of substantial gainful activity after the end of the trial work period. Mrs. H. is due payment for March 1997, the month of cessation, and the following 2 months (April 1997 and May 1997) because disability benefits terminate the third month following the earliest month in which she performed substantial gainful activity. We did not average earnings for the period January 1997 and February 1997 with the period beginning March 1997 because there was a significant change in earnings and work activity beginning March 1997. Thus, the earnings of January 1997 and February 1997 could not be averaged with those of March 1997 to reduce March 1997 earnings below the substantial gainful activity level. After we determine that Mrs. H.'s disability had ceased because of her performance of substantial gainful activity, we cannot average her earnings to determine whether she is due payment for any month during or after the reentitlement period. Beginning June 1997, the third month following the cessation month, we would evaluate all of Mrs. H.'s work activity on a month-by-month basis (see § 404.1592a(a)).

Example 2: Ms. M. began receiving disability insurance benefits in March 1992. In January 1995, she began selling cable television subscriptions by telephone solicitation, expending a minimum of time, for which she received $275 monthly. Ms. M. did not work in June 1995, and she resumed selling cable television subscriptions beginning July 1995. In this way, Ms. M. used up her 9-month trial work period during the months of January 1995 through May 1995 and July 1995 through October 1995. After Ms. M.'s trial work period ended, we determined that she had not engaged in substantial gainful activity during her trial work period. Ms. M.'s reentitlement period began November 1995. In December 1995, Ms. M. discontinued her telephone solicitation work to take a course in secretarial skills. In January 1997,

she began work as a part-time temporary secretary in an accounting firm. Ms. M. worked, without any subsidy or impairment-related work expenses, at beginner rates. She earned $460 in January 1997, $420 in February 1997, and $510 in March 1997. In April 1997, she had increased her secretarial skills to journeyman level, and she was assigned as a part-time private secretary to one of the vice presidents of the firm. Ms. M.'s earnings increased to $860 per month effective April 1997. We determined that Ms. M. was engaging in substantial gainful activity beginning April 1997 and that her disability ceased that month, the first month of substantial gainful activity after the end of the trial work period. She is due payment for April 1997, May 1997 and June 1997, because disability benefits terminate the third month following the earliest month in which she performs substantial gainful activity (the month of cessation). We averaged her earnings for the period January 1997 through March 1997 and determined them to be about $467 per month for that period. We did not average earnings for the period January 1997 through March 1997 with earnings for the period beginning April 1997 because there was a significant change in work activity and earnings beginning April 1997. Therefore, we found that the earnings for January 1997 through March 1997 were under the substantial gainful activity level. After we determine that Ms. M.'s disability has ceased because she performed substantial gainful activity, we cannot average her earnings in determining whether she is due payment for any month during or after the reentitlement period. In this example, beginning July 1997, the third month following the month of cessation, we would evaluate all of Ms. M.'s work activity on a month-by-month basis (see § 404.1592a(a)).

[65 FR 42784, July 11, 2000]

§ 404.1575 Evaluation guides if you are self-employed.

(a) *If you are a self-employed person.* If you are working or have worked as a self-employed person, we will use the provisions in paragraphs (a) through (e) of this section that are relevant to your work activity. We will use these provisions whenever they are appropriate, whether in connection with your application for disability benefits (when we make an initial determination on your application and throughout any appeals you may request), after you have become entitled to a period of disability or to disability benefits, or both.

(1) *How we evaluate the work you do after you have become entitled to disability benefits.* If you are entitled to social security disability benefits and you work as a self-employed person, the way we will evaluate your work activity will depend on whether the work activity occurs before or after you have received such benefits for at least 24 months and on the purpose of the evaluation. For purposes of paragraphs (a) and (e) of this section, social security disability benefits means disability insurance benefits for a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability. We will use the rules in paragraph (e)(2) of this section to determine if you have received such benefits for at least 24 months.

(i) We will use the guides in paragraph (a)(2) of this section to evaluate any work activity you do before you have received social security disability benefits for at least 24 months to determine whether you have engaged in substantial gainful activity, regardless of the purpose of the evaluation.

(ii) We will use the guides in paragraph (e) of this section to evaluate any work activity you do after you have received social security disability benefits for at least 24 months to determine whether you have engaged in substantial gainful activity for the purpose of determining whether your disability has ceased because of your work activity.

(iii) If we have determined under § 404.1592a(a)(1) that your disability ceased in a month during the reentitlement period because you performed substantial gainful activity, and we need to decide under § 404.1592a(a)(2)(i) or (a)(3)(i) whether you are doing substantial gainful activity in a subsequent month in or after your reentitlement period, we will use the guides in paragraph (a)(2) of this section (subject to the limitations described in § 404.1592a(a)(2)(i) and (a)(3)(i)) to determine whether your work activity in that month is substantial gainful activity. We will use the guides in paragraph (a)(2) of this section for these purposes, regardless of whether your work activity in that month occurs before or after you have received social security disability benefits for at least 24 months.

(2) *General rules for evaluating your work activity if you are self-employed.* We will consider your activities and their value to your business to decide whether you have engaged in substantial gainful activity if you are self-employed. We will not consider your income alone because the amount of income you actually receive may depend on a number of different factors, such as capital investment and profit-sharing agreements. We will generally consider work that you were forced to stop or reduce to below substantial gainful activity after 6 months or less because of your impairment as an unsuccessful work attempt. See paragraph (d) of this section. We will evaluate your work activity based on the value of your services to the business regardless of whether you receive an immediate income for your services. We determine whether you have engaged in substantial gainful activity by applying three tests. If you have not engaged in substantial gainful activity under test one, then we will consider tests two and three. The tests are as follows:

(i) *Test one:* You have engaged in substantial gainful activity if you render services that are significant to the operation of the business and receive a substantial income from the business. Paragraphs (b) and (c) of this section explain what we mean by significant services and substantial income for purposes of this test.

(ii) *Test Two:* You have engaged in substantial gainful activity if your work activity, in terms of factors such as hours, skills, energy output, efficiency, duties, and responsibilities, is comparable to that of unimpaired individuals in your community who are in the same or similar businesses as their means of livelihood.

(iii) *Test Three:* You have engaged in substantial gainful activity if your work activity, although not comparable to that of unimpaired individuals, is clearly worth the amount shown in §404.1574(b)(2) when considered in terms of its value to the business, or when compared to the salary that an owner would pay to an employee to do the work you are doing.

(b) *What we mean by significant services.* (1) If you are not a farm landlord and you operate a business entirely by yourself, any services that you render are significant to the business. If your business involves the services of more than one person, we will consider you to be rendering significant services if you contribute more than half the total time required for the management of the business, or you render management services for more than 45 hours a month regardless of the total management time required by the business.

(2) If you are a farm landlord, that is, you rent farm land to another, we will consider you to be rendering significant services if you materially participate in the production or the management of the production of the things raised on the rented farm. (See §404.1082 of this chapter for an explanation of *material participation*.) If you were given social security earnings credits because you materially participated in the activities of the farm and you continue these same activities, we will consider you to be rendering significant services.

(c) *What we mean by substantial income*—(1) *Determining countable income.* We deduct your normal business expenses from your gross income to determine net income. Once we determine your net income, we deduct the reasonable value of any significant amount of unpaid help furnished by your spouse, children, or others. Miscellaneous duties that ordinarily would not have commercial value would not be considered significant. We deduct impairment-related work expenses that have not already been deducted in determining your net income. Impairment-related work expenses are explained in §404.1576. We deduct unincurred business expenses paid for you by another individual or agency. An unincurred business expense occurs when a sponsoring agency or another person incurs responsibility for the payment of certain business expenses, e.g., rent, utilities, or purchases and repair of equipment, or provides you with equipment, stock, or other material for the operation of your business. We deduct soil bank payments if they were included as farm income. That part of your income remaining after we have made all applicable deductions represents the actual value of work

performed. The resulting amount is the amount we use to determine if you have done substantial gainful activity. For purposes of this section, we refer to this amount as your countable income. We will generally average your countable income for comparison with the earnings guidelines in § 404.1574(b)(2). See § 404.1574a for our rules on averaging of earnings.

(2) *When countable income is considered substantial.* We will consider your countable income to be substantial if—

(i) It averages more than the amounts described in § 404.1574(b)(2); or

(ii) It averages less than the amounts described in § 404.1574(b)(2) but it is either comparable to what it was before you became seriously impaired if we had not considered your earnings or is comparable to that of unimpaired self-employed persons in your community who are in the same or a similar business as their means of livelihood.

(d) *The unsuccessful work attempt*—(1) *General.* Ordinarily, work you have done will not show that you are able to do substantial gainful activity if, after working for a period of 6 months or less, you were forced by your impairment to stop working or to reduce the amount of work you do so that you are no longer performing substantial gainful activity and you meet the conditions described in paragraphs (d)(2), (3), and (4) of this section. We will use the provisions of this paragraph when we make an initial determination on your application for disability benefits and throughout any appeal you may request. Except as set forth in § 404.1592a(a), we will also apply the provisions of this paragraph if you are already entitled to disability benefits, when you work and we consider whether the work you are doing is substantial gainful activity or demonstrates the ability to do substantial gainful activity.

(2) *Event that must precede an unsuccessful work attempt.* There must be a significant break in the continuity of your work before we will consider you to have begun a work attempt that later proved unsuccessful. You must have stopped working or reduced your work and earnings below substantial gainful activity because of your impairment or because of the removal of special conditions which took into account your impairment and permitted you to work. Examples of such special conditions may include any significant amount of unpaid help furnished by your spouse, children, or others, or unincurred business expenses, as described in paragraph (c) of this section, paid for you by another individual or agency. We will consider your prior work to be ''discontinued'' for a significant period if you were out of work at least 30 consecutive days. We will also consider your prior work to be ''discontinued'' if, because of your impairment, you were forced to change to another type of work.

(3) *If you worked 6 months or less.* We will consider work of 6 months or less to be an unsuccessful work attempt if you stopped working or you reduced your work and earnings below the substantial gainful activity earnings level because of your impairment or because of the removal of special conditions that took into account your impairment and permitted you to work.

(4) *If you worked more than 6 months.* We will not consider work you performed at the substantial gainful activity level for more than 6 months to be an unsuccessful work attempt regardless of why it ended or was reduced below the substantial gainful activity earnings level.

(e) *Special rules for evaluating the work you do after you have received social security disability benefits for at least 24 months*—(1) *General.* We will apply the provisions of this paragraph to evaluate the work you are doing or have done if, at the time you do the work, you are entitled to social security disability benefits and you have received such benefits for at least 24 months. We will apply the provisions of this paragraph only when we are evaluating that work to consider whether you have engaged in substantial gainful activity or demonstrated the ability to engage in substantial gainful activity for the purpose of determining whether your disability has ceased because of your work activity (see §§ 404.1592a(a)(1) and (3)(ii) and 404.1594(d)(5) and (f)(1)). We will use the countable income test described in paragraph (e)(3) of this section to determine whether the work you do after you have received such

benefits for at least 24 months is substantial gainful activity or demonstrates the ability to do substantial gainful activity. We will not consider the services you perform in that work to determine that the work you are doing shows that you are able to engage in substantial gainful activity and are, therefore, no longer disabled. However, we may consider the services you perform to determine that you are not doing substantial gainful activity. We will generally consider work that you were forced to stop or reduce below substantial gainful activity after 6 months or less because of your impairment as an unsuccessful work attempt. See paragraph (d) of this section.

(2) *The 24-month requirement.* For purposes of paragraphs (a)(1) and (e) of this section, we consider you to have received social security disability benefits for at least 24 months beginning with the first day of the first month following the 24th month for which you actually received social security disability benefits that you were due or constructively received such benefits. The 24 months do not have to be consecutive. We will consider you to have constructively received a benefit for a month for purposes of the 24-month requirement if you were otherwise due a social security disability benefit for that month and your monthly benefit was withheld to recover an overpayment. Any months for which you were entitled to benefits but for which you did not actually or constructively receive a benefit payment will not be counted for the 24-month requirement. If you also receive supplemental security income payments based on disability or blindness under title XVI of the Social Security Act, months for which you received only supplemental security income payments will not be counted for the 24-month requirement.

(3) *Countable income test.* We will compare your countable income to the earnings guidelines in § 404.1574(b)(2) to determine if you have engaged in substantial gainful activity. See paragraph (c)(1) of this section for an explanation of countable income. We will consider that you have engaged in substantial gainful activity if your monthly countable income averages more than the amounts described in § 404.1574(b)(2) for the month(s) in which you work, unless the evidence shows that you did not render significant services in the month(s). See paragraph (b) of this section for what we mean by significant services. If your average monthly countable income is equal to or less than the amounts in § 404.1574(b)(2) for the month(s) in which you work, or if the evidence shows that you did not render significant services in the month(s), we will consider that your work as a self-employed person shows that you have not engaged in substantial gainful activity.

[46 FR 4870, Jan. 19, 1981, as amended at 48 FR 21936, May 16, 1983; 49 FR 22272, May 29, 1984; 65 FR 42785, July 11, 2000; 71 FR 66854, Nov. 17, 2006; 81 FR 71369, Oct. 17, 2016]

§ 404.1576 Impairment-related work expenses.

(a) *General.* When we figure your earnings in deciding if you have done substantial gainful activity, we will subtract the reasonable costs to you of certain items and services which, because of your impairment(s), you need and use to enable you to work. The costs are deductible even though you also need or use the items and services to carry out daily living functions unrelated to your work. Paragraph (b) of this section explains the conditions for deducting work expenses. Paragraph (c) of this section describes the expenses we will deduct. Paragraph (d) of this section explains when expenses may be deducted. Paragraph (e) of this section describes how expenses may be allocated. Paragraph (f) of this section explains the limitations on deducting expenses. Paragraph (g) of this section explains our verification procedures.

(b) *Conditions for deducting impairment-related work expenses.* We will deduct impairment-related work expenses if—

(1) You are otherwise disabled as defined in §§ 404.1505, 404.1577 and 404.1581–404.1583;

(2) The severity of your impairment(s) requires you to purchase (or rent) certain items and services in order to work;

(3) You pay the cost of the item or service. No deduction will be allowed to the extent that payment has been or

will be made by another source. No deduction will be allowed to the extent that you have been, could be, or will be reimbursed for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if you purchase crutches for $80 but you were, could be, or will be reimbursed $64 by some agency, plan, or program, we will deduct only $16;

(4) You pay for the item or service in a month you are working (in accordance with paragraph (d) of this section); and

(5) Your payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

(c) *What expenses may be deducted*—(1) *Payments for attendant care services.* (i) If because of your impairment(s) you need assistance in traveling to and from work, or while at work you need assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments you make for those services may be deducted.

(ii) If because of your impairment(s) you need assistance with personal functions (e.g., dressing, administering medications) at home in preparation for going to and assistance in returning from work, the payments you make for those services may be deducted.

(iii)(A) We will deduct payments you make to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

(B) We consider a family member to be anyone who is related to you by blood, marriage or adoption, whether or not that person lives with you.

(iv) If only part of your payment to a person is for services that come under the provisions of paragraph (c)(1) of this section, we will only deduct that part of the payment which is attributable to those services. For example, an attendant gets you ready for work and helps you in returning from work, which takes about 2 hours a day. The rest of his or her 8 hour day is spent cleaning your house and doing your laundry, etc. We would only deduct one-fourth of the attendant's daily wages as an impairment-related work expense.

(2) *Payments for medical devices.* If your impairment(s) requires that you utilize medical devices in order to work, the payments you make for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment which can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(3) *Payments for prosthetic devices.* If your impairment(s) requires that you utilize a prosthetic device in order to work, the payments you make for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

(4) *Payments for equipment.* (i) *Work-related equipment.* If your impairment(s) requires that you utilize special equipment in order to do your job, the payments you make for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, vision aids, sensory aids for the blind, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

(ii) *Residential modifications.* If your impairment(s) requires that you make modifications to your residence, the location of your place of work will determine if the cost of these modifications will be deducted. If you are employed away from home, only the cost of changes made outside of your home to permit you to get to your means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of your home will not be deducted. If you work at home, the costs of modifying the inside of your home in order to create a working space to accommodate your impairment(s) will be deducted to

the extent that the changes pertain specifically to the space in which you work. Examples of such changes are the enlargement of a doorway leading into the workspace or modification of the workspace to accommodate problems in dexterity. However, if you are self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) *Nonmedical appliances and equipment.* Expenses for appliances and equipment which you do not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is essential for the control of your disabling condition, thus enabling you to work. To be considered essential, the item must be of such a nature that if it were not available to you there would be an immediate adverse impact on your ability to function in your work activity. In this situation, the expense is deductible whether the item is used at home or in the working place. An example would be the need for an electric air cleaner by an individual with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If it is prescribed and used as necessary treatment of your impairment and necessary to enable you to work, we will deduct payments you make toward its cost.

(5) *Payments for drugs and medical services.* (i) If you must use drugs or medical services (including diagnostic procedures) to control your impairment(s) the payments you make for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of your impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are anticonvulsant drugs to control epilepsy or anticonvulsant blood level monitoring; antidepressant medication for mental disorders; medication used to allay the side effects of certain treatments; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal disorders; electroencephalograms and brain scans related to a disabling epileptic condition; tests to determine the efficacy of medication on a diabetic condition; and immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) We will only deduct the costs of drugs or services that are directly related to your impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

(6) *Payments for similar items and services*—(i) *General.* If you are required to utilize items and services not specified in paragraphs (c) (1) through (5) of this section but which are directly related to your impairment(s) and which you need to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, the purchase and maintenance of a dog guide which you need to work, and transportation.

(ii) *Medical supplies and services not described above.* We will deduct payments you make for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. We will also deduct payments you make for physical therapy which you require because of your impairment(s) and which you need in order to work.

(iii) *Payments for transportation costs.* We will deduct transportation costs in these situations:

(A) Your impairment(s) requires that in order to get to work you need a vehicle that has structural or operational modifications. The modifications must be critical to your operation or use of the vehicle and directly related to your

impairment(s). We will deduct the costs of the modifications, but not the cost of the vehicle. We will also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs.

(B) Your impairment(s) requires you to use driver assistance, taxicabs or other hired vehicles in order to work. We will deduct amounts paid to the driver and, if your own vehicle is used, we will also deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(C) Your impairment(s) prevents your taking available public transportation to and from work and you must drive your (unmodified) vehicle to work. If we can verify through your physician or other sources that the need to drive is caused by your impairment(s) (and not due to the unavailability of public transportation), we will deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(7) *Payments for installing, maintaining, and repairing deductible items.* If the device, equipment, appliance, etc., that you utilize qualifies as a deductible item as described in paragraphs (c) (2), (3), (4) and (6) of this section, the costs directly related to installing, maintaining and repairing these items are also deductible. (The costs which are associated with modifications to a vehicle are deductible. Except for a mileage allowance, as provided for in paragraph (c)(6)(iii) of this section, the costs which are associated with the vehicle itself are not deductible.)

(d) *When expenses may be deducted*—(1) *Effective date.* To be deductible an expense must be incurred after November 30, 1980. An expense may be considered incurred after that date if it is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

(2) *Payments for services.* A payment you make for services may be deducted if the services are received while you are working and the payment is made in a month you are working. We consider you to be working even though you must leave work temporarily to receive the services.

(3) *Payments for items.* A payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if payment is made in a month you are working. See paragraph (e)(4) of this section when purchases are made in anticipation of work.

(e) *How expenses are allocated*—(1) *Recurring expenses.* You may pay for services on a regular periodic basis, or you may purchase an item on credit and pay for it in regular periodic installments or you may rent an item. If so, each payment you make for the services and each payment you make toward the purchase or rental (including interest) is deductible in the month it is made.

Example: B starts work in October 1981 at which time she purchases a medical device at a cost of $4,800 plus interest charges of $720. Her monthly payments begin in October. She earns and receives $400 a month. The term of the installment contract is 48 months. No downpayment is made. The monthly allowable deduction for the item would be $115 ($5520 divided by 48) for each month of work during the 48 months.

(2) *Nonrecurring expenses.* Part or all of your expenses may not be recurring. For example, you may make a one-time payment in full for an item or service or make a downpayment. If you are working when you make the payment we will either deduct the entire amount in the month you pay it or allocate the amount over a 12 consecutive month period beginning with the month of payment, whichever you select.

Example: A begins working in October 1981 and earns $525 a month. In the same month he purchases and pays for a deductible item at a cost of $250. In this situation we could allow a $250 deduction for October 1981, reducing A's earnings below the SGA level for that month.

If A's earnings had been $15 above the SGA earnings amount, A probably would select the option of projecting the $250 payment over the 12-month period, October 1981–September 1982, giving A an allowable deduction of $20.83 a month for each month of work during that period. This deduction would reduce A's earnings below the SGA level for 12 months.

(3) *Allocating downpayments.* If you make a downpayment we will, if you choose, make a separate calculation for the downpayment in order to provide for uniform monthly deductions. In these situations we will determine the total payment that you will make over a 12 consecutive month period beginning with the month of the downpayment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period if your regular monthly payments will extend over a period of less than 12 months.

Example 1. C starts working in October 1981, at which time he purchases special equipment at a cost of $4,800, paying $1,200 down. The balance of $3,600, plus interest of $540, is to be repaid in 36 installments of $115 a month beginning November 1981. C earns $500 a month. He chooses to have the downpayment allocated. In this situation we would allow a deduction of $205.42 a month for each month of work during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of $115 for each month of work during the remaining installment period.

Explanation:

Downpayment in 10/81	$1,200	
Monthly payments 11/81 through 09/82	1,265	
	12) 2,465	= $205.42

Example 2. D, while working, buys a deductible item in July 1981, paying $1,450 down. However, his first monthly payment of $125 is not due until September 1981. D chooses to have the downpayment allocated. In this situation we would allow a deduction of $225 a month for each month of work during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of $125 for each month of work.

Explanation:

Downpayment in 07/81	$1,450	
Monthly payments 09/81 through 06/82	1,250	
	12) 2,700	= $225

(4) *Payments made in anticipation of work.* A payment toward the cost of a deductible item that you made in any of the 11 months preceding the month you started working will be taken into account in determining your impairment-related work expenses. When an item is paid for in full during the 11 months preceding the month you started working the payment will be allocated over the 12-consecutive month period beginning with the month of the payment. However, the only portion of the payment which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of $600, the deductible amount would be $450 ($600 divided by 12, multiplied by 9). Installment payments (including a downpayment) that you made for a particular item during the 11 months preceding the month you started working will be totaled and considered to have been made in the month of your first payment for that item within this 11 month period. The sum of these payments will be allocated over the 12-consecutive month period beginning with the month of your first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for in 3 monthly installments of $200 each, the total payment of $600 will be considered to have been made in the month of the first payment, that is, 3 months before the month work began. The deductible amount would be $450 ($600 divided by 12, multiplied by 9). The amount, as determined by these formulas, will then be considered to have been paid in the first month of work. We will deduct either this entire amount in the first month of work or allocate it over a 12-consecutive month period beginning with the first month of work, whichever you select. In the above examples, the individual would have the choice of having the entire $450 deducted in the first month of work or of having $37.50 a month ($450 divided by 12) deducted for each month that he works over a 12-consecutive month period, beginning with the first month of work. To be deductible the payments must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, nonmedical appliances

and vehicle modifications. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for purposes of this paragraph.

(f) *Limits on deductions.* (1) We will deduct the actual amounts you pay towards your impairment-related work expenses unless the amounts are unreasonable. With respect to durable medical equipment, prosthetic devices, medical services, and similar medically-related items and services, we will apply the prevailing charges under Medicare (part B of title XVIII, Health Insurance for the Aged and Disabled) to the extent that this information is readily available. Where the Medicare guides are used, we will consider the amount that you pay to be reasonable if it is no more than the prevailing charge for the same item or service under the Medicare guidelines. If the amount you actually pay is more than the prevailing charge for the same item under the Medicare guidelines, we will deduct from your earnings the amount you paid to the extent you establish that the amount is consistent with the standard or normal charge for the same or similar item or service in your community. For items and services that are not listed in the Medicare guidelines, and for items and services that are listed in the Medicare guidelines but for which such guides cannot be used because the information is not readily available, we will consider the amount you pay to be reasonable if it does not exceed the standard or normal charge for the same or similar item(s) or service(s) in your community.

(2) Impairment-related work expenses are not deducted in computing your earnings for purposes of determining whether your work was ''services'' as described in § 404.1592(b).

(3) The decision as to whether you performed substantial gainful activity in a case involving impairment-related work expenses for items or services necessary for you to work generally will be based upon your ''earnings'' and not on the value of ''services'' you rendered. (See §§ 404.1574(b)(6) (i) and (ii), and 404.1575(a)). This is not necessarily so, however, if you are in a position to control or manipulate your earnings.

(4) The amount of the expenses to be deducted must be determined in a uniform manner in both the disability insurance and SSI programs.

(5) No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent that you have been, could be, or will be, reimbursed for payments you made. (See paragraph (b)(3) of this section.)

(6) The provisions described in the foregoing paragraphs of this section are effective with respect to expenses incurred on and after December 1, 1980, although expenses incurred after November 1980 as a result of contractual or other arrangements entered into before December 1980, are deductible. For months before December 1980 we will deduct impairment-related work expenses from your earnings only to the extent they exceeded the normal work-related expenses you would have had if you did not have your impairment(s). We will not deduct expenses, however, for those things which you needed even when you were not working.

(g) *Verification.* We will verify your need for items or services for which deductions are claimed, and the amount of the charges for those items or services. You will also be asked to provide proof that you paid for the items or services.

[48 FR 21936, May 16, 1983]

WIDOWS, WIDOWERS, AND SURVIVING DIVORCED SPOUSES

§ 404.1577 Disability defined for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.

For monthly benefits payable for months prior to January 1991, the law provides that to be entitled to a widow's or widower's benefit as a disabled widow, widower, or surviving divorced spouse, you must have a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. The impairment(s) must have been of a level of severity to prevent a person from doing

any gainful activity. To determine whether you were disabled, we consider only your physical or mental impairment(s). We do not consider your age, education, and work experience. We also do not consider certain felony-related and prison-related impairments, as explained in § 404.1506. (For monthly benefits payable for months after December 1990, see § 404.1505(a).)

[57 FR 30120, July 8, 1992]

§ 404.1578 How we determine disability for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.

(a) For monthly benefits payable for months prior to January 1991, we will find that you were disabled and pay you widow's or widower's benefits as a widow, widower, or surviving divorced spouse if—

(1) Your impairment(s) had specific clinical findings that were the same as those for any impairment in the Listing of Impairments in appendix 1 of this subpart or were medically equivalent to those for any impairment shown there;

(2) Your impairment(s) met the duration requirement.

(b) However, even if you met the requirements in paragraphs (a) (1) and (2) of this section, we will not find you disabled if you were doing substantial gainful activity.

[57 FR 30121, July 8, 1992]

§ 404.1579 How we will determine whether your disability continues or ends.

(a) *General.* (1) The rules for determining whether disability continues for widow's or widower's monthly benefits for months after December 1990 are discussed in §§ 404.1594 through 404.1598. The rules for determining whether disability continues for monthly benefits for months prior to January 1991 are discussed in paragraph (a)(2) of this section and paragraphs (b) through (h) of this section.

(2) If you are entitled to disability benefits as a disabled widow, widower, or surviving divorced spouse, and we must decide whether your disability continued or ended for monthly benefits for months prior to January 1991, there are a number of factors we consider in deciding whether your disability continued. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not so medically improved, we must address whether one or more exceptions applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases (see paragraph (e) of this section for exceptions) before we can find that you are no longer disabled, we must also show that your impairment(s), as shown by current medical evidence, is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity.

(b) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review your claim to determine whether your disability continues.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus which was determined to equal the level of severity contemplated by Listing 1.05.C. At the time of our prior favorable decision, you had had a laminectomy. Postoperatively, a myelogram still showed evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim your treating physician reported that he had seen you regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of

pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has *not* occurred because there has been no decrease in the severity of your back impairment as shown by changes in symptoms, signs, or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis of a severity as described in Listing 1.02 of appendix 1 of this subpart. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remissions and exacerbations the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would then determine if this medical improvement is related to your ability to work.

(2) *Determining whether medical improvement is related to your ability to work.* If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the listing section which was used in making our most recent favorable decision, we will find that the medical improvement was related to your ability to work. We make this finding because the criteria in appendix 1 of this subpart are related to ability to work because they reflect impairments which are considered severe enough to prevent a person from doing any gainful work. We must, of course, also establish that, considering all of your current impairments not just those which existed at the time of the most recent prior favorable medical decision, your condition does not meet or equal the requirements of appendix 1 before we could find that your disability has ended. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

(3) *Determining whether your impairment(s) is deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity.* Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases before we can find that you are no longer disabled, we must also show that your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. All current impairments will be considered, not just the impairment(s) present at the time of our most recent favorable determination. Sections 404.1525, 404.1526, and 404.1578 set out how we will decide whether your impairment(s) meets or equals the requirements of appendix 1 of this subpart.

(4) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources. What constitutes ''evidence'' and our procedures for obtaining it are set out in §§ 404.1512 through 404.1518. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(5) *Point of comparison.* For purposes of determining whether medical improvement has occurred, we will compare the current severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will determine whether the medical improvement is related to your ability to do work based on this previously existing impairment(s). The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(c) *Determining medical improvement and its relationship to your ability to do work.* Paragraphs (b) (1) and (2) of this section discuss what we mean by medical improvement and how we determine whether medical improvement is related to your ability to work.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. Whether medical improvement has occurred is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(2) *Determining whether medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the signs, symptoms and laboratory findings, we then must determine if it is related to your ability to do work, as explained in paragraph (b)(2) of this section. In determining if the medical improvement that has occurred is related to your ability to work, we will assess whether the previously existing impairments still meet or equal the level of severity contemplated by the same listing section in appendix 1 of this subpart which was used in making our most recent favorable decision. Appendix 1 of this subpart describes impairments which, if severe enough, affect a person's ability to work. If the appendix level of severity is met or equaled, the individual is deemed, in the absence of evidence of the contrary, to be unable to engage in gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. Unless an objective assessment shows that the listing requirement is no longer met or equaled based on actual changes shown by the medical evidence, the medical improvement that has occurred will not be considered to be related to your ability to work.

(3) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether your current impairment(s) is deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. (In this way, we will be able to determine that your disability continues at the earliest time without addressing the issue of reconstructing prior evidence which can be a lengthy process.) If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (e) of this section). If not, we will determine whether an attempt should be made to reconstruct those portions of the file that were relevant to our most recent favorable medical decision (e.g., medical evidence from treating sources and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation, etc.; and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with the rules in § 404.988.

(4) *Impairment(s) subject to temporary remission.* In some cases the evidence shows that an individual's impairment is subject to temporary remission. In assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairment(s), including the occurrence of prior remissions, and prospects for future worsening of the impairment(s). Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(5) *Applicable listing has been revised since the most recent favorable medical decision.* When determining whether any medical improvement is related to your ability to work, we use the same listing section in appendix 1 of this

subpart which was used to make our prior favorable decision. We will use the listing as it appeared at the time of the prior decision, even where the requirement(s) of the listing was subsequently changed. The current revised listing requirement will be used if we determine that you have medically improved and it is necessary to determine whether you are now considered unable to engage in gainful activity.

(d) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if your impairment(s) is no longer considered, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, before we can find you are no longer disabled, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. As part of the review process, you will be asked about any medical therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception does or does not apply.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical therapy or technology (related to your ability to work).* Advances in medical therapy or technology are improvements in treatment or rehabilitative methods which have favorably affected the severity of your impairment(s). We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment(s). This decision will be based on new medical evidence. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of this subpart will be based on new or improved diagnostic or evaluative techniques. Such listing changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) A cumulative list since 1970 of new or improved diagnostic techniques or evaluations, how they changed the evaluation of the applicable impairment and the month and year they became generally available, will be published in the *Notices* section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically. The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(3) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 of this subpart was misapplied).

Example: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether your current impairment(s) meets or equals the requirements of appendix 1 of this subpart.

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously granted disability benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments.

The prior record shows that you had ''brittle'' diabetes for which you were taking insulin. Your urine was 3 + for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator believes, however, that your impairment does not equal the severity contemplated by the listings. Error *cannot* be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see § 404.988) are met.

(4) *You are currently engaging in substantial gainful activity.* If you are currently engaging in substantial gainful activity before we determine whether you are no longer disabled because of your work activity, we will consider whether you are entitled to a trial work period as set out in § 404.1592. We will find that your disability has ended in the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether you continue to have a disabling impairment(§ 404.1511) for purposes of deciding your eligibility for a reentitlement period (§ 404.1592a).

(e) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in gainful activity.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 404.988. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will determine that your disability has ended. The month your disability ends will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 404.1530(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(f) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may stop and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are

still unable to engage in gainful activity. The steps are:

(1) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended.

(2) If you are not, has there been medical improvement as defined in paragraph (b)(1) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (3). If there has been no decrease in medical severity, there has been no medical improvement. (see step (4).)

(3) If there has been medical improvement, we must determine (in accordance with paragraph (b)(2) of this section) whether it is related to your ability to work. If medical improvement is *not* related to your ability to do work, see step (4). If medical improvement is related to your ability to do work, see step (5).

(4) If we found at step (2) that there has been no medical improvement or if we found at step (3) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (d) and (e) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement (see paragraph (d) of this section) applies, we will proceed to step (5). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(5) If medical improvement is related to your ability to work or if one of the first group of exceptions to medical improvement applies, we will determine (considering all your impairments) whether the requirements of appendix 1 of this subpart are met or equaled. If your impairment(s) meets or equals the requirements of appendix 1 of this subpart, your disability will be found to continue. If not, your disability will be found to have ended.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the earliest of the following months—

(1) The month the evidence shows you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See § 404.1592 for a discussion of the trial work period, § 404.1592a for a discussion of the reentitlement period, and § 404.337 for when your benefits will end.);

(4) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, as long as we expected your impairment(s) to improve (see § 404.1591);

(5) The first month in which you failed to do what we asked, without good cause when the rule set out in paragraph (e)(2) of this section applies;

(6) The first month in which the question of continuing disability arose and we could not find you, when the rule set out in paragraph (e)(3) of this section applies;

(7) The first month in which you failed to follow prescribed treatment without good cause, when the rule set out in paragraph (e)(4) of this section applies; or

(8) The first month you were told by your physician that you could return to work provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by medical evidence.

(h) *Before we stop your benefits.* Before we determine you are no longer disabled, we will give you a chance to explain why we should not do so. Sections 404.1595 and 404.1597 describe your rights (including appeal rights) and the procedures we will follow.

[50 FR 50126, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 57 FR 30121, July 8, 1992; 59 FR 1635, Jan. 12, 1994; 82 FR 5871, Jan. 18, 2017]

BLINDNESS

§ 404.1581 Meaning of blindness as defined in the law.

We will consider you blind under the law for a period of disability and for payment of disability insurance benefits if we determine that you are statutorily blind. Statutory blindness is defined in the law as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less. Your blindness must meet the duration requirement in § 404.1509. We do not consider certain felony-related and prison-related impairments, as explained in § 404.1506.

[45 FR 55584, Aug. 20, 1980, as amended at 48 FR 5715, Feb. 8, 1983]

§ 404.1582 A period of disability based on blindness.

If we find that you are blind and you meet the insured status requirement, we may establish a period of disability for you regardless of whether you can do substantial gainful activity. A period of disability protects your earnings record under Social Security so that the time you are disabled will not count against you in determining whether you will have worked long enough to qualify for benefits and the amount of your benefits. However, you will not necessarily be entitled to receive disability insurance cash benefits even though you are blind. If you are a blind person under age 55, you must be unable to do any substantial gainful activity in order to be paid disability insurance cash benefits.

§ 404.1583 How we determine disability for blind persons who are age 55 or older.

We will find that you are eligible for disability insurance benefits even though you are still engaging in substantial gainful activity, if—

(a) You are blind;

(b) You are age 55 or older; and

(c) You are unable to use the skills or abilities like the ones you used in any substantial gainful activity which you did regularly and for a substantial period of time. (However, you will not be paid any cash benefits for any month in which you are doing substantial gainful activity.)

§ 404.1584 Evaluation of work activity of blind people.

(a) *General.* If you are blind (as explained in § 404.1581), we will consider the earnings from the work you are doing to determine whether or not you should be paid cash benefits.

(b) *Under Age 55.* If you are under age 55, we will evaluate the work you are doing using the guides in paragraph (d) of this section to determine whether or not your work shows that you are doing substantial gainful activity. If you are not doing substantial gainful activity, we will pay you cash benefits. If you are doing substantial gainful activity, we will not pay you cash benefits. However, you will be given a period of disability as described in subpart D of this part.

(c) *Age 55 or older.* If you are age 55 or older, we will evaluate your work using the guides in paragraph (d) of this section to determine whether or not your work shows that you are doing substantial gainful activity. If you have not shown this ability, we will pay you cash benefits. If you have shown an ability to do substantial gainful activity, we will evaluate your work activity to find out how your work compares with the work you did before. If the skills and abilities of your new work are about the same as those you used in the work you did before, we will not pay you cash benefits. However, if your new work requires skills and abilities which are less than or different than those you used in the work you did before, we will pay you cash benefits, but not for any month in

which you actually perform substantial gainful activity.

(d) *Evaluation of earnings*—(1) *Earnings that will ordinarily show that you have engaged in substantial gainful activity*. We will ordinarily consider that your earnings from your work activities show that you have engaged in substantial gainful activity if your monthly earnings average more than the amount(s) shown in paragraphs (d)(2) and (3) of this section. We will apply §§ 404.1574(a)(2), 404.1575(c), and 404.1576 in determining the amount of your average earnings.

(2) *Substantial gainful activity guidelines for taxable years before 1978*. For work activity performed in taxable years before 1978, the average earnings per month that we ordinarily consider enough to show that you have done substantial gainful activity are the same for blind people as for others. See § 404.1574(b)(2) for the earnings guidelines for other than blind individuals.

(3) *Substantial gainful activity guidelines for taxable years beginning 1978*. For taxable years beginning 1978, if you are blind, the law provides different earnings guidelines for determining if your earnings from your work activities are substantial gainful activity. Ordinarily, we consider your work to be substantial gainful activity, if your average monthly earnings are more than those shown in Table I. For years after 1977 and before 1996, increases in the substantial gainful activity guideline were linked to increases in the monthly exempt amount under the retirement earnings test for individuals aged 65 to 69. Beginning with 1996, increases in the substantial gainful activity amount have depended only on increases in the national average wage index.

TABLE I

Over	In year(s)
$334	1978
$375	1979
$417	1980
$459	1981
$500	1982
$550	1983
$580	1984
$610	1985
$650	1986
$680	1987
$700	1988
$740	1989
$780	1990
$810	1991
$850	1992
$880	1993
$930	1994
$940	1995
$960	1996
$1,000	1997
$1,050	1998
$1,110	1999
$1,170	2000

[45 FR 55584, Aug. 20, 1980, as amended at 48 FR 21939, May 16, 1983; 65 FR 42786, July 11, 2000]

§ 404.1585 Trial work period for persons age 55 or older who are blind.

If you become eligible for disability benefits even though you were doing substantial gainful activity because you are blind and age 55 or older, you are entitled to a trial work period if—

(a) You later return to substantial gainful activity that requires skills or abilities comparable to those required in the work you regularly did before you became blind or became 55 years old, whichever is later; or

(b) Your last previous work ended because of an impairment and the current work requires a significant vocational adjustment.

§ 404.1586 Why and when we will stop your cash benefits.

(a) *When you are not entitled to benefits.* If you become entitled to disability cash benefits as a statutorily blind person, we will find that you are no longer entitled to benefits beginning with the earliest of—

(1) The month your vision, based on current medical evidence, does not meet the definition of blindness and your disability does not continue under the rules in § 404.1594 and you were disabled only for a specified period of time in the past;

(2) The month your vision, based on current medical evidence, does not meet the definition of blindness and your disability does not continue under the rules in § 404.1594, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) If you are under age 55, the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See § 404.1592a for a discussion of the reentitlement period, and § 404.316 on when your benefits will end.); or

(4) If you are age 55 or older, the month (following completion of a trial work period) when your work activity shows you are able to use, in substantial gainful activity, skills and abilities comparable to those of some gainful activity which you did with some regularity and over a substantial period of time. The skills and abilities are compared to the activity you did prior to age 55 or prior to becoming blind, whichever is later.

(b) *If we find that you are not entitled to disability cash benefits.* If we find that you are not entitled to disability cash benefits on the basis of your work activity but your visual impairment is sufficiently severe to meet the definition of blindness, the period of disability that we established for you will continue.

(c) *If you do not follow prescribed treatment.* If treatment has been prescribed for you that can restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have a good reason for failing to follow that treatment (see § 404.1530(c)), we will find that your disability has ended. The month in which your disability will be found to have ended will be the first month in which you failed to follow the prescribed treatment.

(d) *If you do not cooperate with us.* If we ask you to give us medical or other evidence or to go for a medical examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability will be found to have ended will be the month in which you failed to do what we asked.

(e) *If we are unable to find you.* If there is a question about whether you continue to be disabled by blindness and we are unable to find you to resolve the question, we will find that your disability, has ended. The month it ends will be the first month in which the question arose and we could not find you.

(f) *Before we stop your benefits.* Before we stop your benefits or period of disability, we will give you a chance to give us your reasons why we should not stop your benefits or your period of disability. Section 404.1595 describes your rights and the procedures we will follow.

(g) *If you are in an appropriate program of vocational rehabilitation services, employment services, or other support services.* (1) Your benefits, and those of your dependents, may be continued after your impairment is no longer disabling if—

(i) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 404.327(a) and (b);

(ii) You began participating in the program before the date your disability ended; and

(iii) We have determined under § 404.328 that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(2) We generally will stop your benefits with the earliest of these months—

(i) The month in which you complete the program; or

(ii) The month in which you stop participating in the program for any reason (see § 404.327(b) for what we mean by ''participating'' in the program); or

(iii) The month in which we determine under § 404.328 that your continuing participation in the program will no longer increase the likelihood that you will not have to return to the disability benefit rolls.

Exception to paragraph (d): In no case will we stop your benefits with a month earlier than the second month

after the month your disability ends, provided that you meet all other requirements for entitlement to and payment of benefits through such month.

[45 FR 55584, Aug. 20, 1980, as amended at 47 FR 31543, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 49 FR 22272, May 29, 1984; 50 FR 50130, Dec. 6, 1985; 51 FR 17617, May 14, 1986; 59 FR 1635, Jan. 12, 1994; 70 FR 36507, June 24, 2005]

§ 404.1587 Circumstances under which we may suspend and terminate your benefits before we make a determination.

(a) *We will suspend your benefits if you are not disabled.* We will suspend your benefits if all of the information we have clearly shows that you are not disabled and we will be unable to complete a determination soon enough to prevent us from paying you more monthly benefits than you are entitled to. This may occur when you are blind as defined in the law and age 55 or older and you have returned to work similar to work you previously performed.

(b) *We will suspend your benefits if you fail to comply with our request for necessary information.* We will suspend your benefits effective with the month in which it is determined in accordance with § 404.1596(b)(2)(i) that your disability benefits should stop due to your failure, without good cause (see § 404.911), to comply with our request for necessary information. When we have received the information, we will reinstate your benefits for any previous month for which they are otherwise payable, and continue with the CDR process.

(c) *We will terminate your benefits.* We will terminate your benefits following 12 consecutive months of benefit suspension because you did not comply with our request for information in accordance with § 404.1596(b)(2)(i). We will count the 12-month suspension period from the start of the first month that you stopped receiving benefits (see paragraph (b) of this section). This termination is effective with the start of the 13th month after the suspension began because you failed to cooperate.

[71 FR 60822, Oct. 17, 2006]

CONTINUING OR STOPPING DISABILITY

§ 404.1588 Your responsibility to tell us of events that may change your disability status.

(a) *Your responsibility to report changes to us.* If you are entitled to cash benefits or to a period of disability because you are disabled, you should promptly tell us if—

(1) Your condition improves;

(2) You return to work;

(3) You have a new employer;

(4) You increase the amount of your work; or

(5) Your earnings increase.

(b) *Effect of authorizing us to obtain your information from payroll data providers.* (1) We will reduce your reporting responsibilities as described in paragraphs (a)(4) and (5) of this section if we have your authorization to obtain wage and employment information from a payroll data provider (see § 404.703), and we receive your wage and employment information from your employer(s) through a participating payroll data provider (see § 404.702). You will not be subject to a penalty described in § 404.459 related to any wage and employment information we receive from a payroll data provider.

(2) We will notify you in writing whenever there is a change in your reporting responsibilities relating to the authorization described in § 404.703. You are always required to submit any changes described in paragraphs (a)(1) through (3) of this section.

(3) When your reporting requirements will change—

(i) If we have your authorization to obtain wage and employment information from a payroll data provider (see § 404.703), and we receive your wage and employment information from your employer through a participating payroll data provider, you will not have to report an increase in the amount of work for that employer or an increase in earnings from that employer.

(ii) If we have your authorization to obtain wage and employment information from a payroll data provider (see § 404.703), but we do not receive your wage and employment information from your employer through a participating payroll data provider, we will

not reduce your reporting responsibilities.

(iii) If we have your authorization to obtain wage and employment information from a payroll data provider (see § 404.703) and you have more than one employer:

(A) You do not need to report an increase in the amount of work or an increase in earnings for an employer if we receive your wage and employment information for that employer through a participating payroll data provider; and

(B) You must still report an increase in the amount of work or an increase in earnings for an employer if we do not receive your wage and employment information for that employer through a participating payroll data provider.

(4) You may revoke your authorization at any time, but you must do so in writing. We will apply the revocation to all pending or approved disability claims under this title, as well as all pending or approved claims under title XVI, from the time we process your revocation. If you revoke your authorization, all your reporting responsibilities will resume, and you will again be subject to all related penalties. We will notify you in writing of these changes.

(c) *Our responsibility when you report your work to us.* When you or your representative report changes in your work activity to us under paragraphs (a)(2) through (5) of this section, we will issue a receipt to you or your representative.

[89 FR 107259, Dec. 31, 2024]

§ 404.1589 We may conduct a review to find out whether you continue to be disabled.

After we find that you are disabled, we must evaluate your impairment(s) from time to time to determine if you are still eligible for disability cash benefits. We call this evaluation a continuing disability review. We may begin a continuing disability review for any number of reasons including your failure to follow the provisions of the Social Security Act or these regulations. When we begin such a review, we will notify you that we are reviewing your eligibility for disability benefits, why we are reviewing your eligibility, that in medical reviews the medical improvement review standard will apply, that our review could result in the termination of your benefits, and that you have the right to submit medical and other evidence for our consideration during the continuing disability review. In doing a medical review, we will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that you are no longer under a disability. If this review shows that we should stop payment of your benefits, we will notify you in writing and give you an opportunity to appeal. In § 404.1590 we describe those events that may prompt us to review whether you continue to be disabled.

[51 FR 16825, May 7, 1986]

§ 404.1590 When and how often we will conduct a continuing disability review.

(a) *General.* We conduct continuing disability reviews to determine whether or not you continue to meet the disability requirements of the law. Payment of cash benefits or a period of disability ends if the medical or other evidence shows that you are not disabled as determined under the standards set out in section 223(f) of the Social Security Act. In paragraphs (b) through (g) of this section, we explain when and how often we conduct continuing disability reviews for most individuals. In paragraph (h) of this section, we explain special rules for some individuals who are participating in the Ticket to Work program. In paragraph (i) of this section, we explain special rules for some individuals who work.

(b) *When we will conduct a continuing disability review.* Except as provided in paragraphs (h) and (i) of this section, we will start a continuing disability review if—

(1) You have been scheduled for a medical improvement expected diary review;

(2) You have been scheduled for a periodic review (medical improvement possible or medical improvement not expected) in accordance with the provisions of paragraph (d) of this section;

(3) We need a current medical or other report to see if your disability continues. (This could happen when, for example, an advance in medical

technology, such as improved treatment for Alzheimer's disease or a change in vocational therapy or technology raises a disability issue.);

(4) You return to work and successfully complete a period of trial work;

(5) Substantial earnings are reported to your wage record;

(6) You tell us that—

(i) You have recovered from your disability; or

(ii) You have returned to work;

(7) Your State Vocational Rehabilitation Agency tells us that—

(i) The services have been completed; or

(ii) You are now working; or

(iii) You are able to work;

(8) Someone in a position to know of your physical or mental condition tells us any of the following, and it appears that the report could be substantially correct:

(i) You are not disabled; or

(ii) You are not following prescribed treatment; or

(iii) You have returned to work; or

(iv) You are failing to follow the provisions of the Social Security Act or these regulations;

(9) Evidence we receive raises a question as to whether your disability continues; or

(10) You have been scheduled for a vocational reexamination diary review.

(c) *Definitions.* As used in this section—

Medical improvement expected diary—refers to a case which is scheduled for review at a later date because the individual's impairment(s) is expected to improve. Generally, the diary period is set for not less than 6 months or for not more than 18 months. Examples of cases likely to be scheduled for medical improvement expected diary are fractures and cases in which corrective surgery is planned and recovery can be anticipated.

Permanent impairment—medical improvement not expected—refers to a case in which any medical improvement in the person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability programs to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity. The interaction of the individual's age, impairment consequences and lack of recent attachment to the labor market may also be considered in determining whether an impairment is permanent. Improvement which is considered temporary under §404.1579(c)(4) or §404.1594(c)(3)(iv), as appropriate, will not be considered in deciding if an impairment is permanent. Examples of permanent impairments taken from the list contained in our other written guidelines which are available for public review are as follows and are not intended to be all inclusive:

(1) Parkinsonian Syndrome which has reached the level of severity necessary to meet the Listing in appendix 1.

(2) Amyotrophic Lateral Sclerosis which has reached the level of severity necessary to meet the Listing in appendix 1.

(3) Diffuse pulmonary fibrosis in an individual age 55 or over which has reached the level of severity necessary to meet the Listing in appendix 1.

(4) Amputation of leg at hip.

Nonpermanent impairment—refers to a case in which any medical improvement in the person's impairment(s) is possible. This means an impairment for which improvement cannot be predicted based on current experience and the facts of the particular case but which is not at the level of severity of an impairment that is considered permanent. Examples of nonpermanent impairments are: regional enteritis, hyperthyroidism, and chronic ulcerative colitis.

Vocational reexamination diary—refers to a case which is scheduled for review at a later date because the individual is undergoing vocational therapy, training or an educational program which may improve his or her ability to work so that the disability requirement of the law is no longer met. Generally, the diary period will be set for the length of the training, therapy, or program of education.

(d) *Frequency of review.* If your impairment is expected to improve, generally we will review your continuing

eligibility for disability benefits at intervals from 6 months to 18 months following our most recent decision. Our notice to you about the review of your case will tell you more precisely when the review will be conducted. If your disability is not considered permanent but is such that any medical improvement in your impairment(s) cannot be accurately predicted, we will review your continuing eligibility for disability benefits at least once every 3 years. If your disability is considered permanent, we will review your continuing eligibility for benefits no less frequently than once every 7 years but no more frequently than once every 5 years. Regardless of your classification, we will conduct an immediate continuing disability review if a question of continuing disability is raised pursuant to paragraph (b) of this section.

(e) *Change in classification of impairment.* If the evidence developed during a continuing disability review demonstrates that your impairment has improved, is expected to improve, or has worsened since the last review, we may reclassify your impairment to reflect this change in severity. A change in the classification of your impairment will change the frequency with which we will review your case. We may also reclassify certain impairments because of improved tests, treatment, and other technical advances concerning those impairments.

(f) *Review after administrative appeal.* If you were found eligible to receive or to continue to receive disability benefits on the basis of a decision by an administrative law judge, the Appeals Council or a Federal court, we will not conduct a continuing disability review earlier than 3 years after that decision unless your case should be scheduled for a medical improvement expected or vocational reexamination diary review or a question of continuing disability is raised pursuant to paragraph (b) of this section.

(g) *Waiver of timeframes.* All cases involving a nonpermanent impairment will be reviewed by us at least once every 3 years unless we, after consultation with the State agency, determine that the requirement should be waived to ensure that only the appropriate number of cases are reviewed. The appropriate number of cases to be reviewed is to be based on such considerations as the backlog of pending reviews, the projected number of new applications, and projected staffing levels. Such waiver shall be given only after good faith effort on the part of the State to meet staffing requirements and to process the reviews on a timely basis. Availability of independent medical resources may also be a factor. A *waiver* in this context refers to our administrative discretion to determine the appropriate number of cases to be reviewed on a State by State basis. Therefore, your continuing disability review may be delayed longer than 3 years following our original decision or other review under certain circumstances. Such a delay would be based on our need to ensure that backlogs, reviews required to be performed by the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98–460), and new disability claims workloads are accomplished within available medical and other resources in the State agency and that such reviews are done carefully and accurately.

(h) *If you are participating in the Ticket to Work program.* If you are participating in the Ticket to Work program, we will not start a continuing disability review during the period in which you are using a ticket. However, this provision does not apply to reviews we conduct using the rules in §§ 404.1571–404.1576 to determine whether the work you have done shows that you are able to do substantial gainful activity and are, therefore, no longer disabled. See subpart C of part 411 of this chapter.

(i) *If you are working and have received social security disability benefits for at least 24 months*—(1) *General.* Notwithstanding the provisions in paragraphs (b)(4), (b)(5), (b)(6)(ii), (b)(7)(ii), and (b)(8)(iii) of this section, we will not start a continuing disability review based solely on your work activity if—

(i) You are currently entitled to disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability; and

(ii) You have received such benefits for at least 24 months (see paragraph (i)(2) of this section).

(2) *The 24-month requirement.* (i) The months for which you have actually received disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability that you were due, or for which you have constructively received such benefits, will count for the 24-month requirement under paragraph (i)(1)(ii) of this section, regardless of whether the months were consecutive. We will consider you to have constructively received a benefit for a month for purposes of the 24-month requirement if you were otherwise due a social security disability benefit for that month and your monthly benefit was withheld to recover an overpayment. Any month for which you were entitled to benefits but for which you did not actually or constructively receive a benefit payment will not be counted for the 24-month requirement. Months for which your social security disability benefits are continued under § 404.1597a pending reconsideration and/or a hearing before an administrative law judge on a medical cessation determination will not be counted for the 24-month requirement. If you also receive supplemental security income payments based on disability or blindness under title XVI of the Social Security Act, months for which you received only supplemental security income payments will not be counted for the 24-month requirement.

(ii) In determining whether paragraph (i)(1) of this section applies, we consider whether you have received disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability for at least 24 months as of the date on which we start a continuing disability review. For purposes of this provision, the date on which we start a continuing disability review is the date on the notice we send you that tells you that we are beginning to review your disability case.

(3) *When we may start a continuing disability review even if you have received social security disability benefits for at least 24 months.* Even if you meet the requirements of paragraph (i)(1) of this section, we may still start a continuing disability review for a reason(s) other than your work activity. We may start a continuing disability review if we have scheduled you for a periodic review of your continuing disability, we need a current medical or other report to see if your disability continues, we receive evidence which raises a question as to whether your disability continues, or you fail to follow the provisions of the Social Security Act or these regulations. For example, we will start a continuing disability review when you have been scheduled for a medical improvement expected diary review, and we may start a continuing disability review if you failed to report your work to us.

(4) *Reviews to determine whether the work you have done shows that you are able to do substantial gainful activity.* Paragraph (i)(1) of this section does not apply to reviews we conduct using the rules in §§ 404.1571–404.1576 to determine whether the work you have done shows that you are able to do substantial gainful activity and are, therefore, no longer disabled.

(5) *Erroneous start of the continuing disability review.* If we start a continuing disability review based solely on your work activity that results in a medical cessation determination, we will vacate the medical cessation determination if—

(i) You provide us evidence that establishes that you met the requirements of paragraph (i)(1) of this section as of the date of the start of your continuing disability review and that the start of the review was erroneous; and

(ii) We receive the evidence within 12 months of the date of the notice of the initial determination of medical cessation.

[51 FR 16825, May 7, 1986, as amended at 71 FR 66856, Nov. 17, 2006]

§ 404.1591 If your medical recovery was expected and you returned to work.

If your impairment was expected to improve and you returned to full-time work with no significant medical limitations and acknowledge that medical improvement has occurred, we may

find that your disability ended in the month you returned to work. Unless there is evidence showing that your disability has not ended, we will use the medical and other evidence already in your file and the fact that you returned to full-time work without significant limitations to determine that you are no longer disabled. (If your impairment is not expected to improve, we will not ordinarily review your claim until the end of the trial work period, as described in § 404.1592.)

Example: Evidence obtained during the processing of your claim showed that you had an impairment that was expected to improve about 18 months after your disability began. We, therefore, told you that your claim would be reviewed again at that time. However, before the time arrived for your scheduled medical re-examination, you told us that you had returned to work and your impairment had improved. We investigated immediately and found that, in the 16th month after your disability began, you returned to full-time work without any significant medical restrictions. Therefore, we would find that your disability ended in the first month you returned to full-time work.

[50 FR 50130, Dec. 6, 1985]

§ 404.1592 The trial work period.

(a) *Definition of the trial work period.* The trial work period is a period during which you may test your ability to work and still be considered disabled. It begins and ends as described in paragraph (e) of this section. During this period, you may perform *services* (see paragraph (b) of this section) in as many as 9 months, but these months do not have to be consecutive. We will not consider those services as showing that your disability has ended until you have performed services in at least 9 months. However, after the trial work period has ended we will consider the work you did during the trial work period in determining whether your disability ended at any time after the trial work period.

(b) *What we mean by services.* When used in this section, *services* means any activity (whether legal or illegal), even though it is not substantial gainful activity, which is done in employment or self-employment for pay or profit, or is the kind normally done for pay or profit. We generally do not consider work done without remuneration to be *services* if it is done merely as therapy or training or if it is work usually done in a daily routine around the house or in self-care. We will not consider work you have done as a volunteer in the federal programs described in section 404.1574(d) in determining whether you have performed services in the trial work period.

(1) *If you are an employee.* We will consider your work as an employee to be *services* if:

(i) *Before January 1, 2002,* your earnings in a month were more than the amount(s) indicated in Table 1 for the year(s) in which you worked.

(ii) *Beginning January 1, 2002,* your earnings in a month are more than an amount determined for each calendar year to be the larger of:

(A) Such amount for the previous year, or

(B) An amount adjusted for national wage growth, calculated by multiplying $530 by the ratio of the national average wage index for the year 2 calendar years before the year for which the amount is being calculated to the national average wage index for 1999. We will then round the resulting amount to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

(2) *If you are self-employed.* We will consider your activities as a self-employed person to be *services* if:

(i) *Before January 1, 2002,* your net earnings in a month were more than the amount(s) indicated in Table 2 of this section for the year(s) in which you worked, or the hours you worked in the business in a month are more than the number of hours per month indicated in Table 2 for the years in which you worked.

(ii) *Beginning January 1, 2002,* you work more than 80 hours a month in the business, or your net earnings in a month are more than an amount determined for each calendar year to be the larger of:

(A) Such amount for the previous year, or

(B) An amount adjusted for national wage growth, calculated by multiplying $530 by the ratio of the national average wage index for the year 2 calendar years before the year for which

the amount is being calculated to the national average wage index for 1999. We will then round the resulting amount to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

TABLE 1—FOR EMPLOYEES

For months	You earn more than
In calendar years before 1979	$50
In calendar years 1979–1989	75
In calendar years 1990–2000	200
In calendar year 2001	530

TABLE 2—FOR THE SELF-EMPLOYED

For months	Your net earnings are more than	Or you work in the business more than
In calendar years before 1979	$50	15 hours.
In calendar years 1979–1989	75	15 hours.
In calendar years 1990–2000	200	40 hours.
In calendar year 2001	530	80 hours.

(c) *Limitations on the number of trial work periods.* You may have only one trial work period during a period of entitlement to cash benefits.

(d) *Who is and is not entitled to a trial work period.* (1) You are generally entitled to a trial work period if you are entitled to disability insurance benefits, child's benefits based on disability, or widow's or widower's or surviving divorced spouse's benefits based on disability.

(2) You are not entitled to a trial work period—

(i) If you are entitled to a period of disability but not to disability insurance benefits, and you are not entitled to any other type of disability benefit under title II of the Social Security Act (*i.e.*, child's benefits based on disability, or widow's or widower's benefits or surviving divorced spouse's benefits based on disability);

(ii) If you perform work demonstrating the ability to engage in substantial gainful activity during any required waiting period for benefits;

(iii) If you perform work demonstrating the ability to engage in substantial gainful activity within 12 months of the onset of the impairment(s) that prevented you from performing substantial gainful activity and before the date of any notice of determination or decision finding that you are disabled; or

(iv) For any month prior to the month of your application for disability benefits (see paragraph (e) of this section).

(e) *When the trial work period begins and ends.* The trial work period begins with the month in which you become entitled to disability insurance benefits, to child's benefits based on disability or to widow's, widower's, or surviving divorced spouse's benefits based on disability. It cannot begin before the month in which you file your application for benefits, and for widows, widowers, and surviving divorced spouses, it cannot begin before December 1, 1980. It ends with the close of whichever of the following calendar months is the earliest:

(1) The 9th month (whether or not the months have been consecutive) in which you have performed services if that 9th month is prior to January 1992;

(2) The 9th month (whether or not the months have been consecutive and whether or not the previous 8 months of services were prior to January 1992) in which you have performed services within a period of 60 consecutive months if that 9th month is after December 1991; or

(3) The month in which new evidence, other than evidence relating to any work you did during the trial work period, shows that you are not disabled, even though you have not worked a full 9 months. We may find that your disability has ended at any time during the trial work period if the medical or other evidence shows that you are no longer disabled. See § 404.1594 for information on how we decide whether your disability continues or ends.

(f) *Nonpayment of benefits for trial work period service months.* See § 404.471 for an explanation of when benefits for trial work period service months are not payable if you are convicted by a Federal court of fraudulently concealing your work activity.

[45 FR 55584, Aug. 20, 1980, as amended at 49 FR 22273, May 29, 1984; 50 FR 50130, Dec. 6, 1985; 54 FR 53605, Dec. 29, 1989; 65 FR 42787, July 11, 2000; 65 FR 82910, Dec. 29, 2000; 71 FR 66866, Nov. 17, 2006]

§ 404.1592a The reentitlement period.

(a) *General.* The reentitlement period is an additional period after 9 months of trial work during which you may continue to test your ability to work if you have a *disabling impairment,* as defined in § 404.1511. If you work during the reentitlement period, we may decide that your disability has ceased because your work is substantial gainful activity and stop your benefits. However, if, after the month for which we found that your disability ceased because you performed substantial gainful activity, you stop engaging in substantial gainful activity, we will start paying you benefits again; you will not have to file a new application. The following rules apply if you complete a trial work period and continue to have a disabling impairment:

(1) The first time you work after the end of your trial work period *and* engage in substantial gainful activity, we will find that your disability ceased. When we decide whether this work is substantial gainful activity, we will apply all of the relevant provisions of §§ 404.1571–404.1576 including, but not limited to, the provisions for averaging earnings, unsuccessful work attempts, and deducting impairment-related work expenses, as well as the special rules for evaluating the work you do after you have received disability benefits for at least 24 months. We will find that your disability ceased in the first month after the end of your trial work period in which you do substantial gainful activity, applying all the relevant provisions in §§ 404.1571–404.1576.

(2)(i) If we determine under paragraph (a)(1) of this section that your disability ceased during the reentitlement period because you perform substantial gainful activity, you will be paid benefits for the first month after the trial work period in which you do substantial gainful activity (*i.e.*, the month your disability ceased) and the two succeeding months, whether or not you do substantial gainful activity in those succeeding months. After those three months, we will stop your benefits for any month in which you do substantial gainful activity. (See §§ 404.316, 404.337, 404.352 and 404.401a.) If your benefits are stopped because you do substantial gainful activity, they may be started again without a new application and a new determination of disability if you stop doing substantial gainful activity in a month during the reentitlement period. In determining whether you do substantial gainful activity in a month for purposes of stopping or starting benefits during the reentitlement period, we will consider only your work in, or earnings for, that month. Once we have determined that your disability has ceased during the reentitlement period because of the performance of substantial gainful activity as explained in paragraph (a)(1) of this section, we will not apply the provisions of §§ 404.1574(c) and 404.1575(d) regarding unsuccessful work attempts, the provisions of § 404.1574a regarding averaging of earnings, or the special rules in §§ 404.1574(b)(3)(iii) and 404.1575(e) for evaluating the work you do after you have received disability benefits for at least 24 months, to determine whether benefits should be paid for any particular month in the reentitlement period that occurs after the month your disability ceased.

(ii) If anyone else is receiving monthly benefits based on your earnings record, that individual will not be paid benefits for any month for which you cannot be paid benefits during the reentitlement period.

(3) The way we will consider your work activity after your reentitlement period ends (see paragraph (b)(2) of this section) will depend on whether you worked during the reentitlement period and if you did substantial gainful activity.

(i) If you worked during the reentitlement period and we decided that your disability ceased during the reentitlement period because of your

work under paragraph (a)(1) of this section, we will find that your entitlement to disability benefits terminates in the first month in which you engaged in substantial gainful activity after the end of the reentitlement period (see § 404.325). (See § 404.321 for when entitlement to a period of disability ends.) When we make this determination, we will consider only your work in, or earnings for, that month; we will not apply the provisions of §§ 404.1574(c) and 404.1575(d) regarding unsuccessful work attempts, the provisions of § 404.1574a regarding averaging of earnings, or the special rules in §§ 404.1574(b)(3)(iii) and 404.1575(e) for evaluating the work you do after you have received disability benefits for at least 24 months.

(ii) If we did not find that your disability ceased because of work activity during the reentitlement period, we will apply all of the relevant provisions of §§ 404.1571–404.1576 including, but not limited to, the provisions for averaging earnings, unsuccessful work attempts, and deducting impairment-related work expenses, as well as the special rules for evaluating the work you do after you have received disability benefits for at least 24 months, to determine whether your disability ceased because you performed substantial gainful activity after the reentitlement period. If we find that your disability ceased because you performed substantial gainful activity in a month after your reentitlement period ended, you will be paid benefits for the month in which your disability ceased and the two succeeding months. After those three months, your entitlement to a period of disability or to disability benefits terminates (see §§ 404.321 and 404.325).

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of 9 months of trial work but cannot begin earlier than December 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which your impairment no longer exists or is not medically disabling; or

(2)(i) The last day of the 15th month following the end of your trial work period if you were not entitled to benefits after December 1987; or

(ii) The last day of the 36th month following the end of your trial work period if you were entitled to benefits after December 1987 or if the 15-month period described in paragraph (b)(2)(i) of this section had not ended as of January 1988. (See §§ 404.316, 404.337, and 404.352 for when your benefits end.)

(c) *When you are not entitled to a reentitlement period.* You are not entitled to a reentitlement period if:

(1) You are entitled to a period of disability, but not to disability insurance cash benefits;

(2) You are not entitled to a trial work period;

(3) Your entitlement to disability insurance benefits ended before you completed 9 months of trial work in that period of disability.

[49 FR 22273, May 29, 1984, as amended at 58 FR 64883, Dec. 10, 1993; 65 FR 42787, July 11, 2000; 71 FR 66856, Nov. 17, 2006]

§ 404.1592b What is expedited reinstatement?

The expedited reinstatement provision provides you another option for regaining entitlement to benefits when we previously terminated your entitlement to disability benefits due to your work activity. The expedited reinstatement provision provides you the option of requesting that your prior entitlement to disability benefits be reinstated, rather than filing a new application for a new period of entitlement. Since January 1, 2001, you can request to be reinstated to benefits if you stop doing substantial gainful activity within 60 months of your prior termination. You must not be able to do substantial gainful activity because of your medical condition. Your current impairment must be the same as or related to your prior impairment and you must be disabled. To determine if you are disabled, we will use our medical improvement review standard that we use in our continuing disability review process. The advantage of using the medical improvement review standard is that we will generally find that you are disabled unless your impairment has improved so that you are able to work or unless an exception under the medical improvement review standard

process applies. We explain the rules for expedited reinstatement in §§ 404.1592c through 404.1592f.

[70 FR 57142, Sept. 30, 2005]

§ 404.1592c Who is entitled to expedited reinstatement?

(a) You can have your entitlement to benefits reinstated under expedited reinstatement if—

(1) You were previously entitled to a disability benefit on your own record of earnings as indicated in § 404.315, or as a disabled widow or widower as indicated in § 404.335, or as a disabled child as indicated in § 404.350, or to Medicare entitlement based on disability and Medicare qualified government employment as indicated in 42 CFR 406.15;

(2) Your disability entitlement referred to in paragraph (a)(1) of this section was terminated because you did substantial gainful activity;

(3) You file your request for reinstatement timely under § 404.1592d; and

(4) In the month you file your request for reinstatement—

(i) You are not able or become unable to do substantial gainful activity because of your medical condition as determined under paragraph (c) of this section;

(ii) Your current impairment is the same as or related to the impairment that we used as the basis for your previous entitlement referred to in paragraph (a)(2) of this section; and

(iii) You are disabled, as determined under the medical improvement review standard in §§ 404.1594(a) through (e).

(b) You are entitled to reinstatement on the record of an insured person who is or has been reinstated if—

(1) You were previously entitled to one of the following benefits on the record of the insured person—

(i) A spouse or divorced spouse benefit under §§ 404.330 and 404.331;

(ii) A child's benefit under § 404.350; or

(iii) A parent's benefit under § 404.370;

(2) You were entitled to benefits on the record when we terminated the insured person's entitlement;

(3) You meet the requirements for entitlement to the benefit described in the applicable paragraph (b)(1)(i) through (b)(1)(iii) of this section; and

(4) You request to be reinstated.

(c) We will determine that you are not able to do substantial gainful activity because of your medical condition, under paragraph (a)(4)(i) of this section, when:

(1) You certify under § 404.1592d(d)(2) that you are unable to do substantial gainful activity because of your medical condition;

(2) You are not able or become unable to do substantial gainful activity in the month you file your request for reinstatement; and

(3) We determine that you are disabled under paragraph (a)(4)(iii) of this section.

[70 FR 57142, Sept. 30, 2005, as amended at 81 FR 71369, Oct. 17, 2016]

§ 404.1592d How do I request reinstatement?

(a) You must make your request for reinstatement in writing.

(b) You must have filed your request on or after January 1, 2001.

(c) You must provide the information we request so that we can determine whether you meet the requirements for reinstatement as indicated in § 404.1592c.

(d) If you request reinstatement under § 404.1592c(a)—

(1) We must receive your request within the consecutive 60-month period that begins with the month in which your entitlement terminated due to doing substantial gainful activity. If we receive your request after the 60-month period we can grant you an extension if we determine you had good cause under the standards explained in § 404.911 for not filing the request timely; and

(2) You must certify that you are disabled, that your current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the benefit you are requesting to be reinstated, and that you are unable to do substantial gainful activity because of your medical condition.

[70 FR 57142, Sept. 30, 2005]

§ 404.1592e How do we determine provisional benefits?

(a) You may receive up to 6 consecutive months of provisional cash benefits and Medicare during the provisional benefit period, while we determine whether we can reinstate your disability benefit entitlement under § 404.1592c—

(1) We will pay you provisional benefits, and reinstate your Medicare if you are not already entitled to Medicare, beginning with the month you file your request for reinstatement under § 404.1592c(a) if you do not perform substantial gainful activity in that month. We will pay you provisional benefits, and reinstate your Medicare if you are not already entitled to Medicare, beginning with the month after you file your request for reinstatement under § 404.1592c(a) if you perform substantial gainful activity in the month in which you file your request for reinstatement.

(2) We will pay you a monthly provisional benefit amount equal to the last monthly benefit payable to you during your prior entitlement, increased by any cost of living increases that would have been applicable to the prior benefit amount under § 404.270. The last monthly benefit payable is the amount of the monthly insurance benefit we determined that was actually paid to you for the month before the month in which your entitlement was terminated, after we applied the reduction, deduction and nonpayment provisions in § 404.401 through § 404.480.

(3) If you are entitled to another monthly benefit payable under the provisions of title II of the Act for the same month you can be paid a provisional benefit, we will pay you an amount equal to the higher of the benefits payable.

(4) If you request reinstatement for more than one benefit entitlement, we will pay you an amount equal to the higher of the provisional benefits payable.

(5) If you are eligible for Supplemental Security Income payments, including provisional payments, we will reduce your provisional benefits under § 404.408b if applicable.

(6) We will not reduce your provisional benefit, or the payable benefit to other individuals entitled on an earnings record, under § 404.403, when your provisional benefit causes the total benefits payable on the earnings record to exceed the family maximum.

(b) You cannot receive provisional cash benefits or Medicare a second time under this section when—

(1) You request reinstatement under § 404.1592c(a);

(2) You previously received provisional cash benefits or Medicare under this section based upon a prior request for reinstatement filed under § 404.1592c(a); and

(3) Your requests under paragraphs (b)(1) and (b)(2) are for the same previous disability entitlement referred to in § 404.1592c(a)(2).

(4) *Examples:*

Example 1: Mr. K files a request for reinstatement in April 2004. His disability benefit had previously terminated in January 2003. Since Mr. K meets other factors for possible reinstatement (*i.e.*, his prior entitlement was terminated within the last 60 months because he was engaging in substantial gainful activity), we start paying him provisional benefits beginning April 2004 while we determine whether he is disabled and whether his current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the benefit that was terminated in January 2003. In July 2004 we determine that Mr. K cannot be reinstated because he is not disabled under the medical improvement review standard; therefore we stop his provisional benefits. Mr. K does not request review of that determination. In January 2005 Mr. K again requests reinstatement on the entitlement that terminated in January 2003. Since this request meets all the factors for possible reinstatement, and his request is still within 60 months from January 2003, we will make a new determination on whether he is disabled and whether his current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the benefit that was terminated in January 2003. Since the January 2005 request and the April 2004 request both request reinstatement on the same entitlement that terminated in January 2003, and since we already paid Mr. K provisional benefits based upon the April 2004 request, we will not pay additional provisional benefits on the January 2005 request for reinstatement.

Example 2: Assume the same facts as shown in Example 1 of this section, with the addition of these facts. We approve Mr. K's January 2005 request for reinstatement and start his reinstated benefits beginning January 2005. Mr. K subsequently returns to work and

his benefits are again terminated due to engaging in substantial gainful activity in January 2012. Mr. K must again stop work and requests reinstatement in January 2015. Since Mr. K meets other factors for possible reinstatement (*i.e.*, his prior entitlement was terminated within the last 60 months because he was engaging in substantial gainful activity) we start paying him provisional benefits beginning January 2015 while we determine whether he is disabled and whether his current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the benefit that was terminated in January 2012.

(c) We will not pay you a provisional benefit for a month when an applicable nonpayment rule applies. Examples of when we will not pay a benefit include, but are not limited to—

(1) If you are a prisoner under § 404.468;

(2) If you have been removed/deported under § 404.464; or

(3) If you are an alien outside the United States under § 404.460.

(d) We will not pay you a provisional benefit for any month that is after the earliest of the following months—

(1) The month we send you a notice of our determination on your request for reinstatement;

(2) The month you do substantial gainful activity;

(3) The month before the month you attain full retirement age; or

(4) The fifth month following the month you requested expedited reinstatement.

(e) You are not entitled to provisional benefits if—

(1) Prior to starting your provisional benefits, we determine that you do not meet the requirements for reinstatement under §§ 404.1592c(a); or

(2) We determine that your statements on your request for reinstatement, made under § 404.1592d(d)(2), are false.

(f) Determinations we make regarding your provisional benefits under paragraphs (a) through (e) of this section are final and are not subject to administrative and judicial review under subpart J of part 404.

(g) If you were previously overpaid benefits under title II or title XVI of the Act, we will not recover the overpayment from your provisional benefits unless you give us permission. We can recover Medicare premiums you owe from your provisional benefits.

(h) If we determine you are not entitled to reinstated benefits, provisional benefits we have already paid you under this section that were made prior to the termination month under paragraph (d) of this section will not be subject to recovery as an overpayment unless we determine that you knew, or should have known, you did not meet the requirements for reinstatement in § 404.1592c. If we inadvertently pay you provisional benefits when you are not entitled to them because we have already made a determination described in paragraph (e) of this section, they will be subject to recover as an overpayment under subpart F of part 404.

[70 FR 57142, Sept. 30, 2005, as amended at 81 FR 71369, Oct. 17, 2016]

§ 404.1592f How do we determine reinstated benefits?

(a) If you meet the requirements for reinstatement under § 404.1592c(a), we will then consider in which month to reinstate your entitlement. We will reinstate your entitlement with the earliest month, in the 12-month period that ends with the month before you filed your request for reinstatement, that you would have met all of the requirements under § 404.1592c(a) if you had filed your request for reinstatement in that month. Otherwise, you will be entitled to reinstated benefits beginning with the month in which you filed your request for such benefits if you did not perform substantial gainful activity in that month. If you performed substantial gainful activity in the month of filing, but are no longer able to perform substantial gainful activity, we will reinstate your benefits with the month after the month you filed your request for reinstatement. We cannot reinstate your entitlement for any month prior to January 2001.

(b) When your entitlement is reinstated, you are also entitled to Medicare benefits under the provisions of 42 CFR part 406.

(c) We will compute your reinstated benefit amount and determine benefits payable under the applicable paragraphs of §§ 404.201 through 404.480 with certain exceptions—

(1) We will reduce your reinstated benefit due in a month by the amount of the provisional benefit we already paid you for that month. If your provisional benefit paid for a month exceeds the reinstated benefit, we will treat the difference as an overpayment under §§ 404.501 through 404.527.

(2) If you are reinstated on your own earnings record, we will compute your primary insurance amount with the same date of onset we used in your most recent period of disability on your earnings record.

(d) We will not pay you reinstated benefits for any months of substantial gainful activity during your initial reinstatement period. During the initial reinstatement period, the trial work period provisions of § 404.1592 and the reentitlement period provisions of § 404.1592a do not apply. The initial reinstatement period begins with the month your reinstated benefits begin under paragraph (a) of this section and ends when you have had 24 payable months of reinstated benefits. We consider you to have a payable month for the purposes of this paragraph when you do not do substantial gainful activity in that month and when the nonpayment provisions in subpart E of part 404 also do not apply. If the amount of the provisional benefit already paid you for a month equals or exceeds the amount of the reinstated benefit payable for that month so that no additional payment is due, we will consider that month a payable month. When we determine if you have done substantial gainful activity in a month during the initial reinstatement period, we will consider only your work in, or earnings for, that month. We will not apply the unsuccessful work attempt provisions of §§ 404.1574(c) and 404.1575(d) or the averaging of earnings provisions in § 404.1574a.

(e) After you complete the 24-month initial reinstatement period as indicated in paragraph (d) of this section, your subsequent work will be evaluated under the trial work provisions in § 404.1592 and then the reentitlement period in § 404.1592a.

(f) Your entitlement to reinstated benefits ends with the month before the earliest of the following months—

(1) The month an applicable terminating event in § 404.301 through 404.389 occurs;

(2) The month in which you reach retirement age;

(3) The third month following the month in which your disability ceases; or

(4) The month in which you die.

(g) Determinations we make under §§ 404.1592f are initial determinations under § 404.902 and subject to review under subpart J of part 404.

(h) If we determine you are not entitled to reinstated benefits we will consider your request filed under § 404.1592c(a) your intent to claim benefits under § 404.630.

[70 FR 57142, Sept. 30, 2005, as amended at 82 FR 7648, Jan. 21, 2017]

§ 404.1593 Medical evidence in continuing disability review cases.

(a) *General.* If you are entitled to benefits or if a period of disability has been established for you because you are disabled, we will have your case file with the supporting medical evidence previously used to establish or continue your entitlement. Generally, therefore, the medical evidence we will need for a continuing disability review will be that required to make a current determination or decision as to whether you are still disabled, as defined under the medical improvement review standard. See §§ 404.1579 and 404.1594.

(b) *Obtaining evidence from your medical sources.* You must provide us with reports from your physician, psychologist, or others who have treated or evaluated you, as well as any other evidence that will help us determine if you are still disabled. See § 404.1512. You must have a good reason for not giving us this information or we may find that your disability has ended. See § 404.1594(e)(2). If we ask you, you must contact your medical sources to help us get the medical reports. We will make every reasonable effort to help you in getting medical reports when you give us permission to request them from your physician, psychologist, or other medical sources. See § 404.1512(d)(1) concerning what we mean by every reasonable effort. In some instances, such as when a source

is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. Before deciding that your disability has ended, we will develop a complete medical history covering at least the 12 months preceding the date you sign a report about your continuing disability status. See § 404.1512(c).

(c) *When we will purchase a consultative examination.* A consultative examination may be purchased when we need additional evidence to determine whether or not your disability continues. As a result, we may ask you, upon our request and reasonable notice, to undergo consultative examinations and tests to help us determine if you are still disabled. See § 404.1517. We will decide whether or not to purchase a consultative examination in accordance with the standards in §§ 404.1519a through 404.1519b.

[56 FR 36962, Aug. 1, 1991]

§ 404.1594 How we will determine whether your disability continues or ends.

(a) *General.* There is a statutory requirement that, if you are entitled to disability benefits, your continued entitlement to such benefits must be reviewed periodically. If you are entitled to disability benefits as a disabled worker or as a person disabled since childhood, or, for monthly benefits payable for months after December 1990, as a disabled widow, widower, or surviving divorced spouse, there are a number of factors we consider in deciding whether your disability continues. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not medically improved we must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases (see paragraph (e) of this section for exceptions), we must also show that you are currently able to engage in substantial gainful activity before we can find that you are no longer disabled.

(b) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review whether your disability continues. In addition, see paragraph (i) of this section if you work during your current period of entitlement based on disability or during certain other periods.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on improvement in the symptoms, signs, and/or laboratory findings associated with your impairment(s).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus. At the time of our prior decision granting you benefits you had had a laminectomy. Postoperatively, a myelogram still shows evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim, your medical source, who has treated you, reported that he or she had seen you regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has *not* occurred because there has been no decrease in the severity of your back impairment as shown by changes in symptoms, signs or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that

for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remission and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would then determine if this medical improvement is related to your ability to work.

(2) *Medical improvement not related to ability to do work.* Medical improvement is not related to your ability to work if there has been a decrease in the severity of the impairment(s) as defined in paragraph (b)(1) of this section, present at the time of the most recent favorable medical decision, but *no* increase in your functional capacity to do basic work activities as defined in paragraph (b)(4) of this section. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

Example: You are 65 inches tall and weighed 246 pounds at the time your disability was established. You had venous insufficiency and persistent edema in your legs. At the time, your ability to do basic work activities was affected because you were able to sit for 6 hours, but were able to stand or walk only occasionally. At the time of our continuing disability review, you had undergone a vein stripping operation. You now weigh 220 pounds and have intermittent edema. You are still able to sit for 6 hours at a time and to stand or walk only occasionally although you report less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by your weight loss and the improvement in your edema. This medical improvement is not related to your ability to work, however, because your functional capacity to do basic work activities (*i.e.*, the ability to sit, stand and walk) has not increased.

(3) *Medical improvement that is related to ability to do work.* Medical improvement is related to your ability to work if there has been a decrease in the severity, as defined in paragraph (b)(1) of this section, of the impairment(s) present at the time of the most recent favorable medical decision *and* an increase in your functional capacity to do basic work activities as discussed in paragraph (b)(4) of this section. A determination that medical improvement related to your ability to do work has occurred does not, necessarily, mean that your disability will be found to have ended unless it is also shown that you are currently able to engage in substantial gainful activity as discussed in paragraph (b)(5) of this section.

Example 1: You have a back impairment and had a laminectomy to relieve the nerve root impingement and weakness in your left leg. At the time of our prior decision, basic work activities were affected because you were able to stand less than 6 hours, and sit no more than ½ hour at a time. You had a successful fusion operation on your back about 1 year before our review of your entitlement. At the time of our review, the weakness in your leg has decreased. Your functional capacity to perform basic work activities now is unimpaired because you now have no limitation on your ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of your impairment as demonstrated by the decreased weakness in your leg. This medical improvement is related to your ability to work because there has also been an increase in your functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on your ability to sit, walk, or stand. Whether or not your disability is found to have ended, however, will depend on our determination as to whether you can currently engage in substantial gainful activity.

Example 2: You were injured in an automobile accident receiving a compound fracture to your right femur and a fractured pelvis. When you applied for disability benefits 10 months after the accident your doctor reported that neither fracture had yet achieved solid union based on his clinical examination. X-rays supported this finding. Your doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of our review 6 months later, solid union had occurred and you had been returned to full weight-bearing for over a month. Your doctor reported this and the fact that your prior fractures no longer placed any limitation on your ability to walk, stand, lift, etc., and, that in fact, you could return to fulltime work if you so desired.

Medical improvement has occurred because there has been a decrease in the severity of your impairments as shown by X-ray and clinical evidence of solid union and your return to full weight-bearing. This medical improvement is related to your ability to work

because you no longer meet the same listed impairment in appendix 1 of this subpart (see paragraph (c)(3)(i) of this section). In fact, you no longer have an impairment which is severe (see § 404.1521) and your disability will be found to have ended.

(4) *Functional capacity to do basic work activities.* Under the law, disability is defined, in part, as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment(s). In determining whether you are disabled under the law, we must measure, therefore, how and to what extent your impairment(s) has affected your ability to do work. We do this by looking at how your functional capacity for doing basic work activities has been affected. Basic work activities means the abilities and aptitudes necessary to do most jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and nonexertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes and dealing with both supervisors and fellow workers. A person who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment will result in some limitation to the functional capacity to do one or more of these basic work activities. Diabetes, for example, can result in circulatory problems which could limit the length of time a person could stand or walk and damage to his or her eyes as well, so that the person also had limited vision. What a person can still do despite an impairment, is called his or her residual functional capacity. How the residual functional capacity is assessed is discussed in more detail in § 404.1545. Unless an impairment is so severe that it is deemed to prevent you from doing substantial gainful activity (see §§ 404.1525 and 404.1526), it is this residual functional capacity that is used to determine whether you can still do your past work or, in conjunction with your age, education and work experience, any other work.

(i) A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the person can stand or walk for longer periods. When new evidence showing a change in signs, symptoms and laboratory findings establishes that both medical improvement has occurred and your functional capacity to perform basic work activities, or residual functional capacity, has increased, we say that medical improvement which is related to your ability to do work has occurred. A residual functional capacity assessment is also used to determine whether you can engage in substantial gainful activity and, thus, whether you continue to be disabled (see paragraph (b)(5) of this section).

(ii) Many impairment-related factors must be considered in assessing your functional capacity for basic work activities. Age is one key factor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits become irreversible over time and that maximum exercise performance diminishes with age. Other changes related to sustained periods of inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the cardiac and respiratory systems which limit the exertional range.

(iii) Studies have also shown that the longer an individual is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if you are age 50 or over and have been receiving disability benefits for a considerable period of time, we will consider this factor along with your age in assessing your residual functional capacity. This will ensure that the disadvantages resulting from inactivity and the aging process during

a long period of disability will be considered. In some instances where available evidence does not resolve what you can or cannot do on a sustained basis, we will provide special work evaluations or other appropriate testing.

(5) *Ability to engage in substantial gainful activity.* In most instances, we must show that you are able to engage in substantial gainful activity before your benefits are stopped. When doing this, we will consider all your current impairments not just that impairment(s) present at the time of the most recent favorable determination. If we cannot determine that you are still disabled based on medical considerations alone (as discussed in §§ 404.1525 and 404.1526), we will use the new symptoms, signs and laboratory findings to make an objective assessment of your functional capacity to do basic work activities or residual functional capacity and we will consider your vocational factors. See §§ 404.1545 through 404.1569.

(6) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources. What constitutes *evidence* and our procedures for obtaining it are set out in §§ 404.1512 through 404.1518. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(7) *Point of comparison.* For purposes of determining whether medical improvement has occurred, we will compare the current medical severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will compare your current functional capacity to do basic work activities (*i.e.*, your residual functional capacity) based on this previously existing impairment(s) with your prior residual functional capacity in order to determine whether the medical improvement is related to your ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(c) *Determining medical improvement and its relationship to your abilities to do work.* Paragraphs (b) (1) through (3) of this section discuss what we mean by medical improvement, medical improvement not related to your ability to work and medical improvement that is related to your ability to work. (In addition, see paragraph (i) of this section if you work during your current period of entitlement based on disability or during certain other periods.) How we will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed below.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled and is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(2) *Determining if medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, we then must determine if it is related to your ability to do work. In paragraph (b)(4) of this section, we explain the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect your residual functional capacity. In determining whether medical improvement that has occurred is related to your ability to do work, we will assess your residual functional capacity (in accordance with paragraph (b)(4) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision. Your new residual functional

capacity will then be compared to your residual functional capacity at the time of our most recent favorable medical decision. Unless an increase in the current residual functional capacity is based on changes in the signs, symptoms, or laboratory findings, any medical improvement that has occurred will not be considered to be related to your ability to do work.

(3) Following are some additional factors and considerations which we will apply in making these determinations.

(i) *Previous impairment met or equaled listings.* If our most recent favorable decision was based on the fact that your impairment(s) at the time met or equaled the severity contemplated by the Listing of Impairments in appendix 1 of this subpart, an assessment of your residual functional capacity would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing section used to make our most recent favorable decision, we will find that the medical improvement was related to your ability to work. Appendix 1 of this subpart describes impairments which, if severe enough, affect a person's ability to work. If the appendix level of severity is met or equaled, the individual is deemed, in the absence of evidence to the contrary, to be unable to engage in substantial gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. We must, of course, also establish that you can currently engage in gainful activity before finding that your disability has ended.

(ii) *Prior residual functional capacity assessment made.* The residual functional capacity assessment used in making the most recent favorable medical decision will be compared to the residual functional capacity assessment based on current evidence in order to determine if your functional capacity for basic work activities has increased. There will be no attempt made to reassess the prior residual functional capacity.

(iii) *Prior residual functional capacity assessment should have been made, but was not.* If the most recent favorable medical decision should have contained an assessment of your residual functional capacity (*i.e.*, your impairments did not meet or equal the level of severity contemplated by the Listing of Impairments in appendix 1 of this subpart) but does not, either because this assessment is missing from your file or because it was not done, we will reconstruct the residual functional capacity. This reconstructed residual functional capacity will accurately and objectively assess your functional capacity to do basic work activities. We will assign the maximum functional capacity consistent with an allowance.

Example: You were previously found to be disabled on the basis that ''while your impairment did not meet or equal a listing, it did prevent you from doing your past or any other work.'' The prior adjudicator did not, however, include a residual functional capacity assessment in the rationale of this decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, *i.e.*, medical improvement, has occurred, the residual functional capacity based on the current level of severity of your impairment will have to be compared with your residual functional capacity based on its prior severity in order to determine if the medical improvement is related to your ability to do work. In order to make this comparison, we will review the prior evidence and make an objective assessment of your residual functional capacity at the time of our most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

(iv) *Impairment subject to temporary remission.* In some cases the evidence shows that an individual's impairments are subject to temporary remission. In assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairments, including the occurrence of prior remission, and prospects for future worsenings. Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(v) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether you are able to

now engage in substantial gainful activity based on all your current impairments. (In this way, we will be able to determine that your disability continues at the earliest point without addressing the often lengthy process of reconstructing prior evidence.) If you cannot engage in substantial gainful activity currently, your benefits will continue unless one of the second group of exceptions applies (see paragraph (e) of this section). If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence, and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation; and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with the rules in § 404.988.

(d) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if you can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, you are now able to engage in substantial gainful activity before your disability can be found to have ended. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased your ability to do basic work activities. We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment or your ability to do basic work activities. This decision will be based on new medical evidence and a new residual functional capacity assessment. (See § 404.1545.) In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that you have undergone vocational therapy (related to your ability to work).* Vocational therapy (related to your ability to work) may include, but is not limited to, additional education, training, or work experience that improves your ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. (See § 404.1545.) If, at the time of our review you have not completed vocational therapy which could affect the continuance of your disability, we will review your claim upon completion of the therapy.

Example 1: You were found to be disabled because the limitations imposed on you by your impairment allowed you to only do

work that was at a sedentary level of exertion. Your prior work experience was work that required a medium level of exertion. Your age and education at the time would not have qualified you for work that was below this medium level of exertion. You enrolled in and completed a specialized training course which qualifies you for a job in data processing as a computer programmer in the period since you were awarded benefits. On review of your claim, current evidence shows that there is no medical improvement and that you can still do only sedentary work. As the work of a computer programmer is sedentary in nature, you are now able to engage in substantial gainful activity when your new skills are considered.

Example 2: You were previously entitled to benefits because the medical evidence and assessment of your residual functional capacity showed you could only do light work. Your prior work was considered to be heavy in nature and your age, education and the nature of your prior work qualified you for work which was no less than medium in exertion. The current evidence and residual functional capacity show there has been no medical improvement and that you can still do only light work. Since you were originally entitled to benefits, your vocational rehabilitation agency enrolled you in and you successfully completed a trade school course so that you are now qualified to do small appliance repair. This work is light in nature, so when your new skills are considered, you are now able to engage in substantial gainful activity even though there has been no change in your residual functional capacity.

(3) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if you can currently engage in substantial gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of this subpart will be based on new or improved diagnostic or evaluative techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) A cumulative list since 1970 of new or improved diagnostic techniques or evaluations, how they changed the evaluation of the applicable impairment and the month and year they became generally available, will be published in the *Notices* section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically.

The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in substantial gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(4) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 or a medical/vocational rule in appendix 2 of this subpart was misapplied).

Example 1: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether you could currently engage in substantial gainful activity.

Example 2: Your prior award of benefits was based on vocational rule 201.12 in appendix 2 of this subpart. This rule applies to a person age 50–54 who has at least a high school education, whose previous work was entirely at a semiskilled level, and who can do only sedentary work. On review, it is found that at the time of the prior determination you were actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of your claim and the prior decision is found to have been in error. Continuation of your disability would depend on a finding of your current ability to engage in substantial gainful activity.

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: You were found disabled on the basis of chronic obstructive pulmonary disease. The severity of your impairment was documented primarily by pulmonary function testing results. The evidence showed that you could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that your impairment does not limit your ability to perform basic work activities in any way. Error is found based on the fact that required, material evidence which was originally missing now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously found entitled to benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments.

The prior record shows that you had ''brittle'' diabetes for which you were taking insulin. Your urine was 3 + for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that your impairment clearly does not equal the severity contemplated by the listings. Error *cannot* be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see § 404.988) are met.

(5) *You are currently engaging in substantial gainful activity.* If you are currently engaging in substantial gainful activity before we determine whether you are no longer disabled because of your work activity, we will consider whether you are entitled to a trial work period as set out in § 404.1592. We will find that your disability has ended in the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether you continue to have a disabling impairment(s) (§ 404.1511) for purposes of deciding your eligibility for a reentitlement period (§ 404.1592a).

(e) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in substantial gainful activity.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 404.988. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will determine that your disability has ended. The month your disability ends will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in substantial gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 404.1530(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(f) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are

still unable to engage in substantial gainful activity. The steps are as follows. (See paragraph (i) of this section if you work during your current period of entitlement based on disability or during certain other periods.)

(1) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended (see paragraph (d)(5) of this section).

(2) If you are not, do you have an impairment or combination of impairments which meets or equals the severity of an impairment listed in appendix 1 of this subpart? If you do, your disability will be found to continue.

(3) If you do not, has there been medical improvement as defined in paragraph (b)(1) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (4). If there has been no decrease in medical severity, there has been no medical improvement. (See step (5).)

(4) If there has been medical improvement, we must determine whether it is related to your ability to do work in accordance with paragraphs (b) (1) through (4) of this section; *i.e.*, whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to your ability to do work, see step (5). If medical improvement *is* related to your ability to do work, see step (6).

(5) If we found at step (3) that there has been no medical improvement or if we found at step (4) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (d) and (e) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (6). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(6) If medical improvement is shown to be related to your ability to do work or if one of the first group of exceptions to medical improvement applies, we will determine whether all your current impairments in combination are severe (see § 404.1521). This determination will consider all your current impairments and the impact of the combination of those impairments on your ability to function. If the residual functional capacity assessment in step (4) above shows significant limitation of your ability to do basic work activities, see step (7). When the evidence shows that all your current impairments in combination do not significantly limit your physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature. If so, you will no longer be considered to be disabled.

(7) If your impairment(s) is severe, we will assess your current ability to do substantial gainful activity in accordance with § 404.1560. That is, we will assess your residual functional capacity based on all your current impairments and consider whether you can still do work you have done in the past. If you can do such work, disability will be found to have ended.

(8) If you are not able to do work you have done in the past, we will consider whether you can do other work given the residual functional capacity assessment made under paragraph (f)(7) of this section and your age, education, and past work experience (*see* paragraph (f)(9) of this section for an exception to this rule). If you can, we will find that your disability has ended. If you cannot, we will find that your disability continues.

(9) We may proceed to the final step, described in paragraph (f)(8) of this section, if the evidence in your file about your past relevant work is not sufficient for us to make a finding under paragraph (f)(7) of this section about whether you can perform your past relevant work. If we find that you can adjust to other work based solely on your age, education, and residual functional capacity, we will find that you are no longer disabled, and we will not make a finding about whether you can do your past relevant work under paragraph (f)(7) of this section. If we find that you may be unable to adjust to other work or if § 404.1562 may apply, we will assess

your claim under paragraph (f)(7) of this section and make a finding about whether you can perform your past relevant work.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the earliest of the following months.

(1) The month the evidence shows you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See § 404.1592a for a discussion of the reentitlement period. If you are receiving benefits on your own earnings record, see § 404.316 for when your benefits will end. See § 404.352 if you are receiving benefits on a parent's earnings as a disabled adult child.);

(4) The month in which you actually do substantial gainful activity (where you are not entitled to a trial work period);

(5) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see § 404.1591);

(6) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (e)(2) of this section applies;

(7) The first month in which the question of continuing disability arose and we could not find you, when the rule set out in paragraph (e)(3) of this section applies;

(8) The first month in which you failed without good cause to follow prescribed treatment, when the rule set out in paragraph (e)(4) of this section applies; or

(9) The first month you were told by your physician that you could return to work, provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by substantial evidence.

(h) *Before we stop your benefits.* Before we stop your benefits or a period of disability, we will give you a chance to explain why we should not do so. Sections 404.1595 and 404.1597 describe your rights (including appeal rights) and the procedures we will follow.

(i) *If you work during your current period of entitlement based on disability or during certain other periods.* (1) We will not consider the work you are doing or have done during your current period of entitlement based on disability (or, when determining whether you are entitled to expedited reinstatement of benefits under section 223(i) of the Act, the work you are doing or have done during or after the previously terminated period of entitlement referred to in section 223(i)(1)(B) of the Act) to be past relevant work under paragraph (f)(7) of this section or past work experience under paragraph (f)(8) of this section. In addition, if you are currently entitled to disability benefits under title II of the Social Security Act, we may or may not consider the physical and mental activities that you perform in the work you are doing or have done during your current period of entitlement based on disability, as explained in paragraphs (i)(2) and (3) of this section.

(2) If you are currently entitled to disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability under title II of the Social Security Act, and at the time we are making a determination on your case you have received such benefits for at least 24 months, we will not consider the activities you perform in the work you are doing or have done during your current period of entitlement based on disability if they support a finding that your disability has ended. (We will use the rules in § 404.1590(i)(2) to determine

whether the 24-month requirement is met.) However, we will consider the activities you do in that work if they support a finding that your disability continues or they do not conflict with a finding that your disability continues. We will not presume that you are still disabled if you stop working.

(3) If you are not a person described in paragraph (i)(2) of this section, we will consider the activities you perform in your work at any of the evaluation steps in paragraph (f) of this section at which we need to assess your ability to function.

[50 FR 50130, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 52 FR 44971, Nov. 24, 1987; 57 FR 30121, July 8, 1992; 59 FR 1635, Jan. 12, 1994; 65 FR 42788, July 11, 2000; 68 FR 51163, Aug. 26, 2003; 71 FR 66857, Nov. 17, 2006; 77 FR 43495, July 25, 2012; 82 FR 5871, Jan. 18, 2017]

§ 404.1595 When we determine that you are not now disabled.

(a) *When we will give you advance notice.* Except in those circumstances described in paragraph (d) of this section, we will give you advance notice when we have determined that you are not now disabled because the information we have conflicts with what you have told us about your disability. If your dependents are receiving benefits on your Social Security number and do not live with you, we will also give them advance notice. To give you advance notice, we will contact you by mail, telephone or in person.

(b) *What the advance notice will tell you.* We will give you a summary of the information we have. We will also tell you why we have determined that you are not now disabled, and will give you a chance to reply. If it is because of—

(1) *Medical reasons.* The advance notice will tell you what the medical information in your file shows;

(2) *Your work activity.* The advance notice will tell you what information we have about the work you are doing or have done, and why this work shows that you are not disabled; or

(3) *Your failure to give us information we need or do what we ask.* The advance notice will tell you what information we need and why we need it or what you have to do and why.

(c) *What you should do if you receive an advance notice.* If you agree with the advance notice, you do not need to take any action. If you desire further information or disagree with what we have told you, you should immediately write or telephone the State agency or the social security office that gave you the advance notice or you may visit any social security office. If you believe you are now disabled, you should tell us why. You may give us any additional or new information, including reports from your doctors, hospitals, employers or others, that you believe we should have. You should send these as soon as possible to the local social security office or to the office that gave you the advance notice. We consider 10 days to be enough time for you to tell us, although we will allow you more time if you need it. You will have to ask for additional time beyond 10 days if you need it.

(d) *When we will not give you advance notice.* We will not give you advance notice when we determine that you are not disabled if—

(1) We recently told you that the information we have shows that you are not now disabled, that we were gathering more information, and that your benefits will stop; or

(2) We are stopping your benefits because you told us you are not now disabled; or

(3) We recently told you that continuing your benefits would probably cause us to overpay you and you asked us to stop your benefits.

§ 404.1596 Circumstances under which we may suspend and terminate your benefits before we make a determination.

(a) *General.* Under some circumstances, we may stop your benefits before we make a determination. Generally, we do this when the information we have clearly shows you are not now disabled but we cannot determine when your disability ended. These situations are described in paragraph (b)(1) and other reasons are given in paragraph (b)(2) of this section. We refer to this as a suspension of benefits. Your benefits, as well as those of your dependents (regardless of where they receive their benefits), may be suspended. When we

do this we will give you advance notice. (See § 404.1595.) We will contact your spouse and children if they are receiving benefits on your Social Security number, and the benefits are being mailed to an address different from your own.

(b) *When we will suspend your benefits*—(1) *You are not now disabled.* We will suspend your benefits if the information we have clearly shows that you are not disabled and we will be unable to complete a determination soon enough to prevent us from paying you more monthly benefits than you are entitled to. This may occur when—

(i) New medical or other information clearly shows that you are able to do substantial gainful activity and your benefits should have stopped more than 2 months ago;

(ii) You completed a 9-month period of trial work more than 2 months ago and you are still working;

(iii) At the time you filed for benefits your condition was expected to improve and you were expected to be able to return to work. You subsequently did return to work more than 2 months ago with no significant medical restrictions; or

(iv) You are not entitled to a trial work period and you are working.

(2) *Other reasons.* We will also suspend your benefits if—

(i) You have failed to respond to our request for additional medical or other evidence and we are satisfied that you received our request and our records show that you should be able to respond; or

(ii) We are unable to locate you and your checks have been returned by the Post Office as undeliverable.

(c) *When we will not suspend your cash benefits.* We will not suspend your cash benefits if—

(1) You have become disabled by another impairment; or

(2) Even though your impairment is no longer disabling,

(i) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 404.327(a) and (b);

(ii) You began participating in the program before the date your disability ended; and

(iii) We have determined under § 404.328 that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(d) *When the suspension is effective.* We will suspend your benefits effective with the month in which it is determined in accordance with paragraph (b)(2)(i) of this section that your disability benefits should stop due to your failure, without good cause (see § 404.911), to comply with our request for necessary information for your continuing disability review. This review is to determine whether or not you continue to meet the disability requirements of the law. When we have received the information, we will reinstate your benefits for any previous month for which they are otherwise payable, and continue with the CDR process.

(e) *When we will terminate your benefits.* We will terminate your benefits following 12 consecutive months of benefit suspension because you did not comply with our request for information in accordance with paragraph (b)(2)(i) of this section. We will count the 12-month suspension period from the start of the first month that you stopped receiving benefits (see paragraph (d) of this section). This termination is effective with the start of the 13th month after the suspension began because you failed to cooperate.

[45 FR 55584, Aug. 20, 1980, as amended at 47 FR 31543, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 51 FR 17617, May 14, 1986; 68 FR 40123, July 7, 2003; 70 FR 36507, June 24, 2005; 71 FR 60822, Oct. 17, 2006]

§ 404.1597 After we make a determination that you are not now disabled.

(a) *General.* If we determine that you do not meet the disability requirements of the law, your benefits generally will stop. We will send you a formal written notice telling you why we believe you are not disabled and when your benefits should stop. If your spouse and children are receiving benefits on your social security number, we will also stop their benefits and tell them why. The notices will explain your right to reconsideration if you

disagree with our determination. However, your benefits may continue even though your impairment is no longer disabling, if you are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services (see § 404.327). You must have started participating in the program before the date your disability ended. In addition, we must have determined that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls. (See §§ 404.316(c), 404.328, 404.337(c), 404.352(d), and 404.1586(g).) You may still appeal our determination that you are not disabled even though your benefits are continuing because of your participation in an appropriate program of vocational rehabilitation services, employment services, or other support services. You may also appeal a determination that your completion of the program, or your continuation in the program for a specified period of time, will not increase the likelihood that you will not have to return to the disability benefit rolls and, therefore, you are not entitled to continue to receive benefits.

(b) *If we make a determination that your physical or mental impairment(s) has ceased, did not exist, or is no longer disabling (Medical Cessation Determination).* If we make a determination that the physical or mental impairment(s) on the basis of which benefits were payable has ceased, did not exist, or is no longer disabling (a medical cessation determination), your benefits will stop. As described in paragraph (a) of this section, you will receive a written notice explaining this determination and the month your benefits will stop. The written notice will also explain your right to appeal if you disagree with our determination and your right to request that your benefits and the benefits, if any, of your spouse or children, be continued under § 404.1597a. For the purpose of this section, *benefits* means disability cash payments and/or Medicare, if applicable. The continued benefit provisions of this section do not apply to an initial determination on an application for disability benefits, or to a determination that you were disabled only for a specified period of time.

[47 FR 31544, July 21, 1982, as amended at 51 FR 17618, May 14, 1986; 53 FR 29020, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988; 70 FR 36507, June 24, 2005]

§ 404.1597a Continued benefits pending appeal of a medical cessation determination.

(a) *General.* If we determine that you are not entitled to benefits because the physical or mental impairment(s) on the basis of which such benefits were payable is found to have ceased, not to have existed, or to no longer be disabling, and you appeal that determination, you may choose to have your benefits continued pending reconsideration and/or a hearing before an administrative law judge on the disability cessation determination. For the purpose of this entire section, the election of *continued benefits* means the election of disability cash payments and/or Medicare, if applicable. You can also choose to have the benefits continued for anyone else receiving benefits based on your wages and self-employment income (and anyone else receiving benefits because of your entitlement to benefits based on disability). If you appeal a medical cessation under both title II and title XVI (a concurrent case), the title II claim will be handled in accordance with title II regulations while the title XVI claim will be handled in accordance with the title XVI regulations.

(b) *When the provisions of this section are available.* (1) Benefits may be continued under this section only if the determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling is made on or after January 12, 1983 (or before January 12, 1983, and a timely request for reconsideration or a hearing before an administrative law judge is pending on that date).

(2) Benefits may be continued under this section only for months beginning with January 1983, or the first month

for which benefits are no longer otherwise payable following our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, whichever is later.

(3) Continued payment of benefits under this section will stop effective with the earlier of:

(i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of a new administrative law judge decision (or final action by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or

(ii) The month before the month no timely request for a reconsideration or a hearing before an administrative law judge is pending. These continued benefits may be stopped or adjusted because of certain events (such as work and earnings or receipt of worker's compensation) which occur while you are receiving these continued benefits and affect your right to receive continued benefits.

(c) *Continuation of benefits for anyone else pending your appeal.* (1) When you file a request for reconsideration or hearing before an administrative law judge on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or your case has been sent back (remanded) to an administrative law judge for further action, you may also choose to have benefits continue for anyone else who is receiving benefits based on your wages and self-employment income (and for anyone else receiving benefits because of your entitlement to benefits based on disability), pending the outcome of your appeal.

(2) If anyone else is receiving benefits based on your wages and self-employment income, we will notify him or her of the right to choose to have his or her benefits continue pending the outcome of your appeal. Such benefits can be continued for the time period in paragraph (b) of this section only if he or she chooses to have benefits continued and you also choose to have his or her benefits continued.

(d) *Statement of choice.* When you or another party request reconsideration under § 404.908(a) or a hearing before an administrative law judge under § 404.932(a) on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or if your case is sent back (remanded) to an administrative law judge for further action, we will explain your right to receive continued benefits and ask you to complete a statement specifying which benefits you wish to have continued pending the outcome of the reconsideration or hearing before an administrative law judge. You may elect to receive only Medicare benefits during appeal even if you do not want to receive continued disability benefits. If anyone else is receiving benefits based on your wages and self-employment income (or because of your entitlement to benefits based on disability), we will ask you to complete a statement specifying which benefits you wish to have continued for them, pending the outcome of the request for reconsideration or hearing before an administrative law judge. If you request appeal but you do not want to receive continued benefits, we will ask you to complete a statement declining continued benefits indicating that you do not want to have your benefits and those of your family, if any, continued during the appeal.

(e) *Your spouse's or children's statement of choice.* If you request, in accordance with paragraph (d) of this section, that benefits also be continued for anyone who had been receiving benefits based on your wages and self-employment, we will send them a written notice. The notice will explain their rights and ask them to complete a statement either declining continued benefits, or specifying which benefits they wish to have continued, pending the outcome of the request for reconsideration or a hearing before an administrative law judge.

(f) *What you must do to receive continued benefits pending notice of our reconsideration determination.* (1) If you want to receive continued benefits pending

the outcome of your request for reconsideration, you must request reconsideration and continuation of benefits no later than 10 days after the date you receive the notice of our initial determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Reconsideration must be requested as provided in §404.909, and you must request continued benefits using a statement in accordance with paragraph (d) of this section.

(2) If you fail to request reconsideration and continued benefits within the 10-day period required by paragraph (f)(1) of this section, but later ask that we continue your benefits pending a reconsidered determination, we will use the rules in §404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the notice of the initial cessation determination. If you request continued benefits after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(g) *What you must do to receive continued benefits pending an administrative law judge's decision.* (1) To receive continued benefits pending an administrative law judge's decision on our reconsideration determination, you must request a hearing and continuation of benefits no later than 10 days after the date you receive the notice of our reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. A hearing must be requested as provided in §404.933, and you must request continued benefits using a statement in accordance with paragraph (d) of this section.

(2) If you request continued benefits pending an administrative law judge's decision but did not request continued benefits while we were reconsidering the initial cessation determination, your benefits will begin effective the month of the reconsideration determination.

(3) If you fail to request continued payment of benefits within the 10-day period required by paragraph (g)(1) of this section, but you later ask that we continue your benefits pending an administrative law judge's decision on our reconsidered determination, we will use the rules as provided in §404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the reconsideration determination. If you request continued benefits after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(h) *What anyone else must do to receive continued benefits pending our reconsideration determination or an administrative law judge's decision.* (1) When you or another party (see §§404.908(a) and 404.932(a)) request a reconsideration or a hearing before an administrative law judge on our medical cessation determination or when your case is sent back (remanded) to an administrative law judge for further action, you may choose to have benefits continue for anyone else who is receiving benefits based on your wages and self-employment income. An eligible individual must also choose whether or not to have his or her benefits continue pending your appeal by completing a separate statement of election as described in paragraph (e) of this section.

(2) He or she must request continuation of benefits no later than 10 days after the date he or she receives notice of termination of benefits. He or she will then receive continued benefits beginning with the later of January 1983, or the first month for which benefits are no longer otherwise payable following our initial or reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Continued benefits will continue until the earlier of:

(i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of the new administrative law judge decision (or final action is taken by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or

(ii) The month before the month no timely request for a reconsideration or a hearing before an administrative law judge is pending. These continued benefits may be stopped or adjusted because of certain events (such as work and earnings or payment of worker's compensation) which occur while an eligible individual is receiving continued benefits and affect his or her right to receive continued benefits.

(3) If he or she fails to request continuation of benefits within the 10-day period required by this paragraph, but requests continuation of benefits at a later date, we will use the rules as provided in § 404.911 to determine whether good cause exists for his or her failure to request continuation of benefits within 10 days after receipt of the notice of termination of his or her benefits. His or her late request will be considered to be timely and we will pay him or her continued benefits only if good cause for delay is established.

(4) If you choose not to have benefits continued for anyone else who is receiving benefits based on your wages and self-employment income, pending the appeal on our determination, we will not continue benefits to him or her.

(i) *What you must do when your case is remanded to an administrative law judge.* If we send back (remand) your case to an administrative law judge for further action under the rules provided in § 404.977, and the administrative law judge's decision or dismissal order issued on your medical cessation appeal is vacated and is no longer in effect, continued benefits are payable pending a new decision by the administrative law judge or final action is taken by the Appeals Council on the administrative law judge's recommended decision.

(1) If you (and anyone else receiving benefits based on your wages and self-employment income or because of your disability) previously elected to receive continued benefits pending the administrative law judge's decision, we will automatically start these same continued benefits again. We will send you a notice telling you this, and that you do not have to do anything to have these same benefits continued until the month before the month the new decision of order of dismissal is issued by the administrative law judge or until the month before the month the Appeals Council takes final action on the administrative law judge's recommended decision. These benefits will begin again with the first month of nonpayment based on the prior administrative law judge hearing decision or dismissal order. Our notice explaining reinstatement of continued benefits will also tell you to report to us any changes or events that affect your receipt of benefits.

(2) After we automatically reinstate your continued benefits as described in paragraph (h)(1) of this section, we will contact you to determine if any adjustment is required to the amount of continued benefits payable due to events that affect the right to receive benefits involving you, your spouse and/or children. If you have returned to work, we will request additional information about this work activity. If you are working, your continued benefits will not be stopped while your appeal of the medical cessation of disability is still pending unless you have completed a trial work period and are engaging in substantial gainful activity. In this event, we will suspend your continued benefits. If any other changes have occurred which would require a reduction in benefit amounts, or nonpayment of benefits, we will send an advance notice to advise of any adverse change before the adjustment action is taken. The notice will also advise you of the right to explain why these benefits should not be adjusted or stopped. You will also receive a written notice of our determination. The notice will also explain your right to reconsideration if you disagree with this determination.

(3) If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of your right to benefits, if any, before you engaged in substantial gainful activity and to reentitlement should you stop performing substantial gainful activity. If you disagree with our determination, you will have the right to appeal this decision.

(4) If the final decision on your appeal of your medical cessation is an unfavorable one (the cessation is affirmed), you will also be sent a written notice advising you of our determination, and your right to appeal if you think we are wrong.

(5) If you (or the others receiving benefits based on your wages and self-employment income or because of your disability) did not previously elect to have benefits continued pending an administrative law judge decision, and you now want to elect continued benefits, you must request to do so no later than 10 days after you receive our notice telling you about continued benefits. If you fail to request continued benefits within the 10-day period required by paragraph (f)(1) of this section, but later ask that we continue your benefits pending an administrative law judge remand decision, we will use the rules in § 404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the notice telling you about benefit continuation. We will consider the request to be timely and will pay continued benefits only if good cause for delay is established. If you make this new election, benefits may begin with the month of the order sending (remanding) your case back to the administrative law judge. Before we begin to pay you continued benefits as described in paragraph (h)(1) of this section we will contact you to determine if any adjustment is required to the amount of continued benefits payable due to events which may affect your right to benefits. If you have returned to work, we will request additional information about this work activity. If you are working, continued benefits may be started and will not be stopped because of your work while your appeal of the medical cessation of your disability is still pending unless you have completed a trial work period and are engaging in substantial gainful activity. If any changes have occurred which establish a basis for not paying continued benefits or a reduction in benefit amount, we will send you a notice explaining the adjustment or the reason why we cannot pay continued benefits. The notice will also explain your right to reconsideration if you disagree with this determination. If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of your right to benefits, if any, before you engaged in substantial gainful activity and to reentitlement should you stop performing substantial gainful activity. If you disagree with our determination, you will have the right to appeal this decision. If the final decision on your appeal of your medical cessation is an unfavorable one (the cessation is affirmed), you will also be sent a written notice advising you of our determination, and your right to appeal if you think we are wrong.

(6) If a court orders that your case be sent back to us (remanded) and your case is sent to an administrative law judge for further action under the rules provided in § 404.983, the administrative law judge's decision or dismissal order on your medical cessation appeal is vacated and is no longer in effect. Continued benefits are payable to you and anyone else receiving benefits based on your wages and self-employment income or because of your disability pending a new decision by the administrative law judge or final action is taken by the Appeals Council on the administrative law judge's recommended decision. In these court-remanded cases reaching the administrative law judge, we will follow the same rules provided in paragraphs (i) (1), (2), (3), (4) and (5) of this section.

(j) *Responsibility to pay back continued benefits.* (1) If the final decision of the Commissioner affirms the determination that you are not entitled to benefits, you will be asked to pay back any continued benefits you receive. However, as described in the overpayment recovery and waiver provisions of subpart F of this part, you will have the right to ask that you not be required to pay back the benefits. You will not be asked to pay back any Medicare benefits you received during the appeal.

(2) Anyone else receiving benefits based on your wages and self-employment income (or because of your disability) will be asked to pay back any continued benefits he or she received if the determination that your physical

or mental impairment(s) has ceased, has never existed, or is no longer disabling, is not changed by the final decision of the Commissioner. However, he or she will have the right to ask that he or she not be required to pay them back, as described in the overpayment recovery and waiver provisions of subpart F of this part. He or she will not be asked to pay back any Medicare benefits he or she received during the appeal.

(3) Waiver of recovery of an overpayment resulting from the continued benefits paid to you or anyone else receiving benefits based on your wages and self-employment income (or because of your disability) may be considered as long as the determination was appealed in good faith. It will be assumed that such appeal is made in good faith and, therefore, any overpaid individual has the right to waiver consideration *unless* such individual fails to cooperate in connection with the appeal, e.g., if the individual fails (without good reason) to give us medical or other evidence we request, or to go for a physical or mental examination when requested by us, in connection with the appeal. In determining whether an individual has good cause for failure to cooperate and, thus, whether an appeal was made in good faith, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have which may have caused the individual's failure to cooperate.

[53 FR 29020, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988, as amended at 57 FR 1383, Jan. 14, 1992; 59 FR 1635, Jan. 12, 1994; 62 FR 38451, July 18, 1997; 65 FR 16814, Mar. 30, 2000]

§ 404.1598 If you become disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which your last impairment(s) ends, we will find that your disability is continuing. The new impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep you from doing substantial gainful activity, or severe enough so that you are still disabled under § 404.1594.

[50 FR 50136, Dec. 6, 1985]

§ 404.1599 Work incentive experiments and rehabilitation demonstration projects in the disability program.

(a) *Authority and purpose.* Section 505(a) of the Social Security Disability Amendments of 1980, Pub. L. 96–265, directs the Commissioner to develop and conduct experiments and demonstration projects designed to provide more cost-effective ways of encouraging disabled beneficiaries to return to work and leave benefit rolls. These experiments and demonstration projects will test the advantages and disadvantages of altering certain limitations and conditions that apply to title II disabled beneficiaries. The objective of all work incentive experiments or rehabilitation demonstrations is to determine whether the alternative requirements will save Trust Fund monies or otherwise improve the administration of the disability program established under title II of the Act.

(b) *Altering benefit requirements, limitations or conditions.* Notwithstanding any other provision of this part, the Commissioner may waive compliance with the entitlement and payment requirements for disabled beneficiaries to carry our experiments and demonstration projects in the title II disability program. The projects involve altering certain limitations and conditions that currently apply to applicants and beneficiaries to test their effect on the program.

(c) *Applicability and scope*—(1) *Participants and nonparticipants.* If you are selected to participate in an experiment or demonstration project, we may temporarily set aside one or more of the current benefit entitlement or payment requirements, limitations or conditions and apply alternative provisions to you. We may also modify current methods of administering the Act as part of a project and apply alternative procedures or policies to you. The alternative provisions or methods of administration used in the projects will not disadvantage you in contrast to current provisions, procedures or policies. If you are not selected to participate in the experiments or demonstration projects (or if you are placed in a control group which is not subject to alternative requirements and methods) we will continue to apply

to you the current benefit entitlement and payment requirements, limitations and conditions and methods of administration in the title II disability program.

(2) *Alternative provisions or methods of administration.* The alternative provisions or methods of administration that apply to you in an experiment or demonstration project may include (but are not limited to) one or more of the following:

(i) Reducing your benefits (instead of not paying) on the basis of the amount of your earnings in excess of the SGA amount;

(ii) Extending your benefit eligibility period that follows 9 months of trial work, perhaps coupled with benefit reductions related to your earnings;

(iii) Extending your Medicare benefits if you are severely impaired and return to work even though you may not be entitled to monthly cash benefits;

(iv) Altering the 24-month waiting period for Medicare entitlement; and

(v) Stimulating new forms of rehabilitation.

(d) *Selection of participants.* We will select a probability sample of participants for the work incentive experiments and demonstration projects from newly awarded beneficiaries who meet certain pre-selection criteria (for example, individuals who are likely to be able to do substantial work despite continuing severe impairments). These criteria are designed to provide larger subsamples of beneficiaries who are not likely either to recover medically or die. Participants may also be selected from persons who have been receiving DI benefits for 6 months or more at the time of selection.

(e) *Duration of experiments and demonstration projects.* A notice describing each experiment or demonstration project will be published in the FEDERAL REGISTER before each experiment or project is placed in operation. The work incentive experiments and rehabilitation demonstrations will be activated in 1982. A final report on the results of the experiments and projects is to be completed and transmitted to Congress by June 9, 1993. However, the authority for the experiments and demonstration projects will not terminate at that time. Some of the alternative provisions or methods of administration may continue to apply to participants in an experiment or demonstration project beyond that date in order to assure the validity of the research. Each experiment and demonstration project will have a termination date (up to 10 years from the start of the experiment or demonstration project).

[48 FR 7575, Feb. 23, 1983, as amended at 52 FR 37605, Oct. 8, 1987; 55 FR 51687, Dec. 17, 1990; 62 FR 38451, July 18, 1997]

APPENDIX 1 TO SUBPART P OF PART 404—LISTING OF IMPAIRMENTS

The body system listings in parts A and B of the Listing of Impairments will no longer be effective on the following dates unless extended by the Commissioner or revised and promulgated again.

1. Low Birth Weight and Failure to Thrive (100.00): August 14, 2026.
2. Musculoskeletal Disorders (1.00 and 101.00): April 2, 2026.
3. Special Senses and Speech (2.00 and 102.00): June 5, 2026.
4. Respiratory Disorders (3.00 and 103.00): December 12, 2025.
5. Cardiovascular System (4.00 and 104.00): February 6, 2026.
6. Digestive Disorders (5.00 and 105.00): October 6, 2028.
7. Genitourinary Disorders (6.00 and 106.00): December 12, 2025.
8. Hematological Disorders (7.00 and 107.00): June 5, 2026.
9. Skin Disorders (8.00 and 108.00): October 6, 2028.
10. Endocrine Disorders (9.00 and 109.00): August 14, 2026.
11. Congenital Disorders That Affect Multiple Body Systems (10.00 and 110.00): June 5, 2026.
12. Neurological Disorders (11.00 and 111.00): September 29, 2025.
13. Mental Disorders (12.00 and 112.00): December 12, 2025.
14. Cancer (Malignant Neoplastic Diseases) (13.00 and 113.00): August 14, 2026.
15. Immune System Disorders (14.00 and 114.00): February 6, 2026.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.

1.00 Musculoskeletal Disorders
2.00 Special Senses and Speech.
3.00 Respiratory Disorders.
4.00 Cardiovascular System.
5.00 Digestive Disorders
6.00 Genitourinary Disorders.

7.00 Hematological Disorders.
8.00 Skin Disorders.
9.00 Endocrine Disorders.
10.00 Congenital Disorders That Affect Multiple Body Systems
11.00 Neurological Disorders.
12.00 Mental Disorders.
13.00 Cancer (Malignant Neoplastic Diseases).
14.00 Immune System Disorders.

1.00 Musculoskeletal Disorders

A. *Which musculoskeletal disorders do we evaluate under these listings?*

1. We evaluate disorders of the skeletal spine (vertebral column) or of the upper or lower extremities that affect musculoskeletal functioning under these listings. We use the term ''skeletal'' when we are referring to the structure of the bony skeleton. The *skeletal spine* refers to the bony structures, ligaments, and discs making up the spine. We refer to the skeletal spine in some musculoskeletal listings to differentiate it from the *neurological spin*e (see 1.00B1). Musculoskeletal disorders may be congenital or acquired, and may include deformities, amputations, or other abnormalities. These disorders may involve the bones or major joints; or the tendons, ligaments, muscles, or other soft tissues.

2. We evaluate soft tissue injuries (including burns) or abnormalities that are under continuing surgical management (see 1.00O1). The injuries or abnormalities may affect any part of the body, including the face and skull.

3. We evaluate curvatures of the skeletal spine that affect musculoskeletal functioning under 1.15. If a curvature of the skeletal spine is under continuing surgical management (see 1.00O1), we will evaluate it under 1.21 using our rules for determining medical equivalence. See §§ 404.1526 and 416.926 of this chapter.

B. *Which related disorders do we evaluate under other listings?*

1. We evaluate a disorder or injury of the skeletal spine that results in damage to, and neurological dysfunction of, the spinal cord and its associated nerves (for example, paraplegia or quadriplegia) under the listings in 11.00.

2. We evaluate inflammatory arthritis (for example, rheumatoid arthritis) under the listings in 14.00.

3. We evaluate curvatures of the skeletal spine that interfere with your ability to breathe under the listings in 3.00, impair myocardial function under the listings in 4.00, or result in social withdrawal or depression under the listings in 12.00.

4. We evaluate non-healing or pathological fractures due to cancer, whether it is a primary site or metastases, under the listings in 13.00.

5. We evaluate the leg pain associated with peripheral vascular claudication and foot ulceration associated with peripheral arterial disease under the listings in 4.00.

6. We evaluate burns that do not require continuing surgical management under the listings in 8.00.

C. *What evidence do we need to evaluate your musculoskeletal disorder?*

1. *General.* We need objective medical evidence from an acceptable medical source to establish that you have a medically determinable musculoskeletal disorder. We also need evidence from both medical and nonmedical sources, who can describe how you function, to assess the severity and duration of your musculoskeletal disorder. We will determine the extent and kinds of evidence we need from medical and nonmedical sources based on the individual facts about your disorder. For our basic rules on evidence, see §§ 404.1512, 404.1513, 404.1520b, 416.912, 416.913, and 416.920b of this chapter. For our rules on evidence about your symptoms, see §§ 404.1529 and 416.929 of this chapter.

2. *Physical examination report(s).* In the report(s) of your physical examination, we require a medical source's detailed description of the orthopedic, neurologic, or other objective clinical findings appropriate to your specific musculoskeletal disorder from his or her direct observations during your physical examination. We will not accept a report of your statements about your symptoms and limitations in place of the medical source's report of objective clinical findings. We will not use findings on imaging or other diagnostic tests (see 1.00C3) as a substitute for findings on physical examination.

a. When the medical source reports that a clinical test sign(s) is positive, unless we have evidence to the contrary, we will assume that he or she performed the test properly and accept the medical source's interpretation of the test. For example, we will assume a straight-leg raising test was conducted properly (that is, in sitting and supine positions), even if the medical source does not specify the positions in which the test was performed.

b. If you use an assistive device (see 1.00C6), the report must support the medical need for the device.

c. If your musculoskeletal disorder causes a reduction in muscle strength, the report must document measurement of the strength of the muscle(s) in question. The measurement should be based on a muscle strength grading system that is considered medically acceptable based on your age and impairments. For example, a grading system of 0 to 5, with 0 indicating complete loss of strength and 5 indicating maximum strength or equivalent medically acceptable scale (see Table 1). Reduction in muscle strength is demonstrated by evidence that your muscle strength is less than active range of motion

(ROM) against gravity with maximum resistance. If the reduction in muscle strength involves one or both of your hands, the report must also document measurements of grip and pinch strength.

TABLE 1—GRADING SYSTEM OF MUSCLE FUNCTION

Grade	Function of the muscle
0—None	No visible or palpable contraction.
1—Trace	Visible or palpable contraction with no motion.
2—Poor	Active ROM with gravity eliminated.
3—Fair	Active ROM against gravity only, without resistance.
4—Good	Active ROM against gravity, moderate resistance.
5—Normal	Active ROM against gravity, maximum resistance.

3. *Imaging and other diagnostic tests.*

a. *Imaging* refers to medical imaging techniques, such as x-ray, computed tomography (CT), magnetic resonance imaging (MRI), and radionuclide scanning. For the purpose of these listings, the imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder.

b. Findings on imaging must have lasted, or be expected to last, for a continuous period of at least 12 months.

c. Imaging and other diagnostic tests can provide evidence of physical abnormalities; however, these abnormalities may correlate poorly with your symptoms, including pain, or with your musculoskeletal functioning. Accordingly, we will not use findings on imaging or other diagnostic tests as a substitute for findings on physical examination about your ability to function, nor can we infer severity or functional limitations based solely on such tests.

d. For our rules on purchasing imaging and other diagnostic tests, see §§404.1519k, 404.1519m, 416.919k, and 416.919m of this chapter.

4. *Operative reports.* If you have had a surgical procedure, we need a copy of the operative report, including details of the findings at surgery and information about any medical complications that may have occurred. If we do not have the operative report, we need confirmatory evidence of the surgical procedure from a medical source (for example, detailed follow-up reports or notations in the medical records concerning the surgical procedure in your medical history).

5. *Effects of treatment.*

a. *General.* Treatments for musculoskeletal disorders may have beneficial or adverse effects, and responses to treatment vary from person to person. We will evaluate all of the effects of treatment (including surgical treatment, medications, and therapy) on the symptoms, signs, and laboratory findings of your musculoskeletal disorder, and on your musculoskeletal functioning.

b. *Response to treatment.* To evaluate your musculoskeletal functioning in response to treatment, we need the following: A description, including the frequency of the administration, of your medications; the type and frequency of therapy you receive; and a description of your response to treatment and any complications you experience related to your musculoskeletal disorder. The effects of treatment may be temporary or long-term. We need information over a sufficient period to determine the effects of treatment on your current musculoskeletal functioning and permit reasonable projections about your future functioning. We will determine the amount of time that constitutes a sufficient period in consultation with a medical consultant on a case-by-case basis. In some cases, we will need additional evidence to make an assessment about your response to treatment. Your musculoskeletal disorder may meet or medically equal one of these listings regardless of whether you were prescribed opioid medication, or whether you were prescribed opioid medication and did not follow this prescribed treatment.

6. *Assistive devices.*

a. *General.* An assistive device, for the purposes of these listings, is any device that you use to improve your stability, dexterity, or mobility. An assistive device can be worn (see 1.00C6b and 1.00C6c), hand-held (see 1.00C6d), or used in a seated position (see 1.00C6e). When we use the phrase ''documented medical need,'' we mean that there is evidence from a medical source that supports your medical need for an assistive device (see 1.00C2b) for a continuous period of at least 12 months (see 1.00C6a). This evidence must describe any limitation(s) in your upper or lower extremity functioning and the circumstances for which you need to use the assistive device. We do not require that you have a specific prescription for the assistive device.

b. *Prosthesis(es).* A prosthesis is a wearable device, such as an artificial limb, that takes the place of an absent body part. If you have a prosthesis(es), we need evidence from a medical source documenting your ability to walk, or perform fine and gross movements (see 1.00E4), with the prosthesis(es) in place. When amputation(s) involves one or both

lower extremities, it is not necessary for the medical source to evaluate your ability to walk without the prosthesis(es) in place. If you cannot use your prosthesis(es) due to complications affecting your residual limb(s), we need evidence from a medical source documenting the condition of your residual limb(s) and the medical basis for your inability to use the device(s).

c. *Orthosis(es)*. An orthosis is a wearable device, such as a brace, that prevents or corrects a dysfunction or deformity by aligning or supporting the affected body part. If you have an orthosis(es), we need evidence from a medical source documenting your ability to walk, or perform fine and gross movements (see 1.00E4), with the orthosis(es) in place. If you cannot use your orthosis(es), we need evidence from a medical source documenting the medical basis for your inability to use the device(s).

d. *Hand-held assistive devices*. Hand-held assistive devices include walkers, canes, or crutches, which you hold onto with your hand(s) to support or aid you in walking. When you use a one-handed, hand-held assistive device (such as a cane) with one upper extremity to walk and you cannot use your other upper extremity for fine or gross movements (see 1.00E4), the need for the assistive device limits the use of both upper extremities. If you use a hand-held assistive device, we need evidence from a medical source describing how you walk with the device.

e. *Wheeled and seated mobility devices*. Wheeled and seated mobility devices are assistive devices that you use in a seated position, such as manual wheelchairs, motorized wheelchairs, rollators, and power operated vehicles. If you use a wheeled and seated mobility device, we need evidence from a medical source describing the type of wheeled and seated mobility device that you use and how you use the assistive device including any customizations or modifications to the assistive device itself or for your use of the assistive device. For example, if you use a wheelchair that typically requires the use of both hands but has been customized for your use with one hand, then we will evaluate your use of the assistive device using the criteria in 1.00E3b and not 1.00E3a.

(i) *Wheeled and seated mobility devices involving the use of both hands*. Some wheeled and seated mobility devices involve the use of both hands to use the assistive device (for example, most manual wheelchairs). If you use a wheeled and seated mobility device that involves the use of both hands, then the need for the assistive device limits the use of both upper extremities.

(ii) *Wheeled and seated devices involving the use of one hand*. Some wheeled and seated mobility devices involve the use of one hand to use the assistive device (for example, most motorized wheelchairs). If you use a wheeled and seated mobility device that involves the use of one upper extremity and you cannot use your other upper extremity for fine or gross movements (see 1.00E4), then the need for the assistive device limits the use of both upper extremities.

7. *Longitudinal evidence*.

a. The term *pandemic period* as used in 1.00C7c means the period beginning on April 2, 2021, and ending on May 11, 2025. The term *post-pandemic evaluation period* as used in 1.00C7c means the period beginning on May 12, 2025, and ending on May 11, 2029.

b. We generally need a longitudinal medical record to assess the severity and duration of your musculoskeletal disorder because the severity of symptoms, signs, and laboratory findings related to most musculoskeletal disorders may improve over time or respond to treatment. Evidence over an extended period will show whether your musculoskeletal functioning is improving, worsening, or unchanging.

c. For 1.15, 1.16, 1.17, 1.18, 1.20C, 1.20D, 1.22, and 1.23, all of the required criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed to meet the listing. The phrase ''within a close proximity of time'' means that all of the relevant criteria must appear in the medical record within a consecutive 4-month period, except for claims determined or decided during the pandemic period or post-pandemic evaluation period. For claims determined or decided during the pandemic period or post-pandemic evaluation period, all of the relevant criteria must appear in the medical record within a consecutive 12-month period. When the criterion is imaging, we mean that we could reasonably expect the findings on imaging to have been present at the date of impairment or date of onset. For listings that use the word ''and'' to link the elements of the required criteria, the medical record must establish the simultaneous presence, or presence within a close proximity of time, of all the required medical criteria. Once this level of severity is established, the medical record must also show that this level of severity has continued, or is expected to continue, for a continuous period of at least 12 months.

8. *Surgical treatment and physical therapy*. For some musculoskeletal disorders, a medical source may recommend surgery or physical therapy (PT). If you have not yet had the recommended surgery or PT, we will not assume that these interventions will resolve your disorder or improve your functioning. We will assess each case on an individual basis. Depending on your response to treatment, or your medical sources' treatment plans, we may defer our findings regarding the effect of surgery or PT, until a sufficient period has passed to permit proper consideration or judgment about your future functioning. When necessary, we will follow the rules on following prescribed treatment in

§§ 404.1530 and 416.930 of this chapter, including consideration of your reasons for failure to follow prescribed treatment.

D. *How do we consider symptoms, including pain, under these listings?*

1. Musculoskeletal disorders may cause pain or other symptoms; however, your statements about your pain or other symptoms will not alone establish that you are disabled. We will not substitute an alleged or a reported increase in the intensity of a symptom, such as pain, no matter how severe, for a medical sign or diagnostic finding present in the listing criteria. Pain is included as just one consideration in 1.15A, 1.16A, and 1.18A, but it is not required to satisfy the criteria in 1.15, 1.16, and 1.18.

2. To consider your symptom(s), we require objective medical evidence from an acceptable medical source showing the existence of a medically determinable musculoskeletal impairment that we could reasonably expect to produce the symptom(s). See §§ 404.1529 and 416.929 of this chapter for how we evaluate symptoms, including pain, related to your musculoskeletal disorder.

E. *How do we use the functional criteria to evaluate your musculoskeletal disorder under these listings?*

1. *General.* The functional criteria are based on impairment-related physical limitations in your ability to use both upper extremities, one or both lower extremities, or a combination of one upper and one lower extremity. The required impairment-related physical limitation of musculoskeletal functioning must have lasted, or be expected to last, for a continuous period of at least 12 months. We do not use the functional criteria in 1.20A, 1.20B, or 1.21.

2. *Work environment.* We use the relevant evidence that we have to evaluate your musculoskeletal functioning with respect to the work environment rather than the home environment. For example, an ability to walk independently at home without an assistive device does not, in and of itself, indicate an ability to walk without an assistive device in a work environment.

3. *Functional criteria.* A musculoskeletal disorder satisfies the functional criteria of a listing when the medical documentation shows the presence of at least one of the impairment-related limitations cited in the listing. The required impairment-related limitation of musculoskeletal functioning must be medically documented by one of the following:

a. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i));

b. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4), and a documented medical need (see 1.00C6a) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of your other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii));

c. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4).

4. *Fine and gross movements. Fine* movements, for the purposes of these listings, involve use of your wrists, hands, and fingers; such movements include picking, pinching, manipulating, and fingering. *Gross* movements involve use of your shoulders, upper arms, forearms, and hands; such movements include handling, gripping, grasping, holding, turning, and reaching. Gross movements also include exertional abilities such as lifting, carrying, pushing, and pulling. Examples of performing fine and gross movements include, but are not limited to, taking care of personal hygiene, sorting and handling papers or files, and placing files in a file cabinet at or above waist level.

F. *What do we consider when we evaluate disorders of the skeletal spine resulting in compromise of a nerve root(s) (1.15)?*

1. *General.* We consider musculoskeletal disorders such as herniated nucleus pulposus, spinal osteoarthritis (spondylosis), vertebral slippage (spondylolisthesis), degenerative disc disease, facet arthritis, and vertebral fracture or dislocation. Spinal disorders may cause cervical or lumbar spine dysfunction when abnormalities of the skeletal spine compromise nerve roots of the cervical spine, a nerve root of the lumbar spine, or a nerve root of both cervical and lumbar spines. We consider spinal nerve disorders that originate in the nervous system (for example, spinal arachnoiditis), under the neurological disorders body system, 11.00.

2. *Compromise of a nerve root(s).* Compromise of a nerve root, sometimes referred to as ''nerve root impingement,'' is a phrase used when a physical object, such as a tumor, herniated disc, foreign body, or arthritic spur, is pushing on the nerve root as seen on imaging or during surgery. It can occur when a musculoskeletal disorder produces irritation, inflammation, or compression of the nerve root(s) as it exits the skeletal spine between the vertebrae. Related symptoms must be associated with, or follow the path of, the affected nerve root(s).

a. *Compromise of unilateral nerve root of the cervical spine.* Compromise of a nerve root as it exits the cervical spine between the vertebrae may affect the functioning of the associated upper extremity. The physical examination reproduces the related symptoms based on radicular signs and clinical tests appropriate to the specific cervical nerve root (for example, a positive Spurling test).

b. *Compromise of bilateral nerve roots of the cervical spine.* Although uncommon, if compromise of a nerve root occurs on both sides of the cervical spinal column, functioning of both upper extremities may be limited.

c. *Compromise of a nerve root(s) of the lumbar spine.* Compromise of a nerve root as it exits the lumbar spine between the vertebrae may limit the functioning of the associated lower extremity. The physical examination reproduces the related symptoms based on radicular signs and clinical tests. When a nerve root of the lumbar spine is compromised, we require a positive straight-leg raising test (also known as a Lasègue test) in both supine and sitting positions appropriate to the specific lumbar nerve root that is compromised.

G. *What do we consider when we evaluate lumbar spinal stenosis resulting in compromise of the cauda equina (1.16)?*

1. *General.* We consider how pain, sensory changes, and muscle weakness caused by compromise of the cauda equina due to lumbar spinal stenosis affect your functioning. The cauda equina is a bundle of nerve roots that descends from the lower part of the spinal cord. Lumbar spinal stenosis can compress the nerves of the cauda equina, causing sensory changes and muscle weakness that may affect your ability to stand or walk. Pain related to compromise of the cauda equina is nonradicular because it is not typically associated with a specific nerve root (as is radicular pain in the cervical or lumbar spine).

2. *Compromise of the cauda equina* due to lumbar spinal stenosis can affect your ability to walk or stand because of neurogenic claudication (also known as pseudoclaudication), a condition usually causing nonradicular pain that starts in the low back and radiates bilaterally (or less commonly, unilaterally) into the buttocks and lower extremities (or extremity). Extension of the lumbar spine, which occurs when you walk or stand, may provoke the pain of neurogenic claudication. The pain may be relieved by forward flexion of the lumbar spine or by sitting. In contrast, the leg pain associated with peripheral vascular claudication results from inadequate arterial blood flow to a lower extremity. It occurs repeatedly and consistently when a person walks a certain distance and is relieved when the person rests.

H. *What do we consider when we evaluate reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (1.17)?*

1. *General.* We consider reconstructive surgery or surgical arthrodesis when an acceptable medical source(s) documents the surgical procedure(s) and associated medical treatments to restore function of, or eliminate motion in, the affected major weight-bearing joint. Reconstructive surgery may be done in a single procedure or a series of procedures directed toward the salvage or restoration of functional use of the affected joint.

2. *Major weight-bearing joints* are the hip, knee, and ankle-foot. The ankle and foot are considered together as one major joint.

3. *Surgical arthrodesis* is the artificial fusion of the bones that form a joint, essentially eliminating the joint.

I. *What do we consider when we evaluate abnormality of a major joint(s) in any extremity (1.18)?*

1. *General.* We consider musculoskeletal disorders that produce anatomical abnormalities of major joints of the extremities, which result in functional abnormalities in the upper or lower extremities (for example, osteoarthritis, chronic infections of bones and joints, and surgical arthrodesis of a joint). Abnormalities of the joints include ligamentous laxity or rupture, soft tissue contracture, or tendon rupture, and can cause muscle weakness of the affected joint(s).

a. An *anatomical* abnormality is one that is readily observable by a medical source during a physical examination (for example, subluxation or contracture), or is present on imaging (for example, joint space narrowing, bony destruction, ankylosis, or deformity).

b. A *functional* abnormality is abnormal motion or instability of the affected joint(s), including limitation of motion, excessive motion (hypermobility), movement outside the normal plane of motion for the joint (for example, lateral deviation), or fixation of the affected joint(s).

2. *Major joint of an upper extremity* refers to the shoulder, elbow, and wrist-hand. We consider the wrist and hand together as one major joint.

3. *Major joint of a lower extremity* refers to the hip, knee, and ankle-foot. We consider the ankle and hindfoot together as one major joint.

J. *What do we consider when we evaluate pathologic fractures due to any cause (1.19)?* We consider pathologic fractures of the bones in the skeletal spine, extremities, or other parts of the skeletal system. Pathologic fractures result from disorders that weaken the bones, making them vulnerable to breakage. Pathologic fractures may occur with osteoporosis, osteogenesis imperfecta or any other skeletal dysplasias, side effects of medications, and disorders of the endocrine or other body systems. Under 1.19, the fractures must have occurred on separate, distinct occasions, rather than multiple fractures occurring at the same time, but the fractures may affect the same bone(s) multiple times. There is no required time that must elapse between the fractures, but all three must occur within a 12-month period; for example, separate incidents may occur

within hours or days of each other. We evaluate non-healing or complex traumatic fractures without accompanying pathology under 1.22 or 1.23.

K. *What do we consider when we evaluate amputation due to any cause (1.20)?*

1. *General.* We consider amputation (the full or partial loss or absence of any extremity) due to any cause including trauma, congenital abnormality or absence, surgery for treatment of conditions such as cancer or infection, or complications of peripheral vascular disease or diabetes mellitus.

2. *Amputation of both upper extremities (1.20A).* Under 1.20A, we consider upper extremity amputations that occur at any level at or above the wrists (carpal joints), up to and including disarticulation of the shoulder (glenohumeral) joint. If you have had both upper extremities amputated at any level at or above the wrists up to and including the shoulder, your impairment satisfies the duration requirement in §§ 404.1509 and 416.909 of this chapter. For amputations below the wrist, we will follow the rules described in 1.00S. We do not evaluate amputations below the wrist under 1.20A because the resulting limitation of function of the thumb(s), finger(s), or hand(s) will vary, depending on the extent of loss and corresponding effect on fine and gross movements.

3. *Hemipelvectomy or hip disarticulation (1.20B).* Under 1.20B, we consider hemipelvectomy, which involves amputation of an entire lower extremity through the sacroiliac joint, and hip disarticulation, which involves amputation of an entire lower extremity through the hip joint capsule and closure of the remaining musculature over the exposed acetabular bone. If you have had a hemipelvectomy or hip disarticulation, your impairment satisfies the duration requirement in §§ 404.1509 and 416.909 of this chapter.

4. *Amputation of one upper extremity and one lower extremity (1.20C).* Under 1.20C, we consider the amputation of one upper extremity at any level at or above the wrist and one lower extremity at or above the ankle. If you have a documented medical need for a one-handed, hand-held assistive device (such as a cane) or a wheeled and seated mobility device involving the use of one hand (such as a motorized wheelchair), then you must use your remaining upper extremity to hold the device, making the extremity unavailable to perform other fine and gross movements (see 1.00E4).

5. *Amputation of one lower extremity or both lower extremities with complications of the residual limb(s) (1.20D).* Under 1.20D, we consider the amputation of one lower extremity or both lower extremities at or above the ankle. We also consider the condition of your residual limb(s), whether you can wear a prosthesis(es) (see 1.00C6b), and whether you have a documented medical need (see 1.00C6a) for a hand-held assistive device(s) (see 1.00C6d) or a wheeled and seated mobility device (see 1.00C6e). If you have a non-healing residual limb(s) and are receiving ongoing surgical treatment expected to re-establish or improve function, and that ongoing surgical treatment has not ended, or is not expected to end, within at least 12 months of the initiation of the surgical management (see 1.00L), we evaluate your musculoskeletal disorder under 1.21.

L. *What do we consider when we evaluate soft tissue injuries or abnormalities under continuing surgical management (1.21)?*

1. *General.*

a. We consider any soft tissue injury or abnormality involving the soft tissues of the body, whether congenital or acquired, when an acceptable medical source(s) documents the need for ongoing surgical procedures and associated medical treatments to restore function of the affected body part(s) (see 1.00O1). Surgical management includes the surgery(ies) itself, as well as various post-surgical procedures, surgical complications, infections or other medical complications, related illnesses, or related treatments that delay your attainment of maximum benefit from therapy (see 1.00O2).

b. Surgical procedures and associated treatments typically take place over extended periods, which may render you unable to perform work-related activity on a sustained basis. To document such inability, we must have evidence from an acceptable medical source(s) confirming that the surgical management has continued, or is expected to continue, for at least 12 months from the date of the first surgical intervention. These procedures and treatments must be directed toward saving, reconstructing, or replacing the affected part of the body to re-establish or improve its function, and not for cosmetic appearances alone.

c. Examples include malformations, third- and fourth-degree burns, crush injuries, craniofacial injuries, avulsive injuries, and amputations with complications of the residual limb(s).

d. We evaluate skeletal spine abnormalities or injuries under 1.15 or 1.16, as appropriate. We evaluate abnormalities or injuries of bones in the lower extremities under 1.17, 1.18, or 1.22. We evaluate abnormalities or injuries of bones in the upper extremities under 1.18 or 1.23.

2. *Documentation.* In addition to the objective medical evidence we need to establish your soft tissue injury or abnormality, we also need all of the following medically documented evidence about your continuing surgical management:

a. Operative reports and related laboratory findings;

b. Records of post-surgical procedures;

c. Records of any surgical or medical complications (for example, related infections or systemic illnesses);

d. Records of any prolonged post-operative recovery periods and related treatments (for example, surgeries and treatments for burns);

e. An acceptable medical source's plans for additional surgeries; and

f. Records detailing any other factors that have delayed, or that an acceptable medical source expects to delay, the saving, restoring, or replacing of the involved part for a continuous period of at least 12 months following the initiation of the surgical management.

3. *Burns.* Third- and fourth-degree burns damage or destroy nerve tissue, reducing or preventing transmission of signals through those nerves. Such burns frequently require multiple surgical procedures and related therapies to re-establish or improve function, which we evaluate under 1.21. When burns are no longer *under continuing surgical management* (see 1.00O1), we evaluate the residual impairment(s). When the residual impairment(s) affects the musculoskeletal system, as often occurs in third- and fourth-degree burns, it can result in permanent musculoskeletal tissue loss, joint contractures, or loss of extremities. We will evaluate such impairments under the relevant musculoskeletal disorders listing, for example, 1.18 or 1.20. When the residual impairment(s) involves another body system, we will evaluate the impairment(s) under the listings in the relevant body system(s).

4. *Craniofacial injuries.* Surgeons may treat craniofacial injuries with multiple surgical procedures. These injuries may affect vision, hearing, speech, and the initiation of the digestive process, including mastication. When the craniofacial injury-related residual impairment(s) involves another body system(s), we will evaluate the impairment(s) under the listings in the relevant body system(s).

M. *What do we consider when we evaluate non-healing or complex fractures of the femur, tibia, pelvis, or one or more of the talocrural bones (1.22)?*

1. *Non-healing fracture.* A non-healing (nonunion) fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months has elapsed since the injury and the fracture site has shown no, or minimal, progressive signs of healing for a minimum of 3 months.

2. *Complex fracture.* A complex fracture is a fracture with one or more of the following:

a. Comminuted (broken into many pieces) bone fragments;

b. Multiple fractures in a single bone;

c. Bone loss due to severe trauma;

d. Damage to the surrounding soft tissue;

e. Severe cartilage damage to the associated joint; or

f. Dislocation of the associated joint.

3. When a complex fracture involves soft tissue damage, the treatment may involve continuing surgical management to restore or improve functioning. In such cases, we may evaluate the fracture(s) under 1.21.

N. *What do we consider when we evaluate non-healing or complex fracture of an upper extremity (1.23)?*

1. *Non-healing fracture.* A non-healing (nonunion) fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months has elapsed since the injury and the fracture site has shown no, or minimal, progressive signs of healing for a minimum of 3 months.

2. *Complex fracture.* A complex fracture is a fracture with one or more of the following:

a. Comminuted (broken into many pieces) bone fragments;

b. Multiple fractures in a single bone;

c. Bone loss due to severe trauma;

d. Damage to the surrounding soft tissue;

e. Severe cartilage damage to the associated joint; or

f. Dislocation of the associated joint.

3. When a complex fracture involves soft tissue damage, the treatment may involve continuing surgical management to restore or improve functioning. In such cases, we may evaluate the fracture(s) under 1.21.

O. *How will we determine whether your soft tissue injury or abnormality or your upper extremity fracture is no longer under continuing surgical management or you have received maximum benefit from therapy?*

1. We will determine that your soft tissue injury or abnormality, or your upper extremity fracture, is no longer *under continuing surgical management,* as used in 1.21 and 1.23, when the last surgical procedure or medical treatment directed toward the re-establishment or improvement of function of the involved part has occurred.

2. We will determine that you have received *maximum benefit from therapy,* as used in 1.21, if there are no significant changes in physical findings or on appropriate imaging for any 6-month period after the last surgical procedure or medical treatment. We may also determine that you have received maximum benefit from therapy if your medical source(s) indicates that further improvement is not expected after the last surgical procedure or medical treatment.

3. When you have received maximum benefit from therapy, we will evaluate any impairment-related residual symptoms, signs, and laboratory findings (including those on imaging), any complications associated with your surgical procedures or medical treatments, and any residual limitations in your functioning (see 1.00S).

P. *How do we evaluate your musculoskeletal disorder if there is no record of ongoing treatment?*

1. Despite having a musculoskeletal disorder, you may not have received ongoing

treatment, may have just begun treatment, may not have access to prescribed medical treatment, or may not have an ongoing relationship with the medical community. In any of these situations, you will not have a longitudinal medical record for us to review when we evaluate your disorder and we may ask you to attend a consultative examination to determine the severity and potential duration of your disorder. See §§404.1519a(b) and 416.919a(b) of this chapter.

2. In some instances, we may be able to assess the severity and duration of your musculoskeletal disorder based on your medical record and current evidence alone. If the information in your case record is not sufficient to show that you have a musculoskeletal disorder that meets the criteria of one of the musculoskeletal disorders listings, we will follow the rules described in 1.00S.

Q. *How do we consider the effects of obesity when we evaluate your musculoskeletal disorder?* Obesity is a medically determinable impairment that is often associated with musculoskeletal disorders. Obesity increases stress on weight-bearing joints and may contribute to limitation of the range of motion of the skeletal spine and extremities. The combined effects of obesity with a musculoskeletal disorder can be greater than the effects of each of the impairments considered separately. We consider the additional and cumulative effects of your obesity when we determine whether you have a severe musculoskeletal disorder, a listing-level musculoskeletal disorder, a combination of impairments that medically equals the severity of a listed impairment, and when we assess your residual functional capacity.

R. *How do we evaluate your musculoskeletal disorder if there is evidence establishing a substance use disorder?* If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability. See §§404.1535 and 416.935 of this chapter.

S. *How do we evaluate musculoskeletal disorders that do not meet one of these listings?*

1. These listings are only examples of musculoskeletal disorders that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §§404.1526 and 416.926 of this chapter. If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. We proceed to the fourth step and, if necessary, the fifth step of the sequential evaluation process in §§404.1520 and 416.920 of this chapter.

3. We use the rules in §§404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

1.01 Category of Impairments, Musculoskeletal Disorders

1.15 *Disorders of the skeletal spine resulting in compromise of a nerve root(s)* (see 1.00F), documented by A, B, C, *and* D:

A. Neuro-anatomic (radicular) distribution of one or more of the following *symptoms* consistent with compromise of the affected nerve root(s):

1. Pain; or
2. Paresthesia; or
3. Muscle fatigue.

AND

B. Radicular distribution of neurological *signs* present during physical examination (see 1.00C2) or on a diagnostic test (see 1.00C3) and evidenced by 1, 2, and either 3 or 4:

1. Muscle weakness; and
2. Sign(s) of nerve root irritation, tension, or compression, consistent with compromise of the affected nerve root (see 1.00F2); and
3. Sensory changes evidenced by:

a. Decreased sensation; or

b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; *or*

4. Decreased deep tendon reflexes.

AND

C. Findings on imaging (see 1.00C3) consistent with compromise of a nerve root(s) in the cervical or lumbosacral spine.

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4), *and* a documented medical need (see 1.00C6a) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used

to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4).

1.16 *Lumbar spinal stenosis resulting in compromise of the cauda equina* (see 1.00G), documented by A, B, C, *and* D:

A. Symptom(s) of neurological compromise manifested as:

1. Nonradicular distribution of pain in one or both lower extremities; or

2. Nonradicular distribution of sensory loss in one or both lower extremities; or

3. Neurogenic claudication.

AND

B. Nonradicular neurological signs present during physical examination (see 1.00C2) or on a diagnostic test (see 1.00C3) and evidenced by 1 and either 2 or 3:

1. Muscle weakness.

2. Sensory changes evidenced by:

a. Decreased sensation; or

b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; or

c. Areflexia, trophic ulceration, or bladder or bowel incontinence.

3. Decreased deep tendon reflexes in one or both lower extremities.

AND

C. Findings on imaging (see 1.00C3) or in an operative report (see 1.00C4) consistent with compromise of the cauda equina with lumbar spinal stenosis.

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4), *and* a documented medical need (see 1.00C6a) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)).

1.17 *Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint* (see 1.00H), documented by A, B, *and* C:

A. History of reconstructive surgery or surgical arthrodesis of a major weight-bearing joint.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months.

AND

C. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)).

1.18 *Abnormality of a major joint(s) in any extremity* (see 1.00I), documented by A, B, C, *and* D:

A. Chronic joint pain or stiffness.

AND

B. Abnormal motion, instability, or immobility of the affected joint(s).

AND

C. Anatomical abnormality of the affected joint(s) noted on:

1. Physical examination (for example, subluxation, contracture, or bony or fibrous ankylosis); or

2. Imaging (for example, joint space narrowing, bony destruction, or ankylosis or arthrodesis of the affected joint).

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4), *and* a documented medical need (see 1.00C6a) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4).

1.19 *Pathologic fractures due to any cause* (see 1.00J), documented by A *and* B:

A. Pathologic fractures occurring on three separate occasions within a 12-month period.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral

crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4), *and* a documented medical need (see 1.00C6a) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4).

1.20 *Amputation due to any cause* (see 1.00K), documented by A, B, C, *or* D:

A. Amputation of both upper extremities, occurring at any level at or above the wrists (carpal joints), up to and including the shoulder (glenohumeral) joint.

OR

B. Hemipelvectomy or hip disarticulation.

OR

C. Amputation of one upper extremity, occurring at any level at or above the wrist (carpal joints), and amputation of one lower extremity, occurring at or above the ankle (talocrural joint), *and* medical documentation of at least *one* of the following:

1. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

2. A documented medical need (see 1.00C6a) for a one-handed, hand-held assistive device (see 1.00C6d) requiring the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

3. The inability to use the remaining upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (1.00E4).

OR

D. Amputation of one or both lower extremities, occurring at or above the ankle (talocrural joint), with complications of the residual limb(s) that have lasted, or are expected to last, for a continuous period of at least 12 months, *and* medical documentation of 1 and 2:

1. The inability to use a prosthesis(es); and

2. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)).

1.21 *Soft tissue injury or abnormality under continuing surgical management* (see 1.00L), documented by A, B, *and* C:

A. Evidence confirms continuing surgical management (see 1.00O1) directed toward saving, reconstructing, or replacing the affected part of the body.

AND

B. The surgical management has been, or is expected to be, ongoing for a continuous period of at least 12 months.

AND

C. Maximum benefit from therapy (see 1.00O2) has not yet been achieved.

1.22 *Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the talocrural bones* (see 1.00M), documented by A, B, *and* C:

A. Solid union not evident on imaging (see 1.00C3) and not clinically solid.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months.

AND

C. A documented medical need (see 1.00C6a) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)).

1.23 *Non-healing or complex fracture of an upper extremity* (see 1.00N), documented by A *and* B:

A. Nonunion or complex fracture of the shaft of the humerus, radius, or ulna, under continuing surgical management (see 1.00O1) directed toward restoration of functional use of the extremity.

AND

B. Medical documentation of an inability to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 1.00E4) that has lasted, or is expected to last, for a continuous period of at least 12 months.

2.00 Special Senses and Speech

A. *How do we evaluate visual disorders?*

1. *What are visual disorders?* Visual disorders are abnormalities of the eye, the optic nerve, the optic tracts, or the brain that may cause a loss of visual acuity or visual fields. A loss of visual acuity limits your ability to distinguish detail, read, or do fine work. A loss of visual fields limits your ability to perceive visual stimuli in the peripheral extent of vision.

2. *How do we define statutory blindness?* Statutory blindness is blindness as defined in sections 216(i)(1) and 1614(a)(2) of the Social Security Act (Act).

a. The Act defines blindness as central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. We use your best-corrected central visual acuity for

distance in the better eye when we determine if this definition is met. (For visual acuity testing requirements, see 2.00A5.)

b. The Act also provides that an eye that has a visual field limitation such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered as having a central visual acuity of 20/200 or less. (For visual field testing requirements, see 2.00A6.)

c. You have statutory blindness only if your visual disorder meets the criteria of 2.02 or 2.03A. You do not have statutory blindness if your visual disorder medically equals the criteria of 2.02 or 2.03A or meets or medically equals the criteria of 2.03B, 2.03C, 2.04A, or 2.04B because your disability is based on criteria other than those in the statutory definition of blindness.

3. *What evidence do we need to establish statutory blindness under title XVI?* To establish that you have statutory blindness under title XVI, we need evidence showing only that your central visual acuity in your better eye or your visual field in your better eye meets the criteria in 2.00A2, provided that those measurements are consistent with the other evidence in your case record. We do not need documentation of the cause of your blindness. Also, there is no duration requirement for statutory blindness under title XVI (see §§ 416.981 and 416.983 of this chapter).

4. *What evidence do we need to evaluate visual disorders, including those that result in statutory blindness under title II?* To evaluate your visual disorder, we usually need a report of an eye examination that includes measurements of your best-corrected central visual acuity (see 2.00A5) or the extent of your visual fields (see 2.00A6), as appropriate. If you have visual acuity or visual field loss, we need documentation of the cause of the loss. A standard eye examination will usually indicate the cause of any visual acuity loss. A standard eye examination can also indicate the cause of some types of visual field deficits. Some disorders, such as cortical visual disorders, may result in abnormalities that do not appear on a standard eye examination. If the standard eye examination does not indicate the cause of your vision loss, we will request the information used to establish the presence of your visual disorder. If your visual disorder does not satisfy the criteria in 2.02, 2.03, or 2.04, we will request a description of how your visual disorder affects your ability to function.

5. *How do we measure your best-corrected central visual acuity?*

a. *Visual acuity testing.* When we need to measure your best-corrected central visual acuity (your optimal visual acuity attainable with the use of a corrective lens), we use visual acuity testing for distance that was carried out using Snellen methodology or any other testing methodology that is comparable to Snellen methodology.

(i) Your best-corrected central visual acuity for distance is usually measured by determining what you can see from 20 feet. If your visual acuity is measured for a distance other than 20 feet, we will convert it to a 20-foot measurement. For example, if your visual acuity is measured at 10 feet and is reported as 10/40, we will convert this measurement to 20/80.

(ii) A visual acuity recorded as CF (counts fingers), HM (hand motion only), LP or LPO (light perception or light perception only), or NLP (no light perception) indicates that no optical correction will improve your visual acuity. If your central visual acuity in an eye is recorded as CF, HM, LP or LPO, or NLP, we will determine that your best-corrected central visual acuity is 20/200 or less in that eye.

(iii) We will not use the results of pinhole testing or automated refraction acuity to determine your best-corrected central visual acuity. These tests provide an estimate of potential visual acuity but not an actual measurement of your best-corrected central visual acuity.

b. *Other test charts.* Most test charts that use Snellen methodology do not have lines that measure visual acuity between 20/100 and 20/200. Some test charts, such as the Bailey-Lovie or the Early Treatment Diabetic Retinopathy Study (ETDRS), used mostly in research settings, have such lines. If your visual acuity is measured with one of these charts, and you cannot read any of the letters on the 20/100 line, we will determine that you have statutory blindness based on a visual acuity of 20/200 or less. For example, if your best-corrected central visual acuity for distance in the better eye is 20/160 using an ETDRS chart, we will find that you have statutory blindness. Regardless of the type of test chart used, you do not have statutory blindness if you can read at least one letter on the 20/100 line. For example, if your best-corrected central visual acuity for distance in the better eye is 20/125 + 1 using an ETDRS chart, we will find that you do not have statutory blindness because you are able to read one letter on the 20/100 line.

c. *Testing using a specialized lens.* In some instances, you may have visual acuity testing performed using specialized lens, such as a contact lens. We will use the visual acuity measurements obtained with a specialized lens only if you have demonstrated the ability to use the specialized lens on a sustained basis. We will not use visual acuity measurements obtained with telescopic lenses.

d. *Cycloplegic refraction* is an examination of the eye performed after administering cycloplegic eye drops capable of relaxing the ability of the pupil to become smaller and temporarily paralyzing the focusing muscles. If your case record contains the results of

cycloplegic refraction, we may use the results to determine your best-corrected central visual acuity. We will not purchase cycloplegic refraction.

e. *Visual evoked response (VER) testing* measures your response to visual events and can often detect dysfunction that is undetectable through other types of examinations. If you have an absent response to VER testing in your better eye, we will determine that your best-corrected central visual acuity is 20/200 or less in that eye and that your visual acuity loss satisfies the criterion in 2.02 when these test results are consistent with the other evidence in your case record. If you have a positive response to VER testing in an eye, we will not use that result to determine your best-corrected central visual acuity in that eye.

6. *How do we measure your visual fields?*

a. *General.* We generally need visual field testing when you have a visual disorder that could result in visual field loss, such as glaucoma, retinitis pigmentosa, or optic neuropathy, or when you display behaviors that suggest a visual field loss. When we need to measure the extent of your visual field loss, we use visual field testing (also referred to as perimetry) carried out using automated static threshold perimetry performed on an acceptable perimeter. (For perimeter requirements, see 2.00A9.)

b. *Automated static threshold perimetry requirements.*

(i) The test must use a white size III Goldmann stimulus and a 31.5 apostilb (asb) white background (or a 10 candela per square meter (cd/m^2) white background). The stimuli test locations must be no more than 6 degrees apart horizontally or vertically. Measurements must be reported on standard charts and include a description of the size and intensity of the test stimulus.

(ii) We measure the extent of your visual field loss by determining the portion of the visual field in which you can see a white III4e stimulus. The ''III'' refers to the standard Goldmann test stimulus size III (4 mm^2), and the ''4e'' refers to the standard Goldmann intensity filter (0 decibel (dB) attenuation, which allows presentation of the maximum luminance) used to determine the intensity of the stimulus.

(iii) In automated static threshold perimetry, the intensity of the stimulus varies. The intensity of the stimulus is expressed in decibels (dB). A perimeter's maximum stimulus luminance is usually assigned the value 0 dB. We need to determine the dB level that corresponds to a 4e intensity for the particular perimeter being used. We will then use the dB printout to determine which points you see at a 4e intensity level (a ''seeing point''). For example:

A. When the maximum stimulus luminance (0 dB stimulus) on an acceptable perimeter is 10,000 asb, a 10 dB stimulus is equivalent to a 4e stimulus. Any point you see at 10 dB or greater is a seeing point.

B. When the maximum stimulus luminance (0 dB stimulus) on an acceptable perimeter is 4,000 asb, a 6 dB stimulus is equivalent to a 4e stimulus. Any point you see at 6 dB or greater is a seeing point.

C. When the maximum stimulus luminance (0 dB stimulus) on an acceptable perimeter is 1,000 asb, a 0 dB stimulus is equivalent to a 4e stimulus. Any point you see at 0 dB or greater is a seeing point.

c. *Evaluation under 2.03A.* To determine statutory blindness based on visual field loss in your better eye (2.03A), we need the results of a visual field test that measures the central 24 to 30 degrees of your visual field; that is, the area measuring 24 to 30 degrees from the point of fixation. Acceptable tests include the Humphrey Field Analyzer (HFA) 30–2, HFA 24–2, and Octopus 32.

d. *Evaluation under 2.03B.* To determine whether your visual field loss meets listing 2.03B, we use the mean deviation or defect (MD) from acceptable automated static threshold perimetry that measures the central 30 degrees of the visual field. MD is the average sensitivity deviation from normal values for all measured visual field locations. When using results from HFA tests, which report the MD as a negative number, we use the absolute value of the MD to determine whether your visual field loss meets listing 2.03B. We cannot use tests that do not measure the central 30 degrees of the visual field, such as the HFA 24–2, to determine if your impairment meets or medically equals 2.03B.

e. *Other types of perimetry.* If the evidence in your case contains visual field measurements obtained using manual or automated kinetic perimetry, such as Goldmann perimetry or the HFA ''SSA Test Kinetic,'' we can generally use these results if the kinetic test was performed using a white III4e stimulus projected on a white 31.5 asb (10 cd/m^2) background. Automated kinetic perimetry, such as the HFA ''SSA Test Kinetic,'' does not detect limitations in the central visual field because testing along a meridian stops when you see the stimulus. If your visual disorder has progressed to the point at which it is likely to result in a significant limitation in the central visual field, such as a scotoma (see 2.00A6h), we will not use *automated* kinetic perimetry to determine the extent of your visual field loss. Instead, we will determine the extent of your visual field loss using automated static threshold perimetry or manual kinetic perimetry.

f. *Screening tests.* We will not use the results of visual field screening tests, such as confrontation tests, tangent screen tests, or automated static screening tests, to determine that your impairment meets or medically equals a listing or to evaluate your residual functional capacity. We can consider

normal results from visual field screening tests to determine whether your visual disorder is severe when these test results are consistent with the other evidence in your case record. (See §§404.1520(c), 404.1521, 416.920(c), and 416.921 of this chapter.) We will not consider normal test results to be consistent with the other evidence if the clinical findings indicate that your visual disorder has progressed to the point that it is likely to cause visual field loss, or you have a history of an operative procedure for retinal detachment.

g. *Use of corrective lenses.* You must not wear eyeglasses during visual field testing because they limit your field of vision. You may wear contact lenses to correct your visual acuity during the visual field test to obtain the most accurate visual field measurements. For this single purpose, you do not need to demonstrate that you have the ability to use the contact lenses on a sustained basis.

h. *Scotoma.* A scotoma is a field defect or non-seeing area (also referred to as a ''blind spot'') in the visual field surrounded by a normal field or seeing area. When we measure your visual field, we subtract the length of any scotoma, other than the normal blind spot, from the overall length of any diameter on which it falls.

7. *How do we determine your visual acuity efficiency, visual field efficiency, and visual efficiency?*

a. *General. Visual efficiency*, a calculated value of your remaining visual function, is the combination of your *visual acuity efficiency* and your *visual field efficiency* expressed as a percentage.

b. *Visual acuity efficiency.* Visual acuity efficiency is a percentage that corresponds to the best-corrected central visual acuity for distance in your better eye. See Table 1.

TABLE 1—VISUAL ACUITY EFFICIENCY

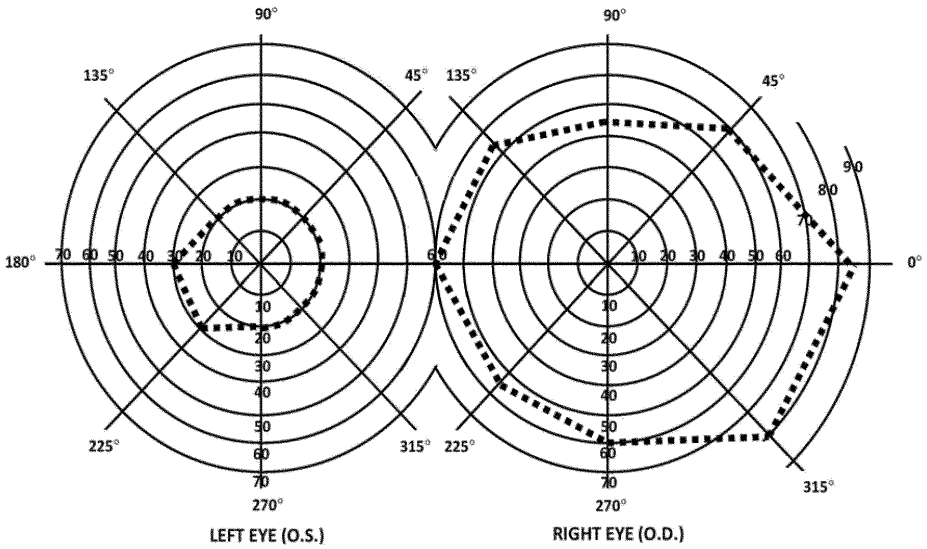
Snellen best-corrected central visual acuity for distance		Visual acuity efficiency (%) (2.04A)
English	Metric	
20/16	6/5	100
20/20	6/6	100
20/25	6/7.5	95
20/30	6/9	90
20/40	6/12	85
20/50	6/15	75
20/60	6/18	70
20/70	6/21	65
20/80	6/24	60
20/100	6/30	50

c. *Visual field efficiency.* Visual field efficiency is a percentage that corresponds to the visual field in your better eye. Under 2.03C, we require kinetic perimetry to determine your visual field efficiency percentage. We calculate the visual field efficiency percentage by adding the number of degrees you see along the eight principal meridians found on a visual field chart (0, 45, 90, 135, 180, 225, 270, and 315) in your better eye and dividing by 5. For example, in Figure 1:

A. The diagram of the left eye illustrates a visual field, as measured with a III4e stimulus, contracted to 30 degrees in two meridians (180 and 225) and to 20 degrees in the remaining six meridians. The visual efficiency percentage of this field is: $((2 \times 30) + (6 \times 20)) \div 5 = 36$ percent.

B. The diagram of the right eye illustrates the extent of a normal visual field as measured with a III4e stimulus. The sum of the eight principal meridians of this field is 500 degrees. The visual efficiency percentage of this field is $500 \div 5 = 100$ percent.

Figure 1:



d. *Visual efficiency.* Under 2.04A, we calculate the visual efficiency percentage by multiplying your visual acuity efficiency percentage (see 2.00A7b) by your visual field efficiency percentage (see 2.00A7c) and dividing by 100. For example, if your visual acuity efficiency percentage is 75 and your visual field efficiency percentage is 36, your visual efficiency percentage is: (75 × 36) ÷ 100 = 27 percent.

8. *How do we determine your visual acuity impairment value, visual field impairment value, and visual impairment value?*

a. *General. Visual impairment value,* a calculated value of your loss of visual function, is the combination of your *visual acuity impairment value* and your *visual field impairment value.*

b. *Visual acuity impairment value.* Your visual acuity impairment value corresponds to the best-corrected central visual acuity for distance in your better eye. See Table 2.

TABLE 2—VISUAL ACUITY IMPAIRMENT VALUE

Snellen best-corrected central visual acuity for distance		Visual acuity impairment value (2.04B)
English	Metric	
20/16	6/5	0.00
20/20	6/6	0.00
20/25	6/7.5	0.10
20/30	6/9	0.18
20/40	6/12	0.30
20/50	6/15	0.40
20/60	6/18	0.48
20/70	6/21	0.54
20/80	6/24	0.60
20/100	6/30	0.70

c. *Visual field impairment value.* Your visual field impairment value corresponds to the visual field in your better eye. Using the MD from acceptable automated static threshold perimetry, we calculate the visual field impairment value by dividing the absolute value of the MD by 22. For example, if your MD on an HFA 30–2 is −16, your visual field impairment value is: $-16\sqrt{} \div 22 = 0.73$.

d. *Visual impairment value.* Under 2.04B, we calculate the visual impairment value by adding your visual acuity impairment value (see 2.00A8b) and your visual field impairment value (see 2.00A8c). For example, if your visual acuity impairment value is 0.48 and your visual field impairment value is 0.73, your visual impairment value is: 0.48 + 0.73 = 1.21.

9. *What are our requirements for an acceptable perimeter?* We will use results from automated static threshold perimetry performed on a perimeter that:

a. Uses optical projection to generate the test stimuli.

b. Has an internal normative database for automatically comparing your performance with that of the general population.

c. Has a statistical analysis package that is able to calculate visual field indices, particularly MD.

d. Demonstrates the ability to correctly detect visual field loss and correctly identify normal visual fields.

e. Demonstrates good test-retest reliability.

f. Has undergone clinical validation studies by three or more independent laboratories with results published in peer-reviewed ophthalmic journals.

B. *How do we evaluate hearing loss?*

1. *What evidence do we need?*

a. We need evidence showing that you have a medically determinable impairment that causes your hearing loss and audiometric measurements of the severity of your hearing loss. We generally require both an otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another otologic examination. We will consider your test scores together with any other relevant information we have about your hearing, including information from outside of the test setting.

b. The otologic examination must be performed by a licensed physician (medical or osteopathic doctor) or audiologist. It must include your medical history, your description of how your hearing loss affects you, and the physician's or audiologist's description of the appearance of the external ears (pinnae and external ear canals), evaluation of the tympanic membranes, and assessment of any middle ear abnormalities.

c. Audiometric testing must be performed by, or under the directsupervision of, a licensed audiologist or an otolaryngologist.

2. *What audiometric testing do we need when you do not have a cochlear implant?*

a. We generally need pure tone air conduction and bone conduction testing, speech reception threshold (SRT) testing (also referred to as ''spondee threshold'' or ''ST'' testing), and word recognition testing (also referred to as ''word discrimination'' or ''speech discrimination'' testing). This testing must be conducted in a sound-treated booth or room and must be in accordance with the most recently published standards of the American National Standards Institute (ANSI). Each ear must be tested separately.

b. You must not wear hearing aids during the testing. Additionally, a person described in 2.00B1c must perform an otoscopic examination immediately before the audiometric testing. (An *otoscopic examination* provides a description of the appearance of your external ear canals and an evaluation of the tympanic membranes. In these rules, we use the term to include otoscopic examinations performed by physicians and otoscopic inspections performed by audiologists and others.) The otoscopic examination must show that there are no conditions that would prevent valid audiometric testing, such as fluid in the ear, ear infection, or obstruction in an ear canal. The person performing the test should also report on any other factors, such as your cooperation with the test, that can affect the interpretation of the test results.

c. To determine whether your hearing loss meets the air and bone conduction criteria in 2.10A, we will average your air and bone conduction hearing thresholds at 500, 1000, and 2000 Hertz (Hz). If you do not have a response at a particular frequency, we will use a threshold of 5 decibels (dB) over the limit of the audiometer.

d. The SRT is the minimum dB level required for you to recognize 50 percent of the words on a standard list of spondee words. (Spondee words are two-syllable words that have equal stress on each syllable.) The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy must be documented. If we cannot determine that there is a medical basis for the discrepancy, we will not use the results of the testing to determine whether your hearing loss meets a listing.

e. Word recognition testing determines your ability to recognize a standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The list may be recorded or presented live, but in either case the words should be presented at a level of amplification that will measure your maximum ability to discriminate words, usually 35 to 40 dB above your SRT. However, the amplification level used in the testing must be medically appropriate, and you must be able to tolerate it. If you cannot be tested at 35 to 40 dB above your SRT, the person who performs the test should report your word recognition testing score at your highest comfortable level of amplification.

3. *What audiometric testing do we need when you have a cochlear implant?*

a. If you have a cochlear implant, we will consider you to be disabled until 1 year after initial implantation.

b. After that period, we need word recognition testing performed with any version of the Hearing in Noise Test (HINT) to determine whether your impairment meets 2.11B. This testing must be conducted in quiet in a sound field. Your implant must be functioning properly and adjusted to your normal settings. The sentences should be presented at 60 dB HL (Hearing Level) and without any visual cues.

4. *How do we evaluate your word recognition ability if you are not fluent in English?*

If you are not fluent in English, you should have word recognition testing using an appropriate word list for the language in which you are most fluent. The person conducting the test should be fluent in the language used for the test. If there is no appropriate word list or no person who is fluent in the language and qualified to perform the test, it may not be possible to measure your word recognition ability. If your word recognition ability cannot be measured, your hearing loss cannot meet 2.10B or 2.11B. Instead, we will consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals 2.10B or 2.11B. For example, we will consider how you interact with family members, interpreters, and other persons who speak the language in which you are most fluent.

C. *How do we evaluate vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease?*

1. These disturbances of balance are characterized by an hallucination of motion or loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of ''dizziness'' which is described as lightheadedness, unsteadiness, confusion, or syncope.

2. Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be longlasting; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

3. The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appropriate special examinations, such as Bekesy audiometry, are necessary. Vestibular functions is assessed by positional and caloric testing, preferably by electronystagmography. When polytomograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to appropriate medically acceptable imaging reports of the skull and temporal bone. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

D. *Loss of speech.* In evaluating the loss of speech, the ability to produce speech by any means includes the use of mechanical or electronic devices that improve voice or articulation. Impairments of speech may also be evaluated under the body system for the underlying disorder, such as neurological disorders, 11.00ff.

E. *How do we evaluate impairments that do not meet one of the special senses and speech listings?*

1. These listings are only examples of common special senses and speech disorders that we consider severe enough to prevent an individual from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a medically determinable impairment(s) that does not meet a listing, we will determine whether the impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926.) If you have an impairment(s) that does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. Therefore, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. When we decide whether you continue to be disabled, we use the rules in §§ 404.1594, 416.994, or 416.994a, as appropriate.

2.01 Category of Impairments, Special Senses and Speech

2.02 *Loss of central visual acuity.* Remaining vision in the better eye after best correction is 20/200 or less.

2.03 *Contraction of the visual field in the better eye*, with:

A. The widest diameter subtending an angle around the point of fixation no greater than 20 degrees.

OR

B. An MD of 22 decibels or greater, determined by automated static threshold perimetry that measures the central 30 degrees of the visual field (see 2.00A6d).

OR

C. A visual field efficiency of 20 percent or less, determined by kinetic perimetry (see 2.00A7c).

2.04 *Loss of visual efficiency, or visual impairment, in the better eye:*

A. A visual efficiency percentage of 20 or less after best correction (see 2.00A7d).

OR

B. A visual impairment value of 1.00 or greater after best correction (see 2.00A8d).

2.07 *Disturbance of labyrinthine-vestibular function (including Meniere's disease)*, characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

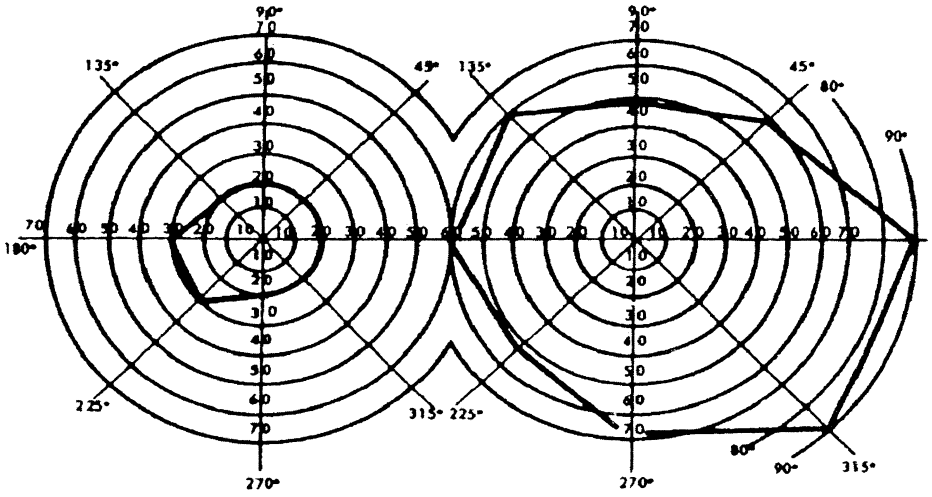
B. Hearing loss established by audiometry.

2.09 *Loss of speech* due to any cause, with inability to produce by any means speech that can be heard, understood, or sustained.

TABLE 1—PERCENTAGE OF VISUAL ACUITY EFFICIENCY CORRESPONDING TO THE BEST-CORRECTED VISUAL ACUITY MEASUREMENT FOR DISTANCE IN THE BETTER EYE

Snellen		Percent visual acuity efficiency
English	Metric	
20/16	6/5	100
20/20	6/6	100
20/25	6/7.5	95
20/30	6/9	90
20/40	6/12	85
20/50	6/15	75
20/60	6/18	70
20/70	6/21	65
20/80	6/24	60
20/100	6/30	50

TABLE 2—CHART OF VISUAL FIELDS



1. The diagram of the right eye illustrates the extent of a normal visual field as measured with a III4e stimulus. The sum of the eight principal meridians of this field is 500 degrees.

2. The diagram of the left eye illustrates a visual field contracted to 30 degrees in two meridians and to 20 degrees in the remaining six meridians. The percent of visual field efficiency of this field is: $(2 \times 30) + (6 \times 20) = 180 \div 500 = 0.36$ or 36 percent visual field efficiency.

2.10 *Hearing loss not treated with cochlear implantation.*

A. An average air conduction hearing threshold of 90 decibels or greater in the better ear and an average bone conduction hearing threshold of 60 decibels or greater in the better ear (*see* 2.00B2c).

OR

B. A word recognition score of 40 percent or less in the better ear determined using a standardized list of phonetically balanced monosyllabic words (see 2.00B2e).

2.11 *Hearing loss treated with cochlear implantation.*

A. Consider under a disability for 1 year after initial implantation.

OR

B. If more than 1 year after initial implantation, a word recognition score of 60 percent or less determined using the HINT (*see* 2.00B3b).

3.00 Respiratory Disorders

A. *Which disorders do we evaluate in this body system?*

1. We evaluate respiratory disorders that result in obstruction (difficulty moving air out of the lungs) or restriction (difficulty moving air into the lungs), or that interfere with diffusion (gas exchange) across cell membranes in the lungs. Examples of such disorders and the listings we use to evaluate them include chronic obstructive pulmonary disease (chronic bronchitis and emphysema, 3.02), pulmonary fibrosis and pneumoconiosis (3.02), asthma (3.02 or 3.03), cystic fibrosis (3.04), and bronchiectasis (3.02 or 3.07). We also use listings in this body system to evaluate respiratory failure (3.04D or 3.14), chronic pulmonary hypertension (3.09), and lung transplantation (3.11).

2. We evaluate cancers affecting the respiratory system under the listings in 13.00. We evaluate the pulmonary effects of neuromuscular and autoimmune disorders under these listings or under the listings in 11.00 or 14.00, respectively.

B. *What are the symptoms and signs of respiratory disorders?* Symptoms and signs of respiratory disorders include dyspnea (shortness of breath), chest pain, coughing, wheezing, sputum production, hemoptysis (coughing up blood from the respiratory tract), use of accessory muscles of respiration, and tachypnea (rapid rate of breathing).

C. *What abbreviations do we use in this body system?*

1. *ABG* means arterial blood gas.

2. *BiPAP* means bi-level positive airway pressure ventilation.

3. *BTPS* means body temperature and ambient pressure, saturated with water vapor.

4. *CF* means cystic fibrosis.

5. *CFRD* means CF-related diabetes.

6. *CFTR* means CF transmembrane conductance regulator.

7. *CO* means carbon monoxide.

8. *COPD* means chronic obstructive pulmonary disease.

9. *DLCO* means diffusing capacity of the lungs for carbon monoxide.

10. FEV_1 means forced expiratory volume in the first second of a forced expiratory maneuver.

11. *FVC* means forced vital capacity.

12. *L* means liter.

13. *mL CO (STPD)/min/mmHg* means milliliters of carbon monoxide at standard temperature and pressure, dry, per minute, per millimeter of mercury.

14. P_aO_2 means arterial blood partial pressure of oxygen.

15. P_aCO_2 means arterial blood partial pressure of carbon dioxide.

16. S_pO_2 means percentage of oxygen saturation of blood hemoglobin measured by pulse oximetry.

17. *6MWT* means 6-minute walk test.

18. *VI* means volume of inhaled gas during a DLCO test.

D. *What documentation do we need to evaluate your respiratory disorder?*

1. We need *medical evidence* to document and assess the severity of your respiratory disorder. Medical evidence should include your medical history, physical examination findings, the results of imaging (see 3.00D3), pulmonary function tests (see 3.00D4), other relevant laboratory tests, and descriptions of any prescribed treatment and your response to it. We may not need all of this evidence depending on your particular respiratory disorder and its effects on you.

2. If you use *supplemental oxygen,* we still need medical evidence to establish the severity of your respiratory disorder.

3. *Imaging* refers to medical imaging techniques, such as x-ray and computerized tomography. The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder.

4. *Pulmonary function tests* include *spirometry* (which measures ventilation of the lungs), *DLCO* tests (which measure gas diffusion in the lungs), *ABG* tests (which measure the partial pressure of oxygen, P_aO_2, and carbon dioxide, P_aCO_2, in the arterial blood), and *pulse oximetry* (which measures oxygen saturation, S_pO_2, of peripheral blood hemoglobin).

E. *What is spirometry and what are our requirements for an acceptable test and report?*

1. Spirometry, which measures how well you move air into and out of your lungs, involves at least three forced expiratory maneuvers during the same test session. A forced expiratory maneuver is a maximum inhalation followed by a forced maximum exhalation, and measures exhaled volumes of air over time. The volume of air you exhale in the first second of the forced expiratory maneuver is the FEV_1. The total volume of air that you exhale during the entire forced expiratory maneuver is the FVC. We use your highest FEV_1 value to evaluate your respiratory disorder under 3.02A, 3.03A, and 3.04A, and your highest FVC value to evaluate your respiratory disorder under 3.02B, regardless of whether the values are from the same forced expiratory maneuver or different forced expiratory maneuvers.

2. We have the following requirements for spirometry under these listings:

a. You must be medically stable at the time of the test. Examples of when we would not consider you to be medically stable include when you are:

(i) Within 2 weeks of a change in your prescribed respiratory medication.

(ii) Experiencing, or within 30 days of completion of treatment for, a lower respiratory tract infection.

(iii) Experiencing, or within 30 days of completion of treatment for, an acute exacerbation (temporary worsening) of a chronic respiratory disorder. Wheezing by itself does not indicate that you are not medically stable.

(iv) Hospitalized, or within 30 days of a hospital discharge, for an acute myocardial infarction (heart attack).

b. During testing, if your FEV_1 is less than 70 percent of your predicted normal value, we require repeat spirometry after inhalation of a bronchodilator to evaluate your respiratory disorder under these listings, unless it is medically contraindicated. If you used a bronchodilator before the test and your FEV_1 is less than 70 percent of your predicted normal value, we still require repeat spirometry after inhalation of a bronchodilator unless the supervising physician determines that it is not safe for you to take a bronchodilator again (in which case we may need to reschedule the test). If you do not have post-bronchodilator spirometry, the test report must explain why. We can use the results of spirometry administered without bronchodilators when the use of bronchodilators is medically contraindicated.

c. Your forced expiratory maneuvers must be satisfactory. We consider a forced expiratory maneuver to be satisfactory when you exhale with maximum effort following a full inspiration, and when the test tracing has a sharp takeoff and rapid rise to peak flow, has a smooth contour, and either lasts for at least 6 seconds or maintains a plateau for at least 1 second.

3. The spirometry report must include the following information:

a. The date of the test and your name, age or date of birth, gender, and height without shoes. (We will assume that your recorded height on the date of the test is without shoes, unless we have evidence to the contrary.) If your spine is abnormally curved (for example, you have kyphoscoliosis), we will substitute the longest distance between your outstretched fingertips with your arms abducted 90 degrees in place of your height when this measurement is greater than your standing height without shoes.

b. Any factors, if applicable, that can affect the interpretation of the test results (for example, your cooperation or effort in doing the test).

c. Legible tracings of your forced expiratory maneuvers in a volume-time format showing your name and the date of the test for each maneuver.

4. If we purchase spirometry, the medical source we designate to administer the test is solely responsible for deciding whether it is safe for you to do the test and for how to administer it.

F. *What is a DLCO test, and what are our requirements for an acceptable test and report?*

1. A DLCO test measures the gas exchange across cell membranes in your lungs. It measures how well CO diffuses from the alveoli (air sacs) of your lungs into your blood. DLCO may be severely reduced in some disorders, such as interstitial lung disease (for example, idiopathic pulmonary fibrosis, asbestosis, and sarcoidosis) and COPD (particularly emphysema), even when the results of spirometry are not significantly reduced. We use the average of two of your unadjusted (that is, uncorrected for hemoglobin concentration) DLCO measurements reported in mL CO (STPD)/min/mmHg to evaluate your respiratory disorder under 3.02C1.

2. We have the following requirements for DLCO tests under these listings:

a. You must be medically stable at the time of the test. See 3.00E2a.

b. The test must use the single-breath technique.

(i) The VI during the DLCO maneuver must be at least 85 percent of your current FVC, and your time of inhalation must be less than 4 seconds. (See 3.00E for our rules for programmatically acceptable spirometry.) If you do not have an FVC measurement on the same day as the DLCO test, we may use your FVC from programmatically acceptable spirometry administered within 90 days of the DLCO test.

(ii) Your breath-hold time must be between 8 and 12 seconds.

(iii) Your total exhalation time must be less than or equal to 4 seconds, with a sample collection time of less than 3 seconds. If your FVC is at least 2.0 L, the washout volume must be between 0.75 L and 1.0 L. If your FVC is less than 2.0 L, the washout volume must be at least 0.5 L.

3. The DLCO test report must include the following information:

a. The date of the test and your name, age or date of birth, gender, and height without shoes. (We will assume that your recorded height on the date of the test is without shoes, unless we have evidence to the contrary.) If your spine is abnormally curved (for example, you have kyphoscoliosis), we will substitute the longest distance between your outstretched fingertips with your arms abducted 90 degrees in place of your height when this measurement is greater than your standing height without shoes.

b. Any factors, if applicable, that can affect the interpretation of the test results (for example, your cooperation or effort in doing the test).

c. Legible tracings of your VI, breath-hold maneuver, and volume of exhaled gas showing your name and the date of the test for each DLCO maneuver.

d. At least two acceptable (see 3.00F2) DLCO measurements within 3 mL CO (STPD)/min/mmHg of each other *or* within 10 percent of the highest value.

4. We may need to purchase a DLCO test to determine whether your disorder meets 3.02C1 when we have evidence showing that you have a chronic respiratory disorder that could result in impaired gas exchange, unless we can make a fully favorable determination or decision on another basis. Since the DLCO calculation requires a current FVC measurement, we may also purchase spirometry at the same time as the DLCO test, even if we already have programmatically acceptable spirometry.

5. Before we purchase a DLCO test, a medical consultant (see §§ 404.1616 and 416.1016 of this chapter), preferably one with experience in the care of people with respiratory disorders, must review your case record to determine if we need the test. The medical source we designate to administer the test is solely responsible for deciding whether it is safe for you to do the test and for how to administer it.

G. *What is an ABG test, and what are our requirements for an acceptable test and report?*

1. *General.* An ABG test measures P_aO_2, P_aCO_2, and the concentration of hydrogen ions in your arterial blood. We use a resting or an exercise ABG measurement to evaluate your respiratory disorder under 3.02C2.

2. *Resting ABG tests.*

a. We have the following requirements for resting ABG tests under these listings:

(i) You must be medically stable at the time of the test. See 3.00E2a.

(ii) The test must be administered while you are breathing room air; that is, without oxygen supplementation.

b. The resting ABG test report must include the following information:

(i) Your name, the date of the test, and either the altitude or both the city and State of the test site.

(ii) The P_aO_2 and P_aCO_2 values.

c. We may need to purchase a resting ABG test to determine whether your disorder meets 3.02C2 when we have evidence showing that you have a chronic respiratory disorder that could result in impaired gas exchange, unless we can make a fully favorable determination or decision on another basis.

d. Before we purchase a resting ABG test, a medical consultant (see §§ 404.1616 and 416.1016 of this chapter), preferably one with experience in the care of people with respiratory disorders, must review your case record to determine if we need the test. The medical source we designate to administer the test is solely responsible for deciding whether it is safe for you to do the test and for how to administer it.

3. *Exercise ABG tests.*

a. We will *not* purchase an exercise ABG test.

b. We have the following requirements for exercise ABG tests under these listings:

(i) You must have done the exercise under steady state conditions while breathing room air. If you were tested on a treadmill, you generally must have exercised for at least 4 minutes at a grade and speed providing oxygen (O_2) consumption of approximately 17.5 milliliters per kilogram per minute (mL/kg/min) or 5.0 metabolic equivalents (METs). If you were tested on a cycle ergometer, you generally must have exercised for at least 4 minutes at an exercise equivalent of 5.0 METs.

(ii) We may use a test in which you have not exercised for at least 4 minutes. If you were unable to complete at least 4 minutes of steady state exercise, we need a statement by the person administering the test about whether the results are a valid indication of your respiratory status. For example, this statement may include information about your cooperation or effort in doing the test and whether you were limited in completing the test because of your respiratory disorder or another impairment.

c. The exercise ABG test report must include the following information:

(i) Your name, the date of the test, and either the altitude or both the city and state of the test site.

(ii) The P_aO_2 and P_aCO_2 values.

H. *What is pulse oximetry, and what are our requirements for an acceptable test and report?*

1. Pulse oximetry measures S_pO_2, the percentage of oxygen saturation of blood hemoglobin. We use a pulse oximetry measurement (either at rest, during a 6MWT, or after a 6MWT) to evaluate your respiratory disorder under 3.02C3 or, if you have CF, to evaluate it under 3.04F.

2. We have the following requirements for pulse oximetry under 3.02C3:

a. You must be medically stable at the time of the test. See 3.00E2a.

b. Your pulse oximetry measurement must be recorded while you are breathing room air; that is, without oxygen supplementation.

c. Your pulse oximetry measurement must be stable. By ''stable,'' we mean that the range of S_pO_2 values (that is, lowest to highest) during any 15-second interval cannot exceed 2 percentage points. For example: (1) The measurement is stable if the lowest S_pO_2 value during a 15-second interval is 87 percent and the highest value is 89 percent—a range of 2 percentage points. (2) The measurement is not stable if the lowest value is 86

percent and the highest value is 89 percent—a range of 3 percentage points.

d. If you have had more than one measurement (for example, at rest and after a 6MWT), we will use the measurement with the lowest S_pO_2 value.

e. The pulse oximetry report must include the following information:

(i) Your name, the date of the test, and either the altitude or both the city and State of the test site.

(ii) A graphical printout showing your S_pO_2 value and a concurrent, acceptable pulse wave. An acceptable pulse wave is one that shows the characteristic pulse wave; that is, sawtooth-shaped with a rapid systolic upstroke (nearly vertical) followed by a slower diastolic downstroke (angled downward).

f. We may need to purchase pulse oximetry at rest to determine whether your disorder meets 3.02C3 when we have evidence showing that you have a chronic respiratory disorder that could result in impaired gas exchange, unless we can make a fully favorable determination or decision on another basis. We may purchase pulse oximetry during and after a 6MWT if your S_pO_2 value at rest is greater than the value in Table V.

g. Before we purchase pulse oximetry, a medical consultant (see §§404.1616 and 416.1016 of this chapter), preferably one with experience in the care of people with respiratory disorders, must review your case record to determine if we need the test. The medical source we designate to administer the test is solely responsible for deciding whether it is safe for you to do the test and for how to administer it.

3. We have the following requirements for pulse oximetry under 3.04F:

a. You must be medically stable at the time of the test. See 3.00E2a.

b. Your pulse oximetry measurement must be recorded while you are breathing room air; that is, without oxygen supplementation.

c. If you have had more than one measurement (for example, at rest and after a 6MWT), we will use the measurement with the lowest S_pO_2 value.

d. The pulse oximetry report must include your name, the date of the test, and either the altitude or both the city and State of the test site. If you have CF, we do not require a graphical printout showing your S_pO_2 value and a concurrent, acceptable pulse wave.

I. *What is asthma and how do we evaluate it?*

1. *Asthma* is a chronic inflammatory disorder of the lung airways that we evaluate under 3.02 or 3.03. If you have respiratory failure resulting from chronic asthma (see 3.00N), we will evaluate it under 3.14.

2. For the purposes of 3.03:

a. We need evidence showing that you have listing-level (see Table VI in 3.03A) airflow obstruction at baseline while you are medically stable.

b. The phrase ''consider under a disability for 1 year'' in 3.03B does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your asthma continues to meet a listing or is otherwise disabling.

c. We determine the onset of your disability based on the facts of your case, but it will be no later than the admission date of your first of three hospitalizations that satisfy the criteria of 3.03B.

J. *What is CF and how do we evaluate it?*

1. *General.* We evaluate *CF,* a genetic disorder that results in abnormal salt and water transport across cell membranes in the lungs, pancreas, and other body organs, under 3.04. We need the evidence described in 3.00J2 to establish that you have CF.

2. *Documentation of CF.* We need a report signed by a physician (see §§404.1513(a) and 416.913(a) of this chapter) showing both a *and* b:

a. One of the following:

(i) A positive newborn screen for CF; or

(ii) A history of CF in a sibling; or

(iii) Documentation of at least one specific CF phenotype or clinical criterion (for example, chronic sino-pulmonary disease with persistent colonization or infections with typical CF pathogens, pancreatic insufficiency, or salt-loss syndromes); *and*

b. One of the following definitive laboratory tests:

(i) An elevated sweat chloride concentration equal to or greater than 60 millimoles per L; or

(ii) The identification of two CF gene mutations affecting the CFTR; or

(iii) Characteristic abnormalities in ion transport across the nasal epithelium.

c. When we have the report showing a and b, but it is not signed by a physician, we also need a report from a physician stating that you have CF.

d. When we do not have the report showing a and b, we need a report from a physician that is persuasive that a positive diagnosis of CF was confirmed by an appropriate definitive laboratory test. To be persuasive, this report must include a statement by the physician that you had the appropriate definitive laboratory test for diagnosing CF. The report must provide the test results or explain how your diagnosis was established that is consistent with the prevailing state of medical knowledge and clinical practice.

3. *CF pulmonary exacerbations.* Examples of CF pulmonary exacerbations include increased cough and sputum production, hemoptysis, increased shortness of breath, increased fatigue, and reduction in pulmonary function. Treatment usually includes intravenous antibiotics and intensified airway clearance therapy (for example, increased frequencies of chest percussion or

increased use of inhaled nebulized therapies, such as bronchodilators or mucolytics).

4. For 3.04G, we require any two exacerbations or complications from the list in 3.04G1 through 3.04G4 within a 12-month period. You may have two of the same exacerbation or complication or two different ones.

a. If you have two of the acute exacerbations or complications we describe in 3.04G1 and 3.04G2, there must be at least 30 days between the two.

b. If you have one of the acute exacerbations or complications we describe in 3.04G1 and 3.04G2 and one of the chronic complications we describe in 3.04G3 and 3.04G4, the two can occur during the same time. For example, your CF meets 3.04G if you have the pulmonary hemorrhage we describe in 3.04G2 and the weight loss we describe in 3.04G3 even if the pulmonary hemorrhage occurs during the 90-day period in 3.04G3.

c. Your CF also meets 3.04G if you have both of the chronic complications in 3.04G3 and 3.04G4.

5. CF may also affect other body systems such as digestive or endocrine. If your CF, including pulmonary exacerbations and nonpulmonary complications, does not meet or medically equal a respiratory disorders listing, we may evaluate your CF-related impairments under the listings in the affected body system.

K. *What is bronchiectasis and how do we evaluate it?* Bronchiectasis is a chronic respiratory disorder that is characterized by abnormal and irreversible dilatation (enlargement) of the airways below the trachea, which may be associated with the accumulation of mucus, bacterial infections, and eventual airway scarring. We require imaging (see 3.00D3) to document this disorder. We evaluate your bronchiectasis under 3.02, or under 3.07 if you are having exacerbations or complications (for example, acute bacterial infections, increased shortness of breath, or coughing up blood) that require hospitalization.

L. *What is chronic pulmonary hypertension and how do we evaluate it?*

1. Chronic pulmonary hypertension is an increase in the blood pressure of the blood vessels of the lungs. If pulmonary hypertension is not adequately treated, it can eventually result in right heart failure. We evaluate chronic pulmonary hypertension due to any cause under 3.09.

2. Chronic pulmonary hypertension is usually diagnosed by catheterization of the pulmonary artery. We will not purchase cardiac catheterization.

M. *How do we evaluate lung transplantation?* If you receive a lung transplant (or a lung transplant simultaneously with other organs, such as the heart), we will consider you to be disabled under 3.11 for 3 years from the date of the transplant. After that, we evaluate your residual impairment(s) by considering the adequacy of your post-transplant function, the frequency and severity of any rejection episodes you have, complications in other body systems, and adverse treatment effects. People who receive organ transplants generally have impairments that meet our definition of disability before they undergo transplantation. The phrase ''consider under a disability for 3 years'' in 3.11 does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling. We determine the onset of your disability based on the facts of your case.

N. *What is respiratory failure and how do we evaluate it?* Respiratory failure is the inability of the lungs to perform their basic function of gas exchange. We evaluate respiratory failure under 3.04D if you have CF-related respiratory failure, or under 3.14 if you have respiratory failure due to any other *chronic* respiratory disorder. Continuous positive airway pressure does not satisfy the criterion in 3.04D or 3.14, and cannot be substituted as an equivalent finding, for invasive mechanical ventilation or noninvasive ventilation with BiPAP.

O. *How do we consider the effects of obesity when we evaluate your respiratory disorder?* Obesity is a medically determinable impairment that is often associated with respiratory disorders. Obesity makes it harder for the chest and lungs to expand, which can compromise the ability of the respiratory system to supply adequate oxygen to the body. The combined effects of obesity with a respiratory disorder can be greater than the effects of each of the impairments considered separately. We consider any additional and cumulative effects of your obesity when we determine whether you have a severe respiratory disorder, a listing-level respiratory disorder, a combination of impairments that medically equals the severity of a listed impairment, and when we assess your residual functional capacity.

P. *What are sleep-related breathing disorders and how do we evaluate them?*

1. *Sleep-related breathing disorders* (for example, sleep apnea) are characterized by transient episodes of interrupted breathing during sleep, which disrupt normal sleep patterns. Prolonged episodes can result in disorders such as hypoxemia (low blood oxygen) and pulmonary vasoconstriction (restricted blood flow in pulmonary blood vessels). Over time, these disorders may lead to chronic pulmonary hypertension or other complications.

2. We evaluate the complications of sleep-related breathing disorders under the listings in the affected body system(s). For example, we evaluate chronic pulmonary hypertension due to any cause under 3.09; chronic heart failure under 4.02; and disturbances in mood, cognition, and behavior under

12.02 or another appropriate mental disorders listing. We will not purchase polysomnography (sleep study).

Q. *How do we evaluate mycobacterial, mycotic, and other chronic infections of the lungs?* We evaluate chronic infections of the lungs that result in limitations in your respiratory function under 3.02.

R. *How do we evaluate respiratory disorders that do not meet one of these listings?*

1. These listings are only examples of common respiratory disorders that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system. For example, if your CF has resulted in chronic pancreatic or hepatobiliary disease, we evaluate your impairment under the listings in 5.00.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §§ 404.1526 and 416.926 of this chapter. Respiratory disorders may be associated with disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. We proceed to the fourth step and, if necessary, the fifth step of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

3.01 Category of Impairments, Respiratory Disorders

3.02 *Chronic respiratory disorders* due to any cause except CF (for CF, see 3.04) with A, B, C, or D:

A. FEV_1 (see 3.00E) less than or equal to the value in Table I–A or I–B for your age, gender, and height without shoes (see 3.00E3a).

TABLE I—FEV_1 CRITERIA FOR 3.02A

Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	*Table I–A*		*Table I–B*	
		Age 18 to attainment of age 20		Age 20 or older	
		Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)	Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)
<153.0	<60.25	1.20	1.45	1.05	1.20
153.0 to <159.0	60.25 to <62.50	1.30	1.55	1.15	1.35
159.0 to <164.0	62.50 to <64.50	1.40	1.65	1.25	1.40
164.0 to <169.0	64.50 to <66.50	1.45	1.75	1.35	1.50
169.0 to <174.0	66.50 to <68.50	1.55	1.85	1.45	1.60
174.0 to <180.0	68.50 to <70.75	1.65	2.00	1.55	1.75
180.0 to <185.0	70.75 to <72.75	1.75	2.10	1.65	1.85
185.0 or more	72.75 or more	1.80	2.15	1.70	1.90

OR

B. FVC (see 3.00E) less than or equal to the value in Table II–A or II–B for your age, gender, and height without shoes (see 3.00E3a).

Height without shoes (centimeters) < means less than	Height without shoes (inches) < means less than	Table II–A		Table II–B	
		Age 18 to attainment of age 20		Age 20 or older	
		Females FVC less than or equal to (L, BTPS)	Males FVC less than or equal to (L, BTPS)	Females FVC less than or equal to (L, BTPS)	Males FVC less than or equal to (L, BTPS)
<153.0	<60.25	1.35	1.65	1.30	1.50
153.0 to <159.0	60.25 to <62.50	1.50	1.80	1.40	1.65
159.0 to <164.0	62.50 to <64.50	1.60	1.90	1.50	1.75
164.0 to <169.0	64.50 to <66.50	1.70	2.05	1.60	1.90
169.0 to <174.0	66.50 to <68.50	1.80	2.20	1.70	2.00
174.0 to <180.0	68.50 to <70.75	1.90	2.35	1.85	2.20
180.0 to <185.0	70.75 to <72.75	2.05	2.50	1.95	2.30
185.0 or more	72.75 or more	2.10	2.60	2.00	2.40

OR

C. Chronic impairment of gas exchange demonstrated by 1, 2, or 3:

1. Average of two unadjusted, single-breath DLCO measurements (see 3.00F) less than or equal to the value in Table III for your gender and height without shoes (see 3.00F3a); or

TABLE III—DLCO CRITERIA FOR 3.02C1

Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	Females DLCO less than or equal to (mL CO (STPD)/min/mmHg)	Males DLCO less than or equal to (mL CO (STPD)/min/mmHg)
<153.0	< 60.25	8.0	9.0
153.0 to <159.0	60.25 to <62.50	8.5	9.5
159.0 to <164.0	62.50 to <64.50	9.0	10.0
164.0 to <169.0	64.50 to <66.50	9.5	10.5
169.0 to <174.0	66.50 to <68.50	10.0	11.0
174.0 to <180.0	68.50 to <70.75	10.5	11.5
180.0 to <185.0	70.75 to <72.75	11.0	12.0
185.0 or more	72.75 or more	11.5	12.5

2. Arterial P_aO_2 and P_aCO_2 measured concurrently by an ABG test, while at rest or during steady state exercise, breathing room air (see 3.00G3b), less than or equal to the applicable values in Table IV–A, IV–B, or IV–C; or

Tables IV–A, IV–B, and IV–C—ABG Criteria for 3.02C2

TABLE IV–A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial P_aCO_2 (mm Hg) *and*	Arterial P_aO_2 less than or equal to (mm Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE IV–B

[Applicable at test sites from 3,000 through 6,000 feet above sea level]

Arterial P_aCO_2 (mm Hg) *and*	Arterial P_aO_2 less than or equal to (mm Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE IV–C

[Applicable at test sites over 6,000 feet above sea level]

Arterial P_aCO_2 (mm Hg) *and*	Arterial P_aO_2 less than or equal to (mm Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

3. S_pO_2 measured by pulse oximetry (see 3.00H2) either at rest, during a 6MWT, or after a 6MWT, less than or equal to the value in Table V.

TABLE V—S_pO_2 CRITERIA FOR 3.02C3

Test site altitude (feet above sea level)	S_pO_2 less than or equal to
Less than 3,000	87 percent.
3,000 through 6,000	85 percent.
Over 6,000	83 percent.

OR

D. Exacerbations or complications requiring three hospitalizations within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

3.03 *Asthma* (see 3.00I), with both A and B:

A. FEV_1 (see 3.00E1) less than or equal to the value in Table VI–A or VI–B for your age, gender, and height without shoes (see

3.00E3a) measured within the same 12-month period as the hospitalizations in 3.03B.

TABLE VI—FEV_1 CRITERIA FOR 3.03A

Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	*Table VI–A*		*Table VI–B*	
		Age 18 to attainment of age 20		Age 20 or older	
		Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)	Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)
<153.0	<60.25	1.65	1.90	1.45	1.60
153.0 to <159.0	60.25 to <62.50	1.75	2.05	1.55	1.75
159.0 to <164.0	62.50 to <64.50	1.85	2.15	1.65	1.90
164.0 to <169.0	64.50 to <66.50	1.95	2.30	1.75	2.00
169.0 to <174.0	66.50 to <68.50	2.05	2.45	1.85	2.15
174.0 to <180.0	68.50 to <70.75	2.20	2.60	2.00	2.30
180.0 to <185.0	70.75 to <72.75	2.35	2.75	2.10	2.45
185.0 or more	72.75 or more	2.40	2.85	2.20	2.55

AND

B. Exacerbations or complications requiring three hospitalizations within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization. Consider under a disability for 1 year from the discharge date of the last hospitalization; after that, evaluate the residual impairment(s) under 3.03 or another appropriate listing.

3.04 *Cystic fibrosis* (documented as described in 3.00J2) with A, B, C, D, E, F, or G:

A. FEV_1 (see 3.00E) less than or equal to the value in Table VII–A or VII–B for your age, gender, and height without shoes (see 3.00E3a).

TABLE VII—FEV_1 CRITERIA FOR 3.04A

Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	*Table VII–A*		*Table VII–B*	
		Age 18 to attainment of age 20		Age 20 or older	
		Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)	Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)
<153.0	<60.25	1.65	1.90	1.45	1.60
153.0 to <159.0	60.25 to <62.50	1.75	2.05	1.55	1.75
159.0 to <164.0	62.50 to <64.50	1.85	2.15	1.65	1.90
164.0 to <169.0	64.50 to <66.50	1.95	2.30	1.75	2.00
169.0 to <174.0	66.50 to <68.50	2.05	2.45	1.85	2.15
174.0 to <180.0	68.50 to <70.75	2.20	2.60	2.00	2.30
180.0 to <185.0	70.75 to <72.75	2.35	2.75	2.10	2.45
185.0 or more	72.75 or more	2.40	2.85	2.20	2.55

OR

B. Exacerbations or complications (see 3.00J3) requiring three hospitalizations of any length within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review).

OR

C. Spontaneous pneumothorax, secondary to CF, requiring chest tube placement.

OR

D. Respiratory failure (see 3.00N) requiring invasive mechanical ventilation, noninvasive ventilation with BiPAP, or a combination of both treatments, for a continuous period of at least 48 hours, or for a continuous period of at least 72 hours if postoperatively.

OR

E. Pulmonary hemorrhage requiring vascular embolization to control bleeding.

OR

F. S_pO_2 measured by pulse oximetry (see 3.00H3) either at rest, during a 6MWT, or after a 6MWT, less than or equal to the value

in Table VIII, *twice* within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review).

TABLES VIII—S_pO_2 CRITERIA FOR 3.04F

Test site altitude (feet above sea level)	S_pO_2 less than or equal to
Less than 3,000	89 percent.
3,000 through 6,000	87 percent.
Over 6,000	85 percent.

OR

G. Two of the following exacerbations or complications (either two of the same or two different, see 3.00J3 and 3.00J4) within a 12-month period (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review):

1. Pulmonary exacerbation requiring 10 consecutive days of intravenous antibiotic treatment.

2. Pulmonary hemorrhage (hemoptysis with more than blood-streaked sputum but not requiring vascular embolization) requiring hospitalization of any length.

3. Weight loss requiring daily supplemental enteral nutrition via a gastrostomy for at least 90 consecutive days *or* parenteral nutrition via a central venous catheter for at least 90 consecutive days.

4. CFRD requiring daily insulin therapy for at least 90 consecutive days.

3.05 [Reserved]

3.06 [Reserved]

3.07 *Bronchiectasis* (see 3.00K), documented by imaging (see 3.00D3), with exacerbations or complications requiring three hospitalizations within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

3.08 [Reserved]

3.09 *Chronic pulmonary hypertension due to any cause* (see 3.00L) documented by mean pulmonary artery pressure equal to or greater than 40 mm Hg as determined by cardiac catheterization while medically stable (see 3.00E2a).

3.10 [Reserved]

3.11 *Lung transplantation* (see 3.00M). Consider under a disability for 3 years from the date of the transplant; after that, evaluate the residual impairment(s).

3.12 [Reserved]

3.13 [Reserved]

3.14 *Respiratory failure* (see 3.00N) resulting from any underlying chronic respiratory disorder except CF (for CF, see 3.04D), requiring invasive mechanical ventilation, noninvasive ventilation with BiPAP, or a combination of both treatments, for a continuous period of at least 48 hours, or for a continuous period of at least 72 hours if postoperatively, *twice* within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review).

4.00 CARDIOVASCULAR SYSTEM

A. General

1. *What do we mean by a cardiovascular impairment?*

a. We mean any disorder that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage). The disorder can be congenital or acquired.

b. Cardiovascular impairment results from one or more of four consequences of heart disease:

(i) Chronic heart failure or ventricular dysfunction.

(ii) Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.

(iii) Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause, such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.

(iv) Central cyanosis due to right-to-left shunt, reduced oxygen concentration in the arterial blood, or pulmonary vascular disease.

c. Disorders of the veins or arteries (for example, obstruction, rupture, or aneurysm) may cause impairments of the lower extremities (peripheral vascular disease), the central nervous system, the eyes, the kidneys, and other organs. We will evaluate peripheral vascular disease under 4.11 or 4.12 and impairments of another body system(s) under the listings for that body system(s).

2. *What do we consider in evaluating cardiovascular impairments?* The listings in this section describe cardiovascular impairments based on symptoms, signs, laboratory findings, response to a regimen of prescribed treatment, and functional limitations.

3. *What do the following terms or phrases mean in these listings?*

a. *Medical consultant* is an individual defined in §§ 404.1616(a) and 416.1016(a). This term does not include medical sources who provide consultative examinations for us. We use the abbreviation ''MC'' throughout this section to designate a medical consultant.

b. *Persistent* means that the longitudinal clinical record shows that, with few exceptions, the required finding(s) has been present, or is expected to be present, for a continuous period of at least 12 months, such that a pattern of continuing severity is established.

c. *Recurrent* means that the longitudinal clinical record shows that, within a consecutive 12-month period, the finding(s) occurs at least three times, with intervening periods of improvement of sufficient duration that it is clear that separate events are involved.

d. *Appropriate medically acceptable imaging* means that the technique used is the proper one to evaluate and diagnose the impairment and is commonly recognized as accurate for assessing the cited finding.

e. *A consecutive 12-month period* means a period of 12 consecutive months, all or part of which must occur within the period we are considering in connection with an application or continuing disability review.

f. *Uncontrolled* means the impairment does not adequately respond to standard prescribed medical treatment.

B. Documenting Cardiovascular Impairment

1. *What basic documentation do we need?* We need sufficiently detailed reports of history, physical examinations, laboratory studies, and any prescribed treatment and response to allow us to assess the severity and duration of your cardiovascular impairment. A longitudinal clinical record covering a period of not less than 3 months of observations and treatment is usually necessary, unless we can make a determination or decision based on the current evidence.

2. *Why is a longitudinal clinical record important?* We will usually need a longitudinal clinical record to assess the severity and expected duration of your impairment(s). If you have a listing-level impairment, you probably will have received medically prescribed treatment. Whenever there is evidence of such treatment, your longitudinal clinical record should include a description of the ongoing management and evaluation provided by your treating or other medical source. It should also include your response to this medical management, as well as information about the nature and severity of your impairment. The record will provide us with information on your functional status over an extended period of time and show whether your ability to function is improving, worsening, or unchanging.

3. *What if you have not received ongoing medical treatment?*

a. You may not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). In this situation, we will base our evaluation on the current objective medical evidence and the other evidence we have. If you do not receive treatment, you cannot show an impairment that meets the criteria of most of these listings. However, we may find you disabled because you have another impairment(s) that in combination with your cardiovascular impairment medically equals the severity of a listed impairment or based on consideration of your residual functional capacity and age, education, and work experience.

b. Unless we can decide your claim favorably on the basis of the current evidence, a longitudinal record is still important. In rare instances where there is no or insufficient longitudinal evidence, we may purchase a consultative examination(s) to help us establish the severity and duration of your impairment.

4. *When will we wait before we ask for more evidence?*

a. We will wait when we have information showing that your impairment is not yet stable and the expected change in your impairment might affect our determination or decision. In these situations, we need to wait to properly evaluate the severity and duration of your impairment during a stable period. Examples of when we might wait are:

(i) If you have had a recent acute event; for example, a myocardial infarction (heart attack).

(ii) If you have recently had a corrective cardiac procedure; for example, coronary artery bypass grafting.

(iii) If you have started new drug therapy and your response to this treatment has not yet been established; for example, beta-blocker therapy for dilated congestive cardiomyopathy.

b. In these situations, we will obtain more evidence 3 months following the event before we evaluate your impairment. However, we will not wait if we have enough information to make a determination or decision based on all of the relevant evidence in your case.

5. *Will we purchase any studies?* In appropriate situations, we will purchase studies necessary to substantiate the diagnosis or to document the severity of your impairment, generally after we have evaluated the medical and other evidence we already have. We will not purchase studies involving exercise testing if there is significant risk involved or if there is another medical reason not to perform the test. We will follow sections 4.00C6, 4.00C7, and 4.00C8 when we decide whether to purchase exercise testing.

6. *What studies will we not purchase?* We will not purchase any studies involving cardiac catheterization, such as coronary angiography, arteriograms, or electrophysiological studies. However, if the results of catheterization are part of the existing evidence we have, we will consider them together with the other relevant evidence. See 4.00C15a.

C. Using Cardiovascular Test Results

1. *What is an ECG?*

a. *ECG* stands for *electrocardiograph* or *electrocardiogram.* An electrocardiograph is a machine that records electrical impulses of your heart on a strip of paper called an electrocardiogram or a *tracing.* To record the ECG, a technician positions a number of

small contacts (or *leads*) on your arms, legs, and across your chest to connect them to the ECG machine. An ECG may be done while you are resting or exercising.

b. The ECG tracing may indicate that you have a heart abnormality. It may indicate that your heart muscle is not getting as much oxygen as it needs (ischemia), that your heart rhythm is abnormal (arrhythmia), or that there are other abnormalities of your heart, such as left ventricular enlargement.

2. *How do we evaluate ECG evidence?* We consider a number of factors when we evaluate ECG evidence:

a. An original or legible copy of the 12-lead ECG obtained at rest must be appropriately dated and labeled, with the standardization inscribed on the tracing. Alteration in standardization of specific leads (such as to accommodate large QRS amplitudes) must be identified on those leads.

(i) Detailed descriptions or computer-averaged signals without original or legible copies of the ECG as described in listing 4.00C2a are not acceptable.

(ii) The effects of drugs or electrolyte abnormalities must be considered as possible noncardiac causes of ECG abnormalities of ventricular repolarization; that is, those involving the ST segment and T wave. If available, the predrug (especially digitalis glycosides) ECG should be submitted.

b. ECGs obtained in conjunction with treadmill, bicycle, or arm exercise tests should meet the following specifications:

(i) ECG reports must include the original calibrated ECG tracings or a legible copy.

(ii) A 12-lead baseline ECG must be recorded in the upright position before exercise.

(iii) A 12-lead ECG should be recorded at the end of each minute of exercise.

(iv) If ECG documentation of the effects of hyperventilation is obtained, the exercise test should be deferred for at least 10 minutes because metabolic changes of hyperventilation may alter the physiologic and ECG-recorded response to exercise.

(v) Post-exercise ECGs should be recorded using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice.

(vi) All resting, exercise, and recovery ECG strips must have the standardization inscribed on the tracing. The ECG strips should be labeled to indicate the date, the times recorded and the relationship to the stage of the exercise protocol. The speed and grade (treadmill test) or work rate (bicycle or arm ergometric test) should be recorded. The highest level of exercise achieved, heart rate and blood pressure levels during testing, and the reason(s) for terminating the test (including limiting signs or symptoms) must be recorded.

3. *What are exercise tests and what are they used for?*

a. Exercise tests have you perform physical activity and record how your cardiovascular system responds. Exercise tests usually involve walking on a treadmill, but other forms of exercise, such as an exercise bicycle or an arm exercise machine, may be used. Exercise testing may be done for various reasons; such as to evaluate the severity of your coronary artery disease or peripheral vascular disease or to evaluate your progress after a cardiac procedure or an acute event, like a myocardial infarction (heart attack). Exercise testing is the most widely used testing for identifying the presence of myocardial ischemia and for estimating maximal aerobic capacity (usually expressed in METs—metabolic equivalents) if you have heart disease.

b. We include exercise tolerance test (ETT) criteria in 4.02B3 (chronic heart failure) and 4.04A (ischemic heart disease). To meet the ETT criteria in these listings, the ETT must be a sign-or symptom-limited test in which you exercise while connected to an ECG until you develop a sign or symptom that indicates that you have exercised as much as is considered safe for you.

c. In 4.12B, we also refer to exercise testing for peripheral vascular disease. In this test, you walk on a treadmill, usually for a specified period of time, and the individual who administers the test measures the effect of exercise on the flow of blood in your legs, usually by using ultrasound. The test is also called an exercise Doppler test. Even though this test is intended to evaluate peripheral vascular disease, it will be stopped for your safety if you develop abnormal signs or symptoms because of heart disease.

d. Each type of test is done in a certain way following specific criteria, called a *protocol.* For our program, we also specify certain aspects of how any exercise test we purchase is to be done. See 4.00C10 and 4.00C17.

4. *Do ETTs have limitations?* An ETT provides an estimate of aerobic capacity for walking on a grade, bicycling, or moving one's arms in an environmentally controlled setting. Therefore, ETT results do not correlate with the ability to perform other types of exertional activities, such as lifting and carrying heavy loads, and do not provide an estimate of the ability to perform activities required for work in all possible work environments or throughout a workday. Also, certain medications (such as beta blockers) and conduction disorders (such as left or right bundle branch blocks) can cause false-negative or false-positive results. Therefore, we must consider the results of an ETT together with all the other relevant evidence in your case record.

5. *How does an ETT with measurement of maximal or peak oxygen uptake (VO_2) differ from other ETTs?* Occasionally, medical evidence

will include the results of an ETT with VO_2 While ETTs without measurement of VO_2 provide only an estimate of aerobic capacity, measured maximal or peak oxygen uptake provides an accurate measurement of aerobic capacity, which is often expressed in METs (metabolic equivalents). The MET level may not be indicated in the report of attained maximal or peak VO_2 testing, but can be calculated as follows: 1 MET = 3.5 milliliters (ml) of oxygen uptake per kilogram (kg) of body weight per minute. For example, a 70 kg (154 lb.) individual who achieves a maximal or peak VO_2 of 1225 ml in 1 minute has attained 5 METs (1225 ml/70 kg/1 min = 17.5 ml/kg/min. 17.5/3.5 = 5 METs).

6. *When will we consider whether to purchase an exercise test?*

a. We will consider whether to purchase an exercise test when:

(i) There is a question whether your cardiovascular impairment meets or medically equals the severity of one of the listings, or there is no timely test in the evidence we have (see 4.00C9), and we cannot find you disabled on some other basis; or

(ii) We need to assess your residual functional capacity and there is insufficient evidence in the record to make a determination or decision.

b. We will not purchase an exercise test when we can make our determination or decision based on the evidence we already have.

7. *What must we do before purchasing an exercise test?*

a. Before we purchase an exercise test, an MC, preferably one with experience in the care of patients with cardiovascular disease, must review the pertinent history, physical examinations, and laboratory tests that we have to determine whether the test would present a significant risk to you or if there is some other medical reason not to purchase the test (see 4.00C8).

b. If you are under the care of a treating source (see §§404.1502 and 416.902) for a cardiovascular impairment, this source has not performed an exercise test, and there are no reported significant risks to testing, we will request a statement from that source explaining why it was not done or should not be done before we decide whether we will purchase the test.

c. The MC, in accordance with the regulations and other instructions on consultative examinations, will generally give great weight to the treating source's opinion about the risk of exercise testing to you and will generally not override it. In the rare situation in which the MC does override the treating source's opinion, the MC must prepare a written rationale documenting the reasons for overriding the opinion.

d. If you do not have a treating source or we cannot obtain a statement from your treating source, the MC is responsible for assessing the risk to exercise testing based on a review of the records we have before purchasing an exercise test for you.

e. We must also provide your records to the medical source who performs the exercise test for review prior to conducting the test if the source does not already have them. The medical source who performs the exercise test has the ultimate responsibility for deciding whether you would be at risk.

8. *When will we not purchase an exercise test or wait before we purchase an exercise test?*

a. We will not purchase an exercise test when an MC finds that you have one of the following significant risk factors:

(i) Unstable angina not previously stabilized by medical treatment.

(ii) Uncontrolled cardiac arrhythmias causing symptoms or hemodynamic compromise.

(iii) An implanted cardiac defibrillator.

(iv) Symptomatic severe aortic stenosis.

(v) Uncontrolled symptomatic heart failure.

(vi) Aortic dissection.

(vii) Severe pulmonary hypertension (pulmonary artery systolic pressure greater than 60 mm Hg).

(viii) Left main coronary stenosis of 50 percent or greater that has not been bypassed.

(ix) Moderate stenotic valvular disease with a systolic gradient across the aortic valve of 50 mm Hg or greater.

(x) Severe arterial hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg).

(xi) Hypertrophic cardiomyopathy with a systolic gradient of 50 mm Hg or greater.

b. We also will not purchase an exercise test when you are prevented from performing exercise testing due to another impairment affecting your ability to use your arms and legs.

c. We will not purchase an ETT to document the presence of a cardiac arrhythmia.

d. We will wait to purchase an exercise test until 3 months after you have had one of the following events. This will allow for maximal, attainable restoration of functional capacity.

(i) Acute myocardial infarction.

(ii) Surgical myocardial revascularization (bypass surgery).

(iii) Other open-heart surgical procedures.

(iv) Percutaneous transluminal coronary angioplasty with or without stenting.

e. If you are deconditioned after an extended period of bedrest or inactivity and could improve with activity, or if you are in acute heart failure and are expected to improve with treatment, we will wait an appropriate period of time for you to recuperate before we purchase an exercise test.

9. *What do we mean by a ''timely'' test?*

a. We consider exercise test results to be timely for 12 months after the date they are performed, provided there has been no

change in your clinical status that may alter the severity of your cardiovascular impairment.

b. However, an exercise test that is older than 12 months, especially an abnormal one, can still provide information important to our adjudication. For example, a test that is more than 12 months old can provide evidence of ischemic heart disease or peripheral vascular disease, information on decreased aerobic capacity, or information about the duration or onset of your impairment. Such tests can be an important component of the longitudinal record.

c. When we evaluate a test that is more than 12 months old, we must consider the results in the context of all the relevant evidence, including why the test was performed and whether there has been an intervening event or improvement or worsening of your impairment.

d. We will purchase a new exercise test only if we cannot make a determination or decision based on the evidence we have.

10. *How must ETTs we purchase be performed?*

a. The ETT must be a sign- or symptom-limited test characterized by a progressive multistage regimen. It must be performed using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice. A description of the protocol that was followed must be provided, and the test must meet the requirements of 4.00C2b and this section. A radionuclide perfusion scan may be useful for detecting or confirming ischemia when resting ECG abnormalities, medications, or other factors may decrease the accuracy of ECG interpretation of ischemia. (The perfusion imaging is done at the termination of exercise, which may be at a higher MET level than that at which ischemia first occurs. If the imaging confirms the presence of reversible ischemia, the exercise ECG may be useful for detecting the MET level at which ischemia initially appeared.) Exercise tests may also be performed using echocardiography to detect stress-induced ischemia and left ventricular dysfunction (see 4.00C12 and 4.00C13).

b. The exercise test must be paced to your capabilities and be performed following the generally accepted standards for adult exercise test laboratories. With a treadmill test, the speed, grade (incline), and duration of exercise must be recorded for each exercise test stage performed. Other exercise test protocols or techniques should use similar workloads. The exercise protocol may need to be modified in individual cases to allow for a lower initial workload with more slowly graded increments than the standard Bruce protocol.

c. Levels of exercise must be described in terms of workload and duration of each stage; for example, treadmill speed and grade, or bicycle ergometer work rate in kpm/min or watts.

d. The exercise laboratory's physical environment, staffing, and equipment must meet the generally accepted standards for adult exercise test laboratories.

11. *How do we evaluate ETT results?* We evaluate ETT results on the basis of the work level at which the test becomes abnormal, as documented by onset of signs or symptoms and any ECG or imaging abnormalities. The absence of an ischemic response on an ETT alone does not exclude the diagnosis of ischemic heart disease. We must consider the results of an ETT in the context of all of the other evidence in your case record.

12. *When are ETTs done with imaging?* When resting ECG abnormalities preclude interpretation of ETT tracings relative to ischemia, a radionuclide (for example, thallium-201 or technetium-99m) perfusion scan or echocardiography in conjunction with an ETT provides better results. You may have resting ECG abnormalities when you have a conduction defect—for example, Wolff-Parkinson-White syndrome, left bundle branch block, left ventricular hypertrophy—or when you are taking digitalis or other antiarrhythmic drugs, or when resting ST changes are present. Also, these techniques can provide a reliable estimate of ejection fraction.

13. *Will we purchase ETTs with imaging?* We may purchase an ETT with imaging in your case after an MC, preferably one with experience in the care of patients with cardiovascular disease, has reviewed your medical history and physical examination, any report(s) of appropriate medically acceptable imaging, ECGs, and other appropriate tests. We will consider purchasing an ETT with imaging when other information we have is not adequate for us to assess whether you have severe ventricular dysfunction or myocardial ischemia, there is no significant risk involved (see 4.00C8a), and we cannot make our determination or decision based on the evidence we already have.

14. *What are drug-induced stress tests?* These tests are designed primarily to provide evidence about myocardial ischemia or prior myocardial infarction, but do not require you to exercise. These tests are used when you cannot exercise or cannot exercise enough to achieve the desired cardiac stress. Drug-induced stress tests can also provide evidence about heart chamber dimensions and function; however, these tests do not provide information about your aerobic capacity and cannot be used to help us assess your ability to function. Some of these tests use agents, such as Persantine or adenosine, that dilate the coronary arteries and are used in combination with nuclear agents, such as thallium or technetium (for example, Cardiolyte or Myoview), and a myocardial

scan. Other tests use agents, such as dobutamine, that stimulate the heart to contract more forcefully and faster to simulate exercise and are used in combination with a 2-dimensional echocardiogram. We may, when appropriate, purchase a drug-induced stress test to confirm the presence of myocardial ischemia after a review of the evidence in your file by an MC, preferably one with experience in the care of patients with cardiovascular disease.

15. *How do we evaluate cardiac catheterization evidence?*

a. We will not purchase cardiac catheterization; however, if you have had catheterization, we will make every reasonable effort to obtain the report and any ancillary studies. We will consider the quality and type of data provided and its relevance to the evaluation of your impairment. For adults, we generally see two types of catheterization reports: Coronary arteriography and left ventriculography.

b. For coronary arteriography, the report should provide information citing the method of assessing coronary arterial lumen diameter and the nature and location of obstructive lesions. Drug treatment at baseline and during the procedure should be reported. Some individuals with significant coronary atherosclerotic obstruction have collateral vessels that supply the myocardium distal to the arterial obstruction so that there is no evidence of myocardial damage or ischemia, even with exercise. When the results of quantitative computer measurements and analyses are included in your case record, we will consider them in interpreting the severity of stenotic lesions.

c. For left ventriculography, the report should describe the wall motion of the myocardium with regard to any areas of hypokinesis (abnormally decreased motion), akinesis (lack of motion), or dyskinesis (distortion of motion), and the overall contraction of the ventricle as measured by the ejection fraction. Measurement of chamber volumes and pressures may be useful. Quantitative computer analysis provides precise measurement of segmental left ventricular wall thickness and motion. There is often a poor correlation between left ventricular function at rest and functional capacity for physical activity.

16. *What details should exercise Doppler test reports contain?* The reports of exercise Doppler tests must describe the level of exercise; for example, the speed and grade of the treadmill settings, the duration of exercise, symptoms during exercise, and the reasons for stopping exercise if the expected level of exercise was not attained. They must also include the blood pressures at the ankle and other pertinent sites measured after exercise and the time required for the systolic blood pressure to return toward or to the pre-exercise level. The graphic tracings, if available, should also be included with the report. All tracings must be annotated with the standardization used by the testing facility.

17. *How must exercise Doppler tests we purchase be performed?* When we purchase an exercise Doppler test, you must exercise on a treadmill at 2 mph on a 12 percent grade for up to 5 minutes. The reports must include the information specified in 4.00C16. Because this is an exercise test, we must evaluate whether such testing would put you at significant risk, in accordance with the guidance found in 4.00C6, 4.00C7, and 4.00C8.

D. Evaluating Chronic Heart Failure

1. *What is chronic heart failure (CHF)?*

a. *CHF* is the inability of the heart to pump enough oxygenated blood to body tissues. This syndrome is characterized by symptoms and signs of pulmonary or systemic congestion (fluid retention) or limited cardiac output. Certain laboratory findings of cardiac functional and structural abnormality support the diagnosis of CHF. There are two main types of CHF:

(i) *Predominant systolic dysfunction* (the inability of the heart to contract normally and expel sufficient blood), which is characterized by a dilated, poorly contracting left ventricle and reduced ejection fraction (abbreviated EF, it represents the percentage of the blood in the ventricle actually pumped out with each contraction), and

(ii) *Predominant diastolic dysfunction* (the inability of the heart to relax and fill normally), which is characterized by a thickened ventricular muscle, poor ability of the left ventricle to distend, increased ventricular filling pressure, and a normal or increased EF.

b. CHF is considered in these listings as a single category whether due to atherosclerosis (narrowing of the arteries), cardiomyopathy, hypertension, or rheumatic, congenital, or other heart disease. However, if the CHF is the result of primary pulmonary hypertension secondary to disease of the lung (cor pulmonale), we will evaluate your impairment using 3.09, in the respiratory system listings.

2. *What evidence of CHF do we need?*

a. Cardiomegaly or ventricular dysfunction must be present and demonstrated by appropriate medically acceptable imaging, such as chest x-ray, echocardiography (M-Mode, 2-dimensional, and Doppler), radionuclide studies, or cardiac catheterization.

(i) Abnormal cardiac imaging showing increased left ventricular end diastolic diameter (LVEDD), decreased EF, increased left atrial chamber size, increased ventricular filling pressures measured at cardiac catheterization, or increased left ventricular wall or septum thickness, provides objective measures of both left ventricular function and structural abnormality in heart failure.

(ii) An LVEDD greater than 6.0 cm or an EF of 30 percent or less measured during a period of stability (that is, not during an episode of acute heart failure) may be associated clinically with systolic failure.

(iii) Left ventricular posterior wall thickness added to septal thickness totaling 2.5 cm or greater with left atrium enlarged to 4.5 cm or greater may be associated clinically with diastolic failure.

(iv) However, these measurements alone do not reflect your functional capacity, which we evaluate by considering all of the relevant evidence. In some situations, we may need to purchase an ETT to help us assess your functional capacity.

(v) Other findings on appropriate medically acceptable imaging may include increased pulmonary vascular markings, pleural effusion, and pulmonary edema. These findings need not be present on each report, since CHF may be controlled by prescribed treatment.

b. To establish that you have *chronic* heart failure, your medical history and physical examination should describe characteristic symptoms and signs of pulmonary or systemic congestion or of limited cardiac output associated with the abnormal findings on appropriate medically acceptable imaging. When an acute episode of heart failure is triggered by a remediable factor, such as an arrhythmia, dietary sodium overload, or high altitude, cardiac function may be restored and a chronic impairment may not be present.

(i) Symptoms of congestion or of limited cardiac output include easy fatigue, weakness, shortness of breath (dyspnea), cough, or chest discomfort at rest or with activity. Individuals with CHF may also experience shortness of breath on lying flat (orthopnea) or episodes of shortness of breath that wake them from sleep (paroxysmal nocturnal dyspnea). They may also experience cardiac arrhythmias resulting in palpitations, lightheadedness, or fainting.

(ii) Signs of congestion may include hepatomegaly, ascites, increased jugular venous distention or pressure, rales, peripheral edema, or rapid weight gain. However, these signs need not be found on all examinations because fluid retention may be controlled by prescribed treatment.

3. *Is it safe for you to have an ETT, if you have CHF?* The presence of CHF is not necessarily a contraindication to an ETT, unless you are having an acute episode of heart failure. Measures of cardiac performance are valuable in helping us evaluate your ability to do work-related activities. Exercise testing has been safely used in individuals with CHF; therefore, we may purchase an ETT for evaluation under 4.02B3 if an MC, preferably one experienced in the care of patients with cardiovascular disease, determines that there is no significant risk to you. (See 4.00C6 for when we will consider the purchase of an ETT. See 4.00C7–4.00C8 for what we must do before we purchase an ETT and when we will not purchase one.) ST segment changes from digitalis use in the treatment of CHF do not preclude the purchase of an ETT.

4. *How do we evaluate CHF using 4.02?*

a. We must have objective evidence, as described in 4.00D2, that you have chronic heart failure.

b. To meet the required level of severity for this listing, your impairment must satisfy the requirements of one of the criteria in A and one of the criteria in B.

c. In 4.02B2, the phrase *periods of stabilization* means that, for at least 2 weeks between episodes of acute heart failure, there must be objective evidence of clearing of the pulmonary edema or pleural effusions and evidence that you returned to, or you were medically considered able to return to, your prior level of activity.

d. Listing 4.02B3c requires a decrease in systolic blood pressure below the baseline level (taken in the standing position immediately prior to exercise) or below any systolic pressure reading recorded during exercise. This is because, normally, systolic blood pressure and heart rate increase gradually with exercise. Decreases in systolic blood pressure below the baseline level that occur during exercise are often associated with ischemia-induced left ventricular dysfunction resulting in decreased cardiac output. However, a blunted response (that is, failure of the systolic blood pressure to rise 10 mm Hg or more), particularly in the first 3 minutes of exercise, may be drug-related and is not necessarily associated with left ventricular dysfunction. Also, some individuals with increased sympathetic responses because of deconditioning or apprehension may increase their systolic blood pressure and heart rate above their baseline level just before and early into exercise. This can be associated with a drop in systolic pressure in early exercise that is not due to left ventricular dysfunction. Therefore, an early decrease in systolic blood pressure must be interpreted within the total context of the test; that is, the presence or absence of symptoms such as lightheadedness, ischemic changes, or arrhythmias on the ECG.

E. Evaluating Ischemic Heart Disease

1. *What is ischemic heart disease (IHD)?* IHD results when one or more of your coronary arteries is narrowed or obstructed or, in rare situations, constricted due to vasospasm, interfering with the normal flow of blood to your heart muscle (ischemia). The obstruction may be the result of an embolus, a thrombus, or plaque. When heart muscle tissue dies as a result of the reduced blood supply, it is called a myocardial infarction (heart attack).

2. *What causes chest discomfort of myocardial origin?*

a. Chest discomfort of myocardial ischemic origin, commonly known as angina pectoris, is usually caused by coronary artery disease (often abbreviated CAD). However, ischemic discomfort may be caused by a noncoronary artery impairment, such as aortic stenosis, hypertrophic cardiomyopathy, pulmonary hypertension, or anemia.

b. Instead of typical angina pectoris, some individuals with IHD experience atypical angina, anginal equivalent, variant angina, or silent ischemia, all of which we may evaluate using 4.04. We discuss the various manifestations of ischemia in 4.00E3–4.00E7.

3. *What are the characteristics of typical angina pectoris?* Discomfort of myocardial ischemic origin (angina pectoris) is discomfort that is precipitated by effort or emotion and promptly relieved by rest, sublingual nitroglycerin (that is, nitroglycerin tablets that are placed under the tongue), or other rapidly acting nitrates. Typically, the discomfort is located in the chest (usually substernal) and described as pressing, crushing, squeezing, burning, aching, or oppressive. Sharp, sticking, or cramping discomfort is less common. Discomfort occurring with activity or emotion should be described specifically as to timing and usual inciting factors (type and intensity), character, location, radiation, duration, and response to nitrate treatment or rest.

4. *What is atypical angina? Atypical angina* describes discomfort or pain from myocardial ischemia that is felt in places other than the chest. The common sites of cardiac pain are the inner aspect of the left arm, neck, jaw(s), upper abdomen, and back, but the discomfort or pain can be elsewhere. When pain of cardiac ischemic origin presents in an atypical site in the absence of chest discomfort, the source of the pain may be difficult to diagnose. To represent atypical angina, your discomfort or pain should have precipitating and relieving factors similar to those of typical chest discomfort, and we must have objective medical evidence of myocardial ischemia; for example, ECG or ETT evidence or appropriate medically acceptable imaging.

5. *What is anginal equivalent?* Often, individuals with IHD will complain of shortness of breath (dyspnea) on exertion without chest pain or discomfort. In a minority of such situations, the shortness of breath is due to myocardial ischemia; this is called *anginal equivalent*. To represent anginal equivalent, your shortness of breath should have precipitating and relieving factors similar to those of typical chest discomfort, and we must have objective medical evidence of myocardial ischemia; for example, ECG or ETT evidence or appropriate medically acceptable imaging. In these situations, it is essential to establish objective evidence of myocardial ischemia to ensure that you do not have effort dyspnea due to non-ischemic or non-cardiac causes.

6. *What is variant angina?*

a. *Variant angina* (Prinzmetal's angina, vasospastic angina) refers to the occurrence of anginal episodes at rest, especially at night, accompanied by transitory ST segment elevation (or, at times, ST depression) on an ECG. It is due to severe spasm of a coronary artery, causing ischemia of the heart wall, and is often accompanied by major ventricular arrhythmias, such as ventricular tachycardia. We will consider variant angina under 4.04 only if you have spasm of a coronary artery in relation to an obstructive lesion of the vessel. If you have an arrhythmia as a result of variant angina, we may consider your impairment under 4.05.

b. Variant angina may also occur in the absence of obstructive coronary disease. In this situation, an ETT will not demonstrate ischemia. The diagnosis will be established by showing the typical transitory ST segment changes during attacks of pain, and the absence of obstructive lesions shown by catheterization. Treatment in cases where there is no obstructive coronary disease is limited to medications that reduce coronary vasospasm, such as calcium channel blockers and nitrates. In such situations, we will consider the frequency of anginal episodes despite prescribed treatment when evaluating your residual functional capacity.

c. Vasospasm that is catheter-induced during coronary angiography is not variant angina.

7. *What is silent ischemia?*

a. Myocardial ischemia, and even myocardial infarction, can occur without perception of pain or any other symptoms; when this happens, we call it *silent ischemia*. Pain sensitivity may be altered by a variety of diseases, most notably diabetes mellitus and other neuropathic disorders. Individuals also vary in their threshold for pain.

b. Silent ischemia occurs most often in:

(i) Individuals with documented past myocardial infarction or established angina without prior infarction who do not have chest pain on ETT, but have a positive test with ischemic abnormality on ECG, perfusion scan, or other appropriate medically acceptable imaging.

(ii) Individuals with documented past myocardial infarction or angina who have ST segment changes on ambulatory monitoring (Holter monitoring) that are similar to those that occur during episodes of angina. ST depression shown on the ambulatory recording should not be interpreted as positive for ischemia unless similar depression is also seen during chest pain episodes annotated in the diary that the individual keeps while wearing the Holter monitor.

c. ST depression can result from a variety of factors, such as postural changes and variations in cardiac sympathetic tone. In addition, there are differences in how different Holter monitors record the electrical responses. Therefore, we do not consider the Holter monitor reliable for the diagnosis of silent ischemia except in the situation described in 4.00E7b(ii).

8. *What other sources of chest discomfort are there?* Chest discomfort of nonischemic origin may result from other cardiac impairments, such as pericarditis. Noncardiac impairments may also produce symptoms mimicking that of myocardial ischemia. These impairments include acute anxiety or panic attacks, gastrointestinal tract disorders, such as esophageal spasm, esophagitis, hiatal hernia, biliary tract disease, gastritis, peptic ulcer, and pancreatitis, and musculoskeletal syndromes, such as chest wall muscle spasm, chest wall syndrome (especially after coronary bypass surgery), costochondritis, and cervical or dorsal spine arthritis. Hyperventilation may also mimic ischemic discomfort. Thus, in the absence of documented myocardial ischemia, such disorders should be considered as possible causes of chest discomfort.

9. *How do we evaluate IHD using 4.04?*

a. We must have objective evidence, as described under 4.00C, that your symptoms are due to myocardial ischemia.

b. Listing-level changes on the ECG in 4.04A1 are the classically accepted changes of horizontal or downsloping ST depression occurring both during exercise and recovery. Although we recognize that ischemic changes may at times occur only during exercise or recovery, and may at times be upsloping with only junctional ST depression, such changes can be false positive; that is, occur in the absence of ischemia. Diagnosis of ischemia in this situation requires radionuclide or echocardiogram confirmation. See 4.00C12 and 4.00C13.

c. Also in 4.04A1, we require that the depression of the ST segment last for at least 1 minute of recovery because ST depression that occurs during exercise but that rapidly normalizes in recovery is a common false-positive response.

d. In 4.04A2, we specify that the ST elevation must be in non-infarct leads during both exercise and recovery. This is because, in the absence of ECG signs of prior infarction, ST elevation during exercise denotes ischemia, usually severe, requiring immediate termination of exercise. However, if there is baseline ST elevation in association with a prior infarction or ventricular aneurysm, further ST elevation during exercise does not necessarily denote ischemia and could be a false-positive ECG response. Diagnosis of ischemia in this situation requires radionuclide or echocardiogram confirmation. See 4.00C12 and 4.00C13.

e. Listing 4.04A3 requires a decrease in systolic blood pressure below the baseline level (taken in the standing position immediately prior to exercise) or below any systolic pressure reading recorded during exercise. This is the same finding required in 4.02B3c. See 4.00D4d for full details.

f. In 4.04B, each of the three ischemic episodes must require revascularization or be not amenable to treatment. *Revascularization* means angioplasty (with or without stent placement) or bypass surgery. However, reocclusion that occurs after a revascularization procedure but during the same hospitalization and that requires a second procedure during the same hospitalization will not be counted as another ischemic episode. Not amenable means that the revascularization procedure could not be done because of another medical impairment or because the vessel was not suitable for revascularization.

g. We will use 4.04C only when you have symptoms due to myocardial ischemia as described in 4.00E3–4.00E7 while on a regimen of prescribed treatment, you are at risk for exercise testing (see 4.00C8), and we do not have a timely ETT or a timely normal drug-induced stress test for you. See 4.00C9 for what we mean by a timely test.

h. In 4.04C1 the term *nonbypassed* means that the blockage is in a vessel that is potentially bypassable; that is, large enough to be bypassed and considered to be a cause of your ischemia. These vessels are usually major arteries or one of a major artery's major branches. A vessel that has become obstructed again after angioplasty or stent placement and has remained obstructed or is not amenable to another revascularization is considered a nonbypassed vessel for purposes of this listing. When you have had revascularization, we will not use the pre-operative findings to assess the current severity of your coronary artery disease under 4.04C, although we will consider the severity and duration of your impairment prior to your surgery in making our determination or decision.

F. Evaluating Arrhythmias

1. *What is an arrhythmia?* An *arrhythmia* is a change in the regular beat of the heart. Your heart may seem to skip a beat or beat irregularly, very quickly (tachycardia), or very slowly (bradycardia).

2. *What are the different types of arrhythmias?*

a. There are many types of arrhythmias. Arrhythmias are identified by where they occur in the heart (atria or ventricles) and by what happens to the heart's rhythm when they occur.

b. Arrhythmias arising in the cardiac atria (upper chambers of the heart) are called atrial or supraventricular arrhythmias. Ventricular arrhythmias begin in the ventricles

(lower chambers). In general, ventricular arrhythmias caused by heart disease are the most serious.

3. *How do we evaluate arrhythmias using 4.05?*

a. We will use 4.05 when you have arrhythmias that are not fully controlled by medication, an implanted pacemaker, or an implanted cardiac defibrillator and you have uncontrolled recurrent episodes of syncope or near syncope. If your arrhythmias are controlled, we will evaluate your underlying heart disease using the appropriate listing. For other considerations when we evaluate arrhythmias in the presence of an implanted cardiac defibrillator, see 4.00F4.

b. We consider *near syncope* to be a period of altered consciousness, since syncope is a loss of consciousness or a faint. It is not merely a feeling of light-headedness, momentary weakness, or dizziness.

c. For purposes of 4.05, there must be a documented association between the syncope or near syncope and the recurrent arrhythmia. The recurrent arrhythmia, not some other cardiac or non-cardiac disorder, must be established as the cause of the associated symptom. This documentation of the association between the symptoms and the arrhythmia may come from the usual diagnostic methods, including Holter monitoring (also called ambulatory electrocardiography) and tilt-table testing with a concurrent ECG. Although an arrhythmia may be a coincidental finding on an ETT, we will not purchase an ETT to document the presence of a cardiac arrhythmia.

4. *What will we consider when you have an implanted cardiac defibrillator and you do not have arrhythmias that meet the requirements of 4.05?*

a. Implanted cardiac defibrillators are used to prevent sudden cardiac death in individuals who have had, or are at high risk for, cardiac arrest from life-threatening ventricular arrhythmias. The largest group at risk for sudden cardiac death consists of individuals with cardiomyopathy (ischemic or non-ischemic) and reduced ventricular function. However, life-threatening ventricular arrhythmias can also occur in individuals with little or no ventricular dysfunction. The shock from the implanted cardiac defibrillator is a unique form of treatment; it rescues an individual from what may have been cardiac arrest. However, as a consequence of the shock(s), individuals may experience psychological distress, which we may evaluate under the mental disorders listings in 12.00ff.

b. Most implantable cardiac defibrillators have rhythm-correcting and pacemaker capabilities. In some individuals, these functions may result in the termination of ventricular arrhythmias without an otherwise painful shock. (The shock is like being kicked in the chest.) Implanted cardiac defibrillators may deliver inappropriate shocks, often repeatedly, in response to benign arrhythmias or electrical malfunction. Also, exposure to strong electrical or magnetic fields, such as from MRI (magnetic resonance imaging), can trigger or reprogram an implanted cardiac defibrillator, resulting in inappropriate shocks. We must consider the frequency of, and the reason(s) for, the shocks when evaluating the severity and duration of your impairment.

c. In general, the exercise limitations imposed on individuals with an implanted cardiac defibrillator are those dictated by the underlying heart impairment. However, the exercise limitations may be greater when the implanted cardiac defibrillator delivers an inappropriate shock in response to the increase in heart rate with exercise, or when there is exercise-induced ventricular arrhythmia.

G. Evaluating Peripheral Vascular Disease

1. *What is peripheral vascular disease (PVD)?* Generally, *PVD* is any impairment that affects either the arteries (peripheral arterial disease) or the veins (venous insufficiency) in the extremities, particularly the lower extremities. The usual effect is blockage of the flow of blood either from the heart (arterial) or back to the heart (venous). If you have peripheral arterial disease, you may have pain in your calf after walking a distance that goes away when you rest (intermittent claudication); at more advanced stages, you may have pain in your calf at rest or you may develop ulceration or gangrene. If you have venous insufficiency, you may have swelling, varicose veins, skin pigmentation changes, or skin ulceration.

2. *How do we assess limitations resulting from PVD?* We will assess your limitations based on your symptoms together with physical findings, Doppler studies, other appropriate non-invasive studies, or angiographic findings. However, if the PVD has resulted in amputation, we will evaluate any limitations related to the amputation under the musculoskeletal listings, 1.00ff.

3. *What is brawny edema? Brawny edema* (4.11A) is swelling that is usually dense and feels firm due to the presence of increased connective tissue; it is also associated with characteristic skin pigmentation changes. It is not the same thing as pitting edema. Brawny edema generally does not pit (indent on pressure), and the terms are not interchangeable. Pitting edema does not satisfy the requirements of 4.11A.

4. *What is lymphedema and how will we evaluate it?*

a. *Lymphedema* is edema of the extremities due to a disorder of the lymphatic circulation; at its worst, it is called elephantiasis. Primary lymphedema is caused by abnormal development of lymph vessels and may be present at birth (congenital lymphedema),

but more often develops during the teens (lymphedema praecox). It may also appear later, usually after age 35 (lymphedema tarda). Secondary lymphedema is due to obstruction or destruction of normal lymphatic channels due to tumor, surgery, repeated infections, or parasitic infection such as filariasis. Lymphedema most commonly affects one extremity.

b. Lymphedema does not meet the requirements of 4.11, although it may medically equal the severity of that listing. We will evaluate lymphedema by considering whether the underlying cause meets or medically equals any listing or whether the lymphedema medically equals a cardiovascular listing, such as 4.11, or a musculoskeletal disorders listing, such as 1.18. If no listing is met or medically equaled, we will evaluate any functional limitations imposed by your lymphedema when we assess your residual functional capacity.

5. *When will we purchase exercise Doppler studies for evaluating peripheral arterial disease (PAD)?* If we need additional evidence of your PAD, we will generally purchase exercise Doppler studies (see 4.00C16 and 4.00C17) when your resting ankle/brachial systolic blood pressure ratio is at least 0.50 but less than 0.80, and only rarely when it is 0.80 or above. We will not purchase exercise Doppler testing if you have a disease that results in abnormal arterial calcification or small vessel disease, but will use your resting toe systolic blood pressure or resting toe/brachial systolic blood pressure ratio. (See 4.00G7c and 4.00G8.) There are no current medical standards for evaluating exercise toe pressures. Because any exercise test stresses your entire cardiovascular system, we will purchase exercise Doppler studies only after an MC, preferably one with experience in the care of patients with cardiovascular disease, has determined that the test would not present a significant risk to you and that there is no other medical reason not to purchase the test (see 4.00C6, 4.00C7, and 4.00C8).

6. *Are there any other studies that are helpful in evaluating PAD?* Doppler studies done using a recording ultrasonic Doppler unit and strain-gauge plethysmography are other useful tools for evaluating PAD. A recording Doppler, which prints a tracing of the arterial pulse wave in the femoral, popliteal, dorsalis pedis, and posterior tibial arteries, is an excellent evaluation tool to compare wave forms in normal and compromised peripheral blood flow. Qualitative analysis of the pulse wave is very helpful in the overall assessment of the severity of the occlusive disease. Tracings are especially helpful in assessing severity if you have small vessel disease related to diabetes mellitus or other diseases with similar vascular changes, or diseases causing medial calcifications when ankle pressure is either normal or falsely high.

7. *How do we evaluate PAD under 4.12?*

a. The ankle blood pressure referred to in 4.12A and B is the higher of the pressures recorded from the posterior tibial and dorsalis pedis arteries in the affected leg. The higher pressure recorded from the two sites is the more significant measurement in assessing the extent of arterial insufficiency. Techniques for obtaining ankle systolic blood pressures include Doppler (See 4.00C16 and 4.00C17), plethysmographic studies, or other techniques. We will request any available tracings generated by these studies so that we can review them.

b. In 4.12A, the ankle/brachial systolic blood pressure ratio is the ratio of the systolic blood pressure at the ankle to the systolic blood pressure at the brachial artery; both taken at the same time while you are lying on your back. We do not require that the ankle and brachial pressures be taken on the same side of your body. This is because, as with the ankle pressure, we will use the higher brachial systolic pressure measured. Listing 4.12A is met when your resting ankle/brachial systolic blood pressure ratio is less than 0.50. If your resting ankle/brachial systolic blood pressure ratio is 0.50 or above, we will use 4.12B to evaluate the severity of your PAD, unless you also have a disease causing abnormal arterial calcification or small vessel disease, such as diabetes mellitus. See 4.00G7c and 4.00G8.

c. We will use resting toe systolic blood pressures or resting toe/brachial systolic blood pressure ratios (determined the same way as ankle/brachial ratios, see 4.00G7b) when you have intermittent claudication and a disease that results in abnormal arterial calcification (for example, Monckeberg's sclerosis or diabetes mellitus) or small vessel disease (for example, diabetes mellitus). These diseases may result in misleadingly high blood pressure readings at the ankle. However, high blood pressures due to vascular changes related to these diseases seldom occur at the toe level. While the criteria in 4.12C and 4.12D are intended primarily for individuals who have a disease causing abnormal arterial calcification or small vessel disease, we may also use them for evaluating anyone with PAD.

8. *How are toe pressures measured?* Toe pressures are measured routinely in most vascular laboratories through one of three methods: most frequently, photoplethysmography; less frequently, plethysmography using strain gauge cuffs; and Doppler ultrasound. Toe pressure can also be measured by using any blood pressure cuff that fits snugly around the big toe and is neither too tight nor too loose. A neonatal cuff or a cuff designed for use on fingers or toes can be used in the measurement of toe pressure.

9. *How do we use listing 4.12 if you have had a peripheral graft?* Peripheral grafting serves the same purpose as coronary grafting; that

is, to bypass a narrow or obstructed arterial segment. If intermittent claudication recurs or persists after peripheral grafting, we may purchase Doppler studies to assess the flow of blood through the bypassed vessel and to establish the current severity of the peripheral arterial impairment. However, if you have had peripheral grafting done for your PAD, we will not use the findings from before the surgery to assess the current severity of your impairment, although we will consider the severity and duration of your impairment prior to your surgery in making our determination or decision.

H. Evaluating Other Cardiovascular Impairments

1. *How will we evaluate hypertension?* Because *hypertension* (high blood pressure) generally causes disability through its effects on other body systems, we will evaluate it by reference to the specific body system(s) affected (heart, brain, kidneys, or eyes) when we consider its effects under the listings. We will also consider any limitations imposed by your hypertension when we assess your residual functional capacity.

2. *How will we evaluate symptomatic congenital heart disease? Congenital heart disease* is any abnormality of the heart or the major blood vessels that is present at birth. Because of improved treatment methods, more children with congenital heart disease are living to adulthood. Although some types of congenital heart disease may be corrected by surgery, many individuals with treated congenital heart disease continue to have problems throughout their lives (symptomatic congenital heart disease). If you have congenital heart disease that results in chronic heart failure with evidence of ventricular dysfunction or in recurrent arrhythmias, we will evaluate your impairment under 4.02 or 4.05. Otherwise, we will evaluate your impairment under 4.06.

3. *What is cardiomyopathy and how will we evaluate it? Cardiomyopathy* is a disease of the heart muscle. The heart loses its ability to pump blood (heart failure), and in some instances, heart rhythm is disturbed, leading to irregular heartbeats (arrhythmias). Usually, the exact cause of the muscle damage is never found (idiopathic cardiomyopathy). There are various types of cardiomyopathy, which fall into two major categories: *Ischemic* and *nonischemic* cardiomyopathy. Ischemic cardiomyopathy typically refers to heart muscle damage that results from coronary artery disease, including heart attacks. Nonischemic cardiomyopathy includes several types: Dilated, hypertrophic, and restrictive. We will evaluate cardiomyopathy under 4.02, 4.04, 4.05, or 11.04, depending on its effects on you.

4. *How will we evaluate valvular heart disease?* We will evaluate valvular heart disease under the listing appropriate for its effect on you. Thus, we may use 4.02, 4.04, 4.05, 4.06, or an appropriate neurological listing in 11.00ff.

5. *What do we consider when we evaluate heart transplant recipients?*

a. After your heart transplant, we will consider you disabled for 1 year following the surgery because there is a greater likelihood of rejection of the organ and infection during the first year.

b. However, heart transplant patients generally meet our definition of disability before they undergo transplantation. We will determine the onset of your disability based on the facts in your case.

c. We will not assume that you became disabled when your name was placed on a transplant waiting list. This is because you may be placed on a waiting list soon after diagnosis of the cardiac disorder that may eventually require a transplant. Physicians recognize that candidates for transplantation often have to wait months or even years before a suitable donor heart is found, so they place their patients on the list as soon as permitted.

d. When we do a continuing disability review to determine whether you are still disabled, we will evaluate your residual impairment(s), as shown by symptoms, signs, and laboratory findings, including any side effects of medication. We will consider any remaining symptoms, signs, and laboratory findings indicative of cardiac dysfunction in deciding whether medical improvement (as defined in §§404.1594 and 416.994) has occurred.

6. *When does an aneurysm have ''dissection not controlled by prescribed treatment,'' as required under 4.10?* An aneurysm (or bulge in the aorta or one of its major branches) is *dissecting* when the inner lining of the artery begins to separate from the arterial wall. We consider the dissection not controlled when you have persistence of chest pain due to progression of the dissection, an increase in the size of the aneurysm, or compression of one or more branches of the aorta supplying the heart, kidneys, brain, or other organs. An aneurysm with dissection can cause heart failure, renal (kidney) failure, or neurological complications. If you have an aneurysm that does not meet the requirements of 4.10 and you have one or more of these associated conditions, we will evaluate the condition(s) using the appropriate listing.

7. *What is hyperlipidemia and how will we evaluate it? Hyperlipidemia* is the general term for an elevation of any or all of the lipids (fats or cholesterol) in the blood; for example, hypertriglyceridemia, hypercholesterolemia, and hyperlipoproteinemia. These disorders of lipoprotein metabolism and transport can cause defects throughout the body. The effects most likely to interfere with function are those produced by atherosclerosis (narrowing of the arteries) and coronary artery

disease. We will evaluate your lipoprotein disorder by considering its effects on you.

8. *What is Marfan syndrome and how will we evaluate it?*

a. Marfan syndrome is a genetic connective tissue disorder that affects multiple body systems, including the skeleton, eyes, heart, blood vessels, nervous system, skin, and lungs. There is no specific laboratory test to diagnose Marfan syndrome. The diagnosis is generally made by medical history, including family history, physical examination, including an evaluation of the ratio of arm/leg size to trunk size, a slit lamp eye examination, and a heart test(s), such as an echocardiogram. In some cases, a genetic analysis may be useful, but such analyses may not provide any additional helpful information.

b. The effects of Marfan syndrome can range from mild to severe. In most cases, the disorder progresses as you age. Most individuals with Marfan syndrome have abnormalities associated with the heart and blood vessels. Your heart's mitral valve may leak, causing a heart murmur. Small leaks may not cause symptoms, but larger ones may cause shortness of breath, fatigue, and palpitations. Another effect is that the wall of the aorta may be weakened and abnormally stretch (aortic dilation). This aortic dilation may tear, dissect, or rupture, causing serious heart problems or sometimes sudden death. We will evaluate the manifestations of your Marfan syndrome under the appropriate body system criteria, such as 4.10, or if necessary, consider the functional limitations imposed by your impairment.

I. Other Evaluation Issues

1. *What effect does obesity have on the cardiovascular system and how will we evaluate it?* Obesity is a medically determinable impairment that is often associated with disorders of the cardiovascular system. Disturbance of this system can be a major cause of disability if you have obesity. Obesity may affect the cardiovascular system because of the increased workload the additional body mass places on the heart. Obesity may make it harder for the chest and lungs to expand. This can mean that the respiratory system must work harder to provide needed oxygen. This in turn would make the heart work harder to pump blood to carry oxygen to the body. Because the body would be working harder at rest, its ability to perform additional work would be less than would otherwise be expected. Thus, the combined effects of obesity with cardiovascular impairments can be greater than the effects of each of the impairments considered separately. We must consider any additional and cumulative effects of obesity when we determine whether you have a severe cardiovascular impairment or a listing-level cardiovascular impairment (or a combination of impairments that medically equals the severity of a listed impairment), and when we assess your residual functional capacity.

2. *How do we relate treatment to functional status?* In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The amount of function restored and the time required for improvement after treatment (medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, we may need to defer evaluation of the impairment for a period of up to 3 months from the date treatment began to permit consideration of treatment effects, unless we can make a determination or decision using the evidence we have. See 4.00B4.

3. *How do we evaluate impairments that do not meet one of the cardiovascular listings?*

a. These listings are only examples of common cardiovascular impairments that we consider severe enough to prevent you from doing any gainful activity. If your severe impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

b. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairments(s) medically equals a listing. (See §§ 404.1526 and 416.926.) If you have a severe impairment(s) that does not meet or medically equal the criteria of a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. Therefore, we proceed to the fourth and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. If you are an adult, we use the rules in §§ 404.1594 or 416.994, as appropriate, when we decide whether you continue to be disabled.

4.01 Category of Impairments, Cardiovascular System

4.02 *Chronic heart failure* while on a regimen of prescribed treatment, with symptoms and signs described in 4.00D2. The required level of severity for this impairment is met when the requirements in *both A and B* are satisfied.

A. Medically documented presence of one of the following:

1. Systolic failure (see 4.00D1a(i)), with left ventricular end diastolic dimensions greater than 6.0 cm or ejection fraction of 30 percent or less during a period of stability (not during an episode of acute heart failure); or

2. Diastolic failure (see 4.00D1a(ii)), with left ventricular posterior wall plus septal

thickness totaling 2.5 cm or greater on imaging, with an enlarged left atrium greater than or equal to 4.5 cm, with normal or elevated ejection fraction during a period of stability (not during an episode of acute heart failure);

AND

B. Resulting in one of the following:

1. Persistent symptoms of heart failure which very seriously limit the ability to independently initiate, sustain, or complete activities of daily living in an individual for whom an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that the performance of an exercise test would present a significant risk to the individual; or

2. Three or more separate episodes of acute congestive heart failure within a consecutive 12-month period (see 4.00A3e), with evidence of fluid retention (see 4.00D2b(ii)) from clinical and imaging assessments at the time of the episodes, requiring acute extended physician intervention such as hospitalization or emergency room treatment for 12 hours or more, separated by periods of stabilization (see 4.00D4c); or

3. Inability to perform on an exercise tolerance test at a workload equivalent to 5 METs or less due to:

a. Dyspnea, fatigue, palpitations, or chest discomfort; or

b. Three or more consecutive premature ventricular contractions (ventricular tachycardia), or increasing frequency of ventricular ectopy with at least 6 premature ventricular contractions per minute; or

c. Decrease of 10 mm Hg or more in systolic pressure below the baseline systolic blood pressure or the preceding systolic pressure measured during exercise (see 4.00D4d) due to left ventricular dysfunction, despite an increase in workload; or

d. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion.

4.04 *Ischemic heart disease*, with symptoms due to myocardial ischemia, as described in 4.00E3–4.00E7, while on a regimen of prescribed treatment (see 4.00B3 if there is no regimen of prescribed treatment), with one of the following:

A. Sign-or symptom-limited exercise tolerance test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

1. Horizontal or downsloping depression, in the absence of digitalis glycoside treatment or hypokalemia, of the ST segment of at least −0.10 millivolts (−1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead other than aVR, and depression of at least −0.10 millivolts lasting for at least 1 minute of recovery; or

2. At least 0.1 millivolt (1 mm) ST elevation above resting baseline in non-infarct leads during both exercise and 1 or more minutes of recovery; or

3. Decrease of 10 mm Hg or more in systolic pressure below the baseline blood pressure or the preceding systolic pressure measured during exercise (see 4.00E9e) due to left ventricular dysfunction, despite an increase in workload; or

4. Documented ischemia at an exercise level equivalent to 5 METs or less on appropriate medically acceptable imaging, such as radionuclide perfusion scans or stress echocardiography.

OR

B. Three separate ischemic episodes, each requiring revascularization or not amenable to revascularization (see 4.00E9f), within a consecutive 12-month period (see 4.00A3e).

OR

C. Coronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation) or other appropriate medically acceptable imaging, and in the absence of a timely exercise tolerance test or a timely normal drug-induced stress test, an MC, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise tolerance testing would present a significant risk to the individual, with both 1 and 2:

1. Angiographic evidence showing:

a. 50 percent or more narrowing of a nonbypassed left main coronary artery; or

b. 70 percent or more narrowing of another nonbypassed coronary artery; or

c. 50 percent or more narrowing involving a long (greater than 1 cm) segment of a nonbypassed coronary artery; or

d. 50 percent or more narrowing of at least two nonbypassed coronary arteries; or

e. 70 percent or more narrowing of a bypass graft vessel; and

2. Resulting in very serious limitations in the ability to independently initiate, sustain, or complete activities of daily living.

4.05 *Recurrent arrhythmias*, not related to reversible causes, such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled (see 4.00A3f), recurrent (see 4.00A3c) episodes of cardiac syncope or near syncope (see 4.00F3b), despite prescribed treatment (see 4.00B3 if there is no prescribed treatment), and documented by resting or ambulatory (Holter) electrocardiography, or by other appropriate medically acceptable testing, coincident with the occurrence of syncope or near syncope (see 4.00F3c).

4.06 *Symptomatic congenital heart disease* (cyanotic or acyanotic), documented by appropriate medically acceptable imaging (see 4.00A3d) or cardiac catheterization, with one of the following:

A. Cyanosis at rest, and:

1. Hematocrit of 55 percent or greater; or

2. Arterial O_2 saturation of less than 90 percent in room air, or resting arterial PO_2 of 60 Torr or less.

OR

B. Intermittent right-to-left shunting resulting in cyanosis on exertion (e.g., Eisenmenger's physiology) and with arterial PO_2 of 60 Torr or less at a workload equivalent to 5 METs or less.

OR

C. Secondary pulmonary vascular obstructive disease with pulmonary arterial systolic pressure elevated to at least 70 percent of the systemic arterial systolic pressure.

4.09 *Heart transplant.* Consider under a disability for 1 year following surgery; thereafter, evaluate residual impairment under the appropriate listing.

4.10 *Aneurysm of aorta or major branches*, due to any cause (e.g., atherosclerosis, cystic medial necrosis, Marfan syndrome, trauma), demonstrated by appropriate medically acceptable imaging, with dissection not controlled by prescribed treatment (see 4.00H6).

4.11 *Chronic venous insufficiency* of a lower extremity with incompetency or obstruction of the deep venous system and one of the following:

A. Extensive brawny edema (see 4.00G3) involving at least two-thirds of the leg between the ankle and knee or the distal one-third of the lower extremity between the ankle and hip.

OR

B. Superficial varicosities, stasis dermatitis, and either recurrent ulceration or persistent ulceration that has not healed following at least 3 months of prescribed treatment.

4.12 *Peripheral arterial disease*, as determined by appropriate medically acceptable imaging (see 4.00A3d, 4.00G2, 4.00G5, and 4.00G6), causing intermittent claudication (see 4.00G1) and one of the following:

A. Resting ankle/brachial systolic blood pressure ratio of less than 0.50.

OR

B. Decrease in systolic blood pressure at the ankle on exercise (see 4.00G7a and 4.00C16–4.00C17) of 50 percent or more of pre-exercise level and requiring 10 minutes or more to return to pre-exercise level.

OR

C. Resting toe systolic pressure of less than 30 mm Hg (see 4.00G7c and 4.00G8).

OR

D. Resting toe/brachial systolic blood pressure ratio of less than 0.40 (see 4.00G7c).

5.00 Digestive Disorders

A. *Which digestive disorders do we evaluate in this body system?* We evaluate digestive disorders that result in severe dysfunction of the liver, pancreas, and gastrointestinal tract (the large, muscular tube that extends from the mouth to the anus, where the movement of muscles, along with the release of hormones and enzymes, allows for the digestion of food) in this body system. Examples of these disorders and the listings we use to evaluate them include chronic liver disease (5.05), inflammatory bowel disease (5.06), and intestinal failure (5.07). We also use this body system to evaluate gastrointestinal hemorrhaging from any cause (5.02), weight loss due to any digestive disorder (5.08), liver transplantation (5.09), small intestine transplantation (5.11), and pancreas transplantation (5.12). We evaluate cancers affecting the digestive system under the listings in 13.00.

B. *What evidence do we need to evaluate your digestive disorder?*

1. *General.* To establish that you have a digestive disorder, we need medical evidence about the existence of your digestive disorder and its severity. Medical evidence should include your medical history, physical examination findings, operative reports, and relevant laboratory findings.

2. *Laboratory findings.* We need laboratory reports such as results of imaging (see 5.00B3), endoscopy, and other diagnostic procedures. We may also need clinical laboratory and pathology results.

3. *Imaging* refers to medical imaging techniques, such as x-ray, ultrasound, magnetic resonance imaging, and computerized tomography. The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as a proper technique to support the evaluation of the disorder.

C. *What is chronic liver disease (CLD), and how do we evaluate it under 5.05?*

1. *General.* CLD is loss of liver function with cell necrosis (cell death), inflammation, or scarring of the liver that persists for more than 6 months. Common causes of CLD in adults include chronic infection with hepatitis B virus or hepatitis C virus, and prolonged alcohol abuse.

a. We will evaluate your signs of CLD, such as jaundice, changes in size of the liver and spleen, ascites, peripheral edema, and altered mental status. We will also evaluate your symptoms of CLD, such as pruritus (itching), fatigue, nausea, loss of appetite, and sleep disturbances when we assess the severity of your impairment(s) and how it affects your ability to function. In the absence of evidence of a chronic liver impairment, episodes of acute liver disease do not meet the requirements of 5.05.

b. *Laboratory findings* of your CLD may include decreased serum albumin, increased International Normalized Ratio (INR), arterial deoxygenation (hypoxemia), increased serum creatinine, oliguria (reduced urine output), or sodium retention. Another laboratory finding that may be included in the

evidence is a liver biopsy. If you have had a liver biopsy, we will make every reasonable effort to obtain the results; however, we will not purchase a liver biopsy.

2. *Manifestations of CLD.*

a. *Gastrointestinal hemorrhaging* (5.05A), as a consequence of cirrhosis and high pressure in the liver's portal venous system, may occur from varices (dilated veins in the esophagus or the stomach) or from portal hypertensive gastropathy (abnormal mucosal changes in the stomach). When gastrointestinal hemorrhaging is due to a cause other than CLD, we evaluate it under 5.02. The phrase ''consider under a disability for 1 year'' in 5.02 and 5.05A does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling. We determine the onset of your disability based on the facts of your case.

b. *Ascites or hydrothorax* (5.05B) is a pathologic accumulation of fluid in the peritoneal cavity (ascites) or pleural space (hydrothorax). Ascites or hydrothorax may be diagnosed by removing some of the fluid with needle aspiration (paracentesis or thoracentesis), physical examination, or imaging. The most common causes of ascites are portal hypertension and low serum albumin resulting from CLD. We evaluate other causes of ascites and hydrothorax that are unrelated to CLD, such as congestive heart failure and cancer, under the listings in the affected body systems.

c. *Spontaneous bacterial peritonitis (SBP)* (5.05C) is an acute bacterial infection of peritoneal fluid and is most commonly associated with CLD. SBP is diagnosed by laboratory analysis of peritoneal fluid (obtained by paracentesis) that contains a neutrophil count (also called absolute neutrophil count) of at least 250 cells/mm^3. 5.05C is satisfied with one evaluation documenting peritoneal infection. We evaluate other causes of peritonitis that are unrelated to CLD, such as tuberculosis, malignancy, and perforated bowel, under the listings in the affected body systems.

d. *Hepatorenal syndrome* (5.05D) is renal failure associated with CLD in the absence of underlying kidney pathology. Findings associated with hepatorenal syndrome include elevation of serum creatinine, sodium retention with low urinary sodium excretion, and oliguria. We evaluate renal dysfunction with known underlying kidney pathology, such as glomerulonephritis, tubular necrosis, and renal infections, under the listings in 6.00.

e. *Hepatopulmonary syndrome* (5.05E) is arterial deoxygenation due to intrapulmonary vascular dilation and arteriovenous shunting associated with CLD. Clinical findings of hepatopulmonary syndrome include platypnea (shortness of breath relieved when lying down) and orthodeoxia (low arterial blood oxygen while in the upright position), when presenting in the context of CLD. We evaluate pulmonary dysfunction with known underlying respiratory pathology, such as asthma, pneumonia, and pulmonary infections, under the listings in 3.00.

(i) Under 5.05E1, we require a resting arterial blood gas (ABG) measurement obtained while you are breathing room air; that is, without oxygen supplementation. The ABG report must include the P_aO_2 value, your name, the date of the test, and either the altitude or both the city and State of the test site.

(ii) We will not purchase the specialized imaging techniques described in 5.05E2; however, if you have had the test(s) at a time relevant to your claim, we will make every reasonable effort to obtain the report.

f. *Hepatic encephalopathy* (5.05F), also known as portosystemic encephalopathy, is a recurrent or chronic neuropsychiatric disorder associated with CLD.

(i) Under 5.05F2, we require documentation of a mental impairment associated with hepatic encephalopathy. A mental impairment can include abnormal behavior, changes in mental status, or an altered state of consciousness. Reports of abnormal behavior may show that you are experiencing delusions, paranoia, or hallucinations. Reports of changes in mental status may show change in sleep patterns, personality or mood changes, poor concentration, or poor judgment or cognitive dysfunction (for example, impaired memory, poor problem-solving ability, or attention deficits). Reports of altered state of consciousness may show that you are experiencing confusion, delirium, or stupor.

(ii) Signs and laboratory findings that document the severity of hepatic encephalopathy when not attributable to other causes may include a ''flapping tremor'' (asterixis), characteristic abnormalities found on an electroencephalogram (EEG), or abnormal serum albumin or coagulation values. We will not purchase an EEG; however, if you have had this test at a time relevant to your claim, we will make every reasonable effort to obtain the report for the purpose of establishing whether your impairment meets the criteria of 5.05F.

(iii) We will not evaluate acute encephalopathy under 5.05F if it results from conditions other than CLD. For example, we will evaluate acute encephalopathy caused by vascular events under the listings in 11.00 and acute encephalopathy caused by cancer under the listings in 13.00.

3. *SSA Chronic Liver Disease (SSA CLD) score* (5.05G). Listing 5.05G requires two SSA CLD scores, each requiring three or four laboratory values. The ''date of the SSA CLD score'' is the date of the earliest of the three or four laboratory values used for its calculation. The date of the second SSA CLD

score must be at least 60 days after the date of the first SSA CLD score and both scores must be within the required 12-month period. If you have the two SSA CLD scores required by 5.05G, we will find that your impairment meets the criteria of the listing from at least the date of the first SSA CLD score.

a. We calculate the SSA CLD score using a formula that includes up to four laboratory values: Serum creatinine (mg/dL), total bilirubin (mg/dL), INR, and under certain conditions, serum sodium (mmol/L). The SSA CLD score calculation contains at least one, and sometimes two, parts, as described in (i) and (ii).

(i) The initial calculation is:

$SSA\ CLD_i =$
$9.57 \times [\log_e(\text{serum creatinine mg/dL})]$
$+ 3.78 \times [\log_e(\text{serum total bilirubin mg/dL})]$
$+11.2 \times [\log_e(\text{INR})]$
$+ 6.43$
rounded to the nearest whole integer.

(ii) If the value from the initial calculation is 11 or below, the SSA CLD score will be the $SSA\ CLD_i$ value. If the value from the initial calculation is greater than 11, the SSA CLD score will be re-calculated as:

$SSA\ CLD =$
$SSA\ CLD_i$
$+ 1.32 \times (137 - \text{serum sodium mmol/L})$
$-[0.033 \times SSA\ CLD_i \times (137 - \text{serum sodium mmol/L})]$

(iii) We round the results of your SSA CLD score calculation to the nearest whole integer to arrive at your SSA CLD score.

b. For any SSA CLD score calculation, all of the required laboratory values (serum creatinine, serum total bilirubin, INR, and serum sodium) must have been obtained within a continuous 30-day period.

(i) We round values for serum creatinine (mg/dL), serum total bilirubin (mg/dL), or INR less than 1.0 up to 1.0 to calculate your SSA CLD score.

(ii) We round values for serum creatinine (mg/dL) greater than 4.0 down to 4.0 to calculate your SSA CLD score.

(iii) If there are multiple laboratory values within the 30-day interval for serum creatinine (mg/dL), serum total bilirubin (mg/dL), or INR, we use the *highest* value to calculate your SSA CLD score. We will not use any INR values derived from testing done while you are on anticoagulant treatment in our SSA CLD calculation.

(iv) If there are multiple laboratory values within the 30-day interval for serum sodium (mmol/L), we use the *lowest* value to calculate your SSA CLD score.

(v) If you are in renal failure or on renal dialysis within a week of any serum creatinine test in the period used for the SSA CLD calculation, we will use a serum creatinine value of 4.0, which is the maximum serum creatinine level allowed in the calculation, to calculate your SSA CLD score.

(vi) If your serum sodium is less than 125 mmol/L, we will set your serum sodium to 125 mmol/L for purposes of calculation of the SSA CLD score. If your serum sodium is higher than 137 mmol/L, we will set your serum sodium to 137 mmol/L for purposes of calculation of the SSA CLD score.

c. When we indicate ''$\log_e$'' (also abbreviated ''ln'') in the formula for the SSA CLD score calculation, we mean the ''base e logarithm'' or ''natural logarithm'' of the numerical laboratory value, not the ''base 10 logarithm'' or ''common logarithm'' (log) of the laboratory value, and not the actual laboratory value. For example, if a person has laboratory values of serum creatinine 1.4 mg/dL, serum total bilirubin 1.3 mg/dL, INR 1.32, and serum sodium 119 mmol/L, we compute the SSA CLD score as follows:

$SSA\ CLD_i =$
$9.57 \times [\log_e(\text{serum creatinine 1.4 mg/dL}) = 0.336]$
$+ 3.78 \times [\log_e(\text{serum total bilirubin 1.3 mg/dL}) = 0.262]$
$+ 11.2 \times [\log_e(\text{INR 1.32}) = .278]$
$+ 6.43$
$= 3.22 + 0.99 + 3.11 + 6.43$
$= 13.75$, which we round to an $SSA\ CLD_i$ score of 14.

Because the $SSA\ CLD_i$ score is over 11, we then move to the second step of calculating the SSA CLD:

$SSA\ CLD = 14$
$+ 1.32 \times (137 - \text{serum sodium 125 mmol/L})$
$-[0.033 \times SSA\ CLD_i\ 14 \times (137 - \text{serum sodium 125 mmol/L})$
$= 14 + 15.84 - 5.54$
$= 24.3$, which we round to an SSA CLD score of 24.

D. *What is inflammatory bowel disease (IBD), and how do we evaluate it under 5.06?*

1. IBD is a group of inflammatory conditions of the small intestine and colon. The most common IBD disorders are Crohn's disease and ulcerative colitis. Remissions and exacerbations of variable duration are a hallmark of IBD.

2. We evaluate your signs and symptoms of IBD, such as diarrhea, fecal incontinence, rectal bleeding, abdominal pain, fatigue, fever, nausea, vomiting, arthralgia, abdominal tenderness, palpable abdominal mass (usually inflamed loops of bowel), and perianal disease (for example, fissure, fistulas, abscesses, or anal canal stenosis), when we assess the severity of your impairment(s). You may require supplemental daily nutrition due to IBD. There are two forms of supplemental daily nutrition we consider under 5.06B5: enteral nutrition (delivered directly to a part of your digestive system) via a gastrostomy, duodenostomy, or jejunostomy, and parenteral nutrition delivered via a central venous catheter. Enteral tube feedings delivered via nasal or

oral tubes do not satisfy the requirement in 5.06B5.

3. Surgical diversion of the intestinal tract, including ileostomy and colostomy, does not preclude the ability to perform any gainful activity if you are able to maintain adequate nutrition and function of the stoma. However, if you are not able to maintain adequate nutrition, we will evaluate your impairment under 5.08.

4. IBD may also be associated with significant extraintestinal manifestations in a variety of body systems. These include, but are not limited to, involvement of the eye (for example, uveitis, episcleritis, or iritis); hepatobiliary disease (for example, gallstones or primary sclerosing cholangitis); urologic disease (for example, kidney stones or obstructive hydronephrosis); skin involvement (for example, erythema nodosum or pyoderma gangrenosum); or non-destructive inflammatory arthritis. You may also have associated thromboembolic disorders or vascular disease. These manifestations may not correlate with the severity of your IBD. If your impairment does not meet any of the criteria of 5.06, we will consider the effects of your extraintestinal manifestations in determining whether you have an impairment(s) that meets or medically equals another listing, and when we assess your residual functional capacity.

5. *Repeated complications of IBD.*

a. Examples of complications of IBD include abscesses, intestinal perforation, toxic megacolon, infectious colitis, pyoderma gangrenosum, ureteral obstruction, primary sclerosing cholangitis, and hypercoagulable state (which may lead to thromboses or embolism). When we evaluate repeated complications of IBD, we consider all relevant information in your case record to determine the effects of your IBD on your ability to function independently, appropriately, effectively, and on a sustained basis. Factors we consider include, but are not limited to: your symptoms, the frequency and duration of your complications, periods of exacerbation and remission, and the functional effects of your treatment, including the side effects of your medication. Your impairment will satisfy this criterion regardless of whether you have the same kind of complication repeatedly, all different complications, or any other combination of complications; for example, two of the same kind of complication and a different one.

b. To satisfy the requirements described under 5.06C, your IBD must result in repeated complications and marked limitation in one of three areas of functioning: activities of daily living; maintaining social functioning; or completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace. If the complications do not last as long or occur as frequently as required under 5.06C, we will consider whether your IBD medically equals the listing.

c. *Marked* limitation means that the signs and symptoms of your IBD interfere *seriously* with your ability to function. Although we do not require the use of such a scale, ''marked'' would be the fourth point on a five-point rating scale consisting of no limitation, mild limitation, moderate limitation, marked limitation, and extreme limitation. We do not define ''marked'' by a specific number of activities of daily living or different behaviors in which your social functioning is impaired, or a specific number of tasks that you are able to complete, but by the nature and overall degree of interference with your functioning. You may have marked limitation when several activities or functions are impaired, or when only one is impaired. Additionally, you need not be totally precluded from performing an activity to have marked limitation, as long as the degree of limitation interferes seriously with your ability to function independently, appropriately, and effectively. The term ''marked'' does not imply that you must be confined to bed, hospitalized, or in a nursing home.

d. *Activities of daily living* include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, or paying bills. We will find that you have ''marked'' limitation in activities of daily living if you have a serious limitation in your ability to maintain a household or take public transportation because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your IBD (including complications of the disorder) or its treatment, even if you are able to perform some self-care activities.

e. *Maintaining social functioning* includes the capacity to interact independently, appropriately, effectively, and on a sustained basis with others. It includes the ability to communicate effectively with others. We will find that you have ''marked'' limitation in maintaining social functioning if you have a serious limitation in social interaction on a sustained basis because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, or a pattern of exacerbation and remission, caused by your IBD (including complications of the disorder) or its treatment, even if you are able to communicate with close friends or relatives.

f. *Completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace* involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings. We will find that you have ''marked'' limitation in completing tasks if you have a serious limitation in your ability to sustain concentration or pace adequate to complete work-related tasks because of

symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your IBD (including complications of the disorder) or its treatment, even if you are able to do some routine activities of daily living.

E. *What is intestinal failure, and how do we evaluate it under 5.07?*

1. *Intestinal failure* is a condition resulting in gut function below the minimum necessary for the absorption of macronutrients or water and electrolytes, resulting in a requirement for intravenous supplementation (*i.e.*, parenteral nutrition) to maintain health. Examples of conditions that may result in intestinal failure include short bowel syndrome, extensive small bowel mucosal disease, and chronic motility disorders.

2. *Short bowel syndrome* is a malabsorption disorder that occurs when ischemic vascular insults (caused, for example, by volvulus or necrotizing enterocolitis), trauma, or IBD complications require(s) surgical resection of any amount of the small intestine, resulting in chronic malnutrition.

3. *Extensive small bowel mucosal disease* means that the mucosal surface of the small bowel does not efficiently absorb nutrients or loses nutrients. Common causes of small bowel mucosal disease include microvillous inclusion disease and tufting enteropathy.

4. *Chronic motility disorder* refers to a chronic disorder of the propulsion of gut content without fixed obstructions, causing intolerance to oral nutrition and inadequate nutritional intake. This type of disorder may also be known as a chronic intestinal pseudo-obstruction (CIPO), because the gut dysfunction mimics that of an obstructed intestine, but without evidence of an actual obstruction. Primary CIPO may have an unknown underlying cause. Chronic motility disorders may also result from congenital, neuromuscular, or autoimmune conditions, such as gastroschisis, omphalocele, long segment Hirschprung's disease, Crohn's disease, and mitochondrial disorders.

5. For short bowel syndrome, we require a copy of the operative report that includes details of the surgical findings, or postoperative imaging indicating a resection of the small intestine. If we cannot get one of these reports, we need other medical reports that include details of the surgical findings. For other chronic motility disorders or extensive small bowel mucosal disease, we need medical reports that include details of your intestinal dysfunction. For any impairment evaluated under 5.07, we also need medical documentation that you are dependent on daily parenteral nutrition to provide most of your nutritional requirements.

F. *How do we evaluate weight loss due to any digestive disorder under 5.08?*

1. In addition to the impairments specifically mentioned in these listings, other digestive disorders, such as esophageal stricture, pancreatic insufficiency, and malabsorption, may result in significant weight loss. Impairments other than digestive disorders that cause weight loss should be evaluated under the appropriate body system for that impairment. For instance, weight loss as a result of chronic kidney disease should be evaluated under our rules for genitourinary disorders (see 6.00), and weight loss as the result of an eating disorder should be evaluated under our rules for mental disorders (see 12.00). However, if you develop a digestive disorder as the result of your other impairment, we will evaluate the acquired digestive disorder under our rules for digestive disorders. We evaluate weight loss due to any digestive disorder under 5.08 by using the body mass index (BMI).

2. BMI is the ratio of your weight to the square of your height. Calculation and interpretation of the BMI are independent of gender in adults.

a. We calculate BMI using inches and pounds, meters and kilograms, or centimeters and kilograms. We must have measurements of your weight and height without shoes for these calculations.

b. We calculate BMI using one of the following formulas:

English Formula

BMI = [Weight in Pounds/(Height in Inches × Height in Inches)] × 703

Metric Formulas

BMI = Weight in Kilograms/(Height in Meters × Height in Meters)

BMI = [Weight in Kilograms/(Height in Centimeters × Height in Centimeters)] × 10,000

G. *How do we evaluate digestive organ transplantation?* If you receive a liver (5.09), small intestine (5.11), or pancreas (5.12) transplant, we will consider you disabled under the listing for 1 year from the date of the transplant. After that, we evaluate your residual impairment(s) by considering the adequacy of your post-transplant function, the frequency and severity of any rejection episodes you have, complications in other body systems, and adverse treatment effects. People who receive digestive organ transplants generally have impairments that meet our definition of disability before they undergo transplantation. The phrase ''consider under a disability for 1 year'' in 5.09, 5.11, and 5.12 does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling. We determine the onset of your disability based on the facts of your case.

H. *How do we evaluate your digestive disorder if there is no record of ongoing treatment?* If there is no record of ongoing treatment despite the existence of a severe impairment(s), we will assess the severity and duration of your digestive disorder based on the current medical and other evidence in your

case record. If there is no record of ongoing treatment, you may not be able to show an impairment that meets a digestive disorders listing, but your impairment may medically equal a listing, or be disabling based on consideration of your residual functional capacity, age, education, and work experience.

I. *How do we evaluate your digestive disorder if there is evidence establishing a substance use disorder?* If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability. See §§404.1535 and 416.935 of this chapter. Digestive disorders resulting from drug or alcohol use are often chronic in nature and will not necessarily improve with cessation in drug or alcohol use.

J. *How do we evaluate digestive disorders that do not meet one of these listings?*

1. These listings are only examples of common digestive disorders that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §§404.1526 and 416.926 of this chapter. Digestive disorders may be associated with disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. We proceed to the fourth step and, if necessary, the fifth step of the sequential evaluation process in §§404.1520 and 416.920 of this chapter. We use the rules in §§404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

5.01 Category of Impairments, Digestive Disorders

5.02 *Gastrointestinal hemorrhaging from any cause, requiring three blood transfusions* of at least 2 units of blood per transfusion, within a consecutive 12-month period and at least 30 days apart. Consider under a disability for 1 year following the last documented transfusion; after that, evaluate the residual impairment(s).

5.03–5.04 [Reserved]

5.05 *Chronic liver disease (CLD)* (see 5.00C) with A, B, C, D, E, F, or G:

A. Hemorrhaging from esophageal, gastric, or ectopic varices, or from portal hypertensive gastropathy (see 5.00C2a), documented by imaging (see 5.00B3); resulting in 1 and 2:

1. Hemodynamic instability indicated by signs such as pallor (pale skin), diaphoresis (profuse perspiration), rapid pulse, low blood pressure, postural hypotension (pronounced fall in blood pressure when arising to an upright position from lying down), or syncope (fainting); and

2. Requiring hospitalization for transfusion of at least 2 units of blood. Consider under a disability for 1 year following the documented transfusion; after that, evaluate the residual impairment(s).

OR

B. Ascites or hydrothorax not attributable to other causes (see 5.00C2b), present on two evaluations within a consecutive 12-month period and at least 60 days apart. Each evaluation must document the ascites or hydrothorax by 1, 2, or 3:

1. Paracentesis; or

2. Thoracentesis; or

3. Imaging or physical examination with a or b:

a. Serum albumin of 3.0 g/dL or less; or

b. INR of at least 1.5.

OR

C. Spontaneous bacterial peritonitis (see 5.00C2c) documented by peritoneal fluid containing a neutrophil count of at least 250 cells/mm^3.

OR

D. Hepatorenal syndrome (see 5.00C2d) documented by 1, 2, or 3:

1. Serum creatinine elevation of at least 2 mg/dL; or

2. Oliguria with 24-hour urine output less than 500 mL; or

3. Sodium retention with urine sodium less than 10 mEq per liter.

OR

E. Hepatopulmonary syndrome (see 5.00C2e) documented by 1 or 2:

1. Arterial P_aO_2 measured by an ABG test, while at rest, breathing room air, less than or equal to:

a. 60 mm Hg, at test sites less than 3,000 feet above sea level; or

b. 55 mm Hg, at test sites from 3,000 through 6,000 feet above sea level; or

c. 50 mm Hg, at test sites over 6,000 feet above sea level; or

2. Intrapulmonary arteriovenous shunting as shown by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.

OR

F. Hepatic encephalopathy (see 5.00C2f) with documentation of abnormal behavior, cognitive dysfunction, changes in mental

status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on two evaluations within a consecutive 12-month period and at least 60 days apart and either 1 or 2:

1. History of transjugular intrahepatic portosystemic shunt (TIPS) or other surgical portosystemic shunt; or

2. One of the following on at least two evaluations at least 60 days apart within the same consecutive 12-month period as in F:

a. Asterixis or other fluctuating physical neurological abnormalities; or

b. EEG demonstrating triphasic slow wave activity; or

c. Serum albumin of 3.0 g/dL or less; or

d. INR of 1.5 or greater.

OR

G. Two SSA CLD scores (see 5.00C3) of at least 20 within a consecutive 12-month period and at least 60 days apart. Consider under a disability from at least the date of the first score.

5.06 *Inflammatory bowel disease (IBD)* (see 5.00D) documented by endoscopy, biopsy, imaging, or operative findings, *and* demonstrated by A, B, or C:

A. Obstruction of stenotic areas (not adhesions) in the small intestine or colon with proximal dilatation, confirmed by imaging or in surgery, requiring two hospitalizations for intestinal decompression or for surgery, within a consecutive 12-month period and at least 60 days apart.

OR

B. Two of the following occurring within a consecutive 12-month period and at least 60 days apart:

1. Anemia with hemoglobin of less than 10.0 g/dL, present on at least two evaluations at least 60 days apart; or

2. Serum albumin of 3.0 g/dL or less, present on at least two evaluations at least 60 days apart; or

3. Clinically documented tender abdominal mass palpable on physical examination with abdominal pain or cramping; or

4. Perianal disease with a draining abscess or fistula; or

5. Need for supplemental daily enteral nutrition via a gastrostomy, duodenostomy, or jejunostomy, or daily parenteral nutrition via a central venous catheter.

OR

C. Repeated complications of IBD (see 5.00D5a), occurring an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more, within a consecutive 12-month period, and marked limitation (see 5.00D5c) in one of the following:

1. Activities of daily living (see 5.00D5d); or

2. Maintaining social functioning (see 5.00D5e); or

3. Completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace (see 5.00D5f).

5.07 *Intestinal failure* (see 5.00E) due to short bowel syndrome, chronic motility disorders, or extensive small bowel mucosal disease, resulting in dependence on daily parenteral nutrition via a central venous catheter for at least 12 months.

5.08 *Weight loss due to any digestive disorder* (see 5.00F), despite adherence to prescribed medical treatment, with BMI of less than 17.50 calculated on at least two evaluations at least 60 days apart within a consecutive 12-month period.

5.09 *Liver transplantation* (see 5.00G). Consider under a disability for 1 year from the date of the transplant; after that, evaluate the residual impairment(s).

5.10 [Reserved]

5.11 *Small intestine transplantation* (see 5.00G). Consider under a disability for 1 year from the date of the transplant; after that, evaluate the residual impairment(s).

5.12 *Pancreas transplantation* (see 5.00G). Consider under a disability for 1 year from the date of the transplant; after that, evaluate the residual impairment(s).

6.00 GENITOURINARY DISORDERS

A. Which disorders do we evaluate under these listings?

We evaluate genitourinary disorders resulting in chronic kidney disease (CKD). Examples of such disorders include chronic glomerulonephritis, hypertensive nephropathy, diabetic nephropathy, chronic obstructive uropathy, and hereditary nephropathies. We also evaluate nephrotic syndrome due to glomerular dysfunction under these listings.

B. What evidence do we need?

1. We need evidence that documents the signs, symptoms, and laboratory findings of your CKD. This evidence should include reports of clinical examinations, treatment records, and documentation of your response to treatment. Laboratory findings, such as serum creatinine or serum albumin levels, may document your kidney function. We generally need evidence covering a period of at least 90 days unless we can make a fully favorable determination or decision without it.

2. *Estimated glomerular filtration rate (eGFR).* The eGFR is an estimate of the filtering capacity of the kidneys that takes into account serum creatinine concentration and other variables, such as your age, gender, and body size. If your medical evidence includes eGFR findings, we will consider them when we evaluate your CKD under 6.05.

3. *Kidney or bone biopsy.* If you have had a kidney or bone biopsy, we need a copy of the pathology report. When we cannot get a copy of the pathology report, we will accept a

statement from an acceptable medical source verifying that a biopsy was performed and describing the results.

C. What other factors do we consider when we evaluate your genitourinary disorder?

1. *Chronic hemodialysis or peritoneal dialysis.*

a. Dialysis is a treatment for CKD that uses artificial means to remove toxic metabolic byproducts from the blood. Hemodialysis uses an artificial kidney machine to clean waste products from the blood; peritoneal dialysis uses a dialyzing solution that is introduced into and removed from the abdomen (peritoneal cavity) either continuously or intermittently. Under 6.03, your ongoing dialysis must have lasted or be expected to last for a continuous period of at least 12 months. To satisfy the requirements in 6.03, we will accept a report from an acceptable medical source that describes your CKD and your current dialysis, and indicates that your dialysis will be ongoing.

b. If you are undergoing chronic hemodialysis or peritoneal dialysis, your CKD may meet our definition of disability before you started dialysis. We will determine the onset of your disability based on the facts in your case record.

2. *Kidney transplant.*

a. If you receive a kidney transplant, we will consider you to be disabled under 6.04 for 1 year from the date of transplant. After that, we will evaluate your residual impairment(s) by considering your post-transplant function, any rejection episodes you have had, complications in other body systems, and any adverse effects related to ongoing treatment.

b. If you received a kidney transplant, your CKD may meet our definition of disability before you received the transplant. We will determine the onset of your disability based on the facts in your case record.

3. *Renal osteodystrophy.* This condition is the bone degeneration resulting from chronic kidney disease-mineral and bone disorder (CKD–MBD). CKD–MBD occurs when the kidneys are unable to maintain the necessary levels of minerals, hormones, and vitamins required for bone structure and function. Under 6.05B1, ''severe bone pain'' means frequent or intractable (resistant to treatment) bone pain that interferes with physical activity or mental functioning.

4. *Peripheral neuropathy.* This disorder results when the kidneys do not adequately filter toxic substances from the blood. These toxins can adversely affect nerve tissue. The resulting neuropathy may affect peripheral motor or sensory nerves, or both, causing pain, numbness, tingling, and muscle weakness in various parts of the body. Under 6.05B2, the peripheral neuropathy must be a severe impairment. (See §§ 404.1520(c), 404.1521, 416.920(c), and 416.921 of this chapter.) It must also have lasted or be expected to last for a continuous period of at least 12 months.

5. *Fluid overload syndrome.* This condition occurs when excess sodium and water retention in the body due to CKD results in vascular congestion. Under 6.05B3, we need a description of a physical examination that documents signs and symptoms of vascular congestion, such as congestive heart failure, pleural effusion (excess fluid in the chest), ascites (excess fluid in the abdomen), hypertension, fatigue, shortness of breath, or peripheral edema.

6. *Anasarca* (generalized massive edema or swelling). Under 6.05B3 and 6.06B, we need a description of the extent of edema, including pretibial (in front of the tibia), periorbital (around the eyes), or presacral (in front of the sacrum) edema. We also need a description of any ascites, pleural effusion, or pericardial effusion.

7. *Anorexia (diminished appetite) with weight loss.* Anorexia is a frequent sign of CKD and can result in weight loss. We will use body mass index (BMI) to determine the severity of your weight loss under 6.05B4. (BMI is the ratio of your measured weight to the square of your measured height.) We calculate your BMI using the formulas in the digestive disorders body system (5.00).

8. *Complications of CKD.* The hospitalizations in 6.09 may be for different complications of CKD. Examples of complications from CKD that may result in hospitalization include stroke, congestive heart failure, hypertensive crisis, or acute kidney failure requiring a short course of hemodialysis. If the CKD complication occurs during a hospitalization that was initially for a co-occurring condition, we will evaluate it under our rules for determining medical equivalence. (See §§ 404.1526 and 416.926 of this chapter.) We will evaluate co-occurring conditions, including those that result in hospitalizations, under the listings for the affected body system or under our rules for medical equivalence.

D. How do we evaluate disorders that do not meet one of the genitourinary listings?

1. The listed disorders are only examples of common genitourinary disorders that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926 of this chapter.) Genitourinary disorders may be associated with

disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not meet or medically equal the criteria of a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. We proceed to the fourth and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

6.01 Category of Impairments, Genitourinary Disorders

6.03 *Chronic kidney disease,* with chronic hemodialysis or peritoneal dialysis (see 6.00C1).

6.04 *Chronic kidney disease,* with kidney transplant. Consider under a disability for 1 year following the transplant; thereafter, evaluate the residual impairment (see 6.00C2).

6.05 *Chronic kidney disease,* with impairment of kidney function, with A and B:

A. Reduced glomerular filtration evidenced by one of the following laboratory findings documented on at least two occasions at least 90 days apart during a consecutive 12-month period:

1. Serum creatinine of 4 mg/dL or greater; or

2. Creatinine clearance of 20 ml/min. or less; or

3. Estimated glomerular filtration rate (eGFR) of 20 ml/min/1.73m^2 or less.

AND

B. One of the following:

1. Renal osteodystrophy (see 6.00C3) with severe bone pain and imaging studies documenting bone abnormalities, such as osteitis fibrosa, osteomalacia, or pathologic fractures; or

2. Peripheral neuropathy (see 6.00C4); or

3. Fluid overload syndrome (see 6.00C5) documented by one of the following:

a. Diastolic hypertension greater than or equal to diastolic blood pressure of 110 mm Hg despite at least 90 consecutive days of prescribed therapy, documented by at least two measurements of diastolic blood pressure at least 90 days apart during a consecutive 12-month period; or

b. Signs of vascular congestion or anasarca (see 6.00C6) despite at least 90 consecutive days of prescribed therapy, documented on at least two occasions at least 90 days apart during a consecutive 12-month period; or

4. Anorexia with weight loss (see 6.00C7) determined by body mass index (BMI) of 18.0 or less, calculated on at least two occasions at least 90 days apart during a consecutive 12-month period.

6.06 *Nephrotic syndrome,* with A and B:

A. Laboratory findings as described in 1 or 2, documented on at least two occasions at least 90 days apart during a consecutive 12-month period:

1. Proteinuria of 10.0 g or greater per 24 hours; or

2. Serum albumin of 3.0 g/dL or less, and

a. Proteinuria of 3.5 g or greater per 24 hours; or

b. Urine total-protein-to-creatinine ratio of 3.5 or greater.

AND

B. Anasarca (see 6.00C6) persisting for at least 90 days despite prescribed treatment.

6.09 *Complications of chronic kidney disease* (see 6.00C8) requiring at least three hospitalizations within a consecutive 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

7.00 HEMATOLOGICAL DISORDERS

A. What hematological disorders do we evaluate under these listings?

1. We evaluate non-malignant (non-cancerous) hematological disorders, such as hemolytic anemias (7.05), disorders of thrombosis and hemostasis (7.08), and disorders of bone marrow failure (7.10). These disorders disrupt the normal development and function of white blood cells, red blood cells, platelets, and clotting-factor proteins (factors).

2. We evaluate malignant (cancerous) hematological disorders, such as lymphoma, leukemia, and multiple myeloma, under the appropriate listings in 13.00, except for two lymphomas associated with human immunodeficiency virus (HIV) infection. We evaluate primary central nervous system lymphoma associated with HIV infection under 14.11B, and primary effusion lymphoma associated with HIV infection under 14.11C.

B. What evidence do we need to document that you have a hematological disorder?

We need the following evidence to document that you have a hematological disorder:

1. A laboratory report of a definitive test that establishes a hematological disorder, signed by a physician; or

2. A laboratory report of a definitive test that establishes a hematological disorder that is not signed by a physician and a report from a physician that states you have the disorder; or

3. When we do not have a laboratory report of a definitive test, a persuasive report from a physician that a diagnosis of your

hematological disorder was confirmed by appropriate laboratory analysis or other diagnostic method(s). To be persuasive, this report must state that you had the appropriate definitive laboratory test or tests for diagnosing your disorder and provide the results, or explain how your diagnosis was established by other diagnostic method(s) consistent with the prevailing state of medical knowledge and clinical practice.

4. We will make every reasonable effort to obtain the results of appropriate laboratory testing you have had. We will not purchase complex, costly, or invasive tests, such as tests of clotting-factor proteins, and bone marrow aspirations.

C. What are hemolytic anemias, and how do we evaluate them under 7.05?

1. *Hemolytic anemias, both congenital and acquired*, are disorders that result in premature destruction of red blood cells (RBCs). Hemolytic disorders include abnormalities of hemoglobin structure (hemoglobinopathies), abnormal RBC enzyme content and function, and RBC membrane (envelope) defects that are congenital or acquired. The diagnosis of hemolytic anemia is based on hemoglobin electrophoresis or analysis of the contents of the RBC (enzymes) and membrane. Examples of congenital hemolytic anemias include sickle cell disease, thalassemia and their variants, and hereditary spherocytosis. Acquired hemolytic anemias may result from autoimmune disease (for example, systemic lupus erythematosus) or mechanical devices (for example, heart valves, intravascular patches).

2. The hospitalizations in 7.05B do not all have to be for the same complication of the hemolytic anemia. They may be for three different complications of the disorder. Examples of complications of hemolytic anemia that may result in hospitalization include osteomyelitis, painful (vaso-occlusive) crisis, pulmonary infections or infarctions, acute chest syndrome, pulmonary hypertension, chronic heart failure, gallbladder disease, hepatic (liver) failure, renal (kidney) failure, nephrotic syndrome, aplastic crisis, and stroke. We will count the hours you receive emergency treatment in a comprehensive sickle cell disease center immediately before the hospitalization if this treatment is comparable to the treatment provided in a hospital emergency department.

3. For 7.05C, we do not require hemoglobin to be measured during a period in which you are free of pain or other symptoms of your disorder. We will accept hemoglobin measurements made while you are experiencing complications of your hemolytic anemia.

4. 7.05D refers to the most serious type of beta thalassemia major in which the bone marrow cannot produce sufficient numbers of normal RBCs to maintain life. The only available treatments for beta thalassemia major are life-long RBC transfusions (sometimes called hypertransfusion) or bone marrow transplantation. For purposes of 7.05D, we do not consider prophylactic RBC transfusions to prevent strokes or other complications in sickle cell disease and its variants to be of equal significance to life-saving RBC transfusions for beta thalassemia major. However, we will consider the functional limitations associated with prophylactic RBC transfusions and any associated side effects (for example, iron overload) under 7.18 and any affected body system(s). We will also evaluate strokes and resulting complications under 11.00 and 12.00.

D. What are disorders of thrombosis and hemostasis, and how do we evaluate them under 7.08?

1. *Disorders of thrombosis and hemostasis* include both clotting and bleeding disorders, and may be congenital or acquired. These disorders are characterized by abnormalities in blood clotting that result in hypercoagulation (excessive blood clotting) or hypocoagulation (inadequate blood clotting). The diagnosis of a thrombosis or hemostasis disorder is based on evaluation of plasma clotting-factor proteins (factors) and platelets. Protein C or protein S deficiency and Factor V Leiden are examples of hypercoagulation disorders. Hemophilia, von Willebrand disease, and thrombocytopenia are examples of hypocoagulation disorders. Acquired excessive blood clotting may result from blood protein defects and acquired inadequate blood clotting (for example, acquired hemophilia A) may be associated with inhibitor autoantibodies.

2. The hospitalizations in 7.08 do not all have to be for the same complication of a disorder of thrombosis and hemostasis. They may be for three different complications of the disorder. Examples of complications that may result in hospitalization include anemias, thromboses, embolisms, and uncontrolled bleeding requiring multiple factor concentrate infusions or platelet transfusions. We will also consider any surgery that you have, even if it is not related to your hematological disorder, to be a complication of your disorder of thrombosis and hemostasis if you require treatment with clotting-factor proteins (for example, factor VIII or factor IX) or anticoagulant medication to control bleeding or coagulation in connection with your surgery. We will count the hours you receive emergency treatment in a comprehensive hemophilia treatment center immediately before the hospitalization if this treatment is comparable to the treatment provided in a hospital emergency department.

E. What are disorders of bone marrow failure, and how do we evaluate them under 7.10?

1. *Disorders of bone marrow failure* may be congenital or acquired, characterized by bone marrow that does not make enough healthy RBCs, platelets, or granulocytes (specialized types of white blood cells); there may also be a combined failure of these bone marrow-produced cells. The diagnosis is based on peripheral blood smears and bone marrow aspiration or bone marrow biopsy, but not peripheral blood smears alone. Examples of these disorders are myelodysplastic syndromes, aplastic anemia, granulocytopenia, and myelofibrosis. Acquired disorders of bone marrow failure may result from viral infections, chemical exposure, or immunologic disorders.

2. The hospitalizations in 7.10A do not all have to be for the same complication of bone marrow failure. They may be for three different complications of the disorder. Examples of complications that may result in hospitalization include uncontrolled bleeding, anemia, and systemic bacterial, viral, or fungal infections.

3. For 7.10B, the requirement of life-long RBC transfusions to maintain life in myelodysplastic syndromes or aplastic anemias has the same meaning as it does for beta thalassemia major. (See 7.00C4.)

F. How do we evaluate bone marrow or stem cell transplantation under 7.17?

We will consider you to be disabled for 12 months from the date of bone marrow or stem cell transplantation, or we may consider you to be disabled for a longer period if you are experiencing any serious post-transplantation complications, such as graft-versus-host (GVH) disease, frequent infections after immunosuppressive therapy, or significant deterioration of organ systems. We do not restrict our determination of the onset of disability to the date of the transplantation in 7.17. We may establish an earlier onset date of disability due to your transplantation if evidence in your case record supports such a finding.

G. How do we use the functional criteria in 7.18?

1. When we use the functional criteria in 7.18, we consider all relevant information in your case record to determine the impact of your hematological disorder on your ability to function independently, appropriately, effectively, and on a sustained basis in a work setting. Factors we will consider when we evaluate your functioning under 7.18 include, but are not limited to: Your symptoms, the frequency and duration of complications of your hematological disorder, periods of exacerbation and remission, and the functional impact of your treatment, including the side effects of your medication.

2. *Repeated complications* means that the complications occur on an average of three times a year, or once every 4 months, each lasting 2 weeks or more; or the complications do not last for 2 weeks but occur substantially more frequently than three times in a year or once every 4 months; or they occur less frequently than an average of three times a year or once every 4 months but last substantially longer than 2 weeks. Your impairment will satisfy this criterion regardless of whether you have the same kind of complication repeatedly, all different complications, or any other combination of complications; for example, two of the same kind of complication and a different one. You must have the required number of complications with the frequency and duration required in this section. Additionally, the complications must occur within the period we are considering in connection with your application or continuing disability review.

3. To satisfy the functional criteria in 7.18, your hematological disorder must result in a ''marked'' level of limitation in one of three general areas of functioning: Activities of daily living, social functioning, or difficulties in completing tasks due to deficiencies in concentration, persistence, or pace. Functional limitations may result from the impact of the disease process itself on your mental functioning, physical functioning, or both your mental and physical functioning. This limitation could result from persistent or intermittent symptoms, such as pain, severe fatigue, or malaise, resulting in a limitation of your ability to do a task, to concentrate, to persevere at a task, or to perform the task at an acceptable rate of speed. (*Severe fatigue* means a frequent sense of exhaustion that results in significant reduced physical activity or mental function. *Malaise* means frequent feelings of illness, bodily discomfort, or lack of well-being that result in significantly reduced physical activity or mental function.) You may also have limitations because of your treatment and its side effects.

4. *Marked* limitation means that the symptoms and signs of your hematological disorder interfere *seriously* with your ability to function. Although we do not require the use of such a scale, ''marked'' would be the fourth point on a five-point scale consisting of no limitation, mild limitation, moderate limitation, marked limitation, and extreme limitation. We do not define ''marked'' by a specific number of different activities of daily living or different behaviors in which your social functioning is impaired, or a specific number of tasks that you are able to complete, but by the nature and overall degree of interference with your functioning. You may have a marked limitation when several activities or functions are impaired, or even when only one is impaired. Additionally, you need not be totally precluded from

performing an activity to have a marked limitation, as long as the degree of limitation interferes seriously with your ability to function independently, appropriately, and effectively. The term ''marked'' does not imply that you must be confined to bed, hospitalized, or in a nursing home.

5. *Activities of daily living* include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, or paying bills. We will find that you have a ''marked'' limitation in activities of daily living if you have a serious limitation in your ability to maintain a household or take public transportation because of symptoms such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your hematological disorder (including complications of the disorder) or its treatment, even if you are able to perform some self-care activities.

6. *Social functioning* includes the capacity to interact with others independently, appropriately, effectively, and on a sustained basis. It includes the ability to communicate effectively with others. We will find that you have a ''marked'' limitation in maintaining social functioning if you have a serious limitation in social interaction on a sustained basis because of symptoms such as pain, severe fatigue, anxiety, or difficulty concentrating, or a pattern of exacerbation and remission, caused by your hematological disorder (including complications of the disorder) or its treatment, even if you are able to communicate with close friends or relatives.

7. *Completing tasks in a timely manner* involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings. We will find that you have a ''marked'' limitation in completing tasks if you have a serious limitation in your ability to sustain concentration or pace adequate to complete work-related tasks because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating caused by your hematological disorder (including complications of the disorder) or its treatment, even if you are able to do some routine activities of daily living.

H. How do we consider your symptoms, including your pain, severe fatigue, and malaise?

Your symptoms, including pain, severe fatigue, and malaise, may be important factors in our determination whether your hematological disorder(s) meets or medically equals a listing, or in our determination whether you are otherwise able to work. We cannot consider your symptoms unless you have medical signs or laboratory findings showing the existence of a medically determinable impairment(s) that could reasonably be expected to produce the symptoms. If you have such an impairment(s), we will evaluate the intensity, persistence, and functional effects of your symptoms using the rules throughout 7.00 and in our other regulations. (See sections 404.1521, 404.1529, 416.921, and 416.929 of this chapter.) Additionally, when we assess the credibility of your complaints about your symptoms and their functional effects, we will not draw any inferences from the fact that you do not receive treatment or that you are not following treatment without considering all of the relevant evidence in your case record, including any explanations you provide that may explain why you are not receiving or following treatment.

I. How do we evaluate episodic events in hematological disorders?

Some of the listings in this body system require a specific number of events within a consecutive 12-month period. (See 7.05, 7.08, and 7.10A.) When we use such criteria, a consecutive 12-month period means a period of 12 consecutive months, all or part of which must occur within the period we are considering in connection with your application or continuing disability review. These events must occur at least 30 days apart to ensure that we are evaluating separate events.

J. How do we evaluate hematological disorders that do not meet one of these listings?

1. These listings are only common examples of hematological disorders that we consider severe enough to prevent a person from doing any gainful activity. If your disorder does not meet the criteria of any of these listings, we must consider whether you have a disorder that satisfies the criteria of a listing in another body system. For example, we will evaluate hemophilic joint deformity or bone or joint pain from myelofibrosis under 1.00; polycythemia vera under 3.00, 4.00, or 11.00; chronic iron overload resulting from repeated RBC transfusion (transfusion hemosiderosis) under 3.00, 4.00, or 5.00; and the effects of intracranial bleeding or stroke under 11.00 or 12.00.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See sections 404.1526 and 416.926 of this chapter.) Hematological disorders may be associated with disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. We proceed to the fourth, and, if necessary, the fifth steps of the sequential evaluation process in sections

404.1520 and 416.920. We use the rules in sections 404.1594, 416.994, and 416.994a of this chapter, as appropriate, when we decide whether you continue to be disabled.

7.01 Category of Impairments, Hematological Disorders

7.05 *Hemolytic anemias*, including sickle cell disease, thalassemia, and their variants (see 7.00C), with:

A. Documented painful (vaso-occlusive) crises requiring parenteral (intravenous or intramuscular) narcotic medication, occurring at least six times within a 12-month period with at least 30 days between crises.

OR

B. Complications of hemolytic anemia requiring at least three hospitalizations within a 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, which can include hours in a hospital emergency department or comprehensive sickle cell disease center immediately before the hospitalization (see 7.00C2).

OR

C. Hemoglobin measurements of 7.0 grams per deciliter (g/dL) or less, occurring at least three times within a 12-month period with at least 30 days between measurements.

OR

D. Beta thalassemia major requiring lifelong RBC transfusions at least once every 6 weeks to maintain life (see 7.00C4).

7.08 *Disorders of thrombosis and hemostasis*, including hemophilia and thrombocytopenia (see 7.00D), with complications requiring at least three hospitalizations within a 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, which can include hours in a hospital emergency department or comprehensive hemophilia treatment center immediately before the hospitalization (see 7.00D2).

7.10 *Disorders of bone marrow failure*, including myelodysplastic syndromes, aplastic anemia, granulocytopenia, and myelofibrosis (see 7.00E), with:

A. Complications of bone marrow failure requiring at least three hospitalizations within a 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, which can include hours in a hospital emergency department immediately before the hospitalization (see 7.00E2).

OR

B. Myelodysplastic syndromes or aplastic anemias requiring life-long RBC transfusions at least once every 6 weeks to maintain life (see 7.00E3).

7.17 *Hematological disorders treated by bone marrow or stem cell transplantation* (see 7.00F). Consider under a disability for at least 12 consecutive months from the date of transplantation. After that, evaluate any residual impairment(s) under the criteria for the affected body system.

7.18 *Repeated complications of hematological disorders* (see 7.00G2), including those complications listed in 7.05, 7.08, and 7.10 but without the requisite findings for those listings, or other complications (for example, anemia, osteonecrosis, retinopathy, skin ulcers, silent central nervous system infarction, cognitive or other mental limitation, or limitation of joint movement), resulting in significant, documented symptoms or signs (for example, pain, severe fatigue, malaise, fever, night sweats, headaches, joint or muscle swelling, or shortness of breath), and one of the following at the marked level (see 7.00G4):

A. Limitation of activities of daily living (see 7.00G5).

B. Limitation in maintaining social functioning (see 7.00G6).

C. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace (see 7.00G7).

8.00 Skin Disorders

A. *Which skin disorders do we evaluate under these listings?* We use these listings to evaluate skin disorders that result from hereditary, congenital, or acquired pathological processes. We evaluate genetic photosensitivity disorders (8.07), burns (8.08), and chronic conditions of the skin or mucous membranes such as ichthyosis, bullous disease, dermatitis, psoriasis, and hidradenitis suppurativa (8.09) under these listings.

B. *What are our definitions for the following terms used in this body system?*

1. *Assistive device(s):* An assistive device, for the purposes of these listings, is any device used to improve stability, dexterity, or mobility. An assistive device can be hand-held, such as a cane(s), a crutch(es), or a walker; used in a seated position, such as a wheelchair, rollator, or power operated vehicle; or worn, such as a prosthesis or an orthosis.

2. *Chronic skin lesions:* Chronic skin lesions can have recurrent exacerbations (see 8.00B7). They can occur despite prescribed medical treatment. These chronic skin lesions can develop on any part of your body, including upper extremities, lower extremities, palms of your hands, soles of your feet, the perineum, inguinal (groin) region, and axillae (underarms). Chronic skin lesions may result in functional limitations as described in 8.00D2.

3. *Contractures:* Contractures are permanent fibrous scar tissue resulting in tightening and thickening of skin that prevents normal movement of the damaged area. They can develop on any part of your musculoskeletal system, including upper extremities, lower extremities, palms of your hands, soles of your feet, the perineum, inguinal

(groin) region, and axillae (underarms). Contractures may result in functional limitations as described in 8.00D2.

4. *Documented medical need:* When we use the term ''documented medical need,'' we mean that there is evidence (see §§ 404.1513 and 416.913 of this chapter) from your medical source(s) in the medical record that supports your need for an assistive device (see 8.00B1) for a continuous period of at least 12 months. The evidence must include documentation from your medical source(s) describing any limitation(s) in your upper or lower extremity functioning that supports your need for the assistive device and describing the circumstances for which you need it. The evidence does not have to include a specific prescription for the device.

5. *Fine and gross movements:* Fine movements, for the purposes of these listings, involve use of your wrists, hands, and fingers; such movements include picking, pinching, manipulating, and fingering. Gross movements involve use of your shoulders, upper arms, forearms, and hands; such movements include handling, gripping, grasping, holding, turning, and reaching. Gross movements also include exertional activities such as lifting, carrying, pushing, and pulling.

6. *Surgical management:* For the purposes of these listings, surgical management includes the surgery(ies) itself, as well as various post-surgical procedures, surgical complications, infections or other medical complications, related illnesses, or related treatments that delay a person's attainment of maximum benefit from surgery.

7. *Exacerbation:* For the purposes of these listings, exacerbation means an increase in the signs or symptoms of the skin disorder. Exacerbation may also be referred to as flare, flare-up, or worsening of the skin disorder.

C. *What evidence do we need to evaluate your skin disorder?*

1. To establish the presence of a skin disorder as a medically determinable impairment, we need objective medical evidence from an acceptable medical source (AMS) who has examined you for the disorder.

2. We will make every reasonable effort to obtain your medical history, treatment records, and relevant laboratory findings, but we will not purchase genetic testing.

3. When we evaluate the presence and severity of your skin disorder(s), we generally need information regarding:

a. The onset, duration, and frequency of exacerbations (see 8.00B7);

b. The prognosis of your skin disorder;

c. The location, size, and appearance of lesions and contractures;

d. Any available history of familial incidence;

e. Your exposure to toxins, allergens or irritants; seasonal variations; and stress factors;

f. Your ability to function outside of a highly protective environment (see 8.00E4);

g. Laboratory findings (for example, a biopsy obtained independently of Social Security disability evaluation or results of blood tests);

h. Evidence from other medically acceptable methods consistent with the prevailing state of medical knowledge and clinical practice; and

i. Statements you or others make about your disorder(s), your restrictions, and your daily activities.

D. *How do we evaluate the severity of skin disorders?*

1. *General.* We evaluate the severity of skin disorders based on the site(s) of your chronic skin lesions (see 8.00B2) or contractures (see 8.00B3), functional limitations caused by your signs and symptoms (including pain) (see 8.00D2), and how your prescribed treatment affects you. We consider the frequency and severity of your exacerbations (see 8.00B7), how quickly they resolve, and how you function between exacerbations (see 8.00B7), to determine whether your skin disorder meets or medically equals a listing (see 8.00D3). If there is no record of ongoing medical treatment for your disorder, we will follow the guidelines in 8.00D6. We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For our basic rules on evidence, see §§ 404.1512, 404.1513, 404.1520b, 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating your symptoms, see §§ 404.1529 and 416.929 of this chapter.

2. *Limitation(s) of physical functioning due to skin disorders.*

a. Skin disorders may be due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3), and may cause pain or restrict movement, which can limit your ability to initiate, sustain, and complete work-related activities. For example, skin lesions in the axilla may limit your ability to raise or reach with the affected arm, or lesions in the inguinal region may limit your ability to ambulate, sit, or lift and carry. To evaluate your skin disorder(s) under 8.07B, 8.08, and 8.09, we require medically documented evidence of physical limitation(s) of functioning related to your disorder. The decrease in physical function must have lasted, or can be expected to last, for a continuous period of at least 12 months (see §§ 404.1509 and 416.909 of this chapter). Xeroderma pigmentosum is the only skin disorder that does not include functional criteria because the characteristics and severity of the disorder itself are sufficient to meet the criteria in 8.07A.

b. The functional criteria require impairment-related physical limitations in using upper or lower extremities that have lasted, or can be expected to last, for a continuous

period of at least 12 months, medically documented by one of the following:

(i) Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3); or

(ii) Inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3), and a documented medical need (see 8.00B4) for an assistive device (see 8.00B1) that requires the use of the other upper extremity; or

(iii) Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete work-related activities due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region); or

(iv) Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete work-related activities due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

3. *Frequency of exacerbations due to chronic skin lesions.* A skin disorder resulting in chronic skin lesions (see 8.00B2) may have frequent exacerbations (see 8.00B7) severe enough to meet a listing even if each individual skin lesion exacerbation (see 8.00B7) did not last for an extended amount of time. We will consider the frequency, severity, and duration of skin lesion exacerbations (see 8.00B7), how quickly they resolve, and how you function in the time between skin lesion exacerbations (see 8.00B7), to determine whether your skin disorder meets or medically equals a listing.

4. *Symptoms (including pain).* Your symptoms may be an important factor in our determination of whether your skin disorder(s) meets or medically equals a listing, or whether you are otherwise able to work. We consider your symptoms only when you have a medically determinable impairment that could reasonably be expected to produce the symptoms. See §§ 404.1529 and 416.929 of this chapter.

5. *Treatment.*

a. *General.* Treatments for skin disorders may have beneficial or adverse effects, and responses to treatment vary from person to person. Your skin disorder's response to treatment may vary due to treatment resistance or side effects that can result in functional limitations. We will evaluate all of the effects of treatment (including surgical treatment, medications, and therapy) on the symptoms, signs, and laboratory findings of your skin disorder, and on your ability to function.

b. *Despite adherence to prescribed medical treatment for 3 months.* Under 8.09, we require that your symptoms persist ''despite adherence to prescribed medical treatment for 3 months.'' This requirement means that you must have taken prescribed medication(s) or followed other medical treatment prescribed by a medical source for 3 consecutive months. Treatment or effects of treatment may be temporary. In most cases, sufficient time must elapse to allow us to evaluate your response to treatment, including any side effects. For our purposes, ''sufficient time'' means a period of at least 3 months. If your treatment has not lasted for at least 3 months, we will follow the rules in 8.00D6a. The 3 months adherence to prescribed medical treatment must be within the period of at least 12 months that we use to evaluate severity.

c. *Treatment with PUVA (psoralen and ultraviolet A (UVA) light) or biologics.* If you receive additional treatment with PUVA or biologics to treat your skin disorder(s), we will defer adjudication of your claim for 6 months from the start of treatment with PUVA or biologics to evaluate the effectiveness of these treatments unless we can make a fully favorable determination or decision on another basis.

6. *No record of ongoing treatment.*

a. Despite having a skin disorder, you may not have received ongoing treatment, may have just begun treatment, may not have access to prescribed medical treatment, or may not have an ongoing relationship with the medical community. In any of these situations, you will not have a longitudinal medical record for us to review when we evaluate your disorder. In some instances, we may be able to assess the severity and duration of your skin disorder based on your medical record and current evidence alone. We may ask you to attend a consultative examination to determine the severity and potential duration of your skin disorder (see §§ 404.1519a and 416.919a of this chapter).

b. If, for any reason, you have not received treatment, your skin disorder cannot meet the criteria for 8.09. If the information in your case record is not sufficient to show that you have a skin disorder that meets the criteria of one of the skin disorders listings, we will follow the rules in 8.00I.

E. *How do we evaluate genetic photosensitivity disorders under 8.07?* Genetic photosensitivity disorders are disorders of the skin caused by an increase in the sensitivity of the skin to sources of ultraviolet light, including sunlight.

1. *Xeroderma pigmentosum (XP) (8.07A).* XP is a genetic photosensitivity disorder with lifelong hypersensitivity to all forms of ultraviolet light. Laboratory testing confirms the diagnosis by documenting abnormalities in the body's ability to repair DNA (deoxyribonucleic acid) mutations after ultraviolet light exposure. Your skin disorder meets the requirements of 8.07A if you have clinical and laboratory findings supporting a diagnosis of XP (see 8.00E3).

2. *Other genetic photosensitivity disorders (8.07B).* The effects of other genetic photosensitivity disorders may vary and may not persist over time. To meet the requirements of 8.07B, a genetic photosensitivity disorder other than XP must be established by clinical and laboratory findings (see 8.00C) and must result either in chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) that result in functional limitations (see 8.00D2), or must result in the inability to function outside of a highly protective environment (see 8.00E4). Some genetic photosensitivity disorders can have very serious effects on other body systems, especially special senses and speech, neurological, mental, and cancer. We will evaluate your disorder(s) under the listings in 2.00, 11.00, 12.00, or 13.00, as appropriate.

3. *What evidence do we need to document that you have XP or another genetic photosensitivity disorder?* We will make a reasonable effort to obtain evidence of your disorder(s), but we will not purchase genetic testing. When the results of genetic tests are part of the existing evidence in your case record, we will evaluate the test results with all other relevant evidence. We need the following clinical and laboratory findings to document that you have XP or another genetic photosensitivity disorder:

a. A laboratory report of a definitive genetic test documenting appropriate chromosomal changes, including abnormal DNA repair or another DNA abnormality specific to your type of photosensitivity disorder, signed by an AMS; or

b. A laboratory report of a definitive test that is not signed by an AMS, and a report from an AMS stating that you have undergone definitive genetic laboratory studies documenting appropriate chromosomal changes, including abnormal DNA repair or another DNA abnormality specific to your type of photosensitivity disorder; or

c. If we do not have a laboratory report of a definitive test, we need documentation from an AMS that an appropriate laboratory analysis or other diagnostic method(s) confirms a positive diagnosis of your skin disorder. This documentation must state that you had the appropriate definitive laboratory test(s) for diagnosing your disorder and provide the results, or explain how another diagnostic method(s), consistent with the prevailing state of medical knowledge and clinical practice, established your diagnosis.

4. *Inability to function outside of a highly protective environment* means that you must avoid exposure to ultraviolet light (including sunlight passing through windows and light from similar unshielded light sources), wear protective clothing and eyeglasses, and use opaque broad-spectrum sunscreens in order to avoid skin cancer or other serious effects.

F. *How do we evaluate burns under 8.08?*

1. Electrical, chemical, or thermal burns frequently affect other body systems, for example, musculoskeletal, special senses and speech, respiratory, cardiovascular, genitourinary, neurological, or mental. We evaluate burns in the same way we evaluate other disorders that can affect the skin and other body systems, using the listing for the predominant feature of your disorder. For example, if your soft tissue injuries resulting from burns are under surgical management (as defined in 8.00B6), we will evaluate your disorder under the listings in 1.00.

2. We evaluate burns resulting in chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) that have been documented by an AMS to have reached maximum therapeutic benefit and therefore are no longer receiving surgical management, under 8.08. To be disabling, these burns must result in functional limitation(s) (see 8.00D2) that has lasted or can be expected to last for a continuous period of at least 12 months.

G. *How do we evaluate chronic conditions of the skin or mucous membranes under 8.09?* We evaluate skin disorders that result in chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) under 8.09. These disorders must result in chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) that continue to persist despite adherence to prescribed medical treatment for 3 months (see 8.00D5b) and cause functional limitations (see 8.00D2). Examples of skin disorders evaluated under this listing are ichthyosis, bullous diseases (such as pemphigus, epidermolysis bullosa, and dermatitis herpetiformis), chronic skin infections, dermatitis, psoriasis, and hidradenitis suppurativa.

H. *How do we evaluate disorders in other body systems that affect the skin?* When your disorder(s) in another body system affects your skin, we first evaluate the predominant feature of your disorder(s) under the appropriate body system. Examples of disorders in other body systems that may affect the skin include the following:

1. *Diabetes mellitus.* Diabetes mellitus that is not well controlled, despite treatment, can cause chronic hyperglycemia resulting in serious, long-lasting or recurrent exacerbations (see 8.00B7) or complications. We evaluate those exacerbations (see 8.00B7) or

complications under the affected body system(s). If the complication involves soft tissue or amputation(s), we evaluate these features under the listings in 1.00. If the exacerbations (see 8.00B7) or complications involve chronic bacterial or fungal skin lesions resulting from diabetes mellitus, we evaluate your limitations from the skin disorder under listing 8.09.

2. *Tuberous sclerosis.* The predominant functionally limiting features of tuberous sclerosis are seizures and intellectual disorder or other mental disorders. We evaluate these features under the listings in 11.00 or 12.00, as appropriate.

3. *Malignant tumors of the skin.* Malignant tumors of the skin (for example, malignant melanomas) are cancers, or malignant neoplastic diseases, that we evaluate under the listings in 13.00.

4. *Immune system disorders.* We evaluate skin manifestations of immune system disorders such as systemic lupus erythematosus, scleroderma, psoriasis, and human immunodeficiency virus (HIV) infection under the listings in 14.00.

5. *Head or facial disfigurement or deformity, and other physical deformities caused by skin disorders.* A head or facial disfigurement or deformity may result in loss of your sight, hearing, speech, or ability to chew. In addition to head and facial disfigurement and deformity, other physical deformities may result in associated psychological problems (for example, depression). We evaluate the effects of head or facial disfigurement or deformity, or other physical deformities caused by skin disorders under the listings in 1.00, 2.00, 5.00, or 12.00, as appropriate.

I. *How do we evaluate skin disorders that do not meet one of these listings?*

1. These listings are only examples of common skin disorders that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §§ 404.1526 and 416.926 of this chapter. If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. We proceed to the fourth step and, if necessary, the fifth step of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

8.01 Category of Impairments, Skin Disorders

8.02–8.06 [Reserved]

8.07 *Genetic photosensitivity disorders,* established as described in 8.00E. The requirements of this listing are met if either paragraph A or paragraph B is satisfied.

A. Xeroderma pigmentosum (see 8.00E1).

OR

B. Other genetic photosensitivity disorders (see 8.00E2) with either 1 or 2:

1. Chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) that cause an inability to function outside of a highly protective environment (see 8.00E4); or

2. Chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) causing chronic pain or other physical limitation(s) that result in impairment-related functional limitations (see 8.00D2), as evidenced by:

a. Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3); or

b. Inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3), and a documented medical need (see 8.00B4) for an assistive device (see 8.00B1) that requires the use of the other upper extremity; or

c. Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete work-related activities due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region); or

d. Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete work-related activities, due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

8.08 *Burns* (see 8.00F). Burns that do not require continuing surgical management (see 8.00B6), or that have been documented by an acceptable medical source to have reached maximum therapeutic benefit and therefore are no longer receiving surgical management, resulting in chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) causing chronic pain or other physical limitation(s) that result in impairment-related functional limitations (see 8.00D2), as evidenced by:

A. Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine

and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3).

OR

B. Inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3), and a documented medical need (see 8.00B4) for an assistive device (see 8.00B1) that requires the use of the other upper extremity.

OR

C. Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete work-related activities due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

OR

D. Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete work-related activities due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

8.09 *Chronic conditions of the skin or mucous membranes* (see 8.00G) resulting in:

A. Chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) causing chronic pain or other physical limitation(s) that persist despite adherence to prescribed medical treatment for 3 months (see 8.00D5b).

AND

B. Impairment-related functional limitations (see 8.00D2) demonstrated by 1, 2, 3, or 4:

1. Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3); or

2. Inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 8.00B5) due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3), and a documented medical need (see 8.00B4) for an assistive device (see 8.00B1) that requires the use of the other upper extremity; or

3. Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete work-related activities due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region); or

4. Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete work-related activities due to chronic skin lesions (see 8.00B2) or contractures (see 8.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

9.00 Endocrine Disorders

A. *What is an endocrine disorder?*

An endocrine disorder is a medical condition that causes a hormonal imbalance. When an endocrine gland functions abnormally, producing either too much of a specific hormone (hyperfunction) or too little (hypofunction), the hormonal imbalance can cause various complications in the body. The major glands of the endocrine system are the pituitary, thyroid, parathyroid, adrenal, and pancreas.

B. *How do we evaluate the effects of endocrine disorders?* We evaluate impairments that result from endocrine disorders under the listings for other body systems. For example:

1. *Pituitary gland disorders* can disrupt hormone production and normal functioning in other endocrine glands and in many body systems. The effects of pituitary gland disorders vary depending on which hormones are involved. For example, when pituitary hypofunction affects water and electrolyte balance in the kidney and leads to diabetes insipidus, we evaluate the effects of recurrent dehydration under 6.00.

2. *Thyroid gland disorders* affect the sympathetic nervous system and normal metabolism. We evaluate thyroid-related changes in blood pressure and heart rate that cause arrhythmias or other cardiac dysfunction under 4.00; thyroid-related weight loss under 5.00; hypertensive cerebrovascular accidents (strokes) under 11.00; and cognitive limitations, mood disorders, and anxiety under 12.00.

3. *Parathyroid gland disorders* affect calcium levels in bone, blood, nerves, muscle, and other body tissues. We evaluate parathyroid-related osteoporosis and fractures under 1.00; abnormally elevated calcium levels in the blood (hypercalcemia) that lead to cataracts under 2.00; kidney failure under 6.00; and recurrent abnormally low blood calcium levels (hypocalcemia) that lead to increased excitability of nerves and muscles, such as tetany and muscle spasms, under 11.00.

4. *Adrenal gland disorders* affect bone calcium levels, blood pressure, metabolism, and

mental status. We evaluate adrenal-related osteoporosis with fractures that compromises the ability to walk or to use the upper extremities under 1.00; adrenal-related hypertension that worsens heart failure or causes recurrent arrhythmias under 4.00; adrenal-related weight loss under 5.00; and mood disorders under 12.00.

5. *Diabetes mellitus and other pancreatic gland disorders* disrupt the production of several hormones, including insulin, that regulate metabolism and digestion. Insulin is essential to the absorption of glucose from the bloodstream into body cells for conversion into cellular energy. The most common pancreatic gland disorder is *diabetes mellitus* (DM). There are two major types of DM: type 1 and type 2. Both type 1 and type 2 DM are chronic disorders that can have serious disabling complications that meet the duration requirement. Type 1 DM—previously known as ''juvenile diabetes'' or ''insulin-dependent diabetes mellitus'' (IDDM)—is an absolute deficiency of insulin production that commonly begins in childhood and continues throughout adulthood. Treatment of type 1 DM always requires lifelong daily insulin. With type 2 DM—previously known as ''adult-onset diabetes mellitus'' or ''non-insulin-dependent diabetes mellitus'' (NIDDM)—the body's cells resist the effects of insulin, impairing glucose absorption and metabolism. Treatment of type 2 DM generally requires lifestyle changes, such as increased exercise and dietary modification, and sometimes insulin in addition to other medications. While both type 1 and type 2 DM are usually controlled, some persons do not achieve good control for a variety of reasons including, but not limited to, hypoglycemia unawareness, other disorders that can affect blood glucose levels, inability to manage DM due to a mental disorder, or inadequate treatment.

a. *Hyperglycemia.* Both types of DM cause hyperglycemia, which is an abnormally high level of blood glucose that may produce acute and long-term complications. Acute complications of hyperglycemia include diabetic ketoacidosis. Long-term complications of chronic hyperglycemia include many conditions affecting various body systems.

(i) *Diabetic ketoacidosis (DKA).* DKA is an acute, potentially life-threatening complication of DM in which the chemical balance of the body becomes dangerously hyperglycemic and acidic. It results from a severe insulin deficiency, which can occur due to missed or inadequate daily insulin therapy or in association with an acute illness. It usually requires hospital treatment to correct the acute complications of dehydration, electrolyte imbalance, and insulin deficiency. You may have serious complications resulting from your treatment, which we evaluate under the affected body system. For example, we evaluate cardiac arrhythmias under 4.00, intestinal necrosis under 5.00, and cerebral edema and seizures under 11.00. Recurrent episodes of DKA may result from mood or eating disorders, which we evaluate under 12.00.

(ii) *Chronic hyperglycemia.* Chronic hyperglycemia, which is longstanding abnormally high levels of blood glucose, leads to long-term diabetic complications by disrupting nerve and blood vessel functioning. This disruption can have many different effects in other body systems. For example, we evaluate diabetic peripheral neurovascular disease that leads to gangrene and subsequent amputation of an extremity under 1.00; diabetic retinopathy under 2.00; coronary artery disease and peripheral vascular disease under 4.00; diabetic gastroparesis that results in abnormal gastrointestinal motility under 5.00; diabetic nephropathy under 6.00; poorly healing bacterial and fungal skin infections under 8.00; diabetic peripheral and sensory neuropathies under 11.00; and cognitive impairments, depression, and anxiety under 12.00.

b. *Hypoglycemia.* Persons with DM may experience episodes of hypoglycemia, which is an abnormally low level of blood glucose. Most adults recognize the symptoms of hypoglycemia and reverse them by consuming substances containing glucose; however, some do not take this step because of hypoglycemia unawareness. Severe hypoglycemia can lead to complications, including seizures or loss of consciousness, which we evaluate under 11.00, or altered mental status and cognitive deficits, which we evaluate under 12.00.

C. *How do we evaluate endocrine disorders that do not have effects that meet or medically equal the criteria of any listing in other body systems?* If your impairment(s) does not meet or medically equal a listing in another body system, you may or may not have the residual functional capacity to engage in substantial gainful activity. In this situation, we proceed to the fourth and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. When we decide whether you continue to be disabled, we use the rules in §§ 404.1594, 416.994, and 416.994a.

10.00 Congenital Disorders That Affect Multiple Body Systems

A. *Which disorder do we evaluate under this body system?* Although Down syndrome exists in non-mosaic and mosaic forms, we evaluate only non-mosaic Down syndrome under this body system.

B. *What is non-mosaic Down syndrome?* Nonmosaic Down syndrome is a genetic disorder. Most people with non-mosaic Down syndrome have three copies of chromosome 21 in all of their cells (chromosome 21 trisomy); some have an extra copy of chromosome 21 attached to a different chromosome in all of their cells (chromosome 21 translocation).

Virtually all people with non-mosaic Down syndrome have characteristic facial or other physical features, delayed physical development, and intellectual disability. People with non-mosaic Down syndrome may also have congenital heart disease, impaired vision, hearing problems, and other disorders. We evaluate non-mosaic Down syndrome under 10.06. If you have non-mosaic Down syndrome documented as described in 10.00C, we consider you disabled from birth.

C. What evidence do we need to document non-mosaic Down syndrome under 10.06?

1. Under 10.06A, we will find you disabled based on laboratory findings.

a. To find that your disorder meets 10.06A, we need a copy of the laboratory report of karyotype analysis, which is the definitive test to establish non-mosaic Down syndrome. We will not purchase karyotype analysis. We will not accept a fluorescence in situ hybridization (FISH) test because it does not distinguish between the mosaic and non-mosaic forms of Down syndrome.

b. If a physician (see §§404.1513(a)(1) and 416.913(a)(1) of this chapter) has not signed the laboratory report of karyotype analysis, the evidence must also include a physician's statement that you have Down syndrome.

c. For purposes of 10.06A, we do not require additional evidence stating that you have the distinctive facial or other physical features of Down syndrome.

2. If we do not have a laboratory report of karyotype analysis showing that you have non-mosaic Down syndrome, we may find you disabled under 10.06B or 10.06C.

a. Under 10.06B, we need a physician's report stating: (i) your karyotype diagnosis or evidence that documents your type of Down syndrome is consistent with prior karyotype analysis (for example, reference to a diagnosis of ''trisomy 21''), and (ii) that you have the distinctive facial or other physical features of Down syndrome. We do not require a detailed description of the facial or other physical features of the disorder. However, we will not find that your disorder meets 10.06B if we have evidence—such as evidence of functioning inconsistent with the diagnosis—that indicates that you do not have non-mosaic Down syndrome.

b. If we do not have evidence of prior karyotype analysis (you did not have testing, or you had testing but we do not have information from a physician about the test results), we will find that your disorder meets 10.06C if we have: (i) a physician's report stating that you have the distinctive facial or other physical features of Down syndrome, and (ii) evidence that your functioning is consistent with a diagnosis of non-mosaic Down syndrome. This evidence may include medical or nonmedical information about your physical and mental abilities, including information about your education, work history, or the results of psychological testing. However, we will not find that your disorder meets 10.06C if we have evidence—such as evidence of functioning inconsistent with the diagnosis—that indicates that you do not have non-mosaic Down syndrome.

D. How do we evaluate mosaic Down syndrome and other congenital disorders that affect multiple body systems?

1. *Mosaic Down syndrome.* Approximately 2 percent of people with Down syndrome have the mosaic form. In mosaic Down syndrome, there are some cells with an extra copy of chromosome 21 and other cells with the normal two copies of chromosome 21. Mosaic Down syndrome can be so slight as to be undetected clinically, but it can also be profound and disabling, affecting various body systems.

2. *Other congenital disorders that affect multiple body systems.* Other congenital disorders, such as congenital anomalies, chromosomal disorders, dysmorphic syndromes, inborn metabolic syndromes, and perinatal infectious diseases, can cause deviation from, or interruption of, the normal function of the body or can interfere with development. Examples of these disorders include both the juvenile and late-onset forms of Tay-Sachs disease, trisomy X syndrome (XXX syndrome), fragile X syndrome, phenylketonuria (PKU), caudal regression syndrome, and fetal alcohol syndrome. For these disorders and other disorders like them, the degree of deviation, interruption, or interference, as well as the resulting functional limitations and their progression, may vary widely from person to person and may affect different body systems.

3. *Evaluating the effects of mosaic Down syndrome or another congenital disorder under the listings.* When the effects of mosaic Down syndrome or another congenital disorder that affects multiple body systems are sufficiently severe we evaluate the disorder under the appropriate affected body system(s), such as musculoskeletal, special senses and speech, neurological, or mental disorders. Otherwise, we evaluate the specific functional limitations that result from the disorder under our other rules described in 10.00E.

E. What if your disorder does not meet a listing?

If you have a severe medically determinable impairment(s) that does not meet a listing, we will consider whether your impairment(s) medically equals a listing. See §§404.1526 and 416.926 of this chapter. If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. We proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in

§§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

10.01 CATEGORY OF IMPAIRMENTS, CONGENITAL DISORDERS THAT AFFECT MULTIPLE BODY SYSTEMS

10.06 *Non-mosaic Down syndrome* (chromosome 21 trisomy or chromosome 21 translocation), documented by:

A. A laboratory report of karyotype analysis signed by a physician, or both a laboratory report of karyotype analysis not signed by a physician *and* a statement by a physician that you have Down syndrome (see 10.00C1), or

B. A physician's report stating that you have chromosome 21 trisomy or chromosome 21 translocation consistent with prior karyotype analysis with the distinctive facial or other physical features of Down syndrome (see 10.00C2a), or

C. A physician's report stating that you have Down syndrome with the distinctive facial or other physical features *and* evidence demonstrating that you function at a level consistent with non-mosaic Down syndrome (see 10.00C2b).

11.00 NEUROLOGICAL DISORDERS

A. *Which neurological disorders do we evaluate under these listings?* We evaluate epilepsy, amyotrophic lateral sclerosis, coma or persistent vegetative state (PVS), and neurological disorders that cause disorganization of motor function, bulbar and neuromuscular dysfunction, communication impairment, or a combination of limitations in physical and mental functioning. We evaluate neurological disorders that may manifest in a combination of limitations in physical and mental functioning. For example, if you have a neurological disorder that causes mental limitations, such as Huntington's disease or early-onset Alzheimer's disease, which may limit executive functioning (e.g., regulating attention, planning, inhibiting responses, decision-making), we evaluate your limitations using the functional criteria under these listings (see 11.00G). Under this body system, we evaluate the limitations resulting from the impact of the neurological disease process itself. If your neurological disorder results in only mental impairment or if you have a co-occurring mental condition that is not caused by your neurological disorder (for example, dementia), we will evaluate your mental impairment under the mental disorders body system, 12.00.

B. *What evidence do we need to document your neurological disorder?*

1. We need both medical and non-medical evidence (signs, symptoms, and laboratory findings) to assess the effects of your neurological disorder. Medical evidence should include your medical history, examination findings, relevant laboratory tests, and the results of imaging. Imaging refers to medical imaging techniques, such as x-ray, computerized tomography (CT), magnetic resonance imaging (MRI), and electroencephalography (EEG). The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder. In addition, the medical evidence may include descriptions of any prescribed treatment and your response to it. We consider non-medical evidence such as statements you or others make about your impairments, your restrictions, your daily activities, or your efforts to work.

2. We will make every reasonable effort to obtain the results of your laboratory and imaging evidence. When the results of any of these tests are part of the existing evidence in your case record, we will evaluate the test results and all other relevant evidence. We will not purchase imaging, or other diagnostic tests, or laboratory tests that are complex, may involve significant risk, or that are invasive. We will not routinely purchase tests that are expensive or not readily available.

C. *How do we consider adherence to prescribed treatment in neurological disorders?* In 11.02 (Epilepsy), 11.06 (Parkinsonian syndrome), and 11.12 (Myasthenia gravis), we require that limitations from these neurological disorders exist despite adherence to prescribed treatment. ''Despite adherence to prescribed treatment'' means that you have taken medication(s) or followed other treatment procedures for your neurological disorder(s) as prescribed by a physician for three consecutive months but your impairment continues to meet the other listing requirements despite this treatment. You may receive your treatment at a health care facility that you visit regularly, even if you do not see the same physician on each visit.

D. *What do we mean by disorganization of motor function?*

1. *Disorganization of motor function* means interference, due to your neurological disorder, with movement of two extremities; *i.e.,* the lower extremities, or upper extremities (including fingers, wrists, hands, arms, and shoulders). By two extremities we mean both lower extremities, or both upper extremities, or one upper extremity and one lower extremity. All listings in this body system, except for 11.02 (Epilepsy), 11.10 (Amyotrophic lateral sclerosis), and 11.20 (Coma and persistent vegetative state), include criteria for disorganization of motor function that results in an extreme limitation in your ability to:

a. Stand up from a seated position; or

b. Balance while standing or walking; or

c. Use the upper extremities (including fingers, wrists, hands, arms, and shoulders).

2. *Extreme limitation* means the inability to stand up from a seated position, maintain balance in a standing position and while walking, or use your upper extremities to independently initiate, sustain, and complete work-related activities. The assessment of motor function depends on the degree of interference with standing up; balancing while standing or walking; or using the upper extremities (including fingers, hands, arms, and shoulders).

a. Inability to stand up from a seated position means that once seated you are unable to stand and maintain an upright position without the assistance of another person or the use of an assistive device, such as a walker, two crutches, or two canes.

b. Inability to maintain balance in a standing position means that you are unable to maintain an upright position while standing or walking without the assistance of another person or an assistive device, such as a walker, two crutches, or two canes.

c. Inability to use your upper extremities means that you have a loss of function of both upper extremities (including fingers, wrists, hands, arms, and shoulders) that very seriously limits your ability to independently initiate, sustain, and complete work-related activities involving fine and gross motor movements. Inability to perform fine and gross motor movements could include not being able to pinch, manipulate, and use your fingers; or not being able to use your hands, arms, and shoulders to perform gross motor movements, such as handling, gripping, grasping, holding, turning, and reaching; or not being able to engage in exertional movements such a lifting, carrying, pushing, and pulling.

E. *How do we evaluate communication impairments under these listings?* We must have a description of a recent comprehensive evaluation including all areas of communication, performed by an acceptable medical source, to document a communication impairment associated with a neurological disorder. A communication impairment may occur when a medically determinable neurological impairment results in dysfunction in the parts of the brain responsible for speech and language. We evaluate communication impairments associated with neurological disorders under 11.04A, 11.07C, or 11.11B. We evaluate communication impairments due to non-neurological disorders under 2.09.

1. Under 11.04A, we need evidence documenting that your central nervous system vascular accident or insult (CVA) and sensory or motor aphasia have resulted in ineffective speech or communication. *Ineffective speech or communication* means there is an extreme limitation in your ability to understand or convey your message in simple spoken language resulting in your inability to demonstrate basic communication skills, such as following one-step commands or telling someone about your basic personal needs without assistance.

2. Under 11.07C, we need evidence documenting that your cerebral palsy has resulted in significant interference in your ability to speak, hear, or see. We will find you have ''significant interference'' in your ability to speak, hear, or see if your signs, such as aphasia, strabismus, or sensorineural hearing loss, seriously limit your ability to communicate on a sustained basis.

3. Under 11.11B, we need evidence documenting that your post-polio syndrome has resulted in the inability to produce intelligible speech.

F. *What do we mean by bulbar and neuromuscular dysfunction?* The bulbar region of the brain is responsible for controlling the bulbar muscles in the throat, tongue, jaw, and face. Bulbar and neuromuscular dysfunction refers to weakness in these muscles, resulting in breathing, swallowing, and speaking impairments. Listings 11.11 (Post-polio syndrome), 11.12 (Myasthenia gravis), and 11.22 (Motor neuron disorders other than ALS) include criteria for evaluating bulbar and neuromuscular dysfunction. If your neurological disorder has resulted in a breathing disorder, we may evaluate that condition under the respiratory system, 3.00.

G. *How do we evaluate limitations in physical and mental functioning under these listings?*

1. Neurological disorders may manifest in a combination of limitations in physical and mental functioning. We consider all relevant information in your case record to determine the effects of your neurological disorder on your physical and mental functioning. To satisfy the requirement described under 11.00G, your neurological disorder must result in a marked limitation in physical functioning and a marked limitation in at least one of four areas of mental functioning: Understanding, remembering, or applying information; interacting with others; concentrating, persisting, or maintaining pace; or adapting or managing oneself. If your neurological disorder results in an extreme limitation in at least one of the four areas of mental functioning, or results in marked limitation in at least two of the four areas of mental functioning, but you do not have at least a marked limitation in your physical functioning, we will consider whether your condition meets or medically equals one of the mental disorders body system listings, 12.00.

2. *Marked Limitation.* To satisfy the requirements of the functional criteria, your neurological disorder must result in a marked limitation in physical functioning and a marked limitation in one of the four areas of mental functioning (see 11.00G3). Although we do not require the use of such a scale, ''marked'' would be the fourth point on a five-point scale consisting of no limitation, mild limitation, moderate limitation, marked limitation, and extreme limitation.

We consider the nature and overall degree of interference with your functioning. The term ''marked'' does not require that you must be confined to bed, hospitalized, or in a nursing home.

a. *Marked limitation and physical functioning.* For this criterion, a marked limitation means that, due to the signs and symptoms of your neurological disorder, you are seriously limited in the ability to independently initiate, sustain, and complete work-related physical activities (see 11.00G3). You may have a marked limitation in your physical functioning when your neurological disease process causes persistent or intermittent symptoms that affect your abilities to independently initiate, sustain, and complete work-related activities, such as standing, balancing, walking, using both upper extremities for fine and gross movements, or results in limitations in using one upper and one lower extremity. The persistent and intermittent symptoms must result in a serious limitation in your ability to do a task or activity on a sustained basis. We do not define ''marked'' by a specific number of different physical activities or tasks that demonstrate your ability, but by the overall effects of your neurological symptoms on your ability to perform such physical activities on a consistent and sustained basis. You need not be totally precluded from performing a function or activity to have a marked limitation, as long as the degree of limitation seriously limits your ability to independently initiate, sustain, and complete work-related physical activities.

b. *Marked limitation and mental functioning.* For this criterion, a marked limitation means that, due to the signs and symptoms of your neurological disorder, you are seriously limited in the ability to function independently, appropriately, effectively, and on a sustained basis in work settings (see 11.03G3). We do not define ''marked'' by a specific number of mental activities, such as: The number of activities that demonstrate your ability to understand, remember, and apply information; the number of tasks that demonstrate your ability to interact with others; a specific number of tasks that demonstrate you are able to concentrate, persist or maintain pace; or a specific number of tasks that demonstrate you are able to manage yourself. You may have a marked limitation in your mental functioning when several activities or functions are impaired, or even when only one is impaired. You need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation seriously limits your ability to function independently, appropriately, and effectively on a sustained basis, and complete work-related mental activities.

3. *Areas of physical and mental functioning.*

a. *Physical functioning.* Examples of this criterion include specific motor abilities, such as independently initiating, sustaining, and completing the following activities: Standing up from a seated position, balancing while standing or walking, or using both your upper extremities for fine and gross movements (see 11.00D). Physical functioning may also include functions of the body that support motor abilities, such as the abilities to see, breathe, and swallow (see 11.00E and 11.00F). Examples of when your limitation in seeing, breathing, or swallowing may, on its own, rise to a ''marked'' limitation include: Prolonged and uncorrectable double vision causing difficulty with balance; prolonged difficulty breathing requiring the use of a prescribed assistive breathing device, such as a portable continuous positive airway pressure machine; or repeated instances, occurring at least weekly, of aspiration without causing aspiration pneumonia. Alternatively, you may have a combination of limitations due to your neurological disorder that together rise to a ''marked'' limitation in physical functioning. We may also find that you have a ''marked'' limitation in this area if, for example, your symptoms, such as pain or fatigue (see 11.00T), as documented in your medical record, and caused by your neurological disorder or its treatment, seriously limit your ability to independently initiate, sustain, and complete these work-related motor functions, or the other physical functions or physiological processes that support those motor functions. We may also find you seriously limited in an area if, while you retain some ability to perform the function, you are unable to do so consistently and on a sustained basis. The limitation in your physical functioning must last or be expected to last at least 12 months. These examples illustrate the nature of physical functioning. We do not require documentation of all of the examples.

b. *Mental functioning.*

(i) *Understanding, remembering, or applying information.* This area of mental functioning refers to the abilities to learn, recall, and use information to perform work activities. Examples include: Understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing work activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make work-related decisions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

(ii) *Interacting with others.* This area of mental functioning refers to the abilities to relate to and work with supervisors, co-

workers, and the public. Examples include: Cooperating with others; asking for help when needed; handling conflicts with others; stating your own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

(iii) *Concentrating, persisting, or maintaining pace.* This area of mental functioning refers to the abilities to focus attention on work activities and to stay on-task at a sustained rate. Examples include: Initiating and performing a task that you understand and know how to do; working at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while working; changing activities or work settings without being disruptive; working close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at work; and working a full day without needing more than the allotted number or length of rest periods during the day. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

(iv) *Adapting or managing oneself.* This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in a work setting. Examples include: Responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable work performance; setting realistic goals; making plans for yourself independently of others; maintaining personal hygiene and attire appropriate to a work setting; and being aware of normal hazards and taking appropriate precautions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

4. *Signs and symptoms of your disorder and the effects of treatment.*

a. We will consider your signs and symptoms and how they affect your ability to function in the work place. When we evaluate your functioning, we will consider whether your signs and symptoms are persistent or intermittent, how frequently they occur and how long they last, their intensity, and whether you have periods of exacerbation and remission.

b. We will consider the effectiveness of treatment in improving the signs, symptoms, and laboratory findings related to your neurological disorder, as well as any aspects of treatment that may interfere with your ability to function. We will consider, for example: The effects of medications you take (including side effects); the time-limited efficacy of some medications; the intrusiveness, complexity, and duration of your treatment (for example, the dosing schedule or need for injections); the effects of treatment, including medications, therapy, and surgery, on your functioning; the variability of your response to treatment; and any drug interactions.

H. *What is epilepsy, and how do we evaluate it under 11.02?*

1. *Epilepsy* is a pattern of recurrent and unprovoked seizures that are manifestations of abnormal electrical activity in the brain. There are various types of generalized and ''focal'' or partial seizures. However, psychogenic nonepileptic seizures and pseudoseizures are not epileptic seizures for the purpose of 11.02. We evaluate psychogenic seizures and pseudoseizures under the mental disorders body system, 12.00. In adults, the most common potentially disabling seizure types are *generalized tonic-clonic seizures* and *dyscognitive seizures* (formerly complex partial seizures).

a. *Generalized tonic-clonic seizures* are characterized by loss of consciousness accompanied by a tonic phase (sudden muscle tensing causing the person to lose postural control) followed by a clonic phase (rapid cycles of muscle contraction and relaxation, also called convulsions). Tongue biting and incontinence may occur during generalized tonic-clonic seizures, and injuries may result from falling.

b. *Dyscognitive seizures* are characterized by alteration of consciousness without convulsions or loss of muscle control. During the seizure, blank staring, change of facial expression, and automatisms (such as lip smacking, chewing or swallowing, or repetitive simple actions, such as gestures or verbal utterances) may occur. During its course, a dyscognitive seizure may progress into a generalized tonic-clonic seizure (see 11.00H1a).

2. *Description of seizure.* We require at least one detailed description of your seizures from someone, preferably a medical professional, who has observed at least one of your typical seizures. If you experience more than one type of seizure, we require a description of each type.

3. *Serum drug levels.* We do not require serum drug levels; therefore, we will not purchase them. However, if serum drug levels are available in your medical records, we will evaluate them in the context of the other evidence in your case record.

4. *Counting seizures.* The period specified in 11.02A, B, C, or D cannot begin earlier than one month after you began prescribed treatment. The required number of seizures must occur within the period we are considering in

connection with your application or continuing disability review. When we evaluate the frequency of your seizures, we also consider your adherence to prescribed treatment (see 11.00C). When we determine the number of seizures you have had in the specified period, we will:

a. Count multiple seizures occurring in a 24-hour period as one seizure.

b. Count status epilepticus (a continuous series of seizures without return to consciousness between seizures) as one seizure.

c. Count a dyscognitive seizure that progresses into a generalized tonic-clonic seizure as one generalized tonic-clonic seizure.

d. We do not count seizures that occur during a period when you are not adhering to prescribed treatment without good reason. When we determine that you had good reason for not adhering to prescribed treatment, we will consider your physical, mental, educational, and communicative limitations (including any language barriers). We will consider you to have good reason for not following prescribed treatment if, for example, the treatment is very risky for you due to its consequences or unusual nature, or if you are unable to afford prescribed treatment that you are willing to accept, but for which no free community resources are available. We will follow guidelines found in our policy, such as §§404.1530(c) and 416.930(c) of this chapter, when we determine whether you have a good reason for not adhering to prescribed treatment.

e. We do not count psychogenic nonepileptic seizures or pseudoseizures under 11.02. We evaluate these seizures under the mental disorders body system, 12.00.

5. *Electroencephalography (EEG) testing.* We do not require EEG test results; therefore, we will not purchase them. However, if EEG test results are available in your medical records, we will evaluate them in the context of the other evidence in your case record.

I. *What is vascular insult to the brain, and how do we evaluate it under 11.04?*

1. *Vascular insult to the brain* (cerebrum, cerebellum, or brainstem), commonly referred to as stroke or cerebrovascular accident (CVA), is brain cell death caused by an interruption of blood flow within or leading to the brain, or by a hemorrhage from a ruptured blood vessel or aneurysm in the brain. If you have a vision impairment resulting from your vascular insult, we may evaluate that impairment under the special senses body system, 2.00.

2. We need evidence of sensory or motor aphasia that results in ineffective speech or communication under 11.04A (see 11.00E). We may evaluate your communication impairment under listing 11.04C if you have marked limitation in physical functioning and marked limitation in one of the four areas of mental functioning.

3. We generally need evidence from at least 3 months after the vascular insult to evaluate whether you have disorganization of motor functioning under 11.04B, or the impact that your disorder has on your physical and mental functioning under 11.04C. In some cases, evidence of your vascular insult is sufficient to allow your claim within 3 months post-vascular insult. If we are unable to allow your claim within 3 months after your vascular insult, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-vascular insult.

J. *What are benign brain tumors, and how do we evaluate them under 11.05?* Benign brain tumors are noncancerous (nonmalignant) abnormal growths of tissue in or on the brain that invade healthy brain tissue or apply pressure on the brain or cranial nerves. We evaluate their effects on your functioning as discussed in 11.00D and 11.00G. We evaluate malignant brain tumors under the cancer body system in 13.00. If you have a vision impairment resulting from your benign brain tumor, we may evaluate that impairment under the special senses body system, 2.00.

K. *What is Parkinsonian syndrome, and how do we evaluate it under 11.06?* Parkinsonian syndrome is a term that describes a group of chronic, progressive movement disorders resulting from loss or decline in the function of dopamine-producing brain cells. Dopamine is a neurotransmitter that regulates muscle movement throughout the body. When we evaluate your Parkinsonian syndrome, we will consider your adherence to prescribed treatment (see 11.00C).

L. *What is cerebral palsy, and how do we evaluate it under 11.07?*

1. *Cerebral palsy (CP)* is a term that describes a group of static, nonprogressive disorders caused by abnormalities within the brain that disrupt the brain's ability to control movement, muscle coordination, and posture. The resulting motor deficits manifest very early in a person's development, with delayed or abnormal progress in attaining developmental milestones. Deficits may become more obvious as the person grows and matures over time.

2. We evaluate your signs and symptoms, such as ataxia, spasticity, flaccidity, athetosis, chorea, and difficulty with precise movements when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements. We will also evaluate your signs, such as dysarthria and apraxia of speech, and receptive and expressive language problems when we determine your ability to communicate.

3. We will consider your other impairments or signs and symptoms that develop secondary to the disorder, such as post-impairment syndrome (a combination of pain, fatigue, and weakness due to muscle abnormalities); overuse syndromes (repetitive motion injuries); arthritis; abnormalities of proprioception (perception of the movements and position of the body); abnormalities of stereognosis (perception and identification of objects by touch); learning problems; anxiety; and depression.

M. *What are spinal cord disorders, and how do we evaluate them under 11.08?*

1. *Spinal cord disorders* may be congenital or caused by injury to the spinal cord. Motor signs and symptoms of spinal cord disorders include paralysis, flaccidity, spasticity, and weakness.

2. *Spinal cord disorders with complete loss of function* (11.08A) addresses spinal cord disorders that result in a complete lack of motor, sensory, and autonomic function of the affected part(s) of the body.

3. *Spinal cord disorders with disorganization of motor function* (11.08B) addresses spinal cord disorders that result in less than a complete loss of function of the affected part(s) of the body, reducing, but not eliminating, motor, sensory, and autonomic function.

4. When we evaluate your spinal cord disorder, we generally need evidence from at least 3 months after your symptoms began in order to evaluate your disorganization of motor function. In some cases, evidence of your spinal cord disorder may be sufficient to allow your claim within 3 months after the spinal cord disorder. If the medical evidence demonstrates total cord transection causing a loss of motor and sensory functions below the level of injury, we will not wait 3 months but will make the allowance decision immediately.

N. *What is multiple sclerosis, and how do we evaluate it under 11.09?*

1. *Multiple sclerosis (MS)* is a chronic, inflammatory, degenerative disorder that damages the myelin sheath surrounding the nerve fibers in the brain and spinal cord. The damage disrupts the normal transmission of nerve impulses within the brain and between the brain and other parts of the body, causing impairment in muscle coordination, strength, balance, sensation, and vision. There are several forms of MS, ranging from mildly to highly aggressive. Milder forms generally involve acute attacks (exacerbations) with partial or complete recovery from signs and symptoms (remissions). Aggressive forms generally exhibit a steady progression of signs and symptoms with few or no remissions. The effects of all forms vary from person to person.

2. We evaluate your signs and symptoms, such as flaccidity, spasticity, spasms, incoordination, imbalance, tremor, physical fatigue, muscle weakness, dizziness, tingling, and numbness when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements. When determining whether you have limitations of physical and mental functioning, we will consider your other impairments or signs and symptoms that develop secondary to the disorder, such as fatigue; visual loss; trouble sleeping; impaired attention, concentration, memory, or judgment; mood swings; and depression. If you have a vision impairment resulting from your MS, we may evaluate that impairment under the special senses body system, 2.00.

O. *What is amyotrophic lateral sclerosis, and how do we evaluate it under 11.10? Amyotrophic lateral sclerosis (ALS)* is a type of motor neuron disorder that rapidly and progressively attacks the nerve cells responsible for controlling voluntary muscles. We establish ALS under 11.10 when you have a documented diagnosis of ALS. We require documentation based on generally accepted methods consistent with the prevailing state of medical knowledge and clinical practice. We require laboratory testing to establish the diagnosis when the clinical findings of upper and lower motor neuron disease are not present in three or more regions. Electrophysiological studies, such as nerve conduction velocity studies and electromyography (EMG), may support your diagnosis of ALS; however, we will not purchase these studies.

P. *What are neurodegenerative disorders of the central nervous system, such as Huntington's disease, Friedreich's ataxia, and spinocerebellar degeneration, and how do we evaluate them under 11.17?* Neurodegenerative disorders of the central nervous system are disorders characterized by progressive and irreversible degeneration of neurons or their supporting cells. Over time, these disorders impair many of the body's motor, cognitive, and other mental functions. We consider neurodegenerative disorders of the central nervous system under 11.17 that we do not evaluate elsewhere in section 11.00, such as Huntington's disease (HD), Friedreich's ataxia, spinocerebellar degeneration, Creutzfeldt-Jakob disease (CJD), progressive supranuclear palsy (PSP), early-onset Alzheimer's disease, and frontotemporal dementia (Pick's disease). When these disorders result in solely cognitive and other mental function effects, we will evaluate the disorder under the mental disorder listings.

Q. *What is traumatic brain injury, and how do we evaluate it under 11.18?*

1. *Traumatic brain injury (TBI)* is damage to the brain resulting from skull fracture, collision with an external force leading to a closed head injury, or penetration by an object that enters the skull and makes contact with brain tissue. We evaluate TBI that results in coma or persistent vegetative state (PVS) under 11.20.

2. We generally need evidence from at least 3 months after the TBI to evaluate whether you have disorganization of motor function under 11.18A or the impact that your disorder has on your physical and mental functioning under 11.18B. In some cases, evidence of your TBI is sufficient to determine disability within 3 months post-TBI. If we are unable to allow your claim within 3 months post-TBI, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-TBI. If a finding of disability still is not possible at that time, we will again defer adjudication of the claim until we obtain evidence at least 6 months after your TBI.

R. *What are coma and persistent vegetative state, and how do we evaluate them under 11.20?* Coma is a state of unconsciousness in which a person does not exhibit a sleep/wake cycle, and is unable to perceive or respond to external stimuli. People who do not fully emerge from coma may progress into a persistent vegetative state (PVS). PVS is a condition of partial arousal in which a person may have a low level of consciousness but is still unable to react to external stimuli. In contrast to coma, a person in a PVS retains sleep/wake cycles and may exhibit some key lower brain functions, such as spontaneous movement, opening and moving eyes, and grimacing. Coma or PVS may result from TBI, a nontraumatic insult to the brain (such as a vascular insult, infection, or brain tumor), or a neurodegenerative or metabolic disorder. Medically induced comas are not considered under 11.20 and should be considered under the section pertaining to the underlying reason the coma was medically induced and not under this section.

S. *What are motor neuron disorders, other than ALS, and how do we evaluate them under 11.22?* Motor neuron disorders such as progressive bulbar palsy, primary lateral sclerosis (PLS), and spinal muscular atrophy (SMA) are progressive neurological disorders that destroy the cells that control voluntary muscle activity, such as walking, breathing, swallowing, and speaking. We evaluate the effects of these disorders on motor functioning, bulbar and neuromuscular functioning, oral communication, or limitations in physical and mental functioning.

T. *How do we consider symptoms of fatigue in these listings?* Fatigue is one of the most common and limiting symptoms of some neurological disorders, such as multiple sclerosis, post-polio syndrome, and myasthenia gravis. These disorders may result in physical fatigue (lack of muscle strength) or mental fatigue (decreased awareness or attention). When we evaluate your fatigue, we will consider the intensity, persistence, and effects of fatigue on your functioning. This may include information such as the clinical and laboratory data and other objective evidence concerning your neurological deficit, a description of fatigue considered characteristic of your disorder, and information about your functioning. We consider the effects of physical fatigue on your ability to stand up, balance, walk, or perform fine and gross motor movements using the criteria described in 11.00D. We consider the effects of physical and mental fatigue when we evaluate your physical and mental functioning described in 11.00G.

U. *How do we evaluate your neurological disorder when it does not meet one of these listings?*

1. If your neurological disorder does not meet the criteria of any of these listings, we must also consider whether your impairment(s) meets the criteria of a listing in another body system. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §§ 404.1526 and 416.926 of this chapter.

2. If your impairment(s) does not meet or medically equal the criteria of a listing, you may or may not have the residual functional capacity to perform your past relevant work or adjust to other work that exists in significant numbers in the national economy, which we determine at the fourth and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter.

3. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

11.01 Category of Impairments, Neurological Disorders

11.02 *Epilepsy*, documented by a detailed description of a typical seizure and characterized by A, B, C, or D:

A. Generalized tonic-clonic seizures (see 11.00H1a), occurring at least once a month for at least 3 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C); or

B. Dyscognitive seizures (see 11.00H1b), occurring at least once a week for at least 3 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C); or

C. Generalized tonic-clonic seizures (see 11.00H1a), occurring at least once every 2 months for at least 4 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C); and a marked limitation in one of the following:

1. Physical functioning (see 11.00G3a); or

2. Understanding, remembering, or applying information (see 11.00G3b(i)); or

3. Interacting with others (see 11.00G3b(ii)); or

4. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

5. Adapting or managing oneself (see 11.00G3b(iv)); or

D. Dyscognitive seizures (see 11.00H1b), occurring at least once every 2 weeks for at least 3 consecutive months (see 11.00H4) despite adherence to prescribed treatment (see 11.00C); and a marked limitation in one of the following:

1. Physical functioning (see 11.00G3a); or

2. Understanding, remembering, or applying information (see 11.00G3b(i)); or

3. Interacting with others (see 11.00G3b(ii)); or

4. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

5. Adapting or managing oneself (see 11.00G3b(iv)).

11.03 [Reserved]

11.04 *Vascular insult to the brain,* characterized by A, B, or C:

A. Sensory or motor aphasia resulting in ineffective speech or communication (see 11.00E1) persisting for at least 3 consecutive months after the insult; or

B. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the insult; or

C. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a) and in one of the following areas of mental functioning, both persisting for at least 3 consecutive months after the insult:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.05 *Benign brain tumors,* characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.06 *Parkinsonian syndrome,* characterized by A or B despite adherence to prescribed treatment for at least 3 consecutive months (see 11.00C):

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.07 *Cerebral palsy,* characterized by A, B, or C:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)); or

C. Significant interference in communication due to speech, hearing, or visual deficit (see 11.00E2).

11.08 *Spinal cord disorders,* characterized by A, B, or C:

A. Complete loss of function, as described in 11.00M2, persisting for 3 consecutive months after the disorder (see 11.00M4); or

B. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities persisting for 3 consecutive months after the disorder (see 11.00M4); or

C. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a) and in one of the following areas of mental functioning, both persisting for 3 consecutive months after the disorder (see 11.00M4):

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.09 *Multiple sclerosis,* characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an

extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.10 *Amyotrophic lateral sclerosis (ALS)* established by clinical and laboratory findings (see 11.00O).

11.11 *Post-polio syndrome,* characterized by A, B, C, or D:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Unintelligible speech (see 11.00E3); or

C. Bulbar and neuromuscular dysfunction (see 11.00F), resulting in:

1. Acute respiratory failure requiring mechanical ventilation; or

2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter; or

D. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.12 *Myasthenia gravis,* characterized by A, B, or C despite adherence to prescribed treatment for at least 3 months (see 11.00C):

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Bulbar and neuromuscular dysfunction (see 11.00F), resulting in:

1. One myasthenic crisis requiring mechanical ventilation; or

2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter; or

C. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.13 *Muscular dystrophy,* characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.14 *Peripheral neuropathy,* characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.15 [Reserved]

11.16 [Reserved]

11.17 *Neurodegenerative disorders of the central nervous system, such as Huntington's disease, Friedreich's ataxia, and spinocerebellar degeneration,* characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.18 *Traumatic brain injury*, characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the injury; or

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following areas of mental functioning, persisting for at least 3 consecutive months after the injury:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.19 [Reserved]

11.20 *Coma or persistent vegetative state*, persisting for at least 1 month.

11.21 [Reserved]

11.22 *Motor neuron disorders other than ALS*, characterized by A, B, or C:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Bulbar and neuromuscular dysfunction (see 11.00F), resulting in:

1. Acute respiratory failure requiring invasive mechanical ventilation; or

2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter; or

C. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or

2. Interacting with others (see 11.00G3b(ii)); or

3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

12.00 Mental Disorders

A. *How are the listings for mental disorders arranged, and what do they require?*

1. The listings for mental disorders are arranged in 11 categories: Neurocognitive disorders (12.02); schizophrenia spectrum and other psychotic disorders (12.03); depressive, bipolar and related disorders (12.04); intellectual disorder (12.05); anxiety and obsessive-compulsive disorders (12.06); somatic symptom and related disorders (12.07); personality and impulse-control disorders (12.08); autism spectrum disorder (12.10); neurodevelopmental disorders (12.11); eating disorders (12.13); and trauma- and stressor-related disorders (12.15).

2. Listings 12.07, 12.08, 12.10, 12.11, and 12.13 have two paragraphs, designated A and B; your mental disorder must satisfy the requirements of both paragraphs A and B. Listings 12.02, 12.03, 12.04, 12.06, and 12.15 have three paragraphs, designated A, B, and C; your mental disorder must satisfy the requirements of both paragraphs A and B, or the requirements of both paragraphs A and C. Listing 12.05 has two paragraphs that are unique to that listing (see 12.00A3); your mental disorder must satisfy the requirements of either paragraph A or paragraph B.

a. Paragraph A of each listing (except 12.05) includes the medical criteria that must be present in your medical evidence.

b. Paragraph B of each listing (except 12.05) provides the functional criteria we assess, in conjunction with a rating scale (see 12.00E and 12.00F), to evaluate how your mental disorder limits your functioning. These criteria represent the areas of mental functioning a person uses in a work setting. They are: Understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. We will determine the degree to which your medically determinable mental impairment affects the four areas of mental functioning and your ability to function independently, appropriately, effectively, and on a sustained basis (see §§ 404.1520a(c)(2) and 416.920a(c)(2) of this chapter). To satisfy the paragraph B criteria, your mental disorder must result in ''extreme'' limitation of one, or ''marked'' limitation of two, of the four areas of mental functioning. (When we refer to ''paragraph B criteria'' or ''area[s] of mental functioning'' in the introductory text of this body system, we mean the criteria in paragraph B of every listing except 12.05.)

c. Paragraph C of listings 12.02, 12.03, 12.04, 12.06, and 12.15 provides the criteria we use to evaluate ''serious and persistent mental disorders.'' To satisfy the paragraph C criteria, your mental disorder must be ''serious and persistent''; that is, there must be a medically documented history of the existence of the disorder over a period of at least 2 years, and evidence that satisfies the criteria in both C1 and C2 (see 12.00G). (When we refer to ''paragraph C'' or ''the paragraph C criteria'' in the introductory text of this body system, we mean the criteria in paragraph C of listings 12.02, 12.03, 12.04, 12.06, and 12.15.)

3. Listing 12.05 has two paragraphs, designated A and B, that apply to only intellectual disorder. Each paragraph requires that you have significantly subaverage general intellectual functioning; significant deficits in current adaptive functioning; and evidence that demonstrates or supports (is consistent with) the conclusion that your disorder began prior to age 22.

B. *Which mental disorders do we evaluate under each listing category?*

1. *Neurocognitive disorders (12.02).*

a. These disorders are characterized by a clinically significant decline in cognitive functioning. Symptoms and signs may include, but are not limited to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decision-making), visual-spatial functioning, language and speech, perception, insight, judgment, and insensitivity to social standards.

b. Examples of disorders that we evaluate in this category include major neurocognitive disorder; dementia of the Alzheimer type; vascular dementia; dementia due to a medical condition such as a metabolic disease (for example, late-onset Tay-Sachs disease), human immunodeficiency virus infection, vascular malformation, progressive brain tumor, neurological disease (for example, multiple sclerosis, Parkinsonian syndrome, Huntington disease), or traumatic brain injury; or substance-induced cognitive disorder associated with drugs of abuse, medications, or toxins. (We evaluate neurological disorders under that body system (see 11.00). We evaluate cognitive impairments that result from neurological disorders under 12.02 if they do not satisfy the requirements in 11.00 (see 11.00G).)

c. This category does not include the mental disorders that we evaluate under intellectual disorder (12.05), autism spectrum disorder (12.10), and neurodevelopmental disorders (12.11).

2. *Schizophrenia spectrum and other psychotic disorders (12.03).*

a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood, odd beliefs and mannerisms, and paranoia.

b. Examples of disorders that we evaluate in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to another medical condition.

3. *Depressive, bipolar and related disorders (12.04).*

a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, sadness, euphoria, and social withdrawal.

b. Examples of disorders that we evaluate in this category include bipolar disorders (I or II), cyclothymic disorder, major depressive disorder, persistent depressive disorder (dysthymia), and bipolar or depressive disorder due to another medical condition.

4. *Intellectual disorder (12.05).*

a. This disorder is characterized by significantly subaverage general intellectual functioning, significant deficits in current adaptive functioning, and manifestation of the disorder before age 22. Signs may include, but are not limited to, poor conceptual, social, or practical skills evident in your adaptive functioning.

b. The disorder that we evaluate in this category may be described in the evidence as intellectual disability, intellectual developmental disorder, or historically used terms such as ''mental retardation.''

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), autism spectrum disorder (12.10), or neurodevelopmental disorders (12.11).

5. *Anxiety and obsessive-compulsive disorders (12.06).*

a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or people. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent physical complaints.

b. Examples of disorders that we evaluate in this category include social anxiety disorder, panic disorder, generalized anxiety disorder, agoraphobia, and obsessive-compulsive disorder.

c. This category does not include the mental disorders that we evaluate under trauma- and stressor-related disorders (12.15).

6. *Somatic symptom and related disorders (12.07).*

a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the direct effects of a substance, or a culturally sanctioned behavior or experience. These disorders may also be characterized by a preoccupation with having or acquiring a serious medical condition that has not been identified or diagnosed. Symptoms and signs may include, but are not limited to, pain and

other abnormalities of sensation, gastrointestinal symptoms, fatigue, a high level of anxiety about personal health status, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.

b. Examples of disorders that we evaluate in this category include somatic symptom disorder, illness anxiety disorder, and conversion disorder.

7. *Personality and impulse-control disorders (12.08).*

a. These disorders are characterized by enduring, inflexible, maladaptive, and pervasive patterns of behavior. Onset typically occurs in adolescence or young adulthood. Symptoms and signs may include, but are not limited to, patterns of distrust, suspiciousness, and odd beliefs; social detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; and inappropriate, intense, impulsive anger and behavioral expression grossly out of proportion to any external provocation or psychosocial stressors.

b. Examples of disorders that we evaluate in this category include paranoid, schizoid, schizotypal, borderline, avoidant, dependent, obsessive-compulsive personality disorders, and intermittent explosive disorder.

8. *Autism spectrum disorder (12.10).*

a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative activity; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and stagnation of development or loss of acquired skills early in life. Symptoms and signs may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.

b. Examples of disorders that we evaluate in this category include autism spectrum disorder with or without accompanying intellectual impairment, and autism spectrum disorder with or without accompanying language impairment.

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), intellectual disorder (12.05), and neurodevelopmental disorders (12.11).

9. *Neurodevelopmental disorders (12.11).*

a. These disorders are characterized by onset during the developmental period, that is, during childhood or adolescence, although sometimes they are not diagnosed until adulthood. Symptoms and signs may include, but are not limited to, underlying abnormalities in cognitive processing (for example, deficits in learning and applying verbal or nonverbal information, visual perception, memory, or a combination of these); deficits in attention or impulse control; low frustration tolerance; excessive or poorly planned motor activity; difficulty with organizing (time, space, materials, or tasks); repeated accidental injury; and deficits in social skills. Symptoms and signs specific to tic disorders include sudden, rapid, recurrent, non-rhythmic, motor movement or vocalization.

b. Examples of disorders that we evaluate in this category include specific learning disorder, borderline intellectual functioning, and tic disorders (such as Tourette syndrome).

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), autism spectrum disorder (12.10), or personality and impulse-control disorders (12.08).

10. *Eating disorders (12.13).*

a. These disorders are characterized by disturbances in eating behavior and preoccupation with, and excessive self-evaluation of, body weight and shape. Symptoms and signs may include, but are not limited to, restriction of energy consumption when compared with individual requirements; recurrent episodes of binge eating or behavior intended to prevent weight gain, such as self-induced vomiting, excessive exercise, or misuse of laxatives; mood disturbances, social withdrawal, or irritability; amenorrhea; dental problems; abnormal laboratory findings; and cardiac abnormalities.

b. Examples of disorders that we evaluate in this category include anorexia nervosa, bulimia nervosa, binge-eating disorder, and avoidant/restrictive food disorder.

11. *Trauma- and stressor-related disorders (12.15).*

a. These disorders are characterized by experiencing or witnessing a traumatic or stressful event, or learning of a traumatic event occurring to a close family member or close friend, and the psychological aftermath of clinically significant effects on functioning. Symptoms and signs may include, but are not limited to, distressing memories, dreams, and flashbacks related to the trauma or stressor; avoidant behavior; diminished interest or participation in significant activities; persistent negative emotional states (for example, fear, anger) or persistent inability to experience positive emotions (for example, satisfaction, affection); anxiety; irritability; aggression; exaggerated startle response; difficulty concentrating; and sleep disturbance.

b. Examples of disorders that we evaluate in this category include posttraumatic stress disorder and other specified trauma- and

stressor-related disorders (such as adjustment-like disorders with prolonged duration without prolonged duration of stressor).

c. This category does not include the mental disorders that we evaluate under anxiety and obsessive-compulsive disorders (12.06), and cognitive impairments that result from neurological disorders, such as a traumatic brain injury, which we evaluate under neurocognitive disorders (12.02).

C. *What evidence do we need to evaluate your mental disorder?*

1. *General.* We need objective medical evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function in a work setting. We will determine the extent and kinds of evidence we need from medical and nonmedical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (12.05), see 12.00H. For our basic rules on evidence, see §§ 404.1512, 404.1513, 404.1520b, 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating medical opinions, see §§ 404.1520c, 404.1527, 416.920c, and 416.927 of this chapter. For our rules on evidence about your symptoms, see §§ 404.1529 and 416.929 of this chapter.

2. *Evidence from medical sources.* We will consider all relevant medical evidence about your disorder from your physician, psychologist, and other medical sources, which include health care providers such as physician assistants, psychiatric nurse practitioners, licensed clinical social workers, and clinical mental health counselors. Evidence from your medical sources may include:

a. Your reported symptoms.

b. Your medical, psychiatric, and psychological history.

c. The results of physical or mental status examinations, structured clinical interviews, psychiatric or psychological rating scales, measures of adaptive functioning, or other clinical findings.

d. Psychological testing, imaging results, or other laboratory findings.

e. Your diagnosis.

f. The type, dosage, and beneficial effects of medications you take.

g. The type, frequency, duration, and beneficial effects of therapy you receive.

h. Side effects of medication or other treatment that limit your ability to function.

i. Your clinical course, including changes in your medication, therapy, or other treatment, and the time required for therapeutic effectiveness.

j. Observations and descriptions of how you function during examinations or therapy.

k. Information about sensory, motor, or speech abnormalities, or about your cultural background (for example, language or customs) that may affect an evaluation of your mental disorder.

l. The expected duration of your symptoms and signs and their effects on your functioning, both currently and in the future.

3. *Evidence from you and people who know you.* We will consider all relevant evidence about your mental disorder and your daily functioning that we receive from you and from people who know you. We will ask about your symptoms, your daily functioning, and your medical treatment. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so. This evidence may include information from your family, caregivers, friends, neighbors, clergy, case managers, social workers, shelter staff, or other community support and outreach workers. We will consider whether your statements and the statements from third parties are consistent with the medical and other evidence we have.

4. *Evidence from school, vocational training, work, and work-related programs.*

a. *School.* You may have recently attended or may still be attending school, and you may have received or may still be receiving special education services. If so, we will try to obtain information from your school sources when we need it to assess how your mental disorder affects your ability to function. Examples of this information include your Individualized Education Programs (IEPs), your Section 504 plans, comprehensive evaluation reports, school-related therapy progress notes, information from your teachers about how you function in a classroom setting, and information about any special services or accommodations you receive at school.

b. *Vocational training, work, and work-related programs.* You may have recently participated in or may still be participating in vocational training, work-related programs, or work activity. If so, we will try to obtain information from your training program or your employer when we need it to assess how your mental disorder affects your ability to function. Examples of this information include training or work evaluations, modifications to your work duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, sheltered or supported work program, rehabilitation program, or transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work (see 12.00D).

5. *Need for longitudinal evidence.*

a. *General.* Longitudinal medical evidence can help us learn how you function over time, and help us evaluate any variations in

the level of your functioning. We will request longitudinal evidence of your mental disorder when your medical providers have records concerning you and your mental disorder over a period of months or perhaps years (see §§404.1512(d) and 416.912(d) of this chapter).

b. *Non-medical sources of longitudinal evidence.* Certain situations, such as chronic homelessness, may make it difficult for you to provide longitudinal medical evidence. If you have a severe mental disorder, you will probably have evidence of its effects on your functioning over time, even if you have not had an ongoing relationship with the medical community or are not currently receiving treatment. For example, family members, friends, neighbors, former employers, social workers, case managers, community support staff, outreach workers, or government agencies may be familiar with your mental health history. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so.

c. *Absence of longitudinal evidence.* In the absence of longitudinal evidence, we will use current objective medical evidence and all other relevant evidence available to us in your case record to evaluate your mental disorder. If we purchase a consultative examination to document your disorder, the record will include the results of that examination (see §§404.1514 and 416.914 of this chapter). We will take into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you do not have longitudinal evidence, the current evidence alone may not be sufficient or appropriate to show that you have a disorder that meets the criteria of one of the mental disorders listings. In that case, we will follow the rules in 12.00J.

6. *Evidence of functioning in unfamiliar situations or supportive situations.*

a. *Unfamiliar situations.* We recognize that evidence about your functioning in unfamiliar situations does not necessarily show how you would function on a sustained basis in a work setting. In one-time, time-limited, or other unfamiliar situations, you may function differently than you do in familiar situations. In unfamiliar situations, you may appear more, or less, limited than you do on a daily basis and over time.

b. *Supportive situations.* Your ability to complete tasks in settings that are highly structured, or that are less demanding or more supportive than typical work settings does not necessarily demonstrate your ability to complete tasks in the context of regular employment during a normal workday or work week.

c. *Our assessment.* We must assess your ability to complete tasks by evaluating all the evidence, such as reports about your functioning from you and third parties who are familiar with you, with an emphasis on how independently, appropriately, and effectively you are able to complete tasks on a sustained basis.

D. *How do we consider psychosocial supports, structured settings, living arrangements, and treatment?*

1. *General.* Psychosocial supports, structured settings, and living arrangements, including assistance from your family or others, may help you by reducing the demands made on you. In addition, treatment you receive may reduce your symptoms and signs and possibly improve your functioning, or may have side effects that limit your functioning. Therefore, when we evaluate the effects of your mental disorder and rate the limitation of your areas of mental functioning, we will consider the kind and extent of supports you receive, the characteristics of any structured setting in which you spend your time, and the effects of any treatment. This evidence may come from reports about your functioning from you or third parties who are familiar with you, and other third-party statements or information. Following are some examples of the supports you may receive:

a. You receive help from family members or other people who monitor your daily activities and help you to function. For example, family members administer your medications, remind you to eat, shop for you and pay your bills, or change their work hours so you are never home alone.

b. You participate in a special education or vocational training program, or a psychosocial rehabilitation day treatment or community support program, where you receive training in daily living and entry-level work skills.

c. You participate in a sheltered, supported, or transitional work program, or in a competitive employment setting with the help of a job coach or supervisor.

d. You receive comprehensive ''24/7 wrap-around'' mental health services while living in a group home or transitional housing, while participating in a semi-independent living program, or while living in individual housing (for example, your own home or apartment).

e. You live in a hospital or other institution with 24-hour care.

f. You receive assistance from a crisis response team, social workers, or community mental health workers who help you meet your physical needs, and who may also represent you in dealings with government or community social services.

g. You live alone and do not receive any psychosocial support(s); however, you have created a highly structured environment by eliminating all but minimally necessary contact with the world outside your living space.

2. *How we consider different levels of support and structure in psychosocial rehabilitation programs.*

a. Psychosocial rehabilitation programs are based on your specific needs. Therefore, we cannot make any assumptions about your mental disorder based solely on the fact that you are associated with such a program. We must know the details of the program(s) in which you are involved and the pattern(s) of your involvement over time.

b. The kinds and levels of supports and structures in psychosocial rehabilitation programs typically occur on a scale of ''most restrictive'' to ''least restrictive.'' Participation in a psychosocial rehabilitation program at the most restrictive level would suggest greater limitation of your areas of mental functioning than would participation at a less restrictive level. The length of time you spend at different levels in a program also provides information about your functioning. For example, you could begin participation at the most restrictive crisis intervention level but gradually improve to the point of readiness for a lesser level of support and structure and possibly some form of employment.

3. *How we consider the help or support you receive.*

a. We will consider the complete picture of your daily functioning, including the kinds, extent, and frequency of help and support you receive, when we evaluate your mental disorder and determine whether you are able to use the four areas of mental functioning in a work setting. The fact that you have done, or currently do, some routine activities without help or support does not necessarily mean that you do not have a mental disorder or that you are not disabled. For example, you may be able to take care of your personal needs, cook, shop, pay your bills, live by yourself, and drive a car. You may demonstrate both strengths and deficits in your daily functioning.

b. You may receive various kinds of help and support from others that enable you to do many things that, because of your mental disorder, you might not be able to do independently. Your daily functioning may depend on the special contexts in which you function. For example, you may spend your time among only familiar people or surroundings, in a simple and steady routine or an unchanging environment, or in a highly structured setting. However, this does not necessarily show how you would function in a work setting on a sustained basis, throughout a normal workday and workweek. (See 12.00H for further discussion of these issues regarding significant deficits in adaptive functioning for the purpose of 12.05.)

4. *How we consider treatment.* We will consider the effect of any treatment on your functioning when we evaluate your mental disorder. Treatment may include medication(s), psychotherapy, or other forms of intervention, which you receive in a doctor's office, during a hospitalization, or in a day program at a hospital or outpatient treatment program. With treatment, you may not only have your symptoms and signs reduced, but may also be able to function in a work setting. However, treatment may not resolve all of the limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that limit your mental or physical functioning. For example, you may experience drowsiness, blunted affect, memory loss, or abnormal involuntary movements.

E. *What are the paragraph B criteria?*

1. *Understand, remember, or apply information (paragraph B1).* This area of mental functioning refers to the abilities to learn, recall, and use information to perform work activities. Examples include: Understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing work activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make work-related decisions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

2. *Interact with others (paragraph B2).* This area of mental functioning refers to the abilities to relate to and work with supervisors, co-workers, and the public. Examples include: cooperating with others; asking for help when needed; handling conflicts with others; stating own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

3. *Concentrate, persist, or maintain pace (paragraph B3).* This area of mental functioning refers to the abilities to focus attention on work activities and stay on task at a sustained rate. Examples include: Initiating and performing a task that you understand and know how to do; working at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while working; changing activities or work settings without being disruptive; working close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at work; and working a full day without needing more than the allotted

number or length of rest periods during the day. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

4. *Adapt or manage oneself (paragraph B4).* This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in a work setting. Examples include: Responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable work performance; setting realistic goals; making plans for yourself independently of others; maintaining personal hygiene and attire appropriate to a work setting; and being aware of normal hazards and taking appropriate precautions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

F. *How do we use the paragraph B criteria to evaluate your mental disorder?*

1. *General.* We use the paragraph B criteria, in conjunction with a rating scale (see 12.00F2), to rate the degree of your limitations. We consider only the limitations that result from your mental disorder(s). We will determine whether you are able to use each of the paragraph B areas of mental functioning in a work setting. We will consider, for example, the kind, degree, and frequency of difficulty you would have; whether you could function without extra help, structure, or supervision; and whether you would require special conditions with regard to activities or other people (see 12.00D).

2. *The five-point rating scale.* We evaluate the effects of your mental disorder on each of the four areas of mental functioning based on a five-point rating scale consisting of none, mild, moderate, marked, and extreme limitation. To satisfy the paragraph B criteria, your mental disorder must result in extreme limitation of one, or marked limitation of two, paragraph B areas of mental functioning. Under these listings, the five rating points are defined as follows:

a. *No limitation (or none).* You are able to function in this area independently, appropriately, effectively, and on a sustained basis.

b. *Mild limitation.* Your functioning in this area independently, appropriately, effectively, and on a sustained basis is slightly limited.

c. *Moderate limitation.* Your functioning in this area independently, appropriately, effectively, and on a sustained basis is fair.

d. *Marked limitation.* Your functioning in this area independently, appropriately, effectively, and on a sustained basis is seriously limited.

e. *Extreme limitation.* You are not able to function in this area independently, appropriately, effectively, and on a sustained basis.

3. *Rating the limitations of your areas of mental functioning.*

a. *General.* We use all of the relevant medical and non-medical evidence in your case record to evaluate your mental disorder: The symptoms and signs of your disorder, the reported limitations in your activities, and any help and support you receive that is necessary for you to function. The medical evidence may include descriptors regarding the diagnostic stage or level of your disorder, such as ''mild'' or ''moderate.'' Clinicians may use these terms to characterize your medical condition. However, these terms will not always be the same as the degree of your limitation in a paragraph B area of mental functioning.

b. *Areas of mental functioning in daily activities.* You use the same four areas of mental functioning in daily activities at home and in the community that you would use to function at work. With respect to a particular task or activity, you may have trouble using one or more of the areas. For example, you may have difficulty understanding and remembering what to do; or concentrating and staying on task long enough to do it; or engaging in the task or activity with other people; or trying to do the task without becoming frustrated and losing self-control. Information about your daily functioning can help us understand whether your mental disorder limits one or more of these areas; and, if so, whether it also affects your ability to function in a work setting.

c. *Areas of mental functioning in work settings.* If you have difficulty using an area of mental functioning from day-to-day at home or in your community, you may also have difficulty using that area to function in a work setting. On the other hand, if you are able to use an area of mental functioning at home or in your community, we will not necessarily assume that you would also be able to use that area to function in a work setting where the demands and stressors differ from those at home. We will consider all evidence about your mental disorder and daily functioning before we reach a conclusion about your ability to work.

d. *Overall effect of limitations.* Limitation of an area of mental functioning reflects the overall degree to which your mental disorder interferes with that area. The degree of limitation is how we document our assessment of your limitation when using the area of mental functioning independently, appropriately, effectively, and on a sustained basis. It does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test results) can establish the degree of limitation of an area of mental functioning.

e. *Effects of support, supervision, structure on functioning.* The degree of limitation of an area of mental functioning also reflects the kind and extent of supports or supervision you receive and the characteristics of any structured setting where you spend your time, which enable you to function. The more extensive the support you need from others or the more structured the setting you need in order to function, the more limited we will find you to be (see 12.00D).

f. *Specific instructions for paragraphs B1, B3, and B4.* For paragraphs B1, B3, and B4, the greatest degree of limitation of any part of the area of mental functioning directs the rating of limitation of that whole area of mental functioning.

(i) To do a work-related task, you must be able to understand *and* remember *and* apply information required by the task. Similarly, you must be able to concentrate *and* persist *and* maintain pace in order to complete the task, and adapt *and* manage yourself in the workplace. Limitation in any one of these parts (understand *or* remember *or* apply; concentrate *or* persist *or* maintain pace; adapt *or* manage oneself) may prevent you from completing a work-related task.

(ii) We will document the rating of limitation of the whole area of mental functioning, not each individual part. We will not add ratings of the parts together. For example, with respect to paragraph B3, if you have marked limitation in maintaining pace, and mild or moderate limitations in concentrating and persisting, we will find that you have marked limitation in the whole paragraph B3 area of mental functioning.

(iii) Marked limitation in more than one part of the same paragraph B area of mental functioning does not satisfy the requirement to have marked limitation in two paragraph B areas of mental functioning.

4. *How we evaluate mental disorders involving exacerbations and remissions.*

a. When we evaluate the effects of your mental disorder, we will consider how often you have exacerbations and remissions, how long they last, what causes your mental disorder to worsen or improve, and any other relevant information. We will assess any limitation of the affected paragraph B area(s) of mental functioning using the rating scale for the paragraph B criteria. We will consider whether you can use the area of mental functioning on a regular and continuing basis (8 hours a day, 5 days a week, or an equivalent work schedule). We will not find that you are able to work solely because you have a period(s) of improvement (remission), or that you are disabled solely because you have a period of worsening (exacerbation), of your mental disorder.

b. If you have a mental disorder involving exacerbations and remissions, you may be able to use the four areas of mental functioning to work for a few weeks or months. Recurrence or worsening of symptoms and signs, however, can interfere enough to render you unable to sustain the work.

G. *What are the paragraph C criteria, and how do we use them to evaluate your mental disorder?*

1. *General.* The paragraph C criteria are an alternative to the paragraph B criteria under listings 12.02, 12.03, 12.04, 12.06, and 12.15. We use the paragraph C criteria to evaluate mental disorders that are ''serious and persistent.'' In the paragraph C criteria, we recognize that mental health interventions may control the more obvious symptoms and signs of your mental disorder.

2. *Paragraph C criteria.*

a. We find a mental disorder to be ''serious and persistent'' when there is a medically documented history of the existence of the mental disorder in the listing category over a period of at least 2 years, and evidence shows that your disorder satisfies both C1 and C2.

b. The criterion in C1 is satisfied when the evidence shows that you rely, on an ongoing basis, upon medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s), to diminish the symptoms and signs of your mental disorder (see 12.00D). We consider that you receive ongoing medical treatment when the medical evidence establishes that you obtain medical treatment with a frequency consistent with accepted medical practice for the type of treatment or evaluation required for your medical condition. We will consider periods of inconsistent treatment or lack of compliance with treatment that may result from your mental disorder. If the evidence indicates that the inconsistent treatment or lack of compliance is a feature of your mental disorder, and it has led to an exacerbation of your symptoms and signs, we will not use it as evidence to support a finding that you have not received ongoing medical treatment as required by this paragraph.

c. The criterion in C2 is satisfied when the evidence shows that, despite your diminished symptoms and signs, you have achieved only marginal adjustment. ''Marginal adjustment'' means that your adaptation to the requirements of daily life is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. We will consider that you have achieved only marginal adjustment when the evidence shows that changes or increased demands have led to exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you have become unable to function outside of your home or a more restrictive setting, without substantial psychosocial supports (see 12.00D). Such deterioration may have necessitated a significant change in medication or other treatment. Similarly, because of the nature of

your mental disorder, evidence may document episodes of deterioration that have required you to be hospitalized or absent from work, making it difficult for you to sustain work activity over time.

H. *How do we document and evaluate intellectual disorder under 12.05?*

1. *General.* Listing 12.05 is based on the three elements that characterize intellectual disorder: Significantly subaverage general intellectual functioning; significant deficits in current adaptive functioning; and the disorder manifested before age 22.

2. *Establishing significantly subaverage general intellectual functioning.*

a. *Definition.* Intellectual functioning refers to the general mental capacity to learn, reason, plan, solve problems, and perform other cognitive functions. Under 12.05A, we identify significantly subaverage general intellectual functioning by the cognitive inability to function at a level required to participate in standardized intelligence testing. Our findings under 12.05A are based on evidence from an acceptable medical source. Under 12.05B, we identify significantly subaverage general intellectual functioning by an IQ score(s) on an individually administered standardized test of general intelligence that meets program requirements and has a mean of 100 and a standard deviation of 15. A qualified specialist (see 12.00H2c) must administer the standardized intelligence testing.

b. *Psychometric standards.* We will find standardized intelligence test results usable for the purposes of 12.05B1 when the measure employed meets contemporary psychometric standards for validity, reliability, normative data, and scope of measurement; and a qualified specialist has individually administered the test according to all pre-requisite testing conditions.

c. *Qualified specialist.* A ''qualified specialist'' is currently licensed or certified at the independent level of practice in the State where the test was performed, and has the training and experience to administer, score, and interpret intelligence tests. If a psychological assistant or paraprofessional administered the test, a supervisory qualified specialist must interpret the test findings and co-sign the examination report.

d. *Responsibility for conclusions based on testing.* We generally presume that your obtained IQ score(s) is an accurate reflection of your general intellectual functioning, unless evidence in the record suggests otherwise. Examples of this evidence include: a statement from the test administrator indicating that your obtained score is not an accurate reflection of your general intellectual functioning, prior or internally inconsistent IQ scores, or information about your daily functioning. Only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that your obtained IQ score(s) is not an accurate reflection of your general intellectual functioning. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record, such as:

(i) The data obtained in testing;

(ii) Your developmental history, including when your signs and symptoms began;

(iii) Information about how you function on a daily basis in a variety of settings; and

(iv) Clinical observations made during the testing period, such as your ability to sustain attention, concentration, and effort; to relate appropriately to the examiner; and to perform tasks independently without prompts or reminders.

3. *Establishing significant deficits in adaptive functioning.*

a. *Definition.* Adaptive functioning refers to how you learn and use conceptual, social, and practical skills in dealing with common life demands. It is your typical functioning at home and in the community, alone or among others. Under 12.05A, we identify significant deficits in adaptive functioning based on your dependence on others to care for your personal needs, such as eating and bathing. We will base our conclusions about your adaptive functioning on evidence from a variety of sources (see 12.00H3b) and not on your statements alone. Under 12.05B2, we identify significant deficits in adaptive functioning based on whether there is extreme limitation of one, or marked limitation of two, of the paragraph B criteria (see 12.00E; 12.00F).

b. *Evidence.* Evidence about your adaptive functioning may come from:

(i) Medical sources, including their clinical observations;

(ii) Standardized tests of adaptive functioning (see 12.00H3c);

(iii) Third party information, such as a report of your functioning from a family member or friend;

(iv) School records, if you were in school recently;

(v) Reports from employers or supervisors; and

(vi) Your own statements about how you handle all of your daily activities.

c. *Standardized tests of adaptive functioning.* We do not require the results of an individually administered standardized test of adaptive functioning. If your case record includes these test results, we will consider the results along with all other relevant evidence; however, we will use the guidelines in 12.00E and F to evaluate and determine the degree of your deficits in adaptive functioning, as required under 12.05B2.

d. *How we consider common everyday activities.*

(i) The fact that you engage in common everyday activities, such as caring for your

personal needs, preparing simple meals, or driving a car, will not always mean that you do not have deficits in adaptive functioning as required by 12.05B2. You may demonstrate both strengths and deficits in your adaptive functioning. However, a lack of deficits in one area does not negate the presence of deficits in another area. When we assess your adaptive functioning, we will consider all of your activities and your performance of them.

(ii) Our conclusions about your adaptive functioning rest on whether you do your daily activities independently, appropriately, effectively, and on a sustained basis. If you receive help in performing your activities, we need to know the kind, extent, and frequency of help you receive in order to perform them. We will not assume that your ability to do some common everyday activities, or to do some things without help or support, demonstrates that your mental disorder does not meet the requirements of 12.05B2. (See 12.00D regarding the factors we consider when we evaluate your functioning, including how we consider any help or support you receive.)

e. *How we consider work activity.* The fact that you have engaged in work activity, or that you work intermittently or steadily in a job commensurate with your abilities, will not always mean that you do not have deficits in adaptive functioning as required by 12.05B2. When you have engaged in work activity, we need complete information about the work, and about your functioning in the work activity and work setting, before we reach any conclusions about your adaptive functioning. We will consider all factors involved in your work history before concluding whether your impairment satisfies the criteria for intellectual disorder under 12.05B. We will consider your prior and current work history, if any, and various other factors influencing how you function. For example, we consider whether the work was in a supported setting, whether you required more supervision than other employees, how your job duties compared to others in the same job, how much time it took you to learn the job duties, and the reason the work ended, if applicable.

4. *Establishing that the disorder began before age 22.* We require evidence that demonstrates or supports (is consistent with) the conclusion that your mental disorder began prior to age 22. We do not require evidence that your impairment met all of the requirements of 12.05A or 12.05B prior to age 22. Also, we do not require you to have met our statutory definition of disability prior to age 22. When we do not have evidence that was recorded before you attained age 22, we need evidence about your current intellectual and adaptive functioning and the history of your disorder that supports the conclusion that the disorder began before you attained age 22. Examples of evidence that can demonstrate or support this conclusion include:

a. Tests of intelligence or adaptive functioning;

b. School records indicating a history of special education services based on your intellectual functioning;

c. An Individualized Education Program (IEP), including your transition plan;

d. Reports of your academic performance and functioning at school;

e. Medical treatment records;

f. Interviews or reports from employers;

g. Statements from a supervisor in a group home or a sheltered workshop; and

h. Statements from people who have known you and can tell us about your functioning in the past and currently.

I. *How do we evaluate substance use disorders?* If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability (see §§ 404.1535 and 416.935 of this chapter).

J. *How do we evaluate mental disorders that do not meet one of the mental disorders listings?*

1. These listings include only examples of mental disorders that we consider serious enough to prevent you from doing any gainful activity. If your severe mental disorder does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have another impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing (see §§ 404.1526 and 416.926 of this chapter).

3. If your impairment(s) does not meet or medically equal a listing, we will assess your residual functional capacity for engaging in substantial gainful activity (see §§ 404.1545 and 416.945 of this chapter). When we assess your residual functional capacity, we consider all of your impairment-related mental and physical limitations. For example, the side effects of some medications may reduce your general alertness, concentration, or physical stamina, affecting your residual functional capacity for non-exertional or exertional work activities. Once we have determined your residual functional capacity, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994

of this chapter, as appropriate, when we decide whether you continue to be disabled.

12.01 CATEGORY OF IMPAIRMENTS, MENTAL DISORDERS

12.02 *Neurocognitive disorders* (see 12.00B1), satisfied by A and B, or A and C:

A. Medical documentation of a significant cognitive decline from a prior level of functioning in *one* or more of the cognitive areas:

1. Complex attention;
2. Executive function;
3. Learning and memory;
4. Language;
5. Perceptual-motor; or
6. Social cognition.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.03 *Schizophrenia spectrum and other psychotic disorders* (see 12.00B2), satisfied by A and B, or A and C:

A. Medical documentation of *one* or more of the following:

1. Delusions or hallucinations;
2. Disorganized thinking (speech); or
3. Grossly disorganized behavior or catatonia.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.04 *Depressive, bipolar and related disorders* (see 12.00B3), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:

1. Depressive disorder, characterized by *five* or more of the following:

a. Depressed mood;
b. Diminished interest in almost all activities;
c. Appetite disturbance with change in weight;
d. Sleep disturbance;
e. Observable psychomotor agitation or retardation;
f. Decreased energy;
g. Feelings of guilt or worthlessness;
h. Difficulty concentrating or thinking; or
i. Thoughts of death or suicide.

2. Bipolar disorder, characterized by *three* or more of the following:

a. Pressured speech;
b. Flight of ideas;
c. Inflated self-esteem;
d. Decreased need for sleep;
e. Distractibility;
f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
g. Increase in goal-directed activity or psychomotor agitation.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of

at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.05 *Intellectual disorder* (see 12.00B4), satisfied by A or B:

A. Satisfied by 1, 2, and 3 (see 12.00H):

1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and

2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing); and

3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

OR

B. Satisfied by 1, 2, and 3 (see 12.00H):

1. Significantly subaverage general intellectual functioning evidenced by a or b:

a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or

b. A full scale (or comparable) IQ score of 71–75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and

2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:

a. Understand, remember, or apply information (see 12.00E1); or

b. Interact with others (see 12.00E2); or

c. Concentrate, persist, or maintain pace (see 12.00E3); or

d. Adapt or manage oneself (see 12.00E4); and

3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

12.06 *Anxiety and obsessive-compulsive disorders* (see 12.00B5), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. Anxiety disorder, characterized by *three* or more of the following;

a. Restlessness;

b. Easily fatigued;

c. Difficulty concentrating;

d. Irritability;

e. Muscle tension; or

f. Sleep disturbance.

2. Panic disorder or agoraphobia, characterized by *one* or both:

a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or

b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).

3. Obsessive-compulsive disorder, characterized by *one* or both:

a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts; or

b. Repetitive behaviors aimed at reducing anxiety.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.07 *Somatic symptom and related disorders* (see 12.00B6), satisfied by A and B:

A. Medical documentation of *one* or more of the following:

1. Symptoms of altered voluntary motor or sensory function that are not better explained by another medical or mental disorder;

2. One or more somatic symptoms that are distressing, with excessive thoughts, feelings, or behaviors related to the symptoms; or

3. Preoccupation with having or acquiring a serious illness without significant symptoms present.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

12.08 *Personality and impulse-control disorders* (see 12.00B7), satisfied by A and B:

A. Medical documentation of a pervasive pattern of *one* or more of the following:

1. Distrust and suspiciousness of others;

2. Detachment from social relationships;

3. Disregard for and violation of the rights of others;

4. Instability of interpersonal relationships;

5. Excessive emotionality and attention seeking;

6. Feelings of inadequacy;

7. Excessive need to be taken care of;

8. Preoccupation with perfectionism and orderliness; or

9. Recurrent, impulsive, aggressive behavioral outbursts.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

12.09 [Reserved]

12.10 *Autism spectrum disorder* (see 12.00B8), satisfied by A and B:

A. Medical documentation of *both* of the following:

1. Qualitative deficits in verbal communication, nonverbal communication, and social interaction; and

2. Significantly restricted, repetitive patterns of behavior, interests, or activities.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

12.11 *Neurodevelopmental disorders* (see 12.00B9), satisfied by A and B:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. *One* or both of the following:

a. Frequent distractibility, difficulty sustaining attention, and difficulty organizing tasks; or

b. Hyperactive and impulsive behavior (for example, difficulty remaining seated, talking excessively, difficulty waiting, appearing restless, or behaving as if being ''driven by a motor'').

2. Significant difficulties learning and using academic skills; or

3. Recurrent motor movement or vocalization.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

12.12 [Reserved]

12.13 *Eating disorders* (see 12.00B10), satisfied by A and B:

A. Medical documentation of a persistent alteration in eating or eating-related behavior that results in a change in consumption or absorption of food and that significantly impairs physical or psychological health.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

12.15 *Trauma- and stressor-related disorders* (see 12.00B11), satisfied by A and B, or A and C:

A. Medical documentation of *all* of the following:

1. Exposure to actual or threatened death, serious injury, or violence;

2. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);

3. Avoidance of external reminders of the event;

4. Disturbance in mood and behavior; and

5. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

13.00 Cancer (Malignant Neoplastic Diseases)

A. *What impairments do these listings cover?* We use these listings to evaluate all cancers (malignant neoplastic diseases) except certain cancers associated with human immunodeficiency virus (HIV) infection. We use the criteria in 14.11B to evaluate primary central nervous system lymphoma, 14.11C to evaluate primary effusion lymphoma, and 14.11E to evaluate pulmonary Kaposi sarcoma if you also have HIV infection. We evaluate all other cancers associated with HIV infection, for example, Hodgkin lymphoma or non-pulmonary Kaposi sarcoma, under this body system or under 14.11F–I in the immune system disorders body system.

B. *What do we consider when we evaluate cancer under these listings?* We will consider factors including:

1. Origin of the cancer.

2. Extent of involvement.

3. Duration, frequency, and response to anticancer therapy.

4. Effects of any post-therapeutic residuals.

C. *How do we apply these listings?* We apply the criteria in a specific listing to a cancer originating from that specific site.

D. *What evidence do we need?*

1. We need medical evidence that specifies the type, extent, and site of the primary, recurrent, or metastatic lesion. When the primary site cannot be identified, we will use evidence documenting the site(s) of metastasis to evaluate the impairment under 13.27.

2. For operative procedures, including a biopsy or a needle aspiration, we generally need a copy of both the:

a. Operative note, and

b. Pathology report.

3. When we cannot get these documents, we will accept the summary of hospitalization(s) or other medical reports. This evidence should include details of the findings at surgery and, whenever appropriate, the pathological findings.

4. In some situations, we may also need evidence about recurrence, persistence, or progression of the cancer, the response to therapy, and any significant residuals. (See 13.00G.)

E. *When do we need longitudinal evidence?*

1. *Cancer with distant metastases.* We generally do not need longitudinal evidence for cancer that has metastasized beyond the regional lymph nodes because this cancer usually meets the requirements of a listing. Exceptions are for cancer with distant metastases that we expect to respond to anticancer therapy. For these exceptions, we usually need a longitudinal record of 3 months after therapy starts to determine whether the therapy achieved its intended effect, and whether this effect is likely to persist.

2. *Other cancers.* When there are no distant metastases, many of the listings require that we consider your response to initial anticancer therapy; that is, the initial planned treatment regimen. This therapy may consist of a single modality or a combination of modalities; that is, multimodal therapy. (See 13.00I4.)

3. *Types of treatment.*

a. Whenever the initial planned therapy is a single modality, enough time must pass to allow a determination about whether the therapy will achieve its intended effect. If the treatment fails, the failure often happens within 6 months after treatment starts, and there will often be a change in the treatment regimen.

b. Whenever the initial planned therapy is multimodal, we usually cannot make a determination about the effectiveness of the therapy until we can determine the effects of all the planned modalities. In some cases, we may need to defer adjudication until we can assess the effectiveness of therapy. However, we do not need to defer adjudication to determine whether the therapy will achieve its intended effect if we can make a fully favorable determination or decision based on the length and effects of therapy, or the residuals of the cancer or therapy (see 13.00G).

c. We need evidence under 13.02E, 13.11D, and 13.14C to establish that your treating source initiated multimodal anticancer therapy. We do not need to make a determination about the length or effectiveness of your therapy. Multimodal therapy has been initiated, and satisfies the requirements in 13.02E, 13.11D, and 13.14C, when your treating source starts the first modality. We may defer adjudication if your treating source plans multimodal therapy and has not yet initiated it.

F. *How do we evaluate impairments that do not meet one of the cancer listings?*

1. These listings are only examples of cancer that we consider severe enough to prevent you from doing any gainful activity. If your severe impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926 of this chapter.) If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. In that situation, we proceed to the fourth, and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

G. *How do we consider the effects of anticancer therapy?*

1. *How we consider the effects of anticancer therapy under the listings.* In many cases, cancers meet listing criteria only if the therapy is not effective and the cancer persists, progresses, or recurs. However, as explained in the following paragraphs, we will not delay adjudication if we can make a fully favorable determination or decision based on the evidence in the case record.

2. *Effects can vary widely.*

a. We consider each case on an individual basis because the therapy and its toxicity may vary widely. We will request a specific description of the therapy, including these items:

i. Drugs given.

ii. Dosage.

iii. Frequency of drug administration.

iv. Plans for continued drug administration.

v. Extent of surgery.

vi. Schedule and fields of radiation therapy.

b. We will also request a description of the complications or adverse effects of therapy, such as the following:

i. Continuing gastrointestinal symptoms.

ii. Persistent weakness.

iii. Neurological complications.

iv. Cardiovascular complications.

v. Reactive mental disorders.

3. *Effects of therapy may change.* The severity of the adverse effects of anticancer therapy may change during treatment; therefore, enough time must pass to allow us to evaluate the therapy's effect. The residual effects of treatment are temporary in most instances; however, on occasion, the effects may be disabling for a consecutive period of at least 12 months. In some situations, very serious adverse effects may interrupt and prolong multimodal anticancer therapy for a continuous period of almost 12 months. In these situations, we may determine there is an expectation that your impairment will preclude you from engaging in any gainful activity for at least 12 months.

4. *When the initial anticancer therapy is effective.* We evaluate any post-therapeutic residual impairment(s) not included in these listings under the criteria for the affected body system. We must consider any complications of therapy. When the residual impairment(s) does not meet or medically equal a listing, we must consider its effect on your ability to do substantial gainful activity.

H. *How long do we consider your impairment to be disabling?*

1. In some listings, we specify that we will consider your impairment to be disabling until a particular point in time (for example, until at least 12 months from the date of transplantation). We may consider your impairment to be disabling beyond this point when the medical and other evidence justifies it.

2. When a listing does not contain such a specification, we will consider an impairment(s) that meets or medically equals a listing in this body system to be disabling until at least 3 years after onset of complete remission. When the impairment(s) has been in complete remission for at least 3 years, that is, the original tumor or a recurrence (or relapse) and any metastases have not been evident for at least 3 years, the impairment(s) will no longer meet or medically equal the criteria of a listing in this body system.

3. Following the appropriate period, we will consider any residuals, including residuals of the cancer or therapy (see 13.00G), in determining whether you are disabled. If you have a recurrence or relapse of your cancer, your impairment may meet or medically equal one of the listings in this body system again.

I. *What do we mean by the following terms?*

1. *Anticancer therapy* means surgery, radiation, chemotherapy, hormones, immunotherapy, or bone marrow or stem cell transplantation. When we refer to surgery as an anticancer treatment, we mean surgical excision for treatment, not for diagnostic purposes.

2. *Inoperable* means surgery is thought to be of no therapeutic value or the surgery cannot be performed; for example, when you cannot tolerate anesthesia or surgery because of another impairment(s), or you have a cancer that is too large or that has invaded crucial structures. This term does not include situations in which your cancer could have been surgically removed but another method of treatment was chosen; for example, an attempt at organ preservation. Your physician may determine whether the cancer

is inoperable before or after you receive neoadjuvant therapy. *Neoadjuvant therapy* is anticancer therapy, such as chemotherapy or radiation, given before surgery in order to reduce the size of the cancer.

3. *Metastases* means the spread of cancer cells by blood, lymph, or other body fluid. This term does not include the spread of cancer cells by direct extension of the cancer to other tissues or organs.

4. *Multimodal therapy* means anticancer therapy that is a combination of at least two types of treatment given in close proximity as a unified whole and usually planned before any treatment has begun. There are three types of treatment modalities: surgery, radiation, and systemic drug therapy (chemotherapy, hormone therapy, and immunotherapy or biological modifier therapy). Examples of multimodal therapy include:

a. Surgery followed by chemotherapy or radiation.

b. Chemotherapy followed by surgery.

c. Chemotherapy and concurrent radiation.

5. *Persistent* means the planned initial anticancer therapy failed to achieve a complete remission of your cancer; that is, your cancer is evident, even if smaller, after the therapy has ended.

6. *Progressive* means the cancer becomes more extensive after treatment; that is, there is evidence that your cancer is growing after you have completed at least half of your planned initial anticancer therapy.

7. *Recurrent or relapse* means the cancer that was in complete remission or entirely removed by surgery has returned.

8. *Unresectable* means surgery or surgeries did not completely remove the cancer. This term includes situations in which your cancer is incompletely resected or the surgical margins are positive. It does not include situations in which there is a finding of a positive margin(s) if additional surgery obtains a margin(s) that is clear. It also does not include situations in which the cancer is completely resected but you are receiving adjuvant therapy. *Adjuvant therapy* is anticancer therapy, such as chemotherapy or radiation, given after surgery in order to eliminate any remaining cancer cells or lessen the chance of recurrence.

J. *Can we establish the existence of a disabling impairment prior to the date of the evidence that shows the cancer satisfies the criteria of a listing?* Yes. We will consider factors such as:

1. The type of cancer and its location.

2. The extent of involvement when the cancer was first demonstrated.

3. Your symptoms.

K. *How do we evaluate specific cancers?*

1. *Lymphoma.*

a. Many indolent (non-aggressive) lymphomas are controlled by well-tolerated treatment modalities, although the lymphomas may produce intermittent symptoms and signs. We may defer adjudicating these cases for an appropriate period after therapy is initiated to determine whether the therapy will achieve its intended effect, which is usually to stabilize the disease process. (See 13.00E3.) Once your disease stabilizes, we will assess severity based on the extent of involvement of other organ systems and residuals from therapy.

b. A change in therapy for indolent lymphomas is usually an indicator that the therapy is not achieving its intended effect. However, your impairment will not meet the requirements of 13.05A2 if your therapy is changed solely because you or your physician chooses to change it and not because of a failure to achieve stability.

c. We consider Hodgkin lymphoma that recurs more than 12 months after completing initial anticancer therapy to be a new disease rather than a recurrence.

2. *Leukemia.*

a. *Acute leukemia.* The initial diagnosis of acute leukemia, including the accelerated or blast phase of chronic myelogenous (granulocytic) leukemia, is based on definitive bone marrow examination. Additional diagnostic information is based on chromosomal analysis, cytochemical and surface marker studies on the abnormal cells, or other methods consistent with the prevailing state of medical knowledge and clinical practice. Recurrent disease must be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination, or by testicular biopsy. The initial and follow-up pathology reports should be included.

b. *Chronic myelogenous leukemia (CML).* We need a diagnosis of CML based on documented granulocytosis, including immature forms such as differentiated or undifferentiated myelocytes and myeloblasts, and a chromosomal analysis that demonstrates the Philadelphia chromosome. In the absence of a chromosomal analysis, or if the Philadelphia chromosome is not present, the diagnosis may be made by other methods consistent with the prevailing state of medical knowledge and clinical practice. The requirement for CML in the accelerated or blast phase is met in 13.06B if laboratory findings show the proportion of blast (immature) cells in the peripheral blood or bone marrow is 10 percent or greater.

c. *Chronic lymphocytic leukemia.*

i. We require the diagnosis of chronic lymphocytic leukemia (CLL) to be documented by evidence of a chronic lymphocytosis of at least 10,000 cells/mm^3 for 3 months or longer, or other acceptable diagnostic techniques consistent with the prevailing state of medical knowledge and clinical practice.

ii. We evaluate the complications and residual impairment(s) from CLL under the appropriate listings, such as 13.05A2 or the hematological listings (7.00).

d. *Elevated white cell count.* In cases of chronic leukemia (either myelogenous or lymphocytic), an elevated white cell count, in itself, is not a factor in determining the severity of the impairment.

3. *Macroglobulinemia or heavy chain disease.* We require the diagnosis of these diseases to be confirmed by protein electrophoresis or immunoelectrophoresis. We evaluate the resulting impairment(s) under the appropriate listings, such as 13.05A2 or the hematological listings (7.00).

4. *Primary breast cancer.*

a. We evaluate bilateral primary breast cancer (synchronous or metachronous) under 13.10A, which covers local primary disease, and not as a primary disease that has metastasized.

b. We evaluate secondary lymphedema that results from anticancer therapy for breast cancer under 13.10E if the lymphedema is treated by surgery to salvage or restore the functioning of an upper extremity. Secondary lymphedema is edema that results from obstruction or destruction of normal lymphatic channels. We may not restrict our determination of the onset of disability to the date of the surgery; we may establish an earlier onset date of disability if the evidence in your case record supports such a finding.

5. *Carcinoma-in-situ.* Carcinoma-in-situ, or preinvasive carcinoma, usually responds to treatment. When we use the term ''carcinoma'' in these listings, it does not include carcinoma-in-situ.

6. *Primary central nervous system (CNS) cancers.* We use the criteria in 13.13 to evaluate cancers that originate within the CNS (that is, brain and spinal cord cancers).

a. The CNS cancers listed in 13.13A1 are highly malignant and respond poorly to treatment, and therefore we do not require additional criteria to evaluate them. We do not list pituitary gland cancer (for example, pituitary gland carcinoma) in 13.13A1, although this CNS cancer is highly malignant and responds poorly to treatment. We evaluate pituitary gland cancer under 13.13A1 and do not require additional criteria to evaluate it.

b. We consider a CNS tumor to be malignant if it is classified as Grade II, Grade III, or Grade IV under the World Health Organization (WHO) classification of tumors of the CNS (*WHO Classification of Tumours of the Central Nervous System,* 2007).

c. We evaluate benign (for example, WHO Grade I) CNS tumors under 11.05. We evaluate metastasized CNS cancers from non-CNS sites under the primary cancers (see 13.00C). We evaluate any complications of CNS cancers, such as resultant neurological or psychological impairments, under the criteria for the affected body system.

7. *Primary peritoneal carcinoma.* We use the criteria in 13.23E to evaluate primary peritoneal carcinoma in women because this cancer is often indistinguishable from ovarian cancer and is generally treated the same way as ovarian cancer. We use the criteria in 13.15A to evaluate primary peritoneal carcinoma in men because many of these cases are similar to malignant mesothelioma.

8. *Prostate cancer.* We exclude ''biochemical recurrence'' in 13.24A, which is defined as an increase in the serum prostate-specific antigen (PSA) level following the completion of the hormonal intervention therapy. We need corroborating evidence to document recurrence, such as radiological studies or findings on physical examination.

9. *Melanoma.* We evaluate malignant melanoma that affects the skin (cutaneous melanoma), eye (ocular melanoma), or mucosal membranes (mucosal melanoma) under 13.29. We evaluate melanoma that is not malignant that affects the skin (benign melanocytic tumor) under the listings in 8.00 or other affected body systems.

L. *How do we evaluate cancer treated by bone marrow or stem cell transplantation, including transplantation using stem cells from umbilical cord blood?* Bone marrow or stem cell transplantation is performed for a variety of cancers. We require the transplantation to occur before we evaluate it under these listings. We do not need to restrict our determination of the onset of disability to the date of the transplantation (13.05, 13.06, or 13.07) or the date of first treatment under the treatment plan that includes transplantation (13.28). We may be able to establish an earlier onset date of disability due to your transplantation if the evidence in your case record supports such a finding.

1. *Acute leukemia (including T-cell lymphoblastic lymphoma) or accelerated or blast phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of transplantation, whichever is later.

2. *Lymphoma, multiple myeloma, or chronic phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 12 months from the date of transplantation.

3. *Other cancers.* We will evaluate any other cancer treated with bone marrow or stem cell transplantation under 13.28, regardless of whether there is another listing that addresses that impairment. The length of time we will consider you to be disabled depends on whether you undergo allogeneic or autologous transplantation.

a. *Allogeneic bone marrow or stem cell transplantation.* If you undergo allogeneic transplantation (transplantation from an unrelated donor or a related donor other than an identical twin), we will consider you to be disabled until at least 12 months from the date of transplantation.

b. *Autologous bone marrow or stem cell transplantation.* If you undergo autologous transplantation (transplantation of your own cells or cells from your identical twin (syngeneic transplantation)), we will consider you to be disabled until at least 12 months from the date of the first treatment under the treatment plan that includes transplantation. The first treatment usually refers to the initial therapy given to prepare you for transplantation.

4. *Evaluating disability after the appropriate time period has elapsed.* We consider any residual impairment(s), such as complications arising from:

a. Graft-versus-host (GVH) disease.

b. Immunosuppressant therapy, such as frequent infections.

c. Significant deterioration of other organ systems.

13.01 Category of Impairments, Malignant Neoplastic Diseases

13.02 *Soft tissue cancers of the head and neck (except salivary glands—13.08—and thyroid gland—13.09).*

A. Inoperable or unresectable.

OR

B. Persistent or recurrent disease following initial anticancer therapy, except persistence or recurrence in the true vocal cord.

OR

C. With metastases beyond the regional lymph nodes.

OR

D. Small-cell (oat cell) carcinoma.

OR

E. Soft tissue cancers originating in the head and neck treated with multimodal anticancer therapy (see 13.00E3c). Consider under a disability until at least 18 months from the date of diagnosis. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.03 *Skin.*

A. Sarcoma or carcinoma with metastases to or beyond the regional lymph nodes.

OR

B. Carcinoma invading deep extradermal structures (for example, skeletal muscle, cartilage, or bone).

13.04 *Soft tissue sarcoma.*

A. With regional or distant metastases.

OR

B. Persistent or recurrent following initial anticancer therapy.

13.05 *Lymphoma (including mycosis fungoides, but excluding T-cell lymphoblastic lymphoma—13.06).* (*See* 13.00K1 and 13.00K2c.)

A. Non-Hodgkin's lymphoma, as described in 1 or 2:

1. Aggressive lymphoma (including diffuse large B-cell lymphoma) persistent or recurrent following initial anticancer therapy.

2. Indolent lymphoma (including mycosis fungoides and follicular small cleaved cell) requiring initiation of more than one (single mode or multimodal) anticancer treatment regimen within a period of 12 consecutive months. Consider under a disability from at least the date of initiation of the treatment regimen that failed within 12 months.

OR

B. Hodgkin lymphoma with failure to achieve clinically complete remission, or recurrent lymphoma within 12 months of completing initial anticancer therapy.

OR

C. With bone marrow or stem cell transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

D. Mantle cell lymphoma.

13.06 *Leukemia.* (*See* 13.00K2.)

A. Acute leukemia (including T-cell lymphoblastic lymphoma). Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. Chronic myelogenous leukemia, as described in 1 or 2:

1. Accelerated or blast phase (see 13.00K2b). Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

2. Chronic phase, as described in a or b:

a. Consider under a disability until at least 12 months from the date of bone marrow or stem cell transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

b. Progressive disease following initial anticancer therapy.

13.07 *Multiple myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).*

A. Failure to respond or progressive disease following initial anticancer therapy.

OR

B. With bone marrow or stem cell transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.08 *Salivary glands*—carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.09 *Thyroid gland.*

A. Anaplastic (undifferentiated) carcinoma.

OR

B. Carcinoma with metastases beyond the regional lymph nodes progressive despite radioactive iodine therapy.

OR

C. Medullary carcinoma with metastases beyond the regional lymph nodes.

13.10 *Breast (except sarcoma—13.04).* (*See* 13.00K4.)

A. Locally advanced cancer (inflammatory carcinoma, cancer of any size with direct extension to the chest wall or skin, or cancer of any size with metastases to the ipsilateral internal mammary nodes).

OR

B. Carcinoma with metastases to the supraclavicular or infraclavicular nodes, to 10 or more axillary nodes, or with distant metastases.

OR

C. Recurrent carcinoma, except local recurrence that remits with anticancer therapy.

OR

D. Small-cell (oat cell) carcinoma.

OR

E. With secondary lymphedema that is caused by anticancer therapy and treated by surgery to salvage or restore the functioning of an upper extremity. (See 13.00K4b.) Consider under a disability until at least 12 months from the date of the surgery that treated the secondary lymphedema. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.11 *Skeletal system*—sarcoma.

A. Inoperable or unresectable.

OR

B. Recurrent cancer (except local recurrence) after initial anticancer therapy.

OR

C. With distant metastases.

OR

D. All other cancers originating in bone with multimodal anticancer therapy (see 13.00E3c). Consider under a disability for 12 months from the date of diagnosis. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.12 *Maxilla, orbit, or temporal fossa.*

A. Sarcoma or carcinoma of any type with regional or distant metastases.

OR

B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus.

OR

C. Cancer with extension to the orbit, meninges, sinuses, or base of the skull.

13.13 *Nervous system.* (See 13.00K6.)

A. Primary central nervous system (CNS; that is, brain and spinal cord) cancers, as described in 1, 2, or 3:

1. Glioblastoma multiforme, ependymoblastoma, and diffuse intrinsic brain stem gliomas (see 13.00K6a).

2. Any Grade III or Grade IV CNS cancer (see 13.00K6b), including astrocytomas, sarcomas, and medulloblastoma and other primitive neuroectodermal tumors (PNETs).

3. Any primary CNS cancer, as described in a or b:

a. Metastatic.

b. Progressive or recurrent following initial anticancer therapy.

OR

B. Primary peripheral nerve or spinal root cancers, as described in 1 or 2:

1. Metastatic.

2. Progressive or recurrent following initial anticancer therapy.

13.14 *Lungs.*

A. Non-small-cell carcinoma—inoperable, unresectable, recurrent, or metastatic disease to or beyond the hilar nodes.

OR

B. Small-cell (oat cell) carcinoma.

OR

C. Carcinoma of the superior sulcus (including Pancoast tumors) with multimodal anticancer therapy (see 13.00E3c). Consider under a disability until at least 18 months from the date of diagnosis. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.15 *Pleura or mediastinum.*

A. Malignant mesothelioma of pleura.

OR

B. Tumors of the mediastinum, as described in 1 or 2:

1. With metastases to or beyond the regional lymph nodes.

2. Persistent or recurrent following initial anticancer therapy.

OR

C. Small-cell (oat cell) carcinoma.

13.16 *Esophagus or stomach.*

A. Carcinoma or sarcoma of the esophagus.

OR

B. Carcinoma or sarcoma of the stomach, as described in 1 or 2:

1. Inoperable, unresectable, extending to surrounding structures, or recurrent.

2. With metastases to or beyond the regional lymph nodes.

OR

C. Small-cell (oat cell) carcinoma.

13.17 *Small intestine*—carcinoma, sarcoma, or carcinoid.

A. Inoperable, unresectable, or recurrent.

OR

B. With metastases beyond the regional lymph nodes.

OR

C. Small-cell (oat cell) carcinoma.

13.18 *Large intestine (from ileocecal valve to and including anal canal).*

A. Adenocarcinoma that is inoperable, unresectable, or recurrent.

OR

B. Squamous cell carcinoma of the anus, recurrent after surgery.

OR

C. With metastases beyond the regional lymph nodes.

OR

D. Small-cell (oat cell) carcinoma.

13.19 *Liver or gallbladder*—cancer of the liver, gallbladder, or bile ducts.

13.20 *Pancreas.*

A. Carcinoma (except islet cell carcinoma).

OR

B. Islet cell carcinoma that is physiologically active and is either inoperable or unresectable.

13.21 *Kidneys, adrenal glands, or ureters*—carcinoma.

A. Inoperable, unresectable, or recurrent.

OR

B. With metastases to or beyond the regional lymph nodes.

13.22 *Urinary bladder*—carcinoma.

A. With infiltration beyond the bladder wall.

OR

B. Recurrent after total cystectomy.

OR

C. Inoperable or unresectable.

OR

D. With metastases to or beyond the regional lymph nodes.

OR

E. Small-cell (oat cell) carcinoma.

13.23 *Cancers of the female genital tract*—carcinoma or sarcoma (including primary peritoneal carcinoma).

A. Uterus (corpus), as described in 1, 2, or 3:

1. Invading adjoining organs.

2. With metastases to or beyond the regional lymph nodes.

3. Persistent or recurrent following initial anticancer therapy.

OR

B. Uterine cervix, as described in 1, 2, or 3:

1. Extending to the pelvic wall, lower portion of the vagina, or adjacent or distant organs.

2. Persistent or recurrent following initial anticancer therapy.

3. With metastases to distant (for example, para-aortic or supraclavicular) lymph nodes.

OR

C. Vulva or vagina, as described in 1, 2, or 3:

1. Invading adjoining organs.

2. With metastases to or beyond the regional lymph nodes.

3. Persistent or recurrent following initial anticancer therapy.

OR

D. Fallopian tubes, as described in 1 or 2:

1. Extending to the serosa or beyond.

2. Persistent or recurrent following initial anticancer therapy.

E. Ovaries, as described in 1 or 2:

1. All cancers except germ-cell cancers, with at least one of the following:

a. Extension beyond the pelvis; for example, implants on, or direct extension to, peritoneal, omental, or bowel surfaces.

b. Metastases to or beyond the regional lymph nodes.

c. Recurrent following initial anticancer therapy.

2. Germ-cell cancers—progressive or recurrent following initial anticancer therapy.

OR

F. Small-cell (oat cell) carcinoma.

13.24 *Prostate gland*—carcinoma.

A. Progressive or recurrent (not including biochemical recurrence) despite initial hormonal intervention. (See 13.00K8.)

OR

B. With visceral metastases (metastases to internal organs).

OR

C. Small cell (oat cell) carcinoma.

13.25 *Testicles*—cancer with metastatic disease progressive or recurrent following initial chemotherapy.

13.26 *Penis*—carcinoma with metastases to or beyond the regional lymph nodes.

13.27 *Primary site unknown after appropriate search for primary*—metastatic carcinoma or sarcoma, except for squamous cell carcinoma confined to the neck nodes.

13.28 *Cancer treated by bone marrow or stem cell transplantation.* (See 13.00L.)

A. Allogeneic transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. Autologous transplantation. Consider under a disability until at least 12 months from the date of the first treatment under

the treatment plan that includes transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.29 *Malignant melanoma* (including skin, ocular, or mucosal melanomas), as described in either A, B, or C:

A. Recurrent (except an additional primary melanoma at a different site, which is not considered to be recurrent disease) following either 1 or 2:

1. Wide excision (skin melanoma).

2. Enucleation of the eye (ocular melanoma).

OR

B. With metastases as described in 1, 2, or 3:

1. Metastases to one or more clinically apparent nodes; that is, nodes that are detected by imaging studies (excluding lymphoscintigraphy) or by clinical evaluation (palpable).

2. If the nodes are not clinically apparent, with metastases to four or more nodes.

3. Metastases to adjacent skin (satellite lesions) or distant sites (for example, liver, lung, or brain).

OR

C. Mucosal melanoma.

14.00 Immune System Disorders

A. *What disorders do we evaluate under the immune system disorders listings?*

1. *We evaluate immune system disorders that cause dysfunction in one or more components of your immune system.*

a. The dysfunction may be due to problems in antibody production, impaired cell-mediated immunity, a combined type of antibody/cellular deficiency, impaired phagocytosis, or complement deficiency.

b. Immune system disorders may result in recurrent and unusual infections, or inflammation and dysfunction of the body's own tissues. Immune system disorders can cause a deficit in a single organ or body system that results in extreme (that is, very serious) loss of function. They can also cause lesser degrees of limitations in two or more organs or body systems, and when associated with symptoms or signs, such as severe fatigue, fever, malaise, diffuse musculoskeletal pain, or involuntary weight loss, can also result in extreme limitation.

c. We organize the discussions of immune system disorders in three categories: Autoimmune disorders; Immune deficiency disorders, excluding human immunodeficiency virus (HIV) infection; and HIV infection.

2. *Autoimmune disorders (14.00D).* Autoimmune disorders are caused by dysfunctional immune responses directed against the body's own tissues, resulting in chronic, multisystem impairments that differ in clinical manifestations, course, and outcome. They are sometimes referred to as rheumatic diseases, connective tissue disorders, or collagen vascular disorders. Some of the features of autoimmune disorders in adults differ from the features of the same disorders in children.

3. *Immune deficiency disorders, excluding HIV infection (14.00E).* Immune deficiency disorders are characterized by recurrent or unusual infections that respond poorly to treatment, and are often associated with complications affecting other parts of the body. Immune deficiency disorders are classified as either *primary* (congenital) or *acquired*. Individuals with immune deficiency disorders also have an increased risk of malignancies and of having autoimmune disorders.

4. *Human immunodeficiency virus (HIV) infection (14.00F).* HIV infection may be characterized by increased susceptibility to common infections as well as opportunistic infections, cancers, or other conditions listed in 14.11.

B. *What information do we need to show that you have an immune system disorder?* Generally, we need your medical history, a report(s) of a physical examination, a report(s) of laboratory findings, and in some instances, appropriate medically acceptable imaging or tissue biopsy reports to show that you have an immune system disorder. Therefore, we will make every reasonable effort to obtain your medical history, medical findings, and results of laboratory tests. We explain the information we need in more detail in the sections below.

C. Definitions

1. *Appropriate medically acceptable imaging* includes, but is not limited to, angiography, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

2. *Constitutional symptoms or signs*, as used in these listings, means severe fatigue, fever, malaise, or involuntary weight loss. *Severe fatigue* means a frequent sense of exhaustion that results in significantly reduced physical activity or mental function. *Malaise* means frequent feelings of illness, bodily discomfort, or lack of well-being that result in significantly reduced physical activity or mental function.

3. *Disseminated* means that a condition is spread over a considerable area. The type and extent of the spread will depend on your specific disease.

4. *Dysfunction* means that one or more of the body regulatory mechanisms are impaired, causing either an excess or deficiency of immunocompetent cells or their products.

5. *Extra-articular* means ''other than the joints''; for example, an organ(s) such as the heart, lungs, kidneys, or skin.

6. *Documented medical need* has the same meaning as in 1.00C6a.

7. *Fine and gross movements* has the same meaning as in 1.00E4.

8. *Major joint of an upper or a lower extremity* has the same meaning as in 1.00I2 and 1.00I3.

9. *Persistent* means that a sign(s) or symptom(s) has continued over time. The precise meaning will depend on the specific immune system disorder, the usual course of the disorder, and the other circumstances of your clinical course.

10. *Recurrent* means that a condition that previously responded adequately to an appropriate course of treatment returns after a period of remission or regression. The precise meaning, such as the extent of response or remission and the time periods involved, will depend on the specific disease or condition you have, the body system affected, the usual course of the disorder and its treatment, and the other facts of your particular case.

11. *Resistant to treatment* means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate or a course of treatment is appropriate will depend on the specific disease or condition you have, the body system affected, the usual course of the disorder and its treatment, and the other facts of your particular case.

12. *Severe* means medical severity as used by the medical community. The term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter.

D. How do we document and evaluate the listed autoimmune disorders?

1. *Systemic lupus erythematosus (14.02).*

a. *General.* Systemic lupus erythematosus (SLE) is a chronic inflammatory disease that can affect any organ or body system. It is frequently, but not always, accompanied by constitutional symptoms or signs (severe fatigue, fever, malaise, involuntary weight loss). Major organ or body system involvement can include: Respiratory (pleuritis, pneumonitis), cardiovascular (endocarditis, myocarditis, pericarditis, vasculitis), renal (glomerulonephritis), hematologic (anemia, leukopenia, thrombocytopenia), skin (photosensitivity), neurologic (seizures), mental (anxiety, fluctuating cognition (''lupus fog''), mood disorders, organic brain syndrome, psychosis), or immune system disorders (inflammatory arthritis). Immunologically, there is an array of circulating serum auto-antibodies and pro- and anti-coagulant proteins that may occur in a highly variable pattern.

b. *Documentation of SLE.* Generally, but not always, the medical evidence will show that your SLE satisfies the criteria in the current ''Criteria for the Classification of Systemic Lupus Erythematosus'' by the American College of Rheumatology found in the most recent edition of the *Primer on the Rheumatic Diseases* published by the Arthritis Foundation.

2. *Systemic vasculitis (14.03).*

a. *General.*

(i) Vasculitis is an inflammation of blood vessels. It may occur acutely in association with adverse drug reactions, certain chronic infections, and occasionally, malignancies. More often, it is chronic and the cause is unknown. Symptoms vary depending on which blood vessels are involved. Systemic vasculitis may also be associated with other autoimmune disorders; for example, SLE or dermatomyositis.

(ii) There are several clinical patterns, including but not limited to polyarteritis nodosa, Takayasu's arteritis (aortic arch arteritis), giant cell arteritis (temporal arteritis), and Wegener's granulomatosis.

b. *Documentation of systemic vasculitis.* Angiography or tissue biopsy confirms a diagnosis of systemic vasculitis when the disease is suspected clinically. When you have had angiography or tissue biopsy for systemic vasculitis, we will make every reasonable effort to obtain reports of the results of that procedure. However, we will not purchase angiography or tissue biopsy.

3. *Systemic sclerosis (scleroderma) (14.04).*

a. *General.* Systemic sclerosis (scleroderma) constitutes a spectrum of disease in which thickening of the skin is the clinical hallmark. Raynaud's phenomenon, often medically severe and progressive, is present frequently and may be the peripheral manifestation of a vasospastic abnormality in the heart, lungs, and kidneys. The CREST syndrome (calcinosis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly, and telangiectasia) is a variant that may slowly progress over years to the generalized process, systemic sclerosis.

b. *Diffuse cutaneous systemic sclerosis.* In diffuse cutaneous systemic sclerosis (also known as diffuse scleroderma), major organ or systemic involvement can include the gastrointestinal tract, lungs, heart, kidneys, and muscle in addition to skin or blood vessels. Although arthritis can occur, joint dysfunction results primarily from soft tissue/cutaneous thickening, fibrosis, and contractures.

c. *Localized scleroderma (linear scleroderma and morphea).*

(i) Localized scleroderma (linear scleroderma and morphea) is more common in children than in adults. However, this type of scleroderma can persist into adulthood. To assess the severity of the impairment, we need a description of the extent of involvement of linear scleroderma and the location of the lesions. For example, linear

scleroderma involving the arm but not crossing any joints is not as functionally limiting as sclerodactyly (scleroderma localized to the fingers). Linear scleroderma of a lower extremity involving skin thickening and atrophy of underlying muscle or bone caesult in contractures and leg length discrepancy. In such cases, we may evaluate your impairment under the musculoskeletal listings (1.00).

(ii) When there is isolated morphea of the face causing facial disfigurement from unilateral hypoplasia of the mandible, maxilla, zygoma, or orbit, adjudication may be more appropriate under the criteria in the affected body system, such as special senses and speech (2.00) or mental disorders (12.00).

(iii) Chronic variants of these syndromes include disseminated morphea, Shulman's disease (diffuse fasciitis with eosinophilia), and eosinophilia-myalgia syndrome (often associated with toxins such as toxic oil or contaminated tryptophan), all of which can impose medically severe musculoskeletal dysfunction and may also lead to restrictive pulmonary disease. We evaluate these variants of the disease under the criteria in the musculoskeletal listings (1.00) or respiratory system listings (3.00).

d. *Documentation of systemic sclerosis (scleroderma).* Documentation involves differentiating the clinical features of systemic sclerosis (scleroderma) from other autoimmune disorders. However, there may be an overlap.

4. *Polymyositis and dermatomyositis (14.05).*

a. *General.* Polymyositis and dermatomyositis are related disorders that are characterized by an inflammatory process in striated muscle, occurring alone or in association with other autoimmune disorders or malignancy. The most common manifestations are symmetric weakness, and less frequently, pain and tenderness of the proximal limb-girdle (shoulder or pelvic) musculature. There may also be involvement of the cervical, cricopharyngeal, esophageal, intercostal, and diaphragmatic muscles.

b. *Documentation of polymyositis and dermatomyositis.* Generally, but not always, polymyositis is associated with elevated serum muscle enzymes (creatine phosphokinase (CPK), aminotransferases, and aldolase), and characteristic abnormalities on electromyography and muscle biopsy. In dermatomyositis there are characteristic skin findings in addition to the findings of polymyositis. When you have had electromyography or muscle biopsy for polymyositis or dermatomyositis, we will make every reasonable effort to obtain reports of the results of that procedure. However, we will not purchase electromyography or muscle biopsy.

c. *Additional information about how we evaluate polymyositis and dermatomyositis under the listings.*

(i) Weakness of your pelvic girdle muscles that results in your inability to rise independently from a squatting or sitting position or to climb stairs may be an indication that you are unable to walk without assistance. Weakness of your shoulder girdle muscles may result in your inability to perform lifting, carrying, and reaching overhead, and also may seriously affect your ability to perform activities requiring fine movements. We evaluate these limitations under 14.05A.

(ii) We use the malignant neoplastic diseases listings (13.00) to evaluate malignancies associated with polymyositis or dermatomyositis. We evaluate the involvement of other organs/body systems under the criteria for the listings in the affected body system.

5. *Undifferentiated and mixed connective tissue disease (14.06).*

a. *General.* This listing includes syndromes with clinical and immunologic features of several autoimmune disorders, but which do not satisfy the criteria for any of the specific disorders described. For example, you may have clinical features of SLE and systemic vasculitis, and the serologic (blood test) findings of rheumatoid arthritis.

b. *Documentation of undifferentiated and mixed connective tissue disease.* Undifferentiated connective tissue disease is diagnosed when clinical features and serologic (blood test) findings, such as rheumatoid factor or antinuclear antibody (consistent with an autoimmune disorder) are present but do not satisfy the criteria for a specific disease. Mixed connective tissue disease (MCTD) is diagnosed when clinical features and serologic findings of two or more autoimmune diseases overlap.

6. *Inflammatory arthritis (14.09).*

a. *General.* The spectrum of inflammatory arthritis includes a vast array of disorders that differ in cause, course, and outcome. Clinically, inflammation of major joints in an upper or a lower extremity may be the dominant manifestation causing difficulties with walking or fine and gross movements; there may be joint pain, swelling, and tenderness. The arthritis may affect other joints, or cause less limitation in walking or fine and gross movements. However, in combination with extra-articular features, including constitutional symptoms or signs (severe fatigue, fever, malaise, and involuntary weight loss), inflammatory arthritis may result in an extreme limitation.

b. *Inflammatory arthritis involving the axial spine (spondyloarthropathy).* In adults, inflammatory arthritis involving the axial spine may be associated with disorders such as:

(i) Reiter's syndrome;

(ii) Ankylosing spondylitis;

(iii) Psoriatic arthritis;

(iv) Whipple's disease;

(v) Behçet's disease; and

(vi) Inflammatory bowel disease.

c. *Inflammatory arthritis involving the peripheral joints.* In adults, inflammatory arthritis involving peripheral joints may be associated with disorders such as:

(i) Rheumatoid arthritis;

(ii) Sjögren's syndrome;

(iii) Psoriatic arthritis;

(iv) Crystal deposition disorders (gout and pseudogout);

(v) Lyme disease; and

(vi) Inflammatory bowel disease.

d. *Documentation of inflammatory arthritis.* Generally, but not always, the diagnosis of inflammatory arthritis is based on the clinical features and serologic findings described in the most recent edition of the Primer on the Rheumatic Diseases published by the Arthritis Foundation.

e. *How we evaluate inflammatory arthritis under the listings.*

(i) Listing-level severity in 14.09A and 14.09C1 is shown by the presence of an impairment-related physical limitation of functioning. In 14.09C1, if you have the required ankylosis (fixation) of your cervical or dorsolumbar spine, we will find that you have a listing-level impairment-related physical limitation in your ability to see in front of you, above you, and to the side, even though you might not require bilateral upper limb assistance.

(ii) Listing-level severity in 14.09B, 14.09C2, and 14.09D is shown by inflammatory arthritis that involves various combinations of complications (such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms and signs) of one or more major joints in an upper or a lower extremity (see 14.00C8) or other joints. Extra-articular impairments may also meet listings in other body systems.

(iii) Extra-articular features of inflammatory arthritis may involve any body system; for example: Musculoskeletal (heel enthesopathy), ophthalmologic (iridocyclitis, keratoconjunctivitis sicca, uveitis), pulmonary (pleuritis, pulmonary fibrosis or nodules, restrictive lung disease), cardiovascular (aortic valve insufficiency, arrhythmias, coronary arteritis, myocarditis, pericarditis, Raynaud's phenomenon, systemic vasculitis), renal (amyloidosis of the kidney), hematologic (chronic anemia, thrombocytopenia), neurologic (peripheral neuropathy, radiculopathy, spinal cord or cauda equina compression with sensory and motor loss), mental (cognitive dysfunction, poor memory), and immune system (Felty's syndrome (hypersplenism with compromised immune competence)).

(iv) If both inflammation and chronic deformities are present, we evaluate your impairment under the criteria of any appropriate listing.

7. *Sjögren's syndrome (14.10).*

a. *General.*

(i) Sjögren's syndrome is an immune-mediated disorder of the exocrine glands. Involvement of the lacrimal and salivary glands is the hallmark feature, resulting in symptoms of dry eyes and dry mouth, and possible complications, such as corneal damage, blepharitis (eyelid inflammation), dysphagia (difficulty in swallowing), dental caries, and the inability to speak for extended periods of time. Involvement of the exocrine glands of the upper airways may result in persistent dry cough.

(ii) Many other organ systems may be involved, including musculoskeletal (arthritis, myositis), respiratory (interstitial fibrosis), gastrointestinal (dysmotility, dysphagia, involuntary weight loss), genitourinary (interstitial cystitis, renal tubular acidosis), skin (purpura, vasculitis), neurologic (central nervous system disorders, cranial and peripheral neuropathies), mental (cognitive dysfunction, poor memory), and neoplastic (lymphoma). Severe fatigue and malaise are frequently reported. Sjögren's syndrome may be associated with other autoimmune disorders (for example, rheumatoid arthritis or SLE); usually the clinical features of the associated disorder predominate.

b. *Documentation of Sjögren's syndrome.* If you have Sjögren's syndrome, the medical evidence will generally, but not always, show that your disease satisfies the criteria in the current ''Criteria for the Classification of Sjögren's Syndrome'' by the American College of Rheumatology found in the most recent edition of the *Primer on the Rheumatic Diseases* published by the Arthritis Foundation.

E. How do we document and evaluate immune deficiency disorders, excluding HIV infection?

1. *General.*

a. Immune deficiency disorders can be classified as:

(i) *Primary* (congenital); for example, X-linked agammaglobulinemia, thymic hypoplasia (DiGeorge syndrome), severe combined immunodeficiency (SCID), chronic granulomatous disease (CGD), C1 esterase inhibitor deficiency.

(ii) *Acquired;* for example, medication-related.

b. Primary immune deficiency disorders are seen mainly in children. However, recent advances in the treatment of these disorders have allowed many affected children to survive well into adulthood. Occasionally, these disorders are first diagnosed in adolescence or adulthood.

2. *Documentation of immune deficiency disorders.* The medical evidence must include documentation of the specific type of immune deficiency. Documentation may be by

laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

3. *Immune deficiency disorders treated by stem cell transplantation.*

a. *Evaluation in the first 12 months.* If you undergo stem cell transplantation for your immune deficiency disorder, we will consider you disabled until at least 12 months from the date of the transplant.

b. *Evaluation after the 12-month period has elapsed.* After the 12-month period has elapsed, we will consider any residuals of your immune deficiency disorder as well as any residual impairment(s) resulting from the treatment, such as complications arising from:

(i) Graft-versus-host (GVH) disease.

(ii) Immunosuppressant therapy, such as frequent infections.

(iii) Significant deterioration of other organ systems.

4. *Medication-induced immune suppression.* Medication effects can result in varying degrees of immune suppression, but most resolve when the medication is ceased. However, if you are prescribed medication for long-term immune suppression, such as after an organ transplant, we will evaluate:

a. The frequency and severity of infections.

b. Residuals from the organ transplant itself, after the 12-month period has elapsed.

c. Significant deterioration of other organ systems.

F. *How do we document and evaluate HIV infection?* Any individual with HIV infection, including one with a diagnosis of acquired immune deficiency syndrome (AIDS), may be found disabled under 14.11 if his or her impairment meets the criteria in that listing or is medically equivalent to the criteria in that listing.

1. *Documentation of HIV infection.*

a. *Definitive documentation of HIV infection.* We may document a diagnosis of HIV infection by positive findings on one or more of the following definitive laboratory tests:

(i) HIV antibody screening test (for example, enzyme immunoassay, or EIA), confirmed by a supplemental HIV antibody test such as the Western blot (immunoblot), an immunofluorescence assay, or an HIV–1/HIV–2 antibody differentiation immunoassay.

(ii) HIV nucleic acid (DNA or RNA) detection test (for example, polymerase chain reaction, or PCR).

(iii) HIV p24 antigen (p24Ag) test.

(iv) Isolation of HIV in viral culture.

(v) Other tests that are highly specific for detection of HIV and that are consistent with the prevailing state of medical knowledge.

b. We will make every reasonable effort to obtain the results of your laboratory testing. Pursuant to §§404.1519f and 416.919f of this chapter, we will purchase examinations or tests necessary to make a determination in your claim if no other acceptable documentation exists.

c. *Other acceptable documentation of HIV infection.* We may also document HIV infection without definitive laboratory evidence.

(i) We will accept a persuasive report from a physician that a positive diagnosis of your HIV infection was confirmed by an appropriate laboratory test(s), such as those described in 14.00F1a. To be persuasive, this report must state that you had the appropriate definitive laboratory test(s) for diagnosing your HIV infection and provide the results. The report must also be consistent with the remaining evidence of record.

(ii) We may also document HIV infection by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. For example, we will accept a diagnosis of HIV infection without definitive laboratory evidence of the HIV infection if you have an opportunistic disease that is predictive of a defect in cell-mediated immunity (for example, toxoplasmosis of the brain or *Pneumocystis* pneumonia (PCP)), and there is no other known cause of diminished resistance to that disease (for example, long-term steroid treatment or lymphoma). In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing.

2. *Documentation of the manifestations of HIV infection.*

a. *Definitive documentation of manifestations of HIV infection.* We may document manifestations of HIV infection by positive findings on definitive laboratory tests, such as culture, microscopic examination of biopsied tissue or other material (for example, bronchial washings), serologic tests, or on other generally acceptable definitive tests consistent with the prevailing state of medical knowledge and clinical practice.

b. We will make every reasonable effort to obtain the results of your laboratory testing. Pursuant to §§404.1519f and 416.919f of this chapter, we will purchase examinations or tests necessary to make a determination of your claim if no other acceptable documentation exists.

c. *Other acceptable documentation of manifestations of HIV infection.* We may also document manifestations of HIV infection without definitive laboratory evidence.

(i) We will accept a persuasive report from a physician that a positive diagnosis of your manifestation of HIV infection was confirmed by an appropriate laboratory test(s). To be persuasive, this report must state that

you had the appropriate definitive laboratory test(s) for diagnosing your manifestation of HIV infection and provide the results. The report must also be consistent with the remaining evidence of record.

(ii) We may also document manifestations of HIV infection without the definitive laboratory evidence described in 14.00F2a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. For example, many conditions are now commonly diagnosed based on some or all of the following: Medical history, clinical manifestations, laboratory findings (including appropriate medically acceptable imaging), and treatment responses. In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing.

3. *Disorders associated with HIV infection (14.11A–E).*

a. *Multicentric Castleman disease* (MCD, 14.11A) affects multiple groups of lymph nodes and organs containing lymphoid tissue. This widespread involvement distinguishes MCD from *localized* (or unicentric) Castleman disease, which affects only a single set of lymph nodes. While not a cancer, MCD is known as a lymphoproliferative disorder. Its clinical presentation and progression is similar to that of lymphoma, and its treatment may include radiation or chemotherapy. We require characteristic findings on microscopic examination of the biopsied lymph nodes or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis. Localized (or unicentric) Castleman disease does not meet or medically equal the criterion in 14.11A, but we may evaluate it under the criteria in 14.11H or 14.11I.

b. *Primary central nervous system lymphoma* (PCNSL, 14.11B) originates in the brain, spinal cord, meninges, or eye. Imaging tests (for example, MRI) of the brain, while not diagnostic, may show a single lesion or multiple lesions in the white matter of the brain. We require characteristic findings on microscopic examination of the cerebral spinal fluid or of the biopsied brain tissue, or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

c. *Primary effusion lymphoma* (PEL, 14.11C) is also known as body cavity lymphoma. We require characteristic findings on microscopic examination of the effusion fluid or of the biopsied tissue from the affected internal organ, or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

d. *Progressive multifocal leukoencephalopathy* (PML, 14.11D) is a progressive neurological degenerative syndrome caused by the John Cunningham (JC) virus in immunosuppressed individuals. Clinical findings of PML include clumsiness, progressive weakness, and visual and speech changes. Personality and cognitive changes may also occur. We require appropriate clinical findings, characteristic white matter lesions on MRI, and a positive PCR test for the JC virus in the cerebrospinal fluid to establish the diagnosis. We also accept a positive brain biopsy for JC virus or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

e. *Pulmonary Kaposi sarcoma* (Kaposi sarcoma in the lung, 14.11E) is the most serious form of Kaposi sarcoma (KS). Other internal KS tumors (for example, tumors of the gastrointestinal tract) have a more variable prognosis. We require characteristic findings on microscopic examination of the induced sputum, bronchoalveolar lavage washings, or of the biopsied transbronchial tissue, or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

4. *CD4 measurement (14.11F).* To evaluate your HIV infection under 14.11F, we require one measurement of your absolute CD4 count (also known as CD4 count or CD4+ T-helper lymphocyte count). This measurement must occur within the period we are considering in connection with your application or continuing disability review. If you have more than one measurement of your absolute CD4 count within this period, we will use your lowest absolute CD4 count.

5. *Measurement of CD4 and either body mass index or hemoglobin (14.11G).* To evaluate your HIV infection under 14.11G, we require one measurement of your absolute CD4 count or your CD4 percentage, *and* either a measurement of your body mass index (BMI) or your hemoglobin. These measurements must occur within the period we are considering in connection with your application or continuing disability review. If you have more than one measurement of your CD4 (absolute count or percentage), BMI, or hemoglobin within this period, we will use the lowest of your CD4 (absolute count or percentage), BMI, or hemoglobin. The date of your lowest CD4 (absolute count or percentage) measurement may be different from the date of your lowest BMI or hemoglobin measurement. We calculate your BMI using the formulas in the digestive disorders body system (5.00).

6. *Complications of HIV infection requiring hospitalization (14.11H).*

a. Complications of HIV infection may include infections (common or opportunistic), cancers, and other conditions. Examples of

complications that may result in hospitalization include: Depression; diarrhea; immune reconstitution inflammatory syndrome; malnutrition; and PCP and other severe infections.

b. Under 14.11H, we require three hospitalizations within a 12-month period that are at least 30 days apart and that result from a complication(s) of HIV infection. The hospitalizations may be for the same complication or different complications of HIV infection and are not limited to the examples of complications that may result in hospitalization listed in 14.00F6a. All three hospitalizations must occur within the period we are considering in connection with your application or continuing disability review. Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

c. We will use the rules on medical equivalence in §§ 404.1526 and 416.926 of this chapter to evaluate your HIV infection if you have fewer, but longer, hospitalizations, or more frequent, but shorter, hospitalizations, or if you receive nursing, rehabilitation, or other care in alternative settings.

7. *HIV infection manifestations specific to women.*

a. *General.* Most women with severe immunosuppression secondary to HIV infection exhibit the typical opportunistic infections and other conditions, such as PCP, *Candida* esophagitis, wasting syndrome, cryptococcosis, and toxoplasmosis. However, HIV infection may have different manifestations in women than in men. Adjudicators must carefully scrutinize the medical evidence and be alert to the variety of medical conditions specific to, or common in, women with HIV infection that may affect their ability to function in the workplace.

b. *Additional considerations for evaluating HIV infection in women.* Many of these manifestations (for example, vulvovaginal candidiasis or pelvic inflammatory disease) occur in women with or without HIV infection, but can be more severe or resistant to treatment, or occur more frequently in a woman whose immune system is suppressed. Therefore, when evaluating the claim of a woman with HIV infection, it is important to consider gynecologic and other problems specific to women, including any associated symptoms (for example, pelvic pain), in assessing the severity of the impairment and resulting functional limitations. We may evaluate manifestations of HIV infection in women under 14.11H–I, or under the criteria for the appropriate body system (for example, cervical cancer under 13.23).

8. *HIV-associated dementia (HAD).* HAD is an advanced neurocognitive disorder, characterized by a significant decline in cognitive functioning. We evaluate HAD under 14.11I. Other names associated with neurocognitive disorders due to HIV infection include: AIDS dementia complex, HIV dementia, HIV encephalopathy, and major neurocognitive disorder due to HIV infection.

G. How do we consider the effects of treatment in evaluating your autoimmune disorder, immune deficiency disorder, or HIV infection?

1. *General.* If your impairment does not otherwise meet the requirements of a listing, we will consider your medical treatment in terms of its effectiveness in improving the signs, symptoms, and laboratory abnormalities of your specific immune system disorder or its manifestations, and in terms of any side effects that limit your functioning. We will make every reasonable effort to obtain a specific description of the treatment you receive (including surgery) for your immune system disorder. We consider:

a. The effects of medications you take.

b. Adverse side effects (acute and chronic).

c. The intrusiveness and complexity of your treatment (for example, the dosing schedule, need for injections).

d. The effect of treatment on your mental functioning (for example, cognitive changes, mood disturbance).

e. Variability of your response to treatment (see 14.00G2).

f. The interactive and cumulative effects of your treatments. For example, many individuals with immune system disorders receive treatment both for their immune system disorders and for the manifestations of the disorders or co-occurring impairments, such as treatment for HIV infection and hepatitis C. The interactive and cumulative effects of these treatments may be greater than the effects of each treatment considered separately.

g. The duration of your treatment.

h. Any other aspects of treatment that may interfere with your ability to function.

2. *Variability of your response to treatment.* Your response to treatment and the adverse or beneficial consequences of your treatment may vary widely. The effects of your treatment may be temporary or long term. For example, some individuals may show an initial positive response to a drug or combination of drugs followed by a decrease in effectiveness. When we evaluate your response to treatment and how your treatment may affect you, we consider such factors as disease activity before treatment, requirements for changes in therapeutic regimens, the time required for therapeutic effectiveness of a particular drug or drugs, the limited number of drug combinations that may be available for your impairment(s), and the time-limited efficacy of some drugs. For example, an individual with HIV infection or another immune deficiency disorder who develops pneumonia or tuberculosis may not respond to the same antibiotic regimen used in treating individuals without HIV infection or another

immune deficiency disorder, or may not respond to an antibiotic that he or she responded to before. Therefore, we must consider the effects of your treatment on an individual basis, including the effects of your treatment on your ability to function.

3. *How we evaluate the effects of treatment for autoimmune disorders on your ability to function.* Some medications may have acute or long-term side effects. When we consider the effects of corticosteroids or other treatments for autoimmune disorders on your ability to function, we consider the factors in 14.00G1 and 14.00G2. Long-term corticosteroid treatment can cause ischemic necrosis of bone, posterior subcapsular cataract, weight gain, glucose intolerance, increased susceptibility to infection, and osteoporosis that may result in a loss of function. In addition, medications used in the treatment of autoimmune disorders may also have effects on mental functioning, including cognition (for example, memory), concentration, and mood.

4. *How we evaluate the effects of treatment for immune deficiency disorders, excluding HIV infection, on your ability to function.* When we consider the effects of your treatment for your immune deficiency disorder on your ability to function, we consider the factors in 14.00G1 and 14.00G2. A frequent need for treatment such as intravenous immunoglobulin and gamma interferon therapy can be intrusive and interfere with your ability to work. We will also consider whether you have chronic side effects from these or other medications, including severe fatigue, fever, headaches, high blood pressure, joint swelling, muscle aches, nausea, shortness of breath, or limitations in mental function including cognition (for example, memory), concentration, and mood.

5. *How we evaluate the effects of treatment for HIV infection on your ability to function.*

a. *General.* When we consider the effects of antiretroviral drugs (including the effects of highly active antiretroviral therapy (HAART)) and the effects of treatments for the manifestations of HIV infection on your ability to function, we consider the factors in 14.00G1 and 14.00G2. Side effects of antiretroviral drugs include, but are not limited to: Bone marrow suppression, pancreatitis, gastrointestinal intolerance (nausea, vomiting, diarrhea), neuropathy, rash, hepatotoxicity, lipodystrophy (fat redistribution, such as ''buffalo hump''), glucose intolerance, and lactic acidosis. In addition, medications used in the treatment of HIV infection may also have effects on mental functioning, including cognition (for example, memory), concentration, and mood, and may result in malaise, severe fatigue, joint and muscle pain, and insomnia. The symptoms of HIV infection and the side effects of medication may be indistinguishable from each other. We will consider all of your functional limitations, whether they result from your symptoms or signs of HIV infection or the side effects of your treatment.

b. *Structured treatment interruptions.* A structured treatment interruption (STI, also called a ''drug holiday'') is a treatment practice during which your treating source advises you to stop taking your medications temporarily. An STI in itself does not imply that your medical condition has improved; nor does it imply that you are noncompliant with your treatment because you are following your treating source's advice. Therefore, if you have stopped taking medication because your treating source prescribed or recommended an STI, we will not find that you are failing to follow treatment or draw inferences about the severity of your impairment on this fact alone. We will consider why your treating source has prescribed or recommended an STI and all the other information in your case record when we determine the severity of your impairment.

6. *When there is no record of ongoing treatment.* If you have not received ongoing treatment or have not had an ongoing relationship with the medical community despite the existence of a severe impairment(s), we will evaluate the medical severity and duration of your immune system disorder on the basis of the current objective medical evidence and other evidence in your case record, taking into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you have just begun treatment and we cannot determine whether you are disabled based on the evidence we have, we may need to wait to determine the effect of the treatment on your ability to function. The amount of time we need to wait will depend on the facts of your case. If you have not received treatment, you may not be able to show an impairment that meets the criteria of one of the immune system disorders listings, but your immune system disorder may medically equal a listing or be disabling based on a consideration of your residual functional capacity, age, education, and work experience.

H. How do we consider your symptoms, including your pain, severe fatigue, and malaise?

Your symptoms, including pain, severe fatigue, and malaise, may be important factors in our determination whether your immune system disorder(s) meets or medically equals a listing or in our determination whether you are otherwise able to work. In order for us to consider your symptoms, you must have medical signs or laboratory findings showing the existence of a medically determinable impairment(s) that could reasonably be expected to produce the symptoms. If you have such an impairment(s), we will evaluate the intensity, persistence, and functional effects of your symptoms using the

rules throughout 14.00 and in our other regulations. See §§404.1521, 404.1529, 416.921, and 416.929. Additionally, when we assess the credibility of your complaints about your symptoms and their functional effects, we will not draw any inferences from the fact that you do not receive treatment or that you are not following treatment without considering all of the relevant evidence in your case record, including any explanations you provide that may explain why you are not receiving or following treatment.

I. *How do we use the functional criteria in these listings?*

1. The following listings in this body system include standards for evaluating the functional limitations resulting from immune system disorders: 14.02B, for systemic lupus erythematosus; 14.03B, for systemic vasculitis; 14.04D, for systemic sclerosis (scleroderma); 14.05E, for polymyositis and dermatomyositis; 14.06B, for undifferentiated and mixed connective tissue disease; 14.07C, for immune deficiency disorders, excluding HIV infection; 14.09D, for inflammatory arthritis; 14.10B, for Sjögren's syndrome; and 14.11I, for HIV infection.

2. When we use one of the listings cited in 14.00I1, we will consider all relevant information in your case record to determine the full impact of your immune system disorder on your ability to function on a sustained basis. Important factors we will consider when we evaluate your functioning under these listings include, but are not limited to: Your symptoms, the frequency and duration of manifestations of your immune system disorder, periods of exacerbation and remission, and the functional impact of your treatment, including the side effects of your medication.

3. As used in these listings, ''repeated'' means that the manifestations occur on an average of three times a year, or once every 4 months, each lasting 2 weeks or more; or the manifestations do not last for 2 weeks but occur substantially more frequently than three times in a year or once every 4 months; or they occur less frequently than an average of three times a year or once every 4 months but last substantially longer than 2 weeks. Your impairment will satisfy this criterion regardless of whether you have the same kind of manifestation repeatedly, all different manifestations, or any other combination of manifestations; for example, two of the same kind of manifestation and a different one. You must have the required number of manifestations with the frequency and duration required in this section. Also, the manifestations must occur within the period covered by your claim.

4. To satisfy the functional criterion in a listing, your immune system disorder must result in a ''marked'' level of limitation in one of three general areas of functioning: Activities of daily living, social functioning, or difficulties in completing tasks due to deficiencies in concentration, persistence, or pace. Functional limitation may result from the impact of the disease process itself on your mental functioning, physical functioning, or both your mental and physical functioning. This could result from persistent or intermittent symptoms, such as depression, severe fatigue, or pain, resulting in a limitation of your ability to do a task, to concentrate, to persevere at a task, or to perform the task at an acceptable rate of speed. You may also have limitations because of your treatment and its side effects (see 14.00G).

5. *Marked* limitation means that the signs and symptoms of your immune system disorder interfere *seriously* with your ability to function. Although we do not require the use of such a scale, ''marked'' would be the fourth point on a five-point scale consisting of no limitation, mild limitation, moderate limitation, marked limitation, and extreme limitation. You may have a marked limitation when several activities or functions are impaired, or even when only one is impaired. Also, you need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation seriously interferes with your ability to function independently, appropriately, and effectively. The term ''marked'' does not imply that you must be confined to bed, hospitalized, or in a nursing home.

6. *Activities of daily living* include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, or paying bills. We will find that you have a ''marked'' limitation of activities of daily living if you have a serious limitation in your ability to maintain a household or take public transportation because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your immune system disorder (including manifestations of the disorder) or its treatment, even if you are able to perform some self-care activities.

7. *Social functioning* includes the capacity to interact independently, appropriately, effectively, and on a sustained basis with others. It includes the ability to communicate effectively with others. We will find that you have a ''marked'' limitation in maintaining social functioning if you have a serious limitation in social interaction on a sustained basis because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, or a pattern of exacerbation and remission, caused by your immune system disorder (including manifestations of the disorder) or its treatment, even if you are able to communicate with close friends or relatives.

8. *Completing tasks in a timely manner* involves the ability to sustain concentration,

persistence, or pace to permit timely completion of tasks commonly found in work settings. We will find that you have a ''marked'' limitation in completing tasks if you have a serious limitation in your ability to sustain concentration or pace adequate to complete work-related tasks because of symptoms, such as pain, severe fatigue, anxiety, or difficulty concentrating, caused by your immune system disorder (including manifestations of the disorder) or its treatment, even if you are able to do some routine activities of daily living.

J. How do we evaluate your immune system disorder when it does not meet one of these listings?

1. These listings are only examples of immune system disorders that we consider severe enough to prevent you from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. Individuals with immune system disorders, including HIV infection, may manifest signs or symptoms of a mental impairment or of another physical impairment. For example, HIV infection may accelerate the onset of conditions such as diabetes or affect the course of or treatment options for diseases such as cardiovascular disease or hepatitis. We may evaluate these impairments under the affected body system.

3. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926.) If it does not, you may or may not have the residual functional capacity to engage in substantial gainful activity. Therefore, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. We use the rules in §§ 404.1594, 416.994, and 416.994a as appropriate, when we decide whether you continue to be disabled.

14.01 *Category of Impairments, Immune System Disorders.*

14.02 *Systemic lupus erythematosus.* As described in 14.00D1. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of SLE, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.03 *Systemic vasculitis.* As described in 14.00D2. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of systemic vasculitis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.04 *Systemic sclerosis (scleroderma).* As described in 14.00D3. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. One of the following:

1. Toe contractures or fixed deformity of one or both feet and medical documentation of at least *one* of the following:

a. A documented medical need (see 14.00C6) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7), and a documented medical need (see 14.00C6) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

2. Finger contractures or fixed deformity in both hands and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7); or

3. Atrophy with irreversible damage in one or both lower extremities and medical documentation of at least *one* of the following:

a. A documented medical need (see 14.00C6) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7), and a documented medical need (see 14.00C6) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

4. Atrophy with irreversible damage in *both* upper extremities and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7); or

C. Raynaud's phenomenon, characterized by:

1. Gangrene involving at least two extremities; or

2. Ischemia with ulcerations of toes or fingers and medical documentation of at least *one* of the following:

a. A documented medical need (see 14.00C6) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7), and a documented medical need (see 14.00C6) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

c. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7); or

D. Repeated manifestations of systemic sclerosis (scleroderma), with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.05 *Polymyositis and dermatomyositis.* As described in 14.00D4. With:

A. Proximal limb-girdle (pelvic or shoulder) muscle weakness and medical documentation of at least *one* of the following:

1. A documented medical need (see 14.00C6) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7), and a documented medical need (see 14.00C6) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7); or

B. Impaired swallowing (dysphagia) with aspiration due to muscle weakness.

or

C. Impaired respiration due to intercostal and diaphragmatic muscle weakness.

or

D. Diffuse calcinosis with limitation of joint mobility or intestinal motility.

or

E. Repeated manifestations of polymyositis or dermatomyositis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.06 *Undifferentiated and mixed connective tissue disease.* As described in 14.00D5. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of undifferentiated or mixed connective tissue disease, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.07 *Immune deficiency disorders, excluding HIV infection.* As described in 14.00E. With:

A. One or more of the following infections. The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.

1. Sepsis; or

2. Meningitis; or

3. Pneumonia; or

4. Septic arthritis; or

5. Endocarditis; or

6. Sinusitis documented by appropriate medically acceptable imaging.

or

B. Stem cell transplantation as described under 14.00E3. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

or

C. Repeated manifestations of an immune deficiency disorder, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social function.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.08 [Reserved]

14.09 *Inflammatory arthritis.* As described in 14.00D6. With:

A. Persistent inflammation or persistent deformity of:

1. One or more major joints in a lower extremity (see 14.00C8) and medical documentation of at least *one* of the following:

a. A documented medical need (see 14.00C6) for a walker, bilateral canes, or bilateral crutches (see 1.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 1.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7), and a documented medical need (see 14.00C6) for a one-handed, hand-held assistive device (see 1.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 1.00C6e(ii)); or

2. One or more major joints in each upper extremity (see 14.00C8) and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements (see 14.00C7); or

B. Inflammation or deformity in one or more major joints of an upper or a lower extremity (see 14.00C8) with:

1. Involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

C. Ankylosing spondylitis or other spondyloarthropathies, with:

1. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 45° or more of flexion from the vertical position (zero degrees); or

2. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 30° or more of flexion (but less than 45°) measured from the vertical position (zero degrees), and involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity.

or

D. Repeated manifestations of inflammatory arthritis, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.10 *Sjögren's syndrome.* As described in 14.00D7. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of Sjögren's syndrome, with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

14.11 *Human immunodeficiency virus (HIV) infection.* With documentation as described in 14.00F1 and one of the following:

A. Multicentric (not localized or unicentric) Castleman disease affecting multiple groups of lymph nodes or organs containing lymphoid tissue (see 14.00F3a).

OR

B. Primary central nervous system lymphoma (see 14.00F3b).

OR

C. Primary effusion lymphoma (see 14.00F3c).

OR

D. Progressive multifocal leukoencephalopathy (see 14.00F3d).

OR

E. Pulmonary Kaposi sarcoma (see 14.00F3e).

OR

F. Absolute CD4 count of 50 cells/mm^3 or less (see 14.00F4).

OR

G. Absolute CD4 count of less than 200 cells/mm^3 or CD4 percentage of less than 14 percent, *and* one of the following (values do not have to be measured on the same date) (see 14.00F5):

1. BMI measurement of less than 18.5; or

2. Hemoglobin measurement of less than 8.0 grams per deciliter (g/dL).

OR

H. Complication(s) of HIV infection requiring at least three hospitalizations within a 12-month period and at least 30 days apart (see 14.00F6). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

OR

I. Repeated (as defined in 14.00I3) manifestations of HIV infection, including those listed in 14.11A–H, but without the requisite findings for those listings (for example, Kaposi sarcoma not meeting the criteria in 14.11E), or other manifestations (including, but not limited to, cardiovascular disease (including myocarditis, pericardial effusion, pericarditis, endocarditis, or pulmonary arteritis), diarrhea, distal sensory polyneuropathy, glucose intolerance, gynecologic conditions (including cervical cancer or pelvic inflammatory disease, see 14.00F7), hepatitis, HIV-associated dementia, immune reconstitution inflammatory syndrome (IRIS), infections (bacterial, fungal, parasitic, or viral), lipodystrophy (lipoatrophy or lipohypertrophy), malnutrition, muscle weakness, myositis, neurocognitive or other mental limitations not meeting the criteria in 12.00, oral hairy leukoplakia, osteoporosis, pancreatitis, peripheral neuropathy) resulting in significant, documented symptoms or signs (for example, but not limited to, fever, headaches, insomnia, involuntary weight loss, malaise, nausea, night sweats, pain, severe fatigue, or vomiting) and one of the following at the marked level:

1. Limitation of activities of daily living.

2. Limitation in maintaining social functioning.

3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in part A do not give appropriate consideration to the particular disease process in childhood).

Sec.

100.00 Low Birth Weight and Failure to Thrive.
101.00 Musculoskeletal Disorders.
102.00 Special Senses and Speech.
103.00 Respiratory Disorders.
104.00 Cardiovascular System.
105.00 Digestive Disorders
106.00 Genitourinary Disorders.
107.00 Hematological Disorders.
108.00 Skin Disorders
109.00 Endocrine Disorders.
110.00 Congenital Disorders That Affect Multiple Body Systems.
111.00 Neurological Disorders.
112.00 Mental Disorders.
113.00 Cancer (Malignant Neoplastic Diseases)
114.00 Immune System Disorders.

100.00 Low Birth Weight and Failure to Thrive

A. *What conditions do we evaluate under these listings?* We evaluate low birth weight (LBW) in infants from birth to attainment of age 1 and failure to thrive (FTT) in infants and toddlers from birth to attainment of age 3.

B. *How do we evaluate disability based on LBW under 100.04?* In 100.04A and 100.04B, we use an infant's birth weight as documented by an original or certified copy of the infant's birth certificate or by a medical record signed by a physician. *Birth weight* means the first weight recorded after birth. In 100.04B, *gestational age* is the infant's age based on the date of conception as recorded in the medical record. If the infant's impairment meets the requirements for listing 100.04A or 100.04B, we will follow the rule in §416.990(b)(11) of this chapter.

C. *How do we evaluate disability based on FTT under 100.05?*

1. *General.* We establish FTT with or without a known cause when we have documentation of an infant's or a toddler's growth failure and developmental delay from an acceptable medical source(s) as defined in §416.913(a) of this chapter. We require documentation of growth measurements in

100.05A and developmental delay described in 100.05B or 100.05C within the same consecutive 12-month period. The dates of developmental testing and reports may be different from the dates of growth measurements. After the attainment of age 3, we evaluate growth failure under the affected body system(s).

2. *Growth failure.* Under 100.05A, we use the appropriate table(s) under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile. The child does not need to have a digestive disorder for purposes of 100.05.

a. For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

b. For children age 2 to attainment of age 3, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

c. BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in the digestive disorders body system (105.00).

d. *Growth measurements.* The weight-for-length measurements for children from birth to the attainment of age 2 and BMI-for-age measurements for children age 2 to attainment of age 3 that are required for this listing must be obtained within a 12-month period and at least 60 days apart. If a child attains age 2 during the evaluation period, additional measurements are not needed. Any measurements taken before the child attains age 2 can be used to evaluate the impairment under the appropriate listing for the child's age. If the child attains age 3 during the evaluation period, the measurements can be used to evaluate the impairment in the affected body system.

3. *Developmental delay.*

a. Under 100.05B and C, we use reports from acceptable medical sources to establish delay in a child's development.

b. Under 100.05B, we document the severity of developmental delay with results from a standardized developmental assessment, which compares a child's level of development to the level typically expected for his or her chronological age. If the child was born prematurely, we may use the corrected chronological age (CCA) for comparison. (See §416.924b(b) of this chapter.) CCA is the chronological age adjusted by a period of gestational prematurity. CCA = (chronological age)—(number of weeks premature). Acceptable medical sources or early intervention specialists, physical or occupational therapists, and other sources may conduct standardized developmental assessments and developmental screenings. The results of these tests and screenings must be accompanied by a statement or records from an acceptable medical source who established the child has a developmental delay.

c. Under 100.05C, when there are no results from a standardized developmental assessment in the case record, we need narrative developmental reports from the child's medical sources in sufficient detail to assess the severity of his or her developmental delay. A narrative developmental report is based on clinical observations, progress notes, and well-baby check-ups. To meet the requirements for 100.05C, the report must include: The child's developmental history; examination findings (with abnormal findings noted on repeated examinations); and an overall assessment of the child's development (that is, more than one or two isolated skills) by the medical source. Some narrative developmental reports may include results from developmental screening tests, which can identify a child who is not developing or achieving skills within expected timeframes. Although medical sources may refer to screening test results as supporting evidence in the narrative developmental report, screening test results alone cannot establish a diagnosis or the severity of developmental delay.

D. *How do we evaluate disorders that do not meet one of these listings?*

1. We may find infants disabled due to other disorders when their birth weights are greater than 1200 grams but less than 2000 grams and their weight and gestational age do not meet listing 100.04. The most common disorders of prematurity and LBW include retinopathy of prematurity (ROP), chronic lung disease of infancy (CLD, previously known as bronchopulmonary dysplasia, or BPD), intraventricular hemorrhage (IVH), necrotizing enterocolitis (NEC), and periventricular leukomalacia (PVL). Other disorders include poor nutrition and growth failure, hearing disorders, seizure disorders, cerebral palsy, and developmental disorders. We evaluate these disorders under the affected body systems.

2. We may evaluate infants and toddlers with growth failure that is associated with a known medical disorder under the body system of that medical disorder, for example, the respiratory or digestive body systems.

3. If an infant or toddler has a severe medically determinable impairment(s) that does not meet the criteria of any listing, we must also consider whether the child has an impairment(s) that medically equals a listing (see §416.926 of this chapter). If the child's impairment(s) does not meet or medically equal a listing, we will determine whether the child's impairment(s) functionally equals the listings (see §416.926a of this chapter) considering the factors in §416.924a of this chapter. We use the rule in §416.994a of this chapter when we decide whether a child continues to be disabled.

100.01 Category of Impairments, Low Birth Weight and Failure to Thrive

100.04 *Low birth weight in infants from birth to attainment of age 1.*

A. Birth weight (see 100.00B) of less than 1200 grams.

OR

B. The following gestational age and birth weight:

Gestational age (in weeks)	Birth weight
37–40	2000 grams or less.
36	1875 grams or less.
35	1700 grams or less.
34	1500 grams or less.
33	1325 grams or less.
32	1250 grams or less.

100.05 *Failure to thrive in children from birth to attainment of age 3* (see 100.00C), documented by A and B, or A and C.

A. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2*, three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table in listing 105.08B1; or

2. *For children age 2 to attainment of age 3*, three BMI-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table in listing 105.08B2.

AND

B. Developmental delay (see 100.00C1 and C3), established by an acceptable medical source and documented by findings from one current report of a standardized developmental assessment (see 100.00C3b) that:

1. Shows development not more than two-thirds of the level typically expected for the child's age; or

2. Results in a valid score that is at least two standard deviations below the mean.

OR

C. Developmental delay (see 100.00C3), established by an acceptable medical source and documented by findings from two narrative developmental reports (see 100.00C3c) that:

1. Are dated at least 120 days apart (see 100.00C1); and

2. Indicate current development not more than two-thirds of the level typically expected for the child's age.

101.00 Musculoskeletal Disorders

A. *Which musculoskeletal disorders do we evaluate under these listings?*

1. We evaluate disorders of the skeletal spine (vertebral column) or of the upper or lower extremities that affect musculoskeletal functioning under these listings. We use the term ''skeletal'' when we are referring to the structure of the bony skeleton. The *skeletal spine* refers to the bony structures, ligaments, and discs making up the spine. We refer to the skeletal spine in some musculoskeletal listings to differentiate it from the *neurological spine* (see 101.00B1). Musculoskeletal disorders may be congenital or acquired, and may include deformities, amputations, or other abnormalities. These disorders may involve the bones or major joints; or the tendons, ligaments, muscles, or other soft tissues.

2. We evaluate soft tissue injuries (including burns) or abnormalities that are under continuing surgical management (see 101.00P1). The injuries or abnormalities may affect any part of the body, including the face and skull.

3. We evaluate curvatures of the skeletal spine that affect musculoskeletal functioning under 101.15. If a curvature of the skeletal spine is under continuing surgical management (see 101.00P1), we will evaluate it under 101.21 using our rules for determining medical equivalence. See §416.926 of this chapter.

B. *Which related disorders do we evaluate under other listings?*

1. We evaluate a disorder or injury of the skeletal spine that results in damage to, and neurological dysfunction of, the spinal cord and its associated nerves (for example, paraplegia or quadriplegia) under the listings in 111.00.

2. We evaluate inflammatory arthritis (for example, rheumatoid arthritis) under the listings in 114.00.

3. We evaluate curvatures of the skeletal spine that interfere with your ability to breathe under the listings in 103.00, impair myocardial function under the listings in 104.00, or result in social withdrawal or depression under the listings in 112.00.

4. We evaluate non-healing or pathological fractures due to cancer, whether it is a primary site or metastases, under the listings in 113.00.

5. We evaluate the leg pain associated with peripheral vascular claudication under the listings in 104.00.

6. We evaluate burns that do not require continuing surgical management under the listings in 108.00.

C. *What evidence do we need to evaluate your musculoskeletal disorder?*

1. *General.* We need objective medical evidence from an acceptable medical source to establish that you have a medically determinable musculoskeletal disorder. We also need evidence from both medical and nonmedical sources, who can describe how you function, to assess the severity and duration of your musculoskeletal disorder. We will determine the extent and kinds of evidence we need from medical and nonmedical sources

based on the individual facts about your disorder. For our basic rules on evidence, see §§ 416.912, 416.913, and 416.920b of this chapter. For our rules on evidence about your symptoms, see § 416.929 of this chapter.

2. *Physical examination report(s).* In the report(s) of your physical examination, we require a medical source's detailed description of the orthopedic, neurologic, or other objective clinical findings appropriate to your specific musculoskeletal disorder from his or her direct observations during your physical examination. We will not accept a report of your statements about your symptoms and limitations in place of the medical source's report of objective clinical findings. We will not use findings on imaging or other diagnostic tests (see 101.00C3) as a substitute for findings on physical examination.

a. When the medical source reports that a clinical test sign(s) is positive, unless we have evidence to the contrary, we will assume that he or she performed the test properly and accept the medical source's interpretation of the test. For example, we will assume a straight-leg raising test was conducted properly (that is, in sitting and supine positions), even if the medical source does not specify the positions in which the test was performed.

b. If you use an assistive device (see 101.00C6), the report must support the medical need for the device.

c. If your musculoskeletal disorder causes a reduction in muscle strength, the report must document measurement of the strength of the muscle(s) in question. The measurement should be based on a muscle strength grading system that is considered medically acceptable based on your age and impairments. For example, a grading system of 0 to 5, with 0 indicating complete loss of strength and 5 indicating maximum strength or equivalent medically acceptable scale (see Table 1). Reduction in muscle strength is demonstrated by evidence that your muscle strength is less than active range of motion (ROM) against gravity with maximum resistance. If the reduction in muscle strength involves one or both of your hands, the report must also document measurements of grip and pinch strength.

TABLE 1—GRADING SYSTEM OF MUSCLE FUNCTION

Grade	Function of the muscle
0—None	No visible or palpable contraction.
1—Trace	Visible or palpable contraction with no motion.
2—Poor	Active ROM with gravity eliminated.
3—Fair	Active ROM against gravity only, without resistance.
4—Good	Active ROM against gravity, moderate resistance.
5—Normal	Active ROM against gravity, maximum resistance.

3. *Imaging and other diagnostic tests.*

a. *Imaging* refers to medical imaging techniques, such as x-ray, computed tomography (CT), magnetic resonance imaging (MRI), and radionuclide scanning. For the purpose of these listings, the imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder.

b. Findings on imaging must have lasted, or be expected to last, for a continuous period of at least 12 months.

c. Imaging and other diagnostic tests can provide evidence of physical abnormalities; however, these abnormalities may correlate poorly with your symptoms, including pain, or with your musculoskeletal functioning. Accordingly, we will not use findings on imaging or other diagnostic tests as a substitute for findings on physical examination about your ability to function, nor can we infer severity or functional limitations based solely on such tests.

d. For our rules on purchasing imaging and other diagnostic tests, see §§ 416.919k and 416.919m of this chapter.

4. *Operative reports.* If you have had a surgical procedure, we need a copy of the operative report, including details of the findings at surgery and information about any medical complications that may have occurred. If we do not have the operative report, we need confirmatory evidence of the surgical procedure from a medical source (for example, detailed follow-up reports or notations in the medical records concerning the surgical procedure in your medical history).

5. *Effects of treatment.*

a. *General.* Treatments for musculoskeletal disorders may have beneficial or adverse effects, and responses to treatment vary from person to person. We will evaluate all of the effects of treatment (including surgical treatment, medications, and therapy) on the symptoms, signs, and laboratory findings of your musculoskeletal disorder, and on your musculoskeletal functioning.

b. *Response to treatment.* To evaluate your musculoskeletal functioning in response to treatment, we need the following: A description, including the frequency of the administration, of your medications; the type and frequency of therapy you receive; and a description of your response to treatment and

any complications you experience related to your musculoskeletal disorder. The effects of treatment may be temporary or long-term. We need information over a sufficient period to determine the effects of treatment on your current musculoskeletal functioning and permit reasonable projections about your future functioning. We will determine the amount of time that constitutes a sufficient period in consultation with a medical consultant on a case by case basis. In some cases, we will need additional evidence to make an assessment about your response to treatment. Your musculoskeletal disorder may meet or medically equal one of these listings regardless of whether you were prescribed opioid medication, or whether you were prescribed opioid medication and did not follow this prescribed treatment.

6. *Assistive devices.*

a. *General.* An assistive device, for the purposes of these listings, is any device that you use to improve your stability, dexterity, or mobility. An assistive device can be worn (see 101.00C6b and 101.00C6c), hand-held (see 101.00C6d), or used in a seated position (see 101.00C6e). When we use the phrase ''documented medical need,'' we mean that there is evidence from a medical source that supports your medical need for an assistive device (see 101.00C2b) for a continuous period of at least 12 months (see 101.00c2a). This evidence must describe any limitation(s) in your upper or lower extremity functioning and the circumstances for which you need to use the assistive device. We do not require that you have a specific prescription for the assistive device.

b. *Prosthesis(es).* A prosthesis is a wearable device, such as an artificial limb, that takes the place of an absent body part. If you have a prosthesis(es), we need evidence from a medical source documenting your ability to walk, or perform fine and gross movements (see 101.00E4), with the prosthesis(es) in place. When amputation(s) involves one or both lower extremities, it is not necessary for the medical source to evaluate your ability to walk without the prosthesis(es) in place. If you cannot use your prosthesis(es) due to complications affecting your residual limb(s), we need evidence from a medical source documenting the condition of your residual limb(s) and the medical basis for your inability to use the device(s).

c. *Orthosis(es).* An orthosis is a wearable device, such as a brace, that prevents or corrects a dysfunction or deformity by aligning or supporting the affected body part. If you have an orthosis(es), we need evidence from a medical source documenting your ability to walk, or perform fine and gross movements (see 101.00E4), with the orthosis(es) in place. If you cannot use your orthosis(es), we need evidence from a medical source documenting the medical basis for your inability to use the device(s).

d. *Hand-held assistive devices.* Hand-held assistive devices include walkers, canes, or crutches, which you hold onto with your hand(s) to support or aid you in walking. When you use a one-handed, hand-held assistive device (such as a cane) with one upper extremity to walk and you cannot use your other upper extremity for fine or gross movements (see 101.00E4), the need for the assistive device limits the use of both upper extremities. If you use a hand-held assistive device, we need evidence from a medical source describing how you walk with the device.

e. *Wheeled and seated mobility devices.* Wheeled and seated mobility devices are assistive devices that you use in a seated position, such as manual wheelchairs, motorized wheelchairs, rollators, and power operated vehicles. If you use a wheeled and seated mobility device, we need evidence from a medical source describing the type of wheeled and seated mobility device that you use and how you use the assistive device, including any customizations or modifications to the assistive device itself or for your use of the assistive device. For example, if you use a wheelchair that typically requires the use of both hands but has been customized for your use with one hand, then we will evaluate your use of the assistive device using the criteria in 101.00E3b and not 101.00E3a.

(i) *Wheeled and seated mobility devices involving the use of both hands.* Some wheeled and seated mobility devices involve the use of both hands to use the assistive device (for example, most manual wheelchairs). If you use a wheeled and seated mobility device that involves the use of both hands, then the need for the assistive device limits the use of both upper extremities.

(ii) *Wheeled and seated devices involving the use of one hand.* Some wheeled and seated mobility devices involve the use of one hand to use the assistive device (for example, most motorized wheelchairs). If you use a wheeled and seated mobility device that involves the use of one upper extremity and you cannot use your other upper extremity for fine or gross movements (see 101.00E4), then the need for the assistive device limits the use of both upper extremities.

7. *Longitudinal evidence.*

a. The term *pandemic period* as used in 101.00C7c means the period beginning on April 2, 2021, and ending on May 11, 2025. The term *post-pandemic evaluation period* as used in 101.00C7c means the period beginning on May 12, 2025, and ending on May 11, 2029.

b. We generally need a longitudinal medical record to assess the severity and duration of your musculoskeletal disorder because the severity of symptoms, signs, and laboratory findings related to most musculoskeletal disorders may improve over time or

respond to treatment. Evidence over an extended period will show whether your musculoskeletal functioning is improving, worsening, or unchanging.

c. For 101.15, 101.16, 101.17, 101.18, 101.20C, 101.20D, 101.22, and 101.23, all of the required criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed to meet the listing. The phrase ''within a close proximity of time'' means that all of the relevant criteria must appear in the medical record within a consecutive 4-month period, except for claims determined or decided during the pandemic period or post-pandemic evaluation period. For claims determined or decided during the pandemic period or post-pandemic evaluation period, all of the relevant criteria must appear in the medical record within a consecutive 12-month period. When the criterion is imaging, we mean that we could reasonably expect the findings on imaging to have been present at the date of impairment or date of onset. For listings that use the word ''and'' to link the elements of the required criteria, the medical record must establish the simultaneous presence, or presence within a close proximity of time, of all the required medical criteria. Once this level of severity is established, the medical record must also show that this level of severity has continued, or is expected to continue, for a continuous period of at least 12 months.

8. *Surgical treatment or physical therapy.* For some musculoskeletal disorders, a medical source may recommend surgery, or physical therapy (PT). If you have not yet had the recommended surgery or PT, we will not assume that these interventions will resolve your disorder or improve your functioning. We will assess each case on an individual basis. Depending on your response to treatment, or your medical sources' treatment plans, we may defer our findings regarding the effect of surgery or PT, until a sufficient period has passed to permit proper consideration or judgment about your future functioning. When necessary, we will follow the rules on following prescribed treatment in §416.930 of this chapter, including consideration of your reasons for failure to follow prescribed treatment.

D. *How do we consider symptoms, including pain, under these listings?*

1. Musculoskeletal disorders may cause pain or other symptoms; however, your statements about your pain or other symptoms will not alone establish that you are disabled. We will not substitute an alleged or a reported increase in the intensity of a symptom, such as pain, no matter how severe, for a medical sign or diagnostic finding present in the listing criteria. Pain is included as just one consideration in 101.15A, 101.16A, and 101.18A, but it is not required to satisfy the criteria in 101.15, 101.16, and 101.18.

2. To consider your symptom(s), we require objective medical evidence from an acceptable medical source showing the existence of a medically determinable musculoskeletal impairment that we could reasonably expect to produce the symptom(s). See §416.929 of this chapter for how we evaluate symptoms, including pain, related to your musculoskeletal disorder.

E. *How do we use the functional criteria to evaluate your musculoskeletal disorder under these listings?*

1. *General.* The functional criteria for children age 3 and older are based on impairment-related physical limitations in your ability to use both upper extremities, one or both lower extremities, or a combination of one upper and one lower extremity. We will use the relevant evidence that we have to compare your musculoskeletal functioning to the functioning of children your age who do not have impairments. The required impairment-related physical limitation of musculoskeletal functioning must have lasted, or be expected to last, for a continuous period of at least 12 months. We do not use the functional criteria in 101.20A, 101.20B, 101.21, or 101.24.

2. *Medical and functional criteria, birth to attainment of age 3.* The medical and functional criteria for children in this age group are in 101.24.

3. *Functional criteria, age 3 to attainment of age 18.* The functional criteria are based on impairment-related physical limitations in your ability to use both upper extremities, one or both lower extremities, or a combination of one upper and one lower extremity. A musculoskeletal disorder satisfies the functional criteria of a listing when the medical documentation shows the presence of at least one of the impairment-related limitations cited in the listing. The functional criteria require impairment-related physical limitation of musculoskeletal functioning that has lasted, or can be expected to last, for a continuous period of at least 12 months, medically documented by one of the following:

a. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i));

b. An inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4), and a documented medical need (see 101.00C6a) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of your other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii));

c. An inability to use both upper extremities to the extent that neither can be used

to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4).

4. *Fine and gross movements.* *Fine* movements, for the purposes of these listings, involve use of your wrists, hands, and fingers; such movements include picking, pinching, manipulating, and fingering. *Gross* movements involve use of your shoulders, upper arms, forearms, and hands; such movements include handling, gripping, grasping, holding, turning, and reaching. Gross movements also include exertional abilities such as lifting, carrying, pushing, and pulling.

F. *What do we consider when we evaluate disorders of the skeletal spine resulting in compromise of a nerve root(s) (101.15)?*

1. *General.* We consider musculoskeletal disorders such as skeletal dysplasias, caudal regression syndrome, tethered spinal cord syndrome, vertebral slippage (spondylolisthesis), scoliosis, and vertebral fracture or dislocation. Spinal disorders may cause cervical or lumbar spine dysfunction when abnormalities of the skeletal spine compromise nerve roots of the cervical spine, a nerve root of the lumbar spine, or a nerve root of both cervical and lumbar spines. We consider spinal nerve disorders that originate in the nervous system (for example, spinal arachnoiditis), under the neurological disorders body system, 111.00.

2. *Compromise of a nerve root(s).* Compromise of a nerve root, sometimes referred to as ''nerve root impingement,'' is a phrase used when a physical object, such as a tumor, herniated disc, foreign body, or arthritic spur, is pushing on the nerve root as seen on imaging or during surgery. It can occur when a musculoskeletal disorder produces irritation, inflammation, or compression of the nerve root(s) as it exits the skeletal spine between the vertebrae. Related symptoms must be associated with, or follow the path of, the affected nerve root(s).

a. *Compromise of unilateral nerve root of the cervical spine.* Compromise of a nerve root as it exits the cervical spine between the vertebrae may affect the functioning of the associated upper extremity. The physical examination reproduces the related symptoms based on radicular signs and clinical tests appropriate to the specific cervical nerve root (for example, a positive Spurling test).

b. *Compromise of bilateral nerve roots of the cervical spine.* Although uncommon, if compromise of a nerve root occurs on both sides of the cervical spinal column, functioning of both upper extremities may be limited.

c. *Compromise of a nerve root(s) of the lumbar spine.* Compromise of a nerve root as it exits the lumbar spine between the vertebrae may limit the functioning of the associated lower extremity. The physical examination reproduces the related symptoms based on radicular signs and clinical tests. When a nerve root of the lumbar spine is compromised, we require a positive straight-leg raising test (also known as a Lasègue test) in both supine and sitting positions appropriate to the specific lumbar nerve root that is compromised.

G. *What do we consider when we evaluate lumbar spinal stenosis resulting in compromise of the cauda equina (101.16)?*

1. *General.* We consider how pain, sensory changes, and muscle weakness caused by compromise of the cauda equina due to lumbar spinal stenosis affect your functioning. The cauda equina is a bundle of nerve roots that descends from the lower part of the spinal cord. Lumbar spinal stenosis can compress the nerves of the cauda equina, causing sensory changes and muscle weakness that may affect your ability to stand or walk. Pain related to compromise of the cauda equina is nonradicular because it is not typically associated with a specific nerve root (as is radicular pain in the cervical or lumbar spine).

2. *Compromise of the cauda equina* due to lumbar spinal stenosis can affect your ability to walk or stand because of neurogenic claudication (also known as pseudoclaudication), a condition usually causing nonradicular pain that starts in the low back and radiates bilaterally (or less commonly, unilaterally) into the buttocks and lower extremities (or extremity). Extension of the lumbar spine, which occurs when you walk or stand, may provoke the pain of neurogenic claudication. The pain may be relieved by forward flexion of the lumbar spine or by sitting. In contrast, the leg pain associated with peripheral vascular claudication results from inadequate arterial blood flow to a lower extremity. It occurs repeatedly and consistently when a person walks a certain distance and is relieved when the person rests.

H. *What do we consider when we evaluate reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (101.17)?*

1. *General.* We consider reconstructive surgery or surgical arthrodesis when an acceptable medical source(s) documents the surgical procedure(s) and associated medical treatments to restore function of, or eliminate motion in, the affected major weight-bearing joint(s). Reconstructive surgery may be done in a single procedure or a series of procedures directed toward the salvage or restoration of functional use of the affected joint.

2. *Major weight-bearing joints* are the hip, knee, and ankle-foot. The ankle and foot are considered together as one major joint.

3. *Surgical arthrodesis* is the artificial fusion of the bones that form a joint, essentially eliminating the joint.

I. *What do we consider when we evaluate abnormality of a major joint(s) in any extremity (101.18)?*

1. *General.* We consider musculoskeletal disorders that produce anatomical abnormalities of major joints of the extremities, which result in functional abnormalities in the upper or lower extremities (for example, chronic infections of bones and joints, and surgical arthrodesis of a joint). Abnormalities of the joints include ligamentous laxity or rupture, soft tissue contracture, or tendon rupture, and can cause muscle weakness of the affected joint(s).

a. An *anatomical* abnormality is one that is readily observable by a medical source during a physical examination (for example, subluxation or contracture), or is present on imaging (for example, joint space narrowing, bony destruction, ankylosis, or deformity).

b. A *functional* abnormality is abnormal motion or instability of the affected joint(s), including limitation of motion, excessive motion (hypermobility), movement outside the normal plane of motion for the joint (for example, lateral deviation), or fixation of the affected joint(s).

2. *Major joint of an upper extremity* refers to the shoulder, elbow, and wrist-hand. We consider the wrist and hand together as one major joint.

3. *Major joint of a lower extremity* refers to the hip, knee, and ankle-foot. We consider the ankle and hindfoot together as one major joint.

J. *What do we consider when we evaluate pathologic fractures due to any cause (101.19)?* We consider pathologic fractures of the bones in the skeletal spine, extremities, or other parts of the skeletal system. Pathologic fractures result from disorders that weaken the bones, making them vulnerable to breakage. Pathologic fractures may occur with osteoporosis, osteogenesis imperfecta or any other skeletal dysplasias, side effects of medications, and disorders of the endocrine or other body systems. Under 101.19, the fractures must have occurred on separate, distinct occasions, rather than multiple fractures occurring at the same time, but the fractures may affect the same bone(s) multiple times. There is no required time that must elapse between the fractures, but all three must occur within a 12-month period; for example, separate incidents may occur within hours or days of each other. We evaluate non-healing or complex traumatic fractures without accompanying pathology under 101.22 or 101.23.

K. *What do we consider when we evaluate amputation due to any cause (101.20)?*

1. *General.* We consider amputation (the full or partial loss or absence of any extremity) due to any cause including trauma, congenital abnormality or absence, surgery for treatment of conditions such as cancer or infection, or complications of peripheral vascular disease or diabetes mellitus.

2. *Amputation of both upper extremities (101.20A).* Under 101.20A, we consider upper extremity amputations that occur at any level at or above the wrists (carpal joints), up to and including disarticulation of the shoulder (glenohumeral) joint. If you have had both upper extremities amputated at any level at or above the wrists up to and including the shoulder, your impairment satisfies the duration requirement in §416.909 of this chapter. For amputations below the wrist, we will follow the rules described in 101.00R. We do not evaluate amputations below the wrists under 101.20A because the resulting limitation of function of the thumb(s), finger(s), or hand(s) will vary, depending on the extent of loss and corresponding effect on fine and gross movements.

3. *Hemipelvectomy or hip disarticulation (101.20B).* Under 101.20B, we consider hemipelvectomy, which involves amputation of an entire lower extremity through the sacroiliac joint, and hip disarticulation, which involves amputation of an entire lower extremity through the hip joint capsule and closure of the remaining musculature over the exposed acetabular bone. If you have had a hemipelvectomy or hip disarticulation, your impairment satisfies the duration requirement in §416.909 of this chapter.

4. *Amputation of one upper extremity and one lower extremity (101.20C).* Under 101.20C, we consider the amputation of one upper extremity at any level at or above the wrist and one lower extremity at or above the ankle. If you have a documented medical need for a one-handed, hand-held assistive device (such as a cane) or a wheeled and seated mobility device involving the use of one hand (such as a motorized wheelchair), then you must use your remaining upper extremity to hold the device, making the extremity unavailable to perform other fine and gross movements (see 101.00E4).

5. *Amputation of one lower extremity or both lower extremities with complications of the residual limb(s) (101.20D).* Under 101.20D, we consider the amputation of one lower extremity or both lower extremities at or above the ankle. We also consider the condition of your residual limb(s), whether you can wear a prosthesis(es) (see 101.00C6b), and whether you have a documented medical need (see 101.00C6a) for a hand-held assistive device(s) (see 101.00C6d) or a wheeled and seated mobility device (see 101.00C6e). If you have a nonhealing residual limb(s) and are receiving ongoing surgical treatment expected to re-establish or improve function, and that ongoing surgical treatment has not ended, or is not expected to end, within at least 12 months of the initiation of the surgical management (see 101.00L), we evaluate your musculoskeletal disorder under 101.21.

L. *What do we consider when we evaluate soft tissue injury or abnormality under continuing surgical management (101.21)?*

1. *General.*

a. We consider any soft tissue injury or abnormality involving the soft tissues of the body, whether congenital or acquired, when an acceptable medical source(s) documents the need for ongoing surgical procedures and associated medical treatments to restore function of the affected body part(s) (see 101.00P1). Surgical management includes the surgery(ies) itself, as well as various post-surgical procedures, surgical complications, infections or other medical complications, related illnesses, or related treatments that delay your attainment of maximum benefit from therapy (see 101.00P2).

b. Surgical procedures and associated treatments typically take place over extended periods, which may render you unable to perform age-appropriate activity on a sustained basis. To document such inability, we must have evidence from an acceptable medical source(s) confirming that the surgical management has continued, or is expected to continue, for at least 12 months from the date of the first surgical intervention. These procedures and treatments must be directed toward saving, reconstructing, or replacing the affected part of the body to re-establish or improve its function, and not for cosmetic appearances alone.

c. Examples include malformations, third- and fourth-degree burns, crush injuries, craniofacial injuries, avulsive injuries, and amputations with complications of the residual limb(s).

d. We evaluate skeletal spine abnormalities or injuries under 101.15 or 101.16, as appropriate. We evaluate abnormalities or injuries of bones in the lower extremities under 101.17, 101.18, or 101.22. We evaluate abnormalities or injuries of bones in the upper extremities under 101.18 or 101.23.

2. *Documentation.* In addition to the objective medical evidence we need to establish your soft tissue injury or abnormality, we also need all of the following medically documented evidence about your continuing surgical management:

a. Operative reports and related laboratory findings;

b. Records of post-surgical procedures;

c. Records of any surgical or medical complications (for example, related infections or systemic illnesses);

d. Records of any prolonged post-operative recovery periods and related treatments (for example, surgeries and treatments for burns);

e. An acceptable medical source's plans for additional surgeries; and

f. Records detailing any other factors that have delayed, or that an acceptable medical source expects to delay, the saving, restoring, or replacing of the involved part for a continuous period of at least 12 months following the initiation of the surgical management.

3. *Burns.* Third- and fourth-degree burns damage or destroy nerve tissue, reducing or preventing transmission of signals through those nerves. Such burns frequently require multiple surgical procedures and related therapies to re-establish or improve function, which we evaluate under 101.21. When burns are no longer *under continuing surgical management* (see 101.00P1), we evaluate the residual impairment(s). When the residual impairment(s) affects the musculoskeletal system, as often occurs in third- and fourth-degree burns, it can result in permanent musculoskeletal tissue loss, joint contractures, or loss of extremities. We will evaluate such impairments under the relevant musculoskeletal disorders listing, for example, 101.18 or 101.20. When the residual impairment(s) involves another body system, we will evaluate the impairment(s) under the listings in the relevant body system(s).

4. *Craniofacial injuries or congenital abnormalities.* Surgeons may treat craniofacial injuries or congenital abnormalities with multiple surgical procedures. These injuries or abnormalities may affect vision, hearing, speech, and the initiation of the digestive process, including mastication. When the craniofacial injury-related or congenital abnormality-related residual impairment(s) involves another body system(s), we will evaluate the impairment(s) under the listings in the relevant body system(s).

M. *What do we consider when we evaluate non-healing or complex fractures of the femur, tibia, pelvis, or one or more of the talocrural bones (101.22)?*

1. *Non-healing fracture.* A non-healing (nonunion) fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months has elapsed since the injury and the fracture site has shown no, or minimal, progressive signs of healing for a minimum of 3 months.

2. *Complex fracture.* A complex fracture is a fracture with one or more of the following:

a. Comminuted (broken into many pieces) bone fragments;

b. Multiple fractures in a single bone;

c. Bone loss due to severe trauma;

d. Damage to the surrounding soft tissue;

e. Severe cartilage damage to the associated joint; or

f. Dislocation of the associated joint.

3. When a complex fracture involves soft tissue damage, the treatment may involve continuing surgical management to restore or improve functioning. In such cases, we may evaluate the fracture(s) under 101.21.

N. *What do we consider when we evaluate non-healing or complex fractures of an upper extremity (101.23)?*

1. *Non-healing fracture.* A non-healing (nonunion) fracture is a fracture that has failed to unite completely. Nonunion is usually established when a minimum of 9 months has elapsed since the injury and the fracture site

has shown no, or minimal, progressive signs of healing for a minimum of 3 months.

2. *Complex fracture.* A complex fracture is a fracture with one or more of the following:

a. Comminuted (broken into many pieces) bone fragments;

b. Multiple fractures in a single bone;

c. Bone loss due to severe trauma;

d. Damage to the surrounding soft tissue;

e. Severe cartilage damage to the associated joint; or

f. Dislocation of the associated joint.

3. When a complex fracture involves soft tissue damage, the treatment may involve continuing surgical management to restore or improve functioning. In such cases, we may evaluate the fracture(s) under 101.21.

O. *What do we consider when we evaluate musculoskeletal disorders of infants and toddlers from birth to attainment of age 3 with developmental motor delay (101.24)?*

1. *General.* Under 101.24, we require reports from an acceptable medical source(s) to establish a delay in your motor development as a medically determinable impairment. Examples of disorders we evaluate under this listing include arthrogryposis, clubfoot, osteogenesis imperfecta, caudal regression syndrome, fracture complications, disorders affecting the hip and pelvis, and complications associated with your musculoskeletal disorder or its treatment. Some medical records may simply document your condition as ''developmental motor delay.''

2. *Severity of developmental motor delay.* To evaluate the severity of your developmental motor delay, we need developmental test reports from an acceptable medical source, or from early intervention specialists, physical and occupational therapists, and other sources.

a. If there is a standardized developmental assessment in your medical record, we will use the results to evaluate your developmental motor delay under 101.24A. Such an assessment compares your level of development to the level typically expected for children of your chronological age. If you were born prematurely, we use your corrected chronological age for comparison. See §416.924b(b) of this chapter.

b. If there is no standardized developmental assessment in your medical record, we will use narrative developmental reports from a medical source(s) to evaluate your developmental motor delay under 101.24B. These reports must provide detailed information sufficient for us to assess the severity of your motor delay. If we cannot obtain sufficient detail from narrative reports, we may purchase standardized developmental assessments.

(i) A narrative developmental report is based on clinical observations, progress notes, and well-baby check-ups, and must include your developmental history, examination findings (with abnormal findings noted on repeated examinations), and an overall assessment of your development (that is, more than one or two isolated skills) by the medical source.

(ii) Some narrative developmental reports may include results from developmental screening tests, which can show that you are not developing or achieving skills within expected timeframes. Although medical sources may refer to screening test results as supporting evidence in the narrative developmental report, screening test results alone cannot establish a medically determinable impairment or the severity of developmental motor delay.

P. *How will we determine whether your soft tissue injury or abnormality or your upper extremity fracture is no longer under continuing surgical management or you have received maximum benefit from therapy?*

1. We will determine that your soft tissue injury or abnormality, or your upper extremity fracture, is no longer *under continuing surgical management,* as used in 101.21 and 101.23, when the last surgical procedure or medical treatment directed toward the re-establishment or improvement of function of the involved part has occurred.

2. We will determine that you have received *maximum benefit from therapy*, as used in 101.21, if there are no significant changes in physical findings or on appropriate imaging for any 6-month period after the last surgical procedure or medical treatment. We may also determine that you have received maximum benefit from therapy if your medical source(s) indicates that further improvement is not expected after the last surgical procedure or medical treatment.

3. When you have received maximum benefit from therapy, we will evaluate any impairment-related residual symptoms, signs, and laboratory findings (including those on imaging), any complications associated with your surgical procedures or medical treatments, and any residual limitations in your functioning (see 101.00R).

Q. *How do we evaluate your musculoskeletal disorder if there is no record of ongoing treatment?*

1. Despite having a musculoskeletal disorder, you may not have received ongoing treatment, may have just begun treatment, may not have access to prescribed medical treatment, or may not have an ongoing relationship with the medical community. In any of these situations, you will not have a longitudinal medical record for us to review when we evaluate your disorder and we may ask you to attend a consultative examination to determine the severity and potential duration of your disorder. See §416.919a(b) of this chapter.

2. In some instances, we may be able to assess the severity and duration of your musculoskeletal disorder based on your medical

record and current evidence alone. If the information in your case record is not sufficient to show that you have a musculoskeletal disorder that meets the criteria of one of the musculoskeletal disorders listings, we will follow the rules described in 101.00R.

R. *How do we evaluate musculoskeletal disorders that do not meet one of these listings?*

1. These listings are only examples of musculoskeletal disorders that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §416.926 of this chapter. If your impairment(s) does not meet or medically equal a listing, we will determine whether it functionally equals the listings. See §416.926a of this chapter.

3. We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

101.01 Category of Impairments, Musculoskeletal Disorders

101.15 *Disorders of the skeletal spine resulting in compromise of a nerve root(s)* (see 101.00F), documented by A, B, C, *and* D:

A. Neuro-anatomic (radicular) distribution of one or more of the following *symptoms* consistent with compromise of the affected nerve root(s):

1. Pain; or

2. Paresthesia; or

3. Muscle fatigue.

AND

B. Radicular distribution of neurological *signs* present during physical examination (see 101.00C2) or on a diagnostic test (see 101.00C3) and evidenced by 1, 2, and either 3 or 4:

1. Muscle weakness; and

2. Sign(s) of nerve root irritation, tension, or compression, consistent with compromise of the affected nerve root (see 101.00F2)

3. Sensory changes evidenced by:

a. Decreased sensation; or

b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; *or*

4. Decreased deep tendon reflexes.

AND

C. Findings on imaging (see 101.00C3) consistent with compromise of a nerve root(s) in the cervical or lumbosacral spine.

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 101.C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4), *and* a documented medical need (see 101.00C6a) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4).

101.16 *Lumbar spinal stenosis resulting in compromise of the cauda equina* (see 101.00G), documented by A, B, C, *and* D:

A. Symptom(s) of neurological compromise manifested as:

1. Nonradicular distribution of pain in one or both lower extremities; or

2. Nonradicular distribution of sensory loss in one or both lower extremities; or

3. Neurogenic claudication.

AND

B. Nonradicular neurological signs present during physical examination (see 101.00C2) or on a diagnostic test (see 101.00C3) and evidenced by 1 and either 2 or 3:

1. Muscle weakness.

2. Sensory changes evidenced by:

a. Decreased sensation; or

b. Sensory nerve deficit (abnormal sensory nerve latency) on electrodiagnostic testing; or

c. Areflexia, trophic ulceration, or bladder or bowel incontinence.

3. Decreased deep tendon reflexes in one or both lower extremities.

AND

C. Findings on imaging (see 101.00C3) or in an operative report (see 101.00C4) consistent with compromise of the cauda equina with lumbar spinal stenosis.

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled

and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4), *and* a documented medical need (see 101.00C6a) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)).

101.17 *Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint* (see 101.00H), documented by A, B, *and* C:

A. History of reconstructive surgery or surgical arthrodesis of a major weight-bearing joint.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months.

AND

C. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)).

101.18 *Abnormality of a major joint(s) in any extremity* (see 101.00I), documented by A, B, C, *and* D:

A. Chronic joint pain or stiffness.

AND

B. Abnormal motion, instability, or immobility of the affected joint(s).

AND

C. Anatomical abnormality of the affected joint(s) noted on:

1. Physical examination (for example, subluxation, contracture, or bony or fibrous ankylosis); or

2. Imaging (for example, joint space narrowing, bony destruction, or ankylosis or arthrodesis of the affected joint).

AND

D. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4), *and* a documented medical need (see 101.00C6a) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4).

101.19 *Pathologic fractures due to any cause* (see 101.00J), documented by A *and* B:

A. Pathologic fractures occurring on three separate occasions within a 12-month period.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least *one* of the following:

1. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4), *and* a documented medical need (see 101.00C6a) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4).

101.20 *Amputation due to any cause* (see 101.00K), documented by A, B, C, *or* D:

A. Amputation of both upper extremities, occurring at any level at or above the wrists (carpal joints), up to and including the shoulder (glenohumeral) joint.

OR

B. Hemipelvectomy or hip disarticulation.

OR

C. Amputation of one upper extremity, occurring at any level at or above the wrist (carpal joints), and amputation of one lower extremity, occurring at or above the ankle (talocrural joint), *and* medical documentation of at least *one* of the following:

1. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

2. A documented medical need (see 101.00C6a) for a one-handed, hand-held assistive device (see 101.00C6d) requiring the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

3. The inability to use the remaining upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (101.00E4).
OR

D. Amputation of one or both lower extremities, occurring at or above the ankle (talocrural joint), with complications of the residual limb(s) that have lasted, or are expected to last, for a continuous period of at least 12 months, *and* medical documentation of 1 and 2:

1. The inability to use a prosthesis(es); and

2. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)).

101.21 *Soft tissue injury or abnormality under continuing surgical management* (see 101.00L), documented by A, B, *and* C:

A. Evidence confirms continuing surgical management (see 101.00P1) directed toward saving, reconstructing, or replacing the affected part of the body.

AND

B. The surgical management has been, or is expected to be, ongoing for a continuous period of at least 12 months.

AND

C. Maximum benefit from therapy (see 101.00P2) has not yet been achieved.

101.22 *Non-healing or complex fracture of the femur, tibia, pelvis, or one or more of the talocrural bones* (see 101.00M), documented by A, B, *and* C:

A. Solid union not evident on imaging (see 101.00C3) and not clinically solid.

AND

B. Impairment-related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months.

AND

C. A documented medical need (see 101.00C6a) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)).

101.23 *Non-healing or complex fracture of an upper extremity* (see 101.00N), documented by A *and* B:

A. Nonunion or complex fracture, of the shaft of the humerus, radius, or ulna, under continuing surgical management (see 101.00P1) directed toward restoration of functional use of the extremity.

AND

B. Medical documentation of an inability to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 101.00E4) that has lasted, or is expected to last, for a continuous period of at least 12 months.

101.24 *Musculoskeletal disorders of infants and toddlers, from birth to attainment of age 3, with developmental motor delay* (see 101.00O), documented by A *or* B:

A. A standardized developmental motor assessment that:

1. Shows motor development not more than one-half of the level typically expected for the child's age; or

2. Results in a valid score that is at least three standard deviations below the mean.

OR

B. Two narrative developmental reports that:

1. Are dated at least 120 days apart; and

2. Indicate current motor development not more than one-half of the level typically expected for the child's age.

102.00 Special Senses and Speech

A. *How do we evaluate visual disorders?*

1. *What are visual disorders?* Visual disorders are abnormalities of the eye, the optic nerve, the optic tracts, or the brain that may cause a loss of visual acuity or visual fields. A loss of visual acuity limits your ability to distinguish detail, read, do fine work, or perform other age-appropriate activities. A loss of visual fields limits your ability to perceive visual stimuli in the peripheral extent of vision.

2. *How do we define statutory blindness?* Statutory blindness is blindness as defined in sections 216(i)(1) and 1614(a)(2) of the Social Security Act (Act).

a. The Act defines blindness as central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. We use your best-corrected central visual acuity for distance in the better eye when we determine if this definition is met. (For visual acuity testing requirements, see 102.00A5.)

b. The Act also provides that an eye that has a visual field limitation such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered as having a central visual acuity of 20/200 or less. (For visual field testing requirements, see 102.00A6.)

c. You have statutory blindness only if your visual disorder meets the criteria of 102.02A, 102.02B, or 102.03A. You do not have statutory blindness if your visual disorder medically equals the criteria of 102.02A, 102.02B, or 102.03A or meets or medically equals the criteria of 102.03B, 102.03C, 102.04A, or 102.04B because your disability is based on criteria other than those in the statutory definition of blindness.

3. *What evidence do we need to establish statutory blindness under title XVI?* To establish that you have statutory blindness under title XVI, we need evidence showing only that your central visual acuity in your better eye or your visual field in your better eye meets the criteria in 102.00A2, provided that

those measurements are consistent with the other evidence in your case record. We do not need documentation of the cause of your blindness. Also, there is no duration requirement for statutory blindness under title XVI (see §§ 416.981 and 416.983 of this chapter).

4. *What evidence do we need to evaluate visual disorders, including those that result in statutory blindness under title II?* To evaluate your visual disorder, we usually need a report of an eye examination that includes measurements of your best-corrected central visual acuity (see 102.00A5) or the extent of your visual fields (see 102.00A6), as appropriate. If you have visual acuity or visual field loss, we need documentation of the cause of the loss. A standard eye examination will usually indicate the cause of any visual acuity loss. A standard eye examination can also indicate the cause of some types of visual field deficits. Some disorders, such as cortical visual disorders, may result in abnormalities that do not appear on a standard eye examination. If the standard eye examination does not indicate the cause of your vision loss, we will request the information used to establish the presence of your visual disorder. If your visual disorder does not satisfy the criteria in 102.02, 102.03, or 102.04, we will request a description of how your visual disorder affects your ability to function.

5. *How do we measure your best-corrected central visual acuity?*

a. *Visual acuity testing.* When we need to measure your best-corrected central visual acuity, which is your optimal visual acuity attainable with the use of a corrective lens, we use visual acuity testing for distance that was carried out using Snellen methodology or any other testing methodology that is comparable to Snellen methodology.

(i) Your best-corrected central visual acuity for distance is usually measured by determining what you can see from 20 feet. If your visual acuity is measured for a distance other than 20 feet, we will convert it to a 20-foot measurement. For example, if your visual acuity is measured at 10 feet and is reported as 10/40, we will convert this measurement to 20/80.

(ii) A visual acuity recorded as CF (counts fingers), HM (hand motion only), LP or LPO (light perception or light perception only), or NLP (no light perception) indicates that no optical correction will improve your visual acuity. If your central visual acuity in an eye is recorded as CF, HM, LP or LPO, or NLP, we will determine that your best-corrected central visual acuity is 20/200 or less in that eye.

(iii) We will not use the results of pinhole testing or automated refraction acuity to determine your best-corrected central visual acuity. These tests provide an estimate of potential visual acuity but not an actual measurement of your best-corrected central visual acuity.

(iv) Very young children, such as infants and toddlers, cannot participate in testing using Snellen methodology or other comparable testing. If you are unable to participate in testing using Snellen methodology or other comparable testing due to your young age, we will consider clinical findings of your fixation and visual-following behavior. If both these behaviors are absent, we will consider the anatomical findings or the results of neuroimaging, electroretinogram, or visual evoked response (VER) testing when this testing has been performed.

b. *Other test charts.*

(i) Children between the ages of 3 and 5 often cannot identify the letters on a Snellen or other letter test chart. Specialists with expertise in assessment of childhood vision use alternate methods for measuring visual acuity in young children. We consider alternate methods, for example, the Landolt C test or the tumbling-E test, which are used to evaluate young children who are unable to participate in testing using Snellen methodology, to be comparable to testing using Snellen methodology.

(ii) Most test charts that use Snellen methodology do not have lines that measure visual acuity between 20/100 and 20/200. Some test charts, such as the Bailey-Lovie or the Early Treatment Diabetic Retinopathy Study (ETDRS), used mostly in research settings, have such lines. If your visual acuity is measured with one of these charts, and you cannot read any of the letters on the 20/100 line, we will determine that you have statutory blindness based on a visual acuity of 20/200 or less. For example, if your best-corrected central visual acuity for distance in the better eye is 20/160 using an ETDRS chart, we will find that you have statutory blindness. Regardless of the type of test chart used, you do not have statutory blindness if you can read at least one letter on the 20/100 line. For example, if your best-corrected central visual acuity for distance in the better eye is 20/125 + 1 using an ETDRS chart, we will find that you do not have statutory blindness because you are able to read one letter on the 20/100 line.

c. *Testing using a specialized lens.* In some instances, you may have visual acuity testing performed using a specialized lens, such as a contact lens. We will use the visual acuity measurements obtained with a specialized lens only if you have demonstrated the ability to use the specialized lens on a sustained basis. We will not use visual acuity measurements obtained with telescopic lenses.

d. *Cycloplegic refraction* is an examination of the eye performed after administering cycloplegic eye drops capable of relaxing the ability of the pupil to become smaller and temporarily paralyzing the focusing muscles.

If your case record contains the results of cycloplegic refraction, we may use the results to determine your best-corrected central visual acuity. We will not purchase cycloplegic refraction.

e. *VER testing* measures your response to visual events and can often detect dysfunction that is undetectable through other types of examinations. If you have an absent response to VER testing in your better eye, we will determine that your best-corrected central visual acuity is 20/200 or less in that eye and that your visual acuity loss satisfies the criterion in 102.02A or 102.02B4, as appropriate, when these test results are consistent with the other evidence in your case record. If you have a positive response to VER testing in an eye, we will not use that result to determine your best-corrected central visual acuity in that eye.

6. *How do we measure your visual fields?*

a. *General.* We generally need visual field testing when you have a visual disorder that could result in visual field loss, such as glaucoma, retinitis pigmentosa, or optic neuropathy, or when you display behaviors that suggest a visual field loss. When we need to measure the extent of your visual field loss, we use visual field testing (also referred to as perimetry) carried out using automated static threshold perimetry performed on an acceptable perimeter. (For perimeter requirements, see 102.00A9.)

b. *Automated static threshold perimetry requirements.*

(i) The test must use a white size III Goldmann stimulus and a 31.5 apostilb (asb) white background (or a 10 candela per square meter (cd/m^2) white background). The stimuli test locations must be no more than 6 degrees apart horizontally or vertically. Measurements must be reported on standard charts and include a description of the size and intensity of the test stimulus.

(ii) We measure the extent of your visual field loss by determining the portion of the visual field in which you can see a white III4e stimulus. The ''III'' refers to the standard Goldmann test stimulus size III (4 mm^2), and the ''4e'' refers to the standard Goldmann intensity filter (0 decibel (dB) attenuation, which allows presentation of the maximum luminance) used to determine the intensity of the stimulus.

(iii) In automated static threshold perimetry, the intensity of the stimulus varies. The intensity of the stimulus is expressed in decibels (dB). A perimeter's maximum stimulus luminance is usually assigned the value 0 dB. We need to determine the dB level that corresponds to a 4e intensity for the particular perimeter being used. We will then use the dB printout to determine which points you see at a 4e intensity level (a ''seeing point''). For example:

A. When the maximum stimulus luminance (0 dB stimulus) on an acceptable perimeter is 10,000 asb, a 10 dB stimulus is equivalent to a 4e stimulus. Any point you see at 10 dB or greater is a seeing point.

B. When the maximum stimulus luminance (0 dB stimulus) on an acceptable perimeter is 4,000 asb, a 6 dB stimulus is equivalent to a 4e stimulus. Any point you see at 6 dB or greater is a seeing point.

C. When the maximum stimulus luminance (0 dB stimulus) on an acceptable perimeter is 1,000 asb, a 0 dB stimulus is equivalent to a 4e stimulus. Any point you see at 0 dB or greater is a seeing point.

c. *Evaluation under 102.03A.* To determine statutory blindness based on visual field loss in your better eye (102.03A), we need the results of a visual field test that measures the central 24 to 30 degrees of your visual field; that is, the area measuring 24 to 30 degrees from the point of fixation. Acceptable tests include the Humphrey Field Analyzer (HFA) 30–2, HFA 24–2, and Octopus 32.

d. *Evaluation under 102.03B.* To determine whether your visual field loss meets listing 102.03B, we use the mean deviation or defect (MD) from acceptable automated static threshold perimetry that measures the central 30 degrees of the visual field. MD is the average sensitivity deviation from normal values for all measured visual field locations. When using results from HFA tests, which report the MD as a negative number, we use the absolute value of the MD to determine whether your visual field loss meets listing 102.03B. We cannot use tests that do not measure the central 30 degrees of the visual field, such as the HFA 24–2, to determine if your impairment meets or medically equals 102.03B.

e. *Other types of perimetry.* If your case record contains visual field measurements obtained using manual or automated kinetic perimetry, such as Goldmann perimetry or the HFA ''SSA Test Kinetic,'' we can generally use these results if the kinetic test was performed using a white III4e stimulus projected on a white 31.5 asb (10 cd/m^2) background. Automated kinetic perimetry, such as the HFA ''SSA Test Kinetic,'' does not detect limitations in the central visual field because testing along a meridian stops when you see the stimulus. If your visual disorder has progressed to the point at which it is likely to result in a significant limitation in the central visual field, such as a scotoma (see 102.00A6h), we will not use *automated* kinetic perimetry to determine the extent of your visual field loss. Instead, we will determine the extent of your visual field loss using automated static threshold perimetry or manual kinetic perimetry.

f. *Screening tests.* We will not use the results of visual field screening tests, such as confrontation tests, tangent screen tests, or automated static screening tests, to determine that your impairment meets or medically equals a listing, or functionally equals

the listings. We can consider normal results from visual field screening tests to determine whether your visual disorder is severe when these test results are consistent with the other evidence in your case record. (See § 416.924(c) of this chapter.) We will not consider normal test results to be consistent with the other evidence if the clinical findings indicate that your visual disorder has progressed to the point that it is likely to cause visual field loss, or you have a history of an operative procedure for retinal detachment.

g. *Use of corrective lenses.* You must not wear eyeglasses during visual field testing because they limit your field of vision. You may wear contact lenses to correct your visual acuity during the visual field test to obtain the most accurate visual field measurements. For this single purpose, you do not need to demonstrate that you have the ability to use the contact lenses on a sustained basis.

h. *Scotoma.* A scotoma is a field defect or non-seeing area (also referred to as a ''blind spot'') in the visual field surrounded by a normal field or seeing area. When we measure your visual field, we subtract the length of any scotoma, other than the normal blind spot, from the overall length of any diameter on which it falls.

7. *How do we determine your visual acuity efficiency, visual field efficiency, and visual efficiency?*

a. *General. Visual efficiency,* a calculated value of your remaining visual function, is the combination of your *visual acuity efficiency* and your *visual field efficiency* expressed as a percentage.

b. *Visual acuity efficiency.* Visual acuity efficiency is a percentage that corresponds to the best-corrected central visual acuity for distance in your better eye. See Table 1.

TABLE 1—VISUAL ACUITY EFFICIENCY

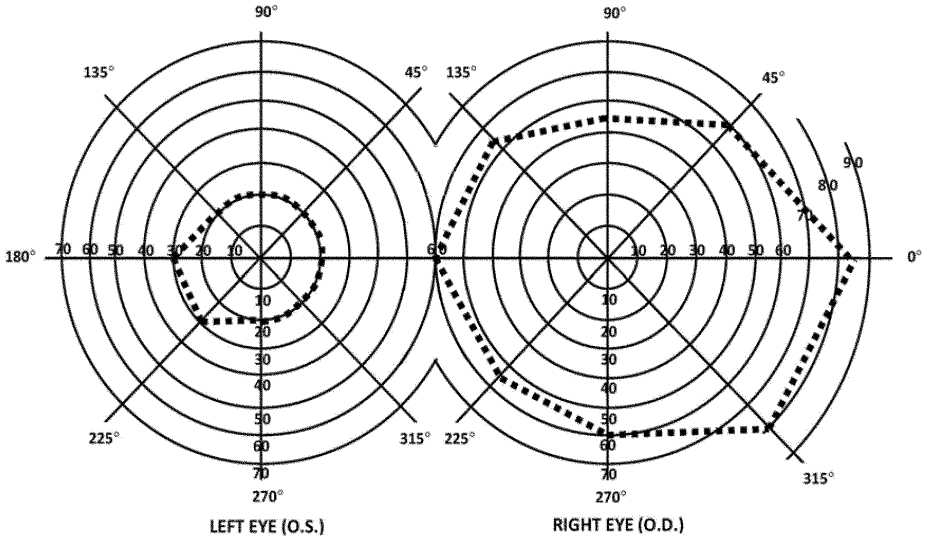
Snellen best-corrected central visual acuity for distance		Visual acuity efficiency (%) (102.04A)
English	Metric	
20/16	6/5	100
20/20	6/6	100
20/25	6/7.5	95
20/30	6/9	90
20/40	6/12	85
20/50	6/15	75
20/60	6/18	70
20/70	6/21	65
20/80	6/24	60
20/100	6/30	50

c. *Visual field efficiency.* Visual field efficiency is a percentage that corresponds to the visual field in your better eye. Under 102.03C, we require kinetic perimetry to determine your visual field efficiency percentage. We calculate the visual field efficiency percentage by adding the number of degrees you see along the eight principal meridians found on a visual field chart (0, 45, 90, 135, 180, 225, 270, and 315) in your better eye and dividing by 5. For example, in Figure 1:

A. The diagram of the left eye illustrates a visual field, as measured with a III4e stimulus, contracted to 30 degrees in two meridians (180 and 225) and to 20 degrees in the remaining six meridians. The visual efficiency percentage of this field is: $((2 \times 30) + (6 \times 20)) \div 5 = 36$ percent.

B. The diagram of the right eye illustrates the extent of a normal visual field as measured with a III4e stimulus. The sum of the eight principal meridians of this field is 500 degrees. The visual efficiency percentage of this field is $500 \div 5 = 100$ percent.

Figure 1:



d. *Visual efficiency.* Under 102.04A, we calculate the visual efficiency percentage by multiplying your visual acuity efficiency percentage (see 102.00A7b) by your visual field efficiency percentage (see 102.00A7c) and dividing by 100. For example, if your visual acuity efficiency percentage is 75 and your visual field efficiency percentage is 36, your visual efficiency percentage is: (75 × 36) ÷ 100 = 27 percent.

8. *How do we determine your visual acuity impairment value, visual field impairment value, and visual impairment value?*

a. *General. Visual impairment value,* a calculated value of your loss of visual function, is the combination of your *visual acuity impairment value* and your *visual field impairment value.*

b. *Visual acuity impairment value.* Your visual acuity impairment value corresponds to the best-corrected central visual acuity for distance in your better eye. See Table 2.

TABLE 2—VISUAL ACUITY IMPAIRMENT VALUE

Snellen best-corrected central visual acuity for distance		Visual acuity impairment value (102.04B)
English	Metric	
20/16	6/5	0.00
20/20	6/6	0.00
20/25	6/7.5	0.10
20/30	6/9	0.18
20/40	6/12	0.30
20/50	6/15	0.40
20/60	6/18	0.48

TABLE 2—VISUAL ACUITY IMPAIRMENT VALUE—Continued

Snellen best-corrected central visual acuity for distance		Visual acuity impairment value (102.04B)
English	Metric	
20/70	6/21	0.54
20/80	6/24	0.60
20/100	6/30	0.70

c. *Visual field impairment value.* Your visual field impairment value corresponds to the visual field in your better eye. Using the MD from acceptable automated static threshold perimetry, we calculate the visual field impairment value by dividing the absolute value of the MD by 22. For example, if your MD on an HFA 30–2 is −16, your visual field impairment value is: |−16| ÷ 22 = 0.73.

d. *Visual impairment value.* Under 102.04B, we calculate the visual impairment value by adding your visual acuity impairment value (see 102.00A8b) and your visual field impairment value (see 102.00A8c). For example, if your visual acuity impairment value is 0.48 and your visual field impairment value is 0.73, your visual impairment value is: 0.48 + 0.73 = 1.21.

9. *What are our requirements for an acceptable perimeter?* We will use results from automated static threshold perimetry performed on a perimeter that:

a. Uses optical projection to generate the test stimuli.

b. Has an internal normative database for automatically comparing your performance with that of the general population.

c. Has a statistical analysis package that is able to calculate visual field indices, particularly mean deviation or mean defect.

d. Demonstrates the ability to correctly detect visual field loss and correctly identify normal visual fields.

e. Demonstrates good test-retest reliability.

f. Has undergone clinical validation studies by three or more independent laboratories with results published in peer-reviewed ophthalmic journals.

B. *How do we evaluate hearing loss?*

1. *What evidence do we need?*

a. We need evidence showing that you have a medically determinable impairment that causes your hearing loss and audiometric measurements of the severity of your hearing loss. We generally require both an otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another otologic examination. We will consider your test scores together with any other relevant information we have about your hearing, including information from outside of the test setting.

b. The otologic examination must be performed by a licensed physician (medical or osteopathic doctor) or audiologist. It must include your medical history, your description of how your hearing loss affects you, and the physician's or audiologist's description of the appearance of the external ears (pinnae and external ear canals), evaluation of the tympanic membranes, and assessment of any middle ear abnormalities.

c. Audiometric testing must be performed by, or under the direct supervision of, a licensed audiologist or an otolaryngologist.

2. *What audiometric testing do we need when you do not have a cochlear implant?*

a. *General.* We need either physiologic or behavioral testing (other than screening testing, see 102.00B2g) that is appropriate for your age at the time of testing. *See* 102.00B2c–102.00B2f. We will make every reasonable effort to obtain the results of physiologic testing that has been done; however, we will not purchase such testing.

b. *Testing requirements.* The testing must be conducted in accordance with the most recently published standards of the American National Standards Institute (ANSI). You must not wear hearing aids during the testing. Additionally, a person described in 102.00B1c must perform an otoscopic examination immediately before the audiometric testing. (An *otoscopic examination* provides a description of the appearance of your external ear canals and an evaluation of the tympanic membranes. In these rules, we use the term to include otoscopic examinations performed by physicians and otoscopic inspections performed by audiologists and others.) The otoscopic examination must show that there are no conditions that would prevent valid audiometric testing, such as fluid in the ear, ear infection, or obstruction in an ear canal. The person performing the test should also report on any other factors, such as your ability to maintain attention, that can affect the interpretation of the test results.

c. *Children from birth to the attainment of age 6 months.*

(i) We need physiologic testing, such as auditory brainstem response (ABR) testing.

(ii) To determine whether your hearing loss meets 102.10A, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hertz (Hz). If you do not have a response at a particular frequency, we will use a threshold of 5 decibels (dB) over the limit of the audiometer.

d. *Children from age 6 months to the attainment of age 2.*

(i) We need air conduction thresholds determined by a behavioral assessment, usually visual reinforcement audiometry (VRA). We can use ABR testing if the behavioral assessment cannot be completed or if the results are inconclusive or unreliable.

(ii) To determine whether your hearing loss meets 102.10A, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hz. If you do not have a response at a particular frequency, we will use a threshold of 5 dB over the limit of the audiometer.

(iii) For this age group, behavioral assessments are often performed in a sound field, and each ear is not tested separately. If each ear is not tested separately, we will consider the test results to represent the hearing in the better ear.

e. *Children from age 2 to the attainment of age 5.*

(i) We need air conduction thresholds determined by a behavioral assessment, such as conditioned play audiometry (CPA), tangible or visually reinforced operant conditioning audiometry (TROCA, VROCA), or VRA. If you have had ABR testing, we can use the results of that testing if the behavioral assessment cannot be completed or the results are inconclusive or unreliable.

(ii) To determine whether your hearing loss meets 102.10A, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hz. If you do not have a response at a particular frequency, we will use a threshold of 5 dB over the limit of the audiometer.

(iii) For this age group, behavioral assessments are often performed in a sound field

and each ear is not tested separately. If each ear is not tested separately, we will consider the test results to represent the hearing in the better ear.

f. *Children from age 5 to the attainment of age 18.*

(i) We generally need pure tone air conduction and bone conduction testing, speech reception threshold (SRT) testing (also referred to as ''spondee threshold'' or ''ST'' testing), and word recognition testing (also referred to as ''word discrimination'' or ''speech discrimination'' testing). This testing must be conducted in a sound-treated booth or room and must be in accordance with the most recently published ANSI standards. Each ear must be tested separately.

(ii) To determine whether your hearing loss meets the air and bone conduction criterion in 102.10B1 or 102.10B3, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hz. If you do not have a response at a particular frequency, we will use a threshold of 5 dB over the limit of the audiometer.

(iii) The SRT is the minimum dB level required for you to recognize 50 percent of the words on a standard list of spondee words. (Spondee words are two-syllable words that have equal stress on each syllable.) The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy must be documented. If we cannot determine that there is a medical basis for the discrepancy, we will not use the results of the testing to determine whether your hearing loss meets a listing.

(iv) Word recognition testing determines your ability to recognize an age-appropriate, standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The list may be recorded or presented live, but in either case, the words should be presented at a level of amplification that will measure your maximum ability to discriminate words, usually 35 to 40 dB above your SRT. However, the amplification level used in the testing must be medically appropriate, and you must be able to tolerate it. If you cannot be tested at 35 to 40 dB above your SRT, the person who performs the test should report your word recognition testing score at your highest comfortable level of amplification.

g. *Screening testing.* Physiologic testing, such as ABR and otoacoustic emissions (OAE), and pure tone testing can be used as hearing screening tests. We will not use these tests to determine that your hearing loss meets or medically equals a listing, or to assess functional limitations due to your hearing loss, when they are used only as screening tests. We can consider normal results from hearing screening tests to determine that your hearing loss is not ''severe'' when these test results are consistent with the other evidence in your case record. *See* §416.924(c).

3. *What audiometric testing do we need when you have a cochlear implant?*

a. If you have a cochlear implant, we will consider you to be disabled until age 5, or for 1 year after initial implantation, whichever is later.

b. After that period, we need word recognition testing performed with any age-appropriate version of the Hearing in Noise Test (HINT) or the Hearing in Noise Test for Children (HINT–C) to determine whether your impairment meets 102.11B. This testing must be conducted in quiet in a sound field. Your implant must be functioning properly and adjusted to your normal settings. The sentences should be presented at 60 dB HL (Hearing Level) and without any visual cues.

4. *How do we evaluate your word recognition ability if you are not fluent in English?*

If you are not fluent in English, you should have word recognition testing using an appropriate word list for the language in which you are most fluent. The person conducting the test should be fluent in the language used for the test. If there is no appropriate word list or no person who is fluent in the language and qualified to perform the test, it may not be possible to measure your word recognition ability. If your word recognition ability cannot be measured, your hearing loss cannot meet 102.10B2 or 102.11B. Instead, we will consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals 102.10B2 or 102.11B. For example, we will consider how you interact with family members, interpreters, and other persons who speak the language in which you are most fluent.

5. *What do we mean by a marked limitation in speech or language as used in 102.10B3?*

a. We will consider you to have a marked limitation in speech if:

(i) Entire phrases or sentences in your conversation are intelligible to unfamiliar listeners at least 50 percent (half) of the time but no more than 67 percent (two-thirds) of the time on your first attempt; and

(ii) Your sound production or phonological patterns (the ways in which you combine speech sounds) are atypical for your age.

b. We will consider you to have a marked limitation in language when your current and valid test score on an appropriate comprehensive, standardized test of overall language functioning is at least two standard deviations below the mean. In addition, the evidence of your daily communication functioning must be consistent with your test score. If you are not fluent in English, it may not be possible to test your language

performance. If we cannot test your language performance, your hearing loss cannot meet 102.10B3. Instead, we will consider the facts of your case to determine whether your hearing loss medically equals 102.10B3.

102.01 *Category of Impairments, Special Senses and Speech*

102.02 *Loss of central visual acuity.*

A. Remaining vision in the better eye after best correction is 20/200 or less.

OR

B. An inability to participate in visual acuity testing using Snellen methodology or other comparable testing, clinical findings that fixation and visual-following behavior are absent in the better eye, and one of the following:

1. Abnormal anatomical findings indicating a visual acuity of 20/200 or less in the better eye (such as the presence of Stage III or worse retinopathy of prematurity despite surgery, hypoplasia of the optic nerve, albinism with macular aplasia, or bilateral optic atrophy); or

2. Abnormal neuroimaging documenting damage to the cerebral cortex which would be expected to prevent the development of a visual acuity better than 20/200 in the better eye (such as neuroimaging showing bilateral encephalomyelitis or bilateral encephalomalacia); or

3. Abnormal electroretinogram documenting the presence of Leber's congenital amaurosis or achromatopsia in the better eye; or

4. An absent response to VER testing in the better eye.

102.03 *Contraction of the visual field in the better eye*, with:

A. The widest diameter subtending an angle around the point of fixation no greater than 20 degrees.

OR

B. An MD of 22 decibels or greater, determined by automated static threshold perimetry that measures the central 30 degrees of the visual field (see 102.00A6d.).

OR

C. A visual field efficiency of 20 percent or less, determined by kinetic perimetry (see 102.00A7c).

102.04 *Loss of visual efficiency, or visual impairment, in the better eye:*

A. A visual efficiency percentage of 20 or less after best correction (see 102.00A7d.).

OR

B. A visual impairment value of 1.00 or greater after best correction (see 102.00A8d).

102.10 *Hearing loss not treated with cochlear implantation.*

A. For children from birth to the attainment of age 5, an average air conduction hearing threshold of 50 decibels or greater in the better ear (see 102.00B2).

OR

B. For children from age 5 to the attainment of age 18:

1. An average air conduction hearing threshold of 70 decibels or greater in the better ear and an average bone conduction hearing threshold of 40 decibels or greater in the better ear (see 102.00B2f); or

2. A word recognition score of 40 percent or less in the better ear determined using a standardized list of phonetically balanced monosyllabic words (see 102.00B2f); or

3. An average air conduction hearing threshold of 50 decibels or greater in the better ear and a marked limitation in speech or language (see 102.00B2f and 102.00B5).

102.11 *Hearing loss treated with cochlear implantation.*

A. Consider under a disability until the attainment of age 5 or for 1 year after initial implantation, whichever is later.

OR

B. Upon the attainment of age 5 or 1 year after initial implantation, whichever is later, a word recognition score of 60 percent or less determined using the HINT or the HINT–C (*see* 102.00B3b).

103.00 Respiratory Disorders

A. *Which disorders do we evaluate in this body system?*

1. We evaluate respiratory disorders that result in obstruction (difficulty moving air out of the lungs) or restriction (difficulty moving air into the lungs), or that interfere with diffusion (gas exchange) across cell membranes in the lungs. Examples of such disorders and the listings we use to evaluate them include chronic obstructive pulmonary disease (103.02), chronic lung disease of infancy (also known as bronchopulmonary dysplasia, 103.02C or 103.02E), pulmonary fibrosis (103.02), asthma (103.02 or 103.03), and cystic fibrosis (103.04). We also use listings in this body system to evaluate respiratory failure resulting from an underlying chronic respiratory disorder (103.04E or 103.14) and lung transplantation (103.11).

2. We evaluate cancers affecting the respiratory system under the listings in 113.00. We evaluate the pulmonary effects of neuromuscular and autoimmune disorders under these listings or under the listings in 111.00 or 114.00, respectively.

B. *What are the symptoms and signs of respiratory disorders?* Symptoms and signs of respiratory disorders include dyspnea (shortness of breath), chest pain, coughing, wheezing, sputum production, hemoptysis (coughing up blood from the respiratory tract), use of accessory muscles of respiration, and tachypnea (rapid rate of breathing).

C. *What abbreviations do we use in this body system?*

1. *BiPAP* means bi-level positive airway pressure ventilation.

2. *BTPS* means body temperature and ambient pressure, saturated with water vapor.
3. *CF* means cystic fibrosis.
4. *CFRD* means CF-related diabetes.
5. *CFTR* means CF transmembrane conductance regulator.
6. *CLD* means chronic lung disease of infancy.
7. *FEV_1* means forced expiratory volume in the first second of a forced expiratory maneuver.
8. *FVC* means forced vital capacity.
9. *L* means liter.

D. *What documentation do we need to evaluate your respiratory disorder?*

1. We need *medical evidence* to document and assess the severity of your respiratory disorder. Medical evidence should include your medical history, physical examination findings, the results of imaging (see 103.00D3), spirometry (see 103.00E), other relevant laboratory tests, and descriptions of any prescribed treatment and your response to it. We may not need all of this evidence depending on your particular respiratory disorder and its effects on you.

2. If you use *supplemental oxygen*, we still need medical evidence to establish the severity of your respiratory disorder.

3. *Imaging* refers to medical imaging techniques, such as x-ray and computerized tomography. The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder.

E. *What is spirometry and what are our requirements for an acceptable test and report?*

1. Spirometry, which measures how well you move air into and out of your lungs, involves at least three forced expiratory maneuvers during the same test session. A forced expiratory maneuver is a maximum inhalation followed by a forced maximum exhalation, and measures exhaled volumes of air over time. The volume of air you exhale in the first second of the forced expiratory maneuver is the FEV_1. The total volume of air that you exhale during the entire forced expiratory maneuver is the FVC. We use your highest FEV_1 value to evaluate your respiratory disorder under 103.02A and 103.04A, and your highest FVC value to evaluate your respiratory disorder under 103.02B, regardless of whether the values are from the same forced expiratory maneuver or different forced expiratory maneuvers. We will not purchase spirometry for children who have not attained age 6.

2. We have the following requirements for spirometry under these listings:

a. You must be medically stable at the time of the test. Examples of when we would not consider you to be medically stable include when you are:

(i) Within 2 weeks of a change in your prescribed respiratory medication.

(ii) Experiencing, or within 30 days of completion of treatment for, a lower respiratory tract infection.

(iii) Experiencing, or within 30 days of completion of treatment for, an acute exacerbation (temporary worsening) of a chronic respiratory disorder. Wheezing by itself does not indicate that you are not medically stable.

b. During testing, if your FEV_1 is less than 70 percent of your predicted normal value, we require repeat spirometry after inhalation of a bronchodilator to evaluate your respiratory disorder under these listings, unless it is medically contraindicated. If you used a bronchodilator before the test and your FEV_1 is less than 70 percent of your predicted normal value, we still require repeat spirometry after inhalation of a bronchodilator unless the supervising physician determines that it is not safe for you to take a bronchodilator again (in which case we may need to reschedule the test). If you do not have post-bronchodilator spirometry, the test report must explain why. We can use the results of spirometry administered without bronchodilators when the use of bronchodilators is medically contraindicated.

c. Your forced expiratory maneuvers must be satisfactory. We consider a forced expiratory maneuver to be satisfactory when you exhale with maximum effort following a full inspiration, and when the test tracing has a sharp takeoff and rapid rise to peak flow, has a smooth contour, and either lasts for at least 6 seconds (for children age 10 and older) or for at least 3 seconds (for children who have not attained age 10), or maintains a plateau for at least 1 second.

3. The spirometry report must include the following information:

a. The date of the test and your name, age or date of birth, gender, and height without shoes. (We will assume that your recorded height on the date of the test is without shoes, unless we have evidence to the contrary.) If your spine is abnormally curved (for example, you have kyphoscoliosis), we will substitute the longest distance between your outstretched fingertips with your arms abducted 90 degrees in place of your height when this measurement is greater than your standing height without shoes.

b. Any factors, if applicable, that can affect the interpretation of the test results (for example, your cooperation or effort in doing the test).

c. Legible tracings of your forced expiratory maneuvers in a volume-time format showing your name and the date of the test for each maneuver.

4. If you have attained age 6, we may need to purchase spirometry to determine whether your disorder meets a listing, unless we can make a fully favorable determination or decision on another basis.

5. Before we purchase spirometry for a child age 6 or older, a medical consultant (see §416.1016 of this chapter), preferably one with experience in the care of children with respiratory disorders, must review your case record to determine if we need the test. If we purchase spirometry, the medical source we designate to administer the test is solely responsible for deciding whether it is safe for you to do the test and for how to administer it.

F. *What is CLD and how do we evaluate it?*

1. *CLD,* also known as bronchopulmonary dysplasia, or BPD, is scarring of the immature lung. CLD may develop as a complication of mechanical ventilation and oxygen therapy for infants with significant neonatal respiratory problems. Within the first 6 months of life, most infants with CLD are successfully weaned from mechanical ventilation, and then weaned from oxygen supplementation. We evaluate CLD under 103.02C, 103.02E, or if you are age 2 or older, under 103.03 or another appropriate listing.

2. If you have CLD, are not yet 6 months old, and need 24-hour-per-day oxygen supplementation, we will not evaluate your CLD under 103.02C until you are 6 months old. Depending on the evidence in your case record, we may make a fully favorable determination or decision under other rules before you are 6 months old.

3. We evaluate your CLD under 103.02C if you are at least 6 months old and you need 24-hour-per-day oxygen supplementation. (If you were born prematurely, we use your corrected chronological age. See §416.924b(b) of this chapter.) We also evaluate your CLD under 103.02C if you were weaned off oxygen supplementation but needed it again by the time you were 6 months old or older.

4. We evaluate your CLD under 103.02E if you are any age from birth to the attainment of age 2 and have CLD exacerbations or complications (for example, wheezing, lower respiratory tract infections, or acute respiratory distress) that require hospitalization. For the purpose of 103.02E, we count your initial birth hospitalization as one hospitalization. The phrase ''consider under a disability for 1 year from the discharge date of the last hospitalization *or* until the attainment of age 2, whichever is later'' in 103.02E does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling.

G. *What is asthma and how do we evaluate it?*

1. *Asthma* is a chronic inflammatory disorder of the lung airways that we evaluate under 103.02 or 103.03. If you have respiratory failure resulting from chronic asthma (see 103.00J), we will evaluate it under 103.14.

2. For the purposes of 103.03:

a. The phrase ''consider under a disability for 1 year'' explains how long your asthma can meet the requirements of the listing. It does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your asthma continues to meet a listing or is otherwise disabling.

b. We determine the onset of your disability based on the facts of your case, but it will be no later than the admission date of your first of three hospitalizations that satisfy the criteria of 103.03.

H. *What is CF and how do we evaluate it?*

1. *General.* We evaluate *CF,* a genetic disorder that results in abnormal salt and water transport across cell membranes in the lungs, pancreas, and other body organs, under 103.04. We need the evidence described in 103.00H2 to establish that you have CF.

2. *Documentation of CF.* We need a report signed by a physician (see §416.913(a) of this chapter) showing both a *and* b:

a. One of the following:

(i) A positive newborn screen for CF; or

(ii) A history of CF in a sibling; or

(iii) Documentation of at least one specific CF phenotype or clinical criterion (for example, chronic sino-pulmonary disease with persistent colonization or infections with typical CF pathogens, pancreatic insufficiency, or salt-loss syndromes); *and*

b. One of the following definitive laboratory tests:

(i) An elevated sweat chloride concentration equal to or greater than 60 millimoles per L; or

(ii) The identification of two CF gene mutations affecting the CFTR; or

(iii) Characteristic abnormalities in ion transport across the nasal epithelium.

c. When we have the report showing a and b, but it is not signed by a physician, we also need a report from a physician stating that you have CF.

d. When we do not have the report showing a and b, we need a report from a physician that is persuasive that a positive diagnosis of CF was confirmed by an appropriate definitive laboratory test. To be persuasive, this report must include a statement by the physician that you had the appropriate definitive laboratory test for diagnosing CF. The report must provide the test results or explain how your diagnosis was established that is consistent with the prevailing state of medical knowledge and clinical practice.

3. *CF pulmonary exacerbations.* Examples of CF pulmonary exacerbations include increased cough and sputum production, hemoptysis, increased shortness of breath, increased fatigue, and reduction in pulmonary function. Treatment usually includes intravenous antibiotics and intensified airway clearance therapy (for example, increased frequencies of chest percussion or increased use of inhaled nebulized therapies, such as bronchodilators or mucolytics).

4. For 103.04G, we require any two exacerbations or complications from the list in 103.04G1 through 103.04G4 within a 12-month period. You may have two of the same exacerbation or complication or two different ones.

a. If you have two of the acute exacerbations or complications we describe in 103.04G1 and 103.04G2, there must be at least 30 days between the two.

b. If you have one of the acute exacerbations or complications we describe in 103.04G1 and 103.04G2 and one of the chronic complications we describe in 103.04G3 and 103.04G4, the two can occur during the same time. For example, your CF meets 103.04G if you have the pulmonary hemorrhage we describe in 103.04G2 and the weight loss we describe in 103.04G3 even if the pulmonary hemorrhage occurs during the 90-day period in 103.04G3.

c. Your CF also meets 103.04G if you have both of the chronic complications in 103.04G3 and 103.04G4.

5. CF may also affect other body systems such as digestive or endocrine. If your CF, including pulmonary exacerbations and nonpulmonary complications, does not meet or medically equal a respiratory disorders listing, we may evaluate your CF-related impairments under the listings in the affected body system.

I. *How do we evaluate lung transplantation?* If you receive a lung transplant (or a lung transplant simultaneously with other organs, such as the heart), we will consider you to be disabled under 103.11 for 3 years from the date of the transplant. After that, we evaluate your residual impairment(s) by considering the adequacy of your post-transplant function, the frequency and severity of any rejection episodes you have, complications in other body systems, and adverse treatment effects. Children who receive organ transplants generally have impairments that meet our definition of disability before they undergo transplantation. The phrase ''consider under a disability for 3 years'' in 103.11 does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling. We determine the onset of your disability based on the facts of your case.

J. *What is respiratory failure and how do we evaluate it?* Respiratory failure is the inability of the lungs to perform their basic function of gas exchange. We evaluate respiratory failure under 103.04E if you have CF-related respiratory failure, or under 103.14 if you have respiratory failure due to any other *chronic* respiratory disorder. Continuous positive airway pressure does not satisfy the criterion in 103.04E or 103.14, and cannot be substituted as an equivalent finding, for invasive mechanical ventilation or noninvasive ventilation with BiPAP.

K. *How do we evaluate growth failure due to any chronic respiratory disorder?*

1. To evaluate growth failure due to any chronic respiratory disorder, we require documentation of the oxygen supplementation described in 103.06A and the growth measurements in 103.06B within the same consecutive 12-month period. The dates of oxygen supplementation may be different from the dates of growth measurements.

2. Under 103.06B, we use the appropriate table(s) under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile.

a. For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

b. For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

c. BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in the digestive disorders body system (105.00).

L. *How do we evaluate respiratory disorders that do not meet one of these listings?*

1. These listings are only examples of common respiratory disorders that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system. For example, if your CF has resulted in chronic pancreatic or hepatobiliary disease, we evaluate your impairment under the listings in 105.00.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §416.926 of this chapter. Respiratory disorders may be associated with disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not meet or medically equal a listing, we will also consider whether it functionally equals the listings. See §416.926a of this chapter. We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

103.01 Category of Impairments, Respiratory Disorders

103.02 *Chronic respiratory disorders* due to any cause except CF (for CF, see 103.04), with A, B, C, D, or E:

A. FEV_1 (see 103.00E) less than or equal to the value in Table I–A or I–B for your age,

gender, and height without shoes (see 103.00E3a).

TABLE I—FEV_1 CRITERIA FOR 103.02A

Table I–A			*Table I–B*			
Age 6 to attainment of age 13 (for both females and males)			Age 13 to attainment of age 18			
Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	FEV_1 less than or equal to (L, BTPS)	Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)
<123.0	<48.50	0.80	<153.0	<60.25	1.35	1.40
123.0 to <129.0	48.50 to <50.75	0.90	153.0 to <159.0	60.25 to <62.50	1.45	1.50
129.0 to <134.0	50.75 to <52.75	1.00	159.0 to <164.0	62.50 to <64.50	1.55	1.60
134.0 to <139.0	52.75 to <54.75	1.10	164.0 to <169.0	64.50 to <66.50	1.65	1.70
139.0 to <144.0	54.75 to <56.75	1.20	169.0 to <174.0	66.50 to <68.50	1.75	1.85
144.0 to <149.0	56.75 to <58.75	1.30	174.0 to <180.0	68.50 to <70.75	1.85	2.00
149.0 or more	58.75 or more	1.40	180.0 or more	70.75 or more	1.95	2.10

OR

B. FVC (see 103.00E) less than or equal to the value in Table II–A or II–B for your age, gender, and height without shoes (see 103.00E3a).

TABLE II—FVC CRITERIA FOR 103.02B

Table II–A			*Table II–B*			
Age 6 to attainment of age 13 (for both females and males)			Age 13 to attainment of age 18			
Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	FVC less than or equal to (L, BTPS)	Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	Females FVC less than or equal to (L, BTPS)	Males FVC less than or equal to (L, BTPS)
<123.0	<48.50	0.85	<153.0	<60.25	1.65	1.65
123.0 to <129.0	48.50 to <50.75	1.00	153.0 to <159.0	60.25 to <62.50	1.70	1.80
129.0 to <134.0	50.75 to <52.75	1.10	159.0 to <164.0	62.50 to <64.50	1.80	1.95
134.0 to <139.0	52.75 to <54.75	1.30	164.0 to <169.0	64.50 to <66.50	1.95	2.10
139.0 to <144.0	54.75 to <56.75	1.40	169.0 to <174.0	66.50 to <68.50	2.05	2.25
144.0 to <149.0	56.75 to <58.75	1.55	174.0 to <180.0	68.50 to <70.75	2.20	2.45
149.0 or more	58.75 or more	1.70	180.0 or more	70.75 or more	2.30	2.55

OR

C. Hypoxemia with the need for at least 1.0 L per minute of continuous (24 hours per day) oxygen supplementation for at least 90 consecutive days.

OR

D. The presence of a tracheostomy.

1. Consider under a disability until the attainment of age 3; or

2. Upon the attainment of age 3, documented need for mechanical ventilation via a tracheostomy for at least 4 hours per day and for at least 90 consecutive days.

OR

E. For children who have not attained age 2, CLD (see 103.00F) with exacerbations or complications requiring three hospitalizations within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization. (A child's initial birth hospitalization when CLD is first diagnosed counts as one hospitalization.) Consider under a disability for 1 year from the discharge date of the last hospitalization *or* until the attainment of age 2, whichever is later. After that, evaluate the impairment(s) under 103.03 or another appropriate listing.

103.03 *Asthma* (see 103.00G) with exacerbations or complications requiring three hospitalizations within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or

continuing disability review). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization. Consider under a disability for 1 year from the discharge date of the last hospitalization; after that, evaluate the residual impairment(s) under 103.03 or another appropriate listing.

103.04 *Cystic fibrosis* (documented as described in 103.00H), with A, B, C, D, E, F, or G:

A. FEV_1 (see 103.00E) less than or equal to the value in Table III–A or Table III–B for your age, gender, and height without shoes (see 103.00E3a).

TABLE III—FEV_1 CRITERIA FOR 103.04A

Table III–A			*Table III–B*			
Age 6 to attainment of age 13 (for both females and males)			Age 13 to attainment of age 18			
Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	FEV_1 less than or equal to (L, BTPS)	Height without shoes (centimeters) < means *less than*	Height without shoes (inches) < means *less than*	Females FEV_1 less than or equal to (L, BTPS)	Males FEV_1 less than or equal to (L, BTPS)
<123.0	<48.50	1.00	<153.0	<60.25	1.75	1.85
123.0 to <129.0	48.50 to <50.75	1.15	153.0 to <159.0	60.25 to <62.50	1.85	2.05
129.0 to <134.0	50.75 to <52.75	1.25	159.0 to <164.0	62.50 to <64.50	1.95	2.15
134.0 to <139.0	52.75 to <54.75	1.40	164.0 to <169.0	64.50 to <66.50	2.10	2.30
139.0 to <144.0	54.75 to <56.75	1.50	169.0 to <174.0	66.50 to <68.50	2.25	2.45
144.0 to <149.0	56.75 to <58.75	1.70	174.0 to <180.0	68.50 to <70.75	2.35	2.60
149.0 or more	58.75 or more	1.80	180.0 or more	70.75 or more	2.50	2.70

OR

B. For children who have not attained age 6, findings on imaging (see 103.00D3) of thickening of the proximal bronchial airways, nodular-cystic lesions, segmental or lobular atelectasis, or consolidation, *and* documentation of one of the following:

1. Shortness of breath with activity; or

2. Accumulation of secretions as manifested by repetitive coughing; or

3. Bilateral rales or rhonchi, or reduction of breath sounds.

OR

C. Exacerbations or complications (see 103.00H3) requiring three hospitalizations of any length within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review).

OR

D. Spontaneous pneumothorax, secondary to CF, requiring chest tube placement.

OR

E. Respiratory failure (see 103.00J) requiring invasive mechanical ventilation, noninvasive ventilation with BiPAP, or a combination of both treatments, for a continuous period of at least 48 hours, or for a continuous period of at least 72 hours if postoperatively.

OR

F. Pulmonary hemorrhage requiring vascular embolization to control bleeding.

OR

G. Two of the following exacerbations or complications (either two of the same or two different, see 103.00H3 and 103.00H4) within a 12-month period (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review):

1. Pulmonary exacerbation requiring 10 consecutive days of intravenous antibiotic treatment.

2. Pulmonary hemorrhage (hemoptysis with more than blood-streaked sputum but not requiring vascular embolization) requiring hospitalization of any length.

3. Weight loss requiring daily supplemental enteral nutrition via a gastrostomy for at least 90 consecutive days *or* parenteral nutrition via a central venous catheter for at least 90 consecutive days.

4. CFRD requiring daily insulin therapy for at least 90 consecutive days.

103.05 [Reserved]

103.06 *Growth failure due to any chronic respiratory disorder* (see 103.00K), documented by:

A. Hypoxemia with the need for at least 1.0 L per min of oxygen supplementation for at least 4 hours per day and for at least 90 consecutive days.

AND

B. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

2. *For children age 2 to attainment of age 18,* three BMI-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

103.07 [Reserved]

103.08 [Reserved]

103.09 [Reserved]

103.10 [Reserved]

103.11 *Lung transplantation* (see 103.00I). Consider under a disability for 3 years from the date of the transplant; after that, evaluate the residual impairment(s).

103.12 [Reserved]

103.13 [Reserved]

103.14 *Respiratory failure* (see 103.00J) resulting from any underlying chronic respiratory disorder except CF (for CF, see 103.04E), requiring invasive mechanical ventilation, noninvasive ventilation with BiPAP, or a combination of both treatments, for a continuous period of at least 48 hours, or for a continuous period of at least 72 hours if postoperatively, *twice* within a 12-month period and at least 30 days apart (the 12-month period must occur within the period we are considering in connection with your application or continuing disability review).

104.00 Cardiovascular System

A. General

1. *What do we mean by a cardiovascular impairment?*

a. We mean any disorder that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage). The disorder can be congenital or acquired.

b. Cardiovascular impairment results from one or more of four consequences of heart disease:

(i) Chronic heart failure or ventricular dysfunction.

(ii) Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.

(iii) Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause, such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.

(iv) Central cyanosis due to right-to-left shunt, reduced oxygen concentration in the arterial blood, or pulmonary vascular disease.

c. Disorders of the veins or arteries (for example, obstruction, rupture, or aneurysm) may cause impairments of the lower extremities (peripheral vascular disease), the central nervous system, the eyes, the kidneys, and other organs. We will evaluate peripheral vascular disease under 4.11 or 4.12 in part A, and impairments of another body system(s) under the listings for that body system(s).

2. *What do we consider in evaluating cardiovascular impairments?* The listings in this section describe cardiovascular impairments based on symptoms, signs, laboratory findings, response to a regimen of prescribed treatment, and functional limitations.

3. *What do the following terms or phrases mean in these listings?*

a. *Medical consultant* is an individual defined in §§404.1616(a) and 416.1016(a). This term does not include medical sources who provide consultative examinations for us. We use the abbreviation ''MC'' throughout this section to designate a medical consultant.

b. *Persistent* means that the longitudinal clinical record shows that, with few exceptions, the required finding(s) has been present, or is expected to be present, for a continuous period of at least 12 months, such that a pattern of continuing severity is established.

c. *Recurrent* means that the longitudinal clinical record shows that, within a consecutive 12-month period, the finding(s) occurs at least three times, with intervening periods of improvement of sufficient duration that it is clear that separate events are involved.

d. *Appropriate medically acceptable imaging* means that the technique used is the proper one to evaluate and diagnose the impairment and is commonly recognized as accurate for assessing the cited finding.

e. *A consecutive 12-month period* means a period of 12 consecutive months, all or part of which must occur within the period we are considering in connection with an application or continuing disability review.

f. *Currently present* means that the finding is present at the time of adjudication.

g. *Uncontrolled* means the impairment does not respond adequately to standard prescribed medical treatment.

B. Documenting Cardiovascular Impairment

1. *What basic documentation do we need?* We need sufficiently detailed reports of history, physical examinations, laboratory studies, and any prescribed treatment and response to allow us to assess the severity and duration of your cardiovascular impairment. A longitudinal clinical record covering a period of not less than 3 months of observations and treatment is usually necessary, unless we can make a determination or decision based on the current evidence.

2. *Why is a longitudinal clinical record important?* We will usually need a longitudinal clinical record to assess the severity and expected duration of your impairment(s). If you have a listing-level impairment, you probably will have received medically prescribed treatment. Whenever there is evidence of such treatment, your longitudinal clinical record should include a description of the ongoing management and evaluation provided by your treating or other medical source. It should also include your response to this medical management, as well as information about the nature and severity of your impairment. The record will provide us with information on your functional status over an extended period of time and show whether your ability to function is improving, worsening, or unchanging.

3. *What if you have not received ongoing medical treatment?*

a. You may not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). In this situation, we will base our evaluation on the current objective medical evidence and the other evidence we have. If you do not receive treatment, you cannot show an impairment that meets the criteria of these listings. However, we may find you disabled because you have another impairment(s) that in combination with your cardiovascular impairment medically equals the severity of a listed impairment or that functionally equals the listings.

b. Unless we can decide your claim favorably on the basis of the current evidence, a longitudinal record is still important. In rare instances where there is no or insufficient longitudinal evidence, we may purchase a consultative examination(s) to help us establish the severity and duration of your impairment.

4. *When will we wait before we ask for more evidence?*

a. We will wait when we have information showing that your impairment is not yet stable and the expected change in your impairment might affect our determination or decision. In these situations, we need to wait to properly evaluate the severity and duration of your impairment during a stable period. Examples of when we might wait are:

(i) If you have had a recent acute event; for example, acute rheumatic fever.

(ii) If you have recently had a corrective cardiac procedure; for example, open-heart surgery.

(iii) If you have started new drug therapy and your response to this treatment has not yet been established; for example, beta-blocker therapy for dilated congestive cardiomyopathy.

b. In these situations, we will obtain more evidence 3 months following the event before we evaluate your impairment. However, we will not wait if we have enough information

to make a determination or decision based on all of the relevant evidence in your case.

5. *Will we purchase any studies?* In appropriate situations, we will purchase studies necessary to substantiate the diagnosis or to document the severity of your impairment, generally after we have evaluated the medical and other evidence we already have. We will not purchase studies involving exercise testing if there is significant risk involved or if there is another medical reason not to perform the test. We will follow sections 4.00C6, 4.00C7, 4.00C8, and 104.00B7 when we decide whether to purchase exercise testing. We will make a reasonable effort to obtain any additional studies from a qualified medical source in an office or center experienced in pediatric cardiac assessment. (See §416.919g.)

6. *What studies will we not purchase?* We will not purchase any studies involving cardiac catheterization, such as coronary angiography, arteriograms, or electrophysiological studies. However, if the results of catheterization are part of the existing evidence we have, we will consider them together with the other relevant evidence. See 4.00C15a in part A.

7. *Will we use exercise tolerance tests (ETTs) for evaluating children with cardiovascular impairment?*

a. ETTs, though increasingly used, are still less frequently indicated in children than in adults, and can rarely be performed successfully by children under 6 years of age. An ETT may be of value in the assessment of some arrhythmias, in the assessment of the severity of chronic heart failure, and in the assessment of recovery of function following cardiac surgery or other treatment.

b. We will purchase an ETT in a childhood claim only if we cannot make a determination or decision based on the evidence we have and an MC, preferably one with experience in the care of children with cardiovascular impairments, has determined that an ETT is needed to evaluate your impairment. We will not purchase an ETT if you are less than 6 years of age. If we do purchase an ETT for a child age 12 or younger, it must be performed by a qualified medical source in a specialty center for pediatric cardiology or other facility qualified to perform exercise tests of children.

c. For full details on ETT requirements and usage, see 4.00C in part A.

C. Evaluating Chronic Heart Failure

1. *What is chronic heart failure (CHF)?*

a. *CHF* is the inability of the heart to pump enough oxygenated blood to body tissues. This syndrome is characterized by symptoms and signs of pulmonary or systemic congestion (fluid retention) or limited cardiac output. Certain laboratory findings of cardiac functional and structural abnormality support the diagnosis of CHF.

b. CHF is considered in these listings as a single category whether due to atherosclerosis (narrowing of the arteries), cardiomyopathy, hypertension, or rheumatic, congenital, or other heart disease. However, if the CHF is the result of primary pulmonary hypertension secondary to disease of the lung (cor pulmonale), we will evaluate your impairment using 3.09 in the respiratory system listings in part A.

2. *What evidence of CHF do we need?*

a. Cardiomegaly or ventricular dysfunction must be present and demonstrated by appropriate medically acceptable imaging, such as chest x-ray, echocardiography (M-Mode, 2-dimensional, and Doppler), radionuclide studies, or cardiac catheterization.

(i) Cardiomegaly is present when:

(*A*) Left ventricular diastolic dimension or systolic dimension is greater than 2 standard deviations above the mean for the child's body surface area;

(*B*) Left ventricular mass is greater than 2 standard deviations above the mean for the child's body surface area; or

(*C*) Chest x-ray (6 foot PA film) is indicative of cardiomegaly if the cardiothoracic ratio is over 60 percent at 1 year of age or less, or 55 percent or greater at more than 1 year of age.

(ii) Ventricular dysfunction is present when indices of left ventricular function, such as fractional shortening or ejection fraction (the percentage of the blood in the ventricle actually pumped out with each contraction), are greater than 2 standard deviations below the mean for the child's age. (Fractional shortening, also called shortening fraction, reflects the left ventricular systolic function in the absence of segmental wall motion abnormalities and has a linear correlation with ejection fraction. In children, fractional shortening is more commonly used than ejection fraction.)

(iii) However, these measurements alone do not reflect your functional capacity, which we evaluate by considering all of the relevant evidence.

(iv) Other findings on appropriate medically acceptable imaging may include increased pulmonary vascular markings, pleural effusion, and pulmonary edema. These findings need not be present on each report, since CHF may be controlled by prescribed treatment.

b. To establish that you have *chronic* heart failure, we require that your medical history and physical examination describe characteristic symptoms and signs of pulmonary or systemic congestion or of limited cardiac output associated with abnormal findings on appropriate medically acceptable imaging. When a remediable factor, such as arrhythmia, triggers an acute episode of heart failure, you may experience restored cardiac function, and a chronic impairment may not be present.

(i) Symptoms of congestion or of limited cardiac output include easy fatigue, weakness, shortness of breath (dyspnea), cough, or chest discomfort at rest or with activity. Children with CHF may also experience shortness of breath on lying flat (orthopnea) or episodes of shortness of breath that wake them from sleep (paroxysmal nocturnal dyspnea). They may also experience cardiac arrhythmias resulting in palpitations, lightheadedness, or fainting. Fatigue or exercise intolerance in an infant may be manifested by prolonged feeding time, often associated with excessive respiratory effort and sweating.

(ii) During infancy, other manifestations of chronic heart failure may include repeated lower respiratory tract infections.

(iii) Signs of congestion may include hepatomegaly, ascites, increased jugular venous distention or pressure, rales, peripheral edema, rapid shallow breathing (tachypnea), or rapid weight gain. However, these signs need not be found on all examinations because fluid retention may be controlled by prescribed treatment.

3. *How do we evaluate growth failure due to CHF?*

a. To evaluate growth failure due to CHF, we require documentation of the clinical findings of CHF described in 104.00C2 and the growth measurements in 104.02C within the same consecutive 12-month period. The dates of clinical findings may be different from the dates of growth measurements.

b. Under 104.02C, we use the appropriate table(s) under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile.

(i) For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

(ii) For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

(iii) BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in the digestive disorders body system (105.00).

D. Evaluating Congenital Heart Disease

1. *What is congenital heart disease?* Congenital heart disease is any abnormality of the heart or the major blood vessels that is present at birth. Examples include:

a. *Abnormalities of cardiac septation,* including ventricular septal defect or atrioventricular canal;

b. *Abnormalities resulting in cyanotic heart disease,* including tetralogy of Fallot or transposition of the great arteries;

c. *Valvular defects or obstructions to ventricular outflow,* including pulmonary or aortic stenosis or coarctation of the aorta; and

d. *Major abnormalities of ventricular development,* including hypoplastic left heart syndrome or pulmonary tricuspid atresia with hypoplastic right ventricle.

2. *How will we evaluate symptomatic congenital heart disease?*

a. Because of improved treatment methods, more children with congenital heart disease are living longer. Although some types of congenital heart disease may be corrected by surgery, many children with treated congenital heart disease continue to have problems throughout their lives (symptomatic congenital heart disease). If you have congenital heart disease that results in chronic heart failure with evidence of ventricular dysfunction or in recurrent arrhythmias, we will evaluate your impairment under 104.02 or 104.05. Otherwise, we will evaluate your impairment under 104.06.

b. For 104.06A2, we will accept pulse oximetry measurements instead of arterial O_2, but the arterial O_2 values are preferred, if available.

c. For 104.06D, examples of impairments that in most instances will require life-saving surgery or a combination of surgery and other major interventional procedures (for example, multiple ''balloon'' catheter procedures) before age 1 include, but are not limited to, the following:

(i) Hypoplastic left heart syndrome,

(ii) Critical aortic stenosis with neonatal heart failure,

(iii) Critical coarctation of the aorta, with or without associated anomalies,

(iv) Complete atrioventricular canal defects,

(v) Transposition of the great arteries,

(vi) Tetralogy of Fallot,

(vii) Pulmonary atresia with intact ventricular septum,

(viii) Single ventricle,

(ix) Tricuspid atresia, and

(x) Multiple ventricular septal defects.

E. Evaluating Arrhythmias

1. *What is an arrhythmia?* An *arrhythmia* is a change in the regular beat of the heart. Your heart may seem to skip a beat or beat irregularly, very quickly (tachycardia), or very slowly (bradycardia).

2. *What are the different types of arrhythmias?*

a. There are many types of arrhythmias. Arrhythmias are identified by where they occur in the heart (atria or ventricles) and by what happens to the heart's rhythm when they occur.

b. Arrhythmias arising in the cardiac atria (upper chambers of the heart) are called atrial or supraventricular arrhythmias. Ventricular arrhythmias begin in the ventricles (lower chambers). In general, ventricular arrhythmias caused by heart disease are the most serious.

3. *How do we evaluate arrhythmias using 104.05?*

a. We will use 104.05 when you have arrhythmias that are not fully controlled by medication, an implanted pacemaker, or an implanted cardiac defibrillator and you have uncontrolled recurrent episodes of syncope or near syncope. If your arrhythmias are controlled, we will evaluate your underlying heart disease using the appropriate listing. For other considerations when we evaluate arrhythmias in the presence of an implanted cardiac defibrillator, see 104.00E4.

b. We consider *near syncope* to be a period of altered consciousness, since syncope is a loss of consciousness or a faint. It is not merely a feeling of light-headedness, momentary weakness, or dizziness.

c. For purposes of 104.05, there must be a documented association between the syncope or near syncope and the recurrent arrhythmia. The recurrent arrhythmia, not some other cardiac or non-cardiac disorder, must be established as the cause of the associated symptom. This documentation of the association between the symptoms and the arrhythmia may come from the usual diagnostic methods, including Holter monitoring (also called ambulatory electrocardiography) and tilt-table testing with a concurrent ECG. Although an arrhythmia may be a coincidental finding on an ETT, we will not purchase an ETT to document the presence of a cardiac arrhythmia.

4. *What will we consider when you have an implanted cardiac defibrillator and you do not have arrhythmias that meet the requirements of 104.05?*

a. Implanted cardiac defibrillators are used to prevent sudden cardiac death in children who have had, or are at high risk for, cardiac arrest from life-threatening ventricular arrhythmias. The largest group of children at risk for sudden cardiac death consists of children with cardiomyopathy (ischemic or non-ischemic) and reduced ventricular function. However, life-threatening ventricular arrhythmias can also occur in children with little or no ventricular dysfunction. The shock from the implanted cardiac defibrillator is a unique form of treatment; it rescues a child from what may have been cardiac arrest. However, as a consequence of the shock(s), children may experience psychological distress, which we may evaluate under the mental disorders listings in 112.00ff.

b. Most implantable cardiac defibrillators have rhythm-correcting and pacemaker capabilities. In some children, these functions may result in the termination of ventricular arrhythmias without an otherwise painful shock. (The shock is like being kicked in the chest.) Implanted cardiac defibrillators may deliver inappropriate shocks, often repeatedly, in response to benign arrhythmias or electrical malfunction. Also, exposure to strong electrical or magnetic fields, such as from MRI (magnetic resonance imaging), can trigger or reprogram an implanted cardiac defibrillator, resulting in inappropriate shocks. We must consider the frequency of, and the reason(s) for, the shocks when evaluating the severity and duration of your impairment.

c. In general, the exercise limitations imposed on children with an implanted cardiac defibrillator are those dictated by the underlying heart impairment. However, the exercise limitations may be greater when the implanted cardiac defibrillator delivers an inappropriate shock in response to the increase in heart rate with exercise, or when there is exercise-induced ventricular arrhythmia.

F. Evaluating Other Cardiovascular Impairments

1. *What is ischemic heart disease (IHD) and how will we evaluate it in children? IHD* results when one or more of your coronary arteries is narrowed or obstructed or, in rare situations, constricted due to vasospasm, interfering with the normal flow of blood to your heart muscle (ischemia). The obstruction may be the result of an embolus, a thrombus, or plaque. When heart muscle tissue dies as a result of the reduced blood supply, it is called a myocardial infarction (heart attack). Ischemia is rare in children, but when it occurs, its effects on children are the same as on adults. If you have IHD, we will evaluate it under 4.00E and 4.04 in part A.

2. *How will we evaluate hypertension?* Because *hypertension* (high blood pressure) generally causes disability through its effects on other body systems, we will evaluate it by reference to the specific body system(s) affected (heart, brain, kidneys, or eyes) when we consider its effects under the listings. We will also consider any limitations imposed by your hypertension when we consider whether you have an impairment that functionally equals the listings.

3. *What is cardiomyopathy and how will we evaluate it? Cardiomyopathy* is a disease of the heart muscle. The heart loses its ability to pump blood (heart failure), and in some instances, heart rhythm is disturbed, leading to irregular heartbeats (arrhythmias). Usually, the exact cause of the muscle damage is never found (idiopathic cardiomyopathy). There are various types of cardiomyopathy, which fall into two major categories: *Ischemic* and *nonischemic* cardiomyopathy. Ischemic cardiomyopathy typically refers to heart muscle damage that results from coronary artery disease, including heart attacks. Nonischemic cardiomyopathy includes several types: Dilated, hypertrophic, and restrictive. We will evaluate cardiomyopathy under 4.04 in part A, 104.02, 104.05, or 111.06, depending on its effects on you.

4. *How will we evaluate valvular heart disease?* We will evaluate valvular heart disease under the listing appropriate for its effect on you. Thus, we may use 4.04 in part A, 104.02, 104.05, 104.06, or an appropriate neurological listing in 111.00ff.

5. *What do we consider when we evaluate heart transplant recipients?*

a. After your heart transplant, we will consider you disabled for 1 year following the surgery because there is a greater likelihood of rejection of the organ and infection during the first year.

b. However, heart transplant patients generally meet our definition of disability before they undergo transplantation. We will determine the onset of your disability based on the facts in your case.

c. We will not assume that you became disabled when your name was placed on a transplant waiting list. This is because you may be placed on a waiting list soon after diagnosis of the cardiac disorder that may eventually require a transplant. Physicians recognize that candidates for transplantation often have to wait months or even years before a suitable donor heart is found, so they place their patients on the list as soon as permitted.

d. When we do a continuing disability review to determine whether you are still disabled, we will evaluate your residual impairment(s), as shown by symptoms, signs, and laboratory findings, including any side effects of medication. We will consider any remaining symptoms, signs, and laboratory findings indicative of cardiac dysfunction in deciding whether medical improvement (as defined in §416.994a) has occurred.

6. *How will we evaluate chronic rheumatic fever or rheumatic heart disease?* The diagnosis should be made in accordance with the current revised Jones criteria for guidance in the diagnosis of rheumatic fever. We will evaluate persistence of rheumatic fever activity under 104.13. If you have evidence of chronic heart failure or recurrent arrhythmias associated with rheumatic heart disease, we will use 104.02 or 104.05.

7. *What is hyperlipidemia and how will we evaluate it? Hyperlipidemia* is the general term for an elevation of any or all of the lipids (fats or cholesterol) in the blood; for example, hypertriglyceridemia, hypercholesterolemia, and hyperlipoproteinemia. These disorders of lipoprotein metabolism and transport can cause defects throughout the body. The effects most likely to interfere with function are those produced by atherosclerosis (narrowing of the arteries) and coronary artery disease. We will evaluate your lipoprotein disorder by considering its effects on you.

8. *How will we evaluate Kawasaki disease?* We will evaluate Kawasaki disease under the listing appropriate to its effects on you, which may include major coronary artery aneurysm or heart failure. A major coronary artery aneurysm may cause ischemia or arrhythmia, which we will evaluate under 4.04 in part A or 104.05. We will evaluate chronic heart failure under 104.02.

9. *What is lymphedema and how will we evaluate it?*

a. *Lymphedema* is edema of the extremities due to a disorder of the lymphatic circulation; at its worst, it is called elephantiasis. Primary lymphedema is caused by abnormal development of lymph vessels and may be present at birth (congenital lymphedema), but more often develops during the teens (lymphedema praecox). Secondary lymphedema is due to obstruction or destruction of normal lymphatic channels due to tumor, surgery, repeated infections, or parasitic infection such as filariasis. Lymphedema most commonly affects one extremity.

b. Lymphedema does not meet the requirements of 4.11 in part A, although it may medically equal the severity of that listing. We will evaluate lymphedema by considering whether the underlying cause meets or medically equals any listing or whether the lymphedema medically equals a cardiovascular listing, such as 4.11, or a musculoskeletal disorders listing, such as 101.18. If no listing is met or medically equaled, we will evaluate any functional limitations imposed by your lymphedema when we consider whether you have an impairment that functionally equals the listings.

10. *What is Marfan syndrome and how will we evaluate it?*

a. Marfan syndrome is a genetic connective tissue disorder that affects multiple body systems, including the skeleton, eyes, heart, blood vessels, nervous system, skin, and lungs. There is no specific laboratory test to diagnose Marfan syndrome. The diagnosis is generally made by medical history, including family history, physical examination, including an evaluation of the ratio of arm/leg size to trunk size, a slit lamp eye examination, and a heart test(s), such as an echocardiogram. In some cases, a genetic analysis may be useful, but such analyses may not provide any additional helpful information.

b. The effects of Marfan syndrome can range from mild to severe. In most cases, the disorder progresses as you age. Most individuals with Marfan syndrome have abnormalities associated with the heart and blood vessels. Your heart's mitral valve may leak, causing a heart murmur. Small leaks may not cause symptoms, but larger ones may cause shortness of breath, fatigue, and palpitations. Another effect is that the wall of the aorta may be weakened and stretch (aortic dilation). This aortic dilation may tear, dissect, or rupture, causing serious heart problems or sometimes sudden death. We will evaluate the manifestations of your

Marfan syndrome under the appropriate body system criteria, such as 4.10 in part A, or if necessary consider the functional limitations imposed by your impairment.

G. Other Evaluation Issues

1. *What effect does obesity have on the cardiovascular system and how will we evaluate it?* Obesity is a medically determinable impairment that is often associated with disorders of the cardiovascular system. Disturbance of this system can be a major cause of disability in children with obesity. Obesity may affect the cardiovascular system because of the increased workload the additional body mass places on the heart. Obesity may make it harder for the chest and lungs to expand. This can mean that the respiratory system must work harder to provide needed oxygen. This in turn would make the heart work harder to pump blood to carry oxygen to the body. Because the body would be working harder at rest, its ability to perform additional work would be less than would otherwise be expected. Thus, the combined effects of obesity with cardiovascular impairments can be greater than the effects of each of the impairments considered separately. We must consider any additional and cumulative effects of obesity when we determine whether you have a severe cardiovascular impairment or a listing-level cardiovascular impairment (or a combination of impairments that medically equals a listing), and when we determine whether your impairment(s) functionally equals the listings.

2. *How do we relate treatment to functional status?* In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The amount of function restored and the time required for improvement after treatment (medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, we may need to defer evaluation of the impairment for a period of up to 3 months from the date treatment began to permit consideration of treatment effects, unless we can make a determination or decision using the evidence we have. See 104.00B4.

3. *How do we evaluate impairments that do not meet one of the cardiovascular listings?*

a. These listings are only examples of common cardiovascular disorders that we consider severe enough to result in marked and severe functional limitations. If your severe impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

b. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §416.926.) If you have a severe impairment(s) that does not meet or medically equal the criteria of a listing, we will consider whether it functionally equals the listings. (See §416.926a.) When we decide whether you continue to be disabled, we use the rules in §416.994a.

104.01 CATEGORY OF IMPAIRMENTS, CARDIOVASCULAR SYSTEM

104.02. *Chronic heart failure* while on a regimen of prescribed treatment, with symptoms and signs described in 104.00C2, and with one of the following:

A. Persistent tachycardia at rest (see Table I);

OR

B. Persistent tachypnea at rest (see Table II) or markedly decreased exercise tolerance (see 104.00C2b);

OR

C. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2*, three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

2. *For children age 2 to attainment of age 18*, three BMI-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

104.05 *Recurrent arrhythmias*, not related to reversible causes such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled (see 104.00A3g), recurrent (see 104.00A3c) episodes of cardiac syncope or near syncope (see 104.00E3b), despite prescribed treatment (see 104.00B3 if there is no prescribed treatment), and documented by resting or ambulatory (Holter) electrocardiography, or by other appropriate medically acceptable testing, coincident with the occurrence of syncope or near syncope (see 104.00E3c).

104.06 *Congenital heart disease*, documented by appropriate medically acceptable imaging (see 104.00A3d) or cardiac catheterization, with one of the following:

A. Cyanotic heart disease, with persistent, chronic hypoxemia as manifested by:

1. Hematocrit of 55 percent or greater on two evaluations 3 months or more apart within a consecutive 12-month period (see 104.00A3e); or

2. Arterial O_2 saturation of less than 90 percent in room air, or resting arterial PO_2 of 60 Torr or less; or

3. Hypercyanotic spells, syncope, characteristic squatting, or other incapacitating symptoms directly related to documented cyanotic heart disease; or

4. Exercise intolerance with increased hypoxemia on exertion.

OR

B. Secondary pulmonary vascular obstructive disease with pulmonary arterial systolic pressure elevated to at least 70 percent of the systemic arterial systolic pressure.

OR

C. Symptomatic acyanotic heart disease, with ventricular dysfunction interfering very seriously with the ability to independently initiate, sustain, or complete activities.

OR

D. For infants under 12 months of age at the time of filing, with life-threatening congenital heart impairment that will require or already has required surgical treatment in the first year of life, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until the attainment of at least 1 year of age, consider the infant to be under disability until the attainment of at least age 1; thereafter, evaluate impairment severity with reference to the appropriate listing.

104.09 *Heart transplant*. Consider under a disability for 1 year following surgery; thereafter, evaluate residual impairment under the appropriate listing.

104.13 *Rheumatic heart disease*, with persistence of rheumatic fever activity manifested by significant murmurs(s), cardiac enlargement or ventricular dysfunction (see 104.00C2a), and other associated abnormal laboratory findings; for example, an elevated sedimentation rate or ECG findings, for 6 months or more in a consecutive 12-month period (see 104.00A3e). Consider under a disability for 18 months from the established onset of impairment, then evaluate any residual impairment(s).

105.00 Digestive Disorders

A. *Which digestive disorders do we evaluate in this body system?* We evaluate digestive disorders that result in severe dysfunction of the liver, pancreas, and gastrointestinal tract (the large, muscular tube that extends from the mouth to the anus, where the movement of muscles, along with the release of hormones and enzymes, allows for the digestion of food) in this body system. Examples of these disorders and the listings we use to evaluate them include chronic liver disease (105.05), inflammatory bowel disease (105.06), and intestinal failure (105.07). We also use this body system to evaluate gastrointestinal hemorrhaging from any cause (105.02), growth failure due to any digestive disorder (105.08), liver transplantation (105.09), need for supplemental daily enteral feeding via a gastrostomy, duodenostomy, or jejunostomy due to any cause for children who have not attained age 3 (105.10), small intestine transplantation (105.11), and pancreas transplantation (105.12). We evaluate cancers affecting the digestive system under the listings in 113.00.

B. *What evidence do we need to evaluate your digestive disorder?*

1. *General.* To establish that you have a digestive disorder, we need medical evidence about the existence of your digestive disorder and its severity. Medical evidence should include your medical history, physical examination findings, operative reports, and relevant laboratory findings.

2. *Laboratory findings.* We need laboratory reports such as results of imaging (see 105.00B3), endoscopy, and other diagnostic procedures. We may also need clinical laboratory and pathology results.

3. *Imaging* refers to medical imaging techniques, such as x-ray, ultrasound, magnetic resonance imaging, and computerized tomography. The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as a proper technique to support the evaluation of the disorder.

C. *What is chronic liver disease (CLD), and how do we evaluate it under 105.05?*

1. *General.* CLD is loss of liver function with cell necrosis (cell death), inflammation, or scarring of the liver that persists for more than 6 months. Common causes of CLD in children include chronic infection with hepatitis B virus or hepatitis C virus, autoimmune hepatitis, and metabolic disease.

a. We will evaluate your signs of CLD, such as jaundice, changes in size of the liver and spleen, ascites, peripheral edema, and altered mental status. We will also evaluate your symptoms of CLD, such as pruritus (itching), fatigue, nausea, loss of appetite, and sleep disturbances when we assess the severity of your impairment(s) and how it affects your ability to function. In the absence of evidence of a chronic liver impairment, episodes of acute liver disease do not meet the requirements of 105.05.

b. *Laboratory findings* of your CLD may include decreased serum albumin, increased International Normalized Ratio (INR), arterial deoxygenation (hypoxemia), increased serum creatinine, oliguria (reduced urine output), or sodium retention. Another laboratory finding that may be included in the evidence is a liver biopsy. If you have had a liver biopsy, we will make every reasonable effort to obtain the results; however, we will not purchase a liver biopsy.

2. *Manifestations of CLD.*

a. *Gastrointestinal hemorrhaging* (105.05A), as a consequence of cirrhosis and high pressure in the liver's portal venous system, may occur from varices (dilated veins in the esophagus or the stomach) or from portal hypertensive gastropathy (abnormal mucosal changes in the stomach). When gastrointestinal hemorrhaging is due to a cause other than CLD, we evaluate it under 105.02. The phrase ''consider under a disability for 1 year'' in 105.02 and 105.05A does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling. We determine the onset of your disability based on the facts of your case.

b. *Ascites or hydrothorax* (105.05B) is a pathologic accumulation of fluid in the peritoneal cavity (ascites) or pleural space (hydrothorax). Ascites or hydrothorax may be diagnosed by removing some of the fluid with needle aspiration (paracentesis or thoracentesis), physical examination, or imaging. The most common causes of ascites are portal hypertension and low serum albumin resulting from CLD. We evaluate other causes of ascites and hydrothorax that are unrelated to CLD, such as congestive heart failure and cancer, under the listings in the affected body systems.

c. *Spontaneous bacterial peritonitis (SBP)* (105.05C) is an acute bacterial infection of peritoneal fluid and is most commonly associated with CLD. SBP is diagnosed by laboratory analysis of peritoneal fluid (obtained by paracentesis) that contains a neutrophil count (also called absolute neutrophil count) of at least 250 cells/mm^3. 105.05C is satisfied with one evaluation documenting peritoneal infection. We evaluate other causes of peritonitis that are unrelated to CLD, such as tuberculosis, malignancy, and perforated bowel, under the listings in the affected body systems.

d. *Hepatorenal syndrome* (105.05D) is renal failure associated with CLD in the absence of underlying kidney pathology. Findings associated with hepatorenal syndrome include elevation of serum creatinine, sodium retention with low urinary sodium excretion, and oliguria. We evaluate renal dysfunction with known underlying kidney pathology, such as glomerulonephritis, tubular necrosis, and renal infections, under the listings in 106.00.

e. *Hepatopulmonary syndrome* (105.05E) is arterial deoxygenation due to intrapulmonary vascular dilation and arteriovenous shunting associated with CLD. Clinical findings of hepatopulmonary syndrome include platypnea (shortness of breath relieved when lying down) and orthodeoxia (low arterial blood oxygen while in the upright position), when presenting in the context of CLD. We evaluate pulmonary dysfunction with known underlying respiratory pathology, such as asthma, pneumonia, and pulmonary infections, under the listings in 103.00.

(i) Under 105.05E1, we require a resting arterial blood gas (ABG) measurement obtained while you are breathing room air; that is, without oxygen supplementation. The ABG report must include the P_aO_2 value, your name, the date of the test, and either the altitude or both the city and State of the test site.

(ii) We will not purchase the specialized imaging techniques described in 105.05E2; however, if you have had the test(s) at a time relevant to your claim, we will make every reasonable effort to obtain the report.

f. *Hepatic encephalopathy* (105.05F), also known as portosystemic encephalopathy, is a recurrent or chronic neuropsychiatric disorder associated with CLD.

(i) Under 105.05F2, we require documentation of a mental impairment associated with hepatic encephalopathy. A mental impairment can include abnormal behavior, changes in mental status, or an altered state of consciousness. Reports of abnormal behavior may show that you are experiencing delusions, paranoia, or hallucinations. Reports of changes in mental status may show change in sleep patterns, personality or mood changes, poor concentration, or poor judgment or cognitive dysfunction (for example, impaired memory, poor problem-solving ability, or attention deficits). Reports of altered state of consciousness may show that you are experiencing confusion, delirium, or stupor.

(ii) Signs and laboratory findings that document the severity of hepatic encephalopathy when not attributable to other causes may include a ''flapping tremor'' (asterixis), characteristic abnormalities found on an electroencephalogram (EEG), or abnormal serum albumin or coagulation values. We will not purchase an EEG; however, if you have had this test at a time relevant to your claim, we will make every reasonable effort to obtain the report for the purpose of establishing whether your impairment meets the criteria of 105.05F.

(iii) We will not evaluate acute encephalopathy under 105.05F if it results from conditions other than CLD. For example, we will evaluate acute encephalopathy caused by vascular events under the listings in 111.00 and acute encephalopathy caused by cancer under the listings in 113.00.

3. *SSA Chronic Liver Disease (SSA CLD) and SSA Chronic Liver Disease-Pediatric (SSA CLD–P) scores* (105.05G). Listing 105.05G1 requires two SSA CLD scores, each requiring three or four laboratory values. Listing 105.05G2 requires one SSA CLD–P score, which requires four parameters (three laboratory values and growth failure). The ''date of the SSA CLD score'' is the date of the earliest of the three or four laboratory values used for its calculation. The ''date of the SSA CLD–P

score'' is the date of the earliest of the three laboratory values used for its calculation. For 105.05G1, the date of the second SSA CLD score must be at least 60 days after the date of the first SSA CLD score and both scores must be within the required 12-month period. If you have the two SSA CLD scores required by 105.05G1, we will find that your impairment meets the criteria of the listing from at least the date of the first SSA CLD score.

a. *SSA CLD score.*

(i) If you are age 12 or older, we will calculate the SSA CLD score using a formula that includes up to four laboratory values: Serum creatinine (mg/dL), total bilirubin (mg/dL), INR, and under certain conditions, serum sodium (mmol/L). The SSA CLD score calculation contains at least one, and sometimes two, parts, as described in (a) and (b).

(a) The initial calculation is:

$SSA\ CLD_i =$
$9.57 \times [\log_e (\text{serum creatinine mg/dL})]$
$+ 3.78 \times [\log_e (\text{serum total bilirubin mg/dL})]$
$+ 11.2 \times [\log_e (\text{INR})]$
$+ 6.43$

rounded to the nearest whole integer.

(b) If the value from the initial calculation is 11 or below, the SSA CLD score will be the $SSA\ CLD_i$ value. If the value from the initial calculation is greater than 11, the SSA CLD score will be re-calculated as:

$SSA\ CLD =$
$SSA\ CLD_i$
$+ 1.32 \times (137 - \text{serum sodium mmol/L})$
$- [0.033 \times SSA\ CLD_i \times (137 - \text{serum sodium mmol/L})]$

(c) We round the results of your SSA CLD score calculation to the nearest whole integer to arrive at your SSA CLD score.

(ii) For any SSA CLD score calculation, all of the required laboratory values (serum creatinine, serum total bilirubin, INR, and serum sodium) must have been obtained within a continuous 30-day period.

(a) We round values for serum creatinine (mg/dL), serum total bilirubin (mg/dL), or INR less than 1.0 up to 1.0 to calculate your SSA CLD score.

(b) We round values for serum creatinine (mg/dL) greater than 4.0 down to 4.0 to calculate your SSA CLD score.

(c) If there are multiple laboratory values within the 30-day interval for serum creatinine (mg/dL), serum total bilirubin (mg/dL), or INR, we use the *highest* value to calculate your SSA CLD score. We will not use any INR values derived from testing done while you are on anticoagulant treatment in our SSA CLD calculation.

(d) If there are multiple laboratory values within the 30-day interval for serum sodium (mmol/L), we use the *lowest* value to calculate your SSA CLD score.

(e) If you are in renal failure or on renal dialysis within a week of any serum creatinine test in the period used for the SSA CLD calculation, we will use a serum creatinine value of 4.0, which is the maximum serum creatinine level allowed in the calculation, to calculate your SSA CLD score.

(f) If your serum sodium is less than 125 mmol/L, we will set your serum sodium to 125 mmol/L for purposes of calculation of the SSA CLD score. If your serum sodium is higher than 137 mmol/L, we will set your serum sodium to 137 mmol/L for purposes of calculation of the SSA CLD score.

(iii) When we indicate ''$\log_e$'' (also abbreviated ''ln'') in the formula for the SSA CLD score calculation, we mean the ''base e logarithm'' or ''natural logarithm'' of the numerical laboratory value, not the ''base 10 logarithm'' or ''common logarithm'' (log) of the laboratory value, and not the actual laboratory value. For example, if a person has laboratory values of serum creatinine 1.4 mg/dL, serum total bilirubin 1.3 mg/dL, INR 1.32, and serum sodium 119 mmol/L, we compute the SSA CLD score as follows:

$SSA\ CLD_i =$
$9.57 \times [\log_e(\text{serum creatinine } 1.4 \text{ mg/dL}) = 0.336]$
$+ 3.78 \times [\log_e(\text{serum total bilirubin } 1.3 \text{ mg/dL}) = 0.262]$
$+ 11.2 \times [\log_e(\text{INR } 1.32) = .278]$
$+ 6.43$
$= 3.22 + 0.99 + 3.11 + 6.43$
$= 13.75$, which we round to an $SSA\ CLD_i$ score of 14.

Because the $SSA\ CLD_i$ score is over 11, we then move to the second step of calculating the SSA CLD:

$SSA\ CLD =$
14
$+ 1.32 \times (137 - \text{serum sodium 125 mmol/L})$
$- [0.033 \times SSA\ CLD_i\ 14 \times (137 - \text{serum sodium 125 mmol/L})$
$= 14 + 15.84 - 5.54$
$= 24.3$, which we round to an SSA CLD score of 24.

b. *SSA CLD–P score*

(i) We calculate the SSA CLD–P score using a formula that includes four parameters: Serum total bilirubin (mg/dL), INR, serum albumin (g/dL), and whether you have growth failure. The formula for the SSA CLD–P score calculation is:

$4.80 \times [\log_e(\text{serum total bilirubin mg/dL})]$
$+ 18.57 \times [\log_e(\text{INR})]$
$- 6.87 \times [\log_e(\text{serum albumin g/dL})]$
$+ 6.67$ if you have growth failure (< -2 standard deviations for weight or height)

(ii) When we indicate ''$\log_e$'' in the formula for the SSA CLD–P score calculation, we mean the ''base *e* logarithm'' or ''natural logarithm'' ($\log_e$) of a numerical laboratory value, not the ''base 10 logarithm'' or ''common logarithm'' (log) of the laboratory value, and not the actual laboratory value. For example, if a female child is 4.0 years old, has growth failure, and has laboratory

values of serum total bilirubin 2.2 mg/dL, INR 1.0, and serum albumin 3.5 g/dL, we compute the SSA CLD–P score as follows:

$4.80 \times [\log_e(\text{serum total bilirubin 2.2 mg/dL}) = 0.788]$
$+ 18.57 \times [\log_e(\text{INR 1.0}) = 0]$
$-6.87 \times [\log_e(\text{serum albumin 3.5 g/dL}) = 1.253]$
$+ 6.67$
$= 3.78 + 0 - 8.61 + 6.67$
$= 1.84$, which we round to an SSA CLD–P score of 2.

(iii) For an SSA CLD–P score calculation, all of the required laboratory values (serum total bilirubin, INR, and serum albumin) must have been obtained within a continuous 30-day period. We round any of the required laboratory values less than 1.0 up to 1.0 to calculate your SSA CLD–P score. If there are multiple laboratory values within the 30-day interval for any given laboratory test, we use the *highest* serum total bilirubin and INR values and the *lowest* serum albumin value to calculate the SSA CLD–P score. We will not use any INR values derived from testing done while you are on anticoagulant treatment in our SSA CLD–P calculation. We will not purchase INR values for children who have not attained age 12. If there is no INR value for a child under 12 within the applicable period, we will use an INR value of 1.1 to calculate the SSA CLD–P score. We round the results of your SSA CLD–P score calculation to the nearest whole integer to arrive at your SSA CLD–P score.

(iv) The weight and length/height measurements used for the calculation must be obtained within the same 30-day period as the laboratory values.

4. *Extrahepatic biliary atresia* (105.05H) presents itself in the first 2 months of life with persistent jaundice. To satisfy 105.05H, the diagnosis of extrahepatic biliary atresia must be confirmed by liver biopsy or intraoperative cholangiogram that shows obliteration of the extrahepatic biliary tree. Biliary atresia is usually treated surgically by portoenterostomy (for example, Kasai procedure). If this surgery is not performed in the first months of life or is not completely successful, liver transplantation is indicated. If you have received a liver transplant, we will evaluate your impairment under 105.09. The phrase ''consider under a disability for 1 year'' in 105.05H does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling. We determine the onset of your disability based on the facts of your case.

D. *What is inflammatory bowel disease (IBD), and how do we evaluate it under 105.06?*

1. *IBD* is a group of inflammatory conditions of the small intestine and colon. The most common IBD disorders are Crohn's disease and ulcerative colitis. Remissions and exacerbations of variable duration are a hallmark of IBD.

2. We evaluate your signs and symptoms of IBD, such as diarrhea, fecal incontinence, rectal bleeding, abdominal pain, fatigue, fever, nausea, vomiting, arthralgia, abdominal tenderness, palpable abdominal mass (usually inflamed loops of bowel), and perianal disease (for example, fissure, fistulas, abscesses, or anal canal stenosis), when we assess the severity of your impairment(s). You may require supplemental daily nutrition due to IBD. There are two forms of supplemental daily nutrition we consider under 105.06B5: enteral nutrition (delivered directly to a part of your digestive system) via a gastrostomy, duodenostomy, or jejunostomy, and parenteral nutrition delivered via a central venous catheter. Enteral tube feedings delivered via nasal or oral tubes do not satisfy the requirement in 105.06B5.

3. Surgical diversion of the intestinal tract, including ileostomy and colostomy, does not very seriously interfere with age-appropriate functioning if you are able to maintain adequate nutrition and function of the stoma. However, if you are not able to maintain adequate nutrition, we will evaluate your impairment under 105.08.

4. IBD may be associated with significant extraintestinal manifestations in a variety of body systems. These include, but are not limited to, involvement of the eye (for example, uveitis, episcleritis, or iritis); hepatobiliary disease (for example, gallstones or primary sclerosing cholangitis); urologic disease (for example, kidney stones or obstructive hydronephrosis); skin involvement (for example, erythema nodosum or pyoderma gangrenosum); or non-destructive inflammatory arthritis. You may also have associated thromboembolic disorders or vascular disease. These manifestations may not correlate with the severity of your IBD. If your impairment does not meet any of the criteria of 105.06, we will consider the effects of your extraintestinal manifestations in determining whether you have an impairment(s) that meets or medically equals another listing, and when we determine whether your impairment(s) functionally equals the listings.

5. Examples of complications of IBD that may result in hospitalization include abscesses, intestinal perforation, toxic megacolon, infectious colitis, pyoderma gangrenosum, ureteral obstruction, primary sclerosing cholangitis, and hypercoagulable state (which may lead to thromboses or embolism).

E. *What is intestinal failure, and how do we evaluate it under 105.07?*

1. *Intestinal failure* is a condition resulting in gut function below the minimum necessary for the absorption of macronutrients

or water and electrolytes, resulting in a requirement for intravenous supplementation (*i.e.*, parenteral nutrition) to maintain health. Examples of conditions that may result in intestinal failure include short bowel syndrome, extensive small bowel mucosal disease, and chronic motility disorders.

2. *Short bowel syndrome* is a malabsorption disorder that occurs when ischemic vascular insults (caused, for example, by volvulus or necrotizing enterocolitis), trauma, or IBD complications require(s) surgical resection of any amount of the small intestine, resulting in chronic malnutrition.

3. *Extensive small bowel mucosal disease* means that the mucosal surface of the small bowel does not efficiently absorb nutrients or loses nutrients. Common causes of small bowel mucosal disease include microvillous inclusion disease and tufting enteropathy.

4. *Chronic motility disorder* refers to a chronic disorder of the propulsion of gut content without fixed obstructions, causing intolerance to oral nutrition and inadequate nutritional intake. This type of disorder may also be known as a chronic intestinal pseudo-obstruction (CIPO), because the gut dysfunction mimics that of an obstructed intestine, but without evidence of an actual obstruction. Primary CIPO may have an unknown underlying cause. Chronic motility disorders may also result from congenital, neuromuscular, or autoimmune conditions, such as gastroschisis, omphalocele, long segment Hirschprung's disease, Crohn's disease, and mitochondrial disorders.

5. For short bowel syndrome, we require a copy of the operative report that includes details of the surgical findings, or postoperative imaging indicating a resection of the small intestine. If we cannot get one of these reports, we need other medical reports that include details of the surgical findings. For other chronic motility disorders or extensive small bowel mucosal disease, we need medical reports that include details of your intestinal dysfunction. For any impairment evaluated under 105.07, we also need medical documentation that you are dependent on daily parenteral nutrition to provide most of your nutritional requirements.

F. *How do we evaluate growth failure due to any digestive disorder under 105.08?*

1. To evaluate growth failure due to any digestive disorder, we require documentation of the laboratory findings of chronic nutritional deficiency described in 105.08A and the growth measurements in 105.08B within the same consecutive 12-month period. The dates of laboratory findings may be different from the dates of growth measurements. Impairments other than digestive disorders that cause weight loss should be evaluated under the appropriate body system. For instance, weight loss as a result of chronic kidney disease should be evaluated under our rules for genitourinary disorders (see 106.00), and weight loss as the result of an eating disorder should be evaluated under our rules for mental disorders (see 112.00). However, if you develop a digestive disorder as the result of your other impairment, we will evaluate the acquired digestive disorder under our rules for digestive disorders.

2. Under 105.08B, we evaluate a child's growth failure by using the appropriate table for age and gender.

a. For children from birth to attainment of age 2, we use the weight-for-length table (see Table I or Table II).

b. For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table (see Table III or Table IV).

c. BMI is the ratio of your weight to the square of your height. We calculate BMI using one of the following formulas:

English Formula

BMI = [Weight in Pounds/(Height in Inches × Height in Inches)] × 703

Metric Formulas

BMI = Weight in Kilograms/(Height in Meters × Height in Meters)

BMI = [Weight in Kilograms/(Height in Centimeters × Height in Centimeters)] × 10,000

G. *How do we evaluate digestive organ transplantation?* If you receive a liver (105.09), small intestine (105.11), or pancreas (105.12) transplant, we will consider you disabled under the listing for 1 year from the date of the transplant. After that, we evaluate your residual impairment(s) by considering the adequacy of your post-transplant function, the frequency and severity of any rejection episodes you have, complications in other body systems, and adverse treatment effects. People who receive digestive organ transplants generally have impairments that meet our definition of disability before they undergo transplantation. The phrase ''consider under a disability for 1 year'' in 105.09, 105.11, and 105.12 does not refer to the date on which your disability began, only to the date on which we must reevaluate whether your impairment(s) continues to meet a listing or is otherwise disabling. We determine the onset of your disability based on the facts of your case.

H. *How do we evaluate the need for supplemental daily enteral feeding via a gastrostomy, duodenostomy, or jejunostomy?* We evaluate the need for supplemental daily enteral feeding via a gastrostomy, duodenostomy, or jejunostomy in children who have not attained age 3 under 105.10 regardless of the medical reason for the stoma. Enteral tube feedings delivered via nasal or oral tubes do not satisfy the requirement in 105.10. After a child attains age 3, we evaluate growth failure due to any digestive disorder under 105.08, IBD

requiring supplemental daily enteral or parenteral nutrition under 105.06, or other medical or developmental disorders under another digestive disorders listing or under a listing in an affected body system(s).

I. *How do we evaluate esophageal stricture or stenosis?* Esophageal stricture or stenosis (narrowing) from congenital atresia (absence or abnormal closure of a tubular body organ) or destructive esophagitis may result in malnutrition or the need for gastrostomy placement, which we evaluate under 105.08 or 105.10. Esophageal stricture or stenosis may also result in complications such as pneumonias due to frequent aspiration, or difficulty in maintaining nutritional status short of listing level severity. While these individual complications usually do not meet the listing criteria, a combination of your impairments may medically equal a listing or functionally equal the listings.

J. *How do we evaluate your digestive disorder if there is no record of ongoing treatment?* If there is no record of ongoing treatment despite the existence of a severe impairment(s), we will assess the severity and duration of your digestive disorder based on the current medical and other evidence in your case record. If there is no record of ongoing treatment, you may not be able to show an impairment that meets a digestive disorders listing, but your impairment may medically equal a listing, or be disabling based on our rules for functional equivalence.

K. *How do we evaluate your digestive disorder if there is evidence establishing a substance use disorder?* If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability. See §416.935 of this chapter. Digestive disorders resulting from drug or alcohol use are often chronic in nature and will not necessarily improve with cessation in drug or alcohol use.

L. *How do we evaluate digestive disorders that do not meet one of these listings?*

1. These listings are only examples of common digestive disorders that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §416.926 of this chapter. Digestive disorders may be associated with disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not meet or medically equal a listing, we will also consider whether it functionally equals the listings. See §416.926a of this chapter. We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

105.01 Category of Impairments, Digestive Disorders

105.02 *Gastrointestinal hemorrhaging from any cause, requiring three blood transfusions* of at least 10 cc of blood/kg of body weight per transfusion, within a consecutive 12-month period and at least 30 days apart. Consider under a disability for 1 year following the last documented transfusion; after that, evaluate the residual impairment(s).

105.03–105.04 [Reserved]

105.05 *Chronic liver disease (CLD)* (see 105.00C) with A, B, C, D, E, F, G, or H:

A. Hemorrhaging from esophageal, gastric, or ectopic varices, or from portal hypertensive gastropathy (see 105.00C2a), documented by imaging (see 105.00B3); resulting in 1 and 2:

1. Hemodynamic instability indicated by signs such as pallor (pale skin), diaphoresis (profuse perspiration), rapid pulse, low blood pressure, postural hypotension (pronounced fall in blood pressure when arising to an upright position from lying down), or syncope (fainting); and

2. Requiring hospitalization for transfusion of at least 10 cc of blood/kg of body weight. Consider under a disability for 1 year following the documented transfusion; after that, evaluate the residual impairment(s).

OR

B. Ascites or hydrothorax not attributable to other causes (see 105.00C2b), present on two evaluations within a consecutive 12-month period and at least 60 days apart. Each evaluation must document the ascites or hydrothorax by 1, 2, or 3:

1. Paracentesis; or

2. Thoracentesis; or

3. Imaging or physical examination with a or b:

a. Serum albumin of 3.0 g/dL or less; or

b. INR of at least 1.5.

OR

C. Spontaneous bacterial peritonitis (see 105.00C2c) documented by peritoneal fluid containing a neutrophil count of at least 250 cells/mm^3.

OR

D. Hepatorenal syndrome (see 105.00C2d) documented by 1, 2, or 3:

1. Serum creatinine elevation of at least 2 mg/dL; or

2. Oliguria with 24-hour urine output less than 1 mL/kg/hr; or

3. Sodium retention with urine sodium less than 10 mEq per liter.

OR

E. Hepatopulmonary syndrome (see 105.00C2e) documented by 1 or 2:

1. Arterial P_aO_2 measured by an ABG test, while at rest, breathing room air, less than or equal to:

a. 60 mm Hg, at test sites less than 3,000 feet above sea level; or

b. 55 mm Hg, at test sites from 3,000 through 6,000 feet above sea level; or

c. 50 mm Hg, at test sites over 6,000 feet above sea level; or

2. Intrapulmonary arteriovenous shunting as shown on contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.

OR

F. Hepatic encephalopathy (see 105.00C2f) with documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on two evaluations within a consecutive 12-month period and at least 60 days apart and either 1 or 2:

1. History of transjugular intrahepatic portosystemic shunt (TIPS) or other surgical portosystemic shunt; or

2. One of the following on at least two evaluations at least 60 days apart within the same consecutive 12-month period as in F:

a. Asterixis or other fluctuating physical neurological abnormalities; or

b. EEG demonstrating triphasic slow wave activity; or

c. Serum albumin of 3.0 g/dL or less; or

d. INR of 1.5 or greater.

OR

G. SSA CLD or SSA CLD–P scores (see 105.00C3):

1. For children age 12 or older, two SSA CLD scores of at least 20 within a consecutive 12-month period and at least 60 days apart. Consider under a disability from at least the date of the first score; or

2. For children who have not attained age 12, one SSA CLD–P score of at least 11.

OR

H. Extrahepatic biliary atresia as diagnosed on liver biopsy or intraoperative cholangiogram (see 105.00C4). Consider under a disability for 1 year following diagnosis; after that, evaluate the residual impairment(s).

105.06 *Inflammatory bowel disease (IBD)* (see 105.00D) documented by endoscopy, biopsy, imaging, or operative findings *and* demonstrated by A or B:

A. Obstruction of stenotic areas (not adhesions) in the small intestine or colon with proximal dilatation, confirmed by imaging or in surgery, requiring two hospitalizations for intestinal decompression or for surgery, within a consecutive 12-month period and at least 60 days apart.

OR

B. Two of the following occurring within a consecutive 12-month period and at least 60 days apart:

1. Anemia with hemoglobin less than 10.0 g/dL, present on at least two evaluations at least 60 days apart; or

2. Serum albumin of 3.0 g/dL or less, present on at least two evaluations at least 60 days apart; or

3. Clinically documented tender abdominal mass palpable on physical examination with abdominal pain or cramping; or

4. Perianal disease with a draining abscess or fistula; or

5. Need for supplemental daily enteral nutrition via a gastrostomy, duodenostomy, or jejunostomy, or daily parenteral nutrition via a central venous catheter (see 105.10 for children who have not attained age 3).

105.07 *Intestinal failure* (see 105.00E) due to short bowel syndrome, chronic motility disorders, or extensive small bowel mucosal disease, resulting in dependence on daily parenteral nutrition via a central venous catheter for at least 12 months.

105.08 *Growth failure due to any digestive disorder* (see 105.00F), documented by A and B:

A. Chronic nutritional deficiency present on two evaluations within a consecutive 12-month period and at least 60 days apart documented by 1 or 2:

1. Anemia with hemoglobin less than 10.0 g/dL; or

2. Serum albumin of 3.0 g/dL or less.

AND

B. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile values in Table I or Table II; or

TABLE I—MALES BIRTH TO ATTAINMENT OF AGE 2

[Third percentile values for weight-for-length]

Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)
45.0	1.597	64.5	6.132	84.5	10.301
45.5	1.703	65.5	6.359	85.5	10.499
46.5	1.919	66.5	6.584	86.5	10.696
47.5	2.139	67.5	6.807	87.5	10.895
48.5	2.364	68.5	7.027	88.5	11.095
49.5	2.592	69.5	7.245	89.5	11.296
50.5	2.824	70.5	7.461	90.5	11.498
51.5	3.058	71.5	7.674	91.5	11.703
52.5	3.294	72.5	7.885	92.5	11.910
53.5	3.532	73.5	8.094	93.5	12.119
54.5	3.771	74.5	8.301	94.5	12.331
55.5	4.010	75.5	8.507	95.5	12.546
56.5	4.250	76.5	8.710	96.5	12.764
57.5	4.489	77.5	8.913	97.5	12.987
58.5	4.728	78.5	9.113	98.5	13.213
59.5	4.966	79.5	9.313	99.5	13.443
60.5	5.203	80.5	9.512	100.5	13.678
61.5	5.438	81.5	9.710	101.5	13.918
62.5	5.671	82.5	9.907	102.5	14.163
63.5	5.903	83.5	10.104	103.5	14.413

TABLE II—FEMALES BIRTH TO ATTAINMENT OF AGE 2

[Third percentile values for weight-for-length]

Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)
45.0	1.613	64.5	5.985	84.5	10.071
45.5	1.724	65.5	6.200	85.5	10.270
46.5	1.946	66.5	6.413	86.5	10.469
47.5	2.171	67.5	6.625	87.5	10.670
48.5	2.397	68.5	6.836	88.5	10.871
49.5	2.624	69.5	7.046	89.5	11.074
50.5	2.852	70.5	7.254	90.5	11.278
51.5	3.081	71.5	7.461	91.5	11.484
52.5	3.310	72.5	7.667	92.5	11.691
53.5	3.538	73.5	7.871	93.5	11.901
54.5	3.767	74.5	8.075	94.5	12.112
55.5	3.994	75.5	8.277	95.5	12.326
56.5	4.220	76.5	8.479	96.5	12.541
57.5	4.445	77.5	8.679	97.5	12.760
58.5	4.669	78.5	8.879	98.5	12.981
59.5	4.892	79.5	9.078	99.5	13.205

TABLE II—FEMALES BIRTH TO ATTAINMENT OF AGE 2—Continued

[Third percentile values for weight-for-length]

Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)	Length (centimeters)	Weight (kilograms)
60.5	5.113	80.5	9.277	100.5	13.431
61.5	5.333	81.5	9.476	101.5	13.661
62.5	5.552	82.5	9.674	102.5	13.895
63.5	5.769	83.5	9.872	103.5	14.132

2. *For children age 2 to attainment of age 18*, three BMI-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile value in Table III or Table IV.

TABLE III—MALES AGE 2 TO ATTAINMENT OF AGE 18

[Third percentile values for BMI-for-age]

Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI
2.0 to 2.1	14.5	10.11 to 11.2	14.3	14.9 to 14.10	16.1
2.2 to 2.4	14.4	11.3 to 11.5	14.4	14.11 to 15.0	16.2
2.5 to 2.7	14.3	11.6 to 11.8	14.5	15.1 to 15.3	16.3
2.8 to 2.11	14.2	11.9 to 11.11	14.6	15.4 to 15.5	16.4
3.0 to 3.2	14.1	12.0 to 12.1	14.7	15.6 to 15.7	16.5
3.3 to 3.6	14.0	12.2 to 12.4	14.8	15.8 to 15.9	16.6
3.7 to 3.11	13.9	12.5 to 12.7	14.9	15.10 to 15.11	16.7
4.0 to 4.5	13.8	12.8 to 12.9	15.0	16.0 to 16.1	16.8
4.6 to 5.0	13.7	12.10 to 13.0	15.1	16.2 to 16.3	16.9
5.1 to 6.0	13.6	13.1 to 13.2	15.2	16.4 to 16.5	17.0
6.1 to 7.6	13.5	13.3 to 13.4	15.3	16.6 to 16.8	17.1
7.7 to 8.6	13.6	13.5 to 13.7	15.4	16.9 to 16.10	17.2
8.7 to 9.1	13.7	13.8 to 13.9	15.5	16.11 to 17.0	17.3
9.2 to 9.6	13.8	13.10 to 13.11	15.6	17.1 to 17.2	17.4
9.7 to 9.11	13.9	14.0 to 14.1	15.7	17.3 to 17.5	17.5
10.0 to 10.3	14.0	14.2 to 14.4	15.8	17.6 to 17.7	17.6
10.4 to 10.7	14.1	14.5 to 14.6	15.9	17.8 to 17.9	17.7
10.8 to 10.10	14.2	14.7 to 14.8	16.0	17.10 to 17.11	17.8

TABLE IV—FEMALES AGE 2 TO ATTAINMENT OF AGE 18

[Third percentile values for BMI-for-age]

Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI	Age (yrs. and mos.)	BMI
2.0 to 2.2	14.1	10.8 to 10.10	14.0	14.3 to 14.5	15.6
2.3 to 2.6	14.0	10.11 to 11.2	14.1	14.6 to 14.7	15.7
2.7 to 2.10	13.9	11.3 to 11.5	14.2	14.8 to 14.9	15.8
2.11 to 3.2	13.8	11.6 to 11.7	14.3	14.10 to 15.0	15.9
3.3 to 3.6	13.7	11.8 to 11.10	14.4	15.1 to 15.2	16.0
3.7 to 3.11	13.6	11.11 to 12.1	14.5	15.3 to 15.5	16.1
4.0 to 4.4	13.5	12.2 to 12.4	14.6	15.6 to 15.7	16.2
4.5 to 4.11	13.4	12.5 to 12.6	14.7	15.8 to 15.10	16.3
5.0 to 5.9	13.3	12.7 to 12.9	14.8	15.11 to 16.0	16.4
5.10 to 7.6	13.2	12.10 to 12.11	14.9	16.1 to 16.3	16.5
7.7 to 8.4	13.3	13.0 to 13.2	15.0	16.4 to 16.6	16.6
8.5 to 8.10	13.4	13.3 to 13.4	15.1	16.7 to 16.9	16.7
8.11 to 9.3	13.5	13.5 to 13.7	15.2	16.10 to 17.0	16.8
9.4 to 9.8	13.6	13.8 to 13.9	15.3	17.1 to 17.3	16.9
9.9 to 10.0	13.7	13.10 to 14.0	15.4	17.4 to 17.7	17.0
10.1 to 10.4	13.8	14.1 to 14.2	15.5	17.8 to 17.11	17.1
10.5 to 10.7	13.9	.....	.....	.....	.....

105.09 *Liver transplantation* (see 105.00G). Consider under a disability for 1 year from the date of the transplant; after that, evaluate the residual impairment(s).

105.10 *Need for supplemental daily enteral feeding via a gastrostomy, duodenostomy, or jejunostomy* (see 105.00H) due to any cause, for children who have not attained age 3; after that, evaluate the residual impairment(s).

105.11 *Small intestine transplantation* (see 105.00G). Consider under a disability for 1 year from the date of the transplant; after that, evaluate the residual impairment(s).

105.12 *Pancreas transplantation* (see 105.00G). Consider under a disability for 1 year from the date of the transplant; after that, evaluate the residual impairment(s).

106.00 GENITOURINARY DISORDERS

A. Which disorders do we evaluate under these listings?

We evaluate genitourinary disorders resulting in chronic kidney disease (CKD). Examples of such disorders include chronic glomerulonephritis, hypertensive nephropathy, diabetic nephropathy, chronic obstructive uropathy, and hereditary nephropathies. We also evaluate nephrotic syndrome due to glomerular dysfunction, and congenital genitourinary disorders, such as ectopic ureter, exstrophic urinary bladder, urethral valves, and Eagle-Barrett syndrome (prune belly syndrome), under these listings.

B. What evidence do we need?

1. We need evidence that documents the signs, symptoms, and laboratory findings of your CKD. This evidence should include reports of clinical examinations, treatment records, and documentation of your response to treatment. Laboratory findings, such as serum creatinine or serum albumin levels, may document your kidney function. We generally need evidence covering a period of at least 90 days unless we can make a fully favorable determination or decision without it.

2. *Estimated glomerular filtration rate (eGFR).* The eGFR is an estimate of the filtering capacity of the kidneys that takes into account serum creatinine concentration and other variables, such as your age, gender, and body size. If your medical evidence includes eGFR findings, we will consider them when we evaluate your CKD under 106.05.

3. *Kidney or bone biopsy.* If you have had a kidney or bone biopsy, we need a copy of the pathology report. When we cannot get a copy of the pathology report, we will accept a statement from an acceptable medical source verifying that a biopsy was performed and describing the results.

C. What other factors do we consider when we evaluate your genitourinary disorder?

1. *Chronic hemodialysis or peritoneal dialysis.*

a. Dialysis is a treatment for CKD that uses artificial means to remove toxic metabolic byproducts from the blood. Hemodialysis uses an artificial kidney machine to clean waste products from the blood; peritoneal dialysis uses a dialyzing solution that is introduced into and removed from the abdomen (peritoneal cavity) either continuously or intermittently. Under 106.03, your ongoing dialysis must have lasted or be expected to last for a continuous period of at least 12 months. To satisfy the requirement in 106.03, we will accept a report from an acceptable medical source that describes your CKD and your current dialysis, and indicates that your dialysis will be ongoing.

b. If you are undergoing chronic hemodialysis or peritoneal dialysis, your CKD may meet our definition of disability before you started dialysis. We will determine the onset of your disability based on the facts in your case record.

2. *Kidney transplant.*

a. If you receive a kidney transplant, we will consider you to be disabled under 106.04 for 1 year from the date of transplant. After that, we will evaluate your residual impairment(s) by considering your post-transplant function, any rejection episodes you have had, complications in other body systems, and any adverse effects related to ongoing treatment.

b. If you received a kidney transplant, your CKD may meet our definition of disability before you received the transplant. We will determine the onset of your disability based on the facts in your case record.

3. *Anasarca* (generalized massive edema or swelling). Under 106.06B, we need a description of the extent of edema, including pretibial (in front of the tibia), periorbital (around the eyes), or presacral (in front of the sacrum) edema. We also need a description of any ascites, pleural effusion, or pericardial effusion.

4. *Congenital genitourinary disorder.* Procedures such as diagnostic cystoscopy or circumcision do not satisfy the requirement for urologic surgical procedures in 106.07.

5. *Growth failure due to any chronic renal disease.*

a. To evaluate growth failure due to any chronic renal disease, we require documentation of the laboratory findings described in 106.08A and the growth measurements in 106.08B within the same consecutive 12-month period. The dates of laboratory findings may be different from the dates of growth measurements.

b. Under 106.08B, we use the appropriate table(s) under 105.08B in the digestive system

to determine whether a child's growth is less than the third percentile.

(i) For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

(ii) For children age 2 to attainment of age 18, we use the body mass index (BMI)-for-age table corresponding to the child's gender (Table III or Table IV).

(iii) BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in the digestive disorders body system (105.00).

6. *Complications of CKD.* The hospitalizations in 106.09 may be for different complications of CKD. Examples of complications from CKD that may result in hospitalization include stroke, congestive heart failure, hypertensive crisis, or acute kidney failure requiring a short course of hemodialysis. If the CKD complication occurs during a hospitalization that was initially for a co-occurring condition, we will evaluate it under our rules for determining medical equivalence. (See §416.926 of this chapter.) We will evaluate co-occurring conditions, including those that result in hospitalizations, under the listings for the affected body system or under our rules for medical equivalence.

D. How do we evaluate disorders that do not meet one of the genitourinary listings?

1. The listed disorders are only examples of common genitourinary disorders that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §416.926 of this chapter.) Genitourinary disorders may be associated with disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not medically equal a listing, we will also consider whether it functionally equals the listings. (See §416.926a of this chapter.) We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

106.01 Category of Impairments, Genitourinary Disorders

106.03 *Chronic kidney disease,* with chronic hemodialysis or peritoneal dialysis (see 106.00C1).

106.04 *Chronic kidney disease,* with kidney transplant. Consider under a disability for 1 year following the transplant; thereafter, evaluate the residual impairment (see 106.00C2).

106.05 *Chronic kidney disease,* with impairment of kidney function, with one of the following documented on at least two occasions at least 90 days apart during a consecutive 12-month period:

A. Serum creatinine of 3 mg/dL or greater;

OR

B. Creatinine clearance of 30 ml/min/1.73m^2 or less;

OR

C. Estimated glomerular filtration rate (eGFR) of 30 ml/min/1.73m^2 or less.

106.06 *Nephrotic syndrome,* with A and B:

A. Laboratory findings as described in 1 or 2, documented on at least two occasions at least 90 days apart during a consecutive 12-month period:

1. Serum albumin of 3.0 g/dL or less, or

2. Proteinuria of 40 mg/m^2/hr or greater;

AND

B. Anasarca (see 106.00C3) persisting for at least 90 days despite prescribed treatment.

106.07 *Congenital genitourinary disorder* (see 106.00C4) requiring urologic surgical procedures at least three times in a consecutive 12-month period, with at least 30 days between procedures. Consider under a disability for 1 year following the date of the last surgery; thereafter, evaluate the residual impairment.

106.09 *Complications of chronic kidney disease* (see 106.00C5) requiring at least three hospitalizations within a consecutive 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

106.08 *Growth failure due to any chronic renal disease* (see 106.00C5), with:

A. Serum creatinine of 2 mg/dL or greater, documented at least two times within a consecutive 12-month period with at least 60 days between measurements.

AND

B. Growth failure as required in 1 or 2:

1. *For children from birth to attainment of age 2,* three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

2. *For children age 2 to attainment of age 18,* three BMI-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

107.00 HEMATOLOGICAL DISORDERS

A. What hematological disorders do we evaluate under these listings?

1. We evaluate non-malignant (non-cancerous) hematological disorders, such as hemolytic anemias (107.05), disorders of thrombosis and hemostasis (107.08), and disorders of bone marrow failure (107.10). These disorders disrupt the normal development and function of white blood cells, red blood cells, platelets, and clotting-factor proteins (factors).

2. We evaluate malignant (cancerous) hematological disorders, such as lymphoma, leukemia, and multiple myeloma, under the appropriate listings in 113.00, except for two lymphomas associated with human immunodeficiency virus (HIV) infection. We evaluate primary central nervous system lymphoma associated with HIV infection under 114.11B, and primary effusion lymphoma associated with HIV infection under 114.11C.

B. What evidence do we need to document that you have a hematological disorder?

We need the following evidence to document that you have a hematological disorder:

1. A laboratory report of a definitive test that establishes a hematological disorder, signed by a physician; or

2. A laboratory report of a definitive test that establishes a hematological disorder that is not signed by a physician and a report from a physician that states you have the disorder; or

3. When we do not have a laboratory report of a definitive test, a persuasive report from a physician that a diagnosis of your hematological disorder was confirmed by appropriate laboratory analysis or other diagnostic method(s). To be persuasive, this report must state that you had the appropriate definitive laboratory test or tests for diagnosing your disorder and provide the results, or explain how your diagnosis was established by other diagnostic method(s) consistent with the prevailing state of medical knowledge and clinical practice.

4. We will make every reasonable effort to obtain the results of appropriate laboratory testing you have had. We will not purchase complex, costly, or invasive tests, such as tests of clotting-factor proteins, and bone marrow aspirations.

C. What are hemolytic anemias, and how do we evaluate them under 107.05?

1. *Hemolytic anemias, both congenital and acquired,* are disorders that result in premature destruction of red blood cells (RBCs). Hemolytic anemias include abnormalities of hemoglobin structure (hemoglobinopathies), abnormal RBC enzyme content and function, and RBC membrane (envelope) defects that are congenital or acquired. The diagnosis of hemolytic anemia is based on hemoglobin electrophoresis or analysis of the contents of the RBC (enzymes) and membrane. Examples of congenital hemolytic anemias include sickle cell disease, thalassemia, and their variants, and hereditary spherocytosis. Acquired hemolytic anemias may result from autoimmune disease (for example, systemic lupus erythematosus) or mechanical devices (for example, heart valves, intravascular patches).

2. The hospitalizations in 107.05B do not all have to be for the same complication of the hemolytic anemia. They may be for three different complications of the disorder. Examples of complications of hemolytic anemia that may result in hospitalization include dactylitis, osteomyelitis, painful (vaso-occlusive) crisis, pulmonary infections or infarctions, acute chest syndrome, pulmonary hypertension, chronic heart failure, gallbladder disease, hepatic (liver) failure, renal (kidney) failure, nephrotic syndrome, aplastic crisis, and strokes. We will count the hours you receive emergency treatment in a comprehensive sickle cell disease center immediately before the hospitalization if this treatment is comparable to the treatment provided in a hospital emergency department.

3. For 107.05C, we do not require hemoglobin to be measured during a period in which you are free of pain or other symptoms of your disorder. We will accept hemoglobin measurements made while you are experiencing complications of your hemolytic anemia.

4. 107.05D refers to the most serious type of beta thalassemia major in which the bone marrow cannot produce sufficient numbers of normal RBCs to maintain life. The only available treatments for beta thalassemia major are life-long RBC transfusions (sometimes called hypertransfusion) or bone marrow transplantation. For purposes of 107.05D, we do not consider prophylactic RBC transfusions to prevent strokes or other complications in sickle cell disease and its variants to be of equal significance to life-saving RBC transfusions for beta thalassemia major. However, we will consider the functional limitations associated with prophylactic RBC transfusions and any associated side effects (for example, iron overload) under functional equivalence and any affected body system(s). We will also evaluate strokes and resulting complications under 111.00 and 112.00.

D. What are disorders of thrombosis and hemostasis, and how do we evaluate them under 107.08?

1. *Disorders of thrombosis and hemostasis* include both clotting and bleeding disorders, and may be congenital or acquired. These disorders are characterized by abnormalities

in blood clotting that result in hypercoagulation (excessive blood clotting) or hypocoagulation (inadequate blood clotting). The diagnosis of a thrombosis or hemostasis disorder is based on evaluation of plasma clotting-factor proteins (factors) and platelets. Protein C or protein S deficiency and Factor V Leiden are examples of hypercoagulation disorders. Hemophilia, von Willebrand disease, and thrombocytopenia are examples of hypocoagulation disorders. Acquired excessive blood clotting may result from blood protein defects and acquired inadequate blood clotting (for example, acquired hemophilia A) may be associated with inhibitor autoantibodies.

2. The hospitalizations in 107.08 do not all have to be for the same complication of a disorder of thrombosis and hemostasis. They may be for three different complications of the disorder. Examples of complications that may result in hospitalization include anemias, thromboses, embolisms, and uncontrolled bleeding requiring multiple factor concentrate infusions or platelet transfusions. We will also consider any surgery that you have, even if it is not related to your hematological disorder, to be a complication of your disorder of thrombosis and hemostasis if you require treatment with clotting-factor proteins (for example, factor VIII or IX) or anticoagulant medication to control bleeding or coagulation in connection with your surgery. We will count the hours you receive emergency treatment in a comprehensive hemophilia treatment center immediately before the hospitalization if this treatment is comparable to the treatment provided in a hospital emergency department.

E. What are disorders of bone marrow failure, and how do we evaluate them under 107.10?

1. *Disorders of bone marrow failure* may be congenital or acquired, characterized by bone marrow that does not make enough healthy RBCs, platelets, or granulocytes (specialized types of white blood cells); there may also be a combined failure of these bone marrow-producing cells. The diagnosis is based on peripheral blood smears and bone marrow aspiration or bone marrow biopsy, but not peripheral blood smears alone. Examples of these disorders are myelodysplastic syndromes, aplastic anemia, granulocytopenia, and myelofibrosis. Acquired disorders of bone marrow failure may result from viral infections, chemical exposure, or immunologic disorders.

2. The hospitalizations in 107.10A do not all have to be for the same complication of bone marrow failure. They may be for three different complications of the disorder. Examples of complications that may result in hospitalization include uncontrolled bleeding, anemia, and systemic bacterial, viral, or fungal infections.

3. For 107.10B, the requirement of life-long RBC transfusions to maintain life in myelodysplastic syndromes or aplastic anemias has the same meaning as it does for beta thalassemia major. (See 107.00C4.)

F. How do we evaluate bone marrow or stem cell transplantation under 107.17?

We will consider you to be disabled for 12 months from the date of bone marrow or stem cell transplantation, or we may consider you to be disabled for a longer period if you are experiencing any serious post-transplantation complications, such as graft-versus-host (GVH) disease, frequent infections after immunosuppressive therapy, or significant deterioration of organ systems. We do not restrict our determination of the onset of disability to the date of the transplantation in 107.17. We may establish an earlier onset of disability due to your transplantation if evidence in your case record supports such a finding.

G. How do we consider your symptoms, including your pain, severe fatigue, and malaise?

Your symptoms, including pain, severe fatigue, and malaise, may be important factors in our determination whether your hematological disorder meets or medically equals a listing, or in our determination whether you otherwise have marked and severe functional limitations. We cannot consider your symptoms unless you have medical signs or laboratory findings showing the existence of a medically determinable impairment(s) that could reasonably be expected to produce the symptoms. If you have such an impairment(s), we will evaluate the intensity, persistence, and functional effects of your symptoms using the rules throughout 107.00 and in our other regulations. (See sections 416.921 and 416.929 of this chapter.) Additionally, when we assess the credibility of your complaints about your symptoms and their functional effects, we will not draw any inferences from the fact that you do not receive treatment or that you are not following treatment without considering all of the relevant evidence in your case record, including any explanations you provide on why you are not receiving or following treatment.

H. How do we evaluate episodic events in hematological disorders?

Some of the listings in this body system require a specific number of events within a consecutive 12-month period. (See 107.05, 107.08, and 107.10A.) When we use such criteria, a consecutive 12-month period means a period of 12 consecutive months, all or part of which must occur within the period we are

considering in connection with your application or continuing disability review. These events must occur at least 30 days apart to ensure that we are evaluating separate events.

I. How do we evaluate hematological disorders that do not meet one of these listings?

1. These listings are only common examples of hematological disorders that we consider severe enough to result in marked and severe functional limitations. If your disorder does not meet the criteria of any of these listings, we must consider whether you have a disorder that satisfies the criteria of a listing in another body system. For example, we will evaluate hemophilic joint deformity under 101.00; polycythemia vera under 103.00, 104.00, or 111.00; chronic iron overload resulting from repeated RBC transfusion (transfusion hemosiderosis) under 103.00, 104.00, or 105.00; and the effects of intracranial bleeding or stroke under 111.00 or 112.00.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See section 416.926 of this chapter.) Hematological disorders may be associated with disorders in other body systems, and we consider the combined effects of multiple impairments when we determine whether they medically equal a listing. If your impairment(s) does not medically equal a listing, we will also consider whether it functionally equals the listings. (See section 416.926a of this chapter.) We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

107.01 Category of Impairments, Hematological Disorders

107.05 *Hemolytic anemias,* including sickle cell disease, thalassemia, and their variants (see 107.00C), with:

A. Documented painful (vaso-occlusive) crises requiring parenteral (intravenous or intramuscular) narcotic medication, occurring at least six times within a 12-month period with at least 30 days between crises.

OR

B. Complications of hemolytic anemia requiring at least three hospitalizations within a 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, which can include hours in a hospital emergency department or comprehensive sickle cell disease center immediately before the hospitalization (see 107.00C2).

OR

C. Hemoglobin measurements of 7.0 grams per deciliter (g/dL) or less, occurring at least three times within a 12-month period with at least 30 days between measurements.

OR

D. Beta thalassemia major requiring life-long RBC transfusions at least once every 6 weeks to maintain life (see 107.00C4).

107.08 *Disorders of thrombosis and hemostasis,* including hemophilia and thrombocytopenia (see 107.00D), with complications requiring at least three hospitalizations within a 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, which can include hours in a hospital emergency department or comprehensive hemophilia treatment center immediately before the hospitalization (see 107.00D2).

107.10 *Disorders of bone marrow failure,* including myelodysplastic syndromes, aplastic anemia, granulocytopenia, and myelofibrosis (see 107.00E), with:

A. Complications of bone marrow failure requiring at least three hospitalizations within a 12-month period and occurring at least 30 days apart. Each hospitalization must last at least 48 hours, which can include hours in a hospital emergency department immediately before the hospitalization (see 107.00E2).

OR

B. Myelodysplastic syndromes or aplastic anemias requiring life-long RBC transfusions at least once every 6 weeks to maintain life (see 107.00E3).

107.17 *Hematological disorders treated by bone marrow or stem cell transplantation* (see 107.00F). Consider under a disability for at least 12 consecutive months from the date of transplantation. After that, evaluate any residual impairment(s) under the criteria for the affected body system.

108.00 Skin Disorders

A. *Which skin disorders do we evaluate under these listings?* We use these listings to evaluate skin disorders that result from hereditary, congenital, or acquired pathological processes. We evaluate genetic photosensitivity disorders (108.07), burns (108.08), and chronic conditions of the skin or mucous membranes such as ichthyosis, bullous disease, dermatitis, psoriasis, and hidradenitis suppurativa (108.09) under these listings.

B. *What are our definitions for the following terms used in this body system?*

1. *Assistive device(s):* An assistive device, for the purposes of these listings, is any device used to improve stability, dexterity, or mobility. An assistive device can be hand-held, such as a cane(s), a crutch(es), or a walker; used in a seated position, such as a wheelchair, rollator, or power operated vehicle; or worn, such as a prosthesis or an orthosis.

2. *Chronic skin lesions:* Chronic skin lesions can have recurrent exacerbations (see 108.00B7). They can occur despite prescribed medical treatment. These chronic skin lesions can develop on any part of your body,

including upper extremities, lower extremities, palms of your hands, soles of your feet, the perineum, inguinal (groin) region, and axillae (underarms). Chronic skin lesions may result in functional limitations as described in 108.00D2.

3. *Contractures:* Contractures are permanent fibrous scar tissue resulting in tightening and thickening of skin that prevents normal movement of the damaged area. They can develop on any part of your musculoskeletal system, including upper extremities, lower extremities, palms of your hands, soles of your feet, the perineum, inguinal (groin) region, and axillae (underarms). Contractures may result in functional limitations as described in 108.00D2.

4. *Documented medical need:* When we use the term ''documented medical need,'' we mean that there is evidence (see §416.913 of this chapter) from your medical source(s) in the medical record that supports your need for an assistive device (see 108.00B1) for a continuous period of at least 12 months. The evidence must include documentation from your medical source(s) describing any limitation(s) in your upper or lower extremity functioning that supports your need for the assistive device and describing the circumstances for which you need it. The evidence does not have to include a specific prescription for the device.

5. *Fine and gross movements:* Fine movements, for the purposes of these listings, involve use of your wrists, hands, and fingers; such movements include picking, pinching, manipulating, and fingering. Gross movements involve use of your shoulders, upper arms, forearms, and hands; such movements include handling, gripping, grasping, holding, turning, and reaching. Gross movements also include exertional activities such as lifting, carrying, pushing, and pulling. Evaluation of fine and gross movements is dependent on your age.

6. *Surgical management:* For the purposes of these listings, surgical management includes the surgery(ies) itself, as well as various post-surgical procedures, surgical complications, infections or other medical complications, related illnesses, or related treatments that delay a person's attainment of maximum benefit from surgery.

7. *Exacerbation:* For the purposes of these listings, exacerbation means an increase in the signs or symptoms of the skin disorder. Exacerbation may also be referred to as flare, flare-up, or worsening of the skin disorder.

C. *What evidence do we need to evaluate your skin disorder?*

1. To establish the presence of a skin disorder as a medically determinable impairment, we need objective medical evidence from an acceptable medical source (AMS) who has examined you for the disorder.

2. We will make every reasonable effort to obtain your medical history, treatment records, and relevant laboratory findings, but we will not purchase genetic testing.

3. When we evaluate the presence and severity of your skin disorder(s), we generally need information regarding:

a. The onset, duration, and frequency of exacerbations (see 108.00B7);

b. The prognosis of your skin disorder;

c. The location, size, and appearance of lesions and contractures;

d. Any available history of familial incidence;

e. Your exposure to toxins, allergens or irritants; seasonal variations; and stress factors;

f. Your ability to function outside of a highly protective environment (see 108.00E4);

g. Laboratory findings (for example, a biopsy obtained independently of Social Security disability evaluation or results of blood tests);

h. Evidence from other medically acceptable methods consistent with the prevailing state of medical knowledge and clinical practice; and

i. Statements you or others make about your disorder(s), your restrictions, and your daily activities.

D. *How do we evaluate the severity of skin disorders?*

1. *General.* We evaluate the severity of skin disorders based on the site(s) of your chronic skin lesions (see 108.00B2) or contractures (see 108.00B3), functional limitations caused by your signs and symptoms (including pain) (see 108.00D2), and how your prescribed treatment affects you. We consider the frequency and severity of your exacerbations (see 108.00B7), how quickly they resolve, and how you function between exacerbations (see 108.00B7), to determine whether your skin disorder meets or medically equals a listing (see 108.00D3). If there is no record of ongoing medical treatment for your disorder, we will follow the guidelines in 108.00D6. We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For our basic rules on evidence, see §§416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating your symptoms, see §416.929 of this chapter.

2. *Limitation(s) of physical functioning due to skin disorders.*

a. Skin disorders may be due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3), and may cause pain or restrict movement, which can limit your ability to initiate, sustain, and complete age-appropriate activities. For example, skin lesions in the axilla may limit your ability to raise or reach with the affected arm, or lesions in the inguinal region may limit your ability to ambulate, sit, or lift and carry. To evaluate your skin disorder(s) under 108.07B, 108.08,

and 108.09, we require medically documented evidence of physical limitation(s) of functioning related to your disorder. The decrease in physical function must have lasted, or can be expected to last, for a continuous period of at least 12 months (see §416.909 of this chapter). Xeroderma pigmentosum is the only skin disorder that does not include functional criteria because the characteristics and severity of the disorder itself are sufficient to meet the criteria in 108.07A.

b. The functional criteria require impairment-related physical limitations in using upper or lower extremities that have lasted, or can be expected to last, for a continuous period of at least 12 months, medically documented by one of the following:

(i) Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3); or

(ii) Inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3), and a documented medical need (see 108.00B4) for an assistive device (see 108.00B1) that requires the use of the other upper extremity; or

(iii) Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region); or

(iv) Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

3. *Frequency of exacerbations due to chronic skin lesions.* A skin disorder resulting in chronic skin lesions (see 108.00B2) may have frequent exacerbations (see 108.00B7) severe enough to meet a listing even if each individual skin lesion exacerbation (see 108.00B7) did not last for an extended amount of time. We will consider the frequency, severity, and duration of skin lesion exacerbations (see 108.00B7), how quickly they resolve, and how you function in the time between skin lesion exacerbations (see 108.00B7), to determine whether your skin disorder meets or medically equals a listing.

4. *Symptoms (including pain).* Your symptoms may be an important factor in our determination of whether your skin disorder(s) meets or medically equals a listing. We consider your symptoms only when you have a medically determinable impairment(s) that could reasonably be expected to produce the symptoms. See §416.929 of this chapter.

5. *Treatment.*

a. *General.* Treatments for skin disorders may have beneficial or adverse effects, and responses to treatment vary from person to person. Your skin disorder's response to treatment may vary due to treatment resistance or side effects that can result in functional limitations. We will evaluate all of the effects of treatment (including surgical treatment, medications, and therapy) on the symptoms, signs, and laboratory findings of your skin disorder, and on your ability to function.

b. *Despite adherence to prescribed medical treatment for 3 months.* Under 108.09, we require that your symptoms persist ''despite adherence to prescribed medical treatment for 3 months.'' This requirement means that you must have taken prescribed medication(s) or followed other medical treatment prescribed by a medical source for 3 consecutive months. Treatment or effects of treatment may be temporary. In most cases, sufficient time must elapse to allow us to evaluate your response to treatment, including any side effects. For our purposes, ''sufficient time'' means a period of at least 3 months. If your treatment has not lasted for at least 3 months, we will follow the rules in 108.00D6a. The 3 months adherence to prescribed medical treatment must be within the period of at least 12 months that we use to evaluate severity.

c. *Treatment with PUVA (psoralen and ultraviolet A (UVA) light) or biologics.* If you receive additional treatment with PUVA or biologics to treat your skin disorder(s), we will defer adjudication of your claim for 6 months from the start of treatment with PUVA or biologics to evaluate the effectiveness of these treatments unless we can make a fully favorable determination or decision on another basis.

6. *No record of ongoing treatment.*

a. Despite having a skin disorder, you may not have received ongoing treatment, may have just begun treatment, may not have access to prescribed medical treatment, or may not have an ongoing relationship with the medical community. In any of these situations, you will not have a longitudinal medical record for us to review when we evaluate your disorder. In some instances, we may be able to assess the severity and duration of your skin disorder based on your medical record and current evidence alone. We may ask you to attend a consultative examination to determine the severity and potential duration of your skin disorder (see §416.919a of this chapter).

b. If, for any reason, you have not received treatment, your skin disorder cannot meet the criteria for 108.09. If the information in your case record is not sufficient to show that you have a skin disorder that meets the criteria of one of the skin disorders listings, we will follow the rules in 108.00I.

E. *How do we evaluate genetic photosensitivity disorders under 108.07?* Genetic photosensitivity disorders are disorders of the skin caused by an increase in the sensitivity of the skin to sources of ultraviolet light, including sunlight.

1. *Xeroderma pigmentosum (XP) (108.07A).* XP is a genetic photosensitivity disorder with lifelong hypersensitivity to all forms of ultraviolet light. Laboratory testing confirms the diagnosis by documenting abnormalities in the body's ability to repair DNA (deoxyribonucleic acid) mutations after ultraviolet light exposure. Your skin disorder meets the requirements of 108.07A if you have clinical and laboratory findings supporting a diagnosis of XP (see 108.00E3).

2. *Other genetic photosensitivity disorders (108.07B).* The effects of other genetic photosensitivity disorders may vary and may not persist over time. To meet the requirements of 108.07B, a genetic photosensitivity disorder other than XP must be established by clinical and laboratory findings (see 108.00C) and must result either in chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) that result in functional limitations (108.00D2), or must result in the inability to function outside of a highly protective environment (see 108.00E4). Some genetic photosensitivity disorders can have very serious effects on other body systems, especially special senses and speech, neurological, mental, and cancer. We will evaluate your disorder(s) under the listings in 102.00, 111.00, 112.00, or 113.00, as appropriate.

3. *What evidence do we need to document that you have XP or another genetic photosensitivity disorder?* We will make a reasonable effort to obtain evidence of your disorder(s), but we will not purchase genetic testing. When the results of genetic tests are part of the existing evidence in your case record, we will evaluate the test results with all other relevant evidence. We need the following clinical and laboratory findings to document that you have XP or another genetic photosensitivity disorder:

a. A laboratory report of a definitive genetic test documenting appropriate chromosomal changes, including abnormal DNA repair or another DNA abnormality specific to your type of photosensitivity disorder, signed by an AMS; or

b. A laboratory report of a definitive test that is not signed by an AMS, and a report from an AMS stating that you have undergone definitive genetic laboratory studies documenting appropriate chromosomal changes, including abnormal DNA repair or another DNA abnormality specific to your type of photosensitivity disorder; or

c. If we do not have a laboratory report of a definitive test, we need documentation from an AMS that an appropriate laboratory analysis or other diagnostic method(s) confirms a positive diagnosis of your skin disorder. This documentation must state that you had the appropriate definitive laboratory test(s) for diagnosing your disorder and provide the results, or explain how another diagnostic method(s), consistent with the prevailing state of medical knowledge and clinical practice, established your diagnosis.

4. *Inability to function outside of a highly protective environment* means that you must avoid exposure to ultraviolet light (including sunlight passing through windows and light from similar unshielded light sources), wear protective clothing and eyeglasses, and use opaque broad-spectrum sunscreens in order to avoid skin cancer or other serious effects.

F. *How do we evaluate burns under 108.08?*

1. Electrical, chemical, or thermal burns frequently affect other body systems; for example, musculoskeletal, special senses and speech, respiratory, cardiovascular, genitourinary, neurological, or mental. We evaluate burns in the same way we evaluate other disorders that can affect the skin and other body systems, using the listing for the predominant feature of your disorder. For example, if your soft tissue injuries resulting from burns are under surgical management (as defined in 108.00B6), we will evaluate your disorder under the listings in 101.00.

2. We evaluate burns resulting in chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) that have been documented by an AMS to have reached maximum therapeutic benefit and therefore are no longer receiving surgical management, under 108.08. To be disabling, these burns must result in functional limitation(s) (see 108.00D2) that has lasted or can be expected to last for a continuous period of at least 12 months.

G. *How do we evaluate chronic conditions of the skin or mucous membranes under 108.09?* We evaluate skin disorders that result in chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) under 108.09. These disorders must result in chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) that continue to persist despite adherence to prescribed medical treatment for 3 months (see 108.00D5b) and cause functional limitations (see 108.00D2). Examples of skin disorders evaluated under this listing are ichthyosis, bullous diseases (such as pemphigus, epidermolysis bullosa, and dermatitis herpetiformis), chronic skin infections, dermatitis, psoriasis, and hidradenitis suppurativa.

H. *How do we evaluate disorders in other body systems that affect the skin?* When your disorder(s) in another body system affects your skin, we first evaluate the predominant

feature of your disorder(s) under the appropriate body system. Examples of disorders in other body systems that affect the skin include the following:

1. *Tuberous sclerosis.* The predominant functionally limiting features of tuberous sclerosis are seizures and intellectual disorder or other mental disorders. We evaluate these features under the listings in 111.00 or 112.00, as appropriate.

2. *Malignant tumors of the skin.* Malignant tumors of the skin (for example, malignant melanomas) are cancers, or malignant neoplastic diseases, that we evaluate under the listings in 113.00.

3. *Immune system disorders.* We evaluate skin manifestations of immune system disorders such as systemic lupus erythematosus, scleroderma, psoriasis, and human immunodeficiency virus (HIV) infection under the listings in 114.00.

4. *Head or facial disfigurement or deformity, and other physical deformities caused by skin disorders.* A head or facial disfigurement or deformity may result in loss of your sight, hearing, speech, or ability to chew. In addition to head and facial disfigurement and deformity, other physical deformities may result in associated psychological problems (for example, depression). We evaluate the effects of head or facial disfigurement or deformity, or other physical deformities caused by skin disorders under the listings in 101.00, 102.00, 105.00, or 112.00, as appropriate.

5. *Porphyria.* We evaluate erythropoietic protoporphyria under the listings in 107.00.

6. *Hemangiomas.* We evaluate hemangiomas associated with thrombocytopenia and hemorrhage (for example, Kasabach-Merritt syndrome) involving coagulation defects under the listings in 107.00. When hemangiomas impinge on vital structures or interfere with functioning, we evaluate their primary effects under the listings in the appropriate body system.

I. *How do we evaluate skin disorders that do not meet one of these listings?*

1. These listings are only examples of common skin disorders that we consider severe enough to result in marked and severe limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §416.926 of this chapter. If your impairment(s) does not meet or medically equal a listing, we will also consider whether your impairment(s) functionally equals the listings. See §416.926a of this chapter. We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

108.01 Category of Impairments, Skin Disorders

108.02–108.06 [Reserved]

108.07 *Genetic photosensitivity disorders*, established as described in 108.00E. The requirements of this listing are met if either paragraph A or paragraph B is satisfied.

A. Xeroderma pigmentosum (see 108.00E1).

OR

B. Other genetic photosensitivity disorders (see 108.00E2) with either 1 or 2:

1. Chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) that cause an inability to function outside of a highly protective environment (see 108.00E4); or

2. Chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) causing chronic pain or other physical limitation(s) that result in impairment-related functional limitations (see 108.00D2), as evidenced by:

a. Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3); or

b. Inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3), and a documented medical need (see 108.00B4) for an assistive device (see 108.00B1) that requires the use of the other upper extremity; or

c. Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region); or

d. Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

108.08 *Burns* (see 108.00F). Burns that do not require continuing surgical management (see 108.00B6), or that have been documented by an acceptable medical source to have reached maximum therapeutic benefit and are no longer receiving surgical management, resulting in chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) causing chronic pain or other physical limitation(s) that result in impairment-related functional limitations (see 108.00D2), as evidenced by:

A. Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3).

OR

B. Inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3), and a documented medical need (see 108.00B4) for an assistive device (see 108.00B1) that requires the use of the other upper extremity.

OR

C. Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

OR

D. Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

108.09 *Chronic conditions of the skin or mucous membranes* (see 108.00G) resulting in:

A. Chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) causing chronic pain or other physical limitation(s) that persist despite adherence to prescribed medical treatment for 3 months (see 108.00D5b).

AND

B. Impairment-related functional limitations (see 108.00D2) demonstrated by 1, 2, 3, or 4:

1. Inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3); or

2. Inability to use one upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 108.00B5) due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3), and a documented medical need (see 108.00B4) for an assistive device (see 108.00B1) that requires the use of the other upper extremity; or

3. Inability to stand up from a seated position and maintain an upright position to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting at least two extremities (including when the limitations are due to involvement of the perineum or the inguinal region); or

4. Inability to maintain an upright position while standing or walking to the extent needed to independently initiate, sustain, and complete age-appropriate activities due to chronic skin lesions (see 108.00B2) or contractures (see 108.00B3) affecting both lower extremities (including when the limitations are due to involvement of the perineum or the inguinal region).

109.00 Endocrine Disorders

A. *What is an endocrine disorder?*

An endocrine disorder is a medical condition that causes a hormonal imbalance. When an endocrine gland functions abnormally, producing either too much of a specific hormone (hyperfunction) or too little (hypofunction), the hormonal imbalance can cause various complications in the body. The major glands of the endocrine system are the pituitary, thyroid, parathyroid, adrenal, and pancreas.

B. *How do we evaluate the effects of endocrine disorders?* The only listing in this body system addresses children from birth to the attainment of age 6 who have diabetes mellitus (DM) and require daily insulin. We evaluate other impairments that result from endocrine disorders under the listings for other body systems. For example:

1. *Pituitary gland disorders* can disrupt hormone production and normal functioning in other endocrine glands and in many body systems. The effects of pituitary gland disorders vary depending on which hormones are involved. For example, when pituitary growth hormone deficiency in growing children limits bone maturation and results in pathological short stature, we evaluate this linear growth impairment under 100.00. When pituitary hypofunction affects water and electrolyte balance in the kidney and leads to diabetes insipidus, we evaluate the effects of recurrent dehydration under 106.00.

2. *Thyroid gland disorders* affect the sympathetic nervous system and normal metabolism. We evaluate thyroid-related changes in linear growth under 100.00; thyroid-related changes in blood pressure and heart rate that cause cardiac arrhythmias or other cardiac dysfunction under 104.00; thyroid-related weight loss under 105.00; and cognitive limitations, mood disorders, and anxiety under 112.00.

3. *Parathyroid gland disorders* affect calcium levels in bone, blood, nerves, muscle, and

other body tissues. We evaluate parathyroid-related osteoporosis and fractures under 101.00; abnormally elevated calcium levels in the blood (hypercalcemia) that lead to cataracts under 102.00; kidney failure under 106.00; and recurrent abnormally low blood calcium levels (hypocalcemia) that lead to increased excitability of nerves and muscles, such as tetany and muscle spasms, under 111.00.

4. *Adrenal gland disorders* affect bone calcium levels, blood pressure, metabolism, and mental status. We evaluate adrenal-related linear growth impairments under 100.00; adrenal-related osteoporosis with fractures that compromises the ability to walk or to use the upper extremities under 101.00; adrenal-related hypertension that worsens heart failure or causes recurrent arrhythmias under 104.00; adrenal-related weight loss under 105.00; and mood disorders under 112.00.

5. *Diabetes mellitus and other pancreatic gland disorders* disrupt the production of several hormones, including insulin, that regulate metabolism and digestion. Insulin is essential to the absorption of glucose from the bloodstream into body cells for conversion into cellular energy. The most common pancreatic gland disorder is *diabetes mellitus* (DM). There are two major types of DM: type 1 and type 2. Both type 1 and type 2 DM are chronic disorders that can have serious, disabling complications that meet the duration requirement. Type 1 DM—previously known as ''juvenile diabetes'' or ''insulin-dependent diabetes mellitus'' (IDDM)—is an absolute deficiency of insulin secretion that commonly begins in childhood and continues throughout adulthood. Treatment of type 1 DM always requires lifelong daily insulin. With type 2 DM—previously known as ''adult-onset diabetes mellitus'' or ''non-insulin-dependent diabetes mellitus'' (NIDDM)—the body's cells resist the effects of insulin, impairing glucose absorption and metabolism. Type 2 is less common than type 1 DM in children, but physicians are increasingly diagnosing type 2 DM before age 18. Treatment of type 2 DM generally requires lifestyle changes, such as increased exercise and dietary modification, and sometimes insulin in addition to other medications. While both type 1 and type 2 DM are usually controlled, some children do not achieve good control for a variety of reasons including, but not limited to, hypoglycemia unawareness, other disorders that can affect blood glucose levels, inability to manage DM due to a mental disorder, or inadequate treatment.

a. *Hyperglycemia*. Both types of DM cause hyperglycemia, which is an abnormally high level of blood glucose that may produce acute and long-term complications. Acute complications of hyperglycemia include diabetic ketoacidosis. Long-term complications of chronic hyperglycemia include many conditions affecting various body systems but are rare in children.

b. *Diabetic ketoacidosis (DKA)*. DKA is an acute, potentially life-threatening complication of DM in which the chemical balance of the body becomes dangerously hyperglycemic and acidic. It results from a severe insulin deficiency, which can occur due to missed or inadequate daily insulin therapy or in association with an acute illness. It usually requires hospital treatment to correct the acute complications of dehydration, electrolyte imbalance, and insulin deficiency. You may have serious complications resulting from your treatment, which we evaluate under the affected body system. For example, we evaluate cardiac arrhythmias under 104.00, intestinal necrosis under 105.00, and cerebral edema and seizures under 111.00. Recurrent episodes of DKA in adolescents may result from mood or eating disorders, which we evaluate under 112.00.

c. *Hypoglycemia*. Children with DM may experience episodes of hypoglycemia, which is an abnormally low level of blood glucose. Most children age 6 and older recognize the symptoms of hypoglycemia and reverse them by consuming substances containing glucose; however, some do not take this step because of hypoglycemia unawareness. Severe hypoglycemia can lead to complications, including seizures or loss of consciousness, which we evaluate under 111.00, or altered mental status, cognitive deficits, and permanent brain damage, which we evaluate under 112.00.

C. *How do we evaluate DM in children?* Listing 109.08 is only for children with DM who have not attained age 6 and who require daily insulin. For all other children (that is, children with DM who are age 6 or older and require daily insulin, and children of any age with DM who do not require daily insulin), we follow our rules for determining whether the DM is severe, alone or in combination with another impairment, whether it meets or medically equals the criteria of a listing in another body system, or functionally equals the listings under the criteria in §416.926a of this chapter, considering the factors in §416.924a of this chapter. The management of DM in children can be complex and variable from day to day, and all children with DM require some level of adult supervision. For example, if a child age 6 or older has a medical need for 24-hour-a-day adult supervision of insulin treatment, food intake, and physical activity to ensure survival, we will find that the child's impairment functionally equals the listings based on the example in §416.926a(m)(2) of this chapter.

D. *How do we evaluate other endocrine disorders that do not have effects that meet or medically equal the criteria of any listing in other body systems?* If your impairment(s) does not meet or medically equal a listing in

another body system, we will consider whether your impairment(s) functionally equals the listings under the criteria in §416.926a, considering the factors in §416.924a. When we decide whether you continue to be disabled, we use the rules in §416.994a.

109.01 *Category of Impairments, Endocrine*

109.08 *Any type of diabetes mellitus in a child who requires daily insulin and has not attained age 6.* Consider under a disability until the attainment of age 6. Thereafter, evaluate the diabetes mellitus according to the rules in 109.00B5 and C.

110.00 Congenital Disorders That Affect Multiple Body Systems

A. *Which disorders do we evaluate under this body system?* We evaluate non-mosaic Down syndrome and catastrophic congenital disorders under this body system.

B. *What is non-mosaic Down syndrome?* Non-mosaic Down syndrome is a genetic disorder. Most children with non-mosaic Down syndrome have three copies of chromosome 21 in all of their cells (chromosome 21 trisomy); some have an extra copy of chromosome 21 attached to a different chromosome in all of their cells (chromosome 21 translocation). Virtually all children with non-mosaic Down syndrome have characteristic facial or other physical features, delayed physical development, and intellectual disability. Children with non-mosaic Down syndrome may also have congenital heart disease, impaired vision, hearing problems, and other disorders. We evaluate non-mosaic Down syndrome under 110.06. If you have non-mosaic Down syndrome documented as described in 110.00C, we consider you disabled from birth.

C. What evidence do we need to document non-mosaic Down syndrome under 110.06?

1. Under 110.06A, we will find you disabled based on laboratory findings.

a. To find that your disorder meets 110.06A, we need a copy of the laboratory report of karyotype analysis, which is the definitive test to establish non-mosaic Down syndrome. We will not purchase karyotype analysis. We will not accept a fluorescence in situ hybridization (FISH) test because it does not distinguish between the mosaic and non-mosaic forms of Down syndrome.

b. If a physician (see §§404.1513(a)(1) and 416.913(a)(1) of this chapter) has not signed the laboratory report of karyotype analysis, the evidence must also include a physician's statement that you have Down syndrome.

c. For purposes of 110.06A, we do not require evidence stating that you have the distinctive facial or other physical features of Down syndrome.

2. If we do not have a laboratory report of karyotype analysis documenting that you have non-mosaic Down syndrome, we may find you disabled under 110.06B or 110.06C.

a. Under 110.06B, we need a physician's report stating: (i) your karyotype diagnosis or evidence that documents your type of Down syndrome that is consistent with prior karyotype analysis (for example, reference to a diagnosis of ''trisomy 21'') and (ii) that you have the distinctive facial or other physical features of Down syndrome. We do not require a detailed description of the facial or other physical features of the disorder. However, we will not find that your disorder meets 110.06B if we have evidence—such as evidence of functioning inconsistent with the diagnosis—that indicates that you do not have non-mosaic Down syndrome.

b. If we do not have evidence of prior karyotype analysis (you did not have testing, or you had testing but we do not have information from a physician about the test results), we will find that your disorder meets 110.06C if we have: (i) a physician's report stating that you have the distinctive facial or other physical features of Down syndrome and (ii) evidence that your functioning is consistent with a diagnosis of non-mosaic Down syndrome. This evidence may include medical or nonmedical information about your physical and mental abilities, including information about your development, education, work history, or the results of psychological testing. However, we will not find that your disorder meets 110.06C if we have evidence—such as evidence of functioning inconsistent with the diagnosis—that indicates that you do not have non-mosaic Down syndrome.

D. *What are catastrophic congenital disorders?* Some catastrophic congenital disorders, such as anencephaly, cyclopia, chromosome 13 trisomy (Patau syndrome or trisomy D), and chromosome 18 trisomy (Edwards' syndrome or trisomy E), are usually expected to result in early death. Others such as cri du chat syndrome (chromosome 5p deletion syndrome) and the infantile onset form of Tay-Sachs disease interfere very seriously with development. We evaluate catastrophic congenital disorders under 110.08. The term ''very seriously'' in 110.08 has the same meaning as in the term ''extreme'' in §416.926a(e)(3) of this chapter.

E. *What evidence do we need under 110.08?*

We need one of the following to determine if your disorder meets 110.08A or B:

1. A laboratory report of the definitive test that documents your disorder (for example, genetic analysis or evidence of biochemical abnormalities) signed by a physician.

2. A laboratory report of the definitive test that documents your disorder that is not signed by a physician *and* a report from a physician stating that you have the disorder.

3. A report from a physician stating that you have the disorder with the typical clinical features of the disorder and that you had

definitive testing that documented your disorder. In this case, we will find that your disorder meets 110.08A or B unless we have evidence that indicates that you do not have the disorder.

4. If we do not have the definitive laboratory evidence we need under E1, E2, or E3, we will find that your disorder meets 110.08A or B if we have: (i) a report from a physician stating that you have the disorder and that you have the typical clinical features of the disorder, *and* (ii) other evidence that supports the diagnosis. This evidence may include medical or nonmedical information about your development and functioning.

5. For obvious catastrophic congenital anomalies that are expected to result in early death, such as anencephaly and cyclopia, we need evidence from a physician that demonstrates that the infant has the characteristic physical features of the disorder. In these rare cases, we do not need laboratory testing or any other evidence that confirms the disorder.

F. *How do we evaluate mosaic Down syndrome and other congenital disorders that affect multiple body systems?*

1. *Mosaic Down syndrome.* Approximately 2 percent of children with Down syndrome have the mosaic form. In mosaic Down syndrome, there are some cells with an extra copy of chromosome 21 and other cells with the normal two copies of chromosome 21. Mosaic Down syndrome can be so slight as to be undetected clinically, but it can also be profound and disabling, affecting various body systems.

2. *Other congenital disorders that affect multiple body systems.* Other congenital disorders, such as congenital anomalies, chromosomal disorders, dysmorphic syndromes, inborn metabolic syndromes, and perinatal infectious diseases, can cause deviation from, or interruption of, the normal function of the body or can interfere with development. Examples of these disorders include both the juvenile and late-onset forms of Tay-Sachs disease, trisomy X syndrome (XXX syndrome), fragile X syndrome, phenylketonuria (PKU), caudal regression syndrome, and fetal alcohol syndrome. For these disorders and other disorders like them, the degree of deviation, interruption, or interference, as well as the resulting functional limitations and their progression, may vary widely from child to child and may affect different body systems.

3. *Evaluating the effects of mosaic Down syndrome or another congenital disorder under the listings.* When the effects of mosaic Down syndrome or another congenital disorder that affects multiple body systems are sufficiently severe we evaluate the disorder under the appropriate affected body system(s), such as musculoskeletal, special senses and speech, neurological, or mental disorders. Otherwise, we evaluate the specific functional limitations that result from the disorder under our other rules described in 110.00G.

G. *What if your disorder does not meet a listing?* If you have a severe medically determinable impairment(s) that does not meet a listing, we will consider whether your impairment(s) medically equals a listing. See §416.926 of this chapter. If your impairment(s) does not meet or medically equal a listing, we will consider whether it functionally equals the listings. See §§416.924a and 416.926a of this chapter. We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

110.01 Category of Impairments, Congenital Disorders That Affect Multiple Body Systems

110.06 *Non-mosaic Down syndrome* (chromosome 21 trisomy or chromosome 21 translocation), documented by:

A. A laboratory report of karyotype analysis signed by a physician, or both a laboratory report of karyotype analysis not signed by a physician *and* a statement by a physician that the child has Down syndrome (see 110.00C1), or

B. A physician's report stating that the child has chromosome 21 trisomy or chromosome 21 translocation consistent with karyotype analysis with the distinctive facial or other physical features of Down syndrome (see 110.00C2a), or

C. A physician's report stating that the child has Down syndrome with the distinctive facial or other physical features *and* evidence demonstrating that the child is functioning at the level of a child with non-mosaic Down syndrome (see 110.00C2b).

110.08 *A catastrophic congenital disorder* (see 110.00D and 110.00E) with:

A. Death usually expected within the first months of life, or

B. Very serious interference with development or functioning.

111.00 Neurological Disorders

A. *Which neurological disorders do we evaluate under these listings?* We evaluate epilepsy, coma or persistent vegetative state (PVS), and neurological disorders that cause disorganization of motor function, bulbar and neuromuscular dysfunction, or communication impairment. Under this body system, we evaluate the limitations resulting from the impact of the neurological disease process itself. If you have a neurological disorder(s) that affects your physical and mental functioning, we will evaluate your impairments under the rules we use to determine functional equivalence. If your neurological disorder results in only mental impairment or if you have a co-occurring mental condition

that is not caused by your neurological disorder (for example, Autism spectrum disorder), we will evaluate your mental impairment under the mental disorders body system, 112.00.

B. *What evidence do we need to document your neurological disorder?*

1. We need both medical and non-medical evidence (signs, symptoms, and laboratory findings) to assess the effects of your neurological disorder. Medical evidence should include your medical history, examination findings, relevant laboratory tests, and the results of imaging. Imaging refers to medical imaging techniques, such as x-ray, computerized tomography (CT), magnetic resonance imaging (MRI), and electroencephalography (EEG). The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder. In addition, the medical evidence may include descriptions of any prescribed treatment and your response to it. We consider non-medical evidence such as statements you or others make about your impairments, your restrictions, your daily activities, or, if you are an adolescent, your efforts to work.

2. We will make every reasonable effort to obtain the results of your laboratory and imaging evidence. When the results of any of these tests are part of the existing evidence in your case record, we will evaluate the test results and all other relevant evidence. We will not purchase imaging, or other diagnostic tests or laboratory tests that are complex, may involve significant risk, or that are invasive. We will not routinely purchase tests that are expensive or not readily available.

C. *How do we consider adherence to prescribed treatment in neurological disorders*? In 111.02 (Epilepsy) and 111.12 (Myasthenia gravis), we require that limitations from these neurological disorders exist despite adherence to prescribed treatment. ''Despite adherence to prescribed treatment'' means that you have taken medication(s) or followed other treatment procedures for your neurological disorder(s) as prescribed by a physician for three consecutive months but your impairment continues to meet the other listing requirements despite this treatment. You may receive your treatment at a health care facility that you visit regularly, even if you do not see the same physician on each visit.

D. *What do we mean by disorganization of motor function?*

1. *Disorganization of motor function* means interference, due to your neurological disorder, with movement of two extremities; *i.e.,* the lower extremities, or upper extremities (including fingers, wrists, hands, arms, and shoulders). By two extremities we mean both lower extremities, or both upper extremities, or one upper extremity and one lower extremity. All listings in this body system, except for 111.02 (Epilepsy) and 111.20 (Coma and persistent vegetative state), include criteria for disorganization of motor function that results in an extreme limitation in your ability to:

a. Stand up from a seated position; or

b. Balance while standing or walking; or

c. Use the upper extremities (e.g., fingers, wrists, hands, arms, and shoulders).

2. *Extreme limitation* means the inability to stand up from a seated position, maintain balance in a standing position and while walking, or use your upper extremities to independently initiate, sustain, and complete age-appropriate activities. The assessment of motor function depends on the degree of interference with standing up; balancing while standing or walking; or using the upper extremities (including fingers, hands, arms, and shoulders).

a. Inability to stand up from a seated position means that once seated you are unable to stand and maintain an upright position without the assistance of another person or the use of an assistive device, such as a walker, two crutches, or two canes.

b. Inability to maintain balance in a standing position means that you are unable to maintain an upright position while standing or walking without the assistance of another person or an assistive device, such as a walker, two crutches, or two canes.

c. Inability to use your upper extremities means that you have a loss of function of both upper extremities (e.g., fingers, wrists, hands, arms, and shoulders) that very seriously limits your ability to independently initiate, sustain, and complete age- appropriate activities involving fine and gross motor movements. Inability to perform fine and gross motor movements could include not being able to pinch, manipulate, and use your fingers; or not being able to use your hands, arms, and shoulders to perform gross motor movements, such as handling, gripping, grasping, holding, turning, and reaching; or not being able to engage in exertional movements such a lifting, carrying, pushing, and pulling.

3. For children who are not yet able to balance, stand up, or walk independently, we consider their function based on assessments of limitations in the ability to perform comparable age-appropriate activities with the lower and upper extremities, given normal developmental milestones. For such children, an extreme level of limitation means developmental milestones at less than one-half of the child's chronological age.

E. *What do we mean by bulbar and neuromuscular dysfunction?* The bulbar region of the brain is responsible for controlling the bulbar muscles in the throat, tongue, jaw,

and face. Bulbar and neuromuscular dysfunction refers to weakness in these muscles, resulting in breathing, swallowing, and speaking impairments. Listings 111.12 (Myasthenia gravis) and 111.22 (Motor neuron disorders) include criteria for evaluating bulbar and neuromuscular dysfunction. If your neurological disorder has resulted in a breathing disorder, we may evaluate that condition under the respiratory system, 103.00.

F. *What is epilepsy, and how do we evaluate it under 111.02?*

1. *Epilepsy* is a pattern of recurrent and unprovoked seizures that are manifestations of abnormal electrical activity in the brain. There are various types of generalized and ''focal'' or partial seizures. In children, the most common potentially disabling seizure types are *generalized tonic-clonic seizures, dyscognitive seizures* (formerly complex partial seizures), *and absence seizures*. However, psychogenic nonepileptic seizures and pseudoseizures are not epileptic seizures for the purpose of 111.02. We evaluate psychogenic seizures and pseudoseizures under the mental disorders body system, 112.00.

a. *Generalized tonic-clonic seizures* are characterized by loss of consciousness accompanied by a tonic phase (sudden muscle tensing causing the child to lose postural control) followed by a clonic phase (rapid cycles of muscle contraction and relaxation, also called convulsions). Tongue biting and incontinence may occur during generalized tonic-clonic seizures, and injuries may result from falling.

b. *Dyscognitive seizures* are characterized by alteration of consciousness without convulsions or loss of muscle control. During the seizure, blank staring, change of facial expression, and automatisms (such as lip smacking, chewing or swallowing, or repetitive simple actions, such as gestures or verbal utterances) may occur. During its course, a dyscognitive seizure may progress into a generalized tonic-clonic seizure (see 111.00F1a).

c. *Absence seizures (petit mal)* are also characterized by an alteration in consciousness, but are shorter than other generalized seizures (e.g., tonic-clonic and dyscognitive) seizures, generally lasting for only a few seconds rather than minutes. They may present with blank staring, change of facial expression, lack of awareness and responsiveness, and a sense of lost time after the seizure. An aura never precedes absence seizures. Although absence seizures are brief, frequent occurrence may limit functioning. This type of seizure usually does not occur after adolescence.

d. *Febrile seizures* may occur in young children in association with febrile illnesses. We will consider seizures occurring during febrile illnesses. To meet 111.02, we require documentation of seizures during nonfebrile periods and epilepsy must be established.

2. *Description of seizure.* We require at least one detailed description of your seizures from someone, preferably a medical professional, who has observed at least one of your typical seizures. If you experience more than one type of seizure, we require a description of each type.

3. *Serum drug levels.* We do not require serum drug levels; therefore, we will not purchase them. However, if serum drug levels are available in your medical records, we will evaluate them in the context of the other evidence in your case record.

4. *Counting seizures.* The period specified in 111.02A or B cannot begin earlier than one month after you began prescribed treatment. The required number of seizures must occur within the period we are considering in connection with your application or continuing disability review. When we evaluate the frequency of your seizures, we also consider your adherence to prescribed treatment (see 111.00C). When we determine the number of seizures you have had in the specified period, we will:

a. Count multiple seizures occurring in a 24-hour period as one seizure.

b. Count status epilepticus (a continuous series of seizures without return to consciousness between seizures) as one seizure.

c. Count a dyscognitive seizure that progresses into a generalized tonic-clonic seizure as one generalized tonic-clonic seizure.

d. We do not count seizures that occur during a period when you are not adhering to prescribed treatment without good reason. When we determine that you had a good reason for not adhering to prescribed treatment, we will consider your physical, mental, educational, and communicative limitations (including any language barriers). We will consider you to have good reason for not following prescribed treatment if, for example, the treatment is very risky for you due to its consequences or unusual nature, or if you are unable to afford prescribed treatment that you are willing to accept, but for which no free community resources are available. We will follow guidelines found in our policy, such as §416.930(c) of this chapter, when we determine whether you have a good reason for not adhering to prescribed treatment.

e. We do not count psychogenic nonepileptic seizures or pseudoseizures under 111.02.We evaluate these seizures under the mental disorders body system, 112.00.

5. *Electroencephalography (EEG) testing.* We do not require EEG test results; therefore, we will not purchase them. However, if EEG test results are available in your medical records, we will evaluate them in the context of the other evidence in your case record.

G. *What is vascular insult to the brain, and how do we evaluate it under 111.04?*

1. *Vascular insult to the brain* (cerebrum, cerebellum, or brainstem), commonly referred to as stroke or cerebrovascular accident (CVA), is brain cell death caused by an interruption of blood flow within or leading to the brain, or by a hemorrhage from a ruptured blood vessel or aneurysm in the brain. If you have a vision impairment resulting from your vascular insult, we may evaluate that impairment under the special senses body system, 102.00.

2. We generally need evidence from at least 3 months after the vascular insult to determine whether you have disorganization of motor function under 111.04. In some cases, evidence of your vascular insult is sufficient to allow your claim within 3 months post-vascular insult. If we are unable to allow your claim within 3 months after your vascular insult, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-vascular insult.

H. *What are benign brain tumors, and how do we evaluate them under 111.05?* Benign brain tumors are noncancerous (nonmalignant) abnormal growths of tissue in or on the brain that invade healthy brain tissue or apply pressure on the brain or cranial nerves. We evaluate their effects on your functioning as discussed in 111.00D. We evaluate malignant brain tumors under the cancer body system in 113.00. If you have a vision impairment resulting from your benign brain tumor, we may evaluate that impairment under the special senses body system, 102.00.

I. *What is cerebral palsy, and how do we evaluate it under 111.07?*

1. *Cerebral palsy (CP)* is a term that describes a group of static, nonprogressive disorders caused by abnormalities within the brain that disrupt the brain's ability to control movement, muscle coordination, and posture. The resulting motor deficits manifest very early in a child's development, with delayed or abnormal progress in attaining developmental milestones; deficits may become more obvious as the child grows and matures over time.

2. We evaluate your signs and symptoms, such as ataxia, spasticity, flaccidity, athetosis, chorea, and difficulty with precise movements when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements. We will also evaluate your signs, such as dysarthria and apraxia of speech, and receptive and expressive language problems when we determine your ability to communicate.

3. We will consider your other impairments or signs and symptoms that develop secondary to the disorder, such as post-impairment syndrome (a combination of pain, fatigue, and weakness due to muscle abnormalities); overuse syndromes (repetitive motion injuries); arthritis; abnormalities of proprioception (perception of the movements and position of the body); abnormalities of stereognosis (perception and identification of objects by touch); learning problems; anxiety; and depression.

J. *What are spinal cord disorders, and how do we evaluate them under 111.08?*

1. *Spinal cord disorders* may be congenital or caused by injury to the spinal cord. Motor signs and symptoms of spinal cord disorders include paralysis, flaccidity, spasticity, and weakness.

2. *Spinal cord disorders with complete loss of function* (111.08A) addresses spinal cord disorders that result in complete lack of motor, sensory, and autonomic function of the affected part(s) of the body.

3. *Spinal cord disorders with disorganization of motor function* (111.08B) addresses spinal cord disorders that result in less than complete loss of function of the affected part(s) of the body, reducing, but not eliminating, motor, sensory, and autonomic function.

4. When we evaluate your spinal cord disorder, we generally need evidence from at least 3 months after your symptoms began in order to evaluate your disorganization of motor function. In some cases, evidence of your spinal cord disorder may be sufficient to allow your claim within 3 months after the spinal cord disorder. If the medical evidence demonstrates total cord transection causing a loss of motor and sensory functions below the level of injury, we will not wait 3 months but will make the allowance decision immediately.

K. *What are communication impairments associated with neurological disorders, and how do we evaluate them under 111.09*?

1. Communication impairments result from medically determinable neurological disorders that cause dysfunction in the parts of the brain responsible for speech and language. Under 111.09, we must have recent comprehensive evaluation including all areas of affective and effective communication, performed by a qualified professional, to document a communication impairment associated with a neurological disorder.

2. Under 111.09A, we need documentation from a qualified professional that your neurological disorder has resulted in a speech deficit that significantly affects your ability to communicate. *Significantly affects* means that you demonstrate a serious limitation in communicating, and a person who is unfamiliar with you cannot easily understand or interpret your speech.

3. Under 111.09B, we need documentation from a qualified professional that shows that your neurological disorder has resulted in a comprehension deficit that results in ineffective verbal communication for your age. For the purposes of 111.09B, *comprehension deficit* means a deficit in receptive language. Ineffective verbal communication means that you demonstrate serious limitation in your ability to communicate orally on the same

level as other children of the same age and level of development.

4. Under 111.09C, we need documentation of a neurological disorder that has resulted in hearing loss. Your hearing loss will be evaluated under listing 102.10 or 102.11.

5. We evaluate speech deficits due to nonneurological disorders under 2.09.

L. *What are neurodegenerative disorders of the central nervous system, such as Juvenile-onset Huntington's disease and Friedreich's ataxia, and how do we evaluate them under 111.17?* Neurodegenerative disorders of the central nervous system are disorders characterized by progressive and irreversible degeneration of neurons or their supporting cells. Over time, these disorders impair many of the body's motor or cognitive and other mental functions. We consider neurodegenerative disorders of the central nervous system under 111.17 that we do not evaluate elsewhere in section 111.00, such as juvenile-onset Huntington's disease (HD) and Friedreich's ataxia. When these disorders result in solely cognitive and other mental functional limitations, we will evaluate the disorder under the mental disorder listings, 112.00.

M. *What is traumatic brain injury, and how do we evaluate it under 111.18?*

1. *Traumatic brain injury (TBI)* is damage to the brain resulting from skull fracture, collision with an external force leading to a closed head injury, or penetration by an object that enters the skull and makes contact with brain tissue. We evaluate a TBI that results in coma or persistent vegetative state (PVS) under 111.20.

2. We generally need evidence from at least 3 months after the TBI to evaluate whether you have disorganization of motor function under 111.18. In some cases, evidence of your TBI is sufficient to determine disability. If we are unable to allow your claim within 3 months post-TBI, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-TBI. If a finding of disability still is not possible at that time, we will again defer adjudication of the claim until we obtain evidence at least 6 months after your TBI.

N. *What are coma and persistent vegetative state, and how do we evaluate them under 111.20?* Coma is a state of unconsciousness in which a child does not exhibit a sleep/wake cycle, and is unable to perceive or respond to external stimuli. Children who do not fully emerge from coma may progress into persistent vegetative state (PVS). PVS is a condition of partial arousal in which a child may have a low level of consciousness but is still unable to react to external stimuli. In contrast to coma, a child in a PVS retains sleep/wake cycles and may exhibit some key lower brain functions, such as spontaneous movement, opening and moving eyes, and grimacing. Coma or PVS may result from a TBI, a nontraumatic insult to the brain (such as a vascular insult, infection, or brain tumor), or a neurodegenerative or metabolic disorder. Medically induced comas should be considered under the section pertaining to the underlying reason the coma was medically induced and not under this section.

O. *What is multiple sclerosis, and how do we evaluate it under 111.21?*

1. *Multiple sclerosis (MS)* is a chronic, inflammatory, degenerative disorder that damages the myelin sheath surrounding the nerve fibers in the brain and spinal cord. The damage disrupts the normal transmission of nerve impulses within the brain and between the brain and other parts of the body causing impairment in muscle coordination, strength, balance, sensation, and vision. There are several forms of MS, ranging from slightly to highly aggressive. Milder forms generally involve acute attacks (exacerbations) with partial or complete recovery from signs and symptoms (remissions). Aggressive forms generally exhibit a steady progression of signs and symptoms with few or no remissions. The effects of all forms vary from child to child.

2. We evaluate your signs and symptoms, such as flaccidity, spasticity, spasms, incoordination, imbalance, tremor, physical fatigue, muscle weakness, dizziness, tingling, and numbness when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements, such as using your arms, hands, and fingers. If you have a vision impairment resulting from your MS, we may evaluate that impairment under the special senses body system, 102.00.

P. *What are motor neuron disorders, and how do we evaluate them under 111.22?* Motor neuron disorders are progressive neurological disorders that destroy the cells that control voluntary muscle activity, such as walking, breathing, swallowing, and speaking. The most common motor neuron disorders in children are progressive bulbar palsy and spinal muscular dystrophy syndromes. We evaluate the effects of these disorders on motor functioning or bulbar and neuromuscular functioning.

Q. *How do we consider symptoms of fatigue in these listings?* Fatigue is one of the most common and limiting symptoms of some neurological disorders, such as multiple sclerosis and myasthenia gravis. These disorders may result in physical fatigue (lack of muscle strength) or mental fatigue (decreased awareness or attention). When we evaluate your fatigue, we will consider the intensity, persistence, and effects of fatigue on your functioning. This may include information such as the clinical and laboratory data and other objective evidence concerning your neurological deficit, a description of fatigue considered characteristic of your disorder, and information about your functioning. We consider the effects of physical fatigue on

your ability to stand up, balance, walk, or perform fine and gross motor movements using the criteria described in 111.00D.

R. *How do we evaluate your neurological disorder when it does not meet one of these listings?*

1. If your neurological disorder does not meet the criteria of any of these listings, we must also consider whether your impairment(s) meets the criteria of a listing in another body system. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §416.926 of this chapter.

2. If your impairment(s) does not meet or medically equal a listing, we will consider whether your impairment(s) functionally equals the listings. See §416.926a of this chapter.

3. We use the rules in §416.994a of this chapter when we decide whether you continue to be disabled.

111.01 Category of Impairments, Neurological Disorders

111.02 *Epilepsy*, documented by a detailed description of a typical seizure and characterized by A or B:

A. Generalized tonic-clonic seizures (see 111.00F1a), occurring at least once a month for at least 3 consecutive months (see 111.00F4) despite adherence to prescribed treatment (see 111.00C); or

B. Dyscognitive seizures (see 111.00F1b) or absence seizures (see 111.00F1c), occurring at least once a week for at least 3 consecutive months (see 111.00F4) despite adherence to prescribed treatment (see 111.00C).

111.03 [Reserved]

111.04 *Vascular insult to the brain*, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the insult.

111.05 *Benign brain tumors*, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.06 [Reserved]

111.07 *Cerebral palsy*, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.08 *Spinal cord disorders*, characterized by A or B:

A. Complete loss of function, as described in 111.00J2, persisting for 3 consecutive months after the disorder (see 111.00J4); or

B. Disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities persisting for 3 consecutive months after the disorder (see 111.00J4).

111.09 *Communication impairment*, associated with documented neurological disorder and one of the following:

A. Documented speech deficit that significantly affects (see 111.00K1) the clarity and content of the speech; or

B. Documented comprehension deficit resulting in ineffective verbal communication (see 111.00K2) for age; or

C. Impairment of hearing as described under the criteria in 102.10 or 102.11.

111.10 [Reserved]

111.11 [Reserved]

111.12 *Myasthenia gravis*, characterized by A or B despite adherence to prescribed treatment for at least 3 months (see 111.00C):

A. Disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Bulbar and neuromuscular dysfunction (see 111.00E), resulting in:

1. One myasthenic crisis requiring mechanical ventilation; or

2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter.

111.13 *Muscular dystrophy*, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.14 *Peripheral neuropathy*, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.15 [Reserved]

111.16 [Reserved]

111.17 *Neurodegenerative disorders of the central nervous system, such as Juvenile-onset Huntington's disease and Friedreich's ataxia*, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.18 *Traumatic brain injury*, characterized by disorganization of motor function in

two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the injury.

111.19 [Reserved]

111.20 *Coma or persistent vegetative state*, persisting for at least 1 month.

111.21 *Multiple sclerosis*, characterized by disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

111.22 *Motor neuron disorders*, characterized by A or B:

A. Disorganization of motor function in two extremities (see 111.00D1), resulting in an extreme limitation (see 111.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities; or

B. Bulbar and neuromuscular dysfunction (see 111.00E), resulting in:

1. Acute respiratory failure requiring invasive mechanical ventilation; or

2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter.

112.00 Mental Disorders

A. *How are the listings for mental disorders for children arranged, and what do they require?*

1. The listings for mental disorders for children are arranged in 12 categories: neurocognitive disorders (112.02); schizophrenia spectrum and other psychotic disorders (112.03); depressive, bipolar and related disorders (112.04); intellectual disorder (112.05); anxiety and obsessive-compulsive disorders (112.06); somatic symptom and related disorders (112.07); personality and impulse-control disorders (112.08); autism spectrum disorder (112.10); neurodevelopmental disorders (112.11); eating disorders (112.13); developmental disorders in infants and toddlers (112.14); and trauma- and stressor-related disorders (112.15). All of these listings, with the exception of 112.14, apply to children from age three to attainment of age 18. Listing 112.14 is for children from birth to attainment of age 3.

2. Listings 112.07, 112.08, 112.10, 112.11, 112.13, and 112.14 have two paragraphs, designated A and B; your mental disorder must satisfy the requirements of both paragraphs A and B. Listings 112.02, 112.03, 112.04, 112.06, and 112.15 have three paragraphs, designated A, B, and C; your mental disorder must satisfy the requirements of both paragraphs A and B, or the requirements of both paragraphs A and C. Listing 112.05 has two paragraphs that are unique to that listing (see 112.00A3); your mental disorder must satisfy the requirements of either paragraph A or paragraph B.

a. Paragraph A of each listing (except 112.05) includes the medical criteria that must be present in your medical evidence.

b. Paragraph B of each listing (except 112.05) provides the functional criteria we assess to evaluate how your mental disorder limits your functioning. For children ages 3 to 18, these criteria represent the areas of mental functioning a child uses to perform age-appropriate activities. They are: understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. (See 112.00I for a discussion of the criteria for children from birth to attainment of age 3 under 112.14.) We will determine the degree to which your medically determinable mental impairment affects the four areas of mental functioning and your ability to function age-appropriately in a manner comparable to that of other children your age who do not have impairments. (Hereinafter, the words ''age-appropriately'' incorporate the qualifying statement, ''in a manner comparable to that of other children your age who do not have impairments.'') To satisfy the paragraph B criteria, your mental disorder must result in ''extreme'' limitation of one, or ''marked'' limitation of two, of the four areas of mental functioning. (When we refer to ''paragraph B criteria'' or ''area[s] of mental functioning'' in the introductory text of this body system, we mean the criteria in paragraph B of every listing except 112.05 and 112.14.)

c. Paragraph C of listings 112.02, 112.03, 112.04, 112.06, and 112.15 provides the criteria we use to evaluate ''serious and persistent mental disorders.'' To satisfy the paragraph C criteria, your mental disorder must be ''serious and persistent''; that is, there must be a medically documented history of the existence of the disorder over a period of at least 2 years, and evidence that satisfies the criteria in both C1 and C2 (see 112.00G). (When we refer to ''paragraph C'' or ''the paragraph C criteria'' in the introductory text of this body system, we mean the criteria in paragraph C of listings 112.02, 112.03, 112.04, 112.06, and 112.15.)

3. Listing 112.05 has two paragraphs, designated A and B, that apply to only intellectual disorder. Each paragraph requires that you have significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning.

B. *Which mental disorders do we evaluate under each listing category for children?*

1. *Neurocognitive disorders (112.02).*

a. These disorders are characterized in children by a clinically significant deviation in normal cognitive development or by a decline in cognitive functioning. Symptoms and signs may include, but are not limited

to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decision-making), visual-spatial functioning, language and speech, perception, insight, and judgment.

b. Examples of disorders that we evaluate in this category include major neurocognitive disorder; mental impairments resulting from medical conditions such as a metabolic disease (for example, juvenile Tay-Sachs disease), human immunodeficiency virus infection, vascular malformation, progressive brain tumor, or traumatic brain injury; or substance-induced cognitive disorder associated with drugs of abuse, medications, or toxins. (We evaluate neurological disorders under that body system (see 111.00). We evaluate cognitive impairments that result from neurological disorders under 112.02 if they do not satisfy the requirements in 111.00. We evaluate catastrophic genetic disorders under listings in 110.00, 111.00, or 112.00, as appropriate. We evaluate genetic disorders that are not catastrophic under the affected body system(s).)

c. This category does not include the mental disorders that we evaluate under intellectual disorder (112.05), autism spectrum disorder (112.10), and neurodevelopmental disorders (112.11).

2. *Schizophrenia spectrum and other psychotic disorders (112.03).*

a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood, odd beliefs and mannerisms, and paranoia.

b. Examples of disorders that we evaluate in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to another medical condition.

3. *Depressive, bipolar and related disorders (112.04).*

a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, sadness, euphoria, and social withdrawal. Depending on a child's age and developmental stage, certain features, such as somatic complaints, irritability, anger, aggression, and social withdrawal may be more commonly present than other features.

b. Examples of disorders that we evaluate in this category include bipolar disorders (I or II), cyclothymic disorder, disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), and bipolar or depressive disorder due to another medical condition.

4. *Intellectual disorder (112.05).*

a. This disorder is characterized by significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning. Signs may include, but are not limited to, poor conceptual, social, or practical skills evident in your adaptive functioning.

b. The disorder that we evaluate in this category may be described in the evidence as intellectual disability, intellectual developmental disorder, or historically used terms such as ''mental retardation.''

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), autism spectrum disorder (112.10), or neurodevelopmental disorders (112.11).

5. *Anxiety and obsessive-compulsive disorders (112.06).*

a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or people. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent physical complaints. Depending on a child's age and developmental stage, other features may also include refusal to go to school, academic failure, frequent stomachaches and other physical complaints, extreme worries about sleeping away from home, being overly clinging, and exhibiting tantrums at times of separation from caregivers.

b. Examples of disorders that we evaluate in this category include separation anxiety disorder, social anxiety disorder, panic disorder, generalized anxiety disorder, agoraphobia, and obsessive-compulsive disorder.

c. This category does not include the mental disorders that we evaluate under trauma- and stressor-related disorders (112.15).

6. *Somatic symptom and related disorders (112.07).*

a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the direct effects of a substance, or a culturally sanctioned behavior or experience. Symptoms

and signs may include, but are not limited to, pain and other abnormalities of sensation, gastrointestinal symptoms, fatigue, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.

b. Examples of disorders that we evaluate in this category include somatic symptom disorder and conversion disorder.

7. *Personality and impulse-control disorders (112.08).*

a. These disorders are characterized by enduring, inflexible, maladaptive, and pervasive patterns of behavior. Onset may occur in childhood but more typically occurs in adolescence or young adulthood. Symptoms and signs may include, but are not limited to, patterns of distrust, suspiciousness, and odd beliefs; social detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; and inappropriate, intense, impulsive anger and behavioral expression grossly out of proportion to any external provocation or psychosocial stressors.

b. Examples of disorders that we evaluate in this category include paranoid, schizoid, schizotypal, borderline, avoidant, dependent, obsessive-compulsive personality disorders, and intermittent explosive disorder.

8. *Autism spectrum disorder (112.10).*

a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative play; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and stagnation of development or loss of acquired skills. Symptoms and signs may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.

b. Examples of disorders that we evaluate in this category include autism spectrum disorder with or without accompanying intellectual impairment, and autism spectrum disorder with or without accompanying language impairment.

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), intellectual disorder (112.05), and neurodevelopmental disorders (112.11).

9. *Neurodevelopmental disorders (112.11).*

a. These disorders are characterized by onset during the developmental period, that is, during childhood or adolescence, although sometimes they are not diagnosed until adulthood. Symptoms and signs may include, but are not limited to, underlying abnormalities in cognitive processing (for example, deficits in learning and applying verbal or nonverbal information, visual perception, memory, or a combination of these); deficits in attention or impulse control; low frustration tolerance; excessive or poorly planned motor activity; difficulty with organizing (time, space, materials, or tasks); repeated accidental injury; and deficits in social skills. Symptoms and signs specific to tic disorders include sudden, rapid, recurrent, non-rhythmic, motor movement or vocalization.

b. Examples of disorders that we evaluate in this category include specific learning disorder, borderline intellectual functioning, and tic disorders (such as Tourette syndrome).

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), autism spectrum disorder (112.10), or personality and impulse-control disorders (112.08).

10. *Eating disorders (112.13).*

a. These disorders are characterized in young children by persistent eating of nonnutritive substances or repeated episodes of regurgitation and re-chewing of food, or by persistent failure to consume adequate nutrition by mouth. In adolescence, these disorders are characterized by disturbances in eating behavior and preoccupation with, and excessive self-evaluation of, body weight and shape. Symptoms and signs may include, but are not limited to, failure to make expected weight gains; restriction of energy consumption when compared with individual requirements; recurrent episodes of binge eating or behavior intended to prevent weight gain, such as self-induced vomiting, excessive exercise, or misuse of laxatives; mood disturbances, social withdrawal, or irritability; amenorrhea; dental problems; abnormal laboratory findings; and cardiac abnormalities.

b. Examples of disorders that we evaluate in this category include anorexia nervosa, bulimia nervosa, binge-eating disorder, and avoidant/restrictive food disorder.

11. *Developmental disorders in infants and toddlers (112.14).*

a. Developmental disorders are characterized by a delay or deficit in the development of age-appropriate skills, or a loss of previously acquired skills, involving motor planning and control, learning, relating and communicating, and self-regulating.

b. Examples of disorders that we evaluate in this category include developmental coordination disorder, separation anxiety disorder, autism spectrum disorder, and regulation disorders of sensory processing (difficulties in regulating emotions, behaviors, and motor abilities in response to sensory stimulation). Some infants and toddlers may have only a general diagnosis of ''developmental delay.''

c. This category does not include eating disorders related to low birth weight and

failure to thrive, which we evaluate under that body system (100.00).

12. *Trauma- and stressor-related disorders (112.15).*

a. These disorders are characterized by experiencing or witnessing a traumatic or stressful event, or learning of a traumatic event occurring to a close family member or close friend, and the psychological aftermath of clinically significant effects on functioning. Symptoms and signs may include, but are not limited to, distressing memories, dreams, and flashbacks related to the trauma or stressor; avoidant or withdrawn behavior; constriction of play and significant activities; increased frequency of negative emotional states (for example, fear, sadness) or reduced expression of positive emotions (for example, satisfaction, affection); anxiety; irritability; aggression; exaggerated startle response; difficulty concentrating; sleep disturbance; and a loss of previously acquired developmental skills.

b. Examples of disorders that we evaluate in this category include posttraumatic stress disorder, reactive attachment disorder, and other specified trauma- and stressor-related disorders (such as adjustment-like disorders with prolonged duration without prolonged duration of stressor).

c. This category does not include the mental disorders that we evaluate under anxiety and obsessive-compulsive disorders (112.06), and cognitive impairments that result from neurological disorders, such as a traumatic brain injury, which we evaluate under neurocognitive disorders (112.02).

C. *What evidence do we need to evaluate your mental disorder?*

1. *General.* We need objective medical evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function age-appropriately. We will determine the extent and kinds of evidence we need from medical and nonmedical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (112.05), see 112.00H. For our basic rules on evidence, see §§ 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating medical opinions, see §§ 416.1520c and 416.927 of this chapter. For our rules on evidence about your symptoms, see § 416.929 of this chapter.

2. *Evidence from medical sources.* We will consider all relevant medical evidence about your disorder from your physician, psychologist, and other medical sources, which include health care providers such as physician assistants, psychiatric nurse practitioners, licensed clinical social workers, and clinical mental health counselors. Evidence from your medical sources may include:

a. Your reported symptoms.

b. Your developmental, medical, psychiatric, and psychological history.

c. The results of physical or mental status examinations, structured clinical interviews, psychiatric or psychological rating scales, measures of adaptive functioning, or other clinical findings.

d. Developmental assessments, psychological testing, imaging results, or other laboratory findings.

e. Your diagnosis.

f. The type, dosage, and beneficial effects of medications you take.

g. The type, frequency, duration, and beneficial effects of therapy you receive.

h. Side effects of medication or other treatment that limit your ability to function.

i. Your clinical course, including changes in your medication, therapy, or other treatment, and the time required for therapeutic effectiveness.

j. Observations and descriptions of how you function during examinations or therapy.

k. Information about sensory, motor, or speech abnormalities, or about your cultural background (for example, language or customs) that may affect an evaluation of your mental disorder.

l. The expected duration of your symptoms and signs and their effects on your ability to function age-appropriately, both currently and in the future.

3. *Evidence from you and people who know you.* We will consider all relevant evidence about your mental disorder and your daily functioning that we receive from you and from people who know you. If you are too young or unable to describe your symptoms and your functioning, we will ask for a description from the person who is most familiar with you. We will ask about your symptoms, your daily functioning, and your medical treatment. We will ask for information from third parties who can tell us about your mental disorder, but we must have permission to do so. This evidence may include information from your family, caregivers, teachers, other educators, neighbors, clergy, case managers, social workers, shelter staff, or other community support and outreach workers. We will consider whether your statements and the statements from third parties are consistent with the medical and other evidence we have.

4. *Evidence from early intervention programs, school, vocational training, work, and work-related programs.*

a. *Early intervention programs.* You may receive services in an Early Intervention Program (EIP) to help you with your developmental needs. If so, we will consider information from your Individualized Family Service Plan (IFSP) and the early intervention specialists who help you.

b. *School.* You may receive special education or related services at your preschool

or school. If so, we will try to obtain information from your school sources when we need it to assess how your mental disorder affects your ability to function. Examples of this information include your Individualized Education Programs (IEPs), your Section 504 plans, comprehensive evaluation reports, school-related therapy progress notes, information from your teachers about how you function in a classroom setting, and information from special educators, nurses, school psychologists, and occupational, physical, and speech/language therapists about any special education services or accommodations you receive at school.

c. *Vocational training, work, and work-related programs.* You may have recently participated in or may still be participating in vocational training, work-related programs, or work activity. If so, we will try to obtain information from your training program or your employer when we need it to assess how your mental disorder affects your ability to function. Examples of this information include training or work evaluations, modifications to your work duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, sheltered or supported work program, rehabilitation program, or transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work (see 112.00D).

5. *Need for longitudinal evidence.*

a. *General.* Longitudinal medical evidence can help us learn how you function over time, and help us evaluate any variations in the level of your functioning. We will request longitudinal evidence of your mental disorder when your medical providers have records concerning you and your mental disorder over a period of months or perhaps years (see §416.912(d) of this chapter).

b. *Non-medical sources of longitudinal evidence.* Certain situations, such as chronic homelessness, may make it difficult for you to provide longitudinal medical evidence. If you have a severe mental disorder, you will probably have evidence of its effects on your functioning over time, even if you have not had an ongoing relationship with the medical community or are not currently receiving treatment. For example, family members, caregivers, teachers, neighbors, former employers, social workers, case managers, community support staff, outreach workers, or government agencies may be familiar with your mental health history. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so.

c. *Absence of longitudinal evidence.* In the absence of longitudinal evidence, we will use current objective medical evidence and all other relevant evidence available to us in your case record to evaluate your mental disorder. If we purchase a consultative examination to document your disorder, the record will include the results of that examination (see §416.914 of this chapter). We will take into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you do not have longitudinal evidence, the current evidence alone may not be sufficient or appropriate to show that you have a disorder that meets the criteria of one of the mental disorders listings. In that case, we will follow the rules in 112.00K.

6. *Evidence of functioning in unfamiliar situations or supportive situations.*

a. *Unfamiliar situations.* We recognize that evidence about your functioning in unfamiliar situations does not necessarily show how you would function on a sustained basis in a school or other age-appropriate setting. In one-time, time-limited, or other unfamiliar situations, you may function differently than you do in familiar situations. In unfamiliar situations, you may appear more, or less, limited than you do on a daily basis and over time.

b. *Supportive situations.* Your ability to function in settings that are highly structured, or that are less demanding or more supportive than settings in which children your age without impairments typically function, does not necessarily demonstrate your ability to function age-appropriately.

c. *Our assessment.* We must assess your ability to function age-appropriately by evaluating all the evidence, such as reports about your functioning from third parties who are familiar with you, with an emphasis on how well you can initiate, sustain, and complete age-appropriate activities despite your impairment(s), compared to other children your age who do not have impairments.

D. *How do we consider psychosocial supports, structured settings, living arrangements, and treatment when we evaluate the functioning of children?*

1. *General.* Psychosocial supports, structured settings, and living arrangements, including assistance from your family or others, may help you by reducing the demands made on you. In addition, treatment you receive may reduce your symptoms and signs and possibly improve your functioning, or may have side effects that limit your functioning. Therefore, when we evaluate the effects of your mental disorder and rate the limitation of your areas of mental functioning, we will consider the kind and extent of supports you receive, the characteristics of any structured setting in which you spend your time (compared to children your age without impairments), and the effects of any treatment. This evidence may come from reports about your functioning from third parties who are familiar with you, and other

third-party statements or information. Following are some examples of the supports you may receive:

a. You receive help from family members or other people in ways that children your age without impairments typically do not need in order to function age-appropriately. For example, an aide may accompany you on the school bus to help you control your actions or to monitor you to ensure you do not injure yourself or others.

b. You receive one-on-one assistance in your classes every day; or you have a full-time personal aide who helps you to function in your classroom; or you are a student in a self-contained classroom; or you attend a separate or alternative school where you receive special education services.

c. You participate in a special education or vocational training program, or a psychosocial rehabilitation day treatment or community support program, where you receive training in daily living and entry-level work skills.

d. You participate in a sheltered, supported, or transitional work program, or in a competitive employment setting with the help of a job coach or supervisor.

e. You receive comprehensive ''24/7 wrap-around'' mental health services while living in a group home or transitional housing, while participating in a semi-independent living program, or while living at home.

f. You live in a residential school, hospital, or other institution with 24-hour care.

g. You receive assistance from a crisis response team, social workers, or community mental health workers who help you meet your physical needs, and who may also represent you in dealings with government or community social services.

2. *How we consider different levels of support and structure in psychosocial rehabilitation programs.*

a. Psychosocial rehabilitation programs are based on your specific needs. Therefore, we cannot make any assumptions about your mental disorder based solely on the fact that you are associated with such a program. We must know the details of the program(s) in which you are involved and the pattern(s) of your involvement over time.

b. The kinds and levels of supports and structures in psychosocial rehabilitation programs typically occur on a scale of ''most restrictive'' to ''least restrictive.'' Participation in a psychosocial rehabilitation program at the most restrictive level would suggest greater limitation of your areas of mental functioning than would participation at a less restrictive level. The length of time you spend at different levels in a program also provides information about your functioning. For example, you could begin participation at the most restrictive crisis intervention level but gradually improve to the point of readiness for a lesser level of support and structure and, if you are an older adolescent, possibly some form of employment.

3. *How we consider the help or support you receive.*

a. We will consider the complete picture of your daily functioning, including the kinds, extent, and frequency of help and support you receive, when we evaluate your mental disorder and determine whether you are able to use the four areas of mental functioning age-appropriately. The fact that you have done, or currently do, some routine activities without help or support does not necessarily mean that you do not have a mental disorder or that you are not disabled. For example, you may be able to take age-appropriate care of your personal needs, or you may be old enough and able to cook, shop, and take public transportation. You may demonstrate both strengths and deficits in your daily functioning.

b. You may receive various kinds of help and support from others that enable you to do many things that, because of your mental disorder, you might not be able to do independently. Your daily functioning may depend on the special contexts in which you function. For example, you may spend your time among only familiar people or surroundings, in a simple and steady routine or an unchanging environment, or in a highly structured classroom or alternative school. However, this does not necessarily show whether you would function age-appropriately without those supports or contexts. (See 112.00H for further discussion of these issues regarding significant deficits in adaptive functioning for the purpose of 112.05.)

4. *How we consider treatment.* We will consider the effect of any treatment on your functioning when we evaluate your mental disorder. Treatment may include medication(s), psychotherapy, or other forms of intervention, which you receive in a doctor's office, during a hospitalization, or in a day program at a hospital or outpatient treatment program. With treatment, you may not only have your symptoms and signs reduced, but may also be able to function age-appropriately. However, treatment may not resolve all of the limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that limit your mental or physical functioning. For example, you may experience drowsiness, blunted affect, memory loss, or abnormal involuntary movements.

E. *What are the paragraph B criteria for children age 3 to the attainment of age 18?*

1. *Understand, remember, or apply information (paragraph B1).* This area of mental functioning refers to the abilities to learn, recall, and use information to perform age-appropriate activities. Examples include: Understanding and learning terms, instructions,

procedures; following one- or two-step oral instructions to carry out a task; describing an activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make decisions. These examples illustrate the nature of the area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

2. *Interact with others (paragraph B2).* This area of mental functioning refers to the abilities to relate to others age-appropriately at home, at school, and in the community. Examples include: Engaging in interactive play; cooperating with others; asking for help when needed; initiating and maintaining friendships; handling conflicts with others; stating own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

3. *Concentrate, persist, or maintain pace (paragraph B3).* This area of mental functioning refers to the abilities to focus attention on activities and stay on task age-appropriately. Examples include: Initiating and performing an activity that you understand and know how to do; engaging in an activity at home or in school at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while engaged in an activity or task; changing activities without being disruptive; engaging in an activity or task close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at school; and engaging in activities at home, school, or in the community without needing an unusual amount of rest. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

4. *Adapt or manage oneself (paragraph B4).* This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in age-appropriate activities and settings. Examples include: Responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable performance in community- or school-related activities; setting goals; making plans independently of others; maintaining personal hygiene; and protecting yourself from harm and exploitation by others. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

F. *How do we use the paragraph B criteria to evaluate mental disorders in children?*

1. *General.* We use the paragraph B criteria to rate the degree of your limitations. We consider only the limitations that result from your mental disorder(s). We will determine whether you are able to use each of the paragraph B areas of mental functioning in age-appropriate activities in a manner comparable to that of other children your age who do not have impairments. We will consider, for example, the range of your activities and whether they are age-appropriate; how well you can initiate, sustain, and complete your activities; the kinds and frequency of help or supervision you receive; and the kinds of structured or supportive settings you need in order to function age-appropriately (see 112.00D).

2. *Degrees of limitation.* We evaluate the effects of your mental disorder on each of the four areas of mental functioning. To satisfy the paragraph B criteria, your mental disorder must result in extreme limitation of one, or marked limitation of two, paragraph B areas of mental functioning. See §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter for the definitions of the terms marked and extreme as they apply to children.

3. *Rating the limitations of your areas of mental functioning.*

a. *General.* We use all of the relevant medical and non-medical evidence in your case record to evaluate your mental disorder: The symptoms and signs of your disorder, the reported limitations in your activities, and any help and support you receive that is necessary for you to function. The medical evidence may include descriptors regarding the diagnostic stage or level of your disorder, such as ''mild'' or ''moderate.'' Clinicians may use these terms to characterize your medical condition. However, these terms will not always be the same as the degree of your limitation in a paragraph B area of mental functioning.

b. *Areas of mental functioning in daily activities.* You use the same four areas of mental functioning in daily activities at home, at school, and in the community. With respect to a particular task or activity, you may have trouble using one or more of the areas.

For example, you may have difficulty understanding and remembering what to do; or concentrating and staying on task long enough to do it; or engaging in the task or activity with other people; or trying to do the task without becoming frustrated and losing self-control. Information about your daily functioning in your activities at home, at school, or in your community can help us understand whether your mental disorder limits one or more of these areas; and, if so, whether it also affects your ability to function age-appropriately.

c. *Overall effect of limitations.* Limitation of an area of mental functioning reflects the overall degree to which your mental disorder interferes with that area. The degree of limitation does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test results) can establish whether you have extreme or marked limitation of an area of mental functioning.

d. *Effects of support, supervision, structure on functioning.* The degree of limitation of an area of mental functioning also reflects the kind and extent of supports or supervision you receive (beyond what other children your age without impairments typically receive) and the characteristics of any structured setting where you spend your time, which enable you to function. The more extensive the support you need from others (beyond what is age-appropriate) or the more structured the setting you need in order to function, the more limited we will find you to be (see 112.00D).

e. *Specific instructions for paragraphs B1, B3, and B4.* For paragraphs B1, B3, and B4, the greatest degree of limitation of any part of the area of mental functioning directs the rating of limitation of that whole area of mental functioning.

(i) To do an age-appropriate activity, you must be able to understand *and* remember *and* apply information required by the activity. Similarly, you must be able to concentrate *and* persist *and* maintain pace in order to complete the activity, and adapt *and* manage yourself age-appropriately. Limitation in any one of these parts (understand *or* remember *or* apply; concentrate *or* persist *or* maintain pace; adapt *or* manage oneself) may prevent you from completing age-appropriate activities.

(ii) We will document the rating of limitation of the whole area of mental functioning, not each individual part. We will not add ratings of the parts together. For example, with respect to paragraph B3, if you have marked limitation in concentrating, but your limitations in persisting and maintaining pace do not rise to a marked level, we will find that you have marked limitation in the whole paragraph B3 area of mental functioning.

(iii) Marked limitation in more than one part of the same paragraph B area of mental functioning does not satisfy the requirement to have marked limitation in two paragraph B areas of mental functioning.

4. *How we evaluate mental disorders involving exacerbations and remissions.*

a. When we evaluate the effects of your mental disorder, we will consider how often you have exacerbations and remissions, how long they last, what causes your mental disorder to worsen or improve, and any other relevant information. We will assess whether your mental impairment(s) causes marked or extreme limitation of the affected paragraph B area(s) of mental functioning (see 112.00F2). We will consider whether you can use the area of mental functioning age-appropriately on a sustained basis. We will not find that you function age-appropriately solely because you have a period(s) of improvement (remission), or that you are disabled solely because you have a period of worsening (exacerbation), of your mental disorder.

b. If you have a mental disorder involving exacerbations and remissions, you may be able to use the four areas of mental functioning at home, at school, or in the community for a few weeks or months. Recurrence or worsening of symptoms and signs, however, can interfere enough to render you unable to function age-appropriately.

G. *What are the paragraph C criteria, and how do we use them to evaluate mental disorders in children age 3 to the attainment of age 18?*

1. *General.* The paragraph C criteria are an alternative to the paragraph B criteria under listings 112.02, 112.03, 112.04, 112.06, and 112.15. We use the paragraph C criteria to evaluate mental disorders that are ''serious and persistent.'' In the paragraph C criteria, we recognize that mental health interventions may control the more obvious symptoms and signs of your mental disorder.

2. *Paragraph C criteria.*

a. We find a mental disorder to be ''serious and persistent'' when there is a medically documented history of the existence of the mental disorder in the listing category over a period of at least 2 years, and evidence shows that your disorder satisfies both C1 and C2.

b. The criterion in C1 is satisfied when the evidence shows that you rely, on an ongoing basis, upon medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s), to diminish the symptoms and signs of your mental disorder (see 112.00D). We consider that you receive ongoing medical treatment when the medical evidence establishes that you obtain medical treatment with a frequency consistent with accepted medical practice for the type of treatment or evaluation required for your medical condition. We will consider

periods of inconsistent treatment or lack of compliance with treatment that may result from your mental disorder. If the evidence indicates that the inconsistent treatment or lack of compliance is a feature of your mental disorder, and it has led to an exacerbation of your symptoms and signs, we will not use it as evidence to support a finding that you have not received ongoing medical treatment as required by this paragraph.

c. The criterion in C2 is satisfied when the evidence shows that, despite your diminished symptoms and signs, you have achieved only marginal adjustment. ''Marginal adjustment'' means that your adaptation to the requirements of daily life is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. We will consider that you have achieved only marginal adjustment when the evidence shows that changes or increased demands have led to exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you have become unable to function outside of your home or a more restrictive setting, without substantial psychosocial supports (see 112.00D). Such deterioration may have necessitated a significant change in medication or other treatment. Similarly, because of the nature of your mental disorder, evidence may document episodes of deterioration that have required you to be hospitalized or absent from school, making it difficult for you to sustain age-appropriate activity over time.

H. *How do we document and evaluate intellectual disorder under 112.05?*

1. *General.* Listing 112.05 is based on the two elements that characterize intellectual disorder for children up to age 18: Significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning.

2. *Establishing significantly subaverage general intellectual functioning.*

a. *Definition.* Intellectual functioning refers to the general mental capacity to learn, reason, plan, solve problems, and perform other cognitive functions. Under 112.05A, we identify significantly subaverage general intellectual functioning by the cognitive inability to function at a level required to participate in standardized intelligence testing. Our findings under 112.05A are based on evidence from an acceptable medical source. Under 112.05B, we identify significantly subaverage general intellectual functioning by an IQ score(s) on an individually administered standardized test of general intelligence that meets program requirements and has a mean of 100 and a standard deviation of 15. A qualified specialist (see 112.00H2c) must administer the standardized intelligence testing.

b. *Psychometric standards.* We will find standardized intelligence test results usable for the purposes of 112.05B1 when the measure employed meets contemporary psychometric standards for validity, reliability, normative data, and scope of measurement; and a qualified specialist has individually administered the test according to all prerequisite testing conditions.

c. *Qualified specialist.* A ''qualified specialist'' is currently licensed or certified at the independent level of practice in the State where the test was performed, and has the training and experience to administer, score, and interpret intelligence tests. If a psychological assistant or paraprofessional administered the test, a supervisory qualified specialist must interpret the test findings and co-sign the examination report.

d. *Responsibility for conclusions based on testing.* We generally presume that your obtained IQ score(s) is an accurate reflection of your general intellectual functioning, unless evidence in the record suggests otherwise. Examples of this evidence include: A statement from the test administrator indicating that your obtained score is not an accurate reflection of your general intellectual functioning, prior or internally inconsistent IQ scores, or information about your daily functioning. Only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that your obtained IQ score(s) is not an accurate reflection of your general intellectual functioning. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record, such as:

(i) The data obtained in testing;

(ii) Your developmental history, including when your signs and symptoms began;

(iii) Information about how you function on a daily basis in a variety of settings; and

(iv) Clinical observations made during the testing period, such as your ability to sustain attention, concentration, and effort; to relate appropriately to the examiner; and to perform tasks independently without prompts or reminders.

3. *Establishing significant deficits in adaptive functioning.*

a. *Definition.* Adaptive functioning refers to how you learn and use conceptual, social, and practical skills in dealing with common life demands. It is your typical functioning at home, at school, and in the community, alone or among others. Under 112.05A, we identify significant deficits in adaptive functioning based on your dependence on others to care for your personal needs, such as eating and bathing (grossly in excess of age-appropriate dependence). We will base our conclusions about your adaptive functioning on evidence from a variety of sources (see 112.00H3b) and not on your statements alone.

Under 112.05B2, we identify significant deficits in adaptive functioning based on whether there is extreme limitation of one, or marked limitation of two, of the paragraph B criteria (see 112.00E; 112.00F).

b. *Evidence.* Evidence about your adaptive functioning may come from:

(i) Medical sources, including their clinical observations;

(ii) Standardized tests of adaptive functioning (see 112.00H3c);

(iii) Third party information, such as a report of your functioning from a family member or your caregiver;

(iv) School records;

(v) A teacher questionnaire;

(vi) Reports from employers or supervisors; and

(vii) Your own statements about how you handle all of your daily activities.

c. *Standardized tests of adaptive functioning.* We do not require the results of an individually administered standardized test of adaptive functioning. If your case record includes these test results, we will consider the results along with all other relevant evidence; however, we will use the guidelines in 112.00E and F to evaluate and determine the degree of your deficits in adaptive functioning, as required under 112.05B2.

d. *Standardized developmental assessments.* We do not require the results of standardized developmental assessments, which compare your level of development to the level typically expected for your chronological age. If your case record includes test results, we will consider the results along with all other relevant evidence. However, we will use the guidelines in 112.00E and F to evaluate and determine the degree of your deficits in adaptive functioning, as required under 112.05B2.

e. *How we consider common everyday activities.*

(i) The fact that you engage in common everyday activities, such as caring for your personal needs, preparing simple meals, or driving a car, will not always mean that you do not have deficits in adaptive functioning as required by 112.05B2. You may demonstrate both strengths and deficits in your adaptive functioning. However, a lack of deficits in one area does not negate the presence of deficits in another area. When we assess your adaptive functioning, we will consider all of your activities and your performance of them.

(ii) Our conclusions about your adaptive functioning rest on the quality of your daily activities and whether you do them age-appropriately. If you receive help in performing your activities, we need to know the kind, extent, and frequency of help you receive in order to perform them. We will not assume that your ability to do some common everyday activities, or to do some things without help or support, demonstrates that your mental disorder does not meet the requirements of 112.05B2. (See 112.00D regarding the factors we consider when we evaluate your functioning, including how we consider any help or support you receive.)

f. *How we consider work activity.* The fact that you have engaged in work activity, or that you work intermittently or steadily in a job commensurate with your abilities, will not always mean that you do not have deficits in adaptive functioning as required by 112.05B2. When you have engaged in work activity, we need complete information about the work, and about your functioning in the work activity and work setting, before we reach any conclusions about your adaptive functioning. We will consider all factors involved in your work history before concluding whether your impairment satisfies the criteria for intellectual disorder under 112.05B. We will consider your prior and current work history, if any, and various other factors influencing how you function. For example, we consider whether the work was in a supported setting, whether you required more supervision than other employees, how your job duties compared to others in the same job, how much time it took you to learn the job duties, and the reason the work ended, if applicable.

I. *What additional considerations do we use to evaluate developmental disorders of infants and toddlers?*

1. *General.* We evaluate developmental disorders from birth to attainment of age 3 under 112.14. We evaluate your ability to acquire and maintain the motor, cognitive, social/communicative, and emotional skills that you need to function age-appropriately. When we rate your impairment-related limitations for this listing (see §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter), we consider only limitations you have because of your developmental disorder. If you have a chronic illness or physical abnormality(ies), we will evaluate it under the affected body system, for example, the cardiovascular or musculoskeletal system.

2. *Age and typical development in early childhood.*

a. *Prematurity and age.* If you were born prematurely, we will use your corrected chronological age (CCA) for comparison. CCA is your chronological age adjusted by a period of gestational prematurity. CCA = (chronological age)−(number of weeks premature). If you have not attained age 1, we will correct your chronological age, using the same formula. If you are over age 1, we will decide whether to correct your chronological age, based on our judgment and all the facts of your case (see § 416.924b(b) of this chapter).

b. *Developmental assessment.* We will use the results from a standardized developmental assessment to compare your level of development with that typically expected for your

chronological age. When there are no results from a comprehensive standardized developmental assessment in the case record, we need narrative developmental reports from your medical sources in sufficient detail to assess the limitations resulting from your developmental disorder.

c. *Variation.* When we evaluate your developmental disorder, we will consider the wide variation in the range of normal or typical development in early childhood. At the end of a recognized milestone period, new skills typically begin to emerge. If your new skills begin to emerge later than is typically expected, the timing of their emergence may or may not indicate that you have a developmental delay or deficit that can be expected to last for 1 year.

3. *Evidence.*

a. *Standardized developmental assessments.* We use standardized test reports from acceptable medical sources or from early intervention specialists, physical or occupational therapists, and other qualified professionals. Only the qualified professional who administers the test, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that the assessment results are not an accurate reflection of your development. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record. If the assessment results are not an accurate reflection of your development, we may purchase a new developmental assessment. If the developmental assessment is inconsistent with other information in your case record, we will follow the guidelines in §416.920b of this chapter.

b. *Narrative developmental reports.* A narrative developmental report is based on clinical observations, progress notes, and well-baby check-ups, and includes your developmental history, examination findings (with abnormal findings noted on repeated examinations), and an overall assessment of your development (that is, more than one or two isolated skills) by the medical source. Although medical sources may refer to screening test results as supporting evidence in the narrative developmental report, screening test results alone cannot establish a diagnosis or the severity of developmental disorder.

4. *What are the paragraph B criteria for 112.14?*

a. *General.* The paragraph B criteria for 112.14 are slightly different from the paragraph B criteria for the other listings. They are the developmental abilities that infants and toddlers use to acquire and maintain the skills needed to function age-appropriately. An infant or toddler is expected to use his or her developmental abilities to achieve a recognized pattern of milestones, over a typical range of time, in order to acquire and maintain the skills needed to function age-appropriately. We will find that your developmental disorder satisfies the requirements of 112.14 if it results in extreme limitation of one, or marked limitation of two, of the 112.14 paragraph B criteria. (See §§416.925(b)(2)(ii) and 416.926a(e) of this chapter for the definitions of the terms marked and extreme as they apply to children.)

b. *Definitions of the 112.14 paragraph B developmental abilities.*

(i) *Ability to plan and control motor movement.* This criterion refers to the developmental ability to plan, remember, and execute controlled motor movements by integrating and coordinating perceptual and sensory input with motor output. Using this ability develops gross and fine motor skills, and makes it possible for you to engage in age-appropriate symmetrical or alternating motor activities. You use this ability when, for example, you grasp and hold objects with one or both hands, pull yourself up to stand, walk without holding on, and go up and down stairs with alternating feet. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

(ii) *Ability to learn and remember.* This criterion refers to the developmental ability to learn by exploring the environment, engaging in trial-and-error experimentation, putting things in groups, understanding that words represent things, and participating in pretend play. Using this ability develops the skills that help you understand what things mean, how things work, and how you can make things happen. You use this ability when, for example, you show interest in objects that are new to you, imitate simple actions, name body parts, understand simple cause-and-effect relationships, remember simple directions, or figure out how to take something apart. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

(iii) *Ability to interact with others.* This criterion refers to the developmental ability to participate in reciprocal social interactions and relationships by communicating your feelings and intents through vocal and visual signals and exchanges; physical gestures and contact; shared attention and affection; verbal turn taking; and understanding and sending increasingly complex messages. Using this ability develops the social skills that make it possible for you to influence others (for example, by gesturing for a toy or saying ''no'' to stop an action); invite someone to interact with you (for example, by

smiling or reaching); and draw someone's attention to what interests you (for example, by pointing or taking your caregiver's hand and leading that person). You use this ability when, for example, you use vocalizations to initiate and sustain a ''conversation'' with your caregiver; respond to limits set by an adult with words, gestures, or facial expressions; play alongside another child; or participate in simple group activities with adult help. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

(iv) *Ability to regulate physiological functions, attention, emotion, and behavior.* This criterion refers to the developmental ability to stabilize biological rhythms (for example, by developing an age-appropriate sleep/wake cycle); control physiological functions (for example, by achieving regular patterns of feeding); and attend, react, and adapt to environmental stimuli, persons, objects, and events (for example, by becoming alert to things happening around you and in relation to you, and responding without overreacting or underreacting). Using this ability develops the skills you need to regulate yourself and makes it possible for you to achieve and maintain a calm, alert, and organized physical and emotional state. You use this ability when, for example, you recognize your body's needs for food or sleep, focus quickly and pay attention to things that interest you, cry when you are hurt but become quiet when your caregiver holds you, comfort yourself with your favorite toy when you are upset, ask for help when something frustrates you, or refuse help from your caregiver when trying to do something for yourself. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

5. *Deferral of determination.*

a. *Full-term infants.* In the first few months of life, full-term infants typically display some irregularities in observable behaviors (for example, sleep cycles, feeding, responding to stimuli, attending to faces, self-calming), making it difficult to assess the presence, extent, and duration of a developmental disorder. When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer making a disability determination under 112.14 until you are at least 6 months old. This deferral will allow us to obtain a longitudinal medical history so that we can more accurately evaluate your developmental patterns and functioning over time. In most cases, when you are at least 6 months old, any developmental delay you may have can be better assessed, and you can undergo standardized developmental testing, if indicated.

b. *Premature infants.* When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer your case until you attain a CCA (see 112.00I2a) of at least 6 months in order to better evaluate your developmental delay.

c. *When we will not defer a determination.* We will not defer our determination if we have sufficient evidence to determine that you are disabled under 112.14 or any other listing, or that you have an impairment or combination of impairments that functionally equals the listings. In addition, we will not defer our determination if the evidence demonstrates that you are not disabled.

J. *How do we evaluate substance use disorders?* If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability (see §416.935 of this chapter).

K. *How do we evaluate mental disorders that do not meet one of the mental disorders listings?*

1. These listings include only examples of mental disorders that we consider serious enough to result in marked and severe functional limitations. If your severe mental disorder does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have another impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing (see §416.926 of this chapter).

3. If your impairment(s) does not meet or medically equal a listing, we will consider whether you have an impairment(s) that functionally equals the listings (see §416.926a of this chapter).

4. Although we present these alternatives in a specific sequence above, each represents listing-level severity, and we can evaluate your claim in any order. For example, if the factors of your case indicate that the combination of your impairments may functionally equal the listings, we may start with that analysis. We use the rules in §416.994a of this chapter, as appropriate, when we decide whether you continue to be disabled.

112.01 CATEGORY OF IMPAIRMENTS, MENTAL DISORDERS

112.02 *Neurocognitive disorders* (see 112.00B1), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of a clinically significant deviation in normal cognitive development or by significant cognitive decline from a prior level of functioning in *one* or more of the cognitive areas:

1. Complex attention;
2. Executive function;
3. Learning and memory;
4. Language;
5. Perceptual-motor; or
6. Social cognition.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).
2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.03 *Schizophrenia spectrum and other psychotic disorders* (see 112.00B2), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of *one* or more of the following:

1. Delusions or hallucinations;
2. Disorganized thinking (speech); or
3. Grossly disorganized behavior or catatonia.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).
2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.04 *Depressive, bipolar and related disorders* (see 112.00B3), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. Depressive disorder, characterized by *five* or more of the following:

a. Depressed or irritable mood;
b. Diminished interest in almost all activities;
c. Appetite disturbance with change in weight (or a failure to achieve an expected weight gain);
d. Sleep disturbance;
e. Observable psychomotor agitation or retardation;
f. Decreased energy;
g. Feelings of guilt or worthlessness;
h. Difficulty concentrating or thinking; or
i. Thoughts of death or suicide.

2. Bipolar disorder, characterized by *three* or more of the following:

a. Pressured speech;
b. Flight of ideas;
c. Inflated self-esteem;
d. Decreased need for sleep;
e. Distractibility;
f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
g. Increase in goal-directed activity or psychomotor agitation.

3. Disruptive mood dysregulation disorder, beginning prior to age 10, and *all* of the following:

a. Persistent, significant irritability or anger;
b. Frequent, developmentally inconsistent temper outbursts; and
c. Frequent aggressive or destructive behavior.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); *and*
2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.05 *Intellectual disorder* (see 112.00B4), for children age 3 to attainment of age 18, satisfied by A or B:
A. Satisfied by 1 and 2 (see 112.00H):
1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and
2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing) in excess of age-appropriate dependence.

OR

B. Satisfied by 1 and 2 (see 112.00H):
1. Significantly subaverage general intellectual functioning evidenced by a or b:
a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or
b. A full scale (or comparable) IQ score of 71–75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and
2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:
a. Understand, remember, or apply information (see 112.00E1); or
b. Interact with others (see 112.00E2); or
c. Concentrate, persist, or maintain pace (see 112.00E3); or
d. Adapt or manage oneself (see 112.00E4).

112.06 *Anxiety and obsessive-compulsive disorders* (see 112.00B5), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:
A. Medical documentation of the requirements of paragraph 1, 2, 3, or 4:
1. Anxiety disorder, characterized by *one* or more of the following:
a. Restlessness;
b. Easily fatigued;
c. Difficulty concentrating;
d. Irritability;
e. Muscle tension; or
f. Sleep disturbance.
2. Panic disorder or agoraphobia, characterized by *one* or both:
a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or
b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).
3. Obsessive-compulsive disorder, characterized by *one* or both:
a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts; or;
b. Repetitive behaviors that appear aimed at reducing anxiety.
4. Excessive fear or anxiety concerning separation from those to whom you are attached.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):
1. Understand, remember, or apply information (see 112.00E1).
2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); *and*
2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.07 *Somatic symptom and related disorders* (see 112.00B6), for children age 3 to attainment of age 18, satisfied by A and B:
A. Medical documentation of *one* or both of the following:
1. Symptoms of altered voluntary motor or sensory function that are not better explained by another medical or mental disorder; or

2. One or more somatic symptoms that are distressing, with excessive thoughts, feelings, or behaviors related to the symptoms.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.08 *Personality and impulse-control disorders* (see 112.00B7), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of a pervasive pattern of *one* or more of the following:

1. Distrust and suspiciousness of others;

2. Detachment from social relationships;

3. Disregard for and violation of the rights of others;

4. Instability of interpersonal relationships;

5. Excessive emotionality and attention seeking;

6. Feelings of inadequacy;

7. Excessive need to be taken care of;

8. Preoccupation with perfectionism and orderliness; or

9. Recurrent, impulsive, aggressive behavioral outbursts.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.09 [Reserved]

112.10 *Autism spectrum disorder* (see 112.00B8), for children age 3 to attainment of age 18), satisfied by A and B:

A. Medical documentation of *both* of the following:

1. Qualitative deficits in verbal communication, nonverbal communication, and social interaction; and

2. Significantly restricted, repetitive patterns of behavior, interests, or activities.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.11 *Neurodevelopmental disorders* (see 112.00B9), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. *One* or both of the following:

a. Frequent distractibility, difficulty sustaining attention, and difficulty organizing tasks; or

b. Hyperactive and impulsive behavior (for example, difficulty remaining seated, talking excessively, difficulty waiting, appearing restless, or behaving as if being ''driven by a motor'').

2. Significant difficulties learning and using academic skills; or

3. Recurrent motor movement or vocalization.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.12 [Reserved]

112.13 *Eating disorders* (see 112.00B10), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of a persistent alteration in eating or eating-related behavior that results in a change in consumption or absorption of food and that significantly impairs physical or psychological health.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.14 *Developmental disorders in infants and toddlers* (see 112.00B11, 112.00I), satisfied by A and B:

A. Medical documentation of *one* or both of the following:

1. A delay or deficit in the development of age-appropriate skills; or

2. A loss of previously acquired skills.

AND

B. Extreme limitation of one, or marked limitation of two, of the following developmental abilities (see 112.00F):

1. Plan and control motor movement (see 112.00I4b(i)).

2. Learn and remember (see 112.00I4b(ii)).

3. Interact with others (see 112.00I4b(iii)).

4. Regulate physiological functions, attention, emotion, and behavior (see 112.00I4b(iv)).

112.15 *Trauma- and stressor-related disorders* (see 112.00B11), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:

1. Posttraumatic stress disorder, characterized by *all* of the following:

a. Exposure to actual or threatened death, serious injury, or violence;

b. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);

c. Avoidance of external reminders of the event;

d. Disturbance in mood and behavior (for example, developmental regression, socially withdrawn behavior); and

e. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

2. Reactive attachment disorder, characterized by *two* or all of the following:

a. Rarely seeks comfort when distressed;

b. Rarely responds to comfort when distressed; or

c. Episodes of unexplained emotional distress.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is ''serious and persistent;'' that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); *and*

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

113.00 Cancer (Malignant Neoplastic Diseases)

A. *What impairments do these listings cover?* We use these listings to evaluate all cancers (malignant neoplastic diseases) except certain cancers associated with human immunodeficiency virus (HIV) infection. We use the criteria in 114.11B to evaluate primary central nervous system lymphoma, 114.11C to evaluate primary effusion lymphoma, and 114.11E to evaluate pulmonary Kaposi sarcoma if you also have HIV infection. We evaluate all other cancers associated with HIV infection, for example, Hodgkin lymphoma or non-pulmonary Kaposi sarcoma, under this body system or under 114.11F–I in the immune system disorders body system.

B. *What do we consider when we evaluate cancer under these listings?* We will consider factors including:

1. Origin of the cancer.

2. Extent of involvement.

3. Duration, frequency, and response to anticancer therapy.

4. Effects of any post-therapeutic residuals.

C. *How do we apply these listings?* We apply the criteria in a specific listing to a cancer originating from that specific site.

D. *What evidence do we need?*

1. We need medical evidence that specifies the type, extent, and site of the primary, recurrent, or metastatic lesion. When the primary site cannot be identified, we will use evidence documenting the site(s) of metastasis to evaluate the impairment under 13.27 in part A.

2. For operative procedures, including a biopsy or a needle aspiration, we generally need a copy of both the:

a. Operative note, and

b. Pathology report.

3. When we cannot get these documents, we will accept the summary of hospitalization(s) or other medical reports. This evidence should include details of the findings at surgery and, whenever appropriate, the pathological findings.

4. In some situations, we may also need evidence about recurrence, persistence, or progression of the cancer, the response to therapy, and any significant residuals. (See 113.00G.)

E. *When do we need longitudinal evidence?*

1. *Cancer with distant metastases.* Most cancer of childhood consists of a local lesion with metastases to regional lymph nodes and, less often, distant metastases. We generally do not need longitudinal evidence for cancer that has metastasized beyond the regional lymph nodes because this cancer usually meets the requirements of a listing. Exceptions are for cancer with distant metastases that we expect to respond to anticancer therapy. For these exceptions, we usually need a longitudinal record of 3 months after therapy starts to determine whether the therapy achieved its intended effect, and whether this effect is likely to persist.

2. *Other cancers.* When there are no distant metastases, many of the listings require that

we consider your response to initial anticancer therapy; that is, the initial planned treatment regimen. This therapy may consist of a single modality or a combination of modalities; that is, multimodal therapy (see 113.00I3).

3. *Types of treatment.*

a. Whenever the initial planned therapy is a single modality, enough time must pass to allow a determination about whether the therapy will achieve its intended effect. If the treatment fails, the failure often happens within 6 months after treatment starts, and there will often be a change in the treatment regimen.

b. Whenever the initial planned therapy is multimodal, we usually cannot make a determination about the effectiveness of the therapy until we can determine the effects of all the planned modalities. In some cases, we may need to defer adjudication until we can assess the effectiveness of therapy. However, we do not need to defer adjudication to determine whether the therapy will achieve its intended effect if we can make a fully favorable determination or decision based on the length and effects of therapy, or the residuals of the cancer or therapy (see 113.00G).

F. *How do we evaluate impairments that do not meet one of the cancer listings?*

1. These listings are only examples of cancers that we consider severe enough to result in marked and severe functional limitations. If your severe impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926 of this chapter.) If your impairment(s) does not meet or medically equal a listing, we will also consider whether you have an impairment(s) that functionally equals the listings. (See § 416.926a of this chapter.) We use the rules in § 416.994a of this chapter when we decide whether you continue to be disabled.

G. *How do we consider the effects of anticancer therapy?*

1. *How we consider the effects of anticancer therapy under the listings.* In many cases, cancers meet listing criteria only if the therapy is not effective and the cancer persists, progresses, or recurs. However, as explained in the following paragraphs, we will not delay adjudication if we can make a fully favorable determination or decision based on the evidence in the case record.

2. *Effects can vary widely.*

a. We consider each case on an individual basis because the therapy and its toxicity may vary widely. We will request a specific description of the therapy, including these items:

i. Drugs given.

ii. Dosage.

iii. Frequency of drug administration.

iv. Plans for continued drug administration.

v. Extent of surgery.

vi. Schedule and fields of radiation therapy.

b. We will also request a description of the complications or adverse effects of therapy, such as the following:

i. Continuing gastrointestinal symptoms.

ii. Persistent weakness.

iii. Neurological complications.

iv. Cardiovascular complications.

v. Reactive mental disorders.

3. *Effects of therapy may change.* The severity of the adverse effects of anticancer therapy may change during treatment; therefore, enough time must pass to allow us to evaluate the therapy's effect. The residual effects of treatment are temporary in most instances; however, on occasion, the effects may be disabling for a consecutive period of at least 12 months. In some situations, very serious adverse effects may interrupt and prolong multimodal anticancer therapy for a continuous period of almost 12 months. In these situations, we may determine there is an expectation that your impairment will preclude you from engaging in any age-appropriate activities for at least 12 months.

4. *When the initial anticancer therapy is effective.* We evaluate any post-therapeutic residual impairment(s) not included in these listings under the criteria for the affected body system. We must consider any complications of therapy. When the residual impairment(s) does not meet a listing, we must consider whether it medically equals a listing, or, as appropriate, functionally equals the listings.

H. *How long do we consider your impairment to be disabling?*

1. In some listings, we specify that we will consider your impairment to be disabling until a particular point in time (for example, until at least 12 months from the date of transplantation). We may consider your impairment to be disabling beyond this point when the medical and other evidence justifies it.

2. When a listing does not contain such a specification, we will consider an impairment(s) that meets or medically equals a listing in this body system to be disabling until at least 3 years after onset of complete remission. When the impairment(s) has been in complete remission for at least 3 years, that is, the original tumor or a recurrence (or relapse) and any metastases have not been evident for at least 3 years, the impairment(s) will no longer meet or medically equal the criteria of a listing in this body system.

3. Following the appropriate period, we will consider any residuals, including residuals of the cancer or therapy (see 113.00G), in determining whether you are disabled. If you have a recurrence or relapse of your cancer, your impairment may meet or medically equal one of the listings in this body system again.

I. *What do we mean by the following terms?*

1. *Anticancer therapy* means surgery, radiation, chemotherapy, hormones, immunotherapy, or bone marrow or stem cell transplantation. When we refer to surgery as an anticancer treatment, we mean surgical excision for treatment, not for diagnostic purposes.

2. *Metastases* means the spread of cancer cells by blood, lymph, or other body fluid. This term does not include the spread of cancer cells by direct extension of the cancer to other tissues or organs.

3. *Multimodal therapy* means anticancer therapy that is a combination of at least two types of treatment given in close proximity as a unified whole and usually planned before any treatment has begun. There are three types of treatment modalities: Surgery, radiation, and systemic drug therapy (chemotherapy, hormone therapy, and immunotherapy or biological modifier therapy). Examples of multimodal therapy include:

a. Surgery followed by chemotherapy or radiation.

b. Chemotherapy followed by surgery.

c. Chemotherapy and concurrent radiation.

4. *Persistent* means the planned initial anticancer therapy failed to achieve a complete remission of your cancer; that is, your cancer is evident, even if smaller, after the therapy has ended.

5. *Progressive* means the cancer becomes more extensive after treatment; that is, there is evidence that your cancer is growing after you have completed at least half of your planned initial anticancer therapy.

6. *Recurrent or relapse* means the cancer that was in complete remission or entirely removed by surgery has returned.

J. *Can we establish the existence of a disabling impairment prior to the date of the evidence that shows the cancer satisfies the criteria of a listing?* Yes. We will consider factors such as:

1. The type of cancer and its location.

2. The extent of involvement when the cancer was first demonstrated.

3. Your symptoms.

K. *How do we evaluate specific cancers?*

1. *Lymphoma.*

a. We provide criteria for evaluating lymphomas that are disseminated or have not responded to anticancer therapy in 113.05.

b. Lymphoblastic lymphoma is treated with leukemia-based protocols, so we evaluate this type of cancer under 113.06.

2. *Leukemia.*

a. *Acute leukemia.* The initial diagnosis of acute leukemia, including the accelerated or blast phase of chronic myelogenous (granulocytic) leukemia, is based on definitive bone marrow examination. Additional diagnostic information is based on chromosomal analysis, cytochemical and surface marker studies on the abnormal cells, or other methods consistent with the prevailing state of medical knowledge and clinical practice. Recurrent disease must be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination, or by testicular biopsy. The initial and follow-up pathology reports should be included.

b. *Chronic myelogenous leukemia (CML).* We need a diagnosis of CML based on documented granulocytosis, including immature forms such as differentiated or undifferentiated myelocytes and myeloblasts, and a chromosomal analysis that demonstrates the Philadelphia chromosome. In the absence of a chromosomal analysis, or if the Philadelphia chromosome is not present, the diagnosis may be made by other methods consistent with the prevailing state of medical knowledge and clinical practice. The requirement for CML in the accelerated or blast phase is met in 113.06B if laboratory findings show the proportion of blast (immature) cells in the peripheral blood or bone marrow is 10 percent or greater.

c. *Juvenile chronic myelogenous leukemia (JCML).* JCML is a rare, Philadelphia-chromosome-negative childhood leukemia that is aggressive and clinically similar to acute myelogenous leukemia. We evaluate JCML under 113.06A.

d. *Elevated white cell count.* In cases of chronic leukemia (either myelogenous or lymphocytic), an elevated white cell count, in itself, is not a factor in determining the severity of the impairment.

3. *Malignant solid tumors.* The tumors we consider under 113.03 include the histiocytosis syndromes except for solitary eosinophilic granuloma. We do not evaluate thyroid cancer (see 113.09), retinoblastomas (see 113.12), primary central nervous system (CNS) cancers (see 113.13), neuroblastomas (see 113.21), or malignant melanoma (see 113.29) under this listing.

4. *Primary central nervous system (CNS) cancers.* We use the criteria in 113.13 to evaluate cancers that originate within the CNS (that is, brain and spinal cord cancers).

a. The CNS cancers listed in 113.13A are highly malignant and respond poorly to treatment, and therefore we do not require additional criteria to evaluate them. We do not list pituitary gland cancer (for example, pituitary gland carcinoma) in 113.13A, although this CNS cancer is highly malignant and responds poorly to treatment. We evaluate pituitary gland cancer under 113.13A and

do not require additional criteria to evaluate it.

b. We consider a CNS tumor to be malignant if it is classified as Grade II, Grade III, or Grade IV under the World Health Organization (WHO) classification of tumors of the CNS (*WHO Classification of Tumours of the Central Nervous System,* 2007).

c. We evaluate benign (for example, WHO Grade I) CNS tumors under 111.05. We evaluate metastasized CNS cancers from non-CNS sites under the primary cancers (see 113.00C). We evaluate any complications of CNS cancers, such as resultant neurological or psychological impairments, under the criteria for the affected body system.

5. *Retinoblastoma.* The treatment for bilateral retinoblastoma usually results in a visual impairment. We will evaluate any resulting visual impairment under 102.02.

6. *Melanoma.* We evaluate malignant melanoma that affects the skin (cutaneous melanoma), eye (ocular melanoma), or mucosal membranes (mucosal melanoma) under 113.29. We evaluate melanoma that is not malignant that affects the skin (benign melanocytic tumor) under the listings in 108.00 or other affected body systems.

L. *How do we evaluate cancer treated by bone marrow or stem cell transplantation, including transplantation using stem cells from umbilical cord blood?* Bone marrow or stem cell transplantation is performed for a variety of cancers. We require the transplantation to occur before we evaluate it under these listings. We do not need to restrict our determination of the onset of disability to the date of transplantation (113.05 or 113.06). We may be able to establish an earlier onset date of disability due to your transplantation if the evidence in your case record supports such a finding.

1. *Acute leukemia (including all types of lymphoblastic lymphomas and JCML) or accelerated or blast phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of transplantation, whichever is later.

2. *Lymphoma or chronic phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 12 months from the date of transplantation.

3. *Evaluating disability after the appropriate time period has elapsed.* We consider any residual impairment(s), such as complications arising from:

a. Graft-versus-host (GVH) disease.

b. Immunosuppressant therapy, such as frequent infections.

c. Significant deterioration of other organ systems.

113.01 Category of Impairments, Cancer (Malignant Neoplastic Diseases)

113.01 Category of Impairments, Malignant Neoplastic Diseases

113.03 *Malignant solid tumors.* Consider under a disability:

A. For 24 months from the date of initial diagnosis. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. For 24 months from the date of recurrence of active disease. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

113.05 *Lymphoma (excluding all types of lymphoblastic lymphomas—113.06).* (See 113.00K1.)

A. Non-Hodgkin lymphoma (including Burkitt's and anaplastic large cell), with either 1 or 2:

1. Bone marrow, brain, spinal cord, liver, or lung involvement at initial diagnosis. Consider under a disability for 24 months from the date of diagnosis. Thereafter, evaluate under 113.05A2, or any residual impairments(s) under the criteria for the affected body system.

2. Persistent or recurrent following initial anticancer therapy.

OR

B. Hodgkin lymphoma, with either 1 or 2:

1. Bone marrow, brain, spinal cord, liver, or lung involvement at initial diagnosis. Consider under a disability for 24 months from the date of diagnosis. Thereafter, evaluate under 113.05B2, or any residual impairment(s) under the criteria for the affected body system.

2. Persistent or recurrent following initial anticancer therapy.

OR

C. With bone marrow or stem cell transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria of the affected body system.

OR

D. Mantle cell lymphoma.

113.06 *Leukemia.* (See 113.00K2.)

A. Acute leukemia (including all types of lymphoblastic lymphomas and juvenile chronic myelogenous leukemia (JCML)). Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. Chronic myelogenous leukemia (except JCML), as described in 1 or 2:

1. Accelerated or blast phase (see 113.00K2b). Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the

date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

2. Chronic phase, as described in a or b:

a. Consider under a disability until at least 12 months from the date of bone marrow or stem cell transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

b. Progressive disease following initial antineoplastic therapy.

113.09 *Thyroid gland.*

A. Anaplastic (undifferentiated) carcinoma.

OR

B. Carcinoma with metastases beyond the regional lymph nodes progressive despite radioactive iodine therapy.

OR

C. Medullary carcinoma with metastases beyond the regional lymph nodes.

113.12 *Retinoblastoma.*

A. With extension beyond the orbit.

OR

B. Persistent or recurrent following initial anticancer therapy.

OR

C. With regional or distant metastases.

113.13 *Nervous system.* (See 113.00K4.) Primary central nervous system (CNS; that is, brain and spinal cord) cancers, as described in A, B, or C:

A. Glioblastoma multiforme, ependymoblastoma, and diffuse intrinsic brain stem gliomas (see 113.00K4a).

B. Any Grade III or Grade IV CNS cancer (see 113.00K4b), including astrocytomas, sarcomas, and medulloblastoma and other primitive neuroectodermal tumors (PNETs).

C. Any primary CNS cancer, as described in 1 or 2:

1. Metastatic.

2. Progressive or recurrent following initial anticancer therapy.

113.21 *Neuroblastoma.*

A. With extension across the midline.

OR

B. With distant metastases.

OR

C. Recurrent.

OR

D. With onset at age 1 year or older.

113.29 *Malignant melanoma* (including skin, ocular, or mucosal melanomas), as described in either A, B, or C:

A. Recurrent (except an additional primary melanoma at a different site, which is not considered to be recurrent disease) following either 1 or 2:

1. Wide excision (skin melanoma).

2. Enucleation of the eye (ocular melanoma).

OR

B. With metastases as described in 1, 2, or 3:

1. Metastases to one or more clinically apparent nodes; that is, nodes that are detected by imaging studies (excluding lymphoscintigraphy) or by clinical evaluation (palpable).

2. If the nodes are not clinically apparent, with metastases to four or more nodes.

3. Metastases to adjacent skin (satellite lesions) or distant sites (for example, liver, lung, or brain).

OR

C. Mucosal melanoma.

114.00 Immune System Disorders

A. What disorders do we evaluate under the immune system disorders listings?

1. *We evaluate immune system disorders that cause dysfunction in one or more components of your immune system.*

a. The dysfunction may be due to problems in antibody production, impaired cell-mediated immunity, a combined type of antibody/cellular deficiency, impaired phagocytosis, or complement deficiency.

b. Immune system disorders may result in recurrent and unusual infections, or inflammation and dysfunction of the body's own tissues. Immune system disorders can cause a deficit in a single organ or body system that results in extreme (that is, very serious) loss of function. They can also cause lesser degrees of limitations in two or more organs or body systems, and when associated with symptoms or signs, such as severe fatigue, fever, malaise, diffuse musculoskeletal pain, or involuntary weight loss, can also result in extreme limitation. In children, immune system disorders or their treatment may also affect growth, development, and the performance of age-appropriate activities.

c. We organize the discussions of immune system disorders in three categories: Autoimmune disorders; Immune deficiency disorders, excluding human immunodeficiency virus (HIV) infection; and HIV infection.

2. *Autoimmune disorders (114.00D).* Autoimmune disorders are caused by dysfunctional immune responses directed against the body's own tissues, resulting in chronic, multisystem impairments that differ in clinical manifestations, course, and outcome. They are sometimes referred to as rheumatic diseases, connective tissue disorders, or collagen vascular disorders. Some of the features of autoimmune disorders in children differ from the features of the same disorders in adults. The impact of the disorders or their treatment on physical, psychological, and developmental growth of pre-pubertal children may be considerable, and often differs from that of post-pubertal adolescents or adults.

3. *Immune deficiency disorders, excluding HIV infection (114.00E).* Immune deficiency disorders are characterized by recurrent or unusual infections that respond poorly to treatment, and are often associated with complications affecting other parts of the body. Immune deficiency disorders are classified as either *primary* (congenital) or *acquired*. Children with immune deficiency disorders also have an increased risk of malignancies and of having autoimmune disorders.

4. *Human immunodeficiency virus (HIV) infection (114.00F).* HIV infection may be characterized by increased susceptibility to common infections as well as opportunistic infections, cancers, or other conditions listed in 114.11.

B. What information do we need to show that you have an immune system disorder?

Generally, we need your medical history, a report(s) of a physical examination, a report(s) of laboratory findings, and in some instances, appropriate medically acceptable imaging or tissue biopsy reports to show that you have an immune system disorder. Therefore, we will make every reasonable effort to obtain your medical history, medical findings, and results of laboratory tests. We explain the information we need in more detail in the sections below.

C. Definitions

1. *Appropriate medically acceptable imaging* includes, but is not limited to, angiography, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

2. *Constitutional symptoms or signs,* as used in these listings, means severe fatigue, fever, malaise, or involuntary weight loss. *Severe fatigue* means a frequent sense of exhaustion that results in significantly reduced physical activity or mental function. *Malaise* means frequent feelings of illness, bodily discomfort, or lack of well-being that result in significantly reduced physical activity or mental function.

3. *Disseminated* means that a condition is spread over a considerable area. The type and extent of the spread will depend on your specific disease.

4. *Dysfunction* means that one or more of the body regulatory mechanisms are impaired, causing either an excess or deficiency of immunocompetent cells or their products.

5. *Extra-articular* means ''other than the joints''; for example, an organ(s) such as the heart, lungs, kidneys, or skin.

6. *Documented medical need* has the same meaning as in 101.00C6a.

7. *Fine and gross movements* has the same meaning as in 101.00E4.

8. *Major joint of an upper or a lower extremity* has the same meaning as in 101.00I2 and 101.00I3.

9. *Persistent* means that a sign(s) or symptom(s) has continued over time. The precise meaning will depend on the specific immune system disorder, the usual course of the disorder, and the other circumstances of your clinical course.

10. *Recurrent* means that a condition that previously responded adequately to an appropriate course of treatment returns after a period of remission or regression. The precise meaning, such as the extent of response or remission and the time periods involved, will depend on the specific disease or condition you have, the body system affected, the usual course of the disorder and its treatment, and the other facts of your particular case.

11. *Resistant to treatment* means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate or a course of treatment is appropriate will depend on the specific disease or condition you have, the body system affected, the usual course of the disorder and its treatment, and the other facts of your particular case.

12. *Severe* means medical severity as used by the medical community. The term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation process in §416.920 of this chapter.

D. How do we document and evaluate the listed autoimmune disorders?

1. *Systemic lupus erythematosus (114.02).*

a. *General.* Systemic lupus erythematosus (SLE) is a chronic inflammatory disease that can affect any organ or body system. It is frequently, but not always, accompanied by constitutional symptoms or signs (severe fatigue, fever, malaise, involuntary weight loss). Major organ or body system involvement can include: Respiratory (pleuritis, pneumonitis), cardiovascular (endocarditis, myocarditis, pericarditis, vasculitis), renal (glomerulonephritis), hematologic (anemia, leukopenia, thrombocytopenia), skin (photosensitivity), neurologic (seizures), mental (anxiety, fluctuating cognition (''lupus fog''), mood disorders, organic brain syndrome, psychosis), or immune system disorders (inflammatory arthritis). Immunologically, there is an array of circulating serum auto-antibodies and pro- and anti-coagulant proteins that may occur in a highly variable pattern.

b. *Documentation of SLE.* Generally, but not always, the medical evidence will show that your SLE satisfies the criteria in the current ''Criteria for the Classification of Systemic

Lupus Erythematosus'' by the American College of Rheumatology found in the most recent edition of the *Primer on the Rheumatic Diseases* published by the Arthritis Foundation.

2. *Systemic vasculitis (114.03).*

a. *General.*

(i) Vasculitis is an inflammation of blood vessels. It may occur acutely in association with adverse drug reactions, certain chronic infections, and occasionally, malignancies. More often, it is chronic and the cause is unknown. Symptoms vary depending on which blood vessels are involved. Systemic vasculitis may also be associated with other autoimmune disorders; for example, SLE or dermatomyositis.

(ii) Children can develop the vasculitis of Kawasaki disease, of which the most serious manifestation is formation of coronary artery aneurysms and related complications. We evaluate heart problems related to Kawasaki disease under the criteria in the cardiovascular listings (104.00). Children can also develop the vasculitis of anaphylactoid purpura (Henoch-Schoenlein purpura), which may cause intestinal and renal disorders. We evaluate intestinal and renal disorders related to vasculitis of anaphylactoid purpura under the criteria in the digestive (105.00) or genitourinary (106.00) listings. Other clinical patterns include, but are not limited to, polyarteritis nodosa, Takayasu's arteritis (aortic arch arteritis), and Wegener's granulomatosis.

b. *Documentation of systemic vasculitis.* Angiography or tissue biopsy confirms a diagnosis of systemic vasculitis when the disease is suspected clinically. When you have had angiography or tissue biopsy for systemic vasculitis, we will make every reasonable effort to obtain reports of the results of that procedure. However, we will not purchase angiography or tissue biopsy.

3. *Systemic sclerosis (scleroderma) (114.04).*

a. *General.* Systemic sclerosis (scleroderma) constitutes a spectrum of disease in which thickening of the skin is the clinical hallmark. Raynaud's phenomenon, often medically severe and progressive, is present frequently and may be the peripheral manifestation of a vasospastic abnormality in the heart, lungs, and kidneys. The CREST syndrome (calcinosis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly, and telangiectasia) is a variant that may slowly progress over years to the generalized process, systemic sclerosis.

b. *Diffuse cutaneous systemic sclerosis.* In diffuse cutaneous systemic sclerosis (also known as diffuse scleroderma), major organ or systemic involvement can include the gastrointestinal tract, lungs, heart, kidneys, and muscle in addition to skin or blood vessels. Although arthritis can occur, joint dysfunction results primarily from soft tissue/cutaneous thickening, fibrosis, and contractures.

c. *Localized scleroderma (linear scleroderma and morphea).*

(i) Localized scleroderma (linear scleroderma and morphea) is more common in children than systemic scleroderma. To assess the severity of the impairment, we need a description of the extent of involvement of linear scleroderma and the location of the lesions. For example, linear scleroderma involving the arm but not crossing any joints is not as functionally limiting as sclerodactyly (scleroderma localized to the fingers). Linear scleroderma of a lower extremity involving skin thickening and atrophy of underlying muscle or bone can result in contractures and leg length discrepancy. In such cases, we may evaluate your impairment under the musculoskeletal listings (101.00).

(ii) When there is isolated morphea of the face causing facial disfigurement from unilateral hypoplasia of the mandible, maxilla, zygoma, or orbit, adjudication may be more appropriate under the criteria in the affected body system, such as special senses and speech (102.00) or mental disorders (112.00).

(iii) Chronic variants of these syndromes include disseminated morphea, Shulman's disease (diffuse fasciitis with eosinophilia), and eosinophilia-myalgia syndrome (often associated with toxins such as toxic oil or contaminated tryptophan), all of which can impose medically severe musculoskeletal dysfunction and may also lead to restrictive pulmonary disease. We evaluate these variants of the disease under the criteria in the musculoskeletal listings (101.00) or respiratory system listings (103.00).

d. *Documentation of systemic sclerosis (scleroderma).* Documentation involves differentiating the clinical features of systemic sclerosis (scleroderma) from other autoimmune disorders. However, there may be an overlap.

4. *Polymyositis and dermatomyositis (114.05).*

a. *General.*

(i) Polymyositis and dermatomyositis are related disorders that are characterized by an inflammatory process in striated muscle, occurring alone or in association with other autoimmune disorders. The most common manifestations are symmetric weakness, and less frequently, pain and tenderness of the proximal limb-girdle (shoulder or pelvic) musculature. There may also be involvement of the cervical, cricopharyngeal, esophageal, intercostal, and diaphragmatic muscles.

(ii) Polymyositis occurs rarely in children; the more common presentation in children is dermatomyositis with symmetric proximal muscle weakness and characteristic skin findings. The clinical course of dermatomyositis can be more severe when it is accompanied by systemic vasculitis rather than just localized to striated muscle. Late

in the disease, some children with dermatomyositis develop calcinosis of the skin and subcutaneous tissues, muscles, and joints. We evaluate the involvement of other organs/body systems under the criteria for the listings in the affected body system.

b. *Documentation of polymyositis and dermatomyositis.* Generally, but not always, polymyositis is associated with elevated serum muscle enzymes (creatine phosphokinase (CPK), aminotransferases, and aldolase), and characteristic abnormalities on electromyography and muscle biopsy. In children, the diagnosis of dermatomyositis is supported largely by medical history, findings on physical examination that include the characteristic skin findings, and elevated serum muscle enzymes. Muscle inflammation or vasculitis depicted on MRI is additional evidence supporting the diagnosis of childhood dermatomyositis. When you have had electromyography, muscle biopsy, or MRI for polymyositis or dermatomyositis, we will make every reasonable effort to obtain reports of the results of that procedure. However, we will not purchase electromyography, muscle biopsy, or MRI.

c. *Additional information about how we evaluate polymyositis and dermatomyositis under the listings.*

(i) In newborn and younger infants (birth to attainment of age 1), we consider muscle weakness that affects motor skills, such as head control, reaching, grasping, taking solids, or self-feeding, under 114.05A. In older infants and toddlers (age 1 to attainment of age 3), we also consider muscle weakness affecting your ability to roll over, sit, crawl, or walk under 114.05A.

(ii) If you are of preschool age through adolescence (age 3 to attainment of age 18), weakness of your pelvic girdle muscles that results in your inability to rise independently from a squatting or sitting position or to climb stairs may be an indication that you are unable to walk without assistance. Weakness of your shoulder girdle muscles may result in your inability to perform lifting, carrying, and reaching overhead, and also may seriously affect your ability to perform activities requiring fine movements. We evaluate these limitations under 114.05A.

5. *Undifferentiated and mixed connective tissue disease (114.06).*

a. *General.* This listing includes syndromes with clinical and immunologic features of several autoimmune disorders, but which do not satisfy the criteria for any of the specific disorders described. For example, you may have clinical features of SLE and systemic vasculitis, and the serologic (blood test) findings of rheumatoid arthritis. The most common pattern of undifferentiated autoimmune disorders in children is mixed connective tissue disease (MCTD).

b. *Documentation of undifferentiated and mixed connective tissue disease.* Undifferentiated connective tissue disease is diagnosed when clinical features and serologic (blood test) findings, such as rheumatoid factor or antinuclear antibody (consistent with an autoimmune disorder) are present but do not satisfy the criteria for a specific disease. Children with MCTD have laboratory findings of extremely high antibody titers to extractable nuclear antigen (ENA) or ribonucleoprotein (RNP) without high titers of anti-dsDNA or anti-SM antibodies. There are often clinical findings suggestive of SLE or childhood dermatomyositis. Many children later develop features of scleroderma.

6. *Inflammatory arthritis (114.09).*

a. *General.* The spectrum of inflammatory arthritis includes a vast array of disorders that differ in cause, course, and outcome. Clinically, inflammation of major joints in an upper or a lower extremity may be the dominant manifestation causing difficulties with walking or fine and gross movements; there may be joint pain, swelling, and tenderness. The arthritis may affect other joints, or cause less limitation in walking or fine and gross movements. However, in combination with extra-articular features, including constitutional symptoms or signs (severe fatigue, fever, malaise, and involuntary weight loss), inflammatory arthritis may result in an extreme limitation.

b. *Inflammatory arthritis involving the axial spine (spondyloarthropathy).* In children, inflammatory arthritis involving the axial spine may be associated with disorders such as:

(i) Reactive arthropathies;

(ii) Juvenile ankylosing spondylitis;

(iii) Psoriatic arthritis;

(iv) SEA syndrome (seronegative enthesopathy arthropathy syndrome);

(v) Behçet's disease; and

(vi) Inflammatory bowel disease.

c. *Inflammatory arthritis involving the peripheral joints.* In children, inflammatory arthritis involving peripheral joints may be associated with disorders such as:

(i) Juvenile rheumatoid arthritis;

(ii) Sjöogren's syndrome;

(iii) Psoriatic arthritis;

(iv) Crystal deposition disorders (gout and pseudogout);

(v) Lyme disease; and

(vi) Inflammatory bowel disease.

d. *Documentation of inflammatory arthritis.* Generally, but not always, the diagnosis of inflammatory arthritis is based on the clinical features and serologic findings described in the most recent edition of the *Primer on the Rheumatic Diseases* published by the Arthritis Foundation.

e. *How we evaluate inflammatory arthritis under the listings.*

(i) Listing-level severity in 114.09A and 114.09C1 is shown by the presence of an impairment-related physical limitation of functioning. In 114.09C1, if you have the required

ankylosis (fixation) of your cervical or dorsolumbar spine, we will find that you have a listing-level impairment-related physical limitation in your ability to see in front of you, above you, and to the side, even though you might not require bilateral upper limb assistance.

(ii) Listing-level severity in 114.09B and 114.09C2 is shown by inflammatory arthritis that involves various combinations of complications (such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms and signs) of one or more major joints in an upper or a lower extremity (see 114.00C8) or other joints. Extra-articular impairments may also meet listings in other body systems.

(iii) Extra-articular features of inflammatory arthritis may involve any body system; for example: Musculoskeletal (heel enthesopathy), ophthalmologic (iridocyclitis, keratoconjunctivitis sicca, uveitis), pulmonary (pleuritis, pulmonary fibrosis or nodules, restrictive lung disease), cardiovascular (aortic valve insufficiency, arrhythmias, coronary arteritis, myocarditis, pericarditis, Raynaud's phenomenon, systemic vasculitis), renal (amyloidosis of the kidney), hematologic (chronic anemia, thrombocytopenia), neurologic (peripheral neuropathy, radiculopathy, spinal cord or cauda equina compression with sensory and motor loss), mental (cognitive dysfunction, poor memory), and immune system (Felty's syndrome (hypersplenism with compromised immune competence)).

(iv) If both inflammation and chronic deformities are present, we evaluate your impairment under the criteria of any appropriate listing.

7. *Sjögren's syndrome (114.10).*

a. *General.*

(i) Sjögren's syndrome is an immune-mediated disorder of the exocrine glands. Involvement of the lacrimal and salivary glands is the hallmark feature, resulting in symptoms of dry eyes and dry mouth, and possible complications, such as corneal damage, blepharitis (eyelid inflammation), dysphagia (difficulty in swallowing), dental caries, and the inability to speak for extended periods of time. Involvement of the exocrine glands of the upper airways may result in persistent dry cough.

(ii) Many other organ systems may be involved, including musculoskeletal (arthritis, myositis), respiratory (interstitial fibrosis), gastrointestinal (dysmotility, dysphagia, involuntary weight loss), genitourinary (interstitial cystitis, renal tubular acidosis), skin (purpura, vasculitis,), neurologic (central nervous system disorders, cranial and peripheral neuropathies), mental (cognitive dysfunction, poor memory), and neoplastic (lymphoma). Severe fatigue and malaise are frequently reported. Sjögren's syndrome may be associated with other autoimmune disorders (for example, rheumatoid arthritis or SLE); usually the clinical features of the associated disorder predominate.

b. *Documentation of Sjögren's syndrome.* If you have Sjögren's syndrome, the medical evidence will generally, but not always, show that your disease satisfies the criteria in the current ''Criteria for the Classification of Sjögren's Syndrome'' by the American College of Rheumatology found in the most recent edition of the *Primer on the Rheumatic Diseases* published by the Arthritis Foundation.

E. How do we document and evaluate immune deficiency disorders, excluding HIV infection?

1. *General.*

a. Immune deficiency disorders can be classified as:

(i) *Primary* (congenital); for example, X-linked agammaglobulinemia, thymic hypoplasia (DiGeorge syndrome), severe combined immunodeficiency (SCID), chronic granulomatous disease (CGD), C1 esterase inhibitor deficiency.

(ii) *Acquired;* for example, medication-related.

b. Primary immune deficiency disorders are seen mainly in children. However, recent advances in the treatment of these disorders have allowed many affected children to survive well into adulthood. Occasionally, these disorders are first diagnosed in adolescence or adulthood.

2. *Documentation of immune deficiency disorders.* The medical evidence must include documentation of the specific type of immune deficiency. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

3. *Immune deficiency disorders treated by stem cell transplantation.*

a. *Evaluation in the first 12 months.* If you undergo stem cell transplantation for your immune deficiency disorder, we will consider you disabled until at least 12 months from the date of the transplant.

b. *Evaluation after the 12-month period has elapsed.* After the 12-month period has elapsed, we will consider any residuals of your immune deficiency disorder as well as any residual impairment(s) resulting from the treatment, such as complications arising from:

(i) Graft-versus-host (GVH) disease.

(ii) Immunosuppressant therapy, such as frequent infections.

(iii) Significant deterioration of other organ systems.

4. *Medication-induced immune suppression.* Medication effects can result in varying degrees of immune suppression, but most resolve when the medication is ceased. However, if you are prescribed medication for

long-term immune suppression, such as after an organ transplant, we will evaluate:

a. The frequency and severity of infections.

b. Residuals from the organ transplant itself, after the 12-month period has elapsed.

c. Significant deterioration of other organ systems.

F. *How do we document and evaluate HIV infection?* Any child with HIV infection, including one with a diagnosis of acquired immune deficiency syndrome (AIDS), may be found disabled under 114.11 if his or her impairment meets the criteria in that listing or is medically equivalent to the criteria in that listing.

1. *Documentation of HIV infection.*

a. *Definitive documentation of HIV infection.* We may document a diagnosis of HIV infection by positive findings on one or more of the following definitive laboratory tests:

(i) HIV antibody screening test (for example, enzyme immunoassay, or EIA), confirmed by a supplemental HIV antibody test such as the Western blot (immunoblot) or immunofluorescence assay, for any child age 18 months or older.

(ii) HIV nucleic acid (DNA or RNA) detection test (for example, polymerase chain reaction, or PCR).

(iii) HIV p24 antigen (p24Ag) test, for any child age 1 month or older.

(iv) Isolation of HIV in viral culture.

(v) Other tests that are highly specific for detection of HIV and that are consistent with the prevailing state of medical knowledge.

b. We will make every reasonable effort to obtain the results of your laboratory testing. Pursuant to §416.919f of this chapter, we will purchase examinations or tests necessary to make a determination in your claim if no other acceptable documentation exists.

c. *Other acceptable documentation of HIV infection.* We may also document HIV infection without definitive laboratory evidence.

(i) We will accept a persuasive report from a physician that a positive diagnosis of your HIV infection was confirmed by an appropriate laboratory test(s), such as those described in 114.00F1a. To be persuasive, this report must state that you had the appropriate definitive laboratory test(s) for diagnosing your HIV infection and provide the results. The report must also be consistent with the remaining evidence of record.

(ii) We may also document HIV infection by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. For example, we will accept a diagnosis of HIV infection without definitive laboratory evidence of the HIV infection if you have an opportunistic disease that is predictive of a defect in cell-mediated immunity (for example, toxoplasmosis of the brain or *Pneumocystis* pneumonia (PCP)), and there is no other known cause of diminished resistance to that disease (for example, long-term steroid treatment or lymphoma). In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing.

2. *Documentation of the manifestations of HIV infection.*

a. *Definitive documentation of manifestations of HIV infection.* We may document manifestations of HIV infection by positive findings on definitive laboratory tests, such as culture, microscopic examination of biopsied tissue or other material (for example, bronchial washings), serologic tests, or on other generally acceptable definitive tests consistent with the prevailing state of medical knowledge and clinical practice.

b. We will make every reasonable effort to obtain the results of your laboratory testing. Pursuant to §416.919f of this chapter, we will purchase examinations or tests necessary to make a determination of your claim if no other acceptable documentation exists.

c. *Other acceptable documentation of manifestations of HIV infection.* We may also document manifestations of HIV infection without definitive laboratory evidence.

(i) We will accept a persuasive report from a physician that a positive diagnosis of your manifestation of HIV infection was confirmed by an appropriate laboratory test(s). To be persuasive, this report must state that you had the appropriate definitive laboratory test(s) for diagnosing your manifestation of HIV infection and provide the results. The report must also be consistent with the remaining evidence of record.

(ii) We may also document manifestations of HIV infection without the definitive laboratory evidence described in 114.00F2a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence in your case record. For example, many conditions are now commonly diagnosed based on some or all of the following: Medical history, clinical manifestations, laboratory findings (including appropriate medically acceptable imaging), and treatment responses. In such cases, we will make every reasonable effort to obtain full details of the history, medical findings, and results of testing.

3. *Disorders associated with HIV infection (114.11A–E).*

a. *Multicentric Castleman disease* (MCD, 114.11A) affects multiple groups of lymph nodes and organs containing lymphoid tissue. This widespread involvement distinguishes MCD from *localized* (or unicentric) Castleman disease, which affects only a single set of lymph nodes. While not a cancer,

MCD is known as a lymphoproliferative disorder. Its clinical presentation and progression is similar to that of lymphoma, and its treatment may include radiation or chemotherapy. We require characteristic findings on microscopic examination of the biopsied lymph nodes or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis. Localized (or unicentric) Castleman disease does not meet or medically equal the criterion in 114.11A, but we may evaluate it under the criteria in 114.11G or 14.11I in part A.

b. *Primary central nervous system lymphoma* (PCNSL, 114.11B) originates in the brain, spinal cord, meninges, or eye. Imaging tests (for example, MRI) of the brain, while not diagnostic, may show a single lesion or multiple lesions in the white matter of the brain. We require characteristic findings on microscopic examination of the cerebral spinal fluid or of the biopsied brain tissue, or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

c. *Primary effusion lymphoma* (PEL, 114.11C) is also known as body cavity lymphoma. We require characteristic findings on microscopic examination of the effusion fluid or of the biopsied tissue from the affected internal organ, or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

d. *Progressive multifocal leukoencephalopathy* (PML, 114.11D) is a progressive neurological degenerative syndrome caused by the John Cunningham (JC) virus in immunosuppressed children. Clinical findings of PML include clumsiness, progressive weakness, and visual and speech changes. Personality and cognitive changes may also occur. We require appropriate clinical findings, characteristic white matter lesions on MRI, and a positive PCR test for the JC virus in the cerebrospinal fluid to establish the diagnosis. We also accept a positive brain biopsy for JC virus or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

e. *Pulmonary Kaposi sarcoma* (Kaposi sarcoma in the lung, 114.11E) is the most serious form of Kaposi sarcoma (KS). Other internal KS tumors (for example, tumors of the gastrointestinal tract) have a more variable prognosis. We require characteristic findings on microscopic examination of the induced sputum, bronchoalveolar lavage washings, or of the biopsied transbronchial tissue, or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice to establish the diagnosis.

4. *CD4 measurement (114.11F).* To evaluate your HIV infection under 114.11F, we require one measurement of your absolute CD4 count (also known as CD4 count or CD4+ T-helper lymphocyte count) or CD4 percentage for children from birth to attainment of age 5, or one measurement of your absolute CD4 count for children from age 5 to attainment of age 18. These measurements (absolute CD4 count or CD4 percentage) must occur within the period we are considering in connection with your application or continuing disability review. If you have more than one CD4 measurement within this period, we will use your lowest absolute CD4 count or your lowest CD4 percentage.

5. *Complications of HIV infection requiring hospitalization (114.11G).*

a. Complications of HIV infection may include infections (common or opportunistic), cancers, and other conditions. Examples of complications that may result in hospitalization include: Depression; diarrhea; immune reconstitution inflammatory syndrome; malnutrition; and PCP and other severe infections.

b. Under 114.11G, we require three hospitalizations within a 12-month period that are at least 30 days apart and that result from a complication(s) of HIV infection. The hospitalizations may be for the same complication or different complications of HIV infection and are not limited to the examples of complications that may result in hospitalization listed in 114.00F5a. All three hospitalizations must occur within the period we are considering in connection with your application or continuing disability review. Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

c. We will use the rules on medical equivalence in §416.926 of this chapter to evaluate your HIV infection if you have fewer, but longer, hospitalizations, or more frequent, but shorter, hospitalizations, or if you receive nursing, rehabilitation, or other care in alternative settings.

6. *Neurological manifestations specific to children (114.11H).* The methods of identifying and evaluating neurological manifestations may vary depending on a child's age. For example, in an infant, impaired brain growth can be documented by a decrease in the growth rate of the head. In an older child, impaired brain growth may be documented by brain atrophy on a CT scan or MRI. Neurological manifestations may present in the loss of acquired developmental milestones (developmental regression) in infants and young children or, in the loss of acquired intellectual abilities in school-age children and adolescents. A child may demonstrate loss of intellectual abilities by a decrease in

IQ scores, by forgetting information previously learned, by inability to learn new information, or by a sudden onset of a new learning disability. When infants and young children present with serious developmental delays (without regression), we evaluate the child's impairment(s) under 112.00.

7. *Growth failure due to HIV immune suppression (114.11I).*

a. To evaluate growth failure due to HIV immune suppression, we require documentation of the laboratory values described in 114.11I1 and the growth measurements in 114.11I2 or 114.11I3 within the same consecutive 12-month period. The dates of laboratory findings may be different from the dates of growth measurements.

b. Under 114.11I2 and 114.11I3, we use the appropriate table under 105.08B in the digestive system to determine whether a child's growth is less than the third percentile.

(i) For children from birth to attainment of age 2, we use the weight-for-length table corresponding to the child's gender (Table I or Table II).

(ii) For children from age 2 to attainment of age 18, we use the body mass index (BMI)-for-age corresponding to the child's gender (Table III or Table IV).

(iii) BMI is the ratio of a child's weight to the square of his or her height. We calculate BMI using the formulas in the digestive disorders body system (105.00).

G. How do we consider the effects of treatment in evaluating your autoimmune disorder, immune deficiency disorder, or HIV infection?

1. *General.* If your impairment does not otherwise meet the requirements of a listing, we will consider your medical treatment in terms of its effectiveness in improving the signs, symptoms, and laboratory abnormalities of your specific immune system disorder or its manifestations, and in terms of any side effects that limit your functioning. We will make every reasonable effort to obtain a specific description of the treatment you receive (including surgery) for your immune system disorder. We consider:

a. The effects of medications you take.

b. Adverse side effects (acute and chronic).

c. The intrusiveness and complexity of your treatment (for example, the dosing schedule, need for injections).

d. The effect of treatment on your mental functioning (for example, cognitive changes, mood disturbance).

e. Variability of your response to treatment (see 114.00G2).

f. The interactive and cumulative effects of your treatments. For example, many children with immune system disorders receive treatment both for their immune system disorders and for the manifestations of the disorders or co-occurring impairments, such as treatment for HIV infection and hepatitis C. The interactive and cumulative effects of these treatments may be greater than the effects of each treatment considered separately.

g. The duration of your treatment.

h. Any other aspects of treatment that may interfere with your ability to function.

2. *Variability of your response to treatment.* Your response to treatment and the adverse or beneficial consequences of your treatment may vary widely. The effects of your treatment may be temporary or long term. For example, some children may show an initial positive response to a drug or combination of drugs followed by a decrease in effectiveness. When we evaluate your response to treatment and how your treatment may affect you, we consider such factors as disease activity before treatment, requirements for changes in therapeutic regimens, the time required for therapeutic effectiveness of a particular drug or drugs, the limited number of drug combinations that may be available for your impairment(s), and the time-limited efficacy of some drugs. For example, a child with HIV infection or another immune deficiency disorder who develops otitis media may not respond to the same antibiotic regimen used in treating children without HIV infection or another immune deficiency disorder, or may not respond to an antibiotic that he or she responded to before. Therefore, we must consider the effects of your treatment on an individual basis, including the effects of your treatment on your ability to function.

3. *How we evaluate the effects of treatment for autoimmune disorders on your ability to function.* Some medications may have acute or long-term side effects. When we consider the effects of corticosteroids or other treatments for autoimmune disorders on your ability to function, we consider the factors in 114.00G1 and 114.00G2. Long-term corticosteroid treatment can cause ischemic necrosis of bone, posterior subcapsular cataract, impaired growth, weight gain, glucose intolerance, increased susceptibility to infection, and osteopenia that may result in a loss of function. In addition, medications used in the treatment of autoimmune disorders may also have effects on mental functioning, including cognition (for example, memory), concentration, and mood.

4. *How we evaluate the effects of treatment for immune deficiency disorders, excluding HIV infection, on your ability to function.* When we consider the effects of your treatment for your immune deficiency disorder on your ability to function, we consider the factors in 114.00G1 and 114.00G2. A frequent need for treatment such as intravenous immunoglobulin and gamma interferon therapy can be intrusive and interfere with your ability to function. We will also consider whether you have chronic side effects from these or other medications, including severe

fatigue, fever, headaches, high blood pressure, joint swelling, muscle aches, nausea, shortness of breath, or limitations in mental function including cognition (for example, memory) concentration, and mood.

5. *How we evaluate the effects of treatment for HIV infection on your ability to function.*

a. *General.* When we consider the effects of antiretroviral drugs (including the effects of highly active antiretroviral therapy (HAART)) and the effects of treatments for the manifestations of HIV infection on your ability to function, we consider the factors in 114.00G1 and 114.00G2. Side effects of antiretroviral drugs include, but are not limited to: Bone marrow suppression, pancreatitis, gastrointestinal intolerance (nausea, vomiting, diarrhea), neuropathy, rash, hepatotoxicity, lipodystrophy (fat redistribution, such as ''buffalo hump''), glucose intolerance, and lactic acidosis. In addition, medications used in the treatment of HIV infection may also have effects on mental functioning, including cognition (for example, memory), concentration, and mood, and may result in malaise, severe fatigue, joint and muscle pain, and insomnia. The symptoms of HIV infection and the side effects of medication may be indistinguishable from each other. We will consider all of your functional limitations, whether they result from your symptoms or signs of HIV infection or the side effects of your treatment.

b. *Structured treatment interruptions.* A structured treatment interruption (STI, also called a ''drug holiday'') is a treatment practice during which your treating source advises you to stop taking your medications temporarily. An STI in itself does not imply that your medical condition has improved; nor does it imply that you are noncompliant with your treatment because you are following your treating source's advice. Therefore, if you have stopped taking medication because your treating source prescribed or recommended an STI, we will not find that you are failing to follow treatment or draw inferences about the severity of your impairment on this fact alone. We will consider why your treating source has prescribed or recommended an STI and all the other information in your case record when we determine the severity of your impairment.

6. *When there is no record of ongoing treatment.* If you have not received ongoing treatment or have not had an ongoing relationship with the medical community despite the existence of a severe impairment(s), we will evaluate the medical severity and duration of your immune system disorder on the basis of the current objective medical evidence and other evidence in your case record, taking into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you have just begun treatment and we cannot determine whether you are disabled based on the evidence we have, we may need to wait to determine the effect of the treatment on your ability to develop and function in an age-appropriate manner. The amount of time we need to wait will depend on the facts of your case. If you have not received treatment, you may not be able to show an impairment that meets the criteria of one of the immune system disorders listings, but your immune system disorder may medically equal a listing or functionally equal the listings.

H. How do we consider your symptoms, including your pain, severe fatigue, and malaise?

Your symptoms, including pain, severe fatigue, and malaise, may be important factors in our determination whether your immune system disorder(s) meets or medically equals a listing or in our determination whether you otherwise have marked and severe functional limitations. In order for us to consider your symptoms, you must have medical signs or laboratory findings showing the existence of a medically determinable impairment(s) that could reasonably be expected to produce the symptoms. If you have such an impairment(s), we will evaluate the intensity, persistence, and functional effects of your symptoms using the rules throughout 114.00 and in our other regulations. See §§ 416.921 and 416.929. Additionally, when we assess the credibility of your complaints about your symptoms and their functional effects, we will not draw any inferences from the fact that you do not receive treatment or that you are not following treatment without considering all of the relevant evidence in your case record, including any explanations you provide that may explain why you are not receiving or following treatment.

I. How do we consider the impact of your immune system disorder on your functioning?

1. We will consider all relevant information in your case record to determine the full impact of your immune system disorder, including HIV infection, on your ability to function. Functional limitation may result from the impact of the disease process itself on your mental functioning, physical functioning, or both your mental and physical functioning. This could result from persistent or intermittent symptoms, such as depression, diarrhea, severe fatigue, or pain, resulting in a limitation of your ability to acquire information, to concentrate, to persevere at a task, to interact with others, to move about, or to cope with stress. You may also have limitations because of your treatment and its side effects (see 114.00G).

2. Important factors we will consider when we evaluate your functioning include, but are not limited to: Your symptoms (see

114.00H), the frequency and duration of manifestations of your immune system disorder, periods of exacerbation and remission, and the functional impact of your treatment, including the side effects of your medication (see 114.00G). See §§416.924a and 416.926a of this chapter for additional guidance on the factors we consider when we evaluate your functioning.

3. We will use the rules in §§416.924a and 416.926a of this chapter to evaluate your functional limitations and determine whether your impairment functionally equals the listings.

J. How do we evaluate your immune system disorder when it does not meet one of these listings?

1. These listings are only examples of immune system disorders that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. Children with immune system disorders, including HIV infection, may manifest signs or symptoms of a mental impairment or of another physical impairment. For example, HIV infection may accelerate the onset of conditions such as diabetes or affect the course of or treatment options for diseases such as cardiovascular disease or hepatitis. We may evaluate these impairments under the affected body system.For example, we will evaluate:

a. Growth impairment under 100.00.

b. Musculoskeletal involvement, such as surgical reconstruction of a joint, under 101.00.

c. Ocular involvement, such as dry eye, under 102.00.

d. Respiratory impairments, such as pleuritis, under 103.00.

e. Cardiovascular impairments, such as cardiomyopathy, under 104.00.

f. Digestive impairments, such as hepatitis (including hepatitis C) or weight loss as a result of HIV infection that affects the digestive system, under 105.00.

g. Genitourinary impairments, such as nephropathy, under 106.00.

h. Hematologic abnormalities, such as anemia, granulocytopenia, and thrombocytopenia, under 107.00.

i. Skin impairments, such as persistent fungal and other infectious skin eruptions, and photosensitivity, under 108.00.

j. Neurologic impairments, such as neuropathy or seizures, under 111.00.

k. Mental disorders, such as depression, anxiety, or cognitive deficits, under 112.00.

l. Allergic disorders, such as asthma or atopic dermatitis, under 103.00 or 108.00 or under the criteria in another affected body system.

m. Syphilis or neurosyphilis under the criteria for the affected body system, for example, 102.00 Special senses and speech, 104.00 Cardiovascular system, or 111.00 Neurological.

3. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (See §416.926.) If it does not, we will also consider whether you have an impairment(s) that functionally equals the listings. (See §416.926a.) We use the rules in §416.994a when we decide whether you continue to be disabled.

114.01 *Category of Impairments, Immune System Disorders.*

114.02 *Systemic lupus erythematosus,* as described in 114.00D1. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

114.03 *Systemic vasculitis,* as described in 114.00D2. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

114.04 *Systemic sclerosis (scleroderma).* As described in 114.00D3. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. One of the following:

1. Toe contractures or fixed deformity of one or both feet and medical documentation of at least *one* of the following:

a. A documented medical need (see 114.00C6) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7), and a documented medical need (see 114.00C6) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

2. Finger contractures or fixed deformity in both hands and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7); or

3. Atrophy with irreversible damage in one or both lower extremities and medical documentation of at least *one* of the following:

a. A documented medical need (see 114.00C6) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7), and a documented medical need (see 114.00C6) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

4. Atrophy with irreversible damage in *both* upper extremities and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7); or

C. Raynaud's phenomenon, characterized by:

B. One of the following:

1. Toe contractures or fixed deformity of one or both feet and medical documentation of at least *one* of the following:

a. A documented medical need (see 114.00C6) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7), and a documented medical need (see 114.00C6) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

2. Finger contractures or fixed deformity in both hands and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7); or

3. Atrophy with irreversible damage in one or both lower extremities and medical documentation of at least *one* of the following:

a. A documented medical need (see 114.00C6) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7), and a documented medical need (see 114.00C6) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

4. Atrophy with irreversible damage in *both* upper extremities and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7); or

C. Raynaud's phenomenon, characterized by:

1. Gangrene involving at least two extremities; or

2. Ischemia with ulcerations of toes or fingers and medical documentation of at least *one* of the following:

a. A documented medical need (see 114.00C6) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7), and a documented medical need (see 114.00C6) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

c. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7).

114.05 *Polymyositis and dermatomyositis.* As described in 114.00D4. With:

A. Proximal limb-girdle (pelvic or shoulder) muscle weakness and medical documentation of at least *one* of the following:

1. A documented medical need (see 114.00C6) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

2. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7), and a documented medical need (see 114.00C6) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

3. An inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7); or

B. Impaired swallowing (dysphagia) with aspiration due to muscle weakness.

or

C. Impaired respiration due to intercostal and diaphragmatic muscle weakness.

or

D. Diffuse calcinosis with limitation of joint mobility or intestinal motility.

114.06 *Undifferentiated and mixed connective tissue disease,* as described in 114.00D5. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

114.07 *Immune deficiency disorders, excluding HIV infection.* As described in 114.00E. With:

A. One or more of the following infections. The infection(s) must either be resistant to treatment or require hospitalization or intravenous treatment three or more times in a 12-month period.

1. Sepsis; or

2. Meningitis; or

3. Pneumonia; or

4. Septic arthritis; or

5. Endocarditis; or

6. Sinusitis documented by appropriate medically acceptable imaging.

or

B. Stem cell transplantation as described under 114.00E3. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

114.08 [Reserved]

114.09 *Inflammatory arthritis.* As described in 114.00D6. With:

A. Persistent inflammation or persistent deformity of:

1. One or more major joints in a lower extremity (see 114.00C8) and medical documentation of at least *one* of the following:

a. A documented medical need (see 114.00C6) for a walker, bilateral canes, or bilateral crutches (see 101.00C6d) or a wheeled and seated mobility device involving the use of both hands (see 101.00C6e(i)); or

b. An inability to use *one* upper extremity to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7), and a documented medical need (see 114.00C6) for a one-handed, hand-held assistive device (see 101.00C6d) that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand (see 101.00C6e(ii)); or

2. One or more major joints in each upper extremity (see 114.00C8) and medical documentation of an inability to use *both* upper extremities to the extent that neither can be used to independently initiate, sustain, and complete age-appropriate activities involving fine and gross movements (see 114.00C7); or

B. Inflammation or deformity in one or more major joints of an upper or lower extremity (see 114.00C8) with:

1. Involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

C. Ankylosing spondylitis or other spondyloarthropathies, with:

1. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 45° or more of flexion from the vertical position (zero degrees); or

2. Ankylosis (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 30° or more of flexion (but less than 45°) measured from the vertical position (zero degrees), and involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity.

114.10 *Sjögren's syndrome,* as described in 114.00D7. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

114.11 *Human immunodeficiency virus (HIV) infection.* With documentation as described in 114.00F1 and one of the following:

A. Multicentric (not localized or unicentric) Castleman disease affecting multiple groups of lymph nodes or organs containing lymphoid tissue (see 114.00F3a).

OR

B. Primary central nervous system lymphoma (see 114.00F3b).

OR

C. Primary effusion lymphoma (see 114.00F3c).

OR

D. Progressive multifocal leukoencephalopathy (see 114.00F3d).

OR

E. Pulmonary Kaposi sarcoma (see 114.00F3e).

OR

F. Absolute CD4 count or CD4 percentage (see 114.00F4):

1. For children from birth to attainment of age 1, absolute CD4 count of 500 cells/mm^3 or less, or CD4 percentage of less than 15 percent; or

2. For children from age 1 to attainment of age 5, absolute CD4 count of 200 cells/mm^3 or less, or CD4 percentage of less than 15 percent; or

3. For children from age 5 to attainment of age 18, absolute CD4 count of 50 cells/mm^3 or less.

OR

G. Complication(s) of HIV infection requiring at least three hospitalizations within a 12-month period and at least 30 days apart (see 114.00F5). Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization.

OR

H. A neurological manifestation of HIV infection (for example, HIV encephalopathy or peripheral neuropathy) (see 114.00F6) resulting in one of the following:

1. Loss of previously acquired developmental milestones or intellectual ability (including the sudden onset of a new learning disability), documented on two examinations at least 60 days apart; or

2. Progressive motor dysfunction affecting gait and station or fine and gross motor skills, documented on two examinations at least 60 days apart; or

3. Microcephaly with head circumference that is less than the third percentile for age, documented on two examinations at least 60 days apart; or

4. Brain atrophy, documented by appropriate medically acceptable imaging.

OR

I. Immune suppression and growth failure (see 114.00F7) documented by 1 and 2, or by 1 and 3:

1. CD4 measurement:

a. For children from birth to attainment of age 5, CD4 percentage of less than 20 percent; or

b. For children from age 5 to attainment of age 18, absolute CD4 count of less than 200 cells/mm^3 or CD4 percentage of less than 14 percent; and

2. For children from birth to attainment of age 2, three weight-for-length measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate weight-for-length table under 105.08B1; or

3. For children from age 2 to attainment of age 18, three BMI-for-age measurements that are:

a. Within a consecutive 12-month period; and

b. At least 60 days apart; and

c. Less than the third percentile on the appropriate BMI-for-age table under 105.08B2.

[50 FR 35066, Aug. 28, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting appendix 1, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

EFFECTIVE DATE NOTE: At 90 FR 5590, Jan. 17, 2025, appendix 1 to subpart P of part 404 was amended by:

a. In part A, section 1.00C7, revising paragraphs a and c; and

b. In part B, section 101.00C7, revising paragraphs a and c., effective until May 11, 2029.

APPENDIX 2 TO SUBPART P OF PART 404—MEDICAL-VOCATIONAL GUIDELINES

Sec.

200.00 Introduction.
201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).
202.00 Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).
203.00 Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).
204.00 Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).

200.00 *Introduction.* (a) The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical considerations alone, where an individual with a severe medically determinable physical or mental impairment(s) is not engaging in substantial gainful activity and the individual's impairment(s) prevents the performance of his or her vocationally relevant past work. They also reflect the analysis of the various vocational factors (*i.e.*, age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in

substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. However, each of these findings of fact is subject to rebuttal and the individual may present evidence to refute such findings. Where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not disabled. In any instance where a rule does not apply, full consideration must be given to all of the relevant facts of the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations.

(b) The existence of jobs in the national economy is reflected in the ''Decisions'' shown in the rules; *i.e.*, in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy) as supported by the ''Dictionary of Occupational Titles'' and the ''Occupational Outlook Handbook,'' published by the Department of Labor; the ''County Business Patterns'' and ''Census Surveys'' published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies. Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. However, the existence of such jobs for individuals whose remaining functional capacity or other factors do not coincide with the criteria of a rule must be further considered in terms of what kinds of jobs or types of work may be either additionally indicated or precluded.

(c) In the application of the rules, the individual's residual functional capacity (*i.e.*, the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs), age, education, and work experience must first be determined. When assessing the person's residual functional capacity, we consider his or her symptoms (such as pain), signs, and laboratory findings together with other evidence we obtain.

(d) The correct disability decision (*i.e.*, on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile. If an individual's specific profile is not listed within this appendix 2, a conclusion of disabled or not disabled is not directed. Thus, for example, an individual's ability to engage in substantial gainful work where his or her residual functional capacity falls between the ranges of work indicated in the rules (e.g., the individual who can perform more than light but less than medium work), is decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in this appendix 2. These rules represent various combinations of exertional capabilities, age, education and work experience and also provide an overall structure for evaluation of those cases in which the judgments as to each factor do not coincide with those of any specific rule. Thus, when the necessary judgments have been made as to each factor and it is found that no specific rule applies, the rules still provide guidance for decisionmaking, such as in cases involving combinations of impairments. For example, if strength limitations resulting from an individual's impairment(s) considered with the judgments made as to the individual's age, education and work experience correspond to (or closely approximate) the factors of a particular rule, the adjudicator then has a frame of reference for considering the jobs or types of work precluded by other, nonexertional impairments in terms of numbers of jobs remaining for a particular individual.

(e) Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental, sensory, or skin impairments. In addition, some impairments may result solely in postural and manipulative limitations or environmental restrictions. Environmental restrictions are those restrictions which result in inability to tolerate some physical feature(s) of work settings that occur in certain industries or types of work, e.g., an inability to tolerate dust or fumes.

(1) In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in this appendix 2. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments.

(2) However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide

a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

201.00 *Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).* (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

(b) These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity.

(c) Vocational adjustment to sedentary work may be expected where the individual has special skills or experience relevant to sedentary work or where age and basic educational competences provide sufficient occupational mobility to adapt to the major segment of unskilled sedentary work. Inability to engage in substantial gainful activity would be indicated where an individual who is restricted to sedentary work because of a severe medically determinable impairment lacks special skills or experience relevant to sedentary work, lacks educational qualifications relevant to most sedentary work (e.g., has a limited education or less) and the individual's age, though not necessarily advanced, is a factor which significantly limits vocational adaptability.

(d) The adversity of functional restrictions to sedentary work at advanced age (55 and over) for individuals with no relevant past work or who can no longer perform vocationally relevant past work and have no transferable skills, warrants a finding of disabled in the absence of the rare situation where the individual has recently completed education which provides a basis for direct entry into skilled sedentary work. Advanced age and a history of unskilled work or no work experience would ordinarily offset any vocational advantages that might accrue by reason of any remote past education, whether it is more or less than limited education.

(e) The presence of acquired skills that are readily transferable to a significant range of skilled work within an individual's residual functional capacity would ordinarily warrant a finding of ability to engage in substantial gainful activity regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) In order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) Individuals approaching advanced age (age 50–54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. When such individuals have no past work experience or can no longer perform vocationally relevant past work and have no transferable skills, a finding of disabled ordinarily obtains. However, recently completed education which provides for direct entry into sedentary work will preclude such a finding. For this age group, even a high school education or more (ordinarily completed in the remote past) would have little impact for effecting a vocational adjustment unless relevant work experience reflects use of such education.

(h)(1) The term *younger individual* is used to denote an individual age 18 through 49. For individuals who are age 45–49, age is a less advantageous factor for making an adjustment to other work than for those who are age 18–44. Accordingly, a finding of ''disabled'' is warranted for individuals age 45–49 who:

(i) Are restricted to sedentary work,

(ii) Are unskilled or have no transferable skills,

(iii) Have no past relevant work or can no longer perform past relevant work, and

(iv) Are illiterate.

(2) For individuals who are under age 45, age is a more advantageous factor for making an adjustment to other work. It is usually not a significant factor in limiting such individual's ability to make an adjustment to other work, including an adjustment to unskilled sedentary work, even when the individuals are illiterate.

(3) Nevertheless, a decision of ''disabled'' may be appropriate for some individuals under age 45 (or individuals age 45–49 for whom rule 201.17 does not direct a decision of disabled) who do not have the ability to perform a full range of sedentary work. However, the inability to perform a full range of

sedentary work does not necessarily equate with a finding of ''disabled.'' Whether an individual will be able to make an adjustment to other work requires an adjudicative assessment of factors such as the type and extent of the individual's limitations or restrictions and the extent of the erosion of the occupational base. It requires an individualized determination that considers the impact of the limitations or restrictions on the number of sedentary, unskilled occupations or the total number of jobs to which the individual may be able to adjust, considering his or her age, education and work experience, including any transferable skills or education providing for direct entry into skilled work.

(4) ''Sedentary work'' represents a significantly restricted range of work, and individuals with a maximum sustained work capability limited to sedentary work have very serious functional limitations. Therefore, as with any case, a finding that an individual is limited to less than the full range of sedentary work will be based on careful consideration of the evidence of the individual's medical impairment(s) and the limitations and restrictions attributable to it. Such evidence must support the finding that the individual's residual functional capacity is limited to less than the full range of sedentary work.

(i) While illiteracy may significantly limit an individual's vocational scope, the primary work functions in most unskilled occupations involve working with things (rather than with data or people). In these work functions, education has the least significance. Similarly the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. Thus, the functional capacity for a full range of sedentary work represents sufficient numbers of jobs to indicate substantial vocational scope for those individuals age 18–44, even if they are illiterate.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
201.01 ...	Advanced age	Limited or less	Unskilled or none	Disabled
201.02 ...	.....do	.....do	Skilled or semiskilled—skills not transferable [1].	Do.
201.03 ...	.....do	.....do	Skilled or semiskilled—skills transferable [1].	Not disabled
201.04 ...	.....do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled
201.05 ...	.....do	High school graduate or more—provides for direct entry into skilled work [2].	.....do	Not disabled
201.06 ...	.....do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Disabled
201.07 ...	.....do	.....do	Skilled or semiskilled—skills transferable [1].	Not disabled
201.08 ...	.....do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Do.
201.09 ...	Closely approaching advanced age.	Limited or less	Unskilled or none	Disabled
201.10 ...	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
201.11 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Not disabled
201.12 ...	.....do	High school graduate or more—does not provide for direct entry into skilled work [3].	Unskilled or none	Disabled
201.13 ...	.....do	High school graduate or more—provides for direct entry into skilled work [3].	.....do	Not disabled
201.14 ...	.....do	High school graduate or more—does not provide for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Disabled
201.15 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Not disabled
201.16 ...	.....do	High school graduate or more—provides for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Do.
201.17 ...	Younger individual age 45–49.	Illiterate	Unskilled or none	Disabled.
201.18 ...	.....do	Limited or Marginal, but not Illiterate	.....do	Not disabled.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
201.19 ...	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
201.20 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
201.21 ...	.....do	High school graduate or more	Skilled or semiskilled—skills not transferable.	Do.
201.22 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
201.23 ...	Younger individual age 18–44.	Illiterate	Unskilled or none	[4] Do.
201.24 ...	.....do	Limited or Marginal, but not Illiterate	.....do	[4] Do.
201.25 ...	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.[4]
201.26 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]
201.27 ...	.....do	High school graduate or more	Unskilled or none	Do.[4]
201.28 ...	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.[4]
201.29 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]

[1] See 201.00(f).
[2] See 201.00(d).
[3] See 201.00(g).
[4] See 201.00(h).

202.00 *Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.

(b) The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competences for unskilled work.

(c) However, for individuals of advanced age who can no longer perform vocationally relevant past work and who have a history of unskilled work experience, or who have only skills that are not readily transferable to a significant range of semi-skilled or skilled work that is within the individual's functional capacity, or who have no work experience, the limitations in vocational adaptability represented by functional restriction to light work warrant a finding of disabled. Ordinarily, even a high school education or more which was completed in the remote past will have little positive impact on effecting a vocational adjustment unless relevant work experience reflects use of such education.

(d) A finding of disabled is warranted where the same factors in paragraph (c) of this section regarding education and previous work experience are present, but where age, though not advanced, is a factor which significantly limits vocational adaptability (*i.e.*, closely approaching advanced age, 50–54) and an individual's vocational scope is further significantly limited by illiteracy.

(e) The presence of acquired skills that are readily transferable to a significant range of semi-skilled or skilled work within an individual's residual functional capacity would ordinarily warrant a finding of not disabled regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) For a finding of transferability of skills to light work for persons of advanced age who are closely approaching retirement age (age 60 or older), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) While illiteracy may significantly limit an individual's vocational scope, the primary work functions in most unskilled occupations relate to working with things (rather

than data or people). In these work functions, education has the least significance. Similarly, the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. The capability for light work, which includes the ability to do sedentary work, represents the capability for substantial numbers of such jobs. This, in turn, represents substantial vocational scope for younger individuals (age 18–49), even if they are illiterate.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
202.01	Advanced age	Limited or less	Unskilled or none	Disabled.
202.02	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.03	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
202.04	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
202.05	do	High school graduate or more—provides for direct entry into skilled work [2].	do	Not disabled.
202.06	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Disabled.
202.07	do	do	Skilled or semiskilled—skills transferable [2].	Not disabled.
202.08	do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Do.
202.09	Closely approaching advanced age.	Illiterate	Unskilled or none	Disabled.
202.10	do	Limited or Marginal, but not Illiterate.	do	Not disabled.
202.11	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.12	do	do	Skilled or semiskilled—skills transferable.	Do.
202.13	do	High school graduate or more	Unskilled or none	Do.
202.14	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.15	do	do	Skilled or semiskilled—skills transferable.	Do.
202.16	Younger individual	Illiterate	Unskilled or none	Do.
202.17	do	Limited or Marginal, but not Illiterate.	do	Do.
202.18	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.19	do	do	Skilled or semiskilled—skills transferable.	Do.
202.20	do	High school graduate or more	Unskilled or none	Do.
202.21	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.22	do	do	Skilled or semiskilled—skills transferable.	Do.

[1] See 202.00(f).
[2] See 202.00(c).

203.00 *Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform medium work includes the functional capacity to perform sedentary, light, and medium work. Approximately 2,500 separate sedentary, light, and medium occupations can be identified, each occupation representing numerous jobs in the national economy which do not require skills or previous experience and which can be performed after a short demonstration or within 30 days.

(b) The functional capacity to perform medium work represents such substantial work capability at even the unskilled level that a finding of disabled is ordinarily not warranted in cases where a severely impaired person retains the functional capacity to perform medium work. Even the adversity of

advanced age (55 or over) and a work history of unskilled work may be offset by the substantial work capability represented by the functional capacity to perform medium work. However, we will find that a person who (1) has a marginal education, (2) has work experience of 35 years or more doing only arduous unskilled physical labor, (3) is not working, and (4) is no longer able to do this kind of work because of a severe impairment(s) is disabled, even though the person is able to do medium work. (*See* §404.1562(a) in this subpart and §416.962(a) in subpart I of part 416.)

(c) However, the absence of any relevant work experience becomes a more significant adversity for persons of advanced age (55 and over). Accordingly, this factor, in combination with a limited education or less, militates against making a vocational adjustment to even this substantial range of work and a finding of disabled is appropriate. Further, for persons closely approaching retirement age (60 or older) with a work history of unskilled work and with marginal education or less, a finding of disabled is appropriate.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
203.01	Closely approaching retirement age.	Marginal or Illiterate	Unskilled or none	Disabled.
203.02	...do	Limited or less	None	Do.
203.03	...do	Limited	Unskilled	Not disabled.
203.04	...do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
203.05	...do	...do	Skilled or semiskilled—skills transferable.	Do.
203.06	...do	High school graduate or more	Unskilled or none	Do.
203.07	...do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.08	...do	...do	Skilled or semiskilled—skills transferable.	Do.
203.09	...do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.10	Advanced age	Limited or less	None	Disabled.
203.11	...do	...do	Unskilled	Not disabled.
203.12	...do	...do	Skilled or semiskilled—skills not transferable.	Do.
203.13	...do	...do	Skilled or semiskilled—skills transferable.	Do.
203.14	...do	High school graduate or more	Unskilled or none	Do.
203.15	...do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.16	...do	...do	Skilled or semiskilled—skills transferable.	Do.
203.17	...do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.18	Closely approaching advanced age.	Limited or less	Unskilled or none	Do.
203.19	...do	...do	Skilled or semiskilled—skills not transferable.	Do.
203.20	...do	...do	Skilled or semiskilled—skills transferable.	Do.
203.21	...do	High school graduate or more	Unskilled or none	Do.
203.22	...do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.23	...do	...do	Skilled or semiskilled—skills transferable.	Do.
203.24	...do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.25	Younger individual	Limited or less	Unskilled or none	Do.
203.26	...do	...do	Skilled or semiskilled—skills not transferable.	Do.
203.27	...do	...do	Skilled or semiskilled—skills transferable.	Do.
203.28	...do	High school graduate or more	Unskilled or none	Do.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
203.29	.....do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.30	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.31	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

204.00 *Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).* The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work—either of which would have already provided a basis for a decision of ''not disabled''. Environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991; 68 FR 51164, Aug. 26, 2003; 73 FR 64197, Oct. 29, 2008; 85 FR 10602, Feb. 25, 2020]

Subpart Q—Determinations of Disability

AUTHORITY: Secs. 205(a), 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

SOURCE: 46 FR 29204, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§ 404.1601 Purpose and scope.

This subpart describes the standards of performance and administrative requirements and procedures for States making determinations of disability for the Commissioner under title II of the Act. It also establishes the Commissioner's responsibilities in carrying out the disability determination function.

(a) Sections 404.1601 through 404.1603 describe the purpose of the regulations and the meaning of terms frequently used in the regulations. They also briefly set forth the responsibilities of the Commissioner and the States covered in detail in other sections.

(b) Sections 404.1610 through 404.1618 describe the Commissioner's and the State's responsibilities in performing the disability determination function.

(c) Sections 404.1620 through 404.1633 describe the administrative responsibilities and requirements of the States. The corresponding role of the Commissioner is also set out.

(d) Sections 404.1640 through 404.1650 describe the performance accuracy and processing time standards for measuring State agency performance.

(e) Sections 404.1660 through 404.1661 describe when and what kind of assistance the Commissioner will provide State agencies to help them improve performance.

(f) Sections 404.1670 through 404.1675 describe the level of performance below which the Commissioner will consider a State agency to be substantially failing to make disability determinations consistent with the regulations and other written guidelines and the resulting action the Commissioner will take.

(g) Sections 404.1680 through 404.1683 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(h) Sections 404.1690 through 404.1694 describe when and what action the

Commissioner will take and what action the State will be expected to take if the Commissioner assumes the disability determination function from a State agency.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38451, July 18, 1997; 71 FR 16445, Mar. 31, 2006; 76 FR 24808, May 3, 2011]

§ 404.1602 Definitions.

For purposes of this subpart:

Act means the Social Security Act, as amended.

Class or classes of cases means the categories into which disability claims are divided according to their characteristics.

Commissioner means the Commissioner of Social Security or his or her authorized designee.

Compassionate allowance means a determination or decision we make under a process that identifies for expedited handling claims that involve impairments that invariably qualify under the Listing of Impairments in appendix 1 to subpart P based on minimal, but sufficient, objective medical evidence.

Determination of disability or *disability determination* means one or more of the following decisions:

(a) Whether or not a person is under a disability;

(b) The date a person's disability began; or

(c) The date a person's disability ended.

Disability means *disability* or *blindness* as defined in sections 216(i) and 223 of the Act or as defined in title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Disability determination function means making determinations as to disability and carrying out related administrative and other responsibilities.

Disability program means, as appropriate, the Federal programs for providing disability insurance benefits under title II of the Act and disability benefits under title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Initial means the first level of disability adjudication.

Other written guidelines means written issuances such as Social Security Rulings and memoranda by the Commissioner of Social Security, the Deputy Commissioner for Programs and Policy, or the Associate Commissioner for Disability and the procedures, guides, and operating instructions in the Disability Insurance sections of the Program Operations Manual System, that are instructive, interpretive, clarifying, and/or administrative and not designated as advisory or discretionary. The purpose of including the foregoing material in the definition is to assure uniform national application of program standards and service delivery to the public.

Quick disability determination means an initial determination on a claim that we have identified as one that reflects a high degree of probability that you will be found disabled and where we expect that your allegations will be easily and quickly verified.

Regulations means regulations in this subpart issued under sections 205(a), 221 and 1102 of the Act, unless otherwise indicated.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Columbia, or Guam. It includes the State agency.

State agency means that agency of a State which has been designated by the State to carry out the disability determination function.

We, *us*, and *our* refers to the Social Security Administration (SSA).

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991; 62 FR 38452, July 18, 1997; 72 FR 51177, Sept. 6, 2007; 75 FR 62682, Oct. 13, 2010]

§ 404.1603 Basic responsibilities for us and the State.

(a) *General.* We will work with the State to provide and maintain an effective system for processing claims of those who apply for and who are receiving benefits under the disability program. We will provide program standards, leadership, and oversight. We do not intend to become involved in the State's ongoing management of the program except as is necessary and in accordance with these regulations. The State will comply with our regulations and other written guidelines.

(b) *Our responsibilities.* We will:

(1) Periodically review the regulations and other written guidelines to

determine whether they insure effective and uniform administration of the disability program. To the extent feasible, we will consult with and take into consideration the experience of the States in issuing regulations and guidelines necessary to insure effective and uniform administration of the disability program;

(2) Provide training materials or in some instances conduct or specify training, see § 404.1622;

(3) Provide funds to the State agency for the necessary cost of performing the disability determination function, see § 404.1626;

(4) Monitor and evaluate the performance of the State agency under the established standards, see §§ 404.1644 and 404.1645; and

(5) Maintain liaison with the medical profession nationally and with national organizations and agencies whose interests or activities may affect the disability program.

(c) *Responsibilities of the State.* The State will:

(1) Provide management needed to insure that the State agency carries out the disability determination function so that disability determinations are made accurately and promptly;

(2) Provide an organizational structure, adequate facilities, qualified personnel, medical consultant services, designated quick disability determination examiners (§§ 404.1619 and 404.1620(c)), and a quality assurance function (§§ 404.1620 through 404.1624);

(3) Furnish reports and records relating to the administration of the disability program (§ 404.1625);

(4) Submit budgets (§ 404.1626);

(5) Cooperate with audits (§ 404.1627);

(6) Insure that all applicants for and recipients of disability benefits are treated equally and courteously;

(7) Be responsible for property used for disability program purposes (§ 404.1628);

(8) Take part in the research and demonstration projects (§ 404.1629);

(9) Coordinate with other agencies (§ 404.1630);

(10) Safeguard the records created by the State in performing the disability determination function (§ 404.1631);

(11) Comply with other provisions of the Federal law and regulations that apply to the State in performing the disability determination function;

(12) Comply with other written guidelines (§ 404.1633);

(13) Maintain liaison with the medical profession and organizations that may facilitate performing the disability determination function; and

(14) Assist us in other ways that we determine may promote the objectives of effective and uniform administration.

[46 FR 29204, May 29, 1981, as amended at 72 FR 51177, Sept. 6, 2007]

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

§ 404.1610 How a State notifies us that it wishes to perform the disability determination function.

(a) *Deemed notice.* Any State that has in effect as of June 1, 1981, an agreement with us to make disability determinations will be deemed to have given us notice that it wishes to perform the disability determination function, in lieu of continuing the agreement in effect after June 1, 1981.

(b) *Written notice.* After June 1, 1981, a State not making disability determinations that wishes to perform the disability determination function under these regulations must notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the State's Attorney General verifying the authority of the official who sent the notice to act for the State.

§ 404.1611 How we notify a State whether it may perform the disability determination function.

(a) If a State notifies us in writing that it wishes to perform the disability determination function, we will notify the State in writing whether or not it may perform the function. The State will begin performing the disability determination function beginning with the month we and the State agree upon.

(b) If we have previously found that a State agency has substantially failed to make disability determinations in accordance with the law or these regulations and other written guidelines or

if the State has previously notified us in writing that it does not wish to make disability determinations, the notice will advise the State whether the State agency may again make the disability determinations and, if so, the date and the conditions under which the State may again make them.

§ 404.1613 Disability determinations the State makes.

(a) *General rule.* A State agency will make determinations of disability with respect to all persons in the State except those individuals whose cases are in a class specifically excluded by our written guidelines. A determination of disability made by the State is the determination of the Commissioner, except as described in § 404.1503(d)(1).

(b) *New classes of cases.* Where any new class or classes of cases arise requiring determinations of disability, we will determine the conditions under which a State may choose not to make the disability determinations. We will provide the State with the necessary funding to do the additional work.

(c) *Temporary transfer of classes of cases.* We will make disability determinations for classes of cases temporarily transferred to us by the State agency if the State agency asks us to do so and we agree. The State agency will make written arrangements with us which will specify the period of time and the class or classes of cases we will do.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

§ 404.1614 Responsibilities for obtaining evidence to make disability determinations.

(a) We or the State agency will secure from the claimant or other sources any evidence the State agency needs to make a disability determination. When we secure the evidence, we will furnish it to the State agency for use in making the disability determination.

(b) At our request, the State agency will obtain and furnish medical or other evidence and provide assistance as may be necessary for us to carry out our responsibilities—

(1) For making disability determinations in those classes of cases described in the written guidelines for which the State agency does not make the determination; or

(2) Under international agreements with respect to social security benefits payable under section 233 of the Act.

[46 FR 29204, May 29, 1981, as amended at 79 FR 33682, June 12, 2014]

§ 404.1615 Making disability determinations.

(a) When making a disability determination, the State agency will apply subpart P, part 404, of our regulations.

(b) The State agency will make disability determinations based only on the medical and nonmedical evidence in its files.

(c) Disability determinations will be made by:

(1) A State agency medical or psychological consultant and a State agency disability examiner;

(2) A State agency disability examiner alone when there is no medical evidence to be evaluated (*i.e.*, no medical evidence exists or we are unable, despite making every reasonable effort, to obtain any medical evidence that may exist) and the individual fails or refuses, without a good reason, to attend a consultative examination (see § 404.1518);

(3) A State agency disability examiner alone if the claim is adjudicated under the quick disability determination process (see § 404.1619) or the compassionate allowance process (see § 404.1602), and the initial or reconsidered determination is fully favorable to you. This paragraph (c)(3) will no longer be effective on December 28, 2018 unless we terminate it earlier by publication of a final rule in the FEDERAL REGISTER; or

(4) A State agency disability hearing officer.

See § 404.1616 for the definition of medical or psychological consultant and § 404.915 for the definition of disability hearing officer. The State agency disability examiner and disability hearing officer must be qualified to interpret and evaluate medical reports and other evidence relating to the claimant's physical or mental impairments and as necessary to determine the capacities of the claimant to perform substantial gainful activity.

See § 404.1572 for what we mean by substantial gainful activity.

(d) The State agency will certify each determination of disability to us on forms we provide.

(e) The State agency will furnish us with all the evidence it considered in making its determination.

(f) The State agency will not be responsible for defending in court any determination made, or any procedure for making determinations, under these regulations.

[52 FR 33926, Sept. 9, 1987, as amended at 56 FR 11018, Mar. 14, 1991; 61 FR 11135, Mar. 19, 1996; 62 FR 38452, July 18, 1997; 65 FR 34958, June 1, 2000; 75 FR 62682, Oct. 13, 2010; 78 FR 66639, Nov. 6, 2013; 79 FR 51243, Aug. 28, 2014; 80 FR 63093, Oct. 19, 2015; 81 FR 73028, Oct. 24, 2016; 82 FR 5872, Jan. 18, 2017]

§ 404.1616 Medical consultants and psychological consultants.

(a) *What is a medical consultant?* A medical consultant is a member of a team that makes disability determinations in a State agency (see § 404.1615), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all physical impairment(s) in a claim.

(b) *What qualifications must a medical consultant have?* A medical consultant is a licensed physician, as defined in § 404.1502(a)(1).

(c) *What is a psychological consultant?* A psychological consultant is a member of a team that makes disability determinations in a State agency (see § 404.1615), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all mental impairment(s) in a claim. When we are unable to obtain the services of a qualified psychiatrist or psychologist despite making every reasonable effort (see § 404.1617) in a claim involving a mental impairment(s), a medical consultant will evaluate the mental impairment(s).

(d) *What qualifications must a psychological consultant have?* A psychological consultant can be either a licensed psychiatrist or psychologist. We will only consider a psychologist qualified to be a psychological consultant if he or she:

(1) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

(2)(i) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or

(ii) Is listed in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate; and

(3) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.

(e) *Cases involving both physical and mental impairments.* In a case where there is evidence of both physical and mental impairments, the medical consultant will evaluate the physical impairments in accordance with paragraph (a) of this section, and the psychological consultant will evaluate the mental impairment(s) in accordance with paragraph (c) of this section.

[82 FR 5873, Jan. 18, 2017]

§ 404.1617 Reasonable efforts to obtain review by a physician, psychiatrist, and psychologist.

(a) When the evidence of record indicates the existence of a physical impairment, the State agency must make every reasonable effort to ensure that a medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. When the evidence of record indicates the existence of a mental impairment, the State agency must make every reasonable effort to ensure that a psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. The State agency must determine if additional physicians, psychiatrists, and psychologists are needed to make the necessary reviews. When it does not have sufficient resources to make the

necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional physicians, psychiatrists, and psychologists because of low salary rates or fee schedules, it should attempt to raise the State agency's levels of compensation to meet the prevailing rates for these services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency's efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

(b) Federal resources may include the use of Federal contracts for the services of qualified psychiatrists and psychologists to review mental impairment cases. Where Federal resources are required to perform these reviews, which are a basic State agency responsibility, and where appropriate, the State agency's budget will be reduced accordingly.

(c) Where every reasonable effort is made to obtain the services of a qualified psychiatrist or psychologist to review a mental impairment case, but the professional services are not obtained, a physician who is not a psychiatrist will review the mental impairment case. For these purposes, every reasonable effort to ensure that a qualified psychiatrist or psychologist review mental impairment cases will be considered to have been made only after efforts by both State and Federal agencies as set forth in paragraphs (a) and (b) of this section are made.

[52 FR 33927, Sept. 9, 1987, as amended at 82 FR 5873, Jan. 18, 2017]

§ 404.1618 Notifying claimants of the disability determination.

The State agency will prepare denial notices in accordance with subpart J of this part whenever it makes a disability determination which is fully or partially unfavorable to the claimant.

[46 FR 29204, May 29, 1981, as amended at 75 FR 33168, June 11, 2010]

QUICK DISABILITY DETERMINATIONS

§ 404.1619 Quick disability determination process.

(a) If we identify a claim as one involving a high degree of probability that the individual is disabled, and we expect that the individual's allegations will be easily and quickly verified, we will refer the claim to the State agency for consideration under the quick disability determination process pursuant to this section and § 404.1620(c).

(b) If we refer a claim to the State agency for a quick disability determination, a designated quick disability determination examiner must do all of the following:

(1) Subject to the provisions in paragraph (c) of this section, make the disability determination after consulting with a State agency medical or psychological consultant if the State agency disability examiner determines consultation is appropriate or if consultation is required under § 404.1526(c). The State agency may certify the disability determination forms to us without the signature of the medical or psychological consultant.

(2) Make the quick disability determination based only on the medical and nonmedical evidence in the file.

(3) Subject to the provisions in paragraph (c) of this section, make the quick disability determination by applying the rules in subpart P of this part.

(c) If the quick disability determination examiner cannot make a determination that is fully favorable, or if there is an unresolved disagreement between the disability examiner and the medical or psychological consultant (except when a disability examiner makes the determination alone under § 404.1615(c)(3)), the State agency will adjudicate the claim using the regularly applicable procedures in this subpart.

[72 FR 51177, Sept. 6, 2007, as amended at 75 FR 62682, Oct. 13, 2010]

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

§ 404.1620 General administrative requirements.

(a) The State will provide the organizational structure, qualified personnel, medical consultant services, and a quality assurance function sufficient to ensure that disability determinations are made accurately and promptly. We may impose specific administrative requirements in these areas and in those under ''Administrative Responsibilities and Requirements'' in order to establish uniform, national administrative practices or to correct the areas of deficiencies which may later cause the State to be substantially failing to comply with our regulations or other written guidelines. We will notify the State, in writing, of the administrative requirements being imposed and of any administrative deficiencies it is required to correct. We will allow the State 90 days from the date of this notice to make appropriate corrections. Once corrected, we will monitor the State's administrative practices for 180 days. If the State does not meet the requirements or correct all of the deficiencies, or, if some of the deficiencies recur, we may initiate procedures to determine if the State is substantially failing to follow our regulations or other written guidelines.

(b) The State is responsible for making accurate and prompt disability determinations.

(c) Each State agency will designate experienced disability examiners to handle claims we refer to it under § 404.1619(a).

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991; 72 FR 51177, Sept. 6, 2007]

§ 404.1621 Personnel.

(a) *Equal employment opportunity.* The State will comply with all applicable Federal statutes, executive orders and regulations concerned with equal employment opportunities.

(b) *Selection, tenure, and compensation.* The State agency will, except as may be inconsistent with paragraph (a) of this section, adhere to applicable State approved personnel standards in the selection, tenure, and compensation of any individual employed in the disability program.

(c) *Travel.* The State will make personnel available to attend meetings or workshops as may be sponsored or approved by us for furthering the purposes of the disability program.

(d) *Restrictions.* Subject to appropriate Federal funding, the State will, to the best of its ability, facilitate the processing of disability claims by avoiding personnel freezes, restrictions against overtime work, or curtailment of facilities or activities.

§ 404.1622 Training.

The State will insure that all employees have an acceptable level of competence. We will provide training and other instructional materials to facilitate basic and advanced technical proficiency of disability staff in order to insure uniformity and effectiveness in the administration of the disability program. We will conduct or specify training, as appropriate, but only if:

(a) A State agency's performance approaches unacceptable levels; or

(b) The material required for the training is complex or the capacity of the State to deliver the training is in doubt and uniformity of the training is essential.

§ 404.1623 Facilities.

(a) *Space, equipment, supplies, and other services.* Subject to appropriate Federal funding, the State will provide adequate space, equipment, supplies, and other services to facilitate making accurate and prompt disability determinations.

(b) *Location of facilities.* Subject to appropriate Federal funding, the State will determine the location where the disability determination function is to be performed so that disability determinations are made accurately and promptly.

(c) *Access.* The State will permit us access to the premises where the disability determination function is performed and also where it is managed for the purposes of inspecting and obtaining information about the work and activities required by our regulations and assuring compliance with pertinent Federal statutes and regulations. Access includes personal onsite

visits and other means, such as telecommunications, of contacting the State agency to obtain information about its functions. We will contact the State agency and give reasonable prior notice of the times and purposes of any visits.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11019, Mar. 14, 1991]

§ 404.1624 Medical and other purchased services.

The State will determine the rates of payment for purchasing medical or other services necessary to make determinations of disability. The rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar type of service. The State will maintain documentation to support the rates of payment it uses.

[46 FR 29204, May 29, 1981,as amended at 71 FR 16445, Mar. 31, 2006; 76 FR 24808, May 3, 2011]

§ 404.1625 Records and reports.

(a) The State will establish and maintain the records and furnish the schedules, financial, cost, and other reports relating to the administration of the disability programs as we may require.

(b) The State will permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the work which the State performs under these regulations. These records will be retained by the State for the periods of time specified for retention of records in the Federal Procurement Regulations (41 CFR parts 1–20).

§ 404.1626 Fiscal.

(a) We will give the State funds, in advance or by way of reimbursement, for necessary costs in making disability determinations under these regulations. Necessary costs are direct as well as indirect costs as defined in 41 CFR part 1–15, subpart 1–15.7 of the Federal Procurement Regulations System for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 of the Federal Acquisition Regulations System and Federal Management Circular A–74–4[1] as amended or superseded for costs incurred after March 31, 1984.

(b) The State will submit estimates of anticipated costs in the form of a budget at the time and in the manner we require.

(c) We will notify the State of the amount which will be made available to it as well as what anticipated costs are being approved.

(d) The State may not incur or make expenditures for items of cost not approved by us or in excess of the amount we make available to the State.

(e) After the close of a period for which funds have been made available to the State, the State will submit a report of its expenditures. Based on an audit arranged by the State under Pub. L. 98–502, the Single Audit Act of 1984, or by the Inspector General of the Social Security Administration or based on an audit or review by the Social Security Administration (see § 404.1627), we will determine whether the expenditures were consistent with cost principles described in 41 CFR part 1–15, subpart 1–15.7 for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 and Federal Management Circular A–741–4 for costs incurred after March 31, 1984: and in other applicable written guidelines in effect at the time the expenditures were made or incurred.

(f) Any monies paid to the State which are used for purposes not within the scope of these regulations will be paid back to the Treasury of the United States.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11019, Mar. 14, 1991; 62 FR 38452, July 18, 1997]

§ 404.1627 Audits.

(a) *Audits performed by the State*—(1) *Generally.* Audits of accounts and records pertaining to the administration of the disability program under the Act, will be performed by the States in accordance with the Single Audit Act of 1984 (Pub. L. 98–502) which establishes audit requirements for States receiving Federal assistance. If

[1] The circular is available from the Office of Administration, Publications Unit, Rm. G–236, New Executive Office Bldg., Washington, DC 20503.

the audit performed by the State meets our program requirements, we will accept the findings and recommendations of the audit. The State will make every effort to act upon and resolve any items questioned in the audit.

(2) *Questioned items.* Items questioned as a result of an audit under the Single Audit Act of 1984 of a cross-cutting nature will be resolved by the Department of Health and Human Services, Office of Grant and Contract Financial Management. A cross-cutting issue is one that involves more than one Federal awarding agency. Questioned items affecting only the disability program will be resolved by SSA in accord with paragraph (b)(2) of this section,

(3) *State appeal of audit determinations.* The Office of Grant and Contract Financial Management will notify the State of its determination on questioned cross-cutting items. If the State disagrees with that determination, it may appeal in writing within 60 days of receiving the determination. State appeals of a cross-cutting issue as a result of an audit under the Single Audit Act of 1984 will be made to the Department of Health and Human Services' Departmental Appeals Board. The rules for hearings and appeals are provided in 45 CFR part 16.

(b) *Audits performed by the Commissioner*—(1) *Generally.* If the State does not perform an audit under the Single Audit Act of 1984 or the audit performed is not satisfactory for disability program purposes, the books of account and records in the State pertaining to the administrations of the disability programs under the Act will be audited by the SSA's Inspector General or audited or reviewed by SSA as appropriate. These audits or reviews will be conducted to determine whether the expenditures were made for the intended purposes and in amounts necessary for the proper and efficient administration of the disability programs. Audits or reviews will also be made to inspect the work and activities required by the regulations to ensure compliance with pertinent Federal statutes and regulations. The State will make every effort to act upon and resolve any items questioned in an audit or review.

(2) *Questioned items.* Expenditures of State agencies will be audited or reviewed, as appropriate, on the basis of cost principles and written guidelines in effect at the time the expenditures were made or incurred. Both the State and the State agency will be informed and given a full explanation of any items questioned. They will be given reasonable time to explain items questioned. Any explanation furnished by the State or State agency will be given full consideration before a final determination is made on the audit or review report.

(3) *State appeal of audit determinations.* The appropriate Social Security Administration Regional Commissioner will notify the State of his or her determination on the audit or review report. If the State disagrees with that determination, the State may request reconsideration in writing within 60 days of the date of the Regional Commissioner's notice of the determination. The written request may be made, through the Associate Commissioner, Office of Disability, to the Commissioner of Social Security, room 900, Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235. The Commissioner will make a determination and notify the State of the decision in writing no later than 90 days from the date the Social Security Administration receives the State's appeal and all supporting documents. The decision by the Commissioner on other than monetary disallowances will be final and binding upon the State. The decision by the Commissioner on monetary disallowances will be final and binding upon the State unless the State appeals the decision in writing to the Department of Health and Human Services, Departmental Appeals Board within 30 days after receiving the Commissioner's decision. See § 404.1683.

[56 FR 11019, Mar. 14, 1991, as amended at 62 FR 38452, July 18, 1997]

§ 404.1628 Property.

The State will have title to equipment purchased for disability program purposes. The State will be responsible for maintaining all property it acquires or which we furnish to it for performing the disability determination function. The State will identify the

equipment by labeling and by inventory and will credit the SSA account with the fair market value of disposed property.

In the event we assume the disability determination function from a State, ownership of all property and equipment acquired with SSA funds will be transferred to us effective on the date the State is notified that we are assuming the disability determination function or we are notified that the State is terminating the relationship.

§ 404.1629 Participation in research and demonstration projects.

We will invite State participation in federally funded research and demonstration projects to assess the effectiveness of the disability program and to ascertain the effect of program policy changes. Where we determine that State participation is necessary for the project to be complete, for example, to provide national uniformity in a claims process, State participation is mandatory.

§ 404.1630 Coordination with other agencies.

(a) The State will establish cooperative working relationships with other agencies concerned with serving the disabled and, insofar as practicable, use their services, facilities, and records to:

(1) Assist the State in developing evidence and making determinations of disability; and

(2) Insure that referral of disabled or blind persons for rehabilitation services will be carried out effectively.

(b) The State may pay these agencies for the services, facilities, or records they provide. The State will include these costs in its estimates of anticipated costs and reports of actual expenditures.

§ 404.1631 Confidentiality of information and records.

The State will comply with the confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see § 404.1633).

§ 404.1632 Other Federal laws and regulations.

The State will comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the disability determination function; for example, Treasury Department regulations on letters of credit (31 CFR part 205).

§ 404.1633 Policies and operating instructions.

(a) We will provide the State agency with written guidelines necessary for it to carry out its responsibilities in performing the disability determination function.

(b) The State agency making determinations of disability will comply with our written guidelines that are not designated as advisory or discretionary. (See § 404.1602 for what we mean by written guidelines.)

(c) A representative group of State agencies will be given an opportunity to participate in formulating disability program policies that have an affect on their role in carrying out the disability determination function. State agencies will also be given an opportunity to comment before changes are made in written guidelines unless delay in issuing a change may impair service to the public.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

PERFORMANCE STANDARDS

§ 404.1640 General.

The following sections provide the procedures and guidelines we use to determine whether the State agency is substantially complying with our regulations and other written guidelines, including meeting established national performance standards. We use performance standards to help assure effective and uniform administration of our disability programs and to measure whether the performance of the disability determination function by each State agency is acceptable. Also, the standards are designed to improve overall State agency performance in the disability determination process and to ensure that benefits are made available to all eligible persons in an accurate and efficient manner. We

measure the performance of a State agency in two areas—processing time and quality of documentation and decisions on claims. State agency compliance is also judged by State agency adherence to other program requirements.

[56 FR 11020, Mar. 14, 1991]

§ 404.1641 Standards of performance.

(a) *General.* The performance standards include both a target level of performance and a threshold level of performance for the State agency. The target level represents a level of performance that we and the States will work to attain in the future. The threshold level is the minimum acceptable level of performance. Performance below the threshold level will be the basis for the Commissioner's taking from the State agency partial or complete responsibility for performing the disability determination function. Intermediate State agency goals are designed to help each State agency move from its current performance levels to the target levels.

(b) *The target level.* The target level is the optimum level of performance. There are three targets—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(c) *The threshold level.* The threshold level is the minimum acceptable level of performance. There are three thresholds—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(d) *Intermediate goals.* Intermediate goals are levels of performance between the threshold levels and the target levels established by our appropriate Regional Commissioner after negotiation with each State agency. The intermediate goals are designed to help the State agencies reach the target levels. Failure to meet these goals is not a cause for considering the State agency to be substantially failing to comply with the performance standards. However, failure to meet the intermediate goals may result in consultation and an offer of optional performance support depending on the availability of our resources.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991; 62 FR 38452, July 18, 1997]

§ 404.1642 Processing time standards.

(a) *General.* Title II processing time refers to the average number of days, including Saturdays, Sundays, and holidays, it takes a State agency to process an initial disability claim from the day the case folder is received in the State agency until the day it is released to us by the State agency. Title XVI processing time refers to the average number of days, including Saturdays, Sundays, and holidays, from the day of receipt of the initial disability claim in the State agency until systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Target levels.* The processing time target levels are:

(1) 37 days for title II initial claims.

(2) 43 days for title XVI initial claims.

(c) *Threshold levels.* The processing time threshold levels are:

(1) 49.5 days for title II initial claims.

(2) 57.9 days for title XVI initial claims.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

§ 404.1643 Performance accuracy standard.

(a) *General.* Performance accuracy refers to the percentage of cases that do not have to be returned to State agencies for further development or correction of decisions based on evidence in the files and as such represents the reliability of State agency adjudication. The definition of performance accuracy includes the measurement of factors that have a potential for affecting a decision, as well as the correctness of the decision. For example, if a particular item of medical evidence should have been in the file but was not included, even though its inclusion does not change the result in the case, that is a performance error. Performance accuracy, therefore, is a higher standard than decisional accuracy. As a result, the percentage of correct decisions is

significantly higher than what is reflected in the error rate established by SSA's quality assurance system.

(b) *Target level.* The State agency initial performance accuracy target level for combined title II and title XVI cases is 97 percent with a corresponding decision accuracy rate of 99 percent.

(c) *Intermediate goals.* These goals will be established annually by SSA's regional commissioner after negotiation with the State and should be used as stepping stones to progress towards our targeted level of performance.

(d) *Threshold levels.* The State agency initial performance accuracy threshold level for combined title II and title XVI cases is 90.6 percent.

§ 404.1644 How and when we determine whether the processing time standards are met.

(a) *How we determine processing times.* For all initial title II cases, we calculate the mean number of days, including Saturdays, Sundays and holidays, from the day the case folder is received in the State agency until the day it is released to us by the State agency. For initial title XVI cases, we calculate the mean number of days, including Saturdays, Sundays, and holidays, from the day the case folder is received in the State agency until the day there is a systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Frequency of review.* Title II processing times and title XVI processing times are monitored separately on a quarterly basis. The determination as to whether or not the processing time thresholds have been met is made at the end of each quarter each year. Quarterly State-by-State mean processing times are compared with the threshold levels for both title II and title XVI.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

§ 404.1645 How and when we determine whether the performance accuracy standard is met.

(a) *How we determine performance accuracy.* We determine a State agency's performance accuracy rate on the basis of decision and documentation errors identified in our review of the sample cases.

(b) *Frequency of review.* Title II and title XVI initial performance accuracy are monitored together on a quarterly basis. The determinations as to whether the performance accuracy threshold has been met is made at the end of each quarter each year. Quarterly State-by-State combined initial performance accuracy rates are compared to the established threshold level.

§ 404.1650 Action we will take if a State agency does not meet the standards.

If a State agency does not meet two of the three established threshold levels (one of which must be performance accuracy) for two or more consecutive calendar quarters, we will notify the State agency in writing that it is not meeting the standards. Following our notification, we will provide the State agency appropriate performance support described in §§ 404.1660, 404.1661 and 404.1662 for a period of up to 12 months.

[56 FR 11020, Mar. 14, 1991]

Performance Monitoring and Support

§ 404.1660 How we will monitor.

We will regularly analyze State agency combined title II and title XVI initial performance accuracy rate, title II initial processing time, and title XVI initial processing time. Within budgeted resources, we will also routinely conduct fiscal and administrative management reviews and special onsite reviews. A fiscal and administrative management review is a fact-finding mission to review particular aspects of State agency operations. During these reviews we will also review the quality assurance function. This regular monitoring and review program will allow us to determine the progress each State is making and the type and extent of performance support we will provide to help the State progress toward threshold, intermediate, and/or target levels.

[56 FR 11020, Mar. 14, 1991]

§ 404.1661 When we will provide performance support.

(a) *Optional support.* We may offer, or a State may request, performance support at any time that the regular monitoring and review process reveals that support could enhance performance. The State does not have to be below the initial performance accuracy rate of 90.6 percent to receive performance support. Support will be offered, or granted upon request, based on available resources.

(b) *Mandatory support.* (1) We will provide a State agency with mandatory performance support if regular monitoring and review reveal that two of three threshold levels (one of which must be performance accuracy) are not met for two consecutive calendar quarters.

(2) We may also decide to provide a State agency with mandatory performance support if regular monitoring and review reveal that any one of the three threshold levels is not met for two consecutive calendar quarters. Support will be provided based on available resources.

(3) The threshold levels are:

(i) Combined title II and title XVI initial performance accuracy rate—90.6 percent,

(ii) Title II initial processing time—49.5 days, and

(iii) Title XVI initial processing time—57.9 days.

[56 FR 11020, Mar. 14, 1991]

§ 404.1662 What support we will provide.

Performance support may include, but is not limited to, any or all of the following:

(a) An onsite review of cases processed by the State agency emphasizing adherence to written guidelines.

(b) A request that necessary administrative measures be implemented (e.g., filling staffing vacancies, using overtime, assisting with training activities, etc.).

(c) Provisions for Federal personnel to perform onsite reviews, conduct training, or perform other functions needed to improve performance.

(d) Provisions for fiscal aid to allow for overtime, temporary hiring of additional staff, etc., above the authorized budget.

[56 FR 11020, Mar. 14, 1991]

SUBSTANTIAL FAILURE

§ 404.1670 General.

After a State agency falls below two of three established threshold levels, one being performance accuracy, for two consecutive quarters, and after the mandatory performance support period, we will give the State agency a 3-month adjustment period. During this 3-month period we will not require the State agency to meet the threshold levels. Following the adjustment period, if the State agency again falls below two of three threshold levels, one being performance accuracy, in two consecutive quarters during the next 12 months, we will notify the State that we propose to find that the State agency has substantially failed to comply with our standards and advise it that it may request a hearing on that issue. After giving the State notice and an opportunity for a hearing, if it is found that a State agency has substantially failed to make disability determinations consistent with the Act, our regulations or other written guidelines, we will assume partial or complete responsibility for performing the disability determination function after we have complied with §§ 404.1690 and 404.1692.

[56 FR 11021, Mar. 14, 1991]

§ 404.1671 Good cause for not following the Act, our regulations, or other written guidelines.

If a State has good cause for not following the Act, our regulations, or other written guidelines, we will not find that the State agency has substantially failed to meet our standards. We will determine if good cause exists. Some of the factors relevant to good cause are:

(a) Disasters such as fire, flood, or civil disorder, that—

(1) Require the diversion of significant personnel normally assigned to the disability determination function, or

(2) Destroyed or delayed access to significant records needed to make accurate disability determinations;

(b) Strikes of State agency staff or other government or private personnel necessary to the performance of the disability determination function;

(c) Sudden and unanticipated workload changes which result from changes in Federal law, regulations, or written guidelines, systems modification or systems malfunctions, or rapid, unpredictable caseload growth for a 6-month period or longer.

[56 FR 11021, Mar. 14, 1991]

§ 404.1675 Finding of substantial failure.

A finding of substantial failure with respect to a State may not be made unless and until the State is afforded an opportunity for a hearing.

HEARINGS AND APPEALS

§ 404.1680 Notice of right to hearing on proposed finding of substantial failure.

If, following the mandatory performance support period and the 3-month adjustment period, a State agency again falls below two of three threshold levels (one being performance accuracy) in two consecutive quarters in the succeeding 12 months, we will notify the State in writing that we will find that the State agency has substantially failed to meet our standards unless the State submits a written request for a hearing with the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving the notice. The notice will identify the threshold levels that were not met by the State agency, the period during which the thresholds were not met and the accuracy and processing time levels attained by the State agency during this period. If a hearing is not requested, the State agency will be found to have substantially failed to meet our standards, and we will implement our plans to assume the disability determination function.

[56 FR 11021, Mar. 14, 1991]

§ 404.1681 Disputes on matters other than substantial failure.

Disputes concerning monetary disallowances will be resolved in proceedings before the Department of Health and Human Services' Departmental Appeals Board if the issue cannot be resolved between us and the State. Disputes other than monetary disallowances will be resolved through an appeal to the Commissioner of Social Security, who will make the final decision. (See § 404.1627.)

[56 FR 11021, Mar. 14, 1991]

§ 404.1682 Who conducts the hearings.

If a hearing is required, it will be conducted by the Department of Health and Human Services' Grant Appeals Board (the Board).

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

§ 404.1683 Hearings and appeals process.

The rules for hearings and appeals before the Board are provided in 45 CFR part 16. A notice under § 404.1680 of this subpart will be considered a ''final written decision'' for purposes of Board review.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

§ 404.1690 Assumption when we make a finding of substantial failure.

(a) *Notice to State.* When we find that substantial failure exists, we will notify the State in writing that we will assume responsibility for performing the disability determination function from the State agency, whether the assumption will be partial or complete, and the date on which the assumption will be effective.

(b) *Effective date of assumption.* The date of any partial or complete assumption of the disability determination function from a State agency may not be earlier than 180 days after our finding of substantial failure, and not before compliance with the requirements of § 404.1692.

§ 404.1691 Assumption when State no longer wishes to perform the disability determination function.

(a) *Notice to the Commissioner.* If a State no longer wishes to perform the disability determination function, it will notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the

State's Attorney General verifying the authority of the official who gave the notice.

(b) *Effective date of assumption.* The State agency will continue to perform whatever activities of the disability determination function it is performing at the time the notice referred to in paragraph (a) of this section is given for not less than 180 days or, if later, until we have complied with the requirements of § 404.1692. For example, if the State is not making disability determinations (because we previously assumed responsibility for making them) but is performing other activities related to the disability determination function at the time it gives notice, the State will continue to do these activities until the requirements of this paragraph are met. Thereafter, we will assume complete responsibility for performing the disability determination function.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

§ 404.1692 Protection of State employees.

(a) *Hiring preference.* We will develop and initiate procedures to implement a plan to partially or completely assume the disability determination function from the State agency under § 404.1690 or § 404.1691, as appropriate. Except for the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent), we will give employees of the State agency who are capable of performing duties in the disability determination function preference over any other persons in filling positions with us for which they are qualified. We may also give a preference in hiring to the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent). We will establish a system for determining the hiring priority among the affected State agency employees in those instances where we are not hiring all of them.

(b) *Determination by Secretary of Labor.* We will not assume responsibility for performing the disability determination function from a State until the Secretary of Labor determines that the State has made fair and equitable arrangements under applicable Federal, State and local law to protect the interests of employees who will be displaced from their employment because of the assumption and who we will not hire.

§ 404.1693 Limitation on State expenditures after notice.

The State agency may not, after it receives the notice referred to in § 404.1690, or gives the notice referred to in § 404.1691, make any new commitments to spend funds allocated to it for performing the disability determination function without the approval of the appropriate SSA regional commissioner. The State will make every effort to close out as soon as possible all existing commitments that relate to performing the disability determination function.

§ 404.1694 Final accounting by the State.

The State will submit its final claims to us as soon as possible, but in no event later than 1 year from the effective date of our assumption of the disability determination function unless we grant an extension of time. When the final claim(s) is submitted, a final accounting will be made by the State of any funds paid to the State under § 404.1626 which have not been spent or committed prior to the effective date of our assumption of the disability determination function. Disputes concerning final accounting issues which cannot be resolved between the State and us will be resolved in proceedings before the Departmental Appeals Board as described in 45 CFR part 16.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

Subpart R—Representation of Parties

AUTHORITY: 42 U.S.C. 405(a), 406, 902(a)(5), and 1320a–6.

SOURCE: 45 FR 52090, Aug. 5, 1980, unless otherwise noted.

§ 404.1700 Introduction.

You may appoint someone to represent you in any of your dealings with us. This subpart explains, among other things—

(a) Who may be your representative and what his or her qualifications must be;

(b) How you appoint a representative;

(c) The payment of fees to a representative;

(d) Our rules that representatives must follow; and

(e) What happens to a representative who breaks the rules.

§ 404.1703 Definitions.

As used in this subpart—

Affiliate means to associate with an entity through our prescribed registration process.

Assignment means the transfer of the right to receive direct payment of an authorized fee to an entity as described in § 404.1730(e).

Date we notify him or her means 5 days after the date on the notice, unless the recipient shows us that he or she did not receive it within the 5-day period.

Eligible non-attorney means a non-attorney representative who we determine is qualified to receive direct payment of his or her fee under § 404.1717(a).

Entity means any business, firm, or other association, including but not limited to partnerships, corporations, for-profit organizations, and not-for-profit organizations.

Federal agency refers to any authority of the Executive branch of the Government of the United States.

Federal program refers to any program established by an Act of Congress or administered in whole or in part by a Federal agency.

Legal guardian or court-appointed representative means a court-appointed person, committee, or conservator who is responsible for taking care of and managing the property and rights of an individual who is considered incapable of managing his or her own affairs.

Past-due benefits means the total amount of benefits under title II of the Act that has accumulated to all beneficiaries because of a favorable administrative or judicial determination or decision, up to but not including the month the determination or decision is made. For purposes of calculating fees for representation, we determine past-due benefits before any applicable reduction under section 1127 of the Act (for receipt of benefits for the same period under title XVI). Past-due benefits do not include:

(1) Continued benefits paid pursuant to § 404.1597a of this part; or

(2) Interim benefits paid pursuant to section 223(h) of the Act.

Point of Contact means an individual who registers as a representative in the manner we prescribe and is selected by an entity to speak and act on the entity's behalf and who assumes the affirmative duties and obligations we prescribe.

Registration means a process by which an individual or entity provides the information we require to conduct business with us.

Representational services means services performed for a claimant in connection with any claim the claimant has before us, any asserted right the claimant may have for an initial or reconsidered determination, and any decision or action by an administrative law judge or the Appeals Council.

Representative means an attorney who meets all of the requirements of § 404.1705(a), or a person other than an attorney who meets all of the requirements of § 404.1705(b), and whom you appoint to represent you in dealings with us. For purposes of our Rules of conduct and standards of responsibility for representatives in §§ 404.1740 through 404.1799, Representative also includes an individual who provides representational services and an individual who is listed as a point of contact for an entity, as applicable to their identified role.

We, *our*, or *us* refers to the Social Security Administration.

You or *your* refers to any person claiming a right under the old-age, disability, dependents', or survivors' benefits program.

[45 FR 52090, Aug. 5, 1980, as amended at 72 FR 16724, Apr. 5, 2007; 74 FR 48384, Sept. 23, 2009; 76 FR 45192, July 28, 2011; 76 FR 80245, Dec. 23, 2011; 89 FR 67554, Aug. 21, 2024]

§ 404.1705 Who may be your representative.

(a) You may appoint as your representative in dealings with us, any attorney in good standing who—

(1) Has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States;

(2) Is not disqualified or suspended from acting as a representative in dealings with us; and

(3) Is not prohibited by any law from acting as a representative.

(b) You may appoint any person who is not an attorney to be your representative in dealings with us if the person—

(1) Is capable of giving valuable help to you in connection with your claim;

(2) Is not disqualified or suspended from acting as a representative in dealings with us;

(3) Is not prohibited by any law from acting as a representative; and

(4) Is generally known to have a good character and reputation. Persons lacking good character and reputation, include, but are not limited to, persons who have a final conviction of a felony (as defined by § 404.1506(c)) or any crime involving moral turpitude, dishonesty, false statements, misrepresentation, deceit, or theft.

(c) Your representative(s) must be registered with us in the manner we prescribe.

(d) We may refuse to recognize your chosen representative if the person does not meet the requirements in this section. We will notify you and the proposed representative if we do not recognize the person as your representative.

[45 FR 52090, Aug. 5, 1980, as amended at 76 FR 80245, Dec. 23, 2011; 83 FR 30854, July 2, 2018; 89 FR 67554, Aug. 21, 2024]

§ 404.1706 Notification of options for obtaining attorney representation.

If you are not represented by an attorney and we make a determination or decision that is subject to the administrative review process provided under subpart J of this part and it does not grant all of the benefits or other relief you requested or it adversely affects any entitlement to benefits that we have established or may establish for you, we will include with the notice of that determination or decision information about your options for obtaining an attorney to represent you in dealing with us. We will also tell you that a legal services organization may provide you with legal representation free of charge if you satisfy the qualifying requirements applicable to that organization.

[58 FR 64886, Dec. 10, 1993]

§ 404.1707 Appointing a representative.

We will recognize a person as your representative if:

(a) You and your representative complete and sign our prescribed appointment form; and

(b) You or your representative file our prescribed appointment form in the manner we designate.

[89 FR 67554, Aug. 21, 2024]

§ 404.1710 Authority of a representative.

(a) *What a representative may do.* Your representative may, on your behalf—

(1) Obtain information about your claim to the same extent that you are able to do;

(2) Submit evidence;

(3) Make statements about facts and law; and

(4) Make any request or give any notice about the proceedings before us.

(b) *What a representative may not do.* A representative may not sign an application on behalf of a claimant for rights or benefits under title II of the Act unless authorized to do so under § 404.612.

§ 404.1713 Mandatory use of electronic services.

A representative must conduct business with us electronically at the times and in the manner we prescribe on matters for which the representative requests direct fee payment. (*See* § 404.1740(b)(4)).

[76 FR 56109, Sept. 12, 2011]

§ 404.1715 Notice or request to a representative.

(a) We shall send your representative—

(1) Notice and a copy of any administrative action, determination, or decision; and

(2) Requests for information or evidence.

(b) A notice or request sent to your representative, will have the same

force and effect as if it had been sent to you.

§ 404.1717 Direct payment of fees to eligible non-attorney representatives.

(a) *Criteria for eligibility.* An individual who is a licensed attorney or who is suspended or disbarred from the practice of law in any jurisdiction may not be an eligible non-attorney. A non-attorney representative is eligible to receive direct payment of his or her fee out of your past-due benefits if he or she:

(1) Completes and submits to us an application as described in paragraph (b) of this section;

(2) Pays the application fee as described in paragraph (c) of this section;

(3) Demonstrates that he or she possesses:

(i) A bachelor's degree from an accredited institution of higher learning; or

(ii) At least four years of relevant professional experience and either a high school diploma or a General Educational Development certificate;

(4) Passes our criminal background investigation (including checks of our administrative records), and attests under penalty of perjury that he or she:

(i) Has not been suspended or disqualified from practice before us and is not suspended or disbarred from the practice of law in any jurisdiction;

(ii) Has not had a judgment or lien assessed against him or her by a civil court for malpractice or fraud;

(iii) Has not had a felony conviction; and

(iv) Has not misrepresented information provided on his or her application or supporting materials for the application;

(5) Takes and passes a written examination we administer;

(6) Provides proof of and maintains continuous liability insurance coverage that is underwritten by an entity that is legally permitted to provide professional liability insurance in the States in which the representative conducts business. The policy must include coverage for malpractice claims against the representative and be in an amount we prescribe; and

(7) Completes and provides proof that he or she has completed all continuing education courses that we prescribe by the deadline we prescribe.

(b) *Application.* An applicant must timely submit his or her completed application form during an application period that we prescribe. The application must be postmarked by the last day of the application period. If an applicant timely submits the application fee and a defective application, we will give the applicant 10 calendar days after the date we notify him or her of the defect to correct the application.

(c) *Application fee.* An applicant must timely submit his or her application fee during the application period. We will set the fee annually.

(1) We will refund the fee if:

(i) We do not administer an examination, and an applicant was unable to take the rescheduled examination; or

(ii) Circumstances beyond the applicant's control that could not have been reasonably anticipated and planned for prevent an applicant from taking a scheduled examination.

(2) We will not refund the fee if:

(i) An applicant took and failed the examination; or

(ii) An applicant failed to arrive on time for the examination because of circumstances within the applicant's control that could have been anticipated and planned for.

(d) *Protest procedures.* (1) We may find that a non-attorney representative is ineligible to receive direct fee payment at any time because he or she fails to meet any of the criteria in paragraph (a) of this section. A non-attorney representative whom we find to be ineligible for direct fee payment may protest our finding only if we based it on the representative's failure to:

(i) Attest on the application or provide sufficient documentation that he or she possesses the required education or equivalent qualifications, as described in paragraph (a)(3) of this section;

(ii) Meet at all times the criminal background investigation criteria, as described in paragraph (a)(4) of this section;

(iii) Provide proof that he or she has maintained continuous liability insurance coverage, as described in paragraph (a)(6) of this section, after we

previously determined the representative was eligible to receive direct fee payment; or

(iv) Complete continuing education courses or provide documentation of the required continuing education courses, as described in paragraph (a)(7) of this section.

(2) A non-attorney representative who wants to protest our finding under paragraph (d)(1) of this section must file a protest in writing and provide all relevant supporting documentation to us within 10 calendar days after the date we notify him or her of our finding.

(3) A representative may not file a protest for reasons other than those listed in paragraph (d)(1) of this section. If a representative files a protest for reasons other than those listed in paragraph (d)(1) of this section, we will not process the protest and will implement our finding as if no protest had been filed. Our finding in response to the protest is final and not subject to further review.

(e) *Ineligibility and suspension.* (1) If an applicant does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraphs (a)(3) or (a)(4) of this section, the applicant will be either ineligible to take the written examination for which he or she applied or ineligible to receive direct fee payment if the applicant already took and passed the examination prior to our finding. If an applicant protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the applicant will be either ineligible to take the written examination for which he or she applied or ineligible to receive direct fee payment if the applicant already took and passed the examination prior to our finding.

(2) If an eligible non-attorney representative does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraphs (a)(3) or (a)(4) of this section, the non-attorney representative will be ineligible to receive direct fee payment beginning with the month after the month the protest period ends. If the eligible non-attorney representative protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the non-attorney representative will be ineligible to receive direct fee payment beginning with the month after the month we uphold our finding.

(3) If an eligible non-attorney representative does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraph (a)(6) of this section, the non-attorney representative will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month the protest period ends. If the eligible non-attorney representative protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the non-attorney representative will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month we uphold our finding. In either case, the non-attorney representative may provide us with documentation that he or she has acquired and maintains the required liability insurance coverage described in paragraph (a)(6) of this section, no earlier than the sixth month of the ineligibility. The non-attorney representative will again be eligible to receive direct fee payment beginning in the first month after the month we find that we have received sufficient documentation that the non-attorney representative meets the requirements of paragraph (a)(6) of this section.

(4) If an eligible non-attorney representative does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraph (a)(7) of this section, the non-attorney representative will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month the protest period ends. If the eligible non-attorney representative protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the non-attorney will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month we uphold our finding. In either case, the non-attorney representative may provide us with documentation that he or she has satisfied the criteria in paragraph (a)(7) of

this section at any time. The non-attorney representative will again be eligible to receive direct fee payment beginning in the first month after the month we find that we have received sufficient documentation, but not earlier than the month following the end of the 6 month ineligibility period.

(f) *Reapplying.* A representative may reapply to become eligible to receive direct fee payment under paragraph (a) of this section during any subsequent application period if he or she:

(1) Did not meet the initial criteria for eligibility in paragraphs (a)(1), (a)(2), (a)(3), or (a)(5) of this section in a prior application period; or

(2) Failed to timely correct a defective application in a prior application period, as described in paragraph (b) of this section.

[76 FR 45192, July 28, 2011, as amended at 80 FR 400, Jan. 6, 2015]

§ 404.1720 Fee for a representative's services.

(a) *General.* A representative may charge and receive a fee for his or her services as a representative only as provided in paragraph (b) of this section.

(b) *Charging and receiving a fee.* (1) The representative must file a written request with us before he or she may charge or receive a fee for his or her services.

(2) We decide the amount of the fee, if any, a representative may charge or receive.

(3) Subject to paragraph (e) of this section, a representative must not charge or receive any fee unless we have authorized it, and a representative must not charge or receive any fee that is more than the amount we authorize.

(4) If your representative is an attorney or an eligible non-attorney, and you are entitled to past-due benefits, we will pay the authorized fee, or a part of the authorized fee, directly to the attorney or eligible non-attorney out of the past-due benefits, subject to the limitations described in § 404.1730(b)(1). If the representative is a non-attorney who is ineligible to receive direct fee payment, we assume no responsibility for the payment of any fee that we have authorized.

(c) *Notice of fee determination.* We shall mail to both you and your representative at your last known address a written notice of what we decide about the fee. We shall state in the notice—

(1) The amount of the fee that is authorized;

(2) How we made that decision;

(3) Whether we are responsible for paying the fee from past-due benefits; and

(4) That within 30 days of the date of the notice, either you or your representative may request us to review the fee determination.

(d) *Review of fee determination*—(1) *Request filed on time.* We will review the decision we made about a fee if either you or your representative files a written request for the review at one of our offices within 30 days after the date of the notice of the fee determination. Either you or your representative, whoever requests the review, shall mail a copy of the request to the other person. An authorized official of the Social Security Administration who did not take part in the fee determination being questioned will review the determination. This determination is not subject to further review. The official shall mail a written notice of the decision made on review both to you and to your representative at your last known address.

(2) *Request not filed on time.* (i) If you or your representative requests a review of the decision we made about a fee, but does so more than 30 days after the date of the notice of the fee determination, whoever makes the request shall state in writing why it was not filed within the 30-day period. We will review the determination if we decide that there was good cause for not filing the request on time.

(ii) Some examples of good cause follow:

(A) Either you or your representative was seriously ill and the illness prevented you or your representative from contacting us in person or in writing.

(B) There was a death or serious illness in your family or in the family of your representative.

(C) Material records were destroyed by fire or other accidental cause.

(D) We gave you or your representative incorrect or incomplete information about the right to request review.

(E) You or your representative did not timely receive notice of the fee determination.

(F) You or your representative sent the request to another government agency in good faith within the 30-day period, and the request did not reach us until after the period had ended.

(3) *Payment of fees.* We assume no responsibility for the payment of a fee based on a revised determination if the request for administrative review was not filed on time.

(e) *When we do not need to authorize a fee.* We do not need to authorize a fee when:

(1) An entity or a Federal, State, county, or city government agency pays from its funds the representative fees and expenses and both of the following conditions apply:

(i) You and your auxiliary beneficiaries, if any, are not liable to pay a fee or any expenses, or any part thereof, directly or indirectly, to the representative or someone else; and

(ii) The representative submits to us a writing in the form and manner that we prescribe waiving the right to charge and collect a fee and any expenses from you and your auxiliary beneficiaries, if any, directly or indirectly, in whole or in part; or

(2) A court authorizes a fee for your representative based on the representative's actions as your legal guardian or a court-appointed representative.

(f) *Assignment of direct payment of fees.* A representative who is eligible for direct payment of an authorized fee may assign direct payment of the authorized fee to an entity that is eligible for direct payment of fees (see §§ 404.1730(e) and 404.1735).

[45 FR 52090, Aug. 5, 1980, as amended at 72 FR 16724, Apr. 5, 2007; 74 FR 48384, Sept. 23, 2009; 76 FR 45193, July 28, 2011; 89 FR 67554, Aug. 21, 2024]

§ 404.1725 Request for approval of a fee.

(a) *Filing a request.* In order for your representative to obtain approval of a fee for services he or she performed in dealings with us, he or she shall file a written request with one of our offices. This should be done after the proceedings in which he or she was a representative are completed. The request must contain—

(1) The dates the representative's services began and ended;

(2) A list of the services he or she gave and the amount of time he or she spent on each type of service;

(3) The amount of the fee he or she wants to charge for the services;

(4) The amount of fee the representative wants to request or charge for his or her services in the same matter before any State or Federal court;

(5) The amount of and a list of any expenses the representative incurred for which he or she has been paid or expects to be paid;

(6) A description of the special qualifications which enabled the representative, if he or she is not an attorney, to give valuable help in connection with your claim; and

(7) A statement showing that the representative sent a copy of the request for approval of a fee to you.

(b) *Evaluating a request for approval of a fee.* (1) When we evaluate a representative's request for approval of a fee, we consider the purpose of the social security program, which is to provide a measure of economic security for the beneficiaries of the program, together with—

(i) The extent and type of services the representative performed;

(ii) The complexity of the case;

(iii) The level of skill and competence required of the representative in giving the services;

(iv) The amount of time the representative spent on the case;

(v) The results the representative achieved;

(vi) The level of review to which the claim was taken and the level of the review at which the representative became your representative; and

(vii) The amount of fee the representative requests for his or her services, including any amount authorized or requested before, but not including the amount of any expenses he or she incurred.

(2) Although we consider the amount of benefits, if any, that are payable, we do not base the amount of fee we authorize on the amount of the benefit

alone, but on a consideration of all the factors listed in this section. The benefits payable in any claim are determined by specific provisions of law and are unrelated to the efforts of the representative. We may authorize a fee even if no benefits are payable.

§ 404.1728 Proceedings before a State or Federal court.

(a) *Representation of a party in court proceedings.* We shall not consider any service the representative gave you in any proceeding before a State or Federal court to be services as a representative in dealings with us. However, if the representative also has given service to you in the same connection in any dealings with us, he or she must specify what, if any, portion of the fee he or she wants to charge is for services performed in dealings with us. If the representative charges any fee for those services, he or she must file the request and furnish all of the information required by § 404.1725.

(b) *Attorney fee allowed by a Federal court.* If a Federal court in any proceeding under title II of the Act makes a judgment in favor of a claimant who was represented before the court by an attorney, and the court, under section 206(b) of the Act, allows to the attorney as part of its judgment a fee not in excess of 25 percent of the total of past-due benefits to which the claimant is entitled by reason of the judgment, we may pay the attorney the amount of the fee out of, but not in addition to, the amount of the past-due benefits payable. We will not certify for direct payment any other fee your representative may request.

§ 404.1730 Payment of fees.

(a) *Fees allowed by a Federal court.* We will pay an attorney representative out of your past-due benefits the amount of the fee allowed by a Federal court in a proceeding under title II of the Act. The payment we make to the attorney is subject to the limitations described in paragraph (b)(1) of this section.

(b) *Fees we may pay*—(1) *Attorneys and eligible non-attorneys.* Except as provided in paragraph (c) of this section, if we make a determination or decision in your favor and you were represented by an attorney or an eligible non-attorney (see § 404.1717), and as a result of the determination or decision you have past-due benefits;

(i) We will pay your representative out of the past-due benefits the lesser of the amounts in paragraph (b)(1)(iii) or (iv) of this section, less the amount of the assessment described in paragraph (d) of this section, unless the representative files a waiver of the fee or direct payment of the fee; and

(ii) If there is a valid assignment (see paragraph (e) of this section), we will pay the representative's fee (see paragraph (b)(1)(i) of this section) to an entity.

(iii) Twenty-five percent of the total of the past-due benefits; or

(iv) The amount of the fee that we set.

(2) *Non-attorneys ineligible for direct payment.* If the representative is a non-attorney who is ineligible to receive direct payment of his or her fee, we assume no responsibility for the payment of any fee that we authorized. We will not deduct the fee from your past-due benefits.

(c) *Time limit for filing request for approval of fee to obtain direct payment.* (1) To receive direct fee payment from your past-due benefits, a representative who is an attorney or an eligible non-attorney should file a request for approval of a fee, or written notice of the intent to file a request, at one of our offices, or electronically at the times and in the manner that we prescribe if we give notice that such a method is available, within 60 days of the date we mail the notice of the favorable determination or decision.

(2)(i) If no request is filed within 60 days of the date the notice of the favorable determination is mailed, we will mail a written notice to you and your representative at your last known addresses. The notice will inform you and the representative that unless the representative files, within 20 days from the date of the notice, a written request for approval of a fee under § 404.1725, or a written request for an extension of time, we will pay all the past-due benefits to you.

(ii) The representative must send you a copy of any request made to us for an extension of time. If the request is not filed within 20 days of the date of the

notice, or by the last day of any extension we approved, we will pay all past-due benefits to you. We must approve any fee the representative charges after that time, but the collection of any approved fee is a matter between you and the representative.

(d) *Assessment when we pay a fee directly to a representative.* (1) Whenever we pay a fee directly to a representative from past-due benefits, we impose an assessment on the representative.

(2) The amount of the assessment is equal to the lesser of:

(i) The product we obtain by multiplying the amount of the fee we are paying to the representative by the percentage rate the Commissioner of Social Security determines is necessary to achieve full recovery of the costs of determining and paying fees directly to representatives, but not in excess of 6.3 percent; and

(ii) The maximum assessment amount. The maximum assessment amount was initially set at $75, but by law is adjusted annually to reflect the increase in the cost of living. (See §§ 404.270 through 404.277 for an explanation of how the cost-of-living adjustment is computed.) If the adjusted amount is not a multiple of $1, we round down the amount to the next lower $1, but the amount will not be less than $75. We will announce any increase in the maximum assessment amount and explain how the increase was determined in the FEDERAL REGISTER.

(3) We collect the assessment by subtracting it from the amount of the fee to be paid to the representative. The representative who is subject to an assessment may not, directly or indirectly, request or otherwise obtain reimbursement of the assessment from you.

(e) *Assignment of direct payment of a fee to designated entity.* (1) A representative may assign direct payment of the fee we authorize to an eligible entity if the representative:

(i) Is eligible for direct payment;

(ii) Has not waived the fee or direct payment;

(iii) Assigns direct payment of the entire fee we authorize to one entity in the manner we prescribe;

(iv) Makes the assignment before the date on which we notify you of our first favorable determination or decision; and

(v) Affiliates with the entity through registration.

(2) A representative may rescind an assignment in the manner we prescribe before the date on which we notify you of our first favorable determination or decision.

(3) A representative may not assign direct payment of a fee to an entity that is ineligible to receive direct payment.

(4) A representative may not waive a fee or direct payment of a fee if the representative previously assigned direct payment of a fee in accordance with paragraph (e)(1) of this section and did not timely rescind that assignment in accordance with paragraph (e)(2) of this section.

[72 FR 16724, Apr. 5, 2007, as amended at 76 FR 45193, July 28, 2011; 89 FR 67554, Aug. 21, 2024]

§ 404.1735 Entity eligible for direct payment of fees.

An entity is eligible for direct payment of an authorized fee if the entity:

(a) Has an Employer Identification Number;

(b) Has registered with us in the manner we prescribe;

(c) Has not been found ineligible for direct payment;

(d) Designates and maintains an employee who is registered as a representative in the manner we prescribe as a point of contact to speak and act on the entity's behalf;

(e) Accepts payment via electronic funds transfer; and

(f) Conforms to our rules.

[89 FR 67555, Aug. 21, 2024]

§ 404.1740 Rules of conduct and standards of responsibility for representatives.

(a) *Purpose and scope.* (1) All attorneys or other persons acting on behalf of a party seeking a statutory right or benefit must, in their dealings with us, faithfully execute their duties as agents and fiduciaries of a party. A representative must provide competent

assistance to the claimant and recognize our authority to lawfully administer the process. The following provisions set forth certain affirmative duties and prohibited actions that will govern the relationship between the representative and us, including matters involving our administrative procedures and fee collections.

(2) All representatives must be forthright in their dealings with us and with the claimant and must comport themselves with due regard for the nonadversarial nature of the proceedings by complying with our rules and standards, which are intended to ensure orderly and fair presentation of evidence and argument.

(b) *Affirmative duties.* A representative must, in conformity with the regulations setting forth our existing duties and responsibilities and those of claimants (see §404.1512 in disability and blindness claims):

(1) Act with reasonable promptness to help obtain the information or evidence that the claimant must submit under our regulations, and forward the information or evidence to us for consideration as soon as practicable.

(2) Assist the claimant in complying, as soon as practicable, with our requests for information or evidence at any stage of the administrative decisionmaking process in his or her claim. In disability and blindness claims, this includes the obligation pursuant to §404.1512(c) to assist the claimant in providing, upon our request, evidence about:

(i) The claimant's medical source(s);

(ii) The claimant's age;

(iii) The claimant's education and training;

(iv) The claimant's work experience;

(v) The claimant's daily activities both before and after the date the claimant alleges that he or she became disabled;

(vi) The claimant's efforts to work; and

(vii) Any other factors showing how the claimant's impairment(s) affects his or her ability to work. In §§404.1560 through 404.1569a, we discuss in more detail the evidence we need when we consider vocational factors.

(3) Conduct his or her dealings in a manner that furthers the efficient, fair, and orderly conduct of the administrative decision-making process, including duties to:

(i) Provide competent representation to a claimant. Competent representation requires the knowledge, skill, thoroughness, and preparation reasonably necessary for the representation. A representative must know the significant issue(s) in a claim, have reasonable and adequate familiarity with the evidence in the case, and have a working knowledge of the applicable provisions of the Social Security Act, as amended, the regulations, the Social Security Rulings, and any other applicable provisions of law.

(ii) Act with reasonable diligence and promptness in representing a claimant. This includes providing prompt and responsive answers to our requests for information pertinent to processing of the claim.

(iii) When requested, provide us, in a manner we specify, potential dates and times that the representative will be available for a hearing. We will inform the representative how many potential dates and times we require to coordinate the hearing schedule.

(iv) Only withdraw representation at a time and in a manner that does not disrupt the processing or adjudication of a claim and that provides the claimant adequate time to find new representation, if desired. A representative should not withdraw after we set the time and place for the hearing (see §404.936) unless the representative can show that a withdrawal is necessary due to extraordinary circumstances, as we determine on a case-by-case basis.

(v) Maintain prompt and timely communication with the claimant, which includes, but is not limited to, reasonably informing the claimant of all matters concerning the representation, consulting with the claimant on an ongoing basis during the entire representational period, and promptly responding to a claimant's reasonable requests for information. When we evaluate whether a representative has maintained prompt and timely communication with the claimant, we will consider the difficulty the representative has in locating a particular claimant (e.g., because the claimant is homeless)

and the representative's efforts to keep that claimant informed.

(4) Conduct business with us electronically at the times and in the manner we prescribe on matters for which the representative requests direct fee payment. (*See* § 404.1713).

(5) Disclose in writing, at the time a medical or vocational opinion is submitted to us or as soon as the representative is aware of the submission to us, if:

(i) The representative's employee or any individual contracting with the representative drafted, prepared, or issued the medical or vocational opinion; or

(ii) The representative referred or suggested that the claimant seek an examination from, treatment by, or the assistance of, the individual providing opinion evidence.

(6) Disclose to us immediately if the representative discovers that his or her services are or were used by the claimant to commit fraud against us.

(7) Disclose to us whether the representative is or has been disbarred or suspended from any bar or court to which he or she was previously admitted to practice, including instances in which a bar or court took administrative action to disbar or suspend the representative in lieu of disciplinary proceedings (e.g., acceptance of voluntary resignation pending disciplinary action). If the disbarment or suspension occurs after the appointment of the representative, the representative will immediately disclose the disbarment or suspension to us.

(8) Disclose to us whether the representative is or has been disqualified from participating in or appearing before any Federal program or agency, including instances in which a Federal program or agency took administrative action to disqualify the representative in lieu of disciplinary proceedings (e.g., acceptance of voluntary resignation pending disciplinary action). If the disqualification occurs after the appointment of the representative, the representative will immediately disclose the disqualification to us.

(9) Disclose to us whether the representative has been removed from practice or suspended by a professional licensing authority for reasons that reflect on the person's character, integrity, judgment, reliability, or fitness to serve as a fiduciary. If the removal or suspension occurs after the appointment of the representative, the representative will immediately disclose the removal or suspension to us.

(10) Ensure that all of the representative's employees, assistants, partners, contractors, or any person assisting the representative on claims for which the representative has been appointed, comply with these rules of conduct and standards of responsibility for representatives, when the representative has managerial or supervisory authority over these individuals or otherwise has responsibility to oversee their work. This includes a duty to take remedial action when:

(i) The representative's employees, assistants, partners, contractors or other individuals' conduct violates these rules of conduct and standards of responsibility; and

(ii) The representative has reason to believe a violation of these rules of conduct and standards of responsibility occurred or will occur.

(c) *Prohibited actions.* A representative must not:

(1) In any manner or by any means threaten, coerce, intimidate, deceive or knowingly mislead a claimant, or prospective claimant or beneficiary, regarding benefits or other rights under the Act. This prohibition includes misleading a claimant, or prospective claimant or beneficiary, about the representative's services and qualifications.

(2) Knowingly charge, collect or retain, or make any arrangement to charge, collect or retain, from any source, directly or indirectly, any fee for representational services in violation of applicable law or regulation. This prohibition includes soliciting any gift or any other item of value, other than what is authorized by law.

(3) Make or present, or participate in the making or presentation of, false or misleading oral or written statements, evidence, assertions, or representations about a material fact or law concerning a matter within our jurisdiction, in matters where the representative knows or should have known that those statements, evidence, assertions,

or representations are false or misleading.

(4) Through his or her own actions or omissions, unreasonably delay or cause to be delayed, without good cause (see § 404.911(b)), the processing of a claim at any stage of the administrative decision-making process.

(5) Divulge, without the claimant's consent, except as may be authorized by regulations prescribed by us or as otherwise provided by Federal law, any information we furnish or disclose about a claim or prospective claim.

(6) Attempt to influence, directly or indirectly, the outcome of a decision, determination, or other administrative action by any means prohibited by law, or by offering or granting a loan, gift, entertainment, or anything of value to a presiding official, agency employee, or witness who is or may reasonably be expected to be involved in the administrative decision-making process, except as reimbursement for legitimately incurred expenses or lawful compensation for the services of an expert witness retained on a non-contingency basis to provide evidence.

(7) Engage in actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings, including but not limited to:

(i) Repeated absences from or persistent tardiness at scheduled proceedings without good cause (see § 404.911(b));

(ii) Behavior that has the effect of improperly disrupting proceedings or obstructing the adjudicative process, including but not limited to:

(A) Directing threatening or intimidating language, gestures, or actions at a presiding official, witness, contractor, or agency employee;

(B) Providing misleading information or misrepresenting facts that affect how we process a claim, including, but not limited to, information relating to the claimant's work activity or the claimant's place of residence or mailing address in matters where the representative knows or should have known that the information was misleading and the facts would constitute a misrepresentation; and

(C) Communicating with agency staff or adjudicators outside the normal course of business or other prescribed procedures in an attempt to inappropriately influence the processing or outcome of a claim(s).

(8) Violate any section of the Act for which a criminal or civil monetary penalty is prescribed.

(9) Refuse to comply with any of our rules or regulations.

(10) Suggest, assist, or direct another person to violate our rules or regulations.

(11) Advise any claimant or beneficiary not to comply with any of our rules or regulations.

(12) Knowingly assist a person whom we suspended or disqualified to provide representational services in a proceeding under title II of the Act, or to exercise the authority of a representative described in § 404.1710.

(13) Fail to comply with our sanction(s) decision.

(14) Fail to oversee the representative's employees, assistants, partners, contractors, or any other person assisting the representative on claims for which the representative has been appointed when the representative has managerial or supervisory authority over these individuals or otherwise has responsibility to oversee their work.

(15) While serving as a point of contact for an entity, violate applicable affirmative duties, engage in prohibited actions, or conduct dealings with us in a manner that is untruthful or does not further the efficient and prompt correction of a fee error.

[63 FR 41416, Aug. 4, 1998, as amended at 76 FR 56109, Sept. 12, 2011; 76 FR 80245, Dec. 23, 2011; 80 FR 14837, Mar. 20, 2015; 83 FR 30854, July 2, 2018; 89 FR 67555, Aug. 21, 2024]

§ 404.1745 Violations of our requirements, rules, or standards.

When we have evidence that a representative fails to meet our qualification requirements or has violated the rules governing dealings with us, we may begin proceedings to suspend or disqualify that individual from acting in a representational capacity before us. We may file charges seeking such sanctions when we have evidence that a representative:

(a) Does not meet the qualifying requirements described in § 404.1705;

(b) Has violated the affirmative duties or engaged in the prohibited actions set forth in § 404.1740;

(c) Has been convicted of a violation under section 206 of the Act;

(d) Has been, by reason of misconduct, disbarred or suspended from any bar or court to which he or she was previously admitted to practice (see § 404.1770(a));

(e) Has been, by reason of misconduct, disqualified from participating in or appearing before any Federal program or agency (see § 404.1770(a)); or

(f) Who, as a non-attorney, has been removed from practice or suspended by a professional licensing authority for reasons that reflect on the person's character, integrity, judgment, reliability, or fitness to serve as a fiduciary.

[63 FR 41416, Aug. 4, 1998, as amended at 71 FR 2876, Jan. 18, 2006; 83 FR 30855, July 2, 2018]

§ 404.1750 Notice of charges against a representative.

(a) The General Counsel or other delegated official will prepare a notice containing a statement of charges that constitutes the basis for the proceeding against the representative.

(b) We will send this notice to the representative either by certified or registered mail, to his or her last known address, or by personal delivery.

(c) We will advise the representative to file an answer, within 14 business days from the date of the notice, or from the date the notice was delivered personally, stating why he or she should not be suspended or disqualified from acting as a representative in dealings with us.

(d) The General Counsel or other delegated official may extend the 14-day period specified in paragraph (c) of this section for good cause, in accordance with § 404.911.

(e) The representative must—

(1) Answer the notice in writing under oath (or affirmation); and

(2) File the answer with the Social Security Administration, at the address specified on the notice, within the 14-day time period specified in paragraph (c) of this section.

(f) If the representative does not file an answer within the 14-day time period specified in paragraph (c) of this section (or the period extended in accordance with paragraph (d) of this section), he or she does not have the right to present evidence, except as may be provided in § 404.1765(g).

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24131, May 29, 1991; 62 FR 38452, July 18, 1997; 63 FR 41417, Aug. 4, 1998; 71 FR 2876, Jan. 18, 2006; 76 FR 80246, Dec. 23, 2011; 83 FR 30855, July 2, 2018]

§ 404.1755 Withdrawing charges against a representative.

The General Counsel or other delegated official may withdraw charges against a representative. We will withdraw charges if the representative files an answer, or we obtain evidence, that satisfies us that we should not suspend or disqualify the representative from acting as a representative. When we consider withdrawing charges brought under § 404.1745(d) through (f) based on the representative's assertion that, before or after our filing of charges, the representative has been reinstated to practice by the court, bar, or Federal program or Federal agency that suspended, disbarred, or disqualified the representative, the General Counsel or other delegated official will determine whether such reinstatement occurred, whether it remains in effect, and whether he or she is reasonably satisfied that the representative will in the future act in accordance with the provisions of section 206(a) of the Act and our rules and regulations. If the representative proves that reinstatement occurred and remains in effect and the General Counsel or other delegated official is so satisfied, the General Counsel or other delegated official will withdraw those charges. The action of the General Counsel or other delegated official regarding withdrawal of charges is solely that of the General Counsel or other delegated official and is not reviewable, or subject to consideration in decisions made under §§ 404.1770 and 404.1790. If we withdraw the charges, we will notify the representative by mail at the representative's last known address.

[83 FR 30855, July 2, 2018]

§ 404.1765 Hearing on charges.

(a) *Holding the hearing.* If the General Counsel or other delegated official does not take action to withdraw the charges within 15 days after the date on which the representative filed an answer, we will hold a hearing and make a decision on the charges.

(b) *Hearing officer.* (1) The Deputy Commissioner for the Office of Hearings Operations or other delegated official will assign an administrative law judge, designated to act as a hearing officer, to hold a hearing on the charges.

(2) No hearing officer shall hold a hearing in a case in which he or she is prejudiced or partial about any party, or has any interest in the matter.

(3) If the representative or any party to the hearing objects to the hearing officer who has been named to hold the hearing, we must be notified at the earliest opportunity. The hearing officer shall consider the objection(s) and either proceed with the hearing or withdraw from it.

(4) If the hearing officer withdraws from the hearing, another one will be named.

(5) If the hearing officer does not withdraw, the representative or any other person objecting may, after the hearing, present his or her objections to the Appeals Council explaining why he or she believes the hearing officer's decision should be revised or a new hearing held by another administrative law judge designated to act as a hearing officer.

(c) *Time and place of hearing.* The hearing officer will mail the parties a written notice of the hearing at their last known addresses, at least 14 calendar days before the date set for the hearing. The notice will inform the parties whether the appearance of the parties or any witnesses will be in person, by video teleconferencing, or by telephone. The notice will also include requirements and instructions for filing motions, requesting witnesses, and entering exhibits.

(d) *Change of time and place for hearing.* (1) The hearing officer may change the time and place for the hearing, either on his or her own initiative, or at the request of the representative or the other party to the hearing. The hearing officer will not consider objections to the manner of appearance of parties or witnesses, unless the party shows good cause not to appear in the prescribed manner. To determine whether good cause exists for extending the deadline, we use the standards explained in § 404.911.

(2) The hearing officer may adjourn or postpone the hearing.

(3) Subject to the limitations in paragraph (g)(2) of this section, the hearing officer may reopen the hearing for the receipt of additional evidence at any time before mailing notice of the decision.

(4) The hearing officer shall give the representative and the other party to the hearing reasonable notice of any change in the time or place for the hearing, or of an adjournment or reopening of the hearing.

(e) *Parties.* The representative against whom charges have been made is a party to the hearing. The General Counsel or other delegated official will also be a party to the hearing.

(f) *Subpoenas.* (1) The representative or the other party to the hearing may request the hearing officer to issue a subpoena for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to any matter being considered at the hearing. The hearing officer may, on his or her own initiative, issue subpoenas for the same purposes when the action is reasonably necessary for the full presentation of the facts.

(2) The representative or the other party who wants a subpoena issued shall file a written request with the hearing officer. This must be done at least 5 days before the date set for the hearing. The request must name the documents to be produced, and describe the address or location in enough detail to permit the witnesses or documents to be found.

(3) The representative or the other party who wants a subpoena issued shall state in the request for a subpoena the material facts that he or she expects to establish by the witness or document, and why the facts could not be established by the use of other evidence which could be obtained without use of a subpoena.

(4) We will pay the cost of the issuance and the fees and mileage of any witness subpoenaed, as provided in section 205(d) of the Act.

(g) *Conduct of the hearing.* (1) The representative or the other party may file a motion for decision on the basis of the record prior to the hearing. The hearing officer will give the representative and the other party a reasonable amount of time to submit any evidence and to file briefs or other written statements as to fact and law prior to deciding the motion. If the hearing officer concludes that there is no genuine dispute as to any material fact and the movant is entitled to a decision as a matter of law, the hearing officer may grant the motion and issue a decision in accordance with the provisions of § 404.1770.

(2) If the representative did not file an answer to the charges, he or she has no right to present evidence at the hearing. The hearing officer may make or recommend a decision on the basis of the record, or permit the representative to present a statement about the sufficiency of the evidence or the validity of the proceedings upon which the suspension or disqualification, if it occurred, would be based.

(3) The hearing officer will make the hearing open to the representative, to the other party, and to any persons the hearing officer or the parties consider necessary or proper. The hearing officer will inquire fully into the matters being considered, hear the testimony of witnesses, and accept any documents that are material.

(4) The hearing officer has the right to decide the order in which the evidence and the allegations will be presented and the conduct of the hearing.

(h) *Evidence.* The hearing officer may accept evidence at the hearing, even though it is not admissible under the rules of evidence that apply to Federal court procedure.

(i) *Witnesses.* Witnesses who testify at the hearing shall do so under oath or affirmation. Either the representative or a person representing him or her may question the witnesses. The other party and that party's representative must also be allowed to question the witnesses. The hearing officer may also ask questions as considered necessary, and shall rule upon any objection made by either party about whether any question is proper.

(j) *Oral and written summation.* (1) The hearing officer shall give the representative and the other party a reasonable time to present oral summation and to file briefs or other written statements about proposed findings of fact and conclusions of law if the parties request it.

(2) The party that files briefs or other written statements shall provide enough copies so that they may be made available to any other party to the hearing who requests a copy.

(k) *Record of hearing.* In all cases, the hearing officer shall have a complete record of the proceedings at the hearing made.

(l) *Representation.* The representative, as the person charged, may appear in person and may be represented by an attorney or other representative. The General Counsel or other delegated official will be represented by one or more attorneys from the Office of the General Counsel.

(m) *Failure to appear.* If the representative or the other party to the hearing fails to appear after being notified of the time and place, the hearing officer may hold the hearing anyway so that the party present may offer evidence to sustain or rebut the charges. The hearing officer shall give the party who failed to appear an opportunity to show good cause for failure to appear. If the party fails to show good cause, he or she is considered to have waived the right to be present at the hearing. If the party shows good cause, the hearing officer may hold a supplemental hearing.

(n) *Dismissal of charges.* The hearing officer may dismiss the charges in the event of the death of the representative.

(o) *Cost of transcript.* If the representative or the other party to a hearing requests a copy of the transcript of the hearing, the hearing officer will have it prepared and sent to the party upon

payment of the cost, unless the payment is waived for good cause.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24131, 24132, May 29, 1991; 62 FR 38452, July 18, 1997; 63 FR 41417, Aug. 4, 1998; 71 FR 2877, Jan. 18, 2006; 76 FR 80246, Dec. 23, 2011; 83 FR 30856, July 2, 2018]

§ 404.1770 Decision by hearing officer.

(a) *General.* (1) After the close of the hearing, the hearing officer will issue a decision or certify the case to the Appeals Council. The decision must be in writing, will contain findings of fact and conclusions of law, and be based upon the evidence of record.

(2) In deciding whether a person has been, by reason of misconduct, disbarred or suspended by a court or bar, or disqualified from participating in or appearing before any Federal program or Federal agency, the hearing officer will consider the reasons for the disbarment, suspension, or disqualification action. If the action was taken for solely administrative reasons (e.g., failure to pay dues or to complete continuing legal education requirements), that will not disqualify the person from acting as a representative before us. However, this exception to disqualification does not apply if the administrative action was taken in lieu of disciplinary proceedings (e.g., acceptance of a voluntary resignation pending disciplinary action). Although the hearing officer will consider whether the disbarment, suspension, or disqualification action is based on misconduct when deciding whether a person should be disqualified from acting as a representative before us, the hearing officer will not re-examine or revise the factual or legal conclusions that led to the disbarment, suspension, or disqualification. For purposes of determining whether a person has been, by reason of misconduct, disqualified from participating in or appearing before any Federal program or Federal agency, disqualified refers to any action that prohibits a person from participating in or appearing before any Federal program or Federal agency, regardless of how long the prohibition lasts or the specific terminology used.

(3) If the hearing officer finds that the charges against the representative have been sustained, he or she will either—

(i) Suspend the representative for a specified period of not less than 1 year, nor more than 5 years, from the date of the decision; or

(ii) Disqualify the representative from acting as a representative in dealings with us until he or she may be reinstated under § 404.1799. Disqualification is the sole sanction available if the charges have been sustained because the representative has been disbarred or suspended from any court or bar to which the representative was previously admitted to practice or disqualified from participating in or appearing before any Federal program or Federal agency, or because the representative has collected or received, and retains, a fee for representational services in excess of the amount authorized.

(4) The hearing officer shall mail a copy of the decision to the parties at their last known addresses. The notice will inform the parties of the right to request the Appeals Council to review the decision.

(b) *Effect of hearing officer's decision.* (1) The hearing officer's decision is final and binding unless reversed or modified by the Appeals Council upon review.

(2) If the final decision is that a person is disqualified from being a representative in dealings with us, he or she will not be permitted to represent anyone in dealings with us until authorized to do so under the provisions of § 404.1799.

(3) If the final decision is that a person is suspended for a specified period of time from being a representative in dealings with us, he or she will not be permitted to represent anyone in dealings with us during the period of suspension unless authorized to do so under the provisions of § 404.1799.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 63 FR 41417, Aug. 4, 1998; 71 FR 2877, Jan. 18, 2006; 76 FR 80246, Dec. 23, 2011]

§ 404.1775 Requesting review of the hearing officer's decision.

(a) *General.* After the hearing officer issues a decision, either the representative or the other party to the hearing

may ask the Appeals Council to review the decision.

(b) *Time and place of filing request for review.* The party requesting review will file the request for review in writing with the Appeals Council within 14 business days from the date the hearing officer mailed the notice. The party requesting review will certify that a copy of the request for review and of any documents that are submitted have been mailed to the opposing party.

[45 FR 52090, Aug. 5, 1980, as amended at 83 FR 30856, July 2, 2018]

§ 404.1776 Assignment of request for review of the hearing officer's decision.

Upon receipt of a request for review of the hearing officer's decision, the matter will be assigned to a panel consisting of three members of the Appeals Council none of whom shall be the Chair of the Appeals Council. The panel shall jointly consider and rule by majority opinion on the request for review of the hearing officer's decision, including a determination to dismiss the request for review. Matters other than a final disposition of the request for review may be disposed of by the member designated chair of the panel.

[56 FR 24132, May 29, 1991]

§ 404.1780 Appeals Council's review of hearing officer's decision.

(a) Upon request, the Appeals Council will give the parties a reasonable time to file briefs or other written statements as to fact and law, and to request to appear before the Appeals Council to present oral argument. When oral argument is requested within the time designated by the Appeals Council, the Appeals Council will grant the request for oral argument and determine whether the parties will appear at the oral argument in person, by video teleconferencing, or by telephone. If oral argument is not requested within the time designated by the Appeals Council, the Appeals Council may deny the request.

(b) If a party files a brief or other written statement with the Appeals Council, he or she shall send a copy to the opposing party and certify that the copy has been sent.

[45 FR 52090, Aug. 5, 1980, as amended at 83 FR 30856, July 2, 2018]

§ 404.1785 Evidence permitted on review.

(a) *General.* Generally, the Appeals Council will not consider evidence in addition to that introduced at the hearing. However, if the Appeals Council finds the evidence offered is material to an issue it is considering, it may consider that evidence, as described in paragraph (b) of this section.

(b) *Individual charged filed an answer.* (1) When the Appeals Council finds that additional evidence material to the charges is available, and the individual charged filed an answer to the charges, the Appeals Council will allow the party with the information to submit the additional evidence.

(2) Before the Appeals Council admits additional evidence into the record, it will mail a notice to the parties, informing them that evidence about certain issues was submitted. The Appeals Council will give each party a reasonable opportunity to comment on the evidence and to present other evidence that is material to an issue it is considering.

(3) The Appeals Council will determine whether the additional evidence warrants a new review by a hearing officer or whether the Appeals Council will consider the additional evidence as part of its review of the case.

(c) *Individual charged did not file an answer.* If the representative did not file an answer to the charges, the representative may not introduce evidence that was not considered at the hearing.

[83 FR 30856, July 2, 2018]

§ 404.1790 Appeals Council's decision.

(a) The Appeals Council will base its decision upon the evidence in the hearing record and any other evidence it may permit on review. The Appeals Council will affirm the hearing officer's decision if the action, findings, and conclusions are supported by substantial evidence. If the hearing officer's decision is not supported by substantial evidence, the Appeals Council will either:

(1) Reverse or modify the hearing officer's decision; or

(2) Return the case to the hearing officer for further proceedings.

(b) The Appeals Council, in changing a hearing officer's decision to suspend a representative for a specified period, shall in no event reduce the period of suspension to less than 1 year. In modifying a hearing officer's decision to disqualify a representative, the Appeals Council shall in no event impose a period of suspension of less than 1 year. Further, the Appeals Council shall in no event impose a suspension when disqualification is the sole sanction available in accordance with § 404.1770(a)(3)(ii).

(c) If the Appeals Council affirms or changes a hearing officer's decision, the period of suspension or the disqualification is effective from the date of the Appeals Council's decision.

(d) If the hearing officer did not impose a period of suspension or a disqualification, and the Appeals Council decides to impose one or the other, the suspension or disqualification is effective from the date of the Appeals Council's decision.

(e) The Appeals Council shall make its decision in writing and shall mail a copy of the decision to the parties at their last known addresses.

(f) The Appeals Council may designate and publish certain final decisions as precedent for other actions brought under its representative conduct provisions. Prior to making a decision public, we will remove or redact personally identifiable information from the decision.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 71 FR 2877, Jan. 18, 2006; 83 FR 30856, July 2, 2018]

§ 404.1795 When the Appeals Council will dismiss a request for review.

The Appeals Council may dismiss a request for the review of any proceeding to suspend or disqualify a representative in any of the following circumstances:

(a) *Upon request of party.* The Appeals Council may dismiss a request for review upon written request of the party or parties who filed the request if there is no other party who objects to the dismissal.

(b) *Death of party.* The Appeals Council may dismiss a request for review in the event of the death of the representative.

(c) *Request for review not timely filed.* The Appeals Council will dismiss a request for review if a party failed to file a request for review within the 14 business day time period set forth in § 404.1775(b) and the Appeals Council does not extend the time for good cause.

[45 FR 52090, Aug. 5, 1980, as amended at 84 FR 51367, Sept. 30, 2019]

§ 404.1797 Reinstatement after suspension—period of suspension expired.

We shall automatically allow a person to serve again as a representative in dealings with us at the end of any suspension.

§ 404.1799 Reinstatement after suspension or disqualification—period of suspension not expired.

(a) After more than one year has passed, a person who has been suspended or disqualified may ask the Appeals Council for permission to serve as a representative again. The Appeals Council will assign and process a request for reinstatement using the same general procedures described in § 404.1776.

(b) The suspended or disqualified person must submit any evidence the person wishes to have considered along with the request to be allowed to serve as a representative again.

(c) The General Counsel or other delegated official, upon notification of receipt of the request, will have 30 days in which to present a written report of any experiences with the suspended or disqualified person subsequent to that person's suspension or disqualification. The Appeals Council will make available to the suspended or disqualified person a copy of the report.

(d)(1) The Appeals Council shall not grant the request unless it is reasonably satisfied that the person will in the future act according to the provisions of section 206(a) of the Act, and to our rules and regulations.

(2) If a person was disqualified because he or she had been disbarred, suspended, or removed from practice for the reasons described in § 404.1745(d)

through (f), the Appeals Council will grant a request for reinstatement as a representative only if the criterion in paragraph (d)(1) of this section is met and the disqualified person shows that he or she has been admitted (or readmitted) to and is in good standing with the court, bar, Federal program or agency, or other governmental or professional licensing authority from which he or she had been disbarred, suspended, or removed from practice.

(3) If a person was disqualified because the person had been disqualified from participating in or appearing before a Federal program or Federal agency, the Appeals Council will grant the request for reinstatement only if the criterion in paragraph (d)(1) of this section is met and the disqualified person shows that the person is now qualified to participate in or appear before that Federal program or Federal agency.

(4) If the person was disqualified as a result of collecting or receiving, and retaining, a fee for representational services in excess of the amount authorized, the Appeals Council will grant the request only if the criterion in paragraph (d)(1) of this section is met and the disqualified person shows that full restitution has been made.

(e) The Appeals Council will mail a notice of its decision on the request for reinstatement to the suspended or disqualified person. It will also mail a copy to the General Counsel or other delegated official.

(f) If the Appeals Council decides not to grant the request, it will not consider another request before the end of 3 years from the date of the notice of the previous denial.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 62 FR 38452, July 18, 1997; 63 FR 41417, Aug. 4, 1998; 71 FR 2877, Jan. 18, 2006; 76 FR 80246, Dec. 23, 2011; 83 FR 30857, July 2, 2018]

Subpart S—Payment Procedures

AUTHORITY: Secs. 205 (a) and (n), 207, 702(a)(5), and 708(a) of the Social Security Act (42 U.S.C. 405 (a) and (n), 407, 902(a)(5) and 909(a)).

SOURCE: 45 FR 52095, Aug. 5, 1980, unless otherwise noted.

§ 404.1800 Introduction.

After we have made a determination or decision that you are entitled to benefits under title II of the Act, we begin paying those benefits to you as soon as possible. This subpart explains—

(a) What we must do so that your benefits begin promptly;

(b) When and how you may request that payment of benefits be expedited;

(c) When we may cause your benefits to be withheld;

(d) Our obligation not to assign or transfer your benefits to someone; and

(e) When we will use one check to pay benefits to two or more persons in a family.

§ 404.1805 Paying benefits.

(a) As soon as possible after we have made a determination or decision that you are entitled to benefits, we certify to the Secretary of the Treasury, who is the Managing Trustee of the Trust Funds—

(1) Your name and address, or the name and address of the person to be paid if someone receives your benefits on your behalf as a representative payee;

(2) The amount of the payment or payments to be made from the appropriate Trust Fund; and

(3) The time at which the payment or payments should be made in accordance with § 404.1807.

(b) Under certain circumstances when you have had railroad employment, we will certify the information to the Railroad Retirement Board.

[45 FR 52095, Aug. 5, 1980, as amended at 62 FR 6120, Feb. 11, 1997]

§ 404.1807 Monthly payment day.

(a) *General.* Once we have made a determination or decision that you are entitled to recurring monthly benefits, you will be assigned a monthly payment day. Thereafter, any recurring monthly benefits which are payable to you will be certified to the Managing Trustee for delivery on or before that day of the month as part of our certification under § 404.1805(a)(3). Except as provided in paragraphs (c)(2) through (c)(6) of this section, once you have

been assigned a monthly payment day, that day will not be changed.

(b) *Assignment of payment day.* (1) We will assign the same payment day for all individuals who receive benefits on the earnings record of a particular insured individual.

(2) The payment day will be selected based on the day of the month on which the insured individual was born. Insured individuals born on the 1st through the 10th of the month will be paid on the second Wednesday of each month. Insured individuals born on the 11th through the 20th of the month will be paid on the third Wednesday of each month. Insured individuals born after the 20th of the month will be paid on the fourth Wednesday of each month. See paragraph (c) of this section for exceptions.

(3) We will notify you in writing of the particular monthly payment day that is assigned to you.

(c) *Exceptions.* (1) If you or any other person became entitled to benefits on the earnings record of the insured individual based on an application filed before May 1, 1997, you will continue to receive your benefits on the 3rd day of the month (but see paragraph (c)(6) of this section). All persons who subsequently become entitled to benefits on that earnings record will be assigned to the 3rd day of the month as the monthly payment day.

(2) If you or any other person become entitled to benefits on the earnings record of the insured individual based on an application filed after April 30, 1997, and also become entitled to Supplemental Security Income (SSI) benefits or have income which is deemed to an SSI beneficiary (per §416.1160), all persons who are or become entitled to benefits on that earnings record will be assigned to the 3rd day of the month as the monthly payment day. We will notify you in writing if your monthly payment day is being changed to the 3rd of the month due to this provision.

(3) If you or any other person become entitled to benefits on the earnings record of the insured individual based on an application filed after April 30, 1997, and also reside in a foreign country, all persons who are or become entitled to benefits on that earnings record will be assigned to the 3rd day of the month as the monthly payment day. We will notify you in writing if your monthly payment day is being changed to the 3rd of the month due to this provision.

(4) If you or any other person become entitled on the earnings record of the insured individual based on an application filed after April 30, 1997, and are not entitled to SSI but are or become eligible for the State where you live to pay your Medicare premium under the provisions of section 1843 of the Act, all persons who are or become entitled to benefits on that earnings record will be assigned to the 3rd day of the month as the monthly payment day. We will notify you in writing if your monthly payment day is being changed to the 3rd of the month due to this provision.

(5) After April 30, 1997, all individuals who become entitled on one record and later entitled on another record, without a break in entitlement, will be paid all benefits to which they are entitled no later than their current payment day. Individuals who are being paid benefits on one record on the 3rd of the month, and who become entitled on another record without a break in entitlement, will continue to receive all benefits on the 3rd of the month.

(6) If the day regularly scheduled for the delivery of your benefit payment falls on a Saturday, Sunday, or Federal legal holiday, you will be paid on the first preceding day that is not a Saturday, Sunday, or Federal legal holiday.

[62 FR 6120, Feb. 11, 1997]

§ 404.1810 Expediting benefit payments.

(a) *General.* We have established special procedures to expedite the payment of benefits in certain initial and subsequent claims. This section tells how you may request an expedited payment and when we will be able to hasten your payments by means of this process.

(b) *Applicability of section.* (1) This section applies to monthly benefits payable under title II of the Act, except as indicated in paragraph (b)(2) of this section; and to those cases where we certify information to the Railroad Retirement Board.

(2) This section does not apply—

(i) If an initial determination has been made and a request for a reconsideration, a hearing, a review by the Appeals Council, or review by a Federal court is pending on any issue of entitlement to or payment of a benefit;

(ii) To any benefit for which a check has been cashed; or

(iii) To any benefit based on an alleged disability.

(c) *Request for payment.* (1) You shall submit to us a written request for payment of benefits in accordance with paragraph (c)(2) or (c)(3) of this section. Paragraph (c)(2) of this section applies if you were receiving payments regularly and you then fail to receive payment for one or more months. Paragraph (c)(3) of this section applies if we have not made a determination about your entitlement to benefits, or if we have suspended or withheld payment due, for example, to excess earnings or recovery of an overpayment.

(2) If you received a regular monthly benefit in the month before the month in which a payment was allegedly due, you may make a written request for payment any time 30 days after the 15th day of the month in which the payment was allegedly due. If you request is made before the end of the 30-day period, we will consider it to have been made at the end of the period.

(3)(i) If you did not receive a regular monthly benefit in the month before the month in which a payment was allegedly due, you may make a written request for payment any time 90 days after the later of—

(A) The date on which the benefit is alleged to have been due; or

(B) The date on which you furnished us the last information we requested from you.

(ii) If your request is made before the end of the 90-day period we will consider it to have been made at the end of the period.

(d) *Certification for payment.* If we find that benefits are due, we shall certify the benefits for payment in sufficient time to permit the payment to be made within 15 days after the request for expedited payment is made, or considered to have been made, as provided in paragraph (c) of this section.

(e) *Preliminary certification for payment.* If we determine that there is evidence, although additional evidence may be required for a final decision, that a monthly benefit due to you in a particular month was not paid, we may make preliminary certification of payment even though the 30-day or 90-day periods described in paragraph (c) of this section have not elapsed.

§ 404.1815 Withholding certification or payments.

(a) *When certification may be withheld.* After a determination or decision, we may withhold certification to the Managing Trustee, or, if we have already made certification, we may notify the Managing Trustee to withhold payments. We may do this if a question about the validity of the payment or payments to be made under the determination or decision arises as the result of one of the following events:

(1) A reconsideration (whether at the request of a claimant or on our own motion), hearing, or review is being conducted, or a civil action has been filed in a Federal district court concerning the determination or decision.

(2) An application or request is pending concerning the payment of benefits or a lump sum to another person, and the application or request is inconsistent, in whole or in part, with the payment or payments under the determination or decision.

(b) *When certification will not be withheld.* We will not withhold certification or payment as explained in paragraph (a) of this section unless evidence is submitted with the request or application that is sufficient to raise a reasonable question about the validity of the payment or payments under the determination or decision. We will not withhold certification of any amount of the payment or payments not in question. Your acceptance of any payment or payments will not affect your right to reconsideration, hearing, or review about any additional payment or payments you may claim.

§ 404.1820 Transfer or assignment of payments.

(a) *General.* We shall not certify payment to—

(1) Any person designated as your assignee or transferee; or

(2) Any person claiming payment because of an execution, levy, attachment, garnishment, or other legal process, or because of any bankruptcy or insolvency proceeding against or affecting you.

(b) *Enforcement of a child support or alimony obligation.* If you have a legal obligation to provide child support or make alimony payments and legal process is issued to enforce this obligation, the provisions of paragraph (a) of this section do not apply.

§ 404.1821 Garnishment of payments after disbursement.

(a) Payments that are covered by section 207 of the Social Security Act and made by direct deposit are subject to 31 CFR part 212, Garnishment of Accounts Containing Federal Benefit Payments.

(b) This section may be amended only by a rulemaking issued jointly by the Department of Treasury and the agencies defined as a ''benefit agency'' in 31 CFR 212.3.

[76 FR 9960, Feb. 23, 2011]

§ 404.1825 Joint payments to a family.

(a) *Two or more beneficiaries in same family.* If an amount is payable under title II of the Act for any month to two or more persons who are members of the same family, we may certify any two or more of the individuals for joint payment of the total benefits payable to them for the month.

(b) *Joint payee dies before cashing a check.* (1) If a check has been issued for joint payment to an individual and spouse residing in the same household, and one of the joint payees dies before the check has been cashed, we may authorize the surviving payee to cash the check. We make the authorization by placing on the face of the check a stamped legend signed by an official of the Social Security Administration or the Treasury Disbursing Office redesignating the survivor as the payee of the check.

(2) If the uncashed check represents benefits for a month after the month of death, we will not authorize the surviving payee to cash the check unless the proceeds of the check are necessary to meet the ordinary and necessary living expenses of the surviving payee.

(c) *Adjustment or recovery of overpayment.* If a check representing payment of benefits to an individual and spouse residing in the same household is cashed by the surviving payee under the authorization in paragraph (b) of this section, and the amount of the check exceeds the amount to which the surviving payee is entitled, we shall make appropriate adjustment or recovery of the excess amount.

Subpart T—Totalization Agreements

AUTHORITY: Secs. 205(a), 233, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 433, and 902(a)(5)).

SOURCE: 44 FR 42964, July 23, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.1901 Introduction.

(a) Under section 233 of the Social Security Act, the President may enter into an agreement establishing a totalization arrangement between the social security system of the United States and the social security system of a foreign country. An agreement permits entitlement to and the amount of old-age, survivors, disability, or derivative benefits to be based on a combination of a person's periods of coverage under the social security system of the United States and the social security system of the foreign country. An agreement also provides for the precluding of dual coverage and dual social security taxation for work covered under both systems. An agreement may provide that the provisions of the social security system of each country will apply equally to the nationals of both countries (regardless of where they reside). For this purpose, refugees, stateless persons, and other nonnationals who derive benefit rights from nationals, refugees, or stateless persons may be treated as nationals if they reside within one of the countries.

(b) The regulations in this subpart provide definitions and principles for the negotiation and administration of totalization agreements. Where necessary to accomplish the purposes of totalization, we will apply these definitions and principles, as appropriate and

within the limits of the law, to accommodate the widely diverse characteristics of foreign social security systems.

§ 404.1902 Definitions.

For purposes of this subpart—

Act means the Social Security Act (42 U.S.C. 301 *et seq.*).

Agency means the agency responsible for the specific administration of a social security system including responsibility for implementing an agreement; the Social Security Administration (SSA) is the *agency* in the U.S.

Agreement means the agreement negotiated to provide coordination between the social security systems of the countries party to the agreement. The term agreement includes any administrative agreements concluded for purposes of administering the agreement.

Competent authority means the official with overall responsibility for administration of a country's social security system including applicable laws and international social security agreements; the Commissioner of Social Security is the *competent authority* in the U.S.

Period of coverage means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent under the social security system of the U.S. or under the social security system of the foreign country which is a party to an agreement.

Residence or *ordinarily resides,* when used in agreements, has the following meaning for the U.S. *Residence* or *ordinarily resides* in a country means that a person has established a home in that country intending to remain there permanently or for an indefinite period of time. Generally, a person will be considered to have established a home in a country if that person assumes certain economic burdens, such as the purchase of a dwelling or establishment of a business, and participates in the social and cultural activities of the community. If residence in a country is established, it may continue even though the person is temporarily absent from that country. Generally, an absence of six months or less will be considered temporary. If an absence is for more than six months, residence in the country will generally be considered to continue only if there is sufficient evidence to establish that the person intends to maintain the residence. Sufficient evidence would include the maintenance of a home or apartment in that country, the departure from the country with a reentry permit, or similar acts. The existence of business or family associations sufficient to warrant the person's return would also be considered.

Social security system means a social insurance or pension system which is of general application and which provides for paying periodic benefits, or the actuarial equivalent, because of old-age, death, or disability.

[44 FR 42964, July 23, 1979, as amended at 62 FR 38452, July 18, 1997]

§ 404.1903 Negotiating totalization agreements.

An agreement shall be negotiated with the national government of the foreign country for the entire country. However, agreements may only be negotiated with foreign countries that have a social security system of general application in effect. The system shall be considered to be in effect if it is collecting social security taxes or paying social security benefits.

§ 404.1904 Effective date of a totalization agreement.

Section 233 of the Social Security Act provides that a totalization agreement shall become effective on any date provided in the agreement if—

(a) The date occurs after the expiration of a period during which at least one House of Congress has been in session on each of 60 days following the date on which the agreement is transmitted to Congress by the President; and

(b) Neither House of Congress adopts a resolution of disapproval of the agreement within the 60-day period described in paragraph (a) of this section.

[49 FR 29775, July 24, 1984]

§ 404.1905 Termination of agreements.

Each agreement shall contain provisions for its possible termination. If an agreement is terminated, entitlement

to benefits and coverage acquired by an individual before termination shall be retained. The agreement shall provide for notification of termination to the other party and the effective date of termination.

BENEFIT PROVISIONS

§ 404.1908 Crediting foreign periods of coverage.

(a) *General.* To have foreign periods of coverage combined with U.S. periods of coverage for purposes of determining entitlement to and the amount of benefits payable under title II, an individual must have at least 6 quarters of coverage, as defined in section 213 of the Social Security Act, under the U.S. system. As a rule, SSA will accept foreign coverage information, as certified by the foreign country's agency, unless otherwise specified by the agreement. No credit will be given, however, for periods of coverage acquired before January 1, 1937.

(b) *For quarters of coverage purposes.* (1) Generally, a quarter of coverage (QC) will be credited for every 3 months (or equivalent period), or remaining fraction of 3 months, of coverage in a reporting period certified to SSA by the other country's agency. A reporting period used by a foreign country may be one calendar year or some other period of time. QCs based on foreign periods of coverage may be credited as QCs only to calendar quarters not already QCs under title II. The QCs will be assigned chronologically beginning with the first calendar quarter (not already a QC under title II) within the reporting period and continuing until all the QCs are assigned, or the reporting period ends. Example: Country XYZ, which has an annual reporting period, certifies to SSA that a worker has 8 months of coverage in 1975, from January 1 to August 25. The worker has no QCs under title II in that year. Since 8 months divided by 3 months equals 2 QCs with a remainder of 2 months, the U.S. will credit the worker with 3 QCs. The QCs will be credited to the first 3 calendar quarters in 1975.

(2) If an individual fails to meet the requirements for currently insured status or the insured status needed for establishing a period of disability solely because of the assignment of QCs based on foreign coverage to calendar quarters chronologically, the QCs based on foreign coverage may be assigned to different calendar quarters within the beginning and ending dates of the reporting period certified by the foreign country, but only as permitted under paragraph (b)(1) of this section.

§ 404.1910 Person qualifies under more than one totalization agreement.

(a) An agreement may not provide for combining periods of coverage under more than two social security systems.

(b) If a person qualifies under more than one agreement, the person will receive benefits from the U.S. only under the agreement affording the most favorable treatment.

(c) In the absence of evidence to the contrary, the agreement that affords the most favorable treatment for purposes of paragraph (b) of this section will be determined as follows:

(1) If benefit amounts are the same under all such agreements, benefits will be paid only under the agreement which affords the earliest month of entitlement.

(2) If benefit amounts and the month of entitlement are the same under all such agreements, benefits will be paid only under the agreement under which all information necessary to pay such benefits is first available.

(3) If benefit amounts under all such agreements are not the same, benefits will be paid only under the agreement under which the highest benefit is payable. However, benefits may be paid under an agreement under which a lower benefit is payable for months prior to the month of first entitlement to such higher benefit.

[44 FR 42964, July 23, 1979, as amended at 49 FR 29775, July 24, 1984]

§ 404.1911 Effects of a totalization agreement on entitlement to hospital insurance benefits.

A person may not become entitled to hospital insurance benefits under section 226 or section 226A of the Act by combining the person's periods of coverage under the social security system of the United States with the person's

periods of coverage under the social security system of the foreign country. Entitlement to hospital insurance benefits is not precluded if the person otherwise meets the requirements.

COVERAGE PROVISIONS

§ 404.1913 Precluding dual coverage.

(a) *General.* Employment or self-employment or services recognized as equivalent under the Act or the social security system of the foreign country shall, on or after the effective date of the agreement, result in a period of coverage under the U.S. system or under the foreign system, but not under both. Methods shall be set forth in the agreement for determining under which system the employment, self-employment, or other service shall result in a period of coverage.

(b) *Principles for precluding dual coverage.* (1) An agreement precludes dual coverage by assigning responsibility for coverage to the U.S. or a foreign country. An agreement may modify the coverage provisions of title II of the Act to accomplish this purpose. Where an agreement assigns coverage to the foreign country, it may exempt from coverage services otherwise covered by the Act. Where an agreement assigns coverage to the U.S., it may extend coverage to services not otherwise covered by the Act but only for taxable years beginning on or after April 20, 1983.

(2) If the work would otherwise be covered by both countries, an agreement will exempt it from coverage by one of the countries.

(3) Generally, an agreement will provide that a worker will be covered by the country in which he or she is employed and will be exempt from coverage by the other country.

Example: A U.S. national employed in XYZ country by an employer located in the United States will be covered by XYZ country and exempt from U.S. coverage.

(4) An agreement may provide exceptions to the principle stated in paragraph (b)(3) of this section so that a worker will be covered by the country to which he or she has the greater attachment.

Example: A U.S. national sent by his employer located in the United States to work temporarily for that employer in XYZ country will be covered by the United States and will be exempt from coverage by XYZ country.

(5) Generally, if a national of either country resides in one country and has self employment income that is covered by both countries, an agreement will provide that the person will be covered by the country in which he or she resides and will be exempt from coverage by the other country.

(6) Agreements may provide for variations from the general principles for precluding dual coverage to avoid inequitable or anomalous coverage situations for certain workers. However, in all cases coverage must be provided by one of the countries.

[44 FR 42964, July 23, 1979, as amended at 50 FR 36575, Sept. 9, 1985]

§ 404.1914 Certificate of coverage.

Under some agreements, proof of coverage under one social security system may be required before the individual may be exempt from coverage under the other system. Requests for certificates of coverage under the U.S. system may be submitted by the employer, employee, or self-employed individual to SSA.

§ 404.1915 Payment of contributions.

On or after the effective date of the agreement, to the extent that employment or self-employment (or service recognized as equivalent) under the U.S. social security system or foreign system is covered under the agreement, the agreement shall provide that the work or equivalent service be subject to payment of contributions or taxes under only one system (see sections 1401(c), 3101(c), and 3111(c) of the Internal Revenue Code of 1954). The system under which contributions or taxes are to be paid is the system under which there is coverage pursuant to the agreement.

COMPUTATION PROVISIONS

§ 404.1918 How benefits are computed.

(a) *General.* Unless otherwise provided in an agreement, benefits will be

computed in accordance with this section. Benefits payable under an agreement are based on a pro rata primary insurance amount (PIA), which we determine as follows:

(1) We establish a theoretical earnings record for a worker which attributes to all computation base years (see §§ 404.211(b) and 404.241(c)) the same relative earnings position (REP) as he or she has in the years of his or her actual U.S. covered work. As explained in paragraph (b)(3) of this section, the REP is derived by determining the ratio of the worker's actual U.S. covered earnings in each year to the average of the total U.S. covered wages of all workers for that year, and then averaging the ratios for all such years. This average is the REP and is expressed as a percentage.

(2) We compute a theoretical PIA as prescribed in § 404.1918(c) based on the theoretical earnings record and the provisions of subpart C of this part.

(3) We multiply the theoretical PIA by a fraction equal to the number of quarters of coverage (QC's) which the worker completed under the U.S. Social Security system over the number of calendar quarters in the worker's coverage lifetime (see paragraph (d)(2) of this section). See § 404.140 for the definition of QC.

(4) If the pro rata PIA is higher than the PIA which would be computed if the worker were insured under the U.S. system without totalization, the pro rata PIA will be reduced to the later PIA.

(b) *Establishing a theoretical earnings record.* (1) To establish a worker's theoretical earnings record, we divide his or her U.S. earnings in each year credited with at least one U.S. QC by the average of the total wages of all workers for that year and express the quotient as a percentage. For the years 1937 through 1950, the average of the total wages is as follows:

Year	Average of the total wages of all workers
1937	$1,137.96
1938	1,053.24
1939	1,142.36
1940	1,195.00
1941	1,276.04
1942	1,454.28
1943	1,713.52
1944	1,936.32
1945	2,021.40
1946	1,891.76
1947	2,175.32
1948	2,361.64
1949	2,483.20
1950	2,543.96

(2) For years after 1950, the average of the total wages is as prescribed in § 404.211(c). If a worker has earnings in the year preceding the year of eligibility or death, or in a later year, we may not have been able to establish the average of the total wages of all workers for that year. Therefore, we will divide a worker's actual earnings in these years by the average of the total wages for the latest year for which that information is available. Average wage information is considered available on January 1 of the year following the year in which it is published in the FEDERAL REGISTER.

(3) The percentages for all years of actual covered earnings are then averaged to give the worker's REP for the entire period of work in the U.S. In determining the percentages for all years of covered earnings and the REP, we make adjustments as necessary to take account of the fact that the covered earnings for some years may have involved less than four U.S. QC's. The actual earnings that are taken into account in determining the percentage for any year with 1, 2, or 3 QC's cannot exceed ¼, ½, or ¾, respectively, of the maximum creditable earnings for that year. When we determine the REP from the percentages for all years, we add the percentages for all years, divide this sum by the total number of QC's credited to the worker, and multiply this quotient by 4 (see Example 1 of paragraph (d) of this section). This has the effect of calculating the REP on a quarterly basis.

(4) For each of the worker's computation base years (see §§ 404.211(b), 404.221(b) and 404.241(c)), we multiply the average of the total wages of all workers for that year by the worker's REP. The product is the amount of earnings attributed to the worker for that year, subject to the annual wage limitation (see § 404.1047). The worker's

theoretical earnings record consists of his or her attributed earnings based on his or her REP for all computation base years. However, we do not attribute earnings to computation base years before the year of attainment of age 22 or to computation base years beginning with the year of attainment of retirement age (or the year in which a period of disability begins), unless the worker is actually credited with U.S. earnings in those years. In death cases, earnings for the year of death will be attributed only through the quarter of death, on a proportional basis.

(c) *Determining the theoretical PIA.* We determine the worker's theoretical PIA based on his or her theoretical earnings record by applying the same computation method that would have applied under subpart C if the worker had these theoretical earnings and had qualified for benefits without application of an agreement. However, when the criteria in §404.210(a) for the Average Indexed Monthly Earnings (AIME) computation method are met, only that method is used. If these criteria are not met but the criteria in §404.220(a) for the Average Monthly Wage method are met, then only that method is used. If neither of these criteria are met, then the old-start method described in §404.241 is used. If a theoretical PIA is to be determined based on a worker's AIME, theoretical earnings amounts for each year, determined under paragraph (b) of this section, are indexed in determining the AIME under §404.211.

(d) *Determining the pro rata PIA.* We then determine a pro rata PIA from the theoretical PIA. The pro rata PIA is the product of—

(1) The theoretical PIA; and

(2) The ratio of the worker's actual number of U.S. QC's to the number of calendar quarters in the worker's coverage lifetime. A coverage lifetime means the worker's benefit computation years as determined under §404.211(e), §404.221(c), or §404.241(d).

Example 1: C attains age 62 in 1982 and needs 31 QC's to be insured. C worked under the U.S. system from July 1, 1974 to December 31, 1980 and therefore has only 6½ years during which he worked under the U.S. system (26 QC's). C, however, has worked under the Social Security system of a foreign country that is party to a totalization agreement, and his total U.S. and foreign work, combined as described in §404.1908, equals more than 31 QC's. Thus, the combined coverage gives C insured status. The benefit is computed as follows:

Step 1: Establish C's theoretical earnings record:

The following table shows: (1) C's actual U.S. covered earnings for each year, (2) the average of the total wages of all workers for that year and (3) the ratio of (1) to (2):

Year	QC's	C's actual U.S. covered earnings	National average wage	Percentage ratio of (1) to (2)
		(1)	(2)	(3)
1974	2	$2,045.08	$8,030.76	25.46558
1975	4	7,542.00	8,630.92	87.38350
1976	4	9,016.00	9,226.48	97.71874
1977	4	9,952.00	9,779.44	101.76452
1978	4	10,924.00	10,556.03	103.48587
1979	4	12,851.00	11,479.46	111.94777
1980	4	11,924.00	12,513.46	95.28939

C's REP is the average of the ratios in column 3, adjusted to take account of the fact that C had only 2 QC's in 1974. Thus, the REP equals the sum of the figures in column 3 (623.05537), divided by the total number of C's QC's (26) and multiplied by 4, or 95.85467 percent.

Since C attained age 62 in 1982, his computation base years are 1951 through 1981. To establish his theoretical earnings record we use 95.85467 percent of the national average wage for each of the years 1951 through 1981. Since national average wage data is not available for 1981, for that year we attribute 95.85467 percent of the national average wage for 1980 or $11,994.74. His theoretical earnings record would look like this:

1951	$2,683.13
1952	2,850.07
1953	3,009.30
1954	3,024.83
1955	3,164.58
1956	3,385.93
1957	3,490.76
1958	3,521.51
1959	3,695.96
1960	3,841.01
1961	3,917.35
1962	4,113.51
1963	4,214.38
1964	4,386.62
1965	4,465.60
1966	4,733.65
1967	4,997.33
1968	5,340.79
1969	5,649.44
1970	5,929.80
1971	6,227.75
1972	6,838.08
1973	7,265.94
1974	7,697.86
1975	8,273.14
1976	8,844.01
1977	9,374.05
1978	10,118.45
1979	11,003.60

1980	11,994.74
1981	11,994.74

Step 2: Compute the theoretical PIA: Since C attains age 62 in 1982, we determine his theoretical PIA using an AIME computation. In applying the AIME computation, we index each year's earnings on the theoretical earnings record in accordance with § 404.211(d). In this example, the theoretical PIA is $453.

Step 3: Compute the pro rata PIA:

$$\frac{\text{Theoretical PIA} - \text{Actual U.S. QC's}}{\text{calendar quarters in benefit computation years}}$$

$$\frac{\$453 - 26 \text{ QC's } (6\frac{1}{2} \text{ years})}{104 \text{ quarters } (26 \text{ years})}$$

= $113.20 pro rata PIA

Example 2: M needs 27 QC's to be insured, but she has only 3 years of work (12 QC's) under the U.S. system. M has enough foreign work, however, to be insured. She attained age 62 in 1978, and her U.S. covered earnings were in 1947, 1948 and 1949. Based on M's date of birth, her theoretical PIA can be computed, in accordance with § 404.220, under a new start method. If M's earnings in 1947, 1948, and 1949 were 50 percent, 60 percent and 70 percent, respectively, of the average wage for each year, her REP would be 60 percent. For each year in the computation period, 60 percent of the average wage for that year will be attributed as M's assumed earnings. The theoretical PIA will then be computed as described in §§ 404.220 through 404.222.

To determine M's pro rata PIA, the theoretical PIA will be multiplied by the ratio of the actual number of U.S. QC's to the number of calendar quarters in the benefit computation years. There are 22 benefit computation years, or 88 quarters. The pro rata PIA would, therefore, be $^{12}/_{88}$ × theoretical PIA.

(e) *Rounding of benefits.* (1) If the effective date of the pro rata PIA is before June 1982, we will round to the next higher multiple of 10 cents if it is not already a multiple of 10 cents.

(2) If the effective date of the pro rata PIA is June 1982 or later, we will round to the next lower multiple of 10 cents if it is not already a multiple of 10 cents.

(f) *Auxiliary and survivors benefits; reductions; family maximum.* We will determine auxiliary and survivors benefit amounts (see subpart D) on the basis of the pro rata PIA. We will apply the regular reductions for age under section 202(q) of the Act to the benefits of the worker or to any auxiliaries or survivors which are based on the pro rata PIA (see § 404.410). Benefits will be payable subject to the family maximum (see § 404.403) derived from the pro rata PIA. If the pro rata PIA is less than the minimum PIA, the family maximum will be 1½ times the pro rata PIA.

[49 FR 29775, July 24, 1984]

§ 404.1919 How benefits are recomputed.

Unless otherwise provided in an agreement, we will recompute benefits in accordance with this section. We will recompute the pro rata PIA only if the inclusion of the additional earnings results in an increase in the benefits payable by the U.S. to all persons receiving benefits on the basis of the worker's earnings. Subject to this limitation, the pro rata PIA will be automatically recomputed (see § 404.285) to include additional earnings under the U.S. system. In so doing, a new REP will be established for the worker, taking the additional earnings into account, and assumed earnings in the computation base years used in the original computation will be refigured using the new REP. Assumed earnings will also be determined for the year of additional earnings using the new REP. The additional U.S. earnings will also be used in refiguring the ratio described in § 404.1918(d)(2).

[49 FR 29777, July 24, 1984]

§ 404.1920 Supplementing the U.S. benefit if the total amount of the combined benefits is less than the U.S. minimum benefit.

If a resident of the U.S. receives benefits under an agreement from both the U.S. and from the foreign country, the total amount of the two benefits may be less than the amount for which the resident would qualify under the U.S. system based on the minimum PIA as in effect for persons first becoming eligible for benefits before January 1982. An agreement may provide that in the case of an individual who first becomes eligible for benefits before January 1982, the U.S. will supplement the total amount to raise it to the amount for which the resident would have qualified under the U.S. system based on the minimum PIA. (The minimum benefit

will be based on the first figure in column IV in the table in section 215(a) of the Act for a person becoming eligible for the benefit before January 1, 1979, or the PIA determined under section 215(a)(1)(C)(i)(I) of the Act (as in effect in December 1981) for a person becoming eligible for the benefit after December 31, 1978.)

[49 FR 29777, July 24, 1984]

§ 404.1921 Benefits of less than $1 due.

If the monthly benefit amount due an individual (or several individuals, e.g., children, where several benefits are combined in one check) as a result of a claim filed under an agreement is less than $1, the benefits may be accumulated until they equal or exceed $5.

OTHER PROVISIONS

§ 404.1925 Applications.

(a)(1) An application, or written statement requesting benefits, filed with the competent authority or agency of a country with which the U.S. has concluded an agreement shall be considered an application for benefits under title II of the Act as of the date it is filed with the competent authority or agency if—

(i) An applicant expresses or implies an intent to claim benefits from the U.S. under an agreement; and

(ii) The applicant files an application that meets the requirements in subpart G of this part.

(2) The application described in paragraph (a)(1)(ii) of this section must be filed, even if it is not specifically provided for in the agreement.

(b) Benefits under an agreement may not be paid on the basis of an application filed before the effective date of the agreement.

§ 404.1926 Evidence.

(a) An applicant for benefits under an agreement shall submit the evidence needed to establish entitlement, as provided in subpart H of this part. Special evidence requirements for disability benefits are in subpart P of this part.

(b) Evidence submitted to the competent authority or agency of a country with which the U.S. has concluded an agreement shall be considered as evidence submitted to SSA. SSA shall use the rules in §§ 404.708 and 404.709 to determine if the evidence submitted is sufficient, or if additional evidence is needed to prove initial or continuing entitlement to benefits.

(c) If an application is filed for disability benefits, SSA shall consider medical evidence submitted to a competent authority or agency, as described in paragraph (b) of this section, and use the rules of subpart P of this part for making a disability determination.

§ 404.1927 Appeals.

(a) A request for reconsideration, hearing, or Appeals Council review of a determination that is filed with the competent authority or agency of a country with which the U.S. has concluded an agreement, shall be considered to have been timely filed with SSA if it is filed within the 60-day time period provided in §§ 404.911, 404.918, and 404.946.

(b) A request for reconsideration, hearing, or Appeals Council review of a determination made by SSA resulting from a claim filed under an agreement shall be subject to the provisions in subpart J of this part. The rules governing administrative finality in subpart J of this part shall also apply.

§ 404.1928 Effect of the alien non-payment provision.

An agreement may provide that a person entitled to benefits under title II of the Social Security Act may receive those benefits while residing in the foreign country party to the agreement, regardless of the alien non-payment provision (see § 404.460).

§ 404.1929 Overpayments.

An agreement may not authorize the adjustment of title II benefits to recover an overpayment made under the social security system of a foreign country (see § 404.501). Where an overpayment is made under the U.S. system, the provisions in subpart F of this part will apply.

§ 404.1930 Disclosure of information.

The use of information furnished under an agreement generally shall be governed by the national statutes on

confidentiality and disclosure of information of the country that has been furnished the information. (The U.S. will be governed by pertinent provisions of the Social Security Act, the Freedom of Information Act, the Privacy Act, the Tax Reform Act, and other related statutes.) In negotiating an agreement, consideration, should be given to the compatibility of the other country's laws on confidentiality and disclosure to those of the U.S. To the extent possible, information exchanged between the U.S. and the foreign country should be used exclusively for purposes of implementing the agreement and the laws to which the agreement pertains.

Subpart U—Representative Payment

AUTHORITY: Secs. 205(a), (j), and (k), and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), (j), and (k), and 902(a)(5)).

SOURCE: 47 FR 30472, July 14, 1982, unless otherwise noted.

§ 404.2001 Introduction.

(a) *Explanation of representative payment.* This subpart explains the principles and procedures that we follow in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds he or she receives on behalf of a beneficiary. A representative payee may be either a person or an organization selected by us to receive benefits on behalf of a beneficiary. A representative payee will be selected if we believe that the interest of a beneficiary will be served by representative payment rather than direct payment of benefits. Generally, we appoint a representative payee if we have determined that the beneficiary is not able to manage or direct the management of benefit payments in his or her interest.

(b) *Policy used to determine whether to make representative payment.* (1) Our policy is that every beneficiary has the right to manage his or her own benefits. However, some beneficiaries due to a mental or physical condition or due to their youth may be unable to do so. Under these circumstances, we may determine that the interests of the beneficiary would be better served if we certified benefit payments to another person as a representative payee.

(2) If we determine that representative payment is in the interest of a beneficiary, we will appoint a representative payee. We may appoint a representative payee even if the beneficiary is a legally competent individual. If the beneficiary is a legally incompetent individual, we may appoint the legal guardian or some other person as a representative payee.

(3) If payment is being made directly to a beneficiary and a question arises concerning his or her ability to manage or direct the management of benefit payments, we will, if the beneficiary is 18 years old or older and has not been adjudged legally incompetent, continue to pay the beneficiary until we make a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

§ 404.2010 When payment will be made to a representative payee.

(a) We pay benefits to a representative payee on behalf of a beneficiary 18 years old or older when it appears to us that this method of payment will be in the interest of the beneficiary. We do this if we have information that the beneficiary is—

(1) Legally incompetent or mentally incapable of managing benefit payments; or

(2) Physically incapable of managing or directing the management of his or her benefit payments.

(b) Generally, if a beneficiary is under age 18, we will pay benefits to a representative payee. However, in certain situations, we will make direct payments to a beneficiary under age 18 who shows the ability to manage the benefits. For example, we make direct payments to a beneficiary under age 18 if the beneficiary is—

(1) Receiving disability insurance benefits on his or her own Social Security earnings record; or

(2) Serving in the military services; or

(3) Living alone and supporting himself or herself; or

(4) A parent and files for himself or herself and/or his or her child and he or she has experience in handling his or her own finances; or

(5) Capable of using the benefits to provide for his or her current needs and no qualified payee is available; or

(6) Within 7 months of attaining age 18 and is initially filing an application for benefits.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§ 404.2011 What happens to your monthly benefits while we are finding a suitable representative payee for you?

(a) *We may pay you directly.* We will pay current monthly benefits directly to you while finding a suitable representative payee unless we determine that paying you directly would cause substantial harm to you. We determine substantial harm as follows:

(1) If you are receiving disability payments and we have determined that you have a drug addiction or alcoholism condition, or you are legally incompetent, or you are under age 15, we will presume that substantial harm exists. However, we will allow you to rebut this presumption by presenting evidence that direct payment would not cause you substantial harm.

(2) If you do not fit any of these categories, we make findings of substantial harm on a case-by-case basis. We consider all matters that may affect your ability to manage your benefits in your own best interest. We decide that substantial harm exists if both of the following conditions exist:

(i) Directly receiving benefits can be expected to cause you serious physical or mental injury.

(ii) The possible effect of the injury would outweigh the effect of having no income to meet your basic needs.

(b) *We may delay or suspend your payments.* If we find that direct payment will cause substantial harm to you, we may delay (in the case of initial entitlement to benefits) or suspend (in the case of existing entitlement to benefits) payments for as long as one month while we try to find a suitable representative payee for you. If we do not find a payee within one month, we will pay you directly. If you are receiving disability payments and we have determined that you have a drug addiction and alcoholism condition, or you are legally incompetent, or you are under age 15, we will withhold payment until a representative payee is appointed even if it takes longer than one month. We will, however, as noted in paragraph (a)(1) of this section, allow you to present evidence to rebut the presumption that direct payment would cause you substantial harm. See § 404.2001(b)(3) for our policy on suspending benefits if you are currently receiving benefits directly.

Example 1: Substantial Harm Exists. We are unable to find a representative payee for Mr. X, a 67 year old retirement beneficiary who is an alcoholic. Based on contacts with the doctor and beneficiary, we determine that Mr. X was hospitalized recently for his drinking. Paying him directly will cause serious injury, so we may delay payment for as long as one month based on substantial harm while we locate a suitable representative payee.

Example 2: Substantial Harm Does Not Exist. We approve a claim for Mr. Y, a title II claimant who suffers from a combination of mental impairments but who is not legally incompetent. We determine that Mr. Y needs assistance in managing his benefits, but we have not found a representative payee. Although we believe that Mr. Y may not use the money wisely, there is no indication that receiving funds directly would cause him substantial harm (*i.e.*, serious physical or mental injury). We must pay current benefits directly to Mr. Y while we locate a suitable representative payee.

(c) *How we pay delayed or suspended benefits.* Payment of benefits, which were delayed or suspended pending appointment of a representative payee, can be made to you or your representative payee as a single sum or in installments when we determine that installments are in your best interest.

[69 FR 60232, Oct. 7, 2004]

§ 404.2015 Information considered in determining whether to make representative payments.

In determining whether to make representative payment we consider the following information:

(a) *Court determinations.* If we learn that a beneficiary has been found to be legally incompetent, a certified copy of the court's determination will be the

basis of our determination to make representative payment.

(b) *Medical evidence.* When available, we will use medical evidence to determine if a beneficiary is capable of managing or directing the management of benefit payments. For example, a statement by a physician or other medical professional based upon his or her recent examination of the beneficiary and his or her knowledge of the beneficiary's present condition will be used in our determination, if it includes information concerning the nature of the beneficiary's illness, the beneficiary's chances for recovery and the opinion of the physician or other medical professional as to whether the beneficiary is able to manage or direct the management of benefit payments.

(c) *Other evidence.* We will also consider any statements of relatives, friends and other people in a position to know and observe the beneficiary, which contain information helpful to us in deciding whether the beneficiary is able to manage or direct the management of benefit payments.

§ 404.2018 Advance designation of representative payees.

(a) *General.* An individual who:

(1) Is entitled to or an applicant for a benefit and;

(2) Has attained 18 years of age or is an emancipated minor, may designate in advance one or more individuals to possibly serve as a representative payee for the individual if we determine that payment will be made to a representative payee (see § 404.2010(a)). An individual may not designate in advance possible representative payees if we have information that the individual is either-legally incompetent or mentally incapable of managing his or her benefit payments; or physically incapable of managing or directing the management of his or her benefit payments.

(b) *How to designate possible representative payees in advance.* Individuals who meet the requirements in paragraph (a) of this section may designate in advance their choice(s) for possible representative payees by indicating their decision to designate a representative payee in advance and providing us with the required information. In addition to the required information, an individual may choose to provide us with the relationship of the advance designee(s) to the individual. The information we require before we will consider an advance designee as a possible representative payee is:

(1) The name of the advance designee,

(2) A telephone number of the advance designee, and

(3) The order of priority in which the individual would like us to consider the advance designees, if he or she designates more than one advance designee.

(c) *How to make changes to advance designation.* Individuals who meet the requirements in paragraph (a) of this section may change their advance designees by informing us of the change and providing the required information (see paragraphs (b)(1) through (3) of this section) to us. Individuals who meet the requirements in paragraph (a) of this section may withdraw their advance designation by informing us of the withdrawal.

(d) *How we consider advance designation when we select a representative payee.* (1) If we determine that payment will be made to a representative payee, we will review an individual's advance designees in the order listed by the individual and select the first advance designee who meets the criteria for selection. To meet the criteria for selection—

(i) The advance designee must be willing and able to serve as a representative payee,

(ii) Appointment of the advance designee must comply with the requirements in section 205(j)(2) of the Social Security Act, and

(iii) There must be no other good cause (see §§ 404.2020 and 404.2021) to prevent us from selecting the advance designee.

(2) If none of the advance designees meet the criteria for selection, we will use our list of categories of preferred payees (see § 404.2021), along with our other regulations in subpart U of this part, as a guide to select a suitable representative payee.

(e) *How we consider advance designation when we select a subsequent representative payee.* If an individual who currently has a representative payee

requires a change of representative payee, we will consider any other designees identified by the individual at a time in which that individual was eligible to make an advanced designation, under paragraph (d) of this section.

(f) *Organizations.* An individual may not designate in advance an organization to serve as his or her possible representative payee.

[85 FR 7664, Feb. 11, 2020]

§ 404.2020 Information considered in selecting a representative payee.

In selecting a payee we try to select the person, agency, organization or institution that will best serve the interest of the beneficiary. In making our selection we consider—

(a) The relationship of the person to the beneficiary;

(b) The amount of interest that the person shows in the beneficiary;

(c) Any legal authority the person, agency, organization or institution has to act on behalf of the beneficiary;

(d) Whether the potential payee has custody of the beneficiary;

(e) Whether the potential payee is in a position to know of and look after the needs of the beneficiary;

(f) The potential payee's criminal history; and

(g) Whether the beneficiary made an advance designation (see § 404.2018).

[47 FR 30472, July 14, 1982, as amended at 84 FR 4325, Feb. 15, 2019; 85 FR 7664, Feb. 11, 2020]

§ 404.2021 What is our order of preference in selecting a representative payee for you?

As a guide in selecting a representative payee, we have established categories of preferred payees. These preferences are flexible. We will consider an individual's advance designee(s) (see § 404.2018) before we consider other potential representative payees in the categories of preferred payees listed in this section. When we select a representative payee, we will choose the designee of the beneficiary's highest priority, provided that the designee is willing and able to serve, is not prohibited from serving (see § 404.2022), and supports the best interest of the beneficiary (see § 404.2020). The preferences are:

(a) For beneficiaries 18 years old or older (except those described in paragraph (b) of this section), our preference is—

(1) A legal guardian, spouse (or other relative) who has custody of the beneficiary or who demonstrates strong concern for the personal welfare of the beneficiary;

(2) A friend who has custody of the beneficiary or demonstrates strong concern for the personal welfare of the beneficiary;

(3) A public or nonprofit agency or institution having custody of the beneficiary;

(4) A private institution operated for profit and licensed under State law, which has custody of the beneficiary; and

(5) Persons other than above who are qualified to carry out the responsibilities of a payee and who are able and willing to serve as a payee for a beneficiary; e.g., members of community groups or organizations who volunteer to serve as payee for a beneficiary.

(b) For individuals who are disabled and who have a drug addiction or alcoholism condition our preference is—

(1) A community-based nonprofit social service agency which is licensed by the State, or bonded;

(2) A Federal, State, or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities;

(3) A State or local government agency with fiduciary responsibilities;

(4) A designee of an agency (other than a Federal agency) referred to in paragraphs (b)(1), (2), and (3) of this section, if appropriate; or

(5) A family member.

(c) For beneficiaries under age 18, our preference is—

(1) A natural or adoptive parent who has custody of the beneficiary, or a guardian;

(2) A natural or adoptive parent who does not have custody of the beneficiary, but is contributing toward the beneficiary's support and is demonstrating strong concern for the beneficiary's well being;

(3) A natural or adoptive parent who does not have custody of the beneficiary and is not contributing toward his or her support but is demonstrating

strong concern for the beneficiary's well being;

(4) A relative or stepparent who has custody of the beneficiary;

(5) A relative who does not have custody of the beneficiary but is contributing toward the beneficiary's support and is demonstrating concern for the beneficiary's well being;

(6) A relative or close friend who does not have custody of the beneficiary but is demonstrating concern for the beneficiary's well being; and

(7) An authorized social agency or custodial institution.

[47 FR 30472, July 14, 1982; 47 FR 32936, July 30, 1982, as amended at 69 FR 60232, Oct. 7, 2004; 85 FR 7664, Feb. 11, 2020]

§ 404.2022 Who may not serve as a representative payee?

A representative payee applicant may not serve if he/she:

(a) Has been convicted of a violation under section 208, 811 or 1632 of the Social Security Act.

(b) Has been convicted of an offense resulting in imprisonment for more than 1 year. However, we may make an exception to this prohibition, if the nature of the conviction is such that selection of the applicant poses no risk to the beneficiary and the exception is in the beneficiary's best interest.

(c) Receives title II, VIII, or XVI benefits through a representative payee.

(d) Previously served as a representative payee and was found by us, or a court of competent jurisdiction, to have misused title II, VIII or XVI benefits. However, if we decide to make an exception to this prohibition, we must evaluate the payee's performance at least every 3 months until we are satisfied that the payee poses no risk to the beneficiary's best interest. Exceptions are made on a case-by-case basis if all of the following are true:

(1) Direct payment of benefits to the beneficiary is not in the beneficiary's best interest.

(2) No suitable alternative payee is available.

(3) Selecting the payee applicant as representative payee would be in the best interest of the beneficiary.

(4) The information we have indicates the applicant is now suitable to serve as a representative payee.

(5) The payee applicant has repaid the misused benefits or has a plan to repay them.

(e) Is a creditor. A creditor is someone who provides you with goods or services for consideration. This restriction does not apply to the creditor who poses no risk to you and whose financial relationship with you presents no substantial conflict of interest, and who is any of the following:

(1) A relative living in the same household as you do.

(2) Your legal guardian or legal representative.

(3) A facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State.

(4) A qualified organization authorized to collect a monthly fee from you for expenses incurred in providing representative payee services for you, under § 404.2040a.

(5) An administrator, owner, or employee of the facility in which you live, and we are unable to locate an alternative representative payee.

(6) Any other individual we deem appropriate based on a written determination.

Example 1: Sharon applies to be representative payee for Ron who we have determined cannot manage his benefits. Sharon has been renting a room to Ron for several years and assists Ron in handling his other financial obligations, as needed. She charges Ron a reasonable amount of rent. Ron has no other family or friends willing to help manage his benefits or to act as representative payee. Sharon has demonstrated that her interest in and concern for Ron goes beyond her desire to collect the rent each month. In this instance, we may select Sharon as Ron's representative payee because a more suitable payee is not available, she appears to pose no risk to Ron and there is minimal conflict of interest. We will document this decision.

Example 2: In a situation similar to the one above, Ron's landlord indicates that she is applying to be payee only to ensure receipt of her rent. If there is money left after payment of the rent, she will give it directly to Ron to manage on his own. In this situation, we would not select the landlord as Ron's representative payee because of the substantial conflict of interest and lack of interest in his well being.

(f) Was convicted under Federal or State law of a felony for: Human trafficking, false imprisonment, kidnapping, rape or sexual assault, first-degree homicide, robbery, fraud to obtain access to government assistance, fraud by scheme, theft of government funds or property, abuse or neglect, forgery, or identity theft or identity fraud. We will also apply this provision to a representative payee applicant with a felony conviction of an attempt to commit any of these crimes or conspiracy to commit any of these crimes.

(1) If the representative payee applicant is the custodial parent of a minor child beneficiary, custodial parent of a beneficiary who is under a disability which began before the beneficiary attained the age of 22, custodial spouse of a beneficiary, custodial court-appointed guardian of a beneficiary, or custodial grandparent of the minor child beneficiary for whom the applicant is applying to serve as representative payee, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

(2) If the representative payee applicant is the parent who was previously the representative payee for his or her minor child who has since turned age 18 and continues to be eligible for benefits, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee for that beneficiary. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

(3) If the representative payee applicant received a Presidential or gubernatorial pardon for the relevant conviction, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

[69 FR 60232, Oct. 7, 2004, as amended at 71 FR 61407, Oct. 18, 2006; 84 FR 4325, Feb. 15, 2019]

§ 404.2024 How do we investigate a representative payee applicant?

Before selecting an individual or organization to act as your representative payee, we will perform an investigation.

(a) *Nature of the investigation.* As part of the investigation, we do the following:

(1) Conduct a face-to-face interview with the payee applicant unless it is impracticable as explained in paragraph (c) of this section.

(2) Require the payee applicant to submit documented proof of identity, unless information establishing identity has recently been submitted with an application for title II, VIII or XVI benefits.

(3) Verify the payee applicant's Social Security account number or employer identification number.

(4) Determine whether the payee applicant has been convicted of a violation of section 208, 811 or 1632 of the Social Security Act.

(5) Determine whether the payee applicant has previously served as a representative payee and if any previous appointment as payee was revoked or terminated for misusing title II, VIII or XVI benefits.

(6) Use our records to verify the payee applicant's employment and/or direct receipt of title II, VIII, or XVI benefits.

(7) Verify the payee applicant's concern for the beneficiary with the beneficiary's custodian or other interested person.

(8) Require the payee applicant to provide adequate information showing his or her relationship to the beneficiary and to describe his or her responsibility for the care of the beneficiary.

(9) Determine whether the payee applicant is a creditor of the beneficiary (see § 404.2022(e)).

(10) Conduct a criminal background check on the individual payee applicant.

(b) *Subsequent face-to-face interviews.* After holding a face-to-face interview with a payee applicant, subsequent face-to-face interviews are not required if that applicant continues to be qualified and currently is acting as a payee, unless we determine, within our discretion, that a new face-to-face interview is necessary. We base this decision on the payee's past performance and knowledge of and compliance with our reporting requirements.

(c) *Impracticable.* We may consider a face-to-face interview impracticable if it would cause the payee applicant undue hardship. For example, the payee applicant would have to travel a great distance to the field office. In this situation, we may conduct the investigation to determine the payee applicant's suitability to serve as a representative payee without a face-to-face interview.

[69 FR 60233, Oct. 7, 2004, as amended at 73 FR 66521, Nov. 10, 2008; 84 FR 4325, Feb. 15, 2019; 84 FR 57319, Oct. 25, 2019]

§ 404.2025 What information must a representative payee report to us?

Anytime after we select a representative payee for you, we may ask your payee to give us information showing a continuing relationship with you, a continuing responsibility for your care, and how he/she used the payments on your behalf. If your representative payee does not give us the requested information within a reasonable period of time, we may stop sending your benefit payment to him/her—unless we determine that he/she had a satisfactory reason for not meeting our request and we subsequently receive the requested information. If we decide to stop sending your payment to your representative payee, we will consider paying you directly (in accordance with § 404.2011) while we look for a new payee.

[69 FR 60233, Oct. 7, 2004]

§ 404.2026 How do we investigate an appointed representative payee?

After we select an individual to act as your representative payee, we will conduct a criminal background check on the appointed representative payee at least once every 5 years.

[84 FR 4325, Feb. 15, 2019, as amended at 84 FR 57319, Oct. 25, 2019]

§ 404.2030 How will we notify you when we decide you need a representative payee?

(a) We notify you in writing of our determination to make representative payment. This advance notice explains that we have determined that representative payment is in your interest, and it provides the name of the representative payee we have selected. We provide this notice before we actually appoint the payee. If you are under age 15, an unemancipated minor under the age of 18, or legally incompetent, our written notice goes to your legal guardian or legal representative. The advance notice:

(1) Contains language that is easily understandable to the reader.

(2) Identifies the person designated as your representative payee.

(3) Explains that you, your legal guardian, or your legal representative can appeal our determination that you need a representative payee.

(4) Explains that you, your legal guardian, or your legal representative can appeal our designation of a particular person or organization to serve as your representative payee.

(5) Explains that you, your legal guardian, or your legal representative can review the evidence upon which our designation of a particular representative payee is based and submit additional evidence.

(b) If you, your legal guardian, or your legal representative objects to representative payment or to the designated payee, we will handle the objection as follows:

(1) If you disagree with the decision and wish to file an appeal, we will process it under subpart J of this part.

(2) If you received your advance notice by mail and you protest or file your appeal within 10 days after you receive this notice, we will delay the action until we make a decision on your protest or appeal. (If you received and signed your notice while you were in the local field office, our decision will be effective immediately.)

[69 FR 60233, Oct. 7, 2004]

§ 404.2035 What are the responsibilities of your representative payee?

A representative payee has a responsibility to—

(a) Use the benefits received on your behalf only for your use and benefit in a manner and for the purposes he or she determines, under the guidelines in this subpart, to be in your best interests;

(b) Keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she is your spouse or natural or adoptive parent or stepparent and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement;

(c) Treat any interest earned on the benefits as your property;

(d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them;

(e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us; and

(f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities.

[71 FR 61407, Oct. 18, 2006]

§ 404.2040 Use of benefit payments.

(a) *Current maintenance.* (1) We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes cost incurred in obtaining food, shelter, clothing, medical care, and personal comfort items.

Example: An aged beneficiary is entitled to a monthly Social Security benefit of $400. Her son, who is her payee, disburses her benefits in the following manner:

Rent and utilities	$200
Medical	25
Food	60
Clothing (coat)	55
Savings	30
Miscellaneous	30

The above expenditures would represent proper disbursements on behalf of the beneficiary.

(2) Notwithstanding the provisions of paragraph (a)(1) of this section, if a beneficiary is a member of an Aid to Families With Dependent Children (AFDC) assistance unit, we do not consider it inappropriate for a representative payee to make the benefit payments available to the AFDC assistance unit.

(b) *Institutional care.* If a beneficiary is receiving care in a Federal, State, or private institution because of mental or physical incapacity, current maintenance includes the customary charges made by the institution, as well as expenditures for those items which will aid in the beneficiary's recovery or release from the institution or expenses for personal needs which will improve the beneficiary's conditions while in the institution.

Example: An institutionalized beneficiary is entitled to a monthly Social Security benefit of $320. The institution charges $700 a month for room and board. The beneficiary's brother, who is the payee, learns the beneficiary needs new shoes and does not have any funds to purchase miscellaneous items at the institution's canteen.

The payee takes his brother to town and buys him a pair of shoes for $29. He also takes the beneficiary to see a movie which costs $3. When they return to the institution, the payee gives his brother $3 to be used at the canteen.

Although the payee normally withholds only $25 a month from Social Security benefit for the beneficiary's personal needs, this month the payee deducted the above expenditures and paid the institution $10 less than he usually pays.

The above expenditures represent what we would consider to be proper expenditures for current maintenance.

(c) *Support of legal dependents.* If the current maintenance needs of the beneficiary are met, the payee may use part of the payments for the support of the beneficiary's legally dependent spouse, child, and/or parent.

Example: A disabled beneficiary receives a Veterans Administration (VA) benefit of $325 and a Social Security benefit of $525. The beneficiary resides in a VA hospital and his VA benefits are sufficient to provide for all of his needs; *i.e.*, cost of care and personal needs. The beneficiary's legal dependents—his wife and two children—have a total income of $250 per month in Social Security benefits. However, they have expenses of approximately $450 per month.

Because the VA benefits are sufficient to meet the beneficiary's needs, it would be appropriate to use part of his Social Security benefits to support his dependents.

(d) *Claims of creditors.* A payee may not be required to use benefit payments to satisfy a debt of the beneficiary, if the debt arose prior to the first month for which payments are certified to a payee. If the debt arose prior to this time, a payee may satisfy it only if the current and reasonably foreseeable needs of the beneficiary are met.

Example: A retroactive Social Security check in the amount of $1,640, representing benefits due for July 1980 through January 1981, was issued on behalf of the beneficiary to the beneficiary's aunt who is the representative payee. The check was certified in February 1981.

The nursing home, where the beneficiary resides, submitted a bill for $1,139 to the payee for maintenance expenses the beneficiary incurred during the period from June 1980 through November 1980. (Maintenance charges for December 1980 through February 1981 had previously been paid.)

Because the benefits were not required for the beneficiary's current maintenance, the payee had previously saved over $500 for the beneficiary and the beneficiary had no foreseeable needs which would require large disbursements, the expenditure for the maintenance charges would be consistent with our guidelines.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§ 404.2040a Compensation for qualified organizations serving as representative payees.

(a) *Organizations that can request compensation.* A qualified organization can request us to authorize it to collect a monthly fee from your benefit payment. A qualified organization is:

(1) Any State or local government agency with fiduciary responsibilities or whose mission is to carry out income maintenance, social service, or health care-related activities; or

(2) Any community-based nonprofit social service organization founded for religious, charitable or social welfare purposes, which is tax exempt under section 501(c) of the Internal Revenue Code and which is bonded/insured to cover misuse and embezzlement by officers and employees and which is licensed in each State in which it serves as representative payee (if licensing is available in the State). The minimum amount of bonding or insurance coverage must equal the average monthly amount of social security payments received by the organization plus the amount of the beneficiaries' conserved funds (*i.e.*, beneficiaries' saved social security benefits) plus interest on hand. For example, an organization that has conserved funds of $5,000 and receives an average of $12,000 a month in social security payments must be bonded/insured for a minimum of $17,000. The license must be appropriate under the laws of the State for the type of services the organization provides. An example of an appropriately licensed organization is a community mental health center holding a State license to provide community mental health services.

(b) *Requirements qualified organizations must meet.* Organizations that are qualified under paragraphs (a)(1) or (a)(2) of this section must also meet the following requirements before we can authorize them to collect a monthly fee.

(1) A qualified organization must regularly provide representative payee services concurrently to at least five beneficiaries. An organization which has received our authorization to collect a fee for representative payee services, but is temporarily (not more than 6 months) not a payee for at least five beneficiaries, may request our approval to continue to collect fees.

(2) A qualified organization must demonstrate that it is not a creditor of the beneficiary. See paragraph (c) of

this section for exceptions to the requirement regarding creditors.

(c) *Creditor relationship.* On a case-by-case basis, we may authorize an organization to collect a fee for payee services despite the creditor relationship. (For example, the creditor is the beneficiary's landlord.) To provide this authorization, we will review all of the evidence submitted by the organization and authorize collection of a fee when:

(1) The creditor services (e.g., providing housing) provided by the organization help to meet the current needs of the beneficiary; and

(2) The amount the organization charges the beneficiary for these services is commensurate with the beneficiary's ability to pay.

(d) *Authorization process.* (1) An organization must request in writing and receive an authorization from us *before* it may collect a fee.

(2) An organization seeking authorization to collect a fee must also give us evidence to show that it is qualified, pursuant to paragraphs (a), (b), and (c) of this section, to collect a fee.

(3) If the evidence provided to us by the organization shows that it meets the requirements of this section, and additional investigation by us proves it suitable to serve, we will notify the organization in writing that it is authorized to collect a fee. If we need more evidence, or if we are not able to authorize the collection of a fee, we will also notify the organization in writing that we have not authorized the collection of a fee.

(e) *Revocation and cancellation of the authorization.* (1) We will revoke an authorization to collect a fee if we have evidence which establishes that an organization no longer meets the requirements of this section. We will issue a written notice to the organization explaining the reason(s) for the revocation.

(2) An organization may cancel its authorization at any time upon written notice to us.

(f) *Notices.* The written notice we will send to an organization authorizing the collection of a fee will contain an effective date for the collection of a fee pursuant to paragraphs (a), (b) and (c) of this section. The effective date will be no earlier than the month in which the organization asked for authorization to collect a fee. The notice will be applicable to all beneficiaries for whom the organization was payee at the time of our authorization and all beneficiaries for whom the organization becomes payee while the authorization is in effect.

(g) *Limitation on fees.* (1) An organization authorized to collect a fee under this section may collect from a beneficiary a monthly fee for expenses (including overhead) it has incurred in providing payee services to a beneficiary. The limit on the fee a qualified organization may collect for providing payee services increases by the same percentage as the annual cost of living adjustment (COLA). The increased fee amount (rounded to the nearest dollar) is taken beginning with the benefit for December (received in January).

(2) Any agreement providing for a fee in excess of the amount permitted shall be void and treated as misuse of your benefits by the organization under § 404.2041.

(3) A fee may be collected for any month during which the organization—

(i) Provides representative payee services;

(ii) Receives a benefit payment for the beneficiary; and

(iii) Is authorized to receive a fee for representative payee services.

(4) Fees for services may not be taken from any funds conserved for the beneficiary by a payee in accordance with § 404.2045.

(5) Generally, an organization may not collect a fee for months in which it does not receive a benefit payment. However, an organization will be allowed to collect a fee for months in which it did not receive a payment if we later issue payment for these months and the organization:

(i) Received our approval to collect a fee for the months for which payment is made;

(ii) Provided payee services in the months for which payment is made; and

(iii) Was the payee when the retroactive payment was paid by us.

(6) Fees for services may not be taken from beneficiary benefits for the months for which we or a court of competent jurisdiction determine(s) that

the representative payee misused benefits. Any fees collected for such months will be treated as a part of the beneficiary's misused benefits.

(7) An authorized organization can collect a fee for providing representative payee services from another source if the total amount of the fee collected from both the beneficiary and the other source does not exceed the amount authorized by us.

[69 FR 60234, Oct. 7, 2004, as amended at 71 FR 61407, Oct. 18, 2006]

§ 404.2041 Who is liable if your representative payee misuses your benefits?

(a) A representative payee who misuses your benefits is responsible for paying back misused benefits. We will make every reasonable effort to obtain restitution of misused benefits so that we can repay these benefits to you.

(b) Whether or not we have obtained restitution from the misuser, we will repay benefits in cases when we determine that a representative payee misused benefits and the representative payee is an organization or an individual payee serving 15 or more beneficiaries. When we make restitution, we will pay you or your alternative representative payee an amount equal to the misused benefits less any amount we collected from the misuser and repaid to you.

(c) Whether or not we have obtained restitution from the misuser, we will repay benefits in cases when we determine that an individual representative payee serving 14 or fewer beneficiaries misused benefits and our negligent failure in the investigation or monitoring of that representative payee results in the misuse. When we make restitution, we will pay you or your alternative representative payee an amount equal to the misused benefits less any amount we collected from the misuser and repaid to you.

(d) The term ''negligent failure'' used in this subpart means that we failed to investigate or monitor a representative payee or that we did investigate or monitor a representative payee but did not follow established procedures in our investigation or monitoring. Examples of our negligent failure include, but are not limited to, the following:

(1) We did not follow our established procedures in this subpart when investigating, appointing, or monitoring a representative payee;

(2) We did not timely investigate a reported allegation of misuse; or

(3) We did not take the necessary steps to prevent the issuance of payments to the representative payee after it was determined that the payee misused benefits.

(e) Our repayment of misused benefits under these provisions does not alter the representative payee's liability and responsibility as described in paragraph (a) of this section.

(f) Any amounts that the representative payee misuses and does not refund will be treated as an overpayment to that representative payee. See subpart F of this part.

[69 FR 60234, Oct. 7, 2004, as amended at 71 FR 61408, Oct. 18, 2006]

§ 404.2045 Conservation and investment of benefit payments.

(a) *General.* After the representative payee has used benefit payments consistent with the guidelines in this subpart (see § 404.2040 regarding use of benefits), any remaining amount shall be conserved or invested on behalf of the beneficiary. Conserved funds should be invested in accordance with the rules followed by trustees. Any investment must show clearly that the payee holds the property in trust for the beneficiary.

Example: A State institution for children with intellectual disability, which is receiving Medicaid funds, is representative payee for several Social Security beneficiaries. The checks the payee receives are deposited into one account which shows that the benefits are held in trust for the beneficiaries. The institution has supporting records which show the share each individual has in the account. Funds from this account are disbursed fairly quickly after receipt for the current support and maintenance of the beneficiaries as well as for miscellaneous needs the beneficiaries may have. Several of the beneficiaries have significant accumulated resources in this account. For those beneficiaries whose benefits have accumulated over $150, the funds should be deposited in an interest-bearing account or invested relatively free of risk on behalf of the beneficiaries.

(b) *Preferred investments.* Preferred investments for excess funds are U.S. Savings Bonds and deposits in an interest or dividend paying account in a bank, trust company, credit union, or savings and loan association which is insured under either Federal or State law. The account must be in a form which shows clearly that the representative payee has only a fiduciary and not a personal interest in the funds. If the payee is the legally appointed guardian or fiduciary of the beneficiary, the account may be established to indicate this relationship. If the payee is not the legally appointed guardian or fiduciary, the accounts may be established as follows:

(1) For U.S. Savings Bonds—

_____ (Name of beneficiary) _____ (Social Security Number), for whom ___ (Name of payee) is representative payee for Social Security benefits;

(2) For interest or dividend paying accounts—

_____ (Name of beneficiary) by _____ (Name of payee), representative payee.

(c) *Interest and dividend payments.* The interest and dividends which result from an investment are the property of the beneficiary and may not be considered to be the property of the payee.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989; 78 FR 46501, Aug. 1, 2013]

§ 404.2050 When will we select a new representative payee for you?

When we learn that your interest is not served by sending your benefit payment to your present representative payee or that your present payee is no longer able or willing to carry out payee responsibilities, we will promptly stop sending your payment to the payee. We will then send your benefit payment to an alternative payee or directly to you, until we find a suitable payee. We may suspend payment as explained in § 404.2011(c) if we find that paying you directly would cause substantial harm and we cannot find a suitable alternative representative payee before your next payment is due. We will terminate payment of benefits to your representative payee and find a new payee or pay you directly if the present payee:

(a) Has been found by us or a court of competent jurisdiction to have misused your benefits;

(b) Has not used the benefit payments on your behalf in accordance with the guidelines in this subpart;

(c) Has not carried out the other responsibilities described in this subpart;

(d) Dies;

(e) No longer wishes to be your payee;

(f) Is unable to manage your benefit payments; or

(g) Fails to cooperate, within a reasonable time, in providing evidence, accounting, or other information we request.

[69 FR 60235, Oct. 7, 2004]

§ 404.2055 When representative payment will be stopped.

If a beneficiary receiving representative payment shows us that he or she is mentally and physically able to manage or direct the management of benefit payments, we will make direct payment. Information which the beneficiary may give us to support his or her request for direct payment include the following—

(a) A physician's statement regarding the beneficiary's condition, or a statement by a medical officer of the institution where the beneficiary is or was confined, showing that the beneficiary is able to manage or direct the management of his or her funds; or

(b) A certified copy of a court order restoring the beneficiary's rights in a case where a beneficiary was adjudged legally incompetent; or

(c) Other evidence which establishes the beneficiary's ability to manage or direct the management of benefits.

§ 404.2060 Transfer of accumulated benefit payments.

A representative payee who has conserved or invested benefit payments shall transfer these funds and the interest earned from the invested funds to either a successor payee, to the beneficiary, or to us, as we will specify. If the funds and the earned interest are returned to us, we will recertify them

to a successor representative payee or to the beneficiary.

[47 FR 30472, July 14, 1982; 47 FR 34781, Aug. 11, 1982, as amended at 75 FR 7552, Feb. 22, 2010]

§ 404.2065 How does your representative payee account for the use of benefits?

(a) Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year (except as provided in paragraph (b) of this section and for certain State institutions that participate in a separate onsite review program).

(b) Your representative payee is exempt from the accounting requirement when your representative payee is:

(1) A natural or adoptive parent of a minor child entitled to title II benefits who primarily resides in the same household as the beneficiary;

(2) A legal guardian of a minor child entitled to title II benefits who primarily resides in the same household as the beneficiary;

(3) A natural or adoptive parent of a disabled individual (as defined in section 223(d) of the Act) entitled to title II benefits who primarily resides in the same household as the beneficiary; or

(4) The spouse of an individual entitled to title II benefits.

(c) We may verify how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to make accounting reports and must make those records available upon our request. If your representative payee fails to provide an annual accounting of benefits or other required reports, we may require your payee to receive your benefits in person at the local Social Security field office or a United States Government facility that we designate serving the area in which you reside. The decision to have your representative payee receive your benefits in person may be based on a variety of reasons. Some of these reasons may include the payee's history of past performance or our past difficulty in contacting the payee. We may ask your representative payee to give us the following information:

(1) Where you lived during the accounting period;

(2) Who made the decisions on how your benefits were spent or saved;

(3) How your benefit payments were used; and

(4) How much of your benefit payments were saved and how the savings were invested.

[87 FR 35653, June 13, 2022]

Subpart V—Payments for Vocational Rehabilitation Services

AUTHORITY: Secs. 205(a), 222, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 422, and 902(a)(5)).

SOURCE: 48 FR 6293, Feb. 10, 1983, unless otherwise noted.

GENERAL PROVISIONS

§ 404.2101 General.

Section 222(d) of the Social Security Act authorizes the transfer from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund of such sums as may be necessary to pay for the reasonable and necessary costs of vocational rehabilitation (VR) services provided certain disabled individuals entitled under section 223, 225(b), 202(d), 202(e) or 202(f) of the Social Security Act. The purpose of this provision is to make VR services more readily available to disabled individuals and ensure that savings accrue to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund. Payment will be made for VR services provided on behalf of such an individual in cases where—

(a) The furnishing of the VR services results in the individual's completion of a continuous 9-month period of substantial gainful activity (SGA) as specified in §§ 404.2110 through 404.2111; or

(b) The individual continues to receive disability payments from us, even though his or her disability has ceased, because of his or her continued participation in an approved VR program which we have determined will increase the likelihood that he or she

will not return to the disability rolls (*see* § 404.2112).

[68 FR 40123, July 7, 2003]

§ 404.2102 Purpose and scope.

This subpart describes the rules under which the Commissioner will pay the State VR agencies for VR services. Payment will be provided for VR services provided on behalf of disabled individuals under one or more of the provisions discussed in § 404.2101.

(a) Sections 404.2101 through 404.2103 describe the purpose of these regulations and the meaning of terms we frequently use in them.

(b) Section 404.2104 explains how State VR agencies may participate in the payment program under this subpart.

(c) [Reserved]

(d) Sections 404.2108 through 404.2109 describe the requirements and conditions under which we will pay a State VR agency under this subpart.

(e) Sections 404.2110 through 404.2111 describe when an individual has completed a continuous period of SGA and when VR services will be considered to have contributed to that period.

(f) Section 404.2112 describes when payment will be made to a VR agency because an individual's disability benefits are continued based on his or her participation in a VR program which we have determined will increase the likelihood that he or she will not return to the disability rolls.

(g) Sections 404.2114 through 404.2115 describe services for which payment will be made.

(h) Section 404.2116 describes the filing deadlines for claims for payment for VR services.

(i) Section 404.2117 describes the payment conditions.

(j) [Reserved]

(k) Section 404.2119 describes how we will make payment to State VR agencies for rehabilitation services.

(l) Sections 404.2120 and 404.2121 describe the audits and the prepayment and postpayment validation reviews we will conduct.

(m) Section 404.2122 discusses confidentiality of information and records.

(n) Section 404.2123 provides for the applicability of other Federal laws and regulations.

(o) Section 404.2127 provides for the resolution of disputes.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11912, Mar. 15, 1994; 62 FR 38452, July 18, 1997; 68 FR 40123, July 7, 2003; 83 FR 62456, Dec. 4, 2018]

§ 404.2103 Definitions.

For purposes of this subpart:

Accept the beneficiary as a client for VR services means that the State VR agency determines that the individual is eligible for VR services and places the individual into an active caseload status for development of an individualized written rehabilitation program.

Act means the Social Security Act, as amended.

Commissioner means the Commissioner of Social Security or the Commissioner's designee.

Disability means ''disability'' or ''blindness'' as defined in sections 216(i) and 223 of the Act.

Disability beneficiary means a disabled individual who is entitled to benefits under section 223, 202(d), 202(e) or 202(f) of the act or is continuing to receive payment under section 225(b) of the Act after his or her disabling physical or mental impairments have ceased.

Medical recovery for purposes of this subpart is established when a beneficiary's disability entitlement ceases for any medical reason (other than death). The determination of medical recovery is made by the Commissioner in deciding a beneficiary's continuing entitlement to benefits.

Place the beneficiary into an extended evaluation process means that the State VR agency determines that an extended evaluation of the individual's VR potential is necessary to determine whether the individual is eligible for VR services and places the individual into an extended evaluation status.

SGA means substantial gainful activity performed by an individual as defined in §§ 404.1571 through 404.1575 or § 404.1584 of this subpart.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Columbia, the Virgin Islands, or Guam. It includes the State VR agency.

Trust Funds means the Federal Old-Age and Survivors Insurance Trust

Fund and the Federal Disability Insurance Trust Fund.

Vocational rehabilitation services has the meaning assigned to it under title I of the Rehabilitation Act of 1973.

VR agency means an agency of the State which has been designated by the State to provide vocational rehabilitation services under title I of the Rehabilitation Act of 1973.

Waiting period means a five consecutive calendar month period throughout which an individual must be under a disability and which must be served before disability benefits can be paid (see § 404.315(d)).

We, us and our refer to the Social Security Administration (SSA).

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11912, Mar. 15, 1994; 62 FR 38452, July 18, 1997; 68 FR 40123, July 7, 2003; 83 FR 62456, Dec. 4, 2018]

§ 404.2104 Participation by State VR agencies.

(a) *General.* In order to participate in the payment program under this subpart through its VR agency(ies), a State must have a plan which meets the requirements of title I of the Rehabilitation Act of 1973, as amended.

(b) *Participation by States.* (1) The opportunity to participate through its VR agency(ies) with respect to disability beneficiaries in the State will be offered first to the State in accordance with paragraph (c) of this section, unless the State has notified us in advance under paragraph (e)(1) of this section of its decision not to participate or to limit such participation.

(2) A State with one or more approved VR agencies may choose to limit participation of those agencies to a certain class(es) of disability beneficiaries. For example, a State with separate VR agencies for the blind and disabled may choose to limit participation to the VR agency for the blind. In such a case, we would give the State, through its VR agency for the blind, the opportunity to participate with respect to blind disability beneficiaries in the State in accordance with paragraph (d) of this section. A State that chooses to limit participation of its VR agency(ies) must notify us in advance under paragraph (e)(1) of this section of its decision to limit such participation.

(c) *Opportunity for participation through State VR agencies.* (1) Unless a State has decided not to participate or to limit participation, we will give the State the opportunity to participate through its VR agency(ies) with respect to disability beneficiaries in the State by referring such beneficiaries first to the State VR agency(ies) for necessary VR services. A State, through its VR agency(ies), may participate with respect to any beneficiary so referred by accepting the beneficiary as a client for VR services or placing the beneficiary into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(2)(i) In order for the State to participate with respect to a disability beneficiary whom we referred to a State VR agency, the State VR agency must notify the appropriate Regional Commissioner (SSA) in writing or through electronic notification of its decision either to accept the beneficiary as a client for VR services or to place the beneficiary into an extended evaluation process. The notice must be received by the appropriate Regional Commissioner (SSA) no later than the close of the fourth month following the month in which we referred the beneficiary to the State VR agency.

(ii) In any case in which a State VR agency notifies the appropriate Regional Commissioner (SSA) in writing within the stated time period under paragraph (c)(2)(i) of this section of its decision to place the beneficiary into an extended evaluation process, the State VR agency also must notify that Regional Commissioner in writing upon completion of the evaluation of its decision whether or not to accept the beneficiary as a client for VR services. If we receive a notice of a decision by the State VR agency to accept the beneficiary as a client for VR services following the completion of the extended evaluation, the State may continue to participate with respect to such beneficiary.

(d) *Opportunity for limited participation through State VR agencies.* If a State has decided under paragraph (e)(1) of this section to limit participation of its VR agency(ies) to a certain

class(es) of disability beneficiaries in the State, we will give the State the opportunity to participate with respect to such class(es) of disability beneficiaries by referring such beneficiaries first to the State VR agency(ies) for necessary VR services. The State, through its VR agency(ies), may participate with respect to any beneficiary so referred by accepting the beneficiary as a client for VR services or placing the beneficiary into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(e) *Decision of a State not to participate or to limit participation.* (1) A State may choose not to participate through its VR agency(ies) with respect to any disability beneficiaries in the State, or it may choose to limit participation of its VR agency(ies) to a certain class(es) of disability beneficiaries in the State. A State which decides not to participate or to limit participation must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). Unless a State specifies a later month, a decision not to participate or to limit participation will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA). The notice of the State decision must be submitted by an official authorized to act for the State for this purpose. A State must provide to the appropriate Regional Commissioner (SSA) an opinion from the State's Attorney General verifying the authority of the official who sent the notice to act for the State. This opinion will not be necessary if the notice is signed by the Governor of the State.

(2) [Reserved]

(3) A State which has decided not to participate or to limit participation may participate later through its VR agency(ies) in accordance with paragraph (c) of this section. A State which decides to resume participation under paragraph (c) of this section must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). A decision of a State to resume participation under paragraph (c) of this section will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA) or, if later, with a month specified by the State. The notice of the State decision must be submitted by an official authorized to act for the State as explained in paragraph (e)(1) of this section.

[59 FR 11912, Mar. 15, 1994, as amended at 83 FR 62456, Dec. 4, 2018]

§ 404.2106 [Reserved]

PAYMENT PROVISIONS

§ 404.2108 Requirements for payment.

(a) The State VR agency must file a claim for payment in each individual case within the time periods specified in § 404.2116;

(b) The claim for payment must be in a form prescribed by us and contain the following information:

(1) A description of each service provided;

(2) When the service was provided; and

(3) The cost of the service;

(c) The VR services for which payment is being requested must have been provided during the period specified in § 404.2115;

(d) The VR services for which payment is being requested must have been provided under a State plan for VR services approved under title I of the Rehabilitation Act of 1973, as amended, and must be services that are described in § 404.2114;

(e) The individual must meet one of the VR payment provisions specified in § 404.2101;

(f) The State VR agency must maintain, and provide as we may require, adequate documentation of all services and costs for all disability beneficiaries with respect to whom a State VR agency could potentially request payment for services and costs under this subpart; and

(g) The amount to be paid must be reasonable and necessary and be in compliance with the cost guidelines specified in § 404.2117.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11914, Mar. 15, 1994; 83 FR 62457, Dec. 4, 2018]

§ 404.2109 Responsibility for making payment decisions.

The Commissioner will decide—

(a) Whether a continuous period of 9 months of SGA has been completed;

(b) Whether a disability beneficiary whose disability has ceased should continue to receive benefits under § 404.316(c), 404.337(c), or 404.352(c) for a month after October 1984, based on his or her continued participation in a VR program;

(c) If and when medical recovery has occurred;

(d) Whether documentation of VR services and expenditures is adequate;

(e) If payment is to be based on completion of a continuous 9-month period of SGA, whether the VR services contributed to the continuous period of SGA;

(f) Whether a VR service is a service described in § 404.2114; and

(g) What VR costs were reasonable and necessary and will be paid.

[55 FR 8454, Mar. 8, 1990, as amended at 59 FR 11914, Mar. 15, 1994; 68 FR 40123, July 7, 2003]

§ 404.2110 What we mean by "SGA" and by "a continuous period of 9 months".

(a) *What we mean by ''SGA''.* In determining whether an individual's work is SGA, we will follow the rules in §§ 404.1572 through 404.1575. We will follow these same rules for individuals who are statutorily blind, but we will evaluate the earnings in accordance with the rules in § 404.1584(d).

(b) *What we mean by ''a continuous period of 9 months''.* A continuous period of 9 months ordinarily means a period of 9 consecutive calendar months. Exception: When an individual does not perform SGA in 9 consecutive calendar months, he or she will be considered to have done so if—

(1) The individual performs 9 months of SGA within 10 consecutive months and has monthly earnings that meet or exceed the guidelines in § 404.1574(b)(2), or § 404.1584(d) if the individual is statutorily blind; or

(2) The individual performs at least 9 months of SGA within 12 consecutive months, and the reason for not performing SGA in 2 or 3 of those months was due to circumstances beyond his or her control and unrelated to the impairment (e.g., the employer closed down for 3 months).

(c) *What work we consider.* In determining if a continuous period of SGA has been completed, all of an individual's work activity may be evaluated for purposes of this section, including work performed before October 1981, during the waiting period, during the trial work period and after entitlement to disability benefits terminated. We will ordinarily consider only the first 9 months of SGA that occur. The exception will be if an individual who completed 9 months of SGA later stops performing SGA, receives VR services and then performs SGA for a 9-month period. See § 404.2115 for the use of the continuous period in determining payment for VR services.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990]

§ 404.2111 Criteria for determining when VR services will be considered to have contributed to a continuous period of 9 months.

The State VR agency may be paid for VR services if such services contribute to the individual's performance of a continuous 9-month period of SGA. The following criteria apply to individuals who received more than just evaluation services. If a State VR agency claims payment for services to an individual who received only evaluation services, it must establish that the individual's continuous period or medical recovery (if medical recovery occurred before completion of a continuous period) would not have occurred without the services provided. In applying the criteria below, we will consider services described in § 404.2114 that were initiated, coordinated or provided, including services before October 1, 1981.

(a) *Continuous period without medical recovery.* If an individual who has completed a ''continuous period'' of SGA has not medically recovered as of the date of completion of the period, the determination as to whether VR services contributed will depend on whether the continuous period began one year or less after VR services ended or more than one year after VR services ended.

(1) *One year or less.* Any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(2) *More than one year.* (i) If the continuous period was preceded by transitional work activity (employment or self-employment which gradually evolved, with or without periodic interruption, into SGA), and that work activity began less than a year after VR services ended, any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(ii) If the continuous period was not preceded by transitional work activity that began less than a year after VR services ended, VR services will be considered to have contributed to the continuous period only if it is reasonable to conclude that the work activity which constitutes a continuous period could not have occurred without the VR services (e.g., training).

(b) *Continuous period with medical recovery occurring before completion.* (1) If an individual medically recovers before a continuous period has been completed, VR services under paragraph (a) of this section will not be payable unless some VR services contributed to the medical recovery. VR services will be considered to have contributed to the medical recovery if—

(i) The individualized written rehabilitation program (IWRP) included medical services; and

(ii) The medical recovery occurred, at least in part, because of these medical services. (For example, the individual's medical recovery was based on improvement in a back condition which, at least in part, stemmed from surgery initiated, coordinated or provided under an IWRP).

(2) In some instances, the State VR agency will not have provided, initiated, or coordinated medical services. If this happens, payment for VR services may still be possible under paragraph (a) of this section if:

(i) The medical recovery was not expected by us; and

(ii) The individual's impairment is determined by us to be of such a nature that any medical services provided would not ordinarily have resulted in, or contributed to, the medical cessation.

[48 FR 6293, Feb. 10, 1983, as amended at 59 FR 11914, Mar. 15, 1994; 83 FR 62457, Dec. 4, 2018]

§ 404.2112 Payment for VR services in a case where an individual continues to receive disability payments based on participation in an approved VR program.

Sections 404.1586(g), 404.316(c), 404.337(c), and 404.352(c) explain the criteria we will use in determining if an individual whose disability has ceased should continue to receive disability benefits from us because of his or her continued participation in a VR program. A VR agency can be paid for the cost of VR services provided to an individual if the individual was receiving benefits in a month or months, after October 1984, based on § 404.316(c), § 404.337(c), or § 404.352(c). If this requirement is met, a VR agency can be paid for the costs of VR services provided within the period specified in § 404.2115, subject to the other payment and administrative provisions of this subpart.

[83 FR 62457, Dec. 4, 2018]

§ 404.2114 Services for which payment may be made.

(a) *General.* Payment may be made for VR services provided by a State VR agency in accordance with title I of the Rehabilitation Act of 1973, as amended, subject to the limitations and conditions in this subpart. VR services for which payment may be made under this subpart include only those services described in paragraph (b) of this section which are—

(1) Necessary to determine an individual's eligibility for VR services or the nature and scope of the services to be provided; or

(2) Provided by a State VR agency under an IWRP, but only if the services could reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

(b) *Specific services.* Payment may be made under this subpart only for the following VR services:

(1) An assessment for determining an individual's eligibility for VR services and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology, and which includes determining—

(i) The nature and extent of the physical or mental impairment(s) and the resultant impact on the individual's employability;

(ii) The likelihood that an individual will benefit from vocational rehabilitation services in terms of employability; and

(iii) An employment goal consistent with the capacities of the individual and employment opportunities;

(2) Counseling and guidance, including personal adjustment counseling, and those referrals and other services necessary to help an individual secure needed services from other agencies;

(3) Physical and mental restoration services necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and which constitutes an impediment to suitable employment at or above the SGA level;

(4) Vocational and other training services, including personal and vocational adjustment, books, tools, and other training materials, except that training or training services in institutions of higher education will be covered under this section only if maximum efforts have been made by the State VR agency to secure grant assistance in whole or in part from other sources;

(5) Maintenance expenses that are extra living expenses over and above the individual's normal living expenses and that are incurred solely because of and while the individual is participating in the VR program and that are necessary in order for the individual to benefit from other necessary VR services;

(6) Travel and related expenses necessary to transport an individual for purpose of enabling the individual's participation in other necessary VR services;

(7) Services to family members of a disabled individual only if necessary to the successful vocational rehabilitation of that individual;

(8) Interpreter services and note-taking services for an individual who is deaf and tactile interpreting for an individual who is deaf and blind;

(9) Reader services, rehabilitation teaching services, note-taking services, and orientation and mobility services for an individual who is blind;

(10) Telecommunications, sensory, and other technological aids and devices;

(11) Work-related placement services to secure suitable employment;

(12) Post-employment services necessary to maintain, regain or advance into suitable employment at or above the SGA level;

(13) Occupational licenses, tools, equipment, initial stocks, and supplies;

(14) Rehabilitation technology services; and

(15) Other goods and services that can reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

[59 FR 11915, Mar. 15, 1994, as amended by 83 FR 62457, Dec. 4, 2018]

§ 404.2115 When services must have been provided.

(a) In order for the VR agency to be paid, the services must have been provided—

(1) After September 30, 1981;

(2) No earlier than the beginning of the waiting period or the first month of entitlement, if no waiting period is required; and

(3) Before completion of a continuous 9-month period of SGA or termination of entitlement to disability benefits, whichever occurs first.

(b) If an individual who is entitled to disability benefits under this part also is or has been receiving disability or blindness benefits under part 416 of this chapter, the determination as to when services must have been provided may be made under this section or § 416.2215 of this chapter, whichever is advantageous to the State VR agency that is participating in both VR programs.

[55 FR 8455, Mar. 8, 1990, as amended at 61 FR 31025, June 19, 1996; 83 FR 62457, Dec. 4, 2018]

§ 404.2116 When claims for payment for VR services must be made (filing deadlines).

The State VR agency must file a claim for payment in each individual case within the following time periods:

(a) A claim for payment for VR services based on the individual's completion of a continuous 9-month period of SGA must be filed within 12 months after the month in which the continuous 9-month period of SGA is completed.

(b) A claim for payment for VR services provided to an individual whose disability benefits were continued after disability has ceased because of that individual's continued participation in a VR program must be filed as follows:

(1) If a written notice requesting that a claim be filed was sent to the State VR agency, a claim must be filed within 90 days following the month in which VR services end, or if later, within 90 days after receipt of the notice.

(2) If no written notice was sent to the State VR agency, a claim must be filed within 12 months after the month in which VR services end.

[55 FR 8455, Mar. 8, 1990, as amended at 61 FR 31025, June 19, 1996; 68 FR 40124, July 7, 2003; 83 FR 62457, Dec. 4, 2018]

§ 404.2117 What costs will be paid.

In accordance with section 222(d) of the Social Security Act, the Commissioner will pay the State VR agency for the VR services described in § 404.2114 which were provided during the period described in § 404.2115 and which meet the criteria in § 404.2111 or § 404.2112, but subject to the following limitations:

(a) The cost must have been incurred by the State VR agency;

(b) The cost must not have been paid or be payable from some other source. For this purpose, State VR agencies will be required to seek payment or services from other sources in accordance with the ''similar benefit'' provisions under 34 CFR part 361, including making maximum efforts to secure grant assistance in whole or part from other sources for training or training services in institutions of higher education.

(c)(1) The cost must be reasonable and necessary, in that it complies with the written cost-containment policies of the State VR agency. A cost which complies with these policies will be considered necessary only if the cost is for a VR service described in § 404.2114. The State VR agency must maintain and use these cost-containment policies, including any reasonable and appropriate fee schedules, to govern the costs incurred for all VR services, including the rates of payment for all purchased services, for which payment will be requested under this subpart. For the purpose of this subpart, the written cost-containment policies must provide guidelines designed to ensure—

(i) The lowest reasonable cost for such services; and

(ii) Sufficient flexibility so as to allow for an individual's needs.

(2) The State VR agency shall submit to us before the end of the first calendar quarter of each year a written statement certifying that cost-containment policies are in effect and are adhered to in procuring and providing goods and services for which the State VR agency requests payment under this subpart. Such certification must be signed by the State's chief financial official or the head of the VR agency. Each certification must specify the basis upon which it is made, e.g., a recent audit by an authorized State, Federal or private auditor (or other independent compliance review) and the date of such audit (or compliance review). We may request the State VR agency to submit to us a copy(ies) of its specific written cost-containment policies and procedures (e.g., any guidelines and fee schedules for a given year) if we determine that such additional information is necessary to ensure compliance with the requirements of this subpart. The State VR agency must provide such information when requested by us.

(d) The total payment in each case, including any prior payments related to earlier continuous 9-month periods of SGA made under this subpart, must not be so high as to preclude a ''net saving'' to the trust funds (a ''net saving'' is the difference between the estimated saving to the trust funds, if disability benefits eventually terminate, and the total amount we pay to the State VR agency);

(e) Any payment to the State VR agency for either direct or indirect VR expenses must be consistent with the cost principles described in OMB Circular No. A–87, as revised;

(f) Payment for VR services or costs may be made under more than one of the VR payment provisions described in §§ 404.2111 and 404.2112 of this subpart and similar provisions in §§ 416.2211 and 416.2212 of subpart V of part 416. However, payment will not be made more than once for the same VR service or cost; and

(g) Payment will be made for administrative costs and for counseling and placement costs. This payment may be on a formula basis, or on an actual cost basis, whichever the State VR agency prefers. The formula will be negotiated. The payment will also be subject to the preceding limitations.

[48 FR 6293, Feb. 10, 1983. Redesignated and amended at 55 FR 8454, 8455, Mar. 8, 1990; 59 FR 11915, Mar. 15, 1994; 62 FR 38452, July 18, 1997; 68 FR 40124, July 7, 2003; 83 FR 62457, Dec. 4, 2018]

ADMINISTRATIVE PROVISIONS

§ 404.2118 [Reserved]

§ 404.2119 Method of payment.

Payment to the State VR agencies pursuant to this subpart will be made either by advancement of funds or by payment for services provided (with necessary adjustments for any overpayments and underpayments), as decided by the Commissioner.

[83 FR 62458, Dec. 4, 2018]

§ 404.2120 Audits.

(a) *General.* The State shall permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the services and costs for which payment was requested or made under these regulations. These records shall be retained by the State for the periods of time specified for retention of records in the Federal Acquisition Regulations (48 CFR part 4, subpart 4.7).

(b) *Audit basis.* Auditing will be based on cost principles and written guidelines in effect at the time services were provided and costs were incurred. The State VR agency will be informed and given a full explanation of any questioned items. It will be given a reasonable time to explain questioned items. Any explanation furnished by the State VR agency will be given full consideration before a final determination is made on questioned items in the audit report.

(c) *Appeal of audit determinations.* The appropriate SSA Regional Commissioner will notify the State VR agency in writing of his or her final determination on the audit report. If the State VR agency disagrees with that determination, it may request reconsideration in writing within 60 days after receiving the Regional Commissioner's notice of the determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually, no later than 45 days from the date of appeal. The decision by the Commissioner will be final and conclusive unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving it.

[83 FR 62458, Dec. 4, 2018]

§ 404.2121 Validation reviews.

(a) *General.* We will conduct a validation review of a sample of the claims for payment filed by each State VR agency. We will conduct some of these reviews on a prepayment basis and some on a postpayment basis. We may review a specific claim, a sample of the claims, or all the claims filed by any State VR agency, if we determine that such review is necessary to ensure compliance with the requirements of this subpart. For each claim selected for review, the State VR agency must submit such records of the VR services and costs for which payment has been requested or made under this subpart, or copies of such records, as we may require to ensure that the services and costs meet the requirements for payment. For claims for cases described in § 404.2101(a), a clear explanation or existing documentation which demonstrates how the service contributed to the individual's performance of a continuous 9-month period of SGA

must be provided. For claims for cases described in § 404.2101(b) or (c), a clear explanation or existing documentation which demonstrates how the service was reasonably expected to motivate or assist the individual to return to or continue in SGA must be provided. If we find in any prepayment validation review, that the scope or content of the information is inadequate, we will request additional information and will withhold payment until adequate information has been provided. The State VR agency shall permit us (including duly authorized representatives) access to, and the right to examine, any records relating to such services and costs. Any review performed under this section will not be considered an audit for purposes of this subpart.

(b) *Purpose.* The primary purpose of these reviews is—

(1) To ensure that the VR services and costs meet the requirements for payment under this subpart;

(2) To assess the validity of our documentation requirements; and

(3) To assess the need for additional validation reviews or additional documentation requirements for any State VR agency to ensure compliance with the requirements under this subpart.

(c) *Determinations.* In any validation review, we will determine whether the VR services and costs meet the requirements for payment and determine the amount of payment. We will notify in writing the State VR agency of our determination. If we find in any postpayment validation review that more or less than the correct amount of payment was made for a claim, we will determine that an overpayment or underpayment has occurred and will notify the State VR agency that we will make the appropriate adjustment.

(d) *Appeals.* If the State VR agency disagrees with our determination under this section, it may appeal that determination in accordance with § 404.2127. For purposes of this section, an appeal must be filed within 60 days after receiving the notice of our determination.

[59 FR 11916, Mar. 15, 1994, as amended at 83 FR 62458, Dec. 4, 2018]

§ 404.2122 Confidentiality of information and records.

The State shall comply with the provisions for confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see § 404.2123).

[83 FR 62459, Dec. 4, 2018]

§ 404.2123 Other Federal laws and regulations.

Each State VR agency shall comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the vocational rehabilitation function.

[83 FR 62459, Dec. 4, 2018]

§ 404.2127 Resolution of disputes.

(a) *Disputes on the amount to be paid.* The appropriate SSA official will notify the State VR agency in writing of his or her determination concerning the amount to be paid. If the State VR agency disagrees with that determination, the State VR agency may request reconsideration in writing within 60 days after receiving the notice of determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually no later than 45 days from the date of the State VR agency's appeal. The decision by the Commissioner will be final and conclusive upon the State VR agency unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving the Commissioner's decision.

(b) *Disputes on whether there was a continuous period of SGA and whether VR services contributed to a continuous period of SGA.* The rules in paragraph (a) of this section will apply, except that the Commissioner's decision will be final and conclusive. There is no right of appeal to the Departmental Appeals Board.

(c) *Disputes on determinations made by the Commissioner which affect a disability beneficiary's rights to benefits.* Determinations made by the Commissioner which affect an individual's right to

benefits (e.g., determinations that disability benefits should be terminated, denied, suspended, continued or begun at a different date than alleged) cannot be appealed by a State VR agency. Because these determinations are an integral part of the disability benefits claims process, they can only be appealed by the beneficiary or applicant whose rights are affected or by his or her authorized representative. However, if an appeal of an unfavorable determination is made by the individual and is successful, the new determination would also apply for purposes of this subpart. While a VR agency cannot appeal a determination made by the Commissioner which affects a beneficiary's or applicant's rights, the VR agency can furnish any evidence it may have which would support a revision of a determination.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 62 FR 38452, July 18, 1997; 83 FR 62459, Dec. 4, 2018]

PART 405 [RESERVED]

PART 408—SPECIAL BENEFITS FOR CERTAIN WORLD WAR II VETERANS

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SOURCE: 68 FR 16418, Apr. 4, 2003, unless otherwise noted.

Subpart A—Introduction, General Provision and Definitions

AUTHORITY: Secs. 702(a)(5) and 801–813 of the Social Security Act (42 U.S.C. 902(a)(5) and 1001–1013).

§ 408.101 What is this part about?

The regulations in this part 408 (Regulation No. 8 of the Social Security Administration) relate to the provisions of title VIII of the Social Security Act as added by Pub. L. 106–169 enacted December 14, 1999. Title VIII (Special Benefits for Certain World War II Veterans) established a program for the payment of benefits to certain World War II veterans. The regulations in this part are divided into the following subparts according to subject content.

(a) Subpart A contains this introductory section, a statement of the general purpose underlying the payment of special benefits to World War II veterans, general provisions applicable to the program and its administration, and defines certain terms that we use throughout part 408.

(b) Subpart B contains the requirements for qualification and entitlement to monthly title VIII benefits.

(c) Subpart C contains the provisions relating to the filing and withdrawal of applications.

(d) Subpart D contains the provisions relating to the evidence required for establishing qualification for and entitlement to monthly title VIII benefits.

(e) Subpart E contains the provisions about the amount and payment of monthly benefits.

(f) Subpart F is reserved for future use.

(g) Subpart G contains the provisions on your requirement to report certain events to us.

(h) Subpart H contains the provisions on suspension and termination of title VIII entitlement.

(i) Subpart I contains the provisions on underpayments and overpayments.

(j) Subpart J contains the provisions on determinations and the administrative review process.

(k) Subpart K contains the provisions on claimant representation.

(l) Subpart L contains the provisions on Federal administration of State recognition payments.

[68 FR 16418, Apr. 4, 2003, as amended at 69 FR 25955, May 10, 2004]

§ 408.105 Purpose and administration of the program.

The purpose of the title VIII program is to assure a basic income level for certain veterans who are entitled to supplemental security income (SSI) and who want to leave the United States to live abroad. The title VIII program is administered by the Social Security Administration.

§ 408.110 General definitions and use of terms.

(a) *Terms relating to the Act and regulations.* (1) *The Act* means the Social Security Act as amended (42 U.S.C. Chap.7).

(2) *Title* means the title of the Act.

(3) *Section or §* means a section of the regulations in part 408 of this chapter unless the context indicates otherwise.

(b) *Commissioner; Appeals Council; Administrative Law Judge defined*—(1) *Commissioner* means the Commissioner of Social Security.

(2) *Appeals Council* means the Appeals Council of the Office of Analytics, Review, and Oversight in the Social Security Administration or such member or members thereof as may be designated by the Chair of the Appeals Council.

(3) *Administrative Law Judge* means an Administrative Law Judge in the Office of Hearings Operations in the Social Security Administration.

(c) *Miscellaneous*—(1) *A calendar month.* The period including all of 24 hours of each day of January, February, March, April, May, June, July, August, September, October, November, or December.

(2) *Federal benefit rate (FBR).* The amount of the cash benefit payable under title XVI for the month to an eligible individual who has no income. The FBR does not include any State supplementary payment that is paid by the Commissioner pursuant to an agreement with a State under section 1616(a) of the Act or section 212(b) of Public Law 93–66.

(3) *Qualified individual.* An individual who meets all the requirements for qualification for SVB in § 408.202 and does not meet any of the conditions that prevent qualification in § 408.204.

(4) *Special veterans benefits (SVB).* The benefits payable to certain veterans of World War II under title VIII of the Act.

(5) *State.* Unless otherwise indicated, this means:

(i) A State of the United States

(ii) The District of Columbia; or

(iii) The Northern Mariana Islands.

(6) *Supplemental Security Income (SSI).* SSI is the national program for providing a minimum level of income to aged, blind, and disabled individuals under title XVI of the Act.

(7) *United States.* When used in the geographical sense, this is:

(i) The 50 States;

(ii) The District of Columbia; and

(iii) The Northern Mariana Islands.

(8) *We, us* or *our* means the Social Security Administration (SSA).

(9) *World War II.* The period beginning September 16, 1940 and ending on July 24, 1947.

(10) *You* or *your* means, as appropriate, the person who applies for benefits, the person for whom an application is filed, or the person who is considering applying for benefits.

[68 FR 16418, Apr. 4, 2003, as amended at 85 FR 73158, Nov. 16, 2020]

§ 408.120 Periods of limitations ending on Federal nonworkdays.

Title VIII of the Act and the regulations in this part require you to take certain actions within specified time periods or you may lose your right to a portion or all of your benefits. If any such period ends on a Saturday, Sunday, Federal legal holiday, or any

other day all or part of which is declared to be a nonworkday for Federal employees by statute or Executive Order, you will have until the next Federal workday to take the prescribed action.

Subpart B—SVB Qualification and Entitlement

AUTHORITY: Secs. 702(a)(5), 801, 802, 803, 804, 806, 810 and 1129A of the Social Security Act (42 U.S.C. 902(a)(5), 1001, 1002, 1003, 1004, 1006, 1010 and 1320a–8a); Sec. 251, Pub. L. 106–169, 113 Stat. 1844.

§ 408.201 What is this subpart about?

You are qualified for SVB if you meet the requirements listed in § 408.202 and if none of the conditions listed in § 408.204 exist. However, you cannot be entitled to receive benefits for any month before the first month in which you reside outside the United States on the first day of the month and meet all the qualification requirements. You must give us any information we request and evidence to prove that you meet these requirements. You continue to be qualified for SVB unless we determine that you no longer meet the requirements for qualification in § 408.202 or we determine that you are not qualified because one of the conditions listed in § 404.204 of this chapter exists. You continue to be entitled to receive benefits unless we determine you are no longer residing outside the United States.

§ 408.202 How do you qualify for SVB?

You qualify for SVB if you meet all of the following requirements.

(a) *Age.* You were age 65 or older on December 14, 1999 (the date on which Pub. L. 106–169 was enacted into law).

(b) *World War II veteran.* You are a World War II veteran as explained in § 408.216.

(c) *SSI eligible.* You were eligible for SSI, as explained in § 408.218, for both December 1999 (the month in which Pub. L. 106–169 was enacted into law) and for the month in which you file your application for SVB.

(d) *Application.* You file an application for SVB as explained in subpart C of this part.

(e) *Other benefit income.* You do not have other benefit income, as explained in § 408.220, which is equal to, or more than, 75 percent of the current FBR.

§ 408.204 What conditions will prevent you from qualifying for SVB or being entitled to receive SVB payments?

(a) *General rule.* Even if you meet all the qualification requirements in § 408.202, you will not be qualified for SVB for or entitled to receive SVB payments for any of the following months.

(1) *Removal from the United States.* Any month that begins after the month in which we are advised by the Attorney General that you have been removed (including deported) from the United States pursuant to section 237(a) or 212(a)(6)(A) of the Immigration and Nationality Act and before the month in which you are subsequently lawfully admitted to the United States for permanent residence.

(2) *Fleeing felon.* Any month during any part of which you are fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the United States or the jurisdiction in the United States from which you fled, for a crime or an attempt to commit a crime that is a felony under the laws of the place from which you fled, or in the case of the State of New Jersey, is a high misdemeanor.

(3) *Parole violation.* Any month during any part of which you violate a condition of probation or parole imposed under Federal or State law.

(4) *Residence in certain countries.* Any month during which you are not a citizen or national of the United States and reside in a country to which payments to residents of that country are withheld by the Treasury Department under section 3329 of title 31, United States Code.

(b) *Condition occurs before we determine that you are qualified.* If one of the conditions in paragraph (a) of this section occurs before we determine that you are qualified, we will deny your claim for SVB.

(c) *Condition occurs after we determine that you are qualified.* If one of the conditions in paragraph (a) of this section occurs after we determine that you are

qualified for SVB, you cannot receive SVB payments for any month in which the condition exists.

§ 408.206 What happens when you apply for SVB?

(a) *General rule.* When you apply for SVB, we will ask you for documents and other information that we need to determine if you meet all the requirements for qualification. You must give us complete information (*see* subpart D of this part for our rules on evidence). If you do not meet all of the requirements for qualification listed in § 408.202, or if one of the conditions listed in § 408.204 exists, we will deny your claim.

(b) *If you are a qualified individual residing in the United States.* If you meet all the requirements for qualification listed in § 408.202 and if none of the conditions listed in § 408.204 exist, we will send you a letter telling you the following:

(1) You are qualified for SVB;

(2) In order to become entitled to SVB, you will have to begin residing outside the United States by the end of the fourth calendar month after the month in which your notice of qualification is dated. For example, if our letter is dated May 15, you must establish residence outside the United States before October 1 of that year; and

(3) What documents and information you must give us to establish that you are residing outside the United States.

§ 408.208 What happens if you establish residence outside the United States within 4 calendar months?

If you begin residing outside the United States within 4 calendar months after the month in which your SVB qualification notice is dated, we will send you a letter telling you that you are entitled to SVB and the first month for which SVB payments can be made to you. The letter will also tell you the amount of your monthly benefit payments, whether your payments are reduced because of your other benefit income, and what rights you have to a reconsideration of our determination.

§ 408.210 What happens if you do not establish residence outside the United States within 4 calendar months?

If you do not establish residence outside the United States within 4 calendar months after the month in which your SVB qualification notice is dated, we will deny your SVB claim. We will send you a notice explaining what rights you have to a reconsideration of our determination. You will have to file a new application and meet all the requirements for qualification and entitlement based on the new application to become entitled to SVB.

§ 408.212 What happens if you are a qualified individual already residing outside the United States?

If you meet all the requirements for qualification listed in § 408.202 and if none of the conditions listed in § 408.204 exist, we will ask you for documents and information to establish your residence outside the United States. If you establish that you are residing outside the United States, we will send you a letter telling you that you are entitled to SVB and the first month for which SVB payments can be made to you. The letter will also tell you the amount of your monthly benefit payments, whether your payments are reduced because of your other benefit income, and what rights you have to a reconsideration of our determination.

AGE

§ 408.214 Are you age 65?

You become age 65 on the first moment of the day before the anniversary of your birth corresponding to age 65. Thus, you must have been born on or before December 15, 1934 to be at least age 65 on December 14, 1999 and to qualify for SVB.

MILITARY SERVICE

§ 408.216 Are you a World War II veteran?

(a) *Service requirements.* For SVB purposes, you are a World War II veteran if you:

(1) Served in the active military, naval or air service of the United States during World War II at any time

during the period beginning on September 16, 1940 and ending on July 24, 1947; or

(2) Served in the organized military forces of the Government of the Commonwealth of the Philippines, while the forces were in the service of the U.S. Armed Forces pursuant to the military order of the President dated July 26, 1941, including among the military forces organized guerrilla forces under commanders appointed, designated, or subsequently recognized by the Commander in Chief, Southwest Pacific Area, or other competent authority in the U.S. Army. This service must have been rendered at any time during the period beginning July 26, 1941 and ending on December 30, 1946.

(b) *Discharge requirements.* You must have been discharged or released from this service under conditions other than dishonorable after service of 90 days or more or, if your service was less than 90 days, because of a disability or injury incurred or aggravated in the line of active duty.

SSI ELIGIBILITY

§ 408.218 Do you meet the SSI eligibility requirements?

For SVB purposes, you are eligible for SSI for a given month if all of the following are met:

(a) You have been determined to be eligible for SSI (except as noted in paragraph (c) of this section); you do not have to actually receive a payment for that month;

(b) Your SSI eligibility has not been terminated for that month; and

(c) Your SSI benefits are not subject to a penalty under §416.1340 of this chapter. This includes months in which a penalty has been imposed, as well as months in which a penalty cannot be imposed because you are in SSI nonpay status for some other reason.

OTHER BENEFIT INCOME

§ 408.220 Do you have other benefit income?

(a) *Description of other benefit income.* Other benefit income is any regular periodic payment (such as an annuity, pension, retirement or disability benefit) that you receive. For other benefit income to affect your SVB eligibility, you must have been receiving the other benefit income in any part of the 12-month period before the month in which you filed your application for SVB. Payments received after you become entitled to SVB can be included as other benefit income only if you received a similar payment from the same or a related source during any part of the 12-month period before the month in which you filed your application for SVB.

(b) *When other benefit payments are considered to be similar payments from the same or a related source.* Payments are similar payments from the same or a related source if they are received from sources substantially related to the sources of income received before you became entitled to SVB. For example, if you received U.S. Social Security spouse's benefits in the 12-month period before you filed your application for SVB and these were changed to widower's benefits after you became entitled to SVB, we would consider this to be from the same or a related source.

(c) *Examples of other benefit income.* Other benefit income can come from a source inside or outside the United States. It includes, but is not limited to, any of the following:

(1) Veterans' compensation or pension,

(2) Workers' compensation,

(3) U.S. or foreign Social Security benefits (not including SSI payments from the U.S.),

(4) Railroad retirement annuity or pension,

(5) Retirement or disability pension,

(6) Individual Retirement Account (IRA) payments, and

(7) Unemployment insurance benefit.

(d) *If you receive a lump-sum payment.* Regular periodic payments can also include lump-sum payments made at your request or as an administrative convenience or practice in place of more frequent payments. See §408.224(e) for an explanation of how we determine the monthly amount of your benefit income if you receive a lump-sum payment.

§ 408.222 How does your other benefit income affect your SVB?

(a) *Income began before you qualify for SVB.* If, at the time you file your application for SVB, your other benefit income is equal to, or more than, the maximum SVB payment possible (see § 408.505), we will deny your SVB claim. If it is less, we will reduce any monthly SVB payments you become entitled to by the amount of your other benefit income (see § 408.510 for a description of how we make the reduction).

(b) *Income begins after you qualify for SVB.* If you have been determined to be qualified for SVB, we will reduce any monthly SVB payments you become entitled to by the amount of your other benefit income (see § 408.510 for a description of how we make the reduction).

§ 408.224 How do we determine the monthly amount of your other benefit income?

If your other benefit income is paid in other than monthly amounts, we will compute the equivalent monthly amount as follows:

(a) *Weekly payments.* We multiply the amount of the weekly payment by 52 and divide by 12 to determine the equivalent monthly payment amount.

(b) *Bi-weekly payments.* We multiply the amount of the bi-weekly payment by 26 and divide by 12 to determine the equivalent monthly payment amount.

(c) *Quarterly payments.* We multiply the amount of the quarterly payment by 4 and divide by 12 to determine the equivalent monthly payment amount.

(d) *Semi-annual payments.* We multiply the amount of the semi-annual payment by 2 and divide by 12 to determine the equivalent monthly payment amount.

(e) *Lump sum payment.* If the paying agency will not prorate the lump sum to determine the monthly amount, we will compute the amount as follows:

(1) *If the payment is for a specific period.* We divide the lump sum by the number of months in the period for which the payment was made to determine the equivalent monthly payment amount.

(2) *If the payment is for a lifetime or for an unspecified period.* We divide the lump sum amount by your life expectancy in months at the time the lump sum is paid.

§ 408.226 What happens if you begin receiving other benefit income after you become entitled to SVB?

If you begin receiving other benefit income after you become entitled to SVB, we will reduce your SVB by the amount of those payments only if you were receiving similar benefits from the same or a related source during the 12-month period before you filed for SVB. (See § 408.220(b) for a description of when we consider other benefit income to be from the same or a related source.)

RESIDENCE OUTSIDE THE UNITED STATES

§ 408.228 When do we consider you to be residing outside the United States?

(a) *Effect of residency on SVB eligibility.* You can be paid SVB only for those months in which you are residing outside the United States but you can not be paid for a month that is earlier than the month in which you filed your application for SVB. You are residing outside the United States in a month only if you reside outside the United States on the first day of that month. For SVB purposes, you can be a resident of only one country at a time. You cannot, for example, maintain a residence in the United States and a residence outside the United States at the same time.

(b) *Definition of residing outside the United States.* We consider you to be residing outside the United States if you:

(1) Have established an actual dwelling place outside the United States; and

(2) Intend to continue to live outside the United States.

(c) *When we will assume you intend to continue living outside the United States.* If you tell us, or the evidence shows, that you intend to reside outside the United States for at least 6 months, we will assume you meet the intent requirement in paragraph (b)(2) of this section. Otherwise we will assume, absent convincing evidence to the contrary, that your stay is temporary and that you are not residing outside the United States.

§ 408.230 When must you begin residing outside the United States?

(a) *4-month rule.* Except as provided in paragraph (b) of this section, you must begin residing outside the United States by the end of the fourth calendar month after the month in which the notice explaining that you are qualified for SVB is dated, as explained in § 408.206. If you do not establish residence outside the United States within this 4-month period, we will deny your claim for SVB. You will have to file a new application and meet all the requirements for qualification and entitlement based on the new application to become entitled to SVB.

(b) *When we will extend the 4-month period.* We will extend the 4-month period for establishing residence outside the United States if you are in the United States and are appealing either:

(1) A determination that we made on your SVB claim, or

(2) A determination that we made on a title II and/or a title XVI claim but only if the determination affects your SVB qualification.

(c) *How we extend the 4-month period.* If the requirements in paragraph (b) of this section are met, the 4-month period begins with the month after the month in which your notice of our decision on your appeal is dated or the month in which your appeal rights have expired.

§ 408.232 When do you lose your foreign resident status?

(a) *General rule.* We consider you to have lost or abandoned your residence outside the United States if you:

(1) Enter the United States and stay for more than 1 full calendar month (see § 408.234 for exceptions to this rule);

(2) Tell us that you no longer consider yourself to be residing outside the United States; or

(3) Become eligible (as defined by title XVI) for SSI benefits.

(b) *Resumption of SVB following a period of U.S. residence.* Once you lose or abandon your residence outside the United States, you cannot receive SVB again until you meet all the requirements for SVB qualification and reestablish your residence outside the United States.

Example: You leave your home outside the United States on June 15 to visit your son in the United States and return to your home abroad on August 15. Your SVB payments will continue for the months of June and July. However, because you were in the United States for the entire calendar month of July (*i.e.*, all of the first day through all of the last day of July), you are not entitled to an SVB payment for the month of August. Your SVB payments resume with September, the month you reestablished your residence outside the United States.

§ 408.234 Can you continue to receive SVB payments if you stay in the United States for more than 1 full calendar month?

(a) *When we will consider your foreign residence to continue.* We will continue to consider you to be a foreign resident and will continue to pay you SVB payments even if you have been in the United States for more than 1 full calendar month if you—

(1) Made a good faith effort to return to your home abroad within that 1-month period but were prevented from doing so by circumstances beyond your control (e.g., sickness, a death in the family, a transportation strike, etc.); or

(2) Are exercising your option to be personally present in the United States to present testimony and other evidence in the appeal of an SSA decision on a claim filed under any SSA-administered program. This extension applies only as long as you are participating in activities where you are providing testimony and other evidence in connection with a determination or decision at a specific level of the appeals process (e.g., a hearing before an administrative law judge).

(b) *When you must return to your home abroad.* When the circumstance/event that was the basis for the continuation of your SVB payments ceases to exist, you must return to your home abroad within 1 full calendar month. If you do not return to your home abroad within this 1-calendar-month period, we will consider you to have lost or abandoned your foreign resident status for SVB purposes and we will stop your SVB payments with the first day of the month following the first full calendar month you remain in the United States.

Subpart C—Filing Applications

AUTHORITY: Secs. 702(a)(5), 802, 806, and 810 of the Social Security Act (42 U.S.C. 902(a)(5), 1102, 1106 and 1110); Sec. 251, Pub. L. 106–169, 113 Stat. 1844.

FILING YOUR APPLICATION

§ 408.301 What is this subpart about?

This subpart contains our rules about filing applications for SVB. It explains what an application is, who may sign it, where and when it must be signed and filed, the period of time it is in effect, and how it may be withdrawn. This subpart also explains when a written statement or an oral inquiry may be considered to establish your application filing date.

§ 408.305 Why do you need to file an application to receive benefits?

In addition to meeting other requirements, you must file an application to become entitled to SVB. If you believe you may be entitled to SVB, you should file an application. Filing an application will—

(a) Permit us to make a formal decision on whether you qualify for SVB;

(b) Assure that you receive SVB for any months you are entitled to receive payments; and

(c) Give you the right to appeal if you are dissatisfied with our determination.

§ 408.310 What makes an application a claim for SVB?

To be considered a claim for SVB, an application must generally meet all of the following conditions:

(a) It must be on the prescribed SVB application form (SSA–2000–F6, Application for Special Benefits for World War II Veterans).

(b) It must be completed and filed with SSA as described in § 408.325.

(c) It must be signed by you or by someone who may sign an application for you as described in § 408.315.

(d) You must be alive at the time it is filed.

§ 408.315 Who may sign your application?

(a) *When you must sign.* If you are mentally competent, and physically able to do so, you must sign your own application.

(b) *When someone else may sign for you.* (1) If you are mentally incompetent, or physically unable to sign, your application may be signed by a court-appointed representative or a person who is responsible for your care, including a relative. If you are in the care of an institution, the manager or principal officer of the institution may sign your application.

(2) If it is necessary to protect you from losing benefits and there is good cause why you could not sign the application, we may accept an application signed by someone other than you or a person described in paragraph (b)(1) of this section.

Example: Mr. Smith comes to a Social Security office a few days before the end of a month to file an application for SVB for his neighbor, Mr. Jones. Mr. Jones, a 68-year-old widower, just suffered a heart attack and is in the hospital. He asked Mr. Smith to file the application for him. We will accept an application signed by Mr. Smith because it would not be possible to have Mr. Jones sign and file the application until the next calendar month and a loss of one month's benefits would result.

§ 408.320 What evidence shows that a person has authority to sign an application for you?

(a) A person who signs an application for you will be required to give us evidence of his or her authority to sign the application for you under the following rules:

(1) If the person who signs is a court-appointed representative, he or she must give us a certificate issued by the court showing authority to act for you.

(2) If the person who signs is not a court-appointed representative, he or she must give us a statement describing his or her relationship to you. The statement must also describe the extent to which the person is responsible for your care.

(3) If the person who signs is the manager or principal officer of an institution which is responsible for your care, he or she must give us a statement indicating the person's position of responsibility at the institution.

(b) We may, at any time, require additional evidence to establish the authority of a person to sign an application for you.

§ 408.325 When is your application considered filed?

(a) *General rule.* We consider an application for SVB filed on the day it is received by an SSA employee at one of our offices, by an SSA employee who is authorized to receive it at a place other than one of our offices, or by any office of the U.S. Foreign Service or by the Veterans Affairs Regional Office in the Philippines.

(b) *Exceptions.* (1) When we receive an application that is mailed, we will use the date shown by the United States postmark as the filing date if using the date we receive it would result in your entitlement to additional benefits. If the postmark is unreadable, or there is no United States postmark, we will use the date the application is signed (if dated) or 5 days before the day we receive the signed application, whichever date is later.

(2) We consider an application to be filed on the date of the filing of a written statement or the making of an oral inquiry under the conditions in §§ 408.340 and 408.345.

(3) We will establish a deemed filing date of an application in a case of misinformation under the conditions described in § 408.351. The filing date of the application will be a date determined under § 408.351(b).

§ 408.330 How long will your application remain in effect?

Your application for SVB will remain in effect from the date it is filed until we make a final determination on it, unless there is a hearing decision on your application. If there is a hearing decision, your application will remain in effect until the hearing decision is issued.

Filing Date Based on Written Statement or Oral Inquiry

§ 408.340 When will we use a written statement as your filing date?

If you file with us under the rules stated in § 408.325 a written statement, such as a letter, indicating your intent to claim SVB, we will use the filing date of the written statement as the filing date of your application. If the written statement is mailed, we will use the date the statement was mailed to us as shown by the United States postmark. If the postmark is unreadable or there is no United States postmark, we will use the date the statement is signed (if dated) or 5 days before the day we receive the written statement, whichever date is later, as the filing date. In order for us to use your written statement to protect your filing date, the following requirements must be met:

(a) The statement indicates your intent to file for benefits.

(b) The statement is signed by you, your spouse, or a person described in § 408.315.

(c) You file an application with us on an application form as described in § 408.310(a), or one is filed for you by a person described in § 408.315, within 60 days after the date of a notice we will send advising of the need to file an application. The notice will say that we will make an initial determination of your qualification if an application form is filed within 60 days after the date of the notice. We will send the notice to you. However, if it is clear from the information we receive that you are mentally incompetent, we will send the notice to the person who submitted the written statement.

(d) You are alive when the application is filed.

§ 408.345 When will we use the date of an oral inquiry as your application filing date?

We will use the date of an oral inquiry about SVB as the filing date of your application for SVB if the following requirements are met:

(a) The inquiry asks about your entitlement to SVB.

(b) The inquiry is made by you, your spouse, or a person who may sign an application on your behalf as described in § 408.315.

(c) The inquiry, whether in person or by telephone, is directed to an office or an official described in § 408.325(a).

(d) You, or a person on your behalf as described in § 408.315, file an application on a prescribed form within 60 days

after the date of the notice we will send telling of the need to file an application. The notice will say that we will make an initial determination on whether you qualify for SVB if an application form is filed within 60 days after the date of the notice. However, if it is clear from the information we receive that you are mentally incompetent, we will send the notice to the person who made the inquiry.

(e) You are alive when the prescribed application is filed.

DEEMED FILING DATE BASED ON MISINFORMATION

§ 408.351 What happens if we give you misinformation about filing an application?

(a) *General rule.* You may have considered applying for SVB, for yourself or another person and you may have contacted us in writing, by telephone or in person to inquire about filing an application for SVB. It is possible that in responding to your inquiry, we may have given you misinformation about qualification for such benefits that caused you not to file an application at that time. If this happened and use of that date will result in entitlement to additional benefits, and you later file an application for SVB with us, we may establish an earlier filing date as explained in paragraphs (b) through (f) of this section.

(b) *Deemed filing date of an application based on misinformation.* Subject to the requirements and conditions in paragraphs (c) through (f) of this section, we may establish a deemed filing date of an application for SVB under the following provisions.

(1) If we determine that you failed to apply for SVB because we gave you misinformation about qualification for or entitlement to such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(i) The date on which we gave you the misinformation; or

(ii) The date on which all of the requirements for qualification to SVB were met, other than the requirement of filing an application.

(2) Before we may establish a deemed filing date of an application for SVB under paragraph (b)(1) of this section, you or a person described in § 408.315 must file an application for such benefits.

(c) *Requirements concerning the misinformation.* We apply the following requirements for purposes of paragraph (b) of this section.

(1) The misinformation must have been provided to you by one of our employees while he or she was acting in his or her official capacity as our employee. For purposes of this section, an employee includes an officer of SSA, an employee of a U.S. Foreign Service office, and an employee of the SSA Division of the Veterans Affairs Regional Office in the Philippines who is authorized to take and develop Social Security claims.

(2) Misinformation is information which we consider to be incorrect, misleading, or incomplete in view of the facts which you gave to the employee, or of which the employee was aware or should have been aware, regarding your particular circumstances. In addition, for us to find that the information you were given was incomplete, the employee must have failed to provide you with the appropriate, additional information which he or she would be required to provide in carrying out his or her official duties.

(3) The misinformation may have been provided to you orally or in writing.

(4) The misinformation must have been provided to you in response to a specific request by you to us for information about your qualification for SVB.

(d) *Evidence that misinformation was provided.* We will consider the following evidence in making a determination under paragraph (b) of this section.

(1) *Preferred evidence.* Preferred evidence is written evidence which relates directly to your inquiry about your qualification for SVB and which shows that we gave you misinformation which caused you not to file an application. Preferred evidence includes, but is not limited to, the following—

(i) A notice, letter or other document which was issued by us and addressed to you; or

(ii) Our record of your telephone call, letter or in-person contact.

(2) *Other evidence.* In the absence of preferred evidence, we will consider other evidence, including your statements about the alleged misinformation, to determine whether we gave you misinformation, which caused you not to file an application. We will not find that we gave you misinformation, however, based solely on your statements. Other evidence which you provide or which we obtain must support your statements. Evidence which we will consider includes, but is not limited to, the following—

(i) Your statements about the alleged misinformation, including statements about—

(A) The date and time of the alleged contact(s);

(B) How the contact was made, e.g., by telephone or in person;

(C) The reason(s) the contact was made;

(D) Who gave the misinformation; and

(E) The questions you asked and the facts you gave us, and the questions we asked and the information we gave you, at the time of the contact;

(ii) Statements from others who were present when you were given the alleged misinformation, e.g., a neighbor who accompanied you to our office;

(iii) If you can identify the employee or the employee can recall your inquiry about benefits—

(A) Statements from the employee concerning the alleged contact, including statements about the questions you asked, the facts you gave, the questions the employee asked, and the information provided to you at the time of the alleged contact; and

(B) Our assessment of the likelihood that the employee provided the alleged misinformation;

(iv) An evaluation of the credibility and the validity of your allegations in conjunction with other relevant information; and

(v) Any other information regarding your alleged contact.

(e) *Information which does not constitute satisfactory proof that misinformation was given.* Certain kinds of information will not be considered satisfactory proof that we gave you misinformation which caused you not to file an application. Examples of such information include—

(1) General informational pamphlets that we issue to provide basic program information;

(2) General information which we review or prepare but which is disseminated by the media, e.g., radio, television, magazines, and newspapers; and

(3) Information provided by other governmental agencies, e.g., the Department of Veterans Affairs (except for certain employees of the SSA Division of the Veterans Affairs Regional Office in the Philippines as provided in paragraph (c)(1) of this section), the Department of Defense, State unemployment agencies, and State and local governments.

(f) *Claim for benefits based on misinformation.* You may make a claim for SVB based on misinformation at any time. Your claim must contain information that will enable us to determine if we did provide misinformation to you about qualification for SVB which caused you not to file an application. Specifically, your claim must be in writing and it must explain what information was provided, how, when and where it was provided and by whom, and why the information caused you not to file an application. If you give us this information, we will make a determination on such a claim for benefits if all of the following conditions are also met.

(1) An application for SVB is filed with us by you or someone described in § 408.315 who may file. The application must be filed after the alleged misinformation was provided. This application may be—

(i) An application on which we have made a previous final determination or decision awarding SVB, but only if the claimant continues to be entitled to benefits based on that application;

(ii) An application on which we have made a previous final determination or decision denying the benefits, but only if such determination or decision is reopened; or

(iii) A new application on which we have not made a final determination or decision.

(2) The establishment of a deemed filing date of an application for benefits based on misinformation could result

in entitlement to benefits or payment of additional benefits.

(3) We have not made a previous final determination or decision to which you were a party on a claim for benefits based on alleged misinformation involving the same facts and issues. This provision does not apply, however, if the final determination or decision may be reopened.

WITHDRAWAL OF APPLICATION

§ 408.355 Can you withdraw your application?

(a) Request for withdrawal filed before a determination is made. You may withdraw your application for SVB before we make a determination on it if—

(1) You, or a person who may sign an application for you under § 408.315, file a written request for withdrawal at a place described in § 408.325; and

(2) You are alive at the time the request is filed.

(b) *Request for withdrawal filed after a determination is made.* An application may be withdrawn after we make a determination on it if you repay all benefits already paid based on the application being withdrawn or we are satisfied that the benefits will be repaid.

(c) *Effect of withdrawal.* If we approve your request to withdraw your application, we consider that the application was never filed. If we disapprove your request for withdrawal, we treat your application as though you did not file a request for withdrawal.

§ 408.360 Can you cancel your request to withdraw your application?

You may request to cancel your request to withdraw your application and have your application reinstated if all of the following requirements are met:

(a) You, or someone who may sign an application for you under § 408.315, file a written request for cancellation at a place described in § 408.325;

(b) You are alive at the time you file your request for cancellation; and

(c) A cancellation request received after we have approved your withdrawal must be filed no later than 60 days after the date of the notice of approval.

Subpart D—Evidence Requirements

AUTHORITY: Secs. 702(a)(5), 806, and 810 of the Social Security Act (42 U.S.C. 902(a)(5), 1006, and 1010); sec. 251, Pub. L. 106–169, 113 Stat. 1844.

GENERAL INFORMATION

§ 408.401 What is this subpart about?

We cannot determine your entitlement to SVB based solely on your statements about your qualification for benefits or other facts concerning payments to you. We will ask you for specific evidence or additional information. We may verify the evidence you give us with other sources to ensure that it is correct. This subpart contains our rules about the evidence you need to give us when you claim SVB.

§ 408.402 When do you need to give us evidence?

When you apply for SVB, we will ask you for any evidence we need to make sure that you meet the SVB qualification and entitlement requirements. After you begin receiving SVB, we may ask you for evidence showing whether your SVB payments should be reduced or stopped. We will help you get any documents you need but do not have. If your evidence is a foreign-language record or document, we can have it translated for you. The evidence you give us will be kept confidential and not disclosed to anyone but you except under the rules set out in part 401 of this chapter. You should also be aware that section 811 of the Act provides criminal penalties for misrepresenting the facts or for making false statements to obtain SVB payments for yourself or someone else, or to continue entitlement to benefits.

§ 408.403 Where should you give us your evidence?

You should give your evidence to the people at a Social Security Administration office. In the Philippines, you should give your evidence to the people at the Veterans Affairs Regional Office. Elsewhere outside the United States, you should give your evidence to the

people at the nearest U.S. Social Security office or a United States Foreign Service Office.

§ 408.404 What happens if you fail to give us the evidence we ask for?

(a) *You have not yet qualified for SVB.* Generally, we will ask you to give us specific evidence or information by a certain date to prove that you qualify for SVB or to prove your foreign residence. If we do not receive the evidence or information by that date, we may decide that you do not qualify for SVB or may not receive SVB and deny your claim.

(b) *You have qualified for or become entitled to SVB.* If you have already qualified for or become entitled to SVB, we may ask you to give us information by a specific date to decide whether you should receive benefits or, if you are already receiving benefits, whether your benefits should be stopped or reduced. If you do not give us the requested evidence or information by the date given, we may decide that you are no longer entitled to benefits or that your benefits should be stopped or reduced.

(c) *If you need more time.* You should let us know if you are unable to give us the evidence or information within the specified time and explain why there will be a delay. If this delay is due to illness, failure to receive timely evidence you have asked for from another source, or a similar circumstance, we will give you additional time to give us the evidence.

§ 408.405 When do we require original records or copies as evidence?

(a) *General rule.* To prove your qualification for or continuing entitlement to SVB, you may be asked to show us an original document or record. These original documents or records will be returned to you after we have photocopied them. We will also accept copies of original records that are properly certified and some uncertified birth certifications. These types of records are described in paragraphs (b) and (c) of this section.

(b) *Certified copies of original records.* You may give us copies of original records or extracts from records if they are certified as true and exact copies by:

(1) The official custodian of the record;

(2) A Social Security Administration employee authorized to certify copies;

(3) A Veterans Affairs employee if the evidence was given to that agency to obtain veteran's benefits;

(4) An employee of the Veterans Affairs Regional Office, Manila, Philippines who is authorized to certify copies; or

(5) A U.S. Consular Officer or employee of the Department of State authorized to certify evidence received outside the United States.

(c) *Uncertified copies of original birth records.* You may give us an uncertified photocopy of a birth registration notification as evidence of age where it is the practice of the local birth registrar to issue them in this way.

§ 408.406 How do we evaluate the evidence you give us?

When you give us evidence, we examine it to see if it is convincing evidence. This means that unless we have information in our records that raises a doubt about the evidence, other evidence of the same fact will not be needed. If the evidence you give us is not convincing by itself, we may ask you for additional evidence. In evaluating whether the evidence you give us is convincing, we consider such things as whether:

(a) The information contained in the evidence was given by a person in a position to know the facts;

(b) There was any reason to give false information when the evidence was created;

(c) The information in the evidence was given under oath, or with witnesses present, or with the knowledge that there was a penalty for giving false information;

(d) The evidence was created at the time the event took place or shortly thereafter;

(e) The evidence has been altered or has any erasures on it; and

(f) The information contained in the evidence agrees with other available evidence including our records.

AGE

§ 408.410 When do you need to give us evidence of your age?

To qualify for SVB you must establish that you were age 65 or older on December 14, 1999, the date on which Public Law 106–169 was enacted into law. If we have already established your age or date of birth in connection with your claim for other benefit programs that we administer, you will not have to give us evidence of your age for your SVB claim. If we have not established your age or date of birth, you must give us evidence of your age or date of birth. In the absence of information to the contrary, we generally will not ask for additional evidence of your age or date of birth if you state that you are at least age 68, and you submit documentary evidence that is at least 3 years old when the application is filed and supports your statement.

§ 408.412 What kinds of evidence of age do you need to give us?

For a description of the kinds of evidence of age you may need to give us, see § 416.802 of this chapter.

§ 408.413 How do we evaluate the evidence of age you give us?

In evaluating the evidence of age you give us, we use the rules in § 416.803 of this chapter.

MILITARY SERVICE

§ 408.420 What evidence of World War II military service do you need to give us?

(a) *Kinds of evidence you can give us.* To show that you are a World War II veteran as defined in § 408.216, you can give us any of the documents listed in § 404.1370(b)(1) through (5) of this chapter that were issued by a U.S. Government agency. However, depending on the type of document you give us and what the document shows, we may verify your military service, or the dates of your service, with the National Personnel Records Center (NPRC) in St. Louis, Missouri. If we do, we will use the information in NPRC's records to determine whether you meet the military service requirements for SVB.

(b) *What the evidence must show.* When you file an application for SVB, you must give us evidence of your World War II military service. The evidence you give us must show:

(1) Your name;

(2) The branch of service in which you served;

(3) The dates of your military service;

(4) Your military service serial number;

(5) The character of your discharge; and

(6) If your service was in the organized military forces of the Government of the Commonwealth of the Philippines (including the organized guerrilla forces), the period of your service that was under the control of U.S. Armed Forces.

SSI ELIGIBILITY

§ 408.425 How do we establish your eligibility for SSI?

To qualify for SVB, you must have been eligible for SSI for the month of December 1999, the month in which Public Law 106–169 was enacted, and for the month in which you filed your application for SVB. You do not have to submit evidence of this. We will use our SSI record of your eligibility to determine if you meet these requirements.

OTHER BENEFIT INCOME

§ 408.430 When do you need to give us evidence of your other benefit income?

If you tell us or if we have information indicating that you are receiving other benefit income that could affect your qualification for or the amount of your SVB payments, we will ask you to give us evidence of that income as explained in § 408.432.

§ 408.432 What kind of evidence of your other benefit income do you need to give us?

As evidence of your other benefit income, we may require a document such as an award notice or other letter from the paying agency or written notification from the former employer, insurance company, etc. The evidence should show the benefit payable, the

current amount of the payment, and the date the payment began.

RESIDENCE

§ 408.435 How do you prove that you are residing outside the United States?

(a) *General rule.* To establish that you are residing outside the United States for SVB purposes, you must give us all of the following:

(1) Evidence of the date on which you arrived in the country in which you are residing;

(2) A statement signed by you showing the address at which you are living and that you intend to continue living there; and

(3) Evidence that you are actually living at the address given in your signed statement.

(b) *Evidence of the date you entered the foreign country.* To establish the date you arrived in the country in which you are residing, you can give us evidence such as:

(1) A visa or passport showing the date you entered that country;

(2) Your plane ticket showing the date you arrived in that country; or

(3) An entry permit showing the date you entered that country.

(c) *Evidence of your actual place of residence.* To establish your actual place of residence, you can give us evidence such as:

(1) A lease agreement showing where you live;

(2) Rental or mortgage receipts;

(3) Utility or other bills addressed to you at the address where you live;

(4) A signed statement from a local official showing that he or she knows where you live, when you began living there and how he or she knows this information; or

(5) A Standard Form 1199A, Direct Deposit Sign-Up Form, showing your address abroad and signed by an official of the financial institution after the date you arrived in the country in which you will be residing.

§ 408.437 How do you prove that you had good cause for staying in the United States for more than 1 full calendar month?

(a) *General rule.* If you believe that you meet the requirements in § 408.234 and that you should continue to receive SVB payments even though you have been in the United States for more than 1 full calendar month, you must give us evidence that you had good cause for staying in the United States.

(b) *Circumstances prevent you from returning to your home abroad.* To prove that you had good cause for staying in the United States for more than 1 full calendar month, you must give us evidence of your good faith effort to return to your home abroad before the 1-month period had elapsed and of the circumstances/event which prevented your return to your home abroad.

(1) *Evidence of your good faith effort to return to your home abroad.* Evidence of your plans to return to your home abroad can include, but is not limited to:

(i) A plane ticket showing that you intended to return to your home abroad before the expiration of 1 full calendar month; or

(ii) Notice from a travel agency or airline confirming the cancellation of your reservation to return to your home abroad on a date within 1 full calendar month.

(2) *Evidence of the circumstances preventing your return to your home abroad.* The evidence we will accept from you to support the circumstance or event that prevented you from returning to your home abroad will depend on the reason you are staying in the United States. It can include, but is not limited to, a:

(i) Newspaper article or other publication describing the event or natural disaster which prevented your return; or

(ii) Doctor's statement, etc. showing that you are unable to travel; or

(iii) Death certificate or notice if you are staying in the United States to attend the funeral of a member of your family.

(c) *You are appealing a decision we made.* To establish that you had good cause to stay in the United States for more than 1 full calendar month because you want to appear in person at the appeal of a decision on a claim filed under a program administered by the Social Security Administration, you

must submit evidence of this. The evidence must identify the appeal proceeding and the dates you are scheduled to attend.

(d) *When we may ask for more evidence.* If you stay in the United States for several months, we may ask you to give us more evidence to prove that you are still unable to return to your home abroad.

Subpart E—Amount and Payment of Benefits

AUTHORITY: Secs. 702(a)(5), 801, 805, and 810 of the Social Security Act (42 U.S.C. 902(a)(5), 1001, 1005, and 1010); Sec. 251, Pub. L. 106–169, 113 Stat. 1844.

§ 408.501 What is this subpart about?

This subpart explains how we compute the amount of your monthly SVB payment, including how we reduce your payments if you receive other benefit income. It also explains how we pay benefits under the SVB program.

§ 408.505 How do we determine the amount of your SVB payment?

(a) *Maximum SVB payment.* The maximum monthly SVB payment is equal to 75% of the FBR for an individual under title XVI of the Act. See § 416.410 of this chapter.

(b) *Cost-of-living adjustments in the FBR.* The maximum SVB amount will increase whenever there is a cost-of-living increase in the SSI FBR under the provisions of § 416.405 of this chapter. The basic SVB amount following such an increase is equal to 75 percent of the increased FBR.

(c) *When we will reduce the amount of your basic benefit.* We will reduce your basic benefit by the amount of the other benefit income you receive in that month, as explained in § 408.510.

§ 408.510 How do we reduce your SVB when you receive other benefit income?

(a) *Amount of the reduction.* If you receive other benefit income as defined in § 408.220, we will reduce your SVB payment by the amount of the other benefit income you receive in that month. The reduction is on a dollar-for-dollar and cents-for-cents basis. We do not round SVB payment amounts except as described in paragraph (b) of this section.

(b) *Minimum benefit amount.* If the reduction described in paragraph (a) of this section results in a benefit amount that is greater than zero but less than $1.00, we will pay you a benefit of $1.00 for that month.

§ 408.515 When do we make SVB payments?

SVB payments are made on the first day of each month and represent payment for that month. If the first day of the month falls on a Saturday, Sunday, or Federal legal holiday, payment will be made on the first day preceding such day that is not a Saturday, Sunday, or Federal legal holiday.

Subpart F—Representative Payment

AUTHORITY: Secs. 205(j)(1)(C), 702(a)(5), 807, and 810 of the Social Security Act (42 U.S.C. 405(j)(1)(C), 902(a)(5), 1007, and 1010).

SOURCE: 69 FR 60235, Oct. 7, 2004, unless otherwise noted.

§ 408.601 What is this subpart about?

(a) *Explanation of representative payment.* This subpart explains the policies and procedures we follow to determine whether to pay your benefits to a representative payee and to select a representative payee for you. It also explains the responsibilities your representative payee has for using the funds he or she receives on your behalf. A representative payee may be either an individual or an organization. We will select a representative payee to receive your benefits if we believe your interests will be better served by paying a representative payee than by paying you directly. Generally, we appoint a representative payee if we determine you are unable to manage or direct the management of your own benefit payments. Because the representative payment policies and procedures we use for the title VIII program closely parallel our title II policies and procedures, we provide cross-references to the appropriate material in our title II representative payment rules in subpart U of part 404 of this chapter.

(b) *Policy we use to determine whether to make representative payment.* For an

explanation of the policy we use to determine whether to pay your SVB to a representative payee, see § 404.2001(b) of this chapter.

§ 408.610 When will we send your SVB payments to a representative payee?

In determining when we will pay your benefits to a representative payee, we follow the rules in § 404.2010(a) of this chapter.

§ 408.611 What happens to your monthly benefits while we are finding a suitable representative payee for you?

For an explanation of the policy we use to determine what happens to your monthly benefits while we are finding a suitable representative payee for you, see § 404.2011 of this chapter.

§ 408.615 What information do we consider in determining whether we will pay your benefits to a representative payee?

We determine whether to pay your benefits to a representative payee after considering the information listed in § 404.2015 of this chapter.

§ 408.618 Advance designation of representative payees.

For information about advance designation, how to designate representative payees in advance, how to make changes to advance designations, how we consider an advance designation when we select a representative payee, how we consider an advance designation when we select a subsequent representative payee, and other relevant information, see §§ 404.2018, 404.2020, and 404.2021 of this chapter.

[85 FR 7665, Feb. 11, 2020]

§ 408.620 What information do we consider in selecting the proper representative payee for you?

To select a proper representative payee for you, we consider the information listed in § 404.2020 of this chapter.

§ 408.621 What is our order of preference in selecting a representative payee for you?

We use the preference list in § 404.2021(a) of this chapter as a guide in selecting the proper representative payee for you.

§ 408.622 Who may not serve as a representative payee?

For a list of individuals who may not serve as a representative payee, *see* § 404.2022 of this chapter.

§ 408.624 How do we investigate a representative payee applicant?

Before selecting an individual or organization as your representative payee, we investigate him or her following the rules in § 404.2024 of this chapter.

§ 408.625 What information must a representative payee report to us?

Your representative payee must report to us information as described in § 404.2025 of this chapter.

§ 408.626 How do we investigate an appointed representative payee?

After we select an individual as your representative payee, we investigate him or her following the rules in § 404.2026 of this chapter.

[84 FR 4325, Feb. 15, 2019, as amended at 84 FR 57319, Oct. 25, 2019]

§ 408.630 How will we notify you when we decide you need a representative payee?

(a) We notify you in writing of our determination to make representative payment. If you are legally incompetent, our written notice is sent to your legal guardian or legal representative. The notice explains that we have determined that representative payment is in your interest, and it provides the name of the representative payee we have selected. The notice:

(1) Contains language that is easily understandable to the reader.

(2) Identifies the person designated as your representative payee.

(3) Explains that you, your legal guardian, or your legal representative can appeal our determination that you need a representative payee.

(4) Explains that you, your legal guardian, or your legal representative can appeal our designation of a particular person to serve as representative payee.

(b) If you, your legal guardian, or your legal representative objects to representative payment or to the designated payee, you can file a formal appeal.

§ 408.635 What are the responsibilities of your representative payee?

For a list of your representative payee's responsibilities, see § 404.2035 of this chapter.

§ 408.640 How must your representative payee use your benefits?

Your representative payee must use your benefits in accordance with the rules in § 404.2040 of this chapter.

§ 408.641 Who is liable if your representative payee misuses your benefits?

For the rules we follow to determine who is liable for repayment of misused benefits, see § 404.2041 of this chapter.

§ 408.645 What must your representative payee do with unused benefits?

If your representative payee has accumulated benefits for you, he or she must conserve or invest them as provided in § 404.2045 of this chapter.

§ 408.650 When will we select a new representative payee for you?

We follow the rules in § 404.2050 of this chapter to determine when we will select a new representative payee for you.

§ 408.655 When will we stop making your payments to a representative payee?

To determine when we will stop representative payment for you, we follow the rules in § 404.2055 of this chapter.

§ 408.660 What happens to your accumulated funds when your representative payee changes?

For a description of what happens to your accumulated funds (including the interest earned on the funds) when we change your representative payee or when you begin receiving benefits directly, see § 404.2060 of this chapter.

§ 408.665 How does your representative payee account for the use of your SVB payments?

(a) Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year.

(b) Your representative payee is exempt from the accounting requirement when your representative payee is the spouse of an individual eligible for SVB payments.

(c) We may verify how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to provide accounting reports and must make those records available upon our request. If your representative payee fails to provide an annual accounting of benefits or other required report, we may require your payee to appear in person at the local Social Security field office or a United States Government facility that we designate serving the area in which you reside. The decision to have your representative payee receive your benefits in person may be based on a variety of reasons. Some of these reasons may include the payee's history of past performance or our past difficulty in contacting the payee. We may ask your representative payee to give us the following information:

(1) Where you lived during the accounting period;

(2) Who made the decisions on how your benefits were spent or saved;

(3) How your benefit payments were used; and

(4) How much of your benefit payments were saved and how the savings were invested.

[87 FR 35653, June 13, 2022]

Subpart G—Reporting Requirements

AUTHORITY: Secs. 702(a)(5), 802, 803, 804, 806, 807, and 810 of the Social Security Act (42 U.S.C. 902(a)(5), 1002, 1003, 1004, 1006, 1007, and 1010).

SOURCE: 69 FR 25955, May 10, 2004, unless otherwise noted.

§ 408.701 What is this subpart about?

To achieve efficient administration of the Special Veterans Benefit (SVB) program, we require you (or your representative) to report certain events to us. It is important for us to know about these events because they may affect your right to receive SVB or the amount of your benefits. This subpart tells you what events you must report; what your reports must include; how you should make your report; and when reports are due.

§ 408.704 Who must make reports?

(a) If you receive your own benefits, you are responsible for making required reports to us.

(b) If you have a representative payee, and you have not been legally adjudged incompetent, either you or your representative payee must make the required reports.

(c) If you have a representative payee and you have been legally adjudged incompetent, you are not responsible for making reports to us; however, your representative payee is responsible for making required reports to us.

§ 408.708 What events must you report to us?

This section describes the events that you must report to us. They are—

(a) *A change of address or residence.* You must report to us any change in your mailing address and any change in your residence, *i.e.*, the address where you live.

(b) *A change in your other benefit income.* You must report to us any increase or decrease in your other benefit income as described in § 408.220.

(c) *Certain deaths.* (1) If you are a representative payee, you must report the death of the entitled individual.

(2) If you have a representative payee, you must report the death of your representative payee.

(d) *Entry into the United States.* You must report to us if you enter the United States to visit or live even if you have no intention of abandoning your residence outside the United States.

(e) *Removal (including deportation) from the United States.* You must report to us if you are removed (including deported) from the United States under section 237(a) or 212(a)(6)(A) of the Immigration and Nationality Act.

(f) *Fleeing to avoid criminal prosecution or custody or confinement after conviction, or violating probation or parole.* You must report to us that you are—

(1) Fleeing to avoid prosecution, under the laws of the United States or the jurisdiction within the United States from which you flee, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State);

(2) Fleeing to avoid custody or confinement after conviction under the laws of the United States or the jurisdiction within the United States from which you flee, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(3) Violating a condition of probation or parole imposed under Federal or State law.

§ 408.710 What must your report include?

When you make a report, you must tell us—

(a) The name and social security number of the person to whom the report applies;

(b) The event you are reporting and the date it happened; and

(c) Your name if you are not the person to whom the report applies.

§ 408.712 How should you make your report?

You should make your report in any of the ways described in this section.

(a) *Written reports.* You may write a report on your own paper or on a printed form supplied by us. You may mail a written report or bring it to one of our offices.

(b) *Oral reports.* You may report to us by telephone, or you may come to one of our offices and tell one of our employees what you are reporting.

(c) *Other methods of reporting.* You may use any other suitable method of

reporting—for example, a telegram or a cable.

§ 408.714 When are reports due?

(a) *A reportable event happens.* You should report to us as soon as an event listed in § 408.708 happens.

(b) *We request a report.* We may request a report from you if we need information to determine continuing entitlement or the correct amount of your SVB payments. If you do not make the report within 30 days of our written request, we may determine that you may not continue to receive SVB. We will suspend your benefits effective with the month following the month in which we determine that you are not entitled to receive SVB because of your failure to give us necessary information (*see* § 408.803).

Subpart H—Suspensions and Terminations

AUTHORITY: Secs. 702(a)(5) and 810(d) of the Social Security Act (42 U.S.C. 902(a)(5) and 1010(d)).

SOURCE: 69 FR 25955, May 10, 2004, unless otherwise noted.

§ 408.801 What is this subpart about?

This subpart explains the circumstances that will result in suspension of your SVB payments or termination of your SVB entitlement.

SUSPENSION

§ 408.802 When will we suspend your SVB payments?

(a) *When suspension is proper.* Suspension of SVB payments is required when you no longer meet the SVB qualification requirements (*see* subpart B of this part) and termination in accordance with §§ 408.814 through 408.818 does not apply. (This subpart does not cover suspension of payments for administrative reasons, as, for example, when mail is returned as undeliverable by the Postal Service and we do not have a valid mailing address for you or when your representative payee dies and a search is underway for a substitute representative payee.)

(b) *Effect of suspension.* When we correctly suspend your SVB payments, we will not resume them until you again meet all qualification requirements except the filing of a new application. If you request reinstatement, you are required to submit the evidence necessary to establish that you again meet all requirements for eligibility under this part. Your SVB payments will be reinstated effective with the first month in which you meet all requirements for eligibility except the filing of a new application.

§ 408.803 What happens to your SVB payments if you fail to comply with our request for information?

(a) *Effective date of suspension.* We will suspend your SVB payments effective with the month following the month in which we determine in accordance with § 408.714(b) that you may no longer receive SVB payments because you failed to comply with our request for necessary information.

(b) *Resumption of payments.* When we have information to establish that SVB is again payable, your benefit payments will be reinstated for any previous month for which you continue to meet the requirements of § 408.202.

(c) *When we will not suspend your payments.* We will not suspend your payments for failing to comply with our request for information for any month we can determine your eligibility for or the amount of your payment based on information on record. If we cannot determine your eligibility or the amount of your payment based on the information on record, we will send you a notice of suspension of payment because you failed to comply with our request for information in accordance with §§ 408.820 and 408.1005.

§ 408.806 What happens to your SVB payments if you are no longer residing outside the United States?

(a) *Suspension effective date.* We will suspend your SVB payments effective the first full calendar month you are no longer residing outside the United States.

(b) *Resumption of payments.* If otherwise payable, we will resume your SVB payments effective with the first full calendar month you are again residing outside the United States.

§ 408.808 What happens to your SVB payments if you begin receiving additional benefit income?

(a) *Suspension effective date.* We will suspend your SVB payments for any month your other benefit income (as described in § 408.220(a)) exceeds the maximum SVB amount payable for a month (see § 408.505(a)).

(b) *Resumption of payments.* If otherwise payable, we will resume your SVB payments effective with the first month your other benefit income is less than the maximum SVB amount payable for a month.

§ 408.809 What happens to your SVB payments if you are removed (including deported) from the United States?

(a) *Suspension effective date.* We will suspend your SVB payments effective with the month after the month in which we receive notice from the United States Citizenship and Immigration Service that you have been removed (including deported) from the United States under section 237(a) or 212(a)(6)(A) of the Immigration and Nationality Act.

(b) *Resumption of payments.* If otherwise payable, we will resume your SVB effective with the first month after the month of your removal that you were granted the status of a lawful permanent resident of the United States.

§ 408.810 What happens to your SVB payments if you are fleeing to avoid criminal prosecution or custody or confinement after conviction, or because you violate a condition of probation or parole?

(a) *Basis for suspension.* You may not receive SVB for any month during which you are—

(1) Fleeing to avoid prosecution under the laws of the United States or the jurisdiction within the United States from which you flee for a crime, or attempt to commit a crime, that is a felony under the laws of the place from which you flee (or that, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(2) Fleeing to avoid custody or confinement after conviction under the laws of the United States or the jurisdiction within the United States from which you flee, for a crime, or an attempt to commit a crime, that is a felony under the laws of the place from which you flee (or that, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(3) Violating a condition of probation or parole imposed under Federal or State law.

(b) *Suspension effective date.* Suspension of SVB payments because you are a fugitive as described in paragraph (a)(1) or (a)(2) of this section or a probation or parole violator as described in paragraph (a)(3) of this section is effective with the first day of whichever of the following months is earlier—

(1) The month in which a warrant or order for your arrest or apprehension, an order requiring your appearance before a court or other appropriate tribunal (e.g., a parole board), or similar order is issued by a court or other duly authorized tribunal in the United States on the basis of an appropriate finding that you—

(i) Are fleeing, or have fled, to avoid prosecution as described in paragraph (a)(1) of this section;

(ii) Are fleeing, or have fled, to avoid custody or confinement after conviction as described in paragraph (a)(2) of this section;

(iii) Are violating, or have violated, a condition of your probation or parole as described in paragraph (a)(3) of this section; or

(2) The first month during which you fled to avoid such prosecution, fled to avoid such custody or confinement after conviction, or violated a condition of your probation or parole, if indicated in such warrant or order, or in a decision by a court or other appropriate tribunal in the United States.

(c) *Resumption of payments.* If otherwise payable, we will resume your SVB payments beginning with the first month throughout which you are determined to be no longer fleeing to avoid prosecution, fleeing to avoid custody or confinement after conviction, or violating a condition of your probation or parole.

§ 408.812 What happens to your SVB payments if you are not a citizen or national of the United States and you begin residing in a Treasury-restricted country?

(a) *Suspension effective date.* If you are not a citizen or national of the United States, we will suspend your SVB payments effective with the first full calendar month you are residing in a country to which the Treasury Department restricts payments under 31 U.S.C. 3329.

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the first day of the first month in which you are not residing in a Treasury-restricted country.

TERMINATION

§ 408.814 Can you request termination of your SVB entitlement?

You, your legal guardian, or your representative payee, may voluntarily terminate your SVB entitlement by filing a written request for termination. If your representative payee requests termination, it must be shown that no hardship would result to you if the request is processed. When a termination request is filed, your SVB entitlement ends effective with the month following the month you file your request with us unless you specify some other month. However, we will not terminate your entitlement for any month for which payment has been or will be made unless you repay (or there is an assurance you will repay) any amounts paid for those months. When we process a voluntary request for termination of your SVB entitlement, we will send you a notice of our determination in accordance with § 408.1005. Once terminated, your entitlement can be reestablished only if you file a new application, except as provided by § 408.1009.

§ 408.816 When does SVB entitlement end due to death?

Your SVB entitlement ends with the month in which you die. Payments are terminated effective with the month after the month of death.

§ 408.818 When does SVB entitlement terminate if your benefit payments have been in suspense for 12 consecutive months?

We will terminate your SVB entitlement following 12 consecutive months of benefit suspension for any reason beginning with the first month you were no longer entitled to SVB. We will count the 12-month suspension period from the start of the first month that you are no longer entitled to SVB (*see* § 408.802(a)). This termination is effective with the first day of the 13th month after the suspension began.

§ 408.820 Will we send you a notice of intended action affecting your SVB payment status?

(a) *Advance written notice requirement.* Before we suspend, reduce (*see* subpart E of this part), or terminate your SVB payments, we will send you a written notice explaining our intention to do so, except where we have factual information confirming your death, e.g., as specified in § 404.704(b) of this chapter, or a report by a surviving spouse, a legal guardian, a parent or other close relative, or a landlord.

(b) *Continuation of payment pending an appeal.* The written notice of our intent to suspend, reduce, or terminate payments will give you 60 days after the date you receive the notice to request the appropriate appellate review. If your benefit payments are reduced or suspended and you file an appeal within 10 days after you receive the notice, payments will be continued or reinstated at the previously established payment level (subject to the effects of intervening events on the payment which are not appealed within 10 days of receipt of a required advance notice or which do not require advance notice, e.g., an increase in the benefit amount) until a decision on your initial appeal is issued, unless you specifically waive in writing your right to continuation of payment at the previously established level in accordance with paragraph (c) of this section. Where the request for the appropriate appellate review is filed more than 10 days after the notice is received but within the 60-day period specified in § 408.1009 of this part, you have no right to continuation or reinstatement of payment at the

previously established level unless you establish good cause under the criteria specified in § 408.1011 of this part for failure to appeal within 10 days after receipt of the notice. For purposes of this paragraph, we will presume you received our notice of intent to suspend, reduce, or terminate payments 5 days after the date on the face of the notice, unless there is a reasonable showing to the contrary.

(c) *Waiver of right to continued payment.* In order to avoid the possibility of an overpayment of benefits, you may waive continuation of payment at the previously established level (subject to intervening events which would have increased the benefit for the month in which the incorrect payment was made, in which case the higher amount shall be paid), after you receive a full explanation of your rights. Your request for waiver of continuation of payment must be in writing, state that waiver action is being initiated solely at your request, and state that you understand your right to receive continued payment at the previously established level.

Subpart I—Underpayments and Overpayments

AUTHORITY: Secs. 702(a)(5), 808, and 1147 of the Social Security Act (42 U.S.C. 902(a)(5), 1008, and 1320b–17); 31 U.S.C. 3716; 31 U.S.C. 3720A.

SOURCE: 69 FR 25955, May 10, 2004, unless otherwise noted.

GENERAL RULES

§ 408.900 What is this subpart about?

This subpart explains what happens when you receive less or more than the correct amount of SVB than you are entitled to receive. Sections 408.901 through 408.903 define overpayment and underpayment and describe how we determine the amount of the overpayment or underpayment. When you receive less than the correct amount of SVB (which we refer to as an underpayment), we will take the actions described in §§ 408.904 and 408.905. Waiver of recovery of overpayments (payments of more than the correct amount) is discussed in §§ 408.910 through 408.914, and the methods we use to recover overpayments are discussed in §§ 408.920 through 408.946. In § 408.950, we explain when we will accept a compromise settlement of an overpayment or suspend or terminate collection of an overpayment.

§ 408.901 What is an underpayment?

(a) An underpayment can occur only with respect to a period for which you filed an application for benefits and met all conditions of eligibility for benefits.

(b) An underpayment is:

(1) Nonpayment, where payment was due but was not made; or

(2) Payment of less than the amount due for a period.

(c) For purposes of this section, payment has been made when certified by the Social Security Administration to the Department of the Treasury. Payment is not considered to have been made where payment has not been received by the designated payee, or where payment was returned.

§ 408.902 What is an overpayment?

(a) As used in this subpart, the term overpayment means payment of more than the amount due for any period. For purposes of this section, payment has been made when certified by the Social Security Administration to the Department of the Treasury. Payment is not considered to have been made where payment has not been received by the designated payee, or where payment was returned.

(b) As used in this subpart, the term *pandemic period* for the purposes of the waiver authority in § 408.910 refers exclusively to the period of time beginning on March 1, 2020, and ending on September 30, 2020.

[69 FR 25955, May 10, 2004, as amended at 85 FR 52914, Aug. 27, 2020]

§ 408.903 How do we determine the amount of an underpayment or overpayment?

(a) *General.* The amount of an underpayment or overpayment is the difference between the amount you are paid and the amount you are due for a given period. An underpayment or overpayment period begins with the first month for which there is a difference between the amount paid and

the amount actually due for that month. The period ends with the month in which we make the initial determination of the overpayment or underpayment. With respect to the period established, there can be no underpayment to you if we paid you more than the correct amount of SVB, even though we waived recovery of any overpayment to you for that period under the provisions of §§ 408.910 through 408.914. A later initial determination of an overpayment will require no change with respect to a prior determination of overpayment or to the period relating to such prior determination to the extent that the basis of the prior overpayment remains the same.

(b) *Limited delay in payment of an underpayment.* Where we have detected a potential overpayment but we have not made a determination of the overpayment (*see* § 408.918(a)), we will not delay making a determination of underpayment and paying you unless we can make an overpayment determination before the close of the month following the month in which we discovered the potential underpayment.

(c) *Delay in payment of underpayment to ineligible individual.* If you are no longer entitled to SVB, we will delay a determination and payment of an underpayment that is otherwise due you so that we can resolve all overpayments, incorrect payments, and adjustments.

§ 408.904 How will you receive an underpayment?

We will pay you the amount of any underpayment due you in a separate payment or by increasing the amount of your monthly payment. If you die before we pay you all or any part of an underpayment, the balance of the underpayment reverts to the general fund of the U.S. Treasury.

§ 408.905 Will we withhold or adjust an underpayment to reduce an overpayment if that overpayment occurred in a different period?

We will withhold or adjust any underpayment due you to reduce any overpayment to you that we determine for a different period, unless we have waived recovery of the overpayment under the provisions of §§ 408.910 through 408.914.

WAIVER OF RECOVERY OF SVB OVERPAYMENTS

§ 408.910 When will we waive recovery of an SVB overpayment?

We will waive recovery of an overpayment when:

(a) You are without fault in connection with the overpayment, and

(b) Recovery of such overpayment would either:

(1) Defeat the purpose of the title VIII program, or

(2) Be against equity and good conscience.

(c) We will apply the procedures in this paragraph (c) when an individual requests waiver of all or part of a qualifying overpayment.

(1) For purposes of this paragraph (c), a qualifying overpayment is one that accrued during the *pandemic period* (see § 408.902(b)) because of the actions that we took in response to the COVID–19 national public health emergency, including the suspension of certain of our manual workloads that would have processed actions identifying and stopping certain overpayments.

(2) Notwithstanding any other provision of this subpart, we will presume that an individual who requests waiver of a qualifying overpayment is without fault in causing the overpayment (see § 408.912) unless we determine that the qualifying overpayment made to a beneficiary or a representative payee was the result of fraud or similar fault or involved misuse of benefits by a representative payee (see § 408.641).

(3) If we determine under paragraph (c)(2) of this section that an individual or a representative payee is without fault in causing a qualifying overpayment, we will also determine that recovery of the qualifying overpayment would be against equity and good conscience. For purposes of this paragraph (c)(3) only, ''against equity and good conscience'' is not limited to the meaning used in § 408.914 but means a broad concept of fairness that takes into account all of the facts and circumstances of the case.

(4) The provisions of this paragraph (c) will apply to a qualifying overpayment identified by December 31, 2020.

[69 FR 25955, May 10, 2004, as amended at 85 FR 52914, Aug. 27, 2020]

§ 408.911 What happens when we waive recovery of an SVB overpayment?

Waiver of recovery of an overpayment from you (or, after your death, from your estate) frees you and your estate from the obligation to repay the amount of the overpayment covered by the waiver. *Example:* You filed for waiver of recovery of a $600 overpayment. We found that you are eligible for waiver of recovery of $260 of that amount. Only $340 of the overpayment would be recoverable from you or your estate.

§ 408.912 When are you without fault regarding an overpayment?

(a) *General—when fault is relevant.* If you request waiver of recovery of an overpayment, we must determine whether you were without fault. You are not relieved of liability and are not without fault solely because we may have been at fault in making the overpayment.

(b) *The factors we consider to determine whether you were without fault.* When we determine whether you were without fault, we consider all the pertinent circumstances relating to the overpayment. We consider your understanding of your obligation to give us information affecting your payments, your agreement to report events, your knowledge of the occurrence of events that should have been reported, the efforts you made to comply with the reporting requirements, the opportunities you had to comply with the reporting requirements, your ability to comply with the reporting requirements (e.g., your age, comprehension, memory, physical and mental condition), and your understanding of the obligation to return payments that were not due. In determining whether you are without fault based on these factors, we will take into account any physical, mental, educational, or language limitations (including any lack of facility with the English language) you may have. We will determine that you were at fault if, after considering all of the circumstances, we find that the overpayment resulted from one of the following:

(1) Your failure to furnish information which you knew or should have known was material;

(2) An incorrect statement you made which you knew or should have known was incorrect (this includes furnishing your opinion or conclusion when you were asked for facts), or

(3) You did not return a payment, which you knew, or could have been expected to know, was incorrect.

(c) *Special rule for qualifying overpayments.* Notwithstanding any other provision of this subpart, we will not determine any overpaid individual to be at fault in causing a qualifying overpayment (see § 408.910(c)(1)) unless we determine that the qualifying overpayment made to an individual or a representative payee during the pandemic period (see § 408.902(b)) was the result of fraud or similar fault or involved misuse of benefits by a representative payee (see § 408.641).

[69 FR 25955, May 10, 2004, as amended at 85 FR 52914, Aug. 27, 2020]

§ 408.913 When would overpayment recovery defeat the purpose of the title VIII program?

We will waive recovery of an overpayment when you are without fault (as defined in § 408.912) and recovery of the overpayment would defeat the purpose of the title VIII program. Recovery of an overpayment would defeat the purpose of the title VIII program to the extent that our recovery action would deprive you of income and resources you need to meet your ordinary and necessary living expenses as described in § 404.508(a) of this chapter.

§ 408.914 When would overpayment recovery be against equity and good conscience?

We will waive recovery of an overpayment when you are without fault (as defined in § 408.912) and recovery would be against equity and good conscience. Recovery would be against equity and good conscience if you changed your position for the worse or gave up a valuable right in reliance on our notice that payment would be

made or because of the incorrect payment itself. *Example:* Upon our notice that you are eligible for SVB payments, you signed a lease on an apartment renting for $15 a month more than the one you previously occupied. You were subsequently found ineligible for SVB and no benefits are payable. In this case, recovery of the overpayment would be considered ''against equity and good conscience.''

NOTICES

§ 408.918 What notices will you receive if you are overpaid or underpaid?

(a) *Notice of overpayment or underpayment determination.* Whenever we determine that you were overpaid or underpaid for a given period, as defined in § 408.903, we will send you a written notice of the correct and incorrect amounts you received for each month in the period, even if part or all of the underpayment must be withheld in accordance with § 408.905. The notice of overpayment will advise you about recovery of the overpayment, as explained in §§ 408.920–408.923, and your rights to appeal the determination and to request waiver of recovery of the overpayment under the provisions of § 408.910.

(b) *Notice of waiver determination.* Written notice of an initial determination regarding waiver of recovery will be mailed to you in accordance with § 408.1005 unless you were not given notice of the overpayment in accordance with paragraph (a) of this section.

REFUND OF OVERPAYMENTS

§ 408.920 When will we seek refund of an SVB overpayment?

We will seek refund of an SVB overpayment in every case in which we have not waived recovery. An overpayment may be refunded by you or by anyone on your behalf. If you are receiving SVB currently and you have not refunded the overpayment, adjustment as set forth in § 408.922 will be proposed. If you die before we recover the full overpayment, we will seek refund of the balance from your estate.

ADJUSTMENT OF SVB

§ 408.922 When will we adjust your SVB payments to recover an overpayment?

If you do not refund your overpayment to us, and waiver of recovery is not applicable, we will adjust any SVB payments due you to recover the overpayment. Adjustment will generally be accomplished by withholding each month the amount set forth in § 408.923 from the benefit payable to you.

§ 408.923 Is there a limit on the amount we will withhold from your SVB payments to recover an overpayment?

(a) *Amount of the withholding limit.* Except as provided in paragraphs (b) and (c) of this section, the amount we will withhold from your monthly SVB payment to recover an overpayment is limited to the lesser of (1) the amount of your Federal SVB payment or (2) an amount equal to 10 percent of the maximum SVB monthly payment amount as defined in § 408.505(a).

(b) *Your right to request a different rate of withholding.* When we notify you of the rate we propose to withhold from your monthly SVB payment, we will give you the opportunity to request a higher or lower rate of withholding than that proposed. If you request a rate of withholding that is lower than the one established under paragraph (a) of this section, we will set a rate that is appropriate to your financial condition after we evaluate all the pertinent facts. An appropriate rate is one that will not deprive you of income required for ordinary and necessary living expenses. We will evaluate your income, resources, and expenses as described in § 404.508 of this chapter.

(c) *Fraud, misrepresentation or concealment of material information.* If we determine that there was fraud, willful misrepresentation, or concealment of material information by you in connection with the overpayment, the limits in paragraph (a)(2) of this section do not apply and we will not lower the rate of withholding under paragraph (b) of this section. Concealment of material information means an intentional, knowing, and purposeful delay in making or in failing to make a report that will affect your SVB payment amount

and/or eligibility. It does not include a mere omission on your part; it is an affirmative act to conceal.

ADJUSTMENT OF TITLE II BENEFITS

§ 408.930 Are title II and title XVI benefits subject to adjustment to recover title VIII overpayments?

(a) *Definitions*—(1) *Cross-program recovery*. Cross-program recovery is the process that we will use to collect title VIII overpayments from benefits payable to you under title II or title XVI of the Social Security Act.

(2) *Benefits payable*. For purposes of this section, benefits payable means the amount of title II or title XVI benefits you actually would receive. For title II benefits, it includes your monthly benefit and your past-due benefits after any reductions or deductions listed in § 404.401(a) and (b) of this chapter. For title XVI benefits, it includes your monthly benefit and your past-due benefits as described in § 416.420 of this chapter.

(b) *When may we collect title VIII overpayments using cross-program recovery?* We may use cross-program recovery to collect a title VIII overpayment you owe when benefits are payable to you under title II, title XVI, or both.

[70 FR 15, Jan. 3, 2004]

§ 408.931 How much will we withhold from your title II and title XVI benefits to recover a title VIII overpayment?

(a) If past-due benefits are payable to you, we will withhold the lesser of the entire overpayment balance or the entire amount of past-due benefits.

(b)(1) We will collect the overpayment from current monthly benefits due in a month under title II and title XVI by withholding the lesser of the amount of the entire overpayment balance or:

(i) 10 percent of the monthly title II benefits payable for that month and

(ii) in the case of title XVI benefits, an amount no greater than the lesser of the benefit payable for that month or an amount equal to 10 percent of your income for that month (including such monthly benefit but excluding payments under title II when recovery is also made from title II benefits and excluding income excluded pursuant to §§ 416.1112 and 416.1124 of this chapter).

(2) Paragraph (b)(1) of this section does not apply if:

(i) You request and we approve a different rate of withholding, or

(ii) You or your spouse willfully misrepresented or concealed material information in connection with the overpayment.

(c) In determining whether to grant your request that we withhold less than the amount described in paragraph (b)(1) of this section, we will use the criteria applied under § 408.923 to similar requests about withholding from title VIII benefits.

(d) If you or your spouse willfully misrepresented or concealed material information in connection with the overpayment, we will collect the overpayment by withholding the lesser of the overpayment balance or the entire amount of title II benefits and title XVI benefits payable to you. We will not collect at a lesser rate. (See § 408.923 for what we mean by concealment of material information.)

[70 FR 16, Jan. 3, 2005]

§ 408.932 Will you receive notice of our intention to apply cross-program recovery?

Before we collect an overpayment from you using cross-program recovery, we will send you a written notice that tells you the following information:

(a) We have determined that you owe a specific overpayment balance that can be collected by cross-program recovery;

(b) We will withhold a specific amount from the title II or title XVI benefits (see § 408.931(b));

(c) You may ask us to review this determination that you still owe this overpayment balance;

(d) You may request that we withhold a different amount from your current monthly benefits (the notice will not include this information if § 408.931(d) applies); and

(e) You may ask us to waive collection of this overpayment balance.

[70 FR 16, Jan. 3, 2005]

§ 408.933 When will we begin cross-program recovery from your current monthly benefits?

(a) We will begin collecting the overpayment balance by cross-program recovery from your title II and title XVI current monthly benefits no sooner than 30 calendar days after the date of the notice described in § 408.932. If within that 30-day period you pay us the full overpayment balance stated in the notice, we will not begin cross-program recovery from your current monthly benefits.

(b) If within that 30-day period you ask us to review our determination that you still owe us this overpayment balance, we will not begin cross-program recovery from your current monthly benefits before we review the matter and notify you of our decision in writing.

(c) If within that 30-day period you ask us to withhold a different amount than the amount stated in the notice, we will not begin cross-program recovery from your current monthly benefits until we determine the amount we will withhold. This paragraph does not apply when § 408.931(d) applies.

(d) If within that 30-day period you ask us to waive recovery of the overpayment balance, we will not begin cross-program recovery from your current monthly benefits before we review the matter and notify you of our decision in writing. See §§ 408.910 through 408.914.

[70 FR 16, Jan. 3, 2005]

TAX REFUND OFFSET

§ 408.940 When will we refer an SVB overpayment to the Department of the Treasury for tax refund offset?

(a) *General.* The standards we will apply and the procedures we will follow before requesting the Department of the Treasury to offset income tax refunds due you to recover outstanding overpayments are set forth in §§ 408.940 through 408.946 of this subpart. These standards and procedures are authorized by 31 U.S.C. 3720A, as implemented through Department of the Treasury regulations at 31 CFR 285.2.

(b) We will use the Department of the Treasury tax refund offset procedure to collect overpayments that are certain in amount, past due and legally enforceable and eligible for tax refund offset under regulations issued by the Secretary of the Treasury. We will use these procedures to collect overpayments from you only when you are not currently entitled to monthly SVB under title VIII of the Act, and we are not recovering your SVB overpayment from your monthly benefits payable under title II of the Act. We refer overpayments to the Department of the Treasury for offset against Federal tax refunds regardless of the amount of time the debts have been outstanding.

[69 FR 25955, May 10, 2004, as amended at 76 FR 65108, Oct. 20, 2011]

§ 408.941 Will we notify you before we refer an SVB overpayment for tax refund offset?

Before we request that an overpayment be collected by reduction of Federal and State income tax refunds, we will send a written notice of our action to the overpaid person. In our notice of intent to collect an overpayment through tax refund offset, we will state:

(a) The amount of the overpayment; and

(b) That we will collect the overpayment by requesting that the Department of the Treasury reduce any amounts payable to the overpaid person as refunds of Federal and State income taxes by an amount equal to the amount of the overpayment unless, within 60 calendar days from the date of our notice, the overpaid person:

(1) Repays the overpayment in full; or

(2) Provides evidence to us at the address given in our notice that the overpayment is not past due or legally enforceable; or

(3) Asks us to waive collection of the overpayment under section 204(b) of the Act.

(c) The conditions under which we will waive recovery of an overpayment under section 808(c) of the Act;

(d) That we will review any evidence presented that the overpayment is not past due or not legally enforceable;

(e) That you have the right to inspect and copy our records related to the overpayment as determined by us and you will be informed as to where and

when the inspection and copying can be done after we receive notice from you requesting inspection and copying.

[69 FR 25955, May 10, 2004, as amended at 76 FR 65108, Oct. 20, 2011]

§ 408.942 Will you have a chance to present evidence showing that the overpayment is not past due or is not legally enforceable?

(a) *Notification.* If you receive a notice as described in § 408.941 of this subpart, you have the right to present evidence that all or part of the overpayment is not past due or not legally enforceable. To exercise this right, you must notify us and present evidence regarding the overpayment within 60 calendar days from the date of our notice.

(b) *Submission of evidence.* You may submit evidence showing that all or part of the debt is not past due or not legally enforceable as provided in paragraph (a) of this section. Failure to submit the notification and evidence within 60 calendar days will result in referral of the overpayment to the Department of the Treasury, unless, within this 60-day time period, you ask us to waive collection of the overpayment under § 408.910 and we have not yet determined whether we can grant the waiver request. If you ask us to waive collection of the overpayment, we may ask you to submit evidence to support your request.

(c) *Review of the evidence.* If you submit evidence on a timely basis, we will consider all available evidence related to the overpayment. We will make findings based on a review of the written record, unless we determine that the question of indebtedness cannot be resolved by a review of the documentary evidence.

(d) *Written findings.* We will issue our written findings including supporting rationale to you, your attorney or other representative. The findings will be our final action with respect to the past-due status and enforceability of the overpayment.

§ 408.943 What happens after we make our determination on your request for review or your request for waiver?

(a) If we make a determination that all or part of the overpayment is past due and legally enforceable and/or your waiver request cannot be granted, we will refer the overpayment to the Department of the Treasury for recovery from any Federal income tax refund due you. We will not suspend our referral of the overpayment to the Department of the Treasury under § 408.945 of this subpart pending any further administrative review of the waiver determination that you may seek.

(b) We will not refer the overpayment to the Department of the Treasury if we reverse our prior finding that the overpayment is past due and legally enforceable or, upon consideration of a waiver request, we determine that waiver of recovery of the overpayment is appropriate.

§ 408.944 How can you review our records related to an SVB overpayment?

(a) *What you must do.* If you intend to inspect or copy our records related to the overpayment, you must notify us stating your intention to inspect or copy.

(b) *What we will do.* If you notify us that you intend to inspect or copy our records related to the overpayment as described in paragraph (a) of this section, we will notify you of the location and time when you may do so. We may also, at our discretion, mail copies of the overpayment-related records to you.

§ 408.945 When will we suspend tax refund offset?

If, within 60 days of the date of the notice described in § 408.941 of this subpart, you notify us that you are exercising a right described in § 408.942(a) of this subpart and submit evidence pursuant to § 408.942(b) of this subpart or request a waiver under § 408.910 of this subpart, we will suspend any notice to the Department of the Treasury until we have issued written findings that affirm that an overpayment is past due and legally enforceable and, if applicable, make a determination that a waiver request cannot be granted.

§ 408.946 What happens if your tax refund is insufficient to cover the amount of your SVB overpayment?

If your tax refund is insufficient to recover an overpayment in a given year, the case will remain with the Department of the Treasury for succeeding years, assuming that all criteria for certification are met at that time.

COMPROMISE SETTLEMENTS, OR SUSPENSIONS OR TERMINATION OF COLLECTION

§ 408.950 Will we accept a compromise settlement of an overpayment debt or suspend or terminate collection of an overpayment?

(a) *General.* If we find that you do not, or your estate does not, have the present or future ability to pay the full amount of the overpayment within a reasonable time or the cost of collection is likely to exceed the amount of recovery, we may take any of the following actions, as appropriate.

(1) We may accept a compromise settlement (payment of less than the full amount of the overpayment) to discharge the entire overpayment debt.

(2) We may suspend our efforts to collect the overpayment.

(3) We may terminate our efforts to collect the overpayment.

(b) *Rules we apply.* In deciding whether to take any of the actions described in paragraph (a) of this section, we will apply the rules in §404.515(b), (c), (d), (e), and (f) of this chapter and other applicable rules, including the Federal Claims Collection Standards (31 CFR 900.3 and parts 902 and 903).

(c) *Effect of compromise, suspension or termination.* When we suspend or terminate collection of the overpayment debt, we may take collection action in the future in accordance with provisions of the Social Security Act, other laws, and the standards set forth in 31 CFR chapter IX. A compromise settlement satisfies the obligation to repay the overpayment if you or your estate comply with the terms of the settlement. Failure to make payment in the manner and within the time that we require in the settlement will result in reinstatement of our claim for the full amount of the overpayment less any amounts paid.

Subpart J—Determinations and the Administrative Review Process

AUTHORITY: Secs. 702(a)(5) and 809 of the Social Security Act (42 U.S.C. 902(a)(5) and 1009).

SOURCE: 69 FR 25955, May 10, 2004, unless otherwise noted.

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

§ 408.1000 What is this subpart about?

(a) *Explanation of the administrative review process.* This subpart explains the procedures we follow in determining your appeal rights under title VIII of the Social Security Act. The regulations describe the process of administrative review and explain your right to judicial review after you have taken all the necessary administrative steps. The administrative review process consists of several steps, which usually must be requested within certain time periods and in the following order:

(1) *Initial determination.* This is a determination we make about whether you qualify for and can become entitled to SVB or whether your SVB entitlement can continue. It can also be about any other matter, as discussed in §408.1003, that gives you a right to further review.

(2) *Reconsideration.* If you are dissatisfied with an initial determination, you may ask us to reconsider it.

(3) *Hearing before an administrative law judge.* If you are dissatisfied with the reconsideration determination, you may request a hearing before an administrative law judge.

(4) *Appeals Council review.* If you are dissatisfied with the decision of the administrative law judge, you may request that the Appeals Council review the decision.

(5) *Federal court review.* When you have completed the steps of the administrative review process listed in paragraphs (a)(1) through (a)(4) of this section, we will have made our final decision. If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court.

(6) *Expedited appeals process.* At some time after your initial determination has been reviewed, if you have no dispute with our findings of fact and our application and interpretation of the controlling laws, but you believe that a part of the law is unconstitutional, you may use the expedited appeals process. This process permits you to go directly to a Federal district court so that the constitutional issue may be resolved.

(b) *Nature of the administrative review process.* In making a determination or decision in your case, we conduct the administrative review process in an informal, nonadversary manner. In each step of the review process, you may present any information you feel is helpful to your case. Subject to the limitations on Appeals Council consideration of additional evidence, we will consider at each step of the review process any information you present as well as all the information in our records. You may present the information yourself or have someone represent you, including an attorney. If you are dissatisfied with our decision in the review process, but do not take the next step within the stated time period, you will lose your right to further administrative review and your right to judicial review, unless you can show us that there was good cause for your failure to make a timely request for review.

§ 408.1001 Definitions.

As used in this subpart:

Date you receive notice means 5 days after the date on the notice, unless you show us that you did not receive it within the 5-day period.

Decision means the decision made by an administrative law judge or the Appeals Council.

Determination means the initial determination or the reconsidered determination.

Mass change means a State-initiated change in the level(s) of federally administered State recognition payments applicable to all recipients of such payments due, for example, to State legislative or executive action.

Preponderance of the evidence means such relevant evidence that as a whole shows that the existence of the fact to be proven is more likely than not.

Remand means to return a case for further review.

SVB, for purposes of this subpart, includes qualification for SVB, entitlement to SVB and payments of SVB.

Vacate means to set aside a previous action.

Waive means to give up a right knowingly and voluntarily.

We, us, or *our* refers to the Social Security Administration.

You or *your* refers to any person claiming or receiving SVB.

[69 FR 25955, May 10, 2004, as amended at 73 FR 76944, Dec. 18, 2008]

§ 408.1002 What is an initial determination?

Initial determinations are the determinations we make that are subject to administrative and judicial review. The initial determination will state the important facts and give the reasons for our conclusions. We will base our initial determination on the preponderance of the evidence.

[69 FR 25955, May 10, 2004, as amended at 73 FR 76944, Dec. 18, 2008]

§ 408.1003 Which administrative actions are initial determinations?

Initial determinations regarding SVB include, but are not limited to, determinations about—

(a) Whether you qualify for SVB;

(b) Whether you are entitled to receive SVB payments on the basis of your residence outside the United States;

(c) The amount of your SVB payments;

(d) Suspension or reduction of your SVB payments;

(e) Termination of your SVB entitlement;

(f) Whether an overpayment of benefits must be repaid to us;

(g) Whether payments will be made, on your behalf, to a representative payee, unless you are legally incompetent;

(h) Who will act as your payee if we determine that representative payment will be made;

(i) A claim for benefits under § 408.351 based on alleged misinformation; and

(j) Our calculation of the amount of change in your federally administered State recognition payment amount

(*i.e.*, a reduction, suspension, or termination) which results from a mass change as defined in § 408.1001.

[69 FR 25955, May 10, 2004; 69 FR 45586, July 30, 2004]

§ 408.1004 Which administrative actions are not initial determinations?

Administrative actions that are not initial determinations may be reviewed by us, but they are not subject to the administrative review process provided by this subpart and they are not subject to judicial review. These actions include, but are not limited to, an action about—

(a) Denial of a request to be made your representative payee;

(b) Denial of your request to use the expedited appeals process;

(c) Denial of your request to reopen a determination or a decision;

(d) Disqualifying or suspending a person from acting as your representative in a proceeding before us;

(e) Denial of your request to extend the time period for requesting review of a determination or a decision;

(f) Denial of your request to readjudicate your claim and apply an Acquiescence Ruling;

(g) Declining under § 408.351(f) to make a determination on a claim for benefits based on alleged misinformation because one or more of the conditions specified in § 408.351(f) are not met;

(h) Findings on whether we can collect an overpayment by using the Federal income tax refund offset procedure. (See § 408.943).

(i) The determination to reduce, suspend, or terminate your federally administered State recognition payments due to a State-initiated mass change, as defined in § 408.1001, in the levels of such payments, except as provided in § 408.1003(h).

§ 408.1005 Will we mail you a notice of the initial determination?

(a) We will mail a written notice of the initial determination to you at your last known address. Generally, we will not send a notice if your benefits are stopped because of your death, or if the initial determination is a redetermination that your eligibility for benefits and the amount of your benefits have not changed.

(b) The notice that we send will tell you—

(1) What our initial determination is;

(2) The reasons for our determination; and

(3) What rights you have to a reconsideration of the determination.

(c) If our initial determination is that we must suspend, reduce your SVB payments or terminate your SVB entitlement, the notice will also tell you that you have a right to a reconsideration before the determination takes effect (see § 408.820).

§ 408.1006 What is the effect of an initial determination?

An initial determination is binding unless you request a reconsideration within the stated time period, or we revise the initial determination.

RECONSIDERATION

§ 408.1007 What is reconsideration?

Reconsideration is the first step in the administrative review process that we provide if you are dissatisfied with the initial determination. If you are dissatisfied with our reconsideration determination, you may request a hearing before an administrative law judge.

§ 408.1009 How do you request reconsideration?

(a) *When you must file your request.* We will reconsider an initial determination if you file a written request within 60 days after the date you receive notice of the initial determination (or within the extended time period if we extend the time as provided in paragraph (c) of this section).

(b) *Where to file your request.* You can file your request for reconsideration at:

(1) Any of our offices;

(2) The Veterans Affairs Regional Office in the Philippines;

(3) An office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry; or

(4) A competent authority or agency of a country with which the United States has a totalization agreement (see § 404.1927 of this chapter).

(c) *When we will extend the time period to request a reconsideration.* If you want a reconsideration of the initial determination but do not request one within 60 days after the date you receive notice of the initial determination, you may ask us for more time to request a reconsideration. You must make your request in writing and explain why it was not filed within the stated time period. If you show us that you had good cause for missing the deadline, we will extend the time period. To determine whether good cause exists, we use the standards explained in § 408.1011.

§ 408.1011 How do we determine whether you had good cause for missing the deadline to request review?

(a) In determining whether you have shown that you have good cause for missing a deadline to request review we consider—

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeals Council review or filed a civil suit.

(6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.

(7) You did not receive notice of the initial determination or decision.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.

§ 408.1013 What are the methods for reconsideration?

If you request reconsideration, we will give you a chance to present your case. How you can present your case depends upon the issue involved and whether you are asking us to reconsider an initial determination on an application or an initial determination on an SVB suspension, reduction or termination action. The methods of reconsideration include the following:

(a) *Case review.* We will give you an opportunity to review the evidence in our files and then to present oral and written evidence to us. We will then make a decision based on all of this evidence. The official who reviews the case will make the reconsidered determination.

(b) *Informal conference.* In addition to following the procedures of a case review, an informal conference allows you an opportunity to present witnesses. A summary record of this proceeding will become part of the case record. The official who conducts the informal conference will make the reconsidered determination.

(c) *Formal conference.* In addition to following the procedures of an informal conference, a formal conference allows you an opportunity to request us to subpoena adverse witnesses and relevant documents and to cross-examine adverse witnesses. A summary record

of this proceeding will become a part of the case record. The official who conducts the formal conference will make the reconsidered determination.

§ 408.1014 What procedures apply if you request reconsideration of an initial determination on your application for SVB?

When you appeal an initial determination on your application for benefits, we will offer you a case review, and will make our determination on the basis of that review.

§ 408.1015 What procedures apply if you request reconsideration of an initial determination that results in suspension, reduction, or termination of your SVB?

If you have been entitled to SVB and we notify you that we are going to suspend, reduce or terminate your benefit payments, you can appeal our determination within 60 days of the date you receive our notice. The 60-day period may be extended if you have good cause for an extension of time under the conditions stated in § 408.1011(b). If you appeal, you have the choice of a case review, informal conference or formal conference.

§ 408.1016 What happens if you request a conference?

(a) As soon as we receive a request for a formal or informal conference, we will set the time, date and place for the conference. Formal and informal conferences are held only in the United States.

(b) We will send you a written notice about the conference (either by mailing it to your last known address or by personally serving you with it) at least 10 days before the conference. However, we may hold the conference sooner if we all agree. We will not send written notice of the time, date, and place of the conference if you waive your right to receive it.

(c) We will schedule the conference within 15 days after you request it, but, at our discretion or at your request, we will delay the conference if we think the delay will ensure that the conference is conducted efficiently and properly.

(d) We will hold the conference at one of our offices in the United States, by telephone or in person, whichever you prefer. However, if you are outside the United States, we will hold the conference by telephone only if you request that we do so and time and language differences permit. We will hold the conference in person elsewhere in the United States if you show circumstances that make this arrangement reasonably necessary.

§ 408.1020 How do we make our reconsidered determination?

After you request a reconsideration, we will review the evidence considered in making the initial determination and any other evidence we receive. We will make our determination based on the preponderance of the evidence in the record. The person who makes the reconsidered determination will have had no prior involvement with the initial determination.

[69 FR 25955, May 10, 2004, as amended at 73 FR 76944, Dec. 18, 2008]

§ 408.1021 How does the reconsidered determination affect you?

The reconsidered determination is binding unless—

(a) You request a hearing before an administrative law judge within the stated time period and a decision is made;

(b) The expedited appeals process is used; or

(c) The reconsidered determination is revised.

§ 408.1022 How will we notify you of our reconsidered determination?

We will mail a written notice of the reconsidered determination to you at your last known address. We will state the specific reasons for the determination and tell you about your right to a hearing. If it is appropriate, we will also tell you how to use the expedited appeals process.

EXPEDITED APPEALS PROCESS

§ 408.1030 When can you use the expedited appeals process?

(a) *General rules.* Under the expedited appeals process (EAP), you may go directly to a Federal District Court without first completing the administrative review process. For purposes of this

part, we use the same EAP rules we use in the title XVI program (see §§ 416.1423–416.1428 of this chapter) except as noted in paragraph (b) of this section.

(b) *Exceptions.* In § 416.1425, the words ''one of our offices'' in paragraph (b) are deemed to read ''any of the offices listed in § 408.1009(b)'' and the reference in the last sentence of paragraph (c) to ''§ 416.1411'' is deemed to read ''§ 408.1011.''

HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

§ 408.1040 When can you request a hearing before an administrative law judge (ALJ)?

(a) *General rules.* For purposes of this part, we use the same rules on hearings before an administrative law judge (ALJ) that we use in the title XVI program (*see* §§ 416.1429–1416.1440 of this chapter), except as noted in paragraph (b) of this section.

(b) *Exceptions.* In § 416.1433, the words ''one of our offices'' in paragraph (b) are deemed to read ''any of the offices listed in § 408.1009(b)'' and the reference in the last sentence of § 416.1433(c) to ''§ 416.1411'' is deemed to read ''§ 408.1011.''

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

§ 408.1045 What procedures apply if you request an ALJ hearing?

(a) *General rules.* For purposes of this part, we use the same rules on ALJ hearing procedures that we use in the title XVI program (see §§ 416.1444–416.1461 of this chapter), except as noted in paragraph (b) of this section.

(b) *Exceptions.* (1) In § 416.1446(b)(1), the last sentence does not apply under this part.

(2) In § 416.1452(a)(1)(i), the words ''supplemental security income'' are deemed to read ''SVB.''

(3) In § 416.1457, the provisions of paragraph (c)(4) do not apply under this part.

APPEALS COUNCIL REVIEW

§ 408.1050 When can you request Appeals Council review of an ALJ hearing decision or dismissal of a hearing request?

(a) *General rules.* For purposes of this part, we use the same rules on Appeals Council review that we use in the title XVI program (see §§ 416.1467–416.1482 of this chapter), except as noted in paragraph (b) of this section.

(b) *Exceptions.* (1) In § 416.1468(b), the words ''one of our offices'' in the third sentence are deemed to read ''any of the offices listed in § 408.1009(b).''

(2) In § 416.1469(d), the last sentence does not apply under this part.

(3) In § 416.1471, paragraph (b) does not apply under this part.

(4) In § 416.1482, the reference to ''§ 416.1411'' in the last sentence is deemed to read ''§ 408.1011.''

COURT REMAND CASES

§ 408.1060 What happens if a Federal Court remands your case to the Commissioner?

For purposes of this part, we use the same rules on court remand cases that we use in the title XVI program (see §§ 416.1483–416.1485 of this chapter).

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

§ 408.1070 When will we reopen a final determination?

(a) *General rules.* For purposes of this part, we use the same rules on reopening and revising determinations and decisions that we use in the title XVI program (see §§ 416.1487–416.1494 of this chapter), except as noted in paragraph (b) of this section.

(b) *Exceptions.* (1) In addition to the rule stated in § 416.1488, a determination, revised determination, or revised decision may be reopened at any time if it was fully or partially unfavorable to you, but only to correct—

(i) A clerical error; or

(ii) An error that appears on the face of the evidence that we considered when we made the determination or decision.

(2) In § 416.1492(b), the parenthetical clause is deemed to read ''(see

§ 408.820),'' and paragraph (d) does not apply to this part.

(3) In § 416.1494, the words ''one of our offices'' in the first sentence are deemed to read ''any of the offices listed in § 408.1009(b).''

[69 FR 25955, May 10, 2004, as amended at 75 FR 44138, July 28, 2010]

Subpart K—Representation of Parties

AUTHORITY: Secs. 702(a)(5) and 810(a) of the Social Security Act (42 U.S.C. 902(a)(5) and 1010(a)).

SOURCE: 69 FR 25955, May 10, 2004, unless otherwise noted.

§ 408.1101 Can you appoint someone to represent you?

(a) *General rules.* You may appoint someone to represent you in any of your dealings with us. For purposes of this part, the rules on representation of parties in §§ 416.1500–416.1505, 416.1507–416.1515 and 416.1540–416.1599 of this chapter apply except as noted in paragraph (b) of this section.

(b) *Exceptions.* For purposes of this part:

(1) In § 416.1500, paragraph (c) does not apply.

(2) The last sentence of § 416.1503 is deemed to read: ''You refers to any person claiming or receiving SVB.''

(3) In § 416.1507(c), the words ''one of our offices'' are deemed to read ''any of the offices listed in § 408.1009(b).''

(4) In § 416.1510(b), the reference to ''title XVI of the Act'' is deemed to read ''title VIII of the Act,'' and the reference to ''§ 416.315'' is deemed to read ''§ 408.315.''

(5) In § 416.1540, the parenthetical clause in paragraph (b), the second sentences in paragraphs (b)(1) and (b)(2), and paragraph (c)(2) do not apply, and the references to ''§ 416.1411(b)'' in paragraphs (c)(4) and (c)(7)(i) are deemed to read ''§ 408.1011(b).''

(6) In § 416.1545, paragraph (c) does not apply.

(7) In § 416.1599, paragraph (d) is deemed to read: ''The Appeals Council will not grant the request unless it is reasonably satisfied that the person will in the future act according to the provisions of our regulations.''

Subpart L—Federal Administration of State Recognition Payments

AUTHORITY: Secs. 702(a)(5) and 810A of the Social Security Act (42 U.S.C. 902(a)(5) and 1010a).

SOURCE: 69 FR 25955, May 10, 2004, unless otherwise noted.

§ 408.1201 What are State recognition payments?

(a) *State recognition payments; defined.* State recognition payments are any payments made by a State or one of its political subdivisions to an individual who is entitled to SVB, if the payments are made:

(1) As a supplement to monthly SVB payments; and

(2) Regularly, on a periodic recurring, or routine basis of at least once a quarter; and

(3) In cash, which may be actual currency, or any negotiable instrument convertible into cash upon demand.

(b) *State; defined.* For purposes of this subpart, State means a State of the United States or the District of Columbia.

§ 408.1205 How can a State have SSA administer its State recognition payment program?

A State (or political subdivision) may enter into a written agreement with SSA, under which SSA will make recognition payments on behalf of the State (or political subdivision). The regulations in effect for the SVB program also apply in the Federal administration of State recognition payments except as necessary for the effective and efficient administration of both the SVB program and the State's recognition payment program.

§ 408.1210 What are the essential elements of an administration agreement?

(a) *Payments.* The agreement must provide that recognition payments can only be made to individuals who are receiving SVB payments.

(b) *Administrative costs*—(1) *General rule.* SSA will assess each State that elects Federal administration of its recognition payments an administration fee for administering those payments.

(2) *Determining the administration fee.* The administration fee is assessed and paid monthly and is derived by multiplying the number of State recognition payments we make on behalf of a State for any month in a fiscal year by the applicable dollar rate for the fiscal year. The number of recognition payments we make in a month is the total number of checks we issue, and direct deposits we make, to recipients in that month, that are composed in whole or in part of State recognition funds. The dollar amounts are as follows:

(i) For fiscal year 2001, $8.10;

(ii) For fiscal year 2002, $8.50; and

(iii) For fiscal year 2003 and each succeeding fiscal year—

(A) The applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

(B) A different rate if the Commissioner determines the different rate is appropriate for the State considering the complexity of administering the State's recognition payment program.

(c) *Agreement period.* The agreement period for a State that has elected Federal administration of its recognition payments extends for one year from the date the agreement was signed unless otherwise designated in the agreement. The agreement will be automatically renewed for a period of one year unless either the State or SSA gives written notice not to renew, at least 90 days before the beginning of the new period. For a State to elect Federal administration of its recognition payment program, it must notify SSA of its intent to enter into an agreement, furnishing the necessary payment specifications, at least 120 days before the first day of the month for which it wishes Federal administration to begin, and have executed such agreement at least 30 days before such day.

(d) *Modification or termination.* The agreement may be modified at any time by mutual consent. The State or SSA may terminate the agreement upon 90 days' written notice to the other party, provided the effective date of the termination is the last day of a quarter. However, the State may terminate the agreement upon 45 days written notice to SSA if: (1) The State does not wish to comply with a regulation promulgated by SSA after the execution of the agreement; and (2) the State provides its written notice within 30 days of the effective date of the regulation. The Commissioner is not precluded from terminating the agreement in less than 90 days if the State has failed to materially comply with the provisions of § 408.1235 on State transfer of funds to SSA.

§ 408.1215 How do you establish eligibility for Federally administered State recognition payments?

(a) *Applications.* When you file an application for SVB under subpart C of this part, you are deemed to have filed an application for any Federally administered State recognition payments for which you may be eligible unless you waive your right to such payments as provided for in § 408.1230. However, you will be required to give us a supplemental statement if additional information is necessary to establish your eligibility or to determine the correct amount of your State recognition payment.

(b) *Evidence requirements.* The evidence requirements and developmental procedures of this part also apply with respect to Federally administered State recognition payments.

(c) *Determination.* Where not inconsistent with the provisions of this subpart, we determine your eligibility for and the amount of your State recognition payment using the rules in subparts A through K of this part.

§ 408.1220 How do we pay Federally administered State recognition payments?

(a) *Payment procedures.* We make Federally administered State recognition payments on a monthly basis and we include them in the same check as your SVB payment. The State recognition payment is for the same month as your SVB payment.

(b) *Maximum amount.* Except as specified in paragraph (c) of this section, there is no restriction on the amount

of a State recognition payment that SSA will administer on behalf of a State.

(c) *Minimum amount.* SSA will not administer State recognition payments in amounts less than $1 per month. Hence, recognition payment amounts of less than $1 will be raised to a dollar.

§ 408.1225 What happens if you receive an overpayment?

If we determine that you received an overpayment, we will adjust future Federally administered State recognition payments you are entitled to. Our rules and requirements (see §§ 408.910 through 408.941) that apply to recovery (or waiver) of SVB overpayments also apply to the recovery (or waiver) of Federally administered State recognition overpayments. If your entitlement to State recognition payments ends before you have repaid the overpayment, we will annotate your record (specifying the amount of the overpayment) to permit us to recoup the overpaid amount if you become reentitled to recognition payments from the same State.

§ 408.1226 What happens if you are underpaid?

If we determine that you are due an underpayment of State recognition payments, we will pay the amount you were underpaid directly to you, or to your representative.

§ 408.1230 Can you waive State recognition payments?

(a) *Waiver request in writing.* You may waive your right to receive State recognition payments if you make a written request. If you make your request before you become entitled to SVB, you will not be entitled to State recognition payments. If you make your request after you become entitled to SVB, your request will be effective with the month we receive your request, or with an earlier month if you refund to us the amount of any recognition payment(s) we made to you for the earlier period.

(b) *Cancelling your waiver.* You may cancel your waiver of State recognition payments at any time by making a written request with us. The cancellation will be effective the month in which it is filed. The date your request is received in a Social Security office or the postmarked date, if the written request was mailed, will be the filing date, whichever is earlier.

§ 408.1235 How does the State transfer funds to SSA to administer its recognition payment program?

(a) *Payment transfer and adjustment.* (1) Any State that has entered into an agreement with SSA which provides for Federal administration of such State's recognition payments will transfer to SSA:

(i) An amount of funds equal to SSA's estimate of State recognition payments for any month which will be made by SSA on behalf of such State; and

(ii) An amount of funds equal to SSA's estimate of administration fees for any such month determined in the manner described in § 408.1210(b).

(3) In order for SSA to make State recognition payments on behalf of a State for any month as provided by the agreement, the estimated amount of State funds referred to in paragraph (a)(1)(i) of this section together with the estimated amount of administration fees referred to in paragraph (a)(1)(ii) of this section, for that month, must be on deposit with SSA on the State recognition payment transfer date, which is:

(i) the business day preceding the date that the Commissioner pays such monthly recognition payments; or

(ii) with respect to such monthly payments paid for the month that is the last month of the State's fiscal year, the fifth business day following such date.

(b) *Accounting of State funds.* (1) As soon as feasible after the end of each calendar month, SSA will provide the State with a statement showing, cumulatively, the total amounts paid by SSA on behalf of the State during the current Federal fiscal year; the fees charged by SSA to administer such recognition payments; the State's total liability; and the end-of-month balance of the State's cash on deposit with SSA.

(2) SSA will provide the State with an accounting of State funds received

as State recognition payments and administration fees within three calendar months following the termination of an agreement under §408.1210(d).

(3) Adjustments will be made because of State funds due and payable or amounts of State funds recovered for calendar months for which the agreement was in effect. Interest will be incurred by SSA and the States with respect to the adjustment and accounting of State recognition payments funds in accordance with applicable laws and regulations of the United States Department of the Treasury.

(c) *State audit.* Any State entering into an agreement with SSA which provides for Federal administration of the State's recognition payments has the right to an audit (at State expense) of the payments made by SSA on behalf of such State. The Commissioner and the State shall mutually agree upon a satisfactory audit arrangement to verify that recognition payments paid by SSA on behalf of the State were made in accordance with the terms of the administration agreement under §408.1205. Audit findings will be resolved in accordance with the provisions of the State's agreement with SSA.

PART 411—THE TICKET TO WORK AND SELF-SUFFICIENCY PROGRAM

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Subpart I—Ticket to Work Program Dispute Resolution

DISPUTES BETWEEN BENEFICIARIES AND EMPLOYMENT NETWORKS

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DISPUTES BETWEEN BENEFICIARIES AND STATE VR AGENCIES

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DISPUTES BETWEEN EMPLOYMENT NETWORKS AND PROGRAM MANAGERS

411.650 Is there a process for resolving disputes between ENs that are not State VR agencies and PMs, other than disputes on a payment request?
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AUTHORITY: Secs. 702(a)(5) and 1148 of the Social Security Act (42 U.S.C. 902(a)(5) and 1320b–19); sec. 101(b)–(e), Public Law 106–170, 113 Stat. 1860, 1873 (42 U.S.C. 1320b–19 note).

SOURCE: 66 FR 67420, Dec. 28, 2001, unless otherwise noted.

Subpart A—Introduction

§ 411.100 Scope.

The regulations in this part 411 relate to the provisions of section 1148 of the Social Security Act which establishes the Ticket to Work and Self-Sufficiency Program (hereafter referred to as the ''Ticket to Work program''). The regulations in this part are divided into ten subparts:

(a) Subpart A explains the scope of this part, explains the purpose and manner of implementation of the Ticket to Work program, and provides definitions of terms used in this part.

(b) Subpart B contains provisions relating to the ticket under the Ticket to Work program.

(c) Subpart C contains provisions relating to the suspension of continuing disability reviews for disabled beneficiaries who are considered to be using a ticket.

(d) Subpart D contains provisions relating to the use of one or more program managers to assist us in the administration of the Ticket to Work program.

(e) Subpart E contains provisions relating to employment networks in the Ticket to Work program.

(f) Subpart F contains provisions relating to State vocational rehabilitation agencies' participation in the Ticket to Work program.

(g) Subpart G contains provisions relating to individual work plans in the Ticket to Work program.

(h) Subpart H contains provisions establishing employment network payment systems.

(i) Subpart I contains provisions that establish a procedure for resolving disputes under the Ticket to Work program.

[66 FR 67420, Dec. 28, 2001, as amended at 83 FR 62459, Dec. 4, 2018]

§ 411.105 What is the purpose of the Ticket to Work program?

The purpose of the Ticket to Work program is to expand the universe of service providers available to individuals who are entitled to Social Security benefits based on disability or eligible for Supplemental Security Income (SSI) benefits based on disability or blindness in obtaining the services necessary to find, enter and retain employment. Expanded employment opportunities for these individuals also will increase the likelihood that these individuals will reduce their dependency on Social Security and SSI cash benefits.

§ 411.115 Definitions of terms used in this part.

As used in this part:

(a) *The Act* means the Social Security Act, as amended.

(b) *Commissioner* means the Commissioner of Social Security.

(c) *Cost reimbursement payment system* means the provisions for payment for vocational rehabilitation services under subpart V of part 404 and subpart V of part 416 of this chapter.

(d) *Disabled beneficiary* means a title II disability beneficiary or a title XVI disability beneficiary.

(e) *Employment network* or *EN* means a qualified public or private entity that has entered into an agreement with us to serve under the Ticket to Work program and that assumes responsibility for the coordination and delivery of employment services, vocational rehabilitation services, or other support services to beneficiaries assigning tickets to it. The rules on employment networks are described in subpart E of this part (§§ 411.300–411.330). A State vocational rehabilitation agency may choose, on a case-by-case basis, to function as an employment network with respect to a beneficiary under the Ticket to Work program. The rules on State vocational rehabilitation agencies' participation in the Ticket to Work program are described in subpart F of this part (§§ 411.350–411.435).

(f) *Employment plan* means an individual work plan described in paragraph (i) of this section, or an individualized plan for employment described in paragraph (j) of this section.

(g) *Federal SSI cash benefits* means a ''Supplemental Security Income benefit under title XVI'' based on blindness or disability as described in paragraphs (n) and (r) of this section.

(h) *I*, *my*, *you*, or *your* means the disabled beneficiary.

(i) *Individual work plan* or *IWP* means an employment plan under which an employment network (other than a State vocational rehabilitation agency) provides services to a disabled beneficiary under the Ticket to Work program. An individual work plan must be developed under, and meet the requirements of, the rules in subpart G of this part (§§ 411.450–411.470).

(j) *Individualized plan for employment* or *IPE* means an employment plan under which a State vocational rehabilitation agency provides services to individuals with disabilities (including beneficiaries assigning tickets to it under the Ticket to Work program) under a State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*). An individualized plan for employment must

be developed under, and meet the requirements of, 34 CFR 361.45 and 361.46.

(k) *Program manager* or *PM* means an organization in the private or public sector that has entered into a contract with us to assist us in administering the Ticket to Work program. The rules on the use of one or more program managers to assist us in administering the program are described in subpart D of this part (§§ 411.230–411.250).

(l) *Social Security disability benefits* means the benefits described in paragraph (q) of this section.

(m) *State vocational rehabilitation agency* or *State VR agency* means a State agency administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*). In those States that have one agency that provides VR services to non-blind individuals and another agency that provides services to blind individuals, this term refers to either State agency.

(n) *Supplemental Security Income benefit under title XVI* means a cash benefit under section 1611 or 1619(a) of the Act, and does not include a State supplementary payment, administered Federally or otherwise.

(o) *Ticket* means a document described in § 411.120 which the Commissioner may issue to disabled beneficiaries for participation in the Ticket to Work program.

(p) *Ticket to Work program* or *program* means the Ticket to Work and Self-Sufficiency Program under section 1148 of the Act.

(q) *Title II disability beneficiary* means an individual entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 of the Act based on such individual's disability as defined in section 223(d) of the Act. (See § 404.1505 of this chapter.) An individual is a title II disability beneficiary for each month for which such individual is entitled to such benefits.

(r) *Title XVI disability beneficiary* means an individual eligible for Supplemental Security Income benefits under title XVI on the basis of blindness (within the meaning of section 1614(a)(2) of the Act) (see §§ 416.981 and 416.982 of this chapter) or disability (within the meaning of section 1614(a)(3) of the Act) (see § 416.905 of this chapter). An individual is a title XVI disability beneficiary for each month for which such individual is eligible for such benefits.

(s) *VR cost reimbursement option* means an arrangement under which your ticket is not assigned to the State VR agency but you do receive services pursuant to an individualized plan for employment where the State VR agency has chosen to receive payment under the cost reimbursement payment system.

(t) *We* or *us* means the Social Security Administration.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29338, May 20, 2008; 83 FR 62459, Dec. 4, 2018]

Subpart B—Tickets Under the Ticket to Work Program

§ 411.120 What is a ticket under the Ticket to Work program?

(a) A ticket under the Ticket to Work program is a document which provides evidence of the Commissioner's agreement to pay, under the rules in subpart H of this part, an employment network (EN) or a State VR agency to which a disabled beneficiary's ticket is assigned, for providing employment services, vocational rehabilitation services, and other support services to the beneficiary.

(b) The left side of the ticket includes the beneficiary's name, ticket number, claim account number, and the date we issued the ticket. The ticket number is 12 characters and comprises the beneficiary's own social security number, the letters ''TW,'' and a number (1, 2, etc.) in the last position signifying that this is the first ticket, second ticket, etc., that the beneficiary has received.

(c) The right side of the ticket includes the signature of the Commissioner of Social Security and provides a description of the Ticket to Work program. The description of the program will tell you how you may offer

the ticket to an EN or State VR agency. The description will also tell you how the EN provides services to you.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29339, May 20, 2008]

§ 411.125 Who is eligible to receive a ticket under the Ticket to Work program?

(a) You will be eligible to receive a Ticket to Work in a month in which—

(1) You are age 18 or older and have not attained age 65; and

(2)(i)(A) You are a title II disability beneficiary (other than a beneficiary receiving benefit payments under § 404.316(c), § 404.337(c), § 404.352(d), or § 404.1597a of this chapter); and

(B) You are in current pay status for monthly title II cash benefits based on disability (see subpart E of part 404 of this chapter for our rules on nonpayment of title II benefits); or

(ii)(A) You are a title XVI disability beneficiary (other than a beneficiary receiving disability or blindness benefit payments under § 416.996 or § 416.1338 of this chapter);

(B) If you are an individual described in § 416.987(a)(1) of this chapter, you are eligible for benefits under title XVI based on disability under the standard for evaluating disability for adults following a redetermination of your eligibility under § 416.987 of this chapter; and

(C) Your monthly Federal cash benefits based on disability or blindness under title XVI are not suspended (see subpart M of part 416 of this chapter for our rules on suspension of title XVI benefit payments).

(b) You will not be eligible to receive more than one ticket during any period during which you are either—

(1) Entitled to title II benefits based on disability (see §§ 404.316(b), 404.337(b) and 404.352(b) of this chapter for when entitlement to title II disability benefits ends); or

(2) Eligible for title XVI benefits based on disability or blindness and your eligibility has not terminated (see subpart M of part 416 of this chapter for our rules on when eligibility for title XVI benefits terminates).

(c) If your entitlement to title II benefits based on disability ends and/or your eligibility for title XVI benefits based on disability or blindness terminates as described in § 411.155(b)(1) or (2), you will be eligible to receive a new ticket in a month in which—

(1) Your entitlement to title II benefits based on disability is reinstated under section 223(i) of the Act, or your eligibility for title XVI benefits based on disability or blindness is reinstated under section 1631(p) of the Act; and

(2) You meet the requirements of paragraphs (a)(1) and (2) of this section.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29339, May 20, 2008]

§ 411.130 How will we distribute tickets under the Ticket to Work program?

We may send you a ticket if you are eligible to receive one under § 411.125. All Ticket-eligible beneficiaries may receive a Ticket upon request.

[77 FR 1864, Jan. 12, 2012]

§ 411.135 What do I do when I receive a ticket?

Your participation in the Ticket to Work program is voluntary. When you receive your ticket, you are free to choose when and whether to assign it (see § 411.140 for information on assigning your ticket). If you want to participate in the program, you can take your ticket to any EN you choose or to your State VR agency. You may choose either to assign your ticket to an EN by signing an individual work plan (see §§ 411.450 through 411.470) or receive services from your State VR agency by entering into and signing an individualized plan for employment. If the State VR agency provides services to you, it will decide whether to accept your ticket. If it accepts your ticket, you will have assigned your ticket to the State VR agency and it will receive payment as an EN. If the State VR agency decides to be paid under the cost reimbursement payment system, you have not assigned your ticket and you may assign your ticket after the State VR agency has closed your case.

[73 FR 29339, May 20, 2008]

§ 411.140 When may I assign my ticket and how?

(a) You may assign your ticket during a month in which you meet the requirements of § 411.125(a)(1) and (a)(2). You may assign your ticket during the 90-day period after your case is closed by a State VR agency that elected the VR cost reimbursement option (see § 411.171(d)), without meeting the requirements of § 411.125(a)(2). You may assign your ticket to any EN which is serving under the program and is willing to provide you with services, or you may assign your ticket to a State VR agency acting as an EN if you are eligible to receive VR services under 34 CFR 361.42. You may not assign your ticket to more than one provider of services (*i.e.*, an EN or a State VR agency) at a time. You may not assign your ticket until after the State VR agency has closed your case if you are receiving VR services pursuant to an individualized plan for employment from a State VR agency which has elected the VR cost reimbursement option. You also may not assign your ticket to a State VR agency if that VR agency previously served you and elected the VR cost reimbursement option and closed your case.

(b)(1) In determining which EN you want to work with, you may discuss your rehabilitation and employment plans with as many ENs in your area as you wish. You also may discuss your rehabilitation and employment plans with the State VR agency.

(2) You can obtain a list of the approved ENs in your area from the program manager (PM) we have enlisted to assist in the administration of the Ticket to Work program. (See § 411.115(k) for a definition of the PM.)

(c) If you choose to work with an EN serving under the program, both you and the EN of your choice need to agree upon an individual work plan (IWP) (see § 411.115(i) for a definition of an IWP). If you choose to work with a State VR agency, you must develop an individualized plan for employment (IPE) and your State VR counselor must agree to the terms of the IPE, according to the requirements established in 34 CFR 361.45 and 361.46. (See § 411.115(j) for a definition of an IPE.) The IWP or IPE outlines the services necessary to assist you in achieving your chosen employment goal.

(d) In order for you to assign your ticket to an EN or State VR agency acting as an EN, all of the following requirements must be met:

(1)(i) If you decide to work with an EN, you and a representative of the EN must agree to and sign an IWP; or

(ii) If you decide to work with a State VR agency, you and a representative of the State VR agency must agree to and sign both an IPE and a form that provides the information described in § 411.385(a)(1), (2) and (3).

(2) You must be eligible to assign your ticket under the rules in paragraph (a) of this section.

(3) A representative of the EN must submit a copy of the signed IWP to the PM, or a representative of the State VR agency, acting as an EN, must submit the completed and signed form (as described in § 411.385(a) and (b)) to the PM.

(4) The PM must receive the copy of the IWP or receive the required form, as appropriate.

(e) If all of the requirements in paragraph (d) of this section are met, we will consider your ticket assigned to the EN or State VR agency acting as an EN. The effective date of the assignment of your ticket will be the first day on which the requirements of paragraphs (d)(1) and (2) of this section are met. See §§ 411.160 through 411.225 for an explanation of how assigning your ticket may affect medical reviews that we conduct to determine if you are still disabled under our rules.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29339, May 20, 2008]

§ 411.145 When can my ticket be taken out of assignment?

(a) If you assigned your ticket to an EN or a State VR agency acting as an EN, you may take your ticket out of assignment for any reason. You must notify the PM in writing that you wish to take your ticket out of assignment. The ticket will be no longer assigned to that EN or State VR agency acting as an EN, effective with the first day of the month following the month in which you notify the PM in writing that you wish to take your ticket out

of assignment. You will be sent a notice informing you that your ticket is no longer assigned to that EN or State VR agency. You may reassign your ticket under the rules in § 411.150.

(b) If your EN goes out of business or is no longer approved to participate as an EN in the Ticket to Work program, the PM will take your ticket out of assignment with that EN. The ticket will no longer be assigned to that EN effective on the first day of the month following the month in which the EN goes out of business or is no longer approved to participate in the Ticket to Work program. You will be sent a notice informing you that your ticket is no longer assigned to that EN. In addition, if your EN is no longer willing or able to provide you with services, or if your State VR agency acting as an EN stops providing services to you because you have been determined to be ineligible for VR services under 34 CFR 361.42, the EN or State VR agency acting as an EN may ask the PM to take your ticket out of assignment with that EN or State VR agency. The ticket will no longer be assigned to that EN or State VR agency acting as an EN effective on the first day of the month following the month in which the EN or State VR agency acting as an EN makes a request to the PM that the ticket be taken out of assignment. You will be sent a notice informing you that your ticket is no longer assigned to that EN or State VR agency acting as an EN. You may reassign your ticket under the rules in § 411.150.

(c) For information about how taking a ticket out of assignment may affect medical reviews that we conduct to determine if you are still disabled under our rules, see §§ 411.171(c) and 411.220.

[73 FR 29339, May 20, 2008]

§ 411.150 Can I reassign my ticket?

(a) If you previously assigned your ticket and your ticket is no longer assigned (see § 411.145), you may reassign your ticket, unless you are receiving benefit payments under § 404.316(c), § 404.337(c), § 404.352(d) or § 404.1597a of this chapter, or you are receiving disability or blindness benefit payments under § 416.996 or § 416.1338 of this chapter (the provisions of paragraph (b)(3) of this section notwithstanding). If you previously assigned your ticket to an EN, you may reassign your ticket to a different EN which is serving under the program and is willing to provide you with services, or you may reassign your ticket to a State VR agency acting as an EN if you are eligible to receive VR services under 34 CFR 361.42. If you previously assigned your ticket to a State VR agency acting as an EN, you may reassign your ticket to an EN which is serving under the program and is willing to provide you with services, or to another State VR agency acting as an EN if you are eligible to receive VR services under 34 CFR 361.42.

(b) In order for you to reassign your ticket to an EN or State VR agency, all of the following requirements must be met:

(1) Your ticket must be unassigned. If your ticket is assigned to an EN or a State VR agency, you must first tell the PM in writing that you want to take your ticket out of assignment (see § 411.145).

(2)(i) You and a representative of the new EN must agree to and sign a new IWP; or

(ii) If you wish to reassign your ticket to a State VR agency, you and a representative of the State VR agency must agree to and sign both an IPE and a form that provides the information described in § 411.385(a)(1), (2) and (3).

(3) You must meet the requirements of § 411.125(a)(1) and (2) on or after the day you and a representative of the new EN sign your IWP or you and a representative of the State VR agency sign your IPE and the required form. You may reassign your ticket within 90 days of the effective date your ticket was no longer assigned, without meeting the requirements of § 411.125(a)(2).

(4) A representative of the EN must submit a copy of the signed IWP to the PM or a representative of the State VR agency must submit the completed and signed form (as described in § 411.385(a) and (b)) to the PM.

(5) The PM must receive the copy of the IWP or received the required form, as appropriate.

(c) If all of the requirements in paragraphs (a) and (b) of this section are met, we will consider your ticket reassigned to the new EN or State VR

agency. The effective date of the reassignment of your ticket will be the first day on which the requirements of paragraphs (a) and (b)(1), (2) and (3) of this section are met. See §§ 411.160 through 411.225 for an explanation of how reassigning your ticket may affect medical reviews that we conduct to determine if you are still disabled under our rules.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29340, May 20, 2008]

§ 411.155 When does my ticket terminate?

(a) Your ticket will terminate if and when you are no longer eligible to participate in the Ticket to Work program. If your ticket terminates, you may not assign or reassign it to an EN or State VR agency. We will not pay an EN (including a State VR agency) for milestones or outcomes achieved in or after the month in which your ticket terminates (see § 411.525(c)). Your eligibility to participate in the Ticket to Work program will end, and your ticket will terminate, in the earliest of the following months:

(1) The month in which your entitlement to title II benefits based on disability ends for reasons other than your work activity or earnings, or the month in which your eligibility for benefits under title XVI based on disability or blindness terminates for reasons other than your work activity or earnings, whichever is later;

(2) If you are entitled to widow's or widower's insurance benefits based on disability (see §§ 404.335 and 404.336 of this chapter), the month in which you attain full retirement age;

(3) If you are eligible for benefits under title XVI based on disability or blindness, the month following the month in which you attain age 65; or

(4) The month after the month in which your outcome payment period ends (see § 411.500(b)).

(b) The rules in paragraph (c) of this section apply in determining when your eligibility to participate in the Ticket to Work program will end and your ticket will terminate if—

(1) You were not a concurrent title II/title XVI disability beneficiary, and your entitlement to title II benefits based on disability ends or your eligibility for title XVI benefits based on disability or blindness terminates because of your work activity or earnings; or

(2) You were a concurrent title II/title XVI disability beneficiary and—

(i) Your entitlement to title II benefits based on disability ends because of work activity or earnings and your eligibility for title XVI benefits based on disability or blindness terminates for any reason; or

(ii) Your eligibility for title XVI benefits based on disability or blindness terminates because of your work activity or earnings and your entitlement to title II benefits based on disability ends for any reason.

(c) For purposes of paragraph (b) of this section, the ticket which you received in connection with the previous period during which you were either entitled to title II benefits based on disability or eligible for title XVI benefits based on disability or blindness (as described in § 411.125(b)) will terminate, and your eligibility to participate in the Ticket to Work program based on that ticket will end, in the earliest of the following months:

(1) If we make a final determination or decision that you are not entitled to have title II benefits based on disability reinstated under section 223(i) of the Act or eligible to have title XVI benefits based on disability or blindness reinstated under section 1631(p) of the Act, the month in which we make that determination or decision;

(2) If we make a final determination or decision that you are not entitled to title II benefits based on disability or eligible for title XVI benefits based on disability or blindness after you file an application for benefits, the month in which we make that determination or decision;

(3) The month you attain retirement age (as defined in section 216(l) of the Act);

(4) The month in which you die;

(5) The month in which you become entitled to a title II benefit that is not based on disability or eligible for a title XVI benefit that is not based on disability or blindness;

(6) The month in which you again become entitled to title II benefits based on disability, or eligible for title XVI

benefits based on disability or blindness, based on the filing of an application for such benefits;

(7) If your entitlement to title II benefits based on disability is reinstated under section 223(i) of the Act, or your eligibility for title XVI benefits based on disability or blindness is reinstated under section 1631(p) of the Act, the month in which you are eligible to receive a new ticket under § 411.125(c); or

(8) The month after the month in which your outcome payment period ends (see § 411.500(b)).

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29340, May 20, 2008]

Subpart C—Suspension of Continuing Disability Reviews for Beneficiaries Who Are Using a Ticket

INTRODUCTION

§ 411.160 What does this subpart do?

(a) This subpart explains our rules about continuing disability reviews for disability beneficiaries who are participating in the Ticket to Work program.

(b) Continuing disability reviews are reviews that we conduct to determine if you are still disabled under our rules (see §§ 404.1589, 416.989 and 416.989a of this chapter for the rules on when we may conduct continuing disability reviews). For the purposes of this subpart, continuing disability reviews include the medical reviews we conduct to determine if your medical condition has improved (see §§ 404.1594 and 416.994 of this chapter), but not any review to determine if your disability has ended under § 404.1594(d)(5) of this chapter because you have demonstrated your ability to engage in substantial gainful activity (SGA), as defined in §§ 404.1571–404.1576 of this chapter.

§ 411.165 How does using a ticket under the Ticket to Work program affect my continuing disability reviews?

We periodically review your case to determine if you are still disabled under our rules. However, we will not begin a continuing disability review during the period in which you are using a ticket. Sections 411.170 and 411.171 describe when the period of using a ticket begins and ends. You must meet certain requirements for us to consider you to be using a ticket.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29340, May 20, 2008]

§ 411.166 Glossary of terms used in this subpart.

(a) *Using a ticket* means you have assigned a ticket to an Employment Network (EN) or a State VR agency that has elected to serve you as an EN, and you are making timely progress toward self-supporting employment as defined in § 411.180; or you have a ticket that would otherwise be available for assignment and are receiving VR services pursuant to an individualized plan for employment (IPE) and the State VR agency has chosen to be paid for these services under the cost reimbursement payment system, and you are making timely progress toward self-supporting employment as defined in § 411.180. (See § 411.171 for when the period of using a ticket ends.)

(b) *Timely progress toward self-supporting employment* means you have completed the specified goals of work and earnings, or completed the specified post-secondary education credits at an educational institution (see § 411.167) in pursuit of a degree or certificate, or completed specified course requirements for a vocational or technical training program at an educational institution consisting of a technical, trade or vocational school (see § 411.167), or completed a certain percentage of the work requirement and a certain percentage of the post-secondary education requirement or vocational or technical training requirement and the sum of the two percentages equals 100 or more (see § 411.180(c)), or obtained a high school diploma or General Education Development (GED) certificate in the applicable progress certification period as described in § 411.180.

(c) *Timely progress guidelines* mean the guidelines we use to determine if you are making timely progress toward self-supporting employment (see § 411.180).

(d) *Progress certification period* means any 12-month progress certification period described in § 411.180(b).

(e) *Progress review* means the reviews the PM conducts to determine if you are meeting the timely progress guidelines described in §411.180. We explain the method for conducting progress reviews in §411.200.

(f) *Extension period* is a period of up to 90 days during which you may reassign a ticket without being subject to continuing disability reviews. You may be eligible for an extension period if the ticket is in use and no longer assigned to an EN or State VR agency acting as an EN (see §411.220).

(g) *Inactive status* is a status in which you may place your ticket if you are temporarily or otherwise unable to make timely progress toward self-supporting employment during a progress certification period. See §411.192 for the rules on placing your ticket in inactive status and on reactivating your ticket.

(h) *Variance tolerance* means the margin of flexibility whereby we will consider you to have met the requirement for completing a specified amount of post-secondary credit hours in an educational degree or certification program or the course requirements in a vocational or technical training program under §411.180 in the applicable progress certification period if your completion of credit hours or course requirements in this period is within 10% of the goal. Figures representing the number of credit hours required for the first and second progress certification periods as described in §411.180 will be rounded by dropping any fractions. Under the variance tolerance, we also will consider you to have met the requirements in an applicable progress certification period if you complete a certain percentage of the work requirement and a certain percentage of the post-secondary education requirement or vocational or technical training requirement in the period and the sum of the two percentages is within 10% of the goal. See §411.180(a) and (c).

(i) *VR cost reimbursement option* means an arrangement under which your ticket is not assigned to the State VR agency but you do receive services pursuant to an individualized plan for employment where the State VR agency has chosen to receive payment under the cost reimbursement payment system.

(j) *VR cost reimbursement status* means the status of your ticket under the arrangement described in paragraph (i) of this section. The period during which your ticket is in VR cost reimbursement status begins on the date described in §411.170(b) and ends on the date your case is closed by the State VR agency.

[73 FR 29340, May 20, 2008]

§411.167 What is an educational institution or a technical, trade or vocational school?

(a) *Educational institution* means a school (including a technical, trade, or vocational school), junior college, college or university that is: operated or directly supported by the United States; operated or directly supported by any State or local government or by a political subdivision of any State or local government; or approved by a State agency or subdivision of the State, or accredited by a State-recognized or nationally recognized accrediting body.

(b) *Technical, trade or vocational school* is an educational institution that is approved by a State agency or subdivision of the State or accredited by a State-recognized or nationally recognized accrediting body to provide technical, trade or vocational training.

(c) *State-recognized accrediting body* means an entity designated or recognized by a State as the proper authority for accrediting schools, colleges or universities.

(d) *Nationally recognized accrediting body* means an entity determined to be such by the U.S. Department of Education.

(e) *Approval by a State agency or subdivision of the State* includes approval of a school, college or university as an educational institution, or approval of one or more of the courses offered by a school, college or university.

[73 FR 29341, May 20, 2008]

§411.170 When does the period of using a ticket begin?

(a) The period of using a ticket begins on the effective date of the assignment of your ticket to an EN or State VR agency under §411.140.

(b) If you have a ticket that would otherwise be available for assignment and are receiving VR services pursuant to an individualized plan for employment (IPE) and the State VR agency has elected the VR cost reimbursement option, the period of using a ticket begins on the later of—

(1) The effective date of your IPE; or

(2) The first day your ticket would otherwise have been assignable if you had not been receiving services from a State VR agency that elected the VR cost reimbursement option.

[73 FR 29341, May 20, 2008]

§ 411.171 When does the period of using a ticket end?

The period of using a ticket ends with the earliest of the following—

(a) The last day of the month before the month in which the ticket terminates as a result of one of the events listed in § 411.155 (see § 411.155(a)(4) and (c)(8) for when your ticket terminates if your outcome payment period ends);

(b) The day before the effective date of a decision under § 411.200 or § 411.205 that you are no longer making timely progress toward self-supporting employment;

(c) The last day of the 90-day extension period which begins with the first day of the first month in which your ticket is no longer assigned to an EN or State VR agency acting as an EN (see § 411.145), unless you reassign your ticket within the 90-day extension period (see § 411.220 for an explanation of the 90-day extension period); or

(d) If your ticket was in VR cost reimbursement status as described in § 411.166(j), the 90th day following the date the State VR agency closes your case, unless you assign your ticket during this 90-day period.

[73 FR 29341, May 20, 2008]

§ 411.175 What if a continuing disability review is begun before my ticket is in use?

(a) If we begin a continuing disability review before the date on which your ticket is in use, you may still assign the ticket and receive services from an employment network or a State vocational rehabilitation agency acting as an employment network under the Ticket to Work program, or you may still receive services from a State vocational rehabilitation agency that elects the vocational rehabilitation cost reimbursement option. However, we will complete the continuing disability review. If in this review we determine that you are no longer disabled, in most cases you will no longer be eligible to receive benefit payments. However, if your ticket was in use before we determined that you are no longer disabled, in certain circumstances you may continue to receive benefit payments (see §§ 404.316(c), 404.337(c), 404.352(d), and 416.1338 of this chapter). If you appeal the decision that you are no longer disabled, you may also choose to have your benefits continued pending reconsideration or a hearing before a judge on the cessation determination (see §§ 404.1597a and 416.996 of this chapter).

(b) The date on which we begin the continuing disability review is the date on the notice we send you that tells you that we are beginning to review your disability case.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29341, May 20, 2008; 85 FR 73159, Nov. 16, 2020]

§ 411.180 What is timely progress toward self-supporting employment?

(a) *General.* We consider you to be making timely progress toward self-supporting employment when you show progress as described below toward the ability to work at levels which will reduce your dependence on Social Security disability benefits or SSI benefits. We will also consider you to be making timely progress when you obtain a high school diploma or GED certificate in the first 12-month progress certification period, or if you show progress as described below toward obtaining an educational degree or certificate or vocational or technical training that will enhance your ability to return to work. In addition, if you complete a certain percentage of the work requirement and a certain percentage of the post-secondary education requirement or vocational or technical training requirement in the applicable progress certification period under the guidelines below, and the sum of the two percentages equals 100 or more, we will

consider you to have met the timely progress requirements for purposes of the progress review conducted at the end of the 12-month progress certification period. For example, if you complete 33.3 percent of the work requirement during the first 12-month progress certification period as described in paragraph (c)(1)(i) of this section (*i.e.*, one month of work with earnings equal to or greater than the amount representing a trial work service month), and complete 66.7 percent of the requisite credit hours in an educational program during this period as described in paragraph (c)(1)(iii) of this section (*i.e.*, 40 percent of the post-secondary credit hours that are considered to represent an academic year of full-time study), we will consider you to have met the timely progress requirements for purposes of the progress review conducted at the end of the first 12-month progress certification period. In addition, we will apply the variance tolerance described in § 411.166(h) in determining whether you have met the requirements in paragraph (c)(1)(iii), (iv) or (v), paragraph (c)(2)(ii), (iii) or (iv), paragraph (c)(3)(iii) or (v), paragraph (c)(4)(ii) or (iii), or paragraph (c)(5)(ii) or (iii) of this section.

(b) *12-month progress certification periods.* The first 12-month progress certification period begins with the month following the month in which you first assigned your ticket, or with the month beginning after the date described in § 411.170(b) if you have a ticket that would otherwise be available for assignment and are receiving VR services under an IPE from a State VR agency which has chosen the VR cost reimbursement option. Any subsequent 12-month progress certification period will begin with the month following the end of the previous 12-month progress certification period. In computing any 12-month progress certification period, we do not count any month during which—

(1) Your ticket is not assigned to an EN or State VR agency acting as an EN and is not in VR cost reimbursement status (as described in § 411.166(j)); or

(2) Your ticket is in inactive status (see § 411.192).

(c) *Guidelines.* We will determine if you are making timely progress toward self-supporting employment by using the following guidelines:

(1) During the first 12-month progress certification period, you must be making timely progress as follows:

(i) You must have worked in at least three months within this 12-month period and have earnings in each of those three months that are equal to or greater than the amount representing a trial work service month (see § 404.1592(b) of this chapter); or

(ii) You must have obtained a high school diploma or GED certificate within this 12-month period; or

(iii) You must have been enrolled in a two- or four-year degree or certification program at an educational institution and have completed 60 percent of the post-secondary credit hours that are considered to represent an academic year of full-time study in the program by the end of this 12-month period; or

(iv) You must have been enrolled in a vocational or technical training program at an educational institution consisting of a technical, trade or vocational school and have completed 60 percent of the course requirements that are considered to represent a year of full-time study in the program by the end of this 12-month period; or

(v) You must have completed a percentage of the required number of months of work and earnings described in paragraph (c)(1)(i) of this section and a percentage of the specified amount of post-secondary credit hours or course requirements required under paragraph (c)(1)(iii) or (iv) of this section within this 12-month period so that the sum of the two percentages equals 100 or more.

(2) During the second 12-month progress certification period, at the conclusion of 24 months of ticket use, you must be making timely progress as follows:

(i) You must have worked in at least six months within this 12-month period and have earnings in each of those six months that are equal to or greater than the amount representing a trial work service month (see § 404.1592(b) of this chapter); or

(ii) You must have been enrolled in a two- or four-year degree or certification program at an educational institution and have completed an additional 75 percent of the post-secondary credit hours that are considered to represent an academic year of full-time study in the program by the end of this 12-month period; or

(iii) You must have been enrolled in a vocational or technical training program at an educational institution consisting of a technical, trade or vocational school and have completed an additional 75 percent of the course requirements that are considered to represent a year of full-time study in the program by the end of this 12-month period; or

(iv) You must have completed a percentage of the required number of months of work and earnings described in paragraph (c)(2)(i) of this section and a percentage of the specified amount of post-secondary credit hours or course requirements required under paragraph (c)(2)(ii) or (iii) of this section within this 12-month period so that the sum of the two percentages equals 100 or more.

(3) During the third 12-month progress certification period, at the conclusion of 36 months of ticket use, you must be making timely progress as follows:

(i) You must have worked in at least nine months within this 12-month period and have gross earnings from employment (or net earnings from self-employment as defined in § 404.1080 of this chapter) in each of those nine months that are more than the SGA threshold amount specified in § 404.1574(b)(2) of this chapter; or

(ii) You must have completed the course work and earned a degree or certificate from a two-year degree or certification program at an educational institution by the end of this 12-month period; or

(iii) You must have been enrolled in a four-year degree or certification program at an educational institution and completed additional post-secondary credit hours that are considered to represent an academic year of full-time study in the program by the end of this 12-month period; or

(iv) You must have been enrolled in a vocational or technical training program at an educational institution consisting of a technical, trade or vocational school and have completed the course requirements of the program by the end of this 12-month period; or

(v) You must have completed a percentage of the required number of months of work and earnings described in paragraph (c)(3)(i) of this section and a percentage of the specified amount of post-secondary credit hours required under paragraph (c)(3)(iii) of this section within this 12-month period so that the sum of the two percentages equals 100 or more.

(4) During the fourth 12-month progress certification period, at the conclusion of 48 months of ticket use, you must be making timely progress as follows:

(i) You must have worked in at least nine months within this 12-month period and have gross earnings from employment (or net earnings from self-employment as defined in § 404.1080 of this chapter) in each of those nine months that are more than the SGA threshold amount specified in § 404.1574(b)(2) of this chapter; or

(ii) You must have been enrolled in a four-year degree or certification program at an educational institution and completed additional post-secondary credit hours that are considered to represent an academic year of full-time study in the program by the end of this 12-month period; or

(iii) You must have completed a percentage of the required number of months of work and earnings described in paragraph (c)(4)(i) of this section and a percentage of the specified amount of post-secondary credit hours required under paragraph (c)(4)(ii) of this section within this 12-month period so that the sum of the two percentages equals 100 or more.

(5) During the fifth 12-month progress certification period, at the conclusion of 60 months of ticket use, you must be making timely progress as follows:

(i) You must have worked in at least six months within this 12-month period and have earnings in each of those six months that preclude payment of Social Security disability benefits and Federal SSI cash benefits; or

(ii) You must have been enrolled in a four-year degree or certification program at an educational institution and either completed additional post-secondary credit hours that are considered to represent an academic year of full-time study in the program or completed the course work and earned a degree or certificate from the program by the end of this 12-month period; or

(iii) You must have completed a percentage of the required number of months of work and earnings described in paragraph (c)(5)(i) of this section and a percentage of the specified amount of post-secondary credit hours required under paragraph (c)(5)(ii) of this section within this 12-month period so that the sum of the two percentages equals 100 or more.

(6) During the sixth 12-month progress certification period, at the conclusion of 72 months of ticket use, you must be making timely progress as follows:

(i) You must have worked in at least six months within this 12-month period and have earnings in each of those six months that preclude payment of Social Security disability benefits and Federal SSI cash benefits; or

(ii) You must have completed the course work and earned a degree or certificate from a four-year degree or certification program at an educational institution by the end of this 12-month period.

(7) During all subsequent 12-month progress certification periods, you must have worked in at least six months within the 12-month period and have earnings in each of those six months that preclude payment of Social Security disability benefits and Federal SSI cash benefits.

[73 FR 29341, May 20, 2008]

§ 411.192 What choices do I have if I am unable to make timely progress toward self-supporting employment?

(a) If you report to the PM that you are temporarily or otherwise unable to make timely progress toward self-supporting employment during a progress certification period, the PM will give you the choice of placing your ticket in inactive status or, if applicable, taking your ticket out of assignment with the EN or State VR agency acting as an EN. The choice of placing your ticket in inactive status applies whether your ticket is assigned or in VR cost reimbursement status (as described in § 411.166(j)).

(b) You may place your ticket in inactive status at any time by submitting a written request to the PM asking that your ticket be placed in inactive status. Your ticket will be placed in inactive status beginning with the first day of the month following the month in which you make your request. You are not considered to be using a ticket during months in which your ticket is in inactive status. Therefore, you will be subject to continuing disability reviews during those months. The months in which your ticket is in inactive status do not count toward the time limitations for making timely progress toward self-supporting employment.

(c) You may reactivate your ticket and return to in-use status if your ticket is still assigned to an EN or State VR agency acting as an EN. You may also reactivate your ticket and return to in-use status if you have a ticket which would otherwise be available for assignment, you were receiving services under an IPE from a State VR agency which chose the VR cost reimbursement option, and your VR case has not been closed by the State VR agency. You may reactivate your ticket by submitting a written request to the PM. Your ticket will be reactivated beginning with the first day of the month following the month in which the PM receives your request. The progress certification period will resume counting from the last month of in-use status, and the next progress review will be due when the progress certification period has been completed. Earnings from work, obtaining a high school diploma or GED certificate, or completion of post-secondary education credits in a two- or four-year degree or certification program or course requirements in a vocational or technical training program, as described in § 411.180, during the period your ticket is in inactive status may be counted toward meeting the requirements for the next progress review.

(d) You may take your ticket out of assignment under §411.145(a) at any time.

[73 FR 29343, May 20, 2008]

§ 411.200 How will the PM conduct my progress reviews?

The PM will conduct a progress review at the end of each 12-month progress certification period.

(a) The PM will first review the available administrative records to determine if you completed the work requirements as specified in §411.180 in the applicable progress certification period.

(b) If the administrative records do not indicate that you met the work requirements, the PM will contact either you or your EN or State VR agency to request additional information to determine if you completed the work requirements or have met the educational or training requirements as specified in §411.180 in the applicable progress certification period.

(c) If the PM finds that you completed the work requirements or met the educational or training requirements as specified in §411.180 in the applicable progress certification period, the PM will find that you are making timely progress toward self-supporting employment. On the basis of that finding, we will consider you to be making timely progress toward self-supporting employment until your next scheduled progress review.

(d) If the PM finds that you did not complete the work requirements or meet the educational or training requirements as specified in §411.180 in the applicable progress certification period, the PM will find that you are not making timely progress toward self-supporting employment. If the PM makes such a finding, the PM will send a written notice of the decision to you at your last known address. This notice will explain the reasons for the decision and inform you of the right to ask us to review the decision. This decision will be effective 30 days after the date on which the PM sends the notice of the decision to you, unless you request that we review the decision under §411.205.

[73 FR 29343, May 20, 2008]

§ 411.205 What if I disagree with the PM's decision about whether I am making timely progress toward self-supporting employment?

If you disagree with the PM's decision, you may request that we review the decision. You must make the request before the 30th day after the date on which the PM sends the notice of its decision to you. We will consider you to be making timely progress toward self-supporting employment until we make a decision. We will send a written notice of our decision to you at your last known address. If we decide that you are no longer making timely progress toward self-supporting employment, our decision will be effective on the date on which we send the notice of the decision to you.

Failure To Make Timely Progress

§ 411.210 What happens if I do not make timely progress toward self-supporting employment?

(a) *General.* If it is determined that you are not making timely progress toward self-supporting employment, we will find that you are no longer using a ticket. If this happens, you will once again be subject to continuing disability reviews. However, you may continue participating in the Ticket to Work program. Your EN (including a State VR agency which is serving you as an EN) also may receive any milestone or outcome payments for which it is eligible under §411.500 *et seq.* If you are working with a State VR agency which elected payment under the cost reimbursement payment system, your State VR agency may receive payment for which it is eligible under the cost reimbursement payment system (see subparts F and H of this part).

(b) *Re-entering in-use status.* If you failed to meet the timely progress guidelines for a 12-month progress certification period and you believe that you have now met the applicable requirements for that progress certification period as described in §411.180, you may request that you be reinstated to in-use status. In order to do so, you must submit a written request to the PM asking that you be reinstated to in-use status and you must provide evidence showing that you have met the

applicable requirements for the progress certification period. The PM will decide whether you have satisfied the applicable requirements for the progress certification period and may be reinstated to in-use status. If the PM determines you have met the applicable requirements for the progress certification period, you will be reinstated to in-use status, provided that your ticket is assigned to an EN or State VR agency acting as an EN or in VR cost reimbursement status (as described in § 411.166(j)). See paragraph (c) of this section for when your reinstatement to in-use status will be effective. The month after you are reinstated to in-use status, your next 12-month progress certification period will begin.

(c) *Decisions on re-entering in-use status.* (1) After you have submitted a written request to the PM asking that you be reinstated to in-use status, the PM will decide whether you have satisfied the applicable requirements in this section for re-entering in-use status. The PM will send a written notice of the decision to you at your last known address. The notice will explain the reasons for the decision and inform you of the right to ask us to review the decision. If the PM decides that you have satisfied the requirements for re-entering in-use status (including the requirement that your ticket be assigned to an EN or State VR agency acting as an EN or in VR cost reimbursement status), you will be reinstated to in-use status effective with the date on which the PM sends the notice of the decision to you. If the PM decides that you have not satisfied the requirements for re-entering in-use status, you may request that we review the decision under paragraph (c)(2) of this section.

(2) If you disagree with the PM's decision, you may request that we review the decision. You must make the request before the 30th day after the date on which the PM sends the notice of its decision to you. We will send you a written notice of our decision at your last known address. If we decide that you have satisfied the requirements for re-entering in-use status (including the requirement that your ticket be assigned to an EN or State VR agency acting as an EN or in VR cost reimbursement status), you will be reinstated to in-use status effective with the date on which we send the notice of the decision to you.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29343, May 20, 2008]

THE EXTENSION PERIOD

§ 411.220 What if my ticket is no longer assigned to an EN or State VR agency?

(a) If your ticket was once assigned to an EN or State VR agency acting as an EN and is no longer assigned, you are eligible for an extension period of up to 90 days to reassign your ticket. You are eligible for an extension period if your ticket is in use and no longer assigned because—

(1) You retrieved your ticket because you were dissatisfied with the services being provided (see § 411.145(a)) or because you relocated to an area not served by your previous EN or State VR agency; or

(2) Your EN went out of business, is no longer approved to participate as an EN in the Ticket to Work program, or is no longer willing or able to provide you with services as described in § 411.145(b), or your State VR agency stopped providing services to you as described in § 411.145(b).

(b) During the extension period, the ticket will still be considered to be in use. This means that you will not be subject to continuing disability reviews during this period.

(c) Time spent in the extension period will not count toward the time limitations for the timely progress guidelines.

(d) The extension period—

(1) Begins on the first day on which the ticket is no longer assigned (see § 411.145); and

(2) Ends 90 days after it begins or when you assign your ticket to a new EN or State VR agency, whichever is sooner.

(e) If you do not assign your ticket by the end of the extension period, the ticket will no longer be in use and you will once again be subject to continuing disability reviews.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29344, May 20, 2008]

§ 411.225 What if I reassign my ticket after the end of the extension period?

(a) *General.* You may reassign your ticket after the end of the extension period under the conditions described in § 411.150. If you reassign your ticket after the end of the extension period, you will be reinstated to in-use status beginning on the day on which the reassignment of your ticket is effective under § 411.150(c).

(b) *Time limitations for the timely progress guidelines.* Any month during which your ticket is not assigned and not in VR cost reimbursement status (as described in § 411.166(j)), either during or after the extension period, will not count toward the time limitations for the timely progress guidelines.

(c) *If you reassign your ticket after the end of the extension period.* If you reassign your ticket after the end of the extension period, the period comprising the remaining months in the applicable 12-month progress certification period will begin with the first month beginning after the day on which the reassignment of your ticket is effective under § 411.150(c).

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29344, May 20, 2008]

§ 411.226 How will SSA determine if I am meeting the timely progress guidelines if I assign my ticket prior to July 21, 2008?

(a) If you assigned your ticket to an EN or State VR agency prior to July 21, 2008, we will determine which 12-month progress certification period in § 411.180 you are in as of July 21, 2008 using the rules in paragraph (a)(1) of this section. We will not conduct a progress review at the end of that progress certification period. We will conduct a progress review at the end of your next progress certification period as explained in paragraph (a)(2) of this section.

(1) We will consider you to be in the first or a subsequent 12-month progress certification period under § 411.180 as of July 21, 2008. We will determine your applicable 12-month progress certification period and the number of months remaining in that period as of July 21, 2008 by counting all months during which your ticket was assigned and in use during the period—

(i) Beginning with the month following the month in which you first assigned your ticket under the rules in effect prior to July 21, 2008; and

(ii) Ending with the close of June 2008.

(2) We will use the timely progress guidelines in § 411.180(c) beginning with your next 12-month progress certification period. At the conclusion of that progress certification period, we will conduct a progress review to determine whether you are making timely progress toward self-supporting employment using the guidelines in § 411.180(c) that apply in that period.

(b) Prior to the conclusion of your applicable 12-month progress certification period determined under paragraph (a)(1) of this section, we will send you a notice telling you that we will not conduct a progress review at the end of that progress certification period, and that we will conduct a progress review at the conclusion of your next 12-month progress certification period using the guidelines in § 411.180(c). We will tell you in the notice when this next 12-month progress certification period will begin and will describe the specific timely progress guidelines you must meet in this 12-month period.

(c) Subsequent 12-month progress certification periods will follow the rules in § 411.180.

(d) If, on June 30, 2008, your ticket is in use and assigned to a State VR agency which chose to be paid for services it provides to you under the cost reimbursement payment system, your period of using a ticket may continue under the rules in this subpart, including the rules in paragraphs (a), (b) and (c) of this section. While your ticket may still be considered in-use for the purpose of the suspension of continuing disability reviews, it will no longer be considered assigned to that State VR agency effective July 21, 2008. You may assign your ticket after the State VR agency has closed your case.

[73 FR 29344, May 20, 2008]

Subpart D—Use of One or More Program Managers To Assist in Administration of the Ticket to Work Program

§ 411.230 What is a PM?

A program manager (PM) is an organization in the private or public sector that has entered into a contract to assist us in administering the Ticket to Work program. We will use a competitive bidding process to select one or more PMs.

§ 411.235 What qualifications are required of a PM?

A PM must have expertise and experience in the field of vocational rehabilitation or employment services.

§ 411.240 What limitations are placed on a PM?

A PM is prohibited from directly participating in the delivery of employment services, vocational rehabilitation services, or other support services to beneficiaries with tickets in the PM's designated service delivery area. A PM is also prohibited from holding a financial interest in an employment network (EN) or service provider that provides services under the Ticket to Work program in the PM's designated service delivery area.

§ 411.245 What are a PM's responsibilities under the Ticket to Work program?

A PM will assist us in administering the Ticket to Work program by conducting the following activities:

(a) *Recruiting, recommending, and monitoring ENs.* A PM must recruit and recommend for selection by us public and private entities to function as ENs under the program. A PM is also responsible for monitoring the ENs operating in its service delivery area. Such monitoring must be done to the extent necessary and appropriate to ensure that adequate choices of services are made available to beneficiaries with tickets. A PM may not limit the number of public or private entities being recommended to function as ENs.

(b) *Facilitating access by beneficiaries to ENs.* A PM must assist beneficiaries with tickets in accessing ENs.

(1) A PM must establish and maintain lists of the ENs available to beneficiaries with tickets in its service delivery area and make these lists generally available to the public.

(2) A PM must ensure that all information provided to beneficiaries with tickets about ENs is in accessible formats. For purposes of this section, accessible format means by media that is appropriate to a particular beneficiary's impairment(s).

(3) A PM must take necessary measures to ensure that sufficient ENs are available and that each beneficiary under the Ticket to Work program has reasonable access to employment services, vocational rehabilitation services, and other support services. The PM shall ensure that services such as the following are available in each service area, including rural areas: case management, work incentives planning, supported employment, career planning, career plan development, vocational assessment, job training, placement, follow-up services, and other services that we may require in an agreement with a PM.

(4) A PM must ensure that each beneficiary with a ticket is allowed to change ENs. When a change in the EN occurs, the PM must reassign the ticket based on the choice of the beneficiary.

(c) *Facilitating payments to ENs.* A PM must facilitate payments to the ENs in its service delivery area. Subpart H explains the EN payment systems and the PM's role in administering these systems.

(1) A PM must maintain documentation and provide regular assurances to us that payments to an EN are warranted. The PM shall ensure that an EN is complying with the terms of its agreement and applicable regulations.

(2) Upon the request of an EN, the PM shall make a determination of the allocation of the outcome or milestone payments due to an EN based on the services provided by the EN when a beneficiary has been served by more than one EN.

(d) *Administrative requirements.* A PM will perform such administrative tasks as are required to assist us in administering and implementing the Ticket to Work program. Administrative

tasks required for the implementation of the Program may include, but are not limited to:

(1) Reviewing individual work plans (IWPs) submitted by ENs for ticket assignment. These reviews will be conducted to ensure that the IWPs meet the requirements of §411.465. (The PM will not review individualized plans for employment developed by State VR agencies and beneficiaries.)

(2) Reviewing amendments to IWPs to ensure that the amendments meet the requirements in §411.465.

(3) Ensuring that ENs only refer an individual to a State VR agency for services pursuant to an agreement regarding the conditions under which such services will be provided.

(4) Resolving a dispute between an EN and a State VR agency with respect to agreements regarding the conditions under which services will be provided when an individual is referred by an EN to a State VR agency for services.

EVALUATION OF PROGRAM MANAGER PERFORMANCE

§411.250 How will SSA evaluate a PM?

(a) We will periodically conduct a formal evaluation of the PM. The evaluation will include, but not be limited to, an assessment examining the following areas:

(1) Quality of services;

(2) Cost control;

(3) Timeliness of performance;

(4) Business relations; and

(5) Customer satisfaction.

(b) Our Project Officer will perform the evaluation. The PM will have an opportunity to comment on the evaluation, and then the Contracting Officer will determine the PM's final rating.

(c) These performance evaluations will be made part of our database on contractor past performance to which any Federal agency may have access.

(d) Failure to comply with the standards used in the evaluation may result in early termination of our agreement with the PM.

Subpart E—Employment Networks

§411.300 What is an EN?

An employment network (EN) is any qualified entity that has entered into an agreement with us to function as an EN under the Ticket to Work program and assume responsibility for the coordination and delivery of employment services, vocational rehabilitation services, or other support services to beneficiaries who have assigned their tickets to that EN.

§411.305 Who is eligible to be an EN?

Any qualified agency or instrumentality of a State (or political subdivision thereof) or a private entity that assumes responsibility for the coordination and delivery of services under the Ticket to Work program to disabled beneficiaries is eligible to be an EN. A single entity or an association of or consortium of entities combining their resources is eligible to be an EN. The entity may provide these services directly or by entering into an agreement with other organizations or individuals to provide the appropriate services or other assistance that a beneficiary with a ticket may need to find and maintain employment that reduces dependency on disability benefits. ENs may include, but are not limited to:

(a) Any public or private entity, including charitable and religious organizations, that can provide directly, or arrange for other organizations or entities to provide, employment services, vocational rehabilitation services, or other support services.

(b) State agencies administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*) may choose, on a case-by-case basis, to be paid as an EN under the payment systems described in subpart H of this part. For the rules on State VR agencies' participation in the Ticket to Work program, see subpart F of this part. The rules in this subpart E apply to entities other than State VR agencies.

(c) One-stop delivery systems established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2841 *et seq.*).

(d) [Reserved]

(e) Organizations administering Vocational Rehabilitation Services Projects for American Indians with Disabilities authorized under section

121 of part C of title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 750 *et seq.*).

(f) Public or private schools that provide VR or employment services, conduct job training programs, or make services or programs available that can assist students with disabilities in acquiring specific job skills that lead to employment. This includes transition programs that can help students acquire work skills.

(g) Employers that offer job training or other support services or assistance to help individuals with disabilities obtain and retain employment or arrange for individuals with disabilities to receive relevant services or assistance.

[66 FR 67420, Dec. 28, 2001, as amended at 83 FR 62459, Dec. 4, 2018]

§ 411.310 How does an entity other than a State VR agency apply to be an EN and who will determine whether an entity qualifies as an EN?

(a) An entity other than a State VR agency applies by responding to our Request for Proposal (RFP), which we published in the Commerce Business Daily and which is available online through the Federal government's electronic posting system (*http://www.eps.gov*). This RFP also is available through SSA's website, *http://www.ssa.gov/work*. Since recruitment of ENs will be an ongoing process, the RFP is open and continuous. The entity must respond in a format prescribed in the RFP announcement. In its response, the entity must assure SSA that it is qualified to provide employment services, vocational rehabilitation services, or other support services to disabled beneficiaries, either directly or through arrangements with other entities.

(b) The PM will solicit service providers and other qualified entities to respond to the RFP on an ongoing basis. (See § 411.115(k) for a definition of the PM.) The PM will conduct a preliminary review of responses to the RFP from applicants located in the PM's service delivery area and make recommendations to the Commissioner regarding selection. The Commissioner will decide which applicants will be approved to serve as ENs under the program.

(c) State VR agencies must comply with the requirements in subpart F of this part to participate as an EN in the Ticket to Work program. (See §§ 411.360ff).

(d) One-stop delivery systems established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 *et seq.*) may participate in the Ticket to Work program as ENs and do not need to respond to the RFP. However, in order to participate in the Ticket to Work program, the one-stop delivery system must enter into an agreement with the Commissioner to be an EN and must maintain compliance with general and specific selection criteria as described in § 411.315 in order to remain an EN.

(e) Organizations administering Vocational Rehabilitation Services Projects for American Indians with Disabilities authorized under section 121 of part C of title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 741), may participate in the Ticket to Work program as ENs and do not need to respond to the RFP. However, in order to participate in the Ticket to Work program, the organization administering the project must enter into an agreement with the Commissioner to be an EN and must maintain compliance with general and specific selection criteria as described in § 411.315 in order to remain an EN.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29344, May 20, 2008]

§ 411.315 What are the minimum qualifications necessary to be an EN?

To serve as an EN under the Ticket to Work program, an entity must meet and maintain compliance with both general selection criteria and specific selection criteria.

(a) The general criteria include:

(1) having systems in place to protect the confidentiality of personal information about beneficiaries seeking or receiving services;

(2) being accessible, both physically and programmatically, to beneficiaries seeking or receiving services (examples of being programmatically accessible

include the capability of making documents and literature available in alternate media including Braille, recorded formats, enlarged print, and electronic media; and insuring that data systems available to clients are fully accessible for independent use by persons with disabilities);

(3) not discriminating in the provision of services based on a beneficiary's age, gender, race, color, creed, or national origin;

(4) having adequate resources to perform the activities required under the agreement with us or the ability to obtain them;

(5) complying with the terms and conditions in the agreement with us, including delivering or coordinating the delivery of employment services, vocational rehabilitation services, and other support services; and

(6) implementing accounting procedures and control operations necessary to carry out the Ticket to Work program.

(b) The specific criteria that an entity must meet to qualify as an EN include:

(1)(i) Using staff who are qualified under applicable certification, licensing, or registration standards that apply to their profession including certification or accreditation by national accrediting or certifying organizations; or

(ii) Using staff that are otherwise qualified based on education or experience, such as by using staff with experience or a college degree in a field related to the services the EN wants to provide, such as vocational counseling, human relations, teaching, or psychology; and

(2) Taking reasonable steps to assure that if any medical and related health services are provided, such medical and health related services are provided under the formal supervision of persons licensed to prescribe or supervise the provision of these services in the State in which the services are performed.

(c) Any entity must have applicable certificates, licenses or other credentials if such documentation is required by State law to provide vocational rehabilitation services, employment services or other support services.

(d) We will not use the following as an EN:

(1) any entity that has had its license, accreditation, certification, or registration suspended or revoked for reasons concerning professional competence or conduct or financial integrity;

(2) any entity that has surrendered a license, accreditation, certification, or registration with a disciplinary proceeding pending; or

(3) any entity that is precluded from Federal procurement or non-procurement programs.

(e) One-stop delivery systems established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 *et seq.*) are qualified to be ENs. A one-stop delivery system must enter into an agreement with the Commissioner to be an EN and must maintain compliance with general and specific selection criteria of this section and § 411.305 in order to remain an EN.

(f) Organizations administering Vocational Rehabilitation Services Projects for American Indians with Disabilities authorized under section 121 of part C of title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 741), are qualified to be ENs. An organization administering such a project must enter into an agreement with the Commissioner to be an EN and must maintain compliance with general and specific selection criteria of this section and § 411.305 in order to remain an EN.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29344, May 20, 2008]

§ 411.320 What are an EN's responsibilities as a participant in the Ticket to Work program?

An EN must—

(a) Enter into an agreement with us.

(b) Serve a prescribed service area. The EN must designate the geographic area in which it will provide services. This will be designated in the EN's agreement with us.

(c) Provide services directly, or enter into agreements with other entities to provide employment services, vocational rehabilitation services, or other support services to beneficiaries with tickets.

(d) Ensure that employment services, vocational rehabilitation services, and other support services provided under the Ticket to Work program are provided under appropriate individual work plans (IWPs).

(e) Elect a payment system at the time of signing an agreement with us (see § 411.505).

(f) Develop and implement each IWP in partnership with each beneficiary receiving services in a manner that affords the beneficiary the opportunity to exercise informed choice in selecting an employment goal and specific services needed to achieve that employment goal. Each IWP must meet the requirements described in § 411.465.

§ 411.321 Under what conditions will SSA terminate an agreement with an EN due to inadequate performance?

We will terminate our agreement with an EN if it does not comply with the requirements under §§ 411.320, § 411.325, or the conditions in the agreement between SSA and the EN, including minimum performance standards relating to beneficiaries achieving self-supporting employment and leaving the benefit rolls.

§ 411.325 What reporting requirements are placed on an EN as a participant in the Ticket to Work program?

An EN must:

(a) Report to the PM in writing each time the EN accepts a ticket for assignment or the EN no longer wants a ticket assigned to it;

(b) Submit a copy of each signed IWP to the PM;

(c) Submit to the PM copies of amendments to a beneficiary's IWP;

(d) Submit to the PM a copy of any agreement the EN has established with a State VR agency regarding the conditions under which the State VR agency will provide services to beneficiaries who are referred by the EN under the Ticket to Work program;

(e) Submit information to assist the PM conducting the reviews necessary to assess a beneficiary's timely progress towards self-supporting employment to determine if a beneficiary is using a ticket for purposes of suspending continuing disability reviews (see subpart C of this part);

(f) Report to the PM the specific outcomes achieved with respect to specific services the EN provided or secured on behalf of beneficiaries whose tickets it accepted for assignment. Such reports shall conform to a national model prescribed by us and shall be submitted to the PM at least annually;

(g) Provide a copy of its most recent annual report on outcomes to each beneficiary considering assigning a ticket to it and assure that a copy of its most recent report is available to the public while ensuring that personal information on beneficiaries is kept confidential;

(h) Meet our financial reporting requirements. These requirements will be described in the agreements between ENs and the Commissioner, and will include submitting a financial report to the program manager on an annual basis;

(i) Collect and record such data as we shall require, in a form prescribed by us; and

(j) Adhere to all requirements specified in the agreement with the Commissioner and all regulatory requirements in this part 411.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29345, May 20, 2008]

§ 411.330 How will SSA evaluate an EN's performance?

(a) We will periodically review the results of the work of each EN to ensure effective quality assurance in the provision of services by ENs.

(b) In conducting such a review, we will solicit and consider the views of the individuals the EN serves and the PM which monitors the EN.

(c) ENs must make the results of these periodic reviews available to disabled beneficiaries to assist them in choosing among available ENs.

Subpart F—State Vocational Rehabilitation Agencies' Participation

PARTICIPATION IN THE TICKET TO WORK PROGRAM

§ 411.350 Must a State VR agency participate in the Ticket to Work program?

A State VR agency may elect, but is not required, to participate in the Ticket to Work program as an EN. The State VR agency may elect on a case-by-case basis to participate in the Ticket to Work program as an EN, or it may elect to provide services to beneficiaries under the VR cost reimbursement option. (See § 411.115(s) for a definition of the VR cost reimbursement option.)

[73 FR 29345, May 20, 2008]

§ 411.355 What payment options does a State VR agency have?

(a) The Ticket to Work program provides different payment options that are available to a State VR agency for providing services to disabled beneficiaries who have a ticket. A State VR agency participates in the program in one of two ways when providing services to a particular disabled beneficiary under the program. On a case-by-case basis, the State VR agency may participate either—

(1) As an employment network (EN); or

(2) Under the cost reimbursement payment system (see subpart V of part 404 and subpart V of part 416 of this chapter).

(b) When the State VR agency serves a beneficiary with a ticket as an EN, the State VR agency will use the EN payment system it has elected for this purpose, either the outcome payment system or the outcome-milestone payment system (described in subpart H of this part). The State VR agency will have periodic opportunities to change the payment system it uses when serving as an EN.

(c) The State VR agency may seek payment only under its elected EN payment system whenever it serves as an EN. When serving a beneficiary who does not have a ticket that can be assigned pursuant to § 411.140, the State VR agency may seek payment only under the cost reimbursement payment system.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29345, May 20, 2008]

§ 411.365 How does a State VR agency notify us about its choice of a payment system for use when functioning as an EN?

(a) The State VR agency must send us a letter telling us which EN payment system it will use when it functions as an EN with respect to a beneficiary who has a ticket.

(b) The director of the State agency administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*), or the director's designee must sign the State VR agency's letter described in paragraph (a) of this section.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29345, May 20, 2008]

§ 411.375 Does a State VR agency continue to provide services under the requirements of the State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*), when functioning as an EN?

Yes. The State VR agency must continue to provide services under the requirements of the State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*), even when functioning as an EN.

TICKET STATUS

§ 411.380 What does a State VR agency do if the State VR agency wants to determine whether a person seeking services has a ticket?

A State VR agency can contact the Program Manager (PM) to determine if a person seeking VR services has a ticket and, if so, whether the ticket may be assigned to the State VR agency (see § 411.140) or reassigned to the State VR agency (see § 411.150). (See § 411.115(k) for a definition of the PM.)

§ 411.385 What does a State VR agency do if a beneficiary who is eligible for VR services has a ticket that is available for assignment or reassignment?

(a) Once the State VR agency determines that a beneficiary is eligible for VR services, the beneficiary and a representative of the State VR agency must agree to and sign the individualized plan for employment (IPE) required under section 102(b) of the Rehabilitation Act of 1973, as amended (29 U.S.C. 722(b)). The State VR agency must submit the following information to the PM in order for the beneficiary's ticket to be considered in use:

(1) A statement that an IPE has been agreed to and signed by both the beneficiary and a representative of the State VR agency;

(2) A statement of the vocational goal outlined in the beneficiary's IPE; and

(3) A statement of the State VR agency's selection of the payment system (either the cost reimbursement payment system or the previously elected EN payment system) under which the State VR agency will seek payment for providing services to the beneficiary.

(b) This information must be submitted to the PM in a format prescribed by us and must include the signatures of both the beneficiary, or a representative of the beneficiary, and a representative of the State VR agency.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29345, May 20, 2008]

§ 411.390 What does a State VR agency do if a beneficiary to whom it is already providing services has a ticket that is available for assignment?

If a beneficiary who is receiving services from the State VR agency under an existing IPE becomes eligible for a ticket that is available for assignment, the State VR agency must submit the information required in § 411.385(a) to the PM. We require this information in order for the beneficiary's ticket to be considered in use. If a beneficiary who is receiving services from the State VR agency under an existing IPE becomes eligible for a ticket that is available for assignment, the State VR agency is limited to the cost reimbursement payment system, unless both the beneficiary and the State VR agency agree to have the ticket assigned to the State VR agency.

[73 FR 29345, May 20, 2008]

§ 411.395 Is a State VR agency required to provide periodic reports?

(a) For cases where a State VR agency provided services functioning as an EN, the State VR agency will be required to prepare periodic reports on the specific outcomes achieved with respect to the specific services the State VR agency provided to or secured for disabled beneficiaries whose tickets it accepted for assignment. These reports must be submitted to the PM at least annually.

(b) Regardless of the payment method selected, a State VR agency must submit information to assist the PM conducting the reviews necessary to assess a beneficiary's timely progress toward self-supporting employment to determine if a beneficiary is using a ticket for purposes of suspending continuing disability reviews (see §§ 411.190, 411.195 and 411.200).

Referrals by Employment Networks to State VR Agencies

§ 411.400 Can an EN to which a beneficiary's ticket is assigned refer the beneficiary to a State VR agency for services?

Yes. An EN may refer a beneficiary it is serving under the Ticket to Work program to a State VR agency for services. However, a referral can be made only if the State VR agency and the EN have an agreement that specifies the conditions under which services will be provided by the State VR agency. This agreement must be in writing and signed by the State VR agency and the EN prior to the EN referring any beneficiary to the State VR agency for services.

Agreements Between Employment Networks and State VR Agencies

§ 411.405 When does an agreement between an EN and the State VR agency have to be in place?

Each EN must have an agreement with the State VR agency prior to referring a beneficiary it is serving under

the Ticket to Work program to the State VR agency for specific services.

§ 411.410 Does each referral from an EN to a State VR agency require its own agreement?

No. The agreements between ENs and State VR agencies should be broad-based and apply to all beneficiaries who may be referred by the EN to the State VR agency for services, although an EN and a State VR agency may want to enter into an individualized agreement to meet the needs of a single beneficiary.

§ 411.415 Who will verify the establishment of agreements between ENs and State VR agencies?

The PM will verify the establishment of these agreements. Each EN is required to submit a copy of the agreement it has established with the State VR agency to the PM.

§ 411.420 What information should be included in an agreement between an EN and a State VR agency?

The agreement between an EN and a State VR agency should state the conditions under which the State VR agency will provide services to a beneficiary when the beneficiary is referred by the EN to the State VR agency for services. Examples of this information include-

(a) Procedures for making referrals and sharing information that will assist in providing services;

(b) A description of the financial responsibilities of each party to the agreement;

(c) The terms and procedures under which the EN will pay the State VR agency for providing services; and

(d) Procedures for resolving disputes under the agreement.

§ 411.425 What should a State VR agency do if it gets an attempted referral from an EN and no agreement has been established between the EN and the State VR agency?

The State VR agency should contact the EN to discuss the need to establish an agreement. If the State VR agency and the EN are not able to negotiate acceptable terms for an agreement, the State VR agency should notify the PM that an attempted referral has been made without an agreement.

§ 411.430 What should the PM do when it is informed that an EN has attempted to make a referral to a State VR agency without an agreement being in place?

The PM will contact the EN to explain that a referral cannot be made to the State VR agency unless an agreement has been established that sets out the conditions under which services will be provided when a beneficiary's ticket is assigned to the EN and the EN is referring the beneficiary to the State VR agency for specific services.

Resolving Disputes Arising Under Agreements Between Employment Networks and State VR Agencies

§ 411.435 How will disputes arising under the agreements between ENs and State VR agencies be resolved?

Disputes arising under agreements between ENs and State VR agencies must be resolved using the following steps:

(a) When procedures for resolving disputes are spelled out in the agreement between the EN and the State VR agency, those procedures must be used.

(b) If procedures for resolving disputes are not included in the agreement between the EN and the State VR agency and procedures for resolving disputes under contracts and interagency agreements are provided for in State law or administrative procedures, the State procedures must be used to resolve disputes under agreements between ENs and State VR agencies.

(c) If procedures for resolving disputes are not spelled out in the agreement or in State law or administrative procedures, the EN or the State VR agency may request that the PM recommend a resolution to the dispute.

(1) The request must be in writing and include:

(i) a copy of the agreement;

(ii) information on the issue(s) in dispute; and

(iii) information on the position of both the EN and the State VR agency regarding the dispute.

(2) The PM has 20 calendar days after receiving a written request to recommend a resolution to the dispute. If either the EN or the State VR agency does not agree with the PM's recommended resolution to the dispute, the EN or the State VR agency has 30 calendar days after receiving the PM's recommendation to request a decision by us on the matter in dispute.

Subpart G—Requirements For Individual Work Plans

§ 411.450 What is an Individual Work Plan?

An individual work plan (IWP) is a required written document signed by an employment network (EN) (other than a State VR agency) and a beneficiary, or a representative of a beneficiary, with a ticket. It is developed and implemented in partnership when a beneficiary and an EN have come to a mutual understanding to work together to pursue the beneficiary's employment goal under the Ticket to Work program.

§ 411.455 What is the purpose of an IWP?

The purpose of an IWP is to outline the specific employment services, vocational rehabilitation services and other support services that the EN and beneficiary have determined are necessary to achieve the beneficiary's stated employment goal. An IWP provides written documentation for both the EN and beneficiary. Both parties should develop and implement the IWP in partnership. The EN shall develop and implement the plan in a manner that gives the beneficiary the opportunity to exercise informed choice in selecting an employment goal. Specific services needed to achieve the designated employment goal are discussed and agreed to by both parties.

§ 411.460 Who is responsible for determining what information is contained in the IWP?

The beneficiary and the EN share the responsibility for determining the employment goal and the specific services needed to achieve that employment goal. The EN will present information and options in a way that affords the beneficiary the opportunity to exercise informed choice in selecting an employment goal and specific services needed to achieve that employment goal.

§ 411.465 What are the minimum requirements for an IWP?

(a) An IWP must include at least—

(1) A statement of the vocational goal developed with the beneficiary, including, as appropriate, goals for earnings and job advancement;

(2) A statement of the services and supports necessary for the beneficiary to accomplish that goal;

(3) A statement of any terms and conditions related to the provision of these services and supports;

(4) A statement that the EN may not request or receive any compensation for the costs of services and supports from the beneficiary;

(5) A statement of the conditions under which an EN may amend the IWP or terminate the relationship;

(6) A statement of the beneficiary's rights under the Ticket to Work program, including the right to retrieve the ticket at any time if the beneficiary is dissatisfied with the services being provided by the EN;

(7) A statement of the remedies available to the beneficiary, including information on the availability of advocacy services and assistance in resolving disputes through the State Protection and Advocacy (P&A) System;

(8) A statement of the beneficiary's rights to privacy and confidentiality regarding personal information, including information about the beneficiary's disability;

(9) A statement of the beneficiary's right to seek to amend the IWP (the IWP can be amended if both the beneficiary and the EN agree to the change); and

(10) A statement of the beneficiary's right to have a copy of the IWP made available to the beneficiary, including in an accessible format chosen by the beneficiary.

(b) The EN will be responsible for ensuring that each IWP contains this information.

§ 411.470 When does an IWP become effective?

(a) An IWP becomes effective if the following requirements are met—

(1) It has been signed by the beneficiary or the beneficiary's representative, and by a representative of the EN;

(2)(i) The beneficiary is eligible to assign his or her ticket under § 411.140(a); or

(ii) The beneficiary is eligible to reassign his or her ticket under § 411.150(a) and (b); and

(3) A representative of the EN submits a copy of the signed IWP to the PM and the PM receives the copy of the IWP.

(b) If all of the requirements in paragraph (a) of this section are met, the IWP will be effective on the first day on which the requirements of paragraphs (a)(1) and (a)(2) of this section are met.

Subpart H—Employment Network Payment Systems

§ 411.500 Definitions of terms used in this subpart.

(a) *Payment calculation base* means for any calendar year—

(1) In connection with a title II disability beneficiary (including a concurrent title II/title XVI disability beneficiary), the average monthly disability insurance benefit payable under section 223 of the Act for months during the preceding calendar year to all beneficiaries who are in current pay status for the month for which the benefit is payable; and

(2) In connection with a title XVI disability beneficiary (who is not concurrently a title II disability beneficiary), the average monthly payment of Supplemental Security Income (SSI) benefits based on disability payable under title XVI (excluding State supplementation) for months during the preceding calendar year to all beneficiaries who—

(i) Have attained age 18 but have not attained age 65;

(ii) Are not concurrent title II/title XVI beneficiaries; and

(iii) Are in current pay status for the month for which the payment is made.

(b) *Outcome payment period* means a period of 36 months for a title II disability beneficiary or a period of 60 months for a title XVI disability beneficiary who is not concurrently a title II disability beneficiary, not necessarily consecutive, for which Social Security disability benefits and Federal SSI cash benefits are not payable to the beneficiary because of the performance of substantial gainful activity (SGA) or by reason of earnings from work activity. The outcome payment period begins with the first month, ending after the date on which the ticket was first assigned to an EN (or to a State VR agency acting as an EN), for which such benefits are not payable to the beneficiary because of SGA or by reason of earnings from work activity. The outcome payment period ends as follows:

(1) For a title II disability beneficiary (including a concurrent title II/title XVI disability beneficiary), the outcome payment period ends with the 36th month, consecutive or otherwise, ending after the date on which the ticket was first assigned to an EN (or to a State VR agency acting as an EN), for which Social Security disability benefits and Federal SSI cash benefits are not payable to the beneficiary because of earnings from work activity (except as provided for in § 411.551).

(2) For a title XVI disability beneficiary who is not concurrently a title II disability beneficiary, the outcome payment period ends with the 60th month, consecutive or otherwise, ending after the date on which the ticket was first assigned to an EN (or to a State VR agency acting as an EN), for which Federal SSI cash benefits are not payable to the beneficiary by reason of earnings from work activity (except as provided for in § 411.551).

(c) *Outcome payment system* is a system providing a schedule of payments to an EN (or a State VR agency acting as an EN) for each month, during an individual's outcome payment period, for which Social Security disability benefits and Federal SSI cash benefits are not payable to the individual because of work or earnings.

(d) *Outcome payment* means the payment for an outcome payment month.

(e) *Outcome payment month* means a month, during the beneficiary's outcome payment period, for which Social

Security disability benefits and Federal SSI cash benefits are not payable to the beneficiary because of work or earnings.

(f) *Outcome-milestone payment system* is a system providing a schedule of payments to an EN (or State VR agency acting as an EN) that includes, in addition to any outcome payments which may be made during the individual's outcome payment period, payments for completion by a title II or title XVI disability beneficiary of up to four Phase 1 milestones; and up to eleven Phase 2 milestones for a title II disability beneficiary or a concurrent beneficiary or up to eighteen Phase 2 milestones for a title XVI disability beneficiary who is not a concurrent title II disability beneficiary.

(1) *Phase 1 milestones* are based on the beneficiary achieving a level of earnings that reflects initial efforts at self-supporting employment. They are based on the earnings threshold that we use to establish a trial work period service month as defined in §404.1592(b) of this chapter. We use this threshold amount as defined in §404.1592(b) of this chapter in order to measure whether the beneficiary's earnings level meets the milestone objective.

(2) *Phase 2 milestones* are based on the beneficiary achieving a level of earnings that reflects substantial efforts at self-supporting employment. They are based on the earnings threshold that we use to determine if work activity is SGA. We use the SGA earnings threshold amount in §404.1574(b)(2) of this chapter. We use the SGA threshold amounts in order to measure whether the beneficiary's gross earnings level meets the milestone objective.

(g) *Transition case* is a case where milestones or outcomes had been attained before July 21, 2008 (that is, the work required to meet such a milestone or outcome had been completed by that date). Section 411.551 explains how subsequent payments will be made to the EN (or State VR agency acting as an EN) on a transition case.

(h) *Reconciliation payment* is a final payment equal to the milestone payments that are unpaid when the beneficiary enters the outcome payment period before all the milestone payments are paid (see §§411.525(c) and 411.536).

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29345, May 20, 2008]

§411.505 How is an EN paid?

An EN (including a State VR agency acting as an EN) can elect to be paid under either the outcome payment system or the outcome-milestone payment system. The EN will elect a payment system at the time the EN enters into an agreement with us. (For State VR agencies, see §411.365.) The EN (or State VR agency) may periodically change its elected EN payment system as described in §411.515.

[73 FR 29346, May 20, 2008]

§411.510 How is the State VR agency paid under the Ticket to Work program?

(a) The State VR agency's payment choices are described in §411.355.

(b) The State VR agency's decision to serve the beneficiary must be communicated to the program manager (PM). (See §411.115(k) for a definition of the PM.) At the same time, the State VR agency must notify the PM of its selected payment system for that beneficiary.

(c) If a beneficiary who is receiving services from the State VR agency under an existing IPE becomes eligible for a ticket that is available for assignment, the State VR agency is limited to the cost reimbursement payment system, unless both the beneficiary and the State VR agency agree to have the ticket assigned to the State VR agency (see §411.390).

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29346, May 20, 2008]

§411.515 Can the EN change its elected payment system?

(a) Yes. Any change by an EN in its elected EN payment system will apply to beneficiaries who assign their ticket to the EN after the EN's change in election becomes effective. A change in the EN's election will become effective with the first day of the month following the month in which the EN notifies us of the change. For beneficiaries who already assigned their ticket to the EN under the EN's earlier

elected payment system, the EN's earlier elected payment system will continue to apply. These rules also apply to a change by a State VR agency in its elected EN payment system for cases in which the State VR agency serves a beneficiary as an EN.

(b) After an EN (or a State VR agency) first elects an EN payment system, the EN (or State VR agency) can choose to make one change in its elected payment system in each calendar year (January–December) thereafter. The first EN payment system election constitutes the only election an EN may make for that calendar year.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29346, May 20, 2008]

§ 411.520 How are beneficiaries whose tickets are assigned to an EN affected by a change in that EN's elected payment system?

A change in an EN's (or State VR agency's) elected payment system has no effect upon the beneficiaries who have assigned their ticket to the EN (or State VR agency).

§ 411.525 What payments are available under each of the EN payment systems?

(a) For payments for outcome payment months, both EN payment systems use the payment calculation base as defined in §411.500(a)(1) or (a)(2), as appropriate.

(1)(i) Under the outcome payment system, we can pay up to 36 outcome payments to the EN (or State VR agency acting as an EN) for a title II disability beneficiary (including a concurrent title II/title XVI disability beneficiary). We can pay up to 60 outcome payments to the EN (or State VR agency acting as an EN) for a title XVI disability beneficiary who is not concurrently a title II disability beneficiary. For each month during the beneficiary's outcome payment period for which Social Security disability benefits and Federal SSI cash benefits are not payable to the beneficiary because of the performance of SGA or by reason of earnings from work activity, the EN (or the State VR agency acting as an EN) is eligible for a monthly outcome payment. Payment for an outcome payment month under the outcome payment system is equal to 67% of the payment calculation base for the calendar year in which such month occurs, rounded to the nearest whole dollar (see §411.550).

(ii) If a disabled beneficiary's entitlement to Social Security disability benefits ends (see §§404.316(b), 404.337(b) and 404.352(b) of this chapter) or eligibility for SSI benefits based on disability or blindness terminates (see §416.1335 of this chapter) because of the performance of SGA or by reason of earnings from work activity, we will consider any month after the month with which such entitlement ends or eligibility terminates to be a month for which Social Security disability benefits and Federal SSI cash benefits are not payable to the individual because of work or earnings if—

(A) The individual has gross earnings from employment (or net earnings from self-employment as defined in §416.1110(b) of this chapter) in that month that are more than the SGA threshold amount in §404.1574(b)(2) of this chapter (or in §404.1584(d) of this chapter for an individual who is statutorily blind); and

(B) The individual is not entitled to any monthly benefits under title II or eligible for any benefits under title XVI for that month.

(2) Under the outcome-milestone payment system:

(i) We can pay the EN (or State VR agency acting as an EN) for up to four Phase 1 milestones attained within the required earnings period for a title II or title XVI disability beneficiary who has assigned his or her ticket to the EN (or State VR agency acting as an EN). The first Phase 1 milestone is met when a beneficiary has worked in a month and earned at least 50% of the amount of earnings considered to represent a trial work period service month as defined in §404.1592(b) of this chapter. The second Phase 1 milestone is met after a beneficiary has worked for three months within a six-month period and has gross earnings in each of those three months equal to or greater than a trial work period service amount as defined in §404.1592(b) of this chapter. The third Phase 1 milestone is met after a beneficiary has worked for a total of six months within a twelve-

month period and had gross earnings in each of those six months equal to a trial work period service amount as defined in §404.1592(b) of this chapter. The fourth Phase 1 milestone is met after a beneficiary has worked a total of nine months within an 18-month period and had gross earnings in each of those nine months equal to a trial work period service amount as defined in §404.1592(b) of this chapter and the EN has substantially completed the services agreed to in the IWP/IPE, including any amendments. Earnings used to meet the first, second or third Phase 1 milestone may be counted again when determining if a later Phase 1 milestone is met, provided the earlier earnings fall within the relevant time period for meeting the later milestone.

(ii) We can also pay the EN (or State VR agency acting as an EN) up to eleven Phase 2 milestones achieved by a title II disability beneficiary (including a concurrent title II/title XVI disability beneficiary) or up to eighteen Phase 2 milestones achieved by a title XVI disability beneficiary (who is not concurrently a title II disability beneficiary) who has assigned his or her ticket to the EN (or State VR agency acting as an EN). A Phase 2 milestone is met for each calendar month in which the beneficiary has worked and has gross earnings from employment (or net earnings from self-employment as defined in §404.1080 of this chapter) in that month that are more than the SGA threshold amount as defined in §404.1574 of this chapter.

(iii) We pay available milestone payments in sequence except when the beneficiary's outcome period begins before the beneficiary has achieved all Phase 1 and Phase 2 milestones. Example: The individual, in the first month of employment after assigning the ticket, earns above the SGA level. Despite having exceeded trial work period level earnings and earned above the SGA level as required for Phase 2 payments in paragraph (a)(2)(ii) of this section, based on the individual's earning we would pay the EN the sequentially available milestone, which in this case would be Phase 1, milestone 1.

(iv) In addition to the milestone payments, monthly outcome payments can be paid to the EN (or State VR agency acting as an EN) during the outcome payment period.

(b) The outcome-milestone payment system is designed so that the total payments to the EN (or the State VR agency acting as an EN) for a beneficiary are less than the total amount that would have been paid if the EN were paid under the outcome payment system. Under the outcome-milestone payment system, the total payment to the EN (or the State VR agency acting as an EN) is about 90% of the total that would have been potentially payable under the outcome payment system for the same beneficiary.

(c) Except as provided in §411.536 (reconciliation payments) the milestones for which payments may be made must occur prior to the beginning of the beneficiary's outcome payment period.

(d) We will pay an EN (or State VR agency acting as an EN) to which the beneficiary has assigned a ticket for milestones or outcomes achieved only in months prior to the month in which the ticket terminates (see §411.155). We will not pay a milestone or outcome payment to an EN (or State VR agency acting as an EN) based on a beneficiary's work or earnings activity in or after the month in which the ticket terminates.

(e) If a title XVI disability beneficiary becomes entitled to title II benefits after we authorize the first milestone or outcome payment, we will continue to calculate the EN payments using title XVI payment calculation base under the outcome payment system on the basis of paragraph (a)(1)(i) and under the outcome-milestone payment system on the basis of paragraph (a)(2). This applies even if the title XVI eligibility is subsequently terminated and the person becomes only a title II beneficiary.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29346, May 20, 2008]

§411.535 Under what circumstances will milestones be paid?

(a)(1)(i) Under the outcome-milestone payment system, an EN (or a State VR agency acting as an EN) can earn up to four Phase 1 milestone payments for serving beneficiaries whose gross earnings were less than the trial work level

in each of the 18 months before the ticket was first assigned to an EN. All work and earnings counted toward reaching the four Phase 1 milestones must occur after the ticket is assigned and before the beginning of the beneficiary's outcome payment period (see § 411.500(f)) except as provided in § 411.536 (reconciliation payments).

(ii) Significant work activity prior to ticket assignment will limit the availability of Phase 1 milestone payments. The PM will make this assessment of work activity prior to the first ticket assignment on each ticket, irrespective of the EN's chosen payment system, in order to determine how many milestone payments may be available for serving an individual in the Ticket to Work program. The first Phase 1 milestone payment is not available to be made to an EN if the beneficiary has worked above the trial work level in the calendar month prior to the first ticket assignment on each ticket in the Ticket to Work program. The second Phase 1 milestone payment is not available if the beneficiary has worked above the trial work level in three of the six months prior to the first ticket assignment on each ticket in the Ticket to Work program. The third Phase 1 milestone is not available if the beneficiary has worked above the trial work level in six of the twelve months prior to the first ticket assignment on each ticket in the Ticket to Work program. The fourth Phase 1 milestone is not available if the beneficiary has worked above the trial work level in nine of the 18 months prior to the first ticket assignment on each ticket in the Ticket to Work program.

(iii) If a beneficiary had a ticket that otherwise was available for assignment and chose to receive services under an IPE from a State VR agency that elected the VR cost reimbursement option, payment of Phase 1 milestones to an EN or a different VR agency acting as an EN with respect to the same ticket is precluded if the State VR Agency that elected the VR cost reimbursement option achieved an employment outcome (as described in 34 CFR 361.56) before case closure. An EN or a different VR agency acting as an EN can be paid Phase 2 milestones as described in paragraph (2) of this section with respect to this ticket.

(2) Under the outcome-milestone payment system, an EN can receive up to eleven Phase 2 milestone payments for work by a title II disability beneficiary (including a concurrent title II/title XVI disability beneficiary), or up to eighteen Phase 2 milestone payments for work by a title XVI disability beneficiary. Earnings prior to the first assignment of the ticket in the Ticket to Work program are not taken into account when determining whether sufficient earnings exist for payment of Phase 2 milestones.

(3) If the beneficiary's outcome payment period begins before the beneficiary has achieved all Phase 1 and Phase 2 milestones, then we will pay the EN a final payment in accordance with § 411.536 (reconciliation payments) to account for unpaid milestone payments that had been available when the ticket was first assigned.

(b) An EN can be paid for a milestone only if the milestone is attained after a beneficiary has assigned his or her ticket to the EN. See § 411.575 for other milestone payment criteria.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29347, May 20, 2008]

§ 411.536 Under what circumstances can we make a reconciliation payment under the outcome-milestone payment system?

When the beneficiary's outcome payment period begins before the beneficiary has attained all Phase 1 and Phase 2 milestones, we will pay the EN (or a State VR agency acting as an EN) a reconciliation payment. The reconciliation payment will equal the total amount of the milestone payments that were available with respect to that ticket, when the ticket was first assigned, but that have not yet been paid. The reconciliation payment will be based on the payment calculation base for the calendar year in which the first month of the beneficiary's outcome period occurs, rounded to the nearest whole dollar. The payment will be made after an EN has qualified for 12 outcome payments. Where multiple ENs had the ticket assigned at some time, the PM will apply the rule under § 411.560 to determine

the allocation of the reconciliation payment.

[73 FR 29347, May 20, 2008]

§ 411.540 How are the payment amounts calculated for each of the milestones?

(a) For both title II disability beneficiaries and title XVI disability beneficiaries, the payment amount for each of the Phase 1 milestone payments is equal to 120% of the payment calculation base for title II (as defined in § 411.500(a)(1)) for the calendar year in which the month of attainment of the milestone occurs, rounded to the nearest whole dollar.

(b) The payment amount for each of the Phase 2 milestones:

(1) For title II disability beneficiaries (including concurrent title II/title XVI disability beneficiaries) is equal to 36% of the payment calculation base as defined in § 411.500(a)(1) for the calendar year in which the month of attainment of the milestone occurs, rounded to the nearest whole dollar;

(2) For title XVI beneficiaries (who are not concurrently title II disability beneficiaries) is equal to 36% of the payment calculation base as defined in § 411.500(a)(2) for the calendar year in which the month of attainment of the milestone occurs, rounded to the nearest whole dollar.

[73 FR 29347, May 20, 2008]

§ 411.545 How are the outcome payments calculated under the outcome-milestone payment system?

The amount of each monthly outcome payment under the outcome-milestone payment system is calculated as follows:

(a) For title II disability beneficiaries (including concurrent title II/title XVI disability beneficiaries), an outcome payment is equal to 36 percent of the payment calculation base as defined in § 411.500(a)(1) for the calendar year in which the month occurs, rounded to the nearest whole dollar;

(b) For title XVI disability beneficiaries (who are not concurrently title II/title XVI disability beneficiaries), an outcome payment is equal to 36% of the payment calculation base as defined in § 411.500(a)(2) for the calendar year in which the month occurs, rounded to the nearest whole dollar.

(c) The following chart provides an example of how an EN could receive milestone and outcome payments:

OUTCOME-MILESTONE PAYMENT TABLE

CHART I—NEW OUTCOME-MILESTONE PAYMENT TABLE

[2008 figures for illustration only]

Payment type	Beneficiary earnings	Title II amount of payment	Title XVI amount of payment
Phase 1 (120% of Title II PCB)			
Milestone 1	$335/mo. $670/mo. × 3 mo. work in a 6-month period.	$1,177	$1,177
Milestone 2	$1,177	$1,177.	
Milestone 3	$670/mo. × 6 mo. work in a 12-month period.	$1,177	$1,177
Milestone 4	$670/mo. × 9 mo. work in an 18-month period.	$1,177	$1,177
Total Phase 1 milestones.		$4,708	$4,708
Phase 2 (36% of PCB)	Gross Earnings>SGA		
Title II milestones 1–11	$353 × 11 = $3,883		
Title XVI milestones 1–18	$203 × 18 = $3,654.		
Total Phase 1 + 2	$8,591	$8,362.	
	Outcome payments (36% of PCB).		
Title II = 1–36	Monthly cash benefit not payable due to SGA.	$353 × 36 = $12,708	
Title XVI = 1–60	Sufficient earnings for federal cash benefits = ''0''.	203 × 60 = $12,180.	
Total milestone and outcome payments.	$21,299	$20,542.	

Definitions and amounts: Payment Calculation Base (PCB)—The average title II disability insurance benefit payable under section 223 of the Social Security Act for all beneficiaries for months during the preceding calendar year; and the average payment of supplemental security income benefits based on disability payable under title XVI (excluding State supplementation) for months during the preceding calendar year to all beneficiaries who have attained 18 years of age but have not attained 65 years of age. (2008 title II = $981.17, title XVI = $563.35).

Gross earnings requirements for Phase 1 are based on Trial Work level amounts.

For Phase 1 milestones only, the payments are calculated for both title XVI and title II beneficiaries using the higher title II payment calculation base. All other payments are based on a percentage of the Payment Calculation Base (PCB) for the respective program (title XVI or title II). See § 411.535 for a discussion of the circumstances under which we will pay milestones.

Phase 1 milestones = 120% of PCB.

Phase 2 milestones = 36% of PCB.

Outcome payments (under the outcome-milestone payment system) = 36% of PCB Earnings used to meet the first, second, or third Phase 1 milestone may be counted again when determining if a later milestone is met, provided the earlier earnings fall within the relevant time period for meeting the later Phase 1 milestone (see 411.525(a)(2) for the relevant time period for each milestone).

[73 FR 29348, May 20, 2008]

§ 411.550 How are the outcome payments calculated under the outcome payment system?

The amount of each monthly outcome payment under the outcome payment system is calculated as follows:

(1) For title II disability beneficiaries (including concurrent title II/title XVI disability beneficiaries), an outcome payment is equal to 67% of the payment calculation base as defined in § 411.500(a)(1) for the calendar year in which the month occurs, rounded to the nearest whole dollar;

(2) For title XVI disability beneficiaries (who are not concurrently title II/title XVI disability beneficiaries), an outcome payment is equal to 67% of the payment calculation base as defined in § 411.500(a)(2) for the calendar year in which the month occurs, rounded to the nearest whole dollar.

CHART II—NEW OUTCOME PAYMENT SYSTEM TABLE—TITLE II AND CONCURRENT

[2008 figures for illustration only]

Payment type	Beneficiary earnings	Title II amount of monthly outcome payment	Title II total outcome payments
Outcome payments 1–36 (67% of PCB)	Monthly cash benefit not payable due to SGA	$657.00	$23,652

CHART III—NEW OUTCOME PAYMENT SYSTEM TABLE—TITLE XVI ONLY

[2008 figures for illustration only]

Payment type	Beneficiary earnings	Title XVI amount of monthly outcome payment	Title XVI total outcome payments
Outcome payments 1–60 (67% of PCB)	Earnings sufficient to ''0'' out Federal SSI cash benefits.	$377.00	$22,620

NOTE: Outcome payment (outcome payment system) = 67% of PCB Individual payments are rounded to the nearest dollar amount.

2008 non-blind SGA level = $940.

2008 Blind SGA = $1570.

2008 TWP service amount = $670.

[73 FR 29348, May 20, 2008]

§ 411.551 How are EN payments calculated for transition cases pending on July 21, 2008?

A *Transition case* is a case where a ticket had been assigned and milestones or outcomes had been attained

as of June 30, 2008 (that is, the individual has completed the necessary work to trigger a milestone or outcome payment before July 21, 2008 regardless of whether the payment has actually been made). We will pay outcome and milestone payments at the rate in effect when the work leading to such outcome or milestone is attained. Since milestone and outcome payments are numbered and attained in sequence, the EN must request the final payment for which it expects payment under the prior rules before we can determine the number of the milestone or outcome payment that represents the first payment after July 21, 2008. In addition, for cases on which an EN has attained an outcome payment before July 21, 2008 we must know the sum of the amount paid on the ticket before we can determine the remaining amount that can be paid in outcome payments on the ticket. Therefore, with respect to a ticket, we will only accept payment requests for milestones or outcomes attained under the prior rules until March 31, 2009 or until we make the first payment on the ticket under § 411.525. Payments to an EN (or State VR agency acting as an EN) after July 21, 2008 on a transition case will be made as follows:

(a) The four milestones under the prior rules will be equated with the four Phase 1 milestones available under the rules after July 21, 2008. For example, if a beneficiary had attained milestone 1 under our prior rules (1 month above the gross SGA level, e.g., $940 in 2008), then the next milestone to be achieved would be Phase 1 milestone 2 under these rules (work in three months with gross earnings in each of these months equal to a trial work period service month, e.g., $670 in 2008).

(b) If the beneficiary had attained all four of the milestones under the prior rules, the next milestone to be achieved would be the first Phase 2 milestone (a calendar month in which the beneficiary has worked and has gross earnings from employment or net earnings from self-employment that are more than the substantial gainful activity threshold level, e.g., $900 in 2007).

(c) The maximum number of outcome payments available to an EN with respect to a ticket for a transition case will be computed as follows:

(1) First, we will compute the total dollar amount already paid or payable with respect to a ticket, including all outcome and milestone payments.

(2) Then, we will subtract the total dollar amount already paid from the total value of the ticket under the new rules for the year when these rules take effect. The total value of the ticket will be calculated based on the elected payment system for the beneficiary, *i.e.*, the outcome or the outcome-milestone payment system, and on the appropriate payment calculation base for either a title II disability beneficiary (including a concurrent title II and title XVI disability) or a title XVI disability beneficiary (see §§ 411.500 and 411.505). For accounting purposes, we will use the payment calculation base for 2008 and assume that all payments could be earned in that year in calculating the total value of the ticket.

(3) We then will divide this amount by the applicable outcome payment amount (whether title II or title XVI) payable for 2008 and round the result in accordance with customary rounding principles. The resulting number represents the number of outcome payments available to be paid with respect to the ticket. In no case can this number exceed 60.

[73 FR 29349, May 20, 2008]

§ 411.552 What effect will the subsequent entitlement to title II benefits have on EN payments for title XVI beneficiaries after they assign their ticket?

If a beneficiary is only eligible for title XVI benefits when we authorize the first milestone or outcome for which an EN can be paid, but the beneficiary later becomes entitled to title II benefits, we will continue to make payments as though the beneficiary were only a title XVI beneficiary, up to the maximum number of milestone and outcome payments payable for that ticket for title XVI beneficiaries. If a beneficiary who is eligible for title XVI disability benefits becomes entitled to title II disability benefits before we authorize the first milestone or outcome payment, we will make payments to the EN pursuant to the rate, payment

calculation base and number of payments available for title II beneficiaries, as described in this subpart.

[73 FR 29349, May 20, 2008]

§ 411.555 Can the EN keep the milestone and outcome payments even if the beneficiary does not achieve all outcome months?

(a) Yes. The EN (or State VR agency acting as an EN) can keep each milestone and outcome payment for which the EN (or State VR agency acting as an EN) is eligible, even though the title II beneficiary does not achieve all 36 outcome months or the title XVI beneficiary does not achieve all 60 outcome months.

(b) Except as provided in paragraph (c) of this section, payments which we make or deny to an EN (or a State VR agency acting as an EN) may be subject to adjustment (including recovery, as appropriate) if we determine that more or less than the correct amount was paid. This may happen, for example, because we determine that the payment determination was in error or because of an allocation of payment under § 411.560.

(c) If we determine that an overpayment or underpayment to an EN has occurred, we will notify the EN (or State VR agency acting as an EN) of the adjustment. We will not seek an adjustment if a determination or decision about a beneficiary's right to benefits causes an overpayment to the EN. Any dispute which the EN (or State VR agency) has regarding the adjustment may be resolved under the rules in § 411.590(a) and (b).

[73 FR 29349, May 20, 2008]

§ 411.560 Is it possible to pay a milestone or outcome payment to more than one EN?

It is possible for more than one EN (including a State VR agency acting as an EN) to receive payment based on the same milestone or outcome. If the beneficiary has assigned the ticket to more than one EN (or State VR agency acting as an EN) at different times, and more than one EN (or State VR agency) requests payment for the same milestone, outcome or reconciliation payment under its elected payment system, the PM will make a determination of the allocation of payment to each EN (or State VR agency acting as an EN). The PM will make this determination based upon the contribution of the services provided by each EN (or State VR agency acting as an EN) toward the achievement of the outcomes or milestones. Outcome and milestone payments will not be increased because the payments are shared between two or more ENs (including a State VR agency acting as an EN).

[73 FR 29350, May 20, 2008]

§ 411.565 What happens if two or more ENs qualify for payment on the same ticket but have elected different EN payment systems?

We will pay each EN (or State VR agency acting as an EN) according to its elected EN payment system in effect at the time the beneficiary assigned the ticket to the EN (or the State VR agency acting as an EN).

[73 FR 29350, May 20, 2008]

§ 411.566 May an EN use outcome or milestone payments to make payments to the beneficiary?

Yes, an EN may use milestone or outcome payments to make payments to a beneficiary.

[73 FR 29350, May 20, 2008]

§ 411.570 Can an EN request payment from the beneficiary who assigned a ticket to the EN?

No. Section 1148(b)(4) of the Act prohibits an EN from requesting or receiving compensation from the beneficiary for the services of the EN.

§ 411.575 How does the EN request payment for milestones or outcome payment months achieved by a beneficiary who assigned a ticket to the EN?

The EN (or State VR agency acting as an EN) will send its request for payment, evidence of the beneficiary's work or earnings, and other information to the PM. In addition, we or the PM may require a summary of the services provided as described in the IWP/IPE.

(a) *Milestone payments.* (1) We will pay the EN (or State VR agency acting as an EN) for milestones only if—

(i) The outcome-milestone payment system was the EN's (or State VR agency's) elected payment system in effect at the time the beneficiary assigned a ticket to the EN (or the State VR agency acting as an EN);

(ii) The milestones occur prior to the outcome payment period (see §411.500(b));

(iii) The requirements in §411.535 are met; and

(iv) The ticket has not terminated for any of the reasons listed in §411.155.

(2) The EN (or State VR agency acting as an EN) must request payment for each milestone attained by a beneficiary who has assigned a ticket to the EN (or State VR agency acting as an EN). The request must include evidence that the milestone was attained after ticket assignment and other information as we may require to evaluate the EN's (or State VR agency's) request. If the EN is requesting payment for months after the ticket is no longer assigned to it, the payment request shall include evidence that the services agreed to in the IWP/IPE were provided and those services contributed to the employment milestones or outcomes that the beneficiary attained in months after the ticket had been assigned to the EN. We do not have to stop monthly benefit payments to the beneficiary before we can pay the EN (or State VR agency acting as an EN) for milestones attained by the beneficiary.

(b) *Outcome payments.* (1) We will pay an EN (or State VR agency acting as an EN) an outcome payment for a month if—

(i)(A) Social Security disability benefits and Federal SSI cash benefits are not payable to the individual for that month due to work or earnings; or

(B) The requirements of §411.525(a)(1)(ii) are met in a case where the beneficiary's entitlement to Social Security disability benefits has ended or eligibility for SSI benefits based on disability or blindness has terminated because of work activity or earnings; and

(ii) We have not already paid for 36 outcome payment months for a title II disability beneficiary (or a concurrent title II/title XVI disability beneficiary), or paid for 60 outcome payment months for a title XVI disability beneficiary who is not concurrently a title II disability beneficiary, on the same ticket; and

(iii) The ticket has not terminated for any of the other reasons listed in §411.155.

(2) The EN (or State VR agency acting as an EN) must request payment for outcome payment months. In its initial request, the EN (or State VR agency acting as an EN) must submit evidence of the beneficiary's work or earnings (e.g., a statement of monthly earnings from the employer or the employer's designated payroll preparer, or an unaltered copy of the beneficiary's pay stub). After we have started paying outcome payments to an EN (or State VR agency acting as an EN) based on evidence of the beneficiary's earnings, the EN (or State VR agency) must provide documentation of the beneficiary's continued work or earnings in such a manner or form and at such time or times as we may require. Exception: If the EN (or State VR agency) does not currently hold the ticket because it is assigned to another EN (or State VR agency), the EN (or State VR agency) must request payment, but is not required to submit evidence of the beneficiary's work or earnings. However, if the payment request is for work the beneficiary attained in a month in which the EN no longer held the ticket, the payment request should include evidence that the services agreed to in the IWP/IPE were provided and those services contributed to the beneficiary's work.

(c) *Evidence requirements for payment.* As primary evidence, we require original pay slips, or oral or written statements from an employer or the employer's designated payroll preparer. In lieu of primary evidence, we accept two sources of secondary evidence, such as photocopies of pay slips, a signed beneficiary statement, State unemployment records or federal/state tax returns. The evidence must be clear and legible and include the beneficiary's name, gross earnings or net earnings from self employment, pay date and pay period of wages or monthly net earnings of self-employment earnings.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29350, May 20, 2008]

§ 411.580 Can an EN receive payments for milestones or outcome payment months that occur before the beneficiary assigns a ticket to the EN?

No. An EN (or State VR agency acting as an EN) may be paid only for milestones or outcome payment months that are achieved after the month in which the ticket is assigned to the EN or State VR agency acting as an EN (except as provided for in § 411.536).

[73 FR 29351, May 20, 2008]

§ 411.581 Can an EN receive milestone and outcome payments for months after a beneficiary takes his or her ticket out of assignment?

Yes. If an individual whose ticket is assigned to an EN (or State VR agency acting as an EN) takes his or her ticket out of assignment (see § 411.145), the EN (or State VR agency) can receive payments under its elected payment system for milestones or outcome payment months that occur after the ticket is taken out of assignment, provided the ticket has not terminated for any of the reasons listed in § 411.155. The PM will make a determination about eligibility for a payment based upon the contribution of services provided by an EN toward the achievement of the outcome or milestones. See § 411.560 for situations in which payment may be made to more than one EN or State VR agency based on the same milestone or outcome.

[73 FR 29351, May 20, 2008]

§ 411.582 Can a State VR agency receive payment under the cost reimbursement payment system if a continuous 9-month period of substantial gainful activity is completed after the ticket is assigned to an EN?

Yes. If a State VR agency provides services to a beneficiary under 34 CFR part 361, and elects payment under the cost reimbursement payment system under subpart V of part 404 (or subpart V of part 416) of this chapter, the State VR agency can receive payment under the cost reimbursement payment system for services provided to the beneficiary if all the requirements under subpart V of part 404 (or subpart V of part 416) of this chapter and § 411.585 are met even when these requirements are met after the ticket has been assigned to the EN. The EN can be paid during this period in accordance with §§ 411.525 and 411.535.

[73 FR 29351, May 20, 2008]

§ 411.585 Can a State VR agency and an EN both receive payment for serving the same beneficiary?

Yes. A State VR agency and an EN can both receive payment for serving the same beneficiary, but the ticket can only be assigned to one EN, including a State VR agency acting as an EN, at a time. It also cannot be assigned to an EN and placed in the VR cost reimbursement status at the same time.

(a) A State VR agency may act as an EN and serve a beneficiary. In this case, both the State VR agency acting as an EN and another EN may be eligible for payment based on the same ticket (see § 411.560).

(b) If a State VR agency is paid by us under the VR cost reimbursement option, such payment does not preclude payment by us to an EN or to another State VR agency acting as an EN under its elected EN payment system. A subsequent VR agency also may choose to be paid under the VR cost reimbursement option.

(c) If an EN or a State VR agency acting as an EN is paid by us under one of the EN payment systems, that does not preclude payment by us to a different State VR agency under the VR cost reimbursement option. The subsequent State VR agency also may choose to be paid under its elected EN payment system.

[73 FR 29351, May 20, 2008]

§ 411.590 What can an EN do if the EN disagrees with our decision on a payment request?

(a) If an EN other than a State VR agency has a payment dispute with us, the dispute shall be resolved under the dispute resolution procedures contained in the EN's agreement with us.

(b) If a State VR agency serving a beneficiary as an EN has a dispute with us regarding payment under an EN payment system, the State VR agency may, within 60 days of receiving notice of our decision, request reconsideration in writing. The State VR agency must

send the request for reconsideration to the PM. The PM will forward to us the request for reconsideration and a recommendation. We will notify the State VR agency of our reconsidered decision in writing.

(c) An EN (including a State VR agency) cannot appeal determinations we make about an individual's right to benefits (e.g. determinations that disability benefits should be suspended, terminated, continued, denied, or stopped or started on a different date than alleged). Only the beneficiary or applicant or his or her representative can appeal these determinations. See §§ 404.900 *et seq.* and 416.1400 *et seq.* of this chapter.

(d) Determinations or decisions we make about a beneficiary's right to benefits may cause payments we have already made to an EN (or denial of payment to an EN) to be incorrect, resulting in an underpayment or overpayment to the EN. If this happens, we will make any necessary adjustments to future payments (see § 411.555). See § 411.555(c) for when we will not make an adjustment in a case in which an overpayment results from a determination or decision we make about a beneficiary's right to benefits.) While an EN cannot appeal our determination about an individual's right to benefits, the EN may furnish any evidence the EN has which relates to the issue(s) to be decided on appeal if the individual appeals our determination.

[66 FR 67420, Dec. 28, 2001, as amended at 73 FR 29351, May 20, 2008]

§ 411.595 What oversight procedures are planned for the EN payment systems?

We use audits, reviews, studies and observation of daily activities to identify areas for improvement. Internal reviews of our systems security controls are regularly performed. These reviews provide an overall assurance that our business processes are functioning as intended. The reviews also ensure that our management controls and financial management systems comply with the standards established by the Federal Managers' Financial Integrity Act and the Federal Financial Management Improvement Act. These reviews operate in accordance with the Office of Management and Budget Circulars A–123, A–127 and Appendix III to A–130. Additionally, our Executive Internal Control Committee meets periodically and provides further oversight of program and management control issues.

§ 411.597 Will SSA periodically review the outcome payment system and the outcome-milestone payment system for possible modifications?

(a) Yes. We will periodically review the system of payments and their programmatic results to determine if they provide an adequate incentive for ENs to assist beneficiaries to enter the work force, while providing for appropriate economies.

(b) We will specifically review the limitation on monthly outcome payments as a percentage of the payment calculation base, the difference in total payments between the outcome-milestone payment system and the outcome payment system, the length of the outcome payment period, and the number and amount of milestone payments, as well as the benefit savings and numbers of beneficiaries going to work. We will consider altering the payment system conditions based upon the information gathered and our determination that an alteration would better provide for the incentives and economies noted above.

Subpart I—Ticket to Work Program Dispute Resolution

DISPUTES BETWEEN BENEFICIARIES AND EMPLOYMENT NETWORKS

§ 411.600 Is there a process for resolving disputes between beneficiaries and ENs that are not State VR agencies?

Yes. After an IWP is signed, a process is available which will assure each party a full, fair and timely review of a disputed matter. This process has three steps.

(a) The beneficiary can seek a solution through the EN's internal grievance procedures.

(b) If the EN's internal grievance procedures do not result in an agreeable solution, either the beneficiary or the EN may seek a resolution from the PM. (See § 411.115(k) for a definition of the PM.)

(c) If either the beneficiary or the EN is dissatisfied with the resolution proposed by the PM, either party may request a decision from us.

§ 411.605 What are the responsibilities of the EN that is not a State VR agency regarding the dispute resolution process?

The EN must:

(a) Have grievance procedures that a beneficiary can use to seek a resolution to a dispute under the Ticket to Work program;

(b) Give each beneficiary seeking services a copy of its internal grievance procedures;

(c) Inform each beneficiary seeking services of the right to refer a dispute first to the PM for review, and then to us for a decision; and

(d) Inform each beneficiary of the availability of assistance from the State P&A system.

§ 411.610 When should a beneficiary receive information on the procedures for resolving disputes?

Each EN that is not a State VR agency must inform each beneficiary seeking services under the Ticket to Work program of the procedures for resolving disputes when—

(a) The EN and the beneficiary complete and sign the IWP;

(b) Services in the beneficiary's IWP are reduced, suspended or terminated; and

(c) A dispute arises related to the services spelled out in the beneficiary's IWP or to the beneficiary's participation in the program.

§ 411.615 How will a disputed issue be referred to the PM?

The beneficiary or the EN that is not a State VR agency may ask the PM to review a disputed issue. The PM will contact the EN to submit all relevant information within 10 working days. The information should include:

(a) A description of the disputed issue(s);

(b) A summary of the beneficiary's position, prepared by the beneficiary or a representative of the beneficiary, related to each disputed issue;

(c) A summary of the EN's position related to each disputed issue; and

(d) A description of any solutions proposed by the EN when the beneficiary sought resolution through the EN's grievance procedures, including the reasons the beneficiary rejected each proposed solution.

§ 411.620 How long does the PM have to recommend a resolution to the dispute?

The PM has 20 working days to provide a written recommendation. The recommendation should explain the reasoning for the proposed resolution.

§ 411.625 Can the beneficiary or the EN that is not a State VR agency request a review of the PM's recommendation?

(a) Yes. After receiving the PM's recommendation, either the beneficiary or the EN may request a review by us. The request must be in writing and received by the PM within 15 working days of the receipt of the PM's recommendation for resolving the dispute.

(b) The PM has 10 working days to refer the request for a review to us. The request for a review must include:

(1) A copy of the beneficiary's IWP;

(2) Information and evidence related to the disputed issue(s); and

(3) The PM's conclusion(s) and recommendation(s).

§ 411.630 Is SSA's decision final?

Yes. Our decision is final. If either the beneficiary or the EN that is not a State VR agency is unwilling to accept our decision, either has the right to terminate its relationship with the other.

§ 411.635 Can a beneficiary be represented in the dispute resolution process under the Ticket to Work program?

Yes. Both the beneficiary and the EN that is not a State VR agency may use an attorney or other individual of their choice to represent them at any step in the dispute resolution process. The P&A system in each State and U.S. Territory is available to provide assistance and advocacy services to beneficiaries seeking or receiving services under the Ticket to Work program, including assistance in resolving issues at any stage in the dispute resolution process.

DISPUTES BETWEEN BENEFICIARIES AND STATE VR AGENCIES

§ 411.640 Do the dispute resolution procedures of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*), apply to beneficiaries seeking services from the State VR agency?

Yes. The procedures in the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*) apply to any beneficiary who has assigned a ticket to a State VR agency. ENs that are State VR agencies are subject to the provisions of the Rehabilitation Act. The Rehabilitation Act requires the State VR agency to provide each person seeking or receiving services with a description of the services available through the Client Assistance Program authorized under section 112 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 732). It also provides the opportunity to resolve disputes using formal mediation services or the impartial hearing process in section 102(c) of the Rehabilitation Act of 1973, as amended (29 U.S.C. 722(c)). ENs that are not State VR agencies are not subject to the provisions of Title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720 *et seq.*).

DISPUTES BETWEEN EMPLOYMENT NETWORKS AND PROGRAM MANAGERS

§ 411.650 Is there a process for resolving disputes between ENs that are not State VR agencies and PMs, other than disputes on a payment request?

Yes. Under the agreement to assist us in administering the Ticket to Work program, a PM is required to have procedures to resolve disputes with ENs that do not involve an EN's payment request. (See § 411.590 for the process for resolving disputes on EN payment requests.) This process must ensure that:

(a) The EN can seek a solution through the PM's internal grievance procedures; and

(b) If the PM's internal grievance procedures do not result in a mutually agreeable solution, the PM shall refer the dispute to us for a decision.

§ 411.655 How will the PM refer the dispute to us?

The PM has 20 working days from the failure to come to a mutually agreeable solution with an EN to refer the dispute to us with all relevant information. The information should include:

(a) A description of the disputed issue(s);

(b) A summary of the EN's and PM's position related to each disputed issue; and

(c) A description of any solutions proposed by the EN and PM when the EN sought resolution through the PM's grievance procedures, including the reasons each party rejected each proposed solution.

§ 411.660 Is SSA's decision final?

Yes. Our decision is final.

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

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EDITORIAL NOTE: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

Subpart A—Introduction, General Provisions and Definitions

AUTHORITY: Secs. 702(a)(5) and 1601–1635 of the Social Security Act (42 U.S.C. 902(a)(5) and 1381–1383d); sec. 212, Pub. L. 93–66, 87 Stat. 155 (42 U.S.C. 1382 note); sec. 502(a), Pub. L. 94–241, 90 Stat. 268 (48 U.S.C. 1681 note).

SOURCE: 39 FR 28625, Aug. 9, 1974, unless otherwise noted.

§ 416.101 Introduction.

The regulations in this part 416 (Regulations No. 16 of the Social Security Administration) relate to the provisions of title XVI of the Social Security Act as amended by section 301 of Pub. L. 92–603 enacted October 30, 1972, and as may thereafter be amended. Title XVI (Supplemental Security Income For The Aged, Blind, and Disabled) of the Social Security Act, as amended, established a national program, effective January 1, 1974, for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled. The regulations in this part are divided into the following subparts according to subject content:

(a) This subpart A contains this introduction, a statement of the general purpose underlying the supplemental security income program, general provisions applicable to the program and its administration, and definitions and use of terms occurring throughout this part.

(b) Subpart B of this part covers in general the eligibility requirements which must be met for benefits under the supplemental security income program. It sets forth the requirements regarding residence, citizenship, age, disability, or blindness, and describes the conditions which bar eligibility and generally points up other conditions of eligibility taken up in greater detail elsewhere in the regulations (e.g., limitations on income and resources, receipt of support and maintenance, etc.).

(c) Subpart C of this part sets forth the rules with respect to the filing of applications, requests for withdrawal of applications, cancellation of withdrawal requests and other similar requests.

(d) Subpart D of this part sets forth the rules for computing the amount of benefits payable to an eligible individual and eligible spouse.

(e) Subpart E of this part covers provisions with respect to periodic payment of benefits, joint payments, payment of emergency cash advances, payment of benefits prior to a determination of disability, prohibition against transfer or assignment of benefits, adjustment and waiver of overpayments, and payment of underpayments.

(f) Subpart F of this part contains provisions with respect to the selection of representative payees to receive benefits on behalf of and for the use of recipients and to the duties and responsibilities of representative payees.

(g) Subpart G of this part sets forth rules with respect to the reporting of events and circumstances affecting eligibility or the amount of benefits payable.

(h) Subpart H of this part sets forth rules and guidelines for the submittal and evaluation of evidence of age where age is pertinent to establishing eligibility or the amount of benefits payable.

(i) Subpart I of this part sets forth the rules for establishing disability or blindness where the establishment of disability or blindness is pertinent to eligibility.

(j) Subpart J of this part sets forth the standards, requirements and procedures for States making determinations of disability for the Commissioner. It also sets out the Commissioner's responsibilities in carrying out the disability determination function.

(k) Subpart K of this part defines *income*, *earned income*, and *unearned income* and sets forth the statutory exclusions applicable to earned and unearned income for the purpose of establishing eligibility for and the amount of benefits payable.

(l) Subpart L of this part defines the term *resources* and sets forth the statutory exclusions applicable to resources for the purpose of determining eligibility.

(m) Subpart M of this part deals with events or circumstances requiring suspension or termination of benefits.

(n) Subpart N of this part contains provisions with respect to procedures for making determinations with respect to eligibility, amount of benefits, representative payment, etc., notices of determinations, rights of appeal and procedures applicable thereto, and other procedural due process provisions.

(o) Subpart O of this part contains provisions applicable to attorneys and other individuals who represent applicants in connection with claims for benefits.

(p) Subpart P of this part sets forth the residence and citizenship requirements that are pertinent to eligibility.

(q) Subpart Q of this part contains provisions with respect to the referral of individuals for vocational rehabilitation, treatment for alcoholism and drug addiction, and application for other benefits to which an applicant may be potentially entitled.

(r) Subpart R of this part sets forth the rules for determining marital and other family relationships where pertinent to the establishment of eligibility for or the amount of benefits payable.

(s) Subpart S of this part explains interim assistance and how benefits may be withheld to repay such assistance given by the State.

(t) Subpart T of this part contains provisions with respect to the supplementation of Federal supplemental security income payments by States, agreements for Federal administration of State supplementation programs, and payment of State supplementary payments.

(u) Subpart U of this part contains provisions with respect to agreements with States for Federal determination of Medicaid eligibility of applicants for supplemental security income.

(v) Subpart V of this part explains when payments are made to State vocational rehabilitation agencies for vocational rehabilitation services.

[39 FR 28625, Aug. 9, 1974, as amended at 51 FR 11718, Apr. 7, 1986; 62 FR 38454, July 18, 1997; 83 FR 62459, Dec. 4, 2018]

§ 416.105 Administration.

The Supplemental Security Income for the Aged, Blind, and Disabled program is administered by the Social Security Administration.

[51 FR 11718, Apr. 7, 1986, as amended at 62 FR 38454, July 18, 1997]

§ 416.110 Purpose of program.

The basic purpose underlying the supplemental security income program is to assure a minimum level of income for people who are age 65 or over, or who are blind or disabled and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level. The supplemental security income program replaces the financial assistance programs for the aged, blind, and disabled in the 50 States and the District of Columbia for which grants were made under the Social Security Act. Payments are financed from the general funds of the United States Treasury. Several basic principles underlie the program:

(a) *Objective tests.* The law provides that payments are to be made to aged, blind, and disabled people who have income and resources below specified amounts. This provides objective measurable standards for determining each person's benefits.

(b) *Legal right to payments.* A person's rights to supplemental security income payments—how much he gets and under what conditions—are clearly defined in the law. The area of administrative discretion is thus limited. If an applicant disagrees with the decision on his claim, he can obtain an administrative review of the decision and if still not satisfied, he may initiate court action.

(c) *Protection of personal dignity.* Under the Federal program, payments are made under conditions that are as

protective of people's dignity as possible. No restrictions, implied or otherwise, are placed on how recipients spend the Federal payments.

(d) *Nationwide uniformity of standards.* The eligibility requirements and the Federal minimum income level are identical throughout the 50 States and the District of Columbia. This provides assurance of a minimum income base on which States may build supplementary payments.

(e) *Incentives to work and opportunities for rehabilitation.* Payment amounts are not reduced dollar-for-dollar for work income but some of an applicant's income is counted toward the eligibility limit. Thus, recipients are encouraged to work if they can. Blind and disabled recipients with vocational rehabilitation potential are referred to the appropriate State vocational rehabilitation agencies that offer rehabilitation services to enable them to enter the labor market.

(f) *State supplementation and Medicaid determinations.* (1) Federal supplemental security income payments lessen the variations in levels of assistance and provide a basic level of assistance throughout the nation. States are required to provide mandatory minimum State supplementary payments beginning January 1, 1974, to aged, blind, or disabled recipients of assistance for the month of December 1973 under such State's plan approved under title I, X, XIV, or XVI of the Act in order for the State to be eligible to receive title XIX funds (see subpart T of this part). These payments must be in an amount sufficient to ensure that individuals who are converted to the new program will not have their income reduced below what it was under the State program for December 1973. In addition, each State may choose to provide more than the Federal supplemental security income and/or mandatory minimum State supplementary payment to whatever extent it finds appropriate in view of the needs and resources of its citizens or it may choose to provide no more than the mandatory minimum payment where applicable. States which provide State supplementary payments can enter into agreements for Federal administration of the mandatory and optional State supplementary payments with the Federal Government paying the administrative costs. A State which elects Federal administration of its supplementation program must apply the same eligibility criteria (other than those pertaining to income) applied to determine eligibility for the Federal portion of the supplemental security income payment, except as provided in sec. 1616(c) of the Act (see subpart T of this part). There is a limitation on the amount payable to the Commissioner by a State for the amount of the supplementary payments made on its behalf for any fiscal year pursuant to the State's agreement with the Secretary. Such limitation on the amount of reimbursement is related to the State's payment levels for January 1972 and its total expenditures for calendar year 1972 for aid and assistance under the appropriate State plan(s) (see subpart T of this part).

(2) States with Medicaid eligibility requirements for the aged, blind, and disabled that are identical (except as permitted by § 416.2111) to the supplemental security income eligibility requirements may elect to have the Social Security Administration determine Medicaid eligibility under the State's program for recipients of supplemental security income and recipients of a federally administered State supplementary payment. The State would pay half of Social Security Administration's incremental administrative costs arising from carrying out the agreement.

[39 FR 28625, Aug. 9, 1974, as amended at 53 FR 12941, Apr. 20, 1988; 62 FR 38454, July 18, 1997]

§ 416.120 General definitions and use of terms.

(a) *Terms relating to acts and regulations.* As used in this part:

(1) *The Act* means the Social Security Act as amended (42 U.S.C. Chap. 7).

(2) Wherever a title is referred to, it means such title of the Act.

(3) Vocational Rehabilitation Act means the act approved June 2, 1920 (41 Stat. 735), 29 U.S.C. 31–42, as amended, and as may be amended from time to time hereafter.

(b) *Commissioner; Appeals Council; Administrative Law Judge; Administrative*

Appeals Judge defined—(1) *Commissioner* means the Commissioner of Social Security.

(2) *Appeals Council* means the Appeals Council of the Office of Analytics, Review, and Oversight in the Social Security Administration or such member or members thereof as may be designated by the Chair of the Appeals Council.

(3) *Administrative Law Judge* means an Administrative Law Judge in the Office of Hearings Operations in the Social Security Administration.

(4) *Administrative Appeals Judge* means an Administrative Appeals Judge serving as a member of the Appeals Council.

(c) *Miscellaneous.* As used in this part unless otherwise indicated:

(1) *Supplemental security income benefit* means the amount to be paid to an eligible individual (or eligible individual and his eligible spouse) under title XVI of the Act.

(2) *Income* means the receipt by an individual of any property or service which he can apply, either directly or by sale or conversion, to meeting his basic needs (see subpart K of this part).

(3) *Resources* means cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for support and maintenance (see § 416.1201(a)).

(4) *Attainment of age.* An individual attains a given age on the first moment of the day preceding the anniversary of his birth corresponding to such age.

(5) *Couple* means an eligible individual and his eligible spouse.

(6) *Institution* (see § 416.201).

(7) *Public institution* (see § 416.201).

(8) *Resident of a public institution* (see § 416.201).

(9) *State*, unless otherwise indicated, means a State of the United States, the District of Columbia, or effective January 9, 1978, the Northern Mariana Islands.

(10) The term *United States* when used in a geographical sense means the 50 States, the District of Columbia, and effective January 9, 1978, the Northern Mariana Islands.

(11) Masculine gender includes the feminine, unless otherwise indicated.

(12) *Section* means a section of the regulations in part 416 of this chapter unless the context indicates otherwise.

(13) *Eligible individual* means an aged, blind, or disabled individual who meets all the requirements for eligibility for benefits under the supplemental security income program.

(14) *Eligible spouse* means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who is living with that individual (see § 416.1801(c)).

(d) *Periods of limitation ending on nonwork days.* Pursuant to the Act, where any provision of title XVI, or any provision of another law of the United States (other than the Internal Revenue Code of 1954) relating to or changing the effect of title XVI, or any regulation of the Commissioner issued under title XVI, provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under title XVI or is necessary to establish or protect any rights under title XVI and such period ends on a Saturday, Sunday, or Federal legal holiday or on any other day all or part of which is declared to be a nonworkday for Federal employees by statute or Executive Order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonworkday for Federal employees either by statute or Executive Order. For purposes of this paragraph, the day on which a period ends shall include the final day of any extended period where such extension is authorized by law or by the Commissioner pursuant to law. Such extension of any period of limitation does not apply to periods during which an application for benefits or payments may be accepted as such an application pursuant to subpart C of this part.

[39 FR 28625, Aug. 9, 1974, as amended at 43 FR 25091, June 9, 1978; 51 FR 11719, Apr. 7, 1986; 60 FR 16374, Mar. 30, 1995; 62 FR 38454, July 18, 1997; 85 FR 73159, Nov. 16, 2020]

§ 416.121 Receipt of aid or assistance for December 1973 under an approved State plan under title I, X, XIV, or XVI of the Social Security Act.

(a) *Recipient of aid or assistance defined.* As used in this part 416, the term *individual who was a recipient of aid or assistance for December 1973* under a State plan approved under title I, X, XIV, or XVI of the Social Security Act means an individual who correctly received aid or assistance under such plan for December 1973 even though such aid or assistance may have been received subsequent to December 1973. It also includes an individual who filed an application prior to January 1974 and was otherwise eligible for aid or assistance for December 1973 under the provisions of such State plan but did not in fact receive such aid or assistance. It does not include an individual who received aid or assistance because of the provisions of 45 CFR 205.10(a) (pertaining to continuation of assistance until a fair hearing decision is rendered), as in effect in December 1973, and with respect to whom it is subsequently determined that such aid or assistance would not have been received without application of the provisions of such 45 CFR 205.10(a).

(b) *Aid or assistance defined.* As used in this part 416, the term *aid or assistance* means aid or assistance as defined in titles I, X, XIV, and XVI of the Social Security Act, as in effect in December 1973, and such aid or assistance is eligible for Federal financial participation in accordance with those titles and the provisions of 45 CFR chapter II as in effect in December 1973.

(c) *Determinations of receipt of aid or assistance for December 1973.* For the purpose of application of the provisions of this part 416, the determination as to whether an individual was a recipient of aid or assistance for December 1973 under a State plan approved under title I, X, XIV, or XVI of the Social Security Act will be made by the Social Security Administration. In making such determination, the Social Security Administration may take into consideration a prior determination by the appropriate State agency as to whether the individual was eligible for aid or assistance for December 1973 under such State plan. Such prior determination, however, shall not be considered as conclusive in determining whether an individual was a recipient of aid or assistance for December 1973 under a State plan approved under title I, X, XIV, or XVI of the Social Security Act for purposes of application of the provisions of this part 416.

(d) *Special provision for disabled recipients.* For purposes of § 416.907, the criteria and definitions enumerated in paragraphs (a) through (c) of this section are applicable in determining whether an individual was a recipient of aid or assistance (on the basis of disability) under a State plan approved under title XIV or XVI of the Act for a month prior to July 1973. It is not necessary that the aid or assistance for December 1973 and for a month prior to July 1973 have been paid under the State plan of the same State.

[39 FR 32024, Sept. 4, 1974; 39 FR 33207, Sept. 16, 1974, as amended at 51 FR 11719, Apr. 7, 1986]

Subpart B—Eligibility

AUTHORITY: Secs. 702(a)(5), 1110(b), 1602, 1611, 1614, 1619(a), 1631, and 1634 of the Social Security Act (42 U.S.C. 902(a)(5), 1310(b), 1381a, 1382, 1382c, 1382h(a), 1383, and 1383c); secs. 211 and 212, Pub. L. 93–66, 87 Stat. 154 and 155 (42 U.S.C. 1382 note); sec. 502(a), Pub. L. 94–241, 90 Stat. 268 (48 U.S.C. 1681 note); sec. 2, Pub. L. 99–643, 100 Stat. 3574 (42 U.S.C. 1382h *note*).

SOURCE: 47 FR 3103, Jan. 22, 1982, unless otherwise noted.

GENERAL

§ 416.200 Introduction.

You are eligible for SSI benefits if you meet all the basic requirements listed in § 416.202. However, the first month for which you may receive SSI benefits is the month after the month in which you meet these eligibility requirements. (See § 416.501.) You must give us any information we request and show us necessary documents or other evidence to prove that you meet these requirements. We determine your eligibility for each month on the basis of your countable income in that month. You continue to be eligible unless you lose your eligibility because you no

longer meet the basic requirements or because of one of the reasons given in §§ 416.207 through 416.216.

[64 FR 31972, June 15, 1999, as amended at 68 FR 53508, Sept. 11, 2003]

§ 416.201 General definitions and terms used in this subpart.

Any 9-month period means any period of 9 full calendar months ending with any full calendar month throughout which (as defined in § 416.211) an individual is residing in a public emergency shelter for the homeless (as defined in this section) and including the immediately preceding 8 consecutive full calendar months. January 1988 is the earliest possible month in any 9-month period.

Educational or vocational training means a recognized program for the acquisition of knowledge or skills to prepare an individual for gainful employment. For purposes of these regulations, educational or vocational training does not include programs limited to the acquisition of basic life skills including but not limited to eating and dressing.

Emergency shelter means a shelter for individuals whose homelessness poses a threat to their lives or health.

Homeless individual is one who is not in the custody of any public institution and has no currently usable place to live. By *custody* we mean the care and control of an individual in a mandatory residency where the individual's freedom to come and go as he or she chooses is restricted. An individual in a public institution awaiting discharge and placement in the community is in the custody of that institution until discharged and is not homeless for purposes of this provision.

Institution means an establishment that makes available some treatment or services in addition to food and shelter to four or more persons who are not related to the proprietor.

Medical treatment facility means an institution or that part of an institution that is licensed or otherwise approved by a Federal, State, or local government to provide inpatient medical care and services.

Public emergency shelter for the homeless means a public institution or that part of a public institution used as an emergency shelter by the Federal government, a State, or a political subdivision of a State, primarily for making available on a temporary basis a place to sleep, food, and some services or treatment to homeless individuals. A medical treatment facility (as defined in § 416.201) or any holding facility, detoxification center, foster care facility, or the like that has custody of the individual is not a public emergency shelter for the homeless. Similarly, transitional living arrangements such as a halfway house that are part of an institution's plan to facilitate the individual's adjustment to community living are not public emergency shelters for the homeless.

Public institution means an institution that is operated by or controlled by the Federal government, a State, or a political subdivision of a State such as a city or county. The term *public institution* does not include a publicly operated community residence which serves 16 or fewer residents.

Resident of a public institution means a person who can receive substantially all of his or her food and shelter while living in a public institution. The person need not be receiving treatment and services available in the institution and is a resident regardless of whether the resident or anyone else pays for all food, shelter, and other services in the institution. A person is not a resident of a public institution if he or she is living in a public educational institution for the primary purpose of receiving educational or vocational training as defined in this section. A *resident* of a public institution means the same thing as an *inmate* of a public institution as used in section 1611(e)(1)(A) of the Social Security Act. (See § 416.211(b), (c), and (d) of this subpart for exceptions to the general limitation on the eligibility for Supplemental Security Income benefits of individuals who are residents of a public institution.)

SSI means supplemental security income.

State assistance means payments made by a State to an aged, blind, or disabled person under a State plan approved under title I, X, XIV, or XVI (AABD) of the Social Security Act

which was in effect before the SSI Program.

We or *Us* means the Social Security Administration.

You or *Your* means the person who applies for or receives SSI benefits or the person for whom an application is filed.

[47 FR 3103, Jan. 22, 1982, as amended at 49 FR 19639, May 19, 1984; 50 FR 48570, Nov. 26, 1985; 50 FR 51517, Dec. 18, 1985; 54 FR 19164, May 4, 1989; 72 FR 50874, Sept. 5, 2007]

§ 416.202 Who may get SSI benefits.

You are eligible for SSI benefits if you meet all of the following requirements:

(a) You are—

(1) Aged 65 or older (subpart H);

(2) Blind (subpart I); or

(3) Disabled (subpart I).

(b) You are a resident of the United States (§ 416.1603), and—

(1) A citizen or a national of the United States (§ 416.1610);

(2) An alien lawfully admitted for permanent residence in the United States (§ 416.1615);

(3) An alien permanently residing in the United States under color of law (§ 416.1618); or

(4) A child of armed forces personnel living overseas as described in § 416.216.

(c) You do not have more income than is permitted (subparts K and D).

(d) You do not have more resources than are permitted (subpart L).

(e) You are disabled, drug addiction or alcoholism is a contributing factor material to the determination of disability (see § 416.935), and you have not previously received a total of 36 months of Social Security benefit payments when appropriate treatment was available or 36 months of SSI benefits on the basis of disability where drug addiction or alcoholism was a contributing factor material to the determination of disability.

(f) You are not—

(1) Fleeing to avoid prosecution for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State);

(2) Fleeing to avoid custody or confinement after conviction for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(3) Violating a condition of probation or parole imposed under Federal or State law.

(g) You file an application for SSI benefits (subpart C).

[47 FR 3103, Jan. 22, 1982, as amended at 58 FR 4897, Jan. 19, 1993; 60 FR 8149, Feb. 10, 1995; 61 FR 10277, Mar. 13, 1996; 65 FR 40495, June 30, 2000]

§ 416.203 Initial determinations of SSI eligibility.

(a) *What happens when you apply for SSI benefits.* When you apply for SSI benefits we will ask you for documents and any other information we need to make sure you meet all the requirements. We will ask for information about your income and resources and about other eligibility requirements and you must answer completely. We will help you get any documents you need but do not have.

(b) *How we determine your eligibility for SSI benefits.* We determine that you are eligible for SSI benefits for a given month if you meet the requirements in § 416.202 in that month. However, you cannot become eligible for payment of SSI benefits until the month after the month in which you first become eligible for SSI benefits (see § 416.501). In addition, we usually determine the amount of your SSI benefits for a month based on your income in an earlier month (see § 416.420). Thus, it is possible for you to meet the eligibility requirements in a given month but receive no benefit payment for that month.

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 48570, Nov. 26, 1985; 64 FR 31972, June 15, 1999]

§ 416.204 Redeterminations of SSI eligibility.

(a) *Redeterminations defined.* A redetermination is a review of your eligibility to make sure that you are still eligible and that you are receiving the right amount of SSI benefits. This review deals with the requirements for eligibility other than whether you are

still disabled or blind. Continuation of disability or blindness reviews are discussed in §§ 416.989 and 416.990.

(b) *When we make redeterminations.* (1) We redetermine your eligibility on a scheduled basis at periodic intervals. The length of time between scheduled redeterminations varies depending on the likelihood that your situation may change in a way that affects your benefits.

(2) We may also redetermine your eligibility when you tell us (or we otherwise learn) of a change in your situation which affects your eligibility or the amount of your benefit.

(c) *The period for which a redetermination applies:* (1) The first redetermination applies to—

(i) The month in which we make the redetermination;

(ii) All months beginning with the first day of the latest of the following:

(A) The month of first eligibility or re-eligibility; or

(B) The month of application; or

(C) The month of deferred or updated development; and

(iii) Future months until the second redetermination.

(2) All other redeterminations apply to—

(i) The month in which we make the redetermination;

(ii) All months beginning with the first day of the month the last redetermination was initiated; and

(iii) Future months until the next redetermination.

(3) If we made two redeterminations which cover the same month, the later redetermination is the one we apply to that month.

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 48570, Nov. 26, 1985; 58 FR 64893, Dec. 10, 1993]

REASONS WHY YOU MAY NOT GET SSI BENEFITS FOR WHICH YOU ARE OTHERWISE ELIGIBLE

§ 416.207 You do not give us permission to contact financial institutions.

(a) To be eligible for SSI payments you must give us permission to contact any financial institution and request any financial records that financial institution may have about you. You must give us this permission when you apply for SSI payments or when we ask for it at a later time. You must also provide us with permission from anyone whose income and resources we consider as being available to you, *i.e.*, deemors (*see* §§ 416.1160, 416.1202, 416.1203, and 416.1204).

(b) *Financial institution* means any:

(1) Bank,

(2) Savings bank,

(3) Credit card issuer,

(4) Industrial loan company,

(5) Trust company,

(6) Savings association,

(7) Building and loan,

(8) Homestead association,

(9) Credit union,

(10) Consumer finance institution, or

(11) Any other financial institution as defined in section 1101(1) of the Right to Financial Privacy Act.

(c) *Financial record* means an original of, a copy of, or information known to have been derived from any record held by the financial institution pertaining to your relationship with the financial institution.

(d) We may ask any financial institution for information on any financial account concerning you. We may also ask for information on any financial accounts for anyone whose income and resources we consider as being available to you (*see* §§ 416.1160, 416.1202, 416.1203, and 416.1204).

(e) We ask financial institutions for this information when we think that it is necessary to determine your SSI eligibility or payment amount.

(f) Your permission to contact financial institutions, and the permission of anyone whose income and resources we consider as being available to you, *i.e.*, a deemor (see §§ 416.1160, 416.1202, 416.1203, and 416.1204), remains in effect until a terminating event occurs. The following terminating events only apply prospectively and do not invalidate the permission for past periods.

(1) You cancel your permission in writing and provide the writing to us.

(2) The deemor cancels their permission in writing and provides the writing to us.

(3) The basis on which we consider a deemor's income and resources available to you ends, e.g. when spouses separate or divorce or a child attains age 18.

(4) Your application for SSI is denied, and the denial is final. A denial is final when made, unless you appeal the denial timely as described in §§ 416.1400 through 416.1499.

(5) You are no longer eligible for SSI as described in §§ 416.1331 through 416.1335.

(g) If you don't give us permission to contact any financial institution and request any financial records about you when we think it is necessary to determine your SSI eligibility or payment amount, or if you cancel the permission, you cannot be eligible for SSI payments. Also, except as noted in paragraph (h), if anyone whose income and resources we consider as being available to you (*see* §§ 416.1160, 416.1202, 416.1203, and 416.1204) doesn't give us permission to contact any financial institution and request any financial records about that person when we think it is necessary to determine your eligibility or payment amount, or if that person cancels the permission, you cannot be eligible for SSI payments. This means that if you are applying for SSI payments, you cannot receive them. If you are receiving SSI payments, we will stop your payments.

(h) You may be eligible for SSI payments if there is good cause for your being unable to obtain permission for us to contact any financial institution and request any financial records about someone whose income and resources we consider as being available to you (see §§ 416.1160, 416.1202, 416.1203, and 416.1204).

(1) Good cause exists if permission cannot be obtained from the individual and there is evidence that the individual is harassing you, abusing you, or endangering your life.

(2) Good cause may exist if an individual other than one listed in paragraph (h)(3) of this section refuses to provide permission and: you acted in good faith to obtain permission from the individual but were unable to do so through no fault of your own, or you cooperated with us in our efforts to obtain permission.

(3) Good cause does not apply if the individual is your representative payee and your legal guardian, if you are a minor child and the individual is your representative payee and your custodial parent, or if you are an alien and the individual is your sponsor or the sponsor's living-with spouse.

[68 FR 53508, Sept. 11, 2003]

§ 416.210 You do not apply for other benefits.

(a) *General rule.* You are not eligible for SSI benefits if you do not apply for all other benefits for which you may be eligible.

(b) *What ''other benefits'' includes.* ''Other benefits'' includes any payments for which you can apply that are available to you on an ongoing or one-time basis of a type that includes annuities, pensions, retirement benefits, or disability benefits. For example, ''other benefits'' includes veterans' compensation and pensions, workers' compensation payments, Social Security insurance benefits and unemployment insurance benefits. ''Other benefits'' for which you are required to apply do not include payments that you may be eligible to receive from a fund established by a State to aid victims of crime. (See § 416.1124(c)(17).)

(c) *Our notice to you.* We will give you a dated, written notice that will tell you about any other benefits that we think you are likely to be eligible for. In addition, the notice will explain that your eligibility for SSI benefits will be affected if you do not apply for those other benefits.

(d) *What you must do to apply for other benefits.* In order to apply for other benefits, you must file any required applications and do whatever else is needed so that your eligibility for the other benefits can be determined. For example, if any documents (such as a copy of a birth certificate) are required in addition to the application, you must submit them.

(e) *What happens if you do not apply for the other benefits.* (1) If you do not apply for the other benefits within 30 days from the day that you receive our written notice, you are not eligible for SSI benefits. This means that if you are applying for SSI benefits, you cannot receive them. If you are receiving

SSI benefits, your SSI benefits will stop. In addition, you will have to repay us for any SSI benefits that you received beginning with the month that you received our written notice. We assume (unless you prove otherwise) that you received our written notice 5 days after the date shown on the notice. We will also find that you are not eligible for SSI benefits if you file the required application for other benefits but do not take other necessary steps to obtain them.

(2) We will not find you ineligible for SSI benefits if you have a good reason for not applying for the other benefits within the 30-day period or taking other necessary steps to obtain them. In determining whether a good reason exists, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which may have caused you to fail to apply for other benefits. You may have a good reason if, for example—

(i) You are incapacitated (because of illness you were not able to apply); or

(ii) It would be useless for you to apply (you once applied for the benefits and the reasons why you were turned down have not changed).

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 5573, Feb. 11, 1985; 50 FR 14211, Apr. 11, 1985; 59 FR 1635, Jan. 12, 1994; 61 FR 1712, Jan. 23, 1996]

§ 416.211 You are a resident of a public institution.

(a) *General rule.* (1) Subject to the exceptions described in paragraphs (b), (c), and (d) of this section and § 416.212, you are not eligible for SSI benefits for any month throughout which you are a resident of a public institution as defined in § 416.201. In addition, if you are a resident of a public institution when you apply for SSI benefits and meet all other eligibility requirements, you cannot be eligible for payment of benefits until the first day of the month following the day of your release from the institution.

(2) By *throughout a month* we mean that you reside in an institution as of the beginning of a month and stay the entire month. If you have been a resident of a public institution, you remain a resident if you are transferred from one public institution to another or if you are temporarily absent for a period of not more than 14 consecutive days. A person also is a resident of an institution throughout a month if he or she is born in the institution during the month and resides in the institution the rest of the month or resides in the institution as of the beginning of a month and dies in the institution during the month.

(b) *Exception—SSI benefits payable at a reduced rate.* You may be eligible for SSI benefits at a reduced rate described in § 416.414, if—

(1)(i) You reside throughout a month in a public institution that is a medical treatment facility where Medicaid (title XIX of the Social Security Act) pays a substantial part (more than 50 percent) of the cost of your care; you are a child under the age of 18 residing throughout a month in a public institution that is a medical treatment facility where a substantial part (more than 50 percent) of the cost of your care is paid under a health insurance policy issued by a private provider of such insurance; or, you are a child under the age of 18 residing throughout a month in a public institution that is a medical treatment facility where a substantial part (more than 50 percent) of the cost of your care is paid by a combination of Medicaid payments and payments made under a health insurance policy issued by a private provider of such insurance; or

(ii) You reside for part of a month in a public institution and the rest of the month in a public institution or private medical treatment facility where Medicaid pays a substantial part (more than 50 percent) of the cost of your care; you are a child under the age of 18 residing for part of a month in a public institution and the rest of the month in a public institution or private medical treatment facility where a substantial part (more than 50 percent) of the cost of your care is paid under a health insurance policy issued by a private provider of such insurance; or you are a child under the age of 18 residing for part of a month in a public institution and the rest of the month in a public institution or private medical treatment facility where a substantial part (more than 50 percent) of the cost of

your care is paid by a combination of Medicaid payments and payments made under a health insurance policy issued by a private provider; and

(2) You are ineligible in that month for a benefit described in § 416.212 that is payable to a person temporarily confined in a medical treatment facility.

(c) *Exception for publicly operated community residences which serve no more than 16 residents*—(1) *General rule.* If you are a resident of a publicly operated community residence which serves no more than 16 residents, you may be eligible for SSI benefits.

(2) *Services that a facility must provide in order to be a community residence.* To be a community residence, a facility must provide food and shelter. In addition, it must make available some other services. For example, the other services could be—

(i) Social services;

(ii) Help with personal living activities;

(iii) Training in socialization and life skills; or

(iv) Providing occasional or incidental medical or remedial care.

(3) *Serving no more than 16 residents.* A community residence serves no more than 16 residents if—

(i) It is designed and planned to serve no more than 16 residents, or the design and plan were changed to serve no more than 16 residents; and

(ii) It is in fact serving 16 or fewer residents.

(4) *Publicly operated.* A community residence is publicly operated if it is operated or controlled by the Federal government, a State, or a political subdivision of a State such as a city or county.

(5) *Facilities which are not a publicly operated community residence.* If you live in any of the following facilities, you are not a resident of a publicly operated community residence:

(i) A residential facility which is on the grounds of or next to a large institution or multipurpose complex;

(ii) An educational or vocational training institution whose main function is to provide an approved, accredited, or recognized program to some or all of those who live there;

(iii) A jail or other facility where the personal freedom of anyone who lives there is restricted because that person is a prisoner, is being held under court order, or is being held until charges against that person are disposed of; or

(iv) A medical treatment facility (defined in § 416.201).

(d) *Exception for residents of public emergency shelters for the homeless.* For months after December 1987, if you are a resident of a public emergency shelter for the homeless (defined in § 416.201) you may be eligible for SSI benefits for any 6 months throughout which you reside in a shelter in any 9-month period (defined in § 416.201). The 6 months do not need to be consecutive and we will not count as part of the 6 months any prior months throughout which you lived in the shelter but did not receive SSI benefits. We will also not count any months throughout which you lived in the shelter and received SSI benefits prior to January 1988.

Example: You are receiving SSI benefits when you lose your home and enter a public emergency shelter for the homeless on March 10, 1988. You remain a resident of a shelter until October 10, 1988. Since you were not in the shelter throughout the month of March, you are eligible to receive your benefit for March without having this month count towards the 6-month period. The last full month throughout which you reside in the shelter is September 1988. Therefore, if you meet all eligibility requirements, you will also be paid benefits for April through September (6 months during the 9-month period September 1988 back through January 1988). If you are otherwise eligible, you will receive your SSI benefit for October when you left the shelter, since you were not a resident of the shelter throughout that month.

[47 FR 3103, Jan. 22, 1982, as amended at 50 FR 51518, Dec. 18, 1985; 51 FR 13492, Apr. 21, 1986; 51 FR 17332, May 12, 1986; 51 FR 34464, Sept. 29, 1986; 54 FR 19164, May 4, 1989; 61 FR 10277, Mar. 13, 1996; 62 FR 1055, Jan. 8, 1997; 64 FR 31972, June 15, 1999; 72 FR 50874, Sept. 5, 2007]

§ 416.212 Continuation of full benefits in certain cases of medical confinement.

(a) *Benefits payable under section 1611(e)(1)(E) of the Social Security Act.* Subject to eligibility and regular computation rules (see subparts B and D of this part), you are eligible for the benefits payable under section 1611(e)(1)(E)

of the Social Security Act for up to 2 full months of medical confinement during which your benefits would otherwise be suspended because of residence in a public institution or reduced because of residence in a public or private institution where Medicaid pays a substantial part (more than 50 percent) of the cost of your care or, if you are a child under age 18, reduced because of residence in a public or private institution which receives payments under a health insurance policy issued by a private provider, or a combination of Medicaid and a health insurance policy issued by a private provider, pay a substantial part (more than 50 percent) of the cost of your care if—

(1) You were eligible under either section 1619(a) or section 1619(b) of the Social Security Act in the month before the first full month of residence in an institution;

(2) The institution agrees that no portion of these benefits will be paid to or retained by the institution excepting nominal sums for reimbursement of the institution for any outlay for a recipient's personal needs (e.g., personal hygiene items, snacks, candy); and

(3) The month of your institutionalization is one of the first 2 full months of a continuous period of confinement.

(b) *Benefits payable under section 1611(e)(1)(G) of the Social Security Act.* (1) Subject to eligibility and regular computation rules (see subparts B and D of this part), you are eligible for the benefits payable under section 1611(e)(1)(G) of the Social Security Act for up to 3 full months of medical confinement during which your benefits would otherwise be suspended because of residence in a public institution or reduced because of residence in a public or private institution where Medicaid pays a substantial part (more than 50 percent) of the cost of your care or, if you are a child under age 18, reduced because of residence in a public or private institution which receives payments under a health insurance policy issued by a private provider, or a combination of Medicaid and a health insurance policy issued by a private provider, pay a substantial part (more than 50 percent) of the cost of your care if—

(i) You were eligible for SSI cash benefits and/or federally administered State supplementary payments for the month immediately prior to the first full month you were a resident in such institution;

(ii) The month of your institutionalization is one of the first 3 full months of a continuous period of confinement;

(iii) A physician certifies, in writing, that you are not likely to be confined for longer than 90 full consecutive days following the day you entered the institution, and the certification is submitted to SSA no later than the day of discharge or the 90th full day of confinement, whichever is earlier; and

(iv) You need to pay expenses to maintain the home or living arrangement to which you intend to return after institutionalization and evidence regarding your need to pay these expenses is submitted to SSA no later than the day of discharge or the 90th full day of confinement, whichever is earlier.

(2) We will determine the date of submission of the evidence required in paragraphs (b)(1) (iii) and (iv) of this section to be the date we receive it or, if mailed, the date of the postmark.

(c) *Prohibition against using benefits for current maintenance.* If the recipient is a resident in an institution, the recipient or his or her representative payee will not be permitted to pay the institution any portion of benefits payable under section 1611(e)(1)(G) excepting nominal sums for reimbursement of the institution for any outlay for the recipient's personal needs (e.g., personal hygiene items, snacks, candy). If the institution is the representative payee, it will not be permitted to retain any portion of these benefits for the cost of the recipient's current maintenance excepting nominal sums for reimbursement for outlays for the recipient's personal needs.

[61 FR 10277, Mar. 13, 1996, as amended at 62 FR 1055, Jan. 8, 1997; 72 FR 50874, Sept. 5, 2007]

§ 416.214 You are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *If you do not comply with treatment requirements.* If you receive benefits because you are disabled and drug addiction or alcoholism is a contributing

factor material to the determination of disability (see § 416.935), you must avail yourself of any appropriate treatment for your drug addiction or alcoholism at an approved institution or facility when this treatment is available and make progress in your treatment. You are not eligible for SSI benefits beginning with the month after the month you are notified in writing that we determined that you have failed to comply with the treatment requirements. If your benefits are suspended because you failed to comply with treatment requirements, you will not be eligible to receive benefits until you have demonstrated compliance with treatment for a period of time, as specified in § 416.1326. The rules regarding treatment for drug addiction and alcoholism are in subpart I of this part.

(b) *If you previously received 36 months of SSI or Social Security benefits.* You are not eligible for SSI benefits by reason of disability on the basis of drug addiction or alcoholism as described in § 416.935 if—

(1) You previously received a total of 36 months of SSI benefits on the basis of disability and drug addiction or alcoholism was a contributing factor material to the determination of disability for months beginning March 1995, as described in § 416.935. Not included in these 36 months are months before March 1995 and months for which your benefits were suspended for any reason. The 36-month limit is no longer effective for months beginning after September 2004; or

(2) You previously received a total of 36 months of Social Security benefits counted in accordance with the provisions of §§ 404.316, 404.337, and 404.352 by reason of disability on the basis of drug addiction or alcoholism as described in § 404.1535.

[60 FR 8149, Feb. 10, 1995. Redesignated at 61 FR 10277, Mar. 13, 1996]

§ 416.215 You leave the United States.

You lose your eligibility for SSI benefits for any month during all of which you are outside of the United States. If you are outside of the United States for 30 days or more in a row, you are not considered to be back in the United States until you are back for 30 days in a row. You may again be eligible for SSI benefits in the month in which the 30 days end if you continue to meet all other eligibility requirements.

By *United States,* we mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

[47 FR 3103, Jan. 22, 1982. Redesignated at 61 FR 10277, Mar. 13, 1996]

§ 416.216 You are a child of armed forces personnel living overseas.

(a) *General rule.* For purposes of this part, *overseas* means any location outside the United States as defined in § 416.215; *i.e.*, the 50 States, the District of Columbia and the Northern Mariana Islands. You may be eligible for SSI benefits if you live overseas and if—

(1) You are a child as described in § 416.1856;

(2) You are a citizen of the United States; and

(3) You are living with a parent as described in § 416.1881 who is a member of the armed forces of the United States assigned to permanent duty ashore overseas.

(b) *Living with.* You are considered to be living with your parent who is a member of the armed forces if—

(1) You physically live with the parent who is a member of the armed forces overseas; or

(2) You are not living in the same household as the military parent but your presence overseas is due to his or her permanent duty assignment.

[58 FR 4897, Jan. 19, 1993; 58 FR 9597, Feb. 22, 1993, as amended at 59 FR 41400, Aug. 12, 1994. Redesignated at 61 FR 10277, Mar. 13, 1996; 70 FR 61366, Oct. 24, 2005]

ELIGIBILITY FOR INCREASED BENEFITS BECAUSE OF ESSENTIAL PERSONS

§ 416.220 General.

If you are a *qualified* individual and have an essential person you may be eligible for increased benefits. You may be a qualified individual and have an essential person only if you received benefits under a State assistance plan approved under title I, X, XIV, or XVI (AABD) of the Act for December 1973. Definitions and rules that apply to qualified individuals and essential persons are discussed in §§ 416.221 through 416.223.

§ 416.221 Who is a qualified individual.

You are a qualified individual if—

(a) You received aid or assistance for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI (AABD) of the Act;

(b) The State took into account the needs of another person in deciding your need for the State assistance for December 1973;

(c) That other person was living in your home in December 1973; and

(d) That other person was not eligible for State assistance for December 1973.

§ 416.222 Who is an essential person.

(a) *General rule.* A person is an essential person if—

(1) That person has continuously lived in the home of the same qualified individual since December 1973;

(2) That person was not eligible for State assistance for December 1973;

(3) That person was never eligible for SSI benefits in his or her own right or as an eligible spouse; and

(4) There are State records which show that under a State plan in effect for June 1973, the State took that person's needs into account in determining the qualified individual's need for State assistance for December 1973.

Any person who meets these requirements is an essential person. This means that the qualified individual can have more than one essential person.

(b) *Absence of an essential person from the home of a qualified individual.* An essential person may be temporarily absent from the house of a qualified individual and still be an essential person. For example, the essential person could be hospitalized. We consider an absence to temporary if—

(1) The essential person intends to return;

(2) The facts support this intention;

(3) It is likely that he or she will return; and

(4) The absence is not longer than 90 days.

(c) *Absence of a qualified individual from his or her home.* You may be temporarily absent from your home and still have an essential person. For example, you could be hospitalized. We consider an absence to be temporary if—

(1) You intend to return;

(2) The facts support your intention;

(3) It is likely that you will return; and

(4) Your absence does not exceed six months.

(d) *Essential person becomes eligible for SSI benefits.* If an essential person becomes eligible for SSI benefits, he or she will no longer be an essential person beginning with the month that he or she becomes eligible for the SSI benefits.

§ 416.223 What happens if you are a qualified individual.

(a) *Increased SSI benefits.* We may increase the amount of your SSI benefits if—

(1) You are a qualified individual; and

(2) You have one or more essential persons in your home.

In subpart D, we explain how these increased benefits are calculated.

(b) *Income and resource limits.* If you are a qualified individual, we consider the income and resources of an essential person in your home to be yours. You are eligible for increased SSI benefits if—

(1) Your resources which are counted do not exceed the limit for SSI eligibility purposes (see subpart L); and

(2) Your income which is counted for SSI eligibility purposes (see subpart K) does not exceed the sum of—

(i) The SSI Federal benefit rate (see subpart D); and

(ii) The proper number of essential person increments (for the value of an essential person increment see subpart D). One essential person increment is added to the SSI Federal benefit rate for each essential person in your home.

(c) *Excluding the income and resources of an essential person.* (1) While an essential person increment increases your SSI Federal benefit rate, that person's income which we consider to be yours may actually result in a lower monthly payment to you. We will discuss this with you and explain how an essential person affects your benefit. If you choose to do so, you may ask us in writing to determine your eligibility without your essential person or, if you have more than one essential person, without one or more of your essential persons. We will then figure the amount of your SSI benefits without

counting as your own income and resources of the essential persons that you specify and we will end the essential person increment for those essential persons. You should consider this carefully because once you make the request, you cannot withdraw it. We will make the change beginning with the month following the month that you make the request.

(2) We will not include the income and resources of the essential person if the person's income or resources would cause you to lose your eligibility. The loss of the essential person increment will be permanent.

§ 416.250 Experimental, pilot, and demonstration projects in the SSI program.

(a) *Authority and purpose.* Section 1110(b) of the Act authorizes the Commissioner to develop and conduct experimental, pilot, and demonstration projects to promote the objectives or improve the administration of the SSI program. These projects will test the advantages of altering certain requirements, conditions, or limitations for recipients and test different administrative methods that apply to title XVI applicants and recipients.

(b) *Altering benefit requirements, limitations or conditions.* Notwithstanding any other provision of this part, the Commissioner is authorized to waive any of the requirements, limitations or conditions established under title XVI of the Act and impose additional requirements, limitations or conditions for the purpose of conducting experimental, pilot, or demonstration projects. The projects will alter the provisions that currently apply to applicants and recipients to test their effect on the program. If, as a result of participation in a project under this section, a project participant becomes ineligible for Medicaid benefits, the Commissioner shall make arrangements to extend Medicaid coverage to such participant and shall reimburse the States for any additional expenses incurred due to such continued participation.

(c) *Applicability and scope*—(1) *Participants and nonparticipants.* If you are selected to participate in an experimental, pilot, or demonstration project, we may temporarily set aside one or more current requirements, limitations or conditions of eligibility and apply alternative provisions to you. We may also modify current methods of administering title XVI as part of a project and apply alternative procedures or policies to you. The alternative provisions or methods of administration used in the projects will not substantially reduce your total income or resources as a result of your participation or disadvantage you in comparison to current provisions, policies, or procedures. If you are not selected to participate in the experimental, or pilot, or demonstration projects (or if you are placed in a control group which is not subject to the alternative requirements, limitations, or conditions) we will continue to apply the current requirements, limitations or conditions of eligibility to you.

(2) *Alternative provisions or methods of administration.* The alternative requirements, limitations or conditions that apply to you in an experimental, pilot, or demonstration project may include any of the factors needed for aged, blind, or disabled persons to be eligible for SSI benefits. Experiments that we conduct will include, to the extent feasible, applicants and recipients who are under age 18 as well as adults and will include projects to ascertain the feasibility of treating drug addicts and alcoholics.

(d) *Selection of participants.* Participation in the SSI project will be on a voluntary basis. The voluntary written consent necessary in order to participate in any experimental, pilot, or demonstration project may be revoked by the participant at any time.

(e) *Duration of experimental, pilot, and demonstration projects.* A notice describing each experimental, pilot, or demonstration project will be published in the FEDERAL REGISTER before each project is placed in operation. Each experimental, pilot and demonstration project will have a termination date (up to 10 years from the start of the project).

[48 FR 7576, Feb. 23, 1983, as amended at 52 FR 37605, Oct. 8, 1987; 62 FR 38454, July 18, 1997]

SPECIAL PROVISIONS FOR PEOPLE WHO WORK DESPITE A DISABLING IMPAIRMENT

§ 416.260 General.

The regulations in §§ 416.260 through 416.269 describe the rules for determining eligibility for special SSI cash benefits and for special SSI eligibility status for an individual who works despite a disabling impairment. Under these rules an individual who works despite a disabling impairment may qualify for special SSI cash benefits and in most cases for Medicaid benefits when his or her gross earned income exceeds the applicable dollar amount which ordinarily represents SGA described in § 416.974(b)(2). The calculation of this gross earned income amount, however, is not to be considered an actual SGA determination. Also, for purposes of determining eligibility or continuing eligibility for Medicaid benefits, a blind or disabled individual (no longer eligible for regular SSI benefits or for special SSI cash benefits) who, except for earnings, would otherwise be eligible for SSI cash benefits may be eligible for a special SSI eligibility status under which he or she is considered to be a blind or disabled individual receiving SSI benefits. We explain the rules for eligibility for special SSI cash benefits in §§ 416.261 and 416.262. We explain the rules for the special SSI eligibility status in §§ 416.264 through 416.269.

[59 FR 41403, Aug. 12, 1994]

§ 416.261 What are special SSI cash benefits and when are they payable.

Special SSI cash benefits are benefits that we may pay you in lieu of regular SSI benefits because your gross earned income in a month of initial eligibility for regular SSI benefits exceeds the amount ordinarily considered to represent SGA under § 416.974(b)(2). You must meet the eligibility requirements in § 416.262 in order to receive special SSI cash benefits. Special SSI cash benefits are not payable for any month in which your countable income exceeds the limits established for the SSI program (see subpart K of this part). If you are eligible for special SSI cash benefits, we consider you to be a disabled individual receiving SSI benefits for purposes of eligibility for Medicaid. We compute the amount of special SSI cash benefits according to the rules in subpart D of this part. If your State makes supplementary payments which we administer under a Federal-State agreement, and if your State elects to supplement the special SSI cash benefits, the rules in subpart T of this part will apply to these payments.

[47 FR 15324, Apr. 9, 1982, as amended at 50 FR 46763, Nov. 13, 1985; 59 FR 41403, Aug. 12, 1994]

§ 416.262 Eligibility requirements for special SSI cash benefits.

You are eligible for special SSI cash benefits if you meet the following requirements—

(a) You were eligible to receive a regular SSI benefit or a federally administered State supplementary payment (see § 416.2001) in a month before the month for which we are determining your eligibility for special SSI cash benefits as long as that month was not in a prior period of eligibility which has terminated according to §§ 416.1331 through 416.1335;

(b) In the month for which we are making the determination, your gross earned income exceeds the amount ordinarily considered to represent SGA under § 416.974(b)(2);

(c) You continue to have a disabling impairment;

(d) If your disability is based on a determination that drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 416.935, you have not yet received SSI cash benefits, special SSI cash benefits, or special SSI eligibility status for a total of 36 months, or Social Security benefit payments when treatment was available for a total of 36 months; and

(e) You meet all the nondisability requirements for eligibility for SSI benefits (see § 416.202).

We will follow the rules in this subpart in determining your eligibility for special SSI cash benefits.

[47 FR 15324, Apr. 9, 1982, as amended at 59 FR 41404, Aug. 12, 1994; 60 FR 8149, Feb. 10, 1995; 64 FR 31972, June 15, 1999]

§ 416.263 No additional application needed.

We do not require you to apply for special cash benefits nor is it necessary

for you to apply to have the special SSI eligibility status determined. We will make these determinations automatically.

[47 FR 15324, Apr. 9, 1982]

§ 416.264 When does the special SSI eligibility status apply.

The special SSI eligibility status applies for the purposes of establishing or maintaining your eligibility for Medicaid. For these purposes we continue to consider you to be a blind or disabled individual receiving benefits even though you are in fact no longer receiving regular SSI benefits or special SSI cash benefits. You must meet the eligibility requirements in § 416.265 in order to qualify for the special SSI eligibility status. Special SSI eligibility status also applies for purposes of reacquiring status as eligible for regular SSI benefits or special SSI cash benefits.

[59 FR 41404, Aug. 12, 1994]

§ 416.265 Requirements for the special SSI eligibility status.

In order to be eligible for the special SSI eligibility status, you must have been eligible to receive a regular SSI benefit or a federally administered State supplementary payment (see § 416.2001) in a month before the month for which we are making the special SSI eligibility status determination. The month you were eligible for a regular SSI benefit or a federally administered State supplementary payment may not be in a prior period of eligibility which has been terminated according to §§ 416.1331 through 416.1335. For periods prior to May 1, 1991, you must be under age 65. Also, we must establish that:

(a) You are blind or you continue to have a disabling impairment which, if drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 416.935, has not resulted in your receiving SSI cash benefits, special SSI cash benefits, or special SSI eligibility status for a total of 36 months, or Social Security benefit payments when treatment was available for a total of 36 months;

(b) Except for your earnings, you meet all the nondisability requirements for eligibility for SSI benefits (see § 416.202);

(c) The termination of your eligibility for Medicaid would seriously inhibit your ability to continue working (see § 416.268); and

(d) Your earnings after the exclusions in § 416.1112(c) (6), (8), and (9) are not sufficient to allow you to provide yourself with a reasonable equivalent of the benefits (SSI benefits, federally administered State supplementary payments, Medicaid, and publicly-funded attendant care services, including personal care assistance under § 416.269(d)) which would be available to you if you did not have those earnings (see § 416.269).

[47 FR 15324, Apr. 9, 1982, as amended at 59 FR 41404, Aug. 12, 1994; 59 FR 49291, Sept. 27, 1994; 60 FR 8149, Feb. 10, 1995]

§ 416.266 Continuation of SSI status for Medicaid

If we stop your benefits because of your earnings and you are potentially eligible for the special SSI eligibility status you will continue to be considered an SSI recipient for purposes of eligibility for Medicaid during the time it takes us to determine whether the special eligibility status applies to you.

[47 FR 15324, Apr. 9, 1982]

§ 416.267 General.

We determine whether the special SSI eligibility status applies to you by verifying that you continue to be blind or have a disabling impairment by applying the rules in subpart I of this part, and by following the rules in this subpart to determine whether you meet the requirements in § 416.265(b). If you do not meet these requirements we determine that the special eligibility status does not apply. If you meet these requirements, then we apply special rules to determine if you meet the requirements of § 416.265 (c) and (d). If for the period being evaluated, you meet all of the requirements in § 416.265 we determine that the special status applies to you.

[47 FR 15324, Apr. 9, 1982]

§ 416.268 What is done to determine if you must have Medicaid in order to work.

For us to determine that you need Medicaid benefits in order to continue to work, you must establish:

(a) That you are currently using or have received services which were paid for by Medicaid during the period which began 12 months before our first contact with you to discuss this use; or

(b) That you expect to use these services within the next 12 months; or

(c) That you would need Medicaid to pay for unexpected medical expenses in the next 12 months.

[59 FR 41404, Aug. 12, 1994]

§ 416.269 What is done to determine whether your earnings are too low to provide comparable benefits and services you would receive in the absence of those earnings.

(a) *What we determine.* We must determine whether your earnings are too low to provide you with benefits and services comparable to the benefits and services you would receive if you did not have those earnings (see § 416.265(d)).

(b) *How the determination is made.* In determining whether your earnings are too low to provide you with benefits and services comparable to the benefits and services you would receive if you did not have those earnings, we compare your anticipated gross earnings (or a combination of anticipated and actual gross earnings, as appropriate) for the 12-month period beginning with the month for which your special SSI eligibility status is being determined to a threshold amount for your State of residence. This threshold amount consists of the sum for a 12-month period of two items, as follows:

(1) The amount of gross earnings including amounts excluded under § 416.1112(c) (4), (5) and (7) that would reduce to zero the Federal SSI benefit and the optional State supplementary payment for an individual with no other income living in his or her own household in the State where you reside. This amount will vary from State to State depending on the amount of the State supplementary payment; and

(2) The average expenditures for Medicaid benefits for disabled and blind SSI cash recipients, including recipients of federally administered State supplementary payments only, in your State of residence.

(c) *How the eligibility requirements are met.* (1) You meet the requirements in § 416.265(d) if the comparison shows that your gross earnings are equal to or less than the applicable threshold amount for your State, as determined under paragraphs (b) (1) and (2) of this section. However, if the comparison shows that these earnings exceed the applicable threshold amount for your State, we will establish (and use in a second comparison) an individualized threshold taking into account the total amount of:

(i) The amount determined under paragraph (b)(1) of this section that would reduce to zero the Federal SSI benefit and State supplementary payment for your actual living arrangement;

(ii) The average Medicaid expenditures for your State of residence under paragraph (b)(2) of this section or, if higher, your actual medical expenditures in the appropriate 12-month period;

(iii) Any amounts excluded from your income as impairment-related work expenses (see § 416.1112(c)(6)), work expenses of the blind (see § 416.1112(c)(8)), and income used or set aside for use under an approved plan for achieving self support (see § 416.1112(c)(9)); and

(iv) the value of any publicly-funded attendant care services as described in paragraph (d) of this section (including personal care assistance).

(2) If you have already completed the 12-month period for which we are determining your eligibility, we will consider only the expenditures made in that period.

(d) *Attendant care services.* Expenditures for attendant care services (including personal care assistance) which would be available to you in the absence of earnings that make you ineligible for SSI cash benefits will be considered in the individualized threshold (as described in paragraph (c)(1) of this section) if we establish that they are:

(1) Provided by a paid attendant;

(2) Needed to assist with work-related and/or personal functions; and

(3) Paid from Federal, State, or local funds.

(e) *Annual update of information.* The threshold amounts used in determinations of sufficiency of earnings will be based on information and data updated no less frequently than annually.

[59 FR 41404, Aug. 12, 1994; 59 FR 49291, Sept. 27, 1994]

Subpart C—Filing of Applications

AUTHORITY: Secs. 702(a)(5), 1611, and 1631 (a), (d), and (e) of the Social Security Act (42 U.S.C. 902(a)(5), 1382, and 1383 (a), (d), and (e)).

SOURCE: 45 FR 48120, July 18, 1980, unless otherwise noted.

GENERAL PROVISIONS

§ 416.301 Introduction.

This subpart contains the rules for filing a claim for supplemental security income (SSI) benefits. It tells you what an application is, who may sign it, who must file one to be eligible for benefits, the period of time it is in effect, and how it may be withdrawn. It also tells you when a written statement or an oral inquiry may be considered to establish an application filing date.

§ 416.302 Definitions.

For the purpose of this subpart—

Benefits means any payments made under the SSI program. SSI benefits also include any federally administered State supplementary payments.

Claimant means the person who files an application for himself or herself or the person on whose behalf an application is filed.

We or *us* means the Social Security Administration (SSA).

You or *your* means the person who applies for benefits, the person for whom an application is filed or anyone who may consider applying for benefits.

§ 416.305 You must file an application to receive supplemental security income benefits.

(a) *General rule.* In addition to meeting other requirements, you must file an application to become eligible to receive benefits. If you believe you may be eligible, you should file an application as soon as possible. Filing an application will—

(1) Permit us to make a formal determination whether or not you are eligible to receive benefits;

(2) Assure that you receive benefits for any months you are eligible to receive payment; and

(3) Give you the right to appeal if you disagree with the determination.

(b) *Exceptions.* You need not file a new application if—

(1) You have been receiving benefits as an eligible spouse and are no longer living with your husband or wife;

(2) You have been receiving benefits as an eligible spouse of an eligible individual who has died;

(3) You have been receiving benefits because you are disabled or blind and you are 65 years old before the date we determine that you are no longer blind or disabled.

(4) A redetermination of your eligibility is being made and it is found that you were not eligible for benefits during any part of a period for which we are making a redetermination but you currently meet the requirements for eligibility;

(5) You are notified that your payments of SSI benefits will be stopped because you are no longer eligible and you again meet the requirements for eligibility before your appeal rights are exhausted.

[45 FR 48120, July 18, 1980, as amended at 60 FR 16374, Mar. 30, 1995; 64 FR 31972, June 15, 1999]

APPLICATIONS

§ 416.310 What makes an application a claim for benefits.

An application will be considered a claim for benefits, if the following requirements are met:

(a) An application form prescribed by us must be filled out.

(b) be filed at a social security office, at another Federal or State office we have designated to receive applications for us, or with a person we have authorized to receive applications for us. See § 416.325.

(c) The claimant or someone who may sign an application for the claimant must sign the application. See §§ 416.315 and 416.320.

(d) The claimant must be alive at the time the application is filed. See §§ 416.340, 416.345, and 416.351 for exceptions.

[45 FR 48120, July 18, 1980, as amended at 59 FR 44926, Aug. 31, 1994]

§ 416.315 Who may sign an application.

We will determine who may sign an application according to the following rules:

(a) If you are 18 years old or over, mentally competent, and physically able, you must sign your own application. If you are 16 years old or older and under age 18, you may sign the application if you are mentally competent, have no court appointed representative, and are not in the care of any other person or institution.

(b) If the claimant is under age 18, or is mentally incompetent, or is physically unable to sign the application, a court appointed representative or a person who is responsible for the care of the claimant, including a relative, may sign the application. If the claimant is in the care of an institution, the manager or principal officer of the institution may sign the application.

(c) To prevent a claimant from losing benefits because of a delay in filing an application when there is a good reason why the claimant cannot sign an application, we may accept an application signed by someone other than a person described in this section.

Example: Mr. Smith comes to a Social Security office to file an application for SSI disability benefits for Mr. Jones. Mr. Jones, who lives alone, just suffered a heart attack and is in the hospital. He asked Mr. Smith, whose only relationship is that of a neighbor and friend, to file the application for him. We will accept an application signed by Mr. Smith since it would not be possible to have Mr. Jones sign and file the application at this time. SSI benefits can be paid starting with the first day of the month following the month the individual first meets all eligibility requirements for such benefits, including having filed an application. If Mr. Smith could not sign an application for Mr. Jones, a loss of benefits would result if it is later determined that Mr. Jones is in fact disabled.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13492, Apr. 21, 1986; 64 FR 31972, June 15, 1999]

§ 416.320 Evidence of authority to sign an application for another.

(a) A person who signs an application for someone else will be required to provide evidence of his or her authority to sign the application for the person claiming benefits under the following rules:

(1) If the person who signs is a court appointed representative, he or she must submit a certificate issued by the court showing authority to act for the claimant.

(2) If the person who signs is not a court appointed representative, he or she must submit a statement describing his or her relationship to the claimant. The statement must also describe the extent to which the person is responsible for the care of the claimant. This latter information will not be requested if the application is signed by a parent for a child with whom he or she is living. If the person signing is the manager or principal officer of an institution he or she should show his or her title.

(b) We may, at any time, require additional evidence to establish the authority of a person to sign an application for someone else.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986]

§ 416.325 When an application is considered filed.

(a) *General rule.* We consider an application for SSI benefits filed on the day it is received by an employee at any social security office, by someone at another Federal or State office designated to receive applications for us, or by a person we have authorized to receive applications for us.

(b) *Exceptions.* (1) When we receive an application that is mailed, we will use the date shown by the United States postmark as the filing date if using the date the application is received will result in a loss of benefits. If the postmark is unreadable or there is no postmark, we will use the date the application is signed (if dated) or 5 days before

the day we receive the signed application, whichever date is later.

(2) We consider an application to be filed on the date of the filing of a written statement or the making of an oral inquiry under the conditions in §§ 416.340, 416.345 and 416.350.

(3) We will establish a ''deemed'' filing date of an application in a case of misinformation under the conditions described in § 416.351. The filing date of the application will be a date determined under § 416.351(b).

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986; 59 FR 44926, Aug. 31, 1994]

§ 416.327 Pilot program for photographic identification of disability benefit applicants in designated geographic areas.

(a) To be eligible for SSI disability or blindness benefits in the designated pilot geographic areas during the time period of the pilot, you or a person acting on your behalf must give SSA permission to take your photograph and make this photograph a part of the claims folder. You must give us this permission when you apply for benefits and/or when we ask for it at a later time. Failure to cooperate will result in denial of benefits. We will permit an exception to the photograph requirement when an individual has a sincere religious objection. This pilot will be in effect for a six-month period after these final rules become effective.

(b) *Designated pilot geographic areas* means:

(1) All SSA field offices in the State of South Carolina.

(2) The Augusta, Georgia SSA field office.

(3) All SSA field offices in the State of Kansas.

(4) Selected SSA field offices located in New York City.

[68 FR 23195, May 1, 2003]

EFFECTIVE FILING PERIOD OF APPLICATION

§ 416.330 Filing before the first month you meet the requirements for eligibility.

If you file an application for SSI benefits before the first month you meet all the other requirements for eligibility, the application will remain in effect from the date it is filed until we make a final determination on your application, unless there is a hearing decision on your application. If there is a hearing decision, your application will remain in effect until the hearing decision is issued.

(a) If you meet all the requirements for eligibility while your application is in effect, the earliest month for which we can pay you benefits is the month following the month that you first meet all the requirements.

(b) If you first meet all the requirements for eligibility after the period for which your application was in effect, you must file a new application for benefits. In this case, we can pay you benefits only from the first day of the month following the month that you meet all the requirements based on the new application.

[64 FR 31973, June 15, 1999]

§ 416.335 Filing in or after the month you meet the requirements for eligibility.

When you file an application in the month that you meet all the other requirements for eligibility, the earliest month for which we can pay you benefits is the month following the month you filed the application. If you file an application after the month you first meet all the other requirements for eligibility, we cannot pay you for the month in which your application is filed or any months before that month. See §§ 416.340, 416.345 and 416.350 on how a written statement or an oral inquiry made before the filing of the application form may affect the filing date of the application.

[64 FR 31973, June 15, 1999]

FILING DATE BASED UPON A WRITTEN STATEMENT OR ORAL INQUIRY

§ 416.340 Use of date of written statement as application filing date.

We will use the date a written statement, such as a letter, an SSA questionnaire or some other writing, is received at a social security office, at another Federal or State office designated by us, or by a person we have authorized to receive applications for us as the filing date of an application

for benefits, only if the use of that date will result in your eligibility for additional benefits. If the written statement is mailed, we will use the date the statement was mailed to us as shown by a United States postmark. If the postmark is unreadable or there is no postmark, we will use the date the statement is signed (if dated) or 5 days before the day we receive the written statement, whichever date is later, as the filing date of an application for benefits. In order for us to use your written statement to protect your filing date, the following requirements must be met:

(a) The written statement shows an intent to claim benefits for yourself or for another person.

(b) You, your spouse or a person who may sign an application for you signs the statement.

(c) An application form signed by you or by a person who may sign an application for you is filed with us within 60 days after the date of a notice we will send telling of the need to file an application. The notice will say that we will make an initial determination of eligibility for SSI benefits if an application form is filed within 60 days after the date of the notice. (We will send the notice to the claimant, or where he or she is a minor or incompetent, to the person who gave us the written statement.)

(d)(1) The claimant is alive when the application is filed on a prescribed form, or

(2) If the claimant dies after the written statement is filed, the deceased claimant's surviving spouse or parent(s) who could be paid the claimant's benefits under § 416.542(b), or someone on behalf of the surviving spouse or parent(s) files an application form. If we learn that the claimant has died before the notice is sent or within 60 days after the notice but before an application form is filed, we will send a notice to such a survivor. The notice will say that we will make an initial determination of eligibility for SSI benefits only if an application form is filed on behalf of the deceased within 60 days after the date of the notice to the survivor.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986; 58 FR 52912, Oct. 13, 1993]

§ 416.345 Use of date of oral inquiry as application filing date.

We will use the date of an oral inquiry about SSI benefits as the filing date of an application for benefits only if the use of that date will result in your eligibility for additional benefits and the following requirements are met:

(a) The inquiry asks about the claimant's eligibility for SSI benefits.

(b) The inquiry is made by the claimant, the claimant's spouse, or a person who may sign an application on the claimant's behalf as described in § 416.315.

(c) The inquiry, whether in person or by telephone, is directed to an office or an official described in § 416.310(b).

(d) The claimant or a person on his or her behalf as described in § 416.315 files an application on a prescribed form within 60 days after the date of the notice we will send telling of the need to file an application. The notice will say that we will make an initial determination of eligibility for SSI benefits if an application form is filed within 60 days after the date of the notice. (We will send the notice to the claimant or, where he or she is a minor or incompetent, to the person who made the inquiry.)

(e)(1) The claimant is alive when the application is filed on a prescribed form, or

(2) If the claimant dies after the oral inquiry is made, the deceased claimant's surviving spouse or parent(s) who could be paid the claimant's benefits under § 416.542(b), or someone on behalf of the surviving spouse or parent(s) files an application form. If we learn that the claimant has died before the notice is sent or within 60 days after the notice but before an application form is filed, we will send a notice to such a survivor. The notice will say that we will make an initial determination of eligibility for SSI benefits only if an application form is filed on behalf of the deceased within 60 days

after the date of the notice to the survivor.

[45 FR 48120, July 18, 1980, as amended at 51 FR 13493, Apr. 21, 1986; 58 FR 52912, Oct. 13, 1993]

§ 416.350 Treating a title II application as an oral inquiry about SSI benefits.

(a) When a person applies for benefits under title II (retirement, survivors, or disability benefits) we will explain the requirements for receiving SSI benefits and give the person a chance to file an application for them if—

(1) The person is within 2 months of age 65 or older or it looks as if the person might qualify as a blind or disabled person, and

(2) It is not clear that the person's title II benefits would prevent him or her from receiving SSI or any State supplementary benefits handled by the Social Security Administration.

(b) If the person applying for title II benefits does not file an application for SSI on a prescribed form when SSI is explained to him or her, we will treat his or her filing of an application for title II benefits as an oral inquiry about SSI, and the date of the title II application form may be used to establish the SSI application date if the requirements of § 416.345 (d) and (e) are met.

DEEMED FILING DATE BASED ON MISINFORMATION

§ 416.351 Deemed filing date in a case of misinformation.

(a) *General.* You may have considered applying for SSI benefits for yourself or for another person, and you may have contacted us in writing, by telephone or in person to inquire about filing an application for these benefits. It is possible that in responding to your inquiry, we may have given you misinformation about your eligibility for such benefits, or the eligibility of the person on whose behalf you were considering applying for benefits, which caused you not to file an application at that time. If this happened, and later an application for such benefits is filed with us, we may establish an earlier filing date under this section.

Example 1: Ms. Jones calls a Social Security office to inquire about filing an application for SSI benefits. During her conversation with an SSA employee, she tells the employee about her resources. The SSA employee tells Ms. Jones that because her countable resources are above the allowable limit, she would be ineligible for SSI benefits. The employee fails to consider certain resource exclusions under the SSI program which would have reduced Ms. Jones' countable resources below the allowable limit, making her eligible for benefits. Because Ms. Jones thought that she would be ineligible, she decides not to file an application for SSI benefits. Ms. Jones later reads about resource exclusions under the SSI program. She recontacts the Social Security office to file an SSI application, and alleges that she had been previously misinformed about her eligibility for SSI benefits. She files an application for SSI benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date based upon her receipt of misinformation.

Example 2: Mr. Adams resides in a State which provides State supplementary payments that are administered by SSA under the SSI program. He telephones a Social Security office and tells an SSA employee that he does not have enough income to live on and wants to file for SSI benefits. Mr. Adams states that his only income is his monthly Social Security benefit check. The SSA employee checks Mr. Adams' Social Security record and advises him that he is ineligible for SSI benefits based on the amount of his monthly Social Security benefit. The employee does not consider whether Mr. Adams would be eligible for State supplementary payments. Because Mr. Adams was told that he would not be eligible for benefits under the SSI program, he does not file an application. The employee does not make a record of Mr. Adams' oral inquiry or take any other action. A year later, Mr. Adams speaks to a neighbor who receives the same Social Security benefit amount that Mr. Adams does, but also receives payments under the SSI program. Thinking the law may have changed, Mr. Adams recontacts a Social Security office and learns from an SSA employee that he would be eligible for State supplementary payments under the SSI program and that he could have received these payments earlier had he filed an application. Mr. Adams explains that he did not file an application earlier because he was told by an SSA employee that he was not eligible for SSI benefits. Mr. Adams files an application for the benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date

based on the misinformation provided to him earlier.

(b) *Deemed filing date of an application based on misinformation.* Subject to the requirements and conditions in paragraphs (c) through (g) of this section, we may establish a deemed filing date of an application for SSI benefits under the following provisions.

(1)(i) If we determine that you failed to apply for SSI benefits for yourself because we gave you misinformation about your eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which you met all of the requirements for eligibility for such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for you under paragraph (b)(1)(i) of this section, you or a person described in §416.315 must file an application for such benefits. If you die before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if a person who would be qualified under §416.542(b) to receive any benefits due you, or someone on his or her behalf, files an application for the benefits.

(2)(i) If you had authority under §416.315 to sign an application for benefits for another person, and we determine that you failed to apply for SSI benefits for that person because we gave you misinformation about that person's eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which the person met all of the requirements for eligibility for such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for the person under paragraph (b)(2)(i) of this section, you, such person, or another person described in §416.315 must file an application for such benefits. If the person referred to in paragraph (b)(2)(i) of this section dies before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if a person who would be qualified under §416.542(b) to receive any benefits due the deceased person, or someone on his behalf, files an application for the benefits.

(c) *Requirements concerning the misinformation.* We apply the following requirements for purposes of paragraph (b) of this section.

(1) The misinformation must have been provided to you by one of our employees while he or she was acting in his or her official capacity as our employee. For purposes of this section, an employee includes an officer of SSA.

(2) Misinformation is information which we consider to be incorrect, misleading, or incomplete in view of the facts which you gave to the employee, or of which the employee was aware or should have been aware, regarding your particular circumstances, or the particular circumstances of the person referred to in paragraph (b)(2)(i) of this section. In addition, for us to find that the information you received was incomplete, the employee must have failed to provide you with the appropriate, additional information which he or she would be required to provide in carrying out his or her official duties.

(3) The misinformation may have been provided to you orally or in writing.

(4) The misinformation must have been provided to you in response to a specific request by you to us for information about your eligibility for benefits or the eligibility for benefits of the person referred to in paragraph (b)(2)(i) of this section for which you were considering filing an application.

(d) *Evidence that misinformation was provided.* We will consider the following evidence in making a determination under paragraph (b) of this section.

(1) *Preferred evidence.* Preferred evidence is written evidence which relates directly to your inquiry about your eligibility for benefits or the eligibility of another person and which shows that we gave you misinformation which caused you not to file an application.

Preferred evidence includes, but is not limited to, the following—

(i) A notice, letter, or other document which was issued by us and addressed to you; or

(ii) Our record of your telephone call, letter, or in-person contact.

(2) *Other evidence.* In the absence of preferred evidence, we will consider other evidence, including your statements about the alleged misinformation, to determine whether we gave you misinformation which caused you not to file an application. We will not find that we gave you misinformation, however, based solely on your statements. Other evidence which you provide or which we obtain must support your statements. Evidence which we will consider includes, but is not limited to, the following—

(i) Your statements about the alleged misinformation, including statements about—

(A) The date and time of the alleged contact(s);

(B) How the contact was made, e.g., by telephone or in person;

(C) The reason(s) the contact was made;

(D) Who gave the misinformation; and

(E) The questions you asked and the facts you gave us, and the questions we asked and the information we gave you at the time of the contact;

(ii) Statements from others who were present when you were given the alleged misinformation, e.g., a neighbor who accompanied you to our office;

(iii) If you can identify the employee or the employee can recall your inquiry about benefits—

(A) Statements from the employee concerning the alleged contact, including statements about the questions you asked, the facts you gave, the questions the employee asked, and the information provided to you at the time of the alleged contact; and

(B) Our assessment of the likelihood that the employee provided the alleged misinformation;

(iv) An evaluation of the credibility and the validity of your allegations in conjunction with other relevant information; and

(v) Any other information regarding your alleged contact.

(e) *Information which does not constitute satisfactory proof that misinformation was given.* Certain kinds of information will not be considered satisfactory proof that we gave you misinformation which caused you not to file an application. Examples of such information include—

(1) General informational pamphlets that we issue to provide basic program information;

(2) The SSI Benefit Estimate Letter that is based on an individual's reported and projected income and is an estimate which can be requested at any time;

(3) General information which we review or prepare but which is disseminated by the media, e.g., radio, television, magazines, and newspapers; and

(4) Information provided by other governmental agencies, e.g., the Department of Veterans Affairs, the Department of Defense, State unemployment agencies, and State and local governments.

(f) *Claim for benefits based on misinformation.* You may make a claim for benefits based on misinformation at any time. Your claim must contain information that will enable us to determine if we did provide misinformation to you about your eligibility for SSI benefits, or the eligibility of a person on whose behalf you were considering applying for benefits, which caused you not to file an application for the benefits. Specifically, your claim must be in writing and it must explain what information was provided; how, when, and where it was provided and by whom; and why the information caused you not to file an application. If you give us this information, we will make a determination on such a claim for benefits if all of the following conditions are also met.

(1) An application for the benefits described in paragraph (b)(1)(i) or (b)(2)(i) of this section is filed with us by someone described in paragraph (b)(1)(ii) or (b)(2)(ii) of this section, as appropriate. The application must be filed after the alleged misinformation was provided. This application may be—

(i) An application on which we have made a previous final determination or decision awarding the benefits, but

only if the claimant continues to be eligible for benefits (or again could be eligible for benefits) based on that application;

(ii) An application on which we have made a previous final determination or decision denying the benefits, but only if such determination or decision is reopened under § 416.1488; or

(iii) A new application on which we have not made a final determination or decision.

(2) The establishment of a deemed filing date of an application for benefits based on misinformation could result in the claimant becoming eligible for benefits or for additional benefits.

(3) We have not made a previous final determination or decision to which you were a party on a claim for benefits based on alleged misinformation involving the same facts and issues. This provision does not apply, however, if the final determination or decision may be reopened under § 416.1488.

(g) *Effective date.* This section applies only to misinformation which we provided on or after December 19, 1989. In addition, this section is effective only for benefits payable for months after December 1989.

[59 FR 44926, Aug. 31, 1994]

WITHDRAWAL OF APPLICATION

§ 416.355 Withdrawal of an application.

(a) *Request for withdrawal filed before we make a determination.* If you make a request to withdraw your application before we make a determination on your claim, we will approve the request if the following requirements are met:

(1) You or a person who may sign an application for you signs a written request to withdraw the application and files it at a place described in § 416.325.

(2) You are alive when the request is filed.

(b) *Request for withdrawal filed after a determination is made.* If you make a request to withdraw your application after we make a determination on your claim, we will approve the request if the following requirements are met:

(1) The conditions in paragraph (a) of this section are met.

(2) Every other person who may lose benefits because of the withdrawal consents in writing (anyone who could sign an application for that person may give the consent).

(3) All benefits already paid based on the application are repaid or we are satisfied that they will be repaid.

(c) *Effect of withdrawal.* If we approve your request to withdraw an application, we will treat the application as though you never filed it. If we disapprove your request for withdrawal, we will treat the application as though you never requested the withdrawal.

§ 416.360 Cancellation of a request to withdraw.

You may cancel your request to withdraw your application and your application will still be good if the following requirements are met:

(a) You or a person who may sign an application for you signs a written request for cancellation and files it at a place described in § 416.325.

(b) You are alive at the time the request for cancellation is filed.

(c) For a cancellation request received after we have approved the withdrawal, the cancellation request is filed no later than 60 days after the date of the notice of approval of the withdrawal request.

Subpart D—Amount of Benefits

AUTHORITY: Secs. 702(a)(5), 1611 (a), (b), (c), and (e), 1612, 1617, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382 (a), (b), (c), and (e), 1382a, 1382f, and 1383).

§ 416.401 Scope of subpart.

This subpart D sets forth basic guidelines for establishing the amount of monthly benefits payable to an eligible individual or couple (as defined in § 416.120(c)(5)). This subpart does not contain provisions with respect to establishing the amount of State supplementary payments payable in accordance with an agreement entered into between a State and the Administration under the provisions of subpart T of this part. Provisions with respect to determination and payment of State supplementary payments under such agreements will be administered by the Administration in accordance with the terms set forth in such agreements.

[39 FR 23053, June 26, 1974]

§ 416.405 Cost-of-living adjustments in benefits.

Whenever benefit amounts under title II of the Act (part 404 of this chapter) are increased by any percentage effective with any month as a result of a determination made under Section 215(i) of the Act, each of the dollar amounts in effect for such month under §§ 416.410, 416.412, and 416.413, as specified in such sections or as previously increased under this section or under any provision of the Act, will be increased. We will increase the unrounded yearly SSI benefit amount by the same percentage by which the title II benefits are being increased based on the Consumer Price Index, or, if greater, the percentage they would be increased if the rise in the Consumer Price Index were currently the basis for the title II increase. (See §§ 404.270–404.277 for an explanation of how the title II cost-of-living adjustment is computed.) If the increased annual SSI benefit amount is not a multiple of $12, it will be rounded to the next lower multiple of $12.

[51 FR 12606, Apr. 21, 1986; 51 FR 16016, Apr. 30, 1986]

§ 416.410 Amount of benefits; eligible individual.

The benefit under this part for an eligible individual (including the eligible individual receiving benefits payable under the § 416.212 provisions) who does not have an eligible spouse, who is not subject to either benefit suspension under § 416.1325 or benefit reduction under § 416.414, and who is not a qualified individual (as defined in § 416.221) shall be payable at the rate of $5,640 per year ($470 per month) effective for the period beginning January 1, 1996. This rate is the result of a 2.6 percent cost-of-living adjustment (see § 416.405) to the December 1995 rate. For the period January 1, through December 31, 1995, the rate payable, as increased by the 2.8 percent cost-of-living adjustment, was $5,496 per year ($458 per month). For the period January 1, through December 31, 1994, the rate payable, as increased by the 2.6 percent cost-of-living adjustment, was $5,352 per year ($446 per month). The monthly rate is reduced by the amount of the individual's income which is not excluded pursuant to subpart K of this part.

[61 FR 10278, Mar. 13, 1996]

§ 416.412 Amount of benefits; eligible couple.

The benefit under this part for an eligible couple (including couples where one or both members of the couple are receiving benefits payable under the § 416.212 provisions), neither of whom is subject to suspension of benefits based on § 416.1325 or reduction of benefits based on § 416.414 nor is a qualified individual (as defined in § 416.221) shall be payable at the rate of $8,460 per year ($705 per month), effective for the period beginning January 1, 1996. This rate is the result of a 2.6 percent cost-of-living adjustment (see § 416.405) to the December 1995 rate. For the period January 1, through December 31, 1995, the rate payable, as increased by the 2.8 percent cost-of-living adjustment, was $8,224 per year ($687 per month). For the period January 1, through December 31, 1994, the rate payable, as increased by the 2.6 percent cost-of-living adjustment, was $8,028 per year ($669 per month). The monthly rate is reduced by the amount of the couple's income which is not excluded pursuant to subpart K of this part.

[61 FR 10278, Mar. 13, 1996]

§ 416.413 Amount of benefits; qualified individual.

The benefit under this part for a qualified individual (defined in § 416.221) is payable at the rate for an eligible individual or eligible couple plus an increment for each essential person (defined in § 416.222) in the household, reduced by the amount of countable income of the eligible individual or eligible couple as explained in § 416.420. A qualified individual will receive an increment of $2,820 per year ($235 per month), effective for the period beginning January 1, 1996. This rate is the result of the 2.6 percent cost-of-living adjustment (see § 416.405) to the December 1995 rate, and is for each essential person (as defined in § 416.222) living in the household of a qualified individual. (See § 416.532.) For the period January 1, through December 31, 1995, the rate payable, as increased by the 2.8 percent

cost-of-living adjustment, was $2,748 per year ($229 per month). For the period January 1, through December 31, 1994, the rate payable, as increased by the 2.6 percent cost-of-living adjustment, was $2,676 per year ($223 per month). The total benefit rate, including the increment, is reduced by the amount of the individual's or couple's income that is not excluded pursuant to subpart K of this part.

[61 FR 10278, Mar. 13, 1996]

§ 416.414 Amount of benefits; eligible individual or eligible couple in a medical treatment facility.

(a) *General rule.* Except where the § 416.212 provisions provide for payment of benefits at the rates specified under §§ 416.410 and 416.412, reduced SSI benefits are payable to persons and couples who are in medical treatment facilities where a substantial part (more than 50 percent) of the cost of their care is paid by a State plan under title XIX of the Social Security Act (Medicaid). This reduced SSI benefit rate applies to persons who are in medical treatment facilities where a substantial part (more than 50 percent) of the cost would have been paid by an approved Medicaid State plan but for the application of section 1917(c) of the Social Security Act due to a transfer of assets for less than fair market value. This reduced SSI benefit rate also applies to children under age 18 who are in medical treatment facilities where a substantial part (more than 50 percent) of the cost of their care is paid by a health insurance policy issued by a private provider of such insurance, or where a substantial part (more than 50 percent) of the cost of their care is paid for by a combination of Medicaid payments and payments made under a health insurance policy issued by a private provider of such insurance. Persons and couples to whom these reduced benefits apply are—

(1) Those who are otherwise eligible and who are in the medical treatment facility throughout a month. (By *throughout a month* we mean that you are in the medical treatment facility as of the beginning of the month and stay the entire month. If you are in a medical treatment facility you will be considered to have continuously been staying there if you are transferred from one medical treatment facility to another or if you are temporarily absent for a period of not more than 14 consecutive days.); and

(2) Those who reside for part of a month in a public institution and for the rest of the month are in a public or private medical treatment facility where Medicaid pays or would have paid (but for the application of section 1917(c) of the Act) a substantial part (more than 50 percent) of the cost of their care; and

(3) Children under age 18 who reside for part of a month in a public institution and for the rest of the month are in a public or private medical treatment facility where a substantial part (more than 50 percent) of the cost of their care is being paid under a health insurance policy issued by a private provider or by a combination of Medicaid and payments under a health insurance policy issued by a private provider.

(b) *The benefit rates are*—(1) *Eligible individual.* For months after June 1988, the benefit rate for an eligible individual with no eligible spouse is $30 per month. The benefit payment is figured by subtracting the eligible individual's countable income (see subpart K) from the benefit rate as explained in § 416.420.

(2) *Eligible couple both of whom are temporarily absent from home in medical treatment facilities as described in § 416.1149(c)(1).* For months after June 1988, the benefit rate for a couple is $60 a month. The benefit payment is figured by subtracting the couple's countable income (see subpart K) from the benefit rate as explained in § 416.420.

(3) *Eligible couple with one spouse who is temporarily absent from home as described in § 416.1149(c)(1).* The couple's benefit rate equals:

(i) For months after June 1988, $30 per month for the spouse in the medical treatment facility; plus

(ii) The benefit rate for an eligible individual (see § 416.410) for the spouse who is not in the medical treatment facility. The benefit payment for each spouse is figured by subtracting each individual's own countable income in the appropriate month (see § 416.420) from his or her portion of the benefit

rate shown in paragraphs (b)(3) (i) and (ii).

(c) *Definition.* For purposes of this section, a *medical treatment facility* means an institution or that part of an institution that is licensed or otherwise approved by a Federal, State, or local government to provide inpatient medical care and services.

[47 FR 3106, Jan. 22, 1982, as amended at 50 FR 48571, Nov. 26, 1985; 50 FR 51514, Dec. 18, 1985; 54 FR 19164, May 4, 1989; 58 FR 64894, Dec. 10, 1993; 60 FR 16374, Mar. 30, 1995; 61 FR 10278, Mar. 13, 1996; 62 FR 1056, Jan. 8, 1997; 72 FR 50874, Sept. 5, 2007; 72 FR 54350, Sept. 25, 2007]

§ 416.415 Amount of benefits; eligible individual is disabled child under age 18.

(a) If you are a disabled child under age 18 and meet the conditions in § 416.1165(i) for waiver of deeming, your parents' income will not be deemed to you and your benefit rate will be $30 a month.

(b) If you are a disabled child under age 18 and do not meet the conditions in § 416.1165(i) only because your parents' income is not high enough to make you ineligible for SSI but deeming of your parents' income would result in an SSI benefit less than the amount payable if you received benefits as a child under § 416.1165(i), your benefit will be the amount payable if you received benefits as a child under § 416.1165(i).

[60 FR 361, Jan. 4, 1995]

§ 416.420 Determination of benefits; general.

Benefits shall be determined for each month. The amount of the monthly payment will be computed by reducing the benefit rate (see §§ 416.410, 416.412, 416.413, and 416.414) by the amount of countable income as figured under the rules in subpart K of this part. The appropriate month's countable income to be used to determine how much your benefit payment will be for the current month (the month for which a benefit is payable) will be determined as follows:

(a) *General rule.* We generally use the amount of your countable income in the second month prior to the current month to determine how much your benefit amount will be for the current month. We will use the benefit rate (see §§ 416.410 through 416.414), as increased by a cost-of-living adjustment, in determining the value of the one-third reduction or the presumed maximum value, to compute your SSI benefit amount for the first 2 months in which the cost-of-living adjustment is in effect. If you have been receiving an SSI benefit and a Social Security insurance benefit and the latter is increased on the basis of the cost-of-living adjustment or because your benefit is recomputed, we will compute the amount of your SSI benefit for January, the month of an SSI benefit increase, by including in your income the amount by which your Social Security benefit in January exceeds the amount of your Social Security benefit in November. Similarly, we will compute the amount of your SSI benefit for February by including in your income the amount by which your Social Security benefit in February exceeds the amount of your Social Security benefit in December.

Example 1. Mrs. X's benefit amount is being determined for September (the current month). Mrs. X's countable income in July is used to determine the benefit amount for September.

Example 2. Mr. Z's SSI benefit amount is being determined for January (the current month). There has been a cost-of-living increase in SSI benefits effective January. Mr. Z's countable income in November is used to determine the benefit amount for January. In November, Mr. Z had in-kind support and maintenance valued at the presumed maximum value as described in § 416.1140(a). We will use the January benefit rate, as increased by the COLA, to determine the value of the in-kind support and maintenance Mr. Z received in November when we determine Mr. Z's SSI benefit amount for January.

Example 3. Mr. Y's SSI benefit amount is being determined for January (the current month). Mr. Y has Social Security income of $100 in November, $100 in December, and $105 in January. We find the amount by which his Social Security income in January exceeds his Social Security income in November ($5) and add that to his income in November to determine the SSI benefit amount for January.

(b) *Exceptions to the general rule*—(1) *First month of initial eligibility for payment or the first month of eligibility after a month of ineligibility.* We use your

countable income in the current month to determine your benefit amount for the first month you are initially eligible for payment of SSI benefits (see §416.501) or for the first month you again become eligible for SSI benefits after at least a month of ineligibility. Your payment for a first month of reeligibility after at least one-month of ineligibility will be prorated according to the number of days in the month that you are eligible beginning with the date on which you reattain eligibility.

Example: Mrs. Y applies for SSI benefits in September and meets the requirements for eligibility in that month. (We use Mrs. Y's countable income in September to determine if she is eligible for SSI in September.) The first month for which she can receive payment is October (see §416.501). We use Mrs. Y's countable income in October to determine the amount of her benefit for October. If Mrs. Y had been receiving SSI benefits through July, became ineligible for SSI benefits in August, and again became eligible for such benefits in September, we would use Mrs. Y's countable income in September to determine the amount of her benefit for September. In addition, the proration rules discussed above would also apply to determine the amount of benefits in September in this second situation.

(2) *Second month of initial eligibility for payment or second month of eligibility after a month of ineligibility.* We use your countable income in the first month prior to the current month to determine how much your benefit amount will be for the current month when the current month is the second month of initial eligibility for payment or the second month of reeligibility following at least a month of ineligibility. However, if you have been receiving both an SSI benefit and a Social Security insurance benefit and the latter is increased on the basis of the cost-of-living adjustment or because your benefit is recomputed, we will compute the amount of your SSI benefit for January, the month of an SSI benefit increase, by including in your income the amount by which your Social Security benefit in January exceeds the amount of your Social Security benefit in December.

Example: Mrs. Y was initially eligible for payment of SSI benefits in October. Her benefit amount for November will be based on her countable income in October (first prior month).

(3) *Third month of initial eligibility for payment or third month of eligibility after a month of ineligibility.* We use your countable income according to the rule set out in paragraph (a) of this section to determine how much your benefit amount will be for the third month of initial eligibility for payment or the third month of reeligibility after at least a month of ineligibility.

Example: Mrs. Y was initially eligible for payment of SSI benefits in October. Her benefit amount for December will be based on her countable income in October (second prior month).

(4) *Income derived from certain assistance payments.* We use your income in the current month from the programs listed below to determine your benefit amount for that same month. The assistance programs are as follows:

(i) Aid to Families with Dependent Children under title IV-A of the Social Security Act (the Act);

(ii) Foster Care under title IV-E of the Act;

(iii) Refugee Cash Assistance pursuant to section 412(e) of the Immigration and Nationality Act;

(iv) Cuban and Haitian Entrant Assistance pursuant to section 501(a) of Pub. L. 96–422; and

(v) Bureau of Indian Affairs general assistance and child welfare assistance pursuant to 42 Stat. 208 as amended.

(c) *Reliable information which is currently available for determining benefits.* The Commissioner has determined that no reliable information exists which is currently available to use in determining benefit amounts.

(1) *Reliable information.* For purposes of this section *reliable information* means payment information that is maintained on a computer system of records by the government agency determining the payments (e.g., Department of Veterans Affairs, Office of Personnel Management for Federal civil service information and the Railroad Retirement Board).

(2) *Currently available information.* For purposes of this section *currently available information* means information that is available at such time that it

permits us to compute and issue a correct benefit for the month the information is pertinent.

(d) *Payment of benefits.* See subpart E of this part for the rules on payments and the minimum monthly benefit (as explained in § 416.503).

[50 FR 48571, Nov. 26, 1985; 50 FR 51514, Dec. 18, 1985, as amended at 54 FR 31657, Aug. 1, 1989; 62 FR 30751, June 5, 1997; 63 FR 33546, June 19, 1998; 64 FR 31973, June 15, 1999]

§ 416.421 Determination of benefits; computation of prorated benefits.

(a) In the month that you reacquire eligibility after a month or more of ineligibility (see § 416.1320(b)), your benefit will be prorated according to the number of days in the month that you are eligible beginning with the date on which you meet all eligibility requirements.

(b) In determining the amount of your benefit for a month in which benefits are to be prorated, we first compute the amount of the benefit that you would receive for the month as if proration did not apply. We then determine the date on which you meet all factors of eligibility. (The income limits must be met based on the entire month and the resource limit must be as of the first day of the month.) We then count the number of days in the month beginning with the day on which you first meet all factors of eligibility through the end of the month. We then multiply the amount of your unprorated benefit for the month by the number of days for which you are eligible for benefits and divide that figure by the number of days in the month for which your benefit is being determined. The result is the amount of the benefit that you are due for the month in which benefits are to be prorated.

[51 FR 13493, Apr. 14, 1986, as amended at 64 FR 31973, June 15, 1999]

§ 416.426 Change in status involving an individual; ineligibility occurs.

Whenever benefits are suspended or terminated for an individual because of ineligibility, no benefit is payable for that month.

[50 FR 48571, Nov. 26, 1985]

§ 416.428 Eligible individual without an eligible spouse has an essential person in his home.

When an eligible individual without an eligible spouse has an essential person (as defined in § 416.222 of this part) in his home, the amount by which his rate of payment is increased is determined in accordance with §§ 416.220 through 416.223 and with 416.413 of this part. The essential person's income is deemed to be that of the eligible individual, and the provisions of §§ 416.401 through 416.426 will apply in determining the benefit of such eligible individual.

[39 FR 23053, June 26, 1974, as amended at 51 FR 10616, Mar. 28, 1986; 65 FR 16814, Mar. 30, 2000]

§ 416.430 Eligible individual with eligible spouse; essential person(s) present.

(a) When an eligible individual with an eligible spouse has an essential person (§ 416.222) living in his or her home, or when both such persons each has an essential person, the increase in the rate of payment is determined in accordance with §§ 416.413 and 416.532. The income of the essential person(s) is included in the income of the couple and the payment due will be equally divided between each member of the eligible couple.

(b) When one member of an eligible couple is temporarily absent in accordance with § 416.1149(c)(1) and § 416.222(c) and either one or both individuals has an essential person, add the essential person increment to the benefit rate for the member of the couple who is actually residing with the essential person and include the income of the essential person in that member's income. See § 416.414(b)(3).

[60 FR 16375, Mar. 30, 1995]

§ 416.432 Change in status involving a couple; eligibility continues.

When there is a change in status which involves the formation or dissolution of an eligible couple (for example, marriage, divorce), a redetermination of the benefit amount shall be made for the months subsequent to

the month of such formation or dissolution of the couple in accordance with the following rules:

(a) When there is a dissolution of an eligible couple and each member of the couple becomes an eligible individual, the benefit amount for each person shall be determined individually for each month beginning with the first month after the month in which the dissolution occurs. This shall be done by determining the applicable benefit rate for an eligible individual with no eligible spouse according to §§ 416.410 or 416.413 and 416.414 and applying § 416.420(a). See § 416.1147a for the applicable income rules when in-kind support and maintenance is involved.

(b) When two eligible individuals become an eligible couple, the benefit amount will be determined for the couple beginning with the first month following the month of the change. This shall be done by determining which benefit rate to use for an eligible couple according to §§ 416.412 or 416.413 and 416.414 and applying the requirements in § 416.420(a).

[60 FR 16375, Mar. 30, 1995]

§ 416.435 Change in status involving a couple; ineligibility occurs.

Whenever benefits are suspended or terminated for both members of a couple because of ineligibility, no benefits are payable for that month. However, when benefits are suspended or terminated for one member of a couple because of ineligibility for a month, the member who remains eligible assumes the eligibility status of an eligible individual without an eligible spouse for such month and the benefit rate and payment amount will be determined as an eligible individual for the month.

[50 FR 48572, Nov. 26, 1985]

Subpart E—Payment of Benefits, Overpayments, and Underpayments

AUTHORITY: Secs. 702(a)(5), 1147, 1601, 1602, 1611(c) and (e), and 1631(a)–(d) and (g) of the Social Security Act (42 U.S.C. 902(a)(5), 1320b–17, 1381, 1381a, 1382(c) and (e), and 1383(a)–(d) and (g)); 31 U.S.C. 3716; 31 U.S.C. 3720A.

§ 416.501 Payment of benefits: General.

Payment of SSI benefits will be made for the month after the month of initial eligibility and for each subsequent month provided all requirements for eligibility (see § 416.202) and payment (see § 416.420) are met. In the month the individual re-establishes eligibility after at least a month of ineligibility, benefits are paid for such a month beginning with the date in the month on which the individual meets all eligibility requirements. In some months, while the factors of eligibility based on the current month may be established, it is possible to receive no payment for that month if the factors of eligibility for payment are not met. Payment of benefits may not be made for any period that precedes the first month following the date on which an application is filed or, if later, the first month following the date all conditions for eligibility are met.

[64 FR 31973, June 15, 1999]

§ 416.502 Manner of payment.

For the month an individual reestablishes eligibility after a month of ineligibility, an SSI payment will be made on or after the day of the month on which the individual becomes reeligible to receive benefits. In all other months, a payment will be made on the first day of each month and represents payment for that month. If the first day of the month falls on a Saturday, Sunday, or legal holiday, payments will be made on the first day preceding such day which is not a Saturday, Sunday, or legal holiday. Unless otherwise indicated, the monthly amount for an eligible couple will be divided equally and paid separately to each individual. Section 416.520 explains emergency advance payments.

[55 FR 4422, Feb. 8, 1990, as amended at 64 FR 31974, June 15, 1999]

§ 416.503 Minimum monthly benefit amount.

If you receive an SSI benefit that does not include a State supplement the minimum monthly SSI benefit amount payable is $1. When an SSI

benefit amount of less than $1 is payable, the benefit amount will be increased to $1. If you receive an SSI benefit that does include a State supplement and the SSI benefit amount is less than $1 but when added to the State supplement exceeds $1, the SSI benefit amount will not be increased to $1. Rather, we pay the actual amount of the SSI benefit plus the State supplement.

[50 FR 48572, Nov. 26, 1985]

§ 416.520 Emergency advance payments.

(a) *General.* We may pay a one-time emergency advance payment to an individual initially applying for benefits who is presumptively eligible for SSI benefits and who has a financial emergency. The amount of this payment cannot exceed the Federal benefit rate (see §§ 416.410 through 416.414) plus the federally administered State supplementary payment, if any (see § 416.2020), which apply for the month for which the payment is made. *Emergency advance payment* is defined in paragraph (b)(1) of this section. The actual payment amount is computed as explained in paragraph (c) of this section. An emergency advance payment is an advance of benefits expected to be due that is recoverable as explained in paragraphs (d) and (e) of this section.

(b) *Definition of terms.* For purposes of this subpart—

(1) *Emergency advance payment* means a direct, expedited payment by a Social Security Administration field office to an individual or spouse who is initially applying (see paragraph (b)(3) of this section), who is at least presumptively eligible (see paragraph (b)(4) of this section), and who has a financial emergency (see paragraph (b)(2) of this section).

(2) *Financial emergency* is the financial status of an individual who has insufficient income or resources to meet an immediate threat to health or safety, such as the lack of food, clothing, shelter, or medical care.

(3) *Initially applying* means the filing of an application (see § 416.310) which requires an initial determination of eligibility, such as the first application for SSI benefits or an application filed subsequent to a prior denial or termination of a prior period of eligibility for payment. An individual or spouse who previously received an emergency advance payment in a prior period of eligibility which terminated may again receive such a payment if he or she reapplies for SSI and meets the other conditions for an emergency advance payment under this section.

(4) *Presumptively eligible* is the status of an individual or spouse who presents strong evidence of the likelihood of meeting all of the requirements for eligibility including the income and resources tests of eligibility (see subparts K and L of this part), categorical eligibility (age, disability, or blindness), and technical eligibility (United States residency and citizenship or alien status—see subpart P of this part).

(c) *Computation of payment amount.* To compute the emergency advance payment amount, the maximum amount described in paragraph (a) of this section is compared to both the expected amount payable for the month for which the payment is made (see paragraph (c)(1) of this section) and the amount the applicant requested to meet the emergency. The actual payment amount is no more than the least of these three amounts.

(1) In computing the emergency advance payment amount, we apply the monthly income counting rules appropriate for the month for which the advance is paid, as explained in § 416.420. Generally, the month for which the advance is paid is the month in which it is paid. However, if the advance is paid in the month the application is filed, the month for which the advance is paid is considered to be the first month of expected eligibility for payment of benefits.

(2) For a couple, we separately compute each member's emergency advance payment amount.

(d) *Recovery of emergency advance payment where eligibility is established.* When an individual or spouse is determined to be eligible and retroactive payments are due, any emergency advance payment amounts are recovered in full from the first payment(s) certified to the United States Treasury. However, if no retroactive payments are due and benefits are only due in future months, any emergency advance

payment amounts are recovered through proportionate reductions in those benefits over a period of not more than 6 months. (See paragraph (e) of this section if the individual or spouse is determined to be ineligible.)

(e) *Disposition of emergency advance payments where eligibility is not established.* If a presumptively eligible individual (or spouse) or couple is determined to be ineligible, the emergency advance payment constitutes a recoverable overpayment. (See the exception in § 416.537(b)(1) when payment is made on the basis of presumptive disability or presumptive blindness.)

[55 FR 4422, Feb. 8, 1990; 55 FR 7411, Mar. 1, 1990, as amended at 64 FR 31974, June 15, 1999]

§ 416.525 Reimbursement to States for interim assistance payments.

Notwithstanding § 416.542, the Social Security Administration may, in accordance with the provisions of subpart S of this part, withhold supplemental security income benefits due with respect to an individual and may pay to a State (or political subdivision thereof, if agreed to by the Social Security Administration and the State) from the benefits withheld, an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished on behalf of the individual.

[41 FR 20872, May 21, 1976]

§ 416.532 Method of payment when the essential person resides with more than one eligible person.

(a) When an essential person lives with an eligible individual and an eligible spouse, the State may report that the person is essential to one or both members of the couple. In either event, the income and resources of the essential person will be considered to be available to the family unit. The payment increment attributable to the essential person will be added to the rate of payment for the couple, the countable income subtracted, and the resulting total benefit divided equally between the eligible individual and the eligible spouse.

(b) Where the essential person lives with two eligible individuals (as opposed to an eligible individual and eligible spouse), one of whom has been designated the qualified individual, the income and resources of the essential person will be considered to be available only to the qualified individual (as defined in § 416.221) and any increase in payment will be made to such qualified individual.

(c) In those instances where the State has designated the essential person as essential to two or more eligible individuals so that both are qualified individuals, the payment increment attributable to the essential person must be shared equally, and the income and resources of the essential person divided and counted equally against each qualified individual.

(d) When an essential person lives with an eligible individual and an eligible spouse (or two or more eligible individuals) only one of whom is the qualified individual, essential person status is not automatically retained upon the death of the qualified individual or upon the separation from the qualified individual. A review of the State records established on or before December 31, 1973, will provide the basis for a determination as to whether the remaining eligible individual or eligible spouse meets the definition of qualified individual. Payment in consideration of the essential person will be dependent on whether the essential person continues to live with a qualified individual. If the essential person does reside with a qualified individual, status as an essential person is retained.

[39 FR 33796, Sept. 20, 1974, as amended at 50 FR 48572, Nov. 26, 1985; 51 FR 10616, Mar. 28, 1986; 60 FR 16375, Mar. 30, 1995]

§ 416.533 Transfer or assignment of benefits.

Except as provided in § 416.525 and subpart S of this part, the Social Security Administration will not certify payment of supplemental security income benefits to a transferee or assignee of a person eligible for such benefits under the Act or of a person qualified for payment under § 416.542. The Social Security Administration shall not certify payment of supplemental security income benefits to any person claiming such payment by virtue of an execution, levy, attachment, garnishment, or other legal process or by virtue of any bankruptcy or insolvency

proceeding against or affecting the person eligible for benefits under the Act.

[41 FR 20873, May 21, 1976, as amended at 58 FR 52912, Oct. 13, 1993]

§ 416.534 Garnishment of payments after disbursement.

(a) Payments that are covered by section 1631(d)(1) of the Social Security Act and made by direct deposit are subject to 31 CFR part 212, Garnishment of Accounts Containing Federal Benefit Payments.

(b) This section may be amended only by a rulemaking issued jointly by the Department of Treasury and the agencies defined as a ''benefit agency'' in 31 CFR 212.3.

[76 FR 9961, Feb. 23, 2011]

§ 416.535 Underpayments and overpayments.

(a) *General.* When an individual receives SSI benefits of less than the correct amount, adjustment is effected as described in §§ 416.542 and 416.543, and the additional rules in § 416.545 may apply. When an individual receives more than the correct amount of SSI benefits, adjustment is effected as described in § 416.570. Refund of overpayments is discussed in § 416.560 and waiver of recovery of overpayments is discussed in §§ 416.550 through 416.555.

(b) *Additional rules for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.* When an individual whose drug addiction or alcoholism is a contributing factor material to the determination of disability, as described in § 416.935, receives less than the correct amount of SSI benefits, adjustment is effected as described in §§ 416.542 and 416.543 and the additional rule described in § 416.544 applies.

(c) *Additional rules for eligible individuals under age 18 who have a representative payee.* When an eligible individual under age 18 has a representative payee and receives less than the correct amount of SSI benefits, the additional rules in § 416.546 may apply.

(d) *Additional rules for eligible aliens and for their sponsors.* When an individual who is an alien is overpaid SSI benefits during the 3-year period in which deeming from a sponsor applies (see § 416.1160(a)(3)), the sponsor and the alien may be jointly and individually liable for repayment of the overpayment. The sponsor is liable for the overpayment if he or she failed to report correct information that affected the alien's eligibility or payment amount. This means information about the income and resources of the sponsor and, if they live together, of the sponsor's spouse. However, the sponsor is not liable for repayment if the sponsor was without fault or had good cause for failing to report correctly. A special rule that applies to adjustment of other benefits due the alien and the sponsor to recover an overpayment is described in § 416.570(b).

(e) *Sponsor without fault or good cause exists for failure to report.* Without fault or good cause will be found to exist if the failure to report was not willful. To establish willful failure, the evidence must show that the sponsor knowingly failed to supply pertinent information regarding his or her income and resources.

[52 FR 8881, Mar. 20, 1987, as amended at 60 FR 8149, Feb. 10, 1995; 61 FR 67205, Dec. 20, 1996]

§ 416.536 Underpayments—defined.

An underpayment can occur only with respect to a period for which a recipient filed an application, if required, for benefits and met all conditions of eligibility for benefits. An underpayment, including any amounts of State supplementary payments which are due and administered by the Social Security Administration, is:

(a) Nonpayment, where payment was due but was not made; or

(b) Payment of less than the amount due. For purposes of this section, payment has been made when certified by the Social Security Administration to the Department of the Treasury, except that payment has not been made where payment has not been received by the designated payee, or where payment was returned.

[58 FR 52912, Oct. 13, 1993]

§ 416.537 Overpayments—defined.

(a) *Overpayments.* As used in this subpart, the term *overpayment* means payment of more than the amount due for

any period, including any amounts of State supplementary payments which are due and administered by the Social Security Administration. For purposes of this section, payment has been made when certified by the Social Security Administration to the Department of the Treasury, except that payment has not been made where payment has not been received by the designated payee, or where payment was returned. When a payment of more than the amount due is made by direct deposit to a financial institution to or on behalf of an individual who has died, and the financial institution credits the payment to a joint account of the deceased individual and another person who is the surviving spouse of the deceased individual and was eligible for a payment under title XVI of the Act (including any State supplementation payment paid by the Commissioner) as an eligible spouse (or as either member of an eligible couple) for the month in which the deceased individual died, the amount of the payment in excess of the correct amount will be an overpayment to the surviving spouse.

(b) *Actions which are not overpayments*—(1) *Presumptive disability and presumptive blindness.* Any payment made for any month, including an advance payment of benefits under § 416.520, is not an overpayment to the extent it meets the criteria for payment under § 416.931. Payments made on the basis of presumptive disability or presumptive blindness will not be considered overpayments where ineligibility is determined because the individual or eligible spouse is not disabled or blind. However, where it is determined that all or a portion of the presumptive payments made are incorrect for reasons other than disability or blindness, these incorrect payments are considered overpayments (as defined in paragraph (a) of this section). Overpayments may occur, for example, when the person who received payments on the basis of presumptive disability or presumptive blindness is determined to be ineligible for all or any part of the payments because of excess resources or is determined to have received excess payment for those months based on an incorrect estimate of income.

(2) *Penalty.* The imposition of a penalty pursuant to § 416.724 is not an adjustment of an overpayment and is imposed only against any amount due the penalized recipient, or, after death, any amount due the deceased which otherwise would be paid to a survivor as defined in § 416.542.

(c) *Pandemic period.* As used throughout this subpart, the term *pandemic period* for the purposes of the waiver authority in § 416.550 refers exclusively to the period of time beginning on March 1, 2020, and ending on September 30, 2020.

[40 FR 47763, Oct. 10, 1975, as amended at 43 FR 17354, Apr. 24, 1978; 50 FR 48572, Nov. 26, 1985; 55 FR 7313, Mar. 1, 1990; 58 FR 52912, Oct. 13, 1993; 62 FR 38454, July 18, 1997; 85 FR 52915, Aug. 27, 2020]

§ 416.538 Amount of underpayment or overpayment.

(a) *General.* The amount of an underpayment or overpayment is the difference between the amount paid to a recipient and the amount of payment actually due such recipient for a given period. An underpayment or overpayment period begins with the first month for which there is a difference between the amount paid and the amount actually due for that month. The period ends with the month the initial determination of overpayment or underpayment is made. With respect to the period established, there can be no underpayment to a recipient or his or her eligible spouse if more than the correct amount payable under title XVI of the Act has been paid, whether or not adjustment or recovery of any overpayment for that period to the recipient or his or her eligible spouse has been waived under the provisions of §§ 416.550 through 416.556. A subsequent initial determination of overpayment will require no change with respect to a prior determination of overpayment or to the period relating to such determination to the extent that the basis of the prior overpayment remains the same.

(b) *Limited delay in payment of underpaid amount to recipient or eligible surviving spouse.* Where an apparent overpayment has been detected but determination of the overpayment has not

been made (see § 416.558(a)), a determination of an underpayment and payment of an underpaid amount which is otherwise due cannot be delayed to a recipient or eligible surviving spouse unless a determination with respect to the apparent overpayment can be made before the close of the month following the month in which the underpaid amount was discovered.

(c) *Delay in payment of underpaid amount to ineligible individual or survivor.* A determination of an underpayment and payment of an underpaid amount which is otherwise due an individual who is no longer eligible for SSI or is payable to a survivor pursuant to § 416.542(b) will be delayed for the resolution of all overpayments, incorrect payments, adjustments, and penalties.

(d) *Limited delay in payment of underpaid amount to eligible individual under age 18 who has a representative payee.* When the representative payee of an eligible individual under age 18 is required to establish a dedicated account pursuant to §§ 416.546 and 416.640(e), payment of past-due benefits which are otherwise due will be delayed until the representative payee has established the dedicated account as described in § 416.640(e). Once the account is established, SSA will deposit the past-due benefits payable directly to the account.

(e) *Reduction of underpaid amount.* Any underpayment amount otherwise payable to a survivor on account of a deceased recipient is reduced by the amount of any outstanding penalty imposed against the benefits payable to such deceased recipient or survivor under section 1631(e) of the Act (see § 416.537(b)(2)).

[58 FR 52912, Oct. 13, 1993, as amended at 61 FR 67205, Dec. 20, 1996]

§ 416.542 Underpayments—to whom underpaid amount is payable.

(a) *Underpaid recipient alive—underpayment payable.* (1) If an underpaid recipient is alive, the amount of any underpayment due him or her will be paid to him or her in a separate payment or by increasing the amount of his or her monthly payment. If the underpaid amount meets the formula in § 416.545 and one of the exceptions does not apply, the amount of any past-due benefits will be paid in installments.

(2) If an underpaid recipient whose drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 416.935) is alive, the amount of any underpayment due the recipient will be paid through his or her representative payee in installment payments. No underpayment may be paid directly to the recipient. If the recipient dies before we have paid all benefits due through his or her representative payee, we will follow the rules which apply to underpayments for the payment of any remaining amounts due to any eligible survivor of a deceased recipient as described in paragraph (b) of this section.

(3) If an underpaid individual under age 18 is alive and has a representative payee and is due past-due benefits which meet the formula in § 416.546, SSA will pay the past-due benefits into the dedicated account described in § 416.640(e). If the underpaid individual dies before the benefits have been deposited into the account, we will follow the rules which apply to underpayments for the payment of any unpaid amount due to any eligible survivor of a deceased individual as described in paragraph (b) of this section.

(b) *Underpaid recipient deceased—underpaid amount payable to survivor.* (1) If a recipient dies before we have paid all benefits due or before the recipient endorses the check for the correct payment, we may pay the amount due to the deceased recipient's surviving eligible spouse or to his or her surviving spouse who was living with the underpaid recipient within the meaning of section 202(i) of the Act (see § 404.347) in the month he or she died or within 6 months immediately preceding the month of death.

(2) If the deceased underpaid recipient was a disabled or blind child when the underpayment occurred, the underpaid amount may be paid to the natural or adoptive parent(s) of the underpaid recipient who lived with the underpaid recipient in the month he or she died or within the 6 months preceding death. We consider the underpaid recipient to have been living with the natural or adoptive parent(s) in the

period if the underpaid recipient satisfies the ''living with'' criteria we use when applying § 416.1165 or would have satisfied the criteria had his or her death not precluded the application of such criteria throughout a month.

(3) If the deceased individual was living with his or her spouse within the meaning of section 202(i) of the Act in the month of death or within 6 months immediately preceding the month of death, and was also living with his or her natural or adoptive parent(s) in the month of death or within 6 months preceding the month of death, we will pay the parent(s) any SSI underpayment due the deceased individual for months he or she was a blind or disabled child and we will pay the spouse any SSI underpayment due the deceased individual for months he or she no longer met the definition of ''child'' as set forth at § 416.1856. If no parent(s) can be paid in such cases due to death or other reason, then we will pay the SSI underpayment due the deceased individual for months he or she was a blind or disabled child to the spouse.

(4) No benefits may be paid to the estate of any underpaid recipient, the estate of the surviving spouse, the estate of a parent, or to any survivor other than those listed in paragraph (b) (1) through (3) of this section. Payment of an underpaid amount to an ineligible spouse or surviving parent(s) may only be made for benefits payable for months after May 1986. Payment to surviving parent(s) may be made only for months of eligibility during which the deceased underpaid recipient was a child. We will not pay benefits to a survivor other than the eligible spouse who requests payment of an underpaid amount more than 24 months after the month of the individual's death.

(c) *Underpaid recipient's death caused by an intentional act.* No benefits due the deceased individual may be paid to a survivor found guilty by a court of competent jurisdiction of intentionally causing the underpaid recipient's death.

[40 FR 47763, Oct. 10, 1975, as amended at 58 FR 52913, Oct. 13, 1993; 60 FR 8149, Feb. 10, 1995; 61 FR 67206, Dec. 20, 1996]

§ 416.543 Underpayments—applied to reduce overpayments.

We apply any underpayment due an individual to reduce any overpayment to that individual that we determine to exist (see § 416.558) for a different period, unless we have waived recovery of the overpayment under the provisions of §§ 416.550 through 416.556. Similarly, when an underpaid recipient dies, we first apply any amounts due the deceased recipient that would be payable to a survivor under § 416.542(b) against any overpayment to the survivor unless we have waived recovery of such overpayment under the provisions of §§ 416.550 through 416.556.

Example: A disabled child, eligible for payments under title XVI, and his parent, also an eligible individual receiving payments under title XVI, were living together. The disabled child dies at a time when he was underpaid $100. The deceased child's underpaid benefit is payable to the surviving parent. However, since the parent must repay an SSI overpayment of $225 on his own record, the $100 underpayment will be applied to reduce the parent's own overpayment to $125.

[58 FR 52913, Oct. 13, 1993]

§ 416.544 Paying benefits in installments: Drug addiction or alcoholism.

(a) *General.* For disabled recipients who receive benefit payments through a representative payee because drug addiction or alcoholism is a contributing factor material to the determination of disability, certain amounts due the recipient for a past period will be paid in installments. The amounts subject to payment in installments include:

(1) Benefits due but unpaid which accrued prior to the month payment was effectuated;

(2) Benefits due but unpaid which accrued during a period of suspension for which the recipient was subsequently determined to have been eligible; and

(3) Any adjustment to benefits which results in an accrual of unpaid benefits.

(b) *Installment formula.* Except as provided in paragraph (c) of this section, the amount of the installment payment in any month is limited so that the sum of (1) the amount due for a past period (and payable under paragraph (a) of this section) paid in such

month and (2) the amount of any current benefit due cannot exceed twice the Federal Benefit Rate plus any federally-administered State supplementation payable to an eligible individual for the preceding month.

(c) *Exception to installment limitation.* An exception to the installment payment limitation in paragraph (b) of this section can be granted for the first month in which a recipient accrues benefit amounts subject to payment in installments if the recipient has unpaid housing expenses which result in a high risk of homelessness for the recipient. In that case, the benefit payment may be increased by the amount of the unpaid housing expenses so long as that increase does not exceed the amount of benefits which accrued during the most recent period of nonpayment. We consider a person to be at risk of homelessness if continued nonpayment of the outstanding housing expenses is likely to result in the person losing his or her place to live or if past nonpayment of housing expenses has resulted in the person having no appropriate personal place to live. In determining whether this exception applies, we will ask for evidence of outstanding housing expenses that shows that the person is likely to lose or has already lost his or her place to live. For purposes of this section, homelessness is the state of not being under the control of any public institution and having no appropriate personal place to live. Housing expenses include charges for all items required to maintain shelter (for example, mortgage payments, rent, heating fuel, and electricity).

(d) *Payment through a representative payee.* If the recipient does not have a representative payee, payment of amounts subject to installments cannot be made until a representative payee is selected.

(e) *Underpaid recipient no longer eligible.* In the case of a recipient who is no longer currently eligible for monthly payments, but to whom amounts defined in paragraph (a) of this section are still owing, we will continue to make installment payments of such benefits through a representative payee.

(f) *Recipient currently not receiving SSI benefits because of suspension for noncompliance with treatment.* If a recipient is currently not receiving SSI benefits because his or her benefits have been suspended for noncompliance with treatment (as defined in § 416.936), the payment of amounts under paragraph (a) of this section will stop until the recipient has demonstrated compliance with treatment as described in § 416.1326 and will again commence with the first month the recipient begins to receive benefits.

(g) *Underpaid recipient deceased.* Upon the death of a recipient, any remaining unpaid amounts as defined in paragraph (a) of this section will be treated as underpayments in accordance with § 416.542(b).

[60 FR 8150, Feb. 10, 1995]

§ 416.545 Paying large past-due benefits in installments.

(a) *General.* Except as described in paragraph (c) of this section, when an individual is eligible for past-due benefits in an amount which meets the formula in paragraph (b) of this section, payment of these benefits must be made in installments. If an individual becomes eligible for past-due benefits for a different period while installments are being made, we will notify the individual of the amount due and issue these benefits in the last installment payment. The amounts subject to payment in installments include:

(1) Benefits due but unpaid which accrued prior to the month payment was effectuated;

(2) Benefits due but unpaid which accrued during a period of suspension for which the recipient was subsequently determined to have been eligible; and

(3) Any adjustment to benefits which results in an accrual of unpaid benefits.

(b) *Installment formula.* Installment payments must be made if the amount of the past-due benefits, including any federally administered State supplementation, after applying § 416.525 (reimbursement to States for interim assistance) and applying § 416.1520 (payment of attorney fees), equals or exceeds 3 times the Federal Benefit Rate plus any federally administered State supplementation payable in a month to an eligible individual (or eligible individual and eligible spouse). These installment payments will be paid in not

more than 3 installments and made at 6-month intervals. Except as described in paragraph (d) of this section, the amount of each of the first and second installment payments may not exceed the threshold amount of 3 times the maximum monthly benefit payable as described in this paragraph.

(c) *Exception—When installments payments are not required.* Installment payments are not required and the rules in this section do not apply if, when the determination of an underpayment is made, the individual is (1) afflicted with a medically determinable impairment which is expected to result in death within 12 months, or (2) ineligible for benefits and we determine that he or she is likely to remain ineligible for the next 12 months.

(d) *Exception—Increased first and second installment payments.* (1) The amount of the first and second installment payments may be increased by the total amount of the following debts and expenses:

(i) Outstanding debt for food, clothing, shelter, or medically necessary services, supplies or equipment, or medicine; or

(ii) Current or anticipated expenses in the near future for medically necessary services, supplies or equipment, or medicine, or for the purchase of a home.

(2) The increase described in paragraph (d)(1) of this section only applies to debts or expenses that are not subject to reimbursement by a public assistance program, the Secretary of Health and Human Services under title XVIII of the Act, a State plan approved under title XIX of the Act, or any private entity that is legally liable for payment in accordance with an insurance policy, pre-paid plan, or other arrangement.

[61 FR 67206, Dec. 20, 1996, as amended at 76 FR 453, Jan. 5, 2011; 79 FR 33685, June 12, 2014]

§ 416.546 Payment into dedicated accounts of past-due benefits for eligible individuals under age 18 who have a representative payee.

For purposes of this section, amounts subject to payment into dedicated accounts (see § 416.640(e)) include the amounts described in § 416.545(a) (1), (2), and (3).

(a) For an eligible individual under age 18 who has a representative payee and who is determined to be eligible for past-due benefits (including any federally administered State supplementation) in an amount which, after applying § 416.525 (reimbursement to States for interim assistance) and § 416.1520 (payment of attorney fee), exceeds six times the Federal Benefit Rate plus any federally administered State supplementation payable in a month, this unpaid amount must be paid into the dedicated account established and maintained as described in § 416.640(e).

(b) After the account is established, the representative payee may (but is not required to) deposit into the account any subsequent funds representing past-due benefits under this title to the individual which are equal to or exceed the maximum Federal Benefit Rate (including any federally administered State supplementation).

(c) If the underpaid individual dies before all the benefits due have been deposited into the dedicated account, we will follow the rules which apply to underpayments for the payment of any unpaid amount due to any eligible survivor as described in § 416.542(b).

[61 FR 67206, Dec. 20, 1996, as amended at 76 FR 453, Jan. 5, 2011]

§ 416.550 Waiver of adjustment or recovery—when applicable.

Waiver of adjustment or recovery of an overpayment of SSI benefits may be granted when (EXCEPTION: This section does not apply to a sponsor of an alien):

(a) The overpaid individual was without fault in connection with an overpayment, and

(b) Adjustment or recovery of such overpayment would either:

(1) Defeat the purpose of title XVI, or

(2) Be against equity and good conscience, or

(3) Impede efficient or effective administration of title XVI due to the small amount involved.

(c) We will apply the procedures in this paragraph (c) when an individual requests waiver of all or part of a qualifying overpayment.

(1) For purposes of this paragraph (c), a qualifying overpayment is one that

accrued during the *pandemic period* (see § 416.537(c)) because of the actions that we took in response to the COVID–19 national public health emergency, including the suspension of certain of our manual workloads that would have processed actions identifying and stopping certain overpayments.

(2) Notwithstanding any other provision of this subpart, we will presume that an individual who requests waiver of a qualifying overpayment is without fault in causing the overpayment (see § 416.552) unless we determine that the qualifying overpayment made to a beneficiary or a representative payee was the result of fraud or similar fault or involved misuse of benefits by a representative payee (see § 416.641).

(3) If we determine under paragraph (c)(2) of this section that an individual or a representative payee is without fault in causing a qualifying overpayment, we will also determine that recovery of the qualifying overpayment would be against equity and good conscience. For purposes of this paragraph (c)(3) only, ''against equity and good conscience'' is not limited to the meaning used in § 416.554 but means a broad concept of fairness that takes into account all of the facts and circumstances of the case.

(4) The provisions of this paragraph (c)(4) will apply to a qualifying overpayment identified by December 31, 2020.

[52 FR 8882, Mar. 20, 1987, as amended at 53 FR 16543, May 10, 1988; 85 FR 52915, Aug. 27, 2020]

§ 416.551 Waiver of adjustment or recovery—effect of.

Waiver of adjustment or recovery of an overpayment from the overpaid person himself (or, after his death, from his estate) frees him and his eligible spouse from the obligation to repay the amount of the overpayment covered by the waiver. Waiver of adjustment or recovery of an overpayment from anyone other than the overpaid person himself or his estate (e.g., a surviving eligible spouse) does not preclude adjustment or recovery against the overpaid person or his estate.

Example: The recipient was overpaid $390. It was found that the overpaid recipient was eligible for waiver of adjustment or recovery of $260 of that amount, and such action was taken. Only $130 of the overpayment remained to be recovered by adjustment, refund, or the like.

[40 FR 47763, Oct. 10, 1975]

§ 416.552 Waiver of adjustment or recovery—without fault.

Without fault relates only to the situation of the individual seeking relief from adjustment or recovery of an overpayment. The overpaid individual (and any other individual from whom the Social Security Administration seeks to recover the overpayment) is not relieved of liability and is not *without fault* solely because the Social Security Administration may have been at fault in making the overpayment. Notwithstanding any other provision of this subpart, we will not determine any overpaid individual to be at fault in causing a qualifying overpayment (see § 416.550(c)(1)) unless we determine that the qualifying overpayment made to an individual or a representative payee during the pandemic period (see § 416.537(c)) was the result of fraud or similar fault or involved misuse of benefits by a representative payee (see § 416.641). In determining whether an individual is without fault, the *fault* of the overpaid person and the *fault* of the individual seeking relief under the waiver provision are considered. Whether an individual is *without fault* depends on all the pertinent circumstances surrounding the overpayment in the particular case. The Social Security Administration considers the individual's understanding of the reporting requirements, the agreement to report events affecting payments, knowledge of the occurrence of events that should have been reported, efforts to comply with the reporting requirements, opportunities to comply with the reporting requirements, understanding of the obligation to return checks which were not due, and ability to comply with the reporting requirements (e.g., age, comprehension, memory, physical and mental condition). In determining whether an individual is without fault based on a consideration of these factors, the Social Security Administration will take into account any physical, mental, educational, or linguistic limitations (including any

lack of facility with the English language) the individual may have. Although the finding depends on all of the circumstances in the particular case, an individual will be found to have been at fault in connection with an overpayment when an incorrect payment resulted from one of the following:

(a) Failure to furnish information which the individual knew or should have known was material;

(b) An incorrect statement made by the individual which he knew or should have known was incorrect (this includes the individual's furnishing his opinion or conclusion when he was asked for facts), or

(c) The individual did not return a payment which he knew or could have been expected to know was incorrect.

[40 FR 47763, Oct. 10, 1975, as amended at 59 FR 1636, Jan. 12, 1994; 85 FR 52915, Aug. 27, 2020]

§ 416.553 Waiver of adjustment or recovery—defeat the purpose of the supplemental security income program.

We will waive adjustment or recovery of an overpayment when an individual on whose behalf waiver is being considered is without fault (as defined in § 416.552) and adjustment or recovery of the overpayment would defeat the purpose of the supplemental security income program.

(a) *General rule.* We consider adjustment or recovery of an overpayment to defeat the purpose of the supplemental security income (SSI) program if the individual's income and resources are needed for ordinary and necessary living expenses under the criteria set out in § 404.508(a) of this chapter

(b) *Alternative criteria for individuals currently eligible for SSI benefits.* We consider an individual or couple currently eligible for SSI benefits to have met the test in paragraph (a) of this section if the individual's or couple's current monthly income (that is, the income upon which the individual's or couple's eligibility for the current month is determined) does not exceed—

(1) The applicable Federal monthly benefit rate for the month in which the determination of waiver is made (see subpart D of this part); plus

(2) The $20 monthly general income exclusion described in §§ 416.1112(c)(3) and 416.1124(c)(10); plus

(3) The monthly earned income exclusion described in § 416.1112(c)(4); plus

(4) The applicable State supplementary payment, if any (see subpart T of this part) for the month in which determination of waiver is made.

For those SSI recipients whose income exceeds these criteria, we follow the general rule in paragraph (a) of this section.

[45 FR 72649, Nov. 3, 1980, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.554 Waiver of adjustment or recovery—against equity and good conscience.

We will waive adjustment or recovery of an overpayment when an individual on whose behalf waiver is being considered is without fault (as defined in § 416.552) and adjustment or recovery would be *against equity and good conscience*. Adjustment or recovery is considered to be *against equity and good conscience* if an individual changed his or her position for the worse or relinquished a valuable right because of reliance upon a notice that payment would be made or because of the incorrect payment itself. In addition, adjustment or recovery is considered to be *against equity and good conscience* for an individual who is a member of an eligible couple that is legally separated and/or living apart for that part of an overpayment not received, but subject to recovery under § 416.570.

Example 1: Upon being notified that he was eligible for supplemental security income payments, an individual signed a lease on an apartment renting for $15 a month more than the room he had previously occupied. It was subsequently found that eligibility for the payment should not have been established. In such a case, recovery would be considered ''against equity and good conscience.''

Example 2: An individual fails to take advantage of a private or organization charity, relying instead on the award of supplemental security income payments to support himself. It was subsequently found that the money was improperly paid. Recovery would be considered ''against equity and good conscience.''

Example 3: Mr. and Mrs. Smith—members of an eligible couple—separate in July. Later in July, Mr. Smith receives earned income

resulting in an overpayment to both. Mrs. Smith is found to be without fault in causing the overpayment. Recovery from Mrs. Smith of Mr. Smith's part of the couple's overpayment is waived as being *against equity and good conscience*. Whether recovery of Mr. Smith's portion of the couple's overpayment can be waived will be evaluated separately.

[60 FR 16375, Mar. 30, 1995]

§ 416.555 Waiver of adjustment or recovery—impede administration.

Waiver of adjustment or recovery is proper when the overpaid person on whose behalf waiver is being considered is without fault, as defined in § 416.552, and adjustment or recovery would impede efficient or effective administration of title XVI due to the small amount involved. The amount of overpayment determined to meet such criteria is measured by the current average administrative cost of handling such overpayment case through such adjustment or recovery processes. In determining whether the criterion is met, the overpaid person's financial circumstances are not considered.

[40 FR 47764, Oct. 10, 1975]

§ 416.556 Waiver of adjustment or recovery—countable resources in excess of the limits prescribed in § 416.1205 by $50 or less.

(a) If any overpayment with respect to an individual (or an individual and his or her spouse if any) is attributable solely to the ownership or possession by the individual (and spouse if any) of countable resources having a value which exceeds the applicable dollar figure specified in § 416.1205 by an amount of $50.00 or less, including those resources deemed to an individual in accordance with § 416.1202, such individual (and spouse if any) shall be deemed to have been without fault in connection with the overpayment, and waiver of adjustment or recovery will be made, unless the failure to report the value of the excess resources correctly and in a timely manner was willful and knowing.

(b) Failure to report the excess resources correctly and in a timely manner will be considered to be willful and knowing and the individual will be found to be at fault when the evidence clearly shows the individual (and spouse if any) was fully aware of the requirements of the law and of the excess resources and chose to conceal these resources. When an individual incurred a similar overpayment in the past and received an explanation and instructions at the time of the previous overpayment, we will generally find the individual to be at fault. However, in determining whether the individual is at fault, we will consider all aspects of the current and prior overpayment situations, and where we determine the individual is not at fault, we will waive adjustment or recovery of the subsequent overpayment. In making any determination or decision under this section concerning whether an individual is at fault, including a determination or decision of whether the failure to report the excess resources correctly and in a timely manner was willful and knowing, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) of the individual (and spouse if any).

[53 FR 16544, May 10, 1988, as amended at 59 FR 1636, Jan. 12, 1994]

§ 416.557 Personal conference.

(a) If waiver cannot be approved (*i.e.*, the requirements in § 416.550 (a) and (b) are not met), the individual is notified in writing and given the dates, times and place of the file review and personal conference; the procedure for reviewing the claims file prior to the personal conference; the procedure for seeking a change in the scheduled date, time and/or place; and all other information necessary to fully inform the individual about the personal conference. The file review is always scheduled at least 5 days before the personal conference. We will offer to the individual the option of conducting the personal conference face-to-face at a place we designate, by telephone, or by video teleconference. The notice will advise the individual of the date and time of the personal conference.

(b) At the file review, the individual and the individual's representative have the right to review the claims file and applicable law and regulations with the decisionmaker or another of our representatives who is prepared to

answer questions. We will provide copies of material related to the overpayment and/or waiver from the claims file or pertinent sections of the law or regulations that are requested by the individual or the individual's representative.

(c) At the personal conference, the individual is given the opportunity to:

(1) Appear personally, testify, cross-examine any witnesses, and make arguments;

(2) Be represented by an attorney or other representative (see § 416.1500), although the individual must be present at the conference; and

(3) Submit documents for consideration by the decisionmaker.

(d) At the personal conference, the decisionmaker:

(1) Tells the individual that the decisionmaker was not previously involved in the issue under review, that the waiver decision is solely the decisionmaker's, and that the waiver decision is based only on the evidence or information presented or reviewed at the conference;

(2) Ascertains the role and identity of everyone present;

(3) Indicates whether or not the individual reviewed the claims file;

(4) Explains the provisions of law and regulations applicable to the issue;

(5) Briefly summarizes the evidence already in file which will be considered;

(6) Ascertains from the individual whether the information presented is correct and whether he/she fully understands it;

(7) Allows the individual and the individual's representative, if any, to present the individual's case;

(8) Secures updated financial information and verification, if necessary;

(9) Allows each witness to present information and allows the individual and the individual's representative to question each witness;

(10) Ascertains whether there is any further evidence to be presented;

(11) Reminds the individual of any evidence promised by the individual which has not been presented;

(12) Lets the individual and the individual's representative, if any, present any proposed summary or closing statement;

(13) Explains that a decision will be made and the individual will be notified in writing; and

(14) Explains repayment options and further appeal rights in the event the decision is adverse to the individual.

(e) SSA issues a written decision to the individual (and his or her representative, if any) specifying the findings of fact and conclusions in support of the decision to approve or deny waiver and advising of the individual's right to appeal the decision. If waiver is denied, adjustment or recovery of the overpayment begins even if the individual appeals.

(f) If it appears that the waiver cannot be approved, and the individual declines a personal conference or fails to appear for a second scheduled personal conference, a decision regarding the waiver will be made based on the written evidence of record. Reconsideration is the next step in the appeals process.

[73 FR 1973, Jan. 11, 2008]

§ 416.558 Notice relating to overpayments and underpayments.

(a) *Notice of overpayment and underpayment determination.* Whenever a determination concerning the amount paid and payable for any period is made and it is found that, with respect to any month in the period, more or less than the correct amount was paid, written notice of the correct and incorrect amounts for each such month in the period will be sent to the individual against whom adjustment or recovery of the overpayment as defined in § 416.537(a) may be effected or to whom the underpayment as defined in §§ 416.536 and any amounts subject to installment payments as defined in § 416.544 would be payable, notwithstanding the fact that part or all of the underpayment must be withheld in accordance with § 416.543. When notifying an individual of a determination of overpayment, the Social Security Administration will, in the notice, also advise the individual that adjustment or recovery is required, as set forth in § 416.571, except under certain specified conditions, and of his or her right to request waiver of adjustment or recovery of the overpayment under the provisions of § 416.550.

(b) *Notice of waiver determination.* Written notice of an initial determination of waiver shall be given the individual in accordance with § 416.1404 unless the individual was not given notice of the overpayment in accordance with paragraph (a) of this section.

(c) *Notice relating to installment payments to individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.* Whenever a determination is made concerning the amount of any benefits due for a period that must be paid in installments, the written notice will also explain the amount of the installment payment and when an increased initial installment payment may be made (as described in § 416.544). This written notice will be sent to the individual and his or her representative payee.

[40 FR 47764, Oct. 10, 1975, as amended at 55 FR 33668, Aug. 17, 1990; 60 FR 8150, Feb. 10, 1995]

§ 416.560 Recovery—refund.

An overpayment may be refunded by the overpaid recipient or by anyone on his or her behalf. Refund should be made in every case where the overpaid individual is not currently eligible for SSI benefits. If the individual is currently eligible for SSI benefits and has not refunded the overpayment, adjustment as set forth in § 416.570 will be proposed.

[55 FR 33669, Aug. 17, 1990]

§ 416.570 Adjustment.

(a) *General.* When a recipient has been overpaid, the overpayment has not been refunded, and waiver of adjustment or recovery is not applicable, any payment due the overpaid recipient or his or her eligible spouse (or recovery from the estate of either or both when either or both die before adjustment is completed) is adjusted for recovery of the overpayment. Adjustment will generally be accomplished by withholding each month the amount set forth in § 416.571 from the benefit payable to the individual except that, when the overpayment results from the disposition of resources as provided by §§ 416.1240(b) and 416.1244, the overpayment will be recovered by withholding any payments due the overpaid recipient or his or her eligible spouse before any further payment is made. Absent a specific request from the person from whom recovery is sought, no overpayment made under title XVIII of the Act will be recovered by adjusting SSI benefits. In no case shall an overpayment of SSI benefits be adjusted against title XVIII benefits. No funds properly deposited into a dedicated account (see §§ 416.546 and 416.640(e)) can be used to repay an overpayment while the overpaid individual remains subject to the provisions of those sections.

(b) *Overpayment made to representative payee after the recipient's death.* A representative payee or his estate is solely liable for repaying an overpayment made to the representative payee on behalf of a recipient after the recipient's death. In such case, we will recover the overpayment according to paragraph (a) of this section, except that:

(1) We will not adjust any other payment due to the eligible spouse of the overpaid representative payee to recover the overpayment, and

(2) If the overpaid representative payee dies before we complete adjustment, we will not seek to recover the overpayment from the eligible spouse or the estate of the eligible spouse.

[70 FR 16, Jan. 3, 2005, as amended at 73 FR 65543, Nov. 4, 2008]

§ 416.571 10-percent limitation of recoupment rate—overpayment.

Any adjustment or recovery of an overpayment for an individual in current payment status is limited in amount in any month to the lesser of (1) the amount of the individual's benefit payment for that month or (2) an amount equal to 10 percent of the individual's total income (countable income plus SSI and State supplementary payments) for that month. The countable income used is the countable income used in determining the SSI and State supplementary payments for that month under § 416.420. When the overpaid individual is notified of the proposed SSI and/or federally administered State supplementary overpayment adjustment or recovery, the individual will be given the opportunity to request that such adjustment or recovery be made at a higher or

lower rate than that proposed. If a lower rate is requested, a rate of withholding that is appropriate to the financial condition of the overpaid individual will be set after an evaluation of all the pertinent facts. An appropriate rate is one that will not deprive the individual of income required for ordinary and necessary living expenses. This will include an evaluation of the individual's income, resources, and other financial obligations. The 10-percent limitation does not apply where it is determined that the overpayment occurred because of fraud, willful misrepresentation, or concealment of material information committed by the individual or his or her spouse. Concealment of material information means an intentional, knowing, and purposeful delay in making or failure to make a report that will affect payment amount and/or eligibility. It does not include a mere omission on the part of the recipient; it is an affirmative act to conceal. The 10-percent limitation does not apply to the recovery of overpayments incurred under agreements to dispose of resources pursuant to § 416.1240. In addition, the 10-percent limitation does not apply to the reduction of any future SSI benefits as a consequence of the misuse of funds set aside in accordance with § 416.1231(b) to meet burial expenses. Adjustment or recovery will be suspended if the recipient is subject to a reduced benefit rate under § 416.414 because of residing in a medical treatment facility in which Medicaid is paying a substantial portion of the recipient's cost of care.

[55 FR 33669, Aug. 17, 1990, as amended at 72 FR 50874, Sept. 5, 2007]

§ 416.572 Are title II and title VIII benefits subject to adjustment to recover title XVI overpayments?

(a) *Definitions*—(1) *Cross-program recovery*. Cross-program recovery is the process that we will use to collect title XVI overpayments from benefits payable to you under title II or title VIII of the Social Security Act.

(2) *Benefits payable.* For purposes of this section, benefits payable means the amount of title II or title VIII benefits you actually would receive. For title II benefits, it includes your monthly benefit and your past-due benefits after any reductions or deductions listed in § 404.401(a) and (b) of this chapter. For title VIII benefits, it includes your monthly benefit and any past-due benefits after any reduction by the amount of income for the month as described in §§ 408.505 through 408.510 of this chapter.

(b) *When may we collect title XVI overpayments using cross-program recovery?* We may use cross-program recovery to collect a title XVI overpayment you owe when benefits are payable to you under title II, title VIII, or both.

[70 FR 16, Jan. 3, 2005]

§ 416.573 How much will we withhold from your title II and title VIII benefits to recover a title XVI overpayment?

(a) If past-due benefits are payable to you, we will withhold the lesser of the entire overpayment balance or the entire amount of past-due benefits.

(b)(1) We will collect the overpayment from current monthly benefits due in a month by withholding the lesser of the amount of the entire overpayment balance or 10 percent of the monthly title II benefits and monthly title VIII benefits payable to you in the month.

(2) If we are already recovering a title II, title VIII or title XVI overpayment from your monthly title II benefit, we will figure your monthly withholding from title XVI payments (as described in § 416.571) without including your title II benefits in your total countable income.

(3) Paragraph (b)(1) of this section does not apply if:

(i) You request and we approve a different rate of withholding, or

(ii) You or your spouse willfully misrepresented or concealed material information in connection with the overpayment.

(c) In determining whether to grant your request that we withhold less than the amount described in paragraph (b)(1) of this section, we will use the criteria applied under § 416.571 to similar requests about withholding from title XVI benefits.

(d) If you or your spouse willfully misrepresented or concealed material information in connection with the

overpayment, we will collect the overpayment by withholding the lesser of the overpayment balance or the entire amount of title II benefits and title VIII benefits payable to you. We will not collect at a lesser rate. (See § 416.571 for what we mean by concealment of material information.)

[70 FR 16, Jan. 3, 2005]

§ 416.574 Will you receive notice of our intention to apply cross-program recovery?

Before we collect an overpayment from you using cross-program recovery, we will send you a written notice that tells you the following information:

(a) We have determined that you owe a specific overpayment balance that can be collected by cross-program recovery;

(b) We will withhold a specific amount from the title II or title VIII benefits (see § 416.573);

(c) You may ask us to review this determination that you still owe this overpayment balance;

(d) You may request that we withhold a different amount from your current monthly benefits (the notice will not include this information if § 416.573(d) applies); and

(e) You may ask us to waive collection of this overpayment balance.

[70 FR 16, Jan. 3, 2005]

§ 416.575 When will we begin cross-program recovery from your current monthly benefits?

(a) We will begin collecting the overpayment balance by cross-program recovery from your current monthly title II and title VIII benefits no sooner than 30 calendar days after the date of the notice described in § 416.574. If within that 30-day period you pay us the full overpayment balance stated in the notice, we will not begin cross-program recovery.

(b) If within that 30-day period you ask us to review our determination that you still owe us this overpayment balance, we will not begin cross-program recovery from your current monthly benefits before we review the matter and notify you of our decision in writing.

(c) If within that 30-day period you ask us to withhold a different amount from your current monthly benefits than the amount stated in the notice, we will not begin cross-program recovery until we determine the amount we will withhold. This paragraph does not apply when § 416.573(d) applies.

(d) If within that 30-day period you ask us to waive recovery of the overpayment balance, we will not begin cross-program recovery from your current monthly benefits before we review the matter and notify you of our decision in writing. See §§ 416.550 through 416.556.

[70 FR 16, Jan. 3, 2005]

§ 416.580 Referral of overpayments to the Department of the Treasury for tax refund offset—General.

(a) The standards we will apply and the procedures we will follow before requesting the Department of the Treasury to offset income tax refunds due taxpayers who have an outstanding overpayment are set forth in §§ 416.580 through 416.586 of this subpart. These standards and procedures are authorized by the Deficit Reduction Act of 1984 [31 U.S.C. § 3720A], as implemented through Department of the Treasury regulations at 31 CFR 285.2.

(b) We will use the Department of the Treasury tax refund offset procedure to collect overpayments that are certain in amount, past due and legally enforceable, and eligible for tax refund offset under regulations issued by the Secretary of the Treasury. We will use these procedures to collect overpayments only from persons who are not currently entitled to monthly supplemental security income benefits under title XVI of the Act. We refer overpayments to the Department of the Treasury for offset against Federal tax refunds regardless of the amount of time the debts have been outstanding.

[62 FR 49439, Sept. 22, 1997, as amended at 76 FR 65108, Oct. 20, 2011]

§ 416.581 Notice to overpaid person.

We will make a request for collection by reduction of Federal and State income tax refunds only after we determine that a person owes an overpayment that is past due and provide the

overpaid person with written notice. Our notice of intent to collect an overpayment through tax refund offset will state:

(a) The amount of the overpayment; and

(b) That we will collect the overpayment by requesting that the Department of the Treasury reduce any amounts payable to the overpaid person as refunds of Federal and State income taxes by an amount equal to the amount of the overpayment unless, within 60 calendar days from the date of our notice, the overpaid person:

(1) Repays the overpayment in full; or

(2) Provides evidence to us at the address given in our notice that the overpayment is not past due or legally enforceable; or

(3) Asks us to waive collection of the overpayment under section 204(b) of the Act.

(c) The conditions under which we will waive recovery of an overpayment under section 1631(b)(1)(B) of the Act;

(d) That we will review any evidence presented that the overpayment is not past due or not legally enforceable;

(e) That the overpaid person has the right to inspect and copy our records related to the overpayment as determined by us and will be informed as to where and when the inspection and copying can be done after we receive notice from the overpaid person that inspection and copying are requested.

[62 FR 49439, Sept. 22, 1997, as amended at 76 FR 65109, Oct. 20, 2011]

§ 416.582 Review within SSA that an overpayment is past due and legally enforceable.

(a) *Notification by overpaid individual.* An overpaid individual who receives a notice as described in § 416.581 of this subpart has the right to present evidence that all or part of the overpayment is not past due or not legally enforceable. To exercise this right, the individual must notify us and present evidence regarding the overpayment within 60 calendar days from the date of our notice.

(b) *Submission of evidence.* The overpaid individual may submit evidence showing that all or part of the debt is not past due or not legally enforceable as provided in paragraph (a) of this section. Failure to submit the notification and evidence within 60 calendar days will result in referral of the overpayment to the Department of the Treasury, unless the overpaid individual, within this 60-day time period, has asked us to waive collection of the overpayment under section 1631(b)(1)(B) of the Act and we have not yet determined whether we can grant the waiver request. If the overpaid individual asks us to waive collection of the overpayment, we may ask that evidence to support the request be submitted to us.

(c) *Review of the evidence.* After a timely submission of evidence by the overpaid individual, we will consider all available evidence related to the overpayment. We will make findings based on a review of the written record, unless we determine that the question of indebtedness cannot be resolved by a review of the documentary evidence.

[62 FR 49439, Sept. 22, 1997]

§ 416.583 Findings by SSA.

(a) Following the review of the record, we will issue written findings which include supporting rationale for the findings. Issuance of these findings concerning whether the overpayment or part of the overpayment is past due and legally enforceable is the final Agency action with respect to the past-due status and enforceability of the overpayment. If we make a determination that a waiver request cannot be granted, we will issue a written notice of this determination in accordance with the regulations in subpart E of this part. Our referral of the overpayment to the Department of the Treasury will not be suspended under § 416.585 of this subpart pending any further administrative review of the waiver request that the individual may seek.

(b) Copies of the findings described in paragraph (a) of this section will be distributed to the overpaid individual and the overpaid individual's attorney or other representative, if any.

(c) If the findings referred to in paragraph (a) of this section affirm that all or part of the overpayment is past due and legally enforceable and, if waiver is requested and we determine that the

request cannot be granted, we will refer the overpayment to the Department of the Treasury. However, no referral will be made if, based on our review of the overpayment, we reverse our prior finding that the overpayment is past due and legally enforceable or, upon consideration of a waiver request, we determine that waiver of our collection of the overpayment is appropriate.

[62 FR 49439, Sept. 22, 1997]

§ 416.584 Review of our records related to the overpayment.

(a) *Notification by the overpaid individual.* An overpaid individual who intends to inspect or copy our records related to the overpayment as determined by us must notify us stating his or her intention to inspect or copy.

(b) *Our response.* In response to a notification by the overpaid individual as described in paragraph (a) of this section, we will notify the overpaid individual of the location and time when the overpaid individual may inspect or copy our records related to the overpayment. We may also, at our discretion, mail copies of the overpayment-related records to the overpaid individual.

[62 FR 49439, Sept. 22, 1997]

§ 416.585 Suspension of offset.

If, within 60 days of the date of the notice described in § 416.581 of this subpart, the overpaid individual notifies us that he or she is exercising a right described in § 416.582(a) of this subpart and submits evidence pursuant to § 416.582(b) of this subpart or requests a waiver under § 416.550 of this subpart, we will suspend any notice to the Department of the Treasury until we have issued written findings that affirm that an overpayment is past due and legally enforceable and, if applicable, make a determination that a waiver request cannot be granted.

[62 FR 49440, Sept. 22, 1997]

§ 416.586 Tax refund insufficient to cover amount of overpayment.

If a tax refund is insufficient to recover an overpayment in a given year, the case will remain with the Department of the Treasury for succeeding years, assuming that all criteria for certification are met at that time.

[62 FR 49440, Sept. 22, 1997]

§ 416.590 Are there additional methods for recovery of title XVI benefit overpayments?

(a) *General.* In addition to the methods specified in §§ 416.560, 416.570, 416.572 and 416.580, we may recover an overpayment under title XVI of the Act from you under the rules in subparts D and E of part 422 of this chapter. Subpart D of part 422 of this chapter applies only under the following conditions:

(1) The overpayment occurred after you attained age 18;

(2) You are no longer entitled to benefits under title XVI of the Act; and

(3) Pursuant to paragraph (b) of this section, we have determined that the overpayment is otherwise unrecoverable under section 1631(b) of the Act.

(b) *When we consider an overpayment to be otherwise unrecoverable.* We consider an overpayment under title XVI of the Act to be otherwise unrecoverable under section 1631(b) of the Act if all of the following conditions are met:

(1) We have completed our billing system sequence (*i.e.*, we have sent you an initial notice of the overpayment, a reminder notice, and a past-due notice) or we have suspended or terminated collection activity under applicable rules, such as, the Federal Claims Collection Standards in 31 CFR 903.2 or 903.3.

(2) We have not entered into an installment payment arrangement with you or, if we have entered into such an arrangement, you have failed to make any payment for two consecutive months.

(3) You have not requested waiver pursuant to § 416.550 or § 416.582 or, after a review conducted pursuant to those sections, we have determined that we will not waive collection of the overpayment.

(4) You have not requested reconsideration of the initial overpayment determination pursuant to §§ 416.1407 and 416.1409 or, after a review conducted pursuant to § 416.1413, we have affirmed all or part of the initial overpayment determination.

(5) We cannot recover your overpayment pursuant to § 416.570 by adjustment of benefits payable to any individual other than you. For purposes of this paragraph, if you are a member of an eligible couple that is legally separated and/or living apart, we will deem unrecoverable from the other person that part of your overpayment which he or she did not receive.

[66 FR 67081, Dec. 28, 2001, as amended at 68 FR 74184, Dec. 23, 2003]

Subpart F—Representative Payment

AUTHORITY: Secs. 205(j)(1)(C), 702(a)(5), 1631(a)(2) and (d)(1) of the Social Security Act (42 U.S.C. 405(j)(1)(C), 902(a)(5), 1383(a)(2) and (d)(1)).

SOURCE: 47 FR 30475, July 14, 1982, unless otherwise noted.

§ 416.601 Introduction.

(a) *Explanation of representative payment.* This subpart explains the principles and procedures that we follow in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds he or she receives on behalf of a beneficiary. A representative payee may be either a person or an organization selected by us to receive benefits on behalf of a beneficiary. A representative payee will be selected if we believe that the interest of a beneficiary will be served by representative payment rather than direct payment of benefits. Generally, we appoint a representative payee if we have determined that the beneficiary is not able to manage or direct the management of benefit payments in his or her own interest.

(b) *Policy used to determine whether to make representative payment.* (1) Our policy is that every beneficiary has the right to manage his or her own benefits. However, some beneficiaries due to a mental or physical condition or due to their youth may be unable to do so. Under these circumstances, we may determine that the interests of the beneficiary would be better served if we certified benefit payments to another person as a representative payee. However, we must select a representative payee for an individual who is eligible for benefits solely on the basis of disability if drug addiction or alcoholism is a contributing factor material to the determination of disability.

(2) If we determine that representative payment is in the interest of a beneficiary, we will appoint a representative payee. We may appoint a representative payee even if the beneficiary is a legally competent individual. If the beneficiary is a legally incompetent individual, we may appoint the legal guardian or some other person as a representative payee.

(3) If payment is being made directly to a beneficiary and a question arises concerning his or her ability to manage or direct the management of benefit payments, we will, if the beneficiary is 18 years old or older and has not been adjudged legally incompetent, continue to pay the beneficiary until we make a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

[47 FR 30475, July 14, 1982, as amended at 60 FR 8150, Feb. 10, 1995]

§ 416.610 When payment will be made to a representative payee.

(a) We pay benefits to a representative payee on behalf of a beneficiary 18 years old or older when it appears to us that this method of payment will be in the interest of the beneficiary. We do this if we have information that the beneficiary is—

(1) Legally incompetent or mentally incapable of managing benefit payments; or

(2) Physically incapable of managing or directing the management of his or her benefit payments; or

(3) Eligible for benefits solely on the basis of disability and drug addiction or alcoholism is a contributing factor material to the determination of disability.

(b) Generally, if a beneficiary is under age 18, we will pay benefits to a representative payee. However, in certain situations, we will make direct payments to a beneficiary under age 18 who shows the ability to manage the benefits. For example, we make direct

payment to a beneficiary under age 18 if the beneficiary is—

(1) A parent and files for himself or herself and/or his or her child and he or she has experience in handling his or her own finances; or

(2) Capable of using the benefits to provide for his or her current needs and no qualified payee is available; or

(3) Within 7 months of attaining age 18 and is initially filing an application for benefits.

[47 FR 30475, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989; 60 FR 8150, Feb. 10, 1995]

§ 416.611 What happens to your monthly benefits while we are finding a suitable representative payee for you?

(a) *We may pay you directly.* We will pay current monthly benefits directly to you while finding a suitable representative payee unless we determine that paying you directly would cause substantial harm to you. We determine substantial harm as follows:

(1) If you are receiving disability payments and we have determined that you have a drug addiction or alcoholism condition, or you are legally incompetent, or you are under age 15, we will presume that substantial harm exists. However, we will allow you to rebut this presumption by presenting evidence that direct payment would not cause you substantial harm.

(2) If you do not fit any of these categories, we make findings of substantial harm on a case-by-case basis. We consider all matters that may affect your ability to manage your benefits in your own best interest. We decide that substantial harm exists if both of the following conditions exist:

(i) Directly receiving benefits can be expected to cause you serious physical or mental injury.

(ii) The possible effect of the injury would outweigh the effect of having no income to meet your basic needs.

(b) *We may delay or suspend your payments.* If we find that direct payment will cause substantial harm to you, we may delay (in the case of initial eligibility for benefits) or suspend (in the case of existing eligibility for benefits) payments for as long as one month while we try to find a suitable representative payee. If we do not find a payee within one month, we will pay you directly. If you are receiving disability payments and we have determined that you have a drug addiction or alcoholism condition, or you are legally incompetent, or you are under age 15, we will withhold payment until a representative payee is appointed even if it takes longer than one month. We will, however, as noted in paragraph (a)(1) of this section, allow you to present evidence to rebut the presumption that direct payment would cause you substantial harm. See § 416.601(b)(3) for our policy on suspending the benefits if you are currently receiving benefits directly.

Example 1: Substantial Harm Exists. We are unable to find a representative payee for Mr. X, a 67 year old claimant receiving title XVI benefits based on age who is an alcoholic. Based on contacts with the doctor and beneficiary, we determine that Mr. X was hospitalized recently for his drinking. Paying him directly will cause serious injury, so we may delay payment for as long as one month based on substantial harm while we locate a suitable representative payee.

Example 2: Substantial Harm Does Not Exist. We approve a claim for Mr. Y, a title XVI claimant who suffers from a combination of mental impairments but who is not legally incompetent. We determine that Mr. Y needs assistance in managing benefits, but we have not found a representative payee. Although we believe that Mr. Y may not use the money wisely, there is no indication that receiving funds directly would cause him substantial harm (*i.e.*, serious physical or mental injury). We must pay current benefits directly to Mr. Y while we locate a suitable representative payee.

(c) *How we pay delayed or suspended benefits.* Payment of benefits, which were delayed or suspended pending appointment of a representative payee, can be made to you or your representative payee as a single sum or in installments when we determine that installments are in your best interest.

[69 FR 60236, Oct. 7, 2004]

§ 416.615 Information considered in determining whether to make representative payment.

In determining whether to make representative payment we consider the following information:

(a) *Court determinations.* If we learn that a beneficiary has been found to be

legally incompetent, a certified copy of the court's determination will be the basis of our determination to make representative payment.

(b) *Medical evidence.* When available, we will use medical evidence to determine if a beneficiary is capable of managing or directing the management of benefit payments. For example, a statement by a physician or other medical professional based upon his or her recent examination of the beneficiary and his or her knowledge of the beneficiary's present condition will be used in our determination, if it includes information concerning the nature of the beneficiary's illness, the beneficiary's chances for recovery and the opinion of the physician or other medical professional as to whether the beneficiary is able to manage or direct the management of benefit payments.

(c) *Other evidence.* We will also consider any statements of relatives, friends and other people in a position to know and observe the beneficiary, which contain information helpful to us in deciding whether the beneficiary is able to manage or direct the management of benefit payments.

§ 416.618 Advance designation of representative payees.

(a) *General.* An individual who:

(1) Is eligible for or an applicant for a benefit; and

(2) Has attained 18 years of age or is an emancipated minor, may designate in advance one or more individuals to possibly serve as a representative payee for the individual if we determine that payment will be made to a representative payee (see § 416.610(a)). An individual may not designate in advance possible representative payees if we have information that the individual is either legally incompetent or mentally incapable of managing his or her benefit payments; or physically incapable of managing or directing the management of his or her benefit payments.

(b) *How to designate possible representative payees in advance.* Individuals who meet the requirements in paragraph (a) of this section may designate in advance their choice(s) for possible representative payees by indicating their decision to designate a representative payee in advance and providing us with the required information. In addition to the required information, an individual may choose to provide us with the relationship of the advance designee to the individual. The information we require before we will consider an advance designee as a possible representative payee is:

(1) The name of the advance designee,

(2) A telephone number of the advance designee, and

(3) The order of priority in which the individual would like us to consider the advance designees if he or she designates more than one advance designee.

(c) *How to make changes to advance designation.* Individuals who meet the requirements in paragraph (a) of this section may change their advance designees by informing us of the change and providing the required information (see paragraphs (b)(1) through (3) of this section) to us. Individuals who meet the requirements in paragraph (a) of this section may withdraw their advance designation by informing us of the withdrawal.

(d) *How we consider advance designation when we select a representative payee.* (1) If we determine that payment will be made to a representative payee, we will review advance designees in the order listed by the individual and select the first advance designee who meets the criteria for selection. To meet the criteria for selection—

(i) The advance designee must be willing and able to serve as a representative payee,

(ii) Appointment of the advance designee must comply with the requirements in section 205(j)(2) of the Social Security Act, and

(iii)There must be no other good cause (see §§ 416.620 and 416.621) to prevent us from selecting the advance designee.

(2) If none of the advance designees meet the criteria for selection, we will use our list of categories of preferred payees (see § 416.621), along with our other regulations in subpart F of this part, as a guide to select a suitable representative payee.

(e) *How we consider advance designation when we select a subsequent representative payee.* If an individual who

currently has a representative payee requires a change of representative payee, we will consider any other designees identified by the individual at a time in which that individual was eligible to make an advanced designation, under paragraph (d) of this section.

(f) *Organizations.* An individual may not designate in advance an organization to serve as his or her possible representative payee.

[85 FR 7665, Feb. 11, 2020]

§ 416.620 Information considered in selecting a representative payee.

In selecting a payee we try to select the person, agency, organization or institution that will best serve the interest of the beneficiary. In making our selection we consider—

(a) The relationship of the person to the beneficiary;

(b) The amount of interest that the person shows in the beneficiary;

(c) Any legal authority the person, agency, organization or institution has to act on behalf of the beneficiary;

(d) Whether the potential payee has custody of the beneficiary;

(e) Whether the potential payee is in a position to know of and look after the needs of the beneficiary;

(f) The potential payee's criminal history; and

(g) Whether the beneficiary made an advance designation (see § 416.618).

[47 FR 30475, July 14, 1982, as amended at 84 FR 4325, Feb. 15, 2019; 85 FR 7665, Feb. 11. 2020]

§ 416.621 What is our order of preference in selecting a representative payee for you?

As a guide in selecting a representative payee, we have established categories of preferred payees. These preferences are flexible. We will consider an individual's advance designees (see § 416.618) before we consider other potential representative payees in the categories of preferred payees listed in this section. When we select a representative payee, we will choose the designee of the beneficiary's highest priority, provided that the designee is willing and able to serve, is not prohibited from serving (see § 416.622), and supports the best interest of the beneficiary (see § 416.620). The preferences are:

(a) For beneficiaries 18 years old or older (except those described in paragraph (b) of this section), our preference is—

(1) A legal guardian, spouse (or other relative) who has custody of the beneficiary or who demonstrates strong concern for the personal welfare of the beneficiary;

(2) A friend who has custody of the beneficiary or demonstrates strong concern for the personal welfare of the beneficiary;

(3) A public or nonprofit agency or institution having custody of the beneficiary;

(4) A private institution operated for profit and licensed under State law, which has custody of the beneficiary; and

(5) Persons other than above who are qualified to carry out the responsibilities of a payee and who are able and willing to serve as a payee for the beneficiary; e.g., members of community groups or organizations who volunteer to serve as payee for a beneficiary.

(b) For individuals who are disabled and who have a drug addiction or alcoholism condition our preference is—

(1) A community-based nonprofit social service agency licensed by the State, or bonded;

(2) A Federal, State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities;

(3) A State or local government agency with fiduciary responsibilities;

(4) A designee of an agency (other than a Federal agency) referred to in paragraphs (b)(1), (2), and (3) of this section, if appropriate; or

(5) A family member.

(c) For beneficiaries under age 18, our preference is—

(1) A natural or adoptive parent who has custody of the beneficiary, or a guardian;

(2) A natural or adoptive parent who does not have custody of the beneficiary, but is contributing toward the beneficiary's support and is demonstrating strong concern for the beneficiary's well being;

(3) A natural or adoptive parent who does not have custody of the beneficiary and is not contributing toward his or her support but is demonstrating strong concern for the beneficiary's well being;

(4) A relative or stepparent who has custody of the beneficiary;

(5) A relative who does not have custody of the beneficiary but is contributing toward the beneficiary's support and is demonstrating concern for the beneficiary's well being;

(6) A relative or close friend who does not have custody of the beneficiary but is demonstrating concern for the beneficiary's well being; and

(7) An authorized social agency or custodial institution.

[47 FR 30475, July 14, 1982, as amended at 69 FR 60237, Oct. 7, 2004; 85 FR 7665, Feb. 11, 2020]

§ 416.622 Who may not serve as a representative payee?

A representative payee applicant may not serve if he/she:

(a) Has been convicted of a violation under section 208, 811 or 1632 of the Social Security Act.

(b) Has been convicted of an offense resulting in imprisonment for more than 1 year. However, we may make an exception to this prohibition, if the nature of the conviction is such that selection of the applicant poses no risk to the beneficiary and the exception is in the beneficiary's best interest.

(c) Receives title II, VIII, or XVI benefits through a representative payee.

(d) Previously served as a representative payee and was found by us, or a court of competent jurisdiction, to have misused title II, VIII or XVI benefits. However, if we decide to make an exception to the prohibition, we must evaluate the payee's performance at least every 3 months until we are satisfied that the payee poses no risk to the beneficiary's best interest. Exceptions are made on a case-by-case basis if all of the following are true:

(1) Direct payment of benefits to the beneficiary is not in the beneficiary's best interest.

(2) No suitable alternative payee is available.

(3) Selecting the payee applicant as representative payee would be in the best interest of the beneficiary.

(4) The information we have indicates the applicant is now suitable to serve as a representative payee.

(5) The payee applicant has repaid the misused benefits or has a plan to repay them.

(e) Is a creditor. A creditor is someone who provides you with goods or services for consideration. This restriction does not apply to the creditor who poses no risk to you and whose financial relationship with you presents no substantial conflict of interest, and is any of the following:

(1) A relative living in the same household as you do.

(2) Your legal guardian or legal representative.

(3) A facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State.

(4) A qualified organization authorized to collect a monthly fee from you for expenses incurred in providing representative payee services for you, under § 416.640a.

(5) An administrator, owner, or employee of the facility in which you live and we are unable to locate an alternative representative payee.

(6) Any other individual we deem appropriate based on a written determination.

Example 1: Sharon applies to be representative payee for Ron who we have determined needs assistance in managing his benefits. Sharon has been renting a room to Ron for several years and assists Ron in handling his other financial obligations, as needed. She charges Ron a reasonable amount of rent. Ron has no other family or friends willing to help manage his benefits or to act as representative payee. Sharon has demonstrated that her interest in and concern for Ron goes beyond her desire to collect the rent each month. In this instance, we may select Sharon as Ron's representative payee because a more suitable payee is not available, she appears to pose no risk to Ron and there is minimal conflict of interest. We will document this decision.

Example 2: In a situation similar to the one above, Ron's landlord indicates that she is applying to be payee only to ensure receipt of her rent. If there is money left after payment of the rent, she will give it directly to Ron to manage on his own. In this situation, we would not select the landlord as Ron's

representative payee because of the substantial conflict of interest and lack of interest in his well being.

(f) Was convicted under Federal or State law of a felony for: Human trafficking, false imprisonment, kidnapping, rape or sexual assault, first-degree homicide, robbery, fraud to obtain access to government assistance, fraud by scheme, theft of government funds or property, abuse or neglect, forgery, or identity theft or identity fraud. We will also apply this provision to a representative payee applicant with a felony conviction of an attempt to commit any of these crimes or conspiracy to commit any of these crimes.

(1) If the representative payee applicant is the custodial parent of a minor child beneficiary, custodial parent of a beneficiary who is under a disability which began before the beneficiary attained the age of 22, custodial spouse of a beneficiary, custodial court-appointed guardian of a beneficiary, or custodial grandparent of the minor child beneficiary for whom the applicant is applying to serve as representative payee, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

(2) If the representative payee applicant is the parent who was previously the representative payee for his or her minor child who has since turned age 18 and continues to be eligible for benefits, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee for that beneficiary. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

(3) If the representative payee applicant received a Presidential or gubernatorial pardon for the relevant conviction, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

[69 FR 60237, Oct. 7, 2004, as amended at 71 FR 61408, Oct. 18, 2006; 84 FR 4325, Feb. 15, 2019]

§ 416.624 How do we investigate a representative payee applicant?

Before selecting an individual or organization to act as your representative payee, we will perform an investigation.

(a) *Nature of the investigation.* As part of the investigation, we do the following:

(1) Conduct a face-to-face interview with the payee applicant unless it is impracticable as explained in paragraph (c) of this section.

(2) Require the payee applicant to submit documented proof of identity, unless information establishing identity has recently been submitted with an application for title II, VIII or XVI benefits.

(3) Verify the payee applicant's Social Security account number or employer identification number.

(4) Determine whether the payee applicant has been convicted of a violation of section 208, 811 or 1632 of the Social Security Act.

(5) Determine whether the payee applicant has previously served as a representative payee and if any previous appointment as payee was revoked or terminated for misusing title II, VIII or XVI benefits.

(6) Use our records to verify the payee applicant's employment and/or direct receipt of title II, VIII, or XVI benefits.

(7) Verify the payee applicant's concern for the beneficiary with the beneficiary's custodian or other interested person.

(8) Require the payee applicant to provide adequate information showing his or her relationship to the beneficiary and to describe his or her responsibility for the care of the beneficiary.

(9) Determine whether the payee applicant is a creditor of the beneficiary (see § 416.622(e)).

(10) Conduct a criminal background check on the individual payee applicant.

(b) *Subsequent face-to-face interviews.* After holding a face-to-face interview with a payee applicant, subsequent face-to-face interviews are not required if that applicant continues to be qualified and currently is acting as a payee, unless we determine, within our discretion, that a new face-to-face interview is necessary. We base this decision on the payee's past performance and knowledge of and compliance with our reporting requirements.

(c) *Impracticable.* We may consider a face-to-face interview impracticable if it would cause the payee applicant undue hardship. For example, the payee applicant would have to travel a great distance to the field office. In this situation, we may conduct the investigation to determine the payee applicant's suitability to serve as a representative payee without a face-to-face interview.

[69 FR 60237, Oct. 7, 2004, as amended at 73 FR 66521, Nov. 10, 2008; 84 FR 4326, Feb. 15, 2018; 84 FR 57320, Oct. 25, 2019]

§ 416.625 What information must a representative payee report to us?

Anytime after we select a representative payee for you, we may ask your payee to give us information showing a continuing relationship with you, a continuing responsibility for your care, and how he/she used the payments on your behalf. If your representative payee does not give us the requested information within a reasonable period of time, we may stop sending your benefit payment to him/her—unless we determine that he/she had a satisfactory reason for not meeting our request and we subsequently receive the requested information. If we decide to stop sending your benefit payment to your representative payee, we will consider paying you directly (in accordance with § 416.611) while we look for a new payee.

[69 FR 60238, Oct. 7, 2004]

§ 416.626 How do we investigate an appointed representative payee?

After we select an individual to act as your representative payee, we will conduct a criminal background check on the appointed representative payee at least once every 5 years.

[84 FR 4326, Feb. 15, 2019, as amended at 84 FR 57320, Oct. 25, 2019]

§ 416.630 How will we notify you when we decide you need a representative payee?

(a) We notify you in writing of our determination to make representative payment. This advance notice explains that we have determined that representative payment is in your interest, and it provides the name of the representative payee we have selected. We provide this notice before we actually appoint the payee. If you are under age 15, an unemancipated minor under the age of 18, or legally incompetent, our written notice goes to your legal guardian or legal representative. The advance notice:

(1) Contains language that is easily understandable to the reader.

(2) Identifies the person designated as your representative payee.

(3) Explains that you, your legal guardian, or your legal representative can appeal our determination that you need a representative payee.

(4) Explains that you, your legal guardian, or your legal representative can appeal our designation of a particular person to serve as your representative payee.

(5) Explains that you, your legal guardian, or your legal representative can review the evidence upon which our designation of a particular representative payee is based and submit additional evidence.

(b) If you, your legal guardian, or your legal representative objects to representative payment or to the designated payee, we will handle the objection as follows:

(1) If you disagree with the decision and wish to file an appeal, we will process it under subpart N of this part.

(2) If you received your advance notice by mail and you protest or file your appeal within 10 days after you receive the notice, we will delay the action until we make a decision on your protest or appeal. (If you received and signed your notice while you were in the local field office, our decision will be effective immediately.)

[69 FR 60238, Oct. 7, 2004]

§ 416.635 What are the responsibilities of your representative payee?

A representative payee has a responsibility to—

(a) Use the benefits received on your behalf only for your use and benefit in a manner and for the purposes he or she determines under the guidelines in this subpart, to be in your best interests;

(b) Keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she is your spouse or natural or adoptive parent or stepparent and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement;

(c) Treat any interest earned on the benefits as your property;

(d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them;

(e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us;

(f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities; and

(g) Ensure that you are receiving treatment to the extent considered medically necessary and available for the condition that was the basis for providing benefits (see § 416.994a(i)) if you are under age 18 (including cases in which your low birth weight is a contributing factor material to our determination that you are disabled).

[71 FR 61408, Oct. 18, 2006]

§ 416.640 Use of benefit payments.

(a) *Current maintenance.* We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care and personal comfort items.

Example: A Supplemental Security Income beneficiary is entitled to a monthly benefit of $264. The beneficiary's son, who is the representative payee, disburses the benefits in the following manner:

Rent and Utilities	$166
Medical	20
Food	60
Clothing	10
Miscellaneous	8

The above expenditures would represent proper disbursements on behalf of the beneficiary.

(b) *Institution not receiving Medicaid funds on beneficiary's behalf.* If a beneficiary is receiving care in a Federal, State, or private institution because of mental or physical incapacity, current maintenance will include the customary charges for the care and services provided by an institution, expenditures for those items which will aid in the beneficiary's recovery or release from the institution, and nominal expenses for personal needs (e.g., personal hygiene items, snacks, candy) which will improve the beneficiary's condition. Except as provided under § 416.212, there is no restriction in using SSI benefits for a beneficiary's current maintenance in an institution. Any payments remaining from SSI benefits may be used for a temporary period to maintain the beneficiary's residence outside of the institution unless a physician has certified that the beneficiary is not likely to return home.

Example: A hospitalized disabled beneficiary is entitled to a monthly benefit of $264. The beneficiary, who resides in a boarding home, has resided there for over 6 years. It is doubtful that the beneficiary will leave the boarding home in the near future. The boarding home charges $215 per month for the beneficiary's room and board.

The beneficiary's representative payee pays the boarding home $215 (assuming an unsuccessful effort was made to negotiate a lower rate during the beneficiary's absence) and uses the balance to purchase miscellaneous personal items for the beneficiary. There are no benefits remaining which can be conserved on behalf of the beneficiary. The payee's use of the benefits is consistent with our guidelines.

(c) *Institution receiving Medicaid funds on beneficiary's behalf.* Except in the case of a beneficiary receiving benefits payable under § 416.212, if a beneficiary resides throughout a month in an institution that receives more than 50 percent of the cost of care on behalf of the beneficiary from Medicaid, any payments due shall be used only for the personal needs of the beneficiary and not for other items of current maintenance.

Example: A disabled beneficiary resides in a hospital. The superintendent of the hospital receives $30 per month as the beneficiary's payee. The benefit payment is disbursed in the following manner, which would be consistent with our guidelines:

Miscellaneous canteen items	$10
Clothing	15
Conserved for future needs of the beneficiary	5

(d) *Claims of creditors.* A payee may not be required to use benefit payments to satisfy a debt of the beneficiary, if the debt arose prior to the first month for which payments are certified to a payee. If the debt arose prior to this time, a payee may satisfy it only if the current and reasonably foreseeable needs of the beneficiary are met.

Example: A disabled beneficiary was determined to be eligible for a monthly benefit payment of $208 effective April 1981. The benefits were certified to the beneficiary's brother who was appointed as the representative payee. The payee conserved $27 of the benefits received. In June 1981 the payee received a bill from a doctor who had treated the beneficiary in February and March 1981. The bill was for $175.

After reviewing the beneficiary's current needs and resources, the payee decided not to use any of the benefits to pay the doctor's bill. (Approximately $180 a month is required for the beneficiary's current monthly living expenses—rent, utilities, food, and insurance—and the beneficiary will need new shoes and a coat within the next few months.)

Based upon the above, the payee's decision not to pay the doctor's bill is consistent with our guidelines.

(e) *Dedicated accounts for eligible individuals under age 18.* (1) When past-due benefit payments are required to be paid into a separate dedicated account (see § 416.546), the representative payee is required to establish in a financial institution an account dedicated to the purposes described in paragraph (e)(2) of this section. This dedicated account may be a checking, savings or money market account subject to the titling requirements set forth in § 416.645. Dedicated accounts may not be in the form of certificates of deposit, mutual funds, stocks, bonds or trusts.

(2) A representative payee shall use dedicated account funds, whether deposited on a mandatory or permissive basis (as described in § 416.546), for the benefit of the child and only for the following allowable expenses—

(i) Medical treatment and education or job skills training;

(ii) If related to the child's impairment(s), personal needs assistance; special equipment; housing modification; and therapy or rehabilitation; or

(iii) Other items and services related to the child's impairment(s) that we determine to be appropriate. The representative payee must explain why or how the other item or service relates to the impairment(s) of the child. Attorney fees related to the pursuit of the child's disability claim and use of funds to prevent malnourishment or homelessness could be considered appropriate expenditures.

(3) Representative payees must keep records and receipts of all deposits to and expenditures from dedicated accounts, and must submit these records to us upon our request, as explained in §§ 416.635 and 416.665.

(4) The use of funds from a dedicated account in any manner not authorized by this section constitutes a misapplication of benefits. These misapplied benefits are not an overpayment as defined in § 416.537; however, if we determine that a representative payee knowingly misapplied funds in a dedicated account, that representative payee shall be liable to us in an amount equal to the total amount of the misapplied funds. In addition, if a

recipient who is his or her own payee knowingly misapplies benefits in a dedicated account, we will reduce future benefits payable to that recipient (or to that recipient and his or her spouse) by an amount equal to the total amount of the misapplied funds.

(5) The restrictions described in this section and the income and resource exclusions described in §§ 416.1124(c)(20) and 416.1247 shall continue to apply until all funds in the dedicated account are depleted or eligibility for benefits terminates, whichever comes first. This continuation of the restrictions and exclusions applies in situations where funds remain in the account in any of the following situations—

(i) A child attains age 18, continues to be eligible and receives payments directly;

(ii) A new representative payee is appointed. When funds remaining in a dedicated account are returned to us by the former representative payee, the new representative payee must establish an account in a financial institution into which we will deposit these funds, even if the amount is less than that prescribed in § 416.546; or

(iii) During a period of suspension due to ineligibility as described in § 416.1320, administrative suspension, or a period of eligibility for which no payment is due.

[47 FR 30475, July 14, 1982, as amended at 61 FR 10278, Mar. 13, 1996; 61 FR 67206, Dec. 20, 1996; 76 FR 453, Jan. 5, 2011]

§ 416.640a Compensation for qualified organizations serving as representative payees.

(a) *Organizations that can request compensation.* A qualified organization can request us to authorize it to collect a monthly fee from your benefit payment. A qualified organization is:

(1) Any State or local government agency with fiduciary responsibilities or whose mission is to carry out income maintenance, social service, or health care-related activities; or

(2) Any community-based nonprofit social service organization founded for religious, charitable or social welfare purposes, which is tax exempt under section 501(c) of the Internal Revenue Code and which is bonded/insured to cover misuse and embezzlement by officers and employees and which is licensed in each State in which it serves as representative payee (if licensing is available in the State). The minimum amount of bonding or insurance coverage must equal the average monthly amount of supplemental security income payments received by the organization plus the amount of the beneficiaries' conserved funds (*i.e.*, beneficiaries' saved supplemental security income payments) plus interest on hand. For example, an organization that has conserved funds of $5,000 and receives an average of $12,000 a month in supplemental security income payments must be bonded/insured for a minimum of $17,000. The license must be appropriate under the laws of the State for the type of services the organization provides. An example of an appropriately licensed organization is a community mental health center holding a State license to provide community mental health services.

(b) *Requirements qualified organizations must meet.* Organizations that are qualified under paragraphs (a)(1) or (a)(2) of this section must also meet the following requirements before we can authorize them to collect a monthly fee.

(1) A qualified organization must regularly provide representative payee services concurrently to at least five beneficiaries. An organization which has received our authorization to collect a fee for representative payee services, but is temporarily (not more than 6 months) not a payee for at least five beneficiaries, may request our approval to continue to collect fees.

(2) A qualified organization must demonstrate that it is not a creditor of the beneficiary. See paragraph (c) of this section for exceptions to the requirement regarding creditors.

(c) *Creditor relationship.* On a case-by-case basis, we may authorize an organization to collect a fee for payee services despite the creditor relationship. (For example, the creditor is the beneficiary's landlord.) To provide this authorization, we will review all of the evidence submitted by the organization and authorize collection of a fee when:

(1) The creditor services (e.g., providing housing) provided by the organization help to meet the current needs of the beneficiary; and

(2) The amount the organization charges the beneficiary for these services is commensurate with the beneficiary's ability to pay.

(d) *Authorization process.* (1) An organization must request in writing and receive an authorization from us *before* it may collect a fee.

(2) An organization seeking authorization to collect a fee must also give us evidence to show that it is qualified, pursuant to paragraphs (a), (b), and (c) of this section, to collect a fee.

(3) If the evidence provided to us by the organization shows that it meets the requirements of this section, and additional investigation by us proves it suitable to serve, we will notify the organization in writing that it is authorized to collect a fee. If we need more evidence, or if we are not able to authorize the collection of a fee, we will also notify the organization in writing that we have not authorized the collection of a fee.

(e) *Revocation and cancellation of the authorization.* (1) We will revoke an authorization to collect a fee if we have evidence which establishes that an organization no longer meets the requirements of this section. We will issue a written notice to the organization explaining the reason(s) for the revocation.

(2) An organization may cancel its authorization at any time upon written notice to us.

(f) *Notices.* The written notice we will send to an organization authorizing the collection of a fee will contain an effective date for the collection of a fee pursuant to paragraphs (a), (b) and (c) of this section. The effective date will be no earlier than the month in which the organization asked for authorization to collect a fee. The notice will be applicable to all beneficiaries for whom the organization was payee at the time of our authorization and all beneficiaries for whom the organization becomes payee while the authorization is in effect.

(g) *Limitation on fees.* (1) An organization authorized to collect a fee under this section may collect from a beneficiary a monthly fee for expenses (including overhead) it has incurred in providing payee services to a beneficiary. The limit on the fee a qualified organization may collect for providing payee services increases by the same percentage as the annual cost of living adjustment (COLA). The increased fee amount (rounded to the nearest dollar) is taken beginning with the payment for January.

(2) Any agreement providing for a fee in excess of the amount permitted shall be void and treated as misuse of your benefits by the organization under §416.641.

(3) A fee may be collected for any month during which the organization—

(i) Provides representative payee services;

(ii) Receives a benefit payment for the beneficiary; and

(iii) Is authorized to receive a fee for representative payee services.

(4) Fees for services may not be taken from any funds conserved for the beneficiary by a payee in accordance with §416.645.

(5) Generally, an organization may not collect a fee for months in which it does not receive a benefit payment. However, an organization will be allowed to collect a fee for months in which it did not receive a payment if we later issue payment for these months and the organization:

(i) Received our approval to collect a fee for the months for which payment is made;

(ii) Provided payee services in the months for which payment is made; and

(iii) Was the payee when the retroactive payment was paid by us.

(6) Fees for services may not be taken from beneficiary benefits for the months for which we or a court of competent jurisdiction determine(s) that the representative payee misused benefits. Any fees collected for such months will be treated as a part of the beneficiary's misused benefits.

(7) An authorized organization can collect a fee for providing representative payee services from another source if the total amount of the fee collected from both the beneficiary and the

other source does not exceed the amount authorized by us.

[69 FR 60238, Oct. 7, 2004, as amended at 71 FR 61408, Oct. 18, 2006]

§ 416.641 Who is liable if your representative payee misuses your benefits?

(a) A representative payee who misuses your benefits is responsible for paying back misused benefits. We will make every reasonable effort to obtain restitution of misused benefits so that we can repay these benefits to you.

(b) Whether or not we have obtained restitution from the misuser, we will repay benefits in cases when we determine that a representative payee misused benefits and the representative payee is an organization or an individual payee serving 15 or more beneficiaries. When we make restitution, we will pay you or your alternative representative payee an amount equal to the misused benefits less any amount we collected from the misuser and repaid to you.

(c) Whether or not we have obtained restitution form the misuser, we will repay benefits in cases when we determine that an individual representative payee serving 14 or fewer beneficiaries misused benefits and our negligent failure in the investigation or monitoring of that representative payee results in the misuse. When we make restitution, we will pay you or your alternative representative payee an amount equal to the misused benefits less any amount we collected from the misuser and repaid to you.

(d) The term ''negligent failure'' used in this subpart means that we failed to investigate or monitor a representative payee or that we did investigate or monitor a representative payee but did not follow established procedures in our investigation or monitoring. Examples of our negligent failure include, but are not limited to, the following:

(1) We did not follow our established procedures in this subpart when investigating, appointing, or monitoring a representative payee;

(2) We did not investigate timely a reported allegation of misuse; or

(3) We did not take the steps necessary to prevent the issuance of payments to the representative payee after it was determined that the payee misused benefits.

(e) Our repayment of misused benefits under these provisions does not alter the representative payee's liability and responsibility as described in paragraph (a) of this section.

(f) Any amounts that the representative payee misuses and does not refund will be treated as an overpayment to that representative payee. See subpart E of this part.

[69 FR 60239, Oct. 7, 2004, as amended at 71 FR 61409, Oct. 18, 2006]

§ 416.645 Conservation and investment of benefit payments.

(a) *General.* If payments are not needed for the beneficiary's current maintenance or reasonably foreseeable needs, they shall be conserved or invested on behalf of the beneficiary. Conserved funds should be invested in accordance with the rules followed by trustees. Any investment must show clearly that the payee holds the property in trust for the beneficiary.

Example: A State institution for children with intellectual disability, which is receiving Medicaid funds, is representative payee for several beneficiaries. The checks the payee receives are deposited into one account which shows that the benefits are held in trust for the beneficiaries. The institution has supporting records which show the share each individual has in the account. Funds from this account are disbursed fairly quickly after receipt for the personal needs of the beneficiaries. However, not all those funds were disbursed for this purpose. As a result, several of the beneficiaries have significant accumulated resources in this account. For those beneficiaries whose benefits have accumulated over $150, the funds should be deposited in an interest-bearing account or invested relatively free of risk on behalf of the beneficiaries.

(b) *Preferred investments.* Preferred investments for excess funds are U.S. Savings Bonds and deposits in an interest or dividend paying account in a bank, trust company, credit union, or savings and loan association which is insured under either Federal or State law. The account must be in a form which shows clearly that the representative payee has only a fiduciary and not a personal interest in the funds. If the payee is the legally appointed

guardian or fiduciary of the beneficiary, the account may be established to indicate this relationship. If the payee is not the legally appointed guardian or fiduciary, the accounts may be established as follows:

(1) For U.S. Savings Bonds—

_____ (Name of beneficiary) ___ (Social Security Number), for whom _____ (Name of payee) is representative payee for Supplemental Security Income benefits;

(2) For interest or dividend paying accounts—

_____ (Name of beneficiary) by _____ (Name of payee), representative payee.

(c) *Interest and dividend payments.* The interest and dividends which result from an investment are the property of the beneficiary and may not be considered to be the property of the payee.

[47 FR 30475, July 14, 1982, as amended at 78 FR 46501, Aug. 1, 2013]

§ 416.650 When will we select a new representative payee for you?

When we learn that your interest is not served by sending your benefit payment to your present representative payee or that your present payee is no longer able or willing to carry out payee responsibilities, we will promptly stop sending your payment to the payee. We will then send your benefit payment to an alternative payee or directly to you, until we find a suitable payee. We may suspend payment as explained in § 416.611(c) if we find that paying you directly would cause substantial harm and we cannot find a suitable alternative representative payee before your next payment is due. We will terminate payment of benefits to your representative payee and find a new payee or pay you directly if the present payee:

(a) Has been found by us or a court of competent jurisdiction to have misused your benefits;

(b) Has not used the benefit payments on your behalf in accordance with the guidelines in this subpart;

(c) Has not carried out the other responsibilities described in this subpart;

(d) Dies;

(e) No longer wishes to be your payee;

(f) Is unable to manage your benefit payments; or

(g) Fails to cooperate, within a reasonable time, in providing evidence, accounting, or other information we request.

[69 FR 60239, Oct. 7, 2004]

§ 416.655 When representative payment will be stopped.

If a beneficiary receiving representative payment shows us that he or she is mentally and physically able to manage or direct the management of benefit payments, we will make direct payment. Information which the beneficiary may give us to support his or her request for direct payment include the following—

(a) A physician's statement regarding the beneficiary's condition, or a statement by a medical officer of the institution where the beneficiary is or was confined, showing that the beneficiary is able to manage or direct the management of his or her funds; or

(b) A certified copy of a court order restoring the beneficiary's rights in a case where a beneficiary was adjudged legally incompetent; or

(c) Other evidence which establishes the beneficiary's ability to manage or direct the management of benefits.

§ 416.660 Transfer of accumulated benefit payments.

A representative payee who has conserved or invested benefit payments shall transfer these funds and the interest earned from the invested funds to either a successor payee, to the beneficiary, or to us, as we will specify. If the funds and the earned interest are returned to us, we will recertify them to a successor representative payee or to the beneficiary.

[47 FR 30475, July 14, 1982, as amended at 75 FR 7552, Feb. 22, 2010]

§ 416.665 How does your representative payee account for the use of benefits?

(a) Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year (except as provided in paragraph (b) of this section and for certain State institutions that participate in a separate onsite review program).

(b) Your representative payee is exempt from the accounting requirement when your representative payee is:

(1) A natural or adoptive parent of a minor child eligible for title XVI benefits who primarily resides in the same household as the beneficiary;

(2) A legal guardian of a minor child eligible for title XVI benefits who primarily resides in the same household as the beneficiary;

(3) A natural or adoptive parent of a disabled individual (as defined in section 1614(a)(3) of the Act) eligible for title XVI benefits who primarily resides in the same household as the beneficiary; or

(4) The spouse of an individual eligible for title XVI benefits.

(c) We may verify how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to make accounting reports and must make those records available upon our request. If your representative payee fails to provide an annual accounting of benefits or other required reports, we may require your payee to receive your benefits in person at the local Social Security field office or a United States Government facility that we designate serving the area in which you reside. The decision to have your representative payee receive your benefits in person may be based on a variety of reasons. Some of these reasons may include the payee's history of past performance or our past difficulty in contacting the payee. We may ask your representative payee to give us the following information:

(1) Where you lived during the accounting period;

(2) Who made the decisions on how your benefits were spent or saved;

(3) How your benefit payments were used; and

(4) How much of your benefit payments were saved and how the savings were invested.

[87 FR 35654, June 13, 2022]

Subpart G—Reports Required

AUTHORITY: 42 U.S.C. 902(a)(5), 1320a–8a, 1320e–3, 1382, 1382a, 1382b, 1382c, and 1383; sec. 211, Pub. L. 93–66, 87 Stat. 154 (42 U.S.C. 1382 note); sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

SOURCE: 46 FR 5873, Jan. 21, 1981, unless otherwise noted.

INTRODUCTION

§ 416.701 Scope of subpart.

(a) *Report provisions.* The Social Security Administration, to achieve efficient administration of the Supplemental Security Income (SSI) program for the Aged, Blind, and Disabled, requires that you (or your representative) must report certain events to us. It is important for us to know about these events because they may affect your continued eligibility for SSI benefits or the amount of your benefits. This subpart tells you what events you must report; what your reports must include; when reports are due; and when certain reporting requirements, and penalties relating to reporting requirements, do not apply. The rules regarding reports are in §§ 416.704 through 416.714.

(b) *Penalty deductions.* If you fail to make a required report when it is due, you may suffer a penalty. This subpart describes the penalties; discusses when we may impose them; and explains that we will not impose a penalty if you have good cause for failing to report timely. The rules regarding penalties are in §§ 416.722 through 416.732.

[46 FR 5873, Jan. 21, 1981, as amended at 89 FR 107259, Dec. 31, 2024]

§ 416.702 Definitions.

For purposes of this subpart—

Essential person means someone whose presence was believed to be necessary for your welfare under the State program that preceded the SSI program. (See §§ 416.220 through 416.223 of this part.)

Parent means a natural parent, an adoptive parent, or the spouse of a natural or adoptive parent.

Participating payroll data provider means a payroll data provider that has established an information exchange with us to provide wage and employment information.

Payroll data provider means payroll providers, wage verification companies, and other commercial or non-commercial entities that collect and maintain

information regarding employment and wages.

Representative payee means an individual, an agency, or an institution selected by us to receive and manage SSI benefits on your behalf. (See subpart F of this part for details describing when a representative payee is selected and a representative payee's responsibilities.)

Residence in the United States means that your permanent home is in the United States.

United States or *U.S.* means the 50 States, the District of Columbia, and the Northern Mariana Islands.

We, *Us*, or *Our* means the Social Security Administration.

You or *Your* means an applicant, an eligible individual, an eligible spouse, or an eligible child.

[46 FR 5873, Jan. 21, 1981, as amended at 65 FR 16814, Mar. 30, 2000; 89 FR 107259, Dec. 31, 2024]

REPORT PROVISIONS

§ 416.704 Who must make reports.

(a) You are responsible for making required reports to us if you are—

(1) An eligible individual (see § 416.120(c)(13));

(2) An eligible spouse (see § 416.120(c)(14));

(3) An eligible child (see §§ 416.120(c)(13) and 416.1856); or

(4) An applicant awaiting a final determination upon an application.

(b) If you have a representative payee, and you have not been legally adjudged incompetent, either you or your representative payee must make the required reports.

(c) If you have a representative payee and you have been legally adjudged incompetent, you are not responsible for making reports to us; however, your representative payee is responsible for making required reports to us.

[46 FR 5873, Jan. 21, 1981, as amended at 51 FR 10616, Mar. 28, 1986]

§ 416.708 What you must report.

This section describes the events that you must report to us. They are—

(a) *A change of address.* You must report to us any change in your mailing address and any change in the address where you live.

(b) *A change in living arrangements.* You must report to us any change in the make-up of your household: That is, any person who comes to live in your household and any person who moves out of your household.

(c) *A change in income.* (1) Unless the circumstances in § 416.709(a) and (c) apply, you must report to us any increase or decrease in your income and any increase or decrease in the income of—

(i) Your ineligible spouse who lives with you;

(ii) Your essential person;

(iii) Your parent, if you are an eligible child and your parent lives with you; or

(iv) An ineligible child who lives with you.

(2) However, you need not report an increase in your Social Security benefits if the increase is only a cost-of-living adjustment. (For a complete discussion of what we consider income, see subpart K of this part. See § 416.1323 regarding suspension because of excess income.) If you receive benefits based on disability, when you or your representative report changes in your earned income, we will issue a receipt to you or your representative.

(d) *A change in resources.* You must report to us any resources you receive or part with, and any resources received or parted with by—

(1) Your ineligible spouse who lives with you;

(2) Your essential person; or

(3) Your parent, if you are an eligible child and your parent lives with you. (For a complete discussion of what we consider a resource, see subpart L. See subpart M, § 416.1324 regarding suspension because of excess resources.)

(e) *Eligibility for other benefits.* You must report to us your eligibility for benefits other than SSI benefits. See §§ 416.210 and 416.1330 regarding your responsibility to apply for any other benefits for which you may be eligible.

(f) *Certain deaths.* (1) If you are an eligible individual, you must report the death of your eligible spouse, the death of your ineligible spouse who was living with you, and the death of any other person who was living with you.

(2) If you are an eligible spouse, you must report the death of your spouse,

and the death of any other person who was living with you.

(3) If you are an eligible child, you must report the death of a parent who was living with you, and the death of any other person who was living with you.

(4) If you are a representative payee, you must report the death of an eligible individual, eligible spouse, or eligible child whom you represent; and the death of any other person who was living in the household of the individual you represent.

(5) If you have a representative payee, you must report the death of your representative payee.

(g) *A change in marital status.* You must report to us—

(1) Your marriage, your divorce, or the annulment of your marriage;

(2) The marriage, divorce, or annulment of marriage of your parent who lives with you, if you are an eligible child;

(3) The marriage of an ineligible child who lives with you, if you are an eligible child; and

(4) The marriage of an ineligible child who lives with you if you are an eligible individual living with an ineligible spouse.

(h) *Medical improvements.* If you are eligible for SSI benefits because of disability or blindness, you must report any improvement in your medical condition to us.

(i) [Reserved]

(j) *Refusal to accept treatment for drug addiction or alcoholism; discontinuance of treatment.* If you have been medically determined to be a drug addict or an alcoholic, and you refuse to accept treatment for drug addiction or alcoholism at an approved facility or institution, or if you discontinue treatment, you must report your refusal or discontinuance to us.

(k) *Admission to or discharge from a medical treatment facility, public institution, or private institution.* You must report to us your admission to or discharge from—

(1) A medical treatment facility; or

(2) A public institution (defined in § 416.201); or

(3) A private institution. *Private institution* means an institution as defined in § 416.201 which is not administered by or the responsibility of a governmental unit.

(l) *A change in school attendance.* You must report to us—

(1) A change in your school attendance if you are an eligible child;

(2) A change in school attendance of an ineligible child who is at least age 18 but less than 21 and who lives with you if you are an eligible child; and

(3) A change in school attendance of an ineligible child who is at least age 18 but less than 21 and who lives with you if you are an eligible individual living with an ineligible spouse.

(m) *A termination of residence in the U.S.* You must report to us if you leave the United States voluntarily with the intention of abandoning your residence in the United States or you leave the United States involuntarily (for example, you are deported).

(n) *Leaving the U.S. temporarily.* You must report to us if you leave the United States for 30 or more consecutive days or for a full calendar month (without the intention of abandoning your residence in the U.S.).

(o) *Fleeing to avoid criminal prosecution or custody or confinement after conviction, or violating probation or parole.* You must report to us that you are—

(1) Fleeing to avoid prosecution for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State);

(2) Fleeing to avoid custody or confinement after conviction for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(3) Violating a condition of probation or parole imposed under Federal or State law.

[46 FR 5873, Jan. 21, 1981, as amended at 51 FR 10616, Mar. 14, 1986; 65 FR 40495, June 30, 2000; 68 FR 40124, July 7, 2003; 71 FR 66866, Nov. 17, 2006; 72 FR 50874, Sept. 5, 2007; 89 FR 107259, Dec. 31, 2024]

§ 416.709 Reduced reporting requirements when you authorize us to obtain your information from payroll data providers.

(a) *Authorization to obtain data from a payroll data provider.* We will ask you for written authorization to obtain information about you from a payroll data provider whenever we determine the information is needed in connection with a determination of initial or ongoing eligibility for benefits.

(b) *Scope and duration.* When we ask for your authorization, we will explain the authorization's scope and duration.

(1) We will explain to you that we will use information obtained from a payroll data provider, when it is needed, in connection with a determination of eligibility or the amount of benefits under this title, or for the initial or ongoing entitlement to disability benefits under title II of the Social Security Act, and to prevent improper payments. We will explain to you that we may also use the authorization to obtain wage and employment information from a payroll data provider for claims associated with the claim filed, such as an SSI claim by a spouse or child. We will also explain that we may use and disclose your information consistent with applicable Federal law (see part 401 of this chapter) and any privacy notices we provide to you.

(2) We will also inform you that your authorization will remain effective until the earliest of one of the following occurrences:

(i) You revoke your authorization in writing (see paragraph (c)(4) of this section);

(ii) We have terminated all eligibility for benefits and you have no other claims or appeals pending under this title, and the period for appealing the determination or decision terminating entitlement has lapsed;

(iii) There has been an adverse determination or decision on your claim, you have no other claims or appeals pending under this title, and the period for appealing the determination or decision terminating eligibility has lapsed; or

(iv) Your deeming relationship ends.

(c) *When reporting requirements will change.* We will notify you in writing whenever there is a change in your reporting responsibilities relating to the authorization described in paragraph (a) of this section. Whenever we are getting your wage and employment information from a payroll data provider, we will tell you that you are not subject to a penalty of ineligibility for cash benefits described in § 416.1340 related to any wage and employment information we get from a payroll data provider. We will also tell you when we will find good cause, under § 416.732, for a failure or delay in reporting a change in employer.

(1) If we have your authorization to obtain wage and employment information from a payroll data provider as described in paragraph (a) of this section, and we receive your wage and employment information from your employer(s) through a participating payroll data provider, you will not have to report changes in your wages paid in cash, as defined in § 416.1110(a), from that employer(s). Also, you will not have to report an increase in the amount of work from that employer or an increase in earnings from that employer, as described in § 416.988(a)(4) and (5). All other reporting requirements still apply.

(2) If we have your authorization to obtain wage and employment information from a payroll data provider as described in paragraph (a) of this section, but we do not receive your wage and employment information from your employer(s) through a participating payroll data provider, we will not reduce your reporting responsibilities.

(3) If we have your authorization to obtain wage and employment information from a payroll data provider as described in paragraph (a) of this section, and you have more than one employer,

(i) You do not need to report wages paid in cash, or an increase in the amount of work or earnings, for an employer if we receive your wage and employment information for that employer through a participating payroll data provider, and

(ii) You must still report wages paid in cash, or an increase in the amount of work or earnings, for an employer if we do not receive your wage and employment information for that employer through a participating payroll data provider.

(4) You may revoke your authorization at any time, but you must do so in writing. We will apply the revocation to all pending or approved claims under this title as well as all pending or approved disability claims under title II from the time we process your revocation. If you revoke your authorization, all your reporting responsibilities will resume; you will again be subject to all related penalties; and we may not find good cause, under § 416.732, for a failure to report timely a change in employer. We will notify you in writing of these changes.

[89 FR 107260, Dec. 31, 2024]

§ 416.710 What reports must include.

When you make a report you must tell us—

(a) The name and social security number under which benefits are paid;

(b) The name of the person about whom you are reporting;

(c) The event you are reporting and the date it happened; and

(d) Your name.

§ 416.712 Form of the report.

You may make a report in any of the ways described in this section.

(a) *Written reports.* You may write a report on your own paper or on a printed form supplied by us. You may mail a written report or bring it to one of our offices.

(b) *Oral reports.* You may report to us by telephone, or you may come to one of our offices and tell one of our employees what you are reporting.

(c) *Other forms.* You may use any other suitable method of reporting—for example, a telegram or a cable.

§ 416.714 When reports are due.

(a) *A reportable event happens.* You should report to us as soon as an event listed in § 416.708 happens. If you do not report within 10 days after the close of the month in which the event happens, your report will be late. We may impose a penalty deduction from your benefits for a late report (see §§ 416.722 through 416.732).

(b) *We request a report.* We may request a report from you if we need information to determine continuing eligibility or the correct amount of your SSI benefit payments. If you do not report within 30 days of our written request, we may determine that you are ineligible to receive SSI benefits. We will suspend your benefits effective with the month following the month in which we determine that you are ineligible to receive SSI benefits because of your failure to give us necessary information.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

PENALTY DEDUCTIONS

§ 416.722 Circumstances under which we make a penalty deduction.

A penalty deduction is made from your benefits if—

(a) You fail to make a required report on time (see §§ 416.708 and 416.714);

(b) We must reduce, suspend, or terminate your benefits because of the event you have not reported;

(c) You received and accepted an SSI benefit for the penalty period (see §§ 416.724 through 416.728 for penalty period definitions); and

(d) You do not have good cause for not reporting on time (see § 416.732).

§ 416.724 Amounts of penalty deductions.

(a) *Amounts deducted.* If we find that we must impose a penalty deduction, you will lose from your SSI benefits a total amount of—

(1) $25 for a report overdue in the first penalty period;

(2) $50 for a report overdue in the second penalty period; and

(3) $100 for a report overdue in the third (or any following) penalty period.

(b) *Limit on number of penalties.* Even though more than one required report is overdue from you at the end of a penalty period, we will limit the number of penalty deductions imposed to one penalty deduction for any one penalty period.

§ 416.726 Penalty period: First failure to report.

(a) *First penalty period.* The first penalty period begins on the first day of the month you apply for SSI benefits and ends on the day we first learn that you should have made a required report, but did not do so within 10 days after the close of the month in which

the event happened. There may be more than one required report overdue at the end of the first penalty period, but we will impose no more than one penalty deduction for the period.

(b) *Extension of first penalty period.* If you have good cause for not making a report on time (see § 416.732), we will extend the first penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of the extended first penalty period, but we will impose no more than one penalty deduction for the extended period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.728 Penalty period: Second failure to report.

(a) *Second penalty period.* The second penalty period begins on the day after the first penalty period ends. The second penalty period ends on the day we first learn that you should have made a required report, but did not do so within 10 days after the close of the month in which the event happened. (The event may have happened during the first penalty period, with the reporting due date in the second penalty period. The due date and the failure to report on time are the important factors in establishing a penalty period.) There may be more than one required report overdue at the end of the second penalty period, but we will impose no more than one penalty deduction for the period.

(b) *Extension of second penalty period.* If you have good cause for not making a report on time (see § 416.732), we will extend the second penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of the extended second penalty period, but we will impose no more than one penalty deduction for the extended period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.730 Penalty period: Three or more failures to report.

(a) *Third (or a following) penalty period.* A third (or a following) penalty period begins the day after the last penalty period ends. This penalty period ends on the day we first learn that you should have made a required report during the penalty period, but did not do so within 10 days after the close of the month in which the event happened. (The event may have happened during an earlier penalty period, with the reporting due date in the third (or a following) penalty period. The due date and the failure to report on time are the important factors in establishing a penalty period.) There may be more than one required report overdue at the end of a penalty period, but we will impose no more than one penalty deduction for any one penalty period.

(b) *Extension of third (or a following) penalty period.* Just as with the first and second penalty periods, if you have good cause for not making a report on time during the third (or a following) penalty period (see § 416.732), we will extend the penalty period to the day when we learn that you should have made another required report, but did not do so within 10 days after the close of the month in which the event happened. There may be more than one required report overdue at the end of an extended penalty period, but we will impose no more than one penalty deduction for any one extended penalty period.

[46 FR 5873, Jan. 21, 1981, as amended at 50 FR 48573, Nov. 26, 1985]

§ 416.732 No penalty deduction if you have good cause for failure to report timely.

(a) We will find that you have good cause for failure to report timely and we will not impose a penalty deduction, if—

(1) You are ''without fault'' as defined in § 416.552; or

(2) Your failure or delay in reporting is not willful. ''Not willful'' means that—

(i) You did not have full knowledge of the existence of your obligation to make a required report; or

(ii) You did not intentionally, knowingly, and purposely fail to make a required report.

However, in either case we may require that you refund an overpayment caused by your failure to report. See subpart E of this part for waiver of recovery of overpayments.

(b) In determining whether you have good cause for failure to report timely, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) you may have.

[59 FR 1636, Jan. 12, 1994]

Subpart H—Determination of Age

AUTHORITY: Secs. 702(a)(5), 1601, 1614(a)(1) and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1381, 1382c(a)(1), and 1383).

SOURCE: 39 FR 12731, Apr. 8, 1974, unless otherwise noted.

§ 416.801 Evidence as to age—when required.

An applicant for benefits under title XVI of the Act shall file supporting evidence showing the date of his birth if his age is a condition of eligibility for benefits or is otherwise relevant to the payment of benefits pursuant to such title XVI. Such evidence may also be required by the Administration as to the age of any other individual when such other individual's age is relevant to the determination of the applicant's eligibility or benefit amount. In the absence of evidence to the contrary, if the applicant alleges that he is at least 68 years of age and submits any documentary evidence at least 3 years old which supports his allegation, no further evidence of his age is required. In the absence of evidence to the contrary, if a State required reasonably acceptable evidence of age and provides a statement as to an applicant's age, no further evidence of his age is required unless a statistically valid quality control sample has shown that a State's determination of age procedures do not yield an acceptable low rate of error.

§ 416.802 Type of evidence to be submitted.

Where an individual is required to submit evidence of date of birth as indicated in § 416.801, he shall submit a public record of birth or a religious record of birth or baptism established or recorded before his fifth birthday, if available. Where no such document recorded or established before age 5 is available the individual shall submit as evidence of age another document or documents which may serve as the basis for a determination of the individual's date of birth provided such evidence is corroborated by other evidence or by information in the records of the Administration.

§ 416.803 Evaluation of evidence.

Generally, the highest probative value will be accorded to a public record of birth or a religious record of birth or baptism established or recorded before age 5. Where such record is not available, and other documents are submitted as evidence of age, in determining their probative value, consideration will be given to when such other documents were established or recorded, and the circumstances attending their establishment or recordation. Among the documents which may be submitted for such purpose are: school record, census record, Bible or other family record, church record of baptism or confirmation in youth or early adult life, insurance policy, marriage record, employment record, labor union record, fraternal organization record, military record, voting record, vaccination record, delayed birth certificate, birth certificate of child of applicant, physician's or midwife's record of birth, immigration record, naturalization record, or passport.

§ 416.804 Certified copy in lieu of original.

In lieu of the original of any record, except a Bible or other family record, there may be submitted as evidence of age a copy of such record or a statement as to the date of birth shown by such record, which has been duly certified (see § 404.701(g) of this chapter).

§ 416.805 When additional evidence may be required.

If the evidence submitted is not convincing, additional evidence may be required.

§ 416.806 Expedited adjudication based on documentary evidence of age.

Where documentary evidence of age recorded at least 3 years before the application is filed, which reasonably supports an aged applicant's allegation as to his age, is submitted, payment of benefits may be initiated even though additional evidence of age may be required by §§ 416.801 through 416.805. The applicant will be advised that additional evidence is required and that, if it is subsequently established that the prior finding of age is incorrect, the applicant will be liable for refund of any overpayment he has received. If any of the evidence initially submitted tends to show that the age of the applicant or such other person does not correspond with the alleged age, no benefits will be paid until the evidence required by §§ 416.801 through 416.805 is submitted.

Subpart I—Determining Disability and Blindness

AUTHORITY: 42 U.S.C. 421(m), 902(a)(5), 1382, 1382c, 1382h, 1383, and 1383b; secs. 4(c) and 5, 6(c)–(e), 14(a), and 15, Pub. L. 98–460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, and 1382h note).

SOURCE: 45 FR 55621, Aug. 20, 1980, unless otherwise noted.

GENERAL

§ 416.901 Scope of subpart.

In order for you to become entitled to any benefits based upon disability or blindness you must be disabled or blind as defined in title XVI of the Social Security Act. This subpart explains how we determine whether you are disabled or blind. We have organized the rules in the following way.

(a) We define general terms, then discuss who makes our disability or blindness determinations and state that disability and blindness determinations made under other programs are not binding on our determinations.

(b) We explain the term *disability* and note some of the major factors that are considered in determining whether you are disabled in §§ 416.905 through 416.910.

(c) Sections 416.912 through 416.918 contain our rules on evidence. We explain your responsibilities for submitting evidence of your impairment, state what we consider to be acceptable sources of medical evidence, and describe what information should be included in medical reports.

(d) Our general rules on evaluating disability for adults filing new applications are stated in §§ 416.920 through 416.923. We describe the steps that we go through and the order in which they are considered.

(e) Our general rules on evaluating disability for children filing new applications are stated in § 416.924.

(f) Our rules on medical considerations are found in §§ 416.925 through 416.930. We explain in these rules—

(1) The purpose and use of the Listing of Impairments found in appendix 1 of subpart P of part 404 of this chapter;

(2) What we mean by the terms *medical equivalence* and *functional equivalence* and how we make those findings;

(3) The effect of a conclusion by your physician that you are disabled;

(4) What we mean by symptoms, signs, and laboratory findings;

(5) How we evaluate pain and other symptoms; and

(6) The effect on your benefits if you fail to follow treatment that is expected to restore your ability to work or, if you are a child, to reduce your functional limitations to the point that they are no longer marked and severe, and how we apply the rule in § 416.930.

(g) In §§ 416.931 through 416.934 we explain that we may make payments on the basis of presumptive disability or presumptive blindness.

(h) In §§ 416.935 through 416.939 we explain the rules which apply in cases of drug addiction and alcoholism.

(i) In §§ 416.945 through 416.946 we explain what we mean by the term *residual functional capacity*, state when an assessment of residual functional capacity is required, and who may make it.

(j) Our rules on vocational considerations are in §§ 416.960 through 416.969a. We explain in these rules—

(1) When we must consider vocational factors along with the medical evidence;

(2) How we use our residual functional capacity assessment to determine if you can still do your past relevant work or other work;

(3) How we consider the vocational factors of age, education, and work experience;

(4) What we mean by ''work which exists in the national economy'';

(5) How we consider the exertional, nonexertional, and skill requirements of work, and when we will consider the limitations or restrictions that result from your impairment(s) and related symptoms to be exertional, nonexertional, or a combination of both; and

(6) How we use the Medical-Vocational Guidelines in appendix 2 of subpart P of part 404 of this chapter.

(k) Our rules on substantial gainful activity are found in §§ 416.971 through 416.974. These explain what we mean by substantial gainful activity and how we evaluate your work activity.

(l) In §§ 416.981 through 416.985 we discuss blindness.

(m) Our rules on when disability or blindness continues and stops are contained in §§ 416.986 and 416.988 through 416.998. We explain what your responsibilities are in telling us of any events that may cause a change in your disability or blindness status and when we will review to see if you are still disabled. We also explain how we consider the issue of medical improvement (and the exceptions to medical improvement) in determining whether you are still disabled.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50136, Dec. 6, 1985; 56 FR 5553, Feb. 11, 1991; 56 FR 57944, Nov. 14, 1991; 62 FR 6420, Feb. 11, 1997; 65 FR 42788, July 11, 2000; 65 FR 54777, Sept. 11, 2000; 68 FR 51164, Aug. 26, 2003]

§ 416.902 Definitions for this subpart.

As used in the subpart—

(a) *Acceptable medical source* means a medical source who is a:

(1) Licensed physician (medical or osteopathic doctor);

(2) Licensed psychologist, which includes:

(i) A licensed or certified psychologist at the independent practice level; or

(ii) A licensed or certified school psychologist, or other licensed or certified individual with another title who performs the same function as a school psychologist in a school setting, for impairments of intellectual disability, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrist for impairments of visual disorders, or measurement of visual acuity and visual fields only, depending on the scope of practice in the State in which the optometrist practices;

(4) Licensed podiatrist for impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle;

(5) Qualified speech-language pathologist for speech or language impairments only. For this source, *qualified* means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association;

(6) Licensed audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within the licensed scope of practice only (with respect to claims filed (see § 416.325) on or after March 27, 2017);

(7) Licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title, for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 416.325) on or after March 27, 2017); or

(8) Licensed Physician Assistant for impairments within his or her licensed scope of practice (only with respect to claims filed (see § 416.325) on or after March 27, 2017).

(b) *Adult* means a person who is age 18 or older.

(c) *Child* means a person who has not attained age 18.

(d) *Commissioner* means the Commissioner of Social Security or his or her authorized designee.

(e) *Disability redetermination* means a redetermination of your eligibility based on disability using the rules for new applicants appropriate to your age, except the rules pertaining to performance of substantial gainful activity. For individuals who are working and for whom a disability redetermination is required, we will apply the rules in §§ 416.260 through 416.269. In conducting a disability redetermination, we will not use the rules for determining whether disability continues set forth in § 416.994 or § 416.994a. (See § 416.987.)

(f) *Impairment(s)* means a medically determinable physical or mental impairment or a combination of medically determinable physical or mental impairments.

(g) *Laboratory findings* means one or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Diagnostic techniques include chemical tests (such as blood tests), electrophysiological studies (such as electrocardiograms and electroencephalograms), medical imaging (such as X-rays), and psychological tests.

(h) *Marked and severe functional limitations,* when used as a phrase, means the standard of disability in the Social Security Act for children claiming SSI benefits based on disability. It is a level of severity that meets, medically equals, or functionally equals the listings. (See §§ 416.906, 416.924, and 416.926a.) The words ''marked'' and ''severe'' are also separate terms used throughout this subpart to describe measures of functional limitations; the term ''marked'' is also used in the listings. (See §§ 416.924 and 416.926a.) The meaning of the words ''marked'' and ''severe'' when used as part of the phrase marked and severe functional limitations is not the same as the meaning of the separate terms ''marked'' and ''severe'' used elsewhere in 404 and 416. (See §§ 416.924(c) and 416.926a(e).)

(i) *Medical source* means an individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law, or an individual who is certified by a State as a speech-language pathologist or a school psychologist and acting within the scope of practice permitted under State or Federal law.

(j) *Nonmedical source* means a source of evidence who is not a medical source. This includes, but is not limited to:

(1) You;

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Family members, caregivers, friends, neighbors, employers, and clergy.

(k) *Objective medical evidence* means signs, laboratory findings, or both.

(l) *Signs* means one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception and must also be shown by observable facts that can be medically described and evaluated.

(m) *State agency* means an agency of a State designated by that State to carry out the disability or blindness determination function.

(n) *Symptoms* means your own description of your physical or mental impairment.

(o) *The listings* means the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter. When we refer to an impairment(s) that ''meets, medically equals, or functionally equals the listings,'' we mean that the impairment(s) meets or medically equals the severity of any listing in appendix 1 of subpart P of part 404 of this chapter, as explained in §§ 416.925 and 416.926, or that it functionally equals the severity of the listings, as explained in § 416.926a.

(p) *We* or *us* means, as appropriate, either the Social Security Administration or the State agency making the disability or blindness determination.

(q) *You*, *your*, *me*, *my* and *I* mean, as appropriate, the person who applies for benefits, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

[82 FR 5873, Jan. 18, 2017, as amended at 83 FR 51836, Oct. 15, 2018]

DETERMINATIONS

§ 416.903 Who makes disability and blindness determinations.

(a) *State agencies.* State agencies make disability and blindness determinations for the Commissioner for most persons living in the State. State agencies make these disability and blindness determinations under regulations containing performance standards and other administrative requirements relating to the disability and blindness determination function. States have the option of turning the function over to the Federal Government if they no longer want to make disability determinations. Also, the Commissioner may take the function away from any State which has substantially failed to make disability and blindness determinations in accordance with these regulations. Subpart J of this part contains the rules the States must follow in making disability and blindness determinations.

(b) *Social Security Administration.* The Social Security Administration will make disability and blindness determinations for—

(1) Any person living in a State which is not making for the Commissioner any disability and blindness determinations or which is not making those determinations for the class of claimants to which that person belongs; and

(2) Any person living outside the United States.

(c) *What determinations are authorized.* The Commissioner has authorized the State agencies and the Social Security Administration to make determinations about—

(1) Whether you are disabled or blind;

(2) The date your disability or blindness began; and

(3) The date your disability or blindness stopped.

(d) *Review of State agency determinations.* On review of a State agency determination or redetermination of disability or blindness we may find that—

(1) You are, or are not, disabled or blind, regardless of what the State agency found;

(2) Your disability or blindness began earlier or later than the date found by the State agency; and

(3) Your disability or blindness stopped earlier or later than the date found by the State agency.

(e) *Determinations for childhood impairments.* In making a determination under title XVI with respect to the disability of a child, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

[46 FR 29211, May 29, 1981, as amended at 52 FR 33927, Sept. 9, 1987; 58 FR 47577, Sept. 9, 1993; 62 FR 38454, July 18, 1997; 65 FR 34958, June 1, 2000; 71 FR 16458, Mar. 31, 2006; 72 FR 51178, Sept. 6, 2007; 82 FR 5874, Jan. 18, 2017]

§ 416.903a Program integrity.

We will not use in our program any individual or entity, except to provide existing medical evidence, who is currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; whose license to provide health care services is currently revoked or suspended by any State licensing authority pursuant to adequate due process procedures for reasons bearing on professional competence, professional conduct, or financial integrity; or who until a final determination is made has surrendered such a license while formal disciplinary proceedings involving professional conduct are pending. By individual or entity we mean a medical or psychological consultant, consultative examination provider, or diagnostic test facility. Also see §§ 416.919 and 416.919g(b).

[56 FR 36963, Aug. 1, 1991]

§416.903b Evidence from excluded medical sources of evidence.

(a) *General.* We will not consider evidence from the following medical sources excluded under section 223(d)(5)(C)(i) of the Social Security Act (Act), as amended, unless we find good cause under paragraph (b) of this section:

(1) Any medical source that has been convicted of a felony under section 208 or under section 1632 of the Act;

(2) Any medical source that has been excluded from participation in any Federal health care program under section 1128 of the Act; or

(3) Any medical source that has received a final decision imposing a civil monetary penalty or assessment, or both, for submitting false evidence under section 1129 of the Act.

(b) *Good cause.* We may find good cause to consider evidence from an excluded medical source of evidence under section 223(d)(5)(C)(i) of the Act, as amended, if:

(1) The evidence from the medical source consists of evidence of treatment that occurred before the date the source was convicted of a felony under section 208 or under section 1632 of the Act;

(2) The evidence from the medical source consists of evidence of treatment that occurred during a period in which the source was not excluded from participation in any Federal health care program under section 1128 of the Act;

(3) The evidence from the medical source consists of evidence of treatment that occurred before the date the source received a final decision imposing a civil monetary penalty or assessment, or both, for submitting false evidence under section 1129 of the Act;

(4) The sole basis for the medical source's exclusion under section 223(d)(5)(C)(i) of the Act, as amended, is that the source cannot participate in any Federal health care program under section 1128 of the Act, but the Office of Inspector General of the Department of Health and Human Services granted a waiver of the section 1128 exclusion; or

(5) The evidence is a laboratory finding about a physical impairment and there is no indication that the finding is unreliable.

(c) *Reporting requirements for excluded medical sources of evidence.* Excluded medical sources of evidence (as described in paragraph (a) of this section) must inform us in writing that they are excluded under section 223(d)(5)(C)(i) of the Act, as amended, each time they submit evidence related to a claim for initial or continuing benefits under titles II or XVI of the Act. This reporting requirement applies to evidence that excluded medical sources of evidence submit to us either directly or through a representative, claimant, or other individual or entity.

(1) Excluded medical sources of evidence must provide a written statement, which contains the following information:

(i) A heading stating: ''WRITTEN STATEMENT REGARDING SECTION 223(d)(5)(C) OF THE SOCIAL SECURITY ACT—DO NOT REMOVE''

(ii) The name and title of the medical source;

(iii) The applicable excluding event(s) stated in paragraph (a)(1)–(a)(3) of this section;

(iv) The date of the medical source's felony conviction under sections 208 or 1632 of the Act, if applicable;

(v) The date of the imposition of a civil monetary penalty or assessment, or both, for the submission of false evidence, under section 1129 of the Act, if applicable; and

(vi) The basis, effective date, anticipated length of the exclusion, and whether the Office of the Inspector General of the Department of Health and Human Services waived the exclusion, if the excluding event was the medical source's exclusion from participation in any Federal health care program under section 1128 of the Act.

(2) The written statement provided by an excluded medical source of evidence may not be removed by any individual or entity prior to submitting evidence to us.

(3) We may request that the excluded medical source of evidence provide us with additional information or clarify any information submitted that bears on the medical source's exclusion(s)

under section 223(d)(5)(C)(i) of the Act, as amended.

[81 FR 65540, Sept. 23, 2016]

§ 416.904 Decisions by other governmental agencies and nongovernmental entities.

Other governmental agencies and nongovernmental entities—such as the Department of Veterans Affairs, the Department of Defense, the Department of Labor, the Office of Personnel Management, State agencies, and private insurers—make disability, blindness, employability, Medicaid, workers' compensation, and other benefits decisions for their own programs using their own rules. Because a decision by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits is based on its rules, it is not binding on us and is not our decision about whether you are disabled or blind under our rules. Therefore, in claims filed (see § 416.325) on or after March 27, 2017, we will not provide any analysis in our determination or decision about a decision made by any other governmental agency or a nongovernmental entity about whether you are disabled, blind, employable, or entitled to any benefits. However, we will consider all of the supporting evidence underlying the other governmental agency or nongovernmental entity's decision that we receive as evidence in your claim in accordance with § 416.913(a)(1) through (4).

[82 FR 5874, Jan. 18, 2017, as amended at 82 FR 15132, Mar. 27, 2017]

DEFINITION OF DISABILITY

§ 416.905 Basic definition of disability for adults.

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§ 416.920(e) and 416.945. (*See* § 416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (*See* § 416.920(h) for an exception to this rule.)

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§ 416.981 through 416.985.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5553, Feb. 11, 1991; 68 FR 51164, Aug. 26, 2003; 77 FR 43495, July 25, 2012]

§ 416.906 Basic definition of disability for children.

If you are under age 18, we will consider you disabled if you have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the preceding sentence, if you file a new application for benefits and you are engaging in substantial gainful activity, we will not consider you disabled. We discuss our rules for determining disability in children who file new applications in §§ 416.924 through 416.924b and §§ 416.925 through 416.926a.

[62 FR 6421, Feb. 11, 1997, as amended at 65 FR 54777, Sept. 11, 2000]

§ 416.907 Disability under a State plan.

You will also be considered disabled for payment of supplemental security income benefits if—

(a) You were found to be permanently and totally disabled as defined under a State plan approved under title XIV or XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your disability for the month of December 1973 and for at least one month before July 1973; and

(c) You continue to be disabled as defined under the State plan.

§ 416.908 [Reserved]

§ 416.909 How long the impairment must last.

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

§ 416.910 Meaning of substantial gainful activity.

Substantial gainful activity means work that—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done (or intended) for pay or profit.

(See § 416.972 for further details about what we mean by substantial gainful activity.)

§ 416.911 Definition of disabling impairment.

(a) If you are an adult:

(1) A disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter or which, when considered with your age, education and work experience, would result in a finding that you are disabled under § 416.994, unless the disability redetermination rules in § 416.987(b) apply to you.

(2) If the disability redetermination rules in § 416.987 apply to you, a disabling impairment is an impairment or combination of impairments that meets the requirements in §§ 416.920 (c) through (f).

(b) If you are a child, a disabling impairment is an impairment (or combination of impairments) that causes marked and severe functional limitations. This means that the impairment or combination of impairments:

(1) Must meet, medically equal, or functionally equal the listings, or

(2) Would result in a finding that you are disabled under § 416.994a.

(c) In determining whether you have a disabling impairment, earnings are not considered.

[62 FR 6421, Feb. 11, 1997, as amended at 65 FR 54777, Sept. 11, 2000]

EVIDENCE

§ 416.912 Responsibility for evidence.

(a) *Your responsibility*—(1) *General.* In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (*see* § 416.913). This duty is ongoing and requires you to disclose any additional related evidence about which you become aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge hearing decision. We will consider only impairment(s) you say you have or about which we receive evidence. When you submit evidence received from another source, you must submit that evidence in its entirety, unless you previously submitted the same evidence to us or we instruct you otherwise. If we ask you, you must inform us about:

(i) Your medical source(s);

(ii) Your age;

(iii) Your education and training;

(iv) Your work experience;

(v) Your daily activities both before and after the date you say that you became disabled;

(vi) Your efforts to work; and

(vii) Any other factors showing how your impairment(s) affects your ability to work, or, if you are a child, your functioning. In §§ 416.960 through 416.969, we discuss in more detail the evidence we need when we consider vocational factors.

(2) *Completeness.* The evidence in your case record must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(i) The nature and severity of your impairment(s) for any period in question;

(ii) Whether the duration requirement described in § 416.909 is met; and

(iii) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in §§ 416.920(e) or (f)(1) apply, or, if you are a child, how you typically function compared to children your age who do not have impairments.

(3) *Statutory blindness.* If you are applying for benefits on the basis of statutory blindness, we will require an examination by a physician skilled in diseases of the eye or by an optometrist, whichever you may select.

(b) *Our responsibility*—(1) *Development.* Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical evidence from your own medical sources and entities that maintain your medical sources' evidence when you give us permission to request the reports.

(i) *Every reasonable effort* means that we will make an initial request for evidence from your medical source or entity that maintains your medical source's evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one follow-up request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source's evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) *Complete medical history* means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier.

(2) *Obtaining a consultative examination.* We may ask you to attend one or more consultative examinations at our expense. See §§ 416.917 through 416.919t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. We may order a consultative examination while awaiting receipt of medical source evidence in some instances, such as when we know a source is not productive, is uncooperative, or is unable to provide certain tests or procedures. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

(3) *Other work.* In order to determine under § 416.920(g) that you are able to adjust to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§ 416.960 through 416.969a), given your residual functional capacity (which we have already assessed, as described in § 416.920(e)), age, education, and work experience.

[82 FR 5874, Jan. 18, 2017]

§ 416.913 Categories of evidence.

(a) *What we mean by evidence.* Subject to the provisions of paragraph (b), evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. We consider evidence under §§ 416.920b, 416.920c (or under § 416.927 for claims filed (see § 416.325) before March 27, 2017). We evaluate evidence we receive according to the rules pertaining to the relevant category of evidence. The categories of evidence are:

(1) *Objective medical evidence.* Objective medical evidence is medical signs, laboratory findings, or both, as defined in § 416.902(k).

(2) *Medical opinion.* A medical opinion is a statement from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions in the abilities listed in paragraphs (a)(2)(i)(A)

through (D) and (a)(2)(ii)(A) through (F) of this section. (For claims filed (see §416.325) before March 27, 2017, see §416.927(a) for the definition of medical opinion.)

(i) Medical opinions in adult claims are about impairment-related limitations and restrictions in:

(A) Your ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching);

(B) Your ability to perform mental demands of work activities, such as understanding; remembering; maintaining concentration, persistence, or pace; carrying out instructions; or responding appropriately to supervision, coworkers, or work pressures in a work setting;

(C) Your ability to perform other demands of work, such as seeing, hearing, or using other senses; and

(D) Your ability to adapt to environmental conditions, such as temperature extremes or fumes.

(ii) Medical opinions in child claims are about impairment-related limitations and restrictions in your abilities in the six domains of functioning:

(A) Acquiring and using information (see §416.926a(g));

(B) Attending and completing tasks (see §416.926a(h));

(C) Interacting and relating with others (see §416.926a(i));

(D) Moving about and manipulating objects (see §416.926a(j));

(E) Caring for yourself (see §416.926a(k)); and

(F) Health and physical well-being (see §416.926a(l)).

(3) *Other medical evidence.* Other medical evidence is evidence from a medical source that is not objective medical evidence or a medical opinion, including judgments about the nature and severity of your impairments, your medical history, clinical findings, diagnosis, treatment prescribed with response, or prognosis. (For claims filed (see §416.325) before March 27, 2017, *other medical evidence* does not include a diagnosis, prognosis, or a statement that reflects a judgment(s) about the nature and severity of your impairment(s)).

(4) *Evidence from nonmedical sources.* Evidence from nonmedical sources is any information or statement(s) from a nonmedical source (including you) about any issue in your claim. We may receive evidence from nonmedical sources either directly from the nonmedical source or indirectly, such as from forms we receive and our administrative records.

(5) *Prior administrative medical finding.* A prior administrative medical finding is a finding, other than the ultimate determination about whether you are disabled, about a medical issue made by our Federal and State agency medical and psychological consultants at a prior level of review (see §416.1400) in your current claim based on their review of the evidence in your case record, such as:

(i) The existence and severity of your impairment(s);

(ii) The existence and severity of your symptoms;

(iii) Statements about whether your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(iv) If you are a child, statements about whether your impairment(s) functionally equals the listings in Part 404, Subpart P, Appendix 1;

(v) If you are an adult, your residual functional capacity;

(vi) Whether your impairment(s) meets the duration requirement; and

(vii) How failure to follow prescribed treatment (see §416.930) and drug addiction and alcoholism (see §416.935) relate to your claim.

(b) *Exceptions for privileged communications.*

(1) The privileged communications listed in paragraphs (b)(1)(i) and (b)(1)(ii) of this section are not evidence, and we will neither consider nor provide any analysis about them in your determination or decision. This exception for privileged communications applies equally whether your representative is an attorney or a non-attorney.

(i) Oral or written communications between you and your representative that are subject to the attorney-client

privilege, unless you voluntarily disclose the communication to us.

(ii) Your representative's analysis of your claim, unless he or she voluntarily discloses it to us. This analysis means information that is subject to the attorney work product doctrine, but it does not include medical evidence, medical opinions, or any other factual matter that we may consider in determining whether or not you are entitled to benefits (see paragraph (b)(2) of this section).

(2) The attorney-client privilege generally protects confidential communications between an attorney and his or her client that are related to providing or obtaining legal advice. The attorney work product doctrine generally protects an attorney's analyses, theories, mental impressions, and notes. In the context of your disability claim, neither the attorney-client privilege nor the attorney work product doctrine allow you to withhold factual information, medical opinions, or other medical evidence that we may consider in determining whether or not you are entitled to benefits. For example, if you tell your representative about the medical sources you have seen, your representative cannot refuse to disclose the identity of those medical sources to us based on the attorney-client privilege. As another example, if your representative asks a medical source to complete an opinion form related to your impairment(s), symptoms, or limitations, your representative cannot withhold the completed opinion form from us based on the attorney work product doctrine. The attorney work product doctrine would not protect the source's opinions on the completed form, regardless of whether or not your representative used the form in his or her analysis of your claim or made handwritten notes on the face of the report.

[82 FR 5875, Jan. 18, 2017]

§ 416.913a Evidence from our Federal or State agency medical or psychological consultants.

The following rules apply to our Federal or State agency medical or psychological consultants that we consult in connection with administrative law judge hearings and Appeals Council reviews:

(a) In claims adjudicated by the State agency, a State agency medical or psychological consultant may make the determination of disability together with a State agency disability examiner or provide medical evidence to a State agency disability examiner when the disability examiner makes the initial or reconsideration determination alone (see § 416.1015(c) of this part). The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in § 416.1015(c)(1), he or she will consider the evidence in your case record and make administrative findings about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or medically equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative medical findings are based on the evidence in your case but are not in themselves evidence at the level of the administrative review process at which they are made. See § 416.913(a)(5).

(2) When a State agency disability examiner makes the initial determination alone as provided in § 416.1015(c)(3), he or she may obtain medical evidence from a State agency medical or psychological consultant about one or more of the medical issues listed in paragraph (a)(1) of this section. In these cases, the State agency disability examiner will consider the medical evidence of the State agency medical or psychological consultant under §§ 416.920b, 416.920c, and 416.927.

(3) When a State agency disability examiner makes a reconsideration determination alone as provided in § 416.1015(c)(3), he or she will consider prior administrative medical findings made by a State agency medical or psychological consultant at the initial level of the administrative review process, and any medical evidence provided by such consultants at the initial and

reconsideration levels, about one or more of the medical issues listed in paragraph (a)(1)(i) of this section under §§ 416.920b, 416.920c, and 416.927.

(b) Administrative law judges are responsible for reviewing the evidence and making administrative findings of fact and conclusions of law. They will consider prior administrative medical findings and medical evidence from our Federal or State agency medical or psychological consultants as follows:

(1) Administrative law judges are not required to adopt any prior administrative medical findings, but they must consider this evidence according to §§ 416.920b, 416.920c, and 416.927, as appropriate, because our Federal or State agency medical or psychological consultants are highly qualified and experts in Social Security disability evaluation.

(2) Administrative law judges may also ask for medical evidence from expert medical sources. Administrative law judges will consider this evidence under §§ 416.920b, 416.920c, and 416.927, as appropriate.

(c) When the Appeals Council makes a decision, it will consider prior administrative medical findings according to the same rules for considering prior administrative medical findings as administrative law judges follow under paragraph (b) of this section.

[82 FR 5876, Jan. 18, 2017]

§ 416.914 When we will purchase existing evidence.

We need specific medical evidence to determine whether you are disabled or blind. We will pay for the medical evidence we request, if there is a charge. We will also be responsible for the cost of medical evidence we ask you to get.

§ 416.915 Where and how to submit evidence.

You may give us evidence about your impairment at any of our offices or at the office of any State agency authorized to make disability or blindness determinations. You may also give evidence to one of our employees authorized to accept evidence at another place. For more information about this, see subpart C of this part.

§ 416.916 If you fail to submit medical and other evidence.

You (and if you are a child, your parent, guardian, relative, or other person acting on your behalf) must co-operate in furnishing us with, or in helping us to obtain or identify, available medical or other evidence about your impairment(s). When you fail to cooperate with us in obtaining evidence, we will have to make a decision based on information available in your case. We will not excuse you from giving us evidence because you have religious or personal reasons against medical examinations, tests, or treatment.

[58 FR 47577, Sept. 9, 1993]

§ 416.917 Consultative examination at our expense.

If your medical sources cannot or will not give us sufficient medical evidence about your impairment for us to determine whether you are disabled or blind, we may ask you to have one or more physical or mental examinations or tests. We will pay for these examinations. However, we will not pay for any medical examination arranged by you or your representative without our advance approval. If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person or facility who will do it. We will also give the examiner any necessary background information about your condition.

[56 FR 36964, Aug. 1, 1991]

§ 416.918 If you do not appear at a consultative examination.

(a) *General.* If you are applying for benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arrange for you to get information we need to determine your disability or blindness, we may find that you are not disabled or blind. If you are already receiving benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arranged for you, we may determine that your disability or blindness has stopped because of your failure or refusal. Therefore, if

you have any reason why you cannot go for the scheduled appointment, you should tell us about this as soon as possible before the examination date. If you have a good reason, we will schedule another examination. We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have a good reason for failing to attend a consultative examination.

(b) *Examples of good reasons for failure to appear.* Some examples of what we consider good reasons for not going to a scheduled examination include—

(1) Illness on the date of the scheduled examination or test;

(2) Not receiving timely notice of the scheduled examination or test, or receiving no notice at all;

(3) Being furnished incorrect or incomplete information, or being given incorrect information about the physician involved or the time or place of the examination or test, or;

(4) Having had death or serious illness occur in your immediate family.

(c) *Objections by your medical source(s).* If any of your medical sources tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your medical source(s) may agree to another type of examination for the same purpose.

[45 FR 55621, Aug. 20, 1980, as amended at 59 FR 1636, Jan. 12, 1994; 82 FR 5877, Jan. 18, 2017]

STANDARDS TO BE USED IN DETERMINING WHEN A CONSULTATIVE EXAMINATION WILL BE OBTAINED IN CONNECTION WITH DISABILITY DETERMINATIONS

§ 416.919 The consultative examination.

A consultative examination is a physical or mental examination or test purchased for you at our request and expense from a treating source or another medical source, including a pediatrician when appropriate. The decision to purchase a consultative examination will be made on an individual case basis in accordance with the provisions of § 416.919a through § 416.919f. Selection of the source for the examination will be consistent with the provisions of § 416.903a and §§ 416.919g through 416.919j. The rules and procedures for requesting consultative examinations set forth in §§ 416.919a and 416.919b are applicable at the reconsideration and hearing levels of review, as well as the initial level of determination.

[56 FR 36964, Aug. 1, 1991, as amended at 65 FR 11879, Mar. 7, 2000]

§ 416.919a When we will purchase a consultative examination and how we will use it.

(a) *General.* If we cannot get the information we need from your medical sources, we may decide to purchase a consultative examination. See § 416.912 for the procedures we will follow to obtain evidence from your medical sources and § 416.920b for how we consider evidence. Before purchasing a consultative examination, we will consider not only existing medical reports, but also the disability interview form containing your allegations as well as other pertinent evidence in your file.

(b) *Situations that may require a consultative examination.* We may purchase a consultative examination to try to resolve an inconsistency in the evidence or when the evidence as a whole is insufficient to support a determination or decision on your claim. Some examples of when we might purchase a consultative examination to secure needed medical evidence, such as clinical findings, laboratory tests, a diagnosis, or prognosis, include but are not limited to:

(1) The additional evidence needed is not contained in the records of your medical sources;

(2) The evidence that may have been available from your treating or other medical sources cannot be obtained for reasons beyond your control, such as death or noncooperation of a medical source;

(3) Highly technical or specialized medical evidence that we need is not available from your treating or other medical sources; or

(4) There is an indication of a change in your condition that is likely to affect your ability to work, or, if you are

a child, your functioning, but the current severity of your impairment is not established.

[56 FR 36964, Aug. 1, 1991, as amended at 62 FR 6421, Feb. 11, 1997; 77 FR 10656, Feb. 23, 2012]

§ 416.919b When we will not purchase a consultative examination.

We will not purchase a consultative examination in situations including, but not limited to, the following situations:

(a) When any issues about your actual performance of substantial gainful activity have not been resolved;

(b) When you do not meet all of the nondisability requirements.

[56 FR 36965, Aug. 1, 1991]

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

§ 416.919f Type of purchased examinations.

We will purchase only the specific examinations and tests we need to make a determination in your claim. For example, we will not authorize a comprehensive medical examination when the only evidence we need is a special test, such as an X-ray, blood studies, or an electrocardiogram.

[56 FR 36965, Aug. 1, 1991]

§ 416.919g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own medical source or another medical source. If you are a child, the medical source we choose may be a pediatrician.

(b) By ''qualified,'' we mean that the medical source must be currently licensed in the State and have the training and experience to perform the type of examination or test we will request; the medical source must not be barred from participation in our programs under the provisions of § 416.903a. The medical source must also have the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

(c) The medical source we choose may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse) must meet appropriate licensing or certification requirements of the State. See § 416.903a.

[56 FR 36965, Aug. 1, 1991, as amended at 65 FR 11879, Mar. 7, 2000; 82 FR 5877, Jan. 18, 2017]

§ 416.919h Your medical source.

When, in our judgment, your medical source is qualified, equipped, and willing to perform the additional examination or test(s) for the fee schedule payment, and generally furnishes complete and timely reports, your medical source will be the preferred source for the purchased examination or test(s).

[82 FR 5877, Jan. 18, 2017]

§ 416.919i Other sources for consultative examinations.

We will use a different medical source than your medical source for a purchased examination or test in situations including, but not limited to, the following:

(a) Your medical source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your medical source;

(c) You prefer a source other than your medical source and have a good reason for your preference;

(d) We know from prior experience that your medical source may not be a productive source, such as when he or she has consistently failed to provide complete or timely reports; or

(e) Your medical source is not a qualified medical source as defined in § 416.919g.

[82 FR 5877, Jan, 18, 2017]

§ 416.919j Objections to the medical source designated to perform the consultative examination.

You or your representative may object to your being examined by a medical source we have designated to perform a consultative examination. If

there is a good reason for the objection, we will schedule the examination with another medical source. A good reason may be that the medical source we designated had previously represented an interest adverse to you. For example, the medical source may have represented your employer in a workers' compensation case or may have been involved in an insurance claim or legal action adverse to you. Other things we will consider include: The presence of a language barrier, the medical source's office location (e.g., 2nd floor, no elevator), travel restrictions, and whether the medical source had examined you in connection with a previous disability determination or decision that was unfavorable to you. If your objection is that a medical source allegedly ''lacks objectivity'' in general, but not in relation to you personally, we will review the allegations. See §416.919s. To avoid a delay in processing your claim, the consultative examination in your case will be changed to another medical source while a review is being conducted. We will handle any objection to use of the substitute medical source in the same manner. However, if we had previously conducted such a review and found that the reports of the medical source in question conformed to our guidelines, we will not change your examination.

[65 FR 11879, Mar. 7, 2000]

§ 416.919k Purchase of medical examinations, laboratory tests, and other services.

We may purchase medical examinations, including psychiatric and psychological examinations, X-rays and laboratory tests (including specialized tests, such as pulmonary function studies, electrocardiograms, and stress tests) from a medical source.

(a) The rate of payment for purchasing medical or other services necessary to make determinations of disability may not exceed the highest rate paid by Federal or public agencies in the State for the same or similar types of service. See §§416.1024 and 416.1026 of this part.

(b) If a physician's bill, or a request for payment for a physician's services, includes a charge for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the test was personally performed or supervised by the physician who submitted the bill (or for whose services the request for payment was made) or by another physician with whom that physician shares his or her practice, the payment will be based on the physician's usual and customary charge for the test or the rates of payment which the State uses for purchasing such services, whichever is the lesser amount.

(2) If the bill or request for payment indicates that the test was performed by an independent laboratory, the amount of reimbursement will not exceed the billed cost of the independent laboratory or the rate of payment which the State uses for purchasing such services, whichever is the lesser amount. A nominal payment may be made to the physician for collecting, handling and shipping a specimen to the laboratory if the physician bills for such a service. The total reimbursement may not exceed the rate of payment which the State uses for purchasing such services.

(c) The State will assure that it can support the rate of payment it uses. The State shall also be responsible for monitoring and overseeing the rate of payment it uses to ensure compliance with paragraphs (a) and (b) of this section.

[56 FR 36965, Aug. 1, 1991, as amended at 65 FR 11879, Mar. 7, 2000; 71 FR 16459, Mar. 31, 2006; 76 FR 24810, May 3, 2011]

§ 416.919m Diagnostic tests or procedures.

We will request the results of any diagnostic tests or procedures that have been performed as part of a workup by your treating source or other medical source and will use the results to help us evaluate impairment severity or prognosis. However, we will not order diagnostic tests or procedures that involve significant risk to you, such as myelograms, arteriograms, or cardiac catheterizations for the evaluation of disability under the Supplemental Security Income program. A State agency medical consultant must approve

the ordering of any diagnostic test or procedure when there is a chance it may involve significant risk. The responsibility for deciding whether to perform the examination rests with the medical source designated to perform the consultative examination.

[56 FR 36966, Aug. 1, 1991, as amended at 65 FR 11879, Mar. 7, 2000; 71 FR 16459, Mar. 31, 2006; 76 FR 24810, May 3, 2011]

§416.919n Informing the medical source of examination scheduling, report content, and signature requirements.

The medical sources who perform consultative examinations will have a good understanding of our disability programs and their evidentiary requirements. They will be made fully aware of their responsibilities and obligations regarding confidentiality as described in §401.105(e). We will fully inform medical sources who perform consultative examinations at the time we first contact them, and at subsequent appropriate intervals, of the following obligations:

(a) *Scheduling.* In scheduling full consultative examinations, sufficient time should be allowed to permit the medical source to take a case history and perform the examination, including any needed tests. The following minimum scheduling intervals (*i.e.*, time set aside for the individual, not the actual duration of the consultative examination) should be used.

(1) Comprehensive general medical examination—at least 30 minutes;

(2) Comprehensive musculoskeletal or neurological examination—at least 20 minutes;

(3) Comprehensive psychiatric examination—at least 40 minutes;

(4) Psychological examination—at least 60 minutes (Additional time may be required depending on types of psychological tests administered); and

(5) All others—at least 30 minutes, or in accordance with accepted medical practices.

We recognize that actual practice will dictate that some examinations may require longer scheduling intervals depending on the circumstances in a particular situation. We also recognize that these minimum intervals may have to be adjusted to allow for those claimants that do not attend their scheduled examination. The purpose of these minimum scheduling timeframes is to ensure that such examinations are complete and that sufficient time is made available to obtain the information needed to make an accurate determination in your case. State agencies will monitor the scheduling of examinations (through their normal consultative examination oversight activities) to ensure that any overscheduling is avoided, as overscheduling may lead to examinations that are not thorough.

(b) *Report content.* The reported results of your medical history, examination, requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help us determine the nature, severity, and duration of the impairment, and your residual functional capacity (if you are an adult) or your functioning (if you are a child). The report should reflect your statement of your symptoms, not simply the medical source's statements or conclusions. The medical source's report of the consultative examination should include the objective medical facts as well as observations and opinions.

(c) *Elements of a complete consultative examination.* A complete consultative examination is one which involves all the elements of a standard examination in the applicable medical specialty. When the report of a complete consultative examination is involved, the report should include the following elements:

(1) Your major or chief complaint(s);

(2) A detailed description, within the area of specialty of the examination, of the history of your major complaint(s);

(3) A description, and disposition, of pertinent ''positive'' and ''negative'' detailed findings based on the history, examination and laboratory tests related to the major complaint(s), and any other abnormalities or lack thereof reported or found during examination or laboratory testing;

(4) The results of laboratory and other tests (e.g., X-rays) performed according to the requirements stated in the Listing of Impairments (see appendix 1 of subpart P of part 404 of this chapter);

(5) The diagnosis and prognosis for your impairment(s);

(6) A medical opinion. Although we will ordinarily request a medical opinion as part of the consultative examination process, the absence of a medical opinion in a consultative examination report will not make the report incomplete. See § 416.913(a)(3); and

(7) In addition, the medical source will consider, and provide some explanation or comment on, your major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, evaluation of laboratory test results, and the conclusions will represent the information provided by the medical source who signs the report.

(d) *When a complete consultative examination is not required.* When the evidence we need does not require a complete consultative examination (for example, we need only a specific laboratory test result to complete the record), we may not require a report containing all of the elements in paragraph (c).

(e) *Signature requirements.* All consultative examination reports will be personally reviewed and signed by the medical source who actually performed the examination. This attests to the fact that the medical source doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory test results. The signature of the medical source on a report annotated ''not proofed'' or ''dictated but not read'' is not acceptable. A rubber stamp signature of a medical source or the medical source's signature entered by any other person is not acceptable.

[56 FR 36966, Aug. 1, 1991, as amended at 62 FR 6421, Feb. 11, 1997; 62 FR 13733, Mar. 21, 1997; 65 FR 11879, Mar. 7, 2000; 65 FR 54778, Sept. 11, 2000; 82 FR 5877, Jan. 18, 2017]

§ 416.919o When a properly signed consultative examination report has not been received.

If a consultative examination report is received unsigned or improperly signed we will take the following action.

(a) *When we will make determinations and decisions without a properly signed report.* We will make a determination or decision in the circumstances specified in paragraphs (a)(1) and (a)(2) of this section without waiting for a properly signed consultative examination report. After we have made the determination or decision, we will obtain a properly signed report and include it in the file unless the medical source who performed the original consultative examination has died:

(1) Continuous period of disability allowance with an onset date as alleged or earlier than alleged; or

(2) Continuance of disability.

(b) *When we will not make determinations and decisions without a properly signed report.* We will not use an unsigned or improperly signed consultative examination report to make the determinations or decisions specified in paragraphs (b)(1), (b)(2), (b)(3), and (b)(4) of this section. When we need a properly signed consultative examination report to make these determinations or decisions, we must obtain such a report. If the signature of the medical source who performed the original examination cannot be obtained because the medical source is out of the country for an extended period of time, or on an extended vacation, seriously ill, deceased, or for any other reason, the consultative examination will be rescheduled with another medical source:

(1) Denial; or

(2) Cessation; or

(3) Allowance of disability which has ended; or

(4) Allowance with an onset date later than the filing date.

[56 FR 36967, Aug. 1, 1991, as amended at 65 FR 11880, Mar. 7, 2000]

§416.919p Reviewing reports of consultative examinations.

(a) We will review the report of the consultative examination to determine whether the specific information requested has been furnished. We will consider the following factors in reviewing the report:

(1) Whether the report provides evidence which serves as an adequate basis for decisionmaking in terms of the impairment it assesses;

(2) Whether the report is internally consistent; Whether all the diseases, impairments and complaints described in the history are adequately assessed and reported in the clinical findings; Whether the conclusions correlate the findings from your medical history, clinical examination and laboratory tests and explain all abnormalities;

(3) Whether the report is consistent with the other information available to us within the specialty of the examination requested; Whether the report fails to mention an important or relevant complaint within that specialty that is noted in other evidence in the file (e.g., your blindness in one eye, amputations, pain, alcoholism, depression);

(4) Whether this is an adequate report of examination as compared to standards set out in the course of a medical education; and

(5) Whether the report is properly signed.

(b) If the report is inadequate or incomplete, we will contact the medical source who performed the consultative examination, give an explanation of our evidentiary needs, and ask that the medical source furnish the missing information or prepare a revised report.

(c) With your permission, or when the examination discloses new diagnostic information or test results that reveal a potentially life-threatening situation, we will refer the consultative examination report to your treating source. When we refer the consultative examination report to your treating source without your permission, we will notify you that we have done so.

(d) We will perform ongoing special management studies on the quality of consultative examinations purchased from major medical sources and the appropriateness of the examinations authorized.

(e) We will take steps to ensure that consultative examinations are scheduled only with medical sources who have access to the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

[56 FR 36967, Aug. 1, 1991, as amended at 65 FR 11880, Mar. 7, 2000]

§416.919q Conflict of interest.

All implications of possible conflict of interest between medical or psychological consultants and their medical or psychological practices will be avoided. Such consultants are not only those physicians and psychologists who work for us directly but are also those who do review and adjudication work in the State agencies. Physicians and psychologists who work for us directly as employees or under contract will not work concurrently for a State agency. Physicians and psychologists who do review work for us will not perform consultative examinations for us without our prior approval. In such situations, the physician or psychologist will disassociate himself or herself from further involvement in the case and will not participate in the evaluation, decision, or appeal actions. In addition, neither they, nor any member of their families, will acquire or maintain, either directly or indirectly, any financial interest in a medical partnership, corporation, or similar relationship in which consultative examinations are provided. Sometimes physicians and psychologists who do review work for us will have prior knowledge of a case; for example, when the claimant was a patient. Where this is so, the physician or psychologist will not participate in the review or determination of the case. This does not preclude the physician or psychologist from submitting medical evidence based on treatment or examination of the claimant.

[56 FR 36967, Aug. 1, 1991]

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

§ 416.919s Authorizing and monitoring the consultative examination.

(a) Day-to-day responsibility for the consultative examination process rests with the State agencies that make disability determinations for us.

(b) The State agency will maintain a good working relationship with the medical community in order to recruit sufficient numbers of physicians and other providers of medical services to ensure ready availability of consultative examination providers.

(c) Consistent with Federal and State laws, the State agency administrator will work to achieve appropriate rates of payment for purchased medical services.

(d) Each State agency will be responsible for comprehensive oversight management of its consultative examination program, with special emphasis on key providers.

(e) A key consultative examination provider is a provider that meets at least one of the following conditions:

(1) Any consultative examination provider with an estimated annual billing to the disability programs we administer of at least $150,000; or

(2) Any consultative examination provider with a practice directed primarily towards evaluation examinations rather than the treatment of patients; or

(3) Any consultative examination provider that does not meet the above criteria, but is one of the top five consultative examination providers in the State by dollar volume, as evidenced by prior year data.

(f) State agencies have flexibility in managing their consultative examination programs, but at a minimum will provide:

(1) An ongoing active recruitment program for consultative examination providers;

(2) A process for orientation, training, and review of new consultative examination providers, with respect to SSA's program requirements involving consultative examination report content and not with respect to medical techniques;

(3) Procedures for control of scheduling consultative examinations;

(4) Procedures to ensure that close attention is given to specific evaluation issues involved in each case;

(5) Procedures to ensure that only required examinations and tests are authorized in accordance with the standards set forth in this subpart;

(6) Procedures for providing medical or supervisory approval for the authorization or purchase of consultative examinations and for additional tests or studies requested by consulting medical sources. This includes physician approval for the ordering of any diagnostic test or procedure where the question of significant risk to the claimant/beneficiary might be raised. See § 416.919m.

(7) procedures for the ongoing review of consultative examination results to ensure compliance with written guidelines;

(8) Procedures to encourage active participation by physicians and psychologists in the consultative examination oversight program;

(9) Procedures for handling complaints;

(10) Procedures for evaluating claimant reactions to key providers; and

(11) A program of systematic, onsite reviews of key providers that will include annual onsite reviews of such providers when claimants are present for examinations. This provision does not contemplate that such reviews will involve participation in the actual examinations but, rather, offer an opportunity to talk with claimants at the provider's site before and after the examination and to review the provider's overall operation.

(g) The State agencies will cooperate with us when we conduct monitoring activities in connection with their oversight management of their consultative examination programs.

[56 FR 36967, Aug. 1, 1991, as amended at 65 FR 11880, Mar. 7, 2000; 71 FR 16459, Mar. 31, 2006; 75 FR 32846, June 10, 2010; 76 FR 24810, May 3, 2011]

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

§ 416.919t Consultative examination oversight.

(a) We will ensure that referrals for consultative examinations and purchases of consultative examinations are made in accordance with our policies. We will also monitor both the referral processes and the product of the consultative examinations obtained. This monitoring may include reviews by independent medical specialists under direct contract with SSA.

(b) Through our regional offices, we will undertake periodic comprehensive reviews of each State agency to evaluate each State's management of the consultative examination process. The review will involve visits to key providers, with State staff participating, including a program physician when the visit will deal with medical techniques or judgment, or factors that go to the core of medical professionalism.

(c) We will also perform ongoing special management studies of the quality of consultative examinations purchased from key providers and other sources and the appropriateness of the examinations authorized.

[56 FR 36968, Aug. 1, 1991]

EVALUATION OF DISABILITY

§ 416.920 Evaluation of disability of adults, in general.

(a) *General*—(1) *Purpose of this section.* This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.

(2) *Applicability of these rules.* These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.

(3) *Evidence considered.* We will consider all evidence in your case record when we make a determination or decision whether you are disabled. See § 416.920b.

(4) *The five-step sequential evaluation process.* The sequential evaluation process is a series of five ''steps'' that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (*See* paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (*See* paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (*See* paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (*See* paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and § 416.960(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and § 416.960(c).

(5) *When you are already receiving disability benefits.* If you are already receiving disability benefits, we will use a different sequential evaluation process to decide whether you continue to be disabled. We explain this process in § 416.994(b)(5).

(b) *If you are working.* If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

(d) *When your impairment(s) meets or equals a listed impairment in appendix 1.* If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) *When your impairment(s) does not meet or equal a listed impairment.* If your impairment(s) does not meet or equal a listed impairment, we will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record, as explained in § 416.945. (See paragraph (g)(2) of this section and § 416.962 for an exception to this rule.) We use our residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work (paragraph (f) of this section) and at the fifth step of the sequential evaluation process (if the evaluation proceeds to this step) to determine if you can adjust to other work (paragraph (g) of this section).

(f) *Your impairment(s) must prevent you from doing your past relevant work.* If we cannot make a determination or decision at the first three steps of the sequential evaluation process, we will compare our residual functional capacity assessment, which we made under paragraph (e) of this section, with the physical and mental demands of your past relevant work. See paragraph (h) of this section and § 416.960(b). If you can still do this kind of work, we will find that you are not disabled.

(g) *Your impairment(s) must prevent you from making an adjustment to any other work.* (1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (*See* § 416.960(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.

(2) We use different rules if you meet one of the two special medical-vocational profiles described in § 416.962. If you meet one of those profiles, we will find that you cannot make an adjustment to other work, and that you are disabled.

(h) *Expedited process.* If we do not find you disabled at the third step, and we do not have sufficient evidence about your past relevant work to make a finding at the fourth step, we may proceed to the fifth step of the sequential evaluation process. If we find that you can adjust to other work based solely on your age, education, and the same residual functional capacity assessment we made under paragraph (e) of this section, we will find that you are not disabled and will not make a finding about whether you can do your past relevant work at the fourth step. If we find that you may be unable to adjust to other work or if § 416.962 may apply, we will assess your claim at the fourth step and make a finding about whether you can perform your past relevant work. See paragraph (g) of this section and § 416.960(c).

[50 FR 8728, Mar. 5, 1985; 50 FR 19164, May 7, 1985, as amended at 56 FR 5554, Feb. 11, 1991; 56 FR 36968, Aug. 1, 1991; 65 FR 80308, Dec. 21, 2000; 68 FR 51164, Aug. 26, 2003; 77 FR 10656, Feb. 23, 2012; 77 FR 43495, July 25, 2012]

§416.920a Evaluation of mental impairments.

(a) *General.* The steps outlined in §§416.920 and 416.924 apply to the evaluation of physical and mental impairments. In addition, when we evaluate the severity of mental impairments for adults (persons age 18 and over) and in persons under age 18 when Part A of the Listing of Impairments is used, we must follow a special technique at each level in the administrative review process. We describe this special technique in paragraphs (b) through (e) of this section. Using this technique helps us:

(1) Identify the need for additional evidence to determine impairment severity;

(2) Consider and evaluate functional consequences of the mental disorder(s) relevant to your ability to work; and

(3) Organize and present our findings in a clear, concise, and consistent manner.

(b) *Use of the technique.* (1) Under the special technique, we must first evaluate your pertinent symptoms, signs, and laboratory findings to determine whether you have a medically determinable mental impairment(s). See §416.921 for more information about what is needed to show a medically determinable impairment. If we determine that you have a medically determinable mental impairment(s), we must specify the symptoms, signs, and laboratory findings that substantiate the presence of the impairment(s) and document our findings in accordance with paragraph (e) of this section.

(2) We must then rate the degree of functional limitation resulting from the impairment(s) in accordance with paragraph (c) of this section and record our findings as set out in paragraph (e) of this section.

(c) *Rating the degree of functional limitation.* (1) Assessment of functional limitations is a complex and highly individualized process that requires us to consider multiple issues and all relevant evidence to obtain a longitudinal picture of your overall degree of functional limitation. We will consider all relevant and available clinical signs and laboratory findings, the effects of your symptoms, and how your functioning may be affected by factors including, but not limited to, chronic mental disorders, structured settings, medication, and other treatment.

(2) We will rate the degree of your functional limitation based on the extent to which your impairment(s) interferes with your ability to function independently, appropriately, effectively, and on a sustained basis. Thus, we will consider such factors as the quality and level of your overall functional performance, any episodic limitations, the amount of supervision or assistance you require, and the settings in which you are able to function. See 12.00C through 12.00H of the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter for more information about the factors we consider when we rate the degree of your functional limitation.

(3) We have identified four broad functional areas in which we will rate the degree of your functional limitation: Understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. See 12.00E of the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter.

(4) When we rate your degree of limitation in these areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself), we will use the following five-point scale: None, mild, moderate, marked, and extreme. The last point on the scale represents a degree of limitation that is incompatible with the ability to do any gainful activity.

(d) *Use of the technique to evaluate mental impairments.* After we rate the degree of functional limitation resulting from your impairment(s), we will determine the severity of your mental impairment(s).

(1) If we rate the degrees of your limitation as ''none'' or ''mild,'' we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see §416.922).

(2) If your mental impairment(s) is severe, we must then determine if it meets or is equivalent in severity to a

listed mental disorder. We do this by comparing the medical findings about your impairment(s) and the rating of the degree of functional limitation to the criteria of the appropriate listed mental disorder. We will record the presence or absence of the criteria and the rating of the degree of functional limitation on a standard document at the initial and reconsideration levels of the administrative review process, or in the decision at the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision). See paragraph (e) of this section.

(3) If we find that you have a severe mental impairment(s) that neither meets nor is equivalent in severity to any listing, we will then assess your residual functional capacity.

(e) *Documenting application of the technique.* At the initial and reconsideration levels of the administrative review process, we will complete a standard document to record how we applied the technique. At the administrative law judge hearing and Appeals Council levels (in cases in which the Appeals Council issues a decision), we will document application of the technique in the decision. The following rules apply:

(1) When a State agency medical or psychological consultant makes the determination together with a State agency disability examiner at the initial or reconsideration level of the administrative review process as provided in §416.1015(c)(1) of this part, the State agency medical or psychological consultant has overall responsibility for assessing medical severity. A State agency disability examiner may assist in preparing the standard document. However, our medical or psychological consultant must review and sign the document to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence.

(2) When a State agency disability examiner makes the determination alone as provided in §416.1015(c)(3), the State agency disability examiner has overall responsibility for assessing medical severity and for completing and signing the standard document.

(3) When a disability hearing officer makes a reconsideration determination as provided in §416.1015(c)(4), the determination must document application of the technique, incorporating the disability hearing officer's pertinent findings and conclusions based on this technique.

(4) At the administrative law judge hearing and Appeals Council levels, the written decision must incorporate the pertinent findings and conclusions based on the technique. The decision must show the significant history, including examination and laboratory findings, and the functional limitations that were considered in reaching a conclusion about the severity of the mental impairment(s). The decision must include a specific finding as to the degree of limitation in each of the functional areas described in paragraph (c) of this section.

(5) If the administrative law judge requires the services of a medical expert to assist in applying the technique but such services are unavailable, the administrative law judge may return the case to the State agency or the appropriate Federal component, using the rules in §416.1441 of this part, for completion of the standard document. If, after reviewing the case file and completing the standard document, the State agency or Federal component concludes that a determination favorable to you is warranted, it will process the case using the rules found in §416.1441(d) or (e) of this part. If, after reviewing the case file and completing the standard document, the State agency or Federal component concludes that a determination favorable to you is not warranted, it will send the completed standard document and the case to the administrative law judge for further proceedings and a decision.

[65 FR 50782, Aug. 21, 2000; 65 FR 60584, Oct. 12, 2000, as amended at 71 FR 16459, Mar. 31, 2006; 75 FR 62682, Oct. 13, 2010; 76 FR 24810, May 3, 2011; 81 FR 66178, Sept. 26, 2016; 82 FR 5877, Jan. 18, 2017]

§ 416.920b How we consider evidence.

After we review all of the evidence relevant to your claim, we make findings about what the evidence shows.

(a) *Complete and consistent evidence.* If all of the evidence we receive, including all medical opinion(s), is consistent and there is sufficient evidence for us to determine whether you are disabled, we will make our determination or decision based on that evidence.

(b) *Incomplete or inconsistent evidence.* In some situations, we may not be able to make our determination or decision because the evidence in your case record is insufficient or inconsistent. We consider evidence to be insufficient when it does not contain all the information we need to make our determination or decision. We consider evidence to be inconsistent when it conflicts with other evidence, contains an internal conflict, is ambiguous, or when the medical evidence does not appear to be based on medically acceptable clinical or laboratory diagnostic techniques. If the evidence in your case record is insufficient or inconsistent, we may need to take the additional actions in paragraphs (b)(1) through (4) of this section.

(1) If any of the evidence in your case record, including any medical opinion(s) and prior administrative medical findings, is inconsistent, we will consider the relevant evidence and see if we can determine whether you are disabled based on the evidence we have.

(2) If the evidence is consistent but we have insufficient evidence to determine whether you are disabled, or if after considering the evidence we determine we cannot reach a conclusion about whether you are disabled, we will determine the best way to resolve the inconsistency or insufficiency. The action(s) we take will depend on the nature of the inconsistency or insufficiency. We will try to resolve the inconsistency or insufficiency by taking any one or more of the actions listed in paragraphs (b)(2)(i) through (b)(2)(iv) of this section. We might not take all of the actions listed below. We will consider any additional evidence we receive together with the evidence we already have.

(i) We may recontact your medical source. We may choose not to seek additional evidence or clarification from a medical source if we know from experience that the source either cannot or will not provide the necessary evidence. If we obtain medical evidence over the telephone, we will send the telephone report to the source for review, signature, and return;

(ii) We may request additional existing evidence;

(iii) We may ask you to undergo a consultative examination at our expense (see §§416.917 through 416.919t); or

(iv) We may ask you or others for more information.

(3) When there are inconsistencies in the evidence that we cannot resolve or when, despite efforts to obtain additional evidence, the evidence is insufficient to determine whether you are disabled, we will make a determination or decision based on the evidence we have.

(c) *Evidence that is inherently neither valuable nor persuasive.* Paragraphs (c)(1) through (c)(3) apply in claims filed (see §416.325) on or after March 27, 2017. Because the evidence listed in paragraphs ((c)(1)–(c)(3) of this section is inherently neither valuable nor persuasive to the issue of whether you are disabled or blind under the Act, we will not provide any analysis about how we considered such evidence in our determination or decision, even under §416.920c:

(1) *Decisions by other governmental agencies and nongovernmental entities.* See §416.904.

(2) *Disability examiner findings.* Findings made by a State agency disability examiner made at a previous level of adjudication about a medical issue, vocational issue, or the ultimate determination about whether you are disabled.

(3) *Statements on issues reserved to the Commissioner.* The statements listed in paragraphs (c)(3)(i) through (c)(3)(ix) of this section would direct our determination or decision that you are or are not disabled or blind within the meaning of the Act, but we are responsible for making the determination or decision about whether you are disabled or blind:

(i) Statements that you are or are not disabled, blind, able to work, or able to perform regular or continuing work;

(ii) Statements about whether or not you have a severe impairment(s);

(iii) Statements about whether or not your impairment(s) meets the duration requirement (see § 416.909);

(iv) Statements about whether or not your impairment(s) meets or medically equals any listing in the Listing of Impairments in Part 404, Subpart P, Appendix 1;

(v) If you are a child, statements about whether or not your impairment(s) functionally equals the listings in Part 404 Subpart P Appendix 1 (see § 416.926a);

(vi) If you are an adult, statements about what your residual functional capacity is using our programmatic terms about the functional exertional levels in Part 404, Subpart P, Appendix 2, Rule 200.00 instead of descriptions about your functional abilities and limitations (see § 416.945);

(vii) If you are an adult, statements about whether or not your residual functional capacity prevents you from doing past relevant work (see § 416.960);

(viii) If you are an adult, statements that you do or do not meet the requirements of a medical-vocational rule in Part 404, Subpart P, Appendix 2; and

(ix) Statements about whether or not your disability continues or ends when we conduct a continuing disability review (see § 416.994).

[82 FR 5877, Jan. 18, 2017]

§ 416.920c How we consider and articulate medical opinions and prior administrative medical findings for claims filed on or after March 27, 2017.

For claims filed (see § 416.325) on or after March 27, 2017, the rules in this section apply. For claims filed before March 27, 2017, the rules in § 416.927 apply.

(a) *How we consider medical opinions and prior administrative medical findings.* We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources. When a medical source provides one or more medical opinions or prior administrative medical findings, we will consider those medical opinions or prior administrative medical findings from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. The most important factors we consider when we evaluate the persuasiveness of medical opinions and prior administrative medical findings are supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section). We will articulate how we considered the medical opinions and prior administrative medical findings in your claim according to paragraph (b) of this section.

(b) *How we articulate our consideration of medical opinions and prior administrative medical findings.* We will articulate in our determination or decision how persuasive we find all of the medical opinions and all of the prior administrative medical findings in your case record. Our articulation requirements are as follows:

(1) *Source-level articulation.* Because many claims have voluminous case records containing many types of evidence from different sources, it is not administratively feasible for us to articulate in each determination or decision how we considered all of the factors for all of the medical opinions and prior administrative medical findings in your case record. Instead, when a medical source provides multiple medical opinion(s) or prior administrative medical finding(s), we will articulate how we considered the medical opinions or prior administrative medical findings from that medical source together in a single analysis using the factors listed in paragraphs (c)(1) through (c)(5) of this section, as appropriate. We are not required to articulate how we considered each medical opinion or prior administrative medical finding from one medical source individually.

(2) *Most important factors.* The factors of supportability (paragraph (c)(1) of this section) and consistency (paragraph (c)(2) of this section) are the most important factors we consider when we determine how persuasive we find a medical source's medical opinions or prior administrative medical findings to be. Therefore, we will explain how we considered the supportability and consistency factors for a medical source's medical opinions

or prior administrative medical findings in your determination or decision. We may, but are not required to, explain how we considered the factors in paragraphs (c)(3) through (c)(5) of this section, as appropriate, when we articulate how we consider medical opinions and prior administrative medical findings in your case record.

(3) *Equally persuasive medical opinions or prior administrative medical findings about the same issue.* When we find that two or more medical opinions or prior administrative medical findings about the same issue are both equally well-supported (paragraph (c)(1) of this section) and consistent with the record (paragraph (c)(2) of this section) but are not exactly the same, we will articulate how we considered the other most persuasive factors in paragraphs (c)(3) through (c)(5) of this section for those medical opinions or prior administrative medical findings in your determination or decision.

(c) *Factors.* We will consider the following factors when we consider the medical opinion(s) and prior administrative medical finding(s) in your case:

(1) *Supportability.* The more relevant the objective medical evidence and supporting explanations presented by a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s), the more persuasive the medical opinions or prior administrative medical finding(s) will be.

(2) *Consistency.* The more consistent a medical opinion(s) or prior administrative medical finding(s) is with the evidence from other medical sources and nonmedical sources in the claim, the more persuasive the medical opinion(s) or prior administrative medical finding(s) will be.

(3) *Relationship with the claimant.* This factor combines consideration of the issues in paragraphs (c)(3)(i)–(v) of this section.

(i) *Length of the treatment relationship.* The length of time a medical source has treated you may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(ii) *Frequency of examinations.* The frequency of your visits with the medical source may help demonstrate whether the medical source has a longitudinal understanding of your impairment(s).

(iii) *Purpose of the treatment relationship.* The purpose for treatment you received from the medical source may help demonstrate the level of knowledge the medical source has of your impairment(s).

(iv) *Extent of the treatment relationship.* The kinds and extent of examinations and testing the medical source has performed or ordered from specialists or independent laboratories may help demonstrate the level of knowledge the medical source has of your impairment(s).

(v) *Examining relationship.* A medical source may have a better understanding of your impairment(s) if he or she examines you than if the medical source only reviews evidence in your folder.

(4) *Specialization.* The medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.

(5) *Other factors.* We will consider other factors that tend to support or contradict a medical opinion or prior administrative medical finding. This includes, but is not limited to, evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program's policies and evidentiary requirements. When we consider a medical source's familiarity with the other evidence in a claim, we will also consider whether new evidence we receive after the medical source made his or her medical opinion or prior administrative medical finding makes the medical opinion or prior administrative medical finding more or less persuasive.

(d) *Evidence from nonmedical sources.* We are not required to articulate how we considered evidence from nonmedical sources using the requirements in

paragraphs (a) through (c) in this section.

[82 FR 5878, Jan. 18, 2017]

§ 416.921 Establishing that you have a medically determinable impairment(s).

If you are not doing substantial gainful activity, we will then determine whether you have a medically determinable physical or mental impairment(s) (see § 416.920(a)(4)(ii)). Your impairment(s) must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Therefore, a physical or mental impairment must be established by objective medical evidence from an acceptable medical source. We will not use your statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an impairment(s). After we establish that you have a medically determinable impairment(s), then we determine whether your impairment(s) is severe.

[82 FR 5879, Jan. 18, 2017]

§ 416.922 What we mean by an impairment(s) that is not severe in an adult.

(a) *Non-severe impairment(s).* An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) *Basic work activities.* When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

[82 FR 5879, Jan. 18, 2017]

§ 416.923 Multiple impairments.

(a) *Unrelated severe impairments.* We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) *Concurrent impairments.* If you have two or more concurrent impairments that, when considered in combination, are severe, we must determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

(c) *Combined effect.* In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, we will consider the combined impact of the impairments throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see §§ 416.920 and 416.924).

[82 FR 5879, Jan. 18, 2017]

§ 416.924 How we determine disability for children.

(a) *Steps in evaluating disability.* We consider all relevant evidence in your case record when we make a determination or decision whether you are disabled. If you allege more than one impairment, we will evaluate all the impairments for which we have evidence. Thus, we will consider the combined effects of all your impairments

upon your overall health and functioning. We will also evaluate any limitations in your functioning that result from your symptoms, including pain (see § 416.929). We will also consider all of the relevant factors in §§ 416.924a and 416.924b whenever we assess your functioning at any step of this process. We follow a set order to determine whether you are disabled. If you are doing substantial gainful activity, we will determine that you are not disabled and not review your claim further. If you are not doing substantial gainful activity, we will consider your physical or mental impairment(s) first to see if you have an impairment or combination of impairments that is severe. If your impairment(s) is not severe, we will determine that you are not disabled and not review your claim further. If your impairment(s) is severe, we will review your claim further to see if you have an impairment(s) that meets, medically equals, or functionally equals the listings. If you have such an impairment(s), and it meets the duration requirement, we will find that you are disabled. If you do not have such an impairment(s), or if it does not meet the duration requirement, we will find that you are not disabled.

(b) *If you are working.* If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or age, education, or work experience. (For our rules on how we decide whether you are engaging in substantial gainful activity, see §§ 416.971 through 416.976.)

(c) *You must have a medically determinable impairment(s) that is severe.* If you do not have a medically determinable impairment, or your impairment(s) is a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations, we will find that you do not have a severe impairment(s) and are, therefore, not disabled.

(d) *Your impairment(s) must meet, medically equal, or functionally equal the listings.* An impairment(s) causes marked and severe functional limitations if it meets or medically equals the severity of a set of criteria for an impairment in the listings, or if it functionally equals the listings.

(1) Therefore, if you have an impairment(s) that meets or medically equals the requirements of a listing or that functionally equals the listings, and that meets the duration requirement, we will find you disabled.

(2) If your impairment(s) does not meet the duration requirement, or does not meet, medically equal, or functionally equal the listings, we will find that you are not disabled.

(e) *Other rules.* We explain other rules for evaluating impairments at all steps of this process in §§ 416.924a, 416.924b, and 416.929. We explain our rules for deciding whether an impairment(s) meets a listing in § 416.925. Our rules for how we decide whether an impairment(s) medically equals a listing are in § 416.926. Our rules for deciding whether an impairment(s) functionally equals the listings are in § 416.926a.

(f) *If you attain age 18 after you file your disability application but before we make a determination or decision.* For the period during which you are under age 18, we will use the rules in this section. For the period starting with the day you attain age 18, we will use the disability rules we use for adults who file new claims, in § 416.920.

(g) *How we will explain our findings.* When we make a determination or decision whether you are disabled under this section or whether your disability continues under § 416.994a, we will indicate our findings at each step of the sequential evaluation process as we explain in this paragraph. At the initial and reconsideration levels of the administrative review process, State agency medical and psychological consultants will indicate their findings in writing in a manner that we prescribe. The State agency medical or psychological consultant (see § 416.1016) or other designee of the Commissioner has overall responsibility for completing the prescribed writing and must sign the prescribed writing to attest that it is complete, including the findings of fact and any discussion of supporting evidence. Disability hearing officers, administrative law judges and the administrative appeals judges on the Appeals Council (when the Appeals Council makes a decision) will indicate

their findings at each step of the sequential evaluation process in their determinations or decisions. In claims adjudicated under the procedures in part 405 of this chapter, administrative law judges will also indicate their findings at each step of the sequential evaluation process in their decisions.

[58 FR 47577, Sept. 9, 1993, as amended at 62 FR 6421, Feb. 11, 1997; 65 FR 54778, Sept. 11, 2000; 71 FR 16460, Mar. 31, 2006; 76 FR 24811, May 3, 2011; 76 FR 41687, July 15, 2011]

§ 416.924a Considerations in determining disability for children.

(a) *Basic considerations.* We consider all evidence in your case record (see § 416.913). The evidence in your case record may include information from medical sources (such as your pediatrician or other physician; psychologist; qualified speech-language pathologist; and physical, occupational, and rehabilitation therapists) and nonmedical sources (such as your parents, teachers, and other people who know you).

(1) *Medical evidence*—(i) *General.* Medical evidence of your impairment(s) must describe symptoms, signs, and laboratory findings. The medical evidence may include, but is not limited to, formal testing that provides information about your development or functioning in terms of standard deviations, percentiles, percentages of delay, or age or grade equivalents. It may also include opinions from medical sources about the nature and severity of your impairments. (*See* § 416.920c.)

(ii) *Test scores.* We consider all of the relevant information in your case record and will not consider any single piece of evidence in isolation. Therefore, we will not rely on test scores alone when we decide whether you are disabled. (*See* § 416.926a(e) for more information about how we consider test scores.)

(iii) *Medical sources.* Medical sources will report their findings and observations on clinical examination and the results of any formal testing. A medical source's report should note and resolve any material inconsistencies between formal test results, other medical findings, and your usual functioning. Whenever possible and appropriate, the interpretation of findings by the medical source should reflect consideration of information from your parents or other people who know you, including your teachers and therapists. When a medical source has accepted and relied on such information to reach a diagnosis, we may consider this information to be a sign, as defined in § 416.902(l).

(2) *Statements from nonmedical sources.* Every child is unique, so the effects of your impairment(s) on your functioning may be very different from the effects the same impairment(s) might have on another child. Therefore, whenever possible and appropriate, we will try to get information from people who can tell us about the effects of your impairment(s) on your activities and how you function on a day-to-day basis. These other people may include, but are not limited to:

(i) *Your parents and other caregivers.* Your parents and other caregivers can be important sources of information because they usually see you every day. In addition to your parents, other caregivers may include a childcare provider who takes care of you while your parent(s) works or an adult who looks after you in a before-or after-school program.

(ii) *Early intervention and preschool programs.* If you have been identified for early intervention services (in your home or elsewhere) because of your impairment(s), or if you attend a preschool program (e.g., Headstart or a public school kindergarten for children with special needs), these programs are also important sources of information about your functioning. We will ask for reports from the agency and individuals who provide you with services or from your teachers about how you typically function compared to other children your age who do not have impairments.

(iii) *School.* If you go to school, we will ask for information from your teachers and other school personnel about how you are functioning there on a day-to-day basis compared to other children your age who do not have impairments. We will ask for any reports that the school may have that show the results of formal testing or that describe any special education instruction or services, including home-based

instruction, or any accommodations provided in a regular classroom.

(b) *Factors we consider when we evaluate the effects of your impairment(s) on your functioning*—(1) *General.* We must consider your functioning when we decide whether your impairment(s) is ''severe'' and when we decide whether your impairment(s) functionally equals the listings. We will also consider your functioning when we decide whether your impairment(s) meets or medically equals a listing if the listing we are considering includes functioning among its criteria.

(2) *Factors we consider when we evaluate your functioning.* Your limitations in functioning must result from your medically determinable impairment(s). The information we get from your medical and nonmedical sources can help us understand how your impairment(s) affects your functioning. We will also consider any factors that are relevant to how you function when we evaluate your impairment or combination of impairments. For example, your symptoms (such as pain, fatigue, decreased energy, or anxiety) may limit your functioning. (*See* §416.929.) We explain some other factors we may consider when we evaluate your functioning in paragraphs (b)(3)–(b)(9) of this section.

(3) *How your functioning compares to the functioning of children your age who do not have impairments*—(i) *General.* When we evaluate your functioning, we will look at whether you do the things that other children your age typically do or whether you have limitations and restrictions because of your medically determinable impairment(s). We will also look at how well you do the activities and how much help you need from your family, teachers, or others. Information about what you can and cannot do, and how you function on a day-to-day basis at home, school, and in the community, allows us to compare your activities to the activities of children your age who do not have impairments.

(ii) *How we will consider reports of your functioning.* When we consider the evidence in your case record about the quality of your activities, we will consider the standards used by the person who gave us the information. We will also consider the characteristics of the group to whom you are being compared. For example, if the way you do your classwork is compared to other children in a special education class, we will consider that you are being compared to children who do have impairments.

(4) *Combined effects of multiple impairments.* If you have more than one impairment, we will sometimes be able to decide that you have a ''severe'' impairment or an impairment that meets, medically equals, or functionally equals the listings by looking at each of your impairments separately. When we cannot, we will look comprehensively at the combined effects of your impairments on your day-to-day functioning instead of considering the limitations resulting from each impairment separately. (See §§416.923 and 416.926a(c) for more information about how we will consider the interactive and cumulative effects of your impairments on your functioning.)

(5) *How well you can initiate, sustain, and complete your activities, including the amount of help or adaptations you need, and the effects of structured or supportive settings*—(i) *Initiating, sustaining, and completing activities.* We will consider how effectively you function by examining how independently you are able to initiate, sustain, and complete your activities despite your impairment(s), compared to other children your age who do not have impairments. We will consider:

(A) The range of activities you do;

(B) Your ability to do them independently, including any prompting you may need to begin, carry through, and complete your activities;

(C) The pace at which you do your activities;

(D) How much effort you need to make to do your activities; and

(E) How long you are able to sustain your activities.

(ii) *Extra help.* We will consider how independently you are able to function compared to other children your age who do not have impairments. We will consider whether you need help from other people, or whether you need special equipment, devices, or medications to perform your day-to-day activities. For example, we may consider how much supervision you need to keep from hurting yourself, how much help

you need every day to get dressed or, if you are an infant, how long it takes for your parents or other caregivers to feed you. We recognize that children are often able to do things and complete tasks when given help, but may not be able to do these same things by themselves. Therefore, we will consider how much extra help you need, what special equipment or devices you use, and the medications you take that enable you to participate in activities like other children your age who do not have impairments.

(iii) *Adaptations.* We will consider the nature and extent of any adaptations that you use to enable you to function. Such adaptations may include assistive devices or appliances. Some adaptations may enable you to function normally or almost normally (e.g., eyeglasses). Others may increase your functioning, even though you may still have functional limitations (e.g., ankle-foot orthoses, hand or foot splints, and specially adapted or custom-made tools, utensils, or devices for self-care activities such as bathing, feeding, toileting, and dressing). When we evaluate your functioning with an adaptation, we will consider the degree to which the adaptation enables you to function compared to other children your age who do not have impairments, your ability to use the adaptation effectively on a sustained basis, and any functional limitations that nevertheless persist.

(iv) *Structured or supportive settings.* (A) If you have a serious impairment(s), you may spend some or all of your time in a structured or supportive setting, beyond what a child who does not have an impairment typically needs.

(B) A structured or supportive setting may be your own home in which family members or other people (e.g., visiting nurses or home health workers) make adjustments to accommodate your impairment(s). A structured or supportive setting may also be your classroom at school, whether it is a regular classroom in which you are accommodated or a special classroom. It may also be a residential facility or school where you live for a period of time.

(C) A structured or supportive setting may minimize signs and symptoms of your impairment(s) and help to improve your functioning while you are in it, but your signs, symptoms, and functional limitations may worsen outside this type of setting. Therefore, we will consider your need for a structured setting and the degree of limitation in functioning you have or would have outside the structured setting. Even if you are able to function adequately in the structured or supportive setting, we must consider how you function in other settings and whether you would continue to function at an adequate level without the structured or supportive setting.

(D) If you have a chronic impairment(s), you may have your activities structured in such a way as to minimize stress and reduce the symptoms or signs of your impairment(s). You may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, although at a lesser level of severity. We will consider whether you are more limited in your functioning than your symptoms and signs would indicate.

(E) Therefore, if your symptoms or signs are controlled or reduced in a structured setting, we will consider how well you are functioning in the setting and the nature of the setting in which you are functioning (e.g., home or a special class); the amount of help you need from your parents, teachers, or others to function as well as you do; adjustments you make to structure your environment; and how you would function without the structured or supportive setting.

(6) *Unusual settings.* Children may function differently in unfamiliar or one-to-one settings than they do in their usual settings at home, at school, in childcare or in the community. You may appear more or less impaired on a single examination (such as a consultative examination) than indicated by the information covering a longer period. Therefore, we will apply the guidance in paragraph (b)(5) of this section when we consider how you function in an unusual or one-to-one situation. We will look at your performance in a special situation and at your typical day-

to-day functioning in routine situations. We will not draw inferences about your functioning in other situations based only on how you function in a one-to-one, new, or unusual situation.

(7) *Early intervention and school programs*—(i) *General.* If you are a very young child who has been identified for early intervention services, or if you attend school (including preschool), the records of people who know you or who have examined you are important sources of information about your impairment(s) and its effects on your functioning. Records from physicians, teachers and school psychologists, or physical, occupational, or speech-language therapists are examples of what we will consider. If you receive early intervention services or go to school or preschool, we will consider this information when it is relevant and available to us.

(ii) *School evidence.* If you go to school or preschool, we will ask your teacher(s) about your performance in your activities throughout your school day. We will consider all the evidence we receive from your school, including teacher questionnaires, teacher checklists, group achievement testing, and report cards.

(iii) *Early intervention and special education programs.* If you have received a comprehensive assessment for early intervention services or special education services, we will consider information used by the assessment team to make its recommendations. We will consider the information in your Individualized Family Service Plan, your Individualized Education Program, or your plan for transition services to help us understand your functioning. We will examine the goals and objectives of your plan or program as further indicators of your functioning, as well as statements regarding related services, supplementary aids, program modifications, and other accommodations recommended to help you function, together with the other relevant information in your case record.

(iv) *Special education or accommodations.* We will consider the fact that you attend school, that you may be placed in a special education setting, or that you receive accommodations because of your impairments along with the other information in your case record. The fact that you attend school does not mean that you are not disabled. The fact that you do or do not receive special education services does not, in itself, establish your actual limitations or abilities. Children are placed in special education settings, or are included in regular classrooms (with or without accommodation), for many reasons that may or may not be related to the level of their impairments. For example, you may receive one-to-one assistance from an aide throughout the day in a regular classroom, or be placed in a special classroom. We will consider the circumstances of your school attendance, such as your ability to function in a regular classroom or preschool setting with children your age who do not have impairments. Similarly, we will consider that good performance in a special education setting does not mean that you are functioning at the same level as other children your age who do not have impairments.

(v) *Attendance and participation.* We will also consider factors affecting your ability to participate in your education program. You may be unable to participate on a regular basis because of the chronic or episodic nature of your impairment(s) or your need for therapy or treatment. If you have more than one impairment, we will look at whether the effects of your impairments taken together make you unable to participate on a regular basis. We will consider how your temporary removal or absence from the program affects your ability to function compared to other children your age who do not have impairments.

(8) *The impact of chronic illness and limitations that interfere with your activities over time.* If you have a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) and remission (improvement), we will consider the frequency and severity of your episodes of exacerbation as factors that may be limiting your functioning. Your level of functioning may vary considerably over time. Proper evaluation of your ability to function in any domain requires us to take into account any variations in your level of

functioning to determine the impact of your chronic illness on your ability to function over time. If you require frequent treatment, we will consider it as explained in paragraph (b)(9)(ii) of this section.

(9) *The effects of treatment (including medications and other treatment).* We will evaluate the effects of your treatment to determine its effect on your functioning in your particular case.

(i) *Effects of medications.* We will consider the effects of medication on your symptoms, signs, laboratory findings, and functioning. Although medications may control the most obvious manifestations of your impairment(s), they may or may not affect the functional limitations imposed by your impairment(s). If your symptoms or signs are reduced by medications, we will consider:

(A) Any of your functional limitations that may nevertheless persist, even if there is improvement from the medications;

(B) Whether your medications create any side effects that cause or contribute to your functional limitations;

(C) The frequency of your need for medication;

(D) Changes in your medication or the way your medication is prescribed; and

(E) Any evidence over time of how medication helps or does not help you to function compared to other children your age who do not have impairments.

(ii) *Other treatment.* We will also consider the level and frequency of treatment other than medications that you get for your impairment(s). You may need frequent and ongoing therapy from one or more medical sources to maintain or improve your functional status. (Examples of therapy include occupational, physical, or speech and language therapy, nursing or home health services, psychotherapy, or psychosocial counseling.) Frequent therapy, although intended to improve your functioning in some ways, may also interfere with your functioning in other ways. Therefore, we will consider the frequency of any therapy you must have, and how long you have received or will need it. We will also consider whether the therapy interferes with your participation in activities typical of other children your age who do not have impairments, such as attending school or classes and socializing with your peers. If you must frequently interrupt your activities at school or at home for therapy, we will consider whether these interruptions interfere with your functioning. We will also consider the length and frequency of your hospitalizations.

(iii) *Treatment and intervention, in general.* With treatment or intervention, you may not only have your symptoms or signs reduced, but may also maintain, return to, or achieve a level of functioning that is not disabling. Treatment or intervention may prevent, eliminate, or reduce functional limitations.

[65 FR 54779, Sept. 11, 2000, as amended at 82 FR 5879, Jan. 18, 2017]

§ 416.924b Age as a factor of evaluation in the sequential evaluation process for children.

(a) *General.* In this section, we explain how we consider age when we decide whether you are disabled. Your age may or may not be a factor in our determination whether your impairment(s) meets or medically equals a listing, depending on the listing we use for comparison. However, your age is an important factor when we decide whether your impairment(s) is severe (*see* § 416.924(c)) and whether it functionally equals the listings (*see* § 416.926a). Except in the case of certain premature infants, as described in paragraph (b) of this section, age means chronological age.

(1) When we determine whether you have an impairment or combination of impairments that is severe, we will compare your functioning to that of children your age who do not have impairments.

(2) When we determine whether your impairment(s) meets a listing, we may or may not need to consider your age. The listings describe impairments that we consider of such significance that they are presumed to cause marked and severe functional limitations.

(i) If the listing appropriate for evaluating your impairment is divided into specific age categories, we will evaluate your impairment according to your

age when we decide whether your impairment meets that listing.

(ii) If the listing appropriate for evaluating your impairment does not include specific age categories, we will decide whether your impairment meets the listing without giving consideration to your age.

(3) When we compare an unlisted impairment or a combination of impairments with the listings to determine whether it medically equals the severity of a listing, the way we consider your age will depend on the listing we use for comparison. We will use the same principles for considering your age as in paragraphs (a)(2)(i) and (a)(2)(ii) of this section; that is, we will consider your age only if we are comparing your impairment(s) to a listing that includes specific age categories.

(4) We will also consider your age and whether it affects your ability to be tested. If your impairment(s) is not amenable to formal testing because of your age, we will consider all information in your case record that helps us decide whether you are disabled. We will consider other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice that will help us evaluate the existence and severity of your impairment(s).

(b) *Correcting chronological age of premature infants.* We generally use chronological age (a child's age based on birth date) when we decide whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. However, if you were born prematurely, we may consider you younger than your chronological age when we evaluate your development. We may use a ''corrected'' chronological age (CCA); that is, your chronological age adjusted by a period of gestational prematurity. We consider an infant born at less than 37 weeks' gestation to be born prematurely.

(1) We compute your CCA by subtracting the number of weeks of prematurity (the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from your chronological age. For example, if your chronological age is 20 weeks but you were born at 32 weeks gestation (8 weeks premature), then your CCA is 12 weeks.

(2) We evaluate developmental delay in a premature child until the child's prematurity is no longer a relevant factor, generally no later than about chronological age 2.

(i) If you have not attained age 1 and were born prematurely, we will assess your development using your CCA.

(ii) If you are over age 1 and have a developmental delay, and prematurity is still a relevant factor, we will decide whether to correct your chronological age. We will base our decision on our judgment and all the facts in your case. If we decide to correct your chronological age, we may correct it by subtracting the full number of weeks of prematurity or a lesser number of weeks. If your developmental delay is the result of your medically determinable impairment(s) and is not attributable to your prematurity, we will decide not to correct your chronological age.

(3) Notwithstanding the provisions in paragraph (b)(1) of this section, we will not compute a corrected chronological age if the medical evidence shows that your medical source has already considered your prematurity in his or her assessment of your development. We will not compute a CCA when we find you disabled under listing 100.04 of the Listing of Impairments.

[65 FR 54778, Sept. 11, 2000, as amended at 72 FR 59431, Oct. 19, 2007; 80 FR 19529, Apr. 13, 2015; 82 FR 5880, Jan. 18, 2017]

MEDICAL CONSIDERATIONS

§ 416.925 Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter.

(a) *What is the purpose of the Listing of Impairments?* The Listing of Impairments (the listings) is in appendix 1 of subpart P of part 404 of this chapter. For adults, it describes for each of the major body systems impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience. For children, it describes impairments that cause marked and severe functional limitations.

(b) *How is appendix 1 organized?* There are two parts in appendix 1:

(1) *Part A* contains criteria that apply to individuals age 18 and over. We may also use part A for individuals who are under age 18 if the disease processes have a similar effect on adults and children.

(2)(i) *Part B* contains criteria that apply only to individuals who are under age 18; we never use the listings in part B to evaluate individuals who are age 18 or older. In evaluating disability for a person under age 18, we use part B first. If the criteria in part B do not apply, we may use the criteria in part A when those criteria give appropriate consideration to the effects of the impairment(s) in children. To the extent possible, we number the provisions in part B to maintain a relationship with their counterparts in part A.

(ii) Although the severity criteria in part B of the listings are expressed in different ways for different impairments, ''listing-level severity'' generally means the level of severity described in §416.926a(a); that is, ''marked'' limitations in two domains of functioning or an ''extreme'' limitation in one domain. (See §416.926a(e) for the definitions of the terms *marked* and *extreme* as they apply to children.) Therefore, in general, a child's impairment(s) is of ''listing-level severity'' if it causes marked limitations in two domains of functioning or an extreme limitation in one. However, when we decide whether your impairment(s) meets the requirements of a listing, we will decide that your impairment is of ''listing-level severity'' even if it does not result in marked limitations in two domains of functioning, or an extreme limitation in one, if the listing that we apply does not require such limitations to establish that an impairment(s) is disabling.

(c) *How do we use the listings?* (1) Most body system sections in parts A and B of appendix 1 are in two parts: an introduction, followed by the specific listings.

(2) The introduction to each body system contains information relevant to the use of the listings in that body system; for example, examples of common impairments in the body system and definitions used in the listings for that body system. We may also include specific criteria for establishing a diagnosis, confirming the existence of an impairment, or establishing that your impairment(s) satisfies the criteria of a particular listing in the body system. Even if we do not include specific criteria for establishing a diagnosis or confirming the existence of your impairment, you must still show that you have a severe medically determinable impairment(s), as defined in §§416.921 and 416.924(c).

(3) In most cases, the specific listings follow the introduction in each body system, after the heading, *Category of Impairments.* Within each listing, we specify the objective medical and other findings needed to satisfy the criteria of that listing. We will find that your impairment(s) *meets* the requirements of a listing when it satisfies all of the criteria of that listing, including any relevant criteria in the introduction, and meets the duration requirement (see §416.909).

(4) Most of the listed impairments are permanent or expected to result in death. For some listings, we state a specific period of time for which your impairment(s) will meet the listing. For all others, the evidence must show that your impairment(s) has lasted or can be expected to last for a continuous period of at least 12 months.

(5) If your impairment(s) does not meet the criteria of a listing, it can *medically equal* the criteria of a listing. We explain our rules for medical equivalence in §416.926. We use the listings only to find that you are disabled or still disabled. If your impairment(s) does not meet or medically equal the criteria of a listing, we may find that you are disabled or still disabled at a later step in the sequential evaluation process.

(d) *Can your impairment(s) meet a listing based only on a diagnosis?* No. Your impairment(s) cannot meet the criteria of a listing based only on a diagnosis. To meet the requirements of a listing, you must have a medically determinable impairment(s) that satisfies all of the criteria of the listing.

(e) *How do we consider your symptoms when we determine whether your impairment(s) meets a listing?* Some listed impairments include symptoms, such as pain, as criteria. Section 416.929(d)(2) explains how we consider your symptoms when your symptoms are included as criteria in a listing.

[71 FR 10430, Mar. 1, 2006, as amended at 76 FR 19698, Apr. 8, 2011; 82 FR 5880, Jan. 18, 2017]

§ 416.926 Medical equivalence for adults and children.

(a) *What is medical equivalence?* Your impairment(s) is medically equivalent to a listed impairment in appendix 1 of subpart P of part 404 of this chapter if it is at least equal in severity and duration to the criteria of any listed impairment.

(b) *How do we determine medical equivalence?* We can find medical equivalence in three ways.

(1)(i) If you have an impairment that is described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, but—

(A) You do not exhibit one or more of the findings specified in the particular listing, or

(B) You exhibit all of the findings, but one or more of the findings is not as severe as specified in the particular listing,

(ii) We will find that your impairment is medically equivalent to that listing if you have other findings related to your impairment that are at least of equal medical significance to the required criteria.

(2) If you have an impairment(s) that is not described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is medically equivalent to the analogous listing.

(3) If you have a combination of impairments, no one of which meets a listing described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter (see § 416.925(c)(3)), we will compare your findings with those for closely analogous listed impairments. If the findings related to your impairments are at least of equal medical significance to those of a listed impairment, we will find that your combination of impairments is medically equivalent to that listing.

(4) Section 416.929(d)(3) explains how we consider your symptoms, such as pain, when we make findings about medical equivalence.

(c) *What evidence do we consider when we determine if your impairment(s) medically equals a listing?* When we determine if your impairment medically equals a listing, we consider all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. We do not consider your vocational factors of age, education, and work experience (see, for example, § 416.960(c)(1)). We also consider the opinion given by one or more medical or psychological consultants designated by the Commissioner. (See § 416.1016.)

(d) *Who is a designated medical or psychological consultant?* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. See § 416.1016 for the necessary qualifications for medical consultants and psychological consultants.

(e) *Who is responsible for determining medical equivalence?*

(1) In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 416.1016 of this part) has the overall responsibility for determining medical equivalence.

(2) For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 416.1418 of

this part, with the Associate Commissioner for Disability Policy or his or her delegate.

(3) For cases at the administrative law judge or Appeals Council level, the responsibility for deciding medical equivalence rests with the administrative law judge or Appeals Council.

[45 FR 55621, Aug. 20, 1980, as amended at 52 FR 33928, Sept. 9, 1987; 56 FR 5561, Feb. 11, 1991; 62 FR 6424, Feb. 11, 1997; 62 FR 13538, Mar. 21, 1997; 65 FR 34959, June 1, 2000; 71 FR 10431, Mar. 1, 2006; 71 FR 16460, Mar. 31, 2006; 76 FR 24811, May 3, 2011; 82 FR 5880, Jan. 18, 2017; 82 FR 15132, Mar. 27, 2017]

§ 416.926a Functional equivalence for children.

(a) *General.* If you have a severe impairment or combination of impairments that does not meet or medically equal any listing, we will decide whether it results in limitations that functionally equal the listings. By ''functionally equal the listings,'' we mean that your impairment(s) must be of listing-level severity; *i.e.,* it must result in ''marked'' limitations in two domains of functioning or an ''extreme'' limitation in one domain, as explained in this section. We will assess the functional limitations caused by your impairment(s); *i.e.,* what you cannot do, have difficulty doing, need help doing, or are restricted from doing because of your impairment(s). When we make a finding regarding functional equivalence, we will assess the interactive and cumulative effects of all of the impairments for which we have evidence, including any impairments you have that are not ''severe.'' (*See* § 416.924(c).) When we assess your functional limitations, we will consider all the relevant factors in §§ 416.924a, 416.924b, and 416.929 including, but not limited to:

(1) How well you can initiate and sustain activities, how much extra help you need, and the effects of structured or supportive settings (*see* § 416.924a(b)(5));

(2) How you function in school (*see* § 416.924a(b)(7)); and

(3) The effects of your medications or other treatment (*see* § 416.924a(b)(9)).

(b) *How we will consider your functioning.* We will look at the information we have in your case record about how your functioning is affected during all of your activities when we decide whether your impairment or combination of impairments functionally equals the listings. Your activities are everything you do at home, at school, and in your community. We will look at how appropriately, effectively, and independently you perform your activities compared to the performance of other children your age who do not have impairments.

(1) We will consider how you function in your activities in terms of six domains. These domains are broad areas of functioning intended to capture all of what a child can or cannot do. In paragraphs (g) through (l), we describe each domain in general terms. For most of the domains, we also provide examples of activities that illustrate the typical functioning of children in different age groups. For all of the domains, we also provide examples of limitations within the domains. However, we recognize that there is a range of development and functioning, and that not all children within an age category are expected to be able to do all of the activities in the examples of typical functioning. We also recognize that limitations of any of the activities in the examples do not necessarily mean that a child has a ''marked'' or ''extreme'' limitation, as defined in paragraph (e) of this section. The domains we use are:

(i) Acquiring and using information;

(ii) Attending and completing tasks;

(iii) Interacting and relating with others;

(iv) Moving about and manipulating objects;

(v) Caring for yourself; and,

(vi) Health and physical well-being.

(2) When we evaluate your ability to function in each domain, we will ask for and consider information that will help us answer the following questions about whether your impairment(s) affects your functioning and whether your activities are typical of other children your age who do not have impairments.

(i) What activities are you able to perform?

(ii) What activities are you not able to perform?

(iii) Which of your activities are limited or restricted compared to other children your age who do not have impairments?

(iv) Where do you have difficulty with your activities-at home, in childcare, at school, or in the community?

(v) Do you have difficulty independently initiating, sustaining, or completing activities?

(vi) What kind of help do you need to do your activities, how much help do you need, and how often do you need it?

(3) We will try to get information from sources who can tell us about the effects of your impairment(s) and how you function. We will ask for information from your medical sources who can give us medical evidence, including medical opinions, about your limitations and restrictions. We will also ask for information from your parents and teachers, and may ask for information from others who see you often and can describe your functioning at home, in childcare, at school, and in your community. We may also ask you to go to a consultative examination(s) at our expense. (*See* §§416.912–416.919a regarding medical evidence and when we will purchase a consultative examination.)

(c) *The interactive and cumulative effects of an impairment or multiple impairments.* When we evaluate your functioning and decide which domains may be affected by your impairment(s), we will look first at your activities and your limitations and restrictions. Any given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And any given impairment may have effects in more than one domain; therefore, we will evaluate the limitations from your impairment(s) in any affected domain(s).

(d) *How we will decide that your impairment(s) functionally equals the listings.* We will decide that your impairment(s) functionally equals the listings if it is of listing-level severity. Your impairment(s) is of listing-level severity if you have ''marked'' limitations in two of the domains in paragraph (b)(1) of this section, or an ''extreme'' limitation in one domain. We will not compare your functioning to the requirements of any specific listing. We explain what the terms ''marked'' and ''extreme'' mean in paragraph (e) of this section. We explain how we use the domains in paragraph (f) of this section, and describe each domain in paragraphs (g)–(l). You must also meet the duration requirement. (*See* §416.909.)

(e) *How we define ''marked'' and ''extreme'' limitations*—(1) *General.* (i) When we decide whether you have a ''marked'' or an ''extreme'' limitation, we will consider your functional limitations resulting from all of your impairments, including their interactive and cumulative effects. We will consider all the relevant information in your case record that helps us determine your functioning, including your signs, symptoms, and laboratory findings, the descriptions we have about your functioning from your parents, teachers, and other people who know you, and the relevant factors explained in §§416.924a, 416.924b, and 416.929.

(ii) The medical evidence may include formal testing that provides information about your development or functioning in terms of percentiles, percentages of delay, or age or grade equivalents. Standard scores (e.g., percentiles) can be converted to standard deviations. When you have such scores, we will consider them together with the information we have about your functioning to determine whether you have a ''marked'' or ''extreme'' limitation in a domain.

(2) *Marked limitation.* (i) We will find that you have a ''marked'' limitation in a domain when your impairment(s) interferes seriously with your ability to independently initiate, sustain, or complete activities. Your day-to-day functioning may be seriously limited when your impairment(s) limits only one activity or when the interactive and cumulative effects of your impairment(s) limit several activities. ''Marked'' limitation also means a limitation that is ''more than moderate'' but ''less than extreme.'' It is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.

(ii) If you have not attained age 3, we will generally find that you have a ''marked'' limitation if you are functioning at a level that is more than one-half but not more than two-thirds of your chronological age when there are no standard scores from standardized tests in your case record.

(iii) If you are a child of any age (birth to the attainment of age 18), we will find that you have a ''marked'' limitation when you have a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and your day-to-day functioning in domain-related activities is consistent with that score. (*See* paragraph (e)(4) of this section.)

(iv) For the sixth domain of functioning, ''Health and physical well-being,'' we may also consider you to have a ''marked'' limitation if you are frequently ill because of your impairment(s) or have frequent exacerbations of your impairment(s) that result in significant, documented symptoms or signs. For purposes of this domain, ''frequent means that you have episodes of illness or exacerbations that occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more. We may also find that you have a ''marked'' limitation if you have episodes that occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

(3) *Extreme limitation.* (i) We will find that you have an ''extreme'' limitation in a domain when your impairment(s) interferes very seriously with your ability to independently initiate, sustain, or complete activities. Your day-to-day functioning may be very seriously limited when your impairment(s) limits only one activity or when the interactive and cumulative effects of your impairment(s) limit several activities. ''Extreme'' limitation also means a limitation that is ''more than marked.'' ''Extreme'' limitation is the rating we give to the worst limitations. However, ''extreme limitation'' does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least three standard deviations below the mean.

(ii) If you have not attained age 3, we will generally find that you have an ''extreme'' limitation if you are functioning at a level that is one-half of your chronological age or less when there are no standard scores from standardized tests in your case record.

(iii) If you are a child of any age (birth to the attainment of age 18), we will find that you have an ''extreme'' limitation when you have a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and your day-to-day functioning in domain-related activities is consistent with that score. (*See* paragraph (e)(4) of this section.)

(iv) For the sixth domain of functioning, ''Health and physical well-being,'' we may also consider you to have an ''extreme'' limitation if you are frequently ill because of your impairment(s) or have frequent exacerbations of your impairment(s) that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a ''marked'' limitation in paragraph (e)(2)(iv) of this section. However, if you have episodes of illness or exacerbations of your impairment(s) that we would rate as ''extreme'' under this definition, your impairment(s) should meet or medically equal the requirements of a listing in most cases. *See* §§ 416.925 and 416.926.

(4) *How we will consider your test scores.* (i) As indicated in § 416.924a(a)(1)(ii), we will not rely on any test score alone. No single piece of information taken in isolation can establish whether you have a ''marked'' or an ''extreme'' limitation in a domain.

(ii) We will consider your test scores together with the other information we have about your functioning, including reports of classroom performance and

the observations of school personnel and others.

(A) We may find that you have a ''marked'' or ''extreme'' limitation when you have a test score that is slightly higher than the level provided in paragraph (e)(2) or (e)(3) of this section, if other information in your case record shows that your functioning in day-to-day activities is seriously or very seriously limited because of your impairment(s). For example, you may have IQ scores above the level in paragraph (e)(2), but other evidence shows that your impairment(s) causes you to function in school, home, and the community far below your expected level of functioning based on this score.

(B) On the other hand, we may find that you do not have a ''marked'' or ''extreme'' limitation, even if your test scores are at the level provided in paragraph (e)(2) or (e)(3) of this section, if other information in your case record shows that your functioning in day-to-day activities is not seriously or very seriously limited by your impairment(s). For example, you may have a valid IQ score below the level in paragraph (e)(2), but other evidence shows that you have learned to drive a car, shop independently, and read books near your expected grade level.

(iii) If there is a material inconsistency between your test scores and other information in your case record, we will try to resolve it. The interpretation of the test is primarily the responsibility of the psychologist or other professional who administered the test. But it is also our responsibility to ensure that the evidence in your case is complete and consistent or that any material inconsistencies have been resolved. Therefore, we will use the following guidelines when we resolve concerns about your test scores:

(A) We may be able to resolve the inconsistency with the information we have. We may need to obtain additional information; e.g., by recontact with your medical source(s), by purchase of a consultative examination to provide further medical information, by recontact with a medical source who provided a consultative examination, or by questioning individuals familiar with your day-to-day functioning.

(B) Generally, we will not rely on a test score as a measurement of your functioning within a domain when the information we have about your functioning is the kind of information typically used by medical professionals to determine that the test results are not the best measure of your day-to-day functioning. When we do not rely on test scores, we will explain our reasons for doing so in your case record or in our decision.

(f) *How we will use the domains to help us evaluate your functioning.* (1) When we consider whether you have ''marked'' or ''extreme'' limitations in any domain, we examine all the information we have in your case record about how your functioning is limited because of your impairment(s), and we compare your functioning to the typical functioning of children your age who do not have impairments.

(2) The general descriptions of each domain in paragraphs (g)–(l) help us decide whether you have limitations in any given domain and whether these limitations are ''marked'' or ''extreme.''

(3) The domain descriptions also include examples of some activities typical of children in each age group and some functional limitations that we may consider. These examples also help us decide whether you have limitations in a domain because of your impairment(s). The examples are not all-inclusive, and we will not require our adjudicators to develop evidence about each specific example. When you have limitations in a given activity or activities in the examples, we may or may not decide that you have a ''marked'' or ''extreme'' limitation in the domain. We will consider the activities in which you are limited because of your impairment(s) and the extent of your limitations under the rules in paragraph (e) of this section. We will also consider all of the relevant provisions of §§416.924a, 416.924b, and 416.929.

(g) *Acquiring and using information.* In this domain, we consider how well you acquire or learn information, and how well you use the information you have learned.

(1) *General.* (i) Learning and thinking begin at birth. You learn as you explore the world through sight, sound, taste, touch, and smell. As you play, you acquire concepts and learn that people, things, and activities have names. This lets you understand symbols, which prepares you to use language for learning. Using the concepts and symbols you have acquired through play and learning experiences, you should be able to learn to read, write, do arithmetic, and understand and use new information.

(ii) Thinking is the application or use of information you have learned. It involves being able to perceive relationships, reason, and make logical choices. People think in different ways. When you think in pictures, you may solve a problem by watching and imitating what another person does. When you think in words, you may solve a problem by using language to talk your way through it. You must also be able to use language to think about the world and to understand others and express yourself; e.g., to follow directions, ask for information, or explain something.

(2) *Age group descriptors*—(i) *Newborns and young infants (birth to attainment of age 1).* At this age, you should show interest in, and explore, your environment. At first, your actions are random; for example, when you accidentally touch the mobile over your crib. Eventually, your actions should become deliberate and purposeful, as when you shake noisemaking toys like a bell or rattle. You should begin to recognize, and then anticipate, routine situations and events, as when you grin with expectation at the sight of your stroller. You should also recognize and gradually attach meaning to everyday sounds, as when you hear the telephone or your name. Eventually, you should recognize and respond to familiar words, including family names and what your favorite toys and activities are called.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* At this age, you are learning about the world around you. When you play, you should learn how objects go together in different ways. You should learn that by pretending, your actions can represent real things. This helps you understand that words represent things, and that words are simply symbols or names for toys, people, places, and activities. You should refer to yourself and things around you by pointing and eventually by naming. You should form concepts and solve simple problems through purposeful experimentation (e.g., taking toys apart), imitation, constructive play (e.g., building with blocks), and pretend play activities. You should begin to respond to increasingly complex instructions and questions, and to produce an increasing number of words and grammatically correct simple sentences and questions.

(iii) *Preschool children (age 3 to attainment of age 6).* When you are old enough to go to preschool or kindergarten, you should begin to learn and use the skills that will help you to read and write and do arithmetic when you are older. For example, listening to stories, rhyming words, and matching letters are skills needed for learning to read. Counting, sorting shapes, and building with blocks are skills needed to learn math. Painting, coloring, copying shapes, and using scissors are some of the skills needed in learning to write. Using words to ask questions, give answers, follow directions, describe things, explain what you mean, and tell stories allows you to acquire and share knowledge and experience of the world around you. All of these are called ''readiness skills,'' and you should have them by the time you begin first grade.

(iv) *School-age children (age 6 to attainment of age 12).* When you are old enough to go to elementary and middle school, you should be able to learn to read, write, and do math, and discuss history and science. You will need to use these skills in academic situations to demonstrate what you have learned; e.g., by reading about various subjects and producing oral and written projects, solving mathematical problems, taking achievement tests, doing group work, and entering into class discussions. You will also need to use these skills in daily living situations at home and in the community (e.g., reading street signs, telling time, and making change). You should be able to use

increasingly complex language (vocabulary and grammar) to share information and ideas with individuals or groups, by asking questions and expressing your own ideas, and by understanding and responding to the opinions of others.

(v) *Adolescents (age 12 to attainment of age 18).* In middle and high school, you should continue to demonstrate what you have learned in academic assignments (e.g., composition, classroom discussion, and laboratory experiments). You should also be able to use what you have learned in daily living situations without assistance (e.g., going to the store, using the library, and using public transportation). You should be able to comprehend and express both simple and complex ideas, using increasingly complex language (vocabulary and grammar) in learning and daily living situations (e.g., to obtain and convey information and ideas). You should also learn to apply these skills in practical ways that will help you enter the workplace after you finish school (e.g., carrying out instructions, preparing a job application, or being interviewed by a potential employer).

(3) *Examples of limited functioning in acquiring and using information.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a ''marked'' or ''extreme'' limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a ''marked'' or ''extreme'' limitation in this domain.

(i) You do not demonstrate understanding of words about space, size, or time; e.g., in/under, big/little, morning/night.

(ii) You cannot rhyme words or the sounds in words.

(iii) You have difficulty recalling important things you learned in school yesterday.

(iv) You have difficulty solving mathematics questions or computing arithmetic answers.

(v) You talk only in short, simple sentences and have difficulty explaining what you mean.

(h) *Attending and completing tasks.* In this domain, we consider how well you are able to focus and maintain your attention, and how well you begin, carry through, and finish your activities, including the pace at which you perform activities and the ease with which you change them.

(1) *General.* (i) Attention involves regulating your levels of alertness and initiating and maintaining concentration. It involves the ability to filter out distractions and to remain focused on an activity or task at a consistent level of performance. This means focusing long enough to initiate and complete an activity or task, and changing focus once it is completed. It also means that if you lose or change your focus in the middle of a task, you are able to return to the task without other people having to remind you frequently to finish it.

(ii) Adequate attention is needed to maintain physical and mental effort and concentration on an activity or task. Adequate attention permits you to think and reflect before starting or deciding to stop an activity. In other words, you are able to look ahead and predict the possible outcomes of your actions before you act. Focusing your attention allows you to attempt tasks at an appropriate pace. It also helps you determine the time needed to finish a task within an appropriate timeframe.

(2) *Age group descriptors*—(i) *Newborns and young infants (birth to attainment of age 1).* You should begin at birth to show sensitivity to your environment by responding to various stimuli (e.g., light, touch, temperature, movement). Very soon, you should be able to fix your gaze on a human face. You should stop your activity when you hear voices or sounds around you. Next, you should begin to attend to and follow various moving objects with your gaze, including people or toys. You should be

listening to your family's conversations for longer and longer periods of time. Eventually, as you are able to move around and explore your environment, you should begin to play with people and toys for longer periods of time. You will still want to change activities frequently, but your interest in continuing interaction or a game should gradually expand.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* At this age, you should be able to attend to things that interest you and have adequate attention to complete some tasks by yourself. As a toddler, you should demonstrate sustained attention, such as when looking at picture books, listening to stories, or building with blocks, and when helping to put on your clothes.

(iii) *Preschool children (age 3 to attainment of age 6).* As a preschooler, you should be able to pay attention when you are spoken to directly, sustain attention to your play and learning activities, and concentrate on activities like putting puzzles together or completing art projects. You should also be able to focus long enough to do many more things by yourself, such as getting your clothes together and dressing yourself, feeding yourself, or putting away your toys. You should usually be able to wait your turn and to change your activity when a caregiver or teacher says it is time to do something else.

(iv) *School-age children (age 6 to attainment of age 12).* When you are of school age, you should be able to focus your attention in a variety of situations in order to follow directions, remember and organize your school materials, and complete classroom and homework assignments. You should be able to concentrate on details and not make careless mistakes in your work (beyond what would be expected in other children your age who do not have impairments). You should be able to change your activities or routines without distracting yourself or others, and stay on task and in place when appropriate. You should be able to sustain your attention well enough to participate in group sports, read by yourself, and complete family chores. You should also be able to complete a transition task (e.g., be ready for the school bus, change clothes after gym, change classrooms) without extra reminders and accommodation.

(v) *Adolescents (age 12 to attainment of age 18).* In your later years of school, you should be able to pay attention to increasingly longer presentations and discussions, maintain your concentration while reading textbooks, and independently plan and complete long-range academic projects. You should also be able to organize your materials and to plan your time in order to complete school tasks and assignments. In anticipation of entering the workplace, you should be able to maintain your attention on a task for extended periods of time, and not be unduly distracted by your peers or unduly distracting to them in a school or work setting.

(3) *Examples of limited functioning in attending and completing tasks.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a ''marked'' or ''extreme'' limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a ''marked'' or ''extreme'' limitation in this domain.

(i) You are easily startled, distracted, or overreactive to sounds, sights, movements, or touch.

(ii) You are slow to focus on, or fail to complete activities of interest to you, e.g., games or art projects.

(iii) You repeatedly become sidetracked from your activities or you frequently interrupt others.

(iv) You are easily frustrated and give up on tasks, including ones you are capable of completing.

(v) You require extra supervision to keep you engaged in an activity.

(i) *Interacting and relating with others.* In this domain, we consider how well you initiate and sustain emotional connections with others, develop and use the language of your community, cooperate with others, comply with rules, respond to criticism, and respect and take care of the possessions of others.

(1) *General.* (i) Interacting means initiating and responding to exchanges with other people, for practical or social purposes. You interact with others by using facial expressions, gestures, actions, or words. You may interact with another person only once, as when asking a stranger for directions, or many times, as when describing your day at school to your parents. You may interact with people one-at-a-time, as when you are listening to another student in the hallway at school, or in groups, as when you are playing with others.

(ii) Relating to other people means forming intimate relationships with family members and with friends who are your age, and sustaining them over time. You may relate to individuals, such as your siblings, parents or best friend, or to groups, such as other children in childcare, your friends in school, teammates in sports activities, or people in your neighborhood.

(iii) Interacting and relating require you to respond appropriately to a variety of emotional and behavioral cues. You must be able to speak intelligibly and fluently so that others can understand you; participate in verbal turntaking and nonverbal exchanges; consider others' feelings and points of view; follow social rules for interaction and conversation; and respond to others appropriately and meaningfully.

(iv) Your activities at home or school or in your community may involve playing, learning, and working cooperatively with other children, one-at-a-time or in groups; joining voluntarily in activities with the other children in your school or community; and responding to persons in authority (e.g., your parent, teacher, bus driver, coach, or employer).

(2) *Age group descriptors*—(i) *Newborns and young infants (birth to attainment of age 1).* You should begin to form intimate relationships at birth by gradually responding visually and vocally to your caregiver(s), through mutual gaze and vocal exchanges, and by physically molding your body to the caregiver's while being held. You should eventually initiate give-and-take games (such as pat-a-cake, peek-a-boo) with your caregivers, and begin to affect others through your own purposeful behavior (e.g., gestures and vocalizations). You should be able to respond to a variety of emotions (e.g., facial expressions and vocal tone changes). You should begin to develop speech by using vowel sounds and later consonants, first alone, and then in babbling.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* At this age, you are dependent upon your caregivers, but should begin to separate from them. You should be able to express emotions and respond to the feelings of others. You should begin initiating and maintaining interactions with adults, but also show interest in, then play alongside, and eventually interact with other children your age. You should be able to spontaneously communicate your wishes or needs, first by using gestures, and eventually by speaking words clearly enough that people who know you can understand what you say most of the time.

(iii) *Preschool children (age 3 to attainment of age 6).* At this age, you should be able to socialize with children as well as adults. You should begin to prefer playmates your own age and start to develop friendships with children who are your age. You should be able to use words instead of actions to express yourself, and also be better able to share, show affection, and offer to help. You should be able to relate to caregivers with increasing independence, choose your own friends, and play cooperatively with other children, one-at-a-time or in a group, without continual adult supervision. You should be able to initiate and participate in conversations, using increasingly complex vocabulary and grammar, and speaking clearly enough that both familiar and unfamiliar listeners can understand what you say most of the time.

(iv) *School-age children (age 6 to attainment of age 12).* When you enter school, you should be able to develop more lasting friendships with children who are your age. You should begin to

understand how to work in groups to create projects and solve problems. You should have an increasing ability to understand another's point of view and to tolerate differences. You should be well able to talk to people of all ages, to share ideas, tell stories, and to speak in a manner that both familiar and unfamiliar listeners readily understand.

(v) *Adolescents (age 12 to attainment of age 18).* By the time you reach adolescence, you should be able to initiate and develop friendships with children who are your age and to relate appropriately to other children and adults, both individually and in groups. You should begin to be able to solve conflicts between yourself and peers or family members or adults outside your family. You should recognize that there are different social rules for you and your friends and for acquaintances or adults. You should be able to intelligibly express your feelings, ask for assistance in getting your needs met, seek information, describe events, and tell stories, in all kinds of environments (e.g., home, classroom, sports, extra-curricular activities, or part-time job), and with all types of people (e.g., parents, siblings, friends, classmates, teachers, employers, and strangers).

(3) *Examples of limited functioning in interacting and relating with others.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a ''marked'' or ''extreme'' limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a ''marked'' or ''extreme'' limitation in this domain.

(i) You do not reach out to be picked up and held by your caregiver.

(ii) You have no close friends, or your friends are all older or younger than you.

(iii) You avoid or withdraw from people you know, or you are overly anxious or fearful of meeting new people or trying new experiences.

(iv) You have difficulty playing games or sports with rules.

(v) You have difficulty communicating with others; e.g., in using verbal and nonverbal skills to express yourself, carrying on a conversation, or in asking others for assistance.

(vi) You have difficulty speaking intelligibly or with adequate fluency.

(j) *Moving about and manipulating objects.* In this domain, we consider how you move your body from one place to another and how you move and manipulate things. These are called gross and fine motor skills.

(1) *General.* (i) Moving your body involves several different kinds of actions: Rolling your body; rising or pulling yourself from a sitting to a standing position; pushing yourself up; raising your head, arms, and legs, and twisting your hands and feet; balancing your weight on your legs and feet; shifting your weight while sitting or standing; transferring yourself from one surface to another; lowering yourself to or toward the floor as when bending, kneeling, stooping, or crouching; moving yourself forward and backward in space as when crawling, walking, or running, and negotiating different terrains (e.g., curbs, steps, and hills).

(ii) Moving and manipulating things involves several different kinds of actions: Engaging your upper and lower body to push, pull, lift, or carry objects from one place to another; controlling your shoulders, arms, and hands to hold or transfer objects; coordinating your eyes and hands to manipulate small objects or parts of objects.

(iii) These actions require varying degrees of strength, coordination, dexterity, pace, and physical ability to persist at the task. They also require a sense of where your body is and how it moves in space; the integration of sensory input with motor output; and the capacity to plan, remember, and execute controlled motor movements.

(2) *Age group descriptors*—(i) *Newborns and infants (birth to attainment of age 1).* At birth, you should begin to explore your world by moving your body and by using your limbs. You should learn to hold your head up, sit, crawl, and stand, and sometimes hold onto a stable object and stand actively for brief periods. You should begin to practice your developing eye-hand control by reaching for objects or picking up small objects and dropping them into containers.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* At this age, you should begin to explore actively a wide area of your physical environment, using your body with steadily increasing control and independence from others. You should begin to walk and run without assistance, and climb with increasing skill. You should frequently try to manipulate small objects and to use your hands to do or get something that you want or need. Your improved motor skills should enable you to play with small blocks, scribble with crayons, and feed yourself.

(iii) *Preschool children (age 3 to attainment of age 6).* As a preschooler, you should be able to walk and run with ease. Your gross motor skills should let you climb stairs and playground equipment with little supervision, and let you play more independently; e.g., you should be able to swing by yourself and may start learning to ride a tricycle. Your fine motor skills should also be developing. You should be able to complete puzzles easily, string beads, and build with an assortment of blocks. You should be showing increasing control of crayons, markers, and small pieces in board games, and should be able to cut with scissors independently and manipulate buttons and other fasteners.

(iv) *School-age children (age 6 to attainment of age 12).* As a school-age child, your developing gross motor skills should let you move at an efficient pace about your school, home, and neighborhood. Your increasing strength and coordination should expand your ability to enjoy a variety of physical activities, such as running and jumping, and throwing, kicking, catching and hitting balls in informal play or organized sports. Your developing fine motor skills should enable you to do things like use many kitchen and household tools independently, use scissors, and write.

(v) *Adolescents (age 12 to attainment of age 18).* As an adolescent, you should be able to use your motor skills freely and easily to get about your school, the neighborhood, and the community. You should be able to participate in a full range of individual and group physical fitness activities. You should show mature skills in activities requiring eye-hand coordination, and should have the fine motor skills needed to write efficiently or type on a keyboard.

(3) *Examples of limited functioning in moving about and manipulating objects.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a ''marked'' or ''extreme'' limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a ''marked'' or ''extreme'' limitation in this domain.

(i) You experience muscle weakness, joint stiffness, or sensory loss (e.g., spasticity, hypotonia, neuropathy, or paresthesia) that interferes with your motor activities (e.g., you unintentionally drop things).

(ii) You have trouble climbing up and down stairs, or have jerky or disorganized locomotion or difficulty with your balance.

(iii) You have difficulty coordinating gross motor movements (e.g., bending, kneeling, crawling, running, jumping rope, or riding a bike).

(iv) You have difficulty with sequencing hand or finger movements.

(v) You have difficulty with fine motor movement (e.g., gripping or grasping objects).

(vi) You have poor eye-hand coordination when using a pencil or scissors.

(k) *Caring for yourself.* In this domain, we consider how well you maintain a healthy emotional and physical state, including how well you get your physical and emotional wants and needs met in appropriate ways; how you cope with stress and changes in your environment; and whether you take care of your own health, possessions, and living area.

(1) *General.* (i) Caring for yourself effectively, which includes regulating yourself, depends upon your ability to respond to changes in your emotions and the daily demands of your environment to help yourself and cooperate with others in taking care of your personal needs, health and safety. It is characterized by a sense of independence and competence. The effort to become independent and competent should be observable throughout your childhood.

(ii) Caring for yourself effectively means becoming increasingly independent in making and following your own decisions. This entails relying on your own abilities and skills, and displaying consistent judgment about the consequences of caring for yourself. As you mature, using and testing your own judgment helps you develop confidence in your independence and competence. Caring for yourself includes using your independence and competence to meet your physical needs, such as feeding, dressing, toileting, and bathing, appropriately for your age.

(iii) Caring for yourself effectively requires you to have a basic understanding of your body, including its normal functioning, and of your physical and emotional needs. To meet these needs successfully, you must employ effective coping strategies, appropriate to your age, to identify and regulate your feelings, thoughts, urges, and intentions. Such strategies are based on taking responsibility for getting your needs met in an appropriate and satisfactory manner.

(iv) Caring for yourself means recognizing when you are ill, following recommended treatment, taking medication as prescribed, following safety rules, responding to your circumstances in safe and appropriate ways, making decisions that do not endanger yourself, and knowing when to ask for help from others.

(2) *Age group descriptors*—(i) *Newborns and infants (birth to attainment of age 1.* Your sense of independence and competence begins in being able to recognize your body's signals (e.g., hunger, pain, discomfort), to alert your caregiver to your needs (e.g., by crying), and to console yourself (e.g., by sucking on your hand) until help comes. As you mature, your capacity for self-consolation should expand to include rhythmic behaviors (e.g., rocking). Your need for a sense of competence also emerges in things you try to do for yourself, perhaps before you are ready to do them, as when insisting on putting food in your mouth and refusing your caregiver's help.

(ii) *Older infants and toddlers (age 1 to attainment of age 3).* As you grow, you should be trying to do more things for yourself that increase your sense of independence and competence in your environment. You might console yourself by carrying a favorite blanket with you everywhere. You should be learning to cooperate with your caregivers when they take care of your physical needs, but you should also want to show what you can do; e.g., pointing to the bathroom, pulling off your coat. You should be experimenting with your independence by showing some degree of contrariness (e.g., ''No! No!'') and identity (e.g., hoarding your toys).

(iii) *Preschool children (age 3 to attainment of age 6).* You should want to take care of many of your physical needs by yourself (e.g., putting on your shoes, getting a snack), and also want to try doing some things that you cannot do fully (e.g., tying your shoes, climbing on a chair to reach something up high, taking a bath). Early in this age range, it may be easy for you to agree to do what your caregiver asks. Later, that may be difficult for you because you want to do things your way or not at all. These changes usually mean that you are more confident about your ideas and what you are able to do. You should also begin to understand how to control behaviors that are not good for you (e.g., crossing the street without an adult).

(iv) *School-age children (age 6 to attainment of age 12).* You should be independent in most day-to-day activities (e.g., dressing yourself, bathing yourself), although you may still need to be reminded sometimes to do these routinely. You should begin to recognize that you are competent in doing some activities and that you have difficulty with others. You should be able to identify those circumstances when you feel good about yourself and when you feel bad. You should begin to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior. You should begin to demonstrate consistent control over your behavior, and you should be able to avoid behaviors that are unsafe or otherwise not good for you. You should begin to imitate more of the behavior of adults you know.

(v) *Adolescents (age 12 to attainment of age 18).* You should feel more independent from others and should be increasingly independent in all of your day-to-day activities. You may sometimes experience confusion in the way you feel about yourself. You should begin to notice significant changes in your body's development, and this can result in anxiety or worrying about yourself and your body. Sometimes these worries can make you feel angry or frustrated. You should begin to discover appropriate ways to express your feelings, both good and bad (e.g., keeping a diary to sort out angry feelings or listening to music to calm yourself down). You should begin to think seriously about your future plans, and what you will do when you finish school.

(3) *Examples of limited functioning in caring for yourself.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a ''marked'' or ''extreme'' limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a ''marked'' or ''extreme'' limitation in this domain.

(i) You continue to place non-nutritive or inedible objects in your mouth.

(ii) You often use self-soothing activities showing developmental regression (e.g., thumbsucking, re-chewing food), or you have restrictive or stereotyped mannerisms (e.g., body rocking, headbanging).

(iii) You do not dress or bathe yourself appropriately for your age because you have an impairment(s) that affects this domain.

(iv) You engage in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take your medication), or you ignore safety rules.

(v) You do not spontaneously pursue enjoyable activities or interests.

(vi) You have disturbance in eating or sleeping patterns.

(l) *Health and physical well-being.* In this domain, we consider the cumulative physical effects of physical or mental impairments and their associated treatments or therapies on your functioning that we did not consider in paragraph (j) of this section. When your physical impairment(s), your mental impairment(s), or your combination of physical and mental impairments has physical effects that cause ''extreme'' limitation in your functioning, you will generally have an impairment(s) that ''meets'' or ''medically equals'' a listing.

(1) A physical or mental disorder may have physical effects that vary in kind and intensity, and may make it difficult for you to perform your activities independently or effectively. You may experience problems such as generalized weakness, dizziness, shortness of breath, reduced stamina, fatigue, psychomotor retardation, allergic reactions, recurrent infection, poor growth, bladder or bowel incontinence, or local or generalized pain.

(2) In addition, the medications you take (e.g., for asthma or depression) or the treatments you receive (e.g., chemotherapy or multiple surgeries) may have physical effects that also limit your performance of activities.

(3) Your illness may be chronic with stable symptoms, or episodic with periods of worsening and improvement. We will consider how you function during periods of worsening and how often and for how long these periods occur. You may be medically fragile and need intensive medical care to maintain your level of health and physical well-being. In any case, as a result of the illness itself, the medications or treatment you receive, or both, you may experience physical effects that interfere with your functioning in any or all of your activities.

(4) *Examples of limitations in health and physical well-being.* The following examples describe some limitations we may consider in this domain. Your limitations may be different from the ones listed here. Also, the examples do not necessarily describe a ''marked'' or ''extreme'' limitation. Whether an example applies in your case may depend on your age and developmental stage; e.g., an example below may describe a limitation in an older child, but not a limitation in a younger one. As in any case, your limitations must result from your medically determinable impairment(s). However, we will consider all of the relevant information in your case record when we decide whether your medically determinable impairment(s) results in a ''marked'' or ''extreme'' limitation in this domain.

(i) You have generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy (e.g., fatigue or loss of energy or stamina), or psychomotor retardation because of your impairment(s).

(ii) You have somatic complaints related to your impairments (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches, or insomnia).

(iii) You have limitations in your physical functioning because of your treatment (e.g., chemotherapy, multiple surgeries, chelation, pulmonary cleansing, or nebulizer treatments).

(iv) You have exacerbations from one impairment or a combination of impairments that interfere with your physical functioning.

(v) You are medically fragile and need intensive medical care to maintain your level of health and physical well-being.

(m) *Examples of impairments that functionally equal the listings.* The following are some examples of impairments and limitations that functionally equal the listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to the examples in this paragraph, because these examples do not describe all possible effects of impairments that might be found to functionally equal the listings. As with any disabling impairment, the duration requirement must also be met (*see* §§ 416.909 and 416.924(a)).

(1) Any physical impairment(s) or combination of physical and mental impairments causing complete inability to function independently outside the area of one's home within age-appropriate norms.

(2) Requirement for 24-hour-a-day supervision for medical (including psychological) reasons.

(3) Major congenital organ dysfunction which could be expected to result in death within the first year of life without surgical correction, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until attainment of 1 year of age.

(n) *Responsibility for determining functional equivalence.* In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (*see* § 416.1016 of this part) has the overall responsibility for determining functional equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining functional equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 416.1418 of this part, with the Associate Commissioner for Disability Programs or his or her delegate. For cases

at the administrative law judge or Appeals Council level, the responsibility for deciding functional equivalence rests with the administrative law judge or Appeals Council.

[62 FR 6424, Feb. 11, 1997; 62 FR 13538, 13733, Mar. 21, 1997, as amended at 65 FR 54782, Sept. 11, 2000; 65 FR 80308, Dec. 21, 2000; 66 FR 58045, Nov. 19, 2001; 71 FR 16460, Mar. 31, 2006; 72 FR 59431, Oct. 19, 2007; 76 FR 24811, May 3, 2011; 80 FR 19530, Apr. 13, 2015; 81 FR 37153, June 9, 2016; 82 FR 5880, Jan. 18, 2017; 85 FR 78189, Dec. 3, 2020]

§416.927 Evaluating opinion evidence for claims filed before March 27, 2017.

For claims filed (see §416.325) before March 27, 2017, the rules in this section apply. For claims filed on or after March 27, 2017, the rules in §416.920c apply.

(a) *Definitions.*

(1) *Medical opinions.* Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(2) *Treating source.* Treating source means your own acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment or evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

(b) *How we consider medical opinions.* In determining whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive. See §416.920b.

(c) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's medical opinion controlling weight under paragraph (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship.* Generally, we give more weight to the medical opinion of a source who has examined you than to the medical opinion of a medical source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's medical opinion.

(i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the medical source's medical opinion more weight than we would give it if it were from a nontreating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her medical opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's medical opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support a medical opinion, particularly medical signs and laboratory findings, the more weight we will give that medical opinion. The better an explanation a source provides for a medical opinion, the more weight we will give that medical opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their medical opinions will depend on the degree to which they provide supporting explanations for their medical opinions. We will evaluate the degree to which these medical opinions consider all of the pertinent evidence in your claim, including medical opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent a medical opinion is with the record as a whole, the more weight we will give to that medical opinion.

(5) *Specialization.* We generally give more weight to the medical opinion of a specialist about medical issues related to his or her area of specialty than to the medical opinion of a source who is not a specialist.

(6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the medical opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that a medical source has, regardless of the source of that understanding, and the extent to which a medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(d) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(1) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.*, that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are ''disabled'' or ''unable to work'' does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1

to subpart P of part 404 of this chapter, your residual functional capacity (see §§ 416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

(e) *Evidence from our Federal or State agency medical or psychological consultants.* The rules in § 416.913a apply except that when an administrative law judge gives controlling weight to a treating source's medical opinion, the administrative law judge is not required to explain in the decision the weight he or she gave to the prior administrative medical findings in the claim.

(f) *Opinions from medical sources who are not acceptable medical sources and from nonmedical sources.*

(1) *Consideration.* Opinions from medical sources who are not acceptable medical sources and from nonmedical sources may reflect the source's judgment about some of the same issues addressed in medical opinions from acceptable medical sources. Although we will consider these opinions using the same factors as listed in paragraph (c)(1) through (c)(6) in this section, not every factor for weighing opinion evidence will apply in every case because the evaluation of an opinion from a medical source who is not an acceptable medical source or from a nonmedical source depends on the particular facts in each case. Depending on the particular facts in a case, and after applying the factors for weighing opinion evidence, an opinion from a medical source who is not an acceptable medical source or from a nonmedical source may outweigh the medical opinion of an acceptable medical source, including the medical opinion of a treating source. For example, it may be appropriate to give more weight to the opinion of a medical source who is not an acceptable medical source if he or she has seen the individual more often than the treating source, has provided better supporting evidence and a better explanation for the opinion, and the opinion is more consistent with the evidence as a whole.

(2) *Articulation.* The adjudicator generally should explain the weight given to opinions from these sources or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning, when such opinions may have an effect on the outcome of the case. In addition, when an adjudicator determines that an opinion from such a source is entitled to greater weight than a medical opinion from a treating source, the adjudicator must explain the reasons in the notice of decision in hearing cases and in the notice of determination (that is, in the personalized disability notice) at the initial and reconsideration levels, if the determination is less than fully favorable.

[82 FR 5880, Jan. 18, 2017; 82 FR 15133, Mar. 27, 2017]

§ 416.928 [Reserved]

§ 416.929 How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. We will consider all of your statements about your symptoms, such as pain, and any description your medical sources or nonmedical sources may provide about how the symptoms affect your activities of daily living and your ability to work (or, if you are a child, your functioning). However, statements about your pain or other symptoms will not alone establish that you are disabled. There must be objective medical evidence from an acceptable medical source that shows you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and that, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In

evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements about how your symptoms affect you. We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work (or if you are a child, your functioning).

(b) *Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain.* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect your ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. In cases decided by a State agency (except in disability hearings under §§ 416.1414 through 416.1418 of this part and in fully favorable determinations made by State agency disability examiners alone under § 416.1015(c)(3) of this part), a State agency medical or psychological consultant or other medical or psychological consultant designated by the Commissioner directly participates in determining whether your medically determinable impairment(s) could reasonably be expected to produce your alleged symptoms. In the disability hearing process, a medical or psychological consultant may provide an advisory assessment to assist a disability hearing officer in determining whether your impairment(s) could reasonably be expected to produce your alleged symptoms. At the administrative law judge hearing or Appeals Council level of the administrative review process, the adjudicator(s) may ask for and consider the opinion of a medical or psychological expert concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. The finding that your impairment(s) could reasonably be expected to produce your pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of your symptoms. We will develop evidence regarding the possibility of a medically determinable mental impairment when we have information to suggest that such an impairment exists, and you allege pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work or, if you are a child, your functioning*—(1) *General.* When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work or, if you are a child, your functioning. In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence from your medical sources and nonmedical sources about how your symptoms affect you. We also consider the medical opinions as explained in § 416.920c. Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work (or, if you are a child, your functioning) when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain.

(2) *Consideration of objective medical evidence.* Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such

as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of your symptoms and the effect those symptoms, such as pain, may have on your ability to work or, if you are a child, your functioning. We must always attempt to obtain objective medical evidence and, when it is obtained, we will consider it in reaching a conclusion as to whether you are disabled. However, we will not reject your statements about the intensity and persistence of your pain or other symptoms or about the effect your symptoms have on your ability to work (or if you are a child, to function independently, appropriately, and effectively in an age-appropriate manner) solely because the available objective medical evidence does not substantiate your statements.

(3) *Consideration of other evidence.* Because symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that your medical sources or nonmedical sources provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions that your medical sources or nonmedical sources report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your medical sources, and observations by our employees and other persons. If you are a child, we will also consider all of the evidence presented, including evidence submitted by your medical sources (such as physicians, psychologists, and therapists) and nonmedical sources (such as educational agencies and personnel, parents and other relatives, and social welfare agencies). Section 416.920c explains in detail how we consider medical opinions and prior administrative medical findings about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

(i) Your daily activities;

(ii) The location, duration, frequency, and intensity of your pain or other symptoms;

(iii) Precipitating and aggravating factors;

(iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate your pain or other symptoms;

(v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;

(vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and

(vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms.

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities, or, if you are a child, your functioning).* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities (or if you are a child, your functioning), we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. We will consider your statements about the intensity, persistence, and limiting effects of your symptoms, and we will evaluate your statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether you are disabled. We will consider whether there are any inconsistencies in the evidence and the extent to which there

are any conflicts between your statements and the rest of the evidence, including your history, the signs and laboratory findings, and statements by your medical sources or other persons about how your symptoms affect you. Your symptoms, including pain, will be determined to diminish your capacity for basic work activities (or, if you are a child, your functioning) to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) *Consideration of symptoms in the disability determination process.* We follow a set order of steps to determine whether you are disabled. If you are not doing substantial gainful activity, we consider your symptoms, such as pain, to evaluate whether you have a severe physical or mental impairment(s), and at each of the remaining steps in the process. Sections 416.920 and 416.920a (for adults) and 416.924 (for children) explain this process in detail. We also consider your symptoms, such as pain, at the appropriate steps in our review when we consider whether your disability continues. The procedure we follow in reviewing whether your disability continues is explained in §416.994 (for adults) and §416.994a (for children).

(1) *Need to establish a severe medically determinable impairment(s).* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether your impairment or combination of impairment(s) is severe. (See §416.920(c) for adults and §416.924(c) for children.)

(2) *Decision whether the Listing of Impairments is met.* Some listed impairments include symptoms usually associated with those impairments as criteria. Generally, when a symptom is one of the criteria in a listing, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence, or limiting effects of the symptom as long as all other findings required by the specific listing are present.

(3) *Decision whether the Listing of Impairments is equaled.* If your impairment is not the same as a listed impairment, we must determine whether your impairment(s) is medically equivalent to a listed impairment. Section 416.926 explains how we make this determination. Under §416.926(b), we will consider medical equivalence based on all evidence in your case record about your impairment(s) and its effects on you that is relevant to this finding. In considering whether your symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether your symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute your allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of your impairment(s) to that of a listed impairment. (If you are a child and we cannot find equivalence based on medical evidence only, we will consider pain and other symptoms under §§416.924a and 416.926a in determining whether you have an impairment(s) that functionally equals the listings.) Regardless of whether you are an adult or a child, if the symptoms, signs, and laboratory findings of your impairment(s) are equivalent in severity to those of a listed impairment, we will find you disabled. (If you are a child and your impairment(s) functionally equals the listings under the rules in §416.926a, we will also find you disabled.) If they are not, we will consider the impact of your symptoms on your residual functional capacity if you are an adult. If they are not, we will consider the impact of your symptoms on your residual functional capacity if you are an adult. (See paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity or, if you are a child, on your functioning.* If you have a medically determinable severe physical or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in appendix

1 of subpart P of part 404 of this chapter, we will consider the impact of your impairment(s) and any related symptoms, including pain, or your residual functional capacity, if you are an adult, or, on your functioning if you are a child. (*See* §§ 416.945 and 416.924a–416.924b.)

[56 FR 57944, Nov. 14, 1991, as amended at 62 FR 6429, Feb. 11, 1997; 62 FR 13538, Mar. 21, 1997; 62 FR 38454, July 18, 1997; 65 FR 16814, Mar. 30, 2000; 65 FR 54789, Sept. 11, 2000; 71 FR 10431, Mar. 1, 2006; 71 FR 16461, Mar. 31, 2006; 75 FR 62683, Oct. 13, 2010; 76 FR 24811, May 3, 2011; 82 FR 5882, Jan. 18, 2017]

§ 416.930 Need to follow prescribed treatment.

(a) *What treatment you must follow.* In order to get benefits, you must follow treatment prescribed by your medical source(s) if this treatment is expected to restore your ability to work.

(b) *When you do not follow prescribed treatment.* If you do not follow the prescribed treatment without a good reason, we will not find you disabled or blind or, if you are already receiving benefits, we will stop paying you benefits.

(c) *Acceptable reasons for failure to follow prescribed treatment.* We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have an acceptable reason for failure to follow prescribed treatment. The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of your religion.

(2) The prescribed treatment would be cataract surgery for one eye when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through treatment.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its enormity (e.g., open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for you; or

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

[45 FR 55621, Aug. 20, 1980, as amended at 59 FR 1636, Jan. 12, 1994; 62 FR 6429, Feb. 11, 1997; 82 FR 5882, Jan. 18, 2017]

PRESUMPTIVE DISABILITY AND BLINDNESS

§ 416.931 The meaning of presumptive disability or presumptive blindness.

If you are applying for supplemental security income benefits on the basis of disability or blindness, we may pay you benefits before we make a formal finding of whether or not you are disabled or blind. In order to receive these payments, we must find that you are presumptively disabled or presumptively blind. You must also meet all other eligibility requirements for supplemental security income benefits. We may make these payments to you for a period not longer than 6 months. These payments will not be considered overpayments if we later find that you are not disabled or blind.

[45 FR 55621, Aug. 20, 1980, as amended at 57 FR 53853, Nov. 13, 1992]

§ 416.932 When presumptive payments begin and end.

We may make payments to you on the basis of presumptive disability or presumptive blindness before we make a formal determination about your disability or blindness. The payments can not be made for more than 6 months. They start for a period of not more than 6 months beginning in the month we make the presumptive disability or presumptive blindness finding. The payments end the earliest of—

(a) The month in which we make a formal finding on whether or not you are disabled or blind;

(b) The month for which we make the sixth monthly payment based on presumptive disability or presumptive blindness to you; or

(c) The month in which you no longer meet one of the other eligibility requirements (e.g., your income exceeds the limits).

[45 FR 55621, Aug. 20, 1980, as amended at 57 FR 53853, Nov. 13, 1992]

§ 416.933 How we make a finding of presumptive disability or presumptive blindness.

We may make a finding of presumptive disability or presumptive blindness if the evidence available at the time we make the presumptive disability or presumptive blindness finding reflects a high degree of probability that you are disabled or blind. In the case of readily observable impairments (e.g., total blindness), we will find that you are disabled or blind for purposes of this section without medical or other evidence. For other impairments, a finding of disability or blindness must be based on medical evidence or other information that, though not sufficient for a formal determination of disability or blindness, is sufficient for us to find that there is a high degree of probability that you are disabled or blind. For example, for claims involving the human immunodeficiency virus (HIV), the Social Security Field Office may make a finding of presumptive disability if your medical source provides us with information that confirms that your disease manifestations meet the severity of listing-level criteria for HIV. Of course, regardless of the specific HIV manifestations, the State agency may make a finding of presumptive disability if the medical evidence or other information reflects a high degree of probability that you are disabled.

[58 FR 36063, July 2, 1993, as amended at 66 FR 58046, Nov. 19, 2001]

§ 416.934 Impairments that may warrant a finding of presumptive disability or presumptive blindness.

We may make findings of presumptive disability and presumptive blindness in specific impairment categories without obtaining any medical evidence. These specific impairment categories are—

(a) Amputation of a leg at the hip;

(b) Allegation of total deafness;

(c) Allegation of total blindness;

(d) Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, due to a long-standing condition, excluding recent accident and recent surgery;

(e) Allegation of a stroke (cerebral vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm;

(f) Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.

(g) Allegation of Down syndrome.

(h) Allegation of intellectual disability or another neurodevelopmental impairment (for example, autism spectrum disorder) with complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing) made by another person who files on behalf of a claimant who is at least 4 years old.

(i) Allegation of amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease).

(j) Infants weighing less than 1200 grams at birth, until attainment of 1 year of age.

(k) Infants weighing at least 1200 but less than 2000 grams at birth, and who are small for gestational age, until attainment of 1 year of age. (Small for gestational age means a birth weight that is at or more than 2 standard deviations below the mean or that is less than the third growth percentile for the gestational age of the infant.)

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 5574, Feb. 11, 1985; 53 FR 3741, Feb. 9, 1988; 56 FR 65684, Dec. 18, 1991; 67 FR 58046, Nov. 19, 2001; 68 FR 51693, Aug. 28, 2003; 80 FR 19530, Apr. 13, 2015; 81 FR 66178, Sept. 26, 2016]

DRUG ADDICTION AND ALCOHOLISM

§ 416.935 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability, unless we find that you are eligible for benefits because of your age or blindness.

(b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug

addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

[60 FR 8151, Feb. 10, 1995]

§ 416.936 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) If we determine that you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability, you must avail yourself of appropriate treatment for your drug addiction or alcoholism at an institution or facility approved by us when this treatment is available and make progress in your treatment. Generally, you are not expected to pay for this treatment. You will not be paid benefits for any month after the month we have notified you in writing that—

(1) You did not comply with the terms, conditions and requirements of the treatment which has been made available to you; or

(2) You did not avail yourself of the treatment after you had been notified that it is available to you.

(b) If your benefits are suspended for failure to comply with treatment requirements, your benefits can be reinstated in accordance with the rules in § 416.1326.

[60 FR 8151, Feb. 10, 1995]

§ 416.937 What we mean by appropriate treatment.

By appropriate treatment, we mean treatment for drug addiction or alcoholism that serves the needs of the individual in the least restrictive setting possible consistent with your treatment plan. These settings range from outpatient counseling services through a variety of residential treatment settings including acute detoxification, short-term intensive residential treatment, long-term therapeutic residential treatment, and long-term recovery houses. Appropriate treatment is determined with the involvement of a State licensed or certified addiction professional on the basis of a detailed assessment of the individual's presenting symptomatology, psychosocial profile, and other relevant factors. This assessment may lead to a determination that more than one treatment modality is appropriate for the individual. The treatment will be provided or overseen by an approved institution or facility. This treatment may include (but is not limited to)—

(a) Medical examination and medical management;

(b) Detoxification;

(c) Medication management to include substitution therapy (e.g., methadone);

(d) Psychiatric, psychological, psychosocial, vocational, or other substance abuse counseling in a residential or outpatient treatment setting; or

(e) Relapse prevention.

[60 FR 8151, Feb. 10, 1995]

§ 416.938 What we mean by approved institutions or facilities.

Institutions or facilities that we may approve include—

(a) An institution or facility that furnishes medically recognized treatment for drug addiction or alcoholism in conformity with applicable Federal or State laws and regulations;

(b) An institution or facility used by or licensed by an appropriate State agency which is authorized to refer

persons for treatment of drug addiction or alcoholism;

(c) State licensed or certified care providers;

(d) Programs accredited by the Commission on Accreditation for Rehabilitation Facilities (CARF) and/or the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) for the treatment of drug addiction or alcoholism;

(e) Medicare or Medicaid certified care providers; or

(f) Nationally recognized self-help drug addiction or alcoholism recovery programs (e.g., Alcoholics Anonymous or Narcotics Anonymous) when participation in these programs is specifically prescribed by a treatment professional at an institution or facility described in paragraphs (a) through (e) of this section as part of an individual's treatment plan.

[60 FR 8151, Feb. 10, 1995]

§ 416.939 How we consider whether treatment is available.

Our determination about whether treatment is available to you for your drug addiction or your alcoholism will depend upon—

(a) The capacity of an approved institution or facility to admit you for appropriate treatment;

(b) The location of the approved institution or facility, or the place where treatment, services or resources could be provided to you;

(c) The availability and cost of transportation for you to the place of treatment;

(d) Your general health, including your ability to travel and capacity to understand and follow the prescribed treatment;

(e) Your particular condition and circumstances; and

(f) The treatment that is prescribed for your drug addiction or alcoholism.

[60 FR 8151, Feb. 10, 1995]

§ 416.940 Evaluating compliance with the treatment requirements.

(a) *General.* Generally, we will consider information from the treatment institution or facility to evaluate your compliance with your treatment plan. The treatment institution or facility will—

(1) Monitor your attendance at and participation in treatment sessions;

(2) Provide reports of the results of any clinical testing (such as, hematological or urinalysis studies for individuals with drug addiction and hematological studies and breath analysis for individuals with alcoholism) when such tests are likely to yield important information;

(3) Provide observational reports from the treatment professionals familiar with your individual case (subject to verification and Federal confidentiality requirements); or

(4) Provide their assessment or views on your noncompliance with treatment requirements.

(b) *Measuring progress.* Generally, we will consider information from the treatment institution or facility to evaluate your progress in completing your treatment plan. Examples of milestones for measuring your progress with the treatment which has been prescribed for your drug addiction or alcoholism may include (but are not limited to)—

(1) Abstinence from drug or alcohol use (initial progress may include significant reduction in use);

(2) Consistent attendance at and participation in treatment sessions;

(3) Improved social functioning and levels of gainful activity;

(4) Participation in vocational rehabilitation activities; or

(5) Avoidance of criminal activity.

[60 FR 8151, Feb. 10, 1995]

§ 416.941 Establishment and use of referral and monitoring agencies.

We will contract with one or more agencies in each of the States and the District of Columbia to provide services to individuals whose disabilities are based on a determination that drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 416.935) and to submit information to us which we will use to make decisions about these individuals' benefits. These agencies will be known as referral and monitoring agencies. Their duties and responsibilities include (but are not limited to)—

(a) Identifying appropriate treatment placements for individuals we refer to them;

(b) Referring these individuals for treatment;

(c) Monitoring the compliance and progress with the appropriate treatment of these individuals; and

(d) Promptly reporting to us any individual's failure to comply with treatment requirements as well as failure to achieve progress through the treatment.

[60 FR 8152, Feb. 10, 1995]

RESIDUAL FUNCTIONAL CAPACITY

§ 416.945 Your residual functional capacity.

(a) *General*—(1) *Residual functional capacity assessment.* Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is the most you can still do despite your limitations. We will assess your residual functional capacity based on all the relevant evidence in your case record. (*See* § 416.946.)

(2) *If you have more than one impairment.* We will consider all of your medically determinable impairments of which we are aware, including your medically determinable impairments that are not ''severe,'' as explained in §§ 416.920(c), 416.921, and 416.923, when we assess your residual functional capacity. (*See* paragraph (e) of this section.)

(3) *Evidence we use to assess your residual functional capacity.* We will assess your residual functional capacity based on all of the relevant medical and other evidence. In general, you are responsible for providing the evidence we will use to make a finding about your residual functional capacity. (*See* § 416.912(c).) However, before we make a determination that you are not disabled, we are responsible for developing your complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help you get medical reports from your own medical sources. (*See* §§ 416.912(d) through (e).) We will consider any statements about what you can still do that have been provided by medical sources, whether or not they are based on formal medical examinations. (*See* § 416.913.) We will also consider descriptions and observations of your limitations from your impairment(s), including limitations that result from your symptoms, such as pain, provided by you, your family, neighbors, friends, or other persons. (*See* paragraph (e) of this section and § 416.929.)

(4) *What we will consider in assessing residual functional capacity.* When we assess your residual functional capacity, we will consider your ability to meet the physical, mental, sensory, and other requirements of work, as described in paragraphs (b), (c), and (d) of this section.

(5) *How we will use our residual functional capacity assessment.* (i) We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work. (*See* §§ 416.920(f) and 416.960(b).)

(ii) If we find that you cannot do your past relevant work, you do not have any past relevant work, or if we use the procedures in § 416.920(h) and § 416.962 does not apply, we will use the same assessment of your residual functional capacity at step five of the sequential evaluation process to decide if you can adjust to any other work that exists in the national economy. (*See* §§ 416.920(g) and 416.966.) At this step, we will not use our assessment of your residual functional capacity alone to decide if you are disabled. We will use the guidelines in §§ 416.960 through 416.969a, and consider our residual functional capacity assessment together with the information about your vocational background to make our disability determination or decision. For our rules on residual functional capacity assessment in deciding whether your disability continues or ends, *see* § 416.994.

(b) *Physical abilities.* When we assess your physical abilities, we first assess the nature and extent of your physical limitations and then determine your residual functional capacity for work activity on a regular and continuing

basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce your ability to do past work and other work.

(c) *Mental abilities.* When we assess your mental abilities, we first assess the nature and extent of your mental limitations and restrictions and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, coworkers, and work pressures in a work setting, may reduce your ability to do past work and other work.

(d) *Other abilities affected by impairment(s).* Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If you have this type of impairment(s), we consider any resulting limitations and restrictions which may reduce your ability to do past work and other work in deciding your residual functional capacity.

(e) *Total limiting effects.* When you have a severe impairment(s), but your symptoms, signs, and laboratory findings do not meet or equal those of a listed impairment in appendix 1 of subpart P of part 404 of this chapter, we will consider the limiting effects of all your impairment(s), even those that are not severe, in determining your residual functional capacity. Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of your impairment(s) and any related symptoms, we will consider all of the medical and nonmedical evidence, including the information described in § 416.929(c).

[56 FR 57947, Nov. 14, 1991, as amended at 68 FR 51165, Aug. 26, 2003; 77 FR 10657, Feb. 23, 2012; 77 FR 43495, July 25, 2012]

§ 416.946 Responsibility for assessing your residual functional capacity.

(a) *Responsibility for assessing residual functional capacity at the State agency.* When a State agency medical or psychological consultant and a State agency disability examiner make the disability determination as provided in § 416.1015(c)(1) of this part, a State agency medical or psychological consultant(s) is responsible for assessing your residual functional capacity. When a State agency disability examiner makes a disability determination alone as provided in § 416.1015(c)(3), the disability examiner is responsible for assessing your residual functional capacity.

(b) *Responsibility for assessing residual functional capacity in the disability hearings process.* If your case involves a disability hearing under § 416.1414, a disability hearing officer is responsible for assessing your residual functional capacity. However, if the disability hearing officer's reconsidered determination is changed under § 416.1418, the Associate Commissioner for the Office of Disability Determinations or his or her delegate is responsible for assessing your residual functional capacity.

(c) *Responsibility for assessing residual functional capacity at the administrative law judge hearing or Appeals Council level.* If your case is at the administrative law judge hearing level or at the Appeals Council review level, the administrative law judge or the administrative appeals judge at the Appeals Council (when the Appeals Council

makes a decision) is responsible for assessing your residual functional capacity.

[68 FR 51165, Aug. 26, 2003, as amended at 71 FR 16461, Mar. 31, 2006; 75 FR 62683, Oct. 13, 2010; 76 FR 24812, May 3, 2011]

VOCATIONAL CONSIDERATIONS

§ 416.960 When we will consider your vocational background.

(a) *General.* If you are age 18 or older and applying for supplemental security income benefits based on disability, and we cannot decide whether you are disabled at one of the first three steps of the sequential evaluation process (*see* § 416.920), we will consider your residual functional capacity together with your vocational background, as discussed in paragraphs (b) and (c) of this section.

(b) *Past relevant work.* We will first compare our assessment of your residual functional capacity with the physical and mental demands of your past relevant work. See § 416.920(h) for an exception to this rule.

(1) *Definition of past relevant work*—(i) *What is past relevant work.* Past relevant work is work that you have done within the past five years that was substantial gainful activity and that lasted long enough for you to learn to do it (see § 416.965(a)). We will not consider work to be past relevant work if you started and stopped it in fewer than 30 calendar days (see paragraph (b)(1)(ii) of this section).

(ii) *30 calendar days.* When we consider past relevant work and work experience (see § 416.965), 30 calendar days means a period of 30 consecutive days, including weekends, starting from the first day of work. When we consider whether work lasted 30 calendar days, we generally do not consider the total number of hours or days worked during that period, or whether the work was full-time or part-time. The 30 calendar days requirement is separate from the consideration of substantial gainful activity or whether you worked long enough to learn how to do the work, although the work performed during the 30 calendar days may count toward the time needed for you to learn to do the work. The 30 calendar days requirement also applies if you were self-employed or an independent contractor; we will consider whether you were engaged in the same type of work for 30 calendar days, even if individual work assignments or contracts each lasted fewer than 30 calendar days.

(2) *Determining whether you can do your past relevant work.* We will ask you for information about work you have done in the past. We may also ask other people who know about your work. (*See* § 416.965(b).) We may use the services of vocational experts or vocational specialists, or other resources, such as the ''Dictionary of Occupational Titles'' and its companion volumes and supplements, published by the Department of Labor, to obtain evidence we need to help us determine whether you can do your past relevant work, given your residual functional capacity. A vocational expert or specialist may offer relevant evidence within his or her expertise or knowledge concerning the physical and mental demands of a claimant's past relevant work, either as the claimant actually performed it or as generally performed in the national economy. Such evidence may be helpful in supplementing or evaluating the accuracy of the claimant's description of his past work. In addition, a vocational expert or specialist may offer expert opinion testimony in response to a hypothetical question about whether a person with the physical and mental limitations imposed by the claimant's medical impairment(s) can meet the demands of the claimant's previous work, either as the claimant actually performed it or as generally performed in the national economy.

(3) *If you can do your past relevant work.* If we find that you have the residual functional capacity to do your past relevant work, we will determine that you can still do your past work and are not disabled. We will not consider your vocational factors of age, education, and work experience or whether your past relevant work exists in significant numbers in the national economy.

(c) *Other work.* (1) If we find that your residual functional capacity does not enable you to do any of your past relevant work or if we use the procedures

in § 416.920(h), we will use the same residual functional capacity assessment when we decide if you can adjust to any other work. We will look at your ability to adjust to other work by considering your residual functional capacity and the vocational factors of age, education, and work experience, as appropriate in your case. (*See* § 416.920(h) for an exception to this rule.) Any other work (jobs) that you can adjust to must exist in significant numbers in the national economy (either in the region where you live or in several regions in the country).

(2) In order to support a finding that you are not disabled at this fifth step of the sequential evaluation process, we are responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that you can do, given your residual functional capacity and vocational factors. We are not responsible for providing additional evidence about your residual functional capacity because we will use the same residual functional capacity assessment that we used to determine if you can do your past relevant work.

[68 FR 51166, Aug. 26, 2003, as amended at 77 FR 43495, July 25, 2012; 89 FR 27667, Apr. 18, 2024]

§ 416.962 Medical-vocational profiles showing an inability to make an adjustment to other work.

(a) *If you have done only arduous unskilled physical labor.* If you have no more than a marginal education (*see* § 416.964) and work experience of 35 years or more during which you did only arduous unskilled physical labor, and you are not working and are no longer able to do this kind of work because of a severe impairment(s) (*see* §§ 416.920(c), 416.921, and 416.923), we will consider you unable to do lighter work, and therefore, disabled.

Example to paragraph (a): B is a 58-year-old miner's helper with a fourth grade education who has a lifelong history of unskilled arduous physical labor. B says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a ''severe'' combination of impairments that prevents B from performing his past relevant work. Under these circumstances, we will find that B is disabled.

(b) *If you are at least 55 years old, have no more than a limited education, and have no past relevant work experience.* If you have a severe, medically determinable impairment(s) (*see* §§ 416.920(c), 416.921, and 416.923), are of advanced age (age 55 or older, *see* § 416.963), have a limited education or less (*see* § 416.964), and have no past relevant work experience (*see* § 416.965), we will find you disabled. If the evidence shows that you meet this profile, we will not need to assess your residual functional capacity or consider the rules in appendix 2 to subpart P of part 404 of this chapter.

[68 FR 51166, Aug. 26, 2003]

§ 416.963 Your age as a vocational factor.

(a) *General.* ''Age'' means your chronological age. When we decide whether you are disabled under § 416.920(g)(1), we will consider your chronological age in combination with your residual functional capacity, education, and work experience. We will not consider your ability to adjust to other work on the basis of your age alone. In determining the extent to which age affects a person's ability to adjust to other work, we consider advancing age to be an increasingly limiting factor in the person's ability to make such an adjustment, as we explain in paragraphs (c) through (e) of this section. If you are unemployed but you still have the ability to adjust to other work, we will find that you are not disabled. In paragraphs (b) through (e) of this section and in appendix 2 of subpart P of part 404 of this chapter, we explain in more detail how we consider your age as a vocational factor.

(b) *How we apply the age categories.* When we make a finding about your ability to do other work under § 416.920(f)(1), we will use the age categories in paragraphs (c) through (e) of this section. We will use each of the age categories that applies to you during the period for which we must determine if you are disabled. We will not apply the age categories mechanically in a borderline situation. If you are within a few days to a few months of reaching an older age category, and using the older age category would result in a determination or decision that you are disabled, we will consider

whether to use the older age category after evaluating the overall impact of all the factors of your case.

(c) *Younger person.* If you are a younger person (under age 50), we generally do not consider that your age will seriously affect your ability to adjust to other work. However, in some circumstances, we consider that persons age 45–49 are more limited in their ability to adjust to other work than persons who have not attained age 45. See Rule 201.17 in appendix 2 of subpart P of part 404 of this chapter.

(d) *Person closely approaching advanced age.* If you are closely approaching advanced age (age 50–54), we will consider that your age along with a severe impairment(s) and limited work experience may seriously affect your ability to adjust to other work.

(e) *Person of advanced age.* We consider that at advanced age (age 55 or older), age significantly affects a person's ability to adjust to other work. We have special rules for persons of advanced age and for persons in this category who are closely approaching retirement age (age 60 or older). See § 416.968(d)(4).

(f) *Information about your age.* We will usually not ask you to prove your age. However, if we need to know your exact age to determine whether you get disability benefits, we will ask you for evidence of your age.

[45 FR 55621, Aug. 20, 1980, as amended at 65 FR 18001, Apr. 6, 2000; 68 FR 51166, Aug. 26, 2003; 73 FR 64197, Oct. 29, 2008]

§ 416.964 Your education as a vocational factor.

(a) *General. Education* is primarily used to mean formal schooling or other training which contributes to your ability to meet vocational requirements, for example, reasoning ability, communication skills, and arithmetical ability. However, if you do not have formal schooling, this does not necessarily mean that you are uneducated or lack these abilities. Past work experience and the kinds of responsibilities you had when you were working may show that you have intellectual abilities, although you may have little formal education. Your daily activities, hobbies, or the results of testing may also show that you have significant intellectual ability that can be used to work.

(b) *How we evaluate your education.* The importance of your educational background may depend upon how much time has passed between the completion of your formal education and the beginning of your physical or mental impairment(s) and by what you have done with your education in a work or other setting. Formal education that you completed many years before your impairment began, or unused skills and knowledge that were a part of your formal education, may no longer be useful or meaningful in terms of your ability to work. Therefore, the numerical grade level that you completed in school may not represent your actual educational abilities. These may be higher or lower. However, if there is no other evidence to contradict it, we will use your numerical grade level to determine your educational abilities. In evaluating your educational level, we use the following categories:

(1) *Illiteracy.* Illiteracy means the inability to read or write. We consider someone illiterate if the person cannot read or write a simple message such as instructions or inventory lists even though the person can sign his or her name. Generally, an illiterate person has had little or no formal schooling.

(2) *Marginal education.* Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. We generally consider that formal schooling at a 6th grade level or less is a marginal education.

(3) *Limited education.* Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs. We generally consider that a 7th grade through the 11th grade level of formal education is a limited education.

(4) *High school education and above.* High school education and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. We generally consider that

someone with these educational abilities can do semi-skilled through skilled work.

(c) *Information about your education.* We will ask you how long you attended school, and whether you are able to understand, read, and write, and do at least simple arithmetic calculations. We will also consider other information about how much formal or informal education you may have had through your previous work, community projects, hobbies, and any other activities which might help you to work.

[45 FR 55621, Aug. 20, 1980, as amended at 85 FR 10603, Feb. 25, 2020]

§ 416.965 Your work experience as a vocational factor.

(a) *General. Work experience* means skills and abilities you have acquired through work you have done which show the type of work you may be expected to do. Work you have already been able to do shows the kind of work that you may be expected to do. We consider that your work experience applies when it was done within the last five years, lasted long enough for you to learn to do it, and was substantial gainful activity. We do not usually consider that work you did more than five years before the time we are deciding whether you are disabled applies. A gradual change occurs in most jobs so that after five years it is no longer realistic to expect that skills and abilities acquired in a job done then continue to apply. If you have no work experience or you did work that started and stopped in a period of fewer than 30 calendar days (see § 416.960(b)(1)(ii)) during the five-year period, we generally consider that these do not apply. If you have acquired skills through your past work, we consider you to have these work skills unless you cannot use them in other skilled or semi-skilled work that you can now do. If you cannot use your skills in other skilled or semi-skilled work, we will consider your work background the same as unskilled. However, even if you have no work experience, we may consider that you are able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

(b) *Information about your work.* Under certain circumstances, we will ask you about the work you have done in the past. If you cannot give us all of the information we need, we may try, with your permission, to get it from your employer or other person who knows about your work, such as a member of your family or a co-worker. When we need to consider your work experience to decide whether you are able to do work that is different from what you have done in the past, we will ask you to tell us about all of the jobs you have had in the last five years. You must tell us the dates you worked, all of the duties you did, and any tools, machinery, and equipment you used. We will need to know about the amount of walking, standing, sitting, lifting and carrying you did during the workday, as well as any other physical or mental duties of your job. If all of your work in the past five years has been arduous and unskilled, and you have very little education, we will ask you to tell us about all of your work from the time you first began working. This information could help you to get disability benefits.

[89 FR 27667, Apr. 18, 2024]

§ 416.966 Work which exists in the national economy.

(a) *General.* We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether—

(1) Work exists in the immediate area in which you live;

(2) A specific job vacancy exists for you; or

(3) You would be hired if you applied for work.

(b) *How we determine the existence of work.* Work exists in the national economy when there is a significant number of jobs (in one or more occupations) having requirements which you are able to meet with your physical or mental abilities and vocational qualifications. Isolated jobs that exist only in very limited numbers in relatively few locations outside of the region where you live are not considered *work which exists in the national economy.* We will not deny you disability benefits on

the basis of the existence of these kinds of jobs. If work that you can do does not exist in the national economy, we will determine that you are disabled. However, if work that you can do does exist in the national economy, we will determine that you are not disabled.

(c) *Inability to obtain work.* We will determine that you are not disabled if your residual functional capacity and vocational abilities make it possible for you to do work which exists in the national economy, but you remain unemployed because of—

(1) Your inability to get work;

(2) Lack of work in your local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which you have worked;

(5) Cyclical economic conditions;

(6) No job openings for you;

(7) You would not actually be hired to do work you could otherwise do, or;

(8) You do not wish to do a particular type of work.

(d) *Administrative notice of job data.* When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of—

(1) *Dictionary of Occupational Titles,* published by the Department of Labor;

(2) *County Business Patterns,* published by the Bureau of the Census;

(3) *Census Reports,* also published by the Bureau of the Census;

(4) *Occupational Analyses* prepared for the Social Security Administration by various State employment agencies; and

(5) *Occupational Outlook Handbook,* published by the Bureau of Labor Statistics.

(e) *Use of vocational experts and other specialists.* If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist. We will decide whether to use a vocational expert or other specialist.

§416.967 Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, we classify jobs as *sedentary, light, medium, heavy,* and *very heavy.* These terms have the same meaning as they have in the *Dictionary of Occupational Titles,* published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

(a) *Sedentary work.* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

(c) *Medium work.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

(d) *Heavy work.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If

someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

(e) *Very heavy work.* Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light, and sedentary work.

§ 416.968 Skill requirements.

In order to evaluate your skills and to help determine the existence in the national economy of work you are able to do, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, we use materials published by the Department of Labor. When we make disability determinations under this subpart, we use the following definitions:

(a) *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding and offbearing (that is, placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled jobs.

(b) *Semi-skilled work.* Semi-skilled work is work which needs some skills but does not require doing the more complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

(c) *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

(d) *Skills that can be used in other work (transferability)*—(1) *What we mean by transferable skills.* We consider you to have skills that can be used in other jobs, when the skilled or semi-skilled work activities you did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

(2) *How we determine skills that can be transferred to other jobs.* Transferability is most probable and meaningful among jobs in which—

(i) The same or a lesser degree of skill is required;

(ii) The same or similar tools and machines are used; and

(iii) The same or similar raw materials, products, processes, or services are involved.

(3) *Degrees of transferability.* There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, we consider that they are not transferable.

(4) *Transferability of skills for persons of advanced age.* If you are of *advanced age* (age 55 or older), and you have a severe impairment(s) that limits you to

sedentary or *light* work, we will find that you cannot make an adjustment to other work unless you have skills that you can transfer to other skilled or semiskilled work (or you have recently completed education which provides for direct entry into skilled work) that you can do despite your impairment(s). We will decide if you have transferable skills as follows. If you are of advanced age and you have a severe impairment(s) that limits you to no more than *sedentary* work, we will find that you have skills that are transferable to skilled or semiskilled sedentary work only if the sedentary work is so similar to your previous work that you would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See §416.967(a) and Rule 201.00(f) of appendix 2 of subpart P of part 404 of this chapter.) If you are of advanced age but have not attained age 60, and you have a severe impairment(s) that limits you to no more than *light* work, we will apply the rules in paragraphs (d)(1) through (d)(3) of this section to decide if you have skills that are transferable to skilled or semiskilled light work (see §416.967(b)). If you are *closely approaching retirement age* (age 60 or older) and you have a severe impairment(s) that limits you to no more than *light* work, we will find that you have skills that are transferable to skilled or semiskilled light work only if the light work is so similar to your previous work that you would need to make very little, if any, vocational adjustment in terms of tools, work processes, work settings, or the industry. (See §416.967(b) and Rule 202.00(f) of appendix 2 of subpart P of part 404 of this chapter.)

[45 FR 55621, Aug. 20, 1980, as amended at 65 FR 18001, Apr. 6, 2000; 73 FR 64197, Oct. 29, 2008]

§416.969 Listing of Medical-Vocational Guidelines in appendix 2 of subpart P of part 404 of this chapter.

The *Dictionary of Occupational Titles* includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 provides rules using this data reflecting major functional and vocational patterns. We apply these rules in cases where a person is not doing substantial gainful activity and is prevented by a severe medically determinable impairment from doing vocationally relevant past work. (*See* §416.920(h) for an exception to this rule.) The rules in appendix 2 do not cover all possible variations of factors. Also, as we explain in §200.00 of appendix 2, we do not apply these rules if one of the findings of fact about the person's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, we give full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, we use that rule to decide whether a person is disabled.

[45 FR 55584, Aug. 20, 1980, as amended at 77 FR 43495, July 25, 2012]

§416.969a Exertional and nonexertional limitations.

(a) *General.* Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of both. Limitations are classified as exertional if they affect your ability to meet the strength demands of jobs. The classification of a limitation as exertional is related to the United States Department of Labor's classification of jobs by various exertional levels (sedentary, light, medium, heavy, and very heavy) in terms of the strength demands for sitting, standing, walking, lifting, carrying, pushing, and pulling. Sections 416.967 and 416.969 explain how we use the classification of jobs by exertional levels (strength demands) which is contained in the Dictionary of Occupational Titles published by the Department of Labor, to determine the exertional requirements of work which exists in the national economy. Limitations or restrictions which affect your ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing

or pulling, are considered nonexertional. When we decide whether you can do your past relevant work (*see* §§ 416.920(f) and 416.994(b)(5)(vi)), we will compare our assessment of your residual functional capacity with the demands of your past relevant work. If you cannot do your past relevant work, we will use the same residual functional capacity assessment along with your age, education, and work experience to decide if you can adjust to any other work which exists in the national economy. (*See* §§ 416.920(g) and 416.994(b)(5)(vii).) Paragraphs (b), (c), and (d) of this section explain how we apply the medical-vocational guidelines in appendix 2 of subpart P of part 404 of this chapter in making this determination, depending on whether the limitations or restrictions imposed by your impairment(s) and related symptoms, such as pain, are exertional, nonexertional, or a combination of both.

(b) *Exertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. When your impairment(s) and related symptoms only impose exertional limitations and your specific vocational profile is listed in a rule contained in appendix 2, we will directly apply that rule to decide whether you are disabled.

(c) *Nonexertional limitations.* (1) When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) You have difficulty functioning because you are nervous, anxious, or depressed;

(ii) You have difficulty maintaining attention or concentrating;

(iii) You have difficulty understanding or remembering detailed instructions;

(iv) You have difficulty in seeing or hearing;

(v) You have difficulty tolerating some physical feature(s) of certain work settings, e.g., you cannot tolerate dust or fumes; or

(vi) You have difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in appendix 2.

(d) *Combined exertional and nonexertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we consider that you have a combination of exertional and nonexertional limitations or restrictions. If your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we will not directly apply the rules in appendix 2 unless there is a rule that directs a conclusion that you are disabled based upon your strength limitations; otherwise the rules provide a framework to guide our decision.

[56 FR 57947, Nov. 14, 1991, as amended at 68 FR 51166, Aug. 26, 2003]

SUBSTANTIAL GAINFUL ACTIVITY

§ 416.971 General.

The work, without regard to legality, that you have done during any period in which you believe you are disabled may show that you are able to work at the substantial gainful activity level. If you are able to engage in substantial gainful activity, we will find that you are not disabled. (We explain the rules for persons who are statutorily blind in § 416.984.) Even if the work you have

done was not substantial gainful activity, it may show that you are able to do more work than you actually did. We will consider all of the medical and vocational evidence in your file to decide whether or not you have the ability to engage in substantial gainful activity.

[45 FR 55621, Aug. 20, 1980, as amended at 65 FR 42788, July 11, 2000]

§ 416.972 What we mean by substantial gainful activity.

Substantial gainful activity is work activity that is both substantial and gainful:

(a) *Substantial work activity.* Substantial work activity is work activity that involves doing significant physical or mental activities. Your work may be substantial even if it is done on a part-time basis or if you do less, get paid less, or have less responsibility than when you worked before.

(b) *Gainful work activity.* Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

(c) *Some other activities.* Generally, we do not consider activities like taking care of yourself, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

§ 416.973 General information about work activity.

(a) *The nature of your work.* If your duties require use of your experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that you have the ability to work at the substantial gainful activity level.

(b) *How well you perform.* We consider how well you do your work when we determine whether or not you are doing substantial gainful activity. If you do your work satisfactorily, this may show that you are working at the substantial gainful activity level. If you are unable, because of your impairments, to do ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work, this may show that you are not working at the substantial gainful activity level. If you are doing work that involves minimal duties that make little or no demands on you and that are of little or no use to your employer, or to the operation of a business if you are self-employed, this does not show that you are working at the substantial gainful activity level.

(c) *If your work is done under special conditions.* The work you are doing may be done under special conditions that take into account your impairment, such as work done in a sheltered workshop or as a patient in a hospital. If your work is done under special conditions, we may find that it does not show that you have the ability to do substantial gainful activity. Also, if you are forced to stop or reduce your work because of the removal of special conditions that were related to your impairment and essential to your work, we may find that your work does not show that you are able to do substantial gainful activity. However, work done under special conditions may show that you have the necessary skills and ability to work at the substantial gainful activity level. Examples of the special conditions that may relate to your impairment include, but are not limited to, situations in which—

(1) You required and received special assistance from other employees in performing your work;

(2) You were allowed to work irregular hours or take frequent rest periods;

(3) You were provided with special equipment or were assigned work especially suited to your impairment;

(4) You were able to work only because of specially arranged circumstances, for example, other persons helped you prepare for or get to and from your work;

(5) You were permitted to work at a lower standard of productivity or efficiency than other employees; or

(6) You were given the opportunity to work, despite your impairment, because of family relationship, past association with your employer, or your employer's concern for your welfare.

(d) *If you are self-employed.* Supervisory, managerial, advisory or other significant personal services that you

perform as a self-employed individual may show that you are able to do substantial gainful activity.

(e) *Time spent in work.* While the time you spend in work is important, we will not decide whether or not you are doing substantial gainful activity only on that basis. We will still evaluate the work to decide whether it is substantial and gainful regardless of whether you spend more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

[45 FR 55621, Aug. 20, 1980, as amended at 65 FR 42788, July 11, 2000]

§ 416.974 Evaluation guides if you are an employee.

(a) We use several guides to decide whether the work you have done shows that you are able to do substantial gainful activity. If you are working or have worked as an employee, we will use the provisions in paragraphs (a) through (d) of this section that are relevant to your work activity. We will use these provisions whenever they are appropriate in connection with your application for supplemental security income benefits (when we make an initial determination on your application and throughout any appeals you may request) to determine if you are eligible.

(1) *Your earnings may show you have done substantial gainful activity.* Generally, in evaluating your work activity for substantial gainful activity purposes, our primary consideration will be the earnings you derive from the work activity. We will use your earnings to determine whether you have done substantial gainful activity unless we have information from you, your employer, or others that shows that we should not count all of your earnings. The amount of your earnings from work you have done (regardless of whether it is unsheltered or sheltered work) may show that you have engaged in substantial gainful activity. Generally, if you worked for substantial earnings, we will find that you are able to do substantial gainful activity. However, the fact that your earnings were not substantial will not necessarily show that you are not able to do substantial gainful activity. We generally consider work that you are forced to stop or to reduce below the substantial gainful activity level after a short time because of your impairment to be an unsuccessful work attempt. Your earnings from an unsuccessful work attempt will not show that you are able to do substantial gainful activity. We will use the criteria in paragraph (c) of this section to determine if the work you did was an unsuccessful work attempt.

(2) *We consider only the amounts you earn.* When we decide whether your earnings show that you have done substantial gainful activity, we do not consider any income that is not directly related to your productivity. When your earnings exceed the reasonable value of the work you perform, we consider only that part of your pay which you actually earn. If your earnings are being subsidized, we do not consider the amount of the subsidy when we determine if your earnings show that you have done substantial gainful activity. We consider your work to be subsidized if the true value of your work, when compared with the same or similar work done by unimpaired persons, is less than the actual amount of earnings paid to you for your work. For example, when a person with a serious impairment does simple tasks under close and continuous supervision, our determination of whether that person has done substantial gainful activity will not be based only on the amount of the wages paid. We will first determine whether the person received a subsidy; that is, we will determine whether the person was being paid more than the reasonable value of the actual services performed. We will then subtract the value of the subsidy from the person's gross earnings to determine the earnings we will use to determine if he or she has done substantial gainful activity.

(3) *If you are working in a sheltered or special environment.* If you are working in a sheltered workshop, you may or may not be earning the amounts you are being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that you are not earning all you are being paid.

Since persons in military service being treated for severe impairments usually continue to receive full pay, we evaluate work activity in a therapy program or while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of the work, rather than on the actual amount of the earnings.

(b) *Earnings guidelines.* (1) *General.* If you are an employee, we first consider the criteria in paragraph (a) of this section and §416.976, and then the guides in paragraphs (b)(2) and (3) of this section. When we review your earnings to determine if you have been performing substantial gainful activity, we will subtract the value of any subsidized earnings (see paragraph (a)(2) of this section) and the reasonable cost of any impairment-related work expenses from your gross earnings (see §416.976). The resulting amount is the amount we use to determine if you have done substantial gainful activity. We will generally average your earnings for comparison with the earnings guidelines in paragraphs (b)(2) and (3) of this section. See §416.974a for our rules on averaging earnings.

(2) *Earnings that will ordinarily show that you have engaged in substantial gainful activity.* We will consider that your earnings from your work activity as an employee (including earnings from work in a sheltered workshop or a comparable facility especially set up for severely impaired persons) show that you have engaged in substantial gainful activity if:

(i) *Before January 1, 2001,* they averaged more than the amount(s) in Table 1 of this section for the time(s) in which you worked.

(ii) *Beginning January 1, 2001,* and each year thereafter, they average more than the larger of:

(A) The amount for the previous year, or

(B) An amount adjusted for national wage growth, calculated by multiplying $700 by the ratio of the national average wage index for the year 2 calendar years before the year for which the amount is being calculated to the national average wage index for the year 1998. We will then round the resulting amount to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

TABLE 1

For months:	Your monthly earnings averaged more than:
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
January 1990–June 1999	500
July 1999–December 2000	700

(3) *Earnings that will ordinarily show that you have not engaged in substantial gainful activity*—(i) *General.* If your average monthly earnings are equal to or less than the amount(s) determined under paragraph (b)(2) of this section for the year(s) in which you work, we will generally consider that the earnings from your work as an employee (including earnings from work in a sheltered workshop or comparable facility) will show that you have not engaged in substantial gainful activity. We will generally not consider other information in addition to your earnings except in the circumstances described in paragraph (b)(3)(ii) of this section.

(ii) *When we will consider other information in addition to your earnings.* Unless you meet the criteria set forth in section 416.990 (h) and (i), we will generally consider other information in addition to your earnings if there is evidence indicating that you may be engaging in substantial gainful activity or that you are in a position to control when earnings are paid to you or the amount of wages paid to you (for example, if you are working for a small corporation owned by a relative). Examples of other information we may consider include, whether—

(A) Your work is comparable to that of unimpaired people in your community who are doing the same or similar occupations as their means of livelihood, taking into account the time, energy, skill, and responsibility involved in the work; and

(B) Your work, although significantly less than that done by unimpaired people, is clearly worth the

amounts shown in paragraph (b)(2) of this section, according to pay scales in your community.

(c) *The unsuccessful work attempt*—(1) *General.* Ordinarily, work you have done will not show that you are able to do substantial gainful activity if, after working for a period of 6 months or less, you were forced by your impairment to stop working or to reduce the amount of work you do so that your earnings from such work fall below the substantial gainful activity earnings level in paragraph (b)(2) of this section and you meet the conditions described in paragraphs (c)(2), (3), (4), and (5) of this section.

(2) *Event that must precede an unsuccessful work attempt.* There must be a significant break in the continuity of your work before we will consider you to have begun a work attempt that later proved unsuccessful. You must have stopped working or reduced your work and earnings below the substantial gainful activity earnings level because of your impairment or because of the removal of special conditions that were essential to the further performance of your work. We explain what we mean by special conditions in §416.973(c). We will consider your prior work to be ''discontinued'' for a significant period if you were out of work at least 30 consecutive days. We will also consider your prior work to be ''discontinued'' if, because of your impairment, you were forced to change to another type of work or another employer.

(3) *If you worked 6 months or less.* We will consider work of 6 months or less to be an unsuccessful work attempt if you stopped working or you reduced your work and earnings below the substantial gainful activity earnings level because of your impairment or because of the removal of special conditions that took into account your impairment and permitted you to work.

(4) *If you worked more than 6 months.* We will not consider work you performed at the substantial gainful activity earnings level for more than 6 months to be an unsuccessful work attempt regardless of why it ended or was reduced below the substantial gainful activity earnings level.

(d) *Work activity in certain volunteer programs.* If you work as a volunteer in certain programs administered by the Federal government under the Domestic Volunteer Service Act of 1973 or the Small Business Act, we will not count any payments you receive from these programs as earnings when we determine whether you are engaging in substantial gainful activity. These payments may include a minimal stipend, payments for supportive services such as housing, supplies and equipment, an expense allowance, or reimbursement of out-of-pocket expenses. We will also disregard the services you perform as a volunteer in applying any of the substantial gainful activity tests discussed in paragraph (b)(6) of this section. This exclusion from the substantial gainful activity provisions will apply only if you are a volunteer in a program explicitly mentioned in the Domestic Volunteer Service Act of 1973 or the Small Business Act. Programs explicitly mentioned in those Acts include Volunteers in Service to America, University Year for ACTION, Special Volunteer Programs, Retired Senior Volunteer Program, Foster Grandparent Program, Service Corps of Retired Executives, and Active Corps of Executives. We will not exclude under this paragraph volunteer work you perform in other programs or any nonvolunteer work you may perform, including nonvolunteer work under one of the specified programs. For civilians in certain government-sponsored job training and employment programs, we evaluate the work activity on a case-by-case basis under the substantial gainful activity earnings test. In programs such as these, subsidies often occur. We will subtract the value of any subsidy and use the remainder to determine if you have done substantial gainful activity. See paragraphs (a)(2)–(3) of this section.

(e) *Work activity as a member or consultant of an advisory committee established under the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2.* If you are serving as a member or consultant of an advisory committee, board, commission, council, or similar group established under FACA, we will not count any payments you receive from serving on such committees as

earnings when we determine whether you are engaging in substantial gainful activity. These payments may include compensation, travel expenses, and special assistance. We also will exclude the services you perform as a member or consultant of an advisory committee established under FACA in applying any of the substantial gainful activity tests discussed in paragraph (b)(6) of this section. This exclusion from the substantial gainful activity provision will apply only if you are a member or consultant of an advisory committee specifically authorized by statute, or by the President, or determined as a matter of formal record by the head of a federal government agency. This exclusion from the substantial gainful activity provisions will not apply if your service as a member or consultant of an advisory committee is part of your duties or is required as an employee of any governmental or non-governmental organization, agency, or business.

[46 FR 4871, Jan. 19, 1981, as amended at 48 FR 21939, May 16, 1983; 49 FR 22274, May 29, 1984; 54 FR 53605, Dec. 29, 1989; 64 FR 18570, Apr. 15, 1999; 64 FR 22903, Apr. 28, 1999; 65 FR 42789, July 11, 2000; 65 FR 82911, Dec. 29, 2000; 71 FR 3219, Jan. 20, 2006; 71 FR 66857, Nov. 17, 2006; 81 FR 71369, Oct. 17, 2016]

§ 416.974a When and how we will average your earnings.

(a) To determine your initial eligibility for benefits, we will average any earnings you make during the month you file for benefits and any succeeding months to determine if you are doing substantial gainful activity. If your work as an employee or as a self-employed person was continuous without significant change in work patterns or earnings, and there has been no change in the substantial gainful activity earnings levels, your earnings will be averaged over the entire period of work requiring evaluation to determine if you have done substantial gainful activity.

(b) If you work over a period of time during which the substantial gainful activity earnings levels change, we will average your earnings separately for each period in which a different substantial gainful activity earnings level applies.

(c) If there is a significant change in your work pattern or earnings during the period of work requiring evaluation, we will average your earnings over each separate period of work to determine if any of your work efforts were substantial gainful activity.

[65 FR 42790, July 11, 2000]

§ 416.975 Evaluation guides if you are self-employed.

(a) *If you are a self-employed person.* If you are working or have worked as a self-employed person, we will use the provisions in paragraphs (a) through (d) of this section that are relevant to your work activity. We will use these provisions whenever they are appropriate in connection with your application for supplemental security income benefits (when we make an initial determination on your application and throughout any appeals you may request). We will consider your activities and their value to your business to decide whether you have engaged in substantial gainful activity if you are self-employed. We will not consider your income alone because the amount of income you actually receive may depend on a number of different factors, such as capital investment and profit-sharing agreements. We will generally consider work that you were forced to stop or reduce to below substantial gainful activity after 6 months or less because of your impairment as an unsuccessful work attempt. See paragraph (d) of this section. We will evaluate your work activity based on the value of your services to the business regardless of whether you receive an immediate income for your services. We determine whether you have engaged in substantial gainful activity by applying three tests. If you have not engaged in substantial gainful activity under test one, then we will consider tests two and three. The tests are as follows:

(1) *Test One:* You have engaged in substantial gainful activity if you render services that are significant to the operation of the business and receive a substantial income from the business. Paragraphs (b) and (c) of this section explain what we mean by significant services and substantial income for purposes of this test.

(2) *Test Two:* You have engaged in substantial gainful activity if your work activity, in terms of factors such as hours, skills, energy output, efficiency, duties, and responsibilities, is comparable to that of unimpaired individuals in your community who are in the same or similar businesses as their means of livelihood.

(3) *Test Three:* You have engaged in substantial gainful activity if your work activity, although not comparable to that of unimpaired individuals, is clearly worth the amount shown in § 416.974(b)(2) when considered in terms of its value to the business, or when compared to the salary that an owner would pay to an employee to do the work you are doing.

(b) *What we mean by significant services.* (1) If you are not a farm landlord and you operate a business entirely by yourself, any services that you render are significant to the business. If your business involves the services of more than one person, we will consider you to be rendering significant services if you contribute more than half the total time required for the management of the business, or you render management services for more than 45 hours a month regardless of the total management time required by the business.

(2) If you are a farm landlord, that is, you rent farm land to another, we will consider you to be rendering significant services if you materially participate in the production or the management of the production of the things raised on the rented farm. (See § 404.1082 of this chapter for an explanation of ''material participation''.) If you were given social security earnings credits because you materially participated in the activities of the farm and you continue these same activities, we will consider you to be rendering significant services.

(c) *What we mean by substantial income.* We deduct your normal business expenses from your gross income to determine net income. Once net income is determined, we deduct the reasonable value of any significant amount of unpaid help furnished by your spouse, children, or others. Miscellaneous duties that ordinarily would not have commercial value would not be considered significant. We deduct impairment-related work expenses that have not already been deducted in determining your net income. Impairment-related work expenses are explained in § 416.976. We deduct unincurred business expenses paid for you by another individual or agency. An unincurred business expense occurs when a sponsoring agency or another person incurs responsibility for the payment of certain business expenses, e.g., rent, utilities, or purchases and repair of equipment, or provides you with equipment, stock, or other material for the operation of your business. We deduct soil bank payments if they were included as farm income. That part of your income remaining after we have made all applicable deductions represents the actual value of work performed. The resulting amount is the amount we use to determine if you have done substantial gainful activity. We will generally average your income for comparison with the earnings guidelines in §§ 416.974(b)(2) and 416.974(b)(3). See § 416.974a for our rules on averaging of earnings. We will consider this amount to be substantial if—

(1) It averages more than the amounts described in § 416.974(b)(2); or

(2) It averages less than the amounts described in § 416.974(b)(2) but it is either comparable to what it was before you became seriously impaired if we had not considered your earnings or is comparable to that of unimpaired self-employed persons in your community who are in the same or a similar business as their means of livelihood.

(d) *The unsuccessful work attempt*—(1) *General.* Ordinarily, work you have done will not show that you are able to do substantial gainful activity if, after working for a period of 6 months or less, you were forced by your impairment to stop working or to reduce the amount of work you do so that you are no longer performing substantial gainful activity and you meet the conditions described in paragraphs (d)(2), (3), and (4) of this section.

(2) *Event that must precede an unsuccessful work attempt.* There must be a significant break in the continuity of your work before we will consider you to have begun a work attempt that later proved unsuccessful. You must

have stopped working or reduced your work and earnings below substantial gainful activity because of your impairment or because of the removal of special conditions which took into account your impairment and permitted you to work. Examples of such special conditions may include any significant amount of unpaid help furnished by your spouse, children, or others, or unincurred business expenses, as described in paragraph (c) of this section, paid for you by another individual or agency. We will consider your prior work to be ''discontinued'' for a significant period if you were out of work at least 30 consecutive days. We will also consider your prior work to be ''discontinued'' if, because of your impairment, you were forced to change to another type of work.

(3) *If you worked 6 months or less.* We will consider work of 6 months or less to be an unsuccessful work attempt if you stopped working or you reduced your work and earnings below the substantial gainful activity earnings level because of your impairment or because of the removal of special conditions that took into account your impairment and permitted you to work.

(4) *If you worked more than 6 months.* We will not consider work you performed at the substantial gainful activity level for more than 6 months to be an unsuccessful work attempt regardless of why it ended or was reduced below the substantial gainful activity level.

[46 FR 4872, Jan. 19, 1981, as amended at 48 FR 21940, May 16, 1983; 49 FR 22274, May 29, 1984; 65 FR 42790, July 11, 2000; 81 FR 71369, Oct. 17, 2016]

§ 416.976 Impairment-related work expenses.

(a) *General.* When we figure your earnings in deciding if you have done substantial gainful activity, and in determining your countable earned income (see § 416.1112(c)(5)), we will subtract the reasonable costs to you of certain items and services which, because of your impairment(s), you need and use to enable you to work. The costs are deductible even though you also need or use the items and services to carry out daily living functions unrelated to your work. Paragraph (b) of this section explains the conditions for deducting work expenses. Paragraph (c) of this section describes the expenses we will deduct. Paragraph (d) of this section explains when expenses may be deducted. Paragraph (e) of this section describes how expenses may be allocated. Paragraph (f) of this section explains the limitations on deducting expenses. Paragraph (g) of this section explains our verification procedures.

(b) *Conditions for deducting impairment-related work expenses.* We will deduct impairment-related work expenses if—

(1) You are otherwise disabled as defined in §§ 416.905 through 416.907;

(2) The severity of your impairment(s) requires you to purchase (or rent) certain items and services in order to work;

(3) You pay the cost of the item or service. No deduction will be allowed to the extent that payment has been or will be made by another source. No deduction will be allowed to the extent that you have been, could be, or will be reimbursed for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if you purchase crutches for $80 but you were, could be, or will be reimbursed $64 by some agency, plan, or program, we will deduct only $16;

(4) You pay for the item or service in accordance with paragraph (d) of this section; and

(5) Your payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

(c) *What expenses may be deducted*—(1) *Payments for attendant care services.* (i) If because of your impairment(s) you need assistance in traveling to and from work, or while at work you need assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments you make for those services may be deducted.

(ii) If because of your impairment(s) you need assistance with personal functions (e.g., dressing, administering medications) at home in preparation for going to and assistance in returning from work, the payments you make for those services may be deducted.

(iii)(A) We will deduct payments you make to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

(B) We consider a family member to be anyone who is related to you by blood, marriage or adoption, whether or not that person lives with you.

(iv) If only part of your payment to a person is for services that come under the provisions of paragraph (c)(1) of this section, we will only deduct that part of the payment which is attributable to those services. For example, an attendant gets you ready for work and helps you in returning from work, which takes about 2 hours a day. The rest of his or her 8 hour day is spent cleaning your house and doing your laundry, etc. We would only deduct one-fourth of the attendant's daily wages as an impairment-related work expense.

(2) *Payments for medical devices.* If your impairment(s) requires that you utilize medical devices in order to work, the payments you make for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment which can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(3) *Payments for prosthetic devices.* If your impairment(s) requires that you utilize a prosthetic device in order to work, the payments you make for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

(4) *Payments for equipment*—(i) *Work-related equipment.* If your impairment(s) requires that you utilize special equipment in order to do your job, the payments you make for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

(ii) *Residential modifications.* If your impairment(s) requires that you make modifications to your residence, the location of your place of work will determine if the cost of these modifications will be deducted. If you are employed away from home, only the cost of changes made outside of your home to permit you to get to your means of transportation (e.g., the installation of an exterior ramp for a wheel-chair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of your home will not be deducted. If you work at home, the costs of modifying the inside of your home in order to create a working space to accommodate your impairment(s) will be deducted to the extent that the changes pertain specifically to the space in which you work. Examples of such changes are the enlargement of a doorway leading into the work space or modification of the work space to accommodate problems in dexterity. However, if you are self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) *Nonmedical appliances and equipment.* Expenses for appliances and equipment which you do not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is essential for the control of your disabling condition, thus enabling you to work. To be considered essential, the item must be of such a nature that if it were not available to you there would be an immediate adverse impact on your ability to function in your work activity. In this situation, the expense is deductible whether the item is used at home or in the working place. An example would be the need for an electric air cleaner

by an individual with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If it is prescribed and used as necessary treatment of your impairment and necessary to enable you to work, we will deduct payments you make toward its cost.

(5) *Payments for drugs and medical services.* (i) If you must use drugs or medical services (including diagnostic procedures) to control your impairment(s), the payments you make for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of your impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are anticonvulsant drugs to control epilepsy or anticonvulsant blood level monitoring; antidepressant medication for mental disorders; medication used to allay the side effects of certain treatments; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal disorders; electroencephalograms and brain scans related to a disabling epileptic condition; tests to determine the efficacy of medication on a diabetic condition; and immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) We will only deduct the costs of drugs or services that are directly related to your impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

(6) *Payments for similar items and services*—(i) *General.* If you are required to utilize items and services not specified in paragraph (c) (1) through (5) of this section but which are directly related to your impairment(s) and which you need to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, and transportation.

(ii) *Medical supplies and services not described above.* We will deduct payments you make for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. We will also deduct payments you make for physical therapy which you require because of your impairment(s) and which you need in order to work.

(iii) *Payments for transportation costs.* We will deduct transportation costs in these situations:

(A) Your impairment(s) requires that in order to get to work you need a vehicle that has structural or operational modifications. The modifications must be critical to your operation or use of the vehicle and directly related to your impairment(s). We will deduct the costs of the modifications, but not the cost of the vehicle. We will also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs.

(B) Your impairment(s) requires you to use driver assistance, taxicabs or other hired vehicles in order to work. We will deduct amounts paid to the driver and, if your own vehicle is used, we will also deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(C) Your impairment(s) prevents your taking available public transportation to and from work and you must drive your (unmodified) vehicle to work. If we can verify through your physician or other sources that the need to drive is caused by your impairment(s) (and not due to the unavailability of public transportation), we will deduct a mileage allowance as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(7) *Payments for installing, maintaining, and repairing deductible items.* If the device, equipment, appliance, etc., that you utilize qualifies as a deductible item as described in paragraphs (c)(2), (3), (4), and (6) of this section, the costs directly related to installing, maintaining and repairing these items are

also deductible. (The costs which are associated with modifications to a vehicle are deductible. Except for a mileage allowance, as provided for in paragraph (c)(6)(iii) of this section, the costs which are associated with the vehicle itself are not deductible.)

(d) *When expenses may be deducted*—(1) *Effective date.* To be deductible an expense must be incurred after November 30, 1980. An expense may be considered incurred after that date if it is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

(2) *Payments for services.* For the purpose of determining SGA, a payment you make for services may be deducted if the services are received while you are working and the payment is made in a month you are working. We consider you to be working even though you must leave work temporarily to receive the services. For the purpose of determining your SSI monthly payment amount, a payment you make for services may be deducted if the payment is made in the month your earned income is received and the earned income is for work done in the month you received the services. If you begin working and make a payment before the month earned income is received, the payment is also deductible. If you make a payment after you stop working, and the payment is made in the month you received earned income for work done in the month you received the services, the payment is also deductible.

(3) *Payment for items.* For the purpose of determining SGA, a payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if payment is made in a month you are working. For the purpose of determining your SSI monthly payment amount, a payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if the payment is made in the month your earned income is received and the earned income is for work done in the month you used the item. If you begin working and make a payment before the month earned income is received, the payment is also deductible. If you make a payment after you stop working, and the payment is made in the month you received earned income for work done in the month you used the item, the payment is also deductible. See paragraph (e)(4) of this section when purchases are made in anticipation of work.

(e) *How expenses are allocated*—(1) *Recurring expenses.* You may pay for services on a regular periodic basis, or you may purchase an item on credit and pay for it in regular periodic installments or you may rent an item. If so, each payment you make for the services and each payment you make toward the purchase or rental (including interest) is deductible as described in paragraph (d) of this section.

Example: B starts work in October 1981 at which time she purchases a medical device at a cost of $4,800 plus interest charges of $720. Her monthly payments begin in October. She earns and receives $400 a month. The term of the installment contract is 48 months. No downpayment is made. The monthly allowable deduction for the item would be $115 ($5520 divided by 48) for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the 48 months.

(2) *Nonrecurring expenses.* Part or all of your expenses may not be recurring. For example, you may make a one-time payment in full for an item or service or make a downpayment. For the purpose of determining SGA, if you are working when you make the payment we will either deduct the entire amount in the month you pay it or allocate the amount over a 12 consecutive month period beginning with the month of payment, whichever you select. For the purpose of determining your SSI monthly payment amount, if you are working in the month you make the payment and the payment is made in a month earned income is received, we will either deduct the entire amount in that month, or we will allocate the amount over a 12 consecutive month period, beginning with that month, whichever you select. If you begin working and do not receive earned income in the month you make the payment, we will either deduct or begin allocating the payment amount in the first month you do receive earned income. If you make a payment for services or items after you stopped working, we will deduct the payment if it was made in the month you received

earned income for work done in the month you received the services or used the item.

Example: A begins working in October 1981 and earns and receives $525 a month. In the same month he purchases and pays for a deductible item at a cost of $250. In this situation we could allow a $250 deduction for both SGA and SSI payment purposes for October 1981, reducing A's earnings below the SGA level for that month.

If A's earnings had been $15 above the SGA earnings amount, A probably would select the option of projecting the $250 payment over the 12-month period, October 1981–September 1982, giving A an allowable deduction of $20.83 a month for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during that period. This deduction would reduce A's earnings below the SGA level for 12 months.

(3) *Allocating downpayments.* If you make a downpayment we will, if you choose, make a separate calculation for the downpayment in order to provide for uniform monthly deductions. In these situations we will determine the total payment that you will make over a 12 consecutive month period beginning with the month of the downpayment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period if your regular monthly payments will extend over a period of less than 12 months.

Example 1. C starts working in October 1981, at which time he purchases special equipment at a cost of $4,800, paying $1,200 down. The balance of $3,600, plus interest of $540, is to be repaid in 36 installments of $115 a month beginning November 1981. C earns and receives $500 a month. He chooses to have the downpayment allocated. In this situation we would allow a deduction of $205.42 a month for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of $115 for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the remaining installment period.

Explanation:

Downpayment in 10/81	$1,200
Monthly payments 11/81 through 09/82	1,265
12) 2,465	= $205.42.

Example 2. D, while working, buys a deductible item in July 1981, paying $1,450 down. (D earns and receives $500 a month.) However, his first monthly payment of $125 is not due until September 1981. D chooses to have the downpayment allocated. In this situation we would allow a deduction of $225 a month for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes) during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of $125 for each month of work (for SGA purposes) and for each month earned income is received (for SSI payment purposes).

Explanation:

Downpayment in 07/81	$1,450
Monthly payments 09/81 through 06/82	1,250
12) 2,700	= 225.

(4) *Payments made in anticipation of work.* A payment toward the cost of a deductible item that you made in any of the 11 months preceding the month you started working will be taken into account in determining your impairment-related work expenses. When an item is paid for in full during the 11 months preceding the month you started working the payment will be allocated over the 12-consecutive month period beginning with the month of the payment. However, the only portion of the payment which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of $600, the deductible amount would be $450 ($600 divided by 12, multiplied by 9). Installment payments (including a downpayment) that you made for a particular item during the 11 months preceding the month you started working will be totaled and considered to have been made in the month of your first payment for that item within this 11 month period. The sum of these payments will be allocated over the 12-consecutive month period beginning with the month of your first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins

and the following months. For example, if an item is purchased 3 months before the month work began and is paid for in 3 monthly installments of $200 each, the total payment of $600 will be considered to have been made in the month of the first payment, that is, 3 months before the month work began. The deductible amount would be $450 ($600 divided by 12, multiplied by 9). The amount, as determined by these formulas, will then be considered to have been paid in the first month of work for the purpose of determining SGA and in the first month earned income is received for the purpose of determining the SSI monthly payment amount. For the purpose of determining SGA, we will deduct either the entire amount in the first month of work or allocate it over a 12 consecutive month period beginning with the first month of work, whichever you select. In the above examples, the individual would have the choice of having the entire $450 deducted in the first month of work or of having $37.50 a month ($450 divided by 12) deducted for each month that he works over a 12-consecutive month period, beginning with the first month of work. For the purpose of determining the SSI payment amount, we will either deduct the entire amount in the first month earned income is received or allocate it over a 12-consecutive month period beginning with the first month earned income is received, whichever you select. In the above examples, the individual would have the choice of having the entire $450 deducted in the first month earned income is received or of having $37.50 a month ($450 divided by 12) deducted for each month he receives earned income (for work) over a 12-consecutive month period, beginning with the first month earned income is received. To be deductible the payments must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, nonmedical appliances and vehicle modifications. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for purposes of this paragraph.

(f) *Limits on deductions.* (1) We will deduct the actual amounts you pay toward your impairment-related work expenses unless the amounts are unreasonable. With respect to durable medical equipment, prosthetic devices, medical services, and similar medically related items and services, we will apply the prevailing charges under Medicare (part B of title XVIII, Health Insurance for the Aged and Disabled) to the extent that this information is readily available. Where the Medicare guides are used, we will consider the amount that you pay to be reasonable if it is no more than the prevailing charge for the same item or service under the Medicare guidelines. If the amount you actually pay is more than the prevailing charge for the same item under the Medicare guidelines, we will deduct from your earnings the amount you paid to the extent you establish that the amount is consistent with the standard or normal charge for the same or similar item or service in your community. For items and services that are not listed in the Medicare guidelines, and for items and services that are listed in the Medicare guidelines but for which such guides cannot be used because the information is not readily available, we will consider the amount you pay to be reasonable if it does not exceed the standard or normal charge for the same or similar item(s) or service(s) in your community.

(2) The decision as to whether you performed substantial gainful activity in a case involving impairment-related work expenses for items or services necessary for you to work generally will be based upon your ''earnings'' and not on the value of ''services'' you rendered. (See §§ 416.974(b)(6) (i) and (ii), and 416.975(a)). This is not necessarily so, however, if you are in a position to control or manipulate your earnings.

(3) The amount of the expenses to be deducted must be determined in a uniform manner in both the disability insurance and SSI programs. The amount of deductions must, therefore, be the same for determinations as to substantial gainful activity under both programs. The deductions that apply in determining the SSI payment amounts, though determined in the same manner as for SGA determinations, are applied

so that they correspond to the timing of the receipt of the earned income to be excluded.

(4) No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent that you have been, could be, or will be, reimbursed for payments you made. (See paragraph (b)(3) of this section.)

(5) The provisions described in the foregoing paragraphs of this section are effective with respect to expenses incurred on and after December 1, 1980, although expenses incurred after November 1980 as a result of contractual or other arrangements entered into before December 1980, are deductible. For months before December 1980 we will deduct impairment-related work expenses from your earnings only to the extent they exceeded the normal work-related expenses you would have had if you did not have your impairment(s). We will not deduct expenses, however, for those things which you needed even when you were not working.

(g) *Verification.* We will verify your need for items or services for which deductions are claimed, and the amount of the charges for those items or services. You will also be asked to provide proof that you paid for the items or services.

[48 FR 21940, May 16, 1983, as amended at 65 FR 42791, July 11, 2000]

BLINDNESS

§ 416.981 Meaning of blindness as defined in the law.

We will consider you blind under the law for payment of supplemental security income benefits if we determine that you are statutorily blind. Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

§ 416.982 Blindness under a State plan.

We shall also consider you blind for the purposes of payment of supplemental security income benefits if—

(a) You were found to be blind as defined under a State plan approved under title X or title XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your blindness for the month of December 1973; and

(c) You continue to be blind as defined under the State plan.

§ 416.983 How we evaluate statutory blindness.

We will find that you are blind if you are *statutorily blind* within the meaning of § 416.981. For us to find that you are statutorily blind, it is not necessary—

(a) That your blindness meet the duration requirement; or

(b) That you be unable to do any substantial gainful activity.

§ 416.984 If you are statutorily blind and still working.

There is no requirement that you be unable to work in order for us to find that you are blind. However, if you are working, your earnings will be considered under the income and resources rules in subparts K and L of this part. This means that if your income or resources exceed the limitations, you will not be eligible for benefits, even though you are blind.

§ 416.985 How we evaluate other visual impairments.

If you are not blind as defined in the law, we will evaluate a visual impairment the same as we evaluate other impairments in determining disability. Although you will not qualify for benefits on the basis of blindness, you may still be eligible for benefits if we find that you are disabled as defined in §§ 416.905 through 416.907.

§ 416.986 Why and when we will find that you are no longer entitled to benefits based on statutory blindness.

(a) *If your vision does not meet the definition of blindness.* If you become entitled to payments as a statutorily blind person and your statutory blindness

ends, your eligibility for payments generally will end 2 months after your blindness ends. We will find that your statutory blindness has ended beginning with the earliest of the following months—

(1) The month your vision, based on current medical evidence, does not meet the definition of blindness and you were disabled only for a specified period of time in the past;

(2) The month your vision based on current medical evidence, does not meet the definition of blindness, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not now blind; or

(3) The first month in which you fail to follow prescribed treatment that can restore your ability to work (see § 416.930).

(b) *If you were found blind as defined in a State plan.* If you become eligible for payments because you were blind as defined in a State plan, we will find that your blindness has ended beginning with the first month in which your vision, as shown by medical or other evidence, does not meet the criteria of the appropriate State plan or the first month in which your vision does not meet the definition of statutory blindness (§ 416.981), whichever is later, and in neither event earlier than the month in which we mail you a notice saying that we have determined that you are not now blind under a State plan or not now statutorily blind, as appropriate.

(c) *If you do not cooperate with us.* If you are asked to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your blindness ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your blindness ends will be the month in which you fail to do what we asked.

(d) *Before we stop your payments.* Before we stop payment of your benefits we will give you a chance to give us your reasons why we should not stop payment. Subpart M of this part describes your rights and the procedures we will follow.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50137, Dec. 6, 1985; 51 FR 7603, Feb. 28, 1986; 59 FR 1636, Jan. 12, 1994]

DISABILITY REDETERMINATIONS FOR INDIVIDUALS WHO ATTAIN AGE 18

§ 416.987 Disability redeterminations for individuals who attain age 18.

(a) *Who is affected by this section?* (1) We must redetermine your eligibility if you are eligible for SSI disability benefits and:

(i) You are at least 18 years old; and

(ii) You became eligible for SSI disability benefits as a child (*i.e.*, before you attained age 18); and

(iii) You were eligible for such benefits for the month before the month in which you attained age 18.

(2) We may find that you are not now disabled even though we previously found that you were disabled.

(b) *What are the rules for age-18 redeterminations?* When we redetermine your eligibility, we will use the rules for adults (individuals age 18 or older) who file new applications explained in § 416.920(c) through (h). We will not use the rule in § 416.920(b) for people who are doing substantial gainful activity, and we will not use the rules in § 416.994 for determining whether disability continues. If you are working and we find that you are disabled under § 416.920(d) or (g), we will apply the rules in §§ 416.260ff.

(c) *When will my eligibility be redetermined?* We will redetermine your eligibility either during the 1-year period beginning on your 18th birthday or, in lieu of a continuing disability review, whenever we determine that your case is subject to redetermination under the Act.

(d) *Will I be notified?*—(1) *We will notify you in writing before we begin your disability redetermination.* We will tell you:

(i) That we are redetermining your eligibility for payments;

(ii) Why we are redetermining your eligibility;

(iii) Which disability rules we will apply;

(iv) That our review could result in a finding that your SSI payments based on disability could be terminated;

(v) That you have the right to submit medical and other evidence for our consideration during the redetermination; and

(vi) That we will notify you of our determination, your right to appeal the determination, and your right to request continuation of benefits during appeal.

(2) *We will notify you in writing of the results of the disability redetermination.* The notice will tell you what our determination is, the reasons for our determination, and your right to request reconsideration of the determination. If our determination shows that we should stop your SSI payments based on disability, the notice will also tell you of your right to request that your benefits continue during any appeal. Our initial disability redetermination will be binding unless you request a reconsideration within the stated time period or we revise the initial determination.

(e) *When will we find that your disability ended?* If we find that you are not disabled, we will find that your disability ended in the earliest of:

(1) The month the evidence shows that you are not disabled under the rules in this section, but not earlier than the month in which we mail you a notice saying that you are not disabled.

(2) The first month in which you failed without good cause to follow prescribed treatment under the rules in § 416.930.

(3) The first month in which you failed without good cause to do what we asked. Section 416.1411 explains the factors we will consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination.

[65 FR 54789, Sept. 11, 2000, as amended at 70 FR 36508, June 24, 2005; 77 FR 43495, July 25, 2012]

CONTINUING OR STOPPING DISABILITY OR BLINDNESS

§ 416.988 Your responsibility to tell us of events that may change your disability or blindness status.

(a) If you are entitled to payments because you are disabled or blind, you should promptly tell us if—

(1) Your condition improves;

(2) You return to work;

(3) You have a new employer;

(4) You increase the amount of your work; or

(5) Your earnings increase.

(b) If we have your authorization to obtain wage and employment information (see § 416.709(a)) from a payroll data provider (see § 416.702), and we receive your wage and employment information from your employer(s) through a participating payroll data provider, your reporting requirements under paragraphs (a)(4) and (5) will be reduced as described in § 416.709(c).

[89 FR 107260, Dec. 31, 2024]

§ 416.989 We may conduct a review to find out whether you continue to be disabled.

After we find that you are disabled, we must evaluate your impairment(s) from time to time to determine if you are still eligible for payments based on disability. We call this evaluation a continuing disability review. We may begin a continuing disability review for any number of reasons including your failure to follow the provisions of the Social Security Act or these regulations. When we begin such a review, we will notify you that we are reviewing your eligibility for payments, why we are reviewing your eligibility, that in medical reviews the medical improvement review standard will apply, that our review could result in the termination of your payments, and that you have the right to submit medical and other evidence for our consideration during the continuing disability review. In doing a medical review, we will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that you are no longer under a disability. If this review shows that we should stop your payments, we will notify you in writing

and give you an opportunity to appeal. In § 416.990 we describe those events that may prompt us to review whether you continue to be disabled.

[51 FR 16826, May 7, 1986]

§ 416.989a We may conduct a review to find out whether you continue to be blind.

After we find that you are blind, we must evaluate your impairment(s) from time to time to determine if you are still eligible for payments based on blindness. We call this evaluation a continuing disability review. We may begin a continuing disability review for any number of reasons including your failure to follow the provisions of the Social Security Act or these regulations. When we begin such a review, we will notify you that we are reviewing your eligibility for payments, why we are reviewing your eligibility, that our review could result in the termination of your payments, and that you have the right to submit medical and other evidence for our consideration during the continuing disability review. In doing a medical review, we will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that you are no longer blind. If this review shows that we should stop your payments, we will notify you in writing and give you an opportunity to appeal. In § 416.990 we describe those events that may prompt us to review whether you continue to be blind.

[51 FR 16826, May 7, 1986]

§ 416.990 When and how often we will conduct a continuing disability review.

(a) *General.* We conduct continuing disability reviews to determine whether or not you continue to meet the disability or blindness requirements of the law. Payment ends if the medical or other evidence shows that you are not disabled or blind as determined under the standards set out in section 1614(a) of the Social Security Act if you receive benefits based on disability or § 416.986 of this subpart if you receive benefits based on blindness. In paragraphs (b) through (g) of this section, we explain when and how often we conduct continuing disability reviews for most individuals. In paragraph (h) of this section, we explain special rules for some individuals who are participating in the Ticket to Work program. In paragraph (i) of this section, we explain special rules for some individuals who work and have received social security benefits as well as supplemental security income payments.

(b) *When we will conduct a continuing disability review.* Except as provided in paragraphs (h) and (i) of this section, we will start a continuing disability review if—

(1) You have been scheduled for a medical improvement expected diary review;

(2) You have been scheduled for a periodic review (medical improvement possible or medical improvement not expected) in accordance with the provisions of paragraph (d) of this section;

(3) We need a current medical or other report to see if your disability continues. (This could happen when, for example, an advance in medical technology, such as improved treatment for Alzheimer's disease, or a change in vocational therapy or technology raises a disability issue);

(4) You return to work;

(5) Substantial earnings are reported to your wage record;

(6) You tell us that—

(i) You have recovered from your disability; or

(ii) You have returned to work;

(7) Your State Vocational Rehabilitation Agency tells us that—

(i) The services have been completed; or

(ii) You are now working; or

(iii) You are able to work;

(8) Someone in a position to know of your physical or mental condition tells us any of the following, and it appears that the report could be substantially correct:

(i) You are not disabled or blind; or

(ii) You are not following prescribed treatment; or

(iii) You have returned to work; or

(iv) You are failing to follow the provisions of the Social Security Act or these regulations;

(9) Evidence we receive raises a question whether your disability or blindness continues;

(10) You have been scheduled for a vocational reexamination diary review; or

(11) By your first birthday, if you are a child whose low birth weight was a contributing factor material to our determination that you were disabled; *i.e.*, whether we would have found you disabled if we had not considered your low birth weight. However, we will conduct your continuing disability review later if at the time of our initial determination that you were disabled:

(i) We determine that you have an impairment that is not expected to improve by your first birthday; and

(ii) We schedule you for a continuing disability review after your first birthday.

(c) *Definitions.* As used in this section—

Medical improvement expected diary—refers to a case which is scheduled for review at a later date because the individual's impairment(s) is expected to improve. Generally, the diary period is set for not less than 6 months or for not more than 18 months. Examples of cases likely to be scheduled for medical improvement expected diary are fractures and cases in which corrective surgery is planned and recovery can be anticipated.

Permanent impairment—medical improvement not expected—refers to a case in which any medical improvement in a person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability programs to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity or, if you are a child, unlikely to improve to the point that you will no longer have marked and severe functional limitations. The interaction of the individual's age, impairment consequences and the lack of recent attachment to the labor market may also be considered in determining whether an impairment is permanent. Improvement which is considered temporary under §416.994(b)(2)(iv)(D) or §416.994(c)(2)(iv), as appropriate, will not be considered in deciding if an impairment is permanent. Examples of permanent impairments taken from the list contained in our other written guidelines which are available for public review are as follows and are not intended to be all inclusive:

(1) Parkinsonian Syndrome which has reached the level of severity necessary to meet the Listing in appendix 1 of subpart P or part 404 of this chapter.

(2) Amyotrophic Lateral Sclerosis which has reached the level of severity necessary to meet the Listing in appendix 1 of subpart P of part 404 of this chapter.

(3) Diffuse pulmonary fibrosis in an individual age 55 or over which has reached the level of severity necessary to meet the Listing in appendix 1 of subpart P of part 404 of this chapter.

(4) Amputation of leg at hip.

Nonpermanent impairment—refers to a case in which any medical improvement in the person's impairment(s) is possible. This means an impairment for which improvement cannot be predicted based on current experience and the facts of the particular case but which is not at the level of severity of an impairment that is considered permanent. Examples of nonpermanent impairments are: Regional enteritis, hyperthyroidism, and chronic ulcerative colitis.

Vocational reexamination diary—refers to a case which is scheduled for review at a later date because the individual is undergoing vocational therapy, training or an educational program which may improve his or her ability to work so that the disability or blindness requirement of the law is no longer met. Generally, the diary period will be set for the length of the training, therapy, or program of education.

(d) *Frequency of review.* If your impairment is expected to improve, generally we will review your continuing eligibility for payments based on disability or blindness at intervals from 6 months to 18 months following our most recent decision. Our notice to you about the review of your case will tell you more precisely when the review will be conducted. If your disability is not considered permanent but is such that any medical improvement in your impairment(s) cannot be accurately

predicted, we will review your continuing eligibility for payments at least once every 3 years. If your disability is considered permanent, we will review your continuing eligibility for payments no less frequently than once every 7 years but no more frequently than once every 5 years. Regardless of your classification we will conduct an immediate continuing disability review if a question of continuing disability is raised pursuant to paragraph (b) of this section.

(e) *Change in classification of impairment.* If the evidence developed during a continuing disability review demonstrates that your impairment has improved, is expected to improve, or has worsened since the last review, we may reclassify your impairment to reflect this change in severity. A change in the classification of your impairment will change the frequency with which we will review your case. We may also reclassify certain impairments because of improved tests, treatment, and other technical advances concerning those impairments.

(f) *Review after administrative appeal.* If you were found eligible to receive or to continue to receive, payments on the basis of a decision by an administrative law judge, the Appeals Council or a Federal court, we will not conduct a continuing disability review earlier than 3 years after that decision unless your case should be scheduled for a medical improvement expected or vocational reexamination diary review or a question of continuing disability is raised pursuant to paragraph (b) of this section.

(g) *Waiver of timeframes.* All cases involving a nonpermanent impairment will be reviewed by us at least once every 3 years unless we, after consultation with the State agency, determine that the requirement should be waived to ensure that only the appropriate number of cases are reviewed. The appropriate number of cases to be reviewed is to be based on such considerations as the backlog of pending reviews, the projected number of new applications, and projected staffing levels. Such waiver shall be given only after good faith effort on the part of the State to meet staffing requirements and to process the reviews on a timely basis. Availability of independent medical resources may also be a factor. A *waiver* in this context refers to our administrative discretion to determine the appropriate number of cases to be reviewed on a State by State basis. Therefore, your continuing disability review may be delayed longer than 3 years following our original decision or other review under certain circumstances. Such a delay would be based on our need to ensure that backlogs, reviews required to be performed by the Social Security Disability Benefits Reform Act (Pub. L. 98–460), and new disability claims workloads are accomplished within available medical and other resources in the State agency and that such reviews are done carefully and accurately.

(h) *If you are participating in the Ticket to Work program.* If you are participating in the Ticket to Work program, we will not start a continuing disability review during the period in which you are using a ticket. See subpart C of part 411 of this chapter.

(i) *If you are working and have received social security disability benefits for at least 24 months*—(1) *General.* Notwithstanding the provisions in paragraphs (b)(4), (b)(5), (b)(6)(ii), (b)(7)(ii), and (b)(8)(iii) of this section, we will not start a continuing disability review based solely on your work activity if—

(i) You are currently entitled to disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability under title II of the Social Security Act (see subpart D of part 404 of this chapter); and

(ii) You have received such benefits for at least 24 months (see paragraph (i)(2) of this section).

(2) *The 24-month requirement.* (i) The months for which you have actually received disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability that you were due under title II of the Social Security Act, or for which you have constructively received such benefits, will count for the 24-month requirement under paragraph (i)(1)(ii) of this section, regardless of whether the months were consecutive.

We will consider you to have constructively received a benefit for a month for purposes of the 24-month requirement if you were otherwise due a social security disability benefit for that month and your monthly benefit was withheld to recover an overpayment. Any month for which you were entitled to social security disability benefits but for which you did not actually or constructively receive a benefit payment will not be counted for the 24-month requirement. Months for which your social security disability benefits are continued under §404.1597a pending reconsideration and/or a hearing before an administrative law judge on a medical cessation determination will not be counted for the 24-month requirement. Months for which you received only supplemental security income payments will not be counted for the 24-month requirement.

(ii) In determining whether paragraph (i)(1) of this section applies, we consider whether you have received disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability under title II of the Social Security Act for at least 24 months as of the date on which we start a continuing disability review. For purposes of this provision, the date on which we start a continuing disability review is the date on the notice we send you that tells you that we are beginning to review your disability case.

(3) *When we may start a continuing disability review even if you have received social security disability benefits for at least 24 months.* Even if you meet the requirements of paragraph (i)(1) of this section, we may still start a continuing disability review for a reason(s) other than your work activity. We may start a continuing disability review if we have scheduled you for a periodic review of your continuing disability, we need a current medical or other report to see if your disability continues, we receive evidence which raises a question as to whether your disability or blindness continues, or you fail to follow the provisions of the Social Security Act or these regulations. For example, we will start a continuing disability review when you have been scheduled for a medical improvement expected diary review, and we may start a continuing disability review if you failed to report your work to us.

(4) *Erroneous start of the continuing disability review.* If we start a continuing disability review based solely on your work activity that results in a medical cessation determination, we will vacate the medical cessation determination if—

(i) You provide us evidence that establishes that you met the requirements of paragraph (i)(1) of this section as of the date of the start of your continuing disability review and that the start of the review was erroneous; and

(ii) We receive the evidence within 12 months of the date of the notice of the initial determination of medical cessation.

[51 FR 16826, May 7, 1986, as amended at 62 FR 6430, Feb. 11, 1997; 65 FR 54790, Sept. 11, 2000; 71 FR 66858, Nov. 17, 2006]

§416.991 If your medical recovery was expected and you returned to work.

If your impairment was expected to improve and you returned to full-time work with no significant medical limitations and acknowledge that medical improvement has occurred, we may find that your disability ended in the month you returned to work. Unless there is evidence showing that your disability has not ended, we will use the medical and other evidence already in your file and the fact that you returned to full-time work without significant limitations to determine that you are no longer disabled.

Example: Evidence obtained during the processing of your claim showed that you had an impairment that was expected to improve about 18 months after your disability began. We, therefore, told you that your claim would be reviewed again at that time. However, before the time arrived for your scheduled medical re-examination, you told us that you had returned to work and your impairment had improved. We reviewed your claim immediately and found that, in the 16th month after your disability began, you returned to full-time work without any significant medical restrictions. Therefore, we would find that your disability ended in the first month you returned to full-time work.

[50 FR 50137, Dec. 6, 1985, as amended at 65 FR 42791, July 11, 2000]

§ 416.992 What happens if you fail to comply with our request for information.

We will suspend your payments before we make a determination regarding your continued eligibility for disability payments if you fail to comply, without good cause (see § 416.1411), with our request for information for your continuing disability review or age-18 redetermination. The suspension is effective with the month in which it is determined in accordance with § 416.1322 that your eligibility for disability payments has ended due to your failure to comply with our request for necessary information. When we have received the information, we will reinstate your payments for any previous month for which they are otherwise payable, and continue with the CDR or age-18 redetermination process. We will terminate your eligibility for payments following 12 consecutive months of payment suspension as discussed in § 416.1335.

[71 FR 60823, Oct. 17, 2006]

§ 416.992a [Reserved]

§ 416.993 Medical evidence in continuing disability review cases.

(a) *General.* If you are entitled to benefits because you are disabled, we will have your case file with the supporting medical evidence previously used to establish or continue your entitlement. Generally, therefore, the medical evidence we will need for a continuing disability review will be that required to make a current determination or decision as to whether you are still disabled, as defined under the medical improvement review standard. See §§ 416.987 and 416.994.

(b) *Obtaining evidence from your medical sources.* You must provide us with reports from your physician, psychologist, or others who have treated or evaluated you, as well as any other evidence that will help us determine if you are still disabled. See § 416.912. You must have a good reason for not giving us this information or we may find that your disability has ended. See § 416.994(e)(2). If we ask you, you must contact your medical sources to help us get the medical reports. We will make every reasonable effort to help you in getting medical reports when you give us permission to request them from your physician, psychologist, or other medical sources. See § 416.912(b)(1)(i) concerning what we mean by every reasonable effort. In some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. See § 416.912(b)(1)(ii). See § 416.912(c).

(c) *When we will purchase a consultative examination.* A consultative examination may be purchased when we need additional evidence to determine whether or not your disability continues. As a result, we may ask you, upon our request and reasonable notice, to undergo consultative examinations and tests to help us determine if you are still disabled. See § 416.917. We will decide whether or not to purchase a consultative examination in accordance with the standards in §§ 416.919a through 416.919b.

[56 FR 36970, Aug. 1, 1991, as amended at 65 FR 16815, Mar. 30, 2000; 82 FR 5882, Jan. 18, 2017]

§ 416.994 How we will determine whether your disability continues or ends, disabled adults.

(a) *General.* There is a statutory requirement that, if you are entitled to disability benefits, your continued entitlement to such benefits must be reviewed periodically. Our rules for deciding whether your disability continues are set forth in paragraph (b) of this section. Additional rules apply if you were found disabled under a State plan, as set forth in paragraph (c) of this section.

(b) *Disabled persons age 18 or over (adults).* If you are entitled to disability benefits as a disabled person age 18 or over (adult) there are a number of factors we consider in deciding whether your disability continues. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not

so medically improved, we must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases, (see paragraph (b)(4) of this section for exceptions) we must also show that you are currently able to engage in substantial gainful activity before we can find that you are no longer disabled.

(1) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review whether your disability continues. In addition, see paragraph (b)(8) of this section if you work during your current period of eligibility based on disability or during certain other periods.

(i) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with your impairment(s).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus. At the time of our prior decision granting you benefits you had had a laminectomy. Postoperatively, a myelogram still shows evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim your medical source who has treated you reported that he or she had seen you regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has *not* occurred because there has been no decrease in the severity of your back impairment as shown by changes in symptoms, signs or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remissions and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would then determine if this medical improvement is related to your ability to work.

(ii) *Medical improvement not related to ability to do work.* Medical improvement is not related to your ability to work if there has been a decrease in the severity of the impairment(s) as defined in paragraph (b)(1)(i) of this section, present at the time of the most recent favorable medical decision, but *no* increase in your functional capacity to do basic work activities as defined in paragraph (b)(1)(iv) of this section. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

Example: You are 65 inches tall and weighed 246 pounds at the time your disability was established. You had venous insufficiency and persistent edema in your legs. At the time, your ability to do basic work activities was affected because you were able to sit for 6 hours, but were able to stand or walk only occasionally. At the time of our continuing disability review, you had undergone a vein stripping operation. You now weigh 220 pounds and have intermittent edema. You are still able to sit for 6 hours at a time and to stand or work only occasionally although you report less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by your weight loss and the improvement in your edema. This medical improvement is not related to your ability to work, however, because your functional capacity to do basic work activities (*i.e.*, the ability to sit, stand and walk) has not increased.

(iii) *Medical improvement that is related to ability to do work.* Medical improvement is related to your ability to work if there has been a decrease in the severity, as defined in paragraph (b)(1)(i) of this section, of the impairment(s) present at the time of the most recent favorable medical decision *and* an increase in your functional capacity to do basic work activities as discussed in paragraph (b)(1)(iv) of this section. A determination that medical improvement related to your ability to do work has occurred does not, necessarily, mean that your disability will be found to have ended unless it is also shown that you are currently able to engage in substantial gainful activity as discussed in paragraph (b)(1)(v) of this section.

Example 1: You have a back impairment and had a laminectomy to relieve the nerve root impingement and weakness in your left leg. At the time of our prior decision, basic work activities were affected because you were able to stand less than 6 hours, and sit no more than ½ hour at a time. You had a successful fusion operation on your back about 1 year before our review of your entitlement. At the time of our review, the weakness in your leg has decreased. Your functional capacity to perform basic work activities now is unimpaired because you now have no limitation on your ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of your impairment as demonstrated by the decreased weakness in your leg. This medical improvement is related to your ability to work because there has also been an increase in your functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on your ability to sit, walk, or stand. Whether or not your disability is found to have ended, however, will depend on our determination as to whether you can currently engage in substantial gainful activity.

Example 2: You were injured in an automobile accident receiving a compound fracture to your right femur and a fractured pelvis. When you applied for disability benefits 10 months after the accident your doctor reported that neither fracture had yet achieved solid union based on his clinical examination. X-rays supported this finding. Your doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of our review 6 months later, solid union had occurred and you had been returned to weight-bearing for over a month. Your doctor reported this and the fact that your prior fractures no longer placed any limitation on your ability to walk, stand, lift, etc., and, that in fact, you could return to fulltime work if you so desired.

Medical improvement has occurred because there has been a decrease in the severity of your impairments as shown by X-ray and clinical evidence of solid union and your return to full weight-bearing. This medical improvement is related to your ability to work because you no longer meet the same listed impairment in appendix 1 of subpart P of part 404 of this chapter (see paragraph (b)(2)(iii)(A) of this section). In fact, you no longer have an impairment which is severe (see § 416.921) and your disability will be found to have ended.

(iv) *Functional capacity to do basic work activities.* Under the law, disability is defined, in part, as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment(s). In determining whether you are disabled under the law, we must measure, therefore, how and to what extent your impairment(s) has affected your ability to do work. We do this by looking at how your functional capacity for doing basic work activities has been affected. Basic work activities means the abilities and aptitudes necessary to do most jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and nonexertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes and dealing with both supervisors and fellow workers. A person who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment will result in some limitation to the functional capacity to do one or more of these basic work activities. Diabetes, for example, can result in circulatory problems which could limit the length of time a person could stand or walk and damage to his or her eyes as well, so that the person also had limited vision. What a person can still do despite an impairment, is called his or her residual functional capacity. How the residual functional capacity is assessed is discussed in more detail in § 416.945. Unless an impairment is so severe that it is

deemed to prevent you from doing substantial gainful activity (see §§416.925 and 416.926) it is this residual functional capacity that is used to determine whether you can still do your past work or, in conjunction with your age, education and work experience, any other work.

(A) A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the person can stand or walk for longer periods. When new evidence showing a change in symptoms, signs and laboratory findings establishes that both medical improvement has occurred and your functional capacity to perform basic work activities, or residual functional capacity, has increased, we say that medical improvement which is related to your ability to do work has occurred. A residual functional capacity assessment is also used to determine whether you can engage in substantial gainful activity and, thus, whether you continue to be disabled (see paragraph (b)(1)(vi) of this section).

(B) Many impairment-related factors must be considered in assessing your functional capacity for basic work activities. Age is one key factor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits become irreversible over time and that maximum exercise performance diminishes with age. Other changes related to sustained periods of inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the cardiac and respiratory systems which limit the exertional range.

(C) Studies have also shown that the longer an individual is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if you are age 50 or over and have been receiving disability benefits for a considerable period of time, we will consider this factor along with your age in assessing your residual functional capacity. This will ensure that the disadvantages resulting from inactivity and the aging process during a long period of disability will be considered. In some instances where available evidence does not resolve what you can or cannot do on a sustained basis, we will provide special work evaluations or other appropriate testing.

(v) *Ability to engage in substantial gainful activity.* In most instances, we must show that you are able to engage in substantial gainful activity before your benefits are stopped. When doing this, we will consider all your current impairments not just that impairment(s) present at the time of the most recent favorable determination. If we cannot determine that you are still disabled based on medical consideration alone (as discussed in §§416.925 and 416.926), we will use the new symptoms, signs and laboratory findings to make an objective assessment of your functional capacity to do basic work activities or residual functional capacity and we will consider your vocational factors. See §§416.945 through 416.969.

(vi) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit and that we obtain from your medical sources and nonmedical sources. What constitutes ''evidence'' and our procedures for obtaining it are set out in §§416.912 through 416.918. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(vii) *Point of comparison.* For purpose of determining whether medical improvement has occurred, we will compare the current medical severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were

disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will compare your current functional capacity to do basic work activities (*i.e.*, your residual functional capacity) based on the previously existing impairments with your prior residual functional capacity in order to determine whether the medical improvement is related to your ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(2) *Determining medical improvement and its relationship to your abilities to do work.* Paragraphs (b)(1)(i) through (b)(1)(iii) of this section discuss what we mean by medical improvement, medical improvement not related to your ability to work, and medical improvement that is related to your ability to work. (In addition, see paragraph (b)(8) of this section if you work during your current period of eligibility based on disability or during certain other periods.) How we will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed below.

(i) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled and is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(ii) *Determining if medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, we then must determine if it is related to your ability to do work. In paragraph (b)(1)(iv) of this section, we explain the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect your residual functional capacity. In determining whether medical improvement that has occurred is related to your ability to do work, we will assess your residual functional capacity (in accordance with paragraph (b)(1)(iv) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision.

(iii) Your new residual functional capacity will then be compared to your residual functional capacity at the time of our most recent favorable medical decision. Unless an increase in the current residual functional capacity is based on actual changes in the signs, symptoms, or laboratory findings any medical improvement that has occurred will not be considered to be related to your ability to do work.

(iv) Following are some additional factors and considerations which we will apply in making these determinations.

(A) *Previous impairment met or equaled listings.* If our most recent favorable decision was based on the fact that your impairment(s) at the time met or equaled the severity contemplated by the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, an assessment of your residual functional capacity would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing section used to make our most recent favorable decision, we will find that the medical improvement was related to your ability to work. Appendix 1 of subpart P of part 404 of this chapter describes impairments which, if severe enough, affect a person's ability to work. If the appendix level severity is met or equaled the individual is deemed, in the absence of evidence to the contrary, to be unable to engage in gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. We must, of course, also establish that you can currently engage in substantial gainful activity before finding that your disability has ended.

(B) *Prior residual functional capacity assessment made.* The residual functional capacity assessment used in making the most recent favorable medical decision will be compared to the residual functional capacity assessment based on current evidence in order to determine if your functional capacity for basic work activities has increased. There will be no attempt made to reassess the prior residual functional capacity.

(C) *Prior residual functional capacity assessment should have been made, but was not.* If the most recent favorable medical decision should have contained an assessment of your residual functional capacity (*i.e.*, your impairments did not meet or equal the level of severity contemplated by the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter) but does not, either because this assessment is missing from your file or because it was not done, we will reconstruct the residual functional capacity. This reconstructed residual functional capacity will accurately and objectively assess your functional capacity to do basic work activities. We will assign the maximum functional capacity consistent with a decision of allowance.

Example: You were previously found to be disabled on the basis that ''while your impairment did not meet or equal a listing, it did prevent you from doing your past or any other work.'' The prior adjudicator did not, however, include a residual functional capacity assessment in the rationale of this decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, *i.e.*, medical improvement, has occurred, the residual functional capacity based on the current level of severity of your impairment will have to be compared with your residual functional capacity based on its prior severity in order to determine if the medical improvement is related to your ability to do work. In order to make this comparison, we will review the prior evidence and make an objective assessment of your residual functional capacity at the time of our most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

(D) *Impairment subject to temporary remission.* In some cases the evidence shows that an individual's impairments are subject to temporary remission. In assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairment, including the occurrence of prior remission, and prospects for future worsenings. Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(E) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether you are able to now engage in substantial gainful activity based on all your current impairments. (In this way, we will be able to determine that your disability continues at the earliest point without addressing the often lengthy process of reconstructing prior evidence.) If you cannot engage in substantial gainful activity currently, your benefits will continue unless one of the second group of exceptions applies (see paragraph (b)(4) of this section). If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence, and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation , and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with §416.988.

(3) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if you can engage in substantial gainful activity. These exceptions to medical improvement are intended

to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, you are now able to engage in substantial gainful activity before your disability can be found to have ended. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception applies.

(i) *Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased your ability to do basic work activities. We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment or your ability to do basic work activities. This decision will be based on new medical evidence and a new residual functional capacity assessment. (See § 416.945.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits as explained in § 416.261. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(ii) *Substantial evidence shows that you have undergone vocational therapy (related to your ability to work).* Vocational therapy (related to your ability to work) may include, but is not limited to, additional education, training, or work experience that improves your ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. (See § 416.945.) This exception does not apply if you are eligible to receive special Supplemental Security Income cash benefits as explained in § 416.261. If, at the time of our review, you have not completed vocational therapy which could affect the continuance of your disability, we will review your claim upon completion of the therapy.

Example 1: You were found to be disabled because the limitations imposed on you by your impairment allowed you to only do work that was at a sedentary level of exertion. Your prior work experience was work that required a medium level of exertion. Your age and education at the time would not have qualified you for work that was below this medium level of exertion. You enrolled in and completed a specialized training course which qualifies you for a job in data processing as a computer programmer in the period since you were awarded benefits. On review of your claim, current evidence shows that there is no medical improvement and that you can still do only sedentary work. As the work of a computer programmer is sedentary in nature, you are now able to engage in substantial gainful activity when your new skills are considered.

Example 2: You were previously entitled to benefits because the medical evidence and assessment of your residual functional capacity showed you could only do light work. Your prior work was considered to be heavy in nature and your age, education and the nature of your prior work qualified you for work which was no less than medium in exertion. The current evidence and residual functional capacity show there has been no medical improvement and that you can still do only light work. Since you were originally entitled to benefits, your vocational rehabilitation agency enrolled you in and you successfully completed a trade school course so that you are now qualified to do small appliance repair. This work is light in nature, so when your new skills are considered, you are now able to engage in substantial gainful activity even though there has been no change in your residual functional capacity.

(iii) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and

advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if you can currently engage in substantial gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(A) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(B) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(*1*) Some of the future changes in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter will be based on new or improved diagnostic or evaluation techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved techniques will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(*2*) A cumulative list since 1970 of new or approved diagnostic techniques or evaluations, how they changed the evaluation of the applicable impairment and the month and year they became generally available, will be published in the *Notices* section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically. The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in substantial gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(iv) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(A) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 of subpart P of part 404 of this chapter or a medical/vocational rule in appendix 2 of subpart P of part 404 of this chapter was misapplied).

Example 1: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by electroencephalogram evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether you could currently engage in substantial gainful activity.

Example 2: Your prior award of benefits was based on vocational rule 201.12 in appendix 2 of subpart P of part 404 of this chapter. This rule applies to a person age 50–54 who has at least a high school education, whose previous work was entirely at a semiskilled level, and who can do only sedentary work. On review, it is found that at the time of the prior determination you were actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of your claim and the prior decision is found to have been in error. Continuation of your disability would depend on a finding of your current ability to engage in substantial gainful activity.

(B) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: You were found disabled on the basis of chronic obstructive pulmonary disease. The severity of your impairment was documented primarily by pulmonary function testing results. The evidence showed that you could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that your impairment does not limit your ability to perform basic work activities in any way. Error is found based on the fact that required, material evidence which was originally missing now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

(C) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence, (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously found entitled to benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that you had ''brittle'' diabetes for which you were taking insulin. Your urine was 3 + for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that your impairment clearly does not equal the severity contemplated by the listings. Error *cannot* be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(D) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see §§ 416.1488 through 416.1489) are met.

(4) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in substantial gainful activity.

(i) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim

under the rules in §416.1488. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(ii) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(iii) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will suspend your payments. The month your payments are suspended will be the first month in which the question arose and we could not find you.

(iv) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in substantial gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see §416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(5) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that a decision of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. The steps are as follows. (See paragraph (b)(8) of this section if you work during your current period of eligibility based on disability or during certain other periods.)

(i) *Step 1.* Do you have an impairment or combination of impairments which meets or equals the severity of an impairment listed in appendix 1 of subpart P of part 404 of this chapter? If you do, your disability will be found to continue.

(ii) *Step 2.* If you do not, has there been medical improvement as defined in paragraph (b)(1)(i) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step 3 in paragraph (b)(5)(iii) of this section. If there has been no decrease in medical severity, there has been no medical improvement. (See step 4 in paragraph (b)(5)(iv) of this section.)

(iii) *Step 3.* If there has been medical improvement, we must determine whether it is related to your ability to do work in accordance with paragraphs (b)(1)(i) through (b)(1)(iv) of this section; *i.e.*, whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to your ability to do work, see step 4 in paragraph (b)(5)(iv) of this section. If medical improvement *is* related to your ability to do work, see step 5 in paragraph (b)(5)(v) of this section.

(iv) *Step 4.* If we found at step 2 in paragraph (b)(5)(ii) of this section that there has been no medical improvement or if we found at step 3 in paragraph (b)(5)(iii) of this section that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (b)(3) and (b)(4) of this section apply. If none of them apply, your disability will be found to continue. If one

of the first group of exceptions to medical improvement applies, see step 5 in paragraph (b)(5)(v) of this section. If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(v) *Step 5.* If medical improvement is shown to be related to your ability to do work or if one of the first group of exceptions to medical improvement applies, we will determine whether all your current impairments in combination are severe (see § 416.921). This determination will consider all your current impairments and the impact of the combination of these impairments on your ability to function. If the residual functional capacity assessment in step 3 in paragraph (b)(5)(iii) of this section shows significant limitation of your ability to do basic work activities, see step 6 in paragraph (b)(5)(vi) of this section. When the evidence shows that all your current impairments in combination do not significantly limit your physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature. If so, you will no longer be considered to be disabled.

(vi) *Step 6.* If your impairment(s) is severe, we will assess your current ability to do substantial gainful activity in accordance with § 416.960. That is, we will assess your residual functional capacity based on all your current impairments and consider whether you can still do work you have done in the past. If you can do such work, disability will be found to have ended.

(vii) *Step 7.* If you are not able to do work you have done in the past, we will consider whether you can do other work given the residual functional capacity assessment made under paragraph (b)(5)(vi) of this section and your age, education, and past work experience (*see* paragraph (b)(5)(viii) of this section for an exception to this rule). If you can, we will find that your disability has ended. If you cannot, we will find that your disability continues.

(viii) *Step 8.* We may proceed to the final step, described in paragraph (b)(5)(vii) of this section, if the evidence in your file about your past relevant work is not sufficient for us to make a finding under paragraph (b)(5)(vi) of this section about whether you can perform your past relevant work. If we find that you can adjust to other work based solely on your age, education, and residual functional capacity, we will find that you are no longer disabled, and we will not make a finding about whether you can do your past relevant work under paragraph (b)(5)(vi) of this section. If we find that you may be unable to adjust to other work or if § 416.962 may apply, we will assess your claim under paragraph (b)(5)(vi) of this section and make a finding about whether you can perform your past relevant work.

(6) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the earliest of the following months.

(i) The month the evidence shows that you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(ii) The month the evidence shows that you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(iii) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see § 416.991);

(iv) The first month in which you fail without good cause to follow prescribed treatment, when the rule set out in paragraph (b)(4)(iv) of this section applies;

(v) The first month you were told by your physician that you could return to work, provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by substantial evidence; or

(vi) The first month in which you failed without good cause to do what we asked, when the rule set out in

paragraph (b)(4)(ii) of this section applies.

(7) *Before we stop your benefits.* If we find you are no longer disabled, before we stop your benefits, we will give you a chance to explain why we should not do so. Subparts M and N of this part describe your rights and the procedures we will follow.

(8) *If you work during your current period of eligibility based on disability or during certain other periods.* (i) We will not consider the work you are doing or have done during your current period of eligibility based on disability (or, when determining whether you are eligible for expedited reinstatement of benefits under section 1631(p) of the Act, the work you are doing or have done during or after the previously terminated period of eligibility referred to in section 1631(p)(1)(B) of the Act) to be past relevant work under paragraph (b)(5)(vi) of this section or past work experience under paragraph (b)(5)(vii) of this section. In addition, if you are currently entitled to disability benefits under title II of the Social Security Act, we may or may not consider the physical and mental activities that you perform in the work you are doing or have done during your current period of entitlement based on disability, as explained in paragraphs (b)(8)(ii) and (iii) of this section.

(ii) If you are currently entitled to disability insurance benefits as a disabled worker, child's insurance benefits based on disability, or widow's or widower's insurance benefits based on disability under title II of the Social Security Act, and at the time we are making a determination on your case you have received such benefits for at least 24 months, we will not consider the activities you perform in the work you are doing or have done during your current period of entitlement based on disability if they support a finding that your disability has ended. (We will use the rules in §416.990(i)(2) to determine whether the 24-month requirement is met.) However, we will consider the activities you do in that work if they support a finding that your disability continues or they do not conflict with a finding that your disability continues. We will not presume that you are still disabled if you stop working.

(iii) If you are not a person described in paragraph (b)(8)(ii) of this section, we will consider the activities you perform in your work at any of the evaluation steps in paragraph (b)(5) of this section at which we need to assess your ability to function. However, we will not consider the work you are doing or have done during your current period of eligibility based on disability (or, when determining whether you are eligible for expedited reinstatement of benefits under section 1631(p) of the Act, the work you are doing or have done during or after the previously terminated period of eligibility referred to in section 1631(p)(1)(B) of the Act) to be past relevant work under paragraph (b)(5)(vi) of this section or past work experience under paragraph (b)(5)(vii) of this section.

(c) *Persons who were found disabled under a State plan.* If you became entitled to benefits because you were found to be disabled under a State plan, we will first evaluate your impairment(s) under the rules explained in paragraph (b) of this section. We will apply the same steps as described in paragraph (b) of this section to the last decision granting or affirming entitlement to benefits under the State plan. If we are not able to find that your disability continues on the basis of these rules, we will then evaluate your impairment(s) under the appropriate State plan. If we are not able to find that your disability continues under these State plan criteria, we will find that your disability ends. Disability will be found to end the month the evidence shows that you are no longer disabled under the criteria in paragraph (b) of this section (or appropriate State plan criteria), subject to the rules set out in paragraph (b)(6) of this section.

[50 FR 50137, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 52 FR 44971, Nov. 24, 1987; 56 FR 5562, Feb. 11, 1991; 59 FR 1636, Jan. 12, 1994; 65 FR 42791, July 11, 2000; 68 FR 51167, Aug. 26, 2003; 68 FR 53219, Sept. 9, 2003; 71 FR 66859, Nov. 17, 2006; 77 FR 43496, July 25, 2012; 82 FR 5882, Jan. 18, 2017]

§ 416.994a How we will determine whether your disability continues or ends, and whether you are and have been receiving treatment that is medically necessary and available, disabled children.

(a) *Evaluation of continuing disability, in general.* There is a statutory requirement that, if you are eligible for disability benefits as a disabled child, your continued eligibility for such benefits must be reviewed periodically. There are a number of factors we consider when we decide whether your disability continues.

(1) We will first consider whether there has been medical improvement in your impairment(s). We define ''medical improvement'' in paragraph (c) of this section. If there has been no medical improvement, we will find you are still disabled unless one of the exceptions in paragraphs (e) or (f) of this section applies. If there has been medical improvement, we will consider whether the impairments(s) you had at the time of our most recent favorable determination or decision now meets or medically or functionally equals the severity of the listing it met or equalled at that time. If so, we will find you are still disabled, unless one of the exceptions in paragraphs (e) or (f) of this section applies. If not, we will consider whether your current impairment(s) are disabling under the rules in § 416.924. These steps are described in more detail in paragraph (b) of this section. Even where medical improvement or an exception applies, in most cases, we will find that your disability has ended only if we also find that you are not currently disabled.

(2) Our determinations and decisions under this section will be made on a neutral basis, without any initial inference as to the presence or absence of disability being drawn from the fact that you have been previously found disabled. We will consider all evidence you submit and that we obtain from your medical and nonmedical sources. What constitutes ''evidence'' and our procedures for obtaining it are set out in §§ 416.912 through 416.918. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(b) *Sequence of evaluation.* To ensure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, we follow specific steps in determining whether your disability continues. However, we may skip steps in the sequence if it is clear this would lead to a more prompt finding that your disability continues. For example, we might not consider the issue of medical improvement if it is obvious on the face of the evidence that a current impairment meets the severity of a listed impairment. If we can make a favorable determination or decision at any point in the sequence, we do not review further. The steps are:

(1) *Has there been medical improvement in your condition(s)?* We will determine whether there has been medical improvement in the impairment(s) you had at the time of our most recent favorable determination or decision. (The term medical improvement is defined in paragraph (c) of this section.) If there has been no medical improvement, we will find that your disability continues, unless one of the exceptions to medical improvement described in paragraph (e) or (f) of this section applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 3.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(2) *Does your impairment(s) still meet or equal the severity of the listed impairment that it met or equaled before?* If there has been medical improvement, we will consider whether the impairment(s) that we considered at the time of our most recent favorable determination or decision still meets or equals the severity of the listed impairment it met or equaled at that time. In making this decision, we will consider the current severity of the impairment(s) present and documented at the time of our most recent favorable determination or decision, and the same listing section

used to make that determination or decision as it was written at that time, even if it has since been revised or removed from the Listing of Impairments. If that impairment(s) does not still meet or equal the severity of that listed impairment, we will proceed to the next step. If that impairment(s) still meets or equals the severity of that listed impairment as it was written at that time, we will find that you are still disabled, unless one of the exceptions to medical improvement described in paragraphs (e) or (f) of this section applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 3.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(3) *Are you currently disabled?* If there has been medical improvement in the impairment(s) that we considered at the time of our most recent favorable determination or decision, and if that impairment(s) no longer meets or equals the severity of the listed impairment that it met or equaled at that time, we will consider whether you are disabled under the rules in §§416.924(c) and (d). In determining whether you are currently disabled, we will consider all impairments you now have, including any you did not have at the time of our most recent favorable determination or decision, or that we did not consider at that time. The steps in determining current disability are summarized as follows:

(i) *Do you have a severe impairment or combination of impairment?* If there has been medical improvement in your impairment(s), or if one of the first group of exceptions applies, we will determine whether your current impairment(s) is severe, as defined in §416.924(c). If your impairment(s) is not severe, we will find that your disability has ended. If your impairment(s) is severe, we will then consider whether it meets or medically equals the severity of a listed impairment.

(ii) *Does your impairment(s) meet or medically equal the severity of any impairment listed in appendix 1 of subpart P of part 404 of this chapter?* If your current impairment(s) meets or medically equals the severity of any listed impairment, as described in §§416.925 and 416.926, we will find that your disability continues. If not, we will consider whether it functionally equals the listings.

(iii) *Does your impairment(s) functionally equal the listings?* If your current impairment(s) functionally equals the listings, as described in §416.926a, we will find that your disability continues. If not, we will find that your disability has ended.

(c) *What we mean by medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable decision that you were disabled or continued to be disabled. Although the decrease in severity may be of any quantity or degree, we will disregard minor changes in your signs, symptoms, and laboratory findings that obviously do not represent medical improvement and could not result in a finding that your disability has ended. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs, or laboratory findings associated with your impairment(s).

(1) The most recent favorable decision is the latest final determination or decision involving a consideration of the medical evidence and whether you were disabled or continued to be disabled.

(2) The terms symptoms, signs, and laboratory findings are defined in §416.902. For children, our definitions of the terms *symptoms, signs,* and *laboratory findings* may include any abnormalities of physical and mental functioning that we used in making our most recent favorable decision.

(3) Some impairments are subject to temporary remissions, which can give the appearance of medical improvement when in fact there has been none. If you have the kind of impairment that is subject to temporary remissions, we will be careful to consider the longitudinal history of the impairment, including the occurrence of prior remissions and prospects for future worsenings, when we decide whether there has been medical improvement. Improvements that are only temporary

will not warrant a finding of medical improvement.

(d) *Prior file cannot be located.* If we cannot locate your prior file, we will first determine whether you are currently disabled under the sequence set forth in § 416.924. (In this way, we will determine that your benefits continue at the earliest time without reconstructing prior evidence.) If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (f) of this section). If not, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable determination or decision (e.g., school records, medical evidence, and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation, and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable decision. If relevant parts of the prior record are not reconstructed, either because we decide not to attempt reconstruction or because our efforts failed, we will not find that you have medically improved. The documentation of your current impairment(s) will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any determination or decision under this section, in accordance with § 416.1488.

(e) *First group of exceptions to medical improvement.* The law provides certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if your impairment(s) no longer results in marked and severe functional limitations. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that your impairment(s) does not now result in marked and severe functional limitations, before we can find you are no longer disabled, taking all your current impairments into account, not just those that existed at the time of our most recent favorable determination or decision. The evidence we gather will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that, based on new or improved diagnostic techniques or evaluations, your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic techniques or evaluations have given rise to, and will continue to give rise to, improved methods for determining the causes of (*i.e.*, diagnosing) and measuring and documenting the effects of various impairments on children and their functioning. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable decision, such evidence may serve as a basis for a finding that you are no longer disabled, provided that you do not currently have an impairment(s) that meets, medically equals, or functionally equals the listings, and therefore results in marked and severe functional limitations. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for

payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter will be based on new or improved diagnostic or evaluative techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) From time to time, we will publish in the FEDERAL REGISTER cumulative lists of new or approved diagnostic techniques or evaluations that have been in use since 1970, how they changed the evaluation of the applicable impairment and the month and year they became generally available. We will include any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 that are reflective of new or improved techniques. We will not process any cases under this exception using a new or improved diagnostic technique that we have not included in a published notice until we have published an updated cumulative list. The period between publications will be determined by the volume of changes needed.

(2) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination or decision of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination or decision) demonstrates that a prior determination or decision (of allowance or continuance) was in error. A prior determination or decision will be found in error only if:

(i) Substantial evidence shows on its face that the determination or decision in question should not have been made (e.g., the evidence in your file, such as pulmonary function study values, was misread, or an adjudicative standard, such as a listing in appendix 1 of subpart P of part 404 of this chapter, was misapplied).

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that, had such evidence been present at the time of the prior determination or decision, disability would not have been found.

(iii) New substantial evidence that relates to the prior determination or decision refutes the conclusions that were based upon the prior evidence at the time of that determination or decision (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that, had the new evidence (which relates to the prior determination or decision) been considered at the time of the prior determination or decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable determination or decision will not be the basis for applying this exception.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see §§416.1488 and 416.1489) are met.

(f) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination or decision that you are no longer disabled. In these situations, the determination or decision will be made without a finding that you have demonstrated medical improvement or that you are currently not disabled under the rules in §416.924. There is no set point in the continuing disability review sequence described in paragraph (b) of this section at which we must consider these exceptions; exceptions in the second group may be considered at any point in the process.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination

or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in §416.1488. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will suspend your payments. The month your payments are suspended will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to improve your impairment(s) so that it no longer results in marked and severe functional limitations.* If treatment has been prescribed for you which would be expected to improve your impairment(s) so that it no longer results in marked and severe functional limitations, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see §416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the following month—

(1) The month the evidence shows that you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows that you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you return to, or begin, full-time work with no significant medical restrictions, and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see §416.991);

(4) The first month in which you fail without good cause to follow prescribed treatment, when the rule set out in paragraph (f)(4) of this section applies;

(5) The first month in which you were told by your physician that you could return to normal activities, provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity, and the earlier date is supported by substantial evidence; or

(6) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (f)(2) of this section applies.

(h) *Before we stop your benefits.* If we find you are no longer disabled, before we stop your benefits, we will give you a chance to explain why we should not do so. Subparts M and N of this part describe your rights and the procedures we will follow.

(i) *Requirement for treatment that is medically necessary and available.* If you have a representative payee, the representative payee must, at the time of the continuing disability review, present evidence demonstrating that you are and have been receiving treatment, to the extent considered medically necessary and available, for the condition(s) that was the basis for providing you with SSI benefits, unless we

determine that requiring your representative payee to provide such evidence would be inappropriate or unnecessary considering the nature of your impairment(s). If your representative payee refuses without good cause to comply with this requirement, and if we decide that it is in your best interests, we may pay your benefits to another representative payee or to you directly.

(1) *What we mean by treatment that is medically necessary.* Treatment that is medically necessary means treatment that is expected to improve or restore your functioning and that was prescribed by your medical source. If you do not have a medical source, we will decide whether there is treatment that is medically necessary that could have been prescribed by a medical source. The treatment may include (but is not limited to)—

(i) Medical management;

(ii) Psychological or psychosocial counseling;

(iii) Physical therapy; and

(iv) Home therapy, such as administering oxygen or giving injections.

(2) *How we will consider whether medically necessary treatment is available.* When we decide whether medically necessary treatment is available, we will consider such things as (but not limited to)—

(i) The location of an institution or facility or place where treatment, services, or resources could be provided to you in relationship to where you reside;

(ii) The availability and cost of transportation for you and your payee to the place of treatment;

(iii) Your general health, including your ability to travel for the treatment;

(iv) The capacity of an institution or facility to accept you for appropriate treatment;

(v) The cost of any necessary medications or treatments that are not paid for by Medicaid or another insurer or source; and

(vi) The availability of local community resources (e.g., clinics, charitable organizations, public assistance agencies) that would provide free treatment or funds to cover treatment.

(3) *When we will not require evidence of treatment that is medically necessary and available.* We will not require your representative payee to present evidence that you are and have been receiving treatment if we find that the condition(s) that was the basis for providing you benefits is not amenable to treatment.

(4) *Removal of a payee who does not provide evidence that a child is and has been receiving treatment that is medically necessary and available.* If your representative payee refuses without good cause to provide evidence that you are and have been receiving treatment that is medically necessary and available, we may, if it is in your best interests, suspend payment of benefits to the representative payee, and pay benefits to another payee or to you. When we decide whether your representative payee had good cause, we will consider factors such as the acceptable reasons for failure to follow prescribed treatment in § 416.930(c) and other factors similar to those describing good cause for missing deadlines in § 416.1411.

(5) *If you do not have a representative payee.* If you do not have a representative payee and we make your payments directly to you, the provisions of this paragraph do not apply to you. However, we may still decide that you are failing to follow prescribed treatment under the provisions of § 416.930, if the requirements of that section are met.

[56 FR 5562, Feb. 11, 1991; 56 FR 13266, 13365, Apr. 1, 1991, as amended at 58 FR 47586, Sept. 9, 1993; 59 FR 1637, Jan. 12, 1994; 62 FR 6430, Feb. 11, 1997; 62 FR 13538, 13733, Mar. 21, 1997; 65 FR 16815, Mar. 30, 2000; 65 FR 54790, Sept. 11, 2000; 82 FR 5882, Jan. 18, 2017]

§ 416.995 If we make a determination that your physical or mental impairment(s) has ceased, did not exist or is no longer disabling (Medical Cessation Determination).

If we make a determination that the physical or mental impairment(s) on the basis of which disability or blindness benefits were payable has ceased, did not exist or is no longer disabling (a medical cessation determination), your benefits will stop. You will receive a written notice explaining this determination and the month your benefits will stop. The written notice will also explain your right to appeal if

you disagree with our determination and your right to request that your disability or blindness benefits be continued under § 416.996. The continued benefit provisions of this section do not apply to an initial determination on an application for disability or blindness benefits or to a determination that you were disabled or blind only for a specified period of time.

[53 FR 29023, Aug. 2, 1988]

§ 416.996 Continued disability or blindness benefits pending appeal of a medical cessation determination.

(a) *General.* If we determine that you are not eligible for disability or blindness benefits because the physical or mental impairment(s) on the basis of which such benefits were payable is found to have ceased, not to have existed, or to no longer be disabling, and you appeal that determination, you may choose to have your disability or blindness benefits, including special cash benefits or special SSI eligibility status under §§ 416.261 and 416.264, continued pending reconsideration and/or a hearing before an administrative law judge on the disability/blindness cessation determination. If you appeal a medical cessation under both title II and title XVI (a concurrent case), the title II claim will be handled in accordance with title II regulations while the title XVI claim will be handled in accordance with the title XVI regulations.

(1) Benefits may be continued under this section only if the determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling is made after October 1984.

(2) Continued benefits under this section will stop effective with the earlier of: (i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of a new administrative law judge decision (or final action is taken by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or (ii) the month before the month in which no timely request for reconsideration or administrative law judge hearing is pending after notification of our initial or reconsideration cessation determination. These benefits may be stopped or adjusted because of certain events (such as, change in income or resources or your living arrangements) which may occur while you are receiving these continued benefits, in accordance with § 416.1336(b).

(b) *Statement of choice.* If you or another party (see § 416.1432(a)) request reconsideration under § 416.1409 or a hearing before an administrative law judge in accordance with § 416.1433 on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or if your case is sent back (remanded) to an administrative law judge for further action, we will explain your right to receive continued benefits and ask you to complete a statement indicating that you wish to have benefits continued pending the outcome of the reconsideration or administrative law judge hearing. If you request reconsideration and/or hearing but you do not want to receive continued benefits, we will ask you to complete a statement declining continued benefits indicating that you do not want to have your benefits continued during the appeal. A separate election must be made at each level of appeal.

(c) *What you must do to receive continued benefits pending notice of our reconsideration determination.* (1) If you want to receive continued benefits pending the outcome of your request for reconsideration, you must request reconsideration and continuation of benefits no later than 10 days after the date you receive the notice of our initial determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Reconsideration must be requested as provided in § 416.1409, and you must request continued benefits using a statement in accordance with paragraph (b) of this section.

(2) If you fail to request reconsideration and continued benefits within the 10-day period required by paragraph (c)(1) of this section, but later ask that we continue your benefits pending a reconsidered determination, we will use

the rules in §416.1411 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the notice of the initial cessation determination. If you request continued benefits after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(d) *What you must do to receive continued benefits pending an administrative law judge's decision.* (1) To receive continued benefits pending an administrative law judge's decision on our reconsideration determination, you must request a hearing and continuation of benefits no later than 10 days after the date you receive the notice of our reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. A hearing must be requested as provided in §416.1433, and you must request continued benefits using a statement in accordance with paragraph (b) of this section.

(2) If you fail to request a hearing and continued benefits within the 10-day period required under paragraph (d)(1) of this section, but you later ask that we continue your benefits pending an administrative law judge's decision, we will use the rules as provided in §416.1411 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the reconsideration determination. If you request continued benefits after the 10-day period, we will consider the delayed request to be timely and will pay continued benefits only if good cause for delay is established.

(e) *What you must do when your case is remanded to an administrative law judge.* If we send back (remand) your case to an administrative law judge for further action under the rules provided in §416.1477, and the administrative law judge's decision or dismissal order issued on your medical cessation appeal is vacated and is no longer in effect, you may be eligible for continued benefits pending a new decision by the administrative law judge or final action by the Appeals Council on the administrative law judge's recommended decision.

(1) When your case is remanded to an administrative law judge, and you have elected to receive continued benefits, we will contact you to update our file to verify that you continue to meet the nonmedical requirements to receive benefits based on disability or blindness. To determine your correct payment amount, we will ask you to provide information about events such as changes in living arrangements, income, or resources since our last contact with you. If you have returned to work, we will request additional information about this work activity. Unless your earnings cause your income to be too much to receive benefits, your continued benefits will be paid while your appeal of the medical cessation of your disability/blindness is still pending, unless you have completed a trial work period and are engaging in substantial gainful activity. If you have completed a trial work period and previously received continued benefits you may still be eligible for special cash benefits under §416.261 or special SSI eligibility status under §416.264. (Effective July 1, 1987, a title XVI individual is no longer subject to a trial work period or cessation based on engaging in substantial gainful activity in order to be eligible for special benefits under §416.261 or special status under §416.264.) If we determine that you no longer meet a requirement to receive benefits, we will send you a written notice. The written notice will explain why your continued benefits will not be reinstated or will be for an amount less than you received before the prior administrative law judge's decision. The notice will also explain your right to reconsideration under §416.1407, if you disagree. If you request a reconsideration, you will have the chance to explain why you believe your benefits should be reinstated or should be at a higher amount. If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of any right to reentitlement to benefits including special benefits under §416.261 or special status under §416.264. If you disagree with our determination on your appeal, you will have the right to appeal this decision.

(2) After we verify that you meet all the nonmedical requirements to receive benefits as stated in paragraph (e)(1) of this section, and if you previously elected to receive continued benefits pending the administrative law judge's decision, we will start continued benefits again. We will send you a notice telling you this. You do not have to complete a request to have these same benefits continued through the month before the month the new decision or order of dismissal is issued by the administrative law judge or through the month before the month the Appeals Council takes final action on the administrative law judge's recommended decision. These continued benefits will begin again with the first month of nonpayment based on the prior administrative law judge hearing decision or dismissal order. Our notice explaining continued benefits will also tell you to report to us any changes or events that affect your receipt of benefits.

(3) When your case is remanded to an administrative law judge, and if you did *not* previously elect to have benefits continued pending an administrative law judge decision, we will send you a notice telling you that if you want to change that election, you must request to do so no later than 10 days after you receive our notice. If you do make this new election, and after we verify that you meet all the nonmedical requirements as explained in paragraph (e)(1) of this section, benefits will begin with the month of the Appeals Council remand order and will continue as stated in paragraph (e)(2) of this section.

(4) If a court orders that your case be sent back to us (remanded) and your case is sent to an administrative law judge for further action under the rules provided in §416.1483, the administrative law judge's decision or dismissal order on your medical cessation appeal is vacated and is no longer in effect. You may be eligible for continued benefits pending a new decision by the administrative law judge or final action by the Appeals Council on the administrative law judge's recommended decision. In these court-remanded cases reaching the administrative law judge, we will follow the same rules provided in paragraph (e) (1), (2), and (3) of this section.

(f) *What if your benefits are suspended, reduced or terminated for other reasons.* If we determine that your payments should be reduced, suspended or terminated for reasons not connected with your medical condition (see subpart M of Regulations No. 16) benefits may be continued under the procedure described in §416.1336.

(g) *Responsibility to pay back continued benefits.* (1) If the final decision of the Secretary affirms the determination that you are not entitled to benefits, you will be asked to pay back any continued benefits you receive. However, you will have the right to ask that you not be required to pay back the benefits as described in the overpayment recovery and waiver provisions of subpart E of this part.

(2) Waiver of recovery of an overpayment resulting from continued benefits to you may be considered as long as the cessation determination was appealed in good faith. We will assume that your appeal was made in good faith and, therefore, you have the right to waiver consideration *unless* you fail to cooperate in connection with the appeal, e.g., if you fail (without good reason) to give us medical or other evidence we request, or to go for a physical or mental examination when requested, in connection with the appeal. In determining whether you have good cause for failure to cooperate and, thus, whether an appeal was made in good faith, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) you may have which may have caused your failure to cooperate.

[53 FR 29023, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988, as amended at 59 FR 1637, Jan. 12, 1994]

§ 416.998 If you become disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which your last impairment(s) ends, we will find that your disability is continuing. The new impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep you from doing substantial gainful activity, or severe enough so that

you are still disabled under § 416.994, or, if you are a child, to result in marked and severe functional limitations.

[62 FR 6432, Feb. 11, 1997]

§ 416.999 What is expedited reinstatement?

The expedited reinstatement provision provides you another option for regaining eligibility for benefits when we previously terminated your eligibility for disability benefits due to your work activity. The expedited reinstatement provision provides you the option of requesting that your prior eligibility for disability benefits be reinstated, rather than filing a new application for a new period of eligibility. Since January 1, 2001, you can request to be reinstated to benefits if you stop doing substantial gainful activity within 60 months of your prior termination. You must not be able to do substantial gainful activity because of your medical condition. Your current impairment must be the same as or related to your prior impairment and you must be disabled. To determine if you are disabled, we will use our medical improvement review standard that we use in our continuing disability review process. The advantage of using the medical improvement review standard is that we will generally find that you are disabled unless your impairment has improved so that you are able to work or unless an exception under the medical improvement review standard process applies. We explain the rules for expedited reinstatement in §§ 416.999a through 416.999d.

[70 FR 57144, Sept. 30, 2005]

§ 416.999a Who is eligible for expedited reinstatement?

(a) You can have your eligibility to benefits reinstated under expedited reinstatement if—

(1) You were previously eligible for a benefit based on disability or blindness as explained in § 416.202;

(2) Your disability or blindness eligibility referred to in paragraph (a)(1) of this section was terminated because of earned income or a combination of earned and unearned income;

(3) You file your request for reinstatement timely under § 416.999b; and

(4) In the month you file your request for reinstatement—

(i) You are not able or become unable to do substantial gainful activity because of your medical condition as determined under paragraph (c) of this section.

(ii) Your current impairment is the same as or related to the impairment that we used as the basis for your previous eligibility referred to in paragraph (a)(2) of this section,

(iii) You are disabled or blind, as determined under the medical improvement review standard in §§ 416.994 or 416.994a, and

(iv) You meet the non-medical requirements for eligibility as explained in § 416.202.

(b) You are eligible for reinstatement if you are the spouse of an individual who can be reinstated under § 416.999a if—

(1) You were previously an eligible spouse of the individual;

(2) You meet the requirements for eligibility as explained in § 416.202 except the requirement that you must file an application; and

(3) You request reinstatement.

(c) We will determine that you are not able to do substantial gainful activity because of your medical condition, under paragraph (a)(4)(i) of this section, when:

(1) You certify under § 416.999b(e) that you are unable to do substantial gainful activity because of your medical condition;

(2) You are not able or become unable to do substantial gainful activity in the month you file your request for reinstatement; and

(3) We determine that you are disabled under paragraph (a)(4)(iii) of this section.

[70 FR 57144, Sept. 30, 2005, as amended at 81 FR 71370, Oct. 17, 2016]

§ 416.999b How do I request reinstatement?

(a) You must make your request for reinstatement in writing.

(b) You must have filed your request on or after January 1, 2001.

(c) You must provide the information we request so that we can determine whether you meet the eligibility requirements listed in § 416.999a.

(d) We must receive your request within the consecutive 60-month period that begins with the month in which your eligibility terminated due to earned income, or a combination of earned and unearned income. If we receive your request after the 60-month period, we can grant you an extension if we determine you had good cause, under the standards explained in § 416.1411, for not filing the request timely.

(e) You must certify that you are disabled, that your current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the eligibility you are requesting to be reinstated, that you are unable to do substantial gainful activity because of your medical condition, and that you meet the non-medical requirements for eligibility for benefits.

[70 FR 57144, Sept. 30, 2005]

§ 416.999c How do we determine provisional benefits?

(a) You may receive up to six consecutive months of provisional cash benefits and Medicaid during the provisional benefit period, while we determine whether we can reinstate your disability benefit eligibility under § 416.999a—

(1) We will pay you provisional benefits beginning with the month after you file your request for reinstatement under § 416.999a(a).

(2) If you are an eligible spouse, you can receive provisional benefits with the month your spouse's provisional benefits begin.

(3) If you do not have an eligible spouse, we will pay you a monthly provisional benefit amount equal to the monthly amount that would be payable to an eligible individual under §§ 416.401 through 416.435 with the same kind and amount of income as you have.

(4) If you have an eligible spouse, we will pay you and your spouse a monthly provisional benefit amount equal to the monthly amount that would be payable to an eligible individual and eligible spouse under § 416.401 through 416.435 with the same kind and amount of income as you and your spouse have.

(5) Your provisional benefits will not include state supplementary payments payable under §§ 416.2001 through 416.2176.

(b) You cannot receive provisional cash benefits or Medicaid a second time under this section when—

(1) You request reinstatement under § 416.999a;

(2) You previously received provisional cash benefits or Medicaid under this section based upon a prior request for reinstatement filed under § 416.999a(a); and

(3) Your requests under paragraphs (b)(1) and (b)(2) are for the same previous disability eligibility referred to in § 416.999a(a)(2) of this section.

(4) *Examples:*

Example 1: Mr. K files a request for reinstatement in April 2004. His disability benefit had previously terminated in January 2003. Since Mr. K meets the other factors for possible reinstatement (*i.e.*, his prior eligibility was terminated within the last 60 months because of his work activity) we start paying him provisional benefits beginning May 2004 while we determine whether he is disabled and whether his current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the benefit that was terminated in January 2003. In July 2004 we determine that Mr. K cannot be reinstated because he is not disabled under the medical improvement review standard; therefore we stop his provisional benefits. Mr. K does not request review of the determination. In January 2005 Mr. K again requests reinstatement on the eligibility that terminated in January 2003. Since this request again meets all the other factors for possible reinstatement mentioned above, and his request is still within 60 months from January 2003, we will make a new determination on whether he is disabled and whether his current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the benefit that was terminated in January 2003. Since the January 2005 request and the April 2004 request both request reinstatement on the same benefit that terminated in January 2003, and since we already paid Mr. K provisional benefits based upon the April 2004 request, we will not pay additional provisional benefits on the January 2005 request for reinstatement.

Example 2: Assume the same facts as shown in Example 1 of this section, with the addition of these facts. We approve Mr. K's January 2005 request for reinstatement and start his reinstated benefits beginning February 2005. Mr. K subsequently returns to work and his benefits are again terminated due to his work activity in January 2008. Mr. K again stops work and requests reinstatement in

January 2010. Since Mr. K meets the other factors for possible reinstatement (*i.e.*, his prior eligibility was terminated within the last 60 months because of his work activity) we start paying him provisional benefits beginning February 2010 while we determine whether he is disabled and whether his current impairment(s) is the same as or related to the impairment(s) that we used as the basis for the benefit that was terminated in January 2008.

(c) We will not pay you a provisional benefit for a month where you are not eligible for a payment under §§416.1322, 416.1323, 416.1325, 416.1327, 416.1329, 416.1330, 416.1334, and 416.1339.

(d) We will not pay you a provisional benefit for any month that is after the earliest of either: the month we send you notice of our determination on your request for reinstatement; or, the sixth month following the month you requested expedited reinstatement.

(e) You are not eligible for provisional benefits if—

(1) Prior to starting your provisional benefits we determine that you do not meet the requirements for reinstatement under §§416.999a(a); or

(2) We determine that your statements on your request for reinstatement, made under §416.999b(d)(2), are false.

(f) Determinations we make regarding your provisional benefits under paragraphs (a) through (e) of this section are final and are not subject to administrative and judicial review under subpart N of part 416.

(g) If you were previously overpaid benefits under title II or title XVI of the Act, we will not recover the overpayment from your provisional benefits unless you give us permission.

(h) If we determine you are not eligible to receive reinstated benefits, provisional benefits we have already paid you under this section that were made prior to the termination month under paragraph (d) of this section will not be subject to recovery as an overpayment unless we determine that you knew, or should have known, you did not meet the requirements for reinstatement in §416.999a. If we inadvertently pay you provisional benefits when you are not entitled to them because we have already made a determination described in paragraph (e) of this section, they will be subject to recover as an overpayment under subpart E of part 416.

[70 FR 57144, Sept. 30, 2005]

§416.999d How do we determine reinstated benefits?

(a) If you meet the requirements for reinstatement under §416.999a(a), we will reinstate your benefits with the month after the month you filed your request for reinstatement. We cannot reinstate your eligibility for any month prior to February 2001.

(b) We will compute your reinstated benefit amount and determine benefits payable under the applicable paragraphs in §§416.401 through 416.435. We will reduce your reinstated benefit due in a month by a provisional benefit we already paid you for that month. If your provisional benefit paid for a month equals or exceeds the reinstated benefit due, we will treat the difference as an overpayment under §416.536.

(c) Once you have been reinstated under §416.999a you cannot be reinstated again until you have completed a 24-month initial reinstatement period. Your initial reinstatement period begins with the month your reinstated benefits begin under paragraph (a) of this section and ends when you have had 24 payable months of reinstated benefits. We consider you to have a payable month for the purposes of this paragraph when you are due a cash benefit of any amount for the month based upon our normal computation and payment rules in §416.401 through §416.435 or if you are considered to be receiving SSI benefits in a month under section 1619(b) of the Social Security Act. If your entire benefit payment due you for a month is adjusted for recovery of an overpayment under §§416.570 and 416.571 or if the amount of the provisional benefit already paid you for a month exceeds the amount of the reinstated benefit payable for that month so that no additional payment is due, we will consider the month a payable month.

(d) Your eligibility for reinstated benefits ends with the month preceding the earliest of the following months—

(1) The month an applicable terminating event in §§416.1331 through 416.1339 occurs;

(2) The third month following the month in which your disability ceases; or

(3) The month in which you die.

(e) Determinations we make under this section are initial determinations under § 416.1402 and are subject to review under subpart N of part 416.

(f) If we determine you are not eligible for reinstated benefits, we will consider your request filed under § 416.999a(a) your intent to claim benefits under § 416.340.

[70 FR 57144, Sept. 30, 2005]

Subpart J—Determinations of Disability

AUTHORITY: Secs. 702(a)(5), 1614, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c, 1383, and 1383b).

SOURCE: 46 FR 29211, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§ 416.1001 Purpose and scope.

This subpart describes the standards of performance and administrative requirements and procedures for States making determinations of disability for the Commissioner under title XVI of the Act. It also establishes the Commissioner's responsibilities in carrying out the disability determination function.

(a) Sections 416.1001 through 416.1003 describe the purpose of the regulations and the meaning of terms frequently used in the regulations. They also briefly set forth the responsibilities of the Commissioner and the States covered in detail in other sections.

(b) Sections 416.1010 through 416.1018 describe the Commissioner's and the State's responsibilities in performing the disability determination function.

(c) Sections 416.1020 through 416.1033 describe the administrative responsibilities and requirements of the States. The corresponding role of the Commissioner is also set out.

(d) Sections 416.1040 through 416.1050 describe the performance accuracy and processing time standards for measuring State agency performance.

(e) Sections 416.1060 through 416.1061 describe when and what kind of assistance the Commissioner will provide State agencies to help them improve performance.

(f) Sections 416.1070 through 416.1075 describe the level of performance below which the Commissioner will consider a State agency to be substantially failing to make disability determinations consistent with the regulations and other written guidelines and the resulting action the Commissioner will take.

(g) Sections 416.1080 through 416.1083 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(h) Sections 416.1090 through 416.1094 describe when and what action the Commissioner will take and what action the State will be expected to take if the Commissioner assumes the disability determination function from a State agency.

[46 FR 29211, May 29, 1981, as amended at 62 FR 38454, July 18, 1997; 71 FR 16461, Mar. 31, 2006; 76 FR 24812, May 3, 2011]

§ 416.1002 Definitions.

For purposes of this subpart:

Act means the Social Security Act, as amended.

Class or classes of cases means the categories into which disability claims are divided according to their characteristics.

Commissioner means the Commissioner of Social Security or his or her authorized designee.

Compassionate allowance means a determination or decision we make under a process that identifies for expedited handling claims that involve impairments that invariably qualify under the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter based on minimal, but sufficient, objective medical evidence.

Determination of disability or *disability determination* means one or more of the following decisions:

(a) Whether or not a person is under a disability;

(b) The date a person's disability began; or

(c) The date a person's disability ended.

Disability means *disability* or *blindness* as defined in sections 1614(a) (2) and (3) of the Act.

Disability determination function means making determinations as to disability or blindness and carrying out related administrative and other responsibilities.

Disability program means the Federal program for providing supplemental security income benefits for the blind and disabled under title XVI of the Act, as amended.

Initial means the first level of disability or blindness adjudication.

Other written guidelines means written issuances such as Social Security Rulings and memoranda by the Commissioner of Social Security, the Deputy Commissioner for Programs and Policy, or the Associate Commissioner for Disability and the procedures, guides, and operating instructions in the Disability Insurance sections of the Program Operations Manual System that are instructive, interpretive, clarifying, and/or administrative and not designated as advisory or discretionary. The purpose of including the foregoing material in the definition is to assure uniform national application of program standards and service delivery to the public.

Quick disability determination means an initial determination on a claim that we have identified as one that reflects a high degree of probability that you will be found disabled and where we expect that your allegations will be easily and quickly verified.

Regulations means regulations in this subpart issued under sections 1102, 1631(c) and 1633(a) of the Act, unless otherwise indicated.

State means any of the 50 States of the United States and the District of Columbia. It includes the State agency.

State agency means that agency of a State which has been designated by the State to carry out the disability determination function.

We, us, and *our* refers to the Social Security Administration (SSA).

[46 FR 29211, May 29, 1981, as amended at 56 FR 11021, Mar. 14, 1991; 62 FR 38454, July 18, 1997; 72 FR 51178, Sept. 6, 2007; 75 FR 62683, Oct. 13, 2010]

§ 416.1003 Basic responsibilities for us and the State.

(a) *General.* We will work with the State to provide and maintain an effective system for processing claims of those who apply for and who are receiving benefits under the disability program. We will provide program standards, leadership, and oversight. We do not intend to become involved in the State's ongoing management of the program except as is necessary and in accordance with these regulations. The State will comply with our regulations and other written guidelines.

(b) *Our responsibilities.* We will:

(1) Periodically review the regulations and other written guidelines to determine whether they insure effective and uniform administration of the disability program. To the extent feasible, we will consult with and take into consideration the experience of the States in issuing regulations and guidelines necessary to insure effective and uniform administration of the disability program;

(2) Provide training materials or in some instances conduct or specify training (see § 416.1022);

(3) Provide funds to the State agency for the necessary cost of performing the disability determination function (see § 416.1026);

(4) Monitor and evaluate the performance of the State agency under the established standards (see §§ 416.1044 and 416.1045); and

(5) Maintain liaison with the medical profession nationally and with national organizations and agencies whose interests or activities may affect the disability program.

(c) *Responsibilities of the State.* The State will:

(1) Provide management needed to insure that the State agency carries out the disability determination function so that disability determinations are made accurately and promptly;

(2) Provide an organizational structure, adequate facilities, qualified personnel, medical consultant services, designated quick disability determination examiners (§§ 416.1019 and 416.1020(c)), and a quality assurance function (§§ 416.1020 through 416.1024);

(3) Furnish reports and records relating to the administration of the disability program (§ 416.1025);
(4) Submit budgets (§ 416.1026);
(5) Cooperate with audits (§ 416.1027);
(6) Insure that all applicants for and recipients of disability benefits are treated equally and courteously;
(7) Be responsible for property used for disability program purposes (§ 416.1028);
(8) Take part in the research and demonstration projects (§ 416.1029);
(9) Coordinate with other agencies (§ 416.1030);
(10) Safeguard the records created by the State in performing the disability determination function (§ 416.1031);
(11) Comply with other provisions of the Federal law and regulations that apply to the State in performing the disability determination function;
(12) Comply with other written guidelines (§ 416.1033);
(13) Maintain liaison with the medical profession and organizations that may facilitate performing the disability determination function; and
(14) Assist us in other ways that we determine may promote the objectives of effective and uniform administration.

[46 FR 29211, May 29, 1981, as amended at 72 FR 51178, Sept. 6, 2007]

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

§ 416.1010 How a State notifies us that it wishes to perform the disability determination function.

(a) *Deemed notice.* Any State that has in effect as of June 1, 1981, an agreement with us to make disability determinations will be deemed to have given us notice that it wishes to perform the disability determination function, in lieu of continuing the agreement in effect after June 1, 1981.

(b) *Written notice.* After June 1, 1981, a State not making disability determinations that wishes to perform the disability determination function under these regulations must notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the State's Attorney General verifying the authority of the official who sent the notice to act for the State.

§ 416.1011 How we notify a State whether it may perform the disability determination function.

(a) If a State notifies us in writing that it wishes to perform the disability determination function, we will notify the State in writing whether or not it may perform the function. The State will begin performing the disability determination function beginning with the month we and the State agree upon.

(b) If we have previously found that a State agency has substantially failed to make disability determinations in accordance with the law or these regulations and other written guidelines or if the State has previously notified us in writing that it does not wish to make disability determinations, the notice will advise the State whether the State agency may again make the disability determinations and, if so, the date and the conditions under which the State may again make them.

§ 416.1013 Disability determinations the State makes.

(a) *General rule.* A State agency will make determinations of disability with respect to all persons in the State except those individuals whose cases are in a class specifically excluded by our written guidelines. A determination of disability made by the State is the determination of the Commissioner, except as described in § 416.903(d)(1).

(b) *New classes of cases.* Where any new class or classes of cases arise requiring determinations of disability, we will determine the conditions under which a State may choose not to make the disability determinations. We will provide the State with the necessary funding to do the additional work.

(c) *Temporary transfer of classes of cases.* We will make disability determinations for classes of cases temporarily transferred to us by the State agency if the State agency asks us to do so and we agree. The State agency will make written arrangements with us which will specify the period of time

and the class or classes of cases we will do.

[46 FR 29211, May 29, 1981, as amended at 62 FR 38455, July 18, 1997]

§416.1014 Responsibilities for obtaining evidence to make disability determinations.

(a) We or the State agency will secure from the claimant or other sources any evidence the State agency needs to make a disability determination. When we secure the evidence, we will furnish it to the State agency for use in making the disability determination.

(b) At our request, the State agency will obtain and furnish medical or other evidence and provide assistance as may be necessary for us to carry out our responsibility for making disability determinations in those classes of cases described in the written guidelines for which the State agency does not make the determination.

[46 FR 29211, May 29, 1981, as amended at 79 FR 33683, June 12, 2014]

§416.1015 Making disability determinations.

(a) When making a disability determination, the State agency will apply subpart I, part 416, of our regulations.

(b) The State agency will make disability determinations based only on the medical and nonmedical evidence in its files.

(c) Disability determinations will be made by:

(1) A State agency medical or psychological consultant and a State agency disability examiner;

(2) A State agency disability examiner alone when there is no medical evidence to be evaluated (*i.e.*, no medical evidence exists or we are unable, despite making every reasonable effort, to obtain any medical evidence that may exist) and the individual fails or refuses, without a good reason, to attend a consultative examination (see §416.918);

(3) A State agency disability examiner alone if you are not a child (a person who has not attained age 18), and the claim is adjudicated under the quick disability determination process (see §416.1019) or the compassionate allowance process (see §416.1002), and the initial or reconsidered determination is fully favorable to you. This paragraph (c)(3) will no longer be effective on December 28, 2018 unless we terminate it earlier by publication of a final rule in the FEDERAL REGISTER; or

(4) A State agency disability hearing officer.

See §416.1016 for the definition of medical or psychological consultant and §416.1415 for the definition of disability hearing officer. The State agency disability examiner and disability hearing officer must be qualified to interpret and evaluate medical reports and other evidence relating to the claimant's physical or mental impairments and as necessary to determine the capacities of the claimant to perform substantial gainful activity. See §416.972 for what we mean by substantial gainful activity.

(d) In making a determination under title XVI with respect to the disability of a child to whom paragraph (d) of this section does not apply, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

(e) The State agency will certify each determination of disability to us on forms we provide.

(f) The State agency will furnish us with all the evidence it considered in making its determination.

(g) The State agency will not be responsible for defending in court any determination made, or any procedure for making determinations, under these regulations.

[52 FR 23928, Sept. 9, 1987, as amended at 56 FR 11021, Mar. 14, 1991; 58 FR 47587, Sept. 9, 1993; 61 FR 11136, Mar. 19, 1996; 62 FR 38455, July 18, 1997; 65 FR 34959, June 1, 2000; 75 FR 62684, Oct. 13, 2010; 78 FR 66639, Nov. 6, 2013; 79 FR 51243, Aug. 28, 2014; 80 FR 63093, Oct. 19, 2015; 81 FR 73028, Oct. 24, 2016; 82 FR 5883, Jan. 18, 2017]

§416.1016 Medical consultants and psychological consultants.

(a) *What is a medical consultant?* A medical consultant is a member of a team that makes disability determinations in a State agency (see §416.1015), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The medical consultant completes the medical portion of

the case review and any applicable residual functional capacity assessment about all physical impairment(s) in a claim.

(b) *What qualifications must a medical consultant have?* A medical consultant is a licensed physician, as defined in § 416.902(a)(1).

(c) *What is a psychological consultant?* A psychological consultant is a member of a team that makes disability determinations in a State agency (see § 416.1015), or who is a member of a team that makes disability determinations for us when we make disability determinations ourselves. The psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment about all mental impairment(s) in a claim. When we are unable to obtain the services of a qualified psychiatrist or psychologist despite making every reasonable effort (see § 416.1017) in a claim involving a mental impairment(s), a medical consultant will evaluate the mental impairment(s).

(d) *What qualifications must a psychological consultant have?* A psychological consultant can be either a licensed psychiatrist or psychologist. We will only consider a psychologist qualified to be a psychological consultant if he or she:

(1) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

(2)(i) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or

(ii) Is listed in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate; and

(3) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post-masters degree.

(e) *Cases involving both physical and mental impairments.* In a case where there is evidence of both physical and mental impairments, the medical consultant will evaluate the physical impairments in accordance with paragraph (a) of this section, and the psychological consultant will evaluate the mental impairment(s) in accordance with paragraph (c) of this section.

[82 FR 5883, Jan. 18, 2017]

§ 416.1017 Reasonable efforts to obtain review by a physician, psychiatrist, and psychologist.

(a) When the evidence of record indicates the existence of a physical impairment, the State agency must make every reasonable effort to ensure that a medical consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. When the evidence of record indicates the existence of a mental impairment, the State agency must make every reasonable effort to ensure that a psychological consultant completes the medical portion of the case review and any applicable residual functional capacity assessment. The State agency must determine if additional physicians, psychiatrists, and psychologists are needed to make the necessary reviews. When it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional physicians, psychiatrists, and psychologists because of low salary rates or fee schedules, it should attempt to raise the State agency's levels of compensation to meet the prevailing rates for these services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency's efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

(b) Federal resources may include the use of Federal contracts for the services of qualified psychiatrists and psychologists to review mental impairment cases. Where Federal resources are required to perform these reviews, which are a basic State agency responsibility, and where appropriate, the State agency's budget will be reduced accordingly.

(c) Where every reasonable effort is made to obtain the services of a qualified psychiatrist or psychologist to review a mental impairment case, but the professional services are not obtained, a physician who is not a psychiatrist will review the mental impairment case. For these purposes, every reasonable effort to ensure that a qualified psychiatrist or psychologist review mental impairment cases will be considered to have been made only after efforts by both State and Federal agencies as set forth in paragraphs (a) and (b) of this section are made.

[52 FR 23928, Sept. 9, 1987, as amended at 82 FR 5883, Jan. 18, 2017]

§ 416.1018 Notifying claimant of the disability determination.

The State agency will prepare denial notices in accordance with subpart N of this part whenever it makes a disability determination which is fully or partially unfavorable to the claimant.

[46 FR 29211, May 29, 1981, as amended at 75 FR 33169, June 11, 2010]

QUICK DISABILITY DETERMINATIONS

§ 416.1019 Quick disability determination process.

(a) If we identify a claim as one involving a high degree of probability that the individual is disabled, and we expect that the individual's allegations will be easily and quickly verified, we will refer the claim to the State agency for consideration under the quick disability determination process pursuant to this section and § 416.1020(c).

(b) If we refer a claim to the State agency for a quick disability determination, a designated quick disability determination examiner must do all of the following:

(1) Subject to the provisions in paragraph (c) of this section, make the disability determination after consulting with a State agency medical or psychological consultant if the State agency disability examiner determines consultation is appropriate or if consultation is required under § 416.926(c). The State agency may certify the disability determination forms to us without the signature of the medical or psychological consultant.

(2) Make the quick disability determination based only on the medical and nonmedical evidence in the file.

(3) Subject to the provisions in paragraph (c) of this section, make the quick disability determination by applying the rules in subpart I of this part.

(c) If the quick disability determination examiner cannot make a determination that is fully favorable, or if there is an unresolved disagreement between the disability examiner and the medical or psychological consultant (except when a disability examiner makes the determination alone under § 416.1015(c)(3)), the State agency will adjudicate the claim using the regularly applicable procedures in this subpart.

[72 FR 51178, Sept. 6, 2007, as amended at 75 FR 62684, Oct. 13, 2010]

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

§ 416.1020 General administrative requirements.

(a) The State will provide the organizational structure, qualified personnel, medical consultant services, and a quality assurance function sufficient to ensure that disability determinations are made accurately and promptly. We may impose specific administrative requirements in these areas and in those under ''Administrative Responsibilities and Requirements'' in order to establish uniform, national administrative practices or to correct the areas of deficiencies which may later cause the State to be substantially failing to comply with our regulations or other written guidelines. We will notify the State, in writing, of the administrative requirements being imposed and of any administrative deficiencies it is required to correct. We will allow the State 90 days from the date of this notice to make appropriate corrections. Once corrected, we will monitor the State's administrative practices for 180 days. If the State does not meet the requirements or correct all of the deficiencies, or, if some of the deficiencies recur, we may initiate procedures to determine if the State is substantially failing to follow our regulations or other written guidelines.

(b) The State is responsible for making accurate and prompt disability determinations.

(c) Each State agency will designate experienced disability examiners to handle claims we refer to it under § 416.1019(a).

[46 FR 29211, May 29, 1981, as amended at 56 FR 11021, Mar. 14, 1991; 56 FR 13365, Apr. 1, 1991; 72 FR 51178, Sept. 6, 2007]

§ 416.1021 Personnel.

(a) *Equal Employment Opportunity.* The State will comply with all applicable Federal statutes, executive orders and regulations concerned with equal employment opportunities.

(b) *Selection, tenure, and compensation.* The State agency will, except as may be inconsistent with paragraph (a) of this section, adhere to applicable State approved personnel standards in the selection, tenure, and compensation of any individual employed in the disability program.

(c) *Travel.* The State will make personnel available to attend meetings or workshops as may be sponsored or approved by us for furthering the purposes of the disability program.

(d) *Restrictions.* Subject to appropriate Federal funding, the State will, to the best of its ability, facilitate the processing of disability claims by avoiding personnel freezes, restrictions against overtime work, or curtailment of facilities or activities.

§ 416.1022 Training.

The State will insure that all employees have an acceptable level of competence. We will provide training and other instructional materials to facilitate basic and advanced technical proficiency of disability staff in order to insure uniformity and effectiveness in the administration of the disability program. We will conduct or specify training, as appropriate but only if:

(a) A State agency's performance approaches unacceptable levels or

(b) The material required for the training is complex or the capacity of the State to deliver the training is in doubt and uniformity of the training is essential.

§ 416.1023 Facilities.

(a) *Space, equipment, supplies, and other services.* Subject to appropriate Federal funding, the State will provide adequate space, equipment, supplies, and other services to facilitate making accurate and prompt disability determinations.

(b) *Location of facilities.* Subject to appropriate Federal funding, the State will determine the location where the disability determination function is to be performed so that disability determinations are made accurately and promptly.

(c) *Access.* The State will permit us access to the premises where the disability determination function is performed and also where it is managed for the purposes of inspecting and obtaining information about the work and activities required by our regulations and assuring compliance with pertinent Federal statutes and regulations. Access includes personal onsite visits and other means, such as telecommunications, of contacting the State agency to obtain information about its functions. We will contact the State agency and give reasonable prior notice of the times and purposes of any visits.

[46 FR 29211, May 29, 1981, as amended at 56 FR 11022, Mar. 14, 1991]

§ 416.1024 Medical and other purchased services.

The State will determine the rates of payment for purchasing medical or other services necessary to make determinations of disability. The rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar type of service. The State will maintain documentation to support the rates of payment it uses.

[46 FR 29211, May 29, 1981, as amended at 71 FR 16461, Mar. 31, 2006; 76 FR 24812, May 3, 2011]

§ 416.1025 Records and reports.

(a) The State will establish and maintain the records and furnish the schedules, financial, cost, and other reports relating to the administration of the disability programs as we may require.

(b) The State will permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the work which the State performs under these regulations. These records will be retained by the State for the periods of time specified for retention of records in the Federal Procurement Regulations (41 CFR parts 1–20).

§ 416.1026 Fiscal.

(a) We will give the State funds, in advance or by way of reimbursement, for necessary costs in making disability determinations under these regulations. Necessary costs are direct as well as indirect costs as defined in 41 CFR part 1–15, subpart 1–15.7 of the Federal Procurement Regulations System for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 of the Federal Acquisition Regulations System and Federal Management Circular A–74–4[1] as amended or superseded for costs incurred after March 31, 1984.

(b) The State will submit estimates of anticipated costs in the form of a budget at the time and in the manner we require.

(c) We will notify the State of the amount which will be made available to it as well as what anticipated costs are being approved.

(d) The State may not incur or make expenditures for items of cost not approved by us or in excess of the amount we make available to the State.

(e) After the close of a period for which funds have been made available to the State, the State will submit a report of its expenditures. Based on an audit arranged by the State under Pub. L. 98–502, the Single Audit Act of 1984, or by the Inspector General of the Social Security Administration or based on an audit or review by the Social Security Administration (see § 416.1027), we will determine whether the expenditures were consistent with cost principles described in 41 CFR part 1–15, subpart 1–15.7 for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 and Federal Management Circular A–74–4 for costs incurred after March 31, 1984; and in other applicable written guidelines in effect at the time the expenditures were made or incurred.

(f) Any monies paid to the State which are used for purposes not within the scope of these regulations will be paid back to the Treasury of the United States.

[46 FR 29211, May 29, 1981, as amended at 56 FR 11022, Mar. 14, 1991; 62 FR 38455, July 18, 1997]

§ 416.1027 Audits.

(a) *Audits performed by the State*—(1) *Generally*. Audits of account and records pertaining to the administration of the disability program under the Act, will be performed by the States in accordance with the Single Audit Act of 1984 (Pub. L. 98–502) which establishes audit requirements for States receiving Federal assistance. If the audit performed by the State meets our program requirements, we will accept the findings and recommendations of the audit. The State will make every effort to act upon and resolve any items questioned in the audit.

(2) *Questioned items*. Items questioned as a result of an audit under the Single Audit Act of 1984 of a cross-cutting nature will be resolved by the Department of Health and Human Services, Office of Grant and Contract Financial Management. A cross-cutting issue is one that involves more than one Federal awarding agency. Questioned items affecting only the disability program will be resolved by SSA in accord with paragraph (b)(2) of this section.

(3) *State appeal of audit determinations*. The Office of Grant and Contract Financial Management will notify the State of its determination on questioned cross-cutting items. If the State disagrees with that determination, it may appeal in writing within 60 days of receiving the determination. State appeals of a cross-cutting issue as a result of an audit under the Single Audit Act of 1984 will be made to the Department of Health and Human Services' Departmental Appeals Board. The rules for hearings and appeals are provided in 45 CFR part 16.

[1] The circular is available from the Office of Administration, Publications Unit, Rm. G–236, New Executive Office Bldg., Washington, DC 20503.

(b) *Audits performed by the Commissioner*—(1) *Generally.* If the State does not perform an audit under the Single Audit Act of 1984 or the audit performed is not satisfactory for disability program purposes, the books of account and records in the State pertaining to the administration of the disability programs under the Act will be audited by the SSA's Inspector General or audited or reviewed by SSA as appropriate. These audits or reviews will be conducted to determine whether the expenditures were made for the intended purposes and in amounts necessary for the proper and efficient administration of the disability programs. Audits or reviews will also be made to inspect the work and activities required by the regulations to ensure compliance with pertinent Federal statutes and regulations. The State will make every effort to act upon and resolve any items questioned in an audit or review.

(2) *Questioned items.* Expenditures of State agencies will be audited or reviewed, as appropriate, on the basis of cost principles and written guidelines in effect at the time the expenditures were made or incurred. Both the State and the State agency will be informed and given a full explanation of any items questioned. They will be given reasonable time to explain items questioned. Any explanation furnished by the State or State agency will be given full consideration before a final determination is made on the audit or review report.

(3) *State appeal of audit determinations.* The appropriate Social Security Administration Regional Commissioner will notify the State of his or her determination on the audit or review report. If the State disagrees with that determination, the State may request reconsideration in writing within 60 days of the date of the Regional Commissioner's notice of the determination. The written request may be made, through the Associate Commissioner, Office of Disability, to the Commissioner of Social Security, Room 900, Altmeyer Building, 6401 Security Boulevard, Baltimore, MD 21235. The Commissioner will make a determination and notify the State of the decision in writing no later than 90 days from the date the Social Security Administration receives the State's appeal and all supporting documents. The decision by the Commissioner on other than monetary disallowances will be final and binding upon the State. The decision by the Commissioner on monetary disallowances will be final and binding upon the State unless the State appeals the decision in writing to the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving the Commissioner's decision. See § 416.1083.

[56 FR 11022, Mar. 14, 1991, as amended at 62 FR 38455, July 18, 1997]

§ 416.1028 Property.

The State will have title to equipment purchased for disability program purposes. The State will be responsible for maintaining all property it acquires or which we furnish to it for performing the disability determination function. The State will identify the equipment by labeling and by inventory and will credit the SSA account with the fair market value of disposed property. In the event we assume the disability determination function from a State, ownership of all property and equipment acquired with SSA funds will be transferred to us effective on the date the State is notified that we are assuming the disability determination function or we are notified that the State is terminating the relationship.

§ 416.1029 Participation in research and demonstration projects.

We will invite State participation in federally funded research and demonstration projects to assess the effectiveness of the disability program and to ascertain the effect of program policy changes. Where we determine that State participation is necessary for the project to be complete, for example, to provide national uniformity in a claims process, State participation is mandatory.

§ 416.1030 Coordination with other agencies.

(a) The State will establish cooperative working relationships with other agencies concerned with serving the disabled and, insofar as practicable, use

their services, facilities, and records to:

(1) Assist the State in developing evidence and making determinations of disability; and

(2) Insure that referral of disabled or blind persons for rehabilitation services will be carried out effectively.

(b) The State may pay these agencies for the services, facilities, or records they provide. The State will include these costs in its estimates of anticipated costs and reports of actual expenditures.

§ 416.1031 Confidentiality of information and records.

The State will comply with the confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see § 416.1033).

§ 416.1032 Other Federal laws and regulations.

The State will comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the disability determination function; for example, Treasury Department regulations on letters of credit (31 CFR part 205).

§ 416.1033 Policies and operating instructions.

(a) We will provide the State agency with written guidelines necessary for it to carry out its responsibilities in performing the disability determination function.

(b) The State agency making determinations of disability will comply with our written guidelines that are not designated as advisory or discretionary. (See § 416.1002 for what we mean by written guidelines.)

(c) A representative group of State agencies will be given an opportunity to participate in formulating disability program policies that have an effect on their role in carrying out the disability determination function. State agencies will also be given an opportunity to comment before changes are made in written guidelines unless delay in issuing a change may impair service to the public.

[46 FR 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991]

PERFORMANCE STANDARDS

§ 416.1040 General.

The following sections provide the procedures and guidelines we use to determine whether the State agency is substantially complying with our regulations and other written guidelines, including meeting established national performance standards. We use performance standards to help assure effective and uniform administration of our disability program and to measure whether the performance of the disability determination function by each State agency is acceptable. Also, the standards are designed to improve overall State agency performance in the disability determination process and to ensure that benefits are made available to all eligible persons in an accurate and efficient manner. We measure the performance of a State agency in two areas—processing time and quality of documentation and decisions on claims. State agency compliance is also judged by State agency adherence to other program requirements.

[56 FR 11023, Mar. 14, 1991]

§ 416.1041 Standards of performance.

(a) *General.* The performance standards include both a target level of performance and a threshold level of performance for the State agency. The target level represents a level of performance that we and the States will work to attain in the future. The threshold level is the minimum acceptable level of performance. Performance below the threshold level will be the basis for the Commissioner's taking from the State agency partial or complete responsibility for performing the disability determination function. Intermediate State agency goals are designed to help each State agency move from its current performance levels to the target levels.

(b) *The target level.* The target level is the optimum level of performance.

There are three targets—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(c) *The threshold level.* The threshold level is the minimum acceptable level of performance. There are three thresholds—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(d) *Intermediate goals.* Intermediate goals are levels of performance between the threshold levels and the target levels established by our appropriate Regional Commissioner after negotiation with each State agency. The intermediate goals are designed to help the State agencies reach the target levels. Failure to meet these goals is not a cause for considering the State agency to be substantially failing to comply with the performance standards. However, failure to meet the intermediate goals may result in consultation and an offer of optional performance support depending on the availability of our resources.

[46 FR 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991; 62 FR 38455, July 18, 1997]

§ 416.1042 Processing time standards.

(a) *General.* Title II processing time refers to the average number of days (including Saturdays, Sundays, and holidays) it takes a State agency to process an initial disability claim from the day the case folder is received in the State agency until the day it is released to us by the State agency. Title XVI processing time refers to the average number of days, including Saturdays, Sundays, and holidays, from the day of receipt of the initial disability claim in the State agency until systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Target levels.* The processing time target levels are:

(1) 37 days for title II initial claims.

(2) 43 days for title XVI initial claims.

(c) *Threshold levels.* The processing time threshold levels are:

(1) 49.5 days for title II initial claims.

(2) 57.9 days for title XVI initial claims.

[46 FR 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991]

§ 416.1043 Performance accuracy standard.

(a) *General.* Performance accuracy refers to the percentage of cases that do not have to be returned to State agencies for further development or correction of decisions based on evidence in the files and as such represents the reliability of State agency adjudication. The definition of performance accuracy includes the measurement of factors that have a potential for affecting a decision, as well as the correctness of the decision. For example, if a particular item of medical evidence should have been in the file but was not included, even though its inclusion does not change the result in the case, that is a performance error. Performance accuracy, therefore, is a higher standard than decisional accuracy. As a result, the percentage of correct decisions is significantly higher than what is reflected in the error rate established by SSA's quality assurance system.

(b) *Target level.* The State agency initial performance accuracy target level for combined title II and title XVI cases is 97 percent with a corresponding decision accuracy rate of 99 percent.

(c) *Intermediate goals.* These goals will be established annually by SSA's regional commissioner after negotiation with the State and should be used as stepping stones to progress towards our targeted level of performance.

(d) *Threshold levels.* The State agency initial performance accuracy threshold level for combined title II and title XVI cases is 90.6 percent.

§ 416.1044 How and when we determine whether the processing time standards are met.

(a) *How we determine processing times.* For all initial title II cases, we calculate the mean number of days, including Saturdays, Sundays, and holidays, from the day the case folder is received in the State agency until the day it is released to us by the State agency. For initial title XVI cases, we

calculate the mean number of days, including Saturdays, Sundays, and holidays, from the day the case folder is received in the State agency until the day there is systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Frequency of review.* Title II processing times and title XVI processing times are monitored separately on a quarterly basis. The determination as to whether or not the processing time thresholds have been met is made at the end of each quarter each year. Quarterly State-by-State mean processing times are compared with the threshold levels for both title II and title XVI.

[46 FR 29211, May 29, 1981, as amended at 56 FR 11023, Mar. 14, 1991]

§ 416.1045 How and when we determine whether the performance accuracy standard is met.

(a) *How we determine performance accuracy.* We determine a State agency's performance accuracy rate on the basis of decision and documentation errors identified in our review of the sample cases.

(b) *Frequency of review.* Title II and title XVI initial performance accuracy are monitored together on a quarterly basis. The determinations as to whether the performance accuracy threshold has been met is made at the end of each quarter each year. Quarterly State-by-State combined initial performance accuracy rates are compared to the established threshold level.

§ 416.1050 Action we will take if a State agency does not meet the standards.

If a State agency does not meet two of the three established threshold levels (one of which must be performance accuracy) for two or more consecutive calendar quarters, we will notify the State agency in writing that it is not meeting the standards. Following our notification, we will provide the State agency appropriate performance support described in §§ 416.1060, 416.1061 and 416.1062 for a period of up to 12 months.

[56 FR 11023, Mar. 14, 1991]

PERFORMANCE MONITORING AND SUPPORT

§ 416.1060 How we will monitor.

We will regularly analyze State agency combined title II and title XVI initial performance accuracy rate, title II initial processing time, and title XVI initial processing time. Within budgeted resources, we will also routinely conduct fiscal and administrative management reviews and special onsite reviews. A fiscal and administrative management review is a fact-finding mission to review particular aspects of State agency operations. During these reviews we will also review the quality assurance function. This regular monitoring and review program will allow us to determine the progress each State is making and the type and extent of performance support we will provide to help the State progress toward threshold, intermediate, and/or target levels.

[56 FR 11023, Mar. 14, 1991]

§ 416.1061 When we will provide performance support.

(a) *Optional support.* We may offer, or a State may request, performance support at any time that the regular monitoring and review process reveals that support could enhance performance. The State does not have to be below the initial performance accuracy rate of 90.6 percent to receive performance support. Support will be offered, or granted upon request, based on available resources.

(b) *Mandatory support.* (1) We will provide a State agency with performance support if regular monitoring and review reveal that two of three threshold levels (one of which must be performance accuracy) are not met for two consecutive calendar quarters.

(2) We may also decide to provide a State agency with mandatory performance support if regular monitoring and review reveal that any one of the three threshold levels is not met for two consecutive calendar quarters. Support will be provided based on available resources.

(3) The threshold levels are:

(i) Combined title II and title XVI initial performance accuracy rate—90.6 percent,

(ii) Title II initial processing time—49.5 days, and

(iii) Title XVI initial processing time—57.9 days.

[56 FR 11023, Mar. 14, 1991]

§ 416.1062 What support we will provide.

Performance support may include, but is not limited to, any or all of the following:

(a) An onsite review of cases processed by the State agency emphasizing adherence to written guidelines.

(b) A request that necessary administrative measures be implemented (e.g., filling staffing vacancies, using overtime, assisting with training activities, etc.).

(c) Provisions for Federal personnel to perform onsite reviews, conduct training, or perform other functions needed to improve performance.

(d) Provisions for fiscal aid to allow for overtime, temporary hiring of additional staff, etc., above the authorized budget.

[56 FR 11024, Mar. 14, 1991]

SUBSTANTIAL FAILURE

§ 416.1070 General.

After a State agency falls below two of three established threshold levels, one being performance accuracy, for two consecutive quarters, and after the mandatory performance support period, we will give the State agency a 3-month adjustment period. During this 3-month period we will not require the State agency to meet the threshold levels. Following the adjustment period, if the State agency again falls below two of three threshold levels, one being performance accuracy, in two consecutive quarters during the next 12 months, we will notify the State that we propose to find that the State agency has substantially failed to comply with our standards and advise it that it may request a hearing on that issue. After giving the State notice and an opportunity for a hearing, if it is found that a State agency has substantially failed to make disability determinations consistent with the Act, our regulations, or other written guidelines, we will assume partial or complete responsibility for performing the disability determination function after we have complied with §§ 416.1090 and 416.1092.

[56 FR 11024, Mar. 14, 1991]

§ 416.1071 Good cause for not following the Act, our regulations, or other written guidelines.

If a State has good cause for not following the Act, our regulations, or other written guidelines, we will not find that the State agency has substantially failed to meet our standards. We will determine if good cause exists. Some of the factors relevant to good cause are:

(a) Disasters such as fire, flood, or civil disorder, that—

(1) Require the diversion of significant personnel normally assigned to the disability determination function, or

(2) Destroyed or delayed access to significant records needed to make accurate disability determinations;

(b) Strikes of State agency staff or other government or private personnel necessary to the performance of the disability determination function;

(c) Sudden and unanticipated workload changes which result from changes in Federal law, regulations, or written guidelines, systems modification or systems malfunctions, or rapid, unpredictable caseload growth for a 6-month period or longer.

[56 FR 11024, Mar. 14, 1991]

§ 416.1075 Finding of substantial failure.

A finding of substantial failure with respect to a State may not be made unless and until the State is afforded an opportunity for a hearing.

HEARINGS AND APPEALS

§ 416.1080 Notice of right to hearing on proposed finding of substantial failure.

If, following the mandatory performance support period and the 3-month adjustment period, a State agency again falls below two of three threshold levels (one being performance accuracy) in two consecutive quarters in the succeeding 12 months, we will notify the State in writing that we will

find that the State agency has substantially failed to meet our standards unless the State submits a written request for a hearing with the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving the notice. The notice will identify the threshold levels that were not met by the State agency, the period during which the thresholds were not met, and the accuracy and processing time levels attained by the State agency during this period. If a hearing is not requested, the State agency will be found to have substantially failed to meet our standards, and we will implement our plans to assume the disability determination function.

[56 FR 11024, Mar. 14, 1991]

§416.1081 Disputes on matters other than substantial failure.

Disputes concerning monetary disallowances will be resolved in proceedings before the Department of Health and Human Services, Departmental Appeals Board if the issue cannot be resolved between us and the State. Disputes other than monetary disallowances will be resolved through an appeal to the Commissioner of Social Security, who will make the final decision. (See §416.1027.)

[56 FR 11024, Mar. 14, 1991]

§416.1082 Who conducts the hearings.

If a hearing is required, it will be conducted by the Department of Health and Human Services' Departmental Appeals Board (the Board).

[46 FR 29211, May 29, 1981, as amended at 62 FR 38455, July 18, 1997]

§416.1083 Hearings and appeals process.

The rules for hearings and appeals before the Board are provided in 45 CFR part 16. A notice under §416.1080 of this subpart will be considered a ''final written decision'' for purposes of Board review.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

§416.1090 Assumption when we make a finding of substantial failure.

(a) *Notice to State.* When we find that substantial failure exists, we will notify the State in writing that we will assume responsibility for performing the disability determination function from the State agency, whether the assumption will be partial or complete, and the date on which the assumption will be effective.

(b) *Effective date of assumption.* The date of any partial or complete assumption of the disability determination function from a State agency may not be earlier than 180 days after our finding of substantial failure, and not before compliance with the requirements of §416.1092.

§416.1091 Assumption when State no longer wishes to perform the disability determination function.

(a) *Notice to the Commissioner.* If a State no longer wishes to perform the disability determination function, it will notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the State's Attorney General verifying the authority of the official who gave the notice.

(b) *Effective date of assumption.* The State agency will continue to perform whatever activities of the disability determination function it is performing at the time the notice referred to in paragraph (a) of this section is given for not less than 180 days or, if later, until we have complied with the requirements of §416.1092. For example, if the State is not making disability determinations (because we previously assumed responsibility for making them) but is performing other activities related to the disability determination function at the time it gives notice, the State will continue to do these activities until the requirements of this paragraph are met. Thereafter, we will assume complete responsibility for performing the disability determination function.

[46 FR 29211, May 29, 1981, as amended at 62 FR 38455, July 18, 1997]

§ 416.1092 Protection of State employees.

(a) *Hiring preference.* We will develop and initiate procedures to implement a plan to partially or completely assume the disability determination function from the State agency under § 416.1090 or § 416.1091, as appropriate. Except for the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent), we will give employees of the State agency who are capable of performing duties in the disability determination function preference over any other persons in filling positions with us for which they are qualified. We may also give a preference in hiring to the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent). We will establish a system for determining the hiring priority among the affected State agency employees in those instances where we are not hiring all of them.

(b) *Determination by Secretary of Labor.* We will not assume responsibility for performing the disability determination function from a State until the Secretary of Labor determines that the State has made fair and equitable arrangements under applicable Federal, State and local law to protect the interests of employees who will be displaced from their employment because of the assumption and who we will not hire.

§ 416.1093 Limitation on State expenditures after notice.

The State agency may not, after it receives the notice referred to in § 416.1090, or gives the notice referred to in § 416.1091, make any new commitments to spend funds allocated to it for performing the disability determination function without the approval of the appropriate SSA regional commissioner. The State will make every effort to close out as soon as possible all existing commitments that relate to performing the disability determination function.

§ 416.1094 Final accounting by the State.

The State will submit its final claims to us as soon as possible, but in no event later than 1 year from the effective date of our assumption of the disability determination function unless we grant an extension of time. When the final claim(s) is submitted, a final accounting will be made by the State of any funds paid to the State under § 416.1026 which have not been spent or committed prior to the effective date of our assumption of the disability determination function. Disputes concerning final accounting issues which cannot be resolved between the State and us will be resolved in proceedings before the Grant Appeals Board as described in 45 CFR part 416.

Subpart K—Income

AUTHORITY: 42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, 1383, and 1383b; sec. 211, Pub. L. 93–66, 87 Stat. 154 (42 U.S.C. 1382 note).

SOURCE: 45 FR 65547, Oct. 3, 1980, unless otherwise noted.

GENERAL

§ 416.1100 Income and SSI eligibility.

You are eligible for supplemental security income (SSI) benefits if you are an aged, blind, or disabled person who meets the requirements described in subpart B and who has limited income and resources. Thus, the amount of income you have is a major factor in deciding whether you are eligible for SSI benefits and the amount of your benefit. We count income on a monthly basis. Generally, the more income you have the less your benefit will be. If you have too much income, you are not eligible for a benefit. However, we do not count all of your income to determine your eligibility and benefit amount. We explain in the following sections how we treat your income for the SSI program. These rules apply to the Federal benefit and to any optional State supplement paid by us on behalf of a State (§ 416.2025) except as noted in subpart T and in the Federal-State agreements with individual States. While this subpart explains how we count income, subpart D of these regulations explains how we determine your benefits, including the provision that we generally use countable income in a prior month to determine how much your benefit amount will be

for a month in which you are eligible (§ 416.420).

[50 FR 48573, Nov. 26, 1985]

§ 416.1101 Definition of terms.

As used in this subpart—

Calendar quarter means a period of three full calendar months beginning with January, April, July, or October.

Child means someone who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student. (See § 416.1856)

Couple means an eligible individual and his or her eligible spouse.

Current market value means the price of an item on the open market in your locality.

Federal benefit rate means the monthly payment rate for an eligible individual or couple. It is the figure from which we subtract countable income to find out how much your Federal SSI benefit should be. The Federal benefit rate does not include the rate for any State supplement paid by us on behalf of a State.

Institution means an establishment which makes available some treatment or services beyond food and shelter to four or more persons who are not related to the proprietor. (See § 416.201)

Spouse means someone who lives with another person as that person's husband or wife. (See § 416.1806)

We, Us, or *Our* means the Social Security Administration.

You or *Your* means a person who is applying for, or already receiving, SSI benefits.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48573, Nov. 26, 1985; 51 FR 10616, Mar. 28, 1986; 60 FR 16375, Mar. 30, 1995]

§ 416.1102 What is income?

Income is anything that you receive in cash or in-kind that you can use to meet your needs for food or shelter. For purposes of this definition, income may be received actually or constructively. Income is received constructively, unless there are significant restrictions on your ability to receive it, if it is under your control or you can use it despite not actually receiving it. Sometimes income also includes more or less than you actually receive (see §§ 416.1110 and 416.1123(b)). In-kind income is not cash but is something else that you can use to meet your needs for food or shelter. Exception: Food is not included in the calculations of in-kind support and maintenance, which is a type of unearned income that we have special rules for valuing (see §§ 416.1130 through 416.1148).

[89 FR 21209, Mar. 27, 2024]

§ 416.1103 What is not income?

Some things you receive are not income because you cannot use them as food or shelter, or use them to obtain food or shelter. In addition, what you receive from the sale or exchange of your own property is not income; it remains a resource. The following are some items that are not income:

(a) *Medical care and services.* Medical care and services are not income if they are any of the following:

(1) Given to you free of charge or paid for directly to the provider by someone else;

(2) Room and board you receive during a medical confinement;

(3) Assistance provided in cash or in kind (including food or shelter) under a Federal, State, or local government program whose purpose is to provide medical care or medical services (including vocational rehabilitation);

(4) In-kind assistance (except shelter) provided under a nongovernmental program whose purpose is to provide medical care or medical services;

(5) Cash provided by any nongovernmental medical care or medical services program or under a health insurance policy (except cash to cover food or shelter) if the cash is either:

(i) Repayment for program-approved services you have already paid for; or

(ii) A payment restricted to the future purchase of a program-approved service.

Example: If you have paid for prescription drugs and get the money back from your health insurance, the money is not income.

(6) Direct payment of your medical insurance premiums by anyone on your behalf.

(7) Payments from the Department of Veterans Affairs resulting from unusual medical expenses.

(b) *Social services.* Social services are not income if they are any of the following:

(1) Assistance provided in cash or in kind (but not received in return for a service you perform) under any Federal, State, or local government program whose purpose is to provide social services including vocational rehabilitation (Example: Cash given you by the Department of Veterans Affairs to purchase aid and attendance);

(2) In-kind assistance (except shelter) provided under a nongovernmental program whose purpose is to provide social services; or

(3) Cash provided by a nongovernmental social services program (except cash to cover food or shelter) if the cash is either:

(i) Repayment for program-approved services you already have paid for; or

(ii) A payment restricted to the future purchase of a program-approved service.

Example: If you are unable to do your own household chores and a private social services agency provides you with cash to pay a homemaker the cash is not income.

(c) *Receipts from the sale, exchange, or replacement of a resource.* Receipts from the sale, exchange, or replacement of a resource are not income but are resources that have changed their form. This includes any cash or in-kind item that is provided to replace or repair a resource (see subpart L) that has been lost, damaged, or stolen. Sections 416.1150 and 416.1151 discuss treatment of receipts to replace or repair a resource following a major disaster or following some other event causing damage or loss of a resource.

Example: If you sell your automobile, the money you receive is not income; it is another form of a resource.

(d) *Income tax refunds.* Any amount refunded on income taxes you have already paid is not income.

(e) *Payments by credit life or credit disability insurance.* Payments made under a credit life or credit disability insurance policy on your behalf are not income.

Example: If a credit disability policy pays off the mortgage on your home after you become disabled in an accident, we do not consider either the payment or your increased equity in the home to be income.

(f) *Proceeds of a loan.* Money you borrow or money you receive as repayment of a loan is not income. However, interest you receive on money you have lent is income. Buying on credit is treated as though you were borrowing money and what you purchase this way is not income.

(g) *Bills paid for you.* Payment of your bills by someone else directly to the supplier is not income. However, we count the value of anything you receive because of the payment if it is in-kind income as defined in § 416.1102.

Examples: If your daughter uses her own money to pay your mortgage payment directly to the mortgage lender, the payment itself is not your income because you do not receive it. However, because of your daughter's payment, the transaction provides you with shelter; the mortgage payment is in-kind income for shelter to you. Similarly, if you book a hotel room on credit and your son later pays the bill, the payment to the hotel is not income to you, but the payment of the bill is in-kind income for shelter to you. In this example, if your son pays for the hotel bill in a month after the month of the hotel stay, we will count the in-kind income to you in the month in which he pays the bill. On the other hand, if your brother pays a lawn service to mow your grass, the payment is not income to you because the mowing cannot be used to meet your needs for food or shelter. Therefore, the payment for the lawn service is not in-kind income as defined in § 416.1102.

(h) *Replacement of income you have already received.* If income is lost, destroyed, or stolen and you receive a replacement, the replacement is not income.

Example: If your paycheck is stolen and you get a replacement check, we count the first check as income. The replacement check is not income.

(i) *Weatherization assistance.* Weatherization assistance (Examples: Insulation, storm doors and windows) is not income.

(j) *Receipt of certain noncash items.* Any item you receive (except shelter as defined in § 416.1130) which would be an

excluded nonliquid resource (as described in subpart L of this part) if you kept it, is not income.

Example 1: A community takes up a collection to buy you a specially equipped van, which is your only vehicle. The value of this gift is not income because the van does not provide you with food or shelter and will become an excluded nonliquid resource under § 416.1218 in the month following the month of receipt.

Example 2: You inherit a house which is your principal place of residence. The value of this inheritance is income because the house provides you with shelter and shelter is income. However, we value the house under the rule in § 416.1140.

[45 FR 65547, Oct. 3, 1980, as amended at 49 FR 48038, Dec. 10, 1984; 57 FR 53850, Nov. 13, 1992; 59 FR 33907, July 1, 1994; 70 FR 6344, Feb. 7, 2005; 89 FR 21209, Mar. 27, 2024]

§ 416.1104 Income we count.

We have described generally what income is and is not for SSI purposes (§ 416.1103). There are different types of income, earned and unearned, and we have rules for counting each. The earned income rules are described in §§ 416.1110 through 416.1112 and the unearned income rules are described in §§ 416.1120 through 416.1124. One type of unearned income is in-kind support and maintenance (shelter), which we value depending on your living arrangement. These rules are described in §§ 416.1130 through 416.1148 of this part. In some situations we must consider the income of certain people with whom you live as available to you and part of your income. These rules are described in §§ 416.1160 through 416.1169. We use all of these rules to determine the amount of your countable income—the amount that is left after we subtract what is not income or is not counted.

[45 FR 65547, Oct. 3, 1980, as amended at 65 FR 16815, Mar. 30, 2000; 70 FR 6345, Feb. 7, 2005; 89 FR 21209, Mar. 27, 2024]

EARNED INCOME

§ 416.1110 What is earned income.

Earned income may be in cash or in kind. We may include more of your earned income than you actually receive. We include more than you actually receive if amounts are withheld from earned income because of a garnishment or to pay a debt or other legal obligation, or to make any other payments. Earned income consists of the following types of payments:

(a) *Wages*—(1) *Wages paid in cash—general.* Wages are what you receive (before any deductions) for working as someone else's employee. Wages are the same for SSI purposes as for the social security retirement program's earnings test. (*See* § 404.429(c) of this chapter.) Wages include salaries, commissions, bonuses, severance pay, and any other special payments received because of your employment.

(2) *Wages paid in cash to uniformed service members.* Wages paid in cash to uniformed service members include basic pay, some types of special pay, and some types of allowances. Allowances for on-base housing or privatized military housing are unearned income in the form of in-kind support and maintenance. Cash allowances paid to uniformed service members for private housing are wages.

(3) *Wages paid in kind.* Wages may also include the value of food, clothing, shelter, or other items provided instead of cash. We refer to this type of income as in-kind earned income. However, if you are a domestic or agricultural worker, the law requires us to treat your in-kind pay as unearned income.

(b) *Net earnings from self-employment.* Net earnings from self-employment are your gross income from any trade or business that you operate, less allowable deductions for that trade or business. Net earnings also include your share of profit or loss in any partnership to which you belong. For taxable years beginning before January 1, 2001, net earnings from self-employment under the SSI program are the same net earnings that we would count under the social security retirement insurance program and that you would report on your Federal income tax return. (See § 404.1080 of this chapter.) For taxable years beginning on or after January 1, 2001, net earnings from self-employment under the SSI program will also include the earnings of statutory employees. In addition, for SSI purposes only, we consider statutory

employees to be self-employed individuals. Statutory employees are agent or commission drivers, certain full-time life insurance salespersons, home workers, and traveling or city salespersons. (*See* § 404.1008 of this chapter for a more detailed description of these types of employees).

(c) *Refunds of Federal income taxes and advance payments by employers made in accordance with the earned income credit provisions of the Internal Revenue Code.* Refunds on account of earned income credits are payments made to you under the provisions of section 32 of the Internal Revenue Code of 1986, as amended. These *refunds* may be greater than taxes you have paid. You may receive earned income tax credit payments along with any other Federal income tax refund you receive because of overpayment of your income tax, (Federal income tax refunds made on the basis of taxes you have already paid are not income to you as stated in § 416.1103(d).) Advance payments of earned income tax credits are made by your employer under the provisions of section 3507 of the same code. You can receive earned income tax credit payments only if you meet certain requirements of family composition and income limits.

(d) *Payments for services performed in a sheltered workshop or work activities center.* Payments for services performed in a sheltered workshop or work activities center are what you receive for participating in a program designed to help you become self-supporting.

(e) *Certain royalties and honoraria.* Royalties that are earned income are payments to an individual in connection with any publication of the work of the individual. (See § 416.1110(b) if you receive a royalty as part of your trade or business. See § 416.1121(c) if you receive another type of royalty.) Honoraria that are earned income are those portions of payments, such as an honorary payment, reward, or donation, received in consideration of services rendered for which no payment can be enforced by law. (See § 416.1120 if you receive another type of honorarium.)

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 23179, May 24, 1983; 50 FR 48574, Nov. 26, 1985; 56 FR 3212, Jan. 29, 1991; 59 FR 43471, Aug. 24, 1994; 75 FR 1273, Jan. 11, 2010; 75 FR 54287, Sept. 7, 2010]

§ 416.1111 How we count earned income.

(a) *Wages.* We count wages at the earliest of the following points: when you receive them or when they are credited to your account or set aside for your use. We determine wages for each month. We count wages for services performed as a member of a uniformed service (as defined in § 404.1330 of this chapter) as received in the month in which they are earned.

(b) *Net earnings from self-employment.* We count net earnings from self-employment on a taxable year basis. However, we divide the total of these earnings equally among the months in the taxable year to get your earnings for each month. For example, if your net earnings for a taxable year are $2,400, we consider that you received $200 in each month. If you have net losses from self-employment, we divide them over the taxable year in the same way, and we deduct them only from your other earned income.

(c) *Payments for services in a sheltered workshop or activities center.* We count payments you receive for services performed in a sheltered workshop or work activities center when you receive them or when they are set aside for your use. We determine the amount of the payments for each calendar quarter.

(d) *In-kind earned income.* We use the current market value of in-kind earned income for SSI purposes. (See § 416.1101 for a definition of current market value.) If you receive an item that is not fully paid for and are responsible for the unpaid balance, only the paid-up value is income to you. (See the example in § 416.1123(c)).

(e) *Royalties and honoraria.* We count payments of royalties to you in connection with any publication of your work, and honoraria, to the extent received for services rendered, at the earliest of the following points: when you receive them, when they are credited

to your account, or when they are set aside for your use. (See §416.1111(b) if you receive royalties as part of your trade or business.)

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 23179, May 24, 1983; 48 FR 30357, July 1, 1983; 50 FR 48574, Nov. 26, 1985; 58 FR 63889, Dec. 3, 1993; 59 FR 43471, Aug. 24, 1994; 71 FR 45378, Aug. 9, 2006]

§416.1112 Earned income we do not count.

(a) *General.* While we must know the source and amount of all of your earned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your income in the month. We never reduce your earned income below zero or apply any unused earned income exclusion to unearned income.

(b) *Other Federal laws.* Some Federal laws other than the Social Security Act provide that we cannot count some of your earned income for SSI purposes. We list the laws and exclusions in the appendix to this subpart which we update periodically.

(c) *Other earned income we do not count.* We do not count as earned income—

(1) Any refund of Federal income taxes you receive under section 32 of the Internal Revenue Code (relating to earned income tax credit) and any payment you receive from an employer under section 3507 of the Internal Revenue Code (relating to advance payment of earned income tax credit);

(2) The first $30 of earned income received in a calendar quarter if you receive it infrequently or irregularly. We consider income to be received infrequently if you receive it only once during a calendar quarter from a single source and you did not receive it in the month immediately preceding that month or in the month immediately subsequent to that month. We consider income to be received irregularly if you cannot reasonably expect to receive it.

(3) If you are under age 22 and a student who is regularly attending school as described in §416.1861:

(i) *For earned income beginning January 1, 2002,* monthly and yearly maximum amounts that are the larger of:

(A) The monthly and yearly amounts for the previous year, or

(B) Monthly and yearly maximum amounts increased for changes in the cost-of-living, calculated in the same manner as the Federal benefit rates described in §416.405, except that we will use the calendar year 2001 amounts as the base amounts and will round the resulting amount to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

(ii) *For earned income before January 1, 2002,* the amounts indicated in Table 1 of this section.

TABLE 1

For months	Up to per month	But not more than in a calendar year
In calendar years before 2001 ..	$400	$1,620
In calendar year 2001	1,290	5,200

(4) Any portion of the $20 monthly exclusion in §416.1124(c)(10) which has not been excluded from your unearned income in that same month;

(5) $65 of earned income in a month;

(6) Earned income you use to pay impairment-related work expenses described in §416.976, if you are disabled (but not blind) and under age 65 or you are disabled (but not blind) and received SSI as a disabled individual (or received disability payments under a former State plan) for the month before you reached age 65.

(i) For periods prior to December 1, 1990, you must be able, however, to establish your initial eligibility for Federal benefits without the use of the impairment-related work expense exclusion. Once you establish your initial eligibility without the use of the impairment-related work expense exclusion, the exclusion applies for determining your eligibility for all subsequent consecutive months for which you are eligible for regular SSI benefits, federally administered optional State supplementary payments, special

SSI cash benefits or special SSI eligibility status. If, in a subsequent month, you are not eligible for any of these benefits, you cannot reestablish your eligibility for Federal SSI benefits or federally administered optional State supplementary payments before December 1, 1990, using the impairment-related work expense exclusion.

(ii) For periods after November 30, 1990, you may also use the impairment-related work expense exclusion to establish initial eligibility and reeligibility following a month in which you were not eligible for regular SSI benefits, a federally administered optional State supplementary payment, special SSI cash benefits or special SSI eligibility status.

(7) One-half of remaining earned income in a month;

(8) Earned income used to meet any expenses reasonably attributable to the earning of the income if you are blind and under age 65 or if you receive SSI as a blind person for the month before you reach age 65. (We consider that you ''reach'' a certain age on the day before that particular birthday.);

(9) Any earned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled and under age 65 or blind or disabled and received SSI as a blind or disabled person for the month before you reached age 65. See §§ 416.1180 through 416.1182 for an explanation of plans to achieve self-support and for the rules on when this exclusion applies; and

(10) Payments made to participants in AmeriCorps State and National and AmeriCorps National Civilian Community Corps (NCCC). Payments to participants in AmeriCorps State and National and AmeriCorps NCCC may be made in cash or in-kind and may be made directly to the AmeriCorps participant or on the AmeriCorps participant's behalf. These payments include, but are not limited to: Living allowance payments, stipends, educational awards, and payments in lieu of educational awards.

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 21943, May 16, 1983; 50 FR 48574, Nov. 26, 1985; 58 FR 63889, Dec. 3, 1993; 59 FR 41405, Aug. 12, 1994; 65 FR 82912, Dec. 29, 2000; 71 FR 45378, Aug. 9, 2006; 71 FR 66866, Nov. 17, 2006; 75 FR 54287, Sept. 7, 2010]

UNEARNED INCOME

§ 416.1120 What is unearned income.

Unearned income is all income that is not earned income. We describe some of the types of unearned income in § 416.1121. We consider all of these items as unearned income, whether you receive them in cash or in kind.

§ 416.1121 Types of unearned income.

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

(b) *Alimony and support payments.* For SSI purposes, alimony and support payments are cash or in-kind contributions to meet some or all of a person's needs for food or shelter. Support payments may be made voluntarily or because of a court order. Alimony (sometimes called *maintenance*) is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.

(c) *Dividends, interest, and certain royalties.* Dividends and interest are returns on capital investments, such as stocks, bonds, or savings accounts. Royalties are compensation paid to the owner for the use of property, usually copyrighted material or natural resources such as mines, oil wells, or timber tracts. Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced. (See § 416.1110(b) if you receive royalties as part of your trade or business and § 416.1110(e) if you receive royalties in connection with the publication of your work.)

(d) *Rents.* Rents are payments you receive for the use of real or personal property such as land, housing, or machinery. We deduct from rental payments your ordinary and necessary expenses in the same taxable year. These include only those expenses necessary for the production or collection of the rental income and they must be deducted when paid, not when they are incurred. Some examples of deductible expenses are interest on debts, State and local taxes on real and personal property and on motor fuels, general sales taxes, and expenses of managing or maintaining the property. (Sections 163, 164, and 212 of the Internal Revenue Code of 1954 and related regulations explain this in more detail.) We do not consider depreciation or depletion of property a deductible expense. (See §416.1110(b) for rules on rental income that is earned from self-employment. For example, you may be in the business of renting properties.)

(e) *Death benefits.* We count payments you get which were occasioned by the death of another person except for the amount of such payments that you spend on the deceased person's last illness and burial expenses. Last illness and burial expenses include related hospital and medical expenses, funeral, burial plot and interment expenses, and other related costs.

Example: If you receive $2,000 from your uncle's life insurance policy and you spend $900 on his last illness and burial expenses, the balance, $1,100, is unearned income. If you spend the entire $2,000 for the last illness and burial, there is no unearned income.

(f) *Prizes and awards.* A prize is generally something you win in a contest, lottery or game of chance. An award is usually something you receive as the result of a decision by a court, board of arbitration, or the like.

(g) *Gifts and inheritances.* A gift is something you receive which is not repayment to you for goods or services you provided and which is not given to you because of a legal obligation on the giver's part. An inheritance is something that comes to you as a result of someone's death. It can be in cash or in kind, including any right in real or personal property. Gifts and inheritances occasioned by the death of another person, to the extent that they are used to pay the expenses of the deceased's last illness and burial, as defined in paragraph (e) of this section, are not considered income.

(h) *Support and maintenance in-kind.* This is shelter furnished to you that we value depending on your living arrangement. (Food is not included in the calculations of in-kind support and maintenance.) We use one rule if you are living in another person's household, you receive shelter from others living in the household, and others within the household pay for or provide you with all of your meals. We use different rules for other situations in which you receive shelter. We discuss all of the rules in §§416.1130 through 416.1148.

[45 FR 65547, Oct. 3, 1980, as amended at 56 FR 36000, July 30, 1991; 59 FR 43471, Aug. 24, 1994; 70 FR 6345, Feb. 7, 2005; 89 FR 21209, Mar. 27, 2024]

§416.1123 How we count unearned income.

(a) *When we count unearned income.* We count unearned income at the earliest of the following points: when you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month. We describe exceptions to the rule on how we count unearned income in paragraphs (d), (e) and (f) of this section.

(b) *Amount considered as income.* We may include more or less of your unearned income than you actually receive.

(1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see §416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. *Exception:* We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

Example: Joe, an SSI beneficiary, is also entitled to social security insurance benefits

in the amount of $200 per month. However, because of a prior overpayment of his social security insurance benefits, $20 per month is being withheld to recover the overpayment. In figuring the amount of his SSI benefits, the full monthly social security insurance benefit of $200 is included in Joe's unearned income. However, if Joe was receiving both benefits when the overpayment of the social security insurance benefit occurred and we then included the overpaid amount as income, we will compute his SSI benefit on the basis of receiving $180 as a social security insurance benefit. This is because we recognize that we computed his SSI benefit on the basis of the higher amount when he was overpaid.

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums.

(3) We include less than you actually receive if part of the payment is for an expense you had in getting the payment. For example, if you are paid for damages you receive in an accident, we subtract from the amount of the payment your medical, legal, or other expenses connected with the accident. If you receive a retroactive check from a benefit program other than SSI, legal fees connected with the claim are subtracted. We do not subtract from any taxable unearned income the part you have to use to pay personal income taxes. The payment of taxes is not an expense you have in getting income.

(4) In certain situations, we may consider someone else's income to be available to you, whether or not it actually is. (For the rules on this process, called deeming, see §§ 416.1160 through 416.1169.)

(c) *In-kind income.* We use the current market value (defined in § 416.1101) of in-kind unearned income to determine its value for SSI purposes. We describe some exceptions to this rule in §§ 416.1131 through 416.1147. If you receive an item that is not fully paid for and are responsible for the balance, only the paid-up value is income to you.

Example: You are given a $1500 automobile but must pay the $1000 due on it. You are receiving income of $500.

(d) *Retroactive monthly social security benefits.* We count retroactive monthly social security benefits according to the rule in paragraph (d)(1) of this section, unless the exception in paragraph (d)(2) of this section applies:

(1) *Periods for which SSI payments have been made.* When you file an application for social security benefits and retroactive monthly social security benefits are payable on that application for a period for which you also received SSI payments (including federally-administered State supplementary payments), we count your retroactive monthly social security benefits as unearned income received in that period. Rather than reducing your SSI payments in months prior to your receipt of a retroactive monthly social security benefit, we will reduce the retroactive social security benefits by an amount equal to the amount of SSI payments (including federally-administered State supplementary payments) that we would not have paid to you if your social security benefits had been paid when regularly due rather than retroactively (see § 404.408b(b)). If a balance is due you from your retroactive social security benefits after this reduction, for SSI purposes we will not count the balance as unearned income in a subsequent month in which you receive it. This is because your social security benefits were used to determine the amount of the reduction. This exception to the unearned income counting rule does not apply to any monthly social security benefits for a period for which you did not receive SSI.

(2) *Social security disability benefits where drug addiction or alcoholism is a contributing factor material to the determination of disability.* If your retroactive social security benefits must be paid in installments because of the limitations on paying lump sum retroactive benefits to disabled recipients whose drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.480, we will count the total of such retroactive social security benefits as unearned income in the first month such installments are paid, except to the extent the rule in paragraph (d)(1) of this section would provide that such benefits not be counted.

(e) *Certain veterans benefits.* (1) If you receive a veterans benefit that includes an amount paid to you because of a dependent, we do not count as your unearned income the amount paid to you because of the dependent.

(2) If you are a dependent of an individual who receives a veterans benefit and a portion of the benefit is attributable to you as a dependent, we count the amount attributable to you as your unearned cash income if—

(i) You reside with the individual who receives the veterans benefit, or

(ii) You receive your own separate payment from the Department of Veterans Affairs.

(f) *Uniformed service compensation.* We count compensation for services performed as a member of a uniformed service (as defined in §404.1330 of this chapter) as received in the month in which it is earned.

(Reporting and recordkeeping requirements in paragraph (b) have been approved by the Office of Management and Budget under control number 0960–0128)

[45 FR 65547, Oct. 3, 1980, as amended at 47 FR 4988, Feb. 3, 1982; 47 FR 13794, Apr. 1, 1982; 50 FR 48574, Nov. 26, 1985; 55 FR 20599, May 18, 1990; 56 FR 3212, Jan. 29, 1991; 59 FR 59364, Nov. 17, 1994; 60 FR 8152, Feb. 10, 1995; 71 FR 45378, Aug. 9, 2006]

§416.1124 Unearned income we do not count.

(a) *General.* While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the $20 general exclusion described in paragraph (c)(12) of this section.

(b) *Other Federal laws.* Some Federal laws other than the Social Security Act provide that we cannot count some of your unearned income for SSI purposes. We list the laws and the exclusions in the appendix to this subpart which we update periodically.

(c) *Other unearned income we do not count.* We do not count as unearned income—

(1) Any public agency's refund of taxes on real property or food;

(2) Assistance based on need which is wholly funded by a State or one of its political subdivisions. (For purposes of this rule, an Indian tribe is considered a political subdivision of a State.) Assistance is based on need when it is provided under a program which uses the amount of your income as one factor to determine your eligibility. Assistance based on need includes State supplementation of Federal SSI benefits as defined in subpart T of this part but does not include payments under a Federal/State grant program such as Temporary Assistance for Needy Families under title IV–A of the Social Security Act;

(3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses. However, we do count any portion set aside or actually used for food or shelter;

(4) Food which you or your spouse raise if it is consumed by you or your household;

(5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster. See §416.1150 for a more detailed discussion of this assistance, particularly the treatment of in-kind support and maintenance received as the result of a major disaster;

(6) The first $60 of unearned income received in a calendar quarter if you receive it infrequently or irregularly. We consider income to be received infrequently if you receive it only once during a calendar quarter from a single source and you did not receive it in the month immediately preceding that month or in the month immediately subsequent to that month. We consider income to be received irregularly if you cannot reasonably expect to receive it.

(7) Alaska Longevity Bonus payments made to an individual who is a resident of Alaska and who, prior to

October 1, 1985: met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983; and was eligible for SSI;

(8) Payments for providing foster care to an ineligible child who was placed in your home by a public or private nonprofit child placement or child care agency;

(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of the separate burial fund. (See § 416.1231 for an explanation of the exclusion of burial assets.) This exclusion from income applies to interest earned on burial funds or appreciation in the value of excluded burial arrangements which occur beginning November 1, 1982, or the date you first become eligible for SSI benefits, if later;

(10) Certain support and maintenance assistance as described in § 416.1157;

(11) One-third of support payments made to or for you by an absent parent if you are a child;

(12) The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see § 416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility. The $20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in § 416.1124(c)(2). If you have less than $20 of unearned income in a month and you have earned income in that month, we will use the rest of the $20 exclusion to reduce the amount of your countable earned income;

(13) Any unearned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled and under age 65 or blind or disabled and received SSI as a blind or disabled person for the month before you reached age 65. See §§ 416.1180 through 416.1182 for an explanation of plans to achieve self-support and for the rules on when this exclusion applies;

(14) The value of any assistance paid with respect to a dwelling unit under—

(i) The United States Housing Act of 1937;

(ii) The National Housing Act;

(iii) Section 101 of the Housing and Urban Development Act of 1965;

(iv) Title V of the Housing Act of 1949; or

(v) Section 202(h) of the Housing Act of 1959;

(15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement. This exclusion from income applies to interest accrued on or after April 1, 1990;

(16) The value of any commercial transportation ticket, for travel by you or your spouse among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by you or your spouse and is not converted to cash. If such a ticket is converted to cash, the cash you receive is income in the month you receive the cash;

(17) Payments received by you from a fund established by a State to aid victims of crime;

(18) Relocation assistance provided you by a State or local government that is comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by section 216 of that Act;

(19) Special pay received from one of the uniformed services pursuant to 37 U.S.C. 310;

(20) Interest or other earnings on a dedicated account which is excluded from resources. (See § 416.1247);

(21) Gifts from an organization as described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code, to, or for the benefit of, an individual who has not attained 18 years of age and who has a

life-threatening condition. We will exclude any in-kind gift that is not converted to cash and cash gifts to the extent that the total gifts excluded pursuant to this paragraph do not exceed $2000 in any calendar year. In-kind gifts converted to cash are considered under income counting rules in the month of conversion;

(22) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than section 1613(a) of the Social Security Act; and

(23) AmeriCorps State and National and AmeriCorps National Civilian Community Corps cash or in-kind payments to AmeriCorps participants or on AmeriCorps participants' behalf. These include, but are not limited to: Food and shelter, and clothing allowances;

(24) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:

(i) A veteran (as defined in 38 U.S.C. 101); and

(ii) Blind, disabled, or aged.

[45 FR 65547, Oct. 3, 1980, as amended at 47 FR 55213, Dec. 8, 1982; 48 FR 21943, May 16, 1983; 48 FR 33258, July 21, 1983; 48 FR 57127, Dec. 28, 1983; 50 FR 48574, Nov. 26, 1985; 51 FR 39523, Oct. 29, 1986; 54 FR 19164, May 4, 1989; 55 FR 28378, July 11, 1990; 57 FR 1384, Jan. 14, 1992; 57 FR 53850, Nov. 13, 1992; 58 FR 63888, Dec. 3, 1993; 61 FR 1712, Jan. 23, 1996; 61 FR 49964, Sept. 24, 1996; 61 FR 67207, Dec. 20, 1996; 70 FR 6345, Feb. 7, 2005; 70 FR 41137, July 18, 2005; 71 FR 45378, Aug. 9, 2006; 75 FR 7554, Feb. 22, 2010; 75 FR 54287, Sept. 7, 2010]

IN-KIND SUPPORT AND MAINTENANCE

§ 416.1130 Introduction.

(a) *General.* Both earned income and unearned income include items received in- kind (see § 416.1102). Generally, we value in-kind items at their current market value, and we apply the various exclusions for both earned and unearned income. However, we have special rules for valuing shelter that is received as in-kind support and maintenance (a type of unearned income). This section and the ones that follow discuss these rules. In these sections (*i.e.*, §§ 416.1130 through 416.1148) we use the in-kind support and maintenance you receive in the month as described in § 416.420 to determine your SSI benefit. We value the in-kind support and maintenance using the Federal benefit rate for the month in which you receive it. *Exception:* For the first 2 months for which a cost-of-living adjustment applies, we value in-kind support and maintenance you receive using the VTR or PMV based on the Federal benefit rate as increased by the cost-of-living adjustment.

Example: Mr. Jones resides in his son's house and receives all of his meals from his son. Mr. Jones receives a monthly SSI Federal benefit rate that is reduced by one-third. This one-third represents the value of the in-kind support and maintenance he receives because he lives, throughout a month, in the household of his son, who provides all of his food and shelter. In January, we increase his SSI benefit because of a cost-of-living adjustment. For that month, we determine that the VTR rule applies by considering the food and shelter he received from his son two months earlier in November, and we calculate the SSI payment using the Federal benefit rate for January.

(b) *How we calculate in-kind support and maintenance.*(1) We calculate in-kind support and maintenance considering any shelter that is given to you or that you receive because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services. You are not receiving in-kind support and maintenance in the form of room or rent if you are paying the amount charged under a business arrangement. A business arrangement exists when the amount of monthly required rent to be paid equals or exceeds the presumed maximum value described in § 416.1140(a)(1). If the required amount of rent is less than the presumed maximum value, we will impute as in-kind support and maintenance the difference between the required amount of rent and either the presumed maximum value or the current market rental value (see § 416.1101), whichever is less. In addition, cash payments to uniformed service members as allowances for on-base

housing or privatized military housing are in-kind support and maintenance.

(2) We have two rules for valuing the in-kind support and maintenance that we count. The one-third reduction rule applies if you are living in another person's household, you receive shelter from others living in the household, and others within the household pay for or provide you with all of your meals (see §§ 416.1131 through 416.1133). The presumed value rule applies in all other situations in which you receive countable in-kind support and maintenance (see §§ 416.1140 through 416.1145). If certain conditions exist, we do not count in-kind support and maintenance. These conditions are discussed in §§ 416.1141 through 416.1145.

[89 FR 21209, Mar. 27, 2024, as amended at 89 FR 25514, Apr. 11, 2024]

§ 416.1131 The one-third reduction rule.

(a) *What the rule is.* Instead of determining the actual dollar value of in-kind support and maintenance, we count one-third of the Federal benefit rate as additional income if you (or you and your eligible spouse)—

(1) Live in another person's household (see § 416.1132) for a full calendar month except for temporary absences (see § 416.1149); and

(2) Receive shelter from others living in the household. (If you do not receive shelter from others living in the household, see § 416.1140); and

(3) Others within the household pay for or provide you with all of your meals. If others within the household do not pay for or provide you with all of your meals, any ISM received for shelter will be calculated under the PMV rule (see § 416.1140).

(b) *How we apply the one-third reduction rule.* The one-third reduction applies in full or not at all. When you are living in another person's household, and the one-third reduction rule applies, we do not apply any income exclusions to the reduction amount. However, we do apply appropriate exclusions to any other earned or unearned income you receive. If you have an eligible spouse we apply the rules described in § 416.1147.

(c) *If you receive other support and maintenance.* If the one-third reduction rule applies to you, we do not count any other in-kind support and maintenance you receive.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985; 89 FR 21210, Mar. 27, 2024]

§ 416.1132 What we mean by "living in another person's household".

(a) *Household.* For purposes of this subpart, we consider a household to be a personal place of residence. A commercial establishment such as a hotel or boarding house is not a household but a household can exist within a commercial establishment. If you live in a commercial establishment, we do not automatically consider you to be a member of the household of the proprietor. You may, however, live in the household of a roomer or boarder within the hotel or boarding house. An institution is not a household and a household cannot exist within an institution. (Institution is defined in § 416.1101.)

(b) *Another person's household.* You live in another person's household if paragraph (c) of this section does not apply and if the person who supplies the support and maintenance lives in the same household and is not—

(1) Your spouse (as defined in § 416.1806);

(2) A minor child; or

(3) An ineligible person (your spouse, parent, or essential person) whose income may be deemed to you as described in §§ 416.1160 through 416.1169.

(c) *Your own household—not another person's household.* You are not living in another person's household (you live in your own household) if—

(1) You (or your spouse who lives with you or any person whose income is deemed to you) have an ownership interest or a life estate interest in the home;

(2) You (or your spouse who lives with you or any person whose income is deemed to you) are liable to the landlord for payment of any part of the rental charges;

(3) You live in a noninstitutional care situation as described in § 416.1143;

(4) You pay at least a pro rata share of household and operating expenses (see § 416.1133); or

(5) All members of the household receive public income—maintenance payments (§416.1142).

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985]

§416.1133 What is a pro rata share of household operating expenses.

(a) *General.* If you pay your pro rata share toward monthly household operating expenses, you are living in your own household and are not receiving in-kind support and maintenance from anyone else in the household. The one-third reduction, therefore, does not apply to you. (If you are receiving shelter from someone outside the household, we value it under the rule in §416.1140.)

(b) *How we determine a pro rata share.* Your pro rata share of household operating expenses is the average monthly household operating expenses (based on a reasonable estimate if exact figures are not available) divided by the number of people in the household, regardless of age.

(c) Household operating expenses are the household's total monthly expenditures for rent, mortgage, property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection service. (The term does not include the cost of these items if someone outside the household pays for them.) Generally, we average household operating expenses over the past 12 months to determine a pro rata share.

[45 FR 65547, Oct. 3, 1980, as amended at 70 FR 6345, Feb. 7, 2005; 89 FR 21210, Mar. 27, 2024]

§416.1140 The presumed value rule.

(a) *How we apply the presumed value rule.* (1) When you receive in-kind support and maintenance and the one-third reduction rule does not apply, we use the presumed value rule. Instead of determining the actual dollar value of any shelter you receive, we presume that it is worth a maximum value. This maximum value is one-third of your Federal benefit rate plus the amount of the general income exclusion described in §416.1124(c)(12).

(2) The presumed value rule allows you to show that your in-kind support and maintenance is not equal to the presumed value. We will not use the presumed value if you show us that—

(i) The current market value of any shelter you receive, minus any payment you make for it, is lower than the presumed value; or

(ii) The actual amount someone else pays for your shelter is lower than the presumed value.

(b) *How we determine the amount of your ISM under the presumed value rule.* (1) If you choose not to question the use of the presumed value, or if the presumed value is less than the actual value of the shelter you receive, we use the presumed value to figure your ISM.

(2) If you show us, as provided in paragraph (a)(2) of this section, that the presumed value is higher than the actual value of the shelter you receive, we use the actual amount to figure your ISM.

[89 FR 21210, Mar. 27, 2024]

§416.1141 When the presumed value rule applies.

The presumed value rule applies whenever we count in-kind support and maintenance as unearned income and the one-third reduction rule does not apply. This means that the presumed value rule applies if you are living—

(a) In another person's household (as described in §416.1132(b)); you receive shelter from others living in the household; and others within the household do not pay for or provide you with all of your meals;

(b) In your own household (as described in §416.1132(c)). For exceptions, see §416.1142 if you are in a public assistance household and §416.1143 if you are in a noninstitutional case situation; or

(c) In a nonmedical institution including any—

(1) Public nonmedical institution if you are there for less than a full calendar month;

(2) Public or private nonprofit educational or vocational training institution;

(3) Private nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. For exceptions, see §416.1144; and

(4) For-profit institution where someone else pays for your support and maintenance. If you or the institution pay for it, see § 416.1145.

[45 FR 65547, Oct. 3, 1980, as amended at 89 FR 21210, Mar. 27, 2024]

§ 416.1142 If you live in a public assistance household.

(a) *Definition.* For purposes of our programs, a public assistance household is one that has both an SSI applicant or recipient, and at least one other household member who receives one or more of the listed public income maintenance payments. These are payments made under—

(1) Title IV–A of the Social Security Act (Temporary Assistance for Needy Families);

(2) Title XVI of the Social Security Act (SSI, including federally administered State supplements and State administered mandatory supplements);

(3) The Refugee Act of 1980 (Those payments based on need);

(4) The Disaster Relief and Emergency Assistance Act;

(5) General assistance programs of the Bureau of Indian Affairs;

(6) State or local government assistance programs based on need (tax credits or refunds are not assistance based on need);

(7) U.S. Department of Veterans Affairs programs (those payments based on need); and

(8) The Supplemental Nutrition Assistance Program (SNAP).

(b) *How the presumed value rule applies.* If you live in a public assistance household, we consider that you are not receiving in-kind support and maintenance from members of the household. In this situation, we use the presumed value rule only if you receive food or shelter from someone outside the household.

[45 FR 65547, Oct. 3, 1980, as amended at 57 FR 53850, Nov. 13, 1992; 70 FR 6345, Feb. 7, 2005; 70 FR 41137, July 18, 2005; 89 FR 28622, Apr. 19, 2024]

§ 416.1143 If you live in a noninstitutional care situation.

(a) *Definitions.* For purposes of this subpart you live in a noninstitutional care situation if all the following conditions exist:

(1) You are placed by a public or private agency under a specific program such as foster or family care;

(2) The placing agency is responsible for your care;

(3) You are in a private household (not an institution) which is licensed or approved by the placing agency to provide care; and

(4) You, a public agency, or someone else pays for your care.

(b) *How the presumed value rule applies.* You are not receiving in-kind support and maintenance and the presumed value rule does not apply if you pay the rate the placing agency establishes. We consider this established rate to be the current market value for the in-kind support and maintenance you are receiving. The presumed value rule applies if you pay less than the established rate and the difference is paid by someone else other than a public or private agency providing social services described in § 416.1103(b) or assistance based on need described in § 416.1124(c)(2).

§ 416.1144 If you live in a nonprofit retirement home or similar institution.

(a) *Definitions.* For purposes of this section the following definitions apply:

(1) *Nonprofit retirement home or similar institution* means a nongovernmental institution as defined under § 416.1101, which is, or is controlled by, a private nonprofit organization and which does not provide you with—

(i) Services which are (or could be) covered under Medicaid, or

(ii) Education or vocational training.

(2) *Nonprofit organization* means a private organization which is tax exempt under section 501(a) of the Internal Revenue Code of 1954 and is of the kind described in section 501 (c) or (d) of that code.

(3) An *express obligation to provide your full support and maintenance* means there is either a legally enforceable written contract or set of membership rules providing that the home, institution, or organization—

(i) Will provide at least all of your food and shelter needs; and

(ii) Does not require any current or future payment for that food and shelter. (For purposes of this paragraph, a

lump sum prepayment for lifetime care is not a current payment.)

(b) *How the presumed value rule applies.* The presumed value rule applies if you are living in a nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. The rule does not apply to the extent that—

(1) The home, institution, or nonprofit organization does not have an express obligation to provide your full support and maintenance; and

(2) The home, institution, or nonprofit organization receives no payment for your food or shelter, or receives payment from another nonprofit organization.

[45 FR 65547, Oct. 3, 1980, as amended at 51 FR 34464, Sept. 29, 1986; 70 FR 6345, Feb. 7, 2005]

§416.1145 How the presumed value rule applies in a nonmedical for-profit institution.

If you live in a nonmedical for-profit institution, we consider the amount accepted by that institution as payment in full to be the current market value of whatever food or shelter the institution provides. If you are paying or are legally indebted for that amount, you are not receiving in-kind support and maintenance. We do not use the presumed value rule unless someone else pays for you.

[45 FR 65547, Oct. 3, 1980, as amended at 70 FR 6345, Feb. 7, 2005]

IN-KIND SUPPORT AND MAINTENANCE IN SPECIAL CIRCUMSTANCES

§416.1147 How we value in-kind support and maintenance for a couple.

(a) *Both members of a couple live in another person's household and receive shelter and all of their meals from others living in the household.* When both of you live in another person's household throughout a month, receive shelter from others living in the household, and others within the household pay for or provide you with all of your meals, we apply the one-third reduction to the Federal benefit rate for a couple (§416.1131).

(b) *One member of a couple is in a medical institution and the other member of the couple lives in another person's household and receives shelter and all of their meals from others living in the household.* (1) If one of you is living in the household of another person and receives shelter from others living in the household, and others within the household pay for or provide you with all of your meals, and the other is temporarily absent from the household as provided in §416.1149(c)(1) (in a medical institution that receives substantial Medicaid payments for their care (§416.211(b))), and is ineligible in the month for either benefit payable under §416.212, we compute your benefits as if you were separately eligible individuals (see §416.414(b)(3)). This begins with the first full calendar month that one of you is in the medical institution. The one living in another person's household is eligible at an eligible individual's Federal benefit rate and one-third of that rate is counted as income not subject to any income exclusions. The one in the medical institution cannot receive more than the reduced benefit described in §416.414(b)(3)(i).

(2) If the one member of the couple in the institution is eligible for one of the benefits payable under the §416.212 provisions, we compute benefits as a couple at the rate specified under §416.412. However, if that one member remains in the institution for a full month after expiration of the period benefits based on §416.212 can be paid, benefits will be computed as if each person were separately eligible as described under paragraph (c)(1) of this section. This begins with the first calendar month after expiration of the period benefits based on §416.212 can be paid.

(c) *Both members of a couple are subject to the presumed value rule.* If the presumed value rule applies to both of you, we value any shelter you and your spouse receive at one-third of the Federal benefit rate for a couple plus the amount of the general income exclusion (§416.1124(c)(12)), unless you can show that its value is less as described in §416.1140(a)(2).

(d) *One member of a couple is subject to the presumed value rule and the other member is in a medical institution.* (1) If one of you is subject to the presumed value rule and the other is temporarily absent from the household as provided

in § 416.1149(c)(1) (in a medical institution that receives substantial Medicaid payments for his or her care (§ 416.211(b))), and is ineligible in that month for either benefit payable under § 416.212, we compute your benefits as if both members of the couple are separately eligible individuals (see § 416.414(b)(3)). This begins with the first full calendar month that one of you is in the medical institution (see § 416.211(b)). We value any shelter received by the one outside of the medical institution at one-third of an eligible individual's Federal benefit rate, plus the amount of the general income exclusion (§ 416.1124(c)(12)), unless you can show that its value is less as described in § 416.1140(a)(2). The member of the couple in the medical institution cannot receive more than the reduced benefit described in § 416.414(b)(3)(i).

(2) If one of you is subject to the presumed value rule and the other in the institution is eligible for one of the benefits payable under § 416.212, we compute the benefits as a couple at the rate specified under § 416.412. However, if the one in the institution remains in the institution after the period benefits based on § 416.212 can be paid, we will compute benefits as if each member of the couple were separately eligible as described in paragraph (d)(1) of this section.

[60 FR 16375, Mar. 30, 1995, as amended at 61 FR 10279, Mar. 13, 1996; 70 FR 6345, Feb. 7, 2005; 89 FR 21210, Mar. 27, 2024]

§ 416.1147a Income rules in change-of-status situations involving in-kind support and maintenance.

(a) *General.* This section explains the rules for determining countable income, including in-kind support and maintenance, when eligible individuals become an eligible couple or when an eligible couple becomes eligible individuals. Generally, under retrospective monthly accounting, income in a prior month, including in-kind support and maintenance, affects benefit amounts for a current month. The prior month may be the first or second month prior to the current month (as explained in § 416.420(a)) and the rules in this section apply when a change-of-status becomes effective between the prior month and the current month.

(b) *Eligible individuals become an eligible couple.* If you and your spouse have been eligible individuals and become an eligible couple, we combine the earned and unearned income each of you had as an eligible individual in the prior month. If either or both of you received in-kind support and maintenance, we include its value as income. This may be one-third of the Federal benefit rate that applied in the prior month for one or both of you who lived in the household of another. It may be the presumed maximum value (one-third of the Federal benefit rate plus $20 as explained in § 416.1140) for one or both of you as appropriate. It may also be a combination of the two if each of you received income in one of these forms. We also include income deemed to either or both of you in the prior month.

(c) *Eligible couple becomes one or two eligible individuals.* If you are an eligible individual in the current month but were a member of an eligible couple in the prior month, we determine your countable income in the prior month separately from that of your spouse. We determine the value of any in-kind support and maintenance you and your spouse received in the prior month using the rules contained in § 416.1147. For example, if both of you lived in the household of another and the one-third reduction applied, each of you would have income equal to one-sixth of the Federal benefit rate for a couple. Also, for example, if you received in-kind support and maintenance and the presumed maximum value applied, you would have income equal to one-sixth of the Federal benefit rate for a couple, plus $10. We divide any other income you had as an eligible couple according to who owned the income. If ownership of jointly owned income cannot be determined, we allocate one-half of it to you.

[50 FR 48575, Nov. 26, 1985]

§ 416.1148 If you have both in-kind support and maintenance and income that is deemed to you.

(a) *The one-third reduction and deeming of income.* If you live in the household of your spouse, parent, essential person, or sponsor whose income can be deemed to you, or the household of a parent whose income is not deemed to

you because of the provisions of §416.1165(i), the one-third reduction does not apply to you. The rules on deeming income are in §§416.1160 through 416.1169. However, if you live in another person's household as described in §416.1131, and someone whose income can be deemed to you lives in the same household, we must apply both the one-third reduction and the deeming rules to you.

(b) *The presumed value rule and deeming of income.* (1) If you live in the same household with someone whose income can be deemed to you (§§416.1160 through 416.1169), or with a parent whose income is not deemed to you because of the provisions of §416.1165(i), any shelter that person provides is not income to you. However, if you receive any shelter from another source, it is income and we value it under the presumed value rule (§416.1140). We also apply the deeming rules.

(2) If you are a child under age 18 who lives in the same household with an ineligible parent whose income may be deemed to you, and you are temporarily absent from the household to attend school (§416.1167(b)), any shelter you receive at school is income to you unless your parent purchases it. Unless otherwise excluded, we value this income under the presumed value rule (§416.1140). We also apply the deeming rules to you (§416.1165).

[60 FR 361, Jan. 4, 1995, as amended at 70 FR 6345, Feb. 7, 2005; 89 FR 21211, Mar. 27, 2024]

TEMPORARY ABSENCE

§416.1149 What is a temporary absence from your living arrangement.

(a) *General.* A temporary absence may be due to employment, hospitalization, vacations, or visits. The length of time an absence can be temporary varies depending on the reason for your absence. For purposes of valuing in-kind support and maintenance under §§416.1130 through 416.1148, we apply the rules in this section. In general, we will find a temporary absence from your permanent living arrangement if you (or you and your eligible spouse)—

(1) Become a resident of a public institution, or a public or private medical treatment facility where you otherwise would be subject to the reduced benefit rate described in §416.414, and you are eligible for the benefits payable under §416.212; or

(2) Were in your permanent living arrangement for at least 1 full calendar month prior to the absence and intend to, and do, return to your permanent living arrangement in the same calendar month in which you (or you and your spouse) leave, or in the next month.

(b) *Rules we apply during a temporary absence.* During a temporary absence, we continue to value your support and maintenance the same way that we did in your permanent living arrangement. For example, if the one-third reduction applies in your permanent living arrangement, we continue to apply the same rule during a temporary absence. However, if you receive in-kind support and maintenance only during a temporary absence we do not count it since you are still responsible for maintaining your permanent quarters during the absence.

(c) *Rules for temporary absence in certain circumstances.* (1)(i) If you enter a medical treatment facility where you are eligible for the reduced benefits payable under §416.414 for full months in the facility, and you are not eligible for either benefit payable under §416.212 (and you have not received such benefits during your current period of confinement) and you intend to return to your prior living arrangement, we consider this a temporary absence regardless of the length of your stay in the facility. We use the rules that apply to your permanent living arrangement to value any shelter you receive during the month (for which reduced benefits under §416.414 are not payable) you enter or leave the facility. During any full calendar month you are in the medical treatment facility, you cannot receive more than the Federal benefit rate described in §416.414(b)(1). We do not consider shelter provided during a medical confinement to be income.

(ii) If you enter a medical treatment facility and you are eligible for either benefit payable under §416.212, we also consider this a temporary absence from your permanent living arrangement.

We use the rules that apply to your permanent living arrangement to value any shelter you receive during the month you enter the facility and throughout the period you are eligible for these benefits. We consider your absence to be temporary through the last month benefits under § 416.212 are paid unless you are discharged from the facility in the following month. In that case, we consider your absence to be temporary through the date of discharge.

(2)(i) Generally, if you are a child under age 22, you are temporarily absent while you are away at school, regardless of how long you are away, if you come home on some weekends, lengthy holidays, and vacations (or for extended visits as provided in school regulations).

(ii) However, if you are a child under age 18, and your permanent living arrangement is with an ineligible parent or essential person (§ 416.222), we follow the rules in § 416.1148(b)(2). When you reach age 18, or if you are under age 18 and deeming does not apply, we consider the circumstances of your permanent living arrangement to value any in-kind support and maintenance you receive.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48575, Nov. 26, 1985; 52 FR 8882, Mar. 20, 1987; 61 FR 10279, Mar. 13, 1996; 62 FR 1056, Jan. 8, 1997; 70 FR 6345, Feb. 7, 2005; 72 FR 50874, Sept. 5, 2007; 89 FR 21211, Mar. 27, 2024]

DISASTERS

§ 416.1150 How we treat income received because of a major disaster.

(a) *General.* The Disaster Relief and Emergency Assistance Act and other Federal statutes provide assistance to victims of major disasters. In this section we describe when we do not count certain kinds of assistance you receive under these statutes.

(b) *Support and maintenance.* (1) We do not count the value of support and maintenance (in cash or in kind) received from a Federal, State, or local government source, or from a disaster assistance organization, and the one-third reduction rule does not apply if—

(i) You live in a household which you or you and another person maintain as your home when a catastrophe occurs in the area;

(ii) The President of the United States declares the catastrophe to be a major disaster for purposes of the Disaster Relief and Emergency Assistance Act;

(iii) You stop living in the home because of the catastrophe and within 30 days after the catastrophe you begin to receive support and maintenance; and

(iv) You receive the support and maintenance while living in a residential facility maintained by another person.

(2) We do not count the value of support and maintenance (in cash or in kind) received from any other source, such as from a private household, and the one-third reduction rule does not apply for up to 18 months after you begin to receive it if—

(i) You live in a household which you or you and another person maintain as your home when a catastrophe occurs in the area;

(ii) The President of the United States declares the catastrophe to be a major disaster for purposes of the Disaster Relief and Emergency Assistance Act;

(iii) You stop living in the home because of the catastrophe and within 30 days after the catastrophe you begin to receive support and maintenance; and

(iv) You receive the support and maintenance while living in a residential facility (including a private household) maintained by another person.

(c) *Other assistance you receive.* We do not consider other assistance to be income if you receive it under the Disaster Relief and Emergency Assistance Act or under another Federal statute because of a catastrophe which the President declares to be a major disaster or if you receive it from a State or local government or from a disaster assistance organization. For example, you may receive payments to repair or replace your home or other property.

(d) *Interest payments.* We do not count any interest earned on the assistance payments described in paragraph (c) of this section.

[57 FR 53850, Nov. 13, 1992]

§416.1151 How we treat the repair or replacement of lost, damaged, or stolen resources.

(a) *General rule.* If a resource is lost, damaged, or stolen, you may receive cash to repair or replace it or the resource may be repaired or replaced for you. We do not count the cash or the repair or replacement of the resource as your income.

(b) *Interest on cash for repair or replacement of a noncash resource.* We do not count any interest earned on the cash you receive for repair or replacement of a noncash resource if the interest is earned within 9 months of the date you receive the cash. We can extend the 9-month period for up to an additional 9 months if we find you have good cause for not repairing or replacing the resource within the initial period. Good cause exists, for example, if you show that circumstances beyond your control prevent the repair or replacement, or contracting for the repair or replacement, of the resource within the first 9-month period.

(c) *Temporary replacement of a damaged or destroyed home.* In determining the amount of in-kind support and maintenance you receive (§§416.1130 through 416.1140), we do not count temporary housing if—

(1) Your excluded home is damaged or destroyed, and

(2) You receive the temporary housing only until your home is repaired or replaced.

HOME ENERGY ASSISTANCE

§416.1157 Support and maintenance assistance.

(a) *General.* Section 2639 of Pub. L. 98–369, effective October 1, 1984, amended section 1612(b)(13) to provide that certain support and maintenance assistance, which includes home energy assistance, be excluded from countable income for SSI purposes. This section discusses how we apply section 1612(b)(13).

(b) *Definitions.* For support and maintenance assistance purposes—

Appropriate State agency means the agency designated by the chief executive officer of the State to handle the State's responsibilities as set out in paragraph (c) of this section.

Based on need means that the provider of the assistance:

(1) Does not have an express obligation to provide the assistance;

(2) States that the aid is given for the purpose of support or maintenance assistance or for home energy assistance (e.g., vouchers for heating or cooling bills, storm doors); and

(3) Provides the aid for an SSI claimant, a member of the household in which an SSI claimant lives or an SSI claimant's ineligible spouse, parent, sponsor (or the sponsor's spouse) of an alien, or essential person.

Private nonprofit agency means a religious, charitable, educational, or other organization such as described in section 501(c) of the Internal Revenue Code of 1954. (Actual tax exempt certification by IRS is not necessary.)

Rate-of-return entity means an entity whose revenues are primarily received from the entity's charges to the public for goods or services and such charges are based on rates regulated by a State or Federal governmental body.

Support and maintenance assistance means cash provided for the purpose of meeting food or shelter needs or in-kind support and maintenance as defined in §416.1121(h). Support and maintenance assistance includes home energy assistance. Home energy assistance means any assistance related to meeting the costs of heating or cooling a home. Home energy assistance includes such items as payments for utility service or bulk fuels; assistance in kind such as portable heaters, fans, blankets, storm doors, or other items which help reduce the costs of heating and cooling such as conservation or weatherization materials and services; etc.

(c) *What assistance we do not count as income.* We do not count as income certain support and maintenance assistance received on or after October 1, 1984, by you or your ineligible spouse, parent, sponsor (or your sponsor's spouse) if you are an alien, or an essential person. We also do not consider certain support and maintenance assistance in determining a pro rata share of household operating expenses under §416.1133. We do not count that assistance which is certified in writing

by the appropriate State agency to be both based on need and—

(1) Provided in kind by a private nonprofit agency; or

(2) Provided in cash or in kind by—

(i) A supplier of home heating oil or gas;

(ii) A rate-of-return entity providing home energy; or

(iii) A municipal utility providing home energy.

[51 FR 39523, Oct. 29, 1986; 51 FR 43709, Dec. 3, 1986, as amended at 53 FR 35808, Sept. 15, 1988; 70 FR 6345, Feb. 7, 2005]

DEEMING OF INCOME

§ 416.1160 What is deeming of income?

(a) *General.* We use the term deeming to identify the process of considering another person's income to be your own. When the deeming rules apply, it does not matter whether the income of the other person is actually available to you. We must apply these rules anyway. There are four categories of individuals whose income may be deemed to you.

(1) *Ineligible spouse.* If you live in the same household with your ineligible spouse, we look at your spouse's income to decide whether we must deem some of it to you. We do this because we expect your spouse to use some of his or her income to take care of some of your needs.

(2) *Ineligible parent.* If you are a child to whom deeming rules apply (see § 416.1165), we look at your ineligible parent's income to decide whether we must deem some of it to be yours. If you live with both your parent and your parent's spouse (*i.e.*, your stepparent), we also look at your stepparent's income to decide whether we must deem some of it to be yours. We do this because we expect your parent (and your stepparent, if living with you and your parent) to use some of his or her income to take care of your needs.

(3) *Sponsor of an alien.* If you are an alien who has a sponsor and you first apply for SSI benefits after September 30, 1980, we look at your sponsor's income to decide whether we must deem some of it to be yours. This rule applies for 3 years after you are admitted to the United States for permanent residence and regardless of whether you live in the same household as your sponsor. We deem your sponsor's income to you because your sponsor agreed to support you (signed an affidavit of support) as a condition of your admission to the United States. If two deeming rules could apply to you because your sponsor is also your ineligible spouse or parent who lives with you, we use the appropriate spouse-to-spouse or parent-to-child deeming rules instead of the sponsor-to-alien rules. If you have a sponsor and also have an ineligible spouse or parent who is not your sponsor and whose income can be deemed to you, both rules apply. If your sponsor is not your parent or spouse but is the ineligible spouse or parent of another SSI beneficiary, we use the sponsor-to-alien deeming rules for you and the appropriate spouse-to-spouse or parent-to-child deeming rules for the other SSI beneficiary.

(4) *Essential person.* If you live in the same household with your essential person (as defined in § 416.222), we must look at that person's income to decide whether we must deem some of it to you. We do this because we have increased your benefit to help meet the needs of your essential person.

(b) *When we deem.* We deem income to determine whether you are eligible for a benefit and to determine the amount of your benefit. However, we may consider this income in different months for each purpose.

(1) *Eligibility.* We consider the income of your ineligible spouse, ineligible parent, sponsor or essential person in the current month to determine whether you are eligible for SSI benefits for that month.

(2) *Amount of benefit.* We consider the income of your ineligible spouse, ineligible parent, sponsor, or essential person in the second month prior to the current month to determine your benefit amount for the current month. *Exceptions:*

(i) We use the income from the first month you are initially eligible for payment of SSI benefits (see § 416.501) to determine your benefit amount for that month. In the following month (the second month you are eligible for payment), we use the same countable income that we used in the preceding

month to determine your benefit amount.

(ii) To determine your benefit amount for the first month you again become eligible after you have been ineligible for at least a month, we use the same countable income that we use to determine your eligibility for that month. In the following month (the second month of reeligibility), we use the same countable income that we used in the preceding month to determine your benefit amount.

(iii) To determine the amount of your benefit in the current month, if there are certain changes in your situation which we list below, we use only your own countable income in a prior month, excluding any income deemed to you in that month from an ineligible spouse or parent. These changes are the death of your spouse or parent, your attainment of age 18, or your becoming subject to the $30 Federal benefit rate (§416.211(b)).

(iv) To determine the amount of your benefit for the current month, we do not use income deemed from your essential person beginning with the month you can no longer qualify for the essential person increment (§416.413). We use only your own countable income in a prior month to determine the amount of your benefit for the current month.

(c) *Steps in deeming.* Although the way we deem income varies depending upon whether you are an eligible individual, an eligible child, an alien with a sponsor, or an individual with an essential person, we follow several general steps to determine how much income to deem.

(1) We determine how much earned and unearned income your ineligible spouse, ineligible parent, sponsor, or essential person has, and we apply the appropriate exclusions. (See §416.1161(a) for exclusions that apply to an ineligible parent or spouse, and §416.1161(b) for those that apply to an essential person or to a sponsor.)

(2) Before we deem income to you from either your ineligible spouse or ineligible parent, we allocate an amount for each ineligible child in the household. (Allocations for ineligible children are explained in §§416.1163(b) and 416.1165(b).) We also allocate an amount for each eligible alien who is subject to deeming from your ineligible spouse or parent as a sponsor. (Allocations for eligible aliens are explained in §416.1163(c).)

(3) We then follow the deeming rules which apply to you.

(i) For deeming income from your ineligible spouse, see §416.1163.

(ii) For deeming income from your ineligible parent, see §416.1165.

(iii) For deeming income from your ineligible spouse when you also have an eligible child, see §416.1166.

(iv) For deeming income from your sponsor if you are an alien, see §416.1166a.

(v) For deeming income from your essential person, see §416.1168. The rules on when we stop deeming income from your essential person are in §416.1169.

(vi) For provisions on change in status involving couples see §416.1163(f) and for those involving parents see §416.1165(g).

(d) *Definitions for deeming purposes.* For deeming purposes—

Combat zone means

(i) Any area the President of the United States designates by Executive Order under 26 U.S.C. 112 as an area in which Armed Forces of the United States are or have engaged in combat;

(ii) A qualified hazardous duty area (QHDA) Congress designates be treated in the same manner as an area designated by the President under 26 U.S.C. 112, provided the member of the uniformed services serving in this area is entitled to special pay under 37 U.S.C. 310; or

(iii) An area where the Secretary of Defense or his or her designated representative has certified that Armed Forces members provide direct support for military operations in an area designated by the President under 26 U.S.C. 112 or a QHDA, provided the member of the uniformed services serving in the area certified by the Secretary of Defense or his or her designated representative is entitled to special pay under 37 U.S.C. 310.

Date of admission to or *date of entry into the United States* means the date established by the U.S. Citizenship and Immigration Services as the date the alien is admitted for permanent residence.

Dependent means the same thing as it does for Federal income tax purposes—we mean someone for whom you are entitled to take a deduction on your personal income tax return. *Exception:* An alien and an alien's spouse are not considered to be dependents of the alien's sponsor for the purposes of these rules.

Essential person means someone who was identified as essential to your welfare under a State program that preceded the SSI program. (See §§ 416.220 through 416.223 for the rules on essential persons.)

Ineligible child means your natural child or adopted child, or the natural or adopted child of your spouse, or the natural or adopted child of your parent or of your parent's spouse (as the term *child* is defined in § 416.1101 and the term *spouse* is defined in § 416.1806), who lives in the same household with you, and is not eligible for SSI benefits.

Ineligible parent means a natural or adoptive parent, or the spouse (as defined in § 416.1101) of a natural or adoptive parent, who lives with you and is not eligible for SSI benefits. The income of ineligible parents affects your benefit only if you are a child under age 18.

Ineligible spouse means someone who lives with you as your husband or wife and is not eligible for SSI benefits.

Sponsor means an individual (but not an organization such as the congregation of a church or a service club, or an employer who only guarantees employment for an alien upon entry but does not sign an affidavit of support) who signs an affidavit of support agreeing to support you as a condition of your admission as an alien for permanent residence in the United States.

[52 FR 8882, Mar. 20, 1987, as amended at 54 FR 19164, May 4, 1989; 64 FR 31974, June 15, 1999; 73 FR 28035, May 15, 2008; 75 FR 7554, Feb. 22, 2010]

§ 416.1161 Income of an ineligible spouse, ineligible parent, and essential person for deeming purposes.

The first step in deeming is determining how much income your ineligible spouse, ineligible parent (if you are a child), your sponsor (if you are an alien), or your essential person, has. We do not always include all of their income when we determine how much income to deem. In this section we explain the rules for determining how much of their income is subject to deeming. As part of the process of deeming income from your ineligible spouse or parent, we must determine the amount of income of any ineligible children in the household.

(a) *For an ineligible spouse or parent.* We do not include any of the following types of income (see § 416.1102) of an ineligible spouse or parent:

(1) Income excluded by Federal laws other than the Social Security Act (See the appendix to this subpart.)

(2) Any public income-maintenance payments (§ 416.1142(a)) your ineligible spouse or parent receives, and any income which was counted or excluded in figuring the amount of that payment;

(3) Any of the income of your ineligible spouse or parent that is used by a public income-maintenance program (§ 416.1142(a)) to determine the amount of that program's benefit to someone else;

(4) Any portion of a grant, scholarship, fellowship, or gift used or set aside to pay tuition, fees or other necessary educational expenses;

(5) Money received for providing foster care to an ineligible child;

(6) The value of food stamps and the value of Department of Agriculture donated foods;

(7) Food raised by your parent or spouse and consumed by members of the household in which you live;

(8) Tax refunds on income, real property, or food purchased by the family;

(9) Income used to fulfill an approved plan for achieving self-support (see §§ 416.1180 through 416.1182);

(10) Income used to comply with the terms of court-ordered support, or support payments enforced under title IV-D of the Act;

(11) The value of in-kind support and maintenance;

(12) Alaska Longevity Bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985: met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983; and was eligible for SSI;

(13) Disaster assistance as described in §§ 416.1150 and 416.1151;

(14) Income received infrequently or irregularly (see §§416.1112(c)(1) and 416.1124(c)(6));

(15) Work expenses if the ineligible spouse or parent is blind;

(16) Income of your ineligible spouse or ineligible parent which was paid under a Federal, State, or local government program (For example, payments under title XX of the Social Security Act) to provide you with chore, attendant or homemaker services;

(17) Certain support and maintenance assistance as described in §416.1157(c);

(18) Housing assistance as provided in §416.1124(c)(14);

(19) The value of a commercial transportation ticket as described in §416.1124(c)(16). However, if such a ticket is converted to cash, the cash is income in the month your spouse or parent receives the cash;

(20) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in §416.1112(c);

(21) Payments from a fund established by a State to aid victims of crime (see §416.1124(c)(17));

(22) Relocation assistance, as described in §416.1124(c)(18);

(23) Special pay received from one of the uniformed services pursuant to 37 U.S.C. 310;

(24) Impairment-related work expenses, as described in 20 CFR 404.1576, incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under title II of the Act;

(25) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces (see §416.1124(c) (9) and (15));

(26) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than section 1613(a) of the Social Security Act;

(27) Earned income of a student as described in §416.1112(c)(3); and

(28) Any additional increment in pay, other than any increase in basic pay, received while serving as a member of the uniformed services, if—

(i) Your ineligible spouse or parent received the pay as a result of deployment to or service in a combat zone; and

(ii) Your ineligible spouse or parent was not receiving the additional pay immediately prior to deployment to or service in a combat zone.

(b) *For an essential person or for a sponsor of an alien.* We include all the income (as defined in §416.1102) of an essential person or of a sponsor of an alien and of the spouse of the sponsor (if the sponsor and spouse live in the same household) except for support and maintenance assistance described in §416.1157(c), and income excluded under Federal laws other than the Social Security Act. For information on these laws see the appendix to this subpart.

(c) *For an ineligible child.* Although we do not deem any income to you from an ineligible child, we reduce his or her allocation if the ineligible child has income (see §416.1163(b)(2)). For this purpose, we do not include any of the child's income listed in paragraph (a) of this section. In addition, if the ineligible child is a student (see §416.1861), we exclude his/her earned income subject to the amounts set in §416.1112(c)(3).

(d) *For an eligible alien.* Although we do not deem any income to you from an eligible alien, if your ineligible spouse or ineligible parent is also a sponsor of an eligible alien, we reduce the alien's allocation if he or she has income (see §416.1163(c)(2)). For this purpose exclude any of the alien's income listed in paragraph (a) of this section.

[45 FR 65547, Oct. 3, 1980, as amended at 46 FR 57276, Nov. 23, 1981; 48 FR 33259, July 21, 1983; 50 FR 48576, Nov. 26, 1985; 51 FR 39523, Oct. 29, 1986; 52 FR 8883, Mar. 20, 1987; 52 FR 44971, Nov. 24, 1987; 55 FR 28378, July 11, 1990; 58 FR 63888, 63890, Dec. 3, 1993; 61 FR 1712, Jan. 23, 1996; 61 FR 49964, Sept. 24, 1996; 67 FR 11034, Mar. 12, 2002; 71 FR 45378, Aug. 9, 2006; 71 FR 66866, Nov. 17, 2006; 75 FR 7554, Feb. 22, 2010]

§ 416.1161a Income for deeming purposes where Medicaid eligibility is affected.

(a) *General.* In many States, an individual who is eligible for SSI or a Federally administered State optional supplementary payment is in turn eligible for Medicaid. Also, several other States use SSI deeming rules in determining eligibility for Medicaid. In all of these States, in extraordinary cases, the Department will not apply the usual rules on deeming of income where those rules would result in an individual's being ineligible for SSI (or a Federally administered State optional supplementary payment) and Medicaid. Any determination made under this section may at any time be revised based on new information or changed circumstances.

(b) *When special deeming rules apply:*

(1) The Department will consider not applying the usual deeming rules only upon application by a State Medicaid agency (requirement approved under OMB No. 0960–0304) and on condition that the agency must show:

(i) Deeming would result in lack of Medicaid eligibility for the individual.

(ii) Medicaid eligibility would, prospectively, result in savings to the Medicaid program; and

(iii) The quality of medical care necessary for the individual would be maintained under the arrangements contemplated.

(2) The Department may also in particular cases require that additional facts be demonstrated, or that other criteria or standards be met, before it determines not to apply the usual deeming rules.

(c) *Amount of income to be deemed.* If the usual rules of deeming do not apply, the Department will determine an amount, if any, to be deemed.

(d) *Temporary effect of special deeming rules.* This provision is temporary and will be continued only through December 31, 1984. Determinations made under this section will nevertheless remain in effect unless they are revised based on changed circumstances (including establishment in the State of a Medicaid program of home and community-based services or eligibility under a State plan provision) or new information.

[49 FR 5747, Feb. 15, 1984]

§ 416.1163 How we deem income to you from your ineligible spouse.

If you have an ineligible spouse who lives in the same household, we apply the deeming rules to your ineligible spouse's income in the following order.

(a) *Determining your ineligible spouse's income.* We first determine how much earned and unearned income your ineligible spouse has, using the appropriate exclusions in § 416.1161(a).

(b) *Allocations for ineligible children.* We then deduct an allocation for ineligible children in the household to help meet their needs. *Exception:* We do not allocate for ineligible children who are receiving public income-maintenance payments (see § 416.1142(a)).

(1) The allocation for each ineligible child is the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual. The amount of the allocation automatically increases whenever the Federal benefit rate increases. The amount of the allocation that we use to determine the amount of a benefit for a current month is based on the Federal benefit rate that applied in the second prior month unless one of the exceptions in § 416.1160(b)(2) applies.

(2) Each ineligible child's allocation is reduced by the amount of his or her own income as described in § 416.1161(c).

(3) We first deduct the allocations from your ineligible spouse's unearned income. If your ineligible spouse does not have enough unearned income to cover the allocations we deduct the balance from your ineligible spouse's earned income.

(c) *Allocations for aliens sponsored by your ineligible spouse.* We also deduct an allocation for eligible aliens who have been sponsored by and who have income deemed from your ineligible spouse.

(1) The allocation for each alien who is sponsored by and who has income deemed from your ineligible spouse is the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual. The amount of the allocation automatically increases whenever the

Federal benefit rate increases. The amount of the allocation that we use to compute your benefit for a current month is based on the Federal benefit rate that applied in the second prior month (unless the current month is the first or second month of eligibility or re-eligibility as explained in §416.420(a) and (b) (2) and (3)).

(2) Each alien's allocation is reduced by the amount of his or her own income as described in §416.1161(d).

(3) We first deduct the allocations from your ineligible spouse's unearned income. If your ineligible spouse does not have enough unearned income to cover the allocations, we deduct the balance from your ineligible spouse's earned income.

(d) *Determining your eligibility for SSI.* (1) If the amount of your ineligible spouse's income that remains after appropriate allocations is not more than the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual, there is no income to deem to you from your spouse. In this situation, we subtract only your own countable income from the Federal benefit rate for an individual to determine whether you are eligible for SSI benefits.

(2) If the amount of your ineligible spouse's income that remains after appropriate allocations is more than the difference between the Federal benefit rate for an eligible couple and the Federal benefit rate for an eligible individual, we treat you and your ineligible spouse as an eligible couple. We do this by:

(i) Combining the remainder of your spouse's unearned income with your own unearned income and the remainder of your spouse's earned income with your earned income;

(ii) Applying all appropriate income exclusions in §§416.1112 and 416.1124; and

(iii) Subtracting the couple's countable income from the Federal benefit rate for an eligible couple. (See §416.2025(b) for determination of the State supplementary payment amount.)

(e) *Determining your SSI benefit.* (1) In determining your SSI benefit amount, we follow the procedure in paragraphs (a) through (d) of this section. However, we use your ineligible spouse's income in the second month prior to the current month. We vary this rule if any of the exceptions in §416.1160(b)(2) applies (for example, if this is the first month you are eligible for payment of an SSI benefit or if you are again eligible after at least a month of being ineligible). In the first month of your eligibility for payment (or re-eligibility), we deem your ineligible spouse's income in the current month to determine both whether you are eligible for a benefit and the amount of your benefit. In the second month, we deem your ineligible spouse's income in that month to determine whether you are eligible for a benefit but we deem your ineligible spouse's income in the first month to determine the amount of your benefit.

(2) Your SSI benefit under the deeming rules cannot be higher than it would be if deeming did not apply. Therefore, your benefit is the lesser of the amount computed under the rules in paragraph (d)(2) of this section or the amount remaining after we subtract only your own countable income from an individual's Federal benefit rate.

(f) *Special rules for couples when a change in status occurs.* We have special rules to determine how to deem your spouse's income to you when there is a change in your situation.

(1) *Ineligible spouse becomes eligible.* If your ineligible spouse becomes eligible for SSI benefits, we treat both of you as newly eligible. Therefore, your eligibility and benefit amount for the first month you are an eligible couple will be based on your income in that month. In the second month, your benefit amount will also be based on your income in the first month.

(2) *Spouses separate or divorce.* If you separate from your ineligible spouse or your marriage to an ineligible spouse ends by divorce, we do not deem your ineligible spouse's income to you to determine your eligibility for benefits beginning with the first month following the event. If you remain eligible, we determine your benefit amount by following the rule in paragraph (e) of this section provided deeming from your spouse applied in the prior month.

(3) *Eligible individual begins living with an ineligible spouse.* If you begin to live with your ineligible spouse, we deem your ineligible spouse's income to you in the first month thereafter to determine whether you continue to be eligible for SSI benefits. If you continue to be eligible, we follow the rule in § 416.420(a) to determine your benefit amount.

(4) *Ineligible spouse dies.* If your ineligible spouse dies, we do not deem your spouse's income to you to determine your eligibility for SSI benefits beginning with the month following the month of death. In determining your benefit amount beginning with the month following the month of death, we use only your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible spouse.

(5) *You become subject to the $30 Federal benefit rate.* If you become a resident of a medical care facility and the $30 Federal benefit rate applies, we do not deem your ineligible spouse's income to you to determine your eligibility for SSI benefits beginning with the first month for which the $30 Federal benefit rate applies. In determining your benefit amount beginning with the first month for which the $30 Federal benefit rate applies, we use only your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible spouse.

(g) *Examples.* These examples show how we deem income from an ineligible spouse to an eligible individual in cases which do not involve any of the exceptions in § 416.1160(b)(2). The income, the income exclusions, and the allocations are monthly amounts. The Federal benefit rates used are those effective January 1, 1986.

Example 1. In September 1986, Mr. Todd, an aged individual, lives with his ineligible spouse, Mrs. Todd, and their ineligible child, Mike. Mr. Todd has a Federal benefit rate of $336 per month. Mrs. Todd receives $252 unearned income per month. She has no earned income and Mike has no income at all. Before we deem any income, we allocate to Mike $168 (the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual). We subtract the $168 allocation from Mrs. Todd's $252 unearned income, leaving $84. Since Mrs. Todd's $84 remaining income is not more than $168, which is the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual, we do not deem any income to Mr. Todd. Instead, we compare only Mr. Todd's own countable income with the Federal benefit rate for an eligible individual to determine whether he is eligible. If Mr. Todd's own countable income is less than his Federal benefit rate, he is eligible. To determine the amount of his benefit, we determine his countable income, including any income deemed from Mrs. Todd, in July and subtract this income from the appropriate Federal benefit rate for September.

Example 2. In September 1986, Mr. Jones, a disabled individual, lives with his ineligible spouse, Mrs. Jones, and ineligible child, Christine. Mr. Jones and Christine have no income. Mrs. Jones has earned income of $401 a month and unearned income of $252 a month. Before we deem any income, we allocate $168 to Christine. We take the $168 allocation from Mrs. Jones' $252 unearned income, leaving $84 in unearned income. Since Mrs. Jones' total remaining income ($84 unearned plus $401 earned) is more than $168, which is the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual, we compute the combined countable income as we do for a couple. We apply the $20 general income exclusion to the unearned income, reducing it further to $64. We then apply the earned income exclusion ($65 plus one-half the remainder) to Mrs. Jones' earned income of $401, leaving $168. We combine the $64 countable unearned income and $168 countable earned income, and compare it ($232) with the $504 September Federal benefit rate for a couple, and determine that Mr. Jones is eligible. Since Mr. Jones is eligible, we determine the amount of his benefit by subtracting his countable income in July (including any deemed from Mrs. Jones) from September's Federal benefit rate for a couple.

Example 3. In September 1986, Mr. Smith, a disabled individual, lives with his ineligible spouse, Mrs. Smith, who earns $201 per month. Mr. Smith receives a pension (unearned income) of $100 a month. Since Mrs. Smith's income is greater than $168, which is the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual, we deem all of her income to be available to both Mr. and Mrs. Smith and compute the combined countable income for the couple. We apply the $20 general income exclusion to Mr. Smith's $100 unearned income, leaving $80. Then we apply the earned income exclusion ($65 plus one-half of the remainder) to Mrs. Smith's $201, leaving

$68. This gives the couple total countable income of $148. This is less than the $504 September Federal benefit rate for a couple, so Mr. Smith is eligible based on deeming. Since he is eligible, we determine the amount of his benefit based on his income (including any deemed from Mrs. Smith) in July.

Example 4. In September 1986, Mr. Simon has a disabled spouse, Mrs. Simon, and has sponsored an eligible alien, Mr. Ollie. Mrs. Simon has monthly unearned income of $100 and Mr. Simon has earned income of $405. From Mr. Simon's earned income we allocate to Mr. Ollie $168, which is the difference between the Federal benefit rate for an eligible couple and the rate for an eligible individual. Mr. Ollie has no other income. This reduces Mr. Simon's earned income from $405 to $237. Since $237 is more than $168 (the difference between the Federal benefit rate for an eligible couple and the rate for an eligible individual), we deem all of Mr. Simon's remaining income to be available to Mr. and Mrs. Simon and compute the combined countable income for the couple. We apply the $20 general income exclusion to Mrs. Simon's unearned income, leaving $80. Then we apply the general earned income exclusion ($65 plus one-half the remainder) to Mr. Simon's $237 earned income, leaving $86. This gives the couple total income of $166 ($80 + $86.). The $166 is less than the $504 Federal benefit rate for a couple so Mrs. Simon would be eligible based on deeming. Since she is eligible, we determine the amount of her benefit based on her income (including any deemed from Mr. Simon) in July. For the way we deem Mr. Simon's income to Mr. Ollie, see the rules in § 416.1166a.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48576, Nov. 26, 1985; 52 FR 8883, Mar. 20, 1987; 53 FR 25151, July 5, 1988; 54 FR 19164, May 4, 1989; 64 FR 31974, June 15, 1999]

§ 416.1165 How we deem income to you from your ineligible parent(s).

If you are a child living with your parents, we apply the deeming rules to you through the month in which you reach age 18. We follow the rules in paragraphs (a) through (e) of this section to determine your eligibility. To determine your benefit amount, we follow the rules in paragraph (f) of this section. The rules in paragraph (g) of this section apply to changes in your family situation. Paragraph (i) of this section discusses the conditions under which we will not deem your ineligible parents' income to you if you are a disabled child living with your parents.

(a) *Determining your ineligible parent's income.* We first determine how much current monthly earned and unearned income your ineligible parents have, using the appropriate exclusions in § 416.1161(a).

(b) *Allocations for ineligible children.* We next deduct an allocation for each ineligible child in the household as described in § 416.1163(b).

(c) *Allocations for aliens who are sponsored by and have income deemed from your ineligible parent.* We also deduct an allocation for eligible aliens who have been sponsored by and have income deemed from your ineligible parent as described in § 416.1163(c).

(d) *Allocations for your ineligible parent(s).* We next deduct allocations for your parent(s). We do not deduct an allocation for a parent who is receiving public income-maintenance payments (see § 416.1142(a)). The allocations are calculated as follows:

(1) We first deduct $20 from the parents' combined unearned income, if any. If they have less than $20 in unearned income, we subtract the balance of the $20 from their combined earned income.

(2) Next, we subtract $65 plus one-half the remainder of their earned income.

(3) We total the remaining earned and unearned income and subtract—

(i) The Federal benefit rate for the month for a couple if both parents live with you; or

(ii) The Federal benefit rate for the month for an individual if only one parent lives with you.

(e)(1) *When you are the only eligible child.* If you are the only eligible child in the household, we deem any of your parents' current monthly income that remains to be your unearned income. We combine it with your own unearned income and apply the exclusions in § 416.1124 to determine your countable unearned income in the month. We add this to any countable earned income you may have and subtract the total from the Federal benefit rate for an individual to determine whether you are eligible for benefits.

(2) *When you are not the only eligible child.* If your parents have more than one eligible child under age 18 in the household, we divide the parental income to be deemed equally among those eligible children.

(3) *When one child's income makes that child ineligible.* We do not deem more income to an eligible child than the amount which, when combined with the child's own income, reduces his or her SSI benefit to zero. (For purposes of this paragraph, an SSI benefit includes any federally administered State supplement). If the share of parental income that would be deemed to a child makes that child ineligible (reduces the amount to zero) because that child has other countable income, we deem any remaining parental income to other eligible children under age 18 in the household in the manner described in paragraph (e)(2) of this section.

(f) *Determining your SSI benefit.* In determining your SSI benefit amount, we follow the procedure in paragraphs (a) through (d) of this section. However, we use your ineligible parents' income in the second month prior to the current month. We vary this rule if any of the exceptions in § 416.1160(b)(2) applies (for example, if this is the first month you are eligible for payment of an SSI benefit or if you are again eligible after at least a month of being ineligible). In the first month of your eligibility for payment (or re-eligibility) we deem your ineligible parents' income in the current month to determine both whether you are eligible for a benefit and the amount of your benefit. In the second month we deem your ineligible parents' income in that month to determine whether you are eligible for a benefit but we again use your countable income (including any that was deemed to you) in the first month to determine the amount of your benefit.

(g) *Special rules for a change in status.* We have special rules to begin or stop deeming your ineligible parents' income to you when a change in your family situation occurs.

(1) *Ineligible parent becomes eligible.* If your ineligible parent becomes eligible for SSI benefits, there will be no income to deem from that parent to you to determine your eligibility for SSI benefits beginning with the month your parent becomes eligible. However, to determine your benefit amount, we follow the rule in § 416.420.

(2) *Eligible parent becomes ineligible.* If your eligible parent becomes ineligible, we deem your parents' income to you in the first month of the parents' ineligibility to determine whether you continue to be eligible for SSI benefits. However, if you continue to be eligible, in order to determine your benefit amount, we follow the regular rule of counting your income in the second month prior to the current month.

(3) *Ineligible parent dies.* If your ineligible parent dies, we do not deem that parent's income to you to determine your eligibility for SSI benefits beginning with the month following the month of death. In determining your benefit amount beginning with the month following the month of death, we use only your own countable income in a prior month, excluding any income deemed to you in that month from your deceased ineligible parent (see § 416.1160(b)(2)(iii)). If you live with two ineligible parents and one dies, we continue to deem income from the surviving ineligible parent who is also your natural or adoptive parent. If you live with a stepparent following the death of your natural or adoptive parent, we do not deem income from the stepparent.

(4) *Ineligible parent and you no longer live in the same household.* If your ineligible parent and you no longer live in the same household, we do not deem that parent's income to you to determine your eligibility for SSI benefits beginning with the first month following the month in which one of you leaves the household. We also will not deem income to you from your parent's spouse (*i.e.*, your stepparent) who remains in the household with you if your natural or adoptive parent has permanently left the household. To determine your benefit amount if you continue to be eligible, we follow the rule in § 416.420 of counting your income including deemed income from your parent and your parent's spouse (*i.e.*, your stepparent) (if the stepparent and parent lived in the household with you) in the second month prior to the current month.

(5) *Ineligible parent and you begin living in the same household.* If your ineligible parent and you begin living in the same household, we consider that parent's income to determine whether you continue to be eligible for SSI benefits

beginning with the month following the month of change. However (if you continue to be eligible), to determine your benefit amount, we follow the rule in §416.420 of counting your income in the second month prior to the current month.

(6) *You become subject to the $30 Federal benefit rate.* If you become a resident of a medical treatment facility and the $30 Federal benefit rate applies, we do not deem your ineligible parent's income to you to determine your eligibility for SSI benefits beginning with the first month for which the $30 Federal benefit rate applies. In determining your benefit amount beginning with the first month for which the $30 Federal benefit rate applies, we only use your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible parent.

(7) *You attain age 18.* In the month following the month in which you attain age 18 and thereafter, we do not deem your ineligible parent's income to you to determine your eligibility for SSI benefits. In determining your benefit amount beginning with the month following your attainment of age 18, we only use your own countable income in a prior month, excluding any income deemed to you in that month from your ineligible parent (see §416.1160(b)(2)(B)). Your income for the current and subsequent months must include any income in the form of cash or in-kind support and maintenance provided by your parents. If you attain age 18 and stop living in the same household with your ineligible parent, these rules take precedence over paragraph (g)(4) of this section which requires continued use of deemed income in the benefit computation for 2 months following the month you no longer live in the same household.

(h) *Examples.* These examples show how we deem an ineligible parent's income to an eligible child when none of the exceptions in §416.1160(b)(2) applies. The Federal benefit rates are those effective January 1, 1992.

Example 1. Henry, a disabled child, lives with his mother and father and a 12-year-old ineligible brother. His mother receives a pension (unearned income) of $365 per month and his father earns $1,165 per month. Henry and his brother have no income. First we deduct an allocation of $211 for Henry's brother from the unearned income. This leaves $154 in unearned income. We reduce the remaining unearned income further by the $20 general income exclusion, leaving $134. We then reduce the earned income of $1,165 by $65 leaving $1,100. Then we subtract one-half of the remainder, leaving $550. To this we add the remaining unearned income of $134 resulting in $684. From this, we subtract the parent allocation of $633 (the Federal benefit rate for a couple) leaving $51 to be deemed as Henry's unearned income. Henry has no other income. We apply Henry's $20 general income exclusion which reduces his countable income to $31. Since that amount is less than the $422 Federal benefit rate for an individual, Henry is eligible. We determine his benefit amount by subtracting his countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See §416.420.

Example 2. James and Tony are disabled children who live with their mother. The children have no income but their mother receives $542 a month in unearned income. We reduce the unearned income by the $20 general income exclusion, leaving $522. We then subtract the amount we allocate for the mother's needs, $422 (the Federal benefit rate for an individual). The amount remaining to be deemed to James and Tony is $100, which we divide equally between them resulting in $50 deemed unearned income to each child. We then apply the $20 general income exclusion, leaving each child with $30 countable income. The $30 of unearned income is less than the $422 Federal benefit rate for an individual, so the children are eligible. We then determine each child's benefit by subtracting his countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See §416.420.

Example 3. Mrs. Jones is the ineligible mother of two disabled children, Beth and Linda, and has sponsored an eligible alien, Mr. Sean. Beth, Linda, and Mr. Sean have no income; Mrs. Jones has unearned income of $924 per month. We reduce the mother's unearned income by the $211 allocation for Mr. Sean, leaving $713. We further reduce her income by the $20 general income exclusion, which leaves a balance of $693. Next, we subtract the amount we allocate for the mother's needs, $422 (the amount of the Federal benefit rate for an individual). The balance of $271 to be deemed is divided equally between Beth and Linda. Each now has unearned income of $135.50 from which we deduct the $20 general income exclusion, leaving each child with $115.50 countable income. Since this is less than the $422 Federal benefit rate for an individual, the girls are eligible. We then determine each child's benefit

by subtracting her countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See § 416.420. (For the way we deem the mother's income to Mr. Sean, see examples No. 3 and No. 4 in § 416.1166a.)

Example 4. Jack, a disabled child, lives with his mother, father, and two brothers, none of whom are eligible for SSI. Jack's mother receives a private pension of $350 per month and his father works and earns $1,525 per month. We allocate a total of $422 for Jack's ineligible brothers and subtract this from the parents' total unearned income of $350; the parents' unearned income is completely offset by the allocations for the ineligible children with an excess allocation of $72 remaining. We subtract the excess of $72 from the parents' total earned income leaving $1,453. We next subtract the combined general income and earned income exclusions of $85 leaving a remainder of $1,368. We subtract one-half the remainder, leaving $684 from which we subtract the parents' allocation of $633. This results in $51 deemed to Jack. Jack has no other income, so we subtract the general income exclusion of $20 from the deemed income leaving $31 as Jack's countable income. Since this is below the $422 Federal benefit rate for an individual, Jack is eligible. We determine his payment amount by subtracting his countable income (including deemed income) in a prior month from the Federal benefit rate for an individual for the current month. See § 416.420.

(i) *Disabled child under age 18.* If you are a disabled child under the age of 18 living with your parents, we will not deem your parents' income to you if—

(1) You previously received a reduced SSI benefit while a resident of a medical treatment facility, as described in § 416.414;

(2) You are eligible for medical assistance under a Medicaid State home care plan approved by the Secretary under the provisions of section 1915(c) or authorized under section 1902(e)(3) of the Act; and

(3) You would otherwise be ineligible for a Federal SSI benefit because of the deeming of your parents' income or resources.

[52 FR 8885, Mar. 20, 1987, as amended at 54 FR 19164, May 4, 1989; 57 FR 48562, Oct. 27, 1992; 60 FR 361, Jan. 4, 1995; 62 FR 1056, Jan. 8, 1997; 64 FR 31974, June 15, 1999; 72 FR 50874, Sept. 5, 2007; 73 FR 28036, May 15, 2008]

§ 416.1166 How we deem income to you and your eligible child from your ineligible spouse.

If you and your eligible child live in the same household with your ineligible spouse, we deem your ineligible spouse's income first to you, and then we deem any remainder to your eligible child. For the purpose of this section, SSI benefits include any federally administered State supplement. We then follow the rules in § 416.1165(e) to determine the child's eligibility for SSI benefits and in § 416.1165(f) to determine the benefit amount.

(a) *Determining your ineligible spouse's income.* We first determine how much earned and unearned income your ineligible spouse has, using the appropriate exclusions in § 416.1161(a).

(b) *Allocations for ineligible children.* We next deduct an allocation for each ineligible child in the household as described in § 416.1163(b).

(c) *Allocations for aliens who are sponsored by and have income deemed from your ineligible spouse.* We also deduct an allocation for eligible aliens who have been sponsored by and have income deemed from your ineligible spouse as described in § 416.1163(c).

(d) *Determining your eligibility for SSI benefits and benefit amount.* We then follow the rules in § 416.1163(c) to find out if any of your ineligible spouse's current monthly income is deemed to you and, if so, to determine countable income for a couple. Next, we follow paragraph (e) of this section to determine your child's eligibility. However, if none of your spouse's income is deemed to you, none is deemed to your child. Whether or not your spouse's income is deemed to you in determining your eligibility, we determine your benefit amount as explained in § 416.1163(e).

(e) *Determining your child's eligibility and amount of benefits.* (1) If you are eligible for SSI benefits after your spouse's income has been deemed to you, we do not deem any income to your child. To determine the child's eligibility, we subtract the child's own countable income without deeming from the benefit rate for an individual.

(2) If you are not eligible for SSI benefits after your ineligible spouse's income has been deemed to you, we deem

to your eligible child any of your spouse's income which was not used to reduce your SSI benefits to zero.

(f) *Examples.* These examples show how we deem income to an eligible individual and an eligible child in the same household. The Federal benefit rates used are those effective January 1, 1984.

Example 1. Mary, a blind individual, lives with her husband, John, and their disabled child, Peter. Mary and Peter have no income, but John is employed and earns $605 per month. We determine Mary's eligibility first. Since John's income is more than $157, which is one-half of the Federal benefit rate for an eligible individual, we treat the entire $605 as earned income available to John and Mary as a couple. Because they have no unearned income, we reduce the $605 by the $20 general income exclusion, and then by the earned income exclusion of $65 plus one-half the remainder. This leaves John and Mary with $260 in countable income. The $260 countable income is less than the $472 Federal benefit rate for a couple, so Mary is eligible; therefore, there is no income to be deemed to Peter.

Example 2. Al, a disabled individual, resides with his ineligible spouse, Dora, and their disabled son, Jeff. Al and Jeff have no income, but Dora is employed and earns $1,065 a month. Since Dora's income is more than $157, which is one-half of the Federal benefit rate for an eligible individual, we treat the entire $1,065 as earned income available to Al and Dora as a couple. We reduce this income by the $20 general income exclusion and then by $65 plus one-half the remainder (earned income exclusion), leaving $490 in countable income. Al is ineligible because the couple's $490 countable income exceeds the $472 Federal benefit rate for a couple. Since Al is ineligible, we deem to Jeff $18, the amount of income over and above the amount which causes Al to be ineligible (the difference between the countable income and the Federal benefit rate for a couple). We treat the $18 deemed to Jeff as unearned income, and we apply the $20 general income exclusion, reducing Jeff's countable income to zero. Jeff is eligible.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48578, Nov. 26, 1985; 52 FR 8887, Mar. 20, 1987; 64 FR 31975, June 15, 1999]

§ 416.1166a How we deem income to you from your sponsor if you are an alien.

Before we deem your sponsor's income to you if you are an alien, we determine how much earned and unearned income your sponsor has under § 416.1161(b). We then deduct allocations for the sponsor and the sponsor's dependents. This is an amount equal to the Federal benefit rate for an individual for the sponsor (or for each sponsor even if two sponsors are married to each other and living together) plus an amount equal to one-half the Federal benefit rate for an eligible individual for each dependent of the sponsor. An ineligible dependent's income is not subtracted from the sponsor's dependent's allocation. We deem the balance of the income to be your unearned income.

(a) *If you are the only alien applying for or already eligible for SSI benefits who has income deemed to you from your sponsor.* If you are the only alien who is applying for or already eligible for SSI benefits and who is sponsored by your sponsor, all the deemed income is your unearned income.

(b) *If you are not the only alien who is applying for or already eligible for SSI benefits and who has income deemed from your sponsor.* If you and other aliens applying for or already eligible for SSI benefits are sponsored by the same sponsor, we deem the income to each of you as though you were the only alien sponsored by that person. The income deemed to you becomes your unearned income.

(c) *When you are an alien and income is no longer deemed from your sponsor.* If you are an alien and have had your sponsor's income deemed to you, we stop deeming the income with the month in which the third anniversary of your admission into the United States occurs.

(d) *When sponsor deeming rules do not apply to you if you are an alien.* If you are an alien, we do not apply the sponsor deeming rules to you if—

(1) *You are a refugee.* You are a refugee admitted to the United States as the result of application of one of three sections of the Immigration and Nationality Act: (1) Section 203(a)(7), effective before April 1, 1980; (2) Section 207(c)(1), effective after March 31, 1980; or (3) Section 212(d)(5);

(2) *You have been granted asylum.* You have been granted political asylum by the Attorney General of the United States; or

(3) *You become blind or disabled.* If you become blind or disabled as defined in § 416.901 (at any age) after your admission to the United States, we do not deem your sponsor's income to you to determine your eligibility for SSI benefits beginning with the month in which your disability or blindness begins. However, to determine your benefit payment, we follow the rule in § 416.420 of counting your income in the second month prior to the current month.

(e) *Examples.* These examples show how we deem a sponsor's income to an eligible individual who is an alien when none of the exceptions in § 416.1160(b)(2) applies. The income, income exclusions, and the benefit rates are in monthly amounts. The Federal benefit rates are those effective January 1, 1986.

Example 1. Mr. John, an alien who has no income, has been sponsored by Mr. Herbert who has monthly earned income of $1,300 and unearned income of $70. Mr. Herbert's wife and three children have no income. We add Mr. Herbert's earned and unearned income for a total of $1,370 and apply the allocations for the sponsor and his dependents. Allocations total $1,008. These are made up of $336 (the Federal benefit rate for an eligible individual) for the sponsor, plus $672 (one-half the Federal benefit rate for an eligible individual, $168 each) for Mr. Herbert's wife and three children. The $1,008 is subtracted from Mr. Herbert's total income of $1,370 which leaves $362 to be deemed to Mr. John as his unearned income. Mr. John's only exclusion is the $20 general income exclusion. Since the $342 balance exceeds the $336 Federal benefit rate, Mr. John is ineligible.

Example 2. Mr. and Mrs. Smith are an alien couple who have no income and who have been sponsored by Mr. Hart. Mr. Hart has earned income of $1,350 and his wife, Mrs. Hart, who lives with him, has earned income of $150. Their two children have no income. We combine Mr. and Mrs. Hart's income ($1,350 + $150 = $1,500). We deduct the allocations of $336 for Mr. Hart (the Federal benefit rate for an individual) and $504 for Mrs. Hart and the two children ($168 or one-half the Federal benefit rate for an eligible individual for each), a total of $840. The allocations ($840) are deducted from the total $1,500 income which leaves $660. This amount must be deemed independently to Mr. and Mrs. Smith. Mr. and Mrs. Smith would qualify for SSI benefits as a couple in the amount of $504 if no income had been deemed to them. The $1,320 ($660 each to Mr. and Mrs. Smith) deemed income is unearned income to Mr. and Mrs. Smith and is subject to the $20 general income exclusion, leaving $1,300. This exceeds the couple's rate of $504 so Mr. and Mrs. Smith are ineligible for SSI benefits.

Example 3. Mr. Bert and Mr. Davis are aliens sponsored by their sister Mrs. Jean, who has earned income of $800. She also receives $250 as survivors' benefits for her two minor children. We do not consider the $250 survivors' benefits to be Mrs. Jean's income because it is the children's income. We exclude $336 for Mrs. Jean (the Federal benefit rate for an individual) plus $336 ($168, one-half the Federal benefit rate for an eligible individual for each child), a total of $672. We subtract the $672 from Mrs. Jean's income of $800, which leaves $128 to be deemed to Mr. Bert and Mr. Davis. Each of the brothers is liable for rent in the boarding house (a commercial establishment) where they live. Each lives in his own household, receives no in-kind support and maintenance, and is eligible for the Federal benefit rate of $336. The $128 deemed income is deemed both to Mr. Bert and to Mr. Davis. As a result, each has countable income of $108 ($128 minus the $20 general income exclusion). This is less than $336, the Federal benefit rate for an individual, so that both are eligible for SSI. We use their income in a prior month to determine their benefit payments.

Example 4. The same situation applies as in example 3 except that one of Mrs. Jean's children is disabled and eligible for SSI benefits. The eligibility of the disabled child does not affect the amount of income deemed to Mr. Bert and Mr. Davis since the sponsor-to-alien and parent-to-child rules are applied independently. The child's countable income is computed under the rules in § 416.1165.

[52 FR 8887, Mar. 20, 1987]

§ 416.1167 Temporary absences and deeming rules.

(a) *General.* During a temporary absence, we continue to consider the absent person a member of the household. A temporary absence occurs when—

(1) You, your ineligible spouse, parent, or an ineligible child leaves the household but intends to and does return in the same month or the month immediately following; or

(2) You enter a medical treatment facility and are eligible for either benefit payable under § 416.212. We consider your absence to be temporary through the last month benefits under § 416.212 were paid unless you were discharged from the facility in the following month. In that case, we consider your absence to be temporary through the date of discharge.

(b) *Child away at school.* If you are an eligible child who is away at school but comes home on some weekends or lengthy holidays and if you are subject to the control of your parents, we consider you temporarily absent from your parents' household. However, if you are not subject to parental control, we do not consider your absence temporary and we do not deem parental income (or resources) to you. Being subject to parental control affects deeming to you only if you are away at school.

(c) *Active duty military service.* If your ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the Armed Forces on active duty, we continue to consider that person to be living in the same household as you, absent evidence to the contrary. If we determine that during such an absence, evidence indicates that your spouse or parent should no longer be considered to be living in the same household as you, then deeming will cease. When such evidence exists, we determine the month in which your spouse or parent should no longer be considered to be living in the same household as you and stop deeming his or her income and resources beginning with the month following that month.

Example: Tom is a child who receives SSI. In January 1996, Tom's father leaves the household due solely to an active duty assignment as a member of the Armed Forces. Five months later in June 1996, while Tom's father is still on an active duty assignment, Tom's parents file for divorce. As a result, Tom's father will not be returning to live in Tom's household. Therefore, Tom's father should no longer be considered to be living in the same household with Tom. Beginning July 1, 1996, deeming from Tom's father will cease.

[50 FR 48579, Nov. 26, 1985, as amended at 61 FR 10280, Mar. 13, 1996; 62 FR 42411, Aug. 7, 1997; 72 FR 50874, Sept. 5, 2007]

§416.1168 How we deem income to you from your essential person.

(a) *Essential person's income.* If you have an essential person, we deem all of that person's income (except any not counted because of other Federal statutes as described in §416.1161(b)) to be your own unearned income. If your essential person is also your ineligible spouse, or if you are a child whose essential person is your ineligible parent, we apply the essential person deeming rules in this section. See §416.1169 for the rules that apply when an ineligible spouse or parent ceases to be your essential person.

(b) *Determining your eligibility for an SSI benefit.* We apply the exclusions to which you are entitled under §§416.1112 and 416.1124 to your earned income and to your unearned income which includes any income deemed from your essential person. After combining the remaining amounts of countable income, we compare the total with the Federal benefit rate for a qualified individual (see §416.413) to determine whether you are eligible for an SSI benefit.

(c) *Determining your SSI benefit amount.* We determine your SSI benefit amount in the same way that we determine your eligibility. However, in following the procedure in paragraphs (a) and (b) of this section we use your essential person's income that we deemed to you in the second month prior to the current month. *Exception:* Beginning with the month in which you no longer have your essential person, we do not use any of the income deemed to you from that essential person in a prior month to determine the amount of your benefit (see §416.1160(a)(3)(ii)(C)). We use only your own countable income in a prior month.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48579, Nov. 26, 1985]

§416.1169 When we stop deeming income from an essential person.

If including the income deemed to you from your essential person causes you to be ineligible for an SSI benefit, you are no longer considered to have that essential person whose income makes you ineligible. To determine your eligibility for that month we deduct only your own countable income from your Federal benefit rate. However, other deeming rules may then apply as follows:

(a) *Essential person is your spouse.* If the person who was your essential person is your ineligible spouse, we apply the deeming rules in §416.1163 beginning with the month that the income of your essential person is no longer deemed to you.

(b) *Essential person is your parent.* If you are a child under age 18, and the person who was your essential person is your ineligible parent, we apply the deeming rules in §416.1165 beginning with the month that the income of your essential person is no longer deemed to you.

[50 FR 48579, Nov. 26, 1985]

ALTERNATIVE INCOME COUNTING RULES FOR CERTAIN BLIND INDIVIDUALS

§ 416.1170 General.

(a) *What the alternative is.* If you are blind and meet the requirements in §416.1171, we use one of two rules to see how much countable income you have. We use whichever of the following rules results in the lower amount of countable income:

(1) The SSI income exclusions in §§416.1112 and 416.1124; or

(2) The disregards that would have applied under the State plan for October 1972.

(b) *State plan.* As used in this subpart, *State plan for October 1972* means a State plan for providing assistance to the blind under title X or XVI (AABD) of the Social Security Act. That plan must have been approved under the provisions of 45 CFR chapter II as in effect for October 1972.

§ 416.1171 When the alternative rules apply.

(a) *Eligibility for the alternative.* We use the alternative income counting rules for you if you meet all the following conditions:

(1) You were eligible for, and received, assistance for December 1973 under a State plan for October 1972;

(2) You have continued to live in that same State since December 1973;

(3) You were transferred to the SSI rolls and received a benefit for January 1974; and

(4) You have not been ineligible for an SSI benefit for any period of more than 6 consecutive months. (For purposes of this section, an SSI benefit means a Federal benefit; it does not include any State supplementation.)

(b) *Living in the same State.* For purposes of this section, you have continued to live in the same State since December 1973 unless you have left it at any time with the intention of moving to another State. If there is no evidence to the contrary, we assume that—

(1) If you leave the State for 90 calendar days or less, the absence is temporary and you still live in that State; and

(2) If you leave the State for more than 90 calendar days, you are no longer living there.

RULES FOR HELPING BLIND AND DISABLED INDIVIDUALS ACHIEVE SELF-SUPPORT

§ 416.1180 General.

One of the objectives of the SSI program is to help blind or disabled persons become self-supporting. If you are blind or disabled, we will pay you SSI benefits and will not count the part of your income (for example, your or a family member's wages, title II benefits, or pension income) that you use or set aside to use for expenses that we determine to be reasonable and necessary to fulfill an approved plan to achieve self-support. (See §§416.1112(c)(9) and 1124(c)(13).) You may develop a plan to achieve self-support on your own or with our help. As appropriate, we will refer you to a State rehabilitation agency or agency for the blind for additional assistance in developing a plan.

[45 FR 65547, Oct. 3, 1980, as amended at 51 FR 10616, Mar. 28, 1986; 62 FR 59813, Nov. 5, 1997; 71 FR 28264, May 16, 2006]

§ 416.1181 What is a plan to achieve self-support (PASS)?

(a) A PASS must—

(1) Be designed especially for you;

(2) Be in writing;

(3) Be approved by us (a change of plan must also be approved by us);

(4) Have a specific employment goal that is feasible for you, that is, a goal that you have a reasonable likelihood of achieving;

(5) Have a plan to reach your employment goal that is viable and financially sustainable, that is, the plan—

(i) Sets forth steps that are attainable in order to reach your goal, and

(ii) Shows that you will have enough money to meet your living expenses

while setting aside income or resources to reach your goal;

(6) Be limited to one employment goal; however, the employment goal may be modified and any changes related to the modification must be made to the plan;

(7) Show how the employment goal will generate sufficient earnings to substantially reduce or eliminate your dependence on SSI or eliminate your need for title II disability benefits;

Example 1: A Substantial Reduction Exists. Your SSI monthly payment amount is $101 and your PASS employment goal earnings will reduce your SSI payment by $90. We may consider that to be a substantial reduction.

Example 2: A Substantial Reduction Exists. You receive a title II benefit of $550 and an SSI payment of $73. Your PASS employment goal will result in work over the SGA level that eliminates your title II benefit but increases your SSI payment by $90. We may consider that a substantial reduction because your work will eliminate your title II payment while only slightly increasing your SSI payment.

Example 3: A Substantial Reduction Does Not Exist. Your SSI monthly payment amount is $603 and your PASS employment goal earnings will reduce your SSI payment by $90. We may not consider that to be a substantial reduction.

(8) Contain a beginning date and an ending date to meet your employment goal;

(9) Give target dates for meeting milestones towards your employment goal;

(10) Show what expenses you will have and how they are reasonable and necessary to meet your employment goal;

(11) Show what money you have and will receive, how you will use or spend it to attain your employment goal, and how you will meet your living expenses; and

(12) Show how the money you set aside under the plan will be kept separate from your other funds.

(b) You must propose a reasonable ending date for your PASS. If necessary, we can help you establish an ending date, which may be different than the ending date you propose. Once the ending date is set and you begin your PASS, we may adjust or extend the ending date of your PASS based on progress towards your goal and earnings level reached.

(c) If your employment goal is self-employment, you must include a business plan that defines the business, provides a marketing strategy, details financial data, outlines the operational procedures, and describes the management plan.

(d) Your progress will be reviewed at least annually to determine if you are following the provisions of your plan.

[71 FR 28264, May 16, 2006]

§ 416.1182 When we begin to count the income excluded under the plan.

We will begin to count the earned and unearned income that would have been excluded under your plan in the month in which any of the following circumstances first exist:

(a) You fail to follow the conditions of your plan;

(b) You abandon your plan;

(c) You complete the time schedule outlined in the plan; or

(d) You reach your goal as outlined in the plan.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48579, Nov. 26, 1985]

Appendix to Subpart K of Part 416—List of Types of Income Excluded Under the SSI Program as Provided by Federal Laws Other Than the Social Security Act

Many Federal statutes in addition to the Social Security Act provide assistance or benefits for individuals and specify that the assistance or benefit will not be considered in deciding eligibility for SSI. We have listed these statutes in this appendix and have placed them in categories according to the kind of income or assistance they provide. The list gives the name of the Federal statute (where possible), the public law number, and the citation. Each item briefly describes what the statute provides that will not reduce or eliminate an SSI payment. More detailed information is available from a social security office or by reference to the statutes.

We update this list periodically. However, when new Federal statutes of this kind are enacted, or existing statutes are changed, we apply the law currently in effect, even before this appendix is updated.

I. FOOD

(a) Value of food coupons under the Food Stamp Act of 1977, section 1301 of Pub. L. 95–113 (91 Stat. 968, 7 U.S.C. 2017(b)).

(b) Value of federally donated foods distributed under section 32 of Pub. L. 74–320 (49 Stat. 774) or section 416 of the Agriculture Act of 1949 (63 Stat. 1058, 7 CFR 250.6(e)(9)).

(c) Value of free or reduced price food for women and children under the—

(1) Child Nutrition Act of 1966, section 11(b) of Pub. L. 89–642 (80 Stat. 889, 42 U.S.C. 1780(b)) and section 17 of that Act as added by Pub. L. 92–433 (86 Stat. 729, 42 U.S.C. 1786); and

(2) National School Lunch Act, section 13(h)(3), as amended by section 3 of Pub. L. 90–302 (82 Stat. 119, 42 U.S.C. 1761(h)(3)).

(d) Services, except for wages paid to residents who assist in providing congregate services such as meals and personal care, provided a resident of an eligible housing project under a congregate services program under section 802 of the Cranston-Gonzales National Affordable Housing Act, Public Law 101–625 (104 Stat. 4313, 42 U.S.C. 8011).

II. HOUSING AND UTILITIES

(a) Assistance to prevent fuel cut-offs and to promote energy efficiency under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program as authorized by section 222(a)(5) of the Economic Opportunity Act of 1964, as amended by section 5(d)(1) of Pub. L. No. 93–644 and section 5(a)(2) of Pub. L. 95–568 (88 Stat. 2294 as amended, 42 U.S.C. 2809(a)(5)).

(b) Home energy assistance payments or allowances under title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97–35, as amended (42 U.S.C. 8624(f)).

NOTE: This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the home energy assistance payments or allowances.

(c) Value of any assistance paid with respect to a dwelling unit under—

(1) The United States Housing Act of 1937;

(2) The National Housing Act;

(3) Section 101 of the Housing and Urban Development Act of 1965; or

(4) Title V of the Housing Act of 1949.

NOTE: This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the housing assistance.

(d) Payments for relocating, made to persons displaced by Federal or federally assisted programs which acquire real property, under section 216 of Pub. L. 91–646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

III. EDUCATION AND EMPLOYMENT

(a) Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under section 507 of the Higher Education Amendments of 1968, Pub. L. 90–575 (82 Stat. 1063).

(b) Any wages, allowances, or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible handicapped individual employed in a project under title VI of the Rehabilitation Act of 1973 as added by title II of Pub. L. 95–602 (92 Stat. 2992, 29 U.S.C. 795(b)(c)).

(c) Student financial assistance for attendance costs received from a program funded in whole or in part under title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Public Law 100–50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu).

IV. NATIVE AMERICANS

(a) *Types of Payments Excluded Without Regard to Specific Tribes or Groups*—

(1) Indian judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93–134 as amended by section 4 of Public Law 97–458 (96 Stat. 2513, 25 U.S.C. 1408). Indian judgment funds include interest and investment income accrued while such funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds. This exclusion does not apply to sales or conversions of initial purchases or to subsequent purchases.

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(2) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe are excluded from income under Public Law 98–64 (97 Stat. 365, 25 U.S.C. 117b). Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore

ANRVC dividend distributions are not excluded from countable income under this exclusion. For ANRVC dividend distributions, see paragraph IV.(a)(3) of this appendix.

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(3) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, to the extent that it does not, in the aggregate, exceed $2,000 per individual each year; stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Public Law 100–241 (101 Stat. 1812, 43 U.S.C. 1626(c)), effective February 3, 1988.

NOTE: This exclusion does not apply in deeming income from sponsors to aliens.

(4) Up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands under section 13736 of Public Law 103–66 (107 Stat. 663, 25 U.S.C. 1408, as amended).

(b) *Payments to Members of Specific Indian Tribes and Groups—*

(1) Per capita payments to members of the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber on the Red Lake Reservation under section 3 of Public Law 85–794 (72 Stat. 958).

(2) Per capita distribution payments by the Blackfeet and Gros Ventre tribal governments to members which resulted from judgment funds to the tribes under section 4 of Public Law 92–254 (86 Stat. 65) and under section 6 of Public Law 97–408 (96 Stat. 2036).

(3) Settlement fund payments and the availability of such funds to members of the Hopi and Navajo Tribes under section 22 of Public Law 93–531 (88 Stat. 1722) as amended by Public Law 96–305 (94 Stat. 929).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(4) Judgment funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability of such funds under section 6 of Public Law 94–189 (89 Stat. 1094).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(5) Judgment funds distributed per capita to, or held in trust for, members of the Grand River Band of Ottawa Indians, and the availability of such funds under section 6 of Public Law 94–540 (90 Stat. 2504).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(6) Any judgment funds distributed per capita to members of the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation under section 2 of Public Law 95–433 (92 Stat. 1047, 25 U.S.C. 609c–1).

(7) Any judgment funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma under section 8 of Public Law 96–318 (94 Stat. 971).

(8) All funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act, and the availability of such funds under section 9 of Public Law 96–420 (94 Stat. 1795, 25 U.S.C. 1728(c)).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(9) Any distributions of judgment funds to members of the San Carlos Apache Indian Tribe of Arizona under section 7 of Public Law 93–134 (87 Stat. 468) and Public Law 97–95 (95 Stat. 1206).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(10) Any distribution of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma under section 6 of Public Law 97–371 (96 Stat. 1814).

(11) Distributions of judgment funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma and the Cherokee Band of Shawnee descendants) under section 7 of Public Law 97–372 (96 Stat. 1816).

(12) Judgment funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana under section 7 of Public Law 97–376 (96 Stat. 1829).

(13) Distributions of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community and the Jamestown Band of Clallam

Indians) under section 6 of Public Law 97–402 (96 Stat. 2021).

(14) Judgment funds distributed per capita or made available for programs for members of the Pembina Chippewa Indians (Turtle Mountain Band of Chippewa Indians, Chippewa Cree Tribe of Rocky Boy's Reservation, Minnesota Chippewa Tribe, Little Shell Band of the Chippewa Indians of Montana, and the nonmember Pembina descendants) under section 9 of Public Law 97–403 (96 Stat. 2025).

(15) Per capita distributions of judgment funds to members of the Assiniboine Tribe of Fort Belknap Indian Community and the Papago Tribe of Arizona under sections 6 and 8(d) of Public Law 97–408 (96 Stat. 2036, 2038).

(16) Up to $2,000 of per capita distributions of judgment funds to members of the Confederated Tribes of the Warm Springs Reservation under section 4 of Public Law 97–436 (96 Stat. 2284).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(17) Judgment funds distributed to the Red Lake Band of Chippewa Indians under section 3 of Public Law 98–123 (97 Stat. 816).

(18) Funds distributed per capita or family interest payments for members of the Assiniboine Tribe of Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana under section 5 of Public Law 98–124 (97 Stat. 818).

(19) Distributions of judgment funds and income derived therefrom to members of the Shoalwater Bay Indian Tribe under section 5 of Public Law 98–432 (98 Stat. 1672).

(20) All distributions to heirs of certain deceased Indians under section 8 of the Old Age Assistance Claims Settlement Act, Public Law 98–500 (98 Stat. 2319).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(21) Judgment funds distributed per capita or made available for any tribal program for members of the Wyandotte Tribe of Oklahoma and the Absentee Wyandottes under section 106 of Public Law 98–602 (98 Stat. 3151).

(22) Per capita and dividend payment distributions of judgment funds to members of the Santee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, the Prairie Island Sioux, Lower Sioux, and Shakopee Mdewakanton Sioux Communities of Minnesota under section 8 of Public Law 99–130 (99 Stat. 552) and section 7 of Public Law 93–134 (87 Stat. 468), as amended by Public Law 97–458 (96 Stat. 2513; 25 U.S.C. 1407).

(23) Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi under section 6 of Public Law 99–146 (99 Stat. 782).

(24) Distributions of claims settlement funds to members of the White Earth Band of Chippewa Indians as allottees, or their heirs, under section 16 of Public Law 99–264 (100 Stat. 70).

(25) Payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the Saginaw Chippewa Indian Tribe of Michigan under section 6 of Public Law 99–346 (100 Stat. 677).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(26) Judgment funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi under section 4 of Public Law 99–377 (100 Stat. 805).

(27) Judgment funds distributed to members of the Cow Creek Band of Umpqua Tribe of Indians under section 4 of Public Law 100–139 (101 Stat. 822).

(28) Per capita payments of claims settlement funds to members of the Coushatta Tribe of Louisiana under section 2 of Public Law 100–411 (102 Stat. 1097) and section 7 of Public Law 93–134 (87 Stat. 468), as amended by Public Law 97–458 (96 Stat. 2513; 25 U.S.C. 1407).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(29) Funds distributed per capita for members of the Hoopa Valley Indian Tribe and the Yurok Indian Tribe under sections 4, 6 and 7 of Public Law 100–580 (102 Stat. 2929, 2930, 2931) and section 3 of Public Law 98–64 (97 Stat. 365; 25 U.S.C. 117b).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(30) Judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi) under section 503 of Public Law 100–581 (102 Stat. 2945).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(31) All funds, assets, and income from the trust fund transferred to the members of the Puyallup Tribe under section 10 of the Puyallup Tribe of Indians Settlement Act of 1989, Public Law 101–41 (103 Stat. 88, 25 U.S.C. 1773h(c)).

NOTE: This exclusion does not apply in deeming income from sponsors to aliens.

(32) Judgment funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida under section 8 of Public Law 101–277 (104 Stat. 145).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(33) Payments, funds, distributions, or income derived from them to members of the Seneca Nation of New York under section 8(b) of the Seneca Nation Settlement Act of 1990, Public Law 101–503 (104 Stat. 1297, 25 U.S.C. 1774f).

NOTE: This exclusion does not apply in deeming income from sponsors to aliens.

(34) Per capita distributions of settlement funds under section 102 of the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990, Public Law 101–618 (104 Stat. 3289) and section 7 of Public Law 93–134 (87 Stat. 468), as amended by Public Law 97–458 (96 Stat. 2513; 25 U.S.C. 1407).

(35) Settlement funds, assets, income, payments, or distributions from Trust Funds to members of the Catawba Indian Tribe of South Carolina under section 11(m) of Public Law 103–116 (107 Stat. 1133).

(36) Settlement funds held in trust (including interest and investment income accruing on such funds) for, and payments made to, members of the Confederated Tribes of the Colville Reservation under section 7(b) of Public Law 103–436 (108 Stat. 4579).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(37) Judgment funds distributed under section 111 of the Michigan Indian Land Claims Settlement Act, (Pub. L. 105–143, 111 Stat. 2665).

(38) Judgment funds distributed under section 4 of the Cowlitz Indian Tribe Distribution of Judgment Funds Act, (Pub. L. 108–222, 118 Stat. 624).

(c) *Receipts from Lands Held in Trust for Certain Tribes or Groups*—

(1) Receipts from land held in trust by the Federal government and distributed to members of certain Indian tribes under section 6 of Public Law 94–114 (89 Stat. 579, 25 U.S.C. 459e).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(2) Receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe under section 6 of Public Law 95–498 (92 Stat. 1677).

(3) Receipts derived from trust lands awarded to the Pueblo of Zia of New Mexico and distributed to members of that tribe under section 6 of Public Law 95–499 (92 Stat. 1680).

V. OTHER

(a) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. 201 *et seq.*), or applicable State law, pursuant to 42 U.S.C. 5044(f)(1).

NOTE: This exclusion does not apply to the income of sponsors of aliens.

(b) Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102(h)(1) of Pub. L. 95–478 (92 Stat. 1515, 42 U.S.C. 3020a).

(c) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts for losses suffered as a result of evacuation, relocation, and internment during World War II, under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Public Law 100–383 (50 U.S.C. App. 1989 b and c).

(d) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Public Law 101–201 (103 Stat. 1795) and section 10405 of Public Law 101–239 (103 Stat. 2489).

(e) Payments made under section 6 of the Radiation Exposure Compensation Act, Public Law 101–426 (104 Stat. 925, 42 U.S.C. 2210).

(f) The value of any child care provided or arranged (or any payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act, as amended by section 8(b) of Public Law 102–586 (106 Stat. 5035).

(g) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103–286 (108 Stat. 1450).

(h) Any matching funds from a demonstration project authorized by the Community Opportunities, Accountability, and Training and Educational Services Act of 1998 (Pub. L. 105–285) and any interest earned on these matching funds in an Individual Development Account, pursuant to section 415 of Pub. L. 105–285 (112 Stat. 2771).

(i) Any earnings, Temporary Assistance for Needy Families matching funds, and interest

in an Individual Development Account, pursuant to section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104–193, 42 U.S.C. 604(h)(4)).

(j) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to section 606 of the Departments of Labor, Health and Human Services and Education and Related Agencies Appropriations Act of 1996 (Pub. L. 105–78).

(k) Payments made to certain Vietnam veterans' children with spina bifida, pursuant to section 421 of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997 (Pub. L. 104–204, 38 U.S.C. 1805(a)).

(l) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to section 401 of the Veterans Benefits and Health Care Improvement Act of 2000 (Pub. L. 106–419 (38 U.S.C. 1833(c)).

(m) Payments of the refundable child tax credit made under section 24 of the Internal Revenue Code of 1986, pursuant to section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107–16 (115 Stat. 49, 26 U.S.C. 24 note).

(n) Assistance provided for flood mitigation activities as provided under section 1324 of the National Flood Insurance Act of 1968, pursuant to section 1 of Public Law 109–64 (119 Stat. 1997, 42 U.S.C. 4031).

(o) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, pursuant to section 1 [Div. C, Title XXXVI section 3646] of Public Law 106–398 (114 Stat. 1654A–510, 42 U.S.C. 7385e).

[45 FR 65547, Oct. 3, 1980, as amended at 52 FR 8888, Mar. 20, 1987; 57 FR 53851, Nov. 13, 1992; 57 FR 55088, Nov. 24, 1992; 59 FR 8538, Feb. 23, 1994; 62 FR 30982, June 6, 1997; 70 FR 41137, July 18, 2005; 75 FR 1273, Jan. 11, 2010]

Subpart L—Resources and Exclusions

AUTHORITY: Secs. 702(a)(5), 1602, 1611, 1612, 1613, 1614(f), 1621, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, 1383, and 1383b); sec. 211, Pub. L. 93–66, 87 Stat. 154 (42 U.S.C. 1382 note).

SOURCE: 40 FR 48915, Oct. 20, 1975, unless otherwise noted.

§ 416.1201 Resources; general.

(a) *Resources; defined.* For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

(2) Support and maintenance assistance not counted as income under § 416.1157(c) will not be considered a resource.

(3) Except for cash reimbursement of medical or social services expenses already paid for by the individual, cash received for medical or social services that is not income under § 416.1103 (a) or (b), or a retroactive cash payment which is income that is excluded from deeming under § 416.1161(a)(16), is not a resource for the calendar month following the month of its receipt. However, cash retained until the first moment of the second calendar month following its receipt is a resource at that time.

(i) For purposes of this provision, a retroactive cash payment is one that is paid after the month in which it was due.

(ii) This provision applies only to the unspent portion of those cash payments identified in this paragraph (a)(3). Once the cash from such payments is spent, this provision does not apply to items purchased with the money, even if the period described above has not expired.

(iii) Unspent money from those cash payments identified in this paragraph (a)(3) must be identifiable from other resources for this provision to apply. The money may be commingled with other funds, but if this is done in such a fashion that an amount from such payments can no longer be separately identified, that amount will count toward the resource limit described in § 416.1205.

(4) Death benefits, including gifts and inheritances, received by an individual, to the extent that they are not income in accordance with paragraphs (e) and (g) of § 416.1121 because they are to be spent on costs resulting from the last

illness and burial of the deceased, are not resources for the calendar month following the month of receipt. However, such death benefits retained until the first moment of the second calendar month following their receipt are resources at that time.

(b) *Liquid resources.* Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in § 416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources. (See § 416.1208 for the treatment of funds held in individual and joint financial institution accounts.)

(c) *Nonliquid resources.* (1) Nonliquid resources are property which is not cash and which cannot be converted to cash within 20 days excluding certain nonwork days as explained in § 416.120(d). Examples of resources that are ordinarily nonliquid are loan agreements, household goods, automobiles, trucks, tractors, boats, machinery, livestock, buildings and land. Nonliquid resources are evaluated according to their equity value except as otherwise provided. (See § 416.1218 for treatment of automobiles.)

(2) For purposes of this subpart L, the *equity value* of an item is defined as:

(i) The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved; minus

(ii) Any encumbrances.

[40 FR 48915, Oct. 20, 1975, as amended at 44 FR 43266, July 24, 1979; 48 FR 33259, July 21, 1983; 52 FR 4283, Feb. 11, 1987; 52 FR 16845, May 6, 1987; 53 FR 23231, June 21, 1988; 56 FR 36001, July 30, 1991; 57 FR 35461, Aug. 10, 1992; 57 FR 55089, Nov. 24, 1992; 59 FR 27988, May 31, 1994]

§ 416.1202 Deeming of resources.

(a) *Married individual.* In the case of an individual who is living with a person not eligible under this part and who is considered to be the husband or wife of such individual under the criteria in §§ 416.1802 through 416.1835 of this part, such individual's resources shall be deemed to include any resources, not otherwise excluded under this subpart, of such spouse whether or not such resources are available to such individual. In addition to the exclusions listed in § 416.1210, we also exclude the following items:

(1) Pension funds that the ineligible spouse may have. *Pension funds* are defined as funds held in individual retirement accounts (IRA), as described by the Internal Revenue Code, or in work-related pension plans (including such plans for self-employed persons, sometimes referred to as Keogh plans);

(2) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of special pay an ineligible spouse received from one of the uniformed services pursuant to 37 U.S.C. 310; and

(3) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of family separation allowance an ineligible spouse received from one of the uniformed services pursuant to 37 U.S.C. 427 as a result of deployment to or service in a combat zone (as defined in § 416.1160(d)).

(b) *Child*—(1) *General.* In the case of a child (as defined in § 416.1856) who is under age 18, we will deem to that child any resources, not otherwise excluded under this subpart, of his or her ineligible parent who is living in the same household with him or her (as described in § 416.1851). We also will deem to the child the resources of his or her ineligible stepparent. As used in this section, the term ''parent'' means the natural or adoptive parent of a child, and the term ''stepparent'' means the spouse (as defined in § 416.1806) of such natural or adoptive parent who is living in the same household with the child and parent. We will deem to a child the resources of his or her parent and stepparent whether or not those resources are available to him or her. We will deem to a child the resources of his or her parent and stepparent only to the extent that those resources exceed the resource limits described in § 416.1205. (If the child is living with

only one parent, we apply the resource limit for an individual. If the child is living with both parents, or the child is living with one parent and a stepparent, we apply the resource limit for an individual and spouse.) We will not deem to a child the resources of his or her parent or stepparent if the child is excepted from deeming under paragraph (b)(2) of this section. In addition to the exclusions listed in § 416.1210, we also exclude the following items:

(i) Pension funds of an ineligible parent (or stepparent). *Pension funds* are defined as funds held in IRAs, as described by the Internal Revenue Code, or in work-related pension plans (including such plans for self-employed persons, sometimes referred to as Keogh plans);

(ii) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of special pay an ineligible parent (or stepparent) received from one of the uniformed services pursuant to 37 U.S.C. 310; and

(iii) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of family separation allowance an ineligible parent (or stepparent) received from one of the uniformed services pursuant to 37 U.S.C. 427 as a result of deployment to or service in a combat zone (as defined in § 416.1160(d)).

(2) *Disabled child under age 18.* In the case of a disabled child under age 18 who is living in the same household with his or her parents, the deeming provisions of paragraph (b)(1) of this section shall not apply if such child—

(i) Previously received a reduced SSI benefit while a resident of a medical treatment facility, as described in § 416.414;

(ii) Is eligible for medical assistance under a Medicaid State home care plan approved by the Secretary under the provisions of section 1915(c) or authorized under section 1902(e)(3) of the Act; and

(iii) Would otherwise be ineligible because of the deeming of his or her parents' resources or income.

(c) *Applicability.* When used in this subpart L, the term *individual* refers to an eligible aged, blind, or disabled person, and also includes a person whose resources are deemed to be the resources of such individual (as provided in paragraphs (a) and (b) of this section).

[40 FR 48915, Oct. 20, 1975, as amended at 50 FR 38982, Sept. 26, 1985; 52 FR 8888, Mar. 20, 1987; 52 FR 29841, Aug. 12, 1987; 52 FR 32240, Aug. 26, 1987; 60 FR 361, Jan. 4, 1995; 62 FR 1056, Jan. 8, 1997; 65 FR 16815, Mar. 30, 2000; 72 FR 50875, Sept. 5, 2007; 73 FR 28036, May 15, 2008; 75 FR 7554, Feb. 22, 2010]

§ 416.1203 Deeming of resources of an essential person.

In the case of a qualified individual (as defined in § 416.221) whose payment standard has been increased because of the presence of an essential person (as defined in § 416.222), the resources of such qualified individual shall be deemed to include all the resources of such essential person with the exception of the resources explained in §§ 416.1210(t) and 416.1249. If such qualified individual would not meet the resource criteria for eligibility (as defined in §§ 416.1205 and 416.1260) because of the deemed resources, then the payment standard increase because of the essential person will be nullified and the provision of this section will not apply; essential person status is lost permanently. However, if such essential person is an ineligible spouse of a qualified individual or a parent (or spouse of a parent) of a qualified individual who is a child under age 21, then the resources of such person will be deemed to such qualified individual in accordance with the provision in § 416.1202.

[39 FR 33797, Sept. 20, 1974, as amended at 51 FR 10616, Mar. 28, 1986; 70 FR 41138, July 18, 2005]

§ 416.1204 Deeming of resources of the sponsor of an alien.

The resources of an alien who first applies for SSI benefits after September 30, 1980, are deemed to include the resources of the alien's sponsor for 3 years after the alien's date of admission into the United States. The *date of admission* is the date established by the U.S. Citizenship and Immigration Services as the date the alien is admitted for permanent residence. The resources of the sponsor's spouse are included if

the sponsor and spouse live in the same household. Deeming of these resources applies regardless of whether the alien and sponsor live in the same household and regardless of whether the resources are actually available to the alien. For rules that apply in specific situations, see § 416.1166a(d).

(a) *Exclusions from the sponsor's resources.* Before we deem a sponsor's resources to an alien, we exclude the same kinds of resources that are excluded from the resources of an individual eligible for SSI benefits. The applicable exclusions from resources are explained in §§ 416.1210 (paragraphs (a) through (i), (k), and (m) through (t)) through 416.1239 and §§ 416.1247 through 416.1249. For resources excluded by Federal statutes other than the Social Security Act, as applicable to the resources of sponsors deemed to aliens, see the appendix to subpart K of part 416. We next allocate for the sponsor or for the sponsor and spouse (if living together). (The amount of the allocation is the applicable resource limit described in § 416.1205 for an eligible individual and an individual and spouse.)

(b) *An alien sponsored by more than one sponsor.* The resources of an alien who has been sponsored by more than one person are deemed to include the resources of each sponsor.

(c) *More than one alien sponsored by one individual.* If more than one alien is sponsored by one individual the deemed resources are deemed to each alien as if he or she were the only one sponsored by the individual.

(d) *Alien has a sponsor and a parent or a spouse with deemable resources.* Resources may be deemed to an alien from both a sponsor and a spouse or parent (if the alien is a child) provided that the sponsor and the spouse or parent are not the same person and the conditions for each rule are met.

(e) *Alien's sponsor is also the alien's ineligible spouse or parent.* If the sponsor is also the alien's ineligible spouse or parent who lives in the same household, the spouse-to-spouse or parent-to-child deeming rules apply instead of the sponsor-to-alien deeming rules. If the spouse or parent deeming rules cease to apply, the sponsor deeming rules will begin to apply. The spouse or parent rules may cease to apply if an alien child reaches age 18 or if either the sponsor who is the ineligible spouse or parent, or the alien moves to a separate household.

(f) *Alien's sponsor also is the ineligible spouse or parent of another SSI beneficiary.* If the sponsor is also the ineligible spouse or ineligible parent of an SSI beneficiary other than the alien, the sponsor's resources are deemed to the alien under the rules in paragraph (a), and to the eligible spouse or child under the rules in §§ 416.1202, 1205, 1234, 1236, and 1237.

[52 FR 8888, Mar. 20, 1987, as amended at 61 FR 1712, Jan. 23, 1996; 70 FR 41138, July 18, 2005; 73 FR 28036, May 15, 2008]

§ 416.1204a Deeming of resources where Medicaid eligibility is affected.

Section 416.1161a of this part describes certain circumstances affecting Medicaid eligibility in which the Department will not deem family income to an individual. The Department will follow the same standards, procedures, and limitations set forth in that section with respect to deeming of resources.

[49 FR 5747, Feb. 15, 1984]

§ 416.1205 Limitation on resources.

(a) *Individual with no eligible spouse.* An aged, blind, or disabled individual with no spouse is eligible for benefits under title XVI of the Act if his or her nonexcludable resources do not exceed $1,500 prior to January 1, 1985, and all other eligibility requirements are met. An individual who is living with an ineligible spouse is eligible for benefits under title XVI of the Act if his or her nonexcludable resources, including the resources of the spouse, do not exceed $2,250 prior to January 1, 1985, and all other eligibility requirements are met.

(b) *Individual with an eligible spouse.* An aged, blind, or disabled individual who has an eligible spouse is eligible for benefits under title XVI of the Act if their nonexcludable resources do not exceed $2,250 prior to January 1, 1985, and all other eligibility requirements are met.

(c) *Effective January 1, 1985 and later.* The resources limits and effective dates for January 1, 1985 and later are as follows:

Effective date	Individual	Individual and spouse
Jan. 1, 1985	$1,600	$2,400
Jan. 1, 1986	1,700	$2,550
Jan. 1, 1987	1,800	$2,700
Jan. 1, 1988	1,900	$2,850
Jan. 1, 1989	2,000	$3,000

[50 FR 38982, Sept. 26, 1985]

§ 416.1207 Resources determinations.

(a) *General.* Resources determinations are made as of the first moment of the month. A resource determination is based on what assets an individual has, what their values are, and whether or not they are excluded as of the first moment of the month.

(b) *Increase in value of resources.* If, during a month, a resource increases in value or an individual acquires an additional resource or replaces an excluded resource with one that is not excluded, the increase in the value of the resources is counted as of the first moment of the next month

(c) *Decrease in value of resources.* If, during a month, a resource decreases in value or an individual spends a resource or replaces a resource that is not excluded with one that is excluded, the decrease in the value of the resources is counted as of the first moment of the next month.

(d) *Treatment of items under income and resource counting rules.* Items received in cash or in kind during a month are evaluated first under the income counting rules and, if retained until the first moment of the following month, are subject to the rules for counting resources at that time.

(e) *Receipts from the sale, exchange, or replacement of a resource.* If an individual sells, exchanges or replaces a resource, the receipts are not income. They are still considered to be a resource. This rule includes resources that have never been counted as such because they were sold, exchanged or replaced in the month in which they were received. See § 416.1246 for the rule on resources disposed of for less than fair market value (including those disposed of during the month of receipt).

Example: Miss L., a disabled individual, receives a $350 unemployment insurance benefit on January 10, 1986. The benefit is unearned income to Miss L. when she receives it. On January 14, Miss L. uses the $350 payment to purchase shares of stock. Miss L. has exchanged one item (cash) for another item (stock). The $350 payment is never counted as a resource to Miss L. because she exchanged it in the same month she received it. The stock is not income; it is a different form of a resource exchanged for the cash. Since a resource is not countable until the first moment of the month following its receipt, the stock is not a countable resource to Miss L. until February 1.

[52 FR 4283, Feb. 11, 1987]

§ 416.1208 How funds held in financial institution accounts are counted.

(a) *General.* Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.

(b) *Individually-held account.* If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.

(c) *Jointly-held account*—(1) *Account holders include one or more SSI claimants or recipients.* If there is only one SSI claimant or recipient account holder on a jointly held account, we presume that all of the funds in the account belong to that individual. If there is more than one claimant or recipient account holder, we presume that all the funds in the account belong to those individuals in equal shares.

(2) *Account holders include one or more deemors.* If none of the account holders is a claimant or recipient, we presume that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one deemor. A deemor is a person whose income and resources are required to be considered when determining eligibility and computing the SSI benefit

for an eligible individual (see §§ 416.1160 and 416.1202).

(3) *Right to rebut presumption of ownership.* If the claimant, recipient, or deemor objects or disagrees with an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, we give the individual the opportunity to rebut the presumption. Rebuttal is a procedure as described in paragraph (c)(4) of this section, which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Successful rebuttal establishes that the individual does not own some or all of the funds. The effect of successful rebuttal may be retroactive as well as prospective.

Example: The recipient's first month of eligibility is January 1993. In May 1993 the recipient successfully establishes that none of the funds in a 5-year-old jointly-held account belong to her. We do not count any of the funds as resources for the months of January 1993 and continuing.

(4) *Procedure for rebuttal.* To rebut an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, the individual must:

(i) Submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(ii) Submit account records showing deposits, withdrawals, and interest (if any) in the months for which ownership of funds is at issue; and

(iii) Correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account holder(s) from his/her own funds and correct the account title on the individual's own funds to show they are solely-owned by the individual.

[59 FR 27989, May 31, 1994]

§ 416.1210 Exclusions from resources; general.

In determining the resources of an individual (and spouse, if any), the following items shall be excluded:

(a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in § 416.1212;

(b) Household goods and personal effects as defined in § 416.1216;

(c) An automobile, if used for transportation, as provided in § 416.1218;

(d) Property of a trade or business which is essential to the means of self-support as provided in § 416.1222;

(e) Nonbusiness property which is essential to the means of self-support as provided in § 416.1224;

(f) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support as provided in § 416.1226;

(g) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see § 416.1228);

(h) Life insurance owned by an individual (and spouse, if any) to the extent provided in § 416.1230;

(i) Restricted allotted Indian lands as provided in § 416.1234;

(j) Payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion is required by such statute;

(k) Disaster relief assistance as provided in § 416.1237;

(l) Burial spaces and certain funds up to $1,500 for burial expenses as provided in § 416.1231;

(m) Title XVI or title II retroactive payments as provided in § 416.1233;

(n) Housing assistance as provided in § 416.1238;

(o) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in § 416.1235;

(p) Payments received as compensation for expenses incurred or losses suffered as a result of a crime as provided in § 416.1229;

(q) Relocation assistance from a State or local government as provided in § 416.1239;

(r) Dedicated financial institution accounts as provided in § 416.1247;

(s) Gifts to children under age 18 with life-threatening conditions as provided in § 416.1248;

(t) Restitution of title II, title VIII or title XVI benefits because of misuse by certain representative payees as provided in § 416.1249;

(u) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses as provided in § 416.1250;

(v) Payment of a refundable child tax credit, as provided in § 416.1235; and

(w) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:

(1) A veteran (as defined in 38 U.S.C. 101); and

(2) Blind, disabled, or aged.

[40 FR 48915, Oct. 20, 1975, as amended at 41 FR 13338, Mar. 30, 1976; 44 FR 15664, Mar. 15, 1979; 48 FR 57127, Dec. 28, 1983; 51 FR 34464, Sept. 29, 1986; 55 FR 28378, July 11, 1990; 58 FR 63890, Dec. 3, 1993; 59 FR 8538, Feb. 23, 1994; 61 FR 1712, Jan. 23, 1996; 61 FR 67207, Dec. 20, 1996; 70 FR 6345, Feb. 7, 2005; 70 FR 41138, July 18, 2005; 71 FR 45378, Aug. 9, 2006; 75 FR 1273, Jan. 11, 2010; 75 FR 54287, Sept. 7, 2010]

§ 416.1212 Exclusion of the home.

(a) *Defined.* A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

(b) *Home not counted.* We do not count a home regardless of its value. However, see §§ 416.1220 through 416.1224 when there is an income-producing property located on the home property that does not qualify under the home exclusion.

(c) *If an individual changes principal place of residence.* If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

(d) *If an individual leaves the principal place of residence due to domestic abuse.* If an individual moves out of his or her home without the intent to return, but is fleeing the home as a victim of domestic abuse, we will not count the home as a resource in determining the individual's eligibility to receive, or continue to receive, SSI payments. In that situation, we will consider the home to be the individual's principal place of residence until such time as the individual establishes a new principal place of residence or otherwise takes action rendering the home no longer excludable.

(e) *Proceeds from the sale of an excluded home.* (1) The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within 3 months of the date of receipt of the proceeds.

(2) The value of a promissory note or similar installment sales contract constitutes a ''proceed'' which can be excluded from resources if—

(i) The note results from the sale of an individual's home as described in § 416.1212(a);

(ii) Within 3 months of receipt (execution) of the note, the individual purchases a replacement home as described in § 416.1212(a) (see paragraph (f) of this section for an exception); and

(iii) All note-generated proceeds are reinvested in the replacement home within 3 months of receipt (see paragraph (g) of this section for an exception).

(3) In addition to excluding the value of the note itself, other proceeds from the sale of the former home are excluded resources if they are used within 3 months of receipt to make payment on the replacement home. Such proceeds, which consist of the downpayment and that portion of any installment amount constituting payment against the principal, represent a conversion of a resource.

(f) *Failure to purchase another excluded home timely.* If the individual does not purchase a replacement home within the 3-month period specified in paragraph (e)(2)(ii) of this section, the value of a promissory note or similar installment sales contract received from the sale of an excluded home is a countable resource effective with the first moment of the month following the month the note is executed. If the individual purchases a replacement home after the expiration of the 3-month period, the note becomes an excluded resource the month following the month of purchase of the replacement home provided that all other proceeds are fully and timely reinvested as explained in paragraph (g) of this section.

(g) *Failure to reinvest proceeds timely.* (1) If the proceeds (e.g., installment amounts constituting payment against the principal) from the sale of an excluded home under a promissory note or similar installment sales contract are not reinvested fully and timely (within 3 months of receipt) in a replacement home, as of the first moment of the month following receipt of the payment, the individual's countable resources will include:

(i) The value of the note; and

(ii) That portion of the proceeds, retained by the individual, which was not timely reinvested

(2) The note remains a countable resource until the first moment of the month following the receipt of proceeds that are fully and timely reinvested in the replacement home. Failure to reinvest proceeds for a period of time does not permanently preclude exclusion of the promissory note or installment sales contract. However, previously received proceeds that were not timely reinvested remain countable resources to the extent they are retained.

Example 1. On July 10, an SSI recipient received his quarterly payment of $200 from the buyer of his former home under an installment sales contract. As of October 31, the recipient has used only $150 of the July payment in connection with the purchase of a new home. The exclusion of the unused $50 (and of the installment contract itself) is revoked back to July 10. As a result, the $50 and the value of the contract as of August 1, are included in a revised determination of resources for August and subsequent months.

Example 2. On April 10, an SSI recipient received a payment of $250 from the buyer of his former home under an installment sales contract. On May 3, he reinvested $200 of the payment in the purchase of a new home. On May 10, the recipient received another $250 payment, and reinvested the full amount on June 3. As of July 31, since the recipient has used only $200 of the April payment in connection with the purchase of the new home, the exclusion of the unused $50 (and of the installment contract itself) is revoked back to April 10. As a result, the $50 and the value of the contract as of May 1 are includable resources. Since the recipient fully and timely reinvested the May payment, the installment contract and the payment are again excludable resources as of June 1. However, the $50 left over from the previous payment remains a countable resource.

(h) *Interest payments.* If interest is received as part of an installment payment resulting from the sale of an excluded home under a promissory note or similar installment sales contract, the interest payments do not represent conversion of a resource. The interest is income under the provisions of §§ 416.1102, 416.1120, and 416.1121(c).

[50 FR 42686, Oct. 22, 1985, as amended at 51 FR 7437, Mar. 4, 1986; 59 FR 43285, Aug. 23, 1994; 75 FR 1273, Jan. 11, 2010]

§ 416.1216 Exclusion of household goods and personal effects.

(a) *Household goods.* (1) We do not count household goods as a resource to an individual (and spouse, if any) if they are:

(i) Items of personal property, found in or near the home, that are used on a regular basis; or

(ii) Items needed by the householder for maintenance, use and occupancy of the premises as a home.

(2) Such items include but are not limited to: Furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.

(b) *Personal effects.* (1) We do not count personal effects as resources to an individual (and spouse, if any) if they are:

(i) Items of personal property ordinarily worn or carried by the individual; or

(ii) Articles otherwise having an intimate relation to the individual.

(2) Such items include but are not limited to: Personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments. We also do not count as resources items of cultural or religious significance to an individual and items required because of an individual's impairment. However, we do count items that were acquired or are held for their value or as an investment because we do not consider these to be personal effects. Such items can include but are not limited to: Gems, jewelry that is not worn or held for family significance, or collectibles. Such items will be subject to the limits in § 416.1205.

[70 FR 6345, Feb. 7, 2005]

§ 416.1218 Exclusion of the automobile.

(a) *Automobile; defined.* As used in this section, the term *automobile* includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

(b) *Limitation on automobiles.* In determining the resources of an individual (and spouse, if any), automobiles are excluded or counted as follows:

(1) *Total exclusion.* One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household.

(2) *Other automobiles.* Any other automobiles are considered to be nonliquid resources. Your equity in the other automobiles is counted as a resource. (See § 416.1201(c).)

[40 FR 48915, Oct. 20, 1975, as amended at 44 FR 43266, July 24, 1979; 50 FR 42687, Oct. 22, 1985; 70 FR 6345, Feb. 7, 2005]

§ 416.1220 Property essential to self-support; general.

When counting the value of resources an individual (and spouse, if any) has, the value of property essential to self-support is not counted, within certain limits. There are different rules for considering this property depending on whether it is income-producing or not. Property essential to self-support can include real and personal property (for example, land, buildings, equipment and supplies, motor vehicles, and tools, etc.) used in a trade or business (as defined in § 404.1066 of part 404), nonbusiness income-producing property (houses or apartments for rent, land other than home property, etc.) and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support.

[50 FR 42687, Oct. 22, 1985]

§ 416.1222 How income-producing property essential to self-support is counted.

(a) *General.* When deciding the value of property used in a trade or business or nonbusiness income-producing activity, only the individual's equity in the property is counted. We will exclude as essential to self-support up to $6,000 of an individual's equity in income-producing property if it produces a net annual income to the individual of at least 6 percent of the excluded equity. If the individual's equity is greater than $6,000, we count only the amount that exceeds $6,000 toward the allowable resource limit specified in § 416.1205 if the net annual income requirement of 6 percent is met on the excluded equity. If the activity produces less than a 6-percent return due to circumstances beyond the individual's control (for example, crop failure, illness, etc.), and there is a reasonable expectation that the individual's activity will again produce a 6-percent return, the property is also excluded. If the individual owns more than one piece of property and each produces income, each is looked at to see if the 6-percent rule is met and then the amounts of the individual's equity in all of those properties producing 6 percent are totaled to see if the total equity is $6,000 or less. The equity in those properties that do not meet the 6-percent rule is counted toward the allowable resource limit specified in § 416.1205. If the individual's total equity in the properties producing 6-percent income is over the $6,000 equity limit, the amount of equity exceeding

$6,000 is counted as a resource toward the allowable resource limit.

Example 1. Sharon has a small business in her home making hand-woven rugs. The looms and other equipment used in the business have a current market value of $7,000. The value of her equity is $5,500 since she owes $1,500 on the looms. Sharon's net earnings from self-employment is $400. Since Sharon's equity in the looms and other equipment ($5,500) is under the $6,000 limit for property essential to self-support and her net income after expenses ($400) is greater than 6 percent of her equity, her income-producing property is excluded from countable resources. The home is not considered in any way in valuing property essential to self-support.

Example 2. Charlotte operates a farm. She owns 3 acres of land on which her home is located. She also owns 10 acres of farm land not connected to her home. There are 2 tool sheds and 2 animal shelters located on the 10 acres. She has various pieces of farm equipment that are necessary for her farming activities. We exclude the house and the 3 acres under the home exclusion (see § 416.1212). However, we look at the other 10 acres of land, the buildings and equipment separately to see if her total equity in them is no more than $6,000 and if the annual rate of return is 6 percent of her equity. In this case, the 10 acres and buildings are valued at $4,000 and the few items of farm equipment and other inventory are valued at $1,500. Charlotte sells produce which nets her more than 6 percent for this year. The 10 acres and other items are excluded as essential to her self-support and they continue to be excluded as long as she meets the 6-percent annual return requirement and the equity value of the 10 acres and other items remains less than $6,000.

Example 3. Henry has an automobile repair business valued at $5,000. There are no debts on the property and bills are paid monthly. For the past 4 years the business has just broken even. Since Henry's income from the business is less then 6 percent of his equity, the entire $5,000 is counted as his resources. Since this exceeds the resources limit as described in § 416.1205, he is not eligible for SSI benefits.

(b) *Exception.* Property that represents the authority granted by a governmental agency to engage in an income-producing activity is excluded as property essential to self-support if it is:

(1) Used in a trade or business or nonbusiness income-producing activity; or

(2) Not used due to circumstances beyond the individual's control, e.g., illness, and there is a reasonable expectation that the use will resume.

Example: John owns a commercial fishing permit granted by the State Commerce Commission, a boat, and fishing tackle. The boat and tackle have an equity value of $6,500. Last year, John earned $2,000 from his fishing business. The value of the fishing permit is not determined because the permit is excluded under the exception. The boat and tackle are producing in excess of a 6 percent return on the excluded equity value, so they are excluded under the general rule (see paragraph (a) of this section) up to $6,000. The $500 excess value is counted toward the resource limit as described in § 416.1205.

[50 FR 42687, Oct. 22, 1985]

§ 416.1224 How nonbusiness property used to produce goods or services essential to self-support is counted.

Nonbusiness property is considered to be essential for an individual's (and spouse, if any) self-support if it is used to produce goods or services necessary for his or her daily activities. This type of property includes real property such as land which is used to produce vegetables or livestock only for personal consumption in the individual's household (for example, corn, tomatoes, chicken, cattle). This type of property also includes personal property necessary to perform daily functions exclusive of passenger cars, trucks, boats, or other special vehicles. (See § 416.1218 for a discussion on how automobiles are counted.) Property used to produce goods or services or property necessary to perform daily functions is excluded if the individual's equity in the property does not exceed $6,000. Personal property which is required by the individual's employer for work is not counted, regardless of value, while the individual is employed. Examples of this type of personal property include tools, safety equipment, uniforms and similar items.

Example: Bill owns a small unimproved lot several blocks from his home. He uses the lot, which is valued at $4,800, to grow vegetables and fruit only for his own consumption. Since his equity in the property is less than $6,000, the property is excluded as necessary to self-support.

[50 FR 42687, Oct. 22, 1985]

§ 416.1225 An approved plan to achieve self-support; general.

If you are blind or disabled, we will pay you SSI benefits and will not count resources that you use or set aside to use for expenses that we determine to be reasonable and necessary to fulfill an approved plan to achieve self-support.

[71 FR 28265, May 16, 2006]

§ 416.1226 What is a plan to achieve self-support (PASS)?

(a) A PASS must—

(1) Be designed especially for you;

(2) Be in writing;

(3) Be approved by us (a change of plan must also be approved by us);

(4) Have a specific employment goal that is feasible for you, that is, a goal that you have a reasonable likelihood of achieving;

(5) Have a plan to reach your employment goal that is viable and financially sustainable, that is, the plan—

(i) Sets forth steps that are attainable in order to reach your goal, and

(ii) Shows that you will have enough money to meet your living expenses while setting aside income or resources to reach your goal;

(6) Be limited to one employment goal; however, the employment goal may be modified and any changes related to the modification must be made to the plan;

(7) Show how the employment goal will generate sufficient earnings to substantially reduce your dependence on SSI or eliminate your need for title II disability benefits;

Example 1: A Substantial Reduction Exists. Your SSI monthly payment amount is $101 and your PASS employment goal earnings will reduce your SSI payment by $90. We may consider that to be a substantial reduction.

Example 2: A Substantial Reduction Exists. You receive a title II benefit of $550 and an SSI payment of $73. Your PASS employment goal will result in work over the SGA level that eliminates your title II benefit but increases your SSI payment by $90. We may consider that a substantial reduction because your work will eliminate your title II payment while only slightly increasing your SSI payment.

Example 3: A Substantial Reduction Does Not Exist. Your SSI monthly payment amount is $603 and your PASS employment goal earnings will reduce your SSI payment by $90. We may not consider that to be a substantial reduction.

(8) Contain a beginning date and an ending date to meet your employment goal;

(9) Give target dates for meeting milestones towards your employment goal;

(10) Show what expenses you will have and how they are reasonable and necessary to meet your employment goal;

(11) Show what resources you have and will receive, how you will use them to attain your employment goal, and how you will meet your living expenses; and

(12) Show how the resources you set aside under the plan will be kept separate from your other resources.

(b) You must propose a reasonable ending date for your PASS. If necessary, we can help you establish an ending date, which may be different than the ending date you propose. Once the ending date is set and you begin your PASS, we may adjust or extend the ending date of your PASS based on progress towards your goal and earnings level reached.

(c) If your employment goal is self-employment, you must include a business plan that defines the business, provides a marketing strategy, details financial data, outlines the operational procedures, and describes the management plan.

(d) Your progress will be reviewed at least annually to determine if you are following the provisions of your plan.

[71 FR 28265, May 16, 2006]

§ 416.1227 When the resources excluded under a plan to achieve self-support begin to count.

The resources that were excluded under the individual's plan will begin to be counted as of the first day of the month following the month in which any of these circumstances occur:

(a) Failing to follow the conditions of the plan:

(b) Abandoning the plan;

(c) Completing the time schedule outlined in the plan; or

(d) Reaching the goal as outlined in the plan.

[50 FR 42688, Oct. 22, 1985]

§ 416.1228 Exclusion of Alaskan natives' stock in regional or village corporations.

(a) In determining the resources of a native of Alaska (and spouse, if any) there will be excluded from resources, shares of stock held in a regional or village corporation during the period of 20 years in which such stock is inalienable, as provided by sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act (43 U.S.C. 1606, 1607). The 20-year period of inalienability terminates on January 1, 1992.

(b) As used in this section, *native of Alaska* has the same meaning as that contained in section 3(b) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b)).

§ 416.1229 Exclusion of payments received as compensation for expenses incurred or losses suffered as a result of a crime.

(a) In determining the resources of an individual (and spouse, if any), any amount received from a fund established by a State to aid victims of crime is excluded from resources for a period of 9 months beginning with the month following the month of receipt.

(b) To be excluded from resources under this section, the individual (or spouse) must demonstrate that any amount received was compensation for expenses incurred or losses suffered as the result of a crime.

[61 FR 1712, Jan. 23, 1996]

§ 416.1230 Exclusion of life insurance.

(a) *General.* In determining the resources of an individual (and spouse, if any), life insurance owned by the individual (and spouse, if any) will be considered to the extent of its cash surrender value. If, however, the total face value of all life insurance policies on any person does not exceed $1,500, no part of the cash surrender value of such life insurance will be taken into account in determining the resources of the individual (and spouse, if any). In determining the face value of life insurance on the individual (and spouse, if any), term insurance and burial insurance will not be taken into account.

(b) *Definitions*—(1) *Life insurance.* Life insurance is a contract under which the insurer agrees to pay a specified amount upon the death of the insured.

(2) *Insurer.* The insurer is the company or association which contracts with the owner of the insurance.

(3) *Insured.* The insured is the person upon whose life insurance is effected.

(4) *Owner.* The owner is the person who has the right to change the policy. This is normally the person who pays the premiums.

(5) *Term insurance.* Term insurance is a form of life insurance having no cash surrender value and generally furnishing insurance protection for only a specified or limited period of time.

(6) *Face value.* Face value is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions.

(7) *Cash surrender value.* Cash surrender value is the amount which the insurer will pay (usually to the owner) upon cancellation of the policy before death of the insured or before maturity of the policy.

(8) *Burial insurance.* Burial insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

§ 416.1231 Burial spaces and certain funds set aside for burial expenses.

(a) *Burial spaces*—(1) *General.* In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources.

(2) *Burial spaces defined.* For purposes of this section ''burial spaces'' include burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial

containers and arrangements for opening and closing the gravesite for burial of the deceased.

(3) *An agreement representing the purchase of a burial space.* The value of an agreement representing the purchase of a burial space, including any accumulated interest, will be excluded from resources. We do not consider a burial space ''held for'' an individual under an agreement unless the individual currently owns and is currently entitled to the use of the space under that agreement. For example, we will not consider a burial space ''held for'' an individual under an installment sales agreement or other similar device under which the individual does not currently own nor currently have the right to use the space, nor is the seller currently obligated to provide the space, until the purchase amount is paid in full.

(4) *Immediate family defined.* For purposes of this section *immediate family* means an individual's minor and adult children, including adopted children and step-children; an individual's brothers, sisters, parents, adoptive parents, and the spouses of those individuals. Neither dependency nor living-in-the-same-household will be a factor in determining whether a person is an immediate family member.

(b) *Funds set aside for burial expenses*—(1) *Exclusion.* In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. This exclusion is in addition to the burial space exclusion.

(2) *Exception for parental deeming situations.* If an individual is an eligible child, the burial funds (up to $1,500) that are set aside for the burial arrangements of the eligible child's ineligible parent or parent's spouse will not be counted in determining the resources of such eligible child.

(3) *Burial funds defined.* For purposes of this section ''burial funds'' are revocable burial contracts, burial trusts, other burial arrangements (including amounts paid on installment sales contracts for burial spaces), cash, accounts, or other financial instruments with a definite cash value clearly designated for the individual's (or spouse's, if any) burial expenses and kept separate from nonburial-related assets. Property other than listed in this definition will not be considered ''burial funds.''

(4) *Recipients currently receiving SSI benefits.* Recipients currently eligible as of July 11, 1990, who have had burial funds excluded which do not meet all of the requirements of paragraphs (b) (1) and (3) of this section must convert or separate such funds to meet these requirements unless there is an impediment to such conversion or separation; *i.e.*, a circumstance beyond an individual's control which makes conversion/separation impossible or impracticable. For so long as such an impediment or circumstance exists, the burial funds will be excluded if the individual remains otherwise continuously eligible for the exclusion.

(5) *Reductions.* Each person's (as described in §§ 416.1231(b)(1) and 416.1231(b)(2)) $1,500 exclusion must be reduced by:

(i) The face value of insurance policies on the life of an individual owned by the individual or spouse (if any) if the cash surrender value of those policies has been excluded from resources as provided in § 416.1230; and

(ii) Amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial expenses.

(6) *Irrevocable trust or other irrevocable arrangement.* Funds in an irrevocable trust or other irrevocable arrangement which are available for burial are funds which are held in an irrevocable burial contract, an irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified as available for burial expenses.

(7) *Increase in value of burial funds.* Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which

occur beginning November 1, 1982, or the date of first SSI eligibility, whichever is later, are excluded from resources if left to accumulate and become part of the separate burial fund.

(8) *Burial funds used for some other purpose.* (i) Excluded burial funds must be used solely for that purpose.

(ii) If any excluded funds are used for a purpose other than the burial arrangements of the individual or the individual's spouse for whom the funds were set aside, future SSI benefits of the individual (or the individual and eligible spouse) will be reduced by an amount equal to the amount of excluded burial funds used for another purpose. This penalty for use of excluded burial funds for a purpose other than the burial arrangements of the individual (or spouse) will apply only if, as of the first moment of the month of use, the individual would have had resources in excess of the limit specified in § 416.1205 without application of the exclusion.

(9) *Extension of burial fund exclusion during suspension.* The exclusion of burial funds and accumulated interest and appreciation will continue to apply throughout a period of suspension as described in § 416.1320, so long as the individual's eligibility has not been terminated as described in §§ 416.1331 through 416.1335.

[48 FR 57127, Dec. 28, 1983, as amended at 55 FR 28377, July 11, 1990; 57 FR 1384, Jan. 14, 1992]

§ 416.1232 Replacement of lost, damaged, or stolen excluded resources.

(a) Cash (including any interest earned on the cash) or in-kind replacement received from any source for purposes of repairing or replacing an excluded resource (as defined in § 416.1210) that is lost, damaged, or stolen is excluded as a resource. This exclusion applies if the cash (and the interest) is used to repair or replace the excluded resource within 9 months of the date the individual received the cash. Any of the cash (and interest) that is not used to repair or replace the excluded resource will be counted as a resource beginning with the month after the 9-month period expires.

(b) The initial 9-month time period will be extended for a reasonable period up to an additional 9 months where we find the individual had good cause for not replacing or repairing the resource. An individual will be found to have good cause when circumstances beyond his or her control prevented the repair or replacement or the contracting for the repair or replacement of the resource. The 9-month extension can only be granted if the individual intends to use the cash or in-kind replacement items to repair or replace the lost, stolen, or damaged excluded resource in addition to having good cause for not having done so. If good cause is found for an individual, any unused cash (and interest) is counted as a resource beginning with the month after the good cause extension period expires. *Exception: For victims of Hurricane Andrew only,* the extension period for good cause may be extended for up to an additional 12 months beyond the 9-month extension when we find that the individual had good cause for not replacing or repairing an excluded resource within the 9-month extension.

(c) The time period described in paragraph (b) of this section (except the time period for individuals granted an additional extension under the Hurricane Andrew provision) may be extended for a reasonable period up to an additional 12 months in the case of a catastrophe which is declared to be a major disaster by the President of the United States if the excluded resource is geographically located within the disaster area as defined by the Presidential order; the individual intends to repair or replace the excluded resource; and, the individual demonstrates good cause why he or she has not been able to repair or replace the excluded resource within the 18-month period.

(d) Where an extension of the time period is made for good cause and the individual changes his or her intent to repair or replace the excluded resource, funds previously held for replacement or repair will be counted as a resource effective with the month that the individual reports this change of intent.

[44 FR 15662, Mar. 15, 1979, as amended at 50 FR 48579, Nov. 26, 1985; 61 FR 5944, Feb. 15, 1996]

§ 416.1233 Exclusion of certain underpayments from resources.

(a) *General.* In determining the resources of an eligible individual (and spouse, if any), we will exclude, for 9 months following the month of receipt, the unspent portion of any title II or title XVI retroactive payment received on or after March 2, 2004. *Exception:* We will exclude for 6 months following the month of receipt the unspent portion of any title II or title XVI retroactive payment received before March 2, 2004. This exclusion also applies to such payments received by any other person whose resources are subject to deeming under this subpart.

(b) *Retroactive payments.* For purposes of this exclusion, a retroactive payment is one that is paid after the month in which it was due. A title XVI retroactive payment includes any retroactive amount of federally administered State supplementation.

(c) *Limitation on exclusion.* This exclusion applies only to any unspent portion of retroactive payments made under title II or XVI. Once the money from the retroactive payment is spent, this exclusion does not apply to items purchased with the money, even if the 6-month or 9-month period, whichever is applicable (see paragraph (a) of this section), has not expired. However, other exclusions may be applicable. As long as the funds from the retroactive payment are not spent, they are excluded for the full 6-month or 9-month period, whichever is applicable.

(d) *Funds must be identifiable.* Unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds but, if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit described in § 416.1205.

(e) *Written notice.* We will give each recipient a written notice of the exclusion limitation when we make the retroactive payment.

[51 FR 34464, Sept. 29, 1986, as amended at 54 FR 19164, May 4, 1989; 70 FR 41138, July 18, 2005]

§ 416.1234 Exclusion of Indian lands.

In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, we will exclude any interest of the individual (or spouse, if any) in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the Federal Government.

[59 FR 8538, Feb. 23, 1994]

§ 416.1235 Exclusion of certain payments related to tax credits.

(a) In determining the resources of an individual (and spouse, if any), we exclude for the 9 months following the month of receipt the following funds received on or after March 2, 2004, the unspent portion of:

(1) Any payment of a refundable credit pursuant to section 32 of the Internal Revenue Code (relating to the earned income tax credit);

(2) Any payment from an employer under section 3507 of the Internal Revenue Code (relating to advance payment of the earned income tax credit); or

(3) Any payment of a refundable credit pursuant to section 24 of the Internal Revenue Code (relating to the child tax credit).

(b) Any unspent funds described in paragraph (a) of this section that are retained until the first moment of the tenth month following their receipt are countable as resources at that time.

(c) *Exception:* For any payments described in paragraph (a) of this section received before March 2, 2004, we will exclude for the month following the month of receipt the unspent portion of any such payment.

[75 FR 1273, Jan. 11, 2010]

§ 416.1236 Exclusions from resources; provided by other statutes.

(a) For the purpose of § 416.1210(j), payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion from resources is required by such statute include:

(1) Payments made under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

(2) Payments made to Native Americans as listed in paragraphs (b) and (c) of section IV of the appendix to subpart K of part 416, as provided by Federal statutes other than the Social Security Act.

(3) Indian judgment funds held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93–134, as amended by Public Law 97–458 (25 U.S.C. 1407). Indian judgment funds include interest and investment income accrued while the funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds. This exclusion will not apply to proceeds from sales or conversions of initial purchases or to subsequent purchases.

(4) The value of the coupon allotment in excess of the amount paid for the coupons under the Food Stamp Act of 1964 (78 Stat. 705, as amended, 7 U.S.C. 2016(c)).

(5) The value of assistance to children under the National School Lunch Act (60 Stat. 230, 42 U.S.C. 1751 *et seq.*) as amended by Pub. L. 90–302 (82 Stat. 117, 42 U.S.C. 1761(h)(3)).

(6) The value of assistance to children under the Child Nutrition Act of 1966 (80 Stat. 889, 42 U.S.C. 1780(b)).

(7) Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education as provided by section 507 of the Higher Education Amendments of 1968, Pub. L. 90–575 (82 Stat. 1063).

(8) Incentive allowances received under title I of the Comprehensive Employment and Training Act of 1973 (87 Stat. 849, 29 U.S.C. 821(a)).

(9) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. 201 *et seq.*), or applicable State law, pursuant to 42 U.S.C. 5044(f)(1).

(10) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, is disregarded to the extent that it does not, in the aggregate, exceed $2,000 per individual each year (the $2,000 limit is applied separately each year, and cash distributions up to $2,000 which an individual received in a prior year and retained into subsequent years will not be counted as resources in those years); stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to the exclusion under section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Public Law 100–241 (43 U.S.C. 1626(c)), effective February 3, 1988.

(11) Value of Federally donated foods distributed pursuant to section 32 of Pub. L. 74–320 or section 416 of the Agriculture Act of 1949 (7 CFR 250.6(e)(9) as authorized by 5 U.S.C. 301).

(12) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Public Law 98–64. Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from resources under this exclusion. For the treatment of ANRVC dividend distributions, see paragraph (a)(10) of this section.

(13) Home energy assistance payments or allowances under the Low-Income Home Energy Assistance Act of 1981, as added by title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97–35 (42 U.S.C. 8624(f)).

(14) Student financial assistance for attendance costs received from a program funded in whole or in part under title IV of the Higher Education Act of

1965, as amended, or under Bureau of Indian Affairs student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Public Law 100–50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu), or under Bureau of Indian Affairs student assistance programs.

(15) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Public Law 100–383 (50 U.S.C. app. 1989 b and c).

(16) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Public Law 101–201 (103 Stat. 1795) and section 10405 of Public Law 101–239 (103 Stat. 2489).

(17) Payments made under section 6 of the Radiation Exposure Compensation Act, Public Law 101–426 (104 Stat. 925, 42 U.S.C. 2210).

(18) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103–286 (108 Stat. 1450).

(19) Any matching funds and interest earned on matching funds from a demonstration project authorized by Public Law 105–285 that are retained in an Individual Development Account, pursuant to section 415 of Public Law 105–285 (112 Stat. 2771).

(20) Any earnings, Temporary Assistance for Needy Families matching funds, and accrued interest retained in an Individual Development Account, pursuant to section 103 of Public Law 104–193 (42 U.S.C. 604(h)(4)).

(21) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to section 606 of Public Law 105–78 and section 657 of Public Law 104–201 (110 Stat. 2584).

(22) Payments made to certain Vietnam veterans' children with spina bifida, pursuant to section 421 of Public Law 104–204 (38 U.S.C. 1805(d)).

(23) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to section 401 of Public Law 106–419, (38 U.S.C. 1833(c)).

(24) Assistance provided for flood mitigation activities under section 1324 of the National Flood Insurance Act of 1968, pursuant to section 1 of Public Law 109–64 (119 Stat. 1997, 42 U.S.C. 4031).

(25) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, pursuant to section 1, app. [Div. C. Title XXXVI section 3646] of Public Law 106–398 (114 Stat. 1654A–510, 42 U.S.C. 7385e).

(b) In order for payments and benefits listed in paragraph (a) to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

[41 FR 13338, Mar. 30, 1976, as amended at 42 FR 44221, Sept. 2, 1977; 42 FR 54945, Oct. 12, 1977; 43 FR 45555, Oct. 3, 1978; 57 FR 53851, Nov. 13, 1992; 57 FR 55089, Nov. 24, 1992; 59 FR 8538, Feb. 23, 1994; 62 FR 30983, June 6, 1997; 70 FR 41138, July 18, 2005; 75 FR 1274, Jan. 11, 2010]

§ 416.1237 Assistance received on account of major disaster.

(a) Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States or comparable assistance received from a State or local government, or from a disaster assistance organization, is excluded in determining countable resources under § 416.1210.

(b) Interest earned on the assistance is excluded from resources.

[57 FR 53852, Nov. 13, 1992]

§ 416.1238 Exclusion of certain housing assistance.

The value of any assistance paid with respect to a dwelling under the statutes listed in § 416.1124(c)(14) is excluded from resources.

[55 FR 28378, July 11, 1990]

§ 416.1239 Exclusion of State or local relocation assistance payments.

In determining the resources of an individual (or spouse, if any), relocation assistance provided by a State or local government (as described in § 416.1124(c)(18)) is excluded from resources for a period of 9 months beginning with the month following the month of receipt.

[61 FR 1712, Jan. 23, 1996]

§ 416.1240 Disposition of resources.

(a) Where the resources of an individual (and spouse, if any) are determined to exceed the limitations prescribed in § 416.1205, such individual (and spouse, if any) shall not be eligible for payment except under the conditions provided in this section. Payment will be made to an individual (and spouse, if any) if the individual agrees in writing to:

(1) Dispose of, at current market value, the nonliquid resources (as defined in § 416.1201(c)) in excess of the limitations prescribed in § 416.1205 within the time period specified in § 416.1242; and

(2) Repay any overpayments (as defined in § 416.1244) with the proceeds of such disposition.

(b) Payment made for the period during which the resources are being disposed of will be conditioned upon the disposition of those resources as prescribed in paragraphs (a)(1) and (a)(2) of this section. Any payments so made are (at the time of disposition) considered overpayments to the extent they would not have been paid had the disposition occurred at the beginning of the period for which such payments were made.

(c) If an individual fails to dispose of the resources as prescribed in paragraphs (a)(1) and (a)(2) of this section, regardless of the efforts he or she makes to dispose of them, the resources will be counted at their current market value and the individual will be ineligible due to excess resources. We will use the original estimate of current market value unless the individual submits evidence establishing a lower value (e.g., an estimate from a disinterested knowledgeable source).

[75 FR 1274, Jan. 11, 2010]

§ 416.1242 Time limits for disposing of resources.

(a) In order for payment conditioned on the disposition of nonliquid resources to be made, the individual must agree in writing to dispose of real property within 9 months and personal property within 3 months. The time period for disposal of property begins on the date we accept the individual's signed written agreement to dispose of the property. If we receive a signed agreement on or after the date we have determined that the individual meets the eligibility requirements described in § 416.202 of this part, with the exception of the resource requirements described in this subpart, our acceptance of the written agreement will occur on the date the individual receives our written notice that the agreement is in effect. If we receive a signed agreement prior to the date we determine that all nonresource requirements are met, our acceptance of the written agreement will not occur until the date the individual receives our written notice that all nonresource requirements are met and that the agreement is in effect. When the written notice is mailed to the individual, we assume that the notice was received 5 days after the date shown on the notice unless the individual shows us that he or she did not receive it within the 5-day period.

(b) The 3-month time period for disposition of personal property will be extended an additional 3 months where it is found that the individual had ''good cause'' for failing to dispose of the resources within the original time period. The rules on the valuation of real property not disposed of within 9 months are described in § 416.1245(b).

(c) An individual will be found to have ''good cause'' for failing to dispose of a resource if, despite reasonable and diligent effort on his part, he was prevented by circumstances beyond his control from disposing of the resource.

(d) In determining whether the appropriate time limits discussed in paragraphs (a) and (b) of this section have elapsed, no month will be counted for which an individual's benefits have been suspended as described in § 416.1320, provided that the reason for the suspension is unrelated to the requirements in § 416.1245(b) and that the individual's eligibility has not been terminated as defined in §§ 416.1331 through 416.1335.

[40 FR 48915, Oct. 20, 1975, as amended at 53 FR 13257, Apr. 22, 1988; 55 FR 10419, Mar. 21, 1990; 58 FR 60105, Nov. 15, 1993]

§ 416.1244 Treatment of proceeds from disposition of resources.

(a) Upon disposition of the resources, the net proceeds to the individual from the sale are considered available to repay that portion of the payments that would not have been made had the disposition occurred at the beginning of the period for which payment was made.

(b) The net proceeds from disposition will normally be the sales price less any encumbrance on the resource and the expenses of sale such as transfer taxes, fees, advertising costs, etc. where, however, a resource has been sold (or otherwise transferred) by an individual to a friend or relative for less than its current market value, the net proceeds will be the current market value less costs of sale and encumbrance.

(c) After deducting any amount necessary to raise the individual's (and spouse's, if any) resources to the applicable limits described in § 416.1205, as of the beginning of the disposition period, the balance of the net proceeds will be used to recover the payments made to the individual (and spouse, if any). Any remaining proceeds are considered liquid resources.

(d) The overpayment to be recovered is equal to the balance of the net proceeds (as described in paragraph (c) of this section) or the total payments made to the individual (and spouse, if any) for the period of disposition, whichever is less.

[40 FR 48915, Oct. 20, 1975, as amended at 50 FR 38982, Sept. 28, 1985]

§ 416.1245 Exceptions to required disposition of real property.

(a) *Loss of housing for joint owner.* Excess real property which would be a resource under § 416.1201 is not a countable resource for conditional benefit purposes when: it is jointly owned; and sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when the property serves as the principal place of residence for one (or more) of the other owners, sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner (e.g., the other owner does not own another house that is legally available for occupancy). However, if undue hardship ceases to exist, its value will be included in countable resources as described in § 416.1207.

(b) *Reasonable efforts to sell.* (1) Excess real property is not included in countable resources for so long as the individual's reasonable efforts to sell it have been unsuccessful. The basis for determining whether efforts to sell are reasonable, as well as unsuccessful, will be a 9-month disposal period described in § 416.1242. If it is determined that reasonable efforts to sell have been unsuccessful, further SSI payments will not be conditioned on the disposition of the property and only the benefits paid during the 9-month disposal period will be subject to recovery. In order to be eligible for payments after the conditional benefits period, the individual must continue to make reasonable efforts to sell.

(2) A conditional benefits period involving excess real property begins as described at § 416.1242(a). The conditional benefits period ends at the earliest of the following times:

(i) Sale of the property;

(ii) Lack of continued reasonable efforts to sell;

(iii) The individual's written request for cancellation of the agreement;

(iv) Countable resources, even without the conditional exclusion, fall below the applicable limit (e.g., liquid resources have been depleted); or

(v) The 9-month disposal period has expired.

(3) Reasonable efforts to sell property consist of taking all necessary steps to sell it in the geographic area covered by the media serving the area in which the property is located, unless the individual has good cause for not taking these steps. More specifically, making a reasonable effort to sell means that:

(i) Except for gaps of no more than 1 week, an individual must attempt to sell the property by listing it with a real estate agent or by undertaking to sell it himself;

(ii) Within 30 days of receiving notice that we have accepted the individual's signed written agreement to dispose of the property, and absent good cause for not doing so, the individual must:

(A) List the property with an agent; or

(B) Begin to advertise it in at least one of the appropriate local media, place a ''For Sale'' sign on the property (if permitted), begin to conduct ''open houses'' or otherwise show the property to interested parties on a continuous basis, and attempt any other appropriate methods of sale; and

(iii) The individual accepts any reasonable offer to buy and has the burden of demonstrating that an offer was rejected because it was not reasonable. If the individual receives an offer that is at least two-thirds of the latest estimate of current market value, the individual must present evidence to establish that the offer was unreasonable and was rejected.

(4) An individual will be found to have ''good cause'' for failing to make reasonable efforts to sell under paragraph (b)(3) of this section if he or she was prevented by circumstances beyond his or her control from taking the steps specified in paragraph (b)(3) (i) through (ii) of this section.

(5) An individual who has received conditional benefits through the expiration of the 9 month disposal period and whose benefits have been suspended as described at § 416.1320 for reasons unrelated to the property excluded under the conditional benefits agreement, but whose eligibility has not been terminated as defined at §§ 416.1331 through 416.1335, can continue to have the excess real property not included in countable resources upon reinstatement of SSI payments if reasonable efforts to sell the property resume within 1 week of reinstatement. Such an individual will not have to go through a subsequent conditional benefits period. However, the individual whose eligibility has been terminated as defined at §§ 416.1331 through 416.1335 and who subsequently reapplies would be subject to a new conditional benefits period if there is still excess real property.

[55 FR 10419, Mar. 21, 1990, as amended at 62 FR 30983, June 6, 1997; 64 FR 31975, June 15, 1999]

§ 416.1246 Disposal of resources at less than fair market value.

(a) *General.* (1) An individual (or eligible spouse) who gives away or sells a nonexcluded resource for less than fair market value for the purpose of establishing SSI or Medicaid eligibility will be charged with the difference between the fair market value of the resource and the amount of compensation received. The difference is referred to as uncompensated value and is counted toward the resource limit (see § 416.1205) for a period of 24 months from the date of transfer.

(2) If the transferred resource (asset) is returned to the individual, the uncompensated value is no longer counted as of the date of return. If the transferred asset is cash, the uncompensated value is reduced as of the date of return by the amount of cash that is returned. No income will be charged as a result of such returns. The returned asset will be evaluated as a resource according to the rules described in §§ 416.1201 through 416.1230 as of the first day of the following month.

(3) If the individual receives additional compensation in the form of cash for the transferred asset the uncompensated value is reduced, as of the date the additional cash compensation is received, by the amount of that additional compensation.

(b) *Fair market value.* Fair market value is equal to the current market value of a resource at the time of transfer or contract of sale, if earlier. See § 416.1101 for definition of current market value.

(c) *Compensation.* The compensation for a resource includes all money, real or personal property, food, shelter, or

services received by the individual (or eligible spouse) at or after the time of transfer in exchange for the resource if the compensation was provided pursuant to a binding (legally enforceable) agreement in effect at the time of transfer. Compensation also includes all money, real or personal property, food, shelter, or services received prior to the actual transfer if they were provided pursuant to a binding (legally enforceable) agreement whereby the eligible individual would transfer the resource or otherwise pay for such items. In addition, payment or assumption of a legal debt owed by the eligible individual in exchange for the asset is considered compensation.

(d)(1) *Uncompensated value—General.* The uncompensated value is the fair market value of a resource at the time of transfer minus the amount of compensation received by the individual (or eligible spouse) in exchange for the resource. However, if the transferred resource was partially excluded, we will not count uncompensated value in an amount greater than the countable value of the resources at the time of transfer.

(2) *Suspension of counting as a resource the uncompensated value where necessary to avoid undue hardship.* We will suspend counting as a resource the uncompensated value of the transferred asset for any month in the 24-month period if such counting will result in undue hardship. We will resume counting the uncompensated value as a resource for any month of the 24-month period in which counting will not result in undue hardship. We will treat as part of the 24-month period any months during which we suspend the counting of uncompensated value.

(3) *When undue hardship exists.* Undue hardship exists when:

(i) An individual alleges that failure to receive SSI benefits would deprive the individual of food or shelter; and

(ii) The applicable Federal benefit rate (plus the federally-administered State supplementary payment level) exceeds the sum of: The individual's monthly countable and excludable income and monthly countable and excludable liquid resources.

(e) *Presumption that resource was transferred to establish SSI or Medicaid eligibility.* Transfer of a resource for less than fair market value is presumed to have been made for the purpose of establishing SSI or Medicaid eligibility unless the individual (or eligible spouse) furnishes convincing evidence that the resource was transferred exclusively for some other reason. Convincing evidence may be pertinent documentary or non-documentary evidence which shows, for example, that the transfer was ordered by a court, or that at the time of transfer the individual could not have anticipated becoming eligible due to the existence of other circumstances which would have precluded eligibility. The burden of rebutting the presumption that a resource was transferred to establish SSI or Medicaid eligibility rests with the individual (or eligible spouse).

(f) *Applicability.* This section applies only to transfers of resources that occurred before July 1, 1988. Paragraphs (d)(2) and (d)(3) of this section, regarding undue hardship, are effective for such transfers on or after April 1, 1988.

[48 FR 40885, Sept. 12, 1983, as amended at 50 FR 38982, Sept. 26, 1985; 53 FR 13257, Apr. 22, 1988; 55 FR 10419, Mar. 21, 1990]

§ 416.1247 Exclusion of a dedicated account in a financial institution.

(a) *General.* In determining the resources of an individual (or spouse, if any), the funds in a dedicated account in a financial institution established and maintained in accordance with § 416.640(e) will be excluded from resources. This exclusion applies only to benefits which must or may be deposited in such an account, as specified in § 416.546, and accrued interest or other earnings on these benefits. If these funds are commingled with any other funds (other than accumulated earnings or interest) this exclusion will not apply to any portion of the funds in the dedicated account.

(b) *Exclusion during a period of suspension or termination*—(1) *Suspension.* The exclusion of funds in a dedicated account and interest and other earnings thereon continues to apply during a period of suspension due to ineligibility as described in § 416.1320, administrative suspension, or a period of eligibility for which no payment is due, so long as the individual's eligibility has

not been terminated as described in §§ 416.1331 through 416.1335.

(2) *Termination.* Once an individual's eligibility has been terminated, any funds previously excluded under paragraph (a) of this section may not be excluded if the individual establishes a subsequent period of eligibility by filing a new application.

[61 FR 67207, Dec. 20, 1996]

§ 416.1248 Exclusion of gifts to children with life-threatening conditions.

In determining the resources of an individual who has not attained 18 years of age and who has a life-threatening condition, we will exclude any gifts from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code. We will exclude any in-kind gift that is not converted to cash and cash gifts to the extent that the total gifts excluded pursuant to this paragraph do not exceed $2000 in any calendar year. In-kind gifts converted to cash are considered under income counting rules in the month of conversion.

[70 FR 41139, July 18, 2005]

§ 416.1249 Exclusion of payments received as restitution for misuse of benefits by a representative payee.

In determining the resources of an individual (and spouse, if any), the unspent portion of any payment received by the individual as restitution for title II, title VIII or title XVI benefits misused by a representative payee under § 404.2041, § 408.641 or § 416.641, respectively, is excluded for 9 months following the month of receipt.

[70 FR 41139, July 18, 2005]

§ 416.1250 How we count grants, scholarships, fellowships or gifts.

(a) When we determine your resources (or your spouse's, if any), we will exclude for 9 months any portion of any grant, scholarship, fellowship, or gift that you use or set aside to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational or technical institutions. The 9 months begin the month after the month you receive the educational assistance.

(b)(1) We will count as a resource any portion of a grant, scholarship, fellowship, or gift you (or your spouse, if any) did not use or set aside to pay tuition, fees, or other necessary educational expenses. We will count such portion of a grant, scholarship, fellowship or gift as a resource in the month following the month of receipt.

(2) If you use any of the funds that were set aside for tuition, fees, or other necessary educational expenses for another purpose within the 9-month exclusion period, we will count such portion of the funds used for another purpose as income in the month you use them.

(3) If any portion of the funds are no longer set aside for paying tuition, fees, or other necessary educational expenses within the 9-month exclusion period, we will count the portion of the funds no longer set aside as income in the month when they are no longer set aside for paying tuition, fees, or other necessary educational expenses. We will consider any remaining funds that are no longer set aside or used to pay tuition, fees, or other educational expenses as a resource in the month following the month we count them as income.

(4) We will count any portion of grants, scholarships, fellowships, or gifts remaining unspent after the 9-month exclusion period as a resource beginning with the 10th month after you received the educational assistance.

[71 FR 45378, Aug. 9, 2006]

§ 416.1260 Special resource provision for recipients under a State plan.

(a) *General.* In the case of any individual (or individual and spouse, as the case may be) who for the month of December 1973 was a recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI, of the Act (see § 416.121), the resources of such individual (or individual and spouse, as the case may be) shall be deemed not to exceed the amount specified in § 416.1205 during any period that the resources of such individual (or individual and spouse, as the case may be) do not exceed the maximum amount of

resources specified in such State plan as in effect in October 1972, provided that such individual:

(1) Has, since December 1973, resided continuously in the State under whose plan he was eligible for the month of December 1973; and

(2) Has not, since December 1973, been ineligible for an SSI benefit for a period exceeding 6 consecutive months. An SSI benefit means a Federal benefit only; it does not include any State supplementation.

(b) For purposes of this section, an individual will cease to reside continuously in a State if he leaves the State with the present intention to abandon his home there. In the absence of evidence to the contrary,

(1) If an individual leaves the State for a period of 90 calendar days or less, his absence from the State will be considered temporary and he will be considered to continue to reside in such State; and

(2) If an individual leaves the State for a period in excess of 90 calendar days, he will no longer be considered to reside continuously in such State.

(c) *State plan; defined.* As used in this subpart, *an approved State plan as in effect in October 1972* and *State plan for October 1972* means a State plan as approved under the provisions of 45 CFR Ch. II as in effect in October 1972.

[41 FR 47424, Oct. 29, 1976, as amended at 52 FR 29841, Aug. 12, 1987]

§ 416.1261 Application of special resource provision.

In determining the resources of an individual (and spouse, if any) who meets the conditions specified in § 416.1260(a), either the State plan resource limit and exclusions (as specified in § 416.1260) or the resource limit (as specified in § 416.1205) and exclusions (as specified in § 416.1210), whichever is most advantageous to the individual (and spouse, if any) will be used.

§ 416.1262 Special resource provision applicable in cases involving essential persons.

(a) *Essential persons continuously meet criteria of eligibility.* In determining the resources of an individual (and spouse, if any) who meet the conditions specified in § 416.1260 and whose payment standard is increased because such individual has in his home an essential person (as defined in § 416.222), either the State plan resource limit and exclusions (as specified in § 416.1260) applicable to cases in which the needs of an essential person are taken into account in determining the individual's needs, or the resource limit as specified in § 416.1205 and exclusions as specified in § 416.1210, whichever is most advantageous to the individual (and spouse), will be used.

(b) *Essential person fails to meet criteria of eligibility.* If for any month after December 1973 a person fails to meet the criteria for an essential person as specified in § 416.222, in determining the resources of an individual (and spouse, if any) either the State plan resource limit and criteria as specified in § 416.1260 applicable to the individual or individual and spouse, as the case may be, or the resource limit as specified in § 416.1205 and exclusions as specified in § 416.1210, whichever is most advantageous to the individual (and spouse), will be used.

[39 FR 33797, Sept. 20, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§ 416.1264 Spouse ineligible under a State plan in December 1973.

In the case of an individual who meets the conditions specified in § 416.1260 but whose spouse does not meet such conditions, whichever of the following is most advantageous for the individual (and spouse, if any) will be applied:

(a) The resource limitation and exclusions for an individual as in effect under the approved State plan for October 1972, or

(b) The resource limitation (as specified in § 416.1205) and exclusions (as specified in § 416.1210) for an individual and eligible spouse or an individual living with an ineligible spouse.

§ 416.1266 Individual under special resource provision dies after December 1973.

Where only one person, either the eligible individual or the eligible spouse, meets the conditions specified in § 416.1260 and that person dies after December 1973, the State plan resource limitation and exclusions will not be

applied to determine the amount of resources of the surviving individual. The resource limitation (as specified in § 416.1205) and exclusions (as specified in § 416.1210) will be applied for the now eligible individual beginning with the month such person is considered the eligible individual as defined in subpart A of this part.

Subpart M—Suspensions and Terminations

AUTHORITY: Secs. 702(a)(5), 1129A, 1611–1614, 1619, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1320a–8a, 1382–1382c, 1382h, and 1383).

SOURCE: 40 FR 1510, Jan. 8, 1975, unless otherwise noted.

§ 416.1320 Suspensions; general.

(a) *When suspension is proper.* Suspension of benefit payments is required when a recipient is alive but no longer meets the requirements of eligibility under title XVI of the Act (see subpart B of this part) and termination in accordance with §§ 416.1331 through 416.1335 does not apply. (This subpart does not cover suspension of payments for administrative reasons, as, for example, when mail is returned as undeliverable by the Postal Service and the Administration does not have a valid mailing address for a recipient or when the representative payee dies and a search is underway for a substitute representative payee.)

(b) *Effect of suspension.* (1) When payments are correctly suspended due to the ineligibility of a recipient, payments shall not be resumed until the individual again meets all requirements for eligibility except the filing of a new application. Such recipient, upon requesting reinstatement, shall be required to submit such evidence as may be necessary (except evidence of age, disability, or blindness) to establish that he or she again meets all requirements for eligibility under this part. Payments to such recipient shall be reinstated effective with the first day such recipient meets all requirements for eligibility except the filing of a new application.

(2) A month of ineligibility for purposes of determining when to prorate the SSI benefit payment for a subsequent month, is a month for which the individual is ineligible for any Federal SSI benefit and any federally administered State supplementation.

(c) *Actions which are not suspensions.* Payments are not ''suspended,'' but the claim is disallowed, when it is found that:

(1) The claimant was notified in accordance with § 416.210(c) at or about the time he filed application and before he received payment of a benefit that he should file a claim for a payment of the type discussed in § 416.1330 and such claimant has failed, without good cause (see § 416.210(e)(2)), to take all appropriate steps within 30 days after receipt of such notice to file and prosecute an application for such payment;

(2) Upon initial application, payment of benefits was conditioned upon disposal of specified resources which exceeded the permitted amount and the claimant did not comply with the agreed-upon conditions;

(3) Payment was made to an individual faced with a financial emergency who was later found to have been not eligible for payment; or

(4) Payment was made to an individual presumed to be disabled and such disability is not established.

(d) *Exception.* Even though conditions described in paragraph (a) of this section apply because your impairment is no longer disabling or you are no longer blind under § 416.986(a)(1), (a)(2) or (b), we will not suspend your benefits for this reason if—

(1) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 416.1338(c) and (d);

(2) You began participating in the program before the date your disability or blindness ended; and

(3) We have determined under § 416.1338(e) that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you

will not have to return to the disability or blindness benefit rolls.

[40 FR 1510, Jan. 8, 1975, and 47 FR 31544, July 21, 1982; 47 FR 52693, Nov. 23, 1982, as amended at 51 FR 13494, Apr. 21, 1986; 51 FR 17618, May 14, 1986; 56 FR 55453, Oct. 28, 1991. Redesignated at 68 FR 53509, Sept. 11, 2003; 70 FR 36508, June 24, 2005]

§ 416.1321 Suspension for not giving us permission to contact financial institutions.

(a) If you don't give us permission to contact any financial institution and request any financial records about you when we think it is necessary to determine your SSI eligibility or payment amount, or if you cancel the permission, you cannot be eligible for SSI payments (*see* § 416.207) and we will stop your payments. Also, if anyone whose income and resources we consider as being available to you (see §§ 416.1160, 416.1202, 416.1203 and 416.1204) doesn't give us permission to contact any financial institution and request any financial records about that person when we think it is necessary to determine your SSI eligibility or payment amount, or that person cancels the permission, you cannot be eligible for SSI payments and we will stop your payments. We will not find you ineligible and/or stop your payments if the person whose income and resources we consider as being available to you fails to give or continue permission and good cause, as discussed in § 416.207(h), exists.

(b) We will suspend your payments starting with the month after the month in which we notify you in writing that:

(1) You failed to give us permission to contact any financial institution and request any financial records about you, or

(2) The person(s) whose income and resources we consider as being available to you failed to give us such permission.

(c) If you are otherwise eligible, we will start your benefits in the month following the month in which:

(1) You give us permission to contact any financial institution and request any financial records about you, or

(2) The person(s) whose income and resources we consider as being available to you gives us such permission.

[68 FR 53509, Sept. 11, 2003]

§ 416.1322 Suspension due to failure to comply with request for information.

(a) Suspension of benefit payments is required effective with the month following the month in which it is determined in accordance with § 416.714(b) that the individual is ineligible for payment due to his or her failure to comply with our request for necessary information. When we have information to establish that benefit payments are again payable, the benefit payments will be reinstated for any previous month for which the individual continued to meet the eligibility requirements of § 416.202. If the reason that an individual's benefits were suspended was failure to comply with our request for information, the payments for the months that benefits are reinstated will not be prorated under § 416.421.

(b) A suspension of payment for failure to comply with our request for information will not apply with respect to any month for which a determination as to eligibility for or amount of payment can be made based on information on record, whether or not furnished by an individual specified in § 416.704(a). Where it is determined that the information of record does not permit a determination with respect to eligibility for or amount of payment, notice of a suspension of payment due to a recipient's failure to comply with a request for information will be sent in accordance with §§ 416.1336 and 416.1404.

[51 FR 13494, Apr. 21, 1986]

§ 416.1323 Suspension due to excess income.

(a) *Effective date.* Suspension of payments due to ineligibility for benefits because of excess income is effective with the first month in which ''countable income'' (see §§ 416.1100 through 416.1124 of this part) equals or exceeds the amount of benefits otherwise payable for such month (see subpart D of this part). This rule applies regardless

of the month in which the income is received.

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the first month in which a recipient's monthly countable income becomes less than the applicable Federal benefit rate (or the sum of that rate and the level for any federally administered State supplementary payment) for that month. If the reason that a recipient's benefits were suspended was excess income, the payment for the first month that benefits are reinstated will not be prorated under §416.421.

[40 FR 1510, Jan. 8, 1975, as amended at 51 FR 13494, Apr. 21, 1986; 65 FR 16815, Mar. 30, 2000]

§416.1324 Suspension due to excess resources.

(a) *Effective date.* Except as specified in §§416.1240 through 416.1242, suspension of benefit payments because of excess resources is required effective with the month in which:

(1) Ineligibility exists because countable resources are in excess of:

(i) The resource limits prescribed in §416.1205 for an individual and an individual and spouse, or

(ii) In the case of an eligible individual (and eligible spouse, if any) who for the month of December 1973 was a recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Act, the maximum amount of resources specified in such State plan as in effect for October 1972, if greater than the amounts specified in §416.1205, as applicable; or

(2) After eligibility has been established, payment of benefits was conditioned upon disposal of specified resources, which exceeded the permitted amount and the claimant did not comply with the agreed upon conditions.

(3) The amount of an individual's or couple's countable resources is determined as of the first moment of each calendar quarter.

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the start of the month after the month in which a recipient's countable resources no longer exceed the limit that applies. If the reason that a recipient's benefits were suspended was excess resources, the payment for the first month that benefits are reinstated will not be prorated under §416.421.

[40 FR 1510, Jan. 8, 1975, as amended at 50 FR 38982, Sept. 26, 1985; 51 FR 13494, Apr. 21, 1986]

§416.1325 Suspension due to status as a resident of a public institution.

(a) Except as provided in §416.211 (b) and (c), a recipient is ineligible for benefits for the first full calendar month in which he or she is a resident of a public institution (as defined in §416.201) throughout the calendar month (as defined in §416.211(a)), and payments are suspended effective with such first full month. Such ineligibility continues for so long as such individual remains a resident of a public institution.

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the earliest day of the month in which a recipient is no longer a resident of a public institution. See §416.421. A transfer from one public institution to another or a temporary absence from the institution lasting 14 days or less, however, will not change his or her status as a resident, and the suspension will continue.

[51 FR 13494, Apr. 21, 1986]

§416.1326 Suspension for failure to comply with treatment for drug addiction or alcoholism.

(a) *Basis for suspension.* If you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability as described in §416.935, we will refer you to appropriate treatment as defined in §416.937. You will not be an eligible individual and we will suspend your benefits if you do not comply with the terms, conditions and requirements of treatment prescribed by the institution or facility. (See §416.940 which explains how we evaluate compliance with treatment.)

(b) *Date of suspension.* We will suspend your benefits for a period starting with the first month after we notify you in writing that you failed to comply with prescribed treatment.

(c) *Resumption of benefits.* If you are complying with prescribed treatment and are otherwise eligible for benefits, we will resume benefits effective with

the first day of the month after you demonstrate and maintain compliance with appropriate treatment for these periods—

(1) 2 consecutive months for the first determination of noncompliance;

(2) 3 consecutive months for the second determination of noncompliance; and

(3) 6 consecutive months for the third and all subsequent determinations of noncompliance.

[60 FR 8152, Feb. 10, 1995]

§ 416.1327 Suspension due to absence from the United States.

(a) *Suspension effective date.* A recipient is not eligible for SSI benefits if he is outside the United States for a full calendar month. For purposes of this paragraph—

(1) *United States* means the 50 States, the District of Columbia, and the Northern Mariana Islands:

(2) *Day* means a full 24–hour day; and

(3) In determining whether a recipient has been outside the United States for a full calendar month, it must be established whether the recipient is outside the United States for 30 consecutive days or more. If yes, he or she will be treated as remaining outside the United States until he or she has returned to and remained in the United States for a period of 30 consecutive days. When a recipient has been outside the United States, the first period of 30 consecutive days of absence is counted beginning with the day after the day the recipient departs from the United States and ending with the day before the day on which he or she returns to the United States. When a recipient has returned to the United States, the second period of 30 consecutive days starts on the day the individual returned and ends on the 30th day of continuous presence in the United States. Benefits will be suspended effective with the first full calendar month in which a recipient is outside the United States.

(b) *Resumption of payments after absence from the United States.* If benefits are otherwise payable they will be resumed—

(1) Effective with the day following the 30th day of continuous presence in the United States after the recipient's return if the absence was for 30 consecutive days or more.

(2) Effective with the day the recipient returned to the United States, if the absence from the United States was for a full calendar month, but for less than 30 consecutive days (this can occur only for the calendar month of February).

Example 1: Mike left the United States on March 1 and returned on April 1. Counting March 2 through March 31, he was outside the United States for 30 consecutive days; thus he is also deemed to be outside the United States for 30 additional consecutive days. Therefore, for April 1 through April 30, he is deemed to be outside the United States and not eligible for the calendar month of April. Payments start effective May 1.

Example 2: Mary left the United States on April 15 and returned on July 1. Counting April 16 through June 30, she was actually outside the United States and not eligible for the calendar months of May and June. Since she was absent for more than 30 consecutive days, she is deemed to be outside the United States for 30 additional consecutive days. Therefore, for July 1 through July 30, she is deemed to be outside the United States and not eligible for payment until July 31.

[51 FR 13494, Apr. 21, 1986; 51 FR 17332, May 12, 1986]

§ 416.1329 Suspension due to loss of United States residency, United States citizenship, or status as an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(a) A recipient ceases to be an eligible individual or eligible spouse, under section 1614(a)(1)(B) of the Act, when he or she ceases to meet the requirement of § 416.202(b) with respect to United States residency, United States citizenship, or status as an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payments are suspended effective with the first month after the last month in which a recipient meets the requirements of § 416.202(b).

(b) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the earliest day of the month on which the recipient again

meets both the residence and citizenship or lawfully admitted alien or color of law requirements. See §416.421.

[51 FR 13495, Apr. 21, 1986]

§416.1330 Suspension due to failure to apply for and obtain other benefits.

(a) *Suspension effective date.* A recipient ceases to be an eligible individual or eligible spouse when, in the absence of a showing of incapacity to do so, or other good cause, he or she fails within 30 days after notice from the Social Security Administration of probable eligibility, to take all appropriate steps to apply for and, if eligible, to obtain payments such as an annuity, pension, retirement, or disability benefit, including veterans' compensation, old-age, survivors, and disability insurance benefit, railroad retirement annuity or pension, or unemployment insurance benefit. Benefit payments are suspended due to such ineligibility effective with the month in which the recipient was notified in writing of the requirement that he or she file and take all appropriate steps to receive the other benefits. See §416.210(e).

(b) *Resumption of payment.* If benefits are otherwise payable, they will be resumed effective with the earliest day of the month on which the recipient takes the necessary steps to obtain the other benefits. See §416.421.

[51 FR 13495, Apr. 21, 1986]

§416.1331 Termination of your disability or blindness payments.

(a) *General.* The last month for which we can pay you benefits based on disability or blindness is the second month after the month in which your disability or blindness ends. (See §§416.987(e), 416.994(b)(6) and 416.994a(g) for when disability ends, and §416.986 for when blindness ends.) See §416.1338 for an exception to this rule if you are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services. You must meet the income, resources, and other eligibility requirements to receive any of the benefits referred to in this paragraph. We will also stop payment of your benefits if you have not cooperated with us in getting information about your disability or blindness.

(b) *After we make a determination that you are not now disabled or blind.* If we determine that you do not meet the disability or blindness requirements of the law, we will send you an advance written notice telling you why we believe you are not disabled or blind and when your benefits should stop. The notice will explain your right to appeal if you disagree with our determination. You may still appeal our determination that you are not now disabled or blind even though your payments are continuing because of your participation in an appropriate program of vocational rehabilitation services, employment services, or other support services. You may also appeal a determination that your completion of, or continuation for a specified period of time in, an appropriate program of vocational rehabilitation services, employment services, or other support services will not increase the likelihood that you will not have to return to the disability or blindness benefit rolls and, therefore, you are not eligible to continue to receive benefits.

(c) *When benefits terminate due to 12 consecutive suspension months for failure to comply with treatment for drug addiction or alcoholism.* If you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability as described in §416.935, your benefits will terminate after 12 consecutive months of suspension for noncompliance with treatment requirements as described in §416.1326.

(d) *When benefits terminate due to payment of 36 months of benefits based on disability when drug addiction or alcoholism is a contributing factor material to the determination of disability.* If you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability as described in §416.935, your benefits will terminate after you receive a total of 36 months of SSI benefits. The 36-month limit is no longer effective for benefits for months beginning after September 2004.

(e) *Months we count in determining the 36 months of benefits when drug addiction or alcoholism is a contributing factor material to the determination of disability.*

Beginning March 1995, we will count all months for which you were paid an SSI benefit, a federally-administered State supplement, a special SSI cash benefit, or you were in special SSI eligibility status, toward the 36 months described in paragraph (d) of this section. Months for which you were not eligible for benefits will not count toward the 36 months.

[49 FR 22274, May 29, 1984, as amended at 60 FR 8152, Feb. 10, 1995; 65 FR 42792, July 11, 2000; 70 FR 36508, June 24, 2005]

§ 416.1332 Termination of benefit for disabled individual: Exception.

Special SSI cash benefits (see § 416.261) will be payable for the period beginning January 1, 1981, and ending June 30, 1987 if you meet eligibility requirements in § 416.262. These requirements apply if you, as a disabled recipient, are no longer eligible for regular SSI benefits because you demonstrate that you are able to engage in SGA.

[47 FR 15325, Apr. 9, 1982, as amended at 50 FR 46763, Nov. 13, 1985]

§ 416.1333 Termination at the request of the recipient.

A recipient, his legal guardian, or his representative payee, may terminate his eligibility for benefits under this part by filing a written request for termination which shows an understanding that such termination may extend to other benefits resulting from eligibility under this part. In the case of a representative payee there must also be a showing which establishes that no hardship would result if an eligible recipient were not covered by the supplemental security income program. When such a request is filed, the recipient ceases to be an eligible individual, or eligible spouse, effective with the month following the month the request is filed with the Social Security Administration unless the recipient specifies some other month. However, the Social Security Administration will not effectuate the request for any month for which payment has been or will be made unless there is repayment, or assurance of repayment, of any amounts paid for those months (e.g., from special payments which would be payable for such months under section 228 of the Act). When the Social Security Administration effectuates a termination of eligibility at the request of the recipient, his legal guardian, or his representative payee, notice of the determination will be sent in accordance with § 416.1404, and eligibility, once terminated, can be reestablished, except as provided by § 416.1408, only upon the filing of a new application.

[42 FR 39100, Aug. 2, 1977]

§ 416.1334 Termination due to death of recipient.

Eligibility for benefits ends with the month in which the recipient dies. Payments are terminated effective with the month after the month of death.

§ 416.1335 Termination due to continuous suspension.

We will terminate your eligibility for benefits following 12 consecutive months of benefit suspension for any reason beginning with the first month you were no longer eligible for regular SSI cash benefits, federally-administered State supplementation, special SSI cash benefits described in § 416.262, or special SSI eligibility status described in § 416.265. We will count the 12-month suspension period from the start of the first month that you are no longer eligible for SSI benefits (see § 416.1320(a)) or the start of the month after the month your special SSI eligibility status described in § 416.265 ended. This termination is effective with the start of the 13th month after the suspension began.

[60 FR 8153, Feb. 10, 1995, as amended at 64 FR 31975, June 15, 1999]

§ 416.1336 Notice of intended action affecting recipient's payment status.

(a) *Advance written notice requirement.* Advance written notice of intent to discontinue payment because of an event requiring suspension, reduction (see subpart D of this part), or termination of payments shall be given in all cases, prior to effectuation of the action, except where the Social Security Administration has factual information confirming the death of the recipient, e.g., as enumerated in § 404.704(b)

of this chapter, or a report by a surviving spouse, a legal guardian, a parent or other close relative, or a landlord.

(b) *Continuation of payment pending an appeal.* The written notice of intent to suspend, reduce, or terminate payments shall allow 60 days after the date of receipt of the notice for the recipient to request the appropriate appellate review (see subpart N of this part). If appeal is filed within 10 days after the individual's receipt of the notice, the payment shall be continued or reinstated at the previously established payment level (subject to the effects of intervening events on the payment which are not appealed within 10 days of receipt of a required advance notice or which do not require advance notice, e.g., an increase in the benefit amount) until a decision on such initial appeal is issued, unless the individual specifically waives in writing his right to continuation of payment at the previously established level in accordance with paragraph (c) of this section. (See §416.1337 for exceptions to the continuation of payment level.) Where the request for the appropriate appellate review is filed more than 10 days after the notice is received but within the 60-day period specified in §416.1413 or §416.1425 of this part, there shall be no right to continuation or reinstatement of payment at the previously established level unless good cause is established under the criteria specified in §416.1411 of this part for failure to appeal within 10 days after receipt of the notice. For purposes of this paragraph, the date of receipt of the notice of intent to suspend, reduce, or terminate payments shall be presumed to be 5 days after the date on the face of such notice, unless there is a reasonable showing to the contrary.

(c) *Waiver of right to continued payment.* Notwithstanding any other provisions of this section, the recipient, in order to avoid the possibility of an overpayment of benefits, may waive continuation of payment at the previously established level (subject to intervening events which would have increased the benefit for the month in which the incorrect payment was made, in which case the higher amount shall be paid), after having received a full explanation of his rights. The request for waiver of continuation of payment shall be in writing, state that waiver action is being initiated solely at the recipient's request, and state that the recipient understands his right to receive continued payment at the previously established level.

[43 FR 18170, Apr. 28, 1978, as amended at 65 FR 16815, Mar. 30, 2000]

§416.1337 Exceptions to the continuation of previously established payment level.

(a) *Multiple payments exception.* (1) Where it is determined that a recipient is receiving two or more regular monthly payments in one month, the Social Security Administration shall determine the correct payment amount and, as soon as practicable thereafter, send the recipient an advance written notice of intent to make subsequent payment in that amount. Payment for the following month shall be made in the correct amount, except as provided in paragraph (a)(3) of this section.

(2) The advance notice shall explain:

(i) That multiple payments were made in the one or more months identified in the notice;

(ii) The correct amount of monthly benefits that the recipient is eligible to receive; and

(iii) The recipient's appeal rights.

(3) If an appeal is filed within 10 days after receipt of the written notice of intent, the highest of the two or more check amounts, or the correct amount if higher (subject to the dollar limitation provisions), shall be continued until a decision on such initial level of appeal is issued. See §416.1474 for criteria as to good cause for failure to file a timely appeal. For purposes of this paragraph, the date of receipt of the notice of intent shall be presumed to be 5 days after the date on the face of such notice, unless there is a reasonable showing to the contrary.

(4) The fact that a recipient is receiving multiple payments is established if the records of the Social Security Administration show that:

(i) Two or more checks are being sent to an individual under the same name or a common logical spelling variation of the name;

(ii) The social security number is the same or a pseudo number appears;

(iii) The checks are being sent to the same address;

(iv) The sex code for such individual is the same; and

(v) The date of birth for such individual is the same.

(b) *Dollar limitation exception.* (1) Where it is determined that a recipient is receiving an erroneous monthly payment which exceeds the dollar limitation applicable to the recipient's payment category, as set forth in paragraph (b)(4) of this section, the Social Security Administration shall determine the correct payment amount and, as soon as practicable thereafter, send the recipient an advance written notice of intent to make subsequent payment in that amount. Payment for the following month shall be made in the correct amount, except as provided in paragraph (b)(3) of this section.

(2) The advance notice shall explain:

(i) That an erroneous monthly payment which exceeds the dollar limitation applicable to the recipient's payment category was made in the one or more months identified in the notice;

(ii) The correct amount of monthly benefits that the recipient is eligible to receive; and

(iii) The recipient's appeal rights.

(3) If an appeal is filed within 10 days after receipt of the written notice of the intent (see § 416.1474 for criteria as to good cause for failure to file a timely appeal), the amount of payment to be continued, pending decision on appeal, shall be determined as follows:

(i) *Recipient in payment status.* Where the recipient is in payment status, the payment shall be in the amount the recipient received in the month immediately preceding the month the dollar limitation was first exceeded (subject to intervening events which would have increased the benefit for the month in which the incorrect payment was made, in which case the higher amount shall be paid).

(ii) *Recipient in nonpayment status.* If the recipient's benefits were suspended in the month immediately preceding the month the dollar limitation was first exceeded, the payment shall be based on that amount which should have been paid in the month in which the incorrect payment was made. However, if the individual's benefits had been correctly suspended as provided in §§ 416.1320 through 416.1330 or § 416.1339 and they should have remained suspended but a benefit that exceeded the dollar limitation was paid, no further payment shall be made to him or her at this time and notice of the planned action shall not contain any provision regarding continuation of payment pending appeal.

For purposes of this paragraph, the date of receipt of the notice of planned action shall be presumed to be 5 days after the date on the face of such notice, unless there is a reasonable showing to the contrary.

(4) The payment categories and dollar limitations are as follows:

PAYMENT CATEGORY AND DOLLAR LIMITATION

(i) *Federal supplemental security income benefit only*—$200.

Recipients whose records indicate eligibility for Federal supplemental security income benefits for the month before the month the dollar limitation was first exceeded.

(ii) *Federal supplemental security income benefit and optional supplementation, or optional supplementation only*—$700

Recipients whose records indicate they were eligible for Federal supplemental security income benefits plus federally-administered optional supplementation, or eligible for federally-administered optional supplementation only, for the month before the month the dollar limitation was first exceeded.

(iii) *Federal supplemental security income benefit and mandatory or other supplementation, or mandatory supplementation only*—$2,000

Recipients whose records show eligibility for Federal supplemental security income benefits and federally-administered mandatory supplementation or essential person increment for the month before the month the dollar limitation was first exceeded. This category also includes those eligible for federally-administered mandatory supplementation only and those eligible for Federal supplemental security income benefits plus an essential person increment and federally-administered optional supplementation.

[43 FR 18170, Apr. 28, 1978, as amended at 65 FR 40495, June 30, 2000]

§ 416.1338 If you are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services.

(a) *When may your benefits based on disability or blindness be continued?* Your benefits based on disability or blindness may be continued after your impairment is no longer disabling, you are no longer blind as determined under § 416.986(a)(1), (a)(2) or (b), or your disability has ended as determined under § 416.987(b) and (e)(1) in an age-18 redetermination, if—

(1) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in paragraphs (c) and (d) of this section;

(2) You began participating in the program before the date your disability or blindness ended; and

(3) We have determined under paragraph (e) of this section that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability or blindness benefit rolls.

(b) *When will we stop your benefits?* We generally will stop your benefits with the earliest of these months—

(1) The month in which you complete the program; or

(2) The month in which you stop participating in the program for any reason (see paragraph (d) of this section for what we mean by ''participating'' in the program); or

(3) The month in which we determine under paragraph (e) of this section that your continuing participation in the program will no longer increase the likelihood that you will not have to return to the disability or blindness benefit rolls.

Exception to paragraph (b): In no case will we stop your benefits with a month earlier than the second month after the month your disability or blindness ends, provided that you are otherwise eligible for benefits through such month.

(c) *What is an appropriate program of vocational rehabilitation services, employment services, or other support services?* An appropriate program of vocational rehabilitation services, employment services, or other support services means—

(1) A program that is carried out under an individual work plan with an employment network under the Ticket to Work and Self-Sufficiency Program under part 411 of this chapter;

(2) A program that is carried out under an individualized plan for employment with—

(i) A State vocational rehabilitation agency (*i.e.*, a State agency administering or supervising the administration of a State plan approved under title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 720–751)) under 34 CFR part 361; or

(ii) An organization administering a Vocational Rehabilitation Services Project for American Indians with Disabilities authorized under section 121 of part C of title I of the Rehabilitation Act of 1973, as amended (29 U.S.C. 741);

(3) A program of vocational rehabilitation services, employment services, or other support services that is carried out under a similar, individualized written employment plan with—

(i) An agency of the Federal government (for example, the Department of Veterans Affairs);

(ii) A one-stop delivery system or specialized one-stop center described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)); or

(iii) Another provider of services approved by us; providers we may approve include, but are not limited to—

(A) A public or private organizations with expertise in the delivery or coordination of vocational rehabilitation services, employment services, or other support services; or

(B) A public, private or parochial school that provides or coordinates a program of vocational rehabilitation services, employment services, or other support services carried out under an individualized program or plan;

(4) An individualized education program developed under policies and procedures approved by the Secretary of Education for assistance to States for the education of individuals with disabilities under the Individuals with Disabilities Education Act, as amended (20 U.S.C. 1400 *et seq.*); you must be age

18 through age 21 for this provision to apply.

(d) When are you participating in the program? (1) You are participating in a program described in paragraph (c)(1), (c)(2) or (c)(3) of this section when you are taking part in the activities and services outlined in your individual work plan, your individualized plan for employment, or your similar individualized written employment plan, as appropriate.

(2) If you are a student age 18 through 21 receiving services under an individualized education program described in paragraph (c)(4) of this section, you are participating in your program when you are taking part in the activities and services outlined in your program or plan.

(3) You are participating in your program under paragraph (d)(1) or (2) of this section during temporary interruptions in your program. For an interruption to be considered temporary, you must resume taking part in the activities and services outlined in your plan or program, as appropriate, no more than three months after the month the interruption occurred.

(e) *How will we determine whether or not your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability or blindness benefit rolls?* (1) We will determine that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability or blindness benefit rolls if your completion of or your continuation in the program will provide you with—

(i) Work experience (see § 416.965) so that you would more likely be able to do past relevant work (see § 416.960(b)), despite a possible future reduction in your residual functional capacity (see § 416.945); or

(ii) Education (see § 416.964) and/or skilled or semi-skilled work experience (see § 416.968) so that you would more likely be able to adjust to other work that exists in the national economy (see § 416.960(c)), despite a possible future reduction in your residual functional capacity (see § 416.945).

(2) If you are a student age 18 through age 21 participating in an individualized education program described in paragraph (c)(4) of this section, we will find that your completion of or continuation in the program will increase the likelihood that you will not have to return to the disability or blindness benefit rolls.

(3) If you are receiving transition services after having completed an individualized education program as described in paragraph (e)(2) of this section, we will determine that the transition services will increase the likelihood that you will not have to return to the disability benefit rolls if they meet the requirements in paragraph (e)(1) of this section.

[70 FR 36508, June 24, 2005]

§ 416.1339 Suspension due to flight to avoid criminal prosecution or custody or confinement after conviction, or due to violation of probation or parole.

(a) *Basis for suspension.* An individual is ineligible for SSI benefits for any month during which he or she is—

(1) Fleeing to avoid prosecution for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(2) Fleeing to avoid custody or confinement after conviction for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(3) Violating a condition of probation or parole imposed under Federal or State law.

(b) *Suspension effective date.* (1) Suspension of benefit payments because an individual is a fugitive as described in paragraph (a)(1) or (a)(2) of this section or a probation or parole violator as described in paragraph (a)(3) of this section is effective with the first day of whichever of the following months is earlier—

(i) The month in which a warrant or order for the individual's arrest or apprehension, an order requiring the individual's appearance before a court or other appropriate tribunal (e.g., a parole board), or similar order is issued by a court or other duly authorized tribunal on the basis of an appropriate finding that the individual—

(A) Is fleeing, or has fled, to avoid prosecution as described in paragraph (a)(1) of this section;

(B) Is fleeing, or has fled, to avoid custody or confinement after conviction as described in paragraph (a)(2) of this section;

(C) Is violating, or has violated, a condition of his or her probation or parole as described in paragraph (a)(3) of this section; or

(ii) The first month during which the individual fled to avoid such prosecution, fled to avoid such custody or confinement after conviction, or violated a condition of his or her probation or parole, if indicated in such warrant or order, or in a decision by a court or other appropriate tribunal.

(2) An individual will not be considered to be ineligible for SSI benefits and benefit payments will not be suspended under this section for any month prior to August 1996.

(c) *Resumption of payments.* If benefits are otherwise payable, they will be resumed effective with the first month throughout which the individual is determined to be no longer fleeing to avoid such prosecution, fleeing to avoid such custody or confinement after conviction, or violating a condition of his or her probation or parole.

[65 FR 40495, June 30, 2000]

§416.1340 Penalty for making false or misleading statements or withholding information.

(a) *Why would SSA penalize me?* You will be subject to a penalty if:

(1) You make, or cause to be made, a statement or representation of a material fact, for use in determining any initial or continuing right to, or the amount of, monthly insurance benefits under title II or benefits or payments under title XVI, that you know or should know is false or misleading; or

(2) You make a statement or representation of a material fact for use as described in paragraph (a)(1) of this section with knowing disregard for the truth; or

(3) You omit from a statement or representation made for use as described in paragraph (a)(1) of this section, or otherwise withhold disclosure (for example, fail to come forward to notify us) of, a fact which you know or should know is material to the determination of any initial or continuing right to, or the amount of, monthly insurance benefits under title II or benefits or payments under title XVI, if you know, or should know, that the statement or representation with such omission is false or misleading or that the withholding of such disclosure is misleading.

(b) *What is the penalty?* The penalty is ineligibility for cash benefits under title XVI (including State supplementary payments made by SSA according to §416.2005) and nonpayment of any benefits under title II that we would otherwise pay you.

(c) *How long will the penalty last?* The penalty will last—

(1) Six consecutive months the first time we penalize you;

(2) Twelve consecutive months the second time we penalize you; and

(3) Twenty-four consecutive months the third or subsequent time we penalize you.

(d) *Will this penalty affect any of my other government benefits?* If we penalize you, the penalty will apply only to your eligibility for benefits under titles II and XVI (including State supplementary payments made by us according to §416.2005). The penalty will not affect—

(1) Your eligibility for benefits that you would otherwise be eligible for under titles XVIII and XIX but for the imposition of the penalty; and

(2) The eligibility or amount of benefits payable under titles II or XVI to another person. For example, if you and your spouse are receiving title XVI benefits, those benefit payments to your spouse based on the benefit rate for a couple will not be affected because of the penalty. Your spouse will receive one half of the couple rate.

(e) *How will SSA make its decision to penalize me?* In order to impose a penalty on you, we must find that you

knowingly (knew or should have known or acted with knowing disregard for the truth) made a false or misleading statement or omitted or failed to report a material fact if you knew, or should have known, that the omission or failure to disclose was misleading. We will base our decision to penalize you on the evidence and the reasonable inferences that can be drawn from that evidence, not on speculation or suspicion. Our decision to penalize you will be documented with the basis and rationale for that decision. In determining whether you knowingly made a false or misleading statement or omitted or failed to report a material fact so as to justify imposition of the penalty, we will consider all evidence in the record, including any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time. In determining whether you acted knowingly, we will also consider the significance of the false or misleading statement or omission or failure to disclose in terms of its likely impact on your benefits.

(f) *What should I do if I disagree with SSA's initial determination to penalize me?* If you disagree with our initial determination to impose a penalty, you have the right to request reconsideration of the penalty decision as explained in § 416.1407. We will give you a chance to present your case, including the opportunity for a face-to-face conference. If you request reconsideration of our initial determination to penalize you, you have the choice of a case review, informal conference, or formal conference, as described in § 416.1413(a) through (c). If you disagree with our reconsidered determination you have the right to follow the normal administrative and judicial review process by requesting a hearing before an administrative law judge, Appeals Council review and Federal court, review as explained in § 416.1400.

(g) *When will the penalty period begin and end?* Subject to the additional limitations noted in paragraphs (g)(1) and (g)(2) of this section, the penalty period will begin the first day of the month for which you would otherwise receive payment of benefits under title II or title XVI were it not for imposition of the penalty. Once a sanction begins, it will run continuously even if payments are intermittent. If more than one penalty has been imposed, but they have not yet run, the penalties will not run concurrently.

(1) If you do not request reconsideration of our initial determination to penalize you, the penalty period will begin no earlier than the first day of the second month following the month in which the time limit for requesting reconsideration ends. The penalty period will end on the last day of the final month of the penalty period. For example, if the time period for requesting reconsideration ends on January 10, a 6-month period of nonpayment begins on March 1 if you would otherwise be eligible to receive benefits for that month, and ends on August 31.

(2) If you request reconsideration of our initial determination to penalize you and the reconsidered determination does not change our original decision to penalize you, the penalty period will begin no earlier than the first day of the second month following the month we notify you of our reconsidered determination. The penalty period will end on the last day of the final month of the penalty period. For example, if we notify you of our reconsidered determination on August 31, 2001, and you are not otherwise eligible for payment of benefits at that time, but would again be eligible to receive payment of benefits on October 1, 2003, a 6-month period of nonpayment would begin on October 1, 2003 and end on March 31, 2004.

[65 FR 42286, July 10, 2000, as amended at 71 FR 61409, Oct. 18, 2006]

Subpart N—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

AUTHORITY: Secs. 702(a)(5), 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1383, and 1383b); sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

SOURCE: 45 FR 52096, Aug. 5, 1980, unless otherwise noted.

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

§416.1400 Introduction.

(a) *Explanation of the administrative review process.* This subpart explains the procedures we follow in determining your rights under title XVI of the Social Security Act. The regulations describe the process of administrative review and explain your right to judicial review after you have taken all the necessary administrative steps. The administrative review process consists of several steps, which usually must be requested within certain time periods and in the following order:

(1) *Initial determination.* This is a determination we make about your eligibility or your continuing eligibility for benefits or about any other matter, as discussed in §416.1402, that gives you a right to further review.

(2) *Reconsideration.* If you are dissatisfied with an initial determination, you may ask us to reconsider it.

(3) *Hearing before an administrative law judge.* If you are dissatisfied with the reconsideration determination, you may request a hearing before an administrative law judge.

(4) *Appeals Council review.* If you are dissatisfied with the decision of the administrative law judge, you may request that the Appeals Council review the decision.

(5) *Federal court review.* When you have completed the steps of the administrative review process listed in paragraphs (a)(1) through (a)(4) of this section, we will have made our final decision. If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court.

(6) *Expedited appeals process.* At some time after your initial determination has been reviewed, if you have no dispute with our findings of fact and our application and interpretation of the controlling laws, but you believe that a part of the law is unconstitutional, you may use the expedited appeals process. This process permits you to go directly to a Federal district court so that the constitutional issue may be resolved.

(b) *Nature of the administrative review process.* In making a determination or decision in your case, we conduct the administrative review process in an informal, non-adversarial manner. Subject to certain timeframes at the hearing level (see §416.1435) and the limitations on Appeals Council consideration of additional evidence (see §416.1470), we will consider at each step of the review process any information you present as well as all the information in our records. You may present the information yourself or have someone represent you, including an attorney. If you are dissatisfied with our decision in the review process, but do not take the next step within the stated time period, you will lose your right to further administrative review and your right to judicial review, unless you can show us that there was good cause for your failure to make a timely request for review.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 305, Jan. 3, 1986; 52 FR 4004, Feb. 9, 1987; 80 FR 14838, Mar. 20, 2015; 81 FR 90995, Dec. 16, 2016]

§416.1401 Definitions.

As used in this subpart:

Date you receive notice means 5 days after the date on the notice, unless you show us that you did not receive it within the 5-day period.

Decision means the decision made by an administrative law judge or the Appeals Council.

Determination means the initial determination or the reconsidered determination.

Mass change means a State-initiated change in the level(s) of federally administered State supplementary payments applicable to all recipients of such payments, or to categories of such recipients, due, for example, to State legislative or executive action.

Preponderance of the evidence means such relevant evidence that as a whole shows that the existence of the fact to be proven is more likely than not.

Remand means to return a case for further review.

Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.

Vacate means to set aside a previous action.

Waive means to give up a right knowingly and voluntarily.

We, *us*, or *our* refers to the Social Security Administration.

You or *your* refers to any person or the eligible spouse of any person claiming or receiving supplemental security income benefits.

[45 FR 52096, Aug. 5, 1980, as amended at 59 FR 43038, Aug. 22, 1994; 73 FR 76944, Dec. 18, 2008]

§ 416.1402 Administrative actions that are initial determinations.

Initial determinations are the determinations we make that are subject to administrative and judicial review. We will base our initial determination on the preponderance of the evidence. We will state the important facts and give the reasons for our conclusions in the initial determination. Initial determinations regarding supplemental security income benefits include, but are not limited to, determinations about—

(a) Your eligibility for, or the amount of, your supplemental security income benefits or your special SSI cash benefits under § 416.262, except actions solely involving transitions to eligibility between these types of benefits (see §§ 416.1403 (a)(13) and (a)(14)).

(b) Suspension, reduction, or termination of your SSI benefits or special SSI cash benefits (see §§ 416.261 and 416.262) or suspension or termination of your special SSI eligibility status (see §§ 416.264 through 416.269);

(c) Whether an overpayment of benefits must be repaid to us;

(d) Whether the payment of your benefits will be made, on your behalf, to a representative payee;

(e) Who will act as your payee if we determine that representative payment will be made;

(f) Imposing penalties for failing to report important information;

(g) Your drug addiction or alcoholism;

(h) Whether you are eligible for special SSI eligibility status under § 416.265;

(i) Your disability;

(j) Whether your completion of, or continuation for a specified period of time in, an appropriate program of vocational rehabilitation services, employment services, or other support services will increase the likelihood that you will not have to return to the disability or blindness benefit rolls, and thus, whether your benefits may be continued even though you are not disabled or blind;

(k) Whether or not you have a disabling impairment as defined in § 416.911;

(l) How much and to whom benefits due a deceased individual will be paid;

(m) A claim for benefits under § 416.351 based on alleged misinformation;

(n) Our calculation of the amount of change in your federally administered State supplementary payment amount (*i.e.*, a reduction, suspension, or termination) which results from a mass change, as defined in § 416.1401; and

(o) Whether we were negligent in investigating or monitoring or failing to investigate or monitor your representative payee, which resulted in the misuse of benefits by your representative payee.

[45 FR 52096, Aug. 5, 1980, as amended at 47 FR 15325, Apr. 9, 1982; 49 FR 22275, May 29, 1984; 58 FR 52913, Oct. 13, 1993; 59 FR 41405, Aug. 12, 1994; 59 FR 43039, Aug. 22, 1994; 59 FR 44928, Aug. 31, 1994; 60 FR 8153, Feb. 10, 1995; 60 FR 14215, Mar. 15, 1995; 69 FR 60240, Oct. 7, 2004; 70 FR 36509, June 24, 2005; 73 FR 76944, Dec. 18, 2008]

§ 416.1403 Administrative actions that are not initial determinations.

(a) Administrative actions that are not initial determinations may be reviewed by us, but they are not subject to the administrative review process provided by this subpart and they are not subject to judicial review. These actions include, but are not limited to, an action about—

(1) Presumptive disability or presumptive blindness;

(2) An emergency advance payment (as defined in § 416.520(b));

(3) Denial of a request to be made a representative payee;

(4) Denial of a request to use the expedited appeals process;

(5) Denial of a request to reopen a determination or a decision;

(6) The fee that may be charged or received by a person who has represented you in connection with a proceeding before us;

(7) Refusing to recognize, disqualifying, or suspending a person from acting as your representative in a proceeding before us (see §§ 416.1505 and 416.1545);

(8) Denying your request to extend the time period for requesting review of a determination or a decision;

(9) Determining whether (and the amount of) travel expenses incurred are reimbursable in connection with proceedings before us;

(10) Denying your request to readjudicate your claim and apply an Acquiescence Ruling;

(11) Determining whether an organization may collect a fee from you for expenses it incurs in serving as your representative payee (see § 416.640a);

(12) Declining under § 416.351(f) to make a determination on a claim for benefits based on alleged misinformation because one or more of the conditions specified in § 416.351(f) are not met;

(13) Transition to eligibility for special SSI cash benefits (§ 416.262) in a month immediately following a month for which you were eligible for regular SSI benefits;

(14) Transition to eligibility for regular SSI benefits in a month immediately following a month for which you were eligible for special SSI cash benefits (§ 416.262);

(15) The determination to reduce, suspend, or terminate your federally administered State supplementary payments due to a State-initiated mass change, as defined in § 416.1401, in the levels of such payments, except as provided in § 416.1402(n);

(16) Termination of Federal administration of State supplementary payments;

(17) Findings on whether we can collect an overpayment by using the Federal income tax refund offset procedure. (see § 416.583);

(18) Determining whether we will refer information about your overpayment to a consumer reporting agency (see §§ 416.590 and 422.305 of this chapter);

(19) Determining whether we will refer your overpayment to the Department of the Treasury for collection by offset against Federal payments due you (see §§ 416.590 and 422.310 of this chapter);

(20) Determining whether we will order your employer to withhold from your disposable pay to collect an overpayment you received under title XVI of the Social Security Act (see part 422, subpart E, of this chapter);

(21) Determining when provisional benefits are payable, the amount of the provisional benefit payable, and when provisional benefits terminate (see § 416.999c);

(22) Determining whether to select your claim for the quick disability determination process under § 416.1019;

(23) The removal of your claim from the quick disability determination process under § 416.1019;

(24) Starting or discontinuing a continuing disability review;

(25) Issuing a receipt in response to your report of a change in your earned income; and

(26) Determining whether a non-attorney representative is eligible to receive direct fee payment as described in § 416.1517 of this part.

(b) We send some notices of actions that are not initial determinations:

(1) If you receive an emergency advance payment; presumptive disability or presumptive blindness payment, or provisional payment, we will provide a notice explaining the nature and conditions of the payments.

(2) If you receive presumptive disability or presumptive blindness payments, or provisional payments, we shall send you a notice when those payments are exhausted.

(3) If there is a termination of Federal administration of State supplementary payments.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 8809, Mar. 14, 1986; 55 FR 1020, Jan. 11, 1990; 55 FR 4423, Feb. 8, 1990; 57 FR 23058, June 1, 1992; 59 FR 41405, Aug. 12, 1994; 59 FR 43039, Aug. 22, 1994; 59 FR 44928, Aug. 31, 1994; 62 FR 49440, Sept. 22, 1997; 66 FR 67081, Dec. 28, 2001; 68 FR 74184, Dec. 23, 2003; 70 FR 57146, Sept. 30, 2005; 71 FR 16461, Mar. 31, 2006; 71 FR 66859, 66867, Nov. 17, 2006; 72 FR 51178, Sept. 6, 2007; 76 FR 45194, July 28, 2011; 76 FR 80247, Dec. 23, 2011; 80 FR 400, Jan. 6, 2015]

§ 416.1404 Notice of the initial determination.

(a) We will mail a written notice of our initial determination to you at

your last known address. The written notice will explain in simple and clear language what we have determined and the reasons for and the effect of our determination. If our determination involves a determination of disability that is in whole or in part unfavorable to you, our written notice also will contain in understandable language a statement of the case setting forth the evidence on which our determination is based. The notice also will inform you of your right to reconsideration. We will not mail a notice if the beneficiary's entitlement to benefits has ended because of his or her death.

(b) If our initial determination is that we must suspend, reduce or terminate your benefits, the notice will also tell you that you have a right to a reconsideration before the determination takes effect (see § 416.1336).

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 305, Jan. 3, 1986; 72 FR 51179, Sept. 6, 2007]

§ 416.1405 Effect of an initial determination.

An initial determination is binding unless you request a reconsideration within the stated time period, or we revise the initial determination.

[51 FR 305, Jan. 3, 1986]

§ 416.1406 Testing modifications to the disability determination procedures.

(a) *Applicability and scope.* Notwithstanding any other provision in this part or part 422 of this chapter, we are establishing the procedures set out in this section to test modifications to our disability determination process. These modifications will enable us to test, either individually or in one or more combinations, the effect of: having disability claim managers assume primary responsibility for processing an application for SSI payments based on disability; providing persons who have applied for benefits based on disability with the opportunity for an interview with a decisionmaker when the decisionmaker finds that the evidence in the file is insufficient to make a fully favorable determination or requires an initial determination denying the claim; having a single decisionmaker make the initial determination with assistance from medical consultants, where appropriate; and eliminating the reconsideration step in the administrative review process and having a claimant who is dissatisfied with the initial determination request a hearing before an administrative law judge. The model procedures we test will be designed to provide us with information regarding the effect of these procedural modifications and enable us to decide whether and to what degree the disability determination process would be improved if they were implemented on a national level.

(b) *Procedures for cases included in the tests.* Prior to commencing each test or group of tests in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe which model or combinations of models we intend to test, where the specific test site(s) will be, and the duration of the test(s). The individuals who participate in the test(s) will be randomly assigned to a test group in each site where the tests are conducted. Paragraph (b) (1) through (4) of this section lists descriptions of each model.

(1) In the disability claim manager model, when you file an application for SSI payments based on disability, a disability claim manager will assume primary responsibility for the processing of your claim. The disability claim manager will be the focal point for your contacts with us during the claims intake process and until an initial determination on your claim is made. The disability claim manager will explain the SSI disability program to you, including the definition of disability and how we determine whether you meet all the requirements for SSI payments based on disability. The disability claim manager will explain what you will be asked to do throughout the claims process and how you can obtain information or assistance through him or her. The disability claim manager will also provide you with information regarding your right to representation, and he or she will provide you with appropriate referral sources for representation. The disability claim manager may be either a State agency employee or a Federal employee. In some instances, the disability claim manager may be assisted by other individuals.

(2) In the single decisionmaker model, the decisionmaker will make the disability determination and may also determine whether the other conditions of eligibility for SSI payments based on disability are met. The decisionmaker will make the disability determination after any appropriate consultation with a medical or psychological consultant. The medical or psychological consultant will not be required to sign the disability determination forms we use to have the State agency certify the determination of disability to us (see §416.1015). However, before an initial determination is made in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see §416.1017). Similarly, in making an initial determination with respect to the disability of a child under age 18 claiming SSI payments based on disability, the decisionmaker will make reasonable efforts to ensure that a qualified pediatrician, or other individual who specializes in a field of medicine appropriate to the child's impairment(s), evaluates the claim of such child (see §416.903(f)). In some instances the decisionmaker may be the disability claim manager described in paragraph (b)(1) of this section. When the decisionmaker is a State agency employee, a team of individuals that includes a Federal employee will determine whether the other conditions of eligibility for SSI payments are met.

(3) In the predecision interview model, if the decisionmaker(s) finds that the evidence in your file is insufficient to make a fully favorable determination or requires an initial determination denying your claim, a predecision notice will be mailed to you. The notice will tell you that, before the decisionmaker(s) makes an initial determination about whether you are disabled, you may request a predecision interview with the decisionmaker(s). The notice will also tell you that you may also submit additional evidence. You must request a predecision interview within 10 days after the date you receive the predecision notice. You must also submit any additional evidence within 10 days after the date you receive the predecision notice. If you request a predecision interview, the decisionmaker(s) will conduct the predecision interview in person, by videoconference, or by telephone as the decisionmaker(s) determines is appropriate under the circumstances. If you make a late request for a predecision interview, or submit additional evidence late, but show in writing that you had good cause under the standards in §416.1411 for missing the deadline, the decisionmaker(s) will extend the deadline. If you do not request the predecision interview or if you do not appear for a scheduled predecision interview and do not submit additional evidence, or if you do not respond to our attempts to communicate with you, the decisionmaker(s) will make an initial determination based upon the evidence in your file. If you identify additional evidence during the predecision interview, which was previously not available, the decisionmaker(s) will advise you to submit the evidence. If you are unable to do so, the decisionmaker(s) may assist you in obtaining it. The decisionmaker(s) also will advise you of the specific timeframes you have for submitting any additional evidence identified during the predecision interview. If you have no treating source(s) (see §416.902), or your treating source(s) is unable or unwilling to provide the necessary evidence, or there is a conflict in the evidence that cannot be resolved through evidence from your treating source(s), the decisionmaker(s) may arrange a consultative examination or resolve conflicts according to existing procedures (see §416.919a). If you attend the predecision interview, or do not attend the predecision interview but you submit additional evidence, the decisionmaker(s) will make an initial determination based on the evidence in your file, including the additional evidence you submit or the evidence obtained as a result of the predecision notice or interview, or both.

(4) In the reconsideration elimination model, we will modify the disability determination process by eliminating the reconsideration step of the administrative review process. If you receive an initial determination on your claim for SSI payments based on disability, and you are dissatisfied with the determination, we will notify you that you may request a hearing before an administrative law judge.

[60 FR 20028, Apr. 24, 1995, as amended at 73 FR 2416, Jan. 15, 2008; 76 FR 24812, May 3, 2011; 82 FR 5883, Jan. 18, 2017]

RECONSIDERATION

§ 416.1407 Reconsideration—general.

Reconsideration is the first step in the administrative review process that we provide if you are dissatisfied with the initial determination. If you are dissatisfied with our reconsideration determination, you may request a hearing before an administrative law judge.

[51 FR 305, Jan. 3, 1986]

§ 416.1408 Parties to a reconsideration.

(a) *Who may request a reconsideration.* If you are dissatisfied with the initial determination, you may request that we reconsider it. In addition, a person who shows in writing that his or her rights may be adversely affected by the initial determination may request a reconsideration.

(b) *Who are parties to a reconsideration.* After a request for the reconsideration, you and any person who shows in writing that his or her rights are adversely affected by the initial determination will be parties to the reconsideration.

§ 416.1409 How to request reconsideration.

(a) We shall reconsider an initial determination if you or any other party to the reconsideration files a written request at one of our offices within 60 days after the date you receive notice of the initial determination (or within the extended time period if we extend the time as provided in paragraph (b) of this section).

(b) *Extension of time to request a reconsideration.* If you want a reconsideration of the initial determination but do not request one in time, you may ask us for more time to request a reconsideration. Your request for an extension of time must be in writing and it must give the reasons why the request for reconsideration was not filed within the stated time period. If you show us that you had good cause for missing the deadline, we will extend the time period. To determine whether good cause exists, we use the standards explained in § 416.1411.

§ 416.1411 Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you have good cause for missing a deadline to request review we consider—

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeals Council review or filed a civil suit.

(6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.

(7) You did not receive notice of the initial determination or decision.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.

[45 FR 52096, Aug. 5, 1980, as amended at 59 FR 1637, Jan. 12, 1994]

§ 416.1413 Reconsideration procedures.

If you request reconsideration, we will give you a chance to present your case. How you can present your case depends upon the issue involved and whether you are asking us to reconsider an initial determination on an application or an initial determination on a suspension, reduction or termination of benefits. The methods of reconsideration include the following:

(a) *Case review.* We will give you and the other parties to the reconsideration an opportunity to review the evidence in our files and then to present oral and written evidence to us. We will then make a decision based on all of this evidence. The official who reviews the case will make the reconsidered determination.

(b) *Informal conference.* In addition to following the procedures of a case review, an informal conference allows you and the other parties to the reconsideration an opportunity to present witnesses. A summary record of this proceeding will become part of the case record. The official who conducts the informal conference will make the reconsidered determination.

(c) *Formal conference.* In addition to following the procedures of an informal conference, a formal conference allows you and the other parties to a reconsideration an opportunity to request us to subpoena adverse witnesses and relevant documents and to cross-examine adverse witnesses. A summary record of this proceeding will become a part of the case record. The official who conducts the formal conference will make the reconsidered determination.

(d) *Disability hearing.* If you have been receiving supplemental security income benefits because you are blind or disabled and you request reconsideration of an initial or revised determination that, based on medical factors, you are not now blind or disabled, we will give you and the other parties to the reconsideration an opportunity for a disability hearing. (See §§ 416.1414 through 416.1418.)

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 305, Jan. 3, 1986]

§ 416.1413a Reconsiderations of initial determinations on applications.

The method of reconsideration we will use when you appeal an initial determination on your application for benefits depends on the issue involved in your case.

(a) *Nonmedical issues.* If you challenge our finding on a nonmedical issue, we shall offer you a case review or an informal conference, and will reach our reconsidered determination on the basis of the review you select.

(b) *Medical issues.* If you challenge our finding on a medical issue (even if you received payments because we presumed you were blind or disabled), we shall reach our reconsidered determination on the basis of a case review.

[45 FR 52096, Aug. 5, 1980. Redesignated at 51 FR 305, Jan. 3, 1986]

§ 416.1413b Reconsideration procedures for post-eligibility claims.

If you are eligible for supplemental security income benefits and we notify you that we are going to suspend, reduce or terminate your benefits, you can appeal our determination within 60 days of the date you receive our notice. The 60-day period may be extended if you have good cause for an extension of time under the conditions stated in § 416.1411(b). If you appeal a suspension, reduction, or termination of benefits, the method of reconsideration we will use depends on the issue in your case. If the issue in your case is that you are no longer blind or disabled for medical

reasons, you will receive an opportunity for a disability hearing. If any other issue is involved, you have the choice of a case review, informal conference or formal conference.

[51 FR 305, Jan. 3, 1986]

§ 416.1413c Arrangement for conferences.

(a) As soon as we receive a request for a formal or informal conference, we shall set the time, date and place for the conference.

(b) We shall send you and any other parties to the reconsideration a written notice about the conference (either by mailing it to your last known address or by personally serving you with it) at least 10 days before the conference. However, we may hold the conference sooner if we all agree. We will not send written notice of the time, date, and place of the conference if you waive your right to receive it.

(c) We shall schedule the conference within 15 days after you request it, but, at our discretion or at your request, we will delay the conference if we think the delay will ensure that the conference is conducted efficiently and properly.

(d) We shall hold the conference at one of our offices, by telephone or in person, whichever you prefer. We will hold the conference elsewhere in person if you show circumstances that make this arrangement reasonably necessary.

[45 FR 52096, Aug. 5, 1980. Redesignated at 51 FR 305, Jan. 3, 1986]

§ 416.1414 Disability hearing—general.

(a) *Availability*. We will provide you with an opportunity for a disability hearing if:

(1) You have been receiving supplemental security income benefits based on a medical impairment that renders you blind or disabled;

(2) We have made an initial or revised determination based on medical factors that you are not blind or disabled because your impairment:

(i) Has ceased;

(ii) Did not exist; or

(iii) Is no longer disabling; and

(3) You make a timely request for reconsideration of the initial or revised determination.

(b) *Scope*. The disability hearing will address only the initial or revised determination, based on medical factors, that you are not now blind or disabled. Any other issues you raise in connection with your request for reconsideration will be reviewed in accordance with the reconsideration procedures described in § 416.1413 (a) through (c).

(c) *Time and place*—(1) *General*. Either the State agency or the Associate Commissioner for Disability Determinations or his or her delegate, as appropriate, will set the time and place of your disability hearing. We will send you a notice of the time and place of your disability hearing at least 20 days before the date of the hearing. You may be expected to travel to your disability hearing. (See §§ 416.1495–416.1499 regarding reimbursement for travel expenses.)

(2) *Change of time or place*. If you are unable to travel or have some other reason why you cannot attend your disability hearing at the scheduled time or place, you should request at the earliest possible date that the time or place of your hearing be changed. We will change the time or place if there is good cause for doing so under the standards in § 416.1436 (c) and (d).

(d) *Combined issues*. If a disability hearing is available to you under paragraph (a) of this section, and you file a new application for benefits while your request for reconsideration is still pending, we may combine the issues on both claims for the purpose of the disability hearing and issue a combined initial/reconsidered determination which is binding with respect to the common issues on both claims.

(e) *Definition*. For purposes of the provisions regarding disability hearings (§§ 416.1414 through 416.1418) *we, us,* or *our* means the Social Security Administration or the State agency.

[51 FR 305, Jan. 3, 1986, as amended at 51 FR 8809, Mar. 14, 1986; 71 FR 10432, Mar. 1, 2006]

§ 416.1415 Disability hearing—disability hearing officers.

(a) *General*. Your disability hearing will be conducted by a disability hearing officer who was not involved in

making the determination you are appealing. The disability hearing officer will be an experienced disability examiner, regardless of whether he or she is appointed by a State agency or by the Associate Commissioner for Disability Determinations or his or her delegate, as described in paragraphs (b) and (c) of this section.

(b) *State agency hearing officers*—(1) *Appointment of State agency hearing officers.* If a State agency made the initial or revised determination that you are appealing, the disability hearing officer who conducts your disability hearing may be appointed by a State agency. If the disability hearing officer is appointed by a State agency, that individual will be employed by an adjudicatory unit of the State agency other than the adjudicatory unit which made the determination you are appealing.

(2) *State agency defined.* For purposes of this subpart, *State agency* means the adjudicatory component in the State which issues disability determinations.

(c) *Federal hearing officers.* The disability hearing officer who conducts your disability hearing will be appointed by the Associate Commissioner for Disability Determinations or his or her delegate if:

(1) A component of our office other than a State agency made the determination you are appealing; or

(2) The State agency does not appoint a disability hearing officer to conduct your disability hearing under paragraph (b) of this section.

[51 FR 305, Jan. 3, 1986, as amended at 71 FR 10432, Mar. 1, 2006]

§416.1416 Disability hearing—procedures.

(a) *General.* The disability hearing will enable you to introduce evidence and present your views to a disability hearing officer if you are dissatisfied with an initial or revised determination, based on medical factors, that you are not now blind or disabled, as described in §416.1414(a)(2).

(b) *Your procedural rights.* We will advise you that you have the following procedural rights in connection with the disability hearing process:

(1) You may request that we assist you in obtaining pertinent evidence for your disability hearing and, if necessary, that we issue a subpoena to compel the production of certain evidence or testimony. We will follow subpoena procedures similar to those described in §416.1450(d) for the administrative law judge hearing process;

(2) You may have a representative at the hearing appointed under subpart O of this part, or you may represent yourself;

(3) You or your representative may review the evidence in your case file, either on the date of your hearing or at an earlier time at your request, and present additional evidence;

(4) You may present witnesses and question any witnesses at the hearing; and

(5) You may waive your right to appear at the hearing. If you do not appear at the hearing, the disability hearing officer will prepare and issue a written reconsidered determination based on the information in your case file.

(c) *Case preparation.* After you request reconsideration, your case file will be reviewed and prepared for the hearing. This review will be conducted in the component of our office (including a State agency) that made the initial or revised determination, by personnel who were not involved in making the initial or revised determination. Any new evidence you submit in connection with your request for reconsideration will be included in this review. If necessary, further development of evidence, including arrangements for medical examinations, will be undertaken by this component. After the case file is prepared for the hearing, it will be forwarded by this component to the disability hearing officer for a hearing. If necessary, the case file may be sent back to this component at any time prior to the issuance of the reconsidered determination for additional development. Under paragraph (d) of this section, this component has the authority to issue a favorable reconsidered determination at any time in its development process.

(d) *Favorable reconsidered determination without a hearing.* If the evidence in your case file supports a finding that you are now blind or disabled, either the component that prepares your case

for hearing under paragraph (c) or the disability hearing officer will issue a written favorable reconsidered determination, even if a disability hearing has not yet been held.

(e) *Opportunity to submit additional evidence after the hearing.* At your request, the disability hearing officer may allow up to 15 days after your disability hearing for receipt of evidence which is not available at the hearing, if:

(1) The disability hearing officer determines that the evidence has a direct bearing on the outcome of the hearing; and

(2) The evidence could not have been obtained before the hearing.

(f) *Opportunity to review and comment on evidence obtained or developed by us after the hearing.* If, for any reason, additional evidence is obtained or developed by us after your disability hearing, and all evidence taken together can be used to support a reconsidered determination that is unfavorable to you with regard to the medical factors of eligibility, we will notify you, in writing, and give you an opportunity to review and comment on the additional evidence. You will be given 10 days from the date you receive our notice to submit your comments (in writing or, in appropriate cases, by telephone), unless there is good cause for granting you additional time, as illustrated by the examples in § 416.1411(b). Your comments will be considered before a reconsidered determination is issued. If you believe that it is necessary to have further opportunity for a hearing with respect to the additional evidence, a supplementary hearing may be scheduled at your request. Otherwise, we will ask for your written comments on the additional evidence, or, in appropriate cases, for your telephone comments.

[51 FR 306, Jan. 3, 1986]

§ 416.1417 Disability hearing—disability hearing officer's reconsidered determination.

(a) *General.* The disability hearing officer who conducts your disability hearing will prepare and will issue a written reconsidered determination, unless:

(1) The disability hearing officer sends the case back for additional development by the component that prepared the case for the hearing, and that component issues a favorable determination, as permitted by § 416.1416(c);

(2) It is determined that you are engaging in substantial gainful activity and that you are therefore not disabled; or

(3) The reconsidered determination prepared by the disability hearing officer is reviewed under § 416.1418.

(b) *Content.* The disability hearing officer's reconsidered determination will give the findings of fact and the reasons for the reconsidered determination. The disability hearing officer must base the reconsidered determination on the preponderance of the evidence offered at the disability hearing or otherwise included in your case file.

(c) *Notice.* We will mail you and the other parties a notice of reconsidered determination in accordance with § 416.1422.

(d) *Effect.* The disability hearing officer's reconsidered determination, or, if it is changed under § 416.1418, the reconsidered determination that is issued by the Associate Commissioner for Disability Determinations or his or her delegate, is binding in accordance with § 416.1421, subject to the exceptions specified in that section.

[51 FR 306, Jan. 3, 1986, as amended at 71 FR 10432, Mar. 1, 2006; 73 FR 76944, Dec. 18, 2008]

§ 416.1418 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.

(a) *General.* The Associate Commissioner for Disability Determinations or his or her delegate may select a sample of disability hearing officers' reconsidered determinations, before they are issued, and review any such case to determine its correctness on any grounds he or she deems appropriate. The Associate Commissioner or his or her delegate shall review any case within the sample if:

(1) There appears to be an abuse of discretion by the hearing officer;

(2) There is an error of law; or

(3) The action, findings or conclusions of the disability hearing officer

are not supported by substantial evidence.

NOTE TO PARAGRAPH (a): If the review indicates that the reconsidered determination prepared by the disability hearing officer is correct, it will be dated and issued immediately upon completion of the review. If the reconsidered determination prepared by the disability hearing officer is found by the Associate Commissioner or his or her delegate to be deficient, it will be changed as described in paragraph (b) of this section.

(b) *Methods of correcting deficiencies in the disability hearing officer's reconsidered determination.* If the reconsidered determination prepared by the disability hearing officer is found by the Associate Commissioner for Disability Determinations or his or her delegate to be deficient, the Associate Commissioner or his or her delegate will take appropriate action to assure that the deficiency is corrected before a reconsidered determination is issued. The action taken by the Associate Commissioner or his or her delegate will take one of two forms:

(1) The Associate Commissioner or his or her delegate may return the case file either to the component responsible for preparing the case for hearing or to the disability hearing officer, for appropriate further action; or

(2) The Associate Commissioner or his or her delegate may issue a written reconsidered determination which corrects the deficiency.

(c) *Further action on your case if it is sent back by the Associate Commissioner for Disability Determinations or his or her delegate either to the component that prepared your case for hearing or to the disability hearing officer.* If the Associate Commissioner for Disability Determinations or his or her delegate sends your case back either to the component responsible for preparing the case for hearing or to the disability hearing officer for appropriate further action, as provided in paragraph (b)(1) of this section, any additional proceedings in your case will be governed by the disability hearing procedures described in § 416.1416(f) or if your case is returned to the disability hearing officer and an unfavorable determination is indicated, a supplementary hearing may be scheduled for you before a reconsidered determination is reached in your case.

(d) *Opportunity to comment before the Associate Commissioner for Disability Determinations or his or her delegate issues a reconsidered determination that is unfavorable to you.* If the Associate Commissioner for Disability Determinations or his or her delegate proposes to issue a reconsidered determination as described in paragraph (b)(2) of this section, and that reconsidered determination is unfavorable to you, he or she will send you a copy of the proposed reconsidered determination with an explanation of the reasons for it, and will give you an opportunity to submit written comments before it is issued. At your request, you will also be given an opportunity to inspect the pertinent materials in your case file, including the reconsidered determination prepared by the disability hearing officer, before submitting your comments. You will be given 10 days from the date you receive the Associate Commissioner's notice of proposed action to submit your written comments, unless additional time is necessary to provide access to the pertinent file materials or there is good cause for providing more time, as illustrated by the examples in § 416.1411(b). The Associate Commissioner or his or her delegate will consider your comments before taking any further action on your case.

[71 FR 10432, Mar. 1, 2006]

§ 416.1419 Notice of another person's request for reconsideration.

If any other person files a request for reconsideration of the initial determination in your case, we shall notify you at your last known address before we reconsider the initial determination. We shall also give you an opportunity to present any evidence you think helpful to the reconsidered determination.

[45 FR 52096, Aug. 5, 1980. Redesignated at 51 FR 306, Jan. 3, 1986]

§ 416.1420 Reconsidered determination.

After you or another person requests a reconsideration, we will review the evidence we considered in making the initial determination and any other evidence we receive. We will make our

determination based on the preponderance of the evidence. The person who makes the reconsidered determination will have had no prior involvement with the initial determination.

[73 FR 76945, Dec. 18, 2008]

§ 416.1421 Effect of a reconsidered determination.

The reconsidered determination is binding unless—

(a) You or any other party to the reconsideration requests a hearing before an administrative law judge within the stated time period and a decision is made;

(b) The expedited appeals process is used; or

(c) The reconsidered determination is revised.

[51 FR 307, Jan. 3, 1986]

§ 416.1422 Notice of a reconsidered determination.

We shall mail a written notice of the reconsidered determination to the parties at their last known address. We shall state the specific reasons for the determination and tell you and any other parties of the right to a hearing. If it is appropriate, we will also tell you and any other parties how to use the expedited appeals process.

[45 FR 52096, Aug. 5, 1980. Redesignated at 51 FR 306, Jan. 3, 1986]

EXPEDITED APPEALS PROCESS

§ 416.1423 Expedited appeals process—general.

By using the expedited appeals process you may go directly to a Federal district court without first completing the administrative review process that is generally required before the court will hear your case.

§ 416.1424 When the expedited appeals process may be used.

You may use the expedited appeals process if all of the following requirements are met:

(a) We have made an initial and a reconsidered determination; an administrative law judge has made a hearing decision; or Appeals Council review has been requested, but a final decision has not been issued.

(b) You are a party to the reconsidered determination or the hearing decision.

(c) You have submitted a written request for the expedited appeals process.

(d) You have claimed, and we agree, that the only factor preventing a favorable determination or decision is a provision in the law that you believe is unconstitutional.

(e) If you are not the only party, all parties to the determination or decision agree to request the expedited appeals process.

§ 416.1425 How to request expedited appeals process.

(a) *Time of filing request.* You may request the expedited appeals process—

(1) Within 60 days after the date you receive notice of the reconsidered determination (or within the extended time period if we extend the time as provided in paragraph (c) of this section);

(2) At any time after you have filed a timely request for a hearing but before you receive notice of the administrative law judge's decision;

(3) Within 60 days after the date you receive a notice of the administrative law judge's decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (c) of this section); or

(4) At any time after you have filed a timely request for Appeals Council review, but before you receive notice of the Appeals Council's action.

(b) *Place of filing request.* You may file a written request for the expedited appeals process at one of our offices.

(c) *Extension of time to request expedited appeals process.* If you want to use the expedited appeals process but do not request it within the stated time period, you may ask for more time to submit your request. Your request for an extension of time must be in writing and it must give the reasons why the request for the expedited appeals process was not filed within the stated time period. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 416.1411.

§ 416.1426 Agreement in expedited appeals process.

If you meet all the requirements necessary for the use of the expedited appeals process, our authorized representative shall prepare an agreement. The agreement must be signed by you, by every other party to the determination or decision, and by our authorized representative. The agreement must provide that—

(a) The facts in your claim are not in dispute;

(b) The sole issue in dispute is whether a provision of the Act that applies to your case is unconstitutional;

(c) Except for your belief that a provision of the Act is unconstitutional, you agree with our interpretation of the law;

(d) If the provision of the Act that you believe is unconstitutional were not applied to your case, your claim would be allowed; and

(e) Our determination or the decision is final for the purpose of seeking judicial review.

§ 416.1427 Effect of expedited appeals process agreement.

After an expedited appeals process agreement is signed, you will not need to complete the remaining steps of the administrative review process. Instead, you may file an action in a Federal district court within 60 days after the date you receive notice (a signed copy of the agreement will be mailed to you and will constitute notice) that the agreement has been signed by our authorized representative.

[45 FR 52096, Aug. 5, 1980, as amended at 49 FR 46370, Nov. 26, 1984]

§ 416.1428 Expedited appeals process request that does not result in agreement.

If you do not meet all of the requirements necessary to use the expedited appeals process, we shall tell you that your request to use this process is denied and that your request will be considered as a request for a hearing, or Appeals Council review, whichever is appropriate.

Hearing Before an Administrative Law Judge

§ 416.1429 Hearing before an administrative law judge—general.

If you are dissatisfied with one of the determinations or decisions listed in § 416.1430, you may request a hearing. Subject to § 416.1456, the Deputy Commissioner for Hearings Operations, or their delegate, will appoint an administrative law judge to conduct the hearing. If circumstances warrant, the Deputy Commissioner for Hearings Operations, or their delegate, may assign your case to another administrative law judge. We will schedule you to appear by audio, agency video, online video, or in person as set forth in § 416.1436. Audio means telephone or similar audio-based technology in a private location you choose. Agency video means video, with audio functionality, using our equipment in one of our offices. Online video means video, with audio functionality, using a personal electronic device in a private location you choose. When we determine your manner of appearance, we consider the factors described in § 416.1436 (c)(1)(i) through (ii). You may submit new evidence (subject to the provisions of § 416.1435), examine the evidence used in making the determination or decision under review, and present and question witnesses. The administrative law judge who conducts the hearing may ask you questions. The administrative law judge will issue a decision based on the preponderance of the evidence in the hearing record. If you waive your right to appear at the hearing, the administrative law judge will make a decision based on the preponderance of the evidence that is in the file and, subject to the provisions of § 416.1435, any new evidence that may have been submitted for consideration.

[89 FR 68362, Aug. 26, 2024]

§ 416.1430 Availability of a hearing before an administrative law judge.

(a) You or another party may request a hearing before an administrative law judge if we have made—

(1) A reconsidered determination;

(2) A reconsideration of a revised determination of an initial or reconsidered determination that involves a suspension, reduction or termination of benefits;

(3) A revised initial determination or revised reconsidered determination that does not involve a suspension, reduction or termination of benefits; or

(4) A revised decision based on evidence not included in the record on which the prior decision was based.

(b) We will hold a hearing only if you or another party to the hearing file a written request for a hearing.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986; 73 FR 2416, Jan. 15, 2008; 76 FR 24812, May 3, 2011]

§ 416.1432 Parties to a hearing before an administrative law judge.

(a) *Who may request a hearing.* You may request a hearing if a hearing is available under § 416.1430. In addition, a person who shows in writing that his or her rights may be adversely affected by the decision may request a hearing.

(b) *Who are parties to a hearing.* After a request for a hearing is made, you, the other parties to the initial, reconsidered, or revised determination, and any other person who shows in writing that his or her rights may be adversely affected by the hearing, are parties to the hearing. In addition, any other person may be made a party to the hearing if his or her rights may be adversely affected by the decision, and we notify the person to appear at the hearing or to present evidence supporting his or her interest.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986; 75 FR 39160, July 8, 2010]

§ 416.1433 How to request a hearing before an administrative law judge.

(a) *Written request.* You may request a hearing by filing a written request. You should include in your request—

(1) Your name and social security number;

(2) The name and social security number of your spouse, if any;

(3) The reasons you disagree with the previous determination or decision;

(4) A statement of additional evidence to be submitted and the date you will submit it; and

(5) The name and address of any designated representative.

(b) *When and where to file.* The request must be filed at one of our offices within 60 days after the date you receive notice of the previous determination or decision (or within the extended time period if we extend the time as provided in paragraph (c) of this section).

(c) *Extension of time to request a hearing.* If you have a right to a hearing but do not request one in time, you may ask for more time to make your request. The request for an extension of time must be in writing and it must give the reasons why the request for a hearing was not filed within the stated time period. You may file your request for an extension of time at one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 416.1411.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1435 Submitting written evidence to an administrative law judge.

(a) When you submit your request for hearing, you should also submit information or evidence as required by § 416.912 or any summary of the evidence to the administrative law judge. Each party must make every effort to ensure that the administrative law judge receives all of the evidence and must inform us about or submit any written evidence, as required in § 416.912, no later than 5 business days before the date of the scheduled hearing. If you do not comply with this requirement, the administrative law judge may decline to consider or obtain the evidence unless the circumstances described in paragraph (b) of this section apply.

(b) If you have evidence required under § 416.912 but you have missed the deadline described in paragraph (a) of this section, the administrative law judge will accept the evidence if he or she has not yet issued a decision and you did not inform us about or submit the evidence before the deadline because:

(1) Our action misled you;

(2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier; or

(3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:

(i) You were seriously ill, and your illness prevented you from contacting us in person, in writing, or through a friend, relative, or other person;

(ii) There was a death or serious illness in your immediate family;

(iii) Important records were destroyed or damaged by fire or other accidental cause; or

(iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing.

(c) *Claims Not Based on an Application For Benefits.* Notwithstanding the requirements in paragraphs (a)–(b) of this section, for claims that are not based on an application for benefits, the evidentiary requirement to inform us about or submit evidence no later than 5 business days before the date of the scheduled hearing will not apply if our other regulations allow you to submit evidence after the date of an administrative law judge decision.

[81 FR 90994, Dec. 16, 2016

§416.1436 Time, place, and manner of appearance for a hearing before an administrative law judge.

(a) *General.* We set the time and manner(s) of appearance for any hearing. We will set the place of a hearing when we schedule you and any other parties to the hearing to appear in person or by agency video. We may change the time, manner(s) of appearance, or place, if it is necessary. After sending you reasonable notice of the proposed action, the administrative law judge may adjourn or postpone the hearing or reopen it to receive additional evidence any time before the administrative law judge notifies you of a hearing decision.

(b) *Place of hearing.* If we set the place of the hearing, it can be in the 50 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands. The ''place'' of the hearing is the hearing office or other site(s) at which you and any other parties to the hearing are located when you make your appearance(s) before the administrative law judge by agency video or in person. A party to a hearing may only appear from the geographic areas, noted in this subsection, in which we hold hearings.

(c) *Determining manner of appearance to schedule.* We will schedule you or any other party to the hearing to appear by audio, agency video, online video, or in person. We may schedule you to appear by online video only if you agree to appear in that manner.

(1) When we determine your manner of appearance at the hearing, we consider the following factors:

(i) Which manner of appearance would be the most efficient for conducting the hearing; and

(ii) Any facts in your particular case that provide a good reason to schedule your appearance by audio, agency video, online video, or in person.

(2) We will generally direct any person we call as a witness, other than you or any other party to the hearing, to appear by audio, by agency video, or by online video. Witnesses include medical experts and vocational experts. Witnesses you call will appear at the hearing pursuant to §416.1450(e). If they are unable to appear with you in the same manner as you, we will generally direct them to appear by agency video or by audio. We will consider directing witnesses to appear in person only when:

(i) A witness is unable to appear by other available manners of appearance;

(ii) We determine that an alternate manner of appearance would be less efficient than conducting the appearance in person; or

(iii) We find that there are facts in your particular case that provide a good reason to schedule this individual's appearance in person.

(3) We follow the procedures set forth in §416.1437 to ensure the safety of the public and our employees in our hearing process.

(d) *Objecting to appearing by audio, by agency video, or both.* Prior to scheduling your hearing, we will notify you that we may schedule you to appear by audio or by agency video, or, if you agree, by online video. If you object to appearing by audio, by agency video, or both, you must notify us in writing within 30 days after the date you receive the notice. If you only object to appearing by audio, we may schedule you to appear in person, by agency video, or, if you agree, by online video. Similarly, if you only object to appearing by agency video, we may schedule you to appear in person, by audio, or, if you agree, by online video. If you object to appearing by both audio and agency video, and your residence does not change while your request for hearing is pending, we will schedule you to appear before the administrative law judge in person or, if you agree, by online video.

(1) If you notify us that you object to appearing by audio, by agency video, or both, more than 30 days after the date you receive our notice, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 416.1411.

(2) Notwithstanding any objections you may have to appearing by audio and subject to paragraph (d)(3) of this section, we will schedule you or any other party to the hearing to appear by audio when we cannot schedule you to appear by agency video or by online video and extraordinary circumstances prevent you from appearing in person. For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(3) Notwithstanding any objections you may have to appearing by audio, if you are incarcerated and an appearance by agency video and online video is not available, we will schedule you to appear by audio, unless we find that there are facts in your particular case that provide a good reason to schedule you to appear in person, if allowed by the place of confinement, or by agency video, online video, or in person upon your release. For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(4) Notwithstanding any objections you may have to appearing by audio, by agency video, or both, if you change your residence while your request for hearing is pending, we will determine how you will appear, including by audio or by agency video, as provided in paragraph (c) of this section. For us to consider your change of residence when we schedule your hearing, you must submit evidence verifying your new residence. For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(5) Notwithstanding any objection you may have to appearing by audio, we will schedule you or any other party to the hearing to appear by audio in the circumstances provided in § 416.1437(b)(2)(ii) and (c). For audio appearances under this subsection, we will call you or any other party to the hearing using your or their telephone number(s).

(e) *Time period to agree to an appearance by online video.* Prior to scheduling your hearing, we will notify you that we may schedule you to appear by online video if you agree to appear in that manner. To agree to appear by online video, you must notify us in writing within 30 days after the date you receive the notice. If you notify us that you agree to appearing by online video more than 30 days after the date you receive our notice, we will extend the time period if you show you had good cause for missing the deadline. To determine whether good cause exists for extending the deadline, we use the standards explained in § 416.1411. You may withdraw your agreement any time before the start of your hearing.

(f) *Objecting to the time or place of the hearing.* (1) If you wish to object to the time or place of the hearing, you must:

(i) Notify us in writing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or 30 days after receiving notice of the hearing, whichever is earlier; and

(ii) State the reason(s) for your objection and state the time or place you want the hearing to be held. If the administrative law judge finds you have

good cause, as determined under paragraph (e) of this section, we will change the time or place of the hearing.

(2) If you notify us that you object to the time or place of hearing less than 5 days before the date set for the hearing or, if earlier, more than 30 days after receiving notice of the hearing, we will consider this objection only if you show you had good cause for missing the deadline. To determine whether good cause exists for missing this deadline, we use the standards explained in § 416.1411.

(g) *Good cause for changing the time or place.* The administrative law judge will determine whether good cause exists for changing the time or place of your scheduled hearing. If the administrative law judge finds that good cause exists, we will set the time or place of the new hearing. A finding that good cause exists to reschedule the time or place of your hearing will generally not change the assignment of the administrative law judge or how you or another party will appear at the hearing, unless we determine a change will promote efficiency in our hearing process.

(1) The administrative law judge will find good cause to change the time or place of your hearing if he or she determines that, based on the evidence:

(i) A serious physical or mental condition or incapacitating injury makes it impossible for you or your representative to travel to the hearing, or a death in the family occurs; or

(ii) Severe weather conditions make it impossible for you or your representative to travel to the hearing.

(2) In determining whether good cause exists in circumstances other than those set out in paragraph (f)(1) of this section, the administrative law judge will consider your reason(s) for requesting the change, the facts supporting it, and the impact of the proposed change on the efficient administration of the hearing process. Factors affecting the impact of the change include, but are not limited to, the effect on the processing of other scheduled hearings, delays that might occur in rescheduling your hearing, and whether we previously granted you any changes in the time or place of your hearing. Examples of such other circumstances that you might give for requesting a change in the time or place of the hearing include, but are not limited to, the following:

(i) You unsuccessfully attempted to obtain a representative and need additional time to secure representation;

(ii) Your representative was appointed within 30 days of the scheduled hearing and needs additional time to prepare for the hearing;

(iii) Your representative has a prior commitment to be in court or at another administrative hearing on the date scheduled for the hearing;

(iv) A witness who will testify to facts material to your case would be unavailable to attend the scheduled hearing and the evidence cannot be otherwise obtained;

(v) Transportation is not readily available for you to travel to the hearing; or

(vi) You are unrepresented, and you are unable to respond to the notice of hearing because of any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

[84 FR 69307, Dec. 18, 2019, as amended at 89 FR 68362, Aug. 26, 2024]

§ 416.1437 Protecting the safety of the public and our employees in our hearing process.

(a) Notwithstanding any other provision in this part or part 422 of this chapter, we are establishing the procedures set out in this section to ensure the safety of the public and our employees in our hearing process.

(b)(1) At the request of any hearing office employee, the Hearing Office Chief Administrative Law Judge will determine, after consultation with the presiding administrative law judge, whether a claimant or other individual poses a reasonable threat to the safety of our employees or other participants in the hearing. The Hearing Office Chief Administrative Law Judge will find that a claimant or other individual poses a threat to the safety of our employees or other participants in the hearing when he or she determines that the individual has made a threat and there is a reasonable likelihood that the claimant or other individual

could act on the threat or when evidence suggests that a claimant or other individual poses a threat. In making a finding under this paragraph, the Hearing Office Chief Administrative Law Judge will consider all relevant evidence, including any information we have in the claimant's record and any information we have regarding the claimant's or other individual's past conduct.

(2) If the Hearing Office Chief Administrative Law Judge determines that the claimant or other individual poses a reasonable threat to the safety of our employees or other participants in the hearing, the Hearing Office Chief Administrative Law Judge will either:

(i) Require the presence of a security guard at the hearing; or

(ii) Require that the hearing be conducted by audio, notwithstanding any objection to appearing by audio, or, if the claimant agrees, by online video.

(c) If we have banned a claimant from any of our facilities, we will provide the claimant with the opportunity for a hearing that will be conducted by audio, notwithstanding any objection to appearing by audio, or, if the claimant agrees, by online video.

(d) The actions of the Hearing Office Chief Administrative Law Judge taken under this section are final and not subject to further review.

(e) For audio appearances under this section, we will call you or any other party to the hearing using your or their telephone number(s).

[76 FR 13508, Mar. 14, 2011, as amended at 77 FR 10658, Feb. 23, 2012; 89 FR 68363, Aug. 26, 2024]

§ 416.1438 Notice of a hearing before an administrative law judge.

(a) *Issuing the notice.* After we set the time and place of the hearing, we will mail notice of the hearing to you at your last known address, or give the notice to you by personal service, unless you have indicated in writing that you do not wish to receive this notice. We will mail or serve the notice at least 75 days before the date of the hearing.

(b) *Notice information.* The notice of hearing will tell you:

(1) The specific issues to be decided in your case;

(2) That you may designate a person to represent you during the proceedings;

(3) How to request that we change the time or place of your hearing;

(4) That your hearing may be dismissed if neither you nor the person you designate to act as your representative appears at your scheduled hearing without good reason under § 416.1457;

(5) The time and manner(s) in which you, or any other party or witness, will appear. If we schedule you to appear in person or by agency video, as set forth in § 416.1436, the notice of hearing will tell you the place of the hearing.

(6) That you must make every effort to inform us about or submit all written evidence that is not already in the record no later than 5 business days before the date of the scheduled hearing, unless you show that your circumstances meet the conditions described in § 416.1435(b); and

(7) Any other information about the scheduling and conduct of your hearing.

(c) *Acknowledging the notice of hearing.* The notice of hearing will ask you to return a form to let us know that you received the notice. If you or your representative do not acknowledge receipt of the notice of hearing, we will attempt to contact you for an explanation. If you tell us that you did not receive the notice of hearing, an amended notice will be sent to you by certified mail.

(d) *Amended notice of hearing or notice of supplemental hearing.* If we need to send you an amended notice of hearing, we will mail or serve the notice at least 20 days before the date of the hearing. Similarly, if we schedule a supplemental hearing, after the initial hearing was continued by the assigned administrative law judge, we will mail or serve a notice of hearing at least 20 days before the date of the hearing.

[68 FR 5220, Feb. 3, 2003, as amended at 75 FR 39161, July 8, 2010; 78 FR 29628, May 21, 2013; 79 FR 35934, June 25, 2014; 81 FR 90995, Dec. 16, 2016; 84 FR 69308, Dec. 18, 2019; 89 FR 68363, Aug. 26, 2024]

§ 416.1439 Objections to the issues.

If you object to the issues to be decided at the hearing, you must notify

the administrative law judge in writing at the earliest possible opportunity, but no later than 5 business days before the date set for the hearing, unless you show that your circumstances meet the conditions described in §416.1435(b). You must state the reason(s) for your objection(s). The administrative law judge will make a decision on your objection(s) either at the hearing or in writing before the hearing.

[81 FR 90995, Dec. 16, 2016

§416.1440 Disqualification of the administrative law judge.

An administrative law judge shall not conduct a hearing if he or she is prejudiced or partial with respect to any party or has any interest in the matter pending for decision. If you object to the administrative law judge who will conduct the hearing, you must notify the administrative law judge at your earliest opportunity. The administrative law judge shall consider your objections and shall decide whether to proceed with the hearing or withdraw. If he or she withdraws, the Associate Commissioner for Hearings and Appeals, or his or her delegate, will appoint another administrative law judge to conduct the hearing. If the administrative law judge does not withdraw, you may, after the hearing, present your objections to the Appeals Council as reasons why the hearing decision should be revised or a new hearing held before another administrative law judge.

§416.1441 Prehearing case review.

(a) *General.* After a hearing is requested but before it is held, we may, for the purposes of a prehearing case review, forward the case to the component of our office (including a State agency) that issued the determination being reviewed. That component will decide whether it should revise the determination based on the preponderance of the evidence. A revised determination may be fully or partially favorable to you. A prehearing case review will not delay the scheduling of a hearing unless you agree to continue the review and delay the hearing. If the prehearing case review is not completed before the date of the hearing, the case will be sent to the administrative law judge unless a favorable revised determination is in process or you and the other parties to the hearing agree in writing to delay the hearing until the review is completed.

(b) *When a prehearing case review may be conducted.* We may conduct a prehearing case review if—

(1) Additional evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulation; or

(4) There is an error in the file or some other indication that the prior determination may be revised.

(c) *Notice of a prehearing revised determination.* If we revise the determination in a prehearing case review, we will mail a written notice of the revised determination to all parties at their last known addresses. We will state the basis for the revised determination and advise all parties of the effect of the revised determination on the request for a hearing.

(d) *Effect of a fully favorable revised determination.* If the revised determination is fully favorable to you, we will tell you in the notice that an administrative law judge will dismiss the request for a hearing. We will also tell you that you or another party to the hearing may request that the administrative law judge vacate the dismissal and reinstate the request for a hearing if you or another party to the hearing disagrees with the revised determination for any reason. If you wish to make this request, you must do so in writing and send it to us within 60 days of the date you receive notice of the dismissal. If the request is timely, an administrative law judge will vacate the dismissal, reinstate the request for a hearing, and offer you and all parties an opportunity for a hearing. The administrative law judge will extend the time limit if you show that you had good cause for missing the deadline. The administrative law judge will use the standards in §416.1411 to determine whether you had good cause.

(e) *Effect of a partially favorable revised determination.* If the revised determination is partially favorable to you, we will tell you in the notice what was not favorable. We will also tell you that an administrative law judge will

hold the hearing you requested unless you and all other parties to the hearing agree in writing to dismiss the request for a hearing. An administrative law judge will dismiss the request for a hearing if we receive the written statement(s) agreeing to dismiss the request for a hearing before an administrative law judge mails a notice of his or her hearing decision.

[45 FR 52096, Aug. 5, 1980, as amended at 73 FR 76945, Dec. 18, 2008; 75 FR 33169, June 11, 2010; 76 FR 65370, Oct. 21, 2011]

§ 416.1442 Prehearing proceedings and decisions by attorney advisors.

(a) *General.* After a hearing is requested but before it is held, an attorney advisor may conduct prehearing proceedings as set out in paragraph (c) of this section. If after the completion of these proceedings we can make a decision that is fully favorable to you and all other parties based on the preponderance of the evidence, an attorney advisor, instead of an administrative law judge, may issue the decision. The conduct of the prehearing proceedings by the attorney advisor will not delay the scheduling of a hearing. If the prehearing proceedings are not completed before the date of the hearing, the case will be sent to the administrative law judge unless a fully favorable decision is in process or you and all other parties to the hearing agree in writing to delay the hearing until the proceedings are completed.

(b) *When prehearing proceedings may be conducted by an attorney advisor.* An attorney advisor may conduct prehearing proceedings if you have filed a claim for SSI benefits based on disability and—

(1) New and material evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulations; or

(4) There is an error in the file or some other indication that a fully favorable decision may be issued.

(c) *Nature of the prehearing proceedings that may be conducted by an attorney advisor.* As part of the prehearing proceedings, the attorney advisor, in addition to reviewing the existing record, may—

(1) Request additional evidence that may be relevant to the claim, including medical evidence; and

(2) If necessary to clarify the record for the purpose of determining if a fully favorable decision is warranted, schedule a conference with the parties.

(d) *Notice of a decision by an attorney advisor.* If an attorney advisor issues a fully favorable decision under this section, we will mail a written notice of the decision to all parties at their last known addresses. We will state the basis for the decision and advise all parties that they may request that an administrative law judge reinstate the request for a hearing if they disagree with the decision for any reason. Any party who wants to make this request must do so in writing and send it to us within 60 days of the date he or she receives notice of the decision. The administrative law judge will extend the time limit if the requestor shows good cause for missing the deadline. The administrative law judge will use the standards in § 416.1411 to determine whether there is good cause. If the request is timely, an administrative law judge will reinstate the request for a hearing and offer all parties an opportunity for a hearing.

(e) *Effect of an attorney advisor's decision.* An attorney advisor's decision under this section is binding unless—

(1) You or another party to the hearing submits a timely request that an administrative law judge reinstate the request for a hearing under paragraph (d) of this section;

(2) The Appeals Council reviews the decision on its own motion pursuant to § 416.1469 as explained in paragraph (f)(3) of this section; or

(3) The decision of the attorney advisor is revised under the procedures explained in § 416.1487.

(f) *Ancillary provisions.* For the purposes of the procedures authorized by this section, the regulations of part 416 shall apply to—

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§ 416.913a, 416.920a, 416.926, and 416.946.

(2) Define the term ''decision'' to include a decision made by an attorney advisor, as well as the decisions identified in § 416.1401; and

(3) Make the decision of an attorney advisor under paragraph (d) of this section subject to review by the Appeals Council if the Appeals Council decides to review the decision of the attorney advisor anytime within 60 days after the date of the decision under §416.1469.

[60 FR 34132, June 30, 1995, as amended at 63 FR 35516, June 30, 1998; 64 FR 13678, Mar. 22, 1999; 64 FR 51894, Sept. 27, 1999; 65 FR 16815, Mar. 30, 2000; 72 FR 44765, Aug. 9, 2007; 73 FR 76945, Dec. 18, 2008; 74 FR 33328, July 13, 2009; 76 FR 18384, Apr. 4, 2011; 76 FR 65371, Oct. 21, 2011; 78 FR 45460, July 29, 2013; 80 FR 31991, June 5, 2015; 82 FR 5884, Jan. 18, 2017; 83 FR 712, Jan. 8, 2018; 83 FR 28993, June 22, 2018; 83 FR 40453, Aug. 15, 2018]

§416.1443 Responsibilities of the adjudication officer.

(a)(1) *General.* Under the procedures set out in this section we will test modifications to the procedures we follow when you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether you are under a disability as defined in §§416.905 and 416.906 is at issue. These modifications will enable us to test the effect of having an adjudication officer be your primary point of contact after you file a hearing request and before you have a hearing with an administrative law judge. The tests may be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under §416.1406. The adjudication officer, working with you and your representative, if any, will identify issues in dispute, develop evidence, conduct informal conferences, and conduct any other prehearing proceeding as may be necessary. The adjudication officer has the authority to make a decision fully favorable to you if the evidence so warrants. If the adjudication officer does not make a decision on your claim, your hearing request will be assigned to an administrative law judge for further proceedings.

(2) *Procedures for cases included in the tests.* Prior to commencing tests of the adjudication officer position in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe where the specific test site(s) will be and the duration of the test(s). We will also state whether the tests of the adjudication officer position in each site will be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under §416.1406. The individuals who participate in the test(s) will be assigned randomly to a test group in each site where the tests are conducted.

(b)(1) *Prehearing procedures conducted by an Adjudication Officer.* When you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether you are under a disability as defined in §§416.905 and 416.906 is at issue, the adjudication officer will conduct an interview with you. The interview may take place in person, by telephone, or by videoconference, as the adjudication officer determines is appropriate under the circumstances of your case. If you file a request for an extension of time to request a hearing in accordance with §416.1433(c), the adjudication officer may develop information on, and may decide where the adjudication officer issues a fully favorable decision to you that you had good cause for missing the deadline for requesting a hearing. To determine whether you had good cause for missing the deadline, the adjudication officer will use the standards contained in §416.1411.

(2) *Representation.* The adjudication officer will provide you with information regarding the hearing process, including your right to representation. As may be appropriate, the adjudication officer will provide you with referral sources for representation, and give you copies of necessary documents to facilitate the appointment of a representative. If you have a representative, the adjudication officer will conduct an informal conference with the representative, in person or by telephone, to identify the issues in dispute and prepare proposed written agreements for the approval of the administrative law judge regarding those issues which are not in dispute and those issues proposed for the hearing. If you decide to proceed without representation, the adjudication officer may hold an informal conference with

you. If you obtain representation after the adjudication officer has concluded that your case is ready for a hearing, the administrative law judge will return your case to the adjudication officer who will conduct an informal conference with you and your representative.

(3) *Evidence.* You, or your representative, may submit, or may be asked to obtain and submit, additional evidence to the adjudication officer. As the adjudication officer determines is appropriate under the circumstances of your case, the adjudication officer may refer the claim for further medical or vocational evidence.

(4) *Referral for a hearing.* The adjudication officer will refer the claim to the administrative law judge for further proceedings when the development of evidence is complete, and you or your representative agree that a hearing is ready to be held. If you or your representative are unable to agree with the adjudication officer that the development of evidence is complete, the adjudication officer will note your disagreement and refer the claim to the administrative law judge for further proceedings. At this point, the administrative law judge conducts all further hearing proceedings, including scheduling and holding a hearing, (§ 416.1436), considering any additional evidence or arguments submitted (§§ 416.1435, 416.1444, 416.1449, 416.1450), and issuing a decision or dismissal of your request for a hearing, as may be appropriate (§§ 416.1448, 416.1453, 416.1457). In addition, if the administrative law judge determines on or before the date of your hearing that the development of evidence is not complete, the administrative law judge may return the claim to the adjudication officer to complete the development of the evidence and for such other action as necessary.

(c)(1) *Fully favorable decisions issued by an adjudication officer.* If, after a hearing is requested but before it is held, the adjudication officer decides that the evidence in your case warrants a decision which is fully favorable to you, the adjudication officer may issue such a decision. For purposes of the tests authorized under this section, the adjudication officer's decision shall be considered to be a decision as defined in § 416.1401. If the adjudication officer issues a decision under this section, it will be in writing and will give the findings of fact and the reasons for the decision. The adjudication officer will evaluate the issues relevant to determining whether or not you are disabled in accordance with the provisions of the Social Security Act, the rules in this part and part 422 of this chapter and applicable Social Security Rulings. For cases in which the adjudication officer issues a decision, he or she may determine your residual functional capacity in the same manner that an administrative law judge is authorized to do so in § 416.946. The adjudication officer may also evaluate the severity of your mental impairments in the same manner that an administrative law judge is authorized to do so under § 416.920a. The adjudication officer's decision will be based on the evidence which is included in the record and, subject to paragraph (c)(2) of this section, will complete the actions that will be taken on your request for hearing. A copy of the decision will be mailed to all parties at their last known address. We will tell you in the notice that the administrative law judge will not hold a hearing unless a party to the hearing requests that the hearing proceed. A request to proceed with the hearing must be made in writing within 30 days after the date the notice of the decision of the adjudication officer is mailed.

(2) *Effect of a decision by an adjudication officer.* A decision by an adjudication officer which is fully favorable to you under this section, and notification thereof, completes the administrative action on your request for hearing and is binding on all parties to the hearing and not subject to further review, unless—

(i) You or another party requests that the hearing continue, as provided in paragraph (c)(1) of this section;

(ii) The Appeals Council decides to review the decision on its own motion under the authority provided in § 416.1469;

(iii) The decision is revised under the procedures explained in §§ 416.1487 through 416.1489; or

(iv) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 416.1484.

(3) *Fee for a representative's services.* The adjudication officer may authorize a fee for your representative's services if the adjudication officer makes a decision on your claim that is fully favorable to you, and you are represented. The actions of, and any fee authorization made by, the adjudication officer with respect to representation will be made in accordance with the provisions of subpart O of this part.

(d) *Who may be an adjudication officer.* The adjudication officer described in this section may be an employee of the Social Security Administration or a State agency that makes disability determinations for us.

[60 FR 47476, Sept. 13, 1995, as amended at 75 FR 33169, June 11, 2010]

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

§ 416.1444 Administrative law judge hearing procedures—general.

A hearing is open to the parties and to other persons the administrative law judge considers necessary and proper. At the hearing, the administrative law judge looks fully into the issues, questions you and the other witnesses, and, subject to the provisions of § 416.1435, accepts as evidence any documents that are material to the issues; may stop the hearing temporarily and continue it at a later date if the administrative law judge finds that there is material evidence missing at the hearing or one or more variables outside of our control, such as audio quality or video quality, materially affects the hearing; and may reopen the hearing at any time before the administrative law judge mails a notice of the decision in order to receive new and material evidence. For purposes of this section, materially affects means prevents the hearing from proceeding. The administrative law judge may decide when the evidence will be presented and when the issues will be discussed.

[89 FR 68363, Aug. 26, 2024]

§ 416.1446 Issues before an administrative law judge.

(a) *General.* The issues before the administrative law judge include all the issues brought out in the initial, reconsidered or revised determination that were not decided entirely in your favor. However, if evidence presented before or during the hearing causes the administrative law judge to question a fully favorable determination, he or she will notify you and will consider it an issue at the hearing.

(b) *New issues*—(1) *General.* The administrative law judge may consider a new issue at the hearing if he or she notifies you and all the parties about the new issue any time after receiving the hearing request and before mailing notice of the hearing decision. The administrative law judge or any party may raise a new issue; an issue may be raised even though it arose after the request for a hearing and even though it has not been considered in an initial or reconsidered determination. However, it may not be raised if it involves a claim that is within the jurisdiction of a State agency under a Federal-State agreement concerning the determination of disability.

(2) *Notice of a new issue.* The administrative law judge shall notify you and any other party if he or she will consider any new issue. Notice of the time and place of the hearing on any new issues will be given in the manner described in § 416.1438, unless you have indicated in writing that you do not wish to receive the notice.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986]

§ 416.1448 Deciding a case without an oral hearing before an administrative law judge.

(a) *Decision fully favorable.* If the evidence in the hearing record supports a finding in favor of you and all the parties on every issue, the administrative law judge may issue a hearing decision based on a preponderance of the evidence without holding an oral hearing. The notice of the decision will state that you have the right to an oral hearing and to examine the evidence on which the administrative law judge based the decision.

(b) *Parties do not wish to appear.* (1) The administrative law judge may decide a case on the record and not conduct an oral hearing if—

(i) You and all the parties indicate in writing that you do not wish to appear before the administrative law judge at an oral hearing; or

(ii) You live outside the United States, you do not inform us that you wish to appear, and there are no other parties who wish to appear.

(2) When an oral hearing is not held, the administrative law judge shall make a record of the material evidence. The record will include the applications, written statements, certificates, reports, affidavits, and other documents which were used in making the determination under review and any additional evidence you or any other party to the hearing present in writing. The decision of the administrative law judge must be based on this record.

(c) *Case remanded for a revised determination.* (1) The administrative law judge may remand a case to the appropriate component of our office for a revised determination if there is reason to believe that the revised determination would be fully favorable to you. This could happen if the administrative law judge receives new and material evidence or if there is a change in the law that permits the favorable determination.

(2) Unless you request the remand the administrative law judge shall notify you that your case has been remanded and tell you that if you object, you must notify him or her of your objections within 10 days of the date the case is remanded or we will assume that you agree to the remand. If you object to the remand, the administrative law judge will consider the objection and rule on it in writing.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986; 73 FR 76945, Dec. 18, 2008; 75 FR 33169, June 11, 2010; 76 FR 65371, Oct. 21, 2011]

§ 416.1449 Presenting written statements and oral arguments.

You or a person you designate to act as your representative may appear before the administrative law judge to state your case, present a written summary of your case, or enter written statements about the facts and law material to your case in the record. If presenting written statements prior to hearing, you must provide a copy of your written statements for each party no later than 5 business days before the date set for the hearing, unless you show that your circumstances meet the conditions described in § 416.1435(b).

[81 FR 90996, Dec. 16, 2016]

§ 416.1450 Presenting evidence at a hearing before an administrative law judge.

(a) *The right to appear and present evidence.* Any party to a hearing has a right to appear before the administrative law judge, in the manner set forth in § 416.1436, to present evidence and to state their position. A party may also make their appearance by means of a designated representative, who may make their appearance in the manner set forth in § 416.1436.

(b) *Waiver of the right to appear.* You may send the administrative law judge a waiver or a written statement indicating that you do not wish to appear at the hearing. You may withdraw this waiver any time before a notice of the hearing decision is mailed to you. Even if all of the parties waive their right to appear at a hearing, we may notify them of a time and a place for an oral hearing, if the administrative law judge believes that a personal appearance and testimony by you or any other party is necessary to decide the case.

(c) *Admissible evidence.* Subject to the provisions of § 416.1435, the administrative law judge may receive any evidence at the hearing that he or she believes is material to the issues, even though the evidence would not be admissible in court under the rules of evidence used by the court.

(d) *Subpoenas.* (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.

(2) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the administrative law judge or at one of our offices at least 10 business days before the hearing date, unless you show that your circumstances meet the conditions described in § 416.1435(b). The written request must give the names of the witnesses or documents to be produced; describe the address or location of the witnesses or documents with sufficient detail to find them; state the important facts that the witness or document is expected to prove; and indicate why these facts could not be proven without issuing a subpoena.

(3) We will pay the cost of issuing the subpoena.

(4) We will pay subpoenaed witnesses the same fees and mileage they would receive if they had been subpoenaed by a Federal district court.

(e) *Witnesses at a hearing.* Witnesses you call may appear at a hearing with you in the same manner in which you are scheduled to appear. If they are unable to appear with you in the same manner as you, they may appear as prescribed in § 416.1436(c)(2). Witnesses called by the administrative law judge will appear in the manner prescribed in § 416.1436(c)(2). They will testify under oath or affirmation unless the administrative law judge finds an important reason to excuse them from taking an oath or affirmation. The administrative law judge may ask the witness any questions material to the issues and will allow the parties or their designated representatives to do so.

(f) *Collateral estoppel—issues previously decided.* An issue at your hearing may be a fact that has already been decided in one of our previous determinations or decisions in a claim involving the same parties, but arising under a different title of the Act or under the Federal Coal Mine Health and Safety Act. If this happens, the administrative law judge will not consider the issue again, but will accept the factual finding made in the previous determination or decision unless there are reasons to believe that it was wrong.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 307, Jan. 3, 1986; 68 FR 5221, Feb. 3, 2003; 75 FR 39161, July 8, 2010; 78 FR 29628, May 21, 2013; 81 FR 90996, Dec. 16, 2016; 84 FR 69308, Dec. 18, 2019; 89 FR 68364, Aug. 26, 2024]

§ 416.1451 Official record.

(a) *Hearing recording.* All hearings will be recorded. The hearing recording will be prepared as a typed copy of the proceedings if—

(1) The case is sent to the Appeals Council without a decision or with a recommended decision by the administrative law judge;

(2) You seek judicial review of your case by filing an action in a Federal district court within the stated time period, unless we request the court to remand the case; or

(3) An administrative law judge or the Appeals Council asks for a written record of the proceedings.

(b) *Contents of the official record.* All evidence upon which the administrative law judge relies for the decision must be contained in the record, either directly or by appropriate reference. The official record will include the applications, written statements, certificates, reports, affidavits, medical records, and other documents that were used in making the decision under review and any additional evidence or written statements that the administrative law judge admits into the record under §§ 416.1429 and 416.1435. All exhibits introduced as evidence must be marked for identification and incorporated into the record. The official record of your claim will contain all of the marked exhibits and a verbatim recording of all testimony offered at the hearing. It also will include any prior initial determinations or decisions on your claim.

[81 FR 90996, Dec. 16, 2016

§ 416.1452 Consolidated hearings before an administrative law judge.

(a) *General.* (1) A consolidated hearing may be held if—

(i) You have requested a hearing to decide your eligibility for supplemental security income benefits and you have also requested a hearing to

decide your rights under another law we administer; and

(ii) One or more of the issues to be considered at the hearing you requested are the same issues that are involved in another claim you have pending before us.

(2) If the administrative law judge decides to hold the hearing on both claims, he or she decides both claims, even if we have not yet made an initial or reconsidered determination on the other claim.

(b) *Record, evidence, and decision.* There will be a single record at a consolidated hearing. This means that the evidence introduced in one case becomes evidence in the other(s). The administrative law judge may make either a separate or consolidated decision.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1453 The decision of an administrative law judge.

(a) *General.* The administrative law judge shall issue a written decision which gives the findings of fact and the reasons for the decision. The administrative law judge must base the decision on the preponderance of the evidence offered at the hearing or otherwise included in the record. The administrative law judge shall mail a copy of the decision to all the parties at their last known address. The Appeals Council may also receive a copy of the decision.

(b) *Fully favorable oral decision entered into the record at the hearing.* The administrative law judge may enter a fully favorable oral decision based on the preponderance of the evidence into the record of the hearing proceedings. If the administrative law judge enters a fully favorable oral decision into the record of the hearing proceedings, the administrative law judge may issue a written decision that incorporates the oral decision by reference. The administrative law judge may use this procedure only in those categories of cases that we identify in advance. The administrative law judge may only use this procedure in those cases where the administrative law judge determines that no changes are required in the findings of fact or the reasons for the decision as stated at the hearing. If a fully favorable decision is entered into the record at the hearing, the administrative law judge will also include in the record, as an exhibit entered into the record at the hearing, a document that sets forth the key data, findings of fact, and narrative rationale for the decision. If the decision incorporates by reference the findings and the reasons stated in an oral decision at the hearing, the parties shall also be provided, upon written request, a record of the oral decision.

(c) *Time for the administrative law judge's decision.* (1) The administrative law judge must issue the hearing decision no later than 90 days after the request for hearing is filed, unless—

(i) The matter to be decided is whether you are disabled; or

(ii) There is good cause for extending the time period because of unavoidable circumstances.

(2) Good cause for extending the time period may be found under the following circumstances:

(i) *Delay caused by you or by your representative's action.* The time period for decision in this instance may be extended by the total number of days of the delays. The delays include delays in submitting evidence, briefs, or other statements, postponements or adjournments made at your request, and any other delays caused by you or your representative.

(ii) *Other delays.* The time period for decision may be extended where delays occur through no fault of the Commissioner. In this instance, the decision will be issued as soon as practicable.

(d) *Recommended decision.* Although an administrative law judge will usually make a decision, the administrative law judge may send the case to the Appeals Council with a recommended decision based on a preponderance of the evidence when appropriate. The administrative law judge will mail a copy of the recommended decision to the parties at their last known addresses and send the recommended decision to the Appeals Council.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986; 54 FR 37793, Sept. 13, 1989; 62 FR 38455, July 18, 1997; 69 FR 61597, Oct. 20, 2004; 73 FR 76945, Dec. 18, 2008; 75 FR 33169, June 11, 2010]

§ 416.1455 The effect of a hearing decision.

The decision of the administrative law judge is binding on all parties to the hearing unless—

(a) You or another party request a review of the decision by the Appeals Council within the stated time period, and the Appeals Council reviews your case;

(b) You or another party requests a review of the decision by the Appeals Council within the stated time period, the Appeals Council denies your request for review, and you seek judicial review of your case by filing an action in a Federal district court;

(c) The Appeals Council decides on its own motion to review the decision under the procedures in § 416.1469;

(d) The decision is revised by an administrative law judge or the Appeals Council under the procedures explained in § 416.1487;

(e) The expedited appeals process is used;

(f) The decision is a recommended decision directed to the Appeals Council; or

(g) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 416.1484.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986; 54 FR 37793, Sept. 13, 1989; 85 FR 73159, Nov. 16, 2020]

§ 416.1456 Removal of a hearing request(s) to the Appeals Council.

(a) *Removal.* The Appeals Council may assume responsibility for a hearing request(s) pending at the hearing level of the administrative review process.

(b) *Notice.* We will mail a notice to all parties at their last known address telling them that the Appeals Council has assumed responsibility for the case(s).

(c) *Procedures applied.* If the Appeals Council assumes responsibility for a hearing request(s), it shall conduct all proceedings in accordance with the rules set forth in §§ 416.1429 through 416.1461, as applicable.

(d) *Appeals Council review.* If the Appeals Council assumes responsibility for your hearing request under this section and you or any other party is dissatisfied with the hearing decision or with the dismissal of a hearing request, you may request that the Appeals Council review that action following the procedures in §§ 416.1467 through 416.1482. The Appeals Council may also decide on its own motion to review the action that was taken in your case under § 416.1469. The administrative appeals judge who conducted a hearing, issued a hearing decision in your case, or dismissed your hearing request will not participate in any action associated with your request for Appeals Council review of that case.

(e) *Ancillary provisions.* For the purposes of the procedures authorized by this section, the regulations of part 416 shall apply to authorize a member of the Appeals Council to exercise the functions performed by an administrative law judge under subpart N of part 416.

[85 FR 73159, Nov. 16, 2020]

§ 416.1457 Dismissal of a request for a hearing before an administrative law judge.

An administrative law judge may dismiss a request for a hearing under any of the following conditions:

(a) At any time before notice of the hearing decision is mailed, you or the party or parties that requested the hearing ask to withdraw the request. This request may be submitted in writing to the administrative law judge or made orally at the hearing.

(b)(1)(i) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and you have been notified before the time set for the hearing that your request for a hearing may be dismissed without further notice if you did not appear at the time and place of hearing, and good cause has not been found by the administrative law judge for your failure to appear; or

(ii) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and within 10 days after the administrative law judge mails you a notice asking why you did not appear, you do not give a good reason for the failure to appear.

(2) In determining good cause or good reason under this paragraph, we will

consider any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

(c) The administrative law judge decides that there is cause to dismiss a hearing request entirely or to refuse to consider any one or more of the issues because—

(1) The doctrine of *res judicata* applies in that we have made a previous determination or decision under this subpart about your rights on the same facts and on the same issue or issues, and this previous determination or decision has become final by either administrative or judicial action;

(2) The person requesting a hearing has no right to it under § 416.1430;

(3) You did not request a hearing within the stated time period and we have not extended the time for requesting a hearing under § 416.1433(c); or

(4) You die, there are no other parties, and we have no information to show that you may have a survivor who may be paid benefits due to you under § 416.542(b) and who wishes to pursue the request for hearing, or that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act. The administrative law judge, however, will vacate a dismissal of the hearing request if, within 60 days after the date of the dismissal:

(i) A person claiming to be your survivor, who may be paid benefits due to you under § 416.542(b), submits a written request for a hearing, and shows that a decision on the issues that were to be considered at the hearing may adversely affect him or her; or

(ii) We receive information showing that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act.

[45 FR 52096, Aug. 5, 1980, as amended at 50 FR 21439, May 24, 1985; 51 FR 308, Jan. 3, 1986; 58 FR 52913, Oct. 13, 1993; 59 FR 1637, Jan. 12, 1994]

§ 416.1458 Notice of dismissal of a request for a hearing before an administrative law judge.

We shall mail a written notice of the dismissal of the hearing request to all parties at their last known address. The notice will state that there is a right to request that the Appeals Council vacate the dismissal action.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1459 Effect of dismissal of a request for a hearing before an administrative law judge.

The dismissal of a request for a hearing is binding, unless it is vacated by an administrative law judge or the Appeals Council.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1460 Vacating a dismissal of a request for a hearing before an administrative law judge.

(a) Except as provided in paragraph (b) of this section, an administrative law judge or the Appeals Council may vacate a dismissal of a request for a hearing if you request that we vacate the dismissal. If you or another party wish to make this request, you must do so within 60 days of the date you receive notice of the dismissal, and you must state why our dismissal of your request for a hearing was erroneous. The administrative law judge or Appeals Council will inform you in writing of the action taken on your request. The Appeals Council may also vacate a dismissal of a request for a hearing on its own motion. If the Appeals Council decides to vacate a dismissal on its own motion, it will do so within 60 days of the date we mail the notice of dismissal and will inform you in writing that it vacated the dismissal.

(b) If you wish to proceed with a hearing after you received a fully favorable revised determination under the prehearing case review process in § 416.1441, you must follow the procedures in § 416.1441(d) to request that an administrative law judge vacate his or her order dismissing your request for a hearing.

[76 FR 65371, Oct. 21, 2011]

§ 416.1461 Prehearing and posthearing conferences.

The administrative law judge may decide on his or her own, or at the request of any party to the hearing, to

hold a prehearing or posthearing conference to facilitate the hearing or the hearing decision. The administrative law judge shall tell the parties of the time, place and purpose of the conference at least seven days before the conference date, unless the parties have indicated in writing that they do not wish to receive a written notice of the conference. At the conference, the administrative law judge may consider matters in addition to those stated in the notice, if the parties consent in writing. A record of the conference will be made. The administrative law judge shall issue an order stating all agreements and actions resulting from the conference. If the parties do not object, the agreements and actions become part of the hearing record and are binding on all parties.

§ 416.1465 [Reserved]

APPEALS COUNCIL REVIEW

§ 416.1466 [Reserved]

§ 416.1467 Appeals Council review—general.

If you or any other party is dissatisfied with the hearing decision or with the dismissal of a hearing request, you may request that the Appeals Council review that action. The Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or remand the case to an administrative law judge. The Appeals Council shall notify the parties at their last known address of the action it takes.

§ 416.1468 How to request Appeals Council review.

(a) *Time and place to request Appeals Council review.* You may request Appeals Council review by filing a written request. You should submit any evidence you wish to have considered by the Appeals Council with your request for review, and the Appeals Council will consider the evidence in accordance with § 416.1470. You may file your request at one of our offices within 60 days after the date you receive notice of the hearing decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (b) of this section).

(b) *Extension of time to request review.* You or any party to a hearing decision may ask that the time for filing a request for the review be extended. The request for an extension of time must be in writing. It must be filed with the Appeals Council, and it must give the reasons why the request for review was not filed within the stated time period. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 416.1411.

[45 FR 52096, Aug. 5, 1980, as amended at 81 FR 90996, Dec. 16, 2016]

§ 416.1469 Appeals Council initiates review.

(a) *General.* Anytime within 60 days after the date of a decision or dismissal that is subject to review under this section, the Appeals Council may decide on its own motion to review the action that was taken in your case. We may refer your case to the Appeals Council for it to consider reviewing under this authority.

(b) *Identification of cases.* We will identify a case for referral to the Appeals Council for possible review under its own-motion authority before we effectuate a decision in the case. We will identify cases for referral to the Appeals Council through random and selective sampling techniques, which we may use in association with examination of the cases identified by sampling. We will also identify cases for referral to the Appeals Council through the evaluation of cases we conduct in order to effectuate decisions.

(1) *Random and selective sampling and case examinations.* We may use random and selective sampling to identify cases involving any type of action (*i.e.*, fully or partially favorable decisions, unfavorable decisions, or dismissals) and any type of benefits (*i.e.*, benefits based on disability and benefits not based on disability). We will use selective sampling to identify cases that exhibit problematic issues or fact patterns that increase the likelihood of error. Neither our random sampling procedures nor our selective sampling procedures will identify cases based on the identity of the decisionmaker or the identity of the office issuing the

decision. We may examine cases that have been identified through random or selective sampling to refine the identification of cases that may meet the criteria for review by the Appeals Council.

(2) *Identification as a result of the effectuation process.* We may refer a case requiring effectuation to the Appeals Council if, in the view of the effectuating component, the decision cannot be effectuated because it contains a clerical error affecting the outcome of the claim; the decision is clearly inconsistent with the Social Security Act, the regulations, or a published ruling; or the decision is unclear regarding a matter that affects the claim's outcome.

(c) *Referral of cases.* We will make referrals that occur as the result of a case examination or the effectuation process in writing. The written referral based on the results of such a case examination or the effectuation process will state the referring component's reasons for believing that the Appeals Council should review the case on its own motion. Referrals that result from selective sampling without a case examination may be accompanied by a written statement identifying the issue(s) or fact pattern that caused the referral. Referrals that result from random sampling without a case examination will only identify the case as a random sample case.

(d) *Appeals Council's action.* If the Appeals Council decides to review a decision or dismissal on its own motion, it will mail a notice of review to all the parties as provided in § 416.1473. The Appeals Council will include with that notice a copy of any written referral it has received under paragraph (c) of this section. The Appeals Council's decision to review a case is established by its issuance of the notice of review. If it is unable to decide within the applicable 60-day period whether to review a decision or dismissal, the Appeals Council may consider the case to determine if the decision or dismissal should be reopened pursuant to §§ 416.1487 and 416.1488. If the Appeals Council decides to review a decision on its own motion or to reopen a decision as provided in §§ 416.1487 and 416.1488, the notice of review or the notice of reopening issued by the Appeals Council will advise, where appropriate, that interim benefits will be payable if a final decision has not been issued within 110 days after the date of the decision that is reviewed or reopened, and that any interim benefits paid will not be considered overpayments unless the benefits are fraudulently obtained.

[63 FR 36571, July 7, 1998, as amended at 75 FR 33169, June 11, 2010]

§ 416.1470 Cases the Appeals Council will review.

(a) The Appeals Council will review a case at a party's request or on its own motion if—

(1) There appears to be an abuse of discretion by the administrative law judge or administrative appeals judge who heard the case;

(2) There is an error of law;

(3) The action, findings or conclusions in the hearing decision or dismissal order are not supported by substantial evidence;

(4) There is a broad policy or procedural issue that may affect the general public interest; or

(5) Subject to paragraph (b) of this section, the Appeals Council receives additional evidence that is new, material, and relates to the period on or before the date of the hearing decision, and there is a reasonable probability that the additional evidence would change the outcome of the decision.

(b) In reviewing decisions other than those based on an application for benefits, the Appeals Council will consider the evidence in the administrative law judge hearing record and any additional evidence it believes is material to an issue being considered. However, in reviewing decisions based on an application for benefits, the Appeals Council will only consider additional evidence under paragraph (a)(5) of this section if you show good cause for not informing us about or submitting the evidence as described in § 416.1435 because:

(1) Our action misled you;

(2) You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier; or

(3) Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier. Examples include, but are not limited to:

(i) You were seriously ill, and your illness prevented you from contacting us in person, in writing, or through a friend, relative, or other person;

(ii) There was a death or serious illness in your immediate family;

(iii) Important records were destroyed or damaged by fire or other accidental cause;

(iv) You actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing; or

(v) You received a hearing level decision on the record and the Appeals Council reviewed your decision.

(c) If you submit additional evidence that does not relate to the period on or before the date of the administrative law judge hearing decision as required in paragraph (a)(5) of this section, or the Appeals Council does not find you had good cause for missing the deadline to submit the evidence in §416.1435, the Appeals Council will send you a notice that explains why it did not accept the additional evidence and advises you of your right to file a new application. The notice will also advise you that if you file a new application within 60 days after the date of the Appeals Council's notice, your request for review will constitute a written statement indicating an intent to claim benefits under §416.340. If you file a new application within 60 days of the Appeals Council's notice, we will use the date you requested Appeals Council review as the filing date for your new application.

[81 FR 90996, Dec. 16, 2016, as amended at 85 FR 73160, Nov. 16, 2020]

§416.1471 Dismissal by Appeals Council.

The Appeals Council will dismiss your request for review if you did not file your request within the stated period of time and the time for filing has not been extended. The Appeals Council may also dismiss any proceedings before it if—

(a) You and any other party to the proceedings files a written request for dismissal; or

(b) You die, there are no other parties, and we have no information to show that you may have a survivor who may be paid benefits due to you under §416.542(b) and who wishes to pursue the request for review, or that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act. The Appeals Council, however, will vacate a dismissal of the request for review if, within 60 days after the date of the dismissal:

(1) A person claiming to be your survivor, who may be paid benefits due to you under §416.542(b), submits a written request for review, and shows that a decision on the issues that were to be considered on review may adversely affect him or her; or

(2) We receive information showing that you authorized interim assistance reimbursement to a State pursuant to section 1631(g) of the Act.

[45 FR 52096, Aug. 5, 1980, as amended at 58 FR 52914, Oct. 13, 1993]

§416.1472 Effect of dismissal of request for Appeals Council review.

The dismissal of a request for Appeals Council review is binding and not subject to further review.

§416.1473 Notice of Appeals Council review.

When the Appeals Council decides to review a case, it shall mail a prior notice to all parties at their last known address stating the reasons for the review and the issues to be considered. However, when the Appeals Council plans to issue a decision that is fully favorable to all parties, plans to remand the case for further proceedings, or plans to issue a decision that is favorable in part and remand the remaining issues for further proceedings, it may send the notice of Appeals Council review to all parties with the decision or remand order.

[85 FR 73160, Nov. 16, 2020]

§ 416.1474 Obtaining evidence from Appeals Council.

You may request and receive copies or a statement of the documents or other written evidence upon which the hearing decision or dismissal was based and a copy or summary of the transcript of oral evidence. However, you will be asked to pay the costs of providing these copies unless there is a good reason why you should not pay.

§ 416.1475 Filing briefs with the Appeals Council.

Upon request, the Appeals Council shall give you and all other parties a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case. A copy of each brief or statement should be filed for each party.

§ 416.1476 Procedures before the Appeals Council.

(a) *Limitation of issues.* The Appeals Council may limit the issues it considers if it notifies you and the other parties of the issues it will review.

(b) *Evidence the Appeals Council will exhibit.* The Appeals Council will evaluate all additional evidence it receives, but will only mark as an exhibit and make part of the official record additional evidence that it determines meets the requirements of § 416.1470(a)(5) and (b). If we need to file a certified administrative record in Federal court, we will include in that record all additional evidence the Appeals Council received during the administrative review process, including additional evidence that the Appeals Council received but did not exhibit or make part of the official record.

(c) *Oral argument.* You may request to appear before the Appeals Council to present oral argument in support of your request for review. The Appeals Council will grant your request if it decides that your case raises an important question of law or policy or that oral argument would help to reach a proper decision. If your request to appear is granted, the Appeals Council will tell you the time and place of the oral argument at least 10 business days before the scheduled date. The Appeals Council will determine whether your appearance will be by audio, agency video, online video, or in person as set forth in § 416.1436. The Appeals Council will determine whether any other person relevant to the proceeding will appear by audio, agency video, online video, or in person as set forth in § 416.1436(c)(2).

[81 FR 90996, Dec. 16, 2016, as amended at 84 FR 69308, Dec. 18, 2019; 85 FR 73160, Nov. 16, 2020; 89 FR 68364, Aug. 26, 2024]

§ 416.1477 Case remanded by Appeals Council.

(a) *When the Appeals Council may remand a case.* The Appeals Council may remand a case to an administrative law judge so that he or she may hold a hearing and issue a decision or a recommended decision. The Appeals Council may also remand a case in which additional evidence is needed or additional action by the administrative law judge is required.

(b) *Action by administrative law judge on remand.* The administrative law judge shall take any action that is ordered by the Appeals Council and may take any additional action that is not inconsistent with the Appeals Council's remand order.

(c) *Notice when case is returned with a recommended decision.* When the administrative law judge sends a case to the Appeals Council with a recommended decision, a notice is mailed to the parties at their last known address. The notice tells them that the case has been sent to the Appeals Council, explains the rules for filing briefs or other written statements with the Appeals Council, and includes a copy of the recommended decision.

(d) *Filing briefs with and obtaining evidence from the Appeals Council.* (1) You may file briefs or other written statements about the facts and law relevant to your case with the Appeals Council within 20 days of the date that the recommended decision is mailed to you. Any party may ask the Appeals Council for additional time to file briefs or statements. The Appeals Council will extend this period, as appropriate, if you show that you had good cause for missing the deadline.

(2) All other rules for filing briefs with and obtaining evidence from the Appeals Council follow the procedures explained in this subpart.

(e) *Procedures before the Appeals Council.* (1) The Appeals Council after receiving a recommended decision will conduct its proceedings and issue its decision according to the procedures explained in this subpart.

(2) If the Appeals Council believes that more evidence is required, it may again remand the case to an administrative law judge for further inquiry into the issues, rehearing, receipt of evidence, and another decision or recommended decision. However, if the Appeals Council decides that it can get the additional evidence more quickly, it will take appropriate action.

§ 416.1479 Decision of Appeals Council.

After it has reviewed all the evidence in the administrative law judge hearing record and any additional evidence received, subject to the limitations on Appeals Council consideration of additional evidence in § 416.1470, the Appeals Council will make a decision or remand the case to an administrative law judge. The Appeals Council may affirm, modify or reverse the administrative law judge hearing decision or it may adopt, modify or reject a recommended decision. If the Appeals Council issues its own decision, it will base its decision on the preponderance of the evidence. A copy of the Appeals Council's decision will be mailed to the parties at their last known address.

[52 FR 4005, Feb. 9, 1987, as amended at 73 FR 76945, Dec. 18, 2008; 81 FR 90994, Dec. 16, 2016]

§ 416.1481 Effect of Appeals Council's decision or denial of review.

The Appeals Council may deny a party's request for review or it may decide to review a case and make a decision. The Appeals Council's decision, or the decision of the administrative law judge if the request for review is denied, is binding unless you or another party file an action in Federal district court, or the decision is revised. You may file an action in a Federal district court within 60 days after the date you receive notice of the Appeals Council's action.

§ 416.1482 Extension of time to file action in Federal district court.

Any party to the Appeals Council's decision or denial of review, or to an expedited appeals process agreement, may request that the time for filing an action in a Federal district court be extended. The request must be in writing and it must give the reasons why the action was not filed within the stated time period. The request must be filed with the Appeals Council, or if it concerns an expedited appeals process agreement, with one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 416.1411.

COURT REMAND CASES

§ 416.1483 Case remanded by a Federal court.

(a) *General rule.* When a Federal court remands a case to the Commissioner for further consideration, the Appeals Council, acting on behalf of the Commissioner, may make a decision following the provisions in paragraph (b) or (c) of this section, dismiss the proceedings, except as provided in paragraph (d) of this section, or remand the case to an administrative law judge following the provisions in paragraph (e) of this section with instructions to take action and issue a decision or return the case to the Appeals Council with a recommended decision. Any issues relating to the claim(s) may be considered by the Appeals Council or administrative law judge whether or not they were raised in the administrative proceedings leading to the final decision in the case.

(b) *Appeals Council decision without a hearing.* If the Appeals Council assumes responsibility under paragraph (a) of this section for issuing a decision without a hearing, it will follow the procedures explained in §§ 416.1473 and 416.1479.

(c) *Administrative appeals judge decision after holding a hearing.* If the Appeals Council assumes responsibility for issuing a decision and a hearing is necessary to complete adjudication of the claim(s), an administrative appeals judge will hold a hearing using the procedures set forth in §§ 416.1429 through 416.1461, as applicable.

(d) *Appeals Council dismissal.* After a Federal court remands a case to the

Commissioner for further consideration, the Appeals Council may dismiss the proceedings before it for any reason that an administrative law judge may dismiss a request for a hearing under § 416.1457. The Appeals Council will not dismiss the proceedings in a claim where we are otherwise required by law or a judicial order to file the Commissioner's additional and modified findings of fact and decision with a court.

(e) *Appeals Council remand.* If the Appeals Council remands a case under paragraph (a) of this section, it will follow the procedures explained in § 416.1477.

[85 FR 73160, Nov. 16, 2020]

§ 416.1484 Appeals Council review of hearing decision in a case remanded by a Federal court.

(a) *General.* In accordance with § 416.1483, when a case is remanded by a Federal court for further consideration and the Appeals Council remands the case to an administrative law judge, or an administrative appeals judge issues a decision pursuant to § 416.1483(c), the decision of the administrative law judge or administrative appeals judge will become the final decision of the Commissioner after remand on your case unless the Appeals Council assumes jurisdiction of the case. The Appeals Council may assume jurisdiction, using the standard set forth in § 416.1470, based on written exceptions to the decision which you file with the Appeals Council or based on its authority pursuant to paragraph (c) of this section. If the Appeals Council assumes jurisdiction of the case, it will not dismiss the request for a hearing in a claim where we are otherwise required by law or a judicial order to file the Commissioner's additional and modified findings of fact and decision with a court.

(b) *You file exceptions disagreeing with the hearing decision.* (1) If you disagree with the hearing decision, in whole or in part, you may file exceptions to the decision with the Appeals Council. Exceptions may be filed by submitting a written statement to the Appeals Council setting forth your reasons for disagreeing with the decision of the administrative law judge or administrative appeals judge. The exceptions must be filed within 30 days of the date you receive the hearing decision or an extension of time in which to submit exceptions must be requested in writing within the 30-day period. A timely request for a 30-day extension will be granted by the Appeals Council. A request for an extension of more than 30 days should include a statement of reasons as to why you need the additional time.

(2) If written exceptions are timely filed, the Appeals Council will consider your reasons for disagreeing with the hearing decision and all the issues presented by your case. If the Appeals Council concludes that there is no reason to change the hearing decision, it will issue a notice to you addressing your exceptions and explaining why no change in the hearing decision is warranted. In this instance, the hearing decision is the final decision of the Commissioner after remand.

(3) When you file written exceptions to the hearing decision, the Appeals Council may assume jurisdiction at any time, even after the 60-day time period which applies when you do not file exceptions. If the Appeals Council assumes jurisdiction of your case, any issues relating to your claim may be considered by the Appeals Council whether or not they were raised in the administrative proceedings leading to the final decision in your case or subsequently considered by the administrative law judge or administrative appeals judge in the administrative proceedings following the court's remand order. The Appeals Council will either make a new, independent decision pursuant to § 416.1483(b) or § 416.1483(c), based on a preponderance of the evidence in the record that will be the final decision of the Commissioner after remand, dismiss the request for a hearing, or remand the case to an administrative law judge for further proceedings, including a new decision.

(c) *Appeals Council assumes jurisdiction without exceptions being filed.* Any time within 60 days after the date of the hearing decision, the Appeals Council may decide to assume jurisdiction of your case even though no written exceptions have been filed. Notice of this action will be mailed to all parties at their last known address. You will be

provided with the opportunity to file briefs or other written statements with the Appeals Council about the facts and law relevant to your case. After the Appeals Council receives the briefs or other written statements, or the time allowed (usually 30 days) for submitting them has expired, the Appeals Council will either make a new, independent decision pursuant to §416.1483(b) or §416.1483(c), based on a preponderance of the evidence in the record that will be the final decision of the Commissioner after remand, dismiss the request for a hearing, or remand the case to an administrative law judge for further proceedings, including a new decision.

(d) *Exceptions are not filed and the Appeals Council does not otherwise assume jurisdiction.* If no exceptions are filed and the Appeals Council does not assume jurisdiction of your case, the decision of the administrative law judge or administrative appeals judge becomes the final decision of the Commissioner after remand.

[85 FR 73160, Nov. 16, 2020]

§416.1485 Application of circuit court law.

The procedures which follow apply to administrative determinations or decisions on claims involving the application of circuit court law.

(a) *General.* We will apply a holding in a United States Court of Appeals decision that we determine conflicts with our interpretation of a provision of the Social Security Act or regulations unless the Government seeks further judicial review of that decision or we relitigate the issue presented in the decision in accordance with paragraphs (c) and (d) of this section. We will apply the holding to claims at all levels of the administrative review process within the applicable circuit unless the holding, by its nature, applies only at certain levels of adjudication.

(b) *Issuance of an Acquiescence Ruling.* When we determine that a United States Court of Appeals holding conflicts with our interpretation of a provision of the Social Security Act or regulations and the Government does not seek further judicial review or is unsuccessful on further review, we will issue a Social Security Acquiescence Ruling. The Acquiescence Ruling will describe the administrative case and the court decision, identify the issue(s) involved, and explain how we will apply the holding, including, as necessary, how the holding relates to other decisions within the applicable circuit. These Acquiescence Rulings will generally be effective on the date of their publication in the FEDERAL REGISTER and will apply to all determinations, redeterminations, and decisions made on or after that date unless an Acquiescence Ruling is rescinded as stated in paragraph (e) of this section. The process we will use when issuing an Acquiescence Ruling follows:

(1) We will release an Acquiescence Ruling for publication in the FEDERAL REGISTER for any precedential circuit court decision that we determine contains a holding that conflicts with our interpretation of a provision of the Social Security Act or regulations no later than 120 days from the receipt of the court's decision. This timeframe will not apply when we decide to seek further judicial review of the circuit court decision or when coordination with the Department of Justice and/or other Federal agencies makes this timeframe no longer feasible.

(2) If we make a determination or decision on your claim between the date of a circuit court decision and the date we publish an Acquiescence Ruling, you may request application of the published Acquiescence Ruling to the prior determination or decision. You must demonstrate that application of the Acquiescence Ruling could change the prior determination or decision in your case. You may demonstrate this by submitting a statement that cites the Acquiescence Ruling or the holding or portion of a circuit court decision which could change the prior determination or decision in your case. If you can so demonstrate, we will readjudicate the claim in accordance with the Acquiescence Ruling at the level at which it was last adjudicated. Any readjudication will be limited to consideration of the issue(s) covered by the Acquiescence Ruling and any new determination or decision on readjudication will be subject to administrative and judicial review in accordance

with this subpart. Our denial of a request for readjudication will not be subject to further administrative or judicial review. If you file a request for readjudication within the 60-day appeal period and we deny that request, we shall extend the time to file an appeal on the merits of the claim to 60 days after the date that we deny the request for readjudication.

(3) After we receive a precedential circuit court decision and determine that an Acquiescence Ruling may be required, we will begin to identify those claims that are pending before us within the circuit and that might be subject to readjudication if an Acquiescence Ruling is subsequently issued. When an Acquiescence Ruling is published, we will send a notice to those individuals whose cases we have identified which may be affected by the Acquiescence Ruling. The notice will provide information about the Acquiescence Ruling and the right to request readjudication under that Acquiescence Ruling, as described in paragraph (b)(2) of this section. It is not necessary for an individual to receive a notice in order to request application of an Acquiescence Ruling to his or her claim, as described in paragraph (b)(2) of this section.

(c) *Relitigation of court's holding after publication of an Acquiescence Ruling.* After we have published an Acquiescence Ruling to reflect a holding of a United States Court of Appeals on an issue, we may decide under certain conditions to relitigate that issue within the same circuit. We may relitigate only when the conditions specified in paragraphs (c)(2) and (3) of this section are met, and, in general, one of the events specified in paragraph (c)(1) of this section occurs.

(1) Activating events:

(i) An action by both Houses of Congress indicates that a circuit court decision on which an Acquiescence Ruling was based was decided inconsistently with congressional intent, such as may be expressed in a joint resolution, an appropriations restriction, or enactment of legislation which affects a closely analogous body of law;

(ii) A statement in a majority opinion of the same circuit indicates that the court might no longer follow its previous decision if a particular issue were presented again;

(iii) Subsequent circuit court precedent in other circuits supports our interpretation of the Social Security Act or regulations on the issue(s) in question; or

(iv) A subsequent Supreme Court decision presents a reasonable legal basis for questioning a circuit court holding upon which we base an Acquiescence Ruling.

(2) The General Counsel of the Social Security Administration, after consulting with the Department of Justice, concurs that relitigation of an issue and application of our interpretation of the Social Security Act or regulations to selected claims in the administrative review process within the circuit would be appropriate.

(3) We publish a notice in the FEDERAL REGISTER that we intend to relitigate an Acquiescence Ruling issue and that we will apply our interpretation of the Social Security Act or regulations within the circuit to claims in the administrative review process selected for relitigation. The notice will explain why we made this decision.

(d) *Notice of relitigation.* When we decide to relitigate an issue, we will provide a notice explaining our action to all affected claimants. In adjudicating claims subject to relitigation, decisionmakers throughout the SSA administrative review process will apply our interpretation of the Social Security Act and regulations, but will also state in written determinations or decisions how the claims would have been decided under the circuit standard. Claims not subject to relitigation will continue to be decided under the Acquiescence Ruling in accordance with the circuit standard. So that affected claimants can be readily identified and any subsequent decision of the circuit court or the Supreme Court can be implemented quickly and efficiently, we will maintain a listing of all claimants who receive this notice and will provide them with the relief ordered by the court.

(e) *Rescission of an Acquiescence Ruling.* We will rescind as obsolete an Acquiescence Ruling and apply our interpretation of the Social Security Act or regulations by publishing a notice in

the FEDERAL REGISTER when any of the following events occurs:

(1) The Supreme Court overrules or limits a circuit court holding that was the basis of an Acquiescence Ruling;

(2) A circuit court overrules or limits itself on an issue that was the basis of an Acquiescence Ruling;

(3) A Federal law is enacted that removes the basis for the holding in a decision of a circuit court that was the subject of an Acquiescence Ruling; or

(4) We subsequently clarify, modify or revoke the regulation or ruling that was the subject of a circuit court holding that we determined conflicts with our interpretation of the Social Security Act or regulations, or we subsequently publish a new regulation(s) addressing an issue(s) not previously included in our regulations when that issue(s) was the subject of a circuit court holding that conflicted with our interpretation of the Social Security Act or regulations and that holding was not compelled by the statute or Constitution.

[63 FR 24933, May 6, 1998]

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

§ 416.1487 Reopening and revising determinations and decisions.

(a) *General.* Generally, if you are dissatisfied with a determination or decision made in the administrative review process, but do not request further review within the stated time period, you lose your right to further review and that determination or decision becomes final. However, a determination or a decision made in your case which is otherwise final and binding may be reopened and revised by us.

(b) *Procedure for reopening and revision.* We may reopen a final determination or decision on our own initiative, or you may ask that a final determination or a decision to which you were a party be reopened. In either instance, if we reopen the determination or decision, we may revise that determination or decision. The conditions under which we may reopen a previous determination or decision, either on our own initiative or at your request, are explained in § 416.1488.

[59 FR 8535, Feb. 23, 1994]

§ 416.1488 Conditions for reopening.

A determination, revised determination, decision, or revised decision may be reopened—

(a) Within 12 months of the date of the notice of the initial determination, for any reason;

(b) Within two years of the date of the notice of the initial determination if we find good cause, as defined in § 416.1489, to reopen the case; or

(c) At any time if it was obtained by fraud or similar fault. In determining whether a determination or decision was obtained by fraud or similar fault, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

[45 FR 52096, Aug. 5, 1980, as amended at 59 FR 1637, Jan. 12, 1994]

§ 416.1489 Good cause for reopening.

(a) We will find that there is good cause to reopen a determination or decision if—

(1) New and material evidence is furnished;

(2) A clerical error was made; or

(3) The evidence that was considered in making the determination or decision clearly shows on its face that an error was made.

(b) We will not find good cause to reopen your case if the only reason for reopening is a change of legal interpretation or administrative ruling upon which the determination or decision was made.

§ 416.1491 Late completion of timely investigation.

We may revise a determination or decision after the applicable time period in § 416.1488(a) or § 416.1488(b) expires if we begin an investigation into whether to revise the determination or decision before the applicable time period expires. We may begin the investigation either based on a request by you or by an action on our part. The investigation is a process of gathering facts after a determination or decision has been reopened to determine if a revision of the determination or decision is applicable.

(a) If we have diligently pursued the investigation to its conclusion, we may revise the determination or decision. The revision may be favorable or unfavorable to you. ''Diligently pursued'' means that in light of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if we conclude the investigation and if necessary, revise the determination or decision within 6 months from the date we began the investigation.

(b) If we have not diligently pursued the investigation to its conclusion, we will revise the determination or decision if a revision is applicable and if it will be favorable to you. We will not revise the determination or decision if it will be unfavorable to you.

[49 FR 46370, Nov. 26, 1984; 49 FR 48036, Dec. 10, 1984]

§ 416.1492 Notice of revised determination or decision.

(a) When a determination or decision is revised, notice of the revision will be mailed to the parties at their last known address. The notice will state the basis for the revised determination or decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a determination is revised and the revised determination requires that your benefits be suspended, reduced, or terminated, the notice will inform you of your right to continued payment (see § 416.1336 and the exceptions set out in § 416.1337) and of your right of reconsideration.

(c) If a determination is revised and the revised determination does not require that your benefits be suspended, reduced, or terminated, the notice will inform you of your right to a hearing before an administrative law judge.

(d) If a reconsidered determination that you are blind or disabled, based on medical factors, is reopened for the purpose of being revised, you will be notified, in writing, of the proposed revision and of your right to request that a disability hearing be held before a revised reconsidered determination is issued. If a revised reconsidered determination is issued, you may request a hearing before an administrative law judge.

(e) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based on evidence not included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action and of your right to request that a hearing be held before any further action is taken. If a revised decision is issued by an administrative law judge, you and any other party may request that it be reviewed by the Appeals Council, or the Appeals Council may review the decision on its own initiative.

(f) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action. If a revised decision is issued by an administrative law judge, you and any other party may request that it be reviewed by the Appeals Council, or the Appeals Council may review the decision on its own initiative.

(g) An administrative law judge may, in connection with a valid request for a hearing, propose to reopen an issue other than the issue on which the request for a hearing was based. The administrative law judge will follow the time limits for reopenings set out in § 416.1488. The administrative law judge shall mail to the parties at their last known address a notice of the reopening.

[45 FR 52096, Aug. 5, 1980, as amended at 51 FR 308, Jan. 3, 1986]

§ 416.1493 Effect of revised determination or decision.

A revised determination or decision is binding unless—

(a) You or a party to the revised determination file a written request for a reconsideration or a hearing;

(b) You or another party to the revised decision file, as appropriate, a request for review by the Appeals Council or a hearing;

(c) The Appeals Council reviews the revised decision; or

(d) The revised determination or decision is further revised.

§ 416.1494 Time and place to request further review or a hearing on revised determination or decision.

You or another party to the revised determination or decision may request, as appropriate, further review or a hearing on the revision by filing a request in writing at one of our offices within 60 days after the date you receive notice of the revision. Further review or a hearing will be held on the revision according to the rules of this subpart.

PAYMENT OF CERTAIN TRAVEL EXPENSES

§ 416.1495 Payment of certain travel expenses—general.

When you file a claim for supplemental security income (SSI) benefits, you may incur certain travel expenses in pursuing your claim. Sections 416.1496 through 416.1499 explain who may be reimbursed for travel expenses, the types of travel expenses that are reimbursable, and when and how to claim reimbursement. Generally, the agency that requests you to travel will be the agency that reimburses you. No later than when it notifies you of the examination or hearing described in § 416.1496(a), that agency will give you information about the right to travel reimbursement, the right to advance payment and how to request it, the rules on means of travel and unusual travel costs, and the need to submit receipts.

[51 FR 8810, Mar. 14, 1986]

§ 416.1496 Who may be reimbursed.

(a) The following individuals may be reimbursed for certain travel expenses—

(1) You, when you attend medical examinations upon request in connection with disability determinations; these are medical examinations requested by the State agency or by us when additional medical evidence is necessary to make a disability determination (also referred to as consultative examinations, see § 416.917);

(2) You, your representative (see § 416.1505 (a) and (b)), and all unsubpoenaed witnesses we or the State agency determines to be reasonably necessary who attend disability hearings; and

(3) You, your representative, and all unsubpoenaed witnesses we determine to be reasonably necessary who attend hearings on any claim for SSI benefits before an administrative law judge.

(b) Sections 416.1495 through 416.1499 do not apply to subpoenaed witnesses. They are reimbursed under §§ 416.1450(d) and 416.1416(b)(1).

[51 FR 8810, Mar. 14, 1986]

§ 416.1498 What travel expenses are reimbursable.

Reimbursable travel expenses include the ordinary expenses of public or private transportation as well as unusual costs due to special circumstances.

(a) Reimbursement for ordinary travel expenses is limited—

(1) To the cost of travel by the most economical and expeditious means of transportation available and appropriate to the individual's condition of health as determined by the State agency or by us, considering the available means in the following order—

(i) Common carrier (air, rail, or bus);

(ii) Privately owned vehicles;

(iii) Commercially rented vehicles and other special conveyances;

(2) If air travel is necessary, to the coach fare for air travel between the specified travel points involved unless first-class air travel is authorized in advance by the State agency or by the Secretary in instances when—

(i) Space is not available in less-than-first-class accommodations on any scheduled flights in time to accomplish the purpose of the travel;

(ii) First-class accommodations are necessary because you, your representative, or reasonably necessary witness is so handicapped or otherwise impaired that other accommodations are not practical and the impairment is substantiated by competent medical authority;

(iii) Less-than-first-class accommodations on foreign carriers do not provide adequate sanitation or health standards; or

(iv) The use of first-class accommodations would result in an overall savings to the government based on economic considerations, such as the avoidance of additional subsistence

costs that would be incurred while awaiting availability of less-than-first-class accommodations.

(b) Unusual travel costs may be reimbursed but must be authorized in advance and in writing by us or the appropriate State official, as applicable, unless they are unexpected or unavoidable; we or the State agency must determine their reasonableness and necessity and must approve them before payment can be made. Unusual expenses that may be covered in connection with travel include, but are not limited to—

(1) Ambulance services;

(2) Attendant services;

(3) Meals;

(4) Lodging; and

(5) Taxicabs.

(c) If we reimburse you for travel, we apply the rules in §§ 416.1496 through 416.1499 and the same rates and conditions of payment that govern travel expenses for Federal employees as authorized under 41 CFR chapter 301. If a State agency reimburses you, the reimbursement rates shall be determined by the rules in §§ 416.1496 through 416.1499 and that agency's rules and regulations and may differ from one agency to another and also may differ from the Federal reimbursement rates.

(1) When public transportation is used, reimbursement will be made for the actual costs incurred, subject to the restrictions in paragraph (a)(2) of this section on reimbursement for first-class air travel.

(2) When travel is by a privately owned vehicle, reimbursement will be made at the current Federal or State mileage rate specified for that geographic location plus the actual costs of tolls and parking, if travel by a privately owned vehicle is determined appropriate under paragraph (a)(1) of this section. Otherwise, the amount of reimbursement for travel by privately owned vehicle cannot exceed the total cost of the most economical public transportation for travel between the same two points. ''Total cost'' includes the cost for all the authorized travelers who travel in the same privately owned vehicle. Advance approval of travel by privately owned vehicle is not required (but could give you assurance of its approval).

(3) Sometimes your health condition dictates a mode of transportation different from most economical and expeditious. In order for your health to require a mode of transportation other than common carrier or passenger car, you must be so handicapped or otherwise impaired as to require special transportation arrangements and the condition must be substantiated by competent medical authority.

(d) For travel to a hearing—

(1) Reimbursement is limited to travel within the U.S. For this purpose, the U.S. includes the U.S. as defined in § 416.120(c)(10).

(2) When the travel is performed after September 30, 1981, we or the State agency will reimburse you, your representative, or an unsubpoenaed witness only if the distance from the person's residence or office (whichever he or she travels from) to the hearing site exceeds 75 miles.

(3) For travel expenses incurred on or after April 1, 1991, the amount of reimbursement under this section for travel by your representative to attend a disability hearing or a hearing before an administrative law judge shall not exceed the maximum amount allowable under this section for travel to the hearing site from any point within the geographic area of the office having jurisdiction over the hearing.

(i) The geographic area of the office having jurisdiction over the hearing means, as appropriate—

(A) The designated geographic service area of the State agency adjudicatory unit having responsibility for providing the disability hearing;

(B) If a Federal disability hearing officer holds the disability hearing, the geographic area of the State (as defined in § 416.120(c)(9)) in which the claimant resides or, if the claimant is not a resident of a State, in which the hearing officer holds the disability hearing; or

(C) The designated geographic service area of the Office of Hearings Operations hearing office having responsibility for providing the hearing.

(ii) We or the State agency determine the maximum amount allowable for travel by a representative based on the distance to the hearing site from the farthest point within the appropriate

geographic area. In determining the maximum amount allowable for travel between these two points, we or the State agency apply the rules in paragraphs (a) through (c) of this section and the limitations in paragraph (d) (1) and (4) of this section. If the distance between these two points does not exceed 75 miles, we or the State agency will not reimburse any of your representative's travel expenses.

(4) If a change in the location of the hearing is made at your request from the location we or the State agency selected to one farther from your residence or office, neither your additional travel expenses nor the additional travel expenses of your representative and witnesses will be reimbursed.

[51 FR 8810, Mar. 14, 1986, as amended at 59 FR 8532, Feb. 23, 1994; 85 FR 73161, Nov. 16, 2020]

§ 416.1499 When and how to claim reimbursement.

(a)(1) Generally, you will be reimbursed for your expenses after your trip. However, travel advances may be authorized if you request prepayment and show that the requested advance is reasonable and necessary.

(2) You must submit to us or the State agency, as appropriate, an itemized list of what you spent and supporting receipts to be reimbursed.

(3) Arrangements for special means of transportation and related unusual costs may be made only if we or the State agency authorizes the costs in writing in advance of travel, unless the costs are unexpected or unavoidable. If they are unexpected or unavoidable we or the State agency must determine their reasonableness and necessity and must approve them before payment may be made.

(4) If you receive prepayment, you must, within 20 days after your trip, provide to us or the State agency, as appropriate, an itemized list of your actual travel costs and submit supporting receipts. We or the State agency will require you to pay back any balance of the advanced amount that exceeds any approved travel expenses within 20 days after you are notified of the amount of that balance. (State agencies may have their own time limits in place of the 20-day periods in the preceding two sentences.)

(b) You may claim reimbursable travel expenses incurred by your representative for which you have been billed by your representative, except that if your representative makes a claim for them to us or the State, he or she will be reimbursed directly.

(Approved by the Office of Management and Budget under control number 0960–0434)

[51 FR 8810, Mar. 14, 1986, as amended at 51 FR 44983, Dec. 16, 1986]

Subpart O—Representation of Parties

AUTHORITY: 42 U.S.C. 405(a), 406, 902(a)(5), 1320a-6, and 1383(d).

SOURCE: 45 FR 52106, Aug. 5, 1980, unless otherwise noted.

§ 416.1500 Introduction.

You may appoint someone to represent you in any of your dealings with us. This subpart explains, among other things—

(a) Who may be your representative and what his or her qualifications must be;

(b) How you appoint a representative;

(c) The payment of fees to a representative;

(d) Our rules that representatives must follow; and

(e) What happens to a representative who breaks the rules.

§ 416.1503 Definitions.

As used in this subpart:

Affiliate means to associate with an entity through our prescribed registration process.

Assignment means the transfer of the right to receive direct payment of an authorized fee to an entity as described in § 416.1530(e).

Date we notify him or her means 5 days after the date on the notice, unless the recipient shows us that he or she did not receive it within the 5-day period.

Eligible non-attorney means a non-attorney representative who we determine is qualified to receive direct payment of his or her fee under § 416.1517(a).

Entity means any business, firm, or other association, including but not

limited to partnerships, corporations, for-profit organizations, and not-for-profit organizations.

Federal agency refers to any authority of the Executive branch of the Government of the United States.

Federal program refers to any program established by an Act of Congress or administered in whole or in part by a Federal agency.

Legal guardian or court-appointed representative means a court-appointed person, committee, or conservator who is responsible for taking care of and managing the property and rights of an individual who is considered incapable of managing his or her own affairs.

Past-due benefits means the total amount of payments under title XVI of the Act, the Supplemental Security Income (SSI) program, including any Federally administered State payments, that has accumulated to you and your spouse because of a favorable administrative or judicial determination or decision, up to but not including the month the determination or decision is made. For purposes of calculating fees for representation, we first determine the SSI past-due benefits before any applicable reduction for reimbursement to a State (or political subdivision) for interim assistance reimbursement, and before any applicable reduction under section 1127 of the Act (for receipt of benefits for the same period under title II). We then reduce that figure by the amount of any reduction of title II or title XVI benefits that was required by section 1127. We do this whether the actual offset, as provided under section 1127, reduced the title II or title XVI benefits. Past-due benefits do not include:

(1) Continued benefits paid pursuant to § 416.996 of this part;

(2) Continued benefits paid pursuant to § 416.1336(b) of this part; or

(3) Interim benefits paid pursuant to section 1631(a)(8) of the Act.

Point of Contact means an individual who registers as a representative in the manner we prescribe and is selected by an entity to speak and act on the entity's behalf and who assumes the affirmative duties and obligations we prescribe.

Registration means a process by which an individual or entity provides the information we require to conduct business with us.

Representational services means services performed for a claimant in connection with any claim the claimant has before us, any asserted right the claimant may have for an initial or reconsidered determination, and any decision or action by an administrative law judge or the Appeals Council.

Representative means an attorney who meets all of the requirements of § 416.1505(a), or a person other than an attorney who meets all of the requirements of § 416.1505(b), and whom you appoint to represent you in dealings with us. For purposes of our Rules of conduct and standards of responsibility for representatives in §§ 416.1540 through 416.1599, *Representative* also includes an individual who provides representational services and an individual who is listed as a point of contact for an entity, as applicable to their identified role.

We, *our*, or *us* refers to the Social Security Administration (SSA).

You or *your* refers to any person or the eligible spouse of any person claiming or receiving supplemental security income benefits.

[45 FR 52106, Aug. 5, 1980, as amended at 62 FR 38455, July 18, 1997; 72 FR 16725, Apr. 5, 2007; 74 FR 48384, Sept. 23, 2009; 76 FR 45194, July 28, 2011; 76 FR 80247, Dec. 23, 2011; 89 FR 67555, Aug. 21, 2024]

§ 416.1505 Who may be your representative.

(a) You may appoint as your representative in dealings with us any attorney in good standing who—

(1) Has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States;

(2) Is not disqualified or suspended from acting as a representative in dealings with us; and

(3) Is not prohibited by any law from acting as a representative.

(b) You may appoint any person who is not an attorney to be your representative in dealings with us if the person—

(1) Is capable of giving valuable help to you in connection with your claim;

(2) Is not disqualified or suspended from acting as a representative in dealings with us;

(3) Is not prohibited by any law from acting as a representative; and

(4) Is generally known to have a good character and reputation. Persons lacking good character and reputation, include, but are not limited to, persons who have a final conviction of a felony (as defined by §404.1506(c) of this chapter), or any crime involving moral turpitude, dishonesty, false statement, misrepresentations, deceit, or theft.

(c) Your representative(s) must be registered with us in the manner we prescribe.

(d) We may refuse to recognize your chosen representative if the person does not meet the requirements in this section. We will notify you and the proposed representative if we do not recognize the person as your representative.

[45 FR 52106, Aug. 5, 1980, as amended at 76 FR 80247, Dec. 23, 2011; 83 FR 30857, July 2, 2018; 89 FR 67555, Aug. 21, 2024]

§416.1506 Notification of options for obtaining attorney representation.

If you are not represented by an attorney and we make a determination or decision that is subject to the administrative review process provided under subpart N of this part and it does not grant all of the benefits or other relief you requested or it adversely affects any eligibility to benefits that we have established or may establish for you, we will include with the notice of that determination or decision information about your options for obtaining an attorney to represent you in dealing with us. We will also tell you that a legal services organization may provide you with legal representation free of charge if you satisfy the qualifying requirements applicable to that organization.

[58 FR 64886, Dec. 10, 1993]

§416.1507 Appointing a representative.

We will recognize a person as your representative if:

(a) You and your representative complete and sign our prescribed appointment form; and

(b) You or your representative file our prescribed appointment form in the manner we designate.

[89 FR 67555, Aug. 21, 2024]

§416.1510 Authority of a representative.

(a) *What a representative may do.* Your representative may, on your behalf—

(1) Obtain information about your claim to the same extent that you are able to do;

(2) Submit evidence;

(3) Make statements about facts and law; and

(4) Make any request or give any notice about the proceedings before us.

(b) *What a representative may not do.* A representative may not sign an application on behalf of a claimant for rights or benefits under title XVI of the Act unless authorized to do so under §416.315.

§416.1513 Mandatory use of electronic services.

A representative must conduct business with us electronically at the times and in the manner we prescribe on matters for which the representative requests direct fee payment. (*See* §416.1540(b)(4)).

[76 FR 56109, Sept. 12, 2011]

§416.1515 Notice or request to a representative.

(a) We shall send your representative—

(1) Notice and a copy of any administrative action, determination, or decision; and

(2) Requests for information or evidence.

(b) A notice or request sent to your representative will have the same force and effect as if it had been sent to you.

§416.1517 Direct payment of fees to eligible non-attorney representatives.

(a) *Criteria for eligibility.* An individual who is a licensed attorney or who is suspended or disbarred from the practice of law in any jurisdiction may not be an eligible non-attorney. A non-attorney representative is eligible to receive direct payment of his or her fee out of your past-due benefits if he or she:

(1) Completes and submits to us an application as described in paragraph (b) of this section;

(2) Pays the application fee as described in paragraph (c) of this section;

(3) Demonstrates that he or she possesses:

(i) A bachelor's degree from an accredited institution of higher learning; or

(ii) At least four years of relevant professional experience and either a high school diploma or a General Educational Development certificate;

(4) Passes our criminal background investigation (including checks of our administrative records), and attests under penalty of perjury that he or she:

(i) Has not been suspended or disqualified from practice before us and is not suspended or disbarred from the practice of law in any jurisdiction;

(ii) Has not had a judgment or lien assessed against him or her by a civil court for malpractice or fraud;

(iii) Has not had a felony conviction; and

(iv) Has not misrepresented information provided on his or her application or supporting materials for the application;

(5) Takes and passes a written examination we administer;

(6) Provides proof of and maintains continuous liability insurance coverage that is underwritten by an entity that is legally permitted to provide professional liability insurance in the States in which the representative conducts business. The policy must include coverage for malpractice claims against the representative and be in an amount we prescribe; and

(7) Completes and provides proof that he or she has completed all continuing education courses that we prescribe by the deadline we prescribe.

(b) *Application.* An applicant must timely submit his or her completed application form during an application period that we prescribe. The application must be postmarked by the last day of the application period. If an applicant timely submits the application fee and a defective application, we will give the applicant 10 calendar days after the date we notify him or her of the defect to correct the application.

(c) *Application fee.* An applicant must timely submit his or her application fee during the application period. We will set the fee annually.

(1) We will refund the fee if:

(i) We do not administer an examination, and an applicant was unable to take the rescheduled examination; or

(ii) Circumstances beyond the applicant's control that could not have been reasonably anticipated and planned for prevent an applicant from taking a scheduled examination.

(2) We will not refund the fee if:

(i) An applicant took and failed the examination; or

(ii) An applicant failed to arrive on time for the examination because of circumstances within the applicant's control that could have been anticipated and planned for.

(d) *Protest procedures.* (1) We may find that a non-attorney representative is ineligible to receive direct fee payment at any time because he or she fails to meet any of the criteria in paragraph (a) of this section. A non-attorney representative whom we find to be ineligible for direct fee payment may protest our finding only if we based it on the representative's failure to:

(i) Attest on the application or provide sufficient documentation that he or she possesses the required education or equivalent qualifications, as described in paragraph (a)(3) of this section;

(ii) Meet at all times the criminal background investigation criteria, as described in paragraph (a)(4) of this section;

(iii) Provide proof that he or she has maintained continuous liability insurance coverage, as described in paragraph (a)(6) of this section, after we previously determined the representative was eligible to receive direct fee payment; or

(iv) Complete continuing education courses or provide documentation of the required continuing education courses, as described in paragraph (a)(7) of this section.

(2) A non-attorney representative who wants to protest our finding under paragraph (d)(1) of this section must file a protest in writing and provide all relevant supporting documentation to us within 10 calendar days after the

date we notify him or her of our finding.

(3) A representative may not file a protest for reasons other than those listed in paragraph (d)(1) of this section. If a representative files a protest for reasons other than those listed in paragraph (d)(1) of this section, we will not process the protest and will implement our finding as if no protest had been filed. Our finding in response to the protest is final and not subject to further review.

(e) *Ineligibility and suspension.* (1) If an applicant does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraphs (a)(3) or (a)(4) of this section, the applicant will be either ineligible to take the written examination for which he or she applied or ineligible to receive direct fee payment if the applicant already took and passed the examination prior to our finding. If an applicant protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the applicant will be either ineligible to take the written examination for which he or she applied or ineligible to receive direct fee payment if the applicant already took and passed the examination prior to our finding.

(2) If an eligible non-attorney representative does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraphs (a)(3) or (a)(4) of this section, the non-attorney representative will be ineligible to receive direct fee payment beginning with the month after the month the protest period ends. If the eligible non-attorney representative protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the non-attorney representative will be ineligible to receive direct fee payment beginning with the month after the month we uphold our finding.

(3) If an eligible non-attorney representative does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraph (a)(6) of this section, the non-attorney representative will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month the protest period ends. If the eligible non-attorney representative protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the non-attorney representative will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month we uphold our finding. In either case, the non-attorney representative may provide us with documentation that he or she has acquired and maintains the required liability insurance coverage described in paragraph (a)(6) of this section, no earlier than the sixth month of the ineligibility. The non-attorney representative will again be eligible to receive direct fee payment beginning in the first month after the month we find that we have received sufficient documentation that the non-attorney representative meets the requirements of paragraph (a)(6) of this section.

(4) If an eligible non-attorney representative does not protest, in accordance with paragraph (d)(2) of this section, our finding about the criteria in paragraph (a)(7) of this section, the non-attorney representative will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month the protest period ends. If the eligible non-attorney representative protests in accordance with paragraph (d)(2) of this section and we uphold our finding, the non-attorney will be ineligible to receive direct fee payment for 6 full calendar months beginning with the month after the month we uphold our finding. In either case, the non-attorney representative may provide us with documentation that he or she has satisfied the criteria in paragraph (a)(7) of this section at any time. The non-attorney representative will again be eligible to receive direct fee payment beginning in the first month after the month we find that we have received sufficient documentation, but not earlier than the month following the end of the 6 month ineligibility period.

(f) *Reapplying.* A representative may reapply to become eligible to receive direct fee payment under paragraph (a) of this section during any subsequent application period if he or she:

(1) Did not meet the initial criteria for eligibility in paragraph (a)(1), (2),

(3), or (5) of this section in a prior application period; or

(2) Failed to timely correct a defective application in a prior application period as described in paragraph (b) of this section.

[76 FR 45194, July 28, 2011, as amended at 80 FR 400, Jan. 6, 2015]

§ 416.1520 Fee for a representative's services.

(a) *General.* A representative may charge and receive a fee for his or her services as a representative only as provided in paragraph (b) of this section.

(b) *Charging and receiving a fee.* (1) The representative must file a written request with us before he or she may charge or receive a fee for his or her services.

(2) We decide the amount of the fee, if any, a representative may charge or receive.

(3) Subject to paragraph (e) of this section, a representative must not charge or receive any fee unless we have authorized it, and a representative must not charge or receive any fee that is more than the amount we authorize.

(4) If your representative is an attorney or an eligible non-attorney, and you are entitled to past-due benefits, we will pay the authorized fee, or a part of the authorized fee, directly to the attorney or eligible non-attorney out of the past-due benefits, subject to the limitations described in § 416.1530(b)(1). If the representative is a non-attorney who is ineligible to receive direct fee payment, we assume no responsibility for the payment of any fee that we have authorized.

(c) *Notice of fee determination.* We shall mail to both you and your representative at your last known address a written notice of what we decide about the fee. We shall state in the notice—

(1) The amount of the fee that is authorized;

(2) How we made that decision;

(3) Whether we are responsible for paying the fee from past-due benefits; and

(4) That within 30 days of the date of the notice, either you or your representative may request us to review the fee determination.

(d) *Review of fee determination*—(1) *Request filed on time.* We will review the decision we made about a fee if either you or your representative files a written request for the review at one of our offices within 30 days after the date of the notice of the fee determination. Either you or your representative, whoever requests the review, shall mail a copy of the request to the other person. An authorized official of the Social Security Administration who did not take part in the fee determination being questioned will review the determination. This determination is not subject to further review. The official shall mail a written notice of the decision made on review both to you and to your representative at your last known address.

(2) *Request not filed on time.* (i) If you or your representative requests a review of the decision we made about a fee, but does so more than 30 days after the date of the notice of the fee determination, whoever makes the request shall state in writing why it was not filed within the 30-day period. We will review the determination if we decide that there was good cause for not filing the request on time.

(ii) Some examples of good cause follow:

(A) Either you or your representative was seriously ill and the illness prevented you or your representative from contacting us in person or in writing.

(B) There was a death or serious illness in your family or in the family of your representative.

(C) Material records were destroyed by fire or other accidental cause.

(D) We gave you or your representative incorrect or incomplete information about the right to request review.

(E) You or your representative did not timely receive notice of the fee determination.

(F) You or your representative sent the request to another government agency in good faith within the 30-day period, and the request did not reach us until after the period had ended.

(3) *Payment of fees.* We assume no responsibility for the payment of a fee based on a revised determination if the

request for administrative review was not filed on time.

(e) *When we do not need to authorize a fee.* We do not need to authorize a fee when:

(1) An entity or a Federal, State, county, or city government agency pays from its funds the representative fees and expenses and both of the following conditions apply:

(i) You are not liable to pay a fee or any expenses, or any part thereof, directly or indirectly, to the representative or someone else; and

(ii) The representative submits to us a writing in the form and manner we prescribe waiving the right to charge and collect a fee and any expenses from you directly or indirectly, in whole or in part; or

(2) A court authorizes a fee for your representative based on the representative's actions as your legal guardian or a court-appointed representative.

(f) *Assignment of direct payment of fees.* A representative who is eligible for direct payment of an authorized fee may assign direct payment of the authorized fee to an entity that is eligible for direct payment of fees (see §§416.1530(e) and 416.1535).

[45 FR 52106, Aug. 5, 1980, as amended at 72 FR 16725, Apr. 5, 2007; 74 FR 48384, Sept. 23, 2009; 76 FR 45195, July 28, 2011; 89 FR 67555, Aug. 21, 2024]

§416.1525 Request for approval of a fee.

(a) *Filing a request.* In order for your representative to obtain approval of a fee for services he or she performed in dealings with us, he or she shall file a written request with one of our offices. This should be done after the proceedings in which he or she was a representative are completed. The request must contain—

(1) The dates the representative's services began and ended;

(2) A list of the services he or she gave and the amount of time he or she spent on each type of service;

(3) The amount of the fee he or she wants to charge for the services;

(4) The amount of fee the representative wants to request or charge for his or her services in the same matter before any State or Federal court;

(5) The amount of and a list of any expenses the representative incurred for which he or she has been paid or expects to be paid;

(6) A description of the special qualifications which enabled the representative, if he or she is not an attorney, to give valuable help to you in connection with your claim; and

(7) A statement showing that the representative sent a copy of the request for approval of a fee to you.

(b) *Evaluating a request for approval of a fee.* (1) When we evaluate a representative's request for approval of a fee, we consider the purpose of the supplemental security income program, which is to assure a minimum level of income for the beneficiaries of the program, together with—

(i) The extent and type of services the representative performed;

(ii) The complexity of the case;

(iii) The level of skill and competence required of the representative in giving the services;

(iv) The amount of time the representative spent on the case;

(v) The results the representative achieved;

(vi) The level of review to which the claim was taken and the level of the review at which the representative became your representative; and

(vii) The amount of fee the representative requests for his or her services, including any amount authorized or requested before, but not including the amount of any expenses he or she incurred.

(2) Although we consider the amount of benefits, if any, that are payable, we do not base the amount of fee we authorize on the amount of the benefit alone, but on a consideration of all the factors listed in this section. The benefits payable in any claim are determined by specific provisions of law and are unrelated to the efforts of the representative. We may authorize a fee even if no benefits are payable.

§416.1528 Proceedings before a State or Federal court.

(a) *Representation of a party in court proceedings.* We shall not consider any service the representative gave you in

any proceeding before a State or Federal court to be services as a representative in dealings with us. However, if the representative also has given service to you in the same connection in any dealings with us, he or she must specify what, if any, portion of the fee he or she wants to charge is for services performed in dealings with us. If the representative charges any fee for those services, he or she must file the request and furnish all of the information required by § 416.1525.

(b) *Attorney fee allowed by a Federal court.* If a Federal court in any proceeding under title XVI of the Act makes a judgment in favor of the claimant who was represented before the court by an attorney, and the court, under section 1631(d)(2) of the Act, allows to the attorney as part of its judgment a fee not in excess of 25 percent of the total of past-due benefits to which the claimant is eligible by reason of the judgment, we may pay the attorney the amount of the fee out of, but not in addition to, the amount of the past-due benefits payable. We will not pay directly any other fee your representative may request.

[72 FR 16725, Apr. 5, 2007]

§ 416.1530 Payment of fees.

(a) *Fees allowed by a Federal court.* We will pay an attorney representative out of your past-due benefits the amount of the fee allowed by a Federal court in a proceeding under title XVI of the Act. The payment we make to the attorney is subject to the limitations described in paragraph (b)(1) of this section.

(b) *Fees we may pay*—(1) *Attorneys and eligible non-attorneys.* Except as provided in paragraph (c) of this section, if we make a determination or decision in your favor and you were represented by an attorney or an eligible non-attorney (see § 416.1517), and as a result of the determination or decision you have past-due benefits;

(i) We will pay your representative out of the past-due benefits the smallest of the amounts in paragraphs (b)(1)(iii) through (v) of this section, less the amount of the assessment described in paragraph (d) of this section, unless the representative files a waiver of the fee or direct payment of the fee; and

(ii) If there is a valid assignment (see paragraph (e) of this section), we will pay the representative's fee (see paragraph (b)(1)(i) of this section) to an entity.

(iii) Twenty-five percent of the total of the past-due benefits, as determined before any payment to a State (or political subdivision) to reimburse the State (or political subdivision) for interim assistance furnished you, as described in § 416.525 of this part, and reduced by the amount of any reduction in benefits under this title or title II pursuant to section 1127 of the Act;

(iv) The amount of past-due benefits remaining after we pay to a State (or political subdivision) an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished you, as described in § 416.525 of this part, and after any applicable reductions under section 1127 of the Act; or

(v) The amount of the fee that we set.

(2) *Non-attorneys ineligible for direct payment.* If the representative is a non-attorney who is ineligible to receive direct payment of his or her fee, we assume no responsibility for the payment of any fee that we authorized. We will not deduct the fee from your past-due benefits.

(c) *Time limit for filing request for approval of fee to obtain direct payment.* (1) To receive direct fee payment from your past-due benefits, a representative who is an attorney or an eligible non-attorney should file a request for approval of a fee, or written notice of the intent to file a request, at one of our offices, or electronically at the times and in the manner that we prescribe if we give notice that such a method is available, within 60 days of the date we mail the notice of the favorable determination or decision.

(2)(i) If no request is filed within 60 days of the date the notice of the favorable determination is mailed, we will mail a written notice to you and your representative at your last known addresses. The notice will inform you and the representative that unless the representative files, within 20 days from the date of the notice, a written request for approval of a fee under § 416.1525, or a written request for an

extension of time, we will pay all the past-due benefits to you.

(ii) The representative must send you a copy of any request made to us for an extension of time. If the request is not filed within 20 days of the date of the notice, or by the last day of any extension we approved, we will pay to you all past-due benefits remaining after we reimburse the State for any interim assistance you received. We must approve any fee the representative charges after that time, but the collection of any approved fee is a matter between you and the representative.

(d) *Assessment when we pay a fee directly to a representative.* (1) Whenever we pay a fee directly to a representative from past-due benefits, we impose an assessment on the representative.

(2) The amount of the assessment is equal to the lesser of:

(i) The product we obtain by multiplying the amount of the fee we are paying to the representative by the percentage rate the Commissioner of Social Security determines is necessary to achieve full recovery of the costs of determining and paying fees directly to representatives, but not in excess of 6.3 percent; and

(ii) The maximum assessment amount. The maximum assessment amount was initially set at $75, but by law is adjusted annually to reflect the increase in the cost of living. (See §§ 404.270 through 404.277 for an explanation of how the cost-of-living adjustment is computed.) If the adjusted amount is not a multiple of $1, we round down the amount to the next lower $1, but the amount will not be less than $75. We will announce any increase in the maximum assessment amount, and explain how that increase was determined in the FEDERAL REGISTER.

(3) We collect the assessment by subtracting it from the amount of the fee to be paid to the representative. The representative who is subject to an assessment may not, directly or indirectly, request or otherwise obtain reimbursement of the assessment from you.

(e) *Assignment of direct payment of a fee to designated entity.* (1) A representative may assign direct payment of the fee we authorize to an eligible entity if the representative:

(i) Is eligible for direct payment;

(ii) Has not waived the fee or direct payment;

(iii) Assigns direct payment of the entire fee we authorize to one entity in the manner we prescribe;

(iv) Makes the assignment before the date on which we notify you of our first favorable determination or decision; and

(v) Affiliates with the entity through registration.

(2) A representative may rescind an assignment in the manner we prescribe before the date on which we notify you of our first favorable determination or decision.

(3) A representative may not assign direct payment of a fee to an entity that is ineligible to receive direct payment.

(4) A representative may not waive a fee or direct payment of a fee if the representative previously assigned direct payment of a fee in accordance with paragraph (e)(1) of this section and did not timely rescind that assignment in accordance with paragraph (e)(2) of this section.

(f) *Effective dates for extension of direct payment of fee to attorneys.* The provisions of this subpart authorizing the direct payment of fees to attorneys and the withholding of title XVI benefits for that purpose, apply in claims for benefits with respect to which the agreement for representation is entered into before March 1, 2010.

[72 FR 16726, Apr. 5, 2007, as amended at 76 FR 45195, July 28, 2011; 89 FR 67555, Aug. 21, 2024]

§ 416.1535 Entity eligible for direct payment of fees.

An entity is eligible for direct payment of an authorized fee if the entity:

(a) Has an Employer Identification Number;

(b) Has registered with us in the manner we prescribe;

(c) Has not been found ineligible for direct payment;

(d) Designates and maintains an employee who is registered as a representative in the manner we prescribe as a point of contact to speak and act on the entity's behalf;

(e) Accepts payment via electronic funds transfer; and

(f) Conforms to our rules.

[89 FR 67556, Aug. 21, 2024]

§ 416.1540 Rules of conduct and standards of responsibility for representatives.

(a) *Purpose and scope.* (1) All attorneys or other persons acting on behalf of a party seeking a statutory right or benefit must, in their dealings with us, faithfully execute their duties as agents and fiduciaries of a party. A representative must provide competent assistance to the claimant and recognize our authority to lawfully administer the process. The following provisions set forth certain affirmative duties and prohibited actions that will govern the relationship between the representative and us, including matters involving our administrative procedures and fee collections.

(2) All representatives must be forthright in their dealings with us and with the claimant and must comport themselves with due regard for the nonadversarial nature of the proceedings by complying with our rules and standards, which are intended to ensure orderly and fair presentation of evidence and argument.

(b) *Affirmative duties.* A representative must, in conformity with the regulations setting forth our existing duties and responsibilities and those of claimants (see § 416.912 in disability and blindness claims):

(1) Act with reasonable promptness to help obtain the information or evidence that the claimant must submit under our regulations, and forward the information or evidence to us for consideration as soon as practicable.

(2) Assist the claimant in complying, as soon as practicable, with our requests for information or evidence at any stage of the administrative decisionmaking process in his or her claim. In disability and blindness claims, this includes the obligation pursuant to § 416.912(c) to assist the claimant in providing, upon our request, evidence about:

(i) The claimant's medical source(s);

(ii) The claimant's age;

(iii) The claimant's education and training;

(iv) The claimant's work experience;

(v) The claimant's daily activities both before and after the date the claimant alleges that he or she became disabled;

(vi) The claimant's efforts to work; and

(vii) Any other factors showing how the claimant's impairment(s) affects his or her ability to work. In §§ 416.960 through 416.969a, we discuss in more detail the evidence we need when we consider vocational factors.

(3) Conduct his or her dealings in a manner that furthers the efficient, fair, and orderly conduct of the administrative decision-making process, including duties to:

(i) Provide competent representation to a claimant. Competent representation requires the knowledge, skill, thoroughness, and preparation reasonably necessary for the representation. A representative must know the significant issue(s) in a claim, have reasonable and adequate familiarity with the evidence in the case, and have a working knowledge of the applicable provisions of the Social Security Act, as amended, the regulations, the Social Security Rulings, and any other applicable provisions of law.

(ii) Act with reasonable diligence and promptness in representing a claimant. This includes providing prompt and responsive answers to our requests for information pertinent to processing of the claim.

(iii) When requested, provide us, in a manner we specify, potential dates and times that the representative will be available for a hearing. We will inform the representative how many potential dates and times we require to coordinate the hearing schedule.

(iv) Only withdraw representation at a time and in a manner that does not disrupt the processing or adjudication of a claim and that provides the claimant adequate time to find new representation, if desired. A representative should not withdraw after we set the time and place for the hearing (see § 416.1436) unless the representative can show that a withdrawal is necessary due to extraordinary circumstances, as we determine on a case-by-case basis.

(v) Maintain prompt and timely communication with the claimant, which

includes, but is not limited to, reasonably informing the claimant of all matters concerning the representation, consulting with the claimant on an ongoing basis during the entire representational period, and promptly responding to a claimant's reasonable requests for information. When we evaluate whether a representative has maintained prompt and timely communication with the claimant, we will consider the difficulty the representative has in locating a particular claimant (e.g., because the claimant is homeless) and the representative's efforts to keep that claimant informed.

(4) Conduct business with us electronically at the times and in the manner we prescribe on matters for which the representative requests direct fee payment. (*See* §416.1513).

(5) Disclose in writing, at the time a medical or vocational opinion is submitted to us or as soon as the representative is aware of the submission to us, if:

(i) The representative's employee or any individual contracting with the representative drafted, prepared, or issued the medical or vocational opinion; or

(ii) The representative referred or suggested that the claimant seek an examination from, treatment by, or the assistance of, the individual providing opinion evidence.

(6) Disclose to us immediately if the representative discovers that his or her services are or were used by the claimant to commit fraud against us.

(7) Disclose to us whether the representative is or has been disbarred or suspended from any bar or court to which he or she was previously admitted to practice, including instances in which a bar or court took administrative action to disbar or suspend the representative in lieu of disciplinary proceedings (e.g., acceptance of voluntary resignation pending disciplinary action). If the disbarment or suspension occurs after the appointment of the representative, the representative will immediately disclose the disbarment or suspension to us.

(8) Disclose to us whether the representative is or has been disqualified from participating in or appearing before any Federal program or agency, including instances in which a Federal program or agency took administrative action to disqualify the representative in lieu of disciplinary proceedings (e.g., acceptance of voluntary resignation pending disciplinary action). If the disqualification occurs after the appointment of the representative, the representative will immediately disclose the disqualification to us.

(9) Disclose to us whether the representative has been removed from practice or suspended by a professional licensing authority for reasons that reflect on the person's character, integrity, judgment, reliability, or fitness to serve as a fiduciary. If the removal or suspension occurs after the appointment of the representative, the representative will immediately disclose the removal or suspension to us.

(10) Ensure that all of the representative's employees, assistants, partners, contractors, or any person assisting the representative on claims for which the representative has been appointed, comply with these rules of conduct and standards of responsibility for representatives, when the representative has managerial or supervisory authority over these individuals or otherwise has responsibility to oversee their work. This includes a duty to take remedial action when:

(i) The representative's employees, assistants, partners, contractors or other individuals' conduct violates these rules of conduct and standards of responsibility; and

(ii) The representative has reason to believe a violation of these rules of conduct and standards of responsibility occurred or will occur.

(c) *Prohibited actions.* A representative must not:

(1) In any manner or by any means threaten, coerce, intimidate, deceive or knowingly mislead a claimant, or prospective claimant or beneficiary, regarding benefits or other rights under the Act. This prohibition includes misleading a claimant, or prospective claimant or beneficiary, about the representative's services and qualifications.

(2) Knowingly charge, collect or retain, or make any arrangement to charge, collect or retain, from any source, directly or indirectly, any fee

for representational services in violation of applicable law or regulation. This prohibition includes soliciting any gift or any other item of value, other than what is authorized by law.

(3) Make or present, or participate in the making or presentation of, false or misleading oral or written statements, evidence, assertions, or representations about a material fact or law concerning a matter within our jurisdiction, in matters where the representative knows or should have known that those statements, evidence, assertions or representations are false or misleading.

(4) Through his or her own actions or omissions, unreasonably delay or cause to be delayed, without good cause (see § 416.1411(b)), the processing of a claim at any stage of the administrative decision-making process.

(5) Divulge, without the claimant's consent, except as may be authorized by regulations prescribed by us or as otherwise provided by Federal law, any information we furnish or disclose about a claim or prospective claim.

(6) Attempt to influence, directly or indirectly, the outcome of a decision, determination, or other administrative action by any means prohibited by law, or offering or granting a loan, gift, entertainment, or anything of value to a presiding official, agency employee, or witness who is or may reasonably be expected to be involved in the administrative decision-making process, except as reimbursement for legitimately incurred expenses or lawful compensation for the services of an expert witness retained on a non-contingency basis to provide evidence.

(7) Engage in actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings, including but not limited to:

(i) Repeated absences from or persistent tardiness at scheduled proceedings without good cause (see § 416.1411(b));

(ii) Behavior that has the effect of improperly disrupting proceedings or obstructing the adjudicative process, including but not limited to:

(A) Directing threatening or intimidating language, gestures, or actions at a presiding official, witness, contractor, or agency employee;

(B) Providing misleading information or misrepresenting facts that affect how we process a claim, including, but not limited to, information relating to the claimant's work activity or the claimant's place of residence or mailing address in matters where the representative knows or should have known that the information was misleading and the facts would constitute a misrepresentation; and

(C) Communicating with agency staff or adjudicators outside the normal course of business or other prescribed procedures in an attempt to inappropriately influence the processing or outcome of a claim(s).

(8) Violate any section of the Act for which a criminal or civil monetary penalty is prescribed.

(9) Refuse to comply with any of our rules or regulations.

(10) Suggest, assist, or direct another person to violate our rules or regulations.

(11) Advise any claimant or beneficiary not to comply with any of our rules or regulations.

(12) Knowingly assist a person whom we suspended or disqualified to provide representational services in a proceeding under title XVI of the Act, or to exercise the authority of a representative described in § 416.1510.

(13) Fail to comply with our sanction(s) decision.

(14) Fail to oversee the representative's employees, assistants, partners, contractors, or any other person assisting the representative on claims for which the representative has been appointed when the representative has managerial or supervisory authority over these individuals or otherwise has responsibility to oversee their work.

(15) While serving as a point of contact for an entity, violate applicable affirmative duties, engage in prohibited actions, or conduct dealings with us in a manner that is untruthful or does not further the efficient and prompt correction of a fee error.

[63 FR 41417, Aug. 4, 1998, as amended at 76 FR 56109, Sept. 12, 2011; 76 FR 80247, Dec. 23, 2011; 80 FR 14838, Mar. 20, 2015; 83 FR 30857, July 2, 2018; 89 FR 67556, Aug. 21, 2024]

§ 416.1545 Violations of our requirements, rules, or standards.

When we have evidence that a representative fails to meet our qualification requirements or has violated the rules governing dealings with us, we may begin proceedings to suspend or disqualify that individual from acting in a representational capacity before us. We may file charges seeking such sanctions when we have evidence that a representative:

(a) Does not meet the qualifying requirements described in § 416.1505;

(b) Has violated the affirmative duties or engaged in the prohibited actions set forth in § 416.1540;

(c) Has been convicted of a violation under section 1631(d) of the Act;

(d) Has been, by reason of misconduct, disbarred or suspended from any bar or court to which he or she was previously admitted to practice (see § 416.1570(a));

(e) Has been, by reason of misconduct, disqualified from participating in or appearing before any Federal program or agency (see § 416.1570(a)); or

(f) Who, as a non-attorney, has been removed from practice or suspended by a professional licensing authority for reasons that reflect on the person's character, integrity, judgment, reliability, or fitness to serve as a fiduciary.

[63 FR 41418, Aug. 4, 1998, as amended at 71 FR 2877, Jan. 18, 2006; 83 FR 30858, July 2, 2018]

§ 416.1550 Notice of charges against a representative.

(a) The General Counsel or other delegated official will prepare a notice containing a statement of charges that constitutes the basis for the proceeding against the representative.

(b) We will send this notice to the representative either by certified or registered mail, to his or her last known address, or by personal delivery.

(c) We will advise the representative to file an answer, within 14 business days from the date of the notice, or from the date the notice was delivered personally, stating why he or she should not be suspended or disqualified from acting as a representative in dealings with us.

(d) The General Counsel or other delegated official may extend the 14-day period specified in paragraph (c) of this section for good cause in accordance with § 416.1411.

(e) The representative must—

(1) Answer the notice in writing under oath (or affirmation); and

(2) File the answer with the Social Security Administration, at the address specified on the notice, within the 14-day time period specified in paragraph (c) of this section.

(f) If the representative does not file an answer within the 14-day time period specified in paragraph (c) of this section (or the period extended in accordance with paragraph (d) of this section), he or she does not have the right to present evidence, except as may be provided in § 416.1565(g).

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 62 FR 38455, July 18, 1997; 63 FR 41418, Aug. 4, 1998; 71 FR 2878, Jan. 18, 2006; 76 FR 80247, Dec. 23, 2011; 83 FR 30858, July 2, 2018]

§ 416.1555 Withdrawing charges against a representative.

The General Counsel or other delegated official may withdraw charges against a representative. We will withdraw charges if the representative files an answer, or we obtain evidence, that satisfies us that we should not suspend or disqualify the representative from acting as a representative. When we consider withdrawing charges brought under § 416.1545(d) through (f) based on the representative's assertion that, before or after our filing of charges, the representative has been reinstated to practice by the court, bar, or Federal program or Federal agency that suspended, disbarred, or disqualified the representative, the General Counsel or other delegated official will determine whether such reinstatement occurred, whether it remains in effect, and whether he or she is reasonably satisfied that the representative will in the future act in accordance with the provisions of section 206(a) of the Act and our rules and regulations. If the representative proves that reinstatement occurred and remains in effect and the General Counsel or other delegated official is so satisfied, the General Counsel or other delegated official will

withdraw those charges. The action of the General Counsel or other delegated official regarding withdrawal of charges is solely that of the General Counsel or other delegated official and is not reviewable, or subject to consideration in decisions made under §§ 416.1570 and 416.1590. If we withdraw the charges, we will notify the representative by mail at the representative's last known address.

[83 FR 30859, July 2, 2018]

§ 416.1565 Hearing on charges.

(a) *Holding the hearing.* If the General Counsel or other delegated official does not take action to withdraw the charges within 15 days after the date on which the representative filed an answer, we will hold a hearing and make a decision on the charges.

(b) *Hearing officer.* (1) The Deputy Commissioner for the Office of Hearings Operations or other delegated official will assign an administrative law judge, designated to act as a hearing officer, to hold a hearing on the charges.

(2) No hearing officer shall hold a hearing in a case in which he or she is prejudiced or partial about any party, or has any interest in the matter.

(3) If the representative or any party to the hearing objects to the hearing officer who has been named to hold the hearing, we must be notified at the earliest opportunity. The hearing officer shall consider the objection(s) and either proceed with the hearing or withdraw from it.

(4) If the hearing officer withdraws from the hearing, another one will be named.

(5) If the hearing officer does not withdraw, the representative or any other person objecting may, after the hearing, present his or her objections to the Appeals Council explaining why he or she believes the hearing officer's decision should be revised or a new hearing held by another administrative law judge designated to act as a hearing officer.

(c) *Time and place of hearing.* The hearing officer shall mail the parties a written notice of the hearing at their last known addresses, at least 14 calendar days before the date set for the hearing. The notice will inform the parties whether the appearance of the parties or any witnesses will be in person, by video teleconferencing, or by telephone. The notice will also include requirements and instructions for filing motions, requesting witnesses, and entering exhibits.

(d) *Change of time and place for hearing.* (1) The hearing officer may change the time and place for the hearing, either on his or her own initiative, or at the request of the representative or the other party to the hearing. The hearing officer will not consider objections to the manner of appearance of parties or witnesses, unless the party shows good cause not to appear in the prescribed manner. To determine whether good cause exists for extending the deadline, we use the standards explained in § 416.1411.

(2) The hearing officer may adjourn or postpone the hearing.

(3) Subject to the limitations in paragraph (g)(2) of this section, the hearing officer may reopen the hearing for the receipt of additional evidence at any time before mailing notice of the decision.

(4) The hearing officer shall give the representative and the other party to the hearing reasonable notice of any change in the time or place for the hearing, or of an adjournment or reopening of the hearing.

(e) *Parties.* The representative against whom charges have been made is a party to the hearing. The General Counsel or other delegated official will also be a party to the hearing.

(f) *Subpoenas.* (1) The representative or the other party to the hearing may request the hearing officer to issue a subpoena for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to any matter being considered at the hearing. The hearing officer may, on his or her own, initiative, issue subpoenas for the same purposes when the action is reasonably necessary for the full presentation of the facts.

(2) The representative or the other party who wants a subpoena issued shall file a written request with the hearing officer. This must be done at least 5 days before the date set for the

hearing. The request must name the documents to be produced, and describe the address or location in enough detail to permit the witnesses or documents to be found.

(3) The representative or the other party who wants a subpoena issued shall state in the request for a subpoena the material facts that he or she expects to establish by the witness or document, and why the facts could not be established by the use of other evidence which could be obtained without use of a subpoena.

(4) We will pay the cost of the issuance and the fees and mileage of any witness subpoenaed, as provided in section 205(d) of the Act.

(g) *Conduct of the hearing.* (1) The representative or the other party may file a motion for decision on the basis of the record prior to the hearing. The hearing officer will give the representative and the other party a reasonable amount of time to submit any evidence and to file briefs or other written statements as to fact and law prior to deciding the motion. If the hearing officer concludes that there is no genuine dispute as to any material fact and the movant is entitled to a decision as a matter of law, the hearing officer may grant the motion and issue a decision in accordance with the provisions of §416.1570.

(2) If the representative did not file an answer to the charges, he or she has no right to present evidence at the hearing. The hearing officer may make or recommend a decision on the basis of the record, or permit the representative to present a statement about the sufficiency of the evidence or the validity of the proceedings upon which the suspension or disqualification, if it occurred, would be based.

(3) The hearing officer will make the hearing open to the representative, to the other party, and to any persons the hearing officer or the parties consider necessary or proper. The hearing officer will inquire fully into the matters being considered, hear the testimony of witnesses, and accept any documents that are material.

(4) The hearing officer has the right to decide the order in which the evidence and the allegations will be presented and the conduct of the hearing.

(h) *Evidence.* The hearing officer may accept evidence at the hearing, even though it is not admissible under the rules of evidence that apply to Federal court procedure.

(i) *Witnesses.* Witnesses who testify at the hearing shall do so under oath or affirmation. Either the representative or a person representing him or her may question the witnesses. The other party and that party's representative must also be allowed to question the witnesses. The hearing officer may also ask questions as considered necessary, and shall rule upon any objection made by either party about whether any question is proper.

(j) *Oral and written summation.* (1) The hearing officer shall give the representative and the other party a reasonable time to present oral summation and to file briefs or other written statements about proposed findings of fact and conclusions of law if the parties request it.

(2) The party that files briefs or other written statements shall provide enough copies so that they may be made available to any other party to the hearing who requests a copy.

(k) *Record of hearing.* In all cases, the hearing officer shall have a complete record of the proceedings at the hearing made.

(l) *Representation.* The representative, as the person charged, may appear in person and may be represented by an attorney or other representative. The General Counsel or other delegated official will be represented by one or more attorneys from the Office of the General Counsel.

(m) *Failure to appear.* If the representative or the other party to the hearing fails to appear after being notified of the time and place, the hearing officer may hold the hearing anyway so that the party present may offer evidence to sustain or rebut the charges. The hearing officer shall give the party who failed to appear an opportunity to show good cause for failure to appear. If the party fails to show good cause, he or she is considered to have waived the right to be present at the hearing. If the party shows good cause, the hearing officer may hold a supplemental hearing.

(n) *Dismissal of charges.* The hearing officer may dismiss the charges in the event of the death of the representative.

(o) *Cost of transcript.* If the representative or the other party to a hearing requests a copy of the transcript of the hearing, the hearing officer will have it prepared and sent to the party upon payment of the cost, unless the payment is waived for good cause.

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 62 FR 38455, July 18, 1997; 63 FR 41418, Aug. 4, 1998; 71 FR 2878, Jan. 18, 2006; 76 FR 80248, Dec. 23, 2011; 83 FR 30859, July 2, 2018]

§ 416.1570 Decision by hearing officer.

(a) *General.* (1) After the close of the hearing, the hearing officer will issue a decision or certify the case to the Appeals Council. The decision must be in writing, will contain findings of fact and conclusions of law, and be based upon the evidence of record.

(2) In deciding whether a person has been, by reason of misconduct, disbarred or suspended by a court or bar, or disqualified from participating in or appearing before any Federal program or Federal agency, the hearing officer will consider the reasons for the disbarment, suspension, or disqualification action. If the action was taken for solely administrative reasons (e.g., failure to pay dues or to complete continuing legal education requirements), that will not disqualify the person from acting as a representative before us. However, this exception to disqualification does not apply if the administrative action was taken in lieu of disciplinary proceedings (e.g., acceptance of a voluntary resignation pending disciplinary action). Although the hearing officer will consider whether the disbarment, suspension, or disqualification action is based on misconduct when deciding whether a person should be disqualified from acting as a representative before us, the hearing officer will not re-examine or revise the factual or legal conclusions that led to the disbarment, suspension, or disqualification. For purposes of determining whether a person has been, by reason of misconduct, disqualified from participating in or appearing before any Federal program or Federal agency, disqualified refers to any action that prohibits a person from participating in or appearing before any Federal program or Federal agency, regardless of how long the prohibition lasts or the specific terminology used.

(3) If the hearing officer finds that the charges against the representative have been sustained, he or she will either—

(i) Suspend the representative for a specified period of not less than 1 year, nor more than 5 years, from the date of the decision; or

(ii) Disqualify the representative from acting as a representative in dealings with us until he or she may be reinstated under § 416.1599. Disqualification is the sole sanction available if the charges have been sustained because the representative has been disbarred or suspended from any court or bar to which the representative was previously admitted to practice or disqualified from participating in or appearing before any Federal program or Federal agency, or because the representative has collected or received, and retains, a fee for representational services in excess of the amount authorized.

(4) The hearing officer shall mail a copy of the decision to the parties at their last known addresses. The notice will inform the parties of the right to request the Appeals Council to review the decision.

(b) *Effect of hearing officer's decision.* (1) The hearing officer's decision is final and binding unless reversed or modified by the Appeals Council upon review.

(2) If the final decision is that a person is disqualified from being a representative in dealings with us, he or she will not be permitted to represent anyone in dealings with us until authorized to do so under the provisions of § 416.1599.

(3) If the final decision is that a person is suspended for a specified period of time from being a representative in dealings with us, he or she will not be

permitted to represent anyone in dealings with us during the period of suspension unless authorized to do so under the provisions of § 416.1599.

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 71 FR 2878, Jan. 18, 2006; 76 FR 80248, Dec. 23, 2011]

§ 416.1575 Requesting review of the hearing officer's decision.

(a) *General.* After the hearing officer issues a decision, either the representative or the other party to the hearing may ask the Appeals Council to review the decision.

(b) *Time and place of filing request for review.* The party requesting review will file the request for review in writing with the Appeals Council within 14 business days from the date the hearing officer mailed the notice. The party requesting review will certify that a copy of the request for review and of any documents that are submitted have been mailed to the opposing party.

[45 FR 52106, Aug. 5, 1980, as amended at 83 FR 30859, July 2, 2018]

§ 416.1576 Assignment of request for review of the hearing officer's decision.

Upon receipt of a request for review of the hearing officer's decision, the matter will be assigned to a panel consisting of three members of the Appeals Council none of whom shall be the Chair of the Appeals Council. The panel shall jointly consider and rule by majority opinion on the request for review of the hearing officer's decision, including a determination to dismiss the request for review. Matters other than a final disposition of the request for review may be disposed of by the member designated chair of the panel.

[56 FR 24132, May 29, 1991]

§ 416.1580 Appeals Council's review of hearing officer's decision.

(a) Upon request, the Appeals Council will give the parties a reasonable time to file briefs or other written statements as to fact and law, and to request to appear before the Appeals Council to present oral argument. When oral argument is requested within the time designated by the Appeals Council, the Appeals Council will grant the request for oral argument and determine whether the parties will appear at the oral argument in person, by video teleconferencing, or by telephone. If oral argument is not requested within the time designated by the Appeals Council, the Appeals Council may deny the request.

(b) If a party files a brief or other written statement with the Appeals Council, he or she shall send a copy to the opposing party and certify that the copy has been sent.

[45 FR 52106, Aug. 5, 1980, as amended at 83 FR 30859, July 2, 2018]

§ 416.1585 Evidence permitted on review.

(a) *General.* Generally, the Appeals Council will not consider evidence in addition to that introduced at the hearing. However, if the Appeals Council finds the evidence offered is material to an issue it is considering, it may consider that evidence, as described in paragraph (b) of this section.

(b) *Individual charged filed an answer.* (1) When the Appeals Council finds that additional evidence material to the charges is available, and the individual charged filed an answer to the charges, the Appeals Council will allow the party with the information to submit the additional evidence.

(2) Before the Appeals Council admits additional evidence into the record, it will mail a notice to the parties, informing them that evidence about certain issues was submitted. The Appeals Council will give each party a reasonable opportunity to comment on the evidence and to present other evidence that is material to an issue it is considering.

(3) The Appeals Council will determine whether the additional evidence warrants a new review by a hearing officer or whether the Appeals Council will consider the additional evidence as part of its review of the case.

(c) *Individual charged did not file an answer.* If the representative did not file an answer to the charges, the representative may not introduce evidence that was not considered at the hearing.

[83 FR 30859, July 2, 2018]

§ 416.1590 Appeals Council's decision.

(a) The Appeals Council will base its decision upon the evidence in the hearing record and any other evidence it may permit on review. The Appeals Council will affirm the hearing officer's decision if the action, findings, and conclusions are supported by substantial evidence. If the hearing officer's decision is not supported by substantial evidence, the Appeals Council will either:

(1) Reverse or modify the hearing officer's decision; or

(2) Return a case to the hearing officer for further proceedings.

(b) The Appeals Council, in changing a hearing officer's decision to suspend a representative for a specified period, shall in no event reduce the period of suspension to less than 1 year. In modifying a hearing officer's decision to disqualify a representative, the Appeals Council shall in no event impose a period of suspension of less than 1 year. Further, the Appeals Council shall in no event impose a suspension when disqualification is the sole sanction available in accordance with § 416.1570(a)(3)(ii).

(c) If the Appeals Council affirms or changes a hearing officer's decision, the period of suspension or the disqualification is effective from the date of the Appeals Council's decision.

(d) If the hearing officer did not impose a period of suspension or a disqualification, and the Appeals Council decides to impose one or the other, the suspension or disqualification is effective from the date of the Appeals Council's decision.

(e) The Appeals Council shall make its decision in writing and shall mail a copy of the decision to the parties at their last known addresses.

(f) The Appeals Council may designate and publish certain final decisions as precedent for other actions brought under its representative conduct provisions. Prior to making a decision public, we will remove or redact personally identifiable information from the decision.

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24133, May 29, 1991; 71 FR 2878, Jan. 18, 2006; 83 FR 30860, July 2, 2018]

§ 416.1595 When the Appeals Council will dismiss a request for review.

The Appeals Council may dismiss a request for the review of any proceeding to suspend or disqualify a representative in any of the following circumstances:

(a) *Upon request of party*. The Appeals Council may dismiss a request for review upon written request of the party or parties who filed the request, if there is no other party who objects to the dismissal.

(b) *Death of party*. The Appeals Council may dismiss a request for review in the event of the death of the representative.

(c) *Request for review not timely filed*. The Appeals Council will dismiss a request for review if a party failed to file a request for review within the 14 business day time period set forth in § 404.1775(b) and the Appeals Council does not extend the time for good cause.

[45 FR 52106, Aug. 5, 1980, as amended at 84 FR 51367, Sept. 30, 2019]

§ 416.1597 Reinstatement after suspension—period of suspension expired.

We shall automatically allow a person to serve again as a representative in dealings with us at the end of any suspension.

§ 416.1599 Reinstatement after suspension or disqualification—period of suspension not expired.

(a) After more than one year has passed, a person who has been suspended or disqualified may ask the Appeals Council for permission to serve as a representative again. The Appeals Council will assign and process a request for reinstatement using the same general procedures described in § 416.1576.

(b) The suspended or disqualified person must submit any evidence the person wishes to have considered along with the request to be allowed to serve as a representative again.

(c) The General Counsel or other delegated official, upon notification of receipt of the request, will have 30 days in which to present a written report of any experiences with the suspended or disqualified person subsequent to that person's suspension or disqualification.

The Appeals Council will make available to the suspended or disqualified person a copy of the report.

(d)(1) The Appeals Council shall not grant the request unless it is reasonably satisfied that the person will in the future act according to the provisions of section 206(a) of the Act, and to our rules and regulations.

(2) If a person was disqualified because he or she had been disbarred, suspended, or removed from practice for the reasons described in § 416.1545(d) through (f), the Appeals Council will grant a request for reinstatement as a representative only if the criterion in paragraph (d)(1) of this section is met and the disqualified person shows that he or she has been admitted (or readmitted) to and is in good standing with the court, bar, Federal program or agency, or other governmental or professional licensing authority from which he or she had been disbarred, suspended, or removed from practice.

(3) If a person was disqualified because the person had been disqualified from participating in or appearing before a Federal program or Federal agency, the Appeals Council will grant the request for reinstatement only if the criterion in paragraph (d)(1) of this section is met and the disqualified person shows that the person is now qualified to participate in or appear before that Federal program or Federal agency.

(4) If the person was disqualified as a result of collecting or receiving, and retaining, a fee for representational services in excess of the amount authorized, the Appeals Council will grant the request only if the criterion in paragraph (d)(1) of this section is met and the disqualified person shows that full restitution has been made.

(e) The Appeals Council will mail a notice of its decision on the request for reinstatement to the suspended or disqualified person. It will also mail a copy to the General Counsel or other delegated official.

(f) If the Appeals Council decides not to grant the request, it will not consider another request before the end of 3 years from the date of the notice of the previous denial.

[45 FR 52106, Aug. 5, 1980, as amended at 56 FR 24133, May 29, 1991; 62 FR 38455, July 18, 1997; 63 FR 41418, Aug. 4, 1998; 71 FR 2878, Jan. 18, 2006; 76 FR 80248, Dec. 23, 2011; 83 FR 30860, July 2, 2018]

Subpart P—Residence and Citizenship

AUTHORITY: Secs. 702(a)(5), 1614 (a)(1)(B) and (e), and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382c (a)(1)(B) and (e), and 1383); 8 U.S.C. 1254a; sec. 502, Pub. L. 94–241, 90 Stat. 268 (48 U.S.C. 1681 note).

SOURCE: 47 FR 3106, Jan. 22, 1982, unless otherwise noted.

§ 416.1600 Introduction.

You are eligible for supplemental security income (SSI) benefits if you meet the requirements in subpart B. Among these are requirements that you must be a resident of the United States and either a citizen, a national, or an alien with a lawful right to reside permanently in the United States. In this subpart, we tell you what kinds of evidence show that you are a resident of the United States (see § 416.1603) and—

(a) A citizen or a national of the United States (see § 416.1610);

(b) An alien lawfully admitted for permanent residence in the United States (see § 416.1615); or

(c) An alien permanently residing in the United States under color of law (see § 416.1618).

§ 416.1601 Definitions and terms used in this subpart.

We or *Us* means the Social Security Administration.

You or *Your* means the person who applies for or receives SSI benefits or the person for whom an application is filed.

§ 416.1603 How to prove you are a resident of the United States.

(a) *What you should give us.* Your home address in the United States may be sufficient to establish that you are a resident. However, if we have any reason to question that you are a resident of the United States we will ask for

evidence. You can prove you are a resident of the United States by giving us papers or documents showing that you live in the United States such as—

(1) Property, income, or other tax forms or receipts;

(2) Utility bills, leases or rent payment records;

(3) Documents that show you participate in a social services program in the United States; or

(4) Other records or documents that show you live in the United States.

(b) *What ''resident of the United States'' means.* We use the term *resident of the United States* to mean a person who has established an actual dwelling place within the geographical limits of the United States with the intent to continue to live in the United States.

(c) *What ''United States'' means.* We use the term *United States* in this section to mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

[47 FR 3106, Jan. 22, 1982, as amended at 62 FR 59813, Nov. 5, 1997]

§ 416.1610 How to prove you are a citizen or a national of the United States.

(a) *What you should give us.* You can prove that you are a citizen or a national of the United States by giving us—

(1) A certified copy of your birth certificate which shows that you were born in the United States;

(2) A certified copy of a religious record of your birth or baptism, recorded in the United States within 3 months of your birth, which shows you were born in the United States;

(3) Your naturalization certificate;

(4) Your United States passport;

(5) Your certificate of citizenship;

(6) An identification card for use of resident citizens in the United States (Immigration and Naturalization Service Form I–197); or

(7) An identification card for use of resident citizens of the United States by both or naturalization of parents (INS Form I–179).

(b) *How to prove you are an interim citizen of the United States if you live in the Northern Mariana Islands.* As a resident of the Northern Mariana Islands you must meet certain conditions to prove you are an interim citizen of the United States. You must prove that you were domiciled in the Northern Mariana Islands as required by section 8 of the Schedule of Transitional Matters of the Constitution of the Northern Mariana Islands, or that you were born there after March 6, 1977. By ''domiciled'' we mean that you maintained a residence with the intention of continuing that residence for an unlimited or indefinite period, and that you intended to return to that residence whenever absent, even for an extended period. You must also give us proof of your citizenship if you are a citizen of the Trust Territory of the Pacific Islands of which the Marianas are a part.

(1) You can prove you were domiciled in the Northern Mariana Islands by giving us—

(i) Statements of civil authorities; or

(ii) Receipts or other evidence that show you were domiciled there.

(2) You can prove that you are a citizen of the Trust Territory of the Pacific Islands by giving us—

(i) Your identification card issued by the Trust Territory of the Pacific Islands and a public or religious record of age which shows you were born in this territory;

(ii) Your voter's registration card;

(iii) A Chammoro Family Record showing your birth in the Trust Territory of the Pacific Islands; or

(iv) Your naturalization certificate.

(c) *What to do if you cannot give us the information listed in paragraph (a) or (b).* If you cannot give us any of the documents listed in paragraph (a) or (b), we may find you to be a citizen or a national of the United States if you—

(1) Explain why you cannot give us any of the documents; and

(2) Give us any information you have which shows or results in proof that you are a citizen or a national of the United States. The kind of information we are most concerned about shows—

(i) The date and place of your birth in the United States;

(ii) That you have voted or are otherwise known to be a citizen or national of the United States; or

(iii) The relationship to you and the citizenship of any person through whom you obtain citizenship.

(d) *What ''United States'' means.* We use the term *United States* in this section to mean the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands of the United States, American Samoa, Swain's Island, and the Northern Mariana Islands.

[47 FR 3106, Jan. 22, 1982, as amended at 62 FR 59813, Nov. 5, 1997]

§ 416.1615 How to prove you are lawfully admitted for permanent residence in the United States.

(a) *What you should give us.* You can prove that you are lawfully admitted for permanent residence in the United States by giving us—

(1) An Alien Registration Receipt Card issued by the Immigration and Naturalization Service (INS) in accordance with that Agency's current regulations;

(2) A reentry permit;

(3) An alien identification card issued by the government of the Northern Mariana Islands showing that you are admitted to the Northern Mariana Islands for permanent residence; or

(4) INS Form I–688 which shows that you have been granted lawful temporary resident status under section 210 or section 210A of the Immigration and Nationality Act.

(b) *What to do if you cannot give us the information listed in paragraph (a).* If you cannot give us any of the documents listed in paragraph (a), we may find you to be lawfully admitted for permanent residence in the United States if you—

(1) Explain why you cannot give us any of the documents; and

(2) Give us any information you have which shows or results in proof that you are lawfully admitted for permanent residence in the United States.

(c) *What ''United States'' means.* We use the term *United States* in this section to mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

(Approved by the Office of Management and Budget under control number 0960–0451)

[47 FR 3106, Jan. 22, 1982, as amended at 52 FR 21943, June 10, 1987; 56 FR 55075, Oct. 24, 1991; 61 FR 56134, Oct. 31, 1996]

§ 416.1618 When you are considered permanently residing in the United States under color of law.

(a) *General.* We will consider you to be permanently residing in the United States under color of law and you may be eligible for SSI benefits if you are an alien residing in the United States with the knowledge and permission of the Immigration and Naturalization Service and that agency does not contemplate enforcing your departure. The Immigration and Naturalization Service does not contemplate enforcing your departure if it is the policy or practice of that agency not to enforce the departure of aliens in the same category or if from all the facts and circumstances in your case it appears that the Immigration and Naturalization Service is otherwise permitting you to reside in the United States indefinitely. We make these decisions by verifying your status with the Immigration and Naturalization Service following the rules contained in paragraphs (b) through (e) of this section.

(b) *Categories of aliens who are permanently residing in the United States under color of law.* Aliens who are permanently residing in the United States under color of law are listed below. None of the categories includes applicants for an Immigration and Naturalization status other than those applicants listed in paragraph (b)(6) of this section or those covered under paragraph (b)(17) of this section. None of the categories allows SSI eligibility for nonimmigrants; for example, students or visitors. Also listed are the most common documents that the Immigration and Naturalization Service provides to aliens in these categories:

(1) Aliens admitted to the United States pursuant to 8 U.S.C. 1153(a)(7), (section 203(a)(7) of the Immigration and Nationality Act). We ask for INS Form I–94 endorsed ''Refugee-Conditional Entry'';

(2) Aliens paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) (section 212(d)(5) of the Immigration and Nationality Act) including Cuban/Haitian Entrants. We ask for INS Form I–94 with the notation that the alien was paroled pursuant to section

212(d)(5) of the Immigration and Nationality Act. For Cuban/Haitian Entrants, we ask for INS Form I–94 stamped ''Cuban/Haitian Entrant (Status Pending) reviewable January 15, 1981. Employment authorized until January 15, 1981.'' (Although the forms bear this notation, Cuban/Haitian Entrants are admitted under section 212(d)(5) of the Immigration and Nationality Act.);

(3) Aliens residing in the United States pursuant to an indefinite stay of deportation. We ask for an Immigration and Naturalization Service letter with this information or INS Form I–94 with such a notation;

(4) Aliens residing in the United States pursuant to an indefinite voluntary departure. We ask for an Immigration and Naturalization Service letter or INS Form I–94 showing that a voluntary departure has been granted for an indefinite time period;

(5) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for a copy of INS Form I–94 or I–210 letter showing that status;

(6) Aliens who have filed applications for adjustment of status pursuant to section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the Immigration and Naturalization Service has accepted as ''properly filed'' (within the meaning of 8 CFR 245.2(a)(1) or (2)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for INS Form I–181 or a passport properly endorsed;

(7) Aliens granted stays of deportation by court order, statute or regulation, or by individual determination of the Immigration and Naturalization Service pursuant to section 106 of the Immigration and Nationality Act (8 U.S.C. 1105a) or relevant Immigration and Naturalization Service instructions, whose departure that agency does not contemplate enforcing. We ask for INS Form I–94 or a letter from the Immigration and Naturalization Service, or copy of a court order establishing the alien's status;

(8) Aliens granted asylum pursuant to section 208 of the Immigration and Nationality Act (8 U.S.C. 1158). We ask for INS Form I–94 and a letter establishing this status;

(9) Aliens admitted as refugees pursuant to section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)). We ask for INS Form I–94 properly endorsed;

(10) Aliens granted voluntary departure pursuant to section 242(b) of the Immigration and Nationality Act (8 U.S.C. 1252(b)) or 8 CFR 242.5 whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for INS Form I–94 or I–210 bearing a departure date;

(11) Aliens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1(a)(ii) prior to June 15, 1984 or 242.1(a)(22) issued June 15, 1984 and later. We ask for INS Form I–210 or a letter showing that departure has been deferred;

(12) Aliens residing in the United States under orders of supervision pursuant to section 242 of the Immigration and Nationality Act (8 U.S.C. 1252(d)). We ask for INS Form I–220B;

(13) Aliens who have entered and continuously resided in the United States since before January 1, 1972 (or any date established by section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259). We ask for any proof establishing this entry and continuous residence;

(14) Aliens granted suspension of deportation pursuant to section 244 of the Immigration and Nationality Act (8 U.S.C. 1254) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for an order from the immigration judge;

(15) Aliens whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)). We ask for an order from an immigration judge showing that deportation has been withheld;

(16) Aliens granted lawful temporary resident status pursuant to section 245A of the Immigration and Nationality Act (8 U.S.C. 1255a). We ask for INS form I–688 showing that status; or

(17) Any other aliens living in the United States with the knowledge and permission of the Immigration and Naturalization Service and whose departure that agency does not contemplate enforcing.

(c) *How to prove you are in a category listed in paragraph (b) of this section.* You must give us proof that you are in one of the categories in paragraph (b) of this section. You may give us—

(1) Any of the documents listed in paragraph (b) of this section; or

(2) Other information which shows that you are in one of the categories listed in paragraph (b) of this section.

(d) *We must contact the Immigration and Naturalization Service.* (1) We must contact the Immigration and Naturalization Service to verify the information you give us to prove you are permanently residing in the United States under color of law.

(2) If you give us any of the documents listed in paragraphs (b) (1), (2), (3), (4), (8), (9), (11), (12), (13), (15), or (16) of this section, we will pay you benefits if you meet all other eligibility requirements. We will contact the Immigration and Naturalization Service to verify that the document you give us is currently valid.

(3) If you give us any of the documents listed in paragraphs (b) (5), (6), (7), (10), or (14) of this section, or documents that indicate that you meet paragraph (b)(17) of this section, or any other information to prove you are permanently residing in the United States under color of law, we will contact the Immigration and Naturalization Service to verify that the document or other information is currently valid. We must also get information from the Immigration and Naturalization Service as to whether that agency contemplates enforcing your departure. We will apply the following rules:

(i) If you have a document that shows that you have an Immigration and Naturalization Service status that is valid for an indefinite period we will assume that the Immigration and Naturalization Service does not contemplate enforcing your departure. Therefore, we will pay you benefits if you meet all other eligibility requirements. If, based on the information we get from the Immigration and Naturalization Service, we find that your document is currently valid, we will consider this sufficient proof that the Immigration and Naturalization Service does not contemplate enforcing your departure. We will continue your benefits. However, if we find that your document is not currently valid, we will suspend your benefits under §416.1320.

(ii) If you have a document that appears currently valid and shows you have an Immigration and Naturalization Service status for at least 1 year, or that shows the Immigration and Naturalization Service is allowing you to remain in the United States for a specified period due to conditions in your home country, we will assume that the Immigration and Naturalization Service does not contemplate enforcing your departure. Therefore, we will pay you benefits if you meet all other eligibility requirements. If, based on the information we get from the Immigration and Naturalization Service, we learn that your document is currently valid and that agency does not contemplate enforcing your departure, we will continue your benefits. However, if we learn that your document is not currently valid or that the Immigration and Naturalization Service does contemplate enforcing your departure, we will suspend your benefits under §416.1320.

(iii) If you have a document that shows you have an Immigration and Naturalization Service status valid for less than 1 year, or if your document has no expiration date, or if you have no document, we will not pay you benefits until the Immigration and Naturalization Service confirms that your document is currently valid and we get information from that agency that indicates whether it contemplates enforcing your departure. If that agency does not contemplate enforcing your departure, we will pay you benefits if you meet all other eligibility requirements.

(iv) If at any time after you begin receiving benefits we receive information

from the Immigration and Naturalization Service which indicates that the Immigration and Naturalization Service contemplates enforcing your departure, we will suspend your benefits under § 416.1320 and any benefits you have received after the date that the Immigration and Naturalization Service began contemplating enforcing departure will be overpayments under subpart E of this part.

(e) *What ''United States'' means.* We use the term *United States* in this section to mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

(Approved by the Office of Management and Budget under control number 0960–0451)

[52 FR 21943, June 10, 1987, as amended at 56 FR 55075, Oct. 24, 1991; 56 FR 61287, Dec. 2, 1991]

§ 416.1619 When you cannot be considered permanently residing in the United States under color of law.

We will not consider you to be permanently residing in the United States under color of law and you are not eligible for SSI benefits during a period in which you have been granted temporary protected status by the Immigration and Naturalization Service under section 244A of the Immigration and Nationality Act.

[58 FR 41182, Aug. 3, 1993]

Subpart Q—Referral of Persons Eligible for Supplemental Security Income to Other Agencies

AUTHORITY: Secs. 702(a)(5), 1611(e)(3), 1615, and 1631 of the Social Security Act (42 U.S.C. 902(a)(5), 1382(e)(3), 1382d, and 1383).

SOURCE: 45 FR 70859, Oct. 27, 1980, unless otherwise noted.

GENERAL

§ 416.1701 Scope of subpart.

This subpart describes whom we refer to agencies for (a) vocational rehabilitation services or (b) treatment for alcoholism or drug addiction. The purpose of these services or treatments is to restore your ability to work. This subpart also describes the conditions under which you can refuse treatment after we have referred you. If these conditions are not met, this subpart describes how your benefits are affected when you refuse treatment.

[45 FR 70859, Oct. 27, 1980, as amended at 68 FR 40124, July 7, 2003]

§ 416.1705 Definitions.

As used in this subpart—

Vocational rehabilitation services refers to services provided blind or disabled persons under the State plan approved under the Rehabilitation Act of 1973 (see 45 CFR 401.120ff for requirements of these State plans).

We or *us* refers to either the Social Security Administration or the State agency making the disability or blindness determination.

You or *your* refers to the person who applies for or receives benefits or the person for whom an application is filed.

REFERRAL FOR VOCATIONAL REHABILITATION SERVICES

§ 416.1710 Whom we refer and when.

(a) *Whom we refer.* If you are 16 years of age or older and under 65 years old, and receiving supplemental security income (SSI) benefits, we will refer you to the State agency providing vocational rehabilitation services. If you are under age 16, we will refer you to an agency administering services under the Maternal and Child Health Services (Title V) Block Grant Act.

(b) *When we refer.* We will make this referral when we find you eligible for benefits or at any other time that we find you might be helped by vocational rehabilitation services.

[45 FR 70859, Oct. 27, 1980, as amended at 48 FR 6297, Feb. 23, 1983]

REFERRAL FOR TREATMENT OF ALCOHOLISM OR DRUG ADDICTION

§ 416.1720 Whom we refer.

We will refer you to an approved facility for treatment of your alcoholism or drug addiction if—

(a) You are disabled;

(b) You are not blind;

(c) You are not 65 years old or older; and

(d) Alcoholism or drug addiction is a contributing factor to your disability.

§ 416.1725 Effect of your failure to comply with treatment requirements for your drug addiction or alcoholism.

(a) *Suspension of benefits.* Your eligibility for benefits will be suspended beginning with the first month after we notify you in writing that we have determined that you have failed to comply with the treatment requirements for your drug addiction or alcoholism as defined in § 416.940. Your benefits will be suspended and reinstated in accordance with the provisions in § 416.1326.

(b) *Termination of benefits.* If your benefits are suspended for 12 consecutive months for failure to comply with treatment in accordance with § 416.1326, your eligibility for disability benefits will be terminated in accordance with § 416.1331.

[60 FR 8153, Feb. 10, 1995]

Subpart R—Relationship

AUTHORITY: Secs. 702(a)(5), 1612(b), 1614(b), (c), and (d), and 1631(d)(1) and (e) of the Social Security Act (42 U.S.C. 902(a)(5), 1382a(b), 1382c(b), (c), and (d) and 1383(d)(1) and (e)).

SOURCE: 45 FR 71795, Oct. 30, 1980, unless otherwise noted. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981.

§ 416.1801 Introduction.

(a) *What is in this subpart.* This subpart contains the basic rules for deciding for SSI purposes whether a person is considered married and, if so, to whom; whether a person is considered a child; and whether a person is considered another person's parent. It tells what information and evidence we need to decide these facts.

(b) *Related subparts.* Subpart D discusses how to determine the amount of a person's benefits; subpart G discusses what changes in a person's situation he or she must report to us; subpart K discusses how we count income; and subpart L discusses how we count resources (money and property). The questions of whether a person is married, to whom a person is married, whether a person is a child, and who is a person's parent must be answered in order to know which rules in subparts D, G, K, and L apply.

(c) *Definitions.* In this subpart—

Eligible spouse means a person—

(1) Who is eligible for SSI,

(2) Whom we consider the spouse of another person who is eligible for SSI, and

(3) Who was living in the same household with that person on—

(i) The first day of the month following the date the application is filed (for the initial month of eligibility for payment based on that application);

(ii) The date a request for reinstatement of eligibility is filed (for the month of such request); or

(iii) The first day of the month, for all other months. An individual is considered to be living with an eligible spouse during temporary absences as defined in § 416.1149 and while receiving continued benefits under section 1611(e)(1) (E) or (G) of the Act.

Spouse means a person's husband or wife under the rules of §§ 416.1806 through 416.1835 of this part.

We and *us* mean the Social Security Administration.

You means a person who has applied for or has been receiving SSI benefits, or a person for whom someone else has applied for or has been receiving SSI benefits.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 60 FR 16376, Mar. 30, 1995; 64 FR 31975, June 15, 1999; 65 FR 16815, Mar. 30, 2000]

WHO IS CONSIDERED YOUR SPOUSE

§ 416.1802 Effects of marriage on eligibility and amount of benefits.

(a) *If you have an ineligible spouse*—(1) *Counting income.* If you apply for or receive SSI benefits, and you are married to someone who is not eligible for SSI benefits and are living in the same household as that person, we may count part of that person's income as yours. Counting part of that person's income as yours may reduce the amount of your benefits or even make you ineligible. Section 416.410 discusses the amount of benefits and § 416.1163 explains how we count income for an individual with an ineligible spouse.

(2) *Counting resources.* If you are married to someone who is not eligible for SSI benefits and are living in the same household as that person, we will count

the value of that person's resources (money and property), minus certain exclusions, as yours when we determine your eligibility. Section 416.1202(a) gives a more detailed statement of how we count resources and § 416.1205(a) gives the limit of resources allowed for eligibility of a person with an ineligible spouse.

(b) *If you have an eligible spouse*—(1) *Counting income.* If you apply for or receive SSI benefits and have an eligible spouse as defined in § 416.1801(c), we will count your combined income and calculated the benefit amount for you as a couple. Section 416.412 gives a detailed statement of the amount of benefits and subpart K of this part explains how we count income for an eligible couple.

(2) *Counting resources.* If you have an eligible spouse as defined in § 416.1801(c), we will count the value of your combined resources (money and property), minus certain exclusions, and use the couple's resource limit when we determine your eligibility. Section 416.1205(b) gives a detailed statement of the resource limit for an eligible couple.

(c) *If you are married, we do not consider you a child.* The rules for counting income and resources are different for children than for adults. (Section 416.1851 discusses the effects of being considered a child on eligibility and amount of benefits.) Regardless of your age, if you are married we do not consider you to be a child.

(d)(1) *General rule:* Benefits depend on whether you are married or not married at the beginning of each month. If you get married, even on the first day of a month we will treat you as single until the next month. If your marriage ends, even on the first day of a month, we will treat you as married until the next month.

(2) *Exception: If you both meet eligibility requirements after your date of marriage or after your marriage ends.* If, in the month that you marry, each of you first meets all eligibility requirements after the date of your marriage, we will treat you as an eligible couple for that month. If, in the month that your marriage ends, each of you first meets all eligibility requirements after the date your marriage ends, we will treat you as eligible individuals. (See subparts D and E regarding how your benefits will be prorated.)

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, and amended at 51 FR 13495, Apr. 21, 1986; 60 FR 16376, Mar. 30, 1995]

§ 416.1806 Whether you are married and who is your spouse.

(a) We will consider someone to be your spouse (and therefore consider you to be married) for SSI purposes if—

(1) You are legally married under the laws of the State where your and his or her permanent home is (or was when you lived together);

(2) We have decided that either of you is entitled to husband's or wife's Social Security insurance benefits as the spouse of the other (this decision will not affect your SSI benefits for any month before it is made); or

(3) You and an unrelated person of the opposite sex are living together in the same household at or after the time you apply for SSI benefits, and you both lead people to believe that you are husband and wife.

(b) if more than one person would qualify as your husband or wife under paragraph (a) of this section, we will consider the person you are presently living with to be your spouse for SSI purposes.

[60 FR 16376, Mar. 30, 1995]

§ 416.1816 Information we need concerning marriage when you apply for SSI.

When you apply for SSI benefits, we will ask whether you are married. If you are married, we will ask whether you are living with your spouse. If you are unmarried or you are married but not living with your spouse, we will ask whether you are living in the same household with anyone of the opposite sex who is not related to you. If you are, we will ask whether you and that person lead other people to believe that you are husband and wife.

§ 416.1821 Showing that you are married when you apply for SSI.

(a) *General rule: Proof is unnecessary.* If you tell us you are married we will consider you married unless we have information to the contrary. We will also consider you married, on the basis

of your statement, if you say you are living with an unrelated person of the opposite sex and you both lead people to believe you are married. However, if we have information contrary to what you tell us, we will ask for evidence as described in paragraph (c).

(b) *Exception: If you are a child to whom parental deeming rules apply.* If you are a child to whom the parental deeming rules apply and we receive information from you or others that you are married, we will ask for evidence of your marriage. The rules on deeming parental income are in §§ 416.1165 and 416.1166. The rules on deeming of parental resources are in § 416.1202.

(c) *Evidence of marriage.* If paragraph (a) or (b) of this section indicates that you must show us evidence that you are married, you must show us your marriage certificate (which can be the original certificate, a certified copy of the public record of marriage, or a certified copy of the church record) if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, and amended at 52 FR 8889, Mar. 20, 1987]

§ 416.1826 Showing that you are not married when you apply for SSI.

(a) *General rule: Proof is unnecessary.* If you do not live with an unrelated person of the opposite sex and you say that you are not married, we will generally accept your statement unless we have information to the contrary.

(b) *Exception: If you are under age 22 and have been married.* If you are under age 22 and have been married, to prove that your marriage has ended you must show us the decree of divorce or annulment or the death certificate if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

(c) *Exception: If you are living with an unrelated person of the opposite sex.* (1) If you are living with an unrelated person of the opposite sex, you and the person you are living with must explain to us what your relationship is and answer questions such as the following:

(i) What names are the two of you known by?

(ii) Do you introduce yourselves as husband and wife? If not, how are you introduced?

(iii) What names are used on mail for each of you?

(iv) Who owns or rents the place where you live?

(v) Do any deeds, leases, time payment papers, tax papers, or any other papers show you as husband and wife?

(2) We will consider you married to the person you live with unless the information we have, including the answers to the questions in paragraph (c)(1) of this section, all considered together, show that the two of you do not lead people to believe that you are each other's husband and wife.

§ 416.1830 When we stop considering you and your spouse an eligible couple.

We will stop considering you and your spouse an eligible couple, even if you both remain eligible, at the beginning of whichever of these months comes first—

(a) The calendar month after the month you stopped living with your eligible spouse, or

(b) The calendar month after the month in which your marriage ends.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 60 FR 16376, Mar. 30, 1995]

§ 416.1832 When we consider your marriage ended.

We consider your marriage ended when—

(a) Your spouse dies;

(b) Your divorce or annulment becomes final;

(c) We decide that either of you is not a spouse of the other for purposes of husband's or wife's social security insurance benefits, if we considered you married only because of § 416.1806(a)(2); or

(d) You and your spouse stop living together, if we considered you married only because of § 416.1806(a)(3).

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 60 FR 16376, Mar. 30, 1995]

§ 416.1835 Information we need about separation or end of marriage after you become eligible for SSI.

(a) *If you and your spouse stop living together.* If you and your spouse stop living together, you must promptly report that fact to us, so that we can decide whether there has been a change that affects either person's benefits. You must also answer questions such as the following. If you cannot answer our questions you must tell us why not and give us whatever information you can.

(1) When did you stop living together?

(2) Do you expect to live together again?

(3) If so, when?

(4) Where is your husband or wife living?

(5) Is either of you living with someone else as husband and wife?

(b) *Evidence of end of marriage*—(1) *Death.* We will accept your statement that your husband or wife died unless we have information to the contrary. If we have contrary information, you must show us the death certificate if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

(2) *Divorce or annulment.* If your marriage ends by divorce or annulment, you must show us the decree of divorce or annulment if you can. If you cannot, you must tell us why not and give us whatever evidence you can.

(3) *Other reason.* If your marriage ends for reasons other than death, divorce, or annulment, you must give us any information we ask you to give us about the end of the marriage. If you cannot, you must explain why you cannot. We will consider all of the relevant information to decide if and when your marriage ends.

WHO IS CONSIDERED A CHILD

§ 416.1851 Effects of being considered a child.

If we consider you to be a child for SSI purposes, the rules in this section apply when we determine your eligibility for SSI and the amount of your SSI benefits.

(a) If we consider you to be a student, we will not count all of your earned income when we determine your SSI eligibility and benefit amount. Section 416.1110 tells what we mean by earned income. Section 416.1112(c)(2) tells how much of your earned income we will not count.

(b) If you have a parent who does not live with you but who pays money to help support you, we will not count one-third of that money when we count your income. Section 416.1124(c)(9) discusses this rule.

(c) If you are under age 18 and live with your parent(s) who is not eligible for SSI benefits, we consider (deem) part of his or her income and resources to be your own. If you are under age 18 and live with both your parent and your parent's spouse (stepparent) and neither is eligible for SSI benefits, we consider (deem) part of their income and resources to be your own. Sections 416.1165 and 416.1166 explain the rules and the exception to the rules on deeming your parent's income to be yours, and § 416.1202 explains the rules and the exception to the rules on deeming your parent's resources to be yours.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, and amended at 52 FR 8889, Mar. 20, 1987; 73 FR 28036, May 15, 2008]

§ 416.1856 Who is considered a child.

We consider you to be a child if—

(a)(1) You are under 18 years old; or

(2) You are under 22 years old and you are a student regularly attending school or college or training that is designed to prepare you for a paying job;

(b) You are not married; and

(c) You are not the head of a household.

§ 416.1861 Deciding whether you are a child: Are you a student?

(a) *Are you a student?* You are a student regularly attending school or college or training that is designed to prepare you for a paying job if you are enrolled for one or more courses of study and you attend class—

(1) In a college or university for at least 8 hours a week under a semester or quarter system;

(2) In grades 7–12 for at least 12 hours a week;

(3) In a course of training to prepare you for a paying job, and you are attending that training for at least 15 hours a week if the training involves shop practice or 12 hours a week if it does not involve shop practice (this kind of training includes anti-poverty programs, such as the Job Corps, and government-supported courses in self-improvement); or

(4) Less than the amount of time given in paragraph (a) (1), (2), or (3) of this section for reasons you cannot control, such as illness, if the circumstances justify your reduced credit load or attendance.

(b) *If you are instructed at home.* You may be a student regularly attending school if you are instructed at home in grades 7–12 in accordance with a home school law of the State or other jurisdiction in which you reside and for at least 12 hours a week.

(c) *If you have to stay home.* You may be a student regularly attending school, college, or training to prepare you for a paying job if—

(1) You have to stay home because of your disability;

(2) You are studying at home a course or courses given by a school (grades 7–12), college, university, or government agency; and

(3) A home visitor or tutor directs your study or training.

(d) *When you are not in school*—(1) *When school is out.* We will consider you to be a student regularly attending school, college, or training to prepare you for a paying job even when classes are out if you actually attend regularly just before the time classes are out and you—

(i) Tell us that you intend to resume attending regularly when school opens again; or

(ii) Actually do resume attending regularly when school opens again.

(2) *Other times.* Your counselor or teacher may believe you need to stay out of class for a short time during the course or between courses to enable you to continue your study or training. That will not stop us from considering you to be a student regularly attending school, college, or training to prepare you for a paying job if you are in—

(i) A course designed to prepare disabled people for work; or

(ii) A course to prepare you for a job that is specially set up for people who cannot work at ordinary jobs.

(e) *Last month of school.* We will consider you to be a student regularly attending school, college, or training to prepare you for a paying job for the month in which you complete or stop your course of study or training.

(f) *When we need evidence that you are a student.* We need evidence that you are a student if you are 18 years old or older but under age 22, because we will not consider you to be a child unless we consider you to be a student.

(g) *What evidence we need.* If we need evidence that you are a student, you must—

(1) Show us any paper you have that shows you are a student in a school, college, or training program, such as a student identification card or tuition receipt; and

(2) Tell us—

(i) What courses you are taking;

(ii) How many hours a week you spend in classes;

(iii) The name and address of the school or college you attend or the agency training you; and

(iv) The name and telephone number of someone at the school, college, or agency who can tell us more about your courses, in case we need information you cannot give us.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 71 FR 66867, Nov. 17, 2006]

§ 416.1866 Deciding whether you are a child: Are you the head of a household?

(a) *Meaning of head of household.* You are the head of a household if you have left your parental home on a permanent basis and you are responsible for the day-to-day decisions on the operation of your own household. If you live with your parent(s) or stepparents, we will ordinarily assume you are not the head of a household. However, we will consider you to be the head of a household if for some reason (such as your parent's illness) you are the one who makes the day-to-day decisions. You need not have someone living with you to be the head of a household.

(b) *If you share decision-making equally.* If you live with one or more people

and everyone has an equal voice in the decision-making (for example, a group of students who share off-campus housing), that group is not a household. Each person who has left the parental home on a permanent basis is the head of his or her own household.

WHO IS CONSIDERED A STUDENT FOR PURPOSES OF THE STUDENT EARNED INCOME EXCLUSION

§ 416.1870 Effect of being considered a student.

If we consider you to be a student, we will not count all of your earned income when we determine your SSI eligibility and benefit amount. If you are an ineligible spouse or ineligible parent for deeming purposes and we consider you to be a student, we will not count all of your income when we determine how much of your income to deem. Section 416.1110 explains what we mean by earned income. Section 416.1112(c)(3) explains how much of your earned income we will not count. Section 416.1161(a)(27) explains how the student earned income exclusion applies to deemors.

[71 FR 66867, Nov. 17, 2006]

§ 416.1872 Who is considered a student.

We consider you to be a student if you are under 22 years old and you regularly attend school or college or training that is designed to prepare you for a paying job as described in § 416.1861(a) through (e).

[71 FR 66867, Nov. 17, 2006]

§ 416.1874 When we need evidence that you are a student.

We need evidence that you are a student if you are under age 22 and you expect to earn over $65 in any month. Section 416.1861(g) explains what evidence we need.

[71 FR 66867, Nov. 17, 2006]

WHO IS CONSIDERED YOUR PARENT

§ 416.1876 Effects a parent (or parents) can have on the child's benefits.

Section 416.1851 (b) and (c) tells what effects a parent's income and resources can have on his or her child's benefits.

§ 416.1881 Deciding whether someone is your parent or stepparent.

(a) We consider your parent to be—

(1) Your natural mother or father; or

(2) A person who legally adopted you.

(b) We consider your stepparent to be the present husband or wife of your natural or adoptive parent. A person is not your stepparent if your natural or adoptive parent, to whom your stepparent was married, has died, or if your parent and stepparent have been divorced or their marriage has been annulled.

(c) *Necessary evidence.* We will accept your statement on whether or not someone is your parent or stepparent unless we have information to the contrary. If we have contrary information, you must show us, if you can, one or more of the following kinds of evidence that would help to prove whether or not the person is your parent or stepparent: Certificate of birth, baptism, marriage, or death, or decree of adoption, divorce, or annulment. If you cannot, you must tell us why not and show us any other evidence that would help to show whether or not the person is your parent or stepparent.

Subpart S—Interim Assistance Provisions

AUTHORITY: Secs. 702(a)(5) and 1631 of the Social Security Act (42 U.S.C. 902(a)(5) and 1383).

SOURCE: 46 FR 47449, Sept. 27, 1981, unless otherwise noted.

INTRODUCTION

§ 416.1901 Scope of subpart S.

(a) *General.* This subpart explains that we may withhold your SSI benefit and/or State supplementary payments and send them to the State (or a political subdivision of the State) as repayment for interim assistance it gave you while your application for SSI was pending, or while your SSI benefits were suspended or terminated if you are subsequently found to have been eligible for such benefits. Before we will do this, the State must have entered into an interim assistance agreement with us authorizing such reimbursement, and you must have given written

authorization for us to repay the State (or a political subdivision of the State).

(b) *Organization of this subpart.* We have organized this subpart as follows:

(1) *Definitions.* Section 416.1902 contains definitions of terms used in this subpart.

(2) *Authorizations.* Sections 416.1904 through 416.1908 give the rules that apply to your written authorization.

(3) *Interim assistance agreements.* Section 416.1910 gives the requirements for interim assistance agreements between us and the State.

(4) *Appeals.* Sections 416.1920 through 416.1922 describe your appeal rights in the State and in SSA.

[46 FR 47449, Sept. 27, 1981, as amended at 56 FR 19262, Apr. 26, 1991]

§ 416.1902 Definitions.

For purposes of this subpart—

Authorization means your written permission, in a form legally acceptable to us and to the State from which you received interim assistance, for us to withhold the appropriate SSI benefit payment and send it to the State.

Interim assistance means assistance the State gives you, including payments made on your behalf to providers of goods or services, to meet your basic needs, beginning with the first month for which you are eligible for payment of SSI benefits and ending with, and including, the month your SSI payments begin, or assistance the State gives you beginning with the day for which your eligibility for SSI benefits is reinstated after a period of suspension or termination and ending with, and including, the month the Commissioner makes the first payment of benefits following the suspension or termination if it is determined subsequently that you were eligible for benefits during that period. It does not include assistance the State gives to or for any other person. If the State has prepared and cannot stop delivery of its last assistance payment to you when it receives your SSI benefit payment from us, that assistance payment is included as interim assistance to be reimbursed. Interim assistance does not include assistance payments financed wholly or partly with Federal funds.

SSI benefit payment means your Federal benefit and any State supplementary payment made by us to you on behalf of a State (see subpart T of this part) which is due you at the time we make the first payment of benefits or when your benefits are reinstated after suspension or termination. Advance payment, as defined in § 416.520, payment based upon presumptive disability or presumptive blindness, as defined in § 416.931, or certain payments made under the administrative immediate payment procedure, are not considered SSI benefit payments for interim assistance purposes.

State for purposes of an interim assistance agreement, means a State of the United States, the District of Columbia, or the Northern Mariana Islands. For all other purposes (for example, payment, appeals, notices) *State* also means a political subdivision of any of these.

We, Us, or *Our* means the Social Security Administration.

You or *Your* means someone who has applied for or is already receiving SSI benefits.

[46 FR 47449, Sept. 28, 1981; 46 FR 50947, Oct. 16, 1981, as amended at 56 FR 19262, Apr. 26, 1991; 56 FR 25446, June 4, 1991; 62 FR 38455, July 18, 1997; 64 FR 31975, June 15, 1999]

AUTHORIZATIONS

§ 416.1904 Authorization to withhold SSI benefits.

We may withhold your SSI benefit payment and send it to the State to repay the State for the interim assistance it gave to you, if—

(a) We have an interim assistance agreement with the State at the time your authorization goes into effect; and

(b) Your authorization is in effect at the time we make the SSI benefit payment.

§ 416.1906 When your authorization is in effect.

Your authorization for us to withhold your SSI benefit payment, to repay the State for interim assistance the State gives you, is effective when we receive it, or (if our agreement with the State allows) when we receive notice from

the State that it has received your authorization. It remains in effect until—

(a) We make the first SSI benefit payment on your initial application for benefits or, in the case of an authorization effective for a period of suspense or termination, until the initial payment following the termination or suspension of your benefits.

(b) We make a final determination on your claim (if your SSI claim is denied, the denial is the final determination, unless you file a timely appeal as described in subpart N of this part);

(c) You and the State agree to terminate your authorization; or

(d) If earlier than the event in paragraph (a), (b), or (c) of this section, the date (if any) specified in your authorization.

[46 FR 47449, Sept. 27, 1981, as amended at 56 FR 19262, Apr. 26, 1991]

§ 416.1908 When we need another authorization.

Once an event described in § 416.1906 occurs, your authorization is no longer effective. If you reapply for SSI benefits, or the authorization has expired, the State must obtain a new authorization from you in order for us to repay the State for interim assistance it gives you.

INTERIM ASSISTANCE AGREEMENTS

§ 416.1910 Requirements for interim assistance agreement.

An interim assistance agreement must be in effect between us and the State if we are to repay the State for interim assistance. The following requirements must be part of the agreement:

(a) *SSA to repay the State.* We must agree to repay the State for interim assistance it gives you. Repayment to the State takes priority over any underpayments due you (see §§ 416.525 and 416.542).

(b) *State to pay any excess repayment to you.* The State must agree that, if we repay it an amount greater than the amount of interim assistance it gave to you, the State will—

(1) Pay the excess amount to you no later than 10 working days from the date the State receives repayment from us; or

(2) Refund the excess amount to us for disposition under the rules in subpart E of the this part on payment of benefits if the State cannot pay it to you (for example, you die or you move and the State cannot locate you).

(c) *State to notify you.* The State must agree to give you written notice explaining—

(1) How much we have repaid the State for interim assistance it gave you;

(2) The excess amount, if any, due you; and

(3) That it will give you an opportunity for a hearing if you disagree with State's actions regarding repayment of interim assistance.

(d) *Duration of the agreement.* We and the State must agree to the length of time that the agreement will remain in effect.

(e) *State to comply with other regulations.* The State must agree to comply with any other regulations that we find necessary to administer the interim assistance provisions.

APPEALS

§ 416.1920 Your appeal rights in the State.

Under its interim assistance agreement with us, the State must agree to give you an opportunity for a hearing if you disagree with the State's actions regarding repayment of interim assistance. For example, you are entitled to a hearing by the State if you disagree with the State regarding the amount of the repayment the State keeps or the amount of any excess the State pays to you. You are not entitled to a Federal hearing on the State's actions regarding repayment of interim assistance.

§ 416.1922 Your appeal rights in SSA.

If you disagree with the total amount of money we have withheld and sent to the State for the interim assistance it gave to you, you have a right to appeal to us, as described in subpart N of this part.

Subpart T—State Supplementation Provisions; Agreement; Payments

AUTHORITY: Secs. 702(a)(5), 1616, 1618, and 1631 of the Social Security Act (42 U.S.C.

902(a)(5), 1382e, 1382g, and 1383); sec. 212, Pub. L. 93–66, 87 Stat. 155 (42 U.S.C. 1382 note); sec. 8(a), (b)(1)–(b)(3), Pub. L. 93–233, 87 Stat. 956 (7 U.S.C. 612c note, 1431 note and 42 U.S.C. 1382e note); secs. 1(a)–(c) and 2(a), 2(b)(1), 2(b)(2), Pub. L. 93–335, 88 Stat. 291 (42 U.S.C. 1382 note, 1382e note).

SOURCE: 40 FR 7640, Feb. 21, 1975, unless otherwise noted.

§ 416.2001 State supplementary payments; general.

(a) *State supplementary payments; defined.* State supplementary payments are any payments made by a State or one of its political subdivisions (including any such payments for which reimbursement is available from the Social Security Administration pursuant to Pub. L. 94–23, as amended) to a recipient of supplemental security income benefits (or to an individual who would be eligible for such benefits except for income), if the payments are made:

(1) In supplementation of the Federal supplemental security income benefits; *i.e.*, as a complement to the Federal benefit amount, thereby increasing the amount of income available to the recipient to meet his needs; and

(2) Regularly, on a periodic recurring, or routine basis of at least once a quarter; and

(3) In cash, which may be actual currency or any negotiable instrument, convertible into cash upon demand; and

(4) In an amount based on the need or income of an individual or couple.

(b) *State; defined.* For purposes of this subpart, *State* means a State of the United States or the District of Columbia.

(c) *Mandatory minimum supplementary payments.* In order for a State to be eligible for payments pursuant to title XIX of the Act with respect to expenditures for any quarter beginning after December 1973, such State must have in effect an agreement with the Commissioner under which such State will provide to aged, blind, and disabled individuals (as defined in § 416.202) residing in the State who were recipients of aid or assistance for December 1973 as defined in § 416.121, under such State's plan approved under title I, X, XIV, or XVI of the Act, mandatory minimum supplementary payments beginning in January 1974 in an amount determined in accordance with § 416.2050 in order to maintain their income levels of December 1973. (See §§ 416.2065 and 416.2070.)

(d) *Supplementary payments for recipients of special SSI cash benefits.* A State which makes supplementary payments (regardless of whether they are mandatory or optional and whether the payments are federally administered), has the option of making those payments to individuals who receive cash benefits under section 1619(a) of the Act (see § 416.261), or who would be eligible to receive cash benefits except for their income.

[40 FR 7640, Feb. 21, 1975, as amended at 43 FR 48995, Oct. 20, 1978; 45 FR 54748, July 18, 1980; 47 FR 15326, Apr. 9, 1982; 62 FR 38455, July 18, 1997]

§ 416.2005 Administration agreements with SSA.

(a) *Agreement-mandatory only.* Subject to the provisions of paragraph (d) of this section, any State having an agreement with the Social Security Administration (SSA) under § 416.2001(c) may enter into an administration agreement with SSA under which SSA will make the mandatory minimum supplementary payments on behalf of such State. An agreement under § 416.2001(c) and an administration agreement under this paragraph may be consolidated into one agreement.

(b) *Agreement—mandatory and optional payments.* Subject to the provisions of paragraph (d) of this section, any State may enter into an agreement with SSA under which the State will provide both mandatory and optional State supplementary payments and elect Federal administration of such State supplementary payment programs. If SSA agrees to administer such State's optional supplementary payments, the State must also have SSA administer its mandatory minimum supplementary payments unless the State is able to provide sufficient justification for exemption from this requirement.

(c) *Administration—combination.* Any State may enter into an agreement with SSA under which the State will provide mandatory minimum supplementary payments and elect Federal administration of such payments while

providing optional State supplementary payments which it shall administer itself. If the State chooses to administer such payment itself, it may establish its own criteria for determining eligibility requirements as well as the amounts.

(d) *Conditions of administration agreement.* The State and SSA may, subject to the provisions of this subpart, enter into a written agreement, in such form and containing such provisions not inconsistent with this part as are found necessary by SSA, under which SSA will administer the State supplementary payments on behalf of a State (or political subdivision). Under such an agreement between SSA and a State, specific Federal and State responsibilities for administration and fiscal responsibilities will be stipulated. The regulations in effect for the supplemental security income program shall be applicable in the Federal administration of State supplementary payments except as may otherwise be provided in this subpart as found by SSA to be necessary for the effective and efficient administration of both the basic Federal benefit and the State supplementary payment. If the State elects options available under this subpart (specified in §§ 416.2015–416.2035), such options must be specified in the administration agreement.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 312, Jan. 3, 1997]

§ 416.2010 Essentials of the administration agreements.

(a) *Payments.* Any agreement between SSA and a State made pursuant to § 416.2005 must provide that, if for optional supplementation, such State supplementary payments are made to all individuals and/or couples who are:

(1) Receiving (or at the option of the State would, but for the amount of their income, be eligible to receive) supplemental security income benefits under title XVI of the Social Security Act, and

(2) Within the variations and categories (as defined in § 416.2030) for which the State (or political subdivision) wishes to provide a supplementary payment, and

(3) Residing, subject to the provisions of § 416.2035(a), in such State (or political subdivision thereof).

(b) *Administrative costs.* (1) SSA shall assess each State that had elected Federal administration of optional and/or mandatory State supplementary payments an administration fee for administering those payments. The administration fee is assessed and paid monthly and is derived by multiplying the number of State supplementary payments made by SSA on behalf of a State for any month in a fiscal year by the applicable dollar rate for the fiscal year. The number of supplementary payments made by SSA in a month is the total number of checks issued, and direct deposits made, to recipients in that month, that are composed in whole or in part of State supplementary funds. The dollar rates are as follows:

(i) For fiscal year 1994, $1.67;
(ii) For fiscal year 1995, $3.33;
(iii) For fiscal year 1996, $5.00;
(iv) For fiscal year 1997, $5.00;
(v) For fiscal year 1998, $6.20;
(vi) For fiscal year 1999, $7.60;
(vii) For fiscal year 2000, $7.80;
(viii) For fiscal year 2001, $8.10;
(ix) For fiscal year 2002, $8.50; and
(x) For fiscal year 2003 and each succeeding fiscal year—

(A) The applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

(B) Such different rate as the Commissioner determines is appropriate for the State taking into account the complexity of administering the State's supplementary payment program.

(2) SSA shall charge a State an additional services fee if, at the request of the State, SSA agrees to provide the State with additional services beyond the level customarily provided in the administration of State supplementary payments. The additional services fee shall be in an amount that SSA determines is necessary to cover all costs, including indirect costs, incurred by

the Federal Government in furnishing the additional services. SSA is not required to perform any additional services requested by a State and may, at its sole discretion, refuse to perform those additional services. An additional services fee charged a State may be a one-time charge or, if the furnished services result in ongoing costs to the Federal Government, a monthly or less frequent charge to the State for providing such services.

(c) *Agreement period.* The agreement period for a State which has elected Federal administration of its supplementary payments will extend for one year from the date the agreement was signed unless otherwise designated. The agreement will be automatically renewed for a period of one year unless either the State or SSA gives written notice not to renew, at least 90 days before the beginning of the new period. For a State to elect Federal administration, it must notify SSA of its intent to enter into an agreement, furnishing the necessary payment specifications, at least 120 days before the first day of the month for which it wishes Federal administration to begin, and have executed such agreement at least 30 days before such day.

(d) *Modification or termination.* The agreement may be modified at any time by mutual consent. The State or SSA may terminate the agreement upon 90 days written notice to the other party, provided the effective date of the termination is the last day of a quarter. However, the State may terminate the agreement upon 45 days written notice to SSA where: (1) The State does not wish to comply with a regulation promulgated by SSA subsequent to the execution of the agreement; and (2) the State provides such written notice within 30 days of the effective date of the regulation. The Secretary is not precluded from terminating the agreement in less than 90 days where he finds that a State has failed to materially comply with the provisions of paragraph (f) of this section or § 416.2090.

(e) *Mandatory minimum State supplementation.* Any administration agreement between SSA and a State under which SSA will make such State's mandatory minimum State supplementary payments shall provide that the State will:

(1) *Certify income and payment amount.* Certify to SSA the names of each individual who, for December 1973 was eligible for and a recipient of aid or assistance in the form of money payments under a plan of such State approved under title I, X, XIV, or XVI of the Act (§ 416.121), together with the amount of such aid or assistance payable to each such individual and the amount of such individual's other income (as defined in § 416.2050(b)(2)), and

(2) *Additional data.* Provide SSA with such additional data at such times as SSA may reasonably require in order to properly, economically, and efficiently carry out such administration agreement. This shall include required information on changes in countable income as well as changes in special needs and circumstances that would result in a decrease in the mandatory income level being maintained by the State, unless the State has specified in the agreement that the minimum income level shall not be lowered by such changes.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 313, Jan. 3, 1997; 63 FR 33849, June 22, 1998]

§ 416.2015 Establishing eligibility.

(a) *Applications.* Any person who meets the application requirements of subpart C of this part is deemed to have filed an application for any federally administered State supplementation for which he may be eligible unless supplementation has been waived pursuant to § 416.2047. However, a supplemental statement will be required where additional information is necessary to establish eligibility or to determine the correct payment amount.

(b) *Evidentiary requirements.* The evidentiary requirements and developmental procedures of this part are applicable with respect to federally administered State supplementary payments.

(c) *Determination.* Where not inconsistent with the provisions of this subpart, eligibility for and the amount of the State supplementary payment will be determined pursuant to the provisions of subparts A through Q of this part.

(d) *Categories; aged, blind, disabled.* An applicant will be deemed to have filed for the State supplementary payment amount provided for the category under which his application for a Federal supplemental security income benefit is filed. As in the Federal supplemental security income program, an individual who establishes eligibility as a blind or disabled individual, and continually remains on the rolls, will continue to be considered blind or disabled after he attains age 65.

(e) *Concurrent categories.* (1) In States where the supplementary payment provided for the aged category is higher than for the blind or disabled category aged individuals will be paid the State supplement on the basis of age.

(2) If the administration agreement pursuant to §416.2005(b) provides for higher supplementary payments to the blind or disabled than to the aged category, then, at the option of the State, the agreement may provide that individuals who are age 65 or over at time of application and who are blind or disabled may elect to receive such higher supplementary payments.

§ 416.2020 Federally administered supplementary payments.

(a) *Payment procedures.* A federally administered State supplementary payment will be made on a monthly basis and will be included in the same check as a Federal benefit that is payable. A State supplementary payment shall be for the same month as the Federal benefit.

(b) *Maximum amount.* There is no restriction on the amount of a State supplementary payment that the Federal Government will administer on behalf of a State.

(c) *Minimum amount.* The Federal Government will not administer optional State supplementary payments in amounts less than $1 per month. Hence, optional supplementary payment amounts of less than $1 will be raised to a dollar.

(d) *Optional supplementation: nine categories possible.* A State may elect Federal administration of its supplementary payments for up to nine categories, depending on the assistance titles in effect in that State in January 1972 (*i.e.*, title I, X, XIV, or XVI). It can have no more than two categories (one for individuals and one for couples) for each title in effect for January 1972:

(1) Since a State with a title XVI program had just the one title in effect, it can supplement only to two categories, the individual (aged, blind, or disabled), the couple (both of whom are aged, blind, or disabled).

(2) Other States could supplement up to nine categories, depending on the plans they had in effect. Six of these categories would be for:

(i) Aged Individual,
(ii) Aged Couple,
(iii) Blind Individual,
(iv) Blind Couple,
(v) Disabled Individual,
(vi) Disabled Couple.

(3) In addition to those enumerated in paragraph (d)(2) of this section, there are three additional couple categories for which a State may elect to provide a federally administered supplement. These categories are created when one individual in the couple is:

(i) Aged and the other blind, or
(ii) Aged and the other disabled, or
(iii) Blind and the other disabled.

[40 FR 7640, Feb. 21, 1975, as amended at 50 FR 48579, Nov. 26, 1985]

§ 416.2025 Optional supplementation: Countable income.

(a) *Earned and unearned income.* No less than the amounts of earned or unearned income which were excluded in determining eligibility for or amount of a title XVI supplemental security income benefit must be excludable by a State in the Federal-State agreement for purposes of determining eligibility for or amount of the State supplementary payment.

(b) *Effect of countable income on payment amounts. Countable income* of an eligible individual or eligible couple is determined in the same manner as such income is determined under the title XVI supplemental security income program. Countable income will affect the amount of the State supplementary payments as follows:

(1) As provided in §416.420, countable income will first be deducted from the Federal benefit rate applicable to an eligible individual or eligible couple. In the case of an eligible individual living with an ineligible spouse with income

(the deeming provisions of § 416.1163 apply), the Federal benefit rate from which countable income will be deducted is the Federal benefit rate applicable to an eligible couple, except that an eligible individual's payment amount may not exceed the amount he or she would have received if he or she were not subject to the deeming provisions (§ 416.1163(e)(2)).

(2) If countable income is equal to or less than the amount of the Federal benefit rate, the full amount of the State supplementary payment as specified in the Federal agreement will be made.

(3) If countable income exceeds the amount of the Federal benefit rate, the State supplementary benefit will be reduced by the amount of such excess. In the case of an eligible individual living with an ineligible spouse with income (the deeming methodology of § 416.1163 applies), the State supplementary payment rate from which the excess income will be deducted is the higher of the State supplementary rates for an eligible couple or an eligible individual, except that an eligible individual's payment amount may not exceed the amount he or she would have received if he or she were not subject to the deeming provisions (see § 416.1163(e)(2)). For purposes of determining the State supplementary couple rate, the ineligible spouse is considered to be in the same category as the eligible individual.

(4) No State supplementary payment will be made where countable income is equal to or exceeds the sum of the Federal benefit rate and the State supplementary payment rate.

(c) *Effect of additional income exclusions on payment amounts.* A State has the option of excluding amounts of earned and unearned income in addition to the amounts it is required to exclude under paragraph (a) of this section in determining a person's eligibility for State supplementary payments. Such additional income exclusions affect the amount of the State supplementary payments as follows:

(1) Countable income (as determined under the Federal eligibility rules) will first be deducted from the Federal benefit rate applicable to an eligible individual or eligible couple.

(2) Such countable income is then reduced by the amount of the additional income exclusion specified by the State.

(3) If the remaining countable income is equal to or less than the amount of the Federal benefit rate, the full amount of the State supplementary payment will be made.

(4) If the remaining countable income exceeds the amount of the Federal benefit rate, the State supplementary payment will be reduced by the amount of such excess.

(Secs. 1102, 1614(f), 1616(a), 1631, Social Security Act, as amended, 49 Stat. 647, as amended, 86 Stat. 1473, 1474(a), and 1475 (42 U.S.C. 1302, 1382c(f), 1382e(a), 1383))

[40 FR 7640, Feb. 21, 1975, as amended at 43 FR 39570, Sept. 6, 1978; 53 FR 25151, July 5, 1988]

§ 416.2030 Optional supplementation: Variations in payments.

(a) *Payment level.* The level of State supplementary payments may vary for each category the State elects to include in its federally administered supplement. These categorical variations of payment levels must be specified in the agreement between the Commissioner and the State. If any State has in effect for July 1974 an agreement which provides for variations in addition to those specified in this section, the State may, at its option, continue such variations but only for periods ending before July 1, 1976.

(1) *Geographical variations.* A State may elect to include two different geographical variations. A third may be elected if adequate justification, e.g., substantial differences in living costs, can be demonstrated. All such variations must be readily identifiable by county or ZIP code or other readily identifiable factor.

(2) *Living arrangements.* In addition, a State may elect up to six variations in recognition of the different needs which result from various living arrangements. If a State elects six payment level variations based on differences in living arrangements, one of these six variations must apply only to individuals in Medicaid facilities, that is, facilities receiving title XIX payments with respect to such persons for the cost of their care (see

§ 416.211(b)(1)). In any event, States are limited to one payment level variation for residents of Medicaid facilities. Types of other living arrangements for which payment variations may be allowed include arrangements such as:

(i) Living alone;

(ii) Living with an ineligible spouse;

(iii) Personal care facility; or,

(iv) Domiciliary or congregate care facility.

(b) *Relationship to actual cost differences.* Under the agreement, variations in State supplementary payment levels will be permitted for each living arrangement the State elects. These differences must be based on rational distinctions between both the types of living arrangements and the costs of those arrangements.

(c) *Effective month of State supplementary payment category.* The State supplementary payment category which applies in the current month will be used to determine the State payment level in that month. This rule applies even if the countable income in a prior month is used to determine the amount of State supplementary payment.

[40 FR 7640, Feb. 21, 1975, as amended at 50 FR 48579, Nov. 26, 1985; 56 FR 41455, Aug. 21, 1991; 62 FR 38455, July 18, 1997]

§ 416.2035 Optional supplementation: Additional State options.

(a) *Residency requirement.* A State or political subdivision may impose, as a condition of eligibility, a residency requirement which excludes from eligibility for State supplementary payment any individual who has resided in such State (or political subdivision thereof) for less than a minimum period prescribed by the State. Any such residency requirement will be specified in the agreement.

(b) *Lien and relative responsibility.* A State which elects Federal administration of its supplementary payments may place a lien upon property of an individual as a consequence of the receipt of such payments or may require that a relative of the individual contribute to a reasonable extent to the support of the individual, providing it is stated in the agreement that:

(1) The Commissioner has determined that the specific State laws and their enforcement are consistent with the supplemental security income program purpose of providing unencumbered cash payments to recipients; and

(2) The Federal Government is not involved in the administration of such laws and will not vary the State supplementary payment amount it makes to comply with such laws; and

(3) Neither the basic Federal benefit nor any part of the State supplementary payment financed by Federal funds will be subject to the liens or encumbrances of such laws.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§ 416.2040 Limitations on eligibility.

Notwithstanding any other provision of this subpart, the eligibility of an individual (or couple) for optional State supplementary payments administered by the Federal Government in accordance with this subpart shall be limited as follows:

(a) *Inmate of public institution.* A person who is a resident in a public institution for a month, is ineligible for a Federal benefit for that month under the provision of § 416.211(a), and does not meet the requirements for any of the exceptions in § 416.211 (b), (c), or (d), or § 416.212, also shall be ineligible for a federally administered State supplementary payment for that month.

(b) *Ineligible persons.* No person who is ineligible for a Federal benefit for any month under sections 1611(e)(1)(A), (2), (3), or (f) of the Act (failure to file; refuses treatment for drug addiction or alcoholism; outside the United States) or other reasons (other than the amount of income) shall be eligible for such State supplementation for such month.

(c) *Recipient eligible for benefits under § 416.212.* A recipient who is institutionalized and is eligible for either benefit payable under § 416.212 for a month or months may also receive federally administered State supplementation for that month. Additionally, a recipient who would be eligible for benefits under § 416.212 but for countable income which reduces his or her Federal SSI benefit to zero, may still be eligible to

receive federally administered State supplementation.

[40 FR 7640, Feb. 21, 1975, as amended at 56 FR 41455, Aug. 21, 1991; 61 FR 10280, Mar. 13, 1996; 68 FR 40124, July 7, 2003]

§ 416.2045 Overpayments and underpayments; federally administered supplementation.

(a) *Overpayments.* Upon determination that an overpayment has been made, adjustments will be made against future federally administered State supplementary payments for which the person is entitled. Rules and requirements (see §§ 416.550 through 416.586) in effect for recovery (or waiver) of supplemental security income benefit overpayments shall also apply to the recovery (or waiver) of federally administered State supplementary overpaid amounts. If the overpaid person's entitlement to the State supplementary payments is terminated prior to recoupment of the overpaid State supplementary payment amount, and the overpayment cannot be recovered from a Federal benefit payable under this part, the person's record will be annotated (specifying the amount of the overpayment) to permit recoupment if the person becomes reentitled to supplementary payments of such State or to a Federal benefit under this part.

(b) *Underpayments.* Upon determination that an underpayment of State supplementary payments is due and payable, the underpaid amount shall be paid to the underpaid claimant directly, or his representative. If the underpaid person dies before receiving the underpaid amount of State supplementary payment the underpaid amount shall be paid to the claimant's eligible spouse. If the deceased claimant has no eligible spouse, no payment of the underpaid amount shall be made. (See §§ 416.538 through 416.543.)

[40 FR 7640, Feb. 21, 1975, as amended at 65 FR 16815, Mar. 30, 2000]

§ 416.2047 Waiver of State supplementary payments.

(a) *Waiver request in writing.* Any person who is eligible to receive State supplementary payments or who would be eligible to receive such State supplementary payments may waive his right to receive such payments if such person makes a written request for waiver of State supplementary payments. Any such request made at time of application for the Federal benefit shall be effective immediately. Any such request filed after the application is filed shall be effective the month the request is received in a social security office, or earlier if the recipient refunds to the Social Security Administration the amount of any supplementary payment(s) made to him for the subject period.

(b) *Revocation of waiver.* Any individual who has waived State supplementary payments may revoke such waiver at any time by making a written request to any social security office. The revocation will be effective the month in which it is filed. The date such request is received in a social security office or the postmarked date, if the written request was mailed, will be the filing date, whichever is earlier.

§ 416.2050 Mandatory minimum State supplementation.

(a) *Determining the amount.* The amount of a mandatory State supplementary payment in the case of any eligible individual or couple for any month is equal to:

(1) The amount by which such individual or couple's December 1973 income (as defined in paragraph (b) of this section) exceeds the amount of such individual or couple's title XVI benefit plus other income which would have been used by such State in computing the assistance payable under the State's approved plan for such month; or

(2) Such greater amount as the State may specify.

(b) *December 1973 income.* ''December 1973 income'' means an amount equal to the aggregate of:

(1) *Money payments.* The amount of the aid or assistance in the form of money payments (as defined in 45 CFR 234.11(a)) which an individual would have received (including any part of such amount which is attributable to meeting special needs or special circumstances) under a State plan approved under title I, X, XIV, or XVI of the Act in accordance with the terms and conditions of such plan relating to

eligibility for and amount of such aid or assistance payable thereunder which were in effect for the month of June 1973 together with the bonus value of food stamps for January 1972 if for such month such individual resides in a State which SSA has determined provides supplementary payments the level of which has been found by SSA pursuant to section 8 of Pub. L. 93–233 (87 Stat. 956) to have been specifically increased so as to include the bonus value of food stamps, and

(2) *Income.* The amount of the income of such individual other than aid or assistance, received by such individual in December 1973, remaining after application of all appropriate income exclusions and used in computation of the amount of aid or assistance, minus any such income which did not result, but which if properly reported, would have resulted in a reduction in the amount of such aid or assistance. Income, which because a State paid less than 100% of its standard of need, did not cause a reduction in the amount of aid or assistance is included.

(c) *Special needs or circumstances.* Special needs or circumstances include needs of essential persons (as defined in § 416.222), special allowances for housing, and such other situations for which money payments to or for an eligible individual were made under a State plan approved under title I, X, XIV, or XVI of the Act as in effect for June 1973.

(d) *Optional supplement payable.* A recipient meeting the requirements of paragraph (a) of this section who would otherwise qualify for a payment under a State's program of optional State supplementation (provided for by § 416.2010) which is greater than the amount required by paragraph (a) of this section, shall be paid such greater amount.

[40 FR 7640, Feb. 21, 1975, as amended at 51 FR 10616, Mar. 14, 1986; 62 FR 313, Jan. 3, 1997]

§ 416.2055 Mandatory minimum supplementation reduced.

If for any month after December 1973 there is a change with respect to any special need or special circumstance which, if such change had existed in December 1973, would have caused a reduction in the amount of such individual's aid or assistance payment, then, for such month and for each month thereafter, the amount of the mandatory minimum supplement payable to such individual may, at the option of the State, be reduced in accordance with the terms and conditions of the State's plan approved under title I, X, XIV, or XVI of the Act in effect for the month of June 1973.

§ 416.2060 Mandatory minimum supplementary payments not applicable.

An individual eligible for mandatory minimum supplementary payments from a State beginning in January 1974 shall not be eligible for such payments:

(a) *Month after the month of death.* Beginning with the month after the month in which the individual dies; or

(b) *Not aged, blind, or disabled.* Beginning with the first month after the month in which such individual ceases to be an aged, blind, or disabled individual (as defined in § 416.202); or

(c) *Not entitled to a Federal payment.* During any month in which such individual was ineligible to receive supplemental income benefits under title XVI of the Social Security Act by reason of the provisions of section 1611(e) (1)(A), (2) or (3), 1611(f), or 1615(c) of such Act; or

(d) *Month of change in residence.* During any full month such individual is not a resident of such State.

§ 416.2065 Mandatory minimum State supplementation: Agreement deemed.

A State shall be deemed to have entered into an agreement with the Commissioner under which such State shall provide mandatory minimum supplementary payments if such State has entered into an agreement with the Commissioner under section 1616 of the Act under which:

(a) *Other eligible individuals.* Supplementary payments are made to individuals other than those aged, blind, and disabled individuals who were eligible to receive aid or assistance in the form of money payments for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI of the Act, under terms and conditions of such plan in effect for June 1973, and

(b) *Minimum requirements.* Supplementary payments which meet the mandatory minimum requirements of this subpart are payable to all aged, blind, or disabled individuals who were eligible to receive aid or assistance in the form of money payments for the month of December 1973 under a State plan approved under title I, X, XIV, or XVI of the Act, under terms and conditions of such plan in effect for June 1973.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§ 416.2070 Mandatory supplementation: State compliance not applicable.

The requirement that a State must have in effect an agreement with the Commissioner whereby such State shall provide individual aged, blind, and disabled recipients residing in the State mandatory minimum supplementary payments beginning in January 1974 shall not be applicable in the case of any State where:

(a) *State constitution.* The State constitution limits expenditures that may be paid as public assistance to, or on behalf of, any needy person to an amount that does not exceed the amount of State public assistance payments that are matched by Federal funds under title I, IV, X, XIV, XVI or XIX of the Social Security Act making it impossible for such State to enter into and commence carrying out (on January 1, 1974) such agreement with the Commissioner, and

(b) *Attorney General decision.* The Attorney General (or other appropriate State official) has, prior to July 1, 1973, made a finding that the State constitution of such State contains limitations which prevent such State from making supplementary payments of the type described in section 1616 of the Act.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§ 416.2075 Monitoring of mandatory minimum supplementary payments.

(a) *Access to records.* Any State entering into an agreement with the Commissioner whereby such State will provide mandatory minimum supplementary payments in accordance with § 416.2001(c) shall agree that the Commissioner shall have access to and the right to examine any directly pertinent books, documents, papers, and records of the State involving transactions related to this agreement.

(b) *Additional data.* Any State entering into an agreement in accordance with § 416.2005 shall provide the Commissioner with such additional data at such times as the Commissioner may reasonably require in order to properly, economically, and efficiently be assessed of such State's compliance with such State agreements.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§ 416.2090 State funds transferred for supplementary payments.

(a) *Payment transfer and adjustment.* (1) Any State which has entered into an agreement with SSA which provides for Federal administration of such State's supplementary payments shall transfer to SSA:

(i) An amount of funds equal to SSA's estimate of State supplementary payments for any month which shall be made by SSA on behalf of such State; and

(ii) An amount of funds equal to SSA's estimate of administration fees for any such month determined in the manner described in § 416.2010(b)(1); and

(iii) If applicable, an amount of funds equal to SSA's determination of the costs incurred by the Federal government in furnishing additional services for the State as described in § 416.2010(b)(2).

(2) In order for SSA to make State supplementary payments on behalf of a State for any month as provided by the agreement, the estimated amount of State funds referred to in paragraph (a)(1)(i) of this section, necessary to make those payments for the month, together with the estimated amount of administration fees referred to in paragraph (a)(1)(ii) of this section, for that month, must be on deposit with SSA on the State supplementary payment transfer date, which is the fifth Federal business day following the day in the month that the regularly recurring monthly supplemental security income payments are issued. The additional services fee referred to in paragraph

(a)(1)(iii) of this section shall be on deposit with SSA on the date specified by SSA. The amount of State funds paid to SSA for State supplementary payments and the amount paid for administration fees will be adjusted as necessary to maintain the balance with State supplementary payments paid out by SSA on behalf of the State, and administration fees owed to SSA, respectively.

(b) *Accounting of State funds.* (1) As soon as feasible, after the end of each calendar month, SSA will provide the State with a statement showing, cumulatively, the total amounts paid by SSA on behalf of the State during the current Federal fiscal year; the fees charged by SSA to administer such supplementary payments; any additional services fees charged the State; the State's total liability therefore; and the end-of-month balance of the State's cash on deposit with SSA.

(2) SSA shall provide an accounting of State funds received as State supplementary payments, administration fees, and additional services fees, within three calendar months following the termination of an agreement under § 416.2005.

(3) Adjustments will be made because of State funds due and payable or amounts of State funds recovered for calendar months for which the agreement was in effect. Interest will be incurred by SSA and the States with respect to the adjustment and accounting of State supplementary payments funds in accordance with applicable laws and regulations of the United States Department of the Treasury.

(c) *State audit.* Any State entering into an agreement with SSA which provides for Federal administration of the State's supplementary payments has the right to an audit (at State expense) of the payments made by SSA on behalf of such State. The Secretary and the State shall mutually agree upon a satisfactory audit arrangement to verify that supplementary payments paid by SSA on behalf of the State were made in accordance with the terms of the administration agreement under § 416.2005. Resolution of audit findings shall be made in accordance with the provisions of the State's agreement with SSA.

(d) *Advance payment and adjustment not applicable.* The provisions of paragraphs (a) and (b) of this section shall not apply with respect to any State supplementary payment for which reimbursement is available from the Social and Rehabilitation Service pursuant to the Indochina Migration and Refugee Assistance Act of 1975 (Pub. L. 94–23; 89 Stat. 87), as amended, since such amounts are not considered to be State supplementary payments.

[40 FR 7640, Feb. 21, 1975, as amended at 41 FR 36018, Aug. 26, 1976; 62 FR 313, Jan. 3, 1997]

§ 416.2095 Pass-along of Federal benefit increases.

(a) *General.* This section and the four sections that follow describe the rules for passing along increases in the Federal SSI benefit to recipients of State supplementary payments.

(1) Section 416.2095(b) indicates when the pass-along rules apply to State supplementary payments.

(2) Section 416.2096 describes the basic pass-along rules. The States must have an agreement to ''pass-along'' increases in Federal SSI benefits. A State passes along an increase when it maintains (rather than decreases) the levels of all its supplementary payments after a Federal benefit increase has occurred. Generally, a pass-along of the increase permits recipients to receive an additional amount in combined benefits equal to the Federal benefit increase. Except for the supplementary payment level made to residents of Medicaid facilities (see § 416.2096(d)), a State can decrease one or more of its payment levels if it meets an annual total expenditures test.

(3) Section 416.2097 explains the required combined supplementary/SSI payment level.

(4) Section 416.2098 explains how to compute the March 1983, December 1981, and December 1976 supplementary payment levels.

(5) Section 416.2099 discusses what information a State must provide to the Commissioner concerning its supplementation programs so that the Commissioner can determine whether the State is in compliance. That section also discusses the basis for findings of noncompliance and what will

occur if a State is found out of compliance.

(b) *When the pass-along provisions apply.* (1) The pass-along requirements apply to all States (and the District of Columbia) that make supplementary payments on or after June 30, 1977, and wish to participate in the Medicaid program.

(2) The pass-along requirements apply to both optional State supplementary payments of the type described in §416.2001(a) and mandatory minimum State supplementary payments as described in §416.2001(c), whether or not these State supplementary payments are Federally administered.

(3) The requirements apply to State supplementary payments both for recipients who receive Federal SSI benefits and those who, because of countable income, receive only a State supplementary payment.

(4) The requirements apply to State supplementary payments for recipients eligible for a State supplementary payment on or after June 30, 1977.

(5) Supplementary payments made by a State include payments made by a political subdivision (including Indian tribes) where—

(i) The payment levels are set by the State; and

(ii) The payments are funded in whole or in part by the State.

[52 FR 36241, Sept. 28, 1987, as amended at 54 FR 19165, May 4, 1989; 62 FR 38455, July 18, 1997]

§416.2096 Basic pass-along rules.

(a) *State agreements to maintain supplementary payment levels.* (1) In order to be eligible to receive Medicaid reimbursement, any State that makes supplementary payments, other than payments to residents of Medicaid facilities where Medicaid pays more than 50 percent of the cost of their care (see paragraph (d) of this section for definition of Medicaid facility and §416.414 for discussion of the reduced SSI benefit amount payable to residents of Medicaid facilities), on or after June 30, 1977, must have in effect an agreement with the Commissioner. In this agreement—

(i) The State must agree to continue to make the supplementary payments;

(ii) For months from July 1977 through March 1983, the State must agree to maintain the supplementary payments at levels at least equal to the December 1976 levels (or, if a State first makes supplementary payments after December 1976, the levels for the first month the State makes supplementary payments). For months in the period July 1, 1982 through March 31, 1983, a State may elect to maintain the levels described in paragraph (b)(2) of this section; and

(iii) For months after March 1983, the State must agree to maintain supplementary payments at least sufficient to maintain the combined supplementary/SSI payment levels in effect in March 1983, increased by any subsequent SSI benefit increases, except as provided in §416.2097(b) and §416.2097(c).

(2) We will find that the State has met the requirements of paragraph (a)(1) of this section if the State has the appropriate agreement in effect and complies with the conditions in either paragraph (b) or (c) of this section. We will consider a State to have made supplementary payments on or after June 30, 1977, unless the State furnishes us satisfactory evidence to the contrary.

(b) *Meeting the pass-along requirements—supplementary payment levels.* The provisions of this paragraph do not apply to the supplementary payment level for residents of Medicaid facilities (see paragraph (d) of this section).

(1) We will consider a State to have met the requirements for maintaining its supplementary payment levels (described in §416.2098) for a particular month or months after March 1983 if the combined supplementary/SSI payment levels have not been reduced below the levels in effect in March 1983 (or if a State first made supplementary payments after March 1983, the combined supplementary/SSI payment levels in effect the first month the State made supplementary payments), increased by any subsequent Federal SSI benefit increases, except as provided in §416.2097(b) and §416.2097(c). We will consider a State to have met the requirements for maintaining its supplementary payment levels for a particular month or months between June

1977 and April 1983 if the supplementary payment levels have not been reduced below the levels in effect in December 1976 (or if a State first made supplementary payments after December 1976, the levels in effect the first month the State made supplementary payments, or in certain cases described in paragraph (b)(2) of this section, the levels in effect in December 1981.)

(2) We will also consider a State to have met the requirements for maintaining its supplementary payment levels for a particular month or months in the period July 1, 1982, through March 31, 1983, if the State had met the requirements of paragraph (c) of this section for a particular month or months in the 12-month period July 1, 1981 through June 30, 1982, and, with respect to any month in the period July 1, 1982 through March 31, 1983, the State maintained the payment levels in effect in December 1981.

(3) If a State reduced any of its supplementary payment levels for a month or months within any 12-month period beginning with the effective date of a Federal benefit increase, we will consider the State to have met the requirement to maintain its supplementary payment levels if—

(i) Within 12 months after the relevant 12-month period, the State restores the levels retroactively; and

(ii) The State makes a single retroactive benefit payment to each of the beneficiaries eligible for the retroactive payment.

(c) *Meeting the passalong requirement—total expenditures. Exception—* The provisions of this paragraph do not apply to the supplementary payment level for residents of Medicaid facilities (see paragraph (d) of this section).

(1) If a State does not meet the conditions in paragraph (b) of this section, we will consider a State to have met the requirement for maintaining supplementary payment levels for a particular month or months if total State expenditures for supplementary payments in the 12-month period within which the month or months fall, beginning on the effective date of a Federal SSI benefit increase, are at least equal to the total State expenditures for supplementary payments in the 12-month period immediately before the Federal SSI benefit increase provided that the State was in compliance for such preceding 12-month period. The combined Federal/State payment level for those persons receiving a mandatory minimum State supplementary payment can be no lower than the recipient's total income for December 1973 as defined in section 212(a)(3)(B) of Pub. L. 93–66.

(2) If total State expenditures in the relevant 12-month period are less than the total expenditures in the preceding 12-month period (a ''shortfall''), we also will consider a State to have met the requirement for maintaining supplementary payment levels for the relevant 12-month period if in the following 12-month period the State increases the total expenditures required for that period by an amount at least equal to the amount of the shortfall in the relevant 12-month period. The increased amount up to the amount needed to correct the shortfall shall be deemed to be an expenditure in the relevant 12-month period, for pass-along purposes only. (See paragraph (c)(5) of this section.)

(3)(i) Exception for the 6-month period from July 1, 1983 through December 31, 1983: We will consider the State to have met the total-expenditures requirement for the 6-month period July 1, 1983 through December 31, 1983, if—

(A) Total expenditures for State supplementary payments for the period July 1, 1983 through December 31, 1983, equal or exceed the total of such expenditures for the period July l, 1982 through December 31, 1982;

(B) Total expenditures for State supplementary payments for the period January 1, 1983 through December 31, 1983, equal or exceed the total of such expenditures for the period January 1, 1982 through December 31, 1982; or

(C) Total expenditures for State supplementary payments for the period July 1, 1983 through December 31, 1983 equal or exceed one-half of the total of such expenditures for the period July 1, 1982 through June 30, 1983. The provisions of paragraphs (c)(4) and (c)(5) of this section and of § 416.2099 (b), (c), and (d) shall apply to this 6-month period in the same manner as they apply to the 12-month periods referred to therein.

(ii) Exception for the 12-month period ending June 30, 1981: If a State did not meet the conditions in paragraph (b) of this section, we will consider a State to have met the maintenance-of-supplementary-payment-levels requirement for this 12-month period if the State's expenditures for supplementary payments in that period were at least equal to its expenditures for such payments for the 12-month period ending June 30, 1977 (or, if the State made no supplementary payments in that period, the expenditures for the first 12-month period ending June 30 in which the State made such payments); if a State made additional State supplementary payments during the period July 1, 1981 through June 30, 1982, in order to make up a shortfall in the 12-month period ending June 30, 1981 (determined by a comparison with the preceding 12-month period) which later resulted in an excess payment (determined by comparison with the 12-month period July 1, 1976 through June 30, 1977) we will credit the State with the amount of the excess payments if the State so requests. This credit will be applied to any shortfall(s) in total expenditures (should one exist) in any period(s) ending on or before December 31, 1986.

(4) Total State expenditures for supplementary payments are the State's total payments for both mandatory minimum and optional State supplementary payments in the appropriate 12-month period less any amounts deemed to be expenditures for another 12-month period under paragraph (c)(2) of this section, less the amount of any payments recovered and other adjustments made in that period. Total State expenditures do not include State administrative expenses, interim assistance payments, vendor payments, or payments made under other Federal programs, such as titles IV, XIX, or XX of the Social Security Act.

(5) Adjustments in total State supplementary payments made after the expiration of the relevant 12-month period for purposes of meeting total State expenditures under paragraph (c) of this section shall be considered a State expenditure in the relevant 12-month period only for purposes of the pass-along requirement. For purposes of § 416.2090 of this part, which discusses the rules for limitation on fiscal liability of States (hold harmless), these retroactive adjustments are State expenditures when made and shall be counted as a State expenditure in the fiscal year in which the adjustments are made.

(6) To determine whether a State's expenditures for supplementary payments in the 12-month period beginning on the effective date of any increase in the level of SSI benefits are not less than the State's expenditures for the payments in the preceding 12-month period, in computing the State's expenditures, we disregard, pursuant to a one-time election of the State, all expenditures by the State for the retroactive supplementary payments that are required to be made under the *Sullivan* v. *Zebley*, 493 U.S. 521 (1990) class action.

(d) *Payments to residents to Medicaid facilities.* A Medicaid facility is a medical care facility where Medicaid pays more than 50 percent of the cost of a person's care. In order to be eligible to receive Medicaid reimbursement, any State that has a supplementary payment level for residents of Medicaid facilities on or after October 1, 1987, must have in effect an agreement with the Commissioner to maintain such supplementary payment level at least equal to the October 1987 level (or if a State first makes such supplementary payments after October 1, 1987, but before July 1, 1988, the level for the first month the State makes such supplementary payments).

[52 FR 36241, Sept. 28, 1987, as amended at 54 FR 19165, May 4, 1989; 56 FR 55453, Oct. 28, 1991; 62 FR 30984, June 6, 1997; 62 FR 38455, July 18, 1997; 65 FR 16815, Mar. 30, 2000]

§ 416.2097 Combined supplementary/SSI payment levels.

(a) Other than the level for residents of Medicaid facilities (see paragraph (d) of this section), the combined supplementary/SSI payment level for each payment category that must be provided in any month after March 1983 (or if a State first made supplementary payments after March 1983, the combined supplementary SSI payment levels in effect the first month the State made supplementary payments) in

order for a State to meet the requirement of the first sentence of § 416.2096(b) is the sum of—

(1) The SSI Federal benefit rate (FBR) for March 1983 for a recipient with no countable income;

(2) That portion of the July 1983 benefit increase computed in accordance with paragraph (b) of this section;

(3) The full amount of all SSI benefit increases after July 1983; and

(4) The State supplementary payment level for March 1983 as determined under § 416.2098.

(b) The monthly FBR's were increased in July 1983 by $20 for an eligible individual and $30 for an eligible couple, and the monthly increment for essential persons was increased by $10 in lieu of the expected cost-of-living adjustment which was delayed until January 1984. However, in computing the required combined supplementary/SSI payment levels for the purpose of determining pass-along compliance, we use only the amounts by which the FBR's and the essential person increment would have increased had there been a cost-of-living adjustment in July 1983 (a 3.5 percent increase would have occurred). These amounts are $9.70 for an eligible individual, $14.60 for an eligible couple and $4.50 for an essential person.

(c) For the 24-month period January 1, 1984, through December 31, 1985, a State will not be found out of compliance with respect to its payment levels if in the period January 1, 1986, through December 31, 1986, its supplementary payment levels are not less than its supplementary payment levels in effect in December 1976 increased by the percentage by which the FBR has increased after December 1976 and before February 1986. The FBR for an individual in December 1976 was $167.80. The FBR for an individual in effect on January 31, 1986, was $336.00, an increase of 100.24 percent over the December 1976 FBR. In order for a State to take advantage of this provision for the 24-month period January 1, 1984, through December 31, 1985, the State supplementary payment levels in effect for calendar year 1986 must be at least 100.24 percent higher than the State supplementary payment levels in effect in December 1976. This provision does not apply to State supplementary payments to recipients in Federal living arrangement ''D'' (residents of a medical facility where title XIX pays more than 50 percent of the costs).

(d) The combined supplementary/SSI payment level which must be maintained for residents of Medicaid facilities is the State supplement payable on October 1, 1987, or if no such payments were made on October 1, 1987, the supplementary payment amount made in the first month that a supplementary payment was made after October 1987 but before July 1, 1988, plus the Federal benefit rate in effect in October 1987 increased by $5 for an individual/$10 for a couple effective July 1, 1988.

[52 FR 36242, Sept. 28, 1987, as amended at 54 FR 19165, May 4, 1989; 54 FR 23018, May 30, 1989]

§ 416.2098 Supplementary payment levels.

(a) *General.* For the purpose of determining the combined supplementary/SSI payment levels described in § 416.2097(a) (*i.e.*, the levels that must be provided in any month after March 1983), the supplementary payment level, except for the level for residents of Medicaid facilities (see § 416.2097(d)), for each payment category must be no less than the total State payment for March 1983 for that payment category that a State provided an eligible individual (or couple) with no countable income in excess of the FBR for March 1983. For States that did not make supplementary payments in March 1983, the supplementary payment level for each payment category must be no less than the total State payment for the first month after March 1983 in which a State makes supplementary payments.

(b) *Calculation of the required mandatory minimum State supplementary payment level.* (1) Except for States described in paragraph (b)(2) of this section, the mandatory minimum State supplementary payment level for March 1983 is a recipient's December 1973 income, as defined in section 212(a)(3)(B) of Pub. L. 93–66, plus any State increases prior to April 1983, less any reductions made at any time after December 1973 due to changes in special needs or circumstances, less the

March 1983 FBR. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later the amount calculated in the first sentence shall continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (*i.e.*, $10.30), so long as that reduction does not cause the mandatory minimum State supplementary level to fall below that required by section 212(a)(3)(A) of Pub. L. 93–66.

(2) Section 1618(c) of the Act permitted any State that had satisfied the requirements of section 1618 of the Act by the total-expenditures method for the 12-month period July 1, 1981, through June 30, 1982, and that elected to change and meet the section 1618 requirements by the maintenance-of-payment-levels method for the period July 1, 1982, through June 30, 1983, to do so by paying benefits at levels no lower than the levels of such payments in effect for December 1981. However, a recipient's December 1981 total income (December 1981 mandatory minimum State supplement plus the FBR) could not be less than the recipient's total income for December 1973 as defined in section 212(a)(3)(B) of Pub. L. 93–66. For a State that elected the option in the preceding two sentences, the mandatory minimum State supplementary payment level for March 1983 is a recipient's December 1981 total income (but not less than the total income for December 1973 as defined by section 212(a)(3)(B) of Pub. L. 93–66) plus any State increases after December 1981 and prior to April 1983, less any reductions made at any time after December 1981 due to changes in special needs or circumstances, less the March 1983 FBR. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later, the amount calculated under the preceding sentence defining the required March 1983 mandatory minimum State supplementary payment level would continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (*i.e.*, $10.30), so long as that reduction does not cause the mandatory minimum State supplementary level to fall below that required by section 212(a)(3)(A) of Pub. L. 93–66.

(c) *Calculation of the required optional State supplementary payment level for flat grant amounts.* The optional State supplementary payment level for March 1983 for flat grant amounts is the total amount that an eligible individual (or couple) with no countable income received for March 1983 in excess of the FBR for March 1983. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later the amount calculated in the first sentence shall continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (*i.e.*, $10.30). If the State varied its payment levels for different groups of recipients (e.g., paid recipients different amounts based on eligibility categories, geographic areas, living arrangements, or marital status), each variation represents a separate supplementary payment level.

(d) *Calculation of the required optional State supplementary payment level for individually budgeted grant amounts.* The optional State supplementary payment level for individually budgeted grant amounts for March 1983 is the amount that the State budgeted for March 1983 in excess of the March 1983 FBR for an eligible individual (or couple) having the same needs and no countable income. The amount determined under the previous sentence shall continue for April, May, and June 1983. For July 1983 and later the amount calculated in the first sentence shall continue except that it may be reduced by the amount of the July 1983 Federal increase that was not related to the cost of living (*i.e.*, $10.30).

(e) *Optional State supplementary payment level for per diem based grant amounts.* (1) The optional State supplementary payment level for March 1983 for per diem grant amounts is the total dollar amount that the State paid to an eligible individual (or couple) with no countable income at rates in effect for March 1983 (number of days in the calendar month multiplied by the March 1983 per diem rate plus any March 1983 personal needs allowance) in excess of the March 1983 FBR.

Example:

March 1983:	
$15.40	Per diem rate.
×31	Days in month.
477.40	
477.40	
+ 42.00	Personal needs allowance.
519.40	
519.40	Combined State supplementary/SSI payment.
−284.30	March 1983 FBR.
235.10	State supplementary payment level.

(2) The optional State supplementary payment level for months subsequent to March 1983 for per diem grant amounts is the total dollar amount that the State paid to an individual (or couple) with no countable income at rates in effect in March 1983 (number of days in the calendar month multiplied by the March 1983 per diem rate plus any March 1983 personal needs allowance) in excess of the March 1983 FBR for an individual (or couple) with no countable income increased by all FBR increases subsequent to March 1983 with the exception of the July 1, 1983 increase. For the July 1, 1983 increase to the FBR, a State need pass-along only that portion of the increase which represented the increase in the cost of living adjustment (3.5 percent).

Example: NOTE: Example assumes the State passed along only $9.70 of the $20.00 increase in the FBR effective July 1, 1983.

The March 1983 combined supplementary/SSI payment level for a 31-day month was $519.40.

July 1983 level:	
$519.40	March 1983 combined payment.
+ 9.70	July 1983 COLA-equivalent.
529.10	Required July 1983 combined payment level.
529.10	Required July 1983 combined payment level.
−304.30	July 1983 FBR.
224.80	Required State Supplementary payment level.
529.10	Required July 1983 combined payment level.
−42.00	Personal needs allowance.
487.10	
487.10	
+ 31	Days in month.
15.71	Per diem rate.

The required July 1983 combined supplementary/SSI payment level for a 31-day month was $529.10. This amount is equal to the March 1983 combined payment amount for a 31-day month plus the July 1983 COLA-equivalent ($519.40 + $9.70).

(f) *Required optional State supplementary payment level for months prior to April 1983.* In determining pass-along compliance under the maintenance-of-payment-levels test for months from July 1977 through March 1983, we used December 1976 (or December 1981 under the circumstances described in paragraph (g) of this section) as the standard month for determining the required State supplementary payment level. To determine the December 1976 State supplementary payment levels for categories described in paragraphs (a) through (e) of this section substitute ''December 1976'' for ''March 1983'' and ''January 1977'' for ''April 1983'' whenever they appear in these paragraphs only.

(g) *Alternative required optional State supplementary payment level for July 1982 through March 1983.* States which were in compliance solely under the total-expenditures test for the 12-month period ending June 30, 1982, had the option of substituting December 1981 for December 1976 and switching to the maintenance-of-payment-levels test for July 1982 through March 1983 (see § 416.2096(b)(2)). If this situation applies, determine the December 1981 State supplementary payment levels for categories described in paragraphs (a) through (e) of this section by substituting ''December 1981'' for ''March 1983'' and ''January 1982'' for ''April 1983'' whenever they appear in these paragraphs only.

[52 FR 36243, Sept. 28, 1987; 53 FR 4135, Feb. 12, 1988, as amended at 54 FR 19165, May 4, 1989; 54 FR 23018, May 30, 1989]

§ 416.2099 Compliance with pass-along.

(a) *Information regarding compliance.* Any State required to enter into a pass-along agreement with the Commissioner shall provide appropriate and timely information to demonstrate to the Commissioner's satisfaction that the State is meeting the pass-along requirements. The information shall include, where relevant—

(1) The State's December 1976 supplementary payment levels, any subsequent supplementary payment levels,

and any change in State eligibility requirements. If the State made no supplementary payments in December 1976, it shall provide such information about the first month in which it makes supplementary payments;

(2) The State's March 1983 supplementary payment levels, any subsequent supplementary payment levels, and any changes in State eligibility requirements;

(3) The total State expenditures for supplementary payments in the 12-month period beginning July 1976 through June 1977, in each subsequent 12-month period, and in any other 12-month period beginning on the effective date of a Federal SSI benefit increase. The State shall also submit advance estimates of its total supplementary payments in each 12-month period covered by the agreement;

(4) The total State expenditures for supplementary payments in the 6-month periods July 1, 1982 through December 31, 1982 and July 1, 1983 through December 31, 1983; and

(5) The State supplementary payment level payable to residents of Medicaid facilities (see §416.2096(d)) on October 1, 1987 (or, if a State first makes such supplementary payments after October 1, 1987, but before July 1, 1988, the level for the month the State first makes such supplementary payments). The State shall also report all changes in such payment levels.

(b) *Records.* Except where the Commissioner administers the State supplementary payments, the State shall maintain records about its supplementary payment levels and total 12-month (or 6-month where applicable) expenditures for supplementary payments and permit inspection and audit by the Commissioner or someone designated by the Commissioner.

(c) *Noncompliance by the States.* Any State that makes supplementary payments on or after June 30, 1977, and does not have a pass-along agreement with the Commissioner in effect, shall be determined by the Commissioner to be ineligible for payments under title XIX of the Act. A State does not have an agreement in effect if it has not entered into an agreement or has not complied with the terms of the agreement. Ineligibility shall apply to total expenditures for any calendar quarter beginning after June 30, 1977, for which a State has not entered into an agreement. A State that enters into an agreement but does not maintain its payment levels or meet the total-expenditures test in a particular 12-month or transitional 6-month period, shall be determined by the Commissioner not to have an agreement in effect for any month that the State did not meet the pass-along requirements during that particular period. The State shall then be ineligible for title XIX payments for any calendar quarter containing a month for which an agreement was not in effect. If a State first makes supplementary payments beginning with a month after June 1977, ineligibility shall apply to any calendar quarter beginning after the calendar quarter in which the State first makes payments.

(d) *Notices to States about potential noncompliance.* Within 90 days after the end of the relevant 12-month period, the Commissioner shall send a notice to any State that has not maintained its supplementary payment levels and that appears not to have maintained its total expenditures during the period. The notice will advise the State of the available methods of compliance and the time within which corrective action must be taken (see §§416.2096(b)(3) and 416.2096(c)(2)) in order to avoid a determination of noncompliance. If the State fails to take the corrective action, the Commissioner shall make a timely determination of noncompliance.

(Approved by the Office of Management and Budget under control number 0960–0240)

[52 FR 36244, Sept. 28, 1987, as amended at 54 FR 19165, May 4, 1989; 62 FR 38455, July 18, 1997]

Subpart U—Medicaid Eligibility Determinations

AUTHORITY: Secs. 702(a)(5), 1106, 1631(d)(1), and 1634 of the Social Security Act (42 U.S.C. 902(a)(5), 1306, 1383(d)(1), and 1383c).

SOURCE: 53 FR 12941, Apr. 20, 1988, unless otherwise noted.

§ 416.2101 Introduction.

(a) *What is in this subpart.* This subpart describes the agreements we make with States under which we determine the Medicaid eligibility of individuals who receive Supplemental Security Income (SSI) benefits. It includes a general description of the services we will provide under these agreements and the costs to the States for the services.

(b) *Related regulations.* The comprehensive regulations on eligibility for the Medicaid program, administered by the Health Care Financing Administration, are in part 435 of title 42 of the Code of Federal Regulations.

(c) *Definitions.* In this subpart—

SSI benefits means Federal SSI benefits, including special SSI cash benefits under section 1619(a) of the Social Security Act. In addition, we consider a person who has special SSI eligibility status under section 1619(b) of the Social Security Act to be receiving SSI benefits.

State Medicaid Plan means a State's medical assistance plan which the Secretary has approved under title XIX of the Act for Federal payment of a share of the State's medical assistance expenses.

State supplementary payments means supplementary payments we administer for a State under subpart T of this part.

We, us, or *our* refers to the Social Security Administration.

§ 416.2111 Conditions for our agreeing to make Medicaid eligibility determinations.

We will agree to make Medicaid eligibility determinations for a State only if the State's Medicaid eligibility requirements for recipients of SSI benefits and for recipients of State supplementary payments are the same as the requirements for receiving SSI benefits and the requirements for receiving State supplementary payments, respectively. Exceptions: We may agree to make Medicaid eligibility determinations—

(a) For one, two, or all of the three categories of people (*i.e.*, aged, blind, and disabled) who receive SSI benefits or State supplementary payments; or

(b) Even though the State's Medicaid eligibility requirements for recipients of SSI benefits or of State supplementary payments, or both, differ from the requirements for SSI or State supplementary payments, or both, in ways mandated by Federal law.

§ 416.2116 Medicaid eligibility determinations.

If a State requests, we may agree, under the conditions in this subpart, to make Medicaid eligibility determinations on behalf of the State. Under these agreements, we make the Medicaid determinations when determinations or redeterminations are necessary for SSI purposes. Our determinations may include non-SSI requirements that are mandated by Federal law. When we determine that a person is eligible for Medicaid in accordance with § 416.2111 or that we are not making the determination, we notify the State of that fact.

§ 416.2130 Effect of the agreement and responsibilities of States.

(a) An agreement under this subpart does not change—

(1) The provisions of a State's Medicaid plan;

(2) The conditions under which the Secretary will approve a State's Medicaid plan; or

(3) A State's responsibilities under the State Medicaid plan.

(b) Following are examples of functions we will not agree to carry out for the State:

(1) Stationing of our employees at hospitals or nursing homes to take Medicaid applications;

(2) Determining whether a person is eligible for Medicaid for any period before he or she applied for SSI benefits;

(3) Giving approval for emergency medical care under Medicaid before a determination has been made on whether a person is eligible for SSI benefits;

(4) Setting up or running a State's system for requiring a person to pay part of the cost of services he or she receives under Medicaid; or

(5) Giving identification cards to people to show that they are eligible for Medicaid.

§416.2140 Liability for erroneous Medicaid eligibility determinations.

If the State suffers any financial loss, directly or indirectly, through using any information we provide under an agreement described in this subpart, we will not be responsible for that loss. However, if we erroneously tell a State that a person is eligible for Medicaid and the State therefore makes erroneous Medicaid payments, the State will be paid the Federal share of those payments under the Medicaid program as if they were correct.

§416.2145 Services other than Medicaid determinations.

We will agree under authority of section 1106 of the Act and 31 U.S.C. 6505 to provide services other than Medicaid determinations to help the State administer its Medicaid program. We will do this only if we determine it is the most efficient and economical way to accomplish the State's purpose and does not interfere with administration of the SSI program. The services can be part of a Medicaid eligibility determination agreement or a separate agreement. Under either agreement we will—

(a) Give the State basic information relevant to Medicaid eligibility from individuals' applications for SSI benefits;

(b) Give the State answers to certain purely Medicaid-related questions (in addition to any that may be necessary under §416.2111(b)), such as whether the SSI applicant has any unpaid medical expenses for the current month or the previous 3 calendar months;

(c) Conduct statistical or other studies for the State; and

(d) Provide other services the State and we agree on.

§416.2161 Charges to States.

(a) *States with Medicaid eligibility determination agreement.* A State with which we have an agreement to make Medicaid eligibility determinations is charged in the following manner:

(1) If making Medicaid determinations and providing basic SSI application information for a State causes us additional cost, the State must pay half of that additional cost. ''Additional cost'' in this section means cost in addition to costs we would have had anyway in administering the SSI program.

(2) The State must pay half our additional cost caused by providing any information that we collect for Medicaid purposes and by any other services directly related to making Medicaid eligibility determinations.

(3) The State must pay our full additional cost for statistical or other studies and any other services that are not directly related to making Medicaid eligibility determinations.

(b) *States without Medicaid eligibility determination agreement.* A State with which we do not have an agreement to make Medicaid eligibility determinations is charged in the following manner:

(1) If providing basic SSI application information causes us additional cost, the State must pay our full additional cost.

(2) The State must pay our full additional cost caused by providing any information that we collect for Medicaid purposes and for statistical or other studies and any other services.

§416.2166 Changing the agreement.

The State and we can agree in writing to change the agreement at any time.

§416.2171 Duration of agreement.

An agreement under this subpart is automatically renewed for 1 year at the end of the term stated in the agreement and again at the end of each 1-year renewal term, unless—

(a) The State and we agree in writing to end it at any time;

(b) Either the State or we end it at any time without the other's consent by giving written notice at least 90 days before the end of a term, or 120 days before any other ending date selected by whoever wants to end the agreement; or

(c)(1) The State fails to pay our costs as agreed;

(2) We notify the State in writing, at least 30 days before the ending date we select, why we intend to end the agreement; and

(3) The State does not give a good reason for keeping the agreement in

force beyond the ending date we selected. If the State does provide a good reason, the termination will be postponed or the agreement will be kept in force until the end of the term.

§ 416.2176 Disagreements between a State and us.

(a) If a State with which we have an agreement under this subpart and we are unable to agree about any question of performance under the agreement, the State may appeal the question to the Commissioner of Social Security. The Commissioner or his or her designee will, within 90 days after receiving the State's appeal, give the State either a written decision or a written explanation of why a decision cannot be made within 90 days, what is needed before a decision can be made, and when a decision is expected to be made.

(b) The Commissioner's decision will be the final decision of the Social Security Administration.

[53 FR 12941, Apr. 20, 1988, as amended at 62 FR 38456, July 18, 1997]

Subpart V—Payments for Vocational Rehabilitation Services

AUTHORITY: Secs. 702(a)(5), 1615, 1631(d)(1) and (e), and 1633(a) of the Social Security Act (42 U.S.C. 902(a)(5), 1382d, 1383(d)(1) and (e), and 1383b(a)).

SOURCE: 48 FR 6297, Feb. 10, 1983, unless otherwise noted.

GENERAL PROVISIONS

§ 416.2201 General.

In general, sections 1615(d) and (e) of the Social Security Act (the Act) authorize payment from the general fund for the reasonable and necessary costs of vocational rehabilitation (VR) services provided certain disabled or blind individuals who are eligible for supplemental security income (SSI) benefits, special SSI eligibility status, or federally administered State supplementary payments. In this subpart, such benefits, status, or payments are referred to as disability or blindness benefits (see § 416.2203). Subject to the provisions of this subpart, payment may be made for VR services provided an individual during a month(s) for which the individual is eligible for disability or blindness benefits, including the continuation of such benefits under section 1631(a)(6) of the Act, or for which the individual's disability or blindness benefits are suspended (see § 416.2215). Paragraphs (a) and (b) of this section describe the cases in which the State VR agencies can be paid for the VR services provided such an individual under this subpart. The purpose of sections 1615(d) and (e) of the Act is to make VR services more readily available to disabled or blind individuals and ensure that savings accrue to the general fund. Payment will be made for VR services provided on behalf of such an individual in cases where—

(a) The furnishing of the VR services results in the individual's completion of a continuous 9-month period of substantial gainful activity (SGA) as specified in §§ 416.2210 through 416.2211; or

(b) The individual continues to receive disability or blindness benefits, even though his or her disability or blindness has ceased, under section 1631(a)(6) of the Act because of his or her continued participation in an approved VR program which we have determined will increase the likelihood that he or she will not return to the disability or blindness rolls (*see* § 416.2212).

[68 FR 40124, July 7, 2003, as amended at 83 FR 62460, Dec. 4, 2018]

§ 416.2202 Purpose and scope.

This subpart describes the rules under which the Commissioner will pay the State VR agencies for VR services. Payment will be provided for VR services provided on behalf of disabled or blind individuals under one or more of the provisions discussed in § 416.2201.

(a) Sections 416.2201 through 416.2203 describe the purpose of these regulations and the meaning of terms we frequently use in them.

(b) Section 416.2204 explains how State VR agencies may participate in the payment program under this subpart.

(c) [Reserved]

(d) Sections 416.2208 through 416.2209 describe the requirements and conditions under which we will pay a State VR agency under this subpart.

(e) Sections 416.2210 through 416.2211 describe when an individual has completed a continuous period of SGA and when VR services will be considered to have contributed to that period.

(f) Section 416.2212 describes when payment will be made to a VR agency because an individual's disability or blindness benefits are continued based on his or her participation in a VR program which we have determined will increase the likelihood that he or she will not return to the disability rolls.

(g) Sections 416.2214 through 416.2215 describe services for which payment will be made.

(h) Section 416.2216 describes the filing deadlines for claims for payment for VR services.

(i) Section 416.2217 describes the payment conditions.

(j) [Reserved]

(k) Section 416.2219 describes how we will make payment to State VR agencies for rehabilitation services.

(l) Sections 416.2220 and 416.2221 describe the audits and the prepayment and postpayment validation reviews we will conduct.

(m) Section 416.2222 discusses confidentiality of information and records.

(n) Section 416.2223 provides for the applicability of other Federal laws and regulations.

(o) Section 416.2227 provides for the resolution of disputes.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 59 FR 11916, Mar. 15, 1994; 62 FR 38456, July 18, 1997; 68 FR 40124, July 7, 2003; 83 FR 62460, Dec. 4, 2018]

§ 416.2203 Definitions.

For purposes of this subpart:

Accept the recipient as a client for VR services means that the State VR agency determines that the individual is eligible for VR services and places the individual into an active caseload status for development of an individualized written rehabilitation program.

Act means the Social Security Act, as amended.

Blindness means ''blindness'' as defined in section 1614(a)(2) of the Act.

Commissioner means the Commissioner of Social Security or the Commissioner's designee.

Disability means ''disability'' as defined in section 1614(a)(3) of the Act.

Disability or blindness benefits, as defined for this subpart only, refers to regular SSI benefits under section 1611 of the Act (see § 416.202), special SSI cash benefits under section 1619(a) of the Act (see § 416.261), special SSI eligibility status under section 1619(b) of the Act (see § 416.264), and/or a federally administered State supplementary payment under section 1616 of the Act or section 212(b) of Public Law 93–66 (see § 416.2001), for which an individual is eligible based on disability or blindness, as appropriate.

Medical recovery for purposes of this subpart is established when a disabled or blind recipient's eligibility ceases for any medical reason (other than death). The determination of medical recovery is made by the Commissioner in deciding a recipient's continuing eligibility for benefits.

Place the recipient into an extended evaluation process means that the State VR agency determines that an extended evaluation of the individual's VR potential is necessary to determine whether the individual is eligible for VR services and places the individual into an extended evaluation status.

SGA means substantial gainful activity performed by an individual as defined in §§ 416.971 through 416.975 of this subpart or § 404.1584 of this chapter.

Special SSI eligibility status refers to the special status described in §§ 416.264 through 416.269 relating to eligibility for Medicaid.

State means any of the 50 States of the United States, the District of Columbia, or the Northern Mariana Islands. It includes the State VR agency.

Vocational rehabilitation services has the meaning assigned to it under title I of the Rehabilitation Act of 1973.

VR agency means an agency of the State which has been designated by the State to provide vocational rehabilitation services under title I of the Rehabilitation Act of 1973.

We, *us*, and *our* refer to the Social Security Administration (SSA).

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 55 FR 19423, May 9, 1990; 59 FR 1637, Jan. 12, 1994; 59 FR 11916, Mar. 15, 1994; 61 FR 31026, June 19, 1996; 62 FR 38456, July 18, 1997; 68 FR 40125, July 7, 2003; 83 FR 62460, Dec. 4, 2018]

§ 416.2204 Participation by State VR agencies.

(a) *General.* In order to participate in the payment program under this subpart through its VR agency(ies), a State must have a plan which meets the requirements of title I of the Rehabilitation Act of 1973, as amended.

(b) *Participation by States.* (1) The opportunity to participate through its VR agency(ies) with respect to disabled or blind recipients in the State will be offered first to the State in accordance with paragraph (c) of this section, unless the State has notified us in advance under paragraph (e)(1) of this section of its decision not to participate or to limit such participation.

(2) A State with one or more approved VR agencies may choose to limit participation of those agencies to a certain class(es) of disabled or blind recipients. For example, a State with separate VR agencies for the blind and disabled may choose to limit participation to the VR agency for the blind. In such a case, we would give the State, through its VR agency for the blind, the opportunity to participate with respect to blind recipients in the State in accordance with paragraph (d) of this section. A State that chooses to limit participation of its VR agency(ies) must notify us in advance under paragraph (e)(1) of this section of its decision to limit such participation.

(c) *Opportunity for participation through State VR agencies.* (1) Unless a State has decided not to participate or to limit participation, we will give the State the opportunity to participate through its VR agency(ies) with respect to disabled or blind recipients in the State by referring such recipients first to the State VR agency(ies) for necessary VR services. A State, through its VR agency(ies), may participate with respect to any recipient so referred by accepting the recipient as a client for VR services or placing the recipient into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(2)(i) In order for the State to participate with respect to a disabled or blind recipient whom we referred to a State VR agency, the State VR agency must notify the appropriate Regional Commissioner (SSA) in writing or through electronic notification of its decision either to accept the recipient as a client for VR services or to place the recipient into an extended evaluation process. The notice must be received by the appropriate Regional Commissioner (SSA) no later than the close of the fourth month following the month in which we referred the recipient to the State VR agency.

(ii) In any case in which a State VR agency notifies the appropriate Regional Commissioner (SSA) in writing within the stated time period under paragraph (c)(2)(i) of this section of its decision to place the recipient into an extended evaluation process, the State VR agency also must notify that Regional Commissioner in writing upon completion of the evaluation of its decision whether or not to accept the recipient as a client for VR services. If we receive a notice of a decision by the State VR agency to accept the recipient as a client for VR services following the completion of the extended evaluation, the State may continue to participate with respect to such recipient.

(d) *Opportunity for limited participation through State VR agencies.* If a State has decided under paragraph (e)(1) of this section to limit participation of its VR agency(ies) to a certain class(es) of disabled or blind recipients in the State, we will give the State the opportunity to participate with respect to such class(es) of disabled or blind recipients by referring such recipients first to the State VR agency(ies) for necessary VR services. The State, through its VR agency(ies), may participate with respect to any recipient so referred by accepting the recipient as a client for VR services or placing the recipient into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(e) *Decision of a State not to participate or to limit participation.* (1) A State may choose not to participate through its VR agency(ies) with respect to any disabled or blind recipients in the State, or it may choose to limit participation of its VR agency(ies) to a certain class(es) of disabled or blind recipients in the State. A State which decides not

to participate or to limit participation must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). Unless a State specifies a later month, a decision not to participate or to limit participation will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA). The notice of the State decision must be submitted by an official authorized to act for the State for this purpose. A State must provide to the appropriate Regional Commissioner (SSA) an opinion from the State's Attorney General, verifying the authority of the official who sent the notice to act for the State. This opinion will not be necessary if the notice is signed by the Governor of the State.

(2) [Reserved]

(3) A State which has decided not to participate or to limit participation may participate later through its VR agency(ies) in accordance with paragraph (c) of this section. A State that decides to resume participation under paragraph (c) of this section must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). A decision of a State to resume participation under paragraph (c) of this section will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA) or, if later, with a month specified by the State. The notice of the State decision must be submitted by an official authorized to act for the State as explained in paragraph (e)(1) of this section.

[59 FR 11917, Mar. 15, 1994, as amended at 83 FR 62460, Dec. 4, 2018]

§ 416.2206 [Reserved]

PAYMENT PROVISIONS

§ 416.2208 Requirements for payment.

(a) The State VR agency must file a claim for payment in each individual case within the time periods specified in § 416.2216;

(b) The claim for payment must be in a form prescribed by us and contain the following information:

(1) A description of each service provided;

(2) When the service was provided; and

(3) The cost of the service;

(c) The VR services for which payment is being requested must have been provided during the period specified in § 416.2215;

(d) The VR services for which payment is being requested must have been provided under a State plan for VR services approved under title I of the Rehabilitation Act of 1973, as amended, and must be services that are described in § 416.2214;

(e) The individual must meet one of the VR payment provisions specified in § 416.2201;

(f) The State VR agency must maintain, and provide as we may require, adequate documentation of all services and costs for all disabled or blind recipients with respect to whom a State VR agency could potentially request payment for services and costs under this subpart; and

(g) The amount to be paid must be reasonable and necessary and be in compliance with the cost guidelines specified in § 416.2217.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 59 FR 11918, Mar. 15, 1994; 83 FR 62460, Dec. 4, 2018]

§ 416.2209 Responsibility for making payment decisions.

The Commissioner will decide:

(a) Whether a continuous period of 9 months of SGA has been completed;

(b) Whether a disability or blindness recipient whose disability or blindness has ceased should continue to receive benefits under section 1631(a)(6) of the Social Security Act for a month after October 1984 or, in the case of a blindness recipient, for a month after March 1988, based on his or her continued participation in a VR program;

(c) If and when medical recovery has occurred;

(d) Whether documentation of VR services and expenditures is adequate;

(e) If payment is to be based on completion of a continuous 9-month period

of SGA, whether the VR services contributed to the continuous period of SGA;

(f) Whether a VR service is a service described in § 416.2214; and

(g) What VR costs were reasonable and necessary and will be paid.

[55 FR 8456, Mar. 8, 1990, as amended at 59 FR 11918, Mar. 15, 1994; 61 FR 31026, June 19, 1996; 68 FR 40125, July 7, 2003]

§ 416.2210 What we mean by "SGA" and by "a continuous period of 9 months".

(a) *What we mean by ''SGA''.* In determining whether an individual's work is SGA, we will follow the rules in §§ 416.972 through 416.975. We will follow these same rules for individuals who are statutorily blind, but we will evaluate the earnings in accordance with the rules in § 404.1584(d) of this chapter.

(b) *What we mean by ''a continuous period of 9 months''.* A continuous period of 9 months ordinarily means a period of 9 consecutive calendar months. Exception: When an individual does not perform SGA in 9 consecutive calendar months, he or she will be considered to have done so if—

(1) The individual performs 9 months of SGA within 10 consecutive months and has monthly earnings that meet or exceed the guidelines in § 416.974(b)(2), or § 404.1584(d) of this chapter if the individual is statutorily blind, or

(2) The individual performs at least 9 months of SGA within 12 consecutive months, and the reason for not performing SGA in 2 or 3 of those months was due to circumstances beyond his or her control and unrelated to the impairment (e.g., the employer closed down for 3 months).

(c) *What work we consider.* In determining if a continuous period of SGA has been completed, all of an individual's work activity may be evaluated for purposes of this section, including work performed before October 1, 1981, during a trial work period, and after eligibility for disability or blindness payments ended. We will ordinarily consider only the first 9 months of SGA that occurs. The exception will be if an individual who completed 9 months of SGA later stops performing SGA, received VR services and then performs SGA for a 9-month period. See § 416.2215 for the use of the continuous period in determining payment for VR services.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8457, Mar. 8, 1990]

§ 416.2211 Criteria for determining when VR services will be considered to have contributed to a continuous period of 9 months.

The State VR agency may be paid for VR services if such services contribute to the individual's performance of a continuous 9-month period of SGA. The following criteria apply to individuals who received more than just evaluation services. If a State VR agency claims payment for services to an individual who received only evaluation services, it must establish that the individual's continuous period or medical recovery (if medical recovery occurred before completion of a continuous period) would not have occurred without the services provided. In applying the criteria below, we will consider services described in § 416.2214 that were initiated, coordinated or provided, including services before October 1, 1981.

(a) *Continuous period without medical recovery.* If an individual who has completed a ''continuous period'' of SGA has not medically recovered as of the date of completion of the period, the determination as to whether VR services contributed will depend on whether the continuous period began one year or less after VR services ended or more than one year after VR services ended.

(1) *One year or less.* Any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(2) *More than one year.* (i) If the continuous period was preceded by transitional work activity (employment or self-employment which gradually evolved, with or without periodic interruption, into SGA), and that work activity began less than a year after VR services ended, any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(ii) If the continuous period was not preceded by transitional work activity that began less than a year after VR services ended, VR services will be considered to have contributed to the continuous period only if it is reasonable to conclude that the work activity which constitutes a continuous period could not have occurred without the VR services (e.g., training).

(b) *Continuous period with medical recovery occurring before completion.* (1) If an individual medically recovers before a continuous period has been completed, VR services under paragraph (a) of this section will not be payable unless some VR services contributed to the medical recovery. VR services will be considered to have contributed to the medical recovery if—

(i) The individualized written rehabilitation program (IWRP), included medical services; and

(ii) The medical recovery occurred, at least in part, because of these medical services. (For example, the individual's medical recovery was based on improvement in a back condition which, at least in part, stemmed from surgery initiated, coordinated or provided under an IWRP).

(2) In some instances, the State VR agency will not have provided, initiated, or coordinated medical services. If this happens, payment for VR services may still be possible under paragraph (a) of this section if:

(i) The medical recovery was not expected by us; and

(ii) The individual's impairment is determined by us to be of such a nature that any medical services provided would not ordinarily have resulted in, or contributed to, the medical cessation.

[48 FR 6297, Feb. 10, 1983, as amended at 59 FR 11918, Mar. 15, 1994; 83 FR 62460, Dec. 4, 2018]

§ 416.2212 Payment for VR services in a case where an individual continues to receive disability or blindness benefits based on participation in an approved VR program.

Section 1631(a)(6) of the Act contains the criteria we will use in determining if an individual whose disability or blindness has ceased should continue to receive disability or blindness benefits because of his or her continued participation in an approved VR program. A VR agency can be paid for the cost of VR services provided to an individual if the individual was receiving benefits based on this provision in a month(s) after October 1984 or, in the case of a blindness recipient, in a month(s) after March 1988. If this requirement is met, a VR agency can be paid for the costs of VR services provided within the period specified in § 416.2215, subject to the other payment and administrative provisions of this subpart.

[83 FR 62461, Dec. 4, 2018]

§ 416.2214 Services for which payment may be made.

(a) *General.* Payment may be made for VR services provided by a State VR agency in accordance with title I of the Rehabilitation Act of 1973, as amended, subject to the limitations and conditions in this subpart. VR services for which payment may be made under this subpart include only those services described in paragraph (b) of this section which are—

(1) Necessary to determine an individual's eligibility for VR services or the nature and scope of the services to be provided; or

(2) Provided by a State VR agency under an IWRP, but only if the services could reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

(b) *Specific services.* Payment may be made under this subpart only for the following VR services:

(1) An assessment for determining an individual's eligibility for VR services and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology, and which includes determining—

(i) The nature and extent of the physical or mental impairment(s) and the resultant impact on the individual's employability;

(ii) The likelihood that an individual will benefit from vocational rehabilitation services in terms of employability; and

(iii) An employment goal consistent with the capacities of the individual and employment opportunities;

(2) Counseling and guidance, including personal adjustment counseling, and those referrals and other services necessary to help an individual secure needed services from other agencies;

(3) Physical and mental restoration services necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and which constitutes an impediment to suitable employment at or above the SGA level;

(4) Vocational and other training services, including personal and vocational adjustment, books, tools, and other training materials, except that training or training services in institutions of higher education will be covered under this section only if maximum efforts have been made by the State VR agency to secure grant assistance in whole or in part from other sources;

(5) Maintenance expenses that are extra living expenses over and above the individual's normal living expenses and that are incurred solely because of and while the individual is participating in the VR program and that are necessary in order for the individual to benefit from other necessary VR services;

(6) Travel and related expenses necessary to transport an individual for purpose of enabling the individual's participation in other necessary VR services;

(7) Services to family members of a disabled or blind individual only if necessary to the successful vocational rehabilitation of that individual;

(8) Interpreter services and note-taking services for an individual who is deaf and tactile interpreting for an individual who is deaf and blind;

(9) Reader services, rehabilitation teaching services, note-taking services, and orientation and mobility services for an individual who is blind;

(10) Telecommunications, sensory, and other technological aids and devices;

(11) Work-related placement services to secure suitable employment;

(12) Post-employment services necessary to maintain, regain or advance into suitable employment at or above the SGA level;

(13) Occupational licenses, tools, equipment, initial stocks, and supplies;

(14) Rehabilitation technology services; and

(15) Other goods and services that can reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

[59 FR 11919, Mar. 15, 1994, as amended at 83 FR 62461, Dec. 4, 2018]

§ 416.2215 When services must have been provided.

(a) In order for the VR agency to be paid, the services must have been provided—

(1) After September 30, 1981;

(2) During a month(s) for which—

(i) The individual is eligible for disability or blindness benefits or continues to receive such benefits under section 1631(a)(6) of the Act (see § 416.2212); or

(ii) The disability or blindness benefits of the individual are suspended due to his or her ineligibility for the benefits (see subpart M of this part concerning suspension for ineligibility); and

(3) Before completion of a continuous 9-month period of SGA or termination of disability or blindness benefits, whichever occurs first (see subpart M of this part concerning termination of benefits).

(b) If an individual who is receiving disability or blindness benefits under this part, or whose benefits under this part are suspended, also is entitled to disability benefits under part 404 of this chapter, the determination as to when services must have been provided may be made under this section or § 404.2115 of this chapter, whichever is advantageous to the State VR agency that is participating in both VR programs.

[61 FR 31026, June 19, 1996, as amended at 83 FR 62461, Dec. 4, 2018]

§ 416.2216 When claims for payment for VR services must be made (filing deadlines).

The State VR agency must file a claim for payment in each individual case within the following time periods:

(a) A claim for payment for VR services based on the completion of a continuous 9-month period of SGA must be

filed within 12 months after the month in which the continuous 9-month period of SGA is completed.

(b) A claim for payment for VR services provided to an individual whose disability or blindness benefits were continued after disability or blindness has ceased because of that individual's continued participation in a VR program must be filed as follows:

(1) If a written notice requesting that a claim be filed was sent to the State VR agency, a claim must be filed within 90 days following the month in which VR services end, or if later, within 90 days after receipt of the notice.

(2) If no written notice was sent to the State VR agency, a claim must be filed within 12 months after the month in which VR services end.

[55 FR 8457, Mar. 8, 1990, as amended at 61 FR 31026, June 19, 1996; 68 FR 40125, July 7, 2003; 83 FR 62461, Dec. 4, 2018]

§416.2217 What costs will be paid.

In accordance with section 1615(d) and (e) of the Social Security Act, the Commissioner will pay the State VR agency for the VR services described in §416.2214 which were provided during the period described in §416.2215 and which meet the criteria in §416.2211 or §416.2212, but subject to the following limitations:

(a) The cost must have been incurred by the State VR agency;

(b) The cost must not have been paid or be payable from some other source. For this purpose, State VR agencies will be required to seek payment or services from other sources in accordance with the ''similar benefit'' provisions under 34 CFR part 361, including making maximum efforts to secure grant assistance in whole or part from other sources for training or training services in institutions of higher education.

(c)(1) The cost must be reasonable and necessary, in that it complies with the written cost-containment policies of the State VR agency. A cost which complies with these policies will be considered necessary only if the cost is for a VR service described in §416.2214. The State VR agency must maintain and use these cost-containment policies, including any reasonable and appropriate fee schedules, to govern the costs incurred for all VR services, including the rates of payment for all purchased services, for which payment will be requested under this subpart. For the purpose of this subpart, the written cost-containment policies must provide guidelines designed to ensure—

(i) The lowest reasonable cost for such services; and

(ii) Sufficient flexibility so as to allow for an individual's needs.

(2) The State VR agency shall submit to us before the end of the first calendar quarter of each year a written statement certifying that cost-containment policies are in effect and are adhered to in procuring and providing goods and services for which the State VR agency requests payment under this subpart. Such certification must be signed by the State's chief financial official or the head of the VR agency. Each certification must specify the basis upon which it is made, e.g., a recent audit by an authorized State, Federal or private auditor (or other independent compliance review) and the date of such audit (or compliance review). We may request the State VR agency to submit to us a copy(ies) of its specific written cost-containment policies and procedures (e.g., any guidelines and fee schedules for a given year), if we determine that such additional information is necessary to ensure compliance with the requirements of this subpart. The State VR agency shall provide such information when requested by us.

(d) The total payment in each case, including any prior payments related to earlier continuous 9-month periods of SGA made under this subpart, must not be so high as to preclude a ''net saving'' to the general funds (a ''net saving'' is the difference between the estimated savings to the general fund, if payments for disability or blindness remain reduced or eventually terminate, and the total amount we pay to the State VR agency);

(e) Any payment to the State VR agency for either direct or indirect VR expenses must be consistent with the cost principles described in OMB Circular No. A–87, as revised;

(f) Payment for VR services or costs may be made under more than one of

the VR payment provisions described in §§ 416.2211 and 416.2212 of this subpart and similar provisions in §§ 404.2111 and 404.2112 of subpart V of part 404. However, payment will not be made more than once for the same VR service or cost; and

(g) Payment will be made for administrative costs and for counseling and placement costs. This payment may be on a formula basis, or on an actual cost basis, whichever the State VR agency prefers. The formula will be negotiated. The payment will also be subject to the preceding limitations.

[48 FR 6297, Feb. 10, 1983. Redesignated and amended at 55 FR 8457, 8458, Mar. 8, 1990; 55 FR 14916, Apr. 19, 1990; 59 FR 11919, Mar. 15, 1994; 61 FR 31027, June 19, 1996; 62 FR 38456, July 18, 1997; 68 FR 40125, July 7, 2003; 83 FR 62461, Dec. 4, 2018]

ADMINISTRATIVE PROVISIONS

§ 416.2218 [Reserved]

§ 416.2219 Method of payment.

Payment to the State VR agencies pursuant to this subpart will be made either by advancement of funds or by payment for services provided (with necessary adjustments for any overpayments and underpayments), as decided by the Commissioner.

[83 FR 62462, Dec. 4, 2018]

§ 416.2220 Audits.

(a) *General.* The State shall permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the services and costs for which payment was requested or made under these regulations. These records shall be retained by the State for the periods of time specified for retention of records in the Federal Acquisition Regulations (48 CFR part 4, subpart 4.7).

(b) *Audit basis.* Auditing will be based on cost principles and written guidelines in effect at the time services were provided and costs were incurred. The State VR agency will be informed and given a full explanation of any questioned items. They will be given a reasonable time to explain questioned items. Any explanation furnished by the State VR agency will be given full consideration before a final determination is made on questioned items in the audit report.

(c) *Appeal of audit determinations.* The appropriate SSA Regional Commissioner will notify the State VR agency in writing of his or her final determination on the audit report. If the State VR agency disagrees with that determination, it may request reconsideration in writing within 60 days after receiving the Regional Commissioner's notice of the determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually, no later than 45 days from the date of the appeal. The decision by the Commissioner will be final and conclusive unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving it.

[83 FR 62462, Dec. 4, 2018]

§ 416.2221 Validation reviews.

(a) *General.* We will conduct a validation review of a sample of the claims for payment filed by each State VR agency. We will conduct some of these reviews on a prepayment basis and some on a postpayment basis. We may review a specific claim, a sample of the claims, or all the claims filed by any State VR agency, if we determine that such review is necessary to ensure compliance with the requirements of this subpart. For each claim selected for review, the State VR agency must submit such records of the VR services and costs for which payment has been requested or made under this subpart, or copies of such records, as we may require to ensure that the services and costs meet the requirements for payment. For claims for cases described in § 416.2201(a), a clear explanation or existing documentation which demonstrates how the service contributed to the individual's performance of a continuous 9-month period of SGA must be provided. For claims for cases described in § 416.2201(b) or (c), a clear explanation or existing documentation which demonstrates how the service was reasonably expected to motivate or assist the individual to return to or

continue in SGA must be provided. If we find in any prepayment validation review that the scope or content of the information is inadequate, we will request additional information and will withhold payment until adequate information has been provided. The State VR agency shall permit us (including duly authorized representatives) access to, and the right to examine, any records relating to such services and costs. Any review performed under this section will not be considered an audit for purposes of this subpart.

(b) *Purpose.* The primary purpose of these reviews is—

(1) To ensure that the VR services and costs meet the requirements for payment under this subpart;

(2) To assess the validity of our documentation requirements; and

(3) To assess the need for additional validation reviews or additional documentation requirements for any State VR agency to ensure compliance with the requirements under this subpart.

(c) *Determinations.* In any validation review, we will determine whether the VR services and costs meet the requirements for payment and determine the amount of payment. We will notify in writing the State VR agency of our determination. If we find in any postpayment validation review that more or less than the correct amount of payment was made for a claim, we will determine that an overpayment or underpayment has occurred and will notify the State VR agency that we will make the appropriate adjustment.

(d) *Appeals.* If the State VR agency disagrees with our determination under this section, it may appeal that determination in accordance with § 416.2227. For purposes of this section, an appeal must be filed within 60 days after receiving the notice of our determination.

[59 FR 11920, Mar. 15, 1994, as amended at 62462, Dec. 4, 2018]

§ 416.2222 Confidentiality of information and records.

The State shall comply with the provisions for confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see § 416.2223).

[83 FR 62462, Dec. 4, 2018]

§ 416.2223 Other Federal laws and regulations.

Each State VR agency shall comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the vocational rehabilitation function.

[83 FR 62462, Dec. 4, 2018]

§ 416.2227 Resolution of disputes.

(a) *Disputes on the amount to be paid.* The appropriate SSA official will notify the State VR agency in writing of his or her determination concerning the amount to be paid. If the State VR agency disagrees with that determination, the State VR agency may request reconsideration in writing within 60 days after receiving the notice of determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually, no later than 45 days from the date of the State VR agency's appeal. The decision by the Commissioner will be final and conclusive upon the State VR agency unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving the Commissioner's decision.

(b) *Disputes on whether there was a continuous period of SGA and whether VR services contributed to a continuous period of SGA.* The rules in paragraph (a) of this section will apply, except that the Commissioner's decision will be final and conclusive. There is no right of appeal to the Departmental Appeals Board.

(c) *Disputes on determinations made by the Commissioner which affect a disabled or blind beneficiary's rights to benefits.* Determinations made by the Commissioner which affect an individual's right to benefits (e.g., determinations that disability or blindness benefits should be terminated, denied, suspended, continued or begun at a different date than alleged) cannot be appealed by a State VR agency. Because these determinations are an integral

part of the disability or blindness benefits claims process, they can only be appealed by the beneficiary or applicant whose rights are affected or by his or her authorized representative. However, if an appeal of an unfavorable determination is made by the individual and is successful, the new determination would also apply for purposes of this subpart. While a VR agency cannot appeal a determination made by the Commissioner which affects a beneficiary's or applicant's rights, the VR agency can furnish any evidence it may have which would support a revision of a determination.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8458, Mar. 8, 1990; 62 FR 38456, July 18, 1997; 83 FR 62462, Dec. 4, 2018]

PART 418—MEDICARE SUBSIDIES

Subpart A [Reserved]

Subpart B—Medicare Part B Income-Related Monthly Adjustment Amount

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SOURCE: 70 FR 77675, Dec. 30, 2005, unless otherwise noted.

Subpart A [Reserved]

Subpart B—Medicare Part B Income-Related Monthly Adjustment Amount

AUTHORITY: Secs. 702(a)(5) and 1839(i) of the Social Security Act (42 U.S.C. 902(a)(5) and 1395r(i)).

SOURCE: 71 FR 62931, Oct. 27, 2006, unless otherwise noted.

INTRODUCTION, GENERAL PROVISIONS, AND DEFINITIONS

§418.1001 What is this subpart about?

This subpart relates to section 1839(i) of the Social Security Act (the Act), as amended. Section 1839(i) establishes an income-related monthly adjustment to the Medicare Part B premium. Beneficiaries enrolled in Medicare Part B who have modified adjusted gross income over a threshold amount established in the statute will pay an income-related monthly adjustment amount in addition to the Medicare Part B standard monthly premium and any applicable premium increases as described in 42 CFR 408.20. The regulations in this subpart explain how we decide whether you are required to pay an income-related monthly adjustment amount, and if you are, the amount of your adjustment. The rules are divided into the following groups of sections:

(a) Sections 418.1001 through 418.1010 contain the introduction, a statement of the general purpose of the income-related monthly adjustment amount, general provisions that apply to the income-related monthly adjustment amount, and definitions of terms that we use in this subpart.

(b) Sections 418.1101 through 418.1150 describe what information about your modified adjusted gross income we will use to determine if you are required to pay an income-related monthly adjustment amount. In these sections, we also describe how the income-related monthly adjustment amount will affect your total Medicare Part B premium.

(c) Sections 418.1201 through 418.1270 contain an explanation of the standards that you must meet for us to grant your request to use modified adjusted gross income information that you provide for a more recent tax year rather than the information described in paragraph (b) of this section. These sections explain when we may consider such a request, and the evidence that you will be required to provide. These sections also explain when income-related monthly adjustment amount determinations based on information you provide will be effective, and how long they will remain in effect. Additionally, these sections describe how retroactive adjustments of the income-related monthly adjustment amount will be made based on information you provide, updated information you provide, and information we later receive from the Internal Revenue Service (IRS).

(d) Sections 418.1301 through 418.1355 contain the rules that we will apply when you disagree with our determination regarding your income-related monthly adjustment amount. These sections explain your appeal rights and the circumstances under which you may request that we make a new initial determination of your income-related monthly adjustment amount.

[71 FR 62931, Oct. 27, 2006, as amended at 78 FR 57259, Sept. 18, 2013; 83 FR 55628, Nov. 7, 2018]

§ 418.1005 Purpose and administration.

(a) The purpose of the income-related monthly adjustment amount is to reduce the Federal subsidy of the Medicare Part B program for beneficiaries with modified adjusted gross income above an established threshold. These beneficiaries will pay a greater share of actual program costs. Medicare Part B premiums paid by beneficiaries cover approximately 25 percent of total Medicare Part B program costs and the remaining 75 percent of program costs are subsidized by the Federal Government's contributions to the Federal Supplementary Medical Insurance Trust Fund. The reduction in the Medicare Part B premium subsidy results in an increase in the total amount that affected beneficiaries pay for Medicare Part B coverage. A beneficiary with modified adjusted gross income above the threshold amount will pay:

(1) The Medicare Part B standard monthly premium; plus

(2) Any applicable increase in the standard monthly premium for late enrollment or reenrollment; plus

(3) An income-related monthly adjustment amount.

(b) The Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS) publishes the Medicare Part B standard monthly premium each year. CMS also establishes rules for entitlement to a nonstandard premium, as well as premium penalties for late enrollment or reenrollment (42 CFR 408.20 through 408.27).

(c) We use information that we get from IRS to determine if beneficiaries who are enrolled in Medicare Part B are required to pay an income-related monthly adjustment amount. We also change income-related monthly adjustment amount determinations using information provided by a beneficiary under certain circumstances. In addition, we notify beneficiaries when the social security benefit amounts they receive will change based on our income-related monthly adjustment amount determination.

§ 418.1010 Definitions.

(a) *Terms relating to the Act and regulations.* For the purposes of this subpart:

(1) *Administrator* means the Administrator of the Centers for Medicare & Medicaid Services (CMS) in HHS.

(2) *CMS* means the Centers for Medicare & Medicaid Services in HHS.

(3) *Commissioner* means the Commissioner of Social Security.

(4) *HHS* means the Department of Health and Human Services which oversees the Centers for Medicare & Medicaid Services, the Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council (MAC).

(5) *IRS* means the Internal Revenue Service in the Department of the Treasury.

(6) *MAC* means the Medicare Appeals Council in HHS.

(7) *OMHA* means the Office of Medicare Hearings and Appeals in HHS.

(8) *Section* means a section of the regulations in this part unless the context indicates otherwise.

(9) *The Act* means the Social Security Act, as amended.

(10) *Title* means a title of the Act.

(11) *We*, *our*, or *us* means the Social Security Administration (SSA).

(b) *Miscellaneous.* For the purposes of this subpart:

(1) *Amended tax return* means a Federal income tax return for which an amended tax return using the required IRS form(s) has been filed by an individual or couple and accepted by IRS.

(2) *Effective year* means the calendar year for which we make an income-related monthly adjustment amount determination.

(3) *Federal premium subsidy* is the portion of the full cost of providing Medicare Part B coverage that is paid by the Federal Government through transfers into the Federal Supplementary Medical Insurance Trust Fund.

(4) *Income-related monthly adjustment amount* is an additional amount of premium that you will pay for Medicare Part B coverage if you have income above the threshold. The amount of your income-related monthly adjustment amount is based on your modified adjusted gross income.

(5) *Medicare Part B standard monthly premium* means the monthly Medicare Part B premium amount which is set annually by CMS, according to regulations in 42 CFR 408.20 through 408.27.

(6) *Modified adjusted gross income* is your adjusted gross income as defined by the Internal Revenue Code, plus the following forms of tax-exempt income:

(i) Tax-exempt interest income;

(ii) Income from United States savings bonds used to pay higher education tuition and fees;

(iii) Foreign earned income;

(iv) Income derived from sources within Guam, American Samoa, or the Northern Mariana Islands; and

(v) Income from sources within Puerto Rico.

(7) *Modified adjusted gross income ranges* are the groupings of modified adjusted gross income above the threshold. There are four ranges for most individuals, based on their tax filing status. There are two ranges for those with a tax filing status of married, filing separately, who also lived with their spouse for part of the year. The dollar amounts of the modified adjusted gross income ranges are specified in § 418.1115.

(8) *Non-standard premium* means a Medicare Part B premium that some beneficiaries pay for Medicare Part B, rather than the standard premium. The rules for applying a non-standard premium are in 42 CFR 408.20(e). The non-standard premium does not apply to beneficiaries who must pay an income-related monthly adjustment amount.

(9) *Premium* is a payment that an enrolled beneficiary pays for Medicare Part B coverage. The rules that CMS uses to annually establish the premium amount are found in 42 CFR 408.20 through 408.27.

(10) *Representative* means, for the purposes of the initial determination and reconsidered determination, an individual as defined in § 404.1703 of this chapter, and for purposes of an ALJ hearing or review by the MAC, an individual as defined in 42 CFR 405.910.

(11) *Tax filing status* means the filing status shown on your individual income tax return. It may be single, married filing jointly, married filing separately, head of household, or qualifying widow(er) with dependent child.

(12) *Tax year* means the year for which your Federal income tax return has been filed or will be filed with the IRS.

(13) *Threshold* means a modified adjusted gross income amount above which the beneficiary will have to pay an income-related monthly adjustment amount described in paragraph (b)(4) of this section. The dollar amount of the threshold is specified in § 418.1105.

(14) *You* or *your* means the person or representative of the person who is subject to the income-related monthly adjustment amount.

DETERMINATION OF THE INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT

§ 418.1101 What is the income-related monthly adjustment amount?

(a) The income-related monthly adjustment amount is an amount that you will pay in addition to the Medicare Part B standard monthly premium plus any applicable increase in that premium as described in 42 CFR 408.22 for your Medicare Part B coverage when your modified adjusted gross income is above the threshold described in § 418.1105.

(b) Your income-related monthly adjustment amount is based on your applicable modified adjusted gross income as described in § 418.1115 and your tax filing status.

(c) We will determine your income-related monthly adjustment amount using the method described in § 418.1120.

[71 FR 62931, Oct. 27, 2006, as amended at 78 FR 57259, Sept. 18, 2013]

§ 418.1105 What is the threshold?

(a) The threshold is a level of modified adjusted gross income above which the beneficiary will have to pay the income-related monthly adjustment amount.

(b) From January 1, 2011 through December 31, 2019, the modified adjusted gross income threshold is $170,000 for individuals with a Federal income tax filing status of married filing jointly. The threshold is $85,000 for individuals with any other filing status.

(c) Starting on January 1, 2020, the threshold amounts will resume adjustment for inflation as required by section 1839(i)(5) of the Act. In each year thereafter, CMS will set all modified adjusted gross income threshold

amounts for the following year by increasing the preceding year's threshold amounts by any percentage increase in the Consumer Price Index rounded to the nearest $1,000. CMS will publish the amounts in the FEDERAL REGISTER in September of each year. Published threshold amounts will be effective January 1 of the next calendar year, for the full calendar year.

[71 FR 62931, Oct. 27, 2006, as amended at 78 FR 57259, Sept. 18, 2013]

§ 418.1110 What is the effective date of our initial determination about your income-related monthly adjustment amount?

(a) Generally, an income-related monthly adjustment amount will be effective for all months that you are enrolled in Medicare Part B during the year for which we determine you must pay an income-related monthly adjustment amount. We will follow the rules in 42 CFR part 408, subpart C, regarding premium collections to withhold your income-related monthly adjustment amount from a benefit payment or to determine if you will be billed directly.

(b) When we have used modified adjusted gross income information from IRS for the tax year 3 years prior to the effective year to determine your income-related monthly adjustment amount and modified adjusted gross income information for the tax year 2 years prior later becomes available from IRS, we will review the new information to determine if we should revise our initial determination. If we revise our initial determination, the effective date of the new initial determination will be January 1 of the effective year, or the first month you were enrolled or re-enrolled in Medicare Part B if later than January.

(c) When we use your amended tax return, as described in § 418.1150, the effective date will be January 1 of the year(s) that is affected, or the first month in that year that you were enrolled or reenrolled in Medicare Part B if later than January.

Example: You are enrolled in Medicare Part B throughout 2011. We use your 2009 modified adjusted gross income as reported to us by IRS to determine your 2011 income-related monthly adjustment amount. In 2012 you submit to us a copy of your 2009 amended tax return that you filed with IRS. The modified adjusted gross income reported on your 2009 amended tax return is significantly less than originally reported to IRS. We use the modified adjusted gross income that was reported on your 2009 amended tax return to determine your income-related monthly adjustment amount. That income-related monthly adjustment amount is effective January 1, 2011. We will retroactively adjust for any differences between the amount paid in 2011 and the amount that should have been paid based on the amended tax return.

(d) When we use evidence that you provide which proves that the IRS modified adjusted gross income information we used is incorrect, as described in § 418.1335, the effective date will be January of the year(s) that is affected or the first month in that year that you were enrolled or reenrolled in Medicare Part B if later than January.

(e) When we use information from a more recent tax year that you provide due to a major life-changing event, as described in § 418.1201, the effective date is described in § 418.1230.

§ 418.1115 What are the modified adjusted gross income ranges?

(a) We list the modified adjusted gross income ranges for the calendar years 2011 through and including 2017, 2018, and for years beginning in 2019 for each Federal tax filing category in paragraphs (b), (c) and (d) of this section. We will use your modified adjusted gross income amount together with your tax filing status to determine the amount of your income-related monthly adjustment for these calendar years.

(b) The modified adjusted gross income ranges for individuals with a Federal tax filing status of single, head of household, qualifying widow(er) with dependent child, and married filing separately when the individual has lived apart from his/her spouse for the entire tax year for the year we use to make our income-related monthly adjustment amount determination are as follows.

(1) For calendar years 2011 through and including 2017—

(i) Greater than $85,000 but less than or equal to $107,000;

(ii) Greater than $107,000 but less than or equal to $160,000;

(iii) Greater than $160,000 but less than or equal to $214,000; and

(iv) Greater than $214,000.

(2) For calendar year 2018—

(i) Greater than $85,000 but less than or equal to $107,000;

(ii) Greater than $107,000 but less than or equal to $133,500;

(iii) Greater than $133,500 but less than or equal to $160,000; and

(iv) Greater than $160,000

(3) For calendar years beginning with 2019—

(i) Greater than $85,000 but less than or equal to $107,000;

(ii) Greater than $107,000 but less than or equal to $133,500;

(iii) Greater than $133,500 but less than or equal to $160,000;

(iv) Greater than $160,000 but less than $500,000; and

(v) Greater than or equal to $500,000.

(c) The modified adjusted gross income ranges for individuals who are married and filed a joint tax return for the tax year we use to make the income-related monthly adjustment amount determination are as follows.

(1) For calendar years 2011 through and including 2017—

(i) Greater than $170,000 but less than or equal to $214,000;

(ii) Greater than $214,000 but less than or equal to $320,000;

(iii) Greater than $320,000 but less than or equal to $428,000; and

(iv) Greater than $428,000.

(2) For calendar year 2018—

(i) Greater than $170,000 but less than or equal to $214,000;

(ii) Greater than $214,000 but less than or equal to $267,000;

(iii) Greater than $267,000 but less than or equal to $320,000; and

(iv) Greater than $320,000.

(3) For calendar years beginning in 2019—

(i) Greater than $170,000 but less than or equal to $214,000;

(ii) Greater than $214,000 but less than or equal to $267,000;

(iii) Greater than $267,000 but less than or equal to $320,000;

(iv) Greater than $320,000 but less than $750,000; and

(v) Greater than or equal to $750,000.

(d) The modified adjusted gross income ranges for married individuals who file a separate return and have lived with their spouse at any time during the tax year we use to make the income-related monthly adjustment amount determination are as follows.

(1) For calendar years 2011 through and including 2017—

(i) Greater than $85,000 but less than or equal to $129,000; and

(ii) Greater than $129,000.

(2) For calendar year 2018—Greater than $85,000.

(3) For calendar years beginning in 2019—

(i) Greater than $85,000 but less than $415,000; and

(ii) Greater than or equal to $415,000.

(e)(1) Subject to paragraph (e)(2) of this section, in 2019, CMS will set the modified adjusted gross income ranges for 2020 and publish them in the FEDERAL REGISTER. In each year thereafter, CMS will set the modified adjusted gross income ranges by increasing the preceding year's ranges by any percentage increase in the Consumer Price Index rounded to the nearest $1,000 and will publish the amounts for the following year in September of each year.

(2) The amounts listed in paragraphs (b), (c), and (d) of $415,000, $500,000, and $750,000 will not be adjusted under paragraph (e)(1) of this section until 2028. Beginning in 2027, and in each year thereafter, CMS will adjust these range amounts for the following year under paragraph (e)(1) of this section and publish the updated ranges in the FEDERAL REGISTER.

[78 FR 57259, Sept. 18, 2013, as amended at 83 FR 55628, Nov. 7, 2018]

§ 418.1120 How do we determine your income-related monthly adjustment amount?

(a) We will determine your income-related monthly adjustment amount by using your tax filing status and modified adjusted gross income.

(b) *Tables of applicable percentage.* The tables in paragraphs (b)(1) through (b)(3) of this section contain the modified adjusted gross income ranges for calendar years 2011 through and including 2017, 2018, and beginning in 2019 in the column on the left in each table. The middle column in each table shows the percentage of the unsubsidized Medicare Part B premium that will be paid by individuals with modified adjusted gross income that falls within

each of the ranges. The column on the right in each table shows the percentage of the Medicare Part B premium that will be subsidized by contributions from the Federal Government. We use your tax filing status and your modified adjusted gross income for the tax year to determine which income-related monthly adjustment amount to apply to you. The dollar amount of income-related monthly adjustment for each range will be set annually for each year after 2019 as described in paragraph (c) of this section. The modified adjusted gross income ranges will be adjusted annually after 2019 as described in § 418.1115(e).

(1) *General tables of applicable percentages.* If, for the tax year, we use your filing status for your Federal income taxes for the tax year is single; head of household; qualifying widow(er) with dependent child; or married filing separately and you lived apart from your spouse for the entire tax year, we will use the general tables of applicable percentages. When your modified adjusted gross income for the year we use is in the range listed in the left column in the following tables, then the Federal Government's Part B premium subsidy of 75 percent is reduced to the percentage listed in the right column. You will pay an amount based on the percentage listed in the center column.

Table 1 to paragraph (b)(1): Modified adjusted gross income effective in 2011–2017	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $85,000 but less than or equal to $107,000	35	65
Greater than $107,000 but less than or equal to $160,000	50	50
Greater than $160,000 but less than or equal to $214,000	65	35
Greater than $214,000	80	20

Table 2 to paragraph (b)(1): Modified adjusted gross income effective in 2018	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $85,000 but less than or equal to $107,000	35	65
Greater than $107,000 but less than or equal to $133,500	50	50
Greater than $133,500 less than or equal to $160,000	65	35
Greater than $160,000	80	20

Table 3 to paragraph (b)(1): Modified adjusted gross income effective beginning in 2019	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $85,000 but less than or equal to $107,000	35	65
Greater than $107,000 but less than or equal to $133,500	50	50
Greater than $133,500 but less than or equal to $160,000	65	35
Greater than $160,000 but less than $500,000	80	20
Greater than or equal to $500,000	85	15

(2) *Tables of applicable percentages for joint returns.* If, for the tax year, we use your Federal tax filing status is married filing jointly for the tax year and your modified adjusted gross income for that tax year is in the range listed in the left column in the following tables, then the Federal Government's Part B premium subsidy of 75 percent is reduced to the percentage listed in the right column. You will pay an amount based on the percentage listed in the center column.

Table 1 to paragraph (b)(2): Modified adjusted gross income effective in 2011–2017	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $170,000 but less than or equal to $214,000	35	65
Greater than $214,000 but less than or equal to $320,000	50	50
Greater than $320,000 but less than or equal to $428,000	65	35

Table 1 to paragraph (b)(2): Modified adjusted gross income effective in 2011–2017	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $428,000	80	20

Table 2 to paragraph (b)(2): Modified adjusted gross income effective in 2018	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $170,000 but less than or equal to $214,000	35	65
Greater than $214,000 but less than or equal to $267,000	50	50
Greater than $267,000 but less than or equal to $320,000	65	35
Greater than $320,000	80	20

Table 3 to paragraph (b)(2): Modified adjusted gross income effective beginning in 2019	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $170,000 but less than or equal to $214,000	35	65
Greater than $214,000 but less than or equal to $267,000	50	50
Greater than $267,000 but less than or equal to $320,000	65	35
Greater than $320,000 but less than $750,000	80	20
Greater than or equal to $750,000	85	15

(3) *Tables of applicable percentages for married individuals filing separate returns.* If, for the tax year, we use your Federal tax filing status is married filing separately, you lived with your spouse at some time during that tax year, and your modified adjusted gross income is in the range listed in the left column in the following tables, then the Federal Government's Part B premium subsidy of 75 percent is reduced to the percentage listed in the right column. You will pay an amount based on the percentage listed in the center column.

Table 1 to paragraph (b)(3): Modified adjusted gross income effective in 2011–2017	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $85,000 but less than or equal to $129,000	65	35
Greater than $129,000	80	20

Table 2 to paragraph (b)(3): Modified adjusted gross income effective in 2018	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $85,000	80	20

Table 3 to paragraph (b)(3): Modified adjusted gross income effective beginning in 2019	Beneficiary percentage (percent)	Federal premium subsidy (percent)
Greater than $85,000 but less than $415,000	80	20
Greater than or equal to $415,000	85	15

(c) For each year after 2019, CMS will annually publish in the FEDERAL REGISTER the dollar amounts for the income-related monthly adjustment amount described in paragraph (b) of this section.

[78 FR 57259, Sept. 18, 2013, as amended at 83 FR 55628, Nov. 7, 2018]

§ 418.1125 How will the income-related monthly adjustment amount affect your total Medicare Part B premium?

(a) If you must pay an income-related monthly adjustment amount, your total Medicare Part B premium will be the sum of:

(1) The Medicare Part B standard monthly premium, determined using the rules in 42 CFR 408.20; plus

(2) Any applicable increase in the Medicare Part B standard monthly premium as described in 42 CFR 408.22; plus

(3) Your income-related monthly adjustment amount.

(b) The nonstandard Medicare Part B premium amount described in 42 CFR 408.20 does not apply to individuals who must pay an income-related monthly adjustment amount. Such individuals must pay the full Medicare Part B standard monthly premium plus any applicable penalties for late enrollment or reenrollment plus the income-related adjustment.

[71 FR 62931, Oct. 27, 2006, as amended at 78 FR 57260, Sept. 18, 2013]

§ 418.1130 [Reserved]

§ 418.1135 What modified adjusted gross income information will we use to determine your income-related monthly adjustment amount?

(a) In general, we will use your modified adjusted gross income provided by IRS for the tax year 2 years prior to the effective year of the income-related monthly adjustment amount determination. Modified adjusted gross income is based on information you provide to IRS when you file your Federal income tax return.

(b) We will use your modified adjusted gross income for the tax year 3 years prior to the effective year of the income-related monthly adjustment amount determination when IRS does not provide the information specified in paragraph (a) of this section. If IRS can provide modified adjusted gross income for the tax year 3 years prior to the income-related monthly adjustment amount effective year, we will temporarily use that information to determine your income-related monthly adjustment amount and make adjustments as described in § 418.1110(b) to all affected income-related monthly adjustment amounts when information for the year specified in paragraph (a) of this section is provided by IRS.

(c) When we have used the information in paragraph (b) of this section, you may provide us with evidence of your modified adjusted gross income for the year in paragraph (a) of this section. You must provide a retained copy of your signed Federal income tax return for that year, if available. If you filed a return for that year, but did not retain a copy, you must request a transcript or a copy of your return from IRS and provide it to us. When we use this evidence, we will later confirm this information with IRS records.

(d) When you meet the conditions specified in § 418.1150 because you have amended your Federal income tax return, or when you believe we have used information provided by IRS which is incorrect, as described in § 418.1335, we will use information that you provide directly to us regarding your modified adjusted gross income.

(e) We may use information that you give us about your modified adjusted gross income for a more recent tax year than those discussed in paragraphs (a) or (b) of this section as described in §§ 418.1201 through 418.1270.

(f) If you fail to file an income tax return for any year after 2004 and IRS informs us that you had modified adjusted gross income above the threshold applicable 2 years after the tax year when you failed to file an income tax return, we will impose the highest income-related adjustment percentage applicable to your income filing status for the effective year. If we later determine that the amount of the income-related monthly adjustment amount imposed was inconsistent with your modified adjusted gross income, we will correct it. The rules in 42 CFR 408.40 through 408.92 will apply to the collection of any retroactive premiums due.

§ 418.1140 What will happen if the modified adjusted gross income information from IRS is different from the modified adjusted gross income information we used to determine your income-related monthly adjustment amount?

In general, we will use modified adjusted gross income information from IRS to determine your income-related monthly adjustment. We will make retroactive adjustments to your income-related monthly adjustment amount as described in paragraphs (a), (b), and (d) of this section.

(a) When we have used modified adjusted gross income from the tax year 3 years prior to the effective year as described in § 418.1135(b), and IRS provides modified adjusted gross income information from the tax year 2 years prior to the effective year, we will use the new information to make an initial determination for the effective year. We will make retroactive adjustments back to January 1 of the effective year, or the first month you were enrolled or reenrolled in Medicare Part B if later than January.

(b) When we have used the modified adjusted gross income information that you provided for the tax year 2 years prior to the effective year and the modified adjusted gross income information we receive from IRS for that same year is different from the information you provided, we will use the modified adjusted gross income information provided to us by IRS to make a new initial determination. We will make retroactive adjustments back to January 1 of the effective year, or the first month you were enrolled or reenrolled in Medicare Part B if later than January.

(c) When we have used information from your amended Federal tax return that you provide, as explained in § 418.1150, or you provide proof that the information IRS provided to us is incorrect as described in § 418.1335, we will not make any adjustments to your income-related monthly adjustment amount for the effective year or years based on IRS information we receive later from IRS.

(d) When we use modified adjusted gross income information that you provided due to a qualifying life-changing event and we receive different information from IRS, we will use the IRS information to make retroactive corrections to all months in the effective year(s) during which you were enrolled in Medicare Part B, except when paragraph (c) of this section applies.

(e) When we used the table in § 418.1120(b)(3) to determine your income-related monthly adjustment amount, and you lived apart from your spouse throughout that year, we will ask you for a signed statement or attestation that you lived apart from your spouse throughout that year. We will also ask you to provide information about the addresses of you and your spouse during that year. If you provide a signed statement or attestation that you lived apart from your spouse throughout that year, and information about your respective addresses that year, we will use the table in § 418.1120(b)(1) to determine your income-related monthly adjustment amount.

§ 418.1145 How do we determine your income-related monthly adjustment amount if IRS does not provide information about your modified adjusted gross income?

In general, if we do not receive any information for you from IRS showing that you had modified adjusted gross income above the threshold in the tax year we request, we will not make an income-related monthly adjustment amount determination.

§ 418.1150 When will we use your amended tax return filed with IRS?

You may provide your amended tax return for a tax year we used within 3 calendar years following the close of the tax year for which you filed the amended tax return. You must provide us with your retained copy of your amended U.S. Individual Income Tax Return on the required IRS form and a copy of the IRS letter confirming the amended tax return was filed or a transcript from IRS if they did not send a letter. If you cannot provide your retained copy of the amended tax return, you must obtain a copy of the return from IRS. We will then make any necessary retroactive corrections as defined in § 418.1110(c) to your income-related monthly adjustment amount.

DETERMINATIONS USING A MORE RECENT TAX YEAR'S MODIFIED ADJUSTED GROSS INCOME

§ 418.1201 When will we determine your income-related monthly adjustment amount based on the modified adjusted gross income information that you provide for a more recent tax year?

We will use a more recent tax year than the years described in § 418.1135(a) or (b) to reduce or eliminate your income-related monthly adjustment amount when all of the following occur:

(a) You experience a major life-changing event as defined in § 418.1205; and

(b) That major life-changing event results in a significant reduction in your modified adjusted gross income for the year which you request we use and the next year, if applicable. For purposes of this section, a significant reduction in your modified adjusted gross income is one that results in the decrease or elimination of your income-related monthly adjustment amount; and

(c) You request that we use a more recent tax year's modified adjusted gross income; and

(d) You provide evidence as described in §§ 418.1255 and 418.1265.

§ 418.1205 What is a major life-changing event?

For the purposes of this subpart, we will consider the following to be major life-changing events:

(a) Your spouse dies;

(b) You marry;

(c) Your marriage ends through divorce or annulment;

(d) You or your spouse stop working or reduce the hours you work;

(e) You or your spouse experiences a loss of income-producing property, provided the loss is not at the direction of you or your spouse (e.g., due to the sale or transfer of the property) and is not a result of the ordinary risk of investment. Examples of the type of property loss include, but are not limited to: Loss of real property within a Presidentially or Gubernatorially-declared disaster area, destruction of livestock or crops by natural disaster or disease, loss from real property due to arson, or loss of investment property as a result of fraud or theft due to a criminal act by a third party;

(f) You or your spouse experiences a scheduled cessation, termination, or reorganization of an employer's pension plan;

(g) You or your spouse receives a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization.

[71 FR 62931, Oct. 27, 2006, as amended at 75 FR 41086, July 15, 2010]

§ 418.1210 What is not a major life-changing event?

We will not consider events other than those described in § 418.1205 to be major life-changing events. Certain types of events are not considered major life-changing events for the purposes of this subpart, such as:

(a) Events that affect your expenses, but not your income; or

(b) Events that result in the loss of dividend income because of the ordinary risk of investment.

[71 FR 62931, Oct. 27, 2006, as amended at 75 FR 41086, July 15, 2010]

§ 418.1215 What is a significant reduction in your income?

For purposes of this subpart, we will consider a reduction in your income to be significant if your modified adjusted gross income decreases; and

(a) The decrease reduces the percentage of the income-related monthly adjustment amount you must pay according to the Table of Applicable Percentages in § 418.1120; or

(b) The decrease reduces your modified adjusted gross income to an amount below the threshold described in § 418.1105 and eliminates any income-related monthly adjustment amount you must pay.

§ 418.1220 What is not a significant reduction in your income?

For purposes of this subpart, we will not consider a reduction in your income to be significant unless the reduction affects the amount of income-related monthly adjustment you must pay.

§ 418.1225 Which more recent tax year will we use?

We will consider evidence of your modified adjusted gross income that you provide for a tax year that is more recent than the year described in § 418.1135 (a) or (b) when you meet all of the requirements described in § 418.1201. We will always ask you for your retained copy of your filed Federal income tax return for the more recent year you request that we use and will use that information to make an initial determination. If you have not filed your Federal income tax return for the more recent year you request that we use, you must provide us with evidence that is equivalent to a copy of a filed Federal income tax return. Evidence that is equivalent to a copy of a filed Federal income tax return is defined in § 418.1265(c).

§ 418.1230 What is the effective date of an income-related monthly adjustment amount initial determination that is based on a more recent tax year?

(a) Subject to paragraph (b) of this section, when your modified adjusted gross income for the more recent tax year is significantly reduced as a result of a major life-changing event, our initial determination is generally effective on January 1 of the year in which you make your request. If your first month of enrollment or reenrollment in Medicare Part B is after January of the year for which you make your request, our initial determination is effective on the first day of your Medicare Part B enrollment or reenrollment.

(b) We will make a determination about your income-related monthly adjustment amount for the year preceding the year that you make your request in the limited circumstances explained in § 418.1310(a)(4). When we make a determination for the preceding year, our initial determination is generally effective on January 1 of that year. If your first month of enrollment or reenrollment in Medicare Part B is after January of that year, our initial determination is effective on the first day of your Medicare Part B enrollment or reenrollment.

(c) Our initial determination will be effective January 1 of the year following the year you make your request, when your modified adjusted gross income will not be significantly reduced as a result of one or more of the events described in § 418.1205(a) through (g) until the year following the year you make your request.

[71 FR 62931, Oct. 27, 2006, as amended at 75 FR 41086, July 15, 2010; 78 FR 57260, Sept. 28, 2013]

§ 418.1235 When will we stop using your more recent tax year's modified adjusted gross income to determine your income-related monthly adjustment amount?

We will use your more recent tax year's modified adjusted gross income to determine your income-related monthly adjustment amount effective with the month and year described in § 418.1230 and for each year thereafter until one of the following occurs:

(a) We receive your modified adjusted gross income from IRS for the more recent tax year we used or a later tax year;

(b) Your more recent tax year modified adjusted gross income that we used is for a tax year more than 3 years prior to the income-related monthly adjustment amount effective year;

(c) You request we use a more recent tax year based on another major life-changing event as described in § 418.1201; or

(d) You notify us of a change in your modified adjusted gross income for the more recent tax year we used as described in § 418.1240.

§ 418.1240 Should you notify us if the information you gave us about your modified adjusted gross income for the more recent tax year changes?

If you know that the information you provided to us about the more recent tax year that we used has changed, you should tell us so that we can determine if your income-related monthly adjustment amount should be eliminated or adjusted. We will accept new modified adjusted gross income information at any time after your request until the end of the calendar year following the more recent tax year(s) that we used.

For us to make a new initial determination using your new modified adjusted gross income information, you must provide evidence as described in § 418.1265 to support the reduction or increase in your modified adjusted gross income. If you amend your Federal income tax return for the more recent tax year we used, we will use the rules in § 418.1150.

§ 418.1245 What will happen if you notify us that your modified adjusted gross income for the more recent tax year changes?

(a) If you notify us that your modified adjusted gross income for the more recent tax year has changed from what is in our records, we may make a new initial determination for each effective year involved. To make a new initial determination(s) we will take into account:

(1) The new modified adjusted gross income information for the more recent tax year you provide; and

(2) Any modified adjusted gross income information from IRS, as described in § 418.1135, that we have available for each effective year; and

(3) Any modified adjusted gross income information from you, as described in § 418.1135, that we have available for each effective year.

(b) For each new initial determination that results in a change in your income-related monthly adjustment amount, we will make retroactive adjustments that will apply to all enrolled months of the effective year.

(c) We will continue to use a new initial determination described in paragraph (a) of this section to determine additional yearly income-related monthly adjustment amount(s) until an event described in § 418.1235 occurs.

(d) We will make a new determination about your income-related monthly adjustment amount when we receive modified adjusted gross income for the effective year from IRS, as described in § 418.1140(d).

§ 418.1250 What evidence will you need to support your request that we use a more recent tax year?

When you request that we use a more recent tax year to determine your income-related monthly adjustment amount, we will ask for evidence of the major life-changing event and how the event significantly reduced your modified adjusted gross income as described in §§ 418.1255 and 418.1265. Unless we have information in our records that raises a doubt about the evidence, additional evidence documenting the major life-changing event(s) will not be needed.

§ 418.1255 What kind of major life-changing event evidence will you need to support your request for us to use a more recent tax year?

(a) If your spouse died and we do not have evidence of the death in our records, we will require proof of death as described in § 404.720(b) or (c) or § 404.721 of this chapter.

(b) If you marry and we do not have evidence of the marriage in our records, we will require proof of marriage as described in §§ 404.725 through 404.727 of this chapter.

(c) If your marriage ends and we do not have evidence that the marriage has ended in our records, we will require proof that the marriage has ended as described in § 404.728(b) or (c) of this chapter.

(d) If you or your spouse stop working or reduce your work hours, we will require evidence documenting the change in work activity. Examples of acceptable documentation include, but are not limited to, documents we can corroborate such as a signed statement from your employer, proof of the transfer of your business, or your signed statement under penalty of perjury, describing your work separation or a reduction in hours.

(e) If you or your spouse experiences a loss of income-producing property, we will require evidence documenting the loss. Examples of acceptable evidence include, but are not limited to, insurance claims or an insurance adjuster's statement. If the claim of loss is due to criminal fraud or theft by a third party, we will also require proof of conviction for the fraud or theft, such as a court document.

(f) If you or your spouse experiences a scheduled cessation, termination, or reorganization of an employer's pension plan, we will require evidence documenting the change in or loss of the

pension. An example of acceptable evidence includes, but is not limited to, a statement from your pension fund administrator explaining the reduction or termination of your benefits.

(g) If you or your spouse receives a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization, we will require evidence documenting the settlement and the reason(s) for the settlement. An example of acceptable evidence includes, but is not limited to, a letter from the former employer stating the settlement terms and how they affect you or your spouse.

[71 FR 62931, Oct. 27, 2006, as amended at 75 FR 41086, July 15, 2010]

§ 418.1260 What major life-changing event evidence will we not accept?

(a) We will not accept evidence of death that fails to meet the requirements in §§ 404.720 through 404.721 of this chapter.

(b) We will not accept evidence of marriage that fails to meet the requirements in §§ 404.725 through 404.727 of this chapter.

(c) We will not accept evidence that your marriage has ended if the evidence fails to meet the requirements in § 404.728 of this chapter.

(d) We will not accept documents supporting loss of income from income-producing property, or failure of or loss from a defined benefit pension plan unless the documents are original documents or copies from the original source.

(e) We will not accept evidence of work reduction or work stoppage that cannot be substantiated.

§ 418.1265 What kind of significant modified adjusted gross income reduction evidence will you need to support your request?

(a) You must provide evidence that one or more of the major life-changing events described in § 418.1205 resulted in a significant reduction in your modified adjusted gross income for the tax year you request we use.

(b) The preferred evidence is your retained copy of your filed Federal income tax return, your retained copy of your amended tax return with an IRS letter of receipt of the amended tax return, your copy of proof of a correction of the IRS information we used or a copy of your return or amended or proof of a correction of tax return information that you obtain from IRS for the more recent tax year you request we use.

(c) When a copy of your filed Federal income tax return is not available for the more recent tax year in which your modified adjusted gross income was significantly reduced, we will accept equivalent evidence. Equivalent evidence is the appropriate proof(s) in paragraphs (c)(1), (2) and (3) of this section, plus your signed statement under penalty of perjury that the information you provide is true and correct. When the major life-changing event changes your tax filing status, or the income-related monthly adjustment amount determination could be affected by your tax filing status, you will also be required to sign a statement regarding your intended income tax filing status for the tax year you request we use.

(1) If you experience one or more of the events described in § 418.1205(a), (b), or (c), you must provide evidence as to how the event(s) significantly reduced your modified adjusted gross income. Examples of the type of evidence include, but are not limited to, evidence of your spouse's modified adjusted gross income and/or your modified adjusted gross income for the tax year we use.

(2) If you experience one or more of the events described in § 418.1205(d), (e), (f), or (g), you must provide evidence of how the event(s) significantly reduced your modified adjusted gross income, such as a statement explaining any modified adjusted gross income changes for the tax year we used and a copy of your filed Federal income tax return (if you have filed one).

(3) If your spouse experiences one or more of the events described in § 418.1205(d), (e), (f), or (g), you must provide evidence of the resulting significant reduction in your modified adjusted gross income. The evidence requirements are described in paragraph (c)(2) of this section.

(d) When we use information described in paragraph (c) of this section, we will request that you provide your

retained copy of your Federal income tax return for the year we used when you file your taxes. We will use that information to make timely adjustments to your Medicare premium, if necessary. We will later verify the information you provide when we receive information about that tax year from IRS, as described in § 418.1140(d).

[71 FR 62931, Oct. 27, 2006, as amended at 75 FR 41087, July 15, 2010]

§ 418.1270 What modified adjusted gross income evidence will we not accept?

We will not accept a correction or amendment of your income tax return without a letter from IRS acknowledging the change. We will also not accept illegible or unsigned copies of income tax returns or attestations or other statements of income unless they are provided under penalty of perjury.

DETERMINATIONS AND THE ADMINISTRATIVE REVIEW PROCESS

§ 418.1301 What is an initial determination regarding your income-related monthly adjustment amount?

An initial determination is the determination we make about your income-related monthly adjustment amount that is subject to administrative review. For the purposes of administering the income-related monthly adjustment amount, initial determinations include but are not limited to determinations about:

(a) The amount of your income-related monthly adjustment amount based on information provided by IRS; and

(b) Any change in your income-related monthly adjustment amount based on one of the circumstances listed in § 418.1310(a)(1) through (a)(4).

§ 418.1305 What is not an initial determination regarding your income-related monthly adjustment amount?

Administrative actions that are not initial determinations may be reviewed by us, but they are not subject to the administrative review process as provided by §§ 418.1320 through 418.1325 and §§ 418.1340 through 418.1355, and they are not subject to judicial review. These actions include, but are not limited to, our dismissal of a request for reconsideration as described in § 418.1330 and our dismissal of a request for a new initial determination as described in § 418.1310(d).

§ 418.1310 When may you request that we make a new initial determination?

(a) You may request that we make a new initial determination in the following circumstances:

(1) You provide a copy of your filed Federal income tax return for the tax year 2 years prior to the effective year when IRS has provided information for the tax year 3 years prior to the effective year. You may request a new initial determination beginning with the date you receive a notice from us regarding your income-related monthly adjustment amount until the end of the effective year, with one exception. If you receive the notice during the last 3 months of a calendar year, you may request a new initial determination beginning with the date you receive the notice until March 31 of the following year. We will follow the rules and procedures in §§ 418.1110(b) and 418.1140(b) to make a new initial determination and any necessary retroactive adjustments back to January 1 of the effective year, or the first month you were enrolled in Medicare Part B in the effective year if later than January.

(2) You provide a copy of an amended tax return filed with IRS, as defined in § 418.1010(b)(1). We will use your amended tax return for the same tax year as the year used to determine your income-related monthly adjustment amount. You must request the new initial determination within the timeframe described in § 418.1150.

(3) You provide proof that the tax return information about your modified adjusted gross income or tax filing status IRS gave us is incorrect. We will use proof that you obtain from IRS of a correction of your tax return information for the same tax year instead of the information that was provided to us by IRS, as explained in § 418.1335(a). You may request a new initial determination at any time after you receive a notice from us regarding your income-related monthly adjustment

amount if you have such proof. We will use the rules and procedures in § 418.1335.

(4) You have a major life-changing event. You may request a new initial determination based on a major life-changing event when you meet all the requirements described in § 418.1201. You may make such a request at any time during the calendar year in which you experience a significant reduction in your modified adjusted gross income caused by a major life-changing event. When you have a major life-changing event that occurs in the last 3 months of a calendar year and your modified adjusted gross income for that year is significantly reduced as a result of the event, you may request that we make a new initial determination based on your major life-changing event from the date of the event until March 31 of the next year. We will follow the rules in § 418.1230 when we make a new initial determination based on your major life-changing event.

(b) If a request for a new initial determination based on any of the circumstances in paragraph (a) of this section is made after the time frame provided for each type of listed circumstance, we will review the request under the rules in § 404.911 of this chapter to determine if there is good cause for a late request.

(c) We will notify you of the new initial determination as described in § 418.1315.

(d) We will dismiss your request to make a new initial determination if it does not meet one of the circumstances specified in paragraphs (a)(1) through (a)(4) of this section. Our dismissal of your request for a new initial determination is not an initial determination subject to further administrative or judicial review.

§ 418.1315 How will we notify you and what information will we provide about our initial determination?

(a) We will mail a written notice of all initial determinations to you. The notice of the initial determination will state the important facts and give the reasons for our conclusions. Generally, we will not send a notice if your income-related monthly adjustment amount stops because of your death.

(b) The written notice that we send will tell you:

(1) What our initial determination is;

(2) What modified adjusted gross income information we used to make our determination;

(3) The reason for our determination;

(4) The effect of the initial determination; and

(5) Your right to a reconsideration or a new initial determination.

§ 418.1320 What is the effect of an initial determination?

An initial determination is binding unless you request a reconsideration within the time period described in §§ 404.909 and 404.911 of this chapter or we revise the initial determination or issue a new initial determination.

§ 418.1322 How will a Medicare prescription drug coverage income-related monthly adjustment amount determination for the effective year affect your Medicare Part B?

If we make an income-related monthly adjustment amount determination for you for the effective year under subpart C of this part (Medicare Prescription Drug Coverage Income-Related Monthly Adjustment Amount), we will apply that income-related monthly adjustment amount determination under this subpart to determine your Part D income-related monthly adjustment amount for the same effective year. Therefore, if you become enrolled in Medicare Part B in the effective year after we make an income-related monthly adjustment amount determination about your Medicare prescription drug coverage, the income-related monthly adjustment amount determination for your Medicare prescription drug coverage will also be used to determine your Medicare Part B income-related monthly adjustment amount. Any change in your net benefit due will be accompanied by a letter explaining the change in your net benefit and your right to appeal the change.

[75 FR 75890, Dec. 7, 2010]

§ 418.1325 When may you request a reconsideration?

If you are dissatisfied with our initial determination about your income-related monthly adjustment amount, you may request that we reconsider it. In addition, a person who shows that his or her rights may be adversely affected by the initial determination may request a reconsideration. We may accept requests for reconsideration that are filed by electronic or other means that we determine to be appropriate. Subject to the provisions of this section and § 418.1330, when you request a reconsideration, we will use the rules in §§ 404.907 through 404.922 of this chapter.

§ 418.1330 Can you request a reconsideration when you believe that the IRS information we used is incorrect?

If you request a reconsideration solely because you believe that the information that IRS gave us is incorrect, we will dismiss your request for a reconsideration and notify you to obtain proof of a correction from IRS and request a new initial determination (§ 418.1335). Our dismissal of your request for reconsideration is not an initial determination subject to further administrative or judicial review.

§ 418.1335 What should you do if our initial determination is based on modified adjusted gross income information you believe to be incorrect?

If you believe that IRS or you provided incorrect modified adjusted gross income information to us that we used to determine your income-related monthly adjustment amount, you can request information from us on how to contact IRS regarding the information we used.

(a) If IRS determines that the information it provided is not correct, IRS will provide you with documentation of the error, such as a copy of your Federal income tax return. If you would like us to use the revised or corrected information to determine your income-related monthly adjustment amount, you will need to request that we use that information and provide us with the IRS documentation confirming the error. We will make any necessary retroactive corrections as described in § 418.1110(d) to your income-related monthly adjustment amount.

(b) If you provided information to us about your modified adjusted gross income that we used to determine your income-related monthly adjustment amount, and that information is not correct, you may provide revised or corrected information. We will use the revised or corrected information if it reduces or eliminates your income-related monthly adjustment amount. We will make any necessary retroactive corrections as described in § 418.1110 to your income-related monthly adjustment amount. If you are providing corrected information about a more recent tax year's modified adjusted gross income that we used due to your major life-changing event, as described in § 418.1240, we will use the rules in § 418.1245 to determine how it will affect your income-related monthly adjustment amount.

§ 418.1340 What are the rules for our administrative review process?

To the extent that they are not inconsistent with the rules in this subpart for making initial determinations and reconsidered determinations, we will use the same rules for the administrative review process that we use for determinations and decisions about your rights regarding non-medical issues under title II of the Act, as described in subpart J of part 404 of this chapter. We will accept oral requests as well as the written requests required in subpart J of part 404 of this chapter for requesting administrative review of our determination. If you are dissatisfied with our reconsidered determination, you may request review in accordance with § 418.1350 for this subpart. A request for a new initial determination, described in § 418.1310, is not the same as a request for reconsideration or further administrative review.

§ 418.1345 Is reopening of an initial or reconsidered determination made by us ever appropriate?

We may reopen an initial or reconsidered determination made by us when the conditions for reopening are met as described in § 404.988 of this chapter. We

will use the rules in §§ 404.987 through 404.991a of this chapter when we reopen determinations made by us.

§ 418.1350 What are the rules for review of a reconsidered determination or an administrative law judge decision?

You may request a hearing before an OMHA administrative law judge consistent with HHS' regulations at 42 CFR part 405. You may seek further review of the administrative law judge's decision by requesting MAC review and judicial review in accordance with HHS' regulations.

[78 FR 57260, Sept. 18, 2013]

§ 418.1355 What are the rules for reopening a decision by an administrative law judge of the Office of Medicare Hearings and Appeals (OMHA) or by the Medicare Appeals Council (MAC)?

The rules in 42 CFR 405.980 through 405.986 govern reopenings of decisions by an administrative law judge of the OMHA and decisions by the MAC. A decision by an administrative law judge of the OMHA may be reopened by the administrative law judge or by the MAC. A decision by the MAC may be reopened only by the MAC.

Subpart C—Income-Related Monthly Adjustments to Medicare Prescription Drug Coverage Premiums

AUTHORITY: Secs. 702(a)(5), 1860D–13(a) and (c) of the Social Security Act (42 U.S.C. 902(a)(5), 1395w–113(a) and (c)).

SOURCE: 75 FR 75891, Dec. 7, 2010, unless otherwise noted.

INTRODUCTION, GENERAL PROVISIONS, AND DEFINITIONS

§ 418.2001 What is this subpart about?

This subpart implements sections 1860D–13(a)(7) and 1860D–13(c)(4) of the Social Security Act (the Act), as added by section 3308 of the Affordable Care Act (Pub. L. 111–148). Section 3308(a) establishes an income-related monthly adjustment to Medicare prescription drug coverage premiums. Persons enrolled in Medicare prescription drug plans, Medicare Advantage plans with prescription drug coverage, Programs of All-Inclusive Care for the Elderly plans, and cost plans offering prescription drug coverage who have modified adjusted gross income over a threshold amount established in the statute will pay an income-related monthly adjustment amount in addition to their Medicare prescription drug coverage plan's monthly premium and any applicable premium increases as described in 42 CFR 423.286. The regulations in this subpart explain how we determine whether you are required to pay an income-related monthly adjustment amount, and if you are, the amount of your adjustment. We have divided the rules into the following groups of sections:

(a) Sections 418.2001 through 418.2010 contain the introduction, a statement of the general purpose of the income-related monthly adjustment amount, general provisions that apply to the income-related monthly adjustment amount, and definitions of terms that we use in this subpart.

(b) Sections 418.2101 through 418.2150 describe what information about your modified adjusted gross income we will use to determine if you are required to pay an income-related monthly adjustment amount. In these sections, we also describe how the income-related monthly adjustment amount will affect your total Medicare prescription drug coverage premium.

(c) Sections 418.2201 through 418.2270 contain an explanation of the standards that you must meet for us to grant your request to use modified adjusted gross income information that you provide for a more recent tax year rather than the information described in paragraph (b) of this section. These sections explain when we may consider such a request, and the evidence that you will be required to provide. These sections also explain when an income-related monthly adjustment amount determination based on information you provide will be effective, and how long it will remain in effect. Additionally, these sections describe how we make retroactive adjustments of the income-related monthly adjustment amount based on information you provide, updated information you provide,

and information we later receive from the Internal Revenue Service.

(d) Sections 418.2301 through 418.2355 explain how we will notify you of our determination regarding your income-related monthly adjustment amount and contain the rules that we will apply when you disagree with our determination. These sections explain your appeal rights and the circumstances under which you may request that we make a new initial determination of your income-related monthly adjustment amount.

§ 418.2005 Purpose and administration.

(a) The purpose of the income-related monthly adjustment amount is for beneficiaries who have modified adjusted gross income above an established threshold to reimburse the Federal Government for a portion of the Federal subsidy of the Medicare prescription drug coverage. Persons who have modified adjusted gross income above the thresholds described in § 418.2105 will pay an income-related monthly adjustment amount in addition to the premium for their prescription drug coverage. The income-related monthly adjustment amount due will be determined based on the base beneficiary premium amount that represents 25.5 percent of the cost of the basic Medicare prescription drug coverage. The application of an income-related monthly adjustment amount results in an increase in the total amount that those who are affected pay for Medicare prescription drug coverage plans. A person who has modified adjusted gross income above the threshold amount will pay:

(1) The Medicare prescription drug coverage plan monthly premium; plus

(2) Any applicable increase for late enrollment or reenrollment;

(3) An income-related monthly adjustment amount; and

(b) The Centers for Medicare & Medicaid Services in the Department of Health and Human Services establishes rules for eligibility for Medicare prescription drug coverage and enrollment in Medicare prescription drug coverage plans, as well as premium penalties for late enrollment or reenrollment (42 CFR 423.30 through 423.56).

(c) We use information from CMS about enrollment in Medicare prescription drug coverage plans to determine the records that we must send to the IRS.

(d) We use information that we get from the IRS to determine if persons enrolled in Medicare prescription drug coverage plans are required to pay an income-related monthly adjustment amount. We also change income-related monthly adjustment amount determinations using information you provide under certain circumstances. In addition, we notify beneficiaries when the social security benefit amounts they receive will change based on our income-related monthly adjustment amount determination.

§ 418.2010 Definitions.

(a) *Terms relating to the Act and regulations.* For the purposes of this subpart:

(1) *Administrator* means the Administrator of CMS in HHS.

(2) *ALJ* means administrative law judge.

(3) *CMS* means the Centers for Medicare & Medicaid Services in HHS.

(4) *Commissioner* means the Commissioner of Social Security.

(5) *HHS* means the Department of Health and Human Services, which oversees the Centers for Medicare & Medicaid Services (CMS), the Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council (MAC)

(6) *IRS* means the Internal Revenue Service in the Department of the Treasury.

(7) *MAC* means the Medicare Appeals Council in HHS.

(8) *Medicare Prescription Drug Coverage Plan* means a Medicare prescription drug plan, a Medicare Advantage plan with prescription drug coverage, a Program for All-inclusive Care for the Elderly plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage.

(9) *OMHA* means the Office of Medicare Hearings and Appeals in HHS.

(10) *Section* means a section of the regulations in this part unless the context indicates otherwise.

(11) *The Act* means the Social Security Act, as amended.

(12) *Title* means a title of the Act.

(13) *We*, *our*, or *us* means the Social Security Administration (SSA).

(b) *Miscellaneous.* For the purposes of this subpart:

(1) *Amended tax return* means a Federal income tax return for which an individual or couple has filed an amended tax return that has been accepted by the IRS.

(2) *Effective year* means the calendar year for which we make an income-related monthly adjustment amount determination.

(3) *Federal premium subsidy* is the portion of the cost of providing Medicare prescription drug coverage that is paid by the Federal Government. The Federal Government pays this amount to Medicare Prescription Drug coverage Plans from payments made into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(4) *Income-related monthly adjustment amount* is an additional amount of premium that you will pay for Medicare prescription drug coverage if you have modified adjusted gross income above the threshold described in 418.2105.

(5) *Modified adjusted gross income* is your adjusted gross income as defined by the Internal Revenue Code, plus the following forms of tax-exempt income:

(i) Tax-exempt interest income;

(ii) Income from United States savings bonds used to pay higher education tuition and fees;

(iii) Foreign earned income;

(iv) Income derived from sources within Guam, American Samoa, or the Northern Mariana Islands; and

(v) Income from sources within Puerto Rico.

(6) *Modified adjusted gross income ranges* are the groupings of modified adjusted gross income above the threshold. There are four ranges for most individuals, based on their tax filing status. There are two ranges for those with a tax filing status of married, filing separately, who also lived with their spouse for part of the year. The dollar amounts of the modified adjusted gross income ranges are specified in §418.2115.

(7) *Premium* is a payment that an enrolled beneficiary pays for Medicare prescription drug coverage to a Medicare prescription drug plan, a Medicare Advantage plan with prescription drug coverage, a Program of All-Inclusive Care for the Elderly Plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage. The rules that CMS use annually to establish premium amounts for Medicare prescription drug coverage are contained in 42 CFR 423.286.

(8) *Representative* means, for the purposes of the initial determination and reconsidered determination, an individual as defined in §404.1703 of this chapter, and for purposes of an ALJ hearing or review by the MAC, an individual as defined in 42 CFR 423.560.

(9) *Tax filing status* means the filing status shown on your individual income tax return. It may be single, married filing jointly, married filing separately, head of household, or qualifying widow(er) with dependent child.

(10) *Tax year* means the year for which you have filed or will file your Federal income tax return with the IRS.

(11) *Threshold* means a modified adjusted gross income amount above which you will have to pay an income-related monthly adjustment amount described in paragraph (b)(4) of this section. The dollar amount of the threshold is specified in §418.2105.

(12) *You* or *your* means the person or representative of the person who is subject to the income-related monthly adjustment amount.

Determination of the Income-Related Monthly Adjustment Amount

§418.2101 What is the income-related monthly adjustment amount?

(a) The income-related monthly adjustment amount is an amount that you will pay in addition to the Medicare prescription drug coverage plan monthly premium, plus any applicable increase in that premium as described in 42 CFR 423.286, for your Medicare prescription drug coverage plan when your modified adjusted gross income is

above the threshold described in § 418.2105.

(b) Your income-related monthly adjustment amount is based on your applicable modified adjusted gross income as described in § 418.2115 and your tax filing status.

(c) We will determine your income-related monthly adjustment amount using the method described in § 418.2120.

§ 418.2105 What is the threshold?

(a) The threshold is a level of modified adjusted gross income above which you will have to pay the income-related monthly adjustment amount.

(b) For calendar years 2011 through and including 2019, the modified adjusted gross income threshold is $85,000 for individuals with a Federal income tax filing status of single, married filing separately, head of household, and qualifying widow(er) with dependent child. The threshold is $170,000 for individuals with a Federal income tax filing status of married filing jointly.

(c) Starting at the end of calendar year 2019 and for each calendar year thereafter, CMS will set the threshold amounts for the following year. CMS will publish the threshold amounts annually in the FEDERAL REGISTER. Published threshold amounts will be effective January 1 of the next calendar year, and remain unchanged for the full calendar year.

§ 418.2110 What is the effective date of our initial determination about your income-related monthly adjustment amount?

(a) Generally, an income-related monthly adjustment amount determination will be effective for all months that you are enrolled in a prescription drug coverage plan during the year for which we determine you must pay an income-related monthly adjustment amount.

(b) When we have used modified adjusted gross income information from the IRS for the tax year 3 years prior to the effective year to determine your income-related monthly adjustment amount, and modified adjusted gross income information for the tax year 2 years prior later becomes available from the IRS, we will review the new information to determine if we should revise our initial determination concerning the income-related monthly adjustment amount. If we revise our initial determination, the effective date of the new initial determination will be January 1 of the effective year, or the first month your enrollment or re-enrollment in a Medicare prescription drug coverage plan became effective if later than January.

(c) When we use your amended tax return, as described in § 418.2150, the effective date will be January 1 of the year(s) that is affected, or the first month in that year that your enrollment or re-enrollment in a Medicare prescription drug coverage plan became effective if later than January.

Example: You are enrolled in Medicare prescription drug coverage throughout 2011. We use your 2009 modified adjusted gross income as reported to us by the IRS to determine your 2011 income-related monthly adjustment amount. In 2012, you submit to us a copy of your 2009 amended tax return that you filed with the IRS. The modified adjusted gross income reported on your 2009 amended tax return is significantly less than originally reported to the IRS. We use the modified adjusted gross income reported on your 2009 amended tax return to determine your income-related monthly adjustment amount. That income-related monthly adjustment amount is effective January 1, 2011. We will retroactively correct any differences between the amount paid in 2011 and the amount you should have paid based on the amended tax return.

(d) When we use evidence that you provide to proves the IRS modified adjusted gross income information we used was incorrect, as described in § 418.2335, the effective date will be January of the year(s) that is affected or the first month in that year that your enrollment or re-enrollment in a Medicare prescription drug coverage plan became effective if later than January.

(e) When we use information from a more recent tax year that you provide due to a major life-changing event, as described in § 418.2201, the effective date is described in § 418.2230.

§ 418.2112 Paying your income-related monthly adjustment amount.

(a) We will deduct the income-related monthly adjustment amount from your Social Security benefits if they are sufficient to cover the amount owed. If

the amount of your Social Security benefits is not sufficient to pay the full amount of your income-related monthly adjustment amount, CMS will bill you for the full amount owed.

(b) If you do not receive Social Security or Railroad Retirement Board benefits, but you receive benefits from the Office of Personnel Management, the Office of Personnel Management will deduct the income-related monthly adjustment amount from your benefits if they are sufficient to cover the amount owed. If the amount of your Office of Personnel Management benefits is not sufficient to pay the full amount of your income-related monthly adjustment amount, CMS will bill you for the full amount owed.

(c) If you do not receive Social Security, Railroad Retirement Board, or Office of Personnel Management benefits, CMS will bill you for your income-related monthly adjustment amount.

§418.2115 What are the modified adjusted gross income ranges?

(a) We list the modified adjusted gross income ranges for the calendar years 2011 through and including 2017, 2018, and beginning in 2019 for each Federal tax filing category in paragraphs (b), (c) and (d) of this section. We will use your modified adjusted gross income amount together with your tax filing status to determine the amount of your income-related monthly adjustment for these calendar years.

(b) The modified adjusted gross income ranges for individuals with a Federal tax filing status of single, head of household, qualifying widow(er) with dependent child, and married filing separately when the individual has lived apart from his/her spouse for the entire tax year for the year we use to make our income-related monthly adjustment amount determination are as follows:

(1) For calendar years 2011 through and including 2017—

(i) Greater than $85,000 but less than or equal to $107,000;

(ii) Greater than $107,000 but less than or equal to $160,000;

(iii) Greater than $160,000 but less than or equal to $214,000; and

(iv) Greater than $214,000.

(2) For calendar year 2018—

(i) Greater than $85,000 but less than $107,000;

(ii) Greater than $107,000 but less than $133,500;

(iii) Greater than $133,500 but less than $160,000; and

(iv) Greater than $160,000.

(3) For calendar years beginning in 2019—

(i) Greater than $85,000 but less than or equal to $107,000;

(ii) Greater than $107,000 but less than or equal to $133,500;

(iii) Greater than $133,500 but less than or equal to $160,000;

(iv) Greater than $160,000 but less than $500,000; and

(v) Greater than or equal to $500,000.

(c) The modified adjusted gross income ranges for individuals who are married and filed a joint tax return for the tax year we use to make the income-related monthly adjustment amount determination are as follows.

(1) For calendar years 2011 through 2017—

(i) Greater than $170,000 but less than or equal to $214,000;

(ii) Greater than $214,000 but less than or equal to $320,000;

(iii) Greater than $320,000 but less than or equal to $428,000; and

(iv) Greater than $428,000.

(2) For calendar year 2018—

(i) Greater than $170,000 but less than or equal to $214,000;

(ii) Greater than $214,000 but less than or equal to $267,000;

(iii) Greater than $267,000 but less than or equal to $320,000; and

(iv) Greater than $320,000.

(3) For calendar years beginning in 2019—

(i) Greater than $170,000 but less than or equal to $214,000;

(ii) Greater than $214,000 but less than or equal to $267,000;

(iii) Greater than $267,000 but less than or equal to $320,000;

(iv) Greater than $320,000 but less than $750,000; and

(v) Greater than or equal to $750,000.

(d) The modified adjusted gross income ranges for married individuals who file a separate return and have lived with their spouse at any time during the tax year we use to make the income-related monthly adjustment amount determination are as follows:

(1) For calendar years 2011 through and including 2017—

(i) Greater than $85,000 but less than or equal to $129,000; and

(ii) Greater than $129,000.

(2) For calendar year 2018—Greater than $85,000.

(3) For calendar years beginning in 2019—

(i) Greater than $85,000 but less than $415,000; and

(ii) Greater than or equal to $415,000.

(e)(1) Subject to paragraph (e)(2) of this section, in 2019, CMS will set the modified adjusted gross income ranges for 2020 and publish them in the FEDERAL REGISTER. In each year thereafter, CMS will set the modified adjusted gross income ranges by increasing the preceding year's ranges by any percentage increase in the Consumer Price Index rounded to the nearest $1,000 and will publish the amounts for the following year in September of each year.

(2) The amounts listed in paragraphs (b), (c), and (d) of $415,000, $500,000, and $750,000 will not be adjusted under paragraph (e)(1) of this section until 2028. Beginning in 2027, and in each year thereafter, CMS will adjust these range amounts for the following year under paragraph (e)(1) of this section and publish the updated ranges in the FEDERAL REGISTER.

[75 FR 75891, Dec. 7, 2010, as amended at 55630, Nov. 7, 2018]

§ 418.2120 How do we determine your income-related monthly adjustment amount?

(a) We will determine your income-related monthly adjustment amount by using your tax filing status and modified adjusted gross income.

(b) *Tables of applicable percentage.* The tables in paragraphs (b)(1) through (b)(3) of this section contain the modified adjusted gross income ranges for calendar years 2011 through and including 2017, 2018, and 2019, and the corresponding percentage of the cost of basic Medicare prescription drug coverage that individuals with modified adjusted gross incomes that fall within each of the ranges will pay. The monthly dollar amounts will be determined by CMS using the formula in section 1860D–13(a)(7)(B) of the Act. Based on your tax filing status for the tax year we use to make a determination about your income-related monthly adjustment amount, we will determine which table is applicable to you. We will use your modified adjusted gross income to determine which income-related monthly adjustment amount to apply to you. The dollar amounts used for each of the ranges of income-related monthly adjustment will be set annually after 2019 as described in paragraph (c) of this section. The modified adjusted gross income ranges will be adjusted annually after 2019 as described in § 418.2115(e).

(1) *General tables of applicable percentages.* If your filing status for your Federal income taxes for the tax year we use is single; head of household; qualifying widow(er) with dependent child; or married filing separately and you lived apart from your spouse for the entire tax year, we will use the general tables of applicable percentages. When your modified adjusted gross income for the year we use is in the range listed in the left column in the following tables, you will pay an amount based on the percentage listed in the right column, which represents a percentage of the cost of basic Medicare prescription drug coverage.

Table 1 to paragraph (b)(1): Modified adjusted gross income effective in 2011–2017	Beneficiary percentage (percent)
Greater than $85,000 but less than or equal to $107,000	35
Greater than $107,000 but less than or equal to $160,000	50
Greater than $160,000 but less than or equal to $214,000	65
Greater than $214,000	80

Table 2 to paragraph (b)(1): Modified adjusted gross income effective in 2018	Beneficiary percentage (percent)
Greater than $85,000 but less than or equal to $107,000	35
Greater than $107,000 but less than or equal to $133,500	50

Table 2 to paragraph (b)(1): Modified adjusted gross income effective in 2018	Beneficiary percentage (percent)
Greater than $133,500 but less than or equal to $160,000	65
Greater than $160,000	80

Table 3 to paragraph (b)(1): Modified adjusted gross income effective beginning in 2019	Beneficiary percentage (percent)
Greater than $85,000 but less than or equal to $107,000	35
Greater than $107,000 but less than or equal to $133,500	50
Greater than $133,500 but less than or equal to $160,000	65
Greater than $160,000 but less than $500,000	80
Greater than or equal to $500,000	85

(2) *Tables of applicable percentages for joint returns.* If your Federal tax filing status is married filing jointly for the tax year we use and your modified adjusted gross income for that tax year is in the range listed in the left column in the following tables, you will pay an amount based on the percentage listed in the right column, which represents a percentage of the cost of basic Medicare prescription drug coverage.

Table 1 to paragraph (b)(2): Modified adjusted gross income effective in 2011–2017	Beneficiary percentage (percent)
Greater than $170,000 but less than or equal to $214,000	35
Greater than $214,000 but less than or equal to $320,000	50
Greater than $320,000 but less than or equal to $428,000	65
Greater than $428,000	80

Table 2 to paragraph (b)(2): Modified adjusted gross income effective in 2018	Beneficiary percentage (percent)
Greater than $170,000 but less than or equal to $214,000	35
Greater than $214,000 but less than or equal to $267,000	50
Greater than $267,000 but less than or equal to $320,000	65
Greater than $320,000	80

Table 3 to paragraph (b)(2): Modified adjusted gross income effective beginning in 2019	Beneficiary percentage (percent)
Greater than $170,000 but less than or equal to $214,000	35
Greater than $214,000 but less than or equal to $267,000	50
Greater than $267,000 but less than or equal to $320,000	65
Greater than $320,000 but less than $750,000	80
Greater than or equal to $750,000	85

(3) *Tables of applicable percentages for married individuals filing separate returns.* If, for the tax year we use, your Federal tax filing status is married filing separately, you lived with your spouse at some time during that tax year, and your modified adjusted gross income is in the range listed in the left column in the following tables, you will pay an amount based on the percentage listed in the right column, which represents a percentage of the cost of basic Medicare prescription drug coverage.

Table 1 to paragraph (b)(3): Modified adjusted gross income effective in 2011–2017	Beneficiary percentage (percent)
Greater than $85,000 but less than or equal to $129,000	65
Greater than $129,000	80

Table 2 to paragraph (b)(3): Modified adjusted gross income effective in 2018	Beneficiary percentage (percent)
Greater than $85,000	80

Table 3 to paragraph (b)(3): Modified adjusted gross income effective beginning in 2019	Beneficiary percentage (percent)
Greater than $85,000 but less than $415,000	80
Greater than or equal to $415,000	85

(c) For each year after 2019, CMS will announce the modified adjusted gross income ranges for the income-related monthly adjustment amount described in paragraph (b) of this section.

[75 FR 75891, Dec. 7, 2010, as amended at 55631, Nov. 3, 2018]

§ 418.2125 How will the income-related monthly adjustment amount affect your total Medicare prescription drug coverage premium?

(a) If you must pay an income-related monthly adjustment amount, your total Medicare prescription drug coverage premium will be the sum of:

(1) Your prescription drug coverage monthly premium, as determined by your plan; plus

(2) Any applicable increase in the prescription drug coverage monthly premium as described in 42 CFR 423.286; plus

(3) Your income-related monthly adjustment amount.

(b) Regardless of the method you use to pay your Medicare prescription drug coverage premiums to your Medicare prescription drug coverage plan, you will pay any income-related monthly adjustment amount you owe using the method described in 418.2112.

§ 418.2135 What modified adjusted gross income information will we use to determine your income-related monthly adjustment amount?

We will follow the rules in § 418.1135, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2140 What will happen if the modified adjusted gross income information from the IRS is different from the modified adjusted gross income information we used to determine your income-related monthly adjustment amount?

We will follow the rules in § 418.1140, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2145 How do we determine your income-related monthly adjustment amount if the IRS does not provide information about your modified adjusted gross income?

We will follow the rules in § 418.1145, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2150 When will we use your amended tax return filed with the IRS?

We will follow the rules in § 418.1150, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

DETERMINATIONS USING A MORE RECENT TAX YEAR'S MODIFIED ADJUSTED GROSS INCOME

§ 418.2201 When will we determine your income-related monthly adjustment amount based on the modified adjusted gross income information that you provide for a more recent tax year?

We will follow the rules in § 418.1201, except that any references in that section to regulations in subpart B of this

part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2205 What is a major life-changing event?

We will follow the rules in § 418.1205, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2210 What is not a major life-changing event?

We will follow the rules in § 418.1210, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2215 What is a significant reduction in your income?

We will follow the rules in § 418.1215, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2220 What is not a significant reduction in your income?

We will follow the rules in § 418.1220, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2225 Which more recent tax year will we use?

We will follow the rules in § 418.1225, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2230 What is the effective date of an income-related monthly adjustment amount initial determination based on a more recent tax year?

We will follow the rules in § 418.1230, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2235 When will we stop using your more recent tax year's modified adjusted gross income to determine your income-related monthly adjustment amount?

We will follow the rules in § 418.1235, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2240 Should you notify us if the information you gave us about your modified adjusted gross income for the more recent tax year changes?

We will follow the rules in § 418.1240, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2245 What will happen if you notify us that your modified adjusted gross income for the more recent tax year changes?

(a) If you notify us that your modified adjusted gross income for the more recent tax year has changed from what is in our records, we may make a new initial determination for each effective year involved. To make a new initial determination(s) we will take into account:

(1) The new modified adjusted gross income information for the more recent tax year you provide; and

(2) Any modified adjusted gross income information from the IRS, as described in § 418.2135, that we have available for each effective year; and

(3) Any modified adjusted gross income information from you, as described in § 418.2135, that we have available for each effective year.

(b) For each new initial determination that results in a change in your income-related monthly adjustment amount, we will make retroactive corrections that will apply to all enrolled months of the effective year.

(c) We will continue to use a new initial determination described in paragraph (a) of this section to determine additional yearly income-related monthly adjustment amount(s) until an event described in § 418.2235 occurs.

(d) We will make a new determination about your income-related monthly adjustment amount when we receive modified adjusted gross income for the effective year from the IRS, as described in § 418.1140(d).

§ 418.2250 What evidence will you need to support your request that we use a more recent tax year?

We will follow the rules in § 418.1250, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2255 What kind of evidence of a major life-changing event will you need to support your request for us to use a more recent tax year?

We will follow the rules in § 418.1255, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2260 What major life-changing event evidence will we not accept?

We will follow the rules in § 418.1260, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2265 What kind of evidence of a significant modified adjusted gross income reduction will you need to support your request?

We will follow the rules in § 418.1265, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2270 What modified adjusted gross income evidence will we not accept?

We will follow the rules in § 418.1270, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

DETERMINATIONS AND THE ADMINISTRATIVE REVIEW PROCESS

§ 418.2301 What is an initial determination regarding your income-related monthly adjustment amount?

We will follow the rules in § 418.1301, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2305 What is not an initial determination regarding your income-related monthly adjustment amount?

We will follow the rules in § 418.1305, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2310 When may you request that we make a new initial determination?

We will follow the rules in § 418.1310, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2315 How will we notify you and what information will we provide about our initial determination?

We will follow the rules in § 418.1315, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2320 What is the effect of an initial determination?

We will follow the rules in § 418.1320, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2322 How will a Medicare Part B income-related monthly adjustment amount determination for the effective year affect your Medicare prescription drug coverage?

If we make an income-related monthly adjustment amount determination for you for the effective year under

subpart B of this part (Medicare Part B Income-Related Monthly Adjustment Amount), we will apply that income-related monthly adjustment amount determination under this subpart to determine your Part D income-related monthly adjustment amount for the same effective year. Therefore, if you obtain Medicare prescription drug coverage in the effective year after we make an income-related monthly adjustment amount determination about your Medicare Part B, the income-related monthly adjustment amount determination we made for your Medicare Part B will also apply to your Medicare prescription drug coverage. Any change in your net benefit due will be accompanied by a letter explaining the change in your net benefit and your right to appeal the change.

§ 418.2325 When may you request a reconsideration?

We will follow the rules in § 418.1325, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2330 Can you request a reconsideration when you believe that the IRS information we used is incorrect?

If you request a reconsideration solely because you believe that the information that the IRS gave us is incorrect, we will dismiss your request for a reconsideration and notify you to obtain proof of a correction from the IRS and request a new initial determination (§ 418.2335). Our dismissal of your request for reconsideration is not an initial determination subject to further administrative or judicial review.

§ 418.2332 Can you request a reconsideration when you believe that the CMS information we used is incorrect?

If you request a reconsideration solely because you believe that the information that CMS gave us about your participation in a Medicare prescription drug coverage plan is incorrect, we will dismiss your request for a reconsideration and notify you that you must contact CMS to get your records corrected. Our dismissal of your request for reconsideration is not an initial determination subject to further administrative or judicial review.

§ 418.2335 What should you do if we base our initial determination on modified adjusted gross income information you believe to be incorrect?

We will follow the rules in § 418.1335, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2340 What are the rules for our administrative review process?

We will follow the rules in § 418.1340, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2345 Is reopening of an initial or reconsidered determination made by us ever appropriate?

We will follow the rules in § 418.1345, except that any references in that section to regulations in subpart B of this part shall be treated as references to the corresponding regulation in this subpart.

§ 418.2350 What are the rules for review of a reconsidered determination or an ALJ decision?

You may request a hearing before an OMHA administrative law judge consistent with HHS' regulations at 42 CFR part 423. You may seek further review of the administrative law judge's decision by requesting MAC review and judicial review in accordance with HHS' regulations.

§ 418.2355 What are the rules for reopening a decision by an ALJ of the Office of Medicare Hearings and Appeals (OMHA) or by the Medicare Appeals Council (MAC)?

The rules in 42 CFR 423.1980 through 423.1986 govern reopenings of decisions by an administrative law judge of the OMHA and decisions by the MAC. A decision by an administrative law judge of the OMHA may be reopened by the administrative law judge or the MAC.

A decision by the MAC may be reopened only by the MAC.

Subpart D—Medicare Part D Subsidies

AUTHORITY: Secs. 702(a)(5) and 1860D–1, 1860D–14 and –15 of the Social Security Act (42 U.S.C. 902(a)(5),1395w–101, 1395w–114, and –115).

INTRODUCTION, GENERAL PROVISIONS, AND DEFINITIONS

§ 418.3001 What is this subpart about?

This subpart D relates to sections 1860D–1 through 1860D–24 of title XVIII of the Social Security Act (the Act) as added by section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173). Sections 1860D–1 through 1860D–24 established Part D of title XVIII of the Act to create a Medicare program known as the Voluntary Prescription Drug Benefit Program. Section 1860D–14, codified into the Act by section 101, includes a provision for subsidies of prescription drug premiums and of Part D cost-sharing requirements for Medicare beneficiaries whose income and resources do not exceed certain levels. The regulations in this subpart explain how we decide whether you are eligible for a Part D premium subsidy as defined in 42 CFR 423.780 and cost-sharing subsidy as defined in 42 CFR 423.782. The rules are divided into the following groups of sections according to subject content:

(a) Sections 418.3001 through 418.3010 contain the introduction, a statement of the general purpose underlying the subsidy program for the Voluntary Prescription Drug Benefit Program under Medicare Part D, general provisions that apply to the subsidy program, a description of how we administer the program, and definitions of terms that we use in this subpart.

(b) Sections 418.3101 through 418.3125 contain the general requirements that you must meet in order to be eligible for a subsidy. These sections set forth the subsidy eligibility requirements of being a Medicare beneficiary, of having income and resources below certain levels, and of filing an application. These sections also explain when we will redetermine your eligibility for a subsidy and the period covered by a redetermination.

(c) Sections 418.3201 through 418.3230 contain the rules that relate to the filing of subsidy applications.

(d) Sections 418.3301 through 418.3350 contain the rules that explain how we consider your income (and your spouse's income, if applicable) and define what income we count when we decide whether you are eligible for a subsidy.

(e) Sections 418.3401 through 418.3425 contain the rules that explain how we consider your resources (and your spouse's resources, if applicable) and define what resources we count when we decide whether you are eligible for a subsidy.

(f) Sections 418.3501 through 418.3515 contain the rules that explain when we will adjust or when we will terminate your eligibility for a subsidy.

(g) Sections 418.3601 through 418.3680 contain the rules that we apply when you appeal our determination regarding your subsidy eligibility or our determination of whether you should receive a full or partial subsidy. They also contain the rules that explain that our decision is binding unless you file an action in Federal district court seeking review of our final decision and what happens if your case is remanded by a Federal court

§ 418.3005 Purpose and administration of the program.

The purpose of the subsidy program is to offer help with the costs of prescription drug coverage for individuals who meet certain income and resources requirements under the law as explained in this subpart. The Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services has responsibility for administration of the Medicare program, including the new Medicare Part D Voluntary Prescription Drug Benefit Program. We notify Medicare beneficiaries who appear to have limited income, based on our records, about the availability of the subsidy if they are not already eligible for this help, and take applications for and determine the eligibility of individuals for a subsidy.

§418.3010 Definitions.

(a) *Terms relating to the Act and regulations.*

(1) *CMS* means the Centers for Medicare & Medicaid Services in the Department of Health and Human Services.

(2) *Commissioner* means the Commissioner of Social Security.

(3) *Section* means a section of the regulations in part 418 of this chapter unless the context indicates otherwise.

(4) *The Act* means the Social Security Act, as amended.

(5) *Title* means a title of the Act.

(6) *We*, *our* or *us* means the Social Security Administration (SSA).

(b) *Miscellaneous.*

(1) *Claimant* means the person who files an application for himself or herself or the person on whose behalf an application is filed.

(2) *Date you receive a notice* means 5 calendar days after the date on the notice, unless you show us you did not receive it within the 5-day period.

(3) *Decision* means the decision we make after a hearing.

(4) *Determination* means the initial determination that we make as defined in §418.3605.

(5) *Family size*, for purposes of this subpart, means family size as defined in 42 CFR 423.772.

(6) *Federal poverty line*, for purposes of this subpart, has the same meaning as Federal poverty line in 42 CFR 423.772.

(7) *Full-benefit dual eligible individual* for purposes of this subpart, has the same meaning as full-benefit dual eligible individual in 42 CFR 423.772.

(8) *Medicare beneficiary* means an individual who is entitled to or enrolled in Medicare Part A (Hospital Insurance) or enrolled in Part B (Supplementary Medical Insurance) or both under title XVIII of the Act.

(9) *Periods of limitations ending on Federal non-workdays* Title XVIII of the Act and regulations in this subpart require you to take certain actions within specified time periods or you may lose your right to a portion of or your entire subsidy. If any such period ends on a Saturday, Sunday, Federal legal holiday, or any other day all or part of which is declared to be a nonworkday for Federal employees by statute or Executive Order, you will have until the next Federal workday to take the prescribed action.

(10) *Representative* or *personal representative* means a personal representative as defined in 42 CFR 423.772.

(11) *State*, unless otherwise indicated, means:

(i) A State of the United States; or

(ii) The District of Columbia.

(12) *Subsidy eligible individual*, for purposes of this subpart, has the same meaning as subsidy eligible individual as defined in 42 CFR 423.773.

(13) *Subsidy* means an amount CMS will pay on behalf of Medicare beneficiaries who are eligible for a subsidy of their Medicare Part D costs. The amount of a subsidy for a Medicare beneficiary depends on the beneficiary's income as related to household size, resources, and late enrollment penalties (if any) as explained in 42 CFR 423.780 and 42 CFR 423.782. We do not determine the amount of the subsidy, only whether or not the individual is eligible for a full or partial subsidy.

(14) *United States* when used in a geographical sense means:

(i) The 50 States; and

(ii) The District of Columbia

(1) *You* or *your* means the person who applies for the subsidy, the person for whom an application is filed or anyone who may consider applying for a subsidy.

ELIGIBILITY FOR A MEDICARE PRESCRIPTION DRUG SUBSIDY

§418.3101 How do you become eligible for a subsidy?

Unless you are deemed eligible as explained in §418.3105 and 42 CFR 423.773(c), you are eligible for a Medicare Part D prescription drug subsidy if you meet all of the following requirements:

(a) You are entitled to or enrolled in Medicare Part A (Hospital Insurance) or enrolled in Medicare Part B (Supplementary Medical Insurance) or both under title XVIII of the Act.

(b) You are enrolled in a Medicare prescription drug plan or Medicare Advantage plan with prescription drug coverage. We can also determine your eligibility for a subsidy before you enroll in one of the above programs. However, as explained in §418.3225(b), if we

determine that you would be eligible for a subsidy before you have enrolled in a Medicare prescription drug plan or Medicare Advantage plan with prescription drug coverage, you must enroll in one of these plans to actually receive a subsidy.

(c) You reside in the United States as defined in § 418.3010.

(d) You (and your spouse, if applicable) meet the income requirements as explained in §§ 418.3301 through 418.3350 and 42 CFR 423.773.

(e) You (and your spouse, if applicable) meet the resources requirements as explained in §§ 418.3401 through 418.3425 and 42 CFR 423.773.

(f) You or your personal representative file an application for a subsidy as explained in §§ 418.3201 through 418.3230.

§ 418.3105 Who does not need to file an application for a subsidy?

Regulations in 42 CFR 423.773(c) explain who is deemed eligible and does not need to file an application for a subsidy to be eligible for this assistance. Full-benefit dual eligible beneficiaries are in this category. If beneficiaries have deemed eligibility status because they receive Medicaid coverage, are enrolled in a Medicare Savings Program within their State, or receive SSI and have Medicare, then their subsidy is effective with the first month they have deemed eligibility status.

§ 418.3110 What happens when you apply for a subsidy?

(a) When you or your personal representative apply for a subsidy, we will ask for information that we need to determine if you meet all the requirements for a subsidy. You must give us complete information. If, based on the information you present to us, you do not meet all the requirements for eligibility listed in § 418.3101, or if one of the events listed in § 418.3115 exists, or you fail to submit information we request, we will deny your claim.

(b) If you meet all the requirements for eligibility listed in § 418.3101, or you meet all the requirements except for enrollment in a Medicare Part D plan or Medicare Advantage plan with prescription drug coverage, we will send you a notice telling you the following:

(1) You are eligible for a full or partial subsidy for a period not to exceed 1 year;

(2) What information we used to make this determination including how we calculated your income and resources;

(3) What you may do if your circumstances change as described in § 418.3120; and

(4) Your appeal rights.

(c) If you are not already enrolled with a Medicare prescription drug plan or a Medicare Advantage plan with prescription drug coverage, you must enroll in order to receive your subsidy.

(d) If you do not meet all the requirements for eligibility listed in § 418.3101 or if § 418.3115 applies to you except for enrollment in a Medicare Part D plan or Medicare Advantage plan with prescription drug coverage as described in § 418.3225, we will send you a notice telling you the following:

(1) You are not eligible for a subsidy;

(2) The information we used to make this determination including how we calculated your income or resources;

(3) You may reapply if your situation changes; and

(4) Your appeal rights.

§ 418.3115 What events will make you ineligible for a subsidy?

Generally, even if you meet the other requirements in §§ 418.3101 through 418.3125, we will deny your claim or you will lose your subsidy if any of the following apply to you:

(a) You lose entitlement to or are not enrolled in Medicare Part A and are not enrolled in Medicare Part B.

(b) You do not enroll or lose your enrollment in a Medicare Part D plan or Medicare Advantage plan with prescription drug coverage.

(c) You do not give us information we need to determine your eligibility and if eligible, whether you should receive a full or partial subsidy; or you do not give us information we need to determine whether you continue to be eligible for a subsidy and if eligible, whether you should receive a full or partial subsidy.

(d) You knowingly give us false or misleading information.

§ 418.3120 What happens if your circumstances change after we determine you are eligible for a subsidy?

(a) After we determine that you are eligible for a subsidy, your subsidy eligibility could change if:

(1) You marry.

(2) You and your spouse, who lives with you, divorce.

(3) Subject to the provisions of paragraph (b)(4) of this section, your spouse, who lives with you, dies.

(4) You and your spouse separate (*i.e.*, you or your spouse move out of the household and you are no longer living with your spouse) unless the separation is a temporary absence as described in § 404.347 of this chapter.

(5) You and your spouse resume living together after having been separated.

(6) You and your spouse, who lives with you, have your marriage annulled.

(7) You (or your spouse, who lives with you, if applicable) expect your estimated annual income to increase or decrease in the next calendar year.

(8) You (or your spouse, who lives with you, if applicable) expect your resources to increase or decrease in the next calendar year.

(9) Your family size as defined in 42 CFR 423.772 has changed or will change (other than a change resulting from one of the events in paragraphs (a)(1) through (6) of this section).

(10) You become eligible for one of the programs listed in 42 CFR 423.773(c).

(b)(1) When you report one of the events listed in paragraphs (a)(1) through (a)(6) of this section, or we receive such a report from another source (e.g., a data exchange of reports of death), we will send you a redetermination form upon receipt of the report. You must return the completed form within 90 days of the date of the form.

(2) When you report one of the events listed in paragraphs (a)(7) through (a)(9) of this section or we receive such a report from another source (e.g., a data exchange involving income records), we will send you a redetermination form between August and December to evaluate the change. You must return the completed form to us within 30 days of the date of the form.

(3) If we increase, decrease, or terminate your subsidy as a result of the redetermination, we will send you a notice telling you:

(i) Whether you can receive a full or partial subsidy as described in 42 CFR 423.780 and 423.782.

(ii) How we calculated your income and resources;

(iii) When the change in your subsidy is effective;

(iv) Your appeal rights;

(v) What to do if your situation changes.

(4) If your spouse who lives with you dies, your spouse's death may result in changes in your income or resources that could decrease or eliminate your subsidy. If we are informed of the death of your spouse and the death would cause a decrease in or elimination of your subsidy, we will notify you that we will not immediately change your subsidy because of your spouse's death. We will defer your redetermination for 1 year from the month following the month we are notified of the death of your spouse, unless we receive a report of another event specified in 418.3120(a) that would affect your eligibility for a subsidy.

(c) If you become eligible for one of the programs listed in 42 CFR 423.773(c), CMS will notify you of any change in your subsidy.

[70 FR 77675, Dec. 30, 2005, as amended at 75 FR 81845, Dec. 29, 2010]

§ 418.3123 When is a change in your subsidy effective?

(a) If we redetermine your subsidy as described in § 418.3120(b)(1), any change in your subsidy will be effective the month following the month of your report.

(b) If we redetermine your subsidy as described in § 418.3120(b)(2), any change in your subsidy will be effective in January of the next year.

(c) If you do not return the redetermination form described in § 418.3120(b)(1), we will terminate your subsidy effective with the month following the expiration of the 90-day period described in § 418.3120(b)(1).

(d) If you do not return the redetermination forms described in § 418.3120(b)(2), we will terminate your

subsidy effective in January of the next year.

(e) *Special rule for widows and widowers.* If your spouse who lives with you dies and the changes in your income or resources resulting from your spouse's death would decrease or eliminate your subsidy, we will defer your next redetermination for 1 year from the month following the month we are notified of the death of your spouse, unless we receive a report of another event specified in 418.3120(a) that would affect your eligibility for a subsidy.

[70 FR 77675, Dec. 30, 2005, as amended at 75 FR 81845, Dec. 29, 2010]

§ 418.3125 What are redeterminations?

(a) *Redeterminations defined.* A redetermination is a periodic review of your eligibility to make sure that you are still eligible for a subsidy and if so, to determine whether you should continue to receive a full or partial subsidy. This review deals with evaluating your income and resources (and those of your spouse, who lives with you) and will not affect past months of eligibility. It will be used to determine your future subsidy eligibility and whether you should receive a full or partial subsidy for future months. We will redetermine your eligibility if we made the initial determination of your eligibility or if you are deemed eligible because you receive SSI benefits. Rules regarding redeterminations of initial eligibility determinations made by a State are described in 42 CFR 423.774.

(b) *When we make redeterminations.* (1) We will redetermine your subsidy eligibility within one year after we determine that you are eligible for the subsidy.

(2) After the first redetermination, we will redetermine your subsidy eligibility at intervals determined by the Commissioner. The length of time between redeterminations varies depending on the likelihood that your situation may change in a way that affects your eligibility and whether you should receive a full or partial subsidy.

(3) We may also redetermine your eligibility and whether you should receive a full or partial subsidy when you tell us of a change in your circumstances described in § 418.3120.

(4) We may redetermine your eligibility when we receive information from you or from data exchanges with Federal and State agencies that may affect whether you should receive a full or partial subsidy or your eligibility for the subsidy.

(5) We will also redetermine eligibility on a random sample of cases for quality assurance purposes. For each collection of sample cases, all factors affecting eligibility and/or whether you should receive a full or partial subsidy may be verified by contact with primary repositories of information relevant to each individual factor (e.g., we may contact employers to verify wage information). Consequently, we may contact a variety of other sources, in addition to recontacting you, to verify the completeness and accuracy of our information.

FILING OF APPLICATION

§ 418.3201 Must you file an application to become eligible for a subsidy?

Unless you are a person covered by § 418.3105, in addition to meeting other requirements, you or your personal representative must file an application to become eligible for a subsidy. If you believe you may be eligible for a subsidy, you should file an application. Filing a subsidy application does not commit you to participate in the Part D program. Filing an application will:

(a) Permit us to make a formal determination on your eligibility for the subsidy and whether you should receive a full or partial subsidy;

(b) Assure that you can receive the subsidy for any months that you are eligible and are enrolled in a Medicare Part D plan or Medicare Advantage plan with prescription drug coverage; and

(c) Give you the right to appeal if you disagree with our determination.

§ 418.3205 What makes an application a claim for a subsidy?

We will consider your application a claim for the subsidy if:

(a) You, or someone acting on your behalf as described in § 418.3215, complete an application on a form prescribed by us;

(b) You, or someone acting on your behalf as described in § 418.3215, file the application with us pursuant to § 418.3220; and

(c) You are alive on the first day of the month in which the application is filed.

§ 418.3210 What is a prescribed application for a subsidy?

If you choose to apply with SSA, you must file for the subsidy on an application prescribed by us. A prescribed application may include a printed form, an application our employees complete on computer screens, or an application available online on our Internet Web site (*www.socialsecurity.gov*). See § 418.3220 for places where an application for the subsidy may be filed and when it is considered filed.

§ 418.3215 Who may file your application for a subsidy?

You or your personal representative (as defined in 42 CFR 423.772) may complete and file your subsidy application.

§ 418.3220 When is your application considered filed?

(a) *General rule.* We consider an application for a subsidy as described in § 418.3210 to be filed with us on the day it is received by either one of our employees at one of our offices or by one of our employees who is authorized to receive it at a place other than one of our offices or it is considered filed on the day it is submitted electronically through our Internet Web site. If a State Medicaid agency forwards to us a subsidy application that you gave to it, we will consider the date you submitted that application to the State Medicaid agency as the filing date. (See 42 CFR 423.774 for applications filed with a State Medicaid agency.)

(b) *Exceptions.* (1) When we receive an application that is mailed, we will assume that we received it 5 days earlier (unless you can show us that you did not receive it within the 5 days) and use the earlier date as the application filing date if it would result in another month of subsidy eligibility.

(2) We may consider an application to be filed on the date a written or oral inquiry about your subsidy eligibility is made, or the date we receive a partially completed Internet subsidy application from our Internet Web site where the requirements set forth in § 418.3230 are met.

§ 418.3225 How long will your application remain in effect?

(a) Your application will remain in effect until our determination or decision has become final and binding under § 418.3620. If you appeal our initial determination, the determination does not become final until we issue a decision on any appeal you have filed under § 418.3655 (see § 418.3675) or dismiss the request for a hearing under § 418.3670.

(b) If, at the time your application is filed or before our determination or decision becomes final and binding, you meet all the requirements for a subsidy as described in 42 CFR 423.773 except for enrollment in a Medicare Part D plan or Medicare Advantage plan with prescription drug coverage, we will send you a notice advising you of your eligibility for the subsidy and the requirement to enroll in such a plan.

(c) If you are not entitled to Medicare Part A and/or enrolled in Medicare Part B at the time your subsidy application is filed but you appear to be in an enrollment period, we will send you a notice advising you that we will not make a determination on your application until you become entitled to Medicare Part A and/or enrolled in Medicare Part B. If you are not entitled to Medicare Part A and/or enrolled in Medicare Part B at the time your application is filed and you do not appear to be in an enrollment period, we will send you a notice advising you that you are not eligible for the subsidy because you are not entitled to Medicare Part A and/or enrolled in Medicare Part B and explain your appeal rights.

§ 418.3230 When will we use your subsidy inquiry as your filing date?

If you or your personal representative (as defined in 42 CFR 423.772) make an oral or written inquiry about the subsidy, or partially complete an Internet subsidy application on our Web site, we will use the date of the inquiry or the date the partial Internet application was started as your filing date if the following requirements are met:

(a) The written or oral inquiry indicates your intent to file for the subsidy, or you submit a partially completed Internet application to us;

(b) The inquiry, whether in person, by telephone, or in writing, is directed to an office or an official described in § 418.3220, or a partially completed Internet subsidy application is received by us;

(c) You or your personal representative (as defined in 42 CFR 423.772) file an application (as defined in § 418.3210) within 60 days after the date of the notice we will send in response to the inquiry. The notice will say that we will make an initial determination of your eligibility for a subsidy, if an application is filed within 60 days after the date of the notice. We will send the notice to you. Where you are a minor or adjudged legally incompetent and your personal representative made the inquiry, we will send the notice to your personal representative; and

(d) You are alive on the first day of the month in which the application is filed.

INCOME

§ 418.3301 What is income?

Income is anything you and your spouse, who lives with you, receive in cash or in-kind that you can use to meet your needs for food and shelter. Income can be earned income or unearned income.

§ 418.3305 What is not income?

Some things you receive are not considered income because you cannot use them to meet your needs for food or shelter. The things that are not income for purposes of determining eligibility and whether you should receive a full or partial subsidy are described in § 416.1103 of this chapter.

§ 418.3310 Whose income do we count?

(a) We count your income. If you are married and live with your spouse in the month you file for a subsidy, or when we redetermine your eligibility for a subsidy as described in § 418.3125, we count your income and your spouse's income regardless of whether one or both of you apply or are eligible for the subsidy.

(b) We will determine your eligibility based on your income alone if you are not married or if you are married but you are separated from your spouse (*i.e.*, you or your spouse move out of the household and you are no longer living with your spouse) at the time you apply for a subsidy or when we redetermine your eligibility for a subsidy as described in § 418.3125.

(c) If your subsidy is based on your income and your spouse's income and we redetermine your subsidy as described in § 418.3120(b)(1), we will stop counting the income of your spouse in the month following the month that we receive a report that your marriage ended due to death, divorce, or annulment; or a report that you and your spouse stopped living together.

(d) If your subsidy is based on your income and your spouse's income, we will continue counting the income of both you and your spouse if one of you is temporarily away from home as described in § 404.347 of this chapter.

§ 418.3315 What is earned income?

Earned income is defined in § 416.1110 of this chapter and may be in cash or in kind. We may count more of your earned income than you actually receive. We count gross income, which is more than you actually receive, if amounts are withheld from earned income because of a garnishment, or to pay a debt or other legal obligation such as taxes, or to make any other similar payments.

§ 418.3320 How do we count your earned income?

(a) *Wages.* We count your wages at the earliest of the following points: when you receive them, when they are credited to you, or when they are set aside for your use.

(b) *Net earnings from self-employment.* We count net earnings from self-employment on a taxable year basis. If you have net losses from self-employment, we deduct them from your other earned income. We do not deduct the net losses from your unearned income.

(c) *Payments for services performed in a sheltered workshop or work activities center.* We count payments you receive for services performed in a sheltered workshop or work activities center when

you receive them or when they are set aside for your use.

(d) *In-kind earned income.* We count the current market value of in-kind earned income. For purposes of this part, we use the definition of current market value in § 416.1101 of this chapter. If you receive an item that is not fully paid for and you are responsible for the unpaid balance, only the paid-up value is income to you (see example in § 416.1123(c) of this chapter).

(e) *Certain honoraria and royalties.* We count honoraria for services rendered and royalty payments that you receive in connection with any publication of your work. We will consider these payments as available to you when you receive them, when they are credited to your account, or when they are set aside for your use, whichever is earliest.

(f) *Period for which earned income is counted.* For purposes of determining subsidy eligibility and, if eligible, whether you should receive a full or partial subsidy, we consider all of the countable earned income you receive (or expect to receive) during the year for which we are determining your eligibility for this subsidy. However, in the first year that you or your spouse apply for the subsidy, we consider all of the countable earned income you and your living-with spouse receive (or expect to receive) starting in the month for which we determine your eligibility based on your application for a subsidy through the end of the year for which we are determining your eligibility. If we count your income for only a portion of the year, the income limit for subsidy eligibility will be adjusted accordingly. For example, if we count your income for 6 consecutive months of the year (July through December), the income limit for subsidy eligibility will be half of the income limit applicable for the full year.

§ 418.3325 What earned income do we not count?

(a) While we must know the source and amount of all of your earned income, we do not count all of it to determine your subsidy eligibility and whether you should receive a full or partial subsidy. We apply these income exclusions in the order listed in paragraph (b) of this section to your income. We never reduce your earned income below zero or apply any unused earned income exclusion to unearned income.

(b) For the year or partial year that we are determining your eligibility for the subsidy, we do not count as earned income:

(1) Any refund of Federal income taxes you or your living-with spouse receive under section 32 of the Internal Revenue Code (relating to the earned income tax credit) and payment you receive from an employer under section 3507 of the Internal Revenue Code (relating to advance payments of earned income tax credit);

(2) Earned income which is received infrequently or irregularly as explained in § 416.1112(c)(2) of this chapter;

(3) Any portion of the $20 per month exclusion described in § 416.1124(c)(12) of this chapter which has not been excluded from your combined unearned income (or the combined unearned income of you and your living-with spouse);

(4) $65 per month of your earned income (or the combined earned income you and your living-with spouse receive in that same year);

(5) Earned income you use to pay impairment-related work expenses described in § 416.976 of this chapter, if you are receiving a social security disability insurance benefit, your disabling condition(s) does not include blindness and you are under age 65. We consider that you attain age 65 on the day before your 65th birthday. In lieu of determining the actual amount of these expenses, we will assume that the value of these work expenses is equal to a standard percentage of your total earned income per month if you tell us that you have impairment-related work expenses. The amount we exclude will be equal to the average percentage of gross earnings excluded for SSI recipients who have such expenses. Initially, the exclusion for impairment-related work expenses will be 16.3 percent of the gross earnings. We may adjust the percentages if the average percentage of gross earnings excluded for supplemental security income (SSI) recipients changes. If we make such a change

we will publish a notice in the FEDERAL REGISTER. If excluding impairment-related work expenses greater than the standard percentage of your earned income would affect your eligibility or subsidy amount, you may establish that your actual expenses are greater than the standard percentage of your total earned income. You may do so by contacting us and providing evidence of your actual expenses. The exclusion of impairment-related work expenses also applies to the earnings of your living-with spouse if he or she is receiving a social security disability insurance benefit, the disabling condition(s) does not include blindness and he or she is under age 65;

(6) One-half of your remaining earned income (or combined earned income of you and your living-with spouse); and

(7) Earned income as described in §416.1112(c)(8) of this chapter that you use to meet any expenses reasonably attributable to the earning of the income if you receive a social security disability insurance benefit based on blindness and you are under age 65. We consider that you attain age 65 on the day before your 65th birthday. In lieu of determining the actual amount of these expenses, we will assume that the value of these expenses is equal to a standard percentage of your total earned income per month. The amount we exclude will be equal to the average percentage of gross earnings excluded for SSI recipients who have such expenses. Initially, the exclusion for blind work expenses will be 25 percent of the gross earnings. We may adjust the percentages if the average percentage of gross earnings excluded for SSI recipients changes. If we make such a change we will publish a notice in the FEDERAL REGISTER. If excluding work expenses greater than the standard percentage of your earned income would affect your eligibility or subsidy amount, you may establish that your actual expenses are greater than the standard percentage of your earned income. You may do so by contacting us and providing evidence of your actual expenses. The exclusion of work expenses also applies to the earnings of your living-with spouse if he or she receives a social security disability insurance benefit based on blindness and is under age 65.

§ 418.3330 What is unearned income?

Unearned income is all income that is not earned income. We describe some of the types of unearned income we count in §418.3335.

§ 418.3335 What types of unearned income do we count?

(a) Some of the types of unearned income we count are described in §416.1121(a) through (g) of this chapter.

(b) For claims filed before January 1, 2010, and redeterminations that are effective before January 1, 2010, we also count in-kind support and maintenance as unearned income. In-kind support and maintenance is any food and shelter given to you or that you receive because someone else pays for it.

[70 FR 77675, Dec. 30, 2005, as amended at 75 FR 81845, Dec. 29, 2010]

§ 418.3340 How do we count your unearned income?

(a) *When income is received.* We count unearned income as available to you at the earliest of the following points: when you receive it, when it is credited to your account, or when it is set aside for your use.

(b) *When income is counted.* For purposes of determining eligibility and whether you should receive a full or partial subsidy, we consider all of the countable unearned income you and your living-with spouse receive (or expect to receive) during the year for which we are determining your eligibility for this benefit. However, in the first year you or your spouse apply for the subsidy, we consider all of the countable unearned income both you and your living-with spouse receive (or expect to receive) starting in the month for which we determine eligibility for you or your living-with spouse based on an application for the subsidy. If we count your income for only a portion of the year, the income limits for subsidy eligibility will be adjusted accordingly. For example, if we count your income for 6 consecutive months of the year (July through December), the income limit for subsidy eligibility will be half of the income limit applicable for the full year.

(c) *Amount considered as income.* We may include more or less of your income than you actually receive.

(1) We include more than you actually receive where another benefit payment (such as a social security benefit) has been reduced to recover an overpayment. In such a situation, you are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of this withholding is part of your unearned income.

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums.

(3) We include less than you actually receive if part of the payment is for an expense you had in getting the payment. For example, if you are paid for damages you receive in an accident, we subtract from the amount of the payment your medical, legal, or other expenses connected with the accident. If you receive a retroactive check from a benefit program, we subtract legal fees connected with the claim. We do not subtract from any taxable unearned income the part you have to use to pay personal income taxes. The payment of taxes is not an expense you have in getting income.

(d) *Retroactive benefits.* We count retroactive monthly benefits such as social security benefits as unearned income in the year you receive the retroactive benefits.

(e) *Certain veterans benefits.* If you receive a veterans benefit that includes an amount paid to you because of a dependent, we do not count as your unearned income the amount paid to you because of the dependent. If you are a dependent of an individual who receives a veterans benefit and a portion of the benefit is attributable to you as a dependent, we count the amount attributable to you as your unearned income if you reside with the veteran or you receive your own separate payment from the Department of Veterans Affairs.

(f) *Social Security cost-of-living adjustment.* We will not count as income the amount of the cost-of-living adjustment for social security benefits for any month through the month following the month in which the annual revision of the Federal poverty guidelines is published.

§ 418.3350 What types of unearned income do we not count?

(a) For claims filed on or after January 1, 2010 and redeterminations that are effective on or after January 1, 2010, we do not count as income in-kind support and maintenance.

(b) While we must know the source and amount of all of your unearned income, we do not count all of it to determine your eligibility for the subsidy. We apply to your unearned income the exclusions in § 418.3350(c) in the order listed. However, we do not reduce your unearned income below zero, and we do not apply any unused unearned income exclusion to earned income except for the $20 per month exclusion described in § 416.1124(c)(12) of this chapter. For purposes of determining eligibility for a subsidy and whether you should receive a full or partial subsidy, we treat the $20 per month exclusion as a $240 per year exclusion.

(c) We do not count as income the unearned income described in § 416.1124(b) and (c) of this chapter, except for paragraph (c)(13).

(d) We do not count as income any dividends or interest earned on resources you or your spouse owns.

[75 FR 81846, Dec. 29, 2010]

RESOURCES

§ 418.3401 What are resources?

For purposes of this subpart, resources are cash or other assets that an individual owns and could convert to cash to be used for his or her support and maintenance.

§ 418.3405 What types of resources do we count?

(a) We count liquid resources. Liquid resources are cash, financial accounts, and other financial instruments that can be converted to cash within 20 workdays, excluding certain non-workdays as explained in § 416.120(d) of this chapter. Examples of resources that are ordinarily liquid include: stocks,

bonds, mutual fund shares, promissory notes, mortgages, life insurance policies (for claims filed before January 1, 2010, and redeterminations that are effective before January 1, 2010), financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit), retirement accounts (such as individual retirement accounts or 401(k) accounts), revocable trusts, funds in an irrevocable trust if the trust beneficiary can direct the use of the funds, and similar items. We will presume that these types of resources can be converted to cash within 20 workdays and are countable as resources for subsidy determinations. However, if you establish that a particular resource cannot be converted to cash within 20 workdays, we will not count it as a resource.

(b) We count the equity value of real property as a resource regardless of whether it can be sold within 20 workdays. However, we do not count the home that is your principal place of residence and the land on which it is situated as a resource as defined in § 418.3425(a).

[70 FR 77675, Dec. 30, 2005, as amended at 75 FR 81846, Dec. 29, 2010]

§ 418.3410 Whose resources do we count?

(a) We count your resources. We count the resources of both you and your spouse regardless of whether one or both of you apply or are eligible for the subsidy if you are married and live with your spouse as of the month for which we determine your eligibility based on an application for a subsidy, as of the month for which we redetermine your eligibility for a subsidy as described in § 418.3125, or as of the month for which we determine your eligibility due to a change you reported as described in § 418.3120.

(b) We will determine your eligibility based on your resources alone if you are not married or if you are married but you are separated from your spouse at the time you apply for a subsidy or at the time we redetermine your eligibility for a subsidy as described in § 418.3125.

(c) If your subsidy is based on the resources of you and your spouse and we redetermine your subsidy as described in § 418.3120(b)(1), we will stop counting the resources of your spouse in the month following the month that we receive a report that your marriage ended due to death, divorce, or annulment; or a report that you and your spouse stopped living together.

(d) If your subsidy is based on the resources of you and your spouse, we will continue counting the resources of both you and your spouse if one of you is temporarily away from home as described in § 404.347 of this chapter.

§ 418.3415 How do we determine countable resources?

(a) *General rule.* Your countable resources are determined as of the first moment of the month for which we determine your eligibility based on your application for a subsidy or for which we redetermine your eligibility for a subsidy. A resource determination is based on what assets you (and your living-with spouse, if any) have, what their values are, and whether they are excluded as of the first moment of the month. We will use this amount as your countable resources at the point when we determine your eligibility for the subsidy unless you report to us that the value of your resources has changed as described in § 418.3120.

(b) *Equity value.* Resources, other than cash, are evaluated according to your (and your spouse's, if any) equity in the resources. For purposes of this subpart, the equity value of an item is defined as the price for which that item, minus any encumbrances, can reasonably be expected to sell on the open market in the particular geographic area involved.

(c) *Relationship of income to resources.* Cash you receive during a month is evaluated under the rules for counting income during the month of receipt. If you retain the cash until the first moment of the following month, the cash is countable as a resource unless it is otherwise excludable.

§ 418.3420 How are funds held in financial institution accounts counted?

(a) *Owner of the account.* Funds held in a financial institution account (including savings, checking, and time deposits also known as certificates of deposit) are considered your resources if you own the account and can use the funds for your support and maintenance. We determine whether you own the account and can use the funds by looking at how the account is held.

(b) *Individually-held account.* If you are designated as the sole owner by the account title and you can withdraw and use funds from that account for your support and maintenance, all of that account's funds are your resource regardless of the source. For as long as these conditions are met, we presume that you own 100 percent of the funds in the account. This presumption is not rebuttable.

(c) *Jointly-held account.* (1) If you are the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, we presume that all of the funds in the account belong to you. If more than one subsidy claimant or subsidy recipient are account holders, we presume that the funds in the account belong to those individuals in equal shares.

(2) If you disagree with the ownership presumption as described in paragraph (c)(1) of this section, you may rebut the presumption. Rebuttal is a procedure which permits you to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to you.

§ 418.3425 What resources do we exclude from counting?

In determining your resources (and the resources of your spouse, if any) the following items shall be excluded:

(a) *Your home.* For purposes of this exclusion, a home is any property in which you (and your spouse, if any) have an ownership interest and which serves as your principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located, and outbuildings;

(b) *Non-liquid resources, other than nonhome real property.* Non-liquid resources are resources that are not liquid resources as defined in § 418.3405. Irrevocable burial trusts and the irrevocable portion of prepaid burial contracts are considered non-liquid resources;

(c) Property of a trade or business which is essential to the means of self-support as provided in § 416.1222 of this chapter;

(d) Nonbusiness property which is essential to the means of self-support as provided in § 416.1224 of this chapter;

(e) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see § 416.1228 of this chapter);

(f) For claims filed on or after January 1, 2010, and redeterminations that are effective on or after January 1, 2010, life insurance owned by an individual (and spouse, if any);

(g) Restricted allotted Indian lands as provided in § 416.1234 of this chapter;

(h) Payments or benefits provided under a Federal statute where exclusion is required by such statute;

(i) Disaster relief assistance as provided in § 416.1237 of this chapter;

(j) Funds up to $1,500 for the individual and $1,500 for the spouse who lives with the individual if these funds are expected to be used for burial expenses of the individual and spouse;

(k) Burial spaces, as provided in § 416.1231(a) of this chapter;

(l) Title XVI or title II retroactive payments as provided in § 416.1233 of this chapter;

(m) Housing assistance as provided in § 416.1238 of this chapter;

(n) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in § 416.1235 of this chapter;

(o) Payments received as compensation incurred or losses suffered as a result of a crime, as provided in § 416.1229 of this chapter;

(p) Relocation assistance from a State or local government, as provided in § 416.1239 of this chapter;

(q) Dedicated financial institution accounts as provided in § 416.1247 of this chapter;

(r) A gift to, or for the benefit of, an individual who has not attained 18

years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code. The resource exclusion applies to any in-kind gift that is not converted to cash, or to a cash gift that does not exceed $2,000; and

(s) Funds received and conserved to pay for medical and/or social services as provided in § 416.1103 of this chapter.

[70 FR 77675, Dec. 30, 2005, as amended at 75 FR 81846, Dec. 29, 2010]

ADJUSTMENTS AND TERMINATIONS

§ 418.3501 What could cause us to increase or reduce your subsidy or terminate your subsidy eligibility?

(a) Certain changes in your circumstances could cause us to increase or reduce your subsidy or terminate your subsidy eligibility. These changes include (but are not limited to) changes to:

(1) Your income;

(2) Your spouse's income if you are married and living with your spouse;

(3) Your resources;

(4) Your spouse's resources if you are married and living with your spouse; and

(5) Your family size.

(b) We will periodically review your circumstances (as described in § 418.3125) to make sure you are still eligible for a subsidy and, if eligible, whether you should receive a full or partial subsidy.

(c) If you report that your circumstances have changed or we receive other notice of such a change after we determine that you are eligible, we will review your circumstances as described in § 418.3120 to determine if you are still eligible.

§ 418.3505 How would an increase, reduction or termination affect you?

(a) An *increase* in your subsidy means that you would be able to pay a lower premium to participate in the Medicare Part D prescription drug program. An increased subsidy may also result in a reduction in any deductible or copayments for which you are responsible.

(b) A *reduction* in your subsidy means that you would have to begin to pay a premium or a higher premium to participate in the Medicare Part D prescription drug program. You may also have to begin to pay a deductible and higher copayments or increase the amounts of these payments.

(c) A *termination* means that you would no longer be eligible for a subsidy under the Medicare Part D prescription drug program.

§ 418.3510 When would an increase, reduction or termination start?

We are required to give you a written notice of our proposed action before increasing, reducing, or terminating your subsidy. We will not give this advance notice where we have factual information confirming your death, such as through a report by your surviving spouse, a legal guardian, a close relative, or a landlord. The notice will tell you the first month that we plan to make the change. The notice will also give you appeal rights which are explained in detail in §§ 418.3601 through 418.3670. Your appeal rights for a reduction or termination will include the right to continue to receive your subsidy at the previously established level until there is a decision on your appeal request if your appeal is filed within 10 days after you receive our notice. You will not be required to pay back any subsidy you received while your appeal was pending.

§ 418.3515 How could you qualify for a subsidy again?

Unless you subsequently qualify as a deemed eligible person (per 42 CFR 423.773(c)), you must file a new application for a subsidy and meet all the requirements in § 418.3101.

DETERMINATIONS AND THE ADMINISTRATIVE REVIEW PROCESS

§ 418.3601 When do you have the right to administrative review?

You have the right to an administrative review of the initial determination we make about your eligibility and about your continuing eligibility for a subsidy and any other matter that gives you the right to further review as

discussed in § 418.3605. If you are married and living with your spouse and your spouse's eligibility for a subsidy may be adversely affected by our decision upon review, we will notify your spouse before our review and give him or her the opportunity to present additional information for us to consider.

§ 418.3605 What is an initial determination?

Initial determinations are the determinations we make that are subject to administrative and judicial review. The initial determination will state the relevant facts and will give the reasons for our conclusions. Examples of initial determinations that are subject to administrative and judicial review include but are not limited to:

(a) The initial calculation of your income and/or resources;

(b) The determination about whether or not you are eligible for a subsidy and if so, whether you receive a full or partial subsidy;

(c) The determination to reduce your subsidy; and

(d) The determination to terminate your subsidy.

§ 418.3610 Is there administrative or judicial review for administrative actions that are not initial determinations?

Administrative actions that are not initial determinations may be reviewed by us, but they are not subject to the administrative or judicial review process as provided by these sections. For example, changes in your prescription drug program or voluntary disenrollment in the Part D program are not initial determinations that are subject to the administrative review process.

§ 418.3615 Will we mail you a notice of the initial determination?

(a) We will mail a written notice of the initial determination to you at your last known address. Generally, we will not send a notice if your premium subsidy stops because of your death or if the initial determination is a redetermination that your eligibility for a subsidy and the amount of your subsidy has not changed.

(b) The written notice that we send will tell you:

(1) What our initial determination is;

(2) The reasons for our determination; and

(3) The effect of our determination on your right to further review.

(c) We will mail you a written notice before increasing, reducing, or terminating your subsidy. The notice will tell you the first month that we plan to make the change and give you appeal rights. Your appeal rights for a reduction or termination will include the right to continue to receive your subsidy at the previously established level until there is a decision on your appeal request if your appeal is filed within 10 days after you receive our notice.

§ 418.3620 What is the effect of an initial determination?

An initial determination is binding unless you request an appeal within the time period stated in § 418.3630(a) or we revise it as provided in § 418.3678.

§ 418.3625 What is the process for administrative review?

The process for administrative review of initial determinations is either a hearing conducted by telephone or a case review. We will provide you with a hearing by telephone when you appeal the initial determination made on your claim, unless you choose not to participate in a telephone hearing. If you choose not to participate in a telephone hearing, the review will consist of a case review. The hearing will be conducted by an individual who was not involved in making the initial determination. The individual who conducts the hearing will make the final decision after the hearing. If you are dissatisfied after we have made a final decision, you may file an action in Federal district court.

(a) *Notice scheduling the telephone hearing.* Once you request a telephone hearing, we will schedule the hearing and send you a notice of the date and time of the hearing at least 20 days before the hearing. The notice will contain a statement of the specific issues to be decided and tell you that you may designate a personal representative (as defined in 42 CFR 423.772) to represent you during the proceedings.

The notice will explain the opportunity and procedure for reviewing your file and for submitting additional evidence prior to the hearing. It also will provide a brief explanation of the proceedings, of the right and process to subpoena witnesses and documents, of the procedures for requesting a change in the time or date of your hearing, and of the procedure for requesting interpreter services.

(b) *Opportunity to review your file.* Prior to the telephone hearing, you will be able to review the information that was used to make an initial determination in your case. You can provide us with additional information you wish to have considered at the hearing.

(c) *Hearing waived, rescheduled, or missed.* If you decide you do not want a hearing by telephone or if you are not available at the time of the scheduled hearing, the decision in your case will be made by a case review. This means that the decision will be based on the information in your file and any additional information you provide. You may ask for a change in the time and date of the telephone hearing; this should be done at the earliest possible opportunity prior to the hearing. Your request must state your reason(s) for needing the change in time or date and state the new time and date you want the hearing to be held. We will change the time and date, but not necessarily to your preferred time or date, of the telephone hearing if you have good cause. If you miss the scheduled hearing and the decision in your case is decided by a case review, we will provide a hearing, at your written request, if we decide you had good cause for missing the scheduled hearing. Examples of good cause include, but are not limited to, the following:

(1) You have attempted to obtain a representative but need additional time;

(2) Your representative was appointed within 30 days of the scheduled hearing and needs additional time to prepare for the hearing;

(3) Your representative has a prior commitment to be in court or at another administrative hearing on the date scheduled for your hearing;

(4) A witness who will testify to facts material to your case would be unavailable to participate in the scheduled hearing and the evidence cannot be obtained any other way;

(5) You are unrepresented, and you are unable to respond to the notice of hearing because of any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) that you may have; or

(6) You did not receive notice of the hearing appointment.

(d) *Witnesses at hearing.* When we determine that it is reasonably necessary for the full presentation of a case, we may issue a subpoena to compel the production of certain evidence or testimony.

§ 418.3630 How do you request administrative review?

(a) *Time period for requesting review.* You must request administrative review within 60 days after the date you receive notice of the initial determination (or within the extended time period if we extend the time as provided in paragraph (c) of this section). You can request administrative review in person, by phone, fax, or mail. If you miss the time frame for requesting administrative review, you may ask us for more time to request a review. The process for requesting an extension is explained further in paragraph (c) of this section.

(b) *Where to file your request.* You can request administrative review by mailing or faxing a request or calling or visiting any Social Security office.

(c) *When we will extend the time period to request administrative review.* If you want a review of the initial determination but do not request one within 60 days after the date you receive notice of the initial determination, you may ask us for more time to request a review. Your request for an extension must explain why it was not filed within the stated time period. If you show us that you had good cause for missing the deadline, we will extend the time period. To determine whether good cause exists, we use the standards explained in § 418.3640.

§ 418.3635 Can anyone request administrative review on your behalf?

Your personal representative (as defined in 42 CFR 423.772) may request administrative review on your behalf. That person can send additional information to us on your behalf and participate in the hearing.

§ 418.3640 How do we determine if you had good cause for missing the deadline to request administrative review?

(a) In determining whether you have shown that you have good cause for missing a deadline to request review we consider:

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested a review.

(6) We gave you incorrect or incomplete information about when and how to request administrative review.

(7) You did not receive notice of the initial determination.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known the need to file timely, or which prevented you from filing timely.

§ 418.3645 Can you request that the decision-maker be disqualified?

The person designated to conduct your hearing will not conduct the hearing if he or she is prejudiced or partial with respect to any party or has any interest in the matter pending for decision. If you object to the person who will be conducting your hearing, you must notify us at your earliest opportunity. The Commissioner or the Commissioner's designee will decide whether to appoint another person to conduct your hearing.

§ 418.3650 How do we make our decision upon review?

After you request review of our initial determination, we will review the information that we considered in making the initial determination and any other information we receive. We will make our decision based on this information. The issues that we will review are the issues with which you disagree. We may consider other issues, but we will provide you with advance notice of these other issues as explained in § 418.3625. If you are dissatisfied with our final decision, you may file an action in Federal district court.

§ 418.3655 How will we notify you of our decision after our review?

We will mail a written notice of our decision on the issue(s) you appealed to you at your last known address. Generally, we will not send a notice if your subsidy stops because of your death. The written notice that we send will tell you:

(a) What our decision is;

(b) The reasons for our decision;

(c) The effect of our decision; and

(d) Your right to judicial review of the decision.

§ 418.3665 Can your request for a hearing or case review be dismissed?

We will dismiss your request for a hearing or case review under any of the following conditions:

(a) At any time before notice of the decision is mailed, you ask that your request for administrative review be withdrawn; or

(b) You failed to request administrative review timely and did not have good cause for missing the deadline for requesting review.

§ 418.3670 How will you be notified of the dismissal?

We will mail a written notice of the dismissal of your request for administrative review to you at your last known address. The dismissal is not subject to judicial review and is binding on you unless we vacate it. The decision-maker may vacate any dismissal of your request for administrative review if, within 60 days after the date you receive the dismissal notice, you request that the dismissal be vacated and show good cause why the request should not be dismissed. The decision-maker shall advise you in writing of any action he or she takes.

§ 418.3675 How does our decision affect you?

Our decision is binding unless you file an action in Federal district court seeking review of our final decision or we revise it as provided in § 418.3678. You may file an action in Federal district court within 60 days after the date you receive notice of the decision. You may request that the time for filing an action in Federal district court be extended. The request must be in writing and it must give the reasons why the action was not filed within the stated time period. The request must be filed with the decision-maker who issued the final decision in your case. If you show that you had good cause for missing the deadline, we will extend the deadline. We will use the standards in § 418.3640 to decide if you had good cause to miss the deadline.

§ 418.3678 What is the process for correcting Agency clerical errors?

If we become aware within 60 days of the date of our initial determination or our decision following a case review or telephone hearing, that a clerical error was made in determining whether or not you are eligible for a subsidy (either in whole or in part), we may issue a revised initial determination which would be effective back to the date you originally filed your application or the effective date of a subsidy changing event, provided you meet the requirements in § 418.3101. We may revise an initial determination or decision regardless of whether such revised determination or decision is favorable or unfavorable to you. If the revised determination or decision (which is a new initial determination) is not favorable to you, you will not be responsible for paying back any subsidy received prior to the revised determination or decision. We will mail you a notice of the revised determination which will explain to you that we have made a revised determination and that this determination replaces an earlier determination, how this determination affects your subsidy eligibility, and your right to request a hearing.

§ 418.3680 What happens if your case is remanded by a Federal court?

When a Federal court remands a case to the Commissioner for further consideration, the decision-maker (as described in § 418.3625) acting on behalf of the Commissioner, may make a decision. That component will follow the procedures in § 418.3625, unless we decide that we can make a decision that is fully favorable to you without another hearing. Any issues relating to your subsidy may be considered by the decision-maker whether or not they were raised in the administrative proceedings leading to the final decision in your case.

[70 FR 77675, Dec. 30, 2005, as amended at 75 FR 33169, June 11, 2010]

PART 422—ORGANIZATION AND PROCEDURES

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SOURCE: 32 FR 13653, Sept. 29, 1967, unless otherwise noted.

Subpart A—Organization and Functions of the Social Security Administration

AUTHORITY: Secs. 205, 218, 221, and 701–704 of the Social Security Act (42 U.S.C. 405, 418, 421, and 901–904).

§ 422.1 Organization and functions.

(a) *General.* A complete description of the organization and functions of the Social Security Administration (pursuant to 5 U.S.C. 552(a), as amended by Pub. L. 90–23, the Public Information Act) was published in the FEDERAL REGISTER of July 15, 1967 (32 FR 10458), and was subsequently revised on April 16, 1968 (33 FR 5828), and amended on July 18, 1968 (33 FR 10292). Further amendments to or revisions of the description will be published in the FEDERAL REGISTER when and if required by changes in the organization or functions of the Social Security Administration. Such description (referred to as the SSA Statement of Organization, Functions, and Delegations of Authority) is printed and kept up to date in the Social Security Administration Organizational Manual, a copy of which is maintained in each district office and branch office of the Social Security Administration and is available for inspection and copying.

(b) *Information included in description.* This description includes information about the organization and functions of each component of the Social Security Administration. It also includes a listing of all district offices and branch offices within the organization of the Bureau of District Office Operations, and a listing of field offices within the organization of the Bureau of Hearings and Appeals where the public may secure information, make submittals or requests, or obtain decisions.

[34 FR 435, Jan. 11, 1969, as amended at 62 FR 38456, July 18, 1997]

§ 422.5 District offices and branch offices.

There are over 700 social security district offices and branch offices located in the principal cities and other urban areas or towns of the United States. In addition, there are over 3,300 contact stations, located in population and

trading centers, which are visited on a regularly, recurring, preannounced basis. A schedule of these visits can be obtained from the nearest district office or branch office. The address of the nearest district office or branch office can be obtained from the local telephone directory or from the post office. Each district office and branch office has a list of all district offices and branch offices throughout the country and their addresses. The principal officer in each district office is the manager. The principal officer in each branch office is the officer-in-charge. Each district office and branch office also has a list of field offices of the Bureau of Hearings and Appeals and their addresses. The administrative hearing examiner is the principal officer in each field office. For procedures relating to claims see § 422.130, subpart J of part 404 of this chapter, and § 404.1520 of this chapter (the latter relating to disability determinations). For procedures on request for hearing by an Administrative Law Judge and review by the Appeals Council see subpart C of this part 422.

Subpart B—General Procedures

AUTHORITY: 42 U.S.C. 405, 432, 902(a)(5), 1320b–1, 1320b–13, and 1320e–3, and sec. 7213(a)(1)(A) of Pub. L. 108–458.

§ 422.101 Material included in this subpart.

This subpart describes the procedures relating to applications for and assignment of social security numbers, maintenance of earnings records of individuals by the Social Security Administration, requests for statements of earnings or for revision of earnings records, and general claims procedures, including filing of applications, submission of evidence, determinations, and reconsideration of initial determinations.

§ 422.103 Social security numbers.

(a) *General.* The Social Security Administration (SSA) maintains a record of the earnings reported for each individual assigned a social security number. The individual's name and social security number identify the record so that the wages or self-employment income reported for or by the individual can be properly posted to the individual's record. Additional procedures concerning social security numbers may be found in Internal Revenue Service, Department of the Treasury regulation 26 CFR 31.6011(b)–2.

(b) *Applying for a number*—(1) *Application.* An individual needing a Social Security number may apply for one by completing a prescribed application and submitting the required evidence. An individual outside the United States (U.S.) may apply for a Social Security number card at the Department of Veterans Affairs Regional Office, Manila, Philippines, at any U.S. Foreign Service post, or at a U.S. military post outside the United States. (See § 422.106 for special procedures for filing applications with other government agencies.) Additionally, a U.S. resident may apply for a Social Security number for a nonresident dependent when the number is necessary for U.S. tax purposes or some other valid reason, the evidence requirements of § 422.107 are met, and we determine that a personal interview with the dependent is not required.

(2) *Birth registration document.* We may enter into an agreement with officials of a State, including, for this purpose, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and New York City, to establish, as part of the official birth registration process, a procedure to assist us in assigning Social Security numbers to newborn children. Where an agreement is in effect, a parent, as part of the official birth registration process, need not complete a prescribed application and may request that we assign a Social Security number to the newborn child.

(3) *Immigration form.* We may enter into an agreement with the Department of State (DOS) and the Department of Homeland Security (DHS) to assist us by collecting enumeration data as part of the immigration process. Where an agreement is in effect, an alien need not complete a prescribed application and may request, through DOS or DHS, as part of the immigration process, that we assign a Social Security number and issue a Social Security number card to him or her. An

alien will request the assignment of a Social Security number through this process in the manner provided by DOS and DHS.

(c) *How numbers are assigned*—(1) *Application.* If you complete a prescribed application, we will require you to furnish evidence, as necessary, to assist us in establishing your age, U.S. citizenship or alien status, true identity, and previously assigned Social Security number(s), if any. (See § 422.107 for evidence requirements.) We may require you to undergo a personal interview before we assign a Social Security number. If you request evidence to show that you have filed a prescribed application for a Social Security number card, we may furnish you with a receipt or equivalent document. We will electronically screen the data from the prescribed application against our files. If we find that you have not been assigned a Social Security number previously, we will assign one to you and issue a Social Security number card. However, if we find that you have been assigned a Social Security number previously, we will issue a replacement Social Security number card.

(2) *Request on birth registration document.* Where a parent has requested a social security number for a newborn child as part of an official birth registration process described in paragraph (b)(2) of this section, the State vital statistics office will electronically transmit the request to SSA's central office in Baltimore, MD, along with the child's name, date and place of birth, sex, mother's maiden name, father's name (if shown on the birth registration), address of the mother, and birth certificate number. This birth registration information received by SSA from the State vital statistics office will be used to establish the age, identity, and U.S. citizenship of the newborn child. Using this information, SSA will assign a number to the child and send the social security number card to the child at the mother's address.

(3) *Request on immigration document.* Where an alien has requested a social security number as part of the immigration process described in paragraph (b)(3) of this section, Department of Homeland Security will electronically transmit to SSA's central office in Baltimore, MD, the data elements collected for immigration purposes, by both Department of Homeland Security and DOS, that SSA needs to assign the alien a social security number along with other data elements as agreed upon by SSA and DOS or Department of Homeland Security. The data elements received by SSA will be used to establish the age, identity, and lawful alien status or authority to work of the alien. Using this data, SSA will assign a social security number to the alien and send the social security number card to him/her at the address the alien provides to DOS or Department of Homeland Security (or to the sponsoring agency of a refugee, if no personal mailing address is available).

(d) *Social security number cards.* A person who is assigned a social security number will receive a social security number card from SSA within a reasonable time after the number has been assigned. (See § 422.104 regarding the assignment of social security number cards to aliens.) Social security number cards are the property of SSA and must be returned upon request.

(e) *Replacement of social security number card*— (1) *When we may issue you a replacement card.* We may issue you a replacement Social Security number card, subject to the limitations in paragraph (e)(2) of this section. You must complete a prescribed application to receive a replacement Social Security number card. We follow the evidence requirements in § 422.107 when we issue you a replacement Social Security number card.

(2) *Limits on the number of replacement cards.* There are limits on the number of replacement social security number cards we will issue to you. You may receive no more than three replacement social security number cards in a year and ten replacement social security number cards per lifetime. We may allow for reasonable exceptions to these limits on a case-by-case basis in compelling circumstances. We also will consider name changes (*i.e.*, verified legal changes to the first name and/or surname) and changes in alien status which result in a necessary change to a restrictive legend on the SSN card (see paragraph (e)(3) of this section) to be

compelling circumstances, and will not include either of these changes when determining the yearly or lifetime limits. We may grant an exception if you provide evidence establishing that you would experience significant hardship if the card were not issued. An example of significant hardship includes, but is not limited to, providing SSA with a referral letter from a governmental social services agency indicating that the social security number card must be shown in order to obtain benefits or services.

(3) *Restrictive legend change defined.* Based on a person's immigration status, a restrictive legend may appear on the face of an SSN card to indicate that work is either not authorized or that work may be performed only with Department of Homeland Security (DHS) authorization. This restrictive legend appears on the card above the individual's name and SSN. Individuals without work authorization in the U.S. receive SSN cards showing the restrictive legend, ''Not Valid for Employment;'' and SSN cards for those individuals who have temporary work authorization in the U.S. show the restrictive legend, ''Valid For Work Only With DHS Authorization.'' U.S. citizens and individuals who are permanent residents receive SSN cards without a restrictive legend. For the purpose of determining a change in restrictive legend, the individual must have a change in immigration status or citizenship which results in a change to or the removal of a restrictive legend when compared to the prior SSN card data. An SSN card request based upon a change in immigration status or citizenship which does not affect the restrictive legend will count toward the yearly and lifetime limits, as in the case of Permanent Resident Aliens who attain U.S. citizenship.

[55 FR 46664, Nov. 6, 1990, as amended at 63 FR 56554, Oct. 22, 1998; 69 FR 55076, Sept. 13, 2004; 70 FR 74651, Dec. 16, 2005; 71 FR 43056, July 31, 2006; 80 FR 47833, Aug. 10, 2015]

§ 422.104 Who can be assigned a social security number.

(a) *Persons eligible for SSN assignment.* We can assign you a social security number if you meet the evidence requirements in § 422.107 and you are:

(1) A United States citizen; or

(2) An alien lawfully admitted to the United States for permanent residence or under other authority of law permitting you to work in the United States (§ 422.105 describes how we determine if a nonimmigrant alien is permitted to work in the United States); or

(3) An alien who cannot provide evidence of alien status showing lawful admission to the U.S., or an alien with evidence of lawful admission but without authority to work in the U.S., if the evidence described in § 422.107(e) does not exist, but only for a valid nonwork reason. We consider you to have a valid nonwork reason if:

(i) You need a social security number to satisfy a Federal statute or regulation that requires you to have a social security number in order to receive a Federally-funded benefit to which you have otherwise established entitlement and you reside either in or outside the U.S.; or

(ii) You need a social security number to satisfy a State or local law that requires you to have a social security number in order to receive public assistance benefits to which you have otherwise established entitlement, and you are legally in the United States.

(b) *Annotation for a nonwork purpose.* If we assign you a social security number as an alien for a nonwork purpose, we will indicate in our records that you are not authorized to work. We will also mark your social security card with a legend such as ''NOT VALID FOR EMPLOYMENT.'' If earnings are reported to us on your number, we will inform the Department of Homeland Security of the reported earnings.

[68 FR 55308, Sept. 25, 2003]

§ 422.105 Presumption of authority of nonimmigrant alien to engage in employment.

(a) *General rule.* Except as provided in paragraph (b) of this section, if you are a nonimmigrant alien, we will presume that you have permission to engage in employment if you present a Form I–94 issued by the Department of Homeland Security that reflects a classification permitting work. (*See* 8 CFR 274a.12 for Form I–94 classifications.) If you have not been issued a Form I–94, or if your

Form I–94 does not reflect a classification permitting work, you must submit a current document authorized by the Department of Homeland Security that verifies authorization to work has been granted e.g., an employment authorization document, to enable SSA to issue an SSN card that is valid for work. (*See* 8 CFR 274a.12(c)(3).)

(b) *Exception to presumption for foreign academic students in immigration classification F–1.* If you are an F–1 student and do not have a separate DHS employment authorization document as described in paragraph (a) of this section *and* you are not authorized for curricular practical training (CPT) as shown on your Student and Exchange Visitor Information System (SEVIS) Form I–20, Certificate of Eligibility for Nonimmigrant (F–1) Student Status, we will not presume you have authority to engage in employment without additional evidence. Before we will assign an SSN to you that is valid for work, you must give us proof (as explained in § 422.107(e)(2)) that:

(1) You have authorization from your school to engage in employment, and

(2) You are engaging in, or have secured, employment.

[69 FR 55075, Sept. 13, 2004]

§ 422.106 Filing applications with other government agencies.

(a) *Agreements.* In carrying out its responsibilities to assign social security numbers, SSA enters into agreements with the United States Attorney General, other Federal officials, and State and local welfare agencies. An example of these agreements is discussed in paragraph (b) of this section.

(b) *States.* SSA and a State may enter into an agreement that authorizes employees of a State or one of its subdivisions to accept social security number card applications from some individuals who apply for or are receiving welfare benefits under a State-administered Federal program. Under such an agreement, a State employee is also authorized to certify the application to show that he or she has reviewed the required evidence of the applicant's age, identity, and U.S. citizenship. The employee is also authorized to obtain evidence to assist SSA in determining whether the applicant has previously been assigned a number. The employee will then send the application to SSA which will issue a social security number card.

[55 FR 46665, Nov. 6, 1990, as amended at 63 FR 56555, Oct. 22, 1998]

§ 422.107 Evidence requirements.

(a) *General.* To obtain an original Social Security number card, you must submit convincing evidence of your age, U.S. citizenship or alien status, and true identity, as described in paragraphs (b) through (e) of this section. If you apply for a replacement Social Security number card, you must submit convincing evidence of your true identity, as described in paragraph (c) of this section, and you may also be required to submit convincing evidence of your age and U.S. citizenship or alien status, as described in paragraphs (b), (d), and (e) of this section. If you apply for an original or replacement Social Security number card, you are also required to submit evidence to assist us in determining the existence and identity of any previously assigned Social Security number(s). We will not assign a Social Security number or issue an original or replacement card unless we determine that you meet all of the evidence requirements. We require an in-person interview if you are age 12 or older and are applying for an original Social Security number, unless you are an alien who requests a Social Security number as part of the immigration process described in § 422.103(b)(3). We may require an in-person interview of other applicants. All paper or other tangible documents submitted as evidence must be originals or copies of the original documents certified by the custodians of the original records and are subject to verification. We may also verify your eligibility factors, as described in paragraphs (b) through (e) of this section, through other means, including but not limited to data matches or other agreements with government agencies or other entities that we determine can provide us with appropriate and secure verification of your eligibility factors.

(b) *Evidence of age.* An applicant for an original social security number is required to submit convincing evidence of age. An applicant for a replacement

social security number card may also be required to submit evidence of age. Examples of the types of evidence which may be submitted are a birth certificate, a religious record showing age or date of birth, a hospital record of birth, or a passport. (*See* § 404.716.)

(c) *Evidence of identity.* (1) If you apply for an original Social Security number or a replacement Social Security number card, you are required to submit convincing evidence of your identity. Evidence of identity may consist of a driver's license, identification card, school record, medical record, marriage record, passport, Department of Homeland Security document, or other similar evidence serving to identify you. The evidence must contain sufficient information to identify you, including your name and:

(i) Your age, date of birth, or parents' names; or

(ii) Your photograph or physical description.

(2) A birth record is not sufficient evidence to establish identity for these purposes.

(d) *Evidence of U.S. citizenship.* Generally, an applicant for an original or replacement social security number card may prove that he or she is a U.S. citizen by birth by submitting a birth certificate or other evidence, as described in paragraphs (b) and (c) of this section, that shows a U.S. place of birth. Where a foreign-born applicant claims U.S. citizenship, the applicant for a social security number or a replacement social security number card is required to present documentary evidence of U.S. citizenship. If required evidence is not available, a social security number card will not be issued until satisfactory evidence of U.S. citizenship is furnished. Any of the following is generally acceptable evidence of U.S. citizenship for a foreign-born applicant:

(1) Certificate of naturalization;

(2) Certificate of citizenship;

(3) U.S. passport;

(4) U.S. citizen identification card issued by the Department of Homeland Security;

(5) Consular report of birth (State Department form FS–240 or FS–545); or

(6) Other verification from the Department of Homeland Security, U.S. Department of State, or Federal or State court records confirming citizenship.

(e) *Evidence of alien status*—(1) *General evidence rules.* When a person who is not a U.S. citizen applies for an original social security number or a replacement social security number card, he or she is required to submit, as evidence of alien status, a current document issued by the Department of Homeland Security in accordance with that agency's regulations. The document must show that the applicant has been lawfully admitted to the United States, either for permanent residence or under authority of law permitting him or her to work in the United States, or that the applicant's alien status has changed so that it is lawful for him or her to work. If the applicant fails to submit such a document, a social security number card will not be issued. If the applicant submits an unexpired Department of Homeland Security document(s) which shows current authorization to work, a social security number will be assigned or verified and a card which can be used for work will be issued. If the authorization of the applicant to work is temporary or subject to termination by the Department of Homeland Security, the SSA records may be so annotated. If the document(s) does not provide authorization to work and the applicant wants a social security number for a work purpose, no social security number will be assigned. If the applicant requests the number for a nonwork purpose and provides evidence documenting that the number is needed for a valid nonwork purpose, the number may be assigned and the card issued will be annotated with a nonwork legend. The SSA record will be annotated to show that a number has been assigned and a card issued for a nonwork purpose. In that case, if earnings are later reported to SSA, the Department of Homeland Security will be notified of the report. SSA may also notify that agency if earnings are reported for a social security number that was valid for work when assigned but for which work authorization expired or was later terminated by the Department of Homeland Security SSA may also annotate the record with other remarks, if appropriate.

(2) *Additional evidence rules for F–1 students*—(i) *Evidence from your designated school official.* If you are an F–1 student and do not have a separate DHS employment authorization document as described in §422.105(a) *and* you are not authorized for curricular practical training (CPT) as shown on your SEVIS Form I–20, Certificate of Eligibility for Nonimmigrant (F–1) Student Status, you must give us documentation from your designated school official that you are authorized to engage in employment. You must submit your SEVIS Form I–20, Certificate of Eligibility for Nonimmigrant (F–1) Student Status. You must also submit documentation from your designated school official that includes:

(A) The nature of the employment you are or will be engaged in, and

(B) The identification of the employer for whom you are or will be working.

(ii) *Evidence of your employment.* You must also provide us with documentation that you are engaging in, or have secured, employment; e.g., a statement from your employer.

(f) *Failure to submit evidence.* If the applicant does not comply with a request for the required evidence or other information within a reasonable time, SSA may attempt another contact with the applicant. If there is still no response, a social security number card will not be issued.

(g) *Inability to verify eligibility factors.* We will not issue an original or replacement Social Security number card when you present invalid or expired documents or when we are unable to verify the required evidence through other means, as described in paragraph (a) of this section. Invalid documents are either forged documents that supposedly were issued by the custodian of the record, or properly issued documents that were improperly changed after they were issued. An expired document is one that was valid for only a limited time and that time has passed.

[55 FR 46665, Nov. 6, 1990, as amended at 60 FR 32446, June 22, 1995; 62 FR 38456, July 18, 1997; 63 FR 56555, Oct. 22, 1998; 68 FR 55308, Sept. 25, 2003; 69 FR 55076, Sept. 13, 2004; 70 FR 74651, Dec. 16, 2005; 80 FR 47834, Aug. 10, 2015]

§ 422.108 Criminal penalties.

A person may be subject to criminal penalties for furnishing false information in connection with earnings records or for wrongful use or misrepresentation in connection with social security numbers, pursuant to section 208 of the Social Security Act and sections of title 18 U.S.C. (42 U.S.C. 408; 18 U.S.C. 1001 and 1546).

[39 FR 10242, Mar. 19, 1974]

§ 422.110 Individual's request for change in record.

(a) *Application.* If you wish to change the name or other personal identifying information you previously submitted in connection with an application for a Social Security number card, you must complete a prescribed application, except as provided in paragraph (b) of this section. You must prove your identity, and you may be required to provide other evidence. (See §422.107 for evidence requirements.) You may complete a request for change in records in the manner we designate, including at any Social Security office, or, if you are outside the U.S., to the Department of Veterans Affairs Regional Office, Manila, Philippines, or to any U.S. Foreign Service post or U.S. military post. If your request is for a change of name on the card (that is, verified legal changes to the first name or surname, or both), we may issue you a replacement Social Security number card bearing the same number and the new name. We will grant an exception to the limitations specified in §422.103(e)(2) for replacement Social Security number cards representing a change in name or, if you are an alien, a change to a restrictive legend shown on the card. (See §422.103(e)(3) for the definition of a change to a restrictive legend.)

(b) *Assisting in enumeration.* We may enter into an agreement with officials of the Department of State and the Department of Homeland Security to assist us by collecting, as part of the immigration process, information to change the name or other personal identifying information you previously submitted in connection with an application or request for a social security number card. If your request is to

change a name on the card (*i.e.*, verified legal changes to the first name and/or surname) or to correct the restrictive legend on the card to reflect a change in alien status, we may issue you a replacement card bearing the same number and the new name or legend. We will grant an exception from the limitations specified in § 422.103(e)(2) for replacement social security number cards representing a change of name or, if you are an alien, a change to a restrictive legend shown on the card. (See § 422.103(e)(3) for the definition of a change to a restrictive legend.)

[71 FR 43056, July 31, 2006, as amended at 80 FR 47834, Aug. 10, 2015]

§ 422.112 Employer identification numbers.

(a) *General.* Most employers are required by section 6109 of the Internal Revenue Code and by Internal Revenue Service (IRS) regulations at 26 CFR 31.6011(b)–1 to obtain an employer identification number (EIN) and to include it on wage reports filed with SSA. A sole proprietor who does not pay wages to one or more employees or who is not required to file any pension or excise tax return is not subject to this requirement. To apply for an EIN, employers file Form SS–4, ''Application for Employer Identification Number,'' with the IRS. For the convenience of employers, Form SS–4 is available at all SSA and IRS offices. Household employers, agricultural employers, and domestic corporations which elect social security coverage for employees of foreign subsidiaries who are citizens or residents of the U.S. may be assigned an EIN by IRS without filing an SS–4.

(b) *State and local governments.* When a State submits a modification to its agreement under section 218 of the Act, which extends coverage to periods prior to 1987, SSA will assign a special identification number to each political subdivision included in that modification. SSA will send the State a Form SSA–214–CD, ''Notice of Identifying Number,'' to inform the State of the special identification number(s). The special number will be used for reporting the pre-1987 wages to SSA. The special number will also be assigned to an interstate instrumentality if pre-1987 coverage is obtained and SSA will send a Form SSA–214–CD to the interstate instrumentality to notify it of the number assigned.

[60 FR 42433, Aug. 16, 1995, as amended at 64 FR 33016, June 21, 1999]

§ 422.114 Annual wage reporting process.

(a) *General.* Under the authority of section 232 of the Act, SSA and IRS have entered into an agreement that sets forth the manner by which SSA and IRS will ensure that the processing of employee wage reports is effective and efficient. Under this agreement, employers are instructed by IRS to file annual wage reports with SSA on paper Forms W-2, ''Wage and Tax Statement,'' and Forms W–3, ''Transmittal of Income and Tax Statements,'' or equivalent W-2 and W–3 magnetic media reports. Special versions of these forms for Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands are also filed with SSA. SSA processes all wage reporting forms for updating to SSA's earnings records and IRS tax records, identifies employer reporting errors and untimely filed forms for IRS penalty assessment action, and takes action to correct any reporting errors identified, except as provided in paragraph (c) of this section. SSA also processes Forms W–3c, ''Transmittal of Corrected Income Tax Statements,'' and W-2c, ''Statement of Corrected Income and Tax Amounts'' (and their magnetic media equivalents) that employers are required to file with SSA when certain previous reporting errors are discovered.

(b) *Magnetic media reporting requirements.* Under IRS regulations at 26 CFR 301.6011–2, employers who file 250 or more W-2 wage reports per year must file them on magnetic media in accordance with requirements provided in SSA publications, unless IRS grants the employer a waiver. Basic SSA requirements are set out in SSA's Technical Instruction Bulletin No. 4, ''Magnetic Media Reporting.'' Special filing requirements for U.S. territorial employers are set out in SSA Technical Instruction Bulletins No. 5 (Puerto Rico), No. 6 (Virgin Islands), and No. 7

(Guam and American Samoa). At the end of each year, SSA mails these technical instructions to employers (or third parties who file wage reports on their behalf) for their use in filing wage reports for that year.

(c) *Processing late and incorrect magnetic media wage transmittals.* If an employer's transmittal of magnetic media wage reports is received by SSA after the filing due date, SSA will notify IRS of the late filing so that IRS can decide whether to assess penalties for late filing, pursuant to section 6721 of the Internal Revenue Code. If reports do not meet SSA processing requirements (unprocessable reports) or are out of balance on critical money amounts, SSA will return them to the employer to correct and resubmit. In addition, beginning with wage reports filed for tax year 1993, if 90 percent or more of an employer's magnetic media wage reports have no social security numbers or incorrect employee names or social security numbers so that SSA is unable to credit their wages to its records, SSA will not attempt to correct the errors, but will instead return the reports to the employer to correct and resubmit (see also §422.120(b)). An employer must correct and resubmit incorrect and unprocessable magnetic media wage reports to SSA within 45 days from the date of the letter sent with the returned report. Upon request, SSA may grant the employer a 15-day extension of the 45-day period. If an employer does not submit corrected reports to SSA within the 45-day (or, if extended by SSA, 60-day) period, SSA will notify IRS of the late filing so that IRS can decide whether to assess a penalty. If an employer timely resubmits the reports as corrected magnetic media reports, but they are unprocessable or out of balance on W-2 money totals, SSA will return the resubmitted reports for the second and last time for the employer to correct and return to SSA. SSA will enclose with the resubmitted and returned forms a letter informing the employer that he or she must correct and return the reports to SSA within 45 days or be subject to IRS penalties for late filing.

(d) *Paper form reporting requirements.* The format and wage reporting instructions for paper forms are determined jointly by IRS and SSA. Basic instructions on how to complete the forms and file them with SSA are provided in IRS forms materials available to the public. In addition, SSA provides standards for employers (or third parties who file wage reports for them) to follow in producing completed reporting forms from computer software; these standards appear in SSA publication, ''Software Specifications and Edits for Annual Wage Reporting.'' Requests for this publication should be sent to: Social Security Administration, Office of Financial Policy and Operations, Attention: AWR Software Standards Project, P.O. Box 17195, Baltimore, MD 21235.

(e) *Processing late and incorrect paper form reports.* If SSA receives paper form wage reports after the due date, SSA will notify IRS of the late filing so that IRS can decide whether to assess penalties for late filing, pursuant to section 6721 of the Internal Revenue Code. SSA will ask an employer to provide replacement forms for illegible, incomplete, or clearly erroneous paper reporting forms, or will ask the employer to provide information necessary to process the reports without having to resubmit corrected forms. (For wage reports where earnings are reported without a social security number or with an incorrect name or social security number, see §422.120.) If an employer fails to provide legible, complete, and correct W-2 reports within 45 days, SSA may identify the employers to IRS for assessment of employer reporting penalties.

(f) *Reconciliation of wage reporting errors.* After SSA processes wage reports, it matches them with the information provided by employers to the IRS on Forms 941, ''Employer's Quarterly Federal Tax Return,'' for that tax year. Based upon this match, if the total social security or medicare wages reported to SSA for employees is less than the totals reported to IRS, SSA will write to the employer and request corrected reports or an explanation for the discrepancy. If the total social security or medicare wages reported to SSA for employees is more than the totals reported to IRS, IRS will resolve the difference with the employer. If the

employer fails to provide SSA with corrected reports or information that shows the wage reports filed with SSA are correct, SSA will ask IRS to investigate the employer's wage and tax reports to resolve the discrepancy and to assess any appropriate reporting penalties.

[60 FR 42433, Aug. 16, 1995]

§ 422.120 Earnings reported without a social security number or with an incorrect employee name or social security number.

(a) *Correcting an earnings report.* If an employer reports an employee's wages to SSA without the employee's social security number or with a different employee name or social security number than shown in SSA's records for him or her, SSA will write to the employee at the address shown on the wage report and request the missing or corrected information. If the wage report does not show the employee's address or shows an incomplete address, SSA will write to the employer and request the missing or corrected employee information. SSA notifies IRS of all wage reports filed without employee social security numbers so that IRS can decide whether to assess penalties for erroneous filing, pursuant to section 6721 of the Internal Revenue Code. If an individual reports self-employment income to IRS without a social security number or with a different name or social security number than shown in SSA's records, SSA will write to the individual and request the missing or corrected information. If the employer, employee, or self-employed individual does not provide the missing or corrected report information in response to SSA's request, the wages or self-employment income cannot be identified and credited to the proper individual's earnings records. In such cases, the information is maintained in a ''Suspense File'' of uncredited earnings. Subsequently, if identifying information is provided to SSA for an individual whose report is recorded in the Suspense File, the wages or self-employment income then may be credited to his or her earnings record.

(b) *Returning incorrect reports.* SSA may return to the filer, unprocessed, an employer's annual wage report submittal if 90 percent or more of the wage reports in that submittal are unidentified or incorrectly identified. In such instances, SSA will advise the filer to return corrected wage reports within 45 days to avoid any possible IRS penalty assessment for failing to file correct reports timely with SSA. (See also § 422.114(c).) Upon request, SSA may grant the employer a 15-day extension of the 45-day period.

[60 FR 42434, Aug. 16, 1995]

§ 422.122 Information on deferred vested pension benefits.

(a) *Claimants for benefits.* Each month, SSA checks the name and social security number of each new claimant for social security benefits or for hospital insurance coverage to see whether the claimant is listed in SSA's electronic pension benefit record. This record contains information received from IRS on individuals for whom private pension plan administrators have reported to IRS, as required by section 6057 of the Internal Revenue Code, as possibly having a right to future retirement benefits under the plan. SSA sends a notice to each new claimant for whom it has pension benefit information, as required by section 1131 of the Act. If the claimant filed for the lump-sum death payment on the social security account of a relative, SSA sends the claimant the pension information on the deceased individual. In either case, SSA sends the notice after it has made a decision on the claim for benefits. The notice shows the type, payment frequency, and amount of pension benefit, as well as the name and address of the plan administrator as reported to the IRS. This information can then be used by the claimant to claim any pension benefits still due from the pension plan.

(b) *Requesting deferred vested pension benefit information from SSA files.* Section 1131 of the Act also requires SSA to provide available pension benefit information on request. SSA will provide this pension benefit information only to the individual who has the pension coverage (or a legal guardian or parent, in the case of a minor, on the individual's behalf). However, if the individual is deceased, the information may be

provided to someone who would be eligible for any underpayment of benefits that might be due the individual under section 204(d) of the Act. All requests for such information must be in writing and should contain the following information: the individual's name, social security number, date of birth, and any information the requestor may have concerning the name of the pension plan involved and the month and year coverage under the plan ended; the name and address of the person to whom the information is to be sent; and the requester's signature under the following statement: ''I am the individual to whom the information applies (or ''I am related to the individual as his or her _____''). I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.'' Such requests should be sent to: Social Security Administration, Office of Central Records Operations, P.O. Box 17055, Baltimore, Maryland 21235.

[60 FR 42434, Aug. 16, 1995]

§ 422.125 Statements of earnings; resolving earnings discrepancies.

(a) *Obtaining a statement of earnings and estimated benefits.* An individual may obtain a statement of the earnings on his earnings record and an estimate of social security benefits potentially payable on his record either by writing, calling, or visiting any social security office, or by waiting until we send him one under the procedure described in § 404.812 of this chapter. An individual may request this statement by completing the proper form or by otherwise providing the information the Social Security Administration requires, as explained in § 404.810(b) of this chapter.

(b) *Statement of earnings and estimated benefits.* Upon receipt of such a request or as required by section 1143(c) of the Social Security Act, the Social Security Administration will provide the individual, without charge, a statement of earnings and benefit estimates or an earnings statement. See §§ 404.811 through 404.812 of this chapter concerning the information contained in these statements.

(c) *Detailed earnings statements.* A more detailed earnings statement will be furnished upon request, generally without charge, where the request is program related under § 402.170 of this part. If the request for a more detailed statement is not program related under § 402.170 of this part, a charge will be imposed according to the guidelines set out in § 402.175 of this part.

(d) *Request for revision of earnings records.* If an individual disagrees with a statement of earnings credited to his social security account, he may request a revision by writing to the Bureau of Data Processing and Accounts, Social Security Administration, Baltimore, MD 21235, or by calling at or writing to any social security district office or branch office or, if the individual is in the Philippines, by calling at or writing to the Veterans' Administration Regional Office, Manila, Philippines. Upon receipt of a request for revision, the Social Security Administration will initiate an investigation of the individual's record of earnings. Form OAR–7008, ''Statement of Employment for Wages and Self-Employment,'' is used by the Social Security Administration for obtaining information from the individual requesting a revision to aid the Administration in the investigation. These forms are available at any of the sources listed in this paragraph. If an individual receives a Form OAR–7008 from the Bureau of Data Processing and Accounts, the completed form should be returned to that office. In the course of the investigation the district office or branch office, where appropriate, contacts the employer and the employee or the self-employed individual, whichever is applicable, for the purpose of obtaining the information and evidence necessary to reconcile any discrepancy between the allegations of the individual and the records of the Administration. See subpart I of part 404 of this chapter for requirements for filing requests for revision, and for limitation on the revision of records of earnings.

(e) *Notice to individual of determination.* After the investigation has been completed and a determination affecting the individual's earnings record has been made, the Social Security Administration will notify the individual in writing of the status of his earnings record and inform him at the same

time of the determination made in his case and of his right to a reconsideration if he is dissatisfied with such determination (see § 422.140).

(f) *Notice to individual of adverse adjustment of his account.* Written notice is given to an individual or his survivor in any case where the Social Security Administration adversely adjusts the individual's self-employment income. Where, subsequent to the issuance of a statement of earnings to an individual, an adverse adjustment is made of an amount of wages included in the statement, written notice of the adverse adjustment is given to the individual or his survivor. Written notice of the adverse adjustment is also given to the survivor if the statement of earnings had been given to such survivor. The individual or his survivor is requested to notify the Social Security Administration promptly if he disagrees, and he is informed that the adjustment will become final unless he notifies the Administration of his disagreement (if any) within 6 months from the date of the letter, or within 3 years, 3 months, and 15 days after the year to which the adjustment relates, whichever is later.

[32 FR 13653, Sept. 29, 1967, as amended at 35 FR 7891, May 22, 1970; 35 FR 8426, May 29, 1970; 39 FR 26721, July 23, 1974; 41 FR 50998, Nov. 19, 1976; 50 FR 28568, July 15, 1985; 57 FR 54919, Nov. 23, 1992; 61 FR 18078, Apr. 24, 1996; 65 FR 16816, Mar. 30, 2000]

§ 422.130 Claim procedure.

(a) *General.* The Social Security Administration provides facilities for the public to file claims and to obtain assistance in completing them. An appropriate application form and related forms for use in filing a claim for monthly benefits, the establishment of a period of disability, a lump-sum death payment, or entitlement to hospital insurance benefits or supplementary medical insurance benefits can be obtained from any district office, branch office, contact station, or resident station of the Social Security Administration, from the Division of Foreign Claims, Post Office Box 1756, Baltimore, MD 21203, or from the Veteran's Administration Regional Office, Manila, Philippines. See § 404.614 of this chapter for offices at which applications may be filed. See 42 CFR part 405, subpart A, for conditions of entitlement to hospital insurance benefits and 42 CFR part 405, subpart B, for information relating to enrollment under the supplementary medical insurance benefits program.

(b) *Submission of evidence.* An individual who files an application for monthly benefits, the establishment of a period of disability, a lump-sum death payment, or entitlement to hospital insurance benefits or supplementary medical insurance benefits, either on his own behalf or on behalf of another, must establish by satisfactory evidence the material allegations in his application, except as to earnings shown in the Social Security Administration's records (*see* subpart H of part 404 of this chapter for evidence requirements in nondisability cases and subpart P of part 404 of this chapter for evidence requirements in disability cases). Instructions, report forms, and forms for the various proofs necessary are available to the public in district offices, branch offices, contact stations, and resident stations of the Social Security Administration, and the Veteran's Administration Regional Office, Manila, Philippines. These offices assist individuals in preparing their applications and in obtaining the proofs required in support of their applications.

(c) *Determinations and notice to individuals.* In the case of an application for benefits, the establishment of a period of disability, a lump-sum death payment, a recomputation of a primary insurance amount, or entitlement to hospital insurance benefits or supplementary medical insurance benefits, after obtaining the necessary evidence, we will determine, based on the preponderance of the evidence (see §§ 404.901 and 416.1401 of this chapter) as to the entitlement of the individual claiming or for whom is claimed such benefits, and will notify the applicant of the determination and of his right to appeal. Section 404.1503 of this chapter has a discussion of the respective roles of State agencies and the Administration in the making of disability determinations and information regarding initial determinations as to entitlement or termination of entitlement in disability claims. See section 1869(a) of

the Social Security Act for determinations under the health insurance for the aged program and sections 1816 and 1842 of the Act for the role of intermediaries, carriers, and State agencies in performing certain functions under such program, e.g., payment of claims pursuant to an agreement with the Social Security Administration.

[32 FR 13653, Sept. 29, 1967, as amended at 44 FR 34942, June 18, 1979; 65 FR 16816, Mar. 30, 2000; 71 FR 16461, Mar. 31, 2006; 73 FR 76945, Dec. 18, 2008; 76 FR 24812, May 3, 2011]

§ 422.135 Reports by beneficiaries.

(a) A recipient of monthly benefits and a person for whom a period of disability has been established are obligated to report to the Social Security Administration the occurrence of certain events which may suspend or terminate benefits or which may cause a cessation of a period of disability. (See §§ 404.415 *et seq.* and 404.1571 of this chapter.)

(b) A person who files an application for benefits receives oral and written instructions about events which may cause a suspension or termination, and also appropriate forms and instruction cards for reporting such events. Pursuant to section 203(h)(1)(A) of the Act, under certain conditions a beneficiary must, within 3 months and 15 days after the close of a taxable year, submit to the Social Security Administration and annual report of his earnings and of any substantial services in self-employment performed during such taxable year. The purpose of the annual report is to furnish the Social Security Administration with information for making final adjustments in the payment of benefits for that year. An individual may also be requested to submit other reports to the Social Security Administration from time to time.

[32 FR 13653, Sept. 29, 1967, as amended at 65 FR 16816, Mar. 30, 2000]

§ 422.140 Reconsideration of initial determination.

If you are dissatisfied with an initial determination with respect to entitlement to monthly benefits, a lump-sum death payment, a period of disability, a revision of an earnings record, with respect to any other right under title II of the Social Security Act, or with respect to entitlement to hospital insurance benefits or supplementary medical insurance benefits, you may request that we reconsider the initial determination. The information in § 404.1503 of this chapter as to the respective roles of State agencies and the Social Security Administration in making disability determinations is also generally applicable to the reconsideration of initial determinations involving disability. However, in cases in which a disability hearing as described in §§ 404.914 through 404.918 and §§ 416.1414 through 416.1418 of this chapter is available, the reconsidered determination may be issued by a disability hearing officer or the Associate Commissioner for Disability Programs or his or her delegate. After the initial determination has been reconsidered, we will mail you written notice and inform you of your right to a hearing before an administrative law judge (*see* § 422.201).

[76 FR 24812, May 3, 2011]

§ 422.150 Guidelines for establishing and maintaining an information exchange with payroll data providers.

(a) *Guidelines for establishing an information exchange with payroll data providers.* In establishing an information exchange under section 1184 of the Social Security Act, we will do the following:

(1) Identify the payroll data providers (as defined in §§ 404.702 and 416.702 of this chapter) that may be interested in participating in an information exchange with us.

(2) Review the payroll data providers and consider factors such as: whether a payroll data provider is able and willing to engage in an information exchange; what data the payroll data provider could provide; whether the data from the payroll data provider is sufficiently accurate, complete, and up to date; and any conditions and limitations associated with our receipt of the data.

(3) Consistent with applicable law and regulations, establish an information exchange with the selected payroll data provider. The arrangement between us and the selected payroll data provider will describe:

(i) The records that will be matched;

(ii) The procedures for the match;

(iii) Any requirements established related to accuracy, completeness, and up-to-date records;

(iv) The procedures for ensuring the administrative, technical, and physical security of the records matched; and

(v) Such other provisions as are necessary.

(4) Prior to receiving payroll data provider information, publish a notice in the FEDERAL REGISTER that describes the information exchange and the extent to which the information received through such exchange is:

(i) Relevant and necessary to:

(A) Accurately determine initial and ongoing entitlement to, and the amount of, disability benefits under title II of the Social Security Act;

(B) Accurately determine eligibility for, and the amount of, benefits under the Supplemental Security Income program under title XVI of the Social Security Act; and

(C) Prevent improper payments of such benefits; and

(ii) Sufficiently accurate, up to date, and complete.

(b) *Guidelines for maintaining an information exchange with payroll data providers.* We will perform the following activities while we maintain an established information exchange with a payroll data provider described in paragraph (a) of this section:

(1) Periodically assess whether the data we receive under the information exchange continues to be accurate, complete, and up to date; and

(2) Monitor compliance with the requirements of the information exchange described in paragraph (a)(3) of this section.

[89 FR 107261, Dec. 31, 2024]

Subpart C—Hearings, Appeals Council Review, and Judicial Review Procedures

AUTHORITY: Secs. 205, 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405, 421, and 902(a)(5)); 30 U.S.C. 923(b).

§ 422.201 Material included in this subpart.

This subpart describes in general the procedures relating to hearings, review by the Appeals Council of the hearing decision or dismissal, and court review in cases decided under the procedures in parts 404, 408, 410, and 416 of this chapter. It also describes the procedures for requesting a hearing or Appeals Council review, and for instituting a civil action for court review of cases decided under these parts. For detailed provisions relating to hearings, review by the Appeals Council, and court review, see the following references as appropriate to the matter involved:

(a) Title II of the Act, §§ 404.929 through 404.983 of this chapter;

(b) Title VIII of the Act, §§ 408.1040 through 408.1060 of this chapter;

(c) Title XVI of the Act, §§ 416.1429 through 416.1483 of this chapter;

(d) Part B of title IV of the Federal Mine Safety and Health Act of 1977 as amended, §§ 410.630 through 410.670.

[41 FR 53791, Dec. 9, 1976, as amended at 44 FR 34942, June 18, 1979; 54 FR 4268, Jan. 30, 1989; 71 FR 16462, Mar. 31, 2006; 76 FR 24812, May 3, 2011; 85 FR 73161, Nov. 16, 2020]

§ 422.203 Hearings.

(a) *Right to request a hearing.* (1) After a reconsidered or a revised determination (i) of a claim for benefits or any other right under title II of the Social Security Act; or (ii) of eligibility or amount of benefits or any other matter under title XVI of the Act, except where an initial or reconsidered determination involving an adverse action is revised, after such revised determination has been reconsidered; or (iii) as to entitlement under part A or part B of title XVIII of the Act, or as to the amount of benefits under part A of such title XVIII (where the amount in controversy is $100 or more); or of health services to be provided by a health maintenance organization without additional costs (where the amount in controversy is $100 or more); or as to the amount of benefits under part B of title XVIII (where the amount in controversy is $500 or more); or as to a determination by a peer review organization (PRO) under title XI (where the amount in controversy is $200 or more);

or as to certain determinations made under section 1154, 1842(1), 1866(f)(2), or 1879 of the Act; any party to such a determination may, pursuant to the applicable section of the Act, file a written request for a hearing on the determination. After a reconsidered determination of a claim for benefits under part B of title IV (Black Lung benefits) of the Federal Mine Safety and Health Act of 1977 (30 U.S.C. 921 through 925), a party to the determination may file a written request for hearing on the determination.

(2) After (i) a reconsidered or revised determination that an institution, facility, agency, or clinic does not qualify as a provider of services, or (ii) a determination terminating an agreement with a provider of services, such institution, facility, agency, or clinic may, pursuant to section 1866 of the Act, file a written request for a hearing on the determination.

(3) After (i) a reconsidered or revised determination that an independent laboratory, supplier of portable X-ray services, or end-stage renal disease treatment facility or other person does not meet the conditions for coverage of its services or (ii) a determination that it no longer meets such conditions has been made, such laboratory, supplier, treatment facility may, under 42 CFR 498.40 of this chapter, file a written request for a hearing on the determination. (For hearing rights of independent laboratories, suppliers of portable X-ray services, and end-stage renal disease treatment facilities and other person see 42 CFR 498.5.)

(b) *Request for a hearing.* (1) A request for a hearing under paragraph (a) of this section may be made using the form(s) we designate for this purpose, or by any other writing requesting a hearing. The request shall be filed either electronically in the manner we prescribe or at an office of the Social Security Administration, usually a district office or a branch office, or at the Veterans' Administration Regional Office in the Philippines (except in title XVI cases), or at a hearing office of the Office of Hearings Operations, or with the Appeals Council. A qualified railroad retirement beneficiary may choose to file a request for a hearing under part A of title XVIII with the Railroad Retirement Board.

(2) Unless an extension of time has been granted for good cause shown, a request for a hearing must be filed within 60 days after the receipt of the notice of the reconsidered or revised determination, or after an initial determination described in 42 CFR 498.3(b) and (c) (see §§ 404.933, 410.631, and 416.1433 of this chapter and 42 CFR 405.722, 498.40, and 417.260.)

(c) *Hearing decision or other action.* Generally, the administrative law judge, or an administrative appeals judge under § 404.956 or § 416.1456 of this chapter, will either decide the case after hearing (unless hearing is waived) or, if appropriate, dismiss the request for a hearing. With respect to a hearing on a determination under paragraph (a)(1) of this section, the administrative law judge may certify the case with a recommended decision to the Appeals Council for decision. The administrative law judge, or an attorney advisor under § 404.942 or § 416.1442 of this chapter, or an administrative appeals judge under § 404.956 or § 416.1456 of this chapter, must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record.

[41 FR 53791, Dec. 9, 1976, as amended at 44 FR 34942, June 18, 1979; 51 FR 308, Jan. 3, 1986; 54 FR 4268, Jan. 30, 1989; 73 FR 76945, Dec. 18, 2008; 85 FR 73161, Nov. 16, 2020]

§ 422.205 Proceedings before the Appeals Council.

(a) *Administrative Appeals Judge hearing decisions.* Administrative Appeals Judge decisions and dismissals issued on hearing requests removed under §§ 404.956 and 416.1456 of this chapter and decisions and dismissals described in § 422.203(c) require the signature of one Administrative Appeals Judge. Requests for review of hearing decisions issued by an Administrative Appeals Judge may be filed pursuant to §§ 404.968 and 416.1468 of this chapter and paragraph (b) of this section.

(b) *Appeals Council review.* Any party to a hearing decision or dismissal may request a review of such action by the Appeals Council. This request may be made on Form HA–520, Request for Review of Hearing Decision/Order, or by

any other writing specifically requesting review. Form HA–520 may be obtained from any Social Security district office or branch office, or at any other office where a request for a hearing may be filed. (For time and place of filing, see §§ 404.968 and 416.1468 of this chapter.)

(c) *Review of a hearing decision, dismissal, or denial.* The denial of a request for review of a hearing decision concerning a determination under § 422.203(a)(1) shall be by such appeals officer or appeals officers or by such member or members of the Appeals Council as may be designated in the manner prescribed by the Chair or Deputy Chair. The denial of a request for review of a hearing dismissal, the dismissal of a request for review, the denial of a request for review of a hearing decision whenever such hearing decision after such denial would not be subject to judicial review as explained in § 422.210(a), or the refusal of a request to reopen a hearing or Appeals Council decision concerning a determination under § 422.203(a)(1) shall be by such member or members of the Appeals Council as may be designated in the manner prescribed by the Chair or Deputy Chair.

(d) *Appeals Council review panel.* Whenever the Appeals Council reviews a hearing decision under §§ 404.967, 404.969, 416.1467, or 416.1469 of this chapter and the claimant does not appear personally or through representation before the Appeals Council to present oral argument, such review will be conducted by a panel of not less than two members of the Appeals Council designated in the manner prescribed by the Chair or Deputy Chair of the Appeals Council. In the event of disagreement between a panel composed of only two members, the Chair or Deputy Chair, or his or her delegate, who must be a member of the Appeals Council, shall participate as a third member of the panel. When the claimant appears in person or through representation before the Appeals Council in the location designated by the Appeals Council, the review will be conducted by a panel of not less than three members of the Appeals Council designated in the manner prescribed by the Chair or Deputy Chair. Concurrence of a majority of a panel shall constitute the decision of the Appeals Council unless the case is considered as provided under paragraph (e) of this section.

(e) *Appeals Council meetings.* On call of the Chair, the Appeals Council may meet en banc or a representative body of Appeals Council members may be convened to consider any case arising under paragraph (c) or (d) of this section. Such representative body shall be comprised of a panel of not less than five members designated by the Chair as deemed appropriate for the matter to be considered. The Chair or Deputy Chair shall preside, or in his or her absence, the Chair shall designate a member of the Appeals Council to preside. A majority vote of the designated panel, or of the members present and voting, shall constitute the decision of the Appeals Council.

(f) *Temporary assignments of ALJs.* The Chair may designate an administrative law judge to serve as a member of the Appeals Council for temporary assignments. An administrative law judge shall not be designated to serve as a member on any panel where such panel is conducting review on a case in which such individual has been previously involved.

[85 FR 73161, Nov. 16, 2020]

§ 422.210 Judicial review.

(a) *General.* A claimant may obtain judicial review of a decision by an administrative law judge or administrative appeals judge if the Appeals Council has denied the claimant's request for review, or of a decision by the Appeals Council when that is the final decision of the Commissioner. A claimant may also obtain judicial review of a reconsidered determination, or of a decision of an administrative law judge or an administrative appeals judge, where, under the expedited appeals procedure, further administrative review is waived by agreement under § 404.926 or § 416.1426 of this chapter or as appropriate. There are no amount-in-controversy limitations on these rights of appeal.

(b) *Court in which to institute civil action.* Any civil action described in paragraph (a) of this section must be instituted in the district court of the United States for the judicial district

in which the claimant resides or where such individual or institution or agency has his principal place of business. If the individual does not reside within any such judicial district, or if such individual or institution or agency does not have his principal place of business within any such judicial district, the civil action must be instituted in the District Court of the United States for the District of Columbia.

(c) *Time for instituting civil action.* Any civil action described in paragraph (a) of this section must be instituted within 60 days after the Appeals Council's notice of denial of request for review of the administrative law judge's decision or notice of the decision by the Appeals Council is received by the individual, institution, or agency, except that this time may be extended by the Appeals Council upon a showing of good cause. For purposes of this section, the date of receipt of notice of denial of request for review of the presiding officer's decision or notice of the decision by the Appeals Council shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary. Where pursuant to the expedited appeals procedures an agreement has been entered into under 42 CFR 405.718c, a civil action under section 205(g) of the Act must be commenced within 60 days from the date of the signing of such agreement by, or on behalf of, the Commissioner, except where the time described in the first sentence of this paragraph (c) has been extended by the Commissioner upon a showing of good cause. Where pursuant to the expedited appeals procedures an agreement has been entered into under § 404.926, § 410.629d, or § 416.1426 of this chapter, a civil action under section 205(g) of the Act must be commenced within 60 days after the date the individual receives notice (a signed copy of the agreement will be mailed to the individual and will constitute notice) of the signing of such agreement by, or on behalf of, the Commissioner, except where the time described in this paragraph (c) has been extended by the Commissioner upon a showing of good cause.

(d) *Proper defendant.* Where any civil action described in paragraph (a) of this section is instituted, the person holding the Office of the Commissioner shall, in his official capacity, be the proper defendant. Any such civil action properly instituted shall survive notwithstanding any change of the person holding the Office of the Commissioner or any vacancy in such office. If the complaint is erroneously filed against the United States or against any agency, officer, or employee of the United States other than the Commissioner, the plaintiff will be notified that he has named an incorrect defendant and will be granted 60 days from the date of receipt of such notice in which to commence the action against the correct defendant, the Commissioner.

(e) *Appeals Council review panel after Federal court remand.* When the Appeals Council holds a hearing under § 404.983 or § 416.1483 of this chapter, such hearing will be conducted and a decision will be issued by a panel of not less than two members of the Appeals Council designated in the manner prescribed by the Chair or Deputy Chair of the Appeals Council. When the Appeals Council issues a decision under §§ 404.983 and 416.1483 of this chapter without holding a hearing, a decision will be issued by a panel of not less than two members of the Council designated in the same manner prescribed by the Chair or Deputy Chair of the Council. In the event of disagreement between a panel composed of only two members, the Chair or Deputy Chair, or his or her delegate, who must be a member of the Council, shall participate as a third member of the panel.

[41 FR 53792, Dec. 9, 1976, as amended at 44 FR 34942, June 18, 1979; 49 FR 46370, Nov. 26, 1984; 49 FR 48036, Dec. 10, 1984; 54 FR 4268, Jan. 30, 1989; 62 FR 38456, July 18, 1997; 85 FR 73162, Nov. 16, 2020]

Subpart D—Claims Collection

AUTHORITY: Secs. 204(f), 205(a), 702(a)(5), and 1631(b) of the Social Security Act (42 U.S.C. 404(f), 405(a), 902(a)(5), and 1383(b)); 5 U.S.C. 5514; 31 U.S.C. 3711(e); 31 U.S.C. 3716.

SOURCE: 62 FR 64278, Dec. 5, 1997, unless otherwise noted.

§ 422.301 Scope of this subpart.

(a) Except as provided in paragraphs (b) and (c) of this section, this subpart

describes the procedures relating to collection of:

(1) Overdue administrative debts, and

(2) Overdue program overpayments described in §§ 404.527 and 416.590 of this chapter.

(b) This subpart does not apply to administrative debts owed by employees of the Social Security Administration, including, but not limited to, overpayment of pay and allowances.

(c) The following exceptions apply only to Federal salary offset as described in § 422.310(a)(1).

(1) We will not use this subpart to collect a debt while the debtor's disability benefits are stopped during the reentitlement period, under § 404.1592a(a)(2) of this chapter, because the debtor is engaging in substantial gainful activity.

(2) We will not use this subpart to collect a debt while the debtor's Medicare entitlement is continued because the debtor is deemed to be entitled to disability benefits under section 226(b) of the Social Security Act (42 U.S.C. 426(b)).

(3) We will not use this subpart to collect a debt if the debtor has decided to participate in the Ticket to Work and Self-Sufficiency Program and the debtor's ticket is in use as described in §§ 411.170 through 411.225 of this chapter.

[71 FR 38070, July 5, 2006]

§ 422.303 Interest, late payment penalties, and administrative costs of collection.

We may charge the debtor with interest, late payment penalties, and our costs of collection on delinquent debts covered by this subpart when authorized by our regulations issued in accordance with the Federal Claims Collection Standards (31 CFR 901.9).

[71 FR 38070, July 5, 2006]

§ 422.305 Report of overdue program overpayment debts to consumer reporting agencies.

(a) *Debts we will report.* We will report to consumer reporting agencies all overdue program overpayment debts over $25.

(b) *Notice to debtor.* Before we report any such debt to a consumer reporting agency, we will send the debtor written notice of the following:

(1) We have determined that payment of the debt is overdue;

(2) We will refer the debt to a consumer reporting agency at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60-day period, the debtor pays the full amount of the debt or takes either of the actions described in paragraphs (b)(6) or (b)(7) of this section;

(3) The specific information we will provide to the consumer reporting agency, including information that identifies the debtor (e.g., name, address, and social security number) and the amount, status, and history of the debt;

(4) The debtor has the right to a complete explanation of the debt;

(5) The debtor may dispute the accuracy of the information to be provided to the consumer reporting agency;

(6) The debtor may request a review of the debt by giving us evidence showing that he or she does not owe all or part of the amount of the debt or that we do not have the right to collect it; and

(7) The debtor may request an installment payment plan.

(c) *Disputing the information that we would send to consumer reporting agencies.* If a debtor believes that the information we propose to send to consumer reporting agencies is incorrect, the debtor may ask us to correct such information. If, within 60 calendar days from the date of our notice described in paragraph (b) of this section, the debtor notifies us that any information to be sent to consumer reporting agencies is incorrect, we will not send the information to consumer reporting agencies until we determine the correct information.

[62 FR 64278, Dec. 5, 1997, as amended at 66 FR 67081, Dec. 28, 2001]

§ 422.306 Report of overdue administrative debts to credit reporting agencies.

(a) *Debts we will report.* We will report to credit reporting agencies all overdue administrative debts over $25. Some examples of administrative debts are as

follows: debts for civil monetary penalties imposed under section 1140(b) of the Act, debts for unpaid fees for reimbursable services performed by SSA (e.g., disclosures of information), and contractor debts.

(b) *Notice to debtor.* Before we report any administrative debt to a credit reporting agency, we will send the debtor written notice of the following:

(1) We have determined that payment of the debt is overdue;

(2) We will refer the debt to a credit reporting agency at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60-day period, the debtor pays the full amount of the debt or takes either of the actions described in paragraphs (b)(6) or (b)(7) of this section;

(3) The specific information we will provide to the credit reporting agency, including information that identifies the debtor (e.g., name, address, social security number, and employer identification number) and the amount, status, and history of the debt;

(4) The debtor has the right to a complete explanation of the debt;

(5) The debtor may dispute the accuracy of the information to be provided to the credit reporting agency;

(6) The debtor may request a review of the debt by giving us evidence showing that he or she does not owe all or part of the amount of the debt or that we do not have the right to collect it; and

(7) The debtor may request an installment payment plan.

[62 FR 64278, Dec. 5, 1997, as amended at 71 FR 38070, July 5, 2006]

§ 422.310 Collection of overdue debts by administrative offset.

(a) *Referral to the Department of the Treasury for offset.* (1) We recover overdue debts by offsetting Federal and State payments due the debtor through the Treasury Offset Program (TOP). TOP is a Government-wide delinquent debt matching and payment offset process operated by the Department of the Treasury, whereby debts owed to the Federal Government are collected by offsetting them against Federal and State payments owed the debtor. Federal payments owed the debtor include current ''disposable pay,'' defined in 5 CFR 550.1103, owed by the Federal Government to a debtor who is an employee of the Federal Government. Deducting from such disposable pay to collect an overdue debt owed by the employee is called ''Federal salary offset'' in this subpart.

(2) Except as provided in paragraphs (b) and (c) of § 422.301, we will use Federal salary offset to collect overdue debts from Federal employees, including employees of the Social Security Administration. A Federal employee's involuntary payment of all or part of a debt collected by Federal salary offset does not amount to a waiver of any rights which the employee may have under any statute or contract, unless a statute or contract provides for waiver of such rights.

(b) *Debts we refer.* We refer for administrative offset all qualifying debts that meet or exceed the threshold amounts used by the Department of the Treasury for collection from State and Federal payments, including Federal salaries.

(c) *Notice to debtor.* Before we refer any debt for collection by administrative offset, we will send the debtor written notice that explains all of the following:

(1) The nature and amount of the debt.

(2) We have determined that payment of the debt is overdue.

(3) We will refer the debt for administrative offset (except as provided in paragraph (c)(9) of this section) at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60-day period:

(i) The debtor pays the full amount of the debt, or

(ii) The debtor takes any of the actions described in paragraphs (c)(6) or (c)(7) of this section.

(4) The frequency and amount of any Federal salary offset deduction (the payment schedule) expressed as a fixed dollar amount or percentage of disposable pay.

(5) The debtor may inspect or copy our records relating to the debt. If the debtor or his or her representative cannot personally inspect the records, the debtor may request and receive a copy of such records.

(6) The debtor may request a review of the debt by giving us evidence showing that the debtor does not owe all or part of the amount of the debt or that we do not have the right to collect it. The debtor may also request review of any payment schedule for Federal salary offset stated in the notice. If the debtor is an employee of the Federal Government and Federal salary offset is proposed, an official designated in accordance with 5 U.S.C. 5514(a)(2) will conduct the review.

(7) The debtor may request to repay the debt voluntarily through an installment payment plan.

(8) If the debtor knowingly furnishes any false or frivolous statements, representations, or evidence, the debtor may be subject to:

(i) Civil or criminal penalties under applicable statutes;

(ii) Appropriate disciplinary procedures under applicable statutes or regulations, when the debtor is a Federal employee.

(9) We will refer the debt for Federal salary offset at the expiration of not less than 30 calendar days after the date of the notice unless, within that 30 day period the debtor takes any actions described in paragraphs (c)(3)(i), (c)(6) or (c)(7) of this section.

(d) *Federal salary offset: amount, frequency and duration of deductions.* (1) We may collect the overdue debt from an employee of the Federal Government through the deduction of an amount not to exceed 15% of the debtor's current disposable pay each payday.

(2) Federal salary offset will begin no sooner than the first payday following 30 calendar days after the date of the notice to the debtor described in paragraph (c) of this section.

(3) Once begun, Federal salary offset will continue until we recover the full amount of the debt, the debt is otherwise resolved, or the debtor's Federal employment ceases, whichever occurs first.

(4) After Federal salary offset begins, the debtor may request a reduction in the amount deducted from disposable pay each payday. When we determine that the amount deducted causes financial harm under the rules in § 422.415(b), (c), and (d) of this chapter, we will reduce that amount.

(e) *Refunds.* We will promptly refund to the debtor any amounts collected that the debtor does not owe. Refunds do not bear interest unless required or permitted by law or contract.

[71 FR 38070, July 5, 2006, as amended at 76 FR 65109, Oct. 20, 2011]

§ 422.315 Review of our records related to the debt.

(a) *Notification by the debtor.* The debtor may request to inspect or copy our records related to the debt.

(b) *Our response.* In response to a request from the debtor described in paragraph (a) of this section, we will notify the debtor of the location and time at which the debtor may inspect or copy our records related to the debt. We may also, at our discretion, mail to the debtor copies of the records relating to the debt.

§ 422.317 Review of the debt.

(a) *Notification and presentation of evidence by the debtor.* A debtor who receives a notice described in § 422.305(b), § 422.306(b), or § 422.310(c) has a right to have a review of the debt and the payment schedule for Federal salary offset stated in the notice. To exercise this right, the debtor must notify us and give us evidence that he or she does not owe all or part of the debt, or that we do not have the right to collect it, or that the payment schedule for Federal salary offset stated in the notice would cause financial hardship.

(1) If the debtor notifies us and presents evidence within 60 calendar days from the date of our notice (except as provided for Federal salary offset in paragraph (a)(3) of this section), we will not take the action described in our notice unless and until review of all of the evidence is complete and we send the debtor the findings that all or part of the debt is overdue and legally enforceable.

(2) If the debtor notifies us and presents evidence after that 60 calendar-day period expires (except as provided for Federal salary offset in paragraph (a)(4) of this section) and paragraph (b) of this section does not apply, the review will occur, but we may take the

actions described in our notice without further delay.

(3) If the debtor notifies us and presents evidence within 30 calendar days from the date of our notice, we will not refer the debt for Federal salary offset unless and until review of all of the evidence is complete and we send the debtor the findings that all or part of the debt is overdue and legally enforceable and (if appropriate) the findings on the payment schedule for Federal salary offset.

(4) If the debtor notifies us and presents evidence after that 30 calendar-day period expires and paragraph (b) of this section does not apply, the review will occur, but we may refer the debt for Federal salary offset without further delay.

(b) *Good cause for failure to timely request review.* (1) If we decide that the debtor has good cause for failing to request review within the applicable period mentioned in paragraphs (a)(1) and (a)(3) of this section, we will treat the request for review as if we received it within the applicable period.

(2) We will determine good cause under the rules in § 422.410(b)(1) and (2) of this chapter.

(c) *Review of the evidence.* The review will cover our records and any evidence and statements presented by the debtor.

(d) *Special rules regarding Federal salary offset.* (1) When we use Federal salary offset to collect a debt owed by an employee of the Federal Government, an official designated in accordance with 5 U.S.C. 5514(a)(2) will conduct the review described in this section and will issue the findings.

(2) In addition to the requirements in paragraphs (a) and (b) of this section, the Federal employee must submit the request for review in writing. The request must

(i) Be signed by the employee,

(ii) Explain with reasonable specificity the facts and evidence that support the employee's position, and

(iii) Include the names of any witnesses.

(3) In reviewing the payment schedule described in the notice to the Federal employee, the reviewing official must apply the rules in § 422.415(b), (c), and (d) of this chapter regarding financial hardship.

(4) The reviewing official will review our records and any documents, written statements, or other evidence submitted by the debtor and issue written findings.

(5) The reviewing official will complete the review within 60 calendar days from the date on which the request for review and the debtor's evidence are received. If the reviewing official does not complete the review within that 60-day period and the debt was referred to the Department of the Treasury for Federal salary offset, we will notify the Department of the Treasury to suspend Federal salary offset. Offset will not begin or resume before we send the debtor findings that all or part of the debt is overdue and legally enforceable or (if appropriate) findings on the payment schedule.

(e) *The findings.* (1) Following the review described in paragraphs (c) or (d) of this section, we will send the written findings to the debtor. The findings will state the nature and origin of the debt, the analysis, findings and conclusions regarding the amount and validity of the debt, and, when appropriate, the repayment schedule for Federal salary offset. Issuance of these findings will be the final action on the debtor's request for review.

(2) If the findings state that an individual does not owe the debt, or the debt is not overdue, or we do not have the right to collect it, we will not send information about the debt to consumer or other credit reporting agencies or refer the debt to the Department of the Treasury for administrative offset. If we had referred the debt to the Department of the Treasury for administrative offset, we will cancel that action. If we had informed consumer or credit reporting agencies about the debt, we will inform them of the findings.

(3) If the findings state that the payment schedule for Federal salary offset would cause financial hardship, we will notify the debtor and the Department of the Treasury of the new payment schedule.

[71 FR 38071, July 5, 2006]

Subpart E—Collection of Debts by Administrative Wage Garnishment

AUTHORITY: Secs. 205(a), 702(a)(5) and 1631(d)(1) of the Social Security Act (42 U.S.C. 405(a), 902(a)(5) and 1383(d)(1)) and 31 U.S.C. 3720D.

SOURCE: 68 FR 74184, Dec. 23, 2003, unless otherwise noted.

§ 422.401 What is the scope of this subpart?

This subpart describes the procedures relating to our use of administrative wage garnishment under 31 U.S.C. 3720D to recover past due debts that you owe.

§ 422.402 What special definitions apply to this subpart?

(a) *Administrative wage garnishment* is a process whereby we order your employer to withhold a certain amount from your disposable pay and send the withheld amount to us. The law requires your employer to comply with our garnishment order.

(b) *Debt* means any amount of money or property that we determine is owed to the United States and that arises from a program that we administer or an activity that we perform. These debts include program overpayments made under title II or title XVI of the Social Security Act and any other debt that meets the definition of ''claim'' or ''debt'' at 31 U.S.C. 3701(b).

(c) *Disposable pay* means that part of your total compensation (including, but not limited to, salary or wages, bonuses, commissions, and vacation pay) from your employer after deduction of health insurance premiums and amounts withheld as required by law. Amounts withheld as required by law include such things as Federal, State and local taxes but do not include amounts withheld under court order.

(d) *We, our,* or *us* means the Social Security Administration.

(e) *You* means an individual who owes a debt to the United States within the scope of this subpart.

§ 422.403 When may we use administrative wage garnishment?

(a) *General.* Subject to the exceptions described in paragraph (b) of this section and the conditions described in paragraphs (c) and (d) of this section, we may use administrative wage garnishment to collect any debt that is past due. We may use administrative wage garnishment while we are taking other action regarding the debt, such as, using tax refund offset under §§ 404.520–404.526 and 416.580–416.586 of this chapter and taking action under subpart D of this part.

(b) *Exceptions.* (1) We will not use this subpart to collect a debt from salary or wages paid by the United States Government.

(2) If you have been separated involuntarily from employment, we will not order your employer to withhold amounts from your disposable pay until you have been reemployed continuously for at least 12 months. You have the burden of informing us about an involuntary separation from employment.

(3) We will not use this subpart to collect a debt while your disability benefits are stopped during the reentitlement period, under § 404.1592a(a)(2) of this chapter, because you are engaging in substantial gainful activity.

(4) We will not use this subpart to collect a debt while your Medicare entitlement is continued because you are deemed to be entitled to disability benefits under section 226(b) of the Social Security Act (42 U.S.C. 426(b)).

(5) We will not use this subpart to collect a debt if you have decided to participate in the Ticket to Work and Self-Sufficiency Program and your ticket is in use as described in §§ 411.170 through 411.225 of this chapter.

(c) *Overpayments under title II of the Social Security Act.* This subpart applies to overpayments under title II of the Social Security Act if all of the following conditions are met:

(1) You are not receiving title II benefits.

(2) We have completed our billing system sequence (*i.e.*, we have sent you an initial notice of the overpayment, a reminder notice, and a past-due notice) or we have suspended or terminated collection activity in accordance with applicable rules, such as, the Federal Claims Collection Standards in 31 CFR 903.2 or 31 CFR 903.3.

(3) We have not made an installment payment arrangement with you or, if

we have made such an arrangement, you have failed to make any payment for two consecutive months.

(4) You have not requested waiver pursuant to § 404.506 or § 404.522 of this chapter or, after a review conducted pursuant to those sections, we have determined that we will not waive collection of the overpayment.

(5) You have not requested reconsideration of the initial overpayment determination pursuant to §§ 404.907 and 404.909 of this chapter or, after a review conducted pursuant to § 404.913 of this chapter, we have affirmed all or part of the initial overpayment determination.

(6) We cannot recover your overpayment pursuant to § 404.502 of this chapter by adjustment of benefits payable to any individual other than you. For purposes of this paragraph, an overpayment will be deemed to be unrecoverable from any individual who was living in a separate household from yours at the time of the overpayment and who did not receive the overpayment.

(d) *Overpayments under title XVI of the Social Security Act.* This subpart applies to overpayments under title XVI of the Social Security Act if all of the following conditions are met:

(1) You are not receiving benefits under title XVI of the Social Security Act.

(2) We are not collecting your title XVI overpayment by reducing title II benefits payable to you.

(3) We have completed our billing system sequence (*i.e.*, we have sent you an initial notice of the overpayment, a reminder notice, and a past-due notice) or we have suspended or terminated collection activity under applicable rules, such as, the Federal Claims Collection Standards in 31 CFR 903.2 or 31 CFR 903.3.

(4) We have not made an installment payment arrangement with you or, if we have made such an arrangement, you have failed to make any payment for two consecutive months.

(5) You have not requested waiver pursuant to § 416.550 or § 416.582 of this chapter or, after a review conducted pursuant to those sections, we have determined that we will not waive collection of the overpayment.

(6) You have not requested reconsideration of the initial overpayment determination pursuant to §§ 416.1407 and 416.1409 of this chapter or, after a review conducted pursuant to § 416.1413 of this chapter, we have affirmed all or part of the initial overpayment determination.

(7) We cannot recover your overpayment pursuant to § 416.570 of this chapter by adjustment of benefits payable to any individual other than you. For purposes of this paragraph, if you are a member of an eligible couple that is legally separated and/or living apart, we will deem unrecoverable from the other person that part of your overpayment which he or she did not receive.

§ 422.405 What notice will we send you about administrative wage garnishment?

(a) *General.* Before we order your employer to collect a debt by deduction from your disposable pay, we will send you written notice of our intention to do so.

(b) *Contents of the notice.* The notice will contain the following information:

(1) We have determined that payment of the debt is past due;

(2) The nature and amount of the debt;

(3) Information about the amount that your employer could withhold from your disposable pay each payday (the payment schedule);

(4) No sooner than 60 calendar days after the date of the notice, we will order your employer to withhold the debt from your disposable pay unless, within that 60-day period, you pay the full amount of the debt or take either of the actions described in paragraphs (b)(6) or (7) of this section;

(5) You may inspect and copy our records about the debt (*see* § 422.420);

(6) You may request a review of the debt (*see* § 422.425) or the payment schedule stated in the notice (*see* § 422.415); and

(7) You may request to pay the debt by monthly installment payments to us.

(c) *Mailing address.* We will send the notice to the most current mailing address that we have for you in our records.

(d) *Electronic record of the notice.* We will keep an electronic record of the notice that shows the date we mailed

the notice to you and the amount of your debt.

§ 422.410 What actions will we take after we send you the notice?

(a) *General.* (1) We will not send an administrative wage garnishment order to your employer before 60 calendar days elapse from the date of the notice described in § 422.405.

(2) If paragraph (b) of this section does not apply and you do not pay the debt in full or do not take either of the actions described in § 422.405(b)(6) or (7) within 60 calendar days from the date of the notice described in § 422.405, we may order your employer to withhold and send us part of your disposable pay each payday until your debt is paid.

(3) If you request review of the debt or the payment schedule after the end of the 60 calendar day period described in paragraph (a)(2) of this section and paragraph (b) of this section does not apply, we will conduct the review. However, we may send the administrative wage garnishment order to your employer without further delay. If we sent the administrative wage garnishment order to your employer and we do not make our decision on your request within 60 calendar days from the date that we received your request, we will tell your employer to stop withholding from your disposable pay. Withholding will not resume before we conduct the review and notify you of our decision.

(4) We may send an administrative wage garnishment order to your employer without further delay if:

(i) You request an installment payment plan after receiving the notice described in § 422.405, and

(ii) We arrange such a plan with you, and

(iii) You fail to make payments in accordance with that arrangement for two consecutive months.

(b) *Good cause for failing to request review on time.* If we decide that you had good cause for failing to request review within the 60-day period mentioned in paragraph (a)(2) of this section, we will treat your request for review as if we received it within that 60-day period.

(1) *Determining good cause.* In determining whether you had good cause, we will consider—

(i) Any circumstances that kept you from making the request on time;

(ii) Whether our action misled you;

(iii) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from making a request on time or from understanding the need to make a request on time.

(2) *Examples of good cause.* Examples of facts supporting good cause include, but are not limited to, the following.

(i) Your serious illness prevented you from contacting us yourself or through another person.

(ii) There was a death or serious illness in your family.

(iii) Fire or other accidental cause destroyed important records.

(iv) You did not receive the notice described in § 422.405.

(v) In good faith, you sent the request to another government agency within the 60-day period, and we received the request after the end of that period.

(3) *If we issued the administrative wage garnishment order.* If we determine that you had good cause under paragraph (b) of this section and we already had sent an administrative wage garnishment order to your employer, we will tell your employer to stop withholding from your disposable pay. Withholding will not resume until we conduct the review and notify you of our decision.

§ 422.415 Will we reduce the amount that your employer must withhold from your pay when withholding that amount causes financial hardship?

(a) *General.* Unless paragraph (d) of this section applies, we will reduce the amount that your employer must withhold from your pay when you request the reduction and we find financial hardship. In any event, we will not reduce the amount your employer must withhold each payday below $10. When we decide to reduce the amount that your employer withholds, we will give you and your employer written notice.

(1) You may ask us at any time to reduce the amount due to financial hardship.

(2) If you request review of the payment schedule stated in the notice described in § 422.405 within the 60-day period stated in the notice, we will not issue a garnishment order to your employer until we notify you of our decision.

(b) *Financial hardship.* We will find financial hardship when you show that withholding a particular amount from your pay would deprive you of income necessary to meet your ordinary and necessary living expenses. You must give us evidence of your financial resources and expenses.

(c) *Ordinary and necessary living expenses.* Ordinary and necessary living expenses include:

(1) Fixed expenses such as food, clothing, housing, utilities, maintenance, insurance, tax payments;

(2) Medical, hospitalization and similar expenses;

(3) Expenses for the support of others for whom you are legally responsible; and

(4) Other reasonable and necessary miscellaneous expenses which are part of your standard of living.

(d) *Fraud and willful concealment or failure to furnish information.* (1) We will not reduce the amount that your employer withholds from your disposable pay if your debt was caused by:

(i) Your intentional false statement, or

(ii) Your willful concealment of, or failure to furnish, material information.

(2) ''Willful concealment'' means an intentional, knowing and purposeful delay in providing, or failure to reveal, material information.

§ 422.420 May you inspect and copy our records related to the debt?

You may inspect and copy our records related to the debt. You must notify us of your intention to review our records. After you notify us, we will arrange with you the place and time the records will be available to you. At our discretion, we may send copies of the records to you.

§ 422.425 How will we conduct our review of the debt?

(a) *You must request review and present evidence.* If you receive a notice described in § 422.405, you have the right to have us review the debt. To exercise this right, you must request review and give us evidence that you do not owe all or part of the debt or that we do not have the right to collect it. If you do not request review and give us this evidence within 60 calendar days from the date of our notice, we may issue the garnishment order to your employer without further delay. If you request review of the debt and present evidence within that 60 calendar-day period, we will not send a garnishment order to your employer unless and until we consider all of the evidence and send you our findings that all or part of the debt is overdue and we have the right to collect it.

(b) *Review of the evidence.* If you request review of the debt, we will review our records related to the debt and any evidence that you present.

(c) *Our findings.* Following our review of all of the evidence, we will send you written findings, including the supporting rationale for the findings. Issuance of these findings will be our final action on your request for review. If we find that you do not owe the debt, or the debt is not overdue, or we do not have the right to collect it, we will not send a garnishment order to your employer.

§ 422.430 When will we refund amounts of your pay withheld by administrative wage garnishment?

If we find that you do not owe the debt or that we have no right to collect it, we will promptly refund to you any amount withheld from your disposable pay under this subpart that we received and cancel any administrative wage garnishment order that we issued. Refunds under this section will not bear interest unless Federal law or contract requires interest.

§ 422.435 What happens when we decide to send an administrative wage garnishment order to your employer?

(a) *The wage garnishment order.* The wage garnishment order that we send to your employer will contain only the information necessary for the employer to comply with the order. This information includes:

(1) Your name, address, and social security number,

(2) The amount of the debt,

(3) Information about the amount to be withheld, and

(4) Information about where to send the withheld amount.

(b) *Electronic record of the garnishment order.* We will keep an electronic record of the garnishment order that shows the date we mailed the order to your employer.

(c) *Employer certification.* Along with the garnishment order, we will send your employer a certification form to complete about your employment status and the amount of your disposable pay available for withholding. Your employer must complete the certification and return it to us within 20 days of receipt.

(d) *Amounts to be withheld from your disposable pay.* After receipt of the garnishment order issued under this section, your employer must begin withholding from your disposable pay each payday the lesser of:

(1) The amount indicated on the order (up to 15% of your disposable pay); or

(2) The amount by which your disposable pay exceeds thirty times the minimum wage as provided in 15 U.S.C. 1673(a)(2).

(e) *Multiple withholding orders.* If your disposable pay is subject to more than one withholding order, we apply the following rules to determine the amount that your employer will withhold from your disposable pay:

(1) Unless otherwise provided by Federal law or paragraph (e)(2) of this section, a garnishment order issued under this section has priority over other withholding orders served later in time.

(2) Withholding orders for family support have priority over garnishment orders issued under this section.

(3) If at the time we issue a garnishment order to your employer amounts are already being withheld from your pay under another withholding order, or if a withholding order for family support is served on your employer at any time, the amounts to be withheld under this section will be the lesser of:

(i) The amount calculated under paragraph (d) of this section; or

(ii) The amount calculated by subtracting the amount(s) withheld under the withholding order(s) with priority from 25% of your disposable pay.

(4) If you owe more than one debt to us, we may issue multiple garnishment orders. If we issue more than one garnishment order, the total amount to be withheld from your disposable pay under such orders will not exceed the amount set forth in paragraph (d) or (e)(3) of this section, as appropriate.

(f) *You may request that your employer withhold more.* If you request in writing that your employer withhold more than the amount determined under paragraphs (d) or (e) of this section, we will order your employer to withhold the amount that you request.

§ 422.440 What are your employer's responsibilities under an administrative wage garnishment order?

(a) *When withholding must begin.* Your employer must withhold the appropriate amount from your disposable pay on each payday beginning on the first payday after receiving the garnishment order issued under this section. If the first payday is within 10 days after your employer receives the order, then your employer must begin withholding on the first or second payday after your employer receives the order. Withholding must continue until we notify your employer to stop withholding.

(b) *Payment of amounts withheld.* Your employer must promptly pay to us all amounts withheld under this section.

(c) *Other assignments or allotments of pay.* Your employer cannot honor an assignment or allotment of your pay to the extent that it would interfere with or prevent withholding under this section, unless the assignment or allotment is made under a family support judgement or order.

(d) *Effect of withholding on employer pay and disbursement cycles.* Your employer will not be required to vary its normal pay and disbursement cycles in order to comply with the garnishment order.

(e) *When withholding ends.* When we have fully recovered the amounts you owe, including interest, penalties, and administrative costs that we charge you as allowed by law, we will tell your

employer to stop withholding from your disposable pay. As an added precaution, we will review our debtors' accounts at least annually to ensure that withholding has been terminated for accounts paid in full.

(f) *Certain actions by an employer against you are prohibited.* Federal law prohibits an employer from using a garnishment order issued under this section as the basis for discharging you from employment, refusing to employ you, or taking disciplinary action against you. If your employer violates this prohibition, you may file a civil action against your employer in a Federal or State court of competent jurisdiction.

§ 422.445 May we bring a civil action against your employer for failure to comply with our administrative wage garnishment order?

(a) We may bring a civil action against your employer for any amount that the employer fails to withhold from your disposable pay in accordance with § 422.435(d), (e) and (f). Your employer may also be liable for attorney fees, costs of the lawsuit and (in the court's discretion) punitive damages.

(b) We will not file a civil action against your employer before we terminate collection action against you, unless earlier filing is necessary to avoid expiration of any applicable statute of limitations period. For purposes of this section, ''terminate collection action'' means that we have terminated collection action in accordance with the Federal Claims Collection Standards (31 CFR 903.3) or other applicable standards. In any event, we will consider that collection action has been terminated if we have not received any payments to satisfy the debt for a period of one year.

Subpart F—Applications and Related Forms

AUTHORITY: 42 U.S.C. 1320b–10(a)(2)(A).

§ 422.501 Applications and other forms used in Social Security Administration programs.

This subpart lists the applications and some of the related forms prescribed by the Social Security Administration for use by the public in applying for benefits under titles II and XVIII of the Social Security Act and the black lung benefits program (Part B, title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended).

[38 FR 11450, May 8, 1973]

§ 422.505 What types of applications and related forms are used to apply for retirement, survivors, and disability insurance benefits?

(a) *Applications.* Prescribed applications include our traditional pre-printed forms, and applications our employees complete on computer screens based on information you give us. We then print a copy on paper, have you sign it and process the signed application electronically. You may also use SSA's Internet website to submit an SSA-approved application to us. You can complete an Internet application on a computer (or other suitable device, such as an electronic kiosk) and electronically transmit the form to us using an SSA-approved electronic signature. If, however, we do not have an approved electronic signature established when you file your Internet application, you must print and sign the completed application and deliver the form to us.

(b) *Related forms.* The following are some related forms:

SSA–3—Marriage Certification. (For use in connection with Application for Wife's or Husband's Insurance Benefits, (Form SSA–2))

SSA–11—Request to be Selected as Payee. (For use when an individual proposing to be substituted for the current payee files an application to receive payment of benefits on behalf of disabled child, or a child under 18, or an incapable or incompetent beneficiary or for himself/herself if he/she has a payee.)

SSA–21—Supplement to Claim of Person Outside of the United States. (To be completed by or on behalf of a person who is, was, or will be outside the United States.)

SSA–25—Certificate of Election for Reduced Spouse's Benefits. (For use by a wife or husband age 62 to full retirement age who has an entitled child in his or her care and elects to receive reduced benefits for months during which he or she will not have a child in his or her care.)

SSA–721—Statement of Death by Funeral Director. (This form may be used as evidence of death (*see* § 404.704 of this chapter).)
SSA–760—Certificate of Support (Parent's, Husband's or Widower's). (For use in collecting evidence of support.)
SSA–766—Statement of Self-Employment Income. (For use by a claimant to establish insured status based on self-employment income in the current year.)
SSA–783—Statement Regarding Contributions. (This form may be used as evidence of total contributions for a child.)
SSA–787—Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits. (This form may be used to request evidence of capability from various medical sources.)
SSA–824—Report on Individual with Mental Impairment. (For use in obtaining medical evidence from medical sources when the claimant has been treated for a mental impairment.)
SSA–827—Authorization for Source to Release Information to the Social Security Administration. (To be completed by a disability claimant to authorize release of medical or other information.)
SSA–1002—Statement of Agricultural Employer (Years Prior to 1988). (For use by employer to provide evidence of annual wage payments for agricultural work.)
SSA–1372—Student's Statement Regarding School Attendance. (For use in connection with request for payment of child's insurance benefits for a child who is age 18 through 19 and a full-time student.
SSA–1724—Claim for Amount Due in the Case of a Deceased Beneficiary. (For use in requesting amounts payable under title II to a deceased beneficiary.)
SSA–3368—Disability Report—Adult. (For use in recording information about the claimant's condition, source of medical evidence and other information needed to process the claim to a determination or decision.)
SSA–3369—Disability Report—Work History. (For use in recording work history information.)
SSA–3826–F4—Medical Report—General. (For use in helping disability claimants in obtaining medical records from their doctors or other medical sources.)
SSA–3827—Medical Report—(Individual with Childhood Impairment). (For use in requesting information to determine if an individual's impairment meets the requirements for payment of childhood disability benefits.)
SSA–4111—Certificate of Election for Reduced Widow(er)s Benefits. (For use by applicants for certain reduced widow's or widower's benefits.)
SSA–7156—Farm Self-Employment Questionnaire. (For use in connection with claims for benefits based on farm income to determine whether the income is covered under the Social Security Act.)
SSA–7160—Employment Relationship Questionnaire. (For use by an individual and the alleged employer to determine the individual's employment status.)
SSA–7163—Questionnaire about Employment or Self-Employment Outside the United States. (To be completed by or on behalf of a beneficiary who is, was, or will be employed or self-employed outside the United States.)

[69 FR 499, Jan. 6, 2004, as amended at 70 FR 14978, Mar. 24, 2005]

§ 422.510 Applications and related forms used in the health insurance for the aged program.

(a) *Application forms.* The following forms are prescribed for use in applying for entitlement to benefits under the health insurance for the aged program:

SSA–18—Application for Hospital Insurance Entitlement. (For use by individuals who are not entitled to retirement benefits under title II of the Social Security Act or under the Railroad Retirement Act. This form may also be used for enrollment in the supplementary medical insurance benefits plan.)
SSA–40—Application for Enrollment in the Supplementary Medical Insurance Program. (This form is mailed directly to beneficiaries at the beginning of their initial enrollment period.)
SSA–40A—Application for Enrollment in Supplementary Medical Insurance. (For use by civil service employees who are not eligible for enrollment in the hospital insurance plan.)
SSA–40B—Application for Medical Insurance. (For general use in requesting medical insurance protection.)
SSA–40C—Application for Enrollment. (This form is mailed to beneficiaries as a followup on Form SSA–40 (Application for Enrollment in the Supplementary Medical Insurance Program).)
SSA–40F—Application for Medical Insurance. (For use by beneficiaries residing outside the United States.)

An individual who upon attainment of age 65 is entitled to a monthly benefit based on application OA-C1, SSA–2, OA–C7, OA–C10, SSA–10A, OA–C13, or SSA–14 is automatically entitled to hospital insurance protection. (For conditions of entitlement to hospital insurance benefits, see 42 CFR part 405, subpart A. For medical insurance protection, an applicant must request supplementary medical insurance coverage (see Forms SSA–40, SSA–40A,

SSA–40B, SSA–40C, and SSA–40F under § 422.510(a)). (For conditions of entitlement to supplementary medical insurance benefits, see 42 CFR part 405, subpart B.)

(b) *Related forms.* The following are the prescribed forms for use in requesting payment for services under the hospital insurance benefits program and the supplementary medical insurance benefits program and other related forms:

SSA–1453—Inpatient Hospital and Extended Care Admission and Billing. (To be completed by hospital for payment of hospital expenses for treatment of patient confined in hospital.)

SSA–1483—Provider Billing for Medical and Other Health Services. (To be completed by hospital for payment of hospital expenses for treatment of patient who is not confined in the hospital.)

SSA–1484—Explanation of Accommodation Furnished. (To be completed by the hospital to explain accommodation of a patient in other than a semiprivate (two- to four-bed) room.)

SSA–1486—Inpatient Admission and Billing—Christian Science Sanatorium. (To be completed by a Christian Science sanatorium for payment for treatment of patients confined in the sanatorium.)

SSA–1487—Home Health Agency Report and Billing. (For use by an organization providing home health services.)

SSA–1490—Request for Medicare Payment. (For use by patient or physician to request payment for medical expenses.)

SSA–1554—Provider Billing for Patient Services by Physicians. (For use by hospital for payment for services provided by hospital-based physicians.)

SSA–1556—Prepayment Plan for Group Medical Practices Dealing Through a Carrier. (For use by organizations (which have been determined to be group practice prepayment plans for medicare purposes) for reimbursement for medical services provided to beneficiaries.)

SSA–1660—Request for Information—Medicare Payment For Services to a Patient Now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

SSA–1739—Request for Enrollment Card Information by Foreign Beneficiary. (Used to notify beneficiaries approaching age 65 who reside in foreign countries that they are eligible to enroll for SMI. They return this form if they wish additional information and an application, SSA–40F.)

SSA–1966—Health Insurance Card. (This card is issued to a person entitled to benefits under the health insurance for the aged program and designates whether he is entitled to hospital insurance benefits or supplementary medical insurance benefits or both.

SSA–1980—Carrier or Intermediary Request for SSA Assistance.

SSA–2384—Third Party Premium Billing Request. (For use by a nonbeneficiary enrollee who must pay premiums by direct remittance and is having his premium notices sent to a third party to assure continuance of supplementary medical insurance.)

[32 FR 18030, Dec. 16, 1967, as amended at 38 FR 11451, May 8, 1973; 44 FR 34943, June 18, 1979]

§ 422.512 Applications and related forms used in the black lung benefits program.

(a) *Application forms.* The following forms are prescribed for use in applying for entitlement to benefits under part B of title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972:

SSA-46—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Coal Miner's Claim of Total Disability).

SSA–47—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Widow's Claim).

SSA-48—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Child's Claim).

SSA-49—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Parent's, Brother's and Sister's Claim).

(b) *Related forms.* The following are some related forms:

SSA-50—Request To Be Selected as Payee. (For use when the individual proposing to be substituted for current payee files application to receive payment of black lung benefits on behalf of himself, a disabled child or child under age 18, a student beneficiary, or an incompetent beneficiary.)

SSA-2179—Report by Person Entitled to Black Lung Benefits. (For use by person entitled to black lung benefits to report events which affect benefits.)

SAA-2210—Statement of Coal Mine Employment by United Mine Workers of America.

SSA-2325—Medical Report (Pneumoconiosis).

[38 FR 11451, May 8, 1973]

§ 422.515 Forms used for withdrawal, reconsideration and other appeals, appointment of representative, and representative registration.

The following is a list of forms prescribed by the Social Security Administration for use by the public to request a withdrawal of an application, a reconsideration of an initial determination, a hearing, a review of an administrative law judge's decision, or for use where a person is authorized to represent a claimant.

SSA-521—Request for Withdrawal of Application. (For use by an individual to cancel his application.)

SSA-561—Request for Reconsideration. (For use by an individual who disagrees with an initial determination concerning (a) entitlement to benefits or any other right under title II of the Social Security Act, or (b) entitlement to hospital insurance benefits or supplementary medical insurance benefits under title XVIII of the act, or (c) entitlement to black lung benefits under title IV of the Federal Coal Mine Health and Safety Act. See § 422.140 for a discussion of the reconsideration procedure.)

SSA–1696—Claimant's Appointment of a Representative. (For use by claimants or representatives as a notice of their appointment of a representative in a claim, issue, or other matter that is pending a determination or a decision before us).

SSA–1699—Representative Registration. (For use by individuals to register with us as representatives prior to appointment as a representative on a claim or designation as a point of contact for an entity).

SSA-1763—Request for Termination of Supplementary Medical Insurance. (For use by an enrollee in requesting that his supplementary medical insurance coverage be terminated.)

SSA-1965—Request for Hearing—Part B Medicare Claim. (For use by an individual enrollee or his assignee to obtain a hearing before a hearing officer designated by the carrier concerning benefits payable under part B of title XVIII.)

HA-501—Request for Hearing. (For use by an individual or institution to obtain a hearing on a claim for title II benefits before an administrative law judge of the Social Security Administration.)

NOTE: This form is also used to request a hearing regarding entitlement to hospital insurance benefits or supplementary medical insurance benefits under title XVIII of the act. (See § 422.203 for a discussion of the hearing procedure.)

HA-501.1—Request for Hearing—Part A Health Insurance. (For use by an individual or institution to obtain a hearing before an administrative law judge of the Social Security Administration concerning the amount of hospital insurance benefits under title XVIII.)

HA-512.1—Notice by Attorney of Appointment as Representative. (For use by an attorney authorized by a claimant to act for him in a claim or related matter.)

HA-520—Request for Review of Hearing Examiner's Action. (For use by an individual or institution to obtain a review of a decision by an administrative law judge of the Social Security Administration.)

[38 FR 11452, May 8, 1973, as amended at 89 FR 67556, Aug. 21, 2024]

§ 422.520 Forms related to maintenance of earnings records.

The following forms are used by the Social Security Administration and by the public in connection with the maintenance of earnings records of wage-earners and self-employed persons:

SS-4—Application for Employer Identification Number.

SS-4A—Agricultural Employer's Application. (For use by employers of agricultural workers to request an employer identification number under the FICA.)

SS-5—Application for a Social Security Number (or Replacement of Lost Card).

SS-15—Certificate Waiving Exemption From Taxes Under the FICA. (For use by certain nonprofit organizations requesting coverage of its employees.)

SS-15a—List of Concurring Employees. (To be signed by each employee who concurs in the filing of the Certificate Waiving Exemption From Taxes Under the FICA, Form SS-15.)

SSI-21—Social Security and Your Household Employee. (For use by employers of household workers to request information from the Internal Revenue Service Center regarding filing employee tax returns.)

OA-702—Social Security Number Card.

Form 2031—Waiver Certificate To Elect Social Security Coverage for Use by Ministers, Certain Members of Religious Orders, and Christian Science Practitioners.

Form 4029—Application for Exemption from Tax on Self-Employment Income and Waiver of Benefits. (To be completed by self-employed individuals who are members of certain recognized religious sects (or division thereof) and do not wish to pay FICA taxes or participate in the programs provided under titles II and XVIII.)

Form 4361—Application for Exemption From Self-Employment Tax for Use by Ministers, Members of Religious Orders, and Christian Science Practitioners.

Form 4415—Election To Exempt From Self-Employment Coverage Fees Received by

Certain Public Officers and Employees of a State or Political Subdivision Thereof.
OAAN-5028—Evidence of Application for Social Security Number Card.
OAAN-7003—Request for Change in Social Security Records. (For use by an individual to change information given on original application for a social security number.)
OAR-7004—Request for Statement of Earnings. (For use by worker to obtain a statement of earnings recorded in his earnings record.)
OAR-7008—Request for Correction of Earnings Record. (For use by an individual who wishes to have his earnings record revised.)
SSA-7011—Statement of Employer. (For use by an employer to provide evidence of wage payments in cases of a wage discrepancy in an individual's earnings record.)

[38 FR 11452, May 8, 1973]

§ 422.525 Where applications and other forms are available.

All applications and related forms prescribed for use in the programs administered by the Social Security Administration pursuant to the provisions of titles II and XVIII of the act, and part B of title IV of the Federal Coal Mine Health and Safety Act of 1969 are printed under the specifications of the Administration and distributed free of charge to the public, institutions, or organizations for the purposes described therein. All prescribed forms can be obtained upon request from any social security district office or branch office (see § 422.5). Forms appropriate for use in requesting payment for services provided under the health insurance for the aged and disabled programs can also be obtained from the intermediaries or carriers (organizations under contract with the Social Security Administration to make payment for such services) without charge. Form 2031 (Waiver Certificate to Elect Social Security Coverage for Use by Ministers, Certain Members of Religious Orders, and Christian Science Practitioners), Form 4029 (Application for Exemption From Tax on Self-Employment Income and Waiver of Benefits), Form 4361 (Application for Exemption From Self-Employment Tax for Use by Ministers, Members of Religious Orders, and Christian Science Practitioners), Form 4415 (Election to Exempt From Self-Employment Coverage Fees Received by Certain Public Officers and Employees of a State or a Political Subdivision Thereof), Form SS-4 (Application for Employer Identification Number), Form SS-4A (Agricultural Employer's Application for Identification Number), Form SS-5 (Application for a Social Security Number (or Replacement of Lost Card)), Form SS-15 (Certificate Waiving Exemption From Taxes Under the FICA), and Form SS-15a (List of Concurring Employees) can also be obtained without charge from offices of the Internal Revenue Service. For other offices where applications and certain other forms can be obtained, see subparts B and C of this part 422.

[38 FR 11452, May 8, 1973]

§ 422.527 Private printing and modification of prescribed applications, forms, and other publications.

Any person, institution, or organization wishing to reproduce, reprint, or distribute any application, form, or publication prescribed by the Administration must obtain prior approval if he or she intends to charge a fee. Requests for approval must be in writing and include the reason or need for the reproduction, reprinting, or distribution; the intended users of the application, form, or publication; the fee to be charged; any proposed modification; the proposed format; the type of machinery (e.g., printer, burster, mail handling), if any, for which the application, form, or publication is being designed; estimated printing quantity; estimated printing cost per thousand; estimated annual usage; and any other pertinent information required by the Administration. Forward all requests for prior approval to: Office of Publications Management, 6401 Security Boulevard, Baltimore, MD 21235–6401.

[72 FR 73261, Dec. 27, 2007]

Subpart G—Administrative Review Process Under the Coal Industry Retiree Health Benefit Act of 1992

AUTHORITY: 26 U.S.C. 9701–9708.

SOURCE: 58 FR 52916, Oct. 13, 1993, unless otherwise noted.

§ 422.601 Scope and purpose.

The regulations in this subpart describe how the Social Security Administration (SSA) will conduct reviews of assignments it makes under provisions of the Coal Industry Retiree Health Benefit Act of 1992 (the Coal Act). Under the Coal Act, certain retired coal miners and their eligible family members (beneficiaries) are assigned to particular coal operators (or related persons). These operators are then responsible for paying the annual health and death benefit premiums for these beneficiaries as well as the annual premiums for certain unassigned coal miners and eligible members of their families. We will notify the assigned operators of these assignments and give each operator an opportunity to request detailed information about an assignment and to request review of an assignment. We also inform the United Mine Workers of America (UMWA) Combined Benefit Fund Trustees of each assignment made and the unassigned beneficiaries so they can assess appropriate annual premiums against the assigned operators. This subpart explains how assigned operators may request such additional information, how they may request review of an assignment, and how reviews will be conducted.

§ 422.602 Terms used in this subpart.

Assignment means our selection of the coal operator or related person to be charged with the responsibility of paying the annual health and death benefit premiums of certain coal miners and their eligible family members.

Beneficiary means either a coal industry retiree who, on July 20, 1992, was eligible to receive, and receiving, benefits as an eligible individual under the 1950 or the 1974 UMWA Benefit Plan, or an individual who was eligible to receive, and receiving, benefits on July 20, 1992 as an eligible relative of a coal industry retiree.

Evidence of a prima facie case of error means documentary evidence, records, and written statements submitted to us by the assigned operator (or related person) that, standing alone, shows our assignment was in error. The evidence submitted must, when considered by itself without reference to other contradictory evidence that may be in our possession, be sufficient to persuade a reasonable person that the assignment was erroneous. Examples of evidence that may establish a prima facie case of error include copies of Federal, State, or local government tax records; legal documents such as business incorporation, merger, and bankruptcy papers; health and safety reports filed with Federal or State agencies that regulate mining activities; payroll and other employment business records; and information provided in trade journals and newspapers.

A related person to a signatory operator means a person or entity which as of July 20, 1992, or, if earlier, the time immediately before the coal operator ceased to be in business, was a member of a controlled group of corporations which included the signatory operator, or was a trade or business which was under common control with a signatory operator, or had a partnership interest (other than as a limited partner) or joint venture with a signatory operator in a business within the coal industry which employed eligible beneficiaries, or is a successor in interest to a person who was a related person.

We or *us* refers to the Social Security Administration.

You as used in this subpart refers to the coal operator (or related person) assigned premium responsibility for a specific beneficiary under the Coal Act.

[58 FR 52916, Oct. 13, 1993, as amended at 62 FR 38456, July 18, 1997]

§ 422.603 Overview of the review process.

Our notice of assignment will inform you as the assigned operator (or related person) which beneficiaries have been assigned to you, the reason for the assignment, and the dates of employment on which the assignment was based. The notice will explain that, if you disagree with the assignment for any beneficiary listed in the notice of assignment, you may request from us detailed information as to the work history of the miner and the basis for the assignment. Such request must be filed with us within 30 days after you receive the notice of assignment, as explained in § 422.604. The notice will also explain that if you still disagree with

the assignment after you have received the detailed information, you may submit evidence that shows there is a prima facie case of error in that assignment and request review. Such request must be filed with us within 30 days after you receive the detailed information, as explained in §422.605. Alternatively, you may request review within 30 days after you receive the notice of assignment, even if you have not first requested the detailed information. In that case, you still may request the detailed information within that 30-day period. (See §422.606(c) for further details.)

§ 422.604 Request for detailed information.

(a) *General.* After you receive our notice of assignment listing the beneficiaries for whom you have premium responsibility, you may request detailed information as to the work histories of any of the listed miners and the basis for the assignment. Your request for detailed information must:

(1) Be in writing;

(2) Be filed with us within 30 days of receipt of that notice of assignment. Unless you submit evidence showing a later receipt of the notice, we will assume the notice was received by you within 5 days of the date appearing on the notice. We will consider the request to be filed as of the date we receive it. However, if we receive the request after the 30-day period, the postmark date on the envelope may be used as the filing date. If there is no postmark or the postmark is illegible, the filing date will be deemed to be the fifth day prior to the day we received the request; and

(3) Identify the individual miners about whom you are requesting the detailed information.

(b) *The detailed information we will provide.* We will send you detailed information as to the work history and the basis for the assignment for each miner about whom you requested such information. This information will include the name and address of each employer for whom the miner has worked since 1978 or since 1946 (whichever period is appropriate), the amount of wages paid by each employer and the period for which the wages were reported. We will send you the detailed information with a notice informing you that you have 30 days from the date you receive the information to submit to SSA evidence of a prima facie case of error (as defined in §422.602) and request review of the assignment if you have not already requested review. The notice will also inform you that, if you are seeking evidence to make a case of prima facie error, you may include with a timely filed request for review a written request for additional time to obtain and submit such evidence to us. Under these circumstances, you will have 90 days from the date of your request to submit the evidence before we determine whether we will review the assignment.

§ 422.605 Request for review.

We will review an assignment if you request review and show that there is a prima facie case of error regarding the assignment. This review is a review on the record and will not entail a face-to-face hearing. We will review an assignment if:

(a) You are an assigned operator (or related person);

(b) Your request is in writing and states your reasons for believing the assignment is erroneous;

(c) Your request is filed with us no later than 30 days from the date you received the detailed information described in §422.604, or no later than 30 days from the date you received the notice of assignment if you choose not to request detailed information. Unless you submit evidence showing a later receipt of the notice, we will assume you received the detailed information or the notice of assignment within 5 days of the date shown thereon. We will consider the request to be filed as of the date we receive it. However, if we receive the request after the 30-day period, the postmark date on the envelope may be used as the filing date. If there is no postmark or the postmark is illegible, the filing date will be deemed to be the fifth day prior to the day we received the request; and

(d) Your request is accompanied by evidence establishing a prima facie case of error regarding the assignment. If your request for review includes a request for additional time to submit

such evidence, we will give you an additional 90 days from the date of your request for review to submit such evidence to us.

§ 422.606 Processing the request for review.

Upon receipt of your written request for review of an assignment and where relevant, the expiration of any additional times allowed under §§ 422.605(d) and 422.606(c), we will take the following action:

(a) *Request not timely filed.* If your request is not filed within the time limits set out in § 422.605(c), we will deny your request for review on that basis and send you a notice explaining that we have taken this action;

(b) *Lack of evidence.* If your request is timely filed under § 422.605(c) but you have not provided evidence constituting a prima facie case of error, we will deny your request for review on that basis and send you a notice explaining that we have taken this action;

(c) *Request for review without requesting detailed information.* If your request is filed within 30 days after you received the notice of assignment and you have not requested detailed information, we will not process your request until at least 30 days after the date you received the notice of assignment. You may still request detailed information within that 30-day period, in which case we will not process your request for review until at least 30 days after you received the detailed information, so that you may submit additional evidence if you wish;

(d) *Reviewing the evidence.* If your request meets the filing requirements of § 422.605 and is accompanied by evidence constituting a prima facie case of error, we will review the assignment. We will review all evidence submitted with your request for review, together with the evidence used in making the assignment. An SSA employee who was not involved in the original assignment will perform the review. The review will be a review on the record and will not involve a face-to-face hearing.

(e) *Original decision correct.* If, following this review of the evidence you have submitted and the evidence in our file, we make a determination that the assignment is correct, we will send you a notice explaining the basis for our decision. We will not review the decision again, except as provided in § 422.607.

(f) *Original decision erroneous.* If, following this review of the evidence you have submitted and the evidence in our file, we make a determination that the assignment is erroneous, we will send you a notice to this effect. We will then determine who the correct operator is and assign the affected beneficiary(s) to that coal operator (or related person). If no assigned operator can be identified, the affected beneficiary(s) will be treated as ''unassigned.'' We will notify the UMWA Combined Benefit Fund Trustees of the review decision so that any premium liability of the initial assigned operator can be adjusted.

§ 422.607 Limited reopening of assignments.

On our own initiative, we may reopen and revise an assignment, whether or not it has been reviewed as described in this subpart, under the following conditions:

(a) The assignment reflects an error on the face of our records or the assignment was based upon fraud; and

(b) We sent to the assigned operator (or related person) notice of the assignment within 12 months of the time we decided to reopen that assignment.

Subpart H—Use of SSA Telephone Lines

AUTHORITY: Secs. 205(a) and 702(a)(5) of the Social Security Act (42 U.S.C. 405 and 902(a)(5)).

SOURCE: 63 FR 57058, Oct. 26, 1998, unless otherwise noted.

§ 422.701 Scope and purpose.

The regulations in this subpart describe the limited circumstances under which SSA is authorized to listen-in to or record telephone conversations. The purpose of this subpart is to inform the public and SSA employees of those circumstances and the procedures that SSA will follow when conducting telephone service observation activities.

§ 422.705 When SSA employees may listen-in to or record telephone conversations.

SSA employees may listen-in to or record telephone conversations on SSA telephone lines under the following conditions:

(a) *Law enforcement/national security*. When performed for law enforcement, foreign intelligence, counterintelligence or communications security purposes when determined necessary by the Commissioner of Social Security or designee. Such determinations shall be in writing and shall be made in accordance with applicable laws, regulations and Executive Orders governing such activities. Communications security monitoring shall be conducted in accordance with procedures approved by the Attorney General. Line identification equipment may be installed on SSA telephone lines to assist Federal law enforcement officials in investigating threatening telephone calls, bomb threats and other criminal activities.

(b) *Public safety*. When performed by an SSA employee for public safety purposes and when documented by a written determination by the Commissioner of Social Security or designee citing the public safety needs. The determination shall identify the segment of the public needing protection and cite examples of the possible harm from which the public requires protection. Use of SSA telephone lines identified for reporting emergency and other public safety-related situations will be deemed as consent to public safety monitoring and recording. (See § 422.710(a)(1))

(c) *Public service monitoring*. When performed by an SSA employee after the Commissioner of Social Security or designee determines in writing that monitoring of such lines is necessary for the purposes of measuring or monitoring SSA's performance in the delivery of service to the public; or monitoring and improving the integrity, quality and utility of service provided to the public. Such monitoring will occur only on telephone lines used by employees to provide SSA-related information and services to the public. Use of such telephone lines will be deemed as consent to public service monitoring. (See § 422.710(a)(2) and (c)).

(d) *All-party consent*. When performed by an SSA employee with the prior consent of all parties for a specific instance. This includes telephone conferences, secretarial recordings and other administrative practices. The failure to identify all individuals listening to a conversation by speaker phone is not prohibited by this or any other section.

§ 422.710 Procedures SSA will follow.

SSA component(s) that plan to listen-in to or record telephone conversations under § 422.705(b) or (c) shall comply with the following procedures.

(a) Prepare a written certification of need to the Commissioner of Social Security or designee at least 30 days before the planned operational date. A certification as used in this section means a written justification signed by the Deputy Commissioner of the requesting SSA component or designee, that specifies general information on the following: the operational need for listening-in to or recording telephone conversations; the telephone lines and locations where monitoring is to be performed; the position titles (or a statement about the types) of SSA employees involved in the listening-in to or recording of telephone conversations; the general operating times and an expiration date for the monitoring. This certification of need must identify the telephone lines which will be subject to monitoring, e.g., SSA 800 number voice and text telephone lines, and include current copies of any documentation, analyses, determinations, policies and procedures supporting the application, and the name and telephone number of a contact person in the SSA component which is requesting authority to listen-in to or record telephone conversations.

(1) When the request involves listening-in to or recording telephone conversations for public safety purposes, the requesting component head or designee must identify the segment of the public needing protection and cite examples of the possible harm from which the public requires protection.

(2) When the request involves listening-in to or recording telephone conversations for public service monitoring purposes, the requesting component head or designee must provide a statement in writing why such monitoring is necessary for measuring or monitoring the performance in the delivery of SSA service to the public; or monitoring and improving the integrity, quality and utility of service provided to the public.

(b) At least every 5 years, SSA will review the need for each determination authorizing listening-in or recording activities in the agency. SSA components or authorized agents involved in conducting listening-in or recording activities must submit documentation as described in § 422.710(a) to the Commissioner of Social Security or a designee to continue or terminate telephone service observation activities.

(c) SSA will comply with the following controls, policies and procedures when listening-in or recording is associated with public service monitoring.

(1) SSA will provide a message on SSA telephone lines subject to public service monitoring that will inform callers that calls on those lines may be monitored for quality assurance purposes. SSA will also continue to include information about telephone monitoring activities in SSA brochures and/or pamphlets as notification that some incoming and outgoing SSA telephone calls are monitored to ensure SSA's clients are receiving accurate and courteous service.

(2) SSA employees authorized to listen-in to or record telephone calls are permitted to annotate personal identifying information about the calls, such as a person's name, Social Security number, address and/or telephone number. When this information is obtained from public service monitoring as defined in § 422.705(c), it will be used for programmatic or policy purposes; e.g., recontacting individuals to correct or supplement information relating to benefits, for assessment of current/proposed policies and procedures, or to correct SSA records. Privacy Act requirements must be followed if data are retrievable by personal identifying information.

(3) SSA will take appropriate corrective action, when possible, if information obtained from monitoring indicates SSA may have taken an incorrect action which could affect the payment of or eligibility to SSA benefits.

(4) Telephone instruments subject to public service monitoring will be conspicuously labeled.

(5) Consent from both parties is needed to tape record SSA calls for public service monitoring purposes.

(d) The recordings and records pertaining to the listening-in to or recording of any conversations covered by this subpart shall be used, safeguarded and destroyed in accordance with SSA records management program.

Subpart I—Administrative Claims Collection

AUTHORITY: Sec. 97, Pub. L. 97–365, 96 Stat. 1749; Sec. 104, Pub. L. 104–134, 110 Stat. 1321; 5 U.S.C. 552; 5 U.S.C. 553; 31 U.S.C. 3711; 31 U.S.C. 3716; 31 U.S.C. 3717; 31 U.S.C. 3720A; 31 U.S.C. 3720B; 31 U.S.C. 3720C; 31 U.S.C. 3720D; 31 U.S.C. 3720E; 31 CFR parts 901–904; 31 CFR part 285; 5 U.S.C. 5514; 5 CFR part 550; 42 U.S.C. 902(a)(5).

SOURCE: 80 FR 61734, Oct. 14, 2015, unless otherwise noted.

§ 422.801 Scope of this subpart.

(a) The regulations in this part are issued under the Debt Collection Act of 1982, as amended by the Debt Collection Improvement Act of (DCIA) 1996 (31 U.S.C. 3701, *et seq.*) and the Federal Claims Collection Standards (31 CFR parts 901–904) issued pursuant to the DCIA by the Department of the Treasury (Treasury) and the Department of Justice (DOJ). These authorities prescribe government-wide standards for administrative collection, compromise, suspension, or termination of agency collection action, disclosure of debt information to credit reporting agencies, referral of claims to private collection contractors for resolution, and referral to the DOJ for litigation to collect debts owed the Government. The regulations under this part also are issued under the Commissioner's general rulemaking authority in the Social Security Act at section 702(a)(5), 42 U.S.C. 902(a)(5), the Treasury's regulations implementing the DCIA (31 CFR part

285), and related statutes and regulations governing the offset of Federal salaries (5 U.S.C. 5512, 5514; 5 CFR part 550, subpart K) and the administrative offset of tax refunds (31 U.S.C. 3720A).

(b) This subpart describes the procedures relating to the collection, compromise, and suspension of administrative debts owed to us, the Social Security Administration (SSA).

(c) Administrative debts include claims against current employees, separated employees, and non-employee debtors.

(1) Employee debts include salary overpayments; advanced sick and annual leave, advanced religious compensatory time, overpayments of health benefit premiums, leave buy back, emergency employee payments, travel, and transit subsidies.

(2) Non-employee debts include vendor overpayments, reimbursable agreements, Supplemental Security Income Medicaid determinations, and economic recovery payments.

(d) This subpart does not apply to programmatic overpayments described in subparts D and E of this part, and §§ 404.527 and § 416.590 of this title.

(e) This subpart does not apply to civil monetary penalties arising from sections 1129 and 1140 of the Social Security Act and collected pursuant to part 498 of this title.

§ 422.803 Collection activities.

(a) We will collect all administrative debts arising out of our activities or that are referred or transferred to us, the Social Security Administration, for collection actions. We will send an initial written demand for payment no later than 30 days after an appropriate official determines that a debt exists.

(b) In accordance with 31 CFR 285.12(c) and (g), we transfer legally enforceable administrative debts that are 120 calendar days or more delinquent to Treasury for debt collection services (*i.e.*, cross-servicing). This requirement does not apply to any debt that:

(1) Is in litigation or foreclosure;

(2) Will be disposed of under an approved asset sale program within one year of becoming eligible for sale;

(3) Has been referred to a private collection contractor for a period acceptable to the Secretary of the Treasury;

(4) Is at a debt collection center for a period of time acceptable to Treasury (see paragraph (c) of this section);

(5) Will be collected under internal offset procedures within three years after the debt first became delinquent; or

(6) Is exempt from this requirement based on a determination by Treasury that exemption for a certain class of debt is in the best interest of the United States.

(c) Pursuant to 31 CFR 285.12(h), we may refer debts less than 120 calendar days delinquent to Treasury or, with the consent of Treasury, to a Treasury-designated debt collection center to accomplish efficient, cost effective debt collection. Referrals to debt collection centers will be at the discretion of, and for a period acceptable to, the Secretary of the Treasury. Referrals may be for servicing, collection, compromise, suspension, or termination of collection action.

(d) We may refer delinquent administrative debts to Treasury for offset through the Treasury Offset Program (TOP). Administered by Treasury, TOP's centralized offset process permits Treasury to withhold funds payable by the United States to a person to collect and satisfy delinquent debts the person owes Federal agencies and States.

(e) We may collect an administrative debt by using Administrative Wage Garnishment.

(f) We may collect an administrative debt by using Federal Salary Offset.

§ 422.805 Demand for payment.

(a) *Written demand for payment.* (1) We will make a written demand, as described in paragraph (b) of this section, promptly to a debtor in terms that inform the debtor of the consequences of failing to cooperate with us to resolve the debt.

(2) We will send a demand letter no later than 30 days after the appropriate official determines that the debt exists. We will send the demand letter to the debtor's last known address.

(3) When necessary to protect the Government's interest, we may take appropriate action under this part, including immediate referral to DOJ for

litigation, before sending the written demand for payment.

(b) *Demand letters.* The specific content, timing, and number of demand letters will depend upon the type and amount of the debt and the debtor's response, if any, to our letters or telephone calls.

(1) The written demand for payment will include the following information:

(i) The nature and amount of the debt, including the basis for the indebtedness;

(ii) The date by which payment should be made to avoid late charges and enforced collection, which must be no later than 30 days from the date the demand letter is mailed;

(iii) Where applicable, the standards for imposing any interest, penalties, or administrative costs as specified under § 422.807;

(iv) The rights, if any, the debtor may have to:

(A) Seek review of our determination of the debt, and for purposes of salary offset or Administrative Wage Garnishment, request a hearing. To request a hearing see §§ 422.810(h) and 422.833(f)); and

(B) Enter into a reasonable repayment agreement when necessary and authorized.

(v) An explanation of how the debtor may exercise any of the rights described in paragraph (b)(1)(iv) of this section;

(vi) The name, address, and phone number of a contact person or office to address any debt-related matters; and

(vii) Our remedies to enforce payment of the debt, which may include:

(A) Garnishing the debtor's wages through Administrative Wage Garnishment;

(B) Offsetting any Federal or State payments due the debtor, including income tax refunds, salary, certain benefit payments;

(C) Referring the debt to a private collection contractor;

(D) Reporting the debt to a credit bureau or other automated database;

(E) Referring the debt to the DOJ for litigation; and

(F) Referring the debt to the Department of the Treasury for any of the collection actions described in paragraphs (b)(1)(vii)(A) through (E) of this section.

(2) The written demand for payment should also include the following information:

(i) The debtor's right to review our records pertaining to the debt, or, if the debtor or the debtor's representative cannot personally review the records, to request and receive copies of such records;

(ii) Our willingness to discuss alternative methods of payment with the debtor;

(iii) If a Federal employee, the debtor may be subject to disciplinary action under 5 CFR part 752 or other applicable authority;

(iv) Any amounts collected and ultimately found to not be owed by the debtor will be refunded;

(v) For salary offset, up to 15 percent of the debtor's current disposable pay may be deducted every pay period until the debt is paid in full; and

(vi) Dependent upon applicable statutory authority, the debtor may be entitled to consideration for a waiver.

(c) *Evidence retention.* We will retain evidence of service indicating the date of mailing of the demand letter. The evidence of service may be retained electronically so long as the manner of retention is sufficient for evidentiary purposes.

(d) *Pursue offset.* Prior to, during, or after the completion of the demand process, if we determine to pursue, or are required to pursue offset, the procedures applicable to offset should be followed (see § 422.821). The availability of funds for debt satisfaction by offset and our determination to pursue collection by offset will release us from the necessity of further compliance with paragraphs (a), (b), and (c) of this section.

(e) *Communications from debtors.* Where feasible, we will respond promptly to communications from debtors within 30 days, and will advise debtors who dispute debts to furnish available evidence to support their contentions.

(f) *Exception.* This section does not require duplication of any notice already contained in a written agreement, letter, or other document signed by, or provided to, the debtor.

§ 422.807 Interest, penalties, and administrative costs.

(a) Except as provided in paragraphs (g), (h), and (i) of this section, we will charge interest, penalties, and administrative costs on delinquent debts owed to the United States. These charges will continue to accrue until the debtor pays the debt in full or otherwise resolves the debt through compromise, termination, or an approved waiver.

(b) *Interest.* We will charge interest on delinquent administrative debts owed the agency as follows:

(1) Interest will accrue from the date of delinquency or as otherwise provided by law. For debts not paid by the date specified in the written demand for payment made under § 422.805, the date of delinquency is the date of mailing of the notice. The date of delinquency for an installment payment is the due date specified in the payment agreement.

(2) Unless a different rate is prescribed by statute, contract, or a repayment agreement, the rate of interest charged will be the rate established annually by the Treasury pursuant to 31 U.S.C. 3717. We may charge a higher rate if necessary to protect the rights of the United States, and the Commissioner has determined and documented a higher rate for delinquent debt is required to protect the Government's interests.

(3) Unless prescribed by statute or contract, the initial rate of interest charged will remain fixed for the duration of the indebtedness. A debtor who defaults on a repayment agreement may seek to enter into a new agreement. If we agree to a new agreement, we may require additional financial information and payment of interest at a new rate that reflects the Treasury rate in effect at the time the new agreement is executed or at a higher rate consistent with paragraph (b)(2) of this section. Interest will not be compounded. That is, we will not charge interest on the interest, penalties, or administrative costs required by this section, except as permitted by statute or contract. If, however, the debtor defaults on a previous repayment agreement, we will add charges that accrued but were not collected under the defaulted agreement to the principal of any new repayment agreement.

(c) *Penalty.* Unless otherwise established by contract, repayment agreement, or statute, we will charge a penalty pursuant to 31 U.S.C. 3717(e)(2) and 31 CFR 901.9 on the amount due on a debt that is delinquent for more than 90 days. This charge will accrue from the date of delinquency.

(d) *Administrative costs.* We will assess administrative costs incurred for processing and handling delinquent debts. We will base the calculation of administrative costs on actual costs incurred or a valid estimate of the actual costs. Calculation of administrative costs will include all direct (personnel, supplies, etc.) and indirect collection costs, including the cost of providing a hearing or any other form of administrative review requested by a debtor and any costs charged by a collection agency under § 422.837. We will assess these charges monthly or per payment period throughout the period that the debt is overdue. Such costs may also be in addition to other administrative costs if collection is being made for another Federal agency or unit.

(e) *Cost of living adjustment.* When there is a legitimate reason to do so, such as when calculating interest and penalties on a debt would be extremely difficult because of the age of the debt, we may increase an administrative debt by the cost of living adjustment in lieu of charging interest and penalties under this section. The cost of living adjustment is the percentage by which the Consumer Price Index for the month of June of the calendar year preceding the adjustment exceeds the Consumer Price Index for the month of June of the calendar year in which the debt was determined or last adjusted. We will manually compute such increases to administrative debts.

(f) *Priority.* When a debt is paid in partial or installment payments, amounts received will be applied first to outstanding penalties, second to administrative charges, third to interest, and last to principal.

(g) *Waiver.* (1) We will waive the collection of interest and administrative costs imposed pursuant to this section on the portion of the debt that is paid within 30 days after the date on which interest began to accrue. Excepting

debt affected by fraud or other misconduct, we may extend this 30-day period on a case-by-case basis if we determine that such action is in the best interest of the Government or is otherwise warranted by equity and good conscience.

(2) We may waive interest, penalties, and administrative charges charged under this section, in whole or in part, without regard to the amount of the debt, based on:

(i) The criteria set forth at § 422.846 (b)(1) for the compromise of debts; or

(ii) A determination by the agency that collection of these charges is:

(A) Against equity and good conscience; or

(B) Not in the best interest of the United States.

(h) *Review.* (1) Except as provided in paragraph (h)(2) of this section, administrative review of a debt will not suspend the assessment of interest, penalties, and administrative costs. While agency review of a debt is pending, the debtor may either pay the debt or be liable for interest and related charges on the uncollected debt. When agency review results in a final determination that any amount was properly a debt and the debtor failed to pay the full amount of the disputed debt, we will collect from the debtor the amount determined to be due, and interest, penalties and administrative costs on the debt amount. We will calculate and assess interest, penalties, and administrative costs under this section starting from the date the debtor was first made aware of the debt and ending when the debt is repaid.

(2) *Exception.* Interest, penalties, and administrative cost charges will not be imposed on a debt for periods during which collection activity has been suspended under § 422.848(c)(1) pending agency review or consideration of waiver, if a statute prohibits collection of the debt during this period. This exception does not apply to interest, penalties, and administrative cost charges on debts affected by fraud or other misconduct unless a statute so requires.

(i) *Common law or other statutory authority.* We may impose and waive interest and related charges on debts not subject to 31 U.S.C. 3717 in accordance with the common law or other statutory authority.

§ 422.809 Collection in installments.

Whenever feasible, we will collect the total amount of a debt in one lump sum payment. If a debtor claims a financial inability to pay a debt in one lump sum, by funds or Administrative Offset, we may accept payment in regular installments provided the debtor establishes the financial need and no evidence indicates that fraud or similar fault affected the debt. We will request financial statements from debtors who represent that they are unable to pay in one lump sum and independently verify such representations as described in § 422.846.

(a) When we agree to accept payments in regular installments, we will obtain a legally enforceable written agreement from the debtor that specifies all the terms and conditions of the agreement and includes a provision accelerating the debt in the event of a default.

(b) The size and frequency of the payments will reasonably relate to the size of the debt and the debtor's ability to pay. Whenever feasible, the installment agreement will provide for full payment of the debt, including interest and charges, in three years or less.

(c) When appropriate, the agreement will include a provision identifying security obtained from the debtor for the deferred payments, such as a surety bond or confession of judgment supporting a lien on any property of the debtor.

(d) An approved installment agreement does not prevent the use of Administrative Wage Garnishment or other collection tools in this subpart.

§ 422.810 Salary offset for current employees.

(a) *Purpose.* This part prescribes the Social Security Administration's (SSA) standards and procedures for the collection of debts owed by current SSA employees to SSA through involuntary salary offset.

(b) *Authority.* 5 U.S.C. 5514; 5 CFR part 550.

(c) *Scope.* (1) This part applies to internal collections of debt by Administrative Offset from the current pay accounts of SSA employees without his or her consent. The part does not apply to current SSA employees indebted to another Federal agency or employees who separate from SSA.

(2) The procedures contained in this part do not apply to any case where an employee consents to collection through deduction(s) from the employee's pay account, or to debts arising under the Internal Revenue Code or the tariff laws of the United States, or where another statute explicitly provides for or prohibits collection of a debt by salary offset (e.g., travel advances in 5 U.S.C. 5705 and employee training expenses in 5 U.S.C. 4108).

(3) This part does not preclude an employee from requesting a waiver of an erroneous payment under 5 U.S.C. 5584, 10 U.S.C. 2774, or 32 U.S.C. 716, or in any way questioning the amount or validity of a debt. Similarly, this part does not preclude an employee from requesting waiver of the collection of a debt under any other applicable statutory authority.

(4) Provided a debt is not affected by fraud and does not exceed $100,000, nothing in this part precludes the compromise of the debt or the suspension or termination of collection actions in accordance with §§ 422.846 and 422.848 of this title.

(d) *Definitions.*

Administrative Offset means withholding funds payable by the United States to, or held by the United States for, a person to satisfy a debt owed by the payee.

Agency means an executive department or agency, a military department, the United States Postal Service, the Postal Rate Commission, the United States Senate, the United States House of Representatives, a court, court administrative office, or instrumentality in the judicial or legislative branches of the Government, or a Government Corporation.

Creditor agency means the agency to which the debt is owed or SSA, including a debt collection center when acting on behalf of a creditor agency in matters pertaining to the collection of a debt.

Day means calendar day. For purposes of computation, the last day of the period will be included unless it is a Saturday, Sunday, or a Federal holiday, in which case the next business day will be considered the last day of the period.

Debt means an amount of funds or other property determined by an appropriate official of the Federal Government to be owed to the United States from any person, organization, or entity or any other debt that meets the definition of ''claim'' or ''debt'' under 31 U.S.C. 3701(b), excluding program overpayments made under title II or title XVI of the Social Security Act.

Debt collection center means the Department of the Treasury (Treasury) or other Government agency or division designated by the Secretary of the Treasury with authority to collect debts on behalf of creditor agencies in accordance with 31 U.S.C. 3711(g).

Debtor means an employee currently employed by SSA who owes a delinquent non-tax debt to the United States.

Delinquent debt means a debt that the debtor does not pay or otherwise resolve by the date specified in the initial demand for payment, or in an applicable written repayment agreement or other instrument, including a post-delinquency repayment agreement.

Disposable pay means that part of the debtor's current basic, special, incentive, retired, and retainer pay, or other authorized pay remaining after deduction of amounts we are required by law to withhold. For purposes of calculating disposable pay, legally required deductions that must be applied first include: Tax levies pursuant to the Internal Revenue Code (title 26, United States Code); properly withheld taxes; Federal Insurance Contributions Act (FICA); Medicare; health, dental, vision, and life insurance premiums; and Thrift Savings Plan and retirement contributions. Amounts deducted under garnishment orders, including child support garnishment orders, are not legally permissible deductions when calculating disposable pay as specified in 5 CFR 550.1103.

Employee means any individual currently employed by SSA, as defined in this section, including seasonal and

temporary employees and current members of the Armed Forces or a Reserve of the Armed Forces (Reserves).

Evidence of service means information retained by the agency indicating the nature of the document to which it pertains, the date of mailing the document, and the address and name of the debtor to whom it is being sent. A copy of the dated and signed notice provided to the debtor pursuant to this part may be considered evidence of service for purposes of this part. We may retain evidence of service electronically so long as the manner of retention is sufficient for evidentiary purposes.

Hearing means a review of the documentary evidence to confirm the existence or amount of a debt or the terms of a repayment schedule. If we determine that the issues in dispute cannot be resolved by such a review, such as when the validity of the claim turns on the issue of credibility or veracity, we may provide an oral hearing.

Hearing official means an administrative law judge or appropriate alternate.

Paying agency means the agency employing the employee and authorizing the payment of his or her current pay.

Salary offset means an Administrative Offset to collect a debt under 5 U.S.C. 5514 owed by a current SSA employee through deductions at one or more officially established pay intervals from the current pay account of the current SSA employee without his or her consent.

Waiver means the cancellation, remission, forgiveness, or non-recovery of a debt owed by an employee to the agency or another agency as required or permitted by 5 U.S.C. 5584, 8346(b), 10 U.S.C. 2774, 32 U.S.C. 716, or any other law.

(e) *General rule.* (1) Whenever an employee owes us a delinquent debt, we may, subject to paragraph (e)(3) of this section, involuntarily offset the amount of the debt from the employee's disposable pay.

(2) Except as provided in paragraph (e)(3) of this section, prior to initiating collection through salary offset under this part, we will first provide the employee with the following:

(i) A notice as described in paragraph (f) of this section; and

(ii) An opportunity to petition for a hearing, and, if a hearing is provided, to receive a written decision from the hearing official within 60 days on the following issues:

(A) The determination concerning the existence or amount of the debt; and

(B) The repayment schedule, unless it was established by written agreement between the employee and us.

(3) The provisions of paragraph (e)(2) of this section do not apply to:

(i) Any adjustment to pay arising out of an employee's election of coverage or a change in coverage under a federal benefits program requiring periodic deduction from pay, if the amount to be recovered was accumulated over four pay periods or less;

(ii) A routine intra-agency adjustment of pay that is made to correct an overpayment of pay attributable to clerical or administrative errors or delays in processing pay documents, if the overpayment occurred within four pay periods preceding the adjustment and, at the time of such adjustment, or as soon thereafter as practical, the individual is provided a notice of the nature and the amount of the adjustment and point of contact for contesting such adjustment; or

(iii) Any adjustment to collect a debt amount in accordance with the amount stated in 5 U.S.C. 5514 as amended by the DCIA, if, at the time of such adjustment, or as soon thereafter as practical, the individual is provided a notice of the nature and the amount of the adjustment and a point of contact for contesting such adjustment.

(f) *Notice requirements before offset.* (1) At least 30 days before the initiation of salary offset under this part, we will send a notice to the employee's last known address, informing the debtor of the following:

(i) We have reviewed the records relating to the debt and have determined that a debt is owed, the amount of the debt, and the facts giving rise to the debt;

(ii) Our intention to collect the debt by means of deduction from the employee's current disposable pay until the debt and all accumulated interest, penalties, and administrative costs are paid in full;

(iii) The amount, stated either as a fixed dollar amount or as a percentage of pay not to exceed 15 percent of disposable pay, the frequency, the commencement date, and the duration of the intended deductions;

(iv) An explanation of our policies concerning the assessment of interest, penalties, and administrative costs, stating that such assessments must be made unless waived in accordance with 31 CFR 901.9 and § 422.807 of this part;

(v) The employee's right to review and copy all of our records pertaining to the debt or, if the employee or the employee's representative cannot personally review the records, to request and receive copies of such records;

(vi) If not previously provided, the opportunity to establish a schedule for the voluntary repayment of the debt through offset or to enter into an agreement to establish a schedule for repayment of the debt in lieu of offset provided the agreement is in writing, signed by both the employee and us, and documented in our files;

(vii) The right to a hearing conducted by an impartial hearing official with respect to the existence and amount of the debt, or the repayment schedule, so long as a petition is filed by the employee as prescribed in paragraph (h) of this section;

(viii) Time limits and other procedures or conditions for reviewing our records pertaining to the debt, establishing an alternative repayment agreement, and requesting a hearing;

(ix) The name, address, and telephone number of the person or office who may be contacted concerning the procedures for reviewing our records, establishing an alternative repayment agreement, and requesting a hearing;

(x) The name and address of the office to send the petition for a hearing;

(xi) A timely and properly filed petition for a hearing will suspend the commencement of the collection proceeding;

(xii) We will initiate action to effect salary offset not less than 30 days from the date of mailing the notice, unless the employee properly files a timely petition for a hearing,

(xiii) A final decision on a hearing, if one is requested, will be issued at the earliest practical date, but not later than 60 days after the filing of the petition requesting the hearing unless the employee requests and the hearing official grants a delay in the proceeding;

(xiv) Notice that an employee who knowingly makes false or frivolous statements or submits false or frivolous representations or evidence may be subject to disciplinary procedures under chapter 75 of title 5, United States Code, Part 752 of title 5, CFR, or any other applicable statutes or regulations;

(xv) Any other rights and remedies available to the employee under statutes or regulations governing the program for which the collection is being made;

(xvi) Unless there are applicable contractual or statutory provisions to the contrary, amounts paid on or deducted for the debt that are later waived or found not owed to the United States will be promptly refunded to the employee; and

(xvii) Proceedings with respect to such debt are governed by 5 U.S.C. 5514.

(2) We will retain evidence of service indicating the date of mailing of the notice.

(g) *Review of records relating to the debt.* (1) To review or copy our records relating to the debt, the employee must send a written request stating his or her intention. We must receive the written request within 15 days from the employee's receipt of the notice.

(2) In response to a timely request as described in paragraph (1) of this section, we will notify the employee of the location and time when the employee may review and copy such records. If the employee or employee's representative is unable to review personally such records as the result of geographical or other constraints, we will arrange to send copies of such records to the employee.

(h) *Hearings*—(1) *Petitions for hearing.* (i) To request a hearing concerning the existence or amount of the debt or the offset schedule established by us, the employee must send a written petition to the office we identified in the notice (see paragraph (f)(1)(x) of this section) within 15 days of receipt of the notice.

(ii) The petition must:

(A) Be signed by the employee;

(B) Fully identify and explain with reasonable specificity all the facts, evidence, and witnesses, if any, that the employee believes support his or her position; and

(C) Specify whether an oral or paper hearing is requested. If an oral hearing is requested, the request should explain why the matter cannot be resolved by a paper hearing, which is a determination of the request for reconsideration based upon a review of the written record.

(iii) The timely filing of a petition for hearing will suspend any further collection proceedings.

(2) *Failure to timely request a hearing.* (i) If the petition for hearing is filed after the 15-day period provided in paragraph (h)(1)(i) of this section, we may grant the request if the employee can establish either that the delay was the result of circumstances beyond the employee's control or that the employee failed to receive actual notice of the filing deadline.

(ii) An employee waives the right to a hearing and will have his or her disposable pay offset in accordance with the offset schedule established by us, if the employee:

(A) Fails to file a timely request for a hearing unless such failure is excused; or

(B) Fails to appear at an oral hearing of which the employee was notified unless the hearing official determines that the failure to appear was due to circumstances beyond the employee's control.

(3) *Form of hearings*—(i) *General.* After the employee requests a hearing, the hearing official must notify the employee of the type of hearing that will occur. If an oral hearing will occur, the notice will state the date, time, and location of the hearing. If a paper hearing will occur, the employee will be notified and required to submit evidence and arguments in writing to the hearing official by the date specified in the notice, after which the record will be closed.

(ii) *Oral hearing.* An employee who requests an oral hearing will be provided an oral hearing if the hearing official determines that the matter cannot be resolved by review of documentary evidence alone because an issue of credibility or veracity is involved. Where an oral hearing is appropriate, the hearing is not an adversarial adjudication and need not take the form of an evidentiary hearing (e.g., the formal rules of evidence need not apply). Oral hearings may take the form of, but are not limited to:

(A) Informal conferences with the hearing official in which the employee and agency representative will be given full opportunities to present evidence, witnesses, and arguments;

(B) Informal meetings in which the hearing official interviews the employee by phone or videoconferencing; or

(C) Formal written submissions with an opportunity for oral presentations.

(iii) *Paper hearing.* If the hearing official determines that an oral hearing is not necessary, the hearing official will make the determination based upon a review of the available written record.

(iv) *Record.* The hearing official will maintain a summary record of any hearing conducted under this part. Witnesses who testify in oral hearings will do so under oath or affirmation.

(4) *Written decision*—(i) *Date of decision.* The hearing officer will issue a written opinion stating his or her decision. This opinion is based upon documentary evidence and information developed at the hearing, as soon as practicable after the hearing, but not later than 60 days after the date on which the hearing petition was received by the creditor agency. This is dependent upon whether the employee requested a delay in the proceedings and the hearing official grants it, in which case the 60-day decision period will be extended by the number of days by which the hearing was postponed. The recipient of an employee's request for a hearing must forward the request expeditiously to the hearing official to avoid jeopardizing the hearing official's ability to issue a decision within this 60-day period.

(ii) *Content of decision.* The written decision will include:

(A) A statement of the facts presented to support the origin, nature, and amount of the debt;

(B) The hearing official's findings, analysis, and conclusions, including a determination whether the employee's

petition for hearing was baseless and resulted from an intent to delay the creditor agency's collection activity; and

(C) The terms of any repayment schedule, if applicable.

(5) *Failure to appear.* In the absence of good cause shown, an employee who fails to appear at a hearing will be deemed, for the purpose of this part, to admit the existence and amount of the debt as described in the notice. If the representative of the creditor agency fails to appear, the hearing official will proceed with the hearing as scheduled and make a determination based upon oral testimony presented and the documentary evidence submitted by both parties. With the agreement of both parties, the hearing official will schedule a new hearing date, and both parties will be given notice of the time and place of the new hearing.

(i) *Obtaining the services of a hearing official.* The office designated in paragraph (f)(1)(x) of this section will schedule a hearing, if one is requested by an employee, before a hearing official.

(1) When we cannot provide a prompt and appropriate hearing before an administrative law judge or a hearing official furnished pursuant to another lawful arrangement, the office designated in paragraph (f)(1)(x) of this section may contact an agent of any agency designated in 5 CFR part 581, appendix A to arrange for a hearing official.

(2)(i) When another agency is the creditor agency, not SSA, it is the responsibility of that agency to arrange for a hearing if one is requested. We will provide a hearing official upon the request of a creditor agency when the debtor is employed by us and the creditor agency cannot provide a prompt and appropriate hearing before a hearing official furnished pursuant to another lawful arrangement.

(ii) Services rendered to a creditor agency under paragraph (i)(2)(i) of this section will be provided on a fully reimbursable basis pursuant to the Economy Act of 1932, as amended by 31 U.S.C. 1535.

(3) The determination of a hearing official designated under this section is considered an official certification regarding the existence and amount of the debt for purposes of executing salary offset under 5 U.S.C. 5514 and this part. A creditor agency may make a certification to the Secretary of the Treasury under 5 CFR 550.1108 or a paying agency under 5 CFR 550.1109 regarding the existence and amount of the debt based on the certification of a hearing official. If a hearing official determines that a debt may not be collected via salary offset, but we find that the debt is still valid, we may still seek collection of the debt through other means, such as offset of other Federal payments or litigation.

(j) *Voluntary repayment agreement in lieu of salary offset.* (1)(i) In response to the notice, the employee may propose to establish an alternative schedule for the voluntary repayment of the debt by submitting a written request. An employee who wishes to repay the debt without salary offset will also submit a proposed written repayment agreement. The proposal will admit the existence of the debt, and the agreement must be in such form that it is legally enforceable. The agreement must:

(A) Be in writing;

(B) Be signed by both the employee and the agency;

(C) Specify all the terms of the arrangement for payment; and

(D) Contain a provision accelerating the debt in the event of default by the employee, but such an increase may not result in a deduction that exceeds 15 percent of the employee's disposable pay unless the employee has agreed in writing to a deduction of a greater amount.

(ii) Any proposal under paragraph (j)(1)(i) of this section must be received within 30 days of the date of the notice.

(2) In response to a timely request as described in paragraph (j)(1) of this section, we will notify the employee whether the proposed repayment schedule is acceptable. It is within our discretion to accept a proposed alternative repayment schedule and to set the necessary terms of a voluntary repayment agreement.

(3) No voluntary repayment agreement will be binding on us unless it is in writing and signed by the employee and us.

(k) *Special review.* (1) At any time, an employee subject to salary offset or a voluntary repayment agreement may request a special review by the agency of the amount of the salary offset or voluntary repayment installments based on materially changed circumstances, such as, but not limited to, catastrophic illness, divorce, death, or disability.

(2)(i) In determining whether an offset would prevent the employee from meeting essential subsistence expenses (e.g., food, housing, clothing, transportation, and medical care), the employee must submit a detailed statement and supporting documents for the employee, his or her spouse, and dependents indicating:

(A) Income from all sources;

(B) Assets and liabilities;

(C) Number of dependents;

(D) Food, housing, clothing, transportation, and medical expenses; and

(E) Exceptional and unusual expenses, if any.

(ii) When requesting a special review under this section, the employee must file an alternative proposed offset or payment schedule and a statement, with supporting documents as described in paragraph (k)(2)(i) of this section, stating why the current salary offset or payments result in an extreme financial hardship to the employee.

(3)(i) We will evaluate the statement and supporting documents and determine whether the original offset or repayment schedule impose extreme financial hardship on the employee.

(ii) Within 30 calendar days of the receipt of the request and supporting documents, we will notify the employee in writing of such determination, including, if appropriate, a revised offset or repayment schedule.

(4) If the special review results in a revised offset or repayment schedule, we will do a new certification based on the result of the review.

(l) *Procedures for salary offset*—(1) *Method and source of deductions.* Unless the employee and the agency have agreed to an alternative repayment arrangement under paragraph (j) of this section, the agency will collect a debt in a lump sum or by installment deductions at officially established pay intervals from an employee's current pay account.

(2) *Limitation on amount of deduction.* Ordinarily, the size of installment deductions must bear a reasonable relationship to the size of the debt and the employee's ability to pay. However, the amount deducted for any pay period must not exceed 15 percent of the disposable pay from which the deduction is made unless the employee has agreed in writing to the deduction of a greater amount, as outlined in paragraph (j) of this section.

(3) *Duration of deductions*—(i) *Lump sum.* If the amount of the debt is equal to or less than 15 percent of the employee's disposable pay for an officially established pay interval, the agency will collect the debt in one lump-sum deduction including lump-sum annual leave amounts.

(ii) If the employee is deemed financially unable to pay in one lump sum or the amount of the debt exceeds 15 percent of the employee's disposable pay for an officially established pay interval, the agency will collect the debt in installments. Except as provided in paragraphs (k)(5) and (6) of this section, installment deductions must be made over a period no longer than the anticipated period of active duty or employment.

(4) *When deductions may begin.* (i) Deductions will begin on the date stated in the notice, unless the agency and individual have agreed to an alternative repayment agreement under paragraph (j) of this section or the employee has filed a timely request for a hearing.

(ii) If the employee files a timely petition for hearing as provided in paragraph (h) of this section, the agency will begin deductions after the hearing official has provided the employee with a hearing and a final written decision has been rendered in favor of the agency.

(5) *Liquidation from final check.* If an employee retires, resigns, or the period of employment ends before collection of the debt is completed, the agency will offset the remainder under 31 U.S.C. 3716 from subsequent agency payments of any nature (e.g., final salary payment or lump-sum leave) due the employee as of the date of separation.

(6) *Recovery from other payments due a separated employee.* If the debt cannot be satisfied by offset from any final payment due the employee on the date of separation, we will liquidate the debt, where appropriate, by Administrative Offset under 31 U.S.C. 3716 from later payments of any kind due the former employee (e.g., lump-sum leave payment).

(m) *Exception to internal salary offset.* SSA may follow Administrative Offset notification requirements when attempting the collection of delinquent travel advances and training expenses, not those associated with Federal employee salary offset. Once the notification procedures have been followed, SSA has the authority to withhold all or part of an employee's salary, retirement benefits, or other amount due the employee including lump-sum payments to recover the amounts owed. No statutory or regulatory limits exist on the amount that can be withheld or offset.

(n) *Salary offset when we are the paying agency but not the creditor agency.* When we are the paying agency and another agency is the creditor agency, the creditor agency must provide written certification to Treasury that the employee owes the debt, the amount and basis of the debt, the date on which payment(s) is due, the date the Government's right to collect the debt first accrued, and that the Office of Personnel Management has approved the creditor agency's regulations implementing 5 U.S.C. 5514. We are not required or authorized to review the merits of the determination with respect to the amount or validity of the debt certified by the creditor agency.

(o) *Interest, penalties, and administrative costs.* Debts owed will be assessed interest, penalties, and administrative costs in accordance with § 422.807.

(p) *Non-waiver of rights.* An employee's involuntary payment of all or any portion of a debt collected under this part will not be construed as a waiver of any rights the employee may have under 5 U.S.C. 5514 or any other provision of law or contract unless there are statutory or contractual provisions to the contrary.

(q) *Refunds.* (1) We will promptly refund any amounts paid or deducted under this part when:

(i) A debt is waived or otherwise found not owed to us; or

(ii) We are directed by administrative or judicial order to refund amount deducted from the employee's current pay.

(2) Unless required or permitted by law or contract, refunds will not bear interest.

(r) *Additional administrative collection action.* Nothing contained in this part is intended to preclude the use of any other appropriate administrative remedy.

§ 422.811 Discretionary referral for cross-servicing.

We may refer legally enforceable non-tax administrative debts that are less than 120 calendar days delinquent to the Department of the Treasury (Treasury) or to Treasury-designated ''debt collection centers'' in accordance with 31 CFR 285.12 to accomplish efficient, cost effective debt collection.

§ 422.813 Mandatory referral for cross-servicing.

(a) Pursuant to the cross-servicing process, creditor agencies must transfer any eligible debt more than 120 calendar days delinquent to the Department of the Treasury (Treasury) for debt collection services. As one such agency, pursuant to 31 CFR 285.12, we are required to transfer to Treasury any legally enforceable nontax debt in excess of $25. We may transfer to Treasury any combination of legally enforceable nontax debts less than $25 that exceeds $25 (in the case of a debtor whose taxpayer identification number (TIN) is unknown, the applicable threshold is $100) that has or have been delinquent for a period of 120 calendar days. Treasury will take appropriate action on behalf of the creditor agency to collect, compromise, suspend, or terminate collection of the debt, including use of debt collection centers and private collection contractors to collect the debt or terminate collection action.

(b) Debts not eligible for mandatory referral of paragraph (a) of this section include:

(1) Debts owed by a Federal agency;

(2) Debts owed by a deceased debtor;

(3) Debts not legally enforceable: A debt is considered legally enforceable for purposes of referral to the Treasury's Bureau of the Fiscal Service if there has been a final agency determination that the debt is due and there are no legal bars to collection;

(4) Debts that are the subject of an administrative appeal until the appeal is concluded and the amount of the debt is fixed;

(5) Debts owed by a debtor who has filed for bankruptcy protection or the debt has been discharged in bankruptcy proceeding; or

(6) Debts that are less than $25 (including interest, penalties, and administrative costs).

(c) A debt is considered delinquent for purposes of this section if it is 120 calendar days past due and is legally enforceable. A debt is past due if it has not been paid by the date specified in the agency's initial written demand for payment or applicable agreement or instrument (including a post-delinquency payment agreement) unless other satisfactory payment arrangements have been made. A debt is legally enforceable if there has been a final agency determination that the debt, in the amount stated, is due and there are no legal bars to collection action. Where, for example, a debt is the subject of a pending administrative review process required by statute or regulation and collection action during the review process is prohibited, the debt is not considered legally enforceable for purposes of mandatory transfer to the Treasury and is not to be transferred even if the debt is more than 120 calendar days past due. When a final agency determination is made after an administrative appeal or review process, the creditor agency must transfer such debt to Treasury, if more than 120 calendar days delinquent, within 30 days after the date of the final decision.

(d) We may also refer debts owed by a foreign country upon consultation with our Office of the General Counsel.

§ 422.815 Referral of administrative debts to the Department of the Treasury.

(a) Agencies are required by law to transfer delinquent, nontax, and legally enforceable debts to Department of the Treasury (Treasury) for collection through cross-servicing and through centralized Administrative Offset. Additionally, we may transfer debts to the Treasury for collection through Administrative Wage Garnishment. Agencies need not make duplicate referrals to Treasury for all these purposes; we may refer a debt to Treasury for purposes of simultaneous collection by cross-servicing, centralized Administrative Offset, and Administrative Wage Garnishment where applicable. However, in some instances a debt exempt from cross-servicing collection may be subject to collection by centralized Administrative Offset, so simultaneous referrals are not always appropriate.

(b) When we refer or transfer administrative debts to Treasury, or Treasury-designated debt collection centers under the authority of 31 U.S.C. 3711(g), Treasury will service, collect, or compromise the debts, or Treasury will suspend or terminate the collection action, in accordance with the statutory requirements and authorities applicable to the collection of such debts.

(c) Debts that are not required for referral include:

(1) Debts delinquent for 120 calendar days or less;

(2) Debts less than $100 and we are unable to obtain the debtor's taxpayer identification number;

(3) Debts in litigation or foreclosure as defined in 31 CFR 285.12(d)(2);

(4) Debts that have been referred to a private collection contractor for a period acceptable to Treasury;

(5) Debts that will be disposed of under an approved asset sale program as defined in 31 CFR 285.12(d)(3)(i);

(6) Debts that will be collected under internal offset procedures within three years after the debt first became delinquent;

(7) Debts at a debt collection center for a period of time acceptable to Treasury; or

(8) Debts exempt from this requirement based on a determination by the

Secretary of the Treasury that exemption for a certain class of debt is in the best interest of the United States. Federal agencies may request that the Secretary of the Treasury exempt specific classes of debts. Any such request by an agency must be sent to the Fiscal Assistant Secretary of the Treasury by the agency's Chief Financial Officer.

§ 422.817 Required certification.

Before referring delinquent administrative debts to the Department of the Treasury (Treasury) for collection, we will certify, in writing, that:

(a) The debts we are transferring are valid and legally enforceable;

(b) There are no legal bars to collection; and

(c) We have complied with all prerequisites to a particular collection action under the laws, regulations, or policies applicable to us, unless we agree that Treasury will do so on our behalf.

§ 422.819 Fees.

Federal agencies operating Department of the Treasury-designated debt collection centers are authorized to charge a fee for services rendered regarding referred or transferred debts. The fee may be paid out of amounts collected and may be added to the debt as an administrative cost.

§ 422.821 Administrative offset.

(a) *Scope.* (1) Administrative Offset is the withholding of funds payable by the United States to, or held by the United States for, a person to satisfy a debt. We will use Administrative Offset to recover administrative debts.

(2) This section does not apply to:

(i) Debts arising under the Social Security Act;

(ii) Payments made under the Social Security Act, except as provided for in 31 U.S.C. 3716(c), and 31 CFR 285.4;

(iii) Debts arising under, or payments made under the Internal Revenue Code or the tariff laws of the United States;

(iv) Offsets against Federal salaries to the extent these standards are inconsistent with regulations published to implement such offsets under 5 U.S.C. 5514 and 31 U.S.C. 3716 (see 5 CFR part 550, subpart K; 31 CFR 285.7; §§ 422.810 and 422.829 of this part);

(v) Offsets under 31 U.S.C. 3728 against a judgment obtained by a debtor against the United States;

(vi) Offsets or recoupments under common law, State law, or Federal statutes specifically prohibiting offsets or recoupments for particular types of debts; or

(vii) Offsets in the course of judicial proceedings, including bankruptcy.

(3) Unless otherwise provided for by contract or law, debts or payments that are not subject to Administrative Offset under 31 U.S.C. 3716 may be collected by Administrative Offset under the common law or other applicable statutory authority.

(4) In bankruptcy cases, the agency may seek legal advice from the Office of the General Counsel concerning the impact of the Bankruptcy Code, particularly 11 U.S.C. 106, 362, and 553, on pending or contemplated collections by offset.

(b) [Reserved]

§ 422.822 Notification of intent to collect by administrative offset.

(a) Prior to initiation of collection by Administrative Offset, we will:

(1) Send the debtor a notice by mail or hand-delivery. The notice will include the type and amount of the debt, the intention of the agency using internal offset or non-centralized Administrative Offset to collect the debt 30 days after the date of the notice, and the name of the Federal agency from which the creditor agency wishes to collect in the case of a non-centralized Administrative Offset. Additionally, if the debt is not satisfied by offset within the Social Security Administration or by agreement with another Federal agency, the notice will include the intent to refer the debt to the Department of the Treasury (Treasury) for collection through centralized Administrative Offset, including offset of tax refunds 60 days after the date of the notice as well as an explanation of the debtor's rights under 31 U.S.C. 3716.

(2) Give the debtor the opportunity:

(i) To make a voluntary payment;

(ii) To review and copy agency records related to the debt;

(iii) For a review within the agency of the determination of indebtedness;

(iv) To make a written agreement to repay the debt.

(b) The procedures set forth in paragraph (a) of this section are not required when:

(1) The offset is in the nature of a recoupment;

(2) The debt arises under a contract subject to the Contracts Disputes Act or Federal Acquisition Regulations;

(3) In the case of a non-centralized Administrative Offset (see § 422.824), the agency first learns of the existence of the amount owed by the debtor when there is insufficient time before payment would be made to the debtor/payee to allow for prior notice and an opportunity for review. When prior notice and an opportunity for review are omitted, we will give the debtor such notice and an opportunity for review as soon as practicable and will promptly refund any money ultimately found not to have been owed to the agency; or

(4) The agency previously has given a debtor any of the notice and review opportunities required under this part, with respect to a particular debt. Subsequently, any interest accrued or any installments coming due after we initiate an offset would not require a new notice and opportunity to review.

(c) The notice will be included as part of a demand letter issued under § 422.805 to advise the debtor of all debt collection possibilities that the agency will seek to employ.

§ 422.823 Debtor rights to review or copy records, submit repayment proposals, or request administrative review.

(a) A debtor who intends to review or copy our records with respect to the debt must notify us in writing within 30 days of the date of the notice as described in section § 422.822. In response, we will notify the debtor of the location, time, and any other conditions for reviewing and copying. The debtor may be liable for reasonable copying expenses.

(b) In response to the notice as described in section § 422.822, the debtor may propose a written agreement to repay the debt as an alternative to Administrative Offset. Any debtor who wishes to do this must submit a written proposal for repayment of the debt, which we must receive within 30 days of the date of the notice as described in section § 422.822 or 15 days after the date of a decision adverse to the debtor. In response, we will notify the debtor whether we need additional information, for example, financial status information. We will obtain any necessary authorization required to approve the agreement, and we will issue a written determination whether the proposed agreement is acceptable. In exercising our discretion, we will balance the Government's interest in collecting the debt against fairness to the debtor.

(c) A debtor must request an administrative review of the debt within 30 days of the date of the notice as described in section § 422.822 for purposes of a proposed collection by non-centralized Administrative Offset pursuant to § 422.824. A debtor must request an administrative review of the debt within 60 days of the date of the notice as described in section § 422.822 for purposes of a proposed collection by centralized Administrative Offset for offset against other Federal payments that would include tax refunds pursuant to § 422.825.

(1) For purposes of this section, whenever we are required to provide a debtor a review within the agency, we will give the debtor a reasonable opportunity for an oral hearing, either by telephone or in person, when the debtor requests reconsideration of the debt and we determine that the question of the indebtedness cannot be resolved by review of the documentary evidence.

(2) Unless otherwise required by law, an oral hearing under this section is not required to be a formal evidentiary hearing, although we will carefully document all significant matters discussed at the hearing.

(3) An oral hearing is not required with respect to debts where determinations of indebtedness rarely involve issues of credibility or veracity, and we have determined that a review of the written record is adequate to correct prior mistakes.

(4) In those cases when an oral hearing is not required by this section, we will provide the debtor a paper hearing, that is, a determination of the request

for reconsideration based upon a review of the written record.

§ 422.824 Non-centralized administrative offset.

(a) Unless otherwise prohibited by law, when centralized Administrative Offset under § 422.825 is not available or appropriate, we may collect a past due, legally enforceable, nontax delinquent debt by conducting non-centralized Administrative Offset internally or in cooperation with the agency certifying or authorizing payments to the debtor. Generally, non-centralized Administrative Offsets are ad hoc case-by-case offsets that an agency conducts at its own discretion, internally or in cooperation with a second agency certifying or authorizing payments to the debtor. In these cases, we may make a request directly to a payment-authorizing agency to offset a payment due a debtor to collect a delinquent debt. We adopt the procedures in 31 CFR 901.3(c) so that we may request the Department of the Treasury or any other payment-authorizing agency to conduct a non-centralized Administrative Offset.

(b) Administrative Offset may be initiated only after:

(1) The debtor has been sent a notice of the type and amount of the debt, the intention to initiate Administrative Offset to collect the debt, and an explanation of the debtor's rights under 31 U.S.C. 3716; and

(2) The debtor has been given:

(i) The opportunity to review and copy records related to the debt;

(ii) The opportunity for a review within the department of the determination of indebtedness; and

(iii) The opportunity to make a written agreement to repay the debt.

(c) The agency may omit the requirements under paragraph (b) of this section when:

(1) Offset is in the nature of a recoupment (*i.e.*, the debt and the payment to be offset arise out of the same transaction or occurrence);

(2) The debt arises under a contract as set forth in *Cecile Industries, Inc.* v. *Cheney*, 995 F.2d 1052 (Fed. Cir. 1993) (notice and other procedural protections set forth in 31 U.S.C. 3716(a) do not supplant or restrict established procedures for contractual offsets covered by the Contracts Disputes Act); or

(3) In the case of non-centralized Administrative Offset conducted under paragraph (a) of this section, the agency first learns of the existence of the amount owed by the debtor when there is insufficient time before payment would be made to the debtor to allow for prior notice and an opportunity for review. When prior notice and an opportunity for review are omitted, we will give the debtor such notice and an opportunity for review as soon as practical and will promptly refund any money ultimately found not to have been owed to the Government.

(d) When the debtor previously has been given any of the required notice and review opportunities with respect to a particular debt, such as under § 422.805, we need not duplicate such notice and review opportunities before Administrative Offset may be initiated.

(e) Before requesting that a payment-authorizing agency conduct non-centralized Administrative Offset, we will:

(1) Provide the debtor with due process as set forth in paragraph (b) of this section; and

(2) Provide the payment-authorizing agency written certification that the debtor owes the past due, legally enforceable delinquent debt in the amount stated and that we have fully complied with this section.

(f) When a creditor agency requests that we, as the payment authorizing agency, conduct non-centralized Administrative Offset, we will comply with the request, unless the offset would not be in the best interest of the United States with respect to the program of the agency, or would otherwise be contrary to law. Appropriate use should be made of the cooperative efforts of other agencies in effecting collection by Administrative Offset, including salary offset.

(g) When collecting multiple debts by non-centralized Administrative Offset, we will apply the recovered amounts to those debts in accordance with the best interests of the United States, as determined by the facts and circumstances of the particular case, particularly the applicable statute of limitations.

§ 422.825 Centralized administrative offset.

(a) *Mandatory referral.* After we provide and meet the notice and review opportunity requirements of § 422.822, we will refer debts that are over 120 calendar days delinquent to the Department of the Treasury (Treasury) for collection through centralized Administrative Offset 61 days after the date of the notice provided in accordance with § 422.822. If the debtor seeks review, referral of the debt must occur within 30 days of the final decision upholding our decision to offset the debt if the debt is more than 120 calendar days delinquent.

(b) *Discretionary referral.* After we provide and meet the notice and review opportunity requirements of § 422.822, and the debtor does not request administrative review or the result of the review is unsuccessful for the debtor, we may refer a debt that is less than 120 calendar days delinquent.

(c) *Procedures for referral.* We will refer debts to Treasury for collection in accordance with Treasury procedures set forth in 31 CFR 285.5 and 31 CFR 901.3(b).

§ 422.827 Offset against tax refunds.

We will take action to effect Administrative Offset against tax refunds due to debtors in accordance with the provisions of 31 U.S.C. 3720A through referral for centralized Administrative Offset under § 422.825.

§ 422.829 Federal salary offset.

(a) *Referral to the Department of the Treasury for offset.* (1) The Department of the Treasury (Treasury) will recover overdue administrative debts by offsetting Federal payments due the debtor through the Treasury Offset Program (TOP). TOP is a government-wide delinquent debt matching and payment offset process operated by Treasury, whereby debts owed to the Federal Government are collected by offsetting them against Federal payments owed the debtor. Federal payments owed the debtor include current ''disposable pay,'' defined in 5 CFR 550.1103, owed by the Federal Government to a debtor who is an employee of the Federal Government. Deducting from such disposable pay to collect an overdue debt owed by the employee is called ''Federal Salary Offset'' in this subpart.

(2) Treasury will use Federal Salary Offset to collect overdue administrative debts from Federal employees, including employees of the Social Security Administration. A Federal employee's involuntary payment of all or part of a debt collected by Federal Salary Offset does not amount to a waiver of any rights that the employee may have under any statute or contract, unless a statute or contract provides for waiver of such rights.

(b) *Debts we will refer.* We will refer all qualifying administrative debts that meet or exceed the threshold amounts used by Treasury for collection from Federal payments, including Federal salaries.

(c) *Notice to debtor.* Before we refer any administrative debt for collection by Administrative Offset, we will send the debtor a notice that explains all of the following:

(1) The nature and amount of the debt;

(2) That we have determined that payment of the debt is overdue; and

(3) That we will refer the debt for Administrative Offset (except as provided in paragraph (c)(9) of this section) at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60-day period:

(i) The debtor pays the full amount of the debt, or

(ii) The debtor takes any of the actions described in paragraphs (c)(6) or (c)(7) of this section.

(4) The frequency and amount of any Federal Salary Offset deduction (the payment schedule) expressed as a fixed dollar amount or percentage of disposable pay.

(5) The debtor may review or copy our records relating to the debt. If the debtor or his or her representative cannot personally review the records, the debtor may request and receive a copy of such records.

(6) The debtor may request a review of the debt by giving us evidence showing that the debtor does not owe all or part of the amount of the debt or that we do not have the right to collect it. The debtor may also request review of any payment schedule for Federal Salary Offset stated in the notice. If the

debtor is an employee of the Federal Government and Federal Salary Offset is proposed, an official designated in accordance with 5 U.S.C. 5514(a)(2) will conduct the review.

(7) The debtor may request to repay the debt voluntarily through an installment payment plan.

(8) If the debtor knowingly furnishes any false or frivolous statements, representations, or evidence, the debtor may be subject to appropriate disciplinary procedures under applicable statutes or regulations when the debtor is a Federal employee.

(9) We will refer the debt for Federal Salary Offset at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60 day period, the debtor takes any actions described in paragraphs (c)(3)(i), (c)(6), or (c)(7) of this section.

(d) *Federal Salary Offset: amount, frequency and duration of deductions.* (1) Treasury may collect the overdue debt from an employee of the Federal Government through the deduction of an amount not to exceed 15 percent of the debtor's current disposable pay each payday.

(2) Federal Salary Offset will begin not less than 60 calendar days after the date of the notice to the debtor described in paragraph (c) of this section.

(3) Once begun, Federal Salary Offset will continue until Treasury recovers the full amount of the debt, the debt is otherwise resolved, or the debtor's Federal employment ceases, whichever occurs first.

(4) After Federal Salary Offset begins, the debtor may request a reduction in the amount deducted from disposable pay each payday. When Treasury determines that the amount deducted causes financial harm under the rules in §422.833(j), they will reduce that amount. Treasury will not reduce the amount from the debtor's disposable pay if the debt was caused by:

(A) An intentional false statement by the debtor, or

(B) The debtor's willful concealment of, or failure to furnish, material information.

(2) ''Willful concealment'' means an intentional, knowing and purposeful delay in providing, or failure to reveal, material information.

(e) *Refunds.* Treasury will promptly refund to the debtor any amounts collected that the debtor does not owe. Refunds do not bear interest unless required or permitted by law or contract.

§ 422.833 Administrative wage garnishment for administrative debts.

(a) *Purpose.* This part prescribes the standards and procedures for collecting money from a debtor's disposable pay by means of Administrative Wage Garnishment to satisfy delinquent non-tax debts owed to us, the Social Security Administration.

(b) *Authority.* These standards and procedures are authorized under the wage garnishment provisions of the Debt Collection Improvement Act of 1996, codified at 31 U.S.C. 3720D, and the Department of the Treasury's (Treasury) Administrative Wage Garnishment regulation at 31 CFR 285.11.

(1) This part will apply notwithstanding any provision of State law.

(2) Nothing in this part precludes the compromise of a debt or the suspension or termination of collection action in accordance with §422.803 of this title or other applicable law or regulation, and the Commissioner has retained the authority. The Department of Justice has exclusive authority to suspend or terminate collection action on a debt affected by fraud.

(3) The receipt of payments pursuant to this part does not preclude us from pursuing other debt collection remedies, including the offset of Federal or State payments to satisfy delinquent non-tax debt owed to the United States. We will pursue such debt collection remedies separately or in conjunction with Administrative Wage Garnishment.

(4) This section does not apply to the collection of delinquent non-tax debts owed to the United States from the wages of Federal employees from their Federal employment. Federal pay is subject to the Federal Salary Offset procedures set forth in 5 U.S.C. 5514 and other applicable laws.

(5) Nothing in this section requires us to duplicate notices or administrative proceedings required by contract or other laws or regulations.

(c) *Definitions.* In this section, the following definitions will apply:

(1) *Business day* means Monday through Friday. For purposes of computation, the last day of the period will be included unless it is a Federal legal holiday, in which case the next business day following the holiday will be considered the last day of the period.

(2) *Day* means calendar day. For purposes of computation, the last day of the period will be included unless it is a Saturday, Sunday, or a Federal legal holiday, in which case the next business day will be considered the last day of the period.

(3) *Debt* means an amount of funds or other property determined by an appropriate official of the Federal Government to be owed to the United States from any person, organization, or entity or any other debt that meets the definition of ''claim'' or ''debt'' under 31 U.S.C. 3701(b), excluding program overpayments made under title II or title XVI of the Social Security Act.

(4) *Debtor* means an individual who owes a delinquent non-tax debt to the United States.

(5) *Delinquent debt* means any non-tax debt that has not been paid by the date specified in the agency's initial written demand for payment, or applicable payment agreement or instrument, unless other satisfactory payment arrangements have been made. For purposes of this part, ''delinquent'' and ''overdue'' have the same meaning.

(6) *Disposable pay* means that part of the debtor's compensation (including, but not limited to, salary, bonuses, commissions, and vacation pay) from an employer remaining after the deduction of health insurance premiums and any amounts required by law to be withheld. For purposes of this part, ''amounts required by law to be withheld'' include amounts for deductions such as social security taxes and withholding taxes, but do not include any amount withheld pursuant to a court order.

(7) *Employer* means a person or entity that employs the services of others and that pays their wages or salaries. The term employer includes, but is not limited to, State and local Governments, but does not include an agency of the Federal Government as defined by 31 CFR 285.11(c).

(8) *Garnishment* means the process of withholding amounts from an employee's disposable pay and paying those amounts to a creditor in satisfaction of a withholding order.

(9) *Hearing* means a review of the documentary evidence concerning the existence or amount of a debt or the terms of a repayment schedule, provided such repayment schedule is established other than by a written agreement entered into pursuant to this part. If the hearing official determines that the issues in dispute cannot be resolved solely by review of the written record, such as when the validity of the debt turns on the issue of credibility or veracity, an oral hearing may be provided.

(10) *Hearing official* means an administrative law judge or appropriate alternate.

(11) *Treasury* means the Department of the Treasury.

(12) *Withholding order* for purposes of this part means ''Wage Garnishment Order (SF329B).'' Also for purposes of this part, the terms ''wage garnishment order'' and ''garnishment order'' have the same meaning as ''withholding order.''

(d) *General rule.* (1) Except as provided in paragraph (d)(2) of this section, whenever an individual owes a delinquent debt, the agency or another Federal agency collecting a debt on our behalf (see § 422.803) may initiate administrative proceedings to garnish the wages of the delinquent debtor.

(2) Treasury will not garnish the wages of a debtor who we know has been involuntarily separated from employment until the debtor has been reemployed continuously for at least 12 months. The debtor has the burden to inform the agency of the circumstances surrounding an involuntary separation from employment.

(e) *Notice*—(1) *Notice requirements.* At least 30 days before the initiation of garnishment proceedings, Treasury will mail, by first class mail, to the debtor's last known address, a notice informing the debtor of:

(i) The nature and amount of the debt;

(ii) The intention to initiate proceedings to collect the debt through deductions from pay until the debt and

all accumulated interest, penalties, and administrative costs are paid in full;

(iii) The debtor's right:

(A) To review and copy our records related to the debt;

(B) To enter into a written repayment which is agreeable to the agency;

(C) To a hearing, in accordance with paragraph (f) of this section, concerning the existence or the amount of the debt or the terms of the proposed repayment schedule under the garnishment order, except that the debtor is not entitled to a hearing concerning the proposed repayment schedule if the terms were established by written agreement pursuant to paragraph (1)(iii)(B) of this section; and

(iv) The periods within which the debtor may exercise his or her rights.

(2) *Treasury will keep a copy of the dated notice.* The notice may be retained electronically so long as the manner of retention is sufficient for evidentiary purposes.

(f) *Hearing*—(1) *In general.* Upon timely written request of the debtor, Treasury will provide a paper or oral hearing concerning the existence or amount of the debt, or the terms of a repayment schedule established other than by written agreement under paragraph (e)(1)(iii)(B) of this section.

(2) *Request for hearing.* (i) The request for a hearing must be signed by the debtor, state each issue being disputed, and identify and explain with reasonable specificity all facts and evidence that the debtor believes support the debtor's position. Supporting documentation identified by the debtor should be attached to the request.

(ii) Effect of timely request: Subject to paragraph (e)(10) of this section, if the debtor's written request is received on or before the 15 business days following the mailing of the notice required under this part, a withholding order will not be issued under paragraph (g) of this section until the debtor has been provided the requested hearing, and a decision in accordance with paragraphs (e)(7) and (8) of this section has been rendered.

(iii) Failure to timely request a hearing: If the debtor's written request is received after the 15th business day following the mailing of the notice required under this part, Treasury will provide a hearing to the debtor. However, Treasury may not delay the issuance of a withholding order unless they determine that the delay in submitting such request was caused by factors beyond the control of the debtor, or receive information that they determine justifies a delay or cancellation of the withholding order.

(3) *Oral hearing.* (i) For purposes of this section, a debtor will be provided a reasonable opportunity for an oral hearing when the hearing official determines that the issues in dispute cannot be resolved by review of the documentary evidence, such as when the validity of the claim turns on the issue of credibility or veracity.

(ii) If the hearing official decides to have a hearing, a debtor can specify to Treasury whether he or she wants to appear in person or by telephone. At the debtor's option, the oral hearing may be conducted in person or by telephone conference. The hearing official will notify the debtor of the date, time, and in the case of an in-person hearing, the location of the hearing. All travel expenses incurred by the debtor in connection with an in-person hearing will be borne by the debtor.

(4) *Paper hearing.* (i) If the hearing official determines an oral hearing is not required by this section, the hearing official will afford the debtor a paper hearing, that is, the issues in dispute will be decided based upon a review of the written record.

(ii) The hearing official will notify the debtor of the deadline for the submission of additional evidence if necessary for a review of the record.

(5) *Burden of proof.* (i) Treasury has the initial burden of proving the existence or amount of the debt.

(ii) Thereafter, if the debtor disputes the existence or amount of the debt, the debtor must present Treasury preponderant evidence that no debt exists or that the amount is incorrect. Debtors challenging the terms of a repayment schedule must provide preponderant evidence to Treasury that the terms of the repayment schedule are unlawful, would cause the debtor financial hardship, or that operation of law prohibits collection of the debt.

(6) *Record.* The hearing official will maintain a summary record of any hearing provided under this part. A hearing is not required to be a formal evidentiary-type hearing, but witnesses who testify in an oral hearing must do so under oath or affirmation.

(7) *Date of decision.* (i) The hearing official will issue a written decision, as soon as practicable, but no later than 60 days after the date on which the request for the hearing was received by the agency.

(ii) If the hearing official is unable to provide the debtor with a hearing and render a decision within 60 days after the receipt of the request for such hearing:

(A) A withholding order may not be issued until the hearing is held and a decision is rendered; or

(B) A withholding order previously issued to the debtor's employer must be suspended beginning on the 61st day after the receipt of the hearing request and continuing until a hearing is held and a decision is rendered.

(8) *Content of decision.* The written decision will include:

(i) A summary of the facts presented;

(ii) The hearing official's findings, analysis, and conclusions; and

(iii) The terms of any repayment schedule, if applicable.

(9) *Final agency action.* The hearing official's decision will be the final agency action for the purposes of judicial review under the Administrative Procedure Act. 5 U.S.C. 701 *et seq.*

(10) *Failure to appear.* In the absence of good cause shown, a debtor who fails to appear at a hearing will be deemed as not having timely filed a request for a hearing.

(g) *Withholding order.* Unless Treasury receives information that determines a justified delay or cancellation of a withholding order, Treasury will send, by first class mail, an SF–329A ''Letter to Employer & Important Notice to Employer,'' an SF–329B ''Wage Garnishment Order,'' an SF–329C ''Wage Garnishment Worksheet,'' and an SF–329D ''Employer Certification'' to the debtor's employer within 30 days after the debtor fails to make a timely request for a hearing or, if the timely request for a hearing is made by the debtor, within 30 days after a final decision is made by the agency to proceed with garnishment.

(h) *Certification by employer.* The employer must complete and return the SF–329D ''Employer Certification'' within 20 days of receipt.

(i) *Amounts withheld.* (1) After receipt of a withholding order issued under this part, the employer will deduct from all disposable pay paid to the debtor during each pay period the amount of garnishment described in paragraph (h)(2) of this section. The employer may use the SF–329C ''Wage Garnishment Worksheet'' to calculate the amount to be deducted from the debtor's disposable pay.

(2) Subject to paragraphs (h)(3)(i) and (h)(4) of this section, the amount of garnishment will be the lesser of:

(i) The amount indicated on the garnishment order up to 15 percent of the debtor's disposable pay; or

(ii) The amount set forth in 15 U.S.C. 1673(a)(2) (Maximum allowable garnishment). The amount set forth at 15 U.S.C. 1673(a)(2) is the amount by which a debtor's disposable pay exceeds an amount equivalent to thirty times the minimum wage. See 29 CFR 870.10.

(3)(i) Except as provided in paragraph (h)(3)(ii) of this section, when a debtor's pay is subject to multiple withholding orders, unless otherwise provided by Federal law, withholding orders issued pursuant to this part will have priority over other withholding orders that are served later.

(ii) Notwithstanding the foregoing, withholding orders for family support will have priority over withholding orders issued under this part.

(iii) If amounts are being withheld from a debtor's pay pursuant to a withholding order served on an employer before a withholding order issued pursuant to this part, or if a withholding order for family support is served on an employer at any time, the amounts withheld pursuant to a withholding order issued under this part will be the lesser of:

(A) The amount calculated under paragraph (h)(3)(iii)(B) of this section; or

(B) An amount equal to 25 percent of the debtor's disposable pay less the amount(s) withheld under the withholding order(s) with priority.

(4) If the debtor owes more than one debt to the agency, Treasury will issue multiple withholding orders provided that the total amount garnished from the debtor's pay for such orders does not exceed the amount set forth in paragraph (h)(2) of this section.

(5) An amount greater than that set forth in paragraphs (h)(2) or (3) of this section may be withheld with the debtor's written consent.

(6) The employer will promptly pay all amounts withheld in accordance with the withholding order issued pursuant to this part.

(7) The employer is not required to vary its normal pay and disbursement cycles in order to comply with the withholding order.

(8) Any assignment or allotment by an employee will be void to the extent it interferes with or prohibits execution of the withholding order issued under this part, except for any assignment or allotment made pursuant to a family support judgment or order.

(9) The employer will withhold the appropriate amount from the debtor's wages for each pay period until the employer receives notification from the agency to discontinue wage withholding.

(10) The withholding order, SF–329B ''Wage Garnishment Order,'' sent to the employer under paragraph (g) of this section, requires the employer to commence wage withholding on the first payday after the employer receives the order. However, if the first payday is within 10 days after receipt of the order, the employer may elect to begin deductions on the second payday.

(11) An employer may not discharge, refuse to employ, or take disciplinary action against any debtor because of the issuance of a withholding order under this part.

(j) *Financial hardship.* (1) A debtor whose wages are subject to a withholding order may, at any time, request a review by Treasury of the amount garnished, based on materially changed circumstances, such as disability, divorce, or catastrophic illness, which result in financial hardship.

(2) A debtor requesting review under paragraph (i)(1) of this section will submit the basis for the claim that the current amount of garnishment results in a financial hardship to the debtor, along with supporting documentation. Treasury will consider any information submitted in accordance with this part.

(3) If Treasury finds financial hardship, to reflect the debtor's financial condition, Treasury will downwardly adjust the amount garnished by an amount and for a period established by the agency. Treasury will notify the employer of any adjustments in the amount to be withheld.

(k) *Fraud and willful concealment or failure to furnish information.* Treasury will not reduce the amount that the employer withholds from disposable pay if the debt was caused by an intentional false statement.

(l) *Refunds.* (1) If the hearing official, pursuant to a hearing under this part, determines that a debt is not legally due and owing to the United States, Treasury will promptly refund any amount collected by means of Administrative Wage Garnishment.

(2) Unless required by Federal law or contract, refunds under this part will not bear interest.

(m) *Ending garnishment.* (1) Once Treasury has fully recovered the amounts owed by the debtor, including interest, penalties, and administrative costs assessed pursuant to and in accordance with § 422.803 of this title, Treasury will send the debtor's employer notification to discontinue wage withholding.

(2) At least annually, Treasury will review debtors' accounts to ensure that garnishment has ended for accounts that have been paid in full.

(n) *Employers' responsibilities and right of action.* (1) The employer of a debtor subject to wage withholding pursuant to this part will pay the agency as directed in a withholding order issued under this part.

(2) Treasury may bring suit against an employer for any amount that the employer fails to withhold from wages owed and payable to a debtor in accordance with paragraphs (g) and (i) of this section, plus attorney's fees, costs, and, if applicable, punitive damages.

(3) A suit under this section may not be filed before the end of the collection action involving a particular debtor, unless earlier filing is necessary to

avoid expiration of any applicable statute of limitations period. For purposes of this section, ''end of collection action'' occurs when we have completed taking collection action in accordance with part 422, subpart I of this title or other applicable law or regulation.

(4) Notwithstanding any other provision or action referred to in this section, the end of the collection action will be deemed to occur one (1) year after the agency does not receive any payment of wages that were subject to a garnishment order issued under this part.

§ 422.835 Debt reporting and use of credit reporting agencies.

(a) *Reporting delinquent debts.* (1) We may report delinquent debts over $25 to credit bureaus or other automated databases.

(2) We will report administrative debts owed by individuals to consumer reporting agencies pursuant to 5 U.S.C. 552a(b)(12). We may disclose only the individual's name, address, and Social Security number and the nature, amount, status, and history of the debt.

(3) Once we refer a debt to the Department of the Treasury (Treasury) for collection, Treasury may handle any subsequent reporting to or updating of a credit bureau or other automated database.

(4) Where there is reason to believe that a debtor has filed a bankruptcy petition, prior to proceeding under this paragraph (a), we will contact the Office of the General Counsel for legal advice concerning the impact of the Bankruptcy Code, particularly with respect to the applicability of the automatic stay, 11 U.S.C. 362, and the procedures for obtaining relief from such stay.

(5) If the debtor has not received prior notice under § 422.805, before reporting a delinquent debt under this section, we will provide the debtor at least 60 days notice including:

(i) The amount and nature of the debt;

(ii) That the debt is delinquent and that we intend to report the debt to a credit bureau;

(iii) The specific information that we will disclose;

(iv) The right to dispute the accuracy and validity of the information being disclosed; and

(v) If a previous opportunity was not provided, the right to request review of the debt or rescheduling of payment.

(b) *Use of credit reporting agencies.* We may use credit-reporting agencies to determine a debtor's ability to repay a debt and to locate debtors. In the case of an individual, we may disclose, as a routine use under 5 U.S.C. 552a(b)(3), only the individual's name, address, and Social Security number, and the purpose for which the information will be used.

§ 422.837 Contracting with private collection contractors and with entities that locate and recover unclaimed assets.

(a) Subject to the provisions of paragraph (b) of this section, we may contract with private collection contractors to recover delinquent debts, if:

(1) We retain the authority to resolve disputes, compromise debts, suspend or terminate collection action, and, as appropriate, to refer debts to the Department of Justice for review and litigation;

(2) The private collection contractor is not allowed to offer the debtor, as an incentive for payment, the opportunity to pay the debt less the private collection contractor's fee, unless we have granted such authority prior to the offer;

(3) The contract provides that the private collection contractor is subject to the Privacy Act of 1974 to the extent specified in 5 U.S.C. 552a(m) and to applicable Federal and State laws and regulations pertaining to debt collection practices, including, but not limited, to the Fair Debt Collection Practices Act, 15 U.S.C. 1692; and

(4) The private collection contractor is required to account for all amounts collected.

(b) We will use government-wide debt collection contracts to obtain debt collection services provided by private collection contractors. However, we may refer debts to private collection contractors pursuant to a contract between the agency and the private collection contractor only if such debts are not subject to the requirement to

transfer debts to the Treasury for debt collection under 31 U.S.C. 3711(g) and 31 CFR 285.12(e).

(c) Debts arising under the Social Security Act (which can be collected by private collection contractors only by Department of the Treasury (Treasury) after the debt has been referred to Treasury for collection) are excluded from this section.

(d) We may fund private collection contractor contracts in accordance with 31 U.S.C. 3718(d) or as otherwise permitted by law. A contract under paragraph (a) of this section may provide that the fee a private collection contractor charges the agency for collecting the debt is payable from the amounts collected.

(e) We may enter into contracts for locating and recovering assets of the United States, including unclaimed assets. However, before entering into a contract to recover assets of the United States that may be held by a State Government or financial institution, we must establish procedures that are acceptable to the Secretary of the Treasury.

(f) We enter into contracts for debtor asset and income search reports. In accordance with 31 U.S.C. 3718(d), such contracts may provide that the fee a contractor charges the agency for such services may be payable from the amounts recovered unless otherwise prohibited by statute.

§ 422.839 Offset against amounts payable from civil service retirement and disability fund and the Federal employees' retirement system.

Upon providing the Office of Personnel Management (OPM) written certification that a debtor has been afforded the procedures provided in § 422.823 of this part, we may request OPM to offset a debtor's anticipated or future benefit payments under the Civil Service Retirement and Disability Fund (Fund) and the Federal Employees' Retirement System (FERS) in accordance with regulations codified at 5 CFR 831.1801 through 831.1808, and 5 CFR part 845 Subpart D. Upon receipt of such a request, OPM will identify and ''flag'' a debtor's account in anticipation of the time when the debtor requests, or becomes eligible to receive, payments from the Fund or FERS.

§ 422.842 Liquidation of collateral.

(a)(1) If the debtor fails to pay the debt(s) within a reasonable time after demand and if such action is in the best interests of the United States, we will liquidate security or collateral through the exercise of a power of sale in the security instrument or a non-judicial foreclosure and apply the proceeds to the applicable debt(s).

(2) Collection from other sources, including liquidation of security or collateral, is not a prerequisite to requiring payment by a surety, insurer, or guarantor unless such action is expressly required by statute or contract.

(3) We will give the debtor reasonable notice of the sale and an accounting of any surplus proceeds and will comply with other requirements under law or contract.

(b) Where there is reason to believe that a bankruptcy petition has been filed with respect to a debtor, we will contact the Office of the General Counsel for legal advice concerning the impact of the Bankruptcy Code, particularly with respect to the applicability of the automatic stay, 11 U.S.C. 362, and the procedures for obtaining relief from such stay prior to proceeding under paragraph (a) of this section.

§ 422.846 Bases for compromise.

(a) *Scope and application*—(1) *Scope.* The standards set forth in this subpart apply to the compromise of administrative debts pursuant to 31 U.S.C. 3711. We may exercise such compromise authority for debts arising out of activities of, or referred or transferred for collection services to, the agency when the amount of the debt then due, exclusive of interest, penalties, and administrative costs, does not exceed $100,000 or any higher amount authorized by the Attorney General.

(2) *Application.* Unless otherwise provided by law, when the principal balance of a debt, exclusive of interest, penalties, and administrative costs, exceeds $100,000 or any higher amount authorized by the Attorney General, the authority to accept a compromise rests with the Department of Justice (DOJ). We will evaluate the compromise offer

using the factors set forth in this subpart. If an offer to compromise any debt in excess of $100,000 is acceptable to the agency, we will refer the debt to the Civil Division or other appropriate litigating division in the DOJ using a Claims Collection Litigation Report (CCLR). A CCLR may be obtained from the DOJ's National Central Intake Facility. The referral will include appropriate financial information and a recommendation for the acceptance of the compromise offer. DOJ approval is not required if we reject a compromise offer.

(b) *Bases for compromise*—(1) *Compromise.* We may compromise a debt if the agency cannot collect the full amount based upon the debtor's inability to pay, inability to collect the full debt, the cost of collection, or if we are doubtful that the debt can be proven in court.

(i) *Inability to pay.* We may compromise a debt if the debtor is unable to pay the full amount in a reasonable time, as verified through credit reports or other financial information. In determining a debtor's inability to pay the full amount of the debt within a reasonable time, we will obtain and verify the debtor's claim of inability to pay by using credit reports and/or a current financial statement from the debtor, executed under penalty of perjury, showing the debtor's assets, liabilities, income, and expenses. We may use a financial information form used in connection with the agency's programs or may request suitable forms from the DOJ or the local United States Attorney's Office. We also may consider other relevant factors such as:

(A) Age and health of the debtor;

(B) Present and potential income;

(C) Inheritance prospects;

(D) The possibility that assets have been concealed or improperly transferred by the debtor; and

(E) The availability of assets or income that may be realized by enforced collection proceedings.

(ii) *Inability to collect full debt.* We may compromise a debt if the Government is unable to collect the debt in full within a reasonable time by enforced collection proceedings.

(A) In determining the Government's ability to enforce collection, we will consider the applicable exemptions available to the debtor under State and Federal law, and we may also consider uncertainty as to the price any collateral or other property will bring at a forced sale.

(B) A compromise affected under this section should be for an amount that bears a reasonable relation to the amount that can be recovered by enforced collection procedures, with regard to any exemptions available to the debtor and the time that collection will take.

(iii) *Cost of collection.* We may compromise a debt if the cost of collecting the debt does not justify the enforced collection of the full amount.

(A) The amount accepted in compromise of such debts may reflect an appropriate discount for the administrative and litigation costs of collection, with consideration given to the time it will take to effect collection. Collection costs may be a substantial factor in the settlement of small debts.

(B) In determining whether the costs of collection justify enforced collection of the full amount, we will consider whether continued collection of the debt, regardless of cost, is necessary to further an enforcement principal, such as the Government's willingness to pursue aggressively defaulting and uncooperative debtors.

(iv) *Doubtful debt can be proven in court.* We may compromise a debt if there is significant doubt concerning the Government's ability to prove its case in court.

(A) If significant doubt exists concerning the Government's ability to prove its case in court for the full amount claimed, either because of the legal issues involved or because of a legitimate dispute as to the facts, then the amount accepted in compromise should fairly reflect the probabilities of successful prosecution to judgment, with due regard to the availability of witnesses and other evidentiary support for the Government's claim.

(B) In determining the litigation risks involved, we will consider the probable amount of court costs and attorney fees a court may impose pursuant to the Equal Access to Justice Act, 28 U.S.C. 2412, if the Government is unsuccessful in litigation.

(2) *Installments.* We may not accept compromises payable in installments. This is not an advantageous form of compromise in terms of time and administrative expense. If, however, payment in installments is necessary in cases of compromise based on paragraphs (b)(1)(i) through (iii) of this section, we will obtain a legally enforceable written agreement providing that, in the event of default, the full original principal balance of the debt prior to compromise, less sums paid thereon, is reinstated. In cases of compromise based on paragraph (b)(1)(iv) of this section, we will consult with the Office of the General Counsel concerning the appropriateness of including such a requirement in the legally enforceable written agreement. Whenever possible, we will obtain security for repayment in the manner set forth in § 422.809.

(c) *Enforcement policy.* Subject to the Commissioner's approval, we may compromise statutory penalties, forfeitures, or claims established as an aid to enforcement and to compel compliance if our enforcement policy, in terms of deterrence and securing compliance, present, and future, will be adequately served by the agency's acceptance of the sum to be agreed upon.

(d) *Joint and several liability.* (1) When two or more debtors are jointly and severally liable, we will pursue collection against all debtors, as appropriate. We will not attempt to allocate the burden of payment between the debtors but will proceed to liquidate the indebtedness as quickly as possible.

(2) We will ensure that a compromise agreement with one debtor does not automatically release the agency's claim against the remaining debtor(s). The amount of a compromise with one debtor will not be considered a precedent or binding in determining the amount that will be required from other debtors jointly and severally liable on the claim.

(e) *Further review of compromise offers.* If we are uncertain whether to accept a firm, written, substantive compromise offer on a debt that is within the agency's statutory compromise authority, we may use a CCLR with supporting data and particulars concerning the debt to refer the offer to the DOJ's Civil Division or other appropriate litigating division. The DOJ may act upon such an offer or return it to the agency with instructions or advice.

(f) *Consideration of tax consequences to the Government.* In negotiating a compromise, we will consider the tax consequences to the Government. In particular, we will consider requiring a waiver of tax-loss-carry-forward and tax-loss-carry-back rights of the debtor. For information on discharge of indebtedness reporting requirements, see § 422.848(e).

(g) *Mutual release of the debtor and the Government.* In all appropriate instances, a compromise that is accepted will be implemented by means of a mutual release. The terms of such mutual release will provide that the debtor is released from further non-tax liability on the compromised debt in consideration of payment in full of the compromise amount, and the Government and its officials, past and present, are released and discharged from any and all claims and causes of action arising from the same transaction that the debtor may have. In the event a mutual release is not executed when a debt is compromised, unless prohibited by law, the debtor is still deemed to have waived any and all claims and causes of action against the Government and its officials related to the transaction giving rise to the compromised debt.

§ 422.848 Suspension and termination of collection activities.

(a) *Scope and application*—(1) *Scope.* The standards set forth in this subpart apply to the suspension or termination of collection activity pursuant to 31 U.S.C. 3711 on debts that do not appear to be fraudulent or that do not exceed $100,000, or such other amount as the Attorney General may direct, exclusive of interest, penalties, and administrative costs, after deducting the amount of partial payments or collections, if any. Prior to referring a debt to the Department of Justice (DOJ) for litigation, we may suspend or terminate collection under this subpart with respect to such debts that arise out of the activities of, or are referred or transferred for collection services to, the agency.

(2) *Application.* (i) If the debt stems from a claim that appears to be fraudulent, false, or misrepresented by a party with an interest in the claim or after deducting the amount of partial payments or collections, the principal amount of the debt exceeds $100,000, or such other amount as the Attorney General may direct, exclusive of interest, penalties, and administrative costs, the authority to suspend or terminate rests solely with the DOJ.

(ii) If we believe that suspension or termination of any debt that relates to a claim that appears to be fraudulent, false, or misrepresented by a party with an interest in the claim or that exceeds $100,000 may be appropriate, we will use the Claims Collection Litigation Report to refer the debt to the Civil Division or other appropriate litigating division in the DOJ. The referral will specify the reasons for our recommendation. If, prior to referral to the DOJ, we determine that a debt is plainly erroneous or clearly without merit, we may terminate collection activity regardless of the suspected fraud or amount involved without obtaining the DOJ's concurrence.

(b) *Suspension of collection activity.* (1) We may suspend collection activity on a debt when:

(i) The debtor cannot be located;

(ii) The debtor's financial condition is not expected to improve; or

(iii) The debtor has requested a legally permissible waiver or review of the debt.

(2) *Financial condition.* Based on the current financial condition of a debtor, we may suspend collection activity on a debt when the debtor's future prospects justify retention of the debt for periodic review and collection activity, and:

(i) No applicable statute of limitations has expired; or

(ii) Future collection can be effected by Administrative Offset, notwithstanding the expiration of the applicable statute of limitations for litigation of claims, with due regard to any statute of limitation for Administrative Offset prescribed by 31 U.S.C. 3716(e)(1); or

(iii) The debtor agrees to pay interest on the amount of the debt on which collection will be suspended and suspension is likely to enhance the debtor's ability to pay the full amount of the principal of the debt with interest at a later date.

(3) *Waiver or review.* (i) We will suspend collection activity during the time required for consideration of the debtor's request for waiver or administrative review of the debt if the statute under which the request is sought prohibits us from collecting the debt during that time.

(ii) If the statute under which the waiver or administrative review request is sought does not prohibit collection activity pending consideration of the request, we may use discretion, on a case-by-case basis, to suspend collection. We will ordinarily suspend collection action upon a request for waiver or review if we are prohibited by statute or regulation from issuing a refund of amounts collected prior to agency consideration of the debtor's request. However, we will not suspend collection when we determine that the request for waiver or review is frivolous or was made primarily to delay collection.

(4) *Bankruptcy.* Upon learning that a bankruptcy petition has been filed with respect to a debtor, we must suspend collection activity on the debt, pursuant to the provisions of 11 U.S.C. 362, 1201, and 1301, unless we can clearly establish that the automatic stay has been lifted or is no longer in effect. In such cases, we will consult our Office of the General Counsel for advice. When appropriate, the Office of the General Counsel will take the necessary legal steps to ensure that no funds or money are paid by the agency to the debtor until relief from the automatic stay is obtained.

(c) *Termination of collection activity.* (1) We may terminate collection activity when:

(i) We are unable to collect any substantial amount through our own efforts or through the efforts of others;

(ii) We are unable to locate the debtor;

(iii) Costs of collection are anticipated to exceed the amount recoverable;

(iv) The debt is legally without merit or enforcement of the debt is barred by any applicable statute of limitations;

(v) The debt cannot be substantiated; or

(vi) The debt against the debtor has been discharged in bankruptcy.

(2)(i) Collection activity will not be terminated before we have pursued all appropriate means of collection and determined, based upon the results of the collection activity, that the debt is uncollectible.

(ii) Termination of collection activity ceases active collection of the debt. The termination of collection activity does not preclude us from retaining a record of the account for purposes of:

(A) Selling the debt, if the Secretary of the Department of the Treasury (Treasury) determines that such sale is in the best interest of the United States;

(B) Pursuing collection at a subsequent date in the event there is a change in the debtor's status or a new collection tool becomes available;

(C) Offsetting against future income or assets not available at the time of termination of collection activity; or

(D) Screening future applicants for prior indebtedness.

(3) We will terminate collection activity on a debt that has been discharged in bankruptcy, regardless of the amount. We may continue collection activity, however, subject to the provisions of the Bankruptcy Code, for any payments provided under a plan of reorganization. Offset and recoupment rights may survive the discharge of the debtor in bankruptcy and, under some circumstances, claims also may survive the discharge. For example, when we are a known creditor of a debtor, the claims of the agency may survive a discharge if we did not receive notice of the bankruptcy proceeding or the debt was affected by fraud. When we believe that the agency has claims or offsets that may have survived the discharge of the debtor, we will contact the Office of the General Counsel for legal advice.

(d) *Exception to termination.* When a significant enforcement policy is involved or recovery of a judgment is a prerequisite to the imposition of administrative sanctions, we may refer debts to the DOJ for litigation even though termination of collection activity may otherwise be appropriate.

(e) *Discharge of indebtedness; reporting requirements.* (1)(i) Before discharging a delinquent debt, also referred to as close out of the debt, we will take all appropriate steps to collect the debt in accordance with 31 U.S.C. 3711(g)(9), and §§ 422.803 and 422.810 of this part, including, as applicable, Administrative Offset; tax refund offset; Federal Salary Offset; credit bureau reporting; Administrative Wage Garnishment; litigation; foreclosure; and referral to the Treasury, Treasury-designated debt collection centers, or private collection contractors.

(ii) Discharge of indebtedness is distinct from termination or suspension of collection activity under this subpart, and is governed by the Internal Revenue Code. When collection action on a debt is suspended or terminated, the debt remains delinquent and further collection action may be pursued at a later date in accordance with the standards set forth in this part and 31 CFR parts 900 through 904.

(iii) When we discharge a debt in full or in part, further collection action is prohibited. Therefore, before discharging a debt, we must:

(A) Make the determination that collection action is no longer warranted; and

(B) Terminate debt collection action.

(2) In accordance with 31 U.S.C. 3711(i), we will use competitive procedures to sell a delinquent debt upon termination of collection action if the Secretary of the Treasury determines such a sale is in the best interests of the United States. Since the discharge of a debt precludes any further collection action, including the sale of a delinquent debt, we may not discharge a debt until the requirements of 31 U.S.C. 3711(i) have been met.

(3) Upon discharge of indebtedness, we must report the discharge to the Internal Revenue Service (IRS) in accordance with the requirements of 26 U.S.C. 6050P and 26 CFR 1.6050P–1. We may request that Treasury or Treasury-designated debt collection centers file such a discharge report to the IRS on our behalf.

(4) When discharging a debt, we must request that litigation counsel release any liens of record securing the debt.

[80 FR 61734, Oct. 14, 2015, as amended at 88 FR 1329, Jan. 10, 2023]

§ 422.850 Referrals to the Department of Justice.

(a) *Prompt referral.* (1)(i) We will promptly refer to the Department of Justice (DOJ) for litigation debts on which aggressive collection activity has been taken in accordance with § 422.803, and that cannot be compromised, or on which collection activity cannot be suspended or terminated, in accordance with § 422.848.

(ii) We may refer debts arising out of activities of, or referred or transferred for collection services to, the agency to DOJ for litigation.

(2)(i) Debts for which the principal amount is over $100,000 or such other amount as the Attorney General may direct, exclusive of interest, penalties, and administrative costs will be referred to the Civil Division or other division responsible for litigating such debts at the DOJ.

(ii) Debts for which the principal amount is $1,000,000 or less, or such other amount as the Attorney General may direct, exclusive of interest, penalties, and administrative costs will be referred to the Nationwide Central Intake Facility at the DOJ as required by the Claims Collections Litigation Report (CCLR) instructions.

(3)(i) Consistent with aggressive agency collection activity and the standards contained in this part and 31 CFR parts 900 through 904, debts will be referred to the DOJ as early as possible and, in any event, well within the period for initiating timely lawsuits against the debtors.

(ii) We will make every effort to refer delinquent debts to the DOJ for litigation within one year of the date such debts last became delinquent. In the case of guaranteed or insured loans, we will make every effort to refer these delinquent debts to the DOJ for litigation within one year from the date the debt was known to the agency.

(4) The DOJ has exclusive jurisdiction over debts referred to it pursuant to this subpart. Upon referral of a debt to the DOJ, we will:

(i) Immediately terminate the use of any administrative collection activities to collect the debt;

(ii) Advise the DOJ of the collection tools utilized and the results of activities to date; and

(iii) Refrain from having any contact with the debtor and direct all debtor inquiries concerning the debt to the DOJ.

(5) After referral of a debt under this subpart, we will immediately notify the DOJ of any payments credited by the agency to the debtor's account. Pursuant to 31 CFR 904.1(b), after referral of the debt under this subpart, the DOJ will notify the agency of any payment received from the debtor.

(b) *Claims Collection Litigation Report.* (1)(i) Unless excepted by the DOJ, we will complete a CCLR and associated signed Certificate of Indebtedness to refer all administratively uncollectible claims to the DOJ for litigation.

(ii) We will complete all sections of the CCLR appropriate to each debt as required by the CCLR instructions and furnish such other information as may be required in specific cases.

(2) We will indicate clearly on the CCLR the actions that we wish the DOJ to take with respect to the referred debt. We may indicate specifically any of a number of litigation activities the DOJ may choose to pursue, including enforced collection, judgment lien only, renew judgment lien only, renew judgment lien and enforced collection, program enforcement, foreclosure only, and foreclosure and deficiency judgment.

(3) We will also use the CCLR to refer a debt to the DOJ for the purpose of obtaining any necessary approval of a proposal to compromise a debt or to suspend or terminate administrative collection activity on a debt.

(c) *Preservation of evidence.* We will maintain and preserve all files and records that may be needed by the DOJ to prove our claim in court. When referring debts to the DOJ for litigation, certified copies of the documents that form the basis for the claim should be provided along with the CCLR. Upon its request, the original documents will be provided to the DOJ.

(d) *Minimum amount of referrals.* (1) Except as provided in paragraph (d)(2)

of this section, we will not refer for litigation claims of less than $2,500 exclusive of interest, penalties, and administrative costs, or such other amount as the Attorney General may prescribe.

(2) We will not refer claims of less than the minimum amount unless:

(i) Litigation to collect such smaller amount is important to ensure compliance with the agency's policies and programs;

(ii) The agency is referring the claim solely for the purpose of securing a judgment against the debtor, which will be filed as a lien against the debtor's property pursuant to 28 U.S.C. 3201 and returned to the agency for enforcement; or

(iii) The debtor has the clear ability to pay the claim and the Government can enforce payment effectively, with due regard for the exemptions available to the debtor under State and Federal law and the judicial remedies available to the Government.

(3) We will consult with the Financial Litigation Staff of the Executive Office for United States Attorneys at DOJ prior to referring claims valued at less than the minimum amount.

Subpart J—Protecting the Public and Our Personnel To Ensure Operational Effectiveness

AUTHORITY: Sec. 702(a)(4)–(5) of the Social Security Act (42 U.S.C. 902(a)(4)–(5)).

SOURCE: 76 FR 54702, Sept. 2, 2011, unless otherwise noted.

§ 422.901 Scope and purpose.

The regulations in this subpart describe the process we will follow when we decide whether to ban you from entering our offices. Due to increasing reports of threats to our personnel and the public, we are taking steps to increase the level of protection we provide to our personnel and to the public. The purpose of this subpart is to inform the public and our personnel of the conduct that will subject an individual to a ban and the procedures we will follow when banning an individual from entering our offices. We expect that the regulations will result in a safer environment for our personnel and the public who visit our facilities, while ensuring that our personnel can continue to serve the American people with as little disruption to our operations as possible.

§ 422.902 Definition of personnel for purposes of this subpart.

We will construe the term ''personnel'' broadly to mean persons responsible for or engaged in carrying out the responsibilities, programs, or services of or on behalf of the agency. Personnel includes, but is not limited to, our employees, contractors, consultants, and examiners and State disability determination services (DDS) employees, contractors, consultants, and examiners.

§ 422.903 Prohibited conduct.

We will ban you from entering our offices if you:

(a) Physically or verbally assault our personnel or a member of the public in our occupied space;

(b) Use force or threats of force against our personnel or offices, including but not limited to communicating threats in person or by phone, facsimile, mail, or electronic mail;

(c) Engage in disruptive conduct that impedes our personnel from performing their duties; or

(d) Engage in disruptive conduct that impedes members of the public from obtaining services from our personnel.

§ 422.904 Notice of the ban.

If an agency manager makes a decision in writing that you pose a threat to the safety of our personnel, visitors, office, or the operational effectiveness of the agency, we will send you a notice banning you from our offices. The notice will contain the following information:

(a) *Type of restriction.* If we ban you from entering our offices, the ban will apply to all of our offices, and you must obtain all future service through alternate means. We will provide you in-person service only if you establish that there are no alternate means available. You must direct your request for in-person service to the manager of the office you are requesting to visit. If we determine that an office visit is warranted, we will schedule an

appointment for you and send you a certified letter notifying you of the date, time, and location of the appointment.

(b) *Prohibited conduct.* We will provide you with specific details of the prohibited conduct that served as the basis for our decision to ban you.

(c) *Alternate means of service.* If you are banned from entering our offices, you still have several means to receive services:

(1) You may use the online services available through our Web site at *http://www.socialsecurity.gov;*

(2) You may call your local office. Your notice will include the contact information for your local office. You should ask to speak with the office manager or a supervisor;

(3) You may call our national toll-free number at 1–800–772–1213 between the hours of 7 a.m. and 7 p.m., Monday through Friday. You should not attempt to schedule an in-person appointment through this number. If you are deaf or hard of hearing, you may call our toll-free TTY number at 1–800–325–0778;

(4) You may write to your local office. You should address all correspondence to the attention of the office manager;

(5) With your written consent, another person may call, write, or visit us to conduct business on your behalf.

(d) *Appeal rights.* The notice will provide you with information on how to appeal the ban.

(e) *Periodic request for review of ban decision.* The notice will provide you with information on how to request review of the ban determination every three years from the date of the ban notice, or if you appeal the ban, the date of the appeal decision.

§ 422.905 Appeal rights.

You may appeal our decision to ban you. You must submit your appeal in writing to the address identified in the notice within 60 days of the date of the notice. You should identify your name, address, Social Security number, and the office that issued the notice of the ban. The appeal should clearly state why we should reconsider our decision and provide any supporting documentation. We may allow an additional 10 days for the late filing of an appeal if you show good cause for the late filing. The ban will remain in effect while the appeal is pending. We will notify you of our decision in writing.

§ 422.906 Periodic request for review of ban decision.

You may request review of our ban decision every three years. The three-year cycle to request review will begin on the date we issued notice of the ban, or if you appealed, the date of our appeal decision. You must submit your request for review of a ban decision in writing to the address identified in the original notice of the ban. Your request for review should identify your name, address, Social Security number, and office that issued the notice of the ban. Your request should clearly state why we should lift the ban and provide relevant documentation that supports removal of the restriction, including medical documentation, applicable psychiatric evaluations, work history, and any criminal record. You must prove by a preponderance of the evidence (meaning that it is more likely than not) that you no longer pose a threat to the safety of our personnel or visitors or the operational effectiveness of the agency. We will notify you of our decision in writing.

§ 422.907 Posting requirement.

We will post the regulation in this subpart in a conspicuous place in our offices that serve the public.

PART 423—SERVICE OF PROCESS

Sec.

423.1 Suits against the Social Security Administration and its employees in their official capacities.
423.3 Other process directed to the Social Security Administration or the Commissioner.
423.5 Process against Social Security Administration officials in their individual capacities.
423.7 Acknowledgment of mailed process.
423.9 Effect of regulations in this part.

AUTHORITY: Sec. 701 and 702(a)(5) of the Social Security Act (42 U.S.C. 901 and 902(a)(5)).

SOURCE: 60 FR 18992, Apr. 14, 1995, unless otherwise noted.

§ 423.1 Suits against the Social Security Administration and its employees in their official capacities.

(a) *Suits involving individual claims arising under title II, VIII, XVI, or XVIII of the Social Security Act.* (1) In cases seeking judicial review of final decisions of the Commissioner of Social Security on individual claims for benefits under title II, VIII, or XVI of the Social Security Act, or on individual claims for a Medicare Part D subsidy under title XVIII of the Act, summonses and complaints to be served by mail on the Social Security Administration or the Commissioner of Social Security should be sent to the Office of the General Counsel, Office of Program Litigation, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235.

(2) We also accept electronic service in these cases, as provided by the Federal Rules of Civil Procedure.

(b) *Other suits.* In cases that do not involve claims described in paragraph (a) of this section, summonses and complaints to be served by mail on the Social Security Administration or the Commissioner of Social Security should be sent to the Office of the General Counsel, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235.

[88 FR 1329, Jan. 10, 2023]

§ 423.3 Other process directed to the Social Security Administration or the Commissioner.

Subpoenas and other process (other than summonses and complaints) that are required to be served on the Social Security Administration or the Commissioner of Social Security in the Commissioner's official capacity should be served as follows:

(a) If authorized by law to be served by mail, any mailed process should be sent to the Office of the General Counsel, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235.

(b) If served by an individual, the process should be delivered to the Office of the General Counsel, via the agency mail room at Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235.

[88 FR 1330, Jan. 10, 2023]

§ 423.5 Process against Social Security Administration officials in their individual capacities.

Process to be served on Social Security Administration officials in their individual capacities must be served in compliance with the requirements for service of process on individuals who are not governmental officials. The Office of the General Counsel is authorized but not required to accept process to be served on Social Security Administration officials in their individual capacities if the suit relates to an employee's official duties.

§ 423.7 Acknowledgment of mailed process.

The Social Security Administration will not provide a receipt or other acknowledgment of process received, except for a return receipt associated with certified mail and where otherwise required by law.

[88 FR 1330, Jan. 10, 2023]

§ 423.9 Effect of regulations in this part.

The regulations in this part are intended solely to identify Social Security Administration officials who are authorized to accept service of process. Litigants must comply with all requirements pertaining to service of process that are established by statute and court rule even though they are not repeated in this part.

PARTS 424–428 [RESERVED]

PART 429—ADMINISTRATIVE CLAIMS UNDER THE FEDERAL TORT CLAIMS ACT AND RELATED STATUTES

Subpart A—Claims Against the Government Under the Federal Tort Claims Act

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AUTHORITY: 42 U.S.C. 902(a)(5); 28 U.S.C. 2672; 31 U.S.C. 3721; 28 CFR 14.11.

SOURCE: 69 FR 48768, Aug. 11, 2004, unless otherwise noted.

Subpart A—Claims Against the Government Under the Federal Tort Claims Act

§ 429.101 What is this subpart about?

(a) This subpart applies only to claims filed under the Federal Tort Claims Act, as amended, 28 U.S.C. 2671–2680 (FTCA), for money damages against the United States for damage to or loss of property or personal injury or death that is caused by the negligent or wrongful act or omission of an employee of the Social Security Administration (SSA). The loss, damage, injury or death must be caused by the employee in the performance of his or her official duties, under circumstances in which the United States, if a private person, would be liable in accordance with the law of the place where the act or omission occurred. This subpart does not apply to any tort claims excluded from the FTCA under 28 U.S.C. 2680.

(b) This subpart is subject to and consistent with the regulations on administrative claims under the FTCA issued by the Attorney General at 28 CFR part 14.

§ 429.102 How do I file a claim under this subpart?

(a) *Filing an initial claim.* You must either file your claim on a properly executed Standard Form 95 or you must submit a written notification of the incident accompanied by a claim for the money damages in a sum certain for damage to or loss of property you believe occurred because of the incident. For purposes of this subpart, we consider your claim to be filed on the date we receive it at the address specified in paragraph (c) of this section. If you mistakenly send your claim to another Federal agency, we will not consider it to be filed until the date that we receive it. If you mistakenly file a claim meant for another Federal agency with SSA, we will transfer it to the appropriate Federal agency, if possible. If we are unable to determine the appropriate agency, we will return the claim to you.

(b) *Filing an amendment to your claim.* You may file an amendment to your properly filed claim at any time before the SSA Claims Officer (as defined in § 429.201(d)(3)) makes a final decision on your claim or before you bring suit under 28 U.S.C. 2675(a). You must submit an amendment in writing and sign it. If you file a timely amendment, SSA has 6 months in which to finally dispose of the amended claim. Your option to file suit does not begin until 6 months after you file the amendment.

(c) *Where to obtain claims forms and file claims.* You can obtain claims forms by writing to the Office of the General Counsel, Office of General Law, Social Security Administration, Attn: FTCA Claims, 6401 Security Boulevard, Baltimore, MD 21235.

[69 FR 48768, Aug. 11, 2004, as amended at 74 FR 16327, Apr. 10, 2009; 79 FR 7577, Feb. 10, 2014; 88 FR 1330, Jan. 10, 2023]

§ 429.103 Who may file my claim?

(a) *Claims for damage to or loss of property.* If you are the owner of the property interest that is the subject of the claim, you, your duly authorized agent, or your legal representative may file the claim.

(b) *Claims for personal injury.* If you suffered the injury, you, your duly authorized agent, or your legal representative may file the claim.

(c) *Claims based on death.* The executor or administrator of your estate or any other person legally entitled to do so may file the claim.

(d) *Claims for loss wholly compensated by an insurer with the rights of a subrogee.* The insurer may file the claim. When an insurer presents a claim asserting the rights of a subrogee, the insurer must present with the claim appropriate evidence that it has the rights of a subrogee.

(e) *Claims for loss partially compensated by an insurer with the rights of a subrogee.* You and the insurer may file, jointly or separately. When an insurer presents a claim asserting the rights of a subrogee, the insurer must present with the claim appropriate evidence that it has the rights of a subrogee.

(f) *Claims by authorized agents or other legal representatives.* Your duly authorized agent or other legal representative may submit your claim, provided satisfactory evidence is submitted establishing that person has express authority to act on your behalf. A claim presented by an agent or legal representative must be presented in your name. If the claim is signed by the agent or legal representative, it must show the person's title or legal capacity and must be accompanied by evidence that the person has the authority to file the claim on your behalf as agent, executor, administrator, parent, guardian or other representative.

§ 429.104 What evidence do I need to submit with my claim?

(a) *Property damage.* To support a claim for property damage, either real or personal, you may be required to submit the following evidence or information:

(1) Proof of ownership.

(2) A detailed statement of the amount claimed with respect to each item of property.

(3) An itemized receipt of payment for necessary repairs or itemized written estimates of the cost of such repairs.

(4) A statement listing date of purchase, purchase price, market value of the property as of date of damage, and salvage value, where repair is not economical.

(5) Any other evidence or information that may have a bearing either on the responsibility of the United States for the injury to or loss of property or the damages claimed.

(b) *Personal injury.* To support a claim for personal injury, including pain and suffering, you may be required to submit the following evidence or information:

(1) A written report from your attending physician or dentist setting forth the nature and extent of your injury, nature and extent of treatment, any degree of temporary or permanent disability, your prognosis, period of hospitalization, and any diminished earning capacity. You may also be required to submit to a physical or mental examination by a physician employed or designated by SSA. If you submit a written request, we will provide you with a copy of the report of the examining physician provided you agree to make available to SSA any other physician's reports made of the physical or mental condition that is the subject of your claim.

(2) Itemized bills for medical, dental, and hospital expenses incurred, or itemized receipts of payment for such expenses.

(3) If your prognosis reveals that you will need future treatment, a statement of expected duration of and expenses for such treatment.

(4) If you claim a loss of time from employment, a written statement from your employer showing actual time lost from employment, whether you are a full or part-time employee, and wages or salary you actually lost.

(5) If you claim a loss of income and are self-employed, documentary evidence showing the amount of earnings you actually lost. For example, we may use income tax returns for several

years prior to the injury in question and the year in which the injury occurred to indicate or measure lost income. A statement of how much it cost you to hire someone to do the same work you were doing at the time of the injury might also be used in measuring lost income.

(6) Any other evidence or information that may have a bearing on either the responsibility of the United States for the personal injury or the damages claimed.

(c) *Claim based on death.* To support the claim, we need the following evidence or information:

(1) An authenticated death certificate or other believable documentation showing cause of death, date of death, and age at the time of death.

(2) The decedent's employment or occupation at time of death, including monthly or yearly salary or earnings (if any), and the duration of last employment or occupation.

(3) Full names, addresses, birth dates, kinship, and marital status of the decedent's survivors, including identification of those survivors who were dependent upon the decedent for support at the time of death.

(4) Degree of support the decedent provided to each survivor dependent on the decedent for support at the time of death.

(5) The decedent's general physical and mental condition before death.

(6) Itemized bills for medical and burial expenses incurred, or itemized receipts of payments for such expenses.

(7) If damages for pain and suffering prior to death are claimed, a physician's detailed statement specifying the injuries suffered, duration of pain and suffering, any drugs administered for pain and the decedent's physical condition in the interval between injury and death.

(8) Any other evidence or information that may have a bearing on either the responsibility of the United States for the death or the damages claimed.

(d) *Time limit for submitting evidence.* You must furnish all the evidence required by this section within a reasonable time. If you fail to furnish all the evidence necessary to determine your claim within 60 days after being asked to do so, we may find that you have decided to abandon your claim.

§ 429.105 What happens when you receive my claim?

When we receive your claim, we will investigate to determine its validity. After our investigation, we will forward your claim to the SSA Claims Officer with our recommendation as to whether your claim should be fully or partially allowed or denied.

§ 429.106 What happens if my claim is denied?

(a) If your claim is denied, the SSA Claims Officer will send you, your agent, or your legal representative a written notice by certified or registered mail. The notice will include an explanation of why your claim was denied and will advise you of your right to file suit in an appropriate U.S. District Court not later than 6 months after the date of the mailing of the notice if you disagree with the determination.

(b) Before filing suit and before expiration of the 6-month period after the date of the mailing of the denial notice, you, your duly authorized agent, or your legal representative may file a written request with SSA for reconsideration by certified or registered mail. If you file a timely request for reconsideration, SSA has 6 months from the date you file your request in which to finally dispose of your claim. Your right to file suit will not begin until 6 months after you file your request for reconsideration. Final SSA action on your request for reconsideration will occur in accordance with the provisions of paragraph (a) of this section.

§ 429.107 If my claim is approved, how do I obtain payment?

(a) *Claims under $2,500.* If your claim is approved, you must complete a ''Voucher for Payment under the Federal Tort Claims Act,'' Standard Form 1145. If you are represented by an attorney, the voucher for payment (SF 1145) must designate both you and your attorney as ''payees''; we will then mail the check to your attorney.

(b) *Claims in excess of $2,500.* If we approve your claim, we will send the appropriate Financial Management Service forms to the Department of the Treasury, which will mail the payment to you.

[69 FR 48768, Aug. 11, 2004, as amended at 88 FR 1330, Jan. 10, 2023]

§ 429.108 What happens if I accept an award, compromise, or settlement under this subpart?

If you, your agent, or your legal representative accept any award, compromise, or settlement under this subpart, your acceptance is final and conclusive on you, your agent or representative, and any other person on whose behalf or for whose benefit the claim was filed. The acceptance constitutes a complete release of any claim against the United States and against any employee of the Government whose act or omission gave rise to the claim, by reason of the same subject matter.

§ 429.109 Are there any penalties for filing false claims?

A person who files a false claim or makes a false or fraudulent statement in a claim against the United States may be imprisoned for not more than 5 years. (18 U.S.C. 287, 1001). In addition, that person may be liable for a civil penalty of not less than $5,000 and not more than $10,000 and damages of triple the loss or damage sustained by the United States, as well as the costs of a civil action brought to recover any penalty or damages. (31 U.S.C. 3729).

§ 429.110 Are there any limitations on SSA's authority under this subpart?

(a) An award, compromise or settlement of a claim under this subpart in excess of $25,000 needs the prior written approval of the Attorney General or his designee. For the purposes of this paragraph, we treat a principal claim and any derivative or subrogated claim as a single claim.

(b) An administrative claim may be adjusted, determined, compromised, or settled under this subpart only after consultation with the Department of Justice when, in the opinion of SSA:

(1) A new precedent or a new point of law is involved;

(2) A question of policy is or may be involved;

(3) The United States is or may be entitled to indemnity or contribution from a third party and SSA is unable to adjust the third-party claim; or

(4) The compromise of a particular claim, as a practical matter, will or may control the disposition of a related claim in which the amount to be paid may exceed $25,000.

(c) An administrative claim may be adjusted, determined, compromised or settled only after consultation with the Department of Justice when it is learned that the United States, or an employee, agent, or cost-plus contractor of the United States, is involved in litigation based on a claim arising out of the same incident or transaction.

Subpart B—Claims Under the Military Personnel and Civilian Employees' Claims Act of 1964

§ 429.201 What is this subpart about?

(a) *Scope and purpose.* This subpart applies to all claims filed by or on behalf of employees of SSA for loss of, or damage to, personal property incident to their service with SSA under the Military Personnel and Civilian Employees Claims Act of 1964, as amended, 31 U.S.C. 3721 (MPCECA). A claim must be substantiated and the possession of the property determined to be reasonable, useful, or proper.

(b) *Maximum payment under this part.* The maximum amount that can be paid for any claim under the Act is $40,000 or, in extraordinary circumstances, $100,000, and property may be replaced in kind at the discretion of the Government.

(c) *Policy.* SSA is not an insurer and does not underwrite all personal property losses that an employee may sustain incident to employment. We encourage employees to carry private insurance to the maximum extent practicable to avoid losses that may not be recoverable from SSA. The procedures set forth in this subpart are designed to enable you to obtain the proper amount of compensation from SSA and/or a private insurer for the loss or damage. If you fail to comply with

these procedures it could reduce or preclude payment of your claim under this subpart.

(d) *Definitions.* (1) ''Quarters,'' unless otherwise indicated, means a house, apartment, or other residence that is an SSA employee's principal residence.

(2) ''State,'' unless otherwise indicated, is defined by § 404.2(c)(5) of title 20 of the Code of Federal Regulations.

(3) ''SSA Claims Officer'' means the SSA official designated to determine claims under the MPCECA. The current designee is the Associate General Counsel for General Law, Office 1.

[69 FR 48768, Aug. 11, 2004, as amended at 88 FR 1330, Jan. 10, 2023]

§ 429.202 How do I file a claim under this subpart?

(a) *Who may file.* (1) You, your duly authorized agent, your legal representative, or your survivor may file the claim. If your survivor files the claim, the order of precedence for filing is spouse, child, parent, sibling.

(2) You may not file a claim on behalf of a subrogee, assignee, conditional vendor, or other third party.

(b) *Where to file.* You must file your claim with the Office of the General Counsel, Office of General Law, Social Security Administration, Attn: MPCECA Claims, 6401 Security Boulevard, Baltimore, MD 21235.

(c) *Evidence required.* You are responsible for proving ownership or possession, the facts surrounding the loss or damage, and the value of the property. Your claim must include the following:

(1) A written statement, signed by you or your authorized agent, explaining how the damage or loss occurred. This statement must also include:

(i) A description of the type, design, model number, or other identification of the property.

(ii) The date you purchased or acquired the property and its original cost.

(iii) The location of the property when the loss or damage occurred.

(iv) The value of the property when lost or damaged.

(v) The actual or estimated cost of the repair of any damaged item.

(vi) The purpose of and authority for travel, if the loss or damage occurred while you were transporting your property or using a motor vehicle.

(vii) All available information as to who was responsible for the loss or damage, if it was not you, and all information as to insurance contracts, whether in your name or in the name of the responsible party.

(viii) Any other evidence about loss or damage that the SSA Claims Officer determines is necessary.

(2) Copies of all available and appropriate documents such as bills of sale, estimates of repairs, or travel orders. In the case of damage to an automobile, you must submit at least two estimates of repair or a certified paid bill showing the damage incurred and the cost of all parts, labor, and other items necessary to the repair of the vehicle or a statement from an authorized dealer or repair garage showing that the cost of such repairs exceeds the value of the vehicle.

(3) A copy of the power of attorney or other authorization if someone else files the claim on your behalf.

(4) A statement from your immediate supervisor confirming that possession of the property was reasonable, useful, or proper under the circumstances and that the damage or loss was incident to your service.

(d) *Time limitations.* You must file a written claim within 2 years after accrual of the claim. For purposes of this subpart, your claim accrues at the later of:

(1) The time of the accident or incident causing the loss or damage;

(2) The time the loss or damage should have been discovered by the claimant by the exercise of due diligence; or

(3) Where valid circumstances prevented you from filing your claim earlier, the time that should be construed as the date of accrual because of a circumstance that prevents the filing of a claim. If war or armed conflict prevents you from filing the claim, your claim accrues on the date hostilities terminate and your claim must be filed within 2 years of that date.

[69 FR 48768, Aug. 11, 2004, as amended at 74 FR 16327, Apr. 10, 2009; 79 FR 7577, Feb. 10, 2014; 88 FR 1330, Jan. 10, 2023]

§ 429.203 When is a claim allowable?

(a) A claim is allowable only if you were using the property incident to your service with SSA, with the knowledge and consent of a superior authority, and:

(1) The damage or loss was not caused wholly or partially by the negligent or improper action or inaction of you, your agent, the members of your family, or your private employee (the standard to be applied is that of reasonable care under the circumstances); and

(2) The possession of the property lost or damaged and the quantity and the quality possessed is determined to have been reasonable, useful, or proper under the circumstances; and

(3) The claim is substantiated by proper and convincing evidence.

(b) Claims that are otherwise allowable under this subpart will not be disallowed solely because you were not the legal owner of the property for which the claim is made.

(c) Subject to the conditions in paragraph (a) of this section and the other provisions of this subpart, any claim you make for damage to, or loss of, personal property that occurs incident to your service with SSA may be considered and allowed. For the purpose of this subpart, if you were performing your official duties at an alternate work location under an approved flexiplace agreement, the alternate work location will be considered an official duty station even if it is located in your principal residence. The alternate work location is not considered to be quarters. The following are examples of the principal types of claims that are allowable, but these examples are not exclusive and other types of claims are allowable, unless specifically excluded under this subpart:

(1) *Property damage in quarters or other authorized places.* Claims are allowable for damage to, or loss of, property arising from fire, flood, hurricane, other natural disaster, theft, or other unusual occurrence, while such property is located at:

(i) Quarters within a state that were assigned to you or otherwise provided in kind by the United States; or

(ii) Any warehouse, office, working area, or other place (except quarters) authorized or apparently authorized for the reception or storage of property.

(2) *Transportation or travel losses.* Claims are allowable for damage to, or loss of, property incident to transportation or storage of such property pursuant to order or in connection with travel under orders, including property in your custody or in the custody of a carrier, an agent or agency of the Government.

(3) *Mobile homes.* Claims may be allowed for damage to, or loss of, mobile homes and their contents under the provisions of paragraph (c)(2) of this section. Claims for structural damage to mobile homes, other than that caused by collision, and damage to contents of mobile homes resulting from such structural damage, must contain conclusive evidence that the damage was not caused by structural deficiency of the mobile home and that it was not overloaded. Claims for damage to, or loss of, tires mounted on mobile homes are not allowable, except in cases of collision, theft, or vandalism.

(4) *Enemy action or public service.* Claims are allowable for damage to, or loss of, property that directly result from:

(i) Enemy action or threat of enemy action, or combat, guerrilla, brigandage, or other belligerent activity, or unjust confiscation by a foreign power or its nationals.

(ii) Action you take to quiet a civil disturbance or to alleviate a public disaster.

(iii) Efforts you make to save human life or Government property.

(5) *Property used for the benefit of the Government.* Claims are allowable for damage to, or loss of, property when used for the benefit of the Government at the request of, or with the knowledge and consent of, superior authority, up to the amount not compensated by private insurance.

(6) *Clothing and accessories.* Claims are allowable for damage to, or loss of, clothing and accessories a person customarily wears and devices such as eyeglasses, hearing aids, dentures, or prosthetics.

(7) *Expenses incident to repair.* You may be reimbursed for the payment of any sales tax and other such fees incurred in connection with repairs to an

item. The costs of obtaining estimates of repair (subject to the limitations set forth in § 429.204(c)) are also allowable.

§ 429.204 Are there any restrictions on what is allowable?

Claims of the type described in this section are only allowable subject to the restrictions noted:

(a) *Money or currency, including coin collections.* Allowable only when lost because of fire, flood, hurricane, other natural disaster, theft from quarters (as limited by § 429.203(c)(1)), or under other reasonable circumstances in which it would be in the Government's best interest to make payment. In cases involving theft from quarters, the evidence must conclusively show that your quarters were locked at the time of the theft. Reimbursement for loss of money or currency is limited to the amount it is determined reasonable for you to have had in your possession at the time of the loss.

(b) *Government property.* Allowable only for property owned by the United States for which you are financially responsible to an agency of the Government other than SSA.

(c) *Estimate fees.* Allowable for fees paid to obtain estimates of repairs only when it is clear that you could not have obtained an estimate without paying a fee. In that case, the fee is allowable only in an amount determined to be reasonable in relation to the value of the property or the cost of the repairs.

(d) *Automobiles and motor vehicles.* (1) Claims may only be allowed for damage to, or loss of, automobiles and other motor vehicles if:

(i) You were required by your supervisor to use a motor vehicle for official Government business (official Government business, as used here, does not include travel, or parking incident to travel, between quarters and office, quarters and an approved telecommuting center, or use of vehicles for the convenience of the owner. However, it does include travel, and parking incident thereto, between quarters and an assigned place of duty specifically authorized by your supervisor as being more advantageous to the Government); or

(ii) Shipment of such motor vehicles was being furnished or provided by the Government, subject to the provisions of § 429.206; or

(2) When a claim involves damage to or loss of automobile or other motor vehicle, you will be required to present proof of insurance coverage, the deductible amount, and the amount, if any, you recovered from the insurer. If your claim is for an amount that exceeds the deductible on the insurance policy, the maximum allowable recovery will be for the amount of the deductible. If the vehicle is uninsured, the maximum allowed will be $500.00.

(e) *Computers and electronics.* Claims may be allowed for loss of, or damage to, cellular phones, fax machines, computers and related hardware and software only when lost or damaged incident to fire, flood, hurricane, other natural disaster, theft from quarters (as limited by § 429.203(c)(1)), other reasonable circumstances in which it would be in the Government's best interest to make payment, or unless being shipped as a part of a change of duty station paid for by the Agency. In incidents of theft from quarters, it must be conclusively shown that your quarters were locked at the time of the theft.

(f) *Alternate work locations.* When a claim is filed for property damage or loss at a non-Government alternate work location at which you are working pursuant to an approved flexiplace work agreement, you are required to present proof of insurance coverage, the deductible amount, and the amount, if any, you recovered from the insurer. If your claim is for an amount that exceeds the deductible on the insurance policy, the maximum allowable recovery will be for the amount of the deductible. If the property is uninsured, the maximum allowed will be $1,000.00.

§ 429.205 What is not allowable under this subpart?

Claims are not allowable for the following:

(a) *Unassigned quarters in United States.* Property loss or damage in quarters you occupied within any state

that were not assigned to you or otherwise provided in kind by the United States.

(b) *Business property*. Property used for business or profit.

(c) *Unserviceable property*. Wornout or unserviceable property.

(d) *Illegal possession*. Property acquired, possessed, or transferred in violation of the law or in violation of applicable regulations or directives.

(e) *Articles of extraordinary value*. Valuable articles, such as cameras, watches, jewelry, furs, or other articles of extraordinary value. This prohibition does not apply to articles in your personal custody or articles properly checked or inventoried with a common carrier, if you took reasonable protection or security measures.

(f) *Intangible property*. Loss of property that has no extrinsic and marketable value but is merely representative or evidence of value, such as non-negotiable stock certificates, promissory notes, bonds, bills of lading, warehouse receipts, insurance policies, baggage checks, and bank books, is not compensable. Loss of a thesis, or other similar item, is compensable only to the extent of the out-of-pocket expenses you incurred in preparing the item such as the cost of the paper or other materials. No compensation is authorized for the time you spent in its preparation or for supposed literary value.

(g) *Incidental expenses and consequential damages*. The MPCECA and this subpart authorize payment for loss of, or damage to, personal property only. Except as provided in §429.203(c)(7), consequential damages or other types of loss or incidental expenses (such as loss of use, interest, carrying charges, cost of lodging or food while awaiting arrival of shipment, attorney fees, telephone calls, cost of transporting you or your family members, inconvenience, time spent in preparation of claim, or cost of insurance premiums) are not compensable.

(h) *Real property*. Damage to real property is not compensable. In determining whether an item is considered to be an item of personal property, as opposed to real property, normally, any movable item is considered personal property even if physically joined to the land.

(i) *Commercial property*. Articles acquired or held for sale or disposition by other commercial transactions on more than an occasional basis, or for use in a private profession or business enterprise.

(j) *Commercial storage*. Property stored at a commercial facility for your convenience and at your expense.

(k) *Claims for minimum amount*. Loss or damage amounting to less than $25.

§429.206 What if my claim involves a commercial carrier or an insurer?

In the event the property that is the subject of the claim was lost or damaged while in the possession of a commercial carrier or was insured, the following procedures will apply:

(a) Whenever property is damaged, lost, or destroyed while being shipped pursuant to authorized travel orders, the owner must file a written claim for reimbursement with the last commercial carrier known or believed to have handled the goods, or the carrier known to be in possession of the property when the damage or loss occurred, according to the terms of its bill of lading or contract, before submitting a claim against the Government under this subpart.

(b) Whenever property is damaged, lost, or destroyed incident to your service and is insured in whole or in part, you must make demand in writing against the insurer for reimbursement under the terms and conditions of the insurance coverage, before filing a claim against the Government.

(c) Failure to make a demand on a carrier or insurer or to make all reasonable efforts to protect and prosecute rights available against a carrier or insurer and to collect the amount recoverable from the carrier or insurer may result in reducing the amount recoverable from the Government by the maximum amount that would have been recoverable from the carrier or insurer had the claim been timely or diligently prosecuted. However, no deduction will be made where the circumstances of your service preclude reasonable filing of a claim or diligent prosecution, or the evidence indicates a demand was impracticable or would have been unavailing.

(d) After you file a claim against the carrier or insurer, you may immediately submit a claim under this subpart, without waiting until the carrier or insurer finally approves or denies your claim.

(1) Upon submitting your claim, you must certify whether you have not gained any recovery from a carrier or insurer, and enclose all pertinent correspondence.

(2) If the carrier or insurer has not taken final action on your claim, you must immediately tell the carrier or insurer to address all correspondence regarding the claim to the SSA Claims Officer, and you must provide a copy of this notice to the SSA Claims Officer.

(3) You must advise the SSA Claims Officer of any action the carrier or insurer takes on the claim and, upon request, must furnish all correspondence, documents, and other evidence pertinent to the matter.

(e) You must assign to the United States, to the extent you accept any payment on the claim, all rights, title, and interest in any claim you may have against any carrier, insurer, or other party arising out of the incident on which your claim against the United States is based. After payment of the claim by the United States, you must, upon receipt of any payment from a carrier or insurer, pay the proceeds to the United States to the extent of the payment you received from the United States.

(f) If you recover for the loss from the carrier or insurer before your claim under this subpart is settled, the amount of recovery will be applied to the claim as follows:

(1) If you recover an amount that is greater than or equal to your total loss as determined under this subpart, no compensation is allowable under this subpart.

(2) If you recover an amount that is less than such total loss, the allowable amount is determined by deducting the recovery from the amount of such total loss.

(3) For this purpose, your total loss is determined without regard to the maximum payment limitations set forth in § 429.201. However, if the resulting amount after making this deduction exceeds the maximum payment limitations, you will only be allowed the maximum amount set forth in § 429.201.

(g) In a claim arising from damage to an automobile or other motor vehicle, in no event may recovery exceed the reasonable deductible on the insurance policy.

§ 429.207 What are the procedures for filing a claim?

(a) *Form of claim.* Your claim must be presented in writing (SSA Form 1481 is available for this purpose). Any writing received by the SSA Claims Officer within the time limits set forth in § 429.202(d) will be accepted and considered a claim under the MPCECA if it constitutes a demand for compensation from SSA. A demand is required to be for a specific sum of money.

(b) *Award.* The SSA Claims Officer is authorized to settle claims filed under this subpart.

(c) *Notification.* The deciding official will provide you with a written determination on your claim.

§ 429.208 How do you determine the award? Is the settlement of my claim final?

(a) The amount allowable for damage to or loss of any item of property may not exceed the lowest of:

(1) The amount you requested for the item as a result of its loss, damage, or the cost of its repair;

(2) The actual or estimated cost of its repair; or

(3) The actual value at the time of its loss, damage, or destruction. The actual value is determined by using the current replacement cost or the depreciated value of the item since you acquired it, whichever is lower, less any salvage value of the item in question, if you retain the item.

(b) Depreciation in value is determined by considering the type of article involved, its cost, its condition when damaged or lost, and the time elapsed between the date you acquired it and the date of damage or loss.

(c) Current replacement cost and depreciated value are determined by use of publicly available adjustment rates or through use of other reasonable methods at the discretion of the SSA Claims Officer.

(d) Replacement of lost or damaged property may be made in kind wherever appropriate at the discretion of the SSA Claims Officer.

(e) At the discretion of the SSA Claims Officer, you may be required to turn over an item alleged to have been damaged beyond economical repair to the United States, in which case no deduction for salvage value will be made in the calculation of actual value.

(f) Settlement of claims under the Act are final and conclusive.

§ 429.209 Are there any restrictions on attorney's fees?

No more than 10 percent of the amount in settlement of each individual claim submitted and settled under this subpart shall be paid or delivered to, or received by, any agent or attorney on account of services rendered in connection with that claim. A person violating this subsection shall be fined not more than $1,000.00 (31 U.S.C. 3721(i)).

§ 429.210 Do I have any appeal rights under this subpart?

(a) *Deciding Official.* While you may not appeal the decision of the SSA Claims Officer in regard to claims under the MPCECA, the SSA Claims Officer may, at his or her discretion, reconsider his or her determination of a claim.

(b) *Claimant.* You may request reconsideration from the SSA Claims Officer by sending a written request for reconsideration to the SSA Claims Officer within 30 days of the date of the original determination. You must clearly state the factual or legal basis upon which you base your request for a more favorable determination. Reconsideration will be granted only for reasons not available or not considered during the original decision.

(c) *Notification.* The SSA Claims Officer will send you a written determination on your request for reconsideration. If the SSA Claims Officer elects to reconsider your claim, the final determination on reconsideration is final and conclusive.

§ 429.211 Are there any penalties for filing false claims?

A person who files a false claim or makes a false or fraudulent statement in a claim against the United States may be imprisoned for not more than 5 years (18 U.S.C. 287, 1001). In addition, that person may be liable for a civil penalty of not less than $5,000 and not more than $10,000 and damages of triple the loss or damage sustained by the United States, as well as the costs of a civil action brought to recover any penalty or damages (31 U.S.C. 3729).

PART 430—PERSONNEL

AUTHORITY: Section 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5))

INDEMNIFICATION OF SSA EMPLOYEES

§ 430.101 Policy.

(a) The Social Security Administration (SSA) may indemnify, in whole or in part, its employees (which for the purpose of this regulation includes former employees) for any verdict, judgment or other monetary award which is rendered against any such employee, provided that the conduct giving rise to the verdict, judgment or award was taken within the scope of his or her employment with SSA and that such indemnification is in the interest of the United States, as determined by the Commissioner, or his or her designee, in his or her discretion.

(b) SSA may settle or compromise a personal damage claim against its employee by the payment of available funds, at any time, provided the alleged conduct giving rise to the personal damage claim was taken within the scope of employment and that such settlement or compromise is in the interest of the United States, as determined by the Commissioner, or his or her designee, in his or her discretion.

(c) Absent exceptional circumstances, as determined by the Commissioner or his or her designee, SSA will not entertain a request either to agree to indemnify or to settle a personal damage claim before entry of an adverse verdict, judgment or monetary award.

(d) When an employee of SSA becomes aware that an action has been filed against the employee in his or her individual capacity as a result of conduct taken within the scope of his or her employment, the employee should immediately notify SSA that such an action is pending.

(e) The employee may, thereafter, request either:

(1) Indemnification to satisfy a verdict, judgment or award entered against the employee; or

(2) Payment to satisfy the requirements of a settlement proposal. The employee shall submit a written request, with documentation including copies of the verdict, judgment, award or settlement proposal, as appropriate, to the Deputy Commissioner or other designated official, who shall thereupon submit to the General Counsel, in a timely manner, a recommended disposition of the request. The General Counsel shall also seek the views of the Department of Justice. The General Counsel shall forward the request, the Deputy Commissioner's or other designated official's recommended disposition, and the General Counsel's recommendation to the Commissioner or his or her designee for decision.

(f) Any payment under this section either to indemnify an SSA employee or to settle a personal damage claim shall be contingent upon the availability of appropriated funds.

[62 FR 39935, July 25, 1997]

PART 431—PROTECTION OF HUMAN SUBJECTS

Sec.

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AUTHORITY: 5 U.S.C. 301; 42 U.S.C. 289(a).

SOURCE: 82 FR 7270, Jan. 19, 2017, unless otherwise noted.

§ 431.101 To what does this policy apply?

(a) Except as detailed in § 431.104, this policy applies to all research involving human subjects conducted, supported, or otherwise subject to regulation by any Federal department or agency that takes appropriate administrative action to make the policy applicable to such research. This includes research conducted by Federal civilian employees or military personnel, except that each department or agency head may adopt such procedural modifications as may be appropriate from an administrative standpoint. It also includes research conducted, supported, or otherwise subject to regulation by the Federal Government outside the United States. Institutions that are engaged in research described in this paragraph and institutional review boards (IRBs) reviewing research that is subject to this policy must comply with this policy.

(b) [Reserved]

(c) Department or agency heads retain final judgment as to whether a particular activity is covered by this

policy and this judgment shall be exercised consistent with the ethical principles of the Belmont Report.[62]

(d) Department or agency heads may require that specific research activities or classes of research activities conducted, supported, or otherwise subject to regulation by the Federal department or agency but not otherwise covered by this policy comply with some or all of the requirements of this policy.

(e) Compliance with this policy requires compliance with pertinent federal laws or regulations that provide additional protections for human subjects.

(f) This policy does not affect any state or local laws or regulations (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe) that may otherwise be applicable and that provide additional protections for human subjects.

(g) This policy does not affect any foreign laws or regulations that may otherwise be applicable and that provide additional protections to human subjects of research.

(h) When research covered by this policy takes place in foreign countries, procedures normally followed in the foreign countries to protect human subjects may differ from those set forth in this policy. In these circumstances, if a department or agency head determines that the procedures prescribed by the institution afford protections that are at least equivalent to those provided in this policy, the department or agency head may approve the substitution of the foreign procedures in lieu of the procedural requirements provided in this policy. Except when otherwise required by statute, Executive Order, or the department or agency head, notices of these actions as they occur will be published in the FEDERAL REGISTER or will be otherwise published as provided in department or agency procedures.

(i) Unless otherwise required by law, department or agency heads may waive the applicability of some or all of the provisions of this policy to specific research activities or classes of research activities otherwise covered by this policy, provided the alternative procedures to be followed are consistent with the principles of the Belmont Report.[63] Except when otherwise required by statute or Executive Order, the department or agency head shall forward advance notices of these actions to the Office for Human Research Protections, Department of Health and Human Services (HHS), or any successor office, or to the equivalent office within the appropriate Federal department or agency, and shall also publish them in the FEDERAL REGISTER or in such other manner as provided in department or agency procedures. The waiver notice must include a statement that identifies the conditions under which the waiver will be applied and a justification as to why the waiver is appropriate for the research, including how the decision is consistent with the principles of the Belmont Report.

(j) Federal guidance on the requirements of this policy shall be issued only after consultation, for the purpose of harmonization (to the extent appropriate), with other Federal departments and agencies that have adopted this policy, unless such consultation is not feasible.

(k) [Reserved]

(l) Compliance dates and transition provisions:

(1) *Pre-2018 Requirements.* For purposes of this section, the *pre-2018 Requirements* means this subpart as published in the 2016 edition of the Code of Federal Regulations.

(2) *2018 Requirements.* For purposes of this section, the *2018 Requirements* means the Federal Policy for the Protection of Human Subjects requirements contained in this part. The general compliance date for the 2018 Requirements is January 21, 2019. The compliance date for § 431.114(b) (cooperative research) of the 2018 Requirements is January 20, 2020.

(3) *Research subject to pre-2018 requirements.* The pre-2018 Requirements shall apply to the following research, unless

[62] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.– Belmont Report. Washington, DC: U.S. Department of Health and Human Services. 1979.

[63] *Id.*

the research is transitioning to comply with the 2018 Requirements in accordance with paragraph (l)(4) of this section:

(i) Research initially approved by an IRB under the pre-2018 Requirements before January 21, 2019;

(ii) Research for which IRB review was waived pursuant to §431.101(i) of the pre-2018 Requirements before January 21, 2019; and

(iii) Research for which a determination was made that the research was exempt under §431.101(b) of the pre-2018 Requirements before January 21, 2019.

(4) *Transitioning research.* If, on or after July 19, 2018, an institution planning or engaged in research otherwise covered by paragraph (l)(3) of this section determines that such research instead will transition to comply with the 2018 Requirements, the institution or an IRB must document and date such determination.

(i) If the determination to transition is documented between July 19, 2018, and January 20, 2019, the research shall:

(A) Beginning on the date of such documentation through January 20, 2019, comply with the pre-2018 Requirements, except that the research shall comply with the following:

(*1*) Section 431.102(l) of the 2018 Requirements (definition of research) (instead of §431.102(d) of the pre-2018 Requirements);

(*2*) Section 431.103(d) of the 2018 Requirements (revised certification requirement that eliminates IRB review of application or proposal) (instead of §431.103(f) of the pre-2018 Requirements); and

(*3*) Section 431.109(f)(1)(i) and (iii) of the 2018 Requirements (exceptions to mandated continuing review) (instead of §431.103(b), as related to the requirement for continuing review, and in addition to §431.109, of the pre-2018 Requirements); and

(B) Beginning on January 21, 2019, comply with the 2018 Requirements.

(ii) If the determination to transition is documented on or after January 21, 2019, the research shall, beginning on the date of such documentation, comply with the 2018 Requirements.

(5) *Research subject to 2018 Requirements.* The 2018 Requirements shall apply to the following research:

(i) Research initially approved by an IRB on or after January 21, 2019;

(ii) Research for which IRB review is waived pursuant to paragraph (i) of this section on or after January 21, 2019; and

(iii) Research for which a determination is made that the research is exempt on or after January 21, 2019.

(m) Severability: Any provision of this part held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this part and shall not affect the remainder thereof or the application of the provision to other persons not similarly situated or to other dissimilar circumstances.

[82 FR 7270, Jan. 19, 2017, as amended at 83 FR 28513, June 19, 2018]

§431.102 Definitions for purposes of this policy.

(a) *Certification* means the official notification by the institution to the supporting Federal department or agency component, in accordance with the requirements of this policy, that a research project or activity involving human subjects has been reviewed and approved by an IRB in accordance with an approved assurance.

(b) *Clinical trial* means a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

(c) *Department or agency head* means the head of any Federal department or agency, for example, the Secretary of HHS, and any other officer or employee of any Federal department or agency to whom the authority provided by these regulations to the department or agency head has been delegated.

(d) *Federal department or agency* refers to a federal department or agency (the

department or agency itself rather than its bureaus, offices or divisions) that takes appropriate administrative action to make this policy applicable to the research involving human subjects it conducts, supports, or otherwise regulates (e.g., the U.S. Department of Health and Human Services, the U.S. Department of Defense, or the Central Intelligence Agency).

(e)(1) *Human subject* means a living individual about whom an investigator (whether professional or student) conducting research:

(i) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or (ii) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens.

(2) *Intervention* includes both physical procedures by which information or biospecimens are gathered (e.g., venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.

(3) *Interaction* includes communication or interpersonal contact between investigator and subject.

(4) *Private information* includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information that has been provided for specific purposes by an individual and that the individual can reasonably expect will not be made public (e.g., a medical record).

(5) *Identifiable private information* is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

(6) *An identifiable biospecimen* is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.

(7) Federal departments or agencies implementing this policy shall:

(i) Upon consultation with appropriate experts (including experts in data matching and re-identification), reexamine the meaning of ''identifiable private information,'' as defined in paragraph (e)(5) of this section, and ''identifiable biospecimen,'' as defined in paragraph (e)(6) of this section. This reexamination shall take place within 1 year and regularly thereafter (at least every 4 years). This process will be conducted by collaboration among the Federal departments and agencies implementing this policy. If appropriate and permitted by law, such Federal departments and agencies may alter the interpretation of these terms, including through the use of guidance.

(ii) Upon consultation with appropriate experts, assess whether there are analytic technologies or techniques that should be considered by investigators to generate ''identifiable private information,'' as defined in paragraph (e)(5) of this section, or an ''identifiable biospecimen,'' as defined in paragraph (e)(6) of this section. This assessment shall take place within 1 year and regularly thereafter (at least every 4 years). This process will be conducted by collaboration among the Federal departments and agencies implementing this policy. Any such technologies or techniques will be included on a list of technologies or techniques that produce identifiable private information or identifiable biospecimens. This list will be published in the FEDERAL REGISTER after notice and an opportunity for public comment. The Secretary, HHS, shall maintain the list on a publicly accessible Web site.

(f) *Institution* means any public or private entity, or department or agency (including federal, state, and other agencies).

(g) *IRB* means an institutional review board established in accord with and for the purposes expressed in this policy.

(h) *IRB approval* means the determination of the IRB that the research has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and by other institutional and federal requirements.

(i) *Legally authorized representative* means an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research. If there is no applicable law

addressing this issue, *legally authorized representative* means an individual recognized by institutional policy as acceptable for providing consent in the nonresearch context on behalf of the prospective subject to the subject's participation in the procedure(s) involved in the research.

(j) *Minimal risk* means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

(k) *Public health authority* means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, an Indian tribe, or a foreign government, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

(l) *Research* means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this part, the following activities are deemed not to be research:

(1) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.

(2) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).

(3) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.

(4) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

(m) *Written,* or *in writing*, for purposes of this part, refers to writing on a tangible medium (e.g., paper) or in an electronic format.

§ 431.103 Assuring compliance with this policy—research conducted or supported by any Federal department or agency.

(a) Each institution engaged in research that is covered by this policy, with the exception of research eligible for exemption under § 431.104, and that is conducted or supported by a Federal department or agency, shall provide written assurance satisfactory to the department or agency head that it will comply with the requirements of this policy. In lieu of requiring submission of an assurance, individual department or agency heads shall accept the existence of a current assurance, appropriate for the research in question, on file with the Office for Human Research Protections, HHS, or any successor office, and approved for Federalwide use by that office. When the existence of an HHS-approved assurance is accepted in lieu of requiring submission of an assurance, reports (except certification) required by this policy to be made to department and agency heads shall also be made to the Office

for Human Research Protections, HHS, or any successor office. Federal departments and agencies will conduct or support research covered by this policy only if the institution has provided an assurance that it will comply with the requirements of this policy, as provided in this section, and only if the institution has certified to the department or agency head that the research has been reviewed and approved by an IRB (if such certification is required by § 431.103(d)).

(b) The assurance shall be executed by an individual authorized to act for the institution and to assume on behalf of the institution the obligations imposed by this policy and shall be filed in such form and manner as the department or agency head prescribes.

(c) The department or agency head may limit the period during which any assurance shall remain effective or otherwise condition or restrict the assurance.

(d) Certification is required when the research is supported by a Federal department or agency and not otherwise waived under § 431.101(i) or exempted under § 431.104. For such research, institutions shall certify that each proposed research study covered by the assurance and this section has been reviewed and approved by the IRB. Such certification must be submitted as prescribed by the Federal department or agency component supporting the research. Under no condition shall research covered by this section be initiated prior to receipt of the certification that the research has been reviewed and approved by the IRB.

(e) For nonexempt research involving human subjects covered by this policy (or exempt research for which limited IRB review takes place pursuant to § 431.104(d)(2)(iii), (d)(3)(i)(C), or (d)(7) or (8)) that takes place at an institution in which IRB oversight is conducted by an IRB that is not operated by the institution, the institution and the organization operating the IRB shall document the institution's reliance on the IRB for oversight of the research and the responsibilities that each entity will undertake to ensure compliance with the requirements of this policy (e.g., in a written agreement between the institution and the IRB, by implementation of an institution-wide policy directive providing the allocation of responsibilities between the institution and an IRB that is not affiliated with the institution, or as set forth in a research protocol).

(Approved by the Office of Management and Budget under Control Number 0990–0260)

§ 431.104 Exempt research.

(a) Unless otherwise required by law or by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the categories in paragraph (d) of this section are exempt from the requirements of this policy, except that such activities must comply with the requirements of this section and as specified in each category.

(b) Use of the exemption categories for research subject to the requirements of subparts B, C, and D: Application of the exemption categories to research subject to the requirements of 45 CFR part 46, subparts B, C, and D, is as follows:

(1) *Subpart B.* Each of the exemptions at this section may be applied to research subject to subpart B if the conditions of the exemption are met.

(2) *Subpart C.* The exemptions at this section do not apply to research subject to subpart C, except for research aimed at involving a broader subject population that only incidentally includes prisoners.

(3) *Subpart D.* The exemptions at paragraphs (d)(1), (4), (5), (6), (7), and (8) of this section may be applied to research subject to subpart D if the conditions of the exemption are met. Paragraphs (d)(2)(i) and (ii) of this section only may apply to research subject to subpart D involving educational tests or the observation of public behavior when the investigator(s) do not participate in the activities being observed. Paragraph (d)(2)(iii) of this section may not be applied to research subject to subpart D.

(c) [Reserved]

(d) Except as described in paragraph (a) of this section, the following categories of human subjects research are exempt from this policy:

(1) Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

(i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

(ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

(iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §431.111(a)(7).

(3)(i) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:

(A) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

(B) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

(C) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §431.111(a)(7).

(ii) For the purpose of this provision, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

(iii) If the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that he or she will be unaware of or misled regarding the nature or purposes of the research.

(4) Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:

(i) The identifiable private information or identifiable biospecimens are publicly available;

(ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human

subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;

(iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164, subparts A and E, for the purposes of ''health care operations'' or ''research'' as those terms are defined at 45 CFR 164.501 or for ''public health activities and purposes'' as described under 45 CFR 164.512(b); or

(iv) The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for nonresearch activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 *et seq*.

(5) Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.

(i) Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal Web site or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.

(ii) [Reserved]

(6) Taste and food quality evaluation and consumer acceptance studies:

(i) If wholesome foods without additives are consumed, or

(ii) If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

(7) Storage or maintenance for secondary research for which broad consent is required: Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use if an IRB conducts a limited IRB review and makes the determinations required by § 431.111(a)(8).

(8) Secondary research for which broad consent is required: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use, if the following criteria are met:

(i) Broad consent for the storage, maintenance, and secondary research use of the identifiable private information or identifiable biospecimens was obtained in accordance with § 431.116(a)(1) through (4), (a)(6), and (d);

(ii) Documentation of informed consent or waiver of documentation of

consent was obtained in accordance with § 431.117;

(iii) An IRB conducts a limited IRB review and makes the determination required by § 431.111(a)(7) and makes the determination that the research to be conducted is within the scope of the broad consent referenced in paragraph (d)(8)(i) of this section; and (iv) The investigator does not include returning individual research results to subjects as part of the study plan. This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

(Approved by the Office of Management and Budget under Control Number 0990–0260)

§§ 431.105–431.106 [Reserved]

§ 431.107 IRB membership.

(a) Each IRB shall have at least five members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members (professional competence), and the diversity of its members, including race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. The IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments (including policies and resources) and regulations, applicable law, and standards of professional conduct and practice. The IRB shall therefore include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a category of subjects that is vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these categories of subjects.

(b) Each IRB shall include at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.

(c) Each IRB shall include at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.

(d) No IRB may have a member participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB.

(e) An IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

§ 431.108 IRB functions and operations.

(a) In order to fulfill the requirements of this policy each IRB shall:

(1) Have access to meeting space and sufficient staff to support the IRB's review and recordkeeping duties;

(2) Prepare and maintain a current list of the IRB members identified by name; earned degrees; representative capacity; indications of experience such as board certifications or licenses sufficient to describe each member's chief anticipated contributions to IRB deliberations; and any employment or other relationship between each member and the institution, for example, full-time employee, part-time employee, member of governing panel or board, stockholder, paid or unpaid consultant;

(3) Establish and follow written procedures for:

(i) Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and the institution;

(ii) Determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review; and

(iii) Ensuring prompt reporting to the IRB of proposed changes in a research activity, and for ensuring that investigators will conduct the research

activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to eliminate apparent immediate hazards to the subject.

(4) Establish and follow written procedures for ensuring prompt reporting to the IRB; appropriate institutional officials; the department or agency head; and the Office for Human Research Protections, HHS, or any successor office, or the equivalent office within the appropriate Federal department or agency of

(i) Any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and

(ii) Any suspension or termination of IRB approval.

(b) Except when an expedited review procedure is used (as described in §431.110), an IRB must review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas. In order for the research to be approved, it shall receive the approval of a majority of those members present at the meeting.

(Approved by the Office of Management and Budget under Control Number 0990–0260)

§431.109 IRB review of research.

(a) An IRB shall review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by this policy, including exempt research activities under §431.104 for which limited IRB review is a condition of exemption (under §431.104(d)(2)(iii), (d)(3)(i)(C), and (d)(7), and (8)).

(b) An IRB shall require that information given to subjects (or legally authorized representatives, when appropriate) as part of informed consent is in accordance with §431.116. The IRB may require that information, in addition to that specifically mentioned in §431.116, be given to the subjects when in the IRB's judgment the information would meaningfully add to the protection of the rights and welfare of subjects.

(c) An IRB shall require documentation of informed consent or may waive documentation in accordance with §431.117.

(d) An IRB shall notify investigators and the institution in writing of its decision to approve or disapprove the proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.

(e) An IRB shall conduct continuing review of research requiring review by the convened IRB at intervals appropriate to the degree of risk, not less than once per year, except as described in §431.109(f).

(f)(1) Unless an IRB determines otherwise, continuing review of research is not required in the following circumstances:

(i) Research eligible for expedited review in accordance with §431.110;

(ii) Research reviewed by the IRB in accordance with the limited IRB review described in §431.104(d)(2)(iii), (d)(3)(i)(C), or (d)(7) or (8);

(iii) Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study:

(A) Data analysis, including analysis of identifiable private information or identifiable biospecimens, or

(B) Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care.

(2) [Reserved]

(g) An IRB shall have authority to observe or have a third party observe the consent process and the research.

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§431.110 Expedited review procedures for certain kinds of research involving no more than minimal risk, and for minor changes in approved research.

(a) The Secretary of HHS has established, and published as a Notice in the FEDERAL REGISTER, a list of categories

of research that may be reviewed by the IRB through an expedited review procedure. The Secretary will evaluate the list at least every 8 years and amend it, as appropriate, after consultation with other federal departments and agencies and after publication in the FEDERAL REGISTER for public comment. A copy of the list is available from the Office for Human Research Protections, HHS, or any successor office.

(b)(1) An IRB may use the expedited review procedure to review the following:

(i) Some or all of the research appearing on the list described in paragraph (a) of this section, unless the reviewer determines that the study involves more than minimal risk;

(ii) Minor changes in previously approved research during the period for which approval is authorized; or

(iii) Research for which limited IRB review is a condition of exemption under §431.104(d)(2)(iii), (d)(3)(i)(C), and (d)(7) and (8).

(2) Under an expedited review procedure, the review may be carried out by the IRB chairperson or by one or more experienced reviewers designated by the chairperson from among members of the IRB. In reviewing the research, the reviewers may exercise all of the authorities of the IRB except that the reviewers may not disapprove the research. A research activity may be disapproved only after review in accordance with the nonexpedited procedure set forth in §431.108(b).

(c) Each IRB that uses an expedited review procedure shall adopt a method for keeping all members advised of research proposals that have been approved under the procedure.

(d) The department or agency head may restrict, suspend, terminate, or choose not to authorize an institution's or IRB's use of the expedited review procedure.

§431.111 Criteria for IRB approval of research.

(a) In order to approve research covered by this policy the IRB shall determine that all of the following requirements are satisfied:

(1) Risks to subjects are minimized:

(i) By using procedures that are consistent with sound research design and that do not unnecessarily expose subjects to risk, and

(ii) Whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

(2) Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge gained in the research (e.g., the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.

(3) Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in which the research will be conducted. The IRB should be particularly cognizant of the special problems of research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons.

(4) Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by, §431.116.

(5) Informed consent will be appropriately documented or appropriately waived in accordance with §431.117.

(6) When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.

(7) When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

(i) The Secretary of HHS will, after consultation with the Office of Management and Budget's privacy office

and other Federal departments and agencies that have adopted this policy, issue guidance to assist IRBs in assessing what provisions are adequate to protect the privacy of subjects and to maintain the confidentiality of data.

(ii) [Reserved]

(8) For purposes of conducting the limited IRB review required by § 431.104(d)(7)), the IRB need not make the determinations at paragraphs (a)(1) through (7) of this section, and shall make the following determinations:

(i) Broad consent for storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens is obtained in accordance with the requirements of § 431.116(a)(1)–(4), (a)(6), and (d);

(ii) Broad consent is appropriately documented or waiver of documentation is appropriate, in accordance with § 431.117; and

(iii) If there is a change made for research purposes in the way the identifiable private information or identifiable biospecimens are stored or maintained, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

(b) When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

§ 431.112 Review by Institution

Research covered by this policy that has been approved by an IRB may be subject to further appropriate review and approval or disapproval by officials of the institution. However, those officials may not approve the research if it has not been approved by an IRB.

§ 431.113 Suspension or Termination of IRB Approval of Research.

An IRB shall have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and the department or agency head.

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§ 431.114 Cooperative Research.

(a) Cooperative research projects are those projects covered by this policy that involve more than one institution. In the conduct of cooperative research projects, each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with this policy.

(b)(1) Any institution located in the United States that is engaged in cooperative research must rely upon approval by a single IRB for that portion of the research that is conducted in the United States. The reviewing IRB will be identified by the Federal department or agency supporting or conducting the research or proposed by the lead institution subject to the acceptance of the Federal department or agency supporting the research.

(2) The following research is not subject to this provision:

(i) Cooperative research for which more than single IRB review is required by law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe); or

(ii) Research for which any Federal department or agency supporting or conducting the research determines and documents that the use of a single IRB is not appropriate for the particular context.

(c) For research not subject to paragraph (b) of this section, an institution participating in a cooperative project may enter into a joint review arrangement, rely on the review of another IRB, or make similar arrangements for avoiding duplication of effort.

§ 431.115 IRB Records.

(a) An institution, or when appropriate an IRB, shall prepare and maintain adequate documentation of IRB activities, including the following:

(1) Copies of all research proposals reviewed, scientific evaluations, if any,

that accompany the proposals, approved sample consent forms, progress reports submitted by investigators, and reports of injuries to subjects.

(2) Minutes of IRB meetings, which shall be in sufficient detail to show attendance at the meetings; actions taken by the IRB; the vote on these actions including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution.

(3) Records of continuing review activities, including the rationale for conducting continuing review of research that otherwise would not require continuing review as described in § 431.109(f)(1).

(4) Copies of all correspondence between the IRB and the investigators.

(5) A list of IRB members in the same detail as described in § 431.108(a)(2).

(6) Written procedures for the IRB in the same detail as described in § 431.108(a)(3) and (4).

(7) Statements of significant new findings provided to subjects, as required by § 431.116(c)(5).

(8) The rationale for an expedited reviewer's determination under § 431.110(b)(1)(i) that research appearing on the expedited review list described in § 431.110(a) is more than minimal risk.

(9) Documentation specifying the responsibilities that an institution and an organization operating an IRB each will undertake to ensure compliance with the requirements of this policy, as described in § 431.103(e).

(b) The records required by this policy shall be retained for at least 3 years, and records relating to research that is conducted shall be retained for at least 3 years after completion of the research. The institution or IRB may maintain the records in printed form, or electronically. All records shall be accessible for inspection and copying by authorized representatives of the Federal department or agency at reasonable times and in a reasonable manner.

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§ 431.116 General Requirements for Informed Consent.

(a) *General.* General requirements for informed consent, whether written or oral, are set forth in this paragraph and apply to consent obtained in accordance with the requirements set forth in paragraphs (b) through (d) of this section. Broad consent may be obtained in lieu of informed consent obtained in accordance with paragraphs (b) and (c) of this section only with respect to the storage, maintenance, and secondary research uses of identifiable private information and identifiable biospecimens. Waiver or alteration of consent in research involving public benefit and service programs conducted by or subject to the approval of state or local officials is described in paragraph (e) of this section. General waiver or alteration of informed consent is described in paragraph (f) of this section. Except as provided elsewhere in this policy:

(1) Before involving a human subject in research covered by this policy, an investigator shall obtain the legally effective informed consent of the subject or the subject's legally authorized representative.

(2) An investigator shall seek informed consent only under circumstances that provide the prospective subject or the legally authorized representative sufficient opportunity to discuss and consider whether or not to participate and that minimize the possibility of coercion or undue influence.

(3) The information that is given to the subject or the legally authorized representative shall be in language understandable to the subject or the legally authorized representative.

(4) The prospective subject or the legally authorized representative must be provided with the information that a reasonable person would want to have in order to make an informed decision about whether to participate, and an opportunity to discuss that information.

(5) Except for broad consent obtained in accordance with paragraph (d) of this section:

(i) Informed consent must begin with a concise and focused presentation of the key information that is most likely

to assist a prospective subject or legally authorized representative in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension.

(ii) Informed consent as a whole must present information in sufficient detail relating to the research, and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject's or legally authorized representative's understanding of the reasons why one might or might not want to participate.

(6) No informed consent may include any exculpatory language through which the subject or the legally authorized representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the institution, or its agents from liability for negligence.

(b) *Basic elements of informed consent.* Except as provided in paragraph (d), (e), or (f) of this section, in seeking informed consent the following information shall be provided to each subject or the legally authorized representative:

(1) A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures that are experimental;

(2) A description of any reasonably foreseeable risks or discomforts to the subject;

(3) A description of any benefits to the subject or to others that may reasonably be expected from the research;

(4) A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

(5) A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;

(6) For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;

(7) An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject;

(8) A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled; and

(9) One of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimens:

(i) A statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or

(ii) A statement that the subject's information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

(c) *Additional elements of informed consent.* Except as provided in paragraph (d), (e), or (f) of this section, one or more of the following elements of information, when appropriate, shall also be provided to each subject or the legally authorized representative:

(1) A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) that are currently unforeseeable;

(2) Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's or the legally authorized representative's consent;

(3) Any additional costs to the subject that may result from participation in the research;

(4) The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;

(5) A statement that significant new findings developed during the course of the research that may relate to the subject's willingness to continue participation will be provided to the subject;

(6) The approximate number of subjects involved in the study;

(7) A statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit;

(8) A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions; and

(9) For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (*i.e.*, sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).

(d) *Elements of broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens.* Broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens (collected for either research studies other than the proposed research or nonresearch purposes) is permitted as an alternative to the informed consent requirements in paragraphs (b) and (c) of this section. If the subject or the legally authorized representative is asked to provide broad consent, the following shall be provided to each subject or the subject's legally authorized representative:

(1) The information required in paragraphs (b)(2), (b)(3), (b)(5), and (b)(8) and, when appropriate, (c)(7) and (9) of this section;

(2) A general description of the types of research that may be conducted with the identifiable private information or identifiable biospecimens. This description must include sufficient information such that a reasonable person would expect that the broad consent would permit the types of research conducted;

(3) A description of the identifiable private information or identifiable biospecimens that might be used in research, whether sharing of identifiable private information or identifiable biospecimens might occur, and the types of institutions or researchers that might conduct research with the identifiable private information or identifiable biospecimens;

(4) A description of the period of time that the identifiable private information or identifiable biospecimens may be stored and maintained (which period of time could be indefinite), and a description of the period of time that the identifiable private information or identifiable biospecimens may be used for research purposes (which period of time could be indefinite);

(5) Unless the subject or legally authorized representative will be provided details about specific research studies, a statement that they will not be informed of the details of any specific research studies that might be conducted using the subject's identifiable private information or identifiable biospecimens, including the purposes of the research, and that they might have chosen not to consent to some of those specific research studies;

(6) Unless it is known that clinically relevant research results, including individual research results, will be disclosed to the subject in all circumstances, a statement that such results may not be disclosed to the subject; and

(7) An explanation of whom to contact for answers to questions about the subject's rights and about storage and use of the subject's identifiable private information or identifiable biospecimens, and whom to contact in the event of a research-related harm.

(e) *Waiver or alteration of consent in research involving public benefit and service programs conducted by or subject to the approval of state or local officials*—(1) *Waiver.* An IRB may waive the requirement to obtain informed consent for research under paragraphs (a) through (c) of this section, provided the IRB

satisfies the requirements of paragraph (e)(3) of this section. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens in accordance with the requirements at paragraph (d) of this section, and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

(2) *Alteration.* An IRB may approve a consent procedure that omits some, or alters some or all, of the elements of informed consent set forth in paragraphs (b) and (c) of this section provided the IRB satisfies the requirements of paragraph (e)(3) of this section. An IRB may not omit or alter any of the requirements described in paragraph (a) of this section. If a broad consent procedure is used, an IRB may not omit or alter any of the elements required under paragraph (d) of this section.

(3) *Requirements for waiver and alteration.* In order for an IRB to waive or alter consent as described in this subsection, the IRB must find and document that:

(i) The research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine:

(A) Public benefit or service programs;

(B) Procedures for obtaining benefits or services under those programs;

(C) Possible changes in or alternatives to those programs or procedures; or

(D) Possible changes in methods or levels of payment for benefits or services under those programs; and

(ii) The research could not practicably be carried out without the waiver or alteration.

(f) *General waiver or alteration of consent*—(1) *Waiver.* An IRB may waive the requirement to obtain informed consent for research under paragraphs (a) through (c) of this section, provided the IRB satisfies the requirements of paragraph (f)(3) of this section. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens in accordance with the requirements at paragraph (d) of this section, and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

(2) *Alteration.* An IRB may approve a consent procedure that omits some, or alters some or all, of the elements of informed consent set forth in paragraphs (b) and (c) of this section provided the IRB satisfies the requirements of paragraph (f)(3) of this section. An IRB may not omit or alter any of the requirements described in paragraph (a) of this section. If a broad consent procedure is used, an IRB may not omit or alter any of the elements required under paragraph (d) of this section.

(3) *Requirements for waiver and alteration.* In order for an IRB to waive or alter consent as described in this subsection, the IRB must find and document that:

(i) The research involves no more than minimal risk to the subjects;

(ii) The research could not practicably be carried out without the requested waiver or alteration;

(iii) If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format;

(iv) The waiver or alteration will not adversely affect the rights and welfare of the subjects; and

(v) Whenever appropriate, the subjects or legally authorized representatives will be provided with additional pertinent information after participation.

(g) *Screening, recruiting, or determining eligibility.* An IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the subject's legally authorized representative, if either of the following conditions are met:

(1) The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, or

(2) The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.

(h) *Posting of clinical trial consent form.* (1) For each clinical trial conducted or supported by a Federal department or agency, one IRB-approved informed consent form used to enroll subjects must be posted by the awardee or the Federal department or agency component conducting the trial on a publicly available Federal Web site that will be established as a repository for such informed consent forms.

(2) If the Federal department or agency supporting or conducting the clinical trial determines that certain information should not be made publicly available on a Federal Web site (e.g. confidential commercial information), such Federal department or agency may permit or require redactions to the information posted.

(3) The informed consent form must be posted on the Federal Web site after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol.

(i) *Preemption.* The informed consent requirements in this policy are not intended to preempt any applicable Federal, state, or local laws (including tribal laws passed by the official governing body of an American Indian or Alaska Native tribe) that require additional information to be disclosed in order for informed consent to be legally effective.

(j) *Emergency medical care.* Nothing in this policy is intended to limit the authority of a physician to provide emergency medical care, to the extent the physician is permitted to do so under applicable Federal, state, or local law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe).

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§ 431.117 Documentation of informed consent.

(a) Except as provided in paragraph (c) of this section, informed consent shall be documented by the use of a written informed consent form approved by the IRB and signed (including in an electronic format) by the subject or the subject's legally authorized representative. A written copy shall be given to the person signing the informed consent form.

(b) Except as provided in paragraph (c) of this section, the informed consent form may be either of the following:

(1) A written informed consent form that meets the requirements of § 431.116. The investigator shall give either the subject or the subject's legally authorized representative adequate opportunity to read the informed consent form before it is signed; alternatively, this form may be read to the subject or the subject's legally authorized representative.

(2) A short form written informed consent form stating that the elements of informed consent required by § 431.116 have been presented orally to the subject or the subject's legally authorized representative, and that the key information required by § 431.116(a)(5)(i) was presented first to the subject, before other information, if any, was provided. The IRB shall approve a written summary of what is to be said to the subject or the legally authorized representative. When this method is used, there shall be a witness to the oral presentation. Only the short form itself is to be signed by the subject or the subject's legally authorized representative. However, the witness shall sign both the short form and a copy of the summary, and the person actually obtaining consent shall sign a copy of the summary. A copy of the summary shall be given to the subject or the subject's legally authorized representative, in addition to a copy of the short form.

(c)(1) An IRB may waive the requirement for the investigator to obtain a signed informed consent form for some or all subjects if it finds any of the following:

(i) That the only record linking the subject and the research would be the

informed consent form and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject (or legally authorized representative) will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern;

(ii) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context; or

(iii) If the subjects or legally authorized representatives are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

(2) In cases in which the documentation requirement is waived, the IRB may require the investigator to provide subjects or legally authorized representatives with a written statement regarding the research.

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§ 431.118 Applications and proposals lacking definite plans for involvement of human subjects.

Certain types of applications for grants, cooperative agreements, or contracts are submitted to Federal departments or agencies with the knowledge that subjects may be involved within the period of support, but definite plans would not normally be set forth in the application or proposal. These include activities such as institutional type grants when selection of specific projects is the institution's responsibility; research training grants in which the activities involving subjects remain to be selected; and projects in which human subjects' involvement will depend upon completion of instruments, prior animal studies, or purification of compounds. Except for research waived under §431.101(i) or exempted under §431.104, no human subjects may be involved in any project supported by these awards until the project has been reviewed and approved by the IRB, as provided in this policy, and certification submitted, by the institution, to the Federal department or agency component supporting the research.

§ 431.119 Research undertaken without the intention of involving human subjects.

Except for research waived under §431.101(i) or exempted under §431.104, in the event research is undertaken without the intention of involving human subjects, but it is later proposed to involve human subjects in the research, the research shall first be reviewed and approved by an IRB, as provided in this policy, a certification submitted by the institution to the Federal department or agency component supporting the research, and final approval given to the proposed change by the Federal department or agency component.

§ 431.120 Evaluation and disposition of applications and proposals for research to be conducted or supported by a Federal department or agency.

(a) The department or agency head will evaluate all applications and proposals involving human subjects submitted to the Federal department or agency through such officers and employees of the Federal department or agency and such experts and consultants as the department or agency head determines to be appropriate. This evaluation will take into consideration the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained.

(b) On the basis of this evaluation, the department or agency head may approve or disapprove the application or proposal, or enter into negotiations to develop an approvable one.

§ 431.121 [Reserved]

§ 431.122 Use of Federal funds.

Federal funds administered by a Federal department or agency may not be expended for research involving human subjects unless the requirements of this policy have been satisfied.

§ 431.123 Early termination of research support: Evaluation of applications and proposals.

(a) The department or agency head may require that Federal department or agency support for any project be terminated or suspended in the manner prescribed in applicable program requirements, when the department or agency head finds an institution has materially failed to comply with the terms of this policy.

(b) In making decisions about supporting or approving applications or proposals covered by this policy the department or agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension under paragraph (a) of this section and whether the applicant or the person or persons who would direct or has/have directed the scientific and technical aspects of an activity has/have, in the judgment of the department or agency head, materially failed to discharge responsibility for the protection of the rights and welfare of human subjects (whether or not the research was subject to federal regulation).

§ 431.124 Conditions.

With respect to any research project or any class of research projects the department or agency head of either the conducting or the supporting Federal department or agency may impose additional conditions prior to or at the time of approval when in the judgment of the department or agency head additional conditions are necessary for the protection of human subjects.

PARTS 432–437 [RESERVED]

PART 438—RESTRICTIONS ON LOBBYING

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APPENDIX A TO PART 438—CERTIFICATION REGARDING LOBBYING
APPENDIX B TO PART 438—DISCLOSURE FORM TO REPORT LOBBYING

AUTHORITY: 5 U.S.C. 301.

SOURCE: 68 FR 28745, May 27, 2003, unless otherwise noted.

Subpart A—General

§ 438.100 Conditions on use of funds.

(a) No appropriated funds may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of SSA, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(b) Each person who requests or receives from SSA a Federal contract, grant, loan, or cooperative agreement must file with SSA a certification, set forth in appendix A to this part, that the person has not made, and will not make, any payment prohibited by paragraph (a) of this section.

(c) Each person who requests or receives from SSA a Federal contract, grant, loan, or a cooperative agreement

must file with SSA a disclosure form, set forth in appendix B to this part, if such person has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered Federal action), which would be prohibited under paragraph (a) of this section if paid for with appropriated funds.

(d) Each person who requests or receives from SSA a commitment providing for the United States to insure or guarantee a loan must file with SSA a statement, set forth in appendix A to this part, whether that person has made or has agreed to make any payment to influence or attempt to influence an officer or employee of SSA, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with that loan insurance or guarantee.

(e) Each person who requests or receives from SSA a commitment providing for the United States to insure or guarantee a loan must file with SSA a disclosure form, set forth in appendix B to this part, if that person has made or has agreed to make any payment to influence or attempt to influence an officer or employee of SSA, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with that loan insurance or guarantee.

§ 438.105 Definitions.

For purposes of this part:

Commissioner means the Commissioner of Social Security.

Covered Federal action means any of the following Federal actions:

(1) The awarding of any Federal contract;

(2) The making of any Federal grant;

(3) The making of any Federal loan;

(4) The entering into of any cooperative agreement; and,

(5) The extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. Covered Federal action does not include receiving from an agency a commitment providing for the United States to insure or guarantee a loan. Loan guarantees and loan insurance are addressed independently within this part.

Federal contract means an acquisition contract awarded by the Social Security Administration, including those subject to the Federal Acquisition Regulation (FAR) (48 CFR chapter 1), and any other acquisition contract for real or personal property or services not subject to the FAR.

Federal cooperative agreement means a cooperative agreement SSA enters into.

Federal grant means an award of financial assistance in the form of money, or property in lieu of money, by the Federal Government or a direct appropriation made by law to any person. The term does not include technical assistance which provides services instead of money, or other assistance in the form of revenue sharing, loans, loan guarantees, loan insurance, interest subsidies, insurance, or direct United States cash assistance to an individual.

Federal loan means a loan made by SSA. The term does not include loan guarantee or loan insurance.

Indian tribe and *tribal organization* have the meaning provided in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450B). Alaskan Natives are included under the definitions of Indian tribes in that Act.

Influencing or *attempting to influence* means making, with the intent to influence, any communication to or appearance before an officer or employee of SSA, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal action.

Loan guarantee and *loan insurance* means SSA's guarantee or insurance of a loan made by a person.

Local government means a unit of government in a State and, if chartered, established, or otherwise recognized by a State for the performance of a governmental duty, including a local public authority, a special district, an intrastate district, a council of governments, a sponsor group representative organization, and any other instrumentality of a local government.

Officer or employee of SSA includes the following individuals who are employed by an agency:

(1) An individual who is appointed to a position in the Government under title 5, U.S. Code, including a position under a temporary appointment;

(2) A member of the uniformed services as defined in section 101(3), title 37, U.S. Code;

(3) A special Government employee as defined in section 202, title 18, U.S. Code; and,

(4) An individual who is a member of a Federal advisory committee, as defined by the Federal Advisory Committee Act, title 5, U.S. Code appendix 2.

Person means an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit or not for profit. This term excludes an Indian tribe, tribal organization, or any other Indian organization with respect to expenditures specifically permitted by other Federal law.

Reasonable compensation means, with respect to a regularly employed officer or employee of any person, compensation that is consistent with the normal compensation for such officer or employee for work that is not furnished to, not funded by, or not furnished in cooperation with the Federal Government.

Reasonable payment means, with respect to professional and other technical services, a payment in an amount that is consistent with the amount normally paid for such services in the private sector.

Recipient includes all contractors, subcontractors at any tier, and subgrantees at any tier of the recipient of funds received in connection with a Federal contract, grant, loan, or cooperative agreement. The term excludes an Indian tribe, tribal organization, or any other Indian organization with respect to expenditures specifically permitted by other Federal law.

Regularly employed means, with respect to an officer or employee of a person requesting or receiving a Federal contract, grant, loan, or cooperative agreement or a commitment providing for the United States to insure or guarantee a loan, an officer or employee who is employed by such person for at least 130 working days within one year immediately preceding the date of the submission that initiates agency consideration of such person for receipt of such contract, grant, loan, cooperative agreement, loan insurance commitment, or loan guarantee commitment. An officer or employee who is employed by such person for less than 130 working days within one year immediately preceding the date of the submission that initiates agency consideration of such person shall be considered to be regularly employed as soon as he or she is employed by such person for 130 working days.

SSA means the Social Security Administration.

State means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, a territory or possession of the United States, an agency or instrumentality of a State, and a multi-State, regional, or interstate entity having governmental duties and powers.

§ 438.110 Certification and disclosure.

(a) Each person must file a certification, and a disclosure form, if required, with each submission that initiates SSA consideration of that person for:

(1) Award of a Federal contract, grant, or cooperative agreement exceeding $100,000; or

(2) An award of a Federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000.

(b) Each person must file a certification, and a disclosure form, if required, if he or she receives:

(1) A Federal contract, grant, or cooperative agreement exceeding $100,000; or

(2) A Federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000, unless such person previously filed a certification, and a disclosure form, if required, under paragraph (a) of this section.

(c) Each person must file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by that person

under paragraphs (a) or (b) of this section. An event that materially affects the accuracy of the information reported includes:

(1) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered Federal action; or

(2) A change in the person(s) or individual(s) influencing or attempting to influence a covered Federal action; or,

(3) A change in the officer(s), employee(s), or Member(s) contacted to influence or attempt to influence a covered Federal action.

(d) Any person who requests or receives from a person referred to in paragraphs (a) or (b) of this section:

(1) A subcontract exceeding $100,000 at any tier under a Federal contract;

(2) A subgrant, contract, or subcontract exceeding $100,000 at any tier under a Federal grant;

(3) A contract or subcontract exceeding $100,000 at any tier under a Federal loan exceeding $150,000; or,

(4) A contract or subcontract exceeding $100,000 at any tier under a Federal cooperative agreement, must file a certification, and a disclosure form, if required, to the next tier above.

(e) All disclosure forms, but not certifications, must be forwarded from tier to tier until received by the person referred to in paragraphs (a) or (b) of this section. That person must forward all disclosure forms to SSA.

(f) Any certification or disclosure form filed under paragraph (e) of this section will be treated as a material representation of fact upon which all receiving tiers must rely. All liability arising from an erroneous representation will be borne solely by the tier filing that representation and will not be shared by any tier to which the erroneous representation is forwarded. Submitting an erroneous certification or disclosure constitutes a failure to file the required certification or disclosure, respectively. If a person fails to file a required certification or disclosure, the United States may pursue all available remedies, including those authorized by section 1352, title 31, U.S. Code.

(g) No reporting is required for an activity paid for with appropriated funds if that activity is allowable under either subpart B or C of this part.

Subpart B—Activities by Own Employees

§ 438.200 Agency and legislative liaison.

(a) The prohibition on the use of appropriated funds, in § 438.100(a), does not apply in the case of a payment of reasonable compensation made to an officer or employee of a person requesting or receiving a Federal contract, grant, loan, or cooperative agreement if the payment is for agency and legislative liaison activities not directly related to a covered Federal action.

(b) For purposes of paragraph (a) of this section, providing any information specifically requested by SSA or Congress is allowable at any time.

(c) For purposes of paragraph (a) of this section, the following agency and legislative liaison activities are allowable at any time only where they are not related to a specific solicitation for any covered Federal action:

(1) Discussing with SSA (including individual demonstrations) the qualities and characteristics of the person's products or services, conditions or terms of sale, and service capabilities; and,

(2) Technical discussions and other activities regarding the application or adaptation of the person's products or services for SSA's use.

(d) For purposes of paragraph (a) of this section, the following agency and legislative liaison activities are allowable only where they are prior to formal solicitation of any covered Federal action:

(1) Providing any information not specifically requested but necessary for SSA to make an informed decision about initiation of a covered Federal action;

(2) Technical discussions regarding the preparation of an unsolicited proposal prior to its official submission; and,

(3) Capability presentations by persons seeking awards from SSA pursuant to the provisions of the Small Business Act, as amended by Public Law 95–507 and other subsequent amendments.

(e) Only those activities expressly authorized by this section are allowable under this section.

§ 438.205 Professional and technical services.

(a) The prohibition on the use of appropriated funds, in § 438.100(a), does not apply in the case of a payment of reasonable compensation made to an officer or employee of a person requesting or receiving a Federal contract, grant, loan, or cooperative agreement or an extension, continuation, renewal, amendment, or modification of a Federal contract, grant, loan, or cooperative agreement if payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal contract, grant, loan, or cooperative agreement or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal contract, grant, loan, or cooperative agreement.

(b) For purposes of paragraph (a) of this section, *professional and technical services* are limited to advice and analysis directly applying any professional or technical discipline. For example, drafting of a legal document accompanying a bid or proposal by a lawyer is allowable. Similarly, technical advice provided by an engineer on the performance or operational capability of a piece of equipment rendered directly in the negotiation of a contract is allowable. However, communications with the intent to influence made by a professional (such as a licensed lawyer) or a technical person (such as a licensed accountant) are not allowable under this section unless they provide advice and analysis directly applying their professional or technical expertise and unless the advice or analysis is rendered directly and solely in the preparation, submission or negotiation of a covered Federal action. Thus, for example, communications with the intent to influence made by a lawyer that do not provide legal advice or analysis directly and solely related to the legal aspects of his or her client's proposal, but generally advocate one proposal over another are not allowable under this section because the lawyer is not providing professional legal services. Similarly, communications with the intent to influence made by an engineer providing an engineering analysis prior to the preparation or submission of a bid or proposal are not allowable under this section since the engineer is providing technical services but not directly in the preparation, submission or negotiation of a covered Federal action.

(c) Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation, or reasonably expected to be required by law or regulation, and any other requirements in the actual award documents.

(d) Only those services expressly authorized by this section are allowable under this section.

§ 438.210 Reporting.

No reporting is required with respect to payments of reasonable compensation made to regularly employed officers or employees of a person.

Subpart C—Activities by Other Than Own Employees

§ 438.300 Professional and technical services.

(a) The prohibition on the use of appropriated funds, in § 438.100(a), does not apply in the case of any reasonable payment to a person, other than an officer or employee of a person requesting or receiving a covered Federal action, if the payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal contract, grant, loan, or cooperative agreement or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal contract, grant, loan, or cooperative agreement.

(b) The reporting requirements in § 438.110 (a) and (b) regarding filing a disclosure form by each person, if required, do not apply with respect to professional or technical services rendered directly in the preparation, submission, or negotiation of any commitment providing for the United States to insure or guarantee a loan.

(c) For purposes of paragraph (a) of this section, *professional and technical services* are limited to advice and analysis directly applying any professional or technical discipline. For example, drafting of a legal document accompanying a bid or proposal by a lawyer is allowable. Similarly, technical advice provided by an engineer on the performance or operational capability of a piece of equipment rendered directly in the negotiation of a contract is allowable. However, communications with the intent to influence made by a professional (such as a licensed lawyer) or a technical person (such as a licensed accountant) are not allowable under this section unless they provide advice and analysis that directly apply to their professional or technical expertise and unless the advice or analysis is rendered directly and solely in the preparation, submission or negotiation of a covered Federal action. Thus, for example, communications with the intent to influence made by a lawyer that do not provide legal advice or analysis directly and solely related to the legal aspects of his or her client's proposal, but generally advocate one proposal over another are not allowable under this section because the lawyer is not providing professional legal services. Similarly, communications with the intent to influence made by an engineer providing an engineering analysis prior to the preparation or submission of a bid or proposal are not allowable under this section since the engineer is providing technical services but not directly in the preparation, submission or negotiation of a covered Federal action.

(d) Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation, or reasonably expected to be required by law or regulation, and any other requirements in the actual award documents.

(e) Persons other than officers or employees of a person requesting or receiving a covered Federal action include consultants and trade associations.

(f) Only those services expressly authorized by this section are allowable under this section.

Subpart D—Penalties and Enforcement

§ 438.400 Penalties.

(a) Any person who makes an expenditure prohibited by this part is subject to a civil penalty of not less than $10,000 and not more than $100,000 for each prohibited expenditure.

(b) Any person who fails to file or amend the disclosure form (see Appendix B to this part) to be filed or amended if required by this part is subject to a civil penalty of not less than $10,000 and not more than $100,000 for each failure.

(c) A filing or amended filing on or after the date on which an administrative action for the imposition of a civil penalty is begun does not prevent the imposition of such civil penalty for a failure occurring before that date. An administrative action begins with respect to a failure when an investigating official determines in writing to begin an investigation of an allegation of such failure.

(d) In determining whether to impose a civil penalty, and the amount of any such penalty, by reason of a violation by any person, SSA will consider the nature, circumstances, extent, and gravity of the violation, the effect on the ability of the person to continue in business, any prior violations by the person, the degree of culpability of the person, the ability of the person to pay the penalty, and any other matters that may be appropriate.

(e) First offenders under paragraphs (a) or (b) of this section are subject to a civil penalty of $10,000, absent aggravating circumstances. Second and subsequent offenses by persons are subject to an appropriate civil penalty between $10,000 and $100,000, as determined by the Commissioner or his or her designee.

(f) Imposition of a civil penalty under this section does not prevent the United States from seeking any other remedy that may apply to the same conduct that is the basis for the imposition of the civil penalty.

§ 438.405 Penalty procedures.

We will impose and collect civil penalties pursuant to the provisions of the Program Fraud and Civil Remedies

Act, 31 U.S.C. sections 3803 (except subsection (c)), 3804, 3805, 3806, 3807, 3808, and 3812, to the extent these provisions are not inconsistent with the requirements in this part.

§ 438.410 Enforcement.

The Commissioner of Social Security will take any actions necessary to ensure that the provisions in this part are vigorously implemented and enforced.

Subpart E—Exemptions

§ 438.500 Secretary of Defense.

(a) The Secretary of Defense may exempt, on a case-by-case basis, a covered Federal action from the prohibition whenever the Secretary determines, in writing, that such an exemption is in the national interest. The Secretary shall transmit a copy of each such written exemption to Congress immediately after making such a determination.

(b) The Department of Defense may issue supplemental regulations to implement paragraph (a) of this section.

Subpart F—Agency Reports

§ 438.600 Semi-annual compilation.

(a) The Commissioner of Social Security will collect and compile the disclosure reports (see appendix B to this part) and, on May 31 and November 30 of each year, submit to the Secretary of the Senate and the Clerk of the House of Representatives a report containing a compilation of the information contained in the disclosure reports received during the 6-month period ending on March 31 or September 30, respectively, of that year.

(b) The report, including the compilation, will be available for public inspection 30 days after receipt of the report by the Secretary and the Clerk.

(c) Information that involves intelligence matters will be reported only to the Select Committee on Intelligence of the Senate, the Permanent Select Committee on Intelligence of the House of Representatives and the Committee on Appropriations of the Senate and the House of Representatives in accordance with procedures agreed to by such committees. Such information will not be available for public inspection.

(d) Information that is classified under Executive Order 12356 or any successor order will be reported only to the Committee on Foreign Relations of the Senate and the Committee on Foreign Affairs of the House of Representatives (whichever such committees have jurisdiction of matters involving such information) and to the Committees on Appropriations of the Senate and the House of Representatives in accordance with procedures agreed to by such committees. Such information will not be available for public inspection.

(e) The first semi-annual compilation was submitted on May 31, 1990, and contains a compilation of the disclosure reports received from December 23, 1989 to March 31, 1990.

(f) Major agencies designated by the Office of Management and Budget (OMB) were required to provide machine-readable compilations to the Secretary of the Senate and the Clerk of the House of Representatives by May 31, 1991. OMB provided detailed specifications in a memorandum to these agencies.

(g) SSA will keep the originals of all disclosure reports in our official files.

§ 438.605 Inspector General report.

(a) The Inspector General of Social Security, or other official as specified in paragraph (b) of this section, will prepare and submit to Congress each year an evaluation of SSA compliance with, and the effectiveness of, the requirements in this part. The evaluation may include any recommended changes that may be necessary to strengthen or improve the requirements.

(b) The annual report will be submitted at the same time we submit our annual budget justification to Congress.

(c) The annual report will include the following: All alleged violations covered by the report, the actions taken by the Commissioner in the year covered by the report with respect to those alleged violations and alleged violations in previous years, and the amounts of civil penalties imposed by SSA in the year covered by the report.

APPENDIX A TO PART 438—CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS, AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form—LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

STATEMENT FOR LOAN GUARANTEES AND LOAN INSURANCE

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form—LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

APPENDIX B TO PART 438—DISCLOSURE FORM TO REPORT LOBBYING

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

Approved by OMB
0348-0046

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	**9. Award Amount**, *if known*: $
10. a. Name and Address of Lobbying Entity (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
(attach Continuation Sheet(s) SF-LLLA, if necessary)	
11. Amount of Payment (*check all that apply*): $ _____ ☐ actual ☐ planned	**13. Type of Payment** (*check all that apply*): ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other; specify: _____
12. Form of Payment (*check all that apply*): ☐ a. cash ☐ b. in-kind; specify: nature _____ value _____	
14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11: *(attach Continuation Sheet(s) SF-LLLA, if necessary)*	
15. Continuation Sheet(s) SF-LLLA attached: ☐ Yes ☐ No	
16. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less that $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLLA Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLLA Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

PARTS 440–497 [RESERVED]

PART 498—CIVIL MONETARY PENALTIES, ASSESSMENTS AND RECOMMENDED EXCLUSIONS

Sec.

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498.224 Harmless error.

AUTHORITY: Secs. 702(a)(5), 1129, and 1140 of the Social Security Act (42 U.S.C. 902(a)(5), 1320a–8, and 1320b–10).

SOURCE: 60 FR 58226, Nov. 27, 1995, unless otherwise noted.

§ 498.100 Basis and purpose.

(a) *Basis.* This part implements sections 1129 and 1140 of the Social Security Act (42 U.S.C. 1320a–8 and 1320b–10).

(b) *Purpose.* This part provides for the imposition of civil monetary penalties and assessments, as applicable, against persons who—

(1) Make or cause to be made false statements or representations or omissions or otherwise withhold disclosure of a material fact for use in determining any right to or amount of benefits under title II or benefits or payments under title VIII or title XVI of the Social Security Act;

(2) Convert any payment, or any part of a payment, received under title II, title VIII, or title XVI of the Social Security Act for the use and benefit of another individual, while acting in the capacity of a representative payee for that individual, to a use that such person knew or should have known was other than for the use and benefit of such other individual; or

(3) Misuse certain Social Security program words, letters, symbols, and emblems; or

(4) With limited exceptions, charge a fee for a product or service that is available from SSA free of charge without including a written notice stating the product or service is available from SSA free of charge.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18079, Apr. 24, 1996; 71 FR 28579, May 17, 2006]

§ 498.101 Definitions.

As used in this part:

Agency means the Social Security Administration.

Assessment means the amount described in § 498.104, and includes the plural of that term.

Commissioner means the Commissioner of Social Security or his or her designees.

Department means the U.S. Department of Health and Human Services.

General Counsel means the General Counsel of the Social Security Administration or his or her designees.

Inspector General means the Inspector General of the Social Security Administration or his or her designees.

Material fact means a fact which the Commissioner of Social Security may consider in evaluating whether an applicant is entitled to benefits under title II or eligible for benefits or payments under title VIII or title XVI of the Social Security Act.

Otherwise withhold disclosure means the failure to come forward to notify the SSA of a material fact when such person knew or should have known that the withheld fact was material

and that such withholding was misleading for purposes of determining eligibility or Social Security benefit amount for that person or another person.

Penalty means the amount described in § 498.103 and includes the plural of that term.

Person means an individual, organization, agency, or other entity.

Respondent means the person upon whom the Commissioner or the Inspector General has imposed, or intends to impose, a penalty and assessment, as applicable.

Secretary means the Secretary of the U.S. Department of Health and Human Services or his or her designees.

SSA means the Social Security Administration.

SSI means Supplemental Security Income.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18079, Apr. 24, 1996; 71 FR 28580, May 17, 2006]

§ 498.102 Basis for civil monetary penalties and assessments.

(a) The Office of the Inspector General may impose a penalty and assessment, as applicable, against any person who it determines in accordance with this part—

(1) Has made, or caused to be made, a statement or representation of a material fact for use in determining any initial or continuing right to or amount of:

(i) Monthly insurance benefits under title II of the Social Security Act; or

(ii) Benefits or payments under title VIII or title XVI of the Social Security Act; and

(2)(i) Knew, or should have known, that the statement or representation was false or misleading, or

(ii) Made such statement with knowing disregard for the truth; or

(3) Omitted from a statement or representation, or otherwise withheld disclosure of, a material fact for use in determining any initial or continuing right to or amount of benefits or payments, which the person knew or should have known was material for such use and that such omission or withholding was false or misleading.

(b) The Office of the Inspector General may impose a penalty and assessment, as applicable, against any representative payee who receives a payment under title II, title VIII, or title XVI for the use and benefit of another individual and who converts such payment, or any part thereof, to a use that such representative payee knew or should have known was other than for the use and benefit of such other individual.

(c) The Office of the Inspector General may impose a penalty against any person who it determines in accordance with this part has made use of certain Social Security program words, letters, symbols, or emblems in such a manner that the person knew or should have known would convey, or in a manner which reasonably could be interpreted or construed as conveying, the false impression that a solicitation, advertisement or other communication was authorized, approved, or endorsed by the Social Security Administration, or that such person had some connection with, or authorization from, the Social Security Administration.

(1) Civil monetary penalties may be imposed for misuse, as set forth in paragraph (c) of this section, of—

(i) The words ''Social Security,'' ''Social Security Account,'' ''Social Security Administration,'' ''Social Security System,'' ''Supplemental Security Income Program,'' ''Death Benefits Update,'' ''Federal Benefit Information,'' ''Funeral Expenses,'' ''Final Supplemental Program,'' or any combination or variation of such words; or

(ii) The letters ''SSA,'' or ''SSI,'' or any other combination or variation of such letters; or

(iii) A symbol or emblem of the Social Security Administration (including the design of, or a reasonable facsimile of the design of, the Social Security card, the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration) or any other combination or variation of such symbols or emblems.

(2) Civil monetary penalties will not be imposed against any agency or instrumentality of a State, or political subdivision of a State, that makes use

of any words, letters, symbols or emblems of the Social Security Administration or instrumentality of the State or political subdivision.

(d) The Office of the Inspector General may impose a penalty against any person who offers, for a fee, to assist an individual in obtaining a product or service that the person knew or should have known the Social Security Administration provides free of charge, unless:

(1) The person provides sufficient notice before the product or service is provided to the individual that the product or service is available free of charge and:

(i) In a printed solicitation, advertisement or other communication, such notice is clearly and prominently placed and written in a font that is distinguishable from the rest of the text;

(ii) In a broadcast or telecast such notice is clearly communicated so as not to be construed as misleading or deceptive.

(2) Civil monetary penalties will not be imposed under paragraph (d) of this section with respect to offers—

(i) To serve as a claimant representative in connection with a claim arising under title II, title VIII, or title XVI; or

(ii) To prepare, or assist in the preparation of, an individual's plan for achieving self-support under title XVI.

(e) The use of a disclaimer of affiliation with the United States Government, the Social Security Administration or its programs, or any other agency or instrumentality of the United States Government will not be considered as a defense in determining a violation of section 1140 of the Social Security Act.

[71 FR 28580, May 17, 2006]

§ 498.103 Amount of penalty.

(a) Under § 498.102(a), the Office of the Inspector General may impose a penalty of not more than $5,000 for each false statement or representation, omission, or receipt of payment or benefit while withholding disclosure of a material fact.

(b) Under § 498.102(b), the Office of the Inspector General may impose a penalty of not more than $5,000 against a representative payee for each time the representative payee receives a payment under title II, title VIII, or title XVI of the Social Security Act for the use and benefit of another individual, and who converts such payment, or any part thereof, to a use that such representative payee knew or should have known was other than for the use and benefit of such other individual.

(c) Under § 498.102(c), the Office of the Inspector General may impose a penalty of not more than $5,000 for each violation resulting from the misuse of Social Security Administration program words, letters, symbols, or emblems relating to printed media and a penalty of not more than $25,000 for each violation in the case that such misuse related to a broadcast or telecast.

(d) Under § 498.102(d), the Office of the Inspector General may impose a penalty of not more than $5,000 for each violation resulting from insufficient notice relating to printed media regarding products or services provided free of charge by the Social Security Administration and a penalty of not more than $25,000 for each violation in the case that such insufficient notice relates to a broadcast or telecast.

(e) For purposes of paragraphs (c) and (d) of this section, a violation is defined as—

(1) In the case of a mailed solicitation, advertisement, or other communication, each separate piece of mail which contains one or more program words, letters, symbols, or emblems or insufficient notice related to a determination under § 498.102(c) or (d); and

(2) In the case of a broadcast or telecast, each airing of a single commercial or solicitation related to a determination under § 498.102(c) or (d).

(f) [Reserved]

(g)(1) The amount of the penalties described in paragraphs (a) through (d) of this section are the maximum penalties which may be assessed under these paragraphs for violations made after June 16, 2006, but before August 1, 2016.

(2)(i) After August 1, 2016 penalties are adjusted in accordance with the Federal Civil Penalties Inflation Adjustment Act of 1990 (Pub. L. 101–410), as amended by the Debt Collection Improvement Act of 1996 (Pub. L. 104–134),

as further amended by the Bipartisan Budget Act of 2015, Section 701: Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (Section 701 of Pub. L. 114–74).

(ii) The maximum penalties which may be assessed under this section is the larger of:

(A) The amount for the previous calendar year; or

(B) An amount adjusted for inflation, calculated by multiplying the amount for the previous calendar year by the percentage by which the Consumer Price Index for all urban consumers for the month of October preceding the current calendar year exceeds the Consumer Price Index for all urban consumers for the month of October of the calendar year two years prior to the current calendar year, adding that amount to the amount for the previous calendar year, and rounding the total to the nearest dollar.

(iii) Notice of the maximum penalty which may be assessed under this section for calendar years after 2016 will be published in the FEDERAL REGISTER on an annual basis on or before January 15 of each calendar year.

[71 FR 28580, May 17, 2006, as amended at 81 FR 41440, June 27, 2016]

§ 498.104 Amount of assessment.

A person subject to a penalty determined under § 498.102(a) may be subject, in addition, to an assessment of not more than twice the amount of benefits or payments paid under title II, title VIII or title XVI of the Social Security Act as a result of the statement, representation, omission, or withheld disclosure of a material fact which was the basis for the penalty. A representative payee subject to a penalty determined under § 498.102(b) may be subject, in addition, to an assessment of not more than twice the amount of benefits or payments received by the representative payee for the use and benefit of another individual and converted to a use other than for the use and benefit of such other individual. An assessment is in lieu of damages sustained by the United States because of such statement, representation, omission, withheld disclosure of a material fact, or conversion, as referred to in § 498.102(a) and (b).

[71 FR 28581, May 17, 2006]

§ 498.105 [Reserved]

§ 498.106 Determinations regarding the amount or scope of penalties and assessments.

(a) In determining the amount or scope of any penalty and assessment, as applicable, in accordance with § 498.103(a) and (b) and 498.104, the Office of the Inspector General will take into account:

(1) The nature of the statements, representations, or actions referred to in § 498.102(a) and (b) and the circumstances under which they occurred;

(2) The degree of culpability of the person committing the offense;

(3) The history of prior offenses of the person committing the offense;

(4) The financial condition of the person committing the offense; and

(5) Such other matters as justice may require.

(b) In determining the amount of any penalty in accordance with § 498.103(c) and (d), the Office of the Inspector General will take into account—

(1) The nature and objective of the advertisement, solicitation, or other communication, and the circumstances under which they were presented;

(2) The frequency and scope of the violation, and whether a specific segment of the population was targeted;

(3) The prior history of the individual, organization, or entity in their willingness or refusal to comply with informal requests to correct violations;

(4) The history of prior offenses of the individual, organization, or entity in their misuse of program words, letters, symbols, and emblems;

(5) The financial condition of the individual or entity; and

(6) Such other matters as justice may require.

(c) In cases brought under section 1140 of the Social Security Act, the use of a disclaimer of affiliation with the United States Government, the Social Security Administration or its programs will not be considered as a mitigating factor in determining the

amount of a penalty in accordance with § 498.106.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18080, Apr. 24, 1996; 71 FR 28581, May 17, 2006]

§ 498.107 [Reserved]

§ 498.108 Penalty and assessment not exclusive.

Penalties and assessments, as applicable, imposed under this part are in addition to any other penalties prescribed by law.

[61 FR 18080, Apr. 24, 1996]

§ 498.109 Notice of proposed determination.

(a) If the Office of the Inspector General seeks to impose a penalty and assessment, as applicable, it will serve written notice of the intent to take such action. The notice will include:

(1) Reference to the statutory basis for the proposed penalty and assessment, as applicable;

(2) A description of the false statements, representations, other actions (as described in § 498.102(a) and (b)), and incidents, as applicable, with respect to which the penalty and assessment, as applicable, are proposed;

(3) The amount of the proposed penalty and assessment, as applicable;

(4) Any circumstances described in § 498.106 that were considered when determining the amount of the proposed penalty and assessment, as applicable; and

(5) Instructions for responding to the notice, including

(i) A specific statement of respondent's right to a hearing; and

(ii) A statement that failure to request a hearing within 60 days permits the imposition of the proposed penalty and assessment, as applicable, without right of appeal.

(b) Any person upon whom the Office of the Inspector General has proposed the imposition of a penalty and assessment, as applicable, may request a hearing on such proposed penalty and assessment.

(c) If the respondent fails to exercise the respondent's right to a hearing within the time permitted under this section, and does not demonstrate good cause for such failure before an administrative law judge, any penalty and assessment, as applicable, becomes final.

[61 FR 18080, Apr. 24, 1996, as amended at 71 FR 28581, May 17, 2006]

§ 498.110 Failure to request a hearing.

If the respondent does not request a hearing within the time prescribed by § 498.109(a), the Office of the Inspector General may seek the proposed penalty and assessment, as applicable, or any less severe penalty and assessment. The Office of the Inspector General shall notify the respondent by certified mail, return receipt requested, of any penalty and assessment, as applicable, that has been imposed and of the means by which the respondent may satisfy the amount owed.

[61 FR 18080, Apr. 24, 1996]

§ 498.114 Collateral estoppel.

In a proceeding under section 1129 of the Social Security Act that—

(a) Is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or *nolo contendere*) of a Federal or State crime; and

(b) Involves the same transactions as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.

[61 FR 18080, Apr. 24, 1996, as amended at 71 FR 28581, May 17, 2006]

§§ 498.115–498.125 [Reserved]

§ 498.126 Settlement.

The Inspector General has exclusive authority to settle any issues or case, without the consent of the administrative law judge or the Commissioner, at any time prior to a final determination. Thereafter, the Commissioner or his or her designee has such exclusive authority.

§ 498.127 Judicial review.

Sections 1129 and 1140 of the Social Security Act authorize judicial review of any penalty and assessment, as applicable, that has become final. Judicial review may be sought by a respondent only in regard to a penalty and assessment, as applicable, with respect to which the respondent requested a hearing, unless the failure or

neglect to urge such objection is excused by the court because of extraordinary circumstances.

[61 FR 18080, Apr. 24, 1996]

§ 498.128 Collection of penalty and assessment.

(a) Once a determination has become final, collection of any penalty and assessment, as applicable, will be the responsibility of the Commissioner or his or her designee.

(b) In cases brought under section 1129 of the Social Security Act, a penalty and assessment, as applicable, imposed under this part may be compromised by the Commissioner or his or her designee and may be recovered in a civil action brought in the United States District Court for the district where the violation occurred or where the respondent resides.

(c) In cases brought under section 1140 of the Social Security Act, a penalty imposed under this part may be compromised by the Commissioner or his or her designee and may be recovered in a civil action brought in the United States district court for the district where, as determined by the Commissioner, the:

(1) Violations referred to in § 498.102(c) or (d) occurred; or

(2) Respondent resides; or

(3) Respondent has its principal office; or

(4) Respondent may be found.

(d) As specifically provided under the Social Security Act, in cases brought under section 1129 of the Social Security Act, the amount of a penalty and assessment, as applicable, when finally determined, or the amount agreed upon in compromise, may also be deducted from:

(1) Monthly title II, title VIII, or title XVI payments, notwithstanding section 207 of the Social Security Act as made applicable to title XVI by section 1631(d)(1) of the Social Security Act;

(2) A tax refund to which a person is entitled to after notice to the Secretary of the Treasury under 31 U.S.C. § 3720A;

(3) By authorities provided under the Debt Collection Act of 1982, as amended, 31 U.S.C. 3711, to the extent applicable to debts arising under the Social Security Act; or

(4) Any combination of the foregoing.

(e) Matters that were raised or that could have been raised in a hearing before an administrative law judge or in an appeal to the United States Court of Appeals under sections 1129 or 1140 of the Social Security Act may not be raised as a defense in a civil action by the United States to collect a penalty and assessment, as applicable, under this part.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18080, Apr. 24, 1996; 71 FR 28581, May 17, 2006]

§ 498.129 Notice to other agencies.

As provided in section 1129 of the Social Security Act, when a determination to impose a penalty and assessment, as applicable, with respect to a physician or medical provider becomes final, the Office of the Inspector General will notify the Secretary of the final determination and the reasons therefore.

[61 FR 18081, Apr. 24, 1996]

§ 498.132 Limitations.

The Office of the Inspector General may initiate a proceeding in accordance with § 498.109(a) to determine whether to impose a penalty and assessment, as applicable—

(a) In cases brought under section 1129 of the Social Security Act, after receiving authorization from the Attorney General pursuant to procedures agreed upon by the Inspector General and the Attorney General; and

(b) Within 6 years from the date on which the violation was committed.

[61 FR 18081, Apr. 24, 1996]

§ 498.201 Definitions.

As used in this part—

ALJ refers to an Administrative Law Judge of the Departmental Appeals Board.

Civil monetary penalty cases refer to all proceedings arising under any of the statutory bases for which the Inspector General, Social Security Administration has been delegated authority to impose civil monetary penalties.

DAB refers to the Departmental Appeals Board of the U.S. Department of Health and Human Services.

[61 FR 65468, Dec. 13, 1996]

§ 498.202 Hearing before an administrative law judge.

(a) A party sanctioned under any criteria specified in §§ 498.100 through 498.132 may request a hearing before an ALJ.

(b) In civil monetary penalty cases, the parties to a hearing will consist of the respondent and the Inspector General.

(c) The request for a hearing must be:

(1) In writing and signed by the respondent or by the respondent's attorney; and

(2) Filed within 60 days after the notice, provided in accordance with § 498.109, is received by the respondent or upon a showing of good cause, the time permitted by an ALJ.

(d) The request for a hearing shall contain a statement as to the:

(1) Specific issues or findings of fact and conclusions of law in the notice letter with which the respondent disagrees; and

(2) Basis for the respondent's contention that the specific issues or findings and conclusions were incorrect.

(e) For purposes of this section, the date of receipt of the notice letter will be presumed to be five days after the date of such notice, unless there is a reasonable showing to the contrary.

(f) The ALJ shall dismiss a hearing request where:

(1) The respondent's hearing request is not filed in a timely manner and the respondent fails to demonstrate good cause for such failure;

(2) The respondent withdraws or abandons respondent's request for a hearing; or

(3) The respondent's hearing request fails to raise any issue which may properly be addressed in a hearing under this part.

[61 FR 65468, Dec. 13, 1996]

§ 498.203 Rights of parties.

(a) Except as otherwise limited by this part, all parties may:

(1) Be accompanied, represented, and advised by an attorney;

(2) Participate in any conference held by the ALJ;

(3) Conduct discovery of documents as permitted by this part;

(4) Agree to stipulations of fact or law which will be made part of the record;

(5) Present evidence relevant to the issues at the hearing;

(6) Present and cross-examine witnesses;

(7) Present oral arguments at the hearing as permitted by the ALJ; and

(8) Submit written briefs and proposed findings of fact and conclusions of law after the hearing.

(b) Fees for any services performed on behalf of a party by an attorney are not subject to the provisions of section 206 of title II of the Social Security Act, which authorizes the Commissioner to specify or limit these fees.

[61 FR 65469, Dec. 13, 1996]

§ 498.204 Authority of the administrative law judge.

(a) The ALJ will conduct a fair and impartial hearing, avoid delay, maintain order and assure that a record of the proceeding is made.

(b) The ALJ has the authority to:

(1) Set and change the date, time, and place of the hearing upon reasonable notice to the parties;

(2) Continue or recess the hearing in whole or in part for a reasonable period of time;

(3) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding;

(4) Administer oaths and affirmations;

(5) Issue subpoenas requiring the attendance of witnesses at hearings and the production of documents at or in relation to hearings;

(6) Rule on motions and other procedural matters;

(7) Regulate the scope and timing of documentary discovery as permitted by this part;

(8) Regulate the course of the hearing and the conduct of representatives, parties, and witnesses;

(9) Examine witnesses;

(10) Receive, exclude, or limit evidence;

(11) Take official notice of facts;

(12) Upon motion of a party, decide cases, in whole or in part, by summary judgment where there is no disputed issue of material fact; and

(13) Conduct any conference or argument in person, or by telephone upon agreement of the parties.

(c) The ALJ does not have the authority to:

(1) Find invalid or refuse to follow Federal statutes or regulations, or delegations of authority from the Commissioner;

(2) Enter an order in the nature of a directed verdict;

(3) Compel settlement negotiations;

(4) Enjoin any act of the Commissioner or the Inspector General; or

(5) Review the exercise of discretion by the Office of the Inspector General to seek to impose a civil monetary penalty or assessment under §§ 498.100 through 498.132.

[61 FR 65469, Dec. 13, 1996]

§ 498.205 Ex parte contacts.

No party or person (except employees of the ALJ's office) will communicate in any way with the ALJ on any matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

[61 FR 65469, Dec. 13, 1996]

§ 498.206 Prehearing conferences.

(a) The ALJ will schedule at least one prehearing conference, and may schedule additional prehearing conferences as appropriate, upon reasonable notice to the parties.

(b) The ALJ may use prehearing conferences to address the following:

(1) Simplification of the issues;

(2) The necessity or desirability of amendments to the pleadings, including the need for a more definite statement;

(3) Stipulations and admissions of fact as to the contents and authenticity of documents and deadlines for challenges, if any, to the authenticity of documents;

(4) Whether the parties can agree to submission of the case on a stipulated record;

(5) Whether a party chooses to waive appearance at a hearing and to submit only documentary evidence (subject to the objection of other parties) and written argument;

(6) Limitation of the number of witnesses;

(7) The time and place for the hearing and dates for the exchange of witness lists and of proposed exhibits;

(8) Discovery of documents as permitted by this part;

(9) Such other matters as may tend to encourage the fair, just, and expeditious disposition of the proceedings; and

(10) Potential settlement of the case.

(c) The ALJ shall issue an order containing the matters agreed upon by the parties or ordered by the ALJ at a prehearing conference.

[61 FR 65469, Dec. 13, 1996]

§ 498.207 Discovery.

(a) For the purpose of inspection and copying, a party may make a request to another party for production of documents which are relevant and material to the issues before the ALJ.

(b) Any form of discovery other than that permitted under paragraph (a) of this section, such as requests for admissions, written interrogatories and depositions, is not authorized.

(c) For the purpose of this section, the term documents includes information, reports, answers, records, accounts, papers, memos, notes and other data and documentary evidence. Nothing contained in this section will be interpreted to require the creation of a document, except that requested data stored in an electronic data storage system will be produced in a form accessible to the requesting party.

(d)(1) A party who has been served with a request for production of documents may file a motion for a protective order. The motion for protective order shall describe the document or class of documents to be protected, specify which of the grounds in § 498.207(d)(2) are being asserted, and explain how those grounds apply.

(2) The ALJ may grant a motion for a protective order if he or she finds that the discovery sought:

(i) Is unduly costly or burdensome;

(ii) Will unduly delay the proceeding; or

(iii) Seeks privileged information.

(3) The burden of showing that discovery should be allowed is on the party seeking discovery.

[61 FR 65469, Dec. 13, 1996]

§ 498.208 Exchange of witness lists, witness statements and exhibits.

(a) At least 15 days before the hearing, the parties shall exchange:

(1) Witness lists;

(2) Copies of prior written statements of proposed witnesses; and

(3) Copies of proposed hearing exhibits, including copies of any written statements that the party intends to offer in lieu of live testimony in accordance with § 498.216.

(b)(1) Failure to comply with the requirements of paragraph (a) of this section may result in the exclusion of evidence or testimony upon the objection of the opposing party.

(2) When an objection is entered, the ALJ shall determine whether good cause justified the failure to timely exchange the information listed under paragraph (a) of this section. If good cause is not found, the ALJ shall exclude from the party's case-in-chief:

(i) The testimony of any witness whose name does not appear on the witness list; and

(ii) Any exhibit not provided to the opposing party as specified in paragraph (a) of this section.

(3) If the ALJ finds that good cause exists, the ALJ shall determine whether the admission of such evidence would cause substantial prejudice to the objecting party due to the failure to comply with paragraph (a) of this section. If the ALJ finds no substantial prejudice, the evidence may be admitted. If the ALJ finds substantial prejudice, the ALJ may exclude the evidence, or at his or her discretion, may postpone the hearing for such time as is necessary for the objecting party to prepare and respond to the evidence.

(c) Unless a party objects by the deadline set by the ALJ's prehearing order pursuant to § 498.206 (b)(3) and (c), documents exchanged in accordance with paragraph (a) of this section will be deemed authentic for the purpose of admissibility at the hearing.

[61 FR 65470, Dec. 13, 1996]

§ 498.209 Subpoenas for attendance at hearing.

(a) A party wishing to procure the appearance and testimony of any individual, whose appearance and testimony are relevant and material to the presentation of a party's case at a hearing, may make a motion requesting the ALJ to issue a subpoena.

(b) A subpoena requiring the attendance of an individual may also require the individual (whether or not the individual is a party) to produce evidence at the hearing in accordance with § 498.207.

(c) A party seeking a subpoena will file a written motion not less than 30 days before the date fixed for the hearing, unless otherwise allowed by the ALJ for good cause shown. Such request will:

(1) Specify any evidence to be produced;

(2) Designate the witness(es); and

(3) Describe the address and location with sufficient particularity to permit such witness(es) to be found.

(d) Within 20 days after the written motion requesting issuance of a subpoena is served, any party may file an opposition or other response.

(e) If the motion requesting issuance of a subpoena is granted, the party seeking the subpoena will serve the subpoena by delivery to the individual named, or by certified mail addressed to such individual at his or her last dwelling place or principal place of business.

(f) The subpoena will specify the time and place at which the witness is to appear and any evidence the witness is to produce.

(g) The individual to whom the subpoena is directed may file with the ALJ a motion to quash the subpoena within 10 days after service.

(h) When a subpoena is served by a respondent on a particular individual or particular office of the Office of the Inspector General, the OIG may comply by designating any of its representatives to appear and testify.

(i) In the case of contumacy by, or refusal to obey a subpoena duly served upon any person, the exclusive remedy is specified in section 205(e) of the Social Security Act (42 U.S.C. 405(e)).

[61 FR 65470, Dec. 13, 1996]

§ 498.210 Fees.

The party requesting a subpoena will pay the cost of the fees and mileage of any witness subpoenaed in the amounts that would be payable to a witness in a proceeding in United States District Court. A check for witness fees and mileage will accompany the subpoena when served, except that when a subpoena is issued on behalf of the Inspector General, a check for witness fees and mileage need not accompany the subpoena.

[61 FR 65470, Dec. 13, 1996]

§ 498.211 Form, filing and service of papers.

(a) *Form.* (1) Unless the ALJ directs the parties to do otherwise, documents filed with the ALJ will include an original and two copies.

(2) Every document filed in the proceeding will contain a caption setting forth the title of the action, the case number, and a designation of the pleading or paper.

(3) Every document will be signed by, and will contain the address and telephone number of the party or the person on whose behalf the document was filed, or his or her representative.

(4) Documents are considered filed when they are mailed.

(b) *Service.* A party filing a document with the ALJ will, at the time of filing, serve a copy of such document on every other party. Service upon any party of any document will be made by delivering a copy, or placing a copy of the document in the United States mail, postage prepaid and addressed, or with a private delivery service, to the party's last known address. When a party is represented by an attorney, service will be made upon such attorney. Proof of service should accompany any document filed with the ALJ.

(c) *Proof of service.* A certificate of the individual serving the document by personal delivery or by mail, setting forth the manner of service, will be proof of service.

[61 FR 65470, Dec. 13, 1996]

§ 498.212 Computation of time.

(a) In computing any period of time under this part or in an order issued thereunder, the time begins with the day following the act, event or default, and includes the last day of the period unless it is a Saturday, Sunday or legal holiday observed by the Federal Government, in which event it includes the next business day.

(b) When the period of time allowed is less than 7 days, intermediate Saturdays, Sundays and legal holidays observed by the Federal Government will be excluded from the computation.

(c) Where a document has been served or issued by placing it in the mail, an additional 5 days will be added to the time permitted for any response. This paragraph does not apply to requests for hearing under § 498.202.

[61 FR 65470, Dec. 13, 1996]

§ 498.213 Motions.

(a) An application to the ALJ for an order or ruling will be by motion. Motions will:

(1) State the relief sought, the authority relied upon and the facts alleged; and

(2) Be filed with the ALJ and served on all other parties.

(b) Except for motions made during a prehearing conference or at a hearing, all motions will be in writing.

(c) Within 10 days after a written motion is served, or such other time as may be fixed by the ALJ, any party may file a response to such motion.

(d) The ALJ may not grant or deny a written motion before the time for filing responses has expired, except upon consent of the parties or following a hearing on the motion.

(e) The ALJ will make a reasonable effort to dispose of all outstanding motions prior to the beginning of the hearing.

(f) There is no right to appeal to the DAB any interlocutory ruling by the ALJ.

[61 FR 65470, Dec. 13, 1996]

§ 498.214 Sanctions.

(a) The ALJ may sanction a person, including any party or attorney, for:

(1) Failing to comply with an order or procedure;

(2) Failing to defend an action; or

(3) Misconduct that interferes with the speedy, orderly or fair conduct of the hearing.

(b) Such sanctions will reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(1) In the case of refusal to provide or permit discovery under the terms of this part, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established;

(2) Prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense;

(3) Striking pleadings, in whole or in part;

(4) Staying the proceedings;

(5) Dismissal of the action; or

(6) Entering a decision by default.

(c) In addition to the sanctions listed in paragraph (b) of this section, the ALJ may:

(1) Order the party or attorney to pay attorney's fees and other costs caused by the failure or misconduct; or

(2) Refuse to consider any motion or other action that is not filed in a timely manner.

[61 FR 65471, Dec. 13, 1996]

§ 498.215 The hearing and burden of proof.

(a) The ALJ will conduct a hearing on the record in order to determine whether the respondent should be found liable under this part.

(b) In civil monetary penalty cases under §§ 498.100 through 498.132:

(1) The respondent has the burden of going forward and the burden of persuasion with respect to affirmative defenses and any mitigating circumstances; and

(2) The Inspector General has the burden of going forward and the burden of persuasion with respect to all other issues.

(c) The burden of persuasion will be judged by a preponderance of the evidence.

(d) The hearing will be open to the public unless otherwise ordered by the ALJ for good cause.

(e)(1) A hearing under this part is not limited to specific items and information set forth in the notice letter to the respondent. Subject to the 15-day requirement under § 498.208, additional items or information may be introduced by either party during its case-in-chief, unless such information or items are inadmissible under § 498.217.

(2) After both parties have presented their cases, evidence may be admitted on rebuttal as to those issues presented in the case-in-chief, even if not previously exchanged in accordance with § 498.208.

[61 FR 65471, Dec. 13, 1996]

§ 498.216 Witnesses.

(a) Except as provided in paragraph (b) of this section, testimony at the hearing will be given orally by witnesses under oath or affirmation.

(b) At the discretion of the ALJ, testimony (other than expert testimony) may be admitted in the form of a written statement. Any such written statement must be provided to all other parties along with the last known address of such witness, in a manner that allows sufficient time for other parties to subpoena such witness for cross-examination at the hearing. Prior written statements of witnesses proposed to testify at the hearing will be exchanged as provided in § 498.208.

(c) The ALJ will exercise reasonable control over the mode and order of witness direct and cross examination and evidence presentation so as to:

(1) Make the examination and presentation effective for the ascertainment of the truth;

(2) Avoid repetition or needless waste of time; and

(3) Protect witnesses from harassment or undue embarrassment.

(d) The ALJ may order witnesses excluded so that they cannot hear the testimony of other witnesses. This does not authorize exclusion of:

(1) A party who is an individual;

(2) In the case of a party that is not an individual, an officer or employee of

the party appearing for the entity pro se or designated as the party's representative; or

(3) An individual whose presence is shown by a party to be essential to the presentation of its case, including an individual engaged in assisting the attorney for the Inspector General.

[61 FR 65471, Dec. 13, 1996]

§ 498.217 Evidence.

(a) The ALJ will determine the admissibility of evidence.

(b) Except as provided in this part, the ALJ will not be bound by the Federal Rules of Evidence, but may be guided by them in ruling on the admissibility of evidence.

(c) Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or by considerations of undue delay or needless presentation of cumulative evidence.

(d) Although relevant, evidence must be excluded if it is privileged under Federal law, unless the privilege is waived by a party.

(e) Evidence concerning offers of compromise or settlement made in this action will be inadmissible to the extent provided in Rule 408 of the Federal Rules of Evidence.

(f)(1) Evidence of crimes, wrongs or acts other than those at issue in the instant case is admissible in order to show motive, opportunity, intent, knowledge, preparation, identity, lack of mistake, or existence of a scheme.

(2) Such evidence is admissible regardless of whether the crimes, wrongs or acts occurred during the statute of limitations period applicable to the acts which constitute the basis for liability in the case, and regardless of whether they were referenced in the IG's notice sent in accordance with § 498.109.

(g) The ALJ will permit the parties to introduce rebuttal witnesses and evidence as to those issues raised in the parties' case-in-chief.

(h) All documents and other evidence offered or taken for the record will be open to examination by all parties, unless otherwise ordered by the ALJ for good cause.

[61 FR 65471, Dec. 13, 1996]

§ 498.218 The record.

(a) The hearing shall be recorded and transcribed. Transcripts may be obtained following the hearing from the ALJ.

(b) The transcript of testimony, exhibits and other evidence admitted at the hearing, and all papers and requests filed in the proceeding constitute the record for the decision by the ALJ.

(c) The record may be inspected and copied (upon payment of a reasonable fee) by any person, unless otherwise ordered by the ALJ for good cause.

[61 FR 65471, Dec. 13, 1996]

§ 498.219 Post-hearing briefs.

(a) Any party may file a post-hearing brief.

(b) The ALJ may require the parties to file post-hearing briefs and may permit the parties to file reply briefs.

(c) The ALJ will fix the time for filing briefs, which is not to exceed 60 days from the date the parties receive the transcript of the hearing or, if applicable, the stipulated record.

(d) The parties' briefs may be accompanied by proposed findings of fact and conclusions of law.

[61 FR 65471, Dec. 13, 1996]

§ 498.220 Initial decision.

(a) The ALJ will issue an initial decision, based only on the record, which will contain findings of fact and conclusions of law.

(b) The ALJ may affirm, deny, increase, or reduce the penalties or assessments proposed by the Inspector General.

(c) The ALJ will issue the initial decision to all parties within 60 days after the time for submission of post-hearing briefs or reply briefs, if permitted, has expired. The decision will be accompanied by a statement describing the right of any party to file a notice of appeal with the DAB and instructions for how to file such appeal. If the ALJ cannot issue an initial decision within the 60 days, the ALJ will

notify the parties of the reason for the delay and will set a new deadline.

(d) Unless an appeal or request for extension pursuant to § 498.221(a) is filed with the DAB, the initial decision of the ALJ becomes final and binding on the parties 30 days after the ALJ serves the parties with a copy of the decision. If service is by mail, the date of service will be deemed to be five days from the date of mailing.

[61 FR 65472, Dec. 13, 1996]

§ 498.221 Appeal to DAB.

(a) Any party may appeal the decision of the ALJ to the DAB by filing a notice of appeal with the DAB within 30 days of the date of service of the initial decision. The DAB may extend the initial 30-day period for a period of time not to exceed 30 days if a party files with the DAB a request for an extension within the initial 30-day period and shows good cause.

(b) If a party files a timely notice of appeal with the DAB, the ALJ will forward the record of the proceeding to the DAB.

(c) A notice of appeal will be accompanied by a written brief specifying exceptions to the initial decision and reasons supporting the exceptions, and identifying which finding of fact and conclusions of law the party is taking exception to. Any party may file a brief in opposition to exceptions, which may raise any relevant issue not addressed in the exceptions, within 30 days of receiving the notice of appeal and accompanying brief. The DAB may permit the parties to file reply briefs.

(d) There is no right to appear personally before the DAB, or to appeal to the DAB any interlocutory ruling by the ALJ.

(e) No party or person (except employees of the DAB) will communicate in any way with members of the DAB on any matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

(f) The DAB will not consider any issue not raised in the parties' briefs, nor any issue in the briefs that could have been, but was not, raised before the ALJ.

(g) If any party demonstrates to the satisfaction of the DAB that additional evidence not presented at such hearing is relevant and material and that there were reasonable grounds for the failure to adduce such evidence at such hearing, the DAB may remand the matter to the ALJ for consideration of such additional evidence.

(h) The DAB may remand a case to an ALJ for further proceedings, or may issue a recommended decision to decline review or affirm, increase, reduce, or reverse any penalty or assessment determined by the ALJ.

(i) When the DAB reviews a case, it will limit its review to whether the ALJ's initial decision is supported by substantial evidence on the whole record or contained error of law.

(j) Within 60 days after the time for submission of briefs or, if permitted, reply briefs has expired, the DAB will issue to each party to the appeal and to the Commissioner a copy of the DAB's recommended decision and a statement describing the right of any respondent who is found liable to seek judicial review upon a final decision.

[61 FR 65472, Dec. 13, 1996]

§ 498.222 Final decision of the Commissioner.

(a) Except with respect to any penalty or assessment remanded to the ALJ, the DAB's recommended decision, including a recommended decision to decline review of the initial decision, shall become the final decision of the Commissioner 60 days after the date on which the DAB serves the parties to the appeal and the Commissioner with a copy of the recommended decision, unless the Commissioner reverses or modifies the DAB's recommended decision within that 60-day period. If the Commissioner reverses or modifies the DAB's recommended decision, the Commissioner's decision is final and binding on the parties. In either event, a copy of the final decision will be served on the parties. If service is by mail, the date of service will be deemed to be five days from the date of mailing.

(b) There shall be no right to personally appear before or submit additional

evidence, pleadings or briefs to the Commissioner.

(c)(1) Any petition for judicial review must be filed within 60 days after the parties are served with a copy of the final decision. If service is by mail, the date of service will be deemed to be five days from the date of mailing.

(2) In compliance with 28 U.S.C. 2112(a), a copy of any petition for judicial review filed in any U.S. Court of Appeals challenging a final action of the Commissioner will be sent by certified mail, return receipt requested, to the SSA General Counsel. The petition copy will be time-stamped by the clerk of the court when the original is filed with the court.

(3) If the SSA General Counsel receives two or more petitions within 10 days after the final decision is issued, the General Counsel will notify the U.S. Judicial Panel on Multidistrict Litigation of any petitions that were received within the 10-day period.

[61 FR 65472, Dec. 13, 1996]

§ 498.223 Stay of initial decision.

(a) The filing of a respondent's request for review by the DAB will automatically stay the effective date of the ALJ's decision.

(b)(1) After issuance of the final decision, pending judicial review, the respondent may file a request for stay of the effective date of any penalty or assessment with the ALJ. The request must be accompanied by a copy of the notice of appeal filed with the Federal court. The filing of such a request will automatically act to stay the effective date of the penalty or assessment until such time as the ALJ rules upon the request.

(2) The ALJ may not grant a respondent's request for stay of any penalty or assessment unless the respondent posts a bond or provides other adequate security.

(3) The ALJ will rule upon a respondent's request for stay within 10 days of receipt.

[61 FR 65472, Dec. 13, 1996]

§ 498.224 Harmless error.

No error in either the admission or the exclusion of evidence, and no error or defect in any ruling or order or in any act done or omitted by the ALJ or by any of the parties is ground for vacating, modifying or otherwise disturbing an otherwise appropriate ruling or order or act, unless refusal to take such action appears to the ALJ or the DAB to be inconsistent with substantial justice. The ALJ and the DAB at every stage of the proceeding will disregard any error or defect in the proceeding that does not affect the substantial rights of the parties.

[61 FR 65472, Dec. 13, 1996]

PART 499 [RESERVED]

FINDING AIDS

A list of CFR titles, subtitles, chapters, subchapters and parts and an alphabetical list of agencies publishing in the CFR are included in the CFR Index and Finding Aids volume to the Code of Federal Regulations which is published separately and revised annually.

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INDEX TO CHAPTER III—SOCIAL SECURITY ACQUIESCENCE RULINGS

EDITORIAL NOTE: This listing is provided for information purposes only. It is compiled and kept up-to-date by the Social Security Administration.

This listing contains all Acquiescence Rulings (ARs) published in the FEDERAL REGISTER under the requirements of 20 CFR 402.160(b)(2) during the period from January 11, 1990, through June 1, 2025. The listing includes the AR number, title, publication date and the FEDERAL REGISTER reference number. (The parenthetical number that follows each AR number refers to the United States judicial circuit involved.) This notice also lists ARs which were rescinded during this period. In addition, SSA has included FEDERAL REGISTER references for three prior cumulative AR listing notices.

SSA believes this publication will assist individuals in finding ARs.

The CFR may not state the circuitwide standard in effect when SSA has determined that the holding in a decision of a United States Court of Appeals is at variance with SSA's national interpretation.

ACQUIESCENCE RULINGS

Published cumulative lists of ARs relating to claims under title II and title XVI of the Social Security Act and part B of the Black Lung Benefits Act were issued for ARs published prior to January 11, 1990.

1. The first notice announcing 14 ARs issued during the period from January 23, 1986, through April 30, 1986, was published in the FEDERAL REGISTER on June 4, 1986 (51 FR 20354).

2. A second notice announcing 12 additional ARs issued during the period from May 20, 1986, through March 31, 1987, was published in the FEDERAL REGISTER on August 7, 1987 (52 FR 29911).

3. A third notice announcing 11 more ARs, issued during the period from May 1, 1987, through November 14, 1988, the withdrawal of one AR which was issued earlier, and the withdrawal of one of the ARs issued during this period was published in the FEDERAL REGISTER on July 10, 1990 (55 FR 28302).

AR 86-2R(2) *Rosenberg* v. *Richardson*, 538 F.2d 487 (2d Cir. 1976); *Capitano* v. *Secretary of HHS*, 732 F.2d 1066 (2d Cir. 1984)—Entitlement of a Deemed Widow When a Legal Widow is Entitled on the Same Earnings Record—Title II of the Social Security Act.

Published: June 25, 1992, at 57 FR 28527.

NOTE: The original AR for the Second Circuit Court of Appeals' holding in *Rosenberg* and *Capitano* (AR 86-2(2)), issued January 23, 1986, was rescinded and replaced by this revised AR.

AR 86-19R(11) *Woodson* v. *Schweiker*, 656 F.2d 1169 (5th Cir. 1981)—Interpretation of the Deemed Marriage Provision—Title II of the Social Security Act.

Published: June 25, 1992, at 57 FR 28524.

NOTE: The original AR applicable in the Eleventh Circuit for the Fifth Circuit Court of Appeals' holding in *Woodson* (AR 86-19(11)), issued May 22, 1986, was rescinded and replaced by this revised AR.

AR 90-1(9) *Paxton* v. *Secretary of Health and Human Services*, 856 F.2d 1352 (9th Cir. 1988)—Treatment of Dependent's Portion of Augmented Veterans Benefit Paid Directly To Veteran—Title XVI of the Social Security Act.

Published: July 16, 1990, at 55 FR 28946. Rescinded—See section on Rescissions in this notice.

AR 90-2(2) *Ruppert* v. *Bowen*, 871 F.2d 1172 (2d Cir. 1989)—Evaluation of a Rental Subsidy as In-Kind Income for Supplemental Security Income (SSI) Benefit Calculation Purposes—Title XVI of the Social Security Act.

Published: July 16, 1990, at 55 FR 28947.

AR 90-3(4) *Smith* v. *Bowen*, 837 F.2d 635 (4th Cir. 1987)—Use of Vocational Expert or Other Vocational Specialist in Determining Whether a Claimant Can Perform Past Relevant Work—Titles II and XVI of the Social Security Act.

Published: July 16, 1990, at 55 FR 28949. Rescinded—See section on Rescissions in this notice.

AR 90-4(4) *Culbertson* v. *Secretary of Health and Human Services*, 859 F.2d 319 (4th Cir. 1988), *Young* v. *Bowen*, 858 F.2d 951 (4th Cir. 1988)—Waiver of Administrative Finality in Proceedings Involving Unrepresented Claimants Who Lack the Mental Competence to Request. Administrative Review—Titles II and XVI of the Social Security Act.

Published: July 16, 1990, at 55 FR 28943.

AR 90-5(2) *Kier* v. *Sullivan*, 888 F.2d 244 (2d Cir. 1989), rehearing denied, January 22, 1990—Assessment of Residual Functional Capacity in Disabled Widows' Cases—Title II of the Social Security Act.

Published: September 18, 1990, at 55 FR 38400. Rescinded—See section on Rescissions in this notice.

AR 90-6(1) *Cassus* v. *Secretary of Health and Human Services*, 893 F.2d 454 (lst Cir. 1990), rehearing denied, April 9, 1990—Assessment of Residual Functional Capacity in Disabled Widows' Cases—Title II of the Social Security Act.

Published: September 18, 1990, at 55 FR 38398. Rescinded—See section on Rescissions in this notice.

AR 90-7(9) *Ruff* v. *Sullivan*, 907 F.2d 915 (9th Cir. 1990)—Assessment of Residual Functional Capacity in Disabled Widows? Cases—Title II of the Social Security Act.

Published: September 18, 1990, at 55 FR 38402. Rescinded—See section on Rescissions in this notice.

AR 91-1(5) *Lidy* v. *Sullivan*, 911 F.2d 1075 (5th Cir. 1990)—Right to Subpoena an examining Physician for Cross-examination Purposes—Titles II and XVI of the Social Security Act.

Published: December 31, 1991, at 56 FR 67625 as AR 91-X(5).

Correction Notice Published: May 1, 1992, at 57 FR 18899—AR number changed to 91-1(5).

AR 92-1(3) *Mazza* v. *Secretary of Health and Human Services*, 903 F.2d 953 (3d Cir. 1990)—Order of Effectuation in Concurrent Application Cases (Title II/Title XVI).

Published: January 10, 1992, at 57 FR 1190 as AR 91-X(3).

Correction Notice Published: May 1, 1992, at 57 FR 18899—AR number changed to 92-1(3).

AR 92-2(6) *Difford* v. *Secretary of Health and Human Services*, 910 F.2d 1316 (6th Cir. 1990), rehearing denied, February 7, 1991—Scope of Review on Appeal in a Medical Cessation of Disability Case—Title II of the Social Security Act.

Published: March 17, 1992, at 57 FR 9262.

AR 92-3(4) *Branham* v. *Heckler*, 775 F.2d 1271 (4th Cir. 1985); *Flowers* v. *U.S. Department of Health and Human Services*, 904 F.2d 211 (4th Cir. 1990)—What Constitutes a Significant-Work-Related Limitation of Function.

Published: March 10, 1992, at 57 FR 8463. Rescinded—See section on Rescissions in this notice.

AR 92-4(11) *Bloodsworth* v. *Heckler*, 703 F.2d 1233 (11th Cir. 1983)—Judicial Review of an Appeals Council Dismissal of a Request for Review of an Administrative Law Judge (ALJ]) Decision.

Published: April 8, 1992, at 57 FR 11961.

AR 92-5(9) *Quinlivan* v. *Sullivan*, 916 F.2d 524 (9th Cir. 1990)—Meaning of the Term ''Against Equity and Good Conscience'' in the Rules for Waiver of Recovery of an Overpayment—Titles II and XV of the Social Security Act; Title IV of the Federal Mine Safety and Health Act of 1977.

Published: June 22, 1992, at 57 FR 27783.

AR 92-6(10) *Walker* v. *Secretary of Health and Human Services*, 943 F.2d 1257 (l0th Cir. 1991)—Entitlement to Trial Work Period Before Approval of an Award for Benefits and Before Twelve Months Have Elapsed Since Onset of Disability—Titles II and XVI of the Social Security Act.

Published: September 17, 1992, at 57 FR 43007.

AR 92-7(9) *Gonzales* v. *Sullivan*, 914 F.2d 1197 (9th Cir. 1990)—Effect of Initial Determination Notice Language on

the Application of Administrative Finality-Titles II and XVI of the Social Security Act.

Published: September 30. 1992, at 57 FR 45061.

AR 93-1(4) *Branham* v. *Heckler*, 775 F.2d 1271 (4th Cir. 1985); *Flowers* v. *U.S. Department of Health and Human Services*, 904 F.2d 211 (4th Cir. 1990)—What Constitutes an Additional and Significant Work-Related Limitation of Function—Titles II and XVI of the Social Security Act.

Published: April 29, 1993, at 58 FR 25996.

NOTE: The original AR for the Fourth Circuit Court of Appeals? holding in *Branham* and *Flowers* (AR 92-31(4)), issued March 10, 1992, was revised to reflect a regulatory change regarding the IQ Listing range. There were no other substantive changes to this AR. Rescinded—See section on Rescissions in this notice.

AR 93-2(2) *Conley* v. *Bowen*, 859 F.2d 261 (2d Cir. 1988)—Determination of Whether an Individual with a Disabling Impairment Has Engaged in Substantial Gainful Activity Following a Reentitlement Period—Title II of the Social Security Act.

Published: May 17, 1993, at 58 FR 28887. Rescinded—See section on Rescissions in this notice.

AR 93-3(6) *Akers* v. *Secretary of Health and Human Services*, 966 F.2d 205 (6th Cir. 1992)—Attorney's Fees Based in Part on Continued Benefits Paid to Social Security Claimants—Title II of the Social Security Act.

Published: July 29, 1993, at 58 FR 40662. Rescinded—See section on Rescissions in this notice.

AR 93-4(2) *Condon and Brodner* v. *Bowen*, 853 F.2d 66 (2d Cir. 1988)—Attorney's Fees Based in Part on Continued Benefits Paid to Social Security Claimants—Title II of the Social Security Act.

Published: July 29, 1993, at 58 FR 40663. Rescinded—See section on Rescissions in this notice.

AR 93-5(11) *Shoemaker* v. *Bowen*, 853 F.2d 858 (11th Cir. 1988)—Attorney's Fees Based in Part on Continued Benefits Paid to Social Security Claimants—Title II of the Social Security Act.

Published: July 29, 1993, at 58 FR 40665. Rescinded—See section on Rescissions in this notice.

AR 93-6(8) *Brewster on Behalf of Keller* v. *Sullivan*, 972 F.2d 898 (8th Cir. 1992)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act

Published: August 16, 1993, at 58 FR 43369. Rescinded—See section on Rescissions in this notice.

AR 94-1(10) *Wolfe* v. *Sullivan*, 988 F.2d 1025 (10th Cir. 1993)—Contributions to Support re: Posthumous Illegitimate Child—Title II of the Social Security Act.

Published: June 27, 1994, at 59 FR 33003.

AR 94-2(4) *Lively* v. *Secretary of Health and Human Services*, 820 F.2d 1391 (4th Cir. 1987)—Effect of Prior Disability Findings on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles Il and XVI of the Social Security Act.

Published: July 7, 1994, at 59 FR 34849. Rescinded—See section on Rescissions in this notice.

AR 95-1(6) *Preslar* v. *Secretary of Health and Human Services*, 14 F.3d 1107 (6th Cir.1994)—Definition of Highly Marketable Skills for Individuals Close to Retirement Age—Titles II and XVI of the Social Security Act.

Published: May 4, 1995, at 60 FR 22091. Rescinded—See section on Rescissions in this notice.

AR 95-2(9) *Hodge* v. *Shalala*, 27 F.3d 430 (9th Cir. 1994)—Workers' Compensation—Proration of a Lump-Sum Award for Permanent Disability Over the Remainder of an Individual's Working Life Under Oregon Workers' Compensation Law-Title II of the Social Security Act.

Published: July 12, 1995, at 60 FR 35987.

AR 96-1(6) *DeSonier* v. *Sullivan*, 906 F.2d 228 (6th Cir. 1990)—Method of Application of State Intestate Succession Law in Determining Entitlement to Child?s Benefits—Title II of the Social Security Act.

Published: June 3, 1996, at 61 FR 27942.

AR 97-1(1) *Parisi By Cooney* v. *Chater*, 69 F.3d 614 (1st Cir. 1995)—Reduction of Benefits Under the Family Maximum in Cases Involving Dual Entitlement—Title II of the Social Security Act.

Published: January 13, 1997, at 62 FR 1792. Rescinded—See section on Rescissions in this notice.

AR 97-2(9) *Gamble* v. *Chater*, 68 F.3d 319 (9th Cir. 1995)—Amputation of a Lower Extremity—When the Inability to Afford the Cost of a Prosthesis Meets the Requirements of Section 1.10C of the Listing of Impairments—Titles II and XVI of the Social Security Act.

Published: January 13, 1997, at 62 FR 1791. Rescinded—See section on Rescissions in this notice.

AR 97-3(11) *Daniels on Behalf of Daniels* v. *Sullivan*, 979 F.2d 1516 (11th Cir. 1992)—Application of a State's Intestacy Law Requirement that Paternity be Established During the Lifetime of the Father—Title II of the Social Security Act.

Published: August 4, 1997, at 62 FR 41989.

AR 97-4(9) *Chavez* v. *Bowen*, 844 F.2d 691 (9th Cir. 1988)—Effect of a Prior Final Decision That a Claimant is Not Disabled, And of Findings Contained Therein, On Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

Published: December 3, 1997, at 62 FR 64038.

AR 98-1(8) *Newton* v. *Chater*, 92 F.3d 688 (8th Cir. 1996)—Entitlement to Trial Work Period Before Approval of an Award for Benefits and Before Twelve Months Have Elapsed Since Onset of Disability—Titles II and XVI of the Social Security Act.

Published: February 23, 1998, at 63 FR 9037. Rescinded—See section on Rescissions in this notice.

AR 98-2(8) *Sird* v. *Chater*, 105 F.3d 401 (8th Cir. 1997)—Mental Retardation—What Constitutes an Additional and Significant Work-Related Limitation of Function—Titles II and XVI of the Social Security Act.

Published: February 24, 1998, at 63 FR 9279. Rescinded—See section on Rescissions in this notice.

AR 98-3(6) *Dennard* v. *Secretary of Health and Human Services*, 907 F.2d 598 (6th Cir. 1990)—Effect of a Prior Finding of the Demands of Past Work on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

Published: June 1, 1998. at 63 FR 29770. Rescinded— See section on Rescissions in this notice.

AR 98-4(6) *Drummond* v. *Commissioner of Social Security*, 126 F.3d 1337 (6th Cir. 1997)—Effect of Prior Findings on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

Published: June 1, 1998, at 63 FR 29771. Rescinded— See section on Rescissions in this notice.

AR 98-5(8) *State of Minnesota* v. *Apfel*, 151 F.3d 742 (8th Cir. 1998)—Coverage for Employees Under a Federal-State Section 218 Agreement or Modification and Application of the Student Services Exclusion From Coverage to Services Performed by Medical Residents—Title II of the Social Security Act.

Published: October 30, 1998, at 63 FR 58444.

AR 99-1(2) *Florez on Behalf of Wallace* v. *Callahan*, 156 F.3d 438 (2d Cir. 1998)—Supplemental Security Income—Deeming of Income From a Stepparent to a Child When the Natural Parent is Not Living In the Same Household—Title XVI of the Social Security Act.

Published: February 1, 1999, at 64 FR 4923. Rescinded—See section on Rescissions in this notice.

AR 99-2(8) *Kerns* v. *Apfel*, 160 F.3d 464 (8th Cir. 1998)—Definition of Highly Marketable Skills for Individuals Close to Retirement Age—Titles II and XVI of the Social Security Act.

Published: March 11, 1999, at 64 FR 12205. Rescinded—See section on Rescissions in this notice.

AR 99-3(5) *McQueen* v. *Apfel*, 168 F.3d 152 (5th Cir. 1999)—Definition of Highly Marketable Skills for Individuals Close to Retirement Age—Titles II and XVI of the Social Security Act.

Published: May 27, 1999, at 64 FR 28853. Rescinded—See section on Rescissions in this notice.

AR 99-4(11) *Bloodsworth* v. *Heckler*, 703 F.2d 1233 (11th Cir. 1983)—Judicial Review of an Appeals Council Dismissal of a Request for Review of an Administrative Law Judge Decision—Titles II and XVI of the Social Security Act.

Published: October 26, 1999, at 64 FR 57687.

NOTE: The original AR for the Eleventh Circuit Court of Appeals' holding in *Bloodsworth* (AR 92-4(11)), issued April 8, 1992, was revised to delete a parenthetical statement and to update the AR?s language. These revisions were technical corrections only and did not involve any substantive changes.

AR 00-1(4) *Albright* v. *Commissioner of the Social Security Administration*, 174 F.3d 473 (4th Cir. 1999)—Effect of Prior Disability Findings on Adjudication of a Subsequent Disability Claim—Titles II and XVI of the Social Security Act.

Published: January 12, 2000, at 65 FR 1936.

AR 00-2(7) *Hickman* v. *Apfel*, 187 F.3d 683 (7th Cir. 1999)—Evidentiary Requirements for Determining Medical Equivalence to a Listed Impairment—Titles II and XVI of the Social Security Act.

Published: May 3, 2000, at 65 FR 25783. Rescinded—See section on Rescissions in this notice.

AR 00-3(10) *Haddock* v. *Apfel*, 196 F.3d 1084 (l0th Cir. 1999)—Use of Vocational Expert Testimony and the Dictionary of Occupational Titles Under 20 CFR 404.1566, 416.966-Titles II and XVI of the Social Security Act.

Published: June 20, 2000, at 65 FR 38312. Rescinded—See section on Rescissions in this notice.

AR 00-4(2) *Curry* v. *Apfel*, 209 F.3d 117 (2d Cir. 2000)—Burden of Proving Residual Functional Capacity at Step Five of the Sequential Evaluation Process for Determining Disability—Titles II and XVI of the Social Security Act.

Published: September 11, 2000, at 65 FR 54879. Rescinded—See section on Rescissions in this notice.

AR 00-5(6) *Salamalekis* v. *Apfel*, 221 F.3d 828 (6th Cir. 2000)—Entitlement to Trial Work Period Before Approval of an Award of Benefits and Before 12 Months Have Elapsed Since the Alleged Onset of Disability—Titles II and XVI of the Social Security Act.

Published: November 15, 2000, at 65 FR 69116. Rescinded—See section on Rescissions in this notice.

AR 01-1(3) *Sykes* v. *Apfel*, 228 F.3d 259 (3d Cir. 2000)—Using the Grid Rules as a Framework for Decisionmaking When an Individual's Occupational Base is Eroded by a Nonexertional Limitation—Titles II and XVI of the Social Security Act.

Published: January 25, 2001, at 66 FR 7829.

AR 03-1(7) *Blakes* v. *Barnhart*, 331 F.3d 565 (7th Cir. 2003)—Cases Involving Sections 12.05 and 112.05 of the Listing of Impairments That Are Remanded By a Court for Further Proceedings Under Titles II and XVI of the Social Security Act.

Published: December 23, 2003, at 68 FR 74279.

AR 04-1(9) *Howard on behalf of Wolff* v. *Barnhart*, 341 F.3d 1006 (9th Cir. 2003)—Applicability of the Statutory Requirement for Pediatrician Review in Childhood Disability Cases to the Hearings and Appeals Levels of the Administrative Review Process Under Title XVI of the Social Security Act.

Published: April 26, 2004, at 69 FR 22578.

AR 05-1(9) *Gillett-Netting* v. *Barnhart*, 371 F.3d 593 (9th Cir. 2004), rehearing denied, December 14, 2004—Applicability of State Law and the Social Security Act in Determining Whether a Child Conceived by Artificial Means after an Insured Person's Death is Eligible for Child's Insurance Benefits—Tit1e II of the Social Security Act.

Published: September 22, 2005, at 70 FR 55656.

AR 06-1(2) *Fowlkes* v. *Adamec*, 432 F.3d 90 (2d Cir. 2005)—Determining Whether an Individual is a Fugitive Felon Under the Social Security Act (Act)—'I'itles II and XVI of the Act.

Published: April 6, 2006, at 71 FR 17551.

RESCISSIONS WITHOUT REPLACEMENT ARS

AR. 86-l(9) *Summy* v. *Schweiker*, 688 F.2d 1233 (9th Cir. 1982)—Third party payments for medical care or services—Title XVI of the Social Security Act.

Notice of Rescission Published: July 5, 1994, at 59 FR 34444.

AR 86-6(3) *Aubrey* v. *Richardson*, 462 F.2d 782 (3d Cir. 1972); Shelnutt v. Heckler, 723 F.2d 1131 (3d Cir. 1983)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act.

Notice of Rescission Published: July 14, 1995, at 60 FR 36327.

AR 86-7(5) *Autrey* v. *Harris*, 639 F.2d 1233 (5th Cir. 1981); Wages v. Schweiker, 659 F.2d 59 (5th Cir. 1981)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act.

Notice of Rescission Published: July 14, 1995, at 60 FR 36327.

AR 86-8(6) *Johnson* v. *Califano*, 607 F.2d 1178 (6th Cir. 1979)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act.

Notice of Rescission Published: July 14, 1995, at 60 FR 36327.

AR 86-9(9) *Secretary of Health, Education and Welfare* v. *Meza*, 386 F.2d 389 (9th Cir. 1966); *Gardner* v. *Wilcox*, 370 F.2d 492 (9th Cir. 1966)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act.

Notice of Rescission Published: July 14, 1995, at 60 FR 36327.

AR 86-10(10) *Edwards* v. *Califano*, 619 F.2d 865 (10th Cir. 1980)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act.

Notice of Rescission Published: July 14, 1995, at 60 FR 36327.

AR 86-11(11) *Autrey* v. *Harris*, 639 F.2d 1233 (5th Cir. 1981)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act.

Notice of Rescission Published: July 14, 1995, at 60 FR 36327.

AR 86-17(9) *Owens* v. *Schweiker*, 692 F.2d 80 (9th Cir. 1982)—Child?s Benefits—Title II of the Social Security Act.

Notice of Rescission Published: October 28, 1998, at 63 FR 57727.

AR 87-1(6) *Webb* v. *Richardson*, 472 F.2d 529 (6th Cir. 1972)—Attorneys' Fees—Single Fee, Not to Exceed 25 Percent of Past-Due Benefits, Set by Tribunal Which Ultimately Upho1ds the Claim—Title II of the Social Security Act.

Notice of Rescission Published: March 3, 1995, at 60 FR 11977.

AR 87-2(11) *Butterworth* v. *Bowen*, 796 F.2d 1379 (11th Cir. 1986)—The Conditions under Which the Appeals Council has the Right to Reopen and Revise Prior Decisions—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: July 7, 1998, at 63 FR 36726.

AR 87-3(9) *Hart* v. *Bowen*, 799 F.2d 567 (9th Cir. 1986)—Current Market Value of an Installment Sa1es Contract as an Excess Resource.

Notice of Rescission Published: February 9, 1995, at 60 FR 7782.

AR 87-4(8) *Iamarino* v. *Heckler*, 795 F.2d 59 (8th Cir. 1986)—Positive Presumption of Substantial Gainful Activity (SGA) for Sheltered Work.

Notice of Rescission Published: July 11, 2000, at 65 FR 42793.

AR 87-5(3) *Velazquez* v. *Heckler*, 802 F.2d 680 (3d Cir. 1986)—Consideration of Vocational Factors in Past Work Determination.

Notice of Rescission Published: July 16, 1990, at 55 FR 28943.

AR 88-1(11) *Patterson* v. *Bowen*, 799 F.2d 1455 (11th Cir. 1986), rehearing denied, February 12, 1987—Use of the Age Factor in the Medical-Vocational Guidelines in Making Disability Decisions.

Notice of Rescission Published: April 6, 2000, at 65 FR 18143.

AR 88-3(7) *McDonald* v. *Bowen*, 800 F.2d 153 (7th Cir. 1986), amended on rehearing, 818 F.2d 559 (7th Cir. 1987)—Entitlement to Benefits Where a Person Returns to Work Less Than 12 Months After Onset of Disability.

Notice of Rescission Published: June 10, 2002, at 67 FR 39781.

AR 88-5(1) *McCuin* v. *Secretary of Health and Human Services*, 817 F.2d 161 (1st Cir. 1987)—Reopening by the Appeals Council of Decisions of Administrative Law Judges under Titles II and XVI of the Social Security Act.

Notice of Rescission Published: February 23, 1994, at 59 FR 8650.

AR 88-7(5) *Hickman* v. *Bowen*, 803 F.2d 1377 (5th Cir. 1986)—Evaluation of Loans of In-Kind Support and Maintenance for Supplemental Security Income Benefit Calculation Purposes.

Notice of Rescission Published: September 8, 1992, at 57 FR 40918.

AR 90-1(9) *Paxton* v. *Secretary of Health and Human Services*, 856 F.2d 1352 (9th Cir.1988)—Treatment of Dependent's Portion of Augmented Veteran's Benefit Paid Directly To Veteran—Title XVI of the Social Security Act.

Notice of Rescission Published: November 17, 1994, at 59 FR 59416.

AR 90-3(4) *Smith* v. *Bowen*, 837 F.2d 635 (4th Cir. 1987)—Use of Vocational Expert or Other Vocational Specialist in Determining Whether a Claimant Can Perform Past Relevant Work—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: August 26, 2003, at 68 FR 51317.

AR 90-5(2) *Kier* v. *Sullivan*, 888 F.2d 244 (2d Cir. 1989), rehearing denied, January 22, 1990—Assessment of Residual Functional Capacity in Disabled Widows? Cases—Title II of the Social Security Act.

Notice of Rescission Published: May 22, 1991, at 56 FR 23592.

AR 90-6(1) *Cassas* v. *Secretary of Health and Human Services*, 393 F.2d 454 (1st Cir. 1990), rehearing denied, April 9, 1990—Assessment of Residual Functional Capacity in Disabled Widows' Cases—Title II of the Social Security Act.

Notice of Rescission Published: May 22, 1991, at 56 FR 23591.

AR 90-7(9) *Ruff* v. *Sullivan*, 907 F.2d 915 (9th Cir. 1990)—Assessment of Residual Functional Capacity in Disabled Widows' Cases—Title II of the Social Security Act.

Notice of Rescission Published: May 22, 1991, at 56 FR 23592.

AR 92-3(4) *Branham* v. *Heckler*, 775 F.2d 1271 (4th Cir. 1985); *Flowers* v. *U.S. Department of Health and Human Services*, 904 F.2d 211 (4th Cir. 1990)—What Constitutes a Significant Work-Related Limitation of Function.

Notice of Rescission Published: August 21, 2000, at 65 FR 50784.

AR 92-6(10) *Walker* v. *Secretary of Health and Human Services*, 943 F.2d 1257 (10th Cir. 1991)—Entitlement to Trial Work Period Before Approval of an Award for Benefits and Before Twelve Months Have Elapsed Since Onset of Disability-Titles II and XVI of the Social Security Act.

Notice of Rescission Published: June 10, 2002, at 67 FR 39871.

AR 93-l(4) *Branham* v. *Heckler*, 775 F.2d 1271 (4th Cir. 1985); *Flowers* v. *U.S. Department of Health and Human Services*, 904 F.2d 211 (4th Cir. 1990)—What Constitutes an Additional and Significant Work-Related Limitation of Function—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: August 21, 2000, at 65 FR 50784.

AR 93-2(2) *Conley* v. *Bowen*, 859 F.2d 261 (3d Cir. 1988)—Determination of Whether an Individual With a Disabling Impairment Has Engaged in Substantial Gainful Activity Following a Reentitlement Period—Title II of the Social Security Act.

Notice of Rescission Published: August 10, 2000, at 65 FR 42793.

AR 93-3(6) *Akers* v. *Secretary of Health and Human Services*, 966 F.2d 205 (6th Cir. 1992)—Attorney's Fees Based in Part on Continued Benefits Paid to Social Security Claimants—Title II of the Social Security Act.

Notice of Rescission Published: April 14, 2000, at 65 FR 20239.

AR 93-4(2) *Condon and Brodner* v. *Bowen*, 853 F.2d 66 (2d Cir. 1988)—Attorney's Fees Based in Part on Continued Benefits Paid to Social Security Claimants—Title II of the Social Security Act.

Notice of Rescission Published: April 14, 2000, at 65 FR 20239.

AR 93-5(11) *Shoemaker* v. *Bowen*, 853 F.2d 858 (11th Cir.1988)—Attorney's Fees Based in Part on Continued Benefits Paid to Social Security Claimants—Title II of the Social Security Act.

Notice of Rescission Published: April 14, 2000, at 65 FR 20239.

AR 93-6(8) *Brewster on Behalf of Keller* v. *Sullivan*, 972 F.2d 898 (8th Cir. 1992)—Interpretation of the Secretary's Regulation Regarding Presumption of Death—Title II of the Social Security Act.

Notice of Rescission Published: July 14, 1995, at 60 FR 36327.

AR 94-2(4) *Lively* v. *Secretary of Health and Human Services*, 820 F.2d 1391 (4th Cir. 1987)—Effect of Prior Disability Findings on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: January 12, 2000, at 65 FR 1936.

AR 95-1(6) *Preslar* v. *Secretary of Health and Human Services*, 14 F.3d 1107 (6th Cir. 1994)—Definition of Highly Marketable Skills for Individuals Close to Retirement Age—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: April 6, 2000, at 65 FR 18144.

AR 97-1(1) *Parisi By Cooney* v. *Chater*, 69 F.3d 814 (1st Cir. 1995)—Reduction of Benefits Under the Family Maximum In Cases Involving Dual Entitlement—Title II of the Social Security Act.

Notice of Rescission Published: October 27, 1999, at 64 FR 57919.

AR 97-2(9) *Gamble* v. *Chater*, 68 F.3d 319 (9th Cir. 1995)—Amputation of a Lower Extremity—When the Inability to Afford the Cost or a Prosthesis Meets the Requirements of Section 1.10C of the Listing of Impairments—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: November 19, 2001, at 66 FR 58047.

AR 98-1(8) *Newton* v. *Chater*, 92 F.3d 688 (8th Cir. 1996)—Entitlement to Trial Work Period Before Approval of an Award for Benefits and Before Twelve Months Have Elapsed Since Onset of Disability—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: June 10, 2002, at 67 FR 39781.

AR 98-2(8) *Sird* v. *Chater*, 105 F.3d 401 (8th Cir. 1997)—Mental Retardation—What Constitutes an Additional and Significant Work-Related Limitation of Function—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: August 21, 2000, at 65 FR 50784.

AR 99-1(2) *Florez on Behalf of Wallace* v. *Callahan*, 156 F.3d 438 (2d Cir. 1998)—Supplemental Security Income—Deeming of Income From a Stepparent to a Child When the Natural Parent is Not Living in the Same Household—Title XVI of the Social Security Act.

Notice of Rescission Published: May 15, 2008, at 73 FR 28181.

AR 99-2(8) *Kerns* v. *Apfel*, 160 F.3d 164 (8th Cir. 1998)—Definition of Highly Marketable Skills for Individuals Close to Retirement Age-Titles II and XVI of the Social Security Act.

Notice of Rescission Published: April 6, 2000, at 65 FR 18144.

AR 99-3(5) *McQueen* v. *Apfel*, 168 F.3d 152 (5th Cir. 1999)—Definition of Highly Marketable Skills for Individuals Close to Retirement Age—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: April 6, 2000, at 65 FR 18144.

AR 00-2(7) *Hickman* v. *Apfel*, 187 F.3d 683 (7th Cir. 1999)—Evidentiary Requirements for Determining Medical Equivalence to a Listed Impairment—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: March 1, 2006, at 71 FR 10584.

AR 00-3(10) *Haddock* v. *Apfel*, 196 F.3d 1084 (10th Cir. 1999)—Use of Vocational Expert Testimony and the Dictionary of Occupational Titles Under 20 CFR 404.1566, 416.966—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: December 4, 2000, at 65 FR 75758.

AR 00-4(2) *Curry* v. *Apfel*, 209 F.3d 117 (2d Cir. 2000)—Burden of Proving Residual Functional Capacity at Step Five of the Sequential Evaluation Process

for Determining Disability—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: August 26, 2003, at 68 FR 51317.

AR 00-5(6) *Salamalekis* v. *Apfel*, 221 F.3d 828 (6th Cir. 2000)—Entitlement to Trial Work Period Before Approval of an Award of Benefits and Before 12 Months Have Elapsed Since the Alleged Onset of Disability—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: June 10, 2002, at 67 FR 39781.

AR 12-1(8) *Petersen* v. *Astrue*, 633 F.3d 633 (8th Cir. 2011)—Whether a National Guard Technician Who Worked in Noncovered Employment is Exempt from the Windfall Elimination Provision (WEP)—Title II of the Social Security Act.

Published: August 27, 2012, at 77 FR 51842.

Correction Notice Published: September, 5, 2012 at 77 FR 54646.

AR 14-1(8) *Brock* v.*Astrue*, 674 F.3d 1062 (8th Cir.2012)—Requiring Vocational Specialist (VS) or Vocational Expert (VE) Evidence When an Individual has a Severe Mental Impairment(s)—Titles II and XVI of the Social Security Act.

Published: May 22, 2014, at 79 FR 29473.

AR 15-1(4) *Radford* v.*Colvin*, 734 F.3d 288 (4th Cir. 2013)—Standard for Meeting Section 1.04A of the Listing of Impairments for Disorders of the Spine with Evidence of Nerve Root Compression—Titles II and XVI of the Social Security Act.

Published: September 23, 2015, at 80 FR 57418.

AR 16-1(7) *Boley* v.*Colvin*, 761 F.3d 803 (7th Cir. 2014)—Judicial Review of an Administrative Law Judge's Order Finding No Good Cause for a Late Hearing Request and Dismissing the Request as Untimely—Titles II and XVI of the Social Security Act.

Published: March 14, 2016, at 81 FR 13438.

AR 19-1(6) *Hicks* v.*Commissioner of Social Security Administration*, 909 F.3d 786 (6th Cir. 2018), rehearing en banc denied, March 29, 2019—Disregarding Evidence During Redeterminations Under Sections 205(u) and 1631(e)(7) of the Social Security Act.

Published: February 4, 2020, at 85 FR 6255.

AR 24-1(6) *Earley* v.*Commissioner of Social Security*, 893 F.3d 929 (6th Cir.2018) (Interpreting Drummond v. Commissioner of Social Security, 126 F.3d 837 (6th Cir. 1997)— Effect of Prior Disability Findings on Adjudication of a Subsequent Disability Claim—Titles II and XVI of the Social Security Act.

Published: November 25, 2024 *Effective:* December 2, 2024, at 89 FR 92995.

AR 86-3(5) *Martinez* v. *Heckler*, 735 F.2d 795 (5th Cir. 1984)—Disability Program)—Individuals Who Are Illiterate and Unable to Communicate in English-Titles II and XVI of the Social Security Act—Titles II and XVI of the Social Security Act.

Published: June 4, 1986, at 51 FR 20354. Rescinded—See section on Rescissions in this notice.

AR 86-3(5) *Martinez* v. *Heckler*, 735 F.2d 795 (5th Cir. 1984)—Disability Program)—Individuals Who Are Illiterate and Unable to Communicate in English-Titles II and XVI of the Social Security Act—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: February 25, 2020, at 85 FR 10806.

AR 15-1(4) *Radford* v. *Colvin*, 734 F.3d 288 (4th Cir. 2013)—Disability Program)—Standard for Meeting the Listing for Disorders of the Spine with Evidence of Nerve Root Compression -Titles II and XVI of the Social Security Act—Titles II and XVI of the Social Security Act.

Published: September 23, 2015, at 80 FR 57418. Rescinded—See section on Rescissions in this notice.

AR 15-1(4) *Radford* v. *Colvin*, 734 F.3d 288 (4th Cir. 2013)—Disability Program)— Standard for Meeting the Listing for Disorders of the Spine with Evidence of Nerve Root Compression -Titles II and XVI of the Social Security Act—Titles II and XVI of the Social Security Act.

Notice of Rescission Published: December 8, 2020, at 85 FR 79063.

AR 12-1(8) *Petersen* v. *Astrue*, 633 F.3d 633 (8th Cir. 2011)— Whether a National Guard Technician Who Worked in Noncovered Employment is Exempt from the Windfall Elimination Provision

(WEP)— Title II of the Social Security Act.

Published: August 27, 2012, at 77 FR 51842. Rescinded— See section on Rescissions in this notice.

AR 12-1(8) *Petersen* v. *Astrue*, 633 F.3d 633 (8th Cir. 2011)— Whether a National Guard Technician Who Worked in Noncovered Employment is Exempt from the Windfall Elimination Provision (WEP)— Title II of the Social Security Act.

Notice of Rescission Published: September 19, 2022, at 87 FR 57246.

AR 98-3(6) *Dennard* v. *Secretary of Health and Human Services*, 907 F.3d 598 (6th Cir. 1990)— Effect of a Prior Finding of the Demands of Past Work on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

Notice of Rescission Effective: December 2, 2024, at 89 FR 92992.

AR 98-4(6) *Drummond* v. *Commissioner of Social Security*, 126 F.3d 837 (6th Cir. 1997)—Effect of Prior Findings on Adjudication of a Subsequent Disability Claim Arising Under the Same Title of the Social Security Act—Titles II and XVI of the Social Security Act.

Notice of Rescission Effective: December 2, 2024, at 89 FR 92992.

List of CFR Sections Affected

All changes in this volume of the Code of Federal Regulations (CFR) that were made by documents published in the FEDERAL REGISTER since January 1, 2020 are enumerated in the following list. Entries indicate the nature of the changes effected. Page numbers refer to FEDERAL REGISTER pages. The user should consult the entries for chapters, parts and subparts as well as sections for revisions.

For changes to this volume of the CFR prior to this listing, consult the annual edition of the monthly List of CFR Sections Affected (LSA). The LSA is available at *www.govinfo.gov*. For changes to this volume of the CFR prior to 2001, see the ''List of CFR Sections Affected, 1949–1963, 1964–1972, 1973–1985, and 1986–2000'' published in 11 separate volumes. The ''List of CFR Sections Affected 1986–2000'' is available at *www.govinfo.gov*.

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AUTHENTICATED
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CODE OF FEDERAL REGULATIONS

Title 20
Employees' Benefits

Parts 500 to 656

Revised as of April 1, 2025

Containing a codification of documents
of general applicability and future effect

As of April 1, 2025

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Cite this Code: CFR

To cite the regulations in this volume use title, part and section number. Thus, 20 CFR 501.1 *refers to title 20, part 501, section 1.*

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The Code of Federal Regulations is a codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government. The Code is divided into 50 titles which represent broad areas subject to Federal regulation. Each title is divided into chapters which usually bear the name of the issuing agency. Each chapter is further subdivided into parts covering specific regulatory areas.

Each volume of the Code is revised at least once each calendar year and issued on a quarterly basis approximately as follows:

Title 1 through Title 16.....as of January 1
Title 17 through Title 27.....as of April 1
Title 28 through Title 41.....as of July 1
Title 42 through Title 50.....as of October 1

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Provisions of the Code that are no longer in force and effect as of the revision date stated on the cover of each volume are not carried. Code users may find the text of provisions in effect on any given date in the past by using the appropriate List of CFR Sections Affected (LSA). For the convenience of the reader, a ''List of CFR Sections Affected'' is published at the end of each CFR volume. For changes to the Code prior to the LSA listings at the end of the volume, consult previous annual editions of the LSA. For changes to the Code prior to 2001, consult the List of CFR Sections Affected compilations, published for 1949-1963, 1964-1972, 1973-1985, and 1986-2000.

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The term ''[Reserved]'' is used as a place holder within the Code of Federal Regulations. An agency may add regulatory information at a ''[Reserved]'' location at any time. Occasionally ''[Reserved]'' is used editorially to indicate that a portion of the CFR was left vacant and not dropped in error.

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What is incorporation by reference? Incorporation by reference was established by statute and allows Federal agencies to meet the requirement to publish regulations in the Federal Register by referring to materials already published elsewhere. For an incorporation to be valid, the Director of the Federal Register must approve it. The legal effect of incorporation by reference is that the material is treated as if it were published in full in the Federal Register (5 U.S.C. 552(a)). This material, like any other properly issued regulation, has the force of law.

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(c) The incorporating document is drafted and submitted for publication in accordance with 1 CFR part 51.

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A subject index to the Code of Federal Regulations is contained in a separate volume, revised annually as of January 1, entitled CFR INDEX AND FINDING AIDS. This volume contains the Parallel Table of Authorities and Rules. A list of CFR titles, chapters, subchapters, and parts and an alphabetical list of agencies publishing in the CFR are also included in this volume.

An index to the text of ''Title 3—The President'' is carried within that volume.

The Federal Register Index is issued monthly in cumulative form. This index is based on a consolidation of the ''Contents'' entries in the daily Federal Register.

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OLIVER A. POTTS,
Director,
Office of the Federal Register
April 1, 2025

THIS TITLE

Title 20—EMPLOYEES' BENEFITS is composed of four volumes. The first volume, containing parts 1–399, includes current regulations issued by the Office of Workers' Compensation Programs, Department of Labor and the Railroad Retirement Board. The second volume, containing parts 400–499, includes all current regulations issued by the Social Security Administration. The third volume, containing parts 500 to 656, includes current regulations issued by the Employees' Compensation Appeals Board, and the Employment and Training Administration. The fourth volume, containing part 657 to End, includes the current regulations issued by the Office of Workers' Compensation Programs, the Benefits Review Board, the Office of the Assistant Secretary for Veterans' Employment and Training Service (all of the Department of Labor) and the Joint Board for the Enrollment of Actuaries. The contents of these volumes represent all current regulations codified under this title of the CFR as of April 1, 2025.

An index to chapter III appears in the second volume.

For this volume, Cheryl E. Sirofchuck was Chief Editor. The Code of Federal Regulations publication program is under the direction of John Hyrum Martinez, assisted by Stephen J. Frattini.

Title 20—Employees' Benefits

(This book contains parts 500 to 656)

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CHAPTER IV—EMPLOYEES' COMPENSATION APPEALS BOARD, DEPARTMENT OF LABOR

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PART 500 [RESERVED]

PART 501—RULES OF PROCEDURE

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AUTHORITY: Federal Employees' Compensation Act (FECA), 5 U.S.C. 8101 *et seq.*

SOURCE: 73 FR 62193, Oct. 20, 2008, unless otherwise noted.

§ 501.1 Definitions.

(a) *FECA* means the Federal Employees' Compensation Act, 5 U.S.C. 8101 *et seq*. and any statutory extension or application thereof.

(b) *The Board* means the Employees' Compensation Appeals Board.

(c) *Chief Judge and Chairman of the Board* means the Chairman of the Employees' Compensation Appeals Board.

(d) *Judge or Alternate Judge* means a member designated and appointed by the Secretary of Labor with authority to hear and make final decisions on appeals taken from determinations and awards by the OWCP in claims arising under the FECA.

(e) *OWCP* means the Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor.

(f) *Director* means the Director of the Office of Workers' Compensation Programs or a person delegated authority to perform the functions of the Director. The Director of OWCP is represented before the Board by an attorney designated by the Solicitor of Labor.

(g) *Appellant* means any person adversely affected by a final decision or order of the OWCP who files an appeal to the Board.

(h) *Representative* means an individual properly authorized by an Appellant in writing to act for the Appellant in connection with an appeal before the Board. The Representative may be any individual or an attorney who has been admitted to practice and who is in good standing with any court of competent jurisdiction.

(i) *Decision*, as prescribed by 5 U.S.C. 8149 of the FECA, means the final determinative action made by the Board on appeal of a claim.

(j) *Clerk or Office of the Clerk* means the Clerk of the Office of the Appellate Boards.

§ 501.2 Scope and applicability of rules; composition and jurisdiction of the Board.

(a) The regulations in this part establish the Rules of Practice and Procedure governing the operation of the Employees' Compensation Appeals Board.

(b) The Board consists of three permanent judges, one of whom is designated as Chief Judge and Chairman of the Board, and such alternate judges as are appointed by the Secretary of Labor. The Chief Judge is the administrative officer of the Board. The functions of the Board are quasi-judicial. For organizational purposes, the Board is placed in the Office of the Secretary of Labor and sits in Washington, DC.

(c) The Board has jurisdiction to consider and decide appeals from final decisions of OWCP in any case arising under the FECA. The Board may review all relevant questions of law, fact and exercises of discretion (or failure to exercise discretion) in such cases.

(1) The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal.

(2) There will be no appeal with respect to any interlocutory matter decided (or not decided) by OWCP during the pendency of a case.

(3) The Board and OWCP may not exercise simultaneous jurisdiction over the same issue in a case on appeal. Following the docketing of an appeal before the Board, OWCP does not retain jurisdiction to render a further decision regarding the issue on appeal until after the Board relinquishes jurisdiction.

§ 501.3 Notice of Appeal.

(a) *Who may file.* Any person adversely affected by a final decision of the Director, or his or her authorized Representative, may file an appeal of such decision to the Board.

(b) *How to file.* (1) Beginning on April 12, 2021, attorneys and lay representatives must file appeals with the Board electronically through the Board's case management system, along with all post-appeal pleadings and motions as set forth in paragraphs (d) and (h) of this section and §§ 501.4(b) through (d), 501.5(b) and (g); 501.7 (a), (e), and (f), and 501.9(b), (c), and (e).

(2) Attorneys and lay representatives may request an exemption (pursuant to § 501.4(d)) for good cause shown. Such a request must include a detailed explanation why e-filing or acceptance of e-service should not be required.

(3) Self-represented parties may either file appeals electronically through the Board's case management system or file appeals by mail or other method of delivery to the Clerk of the Appellate Boards at 200 Constitution Avenue NW, Washington, DC 20210.

(c) *Content of notice of appeal.* A notice of appeal shall contain the following information:

(1) Date of Appeal.

(2) Full name, address, email address, and telephone number of the Appellant and the full name of any deceased employee on whose behalf an appeal is taken. In addition, the Appellant must provide a signed authorization identifying the full name, address, email address, and telephone number of his or her representative, if applicable.

(3) Employing establishment, and the date, description and place of injury.

(4) Date and Case File Number assigned by OWCP concerning the decision being appealed to the Board.

(5) A statement explaining Appellant's disagreement with OWCP's decision and stating the factual and/or legal argument in favor of the appeal.

(6) Signature: An Appellant must sign the notice of appeal. A filing made electronically through the Board's case management system by a registered user containing the Appellant's name in an appropriate signature block constitutes the Appellant's signature.

(d) *Substitution of appellant:* Should the Appellant die after having filed an appeal with the Board, the appeal may proceed to decision provided there is the substitution of a proper Appellant who requests that the appeal proceed to decision by the Board.

(e) *Time limitations for filing.* Any notice of appeal must be filed within 180 days from the date of issuance of a decision of the OWCP. The Board maintains discretion to extend the time period for filing an appeal if an applicant demonstrates compelling circumstances. Compelling circumstances means circumstances beyond the Appellant's control that prevent the timely filing of an appeal and does not include any delay caused by the failure of an individual to exercise due diligence in submitting a notice of appeal.

(f) *Date of filing.* A notice of appeal complying with this paragraph (c) is considered to have been filed only if received by the Clerk of the Appellate Boards within the period specified under paragraph (e) of this section, except as otherwise provided in this subsection:

(1) If the notice of appeal is sent via the U.S. Postal Service or commercial carrier and use of the date of delivery as the date of filing would result in a loss of appeal rights, the appeal will be considered to have been filed as of the date of the postmark or other carriers' date markings. The date appearing on the U.S. Postal Service postmark or other carriers' date markings (when available and legible) shall be prima facie evidence of the date of mailing. If there is no such postmark or date marking, or it is illegible, then other evidence including, but not limited to, certified mail receipts, certificate of service, and affidavits, may be used to establish the mailing date. If a notice of appeal is delivered or sent by means other than the U.S. Postal Service or commercial carrier, including e-filing, personal delivery, or fax, the notice is deemed to be filed when received by the Clerk of the Appellate Boards.

(2) For electronic filings made through the Board's case management system, a document is deemed filed as of the date and time the Board's electronic case management system records its receipt, even if transmitted

after the close of business. To be considered timely, an e-filed document or pleading must be filed by 11:59:59 p.m. Eastern Time on the due date.

(3) In computing the date of filing, the 180-day time period for filing an appeal begins to run on the day following the date of the OWCP decision. The last day of the period so computed shall be included, unless it is a Saturday, Sunday or Federal holiday, in which event the period runs to the close of the next business day.

(g) *Failure to timely file a notice of appeal.* The failure of an Appellant or Representative to file an appeal with the Board within the period specified under paragraph (e) of this section, including any extensions granted by the Board in its discretion based upon compelling circumstances, will foreclose all right to review. The Board will dismiss any untimely appeal for lack of jurisdiction.

(h) *Incomplete notice of appeal.* Any timely notice of appeal that does not contain the information specified in paragraph (c) of this section will be considered incomplete. On receipt by the Board, the Clerk of the Appellate Boards will inform Appellant of the deficiencies in the notice of appeal and specify a reasonable time to submit the requisite information. Such appeal will be dismissed unless Appellant provides the requisite information in the specified time.

[73 FR 62193, Oct. 20, 2008, as amended at 86 FR 1771, Jan. 11, 2021]

§ 501.4 Case record; inspection; submission of pleadings and motions.

(a) *Service on OWCP and transmission of OWCP case record.* The Board shall serve upon the Director a copy of each notice of appeal and accompanying documents. Within 60 days from the date of such service, the Director shall provide to the Board the record of the OWCP proceeding to which the notice refers. On application of the Director, the Board may, in its discretion, extend the time period for submittal of the OWCP case record.

(b) *Inspection of record.* The case record on appeal is an official record of the OWCP.

(1) Upon written application to the Clerk, an Appellant may request inspection of the OWCP case record. At the discretion of the Board, the OWCP case record may either be made available in the Office of the Clerk of the Appellate Boards for inspection by the Appellant, or the request may be forwarded to the Director so that OWCP may make a copy of the OWCP case record and forward this copy to the Appellant. Inspection of the papers and documents included in the OWCP case record of any appeal pending before the Board will be permitted or denied in accordance with 5 CFR 10.10 to 10.13. The Chief Judge (or his or her designee) shall serve as the disclosure officer for purposes of Appendix A to 29 CFR Parts 70 and 71.

(2) Copies of the documents generated in the course of the appeal before the Board will be provided to the Appellant and Appellant's Representative by the Clerk. If the Appellant needs additional copies of such documents while the appeal is pending, the Appellant may obtain this information by contacting the Clerk. Pleadings and motions filed during the appeal in proceedings before the Board will be made part of the official case record of the OWCP.

(c) *Pleadings.* The Appellant, the Appellant's Representative and the Director may file pleadings supporting their position and presenting information, including but not limited to briefs, memoranda of law, memoranda of justification, and optional form AB–1. All pleadings filed must contain the docket number and be filed with the Clerk. The Clerk will issue directions specifying the time allowed for any responses and replies.

(1) The Clerk will distribute copies of any pleading received by the Clerk to ensure that the Appellant, his or her Representative and the Director receive all pleadings. Any pleading should be submitted within 60 days of the filing of an appeal. The Board may, in its discretion, extend the time period for the submittal of any pleading.

(2) Proceedings before the Board are informal and there is no requirement that any pleading be filed. Failure to submit a pleading or to timely submit a pleading does not prejudice the rights of either the Appellant or the Director.

(3) Upon receipt of a pleading, the Appellant and the Director will have the opportunity to submit a response to the Board.

(d) *Motions.* Motions are requests for the Board to take specific action in a pending appeal. Motions include, but are not limited to, motions to dismiss, affirm the decision below, remand, request a substitution, request an extension of time, or other such matter as may be brought before the Board. Motions may be filed by the Appellant, the Appellant's Representative and the Director. The motion must be in writing, contain the docket number, state the relief requested and the basis for the relief requested, and be filed with the Clerk. Any motion received will be sent by the Clerk to ensure that the Appellant, his or her Representative and the Director receive all motions. The Clerk will issue directions specifying the timing of any responses and replies. The Board also may act on its own to issue direction in pending appeals, stating the basis for its determination.

[73 FR 62193, Oct. 20, 2008, as amended at 86 FR 1771, Jan. 11, 2021]

§ 501.5 Oral argument.

(a) *Oral argument.* Oral argument may be held in the discretion of the Board, on its own determination or on application by Appellant or the Director.

(b) *Request.* A request for oral argument must be submitted in writing to the Clerk. The application must specify the issue(s) to be argued and provide a statement supporting the need for oral argument. The request must be made no later than 60 days after the filing of an appeal. Any appeal in which a request for oral argument is not granted by the Board will proceed to a decision based on the case record and any pleadings submitted.

(c) *Notice of argument.* If a request for oral argument is granted, the Clerk will notify the Appellant and the Director at least 30 days prior to the date set for argument. The notice of oral argument will state the issues that the Board has determined will be heard and whether the oral argument will take place in person in Washington, DC or by videoconference.

(d) *Time allowed.* Appellant and any Representative for the Director shall be allowed no more than 30 minutes to present oral argument. The Board may, in its discretion, extend the time allowed.

(e) *Appearances.* An Appellant may appear at oral argument before the Board or designate a Representative. Argument shall be presented by the Appellant or a Representative, not both. The Director may be represented by an attorney with the Solicitor of Labor. Argument is limited to the evidence of record on appeal.

(f) *Location.* Oral argument in person is heard before the Board only in Washington, DC. The Board may, in its discretion, hear oral argument by videoconference. The Board does not reimburse costs associated with an oral argument.

(g) *Continuance.* Once oral argument has been scheduled by the Board, a continuance will not be granted except on a showing of good cause. Good cause may include extreme hardship or where attendance by an Appellant or Representative is mandated at a previously scheduled judicial proceeding. Any request for continuance must be received by the Board at least 15 days before the date scheduled for oral argument and be served by the requester upon Appellant and the Director. No request for a second continuance will be entertained by the Board. In such case, the appeal will proceed to a decision based on the case record. The Board may reschedule or cancel oral argument on its own motion at any time.

(h) *Nonappearance.* The absence of an Appellant, his or her Representative, or the Director at the time and place set for oral argument will not delay the Board's resolution of an appeal. In such event, the Board may, in its discretion, reschedule oral argument, or cancel oral argument and treat the case as submitted on the case record.

[73 FR 62193, Oct. 20, 2008, as amended at 86 FR 1771, Jan. 11, 2021]

§ 501.6 Decisions and orders.

(a) *Decisions.* A decision of the Board will contain a written opinion setting forth the reasons for the action taken and an appropriate order. The decision

is based on the case record, all pleadings and any oral argument. The decision may consist of an affirmance, reversal or remand for further development of the evidence, or other appropriate action.

(b) *Panels.* A decision of not less than two judges will be the decision of the Board.

(c) *Issuance.* The date of the Board's decision is the date of issuance or such date as determined by the Board. Issuance is not determined by the postmark on any letter containing the decision or the date of actual receipt by Appellant or the Director.

(d) *Finality.* The decisions and orders of the Board are final as to the subject matter appealed, and such decisions and orders are not subject to review, except by the Board. The decisions and orders of the Board will be final upon the expiration of 30 days from the date of issuance unless the Board has fixed a different period of time therein. Following the expiration of that time, the Board no longer retains jurisdiction over the appeal unless a timely petition for reconsideration is submitted and granted.

(e) *Dispositive orders.* The Board may dispose of an appeal on a procedural basis by issuing an appropriate order disposing of part or all of a case prior to reaching the merits of the appeal. The Board may proceed to an order on its own or on the written motion of Appellant or the Director.

(f) *Service.* The Board will send its decisions and orders to the Appellant, his or her Representative and the Director at the time of issuance.

§ 501.7 Petition for reconsideration.

(a) *Time for filing.* The Appellant or the Director may file a petition for reconsideration of a decision or order issued by the Board within 30 days of the date of issuance, unless another time period is specified in the Board's order.

(b) *Where to File.* The petition must be filed with the Clerk. Copies will be sent by the Clerk to the Director, the Appellant and his or her Representative in the time period specified by the Board.

(c) *Content of petition.* The petition must be in writing. The petition must contain the docket number, specify the matters claimed to have been erroneously decided, provide a statement of the facts upon which the petitioner relies, and a discussion of applicable law. New evidence will not be considered by the Board in a petition for reconsideration.

(d) *Panel.* The panel of judges who heard and decided the appeal will rule on the petition for reconsideration. If any member of the original panel is unavailable, the Chief Judge may designate a new panel member. The decision or order of the Board will stand as final unless vacated or modified by the vote of at least two members of the reconsideration panel.

(e) *Answer.* Upon the filing of a petition for reconsideration, Appellant or the Director may file an answer to the petition within such time as fixed by the Board.

(f) *Oral argument and decision on reconsideration.* An oral argument may be allowed at the discretion of the Board upon application of the Appellant or Director or the Board may proceed to address the matter upon the papers filed. The Board shall grant or deny the petition for reconsideration and issue such orders as it deems appropriate.

§ 501.8 Clerk of the Office of the Appellate Boards; docket of proceedings; records.

(a) *Location and business hours.* The Office of the Clerk of the Appellate Boards is located at 200 Constitution Avenue, NW., Washington, DC 20210. The Office of the Clerk is open during business hours on all days except Saturdays, Sundays and Federal holidays, from 8:30 a.m. to 5 p.m.

(b) *Docket.* The Clerk will maintain a docket containing a record of all proceedings before the Board. Each docketed appeal will be assigned a number in chronological order based upon the date on which the notice of appeal is received. While the Board generally hears appeals in the order docketed, the Board retains discretion to change the order in which a particular appeal will be considered. The Clerk will prepare a calendar of cases submitted or awaiting oral argument and such other records as may be required by the Board.

(c) *Publication of decisions.* Final decisions of the Board will be published in such form as to be readily available for inspection by the general public.

§ 501.9 Representation; appearances and fees.

(a) *Representation.* In any proceeding before the Board, an Appellant may appear in person or by appointing a duly authorized individual as his or her Representative.

(1) *Counsel.* The designated Representative may be an attorney who has been admitted to practice and who is in good standing with any court of competent jurisdiction.

(2) *Lay representative.* A non-attorney Representative may represent an Appellant before the Board. He or she may be an accredited Representative of an employee organization.

(3) *Former members of the Board and other employees of the Department of Labor.* A former judge of the Board is not allowed to participate as counsel or other Representative before the Board in any proceeding until two years from the termination of his or her status as a judge of the Board. The practice of a former judge or other former employee of the Department of Labor is governed by 29 CFR Part 0, Subpart B.

(b) *Appearance.* No individual may appear as a Representative in a proceeding before the Board without first filing with the Clerk a written authorization signed by the Appellant to be represented. When accepted by the Board, such Representative will continue to be recognized unless the Representative withdraws or abandons such capacity or the Appellant directs otherwise.

(c) *Change of address.* Each Appellant and Representative authorized to appear before the Board must give the Clerk written notice of any change to the address or telephone number of the Appellant or Representative. Such notice must identify the docket number and name of each pending appeal for that Appellant, or, in the case of a Representative, in which he or she is a Representative before the Board. Absent such notice, the mailing of documents to the address most recently provided to the Board will be fully effective.

(d) *Debarment of Counsel or Representative.* In any proceeding, whenever the Board finds that a person acting as counsel or other Representative for the Appellant or the Director, is guilty of unethical or unprofessional conduct, the Board may order that such person be excluded from further acting as counsel or Representative in such proceeding. Such order may be appealed to the Secretary of Labor or his or her designee, but proceedings before the Board will not be delayed or suspended pending disposition of such appeal. However, the Board may suspend the proceeding of an appeal for a reasonable time for the purpose of enabling Appellant or the Director to obtain different counsel or other Representative. Whenever the Board has issued an order precluding a person from further acting as counsel or Representative in a proceeding, the Board will, within a reasonable time, submit to the Secretary of Labor or his or her designee a report of the facts and circumstances surrounding the issuance of such order. The Board will recommend what action the Secretary of Labor should take in regard to the appearance of such person as counsel or Representative in other proceedings before the Board. Before any action is taken debarring a person as counsel or Representative from other proceedings, he or she will be furnished notice and the opportunity to be heard on the matter.

(e) *Fees for attorney, Representative, or other services.* No claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. Under 18 U.S.C. 292, collecting a fee without the approval of the Board may constitute a misdemeanor, subject to fine or imprisonment for up to a year or both. No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. No fee for service will be approved except upon written application to the Clerk, supported by a statement of the extent and nature of the necessary work performed before the Board on behalf of the Appellant. The fee application will be served by the Clerk on the Appellant and a time set in which a response may be filed. Except where such fee is *de minimis*, the

fee request will be evaluated with consideration of the following factors:

(1) Usefulness of the Representative's services;

(2) The nature and complexity of the appeal;

(3) The capacity in which the Representative has appeared;

(4) The actual time spent in connection with the Board appeal; and

(5) Customary local charges for similar services.

PARTS 502–599 [RESERVED]

CHAPTER V—EMPLOYMENT AND TRAINING ADMINISTRATION, DEPARTMENT OF LABOR

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PART 600 [RESERVED]

PART 601—ADMINISTRATIVE PROCEDURE

Subpart A—Approval, Certification and Findings With Respect to State Laws and Plans of Operation for Normal and Additional Tax Credit and Grant Purposes

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601.4 Certification for tax credit.
601.5 Withholding payments and certifications.

Subpart B—Grants, Advances and Audits

601.6 Grants for administration of unemployment compensation laws and employment service.
601.7 [Reserved]
601.8 Agreement with Postmaster General.
601.9 Audits.

AUTHORITY: 5 U.S.C. 301; 26 U.S.C. Chapter 23; 29 U.S.C. 49k; 38 U.S.C. Chapters 41 and 42; 39 U.S.C. 3202(a)(1)(E) and 3202 note; 42 U.S.C. 1302; and Secretary of Labor's Order No. 4–75, 40 FR 18515.

SOURCE: 15 FR 5886, Aug. 31, 1950; 23 FR 1267, Mar. 1, 1958, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 601 appear at 71 FR 35512, June 21, 2006.

Subpart A—Approval, Certification and Findings With Respect to State Laws and Plans of Operation for Normal and Additional Tax Credit and Grant Purposes

§ 601.1 General.

(a) State unemployment compensation laws are approved and certified as provided in section 3304 of the Internal Revenue Code of 1986; findings are made regarding reduced rates permitted by a State law (section 3303(a) of the Internal Revenue Code of 1986) and such laws are certified as provided in section 3303(b) of the Internal Revenue Code of 1986; findings are made regarding the inclusion of specified provisions (section 303(a) of the Social Security Act) in State laws approved under section 3304(a) of the Internal Revenue Code of 1986; findings are made whether the States have accepted the provisions of the Wagner-Peyser Act and whether their plans of operation for public employment offices comply with the provisions of said Act.

(b) Normal and additional tax credit is given to taxpayers against taxes imposed by section 3301 of the Internal Revenue Code of 1986.

(c) Grants of funds are made to States for administration of their employment security laws if their unemployment compensation laws and their plans of operation for public employment offices meet required conditions of Federal law. (Section 303(a) of the Social Security Act; section 3304(a) of the Internal Revenue Code of 1986; sections 6, 7, and 8 of the Wagner-Peyser Act.)

(d) As used throughout this Part, the terms ''Secretary'' or ''Secretary of Labor'' shall refer to the Secretary of Labor, U.S. Department of Labor, or his or her designee.

[15 FR 5886, Aug. 31, 1950; 23 FR 1267, Mar. 1, 1958, as amended at 61 FR 19983, May 3, 1996]

§ 601.2 Approval of State unemployment compensation laws.

States may at their option submit their unemployment compensation laws for approval (section 3304(a) of the Internal Revenue Code of 1986).

(a) *Submission.* The States submit to the Employment and Training Administration (ETA), one copy of the State unemployment compensation law properly certified by an authorized State official to be true and complete, together with a written request for approval.

(b) [Reserved]

(c) *Approval.* The Secretary of Labor determines whether the State law contains the provisions required by section 3304(a) of the Internal Revenue Code of 1986. If the State law is approved, the Secretary notifies the Governor of the State within 30 days of the submission of such law.

(d) *Certification.* On October 31 of each taxable year the Secretary of Labor certifies, for the purposes of normal tax credit (section 3302(a)(1) of the Internal Revenue Code of 1986), to the Secretary of the Treasury each State

the law of which the Secretary has previously approved. (See also § 601.5.)

(Approved by the Office of Management and Budget under control number 1205–0222)

[15 FR 5886, Aug. 31, 1950; 23 FR 1267, Mar. 1, 1958, as amended at 49 FR 18295, Apr. 30, 1984; 50 FR 51241, Dec. 16, 1985; 71 FR 35513, June 21, 2006]

§ 601.3 Findings with respect to State laws and plans of operation.

For purposes of grants, findings are made regarding the inclusion in State unemployment compensation laws, approved under section 3304(a) of the Internal Revenue Code of 1986, of provisions required by section 303(a) of the Social Security Act (see § 601.2); findings are also made whether a State has accepted the provisions of the Wagner-Peyser Act and whether its plan of operation for public employment offices complies with the provisions of said act. For purposes of additional tax credit, findings are made regarding reduced rates of contributions permitted by the State law (section 3303(a) (1) of the Internal Revenue Code of 1986).

So that the Secretary of Labor may be enabled to determine the status of State laws and plans of operation, all relevant State materials, such as statutes, executive and administrative orders, legal opinions, rules, regulations, interpretations, court decisions, etc., are required to be submitted currently.

(a) *Submission.* The States submit currently to the ETA one copy of relevant State material, properly certified by an authorized State official to be true and complete.

(b) [Reserved]

(c) *Findings.* The Secretary makes findings as provided in the cited sections of the Federal law. In the event that the Secretary is unable to make the findings required for certification for payment or for certification of the law for purposes of additional tax credit, further discussions with State officials are undertaken.

(Approved by the Office of Management and Budget under control number 1205–0222)

[15 FR 5886, Aug. 31, 1950; 23 FR 1267, Mar. 1, 1958, as amended at 49 FR 18295, Apr. 30, 1984; 50 FR 51241, Dec. 16, 1985; 71 FR 35513, June 21, 2006]

§ 601.4 Certification for tax credit.

(a) Within 30 days after submittal of a State unemployment compensation law for such purpose, the Secretary certifies to the State agency, in accordance with the provisions of section 3303(b)(3) of the Internal Revenue Code of 1986, the Secretary's findings regarding reduced rates of contributions allowable under such law. On October 31 of each taxable year the Secretary certifies to the Secretary of the Treasury the law of each State, certified with respect to such year under section 3304 of the Internal Revenue Code of 1986 (see § 601.2), which the Secretary finds allows reduced rates with respect to such taxable year only in accordance with the provisions of section 3303(a) of the Internal Revenue Code of 1986.

(b) With regard to certification for payment, see § 601.6.

[15 FR 5886, Aug. 31, 1950; 23 FR 1267, Mar. 1, 1958, as amended at 71 FR 35513, June 21, 2006]

§ 601.5 Withholding payments and certifications.

(a) *When withheld.* Payment of funds to States or yearend certification of State laws, or both, are withheld when the Secretary finds, after reasonable notice and opportunity for hearing:

(1) That any provision required by section 303(a) of the Social Security Act is no longer included in the State unemployment compensation law; or

(2) That the State unemployment compensation law has been so changed as no longer to meet the conditions required by section 3303(a) of the Internal Revenue Code of 1986 (section 3303(b)(3) of the Internal Revenue Code); or

(3) That the State unemployment compensation law has been so amended as no longer to contain the provisions specified in section 3304(a) or has failed to comply substantially with any such provision and such finding has become effective (section 3304(c) of the Internal Revenue Code of 1986); or

(4) That in the administration of the State unemployment compensation law there has been a failure to comply substantially with required provisions of such law (section 303(b)(2) of the Social Security Act and section 3303(b)(3) of the Internal Revenue Code of 1986); or

(5) That in the administration of the State unemployment compensation law there has been a denial, in a substantial number of cases, of benefits due under such law, except that there may be no such finding until the question of entitlement has been decided by the highest judicial authority given jurisdiction under such State law (section 303(b)(1) of the Social Security Act); or

(6) That a State fails to make its unemployment compensation records available to the Railroad Retirement Board or fails to cooperate with Federal agencies charged with the administration of unemployment compensation laws (section 303(c) of the Social Security Act); or

(7) That a State no longer has a plan of operation for public employment offices complying with the provisions of the Wagner-Peyser Act; or

(8) That a State agency has not properly expended, in accordance with an approved plan of operation, the Federal monies paid it for administration of its public employment service.

(b) *Informal discussion.* Such hearings are generally not called, however, until after every reasonable effort has been made by ETA representatives to resolve the question involved by conference and discussion with State officials. Formal notification of the date and place of a hearing does not foreclose further negotiations with State officials.

(c) *Notice of noncertification.* If, at any time during the taxable year, the Secretary of Labor has reason to believe that a State whose unemployment compensation law he/she has previously approved may not be certified, the Secretary promptly notifies the Governor of the State to that effect (section 3304(d) of the Internal Revenue Code of 1986).

(d) *Notice of hearing.* Notice of hearing is sent by the Secretary of Labor to the State unemployment compensation agency. The notice sets forth the purpose of the hearing, the time, date, and place at which the hearing will be held, and the rules of procedure which will be followed. At a hearing the State is given an opportunity to present arguments and all relevant evidence, written or oral. The Secretary makes the necessary determination or findings, on the basis of the record of such hearings. A notice of the Secretary's determination or finding is sent to the State unemployment compensation agency.

(e) *Civil Rights Act issues.* To the extent that any proposed withholding of funds involves circumstances within the scope of title VI of the Civil Rights Act of 1964 and the regulations promulgated thereunder, the procedure set forth in 29 CFR part 31 shall be applicable.

[30 FR 6942, May 22, 1965, as amended at 43 FR 13828, Mar. 31, 1978; 71 FR 35513, June 21, 2006]

Subpart B—Grants, Advances and Audits

§ 601.6 Grants for administration of unemployment compensation laws and employment service.

Grants of funds for administration of State unemployment compensation laws and public employment service programs are made to States under section 302(a) of the Social Security Act, the Wagner-Peyser Act, and the Appropriation Acts.

(a) *Requests for funds.* The forms and instructions used by State agencies in requesting funds are available on the ETA Web site (*http://www.ows.doleta.gov/rjm*). The forms and instructions call for detailed information for each budgetary period concerning the specific amounts requested for personal services and other current expenses of State agencies, supported by workload and unit-cost estimates. Supplementary budget requests are processed in the same manner as regular requests. The Administration's representatives in the regional offices furnish assistance to the State agencies in preparing requests for funds.

(b) *Processing of requests.* (1) State agencies send their requests for funds to the Regional Administrator who reviews the requests and forwards them to the ETA National Office with his/her recommendation as to the amounts necessary for proper and efficient administration of the State unemployment compensation law and employment service program.

(2) The ETA National Office appraises the requests and the recommendations

of the regional representatives from a nationwide point of view, examining each State's request in the light of the experience of other States to insure equitable treatment among the States in the allocation of funds made available by Congress for the administration of State unemployment compensation laws and public employment service programs.

(c) *Action by ETA National Office.* If the ETA National Office approves the State's budget request, the State agency is notified; and, provided the conditions precedent to grants continue during the budgetary period, certifications for payment, under the approved budget, stating the amounts, are made by the ETA National Office to the Secretary of the Treasury quarterly. Upon denial of a request, in whole or in part, the State agency is notified and the Regional Administrator is instructed to negotiate with the State with a view to removing the basis for denial.

(Approved by the Office of Management and Budget under control number 1205–0132)

[15 FR 5886, Aug. 31, 1950, as amended at 42 FR 4724, Jan. 25, 1977; 49 FR 18295, Apr. 30, 1984; 71 FR 35513, June 21, 2006]

§ 601.7 [Reserved]

§ 601.8 Agreement with Postmaster General.

The Secretary of Labor and the Postmaster General have been directed by the Congress (title II of the Labor-Federal Security Agency Appropriation Act, 1950) to prescribe a mutually satisfactory procedure whereby official State employment security postal matter will be handled without the prepayment of postage. In lieu of such prepayments, the Secretary periodically certifies to the Secretary of the Treasury for payment to the U.S. Postal Service the amount necessary to cover the cost of State agency mailings. The amount of payment is based on a formula agreed upon by the Secretary of Labor and the U.S. Postal Service.

[15 FR 5886, Aug. 31, 1950, as amended at 42 FR 4724, Jan. 25, 1977]

§ 601.9 Audits.

The Department of Labor's audit regulations at 29 CFR Part 96 and 29 CFR Part 99 shall apply with respect to employment service and unemployment compensation programs.

[46 FR 7766, Jan. 23, 1981, as amended at 71 FR 35513, June 21, 2006]

PART 602—QUALITY CONTROL IN THE FEDERAL-STATE UNEMPLOYMENT INSURANCE SYSTEM

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602.40 Funding.
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APPENDIX A TO PART 602—STANDARD FOR CLAIM DETERMINATIONS—SEPARATION INFORMATION

AUTHORITY: 42 U.S.C. 1302.

SOURCE: 52 FR 33528, Sept. 3, 1987, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 602 appear at 71 FR 35513, June 21, 2006.

Subpart A—General Provisions

§ 602.1 Purpose.

The purpose of this part is to prescribe a Quality Control (QC) program for the Federal-State unemployment compensation (UC) system, which is applicable to the State UC programs and the Federal unemployment benefit and allowance programs administered by the State unemployment compensation agencies under agreements between the States and the Secretary of

Labor (Secretary). QC will be a major tool to assess the timeliness and accuracy of State administration of the UC program. It is designed to identify errors in claims processes and revenue collections (including payments in lieu of contributions and Extended Unemployment Compensation Account collections), analyze causes, and support the initiation of corrective action.

[52 FR 33528, Sept. 3, 1987, as amended at 71 FR 35513, June 21, 2006]

§ 602.2 Scope.

This part applies to all State laws approved by the Secretary under the Federal Unemployment Tax Act (section 3304 of the Internal Revenue Code of 1986, 26 U.S.C. section 3304), to the administration of the State laws, and to any Federal unemployment benefit and allowance program administered by the State unemployment compensation agencies under agreements between the States and the Secretary. QC is a requirement for all States, initially being applicable to the largest permanently authorized programs (regular UC including Combined-Wage-Claims) and federally-funded programs (Unemployment Compensation for Ex-Servicemembers and Unemployment Compensation for Federal Employees). Other elements of the QC program (e.g., interstate, extended benefit programs, benefit denials, and revenue collections) will be phased in under a schedule determined by the Department in consultation with State agencies.

[52 FR 33528, Sept. 3, 1987, as amended at 71 FR 35513, June 21, 2006]

Subpart B—Federal Requirements

§ 602.10 Federal law requirements.

(a) Section 303(a)(1) of the Social Security Act (SSA), 42 U.S.C. 503(a)(1), requires that a State law include provision for:

> Such methods of administration . . . as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due.

(b) Section 303(a)(6), SSA, 42 U.S.C. 505(a)(6), requires that a State law include provision for:

> The making of such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and compliance with such provisions as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports.

(c) Section 303(b), SSA, 42 U.S.C. 503(b), provides in part that:

> Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that in the administration of the law there is—
>
> * * * * *
>
> (2) a failure to comply substantially with any provision specified in subsection (a);
>
> the Secretary of Labor shall notify such State agency that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such denial or failure to comply. Until he is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State . . . .

(d) Certification of payment of granted funds to a State is withheld only when the Secretary finds, after reasonable notice and opportunity for hearing to the State agency—

(1) That any provision required by section 303(a) of the Social Security Act is no longer included in the State UC law, or

(2) That in the administration of the State UC law there has been a failure to comply substantially with any required provision of such law.

[52 FR 33528, Sept. 3, 1987, as amended at 71 FR 35513, June 21, 2006]

§ 602.11 Secretary's interpretation.

(a) The Secretary interprets section 303(a)(1), SSA, to require that a State law provide for such methods of administration as will reasonably ensure the prompt and full payment of unemployment benefits to eligible claimants, and collection and handling of income for the State unemployment fund (particularly taxes and reimbursements), with the greatest accuracy feasible.

(b) The Secretary interprets sections 303(a)(1) and 303(a)(6), SSA, to authorize the Department of Labor to prescribe standard definitions, methods

and procedures, and reporting requirements for the QC program and to ensure accuracy and verification of QC findings.

(c) The Secretary interprets section 303(b)(2), SSA to require that, in the administration of a State law, there shall be substantial compliance with the provisions required by sections 303(a) (1) and (6). Further, conformity of the State law with those requirements is required by section 303(a) and § 601.5(a) of this chapter.

(d) To satisfy the requirements of sections 303(a) (1) and (6), a State law must contain a provision requiring, or which is construed to require, the establishment and maintenance of a QC program in accordance with the requirements of this part. The establishment and maintenance of such a QC program in accordance with this part shall not require any change in State law concerning authority to undertake redeterminations of claims or liabilities or the finality of any determination, redetermination or decision.

Subpart C—State Responsibilities

§ 602.20 Organization.

Each State shall establish a QC unit independent of, and not accountable to, any unit performing functions subject to evaluation by the QC unit. The organizational location of this unit shall be positioned to maximize its objectivity, to facilitate its access to information necessary to carry out its responsibilities, and to minimize organizational conflict of interest.

§ 602.21 Standard methods and procedures.

Each State shall:

(a) Perform the requirements of this section in accordance with instructions issued by the Department, pursuant to § 602.30(a) of this part, to ensure standardization of methods and procedures in a manner consistent with this part;

(b) Select representative samples for QC study of at least a minimum size specified by the Department to ensure statistical validity (for benefit payments, a minimum of 400 cases of weeks paid per State per year);

(c) Complete prompt and in-depth case investigations to determine the degree of accuracy and timeliness in the administration of the State UC law and Federal programs with respect to benefit determinations, benefit payments, and revenue collections; and conduct other measurements and studies necessary or appropriate for carrying out the purposes of this part; and in conducting investigations each State shall:

(1) Inform claimants in writing that the information obtained from a QC investigation may affect their eligibility for benefits and inform employers in writing that the information obtained from a QC investigation of revenue may affect their tax liability,

(2) Use a questionnaire, prescribed by the Department, which is designed to obtain such data as the Department deems necessary for the operation of the QC program; require completion of the questionnaire by claimants in accordance with the eligibility and reporting authority under State law,

(3) Collect data identified by the Department as necessary for the operation of the QC program; however, the collection of demographic data will be limited to those data which relate to an individual's eligibility for UC benefits and necessary to conduct proportions tests to validate the selection of representative samples (the demographic data elements necessary to conduct proportions tests are claimants' date of birth, sex, and ethnic classification); and

(4) Conclude all findings of inaccuracy as detected through QC investigations with appropriate official actions, in accordance with the applicable State and Federal laws; make any determinations with respect to individual benefit claims in accordance with the Secretary's ''Standard for Claim Determinations—Separation Information'' in the *Employment Security Manual*, part V, sections 6010–6015 (appendix A of this part);

(d) Classify benefit case findings resulting from QC investigations as:

(1) Proper payments, underpayments, or overpayments in benefit payment cases, or

(2) Proper denials or underpayments in benefit denial cases;

(e) Make and maintain records pertaining to the QC program, and make

all such records available in a timely manner for inspection, examination, and audit by such Federal officials as the Secretary may designate or as may be required or authorized by law;

(f) Furnish information and reports to the Department, including weekly transmissions of case data entered into the automated QC system and annual reports, without, in any manner, identifying individuals to whom such data pertain; and

(g) Release the results of the QC program at the same time each year, providing calendar year results using a standardized format to present the data as prescribed by the Department; States will have the opportunity to release this information prior to any release by the Department.

(Approved by the Office of Management and Budget under Control Number 1205–0245)

§ 602.22 Exceptions.

If the Department determines that the QC program, or any constituent part of the QC program, is not necessary for the proper and efficient administration of a State law or in the Department's view is not cost effective, the Department shall use established procedures to advise the State that it is partially or totally excepted from the specified requirements of this part. Any determination under this section shall be made only after consultations with the State agency.

Subpart D—Federal Responsibilities

§ 602.30 Management.

(a) The Department shall establish required methods and procedures (as specified in § 602.21 of this part); and provide technical assistance as needed on the QC process.

(b) The Department shall consider and explore alternatives to the prescribed sampling, study, recordkeeping, and reporting methodologies. This shall include, but not be limited to, testing the obtaining of information needed for QC by telephone and mail rather than in face-to-face interviews.

(c) The Department shall maintain a computerized data base of QC case data which is transmitted to the Department under § 602.21, which will be combined with other data for statistical and other analysis such as assessing the impact of economic cycles, funding levels, and workload levels on program accuracy and timeliness.

§ 602.31 Oversight.

The Department shall review QC operational procedures and samples, and validate QC methodology to ensure uniformity in the administration of the QC program and to ensure compliance with the requirements of this part. The Department shall, for purposes of determining eligibility for grants described in § 602.40, annually review the adequacy of the administration of a State's QC program.

Subpart E—Quality Control Grants to States

§ 602.40 Funding.

(a) The Department shall use established procedures to notify States of the availability of funds for the operation of QC programs in accordance with this part.

(b) The Department may allocate additional resources, if available, to States for analysis of data generated by the QC program, to increase the number of claims sampled in areas where more information is needed, for pilot studies for the purpose of expanding the QC program, and for corrective action.

[52 FR 33528, Sept. 3, 1987, as amended at 71 FR 35513, June 21, 2006]

§ 602.41 Proper expenditure of Quality Control granted funds.

The Secretary may, after reasonable notice and opportunity for hearing to the State agency, take exception to and require repayment of an expenditure for the operation of a QC program if it is found by the Secretary that such expenditure is not necessary for the proper and efficient administration of the QC program in the State. See sections 303(a)(8), 303(a)(9) and 303(b)(2), SSA, and 20 CFR 601.5. For purposes of this section, an expenditure will be

found not necessary for proper and efficient administration if such expenditure fails to comply with the requirements of subpart C of this part.

[52 FR 33528, Sept. 3, 1987, as amended at 52 FR 34343, Sept. 10, 1987]

§ 602.42 Effect of failure to implement Quality Control program.

Any State which the Secretary finds, after reasonable notice and opportunity for hearing, has not implemented or maintained a QC program in accordance with this part will not be eligible for any grants under title III of the Social Security Act until such time as the Secretary is satisfied that there is no longer any failure to conform or to comply substantially with any provision specified in this part. See sections 303(a)(1), 303(a)(6), and 303(b)(2), SSA, and 20 CFR 601.5.

§ 602.43 No incentives or sanctions based on specific error rates.

Neither sanctions nor funding incentives shall be used by the Department to influence the achievement of specified error rates in State UC programs.

APPENDIX A TO PART 602—STANDARD FOR CLAIM DETERMINATIONS—SEPARATION INFORMATION

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 6010–6015)

6010 *Federal Law Requirements.* Section 303(a)(1) of the Social Security Act requires that a State law include provision for:

''Such methods of administration . . . as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

Section 303(a)(3) of the Social Security Act requires that a State law include provision for:

''Opportunity for a fair hearing before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied.''

Section 3304(a)(4) of the Federal Unemployment Tax Act and section 303(a)(5) of the Social Security Act require that a State law include provision for:

''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation. . . .''

Section 3306(h) of the Federal Unemployment Tax Act defines ''compensation'' as ''cash benefits payable to individuals with respect to their unemployment.''

6011 *Secretary's Interpretation of Federal Law Requirements.* The Secretary interprets the above sections to require that a State law include provisions which will insure that:

A. Individuals who may be entitled to unemployment compensation are furnished such information as will reasonably afford them an opportunity to know, establish, and protect their rights under the unemployment compensation law of such State, and

B. The State agency obtains and records in time for the prompt determination and review of benefit claims such information as will reasonably insure the payment of benefits to individuals to whom benefits are due.

6012 *Criteria for Review of State Law Conformity with Federal Requirements:*

In determining the conformity of a State law with the above requirements of the Federal Unemployment Tax Act and the Social Security Act as interpreted by the Secretary, the following criteria will be applied:

A. Is it required that individuals who may be entitled to unemployment compensation be furnished such information of their potential rights to benefits, including the manner and places of filing claims, the reasons for determinations, and their rights of appeal, as will insure them a reasonable opportunity to know, establish, and protect their rights under the law of the State?

B. Is the State agency required to obtain, in time for prompt determination of rights to benefits such information as will reasonably insure the payment of benefits to individuals to whom benefits are due?

C. Is the State agency required to keep records of the facts considered in reaching determinations of rights to benefits?

6013 *Claim Determinations Requirements Designed To Meet Department of Labor Criteria:*

A. *Investigation of claims.* The State agency is required to obtain promptly and prior to a determination of an individual's right to benefits, such facts pertaining thereto as will be sufficient reasonably to insure the payment of benefits when due.

This requirement embraces five separate elements:

1. It is the responsibility of the agency to take the initiative in the discovery of information. This responsibility may not be passed on to the claimant or the employer. In addition to the agency's own records, this information may be obtained from the worker, the employer, or other sources. If the information obtained in the first instance discloses no essential disagreement and provides a sufficient basis for a fair determination, no further investigation is necessary. If the information obtained from other sources differs essentially from that furnished by the

claimant, the agency, in order to meet its responsibility, is required to inform the claimant of such information from other sources and to afford the claimant an opportunity to furnish any further facts he may have.

2. Evidentiary facts must be obtained as distinguished from ultimate facts or conclusions. That a worker was discharged for misconduct is an ultimate fact or conclusion; that he destroyed a machine upon which he was working is a primary or evidentiary fact, and the sort of fact that the requirement refers to.

3. The information obtained must be sufficient reasonably to insure the payment of benefits when due. In general, the investigation made by the agency must be complete enough to provide information upon which the agency may act with reasonable assurance that its decision is consistent with the unemployment compensation law. On the other hand, the investigation should not be so exhaustive and time-consuming as unduly to delay the payment of benefits and to result in excessive costs.

4. Information must be obtained promptly so that the payment of benefits is not unduly delayed.

5. If the State agency requires any particular evidence from the worker, it must give him a reasonable opportunity to obtain such evidence.

B. *Recording of facts.* The agency must keep a written record of the facts considered in reaching its determinations.

C. *Determination notices.*

1. The agency must give each claimant a written notice of:

a. Any monetary determination with respect to his benefit year;

b. Any determination with respect to purging a disqualification if, under the State law, a condition or qualification must be satisfied with respect to each week of disqualification; but in lieu of giving written notice of each determination for each week in which it is determined that the claimant has met the requirements for purging, the agency may inform the claimant that he has purged the disqualification for a week by notation of his applicant identification card or otherwise in writing.

c. Any other determination which adversely affects[1] his rights to benefits, except that written notice of determination need not be given with respect to:

(1) A week in a benefit year for which the claimant's weekly benefit amount is reduced in whole or in part by earnings if, the first time in the benefit year that there is such a reduction, he is required to be furnished a booklet or leaflet containing the information set forth below in paragraph 2f(1). However, a written notice of determination is required if: (a) there is a dispute concerning the reduction with respect to any week (e.g., as to the amount computed as the appropriate reduction, etc.); or (b) there is a change in the State law (or in the application thereof) affecting the reduction; or

(2) Any week in a benefit year subsequent to the first week in such benefit year in which benefits were denied, or reduced in whole or in part for reasons other than earnings, if denial or reduction for such subsequent week is based on the same reason and the same facts as for the first week, and if written notice of determination is required to be given to the claimant with respect to such first week, and with such notice of determination, he is required to be given a booklet or pamphlet containing the information set forth below in paragraphs 2f(2) and 2h. However, a written notice of determination is required if: (a) there is a dispute concerning the denial or reduction of benefits with respect to such week; or (b) there is a change in the State law (or in the application thereof) affecting the denial or reduction; or (c) there is a change in the amount of the reduction except as to the balance covered by the last reduction in a series of reductions.

NOTE: This procedure may be applied to determinations made with respect to any subsequent weeks for the same reason and on the basis of the same facts: (a) that claimant is unable to work, unavailable for work, or is disqualified under the labor dispute provision; and (b) reducing claimant's weekly benefit amount because of income other than earnings or offset by reason of overpayment.

2. The agency must include in written notices of determinations furnished to claimants sufficient information to enable them to understand the determinations, the reasons therefor, and their rights to protest, request reconsideration, or appeal.

[1] A determination ''adversely affects'' claimant's right to benefits if it (1) results in a denial to him of benefits (including a cancellation of benefits or wage credits or any reduction in whole or in part below the weekly or maximum amount established by his monetary determination) for any week or other period; or (2) denies credit for a waiting week; or (3) applies any disqualification or penalty; or (4) determines that he has not satisfied a condition of eligibility, requalification for benefits, or purging a disqualification; or (5) determines that an overpayment has been made or orders repayment or recoupment of any sum paid to him; or (6) applies a previously determined overpayment, penalty, or order for repayment or recoupment; or (7) in any other way denies claimant a right to benefits under the State law.

The written notice of monetary determination must contain the information specified in the following items (except h) unless an item is specifically not applicable. A written notice of any other determination must contain the information specified in as many of the following items as are necessary to enable the claimant to understand the determination and to inform him of his appeal rights. Information specifically applicable to the individual claimant must be contained in the written notice of determination. Information of general application such as (but not limited to) the explanation of benefits for partial unemployment, information as to deductions, seasonality factors, and information as to the manner and place of taking an appeal, extension of the appeal period, and where to obtain information and assistance may be contained in a booklet or leaflet which is given the claimant with his monetary determination.

a. *Base period wages.* The statement concerning base-period wages must be in sufficient detail to show the basis of computation of eligibility and weekly and maximum benefit amounts. (If maximum benefits are allowed, it may not be necessary to show details of earnings.)

b. *Employer name.* The name of the employer who reported the wages is necessary so that the worker may check the wage transcript and know whether it is correct. If the worker is given only the employer number, he may not be able to check the accuracy of the wage transcript.

c. *Explanation of benefit formula—weekly and maximum benefit amounts.* Sufficient information must be given the worker so that he will understand how his weekly benefit amount, including allowances for dependents, and his maximum benefit amount were figured. If benefits are computed by means of a table contained in the law, the table must be furnished with the notice of determination whether benefits are granted or denied.

The written notice of determination must show clearly the weekly benefit amount and the maximum potential benefits to which the claimant is entitled.

The notice to a claimant found ineligible by reason of insufficient earnings in the base period must inform him clearly of the reason for ineligibility. An explanation of the benefit formula contained in a booklet or pamphlet should be given to each claimant at or prior to the time he receives written notice of a monetary determination.

d. *Benefit year.* An explanation of what is meant by the benefit year and identification of the claimant's benefit year must be included in the notice of determination.

e. *Information as to benefits for partial unemployment.* There must be included either in the written notice of determination or in a booklet or pamphlet accompanying the notice an explanation of the claimant's rights to partial benefits for any week with respect to which he is working less than his normal customary full-time workweek because of lack of work and for which he earns less than his weekly benefit amount or weekly benefit amount plus earnings, whichever is provided by the State law. If the explanation is contained in the notice of determination, reference to the item in the notice in which his weekly benefit amount is entered should be made.

f. *Deductions from weekly benefits.*

(1) *Earnings.* Although written notice of determinations deducting earnings from a claimant's weekly benefit amount is generally not required (see paragraph 1 c (1) above), where written notice of determination is required (or given) it shall set forth the amount of earnings, the method of computing the deduction in sufficient detail to enable the claimant to verify the accuracy of the deduction, and his right to protest, request redetermination, and appeal. Where a written notice of determination is given to the claimant because there has been a change in the State law or in the application of the law, an explanation of the change shall be included.

Where claimant is not required to receive a written notice of determination, he must be given a booklet or pamphlet the first time in his benefit year that there is a deduction for earnings which shall include the following information:

(a) The method of computing deductions for earnings in sufficient detail to enable the claimant to verify the accuracy of the deduction;

(b) That he will not automatically be given a written notice of determination for a week with respect to which there is a deduction for earnings (unless there is a dispute concerning the reduction with respect to a week or there has been a change in the State law or in the application of the law affecting the deduction) but that he may obtain such a written notice upon request; and

(c) A clear statement of his right to protest, request a redetermination, and appeal from any determination deducting earnings from his weekly benefit amount even though he does not automatically receive a written notice of determination; and if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

(2) *Other deductions.*

(a) A written notice of determination is required with respect to the first week in claimant's benefit year in which there is a reduction from his benefits for a reason other than earnings. This notice must describe the deduction made from claimant's weekly benefit amount, the reason for the

deduction, the method of computing it in sufficient detail to enable him to verify the accuracy of such deduction, and his right to protest, request redetermination, or appeal.

(b) A written notice of determination is not required for subsequent weeks that a deduction is made for the same reason and on the basis of the same facts, if the notice of determination pursuant to (2)(a), or a booklet or pamphlet given him with such notice explains (i) the several kinds of deductions which may be made under the State law (e.g., retirement pensions, vacation pay, and overpayments); (ii) the method of computing each kind of deduction in sufficient detail that claimant will be able to verify the accuracy of deductions made from his weekly benefit payments; (iii) any limitation on the amount of any deduction or the time in which any deduction may be made; (iv) that he will not automatically be given a written notice of determination for subsequent weeks with respect to which there is a deduction for the same reason and on the basis of the same facts, but that he may obtain a written notice of determination upon request; (v) his right to protest, request redetermination, or appeal with respect to subsequent weeks for which there is a reduction from his benefits for the same reason, and on the basis of the same facts even though he does not automatically receive a written notice of determination; and (vi) that if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

g. *Seasonality factors.* If the individual's determination is affected by seasonality factors under the State law, an adequate explanation must be made. General explanation of seasonality factors which may affect determinations for subsequent weeks may be included in a booklet or pamphlet given claimant with his notice of monetary determination.

h. *Disqualification or ineligibility.* If a disqualification is imposed, or if the claimant is declared ineligible for one or more weeks, he must be given not only a statement of the period of disqualification or ineligibility and the amount of wage-credit reductions, if any, but also an explanation of the reason for the ineligibility or disqualification. This explanation must be sufficiently detailed so that he will understand why he is ineligible or why he has been disqualified, and what he must do in order to requalify for benefits or purge the disqualification. The statement must be individualized to indicate the facts upon which the determination was based, e.g., state, ''It is found that you left your work with Blank Company because you were tired of working; the separation was voluntary, and the reason does not constitute good cause,'' rather than merely the phrase ''voluntary quit.'' Checking a box as to the reason for the disqualification is not a sufficiently detailed explanation. However, this statement of the reason for the disqualification need not be a restatement of all facts considered in arriving at the determination.

i. *Appeal rights.* The claimant must be given information with respect to his appeal rights.

(1) The following information shall be included in the notice of determination:

(a) A statement that he may appeal or, if the State law requires or permits a protest or redetermination before an appeal, that he may protest or request a redetermination.

(b) The period within which an appeal, protest, or request for redetermination must be filed. The number of days provided by statute must be shown as well as either the beginning date or ending date of the period. (It is recommended that the ending date of the appeal period be shown, as this is the more understandable of the alternatives.)

(2) The following information must be included either in the notice of determination or in separate informational material referred to in the notice:

(a) The manner in which the appeal, protest, or request for redetermination must be filed, e.g., by signed letter, written statement, or on a prescribed form, and the place or places to which the appeal, protest, or request for redetermination may be mailed or hand-delivered.

(b) An explanation of any circumstances (such as nonworkdays, good cause, etc.) which will extend the period for the appeal, protest, or request for redetermination beyond the date stated or identified in the notice of determination.

(c) That any further information claimant may need or desire can be obtained together with assistance in filing his appeal, protest, or request for redetermination from the local office.

If the information is given in separate material, the notice of determination would adequately refer to such material if it said, for example, ''For other information about your (appeal), (protest), (redetermination) rights, see pages __ to __ of the ____ (name of pamphlet or booklet) heretofore furnished to you.''

6014 *Separation Information Requirements Designed To Meet Department of Labor Criteria:*

A. *Information to agency.* Where workers are separated, employers are required to furnish the agency promptly, either upon agency request or upon such separation, a notice describing the reasons for and the circumstances of the separation and any additional information which might affect a claimant's right to benefits. Where workers are working less than full time, employers are required to furnish the agency promptly, upon agency request, information concerning

a claimant's hours of work and his wages during the claim periods involved, and other facts which might affect a claimant's eligibility for benefits during such periods.

When workers are separated and the notices are obtained on a request basis, or when workers are working less than full time and the agency requests information, it is essential to the prompt processing of claims that the request be sent out promptly after the claim is filed and the employer be given a specific period within which to return the notice, preferably within 2 working days.

When workers are separated and notices are obtained upon separation, it is essential that the employer be required to send the notice to the agency with sufficient promptness to insure that, if a claim is filed, it may be processed promptly. Normally, it is desirable that such a notice be sent to the central office of the agency, since the employer may not know in which local office the workers will file his claim. The usual procedure is for the employer to give the worker a copy of the notice sent by the employer to the agency.

B. *Information to worker.*

1. *Information required to be given.* Employers are required to give their employees information and instructions concerning the employees' potential rights to benefits and concerning registration for work and filing claims for benefits.

The information furnished to employees under such a requirement need not be elaborate; it need only be adequate to insure that the worker who is separated or who is working less than full time knows he is potentially eligible for benefits and is informed as to what he is to do or where he is to go to file his claim and register for work. When he files his claim, he can obtain more detailed information.

In States that do not require employers to furnish periodically to the State agency detailed reports of the wages paid to their employees, each employer is required to furnish to his employees information as to (a) the name under which he is registered by the State agency, (b) the address where he maintains his payroll records, and (c) the workers' need for this information if and when they file claims for benefits.

2. *Methods for giving information.* The information and instructions required above may be given in any of the following ways:

a. *Posters prominently displayed in the employer's establishment.* The State agency should supply employers with a sufficient number of posters for distribution throughout their places of business and should see that the posters are conspicuously displayed at all times.

b. *Leaflets.* Leaflets distributed either periodically or at the time of separation or reduction of hours. The State agency should supply employers with a sufficient number of leaflets.

c. *Individual notices.* Individual notices given to each employee at the time of separation or reduction in hours.

It is recommended that the State agency's publicity program be used to supplement the employer-information requirements. Such a program should stress the availability and location of claim-filing offices and the importance of visiting those offices whenever the worker is unemployed, wishes to apply for benefits, and to seek a job.

6015 *Evaluation of Alternative State Provisions with Respect to Claim Determinations and Separation Information.* If the State law provisions do not conform to the suggested requirements set forth in sections 6013 and 6014, but the State law contains alternative provisions, the Bureau of Employment Security, in collaboration with the State agency, will study the actual or anticipated effects of the alternative provisions. If the Administrator of the Bureau concludes that the alternative provisions satisfy the criteria in section 6012, he will so notify the State agency. If the Administrator of the Bureau does not so conclude, he will submit the matter to the Secretary. If the Secretary concludes that the alternative provisions satisfy the criteria in section 6012, the State agency will be so notified. If the Secretary concludes that there is a question as to whether the alternative provisions satisfy the criteria, the State agency will be advised that unless the State law provisions are appropriately revised, a notice of hearing will be issued as required by the Code of Federal Regulations, title 20, section 601.5.

PART 603—FEDERAL-STATE UNEMPLOYMENT COMPENSATION (UC) PROGRAM; CONFIDENTIALITY AND DISCLOSURE OF STATE UC INFORMATION

Subpart A—In General

Sec.

603.1 What are the purpose and scope of this part?
603.2 What definitions apply to this part?

Subpart B—Confidentiality and Disclosure Requirements

603.3 What is the purpose and scope of this subpart?
603.4 What is the confidentiality requirement of Federal UC law?
603.5 What are the exceptions to the confidentiality requirement?
603.6 What disclosures are required by this subpart?

603.7 What requirements apply to subpoenas, other compulsory processes, and disclosure to officials with subpoena authority?
603.8 What are the requirements for payment of costs and program income?
603.9 What safeguards and security requirements apply to disclosed information?
603.10 What are the requirements for agreements?
603.11 How do States notify claimants and employers about the uses of their information?
603.12 How are the requirements of this part enforced?

Subpart C—Mandatory Disclosure for Income and Eligibility Verification System (IEVS)

603.20 What is the purpose and scope of this subpart?
603.21 What is a requesting agency?
603.22 What information must State UC agencies disclose for purposes of an IEVS?
603.23 What information must State UC agencies obtain from other agencies, and crossmatch with wage information, for purposes of an IEVS?

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SOURCE: 71 FR 56842, Sept. 27, 2006, unless otherwise noted.

Subpart A—In General

§ 603.1 What are the purpose and scope of this part?

The purpose of this part is to implement the requirements of Federal UC law concerning confidentiality and disclosure of UC information. This part applies to States and State UC agencies, as defined in § 603.2(f) and (g).

§ 603.2 What definitions apply to this part?

For the purposes of this part:

(a)(1) *Claim information* means information about:

(i) Whether an individual is receiving, has received, or has applied for UC;

(ii) The amount of compensation the individual is receiving or is entitled to receive; and

(iii) The individual's current (or most recent) home address.

(2) For purposes of subpart C (IEVS), claim information also includes:

(i) Whether the individual has refused an offer of work and, if so, a description of the job offered including the terms, conditions, and rate of pay; and

(ii) Any other information contained in the records of the State UC agency that is needed by the requesting agency to verify eligibility for, and the amount of, benefits.

(b) *Confidential UC information* and *confidential information* mean any UC information, as defined in paragraph (j) of this section, required to be kept confidential under § 603.4.

(c) *Public domain information* means—

(1) Information about the organization of the State and the State UC agency and appellate authorities, including the names and positions of officials and employees thereof;

(2) Information about the State UC law (and applicable Federal law) provisions, rules, regulations, and interpretations thereof, including statements of general policy and interpretations of general applicability; and

(3) Any agreement of whatever kind or nature, including interstate arrangements and reciprocal agreements and any agreement with the Department of Labor or the Secretary, relating to the administration of the State UC law.

(d) *Public official* means:

(1) An official, agency, or public entity within the executive branch of Federal, State, or local government who (or which) has responsibility for administering or enforcing a law, or an elected official in the Federal, State, or local government.

(2) Public postsecondary educational institutions established and governed under the laws of the State. These include the following:

(i) Institutions that are part of the State's executive branch. This means the head of the institution must derive his or her authority from the Governor, either directly or through a State WDB, commission, or similar entity established in the executive branch under the laws of the State.

(ii) Institutions which are independent of the executive branch. This means the head of the institution derives his or her authority from the State's chief executive officer for the State education authority or agency

when such officer is elected or appointed independently of the Governor.

(iii) Publicly governed, publicly funded community and technical colleges.

(3) Performance accountability and customer information agencies designated by the Governor of a State to be responsible for coordinating the assessment of State and local education or workforce training program performance and/or evaluating education or workforce training provider performance.

(4) The chief elected official of a local area as defined in WIOA sec. 3(9).

(5) A State educational authority, agency, or institution as those terms are used in the Family Educational Rights and Privacy Act, to the extent they are public entities.

(e) *Secretary* and *Secretary of Labor* mean the cabinet officer heading the United States Department of Labor, or his or her designee.

(f) *State* means a State of the United States of America, the District of Columbia, the Commonwealth of Puerto Rico, and the United States Virgin Islands.

(g) *State UC agency* means an agency charged with the administration of the State UC law.

(h) *State UC law* means the law of a State approved under Section 3304(a) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)).

(i) *Unemployment compensation* (UC) means cash benefits payable to individuals with respect to their unemployment.

(j) *UC information* and *State UC information* means information in the records of a State or State UC agency that pertains to the administration of the State UC law. This term includes those State wage reports collected under the IEVS (Section 1137 of the Social Security Act (SSA)) that are obtained by the State UC agency for determining UC monetary eligibility or are downloaded to the State UC agency's files as a result of a crossmatch but does not otherwise include those wage reports. It does not include information in a State's Directory of New Hires, but does include any such information that has been disclosed to the State UC agency for use in the UC program. It also does not include the personnel or fiscal information of a State UC agency.

(k) *Wage information* means information in the records of a State UC agency (and, for purposes of § 603.23 (IEVS)), information reported under provisions of State law which fulfill the requirements of Section 1137, SSA) about the—

(1) Wages paid to an individual,

(2) Social security account number (or numbers, if more than one) of such individual, and

(3) Name, address, State, and the Federal employer identification number of the employer who paid such wages to such individual.

[71 FR 56842, Sept. 27, 2006, as amended at 81 FR 56333, Aug. 19, 2016]

Subpart B—Confidentiality and Disclosure Requirements

§ 603.3 What is the purpose and scope of this subpart?

This subpart implements the basic confidentiality requirement derived from Section 303(a)(1), SSA, and the disclosure requirements of Sections 303(a)(7), (c)(1), (d), (e), (h), and (i), SSA, and Section 3304(a)(16), Federal Unemployment Tax Act (FUTA). This subpart also establishes uniform minimum requirements for the payment of costs, safeguards, and data-sharing agreements when UC information is disclosed, and for conformity and substantial compliance with this proposed rule. This subpart applies to States and State UC agencies, as defined in § 603.2(f) and (g), respectively.

§ 603.4 What is the confidentiality requirement of Federal UC law?

(a) *Statute.* Section 303(a)(1) of the SSA (42 U.S.C. 503(a)(1)) provides that, for the purposes of certification of payment of granted funds to a State under Section 302(a) (42 U.S.C. 502(a)), State law must include provision for such methods of administration as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due.

(b) *Interpretation.* The Department of Labor interprets Section 303(a)(1), SSA, to mean that ''methods of administration'' that are reasonably calculated to

insure the full payment of UC when due must include provision for maintaining the confidentiality of any UC information which reveals the name or any identifying particular about any individual or any past or present employer or employing unit, or which could foreseeably be combined with other publicly available information to reveal any such particulars, and must include provision for barring the disclosure of any such information, except as provided in this part.

(c) *Application.* Each State law must contain provisions that are interpreted and applied consistently with the interpretation in paragraph (b) of this section and with this subpart, and must provide penalties for any disclosure of confidential UC information that is inconsistent with any provision of this subpart.

§ 603.5 What are the exceptions to the confidentiality requirement?

The following are exceptions to the confidentiality requirement. Disclosure of confidential UC information is permissible under the exceptions in paragraphs (a) through (g) of this section only if authorized by State law and if such disclosure does not interfere with the efficient administration of the State UC law. Disclosure of confidential UC information is permissible under the exceptions in paragraphs (h) and (i) of this section without such restrictions.

(a) *Public domain information.* The confidentiality requirement of § 603.4 does not apply to public domain information, as defined at § 603.2(c).

(b) *UC appeals records.* Disclosure of appeals records and decisions, and precedential determinations on coverage of employers, employment, and wages, is permissible provided all social security account numbers have been removed and such disclosure is otherwise consistent with Federal and State law.

(c) *Individual or employer.* Disclosure for non-UC purposes, of confidential UC information about an individual to that individual, or of confidential UC information about an employer to that employer, is permissible.

(d) *Informed consent.* Disclosure of confidential UC information on the basis of informed consent is permissible in the following circumstances—

(1) *Agent*—to one who acts for or in the place of an individual or an employer by the authority of that individual or employer if—

(i) In general—

(A) The agent presents a written release (which may include an electronically submitted release that the State determines is authentic) from the individual or employer being represented;

(B) When a written release is impossible or impracticable to obtain, the agent presents such other form of consent as is permitted by the State UC agency in accordance with State law;

(ii) In the case of an elected official performing constituent services, the official presents reasonable evidence (such as a letter from the individual or employer requesting assistance or a written record of a telephone request from the individual or employer) that the individual or employer has authorized such disclosure; or

(iii) In the case of an attorney retained for purposes related to the State's UC law, the attorney asserts that he or she is representing the individual or employer.

(2) *Third party (other than an agent) or disclosure made on an ongoing basis*—to a third party that is not acting as an agent or that receives confidential information following an informed consent disclosure on an ongoing basis (even if such entity is an agent), but only if that entity obtains a written release from the individual or employer to whom the information pertains.

(i) The release must be signed and must include a statement—

(A) Specifically identifying the information that is to be disclosed;

(B) That State government files will be accessed to obtain that information;

(C) Of the specific purpose or purposes for which the information is sought and a statement that information obtained under the release will only be used for that purpose or purposes; and

(D) Indicating all the parties who may receive the information disclosed.

(ii) The purpose specified in the release must be limited to—

(A) Providing a service or benefit to the individual signing the release that

such individual expects to receive as a result of signing the release; or

(B) Carrying out administration or evaluation of a public program to which the release pertains.

NOTE TO PARAGRAPH (d): The Electronic Signatures in Global and National Commerce Act of 2000 (E-Sign), Pub. L. 106–229, may apply where a party wishes to effectuate electronically an informed consent release (§ 603.5(d)(2)) or a disclosure agreement (§ 603.10(a)) with an entity that uses informed consent releases. E-Sign, among other things, sets forth the circumstances under which electronic signatures, contracts, and other records relating to such transactions (in lieu of paper documents) are legally binding. Thus, an electronic communication may suffice under E-Sign to establish a legally binding contract. The States will need to consider E-Sign's application to these informed consent releases and disclosure agreements. In particular, a State must, to conform and substantially comply with this regulation, assure that these informed consent releases and disclosure agreements are legally enforceable. If an informed consent release or disclosure agreement is to be effectuated electronically, the State must determine whether E-Sign applies to that transaction, and, if so, make certain that the transaction satisfies the conditions imposed by E-Sign. The State must also make certain that the electronic transaction complies with every other condition necessary to make it legally enforceable.

(e) *Public official.* Disclosure of confidential UC information to a public official for use in the performance of his or her official duties is permissible.

(1) ''Performance of official duties'' means administration or enforcement of law or the execution of the official responsibilities of a Federal, State, or local elected official. Administration of law includes research related to the law administered by the public official. Execution of official responsibilities does not include solicitation of contributions or expenditures to or on behalf of a candidate for public or political office or a political party.

(2) For purposes of § 603.2(d)(2) through (5), ''performance of official duties'' includes, in addition to the activities set out in paragraph (e)(1) of this section, use of the confidential UC information for the following limited purposes:

(i) State and local performance accountability under WIOA sec. 116, including eligible training provider performance accountability under WIOA secs. 116(d) and 122;

(ii) The requirements of discretionary Federal grants awarded under WIOA; or

(iii) As otherwise required for education or workforce training program performance accountability and reporting under Federal or State law.

(f) *Agent or contractor of public official.* Disclosure of confidential UC information to an agent or contractor of a public official to whom disclosure is permissible under paragraph (e) of this section.

(g) *Bureau of Labor Statistics.* The confidentiality requirement does not apply to information collected exclusively for statistical purposes under a cooperative agreement with the Bureau of Labor Statistics (BLS). Further, this part does not restrict or impose any condition on the transfer of any other information to the BLS under an agreement, or the BLS's disclosure or use of such information.

(h) *Court order; official with subpoena authority.* Disclosure of confidential UC information in response to a court order or to an official with subpoena authority is permissible as specified in § 603.7(b).

(i) *UC Program Oversight and Audits.* The confidentiality requirement does not apply to any disclosure to a Federal official for purposes of UC program oversight and audits, including disclosures under 20 CFR part 601 and 29 CFR parts 96 and 97.

[71 FR 56842, Sept. 27, 2006, as amended at 81 FR 56333, Aug. 19, 2016]

§ 603.6 What disclosures are required by this subpart?

(a) The confidentiality requirement of 303(a)(1), SSA, and § 603.4 are not applicable to this paragraph (a) and the Department of Labor interprets Section 303(a)(1), SSA, as requiring disclosure of all information necessary for the proper administration of the UC program. This includes disclosures to claimants, employers, the Internal Revenue Service (for purposes of UC tax administration), and the U.S. Citizenship and Immigration Services (for purposes of verifying a claimant's immigration status).

(b) In addition to Section 303(f), SSA (concerning an IEVS), which is addressed in subpart C, the following provisions of Federal UC law also specifically require disclosure of State UC information and State-held information pertaining to the Federal UC and benefit programs of Unemployment Compensation for Federal Employees (UCFE), Unemployment Compensation for Ex-Servicemembers (UCX), Trade Adjustment Assistance (TAA) (except for confidential business information collected by States), Disaster Unemployment Assistance (DUA), and any Federal UC benefit extension program:

(1) Section 303(a)(7), SSA, requires State law to provide for making available, upon request, to any agency of the United States charged with the administration of public works or assistance through public employment, disclosure of the following information with respect to each recipient of UC—

(i) Name;

(ii) Address;

(iii) Ordinary occupation;

(iv) Employment status; and

(v) A statement of such recipient's rights to further compensation under the State law.

(2) Section 303(c)(1), SSA, requires each State to make its UC records available to the Railroad Retirement Board, and to furnish such copies of its UC records to the Railroad Retirement Board as the Board deems necessary for its purposes.

(3) Section 303(d)(1), SSA, requires each State UC agency, for purposes of determining an individual's eligibility benefits, or the amount of benefits, under a food stamp program established under the Food Stamp Act of 1977, to disclose, upon request, to officers and employees of the Department of Agriculture, and to officers or employees of any State food stamp agency, any of the following information contained in the records of the State UC agency—

(i) Wage information,

(ii) Whether an individual is receiving, has received, or has made application for, UC, and the amount of any such compensation being received, or to be received, by such individual,

(iii) The current (or most recent) home address of such individual, and

(iv) Whether an individual has refused an offer of employment and, if so, a description of the employment so offered and the terms, conditions, and rate of pay therefore.

(4) Section 303(e)(1), SSA, requires each State UC agency to disclose, upon request, directly to officers or employees of any State or local child support enforcement agency, any wage information contained in the records of the State UC agency for purposes of establishing and collecting child support obligations (not to include custodial parent support obligations) from, and locating, individuals owing such obligations.

(5) Section 303(h), SSA, requires each State UC agency to disclose quarterly, to the Secretary of Health and Human Services (HHS), wage information and claim information as required under Section 453(i)(1) of the SSA (establishing the National Directory of New Hires), contained in the records of such agency, for purposes of Subsections (i)(1), (i)(3), and (j) of Section 453, SSA (establishing the National Directory of New Hires and its uses for purposes of child support enforcement, Temporary Assistance to Needy Families (TANF), TANF research, administration of the earned income tax credit, and use by the Social Security Administration).

(6) Section 303(i), SSA, requires each State UC agency to disclose, upon request, to officers or employees of the Department of Housing and Urban Development (HUD) and to representatives of a public housing agency, for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under a housing assistance program of HUD, any of the following information contained in the records of such State agency about any individual applying for or participating in any housing assistance program administered by HUD who has signed a consent form approved by the Secretary of HUD—

(i) Wage information, and

(ii) Whether the individual is receiving, has received, or has made application for, UC, and the amount of any such compensation being received (or to be received) by such individual.

(7) Section 3304(a)(16), FUTA requires each State UC agency—

(i) To disclose, upon request, to any State or political subdivision thereof administering a Temporary Assistance to Needy Families Agency (TANF) program funded under part A of Title IV of the SSA, wage information contained in the records of the State UC agency which is necessary (as determined by the Secretary of HHS in regulations) for purposes of determining an individual's eligibility for TANF assistance or the amount of TANF assistance; and

(ii) To furnish to the Secretary of HHS, in accordance with that Secretary's regulations at 45 CFR 303.108, wage information (as defined at 45 CFR 303.108(a)(2)) and UC information (as defined at 45 CFR 303.108(a)(3)) contained in the records of such agency for the purposes of the National Directory of New Hires established under Section 453(i) of the SSA.

(8) To comply with WIOA sec. 116(e)(4), States must, to the extent practicable, cooperate in the conduct of evaluations (including related research projects) provided for by the Secretary of Labor or the Secretary of Education under the provisions of Federal law identified in WIOA sec. 116(e)(1); WIOA secs. 169 and 242(c)(2)(D); sec. 12(a)(5), 14, and 107 of the Rehabilitation Act of 1973 (29 U.S.C. 709(a)(5), 711, 727) (applied with respect to programs carried out under title I of that Act (29 U.S.C. 720 *et seq.*)); and the investigations provided for by the Secretary of Labor under sec. 10(b) of the Wagner-Peyser Act (29 U.S.C. 49i(b)). For purposes of this part, States must disclose confidential UC information to a Federal official (or an agent or contractor of a Federal official) requesting such information in the course of such evaluations. This disclosure must be done in accordance with appropriate privacy and confidentiality protections established in this part. This disclosure must be made to the ''extent practicable'', which means that the disclosure would not interfere with the efficient administration of the State UC law, as required by § 603.5.

(c) Each State law must contain provisions that are interpreted and applied consistently with the requirements listed in this section.

[71 FR 56842, Sept. 27, 2006, as amended at 81 FR 56333, Aug. 19, 2016]

§ 603.7 What requirements apply to subpoenas, other compulsory processes, and disclosure to officials with subpoena authority?

(a) *In general.* Except as provided in paragraph (b) of this section, when a subpoena or other compulsory process is served upon a State UC agency or the State, any official or employee thereof, or any recipient of confidential UC information, which requires the production of confidential UC information or appearance for testimony upon any matter concerning such information, the State or State UC agency or recipient must file and diligently pursue a motion to quash the subpoena or other compulsory process if other means of avoiding the disclosure of confidential UC information are not successful or if the court has not already ruled on the disclosure. Only if such motion is denied by the court or other forum may the requested confidential UC information be disclosed, and only upon such terms as the court or forum may order, such as that the recipient protect the disclosed information and pay the State's or State UC agency's costs of disclosure.

(b) *Exceptions.* The requirement of paragraph (a) of this section to move to quash subpoenas shall not be applicable, so that disclosure is permissible, where—

(1) *Court Decision*—a subpoena or other compulsory legal process has been served and a court has previously issued a binding precedential decision that requires disclosures of this type, or a well-established pattern of prior court decisions have required disclosures of this type, or

(2) *Official with subpoena authority*—Confidential UC information has been subpoenaed, by a local, State or Federal governmental official, other than a clerk of court on behalf of a litigant, with authority to obtain such information by subpoena under State or Federal law. The State or State UC agency may choose to disclose such confidential UC information to these officials without the actual issuance of a subpoena.

§ 603.8 What are the requirements for payment of costs and program income?

(a) *In general.* Except as provided in paragraph (b) of this section, grant funds must not be used to pay any of the costs of making any disclosure of UC information. Grant funds may not be used to pay any of the costs of making any disclosures under § 603.5(d)(2) (third party (other than an agent) or disclosure made on an ongoing basis), § 603.5(e) (optional disclosure to a public official), § 603.5(f) (optional disclosure to an agent or contractor of a public official), and § 603.5(g) (optional disclosure to BLS), § 603.6(b) (mandatory disclosures for non-UC purposes), or § 603.22 (mandatory disclosure for purposes of an IEVS).

(b) *Use of grant funds permitted.* Grant funds paid to a State under Section 302(a), SSA, may be used to pay the costs of only those disclosures necessary for proper administration of the UC program. (This may include some disclosures under § 603.5(a) (concerning public domain information), § 603.5(c) (to an individual or employer), and § 603.5(d)(1) (to an agent).) In addition, grant funds may be used to pay costs of disclosures under § 603.5(i) (for UC Program Oversight and Audits) and § 603.6(a) (for the proper administration of the UC program). Grant funds may also be used to pay costs associated with disclosures under § 603.7(b)(1) (concerning court-ordered compliance with subpoenas) if a court has denied recovery of costs, or to pay costs associated with disclosures under § 603.7(b)(2) (to officials with subpoena authority) if the State UC agency has attempted but not been successful in obtaining reimbursement of costs. Finally, grant funds may be used to pay costs associated with any disclosure of UC information if not more than an incidental amount of staff time and no more than nominal processing costs are involved in making the disclosure.

(c) *Calculation of costs.* The costs to a State or State UC agency of processing and handling a request for disclosure of information must be calculated in accordance with the cost principles and administrative requirements of 29 CFR part 97 and Office of Management and Budget Circular No. A–87 (Revised). For the purpose of calculating such costs, any initial start-up costs incurred by the State UC agency in preparation for making the requested disclosure(s), such as computer reprogramming necessary to respond to the request, and the costs of implementing safeguards and agreements required by §§ 603.9 and 603.10, must be charged to and paid by the recipient. (Start-up costs do not include the costs to the State UC agency of obtaining, compiling, or maintaining information for its own purposes.) Postage or other delivery costs incurred in making any disclosure are part of the costs of making the disclosure. Penalty mail, as defined in 39 U.S.C. 3201(1), must not be used to transmit information being disclosed, except information disclosed for purposes of administration of State UC law. As provided in Sections 453(e)(2) and 453(g) of the SSA, the Secretary of HHS has the authority to determine what constitutes a reasonable amount for the reimbursement for disclosures under Section 303(h), SSA, and Section 3304(a)(16)(B), FUTA.

(d) *Payment of costs.* The costs to a State or State UC agency of making a disclosure of UC information, calculated in accordance with paragraph (c) of this section, must be paid by the recipient of the information or another source paying on behalf of the recipient, either in advance or by way of reimbursement. If the recipient is not a public official, such costs, except for good reason must be paid in advance. For the purposes of this paragraph (d), payment in advance means full payment of all costs before or at the time the disclosed information is given in hand or sent to the recipient. The requirement of payment of costs in this paragraph is met when a State UC agency has in place a reciprocal cost agreement or arrangement with the recipient. As used in this section, *reciprocal* means that the relative benefits received by each are approximately equal. Payment or reimbursement of costs must include any initial start-up costs associated with making the disclosure.

(e) *Program income.* Costs paid as required by this section, and any funds generated by the disclosure of UC information under this part, are program

income and may be used only as permitted by 29 CFR 97.25(g) (on program income). Such income may not be used to benefit a State's general fund or other program.

§ 603.9 What safeguards and security requirements apply to disclosed information?

(a) *In general.* For disclosures of confidential UC information under § 603.5(d)(2) (to a third party (other than an agent) or disclosures made on an ongoing basis); § 603.5(e) (to a public official), except as provided in paragraph (d) of this section; § 603.5(f) (to an agent or contractor of a public official); § 603.6(b)(1) through (4), (6), and (7)(i) (as required by Federal UC law); and § 603.22 (to a requesting agency for purposes of an IEVS), a State or State UC agency must require the recipient to safeguard the information disclosed against unauthorized access or redisclosure, as provided in paragraphs (b) and (c) of this section, and must subject the recipient to penalties provided by the State law for unauthorized disclosure of confidential UC information.

(b) *Safeguards to be required of recipients.* (1) The State or State UC agency must:

(i) Require the recipient to use the disclosed information only for purposes authorized by law and consistent with an agreement that meets the requirements of § 603.10;

(ii) Require the recipient to store the disclosed information in a place physically secure from access by unauthorized persons;

(iii) Require the recipient to store and process disclosed information maintained in electronic format, such as magnetic tapes or discs, in such a way that unauthorized persons cannot obtain the information by any means;

(iv) Require the recipient to undertake precautions to ensure that only authorized personnel are given access to disclosed information stored in computer systems;

(v) Require each recipient agency or entity to:

(A) Instruct all personnel having access to the disclosed information about confidentiality requirements, the requirements of this subpart B, and the sanctions specified in the State law for unauthorized disclosure of information, and

(B) Sign an acknowledgment that all personnel having access to the disclosed information have been instructed in accordance with paragraph (b)(1)(v)(A) of this section and will adhere to the State's or State UC agency's confidentiality requirements and procedures which are consistent with this subpart B and the agreement required by § 603.10, and agreeing to report any infraction of these rules to the State UC agency fully and promptly,

(vi) Require the recipient to dispose of information disclosed or obtained, and any copies thereof made by the recipient agency, entity, or contractor, after the purpose for which the information is disclosed is served, except for disclosed information possessed by any court. Disposal means return of the information to the disclosing State or State UC agency or destruction of the information, as directed by the State or State UC agency. Disposal includes deletion of personal identifiers by the State or State UC agency in lieu of destruction. In any case, the information disclosed must not be retained with personal identifiers for longer than such period of time as the State or State UC agency deems appropriate on a case-by-case basis; and

(vii) Maintain a system sufficient to allow an audit of compliance with the requirements of this part.

(2) In the case of disclosures made under § 603.5(d)(2) (to a third party (other than an agent) or disclosures made on an ongoing basis), the State or State UC agency must also—

(i) Periodically audit a sample of transactions accessing information disclosed under that section to assure that the entity receiving disclosed information has on file a written release authorizing each access. The audit must ensure that the information is not being used for any unauthorized purpose;

(ii) Ensure that all employees of entities receiving access to information disclosed under § 603.5(d)(2) are subject to the same confidentiality requirements, and State criminal penalties for

violation of those requirements, as are employees of the State UC agency.

(c) *Redisclosure of confidential UC information.* (1) A State or State UC agency may authorize any recipient of confidential UC information under paragraph (a) of this section to redisclose information only as follows:

(i) To the individual or employer who is the subject of the information;

(ii) To an attorney or other duly authorized agent representing the individual or employer;

(iii) In any civil or criminal proceedings for or on behalf of a recipient agency or entity;

(iv) In response to a subpoena only as provided in § 603.7;

(v) To an agent or contractor of a public official only if the person redisclosing is a public official, if the redisclosure is authorized by the State law, and if the public official retains responsibility for the uses of the confidential UC information by the agent or contractor;

(vi) From one public official to another if the redisclosure is authorized by the State law;

(vii) When so authorized by Section 303(e)(5), SSA, (redisclosure of wage information by a State or local child support enforcement agency to an agent under contract with such agency for purposes of carrying out child support enforcement) and by State law; or

(viii) When specifically authorized by a written release that meets the requirements of § 603.5(d) (to a third party with informed consent).

(2) Information redisclosed under paragraphs (c)(1)(v) and (vi) of this section must be subject to the safeguards in paragraph (b) of this section.

(d) The requirements of this section do not apply to disclosures of UC information to a Federal agency which the Department has determined, by notice published in the FEDERAL REGISTER, to have in place safeguards adequate to satisfy the confidentiality requirement of Section 303(a)(1), SSA.

§ 603.10 What are the requirements for agreements?

(a) *Requirements.* (1) For disclosures of confidential UC information under § 603.5(d)(2) (to a third party (other than an agent) or disclosures made on an ongoing basis); § 603.5(e) (to a public official), except as provided in paragraph (d) of this section; § 603.5(f) (to an agent or contractor of a public official); § 603.6(b)(1) through (4), (6), and (7)(i) (as required by Federal UC law); and § 603.22 (to a requesting agency for purposes of an IEVS), a State or State UC agency must enter into a written, enforceable agreement with any agency or entity requesting disclosure(s) of such information. The agreement must be terminable if the State or State UC agency determines that the safeguards in the agreement are not adhered to.

(2) For disclosures referred to in § 603.5(f) (to an agent or contractor of a public official), the State or State UC agency must enter into a written, enforceable agreement with the public official on whose behalf the agent or contractor will obtain information. The agreement must hold the public official responsible for ensuring that the agent or contractor complies with the safeguards of § 603.9. The agreement must be terminable if the State or State UC agency determines that the safeguards in the agreement are not adhered to.

(b) *Contents of agreement*—(1) *In general.* Any agreement required by paragraph (a) of this section must include, but need not be limited to, the following terms and conditions:

(i) A description of the specific information to be furnished and the purposes for which the information is sought;

(ii) A statement that those who request or receive information under the agreement will be limited to those with a need to access it for purposes listed in the agreement;

(iii) The methods and timing of requests for information and responses to those requests, including the format to be used;

(iv) Provision for paying the State or State UC agency for any costs of furnishing information, as required by § 603.8 (on costs);

(v) Provision for safeguarding the information disclosed, as required by § 603.9 (on safeguards); and

(vi) Provision for on-site inspections of the agency, entity, or contractor, to assure that the requirements of the

State's law and the agreement or contract required by this section are being met.

(2) In the case of disclosures under § 603.5(d)(2) (to a third party (other than an agent) or disclosures made on an ongoing basis), the agreement required by paragraph (a) of this section must assure that the information will be accessed by only those entities with authorization under the individual's or employer's release, and that it may be used only for the specific purposes authorized in that release.

(c) *Breach of agreement*—(1) *In general.* If an agency, entity, or contractor, or any official, employee, or agent thereof, fails to comply with any provision of an agreement required by this section, including timely payment of the State's or State UC agency's costs billed to the agency, entity, or contractor, the agreement must be suspended, and further disclosure of information (including any disclosure being processed) to such agency, entity, or contractor is prohibited, until the State or State UC agency is satisfied that corrective action has been taken and there will be no further breach. In the absence of prompt and satisfactory corrective action, the agreement must be canceled, and the agency, entity, or contractor must be required to surrender to the State or State UC agency all confidential UC information (and copies thereof) obtained under the agreement which has not previously been returned to the State or State UC agency, and any other information relevant to the agreement.

(2) *Enforcement.* In addition to the actions required to be taken by paragraph (c)(1) of this section, the State or State UC agency must undertake any other action under the agreement, or under any law of the State or of the United States, to enforce the agreement and secure satisfactory corrective action or surrender of the information, and must take other remedial actions permitted under State or Federal law to effect adherence to the requirements of this subpart B, including seeking damages, penalties, and restitution as permitted under such law for any charges to granted funds and all costs incurred by the State or the State UC agency in pursuing the breach of the agreement and enforcement as required by this paragraph (c).

(d) The requirements of this section do not apply to disclosures of UC information to a Federal agency which the Department has determined, by notice published in the FEDERAL REGISTER, to have in place safeguards adequate to satisfy the confidentiality requirement of Section 303(a)(1), SSA, and an appropriate method of paying or reimbursing the State UC agency (which may involve a reciprocal cost arrangement) for costs involved in such disclosures. These determinations will be published in the FEDERAL REGISTER.

§ 603.11 How do States notify claimants and employers about the uses of their information?

(a) *Claimants.* Every claimant for compensation must be notified, at the time of application, and periodically thereafter, that confidential UC information pertaining to the claimant may be requested and utilized for other governmental purposes, including, but not limited to, verification of eligibility under other government programs. Notice on or attached to subsequent additional claims will satisfy the requirement for periodic notice thereafter.

(b) *Employers.* Every employer subject to a State's law must be notified that wage information and other confidential UC information may be requested and utilized for other governmental purposes, including, but not limited to, verification of an individual's eligibility for other government programs.

§ 603.12 How are the requirements of this part enforced?

(a) *Resolving conformity and compliance issues.* For the purposes of resolving issues of conformity and substantial compliance with the requirements set forth in subparts B and C, the provisions of 20 CFR 601.5(b) (informal discussions with the Department of Labor to resolve conformity and substantial compliance issues), and 20 CFR 601.5(d) (Secretary of Labor's hearing and decision on conformity and substantial compliance) apply.

(b) *Conformity and substantial compliance.* Whenever the Secretary of Labor, after reasonable notice and opportunity for a hearing to the State UC

agency of a State, finds that the State law fails to conform, or that the State or State UC agency fails to comply substantially, with:

(1) The requirements of Title III, SSA, implemented in subparts B and C of this part, the Secretary of Labor shall notify the Governor of the State and such State UC agency that further payments for the administration of the State UC law will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, the Department of Labor shall make no further payments to such State.

(2) The FUTA requirements implemented in this subpart B, the Secretary of Labor shall make no certification under that section to the Secretary of the Treasury for such State as of October 31 of the 12-month period for which such finding is made.

Subpart C—Mandatory Disclosure for Income and Eligibility Verification System (IEVS)

§ 603.20 What is the purpose and scope of this subpart?

(a) *Purpose.* Subpart C implements Section 303(f), SSA. Section 303(f) requires States to have in effect an income and eligibility verification system, which meets the requirements of Section 1137, SSA, under which information is requested and exchanged for the purpose of verifying eligibility for, and the amount of, benefits available under several federally assisted programs, including the Federal-State UC program.

(b) *Scope.* This subpart C applies only to a State UC agency.

NOTE TO PARAGRAPH (b): Although not implemented in this part 603, Section 1137(a)(1), SSA, provides that each State must require claimants for compensation to furnish to the State UC agency their social security account numbers, as a condition of eligibility for compensation, and further requires States to utilize such account numbers in the administration of the State UC laws. Section 1137(a)(3), SSA, further provides that employers must make quarterly wage reports to a State UC agency, or an alternative agency, for use in verifying eligibility for, and the amount of, benefits. Section 1137(d)(1), SSA, provides that each State must require claimants for compensation, as a condition of eligibility, to declare in writing, under penalty of perjury, whether the individual is a citizen or national of the United States, and, if not, that the individual is in a satisfactory immigration status. Other provisions of Section 1137(d), SSA, not implemented in this regulation require the States to obtain, and individuals to furnish, information which shows immigration status, and require the States to verify immigration status with the Bureau of Citizenship and Immigration Services.

§ 603.21 What is a requesting agency?

For the purposes of this subpart C, *requesting agency* means:

(a) *Temporary Assistance to Needy Families Agency*—Any State or local agency charged with the responsibility of administering a program funded under part A of Title IV of the SSA.

(b) *Medicaid Agency*—Any State or local agency charged with the responsibility of administering the provisions of the Medicaid program under a State plan approved under Title XIX of the SSA.

(c) *Food Stamp Agency*—Any State or local agency charged with the responsibility of administering the provisions of the Food Stamp Program under the Food Stamp Act of 1977.

(d) *Other SSA Programs Agency*—Any State or local agency charged with the responsibility of administering a program under a State plan approved under Title I, X, XIV, or XVI (Supplemental Security Income for the Aged, Blind, and Disabled) of the SSA.

(e) *Child Support Enforcement Agency*—Any State or local child support enforcement agency charged with the responsibility of enforcing child support obligations under a plan approved under part D of Title IV of the SSA.

(f) *Social Security Administration*—Commissioner of the Social Security Administration in establishing or verifying eligibility or benefit amounts under Titles II (Old-Age, Survivors, and Disability Insurance Benefits) and XVI (Supplemental Security Income for the Aged, Blind, and Disabled) of the SSA.

§ 603.22 What information must State UC agencies disclose for purposes of an IEVS?

(a) *Disclosure of information.* Each State UC agency must disclose, upon request, to any requesting agency, as

defined in § 603.21, that has entered into an agreement required by § 603.10, wage information (as defined at § 603.2(k)) and claim information (as defined at § 603.2(a)) contained in the records of such State UC agency.

(b) *Format.* The State UC agency must adhere to standardized formats established by the Secretary of HHS (in consultation with the Secretary of Agriculture) and set forth in 42 CFR 435.960 (concerning standardized formats for furnishing and obtaining information to verify income and eligibility).

§ 603.23 What information must State UC agencies obtain from other agencies, and crossmatch with wage information, for purposes of an IEVS?

(a) *Crossmatch with information from requesting agencies.* Each State UC agency must obtain such information from the Social Security Administration and any requesting agency as may be needed in verifying eligibility for, and the amount of, compensation payable under the State UC law.

(b) *Crossmatch of wage and benefit information.* The State UC agency must crossmatch quarterly wage information with UC payment information to the extent that such information is likely, as determined by the Secretary of Labor, to be productive in identifying ineligibility for benefits and preventing or discovering incorrect payments.

PART 604—REGULATIONS FOR ELIGIBILITY FOR UNEMPLOYMENT COMPENSATION

Sec.

604.1 Purpose and scope.
604.2 Definitions.
604.3 Able and available requirement—general principles.
604.4 Application—ability to work.
604.5 Application—availability for work.
604.6 Conformity and substantial compliance.

AUTHORITY: 42 U.S.C. 1302(a); 42 U.S.C. 503(a)(2) and (5); 26 U.S.C. 3304(a)(1) and (4); 26 U.S.C. 3306(h); 42 U.S.C. 1320b–7(d); Secretary's Order No. 4–75 (40 FR 18515); and Secretary's Order No. 14–75 (November 12, 1975).

SOURCE: 72 FR 1893, Jan. 16, 2007, unless otherwise noted.

§ 604.1 Purpose and scope.

The purpose of this Part is to implement the requirements of Federal UC law that limit a State's payment of UC to individuals who are able to work and available for work. This regulation applies to all State UC laws and programs.

§ 604.2 Definitions.

(a) *Department* means the United States Department of Labor.

(b) *FUTA* means the Federal Unemployment Tax Act, 26 U.S.C. 3301 *et seq.*

(c) *Social Security Act* means the Social Security Act, 42 U.S.C. 501 *et seq.*

(d) *State* means a State of the United States of America, the District of Columbia, the Commonwealth of Puerto Rico, and the United States Virgin Islands.

(e) *State UC agency* means the agency of the State charged with the administration of the State's UC law.

(f) *State UC law* means the law of a State approved under Section 3304(a), FUTA (26 U.S.C. 3304(a)).

(g) *Unemployment Compensation (UC)* means cash benefits payable to individuals with respect to their unemployment.

(h) *Week of unemployment* means a week of total, part-total or partial unemployment as defined in the State's UC law.

§ 604.3 Able and available requirement—general principles.

(a) A State may pay UC only to an individual who is able to work and available for work for the week for which UC is claimed.

(b) Whether an individual is able to work and available for work under paragraph (a) of this section must be tested by determining whether the individual is offering services for which a labor market exists. This requirement does not mean that job vacancies must exist, only that, at a minimum, the type of services the individual is able and available to perform is generally performed in the labor market. The State must determine the geographical scope of the labor market for an individual under its UC law.

(c) The requirement that an individual be able to work and available for

work applies only to the week of unemployment for which UC is claimed. It does not apply to the reasons for the individual's separation from employment, although the separation may indicate the individual was not able to work or available for work during the week the separation occurred. This Part does not address the authority of States to impose disqualifications with respect to separations. This Part does not limit the States' ability to impose additional able and available requirements that are consistent with applicable Federal laws.

§ 604.4 Application—ability to work.

(a) A State may consider an individual to be able to work during the week of unemployment claimed if the individual is able to work for all or a portion of the week claimed, provided any limitation on his or her ability to work does not constitute a withdrawal from the labor market.

(b) If an individual has previously demonstrated his or her ability to work and availability for work following the most recent separation from employment, the State may consider the individual able to work during the week of unemployment claimed despite the individual's illness or injury, unless the individual has refused an offer of suitable work due to such illness or injury.

§ 604.5 Application—availability for work.

(a) *General application.* A State may consider an individual to be available for work during the week of unemployment claimed under any of the following circumstances:

(1) The individual is available for any work for all or a portion of the week claimed, provided that any limitation placed by the individual on his or her availability does not constitute a withdrawal from the labor market.

(2) The individual limits his or her availability to work which is suitable for such individual as determined under the State UC law, provided the State law definition of suitable work does not permit the individual to limit his or her availability in such a way that the individual has withdrawn from the labor market. In determining whether the work is suitable, States may, among other factors, take into consideration the education and training of the individual, the commuting distance from the individual's home to the job, the previous work history of the individual (including salary and fringe benefits), and how long the individual has been unemployed.

(3) The individual is on temporary lay-off and is available to work only for the employer that has temporarily laid-off the individual.

(b) *Jury service.* If an individual has previously demonstrated his or her availability for work following the most recent separation from employment and is appearing for duty before any court under a lawfully issued summons during the week of unemployment claimed, a State may consider the individual to be available for work. For such an individual, attendance at jury duty may be taken as evidence of continued availability for work. However, if the individual does not appear as required by the summons, the State must determine if the reason for nonattendance indicates that the individual is not able to work or is not available for work.

(c) *Approved training.* A State must not deny UC to an individual for failure to be available for work during a week if, during such week, the individual is in training with the approval of the State agency. However, if the individual fails to attend or otherwise participate in such training, the State must determine if the reason for nonattendance or non-participation indicates that the individual is not able to work or is not available for work.

(d) *Self-employment assistance.* A State must not deny UC to an individual for failure to be available for work during a week if, during such week, the individual is participating in a self-employment assistance program and meets all the eligibility requirements of such self-employment assistance program.

(e) *Short-time compensation.* A State must not deny UC to an individual participating in a short-time compensation (also known as worksharing) program under State UC law for failure to be available for work during a week, but such individual will be required to

be available for his or her normal workweek.

(f) *Alien status.* To be considered available for work in the United States for a week, the alien must be legally authorized to work that week in the United States by the appropriate agency of the United States government. In determining whether an alien is legally authorized to work in the United States, the State must follow the requirements of section 1137(d) of the SSA (42 U.S.C. 1320b-7(d)), which relate to verification of and determination of an alien's status.

(g) *Relation to ability to work requirement.* A State may consider an individual available for work if the State finds the individual able to work under § 604.4(b) despite illness or injury.

(h) *Work search.* The requirement that an individual be available for work does not require an active work search on the part of the individual. States may, however, require an individual to be actively seeking work to be considered available for work, or States may impose a separate requirement that the individual must actively seek work.

§ 604.6 Conformity and substantial compliance.

(a) *In general.* A State's UC law must conform with, and the administration of its law must substantially comply with, the requirements of this regulation for purposes of certification under:

(1) Section 3304(c) of the FUTA (26 U.S.C. 3304(c)), with respect to whether employers are eligible to receive credit against the Federal unemployment tax established by section 3301 of the FUTA (26 U.S.C. 3301), and

(2) Section 302 of the SSA (42 U.S.C. 502), with respect to whether a State is eligible to receive Federal grants for the administration of its UC program.

(b) *Resolving Issues of Conformity and Substantial Compliance.* For the purposes of resolving issues of conformity and substantial compliance with the requirements of this regulation, the following provisions of 20 CFR 601.5 apply:

(1) Paragraph (b) of this section, pertaining to informal discussions with the Department of Labor to resolve conformity and substantial compliance issues, and

(2) Paragraph (d) of this section, pertaining to the Secretary of Labor's hearing and decision on conformity and substantial compliance.

(c) *Result of failure to conform or substantially comply*—(1) *FUTA requirements.* Whenever the Secretary of Labor, after reasonable notice and opportunity for a hearing to the State UC agency, finds that the State UC law fails to conform, or that the State or State UC agency fails to comply substantially, with the requirements of the FUTA, as implemented in this regulation, then the Secretary of Labor shall make no certification under such act to the Secretary of the Treasury for such State as of October 31 of the 12-month period for which such finding is made. Further, the Secretary of Labor must notify the Governor of the State and such State UC agency that further payments for the administration of the State UC law will not be made to the State.

(2) *SSA requirements.* Whenever the Secretary of Labor, after reasonable notice and opportunity for a hearing to the State UC agency, finds that the State UC law fails to conform, or that the State or State UC agency fails to comply substantially, with the requirements of title III, SSA (42 U.S.C. 501–504), as implemented in this regulation, then the Secretary of Labor must notify the Governor of the State and such State UC agency that further payments for the administration of the State UC law will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, the Department of Labor will not make further payments to such State.

PART 606—TAX CREDITS UNDER THE FEDERAL UNEMPLOYMENT TAX ACT; ADVANCES UNDER TITLE XII OF THE SOCIAL SECURITY ACT

Subpart A—General

Sec.

606.1 Purpose and scope.
606.2 Total credits allowable.
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Subpart C—Relief From Tax Credit Reduction

606.20 Cap on tax credit reduction.
606.21 Criteria for cap.
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606.24 Application for avoidance.
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Subpart D—Interest on Advances

606.30 Interest rates on advances.
606.31 Due dates for payment of interest. [Reserved]
606.32 Types of advances subject to interest.
606.33 No payment of interest from unemployment fund. [Reserved]
606.34 Reports of interest payable. [Reserved]
606.35 Order of application for repayments. [Reserved]

Subpart E—Relief from Interest Payment

606.40 May/September delay.
606.41 High unemployment deferral.
606.42 High unemployment delay.
606.44 Notification of determinations.

AUTHORITY: 42 U.S.C. 1102; 42 U.S.C. 1322(b)(2)(C); 26 U.S.C. 7805(a); Secretary's Order No. 3–2007, April 3, 2007 (72 FR 15907).

SOURCE: 53 FR 37429, Sept. 26, 1988, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 606 appear at 71 FR 35513, June 21, 2006.

Subpart A—General

§ 606.1 Purpose and scope.

(a) *In general.* The regulations in this part 606 are issued to implement the tax credit provisions of the Federal Unemployment Tax Act, and the loan provisions of title XII of the Social Security Act. The regulations on tax credits cover all of the subjects of 3302 of the Federal Unemployment Tax Act (FUTA), except subsections (c)(3) and (e). The regulations on loans cover all of the subjects in title XII of the Social Security Act.

(b) *Scope.* This part 606 covers general matters relating to this part in this subpart A, and in the following subparts includes specific subjects described in general terms as follows:

(1) Subpart B describes the tax credit reductions under the Federal Unemployment Tax Act, which relate to outstanding balances of advances made under title XII of the Social Security Act.

(2) Subpart C describes the various forms of relief from tax credit reductions, and the criteria and standards for grant of such relief in the form of—

(i) A cap on tax credit reduction,

(ii) Avoidance of tax credit reduction, and

(iii) Waiver of and substitution for additional tax credit reduction.

(3) Subpart D describes the interest rates on advances made under title XII of the Social Security Act, dues dates for payment of interest, and other related matters.

(4) Subpart E describes the various forms of relief from payment of interest, and the criteria and standards for grant of such relief in the form of—

(i) May/September delay of interest payments,

(ii) High unemployment deferral of interest payments,

(iii) High unemployment delay of interest payments, and

(iv) Maintenance of solvency effort required to retain a deferral previously granted.

§ 606.2 Total credits allowable.

The total credits allowed to an employer subject to the tax imposed by section 3301 of the Federal Unemployment Tax Act shall not exceed 5.4 percent with respect to taxable years beginning after December 31, 1984.

§ 606.3 Definitions.

For the purposes of the Acts cited and this part—

Act means as appropriate the Federal Unemployment Tax Act (26 U.S.C. 3301–3311), or title XII of the Social Security Act (42 U.S.C. 1321–1324).

Advance means a transfer of funds to a State unemployment fund, for the purpose of paying unemployment compensation, from the Federal unemployment account in the Unemployment

Trust Fund, pursuant to section 1202 of the Social Security Act.

Average High Cost Multiple (AHCM) for a State as of December 31 of a calendar year is calculated by dividing the State's reserve ratio, as defined in § 606.3, by the State's average high cost rate (AHCR), as defined in § 606.3, for the same year. Final calculations are rounded to the nearest multiple of 0.01.

Average High Cost Rate (AHCR) for a State is calculated as follows:

(1) Determine the time period over which calculations are to be made by selecting the longer of:

(i) The 20-calendar year period that ends with the year for which the AHCR calculation is made; or

(ii) The number of years beginning with the calendar year in which the first of the last three completed national recessions began, as determined by the National Bureau of Economic Research, and ending with the calendar year for which the AHCR is being calculated.

(2) For each calendar year during the selected time period, calculate the benefit-cost ratio, as defined in § 606.3; and

(3) Average the three highest calendar year benefit cost ratios for the selected time period from paragraph (2) of this definition. Final calculations are rounded to the nearest multiple of 0.01 percent.

Benefit-cost ratio for a calendar year is the percentage obtained by dividing—

(1) The total dollar sum of—

(i) All compensation actually paid under the State law during such calendar year, including in such total sum all regular, additional, and extended compensation, as defined in section 205 of the Federal-State Extended Unemployment Compensation Act of 1970, and excluding from such total sum—

(A) Any such compensation paid for which the State is entitled to reimbursement or was reimbursed under the provisions of any Federal Law, and

(B) Any such compensation paid which is attributable to services performed for a reimbursing employer, and which is not included in the total dollar amount reported under paragraph (c)(1)(i)(A) of this section, and

(ii) Any interest paid during such calendar year on any advance, by

(2) The total wages (as defined in § 606.3) with respect to such calendar year.

(3) For cap purposes, if any percentage determined by this computation for a calendar year is not a multiple of 0.1 percent, such percentage shall be reduced to the nearest multiple of 0.1 percent. For funding goal purposes, if any percentage determined by this computation for a calendar year is not a multiple of 0.01 percent, such percentage is rounded to the nearest multiple of 0.01 percent.

Contributions means payments required by a State law to be made into an unemployment fund by any person on account of having individuals in his employ, to the extent that such payments are made by him without being deducted or deductible from the remuneration of individuals in his employ.

Federal unemployment tax means the excise tax imposed under section 3301 of the Federal Unemployment Tax Act on employers with respect to having individuals in their employ.

Fiscal year means the Federal fiscal year which begins on October 1 of a year and ends on September 30, of the next succeeding year.

FUTA refers to the Federal Unemployment Tax Act.

Reserve ratio is calculated by dividing the balance in the State's account in the unemployment trust fund (UTF) as of December 31 of such year by the total wages paid workers covered by the unemployment compensation (UC) program during the 12 months ending on December 31 of such year. Final calculations are rounded to the nearest multiple of 0.01 percent.

State unemployment fund or *unemployment fund* means a special fund established under a State law for the payment of unemployment compensation to unemployed individuals, and which is an ''unemployment fund'' as defined in section 3306(f) of the Federal Unemployment Tax Act.

Taxable year means the calendar year.

Unemployment tax rate means, for any taxable year and with respect to any

State, the percentage obtained by dividing the total amount of contributions paid into the State unemployment fund with respect to such taxable year by total wages as defined in § 606.3.

Wages, taxable means the total sum of remuneration which is subject to contributions under a State law.

Wages, total means the total sum of all remuneration covered by a State law, disregarding any dollar limitation on the amount of remuneration which is subject to contributions under the State law.

[53 FR 37429, Sept. 26, 1988, as amended at 71 FR 35513, June 21, 2006; 75 FR 57156, Sept. 17, 2010]

§ 606.4 Redelegation of authority.

(a) *Redelegation to OWS Administrator.* The Administrator, Office of Workforce Security (hereinafter ''OWS Administrator''), is redelegated authority to make the determinations required under this part. This redelegation is contained in Employment and Training Order No. 1–84, published in the FEDERAL REGISTER on November 14, 1983 (48 FR 51870).

(b) *Delegation by Governor.* The Governor of a State, as used in this part, refers to the highest executive official of a State. Wherever in this part an action is required by or of the Governor of a State, such action may be taken by the Governor or may be taken by a delegatee of the Governor if the Department is furnished appropriate proof of an authoritative delegation of authority.

[53 FR 37429, Sept. 26, 1988, as amended at 71 FR 35514, June 21, 2006]

§ 606.5 Verification of estimates and review of determinations.

The Department of Labor (hereinafter ''Department'') shall verify all information and data provided by a State under this part, and the State shall comply with such provisions as the Department considers necessary to assure the correctness and verification of such information and data. The State agency of a State affected by a determination made by the OWS Administrator under this part may seek review of such determination by a higher level official of the Employment and Training Administration.

§ 606.6 Information, reports, and studies.

A State shall furnish to the Secretary of Labor such information and reports and conduct such studies as the Secretary determines are necessary or appropriate for carrying out the purposes of this part, including any additional information or data the OWS Administrator may require for the purposes of making determinations under subparts C and E of this part.

[53 FR 37429, Sept. 26, 1988, as amended at 71 FR 35514, June 21, 2006]

Subpart B—Tax Credit Reduction [Reserved]

Subpart C—Relief From Tax Credit Reduction

§ 606.20 Cap on tax credit reduction.

(a) *Applicability.* Subsection (f) of section 3302 of FUTA authorizes a limitation (cap) on the reduction of tax credits by reason of an outstanding balance of advances, if the OWS Administrator determines with respect to a State, on or before November 10 of a taxable year, that—

(1) No action was taken by the State during the 12-month period ending on September 30 of such taxable year which has resulted, or will result, in a reduction in the State's unemployment tax effort, as defined in § 606.21(a);

(2) No action was taken by the State during the 12-month period ending on September 30 of such taxable year which has resulted, or will result, in a net decrease in the solvency of the State unemployment compensation system, as defined in § 606.21(b);

(3) The State unemployment tax rate (as defined in § 606.3) for the taxable year equals or exceeds the average benefit-cost ratio (as defined in § 606.3) for the calendar years in the five-calendar year period ending with the calendar year immediately preceding the taxable year for which the cap is requested, under the rules specified in § 606.21 (c) and (d); and

(4) The outstanding balance of advances to the State on September 30 of the taxable year was not greater than the outstanding balance of advances to

the State on September 30 of the third preceding taxable year.

(b) *Maximum tax credit reduction.* If a State qualifies for a cap, the maximum tax credit reduction for the taxable year shall not exceed 0.6 percent, or, if higher, the tax credit reduction that was in effect for the taxable year preceding the taxable year for which the cap is requested.

(c) *Year not taken into account.* If a State qualifies for a cap for any year, the year and January 1 of the year to which the cap applies will not be taken into account for purposes of determining reduction of tax credit for subsequent taxable years.

(d) *Partial caps.* Partial caps obtained under subsection (f)(8) are no longer available. Nevertheless, for the purposes of applying section 3302(c)(2) to subsequent taxable years, partial cap credits earned will be taken into account for purposes of determining reduction of tax credits. Also, the taxable year to which the partial cap applied (and January 1 thereof) will be taken into account for purposes of determining reduction of tax credits for subsequent taxable years.

[53 FR 37429, Sept. 26, 1988, as amended at 75 FR 57156, Sept. 17, 2010]

§ 606.21 Criteria for cap.

(a) *Reduction in unemployment tax effort.* (1) For purposes of paragraph (a)(1) of § 606.20, a reduction in a State's unemployment tax effort will have occurred with respect to a taxable year if any action is or was taken (legislative, judicial, or administrative,) that is effective during the 12-month period ending on September 30 of such taxable year, which has resulted in or will result in a reduction of the amount of contributions paid or payable or the amounts that were or would have been paid or payable but for such action.

(2) Actions that will result in a reduction in tax effort include, but are not limited to, a reduction in the taxable wage base, the tax rate schedule, tax rates, or taxes payable (including surtaxes) that would not have gone into effect but for the legislative, judicial, or administrative action taken. Notwithstanding the foregoing criterion, a reduction in unemployment tax effort resulting from any provision of the State law enacted prior to August 13, 1981, will not be taken into account as a reduction in the State's unemployment tax effort for the purposes of this section.

(b) *Net decrease in solvency.* For purposes of paragraph (a)(2) of § 606.20, a net decrease in the solvency of the State's unemployment compensation system will have occurred with respect to a taxable year if any action is or was taken (legislative, judicial, or administrative), that is effective during the 12-month period ending on September 30 of such taxable year, which has resulted in or will result in an increase in benefits without at least an equal increase in taxes, or a decrease in taxes without at least an equal decrease in benefits. Notwithstanding the foregoing criterion, a decrease in solvency resulting from any provision of the State law enacted prior to August 13, 1981, will not be taken into account as a reduction in solvency of the State's unemployment compensation system for the purposes of this section.

(c) *State unemployment tax rate.* For purposes of paragraph (a)(3) of § 606.20, the State unemployment tax rate is defined in § 606.3. If such percentage is not a multiple of 0.1 percent, the percentage shall remain unrounded.

(d) *State five-year average benefit cost ratio.* The average benefit-cost ratio for the 5 preceding calendar years is the percentage determined by dividing the sum of the benefit-cost ratios for the 5 years by five. If such percentage is not a multiple of 0.1 percent, the percentage shall remain unrounded.

[53 FR 37429, Sept. 26, 1988, as amended at 75 FR 57156, Sept. 17, 2010]

§ 606.22 Application for cap.

(a) *Application.* (1) The Governor of the State shall make application, addressed to the Secretary of Labor, no later than July 1 of a taxable year with respect to which a State requests a cap on tax credit reduction. The Governor is required to notify the Department on or before October 15 of such taxable year of any action occurring after the date of the initial application and effective prior to October 1 of such year that would impact upon the State's application.

(2) The OWS Administrator will make a determination on the application on or before November 10 of such taxable year, will notify the applicant and the Secretary of the Treasury of such determination, and will cause notice of such determination to be published in the FEDERAL REGISTER.

(b) *Anticipated impact statement.* In support of the application by the Governor, there shall be submitted with the application (on or before October 15), for the purposes of the criteria described in §§ 606.20(a) (1) and (2) and 606.21 (a) and (b), a description of all statutory provisions enacted or amended, regulations adopted or revised, administrative policies and procedures adopted or revised, and judicial decisions given effect, which are effective during the 12-month period ending on September 30 of the taxable year for which a cap on tax credit reduction is requested, and an anticipated impact statement (AIS) for each such program action in the following respect—

(1) The estimated dollar effect on each program action upon expenditures for compensation from the State unemployment fund and for the amounts of contributions paid or payable in such 12-month period, including the effect of interaction among program actions, and with respect to program actions for which dollar impact cannot be estimated or is minor or negligible, indicate whether the impact is positive or negative;

(2) If a program action has no such dollar effect, an explanation of why there is or will be no such effect;

(3) A description of assumptions and methodology used and the basis for the financial estimate of the impact of each program action described in paragraphs (b)(1) and (b)(2) of this section; and

(4) A comparision of the program actions described in paragraphs (b)(1) and (b)(2) of this section with the program actions prior to the Federal fiscal year (as defined in § 606.3) which ends on such September 30.

(c) *Unemployment tax rate.* With respect to the unemployment tax rate criterion described in §§ 606.20(a)(3) and 606.21(c), the application shall include an estimate for the taxable year with respect to which a cap on tax credit reduction is requested and actual data for the prior two years as follows:

(1) The amount of taxable wages as defined in § 606.3;

(2) The amount of total wages as defined in § 606.3; and

(3) The estimated distribution of taxable wages, as defined in § 606.3, by tax rate under the State law.

(d) *Benefit cost ratio.* With respect to the benefit cost ratio criterion described in §§ 606.20(a)(3) and 606.21(d), the application shall include for each of the five calendar years prior to the taxable year for which a cap on tax credit reduction is requested, the following data:

(1) The total dollar sum of compensation actually paid under the State law during the calendar year, including in such total sum all regular, additional, and extended compensation as defined in section 205 of the Federal-State Extended Unemployment Compensation Act of 1970, but excluding from such total sum—

(i) The total dollar amount of such compensation paid for which the State is entitled to reimbursement or was reimbursed under the provisions of any Federal law;

(ii) The total dollar amount of such compensation paid which is attributable to services performed for a reimbursing employer, and which is not included in the total amount reported under paragraph (d)(1)(i) of this section;

(2) The total dollar amount of interest paid during the calendar year on any advance; and

(3) The total dollar amount of wages (as defined in § 606.3) with respect to such calendar year.

(e) *Documentation required.* Copies of the sources of or authority for each program action described in paragraph (b) of this section shall be submitted with each application for a cap on tax credit reduction. In addition, a notation shall be made on each AIS of where all figures referred to are contained in reports required by the Department or in other data sources.

(f) *State contact person.* The Department may request additional information or clarification of information submitted bearing upon an application for a cap on tax credit reduction. To

expedite requests for such information, the name and telephone number of an appropriate State official shall be included in the application by the Governor.

[53 FR 37429, Sept. 26, 1988, as amended at 75 FR 57156, Sept. 17, 2010]

§ 606.23 Avoidance of tax credit reduction.

(a) *Applicability.* Subsection (g) of section 3302 of FUTA authorizes a State to avoid a tax credit reduction for a taxable year by meeting the three requirements of subsection (g). These requirements are met if the OWS Administrator determines that:

(1) Advances were repaid by the State during the one-year period ending on November 9 of the taxable year in an amount not less than the sum of—

(i) The potential additional taxes (as estimated by the OWS Administrator) that would be payable by the State's employers if paragraph (2) of section 3302(c) of FUTA were applied for such taxable year (as estimated with regard to the cap on tax credit reduction for which the State qualifies under §§ 606.20 to 606.22 with respect to such taxable year), and

(ii) Any advances made to such State during such one-year period under title XII of the Social Security Act;

(2) There will be adequate funds in the State unemployment fund (as estimated by the OWS Administrator) sufficient to pay all benefits when due and payable under the State law during the three-month period beginning on November 1 of such taxable year without receiving any advance under title XII of the Social Security Act; and

(3) There is a net increase (as estimated by the OWS Administrator) in the solvency of the State unemployment compensation system for the taxable year and such net increase equals or exceeds the potential additional taxes for such taxable year as estimated under paragraph (a)(1)(i) of this section.

(b) *Net increase in solvency.* (1) The net increase in solvency for a taxable year, as determined for the purposes of paragraph (a)(3) of this section, must be attributable to legislative changes made in the State law after the later of—

(i) September 3, 1982, or

(ii) The date on which the first advance is taken into account in determining the amount of the potential additional taxes.

(2) The OWS Administrator shall determine the net increase in solvency by first estimating the difference between revenue receipts and benefit outlays under the law in effect for the year for which avoidance is requested, as if the relevant changes in State law referred to in paragraph (b)(1) of this section were not in effect for such year. The OWS Administrator shall then estimate the difference between revenue receipts and benefit outlays under the law in effect for the year for which the avoidance is requested, taking into account the relevant changes in State law referred to in paragraph (b)(1) of this section. The amount (if any) by which the second estimated difference exceeds the first estimated difference shall constitute the net increase in solvency for the purposes of this section.

(c) *Year taken into account.* If a State qualifies for avoidance for any year, that year and January 1 of that year to which the avoidance applies will be taken into account for purposes of determining reduction of tax credits for subsequent taxable years.

§ 606.24 Application for avoidance.

(a) *Application.* (1) The Governor of the State shall make application, addressed to the Secretary of Labor, no later than July 1 of a taxable year with respect to which a State requests avoidance of tax credit reduction. The Governor is required to notify the Department on or before October 15 of such taxable year of any action impacting upon the State's application occurring subsequent to the date of the initial application and on or before November 10.

(2) The OWS Administrator will make a determination on the application as of November 10 of such taxable year, will notify the applicant and the Secretary of the Treasury of such determination, and will cause notice of such determination to be published in the FEDERAL REGISTER.

(b) *Information.* (1) The application shall include a statement of the amount of advances repaid and to be

repaid during the one-year period ending on November 9 of the taxable year for which avoidance is requested. If the amount repaid as of the date of the application is less than the amount required to satisfy the provisions of § 606.23(a)(1), the Governor shall provide a report later of the additional repayments that have been made in the remainder of the one-year period ending on November 9 of the taxable year, for the purposes of meeting the provisions of § 606.23(a)(1).

(2) The application also shall include estimates of revenue receipts, benefit outlays, and end-of-month fund balance for each month in the period beginning with September of the taxable year for which avoidance is requested through the subsequent January. Actual data for the comparable period of the preceding year also shall be included in the application in order to determine the reasonableness of such estimates.

(3) The application also shall include a description of State law changes, effective for the taxable year for which the avoidance is requested, which resulted in a net increase in the solvency of the State unemployment compensation system, and documentation which supports the State's estimate of the net increase in solvency for such taxable year.

§ 606.25 Waiver of and substitution for additional tax credit reduction.

A provision of subsection (c)(2) of section 3302 of FUTA provides that, for a State that qualifies, the additional tax credit reduction applicable under subparagraph (C), beginning in the fifth consecutive year of a balance of outstanding advances, shall be waived and the additional tax credit reduction applicable under subparagraph (B) shall be substituted. The waiver and substitution are granted if the OWS Administrator determines that the State has taken no action, effective during the 12-month period ending on September 30 of the year for which the waiver and substitution are requested, which has resulted or will result in a net decrease in the solvency of the State unemployment compensation system as determined for the purposes of §§ 606.20(a)(2) and 606.21(b).

§ 606.26 Application for waiver and substitution.

(a) *Application.* The Governor of the State shall make application addressed to the Secretary of Labor, no later than July 1 of a taxable year with respect to which a State requests waiver and substitution. Any such application shall contain the supportive data and information required by § 606.22(b) for the purposes of §§ 606.20(a)(2) and 606.21(b). The Governor is required to notify the Department on or before October 15 of such taxable year of action occurring after the date of the initial application and effective prior to October 1 of such year that would impact upon the State's application.

(b) *Notification of determination.* The OWS Administrator will make a determination on the application as of November 10 of the taxable year, will notify the applicant and the Secretary of the Treasury of the resulting tax credit reduction to be applied, and will cause notice of such determination to be published in the FEDERAL REGISTER.

Subpart D—Interest on Advances

§ 606.30 Interest rates on advances.

Advances made to States pursuant to title XII of the Social Security Act shall be subject to interest payable on the due dates specified in § 606.31.[1] The interest rate for each calendar year will be 10 percent or, if less, the rate determined by the Secretary of the Treasury and announced to the States by the Department.

[53 FR 37429, Sept. 26, 1988, as amended at 71 FR 35514, June 21, 2006]

§ 606.31 Due dates for payment of interest. [Reserved]

§ 606.32 Types of advances subject to interest.

(a) *Payment of interest.* Except as otherwise provided in paragraph (b) of this section each State shall pay interest on any advance made to such State under title XII of the Social Security Act.

(b) *Cash flow loans*—(1) *Availability of interest-free advances.* Advances are

[1] (EDITORIAL NOTE: This section will be added at a later date.)

deemed cash flow loans and shall be free of interest provided that:

(i) The advances are repaid in full prior to October 1 of the calendar year in which the advances are made;

(ii) The State does not receive an additional advance after September 30 of the same calendar year in which the advance is made. If the State receives an additional advance after September 30 of the same calendar year in which earlier advances were made, interest on the fully repaid earlier advance(s) is due and payable not later than the day following the date of the first such additional advance. The administrator of the State agency must notify the Secretary of Labor no later than September 10 of the same calendar year of those loans deemed to be cash flow loans and not subject to interest. This notification must include the date and amount of each loan made beginning January 01 through September 30 of the same calendar year, and a copy of documentation sent to the Secretary of the Treasury requesting loan repayment transfer(s) from the State's account in the UTF to the Federal unemployment account in the UTF; and

(iii) The State has met the funding goals described in paragraph (b)(2) or (b)(3) of this section.

(2) *Funding goals.* This paragraph (b)(2) is applicable to all States as of January 1, 2019. A State has met the funding goals requirement if:

(i) The State, as of December 31 of any of the 5 consecutive calendar years preceding the calendar year in which such advances are made, had an AHCM of at least 1.00, as determined under § 606.3; and

(ii) The State maintained tax effort as determined under paragraph (b)(4) of this section.

(3) *Phasing in funding goals.* This paragraph (b)(3) applies for calendar years 2014 through 2018. A State has met the funding goals requirement if it has satisfied the solvency criterion in paragraph (i), and the maintenance of tax effort criteria in paragraph (ii), of this § 606.32(b)(3).

(i) A State has met the solvency criterion if:

(A) For calendar year 2014, as of December 31 of any of the 5 consecutively preceding calendar years, the State had an AHCM of at least 0.50, as determined under § 606.3;

(B) For calendar year 2015, as of December 31 of any of the 5 consecutively preceding calendar years, the State had an AHCM of at least 0.60, as determined under § 606.3;

(C) For calendar year 2016, as of December 31 of any of the 5 consecutively preceding calendar years, the State had an AHCM of at least 0.70, as determined under § 606.3;

(D) For calendar year 2017, as of December 31 of any of the 5 consecutively preceding calendar years, the State had an AHCM of at least 0.80, as determined under § 606.3;

(E) For calendar year 2018, as of December 31 of any of the 5 consecutively preceding calendar years, the State had an AHCM of at least 0.90, as determined under § 606.3;

(ii) A State has met the maintenance of tax effort criteria if it maintained tax effort as determined under paragraph (b)(4) of this section.

(4) *Maintenance of tax effort criteria.* A State has maintained tax effort if, for every year between the last calendar year in which it met the solvency criterion in paragraph (b)(2)(i) or (b)(3)(i) of this section and the calendar year in which an interest-free advance is taken, the State's unemployment tax rate as defined in § 606.3 for the calendar year is at least—

(i) 80 percent of the prior year's unemployment tax rate; and

(ii) 75 percent of the State 5-year average benefit-cost ratio, as determined under § 606.21(d).

[53 FR 37429, Sept. 26, 1988, as amended at 75 FR 57156, Sept. 17, 2010]

§ 606.33 No payment of interest from unemployment fund. [Reserved]

§ 606.34 Reports of interest payable. [Reserved]

§ 606.35 Order of application for repayments. [Reserved]

Subpart E—Relief from Interest Payment

§ 606.40 May/September delay.

Subsection (b)(3)(B) of section 1202 of the Social Security Act permits a

State to delay payment of interest accrued on advances made during the last five months of the Federal fiscal year (May, June, July, August, and September) to no later than December 31 of the next succeeding calendar year. If the payment is delayed, interest on the delayed payment will accrue from the normal due date (*i.e.*, September 30) and in the same manner as if the interest due on the advance(s) was an advance made on such due date. The Governor of a State which has decided to delay such interest payment shall notify the Secretary of Labor no later than September 1 of the year with respect to which the delay is applicable.

§ 606.41 High unemployment deferral.

(a) *Applicability*. Subsection (b)(3)(C) of section 1202 of the Social Security Act permits a State to defer payment of, and extend the payment for, 75 percent of interest charges otherwise due prior to October 1 of a year if the OWS Administrator determines that high unemployment conditions existed in the State.

(b) *High unemployment defined*. For purposes of this section, high unemployment conditions existed in the State if the State's rate of insured unemployment (as determined for purposes of 20 CFR 615.12) under the State law with respect to the period consisting of the first six months of the preceding calendar year equalled or exceeded 7.5 percent; this means that in weeks 1 (that week which includes January 1 of the year) through 26 of such preceding calendar year, the rate of insured unemployment reported by the State and accepted by the Department under 20 CFR part 615 must have averaged a percentage equalling or exceeding 7.5 percent.

(c) *Schedule of deferred payments*. The State must pay prior to October 1 one-fourth of the interest due, and must pay a minimum of one-third of the deferred amount prior to October 1 in each of the three years following the year in which deferral was granted; at the State's option payment of deferred interest may be accelerated.

(d) *Related criteria*. Timely payment of one-fourth of the interest due prior to October 1 is a precondition to obtaining deferral of payment of 75 percent of the interest due. No interest shall accrue on such deferred interest.

(e) *Application for deferral and determination*. (1) The Governor of a State which has decided to request such deferral of interest payment shall apply to the Secretary of Labor no later than July 1 of the taxable year for which the deferral is requested.

(2) The OWS Administrator will determine whether deferral is or is not granted on the basis of the Department's records of reports of the rates of insured unemployment and information obtained from the Department of the Treasury as to the timely and full payment of one-fourth of the interest due.

§ 606.42 High unemployment delay.

(a) *Applicability*. Paragraph (9) of section 1202 (b) of the Social Security Act permits a State to delay for a period not exceeding nine months the interest payment due prior to October 1 if, for the most recent 12-month period prior to such October 1 for which data are available, the State had an average total unemployment rate of 13.5 percent or greater.

(b) *Delayed due date*. An interest payment delayed under paragraph (9) must be paid in full not later than the last official Federal business day prior to the following July 1; at the State's option payment of delayed interest may be accelerated. No interest shall accrue on such delayed payment.

(c) *Application for delay in payment and determination*. (1) The Governor of a State which has decided to request delay in payment of interest under paragraph (9) shall apply to the Secretary of Labor no later than July 1 of the taxable year for which the delay is requested.

(2) The OWS Administrator will determine whether delay is or is not granted on the basis of seasonally unadjusted civilian total unemployment rate data published by the Department's Bureau of Labor Statistics.

§ 606.44 Notification of determinations.

The OWS Administrator will make determinations under §§ 606.41, 606.42, and 606.43 on or before September 10 of the taxable year, will promptly notify the applicants and the Secretary of the

Treasury of such determinations, and will cause notice of such determinations to be published in the FEDERAL REGISTER. The OWS Administrator also will inform the Secretary of the Treasury and cause notice to be published in the FEDERAL REGISTER of information with respect to delayed payment of interest as provided in §606.40.

PART 609—UNEMPLOYMENT COMPENSATION FOR FEDERAL CIVILIAN EMPLOYEES

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AUTHORITY: 5 U.S.C. 8508; Secretary's Order No. 4–75, 40 FR 18515; (5 U.S.C. 301). Interpret and apply secs. 8501–8508 of title 5, United States Code.

SOURCE: 47 FR 54687, Dec. 3, 1982, unless otherwise noted.

Subpart A—General Provisions

§609.1 Purpose and application.

(a) *Purpose.* Subchapter I of chapter 85, title 5 of the United States Code, as amended by Pub. L. 94–566, 90 Stat. 2667, 5 U.S.C. 8501–8508, provides for a permanent program of unemployment compensation for unemployed Federal civilian employees. The unemployment compensation provided for in subchapter I is hereinafter referred to as unemployment compensation for Federal employees, or UCFE. The regulations in this part are issued to implement the UCFE Program.

(b) *First rule of construction.* The Act and the implementing regulations in this part shall be construed liberally so as to carry out the purposes of the Act.

(c) *Second rule of construction.* The Act and the implementing regulations in this part shall be construed so as to assure insofar as possible the uniform interpretation and application of the Act throughout the United States.

(d) *Effectuating purpose and rules of construction.* (1) In order to effectuate the provisions of this section, each State agency shall forward to the United States Department of Labor (hereafter Department), not later than 10 days after issuance, a copy of each judicial or administrative decision ruling on an individual's entitlement to payment of UCFE or to credit for a waiting period. On request of the Department, a State agency shall forward to the Department a copy of any determination or redetermination ruling on an individual's entitlement to UCFE or waiting period credit.

(2) If the Department believes that a determination, redetermination, or decision is inconsistent with the Department's interpretation of the Act or this part, the Department may at any time notify the State agency of the Department's view. Thereafter the State agency shall issue a redetermination or appeal if possible, and shall not follow such determination, redetermination, or decision as a precedent; and, in any subsequent proceedings which involve such determination, redetermination, or decision, or wherein such determination, redetermination, or decision is cited as precedent or otherwise relied upon, the State agency shall inform

the claims deputy or hearing officer or court of the Department's view and shall make all reasonable efforts, including appeal or other proceedings in an appropriate forum, to obtain modification, limitation, or overruling of the determination, redetermination, or decision.

(3) If the Department believes that a determination, redetermination, or decision is patently and flagrantly violative of the Act or this part, the Department may at any time notify the State agency of the Department's view. If the determination, redetermination, or decision in question denies UCFE to a claimant, the steps outlined in paragraph (d)(2) of this section shall be followed by the State agency. If the determination, redetermination, or decision in question awards UCFE to a claimant, the benefits are ''due'' within the meaning of section 303(a)(1) of the Social Security Act, 42 U.S.C. 503(a)(1), and therefore must be paid promptly to the claimant. However, the State agency shall take the steps outlined in paragraph (d)(2) of this section, and payments to the claimant may be temporarily delayed if redetermination or appeal action is taken not more than one business day following the day on which the first payment otherwise would be issued to the claimant; and the redetermination action is taken or appeal is filed to obtain a reversal of the award of UCFE and a ruling consistent with the Department's view; and the redetermination action or appeal seeks an expedited redetermination or appeal within not more than two weeks after the redetermination action is taken or the appeal is filed. If redetermination action is not taken or appeal is not filed within the above time limit, or a redetermination or decision is not obtained within the two-week limit, or any redetermination or decision or order is issued which affirms the determination, redetermination, or decision awarding UCFE or allows it to stand in whole or in part, the benefits awarded must be paid promptly to the claimant.

(4)(i) If any determination, redetermination, or decision, referred to in paragraph (d)(2) or paragraph (d)(3) of this section, is treated as a precedent for any future UCFE claim or claim under the UCX Program (part 614 of this chapter), the Secretary will decide whether the Agreement with the State entered into under the Act shall be terminated.

(ii) In the case of any determination, redetermination, or decision that is not legally warranted under the Act or this part, including any determination, redetermination, or decision referred to in paragraph (d)(3) of this section, the Secretary will decide whether the State shall be required to restore the funds of the United States for any sums paid under such a determination, redetermination, or decision, and whether, in the absence of such restoration, the Agreement with the State shall be terminated and whether other action shall be taken to recover such sums for the United States.

(5) A State agency may request reconsideration of a notice issued pursuant to paragraph (d)(2) of paragraph (d)(3) of this section, and shall be given an opportunity to present views and arguments if desired.

(6) Concurrence of the Department in a determination, redetermination, or decision shall not be presumed from the absence of a notice issued pursuant to this section.

§ 609.2 Definitions of terms.

For the purposes of the Act and this part:

(a) *Act* means subchapter I of chapter 85, title 5, United States Code, 5 U.S.C. 8501–8508.

(b) *Agreement* means the agreement entered into pursuant to the Act between a State and the Secretary under which the State agency of the State agrees to make payments of unemployment compensation in accordance with the Act and the regulations and procedures thereunder prescribed by the Department.

(c) *Based period* means the base period as defined by the applicable State law for the benefit year.

(d) *Benefit year* means the benefit year as defined by the applicable State law, and if not so defined the term means the period prescribed in the agreement with the State or, in the absence of an Agreement, the period prescribed by the Department.

(e) *Federal agency* means any department, agency, or governmental body of the United States, including any instrumentality wholly or partially owned by the United States, in any branch of the Government of the United States, which employs any individual in Federal civilian service.

(f) *Federal civilian service* means service performed in the employ of any Federal agency, except service performed—

(1) By an elective official in the executive or legislative branches of the Government of the United States;

(2) As a member of the Armed Forces or the Commissioned Corps of the National Oceanic and Atmospheric Administration;

(3) By Foreign Service personnel for whom special separation allowances are provided under chapter 14 of title 22 of the United States Code;

(4) Outside the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, and the District of Columbia, by an individual who is not a citizen of the United States;

(5) By an individual excluded by regulations of the Office of Personnel Management from civil service retirement coverage provided by subchapter III of chapter 83 of title 5 of the United States Code because the individual is paid on a contract or fee basis;

(6) By an individual receiving nominal pay and allowances of $12 or less a year;

(7) In a hospital, home, or other institution of the United States by a patient or inmate thereof;

(8) By a student-employee as defined by 5 U.S.C. 5351; that is: (i) A student nurse, medical or dental intern, resident-in-training, student dietitian, student physical therapist, or student occupational therapist, assigned or attached to a hospital, clinic, or medical or dental laboratory operated by an agency as defined in section 5351; or

(ii) Any other student-employee, assigned or attached primarily for training purposes to such a hospital, clinic, or medical or dental laboratory operated by such an agency, who is designated by the head of the agency with the approval of the Office of Personnel Management;

(9) By an individual serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(10) By an individual employed under a Federal relief program to relieve the individual from unemployment;

(11) As a member of a State, county, or community committee under the Agricultural Stabilization and Conservation Service or of any other board, council, committee, or other similar body, unless such body is composed exclusively of individuals otherwise in the full-time employ of the United States;

(12) By an officer or member of the crew on or in connection with an American vessel which is:

(i) Owned by or bareboat chartered to the United States, and

(ii) The business of which is conducted by a general agent of the Secretary of Commerce; and

(iii) If contributions on account of such service are required under section 3305(g) of the Internal Revenue Code of 1986 (26 U.S.C. 3305(g)) to be made to an unemployment fund under a State law;

(13) By an individual excluded by any other Federal law from coverage under the UCFE Program; or

(14) By an individual whose service is covered by the UCX Program to which part 614 of this chapter applies.

(g) *Federal employee* means an individual who has performed Federal civilian service.

(h) *Federal findings* means the facts reported by a Federal agency pertaining to an individual as to: (1) Whether or not the individual has performed Federal civilian service for such an agency;

(2) The period or periods of such Federal civilian service;

(3) The individual's Federal wages; and

(4) The reasons for termination of the individual's Federal civilian service.

(i) *Federal wages* means all pay and allowances, in cash and in kind, for Federal civilian service.

(j) *First claim* means an initial claim for unemployment compensation under the UCFE Program, the UCX Program (part 614 of this chapter), a State law, or some combination thereof, whereby

a benefit year is established under an applicable State law.

(k) *Official station* means the State (or country, if outside the United States) designated on a Federal employee's notification of personnel action terminating the individual's Federal civilian service (Standard Form 50 or its equivalent) as the individual's ''duty station.'' If the form of notification does not specify the Federal employee's ''duty station'', the individual's official station shall be the State or country designated under ''name and location of employing office'' on such form or designated as the individual's place of employment on an equivalent form.

(l) *Secretary* means the Secretary of Labor of the United States.

(m) *State* means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(n) *State agency* means the agency of the State which administers the applicable State law and is administering the UCFE Program in the State pursuant to an Agreement with the Secretary.

(o)(1) *State law* means the unemployment compensation law of a State approved by the Secretary under section 3304 of the Internal Revenue Code of 1986, 26 U.S.C. 3304, if the State is certified under section 3304(c) of the Internal Revenue Code of 1986, 26 U.S.C. 3304(c).

(2) *Applicable State law* means the State law made applicable to a UCFE claimant by § 609.8.

(p)(1) *Unemployment compensation* means cash benefits (including dependents' allowances) payable to individuals with respect to their unemployment, and includes regular, additional, emergency, and extended compensation.

(2) *Regular compensation* means unemployment compensation payable to an individual under any State law, but not including additional compensation or extended compensation.

(3) *Additional compensation* means unemployment compensation totally financed by a State and payable under a State law by reason of conditions of high unemployment or by reason of other special factors.

(4) *Emergency compensation* means supplementary unemployment compensation payable under a temporary Federal law after exhaustion of regular and extended compensation.

(5) *Extended compensation* means unemployment compensation payable to an individual for weeks of unemployment in an extended benefit period, under those provisions of a State law which satisfy the requirements of the Federal-State Extended Unemployment Compensation Act of 1970, as amended, 26 U.S.C. 3304 note, and part 615 of this chapter, with respect to the payment of extended compensation.

(q) *Week* means, for purposes of eligibility for and payment of UCFE, a week as defined in the applicable State law.

(r) *Week of unemployment* means a week of total, part-total, or partial unemployment as defined in the applicable State law, which shall be applied in the same manner and to the same extent to all employment and earnings, and in the same manner and to the same extent for the purposes of the UCFE Program, as if the individual filing for UCFE were filing a claim for State unemployment compensation.

[47 FR 54687, Dec. 3, 1982, as amended at 71 FR 35514, June 21, 2006]

Subpart B—Administration of UCFE Program

§ 609.3 Eligibility requirements for UCFE.

An individual shall be eligible to receive a payment of UCFE or to waiting period credit with respect to a week of unemployment if:

(a) The individual has Federal civilian service and Federal wages in the base period under the applicable State law;

(b) The individual meets the qualifying employment and wage requirements of the applicable State law, either on the basis of Federal civilian service and Federal wages alone or in combination with service and wages covered under a State law or under the UCX Program (part 614 of this chapter);

(c) The individual has filed an initial claim for UCFE and, as appropriate, has filed a timely claim for waiting period credit or a payment of UCFE with

respect to that week of unemployment; and

(d) The individual is totally, part-totally, or partially unemployed, and is able to work, available for work, and seeking work within the meaning of or as required by the applicable State law, and is not subject to disqualification under this part or the applicable State law, with respect to that week of unemployment.

§ 609.4 Weekly and maximum benefit amounts.

(a) *Total unemployment.* The weekly amount of UCFE payable to an eligible individual for a week of total unemployment shall be the amount that would be payable to the individual as unemployment compensation for a week of total unemployment as determined under the applicable State law.

(b) *Partial and part-total unemployment.* The weekly amount of UCFE payable for a week of partial or part-total unemployment shall be the amount that would be payable to the individual as unemployment compensation for a week of partial or part-total unemployment as determined under the applicable State law.

(c) *Maximum amount.* The maximum amount of UCFE which shall be payable to an eligible individual during and subsequent to the individual's benefit year shall be the maximum amount of all unemployment compensation that would be payable to the individual as determined under the applicable State law.

(d) *Computation rules.* (1) The weekly and maximum amounts of UCFE payable to an individual under the UCFE Program shall be determined under the applicable State law to be in the same amount, on the same terms, and subject to the same conditions as the State unemployment compensation which would be payable to the individual under the applicable State law if the individual's Federal civilian service and Federal wages assigned or transferred under this part to the State had been included as employment and wages covered by that State law.

(2) All Federal civilian service and Federal wages for all Federal agencies shall be considered employment with a single employer for purposes of the UCFE Program.

§ 609.5 Claims for UCFE.

(a) *First claims.* A first claim for UCFE shall be filed by an individual in any State agency of any State (or Canada) according to the applicable State law, and on a form prescribed by the Department which shall be furnished to the individual by the State agency where the claim is filed.

(b) *Weekly claims.* Claims for waiting week credit and payments of UCFE for weeks of unemployment shall be filed in any State agency (or Canada) at the times and in the manner as claims for State unemployment compensation are filed under the applicable State law, and on forms prescribed by the Department which shall be furnished to the individual by the State agency where the claim is filed.

(c) *Secretary's standard.* The procedure for reporting and filing claims for UCFE and waiting period credit shall be consistent with this part 609 and the Secretary's ''Standard for Claim Filing, Claimant Reporting, Job Finding and Employment Services'' (*Employment Security Manual*, part V, sections 5000 *et seq.*).

§ 609.6 Determinations of entitlement; notices to individual.

(a) *Determination of first claim.* The State agency whose State law applies to an individual under § 609.8 shall, promptly upon the filing of a first claim for UCFE, determine whether the individual is eligible and whether a disqualification applies, and, if the individual is found to be eligible, the individual's benefit year and the weekly and maximum amounts of UCFE payable to the individual.

(b) *Determinations of weekly claims.* The State agency promptly shall, upon the filing of a claim for payment of UCFE or waiting period credit with respect to a week, determine whether the individual is entitled to a payment of UCFE or waiting period credit with respect to such week, and, if entitled, the amount of UCFE or waiting period credit to which the individual is entitled.

(c) *Redetermination.* The provisions of the applicable State law concerning

the right to request, or authority to undertake, reconsideration of a determination pertaining to State unemployment compensation under the applicable State law shall apply to determinations pertaining to UCFE.

(d) *Notices to individual.* The State agency promptly shall give notice in writing to the individual of any determination or redetermination of a first claim, and, except as may be authorized under paragraph (g) of this section, of any determination or redetermination of any weekly claim which denies UCFE or waiting period credit or reduces the weekly amount or maximum amount initially determined to be payable. Each notice of determination or redetermination shall include such information regarding the determination or redetermination and notice of right to reconsideration or appeal, or both, as is furnished with written notices of determinations and redeterminations with respect to claims for State unemployment compensation; and where information furnished by a Federal agency was considered in making the determination, or redetermination, the notice thereof shall include an explanation of the right of the individual to seek additional information pursuant to § 609.23 and/or a reconsideration of Federal findings pursuant to § 609.24.

(e) *Obtaining information for claim determinations.* (1) Information required for the determination of claims for UCFE shall be obtained by the State agency from claimants, employers, and others, in the same manner as information is obtained for claim purposes under the applicable State law, but information (including additional and reconsidered Federal findings) shall be obtained from the Federal agency that employed the UCFE claimant as prescribed in §§ 609.21 through 609.25. On request by a UCFE claimant, the State agency shall seek additional information pursuant to § 609.23 and reconsideration of Federal findings pursuant to § 609.24.

(2) If Federal findings have not been received from a Federal agency within 12 days after the request for information was submitted to the Federal agency, the State agency shall determine the individual's entitlement to UCFE on the basis of an affidavit completed by the individual on a form prescribed by the Department. In addition, the individual shall submit for examination by the State agency any documents issued by the Federal agency (for example, Standard Form 50 or W–2) verifying that the individual performed services for and received wages from such Federal agency.

(3) If Federal findings received by a State agency after a determination has been made under this section contain information which would result in a change in the individual's eligibility for or entitlement to UCFE, the State agency promptly shall make a redetermination and notify the individual, as provided in this section. All payments of UCFE made prior to or after such redetermination shall be adjusted in accordance therewith.

(f) *Promptness.* Full payment of UCFE when due shall be consistent with this part 609 and shall be made with the greatest promptness that is administratively feasible, but the provisions of part 640 of this chapter (relating to promptness of benefit payments) shall not be applicable to the UCFE Program.

(g) *Secretary's standard.* The procedures for making determinations and redeterminations, and furnishing written notices of determinations, redeterminations, and rights of appeal to individuals applying for UCFE, shall be consistent with this part 609 and with the Secretary's ''Standard for Claim Determinations—Separation Information'' (*Employment Security Manual*, part V, sections 6010 *et seq.*).

[47 FR 54687, Dec. 3, 1982, as amended at 71 FR 35514, June 21, 2006]

§ 609.7 Appeal and review.

(a) *Applicable State law.* The provisions of the applicable State law concerning the right of appeal and fair hearing from a determination or redetermination of entitlement to State unemployment compensation shall apply to determinations and redeterminations of eligibility for or entitlement to UCFE and waiting period credit. Any such determination or redetermination shall be subject to appeal and review only in the manner and to the extent provided in the applicable State

law with respect to determinations and redeterminations of entitlement to State unemployment compensation.

(b) *Rights of appeal and fair hearing.* The provisions on right to appeal and opportunity for a fair hearing with respect to claims for UCFE shall be consistent with this part and with sections 303(a)(1) and 303(a)(3) of the Social Security Act, 42 U.S.C. 503(a)(1) and 503(a)(3).

(c) *Promptness on appeals.* (1) Decisions on appeals under the UCFE Program shall accord with the Secretary's ''Standard for Appeals Promptness—Unemployment Compensation'' in part 650 of this chapter, and with § 609.1(d).

(2) Any provision of an applicable State law for advancement or priority of unemployment compensation cases on judicial calendars, or otherwise intended to provide for the prompt payment of unemployment compensation when due, shall apply to proceedings involving claims for UCFE.

(d) *Appeal and review by Federal agency.* If a Federal agency believes that a State agency's determination or redetermination of an individual's eligibility for or entitlement to UCFE is incorrect, the Federal agency may seek appeal and review of such determination or redetermination in the same manner as an interested employer may seek appeal and review under the applicable State law.

[47 FR 54687, Dec. 3, 1982, as amended at 71 FR 35514, June 21, 2006]

§ 609.8 The applicable State for an individual.

(a) *The applicable State.* The applicable State for an individual shall be the State to which the individual's Federal civilian service and Federal wages are assigned or transferred under this section. The applicable State law for the individual shall be the State law of such State.

(b) *Assignment of service and wages.* (1) An individual's Federal civilian service and Federal wages shall be assigned to the State in which the individual had his or her last official station prior to filing a first claim unless:

(i) At the time a first claim is filed the individual resides in another State in which, after separation from Federal civilian service, the individual performed service covered under the State law, in which case all of the individual's Federal civilian service and wages shall be assigned to the latter State; or

(ii) Prior to filing a first claim an individual's last official station was outside the States, in which case all of the individual's Federal civilian service and Federal wages shall be assigned to the State in which the individual resides at the time the individual files a first claim, provided the individual is personally present in a State when the individual files the first claim.

(2) Federal civilian service and wages assigned to a State in error shall be reassigned for use by the proper State agency. An appropriate record of a reassignment shall be made by the State agency which makes the reassignment.

(3) Federal civilian service and Federal wages assigned to a State shall be transferred to another State where such transfer is necessary for the purposes of a combined-wage claim filed by an individual.

(c) *Assignment deemed complete.* All of an individual's Federal civilian service and Federal wages shall be deemed to have been assigned to a State upon the filing of a first claim. Federal civilian service and Federal wages shall be assigned to a State only in accordance with paragraph (b) of this section.

(d) *Use of assigned service and wages.* All assigned Federal civilian service and Federal wages shall be used only by the State to which assigned or transferred in accordance with paragraph (b) of this section.

§ 609.9 Provisions of State law applicable to UCFE claims.

(a) *Particular provisions applicable.* Except where the result would be inconsistent with the provisions of the Act or this part or the procedures thereunder prescribed by the Department, the terms and conditions of the applicable State law which apply to claims for, and the payment of, State unemployment compensation shall apply to claims for, and the payment of, UCFE and claims for waiting period credit. The provisions of the applicable State law which shall apply include, but are not limited to:

(1) Claim filing and reporting;

(2) Information to individuals, as appropriate;

(3) Notices to individuals and Federal agencies, as appropriate, including notice to each individual of each determination and redetermination of eligibility for or entitlement to UCFE;

(4) Determinations and redeterminations;

(5) Ability to work, availability for work, and search for work; and

(6) Disqualifications.

(b) *IBPP.* The *Interstate Benefit Payment Plan* shall apply, where appropriate, to individuals filing claims for UCFE.

(c) *Wage combining.* The State's provisions complying with the *Interstate Arrangement for Combining Employment and Wages* (part 616 of this chapter) shall apply, where appropriate, to individuals filing claims for UCFE.

(d) *Procedural requirements.* The provisions of the applicable State law which apply hereunder to claims for and the payment of UCFE shall be applied consistently with the requirements of title III of the Social Security Act and the Federal Unemployment Tax Act which are pertinent in the case of State unemployment compensation, including but not limited to those standards and requirements specifically referred to in the provisions of this part, except as provided in paragraph (f) of § 609.6.

§ 609.10 Restrictions on entitlement.

(a) *Disqualification.* If the week of unemployment for which an individual claims UCFE is a week to which a disqualification for State unemployment compensation applies under the applicable State law, or would apply but for the fact that the individual has no right to such compensation, the individual shall not be entitled to a payment of UCFE for that week.

(b) *Allocation of terminal annual leave payments.* Lump-sum terminal annual leave payments shall not be allocated by a Federal agency and shall be allocated by a State agency in the same manner as similar payments to individuals employed by private employers are allocated under the applicable State law. In a State in which a private employer has an option as to the period to which such payments shall be allocated, such payments shall be allocated to the date of separation from employment.

§ 609.11 Overpayments; penalties for fraud.

(a) *False statements and representations.* Section 8507(a) of the Act provides that if a State agency, the Department, or a court of competent jurisdiction finds that an individual—

(1) Knowingly has made, or caused to be made by another, a false statement or representation of a material fact, or knowingly has failed, or caused another to fail, to disclose a material fact; and

(2) As a result of that action has received an amount as UCFE to which the individual was not entitled; the individual shall repay the amount to the State agency or the Department. Instead of requiring repayments, the State agency or the Department may recover the amount by deductions from UCFE payable to the individual during the 2-year period after the date of the finding. A finding by a State agency or the Department may be made only after an opportunity for a fair hearing, subject to such further review as may be appropriate under § 609.7.

(b) *Prosecution for fraud.* Section 1919 of title 18, United States Code, provides that whoever makes a false statement or representation of a material fact knowing it to be false, or knowingly fails to disclose a material fact, to obtain or increase for himself or for any other individual any payment authorized to be paid under chapter 85 of title 5, United States Code, or under an agreement thereunder, shall be fined not more than $1,000 or imprisoned not more than one year, or both.

(c) *Absence of fraud.* If a State agency or court of competent jurisdiction finds that an individual has received a payment of UCFE to which the individual was not entitled under the Act and this part, which was not due to a false statement or representation as provided in paragraph (a) or (b) of this section, the individual shall be liable to repay to the applicable State the total sum of the payment to which the individual was not entitled, and the State agency shall take all reasonable measures authorized under any State law or Federal law to recover for the account

of the United States the total sum of the payment to which the individual was not entitled.

(d) *Recovery by offset.* (1) The State agency shall recover, insofar as is possible, the amount of any overpayment which is not repaid by the individual, by deductions from any UCFE payable to the individual under the Act and this part, or from any unemployment compensation payable to the individual under any Federal unemployment compensation law administered by the State agency, or from any assistance or allowance payable to the individual with respect to unemployment under any other Federal law administered by the State agency.

(2) A State agency shall also recover, insofar as is possible, the amount of any overpayment of UCFE made to the individual by another State, by deductions from any UCFE payable by the State agency to the individual under the Act and this part, or from any unemployment compensation payable to the individual under any Federal unemployment compensation law administered by the State agency, or from any assistance or allowance payable to the individual with respect to unemployment under any other Federal law administered by the State agency.

(3) Recoupment of fraudulent overpayments referred to in paragraph (a) of this section shall be limited to the 2-year period stated in that paragraph. Recoupment of fraudulent overpayments referred to in paragraph (b) of this section, and nonfraudulent overpayments referred to in paragraph (c) of this section shall be subject to any time limitation on recoupment provided for in the State law that applies to the case.

(e) *Debts due the United States.* UCFE payable to an individual shall be applied by the State agency for the recovery by offset of any debt due to the United States from the individual, but shall not be applied or used by the State agency in any manner for the payment of any debt of the individual to any State or any other entity or person except pursuant to a court order for child support or alimony in accordance with the law of the State and section 459 of the Social Security Act, 42 U.S.C. 659.

(f) *Application of State law.* (1) Except as indicated in paragraph (a) of this section, any provision of State law that may be applied for the recovery of overpayments or prosecution for fraud, and any provision of State law authorizing waiver of recovery of overpayments of unemployment compensation, shall be applicable to UCFE.

(2) In the case of any finding of false statement or representation under the Act and paragraph (a) of this section, or prosecution for fraud under 18 U.S.C. 1919 or pursuant to paragraph (f)(1) of this section, the individual shall be disqualified or penalized in accordance with the provisions of the applicable State law relating to fraud in connection with a claim for State unemployment compensation.

(g) *Final decision.* Recovery of any overpayment of UCFE shall not be enforced by the State agency until the determination or redetermination establishing the overpayment has become final, or if appeal is taken from the determination or redetermination, until the decision after opportunity for a fair hearing has become final.

(h) *Procedural requirements.* (1) The provisions of paragraphs (c), (d), and (g) of § 609.6 shall apply to determinations and redeterminations made pursuant to this section.

(2) The provisions of § 609.7 shall apply to determinations and redeterminations made pursuant to this section.

(i) *Fraud detection and prevention.* Provisions in the procedures of each State with respect to detection and prevention of fraudulent overpayments of UCFE shall be, as a minimum, commensurate with the procedures adopted by the State with respect to State unemployment compensation and consistent with the Secretary's ''Standard for Fraud and Overpayment Detection'' (*Employment Security Manual,* part V, section 7510 *et seq.*).

(j) *Recovered overpayments.* An amount repaid or recouped under this section shall be—

(1) Deposited in the fund from which payment was made, if the repayment was to a State agency; or

(2) Returned to the Treasury of the United States and credited to the current applicable appropriation, fund, or

account from which payment was made, if the repayment was to the Department.

§ 609.12 Inviolate rights to UCFE.

Except as specifically provided in this part, the rights of individuals to UCFE shall be protected in the same manner and to the same extent as the rights of persons to State unemployment compensation are protected under the applicable State law. Such measures shall include protection of applicants for UCFE from waiver, release, assignment, pledge, encumbrance, levy, execution, attachment, and garnishment of their rights to UCFE, except as provided in § 609.11. In the same manner and to the same extent, individuals shall be protected from discrimination and obstruction in regard to seeking, applying for, and receiving any right to UCFE.

§ 609.13 Recordkeeping; disclosure of information.

(a) *Recordkeeping.* Each State agency will make and maintain records pertaining to the administration of the UCFE Program as the Department requires, and will make all such records available for inspection, examination, and audit by such Federal officials or employees as the Department may designate or as may be required by law.

(b) *Disclosure of Information.* Information in records maintained by a State agency in administering the UCFE Program shall be kept confidential, and information in such records may be disclosed only in the same manner and to the same extent as information with respect to State unemployment compensation and the entitlement of individuals thereto may be disclosed under the applicable State law. This provision on the confidentiality of information maintained in the administration of the UCFE Program shall not apply, however, to the Department or for the purposes of §§ 609.11 or 609.13, or in the case of information, reports and studies required pursuant to §§ 609.17 or 609.25, or where the result would be inconsistent with the Freedom of Information Act (5 U.S.C. 552), the Privacy Act of 1974, as amended (5 U.S.C. 552a), or regulations of the Department promulgated thereunder.

[47 FR 54687, Dec. 3, 1982, as amended at 71 FR 35514, June 21, 2006]

§ 609.14 Payments to States.

(a) *State entitlement.* Each State is entitled to be paid by the United States with respect to each individual whose base period wages included Federal wages, an amount bearing the same ratio to the total amount of compensation paid to such individual as the amount of the individual's Federal wages in the individual's base period bears to the total amount of the individual's base period wages.

(b) *Payment.* Each State shall be paid, either in advance or by way of reimbursement, as may be determined by the Department, the sum that the Department estimates the State is entitled to receive under the Act and this part for each calendar month. The sum shall be reduced or increased by the amount which the Department finds that its estimate for an earlier calendar month was greater or less than the sum which should have been paid to the State. An estimate may be made on the basis of a statistical, sampling, or other method agreed on by the Department and the State agency.

(c) *Certification by the Department.* The Department, from time to time, shall certify to the Secretary of the Treasury the sum payable to each State under this section. The Secretary of the Treasury, before audit or settlement by the General Accounting Office, shall pay the State in accordance with the certification from the funds for carrying out the purposes of the Act and this part.

(d) *Use of money.* Money paid a State under the Act and this part may be used solely for the purposes for which it is paid. Money so paid which is not used solely for these purposes shall be returned, at the time specified by the Agreement, to the Treasury of the United States and credited to the current applicable appropriation, fund, or account from which payments to states under the Act and this part may be made.

§ 609.15 Public access to Agreements.

The State agency of a State will make available to any individual or organization a true copy of the Agreement with the State for inspection and copying. Copies of an Agreement may be furnished on request to any individual or organization upon payment of the same charges, if any, as apply to the furnishing of copies of other records of the State agency.

§ 609.16 Administration in absence of an Agreement.

(a) *Administering Program.* The Department shall administer the UCFE Program through personnel of the Department or through other arrangements under procedures prescribed by the Department, in the case of any State which does not have an Agreement with the Secretary as provided for in 5 U.S.C. 8502. The procedures prescribed by the Department under this section shall be consistent with the Act and this part.

(b) *Applicable State law.* On the filing by an individual of a claim for UCFE in accordance with arrangements under this section, UCFE shall be paid to the individual, if eligible, in the same amount, on the same terms, and subject to the same conditions as would be paid to the individual under the applicable State law if the individual's Federal civilian service and Federal wages had been included as employment and wages under the State law. Any such claim shall include the individual's Federal civilian service and Federal wages, combined with any service and wages covered by State law. However, if the individual, without regard to his or her Federal civilian service and Federal wages, has employment or wages sufficient to qualify for compensation during the benefit year under that State law, then payments of UCFE under this section may be made only on the basis of the individual's Federal civilian service and Federal wages.

(c) *Fair hearing.* An individual whose claim for UCFE is denied under this section is entitled to a fair hearing under rules of procedure prescribed by the Department. A final determination by the Department with respect to entitlement to UCFE under this section is subject to review by the courts in the same manner and to the same extent as is provided by section 205(g) of the Social Security Act, 42 U.S.C. 405(g).

§ 609.17 Information, reports, and studies.

State agencies shall furnish to the Department such information and reports and conduct such studies as the Department determines are necessary or appropriate for carrying out the purposes of the UCFE Program.

Subpart C—Responsibilities of Federal Agencies

§ 609.20 Information to Federal civilian employees.

Each Federal agency shall:

(a) Furnish information to its employees as to their rights and responsibilities under the UCFE Program and 18 U.S.C. 1919; and

(b) Furnish a completed copy of a form approved by the Department, ''Notice to Federal Employee About Unemployment Compensation,'' in accordance with instructions thereon, to each employee at the time of separation from Federal civilian service, when transferred from one payroll office to another, or when the office responsible for distribution of the form is advised that an individual is in nonpay status for seven consecutive days or more.

§ 609.21 Findings of Federal agency.

(a) *Answering request.* Within four workdays after receipt from a State agency of a request for Federal findings on a form furnished by the State agency, and prescribed by the Department, a Federal agency shall make such Federal findings, complete all copies of the form, and transmit the completed copies to the State agency. If documents necessary for completion of the form have been assigned to an agency records center or the Federal Records Center in St. Louis, the Federal agency shall obtain the necessary information from the records center. Any records center shall give priority to such a request.

(b) *Failure to meet time limit.* If a completed form containing the Federal agency's findings cannot be returned

within four workdays of receipt, the Federal agency immediately shall inform the State agency, and shall include an estimated date by which the completed form will be returned.

(c) *Administrative control.* Each Federal agency shall maintain a control of all requests for Federal findings received by it, and the Federal agency's response to each request. The records shall be maintained so as to enable the Federal agency to ascertain at any time the number of such forms that have not been returned to State agencies, and the dates of the Federal agency's receipt of such unreturned forms.

§ 609.22 Correcting Federal findings.

If a Federal agency ascertains at any time within one year after it has returned a completed form reporting its findings, that any of its findings were erroneous, it shall promptly correct its error and forward its corrected findings to the State agency.

§ 609.23 Furnishing additional information.

On receipt of a request for additional information from a State agency, a Federal agency shall consider the information it supplied initially in connection with such request and shall review its findings. The Federal agency promptly shall forward to the State agency such additional findings as will respond to the request. The Federal agency shall, if possible, respond within four workdays after the receipt of a request under this section.

§ 609.24 Reconsideration of Federal findings.

On receipt of a request for reconsideration of Federal findings from a State agency, the Federal agency shall consider the initial information supplied in connection with such request and shall review its findings. The Federal agency shall correct any errors or omissions in its findings and shall affirm, modify, or reverse any or all of its findings in writing. The Federal agency promptly shall forward its reconsidered findings to the requesting authority. The Federal agency shall, if possible, respond within four workdays after the receipt of a request under this section.

§ 609.25 Furnishing other information.

(a) *Additional Information.* In addition to the information required by §§ 609.21, 609.22, 609.23, and 609.24, a Federal agency shall furnish to a State agency or the Department, within the time requested, any information which it is not otherwise prohibited from releasing by law, which the Department determines is necessary for the administration of the UCFE Program.

(b) *Reports.* Federal agencies shall furnish to the Department or State agencies such reports containing such information as the Department determines are necessary or appropriate for carrying out the purposes of the UCFE Program.

§ 609.26 Liaison with Department.

To facilitate the Department's administration of the UCFE Program, each Federal agency shall designate one or more of its officials to be the liaison with the Department. Each Federal agency will inform the Department of its designation(s) and of any change in a designation.

PART 614—UNEMPLOYMENT COMPENSATION FOR EX-SERVICEMEMBERS

Subpart A—General Provisions

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APPENDIX A TO PART 614—STANDARD FOR CLAIM FILING, CLAIMANT REPORTING, JOB FINDING, AND EMPLOYMENT SERVICES
APPENDIX B TO PART 614—STANDARD FOR CLAIM DETERMINATION—SEPARATION INFORMATION
APPENDIX C TO PART 614—STANDARD FOR FRAUD AND OVERPAYMENT DETECTION

AUTHORITY: 5 U.S.C. 8508; Secretary's Order No. 4–75 (40 FR 18515).

SOURCE: 47 FR 54697, Dec. 3, 1982, unless otherwise noted.

Subpart A—General Provisions

§ 614.1 Purpose and application.

(a) *Purpose.* Subchapter II of chapter 85, title 5 of the United States Code (5 U.S.C. 8521-8525) provides for a permanent program of unemployment compensation for unemployed individuals separated from the Armed Forces. The unemployment compensation provided for in subchapter II is hereinafter referred to as Unemployment Compensation for Ex-servicemembers, or UCX. The regulations in this part are issued to implement the UCX Program.

(b) *First rule of construction.* The Act and the implementing regulations in this part shall be construed liberally so as to carry out the purposes of the Act.

(c) *Second rule of construction.* The Act and the implementing regulations in this part shall be construed so as to assure insofar as possible the uniform interpretation and application of the Act throughout the United States.

(d) *Effectuating purpose and rules of construction.* (1) In order to effectuate the provisions of this section, each State agency shall forward to the United States Department of Labor (hereafter Department), not later than 10 days after issuance, a copy of each judicial or administrative decision ruling on an individual's entitlement to payment of UCX or to credit for a waiting period. On request of the Department, a State agency shall forward to the Department a copy of any determination or redetermination ruling on an individual's entitlement to UCX or waiting period credit.

(2)(i) If the Department believes that a determination, redetermination, or decision is inconsistent with the Department's interpretation of the Act or this part, the Department may at any time notify the State agency of the Department's view. Thereafter, the State agency shall issue a redetermination or appeal if possible, and shall not follow such determination, redetermination, or decision as a precedent; and, in any subsequent proceedings which involve such determination, redetermination, or decision, or wherein such determination, redetermination, or decision is cited as precedent or otherwise relied upon, the State agency shall inform the claims deputy or hearing officer or court of the Department's view and shall make all reasonable efforts, including appeal or other proceedings in an appropriate forum, to obtain modification, limitation, or overruling of the determination, redetermination, or decision.

(ii) If the Department believes that a State agency has failed to use, or use in a timely manner, the crossmatch mechanism at the claims control center designated by the Department, the Department may at any time notify the State of the Department's view. Thereafter, the State agency shall take action to ensure that operable procedures for the effective utilization of the claims control center are in place and adhered to. In any case of any determination, redetermination, or decision that is not legally warranted under the Act or this part had the State used, or used in a timely manner, the crossmatch mechanism at the claims control center designated by the Department, State agency shall take the steps outlined in paragraph (d)(2)(i) of this section.

(3) If the Department believes that a determination, redetermination, or decision is patently and flagrantly violative of the Act or this part, the Department may at any time notify the State agency of the Department's view. If the determination, redetermination, or decision in question denies UCX to a

claimant, the steps outlined in paragraph (2) above shall be followed by the State agency. If the determination, redetermination, or decision in question awards UCX to a claimant, the benefits are ''due'' within the meaning of section 303(a)(1) of the Social Security Act, 42 U.S.C. 503(a)(1), and therefore must be paid promptly to the claimant. However, the State agency shall take the steps outlined in paragraph (d)(2) of this section, and payments to the claimant may be temporarily delayed if redetermination or appeal action is taken not more than one business day following the day on which the first payment otherwise would be issued to the claimant; and the redetermination action is taken or appeal is filed to obtain a reversal of the award of UCX and a ruling consistent with the Department's view; and the redetermination action or appeal seeks an expedited redetermination or appeal within not more than two weeks after the redetermination action is taken or the appeal is filed. If redetermination action is not taken or appeal is not filed within the above time limit, or a redetermination or decision is not obtained within the two-week limit, or any redetermination or decision or order is issued which affirms the determination, redetermination, or decision awarding UCX or allows it to stand in whole or in part, the benefits awarded must be paid promptly to the claimant.

(4)(i) If any determination, redetermination, or decision, referred to in paragraph (d)(2) or paragraph (d)(3) of this section, is treated as a precedent for any future UCX claim or claim under the UCFE Program (part 609 of this chapter), the Secretary will decide whether the Agreement with the State entered into under the Act shall be terminated.

(ii) In the case of any determination, redetermination, or decision that is not legally warranted under the Act or this part, including any determination, redetermination, or decision referred to in paragraph (d)(2) or in paragraph (d)(3) of this section, the Secretary will decide whether the State shall be required to restore the funds of the United States for any sums paid under such a determination, redetermination, or decision, and whether, in absence of such restoration, the Agreement with the State shall be terminated and whether other action shall be taken to recover such sums for the United States.

(5) A State agency may request reconsideration of a notice issued pursuant to paragraph (d)(2) or paragraph (d)(3) of this section, and shall be given an opportunity to present views and arguments if desired.

(6) Concurrence of the Department in a determination, redetermination, or decision shall not be presumed from the absence of a notice issued pursuant to this section.

(Approved by the Office of Management and Budget under control number 1205–0163)

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40553, Oct. 17, 1988; 53 FR 43799, Oct. 26, 1988; 57 FR 59799, Dec. 15, 1992]

§ 614.2 Definitions of terms.

For purposes of the Act and this part:

(a) *Act* means subchapter II of chapter 85 of title 5 of the United States Code, 5 U.S.C. 8521–8525.

(b) *Agreement* means the Agreement entered into pursuant to 5 U.S.C. 8502 between a State and the Secretary under which the State agency of the State agrees to make payments of unemployment compensation in accordance with the Act and the regulations and procedures thereunder prescribed by the Department.

(c) *Base period* means the base period as defined by the applicable State law for the benefit year.

(d) *Benefit year* means the benefit year as defined by the applicable State law, and if not so defined the term means the period prescribed in the Agreement with the State or, in the absence of an Agreement, the period prescribed by the Department.

(e) *Ex-servicemember* means an individual who has performed Federal military service.

(f) *Federal military agency* means any of the Armed Forces of the United States, including the Army, Air Force, Navy, Marine Corps, and Coast Guard, and the National Oceanic and Atmospheric Administration (Department of Commerce).

(g) *Federal military service* means active service (not including active duty

in a reserve status unless for a continuous period of 90 days or more) in the Armed Forces or the Commissioned Corps of the National Oceanic and Atmospheric Administration if with respect to that service—

(1) The individual was discharged or released under honorable conditions (and, if an officer, did not resign for the good of the service); and

(2)(i) The individual was discharged or released after completing his/her first full term of active service which the individual initially agreed to serve, or

(ii) The individual was discharged or released before completing such term of active service—

(A) For the convenience of the Government under an early release program,

(B) Because of medical disqualification, pregnancy, parenthood, or any service-incurred injury or disability,

(C) Because of hardship, or

(D) Because of personality disorders or inaptitude but only if the service was continuous for 365 days or more.

(h) *Federal military wages* means all pay and allowances in cash and in kind for Federal military service, computed on the basis of the pay and allowances for the pay grade of the individual at the time of his or her latest discharge or release from Federal/military service, as determined in accordance with the Schedule of Remuneration applicable at the time the individual files his or her first claim for compensation for a benefit year.

(i) *First claim* means an initial claim for unemployment compensation under the UCX Program, the UCFE Program (part 609 of this chapter), or a State law, or some combination thereof, first filed by an individual after the individual's latest discharge or release from Federal military service, whereby a benefit year is established under an applicable State law.

(j) *Military document* means an official document or documents issued to an individual by a Federal military agency relating to the individual's Federal military service and discharge or release from such service.

(k) *Period of active service* means a period of continuous active duty (including active duty for training purposes) in a Federal military agency or agencies, beginning with the date of entry upon active duty and ending on the effective date of the first discharge or release thereafter which is not qualified or conditional.

(l) *Schedule of Remuneration* means the schedule issued by the Department from time to time under 5 U.S.C. 8521(a)(2) and this part, which specifies for purposes of the UCX Program, the pay and allowances for each pay grade of servicemember.

(m) *Secretary* means the Secretary of Labor of the United States.

(n) *State* means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(o) *State agency* means the agency of the State which administers the applicable State unemployment compensation law and is administering the UCX Program in the State pursuant to an Agreement with the Secretary.

(p)(1) *State law* means the unemployment compensation law of a State approved by the Secretary under section 3304 of the Internal Revenue Code of 1986, 26 U.S.C. 3304, if the State is certified under section 3304(c) of the Internal Revenue Code of 1986, 26 U.S.C. 3304(c).

(2) *Applicable State law* means the State law made applicable to a UCX claimant by § 614.8.

(q)(1) *Unemployment compensation* means cash benefits (including dependents' allowances) payable to individuals with respect to their unemployment, and includes regular, additional, emergency, and extended compensation.

(2) *Regular compensation* means unemployment compensation payable to an individual under any State law, but not including additional compensation or extended compensation.

(3) *Additional compensation* means unemployment compensation totally financed by a State and payable under a State law by reason of conditions of high unemployment or by reason of other special factors.

(4) *Emergency compensation* means supplementary unemployment compensation payable under a temporary Federal law after exhaustion of regular and extended compensation.

(5) *Extended compensation* means unemployment compensation payable to an individual for weeks of unemployment in an extended benefit period, under those provisions of a State law which satisfy the requirements of the Federal-State Extended Unemployment Compensation Act of 1970, as amended, 26 U.S.C. 3304 note, and part 615 of this chapter, with respect to the payment of extended compensation.

(r) *Unemployment Compensation for Ex-Servicemember* means the unemployment compensation payable under the Act to claimants eligible for the payments, and is referred to as UCX.

(s) *Week* means, for purposes of eligibility for and payment of UCX, a week as defined in the applicable State law.

(t) *Week of unemployment* means a week of total, part-total, or partial unemployment as defined in the applicable State law, which shall be applied in the same manner and to the same extent to all employment and earnings, and in the same manner and to the same extent for the purposes of the UCX Program, as if the individual filing for UCX were filing a claim for State unemployment compensation.

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40554, Oct. 17, 1988; 53 FR 43799, Oct. 26, 1988; 57 FR 59799, Dec. 15, 1992]

Subpart B—Administration of UCX Program

§ 614.3 Eligibility requirements for UCX.

An individual shall be eligible to receive a payment of UCX or waiting period credit with respect to a week of unemployment if:

(a) The individual has Federal military service and Federal military wages in the base period under the applicable State law;

(b) The individual meets the qualifying employment and wage requirements of the applicable State law, either on the basis of Federal military service and Federal military wages alone or in combination with service and wages covered under a State law or under the UCFE Program (part 609 of this chapter);

(c) The individual has filed an initial claim for UCX and, as appropriate, has filed a timely claim for waiting period credit or payment of UCX with respect to that week of unemployment; and

(d) The individual is totally, part-totally, or partially unemployed, and is able to work, available for work, and seeking work within the meaning of or as required by the applicable State law, and is not subject to disqualification under this part or the applicable State law, with respect to that week of unemployment.

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40554, Oct. 17, 1988; 57 FR 59799, Dec. 15, 1992]

§ 614.4 Weekly and maximum benefit amounts.

(a) *Total unemployment.* The weekly amount of UCX payable to an eligible individual for a week of total unemployment shall be the amount that would be payable to the individual as unemployment compensation for a week of total unemployment as determined under the applicable State law.

(b) *Partial and part-total unemployment.* The weekly amount of UCX payable for a week of partial or part-total unemployment shall be the amount that would be payable to the individual as unemployment compensation for a week of partial or part-total unemployment as determined under the applicable State law.

(c) *Maximum amount.* The maximum amount of UCX which shall be payable to an eligible individual during and subsequent to the individual's benefit year shall be the maximum amount of all unemployment compensation that would be payable to the individual as determined under the applicable State law.

(d) *Computation rules.* The weekly and maximum amounts of UCX payable to an individual under the UCX Program shall be determined under the applicable State law to be in the same amount, on the same terms, and subject to the same conditions as the State unemployment compensation which would be payable to the individual under the applicable State law if the individual's Federal military service and Federal military wages assigned or transferred under this part to the State had been included as employment and wages covered by that State

law, subject to the use of the applicable Schedule of Remuneration.

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40554, Oct. 17, 1988; 57 FR 59800, Dec. 15, 1992]

§ 614.5 Claims for UCX.

(a) *First claims.* A first claim for UCX shall be filed by an individual in any State agency of any State according to the applicable State law, and on a form prescribed by the Department which shall be furnished to the individual by the State agency where the claim is filed.

(b) *Weekly claims.* Claims for waiting week credit and payments of UCX for weeks of unemployment shall be filed in any State agency (or Canada) at the times and in the manner as claims for State unemployment compensation are filed under the applicable State law, and on forms prescribed by the Department which shall be furnished to the individual by the State agency where the claim is filed.

(c) *Secretary's standard.* The procedures for reporting and filing claims for UCX and waiting period credit shall be consistent with this part 614 and the Secretary's ''Standard for Claim Filing, Claimant Reporting, Job Finding and Employment Services'' in the *Employment Security Manual,* part V, sections 5000–5004 (appendix A of this part).

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40554, Oct. 17, 1988]

§ 614.6 Determinations of entitlement; notices to individual and Federal military agency.

(a) *Determinations of first claim.* Except for findings of a Federal military agency and the applicable Schedule of Remuneration which are final and conclusive under § 614.23, the State agency whose State law applies to an individual under § 614.8 shall, promptly upon the filing of a first claim for UCX, determine whether the individual is otherwise eligible, and, if the individual is found to be eligible, the individual's benefit year and the weekly and maximum amounts of UCX payable to the individual.

(b) *Determinations of weekly claims.* The State agency promptly shall, upon the filing of a claim for a payment of UCX or waiting period credit with respect to a week, determine whether the individual is entitled to a payment of UCX or waiting period credit respect to such week, and, if entitled, the amount of UCX or waiting period credit to which the individual is entitled.

(c) *Redetermination.* The provisions of the applicable State law concerning the right to request, or authority to undertake, reconsideration of a determination pertaining to State unemployment compensation under the applicable State law shall apply to determinations pertaining to UCX.

(d) *Notices to individual and Federal military agency.* (1) The State agency promptly shall give notice in writing to the individual of any determination or redetermination of a first claim, and, except as may be authorized under paragraph (g) of this section, of any determination or redetermination of any weekly claim which denies UCX or waiting period credit or reduces the weekly amount or maximum amount initially determined to be payable. Each notice of determination or redetermination shall include such information regarding the determination or redetermination and notice of right to reconsideration or appeal, or both, as is furnished with written notices of determinations and redeterminations with respect to claims for State unemployment compensation. Such notice shall include the findings of any Federal military agency utilized in making the determination or redetermination, and shall inform the individual of the finality of Federal findings and the individual's right to request correction of such findings as is provided in § 614.22.

(2) A notice of claim filing and subsequent notices of monetary and nonmonetary determinations on a UCX claim shall be sent to each Federal military agency for which the individual performed Federal military service during the appropriate base period, together with notice of appeal rights of the Federal military agency to the same extent that chargeable employers are given such notices under State law and practice unless an alternate mechanism is established by the Department of Labor in lieu of such notices.

(e) *Obtaining information for claim determinations.* (1) Information required for the determination of claims for UCX shall be obtained by the State agency from claimants, employers, and others, in the same manner as information is obtained for claim purposes under the applicable State law, but Federal military findings shall be obtained from military documents, the applicable Schedule of Remuneration, and from Federal military agencies as prescribed in §§ 614.21 through 614.24.

(f) *Promptness.* Full payment of UCX when due shall be consistent with this part and shall be made with the greatest promptness that is administratively feasible, but the provisions of part 640 of this chapter (relating to promptness of benefit payments) shall not be applicable to the UCX Program.

(g) *Secretary's standard.* The procedures for making determinations and redeterminations, and furnishing written notices of determinations, redeterminations, and rights of appeal to individuals applying for UCX and to appropriate Federal military agencies shall be consistent with this part 614 and the Secretary's ''Standard for Claim Determinations-Separation Information'' in the *Employment Security Manual*, part V, sections 6010–6015 (Appendix B of this part).

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40554, Oct. 17, 1988; 71 FR 35514, June 21, 2006]

§ 614.7 Appeal and review.

(a) *Applicable State Law.* The provisions of the applicable State law concerning the right of appeal and fair hearing from a determination or redetermination of entitlement to State unemployment compensation (exclusive of findings which are final and conclusive under § 614.25) shall apply to determinations and redeterminations of eligibility for or entitlement to UCX and waiting period credit. Any such determination or redetermination shall be subject to appeal and review only in the manner and to the extent provided in the applicable State law with respect to determinations and redeterminations of entitlement to State unemployment compensation.

(Section 614.24 governs appeals of findings of the Veterans Administration)

(b) *Rights of appeal and fair hearing.* The provisions on right of appeal and opportunity for a fair hearing with respect to claims for UCX shall be consistent with this part and with sections 303(a)(1) and 303(a)(3) of the Social Security Act, 42 U.S.C. 503(a)(1) and 503(a)(3).

(c) *Promptness on appeals.* (1) Decisions on appeals under the UCX Program shall accord with the Secretary's ''Standard for Appeals Promptness—Unemployment Compensation'' in part 650 of this chapter, and with § 614.1(d).

(2) Any provision of an applicable State law for advancement or priority of unemployment compensation cases on judicial calendars, or otherwise intended to provide for the prompt payment of unemployment compensation when due, shall apply to proceedings involving claims for UCX.

(d) *Appeal and review by Federal military agency.* If a Federal military agency believes that a State agency's determination or redetermination of an individual's eligibility for or entitlement to UCX is incorrect, the Federal military agency may seek appeal and review of such determination or redetermination in the same manner as an interested employer may seek appeal and review under the applicable State law.

§ 614.8 The applicable State for an individual.

(a) *The applicable State.* The applicable State for an individual shall be the State to which the individual's Federal military service and Federal military wages are assigned or transferred under this section. The applicable State law for the individual shall be the State law of such State.

(b) *Assignment of service and wages.* (1) When an individual files a first claim, all of the individual's Federal military service and Federal military wages shall be deemed to be assigned to the State in which such claim is filed, which shall be the ''Paying State'' in the case of a combined-wage claim. (§ 616.6(e) of this chapter.)

(2) Federal military service and Federal military wages assigned to a State in error shall be reassigned for use by the proper State agency. An appropriate record of the reassignment shall

be made by the State agency which makes the reassignment.

(c) *Assignment deemed complete.* All of an individual's Federal military service and Federal military wages shall be deemed to have been assigned to a State upon the filing of a first claim. Federal military service and Federal military wages shall be assigned to a State only in accordance with paragraph (b) of this section.

(d) *Use of assigned service and wages.* All assigned Federal military service and Federal military wages shall be used only by the State to which assigned in accordance with paragraph (b) of this section, except that any Federal military service and Federal military wages which are not within the base period of the State to which they were assigned shall be subject to transfer in accordance with part 616 of this chapter for the purposes of any subsequent Combined-Wage Claim filed by the individual.

§ 614.9 Provisions of State law applicable to UCX claims.

(a) *Particular provisions applicable.* Except where the result would be inconsistent with the provisions of the Act or this part or the procedures thereunder prescribed by the Department, the terms and conditions of the applicable State law which apply to claims for, and the payment of, State unemployment compensation shall apply to claims for, and the payment of, UCX and claims for waiting period credit. The provisions of the applicable State law which shall apply include, but are not limited to:

(1) Claim filing and reporting;

(2) Information to individuals, as appropriate;

(3) Notices to individuals, as appropriate, including notice to each individual of each determination and redetermination of eligibility for or entitlement to UCX;

(4) Determinations and redeterminations;

(5) Ability to work, availability for work, and search for work; and

(6) Disqualifications, except in regard to separation from any Federal military agency.

(b) *IBPP.* The *Interstate Benefit Payment Plan* shall apply, where appropriate, to individuals filing claims for UCX.

(c) *Wage combining.* The State's provisions complying with the *Interstate Arrangement for Combining Employment and Wages* (part 616 of this chapter) shall apply, where appropriate, to individuals filing claims for UCX.

(d) *Procedural requirements.* The provisions of the applicable State law which apply hereunder to claims for and the payment of UCX shall be applied consistently with the requirements of title III of the Social Security Act and the Federal Unemployment Tax Act which are pertinent in the case of State unemployment compensation, including but not limited to those standards and requirements specifically referred to in the provisions of this part, except as provided in paragraph (f) of § 614.6.

§ 614.10 Restrictions on entitlement.

(a) *Disqualification.* If the week of unemployment for which an individual claims UCX is a week to which a disqualification for State unemployment compensation applies under the applicable State law, the individual shall not be entitled to a payment of UCX for that week. As provided in § 614.9(a), no disqualification shall apply in regard to separation from any Federal military agency.

(b) *Effect of ''days lost''.* The continuity of a period of an individual's Federal military service shall not be deemed to be interrupted by reason of any ''days lost'' in such period, but ''days lost'' shall not be counted for purposes of determining:

(1) Whether an individual has performed Federal military service;

(2) Whether an individual meets the wage and employment requirements of a State law; or

(3) The amount of an individual's Federal military wages.

(c) *Allocation of military accrued leave.* A State agency shall allocate the number of days of unused military leave specified in an ex-servicemember's military document, for which a lump-sum payment has been made, in the same manner as similar payments by private employers to their employees are allocated under the applicable State law, except that the applicable Schedule of Remuneration instead of

the lump-sum payment shall be used to determine the amount of the claimant's Federal military wages. In a State in which a private employer has an option as to the period to which such payments shall be allocated, such payments shall be allocated to the date of the individual's latest discharge or release from Federal military service. An allocation under this paragraph shall be disregarded in determining whether an individual has had a period of active service constituting Federal military service.

(d) *Education and training allowances.* An individual is not entitled to UCX under the Act or this part for a period with respect to which the individual receives:

(1) A subsistence allowance for vocational rehabilitation training under chapter 31 of title 38 of the United States Code, 38 U.S.C. 1501 *et seq.*, or under part VIII of Veterans Regulation Numbered 1(a); or

(2) An educational assistance allowance or special training allowance under chapter 35 of title 38 of the United States Code, 38 U.S.C. 1700 *et seq.*

§ 614.11 Overpayments; penalties for fraud.

(a) *False statements and representations.* Section 8507(a) of the Act provides that if a State agency, the Department, or a court of competent jurisdiction finds that an individual—

(1) Knowingly has made, or caused to be made by another, a false statement or representation of a material fact, or knowingly has failed, or caused another to fail, to disclose a material fact; and

(2) As a result of that action has received an amount as UCX to which the individual was not entitled; the individual shall repay the amount to the State agency or the Department. Instead of requiring repayment, the State agency or the Department may recover the amount by deductions from UCX payable to the individual during the 2-year period after the date of the finding. A finding by a State agency or the Department may be made only after an opportunity for a fair hearing, subject to such further review as may be appropriate under § 614.7.

(b) *Prosecution for fraud.* Section 1919 of title 18, United States Code, provides that whoever makes a false statement or representation of a material fact knowing it to be false, or knowingly fails to disclose a material fact, to obtain or increase for himself or for any other individual any payment authorized to be paid under chapter 85 of title 5, United States Code, or under an agreement thereunder, shall be fined not more than $1,000 or imprisoned not more than one year, or both.

(c) *Absence of fraud.* If a State agency or court of competent jurisdiction finds that an individual has received a payment of UCX to which the individual was not entitled under the Act and this part, which was not due to a false statement or representation as provided in paragraph (a) or (b) of this section, the individual shall be liable to repay to the applicable State the total sum of the payment to which the individual was not entitled, and the State agency shall take all reasonable measures authorized under any State law or Federal law to recover for the account of the United States the total sum of the payment to which the individual was not entitled.

(d) *Recovery by offset.* (1) The State agency shall recover, insofar as is possible, the amount of any overpayment which is not repaid by the individual, by deductions from any UCX payable to the individual under the Act and this part, or from any unemployment compensation payable to the individual under any Federal unemployment compensation law administered by the State agency, or from any assistance or allowance payable to the individual with respect to unemployment under any other Federal law administered by the State agency.

(2) A State agency shall also recover, insofar as is possible, the amount of any overpayment of UCX made to the individual by another State by deductions from any UCX payable by the State agency to the individual under the Act and this part, or from any unemployment compensation payable to the individual under any Federal unemployment compensation law administered by the State agency, or from any assistance or allowance payable to

the individual with respect to unemployment under any other Federal law administered by the State agency.

(3) Recoupment of fraudulent overpayments referred to in paragraph (a) of this section shall be limited to the 2-year period stated in that paragraph. Recoupment of fraudulent overpayments referred to in paragraph (b) of this section, and nonfraudulent overpayments referred to in paragraph (c) of this section shall be subject to any time limitation on recoupment provided for in the State law that applies to the case.

(e) *Debts due the United States.* UCX payable to an individual shall be applied by the State agency for the recovery by offset of any debt due to the United States from the individual, but shall not be applied or used by the State agency in any manner for the payment of any debt of the individual to any State or any other entity or person except pursuant to a court order for child support or alimony in accordance with the law of the State and section 459 of the Social Security Act, 42 U.S.C. 659.

(f) *Application of State law.* (1) Except as indicated in paragraph (a) of this section, any provision of State law that may be applied for the recovery of overpayments or prosecution for fraud, and any provision of State law authorizing waiver of recovery of overpayments of unemployment compensation, shall be applicable to UCX.

(2) In the case of any finding of false statement of representation under the Act and paragraph (a) of this section, or prosecution for fraud under 18 U.S.C. 1919 or pursuant to paragraph (f)(1) of this section, the individual shall be disqualified or penalized in accordance with the provision of the applicable State law relating to fraud in connection with a claim for State unemployment compensation.

(g) *Final decision.* Recovery of any overpayment of UCX shall not be enforced by the State agency until the determination or redetermination establishing the overpayment has become final, or if appeal is taken from the determination or redetermination, until the decision after opportunity for a fair hearing has become final.

(h) *Procedural requirements.* (1) The provisions of paragraphs (c), (d), and (g) of § 614.6 shall apply to determinations and redeterminations made pursuant to this section.

(2) The provisions of § 614.7 shall apply to determinations and redeterminations made pursuant to this section.

(i) *Fraud detection and prevention.* Provisions in the procedures of each State with respect to detection and prevention of fraudulent overpayments of UCX shall be, as a minimum, commensurate with the procedures adopted by the State with respect to State unemployment compensation and consistent with this part 614 and the Secretary's ''Standard for Fraud and Overpayment Detection'' in the *Employment Security Manual*, part V, sections 7510–7515 (Appendix C of this part), and provide for timely use of any crossmatch mechanism established by the Department.

(j) *Recovered overpayments.* An amount repaid or recouped under this section shall be—

(1) Deposited in the fund from which payment was made, if the repayment was to a State agency; or

(2) Returned to the Treasury of the United States and credited to the current applicable appropriation, fund, or account from which payment was made, if the repayment was to the Department.

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40555, Oct. 17, 1988]

§ 614.12 Schedules of remuneration.

(a) *Authority.* Section 8521(a)(2) of chapter 85, title 5 of the United States Code, 5 U.S.C. 8521(a)(2), requires the Secretary of Labor to issue from time to time, after consultation with the Secretary of Defense, a Schedule of Remuneration specifying the pay and allowances for each pay grade of members of the Armed Forces.

(b) *Elements of schedule.* A schedule reflects representative amounts for appropriate elements of the pay and allowances, whether in cash or kind, for each pay grade of members of the Armed Forces, with a statement of the effective date of the schedule. Benefit amounts for the UCX Program are computed on the basis of the Federal

military wages for the pay grade of the individual at the time of the individual's latest discharge or release from Federal military service, as specified in the schedule applicable at the time the individual files his or her first claim for compensation for the benefit year.

(c) *Effective date.* Any new Schedule of Remuneration shall take effect beginning with the first week of the calendar quarter following the calendar quarter in which such schedule is issued, and shall remain applicable until a subsequent schedule becomes effective. Prior schedules shall continue to remain applicable for the periods they were in effect.

(d) *Publication.* Any new Schedule of Remuneration shall be issued by the Secretary of Labor to the State agencies and the Federal military agencies. Promptly after the issuance of a new Schedule of Remuneration it shall be published as a notice in the FEDERAL REGISTER.

§ 614.13 Inviolate rights to UCX.

Except as specifically provided in this part, the rights of individuals to UCX shall be protected in the same manner and to the same extent as the rights of persons to State unemployment compensation are protected under the applicable State law. Such measures shall include protection of applicants for UCX from waiver, release, assignment, pledge, encumbrance, levy, execution, attachment, and garnishment of their rights to UCX, except as provided in § 614.11. In the same manner and to the same extent, individuals shall be protected from discrimination and obstruction in regard to seeking, applying for, and receiving any right to UCX.

§ 614.14 Recordkeeping; disclosure of information.

(a) *Recordkeeping.* Each State agency will make and maintain records pertaining to the administration of the UCX Program as the Department requires, and will make all such records available for inspection, examination, and audit by such Federal officials or employees as the Department may designate or as may be required by law.

(b) *Disclosure of information.* Information in records maintained by a State agency in administering the UCX Program shall be kept confidential, and information in such records may be disclosed only in the same manner and to the same extent as information with respect to State unemployment compensation and the entitlement of individuals thereto may be disclosed under the applicable State law. This provision on the confidentiality of information maintained in the administration of the UCX Program shall not apply, however, to the Department or for the purposes of §§ 614.11 or 614.14, or in the case of information, reports and studies required pursuant to §§ 614.18 or 614.26, or where the result would be inconsistent with the Freedom of Information Act, 5 U.S.C. 552, the Privacy Act of 1974, 5 U.S.C. 552a, or regulations of the Department promulgated thereunder.

§ 614.15 Payments to States.

(a) *State entitlement.* Each State is entitled to be paid by the United States with respect to each individual whose base period wages included Federal military wages, an amount bearing the same ratio to the total amount of compensation paid to such individual as the amount of the individual's Federal military wages in the individual's base period bears to the total amount of the individual's base period wages.

(b) *Payment.* Each State shall be paid, either in advance or by way of reimbursement, as may be determined by the Department, the sum that the Department estimates the State is entitled to receive under the Act and this part for each calendar month. The sum shall be reduced or increased by the amount which the Department finds that its estimate for an earlier calendar month was greater or less than the sum which should have been paid to the State. An estimate may be made on the basis of a statistical, sampling, or other method agreed on by the Department and the State agency.

(c) *Certification by the Department.* The Department, from time to time, shall certify to the Secretary of the Treasury the sum payable to each State under this section. The Secretary of the Treasury, before audit or settlement by the General Accounting Office, shall pay the State in accordance

with the certification from the funds for carrying out the purposes of the Act and this part.

(d) *Use of money.* Money paid a State under the Act and this part may be used solely for the purposes for which it is paid. Money so paid which is not used solely for these purposes shall be returned, at the time specified by the Agreement, to the Treasury of the United States and credited to the current applicable appropriation, fund, or account from which payments to States under the Act and this part may be made.

§ 614.16 Public access to Agreements.

The State agency of a State will make available to any individual or organization a true copy of the Agreement with the State for inspection and copying. Copies of an Agreement may be furnished on request to any individual or organization upon payment of the same charges, if any, as apply to the furnishing of copies of other records of the State agency.

§ 614.17 Administration in absence of an Agreement.

(a) *Administering program.* The Department shall administer the UCX Program through personnel of the Department or through other arrangements under procedures prescribed by the Department, in the case of any State which does not have an Agreement with the Secretary as provided for in 5 U.S.C. 8502. The procedures prescribed by the Department under this section shall be consistent with the Act and this part.

(b) *Applicable State law.* On the filing by an individual of a claim for UCX in accordance with arrangements under this section, UCX shall be paid to the individual, if eligible, in the same amount, on the same terms, and subject to the same conditions as would be paid to the individual under the applicable State law if the individual's Federal military service and Federal military wages had been included as employment and wages under the State law. Any such claims shall include the individual's Federal military service and Federal military wages, combined with any service and wages covered by State law. However, if the individual, without regard to his or her Federal military service and Federal military wages, has employment or wages sufficient to qualify for compensation during the benefit year under that State law, then payments of UCX under this section may be made only on the basis of the individual's Federal military service and Federal military wages.

(c) *Fair hearing.* An individual whose claim for UCX is denied under this section is entitled to a fair hearing under rules of procedures prescribed by the Department. A final determination by the Department with respect to entitlement to UCX under this section is subject to review by the courts in the same manner and to the same extent as is provided by section 205(g) of the Social Security Act, 42 U.S.C. 405(g).

§ 614.18 Information, reports, and studies.

State agencies shall furnish to the Department such information and reports and conduct such studies as the Department determines are necessary or appropriate for carrying out the purposes of the UCX Program.

Subpart C—Responsibilities of Federal Military Agencies and State Agencies

§ 614.20 Information to ex-servicemembers.

At the time of discharge or release from Federal military service, each Federal military agency shall furnish to each ex-servicemember information explaining rights and responsibilities under the UCX Program and 18 U.S.C. 1919, and military documents necessary for filing claims for UCX.

§ 614.21 Findings of Federal military agency.

(a) *Findings in military documents.* Information contained in a military document furnished to an ex-servicemember shall constitute findings to which § 614.23 applies as to:

(1) Whether the individual has performed active service in the Armed Forces or the Commissioned Corps of the National Oceanic and Atmospheric Administration;

(2) The beginning and ending dates of the period of active service and ''days lost'' during such period;

(3) The type of discharge or release terminating the period of active service;

(4) The individuals' pay grade at the time of discharge or release from active service; and

(5) The narrative reason or other reason for separation from active service.

(b) *Discharges not under honorable conditions.* A military document which shows that an individual's discharge or release was under other than honorable conditions shall also be a finding to which § 614.23 applies.

[53 FR 40555, Oct. 17, 1988]

§ 614.22 Correcting Federal findings.

(a) *Request for correction.* (1) If an individual believes that a finding specified in § 614.21 is incorrect or that information as to any finding has been omitted from a military document, the individual may request the issuing Federal military agency to correct the military document. A request for correction may be made through the State agency, which shall forward such request and any supporting information submitted by the individual to the Federal military agency.

(2) The Federal military agency shall promptly forward to the individual or State agency making the request the corrected military document. Information contained in a corrected military document issued pursuant to such a request shall constitute the findings of the Federal military agency under § 614.21.

(3) If a determination or redetermination based on a finding as to which correction is sought has been issued by a State agency before a request for correction under this paragraph is made, the individual who requested such correction shall file a request for redetermination or appeal from such determination or redetermination with the State agency, and shall inform the State agency of the request for correction.

(4) An individual who files a request for correction of findings under this paragraph shall promptly notify the State agency of the action of the Federal military agency on such request.

(b) *State agency procedure when request made.* (1) If a determination of entitlement has not been made when an individual notifies a State agency of a request for correction under paragraph (a) of this section, the State agency may postpone such determination until the individual has notified the State agency of the action of the Federal military agency on the request.

(2) If a determination of entitlement has been made when an individual notifies a State agency that a request for correction of Federal findings has been made, or if an individual notifies a State agency prior to a determination of entitlement that a request has been made but such determination is not postponed by the State agency, the individual may file a request for redetermination or appeal in accordance with the applicable State law.

(3) Except as provided in paragraph (c) of this section, no redetermination shall be made or hearing scheduled on an appeal until the individual has notified the State agency of the action of the Federal military agency on a request for correction under paragraph (a) of this section.

(c) *State agency procedure when request answered.* On receipt of notice of the action of a Federal military agency on a request for correction of its findings, a State agency shall:

(1) Make a timely determination or redetermination of the individual's entitlement, or

(2) Promptly schedule a hearing on the individual's appeal.

If such notice is not received by a State agency within one year of the date on which an individual first filed a claim, or such notice is not given promptly by an individual, a State agency without further postponement may make such determination or redetermination or schedule such hearing.

(d) *Findings corrected without request.* Information as to any finding specified in § 614.21 contained in a corrected military document issued by a Federal military agency on its own motion shall constitute the findings of such agency under § 614.21, if notice thereof is received by a State agency before the period for redetermination or appeal has expired under the State law. On timely receipt of such notice a

State agency shall take appropriate action under the applicable State law to give effect to the corrected findings.

§ 614.23 Finality of findings.

The findings of a Federal military agency referred to in §§ 614.21 and 614.22, and the Schedules of Remuneration issued by the Department pursuant to the Act and § 614.12, shall be final and conclusive for all purposes of the UCX Program, including appeal and review pursuant to § 614.7 or § 614.17.

[53 FR 40555, Oct. 17, 1988]

§ 614.24 Furnishing other information.

(a) *Additional information.* In addition to the information required by §§ 614.21 and 614.22, a Federal military agency shall furnish to a State agency or the Department, within the time requested, any information which it is not otherwise prohibited from releasing by law, which the Department determines is necessary for the administration of the UCX Program.

(b) *Reports.* Federal military agencies shall furnish to the Department or State agencies such reports containing such information as the Department determines are necessary or appropriate for carrying out the purposes of the UCX Program.

[47 FR 54697, Dec. 3, 1982, as amended at 53 FR 40555, Oct. 17, 1988]

§ 614.25 Liaison with Department

To facilitate the Department's administration of the UCX program, each Federal military agency shall designate one or more of its officials to be the liaison with the Department. Each Federal military agency will inform the Department of its designation(s) and of any change in a designation.

[53 FR 40555, Oct. 17, 1988]

APPENDIX A TO PART 614—STANDARD FOR CLAIM FILING, CLAIMANT REPORTING, JOB FINDING, AND EMPLOYMENT SERVICES

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 5000–5004)*

5000–5099 *Claims Filing*

5000 *Standards for Claim Filing, Claimant Reporting, Job Finding, and Employment Services*

A. *Federal law requirements.* Section 3304(a)(1) of the Federal Unemployment Tax Act and section 303(a)(2) of the Social Security Act require that a State law provide for:

''Payment of unemployment compensation solely through public employment offices or such other agencies as the Secretary may approve.''

Section 3304(a)(4) of the Federal Unemployment Tax Act and section 303(a)(5) of the Social Security Act require that a State law provide for:

''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation. * * *''

Section 303(a)(1) of the Social Security Act requires that the State law provide for:

''Such methods of administration * * * as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

B. *Secretary's interpretation of Federal law requirements.*

1. The Secretary interprets section 3304(a)(1) of the Federal Unemployment Tax Act and section 303(a)(2) of the Social Security Act to require that a State law provide for payment of unemployment compensation solely through public employment offices or claims offices administered by the State employment security agency if such agency provides for such coordination in the operations of its public employment offices and claims offices as will insure: (a) The payment of benefits only to individuals who are unemployed and who are able to work and available for work, and (b) that individuals claiming unemployment compensation (claimants) are afforded such placement and other employment services as are necessary and appropriate to return them to suitable work as soon as possible.

2. The Secretary interprets all the above sections to require that a State law provide for:

a. Such contact by claimants with public employment offices or claims offices or both, (1) as will reasonably insure the payment of unemployment compensation only to individuals who are unemployed and who are able to work and available for work, and (2)

*Revises subgrouping 5000–5004.

that claimants are afforded such placement and other employment services as are necessary and appropriate to facilitate their return to suitable work as soon as possible; and

b. Methods of administration which do not unreasonably limit the opportunity of individuals to establish their right to unemployment compensation due under such State law.

5001 *Claim Filing and Claimant Reporting Requirements Designed to Satisfy Secretary's Interpretation*

A. *Claim filing—total or part-total unemployment.*

1. Individuals claiming unemployment compensation for total or part-total unemployment are required to file a claim weekly or biweekly, in person or by mail, at a public employment office or a claims office (these terms include offices at itinerant points) as set forth below.

2. Except as provided in paragraph 3, a claimant is required to file in person:

a. His new claim with respect to a benefit year, or his continued claim for a waiting week or for his first compensable week of unemployment in such year; and

b. Any other claim, when requested to do so by the claims personnel at the office at which he files his claim(s) because questions about his right to benefits are raised by circumstances such as the following:

(1) The conditions or circumstances of his separation from employment;

(2) The claimant's answers to questions on mail claim(s) indicate that he may be unable to work or that there may be undue restrictions on his availability for work or that his search for work may be inadequate or that he may be disqualified;

(3) The claimant's answers to questions on mail claims create uncertainty about his credibility or indicate a lack of understanding of the applicable requirement; or

(4) The claimant's record shows that he has previously filed a fraudulent claim.

In such circumstances, the claimant is required to continue to file claims in person each week (or biweekly) until the State agency determines that filing claims in person is no longer required for the resolution of such questions.

3. A claimant must be permitted to file a claim by mail in any of the following circumstances:

a. He is located in an area requiring the expenditure of an unreasonable amount of time or money in traveling to the nearest facility established by the State agency for filing claims in person;

b. Conditions make it impracticable for the agency to take claims in person;

c. He has returned to full-time work on or before the scheduled date for his filing a claim, unless the agency makes provision for in-person filing at a time and place that does not interfere with his employment;

d. The agency finds that he has good cause for failing to file a claim in person.

4. A claimant who has been receiving benefits for partial unemployment may continue to file claims as if he were a partially unemployed worker for the first four consecutive weeks of total or part-total unemployment immediately following his period of partial unemployment so long as he remains attached to his regular employer.

B. *Claim filing—partial unemployment.* Each individual claiming unemployment compensation for a week (or other claim period) during which, because of lack of work, he is working less than his normal customary full-time hours for his regular employer and is earning less than the earnings limit provided in the State law, shall not be required to file a claim for such week or other claim period earlier than 2 weeks from the date that wages are paid for such claim period or, if a low earnings report is required by the State law, from the date the employer furnished such report to the individual. State agencies may permit claims for partial unemployment to be filed either in person or by mail, except that in the circumstances set forth in section A 3, filing by mail must be permitted, and in the circumstances set forth in section A 2 b, filing in person may be required.

5002 *Requirement for Job Finding, Placement, and other Employment Services Designed to Satisfy Secretary's Interpretation*

A. Claims personnel are required to assure that each claimant is doing what a reasonable individual in his circumstances would do to obtain suitable work.

B. In the discretion of the State agency:

1. The claims personnel are required to give each claimant such necessary and appropriate assistance as they reasonably can in finding suitable work and at their discretion determine when more complete placement and employment services are necessary and appropriate for a claimant; and if they determine more complete services are necessary and appropriate, the claims personnel are to refer him to employment service personnel in the public employment office in which he has been filing claim(s), or, if he has been filing in a claims office, in the public employment office most accessible to him; *or*

2. All placement and employment services are required to be afforded to each claimant by employment service personnel in the public employment office most accessible to him, in which case the claims personnel in the office in which the claimant files his claim are to refer him to the employment service personnel when placement or other employment services are necessary and appropriate for him.

C. The personnel to whom the State agency assigns the responsibilities outlined in paragraph B above are required to give claimants such job-finding assistance, placement, and other employment services as are necessary and appropriate to facilitate their return to suitable work as soon as possible.

In some circumstances, no such services or only limited services may be required. For example, if a claimant is on a short-term temporary layoff with a fixed return date, the only service necessary and appropriate to be given to him during the period of the layoff is a referral to suitable temporary work if such work is being performed in the labor market area.

Similarly, claimants whose unemployment is caused by a labor dispute presumably will return to work with their employer as soon as the labor dispute is settled. They generally do not need services, nor do individuals in occupations where placement customarily is made by other nonfee charging placement facilities such as unions and professional associations.

Claimants who fall within the classes which ordinarily would require limited services or no services shall, if they request placement and employment services, be afforded such services as are necessary and appropriate for them to obtain suitable work or to achieve their reasonable employment goals.

On the other hand, a claimant who is permanently separated from his job is likely to require some services. He may need only some direction in how to get a job; he may need placement services if he is in an occupation for which there is some demand in the labor market area; if his occupation is outdated, he may require counseling and referral to a suitable training course. The extent and character of the services to be given any particular claimant may change with the length of his unemployment and depend not only on his own circumstances and conditions, but also on the condition of the labor market in the area.

D. Claimants are required to report to employment service personnel, as directed, but such personnel and the claims personnel are required to so arrange and coordinate the contacts required of a claimant as not to place an unreasonable burden on him or unreasonably limit his opportunity to establish his rights to compensation. As a general rule, a claimant is not required to contact in person claims personnel or employment service personnel more frequently than once a week, unless he is directed to report more frequently for a specific service such as referral to a job or a training course or counseling which cannot be completed in one visit.

E. Employment service personnel are required to report promptly to claims personnel in the office in which the claimant files his claim(s): (1) His failure to apply for or accept work to which he was referred by such personnel or when known, by any other nonfee-charging placement facility such as a union or a professional association; and (2) any information which becomes available to it that may have a bearing on the claimant's ability to work or availability for work, or on the suitability of work to which he was referred or which was offered to him.

5004 *Evaluation of Alternative State Provisions.* If the State law provisions do not conform to the ''suggested State law requirements'' set forth in sections 5001 and 5002, but the State law contains alternative provisions, the Manpower Administrator, in collaboration with the State agency, will study the actual or anticipated effect of the alternative provisions. If the Manpower Administrator concludes that the alternative provisions satisfy the requirements of the Federal law as construed by the Secretary (see section 5000 B) he will so notify the State agency. If he does not so conclude, he will submit the matter to the Secretary. If the Secretary concludes that the alternative provisions satisfy such requirements, the State agency will be so notified. If the Secretary concludes that there is a question as to whether the alternative provisions satisfy such requirements, the State agency will be advised that unless the State law provisions are appropriately revised, a notice of hearing will be issued as required by the Code of Federal Regulations, title 20, section 601.3.

[53 FR 40555, Oct. 17, 1988; 53 FR 43799, Oct. 26, 1988]

APPENDIX B TO PART 614—STANDARD FOR CLAIM DETERMINATION—SEPARATION INFORMATION

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 6010–6015)

6010–6019 *Standard for Claim Determinations—Separation Information* *

6010 *Federal Law Requirements.* Section 303(a)(1) of the Social Security Act requires that a State law include provision for:

''Such methods of administration . . . as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

Section 303(a)(3) of the Social Security Act requires that a State law include provision for:

''Opportunity for a fair hearing before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied.''

* Revises subgrouping 6010–6019

Section 3304(a)(4) of the Federal Unemployment Tax Act and section 303(a)(5) of the Social Security Act require that a State law include provision for:

''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation * * *.

Section 3306(h) of the Federal Unemployment Tax Act defines ''compensation'' as ''cash benefits payable to individuals with respect to their unemployment.''

6011 *Secretary's Interpretation of Federal Law Requirements.* The Secretary interprets the above sections to require that a State law include provisions which will insure that:

A. Individuals who may be entitled to unemployment compensation are furnished such information as will reasonably afford them an opportunity to know, establish, and protect their rights under the unemployment compensation law of such State, and

B. The State agency obtains and records in time for the prompt determination and review of benefit claims such information as will reasonably insure the payment of benefits to individuals to whom benefits are due.

6012 *Criteria for Review of State Law Conformity with Federal Requirements*

In determining the conformity of a State law with the above requirements of the Federal Unemployment Tax Act and the Social Security Act as interpreted by the Secretary, the following criteria will be applied:

A. Is it required that individuals who may be entitled to unemployment compensation be furnished such information of their potential rights to benefits, including the manner and places of filing claims, the reasons for determinations, and their rights of appeal, as will insure them a reasonable opportunity to know, establish, and protect their rights under the law of the State?

B. Is the State agency required to obtain, in time for prompt determination of rights to benefits such information as will reasonably insure the payment of benefits to individuals to whom benefits are due?

C. Is the State agency required to keep records of the facts considered in reaching determinations of rights to benefits?

6013 *Claim Determinations Requirements Designed To Meet Department of Labor Criteria*

A. *Investigation of claims.* The State agency is required to obtain promptly and prior to a determination of an individual's right to benefits, such facts pertaining thereto as will be sufficient reasonably to insure the payment of benefits when due.

This requirement embraces five separate elements:

1. It is the responsibility of the agency to take the initiative in the discovery of information. This responsibility may not be passed on the claimant or the employer. In addition to the agency's own records, this information may be obtained from the worker, the employer, or other sources. If the information obtained in the first instance discloses no essential disagreement and provides a sufficient basis for a fair determination, no further investigation is necessary. If the information obtained from other sources differs essentially from that furnished by the claimant, the agency, in order to meet its responsibility, is required to inform the claimant of such information from other sources and to afford the claimant an opportunity to furnish any further facts he may have.

2. Evidentiary facts must be obtained as distinguished from ultimate facts or conclusions. That a worker was discharged for misconduct is an ultimate fact or conclusion; that he destroyed a machine upon which he was working is a primary or evidentiary fact, and the sort of fact that the requirement refers to.

3. The information obtained must be sufficient reasonably to insure the payment of benefits when due. In general, the investigation made by the agency must be complete enough to provide information upon which the agency may act with reasonable assurance that its decision is consistent with the unemployment compensation law. On the other hand, the investigation should not be so exhaustive and time-consuming as unduly to delay the payment of benefits and to result in excessive costs.

4. Information must be obtained promptly so that the payment of benefits is not unduly delayed.

5. If the State agency requires any particular evidence from the worker, it must give him a reasonable opportunity to obtain such evidence.

B. *Recording of facts.* The agency must keep a written record of the facts considered in reaching its determinations.

C. *Determination notices*

1. The agency must give each claimant a written notice of:

a. Any monetary determination with respect to his benefit year;

b. Any determination with respect to purging a disqualification if, under the State law, a condition or qualification must be satisfied with respect to each week of disqualification; but in lieu of giving written notice of each determination for each week in which it is determined that the claimant has met the requirements for purging the agency may inform the claimant that he has purged the disqualification for a week by notation on his applicant identification card or otherwise in writing.

c. Any other determination which adversely affects[1] his rights to benefits, except that written notice of determination need not be given with respect to:

(1) A week in a benefit year for which the claimant's weekly benefit amount is reduced in whole or in part by earnings if, the first time in the benefit year that there is such a reduction, he is required to be furnished a booklet or leaflet containing the information set forth below in paragraph 2f(1). However, a written notice of determination is required if: (a) There is a dispute concerning the reduction with respect to any week (e.g., as to the amount computed as the appropriate reduction, etc.); or (b) there is a change in the State law (or in the application thereof) affecting the reduction; or

(2) Any week in a benefit year subsequent to the first week in such benefit year in which benefits were denied, or reduced in whole or in part for reasons other than earnings, if denial or reduction for such subsequent week is based on the same reason and the same facts as for the first week, and if written notice of determination is required to be given to the claimant with respect to such first week, and with such notice of determination, he is required to be given a booklet or pamphlet containing the information set forth below in paragraphs 2f(2) and 2h. However, a written notice of determination is required if: (a) There is a dispute concerning the denial or reduction of benefits with respect to such week; or (b) there is a change in the State law (or in the application thereof) affecting the denial or reduction; or (c) there is a change in the amount of the reduction except as to the balance covered by the last reduction in a series of reductions.

NOTE: This procedure may be applied to determinations made with respect to any subsequent weeks for the same reason and on the basis of the same facts: (a) That claimant is unable to work, unavailable for work, or is disqualified under the labor dispute provision; and (b) reducing claimant's weekly benefit amount because of income other than earnings or offset by reason of overpayment.

2. The agency must include in written notices of determinations furnished to claimants sufficient information to enable them to understand the determinations, the reasons therefor, and their rights to protest, request reconsideration, or appeal.

The written notice of monetary determination must contain the information specified in the following items (except h) unless an item is specifically not applicable. A written notice of any other determination must contain the information specified in as many of the following items as are necessary to enable the claimant to understand the determination and to inform him of his appeal rights. Information specifically applicable to the individual claimant must be contained in the written notice of determination. Information of general application such as (but not limited to) the explanation of benefits for partial unemployment, information as to deductions, seasonality factors, and information as to the manner and place of taking an appeal, extension of the appeal period, and where to obtain information and assistance may be contained in a booklet or leaflet which is given the claimant with his monetary determination.

a. *Base period wages.* The statement concerning base-period wages must be in sufficient detail to show the basis of computation of eligibility and weekly and maximum benefit amounts. (If maximum benefits are allowed, it may not be necessary to show details of earnings.)

b. *Employer name.* The name of the employer who reported the wages is necessary so that the worker may check the wage transcript and know whether it is correct. If the worker is given only the employer number, he may not be able to check the accuracy of the wage transcript.

c. *Explanation of benefit formula—weekly and maximum benefit amounts.* Sufficient information must be given the worker so that he will understand how his weekly benefit amount, including allowances for dependents, and his maximum benefit amount were figured. If benefits are computed by means of a table contained in the law, the table must be furnished with the notice of determination whether benefits are granted or denied.

The written notice of determination must show clearly the weekly benefit amount and the maximum potential benefits to which the claimant is entitled.

The notice to a claimant found ineligible by reason of insufficient earnings in the base period must inform him clearly of the reason for ineligibility. An explanation of the benefit formula contained in a booklet or pamphlet should be given to each claimant at or

[1] A determination ''adversely affects'' claimant's right to benefits if it: (1) Results in a denial to him of benefits (including a cancellation of benefits or wage credits or any reduction in whole or in part below the weekly or maximum amount established by his monetary determination) for any week or other period; or (2) denies credit for a waiting week; or (3) applies any disqualification or penalty; or (4) determines that he has not satisfied a condition of eligibility, requalification for benefits, or purging a disqualification; or (5) determines that an overpayment has been made or orders repayment or recoupment of any sum paid to him; or (6) applies a previously determined overpayment, penalty, or order for repayment or recoupment; or (7) in any other way denies claimant a right to benefits under the State law.

prior to the time he receives written notice of a monetary determination.

d. *Benefit year.* An explanation of what is meant by the benefit year and identification of the claimant's benefit year must be included in the notice of determination.

e. *Information as to benefits for partial unemployment.* There must be included either in the written notice of determination or in a booklet or pamphlet accompanying the notice an explanation of the claimant's rights to partial benefits for any week with respect to which he is working less than his normal customary full-time workweek because of lack of work and for which he earns less than his weekly benefit amount or weekly amount plus earnings, whichever is provided by the State law. If the explanation is contained in the notice of determination, reference to the item in the notice in which his weekly benefit amount is entered should be made.

f. *Deductions from weekly benefits.*

(1) *Earnings.* Although written notice of determinations deducting earnings from a claimant's weekly benefit amount is generally not required (see paragraph 1c (1) above), where written notice of determination is required (or given) it shall set forth the amount of earnings, the method of computing the deduction in sufficient detail to enable the claimant to verify the accuracy of the deduction, and his right to protest, request redetermination, and appeal. Where a written notice of determination is given to the claimant because there has been a change in the State law or in the application of the law, an explanation of the change shall be included.

Where claimant is not required to receive a written notice of determination, he must be given a booklet or pamphlet the first time in his benefit year that there is a deduction for earnings which shall include the following information:

(a) The method of computing deductions for earnings in sufficient detail to enable the claimant to verify the accuracy of the deduction;

(b) That he will not automatically be given a written notice of determination for a week with respect to which there is a deduction for earnings (unless there is a dispute concerning the reduction with respect to a week or there has been a change in the State law or in the application of the law affecting the deduction) but that he may obtain such a written notice upon request; and

(c) A clear statement of his right to protest, request a redetermination, and appeal from any determination deducting earnings from his weekly benefit amount even though he does not automatically receive a written notice of determination; and if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

(2) *Other deductions.*

(a) A written notice of determination is required with respect to the first week in claimant's benefit year in which there is a reduction from his benefits for a reason other than earnings. This notice must describe the deduction made from claimant's weekly benefit amount, the reason for the deduction, the method of computing it in sufficient detail to enable him to verify the accuracy of such deduction, and his right to protest, request redetermination, or appeal.

(b) A written notice of determination is not required for subsequent weeks that a deduction is made for the same reason and on the basis of the same facts, if the notice of determination pursuant to (2)(a), or a booklet or pamphlet given him with such notice explains: (i) The several kinds of deductions which may be made under the State law (e.g., retirement pensions, vacation pay, and overpayments); (ii) the method of computing each kind of deduction in sufficient detail that claimant will be able to verify the accuracy of deductions made from his weekly benefit payments; (iii) any limitation on the amount of any deduction or the time in which any deduction may be made; (iv) that he will not automatically be given a written notice of determination for subsequent weeks with respect to which there is a deduction for the same reason and on the basis of the same facts, but that he may obtain a written notice of determination upon request; (v) his right to protest, request redetermination, or appeal with respect to subsequent weeks for which there is a reduction from his benefits for the same reason, and on the basis of the same facts even though he does not automatically receive a written notice of determination; and (vi) that if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

g. *Seasonality factors.* If the individual's determination is affected by seasonality factors under the State law, an adequate explanation must be made. General explanations of seasonality factors which may affect determinations for subsequent weeks may be included in a booklet or pamphlet given with his notice of monetary determination.

h. *Disqualification or ineligibility.* If a disqualification is imposed, or if the claimant is declared ineligible for one or more weeks, he must be given not only a statement of the period of disqualification or ineligibility and the amount of wage-credit reductions, if any, but also an explanation of the reason for the ineligibility or disqualification. This explanation must be sufficiently detailed so that he will understand why he is ineligible or

why he has been disqualified, and what he must do in order to requalify for benefits or purge the disqualification. The statement must be individualized to indicate the facts upon which the determination was based, e.g., state, ''It is found that you left your work with Blank Company because you were tired of working; the separation was voluntary, and the reason does not constitute good cause,'' rather than merely the phrase ''voluntary quit.'' Checking a box as to the reason for the disqualification is not a sufficiently detailed explanation. However, this statement of the reason for the disqualification need not be a restatement of all facts considered in arriving at the determination.

i. *Appeal rights.* The claimant must be given information with respect to his appeal rights.

(1) The following information shall be included in the notice of determination:

(a) A statement that he may appeal or, if the State law requires or permits a protest or redetermination before an appeal, that he may protest or request a redetermination.

(b) The period within which an appeal, protest, or request for redetermination must be filed. The number of days provided by statute must be shown as well as either the beginning date or ending date of the period. (It is recommended that the ending date of the appeal period be shown, as this is the more understandable of the alternatives.)

(2) The following information must be included either in the notice of determination or in separate informational material referred to in the notice:

(a) The manner in which the appeal, protest, or request for redetermination must be filed, e.g., by signed letter, written statement, or on a prescribed form, and the place or places to which the appeal, protest, or request for redetermination may be mailed or hand-delivered.

(b) An explanation of any circumstances (such as nonworkdays, good cause, etc.) which will extend the period for the appeal, protest, or request for redetermination beyond the date stated or identified in the notice of determination.

(c) That any further information claimant may need or desire can be obtained together with assistance in filing his appeal, protest, or request for redetermination from the local office.

If the information is given in separate material, the notice of determination would adequately refer to such material if it said, for example, ''For other information about your (appeal), (protest), (redetermination) rights, see pages __ to __ of the _____ (name of pamphlet or booklet) heretofore furnished to you.''

6014 *Separation Information Requirements Designed To Meet Department of Labor Criteria*

A. *Information to agency.* Where workers are separated, employers are required to furnish the agency promptly, either upon agency request or upon such separation, a notice describing the reasons for and the circumstances of the separation and any additional information which might affect a claimant's right to benefits. Where workers are working less than full time, employers are required to furnish the agency promptly, upon agency request, information concerning a claimant's hours of work and his wages during the claim periods invovled, and other facts which might affect a claimant's eligibility for benefits during such periods.

When workers are separated and the notices are obtained on a request basis, or when workers are working less than full time and the agency requests information, it is essential to the prompt processing of claims that the request be sent out promptly after the claim is filed and the employer be given a specific period within which to return the notice, preferably within 2 working days.

When workers are separated and notices are obtained upon separation, it is essential that the empolyer be required to send the notice to the agency with sufficient promptness to insure that, if a claim is filed, it may be processed promptly. Normally, it is desirable that such a notice be sent to the central office of the agency, since the employer may not know in which local office the worker will file his claim. The usual procedure is for the employer to give the worker a copy of the notice sent by the employer to the agency.

B. *Information to worker.*

1. *Information required to be given.* Employees are required to give their employers information and instructions concerning the employees' potential rights to benefits and concerning registration for work and filing claims for benefits.

The information furnished to employees under such a requirement need not be elaborate; it need only be adequate to insure that the worker who is separated or who is working less than full time knows he is potentially eligible for benefits and is informed as to what he is to do or where he is to go to file his claim and register for work. When he files his claim, he can obtain more detailed information.

In States that do not require employers to furnish periodically to the State agency detailed reports of the wages paid to their employees, each employer is required to furnish to his employees information as to: (a) The name under which he is registered by the State agency, (b) the address where he maintains his payroll records, and (c) the workers' need for this information if and when they file claims for benefits.

2. *Methods for giving information.* The information and instructions required above may be given in any of the following ways:

a. *Posters prominently displayed in the employer's establishment.* The State agency should supply employers with a sufficient number of posters for distribution throughout their places of business and should see that the posters are conspicuously displayed at all times.

b. *Leaflets.* Leaflets distributed either periodically or at the time of separation or reduction of hours. The State agency should supply employers with a sufficient number of leaflets.

c. *Individual notices.* Individual notices given to each employee at the time of separation or reduction in hours.

It is recommended that the State agency's publicity program be used to supplement the employer-information requirements. Such a program should stress the availability and location of claim-filing offices and the importance of visiting those offices whenever the worker is unemployed, wishes to apply for benefits, and to seek a job.

6015 *Evaluation of Alternative State Provisions with Respect to Claim Determinations and Separation Information.* If the State law provisions do not conform to the suggested requirements set forth in sections 6013 and 6014, but the State law contains alternative provisions, the Bureau of Employment Security, in collaboration with the State agency, will study the actual or anticipated effects of the alternative provisions. If the Administrator of the Bureau concludes that the alternative provisions satisfy the criteria in section 6012, he will so notify the State agency. If the Administrator of the Bureau does not so conclude, he will submit the matter to the Secretary. If the Secretary concludes that the alternative provisions satisfy the criteria in section 6012, the State agency will be so notified. If the Secretary concludes that there is a question as to whether the alternative provisions satisfy the criteria, the State agency will be advised that unless the State law provisions are appropriately revised, a notice of hearing will be issued as required by the Code of Federal Regulations, title 20, §601.5.

[53 FR 40557, Oct. 17, 1988; 53 FR 43799, Oct. 26, 1988]

APPENDIX C TO PART 614—STANDARD FOR FRAUD AND OVERPAYMENT DETECTION

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 7510–7515)

7510–7519 *Standard for Fraud and Overpayment Detection*

7510 *Federal Law Requirements.* Section 303(a)(1) of the Social Security Act requires that a State law include provision for:

''Such methods of administration * * * as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

Section 1603(a)(4) of the Internal Revenue Code and section 3030(a)(5) of the Social Security Act require that a State law include provision for:

''Expenditure for all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation * * *''

Section 1607(h) of the Internal Revenue Code defines ''compensation'' as ''cash benefits payable to individuals with respect to their unemployment.''

7511 *The Secretary's Interpretation of Federal Law Requirements.* The Secretary of Labor interprets the above sections to require that a State law include provision for such methods of administration as are, within reason, calculated (1) to detect benefits paid through error by the agency or through willful misrepresentation or error by the claimant or others, and (2) to deter claimants from obtaining benefits through willful misrepresentation.

7513 *Criteria for Review of State Conformity With Federal Requirements.* In detemining State conformity with the above requirements of the Internal Revenue Code and the Social Security Act, as interpreted by the Secretary of Labor, the following criteria will be applied:

A. *Are investigations required to be made after the payment of benefits, (or, in the case of interstate claims, are investigations made by the agent State after the processing of claims) as to claimants' entitlement to benefits paid to them in a sufficient proportion of cases to test the effectiveness of the agency's procedures for the prevention of payments which are not due? To carry out investigations, has the agency assigned to some individual or unit, as a basic function, the responsibility of making or functionally directing such investigations?*

Explantaion: It is not feasible to prescribe the extent to which the above activities are required; however, they should always be carried on to such an extent that they will show whether or not error or willful misrepresentation is increasing or decreasing, and will reveal problem areas. The extent and nature of the above activities should be varied according to the seriousness of the problem in the State. The responsible individual or unit should:

1. Check paid claims for overpayment and investigate for willful misrepresentation or, alternatively, advise and assist the operating units in the performance of such functions, or both;

2. Perform consultative services with respect to methods and procedures for the prevention and detection of fraud; and

3. Perform other services which are closely related to the above.

Although a State agency is expected to make a full-time assignment of responsibility to a unit or individual to carry on the functions described above, a small State agency might make these functions a part-time responsibility of one individual. In connection with the detection of overpayments, such a unit or individual might, for example:

(a) Investigate information on suspected benefit fraud received from any agency personnel, and from sources outside the agency, including anonymous complaints;

(b) Investigate information secured from comparisons of benefit payments with employment records to detect cases of concurrent working (whether in covered or noncovered work) and claiming of benefits (including benefit payments in which the agency acted as agent for another State).

The benefit fraud referred to herein may involve employers, agency employees, and witnesses, as well as claimants.

Comparisons of benefit payments with employment records are commonly made either by post-audit or by industry surveys. The so-called ''post-audit'' is a matching of central office wage-record files against benefit payments for the same period. ''Industry surveys'' or ''mass audits'' are done in some States by going directly to employers for pay-roll information to be checked against concurrent benefit lists. A plan

A. of investigation based on a sample post-audit will be considered as partial fulfillment of the investigation program; it would need to be supplemented by other methods capable of detecting overpayments to persons who have moved into noncovered occupations or are claiming interstate benefits.

B. *Are adequate records maintained by which the results of investigations may be evaluated?** *Explanation.* To meet this criterion, the State agency will be expected to maintain records of all its activities in the detection of overpayments, showing whether attributable to error or willful misrepresentation, measuring the results obtained through various methods, and noting the remedial action taken in each case. The adequacy and effectiveness of various methods of checking for willful misrepresentation can be evaluated only if records are kept of the results obtained. Internal reports on fraudulent and erroneous overpayments are needed by State agencies for self-evaluation. Detailed records should be maintained in order that the State agency may determine, for example, which of several methods of checking currently used are the most productive. Such records also will provide the basis for drawing a clear distinction between fraud and error.

C. *Does the agency take adequate action with respect to publicity concerning willful misrepresentation and its legal consequences to deter fraud by claimants?** *Explanation.* To meet this criterion, the State agency must issue adequate material on claimant eligibility requirements and must take necessary action to obtain publicity on the legal consequences of willful misrepresentation or willful nondisclosure of facts.

Public announcements on convictions and resulting penalties for fraud are generally considered necessary as a deterrent to other persons, and to inform the public that the agency is carrying on an effective program to prevent fraud. This alone is not considered adequate publicity. It is important that information be circulated which will explain clearly and understandably the claimant's rights, and the obligations which he must fulfill to be eligible for benefits. Leaflets for distribution and posters placed in local offices are appropriate media for such information.

7515 *Evalauation of Alternative State Provisions with Respect to Erroneous and Illegal Payments.* If the methods of administration provided for by the State law do not conform to the suggested methods of meeting the requirements set forth in section 7511, but a State law does provide for alternative methods of administration designed to accomplish the same results, the Bureau of Employment Security, in collaboration with the State agency, will study the actual or anticipated effect of the alternative methods of administration. If the Bureau concludes that the alternative methods satisfy the criteria in section 7513, it will so notify the State agency. If the Bureau does not so conclude, it will submit to the Secretary the results of the study for his determination of whether the State's alternative methods of administration meet the criteria.*

* Revises section 7513 as issued 5/5/50.

PART 615—EXTENDED BENEFITS IN THE FEDERAL-STATE UNEMPLOYMENT COMPENSATION PROGRAM

Sec.

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AUTHORITY: 26 U.S.C. 7805; 26 U.S.C. 1102; Secretary's Order No. 6–10.

SOURCE: 53 FR 27937, July 25, 1988, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 615 appear at 81 FR 57778, Aug. 24, 2016.

§ 615.1 Purpose.

This part implements the ''Federal-State Extended Unemployment Compensation Act of 1970'' (EUCA). Under the Federal Unemployment Tax Act, 26 U.S.C. 3304(a)(11), an approved State law must provide for the payment of extended compensation to eligible individuals who have exhausted all rights to regular compensation during specified periods of unemployment, as prescribed in EUCA and this part.

[81 FR 57778, Aug. 24, 2016]

§ 615.2 Definitions.

For the purposes of the EUCA and this part—

Additional compensation means compensation totally financed by a State and payable under a State law by reason of conditions of high unemployment or by reason of other special factors and, when so payable, includes compensation payable pursuant to 5 U.S.C. chapter 85.

And, as used in section 202(a)(3)(D)(ii), shall be interpreted to mean ''or''.

Applicable benefit year means, with respect to an individual, the current benefit year if, at the time an initial claim for extended compensation is filed, the individual has an unexpired benefit year only in the State in which such claim is filed, or, in any other case, the individual's most recent benefit year. For this purpose, the most recent benefit year for an individual who has unexpired benefit years in more than one State when an initial claim for extended compensation is filed, is the benefit year with the latest ending date or, if such benefit years have the same ending date, the benefit year in which the latest continued claim for regular compensation was filed. The individual's most recent benefit year which expires in an extended benefit period, when either extended compensation or high unemployment extended compensation is payable, is the applicable benefit year if the individual cannot establish a second benefit year or is precluded from receiving regular compensation in a second benefit year solely by reason of a State law provision which meets the requirement of section 3304(a)(7) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)(7)).

Applicable State means, with respect to an individual, the State with respect to which the individual is an ''exhaustee'' as defined in § 615.5, and in the case of a combined wage claim for regular compensation, the term means the ''paying State'' as defined in § 616.6(e) of this chapter.

Applicable State law means the law of the State which is the applicable State for an individual.

Average weekly benefit amount, for the purposes of section 202(a)(3)(D)(i), means the weekly benefit amount (including dependents' allowances payable for a week of total unemployment and before any reduction because of earnings, pensions or other requirements) applicable to the week in which the individual failed to take an action which results in a disqualification as required by section 202(a)(3)(B) of the EUCA.

Base period means, with respect to an individual, the base period as determined under the applicable State law for the individual's applicable benefit year.

Benefit structure as used in section 204(a)(2)(D), for the requirement to round down to the ''nearest lower full dollar amount'' for Federal reimbursement of sharable regular and sharable extended compensation means all of the following:

(1) Amounts of regular weekly benefit payments,

(2) Amounts of additional and extended weekly benefit payments,

(3) The State maximum or minimum weekly benefit,

(4) Partial and part-total benefit payments,

(5) Amounts payable after deduction for pensions, and

(6) Amounts payable after any other deduction required by State law.

Benefit year means, with respect to an individual, the benefit year as defined in the applicable State law.

Claim filed in any State under the interstate benefit payment plan, as used in section 202(c), means:

(1) Any interstate claim for a week of unemployment filed pursuant to the Interstate Benefit Payment Plan, but does not include—

(i) A claim filed in Canada,

(ii) A visiting claim filed by an individual who has received permission from his/her regular reporting office to report temporarily to a local office in another State and who has been furnished intrastate claim forms on which to file claims, or

(iii) A transient claim filed by an individual who is moving from place to place searching for work, or an intrastate claim for Extended Benefits filed by an individual who does not reside in a State that is in an Extended Benefit Period,

(2) *The first 2 weeks*, as used in section 202(c), means the first 2 weeks for which the individual files compensable claims for Extended Benefits under the Interstate Benefit Payment Plan in an agent State in which an Extended Benefit Period is not in effect during such weeks.

Compensation and *unemployment compensation* means cash benefits (including dependents' allowances) payable to individuals with respect to their unemployment, and includes regular compensation, additional compensation and extended compensation as defined in this section.

Date of a disqualification, as used in section 202(a)(4), means the date the disqualification begins, as determined under the applicable State law.

Department means the United States Department of Labor, and shall include the Employment and Training Administration, the agency of the United States Department of Labor headed by the Assistant Secretary of Labor for Employment and Training to whom has been delegated the Secretary's authority under the EUCA in Secretary's Order No. 6–2010 (75 FR 66268) or any subsequent order.

Eligibility period means, for an individual, the period consisting of—

(1) The weeks in the individual's applicable benefit year which begin in an extended benefit period or high unemployment period, or for a single benefit year, the weeks in the benefit year which begin in more than one extended benefit period or high unemployment period, and

(2) If the applicable benefit year ends within an extended benefit period or high unemployment period, any weeks thereafter which begin in such extended benefit period or high unemployment period,

(3) An individual may not have more than one eligibility period for any one exhaustion of regular benefits, or carry over from one eligibility period to another any entitlement to extended compensation.

Employed, for the purposes of section 202(a)(3)(B)(ii) of the EUCA, and *employment,* for the purposes of section 202(a)(4) of the EUCA, mean service performed in an employer-employee relationship as defined in the State law; and that law also shall govern whether that service must be covered by it, must consist of consecutive weeks, and must consist of more weeks of work than are required under section 202(a)(3)(B) of the EUCA.

EUCA means the Federal-State Extended Unemployment Compensation Act of 1970, title II of Public Law 91–373, 84 Stat. 695, 708 (codified in note to 26 U.S.C. 3304), as amended.

Extended benefit period means the weeks during which extended compensation is payable in a State in accordance with § 615.11.

Extended Benefits Program or *EB Program* means the entire program under which monetary payments are made to workers who have exhausted their regular compensation during periods of high unemployment.

Extended compensation or *extended benefits* means the funds payable to an individual for weeks of unemployment which begin in a regular EB period or high unemployment period (HUP), under those provisions of a State law which satisfy the requirements of

EUCA and this part with respect to the payment of extended unemployment compensation, and, when so payable, includes compensation payable under 5 U.S.C. chapter 85, but does not include regular compensation or additional compensation.

Extended compensation account is the account established for each individual claimant for the payment of regular extended compensation or high unemployment extended compensation.

Extended unemployment compensation means:

(1) Regular extended compensation paid to an eligible individual under those provisions of a State law which are consistent with EUCA and this part, and that does not exceed the smallest of the following:

(i) 50 percent of the total amount of regular compensation payable to the individual during the applicable benefit year; or

(ii) 13 times the individual's weekly amount of extended compensation payable for a week of total unemployment, as determined under §615.6(a); or

(iii) 39 times the individual's weekly benefit amount, referred to in paragraph (1)(ii) of this definition, reduced by the regular compensation paid (or deemed paid) to the individual during the applicable benefit year; or

(2) High unemployment extended compensation paid to an eligible individual under an optional TUR indicator enacted under State law when the State is in a high unemployment period, in accordance with §615.11(e) of this part, and that does not exceed the smallest of the following:

(i) 80 percent of the total amount of regular compensation payable to the individual during the applicable benefit year; or

(ii) 20 times the individual's weekly amount of extended compensation payable for a week of total unemployment, as determined under §615.6(a); or

(iii) 46 times the individual's weekly benefit amount, referred to in paragraph (1)(ii) of this definition, reduced by the regular compensation paid (or deemed paid) to the individual during the applicable benefit year.

Gross average weekly remuneration, for the purposes of section 202(a)(3)(D)(i), means the remuneration offered for a week of work before any deductions for taxes or other purposes and, in case the offered pay may vary from week to week, it shall be determined on the basis of recent experience of workers performing work similar to the offered work for the employer who offered the work.

High unemployment extended compensation means the benefits payable to an individual for weeks of unemployment which begin in a high unemployment period, under those provisions of a State law which satisfy the requirements of EUCA and this part for the payment of high unemployment extended compensation. When so payable, high unemployment extended compensation includes compensation payable under 5 U.S.C. chapter 85, but does not include regular compensation or additional compensation. Regular extended unemployment compensation, along with high unemployment extended compensation, are part of the program referred to in this part as Extended Benefits.

High unemployment period (or HUP) means a period where the Department determines that the Trigger Value in a State, which has enacted the alternative Total Unemployment Rate indicator in law, for the most recent 3 months for which data for all States is published, equals or exceeds 8 percent and such Trigger Value equals or exceeds 110 percent of such Trigger Value for either or both of the corresponding 3-month periods ending in the 2 preceding calendar years.

Hospitalized for treatment of an emergency or life-threatening condition, as used in section 202(a)(3)(A)(ii), has the following meaning: ''Hospitalized for treatment'' means an individual was admitted to a hospital as an inpatient for medical treatment. Treatment is for an ''emergency or life threatening condition'' if determined to be such by the hospital officials or attending physician that provide the treatment for a medical condition existing upon or arising after hospitalization. For purposes of this definition, the term ''medical treatment'' refers to the application of any remedies which have the objective of effecting a cure of the emergency or life-threatening condition. Once an ''emergency condition''

or a ''life-threatening condition'' has been determined to exist by the hospital officials or attending physician, the status of the individual as so determined shall remain unchanged until release from the hospital.

Individual's capabilities, for the purposes of section 202(a)(3)(C), means work which the individual has the physical and mental capacity to perform and which meets the minimum requirements of section 202(a)(3)(D).

Insured Unemployment Rate means the percentage derived by dividing the average weekly number of individuals filing claims for regular compensation in a State for weeks of unemployment in the most recent 13-consecutive-week period as determined by the State on the basis of State reports to the United States Secretary of Labor by the average monthly employment covered under State law for the first 4 of the most recent 6 completed calendar quarters before the end of such 13-week period.

Jury duty, for purposes of section 202(a)(3)(A)(ii), means the performance of service as a juror, during all periods of time an individual is engaged in such service, in any court of a State or the United States pursuant to the law of the State or the United States and the rules of the court in which the individual is engaged in the performance of such service.

Provisions of the applicable State law, as used in section 202(a)(3)(D)(iii) of EUCA, means that State law provisions must not be inconsistent with sections 202(a)(3)(C) and 202(a)(3)(E). Therefore, decisions based on State law provisions must not require an individual to take a job which requires traveling an unreasonable distance to work, or which involves an unreasonable risk to the individual's health, safety or morals. Such State law provisions must also include labor standards and training provisions required under sections 3304(a)(5) and 3304(a)(8) of the Internal Revenue Code of 1986 and section 236(d) of the Trade Act of 1974.

Reasonably short period, for the purposes of section 202(a)(3)(C), means the number of weeks provided by the applicable State law.

Regular compensation means compensation payable to an individual under a State law, and, when so payable, includes compensation payable pursuant to 5 U.S.C. chapter 85, but does not include extended compensation or additional compensation.

Regular extended compensation means the benefits payable to an individual for weeks of unemployment which begin in an extended benefit period, under those provisions of a State law which satisfy the requirements of EUCA and this part for the payment of extended unemployment compensation, and, when so payable, includes compensation payable under 5 U.S.C. chapter 85, but does not include regular compensation or additional compensation. Regular extended compensation, along with high unemployment extended compensation, are part of the program referred to in this part as Extended Benefits.

Regular EB period means a period in which a state is ''on'' the EB Program because either the mandatory or optional IUR indicator satisfies the criteria to be ''on'' and the state is not in a 13-week mandatory ''off'' period; or the State is ''on'' the EB Program because the TUR indicator's Trigger Value is at least 6.5 percent and it is at least 110 percent of the Trigger Value for the comparable 3 months in either of the prior 2 years.

Secretary means the Secretary of Labor of the United States.

Sharable compensation means:

(1) Extended compensation paid to an eligible individual under those provisions of a State law which are consistent with EUCA and this part, and that does not exceed the smallest of the following:

(i) 50 percent of the total amount of regular compensation payable to the individual during the applicable benefit year; or

(ii) 13 times the individual's weekly amount of extended compensation payable for a week of total unemployment, as determined under § 615.6(a); or

(iii) 39 times the individual's weekly benefit amount, referred to in paragraph (1)(ii) of this definition, reduced by the regular compensation paid (or deemed paid) to the individual during the applicable benefit year.

(2) Extended compensation paid to an eligible individual under an optional

TUR indicator enacted under State law when the State is in a high unemployment period, in accordance with § 615.12(f) of this part, and that does not exceed the smallest of the following:

(i) 80 percent of the total amount of regular compensation payable to the individual during the applicable benefit year; or

(ii) 20 times the individual's weekly amount of extended compensation payable for a week of total unemployment, as determined under § 615.6(a); or

(iii) 46 times the individual's weekly benefit amount, referred to in paragraph (1)(ii) of this definition, reduced by the regular compensation paid (or deemed paid) to the individual during the applicable benefit year.

(3) Regular compensation paid to an eligible individual for weeks of unemployment in the individual's eligibility period, but only to the extent that the sum of such compensation, plus the regular compensation paid (or deemed paid) to the individual for prior weeks of unemployment in the applicable benefit year, exceeds 26 times and does not exceed 39 times the average weekly benefit amount (including allowances for dependents) for weeks of total unemployment payable to the individual under the State law in such benefit year: Provided, that such regular compensation is paid under provisions of a State law which are consistent with EUCA and this part.

(4) Notwithstanding the preceding provisions of this paragraph, sharable compensation does not include any regular or extended compensation for which a State is not entitled to a payment under section 202(a)(6) or 204 of EUCA or § 615.14 of this part.

State means the States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and the U. S. Virgin Islands.

State agency means the State unemployment compensation agency of a State which administers the State law.

State law means the unemployment compensation law of a State, approved by the Secretary under section 3304(a) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)).

A *systematic and sustained effort,* for the purposes of section 202(a)(3)(E), means—

(i) A high level of job search activity throughout the given week, compatible with the number of employers and employment opportunities in the labor market reasonably applicable to the individual,

(ii) A plan of search for work involving independent efforts on the part of each individual which results in contacts with persons who have the authority to hire or which follows whatever hiring procedure is required by a prospective employer in addition to any search offered by organized public and private agencies such as the State employment service or union or private placement offices or hiring halls,

(iii) Actions by the individual comparable to those actions by which jobs are being found by people in the community and labor market, but not restricted to a single manner of search for work such as registering with and reporting to the State employment service and union or private placement offices or hiring halls, in the same manner that such work is found by people in the community,

(iv) A search not limited to classes of work or rates of pay to which the individual is accustomed or which represent the individual's higher skills, and which includes all types of work within the individual's physical and mental capabilities, except that the individual, while classified by the State agency as provided in § 615.8(d) as having ''good'' job prospects, shall search for work that is suitable work under State law provisions which apply to claimants for regular compensation (which is not sharable),

(v) A search by every claimant, without exception for individuals or classes of individuals other than those in approved training, as required under section 3304(a)(8) of the Internal Revenue Code of 1986 or section 236(e) of the Trade Act of 1974,

(vi) A search suspended only when severe weather conditions or other calamity forces suspension of such activities by most members of the community, except that

(vii) The individual, while classified by the State agency as provided in § 615.8(d) as having ''good'' job prospects, if such individual normally obtains customary work through a hiring

hall, shall search for work that is suitable work under State law provisions which apply to claimants for regular compensation (which is not sharable).

Tangible evidence of an active search for work, for the purposes of section 202(a)(3)(E), means a written record which can be verified, and which includes the actions taken, methods of applying for work, types of work sought, dates and places where work was sought, the name of the employer or person who was contacted and the outcome of the contact.

Total Unemployment Rate means the number of unemployed individuals in a State (seasonally adjusted) divided by the civilian labor force (seasonally adjusted) in the State for the same period.

Trigger Value or *average rate of total unemployment* means the ratio computed using 3 months of the level of seasonally adjusted unemployment in a State in the numerator and 3 months of the level of the seasonally adjusted civilian labor force in the State in the denominator. This rate is used for triggering States ''on'' and ''off'' the optional Total Unemployment Rate indicator as described in § 615.12(e).

Week means:

(1) For purposes of eligibility for and payment of extended compensation, a week as defined in the applicable State law.

(2) For purposes of computation of extended compensation ''on'' and ''off'' and ''no change'' indicators and insured unemployment rates and the beginning and ending of an EB Period or a HUP, a calendar week.

Week of unemployment means:

(1) A week of total, part-total, or partial unemployment as defined in the applicable State law, which shall be applied in the same manner and to the same extent to the Extended Benefit Program as if the individual filing a claim for Extended Benefits were filing a claim for regular compensation, except as provided in paragraph (2) of this definition.

(2) *Week of unemployment* in section 202(a)(3)(A) of the EUCA means a week of unemployment, as defined in paragraph (1) of this definition, for which the individual claims Extended Benefits or sharable regular benefits.

[81 FR 57778, Aug. 24, 2016]

§ 615.3 Effective period of the program.

An Extended Benefit Program conforming with EUCA and this part shall be a requirement for a State law effective on and after January 1, 1972, pursuant to section 3304(a)(11) of the Internal Revenue Code of 1986, (26 U.S.C. 3304(a)(11)). Continuation of the program by a State in conformity and substantial compliance with EUCA and this part, throughout any 12-month period ending on October 31 of a year subsequent to 1972, shall be a condition of the certification of the State with respect to such 12-month period under section 3304(c) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(c)). Conformity with EUCA and this part in the payment of regular compensation, regular extended compensation, and high unemployment extended compensation (if State law so provides) to any individual is a continuing requirement, applicable to every week as a condition of a State's entitlement to payment for any compensation as provided in EUCA and this part.

[53 FR 27937, July 25, 1988, as amended at 81 FR 57781, Aug. 24, 2016]

§ 615.4 Eligibility requirements for Extended Benefits.

(a) *General.* An individual is entitled to Extended Benefits for a week of unemployment which begins in the individual's eligibility period if, with respect to such week, the individual is an exhaustee as defined in § 615.5, files a timely claim for Extended Benefits, and satisfies the pertinent requirements of the applicable State law which are consistent with EUCA and this part.

(b) *Qualifying for Extended Benefits.* The State law shall specify whether an individual qualifies for Extended Benefits by earnings and employment in the base period for the individual's applicable benefit year as required by section 202(a)(5) of EUCA, (and if it does not also apply this requirement to the payment of sharable regular benefits, the

State will not be entitled to a payment under § 615.14), as follows:

(1) One and one-half times the high quarter wages; or

(2) Forty times the most recent weekly benefit amount, and if this alternative is adopted, it shall use the weekly benefit amount (including dependents' allowances) payable for a week of total unemployment (before any reduction because of earnings, pensions or other requirements) which applied to the most recent week of regular benefits; or

(3) Twenty weeks of full-time insured employment, and if this alternative is adopted, the term ''full-time'' shall have the meaning provided by the State law.

§ 615.5 Definition of "exhaustee."

(a)(1) ''Exhaustee'' means an individual who, with respect to any week of unemployment in the individual's eligibility period:

(i) Has received, prior to such week, all of the regular compensation that was payable under the applicable State law or any other State law (including regular compensation payable to Federal civilian employees and Ex-Servicemembers under 5 U.S.C. chapter 85) for the applicable benefit year that includes such week; or

(ii) Has received, prior to such week, all of the regular compensation that was available under the applicable State law or any other State law (including regular compensation available to Federal civilian employees and Ex-Servicemembers under 5 U.S.C. chapter 85) in the benefit year that includes such week, after the cancellation of some or all of the individual's wage credits or the total or partial reduction of the individual's right to regular compensation; or

(iii) The applicable benefit year having expired prior to such week and the individual is precluded from establishing a second (new) benefit year, or the individual established a second benefit year but is suspended indefinitely from receiving regular compensation, solely by reason of a State law provision which meets the requirement of section 3304(a)(7) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)(7)): *Provided*, that, an individual shall not be entitled to Extended Benefits based on regular compensation in a second benefit year during which the individual is precluded from receiving regular compensation solely by reason of a State law provision which meets the requirement of section 3304(a)(7) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)(7)); or

(iv) The applicable benefit year having expired prior to such week, the individual has insufficient wages or employment, or both, on the basis of which a new benefit year could be established in any State that would include such week; and

(v) Has no right to unemployment compensation for such week under the Railroad Unemployment Insurance Act or such other Federal laws as are specified by the Department pursuant to this paragraph; and

(vi) Has not received and is not seeking for such week unemployment compensation under the unemployment compensation law of Canada, unless the Canadian agency finally determines that the individual is not entitled to unemployment compensation under the Canadian law for such week.

(2) An individual who becomes an exhaustee as defined above shall cease to be an exhaustee commencing with the first week that the individual becomes eligible for regular compensation under any State law or 5 U.S.C. chapter 85, or has any right to unemployment compensation as provided in paragraph (a)(1)(v) of this section, or has received or is seeking unemployment compensation as provided in paragraph (a)(1)(vi) of this section. The individual's Extended Benefit Account shall be terminated upon the occurrence of any such week, and the individual shall have no further right to any balance in that Extended Benefit Account.

(b) *Special Rules.* For the purposes of paragraphs (a)(1)(i) and (a)(1)(ii) of this section, an individual shall be deemed to have received in the applicable benefit year all of the regular compensation payable according to the monetary determination, or available to the individual, as the case may be, even though—

(1) As a result of a pending appeal with respect to wages or employment

or both that were not included in the original monetary determination with respect to such benefit year, the individual may subsequently be determined to be entitled to more or less regular compensation, or

(2) By reason of a provision in the State law that establishes the weeks of the year in which regular compensation may be paid to the individual on the basis of wages in seasonal employment—

(i) The individual may be entitled to regular compensation with respect to future weeks of unemployment in the next season or off season, as the case may be, but such compensation is not payable with respect to the week of unemployment for which Extended Benefits are claimed, and

(ii) The individual is otherwise an exhaustee within the meaning of this section with respect to rights to regular compensation during the season or off season in which that week of unemployment occurs, or

(3) Having established a benefit year, no regular compensation is payable during such year because wage credits were cancelled or the right to regular compensation was totally reduced as the result of the application of a disqualification.

(c) *Adjustment of week.* If it is subsequently determined as the result of a redetermination or appeal that an individual is an exhaustee as of a different week than was previously determined, the individual's rights to Extended Benefits shall be adjusted so as to accord with such redetermination or decision.

[53 FR 27937, July 25, 1988, as amended at 71 FR 35514, June 21, 2006]

§ 615.6 Extended Benefits; weekly amount.

(a) *Total unemployment.* (1) The weekly amount of Extended Benefits payable to an individual for a week of total unemployment in the individual's eligibility period shall be the amount of regular compensation payable to the individual for a week of total unemployment during the applicable benefit year. If the individual had more than one weekly amount of regular compensation for total unemployment during such benefit year, the weekly amount of extended compensation for total unemployment shall be one of the following which applies as specified in the applicable State law:

(i) The average of such weekly amounts of regular compensation,

(ii) The last weekly benefit amount of regular compensation in such benefit year, or

(iii) An amount that is reasonably representative of the weekly amounts of regular compensation payable during such benefit year.

(2) If the method in paragraph (a)(1)(iii) of this section is adopted by a State, the State law shall specify how such amount is to be computed. If the method in paragraph (a)(1)(i) of this section is adopted by a State, and the amount computed is not an even dollar amount, the amount shall be raised or lowered to an even dollar amount as provided by the applicable State law for regular compensation.

(b) *Partial and part-total unemployment.* The weekly amount of Extended Benefits payable for a week of partial or part-total unemployment shall be determined under the provisions of the applicable State law which apply to regular compensation, computed on the basis of the weekly amount of Extended Benefits payable for a week of total unemployment as determined pursuant to paragraph (a) of this section.

§ 615.7 Extended Benefits; maximum amount.

(a) *Individual account.* An Extended Benefit Account shall be established for each individual determined to be eligible for Extended Benefits, in the sum of the maximum amount potentially payable to the individual as computed in accordance with paragraph (b) of this section.

(b) *Computation of amount in individual account.* (1) The amount established in the Extended Benefit Account of an individual, as the maximum amount potentially payable to the individual during the individual's eligibility period, shall be equal to the lesser of—

(i) 50 percent of the total amount of regular compensation (including dependents' allowances) payable to the

individual during the individual's applicable benefit year; or

(ii) 13 times the individual's weekly amount of Extended Benefits payable for a week of total unemployment, as determined pursuant to §615.6(a); or

(iii) 39 times the individual's weekly benefit amount referred to in (ii), reduced by the regular compensation paid (or deemed paid) to the individual during the individual's applicable benefit year.

(2) If the State law so provides, the amount in the individual's Extended Benefit Account shall be reduced by the aggregate amount of additional compensation paid (or deemed paid) to the individual under such law for prior weeks of unemployment in such benefit year which did not begin in an Extended Benefit Period.

(3) If State law provides, in accordance with §615.12(e), for a high unemployment period for weeks of unemployment beginning after March 6, 1993, the provisions of paragraph (b)(1) of this section are applied by substituting:

(i) 80 percent for 50 percent in (b)(1)(i),

(ii) 20 for 13 in (b)(1)(ii), and

(iii) 46 for 39 in (b)(1)(iii).

NOTE TO PARAGRAPH (b)(3). *Provided,* that if an individual's extended compensation account is determined in accordance with the provisions of paragraphs (b)(3)(i) through (b)(3)(iii) (for a ''high unemployment period'' as defined in §615.2) during the individual's eligibility period, upon termination of the high unemployment period, such individual's account must be reduced by the amount in the account that is more than the maximum amount of extended compensation or high extended compensation payable to the individual. *Provided further,* if the account balance is equal to or less than the maximum amount of extended compensation or high unemployment extended compensation payable, there will be no reduction in the account balance upon termination of a high unemployment period. In no case will the individual receive more regular extended compensation or high unemployment extended compensation than the amount determined in accordance with paragraphs (b)(1)(i) through (iii) of this section, nor more extended compensation or high unemployment extended compensation than as provided in paragraphs (b)(2)(i) through (iii) of this section.

(c) *Changes in accounts.* (1) If an individual is entitled to more or less Extended Benefits as a result of a redetermination or an appeal which awarded more or less regular compensation or Extended Benefits, an appropriate change shall be made in the individual's Extended Benefit Account pursuant to an amended determination of the individual's entitlement to Extended Benefits.

(2) If an individual who has received Extended Benefits for a week of unemployment is determined to be entitled to more regular compensation with respect to such week as the result of a redetermination or an appeal, the Extended Benefits paid shall be treated as if they were regular compensation up to the greater amount to which the individual has been determined to be entitled, and the State agency shall make appropriate adjustments between the regular and extended accounts. If the individual is entitled to more Extended Benefits as a result of being entitled to more regular compensation, an amended determination shall be made of the individual's entitlement to Extended Benefits. If the greater amount of regular compensation results in an increased duration of regular compensation, the individual's status as an exhaustee shall be redetermined as of the new date of exhaustion of regular compensation.

(3) If an individual who has received Extended Benefits for a week of unemployment is determined to be entitled to less regular compensation as the result of a redetermination or an appeal, and as a consequence is entitled to less Extended Benefits, any Extended Benefits paid in excess of the amount to which the individual is determined to be entitled after the redetermination or decision on appeal shall be considered an overpayment which the individual shall have to repay on the same basis and in the same manner that excess payments of regular compensation are required to be repaid under the applicable State law. If such decision reduces the duration of regular compensation payable to the individual, the claim for Extended Benefits shall

be backdated to the earliest date, subsequent to the date when the redetermined regular compensation was exhausted and within the individual's eligibility period, that the individual was eligible to file a claim for Extended Benefits. Any such changes shall be made pursuant to an amended determination of the individual's entitlement to Extended Benefits.

(d) *Reduction because of trade readjustment allowances.* Section 233(c) of the Trade Act of 1974 (and section 204(a)(2)(C) of EUCA), requiring a reduction of extended compensation because of the receipt of trade readjustment allowances, must be applied as follows:

(1) The reduction of Extended Benefits shall apply only to an individual who has not exhausted his/her Extended Benefits at the end of the benefit year;

(2) The amount to be deducted is the product of the weekly benefit amount for Extended Benefits multiplied by the number of weeks for which trade readjustment allowances were paid (regardless of the amount paid for any such week) up to the close of the last week that begins in the benefit year; and

(3) The amount to be deducted shall be deducted from the balance of Extended Benefits not used as of the close of the last week which begins in the benefit year.

[53 FR 27937, July 25, 1988, as amended at 81 FR 57781, Aug. 24, 2016]

§ 615.8 Provisions of State law applicable to claims.

(a) *Particular provisions applicable.* Except where the result would be inconsistent with the provisions of EUCA or this part, the terms and conditions of the applicable State law which apply to claims for, and the payment of, regular compensation shall apply to claims for, and the payment of, Extended Benefits. The provisions of the applicable State law which shall apply to claims for, and the payment of, Extended Benefits include, but are not limited to:

(1) Claim filing and reporting;

(2) Information to individuals, as appropriate;

(3) Notices to individuals and employers, as appropriate;

(4) Determinations, redeterminations, and appeal and review;

(5) Ability to work and availability for work, except as provided otherwise in this section;

(6) Disqualifications, including disqualifying income provisions, except as provided by paragraph (c) of this section;

(7) Overpayments, and the recovery thereof;

(8) Administrative and criminal penalties;

(9) The Interstate Benefit Payment Plan;

(10) The Interstate Arrangement for Combining Employment and Wages, in accordance with part 616 of this chapter.

(b) *Provisions not to be applicable.* The State law and regulations shall specify those of its terms and conditions which shall not be applicable to claims for, or payment of, Extended Benefits. Among such terms and conditions shall be at least those relating to—

(1) Any waiting period;

(2) Monetary or other qualifying requirements, except as provided in § 615.4(b); and

(3) Computation of weekly and total regular compensation.

(c) *Terminating disqualifications.* A disqualification in a State law, as to any individual who voluntarily left work, was suspended or discharged for misconduct, gross misconduct or the commission or conviction of a crime, or refused an offer of or a referral to work, as provided in sections 202(a) (4) and (6) of EUCA—

(1) As applied to regular benefits which are not sharable, is not subject to any limitation in sections 202(a) (4) and (6);

(2) As applied to eligibility for Extended Benefits, shall require that the individual be employed again subsequent to the date of the disqualification before it may be terminated, even though it may have been terminated on other grounds for regular benefits which are not sharable; and if the State law does not also apply this provision to the payment of what would otherwise be sharable regular benefits, the State will not be entitled to a payment under EUCA and § 615.14 in regard to such regular compensation; and

(3) Will not apply in regard to eligibility for Extended Benefits in a subsequent eligibility period.

(d) *Classification and determination of job prospects.* (1) As to each individual who files an initial claim for Extended Benefits (or sharable regular compensation), the State agency shall classify the individual's prospects for obtaining work in his/her customary occupation within a reasonably short period, as ''good'' or ''not good,'' and shall promptly (not later than the end of the week in which the initial claim is filed) notify the individual in writing of such classification and of the requirements applicable to the individual under the provisions of the applicable State law corresponding to section 202(a)(3) of EUCA and this part. Such requirements shall be applicable beginning with the week following the week in which the individual is furnished such written notice.

(2) If an individual is thus classified as having good prospects, but those prospects are not realized by the close of the period the State law specifies as a reasonably short period, the individual's prospects will be automatically reclassified as ''not good'' or classified as ''good'' or ''not good'' depending on the individual's job prospects as of that date.

(3) Whenever, as part of a determination of an individual's eligibility for benefits, an issue arises concerning the individual's failure to apply for or accept an offer of work (sections 202(a)(3)(A)(i) and (F) of EUCA and paragraphs (e) and (f) of this section), or to actively engage in seeking work (sections 202(a)(3)(A)(ii) and (E) of EUCA and paragraph (g) of this section), a written appealable determination shall be made which includes a finding as to the individual's job prospects at the time the issue arose. The reasons for allowing or denying benefits in the written notice of determination shall explain how the individual's job prospects relate to the decision to allow or deny benefits.

(4) If an individual's job prospects are determined in accordance with the preceding paragraph (3) to be ''good,'' the suitability of work will be determined under the standard State law provisions applicable to claimants for regular compensation which is not sharable; and if determined to be ''not good,'' the suitability of work will be determined under the definition of suitable work in the State law provisions corresponding to sections 202(a)(3) (C) and (D) of EUCA and this part. Any determination or classification of an individual's job prospects is mutually exclusive, and only one suitable work definition shall be applied to a claimant as to any failure to accept or apply for work or seek work with respect to any week.

(e) *Requirement of referral to work.* (1) The State law shall provide, as required by section 202(a)(3)(F) of EUCA and this part, that the State Workforce Agency shall refer every claimant for Extended Benefits to work which is ''suitable work'' as provided in paragraph (d)(4) of this section, beginning with the week following the week in which the individual is furnished a written notice of classification of job prospects as required by paragraphs (d)(1) and (h) of this section.

(2) To make such referrals, the State Workforce Agency shall assure that each Extended Benefit claimant is registered for work and continues to be considered for referral to job openings as long as he/she continues to claim benefits.

(3) In referring claimants to available job openings, the State Workforce Agency shall apply to Extended Benefit claimants the same priorities, policies, and judgments as it does to other applicants, except that it shall not restrict referrals only to work at higher skill levels, prior rates of pay, customary work, or preferences as to work or pay for individuals whose prospects of obtaining work in their customary occupations have been classified as or determined to be ''not good.''

(4) For referral purposes, any work which does not exceed the individual's capabilities shall be considered suitable work for an Extended Benefit claimant whose job prospects have been classified as or determined to be ''not good'', except as modified by this paragraph (e).

(5) For Extended Benefit claimants whose prospects of obtaining work in their customary occupations have been classified as or determined to be ''not

good'', work shall not be suitable, and referral to a job shall not be made, if—

(i) The gross average weekly remuneration for the work for any week does not exceed the sum of the individual's weekly benefit amount plus any supplemental unemployment benefits (SUB) (as defined in section 501(c)(17)(D) of the Internal Revenue Code of 1986) payable to the individual,

(ii) The work is not offered in writing or is not listed with the State employment service,

(iii) The work pays less than the higher of the minimum wage set in section 6(a)(1) of the Fair Labor Standards Act of 1938, or any applicable State or local minimum wage, without regard to any exemption elsewhere in those laws, or

(iv) Failure to accept or apply for the work would not result in a denial of compensation under the provisions of the applicable State law as defined in § 615.2(o)(7).

(6) In addition, if the State Workforce Agency classifies or determines that an individual's prospects for obtaining work in his/her customary occupation within a reasonably short period are ''good,'' referral shall not be made to a job if such referral would not be made under the State law provisions applicable to claimants for regular benefits which are not sharable, and such referrals shall be limited to work which the individual is required to make a ''systematic and sustained effort'' to search for as defined in § 615.2(o)(8).

(7) For the purposes of the foregoing paragraphs of this paragraph (e), State law applies regarding whether members of labor organizations shall be referred to nonunion work in their customary occupations.

(8) If the State law does not also apply this paragraph (e) to individuals who claim what would otherwise be sharable regular compensation, the State will not be entitled to payment under EUCA and § 615.14 in regard to such regular compensation.

(f) *Refusal of work.* (1) The State law shall provide, as required by section 202(a)(3)(A)(i) of EUCA and this part, that if an individual who claims Extended Benefits fails to accept an offer of work or fails to apply for work to which he/she was referred by the State Workforce Agency—

(i) If the individual's prospects for obtaining work in his/her customary occupation within a reasonably short period are determined to be ''good,'' the State agency shall determine whether the work is suitable under the standard State law provisions which apply to claimants for regular compensation which is not sharable, and if determined to be suitable the individual shall be ineligible for Extended Benefits for the week in which the individual fails to apply for or accept an offer of suitable work and thereafter until the individual is employed in at least four weeks with wages from such employment totalling not less than four times the individual's weekly benefit amount, as provided by the applicable State law; or

(ii) If the individual's prospects for obtaining work in his/her customary occupation are determined to be ''not good,'' the State agency shall determine whether the work is suitable under the applicable State law provisions corresponding to sections 202(a)(3) (C) and (D) of EUCA and paragraphs (e)(5) and (f)(2) of this section, and if determined to be suitable the individual shall be ineligible for Extended Benefits for the week in which the individual fails to apply for or accept an offer of suitable work and thereafter until the individual is employed in at least four weeks with wages from such employment totalling not less than four times the individual's weekly benefit amount, as provided by the applicable State law.

(2) For an individual whose prospects of obtaining work in his/her customary occupation within the period specified by State law are classified or determined to be ''not good,'' the term ''suitable work'' shall mean any work which is within the individual's capabilities, except that work shall not be suitable if—

(i) The gross average weekly remuneration for the work for any week does not exceed the sum of the individual's weekly benefit amount plus any

supplemental unemployment compensation benefits (as defined in section 501(c)(17)(D) of the Internal Revenue Code of 1986) payable to the individual,

(ii) The work is not offered in writing or is not listed with the State employment service,

(iii) The work pays less than the higher of the minimum wage set in section 6(a)(1) of the Fair Labor Standards Act of 1938, or any applicable State or local minimum wage, without regard to any exemption elsewhere in those laws, or

(iv) Failure to accept or apply for the work would not result in a denial of compensation under the provisions of the applicable State law as defined in § 615.2(o)(7).

(3) For the purposes of the foregoing paragraphs of this paragraph (f), State law applies regarding whether members of labor organizations shall be referred to nonunion work in their customary occupations.

(4) If the State law does not also apply this paragraph (f) to individuals who claim what would otherwise be sharable regular compensation, the State will not be entitled to payment under EUCA and § 615.14 in regard to such regular compensation.

(g) *Actively seeking work.* (1) The State law shall provide, as required by sections 202(a)(3) (A)(ii) and (E) of EUCA and this part, that an individual who claims Extended Benefits shall be required to make a systematic and sustained effort (as defined in § 615.2(o)(8)) to search for work which is ''suitable work'' as provided in paragraph (d)(4) of this section, throughout each week beginning with the week following the week in which the individual is furnished a written notice of classification of job prospects as required by paragraphs (d)(1) and (h) of this section, and to furnish to the State agency with each claim tangible evidence of such efforts.

(2) If the individual fails to thus search for work, or to furnish tangible evidence of such efforts, he/she shall be ineligible for Extended Benefits for the week in which the failure occurred and thereafter until the individual is employed in at least four weeks with wages from such employment totalling not less than four times the individual's weekly benefit amount, as provided by the applicable State law.

(3)(i) A State law may provide that eligibility for Extended Benefits be determined under the applicable provisions of State law for regular compensation which is not sharable, without regard to the active search provisions otherwise applicable in paragraph (g)(1) of this section, for any individual who fails to engage in a systematic and sustained search for work throughout any week because such individual is—

(A) Serving on jury duty, or

(B) Hospitalized for treatment of an emergency or life-threatening condition.

(ii) The conditions in (i) (A) and (B) must be applied to individuals filing claims for Extended Benefits in the same manner as applied to individuals filing claims for regular compensation which is not sharable compensation.

(4) For the purposes of the foregoing paragraphs of this paragraph (g), State law applies regarding whether members of labor organizations shall be required to seek nonunion work in their customary occupations.

(5) If the State law does not also apply this paragraph (g) to individuals who claim what would otherwise be sharable regular compensation, the State will not be entitled to payment under EUCA and § 615.14 in regard to such regular compensation.

(h) *Information to claimants.* The State agency or State Workforce Agency, as applicable, shall assure that each Extended Benefit claimant (and claimant for sharable regular compensation) is informed in writing—

(1) Of the State agency's classification of his/her prospects for finding work in his/her customary occupation within the time set out in paragraph (d) as ''good'' or ''not good,''

(2) What kind of jobs he/she may be referred to, depending on the classification of his/her job prospects,

(3) What kind of jobs he/she must be actively engaged in seeking each week depending on the classification of his/her job prospects, and what tangible evidence of such search must be furnished to the State agency with each claim for benefits. In addition, the State must inform the claimant that

he/she is required to apply for and accept suitable work, and

(4) The resulting disqualification if he/she fails to apply for work to which referred, or fails to accept work offered, or fails to actively engage in seeking work or to furnish tangible evidence of such search for each week for which extended compensation or sharable regular benefits is claimed, beginning with the week following the week in which such information shall be furnished in writing to the individual.

[53 FR 27937, July 25, 1988, as amended at 71 FR 35514, June 21, 2006; 81 FR 57781, Aug. 24, 2016]

§ 615.9 Restrictions on entitlement.

(a) *Disqualifications.* If the week of unemployment for which an individual claims Extended Benefits is a week to which a disqualification for regular compensation applies, including a reduction because of the receipt of disqualifying income, or would apply but for the fact that the individual has exhausted all rights to such compensation, the individual shall be disqualified in the same degree from receipt of Extended Benefits for that week.

(b) *Additional compensation.* No individual shall be paid additional compensation and Extended Benefits with respect to the same week. If both are payable by a State with respect to the same week, the State law may provide for the payment of Extended Benefits instead of additional compensation with respect to the week. If Extended Benefits are payable to an individual by one State and additional compensation is payable to the individual for the same week by another State, the individual may elect which of the two types of compensation to claim.

(c) *Interstate claims.* An individual who files claims for Extended Benefits under the Interstate Benefit Payment Plan, in a State which is not in an Extended Benefit Period for the week(s) for which Extended Benefits are claimed, shall not be paid more than the first two weeks for which he/she files such claims.

(d) *Other restrictions.* The restrictions on entitlement specified in this section are in addition to other restrictions in EUCA and this part on eligibility for and entitlement to Extended Benefits.

§ 615.10 Special provisions for employers.

(a) *Charging contributing employers.* (1) Section 3303(a)(1) of the Internal Revenue Code of 1986 (26 U.S.C. 3303(a)(1)) does not require that Extended Benefits paid to an individual be charged to the experience rating accounts of employers.

(2) A State law may, however, consistently with section 3303(a)(1), require the charging of Extended Benefits paid to an individual; and if it does, it may provide for charging all or any portion of such compensation paid.

(3) Sharable regular compensation must be charged as all other regular compensation is charged under the State law.

(b) *Payments by reimbursing employers.* If an employer is reimbursing the State unemployment fund in lieu of paying contributions pursuant to the requirements of State law conforming with sections 3304(a)(6)(B) and 3309(a)(2) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)(6)(B) and 3309(a)(2)), the State law shall require the employer to reimburse the State unemployment fund for not less than 50 percent of any sharable compensation that is attributable under the State law to service with such employer; and as to any compensation which is not sharable compensation under § 615.14, the State law shall require the employer to reimburse the State unemployment fund for 100 percent, instead of 50 percent, of any such compensation paid.

§ 615.11 Extended Benefit Periods.

(a) *Beginning date.* Except as provided in paragraph (d) of this section, an extended benefit period or high unemployment period begins in a State on the first day of the third calendar week after a week for which there is a State ''on'' indicator in that State under either § 615.12(a) or (b).

(b) *Ending date.* Except as provided in paragraphs (c) and (e) of this section, an extended benefit period or high unemployment period in a State ends on the last day of the third week after the first week for which there is a State

''off'' indicator in that State, unless another indicator is in ''on'' status.

(c) *Duration.* When an extended benefit period and/or high unemployment period becomes effective in any State, or triggers ''off,'' the attained status must continue in effect for not less than 13 consecutive weeks.

(d) *Limitation.* No extended benefit period or high unemployment period may begin or end in any State before the most recent week for which data used to trigger the State ''on'' or ''off'' or ''no change'' indicator has been published.

(e) *Specific applications of the 13-week rule.* (1) If a State concludes a 13-week mandatory ''on'' period by virtue of the IUR indicator which, at the end of the 13-week period no longer satisfies the requirements for a State to be ''on,'' the extended benefit period continues if the TUR indicator is ''on'' during the 11th week of the 13-week mandatory ''on'' period.

(2) If a State concludes a 13-week mandatory ''on'' period by virtue of the TUR indicator which, at the end of the 13-week period no longer satisfies the requirements for a State to be ''on,'' the extended benefit period continues if the IUR indicator is ''on'' during the 11th week of the 13-week mandatory ''on'' period.

(f) *Determining if a State remains ''off'' as a result of a total unemployment rate indicator after the 13-week mandatory ''off'' period ends.* (1) The State remains ''off'' if there is not an IUR ''on'' indicator the 11th week of the 13-week mandatory ''off'' period, and there is a TUR ''off'' indicator for the third week before the last week of the 13-week mandatory ''off'' period.

[81 FR 57781, Aug. 24, 2016]

§ 615.12 Determination of "on" and "off" indicators.

(a) *Standard State indicators.* (1) There is a State ''on'' indicator in a State for a week if the head of the State agency determines, in accordance with this section, that, for the period consisting of that week and the immediately preceding 12 weeks, the rate of insured unemployment (not seasonally adjusted) under the State law—

(i) Equalled or exceeded 120 percent of the average of such rates for the corresponding 13-week periods ending in each of the preceding two calendar years, and

(ii) Equalled or exceeded 5.0 percent.

(2) There is a State ''off'' indicator in a State for a week if the head of the State agency determines, in accordance with this section, that, for the period consisting of that week and the immediately preceding 12 weeks, the rate of insured unemployment (not seasonally adjusted) under the State law—

(i) Was less than 120 percent of the average of such rates for the corresponding 13 week periods ending in each of the preceding two calendar years, or

(ii) Was less than 5.0 percent.

(3) The standard State indicators in this paragraph (a) shall apply to weeks beginning after September 25, 1982.

(b) *Optional State indicators.* (1)(i) A State may, in addition to the State indicators in paragraph (a) of this section, provide by its law that there shall be a State ''on'' indicator in the State for a week if the head of the State agency determines, in accordance with this section, that, for the period consisting of that week and the immediately preceding 12 weeks, the rate of insured unemployment (not seasonally adjusted) under the State law equalled or exceeded 6.0 percent even though it did not meet the 120 percent factor required under paragraph (a).

(ii) A State which adopts the optional State indicator must also provide that, when it is in an Extended Benefit Period, there will not be an ''off'' indicator until (A) the State rate of insured unemployment is less than 6.0 percent, and (B) either its rate of insured unemployment is less than 5.0 percent or is less than 120 percent of the average of such rates for the corresponding 13-week periods ending in each of the preceding two calendar years.

(2) The optional State indicators in this paragraph (b) shall apply to weeks beginning after September 25, 1982.

(c) *Computation of rate of insured unemployment*—(1) *Equation.* Each week the State agency head shall calculate the rate of insured unemployment under the State law (not seasonally adjusted) for purposes of determining the State ''on'' and ''off'' and ''no change''

indicators. In making such calculations the State agency head shall use a fraction, the numerator of which shall be the weekly average number of weeks claimed in claims filed (not seasonally adjusted) in the State in the 13-week period ending with the week for which the determination is made, and the denominator of which shall be the average monthly employment covered by the State law for the first four of the last six calendar quarters ending before the close of the 13-week period. The quotient obtained is to be computed to four decimal places, and is not otherwise rounded, and is to be expressed as a percentage by multiplying the resultant decimal fraction by 100.

(2) *Counting weeks claimed.* To determine the average number of weeks claimed in claims filed to serve as the numerator under paragraph (c)(1), the State agency shall include claims for all weeks for regular compensation, including claims taken as agent State under the Interstate Benefit Payment Plan. It shall exclude claims—

(i) For Extended Benefits under any State law,

(ii) For additional compensation under any State law, and

(iii) Under any Federal law except joint claims which combine regular compensation and compensation payable under 5 U.S.C. chapter 85.

(3) *Method of computing the State 120 percent factor.* The rate of insured unemployment for a current 13-week period shall be divided by the average of the rates of insured unemployment for the corresponding 13-week periods in each of the two preceding calendar years to determine whether the rate is equal to 120 percent of the average rate for the two years. The quotient obtained shall be computed to four decimal places and not otherwise rounded, and shall be expressed as a percentage by multiplying the resultant decimal fraction by 100. The average of the rates for the corresponding 13-week periods in each of the two preceding calendar years shall be one-half the sum of such rates computed to four decimal places and not otherwise rounded. To determine which are the corresponding weeks in the preceding years—

(i) The weeks shall be numbered starting with week number 1 as the first week ending in each calendar year.

(ii) The 13-week period ending with any numbered week in the current year shall correspond to the period ending with that same numbered week in each preceding year.

(iii) When that period in the current year ends with week number 53, the corresponding period in preceding years shall end with week number 52 if there is no week number 53.

(d) *Amendment of State indicator rates.* (1) Any determination by the head of a State agency of an ''on'' or ''off'' or ''no change'' IUR indicator may not be corrected more than three weeks after the close of the week to which it applies. If any figure used in the computation of a rate of insured unemployment is later found to be wrong, the correct figure must be used to redetermine the rate of insured unemployment and the 120 percent factor for that week and all later weeks, but no determination of previous ''on'' or ''off'' or ''no change'' indicator shall be affected unless the redetermination is made within the time the indicator may be corrected under the first sentence of this paragraph (d)(1). Any change is subject to the concurrence of the Department as provided in paragraph (e) of this section.

(2) The initial release of the TUR by the Bureau of Labor Statistics (BLS) is subject to revision. However, once a State's TUR indicator is determined using the initial release of the TUR data, it is not subject to revision even if the BLS TUR for that period of time is revised.

(3) The ''on'' period under a State's optional IUR or TUR indicator may not begin before the later of the date of the State's adoption of the optional insured unemployment rate or total unemployment rate indicator, or the effective date of that enactment. The ''off'' period under a State's optional insured unemployment rate or total unemployment rate indicator may not occur until after the effective date of the repeal of the optional insured unemployment rate or total unemployment rate indicator from State law.

(e) *Other optional indicators.* (1) A State may, as an option, in addition to the State indicators in paragraphs (a)

and (b) of this section, provide by its law that there is a State ''on'' or ''off'' indicator in the State for a week if we determine that—

(i) The Trigger Value in such State computed using the most recent 3 months for which data for all States are published before the close of such week equals or exceeds 6.5 percent; and

(ii) The Trigger Value computed using data from the 3-month period referred to in paragraph (e)(1)(i) of this section equals or exceeds 110 percent of the Trigger Value for either (or both) of the corresponding 3-month periods ending in the 2 preceding calendar years. This ''look-back'' is computed by dividing the Trigger Value by the same measure for the corresponding 3 months in each of the applicable prior years, and the resulting decimal fraction is rounded to the hundredths place, multiplied by 100 and reported as an integer and compared to the statutory threshold to help determine the State's EB Program status; and

(iii) There is a State ''off'' indicator for a week if either the requirements of paragraph (e)(1)(i) or (ii) of this section are not satisfied.

(2) Where a State adopts the optional indicator under paragraph (e)(1) of this section, there is a State ''on'' indicator for a high unemployment period (as defined in § 615.2) under State law if—

(i) The Trigger Value in the State computed using the most recent 3 months for which data for all States are published before the close of such week equals or exceeds 8.0 percent, and

(ii) The Trigger Value in the State computed using data from the 3-month period referred to in paragraph (e)(2)(i) of this section equals or exceeds 110 percent of the Trigger Value for either (or both) of the corresponding 3-month periods ending in the 2 preceding calendar years. This ''look-back'' is computed by dividing the Trigger Value by the same measure for the corresponding 3 months in each of the applicable prior years, and the resulting decimal fraction is rounded to the hundredths place, multiplied by 100 and reported as an integer and compared to the statutory threshold to help determine the State's EB Program status; and

(iii) There is a State ''off'' indicator for high unemployment period for a week if either the requirements of paragraph (e)(2)(i) or (ii) of this section are not satisfied.

(3) *Method of computing the average rate of total unemployment.* The average rate of total unemployment is computed by dividing the average of 3 months of the level of seasonally adjusted unemployment in the State by the average of 3 months of the level of seasonally adjusted unemployment and employment in the State. The resulting rate is multiplied by 100 to convert it to a percentage basis and then rounded to the tenths place (the first digit to the right of the decimal place).

(4) *Method of computing the State ''look-back.''* The average rate of total unemployment, ending with a given month, is divided by the same measure for the corresponding 3 months in each of the applicable prior years. The resultant decimal fraction is then rounded to the hundredths place (the second digit to the right of the decimal place). The resulting number is then multiplied by 100 and reported as an integer (no decimal places) and compared to the statutory threshold to help determine the State's EB Program status.

(f) *Notice to Secretary.* Within 10 calendar days after the end of any week for which the head of a State agency has determined that there is an ''on,'' or ''off,'' or ''no change'' IUR indicator in the State, the head of the State agency must notify the Secretary of the determination. The notice must state clearly the State agency head's determination of the specific week for which there is a State ''on'' or ''off'' or ''no change'' indicator. The notice must include also the State agency head's findings supporting the determination, with a certification that the findings are made in accordance with the requirements of § 615.15. The Secretary may provide additional instructions for the contents of the notice to assure the correctness and verification of notices given under this paragraph. The Secretary will accept determinations and findings made in accordance with the provisions of this paragraph and of any instructions issued under this paragraph. A notice does not become final for purposes of EUCA and

this part until the Secretary accepts the notice.

[53 FR 27937, July 25, 1988, as amended at 81 FR 57782, Aug. 24, 2016]

§ 615.13 Announcement of the beginning and ending of Extended Benefit Periods or High Unemployment Periods.

(a) *State indicators*—(1) *Extended benefit period.* Upon receipt of a notice required by § 615.12(f) which the Department determines is acceptable, the Department will publish in the FEDERAL REGISTER a notice of the State agency head's determination that there is an ''on'' or an ''off'' indicator in the State, as the case may be, the name of the State and the beginning or ending of the extended benefit period, or high unemployment period, whichever is appropriate. If an ''on'' or ''off'' EB period is determined by the Department to be based on a State's TUR Trigger Value, the Department publishes that information in the FEDERAL REGISTER as well.

(2) *Notification.* The Department also notifies the heads of all other State agencies, and the Regional Administrators of the Employment and Training Administration of the State agency head's determination of the State ''on'' or ''off'' indicator for an extended benefit period, or high unemployment period (based on the insured unemployment rate in the State), or of the Department's determination of an ''on'' or ''off'' indicator (based on the total unemployment rate in a State) for an extended benefit period or high unemployment period and of the indicator's effect.

(b) *Publicity by State.* (1) Whenever a State agency head determines that there is an ''on'' indicator in the State by reason of which an extended benefit period (based on the insured unemployment rate in the State) will begin in the State, or an ''off'' indicator by reason of which an extended benefit period in the State (based on the insured unemployment rate) will end, the head of the State agency must promptly announce the determination through appropriate news media in the State after the Department accepts notice from the agency head in accordance the 615.12(f).

(2) Whenever the head of a State agency receives notification from the Department in accordance with § 615.12(f) that there is an ''on'' indicator by reason of which an extended benefit period or high unemployment period (based on the total unemployment rate in the State) will begin in the State, or an ''off'' indicator by reason of which a regular extended benefit period or high unemployment period (based on the total unemployment rate) will end, the head of the State agency must promptly announce the determination through the appropriate news media in the State.

(3) Announcements made in accordance with paragraphs (b)(1) or (b)(2) of this section must include the beginning or ending date of the extended benefit period or high unemployment period, whichever is appropriate. In the case of a regular EB period or high unemployment period that is about to begin, the announcement must describe clearly the unemployed individuals who may be eligible for extended compensation or high extended compensation during the period, and in the case of a regular EB period or high unemployment period that is about to end, the announcement must also describe clearly the individuals whose entitlement to extended compensation or high extended compensation will be terminated. If a high unemployment period is ending, but an extended benefit period will remain ''on,'' the announcement must clearly state that fact and the effect on entitlement to extended compensation.

(c) *Notice to individuals.* (1) Whenever there has been a determination that a regular extended benefit period or high unemployment period will begin in a State, the State agency must provide prompt written notice of potential entitlement to Extended Benefits to each individual who has established a benefit year in the State that will not end before the beginning of the regular extended benefit period or high unemployment period, and who exhausted all rights under the State law to regular compensation before the beginning of the regular extended benefit period or high unemployment period.

(2) The State agency must provide the notice promptly to each individual

who begins to claim sharable regular benefits or who exhausts all rights under the State law to regular compensation during a regular extended benefit period or high unemployment period, including exhaustion by reason of the expiration of the individual's benefit year.

(3) The notices required by paragraphs (c)(1) and (2) of this section must describe the actions required of claimants for sharable regular compensation and extended compensation and those disqualifications which apply to the benefits which are different from those applicable to other claimants for regular compensation which is not sharable.

(4) Whenever there is a determination that a regular extended benefit period or high unemployment period will end in a State, the State agency must provide prompt written notice to each individual who is currently filing claims for extended compensation of the forthcoming end of the regular extended benefit period or high unemployment period and its effect on the individual's right to extended compensation.

[81 FR 57783, Aug. 24, 2016]

§ 615.14 Payments to States.

(a) *Sharable compensation.* (1) The Department shall promptly upon receipt of a State's report of its expenditures for a calendar month reimburse the State in the amount of the sharable compensation the State is entitled to receive under EUCA and this part.

(2) The Department may instead advance to a State for any period not greater than one day the amount the Department estimates the State will be entitled to be paid under EUCA and this part for that period.

(3) Any payment to a State under this section shall be based upon the Department's determination of the amount the State is entitled to be paid under EUCA and this part, and such amount shall be reduced or increased, as the case may be, by any amount by which the Department finds that a previous payment was greater or less than the amount that should have been paid to the State.

(4) Any payment to a State pursuant to this paragraph (a) shall be made by a transfer from the extended unemployment compensation account in the Unemployment Trust Fund to the account of the State in such Fund, in accordance with section 204(e) of EUCA.

(b) *Payments not to be made to States.* Because a State law must contain provisions fully consistent with sections 202 and 203 of EUCA, the Department shall make no payment under paragraph (a) of this section, whether or not the State is certified under section 3304(c) of the Internal Revenue Code of 1986—

(1) In respect of any regular or extended compensation paid to any individual for any week if the State does not apply—

(i) The provisions of the State law required by section 202(a)(3) and this part, relating to failure to accept work offered or to apply for work or to actively engage in seeking work or the provisions of State law required by section 202(a)(4) and this part, relating to terminating a disqualification;

(ii) The provisions of the State law required by section 202(a)(5) and this part, relating to qualifying employment; or

(2) In respect of any regular or extended compensation paid to any individual for any week which was not payable by reason of the provision of the State law required by section 202(c) and this part as determined by the Department with regard to each State.

(c) *Payments not to be reimbursed.* The Department shall make no payment under paragraph (a) of this section, whether or not the State is certified under section 3304(c) of the Internal Revenue Code of 1986, in respect of any regular or extended compensation paid under a State law—

(1) As provided in section 204(a)(1) of EUCA and this part, if the payment made was not sharable extended compensation or sharable regular compensation;

(2) As provided in section 204(a)(2)(A) of EUCA, if the State is entitled to reimbursement for the payment under the provisions of any Federal law other than EUCA;

(3) As provided in section 204(a)(2)(B) of EUCA, if for the first week in an individual's eligibility period with respect to which Extended Benefits or sharable regular benefits are paid to

the individual and the State law provides for the payment (at any time or under any circumstances) of regular compensation to any individual for the first week of unemployment in any such individual's benefit year; except that—

(i) In the case of a State law which is changed so that regular compensation is not paid at any time or under any circumstances with respect to the first week of unemployment in any individual's benefit year, this paragraph (c)(3) shall not apply to any week which begins after the effective date of such change in the State law; and

(ii) In the case of a State law which is changed so that regular compensation is paid at any time or under any circumstances with respect to the first week of unemployment in any individual's benefit year, this paragraph (c)(3) shall apply to all weeks which begin after the effective date of such change in the State law;

(4) As provided in section 204(a)(2)(C) of EUCA, for any week in which extended compensation is not payable because of the payment of trade readjustment allowances, as provided in section 233(c) of the Trade Act of 1974, and § 615.7(d).

(5) As provided in section 204(a)(2)(D) of EUCA and this part, if the State does not provide for a benefit structure under which benefits are rounded down to the next lower dollar amount, for the 50 percent Federal share of the amount by which sharable regular or Extended Benefits paid to any individual exceeds the nearest lower full dollar amount.

(6) As provided in section 204(a)(3) of EUCA, to the extent that such compensation is based upon employment and wages in service performed for governmental entities or instrumentalities to which section 3306(c)(7) of the Internal Revenue Code of 1986 (26 U.S.C. 3306(c)(7)) applies, in the proportion that wages for such service in the base period bear to the total base period wages;

(7) If the payment made was not sharable extended compensation or sharable regular compensation because the payment was not consistent with the requirements of—

(i) Section 202(a)(3) of EUCA, and § 615.8 (e), (f), or (g);

(ii) Section 202(a)(4) of EUCA, and § 615.8(c); or

(iii) Section 202(a)(5) of EUCA, and § 615.4(b);

(8) If the payment made was not sharable extended compensation or sharable regular compensation because there was not in effect in the State an Extended Benefit Period in accord with the Act and this part; or

(9) For any week with respect to which the claimant was either ineligible for or not entitled to the payment.

(d) *Effectuating authorization for reimbursement.* (1) If the Department believes that reimbursement should not be authorized with respect to any payments made by a State that are claimed to be sharable compensation paid by the State, because the State law does not contain provisions required by EUCA and this part, or because such law is not interpreted or applied in rules, regulations, determinations or decisions in a manner that is consistent with those requirements, the Department may at any time notify the State agency in writing of the Department's view. The State agency shall be given an opportunity to present its views and arguments if desired.

(2) The Department shall thereupon decide whether the State law fails to include the required provisions or is not interpreted and applied so as to satisfy the requirements of EUCA and this part. If the Department finds that such requirements are not met, the Department shall notify the State agency of its decision and the effect thereof on the State's entitlement to reimbursement under this section and the provisions of section 204 of EUCA.

(3) Thereafter, the Department shall not authorize any payment under paragraph (a) of this section in respect of any sharable regular or extended compensation if the State law does not contain all of the provisions required by sections 202 and 203 of EUCA and this part, or if the State law, rules, regulations, determinations or decisions are not consistent with such requirements, or which would not have been payable if the State law contained

the provisions required by EUCA and this part or if the State law, rules, regulations, determinations or decisions had been consistent with such requirements. Loss of reimbursement for such compensation shall begin with the date the State law was required to contain such provisions, and shall continue until such time as the Department finds that such law, rules and regulations have been revised or the interpretations followed pursuant to such determinations and decisions have been overruled and payments are made or denied so as to accord with the Federal law requirements of EUCA and this part, but no reimbursement shall be authorized with respect to any payment that did not fully accord with EUCA and this part.

(4) A State agency may request reconsideration of a decision issued pursuant to paragraph (d)(2) above, within 10 calendar days of the date of such decision, and shall be given an opportunity to present views and arguments if desired.

(5) Concurrence of the Department in any State law provision, rule, regulation, determination or decision shall not be presumed from the absence of notice issued pursuant to this section or from a certification of the State issued pursuant to section 3304(c) of the Internal Revenue Code of 1986.

(6) Upon finding that a State has made payments for which it claims reimbursement that are not consistent with EUCA or this part, such claim shall be denied; and if the State has already been paid such claim in advance or by reimbursement, it shall be required to repay the full amount to the Department. Such repayment may be made by transfer of funds from the State's account in the Unemployment Trust Fund to the Extended Unemployment Compensation Account in the Fund, or by offset against any current advances or reimbursements to which the State is otherwise entitled, or the amount repayable may be recovered for the Extended Unemployment Compensation Account by other means and from any other sources that may be available to the United States or the Department.

(e) *Compensation under Federal unemployment compensation programs.* The Department shall promptly reimburse each State which has paid sharable compensation based on service covered by the UCFE and UCX Programs (parts 609 and 614 of this chapter, respectively) pursuant to 5 U.S.C. chapter 85, an amount which represents the full amount of such sharable compensation paid under the State law, or may make advances to the State. Such amounts shall be paid from the Federal Employees Compensation Account established for those programs, rather than from the Extended Unemployment Compensation Account.

(f) *Combined-wage claims.* If an individual was paid benefits under the Interstate Arrangement for Combining Employment and Wages (part 616 of this chapter) any payment required by paragraph (a) of this section shall be made to the States which contributed the wage credits.

(g) *Interstate claims.* Where sharable compensation is paid to an individual under the provisions of the Interstate Benefit Payment Plan, any payment required by paragraph (a) of this section shall be made only to the liable State.

[53 FR 27937, July 25, 1988, as amended at 71 FR 35514, June 21, 2006; 81 FR 57783, Aug. 24, 2016]

§ 615.15 Records and reports.

(a) *General.* State agencies must furnish to the Secretary such information and reports and make such studies as the Secretary decides are necessary or appropriate for carrying out the purposes of this part.

(b) *Recordkeeping.* Each State agency must make and maintain records pertaining to the administration of the Extended Benefit Program as the Department requires, and must make all such records available for inspection, examination and audit by such Federal officials or employees as the Department may designate or as may be required by law.

[81 FR 57783, Aug. 24, 2016]

PART 616—INTERSTATE ARRANGEMENT FOR COMBINING EMPLOYMENT AND WAGES

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AUTHORITY: 26 U.S.C. 3304(a)(9)(B); Secretary's Order No. 3–2007, Apr. 3, 2007 (72 FR 15907).

SOURCE: 36 FR 24992, Dec. 28, 1971, unless otherwise noted.

§ 616.1 Purpose of arrangement.

This arrangement is approved by the Secretary under the provisions of section 3304(a)(9)(B) of the Federal Unemployment Tax Act to establish a system whereby an unemployed worker with covered employment or wages in more than one State may combine all such employment and wages in one State, in order to qualify for benefits or to receive more benefits.

§ 616.2 Consultation with the State agencies.

As required by section 3304(a)(9)(B), this arrangement has been developed in consultation with the State unemployment compensation agencies. For purposes of such consultation in its formulation and any future amendment the Secretary recognizes, as agents of the State agencies, the duly designated representatives of the National Association of State Workforce Agencies (NASWA).

[36 FR 24992, Dec. 28, 1971, as amended at 71 FR 35514, June 21, 2006]

§ 616.3 Interstate cooperation.

Each State agency will cooperate with every other State agency by implementing such rules, regulations, and procedures as may be prescribed for the operation of this arrangement. Each State agency shall identify the paying and the transferring State with respect to Combined-Wage Claims filed in its State.

§ 616.4 Rules, regulations, procedures, forms—resolution of disagreements.

All State agencies shall operate in accordance with such rules, regulations, and procedures, and shall use such forms, as shall be prescribed by the Secretary in consultation with the State unemployment compensation agencies. All rules, regulations, and standards prescribed by the Secretary with respect to intrastate claims will apply to claims filed under this arrangement unless they are clearly inconsistent with the arrangement. The Secretary shall resolve any disagreement between State agencies concerning the operation of the arrangement, with the advice of the duly designated representatives of the State agencies.

§ 616.6 Definitions.

These definitions apply for the purpose of this arrangement and the procedures issued to effectuate it.

(a) *State.* ''State'' includes the States of the United States of America, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(b) *State agency.* The agency which administers the unemployment compensation law of a State.

(c) *Combined-Wage Claim.* A claim filed under this arrangement.

(d) *Combined-Wage Claimant.* A claimant who has covered wages under the unemployment compensation law of more than one State and who has filed a claim under this arrangement.

(e) *Paying State.* A single State against which the claimant files a Combined-Wage Claim, if the claimant has wages and employment in that State's base period(s) and the claimant qualifies for unemployment benefits under the unemployment compensation law of that State using combined wages and employment.

(f) *Transferring State.* A State in which a Combined-Wage Claimant had covered employment and wages in the base period of a paying State, and which transfers such employment and wages to the paying State for its use in

determining the benefit rights of such claimant under its law.

(g) *Employment and wages.* ''Employment'' refers to all services which are covered under the unemployment compensation law of a State, whether expressed in terms of weeks of work or otherwise. ''Wages'' refers to all remuneration for such employment.

(h) *Secretary.* The Secretary of Labor of the United States.

(i) *Base period and benefit year.* The base period and benefit year applicable under the unemployment compensation law of the paying State.

[36 FR 24992, Dec. 28, 1971, as amended at 39 FR 45215, Dec. 31, 1974; 43 FR 2625, Jan. 17, 1978; 71 FR 35514, June 21, 2006; 73 FR 63072, Oct. 23, 2008]

§ 616.7 Election to file a Combined-Wage Claim.

(a) Any unemployed individual who has had employment covered under the unemployment compensation law of two or more States, whether or not the individual is monetarily qualified under one or more of them, may elect to file a Combined-Wage Claim. The individual may not so elect, however, if the individual has established a benefit year under any State or Federal unemployment compensation law and:

(1) The benefit year has not ended, and

(2) The individual still has unused benefit rights based on such benefit year.[1]

(b) For the purposes of this arrangement, a claimant will not be considered to have unused benefit rights based on a benefit year which the claimant has established under a State or Federal unemployment compensation law if:

(1) The claimant has exhausted his/her rights to all benefits based on such benefit year; or

(2) The claimant's rights to such benefits have been postponed for an indefinite period or for the entire period in which benefits would otherwise be payable; or

(3) Benefits are affected by the application of a seasonal restriction.

(c) If an individual elects to file a Combined-Wage Claim, all employment and wages in all States in which the individual worked during the base period of the paying State must be included in such combining, except employment and wages which are not transferrable under the provisions of § 616.9(b).

(d) A Combined-Wage Claimant may withdraw his/her Combined-Wage Claim within the period prescribed by the law of the paying State for filing an appeal, protest, or request for redetermination (as the case may be) from the monetary determination of the Combined-Wage Claim, provided the claimant either:

(1) Repays in full any benefits paid to him thereunder, or

(2) Authorizes the State(s) against which the claimant files a substitute claim(s) for benefits to withhold and forward to the paying State a sum sufficient to repay such benefits.

(e) If the Combined-Wage Claimant files his/her claim in a State other than the paying State, the claimant shall do so pursuant to the Interstate Benefit Payment Plan.

(f) If a State denies a Combined-Wage Claim, it must inform the claimant of the option to file in another State in which the claimant has wages and employment during that State's base period(s).

[36 FR 24992, Dec. 28, 1971, as amended at 71 FR 35514, 35515, June 21, 2006; 73 FR 63072, Oct. 23, 2008]

§ 616.8 Responsibilities of the paying State.

(a) *Transfer of employment and wages—payment of benefits.* The paying State shall request the transfer of a Combined-Wage Claimant's employment and wages in all States during its base period, and shall determine the claimant's entitlement to benefits (including additional benefits, extended benefits

[1] The Federal-State Extended Unemployment Compensation Act of 1970, title II, Public Law 91–373, section 202(a)(1), limits the payment of extended benefits with respect to any week to individuals who have no rights to regular compensation with respect to such week under any State unemployment compensation law or to compensation under any other Federal law and in certain other instances. This provision precludes any individual from receiving any Federal-State extended benefits with respect to any week for which the individual is eligible to receive regular benefits based on a Combined Wage Claim. (See section 5752, part V of the Employment Security Manual.)

and dependents' allowances when applicable) under the provisions of its law based on employment and wages in the paying State, and all such employment and wages transferred to it hereunder. The paying State shall apply all the provisions of its law to each determination made hereunder, except that the paying State may not determine an issue which has previously been adjudicated by a transferring State. Such exception shall not apply, however, if the transferring State's determination of the issue resulted in making the Combined-Wage Claim possible under § 616.7(b)(2). If the paying State fails to establish a benefit year for the Combined-Wage Claimant, or if the claimant withdraws his/her claim as provided herein, it shall return to each transferring State all employment and wages thus unused.

(b) *Notices of determination.* The paying State shall give to the claimant a notice of each of its determinations on his/her Combined-Wage Claim that he/she is required to receive under the Secretary's Claim Determinations Standard and the contents of such notice shall meet such Standard. When the claimant is filing his/her Combined-Wage Claims in a State other than the paying State, the paying State shall send a copy of each such notice to the local office in which the claimant filed such claims.

(c) *Redeterminations.* (1) Redeterminations may be made by the paying State in accordance with its law based on additional or corrected information received from any source, including a transferring State, except that such information shall not be used as a basis for changing the paying State if benefits have been paid under the Combined-Wage Claim.

(2) When a determination is made, as provided in paragraph (a) of this section, which suspends the use of wages earned in employment with an educational institution during a prescribed period between successive academic years or terms or other periods as prescribed in the law of the paying State in accordance with section 3304(a)(6)(A)(i)–(iv) of the Internal Revenue Code of 1986, the paying State shall furnish each transferring State involved in the combined-Wage Claim an adjusted determination used to recompute each State's proportionate share of any charges that may accumulate for benefits paid during the period of suspended use of school wages. Wages which are suspended shall be retained by the paying State for possible future reinstatement to the Combined-Wage Claim and shall not be returned to the transferring State.

(d) *Appeals.* (1) Except as provided in paragraph (d)(3) of this section, where the claimant files his/her Combined-Wage Claim in the paying State, any protest, request for redetermination or appeal shall be in accordance with the law of such State.

(2) Where the claimant files his/her Combined-Wage Claim in a State other than the paying State, or under the circumstances described in paragraph (d)(3) of this section, any protest, request for redetermination or appeal shall be in accordance with the Interstate Benefit Payment Plan.

(3) To the extent that any protest, request for redetermination or appeal involves a dispute as to the coverage of the employing unit or services in a transferring State, or otherwise involves the amount of employment and wages subject to transfer, the protest, request for redetermination or appeal shall be decided by the transferring State in accordance with its law.

(e) *Recovery of prior overpayments.* If there is an overpayment outstanding in a transferring State and such transferring State so requests, the overpayment shall be deducted from any benefits the paying State would otherwise pay to the claimant on his/her Combined-Wage Claim except to the extent prohibited by the law of the paying State. The paying State shall transmit the amount deducted to the transferring State or credit the deduction against the transferring State's required reimbursement under this arrangement. This paragraph shall apply to overpayments only if the transferring State certifies to the paying State that the determination of overpayment was made within 3 years before the Combined-Wage Claim was filed and that repayment by the claimant is legally required and enforceable against him/her under the law of the transferring State.

(f) *Statement of benefit charges.* (1) At the close of each calendar quarter, the paying State shall send each transferring State a statement of benefits charged during such quarter to such State as to each Combined-Wage Claimant.

(2) Except as provided in paragraphs (c)(2), (f)(3), and (f)(5) of this section, each such charge shall bear the same ratio to the total benefits paid to the Combined-Wage Claimant by the paying State as the claimant's wages transferred by the transferring State bear to the total wages used in such determination. Each such ratio shall be computed as a percentage, to three or more decimal places.

(3) Charges to the transferring State shall not include the costs of any benefits paid which are funded or reimbursed from the Federal Unemployment Benefits and Allowances account in the U.S. Department of Labor appropriation, including:

(i) Benefits paid pursuant to 5 U.S.C. 8501–8525; and

(ii) Benefits which are reimbursable under part B of title II of the Emergency Jobs and Unemployment Assistance Act of 1974 (Pub. L. 93–567).

(4) Except as provided in paragraphs (f)(3) and (f)(5) of this section, all transferring States will be charged by the paying State for Extended Benefits in the same manner as for regular benefits.

(5) The United States shall be charged directly by the paying State, in the same manner as is provided in paragraphs (f)(1) and (f)(2) of this section, in regard to Federal civilian service and wages and Federal military service and wages assigned or transferred to the paying State and included in Combined-Wage Claims in accordance with this part and parts 609 and 614 of this chapter.

(26 U.S.C. 3304(a)(9)(B); Secretary's Order No. 4–75, (40 FR 18515))

[36 FR 24992, Dec. 28, 1971, as amended at 43 FR 2625, Jan. 17, 1978; 45 FR 47109, July 11, 1980; 71 FR 35515, June 21, 2006; 73 FR 63072, Oct. 23, 2008]

§ 616.9 Responsibilities of transferring States.

(a) *Transfer of employment and wages.* Each transferring State shall promptly transfer to the Paying State the employment and wages the Combined-Wage Claimant had in covered employment during the base period of the paying State. Any employment and wages so transferred shall be transferred without restriction as to their use for determination and benefit payments under the provisions of the paying State's law.

(b) *Employment and wages not transferable.* Employment and wages transferred to the paying State by a transferring State shall not include:

(1) Any employment and wages which have been transferred to any other paying State and not returned unused, or which have been used in the transferring State as the basis of a monetary determination which established a benefit year.

(2) Any employment and wages which have been canceled or are otherwise unavailable to the claimant as a result of a determination by the transferring State made prior to its receipt of the request for transfer, if such determination has become final or is in the process of appeal but is still pending. If the appeal is finally decided in favor of the Combined-Wage Claimant, any employment and wages involved in the appeal shall forthwith be transferred to the paying State and any necessary redetermination shall be made by such paying State.

(c) *Reimbursement of paying State.* Each transferring State shall, as soon as practicable after receipt of a quarterly statement of charges described herein, reimburse the paying State accordingly.

(26 U.S.C. 3304(a)(9)(B); Secretary's Order No. 4–75, (40 FR 18515))

[36 FR 24992, Dec. 28, 1971, as amended at 45 FR 47109, July 11, 1980]

§ 616.10 Reuse of employment and wages.

Employment and wages which have been used under this arrangement for a determination of benefits which establishes a benefit year shall not thereafter be used by any State as the basis for another monetary determination of benefits.

§ 616.11 Amendment of arrangement.

Periodically the Secretary shall review the operation of this arrangement, and shall propose such amendments to the arrangement as the Secretary believes are necessary or appropriate. Any State unemployment compensation agency or NASWA may propose amendments to the arrangement. Any proposal shall constitute an amendment to the arrangement upon approval by the Secretary in consultation with the State unemployment compensation agencies. Any such amendment shall specify when the change shall take effect, and to which claims it shall apply.

[36 FR 24992, Dec. 28, 1971, as amended at 71 FR 35515, June 21, 2006]

PART 617 [RESERVED]

PART 618—TRADE ADJUSTMENT ASSISTANCE UNDER THE TRADE ACT OF 1974, AS AMENDED

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Subpart A–General

§ 618.100 Purpose and scope.

(a) *Purpose.* The Act establishes a Trade Adjustment Assistance for Workers (TAA) Program. The goal of

the TAA Program is to help each worker participating in the program obtain suitable employment whenever possible, and to return to employment as quickly as possible.

(b) *Scope.* Global trade impacts thousands of workers each year across the United States. The TAA Program provides trade-affected workers with opportunities to obtain the skills, credentials, resources, and support necessary to become reemployed in a good job. The TAA Program's benefits and services include: employment and case management services, training, out-of-area job search and relocation allowances, income support through Trade Readjustment Allowances (TRA), the Reemployment Trade Adjustment Assistance (RTAA) benefit for workers aged 50 or older who find qualifying reemployment, and, if available, the Health Coverage Tax Credit (HCTC). Together with its workforce development partners in the one-stop delivery system authorized under the Workforce Innovation and Opportunity Act (WIOA), the TAA Program helps retrain, retool, and rebuild the American workforce. This part 618 applies for all workers determined eligible to apply for TAA except for those covered under certain provisions of the Trade Adjustment Assistance Reform Act of 2002 and the Trade and Globalization Adjustment Assistance Act of 2009, for which administrative guidance will continue to apply.

(c) *Effect.* The regulations in this part are issued to implement the Act.

§ 618.110 Definitions.

The following definitions apply solely in this part.

Act means chapter 2 of title II of the Trade Act of 1974, Public Law 93–618, 88 Stat. 1978 (19 U.S.C. 2271–2323 and 2395), as amended.

Administrator means the Administrator, Office of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Washington, DC, who has responsibility for administering the TAA Program, or his or her designee.

Adversely affected employment means employment in a firm or appropriate subdivision, if workers of the firm or appropriate subdivision are certified as eligible to apply for the TAA Program under subpart B of this part.

Adversely affected worker or *AAW* (also referred to, in combination with an AAIW, as a trade-affected worker) means an individual, including an employer, who, because of lack of work in adversely affected employment, has been totally or partially separated from such employment.

Adversely affected incumbent worker or *AAIW* (also referred to, in combination with an AAW, as a trade-affected worker) means a worker who:

(1) Is a member of a worker group certified as eligible to apply for the TAA Program under subpart B of this part;

(2) Has not been totally or partially separated from adversely affected employment; and

(3) The Department determines, on an individual basis, is threatened with total or partial separation.

Agent State means a State, other than a liable State, that provides benefits or services to a trade-affected worker. A State can be both an agent State and a liable State.

Applicable State law means, for any worker, the State law of the State:

(1) In which such worker is entitled to Unemployment Insurance (UI) (whether or not such worker has filed a UI claim) immediately following such worker's first separation; or

(2) If the worker is not so entitled to UI under the State law of any State immediately following such first separation, or is entitled to UI under the Railroad Unemployment Insurance Act (RRUI), the State law of the State in which such first separation occurred.

Appropriate subdivision means an establishment, facility or facilities, an organizational department, a product line, a project team, an operational unit, or part or combination thereof. The appropriate subdivision is determined on a case-by-case basis and includes all workers or a subset of workers working at, or reporting to, the location(s) identified in the petition, or subsequently identified during the course of the investigation, whose employment is dependent upon the production of the specific article or supply of the specific service identified in the

petition, or identified during the course of the investigation.

Appropriate week means the week in which the AAW's first separation occurred.

Approved training or *TAA approved training* means a training program approved under subpart F of this part (§618.610).

Article means a tangible good or an intangible good sold or produced by a firm. The good must be the subject of the sale or production, and not an object that is produced incidentally to the sale or production. An article can be measured in individual production units or commercial production units, such as with commodities. Sale of an article is the means by which revenue is generated, accumulated, or calculated.

Average weekly hours means the average hours worked by an AAW (excluding overtime) in the employment from which the worker has been or claims to have been separated in the 52 consecutive calendar weeks (excluding weeks during which the worker was sick or on vacation) immediately preceding the worker's total separation or, for a partially separated worker, the week before the appropriate week. The average is obtained by dividing:

(1) Total hours worked (excluding overtime) in the 52 consecutive calendar weeks (excluding weeks in such period during which the worker was sick or on vacation); by

(2) The number of weeks in such 52 consecutive calendar weeks (excluding weeks in such period during which the worker was sick or on vacation).

Average weekly wage means one-thirteenth of the total wages paid to an AAW in the high quarter. For purposes of this computation, the high quarter is the quarter in which the worker's total wages were highest among the first 4 of the last 5 completed calendar quarters immediately preceding the week in which total separation occurred or, in cases where partial separation is claimed, the appropriate week.

Benefit period means, with respect to an AAW:

(1) The benefit year and any ensuing period, as determined under the applicable State law, during which the worker is eligible for regular compensation, additional compensation, or extended compensation; or

(2) The equivalent to such a benefit year or ensuing period provided for under Federal UI law.

Certification or *affirmative determination* or *petition certification* means a determination issued under §618.235(a), or an amendment under §618.250, of eligibility to apply for the TAA Program, with respect to a specified worker group of a firm or appropriate subdivision. Excluded from this definition are ''certifications'' in sections 223(d), 236(a)(5)(H), 239(a)(3), and 247(19) of the Act, and ''affirmative determinations'' in sections 222(e) and 224 of the Act.

Certification date or *date of certification* means the date on which the Certifying Officer signs the certification. This is the date that the certification takes effect.

Certification period means the period of time during which total, partial, or threat of separations from adversely affected employment within a firm or appropriate subdivision of a firm are covered by a certification for worker groups eligible to apply for assistance under section 222(a) and (b) of the Act. It also means the period of time during which total or partial separations from adversely affected employment within a firm are covered by a certification for worker groups eligible to apply for assistance under section 222(e) of the Act. The certification period begins on the impact date and, unless stated otherwise in the certification, ends 2 years after the certification date. A certification may expire sooner than 2 years after the certification date as a result of a termination under §618.240, an amendment under §618.250, or if a certification is based on a determination issued by the International Trade Commission (ITC) under section 222(e) of the Act.

Certifying Officer means an official, including the Administrator of the Office of Trade Adjustment Assistance, Employment and Training Administration, Department of Labor, who has been delegated responsibility to make determinations and issue certifications of eligibility to apply for the TAA Program, and to perform such further duties as may be required.

Co-enrollment means enrollment in the TAA Program and at least one other program that operates as part of the one-stop delivery system, such as the dislocated worker program under title I of WIOA.

Commission or *International Trade Commission* or *ITC* means the U.S. International Trade Commission.

Commuting area means the area in which a trade-affected worker would be expected to travel to and from work on a daily basis as determined under the applicable State law.

Completion of training or *complete training* or *completed training* means that the trade-affected worker has finished all required coursework (including required externships or internships), testing, and professional licensing exams related to TAA approved training.

Component part means an input (tangible or intangible article) that is directly incorporated into the production of another article, although it need not retain its original form or characteristics.

Confidential business information means trade secrets and commercial or financial information received by the Department, or by the States on the Department's behalf, during an investigation under subpart B of this part, which the Department considers to be privileged or confidential as set forth in the Trade Secrets Act (18 U.S.C. 1905), 5 U.S.C. 552(b)(4), or 29 CFR part 70. It does not include publicly available business information, or business information with respect to which the firm or customer submitting the information had notice, at the time of submitting the information, that the information would be released by the Department or the States, or if the firm or customer subsequently consents to the release of the information.

Contributed importantly means a cause that is important but not necessarily more important than any other cause.

Cooperating State agency or *CSA* means the agency at the State level that will act as agent of the Department in receiving applications from and providing benefits and services to trade-affected workers in coordination with the State agency that administers the UI law, if applicable, and such other agency or agencies of the State as the Governor of the State may designate to cooperate with such CSA for performance accountability reporting and other purposes.

Customized training means work-based training that is:

(1) Designed to meet the special requirements of a single employer or group of employers;

(2) Conducted with a commitment by the employer or group of employers to employ a trade-affected worker upon successful completion of the training; and

(3) For which the employer pays for a significant portion (but in no case less than 50 percent) of the cost of such training.

Denial or *negative determination* or *petition denial* means a determination issued under § 618.235(b) that a group of workers is not eligible for TAA Program benefits.

Department of Labor or *Department* means the U.S. Department of Labor.

Downstream producer means a firm that performs additional, value-added production processes or services, such as final assembly, finishing, testing, packaging, or maintenance or transportation services. The value-added production processes or services must be performed directly for another firm that has a worker group certified to apply for the TAA Program under § 618.225, and the production processes or services must be carried out with respect to the article or service on which the certification under § 618.225 was based.

Eligible RTAA recipient means, for HCTC purposes (see definition of *HCTC*), an AAW eligible for RTAA and who is participating in RTAA for a month and is receiving an RTAA benefit for that month.

Eligible TAA recipient means, for HCTC purposes (see definition of *HCTC*), an AAW who receives TRA for any day of the month or who would be eligible to receive TRA but for the fact that the worker has not exhausted his or her UI entitlement.

Employer means any individual or type of organization, including the

Federal Government, a State government, a political subdivision, or an instrumentality of one or more governmental entities, with one or more individuals performing service in employment for it within the United States.

Employment means any service performed for an employer by an officer of a corporation or by an individual for wages.

Enrolled in training means that a worker's application for training is approved by the State under subpart F of this part, and the training provider has furnished written notice to the State that the worker has been accepted in the approved training program, which is to begin within 30 calendar days of the date of such approval.

Exhaustion of UI means exhaustion of all rights to UI in a benefit period by reason of:

(1) Having received all UI to which a worker was entitled under the applicable State law or Federal unemployment compensation law with respect to such benefit period; or

(2) The expiration of such benefit period.

Family means the following members of an adversely affected worker's household whose principal place of abode is with the individual in a home the individual maintains or would maintain but for unemployment:

(1) Spouse;

(2) Domestic partner;

(3) Children of the adversely affected worker, of the worker's spouse, or of the worker's domestic partner, who are unmarried and under 21 years of age or who, regardless of age, are physically or mentally incapable of self-support. (The term ''children'' shall include natural offspring; stepchildren; adopted children; grandchildren, legal minor wards or other dependent children who are under legal guardianship of the worker, of the worker's spouse, or of the domestic partner; and an unborn child(ren) born and moved after the worker's effective date of transfer.);

(4) Dependent parents (including step and legally adoptive parents) of the worker, of the worker's spouse, or of the worker's domestic partner; and

(5) Dependent brothers and sisters (including step and legally adoptive brothers and sisters) of the worker, of the worker's spouse, or of the worker's domestic partner, who are unmarried and under 21 years of age or who, regardless of age, are physically or mentally incapable of self-support.

Filing date means the date on which the petition and attachments to the petition form are determined to be valid by the Department's Office of Trade Adjustment Assistance, in accordance with § 618.205.

Firm means an individual proprietorship, partnership, joint venture, association, corporation (including a development corporation), business trust, cooperative, trustee in bankruptcy, or receiver under decree of any court. A firm, together with any predecessor or successor-in-interest, or together with any affiliated firm controlled or substantially beneficially owned by substantially the same persons may be considered a single firm. Where the term ''firm'' appears in this part, it means ''firm or appropriate subdivision.'' Firm also means an agricultural firm or service sector firm or an appropriate subdivision thereof. For purposes of subpart B of this part only, firm does not include a public agency or any subdivision of a public agency, as defined in 29 U.S.C. 203(x).

First benefit period means the benefit period established after the AAW's first qualifying separation or in which such separation occurs.

Full-time training means:

(1) Attendance in training in accordance with the training provider's established full-time hours in a day (or credit hours) and days in a week; and

(2) In the last semester of training, if the remaining course(s) to complete the training approved under subpart F of this part do not meet the training provider's usual definition of full-time, States must consider the participation in training as full-time training, if no additional training or coursework will be required to complete the training program.

Group of workers means at least two workers employed or formerly employed by the same firm, or an appropriate subdivision thereof, including teleworkers and staffed workers, who file a petition for certification under subpart B of this part, or for whom a petition is filed.

Health Coverage Tax Credit or *HCTC* means the tax credit equal to a specific percentage of the costs of qualified health insurance premiums, which is administered by the Internal Revenue Service under section 35 of the Internal Revenue Code of 1986, as amended (26 U.S.C. 35). When the tax credit is available, eligible TAA and RTAA recipients (see definitions of *eligible TAA recipient* and *eligible RTAA recipient*) and qualifying family members may apply for advance payment of the credit or claim the credit on their income tax return.

Impact date means the date stated in a certification of eligibility to apply for the TAA Program, on which the total or partial separations of the workers covered by the certification began or threatened to begin, but in most cases, is not more than 1 year before the petition date.

Increased imports means that imports have increased either absolutely or relative to domestic production compared to a representative base period. The representative base period will be 1 year consisting of the 4 quarters immediately preceding the date that is 12 months prior to the date of the petition.

Individual employment plan or *IEP* means a revisable document containing an ongoing strategy, jointly developed by the trade-affected worker and the State, identifying the worker's employment goals, appropriate achievement objectives, and appropriate services for the worker to achieve his or her employment goals, objectives, and benchmarks while in training or receiving employment and case management services.

Job finding club means a job search workshop that includes a period of 1 to 2 weeks of structured, supervised activity in which trade-affected workers attempt to obtain jobs.

Job search program or *JSP* means a job search workshop or job finding club.

Job search workshop means a short (1 to 3 days) seminar designed to provide workers with knowledge that will enable the workers to find jobs. Subjects are not limited to, but should include, labor market information, resume writing, interviewing techniques, and techniques for finding job openings.

Lack of work means that the employer does not have work for the worker to perform or does not make that work available to the worker, and includes, but is not limited to, circumstances when:

(1) Work is unavailable because the employer suspends or ceases operations or institutes a lockout; or

(2) Work is unavailable because the employer downsizes the workforce by means of attrition or layoff.

Layoff means a suspension of or separation from employment by a firm for lack of work, initiated by the employer, and expected to be for a definite or indefinite period of time.

Liable State means, with respect to a trade-affected worker making claims for TAA Program benefits, the State whose State UI law is the applicable State law. A State can be both an agent State and a liable State.

Like or directly competitive means, for articles, that articles have characteristics that are substantially identical in inherent or intrinsic characteristics (*i.e.,* material from which the articles are made, appearance, quality) or are used for substantially equivalent purposes and achieve comparable results and are, therefore, commercially interchangeable; and for services, services that have characteristics that are substantially identical in inherent or intrinsic characteristics (*i.e.*, processes and procedures that comprise the activity, sequence of steps or component elements required in the provision of the service or both) or are used for substantially equivalent purposes and achieve comparable results and are, therefore, commercially interchangeable.

Office of Trade Adjustment Assistance or *OTAA* means the organization within the U.S. Department of Labor, Employment and Training Administration that administers the TAA Program, or OTAA's successor organization.

One-stop delivery system means the nationwide system of one-stop career centers, known as American Job Centers, which administer and deliver workforce development, educational, and training activities, as well as supportive services to workers and job seekers, in accordance with title I of WIOA.

On-the-job training or *OJT* means work-based training, provided—under contract with an employer in the public, nonprofit, or private sector—to an AAW who is employed by the employer.

Partial separation or *partially separated* means, with respect to an AAW who has not been totally separated, that:

(1) For purposes of subpart B of this part:

(i) The worker's hours of work have been reduced to 80 percent or less of the worker's average weekly hours at the firm, or appropriate subdivision thereof during the period of investigation; and

(ii) The worker's wages have been reduced to 80 percent or less of the worker's average weekly wage at the firm, or appropriate subdivision thereof during the period of investigation.

(2) For this subpart and subparts C through I of this part:

(i) The worker's hours of work have been reduced to 80 percent or less of the worker's average weekly hours in adversely affected employment during the certification period; and

(ii) The worker's wages have been reduced to 80 percent or less of the worker's average weekly wage in adversely affected employment during the certification period.

Period of duty means active duty served by an AAW before completing training under subpart F of this part for a period of more than 30 days under a call or order to active duty of more than 30 days or, in the case of a member of the Army National Guard of the United States or Air National Guard of the United States, full-time National Guard duty under 32 U.S.C. 502(f), for 30 consecutive days or more when authorized by the President or the Secretary of Defense for the purpose of responding to a national emergency declared by the President and supported by Federal funds.

Petition date means the date a petition form is signed by the petitioner(s). When petitioners sign on different dates, the petition date is the latest of those dates.

Prerequisite education or *prerequisite coursework* or *prerequisite training* means any coursework or training required by a training provider before entering an occupational training program designed to impart the skills and information required to perform a specific job or group of jobs.

Program of remedial education or *remedial education* or *remedial training* means coursework or training that is designed to enhance the employability of a trade-affected worker by upgrading basic academic knowledge through such courses as adult basic education (ABE), basic math and literacy, English language acquisition (ELA) for nonnative speakers, and high school equivalency (HSE) courses, among others.

Qualifying separation means any total or partial separation of an AAW from adversely affected employment within the certification period for the purposes of determining the AAW's eligibility to receive Basic TRA; 26-week period for enrollment in approved training; and Basic TRA eligibility period. The first qualifying separation is used to determine the weekly and maximum amounts of Basic TRA payable to an AAW.

Reemployment Trade Adjustment Assistance or *RTAA* means the TAA Program benefit available to certain AAWs 50 years of age and older who obtain qualifying reemployment.

Regional Administrator means the appropriate Regional Administrator of the U.S. Department of Labor's Employment and Training Administration.

Secretary means the Secretary of Labor, U.S. Department of Labor, or his or her designee.

Separation date means:

(1) For a total separation:

(i) For a worker in employment status and not on employer-authorized leave, the last day worked; or

(ii) For a worker on employer-authorized leave, including leave for military service, the last day the worker would have worked had the worker not been on the employer-authorized leave.

(2) For a partial separation, the last day of the week in which the partial separation occurred.

Service means the work performed by a worker for a service firm or appropriate subdivision. The work of a service firm is measured in units of time, labor, and tasks completed. Services

may include the incidental production of an article, such as a license, ticket, certificate, permit, model, drawing, or prototype. Services are intangible but may involve the use of tangible objects during the supply of the service (such as textbooks in the supply of educational services). Where the revenue of the firm, or appropriate subdivision, is generated from the sale of a service, the firm, or appropriate subdivision, is deemed to be engaged in activity related to the supply of a service.

Significant number or proportion of the workers means:

(1) The lesser of 50 workers or 5 percent of the workers within a firm, or appropriate subdivision, have been totally or partially separated, or both, or are threatened with total or partial separation; or

(2) 2 or more workers within a firm, or appropriate subdivision, with a workforce of fewer than 50 workers, have been totally or partially separated, or both, or are threatened with total or partial separation.

Staffed worker means a worker directly employed by one firm to perform work under the operational control of another firm that is the subject of a petition investigation. These workers were previously referred to as ''leased workers.'' The term excludes independent contractors.

State means the States of the United States, the District of Columbia, and the Commonwealth of Puerto Rico; and the term ''United States,'' when used in the geographical sense, includes the Commonwealth of Puerto Rico.

State agency means the agency at the State level that administers the State law.

State law means the UI law of a State under section 3304 of the Internal Revenue Code of 1986, as amended (26 U.S.C. 3304).

Successor-in-interest means a firm, whether or not named on a certification issued under subpart B of this part, from which trade-affected workers are separated, or threatened with separation, and where most or all of the factors in paragraphs (1) through (7) of this definition are present, relative to a firm named on a determination issued under subpart B:

(1) There is continuity in business operations.

(2) There is continuity in location.

(3) There is continuity in the workforce.

(4) There is continuity in supervisory personnel.

(5) The same jobs exist under similar conditions.

(6) There is continuity in machinery, equipment, and process.

(7) There is continuity in product/service.

Suitable employment means, with respect to a worker, work of a substantially equal or higher skill level than the worker's past adversely affected employment, and wages for such work that are not less than 80 percent of the worker's average weekly wage. Part-time, temporary, short-term, or threatened employment is not suitable employment.

Supplier means a firm that produces and supplies directly to another firm component parts for articles, or services, used in the production of articles or in the supply of services, as the case may be, that were the basis for a certification of eligibility under §618.225 of a worker group employed by such other firm. There is no direct supply where an intervening customer, supplier, or another entity receives the component parts, aside from in a delivery or bailment capacity, or in the case of a service supplier, if an intervening entity performs the service.

Supportive services means services such as local transportation, childcare, dependent care, and housing, provided through WIOA or other programs, that are needed to enable an individual to participate in activities authorized under the Act.

Threatened to become totally or partially separated means that there is evidence of intent to separate workers or that imminent separations are reasonably anticipated.

Threatened to begin means, in the context of reasonably anticipated total or partial separations, the date(s) on which imminent separations will begin.

Total separation or *totally separated* means:

(1) For purposes of subpart B of this part, the layoff or severance of an AAW

from a firm or appropriate subdivision thereof; or

(2) For all other purposes under this part, the layoff or severance of a worker from adversely affected employment with a firm, or appropriate subdivision thereof.

Trade Adjustment Assistance for Workers or *Trade Adjustment Assistance* or *TAA Program* means chapter 2 of title II of the Act, Public Law 93–618, 88 Stat. 1978 (19 U.S.C. 2271–2323 and 2395), as amended, which establishes the Trade Adjustment Assistance for Workers (TAA) Program. The benefits and services established under the Act, including RTAA, are collectively referred to as the Trade Adjustment Assistance Program (TAA Program) and provide assistance to workers adversely affected by foreign trade, as described in this part.

Trade-affected worker means both ''adversely affected workers'' and ''adversely affected incumbent workers.''

Trade Readjustment Allowances or *TRA* means a weekly allowance payable to an AAW who meets the requirements of subpart G of this part. There are three types of TRA: Basic, Additional, and Completion, as described in § 618.710.

Unemployment Insurance or *UI* means the unemployment compensation payable to a worker under any State law or Federal UI law, including chapter 85 of title 5 of the U.S. Code and the RRUI. UI includes:

(1) *Regular compensation* means compensation payable to a worker under any State unemployment compensation law (including compensation payable pursuant to 5 U.S.C. chapter 85), other than extended compensation and additional compensation.

(2) *Additional compensation* means compensation payable to exhaustees by reason of conditions of high unemployment or by reason of other special factors.

(3) *Extended compensation* means compensation (including additional compensation and compensation payable pursuant to 5 U.S.C. chapter 85) payable for weeks of unemployment beginning in an extended benefit period to a worker under those provisions of the State law that satisfy the requirements of the Federal-State Extended Unemployment Compensation Act of 1970 (EUCA) (26 U.S.C. 3304 (note)) with respect to the payment of extended compensation, including one-hundred percent federally funded unemployment compensation extensions.

Value-added production processes or services means such processes or services similar to and including final assembly, finishing, testing, packaging, or maintenance or transportation services.

Wages means:

(1) Remuneration as defined by State law; or

(2) For purposes of calculating a reemployment wage when determining the availability of suitable employment, the stated salary and—to the extent known—the value of any compensation package that would be defined as remuneration under State law, as provided by an employer in a job posting or job offer.

Wagner-Peyser Act means the Wagner-Peyser Act, as amended (29 U.S.C. 49 *et seq.*).

Week means a week as defined in the applicable State law.

Week of unemployment means a week of total, part-total, or partial unemployment as determined under the applicable State law or Federal UI law.

Worker group means two or more workers of the same firm, or appropriate subdivision thereof, named in a certification rendered under subpart B of this part as eligible to apply for TAA Program benefits and services, inclusive of teleworkers and staffed workers.

Workforce Innovation and Opportunity Act or *WIOA* means the Workforce Innovation and Opportunity Act (Pub. L. 113–128, as amended).

§ 618.120 Severability.

Should a court of competent jurisdiction hold any provision(s) of this subpart to be invalid, such action will not affect any other provision of this subpart.

Subpart B—Petitions, Investigations, and Determinations

§ 618.200 Scope.

This subpart relates to petitions, investigations, and determinations of eligibility for a group of workers to apply

for adjustment assistance under the Act. This subpart specifically applies to the initiation, conduct, and effective processing of petitions for certification of eligibility to apply for adjustment assistance. This subpart also contains general provisions with respect to filing of documents, public availability of documents, and the appeals process.

§ 618.205 Petitions.

(a) *Who may file a petition.* A petition for certification of eligibility to apply for adjustment assistance for a group of workers, or a request to amend an existing certification under § 618.250, must be filed simultaneously with the Department and with the State in which such workers' firm is located, by any of the following:

(1) A group of two or more workers from the same firm, on whose behalf the petition is filed;

(2) A certified or recognized union, or other duly authorized representative of the group of workers;

(3) The employer(s) of the group of workers; or

(4) One-stop center operators or one-stop partners, including State workforce officials, employment security agencies, or dislocated worker unit and rapid response team members.

(b) *Form and contents.* Petitioners may obtain a petition form and instructions online at: *https://www.dol.gov/agencies/eta/tradeact,* at a one-stop center (also known as an American Job Center), or by writing to: U.S. Department of Labor, Employment and Training Administration, Office of Trade Adjustment Assistance, 200 Constitution Avenue NW, Washington, DC 20210. A petition, which may include attachments, must provide the following information to be considered valid and for an investigation to commence:

(1) The name and contact information for each petitioner;

(2) The name of the firm;

(3) The address of the location(s) where the group of workers who have been totally or partially separated or threatened with separation report to work (for a teleworker, the address of the location to which they report);

(4) The name and contact information of an official within the firm or an individual authorized to provide information regarding the operation of the group of workers' firm;

(5) The article produced or service supplied by the firm;

(6) The actual or approximate date on which total or partial separations are threatened to occur or did occur;

(7) The actual or estimated total number of workers who have been or may be separated;

(8) A reason why the petitioner believes that worker separations have occurred or may occur at the firm due to foreign trade impacts, or a reason why a request to amend an existing and active certification should be granted; and

(9)(i) Every petition must be signed and dated by at least two members of the petitioning group of workers, or by an official of a certified or recognized union or other duly authorized representative of the group of workers, or by an official of the employer of the group of workers, or by a representative of one of the organizations listed in paragraph (a)(4) of this section.

(ii) Signing of a petition must constitute acknowledgement that the information provided on the petition form will be used for the purposes of determining worker group eligibility and providing notice to petitioners, workers, and the general public that the petition has been filed, and whether the worker group is eligible to apply for TAA Program benefits and services. Knowingly falsifying any information on the petition form is a Federal offense (18 U.S.C. 1001) and a violation of the Act (19 U.S.C. 2316). For the petition to be valid, the petitioner(s) listed on the form must sign and date the form, attesting to the fact that they are authorized to file a petition.

(c) *Supplemental information.* Providing supplemental information, while not required, may assist the investigation. Attachments to the petition form are part of the petition.

(d) *Filing.* (1) Petitions should be filed electronically with the Office of Trade Adjustment Assistance, via *https://www.dol.gov/agencies/eta/tradeact.* Individuals requiring assistance in filing online should contact their nearest one-stop center or the State's rapid response unit.

(2) Alternatively, petitions may be filed via email to *taa.petition@dol.gov*, via fax at (202) 693–3584 or (202) 693–3585, or by mail to: U.S. Department of Labor, Employment and Training Administration, Office of Trade Adjustment Assistance, 200 Constitution Avenue NW, Washington, DC 20210.

(e) *Industry notification of ITC determinations.* Upon receiving notification from the ITC that it has issued an affirmative determination of injury or threat of injury under section 202 or 421 of the Act, under an applicable safeguard provision enacted to implement a trade agreement to which the United States is a party, or an affirmative final determination of material injury of threat thereof in investigation under section 705 or 735 of the Tariff Act of 1930, the Department will notify the affected parties listed in paragraph (e)(1) of this section. To the extent practicable, the Department may also notify other duly authorized representatives of the industry to which the ITC determination applies.

(1) Parties the Department will notify under paragraph (e) of this section include:

(i) Representatives of the domestic industry affected by the determination;

(ii) Firms publicly identified by name during the proceeding related to the ITC determination; and

(iii) Unions representing workers in firms covered by the determination.

(2) The notice provided by the Department under paragraph (e) of this section will include:

(i) A summary of the ITC determination;

(ii) Information about the workers' potential eligibility for TAA Program benefits;

(iii) The benefits and services available under the TAA Program;

(iv) Information regarding the process for filing of petitions; and

(v) The availability of assistance from the State for filing petitions.

(3) The Department will also notify the Governor of each State in which one or more firms covered by an ITC determination are located and will identify those firms to the State.

(f) *Acceptance of petitions.* The Department will review a petition, including attachments, to determine if it is valid within 2 business days of receipt of the petition by the Department. The date on which the petition is determined to be valid under paragraph (b) of this section is the filing date. The Department will not initiate the investigation until it has determined that the petition is valid.

(g) *Multiple petitions for same group of workers.* If the Department receives multiple petitions regarding the same group of workers, it will base the filing date upon the first petition received.

(h) *Publication of notice in the* FEDERAL REGISTER. The Department will publish a notice in the FEDERAL REGISTER and on the Department's website announcing the initiation of an investigation into all valid petitions filed.

(i) *Public access to petitions.* A petition, including attachments, is a record that is available, in redacted form, in accordance with the Freedom of Information Act (FOIA), as amended (5 U.S.C. 552), Executive Order 12600, and 29 CFR part 70. The Department will post all petitions, in redacted form, to the Department's website and make them available for review at the Office of Trade Adjustment Assistance, Washington, DC.

(j) *Receipt of petition by the State.* When the State receives a petition, the State must verify that the Department has also received the petition. If the petition has not been posted to the Department's website within 10 calendar days of receipt by the State, the State must forward the petition to the Department.

§ 618.210 Investigation.

(a) *Timing.* The Department will initiate an investigation once it has deemed the petition valid in accordance with § 618.205(f).

(b) *Period of investigation.* For purposes of this subpart, the period of investigation is the time period it takes to investigate each of the criteria that are part of the Department's determination. The period of investigation varies for some eligibility criteria; § 618.225 describes the period of investigation for each criterion.

(c) *Investigative process.* To determine whether the petitioning group of workers' eligibility criteria for certification have been met, the Department may

take as many of the steps in paragraphs (c)(1) through (8) of this section during the investigation as it deems necessary to identify the group of workers and to reach a determination of eligibility to apply for TAA Program benefits for the identified worker group:

(1) Verify information on the petition form by contacting the petitioner(s);

(2) Provide the petitioner(s) the opportunity to submit additional evidence in support of the petition;

(3) Obtain publicly available information about the workers' firm and industry;

(4) Request information from the workers' firm;

(5) Request information from the customers of the workers' firm;

(6) Request information from the officials of certified or recognized unions or other duly authorized representatives of the group of workers;

(7) Request information from one-stop center operators or one-stop partners; or

(8) Use other available sources of information as necessary.

(d) *Protection of confidential business information.* (1) The Department will determine whether information submitted by a firm or customer is confidential business information in accordance with FOIA, as amended (5 U.S.C. 552), Executive Order 12600, the Trade Secrets Act (18 U.S.C. 1905), and 29 CFR part 70.

(2) The Department will not disclose confidential business information without the consent of the submitting firm or customer, unless under a court order to do so or as otherwise required by law.

(e) *Termination of investigation.* (1) The Department will notify the petitioner of the termination of an investigation, publish a Notice of Termination of Investigation in the FEDERAL REGISTER, and post on the Department's website. The Department may terminate an investigation if the investigation establishes one of the following:

(i) The petition is invalid, which includes petitions identifying a nonexistent group of workers, filed under false pretenses, or perpetuating fraud;

(ii) The petitioner has withdrawn the petition in writing;

(iii) The group of workers identified in the investigation is the same as a group of workers identified in another pending investigation;

(iv) The group of workers identified in the investigation already has been issued a denial, and the period of investigation applicable to the current investigation and the previous denial is the same; or

(v) The group of workers identified in the investigation is already covered by a certification that does not expire within 90 calendar days of the determination.

(2) If appropriate to protect the interests of the group of workers covered by a petition filed and terminated under paragraph (e)(1)(i) or (ii) of this section, the Department may use the original impact date of the terminated petition for the identical group of workers covered under a later, valid, petition covering the identical group of workers, provided that it is filed within 30 calendar days of the filing date of the first petition. Under no circumstances will the Department use the impact date of an earlier petition when that petition was terminated for being invalid under paragraph (e)(1)(i) of this section because it was filed under false pretenses or to perpetuate a fraud.

(3) Section 618.245 describes reconsideration of a termination of investigation.

(f) *Investigative record.* The investigative record of a determination will include the petition that initiated the investigation, the documents and other materials provided to the Department in connection with the determination on the petition, research conducted by the Department, and records of investigation activities (including but not limited to telephone logs and email correspondence, and any determination under § 618.225(a), (b), or (c)). The investigative record excludes information that is privileged or otherwise exempt from disclosure. Personally identifiable information and confidential business information will be protected consistent with all Federal authorities and Departmental administrative guidance.

(g) *Site visits.* The investigation may include one or more site visits to confirm information furnished by the petitioner(s) and to elicit other relevant information, where other methods to obtain or confirm information or both, are unsuccessful.

§ 618.215 Public hearings.

(a) *When held.* (1) A public hearing must be held in connection with an investigation initiated under § 618.210 whenever, but not later than 10 days after the date of publication in the FEDERAL REGISTER of the notice of receipt of the petition, such a hearing is requested in writing by:

(i) The petitioner; or

(ii) Any other person found by the Administrator to have a substantial interest in the proceedings.

(2) Such petitioner and other interested persons must be afforded an opportunity to be present, to produce evidence, and to be heard.

(3) An explanation of why the requestor is requesting the hearing must be provided to the Department.

(b) *Form of request.* A request for public hearing must be filed, in letter format, in the same manner as provided for other documents under § 618.205(d)(2). The request must contain:

(1) The name, address, and telephone number of the person, organization, or group requesting the hearing;

(2) A complete statement of the relationship of the person, organization, or group requesting the hearing to the petitioner or the petition's subject matter; and

(3) An explanation of why the person, organization, or requestor of the hearing is interested in the matter.

(c) *Time, place, and scope.* The time, place, and scope of a public hearing will be set by the presiding officers and published in the FEDERAL REGISTER a reasonable period of time before the scheduled hearing.

(d) *Presiding officer.* The Administrator, or his or her designee, must conduct and preside over public hearings.

(e) *Order of testimony.* Witnesses will testify in the order designated by the presiding officer. Each witness, after being duly sworn, will proceed with testimony. After testifying, the presiding officer or an agent designated by the presiding officer may question the witness. Any person who has entered an appearance in accordance with paragraph (k) of this section may direct questions to the witness, but only for the purpose of assisting the presiding officer in obtaining relevant and material facts with respect to the subject matter of the hearing.

(f) *Evidence.* Witnesses may produce evidence of a relevant and material nature to the subject matter of the hearing.

(g) *Briefs.* Parties who have entered an appearance may file briefs regarding the evidence produced at the hearing. The briefs must be filed with the presiding officer within 10 days of the completion of the hearing.

(h) *Oral argument.* The presiding officer must provide opportunity for oral argument by parties listed in paragraphs (a)(1)(i) and (ii) of this section after conclusion of the testimony in a hearing. The presiding officer will determine in each instance the time to be allowed for argument and the allocation thereof.

(i) *Authentication of evidence.* Evidence, oral or written, submitted at hearings, will, upon order of the presiding officer, be subject to verification from books, papers, and records of the parties submitting such evidence and from any other available sources.

(j) *Transcripts.* All hearings will be transcribed or recorded in compliance with the standards of the Department. Persons interested in records of the hearings may inspect them at the U.S. Department of Labor in Washington, DC.

(k) *Appearances.* Any person showing a substantial interest in the proceedings may enter an appearance at a hearing, either in person or by a duly authorized representative.

§ 618.220 Use of subpoena.

(a) The Administrator may require, by subpoena, in connection with any investigation or hearing, the attendance and testimony of witnesses and the production of evidence the issuing official deems necessary to make a determination under this subpart.

(b) The Department will issue a subpoena to secure evidence from a firm, customer, petitioner, or other person who fails to provide requested information within 20 days of the request, unless the recipient of the subpoena demonstrates to the satisfaction of the Department that the information will be provided within a reasonable time. In making this determination, the Department will consider the following factors:

(1) Submission of a portion of the required information;

(2) Prompt cooperation with inquiries about the information;

(3) Cooperation in previous responses to information requests;

(4) Evidence of effort to obtain the required information; and

(5) Other information the Department determines to be relevant.

(c) Witnesses subpoenaed under this section to appear in person must be paid the same fees and mileage as are paid for like services in the District Court of the United States within the jurisdiction of which the proceeding is taking place. The Department must pay the witness fees and mileage.

(d) Subpoenas issued under paragraph (a) of this section must be signed by the Administrator, or his or her designee, and must be served consistent with Rule 5(b) of the Federal Rules of Civil Procedure. The date for compliance must be 7 calendar days following service of the subpoena, unless otherwise indicated.

(e) If the recipient of the subpoena refuses to provide the requested information, the Department may petition the appropriate District Court of the United States to seek enforcement of the subpoena.

§ 618.225 Criteria for certification of a group of workers.

(a) *Increased imports.* (1) This paragraph (a) includes criteria for certification of a group of workers based upon increased imports of:

(i) Articles like or directly competitive with the articles produced by the workers' firm;

(ii) Services like or directly competitive with the services supplied by the workers' firm;

(iii) Articles like or directly competitive with articles into which one or more component parts produced by the workers' firm are directly incorporated;

(iv) Articles like or directly competitive with articles that are produced directly using services supplied by the workers' firm; or

(v) Articles directly incorporating one or more component parts produced outside the United States that are like or directly competitive with imports of articles incorporating one or more component parts produced by the workers' firm.

(2) After review of the relevant information necessary to make a determination, the Certifying Officer must certify a worker group as eligible to apply for TAA Program benefits and services as impacted by increased imports if all four of the criteria in paragraphs (a)(2)(i) through (iv) of this section are met.

(i) *Criterion 1.* A significant number or proportion of the workers' firm, or appropriate subdivision thereof, have been totally or partially separated, or threatened with such separation, during the 1-year period prior to the petition date.

(A) Information regarding separations may be obtained from:

(*1*) A questionnaire;

(*2*) State workforce agencies;

(*3*) Unions;

(*4*) Workers in the group of workers;

(*5*) Public records; and

(*6*) Other reliable sources.

(B) Analysis of separation data must generally consist of a:

(*1*) Comparison of employment on the petition date to employment on the date that is 1 year prior to the petition date;

(*2*) Review of employment activity during the 1-year period prior to the petition date; and

(*3*) Review of evidence provided by the workers' firm regarding actual and threatened separations that occur, or are scheduled to occur, after the petition date.

(C) Evidence of threat of separation includes, but is not limited to:

(*1*) A Worker Adjustment and Retraining Notice (WARN) letter, or a notification issued under a similar State law;

(*2*) A separation schedule;

(*3*) Information provided to the public, such as a news release or notice on the workers' firm website;

(*4*) Information provided to the worker group; or

(*5*) Internal firm documents, including memoranda or a firm newsletter.

(ii) *Criterion 2.* Sales or production, or both, of the workers' firm has decreased during the 1-year period prior to the petition date.

(A) Information regarding sales or production may be collected from:

(*1*) Questionnaires;

(*2*) Public records; and

(*3*) Other reliable sources.

(B) Analysis of sales or production data must generally consist of a comparison of sales or production data on the petition date to sales or production data on the date that is 1 year prior to the petition date.

(iii) *Criterion 3.* Imports of the article or service have increased during the 1-year period prior to the petition date.

(A) Information regarding imports may be collected from:

(*1*) Questionnaires issued to the workers' firm or customer(s);

(*2*) Public records; and

(*3*) Other reliable sources.

(B) Analysis of the workers' firm import activity must generally consist of a comparison of the workers' firm import data on the petition date to the workers' firm import data on the date that is 1 year prior to the petition date.

(C) Analysis of customer import activity must generally consist of a comparison of the aggregate of customer import data on the petition date to the aggregate of customer import data on the date that is 1 year prior to the petition date.

(iv) *Criterion 4.* Increased imports have contributed importantly to worker separations, or threat of separation, and the decline in sales or production at the workers' firm.

(A) Analysis of the impact of increased imports on worker separations and declines in sales or production at the workers' firm must generally consist of determining:

(*1*) Whether there are one or more events, or factors, that lessen or sever the causal nexus between the increase in imports and worker separations or threat of separation, and the decline in sales and production at the workers' firm;

(*2*) What percentage of the workers' firm sales or production declines was attributable to the firm's increased imports;

(*3*) What percentage of the workers' firm customer(s) sales or production declines was attributable to the firm's increased imports; and

(*4*) Whether there are other events or factors that mitigate or amplify the impact of increased imports on the workers' firm.

(B) The impact may be determined using a quantitative or qualitative analysis.

(b) *Shift.* (1) This paragraph (b) includes criteria for certification of a worker group based on a shift:

(i) In production of like or directly competitive articles by the workers' firm to another country; or

(ii) In the supply of like or directly competitive services by the workers' firm to another country.

(2) After a review of relevant information necessary to make a determination, the Certifying Officer must certify a group of workers as eligible to apply for TAA Program benefits and services as impacted by a shift in production or supply of service if all of the criteria in paragraphs (b)(2)(i) through (iii) of this section of are met.

(i) *Criterion 1.* A significant number or proportion of the workers' firm, or appropriate subdivision thereof, have been totally or partially separated, or threatened with separation, during the 1-year period prior to the petition date.

(A) Information regarding separations may be obtained from:

(*1*) A questionnaire;

(*2*) State workforce agencies;

(*3*) Unions;

(*4*) Workers in the group of workers;

(*5*) Public records; and

(*6*) Other reliable sources.

(B) Analysis of separation data must generally consist of a:

(*1*) Comparison of employment on the petition date to employment on the date that is 1 year prior to the petition date;

(*2*) Review of employment activity during the 1-year period prior to the petition date; and

(*3*) Review of evidence provided by the workers' firm regarding actual and threatened separations that occur, or are scheduled to occur, after the petition date.

(C) Evidence of threat of separation includes, but is not limited to:

(*1*) A WARN letter, or a notification issued under a similar State law;

(*2*) A separation schedule;

(*3*) Information provided to the public, such as a news release or notice on the workers' firm website;

(*4*) Information provided to the worker group; or

(*5*) Internal firm documents, including memoranda or a firm newsletter.

(ii) *Criterion 2.* There has been a shift in the production or supply of services by the workers' firm to a foreign country.

(A) Information regarding shift activity may be collected from:

(*1*) A questionnaire;

(*2*) Public records; and

(*3*) Other reliable sources.

(B) Analysis of shift activity must generally consist of a:

(*1*) Comparison of shift data on the petition date to shift data on the date that is 1 year prior to the petition date;

(*2*) Review of shift activity during the 1-year period prior to the petition date; and

(*3*) Review of evidence provided by the workers' firm regarding shift activity scheduled to occur after the petition date.

(C) Evidence of future planned shift activity must include more than a stated intent to shift activity to a foreign country and includes, but is not limited to, a reassignment of production or service supply; a reassignment of discrete aspects or stages of production or service supply; securing a facility in a foreign country; shipping resources to a foreign country; or acquiring personnel in a foreign country.

(iii) *Criterion 3.* The shift to a foreign country has contributed importantly to worker separations or threat of separation.

(A) Analysis of impact of shift activity on worker separations must generally consist of determining:

(*1*) Whether there are one or more events or factors that sever or lessen the causal nexus between the shift activity and worker separations or threat of separation;

(*2*) What percentage of the workers' firm sales or production declines was attributable to the firm's shift activity;

(*3*) Whether operations at the workers' firm domestic facility or facilities decreased at the same or at a greater rate than operations at the foreign facility or facilities; and

(*4*) Whether there are other events or factors that mitigate or amplify the impact of shift activity on the workers' firm.

(B) The impact may be determined using a quantitative or qualitative analysis.

(c) *Foreign acquisition.* This paragraph (c) includes criteria for certification of a worker group based on a foreign acquisition of like or directly competitive articles by the workers' firm from another country. After review of relevant information necessary to make a determination, the Certifying Officer must certify a group of workers as eligible to apply for TAA Program benefits and services as impacted by a foreign acquisition of articles or services if all of the criteria in paragraphs (c)(1) through (3) of this section are met.

(1) *Criterion 1.* A significant number or proportion of the workers' firm, or appropriate subdivision thereof, have been totally or partially separated, or threatened with separation, during the 1-year period prior to the petition date.

(i) Information regarding separations may be obtained from:

(A) A questionnaire;

(B) State workforce agencies;

(C) Unions;

(D) Workers in the group of workers;

(E) Public records; and

(F) Other reliable sources.

(ii) Analysis of separation data must generally consist of a:

(A) Comparison of employment on the petition date to employment on the

date that is 1 year prior to the petition date;

(B) Review of employment activity during the 1-year period prior to the petition date; and

(C) Review of evidence provided by the workers' firm regarding actual and threatened separations that occur, or are scheduled to occur, after the petition date.

(iii) Evidence of threat of separation includes, but is not limited to:

(A) A WARN letter, or a notification issued under a similar State law;

(B) A separation schedule;

(C) Information provided to the public, such as a news release or notice on the workers' firm website;

(D) Information provided to the worker group; or

(E) Internal firm documents, including memoranda or a firm newsletter.

(2) *Criterion 2.* There has been an acquisition of articles or supply of services by the workers' firm from an entity in a foreign country.

(i) Information regarding separations may be obtained from:

(A) A questionnaire;

(B) State workforce agencies;

(C) Unions;

(D) Workers in the group of workers;

(E) Public records; and

(F) Other reliable sources.

(ii) Analysis of acquisition data must generally consist of a:

(A) Comparison of acquisition data on the petition date to acquisition data on the date that is 1 year prior to the petition date;

(B) Review of acquisition data during the 1-year period prior to the petition date; and

(C) Review of evidence provided by the workers' firm regarding acquisition activity scheduled to occur after the petition date.

(iii) Evidence of future planned acquisitions requires more than a stated intent to procure production of an article or supply of services from an entity in a foreign country and may include, but is not limited to, entering into a contract with a licensee; reassignment of production or service supply to a contractor or licensee; and a reassignment of discrete aspects or stages of production or service supply to a contractor or licensee.

(3) *Criterion 3.* The acquisition from a foreign country has contributed importantly to worker separations or threat of separation.

(i) Analysis of impact of acquisition data on worker separations must generally consist of determining:

(A) Whether there are one or more events or factors that lessen or sever the causal nexus between the acquisition activity and worker separations or threat of separation;

(B) What percentage of the workers' firm sales or production declines was attributable to the firm's acquisition activity;

(C) Whether operations at the workers' firm domestic facility or facilities decreased at the same or at a greater rate than contractor or licensee operations in the foreign country; and

(D) Whether there are other events or factors that mitigate or amplify the impact of acquisition activity on the workers' firm.

(ii) The impact may be determined using a quantitative or qualitative analysis.

(d) *Supplier of component parts or services.* This paragraph (d) contains criteria for certification of a worker group as a supplier to a worker group. After review of relevant information necessary to make a determination, the Certifying Officer must certify a worker group as eligible to apply for TAA Program benefits and services as a supplier to a worker group if all of the criteria in paragraphs (d)(1) through (5) of this section are met.

(1) *Criterion 1.* A significant number or proportion of the workers' firm, or appropriate subdivision thereof, have been totally or partially separated, or threatened with separation, during the 1-year period prior to the petition date.

(i) Information regarding separations may be obtained from:

(A) A questionnaire;

(B) State workforce agencies;

(C) Unions;

(D) Workers in the group of workers;

(E) Public records; and

(F) Other reliable sources.

(ii) Analysis of separation data must generally consist of a:

(A) Comparison of employment on the petition date to employment on the

date that is 1 year prior to the petition date;

(B) Review of employment activity during the 1-year period prior to the petition date; and

(C) Review of evidence provided by the workers' firm regarding actual and threatened separations that occur, or are scheduled to occur, after the petition date.

(iii) Evidence of threat of separation includes, but is not limited to:

(A) A WARN letter, or a notification issued under a similar State law;

(B) A separation schedule;

(C) Information provided to the public, such as a news release or notice on the workers' firm website;

(D) Information provided to the worker group; or

(E) Internal firm documents, including memoranda or a firm newsletter.

(2) *Criterion 2.* The certification of the worker group employed by the firm to which the workers' firm supplied component parts or services has not expired by the petition date.

(3) *Criterion 3.* The workers' firm conducted business with the firm identified in paragraph (d)(2) of this section during the 1-year period prior to the petition date.

(4) *Criterion 4.* The certification identified in paragraph (d)(2) of this section was based on an article or service related to the component part produced or service supplied by the workers' firm.

(5) *Criterion 5.* The component parts supplied to the firm identified in paragraph (d)(2) of this section, represented at least 20 percent of the supplier's production or sales during the 1-year period prior to the petition date, or loss of business with the firm identified in paragraph (d)(2) of this section, during the 1-year period prior to the petition date, contributed importantly to separations or threat of separation at the workers' firm.

(e) *Downstream producer.* After review of relevant information necessary to make a determination, the Certifying Officer must certify a worker group as eligible to apply for TAA Program benefits and services as a downstream producer if all of the criteria in paragraphs (e)(1) through (5) of this section are met.

(1) *Criterion 1.* A significant number or proportion of the workers' firm, or appropriate subdivision thereof, have been totally or partially separated, or threatened with separation, during the 1-year period prior to the petition date.

(i) Information regarding separations may be obtained from a questionnaire, State workforce agencies, unions, workers in the group of workers, public records, and other reliable sources.

(ii) Analysis of separation data must generally consist of a:

(A) Comparison of employment on the petition date to employment on the date that is 1 year prior to the petition date;

(B) Review of employment activity during the 1-year period prior to the petition date; and

(C) Review of evidence provided by the workers' firm regarding actual and threatened separations that occur, or are scheduled to occur, after the petition date.

(iii) Evidence of threat of separation includes, but is not limited to:

(A) A WARN letter, or a notification issued under a similar State law;

(B) A separation schedule;

(C) Information provided to the public, such as a news release or notice on the workers' firm website;

(D) Information provided to the worker group; or

(E) Internal firm documents, including memoranda or a firm newsletter.

(2) *Criterion 2.* The certification of the worker group employed by the firm to which the workers' firm provided value-added production processes or services has not expired by the petition date.

(3) *Criterion 3.* The workers' firm conducted business with the firm identified in paragraph (e)(2) of this section during the 1-year period prior to the petition date.

(4) *Criterion 4.* The certification identified in paragraph (e)(2) of this section was based on an article or service related to the value-added production processes or services supplied by the workers' firm.

(5) *Criterion 5.* Loss of business with the firm identified in paragraph (e)(2) of this section during the 1-year period prior to the petition date contributed

importantly to separations or threat of separation at the workers' firm.

(f) *ITC determinations.* After review of relevant information necessary to make a determination, the Certifying Officer must certify a worker group as eligible to apply for TAA based on a determination issued by the ITC if all of the criteria in paragraphs (f)(1) through (3) of this section are met.

(1) *Criterion 1.* The ITC has publicly identified the workers' firm, by name, as a member of a domestic industry in an investigation resulting in:

(i) An affirmative determination of serious injury or threat thereof under section 202(b)(1) of the Act (19 U.S.C. 2252(b)(1));

(ii) An affirmative determination of market disruption or threat thereof under section 421(b)(1) of the Act (19 U.S.C. 2451(b)(1)); or

(iii) An affirmative final determination of material injury or threat thereof under section 705(b)(1)(A) or 735(b)(1)(A) of the Tariff Act of 1930 (19 U.S.C. 1671d(b)(1)(A) and 1673d(b)(1)(A)).

(2) *Criterion 2.* The petition is filed during the 1-year period beginning on the date on which:

(i) A summary of the report submitted to the President by the ITC under section 202(f)(1) of the Act with respect to the affirmative determination described in paragraph (f)(1)(i) of this section is published in the FEDERAL REGISTER under section 202(f)(3) of the Act; or

(ii) Notice of an affirmative determination described in paragraph (f)(1)(ii) or (iii) of this section is published in the FEDERAL REGISTER.

(3) *Criterion 3.* The workers have become totally or partially separated from the workers' firm within:

(i) The 1-year period described in paragraph (f)(2) of this section; or

(ii) The 1-year period preceding the 1-year period described in paragraph (f)(2) of this section.

(g) *Sales or production decline criteria.* For paragraphs (a) through (c) of this section, in assessing sales or production decline for the period 1 year prior to the petition date, the Department will use a comparison of the latest 2 full calendar year periods and will use a comparison of the year to date period (from the year the petition was filed) to the same year to date period from the prior year. This paragraph (g) does not apply to determining whether a significant number of workers have been separated or threatened with separation.

(h) *Oil and gas.* For workers employed by firms engaged in exploration or drilling for crude oil and natural gas:

(1) Any firm, or appropriate subdivision of a firm, that engages in exploration or drilling for oil or natural gas must be considered to be a firm producing oil or natural gas;

(2) Any firm, or appropriate subdivision of a firm, that engages in exploration or drilling for oil or natural gas, or otherwise produces oil or natural gas, must be considered to be producing articles directly competitive with imports of oil and with imports of natural gas; and

(3) The Department may conduct a parallel investigation to determine whether the group of workers meets the criteria for certification of worker groups under this section for the services provided by the group of workers. The Department will render a determination after all appropriate avenues are considered.

(i) *Staffed workers.* The Department considers staffed workers to be members of a worker group even if they are not specifically mentioned within the determination document issued under § 618.235. The Department will collect information from the workers' firm during the investigation to establish which leasing or staffing entity or entities the firm used under a contract. Once identified, an evaluation of operational control will occur. If a certification is rendered, the Department will notify States regarding the appropriate contact information of the known leasing or staffing entity or entities in order to expedite worker notification of their eligibility to apply individually for TAA Program benefits and services. Factors to be considered in evaluating operational control include:

(1) Whether the contract workers perform only tasks that are independent, discrete projects for the workers' firm (as opposed to performing tasks that are part of the regular business operations of the firm);

(2) Whether the workers' firm has the discretion to hire, fire, and discipline the contract workers;

(3) Whether the workers' firm has the ability to terminate the contract workers' employment with such firm through the staffing or leasing contracted firm;

(4) Whether the workers' firm exercises the authority to supervise the contract workers' daily work activities, including assigning and managing work, and determining how, where, and when the work of contract worker takes place (e.g., factors such as the hours of work, the selection of work, and the manner in which the work is to be performed by each contract worker are relevant);

(5) Whether the services of the contract workers are offered on the open market;

(6) Whether the contract workers work exclusively for the workers' firm;

(7) Whether the workers' firm is responsible for establishing wage rates and the payment of salaries of the contract workers;

(8) Whether the workers' firm provides skills training to the contract workers; and

(9) Whether there are other facts indicating that the workers' firm exercises control over the contract workers.

(j) *Teleworkers.* The Department considers teleworkers (also known as remote, or home-based workers) to be members of a worker group even if they are not specifically mentioned within the determination document issued under §618.235 when they would be a part of the worker group if they worked on-site. Teleworkers do not have to be physically based at the location of the subject firm or in the same city or same State of the location that is identified on the determination document to be members of the certified worker group.

(k) *Successor-in-interest.* The Department considers workers employed by a firm that is a successor-in-interest to be members of a worker group even if they are not mentioned specifically within the determination document issued under §618.235.

§618.230 Evidence.

(a) The Department will verify information obtained during an investigation before considering such information in support of a petition.

(b) Evidence may be accepted from such sources including, but not limited to, petitioners, company officials, current and former workers of the firm, customers of the firm, trade associations, union representatives, Federal agencies, and public sources such as State agencies and academic institutions.

(c) The Department may share affidavits, testimonials, news articles, and other types of information proffered in support of a petition with appropriate parties for verification.

§618.235 Determinations.

Based on the findings of the investigation as set forth in §618.230, a Certifying Officer will make a determination on a petition as provided under paragraph (a) or (b) of this section.

(a) *Affirmative determination or certification.* When the investigation establishes that a group of workers meets the eligibility criteria of §618.225, the Certifying Officer will issue a certification of worker group eligibility to apply for TAA Program benefits and services. The certification will include the name of the firm or appropriate subdivision thereof at which the trade-affected workers covered by the certification have been employed (which need not be limited to the unit specified in the petition), and may identify the worker group by name, as described in §618.225(i) and (j), the certification period, and the certification date.

(1) A certification covers any worker in the worker group eligible to apply for assistance under sec. 222(a) and (b) of the Act, whose last total or partial separation, or threat of a separation, from a firm or appropriate subdivision took place within the certification period, which is the period:

(i) Following the impact date, which is the date 1 year before the petition date; and

(ii) On or before the day the certification expires, which is 2 years after the certification date, or an earlier date on which the Certifying Officer

determines that separations from adversely affected employment may no longer be attributed to the conditions underlying the certification, as described in § 618.240, or the date identified in an amendment described in § 618.250.

(2) A certification covers any worker in the worker group eligible to apply for TAA Program benefits and services under section 222(e) whose last total or partial separation from a firm took place within the certification period, which is the period:

(i) Following the impact date, which is the date 1 year before the ITC publication in the FEDERAL REGISTER; and

(ii) On or before the day the certification expires, which is the date 1 year from the ITC publication in the FEDERAL REGISTER.

(3) A trade-affected worker who is a member of the worker group covered by the certification may apply to the State for benefits and services under subparts C through G of this part.

(b) *Negative determination or denial.* When the investigation establishes that the group of workers does not meet the criteria for eligibility, as described in § 618.225, the Certifying Officer will issue a denial. The denial will include the name of the firm or appropriate subdivision thereof at which the workers covered by the denial have been employed (which need not be limited to the unit specified in the petition), and may identify the worker group by name, as described in § 618.225(i) and (j).

(c) *Determination.* The Certifying Officer issues a determination identifying the article(s) produced or service(s) provided and describing the worker group covered by the certification or denial and stating the reasons for the determination (excluding information designated as confidential business information). The Department will provide a copy of the determination to the petitioner(s) and to the State(s) covered by the determination. The Department will publish in the FEDERAL REGISTER, and on the Department's website, a summary of the determination issued under paragraph (a) or (b) of this section, along with a general statement of the reasons for the determination (except for confidential business information).

(d) *Amended determination.* The Department may amend a certification for any of the purposes described in § 618.250(a), in response to a petition filed under § 618.205, or without an outside request for an amendment. An amended determination will not take effect until the previous determination becomes final, either after the period in which to request reconsideration has lapsed or after the Department makes a determination on reconsideration. Amended certifications are discussed in more detail in § 618.250.

(e) *Administrative action.* The Department may, with or without an outside request, reconsider actions taken under § 618.210(e), 618.235(b), 618.240, 618.245, or 618.250.

§ 618.240 Termination of certification.

(a) *Initiation.* Whenever the Administrator of the Office of Trade Adjustment Assistance has reason to believe, with respect to any nonexpired certification, that the total or partial separations or threat of separation from a firm, or appropriate subdivision thereof, are no longer attributable to the conditions specified in section 222 of the Act and § 618.225, the Administrator must promptly conduct an investigation.

(b) *Notice.* A notice of the initiation of an investigation to terminate a certification must be published in the FEDERAL REGISTER, and on the Department's website, and provided to the petitioner(s) of the certification under investigation, the firm official(s), and State(s) that contain the location(s) of the workers comprising the worker group covered by the certification. The State(s) must also promptly notify the workers in the worker group.

(c) *Opportunity for comment.* Within 10 calendar days after publication of the notice under paragraph (b) of this section, members of the worker group or any other person who has a substantial interest in the matter may provide evidence in writing supporting the continuation of eligibility of certification to show why the certification should not be terminated. If a hearing is requested, it will be conducted in accordance with § 618.215. If no evidence is

provided by any interested party within 10 days from the date of publication to the FEDERAL REGISTER or on the Department's website, whichever is later, a determination must be issued once the investigation is complete. Evidence (except at a timely requested hearing) and hearing requests submitted outside the 10-day period will not be accepted.

(d) *Investigation of termination of a certification.* The Department will conduct a review of the record on which the certification was based, any evidence timely filed under paragraph (c) of this section, and any data submitted with the petition or provided subsequent to the filing of the petition.

(e) *Determination to terminate or partially terminate a certification.* A determination to terminate a certification may cover the entire worker group specified in the certification or a portion of that group. Such termination or partial termination must apply only with respect to total or partial separations occurring after the termination date specified in the determination notice and must only take effect after the determination becomes final, either after the period in which to request reconsideration has lapsed or after a determination on reconsideration is made.

(1) Upon making a determination that the certification should be terminated for all or part of the worker group specified in the certification, the Department will issue a determination, which will contain the reasons for making such determination, and notify the petitioner(s) of the original certification, the firm official(s), and the State(s). The Department will also publish the notice in the FEDERAL REGISTER, and on the Department's website. The State will notify the worker group of the termination or partial termination.

(2) The termination date specified in the determination notice must not be earlier than the date of publication in the FEDERAL REGISTER.

(f) *Determination of continuation of certification.* After an investigation resulting in a decision that the certification should not be terminated, the Department will notify the petitioner(s) of the original certification, firm official(s), and the State(s). The State(s) will notify the worker group of the determination of continuation of certification. The Department will publish the determination in the FEDERAL REGISTER and on the Department's website. After receiving notice by the Department, the State(s) must notify the worker group of the continuation of certification.

(g) *Reconsideration of termination or partial termination of a certification.* Any party that is eligible under § 618.205 to submit a petition may file an application for reconsideration with the Department, following the procedures described in § 618.245.

§ 618.245 Reconsideration of termination of an investigation, denial, or termination or partial termination of certification.

(a) *Application for reconsideration; contents.* (1) Any party who is eligible to file a petition under § 618.205, and any worker in the group of workers, may file a written application seeking reconsideration of a termination of an investigation under § 618.210(e); a negative determination issued under § 618.235(b); or a termination or partial termination of certification issued under § 618.240, via email: *reconsiderations.taa@dol.gov;* fax: (202) 693–3584 or (202) 693–3585; or mail: U.S. Department of Labor, Employment and Training Administration, Office of Trade Adjustment Assistance, 200 Constitution Avenue NW, Washington, DC 20210.

(2) An application for reconsideration must contain the following information to be complete and valid:

(i) The name(s) and contact information of the applicant(s);

(ii) The name or a description of the group of workers on whose behalf the application for reconsideration is filed in the case of an application for reconsideration of a termination of an investigation or a negative determination, or the name or a description of the worker group on whose behalf the application for reconsideration of a termination or partial termination of a certification is filed;

(iii) The petition number identified on the petition or determination that is the subject of the application for reconsideration;

(iv) The reasons for believing that the termination of the investigation, negative determination, or termination or partial termination of a certification identified in paragraph (a)(1) of this section is erroneous, including any issues that the applicant asserts require further investigation;

(v) Any information that may support the application for reconsideration, including material not considered prior to the termination of the investigation, negative determination, or termination or partial termination of a certification; and

(viii) The signature(s) of the party, or representative thereof, requesting reconsideration.

(b) *Time for filing.* An application for reconsideration of the termination of the investigation, negative determination, or termination or partial termination of a certification must be filed no later than 30 calendar days after the notice of the termination of the investigation, negative determination, or termination or partial termination of a certification has been published in the FEDERAL REGISTER. If an application is filed after that time, it will be returned as untimely filed.

(c) *Return of incomplete applications for reconsideration.* The Department will review an application for reconsideration within 2 business days upon its receipt to determine if the application contains all of the necessary information required under paragraph (a)(2) of this section. The Department will not accept an incomplete application for filing, but will return it to the applicant with a brief statement explaining why it is incomplete. Should an applicant wish to refile an application for reconsideration, the refiling must occur no later than 30 calendar days after the notice of the determination has been published in the FEDERAL REGISTER, within the 30-day period identified in paragraph (b) of this section or, if the application is returned less than 5 days before the end of that period, within 5 days of receipt.

(d) *Notice of an application for reconsideration.* After receipt of a complete and timely application for reconsideration, the Department will notify the applicant and publish in the FEDERAL REGISTER and on the Department's website the notice of the application and the initiation of an investigation on reconsideration of the termination of the investigation, negative determination, or termination or partial termination of a certification.

(e) *Opportunity for comment and submission of data on reconsideration.* Within 10 calendar days after publication of a notice under paragraph (d) of this section, any party who is eligible to file a petition under § 618.205 may make written submissions to show why the determination under reconsideration should or should not be modified.

(f) *Investigation on reconsideration.* The Department will conduct a review of the record on which the termination of the investigation, negative determination, or termination or partial termination of a certification was based, any comments timely filed under paragraphs (a)(2)(iv), (a)(2)(v), or (e) of this section, and any data submitted with the original petition or provided subsequent to the filing of the petition. The period of investigation under reconsideration will remain the same as the period of investigation for the original petition.

(g) *Determinations on reconsideration.* The Department will issue a final determination affirming, reversing, or modifying the termination of the investigation, negative determination, or termination or partial termination of a certification within 60 days after the date of receiving a complete and valid application for reconsideration. The Department will notify the applicant(s), the petitioner(s) of the original petition, firm official(s), and the State(s); and publish notice in the FEDERAL REGISTER of the determination on reconsideration and the reasons for it (redacting confidential business information). The State continues to be responsible for notifying trade-affected workers in a certified worker group of their eligibility to apply for TAA, in accordance with § 618.820. If 60 days pass without a determination on reconsideration, the Department will contact the applicant to ascertain whether the applicant wishes the Department to continue the reconsideration investigation and issue a determination on reconsideration or wishes the Department to

terminate the reconsideration investigation, which renders the initial determination as the Department's final determination.

§ 618.250 Amendments of certifications.

(a) *Reasons for amendments.* A Certifying Officer may amend a certification. The Department retains the authority to amend a certification without a petition, where it has determined that an amendment is appropriate. Amendments must not extend the impact date more than 1 year prior to the petition date unless there is a statutory exception, as described in § 618.235(a)(1)(ii). Reasons for amendments include, but are not limited to:

(1) Identifying an ownership change affecting the applicable firm;

(2) Correcting technical errors; or

(3) Clarifying the identification of the worker group.

(b) *Petition filing.* Amendments must be requested through the regular petition process described in § 618.205.

(c) *Notification of amendment.* The Department will publish the amended certification in the FEDERAL REGISTER and on the Department's website. The Department will also notify the affected States and the State must notify any additional certified trade-affected workers, as required by § 618.820.

§ 618.255 Judicial review of determinations.

(a) *General.* A worker, group of workers, certified or recognized union, or authorized representative of such worker or group may commence a civil action for review of the determination by filing a complaint with the United States Court of International Trade (USCIT) within 60 days after the date of publication of the notice of a final determination in the FEDERAL REGISTER, as provided under section 284 of the Act (19 U.S.C. 2395).

(b) *Final determination.* Only determinations issued under § 618.245(g) are final determinations for purposes of judicial review.

(c) *Certified record of the Department.* Upon receiving a copy of the summons and complaint from the clerk of the USCIT, the Department will file with the court a certified record meeting the requirements of the rules of the USCIT. When the certified record contains confidential business information, the Department will file a public version of the record redacting the confidential business information, and a separate version that includes the confidential business information, in accordance with the rules of the USCIT.

(d) *Further proceedings.* Upon remand by the USCIT, the Department will conduct an additional investigation and the Certifying Officer will make new or modified findings of fact and will modify or affirm the previous determination. Upon making this subsequent determination, the Certifying Officer will publish a summary of the determination and the reasons for the determination in the FEDERAL REGISTER, redacting any confidential business information from the published summary. The Certifying Officer also will file the determination upon remand and the record on which the determination is based with the USCIT, in accordance with the rules of USCIT.

(e) *Standard of review.* The determination and findings of fact by the Certifying Officer are conclusive if the USCIT determines that they are supported by substantial evidence, as provided under section 284 of the Act (19 U.S.C. 2395).

(f) *Individual benefits denials.* Appeals of denials of individual benefits are not determinations under section 222 of the Act and are not subject to review by the USCIT under section 284 of the Act.

(g) *Manner of filing.* Requests for judicial review must be filed in accordance with the rules of the USCIT.

§ 618.260 Study regarding certain affirmative determinations by the Commission.

(a) Upon notification from the Commission that it has begun an investigation under section 202 of the Act with respect to an industry, the Department must immediately begin a study of:

(1) The number of workers in the domestic industry producing the like or directly competitive article who have been or are likely to be certified as eligible for adjustment assistance, which includes, but is not limited to, analysis of:

(i) The estimated number of certified workers within the domestic industry named in the ITC affirmative determination;

(ii) Information obtained during the investigation of TAA Program determinations;

(iii) Responses from Domestic Industry Study;

(iv) Information obtained by consultation with ITC Commission industry experts; and

(v) Other pertinent workforce and trade-impact data of companies who are currently participating in the industry.

(2) The extent to which the adjustment of such workers to the import competition may be facilitated through the use of the TAA Program, other Departmental programs and resources, and programs administered by other Federal agencies.

(b) The report of the Department's study under paragraph (a) of this section must be made to the President not later than 15 days after the day on which the Commission makes its report under section 202(f)(1) of the Act. The Department will also publish the report in the FEDERAL REGISTER and on the Department's website.

§ 618.265 Availability of information to the public.

(a) *Information available to the public.* The Department posts all determinations on the Department's website at *https://www.dol.gov/agencies/eta/tradeact*. The Department also posts redacted versions of all petitions on the same website. Upon request to the Administrator of the Office of Trade Adjustment Assistance, members of the public may inspect petitions and other documents filed with the Administrator, transcripts of testimony taken and exhibits submitted at public hearings held under the provisions of this subpart, public notices concerning trade-affected worker assistance under the Act, and other reports and documents issued for general distribution, in accordance with the Department's record retention schedule, FOIA, and the Privacy Act.

(b) *Information not available to the public.* Confidential business information must not be made available to the public.

Subpart C—Employment and Case Management Services

§ 618.300 Scope.

This subpart describes the employment and case management services that the State must make available to trade-affected workers, either directly through the TAA Program or through arrangements with partner programs. This subpart requires States, under the Governor-Secretary Agreement at § 618.804, to integrate the provision of benefits and services available to trade-affected workers under the TAA Program with the delivery of employment services and other assistance provided through the one-stop delivery system (established under title I of WIOA), as required by sections 235 and 239(a), (e), and (g) of the Act. It also implements the requirements of section 221(a)(2)(A) of the Act for the provision of rapid response assistance and appropriate career services described in §§ 682.300 through 682.370, and 680.150 of this chapter, respectively, for workers upon receipt of a petition filed covering a group of workers.

§ 618.305 The Trade Adjustment Assistance Program as a one-stop partner.

(a) As provided by WIOA section 121(b)(1)(B)(vii), the TAA Program is a required one-stop partner under WIOA.

(b) The State must ensure that the TAA Program complies with WIOA's one-stop partnership requirements at WIOA section 121(b)(1)(A)(i) through (v). This includes, among the other requirements, paying infrastructure costs where the TAA Program is being carried out.

(c) The TAA Program must also comply with, and be a party to, the memorandum of understanding required under the regulations implementing WIOA at § 678.500 of this chapter, where the TAA Program is being carried out.

§ 618.310 Responsibilities for the delivery of employment and case management services.

(a) The State is responsible for providing information to workers about

the TAA Program, as required in § 618.816;

(b) As part of the delivery of services, the State must:

(1) Conduct intake, which includes interviewing each trade-affected worker and reviewing suitable training opportunities reasonably available to each worker under subpart F of this part;

(2) Inform trade-affected workers of the employment services and allowances available under the Act and this part, including the application procedures, the filing requirements for such services, and enrollment deadlines for receiving TRA, as described in subpart G of this part;

(3) Determine whether suitable employment, as defined in § 618.110, is available, and assist in job search activities related to securing suitable employment;

(4) Accept applications for training;

(5) Provide information on which training providers offer training programs at a reasonable cost and with a reasonable expectation of employment following the completion of such training, and assist in acquiring such training;

(6) Monitor the progress and attendance of trade-affected workers in approved training programs;

(7) Develop and implement a procedure for determining whether to issue a training waiver and to review waivers to determine whether the conditions under which they were issued have changed, in compliance with subpart G of this part;

(8) Provide access to workshops and other resources related to job search strategies, resume building, interviewing, and other topics available through the TAA Program or through the one-stop delivery system; and

(9) Coordinate the administration and delivery of additional appropriate employment services, benefits, training, supportive services, and supplemental assistance for workers with partner programs for which the trade-affected worker may be eligible.

(c) The State must make available the employment and case management services in paragraphs (c)(1) through (7) of this section to trade-affected workers who apply for or are seeking receipt of TAA Program benefits and services, and ensure that those workers are informed of the availability of:

(1) Comprehensive and specialized assessment of skill levels and service needs, including through:

(i) Diagnostic testing and use of other assessment tools; and

(ii) In-depth interviewing and evaluation to identify employment barriers and appropriate employment goals.

(2) Development of an individual employment plan (IEP) to identify employment goals and objectives, and appropriate training to achieve those goals and objectives.

(3) Information on how to apply for financial aid, including referring workers to educational opportunity centers described in section 402F of the Higher Education Act of 1965, as amended (HEA) (20 U.S.C. 1070a–16), where applicable, and notifying workers that they may request that financial aid administrators at institutions of higher education (as defined in section 102 of HEA (20 U.S.C. 1002)) use the administrators' discretion under section 479A of HEA (20 U.S.C. 1087tt) to use current-year income data, rather than preceding-year income data, for determining the amount of the workers' need for Federal financial assistance under title IV of HEA (20 U.S.C. 1070 *et seq.*).

(4) Short-term prevocational services, including development of learning skills, communications skills, interviewing skills, punctuality, personal maintenance skills, and professional conduct to prepare trade-affected workers for employment or training.

(5) Individual and group career counseling, including job search and placement counseling, during the period in which the worker is receiving a trade adjustment allowance or training under this chapter, and after receiving such training for purposes of job placement and employment retention.

(6) Provision of employment statistics information, including the provision of accurate information relating to local, regional, and national labor market areas, including:

(i) Job-vacancy listings in such labor market areas;

(ii) Information on the job skills necessary to obtain the jobs identified in

the job-vacancy listings described in paragraph (c)(6)(i) of this section;

(iii) Information relating to local occupations that are in demand and the earning potential of those occupations; and

(iv) Skills requirements for local occupations described in paragraph (c)(6)(iii) of this section.

(7) Information relating to the availability of supportive services, available through partner programs, including services relating to childcare, transportation, dependent care, housing assistance, and needs related payments that are necessary to enable a trade-affected worker to participate in training.

(d) To make available, with respect to the employment and case management services described in paragraph (c) of this section, means:

(1) That the State must inform the trade-affected worker of the full suite of services available; and

(2) That the State must offer and provide appropriate services to the trade-affected worker, as requested by the worker or deemed appropriate for the worker; and

(3) That the State must document each service provided to the trade-affected worker and document the reason any service listed in paragraph (c) of this section was not provided. The documentation must be included in the worker's case file, either through case notes or as a stand-alone document.

§ 618.325 Integrated service strategies and Workforce Innovation and Opportunity Act co-enrollment.

(a)(1) A State must co-enroll trade-affected workers who are eligible for WIOA's dislocated worker program. Workers may choose to decline co-enrollment in WIOA. A State cannot deny such a worker benefits or services under the TAA Program solely for declining co-enrollment in WIOA.

(2) A State must also make co-enrollment available to trade-affected workers who are eligible for other one-stop partner programs to ensure that all necessary and appropriate services, including supportive services, are available to the worker.

(b)(1) *Trade-affected worker dislocated worker eligibility*. Most trade-affected workers meet the eligibility criteria of a dislocated worker defined at WIOA section 3(15).

(2) *Partially separated worker and AAIW dislocated worker eligibility*. In certain circumstances, such as a general announcement of a closure, partially separated workers and AAIWs may meet the eligibility criteria as a dislocated worker under WIOA and must also be co-enrolled.

(3) *Trade-affected worker dislocated worker ineligibility*. Some trade-affected workers are ineligible for the WIOA dislocated worker program, including those that do not meet the Selective Service registration requirement, and will be exempt from the co-enrollment requirement in this section.

§ 618.330 Assessment of trade-affected workers.

(a) The assessment process forms the basis for determining which TAA Program benefits and services, including training, are most appropriate to enable trade-affected workers to successfully become reemployed.

(b) The State must schedule an initial assessment that provides sufficient time and information for the trade-affected worker to consider, request, and enroll in training or obtain a waiver of the training requirement in § 618.720(g) to protect the worker's eligibility to receive TRA under subpart G of this part.

(c) Assessments are administered with the cooperation of the trade-affected worker and should include discussion of the worker's interests, skills, aptitudes, and abilities.

(d) The results of assessments must be documented in the case file, either through case notes or as a stand-alone document.

(e) If an assessment has already been administered by a partner program, it must be reviewed once a worker becomes a trade-affected worker to ensure it has the required components as listed in § 618.335 for an initial assessment and, if necessary, § 618.345 for a comprehensive and specialized assessment. If the assessment(s) does not contain the required components, the assessment(s) must be supplemented by the State, in conjunction with the trade-affected worker, to ensure it is

fully compliant with TAA Program requirements in this part.

(f) The State must make the trade-affected worker aware of the advantages of receiving an assessment(s). However, a worker may refuse an assessment. Since portions of the assessment(s) are necessary to determine eligibility for certain TAA Program benefits, a worker's refusal to provide necessary information, either as part of the assessment or outside of the assessment process, may result in a denial of a those benefits. This is detailed further in the applicable benefit sections throughout this part.

§ 618.335 Initial assessment of trade-affected workers.

(a) A State must carry out an initial assessment for each trade-affected worker as part of the intake process described in section 239(g) of the Act. When applicable, a State must use the results of an assessment developed by a partner program, supplemented if necessary, as described in § 618.330(e).

(b) The results of the initial assessment will determine the best service strategy to assist the trade-affected worker in obtaining reemployment and provide insight into which benefits and services under the TAA Program and partner programs would be most beneficial to the worker. The initial assessment of the availability of suitable employment to the worker in the local labor market must take into consideration the following factors:

(1) Prevailing local labor market conditions, including the unemployment rate, local employer skill demands and hiring prerequisites;

(2) The worker's knowledge, skills, and abilities from his or her education and previous employment;

(3) Transferable skills that the worker may possess that would be of interest to other local employers;

(4) Evaluation of a worker's skill levels (including literacy, numeracy, and English language proficiency), aptitudes, abilities (including skills gaps), and supportive service needs; and

(5) Any barriers to the worker's reemployment, such as:

(i) Lack of applicability of skills from the worker's present occupation to other occupations;

(ii) Skills that are in excess supply in the labor market area; or

(iii) Other barriers as outlined in WIOA section 3(24).

(c) Based upon the information gathered in the initial assessment, described in paragraph (a) of this section, the State may:

(1) Determine that suitable employment is available to the trade-affected worker, and if so, the State must make available employment and case management services. If the worker disagrees with the determination, the State must make available to the worker a comprehensive and specialized assessment (under § 618.345) to obtain additional information to determine whether the initial assessment was correct.

(2) Determine that no suitable employment is available to the worker and, if so, the State must make available services as described in § 618.310 (responsibilities for the delivery of employment and case management services) and a comprehensive and specialized assessment (as described in § 618.345) to develop a comprehensive service strategy for the trade-affected worker.

(d) If the State determines under paragraph (c) of this section that suitable employment is not available to a trade-affected worker, even with additional employment and case management services, the State must advise the worker to apply for training under subpart F of this part.

§ 618.345 Comprehensive and specialized assessment of trade-affected workers.

(a) The State must make available a comprehensive and specialized assessment to all trade-affected workers.

(b) The comprehensive and specialized assessment must take into account the trade-affected worker's goals and interests as they relate to employment opportunities either in the worker's commuting area or, where there is no reasonable expectation of securing employment in the worker's commuting area and the worker is interested in relocation, the employment opportunities and demand in the area to which the worker proposes to relocate.

(c) The comprehensive and specialized assessment must expand upon the initial assessment regarding the trade-affected worker's interests, skills, aptitudes, and abilities. This may include use of diagnostic testing tools and instruments and in-depth interviewing and evaluation to identify barriers to employment and appropriate employment goals. The in-depth interviewing of trade-affected workers must include discussion of training opportunities reasonably available to each trade-affected worker, as described in subpart F of this part; reviewing the opportunities with each trade-affected worker; and informing each trade-affected worker of the requirements for participating in training, including the enrollment deadlines required for TRA eligibility.

(d) The State may use information from the comprehensive and specialized assessment to determine whether the trade-affected worker has met the six criteria for approval of training listed in subpart F of this part.

§ 618.350 Individual employment plans for trade-affected workers.

(a) A State must:

(1) Make available an IEP; and

(2) Document an IEP for any trade-affected worker seeking training under subpart F of this part or a job search allowance under subpart D of this part, before the worker receives those benefits and services.

(b) An IEP must use the results of the initial and, if available, comprehensive and specialized assessments to assist in documenting a strategy to provide the trade-affected worker with the services needed to obtain employment, including the items listed in paragraph (c) of this section.

(c) An IEP must document:

(1) The trade-affected worker's employment goal, including the targeted occupation and industry;

(2) The training program proposed, if any;

(3) Any services that will be needed by the worker to obtain suitable employment, including career services, supportive services provided through partner programs, and post-training case management services;

(4) If applicable, any supplemental assistance (subsistence or transportation payments) required for participation in training and the basis for their calculation; and

(5) The worker's responsibilities under the plan.

(d) If an IEP has been previously developed with a trade-affected worker by a partner program, it must be reviewed once the worker becomes TAA Program-eligible to ensure it has the components required by paragraph (c) of this section. If the IEP does not contain the components, the IEP must be supplemented by the State in conjunction with the worker to ensure it is fully compliant with the TAA Program requirements in this part.

(e) The State must monitor the progress of the trade-affected worker in meeting the worker's responsibilities as listed in the IEP, including attendance and achievement in approved training programs.

(f)(1) The State must modify the IEP as necessary to facilitate a successful performance outcome for the trade-affected worker.

(2) The modification must be done with the worker's input.

(3) At a minimum, the IEP must be modified when there is a change in the training program, receipt of supplemental assistance, or both.

(g) The State must make the trade-affected worker aware of the advantages of receiving an IEP. However, a worker may refuse to complete an IEP. Since portions of the IEP are necessary to determine eligibility for job search allowances under subpart D of this part and training under subpart F of this part, a worker's refusal to provide necessary information, either as part of the IEP or outside of the IEP process, may result in a denial of a those benefits and services. This is detailed further in subparts D and F of this part.

§ 618.355 Knowledge, skills, and abilities of staff performing assessments.

(a) Staff performing either the initial or comprehensive and specialized assessment must possess the following knowledge and abilities:

(1) Knowledge of the local labor market;

(2) Knowledge of local employer and occupation skill demands and hiring prerequisites, such as educational requirements and professional certifications;

(3) The ability to identify transferable skills that a trade-affected worker may possess that would be of interest to other local employers outside of the worker's present occupational area;

(4) The ability to evaluate quickly a worker's ability to conduct a self-directed job search; and

(5) The ability to identify barriers to a worker's employment that could be overcome with training and case management services.

(b) The staff performing these initial and comprehensive and specialized assessments may be from any partner program.

(c) Funds under section 235A(1) of the Act may be used to improve and maintain the knowledge and abilities of staff conducting assessments for trade-affected workers.

§ 618.360 Employment and case management services for trade-affected workers in training.

The State must make employment and case management services available, including placement and referrals to supportive services and follow-up services available through partner programs, to trade-affected workers during training, and after completion of training, and for AAWs on a waiver from training.

Subpart D—Job Search and Relocation Allowances

§ 618.400 Scope.

This subpart sets forth the conditions under which an AAW may apply for and receive a job search allowance to help the worker secure suitable employment outside the commuting area but within the United States. This subpart also sets forth the conditions under which an AAW may apply for and receive a relocation allowance to help the worker relocate to suitable employment secured outside the commuting area but within the United States.

§ 618.405 General.

(a) A State must grant a job search allowance to an AAW to help the worker secure suitable employment within the United States if the AAW meets the requirements in this subpart. A job search allowance for activities outside of the worker's commuting area may be provided for costs including, but not limited to:

(1) Travel to and attendance at job fairs and interviews;

(2) Travel to and attendance at prevocational workshops;

(3) Making an in-person visit with a potential employer who may reasonably be expected to have openings for suitable employment;

(4) Completing a job application in person with a potential employer who may reasonably be expected to have openings for suitable employment;

(5) Going to a local one-stop, copy shop, Post Office, or similar entity to print, copy, mail, email, or fax a job application, cover letter, and/or a resume;

(6) Going to a local one-stop, public library, community center, or similar entity to use online job matching systems, to search for job matches, request referrals, submit applications/resumes, attend workshops, and/or apply for jobs; and,

(7) Attending a professional association meeting for networking purposes.

(b) A State must grant a relocation allowance to an AAW to help the worker and the worker's family relocate within the United States if the AAW meets the requirements in this subpart. A State may grant a relocation allowance to a worker only once under a certification. A State may grant a relocation allowance to only one member of a family for the same relocation, even if there are multiple AAWs in the same family. If more than one member of a family applies for a relocation allowance for the same relocation, then the State must pay the allowance to the AAW who files first, if that AAW is otherwise eligible.

§ 618.410 Applying for a job search allowance.

(a) *Forms.* To receive a job search allowance, an AAW must apply to the State, using the State's process.

(b) *Submittal.* An AAW must apply for a job search allowance before beginning a job search to be funded by such an allowance.

§ 618.415 Eligibility for a job search allowance.

(a) *Conditions.* To be eligible for a job search allowance an AAW must:

(1) File an application before either:

(i) The later of the 365th day after either the date of the certification under which the AAW is covered, or the 365th day after the AAW's last total separation; or

(ii) The 182nd day after the date of concluding approved training;

(2) Be an AAW totally separated from the job covered under the certification when beginning the job search;

(3) Receive a determination by the State that the AAW:

(i) Cannot reasonably expect to secure suitable employment in the commuting area; and

(ii) Can reasonably expect to obtain, in the area of the job search, either:

(A) Suitable employment; or

(B) Employment that pays a wage of at least the 75th percentile of national wages, as determined by the National Occupational Employment Wage Estimates, and otherwise meets the definition of suitable employment;

(4) Receive a determination by the State that the worker cannot reasonably expect to secure suitable employment by alternatives to being physically present in the area of the job search, such as by searching and interviewing for employment by means of the internet and other technology;

(5) Not previously have received a relocation allowance under the same certification; and

(6) Complete a State-approved job search within 30 calendar days after the worker leaves the commuting area to begin the job search.

(b) *Completion of job search.* (1) An AAW has completed a job search when the worker either:

(i) Obtains a bona fide offer of employment; or

(ii) Has, with State verification, as provided in § 618.420(a)(2), contacted each employer the worker planned to contact, or to whom the State or other one-stop partner referred the worker as part of the job search.

(2) The job search is complete when one of the actions in paragraph (b)(1) of this section occurs, whichever comes first. For purposes of paragraph (b)(1)(i) of this section, ''bona fide'' means the offer of suitable employment is made in good faith by a prospective employer.

§ 618.420 Findings required for a job search allowance.

(a) *Findings by liable State.* Before a liable State may approve final payment of a job search allowance, the liable State must:

(1) Find that the AAW meets the eligibility requirements for a job search allowance specified in § 618.415(a)(1) through (6); and

(2) Verify that the worker contacted each employer the State certified or to whom the State or one-stop center referred the worker as part of the job search and must find that the worker completed the job search, as described in § 618.415(b) within the time limits stated in § 618.415(a)(6).

(b) *Assistance by agent State.* (1) When an AAW files an application for a job search allowance to conduct a job search in an agent State, the agent State in which the worker conducts the job search is responsible for assisting the worker in conducting the job search, for assisting the liable State by furnishing any information required for the liable State's determination of the claim, and for paying the job search allowance.

(2) The agent State must cooperate fully with the liable State in carrying out its activities and functions with regard to such applications. When requested by the liable State, the agent State must verify with the employer and report to the liable State whether the worker has obtained suitable employment, or a bona fide offer of suitable employment.

§ 618.425 Amount of a job search allowance.

(a) *Computation.* The job search allowance is 90 percent of the total costs of an AAW's travel (as defined in paragraph (a)(1) of this section) and lodging and meals (as defined in paragraph

(a)(2) of this section), up to the limit in paragraph (b) of this section:

(1) *Travel.* The worker's allowable travel expenses may not exceed 90 percent of the prevailing cost per mile by privately owned vehicle under 41 CFR chapters 300 through 304, the Federal Travel Regulation (FTR), found at *https://www.gsa.gov/,* for round trip travel by the usual route from the worker's home to the job search area, though other forms of transportation may be utilized.

(2) *Lodging and meals.* The worker's allowable lodging and meals costs cannot exceed the lesser of:

(i) The actual cost for lodging and meals while engaged in the job search; or

(ii) 50 percent of the prevailing per diem allowance under the FTR, found at *https://www.gsa.gov/,* for the worker's job search area.

(b) *Limit.* The AAW's total job search allowance under a certification may not exceed $1,250, no matter how many job searches the worker undertakes. If the worker is entitled to be paid or reimbursed by another source for any of these travel, lodging, and meals expenses, the State must reduce the job search allowance by the amount of the payment or reimbursement.

(c) *Choice of mode of transportation.* With respect to the limits established in paragraph (a)(1) of this section, an AAW may elect to use a different mode of transportation than the one for which the State calculated the applicable reimbursement amount. However, the State must limit the reimbursement to the worker to the amount calculated under paragraph (a)(1) of this section.

§ 618.430 Determination and payment of a job search allowance.

(a) *Determinations.* The State must promptly make and record determinations necessary to assure an AAW's eligibility for a job search allowance. Sections 618.820 (determinations of eligibility; notices to individuals) and 618.828 (appeals and hearings) apply to these determinations. States must include copies of such applications and all determinations by the State in the AAW's case file.

(b) *Payment.* If the AAW makes a timely application, is covered under a certification, and is otherwise eligible, the State must make payment promptly after the worker has completed a job search and complied with paragraph (d) of this section, provided that funds are available for job search allowances.

(c) *Advances.* Once the State determines that the AAW is eligible for a job search allowance, it may advance the worker up to 60 percent of the estimated amount of the job search allowance subject to the limit in § 618.425(b), but not exceeding $750, within 5 days before the commencement of a job search. The State must deduct the advance from any payment under paragraph (b) of this section.

(d) *Worker evidence.* After the AAW completes a job search, the AAW must certify to the State as to the employer contacts made and must provide documentation of expenses in accordance with FTR and Uniform Guidance at 2 CFR part 200. This may include receipts for all lodging, purchased transportation, or other expenses. If an advance the worker received was more or less than the actual allowance, the State must make an appropriate adjustment and pay the balance entitled, or the worker must repay the excess received.

§ 618.435 Job search program participation.

(a) *Requirements.* An AAW who participates in an approved job search program (JSP), may receive reimbursement for necessary expenses of subsistence and transportation incurred for the worker's participation in the approved JSP, regardless of the worker's approval for, or receipt of, a job search allowance under §§ 618.420 and 618.430.

(b) *Approved JSP.* A State may approve a JSP if:

(1) The JSP is provided through WIOA, the public employment service, or any other Federal- or State-funded program, and meets the definition provided in § 618.110; or

(2) The JSP is sponsored by the firm from which the AAW has been separated.

(c) *JSP allowances.* Subsistence and transportation costs, whether inside or outside the AAW's commuting area,

must be approved for workers participating in JSPs in accordance with § 618.640(a) and within available State funding levels.

§ 618.440 Applying for a relocation allowance.

(a) *Forms.* To receive a relocation allowance, an AAW must apply to the State using the State's process.

(b) *Submittal.* An AAW must apply for a relocation allowance and the State must approve the worker for a relocation allowance before the relocation begins. The State must make a timely determination on a relocation application submitted to allow the worker to promptly begin the relocation.

§ 618.445 Eligibility for a relocation allowance.

(a) *Conditions.* To be eligible for a relocation allowance, the AAW must:

(1) File an application before either:

(i) The later of the 425th day after the date of the certification under which the worker is covered, or the 425th day after the date of the worker's last total separation; or

(ii) The 182nd day after the date the worker concluded training;

(2) Be an AAW totally separated from adversely affected employment when the relocation begins;

(3) Not have already received a relocation allowance under the same certification;

(4) Relocate within the United States but outside the worker's commuting area;

(5) Receive a determination by the State that the worker has no reasonable expectation of securing suitable employment in the commuting area, and has obtained either suitable employment or employment that pays a wage of at least the 75th percentile of national wages, as determined by the National Occupational Employment Wage Estimates, and otherwise meets the suitable employment requirements, or a bona fide offer of such employment, in the area of intended relocation;

(6) Begin the relocation as promptly as possible after the date of certification but no later than:

(i) 182 days after the worker filed the application for a relocation allowance; or

(ii) 182 days after the conclusion of an approved training program, if the worker entered a training program that received supplemental assistance approved under § 618.640(c) (subsistence payments) and (d) (transportation payments), for training outside the worker's commuting area; and

(7) Complete the relocation, as described in § 618.460(f), within a reasonable time as determined in accordance with FTR with the State giving consideration to, among other factors, whether:

(i) Suitable housing is available in the area of relocation;

(ii) The worker can dispose of the worker's residence;

(iii) The worker or a family member is ill; and

(iv) A member of the family is attending school, and when the family can best transfer the member to a school in the area of relocation.

(b) *Job search allowances.* The State may not approve a relocation allowance and a job search allowance for an AAW at the same time. However, if the worker has received a job search allowance, the worker may receive a relocation allowance at a later time or receive a relocation allowance as a result of a successful job search for which the worker received a job search allowance.

§ 618.450 Findings required for a relocation allowance.

(a) *Findings by liable State.* Before the liable State may approve final payment of a relocation allowance, the liable State must make the following findings:

(1) That the AAW meets the eligibility requirements for a relocation allowance specified in § 618.445(a)(1) through (7) and is not also simultaneously receiving a job search allowance as specified in § 618.445(b);

(2) That the worker submitted the application for a relocation allowance within the time limits specified in § 618.445(a)(1);

(3) That the worker began and completed the relocation within the time

limitations specified in § 618.445(a)(6) and (7); and

(4) That the worker obtained suitable employment, or a bona fide offer of such suitable employment, in the area of intended relocation, in accordance with § 618.445(a)(5). The liable State must verify (directly or through the agent State) the suitable employment, or the bona fide offer, with the employer.

(b) *Assistance by agent State.* (1) When an AAW relocates to an agent State, the agent State is responsible for:

(i) Assisting the worker in relocating to the State, completing an application for a relocation allowance with the liable State, and paying the relocation allowance; and

(ii) Assisting the liable State by furnishing any information required for the liable State's determination on the claim.

(2) The agent State must cooperate with the liable State in carrying out its activities and functions with regard to relocation applications. When requested by the liable State, the agent State must verify with the employer and report to the liable State whether the worker has obtained suitable employment, or a bona fide offer of suitable employment.

§ 618.455 Determining the amount of a relocation allowance.

The AAW's relocation allowance includes the information in paragraphs (a) through (c) of this section, as applicable:

(a) *Reimbursement*—(1) *Travel.* (i) The State may reimburse the AAW for up to 90 percent of the prevailing cost per mile by privately owned vehicle under the FTR, found at *https://www.gsa.gov/*, for travel from the AAW's old home to the AAW's new home.

(ii) Separate travel of a family member or members who, for good cause and with the approval of the State, must travel separately to their new home, may also be reimbursed. For purposes of this paragraph (a)(1)(ii), good cause includes, but is not limited to, reasons such as a family member's health, schooling, job, or economic circumstances.

(2) *Lodging and meals.* The State may reimburse the worker for 90 percent of lodging and meal expenses for the worker and his or her family while they are in transit, but such costs may not exceed the lesser of:

(i) The actual lodging and meals cost to the worker and his or her family while they are traveling; or

(ii) 50 percent of the prevailing per diem allowance under the FTR, found at *https://www.gsa.gov/*, for the relocation area for those days while the worker and his or her family are traveling.

(3) *Movement of household goods.* (i) The State may reimburse the worker for 90 percent of the allowable costs of moving the workers and family's household goods and personal effects in accordance with the FTR (41 CFR chapter 302). This includes 90 percent of the costs of moving by the most economical commercial carrier the State can reasonably expect the worker to use, moving by rental truck or trailer (for rental, mileage, and fuel), or moving a house trailer or mobile home. It also includes 90 percent of the costs of temporary storage of household goods for up to 60 days. In approving the move of a house trailer or mobile home, the State must follow the specific requirements of the FTR, found at *https://www.gsa.gov*.

(ii) For a commercial carrier move of household goods or house trailer or mobile home, the worker must obtain an estimate of the moving cost and provide this to the liable State. The estimate may include the cost of insuring such goods and effects for their actual value or $40,000 as delineated in the FTR, whichever is less, against loss or damage in transit.

(iii) If more economical, the State may make direct arrangements for moving and insuring a worker's household goods and personal effects with a carrier and insurer selected by the worker and may make payment of 90 percent of moving and insurance costs directly to the carrier and insurer. No such arrangement releases a carrier from liability otherwise provided by law or contract for loss or damage to the worker's goods and effects. Any contract for moving and insuring an AAW's household goods must provide that the United States must not be or

become liable to either party for personal injury or property loss damage under any circumstances.

(iv) The maximum net weight of the household goods relocated from the worker's old home to the relocation area may not exceed that set by the FTR.

(4) *Lump sum.* As part of the relocation allowance, the worker will receive a lump sum equivalent to three times the worker's average weekly wage, not to exceed $1,250.

(b) *Reduction.* If the AAW is eligible to receive or has received moving expenses from any other source for the same relocation, the State must deduct the amount received from the amount of the relocation allowance as determined in paragraphs (a)(1) through (3) of this section.

(c) *Limitation.* In no case may the State pay a travel allowance for the AAW or a family member more than once for a single relocation.

§ 618.460 Determinations and payment of a relocation allowance.

(a) *Determinations.* The State must promptly make and record determinations necessary to assure an AAW's eligibility for a relocation allowance. Sections 618.820 (determinations of eligibility; notices to individuals) and 618.828 (appeals and hearings) apply to these determinations. The State must include copies of such applications and all determinations by the State in the AAW's case file.

(b) *Payment.* If the AAW makes a timely application, is covered under a certification, and is otherwise eligible, the State must make payment as promptly as possible.

(c) *Travel allowances*—(1) *Payment.* The State must pay the allowances computed under § 618.455 no earlier than 10 days in advance of, and no later than at the time of, the AAW's scheduled departure to begin relocation. The State must make the payment for a family member approved for separate travel 10 days in advance of, or at the time of that family member's scheduled departure.

(2) *Worker evidence.* After an AAW completes the relocation, the AAW must certify to the State the expenses associated with the relocation, in accordance with the FTR and Uniform Guidance in 2 CFR part 200. This may include receipts for all lodging, purchased transportation, or other expenses. If an advance the worker received was more or less than the actual allowance, the State must make an appropriate adjustment and pay the balance entitled, if any, or the worker must repay any excess received, if any.

(d) *Movement of household goods.* The State must pay the amount equal to 90 percent of the estimate of the costs of moving the AAW's household goods by the most economical commercial carrier the State can reasonably expect the worker to use (as described in § 618.455(a)(3) (determining the amount of a relocation allowance) as follows:

(1) *Commercial carrier.* If a commercial carrier moves the worker's household goods and personal effects, the State must provide the worker with an advance equal to 90 percent of the estimated cost of the move, including any other charges that the State has approved, such as insurance. The State must advance the funds to the worker no earlier than 10 days in advance of, and no later than at the time of, the scheduled shipment. If more economical, the State may make direct arrangements for moving and insuring a worker's household goods and personal effects with a carrier and insurer selected by the worker and may make payment of 90 percent of moving and insurance costs directly to the carrier and insurer subject to the conditions of § 618.455(a)(3)(iii). The State must deliver payment to the carrier and insurer no earlier than 10 days in advance of, and no later than at the time of, the scheduled shipment.

(i) On completion of the move, as determined under paragraph (f) of this section, the worker must promptly submit to the State a copy of the carrier's bill of lading, including a receipt showing payment of moving costs.

(ii) If the amount the worker received as an advance is greater than 90 percent of the actual approved moving costs, the worker must reimburse the State for the difference. If the advance the worker received is less than 90 percent of the actual moving costs approved by the State, the State must reimburse the worker for the difference.

(2) *Private truck and trailer, rental truck or trailer, or house trailer move*—(i) *Private vehicle with trailer.* If the move is by private vehicle and trailer, the State must advance 90 percent of the estimated cost for the use of the private vehicle within 10 days in advance of the scheduled move.

(ii) *Truck and trailer rental.* If the move is by rental truck or rental trailer, the State must advance 90 percent of the estimated rental cost within 10 days in advance of the scheduled move. The State may make payment to either the worker or the rental company.

(iii) *House trailer.* If a house trailer or mobile home is moved by commercial carrier, the State must advance 90 percent of the approved estimated cost to the worker within 10 days in advance of the scheduled move. The State may make payment to either the worker or the carrier.

(iv) *Itemized receipt.* Upon completion of the move, the worker must promptly submit an itemized receipt to the State for payment of the rental charges and fuel costs. If the amount the worker received as an advance is greater than 90 percent of the actual moving costs, the worker must reimburse the State for the difference. If the advance the worker received is less than 90 percent of the actual moving costs approved by the State, the State must pay the worker for the difference.

(3) *Temporary storage.* If temporary storage, not to exceed 60 days, of household goods and personal effects is necessary for the relocation, then the State must advance 90 percent of the approved estimated cost within 10 days in advance of the scheduled move. The State may make payment to either the worker or the rental agency.

(e) *Lump sum allowance.* The State must pay the lump sum allowance provided in §618.455(a)(4) when arrangements for the relocation are finalized, but not more than 10 days before the earlier of the AAW's anticipated departure from his or her old home, or the anticipated date of shipment of the worker's household goods and personal effects.

(f) *Relocation completed.* An AAW completes a relocation when the worker and family, if any, along with household goods and personal effects are delivered to the new residence in the area of relocation or to temporary storage. If the worker moves no household goods and personal effects, then a worker completes relocation when the worker and family, if any, arrive in the area of relocation and establish a residence in the new area. When a family member is approved for separate travel, the later arrival of such family member does not alter the date on which the State must consider the relocation completed.

Subpart E—Reemployment Trade Adjustment Assistance

§ 618.500 Scope.

This subpart provides the rules for RTAA. RTAA, authorized under section 246 of the Act, provides 50 percent of the difference between the wages received by the AAW at the time of separation from adversely affected employment and the wages received by the worker from reemployment for workers aged 50 and older who meet the eligibility criteria described in this subpart. This subpart identifies the eligibility criteria and the benefits available to AAWs who are eligible for RTAA.

§ 618.505 Individual eligibility.

(a) *Eligibility criteria.* An AAW from a worker group certified under §618.225 may elect to receive RTAA benefits if the AAW:

(1) Is at least 50 years of age;

(2) Earns not more than, or is projected to earn not more than, $50,000 in reemployment wages each year during the eligibility period, as further defined in §618.520(a);

(3) Earns less than, or is projected to earn less than, the AAW's annualized wages at separation, as further defined in §618.520(a);

(4)(i) Is employed on a full-time basis as defined by the law of the State in which the worker is employed and is not enrolled in any training program approved under subpart F of this part; or

(ii) Is employed at least 20 hours per week and is enrolled in a TAA approved training program; and

(5) Is not employed at the firm, as further defined in paragraph (b) of this

section, from which the worker was separated.

(b) *Eligibility-relevant definitions.* For purposes of RTAA, the following definitions apply:

(1) *Firm.* The State must determine on a case-by-case basis what constitutes the ''firm'' for purposes of determining RTAA eligibility based on the certification. If the Department issues the certification under subpart B of this part for a worker group in an appropriate subdivision of a firm, an AAW in that group is not eligible for RTAA upon a return to employment within that subdivision, but may be eligible for RTAA upon a return to employment at another subdivision of the firm. If, however, the Department issues the certification for a worker group composed of all workers from the firm rather than from a subdivision, then the worker is not eligible for RTAA based on a return to employment in any subdivision of that firm.

(2) *Successor-in-interest.* The State must determine if the firm now employing the AAW is the same firm as the one from which the AAW was separated.

(i) In making its determination, the State should first review the certification under which the worker was covered, look for any amendments to the certification, and compare the name and address of the firm in the certification to the name and address of the firm in which the worker has found reemployment. If they are the same, this is, in most cases, dispositive: The firms are the same and the worker is not eligible for RTAA.

(ii) If, despite the information gathered under paragraph (b)(2)(i) of this section, it nonetheless remains unclear whether the firms are the same, the State may need to obtain further information about the firm reemploying the worker, from the employer and otherwise, to make that determination. To do so, the State should determine whether the firm at which the worker found reemployment is a ''successor-in-interest'' to the firm from which the worker was separated. If the reemploying firm merged with, acquired, or purchased the assets of the firm from which the worker was separated, then the reemploying firm is a successor-in-interest.

(iii) If the reemploying firm does not meet the criteria in paragraph (b)(2)(ii) of this section, or if that information is unavailable, then the State should consider the factors identified in paragraphs (b)(3)(i) through (vii) of this section to determine whether the reemploying firm is a successor-in-interest. If the State determines that the worker returned to employment with a successor-in-interest to the firm from which the worker was separated, then the worker is not eligible for RTAA. The State must make the determination based on the individual application of the worker. A firm, together with any predecessor or successor-in-interest, or together with any affiliated firm controlled or substantially owned by substantially the same persons, is considered a single firm. If the State determines that the reemployment is with a successor-in-interest the State also must seek to identify any additional members of the worker group and notify them of their potential eligibility under the TAA Program, as provided in § 618.816(e).

(3) *Successor-in-interest factors.* A State may consider a firm a successor-in-interest to another firm, if a majority of the following factors are present:

(i) There is continuity in business operations.

(ii) There is continuity in location.

(iii) There is continuity in the workforce.

(iv) There is continuity in supervisory personnel.

(v) The same jobs exist under similar conditions.

(vi) There is continuity in machinery, equipment, and process.

(vii) There is continuity in product/service.

(4) *Year.* For purposes of RTAA, a year represents the 12-month period beginning with the first full week of qualifying reemployment.

(c) *Full-time employment.* For purposes of RTAA, full-time employment is defined per State law in which the reemployment occurs.

(1) If there is no State law addressing the definition of full-time employment referenced under paragraph (a)(4)(i) of this section, the State must issue a

definition of full-time employment for RTAA purposes.

(2) The State must verify reemployment and do so in accordance with State policies.

(3) Where an AAW seeks to establish RTAA eligibility based upon more than one job, the State must combine employment hours in order to determine whether the worker has the number of hours needed to qualify for RTAA.

(4) If the AAW is employed in more than one State, the State must determine full-time employment for the entire duration of the AAW's RTAA eligibility under a single certification under the law of the State in which the AAW has the lowest threshold of hours required to meet the definition of full-time employment.

(d) *Relevance of UI eligibility.* UI eligibility is not a requirement for RTAA eligibility.

(e) *Eligible employment.* (1) Employment for purposes of paragraph (a)(4) of this section must be covered employment under State law; however, employment may not include activity that is unlawful under Federal, State, or local law.

(2) Work involving wages plus commission or piece work may be considered qualifying employment for the purpose of establishing RTAA eligibility, if it otherwise meets the criteria in paragraph (e)(1) of this section.

(3) For purposes of meeting the requirements of paragraphs (a)(4)(i) and (ii) of this section, employment may include one or more jobs unless, in the case of paragraph (a)(4)(i) of this section, the law of the State in which the AAW is employed provides otherwise.

(4) A State must count hours in which an AAW is on employer-authorized leave as hours of work for purposes of meeting the requirements of paragraphs (a)(4)(i) and (ii) of this section unless, in the case of paragraph (a)(4)(i) of this section, the law of the State in which the worker is employed provides otherwise.

§ 618.510 Eligibility period for payments of Reemployment Trade Adjustment Assistance and application deadline.

(a) *Adversely affected worker who has not received TRA.* (1) In the case of an AAW who has not received TRA, the worker may receive benefits as described in § 618.520(a) for a period not to exceed 104 weeks beginning on the earlier of:

(i) The date on which the worker exhausts all rights to UI based on the separation of the worker from the adversely affected employment that is the basis of the certification; or

(ii) The date on which the worker first begins qualifying reemployment as described in § 618.505(e).

(2) Where a worker has more than one separation from adversely affected employment, the relevant separation for determining the date on which the ''worker exhausts all rights to UI'' referenced in paragraph (a)(1)(i) of this section is the worker's last separation from adversely affected employment that qualifies the worker as an AAW. The Department uses the last separation because that separation is the one that triggers the worker's application for RTAA. Accordingly, the State must determine the worker's last separation for lack of work from adversely affected employment before the RTAA application. This principle applies only to the determination of the eligibility period and does not apply to the calculation of RTAA payments, where wages at separation are defined as the annualized hourly rate at the time of the most recent separation, as explained in § 618.520(a).

(b) *Adversely affected worker who has received TRA.* In the case of an AAW who has received TRA, the worker may also receive RTAA benefits based on the same certification for a period of 104 weeks beginning on the date on which the worker first begins qualifying reemployment, reduced by the total number of weeks for which the worker received such TRA.

(c) *Applicable dates.* To make the RTAA determination, the State will need to know the applicable dates for the AAW: The date of reemployment and either the date the worker exhausted all rights to UI, or the dates the worker began and ended receipt of TRA before the date of reemployment. These dates must occur within the 104-week eligibility period identified in the Act.

(d) *Age of AAW when obtaining RTAA-qualifying employment.* An AAW may obtain employment before turning 50 years old and receive RTAA benefits after turning 50 years old, if the employment is determined to be RTAA-qualifying reemployment, as provided at § 618.505(e), and the RTAA eligibility period established after obtaining such employment has not expired when the individual turned 50 years old.

(e) *Exception to filing deadline and eligibility periods.* The filing deadline and eligibility periods in paragraphs (a) and (b) of this section do not apply where:

(1) A negative determination on a petition filed under subpart B of this part has been appealed to the USCIT;

(2) A certification of the worker group covered by that petition is later made; and

(3) The delay in the certification is not attributable to the petitioner or the AAW.

(f) *Reasonable accommodation of filing deadline and eligibility periods.* In the event the filing deadline and eligibility periods in paragraphs (a) and (b) of this section do not apply because the certification meets the conditions in paragraph (e) of this section, the filing deadline and eligibility periods for RTAA will be extended by the State for the period necessary to make RTAA reasonably available to AAWs.

§ 618.515 Continuing eligibility and timing of payments.

(a) *Continuing eligibility for RTAA.* (1) Changing jobs during reemployment does not disqualify an otherwise eligible AAW from receiving subsequent RTAA payments for the remainder of the 104-week (2-year) eligibility period if the new reemployment meets the requirements of § 618.505.

(2) An AAW already receiving RTAA payments who has a period of unemployment will not be eligible to receive RTAA for that period. Upon reemployment, the AAW must notify the State. If the new reemployment meets the requirements of § 618.505 and the worker meets all other eligibility requirements in this part, the AAW will be eligible to receive RTAA in accordance with the requirements of this section for the remaining portion of the 104-week (2-year) eligibility period.

(3) If during a year during the 2-year eligibility period an AAW's cumulative wages exceed, or are projected to exceed, $50,000, the AAW will no longer be eligible to receive additional RTAA payments within that year. The AAW will be eligible for RTAA benefits in the next year and RTAA payments will resume until wages exceed, or are projected to exceed, $50,000, or until the $10,000 benefit limit is reached.

(4) If the worker is employed part-time (at least 20 hours per week) and receiving RTAA while in TAA approved training, the State must verify participation in training on a monthly basis. Verification of participation in TAA approved training will be conducted in accordance with State policies. States may use training benchmarks, described at § 618.660, as a method of verification of participation.

(b) *Timing of RTAA payments.* The State must make RTAA payments on a regular basis, either weekly, biweekly, or monthly, for no more than a 104-week (2-year) period for an AAW under any one certification, beginning no earlier than the first day of reemployment that satisfies the requirements of § 618.505. An AAW may receive retroactive payments, in a lump sum, for payments for which the AAW was eligible, but for which the AAW had not yet applied.

(c) *Periodic verification of employment and reemployment wages.* No less than once a month, the State must review whether an AAW receiving RTAA payments continues to meet the eligibility requirements of § 618.505 and determine whether changes have occurred in the AAW's reemployment wages, as described in § 618.520(a).

(d) *Change in reemployment wages.* The State must recompute the appropriate amount of the RTAA payments if, during its review under paragraph (c) of this section, it determines that an AAW's reemployment wages have changed.

(1) If reemployment wages exceed, or are projected to exceed, $50,000 in a year during the eligibility period, then the State must immediately issue a determination that the AAW is ineligible for further RTAA payments, notify the

AAW of this determination, and cease such RTAA payments.

(2) If reemployment wages change but do not exceed $50,000 in a year during the eligibility period then the RTAA payment must be recomputed every time such a change in reemployment wages occurs. The State must then continue periodic verification in accordance with paragraph (c) of this section, or recommence periodic verification if RTAA payments resume in the second year after such scenario as described in paragraph (a)(3) of this section occurs.

§ 618.520 Benefits available to eligible adversely affected workers.

(a) *Payment.* A RTAA-eligible AAW may receive a maximum of $10,000 over a period of not more than 104 weeks (2 years). If the AAW received TRA, each week of TRA received reduces the total weeks of RTAA available by 1 week and reduces the total RTAA payment amount available in proportion to the reduction in the number of total weeks.

(1) *Total amount of benefits.* RTAA supplements a worker's wages for up to 104 weeks (2 years) (reduced by the number of weeks of TRA received) or $10,000 (reduced in proportion to the reduction in the number of total weeks of TRA received), whichever occurs first, by an amount equal to the annualized wage differential as computed under paragraph (a)(2) of this section for an AAW employed full-time or paragraph (a)(3) of this section for an AAW employed less than full-time.

(2) *Annualized wage differential for initial eligibility of an AAW employed full-time.* This amount is equal to 50 percent of: The AAW's annualized separation wages (as computed under paragraph (a)(2)(i) of this section) minus the amount of the AAW's annualized reemployment wages (as computed under paragraph (a)(2)(ii) of this section).

(i) Annualized separation wages are the product of the AAW's hourly rate during the last full week of the AAW's regular schedule in adversely affected employment, multiplied by the number of hours the AAW worked during the last full week of such employment, multiplied by 52. The computation of annualized wages at separation excludes employer-paid health insurance premiums and employer pension contributions, as well as bonuses, severance payments, buyouts, and similar payments not reflective of the AAW's weekly pay. [(hourly rate × hours worked) × 52]

(ii) Annualized reemployment wages are the product of the AAW's hourly rate during the first full week of reemployment, multiplied by the number of hours the AAW worked during the first full week of such reemployment, multiplied by 52 [(hourly rate × hours worked) × 52]. If the AAW's wages from reemployment change during the eligibility period, then the State must recompute the AAW's annualized wages from reemployment at the new hourly wage and must likewise recompute the appropriate RTAA payment as required by § 618.515(d). The computation of annualized wages from reemployment excludes employer-paid health insurance premiums and employer pension contributions, as well as bonuses, severance payments, buyouts, and similar payments not reflective of the AAW's weekly pay.

(3) *Annualized wage differential for initial eligibility of an AAW employed less than full-time.* This amount, for an AAW employed at least 20 hours per week and enrolled in TAA approved training, is the annualized wages as computed under paragraph (a)(2) of this section multiplied by the ratio of the AAW's number of weekly hours of reemployment to the AAW's number of weekly hours of employment at the time of separation, but in no case more than 50 percent.

(4) *Adjustment to total amount of RTAA benefits for AAWs who received TRA.* A State must adjust of the maximum RTAA benefit for an RTAA-eligible AAW who has received TRA. The RTAA-eligible AAW may receive up to the adjusted RTAA benefit as described in this section within the eligibility period as provided in § 618.510(b). RTAA eligibility is terminated once the AAW reaches either the number of weeks permitted pursuant to § 618.510 or the adjusted RTAA benefit. The adjusted RTAA benefit is calculated by subtracting the number of TRA paid weeks

from the 104-week RTAA eligibility period to determine the percentage of reduced weeks that payments may be made. The maximum payable benefit of $10,000 is then reduced by the same percentage. Once the reduction in RTAA payable weeks and the reduction in the RTAA total payable are reduced by the same percentage, they become the new maximum number of payable weeks and maximum payable benefit.

(b) *Training and related services.* Recipients of RTAA are eligible to receive training approved under subpart F of this part and employment and case management services under subpart C of this part.

(c) *Job search and relocation allowances.* Recipients of RTAA are eligible to receive job search and relocation allowances under subpart D of this part, subject to the eligibility requirements and rules of subpart D.

(d) *HCTC.* Recipients of RTAA are eligible to apply for or claim the HCTC, if available.

(e) *TRA.* Once an AAW has received a payment under RTAA, the AAW is no longer eligible for TRA under the same petition. Receipt of TRA prior to RTAA will result in a reduction of RTAA benefits as described at paragraph (a)(4) of this section.

§ 618.525 Determinations, redeterminations, and appeals.

(a) *Determinations, redeterminations, and appeals.* States must apply the requirements of §§ 618.820 (determinations of eligibility; notices to individuals) and 618.828 (appeals and hearings), respectively, to all determinations, redeterminations, and appeals under this subpart.

(1) Before issuing a determination or redetermination, the State must verify and document the AAW's age, reemployment, and wages in determining whether the worker has met eligibility requirements of § 618.505(a).

(2) A determination of eligibility issued to an AAW must include a notice that the benefit amount will be regularly recomputed (as required by § 618.515(d)) and will change if the eligible AAW's reemployment wages change.

(3) An AAW denied individual eligibility based on nonqualifying reemployment may file a new application for a subsequent reemployment.

(4) A State may approve an RTAA payment retroactively if an AAW becomes reemployed before the Department issues a certification under subpart B of this part, provided that the AAW otherwise meets the eligibility requirements of § 618.505(a).

(b) *Recordkeeping requirements.* The recordkeeping and disclosure of information requirements of § 618.852 apply to the State's administration of RTAA.

§ 618.530 Reductions of Reemployment Trade Adjustment Assistance payments; priority of payments.

(a) *Ordered child support payments.* State laws regarding deductions of payments from UI, TRA, and RTAA must comply with the Social Security Act (SSA). SSA section 303(e)(1) defines child support obligations as only including obligations which are being enforced pursuant to a plan described in section 454 of SSA which has been approved by the Secretary of Health and Human Services under part D of title IV of SSA. SSA does not otherwise permit deductions for alimony or for child support.

(b) *Priority of UI payments.* RTAA does not fit into priority of payments under UI because RTAA is related to employment, not unemployment. UI and RTAA are two separate programs that operate independently of one another.

Subpart F—Training Services

§ 618.600 Scope.

This subpart sets forth the conditions and procedures under which a trade-affected worker may apply for and receive training to help secure reemployment. Training provided under this subpart must, at a reasonable cost and as quickly as possible, assist a trade-affected worker in obtaining the necessary skills to have a reasonable expectation of reemployment. All else being equal, States should prefer training that replaces 100 percent or more of a trade-affected worker's wages in adversely affected employment or that qualifies as suitable employment.

§ 618.605 General procedures.

(a) *Assessments.* The State must ensure and document that every trade-affected worker has an initial assessment and that a comprehensive and specialized assessment is made available, as described in subpart C of this part. If a worker refused to take an assessment, the information necessary to determine eligibility for training must be documented. If a trade-affected worker has an IEP, the assessment results must support the training program set out in the worker's IEP, as described in subpart C of this part, before an application for training is approved. As with assessments, if a worker refused to develop an IEP, the information necessary to determine eligibility for training must be documented.

(b) *Applications.* Applications for training, including requests for TAA Program-funded transportation and subsistence payments, must be made to the State in accordance with any policies and procedures established by the State.

(c) *Determinations.* Decisions on selection for, approval of, or referral of a trade-affected worker to training, including whether to provide TAA Program-funded transportation and subsistence payments, under this subpart, or a decision with respect to any specific training or nonselection, nonapproval, or nonreferral for any reason is a determination to which §§ 618.820 (determinations of eligibility; notices to individuals), 618.824 (liable State and agent State responsibilities), and 618.828 (appeals and hearings) apply.

(d) *Training opportunities.* (1) The State must explore, identify, and secure training opportunities to ensure trade-affected workers return to employment as soon as possible. States must use all necessary and reasonable means to find alternatives when local training resources cannot adequately train trade-affected workers for reemployment. Training resources may be inadequate when they cannot train workers quickly, or at a reasonable cost, or equip workers with skills that meet the demands of the job market.

(2) When available training is inadequate, TAA Program funds may be used to create customized, group training opportunities in response to a particular dislocation event. Funds may be used for trainings that provide intensive remedial education classes, English language training, or contextualized occupational training, which combines academic and occupational training. These group trainings must adhere to the principles described in § 618.600.

(3) States are required to coordinate with other public and private agencies, in cooperation with local workforce development boards (LWDBs) established under WIOA, to ensure a wide-range of training opportunities are available to trade-affected workers in demand occupations.

(e) *Timing of application and approval of training.* A trade-affected worker may apply for training and a State may approve training at any time after the certification date on which his or her worker group is certified under subpart B of this part, without regard to whether such worker has applied for or exhausted all rights to any UI to which the worker is entitled.

§ 618.610 Criteria for approval of training.

The State must consult the trade-affected worker's assessment results and IEP, if available, as described respectively under §§ 618.345 and 618.350, before approving an application for training. Training must be approved for a trade-affected worker if the State determines that all of the criteria in paragraphs (a) through (f) of this section are met:

(a) *Criterion 1.* There is no suitable employment available for the trade-affected worker.

(1) There is no suitable employment available for a trade-affected worker in either the commuting area or another area outside the commuting area to which the worker intends to relocate, and there is no reasonable prospect of such suitable employment becoming available for the worker in the foreseeable future.

(2) If a training program, or an application for training, is denied under paragraph (a)(1) of this section, the State must document the availability of suitable employment through traditional and real-time labor market information including, but not limited

to, projections data, job postings, and job vacancy surveys.

(b) *Criterion 2.* The trade-affected worker would benefit from appropriate training.

(1) The worker would benefit from appropriate training when training, skills training, or remedial education would increase the likelihood of obtaining employment. Appropriate training should improve the worker's chances of obtaining employment at higher wages than in the absence of training or place the worker on a pathway to do so.

(2) The worker must have the knowledge, skills, and abilities to undertake, make satisfactory progress in, and complete the training program.

(c) *Criterion 3.* There is a reasonable expectation of employment following completion of such training. Given the labor market conditions expected to exist at the time of the completion of the training program, a reasonable expectation, fairly and objectively considered, exists that the trade-affected worker is likely to find employment, using the skills and education acquired while in training, upon completion of approved training. The labor market conditions considered must be limited to those in the worker's commuting area, or in the area where the worker intends to relocate.

(1) ''A reasonable expectation of employment'' does not require that employment opportunities for the worker be available, or offered, immediately upon the completion of the approved training program. When initially approving such training, there must be a projection, based on labor market information, of employment opportunities expected to exist at the time of completion of the training program.

(2) The State must measure expected job market conditions using pertinent labor market data, including but not limited to job order activity, short-term projections data, job vacancy surveys, business visitation programs, and local and regional strategic plans. This labor market information should be documented in the trade-affected worker's case file. The State should also work with the LWDBs and their one-stop partners, especially business team members, to understand current labor market conditions and opportunities for work-based learning.

(3) When a worker desires to relocate within the United States, but outside the worker's present commuting area, upon completion of training, the State must document the labor market information, described in paragraph (c)(2) of this section, for the area of the planned relocation.

(4) A reasonable expectation of employment may exist in a limited demand occupation for a single, trained worker in the worker's commuting area or in an area to which the worker desires to relocate. A limited demand for such an occupation does not preclude the approval of training in an occupation where the State has determined that there is a reasonable expectation that the worker can secure employment in that occupation. States must verify with businesses in the commuting area or in the area of intended relocation that demand exists for an individual with such training. These efforts must be documented in the trade-affected workers case file. Before approving training in occupations with limited demand, the State must consider the number of individuals currently enrolled in training that are likely to meet that demand before enrolling additional workers in training for that occupation.

(5) A State may approve a training program in an occupation if it finds that there is a reasonable expectation that the training will lead to self-employment in the occupation for which the worker requests training and that such self-employment will provide the worker with wages or earnings at or near the worker's wages in adversely affected employment.

(6) Training programs that consist solely of OJT or contain an OJT component are not approvable if they are not expected to lead to suitable employment, with the employer providing the OJT, in compliance with section 236(c)(1)(B)(i) of the Act.

(d) *Criterion 4.* Training is reasonably available to the trade-affected worker. In determining whether training is reasonably available, States must first consider training opportunities available within the worker's commuting

area. States may approve training outside the commuting area if none is available at the time in the worker's commuting area. Whether the training is in or outside the commuting area, the training program must be available at a reasonable cost as prescribed in paragraph (f) of this section.

(e) *Criterion 5.* The trade-affected worker is qualified to undertake and complete such training. States must ensure the following:

(1) The worker's knowledge, skills, abilities, educational background, work experience, and financial resources are adequate to undertake and complete the specific training program being considered.

(2) Any initial assessment, comprehensive and specialized assessment, and IEP developed under subpart C of this part must be consulted to support the trade-affected worker's ability to undertake and complete the training program.

(3) Where the worker's remaining available weeks of UI and TRA payments will not equal or exceed the duration of the training program, that the worker will have sufficient financial resources to support completion of the training program within the time limits noted in § 618.615(d). In making this determination, the State must consider:

(i) The worker's remaining weeks of UI and TRA payments in relation to the duration of the proposed training program;

(ii) Other sources of income support available to the worker, including severance, earnings of other family members, and other family resources;

(iii) Other fixed financial obligations and expenses of the worker and family;

(iv) The availability of Federal student financial assistance or any State-funded student financial assistance or any private funding designated for student financial assistance including, but not limited to, nongovernmental scholarships, awards, or grants; and

(v) Whether or not the worker is employed while attending training.

(4) The State must document whether or not the trade-affected worker has sufficient financial resources to complete the training program that exceeds the duration of UI and TRA payments.

(5) If a worker has insufficient financial resources to complete the worker's proposed training program that exceeds the duration of UI and TRA payments, then the State must not approve that training program and must instead consider other training opportunities available to the worker.

(f) *Criterion 6.* Such training is suitable for the trade-affected worker and available at a reasonable cost.

(1) *Suitable for the worker.* The training program being considered must address the criteria set out in paragraphs (e)(1) and (2) of this section and be determined by the State to be appropriate given the worker's knowledge, skills and abilities, background, and experience relative to the worker's employment goal, and criteria set out in paragraph (c) of this section.

(2) *Available at a reasonable cost.* (i) Costs of a training program may include, but are not limited to, tuition and related expenses (e.g., books, tools, computers and other electronic devices, internet access, uniforms and other training-related clothing such as goggles and work boots, laboratory fees, and other academic fees required as part of the approved training program) as well as supplemental assistance (subsistence expenses and transportation expenses as described in § 618.640(c) and (d)). States must pay the costs of initial licensing and certification tests and fees where a license or certification is required for employment.

(A) The State must ensure and document that the training program costs are reasonable by researching costs for similar training programs, whether it is classroom or work-based training.

(B) Related expenses must be necessary for the worker to complete the training program. Other options should be explored before purchasing equipment or related materials.

(ii) Available at a reasonable cost means that training must not be approved at one provider when, all costs being considered, training better or substantially similar in quality, content, and results can be obtained from another provider at a lower total cost *COM007*within a similar time frame. Training

must not be approved when the costs of the training are unreasonably high in comparison with the average costs of training other workers in similar occupations at other providers. The State may approve a higher cost training if that training is reasonably expected to result in a higher likelihood of employment, employment retention, or greater earnings, or to return the worker to employment in a significantly shorter duration.

(iii) Training at facilities outside the worker's commuting area requiring transportation or subsistence payments that add substantially to the total cost of the training program may not be approved if other appropriate training is available in the commuting area at a lower cost, unless the exception described in paragraph (f)(2)(ii) of this section applies.

(iv) Approval of training under paragraph (f) of this section (Criterion 6) is also subject to the provisions of § 618.650.

§ 618.615 Limitations on training approval.

(a) *One training program per certification.* (1) Except as provided under paragraph (d)(4) of this section, no trade-affected worker may receive more than one approved training program under a single certification.

(2) A training program may be amended, as needed, in compliance with § 618.665.

(3) A training program may consist of multiple forms of training, including any or all of the types of training identified in § 618.620, subject to any restrictions or eligibility requirements that may exist.

(b) *Full-time or part-time training.* A State may approve a training program on a full-time or part-time basis. A trade-affected worker's approved training program may consist of either part-time or full-time training, or a combination of both. A worker may switch from part-time to full-time training or from full-time to part-time training during the period of the worker's participation in the program. The training program must be amended each time this occurs, in accordance with § 618.665.

(1) *Full-time.* Full-time training means that the training is in accordance with the definition of *full-time training* provided in § 618.110.

(2) *Part-time.* (i) A State may approve part-time training. Part-time training is any training program that is not full-time in accordance with the established standards of the training provider. The maximum duration for approved training provided in paragraph (d)(3)(i) of this section also applies to part-time training.

(ii) A worker enrolled in part-time training is not eligible for TRA under subpart G of this part, including a worker who ceases full-time training to engage in part-time training. The training approval requirements found in this section also apply to part-time training.

(iii) A worker may participate in part-time training while employed in either part-time or full-time employment.

(iv) The State must clearly inform the worker, before the worker chooses part-time training, that TRA is not available to workers in approved part-time training and that the worker may lose eligibility for the HCTC, if available, while engaged in part-time training.

(v) As provided in § 618.780(b)(1)(i), a worker may not be determined to be ineligible or disqualified for UI, because the worker is enrolled in training approved under § 618.610, including part-time training.

(vi) As further described at § 618.780(b)(1)(ii), State or Federal UI statutes relating to the able, available, or active work search requirements as well as refusal to accept work will not disqualify a worker for UI or other program benefits, during any week of training approved under § 618.610, including part-time training.

(c) *Previous approval of training under other law.* When a TAA Program petition has been filed by or on behalf of a group of workers but a determination of group eligibility has not been made, training may be approved for a worker under another State or Federal law or other authority. Training approved for a worker under another State or Federal law or other authority is not training approved under § 618.610. After

eligibility has been determined, any such training may be approved under § 618.610 (criteria for approval of training), if it meets all of the requirements and limitations of § 618.610 and the other provisions of this subpart. Such approval must not be retroactive for any of the purposes of this part, including payment of the costs of the training and payment of TRA to the trade-affected worker participating in the training, except in the case of a redetermination or decision reversing a training denial as addressed in § 618.828(d), in which case the approval must be retroactive to the date of that denial. Systems must be in place to accommodate a change in funding seamlessly, as appropriate, after TAA Program training program approval is obtained. The cost of training must shift to the TAA Program at the next logical break in training—such as the end of a semester—for workers who become eligible for the TAA Program and whose training is approved under the TAA Program. Training approved under other programs may be amended by the TAA Program to allow a worker additional training in order to meet additional retraining needs identified in the worker's IEP.

(d) *Length of training.* The State, in determining whether to approve a training program, must determine the appropriateness of the length of training, as follows:

(1) *Time necessary to achieve desired skill level.* The training must be of suitable duration to achieve the desired skill level in the shortest possible time, and not in excess of, the limits established in paragraph (d)(3) of this section.

(2) *Factors.* Factors that may impact the length of training include, but are not limited to, the trade-affected worker's employment status (full- or part-time) under § 618.630 (Training of reemployed trade-affected workers), the need for supportive services from partner programs, and breaks in training due to class schedules and availability.

(3) *Duration.* (i) Except as otherwise provided for OJT, apprenticeship, and the exception provided in paragraph (d)(4) of this section, the maximum duration for approvable training under the TAA Program is 130 weeks.

(ii) Only weeks spent in actual training are counted. Scheduled breaks in training, as provided in § 618.760, are not counted.

(iii) If a training program satisfies the duration requirement of paragraph (d)(3)(i) of this section but will extend beyond the period during which TRA is available, the State must determine, under § 618.610(e)(3) (criteria for approval of training), whether the worker has sufficient personal resources (*i.e.*, funds for the worker's living expenses) to support himself or herself while completing the training, while not requiring the worker to obtain such funds as a condition of training approval. The worker must attest to the State that he or she has sufficient resources to sustain himself or herself while in training.

(4) *Exception for certain workers who perform a period of duty in the Uniformed Services.* A member of one of the reserve components of the U.S. Armed Forces who serves a period of duty will have the period for training, under paragraph (a)(3) of this section, suspended upon being called up to duty, provided the requirements specified in paragraphs (a)(4)(i) through (iii) of this section are met. Any such reserve component member may either resume training upon discharge from active service for the training period that remained at the time the reservist left the training program to report for active duty, or be allowed to repeat portions of the training if doing so is necessary for completion of the approved training program or, where appropriate, begin a new approved training program. Where the reservist repeats a training program or begins a new training program, the reservist will be entitled to a new 130-week period to complete approved training. To be eligible to resume, repeat, or begin a new approved training program, the reservist must meet the following requirements:

(i) Before completing training under this subpart, the worker has given prior oral or written notice of the active duty service to the State, unless providing such notice is precluded by military necessity or is otherwise impossible or unreasonable.

(ii) The returning service member must apply to the State for training within 90 days following release from active duty service.

(iii) For purposes of the exception in this paragraph (d)(4), period of duty means:

(A) Serves on active duty for a period of more than 30 days under a call or order to active duty of more than 30 days; or

(B) In the case of a member of the Army National Guard of the United States or Air National Guard of the United States, performs full-time National Guard duty under 32 U.S.C. 502(f) for 30 consecutive days or more when authorized by the President or the Secretary of Defense for the purpose of responding to a national emergency declared by the President and supported by Federal funds.

(e) *Training outside the United States.* A trade-affected worker must not be approved for training under this subpart for any training that is conducted totally or partially at a location outside the United States or if the worker is physically located outside the United States while participating in training. For distance training, this means both the provider and participant must be located within the United States.

§ 618.620 Selection of training program.

(a) *Standards and procedures for selection of training.* The State must document the standards and procedures used to select training providers and training(s) in which the training program under this subpart will be approved.

(1) In determining the types of training to be approved and provided under the standards, the State should consult with partner agencies, including State partner agencies (e.g., State apprenticeship agencies or Federal Offices of Apprenticeship located in the States), WIOA one-stop partners, local employers, appropriate labor organizations, local educational organizations, the LWDB, State and local apprenticeship programs, local advisory councils established under the Strengthening Career and Technical Education for the 21st Century Act (Pub. L. 115–224 (2018), as codified at 20 U.S.C. 2301 *et seq.*), and postsecondary institutions.

(2)(i) States may choose an eligible training provider (ETP) established under WIOA section 122 without establishing additional standards or procedures under the TAA Program.

(ii) As provided in section 236 of the Act, States must not limit training approved under this section to only programs on the ETP list under title I of WIOA.

(b) *Training types.* Eligible trade-affected workers must be provided training using either one, or a combination of, the following methods:

(1) Work-based training, such as apprenticeships, OJT, or customized training, may be approved for AAWs. Customized training with the worker's current employer may only be approved for AAIWs if the training is for a position other than the AAIW's threatened position. See § 618.655(c)(2). AAIWs must not be approved for OJTs. See § 618.655(c)(1). The State must inform the worker of the potential negative effects of work-based training on TRA and the HCTC, if available; or

(2) Institutional training, including training at public area career and technical education schools, as well as community colleges, may be approved alone or in combination with work-based training. This also includes distance learning, including online training, where a worker may complete all or part of an educational or vocational program in a geographical location apart from the institution hosting the training program, and where the final certificate or degree conferred is equivalent in standard of achievement and content to the same program completed on campus or at another institutional training location.

(i) A provider of the distance learning must be based in the United States for training provided to be approved. In addition, the worker must be physically within the United States when participating in distance learning to remain eligible for benefits under the Act.

(ii) Distance learning is subject to all training approval criteria described in this subpart.

(iii) The State must establish and monitor the milestones of a distance-

learning program based on the worker's IEP, as described in subpart C of this part, if available.

(iv) A worker who does not meet the requirements or milestones of a distance-learning program may be determined to have ceased participation in training, as described in § 618.780(b)(3)(ii).

(3) Higher education includes any training or coursework at an accredited institution, as described in section 102 of the Higher Education Act of 1965, as amended (20 U.S.C. 1002), including training or coursework for the purpose of obtaining a degree or certification, or for completing a degree or certification that the worker had begun previously at an accredited institution of higher education. Higher education may be approved alone or in combination with work-based training. The distance learning requirements in paragraph (b)(2) of this section also apply to this paragraph (b)(3).

(c) *Other training.* In addition to the training programs discussed in paragraph (b) of this section, training programs that may be approved under § 618.610 (criteria for approval of training) include, but are not limited to:

(1)(i) Any program of remedial education, including ABE courses and other remedial education courses, ELA courses, and HSE preparation courses.

(ii) Remedial education may occur before, or while participating in, the requested training program;

(2) Career and technical education;

(3) Any training program approvable under § 618.610 for which all, or any portion, of the costs of training the trade-affected worker are paid:

(i) Under any other Federal or State program other than the TAA Program; or

(ii) From any source other than this part;

(4) Any training program provided by a State pursuant to title I of WIOA or any training program approved by an LWDB established under section 102 of WIOA;

(5) Any program of prerequisite education or coursework required by a training provider before advancing to further training; or

(6) Any other training program approved by the State that complies with this subpart.

(d) *Advanced degrees.* Training programs that will lead to an advanced degree may be approved; however, the time limits described at § 618.615(d)(3) must be met. States may not restrict access to advanced degrees where the other criteria of this subpart are met. All training programs must be evaluated on their individual merit.

§ 618.625 Payment restrictions for training programs.

(a) *Funding of training programs.* The costs of a training program approved under the Act may be paid:

(1) Solely from TAA Program funds;

(2) Solely from other public or private funds; or

(3) Partly from TAA Program funds and partly from other public or private funds.

(b) *No duplication of costs allowed.* (1) Any use of TAA Program funds to duplicate the payment of training costs by another source is prohibited.

(2) When the payment of the costs of training has already been made under any other Federal law, or the costs are reimbursable under any other Federal law and a portion of the costs has already been paid under other such Federal law, payment of such training costs may not be made from TAA Program funds.

(3) When the direct costs of a training program approvable under § 618.610 (criteria for approval of training) are payable from TAA Program funds and are also wholly or partially payable from any other source, the State must establish procedures to ensure TAA Program funds will not duplicate funds available from the other source(s). This preclusion of duplication does not prohibit and should not discourage sharing of costs under prearrangements authorized under paragraph (c)(2) of this section.

(c) *Cost sharing permitted.* (1) TAA Program funds are the primary source of Federal assistance to trade-affected workers, as identified in § 618.804(h)(4). If the costs of training a trade-affected worker can be paid under the TAA Program, no other payment for such costs

may be made under any other provision of Federal law.

(2) States may share training costs with authorities administering other non-Federal, State, and private funding sources. Sharing training costs with other Federal sources may only occur if TAA Program funds are not available to cover the total cost of training, as described in paragraph (d)(2)(ii) of this section.

(3) Sharing the future costs of training is authorized where prior costs were paid from another source, but this paragraph (c)(3) does not authorize reimbursement from TAA Program funds of any training costs that were accrued before the date the training program was approved under the TAA Program.

(4) When a mix of TAA Program funds and other funds are used for paying the costs of a training program approved under this subpart, the State must enter into a prearrangement with any entity providing the other source of funds. Any such prearrangement must contain specific commitments from the other authorities to pay the costs they agree to assume and must comply with the nonduplication provisions contained in this part.

(i) Agreements may be entered into on a case-by-case basis to address specific training situations of workers or they may be part of an overall statewide strategy to effectively use and maximize available resources from the TAA Program, workforce development, and other programs.

(ii) Where training costs are shared between the TAA Program and any other funding source, the State must enter into a prearrangement with the other funding source to agree upon the proportion of TAA Program funds and other funds to be used to pay the costs of a training program. A prearrangement must be a specific, binding agreement with the other source(s) to pay the costs they agree to assume, and must be entered into before any TAA Program funds are obligated. If, after TAA Program funds are already committed to a training program, other funds become available to pay for that training, the State may decide to share the costs of the remainder of training program or the State may continue funding the training program in full using TAA Program funds. If the State decides to share the costs, it must enter into a prearrangement with respect to the newly available funds. If the State makes a change to how the training program will be funded going forward, the existing training program must be amended in accordance with § 618.665.

(iii) Before approving any training program under this subpart, which may involve the sharing of training costs under the authority of paragraph (a)(3) of this section, the State must require the worker to enter into a written agreement with the State, under which TAA Program funds will not be applied for or used to pay any portion of the costs of the training the worker has reason to believe will be paid by any other source.

(5)(i) A State may not take into account Federal student financial assistance, including Pell Grants, or any funds provided under any other provision of Federal law that are used for purposes other than the direct payment of training costs, even though they may have the effect of indirectly paying all or a portion of the training costs.

(ii) States must ensure that upon the approval of a training program under this subpart, payments of Federal student financial assistance cease to be applied to the training participant's tuition or other training-related costs covered by TAA Program funds.

(iii) If payments of Federal student financial assistance or other training allowances from other Federal funding sources were made to the training provider instead of the worker and were applied towards the worker's approved training costs, the State must deduct the amount of those other payments from the amount of TAA Program funds payable to the training provider in order to prevent duplication in the payment of training costs.

(iv) A worker may use Federal student financial assistance for other expenses, as allowable under applicable rules for such financial assistance.

(6) If the worker's trade-affected firm agrees to fund all or a portion of the worker's training costs, the State must, if the training is otherwise approvable, enter into a prearrangement

with the firm to assume any unfunded training costs on the worker's behalf.

(d) *No training fees or costs to be paid by trade-affected worker from TAA Program funds.* (1) A training program must not be approved if the trade-affected worker is required to reimburse any portion of the costs of such training program from TAA Program funds, or from wages paid under such training program.

(2)(i) A training program must not be approved if the trade-affected worker is required to pay any of the costs of the training program from funds belonging to the worker, including funds from relatives or friends, or from personal or educational loans that will require repayment.

(ii) As required by § 618.940, if the Department determines that the amount of funds necessary to provide Training and Other Activities (TaOA) will exceed the annual cap under § 618.900 in a fiscal year, the Department will promptly inform the States. If a State estimates that it will exceed all available TAA Program training funds (including TaOA funds remaining from current or prior fiscal years) then the State must seek funding from other sources (other than from trade-affected workers), including WIOA national dislocated worker grants under part 687 of this chapter to cover the costs of training approved under § 618.610. To the extent that a State is unable to fund training costs from those other sources, the agency may approve training where the worker pays those unfunded costs. Where the worker chooses to pay those unfunded costs under this paragraph (d)(2)(ii), the State is not liable for paying those costs and must document this prearrangement in the worker's case file. Where the worker chooses not to pay the unfunded costs, the State must waive the training requirement in § 618.720(g) on the basis that training is not available, in order to preserve any remaining Basic TRA eligibility under § 618.735(b)(3) (waiver of training requirement for Basic TRA).

§ 618.630 Training of reemployed trade-affected workers.

(a) An AAW who obtains new employment and who has been approved for a training program may elect to terminate the employment, reduce the hours worked in the employment, or continue in full- or part-time employment. Such a worker is not subject to ineligibility or disqualification for UI or TRA as a result of such termination or reduction in employment. A worker who continues such full- or part-time employment while a participant in training is considered to be in training under § 618.780(b) (disqualifications). If the worker continues in full- or part-time employment while a participant in an approved training program, the State must inform the worker in writing that such employment may have negative effects on UI and TRA benefit amounts and duration due to income earned from the employment (and also because a worker participating in part-time training is not eligible for TRA), which could also lead to the loss of the HCTC, if available. The State must apply the earnings disregard provisions in subpart G of this part, as appropriate.

(b) An AAW who has been totally separated as described in paragraph (a) of this section may also be eligible for job search and relocation allowances under subpart D of this part.

§ 618.635 Work-based training.

(a) *OJT*—(1) *Description.* OJT is work-based training provided under contract with an employer in the public, non-profit, or private sector to an AAW who is employed by the employer. OJT may be approved if the worker meets the requirements under §§ 618.610, 618.615, and 618.665. The State must determine that the OJT in question:

(i) Can reasonably be expected to lead to suitable employment with the employer offering the OJT;

(ii) Is compatible with the skills of the worker;

(iii) Includes a curriculum through which the worker will gain the knowledge or skills to become proficient in the job for which the worker is being trained; and

(iv) Can be measured by standards or targets that indicate the worker is gaining such knowledge or skills.

(2) *Related education.* Related skills training provided as part of the OJT

contract and sponsored by the employer may be provided in conjunction with the OJT. Such training may be provided at the employment site, or at educational institutions, or other locations. TAA Program funds can be used to pay the OJT participant's expenses associated with the educational or instructional component (e.g., classroom and distance learning, tools, uniforms, equipment, and books) for an AAW's participation in an OJT program.

(3) *Duration.* The OJT contract with the employer must specify the duration of the OJT. The duration of the OJT must be appropriate to the occupational goal for which the AAW is being trained, taking into consideration the skills requirements of the job for which the AAW is being trained, the academic and occupational skill level of the AAW, and the work experience of the AAW, as documented in the worker's IEP, if available. The duration of the training must be long enough for the worker to become sufficiently proficient in the occupation for which the training is being provided to enable the worker to perform as well as workers in comparable positions within the firm. The OJT:

(i) Must not exceed the specific vocational preparation required for the occupation, as listed on O*NET (*www.onetonline.org*); and

(ii) Must not exceed 104 weeks in any case.

(4) *Exclusion of certain employers.* The State may not enter into a contract for OJT with an employer that exhibits a pattern of failing to provide workers receiving OJT from the employer with:

(i) Continued long-term employment as regular employees; and

(ii) Wages, benefits, and working conditions that are equivalent to the wages, benefits and working conditions provided to regular employees who have worked a similar period of time and are doing the same type of work as workers receiving the OJT from the employer.

(5) *Reimbursement.* (i) Pursuant to the OJT contract, the employer is provided reimbursement of not more than 50 percent of the wage rate of the OJT participant, for the costs of providing the training and additional supervision related to the training.

(ii) The reimbursement for OJT must be limited to the duration of approved training as specified in the OJT contract.

(6) *Approval of the costs of OJT.* OJT costs for an AAW may be approved by a State only if a determination is made that:

(i) No currently employed individual is displaced (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) by the AAW;

(ii) Such training does not impair existing contracts for services or collective bargaining agreements;

(iii) In the case of training that would be inconsistent with the terms of a collective bargaining agreement, written concurrence has been obtained from the concerned labor organization;

(iv) No other individual is on layoff from the same or any substantially equivalent job for which the AAW is being trained;

(v) The employer has not terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy by hiring the AAW;

(vi) The job for which the AAW is being trained is not being created in a promotional line that will infringe in any way upon the promotional opportunities of currently employed individuals;

(vii) The training is not for the same occupation from which the AAW was separated with respect to which the AAW's worker group is covered under a certification rendered under subpart B of this part;

(viii) The employer has not received payment under the TAA Program or under any other Federal law for any other OJT provided by such employer that failed to meet the requirements of this section or the requirements of the other Federal laws governing employment practices; and

(ix) The employer has not taken, at any time, any action that violated the terms of this section with respect to any other OJT provided by the employer for which the State has made a payment under the TAA Program.

(7) *Payment of the costs of OJT.* The costs of OJT that are paid from TAA

Program funds must be paid in monthly installments.

(8) *TRA eligibility during OJT.* Under § 618.780(c), an AAW may not be paid TRA for any week during which the worker is in OJT and, therefore, may be ineligible for the HCTC, if available.

(9) *RTAA eligibility during OJT.* Participants enrolled in OJT may be eligible for RTAA. All the requirements at subpart E of this part must be met.

(10) *Use of WIOA funds for OJT.* TAA Program funds may be leveraged with WIOA funds to provide a reimbursement rate equal to that allowable under WIOA. See WIOA section 134(c)(3)(H) (29 U.S.C. 3174(b)(3)(H)).

(11) *No OJT for AAIWs.* The State must not approve OJT for AAIWs.

(b) *Customized training.* (1) Customized training is designed to meet the special requirements of a single employer or a group of employers. The training may be conducted by a training provider, a single employer, or group of employers.

(2) Customized training must be conducted with a commitment by the employer or group of employers to employ an AAW upon successful completion of the training. For purposes of customized training, a commitment by the employer(s) to employ a worker upon successful completion of the training, as required by section 236(f)(2) of the Act, means that the employer(s) must enter into an agreement with the State that describes the conditions that must be met for successful completion of the training and the expectation of employment after the training is completed.

(3) The employer must pay at least 50 percent for the cost of the training.

(4) For AAIWs, approval is limited to customized training for a position other than their current position in adversely affected employment. See § 618.655(c)(2).

(c) *Apprenticeship.* Apprenticeship includes registered apprenticeships under the Act of August 16, 1937 (commonly known as the National Apprenticeship Act; 50 Stat. 664, chapter 663; 29 U.S.C. 50 *et seq.*), as well as other training programs that include a paid work-based learning component and required educational or instructional component that results in the issuance of a recognized postsecondary credential, which includes an industry-recognized credential.

(1) *Duration.* Apprenticeships are not subject to the 104-week statutory duration of OJT training limit. The length of the paid work-based learning component must not exceed 130 weeks. However, the length of the educational or instructional training component of the apprenticeship may exceed 130 weeks and continue through the scheduled completion of that specific apprenticeship training.

(2) *Eligible apprenticeship expenses.* TAA Program funds can be used to pay for:

(i) The expenses associated with the educational or instructional component (e.g., classroom and distance learning, tools, uniforms, equipment, and books) for the apprentice; and

(ii) The employer may be reimbursed not more than 50 percent of the apprentice's regular wage rate for the cost of providing the training and additional supervision related to the work-based learning component provided by the employer.

(3) *Exclusion of certain employers.* The State may not enter into a contract for apprenticeship with an employer that exhibits a pattern of failing to provide apprentices with successful attainment of an industry-recognized credential or the apprenticeship completion certificate in the case of registered apprenticeship, as issued by the U.S. Department of Labor or State apprenticeship agency.

(4) *Approval of the costs of apprenticeship*—(i) *Registered apprenticeships under the National Apprenticeship Act.* Costs for an apprenticeship program may be approved by a State only if the requirements of the National Apprenticeship Act, 29 CFR parts 29 and 30, and Departmental administrative guidance are met.

(ii) *Other apprenticeships.* Costs for an apprenticeship program may be approved by a State only if a determination is made that:

(A) No currently employed worker is displaced (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) by the apprentice;

(B) Such training does not impair existing contracts for services or collective bargaining agreements;

(C) In the case of training that would be inconsistent with the terms of a collective bargaining agreement, written concurrence has been obtained from the concerned labor organization;

(D) No other worker is on layoff from the same or any substantially equivalent job for which the apprentice is being trained;

(E) The employer has not terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created by hiring the apprentice;

(F) The job for which the apprentice is being trained is not being created in a promotional line that will infringe in any way upon the promotional opportunities of currently employed workers;

(G) The training is not for the same occupation as the apprentice's adversely affected employment;

(H) The employer has not received payment under the TAA Program or under any other Federal law for any other apprenticeship provided by such employer that failed to meet the requirements of this section or the requirements of the other Federal laws governing employment practices; and

(I) The employer has not taken, at any time, any action that violated the terms of this section with respect to any other apprenticeship provided by the employer for which the State has made a payment under the TAA Program.

(5) *TRA and HCTC eligibility during apprenticeships.* Workers enrolled in an apprenticeship program, in most cases, will not be able to access TRA income support due to their income earned through wages, but the State must still make individual determinations on TRA benefits. This could also impact HCTC eligibility, if HCTC is available. States must advise workers considering this training option of these issues.

(6) *RTAA eligibility during apprenticeships.* AAWs age 50 or older enrolled in an apprenticeship program may be eligible for RTAA under subpart E of this part.

(7) *State contract with apprenticeship employer.* The State must enter into a contract with the employer that provides the terms and conditions of the apprenticeship.

§ 618.640 Supplemental assistance.

(a) *General.* Supplemental assistance in the form of subsistence and transportation payments must be provided to a trade-affected worker whose training program has been approved under § 618.610 (Criteria for approval of training), to defray reasonable subsistence and transportation expenses while the worker attends training at a facility outside the worker's commuting area. The need for such subsistence and transportation payments must be documented on the worker's IEP, if available, or in the worker's case file. Subsistence and transportation payments may also be documented on a training approval form, or other such form as the State chooses, to ensure that the supplemental assistance is documented in the worker's case file.

(b) *Applications for supplemental assistance.* A trade-affected worker must submit an application for subsistence or transportation payments in accordance with subpart H of this part and processes established by the State. A determination on an application submitted under this section is subject to §§ 618.820 (determinations of eligibility; notices to individuals) and 618.828 (appeals and hearings).

(c) *Subsistence payments*—(1) *General.* Subsistence payments must be made for the reasonable costs of meals and incidental expenses, and of separate maintenance, which means maintaining temporary living quarters, when the training facility is located outside the trade-affected worker's commuting area.

(2) *Requirements for subsistence payments.* (i) A trade-affected worker must be reimbursed for subsistence only for the period when the worker is not receiving or authorized to receive reimbursement or separate payments for such costs from any other source.

(ii) Subsistence payments must not be made for any day such worker receives a daily commuting transportation payment from TAA Program funds or from any other source, except

as specified in paragraph (e) of this section.

(iii) Subsistence payments must not be made for any day of unexcused absence from the training program, as certified by the training provider.

(3) *Amount of subsistence payments.* The State may make a subsistence payment to a trade-affected worker only for the lesser of:

(i) The worker's actual per diem expenses for subsistence; or

(ii) 50 percent of the prevailing per diem allowance rate authorized under the FTR (see 41 CFR chapters 300 through 304) for the location of the training facility.

(4) *Timing of subsistence payments.* The State must make subsistence payments upon a worker's completion of a week of training, but may advance a subsistence payment for a week if the State determines that such advance is necessary to enable the worker to participate in the approved training.

(d) *Transportation payments.* A trade-affected worker must be reimbursed for transportation expenses when commuting to and from a training facility located outside the worker's commuting area. Transportation expenses, funded by the TAA Program, are payable only for the actual days traveled. Mileage eligible for reimbursement is, round-trip, from the first mile outside the boundary of the worker's commuting area to the location of the training facility.

(1) Transportation payments must not be paid when:

(i) Transportation is arranged and paid for by the State for one or more workers;

(ii) Such payments are being provided under any other law; or

(iii) The worker is authorized to be paid or reimbursed for such expenses from any other source.

(2) The daily transportation payment may not exceed the amount of a daily subsistence payment that would be payable under paragraph (c)(3) of this section if the worker resided temporarily in the area of the training.

(3) In addition, while other forms of transportation may be used, transportation payments to a worker may not exceed the cost per mile at the prevailing personal vehicle mileage rate authorized under the FTR. See *http://www.gsa.gov*.

(4) A worker must receive transportation payments promptly after completion of a week of approved training, but at a minimum on a monthly basis. These payments also may be made in advance in order to facilitate the worker's attendance at the training.

(e) *When payment can be made for both subsistence and transportation.* A trade-affected worker receiving subsistence payments may also receive transportation payments only:

(1) At the beginning of the training that the worker is attending outside the worker's commuting area and at the end of the training for travel back to the worker's commuting area; or

(2) When the worker fails, for justifiable cause, as described in §618.780(b)(3)(iii), to complete the training outside the worker's commuting area, and must return home before the scheduled end of the training.

(f) *Adjustments to subsistence and transportation payment advances.* If the State advances subsistence or transportation funds, the State must adjust subsequent subsistence and transportation payments to take into account the amount of the advance that is more or less than the amount that the trade-affected worker is entitled to receive under paragraphs (c) and (d) of this section.

(g) *Worker evidence.* The trade-affected worker must provide receipts for all lodging, purchased transportation expenses, and meals.

§618.645 Voluntary withdrawal from a training program.

(a)(1) The State must advise a trade-affected worker who chooses to withdraw from a TAA approved training program that the withdrawal may, subject to the requirements in subpart H of this part, result in an overpayment.

(2) The State must advise a worker who chooses to withdraw from a TAA approved training program that the withdrawal may, subject to the requirements in subpart G of this part, result in loss of eligibility for TRA.

(b) A trade-affected worker who qualifies for an exception for service in

the Uniformed Services, under the criteria set out in § 618.615(d)(4), may voluntarily withdraw from a training program.

(c) A trade-affected worker who ceases participation in training for justifiable cause, as described in § 618.780(b)(3)(iii) (disqualifications), may resume the approved training program.

(d) The trade-affected worker's eligibility for job search and relocation allowances will not be affected by the decision to withdraw from training. To be eligible for these allowances, the worker must meet all eligibility requirements for these benefits as set forth in §§ 618.410 (job search allowances) and 618.440 (relocation allowances).

(e) If the trade-affected worker obtains suitable employment before training is completed yet remains in his or her training program:

(1) The State must continue funding the approved training program if training benchmarks, described at § 618.660, continue to be satisfactorily met.

(2) The State must consider whether to amend the worker's training program; and

(3) The State must discuss with the worker whether the training program continues to serve a useful purpose.

§ 618.650 State standards and procedures for establishing reasonable cost of training.

(a) A State is not prohibited from setting a statewide limit or limits for local workforce development areas on the amount of training costs considered reasonable and appropriate for training programs. Any limit(s) must reasonably take into account the costs of training available in the local workforce development areas throughout the State and the expenditure must be prudent under the standards of the Office of Management and Budget's (OMB's) Uniform Guidance (2 CFR 200.404) and its attendant interpretive administrative guidance. Additionally, States must comply with the standards for reasonableness in § 618.610(f)(2), including those permitting States to allow training other than the least-cost option if the extra cost is justified by better trade-affected worker outcomes or a faster return to the workforce. If the State chooses to implement a statewide limit, it must arrive at a reasonable limit based upon training costs throughout the State, recognizing that costs may vary significantly between urban areas and rural areas. The State must also develop and implement a method to exceed the limit(s), which must require the local area to secure State approval, as described in paragraph (b) of this section, before training is approved.

(b) The State must develop transparent standards and procedures that provide for prompt consideration of any request for approval of training costs that exceed the established training cost limit(s) set by the State under paragraph (a) of this section. The review standards developed by the State under this paragraph (b) must allow for approval of costs that exceed the applicable training cost limit when a training program that exceeds the cost limit(s) will provide the most reasonable way of returning a particular trade-affected worker to employment at higher wages—or on a pathway to do so—than in the absence of training.

(c) The State must propose an alternative training program consistent with the reasonable cost criteria, as described at § 618.610, when a training program is not approvable under the established limits and does not meet the requirements in paragraph (b) of this section.

(d) The State must review any limits established under paragraph (a) of this section on an annual basis to determine whether they are still appropriate, and change or end such limits when they no longer reasonably reflect the average cost of training available in the local workforce development areas throughout the State.

(e) Whenever a State establishes, changes, or ends State-established limits on training costs payable under paragraph (a) of this section, the State must provide written notice and full documentation supporting its action to the Department for review.

(f) States are not required to establish a limit on training costs.

§ 618.655 Training for adversely affected incumbent workers.

(a) *AAIW training.* Pursuant to sections 236(a)(1) and 247(18) of the Act, a State may approve training for an AAIW, or training for a worker before separation occurs. An AAIW may apply for training and a State may approve training at any time after the date on which the AAIW is determined to be individually threatened with layoff without regard to whether such worker has applied for or exhausted all rights to any UI to which the worker is entitled.

(b) *Threat of layoff.* A State may determine that a worker has been individually threatened with total or partial separation when the worker has received a notice of termination or layoff from employment. Other documentation of a threat of total or partial separation from the firm or other reliable source may be accepted.

(c) *Approval of training.* Except as specified in this section, the provisions of this subpart extend to AAIWs. The following exceptions to the training approval requirements apply to AAIWs:

(1) The State may not approve OJT under § 618.635(a) for AAIWs.

(2) Customized training for AAIWs under § 618.635(b) may be approved only if the training is for a position other than the AAIW's adversely affected position.

(d) *Disqualification and restrictions.* (1) The State must periodically verify that the threat of total or partial separation continues to exist for the AAIW for the duration of the approved training. This may be accomplished by verifying with the AAIW's employer that the threat of separation still exists before funding each subsequent portion of the training.

(2) Funding of a training program must cease upon the removal of the threat. The AAIW must cease the training upon the conclusion of the most recently funded portion, semester or quarter for which expenses have already been accrued. No additional funding will be available while the threat of separation is removed. Funding may resume for the original training program that had been previously approved upon a determination by the State that the threat of separation has been reestablished, or upon total or partial separation from adversely affected employment, if the requirements under § 618.610 are still met. The AAIW's approved training program must be amended, as appropriate, in compliance with § 618.665.

(3) The one training program per certification rule, as described under § 618.615, is applicable to AAIWs. Thus, a training program begun prior to separation and while under a threat of layoff constitutes the one allowed training program available to that AAIW.

(4) The duration of training limitations, at § 618.615(d)(3) are applicable to AAIWs.

(5) An AAIW will not be eligible for a new training program when total or partial separation occurs; however, the existing training may be amended under the provisions of § 618.665.

(6) The State must not consider the AAIW's threatened employment to be suitable employment under § 618.610(a).

(e) *Separation from threatened employment.* (1) Upon a total or partial separation from threatened employment, an AAIW becomes an AAW under the following conditions:

(i) The separation must occur prior to the expiration of the certification period under which the worker was determined to be threatened; and

(ii) The total or partial separation must be for lack of work.

(2) When an AAIW becomes an AAW under the conditions in paragraph (e)(1) of this section:

(i) The State must amend the worker's approved training program, as described in § 618.665; and

(ii) The State must determine what other benefits under the TAA Program the worker may now be eligible for, including TRA. Any time spent in training as an AAIW applies to the duration limits contained in § 618.615.

§ 618.660 Training benchmarks.

(a) *Requirement for training benchmarks.* A State must establish and document training benchmarks, as provided in paragraph (f) of this section, for individual AAWs so that they can meet Completion TRA eligibility requirements, described at § 618.765. The benchmarks must be established when the worker enrolls in an approved training program, so that the State

can monitor the worker's progress toward completing the approved training duration limits established at § 618.615.

(b) *Scope of requirement.* Training benchmarks must be established for all but short-term training programs.

(c) *Measurement against training benchmark.* To review the AAW's progress against the benchmarks, States may request that the training provider provide documentation of the worker's satisfactory progress, including instructor attestations, progress reports, etc. The case manager may attest to the worker's progress after consultation with the training provider and the worker.

(d) *Must be included in IEP.* The training benchmarks must be described in the AAW's IEP, if available, or otherwise documented in the worker's case file.

(e) *Benchmark qualities.* Benchmarks must be flexible enough to allow for some variability, and both practical and measurable enough to allow administration across a broad spectrum of training scenarios.

(f) *Review of benchmarks.* The State must evaluate and document satisfactory progress against the benchmarks in paragraphs (f)(1) and (2) of this section at intervals of not more than 60 days, beginning with the start of the approved training program:

(1) The AAW is maintaining satisfactory academic standing (e.g., not on probation or determined to be ''at risk'' by the instructor or training provider); and

(2) The AAW is on schedule to complete training within the timeframe identified in the approved training program.

(g) *Actions following failure to meet a benchmark.* (1) Upon failure to meet a benchmark, the State must provide a warning to the AAW that his or her eligibility for Completion TRA is in jeopardy. The warning may be provided verbally, in writing, or both, and must be documented in the worker's case file. In consultation with the worker, the State may amend a worker's training program as described in § 618.665.

(2) If a worker who has previously failed to meet a benchmark under paragraph (g)(1) of this section fails to meet a benchmark during a subsequent review under paragraph (f) of this section, the State must notify the worker of his or her ineligibility for Completion TRA. The worker may elect to continue in the approved training but will not receive any Completion TRA payments; or the training program must be amended, according to § 618.665, and Completion TRA may resume.

§ 618.665 Amending approved training.

(a) *Conditions for amending approved training.* The State must, with the cooperation of the trade-affected worker, amend a worker's approved training program under the following conditions:

(1) The State determines that one or more of these conditions are present:

(i) A course or courses designed to satisfy unforeseen needs of the worker, such as remedial education or new employer skills requirements, are necessary;

(ii) A course or courses added to the training program will enhance and complement the worker's original training program, such as preparatory courses to obtain an industry-recognized credential, certification, or license that will improve the worker's chance of being hired;

(iii) Additional assistance such as tutoring or the use of translators would benefit the worker, keep the worker qualified for the training in which he or she is enrolled, and be sufficient for the worker to complete the training program;

(iv) Approval of a longerterm training program that will improve the likelihood of employment upon the completion of such training;

(v) The originally approved training program cannot be successfully completed by the worker;

(vi) The originally approved training program is determined to be of inferior quality;

(vii) Training in another occupation will lead to a greater likelihood of training completion or a better employment outcome, as a result of a change in labor market conditions or the worker's experience in the originally approved training program, or other similar factor;

(viii) The worker is moving from full-time training to part-time training or from part-time training to full-time training;

(ix) An AAIW has been separated from adversely affected employment and has transitioned to become an AAW, or an AAIW is continuing training after a threat of separation was first removed, then resumed; or

(x) An additional source of funding becomes available for which a pre-arrangement is required under § 618.625(c)(4).

(2) The combination of time spent in the originally approved training program and the time it will take to complete the amended training program will not exceed the duration of training limit for the type of training included in the training program, as provided at § 618.615(d)(3).

(3) Amending the approved training program occurs before a worker finishes the originally approved training program and prior to the originally scheduled date of completion.

(b) *Criteria for amending a training program.* The State must determine that the following criteria are met before amending a training program:

(1) *Criterion 1: A reasonable expectation of employment following completion of such training continues to exist.* Given the labor market conditions expected to exist at the time of the completion of the training program, a reasonable expectation, fairly and objectively considered, exists that the trade-affected worker is likely to find employment, using the skills and education acquired while in training, upon completion of approved training. The labor market conditions considered must be limited to those in the worker's commuting area, or in the area where the worker intends to relocate.

(i) ''A reasonable expectation of employment'' does not require that employment opportunities for the worker be available, or offered, immediately upon the completion of the approved training.

(ii) The State must review the expected job market conditions using pertinent labor market data in the worker's case file to ensure it continues to apply to the amended training program and the worker's occupational goal as identified on the worker's IEP, if available, and in the worker's case file.

(iii) When a worker desires to relocate within the United States but outside the worker's present commuting area upon completion of training, the State must ensure the labor market information (described in § 618.610(c)(2)) supports the determination that a reasonable expectation of employment continues to exist within the area of the planned relocation. The labor market information must be in the area of planned relocation.

(iv) A reasonable expectation of employment may exist in a limited demand occupation for a single, trained worker in the worker's commuting area or in the area to which the worker desires to relocate. The State must determine that there continues to be a reasonable expectation that the worker can secure employment in the limited demand occupation.

(v) A State may approve an amended training program in an occupation if it finds that there is a reasonable expectation that the additional training will lead to self-employment in the occupation for which the worker requests training, and that such self-employment will provide the worker with wages or earnings at or near the worker's wages in adversely affected employment.

(vi) Amended training programs that consist of solely OJT or contain an OJT component are not approvable if they are not expected to lead to suitable employment, with the employer providing the OJT, in compliance with section 236(c)(1)(B)(i) of the Act.

(2) *Criterion 2: Training continues to be reasonably available to the worker.* In determining whether training continues to be reasonably available to the worker, the State must first consider training opportunities available in the worker's commuting area. States may approve training outside the commuting area if none is available at the time in the worker's commuting area. Whether the training is in or outside the commuting area, the amended training program must be available at a reasonable cost as prescribed in paragraph (b)(4) of this section.

(3) *Criterion 3: The worker continues to be qualified to undertake and complete such amended training.* States must ensure the following:

(i) The worker's knowledge, skills, and abilities, educational background, work experience, and financial resources remain sufficient to undertake and complete the specific amendment to the training program being considered.

(ii) The initial assessment or comprehensive and specialized assessment, and IEP, if available, developed under subpart C of this part are to be consulted in order to support the trade-affected worker's ability to undertake and complete the proposed amended training program.

(iii) Where the worker's remaining available weeks of UI and TRA payments will not equal or exceed the duration of the amended training program, that the worker will have sufficient financial resources to support completion of the training program within the time limits noted in § 618.615(d) (limitations on training approval). In making this determination, the State must consider:

(A) The worker's remaining weeks of UI and TRA payments in relation to the duration of the proposed amended training program;

(B) Other sources of income support available to the worker including severance, earnings of other family members, and other family resources;

(C) Other fixed financial obligations and expenses of the worker and family;

(D) The availability of Federal student financial assistance or any State-funded student financial assistance or any private funding designated for student financial assistance, including, but not limited to, nongovernmental scholarships, awards, or grants; and

(E) Whether or not the worker is employed while attending training.

(iv) The State must document whether or not the trade-affected worker has sufficient financial resources to complete the amended training program that exceeds the duration of UI and TRA payments.

(v) If a worker has insufficient financial resources to complete the proposed amended training program that exceeds the duration of UI and TRA payments, then the State must not approve that amended training and must instead consider resuming the originally approved training program or other training opportunities available to the worker.

(4) *Criterion 4: Such amended training continues to be suitable for the worker and available at a reasonable cost*—(i) *Suitable for the worker.* The amended training being considered must address the criteria set out in paragraph (b)(3) of this section (Criterion 3), this paragraph (b)(4), and be determined by the State to be appropriate given the worker's knowledge, skills, and abilities, background, and experience relative to the worker's employment goal, and criteria set out in paragraph (b)(1) of this section (Criterion 1).

(ii) *Available at a reasonable cost.* (A) Costs of an amended training program may include, but are not limited to, tuition and related expenses (e.g., books, tools, computers and other electronic devices, internet access, uniforms and other training-related clothing such as goggles and work boots, laboratory fees, and other academic fees required as part of the amended training program) as well as supplemental assistance (subsistence expenses and transportation expenses as described in § 618.640(c) and (d)). States must pay the costs of initial licensing and certification tests and fees where a license or certification is required for employment.

(*1*) The State must ensure and document that the amended training program costs are reasonable by researching costs for similar training programs, whether it is classroom or work-based training.

(*2*) Related expenses must be necessary for the worker to complete the amended training program. Other options should be explored before purchasing equipment or related materials.

(B) Available at a reasonable cost means that amended training must not be approved at one provider when, all costs being considered, training better or substantially similar in quality, content and results can be obtained from another provider at a lower total cost within a similar time frame.

Amended training must not be approved when the costs of the training are unreasonably high in comparison with the average costs of training other workers in similar occupations at other providers. The State may approve a higher cost training if that training is reasonably expected to result in a higher likelihood of employment, employment retention, or greater earnings, or to return the worker to employment in a significantly shorter duration.

(C) Training at facilities outside the worker's commuting area requiring transportation or subsistence payments that add substantially to the total cost of the amended training program may not be approved if other appropriate training is available in the commuting area at a lower cost, unless the exception described in paragraph (b)(4)(ii)(B) of this section applies.

(D) Approval of amended training under paragraph (b)(4) of this section (Criterion 4) is also subject to the provisions of § 618.650.

Subpart G—Trade Readjustment Allowances

§ 618.700 Scope.

This subpart explains the requirements for eligibility, amounts, and duration of Basic TRA, Additional TRA, and Completion TRA, all of which are income support in the form of cash payments for an AAW.

§ 618.705 Definitions.

(a) For purposes of TRA, an AAW is ''participating in approved training'' if:

(1) The worker is either attending and taking part in all scheduled classes, required activities, and required events in a given week, or the training provider has excused the worker's absence or failure to take part in accordance with its written policies.

(2) In the case of distance learning, the worker is either meeting all the requirements of the training provider in a given week in accordance with its rules, regulations, and standards, or the training provider has excused the worker's failure to meet those requirements in accordance with its written policies.

(b) For purposes of TRA, the term ''training allowance'' means any assistance or payment, excluding Federal student financial assistance, that can be used for the same purpose as funds for the costs of training covered by the TAA Program, and that is given or paid directly to the AAW.

(c) For purposes of TRA, the term ''adversely affected employment'' includes employment at a successor-in-interest, and such wages reported to the State or received by an AAW from a successor-in-interest are included as wages under § 618.720(c).

§ 618.710 Categories of Trade Readjustment Allowances.

(a) *Basic TRA.* Basic TRA is payable to an AAW who meets the requirements of § 618.720. Basic TRA is payable for weeks of unemployment after the worker meets the criteria for exhaustion of UI under § 618.720(e) and, consistent with § 618.725, for weeks of unemployment during which the worker either is enrolled in, is participating in, or has completed approved training, or has received a waiver of the training requirement under § 618.735.

(b) *Additional TRA.* Additional TRA is payable to an AAW who meets the requirements of § 618.760. Additional TRA is payable only for weeks of unemployment during which the worker is participating in approved training.

(c) *Completion TRA.* Completion TRA is payable to an AAW who meets the requirements of § 618.765. Completion TRA is payable only for weeks of unemployment during which the worker is participating in approved training. Completion TRA is payable only after the worker has exhausted all rights to Basic and Additional TRA.

§ 618.715 Applications for Trade Readjustment Allowances and payment.

(a) *Timing of applications.* (1) An initial application for TRA must be filed after certification of the appropriate worker group has been made.

(2) An application for TRA must be filed within the time limit applicable to claims for regular compensation under the applicable State law.

(b) *Applicable procedures.* Applications must be filed in accordance with this subpart and on forms furnished to

AAWs by the State. The State's procedures for filing applications for TRA, and for reporting, must be consistent with this part and the Department's ''Standard for Claim Filing, Claimant Reporting, Job Finding, and Employment Services,'' Employment Security Manual, part V, sections 5000 through 5004 (appendix A to this part), except that such procedures may allow for the filing and processing of applications by paper, telephone, the internet, or other similar methods as provided for in paragraph (e)(2) of this section.

(c) *Treatment of determinations.* Determinations on TRA applications are determinations to which §§ 618.820 (determinations of eligibility; notices to individuals), 618.824 (liable State and agent State responsibilities), and 618.828 (appeals and hearings) apply. Copies of such applications for TRA and all determinations by the State on such applications must be included in the AAW's case file.

(d) *Payment of TRA.* (1) A State must not make any payment of TRA until a certification is issued and the State determines that the AAW is a member of a worker group covered under the specified certification.

(2) An AAW, if he or she otherwise meets the eligibility requirements of this subpart, including exhaustion of UI, may be entitled to TRA for any week of unemployment that begins on or after the date of the applicable certification.

(3) An AAW may receive only one form of TRA (Basic, Additional, or Completion) for any given week.

(e) *Taking of applications.* (1) An initial application is required for TRA and a separate application is required for Completion TRA.

(2) Applications may be filed and processed by any means allowed for UI claims in the State.

(3) States must provide notice to the worker when a worker begins receipt of Additional TRA. That notice must include the eligibility requirements under which Additional TRA is payable.

§ 618.720 Qualifying requirements for Basic Trade Readjustment Allowances.

To qualify for Basic TRA for a week of unemployment, an AAW must meet each of the requirements in paragraphs (a) through (g) of this section:

(a) *Certification.* The AAW must be a member of a worker group certified under subpart B of this part.

(b) *Separation.* The AAW must have experienced a qualifying separation during the certification period of the certification in paragraph (a) of this section.

(c) *Wages and employment.* The AAW must meet the following wage and other requirements:

(1) In the 52-week period (*i.e.*, 52 consecutive calendar weeks) ending with the week of the AAW's total or partial separation from adversely affected employment during the certification period, the worker must have had at least 26 weeks of employment at wages of $30 or more a week in adversely affected employment with a single firm or, where there is more than one subdivision, the appropriate subdivision of that firm. Evidence that the worker meets the requirement in this paragraph (c)(1) must be obtained as provided in § 618.740. Employment and wages covered under more than one certification may not be combined to qualify for TRA.

(2) The categories of weeks in paragraphs (c)(2)(i) through (iv) of this section also must be treated as weeks of employment at wages of $30 or more (for purposes of paragraph (c)(1) of this section), regardless of whether the AAW actually receives any wages during such weeks:

(i) All weeks, up to a maximum of 7 weeks, during which the AAW is on employer-authorized leave for vacation, sickness, injury, maternity, or inactive duty or active duty military service for training;

(ii) All weeks, up to a maximum of 7 weeks, during which the AAW had adversely affected employment interrupted to serve as a full-time representative of a labor organization in the firm or subdivision referenced in paragraph (c)(1) of this section;

(iii) All weeks, up to a maximum of 26 weeks, during which the AAW has a

disability compensable under a workers' compensation law or plan of a State or the United States; and

(iv) All weeks, up to a maximum of 26 weeks, during which the AAW is on call-up for the purpose of active duty in a reserve status in the Armed Forces of the United States, if such active duty is ''Federal service'' as defined in 5 U.S.C. 8521(a)(1), but not more than 7 weeks, in the case of weeks described in paragraph (c)(2)(i) or (ii) of this section that occur during the active duty. States may waive provisions of this paragraph (c)(2)(iv) consistent with § 618.884.

(d) *Entitlement to UI.* The AAW must have been entitled to (or would have been entitled to if the worker had applied therefor) UI for a week within the first benefit period.

(e) *Exhaustion of UI.* The AAW must meet the following requirements:

(1) The AAW must have exhausted all rights to any UI, except additional compensation that is funded by a State and not reimbursed from any Federal funds to which such worker was entitled (or would have been entitled had such worker applied therefor), and not have any unexpired waiting period applicable to the worker for any such UI, except as provided at § 618.720(e)(2).

(2) The AAW may elect to receive TRA instead of UI during any week with respect to which the worker:

(i) Is entitled and is able to receive UI as a result of a new benefit year based on employment in which the worker engaged after establishing TRA eligibility following a total separation from adversely affected employment. The entitlement must be after the first UI benefit period. It must also be based in whole or in part upon part-time or short-term employment in which the worker engaged after the worker's most recent total separation from adversely affected employment that established such first UI benefit period. This new employment may include the same adversely affected employment; and

(ii) Is otherwise entitled to TRA, except that the AAW need not have exhausted all rights to UI in the new benefit year.

(3) For AAWs meeting the requirements in paragraph (e)(2) of this section, the State must provide the AAW a summary of his or her potential UI benefits and potential TRA benefits in writing and document the AAW's choice in the case file.

(4) State law governs the status of the UI claim in the second benefit year when the AAW elects to receive TRA instead of UI.

(5) If the AAW elects to receive UI benefits in the second benefit year or any subsequent benefit period thereafter in which the option is available, the AAW must exhaust all UI entitlement before resuming TRA eligibility.

(6) The AAW must have no unexpired waiting period applicable to such worker for any UI.

(f) *Extended Benefits (EB) work test.* The AAW must be able to work and be available for work, as defined in the EB work test in the applicable State law for UI claimants, and must be furnished a classification and a determination as to his or her job prospects as required by 20 CFR 615.8(d). The EB work test must be met for each week by the means described in this paragraph (f), unless an exception in paragraph (f)(2) of this section applies.

(1) *Criteria.* The EB work test requirement must be met by:

(i) Registering for work with the State, in accordance with the applicable provisions of State law that apply to EB claimants and that are consistent with part 615 of this chapter;

(ii) Actively engaging in seeking work;

(iii) Furnishing the State with tangible evidence of work search efforts each week; and

(iv) Accepting any offer of suitable work, including those referred by the State.

(2) *Exceptions.* The able and available requirement and the EB work test requirement in this paragraph (f) do not apply for purposes of TRA eligibility:

(i) When the AAW is enrolled in or participating in approved training;

(ii) During a break in training; or

(iii) With respect to claims for TRA for those weeks of unemployment beginning before the filing of an initial claim for TRA, or for any week that begins before the AAW is notified of coverage by a certification and is fully

informed of the EB work test requirements. Before such notification and advice, the worker must not be subject to the EB work test requirements for TRA eligibility purposes, nor to any State timely filing requirement, but must be required to be unemployed and able to work and available for work under State law with respect to any such week except as provided in paragraphs (f)(2)(i) and (ii) of this section for AAWs enrolled in or participating in approved training.

(3) *Suitable work.* (i) For purposes of this subpart, suitable work means, with respect to a worker, whichever of the following laws is applicable:

(A) Suitable work as defined in the applicable State law for claimants for regular compensation; or

(B) Suitable work as defined in applicable State law provisions consistent with section 202(a)(3) of EUCA.

(ii) Regardless of which of the laws in paragraph (f)(3)(i)(A) or (B) of this section apply, suitable work does not in any case include self-employment or employment as an independent contractor.

(g) *Participation in approved training.* (1) As a condition for receiving Basic TRA, except as provided for in § 618.730, the AAW, after a total or partial separation from the adversely affected employment within the certification period, and by the applicable deadlines in § 618.725 must:

(i) Be enrolled in training, as defined in subpart A of this part;

(ii) Be participating in approved training (as defined in § 618.705); or

(iii) Have a waiver granted under § 618.735 in effect.

(2) An AAW who has not met the requirements in paragraph (g)(1) of this section may, if otherwise eligible, receive Basic TRA before expiration of the applicable training enrollment deadline in § 618.725. Once the training enrollment deadline is reached, the training requirements in paragraph (g)(1) of this section must be met. Basic TRA payments must cease beginning the first week for which the requirements in paragraph (g)(1) of this section were required but not met.

(3) The requirements in paragraph (g)(1) of this section do not apply to an AAW with respect to claims for Basic TRA for weeks of unemployment beginning before the filing of an initial claim for TRA after publication of the certification of the appropriate worker group as provided in § 618.715(a), nor for any week that begins before the AAW is notified that he or she is covered by a certification and is fully informed of the requirements of this section.

(4) An AAW who meets the participation in approved training requirement in paragraph (g)(1) of this section by the applicable deadlines in § 618.725 may continue to receive Basic TRA after the AAW has completed training, even if such participation in training was on a part-time basis, provided that the worker meets all other eligibility requirements for Basic TRA.

§ 618.725 Training enrollment deadlines.

(a) *Training enrollment deadlines.* As a condition for receiving Basic TRA, an AAW must meet the participation in approved training requirement in § 618.720(g)(1) no later than the latest of:

(1) The last day of the 26th week after the AAW's most recent qualifying separation;

(2) The last day of the 26th week after the week in which the certification was issued; or

(3) 45 days after the later of the dates specified in paragraph (a)(1) or (2) of this section, if there are extenuating circumstances that justify an extension of the enrollment period. Extenuating circumstances that justify the 45-day extension are circumstances that would constitute good cause, as established by § 618.730; that is, circumstances under which the AAW acted diligently yet was unable to enroll because of exigent circumstances.

(4) In the case of an AAW who fails to enroll by the date required by paragraph (a)(1), (2), or (3) of this section due to a failure by the State to provide the AAW with timely information regarding the applicable training enrollment deadline, the AAW must be enrolled in training or obtain a waiver by the Monday of the first week occurring 60 consecutive calendar days following the date the worker was properly notified; or

(5) The Monday of the first week occurring 30 consecutive calendar days (or, if the State is closed that last day because that day falls on a weekend or holiday or for any other reason, the next business day) following the day of termination, whether by revocation or expiration or revocation of a waiver under § 618.735.

(b) *Exceptions*—(1) *Extended training enrollment deadline for delayed approval of application for TRA.* (i) The training enrollment deadlines of paragraph (a) of this section do not apply where:

(A) A State's negative determination on an initial application for TRA under § 618.715 has been reversed through redetermination or appeal;

(B) The AAW is unable to meet the training enrollment deadline because of the delay in obtaining the reversal of the negative determination; and

(C) The delay in obtaining the reversal is not attributable to the AAW.

(ii) Where the conditions of paragraph (b)(1)(i) of this section are met, the AAW will have until the last day of the 26th week following the date on which the negative determination was reversed to enroll in training or have a training waiver in effect.

(2) *Extended training enrollment deadline for period of duty in military service.* If an AAW who is a member of a reserve component of the Armed Forces and has served a period of duty during the AAW's Basic TRA eligibility period but before enrolling in training, the AAW's training enrollment deadline will be the last day of the 26th week following the last day of the AAW's period of duty.

(3) *Good cause.* The training enrollment deadline may be extended for good cause as provided for in § 618.730.

§ 618.730 Good cause.

(a) States must waive the time limitations with respect to an application for TRA, enrollment in training, or receipt of a training waiver in this subpart if the AAW shows good cause.

(b) Good cause exists if the AAW acted diligently yet was unable to complete in a timely manner the relevant task at issue described in paragraph (a) of this section because of exigent circumstances.

(c) The State must determine good cause on a worker-by-worker basis.

§ 618.735 Waiver of training requirement for Basic Trade Readjustment Allowances.

(a) *Waiver for Basic TRA.* A State may issue a waiver of the requirement in § 618.720(g) that an AAW be enrolled in or participating in approved training as a condition of Basic TRA eligibility upon a finding that training for such worker is not feasible or appropriate for one or more reasons identified in paragraph (b) of this section. The waiver must contain the information required in paragraph (c) of this section. No waiver of the training requirement is permitted for Additional TRA or Completion TRA eligibility. Waivers must be issued no later than the latest of the applicable deadlines described in § 618.725.

(b) *Bases for a waiver.* The State, in order to issue a written waiver to an AAW, must conclude after assessing the worker that training is not feasible or appropriate for one or more of the reasons in paragraphs (b)(1) through (3) of this section, which must be cited on the waiver:

(1) *Health.* The worker is unable to participate in training due to the health of the worker. A waiver granted for this reason does not exempt the worker from requirements relating to the availability for work, active search for work, or refusal to accept work under Federal or State unemployment compensation laws.

(2) *Enrollment unavailable.* The first available enrollment date for approved training is within 60 consecutive calendar days after the date on which a waiver determination is made or, if later, there are extenuating circumstances, as determined under the criteria in § 618.725(a)(3), that apply to the delay in enrollment in training.

(3) *Training not available.* Approved training is not reasonably available to the worker from governmental agencies or private sources (which may include area vocational education schools, as defined in section 3 of the Strengthening Career and Technical Education for the 21st Century Act (20

U.S.C. 2302), and employers), or suitable training is not available at a reasonable cost, or no training funds are available.

(c) *Contents of a waiver.* (1) A waiver issued under this section may not take effect unless it contains, at a minimum, the following information:

(i) The AAW's name and a unique identifying designation used by the State;

(ii) The name and location of the worker group and the petition number under which the AAW's group was certified;

(iii) A statement of the reasons why training is not feasible or appropriate for the AAW, citing to one or more reasons identified in paragraph (b) of this section;

(iv) The effective date and expiration date of the waiver;

(v) A statement that the waiver must be revoked immediately upon a determination that the basis or bases for the waiver no longer apply; and

(vi) The signature of an official of the State authorized to grant the waiver, and the signature of the AAW or other evidence of the worker's acknowledgement of receipt of the waiver.

(2) Waivers and the required signatures may be issued and maintained electronically.

(d) *Request for a waiver.* States may analyze whether an AAW may qualify for a waiver as part of the AAW's initial assessment, as described in subpart C of this part. An AAW may also request a waiver from the State before the applicable deadline in § 618.725.

(e) *Denial of a waiver.* In any case in which a determination is made to deny a waiver under this section, the AAW to whom the denial pertains must be furnished with a notice of the denial of waiver. The notice of denial of waiver must contain, at minimum, the information in paragraphs (c)(1)(i), (ii), and (vi) of this section; the specific reason(s) for the denial; the date of the denial; and notice of the AAW's appeal rights.

(f) *Duration of a waiver.* (1) A waiver issued under this section may be for a period not to exceed 6 months, or the AAW's period of Basic TRA entitlement, whichever ends first;

(2) Notwithstanding the 6-month limitation in paragraph (f)(1) of this section, a State may extend an AAW's waiver beyond 6 months if:

(i) Training continues not to be feasible or appropriate for such worker for one or more of the reasons described in paragraph (b) of this section; and

(ii) Such worker has not yet exhausted his or her Basic TRA entitlement.

(3) Waivers must be reviewed 3 months after the date on which the State issues the waiver to determine if one or more of the bases in paragraph (b) of this section continue to apply, and every 30 consecutive calendar days thereafter.

(g) *Revocation of a waiver.* The State must revoke a waiver issued under this section if the waiver criteria are no longer met. The State must notify the AAW of the revocation. The notice of revocation must be appealable and must contain the same information as a denial of waiver issued under paragraph (e) of this section.

(h) *Submission of waivers and notices.* The State must develop procedures for compiling and reporting on the number of waivers issued and revoked, by reason, and must submit to the Department, only upon specific request, a record or copy of any or all waivers issued under this section together with a statement of reasons for each such waiver, and a record or copy of any or all notices of revocation of waiver issued under this section together with a statement of reasons for each such revocation. The statements of reason required under paragraphs (c)(1)(iii) and (e) of this section, as applicable, fulfill the requirement for a statement of reasons under this paragraph (h). Electronic records and copies are acceptable.

§ 618.740 Evidence of qualification for Basic, Additional, and Completion Trade Readjustment Allowances.

(a) *State action.* When an AAW applies for Basic, Additional, or Completion TRA, the State having jurisdiction under § 618.820 (determinations of eligibility; notices to individuals) must obtain information necessary to establish:

(1) Whether the AAW meets the qualifying requirements in § 618.720 for Basic TRA, in § 618.760 for Additional TRA, or in § 618.765 for Completion TRA; and

(2) For a partially separated AAW, the average weekly hours and average weekly wage in adversely affected employment.

(b) *Insufficient data.* If information specified in paragraph (a) of this section is not available from State records or from any employer, the State must require the AAW to submit a signed statement setting forth such information as may be required for the State to make the determinations required by paragraph (a) of this section.

(c) *Verification.* A statement made under paragraph (b) of this section must be certified by the AAW to be true to the best of the worker's knowledge and belief and must be supported by evidence including W–2 forms, paycheck stubs, union records, income tax returns, or statements of fellow workers, and must, whenever possible, be verified by the employer.

(d) *Determinations.* The State must make the necessary determinations on the basis of information obtained under this section, except that if, after reviewing information obtained under paragraphs (b) and (c) of this section against other available data, including agency records, it concludes that such information is not reasonably accurate, it must make the determination on the basis of the best available information.

(e) *Timing.* The State must follow the established method used for processing regular UI claims. If an employer does not respond within the timeframe established for UI claims, then the State must act on the best available information.

§ 618.745 Weekly amounts of Basic, Additional, and Completion Trade Readjustment Allowances.

(a) *TRA amount.* The amount of Basic, Additional, or Completion TRA payable for a week of unemployment (including a week of approved training) is an amount equal to the most recent weekly benefit amount of UI (including dependents' allowances) payable to the AAW for a week of total unemployment preceding the worker's first exhaustion of UI following the worker's first qualifying separation, except that:

(1) Where a State calculates a base period amount of UI and calculates dependents' allowances on a weekly supplemental basis, TRA weekly benefit amounts must be calculated in the same manner and under the same terms and conditions as apply to claimants for UI except that the base amount must not change.

(2) For partially separated workers, the weekly amount of TRA must be calculated as determined under the applicable State law.

(b) *Workers who are undergoing training.* Any AAW in approved training who is thereby entitled for any week to TRA and a training allowance (as defined in § 618.705) under any other Federal law for the training of workers, will be paid for each week in which the AAW is undergoing approved training, TRA in the amount (computed for each week) equal to the amount computed under paragraph (a) of this section or, if greater, the amount of any weekly allowance for such training to which the AAW would be entitled under any other Federal law for the training of workers, if the AAW applied for such allowance. TRA must be paid in lieu of any payment for training made directly to the AAW to which the AAW is entitled under such other Federal law.

(c) *Reductions to the TRA weekly amount.* The weekly amount of TRA payable under this section will be reduced (but not below zero) by:

(1) Income that is deductible from UI under the disqualifying income provisions of the applicable State law or Federal UI law, except that in the case of an AAW who is participating in approved training, such income must not include earnings from work for such week that are equal to or less than the most recent weekly benefit amount of the UI payable to the worker for a week of total unemployment preceding the worker's first exhaustion of UI (as determined for purposes of section 231(a)(3)(B) of the Act).

(2) If the amount of a training allowance as defined in § 618.705 (including a training allowance referred to in paragraph (b) of this section) under any Federal law that the AAW receives for

such week is less than the amount of TRA otherwise payable to the AAW for a week, the AAW must, when applying for TRA for the week, be paid TRA in an amount not to exceed the difference between the AAW's regular weekly TRA amount, as determined under § 618.745(a) (regular allowance), and the amount of the training allowance paid to the AAW for the week.

(3) Except as provided in paragraph (c)(4) of this section, if a training allowance under any Federal law other than the Act, is paid to an AAW for any week of unemployment with respect to which the AAW would be entitled (determined without regard to any disqualification under paragraph (b) of this section) to TRA, if the AAW applied for TRA, each such week must be deducted from the total number of weeks of TRA otherwise payable to the AAW when the worker applies for and is determined to be entitled to TRA. If such training allowance paid directly to the worker for any week of unemployment is less than the amount of TRA to which the AAW would be entitled if the worker had applied for it, the AAW must receive (when the worker applies for and is determined to be entitled to TRA) TRA for such week equal to such difference.

(4) If the training allowance (as defined in § 618.705) referred to in paragraphs (c)(2) and (3) of this section is Federal student financial assistance, then the amount of TRA will not be reduced. In the case of an AAW to whom the Federal student financial assistance is available, the State will rely on prearrangements for the sharing of training costs under § 618.625(c)(2) (payment restrictions for training programs) in order to harmonize the provision of Federal student financial assistance with the worker's TRA.

(5) Any amount that would be deductible from UI for days of absence from training under the provisions of the applicable State law that applies to AAWs in approved training.

§ 618.750 Maximum amount of Basic Trade Readjustment Allowances.

(a) *General rule.* Except as provided in paragraph (b) of this section, the maximum amount of Basic TRA payable to an AAW is the product of 52 multiplied by the TRA weekly amount for a week of total unemployment, calculated under § 618.745(a) (weekly amounts of TRA), reduced by the total sum of UI (except State-funded additional compensation) that the AAW was entitled or would have been entitled to had the worker applied in such worker's first benefit period.

(b) *Exceptions.* The maximum amount of TRA determined under paragraph (a) of this section does not include:

(1) The amount of dependents' allowances paid as a supplement to the base weekly amount determined under § 618.745; or

(2) The amount of the difference between the AAW's weekly increased allowances determined under § 618.745(b) and such worker's weekly amount determined under § 618.745(a).

§ 618.755 Eligibility period for Basic Trade Readjustment Allowances.

(a) Except as provided in paragraph (b) of this section, an AAW is ineligible to receive Basic TRA for any week of unemployment beginning after the close of the 104-week period beginning with the first week following the week in which the AAW's most recent qualifying separation occurred or after certification, whichever is later.

(b) A State may not count any period during which a judicial or administrative appeal is pending with respect to a denial of a petition filed under subpart B of this part for the purpose of calculating the period of separation described in paragraph (a) of this section. The separation will be deemed as having occurred on the certification date and the Basic TRA eligibility period will begin on the week that follows the certification date.

§ 618.760 Qualifying requirements for, and timing and duration of, Additional Trade Readjustment Allowances.

(a) *Qualifying requirements for Additional TRA.* An AAW is eligible to receive Additional TRA for any week only if:

(1) The worker meets all qualifying requirements for receipt of Basic TRA in § 618.720; and

(2) Except as provided in § 618.775 for a break in training, the AAW is participating in approved training.

(b) *Timing and duration of Additional TRA.* Additional TRA is payable for up to 65 weeks during the 78 consecutive calendar week period that:

(1) Immediately follows the last week of entitlement to Basic TRA otherwise payable to the AAW;

(2) Begins with the first week of approved training, if such training begins after the last week described in paragraph (b)(1) of this section; or

(3) Begins with the first week in which such training is approved under subpart F of this part, if such training is approved after the training already has commenced (although Additional TRA or training costs may not be paid for any week before the week in which the TAA approved training was approved).

§ 618.765 Qualifying requirements for, and timing and duration of, Completion Trade Readjustment Allowances.

(a) *Qualifying requirements for Completion TRA.* An AAW is eligible to receive Completion TRA if such worker meets all qualifying requirements for receipt of Basic TRA in § 618.720 and Additional TRA in § 618.760, and if the eligibility criteria in paragraphs (a)(1) through (3) of this section are met for that week. The requirements in this paragraph (a) are applied at the time the State approves payment for a week of Completion TRA. The eligibility criteria are:

(1) Payment of Completion TRA is necessary for an AAW to complete the approved training described in paragraph (a)(2) of this section.

(2) The AAW is participating in approved training each week that leads to the completion of a degree or industry-recognized credential and the worker's training program will extend for a period longer than the periods during which Basic and Additional TRA are payable under §§ 618.755 (eligibility period for Basic TRA) and 618.760 (qualifying requirements for, timing and duration of, Additional TRA), and the requested weeks are necessary for the worker to complete training.

(3) The worker–

(i) Has substantially met the performance benchmarks in § 618.660 (training benchmarks) established as part of the approved training under subpart F of this part;

(ii) Is expected to continue to make progress toward the completion of the approved training; and

(iii) Will complete the approved training during the period of eligibility described in paragraph (c) of this section.

(4) If, during the period in which an AAW is eligible to receive Completion TRA, the worker ceases to meet any of the eligibility criteria in paragraphs (a)(1) through (3) of this section, no further Completion TRA is payable to such worker.

(b) *Weeks payable.* A total of up to 13 weeks of payments are allowable during the period of eligibility described in paragraph (c) of this section.

(c) *Eligibility period.* Completion TRA may be payable during the period of 20-week consecutive calendar period that begins with the first week in which an AAW files a claim for Completion TRA and seeks compensation for such week, regardless of when the first payment is received. The eligibility period may be extended if justifiable cause exists, in accordance with § 618.770(a).

(d) *Start date of Completion TRA.* The State must have a process to take applications for Completion TRA. States must not automatically establish the 20-week period for Completion TRA as the week following either expiration of the eligibility period for Additional TRA, or the exhaustion of Additional TRA; filing a claim after either of those first weeks is permitted. Since training that leads to a degree or industry-recognized credential must be completed during the eligibility period described in paragraph (c) of this section, the first week of Completion TRA claimed should be carefully considered in coordination with case management while the AAW's training program is being developed.

§ 618.770 Special rule for justifiable cause.

(a) The eligibility period during which Basic, Additional, and Completion TRA are payable to an AAW may be extended for justifiable cause, which

has the same meaning as good cause in § 618.730.

(b) While the eligibility period for Basic, Additional, and Completion TRA may be extended for justifiable cause as determined by the State, the maximum benefit amount and number of weeks this benefit may be received must not change.

§ 618.775 Payment of Trade Readjustment Allowances during breaks in training.

(a) Basic and Additional TRA are payable to an otherwise eligible AAW during breaks in training (periods within or between courses, terms (quarters or semesters), and academic years) that do not exceed 30 days (counted in accordance with paragraph (b) of this section), only if:

(1) The AAW participated in approved training of this part immediately before the beginning of the break in training;

(2) The break in training was provided in the established schedule of the training provider; and

(3) The AAW resumes participation in the approved training immediately after the break ends.

(b) For the purpose of determining whether a break in training is within the 30-day maximum allowed under this section, all calendar days beginning with the first day of the training break and ending with the last day of the break, as provided in the published schedule of the training provider, must be counted. However, any Saturday, Sunday, or official State or national holiday occurring during the scheduled break in training is excluded from the 30-day count if training normally would not be scheduled in the training program during those days if there was no break.

(c) For Completion TRA, breaks in training are permissible during the 20-week eligibility period. However, payments during breaks in training are not allowed.

§ 618.780 Disqualifications.

(a) *General rule.* Except as stated in paragraph (b)(1) or (c) of this section and in § 618.832(b)(2) (overpayments; penalties for fraud), an AAW may not be paid TRA for any week of unemployment such worker is or would be disqualified from receiving UI under the disqualification provisions of the applicable State law, including the provisions of the applicable State law that apply to EB claimants and are consistent with EUCA.

(b) *Disqualification of trainees*—(1) *State law inapplicable.* A State law may not be applied to disqualify an AAW from receiving UI or TRA because:

(i) Such worker is enrolled in or participating in an approved training program;

(ii) Such worker refuses work to which the State referred such worker because such work either would require discontinuation of approved training or interfere with successful participation in TAA approved training, except that this paragraph (b)(1)(ii) does not apply to an AAW who is ineligible under paragraph (b)(2) of this section;

(iii) Such worker quits work that was not suitable employment and it was reasonable and necessary to quit in order to begin or continue approved training. This includes temporary employment the worker may have engaged in during a break in training;

(iv) Such worker continues full-time or part-time employment while participating in approved training; or

(v) Such worker leaves OJT within the first 30 days because the OJT is not meeting requirements of section 236(c)(1)(B) of the Act.

(2) *Disqualifications.* An AAW who, without justifiable cause (as described in paragraph (b)(3)(iii) of this section), fails to begin participation (as described in paragraph (b)(3)(i) of this section) in approved training, or ceases participation (as described in paragraph (b)(3)(ii) of this section) in such training, or for whom a waiver is revoked under § 618.735(f) (waiver of training requirement for Basic TRA), may not receive Basic TRA for any week in which such failure, cessation, or revocation occurred. The disqualification will continue for any succeeding week thereafter until the week in which such worker begins or resumes participation in an approved training program. A worker who has justifiable cause (as described in paragraph (b)(3)(iii) of this section) for such failure to begin, or for ceasing, participation in training may

receive Basic TRA for any week in which such failure or cessation occurred if the worker otherwise meets the requirements of this subpart. Such failure, cessation, or revocation normally does not change the eligibility periods defined in §§ 618.755, 618.760(b), and 618.765(b) and (c).

(3) *Disqualification conditions.* For determining the disqualification of trainees for all TAA approved training, the following provisions apply:

(i) *Failed to begin participation.* A worker will be determined to have failed to begin participation in an approved training program when the worker fails to attend one or more scheduled training classes and other training activities in the first week of the approved training program, without justifiable cause.

(ii) *Ceased participation.* A worker will be determined to have ceased participation in an approved training program when the worker fails to attend all scheduled training classes and other training activities scheduled by the training provider in any week of the approved training program, without justifiable cause.

(iii) *Justifiable cause.* For purposes of this section, justifiable cause has the same meaning as good cause under § 618.730, except that good cause for absence also includes an absence excused under a training provider's written policy.

(c) *Disqualification while in OJT.* An AAW may not be paid any TRA for any week during which such worker is engaged in OJT, in accordance with § 618.635.

(d) *Disqualification while in part-time training.* An AAW may not be paid any TRA for any week in which the worker is participating in approved training that is part-time. Part-time training is any approved training that does not meet the definition of ''full-time training'' as defined in § 618.110.

Subpart H—Administration by Applicable State Agencies

§ 618.800 Scope.

This subpart covers the general administrative requirements a State must follow in providing the benefits and services available under the TAA Program. The requirements in this subpart include: The provision of rapid response and appropriate career services to groups of workers for whom a petition is filed, delivering TAA Program benefits and services to trade-affected workers, assisting in the filing of petitions for those likely to be eligible for benefits under this part, conducting outreach to groups of workers covered under a petition for TAA filed under subpart B of this part, and notifying UI claimants of the TAA Program.

§ 618.804 Agreements with the Secretary of Labor.

(a) *Authority.* A State or CSA must, before performing any function or exercising any jurisdiction under the Act and this part, execute an Agreement meeting the requirements of the Act with the Secretary.

(b) *Execution.* (1) An Agreement under paragraph (a) of this section must be signed and dated on behalf of the State or the CSA by an authorized official whose authority is certified by the State Attorney General or counsel for the CSA, unless the Agreement is signed by the Governor or the chief elected official of the State. In the event that a State does not execute an Agreement under paragraph (a) of this section, then section 3302(c)(3) of the Internal Revenue Code of 1986, as amended (26 U.S.C. 3302(c)(3)) (loss of unemployment tax credits under section 3302(a) and (b)), applies.

(2) A State or CSA must execute an amended Agreement with the Secretary, upon the request of the Secretary, in response to legislative or regulatory changes to the TAA Program.

(3) The Secretary will execute an Agreement on behalf of the United States.

(c) *Public access to Agreements.* The CSA must make available for inspection and copying, an accurate copy of its Agreement under this section to any individual or organization that requests it. The CSA may furnish copies of the Agreement upon payment of the same charges, if any, as apply to the furnishing of copies of other records of the CSA.

(d) *Agent of the United States.* A State that has executed an Agreement under

this section is an agent of the United States for purposes of receiving applications for and providing payments on the basis provided in this part and must carry out fully the purposes of the Act and this part.

(e) *Breach.* If the Secretary determines that the State or CSA has not fulfilled its commitments under its Agreement stated in this section, the Secretary may terminate the Agreement. The Secretary must provide the State or CSA reasonable notice and an opportunity for a hearing before the Secretary makes a finding that the State has not fulfilled its commitments under its Agreement. In the event that the Secretary determines the State or CSA has not fulfilled its commitments under its Agreement, section 3302(c)(3) of the Internal Revenue Code of 1986, as amended (regarding loss of unemployment tax credits under section 3302(a) and (b)), applies.

(f) *Review of State and CSA compliance.* The Department is responsible for monitoring and reviewing State and CSA compliance with the Agreement entered into under the Act and this section.

(g) *Merit staffing.* States must comply with the staffing flexibility provisions contained in § 618.890.

(h) *Contents.* Each Agreement under this section must contain provisions including, but not limited to, the following:

(1) Provisions consistent with the requirements of section 239 of the Act (19 U.S.C. 2311);

(2) Authorization for the State to issue waivers under § 618.735 (waiver of training requirement for Basic TRA) and the requirement that the State submit, upon request, to the Department a copy of each such waiver and, if not already contained within each waiver, a statement of the reasons for such waiver;

(3) The requirement that the State supply data to the Department on national TAA Program performance goals identified in applicable regulations, the Department's written directives, or any other written means used to communicate such goals; and

(4) Provisions establishing TAA Program funds as the primary source of Federal assistance to trade-affected workers. This means that following certification of a petition under subpart B of this part, the costs for providing services to a worker group should shift from WIOA and other programs to the TAA Program.

(i) *Administration absent State Agreement.* (1) In any State in which no Agreement under this section is in effect, the Secretary will administer the Act and this part through appropriate arrangements made by the Department.

(2) The Secretary will administer TAA in accordance with this part and the provisions of the applicable State law, except to the extent that such State law is inconsistent with this part, section 303 of SSA (42 U.S.C. 503), or section 3304(a) of the Internal Revenue Code of 1986, as amended (26 U.S.C. 3304(a)).

(3) The Secretary will provide for a fair hearing for any individual whose application for TAA is denied. A final determination as to eligibility for TAA will be subject to review as provided in 42 U.S.C 405(g), as required by section 240(b) of the Act.

(4)(i) The Department will issue administrative guidance providing additional detail on the operation of the TAA Program within that State.

(ii) Prior to providing administrative guidance, the Department will consult with the Governor, other State agencies, neighboring States, and other organizations to determine how best to ensure access to the TAA Program within that State. Options to administer the program that the Department may consider include, but are not limited to:

(A) Executing an agreement with another State to operate the TAA Program;

(B) Executing an agreement with a qualified organization within the State that adheres to all TAA Program requirements in this part to operate the TAA Program; and

(C) Directly administering the TAA Program.

(j) *Program coordination.* State agencies providing employment and case management services under subpart C of this part and training under subpart F of this part must, in accordance with their Agreements under this section,

coordinate such services and payments with programs and services provided by WIOA and with the State agency administering the State law. Any agency of the State jointly administering such provisions under this Agreement must be considered to be a CSA for purposes of this part.

§ 618.808 State rulemaking.

(a) A State may establish laws, regulations, procedures, or policies, not inconsistent with the Act or this part, or administrative guidance issued by the Department.

(b) The State must submit the exact text of such proposed law, regulation, procedure, or policy, certified as accurate by a responsible official, employee, or counsel of the State, to the Department.

(c) No law, regulation, procedure, or policy proposed under paragraph (a) of this section may become effective unless and until approved by the Department. The Department may grant approval on a temporary basis, not to exceed 90 days, in cases of administrative necessity.

(d) The Department may withdraw approval at any time with reasonable notice of no less than 30 days to a State.

(e) If public notice and opportunity for hearing would be required under State law for adoption of a similar law, regulation, procedure, or policy involving UI or other State or Federal law, the State must provide such public notice and opportunity for hearing.

§ 618.812 Subpoenas.

(a) A State may require by subpoena the attendance of witnesses and production of evidence necessary for use in the determination of an individual's eligibility for TAA Program services and benefits or to obtain information needed to assist the Department in the petition determination process.

(b) This power includes the ability of the State to subpoena an employer for information necessary to determine whether a certification covers a worker, including the name, address, and Social Security number of the worker.

(c) The State may enforce compliance with subpoenas as provided under State law and, if a State court declines to enforce a subpoena issued under this section, or the State does not attempt a subpoena under State law, the State must petition for an order requiring compliance with such subpoena to the District Court of the United States with jurisdiction over the proceeding.

§ 618.816 Trade Adjustment Assistance Program benefit information and provision of services to workers.

(a) *Providing information to workers.* State agencies must provide information to each worker who applies for UI about the benefit allowances, training, and other services available under this part, and about the application procedures, and the appropriate filing dates, for such allowances, training, and other services.

(b) *Rapid response and appropriate career services.* States must ensure that rapid response assistance and appropriate career services, as described in section 134 of WIOA, are made available to members of a group of workers for whom a petition under subpart B of this part has been filed.

(c) *Providing reemployment services.* (1) For trade-affected workers covered by a certification, States must:

(i) Make available employment and case management services described in subpart C of this part, including testing, counseling, assessment, and placement services; and

(ii) Provide referrals to, assistance in securing of, and approvals of training under subpart F of this part.

(2) If funds provided to carry out this part are insufficient to make such services available, States must arrange to make such services available through other Federal programs.

(d) *Petition filing assistance.* (1) States must facilitate the early filing of petitions for a group of workers that the State considers are likely to be eligible for TAA Program benefits.

(2) For purposes of paragraph (d)(1) of this section, ''likely to be eligible'' means the State has a reasonable belief that a certification will be issued for the group of workers based on observations made by State staff; existence of certifications within the same industry, sector, or supply chain; or information or statements from the firm,

union, workers, media coverage, or other reports.

(3) States must provide assistance to enable individuals and other entities eligible to file to prepare petitions or applications for program benefits.

(4) Petitions must be filed under paragraph (d)(1) of this section even if the firm, a union, elected officials, or members of the group of workers oppose the filing.

(e) *Providing information after issuance of a certification.* (1) States must inform the State's board on vocational and technical education (also called the eligible agency, as defined in 20 U.S.C. 2302(12)) or the equivalent agency in the State and other public or private agencies, institutions, and employers, as appropriate, of each certification issued under subpart B of this part and of projections, if available, of the needs for training under subpart F of this part as a result of such certification.

(2) Upon receipt of a certification issued under subpart B of this part by the Department, the State must provide a written notice through the mail, of the benefits available under this part to each worker known to be covered by the certification when the worker becomes partially or totally separated or as soon as possible after the certification is issued if the worker is already partially or totally separated from adversely affected employment. The State must also provide notice to all workers threatened with separation who may be AAIWs. These notices must contain the following information:

(i) The worker group(s) covered by the TAA certification and the article(s) produced or services rendered as specified in the copy of the certification furnished to the State;

(ii) The name and the address or location of workers' firm;

(iii) The impact, certification, and expiration dates in the certification document.

(iv) A summary of benefits and services available to the workers;

(v) An explanation of how, when, and where the workers may apply for TAA Program benefits and services;

(vi) The training enrollment deadlines (set forth in §618.725) for TRA qualification;

(vii) Whom to contact to get additional information on the certification; and

(viii) A Babel notice (a short notice in multiple languages informing the reader that the communication contains vital information and explaining how to access language services to have the contents of the communication provided in other languages).

(3) In order to identify these workers, the State must obtain from the firm, or another reliable source, the names and addresses of all workers who were partially or totally separated from adversely affected employment before the agency received the certification, and of all workers who are thereafter partially or totally separated or threatened with separation within the certification period. Provision of this information may be compelled under the subpoena provisions at §618.812.

(4) Upon receipt of a copy of a certification issued by the Department affecting workers in a State, the State must publish a notice of the certification in a newspaper of general circulation in areas in which such workers reside. The published notice must include the same information identified in paragraphs (e)(2)(i) through (viii) of this section. The notice may be filed in a print version of the newspaper, or in the online or digital version of the newspaper if it can be reasonably expected to reach the interested parties.

(5) Upon receipt of a copy of a certification issued by the Department, the State must perform outreach to, intake of, and orientation for trade-affected workers covered by the certification with respect to assistance and benefits available under this part.

(6) In addition to the mailed written notice under paragraph (e)(2) of this section, States must also give notice to each worker by at least one method of modern electronic communication reasonably calculated to reach each worker. For example, States may give notice via email to a worker with a known email address, or by text to a worker with a known mobile phone number.

(7) States may also use other modern methods of communication, such as

websites and social media, to reach members of certified worker groups.

(f) *Specific benefit assistance to workers.* States must:

(1) Advise each trade-affected worker, as soon as practicable after the worker is separated from adversely affected employment or, if later, after a certification is issued, or upon notice of the worker's threatened status, of the benefits and services available under this part, including the qualifying requirements, procedures, and deadlines for applying for such benefits and services.

(2) Perform an intake interview for each trade-affected worker (unless the worker declines the interview) as soon as practicable after the worker is separated from adversely affected employment, after a certification is issued, or upon notice of the worker's threatened status. The interview must be scheduled in time for the worker to meet the training enrollment deadline set forth in proposed §618.725(a). During the interview, States must provide information about all of the benefits available under this part.

§ 618.820 Determinations of eligibility; notices to individuals.

(a) *Determinations on initial applications.* The State whose State law is the applicable State law must, upon the filing of an initial application by an individual, promptly determine the individual's eligibility for TAA Program benefits under this part and may accept for such purposes information and findings supplied by another State.

(b) *Determinations on subsequent applications.* The State must, upon the filing of an application for payment of TRA, RTAA, subsistence and transportation, job search allowance, or relocation allowance, promptly determine whether the individual is eligible for such payment and, if eligible, the amount of such payment.

(c) *Redeterminations.* The provision for redeterminations under the applicable State law applies to determinations of eligibility for any benefit under this part.

(d) *Use of State law.* In making determinations or redeterminations under this section, or in reviewing such determinations or redeterminations under §618.820, a State must apply the regulations in this part. As to matters committed by this part to be decided under the applicable State law, a CSA, a hearing officer, or a State court must apply the applicable State law and regulations thereunder, including the procedural requirements of the applicable State law or regulations, except that no provision of State law or State regulations on good cause for waiver of any time limit, or for late filing of any claim, will apply to any time limitation referred to or specified in this part, unless such State law or regulation is made applicable by a specific provision of this part. However, States must follow the good cause provision at §618.730.

(e) *Notices to individuals.* The State must notify individuals in writing of any determination or redetermination of eligibility to TAA Program benefits. Each determination or redetermination must inform the individual of the reason for the determination or redetermination and of the right to reconsideration or appeal in the same manner as determinations of entitlement to UI are subject to redetermination or appeal under the applicable State law.

(f) *Promptness.* States must make full payment of TAA Program benefits when due with the greatest promptness that is administratively feasible.

(g) *Procedure.* Except where otherwise required by the Act or this part, the procedures for making and furnishing determinations, the promptness standards, and written notices of determinations to individuals, must be consistent with the Department's ''Standard for Claim Determinations—Separation Information,'' Employment Security Manual, part V, sections 6010 through 6015 (appendix B of this part).

(h) *Successor-in-interest.* (1) States are authorized to determine whether a firm is a successor-in-interest to a firm named as the employer of a worker group on a determination issued under subpart B of this part.

(2) The factors to be used to determine whether or not there is a successor-in-interest are established in §618.110.

(3) If, after reviewing the successor-in-interest factors, the State believes that a denial of benefits is warranted,

the State must file a new petition requesting an amendment to the certification under § 618.250.

§ 618.824 Liable State and agent State responsibilities.

(a) *Liable State.* The liable State, as defined in § 618.110, is responsible for:

(1) Making all determinations, redeterminations, and decisions on appeals on all claims for program benefits under this part, including job search and relocation allowances under subpart D of this part; RTAA under subpart E of this part; training under subpart F of this part; subsistence and transportation payments under subpart F of this part; Basic, Additional, and Completion TRA under subpart G of this part; and waivers and revocations of waivers under subpart G of this part;

(2) Providing workers with general program information and assistance under § 618.816;

(3)(i) Providing rapid response assistance and appropriate career services, as described under section 134 of WIOA, to the group of workers in the State covered by the petition upon receiving notice of any such workers for whom a petition is filed.

(ii) This includes making career services authorized under other Federal laws available to the workers covered by the petition to the extent authorized under such laws.

(iii) In certain situations, based on the residency of the group of workers, it may be appropriate for agent States to also be involved in the provision of these services, but in all instances the liable State must be ultimately responsible for ensuring the provision of these services;

(4) Providing information and assistance to trade-affected workers under § 618.816(c) (providing reemployment services), (e) (providing information after issuance of a certification), and (f) (specific benefit assistance to workers) upon receiving a certification issued by the Department with respect to affected workers at a firm or appropriate subdivision in the State;

(5) Providing a list of eligible TAA recipients and eligible RTAA recipients, for HCTC purposes, to the Internal Revenue Service if HCTC is available; and

(6) Assisting in other activities and functions required by the Governor-Secretary Agreement at § 618.804, including assisting the Department in the review of petitions by verifying such information and providing such other assistance as the Department may request.

(b) *Agent State.* The agent State, as defined in § 618.110, is responsible for:

(1) Providing interstate claimants with general program information and assistance under § 618.816(a) and petition filing assistance under § 618.816(d);

(2) Cooperating fully with and assisting the liable State in carrying out its responsibilities, activities, and functions, including the provision of rapid response and appropriate career services, as needed;

(3) Cooperating with the liable State in taking applications and claims for TAA Program benefits under this part;

(4) Providing employment and case management services, as described in subpart C of this part, to trade-affected workers covered by a certification issued by the Department under this part;

(5) Cooperating with the liable State by providing information that the liable State needs for it to issue determinations, redeterminations, and decisions on appeals on all claims for program benefits under this part, as described in paragraph (a)(1) of this section;

(6) Securing, and paying the cost of, any approved training under subpart F of this part, and payment of subsistence and transportation under subpart F of this part, according to determinations issued by the liable State;

(7) Paying costs under subpart D of this part for job search and relocation allowances; and

(8) Assisting in other activities and functions required by the Agreement under § 618.804, including assisting in the review of petitions by verifying information and providing such other assistance as the Department may request.

(c) *Responsibilities under this section.* In most instances, the liable State and agent State will be the same State and is responsible for all of the activities and functions described in paragraphs (a) and (b) of this section.

§ 618.828 Appeals and hearings.

(a) *Applicable State law.* Except as provided in paragraph (b) of this section, a determination or redetermination under this part (other than a determination on the eligibility of a group of workers under subpart B of this part, which is subject to review by the USCIT) is subject to review in the same manner and to the same extent as determinations and redeterminations under the applicable State law, and only in that manner and to that extent. Proceedings for review of a determination or redetermination may be consolidated or joined with proceedings for review of other determinations or redeterminations under the applicable State law where convenient or necessary. The right of appeal and opportunity for fair hearing for these proceedings must be consistent with section 303(a)(1) and (3) of SSA (42 U.S.C. 503(a)(1) and (3)).

(b) *Allegations of discrimination.* Complaints alleging that a determination or redetermination under this part violates applicable Federal nondiscrimination laws administered by the U.S. Department of Labor must be handled in accordance with the procedures of 29 CFR parts 31, 32, 35, 36, and 38, as applicable, and as provided in § 618.894 (nondiscrimination and equal opportunity requirements).

(c) *Appeals promptness.* Appeals under paragraph (a) of this section must be decided with a degree of promptness meeting the Department's ''Standard for Appeals Promptness—Unemployment Compensation'' (20 CFR part 650). Any provisions of the applicable State law for advancement or priority of UI cases on judicial calendars, or other provisions intended to provide for prompt payment of UI when due, must apply equally to proceedings involving eligibility for TAA Program benefits and services under this part.

(d) *Retroactivity.* In the case of a redetermination or decision reversing a training denial, the redetermination or decision must be given effect retroactively to the date of issuance of the determination that was subsequently reversed. However, no costs of training may be paid unless such costs actually were incurred for training in which the individual participated. In addition, if a TRA application was filed and denied as a result of the training denial, TRA may only be paid with respect to any week during which the individual was actually participating in the training.

§ 618.832 Overpayments; penalties for fraud.

(a) *Determinations and repayment.* (1) If a State, the Department, or a court of competent jurisdiction determines that any person has received any payment under this part to which the person was not entitled, including a payment referred to in paragraph (b) of this section, such person is required to repay such amount to the State or the Department, as appropriate, except that the State or the Department must waive such repayment if such State or the Department determines that:

(i) The payment was made without fault on the part of such person; and

(ii) Requiring such repayment would cause a financial hardship for the person (or the person's household, if applicable).

(2) States must provide persons determined to have received TAA overpayments a reasonable opportunity to demonstrate their eligibility for waiver under the criteria in paragraphs (a)(1)(i) and (ii) of this section.

(3) A financial hardship exists if recovery of the overpayment would result in the person's (or the person's household's) loss of or inability to pay for ordinary and necessary living expenses. This determination must take into account the income and resources (including liquid financial resources) reasonably available to the person (and the person's household).

(4) Fault exists for purposes of paragraph (a)(1)(i) of this section if any of the following criteria are met:

(i) Whether a material statement or representation was made by the person or individual in connection with the application for TAA that resulted in the overpayment, and whether the person knew or should have known that the statement or representation was inaccurate;

(ii) Whether the person failed or caused another to fail to disclose a material fact in connection with an application for TAA that resulted in the overpayment, and whether the person

knew or should have known that the fact was material;

(iii) Whether the person knew or should have known that the person or individual was not entitled to the TAA payment;

(iv) Whether, for any other reason, the overpayment resulted directly or indirectly, and partially or totally, from any act or omission of the person or of which the person or individual had knowledge, and that was erroneous or inaccurate or otherwise wrong; or

(v) Whether there has been a determination of fraud under paragraph (b) of this section.

(b) *False representation or nondisclosure of material fact.* In addition to any other penalty provided by law, a person will be permanently ineligible for any further payments under this part if a State, the Department, or a court of competent jurisdiction determines that:

(1) Such person:

(i) Knowingly made, or caused another to make, a false statement or representation of a material fact; or

(ii) Knowingly failed, or caused another to fail, to disclose a material fact; and

(2) As a result of such false statement or representation, or of such nondisclosure, such person has received any payment under this part to which the person was not entitled.

(c) *Notice of determination, fair hearing, and finality.* Except for overpayments determined by a court of competent jurisdiction, no repayment may be required, and no deduction may be made, under this section until a determination under paragraph (a)(1) of this section by the State or the Department, as appropriate, has been made, notice of the determination and an opportunity for a fair hearing thereon has been given to the person concerned, and the determination has become final.

(d) *Training, job search and relocation allowances, and RTAA.* (1) If a trade-affected worker fails, with good cause, to complete training, a job search, or a relocation, any payment or portion of a payment made under this part to such person or individual properly and necessarily expended in attempting to complete such training, job search, or relocation is not an overpayment.

(2) If a trade-affected worker fails, without good cause, to complete training, a job search, or a relocation, then the portion of a payment for the noncompleted component of a benefit is an overpayment. Costs for the completed portions of the training program, job search, or relocation are not an overpayment.

(3) For purposes of this paragraph (d), good cause exists if the worker acted diligently yet was unable to complete training, a job search, or relocation because of exigent circumstances. The State must determine good cause on a worker-by-worker basis.

(4) An overpayment established under this paragraph (d) must be recovered or waived as provided in this section.

(5) For RTAA, an individual meets the ''earns not more than $50,000 each year in wages from reemployment'' requirement in section 246 of the Act for a given month if the monthly determination of annualized wages is accurate and complete at the time it is made. Payments derived from the annualized wage projection based on complete and accurate information at the time are valid payments that the individual was entitled to and are not overpayments.

(e) *Overpayment recovery of TAA Program funds by offset.* Unless an overpayment is otherwise recovered or is waived, the State–

(1) Must, subject to the limitation in paragraph (e)(3) of this section, recover the overpayment by deduction from any sums payable to such person under:

(i) This part;

(ii) Any Federal UI law administered by the State; or

(iii) Any other Federal law administered by the State that provides for the payment of unemployment assistance or an allowance with respect to unemployment.

(2) Must recover the overpayment from UI payable to such person under the applicable State law.

(3) Must not allow any single deduction under this paragraph (e) to exceed 50 percent of the amount otherwise payable to the person; except that if the applicable State law provides for

an overpayment recovery deduction that is less than 50 percent of the amount otherwise payable, such recovery must be equal to that lesser percentage.

(f) *Fraud detection and prevention.* State procedures for the detection and prevention of fraudulent overpayments of TAA benefits must be, at a minimum, the same as the procedures adopted by the State with respect to State unemployment compensation, and consistent with the Department's ''Standard for Fraud and Overpayment Detection,'' Employment Security Manual, part V, sections 7510 through 7515 (appendix C to this part).

(g) *Person.* For purposes of this section and §618.836 (recovery of debts due the United States or others by TAA offset), a person includes, in addition to a trade-affected worker or other individual, any employer or other entity or organization as well as the officers and officials thereof, including any training provider as well as the officers and officials thereof, who may bear individual responsibility for the overpayment.

(h) *Criminal penalties.* (1) Any person who makes a false statement of a material fact knowing it to be false, or knowingly fails to disclose a material fact under the circumstances described in paragraph (h)(1)(i) or (ii) of this section, must be imprisoned for not more than 1 year, fined under title 18, United States Code, or both.

(i) For the purpose of obtaining or increasing for that person or for any other person any payment authorized to be furnished under the Act or pursuant to a Governor-Secretary Agreement under section 239 of the Act; or

(ii) When providing information during an investigation of a petition under section 221 of the Act.

(2) Whenever a violation under paragraph (h)(1) of this section is suspected, the State or the Department must refer the conduct to the U.S. Department of Labor Office of the Inspector General.

§618.836 Recovery of debts due the United States or to others by Trade Adjustment Assistance offset.

(a) *Debt due the United States.* Notwithstanding any other provision of this part, the State must apply TAA benefits, payable under this part to a person (as described in §618.832(g)), for the recovery by offset of any debt due the United States from the person.

(b) *Debt due to others.* The State must not apply TAA Program benefits for the payment of any debt of any person to any State or any other entity or person, except for TRA and RTAA benefits as required by Federal UI law.

§618.840 Uniform interpretation and application of this part.

(a) *First rule of construction.* The implementing regulations in this part will be construed liberally to carry out the purposes of the Act.

(b) *Second rule of construction.* The implementing regulations in this part will be construed to assure, insofar as possible, the uniform interpretation and application of the Act and this part throughout the United States.

(c) *Effectuating purposes and rules of construction.* (1) To effectuate the purposes of the Act and this part and to assure uniform interpretation and application of the Act and this part throughout the United States:

(i) A State must, upon request, forward to the Department, not later than 10 days from the date of the request, a copy of any administrative ruling on an individual's eligibility to TAA benefits under this part.

(ii) Notwithstanding paragraph (c)(1)(i) of this section, a State must forward to the Department a copy of any determination or redetermination on an individual's eligibility to TAA benefits under this part appealed to the State's highest UI administrative appeals authority.

(iii) A State must forward to the Department a copy of notice of the institution of a State or Federal court proceeding and any State or Federal court ruling on an individual's eligibility to TAA Program benefits under this part, within 10 days of the notice or ruling.

(2) If the Department concludes that a determination, redetermination, or decision is inconsistent with the Department's interpretation of the Act or this part, the Department may at any time notify the State of the Department's view. Thereafter, the State must issue a redetermination or appeal

if possible and must not follow such determination, redetermination, or decision as a precedent; and, in any subsequent proceedings that involve such determination, redetermination, or decision, or wherein such determination, redetermination, or decision is cited as precedent or otherwise relied upon, the State must inform the claims deputy or hearing officer or court of the Department's view and must make all reasonable efforts, including appeal or other proceedings in an appropriate forum, to obtain modification, limitation, or overruling of the determination, redetermination, or decision.

(3) If the Department concludes that a determination, redetermination, or decision is patently and flagrantly violates of the Act or this part, the Department may at any time notify the State of the Department's view. If the determination, redetermination, or decision in question denies TAA to an individual, the State must follow the steps outlined in paragraph (c)(2) of this section. If the determination, redetermination, or decision in question awards TAA to an individual, the benefits are ''due'' within the meaning of section 303(a)(1) of SSA (42 U.S.C. 503(a)(1)), and therefore must be paid promptly to the individual. However, the State must take the steps outlined in paragraph (c)(2) of this section, and payments to the individual may be temporarily delayed if redetermination or appeal action is taken not more than 1 business day following the day on which the first payment otherwise would be issued to the individual; and the redetermination action is taken or appeal is filed to obtain a reversal of the award of TAA and a ruling consistent with the Department's view; and the redetermination action or appeal seeks an expedited redetermination or appeal within not more than 2 weeks after the redetermination action is taken. If redetermination action is not taken or appeal is not filed within the above time limit, or a redetermination or decision is not obtained within the 2-week limit, or any redetermination or decision or order is issued that affirms the determination, redetermination, or decision awarding TAA or allows it to stand in whole or in part, the benefits awarded must be paid promptly to the individual.

(4)(i) If any determination, redetermination, or decision, referred to in paragraph (c)(2) or (3) of this section, is treated as a precedent for any future application for TAA, the Secretary will decide whether the Agreement with the State entered into under the Act and this part will be terminated and § 618.804(e) applied.

(ii) In the case of any determination, redetermination, or decision that is not legally warranted under the Act or this part, including any determination, redetermination, or decision referred to in paragraph (c)(2) or (3) of this section, the Secretary will decide whether the State must restore the funds of the United States for any sums paid under such a determination, redetermination, or decision, and whether, in the absence of such restoration, the Agreement with the State will be terminated and § 618.804(e) applied and whether other action must be taken to recover such sums for the United States.

(5) A State may request, in writing, within 10 calendar days of receiving a notice under paragraph (c)(2) or (3) of this section, reconsideration of the notice. The State will have an opportunity to present its views and arguments if desired. The State must submit such a request to the Secretary and may include views and arguments on the matters the Secretary is to decide under paragraph (c)(3) of this section. The Secretary must respond to the State's reconsideration request within 30 calendar days of receiving the request.

(6) Concurrence of the Department with a determination, redetermination, or decision must not be presumed from the absence of a notice issued pursuant to this section.

(d) *Payment when due.* If the determination, redetermination, or decision in question awards TAA Program benefits to an individual, the benefits are ''due'' within the meaning of section 303(a)(1) of SSA (42 U.S.C. 503(a)(1)), and therefore must be paid promptly to the individual. Payments to the individual may be temporarily delayed if a redetermination is issued not more than 1 business day following the day on which the first payment otherwise

would be issued to the individual; and the State seeks an expedited appeal decision within not more than 2 calendar weeks after the appeal is filed. If the redetermination is not issued or the appeal is not filed within the time limit in the preceding sentence, or the decision on appeal is not obtained within the 2-calendar week limit in the preceding sentence, or any decision on appeal is issued that affirms the determination, redetermination, or decision awarding benefits under this part or allows it to stand in whole or in part, the benefits awarded must be paid promptly to the individual.

§ 618.844 Inviolate rights to Trade Adjustment Assistance or Reemployment Trade Adjustment Assistance.

(a) Except as specifically provided in this part, the rights of individuals to TAA Program benefits will be protected in the same manner and to the same extent as the rights of persons to UI are protected under the applicable State law. Such measures must include protection of applicants for TAA Program benefits from waiver, release, assignment, pledge, encumbrance, levy, execution, attachment, and garnishment of their rights to TAA Program benefits, except as provided in §§ 618.832 (overpayments; penalties for fraud) and 618.836 (recovery of debts due the United States or others by TAA offset).

(b) In the same manner and to the same extent as the rights of persons to UI are protected under the applicable State law, individuals must be protected from discrimination and obstruction in regard to the right to seek, apply for, and receive any TAA Program benefit.

§ 618.848 Veterans' priority of service.

The State must give priority for approval and funding of TAA Program benefits (including training, where the approval of training criteria are met) to a trade-affected worker meeting the veterans' priority of service criteria established under 38 U.S.C. 4215.

§ 618.852 Recordkeeping and disclosure of information requirements.

(a) *Recordkeeping.* (1) Each State must make and maintain such records pertaining to the administration of the Act as the Department requires and must make all such records available for inspection, examination, and audit by such Federal officials as the Department may designate or as may be required by law.

(2)(i) States must maintain records that contain any information that the Department determines to be appropriate in support of any reports that the Department may require, including those reports specified in §§ 618.860(f) (general fiscal and administrative requirements and cost classification) and 618.864(e) (TAA Program performance).

(ii) States must maintain records as required by 2 CFR 200.333 for 3 years, or as indicated at 2 CFR 200.333(a) through (f).

(3) States must comply with the records requirements established in the Uniform Guidance at 2 CFR 200.333 through 200.337.

(4) States must document that they provided or offered the employment and case management services described in subpart C of this part to all trade-affected workers, either in a paper-based or electronic case management system. States must make these systems available for review upon request by the Department. Additionally, the case management file of each participant must demonstrate that the State notified each worker of the training enrollment deadlines set forth in proposed § 618.725(a).

(b) *Disclosure of information.* (1) Information in records maintained by a State in administering the Act must be kept confidential, and information in such records may be disclosed only in the same manner and to the same extent as information with respect to UI and the entitlement of individuals thereto may be disclosed under the applicable State law. Such information must not, however, be disclosed to an employer or any other person except to the extent necessary to obtain information from the employer or other person for the purposes of this part. The provision in this paragraph (b)(1) on the confidentiality of information maintained in the administration of the Act does not apply in the following circumstances:

(i) Disclosures to the Department;

(ii) For the purposes of § 618.832 or paragraph (a) of this section;

(iii) For providing information, reports, and studies required by § 618.856 (information, reports, and studies); or

(iv) Where nondisclosure would be inconsistent with the Freedom of Information Act (5 U.S.C. 552) or the Privacy Act of 1974 (5 U.S.C. 552a).

(2) Where a State obtains confidential business information as part of assisting in an investigation under subpart B of this part, it must protect that information as required under that subpart.

(c) *Format of records and forms.* Forms and records used and maintained by States in the administration of this part may exist in paper or electronic form or a combination thereof. Regardless of the medium, these records must be available and accessible as required under paragraph (a)(1) of this section for oversight purposes.

(d) *Electronic signatures.* Electronic signatures are allowed where such use is in accordance with the Electronic Signatures in Global and National Commerce Act (Pub. L. 106–229).

§ 618.856 Information, reports, and studies.

A State must furnish to the Department such information and reports and conduct such studies as the Department determines are necessary or appropriate for carrying out the purposes of the Act and this part.

§ 618.860 General fiscal and administrative requirements and cost classification.

(a) *Uniform fiscal and administrative requirements.* (1) Each State receiving funds allocated for the TAA Program from the Department as an agent of the United States, must administer the TAA Program in accordance with the Uniform Guidance at 2 CFR part 200 and 2 CFR part 2900 and with the funding agreement.

(2) A State may expend funds awarded to it during a Federal fiscal year to carry out TAA Program activities under sections 235 through 238 of the Act during that Federal fiscal year and the succeeding 2 Federal fiscal years.

(3) Equipment, as described in 2 CFR 200.33 and computing devices, as described in 2 CFR 200.20, includes equipment acquired with TAA funds under both current and prior Agreements.

(4) The addition method, described at 2 CFR 200.307, must be used for all program income earned under TAA grants. When the cost of generating program income has been charged to such grant, the gross amount earned must be added to such grant. However, when these costs have not been charged to such grant, the cost of generating program income must be subtracted from the amount earned to establish the net amount of program income available for use under such grant.

(b) *Administrative costs.* (1) The administrative cost limit for the fiscal year program funding allocation for training, job search assistance, and relocation allowances is included in the TAA Program Annual Funding Agreement, with which States must comply.

(2) For purposes of the TAA Program, the costs of administration are the costs associated with performing the overall general administrative functions of the TAA Program in paragraphs (b)(2)(i) through (xviii) of this section and the coordination thereof within the American Job Center network established under WIOA:

(i) Accounting, budgeting, financial and cash management functions;

(ii) Procurement and purchasing functions;

(iii) Property management functions;

(iv) Personnel management functions;

(v) Payroll functions;

(vi) Coordinating the resolution of findings arising from audits, reviews, investigations, and incident reports;

(vii) Audit functions;

(viii) General legal services functions;

(ix) Developing systems and procedures, including information systems, required for these administrative functions;

(x) Processing applications for benefits under the Act;

(xi) Rendering and issuing eligibility determinations under the Act;

(xii) Performing oversight and monitoring responsibilities related to administrative functions;

(xiii) Costs of goods and services required for administrative functions of

the program, including goods and services such as rental or purchase of equipment, utilities, office supplies, postage, and rental and maintenance of office space;

(xiv) Travel costs incurred for official business in carrying out administrative activities or the overall management of the TAA Program;

(xv) Costs of information systems related to administrative functions (*i.e.*, personnel, procurement, purchasing, property management, accounting, and payroll systems), including the purchase, systems development, and operating costs of such systems;

(xvi) Processing waivers of training requirements under subpart G of this part;

(xvii) Collecting, validating, and reporting data required under the Act; and

(xviii) Providing RTAA under subpart E of this part.

(3) Awards to subrecipients or contractors that are solely for the performance of administrative functions constitute administrative costs.

(4) Personnel and related nonpersonnel costs of staff that perform both administrative functions specified in paragraph (b)(2) of this section and programmatic services or activities must be allocated as administrative or program costs to the benefitting cost objectives/categories based on documented distributions of actual time worked or other equitable cost allocation methods.

(5) Costs of the information systems in paragraphs (b)(5)(i) through (iii) of this section, including the purchase, systems development, and operational costs, are charged to the program category:

(i) Tracking or monitoring of participant and performance information, including employment and case management services and activities;

(ii) Employment statistics information, including job listing information, job skills information, and demand occupation information. States must leverage existing resources provided under other Federal programs; and

(iii) Maintenance and enhancement of the systems specified in paragraphs (b)(5)(i) and (ii) of this section.

(6) Wherever possible, States must make efforts to streamline the administrative activities and services listed in this section by minimizing duplication and effectively using information technology to improve services and leveraging resources across programs.

(c) *Prior approval.* (1) Equipment purchases under the TAA Program are subject to the provisions at 2 CFR 200.313. In compliance with 2 CFR 2900.16, prior approval is hereby provided for equipment purchases under the TAA Program.

(2) As provided in 2 CFR 200.439(b)(1), the Department retains the prior approval requirement related to capital expenditures (2 CFR 200.13) and for capital assets (2 CFR 200.12) other than equipment.

(d) *Audit and oversight requirements.* (1) All States, local governments, nonprofit organizations, and for-profit entities that are recipients or subrecipients of TAA Program funds must follow the audit requirements under 2 CFR 200.500 through 200.521 and 2 CFR 2900.20.

(2)(i) *Oversight and monitoring.* Each recipient and subrecipient of funds under the Act must conduct regular oversight and monitoring of its program and those of any subrecipients and contractors, as required under section 239(i) of the Act, as well as under 2 CFR part 200, including 2 CFR 200.328, 200.330, and 200.331, and Department exceptions at 2 CFR part 2900, in order to:

(A) Determine that expenditures have been made against the proper cost categories and within the cost limitations specified in the Act, the regulations in this part, and administrative guidance;

(B) Determine whether there is compliance with other provisions of the Act, the regulations in this part, and administrative guidance;

(C) Assure compliance with 2 CFR part 200 and the Department's exceptions at 2 CFR part 2900; and

(D) Determine compliance with the nondiscrimination, disability, and equal opportunity requirements of section 188 of WIOA, including the Assistive Technology Act of 1998 (29 U.S.C. 3003).

(ii) *Resolution of subrecipient-level findings.* (A) The Governor is responsible for resolving findings that arise from the monitoring reviews, investigations, other Federal monitoring reviews, and audits (including under 2 CFR part 200) of subrecipients awarded funds through the Act.

(B) A State must use the written monitoring and audit resolution, debt collection and appeal procedures that it uses for other Federal grant programs.

(C) If a State does not have such written procedures as described in paragraph (d)(2)(ii)(B) of this section, it must prescribe standards and procedures to govern this grant program.

(D) For subrecipients awarded funds through a recipient of grant funds, the direct recipient of the grant funds must have written monitoring and resolution procedures in place that are consistent with 2 CFR part 200.

(iii) *Resolution of State findings.* (A) The Secretary is responsible for resolving findings that arise from Federal audits, monitoring reviews, investigations, incident reports, and audits under 2 CFR part 200 for direct recipients of Federal awards under the Act.

(B) The Secretary will use the Department's audit resolution process, consistent with 2 CFR part 2900, subpart F.

(C) A final determination issued by a Grant Officer under the process in this paragraph (d)(2)(iii) may be appealed to the DOL Office of Administrative Law Judges under the procedures in 2 CFR 2900.22.

(e) *Government-wide debarment and suspension, and government-wide drug-free workplace requirements.* All TAA Program fund recipients and subrecipients must comply with the Government-wide requirements for debarment and suspension under subparts G and H of 2 CFR part 180 and the Government-wide requirements for a drug-free workplace at 29 CFR part 98.

(f) *Fiscal reporting requirements for States.* (1) In accordance with 2 CFR 200.327 and 2 CFR 2900.14, each State must submit a quarterly financial report to the Department as specified in the reporting instructions approved by OMB.

(2) States must report financial data on an accrual basis, and cumulatively by funding year of appropriation. Financial data may also be required on specific program activities as specified in the reporting instructions as approved by OMB.

(3) If the State's accounting system is not on the accrual basis of accounting, the State must develop accrual information through best estimates based on an analysis of the documentation on hand.

(4) The State must:

(i) Obligate funds on not less than a quarterly basis; and

(ii) Periodically review obligations and, in an appropriate and timely manner, de-obligate funds when a participant drops, completes, or is no longer eligible for training.

(g) *Use of funds.* Of the funds awarded to the States to carry out sections 235 through 238 of the Act for a fiscal year, the State must use:

(1) Not more than 10 percent for the costs of administration, provided in paragraph (b)(2)(i) of this section; and

(2) Not less than 5 percent for employment and case management services under section 235 of the Act.

(h) *Technology.* States must maintain sufficient and effective technology for the purpose of tracking and reporting required participant data, and to provide appropriate services under the TAA Program.

(i) *Designation of resources for Management Information Systems (MIS) development.* States are required to dedicate an appropriate portion of administrative and employment and case management funding under TAA for management information systems development, upgrades, and ongoing maintenance.

§ 618.864 Trade Adjustment Assistance Program performance.

(a) *General rule.* Each State must report to the Department comprehensive performance accountability measures, to consist of:

(1) The primary indicators of performance described in paragraph (b) of this section;

(2) The additional indicators of performance established under paragraph (c) of this section, if any; and

(3) A description of efforts made to improve outcomes for workers under the TAA Program that promote efficient and effective program performance as provided in this section.

(b) *Primary indicators of performance*—(1) *Primary indicators.* The primary indicators of performance shall consist of:

(i) The percentage and number of workers who received benefits under the TAA Program who are in unsubsidized employment during the second calendar quarter after exit from the program;

(ii) The percentage and number of workers who received benefits under the TAA Program who are in unsubsidized employment during the fourth calendar quarter after exit from the program;

(iii) The median earnings of workers who are in unsubsidized employment during the second quarter after exit from the program;

(iv) The percentage of those participants enrolled in a training program under subpart F (excluding those in OJT and customized training) who attained a recognized postsecondary credential or a secondary school diploma, or its recognized equivalent, during participation in or within 1 year after exit from the program; and

(v) The percentage and number of workers who received benefits under the TAA Program who, during a year while receiving such benefits, are in an education or training program that leads to a recognized postsecondary credential or employment and who are achieving measurable gains in skills toward such a credential or employment.

(2) *Indicator relating to credential attainment.* For purposes of paragraph (b)(1)(iv) of this section, a worker who received benefits under the TAA Program who obtained a secondary school diploma or its recognized equivalent is included in the percentage counted for purposes of paragraph (b)(1)(iv) of this section only if the worker, in addition to obtaining such a diploma or its recognized equivalent, has obtained or retained employment or is in an education or training program leading to a recognized postsecondary credential within 1 year after exit from the program.

(c) *Additional indicators.* The Department and a State may agree upon additional indicators of performance for the TAA Program, as appropriate.

(d) *Use of wage records.* States must, consistent with State law, use quarterly wage record information, as defined in 20 CFR 677.175, in measuring the progress on program performance indicators in paragraphs (b) and (c) of this section.

(1) The use of Social Security numbers from participants and such other information as is necessary to measure the progress of those participants through quarterly wage record information is authorized.

(2) States that participate in data sharing agreements for the purposes of obtaining wage record information may use such data sharing agreements to obtain wage record information for workers who received benefits under the TAA Program.

(3) To the extent that quarterly wage records are not available for a participant, States may use other information as is necessary to measure the progress of the participant.

(e) *Reporting requirements*—(1) *Data required.* States must report TAA Program demographics, performance, and services data, identified in paragraphs (b) and (c) of this section, to the Department on such forms and in such manner as the Department may prescribe.

(2) *Data reliability and validity.* States are required to establish procedures that are consistent with administrative guidance the Department issues to ensure the data States submit are valid and reliable.

(f) *Publication of performance results.* The Department will publish, annually, through electronic means, including posting on the Department's website, the TAA Program performance results of the States.

(g) *Control measures*—(1) *In general.* Each State must implement effective control measures to effectively oversee the operation and administration of the TAA Program and ensure the accurate collection of program data.

(2) *Location.* The control measures must be internal to a system used by the State to collect data.

(3) *Purpose.* States will implement these control measures in order to:

(i) Oversee the operation and administration of the TAA Program under this part;

(ii) Improve the timeliness and verifiability of reported data; and

(iii) Verify the accuracy of reported data, and must require:

(A) Periodic staff training;

(B) Participation in data validation and integrity efforts, as directed by the Department;

(C) Data analysis and monitoring on a quarterly basis to identify inaccurate data input;

(D) Data analysis and monitoring on a quarterly basis to identify missing data; and

(E) Resubmission of required reports upon correcting data the State identifies as a result of paragraphs (g)(3)(iii)(B) through (D) of this section.

(4) *Monitoring program.* In order to ensure the effective and efficient operation of the TAA Program, States must adopt a formal monitoring program designed to review and audit worker files.

(i) The monitoring program must be designed to identify and share best practices, identify and correct deficiencies, and identify and address staff training needs.

(ii) A minimum quarterly random sample of 20 cases must be audited as part of the monitoring program and must include cases from at least 2 certifications issued under subpart B of this part.

(iii) The four quarterly samples within a calendar year must also cover at least four different areas of the State administering the program.

(iv) If circumstances preclude a State from meeting the criteria in paragraphs (g)(4)(ii) and (iii) of this section, the State must contact the appropriate ETA regional office to design a monitoring program that better suits the TAA Program in that State, and make sure it is sufficient to ensure the accuracy and verifiability of such data.

(h) *Data on benefits received, training, outcomes, rapid response activities, and spending.* Data submitted by the States must be sufficient to provide, at a minimum, the information required in section 249B of the Act, including the following information:

(1) The number of workers receiving benefits under the TAA Program;

(2) The number of workers receiving each type of benefit, including employment and case management services, training, job search and relocation allowances, TRA (Basic, Additional, and Completion) and RTAA payments, and, to the extent feasible, the HCTC, if available;

(3) The average time during which such workers receive each type of benefit;

(4) The average number of weeks TRA were paid to workers;

(5) The number of workers who report that they have received benefits under a prior certification in any of the 10 fiscal years preceding the fiscal year for which the data are collected under this section;

(6) The number of workers who received TAA approved training, classified by major types of training, including but not limited to, classroom training, training through distance learning, training leading to an associate's degree, remedial education, prerequisite education, OJT, and customized training;

(7) The number of workers who exited TAA approved training, including who received prelayoff training or part-time training at any time during that training;

(8) The average duration of training and the average duration of training that does not include remedial or prerequisite education;

(9) The number of training waivers granted, classified by type of waiver;

(10) The number of workers who exited training and the average duration of such training;

(11) The number of workers who do not complete training and the average duration of the training such workers completed;

(12) The average cost per worker of receiving TAA approved training;

(13) The percentage of workers who received TAA approved training and obtained unsubsidized employment in a field related to that training;

(14) The age, preprogram educational level, and post-program credential attainment of the workers;

(15) The median earnings of workers during the second calendar quarter after exit from the program, expressed as a percentage of the median earnings of such workers before the calendar quarter in which such workers began receiving benefits under this part;

(16) The sectors in which workers are employed after receiving benefits under this part;

(17) Whether rapid response activities were provided with respect to each petition filed;

(18) The total amount of funds used to pay for TRA by the State; and

(19) The total amount of the TaOA payments to the State.

§ 618.868 Unemployment Insurance.

UI payable to an AAW shall not be denied or reduced for any week by reason of any right to a payment of TAA under the Act and this part.

§ 618.872 Travel under the Trade Adjustment Assistance Program.

(a) TAA Program participants are subject to the FTR at 41 CFR chapters 300 through 304 for all travel paid for with TAA Program funds.

(b) Except for the definition of ''commuting area,'' States may not apply State or local travel policies and restrictions to TAA Program participants receiving reimbursements for travel under the Act.

(c) In instances where the FTR is silent or defers to the Federal agency's travel policies, the State must apply the relevant policies of the Department.

§ 618.876 Verification of eligibility for program benefits.

(a) *Overall program eligibility*. In addition to all other eligibility criteria contained in this part, an individual must also be authorized to work in the United States to receive benefits under the TAA Program. States are required to verify the status of participants who are not a citizen or national of the United States.

(b) *Initial verification*. All States are required, under section 1137(d) of SSA (42 U.S.C. 1320b–7(d)), to initially verify the immigration status of self-reporting aliens who apply for UI through the system designated by the U.S. Customs and Immigration Service (or USCIS), currently the Systematic Alien Verification for Entitlement (or SAVE) program. No further verification is required except as described in paragraph (c) of this section.

(c) *Reverification*. (1) Once a State has verified satisfactory immigration status initially, the State must reverify the worker's immigration status if the documentation provided during initial verification will expire during the period in which that worker is potentially eligible to receive benefits under this subchapter.

(2) The State must conduct such redetermination in a timely manner, using the immigration status verification system described in section 1137(d) of SSA (42 U.S.C. 1320b–7(d)) or by review of other documentation, as described in that provision.

§ 618.884 Special rule with respect to military service.

(a) *In general*. Notwithstanding any other provision of this part, a State may waive any requirement of this part that the States determines is necessary to ensure that an AAW who is a member of a reserve component of the Armed Forces and serves a period of duty described in paragraph (b) of this section is eligible to receive a trade readjustment allowance, training, and other benefits under this part in the same manner and to the same extent as if the worker had not served the period of duty.

(b) *Period of duty described*. An AAW serves a period of duty described in paragraph (a) of this section if, before completing training under section 236 of the Act, the worker:

(1) Serves on active duty for a period of more than 30 days under a call or order to active duty of more than 30 days; or

(2) In the case of a member of the Army National Guard of the United States or Air National Guard of the United States, performs full-time National Guard duty under 32 U.S.C. 502(f) for 30 consecutive days or more when authorized by the President or the Secretary of Defense for the purpose of responding to a national emergency declared by the President and supported by Federal funds.

§ 618.888 Equitable tolling.

(a) A TAA Program deadline must be equitably tolled when:

(1) An extraordinary circumstance prevented an individual's timely action; and

(2) The individual otherwise acted with diligence.

(b)(1) When an individual fails to take timely action because the State failed to give notice required under this part, that failure is prima facie evidence of an extraordinary circumstance.

(2) If the individual did not receive the required notice, but otherwise received actual notice with sufficient time to take timely action, the lack of receipt of the required notice is not evidence of an extraordinary circumstance.

(c) A TAA Program deadline equitably tolled under this section is tolled for the time period during which the extraordinary circumstance exists. Once that circumstance is resolved, the time period that was tolled begins to run again.

(d) Equitable tolling may extend an otherwise expired TAA Program deadline by no more than 36 months.

§ 618.890 Staffing flexibility.

(a) Staff employed under a merit personnel system as provided in section 303(a)(1) of the Social Security Act must be used for all reviews of benefit determinations under applicable State law.

(b) All determinations on eligibility for TAA Program benefits must be made by State staff, with the exception of the functions in paragraph (a) of this section, which must be made by staff meeting the criteria in paragraph (a) of this section.

(c) All other functions under the TAA Program, not subject to paragraphs (a) and (b) of this section, may be provided under a variety of staffing models.

§ 618.894 Nondiscrimination and equal opportunity requirements.

(a) States and subrecipients of financial assistance under the TAA Program are required to comply with the nondiscrimination and equal opportunity provisions codified in the Department's regulations at 29 CFR parts 31, 32, 35, and 36.

(b) States and subrecipients of financial assistance under the TAA Program are required to comply with the nondiscrimination and equal opportunity requirements of WIOA section 188 and its implementing regulations at 29 CFR part 38 if the agency or subrecipient:

(1) Operates its TAA programs and activities as part of the one-stop delivery system established under the WIOA; or

(2) Otherwise satisfies the definition of ''recipient'' in 29 CFR 38.4(zz).

(c) Questions about the nondiscrimination requirements cited in this section may be directed to the Director, Civil Rights Center, U.S. Department of Labor, Room N–4123, 200 Constitution Avenue NW, Washington, DC 20210.

(d)(1) This section does not affect the rights and protections (and exceptions thereto) available under any other Federal law or regulation regarding discrimination.

(2) This section does not affect the rights and protections (and exceptions thereto) available under any other State or local law or regulation regarding discrimination, except as provided in paragraph (d)(3) of this section.

(3) No State may discriminate on any basis protected by 29 CFR parts 31, 32, 35, 36, and 38 (and exceptions thereto), as applicable, in determining an individual's eligibility for any of the following:

(i) Receiving aid, benefits, services, training, or employment;

(ii) Participating in any TAA program or activity;

(iii) Being employed by any State; or

(iv) Practicing any occupation or profession.

§ 618.898 Applicable State law.

(a) The applicable State law for an AAW remains the applicable State law for such worker until such worker becomes entitled to UI under the State law of another State (whether or not such worker files a UI claim in that other State).

(b) For purposes of determining the applicable State law for UI entitlement:

(1) A worker is deemed entitled to UI under a State law if such worker satisfies the base period employment and wage qualifying requirements of such State law;

(2) In the case of a combined-wage claim, UI entitlement must be determined under the law of the paying State; and

(3) In case of a Federal UI claim, or a joint State and Federal UI claim, UI entitlement must be determined under the law of the applicable State for such claims.

Subpart I—Allocation of Funds to States for Training and Other Activities

§ 618.900 Annual cap on funds available for Training and Other Activities.

(a) The total amount of funds made available for the costs of carrying out sections 235 through 238 of the Act, referenced here as Training and Other Activities (TaOA), will not exceed the annual cap established under section 236(a)(2)(A) of the Act. For each of Fiscal Years (FYs) 2015 through 2021, this cap is $450,000,000.

(b) Funds obligated during a fiscal year to carry out activities under sections 235 through 238 of the Act may be expended by the State receiving such funds during that fiscal year and the succeeding 2 fiscal years.

§ 618.910 Initial allocation of funds.

(a) *Initial allocation.* In the initial allocation for a fiscal year, the Department will allocate 65 percent of the funds available under section 236(a)(2)(A) of the Act for that fiscal year. The Department will announce the amount of each State's initial allocation of funds, determined in accordance with the requirements of this section, at the beginning of each fiscal year. The Department will determine this initial allocation on the basis of the total funds available under the annual cap for that year, even if the full amount has not been appropriated to the Department at that time.

(b) *Timing of the distribution of the initial allocation.* The Department will, as soon as practical, distribute the initial allocation announced under paragraph (a) of this section. However, the Department will not distribute the full amount of the initial allocation until it receives the entire fiscal year's appropriation of funds for TaOA. If the full year's appropriated amount for TaOA is less than the annual cap on funds available for TaOA, then the Department will distribute 65 percent of the amount appropriated.

(c) *Hold harmless provision.* Except as provided in paragraph (d) of this section, or required by the appropriation, in no case will the amount of the initial allocation to a State in a fiscal year be less than 25 percent of the initial allocation to that State in the preceding fiscal year.

(d) *Minimum initial allocation.* If a State has an adjusted initial allocation of less than $100,000, as calculated in accordance with paragraph (e)(2) of this section, that State will not receive an initial allocation, and the funds that otherwise would have been allocated to that State instead will be allocated among the other States in accordance with this section. A State that does not receive an initial allocation may apply to the Department under § 618.920(b) for reserve funds to obtain funding for TaOA.

(e) *Process of determining initial allocation.* (1) The Department will first apply the factors described in paragraph (f) of this section to determine an unadjusted initial allocation for each State.

(2) The Department will then apply the hold harmless provision of paragraph (c) of this section to the unadjusted initial allocation, as follows:

(i) A State whose unadjusted initial allocation is less than its hold harmless amount but is $100,000 or more will have its initial allocation adjusted up to its hold harmless amount in accordance with paragraph (c) of this section. If a State's unadjusted allocation is less than $100,000, the State will receive no initial allocation, in accordance with paragraph (d) of this section, and those funds will be distributed among the other States as provided in paragraph (e)(3) of this section.

(ii) A State whose unadjusted initial allocation is no less than its hold harmless threshold will receive its hold

harmless amount and, in addition, will receive an adjustment equal to the State's share of the remaining initial allocation funds, as provided in paragraph (e)(3) of this section.

(3) Any initial allocation funds remaining after the adjustments to initial allocations are applied as described in paragraph (e)(2)(i) of this section will be distributed among the States with unadjusted initial allocations that were no less than their respective hold harmless amounts, as described in paragraph (e)(2)(ii) of this section (the remaining States). The distribution of the remaining initial allocation funds among the remaining States will be made by using the formula in paragraph (f) of this section. This recalculation will disregard States receiving only their hold harmless amount under paragraph (e)(2)(i) of this section, so that the combined percentages of the remaining States total 100 percent.

(f) *Initial allocation factors.* (1) In determining how to make the initial allocation of funds, the Department will apply, as provided in paragraph (f)(3) of this section, the following factors with respect to each State:

(i) Factor 1: The trend in the number of trade-affected workers covered by certifications during the most recent 4 consecutive calendar quarters for which data are available. The trend will be established by assigning a greater weight to the most recent quarters, giving those quarters a larger share of the factor;

(ii) Factor 2: The trend in the number of workers participating in training during the most recent 4 consecutive calendar quarters for which data are available. The trend will be established by assigning a greater weight to the most recent quarters, giving those quarters a larger share of the factor;

(iii) Factor 3: The number of workers estimated to be participating in training during the fiscal year. The estimate will be calculated by dividing the weighted average number of workers in training for the State determined in paragraph (f)(1)(ii) of this section by the sum of the weighted averages for all States and multiplying the resulting ratio by the projected national average of workers in training for the fiscal year, using the projection methodology underlying the Department's most recent budget submission or update; and

(iv) Factor 4: The amount of funding estimated to be necessary to provide TAA approved training to such workers during the fiscal year. The estimate will be calculated by multiplying the estimated number of training participants in paragraph (f)(1)(iii) of this section by the average training cost for the State. The average training cost will be calculated by dividing total training expenditures for the most recent 4 quarters by the average number of training participants for the same time period.

(2) The four factors listed in paragraphs (f)(1)(i) through (iv) of this section are given equal weight.

(3) For each of the factors in paragraphs (f)(1)(i) through (iv) of this section, the Department will determine the national total and each State's percentage of the national total. Based on a State's percentage of each of these factors, the Department will determine the percentage that the State will receive of the total amount available for initial allocation for that fiscal year. The percentages of the initial allocation amount for all States combined will total 100 percent of the total amount of the initial allocation.

§ 618.920 Reserve fund distributions.

(a) The 35 percent of the TaOA funds for a fiscal year that remains after the initial allocation will be held by the Department as a reserve. Reserve funds will be used, as needed, for additional distributions to States during the remainder of the fiscal year, including distributions to those States that did not receive an initial allocation. The amount of any distributions of reserve funds will be determined by the Department within the time frame described in § 618.930, as appropriate, considering the information provided in reserve fund requests submitted by States as described in paragraph (b) of this section and the level of reserve funds available.

(b) A State requesting reserve funds must demonstrate that:

(1) At least 50 percent of its TaOA funds from the current year (if any

were received) and previous fiscal years have been expended; or

(2) The State needs additional TaOA funds to meet demands for services due to unusual and unexpected events, which includes an unexpected increase in the number of trade-affected workers eligible for TaOA.

(c) A State requesting reserve funds under paragraph (b) of this section also must provide a documented estimate of funding needs through the end of the fiscal year. That estimate must be based on an analysis that includes at least the following:

(1) The average cost of training in the State;

(2) The expected number of participants in training through the end of the fiscal year; and

(3) The remaining TaOA funds the State has available.

§ 618.930 Second distribution.

The Department will distribute at least 90 percent of the total TaOA funds (including § 618.920 reserve funds) for a fiscal year to the States no later than July 15 of that fiscal year. The Department will first fund all acceptable requests for reserve funds filed before June 1. After these requests are satisfied, any funds remaining will be distributed to those States that received an initial allocation in an amount greater than their hold harmless amount, using the methodology described in § 618.910. Any funds remaining after the second distribution will be available for allotment under § 618.920.

§ 618.940 Insufficient funds.

If, during a fiscal year, the Department estimates that the amount of funds necessary to provide TaOA will exceed the annual cap under § 618.900, the Department will decide how the available funds that have not been distributed at the time of the estimate will be allocated among the States for the remainder of the fiscal year, and will communicate this decision to States through administrative guidance.

§ 618.950 Recapture and reallocation of Training and Other Activities funds.

(a) The Department may:

(1) Recapture funds that were allocated to any State to carry out sections 235 through 238 of the Act and that remain unobligated by the State during the second or third fiscal year after the fiscal year in which the funds were provided to the State; and

(2) Reallocate recaptured funds to States to carry out sections 235 through 238 of the Act, in accordance with procedures established in this section.

(b) The Department may recapture and reallocate funds as authorized by paragraph (a) of this section if the Department determines:

(1) There are, or are projected to be, insufficient funds in a State or States to carry out the activities described in sections 235 through 238 of the Act for a fiscal year; or

(2) The recapture and reallocation of funds would likely promote the more efficient and effective use of funds among States to carry out the activities described in sections 235 through 238 of the Act for a fiscal year.

(c) If the Department makes a determination described in paragraph (b)(1) of this section for a fiscal year, the Department may recapture funds, to the extent needed, from one or more of the State or States that have the highest percentage of unobligated or unexpended funds from the second or third fiscal year after the fiscal year in which the funds initially were allocated to such States, as determined by the Department, and reallocate those funds to the States with, or projected to have, insufficient funds. In making the determination that a State has or is projected to have insufficient funds to carry out the activities described in sections 235 through 238 of the Act for a fiscal year, the Department may consider a request submitted by the State in accordance with information required under § 618.920(b) or base such determination on other information the Department determines is appropriate.

(d) If the Department makes a determination described in paragraph (b)(2)

of this section for a fiscal year, the Department may recapture funds from the State or States that have the highest percentage of unobligated or unexpended funds from the second or third fiscal year after the fiscal year in which the funds were initially allocated to such States, as determined by the Department, and reallocate those funds to:

(1) The States with the lowest percentage of unobligated or unexpended funds from the second or third fiscal year after the fiscal year in which the funds initially were allocated to such States as determined by the Department, based on such additional factor or factors as the Department determines is or are appropriate; or

(2) All States from which funds are not being recaptured, in accordance with the formula factors described in §618.910(f), relating to the initial distribution of funds.

(e) If the Department determines to recapture and reallocate funds pursuant to this section, an administrative notice must be issued to the States describing the methodology used and the amounts to be recaptured from and reallocated to each affected State, not less than 15 business days in advance of the recapture of funds.

(f) The reallocation of funds under this section does not extend the period of availability for the expenditure of those funds, which expenditure period remains 2 fiscal years after the fiscal year in which the funds were initially allocated by the Department to the State from which the funds are recaptured.

APPENDIX A TO PART 618—STANDARD FOR CLAIM FILING, CLAIMANT REPORTING, JOB FINDING, AND EMPLOYMENT SERVICES

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 5000–5004)

5000–5099 *Claims Filing*

5000 *Standard for Claim Filing, Claimant Reporting, Job Finding, and Employment Services*

A. *Federal law requirements.* Section 3304(a)(1) of the Federal Unemployment Tax Act and section 303(a)(2) of the Social Security Act require that a State law provide for:

''Payment of unemployment compensation solely through public employment offices or such other agencies as the Secretary may approve.''

Section 3304(a)(4) of the Federal Unemployment Tax and section 303(a)(5) of the Social Security Act require that a State law provide for:

''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation * * *''

Section 303(a)(1) of the Social Security Act requires that the State law provide for:

''Such methods of administration * * * as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

B. *Secretary's interpretation of federal law requirements.*

1. The Secretary interprets section 3304(a)(1) of the Federal Unemployment Tax Act and section 303(a)(2) of the Social Security Act to require that a State law provide for payment of unemployment compensation solely through public employment offices or claims offices administered by the State employment security agency if such agency provides for such coordination in the operations of its public employment offices and claims offices as will insure (a) the payment of benefits only to individuals who are unemployed and who are able to work and available for work, and (b) that individuals claiming unemployment compensation (claimants) are afforded such placement and other employment services as are necessary and appropriate to return them to suitable work as soon as possible.

2. The Secretary interprets all the above sections to require that a State law provide for:

a. Such contact by claimants with public employment offices or claims offices or both, (1) as will reasonably insure the payment of unemployment compensation only to individuals who are unemployed and who are able to work and available for work, and (2) that claimants are afforded such placement and other employment services as are necessary and appropriate to facilitate their return to suitable work as soon as possible; and

b. Methods of administration which do not unreasonably limit the opportunity of individuals to establish their right to unemployment compensation due under such States law.

5001 *Claim Filing and Claimant Reporting Requirements Designed To Satisfy Secretary's Interpretation*

A. *Claim filing—total or part-total unemployment*

1. Individuals claiming unemployment compensation for total or part-total unemployment are required to file a claim weekly

or biweekly, in person or by mail, at a public employment office or a claims office (these terms include offices at itinerant points) as set forth below.

2. Except as provided in paragraph 3, a claimant is required to file in person.

a. His new claim with respect to a benefit year, or his continued claim for a waiting week or for his first compensable week of unemployment in such year; and

b. Any other claim, when requested to do so by the claims personnel at the office at which he files his claim(s) because questions about his right to benefits are raised by circumstances such as the following:

(1) The conditions or circumstances of his separation from employment;

(2) The claimant's answers to questions on mail claim(s) indicate that he may be unable to work or that there may be undue restrictions on his availability for work or that his search for work may be inadequate or that he may be disqualified;

(3) The claimant's answers to questions on mail claims create uncertainty about his credibility or indicate a lack of understanding of the applicable requirements; or

(4) The claimant's record shows that he has previously filed a fraudulent claim.

In such circumstances, the claimant is required to continue to file claims in person each week (or biweekly) until the State agency determines that filing claims in person is no longer required for the resolution of such questions.

3. A claimant must be permitted to file a claim by mail in any of the following circumstances:

a. He is located in an area requiring the expenditure of an unreasonable amount of time or money in traveling to the nearest facility established by the State agency for filing claims in person;

b. Conditions make it impracticable for the agency to take claims in person;

c. He has returned to full-time work on or before the scheduled date for his filing a claim, unless the agency makes provision for in-person filing at a time and place that does not interfere with his employment;

d. The agency finds that he has good cause for failing to file a claim in person.

4. A claimant who has been receiving benefits for partial unemployment may continue to file claims as if he were a partially unemployed worker for the first four consecutive weeks of total or part-total unemployment immediately following his period of partial unemployment so long as he remains attached to his regular employer.

B. *Claim filing—partial unemployment.* Each individual claiming unemployment compensation for a week (or other claim period) during which, because of lack of work, he is working less than his normal customary full-time hours for his regular employer and is earning less than the earnings limit provided in the State law, shall not be required to file a claim for such week or other claim period earlier than 2 weeks from the date that wages are paid for such claim period or, if a low earnings report is required by the State law, from the date the employer furnished such report to the individual. State agencies may permit claims for partial unemployment to be filed either in person or by mail, except that in the circumstances set forth in section A 3, filing by mail must be permitted, and in the circumstances set forth in section A 2 b, filing in person may be required.

5002 *Requirement for Job Finding, Placement, and Other Employment Services Designed To Satisfy Secretary's Interpretation*

A. Claims personnel are required to assure that each claimant is doing what a reasonable individual in his circumstances would do to obtain suitable work.

B. In the discretion of the State agency:

1. The claims personnel are required to give each claimant such necessary and appropriate assistance as they reasonably can in finding suitable work and at their discretion determine when more complete placement and employment services are necessary and appropriate for a claimant; and if they determine more complete services are necessary and appropriate, the claims personnel are to refer him to employment service personnel in the public employment office in which he has been filing claim(s), or, if he has been filing in a claims office, in the public employment office most accessible to him; *or*

2. All placement and employment services are required to be afforded to each claimant by employment service personnel in the public employment office most accessible to him in which case the claims personnel in the office in which the claimant files his claim are to refer him to the employment service personnel when placement or other employment services are necessary and appropriate for him.

C. The personnel to whom the State agency assigns the responsibilities outlined in paragraph B above are required to give claimants such job-finding assistance, placement, and other employment services as are necessary and appropriate to facilitate their return to suitable work as soon as possible.

In some circumstances, no such services or only limited services may be required. For example, if a claimant is on a short-term temporary layoff with a fixed return date, the only service necessary and appropriate to be given to him during the period of the layoff is a referral to suitable temporary work if such work is being performed in the labor market area.

Similarly, claimants whose unemployment is caused by a labor dispute presumably will return to work with their employer as soon

as the labor dispute is settled. They generally do not need services, nor do individuals in occupations where placement customarily is made by other nonfee charging placement facilities such as unions and professional associations.

Claimants who fall within the classes which ordinarily would require limited services or no services shall, if they request placement and employment services, be afforded such services as are necessary and appropriate for them to obtain suitable work or to achieve their reasonable employment goals.

On the other hand, a claimant who is permanently separated from his job is likely to require some services. He may need only some direction in how to get a job; he may need placement services if he is in an occupation for which there is some demand in the labor market area; if his occupation is outdated, he may require counseling and referral to a suitable training course. The extent and character of the services to be given any particular claimant may change with the length of his unemployment and depend not only on his own circumstances and conditions, but also on the condition of the labor market in the area.

D. Claimants are required to report to employment service personnel, as directed, but such personnel and the claims personnel required to so arrange and coordinate the contacts required of a claimant as not to place an unreasonable burden on him or unreasonably limit his opportunity to establish his rights to compensation. As a general rule, a claimant is not required to contact in person claims personnel or employment service personnel more frequently than once a week, unless he is directed to report more frequently for a specific service such as referral to a job or a training course or counseling which cannot be completed in one visit.

E. Employment service personnel are required to report promptly to claims personnel in the office in which the claimant files his claim(s): (1) his failure to apply for or accept work to which he was referred by such personnel or when known, by any other nonfee-charging placement facility such as a union or a professional association; and (2) any information which becomes available to it that may have a bearing on the claimant's ability to work or availability for work, or on the suitability of work to which he was referred or which was offered to him.

5004 *Evaluation of Alternative State Provisions*

If the State law provisions do not conform to the ''suggested State law requirements'' set forth in sections 5001 and 5002, but the State law contains alternative provisions, the Manpower Administrator, in collaboration with the State agency, will study the actual or anticipated affect of the alternative provisions. If the Manpower Administrator concludes that the alternative provisions satisfy the requirements of the Federal law as construed by the Secretary (see section 5000 B) he will so notify the State agency. If he does not so conclude, he will submit the matter to the Secretary. If the Secretary concludes that the alternative provisions satisfy such requirements, the State agency will be so notified. If the Secretary concludes that there is a question as to whether the alternative provisions satisfy such requirements, the State agency will be advised that unless the State law provisions are appropriately revised, a notice of hearing will be issued as required by the Code of Federal Regulations, title 20, section 601.3.

[59 FR 943, Jan. 6, 1994. Redesignated at 85 FR 51972, Aug. 21, 2020.]

APPENDIX B TO PART 618—STANDARD FOR CLAIM DETERMINATIONS—SEPARATION INFORMATION

6010 *Federal Law Requirements.* Section 303(a)(1) of the Social Security Act requires that a State law include provision for:

''Such methods of administration . . . as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

Section 303(a)(3) of the Social Security Act requires that a State law include provision for:

''Opportunity for a fair hearing before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied.''

Section 3304(a)(4) of the Federal Unemployment Tax Act and section 303(a)(5) of the Social Security Act require that a State law include provision for:

''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation. . . .

Section 3306(h) of the Federal Unemployment Tax Act defines ''compensation'' as ''cash benefits payable to individuals with respect to their unemployment.''

6011 *Secretary's Interpretation of Federal Law Requirements.* The Secretary interprets the above sections to require that a State law include provisions which will insure that:

A. Individuals who may be entitled to unemployment compensation are furnished such information as will reasonably afford them an opportunity to know, establish, and protect their rights under the unemployment compensation law of such State, and

B. The State agency obtains and records in time for the prompt determination and review of benefit claims such information as will reasonably insure the payment of benefits to individuals to whom benefits are due.

6012 *Criteria for Review of State Law Conformity with Federal Requirements:*

In determining the conformity of a State law with the above requirements of the Federal Unemployment Tax Act and the Social Security Act as interpreted by the Secretary, the following criteria will be applied:

A. Is it required that individuals who may be entitled to unemployment compensation be furnished such information of their potential rights to benefits, including the manner and places of filing claims, the reasons for determinations, and their rights of appeal, as will insure them a reasonable opportunity to know, establish, and protect their rights under the law of the State?

B. Is the State agency required to obtain, in time for prompt determination of rights to benefits such information as will reasonably insure the payment of benefits to individuals to whom benefits are due?

C. Is the State agency required to keep records of the facts considered in reaching determinations of rights to benefits?

6013 *Claim Determinations Requirements Designed To Meet Department of Labor Criteria:*

A. *Investigation of claims*. The State agency is required to obtain promptly and prior to a determination of an individual's right to benefits, such facts pertaining thereto as will be sufficient reasonably to insure the payment of benefits when due.

This requirement embraces five separate elements:

1. It is the responsibility of the agency to take the initiative in the discovery of information. This responsibility may not be passed on to the claimant or the employer. In addition to the agency's own records, this information may be obtained from the worker, the employer, or other sources. If the information obtained in the first instance discloses no essential disagreement and provides a sufficient basis for a fair determination, no further investigation is necessary. If the information obtained from other sources differs essentially from that furnished by the claimant, the agency, in order to meet its responsibility, is required to inform the claimant of such information from other sources and to afford the claimant an opportunity to furnish any further facts he may have.

2. Evidentiary facts must be obtained as distinguished from ultimate facts or conclusions. That a worker was discharged for misconduct is an ultimate fact or conclusion; that he destroyed a machine upon which he was working is a primary or evidentiary fact, and the sort of fact that the requirement refers to.

3. The information obtained must be sufficient reasonably to insure the payment of benefits when due. In general, the investigation made by the agency must be complete enough to provide information upon which the agency may act with reasonable assurance that its decision is consistent with the unemployment compensation law. On the other hand, the investigation should not be so exhaustive and time-consuming as unduly to delay the payment of benefits and to result in excessive costs.

4. Information must be obtained promptly so that the payment of benefits is not unduly delayed.

5. If the State agency requires any particular evidence from the worker, it must give him a reasonable opportunity to obtain such evidence.

B. *Recording of facts*. The agency must keep a written record of the facts considered in reaching its determinations.

C. *Determination notices:*

1. The agency must give each claimant a written notice of:

a. Any monetary determination with respect to his benefit year;

b. Any determination with respect to purging a disqualification if, under the State law, a condition or qualification must be satisfied with respect to each week of disqualification; but in lieu of giving written notice of each determination for each week in which it is determined that the claimant has met the requirements for purging, the agency may inform the claimant that he has purged the disqualification for a week by notation on his applicant identification card or otherwise in writing.

c. Any other determination which adversely affects his rights to benefits, except that written notice of determination need not be given with respect to:

(1) A week in a benefit year for which the claimant's weekly benefit amount is reduced in whole or in part by earnings if, the first time in the benefit year that there is such a reduction, he is required to be furnished a booklet or leaflet containing the information set forth below in paragraph 2f(1). However, a written notice of determination is required if: (a) there is a dispute concerning the reduction with respect to any week (e.g., as to the amount computed as the appropriate reduction, etc.); or (b) there is a change in the State law (or in the application thereof) affecting the reduction; or

(2) Any week in a benefit year subsequent to the first week in such benefit year in which benefits were denied, or reduced in whole or in part for reasons other than earnings, if denial or reduction for such subsequent week is based on the same reason and the same facts as for the first week, and if written notice of determination is required to be given to the claimant with respect to such first week, and with such notice of determination, he is required to be given a booklet or pamphlet containing the information set forth below in paragraph 2f(2) and 2h. However, a written notice of determination is required if: (a) there is a dispute concerning the denial or reduction of benefits with respect to such week; or (b) there is a

change in the State law (or in the application thereof) affecting the denial or reduction; or (c) there is a change in the amount of the reduction except as to the balance covered by the last reduction in a series of reductions.

NOTE: This procedure may be applied to determinations made with respect to any subsequent weeks for the same reason and on the basis of the same facts: (a) that claimant is unable to work, unavailable for work, or is disqualified under the labor dispute provision; and (b) reducing claimant's weekly benefit amount because of income other than earnings or offset by reason of overpayment.

2. The agency must include in written notices of determinations furnished to claimants sufficient information to enable them to understand the determinations, the reasons therefor, and their rights to protest, request reconsideration, or appeal.

The written notice of monetary determination must contain the information specified in the following items (except h) unless an item is specifically not applicable. A written notice of any other determination must contain the information specified in as many of the following items as are necessary to enable the claimant to understand the determination and to inform him of his appeal rights. Information specifically applicable to the individual claimant must be contained in the written notice of determination. Information of general application such as (but not limited to) the explanation of benefits for partial unemployment, information as to deductions, seasonality factors, and information as to the manner and place of taking an appeal, extension of the appeal period, and where to obtain information and assistance may be contained in a booklet or leaflet which is given the claimant with his monetary determination.

a. *Base period wages.* The statement concerning base-period wages must be in sufficient detail to show the basis of computation of eligibility and weekly and maximum benefit amounts. (If maximum benefits are allowed, it may not be necessary to show details of earnings.)

b. *Employer name.* The name of the employer who reported the wage is necessary so that the worker may check the wage transcript and know whether it is correct. If the worker is given only the employer number, he may not be able to check the accuracy of the wage transcript.

c. *Explanation of benefit formula—weekly and maximum benefit amounts.* Sufficient information must be given the worker so that he will understand how his weekly benefit amount, including allowances for dependents, and his maximum benefit amount were figured. If benefits are computed by means of a table contained in the law, the table must be furnished with the notice of determination whether benefits are granted or denied.

The written notice of determination must show clearly the weekly benefit amount and the maximum potential benefits to which the claimant is entitled.

The notice to a claimant found ineligible by reason of insufficient earnings in the base period must inform him clearly of the reason for ineligibility. An explanation of the benefit formula contained in a booklet or pamphlet should be given to each claimant at or prior to the time he receives written notice of a monetary determination.

d. *Benefit year.* An explanation of what is meant by the benefit year and identification of the claimant's benefit year must be included in the notice of determination.

e. *Information as to benefits for partial unemployment.* There must be included either in the written notice of determination or in a booklet or pamphlet accompanying the notice an explanation of the claimant's rights to partial benefits for any week with respect to which he is working less than his normal customary full-time workweek because of lack of work and for which he earns less than his weekly benefit amount or weekly benefit amount plus earnings, whichever is provided by the State law. If the explanation is contained in the notice of determination, reference to the item in the notice in which his weekly benefit amount is entered should be made.

f. *Deductions from weekly benefits:*

(1) *Earnings.* Although written notice of determinations deducting earnings from a claimant's weekly benefit amount is generally not required (see paragraph 1 c (1) above), where written notice of determination is required (or given) it shall set forth the amount of earnings, the method of computing the deduction in sufficient detail to enable the claimant to verify the accuracy of the deduction, and his right to protest, request redetermination, and appeal. Where a written notice of determination is given to the claimant because there has been a change in the State law or in the application of the law, an explanation of the change shall be included.

When claimant is not required to receive a written notice of determination, he must be given a booklet or pamphlet the first time in his benefit year that there is a deduction for earnings which shall include the following information:

(a) The method of computing deductions for earnings in sufficient detail to enable the claimant to verify the accuracy of the deduction;

(b) That he will not automatically be given a written notice of determination for a week with respect to which there is a deduction for earnings (unless there is a dispute concerning the reduction with respect to a week or there has been a change in the State law

or in the application of the law affecting the deduction) but that he may obtain such a written notice upon request; and

(c) A clear statement of his right to protest, request a redetermination, and appeal from any determination deducting earnings from his weekly benefit amount even though he does not automatically receive a written notice of determination; and if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

(2) *Other deductions:*

(a) A written notice of determination is required with respect to the first week in claimant's benefit year in which there is a reduction from his benefits for a reason other than earnings. This notice must describe the deduction made from claimant's weekly benefit amount, the reason for the deduction, the method of computing it in sufficient detail to enable him to verify the accuracy of such deduction, and his right to protest, request redetermination, or appeal.

(b) A written notice of determination is not required for subsequent weeks that a deduction is made for the same reason and on the basis of the same facts, if the notice of determination pursuant to (2) (a), or a booklet or pamphlet given him with such notice explains (i) the several kinds of deductions which may be made under the State law (e.g., retirement pensions, vacation pay, and overpayments); (ii) the method of computing each kind of deduction in sufficient detail that claimant will be able to verify the accuracy of deductions made from his weekly benefit payments; (iii) any limitation on the amount of any deduction or the time in which any deduction may be made; (iv) that he will not automatically be given a written notice of determination for subsequent weeks with respect to which there is a deduction for the same reason and on the basis of the same facts, but that he may obtain a written notice of determination upon request; (v) his right to protest, request redetermination, or appeal with respect to subsequent weeks for which there is a reduction from his benefits for the same reason, and on the basis of the same facts even though he does not automatically receive a written notice of determination; and (vi) that if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

g. *Seasonality factors.* If the individual's determination is affected by seasonality factors under the State law, an adequate explanation must be made. General explanations of seasonality factors which may affect determinations for subsequent weeks may be included in a booklet or pamphlet given claimant with his notice of monetary determinations.

h. *Disqualification or ineligibility.* If a disqualification is imposed, or if the claimant is declared ineligible for one or more weeks, he must be given not only a statement of the period of disqualification or ineligibility and the amount of wage-credit reductions, if any, but also an explanation of the reason for the ineligibility or disqualification. This explanation must be sufficiently detailed so that he will understand why he is ineligible or why he has been disqualified, and what he must do in order to requalify for benefits or purge the disqualification. The statement must be individualized to indicate the facts upon which the determination was based, e.g., state, ''It is found that you left your work with Blank Company because you were tired of working; the separation was voluntary, and the reason does not constitute good cause,'' rather than merely the phrase ''voluntary quit.'' Checking a box as to the reason for the disqualification is not a sufficiently detailed explanation. However, this statement of the reason for the disqualification need not be a restatement of all facts considered in arriving at the determination.

i. *Appeal rights.* The claimant must be given information with respect to his appeal rights.

(1) The following information shall be included in the notice of determination:

(a) A statement that he may appeal or, if the State law requires or permits a protest or redetermination before an appeal, that he may protest or request a redetermination.

(b) The period within which an appeal, protest, or request for redetermination must be filed. The number of days provided by statute must be shown as well as either the beginning date or ending date of the period. (It is recommended that the ending date of the appeal period be shown, as this is the more understandable of the alternatives.)

(2) The following information must be included either in the notice of determination or in separate informational material referred to in the notice:

(a) The manner in which the appeal, protest, or request for redetermination must be filed, e.g., by signed letter, written statement, or on a prescribed form, and the place or places to which the appeal, protest, or request for redetermination may be mailed or hand-delivered.

(b) An explanation of any circumstances (such as nonworkdays, good cause, etc.) which will extend the period for the appeal, protest, or request for redetermination beyond the date stated or identified in the notice of determination.

(c) That any further information claimant may need or desire can be obtained together with assistance in filing his appeal, protest,

or request for redetermination from the local office.

If the information is given in separate material, the notice of determination would adequately refer to such material if it said, for example, ''For other information about your (appeal), (protest), (redetermination) rights, see pages __ to __ of the __ (name of pamphlet or booklet) heretofore furnished to you.''

6014 *Separation Information Requirements Designed To Meet Department of Labor Criteria:*

A. *Information to agency.* Where workers are separated, employers are required to furnish the agency promptly, either upon agency request or upon such separation, a notice describing the reasons for and the circumstances of the separation and any additional information which might affect a claimant's right to benefits. Where workers are working less than full time, employers are required to furnish the agency promptly, upon agency request, information concerning a claimant's hours of work and his wages during the claim periods involved, and other facts which might affect a claimant's eligibility for benefits during such periods.

When workers are separated and the notices are obtained on a request basis, or when workers are working less than full time and the agency requests information, it is essential to the prompt processing of claims that the request be sent out promptly after the claim is filed and the employer be given a specific period within which to return the notice, preferably within 2 working days.

When workers are separated and notices are obtained upon separation, it is essential that the employer be required to send the notice to the agency with sufficient promptness to insure that, if a claim is filed, it may be processed promptly. Normally, it is desirable that such a notice be sent to the central office of the agency, since the employer may not know in which local office the worker will file his claim. The usual procedure is for the employer to give the worker a copy of the notice sent by the employer to the agency.

B. *Information to worker:*

1. *Information required to be given.* Employers are required to give their employees information and instructions concerning the employees' potential rights to benefits and concerning registration for work and filing claims for benefits.

The information furnished to employees under such a requirement need not be elaborate; it need only be adequate to insure that the worker who is separated or who is working less than full time knows he is potentially eligible for benefits and is informed as to what he is to do or where he is to go to file his claim and register for work. When he files his claim, he can obtain more detailed information.

In States that do not require employers to furnish periodically to the State agency detailed reports of the wages paid to their employees, each employer is required to furnish to his employees information as to (a) the name under which he is registered by the State agency, (b) the address where he maintains his payroll records, and (c) the workers' need for this information if and when they file claims for benefits.

2. *Methods for giving information.* The information and instructions required above may be given in any of the following ways:

a. *Posters prominently displayed in the employer's establishment.* The State agency should supply employers with a sufficient number of posters for distribution throughout their places of business and should see that the posters are conspicuously displayed at all times.

b. *Leaflets.* Leaflets distributed either periodically or at the time of separation or reduction of hours. The State agency should supply employers with a sufficient number of leaflets.

c. *Individual notices.* Individual notices given to each employee at the time of separation or reduction in hours.

It is recommended that the State agency's publicity program be used to supplement the employer-information requirements. Such a program should stress the availability and location of claim-filing offices and the importance of visiting those offices whenever the worker is unemployed, wishes to apply for benefits, and to seek a job.

6015 *Evaluation of Alternative State Provisions with Respect to Claim Determinations and Separation Information.* If the State law provisions do not conform to the suggested requirements set forth in sections 6013 and 6014, but the State law contains alternative provisions, the Bureau of Employment Security, in collaboration with the State agency, will study the actual or anticipated effects of the alternative provisions. If the Administrator of the Bureau concludes that the alternative provisions satisfy the criteria in section 6012, he will so notify the State agency. If the Administrator of the Bureau does not so conclude, he will submit the matter to the Secretary. If the Secretary concludes that the alternative provisions satisfy the criteria in section 6012, the State agency will be so notified. If the Secretary concludes that there is a question as to whether the alternative provisions satisfy the criteria, the State agency will be advised that unless the State law provisions are appropriately revised, a notice of hearing will be issued as required by the Code of Federal Regulations, title 20, §601.5.

[51 FR 45848, Dec. 22, 1986. Redesignated at 59 FR 943, Jan. 6, 1994. Further redesignated at 85 FR 51972, Aug. 21, 2020]

APPENDIX C TO PART 618—STANDARD FOR FRAUD AND OVERPAYMENT DETECTION

7510 *Federal Law Requirements.* Section 303(a)(1) of the Social Security Act requires that a State law include provision for:

''Such methods of administration . . . as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

Section 1603(a)(4) of the Internal Revenue Code and section 3030(a)(5) of the Social Security Act require that a State law include provision for:

''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation . . .''

Section 1607(h) of the Internal Revenue Code defines ''compensation'' as ''cash benefits payable to individuals with respect to their unemployment.''

7511 *The Secretary's Interpretation of Federal Law Requirements.* The Secretary of Labor interprets the above sections to require that a State law include provision for such methods of administration as are, within reason, calculated (1) to detect benefits paid through error by the agency or through willful misrepresentation or error by the claimant or others, and (2) to deter claimants from obtaining benefits through willful misrepresentation.

7513 *Criteria for Review of State Conformity With Federal Requirements.* In determining State conformity with the above requirements of the Internal Revenue Code and the Social Security Act, as interpreted by the Secretary of Labor, the following criteria will be applied:

A. *Are investigations required to be made after the payment of benefits, (or, in the case of interstate claims, are investigations made by the agent State after the processing of claims) as to claimants' entitlement to benefits paid to them in a sufficient proportion of cases to test the effectiveness of the agency's procedures for the prevention of payments which are not due? To carry out investigations, has the agency assigned to some individual or unit, as a basic function, the responsibility of making or functionally directing such investigations?*

Explanation: It is not feasible to prescribe the extent to which the above activities are required; however, they should always be carried on to such an extent that they will show whether or not error or willful misrepresentation is increasing or decreasing, and will reveal problem areas. The extent and nature of the above activities should be varied according to the seriousness of the problem in the State. The responsible individual or unit should:

1. Check paid claims for overpayment and investigate for willful misrepresentation or, alternatively, advise and assist the operating units in the performance of such functions, or both;

2. Perform consultative services with respect to methods and procedures for the prevention and detection of fraud; and

3. Perform other services which are closely related to the above.

Although a State agency is expected to make a full-time assignment of responsibility to a unit or individual to carry on the functions described above, a small State agency might make these functions a part-time responsibility of one individual. In connection with the detection of overpayments, such a unit or individual might, for example:

(a) Investigate information on suspected benefit fraud received from any agency personnel, and from sources outside the agency, including anonymous complaints;

(b) Investigate information secured from comparisons of benefit payments with employment records to detect cases of concurrent working (whether in covered or noncovered work) and claiming of benefits (including benefit payments in which the agency acted as agent for another State).

The benefit fraud referred to herein may involve employers, agency employees, and witnesses, as well as claimants.

Comparisons of benefit payments with employment records are comonly made either by post-audit or by industry surveys. The so-called ''post-audit'' is a matching of central office wage-record files against benefit payments for the same period. ''Industry surveys'' or ''mass audits'' are done in some States by going directly to employers for pay-roll information to be checked against concurrent benefit lists. A plan of investigation based on a sample post-audit will be considered as partial fulfillment of the investigation program; it would need to be supplemented by other methods capable of detecting overpayments to persons who have moved into noncovered occupations or are claiming interstate benefits.

B. *Are adequate records maintained by which the results of investigations may be evaluated?*

Explanation. To meet this criterion, the State agency will be expected to maintain records of all its activities in the detection of overpayments, showing whether attributable to error or willful misrepresentation, measuring the results obtained through various methods, and noting the remedial action taken in each case. The adequacy and effectiveness of various methods of checking for willful misrepresentation can be evaluated only if records are kept of the results obtained. Internal reports on fraudulent and erroneous overpayments are needed by State agencies for self-evaluation. Detailed records should be maintained in order that the State agency may determine, for example, which of several methods of checking currently used are the most productive. Such records

also will provide the basis for drawing a clear distinction between fraud and error.

C. *Does the agency take adequate action with respect to publicity concerning willful misrepresentation and its legal consequences to deter fraud by claimants?*

Explanation. To meet this criterion, the State agency must issue adequate material of claimant eligibility requirements and must take necessary action to obtain publicity on the legal consequences of willful misrepresentation or willful nondisclosure of facts.

Public announcements on convictions and resulting penalties for fraud are generally considered necessary as a deterrent to other persons, and to inform the public that the agency is carrying on an effective program to prevent fraud. This alone is not considered adequate publicity. It is important that information be circulated which will explain clearly and understandably the claimant's rights, and the obligations which he must fulfill to be eligible for benefits. Leaflets for distribution and posters placed in local offices are appropriate media for such information.

*7515 *Evaluation of Alternative State Provisions with Respect to Erroneous and Illegal Payments.* If the methods of administration provided for by the State law do not conform to the suggested methods of meeting the requirements set forth in section 7511, but a State law does provide for alternative methods of administration designed to accomplish the same results, the Bureau of Employment Security, in collaboration with the State agency, will study the actual or anticipated effect of the alternative methods of administration. If the Bureau concludes that the alternative methods satisfy the criteria in section 7513, it will so notify the State agency. If the Bureau does not so conclude, it will submit to the Secretary the results of the study for his determination of whether the State's alternative methods of administration meet the criteria.

[51 FR 45848, Dec. 22, 1986. Redesignated at 59 FR 943, Jan. 6, 1994. Further redesignated at 85 FR 51972, Aug. 21, 2020.]

PART 619—UNEMPLOYMENT COMPENSATION DATA EXCHANGE STANDARDIZATION FOR IMPROVED INTEROPERABILITY

Sec.

619.1 Definitions.
619.2 Data exchange standardization for ICON.
619.3 Data exchange standardization for SIDES.
619.4 Data exchange standardization for the UI Benefits and Tax Systems.

AUTHORITY: 42 U.S.C. 1111; Section 2104(b) of Pub. L. 112–96; 42 U.S.C. 1302(a).

SOURCE: 79 FR 9411, Feb. 19, 2014, unless otherwise noted.

§ 619.1 Definitions.

As used in this part—

Administrator of the Office of Unemployment Insurance means the Department's Employment and Training Administration's chief administrative officer directly responsible for the operation of the Unemployment Insurance (UI) program and oversight of the Unemployment Compensation (UC) program and UC laws.

Department means the United States Department of Labor.

eXtensible Markup Language or *XML* means a markup language that defines a set of rules for encoding documents in a format designed to structure, store and transport data between applications or systems over the Internet. This term includes any future upgrades, iterations, or releases of XML-based language.

Federal funds or *Federally-funded* means funds that include, but are not limited to:

(1) Supplemental budget funds that are designated by the Department for State IT modernization efforts;

(2) General State UI administration funding for State program operations (an administrative grant issued by the Department at the beginning of each fiscal year); and

(3) Special UI funding distributions.

Interstate Connection Network or *ICON* means a secure multi-purpose telecommunications network that supports the transfer of data among the SWAs.

Interstate Wages and Benefits Inquiries/Responses means the ICON application which supports online transmission of interstate wages and benefits inquiries and responses between SWAs.

Major IT Modernization Project means conversion, re-engineering, rewriting, or transferring of an existing system to a modernized framework such as transferring a process from mainframe operations to Web-based operations, converting to modern computer programming languages, or upgrading software libraries, protocols, or hardware platform and infrastructure. These are projects to upgrade UI Benefits and

Tax Systems by SWAs using Federal funds.

State or *States* refers to, individually or collectively, the 50 States of the United States of America, the District of Columbia, the Commonwealth of Puerto Rico, and the United States Virgin Islands.

State Identification Inquiry means the ICON application which allows SWAs to inquire about wages reported to other SWAs by Social Security Number.

State Information Data Exchange System or *SIDES* means an automated response system used by SWAs to collect claim-related information from employers and third-party administrators.

State unemployment compensation law or *UC law* means the law of a State approved under Section 3304(a) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)).

State Workforce Agency or *SWA* means the agency of the State charged with the administration of the State's Unemployment Compensation (UC) law.

Unemployment Compensation or *UC* means cash benefits payable to individuals with respect to their unemployment, as defined in 26 U.S.C. 3306(h).

Unemployment Insurance or *UI* means the Federal-State system and operations administering and implementing UC law.

Withdrawn/Invalid Claims means the ICON application which allows for the posting and viewing of withdrawn or invalid claim information for SWAs.

§ 619.2 Data exchange standardization for ICON.

(a) XML is the data exchange standard for the real-time ICON applications. These applications are: Interstate Wages and Benefits Inquiries/Responses; Withdrawn/Invalid Claims; and State Identification Inquiry.

(b) All SWAs using real-time ICON applications must comply with this XML data exchange standard no later than September 30, 2018. A SWA may request an extension of this deadline if it demonstrates that resources are not available to meet this requirement. These requests must be submitted in writing to the Administrator of the Office of Unemployment Insurance no later than 6 months before the deadline; requests will be approved or denied within 30 days.

§ 619.3 Data exchange standardization for SIDES.

(a) XML is the data exchange standard for SIDES.

(b) This standard applies to any Federally-funded SIDES consortium, and any future agents of the Department providing vendor services for the development, maintenance, support, and operations of the SIDES, and for any State that adopts SIDES. A SIDES consortium involves a group of two or more States jointly establishing a project team to oversee the design, development, and implementation of a new SIDES data exchange module. As States implement SIDES or new data exchange modules of SIDES, they must conform to this data exchange standard by application design.

(c) XML is designated as the data exchange standard to govern the reporting of information through SIDES data exchange modules. The regulation applies to current SIDES data exchange modules and any future SIDES data exchange modules developed with Federal funds.

(d) The standard designated in paragraphs (a), (b), and (c) of this section is effective March 21, 2014.

§ 619.4 Data exchange standardization for the UI Benefits and Tax Systems.

(a) XML is the data exchange standard for the real time ICON applications set out in § 619.2 and for the SIDES exchanges set out in § 619.3 associated with major IT modernization projects, to upgrade UI Benefits and Tax Systems by SWAs using Federal funds.

(b) The standard designated in paragraph (a) of this section is effective March 21, 2014.

PART 620—DRUG TESTING FOR STATE UNEMPLOYMENT COMPENSATION ELIGIBILITY DETERMINATION PURPOSES

Sec.

620.1 Purpose.
620.2 Definitions.
620.3 Occupations that regularly conduct drug testing for purposes of determining

which applicants may be drug tested when applying for State unemployment compensation.
620.4 Testing of unemployment compensation applicants for the unlawful use of a controlled substance.
620.5 Conformity and substantial compliance.

AUTHORITY: 42 U.S.C. 1302(a); 42 U.S.C. 503(l)(1)(A)(ii).

SOURCE: 84 FR 53051, Oct. 4, 2019, unless otherwise noted.

§ 620.1 Purpose.

The regulations in this part implement 42 U.S.C. 503(l). 42 U.S.C. 503(l) permits States to enact legislation to provide for State-conducted testing of an unemployment compensation applicant for the unlawful use of controlled substances, as a condition of unemployment compensation eligibility, if the applicant was discharged for unlawful use of controlled substances by his or her most recent employer, or if suitable work (as defined under the State unemployment compensation law) is only available in an occupation for which drug testing is regularly conducted (as determined under this part). 42 U.S.C. 503(l)(1)(A)(ii) provides that the occupations that regularly conduct drug testing will be determined under regulations issued by the Secretary of Labor.

§ 620.2 Definitions.

As used in this part—

Applicant means an individual who files an initial claim for unemployment compensation under State law. Applicant excludes an individual already found initially eligible and filing a continued claim.

Controlled substance means a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V of part B of 21 U.S.C. 801 *et seq.*, as defined in Sec. 102 of the Controlled Substances Act (21 U.S.C. 802). The term does not include distilled spirits, wine, malt beverages, or tobacco, as those terms are defined or used in subtitle E of the Internal Revenue Code of 1986.

Occupation means a position or class of positions with similar functions and duties. Federal and State laws governing drug testing refer to classes of positions that are required to be drug tested. Other taxonomies of occupations, such as those in the Standard Occupational Classification (SOC) system, may be used by States in determining the boundaries of a position or class of positions with similar functions and duties under § 620.3. Use of the SOC codes, however, is not required, and States may use other taxonomies to identify a position or class of positions with similar functions and duties.

Suitable work means suitable work as defined by the unemployment compensation law of a State against which the claim is filed. It must be the same definition the State law otherwise uses for determining the type of work an individual must seek, given the individual's education, experience, and previous level of remuneration.

Unemployment compensation means any cash benefits payable to an individual with respect to the individual's unemployment under the State law (including amounts payable under an agreement under a Federal unemployment compensation law).

§ 620.3 Occupations that regularly conduct drug testing for purposes of determining which applicants may be drug tested when applying for State unemployment compensation.

In electing to test applicants for unemployment compensation under this part, States may enact legislation to require drug testing for applicants for whom the only suitable work is in one or more of the following occupations that regularly conduct drug testing, for purposes of § 620.4:

(a) An occupation that requires the employee to carry a firearm;

(b) An occupation identified in 14 CFR 120.105 by the Federal Aviation Administration, in which the employee must be tested;

(c) An occupation identified in 49 CFR 382.103 by the Federal Motor Carrier Safety Administration, in which the employee must be tested;

(d) An occupation identified in 49 CFR 219.3 by the Federal Railroad Administration, in which the employee must be tested;

(e) An occupation identified in 49 CFR 655.3 by the Federal Transit Administration, in which the employee must be tested;

(f) An occupation identified in 49 CFR 199.2 by the Pipeline and Hazardous Materials Safety Administration, in which the employee must be tested;

(g) An occupation identified in 46 CFR 16.201 by the United States Coast Guard, in which the employee must be tested;

(h) An occupation specifically identified in Federal law as requiring an employee to be tested for controlled substances;

(i) An occupation specifically identified in the State law of that State as requiring an employee to be tested for controlled substances; and

(j) An occupation where the State has a factual basis for finding that employers hiring employees in that occupation conduct pre- or post-hire drug testing as a standard eligibility requirement for obtaining or maintaining employment in the occupation.

§ 620.4 Testing of unemployment compensation applicants for the unlawful use of a controlled substance.

(a) States may require drug testing for unemployment compensation applicants, as defined in § 620.2, for the unlawful use of one or more controlled substances, as defined in § 620.2, as a condition of eligibility for unemployment compensation, if the individual is one for whom suitable work, as defined in State law, as defined in § 620.2, is only available in an occupation that regularly conducts drug testing as identified under § 620.3.

(b) A State conducting drug testing as a condition of unemployment compensation eligibility, as provided in paragraph (a) of this section, may only elect to require drug testing of applicants for whom the only suitable work is available in one or more of the occupations listed under § 620.3. States are not required to apply drug testing to any applicants for whom the only suitable work is available in any or all of the occupations listed.

(c) No State is required to drug test UC applicants under this part 620.

§ 620.5 Conformity and substantial compliance.

(a) *In general.* A State law implementing the drug testing of applicants for unemployment compensation must conform with—and the law's administration must substantially comply with—the requirements of this part 620 for purposes of certification under 42 U.S.C. 502(a), governing State eligibility to receive Federal grants for the administration of its UC program.

(b) *Resolving issues of conformity and substantial compliance.* For the purposes of resolving issues of conformity and substantial compliance with the requirements of this part 620, the provisions of 20 CFR 601.5 apply.

PART 621 [RESERVED]

PART 625—DISASTER UNEMPLOYMENT ASSISTANCE

Sec.

625.1 Purpose; rules of construction.
625.2 Definitions.
625.3 Reemployment assistance.
625.4 Eligibility requirements for Disaster Unemployment Assistance.
625.5 Unemployment caused by a major disaster.
625.6 Weekly amount; jurisdictions; reductions.
625.7 Disaster Unemployment Assistance: Duration.
625.8 Applications for Disaster Unemployment Assistance.
625.9 Determinations of entitlement; notices to individual.
625.10 Appeal and review.
625.11 Provisions of State law applicable.
625.12 The applicable State for an individual.
625.13 Restrictions on entitlement; disqualification.
625.14 Overpayments; disqualification for fraud.
625.15 Inviolate rights to DUA.
625.16 Recordkeeping; disclosure of information.
625.17 Announcement of the beginning of a Disaster Assistance Period.
625.18 Public access to Agreements.
625.19 Information, reports and studies.
625.20 [Reserved]
625.30 Appeal Procedures for Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, and the Trust Territory of the Pacific Islands.

APPENDIX A TO PART 625—STANDARD FOR CLAIM FILING, CLAIMANT REPORTING, JOB FINDING, AND EMPLOYMENT SERVICES
APPENDIX B TO PART 625—STANDARD FOR CLAIM DETERMINATIONS—SEPARATION INFORMATION
APPENDIX C TO PART 625—STANDARD FOR FRAUD AND OVERPAYMENT DETECTION

AUTHORITY: 42 U.S.C. 1302; 42 U.S.C. 5164; 42 U.S.C. 5189a(c); 42 U.S.C. 5201(a); Executive Order 12673 of March 23, 1989 (54 FR 12571); delegation of authority from the Director of the Federal Emergency Management Agency to the Secretary of Labor, effective December 1, 1985 (51 FR 4988); Secretary's Order No. 4–75 (40 FR 18515).

SOURCE: 42 FR 46712, Sept. 16, 1977, unless otherwise noted.

§ 625.1 Purpose; rules of construction.

(a) *Purpose.* Section 410 of ''The Robert T. Stafford Disaster Relief and Emergency Assistance Act'' amended the program for the payment of unemployment assistance to unemployed individuals whose unemployment is caused by a major disaster, and to provide reemployment assistance services to those individuals. The unemployment assistance provided for in section 410 of the Act is hereinafter referred to as Disaster Unemployment Assistance, or DUA. The regulations in this part are issued to implement sections 410 and 423 of the Act.

(b) *First rule of construction.* Sections 410 and 423 of the Act and the implementing regulations in this part shall be construed liberally so as to carry out the purposes of the Act.

(c) *Second rule of construction.* Sections 410 and 423 of the Act and the implementing regulations in this part shall be construed so as to assure insofar as possible the uniform interpretation and application of the Act throughout the United States.

(d) *Effectuating purpose and rules of construction.* (1) In order to effectuate the provisions of this section, each State agency shall forward to the United States Department of Labor, on receipt of a request from the Department, a copy of any determination or redetermination ruling on an individual's entitlement to DUA.

(2) If the Department believes a determination or redetermination is inconsistent with the Secretary's interpretation of the Act, the Department may at any time notify the State agency of the department's view. Thereafter, the State agency shall appeal if possible, and shall not follow such determination or redetermination as a precedent; and in any subsequent proceedings which involve such determination or redetermination, or wherein such determination or redetermination is cited as precedent or otherwise relied upon, the State agency shall inform the hearing officer of the Department's view and shall make all reasonable efforts to obtain modification, limitation, or overruling of the determination or redetermination.

(3) A State agency may request reconsideration of a notice that a determination or redetermination is inconsistent with the Act, and shall be given an opportunity to present views and arguments if desired. If a determination or redetermination setting a precedent becomes final, which the Department believes to be inconsistent with the Act, the Secretary will decide whether the Agreement with the State shall be terminated.

(4) Concurrence of the Department in a determination or redetermination shall not be presumed from the absence of a notice issued pursuant to this paragraph.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 554, Jan. 5, 1990]

§ 625.2 Definitions.

For the purposes of the Act and this part:

(a) *Act* means sections 410 and 423 of *The Robert T. Stafford Disaster Relief and Emergency Assistance Act* (formerly section 407 of the ''Disaster Relief Act of 1974'', Pub. L. 93–288, 88 Stat. 143, 156, approved May 22, 1974), 42 U.S.C. 5177, 5189a, as amended by The Disaster Relief and Emergency Assistance Amendments of 1988, Pub. L. 100–707, 102 Stat. 4689, 4704, 4705, approved November 23, 1988.

(b) *Agreement* means the Agreement entered into pursuant to the Act, between a State and the Secretary of Labor of the United States, under which the State agency of the State agrees to make payments of Disaster Unemployment Assistance in accordance with the Act and the regulations

and procedures thereunder prescribed by the Secretary.

(c) *Announcement date* means the first day on which the State agency publicly announces the availability of Disaster Unemployment Assistance in the State, pursuant to § 625.17.

(d) *Compensation* means unemployment compensation as defined in section 85(b) of the Internal Revenue Code of 1986, and shall include any assistance or allowance payable to an individual with respect to such individual's unemployment under any State law or Federal unemployment compensation law unless such governmental unemployment compensation program payments are not considered ''compensation'' by ruling of the Internal Revenue Service or specific provision of Federal and/or State law because such payments are based on employee contributions which are not deductible from Federal income tax liability until the total nondeductible contributions paid by the employee to such program has been paid or are not ''compensation'' as defined under paragraph (d)(5) of this section. Governmental unemployment compensation programs include (but are not limited to) programs established under: a State law approved by the Secretary of Labor pursuant to section 3304 of the Internal Revenue Code, chapter 85 of title 5 of the United States Code, the Railroad Unemployment Insurance Act (45 U.S.C. 351 *et seq.*), any Federal supplementary compensation law, and trade readjustment allowances payable under chapter 2 of title II of the Trade Act of 1974 (19 U.S.C. 2271 *et seq.*). ''Compensation'' also includes ''regular compensation'', ''additional compensation'', ''extended compensation'', ''Federal supplementary compensation'', and ''disability payments'' defined as follows:

(1) *Regular compensation* means compensation payable to an individual under any State law or the unemployment compensation plan of a political subdivision of a State and, when so payable, includes compensation payable pursuant to 5 U.S.C. chapter 85 (parts 609 and 614 of this chapter), but not including extended compensation or additional compensation.

(2) *Additional compensation* means compensation totally financed by a State and payable under a State law by reason of conditions of high unemployment or by reason of other special factors, and, when so payable, includes compensation payable pursuant to 5 U.S.C. chapter 85.

(3) *Extended compensation* means compensation payable to an individual for weeks of unemployment in an extended benefit period, under those provisions of a State law which satisfy the requirements of the Federal-State Extended Unemployment Compensation Act of 1970 (title II, Pub. L. 91–373; 84 Stat. 695, 708; part 615 of this chapter), as amended with respect to the payment of extended compensation, and, when so payable, includes additional compensation and compensation payable pursuant to 5 U.S.C. chapter 85.

(4) *Federal supplementary compensation* means supplemental compensation payable under a temporary Federal law after exhaustion of regular and extended compensation.

(5) *Disability payments* means cash disability payments made pursuant to a governmental program as a substitute for cash unemployment payments to an individual who is ineligible for such payments solely because of the disability, except for payments made under workmen's compensation acts for personal injuries or sickness.

(e) *Date the major disaster began* means the date a major disaster first occurred, as specified in the understanding between the Federal Emergency Management Agency and the Governor of the State in which the major disaster occurred.

(f) *Disaster Assistance Period* means the period beginning with the first week following the date the major disaster began, and ending with the 26th week subsequent to the date the major disaster was declared.

(g) *Disaster Unemployment Assistance* means the assistance payable to an individual eligible for the assistance under the Act and this part, and which is referred to as DUA.

(h) *Federal Coordinating Officer* means the official appointed pursuant to section 302 of The Robert T. Stafford Disaster Relief and Emergency Assistance Act, to operate in the affected major disaster area.

(i) *Governor* means the chief executive of a State.

(j) *Initial application* means the first application for DUA filed by an individual, on the basis of which the individual's eligibility for DUA is determined.

(k) *Major disaster* means a major disaster as declared by the President pursuant to section 401 of The Robert T. Stafford Disaster Relief and Emergency Assistance Act.

(l) *Major disaster area* means the area identified as eligible for Federal assistance by the Federal Emergency Management Agency, pursuant to a Presidential declaration of a major disaster.

(m) *Secretary* means the Secretary of Labor of the United States.

(n) *Self-employed individual* means an individual whose primary reliance for income is on the performance of services in the individual's own business, or on the individual's own farm.

(o) *Self-employment* means services performed as a self-employed individual.

(p) *State* means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, the Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, and the Trust Territory of the Pacific Islands.

(q) *State agency* means—

(1) In all States except the Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands and the Trust Territory of the Pacific Islands, the agency administering the State law; and

(2) In the Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands and the Trust Territory of the Pacific Islands, the agency designated in the Agreement entered into by the State.

(r)(1) *State law* means, with respect to—

(i) The States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands, the unemployment compensation law of the State which has been approved under section 3304(a) of the Internal Revenue Code of 1986 (26 U.S.C. 3304(a)); and

(ii) The Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands and the Trust Territory of the Pacific Islands, the Hawaii Employment Security Law.

(2) *Applicable State law* means, for an individual, the State law of the applicable State for an individual as provided in § 625.12.

(s) *Unemployed worker* means an individual who was employed in or was to commence employment in the major disaster area at the time the major disaster began, and whose principal source of income and livelihood is dependent upon the individual's employment for wages, and whose unemployment is caused by a major disaster as provided in § 625.5(a).

(t) *Unemployed self-employed individual* means an individual who was self-employed in or was to commence self-employment in the major disaster area at the time the major disaster began, and whose principal source of income and livelihood is dependent upon the individual's performance of service in self-employment, and whose unemployment is caused by a major disaster as provided in § 625.5(b).

(u) *Wages* means remuneration for services performed for another, and, with respect to a self-employed individual, net income from services performed in self-employment.

(v) *Week* means a week as defined in the applicable State law.

(w) *Week of unemployment* means—

(1) For an unemployed worker, any week during which the individual is totally, part-totally, or partially unemployed. A week of total unemployment is a week during which the individual performs no work and earns no wages, or has less than full-time work and earns wages not exceeding the minimum earnings allowance prescribed in the applicable State law. A week of part-total unemployment is a week of otherwise total unemployment during which the individual has odd jobs or subsidiary work and earns wages not

exceeding the maximum earnings allowance prescribed in the applicable State law. A week of partial unemployment is a week during which the individual works less than regular, full-time hours for the individual's regular employer, as a direct result of the major disaster, and earns wages not exceeding the maximum earnings allowance prescribed by the applicable State law.

(2) For an unemployed self-employed individual, any week during which the individual is totally, part-totally, or partially unemployed. A week of total unemployment is a week during which the individual performs no services in self-employment or in an employer-employee relationship, or performs services less than full-time and earns wages not exceeding the minimum earnings allowance prescribed in the applicable State law. A week of part-total unemployment is a week of otherwise total unemployment during which the individual has odd jobs or subsidiary work and earns wages not exceeding the maximum earnings allowance prescribed in the applicable State law. A week of partial unemployment is a week during which the individual performs less than the customary full-time services in self-employment, as a direct result of the major disaster, and earns wages not exceeding the maximum earnings allowance prescribed by the applicable State law, or during which the only activities or services performed are for the sole purpose of enabling the individual to resume self-employment.

(3) If the week of unemployment for which an individual claims DUA is a week with respect to which the individual is reemployed in a suitable position or has commenced services in self-employment, that week shall be treated as a week of partial unemployment if the week qualifies as a week of partial unemployment as defined in this paragraph.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 554, Jan. 5, 1990; 56 FR 22805, May 16, 1991]

§ 625.3 Reemployment assistance.

(a) *State assistance.* Except as provided in paragraph (b) of this section, the applicable State shall provide, without reimbursement from any funds provided under the Act, reemployment assistance services under any other law administered by the State to individuals applying for DUA and all other individuals who are unemployed because of a major disaster. Such services shall include, but are not limited to, counseling, referrals to suitable work opportunities, and suitable training, to assist the individuals in obtaining reemployment in suitable positions as soon as possible.

(b) *Federal assistance.* In the case of American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, and the Trust Territory of the Pacific Islands, the Department of Labor, in consultation with the Federal Emergency Management Agency, will determine what reemployment services are needed by DUA applicants, and if any available Federal programs of reemployment assistance services can be implemented in that jurisdiction.

[55 FR 554, Jan. 5, 1990, as amended at 56 FR 22806, May 16, 1991]

§ 625.4 Eligibility requirements for Disaster Unemployment Assistance.

An individual shall be eligible to receive a payment of DUA with respect to a week of unemployment, in accordance with the provisions of the Act and this part if:

(a) That week begins during a Disaster Assistance Period;

(b) The applicable State for the individual has entered into an Agreement which is in effect with respect to that week;

(c) The individual is an unemployed worker or an unemployed self-employed individual;

(d) The individual's unemployment with respect to that week is caused by a major disaster, as provided in § 625.5;

(e) The individual has filed a timely initial application for DUA and, as appropriate, a timely application for a payment of DUA with respect to that week;

(f) That week is a week of unemployment for the individual;

(g) The individual is able to work and available for work within the meaning of the applicable State law: *Provided,* That an individual shall be deemed to

meet this requirement if any injury caused by the major disaster is the reason for inability to work or engage in self-employment; or, in the case of an unemployed self-employed individual, the individual performs service or activities which are solely for the purpose of enabling the individual to resume self-employment;

(h) The individual has not refused a bona fide offer of employment in a suitable position, or refused without good cause to resume or commence suitable self-employment, if the employment or self-employment could have been undertaken in that week or in any prior week in the Disaster Assistance Period; and

(i) The individual is not eligible for compensation (as defined in § 625.2(d)) or for waiting period credit for such week under any other Federal or State law, except that an individual determined ineligible because of the receipt of disqualifying income shall be considered eligible for such compensation or waiting period credit. An individual shall be considered ineligible for compensation or waiting period credit (and thus potentially eligible for DUA) if the individual is under a disqualification for a cause that occurred prior to the individual's unemployment due to the disaster, or for any other reason is ineligible for compensation or waiting period credit as a direct result of the major disaster.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 555, Jan. 5, 1990]

§ 625.5 Unemployment caused by a major disaster.

(a) *Unemployed worker.* The unemployment of an unemployed worker is caused by a major disaster if—

(1) The individual has a ''week of unemployment'' as defined in § 625.2(w)(1) following the ''date the major disaster began'' as defined in § 625.2(e), and such unemployment is a direct result of the major disaster; or

(2) The individual is unable to reach the place of employment as a direct result of the major disaster; or

(3) The individual was to commence employment and does not have a job or is unable to reach the job as a direct result of the major disaster; or

(4) The individual has become the breadwinner or major support for a household because the head of the household has died as a direct result of the major disaster; or

(5) The individual cannot work because of an injury caused as a direct result of the major disaster.

(b) *Unemployed self-employed individual.* The unemployment of an unemployed self-employed individual is caused by a major disaster if—

(1) The individual has a ''week of unemployment'' as defined in § 625.2(w)(2) following the ''date the major disaster began'' as defined in § 625.2(e), and such unemployment is a direct result of the major disaster; or

(2) The individual is unable to reach the place where services as a self-employed individual are performed, as a direct result of the major disaster; or

(3) The individual was to commence regular services as a self-employed individual, but does not have a place or is unable to reach the place where the services as a self-employed individual were to be performed, as a direct result of the major disaster; or

(4) The individual cannot perform services as a self-employed individual because of an injury caused as a direct result of the major disaster.

(c) *Unemployment is a direct result of the major disaster.* For the purposes of paragraphs (a)(1) and (b)(1) of this section, a worker's or self-employed individual's unemployment is a direct result of the major disaster where the unemployment is an immediate result of the major disaster itself, and not the result of a longer chain of events precipitated or exacerbated by the disaster. Such an individual's unemployment is a direct result of the major disaster if the unemployment resulted from:

(1) The physical damage or destruction of the place of employment;

(2) The physical inaccessibility of the place of employment in the major disaster area due to its closure by or at the request of the federal, state or local government, in immediate response to the disaster; or

(3) Lack of work, or loss of revenues, provided that, prior to the disaster, the employer, or the business in the case of a self-employed individual, received at

least a majority of its revenue or income from an entity in the major disaster area that was either damaged or destroyed in the disaster, or an entity in the major disaster area closed by the federal, state or local government in immediate response to the disaster.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 555, Jan. 5, 1990; 56 FR 22806, May 16, 1991; 66 FR 56962, Nov. 13, 2001; 68 FR 10937, Mar. 6, 2003]

§ 625.6 Weekly amount; jurisdictions; reductions.

(a) In all States, except as provided in paragraphs (c) and (d) of this section, the amount of DUA payable to an unemployed worker or unemployed self-employed individual for a week of total unemployment shall be the weekly amount of compensation the individual would have been paid as regular compensation, as computed under the provisions of the applicable State law for a week of total unemployment. In no event shall such amount be in excess of the maximum amount of regular compensation authorized under the applicable State law for that week.

(1) Except as provided in paragraph (a)(2) or (b) of this section, in computing an individual's weekly amount of DUA, qualifying employment and wage requirements and benefit formula of the applicable State law shall be applied; and for purposes of this section, employment, wages, and self-employment which are not covered by the applicable State law shall be treated in the same manner and with the same effect as covered employment and wages, but shall not include employment or self-employment, or wages earned or paid for employment or self-employment, which is contrary to or prohibited by any Federal law, such as, but not limited to, section 3304(a)(14)(A) of the Federal Unemployment Tax Act (26 U.S.C. 3304(a)(14)(A)).

(2) For purposes of paragraph (a)(1) of this section, the base period to be utilized in computing the DUA weekly amount shall be the most recent tax year that has ended for the individual (whether an employee or self-employed) prior to the individual's unemployment that was a direct result of the major disaster. The self-employment income to be treated as wages for purposes of computing the weekly amount under this paragraph (a) shall be the net income reported on the tax return of the individual as income from all self-employment that was dependent upon the performance of services by the individual. If an individual has not filed a tax return for the most recent tax year that has ended at the time of such individual's initial application for DUA, such individual shall have a weekly amount determined in accordance with paragraph (e)(3) of this section.

(3) As of the date of filing an initial application for DUA, family members over the age of majority, as defined under the statutes of the applicable State, who were customarily or routinely employed or self-employed as a family unit or in the same self-employment business prior to the individuals' unemployment that was a direct result of the major disaster, shall have the wages from such employment or net income from the self-employment allocated equally among such adult family members for purposes of computing a weekly amount under this paragraph (a), unless the documentation to substantiate employment or self-employment and wages earned or paid for such employment or self-employment submitted as required by paragraph (e) of this section supports a different allocation. Family members under the age of majority as of the date of filing an initial application for DUA shall have a weekly amount computed under this paragraph (a) based on the actual wages earned or paid for employment or self-employment rather than an equal allocation.

(b) If the weekly amount computed under paragraph (a) of this section is less than 50 percent of the average weekly payment of regular compensation in the State, as provided quarterly by the Department, or, if the individual has insufficient wages from employment or insufficient or no net income from self-employment (which includes individuals falling within paragraphs (a)(3) and (b)(3) of § 625.5) in the applicable base period to compute a weekly amount under paragraph (a) of this section, the individual shall be determined entitled to a weekly amount equal to 50 percent of the average

weekly payment of regular compensation in the State.

(1) If an individual was customarily or routinely employed or self-employed less than full-time prior to the individual's unemployment as a direct result of the major disaster, such individual's weekly amount under this paragraph (b)(1) shall be determined by calculating the percent of time the individual was employed or self-employed compared to the customary and usual hours per week that would constitute the average per week hours for year-round full-time employment or self-employment for the occupation, then applying the percentage to the determined 50 percent of the average weekly amount of regular compensation paid in the State. The State agency shall utilize information furnished by the applicant at the time of filing an initial application for DUA and any labor market or occupational information available within the State agency to determine the average per week hours for full-time employment or self-employment for the occupation. If the weekly amount computed for an individual under this paragraph (b)(1) is less than the weekly amount computed under paragraph (a) of this section for the individual, the individual shall be entitled to the higher weekly amount.

(2) The weekly amount so determined under paragraph (b)(1) of this section, if not an even dollar amount, shall be rounded in accordance with the applicable State law.

(c) In the Territory of Guam and the Commonwealth of the Northern Mariana Islands, the amount of DUA payable to an unemployed worker or unemployed self-employed individual for a week of total unemployment shall be the average of the payments of regular compensation made under all State laws referred to in § 625.2(r)(1)(i) for weeks of total unemployment in the first four of the last five completed calendar quarters immediately preceding the quarter in which the major disaster began. The weekly amount so determined, if not an even dollar amount, shall be rounded to the next higher dollar.

(d) In American Samoa, Federated States of Micronesia, Republic of the Marshall Islands and the Trust Territory of the Pacific Islands, the amount of DUA payable to an unemployed worker or unemployed self-employed individual for a week of total unemployment shall be the amount agreed upon by the Regional Administrator, Employment and Training Administration, for Region VI (San Francisco), and the Federal Coordinating Officer, which shall approximate 50 percent of the area-wide average of the weekly wages paid to individuals in the major disaster area in the quarter immediately preceding the quarter in which the major disaster began. The weekly amount so determined, if not an even dollar amount, shall be rounded to the next higher dollar.

(e) The State agency shall immediately determine, upon the filing of an initial application for DUA, a weekly amount under the provisions of paragraphs (a) through (d) of this section, as the case may be, based on the individual's statement of employment or self-employment preceding the individual's unemployment that was a direct result of the major disaster, and wages earned or paid for such employment or self-employment. An immediate determination of a weekly amount shall also be made where, in conjunction with the filing of an initial application for DUA, the individual submits documentation substantiating employment or self-employment and wages earned or paid for such employment or self-employment, or, in the absence of documentation, where any State agency records of employment or self-employment and wages earned or paid for such employment or self-employment, justify the determination of a weekly amount. An immediate determination shall also be made based on the individual's statement or in conjunction with the submittal of documentation in those cases where the individual was to commence employment or self-employment on or after the date the major disaster began but was prevented from doing so as a direct result of the disaster.

(1) In the case of a weekly amount determined in accordance with paragraph (e) of this section, based only on the individual's statement of earnings, the individual shall furnish documentation to substantiate the employment or self-employment or wages

earned from or paid for such employment or self-employment or documentation to support that the individual was to commence employment or self-employment on or after the date the major disaster began. In either case, documentation shall be submitted within 21 calendar days of the filing of the initial application for DUA.

(2) Any individual who fails to submit documentation to substantiate employment or self-employment or the planned commencement of employment or self-employment in accordance with paragraph (e)(1) of this section, shall be determined ineligible for the payment of DUA for any week of unemployment due to the disaster. Any weeks for which DUA was already paid on the application prior to the date of the determination of ineligibility under this paragraph (e)(2) are overpaid and a determination shall be issued in accordance with §625.14(a). In addition, the State agency shall consider whether the individual is subject to a disqualification for fraud in accordance with the provisions set forth in §625.14(i).

(3) For purposes of a computation of a weekly amount under paragraph (a) of this section, if an individual submits documentation to substantiate employment or self-employment in accordance with paragraph (e)(1), but not documentation of wages earned or paid during the base period set forth in paragraph (a)(2) of this section, including those cases where the individual has not filed a tax return for the most recent tax year that has ended, the State agency shall immediately redetermine the weekly amount of DUA payable to the individual in accordance with paragraph (b) of this section.

(4) Any individual determined eligible for a weekly amount of DUA under the provisions of paragraph (e)(3) of this section may submit necessary documentation to substantiate wages earned or paid during the base period set forth in paragraph (a)(2) of this section, including those cases where the individual has not filed a tax return for the most recent tax year that has ended, at any time prior to the end of the disaster assistance period. A redetermination of the weekly amount payable, as previously determined under paragraph (b) of this section, shall immediately be made if the wages earned or paid for services performed in employment or self-employment reflected in such documentation is sufficient to permit a computation under paragraph (a) of this section of a weekly amount higher than was determined under paragraph (b) of this section. Any higher amount so determined shall be applicable to all weeks during the disaster assistance period for which the individual was eligible for the payment of DUA.

(f)(1) The weekly amount of DUA payable to an unemployed worker or unemployed self-employed individual for a week of partial or part-total unemployment shall be the weekly amount determined under paragraph (a), (b), (c) or (d) of this section, as the case may be, reduced (but not below zero) by the amount of wages that the individual earned in that week as determined by applying to such wages the earnings allowance for partial or part-total employment prescribed by the applicable State law.

(2) The weekly amount of DUA payable to an unemployed self-employed individual for a week of unemployment shall be the weekly amount determined under paragraph (a), (b), (c) or (d) of this section, as the case may be, reduced (but not below zero) by the full amount of any income received during the week for the performance of services in self-employment, regardless of whether or not any services were performed during the week, by applying the earnings allowance as set forth in paragraph (f)(1) of this section. Notwithstanding the definition of ''wages'' for a self-employed individual under §625.2(u), the term ''any income'' for purposes of this paragraph (f)(2) means gross income.

[60 FR 25568, May 11, 1995, as amended at 71 FR 35516, June 21, 2006]

§ 625.7 Disaster Unemployment Assistance: Duration.

DUA shall be payable to an eligible unemployed worker or eligible unemployed self-employed individual for all weeks of unemployment which begin during a Disaster Assistance Period.

§ 625.8 Applications for Disaster Unemployment Assistance.

(a) *Initial application.* An initial application for DUA shall be filed by an individual with the State agency of the applicable State within 30 days after the announcement date of the major disaster as the result of which the individual became unemployed, and on a form prescribed by the Secretary which shall be furnished to the individual by the State agency. An initial application filed later than 30 days after the announcement date of the major disaster shall be accepted as timely by the State agency if the applicant had good cause for the late filing, but in no event shall an initial application be accepted by the State agency if it is filed after the expiration of the Disaster Assistance Period. If the 30th day falls on a Saturday, Sunday, or a legal holiday in the major disaster area, the 30-day time limit shall be extended to the next business day.

(b) *Weekly applications.* Applications for DUA for weeks of unemployment shall be filed with respect to the individual's applicable State at the times and in the manner as claims for regular compensation are filed under the applicable State law, and on forms prescribed by the Secretary which shall be furnished to the individual by the State agency.

(c) *Filing in person.* (1) Except as provided in paragraph (c)(2) of this section, all applications for DUA, including initial applications, shall be filed in person.

(2) Whenever an individual has good cause for not filing any application for DUA in person, the application shall be filed at such time, in such place, and in such a manner as directed by the State agency and in accordance with this part and procedures prescribed by the Secretary.

(d) *IBPP.* The ''Interstate Benefit Payment Plan'' shall apply, where appropriate, to an individual filing applications for DUA.

(e) *Wage combining.* The ''Interstate Arrangement for Combining Employment and Wages'' (part 616 of this chapter) shall apply, where appropriate, to an individual filing applications for DUA: *Provided,* That the ''Paying State'' shall be the applicable State for the individual as prescribed in § 625.12.

(f) *Procedural requirements.* (1) The procedures for reporting and filing applications for DUA shall be consistent with this part, and with the Secretary's ''Standard for Claim Filing, Claimant Reporting, Job Finding and Employment Services,'' *Employment Security Manual.* Part V, sections 5000 *et seq.* (appendix A of this part), insofar as such standard is not inconsistent with this part.

(2) The provisions of the applicable State law which apply hereunder to applications for and the payment of DUA shall be applied consistent with the requirements of title III of the Social Security Act and the Federal Unemployment Tax Act which are pertinent in the case of regular compensation, including but not limited to those standards and requirements specifically referred to in the provisions of this part.

(Approved by the Office of Management and Budget under control number 1205–0051)

(Pub. L. No. 96–511)

[42 FR 46712, Sept. 16, 1977, as amended at 49 FR 18295, Apr. 30, 1984; 55 FR 555, Jan. 5, 1990]

§ 625.9 Determinations of entitlement; notices to individual.

(a) *Determination of initial application.* (1) The State agency shall promptly, upon the filing of an initial application for DUA, determine whether the individual is eligible, and if the individual is found to be eligible, the weekly amount of DUA payable to the individual and the period during which DUA is payable.

(2) An individual's eligibility for DUA shall be determined, where a reliable record of employment, self-employment and wages is not obtainable, on the basis of an affidavit submitted to the State agency by the individual, and on a form prescribed by the Secretary which shall be furnished to the individual by the State agency.

(b) *Determinations of weekly applications.* The State agency shall promptly, upon the filing of an application for a payment of DUA with respect to a week of unemployment, determine whether the individual is entitled to a payment of DUA with respect to that week, and, if entitled, the amount of

DUA to which the individual is entitled.

(c) *Redetermination.* The provisions of the applicable State law concerning the right to request, or authority to undertake, reconsideration of a determination pertaining to regular compensation under the applicable State law shall apply to determinations pertaining to DUA.

(d) *Notices to individual.* The State agency shall give notice in writing to the individual, by the most expeditious method, of any determination or redetermination of an initial application, and of any determination of an application for DUA with respect to a week of unemployment which denies DUA or reduces the weekly amount initially determined to be payable, and of any redetermination of an application for DUA with respect to a week of unemployment. Each notice of determination or redetermination shall include such information regarding the determination or redetermination and notice of right to reconsideration or appeal, or both, as is furnished with written notices of determination and written notices of redeterminations with respect to claims for regular compensation.

(e) *Promptness.* Full payment of DUA when due shall be made with the greatest promptness that is administratively feasible.

(f) *Secretary's Standard.* The procedures for making determinations and redeterminations, and furnishing written notices of determinations, redeterminations, and rights of appeal to individuals applying for DUA, shall be consistent with this part and with the Secretary's ''Standard for Claim Determinations—Separation Information,'' *Employment Security Manual.* Part V, sections 6010 *et seq.* (Appendix B of this part).

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(Pub. L. No. 96–511)

[42 FR 46712, Sept. 16, 1977, as amended at 49 FR 18295, Apr. 30, 1984; 55 FR 555, Jan. 5, 1990]

§ 625.10 Appeal and review.

(a) *States of the United States.* (1) Any determination or redetermination made pursuant to § 625.9, by the State agency of a State (other than the State agency of the Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, or the Trust Territory of the Pacific Islands) may be appealed by the applicant in accordance with the applicable State law to the first-stage administrative appellate authority in the same manner and to the same extent as a determination or redetermination of a right to regular compensation may be appealed under the applicable State law, except that the period for appealing shall be 60 days from the date the determination or redetermination is issued or mailed instead of the appeal period provided for in the applicable State law. Any decision on a DUA first-stage appeal must be made and issued within 30 days after receipt of the appeal by the State.

(2) Notice of the decision on appeal, and the reasons therefor, shall be given to the individual by delivering the notice to such individual personally or by mailing it to the individual's last known address, whichever is most expeditious. The decision shall contain information as to the individual's right to review of the decision by the appropriate Regional Administrator, Employment and Training Administration, if requested within 15 days after the decision was mailed or delivered in person to the individual. The notice will include the manner of requesting such review, and the complete address of the Regional Administrator. Notice of the decision on appeal shall be given also to the State agency (with the same notice of right to review) and to the appropriate Regional Administrator.

(b) *Guam, American Samoa, and the Trust Territory of the Pacific Islands.* (1) In the case of an appeal by an individual from a determination or redetermination by the State agency of the Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, or the Trust Territory of the Pacific Islands, the individual shall be entitled to a hearing and decision in accordance with § 625.30 of this part.

(2) Notice of the referee's decision, and the reasons therefor, shall be given to the individual by delivering the notice to the individual personally or by mailing it to the individual's last known address, whichever is most expeditious. The notice of decision shall contain information as to the individual's right to review of the decision by the Regional Administrator, Employment and Training Administration, for Region VI (San Francisco), and the manner of obtaining such review, including the address of the Regional Administrator. Notice of the decision on appeal shall be given also to the State agency and to the Regional Administrator.

(c) *Review by Regional Administrator.* (1) The appropriate Regional Administrator, Employment and Training Administration, upon request for review by an applicant or the State agency shall, or upon the Regional Administrator's own motion may, review a decision on appeal issued pursuant to paragraph (a) or (b) of this section.

(2) Any request for review by an applicant or a State agency shall be filed, and any review on the Regional Administrator's own motion shall be undertaken, within 15 days after notice of the decision on appeal was delivered or mailed to the individual.

(3)(i) A request for review by an individual may be filed with the appropriate State agency, which shall forward the request to the appropriate Regional Administrator, Employment and Training Administration, or may be filed directly with the appropriate Regional Administrator.

(ii) A request for review by a State agency shall be filed with the appropriate Regional Administrator, and a copy shall be served on the individual by delivery to the individual personally or by mail to the individual's last known address.

(iii) When a Regional Administrator undertakes a review of a decision on the Regional Administrator's own motion, notice thereof shall be served promptly on the individual and the State agency.

(iv) Whenever review by a Regional Administrator is undertaken pursuant to an appeal or on the Regional Administrator's own motion, the State agency shall promptly forward to the Regional Administrator the entire record of the case.

(v) Where service on the individual is required by paragraph (c)(3)(ii) of this section, adequate proof of service shall be furnished for the record before the Regional Administrator, and be a condition of the Regional Administrator undertaking review pursuant to this paragraph.

(4) The decision of the Regional Administrator on review shall be rendered promptly, and not later than the earlier of—

(i) 45 days after the appeal is received or is undertaken by the Regional Administrator, or

(ii) 90 days from the date the individual's appeal from the determination or redetermination was received by the State agency.

(5) Notice of the Regional Administrator's decision shall be mailed promptly to the last known address of the individual, to the State agency of the applicable State, and to the Administrator, Office of Workforce Security. The decision of the Regional Administrator shall be the final decision under the Act and this part, unless there is further review by the Assistant Secretary as provided in paragraph (d) of this section.

(d) *Further review by the Assistant Secretary.* (1) The Assistant Secretary for Employment and Training on his or her own motion may review any decision by a Regional Administrator issued pursuant to paragraph (c) of this section.

(2) Notice of a motion for review by the Assistant Secretary shall be given to the applicant, the State agency of the applicable State, the appropriate Regional Administrator, and the Administrator, Office of Workforce Security.

(3) When the Regional Administrator and the State agency are notified of the Assistant Secretary's motion for review, they shall forward all records in the case to the Assistant Secretary.

(4) Review by the Assistant Secretary shall be solely on the record in the case, any other written contentions or evidence requested by the Assistant Secretary, and any further evidence or arguments offered by the individual,

the State agency, the Regional Administrator, or the Administrator, Office of Workforce Security, which are mailed to the Assistant Secretary within 15 days after mailing the notice of motion for review.

(5) Upon review of a case under this paragraph, the Assistant Secretary may affirm, modify, or reverse the decision of the Regional Administrator, and may remand the case for further proceedings and decision in accordance with the Assistant Secretary's decision.

(6) The decision of the Assistant Secretary shall be made promptly, and notice thereof shall be sent to the applicant, the State agency, the Regional Administrator, and the Administrator, Office of Workforce Security.

(7) The decision of the Assistant Secretary shall be final and conclusive, and binding on all interested parties, and shall be a precedent applicable throughout the States.

(e) *Procedural requirements.* (1) All decisions on first-stage appeals from determinations or redeterminations by the State agencies must be made within 30 days of the appeal; therefore, the Secretary's ''Standard for Appeals Promptness-Unemployment Compensation'' in part 650 of this chapter shall not apply to the DUA program.

(2) The provisions on right of appeal and opportunity for hearing and review with respect to applications for DUA shall be consistent with this part and with sections 303(a)(1) and 303(a)(3) of the Social Security Act, 42 U.S.C. 503(a)(1) and 503(a)(3).

(3) Any petition or other matter required to be filed within a time limit under this section shall be deemed to be filed at the time it is delivered to an appropriate office, or at the time of the postmark if it is mailed via the United States Postal Service to an appropriate office.

(4) If any limited time period specified in this section ends on a Saturday, Sunday, or a legal holiday in the major disaster area, the time limit shall be extended to the next business day.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 555, Jan. 5, 1990; 56 FR 22805, May 16, 1991; 71 FR 35516, June 21, 2006]

§ 625.11 Provisions of State law applicable.

The terms and conditions of the State law of the applicable State for an individual, which apply to claims for, and the payment of regular compensation, shall apply to applications for, and the payment of, DUA to each such individual, only as specifically set forth in the provisions of this part.

§ 625.12 The applicable State for an individual.

(a) *Applicable State.* The applicable State for an individual shall be that State in which the individual's unemployment is the result of a major disaster.

(b) *Limitation.* DUA is payable to an individual only by an applicable State as determined pursuant to paragraph (a) of this section, and—

(1) Only pursuant to an Agreement entered into pursuant to the Act and this part, and with respect to weeks in which the Agreement is in effect; and

(2) Only with respect to weeks of unemployment that begin during a Disaster Assistance Period.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 556, Jan. 5, 1990; 71 FR 35516, June 21, 2006]

§ 625.13 Restrictions on entitlement; disqualification.

(a) *Income reductions.* The amount of DUA payable to an individual for a week of unemployment, as computed pursuant to § 625.6, shall be reduced by the amount of any of the following that an individual has received for the week or would receive for the week if the individual filed a claim or application therefor and took all procedural steps necessary under the appropriate law, contract, or policy to receive such payment:

(1) Any benefits or insurance proceed from any source not defined as ''compensation'' under § 625.2(d) for loss of wages due to illness or disability;

(2) A supplemental unemployment benefit pursuant to a collective bargaining agreement.

(3) Private income protection insurance;

(4) Any workers' compensation by virtue of the death of the head of the household as the result of the major disaster in the major disaster area,

prorated by weeks, if the individual has become the head of the household and is seeking suitable work because the head of the household died as the result of the major disaster in the major disaster area; and

(5) The prorated amount of a retirement pension or annuity under a public or private retirement plan or system, prorated, where necessary, by weeks, but only if, and to the extent that, such amount would be deducted from regular compensation payable under the applicable State law.

(6) The prorated amount of primary benefits under title II of the Social Security Act, but only to the extent that such benefits would be deduced from regular compensation if payable to the individual under the applicable State law.

(b) *Disqualification.* (1) An individual shall not be entitled to DUA for any week after the week in which the individual is reemployed in a suitable position.

(2) An individual who refuses without good cause to accept a bona fide offer of reemployment in a position suitable to the individual, or to investigate or accept a referral to a position which is suitable to and available to the individual, shall not be entitled to DUA with respect to the week in which such refusal occurs or in any subsequent week in the Disaster Assistance Period. For the purposes of this paragraph, a position shall not be deemed to be suitable for an individual if the circumstances present any unusual risk to the health, safety, or morals of the individual, if it is impracticable for the individual to accept the position, or if acceptance for the position would, as to the individual, be inconsistent with any labor standard in section 3304(a)(5) of the Federal Unemployment Tax Act, 26 U.S.C. 3304(a)(5), or the comparable provisions of the applicable State law.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 556, Jan. 5, 1990]

§ 625.14 Overpayments; disqualification for fraud.

(a) *Finding and repayment.* If the State agency of the applicable State finds that an individual has received a payment of DUA to which the individual was not entitled under the Act and this part, whether or not the payment was due to the individual's fault or misrepresentation, the individual shall be liable to repay to the applicable State the total sum of the payment to which the individual was not entitled, and the State agency shall take all reasonable measures authorized under any State law or Federal law to recover for the account of the United States the total sum of the payment to which the individual was not entitled.

(b) *Recovery by offset.* (1) The State agency shall recover, insofar as is possible, the amount of any outstanding overpayment of DUA made to the individual by the State, by deductions from any DUA payable to the individual under the Act and this part, or from any compensation payable to the individual under any Federal unemployment compensation law administered by the State agency, or from any assistance or allowance payable to the individual with respect to unemployment under any other Federal law administered by the State agency.

(2) The State agency shall also recover, insofar as possible, the amount of any outstanding overpayment of DUA made to the individual by another State, by deductions from any DUA payable by the State agency to the individual under the Act and this part, or from any compensation payable to the individual under any Federal unemployment compensation law administered by the State agency, or from any assistance or allowance payable to the individual with respect to unemployment under any other Federal law administered by the State agency.

(3) If the State has in effect an agreement to implement the cross-program offset provisions of section 303(g)(2) of the Social Security Act (42 U.S.C. 503(g)(2)), the State shall apply the provisions of such agreement to the recovery of outstanding DUA overpayments.

(c) *Debts due the United States.* DUA payable to an individual shall be applied by the State agency for the recovery by offset of any debt due to the United States from the individual, but shall not be applied or used by the State agency in any manner for the payment of any debt of the individual to any State or any other entity or person.

(d) *Recovered overpayments.* Overpayments recovered in any manner shall be credited or returned, as the case may be, to the appropriate account of the United States.

(e) *Application of State law.* Any provision of State law authorizing waiver of recovery of overpayments of compensation shall not be applicable to DUA.

(f) *Final decision.* Recovery of any overpayment of DUA shall not be enforced by the State agency until the determination establishing the overpayment has become final, or if appeal is taken from the determination, until the decision after opportunity for a fair hearing has become final.

(g) *Procedural requirements.* (1) The provisions of paragraphs (c), (d), and (f) of §625.9 shall apply to determinations and redeterminations made pursuant to this section.

(2) The provisions of §625.10 shall apply to determinations and redeterminations made pursuant to this section.

(h) *Fraud detection and prevention.* Provisions in the procedures of each State with respect to detection and prevention of fraudulent overpayments of DUA shall be, as a minimum, commensurate with the procedures adopted by the State with respect to regular compensation and consistent with the Secretary's ''Standard for Fraud and Overpayment Detection,'' *Employment Security Manual,* part V, sections 7510 *et seq.* (Appendix C of this part).

(i) *Disqualification for fraud.* Any individual who, with respect to a major disaster, makes or causes another to make a false statement or misrepresentation of a material fact, knowing it to be false, or knowingly fails or causes another to fail to disclose a material fact, in order to obtain for the individual or any other person a payment of DUA to which the individual or any other person is not entitled, shall be disqualified as follows:

(1) If the false statement, misrepresentation, or nondisclosure pertains to an initial application for DUA—

(i) The individual making the false statement, misrepresentation, or nondisclosure shall be disqualified from the receipt of any DUA with respect to that major disaster; and

(ii) If the false statement, misrepresentation, or nondisclosure was made on behalf of another individual, and was known to such other individual to be a false statement, misrepresentation, or nondisclosure, such other individual shall be disqualified from the receipt of any DUA with respect to that major disaster; and

(2) If the false statement, misrepresentation, or nondisclosure pertains to a week for which application for a payment of DUA is made—

(i) The individual making the false statement, misrepresentation, or nondisclosure shall be disqualified from the receipt of DUA for that week and the first two compensable weeks in the Disaster Assistance Period that immediately follow that week, with respect to which the individual is otherwise entitled to a payment of DUA; and

(ii) If the false statement, misrepresentation, or nondisclosure was made on behalf of another individual, and was known to such other individual to be a false statement, misrepresentation, or nondisclosure, such other individual shall be disqualified from the receipt of DUA for that week and the first two compensable weeks in the Disaster Assistance Period that immediately follow that week, with respect to which the individual is otherwise entitled to a payment of DUA.

(j) *Criminal penalties.* The provisions of this section on recovery of overpayments and disqualification for fraudulently claiming or receiving any DUA to which an individual was not entitled under the Act and this part shall be in addition to and shall not preclude any applicable criminal prosecution and penalties under State or Federal law.

[42 FR 46712, Sept. 16, 1977, as amended at 55 FR 556, Jan. 5, 1990; 71 FR 35516, June 21, 2006]

§ 625.15 Inviolate rights to DUA.

Except as specifically provided in this part, the right of individuals to DUA shall be protected in the same manner and to the same extent as the rights of persons to regular unemployment compensation are protected under the applicable State law. Such measures shall include protection of applicants for DUA from waiver, release, assignment, pledge, encumbrance, levy, execution, attachment,

and garnishment, of their rights to DUA. In the same manner and to the same extent, individuals shall be protected from discrimination and obstruction in regard to seeking, applying for and receiving any right to DUA.

§ 625.16 Recordkeeping; disclosure of information.

(a) *Recordkeeping.* Each State agency will make and maintain records pertaining to the administration of the Act as the Secretary requires, and will make all such records available for inspection, examination, and audit by such Federal officials or employees as the Secretary may designate or as may be required by law.

(b) *Disclosure of information.* Information in records made and maintained by a State agency in administering the Act shall be kept confidential, and information in such records may be disclosed only in the same manner and to the same extent as information with respect to regular compensation and the entitlement of individuals thereto may be disclosed under the applicable State law, and consistently with section 303(a)(1) of the Social Security Act, 42 U.S.C. 503(a)(1). This provision on the confidentiality of information obtained in the administration of the Act shall not apply, however, to the United States Department of Labor, or in the case of information, reports and studies requested pursuant to §625.19, or where the result would be inconsistent with the Freedom of Information Act (5 U.S.C. 552), the Privacy Act of 1974 (5 U.S.C. 552a), or regulations of the United States Department of Labor promulgated thereunder.

§ 625.17 Announcement of the beginning of a Disaster Assistance Period.

Whenever a major disaster is declared in a State, the State agency shall promptly announce throughout the major disaster area by all appropriate news media that individuals who are unemployed as the result of the major disaster may be entitled to DUA; that they should file initial applications for DUA as soon as possible, but not later than the 30th day after the announcement date; the beginning date of the Disaster Assistance Period; and where individuals may obtain further information and file applications for DUA.

§ 625.18 Public access to Agreements.

The State agency of a State will make available to any individual or organization a true copy of the Agreement with the State for inspection and copying. Copies of an Agreement may be furnished on request to any individual or organization upon payment of the same charges, if any, as apply to the furnishing of copies of other records of the State agency.

§ 625.19 Information, reports and studies.

(a) *Routine responses.* State agencies shall furnish to the Secretary such information and reports and make such studies as the Secretary decides are necessary or appropriate for carrying out the purposes of the Act and this part.

(b) *Final report.* In addition to such other reports as may be required by the Secretary, within 60 days after all payments of Disaster Unemployment Assistance as the result of a major disaster in the State have been made, the State agency shall submit a final report to the Secretary. A final report shall contain a narrative summary, a chronological list of significant events, pertinent statistics about the Disaster Unemployment Assistance provided to disaster victims, brief statements of major problems encountered, discussion of lessons learned, and suggestions for improvement of the program during future major disasters.

(Approved by the Office of Management and Budget under control number 1205–0051)

(Pub. L. No. 96–511)

[15 FR 5886, Aug. 31, 1950; 23 FR 1267, Mar. 1, 1958, as amended at 49 FR 18295, Apr. 30, 1984]

§ 625.20 [Reserved]

§ 625.30 Appeal Procedures for Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, and the Trust Territory of the Pacific Islands.

(a) *Designation of referee.* The Director of the Unemployment Insurance

Service shall designate a referee of a State agency to hear and decide appeals under this section from determinations and redeterminations by the State agencies of the Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, and the Trust Territory of the Pacific Islands.

(b) *Appeals to referee.* (1) A DUA applicant may appeal from a determination or redetermination issued by the State agency of the Territory of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, or the Trust Territory of the Pacific Islands within 60 days after the mailing of notice and a copy of such determination or redetermination to such applicant's last known address, or in the absence of mailing within 60 days after delivery in person thereof to such applicant. The appeal shall be in writing and may be filed with any office of the State agency.

(2) Notice that an appeal has been filed may be given or mailed, in the discretion of the referee, to any person who has offered or is believed to have evidence with respect to the claim.

(3) An appeal shall be promptly scheduled and heard, in order that a decision on the appeal can be issued within 30 days after receipt of the appeal by the State agency. Written notice of hearing, specifying the time and place thereof and those questions known to be in dispute, shall be given or mailed to the applicant, the State agency, and any person who has offered or is believed to have evidence with respect to the claim 7 days or more before the hearing, except that a shorter notice period may be used with the consent of the applicant.

(c) *Conduct of hearings.* Hearings before the referee shall be informal, fair, and impartial, and shall be conducted in such manner as may be best suited to determine the DUA applicants' right to compensation. Hearings shall be open to the public unless sufficient cause for a closed hearing is shown. The referee shall open a hearing by ascertaining and summarizing the issue or issues involved in the appeal. The applicant may examine and cross-examine witnesses, inspect documents, and explain or rebut any evidence. An opportunity to present argument shall be afforded such applicant, and such argument shall be made part of the record. The referee shall give such applicant, if not represented by counsel or other representative, every assistance that does not interfere with the impartial discharge of the referee's duties. The referee may examine such applicant and other witnesses to such extent as the referee deems necessary. Any issue involved in the claim shall be considered and passed upon even though such issue was not set forth as a ground of appeal.

(d) *Evidence.* Oral or written evidence of any nature, whether or not conforming to the legal rules of evidence, may be accepted. Any official record of the State agency, including reports submitted in connection with administration of the DUA program, may be included in the record if the applicant is given an opportunity to examine and rebut the same. A written statement under oath or affirmation may be accepted when it appears impossible or unduly burdensome to require the attendance of a witness, but a DUA applicant adversely affected by such a statement must be given the opportunity to examine such statement, to comment on or rebut any or all portions thereof, and whenever possible to cross-examine a witness whose testimony has been introduced in written form by submitting written questions to be answered in writing.

(e) *Record.* All oral testimony before the referee shall be taken under oath or affirmation and a transcript thereof shall be made and kept. Such transcript together with all exhibits, papers, and requests filed in the proceeding shall constitute the record for decision.

(f) *Withdrawal of appeal.* A DUA applicant who has filed an appeal may withdraw such appeal with the approval of the referee.

(g) *Nonappearance of DUA applicant.* Failure of a DUA applicant to appear at a hearing shall not result in a decision being automatically rendered against such applicant. The referee

shall render a decision on the basis of whatever evidence is properly before him/her unless there appears to be a good reason for continuing the hearing. An applicant who fails to appear at a hearing with respect to his/her appeal may within seven days thereafter petition for a reopening of the hearing. Such petition shall be granted if it appears to the referee that such applicant has shown good cause for his/her failure to attend.

(h) *Notice of referee's decision and further review*—(1) *Decision.* A copy of the referee's decision, which shall include findings and conclusions, shall promptly be given or mailed to the applicant, the State agency, and to the Regional Administrator, Employment and Training Administration, for Region VI (San Francisco). The decision of the referee shall be accompanied by an explanation of the right of such applicant or State agency to request review by the Regional Administrator and the time and manner in which such review may be instituted, as provided in paragraph (a)(2) of §625.10.

(2) *Time limit for decision.* A decision on an appeal to a referee under this section shall be made and issued by the referee not later than 30 days after receipt of the appeal by the State agency.

(3) *Further review.* Further review by the Regional Administrator or the Assistant Secretary with respect to an appeal under this section shall be in accordance with paragraphs (c) and (d) of §625.10.

(i) *Consolidation of appeals.* The referee may consolidate appeals and conduct joint hearings thereon where the same or substantially similar evidence is relevant and material to the matters in issue. Reasonable notice of consolidation and the time and place of hearing shall be given or mailed to the applicants or their representatives, the State agency, and to persons who have offered or are believed to have evidence with respect to the DUA claims.

(j) *Representation.* A DUA applicant may be represented by counsel or other representative in any proceedings before the referee or the Regional Administrator. Any such representative may appear at any hearing or take any other action which such applicant may take under this part. The referee, for cause, may bar any person from representing an applicant, in which event such action shall be set forth in the record. No representative shall charge an applicant more than an amount fixed by the referee for representing the applicant in any proceeding under this section.

(k) *Postponement, continuance, and adjournment of hearings.* A hearing before the referee shall be postponed, continued, or adjourned when such action is necessary to afford a DUA applicant reasonable opportunity for a fair hearing. In such case notice of the subsequent hearing shall be given to any person who received notice of the prior hearing.

(l) *Information from agency records.* Information shall be available to a DUA applicant, either from the records of the State agency or as obtained in any proceeding herein provided for, to the extent necessary for proper presentation of his/her case. All requests for information shall state the nature of the information desired as clearly as possible and shall be in writing unless made at a hearing.

(m) *Filing of decisions.* Copies of all decisions of the referee shall be kept on file at his/her office or agency for at least 3 years.

[55 FR 557, Jan. 5, 1990, as amended at 56 FR 22805, May 16, 1991; 71 FR 35516, June 21, 2006]

APPENDIX A TO PART 625—STANDARD FOR CLAIM FILING, CLAIMANT REPORTING, JOB FINDING, AND EMPLOYMENT SERVICES

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 5000–5004)

5000 *Standard for Claim Filing, Claimant Reporting, Job Finding, and Employment Services*

A. *Federal law requirements.* Section 3304(a)(1) of the Federal Unemployment Tax Act and section 303(a)(2) of the Social Security Act require that a State law provide for: ''Payment of unemployment compensation solely through public employment offices or such other agencies as the Secretary may approve.''

Section 3304(a)(4) of the Federal Unemployment Tax Act and section 303(a)(5) of the Social Security Act require that a State law provide for: ''Expenditure of all money withdrawn from an unemployment fund of such

State, in the payment of unemployment compensation * * *''

Section 303(a)(1) of the Social Security Act requires that the State law provide for: ''Such methods of administration . . . as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

B. *Secretary's interpretation of federal law requirements:* 1. The Secretary interprets section 3304(a)(1) of the Federal Unemployment Tax Act and section 303(a)(2) of the Social Security Act to require that a State law provide for payment of unemployment compensation solely through public employment offices or claims offices administered by the State employment security agency if such agency provides for such coordination in the operations of its public employment offices and claims offices as will insure (a) the payment of benefits only to individuals who are unemployed and who are able to work and available for work, and (b) that individuals claiming unemployment compensation (claimants) are afforded such placement and other employment services as are necessary and appropriate to return them to suitable work as soon as possible.

2. The Secretary interprets all the above sections to require that a State law provide for: a. Such contact by claimants with public employment offices or claims offices or both, (1) as will reasonably insure the payment of unemployment compensation only to individuals who are unemployed and who are able to work and available for work, and (2) that claimants are afforded such placement and other employment services as are necessary and appropriate to facilitate their return to suitable work as soon as possible; and b. Methods of administration which do not unreasonably limit the opportunity of individuals to establish their right to unemployment compensation due under such State law.

5001 *Claim Filing and Claimant Reporting Requirements Designed To Satisfy Secretary's Interpretation*

A. *Claim filing—total or part-total unemployment:* 1. Individuals claiming unemployment compensation for total or part-total unemployment are required to file a claim weekly or biweekly, in person or by mail, at a public employment office or a claims office (these terms include offices at itinerant points) as set forth below.

2. Except as provided in paragraph 3, a claimant is required to file in person: a. His new claim with respect to a benefit year, or his continued claim for a waiting week or for his first compensable week of unemployment in such year; and b. Any other claim, when requested to do so by the claims personnel at the office at which he files his claim(s) because questions about his right to benefits are raised by circumstances such as the following:

(1) The conditions or circumstances of his separation from employment;

(2) The claimant's answers to questions on mail claim(s) indicate that he may be unable to work or that there may be undue restrictions on his availability for work or that his search for work may be inadequate or that he may be disqualified;

(3) The claimant's answers to questions on mail claims create uncertainty about his credibility or indicate a lack of understanding of the applicable requirements; or

(4) The claimant's record shows that he has previously filed a fraudulent claim.

In such circumstances, the claimant is required to continue to file claims in person each week (or biweekly) until the State agency determines that filing claims in person is no longer required for the resolution of such questions.

3. A claimant must be permitted to file a claim by mail in any of the following circumstances: a. He is located in an area requiring the expenditure of an unreasonable amount of time or money in traveling to the nearest facility established by the State agency for filing claims in person; b. Conditions make it impracticable for the agency to take claims in person; c. He has returned to full-time work on or before the scheduled date for his filing a claim, unless the agency makes provision for in-person filing at a time and place that does not interfere with his employment; d. The agency finds that he has good cause for failing to file a claim in person.

4. A claimant who has been receiving benefits for partial unemployment may continue to file claims as if he were a partially unemployed worker for the first four consecutive weeks of total or part-total unemployment immediately following his period of partial unemployment so long as he remains attached to his regular employer.

B. *Claim filing—partial unemployment.* Each individual claiming unemployment compensation for a week (or other claim period) during which, because of lack of work, he is working less than his normal customary full-time hours for his regular employer and is earning less than the earnings limit provided in the State law, shall not be required to file a claim for such week or other claim period earlier than 2 weeks from the date that wages are paid for such claim period or, if a low earnings report is required by the State law, from the date the employer furnished such report to the individual. State agencies may permit claims for partial unemployment to be filed either in person or by mail, except that in the circumstances set forth in section A 3, filing by mail must be permitted, and in the circumstances set forth in section A 2 b, filing in person may be required.

5002 *Requirement for Job Finding, Placement, and other Employment Services Designed To Satisfy Secretary's Interpretation*

A. Claims personnel are required to assure that each claimant is doing what a reasonable individual in his circumstances would do to obtain suitable work.

B. In the discretion of the State agency: 1. The claims personnel are required to give each claimant such necessary and appropriate assistance as they reasonably can in finding suitable work and at their discretion determine when more complete placement and employment services are necessary and appropriate for a claimant; and if they determine more complete services are necessary and appropriate, the claims personnel are to refer him to employment service personnel in the public employment office in which he has been filing claim(s), or, if he has been filing in a claims office, in the public employment office most accessible to him; *or*

2. All placement and employment services are required to be afforded to each claimant by employment service personnel in the public employment office most accessible to him in which case the claims personnel in the office in which the claimant files his claim are to refer him to the employment service personnel when placement or other employment services are necessary and appropriate for him.

C. The personnel to whom the State agency assigns the responsibilities outlined in paragraph B above are required to give claimants such job-finding assistance, placement, and other employment services as are necessary and appropriate to facilitate their return to suitable work as soon as possible.

In some circumstances, no such services or only limited services may be required. For example, if a claimant is on a short-term temporary layoff with a fixed return date, the only service necessary and appropriate to be given to him during the period of the layoff is a referral to suitable temporary work if such work is being performed in the labor market area.

Similarly, claimants whose unemployment is caused by a labor dispute presumably will return to work with their employer as soon as the labor dispute is settled. They generally do not need services, nor do individuals in occupations where placement customarily is made by other nonfee charging placement facilities such as unions and professional associations.

Claimants who fall within the classes which ordinarily would require limited services or no services shall, if they request placement and employment services, be afforded such services as are necessary and appropriate for them to obtain suitable work or to achieve their reasonable employment goals.

On the other hand, a claimant who is permanently separated from his job is likely to require some services. He may need only some direction in how to get a job; he may need placement services if he is in an occupation for which there is some demand in the labor market area; if his occupation is outdated, he may require counseling and referral to a suitable training course. The extent and character of the services to be given any particular claimant may change with the length of his unemployment and depend not only on his own circumstances and conditions, but also on the condition of the labor market in the area.

D. Claimants are required to report to employment service personnel, as directed, but such personnel and the claims personnel are required to so arrange and coordinate the contracts required of a claimant as not to place an unreasonable burden on him or unreasonably limit his opportunity to establish his rights to compensation. As a general rule, a claimant is not required to contact in person claims personnel or employment service personnel more frequently than once a week, unless he is directed to report more frequently for a specific service such as referral to a job or a training course or counseling which cannot be completed in one visit.

E. Employment service personnel are required to report promptly to claims personnel in the office in which the claimant files his claim(s): (1) his failure to apply for or accept work to which he was referred by such personnel or when known, by any other nonfee-charging placement facility such as a union or a professional association; and (2) any information which becomes available to it that may have a bearing on the claimant's ability to work or availability for work, or on the suitability of work to which he was referred or which was offered to him.

5004 *Evaluation of Alternative State Provisions*

If the State law provisions do not conform to the ''suggested State law requirements'' set forth in sections 5001 and 5002, but the State law contains alternative provisions, the Manpower Administrator, in collaboration with the State agency, will study the actual or anticipated affect of the alternative provisions. If the Manpower Administrator concludes that the alternative provisions satisfy the requirements of the Federal law as construed by the Secretary (see section 5000 B) he will so notify the State agency. If he does not so conclude, he will submit the matter to the Secretary. If the Secretary concludes that the alternative provisions satisfy such requirements, the State agency will be so notified. If the Secretary concludes that there is a question as to whether the alternative provisions satisfy such requirements, the State agency will be advised

that unless the State law provisions are appropriately revised, a notice of hearing will be issued as required by the Code of Federal Regulations, title 20, section 601.5.

[55 FR 558, Jan. 5, 1990]

APPENDIX B TO PART 625—STANDARD FOR CLAIM DETERMINATIONS—SEPARATION INFORMATION

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 6010–6015)

6010–6019 *Standard for Claim Determinations—Separation Information*

6010 *Federal Law Requirements.* Section 303(a)(1) of the Social Security Act requires that a State law include provision for: ''Such methods of administration . . . as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

Section 303(a)(3) of the Social Security Act requires that a State law include provision for: ''Opportunity for a fair hearing before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied.''

Section 3304(a)(4) of the Federal Unemployment Tax Act and section 303(a)(5) of the Social Security Act require that a State law include provision for: ''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation . . . .''

Section 3306(h) of the Federal Unemployment Tax Act defines ''compensation'' as ''cash benefits payable to individuals with respect to their unemployment.''

6011 *Secretary's Interpretation of Federal Law Requirements.* The Secretary interprets the above sections to require that a State law include provisions which will insure that: A. Individuals who may be entitled to unemployment compensation are furnished such information as will reasonably afford them an opportunity to know, establish, and protect their rights under the unemployment compensation law of such State, and

B. The State agency obtains and records in time for the prompt determination and review of benefit claims such information as will reasonably insure the payment of benefits to individuals to whom benefits are due.

6012 *Criteria for Review of State Law Conformity with Federal Requirements.* In determining the conformity of a State law with the above requirements of the Federal Unemployment Tax Act and the Social Security Act as interpreted by the Secretary, the following criteria will be applied:

A. Is it required that individuals who may be entitled to unemployment compensation be furnished such information of their potential rights to benefits, including the manner and places of filing claims, the reasons for determinations, and their rights of appeal, as will insure them a reasonable opportunity to know, establish, and protect their rights under the law of the State?

B. Is the State agency required to obtain, in time for prompt determination of rights to benefits such information as will reasonably insure the payment of benefits to individuals to whom benefits are due?

C. Is the State agency required to keep records of the facts considered in reaching determinations of rights to benefits?

6013 *Claim Determinations Requirements Designed To Meet Department of Labor Criteria.*

A. *Investigation of claims.* The State agency is required to obtain promptly and prior to a determination of an individual's right to benefits, such facts pertaining thereto as will be sufficient reasonably to insure the payment of benefits when due.

This requirement embraces five separate elements:

1. It is the responsibility of the agency to take the initiative in the discovery of information. This responsibility may not be passed on to the claimant or the employer. In addition to the agency's own records, this information may be obtained from the worker, the employer, or other sources. If the information obtained in the first instance discloses no essential disagreement and provides a sufficient basis for a fair determination, no further investigation is necessary. If the information obtained from other sources differs essentially from that furnished by the claimant, the agency, in order to meet its responsibility, is required to inform the claimant of such information from other sources and to afford the claimant an opportunity to furnish any further facts he may have.

2. Evidentiary facts must be obtained as distinguished from ultimate facts or conclusions. That a worker was discharged for misconduct is an ultimate fact or conclusion; that he destroyed a machine upon which he was working is a primary or evidentiary fact, and the sort of fact that the requirement refers to.

3. The information obtained must be sufficient reasonably to insure the payment of benefits when due. In general, the investigation made by the agency must be complete enough to provide information upon which the agency may act with reasonable assurance that its decision is consistent with the unemployment compensation law. On the other hand, the investigation should not be so exhaustive and time-consuming as unduly to delay the payment of benefits and to result in excessive costs.

4. Information must be obtained promptly so that the payment of benefits is not unduly delayed.

5. If the State agency requires any particular evidence from the worker, it must

give him a reasonable opportunity to obtain such evidence.

B. *Recording of facts.* The agency must keep a written record of the facts considered in reaching its determinations.

C. *Determination notices*

1. The agency must give each claimant a written notice of:

a. Any monetary determination with respect to his benefit year;

b. Any determination with respect to purging a disqualification if, under the State law, a condition or qualification must be satisfied with respect to each week of disqualification; but in lieu of giving written notice of each determination for each week in which it is determined that the claimant has met the requirements for purging, the agency may inform the claimant that he has purged the disqualification for a week by notation on his application identification card or otherwise in writing.

c. Any other determination which adversely affects[1] his rights to benefits, except that written notice of determination need not be given with respect to:

(1) A week in a benefit year for which the claimant's weekly benefit amount is reduced in whole or in part by earnings if, the first time in the benefit year that there is such a reduction, he is required to be furnished a booklet or leaflet containing the information set forth below in paragraph 2 f (1). However, a written notice of determination is required if: (a) there is a dispute concerning the reduction with respect to any week (e.g., as to the amount computed as the appropriate reduction, etc.); or (b) there is a change in the State law (or in the application thereof) affecting the reduction; or

(2) Any week in a benefit year subsequent to the first week in such benefit year in which benefits were denied, or reduced in whole or in part for reasons other than earnings, if denial or reduction for such subsequent week is based on the same reason and the same facts as for the first week, and if written notice of determination is required to be given to the claimant with respect to such first week, and with such notice of determination, he is required to be given a booklet or pamphlet containing the information set forth below in paragraphs 2 f (2) and 2 h. However, a written notice of determination is required if: (a) there is a dispute concerning the denial or reduction of benefits with respect to such week; or (b) there is a change in the State law (or in the application thereof) affecting the denial or reduction; or (c) there is a change in the amount of the reduction except as to the balance covered by the last reduction in a series of reductions.

NOTE: This procedure may be applied to determinations made with respect to any subsequent weeks for the same reason and on the basis of the same facts: (a) that claimant is unable to work, unavailable for work, or is disqualified under the labor dispute provision; and (b) reducing claimant's weekly benefit amount because of income other than earnings or offset by reason of overpayment.

2. The agency must include in written notices of determinations furnished to claimants sufficient information to enable them to understand the determinations, the reasons therefor, and their rights to protest, request reconsideration, or appeal.

The written notice of monetary determination must contain the information specified in the following items (except h) unless an item is specifically not applicable. A written notice of any other determination must contain the information specified in as many of the following items as are necessary to enable the claimant to understand the determination and to inform him of his appeal rights. Information specifically applicable to the individual claimant must be contained in the written notice of determination. Information of general application such as (but not limited to) the explanation of benefits for partial unemployment, information as to deductions, seasonality factors, and information as to the manner and place of taking an appeal, extension of the appeal period, and where to obtain information and assistance may be contained in a booklet or leaflet which is given the claimant with his monetary determination.

a. *Base period wages.* The statement concerning base-period wages must be in sufficient detail to show the basis of computation of eligibility and weekly and maximum benefit amounts. (If maximum benefits are allowed, it may not be necessary to show details of earnings.)

b. *Employer name.* The name of the employer who reported the wages is necessary so that the worker may check the wage transcript and know whether it is correct. If the

[1] A determination ''adversely affects'' claimant's right to benefits if it (1) results in a denial to him of benefits (including a cancellation of benefits or wage credits or any reduction in whole or in part below the weekly or maximum amount established by his monetary determination) for any week or other period; or (2) denies credit for a waiting week; or (3) applies any disqualification or penalty; or (4) determines that he has not satisfied a condition of eligibility, requalification for benefits, or purging a disqualification; or (5) determines that an overpayment has been made or orders repayment or recoupment of any sum paid to him; or (6) applies a previously determined overpayment, penalty, or order for repayment or recoupment; or (7) in any other way denies claimant a right to benefits under the State law.

worker is given only the employer number, he may not be able to check the accuracy of the wage transcript.

c. *Explanation of benefit formula—weekly and maximum benefit amounts.* Sufficient information must be given the worker so that he will understand how his weekly benefit amount, including allowances for dependents, and his maximum benefit amount were figured. If benefits are computed by means of a table contained in the law, the table must be furnished with the notice of determination whether benefits are granted or denied.

The written notice of determination must show clearly the weekly benefit amount and the maximum potential benefits to which the claimant is entitled.

The notice to a claimant found ineligible by reason of insufficient earnings in the base period must inform him clearly of the reason for ineligibility. An explanation of the benefit formula contained in a booklet or pamphlet should be given to each claimant at or prior to the time he receives written notice of a monetary determination.

d. *Benefit year.* An explanation of what is meant by the benefit year and identification of the claimant's benefit year must be included in the notice of determination.

e. *Information as to benefits for partial unemployment.* There must be included either in the written notice of determination or in a booklet or pamphlet accompanying the notice an explanation of the claimant's rights to partial benefits for any week with respect to which he is working less than his normal customary full-time workweek because of lack of work and for which he earns less than his weekly benefit amount or weekly benefit amount plus earnings, whichever is provided by the State law. If the explanation is contained in the notice of determination, reference to the item in the notice in which his weekly benefit amount is entered should be made.

f. *Deductions from weekly benefits*

(1) *Earnings.* Although written notice of determinations deducting earnings from a claimant's weekly benefit amount is generally not required (see paragraph 1 c(1) above), where written notice of determination is required (or given) it shall set forth the amount of earnings, the method of computing the deduction in sufficient detail to enable the claimant to verify the accuracy of the deduction, and his right to protest, request redetermination, and appeal. Where a written notice of determination is given to the claimant because there has been a change in the State law or in the application of the law, an explanation of the change shall be included.

Where claimant is not required to receive a written notice of determination, he must be given a booklet or pamphlet the first time in his benefit year that there is a deduction for earnings which shall include the following information:

(a) The method of computing deductions for earnings in sufficient detail to enable the claimant to verify the accuracy of the deduction;

(b) That he will not automatically be given a written notice of determination for a week with respect to which there is a deduction for earnings (unless there is a dispute concerning the reduction with respect to a week or there has been a change in the State law or in the application of the law affecting the deduction) but that he may obtain such a written notice upon request; and

(c) A clear statement of his right to protest, request a redetermination, and appeal from any determination deducting earnings from his weekly benefit amount even though he does not automatically receive a written notice of determination; and if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

(2) *Other deductions*

(a) A written notice of determination is required with respect to the first week in claimant's benefit year in which there is a reduction from his benefits for a reason other than earnings. This notice must describe the deduction made from claimaint's weekly benefit amount, the reason for the deduction, the method of computing it in sufficient detail to enable him to verify the accuracy of such deduction, and his right to protest, request redetermination, or appeal.

(b) A written notice of determination is not required for subsequent weeks that a deduction is made for the same reason and on the basis of the same facts, if the notice of determination pursuant to (2)(a), or a booklet or pamphlet given him with such notice explains (i) the several kinds of deductions which may be made under the State law (e.g., retirement pensions, vacation pay, and overpayments); (ii) the method of computing each kind of deduction in sufficient detail that claimant will be able to verify the accuracy of deductions made from his weekly benefit payments; (iii) any limitation on the amount of any deduction or the time in which any deduction may be made; (iv) that he will not automatically be given a written notice of determination for subsequent weeks with respect to which there is a deduction for the same reason and on the basis of the same facts, but that he may obtain a written notice of determination upon request; (v) his right to protest, request redetermination, or appeal with respect to subsequent weeks for which there is a reduction from his benefits for the same reason, and on the basis of the same facts even though he

does not automatically receive a written notice of determination; and (vi) that if the State law requires written notice of determination in order to effectuate a protest, redetermination, or appeal, he must be so advised and advised also that he must request a written notice of determination before he takes any such action.

g. *Seasonality factors.* If the individual's determination is affected by seasonality factors under the State law, an adequate explanation must be made. General explanations of seasonality factors which may affect determinations for subsequent weeks may be included in a booklet or pamphlet given claimant with his notice of monetary determination.

h. *Disqualification or ineligibility.* If a disqualification is imposed, or if the claimant is declared ineligible for one or more weeks, he must be given not only a statement of the period of disqualification or ineligibility and the amount of wage-credit reductions, if any, but also an explanation of the reason for the ineligibility or disqualification. This explanation must be sufficiently detailed so that he will understand why he is ineligible or why he has been disqualified, and what he must do in order to requalify for benefits or purge the disqualification. The statement must be individualized to indicate the facts upon which the determination was based, e.g., state, ''It is found that you left your work with Blank Company because you were tired of working; the separation was voluntary, and the reason does not constitute good cause,'' rather than merely the phrase ''voluntary quit.'' Checking a box as to the reason for the disqualification is not a sufficiently detailed explanation. However, this statement of the reason for the disqualification need not be a restatement of all facts considered in arriving at the determination.

1. *Appeal rights.* The claimant must be given information with respect to his appeal rights.

(1) The following information shall be included in the notice of determination:

(a) A statement that he may appeal or, if the State law requires or permits a protest or redetermination before an appeal, that he may protest or request a redetermination.

(b) The period within which an appeal, protest, or request for redetermination must be filed. The number of days provided by statute must be shown as well as either the beginning date or ending date of the period. (It is recommended that the ending date of the appeal period be shown, as this is the more understandable of the alternatives.)

(2) The following information must be included either in the notice of determination or in separate informational material referred to in the notice:

(a) The manner in which the appeal, protest, or request for redetermination must be filed, e.g., by signed letter, written statement, or on a prescribed form, and the place or places to which the appeal, protest, or request for redetermination may be mailed or hand-delivered.

(b) An explanation of any circumstances (such as nonworkdays, good cause, etc.) which will extend the period for the appeal, protest, or request for redetermination beyond the date stated or identified in the notice of determination.

(c) That any further information claimant may need or desire can be obtained together with assistance in filing his appeal, protest, or request for redetermination from the local office.

If the information is given in separate material, the notice of determination would adequately refer to such material if it said, for example, ''For other information about your (appeal), (protest), (redetermination) rights, see pages __ to __ of the _____ (name of pamphlet or booklet) heretofore furnished to you.''

6014 *Separation Information Requirements Designed To Meet Department of Labor Criteria*

A. *Information to agency.* Where workers are separated, employers are required to furnish the agency promptly, either upon agency request or upon such separation, a notice describing the reasons for and the circumstances of the separation and any additional information which might affect a claimant's right to benefits. Where workers are working less than full time, employers are required to furnish the agency promptly, upon agency request, information concerning a claimant's hours of work and his wages during the claim periods involved, and other facts which might affect a claimant's eligibility for benefits during such periods.

When workers are separated and the notices are obtained on a request basis, or when workers are working less than full time and the agency requests information, it is essential to the prompt processing of claims that the request be sent out promptly after the claim is filed and the employer be given a specific period within which to return the notice, preferably within 2 working days.

When workers are separated and notices are obtained upon separation, it is essential that the employer be required to send the notice to the agency with sufficient promptness to insure that, if a claim is filed, it may be processed promptly. Normally, it is desirable that such a notice be sent to the central office of the agency, since the employer may not know in which local office the worker will file his claim. The usual procedure is for the employer to give the worker a copy of the notice sent by the employer to the agency.

B. *Information of worker.* 1. *Information required to be given.* Employers are required to

give their employees information and instructions concerning the employees' potential rights to benefits and concerning registration for work and filing claims for benefits.

The information furnished to employees under such a requirement need not be elaborate; it need only be adequate to insure that the worker who is separated or who is working less than full time knows he is potentially eligible for benefits and is informed as to what he is to do or where he is to go to file his claim and register for work. When he files his claim, he can obtain more detailed information.

In States that do not require employers to furnish periodically to the State agency detailed reports of the wages paid to their employees, each employer is required to furnish to his employees information as to (a) the name under which he is registered by the State agency, (b) the address where he maintains his payroll records, and (c) the workers' need for this information if and when they file claims for benefits.

2. *Methods for giving information.* The information and instructions required above may be given in any of the following ways:

a. *Posters prominently displayed in the employer's establishment.* The State agency should supply employers with a sufficient number of posters for distribution throughout their places of business and should see that the posters are conspicuously displayed at all times.

b. *Leaflets.* Leaflets distributed either periodically or at the time of separation or reduction of hours. The State agency should supply employers with a sufficient number of leaflets.

c. *Individual notices.* Individual notices given to each employee at the time of separation or reduction in hours.

It is recommended that the State agency's publicity program be used to supplement the employer-information requirements. Such a program should stress the availability and location of claim-filing offices and the importance of visiting those offices whenever the worker is unemployed, wishes to apply for benefits, and to seek a job.

6015 *Evaluation of Alternative State Provisions with Respect to Claim Determinations and Separation Information.* If the State law provisions do not conform to the suggested requirements set forth in sections 6013 and 6014, but the State law contains alternative provisions, the Bureau of Employment Security, in collaboration with the State agency, will study the actual or anticipated effects of the alternative provisions. If the Administrator of the Bureau concludes that the alternative provisions satisfy the criteria in section 6012, he will so notify the State agency. If the Administrator of the Bureau does not so conclude, he will submit the matter to the Secretary. If the Secretary concludes that the alternative provisions satisfy the criteria in section 6012, the State agency will be so notified. If the Secretary concludes that there is a question as to whether the alternative provisions satisfy the criteria, the State agency will be advised that unless the State law provisions are appropriately revised, a notice of hearing will be issued as required by the Code of Federal Regulations, title 20, section 601.5.

[55 FR 559, Jan. 5, 1990]

APPENDIX C TO PART 625—STANDARD FOR FRAUD AND OVERPAYMENT DETECTION

EMPLOYMENT SECURITY MANUAL (PART V, SECTIONS 7510–7515)

7510–7519 *Standard for Fraud and Overpayment Detection*

7510 *Federal Law Requirements.* Section 303(a)(1) of the Social Security Act requires that a State law include provision for:

''Such methods of administration * * * as are found by the Secretary to be reasonably calculated to insure full payment of unemployment compensation when due.''

Section 1603(a)(4) of the Internal Revenue Code and section 3030(a)(5) of the Social Security Act require that a State law include provision for:

''Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation * * *''

Section 1607(h) of the Internal Revenue Code defines ''compensation'' as ''cash benefits payable to individuals with respect to their unemployment.''

7511 *The Secretary's Interpretation of Federal Law Requirements.* The Secretary of Labor interprets the above sections to require that a State law include provision for such methods of administration as are, within reason, calculated (1) to detect benefits paid through error by the agency or through willful misrepresentation or error by the claimant or others, and (2) to deter claimants from obtaining benefits through willful misrepresentation.

7513 *Criteria for Review of State Conformity With Federal Requirements.* In determining State conformity with the above requirements of the Internal Revenue Code and the Social Security Act, as interpreted by the Secretary of Labor, the following criteria will be applied:

A. *Are investigations required to be made after the payment of benefits, (or, in the case of interstate claims, are investigations made by the agent State after the processing of claims) as to claimants' entitlement to benefits paid to them in a sufficient proportion of cases to test the effectiveness of the agency's procedures for the prevention of payments which are not due? To*

carry out investigations, has the agency assigned to some individual or unit, as a basic function, the responsibility of making or functionally directing such investigations?

Explanation: It is not feasible to prescribe the extent to which the above activities are required; however, they should always be carried on to such an extent that they will show whether or not error or willful misrepresentation is increasing or decreasing, and will reveal problem areas. The extent and nature of the above activities should be varied according to the seriousness of the problem in the State. The responsible individual or unit should:

1. Check paid claims for overpayment and investigate for willful misrepresentation or, alternatively, advise and assist the operating units in the performance of such functions, or both;

2. Perform consultative services with respect to methods and procedures for the prevention and detection of fraud; and

3. Perform other services which are closely related to the above.

Although a State agency is expected to make a full-time assignment of responsibility to a unit or individual to carry on the functions described above, a small State agency might make these functions a part-time responsibility of one individual. In connection with the detection of overpayments, such a unit or individual might, for example:

(a) Investigate information on suspected benefit fraud received from any agency personnel, and from sources outside the agency, including anonymous complaints;

(b) Investigate information secured from comparisons of benefit payments with employment records to detect cases of concurrent working (whether in covered or noncovered work) and claiming of benefits (including benefit payments in which the agency acted as agency for another State).

The benefit fraud referred to herein may involve employers, agency employees, and witnesses, as well as claimants.

Comparisons of benefit payments with employment records are commonly made either by post-audit or by industry surveys. The so-called ''post-audit'' is a matching of central office wage-record files against benefit payments for the same period. ''Industry surveys'' or ''mass audits'' are done in some States by going directly to employers for pay-roll information to be checked against concurrent benefit lists. A plan

A. of investigation based on a sample post-audit will be considered as partial fulfillment of the investigation program; it would need to be supplemented by other methods capable of detecting overpayments to persons who have moved into noncovered occupations or are claiming interstate benefits.

B. *Are adequate records maintained by which the results of investigations may be evaluated?*

Explanation: To meet this criterion, the State agency will be expected to maintain records of all its activities in the detection of overpayments, showing whether attributable to error or willful misrepresentation, measuring the results obtained through various methods, and noting the remedial action taken in each case. The adequacy and effectiveness of various methods of checking for willful misrepresentation can be evaluated only if records are kept of the results obtained. Internal reports on fraudulent and erroneous overpayments are needed by State agencies for self-evaluation. Detailed records should be maintained in order that the State agency may determine, for example, which of several methods of checking currently used are the most productive. Such records also will provide the basis for drawing a clear distinction between fraud and error.

C. *Does the agency take adequate action with respect to publicity concerning willful misrepresentation and its legal consequences to deter fraud by claimants?*

Explanation: To meet this criterion, the State agency must issue adequate material on claimant eligibility requirements and must take necessary action to obtain publicity on the legal consequences of willful misrepresentation or willful nondisclosure of facts.

Public announcements on convictions and resulting penalties for fraud are generally considered necessary as a deterrent to other persons, and to inform the public that the agency is carrying on an effective program to prevent fraud. This alone is not considered adequate publicity. It is important that information be circulated which will explain clearly and understandably the claimant's rights, and the obligations which he must fulfill to be eligible for benefits. Leaflets for distribution and posters placed in local offices are appropriate media for such information.

7515 *Evaluation of Alternative State Provisions with Respect to Erroneous and Illegal Payments.* If the methods of administration provided for by the State law do not conform to the suggested methods of meeting the requirements set forth in section 7511, but a State law does provide for alternative methods of administration designed to accomplish the same results, the Bureau of Employment Security, in collaboration with the State agency, will study the actual or anticipated effect of the alternative methods of administration. If the Bureau concludes that the alternative methods satisfy the criteria in section 7513, it will so notify the State agency. If the Bureau does not so conclude, it will submit to the Secretary the results of the study for his determination of whether the State's alternative methods of administration meet the criteria.

[55 FR 562, Jan. 5, 1990]

PARTS 626–638 [RESERVED]

PART 639—WORKER ADJUSTMENT AND RETRAINING NOTIFICATION

Sec.

639.1 Purpose and scope.
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AUTHORITY: 29 U.S.C. 2107(a).

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§ 639.1 Purpose and scope.

(a) *Purpose of WARN.* The Worker Adjustment and Retraining Notification Act (WARN or the Act) provides protection to workers, their families and communities by requiring employers to provide notification 60 calendar days in advance of plant closings and mass layoffs. Advance notice provides workers and their families some transition time to adjust to the prospective loss of employment, to seek and obtain alternative jobs and, if necessary, to enter skill training or retraining that will allow these workers to successfully compete in the job market. WARN also provides for notice to State dislocated worker units so that dislocated worker assistance can be promptly provided.

(b) *Scope of these regulations.* These regulations establish basic definitions and rules for giving notice, implementing the provisions of WARN. The Department's objective is to establish clear principles and broad guidelines which can be applied in specific circumstances. However, the Department recognizes that Federal rulemaking cannot address the multitude of industry and company-specific situations in which advance notice will be given.

(c) *Notice encouraged where not required.* Section 7 of the Act states:

> It is the sense of Congress that an employer who is not required to comply with the notice requirements of section 3 should, to the extent possible, provide notice to its employees about a proposal to close a plant or permanently reduce its workforce.

(d) *WARN enforcement.* Enforcement of WARN will be through the courts, as provided in section 5 of the statute. Employees, their representatives and units of local government may initiate civil actions against employers believed to be in violation of §3 of the Act. The Department of Labor has no legal standing in any enforcement action and, therefore, will not be in a position to issue advisory opinions of specific cases. The Department will provide assistance in understanding these regulations and may revise them from time to time as may be necessary.

(e) *Notice in ambiguous situations.* It is civically desirable and it would appear to be good business practice for an employer to provide advance notice to its workers or unions, local government and the State when terminating a significant number of employees. In practical terms, there are some questions and ambiguities of interpretation inherent in the application of WARN to business practices in the market economy that cannot be addressed in these regulations. It is therefore prudent for employers to weigh the desirability of advance notice against the possibility of expensive and time-consuming litigation to resolve disputes where notice has not been given. The Department encourages employers to give notice in all circumstances.

(f) *Coordination with job placement and retraining programs.* The Department, through these regulations and through the Trade Adjustment Assistance Program (TAA) and Economic Dislocation and Worker Adjustment Assistance Act (EDWAA) regulations, encourages maximum coordination of the actions and activities of these programs to assure that the negative impact of dislocation on workers is lessened to the extent possible. By providing for notice to the State dislocated worker unit, WARN notice begins the process of assisting workers who will be dislocated.

(g) *WARN not to supersede other laws and contracts.* The provisions of WARN do not supersede any laws or collective bargaining agreements that provide for additional notice or additional rights and remedies. If such law or agreement provides for a longer notice period,

WARN notice shall run concurrently with that additional notice period. Collective bargaining agreements may be used to clarify or amplify the terms and conditions of WARN, but may not reduce WARN rights.

§ 639.2 What does WARN require?

WARN requires employers who are planning a plant closing or a mass layoff to give affected employees at least 60 days' notice of such an employment action. While the 60-day period is the minimum for advance notice, this provision is not intended to discourage employers from voluntarily providing longer periods of advance notice. Not all plant closings and layoffs are subject to the Act, and certain employment thresholds must be reached before the Act applies. WARN sets out specific exemptions, and provides for a reduction in the notification period in particular circumstances. Damages and civil penalties can be assessed against employers who violate the Act.

§ 639.3 Definitions.

(a) *Employer*. (1) The term ''employer'' means any business enterprise that employs—

(i) 100 or more employees, excluding part-time employees; or

(ii) 100 or more employees, including part-time employees, who in the aggregate work at least 4,000 hours per week, exclusive of hours of overtime.

Workers on temporary layoff or on leave who have a reasonable expectation of recall are counted as employees. An employee has a ''reasonable expectation of recall'' when he/she understands, through notification or through industry practice, that his/her employment with the employer has been temporarily interrupted and that he/she will be recalled to the same or to a similar job. The term ''employer'' includes non-profit organizations of the requisite size. Regular Federal, State, local and federally recognized Indian tribal governments are not covered. However, the term ''employer'' includes public and quasi-public entities which engage in business (*i.e.*, take part in a commercial or industrial enterprise, supply a service or good on a mercantile basis, or provide independent management of public assets, raising revenue and making desired investments), and which are separately organized from the regular government, which have their own governing bodies and which have independent authority to manage their personnel and assets.

(2) Under existing legal rules, independent contractors and subsidiaries which are wholly or partially owned by a parent company are treated as separate employers or as a part of the parent or contracting company depending upon the degree of their independence from the parent. Some of the factors to be considered in making this determination are (i) common ownership, (ii) common directors and/or officers, (iii) de facto exercise of control, (iv) unity of personnel policies emanating from a common source, and (v) the dependency of operations.

(3) Workers, other than part-time workers, who are exempt from notice under section 4 of WARN are nonetheless counted as employees for purposes of determining coverage as an employer.

(4) An employer may have one or more sites of employment under common ownership or control. An example would be a major auto maker which has dozens of automobile plants throughout the country. Each plant would be considered a site of employment, but there is only one ''employer'', the auto maker.

(b) *Plant closing*. The term ''plant closing'' means the permanent or temporary shutdown of a ''single site of employment'', or one or more ''facilities or operating units'' within a single site of employment, if the shutdown results in an ''employment loss'' during *any 30-day period* at the single site of employment for *50 or more* employees, excluding any part-time employees. An employment action that results in the effective cessation of production or the work performed by a unit, even if a few employees remain, is a shutdown. A ''temporary shutdown'' triggers the notice requirement only if there are a sufficient number of terminations, layoffs exceeding 6 months, or reductions in hours of work as specified under the definition of ''employment loss.''

(c) *Mass layoff*. (1) The term ''mass layoff'' means a reduction in force

which first, is not the result of a plant closing, and second, results in an employment loss at the single site of employment during *any 30-day period* for:

(i) *At least 33 percent* of the active employees, excluding part-time employees, and

(ii) *At least 50 employees*, excluding part-time employees.

Where 500 or more employees (excluding part-time employees) are affected, the 33% requirement does not apply, and notice is required if the other criteria are met. Plant closings involve employment loss which results from the shutdown of one or more distinct units within a single site or the entire site. A mass layoff involves employment loss, regardless of whether one or more units are shut down at the site.

(2) Workers, other than part-time workers, who are exempt from notice under section 4 of WARN are nonetheless counted as employees for purposes of determining coverage as a plant closing or mass layoff. For example, if an employer closes a temporary project on which 10 permanent and 40 temporary workers are employed, a covered plant closing has occurred although only 10 workers are entitled to notice.

(d) *Representative.* The term ''representative'' means an exclusive representative of employees within the meaning of section 9(a) or 8(f) of the National Labor Relations Act or section 2 of the Railway Labor Act.

(e) *Affected employees.* The term ''affected employees'' means employees who may reasonably be expected to experience an employment loss as a consequence of a proposed plant closing or mass layoff by their employer. This includes individually identifiable employees who will likely lose their jobs because of bumping rights or other factors, to the extent that such individual workers reasonably can be identified at the time notice is required to be given. The term ''affected employees'' includes managerial and supervisory employees, but does not include business partners. Consultant or contract employees who have a separate employment relationship with another employer and are paid by that other employer, or who are self-employed, are not ''affected employees'' of the business to which they are assigned. In addition, for purposes of determining whether coverage thresholds are met, either incumbent workers in jobs being eliminated or, if known 60 days in advance, the actual employees who suffer an employment loss may be counted.

(f) *Employment loss.* (1) The term ''employment loss'' means (i) an employment termination, other than a discharge for cause, voluntary departure, or retirement, (ii) a layoff exceeding 6 months, or (iii) a reduction in hours of work of individual employees of more than 50% during each month of any 6-month period.

(2) Where a termination or a layoff (see paragraphs (f)(1)(i) and (ii) of this section) is involved, an employment loss does not occur when an employee is reassigned or transferred to employer-sponsored programs, such as retraining or job search activities, as long as the reassignment does not constitute a constructive discharge or other involuntary termination.

(3) An employee is not considered to have experienced an employment loss if the closing or layoff is the result of the relocation or consolidation of part or all of the employer's business and, prior to the closing or layoff—

(i) The employer offers to transfer the employee to a different site of employment within a reasonable commuting distance with no more than a 6-month break in employment, or

(ii) The employer offers to transfer the employee to any other site of employment regardless of distance with no more than a 6-month break in employment, and the employee accepts within 30 days of the offer or of the closing or layoff, whichever is later.

(4) A ''relocation or consolidation'' of part or all of an employer's business, for purposes of paragraph §639.3(h)(4), means that some definable business, whether customer orders, product lines, or operations, is transferred to a different site of employment and that transfer results in a plant closing or mass layoff.

(g) *Unit of local government.* The term ''unit of local government'' means any general purpose political subdivision of a State, which has the power to levy taxes and spend funds and which also

has general corporate and police powers. When a covered employment site is located in more than one unit of local government, the employer must give notice to the unit to which it determines it directly paid the highest taxes for the year preceding the year for which the determination is made. All local taxes directly paid to the local government should be aggregated for this purpose.

(h) *Part-time employee.* The term ''part-time'' employee means an employee who is employed for an average of fewer than 20 hours per week or who has been employed for fewer than 6 of the 12 months preceding the date on which notice is required, including workers who work full-time. This term may include workers who would traditionally be understood as ''seasonal'' employees. The period to be used for calculating whether a worker has worked ''an average of fewer than 20 hours per week'' is the shorter of the actual time the worker has been employed or the most recent 90 days.

(i) *Single site of employment.* (1) A single site of employment can refer to either a single location or a group of contiguous locations. Groups of structures which form a campus or industrial park, or separate facilities across the street from one another, may be considered a single site of employment.

(2) There may be several single sites of employment within a single building, such as an office building, if separate employers conduct activities within such a building. For example, an office building housing 50 different businesses will contain 50 single sites of employment. The offices of each employer will be its single site of employment.

(3) Separate buildings or areas which are not directly connected or in immediate proximity may be considered a single site of employment if they are in reasonable geographic proximity, used for the same purpose, and share the same staff and equipment. An example is an employer who manages a number of warehouses in an area but who regularly shifts or rotates the same employees from one building to another.

(4) Non-contiguous sites in the same geographic area which do not share the same staff or operational purpose should not be considered a single site. For example, assembly plants which are located on opposite sides of a town and which are managed by a single employer are separate sites if they employ different workers.

(5) Contiguous buildings owned by the same employer which have separate management, produce different products, and have separate workforces are considered separate single sites of employment.

(6) For workers whose primary duties require travel from point to point, who are outstationed, or whose primary duties involve work outside any of the employer's regular employment sites (e.g., railroad workers, bus drivers, salespersons), the single site of employment to which they are assigned as their home base, from which their work is assigned, or to which they report will be the single site in which they are covered for WARN purposes.

(7) Foreign sites of employment are not covered under WARN. U.S. workers at such sites are counted to determine whether an employer is covered as an employer under § 639.3(a).

(8) The term ''single site of employment'' may also apply to truly unusual organizational situations where the above criteria do not reasonably apply. The application of this definition with the intent to evade the purpose of the Act to provide notice is not acceptable.

(j) *Facility or operating unit.* The term ''facility'' refers to a building or buildings. The term ''operating unit'' refers to an organizationally or operationally distinct product, operation, or specific work function within or across facilities at the single site.

(k) *State dislocated worker unit.* The term ''State dislocated worker unit'' means a unit designated or created in each State by the Governor under title III of the Job Training Partnership Act, as amended by EDWAA.

(l) *State.* For the purpose of WARN, the term ''State'' includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands.

§ 639.4 Who must give notice?

Section 3(a) of WARN states that ''an employer shall not order a plant closing or mass layoff until the end of a 60-

day period after the employer serves written notice of such an order * * *.'' Therefore, an employer who is anticipating carrying out a plant closing or mass layoff is required to give notice to affected employees or their representative(s), the State dislocated worker unit and the chief elected official of a unit of local government. (See definitions in § 639.3 of this part.)

(a) It is the responsibility of the employer to decide the most appropriate person within the employer's organization to prepare and deliver the notice to affected employees or their representative(s), the State dislocated worker unit and the chief elected official of a unit of local government. In most instances, this may be the local site plant manager, the local personnel director or a labor relations officer.

(b) An employer who has previously announced and carried out a short-term layoff (6 months or less) which is being extended beyond 6 months due to business circumstances (including unforeseeable changes in price or cost) not reasonably foreseeable at the time of the initial layoff is required to give notice when it becomes reasonably foreseeable that the extension is required. A layoff extending beyond 6 months from the date the layoff commenced for any other reason shall be treated as an employment loss from the date of its commencement.

(c) In the case of the sale of part or all of a business, section 2(b)(1) of WARN defines who the ''employer'' is. The seller is responsible for providing notice of any plant closing or mass layoff which takes place up to and including the effective date (time) of the sale, and the buyer is responsible for providing notice of any plant closing or mass layoff that takes place thereafter. Affected employees are always entitled to notice; at all times the employer is responsible for providing notice.

(1) If the seller is made aware of any definite plans on the part of the buyer to carry out a plant closing or mass layoff within 60 days of purchase, the seller may give notice to affected employees as an agent of the buyer, if so empowered. If the seller does not give notice, the buyer is, nevertheless, responsible to give notice. If the seller gives notice as the buyer's agent, the responsibility for notice still remains with the buyer.

(2) It may be prudent for the buyer and seller to determine the impacts of the sale on workers, and to arrange between them for advance notice to be given to affected employees or their representative(s), if a mass layoff or plant closing is planned.

§ 639.5 When must notice be given?

(a) *General rule.* (1) With certain exceptions discussed in paragraphs (b), (c) and (d) of this section and in § 639.9 of this part, notice must be given at least 60 calendar days prior to any planned plant closing or mass layoff, as defined in these regulations. When all employees are not terminated on the same date, the date of the first individual termination within the statutory 30-day or 90-day period triggers the 60-day notice requirement. A worker's last day of employment is considered the date of that worker's layoff. The first and each subsequent group of terminees are entitled to a full 60 days' notice. In order for an employer to decide whether issuing notice is required, the employer should—

(i) Look ahead 30 days and behind 30 days to determine whether employment actions both taken and planned will, in the aggregate for any 30-day period, reach the minimum numbers for a plant closing or a mass layoff and thus trigger the notice requirement; and

(ii) Look ahead 90 days and behind 90 days to determine whether employment actions both taken and planned each of which separately is not of sufficient size to trigger WARN coverage will, in the aggregate for any 90-day period, reach the minimum numbers for a plant closing or a mass layoff and thus trigger the notice requirement. An employer is not, however, required under section 3(d) to give notice if the employer demonstrates that the separate employment losses are the result of separate and distinct actions and causes, and are not an attempt to evade the requirements of WARN.

(2) The point in time at which the number of employees is to be measured for the purpose of determining coverage is the date the first notice is required to be given. If this ''snapshot'' of the number of employees employed

on that date is clearly unrepresentative of the ordinary or average employment level, then a more representative number can be used to determine coverage. Examples of unrepresentative employment levels include cases when the level is near the peak or trough of an employment cycle or when large upward or downward shifts in the number of employees occur around the time notice is to be given. A more representative number may be an average number of employees over a recent period of time or the number of employees on an alternative date which is more representative of normal employment levels. Alternative methods cannot be used to evade the purpose of WARN, and should only be used in unusual circumstances.

(b) *Transfers.* (1) Notice is not required in certain cases involving transfers, as described under the definition of ''employment loss'' at §639.3(f) of this part.

(2) An offer of reassignment to a different site of employment should not be deemed to be a ''transfer'' if the new job constitutes a constructive discharge.

(3) The meaning of the term ''reasonable commuting distance'' will vary with local and industry conditions. In determining what is a ''reasonable commuting distance'', consideration should be given to the following factors: geographic accessibility of the place of work, the quality of the roads, customarily available transportation, and the usual travel time.

(4) In cases where the transfer is beyond reasonable commuting distance, the employer may become liable for failure to give notice if an offer to transfer is not accepted within 30 days of the offer or of the closing or layoff (whichever is later). Depending upon when the offer of transfer was made by the employer, the normal 60-day notice period may have expired and the plant closing or mass layoff may have occurred. An employer is, therefore, well advised to provide 60-day advance notice as part of the transfer offer.

(c) *Temporary employment.* (1) No notice is required if the closing is of a temporary facility, or if the closing or layoff is the result of the completion of a particular project or undertaking, and the affected employees were hired with the understanding that their employment was limited to the duration of the facility or the project or undertaking.

(2) Employees must clearly understand at the time of hire that their employment is temporary. When such understandings exist will be determined by reference to employment contracts, collective bargaining agreements, or employment practices of an industry or a locality, but the burden of proof will lie with the employer to show that the temporary nature of the project or facility was clearly communicated should questions arise regarding the temporary employment understandings.

(3) Employers in agriculture and construction frequently hire workers for harvesting, processing, or for work on a particular building or project. Such work may be seasonal but recurring. Such work falls under this exemption if the workers understood at the time they were hired that their work was temporary. In uncertain situations, it may be prudent for employers to clarify temporary work understandings in writing when workers are hired. The same employers may also have permanent employees who work on a variety of jobs and tasks continuously through most of the calendar year. Such employees are not included under this exemption. Giving written notice that a project is temporary will not convert permanent employment into temporary work, making jobs exempt from WARN.

(4) Certain jobs may be related to a specific contract or order. Whether such jobs are temporary depends on whether the contract or order is part of a long-term relationship. For example, an aircraft manufacturer hires workers to produce a standard airplane for the U.S. fleet under a contract with the U.S. Air Force with the expectation that its contract will continue to be renewed during the foreseeable future. The employees of this manufacturer would not be considered temporary.

(d) *Strikes or lockouts.* The statute provides an exemption for strikes and lockouts which are not intended to evade the requirements of the Act. A

lockout occurs when, for tactical or defensive reasons during the course of collective bargaining or during a labor dispute, an employer lawfully refuses to utilize some or all of its employees for the performance of available work. A lockout not related to collective bargaining which is intended as a subterfuge to evade the Act does not qualify for this exemption. A plant closing or mass layoff at a site of employment where a strike or lockout is taking place, which occurs for reasons unrelated to a strike or lockout, is not covered by this exemption. An employer need not give notice when permanently replacing a person who is deemed to be an economic striker under the National Labor Relations Act. Non-striking employees at the same single site of employment who experience a covered employment loss as a result of a strike are entitled to notice; however, situations in which a strike or lockout affects non-striking employees at the same plant may constitute an unforeseeable business circumstance, as discussed in §639.9, and reduced notice may apply. Similarly, the ''faltering company'' exception, also discussed in §639.9 may apply in strike situations. Where a union which is on strike represents more than one bargaining unit at the single site, non-strikers includes the non-striking bargaining unit(s). Notice also is due to those workers who are not a part of the bargaining unit(s) which is involved in the labor negotiations that led to the lockout. Employees at other plants which have not been struck, but at which covered plant closings or mass layoffs occur as a direct or indirect result of a strike or lockout are not covered by the strike/lockout exemption. The unforeseeable business circumstances exception to 60 days' notice also may apply to these closings or layoffs at other plants.

§639.6 Who must receive notice?

Section 3(a) of WARN provides for notice to each representative of the affected employees as of the time notice is required to be given or, if there is no such representative at that time, to each affected employee. Notice also must be served on the State dislocated worker unit and the chief elected official of the unit of local government within which a closing or layoff is to occur. Section 2(b)(1) of the Act states that ''any person who is an employee of the seller (other than a parttime employee) as of the effective date [time] of the sale shall be considered an employee of the purchaser immediately after the effective date [time] of the sale.'' This provision preserves the notice rights of the employees of a business that has been sold, but creates no other employment rights. Although a technical termination of the seller's employees may be deemed to have occurred when a sale becomes effective, WARN notice is only required where the employees, in fact, experience a covered employment loss.

(a) *Representative(s) of affected employees.* Written notice is to be served upon the chief elected officer of the exclusive representative(s) or bargaining agent(s) of affected employees at the time of the notice. If this person is not the same as the officer of the local union(s) representing affected employees, it is recommended that a copy also be given to the local union official(s).

(b) *Affected employees.* Notice is required to be given to employees who may reasonably be expected to experience an employment loss. This includes employees who will likely lose their jobs because of bumping rights or other factors, to the extent that such workers can be identified at the time notice is required to be given. If, at the time notice is required to be given, the employer cannot identify the employee who may reasonably be expected to experience an employment loss due to the elimination of a particular position, the employer must provide notice to the incumbent in that position. While part-time employees are not counted in determining whether plant closing or mass layoff thresholds are reached, such workers are due notice.

(c) *State dislocated worker unit.* Notice is to be served upon the State dislocated worker unit. Since the States are restructuring to implement training under EDWAA, service of notice upon the State Governor constitutes service upon the State dislocated worker unit until such time as the Governor makes public State procedures for serving notice to this unit.

(d) *Chief elected official of the unit of local government.* The identity of the chief elected official will vary according to the local government structure. In the case of elected boards, the notice is to be served upon the board's chairperson.

§ 639.7 What must the notice contain?

(a) *Notice must be specific.* (1) All notice must be specific.

(2) Where voluntary notice has been given more than 60 days in advance, but does not contain all of the required elements set out in this section, the employer must ensure that all of the information required by this section is provided in writing to the parties listed in § 639.6 at least 60 days in advance of a covered employment action.

(3) Notice may be given conditional upon the occurrence or nonoccurrence of an event, such as the renewal of a major contract, only when the event is definite and the consequences of its occurrence or nonoccurrence will necessarily, in the normal course of business, lead to a covered plant closing or mass layoff less than 60 days after the event. For example, if the non-renewal of a major contract will lead to the closing of the plant that produces the articles supplied under the contract 30 days after the contract expires, the employer may give notice at least 60 days in advance of the projected closing date which states that if the contract is not renewed, the plant closing will occur on the projected date. The notice must contain each of the elements set out in this section.

(4) The information provided in the notice shall be based on the best information available to the employer at the time the notice is served. It is not the intent of the regulations, that errors in the information provided in a notice that occur because events subsequently change or that are minor, inadvertent errors are to be the basis for finding a violation of WARN.

(b) As used in this section, the term ''date'' refers to a specific date or to a 14-day period during which a separation or separations are expected to occur. If separations are planned according to a schedule, the schedule should indicate the specific dates on which or the beginning date of each 14-day period during which any separations are expected to occur. Where a 14-day period is used, notice must be given at least 60 days in advance of the first day of the period.

(c) Notice to each representative of affected employees is to contain:

(1) The name and address of the employment site where the plant closing or mass layoff will occur, and the name and telephone number of a company official to contact for further information;

(2) A statement as to whether the planned action is expected to be permanent or temporary and, if the entire plant is to be closed, a statement to that effect;

(3) The expected date of the first separation and the anticipated schedule for making separations;

(4) The job titles of positions to be affected and the names of the workers currently holding affected jobs.

The notice may include additional information useful to the employees such as information on available dislocated worker assistance, and, if the planned action is expected to be temporary, the estimated duration, if known.

(d) Notice to each affected employee who does not have a representative is to be written in language understandable to the employees and is to contain:

(1) A statement as to whether the planned action is expected to be permanent or temporary and, if the entire plant is to be closed, a statement to that effect;

(2) The expected date when the plant closing or mass layoff will commence and the expected date when the individual employee will be separated;

(3) An indication whether or not bumping rights exist;

(4) The name and telephone number of a company official to contact for further information.

The notice may include additional information useful to the employees such as information on available dislocated worker assistance, and, if the planned action is expected to be temporary, the estimated duration, if known.

(e) The notices separately provided to the State dislocated worker unit and to the chief elected official of the unit of local government are to contain:

(1) The name and address of the employment site where the plant closing or mass layoff will occur, and the name and telephone number of a company official to contact for further information;

(2) A statement as to whether the planned action is expected to be permanent or temporary and, if the entire plant is to be closed, a statement to that effect;

(3) The expected date of the first separation, and the anticipated schedule for making separations;

(4) The job titles of positions to be affected, and the number of affected employees in each job classification;

(5) An indication as to whether or not bumping rights exist;

(6) The name of each union representing affected employees, and the name and address of the chief elected officer of each union.

The notice may include additional information useful to the employees such as a statement of whether the planned action is expected to be temporary and, if so, its expected duration.

(f) As an alternative to the notices outlined in paragraph (e) above, an employer may give notice to the State dislocated worker unit and to the unit of local government by providing them with a written notice stating the name of address of the employment site where the plant closing or mass layoff will occur; the name and telephone number of a company official to contact for further information; the expected date of the first separation; and the number of affected employees. The employer is required to maintain the other information listed in § 639.7(e) on site and readily accessible to the State disclocated worker unit and to the unit of general local government. Should this information not be available when requested, it will be deemed a failure to give required notice.

§ 639.8 How is the notice served?

Any reasonable method of delivery to the parties listed under § 639.6 of this part which is designed to ensure receipt of notice of least 60 days before separation is acceptable (e.g., first class mail, personal delivery with optional signed receipt). In the case of notification directly to affected employees, insertion of notice into pay envelopes is another viable option. A ticketed notice, *i.e.*, preprinted notice regularly included in each employee's pay check or pay envelope, does not meet the requirements of WARN.

§ 639.9 When may notice be given less than 60 days in advance?

Section 3(b) of WARN sets forth three conditions under which the notification period may be reduced to less than 60 days. The employer bears the burden of proof that conditions for the exceptions have been met. If one of the exceptions is applicable, the employer must give as much notice as is practicable to the union, non-represented employees, the State dislocated worker unit, and the unit of local government and this may, in some circumstances, be notice after the fact. The employer must, at the time notice actually is given, provide a brief statement of the reason for reducing the notice period, in addition to the other elements set out in § 639.7.

(a) The exception under section 3(b)(1) of WARN, termed ''faltering company'', applies to plant closings but not to mass layoffs and should be narrowly construed. To qualify for reduced notice under this exception:

(1) An employer must have been actively seeking capital or business at the time that 60-day notice would have been required. That is, the employer must have been seeking financing or refinancing through the arrangement of loans, the issuance of stocks, bonds, or other methods of internally generated financing; or the employer must have been seeking additional money, credit, or business through any other commercially reasonable method. The employer must be able to identify specific actions taken to obtain capital or business.

(2) There must have been a realistic opportunity to obtain the financing or business sought.

(3) The financing or business sought must have been sufficient, if obtained, to have enabled the employer to avoid or postpone the shutdown. The employer must be able to objectively demonstrate that the amount of capital or the volume of new business sought would have enabled the employer to

keep the facility, operating unit, or site open for a reasonable period of time.

(4) The employer reasonably and in good faith must have believed that giving the required notice would have precluded the employer from obtaining the needed capital or business. The employer must be able to objectively demonstrate that it reasonably thought that a potential customer or source of financing would have been unwilling to provide the new business or capital if notice were given, that is, if the employees, customers, or the public were aware that the facility, operating unit, or site might have to close. This condition may be satisfied if the employer can show that the financing or business source would not choose to do business with a troubled company or with a company whose workforce would be looking for other jobs. The actions of an employer relying on the ''faltering company'' exception will be viewed in a company-wide context. Thus, a company with access to capital markets or with cash reserves may not avail itself of this exception by looking solely at the financial condition of the facility, operating unit, or site to be closed.

(b) The ''unforeseeable business circumstances'' exception under section 3(b)(2)(A) of WARN applies to plant closings and mass layoffs caused by business circumstances that were not reasonably foreseeable at the time that 60-day notice would have been required.

(1) An important indicator of a business circumstance that is not reasonably foreseeable is that the circumstance is caused by some sudden, dramatic, and unexpected action or condition outside the employer's control. A principal client's sudden and unexpected termination of a major contract with the employer, a strike at a major supplier of the employer, and an unanticipated and dramatic major economic downturn might each be considered a business circumstance that is not reasonably foreseeable. A government ordered closing of an employment site that occurs without prior notice also may be an unforeseeable business circumstance.

(2) The test for determining when business circumstances are not reasonably foreseeable focuses on an employer's business judgment. The employer must exercise such commercially reasonable business judgment as would a similarly situated employer in predicting the demands of its particular market. The employer is not required, however, to accurately predict general economic conditions that also may affect demand for its products or services.

(c) The ''natural disaster'' exception in section 3(b)(2)(B) of WARN applies to plant closings and mass layoffs due to any form of a natural disaster.

(1) Floods, earthquakes, droughts, storms, tidal waves or tsunamis and similar effects of nature are natural disasters under this provision.

(2) To qualify for this exception, an employer must be able to demonstrate that its plant closing or mass layoff is a direct result of a natural disaster.

(3) While a disaster may preclude full or any advance notice, such notice as is practicable, containing as much of the information required in § 639.7 as is available in the circumstances of the disaster still must be given, whether in advance or after the fact of an employment loss caused by a natural disaster.

(4) Where a plant closing or mass layoff occurs as an indirect result of a natural disaster, the exception does not apply but the ''unforeseeable business circumstance'' exception described in paragraph (b) of this section may be applicable.

§ 639.10 When may notice be extended?

Additional notice is required when the date or schedule of dates of a planned plant closing or mass layoff is extended beyond the date or the ending date of any 14-day period announced in the original notice as follows:

(a) If the postponement is for less than 60 days, the additional notice should be given as soon as possible to the parties identified in § 639.6 and should include reference to the earlier notice, the date (or 14-day period) to which the planned action is postponed, and the reasons for the postponement. The notice should be given in a manner which will provide the information to all affected employees.

(b) If the postponement is for 60 days or more, the additional notice should be treated as new notice subject to the

provisions of §§639.5, 639.6 and 639.7 of this part. Rolling notice, in the sense of routine periodic notice, given whether or not a plant closing or mass layoff is impending, and with the intent to evade the purpose of the Act rather than give specific notice as required by WARN, is not acceptable.

PART 640—STANDARD FOR BENEFIT PAYMENT PROMPTNESS—UNEMPLOYMENT COMPENSATION

Sec.

640.1 Purpose and scope.
640.2 Federal law requirements.
640.3 Interpretation of Federal law requirements.
640.4 Standard for conformity.
640.5 Criteria for compliance.
640.6 Review of State compliance.
640.7 Benefit payment performance plans.
640.8 Enforcement of the standard.
640.9 Information, reports and studies.

AUTHORITY: Sec. 1102, Social Security Act (42 U.S.C. 1302); Secretary's order No. 4–75, dated April 16, 1975 (40 FR 18515) (5 U.S.C. 553). Interpret and apply secs. 303(a)(1) and 303(b)(2) of the Social Security Act (42 U.S.C. 503(a)(1), 503(b)(2)).

SOURCE: 43 FR 33225, July 28, 1978, unless otherwise noted.

§640.1 Purpose and scope.

(a) *Purpose.* (1) Section 303(a)(1) of the Social Security Act requires, for the purposes of title III of that Act, that a State unemployment compensation law include provision for methods of administration of the law that are reasonably calculated to insure the full payment of unemployment compensation when determined under the State law to be due to claimants. The standard in this part is issued to implement section 303(a)(1) in regard to promptness in the payment of unemployment benefits to eligible claimants.

(2) Although the standard applies to the promptness of all benefit payments and the criteria apply directly to the promptness of first benefit payments, it is recognized that adequate performance is contingent upon the prompt determination of eligibility by the State as a condition for the payment or denial of benefits. Accordingly, implicit in prompt performance with respect to benefit payments is the corresponding need for promptness by the State in making determinations of eligibility. However, applicable Federal laws provide no authority for the Secretary of Labor to determine the eligibility of individuals under a State law.

(b) *Scope.* (1) The standard in this part applies to all State laws approved by the Secretary of Labor under the Federal Unemployment Tax Act (section 3304 of the Internal Revenue Code of 1986, 26 U.S.C. 3304), and to the administration of the State laws.

(2) The standard specified in §640.4 applies to all claims for unemployment compensation. The criteria for State compliance in §640.5 apply to first payments of unemployment compensation under the State law to eligible claimants following the filing of initial claims and first compensable claims.

[43 FR 33225, July 28, 1978, as amended at 71 FR 35516, June 21, 2006]

§640.2 Federal law requirements.

(a) *Conformity.* Section 303(a)(1) of the Social Security Act, 42 U.S.C. 503(a)(1), requires that a State law include provision for:

> Such methods of administration * * * as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due.

(b) *Compliance.* Section 303(b)(2) of the Social Security Act, 42 U.S.C. 503(b)(2), provides in part that:

> Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that in the administration of the law there is:
> (1) * * *
> (2) a failure to comply substantially with any provision specified in subsection (a) of this section;
>
> the Secretary of Labor shall notify such State agency that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such * * * failure to comply.
>
> Until he is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State * * *.

§640.3 Interpretation of Federal law requirements.

(a) *Section 303(a)(1).* The Secretary interprets section 303(a)(1) of the Social Security Act to require that a State law include provision for such methods

of administration as will reasonable insure the full payment of unemployment benefits to eligible claimants with the greatest promptness that is administratively feasible.

(b) *Section 303(b)(2).* (1) The Secretary interprets section 303(b)(2) of the Social Security Act to require that, in the administration of a State law, there shall be substantial compliance with the provision required by section 303(a)(1).

(2) The greatest promptness that is administratively feasible will depend upon the circumstances in each State that impacts upon its performance in paying benefits. Factors reasonably beyond a State's control may cause its performance to drop below the level of adequacy expressed in the table below as criteria for substantial compliance applicable to all States. Where it is demonstrated that failure to meet the criteria of adequacy is attributable to factors reasonably beyond the State's control and, in light of those factors, the State has performed at the highest level administratively feasible, it will be considered that the State is in substantial compliance with the Standard for conformity. Whether or not the State is in substantial compliance, the remedial provisions of §§ 640.7 and 640.8 will be applicable when the pertinent criteria are not met.

§ 640.4 Standard for conformity.

A State law will satisfy the requirement of section 303(a)(1), if it contains a provision requiring, or which is construed to require, such methods of administration as will reasonably insure the full payment of unemployment benefits to eligible claimants with the greatest promptness that is administratively feasible.

§ 640.5 Criteria for compliance.

The criteria in the schedule below shall apply in determining whether, in the administration of a State law, there has been substantial compliance with the provision required by section 303(a)(1) in the issuance of benefit payments to eligible claimants for the first compensable weeks of unemployment in their benefit years:

	Percentage of first payments issued—days following end of first compensable week		
	14 days, waiting week States	21 days, non-waiting week States [1]	35 days, all States
Intrastate Claims			
Performance to be achieved for the 12-mo. period ending on March 31 of each year	87	87	93
Interstate Claims			
Performance to be achieved for the 12-mo. period ending on March 31 of each year	70	70	78

[1] A nonwaiting week State is any State whose law does not require that a non-compensable period of unemployment be served before the payment of benefits commences.

A State will be deemed to comply substantially, as set out in §§ 640.2(b) and 640.3(b), if its average performance, for the period of review, meets or exceeds the applicable criteria set forth above.

[43 FR 33225, July 28, 1978, as amended at 71 FR 35516, June 21, 2006]

§ 640.6 Review of State compliance.

(a) *Annual reviews.* The administration of each State law shall be reviewed annually for compliance, as set out in §§ 640.2(b) and 640.3(b). Annual reviews shall be for the 12-month period ending on March 31 of each year. An annual review with respect to any State shall be based upon the monthly reports of performance submitted to the Department by the State agency, any special reports of performance submitted to the Department by the State agency, any benefit payment performance plan applicable to the period being reviewed, any study or anylysis of performance relevant to the period being reviewed, and any other audit, study, or analysis as directed by the Department of Labor.

(b) *Periodic review.* The administration of any State law may be reviewed at any other time, when there is reason to believe that there may be failure of compliance as set out in §§ 640.2(b) and 640.3(b). Such a review shall be based upon the same elements as may be required for an annual review.

§ 640.7 Benefit payment performance plans.

(a) *Annual plan.* An annual benefit payment performance plan shall be submitted by a State agency to the Department of Labor when average performance over a 12-month period ending on March 31 of any year does not meet the criteria specified in § 640.5. An annual plan shall be submitted by July 31 following the applicable March 31, and shall be a plan for the fiscal year that begins on the succeeding October 1. An annual plan shall be subject to continuing appraisal during the period it is in effect, and shall be subject to modification from time to time as may be directed by the Department of Labor after consultation with the State agency.

(b) *Periodic plan.* A periodic benefit payment performance plan shall be submitted by a State agency when directed by the Department of Labor. A periodic plan may be in addition to, or a modification of an annual plan and may be required even though an annual plan covering the same period is not required. A periodic plan shall be subject to continuing appraisal during the period it is in effect, and shall be subject to modification from time to time as may be directed by the Department of Labor.

(c) *Content of plan.* An annual plan or periodic plan shall set forth such corrective actions, performance and evaluation plans, and other matters as the Department of Labor directs, after consultation with the State agency.

(Approved by the Office of Management and Budget under control number 1205–0132)

(Pub. L. No. 96–511)

[43 FR 33225, July 28, 1978, as amended at 49 FR 18295, Apr. 30, 1984]

§ 640.8 Enforcement of the standard.

(a) *Action by the Department of Labor.* When a State agency fails, for an extended period, to meet the standard set forth in § 640.4 or the criteria specified in § 640.5, or fails to show satisfactory improvement after having submitted a benefit payment performance plan of action, the Department of Labor shall pursue any of the following remedial steps that it deems necessary before considering application of the provisions of § 640.2:

(1) Initiate informal discussion with State agency officials pursuant to § 601.5(b) of this chapter.

(2) Conduct an evaluation of the State's benefit payment processes and analyze the reasons for the State's failure to meet the standard.

(3) Recommend specific actions for the State to take to improve its benefit payment performance.

(4) Request the State to submit a plan for complying with the standard by a prescribed date.

(5) Initiate special reporting requirements for a specified period of time.

(6) Consult with the Governor of the State regarding the consequences of the State's noncompliance with the standard.

(7) Propose to the Governor of the State and on an agreed upon basis arrange for the use of expert Federal staff to furnish technical assistance to the State agency with respect to its payment operations.

(b) *Action by the Assistant Secretary.* If, after all remedial steps have been exhausted, a State fails to take appropriate action, or otherwise fails to meet the standard specified in § 640.4, the Assistant Secretary for Employment and Training shall, after taking all factors into consideration, recommend to the Secretary of Labor that appropriate notice be sent to the State agency and that an opportunity for a hearing be extended in accordance with section 303(b) of the Social Security Act.

§ 640.9 Information, reports and studies.

A State shall furnish to the Secretary of Labor such information and reports and make such studies as the Secretary decides are necessary or appropriate to carry out this part.

PART 641—PROVISIONS GOVERNING THE SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

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Subpart A—Purpose and Definitions

§ 641.100 What does this part cover?

Part 641 contains the Department of Labor's regulations for the Senior Community Service Employment Program (SCSEP), authorized under title V of the Older Americans Act (OAA), 42 U.S.C. 3056 *et seq.*, as amended by the Older Americans Act Reauthorization Act of 2016, Public Law 114–144 (Apr. 19, 2016). This part and other pertinent regulations set forth the regulations applicable to the SCSEP.

(a) Subpart A of this part contains introductory provisions and definitions that apply to this part.

(b) Subpart B of this part describes the required relationship between the OAA and the Workforce Innovation and Opportunity Act (WIOA), Public Law 113–128 (July 22, 2014). These provisions discuss the coordinated efforts to provide services through the integration of the SCSEP within the One-Stop delivery system.

(c) Subpart C of this part sets forth the requirements for the State Plan, such as the four-year strategy, required coordination efforts, public comments, and equitable distribution.

(d) Subpart D of this part establishes grant planning and application requirements, including grantee eligibility and responsibility review provisions that apply to the Department's award of SCSEP funds for State and national grants.

(e) Subpart E of this part details SCSEP participant services.

(f) Subpart F of this part provides the rules for pilot, demonstration, and evaluation projects.

(g) Subpart G of this part outlines the performance accountability requirements. This subpart establishes requirements for performance measures, defines such measures, and establishes corrective actions for failure to meet core performance measures.

(h) Subpart H of this part sets forth the administrative requirements for SCSEP funds.

(i) Subpart I of this part describes the grievance and appeals processes and requirements.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56880, Dec. 1, 2017]

§ 641.110 What is the SCSEP?

The Senior Community Service Employment Program (SCSEP) is a program administered by the Department of Labor that serves unemployed low-income persons who are 55 years of age and older and who have poor employment prospects by training them in part-time community service assignments and by assisting them in developing skills and experience to facilitate their transition to unsubsidized employment.

§ 641.120 What are the purposes of the SCSEP?

The purposes of the SCSEP are to foster individual economic self-sufficiency and promote useful part-time opportunities in community service assignments for unemployed low-income persons who are 55 years of age or older, particularly persons who have poor employment prospects, and to increase the number of older persons who may enjoy the benefits of unsubsidized employment in both the public and private sectors. (OAA § 502(a)(1)).

§ 641.130 What is the scope of this part?

The regulations in this part address the requirements that apply to the SCSEP. More detailed policies and procedures are contained in administrative guidelines issued by the Department. Throughout this part, phrases such as, ''according to instructions (procedures) issued by the Department'' or ''additional guidance will be

provided through administrative issuance'' refer to the documents issued under the Secretary's authority to administer the SCSEP, such as Training and Employment Guidance Letters (TEGLs), Training and Employment Notices (TENs), previously issued SCSEP Older Worker Bulletins that are still in effect, technical assistance guides, and other SCSEP guidance.

§ 641.140 What definitions apply to this part?

The following definitions apply to this part:

At risk for homelessness means an individual is likely to become homeless and the individual lacks the resources and support networks needed to obtain housing.

Authorized position level means the number of SCSEP enrollment opportunities that can be supported for a 12-month period based on the average national unit cost. The authorized position level is derived by dividing the total amount of funds appropriated for a Program Year by the national average unit cost per participant for that Program Year as determined by the Department. The national average unit cost includes all costs of administration, other participant costs, and participant wage and benefit costs as defined in § 506(g) of the OAA.

Career services means those services described in sec. 134(c)(2) of WIOA.

Co-enrollment applies to any individual who meets the qualifications for SCSEP participation and is also enrolled as a participant in WIOA or another employment and training program, as provided in the Individual Employment Plan (IEP).

Community service means:

(1) Social, health, welfare, and educational services (including literacy tutoring), legal and other counseling services and assistance, including tax counseling and assistance and financial counseling, and library, recreational, and other similar services;

(2) Conservation, maintenance, or restoration of natural resources;

(3) Community betterment or beautification;

(4) Antipollution and environmental quality efforts;

(5) Weatherization activities;

(6) Economic development; and

(7) Other such services essential and necessary to the community as the Secretary determines by rule to be appropriate. (OAA § 518(a)(1)).

Community service assignment means part-time, temporary employment paid with grant funds in projects at host agencies through which eligible individuals are engaged in community service and receive work experience and job skills that can lead to unsubsidized employment. (OAA § 518(a)(2)).

Community Service Employment means part-time, temporary employment paid with grant funds in projects at host agencies through which eligible individuals are engaged in community service and receive work experience and job skills that can lead to unsubsidized employment. (OAA sec. 518(a)(2).) The term community service assignment is used interchangeably with community service employment.

Core measures means hours (in the aggregate) of community service employment; the percentage of project participants who are in unsubsidized employment during the second quarter after exit from the project; the percentage of project participants who are in unsubsidized employment during the fourth quarter after exit from the project; the median earnings of project participants who are in unsubsidized employment during the second quarter after exit from the project; indicators of effectiveness in serving employers, host agencies, and project participants; the number of eligible individuals served; and most-in-need (the number of individuals described in sec. 518(a)(3)(B)(ii) or (b)(2) of the OAA). (OAA sec. 513(b)(1).)

Department or DOL means the United States Department of Labor, including its agencies and organizational units.

Disability means a disability attributable to a mental or physical impairment, or a combination of mental and physical impairments, that results in substantial functional limitations in one or more of the following areas of major life activity:

(1) Self-care;

(2) Receptive and expressive language;

(3) Learning;

(4) Mobility;
(5) Self-direction;
(6) Capacity for independent living;
(7) Economic self-sufficiency;
(8) Cognitive functioning; and
(9) Emotional adjustment. (42 U.S.C. 3002(13)).

Equitable distribution report means a report based on the latest available Census or other reliable data, which lists the optimum number of participant positions in each designated area in the State, and the number of authorized participant positions each grantee serves in that area, taking into account the needs of underserved counties and incorporated cities as necessary. This report provides a basis for improving the distribution of SCSEP positions.

Formerly incarcerated individuals mean:

(1) Individuals who were incarcerated at any point within the last 5 years; or

(2) Individuals who were under supervision at any point within the last 5 years, following release from prison or jail.

(3) The 5-year period specified in this definition refers to the 5 years preceding the date of first determination of program eligibility, as described in § 641.505, for initial enrollment into the program.

Frail means an individual 55 years of age or older who is determined to be functionally impaired because the individual—

(1)(i) Is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or

(ii) At the option of the State, is unable to perform at least three such activities without such assistance; or

(2) Due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. (42 U.S.C. 3002(22)).

Grant period means the time period between the effective date of the grant award and the ending date of the award, which includes any modifications extending the period of performance, whether by the Department's exercise of options contained in the grant agreement or otherwise. This is also referred to as ''project period'' or ''award period.''

Grantee means an entity receiving financial assistance directly from the Department to carry out SCSEP activities. The grantee is the legal entity that receives the award and is legally responsible for carrying out the SCSEP, even if only a particular component of the entity is designated in the grant award document. Grantees include public and nonprofit private agencies and organizations, agencies of a State, tribal organizations, and Territories, that receive SCSEP grants from the Department. (OAA §§ 502(b)(1), 506(a)(2)). As used here, ''grantee'' includes ''grantee'' as defined in 29 CFR 97.3 and ''recipient'' as defined in 29 CFR 95.2(gg).

Greatest economic need means the need resulting from an income level at or below the poverty guidelines established by the Department of Health and Human Services and approved by the Office of Management and Budget (OMB). (42 U.S.C. 3002(23)).

Greatest social need means the need caused by non-economic factors, which include: Physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, which restricts the ability of an individual to perform normal daily tasks or threatens the capacity of the individual to live independently. (42 U.S.C. 3002(24)).

Homeless includes:

(1) An individual who lacks a fixed, regular, and adequate nighttime residence; and

(2) An individual who has a primary nighttime residence that is:

(i) A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

(ii) An institution that provides a temporary residence for individuals intended to be institutionalized; or

(iii) A public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human beings. (42 U.S.C. 11302(a)).

Host agency means a public agency or a private nonprofit organization exempt from taxation under §501(c)(3) of the Internal Revenue Code of 1986 which provides a training work site and supervision for one or more participants. Political parties cannot be host agencies. A host agency may be a religious organization as long as the projects in which participants are being trained do not involve the construction, operation, or maintenance of any facility used or to be used as a place for sectarian religious instruction or worship. (OAA §502(b)(1)(D)).

Indian means a person who is a member of an Indian tribe. (42 U.S.C. 3002(26)).

Indian tribe means any tribe, band, nation, or other organized group or community of Indians (including Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 *et seq.*) which: (1) Is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians; or (2) is located on, or in proximity to, a Federal or State reservation or Rancheria. (42 U.S.C. 3002(27)).

Individual employment plan (IEP) means a plan for a participant that is based on an assessment of that participant conducted by the grantee or subrecipient, or a recent assessment or plan developed by another employment and training program, and a related service strategy. The IEP must include an appropriate employment goal (except that after the first IEP, subsequent IEPs need not contain an employment goal if such a goal is not feasible), objectives that lead to the goal, a timeline for the achievement of the objectives; and be jointly agreed upon with the participant. (OAA §502(b)(1)(N)).

Jobs for Veterans Act means Public Law 107–288 (2002). Section 2(a) of the Jobs for Veterans Act, codified at 38 U.S.C. 4215(a), provides a priority of service for Department of Labor employment and training programs for veterans, and certain spouses of veterans, who otherwise meet the eligibility requirements for participation. Priority is extended to veterans. Priority is also extended to the spouse of a veteran who died of a service-connected disability; the spouse of a member of the Armed Forces on active duty who has been listed for a total of more than 90 days as missing in action, captured in the line of duty by a hostile force, or forcibly detained by a foreign government or power; the spouse of any veteran who has a total disability resulting from a service-connected disability; and the spouse of any veteran who died while a disability so evaluated was in existence. (See §641.520(b)).

Job ready refers to individuals who do not require further education or training to perform work that is available in their labor market.

Limited English proficiency means individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

Local Board means a Local Workforce Development Board established under sec. 107 of the Workforce Innovation and Opportunity Act.

Local Workforce Development Area or *local area* means an area designated by the Governor of a State under sec. 106 of the Workforce Innovation and Opportunity Act.

Low employment prospects means the likelihood that an individual will not obtain employment without the assistance of the SCSEP or another workforce development program. Persons with low employment prospects have a significant barrier to employment. Significant barriers to employment may include but are not limited to: Lacking a substantial employment history, basic skills, and/or English-language proficiency; lacking a high school diploma or the equivalent; having a disability; being homeless; or residing in socially and economically isolated rural or urban areas where employment opportunities are limited.

Low literacy skills means the individual computes or solves problems, reads, writes, or speaks at or below the 8th grade level or is unable to compute or solve problems, read, write, or speak at a level necessary to function on the job, in the individual's family, or in society.

Most-in-need means participants with one or more of the following characteristics (OAA sec. 513(b)(1)(F)):

(1) Have a severe disability;

(2) Are frail;

(3) Are age 75 or older;

(4) Are age-eligible but not receiving benefits under title II of the Social Security Act;

(5) Reside in an area with persistent unemployment and have severely limited employment prospects;

(6) Have limited English proficiency;

(7) Have low literacy skills;

(8) Have a disability;

(9) Reside in a rural area;

(10) Are veterans;

(11) Have low employment prospects;

(12) Have failed to find employment after using services provided under title I of the Workforce Innovation and Opportunity Act;

(13) Are homeless or at risk for homelessness; or

(14) Are ''formerly incarcerated'' as defined in this section.

National grantee means a public or non-profit private agency or organization, or Tribal organization, that receives a grant under title V of the OAA (42 U.S.C. 3056 *et seq.*) to administer a SCSEP project. (*See* OAA § 506(g)(5)).

OAA means the Older Americans Act, 42 U.S.C. 3001 *et seq.*, as amended.

One-Stop Center means the One-Stop Center system in a WIOA local area, which must include a comprehensive One-Stop Center through which One-Stop partners provide applicable career services and which provides access to other programs and services carried out by the One-Stop partners. (*See* WIOA sec. 121(e)(2).)

One-Stop delivery system means a system under which employment and training programs, services, and activities are available through a network of eligible One-Stop partners, which assures that information about and access to career services are available regardless of where the individuals initially enter the workforce development system. (*See* WIOA sec. 121(e)(2).)

One-Stop partner means an entity described in sec. 121(b)(1) of the Workforce Innovation and Opportunity Act, *i.e.*, required partners, or an entity described in sec. 121(b)(2) of the Workforce Innovation and Opportunity Act, *i.e.*, additional partners.

Other participant (enrollee) costs means the costs of participant training, including the payment of reasonable costs to instructors, classroom rental, training supplies, materials, equipment, and tuition, and which may be provided before or during a community service assignment, in a classroom setting, or under other appropriate arrangements; job placement assistance, including job development and job search assistance; participant supportive services to enable a participant to successfully participate in a project, including the payment of reasonable costs of transportation, health care and medical services, special job-related or personal counseling, incidentals (such as work shoes, badges, uniforms, eyeglasses, and tools), child and adult care, temporary shelter, and follow-up services; and outreach, recruitment and selection, intake orientation, and assessments. (OAA § 502(c)(6)(A)(ii)–(v)).

Pacific Island and Asian Americans means Americans having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. (OAA sec. 518(a)(6).)

Participant means an individual who is determined to be eligible for the SCSEP, is given a community service assignment, and is receiving any service funded by the program as described in subpart E.

Persistent unemployment means that the annual average unemployment rate for a county or city is more than 20 percent higher than the national average for two out of the last three years.

Poor employment prospects means the significant likelihood that an individual will not obtain employment without the assistance of the SCSEP or another workforce development program. Persons with poor employment prospects have a significant barrier to employment; significant barriers to employment include but are not limited to: lacking a substantial employment history, basic skills, and/or English-language proficiency; lacking

a high school diploma or the equivalent; having a disability; being homeless; or residing in socially and economically isolated rural or urban areas where employment opportunities are limited.

Program operator means a grantee or sub-recipient that receives SCSEP funds from a SCSEP grantee or a higher-tier SCSEP sub-recipient and performs the following activities for all its participants: Eligibility determination, participant assessment, and development of and placement into community service assignments.

Program Year means the one-year period beginning on July 1 and ending on June 30.

Project means an undertaking by a grantee or sub-recipient in accordance with a grant or contract agreement that provides service to communities and training and employment opportunities to eligible individuals.

Recipient means grantee. As used here, ''recipient'' includes ''recipient'' as defined in 29 CFR 95.2(gg) and ''grantee'' as defined in 29 CFR 97.3.

Residence means an individual's declared dwelling place or address as demonstrated by appropriate documentation.

Rural means an area not designated as a metropolitan statistical area by the Census Bureau; segments within metropolitan counties identified by codes 4 through 10 in the Rural Urban Commuting Area (RUCA) system; and RUCA codes 2 and 3 for census tracts that are larger than 400 square miles and have population density of less than 30 people per square mile.

SCSEP means the Senior Community Service Employment Program authorized under title V of the OAA.

Secretary means the Secretary of the U.S. Department of Labor.

Service area means the geographic area served by a local SCSEP project in accordance with a grant agreement.

Severe disability means a severe, chronic disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that—

(1) Is likely to continue indefinitely; and

(2) Results in substantial functional limitation in 3 or more of the following areas of major life activity:

(i) Self-care;

(ii) Receptive and expressive language;

(iii) Learning;

(iv) Mobility;

(v) Self-direction;

(vi) Capacity for independent living;

(vii) Economic self-sufficiency. (42 U.S.C. 3002(48)).

Severely limited employment prospects means the substantial likelihood that an individual will not obtain employment without the assistance of the SCSEP or another workforce development program. Persons with severely limited employment prospects have more than one significant barrier to employment; significant barriers to employment may include but are not limited to: Lacking a substantial employment history, basic skills, and/or English-language proficiency; lacking a high school diploma or the equivalent; having a disability; being homeless; or residing in socially and economically isolated rural or urban areas where employment opportunities are limited.

State Board means a State Workforce Development Board established under WIOA sec. 101.

State grantee means the entity designated by the Governor, or the highest government official, to enter into a grant with the Department to administer a State or Territory SCSEP project under the OAA. Except as applied to funding distributions under § 506 of the OAA, this definition applies to the 50 States, Puerto Rico, the District of Columbia and the following Territories: Guam, American Samoa, U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

State Plan means a plan that the Governor, or the highest government official, of a State must submit to the Secretary that outlines a four-year strategy, and describes the planning and implementation process, for the statewide provision of community service employment and other authorized activities for eligible individuals under SCSEP. (*See* § 641.300).

Sub-recipient means the legal entity to which a sub-award of financial assistance is made by the grantee (or by a higher-tier sub-recipient), and that is accountable to the grantee for the use of the funds provided. As used here, ''sub-recipient'' includes ''sub-grantee'' as defined in 29 CFR 97.3 and ''sub-recipient'' as defined in 29 CFR 95.2(kk).

Supportive services means services, such as transportation, health and medical services, special job-related or personal counseling, incidentals (such as work shoes, badges, uniforms, eyeglasses, and tools), child and adult care, housing, including temporary shelter, follow-up services, and needs-related payments, which are necessary to enable an individual to participate in activities authorized under the SCSEP. (OAA secs. 502(c)(6)(A)(iv) and 518(a)(8).)

Title V of the OAA means 42 U.S.C. 3056 *et seq.*, as amended.

Training services means those services authorized by WIOA sec. 134(c)(3).

Tribal organization means the recognized governing body of any Indian tribe, or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body. (42 U.S.C. 3002(54)).

Unemployed means an individual who is without a job and who wants and is available for work, including an individual who may have occasional employment that does not result in a constant source of income. (OAA sec. 518(a)(9).)

Veteran means an individual who is a ''covered person'' for purposes of the Jobs for Veterans Act, 38 U.S.C. 4215(a)(1).

Workforce Innovation and Opportunity Act (WIOA) means the Workforce Innovation and Opportunity Act, Public Law 113–128 (July 22, 2014), as amended.

Workforce Innovation and Opportunity Act (WIOA) regulations means the regulations in parts 675 through 688 of this chapter, the Wagner-Peyser Act regulations in parts 651 through 654 and part 658 of this chapter, and the regulations implementing WIOA sec. 188 in 29 CFR part 38.

[75 FR 53812, Sept. 1, 2010, as amended at 77 FR 4661, Jan. 31, 2012; 82 FR 56880, Dec. 1, 2017; 87 FR 8189, Feb. 14, 2022]

Subpart B—Coordination With the Workforce Innovation and Opportunity Act

SOURCE: 82 FR 56881, Dec. 1, 2017, unless otherwise noted.

§ 641.200 What is the relationship between the SCSEP and the Workforce Innovation and Opportunity Act?

The SCSEP is a required partner under the Workforce Innovation and Opportunity Act. As such, it is a part of the One-Stop delivery system. When acting in their capacity as WIOA partners, SCSEP grantees and sub-recipients are required to follow all applicable rules under WIOA and its regulations. *See* WIOA sec. 121(b)(1)(B)(v) and 20 CFR 678.400 through 678.440.

§ 641.210 What services, in addition to the applicable career services, must SCSEP grantees and sub-recipients provide through the One-Stop delivery system?

In addition to providing career services, as defined at 20 CFR 678.430, SCSEP grantees and sub-recipients must make arrangements through the One-Stop delivery system to provide eligible and ineligible individuals with referrals to WIOA career and training services and access to other activities and programs carried out by other One-Stop partners.

§ 641.220 Does title I of WIOA require the SCSEP to use OAA funds for individuals who are not eligible for SCSEP services or for services that are not authorized under the OAA?

No, SCSEP requirements continue to apply. OAA title V resources may not be used to serve individuals who are not SCSEP-eligible. The Workforce Innovation and Opportunity Act creates a seamless service delivery system for individuals seeking workforce development services by linking the One-Stop partners in the One-Stop delivery system. Although the overall effect is to provide universal access to career services, SCSEP resources may only be used to provide services that are authorized and provided under the SCSEP to eligible individuals. Note, however, that one allowable SCSEP cost is a SCSEP project's proportionate share of

One-Stop costs. *See* § 641.850(d). Title V funds can be used to pay wages to SCSEP participants receiving career and training services under title I of WIOA provided that the SCSEP participants have each received a community service assignment. All other individuals who are in need of the services provided under the SCSEP, but who do not meet the eligibility criteria to enroll in the SCSEP, should be referred to or enrolled in WIOA or other appropriate partner programs. WIOA sec. 121(b)(1). These arrangements should be negotiated in the Memorandum of Understanding (MOU), which is an agreement developed and executed between the Local Workforce Development Board, with the agreement of the chief local elected official, and the One-Stop partners relating to the operation of the One-Stop delivery system in the local area. The MOU is further described in the WIOA regulations at 20 CFR 678.500 through 678.510.

§ 641.230 Must the individual assessment conducted by the SCSEP grantee or sub-recipient and the assessment performed by the One-Stop delivery system be accepted for use by either entity to determine the individual's need for services in the SCSEP and adult programs under title I, subtitle B of WIOA?

Yes, sec. 502(b)(3) of the OAA provides that an assessment or IEP completed by the SCSEP satisfies any condition for an assessment, service strategy, or IEP completed at the One-Stop and vice-versa. (OAA sec. 502(b)(3).) These reciprocal arrangements and the contents of the SCSEP IEP and WIOA IEP should be negotiated in the MOU.

§ 641.240 Are SCSEP participants eligible for career and training services under title I of WIOA?

(a) Although SCSEP participants are not automatically eligible for career and training services under title I of WIOA, local boards may deem SCSEP participants, either individually or as a group, as satisfying the requirements for receiving adult career and training services under title I of WIOA.

(b) SCSEP participants who have been assessed and for whom an IEP has been developed have received a career service under 20 CFR 680.220(a) of the WIOA regulations. In order to enhance skill development related to the IEP, it may be necessary to provide training beyond the community service assignment to enable participants to meet their unsubsidized employment objectives. The SCSEP grantee or sub-recipient, the host agency, the WIOA program, or another One-Stop partner may provide training as appropriate and as negotiated in the MOU. (See § 641.540 for a further discussion of training for SCSEP participants.)

Subpart C—The State Plan

§ 641.300 What is the State Plan?

The State Plan is a plan, submitted by the Governor, or the highest government official, in each State, as an independent document or as part of the WIOA Combined State Plan, that outlines a 4-year strategy for the statewide provision of community service employment and other authorized activities for eligible individuals under the SCSEP as described in § 641.302. The State Plan also describes the planning and implementation process for SCSEP services in the State, taking into account the relative distribution of eligible individuals and employment opportunities within the State. The State Plan is intended to foster coordination among the various SCSEP grantees and sub-recipients operating within the State and to facilitate the efforts of stakeholders, including State and local boards under WIOA, to work collaboratively through a participatory process to accomplish the SCSEP's goals. (OAA sec. 503(a)(1).) The State Plan provisions are listed in § 641.325.

[82 FR 56882, Dec. 1, 2017]

§ 641.302 What is a four-year strategy?

The State Plan must outline a four-year strategy for the statewide provision of community service employment and other authorized activities for eligible individuals under the SCSEP program. (OAA § 503(a)(1)). The four-year strategy must specifically address the following:

(a) The State's long-term strategy for achieving an equitable distribution

of SCSEP positions within the State that:

(1) Moves positions from over-served to underserved locations within the State, under § 641.365;

(2) Equitably serves rural and urban areas; and

(3) Serves individuals afforded priority for service, pursuant to § 641.520;

(b) The State's long-term strategy for avoiding disruptions to the program when new Census or other reliable data become available, or when there is over-enrollment for any other reason;

(c) The State's long-term strategy for serving minority older individuals under SCSEP;

(d) Long-term projections for job growth in industries and occupations in the State that may provide employment opportunities for older workers, and how those relate to the types of unsubsidized jobs for which SCSEP participants will be trained, and the types of skill training to be provided;

(e) The State's long-term strategy for engaging employers to develop and promote opportunities for the placement of SCSEP participants in unsubsidized employment;

(f) The State's strategy for continuous improvement in the level of performance for entry into unsubsidized employment;

(g) Planned actions to coordinate activities of SCSEP grantees with the activities being carried out in the State under title I of WIOA, including plans for using the WIOA One-Stop delivery system and its partners to serve individuals aged 55 and older;

(h) Planned actions to coordinate activities of SCSEP grantees with the activities being carried out in the State under other titles of the OAA;

(i) Planned actions to coordinate the SCSEP with other public and private entities and programs that provide services to older Americans, such as community and faith-based organizations, transportation programs, and programs for those with special needs or disabilities;

(j) Planned actions to coordinate the SCSEP with other labor market and job training initiatives; and

(k) The State's long-term strategy to improve SCSEP services, including planned longer-term changes to the design of the program within the State, and planned changes in the use of SCSEP grantees and program operators to better achieve the goals of the program; this may include recommendations to the Department, as appropriate.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56882, Dec. 1, 2017]

§ 641.305 Who is responsible for developing and submitting the State Plan?

The Governor, or the highest governmental official, of each State is responsible for developing and submitting the State Plan to the Department.

§ 641.310 May the Governor, or the highest government official, delegate responsibility for developing and submitting the State Plan?

(a) Yes, the Governor, or the highest governmental official of each State, may delegate responsibility for developing and submitting the State Plan, provided that any such delegation is consistent with State law and regulations.

(b) To delegate responsibility, the Governor, or the highest government official, must submit to the Department a signed statement indicating the individual and/or organization that will be submitting the State Plan on his or her behalf.

§ 641.315 Who participates in developing the State Plan?

(a) In developing the State Plan the Governor, or the highest government official, must seek the advice and recommendations of representatives from:

(1) The State and area agencies on aging;

(2) State and local boards under WIOA;

(3) Public and private nonprofit agencies and organizations providing employment services, including each grantee operating a SCSEP project within the State, except as provided in § 641.320(b);

(4) Social service organizations providing services to older individuals;

(5) Grantees under title III of the OAA;

(6) Affected communities;

(7) Unemployed older individuals;

(8) Community-based organizations serving older individuals;

(9) Business organizations; and

(10) Labor organizations.

(b) The Governor, or the highest government official, may also obtain the advice and recommendations of other interested organizations and individuals, including SCSEP program participants, in developing the State Plan. (OAA § 503(a)(2)).

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56882, Dec. 1, 2017]

§ 641.320 Must all national grantees operating within a State participate in the State planning process?

(a) The eligibility provision at OAA § 514(c)(6) requires national grantees to coordinate activities with other organizations at the State and local levels. Therefore, except as provided in paragraph (b) of this section, any national grantee that does not participate in the State planning process may be deemed ineligible to receive SCSEP funds in the following Program Year.

(b) National grantees serving older American Indians, or Pacific Island and Asian Americans, with funds reserved under OAA sec. 506(a)(3), are exempted from the requirement to participate in the State planning processes under sec. 503(a)(9) of the OAA. Although these national grantees may choose not to participate in the State planning process, the Department encourages their participation. Only those grantees using reserved funds are exempt; if a grantee is awarded one grant with reserved funds and another grant with non-reserved funds, the grantee is required under paragraph (a) of this section to participate in the State planning process for purposes of the non-reserved funds grant.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56882, Dec. 1, 2017]

§ 641.325 What information must be provided in the State Plan?

The Department issues instructions detailing the information that must be provided in the State Plan. At a minimum, the State Plan must include the State's four-year strategy, as described in § 641.302, and information on the following:

(a) The ratio of eligible individuals in each service area to the total eligible population in the State;

(b) The relative distribution of:

(1) Eligible individuals residing in urban and rural areas within the State;

(2) Eligible individuals who have the greatest economic need;

(3) Eligible individuals who are minorities;

(4) Eligible individuals who are limited English proficient;

(5) Eligible individuals who have the greatest social need; and

(6) Eligible individuals who are formerly incarcerated individuals as defined in § 641.140;

(c) The current and projected employment opportunities in the State (such as by providing information available under sec. 15 of the Wagner-Peyser Act (29 U.S.C. 49l–2) by occupation), and the types of skills possessed by eligible individuals;

(d) The localities and populations for which projects of the type authorized by OAA title V are most needed;

(e) Actions taken and/or planned to coordinate activities of SCSEP grantees in the State with activities carried out in the State under title I of WIOA;

(f) A description of the process used to obtain advice and recommendations on the State Plan from representatives of organizations and individuals listed in § 641.315, and advice and recommendations on steps to coordinate SCSEP services with activities funded under title I of WIOA from representatives of organizations listed in § 641.335;

(g) A description of the State's procedures and time line for ensuring an open and inclusive planning process that provides meaningful opportunity for public comment as required by § 641.350;

(h) Public comments received, and a summary of the comments;

(i) A description of the steps taken to avoid disruptions to the greatest extent possible as provided in § 641.365; and

(j) Such other information as the Department may require in the State Plan instructions. (OAA § 503(a)).

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56882, Dec. 1, 2017; 87 FR 8189, Feb. 14, 2022]

§ 641.330 How should the State Plan reflect community service needs?

The Governor, or the highest government official, must ensure that the State Plan identifies the types of community services that are needed and the places where these services are most needed. The State Plan should specifically identify the needs and locations of those individuals most in need of community services and the groups working to meet their needs. (OAA § 503(a)(4)(E)).

§ 641.335 How should the Governor, or the highest government official, address the coordination of SCSEP services with activities funded under title I of WIOA?

The Governor, or the highest government official, must seek the advice and recommendations from representatives of the State and local area agencies on aging in the State and the State and local boards established under title I of WIOA. (OAA sec. 503(a)(2).) The State Plan must describe the steps that are being taken to coordinate SCSEP activities within the State with activities being carried out under title I of WIOA. (OAA sec. 503(a)(4)(F).) The State Plan must describe the steps being taken to ensure that the SCSEP is an active partner in each One-Stop delivery system and the steps that will be taken to encourage and improve coordination with the One-Stop delivery system.

[82 FR 56882, Dec. 1, 2017]

§ 641.340 How often must the Governor, or the highest government official, update the State Plan?

(a) Under instructions issued by the Department, the Governor, or the highest government official, must review the State Plan and submit an update to the State Plan to the Secretary for consideration and approval not less often than every two years. OAA § 503(a)(1). States are encouraged to review their State Plan more frequently than every two years, however, and make modifications as circumstances warrant, under § 641.345.

(b) Before development of the update to the State Plan, the Governor, or the highest government official, must seek the advice and recommendations of the individuals and organizations identified in § 641.315 about what, if any, changes are needed, and must publish the State Plan, showing the changes, for public comment. OAA § section 503(a)(2), 503(a)(3).

§ 641.345 What are the requirements for modifying the State Plan?

(a) Modifications may be submitted anytime circumstances warrant.

(b) Modifications to the State Plan are required when:

(1) There are changes in Federal or State law or policy that substantially change the assumptions upon which the State Plan is based;

(2) There are significant changes in the State's vision, four-year strategy, policies, performance indicators, or organizational responsibilities; or

(3) There is a change in a grantee or grantees.

(c) Modifications to the State Plan are subject to the same public comment requirements that apply to the development of the State Plan under § 641.350.

(d) States are not required to seek the advice and recommendations of the individuals and organizations identified in § 641.315 when modifying the State Plan, except that States must seek the advice and recommendations of any national grantees operating in the State. While not required, states are strongly encouraged to seek the advice and recommendation of the relevant entities listed in § 641.315 when or if modifying the State Plan becomes necessary.

(e) The Department will issue additional instructions for the procedures that must be followed when requesting modifications to the State Plan.

§ 641.350 How should public comments be solicited and collected?

The Governor, or the highest government official, should follow established State procedures to solicit and collect public comments. The State Plan must include a description of the State's procedures and schedule for ensuring an open and inclusive planning process that provides meaningful opportunity for public comment.

§ 641.355 Who may comment on the State Plan?

Any individual or organization may comment on the Plan.

§ 641.360 How does the State Plan relate to the equitable distribution report?

The two documents address some of the same areas, but are prepared at different points in time. The equitable distribution report is prepared by State grantees at the beginning of each fiscal year and provides a ''snapshot'' of the actual distribution of all of the authorized positions within the State, grantee-by-grantee, and the optimum number of participant positions in each designated area based on the latest available Census or other reliable data. The State Plan is prepared by the Governor, or the highest government official, and covers many areas in addition to equitable distribution, as discussed in § 641.325, and sets forth a proposed plan for distribution of authorized positions in the State. Any distribution or redistribution of positions made as a result of a State Plan proposal will be reflected in the next equitable distribution report, which then forms the basis for the proposed distribution in the next State Plan update. This process is iterative in that it moves the authorized positions from overserved areas to underserved areas over a period of time.

§ 641.365 How must the equitable distribution provisions be reconciled with the provision that disruptions to current participants should be avoided?

(a) Governors, or highest government officials, must describe in the State Plan the steps that are being taken to comply with the statutory requirement to avoid disruptions in the provision of services for participants. (OAA sec. 503(a)(7).)

(b) When there is new Census or other reliable data indicating that there has been a shift in the location of the eligible population or when there is overenrollment for any other reason, the Department recommends a gradual shift in positions as they become vacant to areas where there has been an increase in the eligible population.

(c) The Department does not define disruptions to mean that participants are entitled to remain in a subsidized community service assignment indefinitely. As discussed in § 641.570, there is a time limit on SCSEP participation, thus permitting positions to be transferred over time.

(d) Grantees and sub-recipients must not transfer positions from one geographic area to another without first notifying the State agency responsible for preparing the State Plan and equitable distribution report.

(e) Grantees must submit, in writing, any proposed changes in distribution that occur after submission of the equitable distribution report to the Department for approval.

(f) All grantees are required to coordinate any proposed changes in position distribution with the other grantees in the State, including the State project director, before submitting the proposed changes to the Department for approval. The request for the Department's approval must include the comments of the State project director, which the Department will consider in making its decision.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56882, Dec. 1, 2017]

§ 641.370 May a State incorporate its 4-year plan for SCSEP into a Combined State Plan under WIOA?

Yes. A State may include its 4-year plan for SCSEP in its WIOA Combined State Plan according to the requirements in 20 CFR 676.140 through 676.145. For a State that obtains approval of that Combined State Plan under 20 CFR 676.143, the requirements of sec. 103 of WIOA and 20 CFR part 676 will apply in lieu of sec. 503(a) of the OAA and this subpart, and any reference in this part to a ''State Plan'' will be considered to be a reference to that Combined State Plan.

[82 FR 56883, Dec. 1, 2017]

Subpart D—Grant Application and Responsibility Review Requirements for State and National SCSEP Grants

§ 641.400 What entities are eligible to apply to the Department for funds to administer SCSEP projects?

(a) *National grants.* Entities eligible to apply for national grants include nonprofit organizations, Federal public agencies, and tribal organizations. These entities must provide information to establish that they are capable of administering a multi-State program, as required by the Secretary. State and local agencies may not apply for these funds.

(b) *State grants.* (1) Section 506(e) of the OAA requires the Department to award each State a grant to provide SCSEP services. Governors, or highest government officials, designate an individual State agency as the organization to administer SCSEP funds.

(2) If the State fails to meet its expected levels of performance for the core indicators for three consecutive years, it is not eligible to designate an agency to administer SCSEP funds in the following year. Instead, the State must conduct a competition to select an organization as the grantee of the funds allotted to the State under § 506(e). Public and nonprofit private agencies and organizations, State agencies other than the previously designated, failed agency, and tribal organizations, are eligible to be selected as a grantee for the funds. Other States may not be selected as a grantee for this funding.

§ 641.410 How does an eligible entity apply?

(a) *General.* An eligible entity must follow the application guidelines issued by the Department. The Department will issue application guidelines announcing the availability of national funds and State funds, whether they are awarded on a competitive or noncompetitive basis. The guidelines will contain application due dates, application instructions, evaluation criteria, and other necessary information.

(b) *National grant applicants.* All applicants for SCSEP national grant funds, except for applications for grants proposing to serve older Indians and Pacific Island and Asian Americans with funds reserved under OAA § 506(a)(3), must submit their applications to the Governor, or the highest government official, of each State in which projects are proposed so that he or she has a reasonable opportunity to make the recommendations described in § 641.480, before submitting the application to the Department. (OAA § 503(a)(5)).

(c) *State applicants.* A State that submits a Combined State Plan under sec. 103 of WIOA may include the State's SCSEP grant application in its Combined State Plan. Any State that submits a SCSEP grant application as part of its WIOA Combined State Plan must address all of the application requirements as published in the Department's instructions. Sections 641.300 through 641.370 address State Plans and modifications.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56883, Dec. 1, 2017]

§ 641.420 What are the eligibility criteria that each applicant must meet?

To be eligible to receive SCSEP funds, each applicant must demonstrate:

(a) An ability to administer a program that serves the greatest number of eligible participants, giving particular consideration to individuals with greatest economic need, individuals with greatest social need, and individuals described in § 641.570(b) or § 641.520(a)(2) through (a)(8).

(b) An ability to administer a program that provides employment in community service assignments for eligible individuals in communities in which they reside, or in nearby communities, that will contribute to the general welfare of the community;

(c) An ability to administer a program that moves eligible participants into unsubsidized employment;

(d) Where the applicant has previously received a SCSEP grant, the applicant's prior performance in meeting SCSEP core measures of performance and addressing SCSEP additional measures of performance; and where the applicant has not received a SCSEP

grant, the applicant's prior performance under other Federal or State programs; relevant past performance will also be used for scoring criterion and will be set forth more fully in the Solicitation for Grant Applications (see § 641.460);

(e) An ability to move participants with multiple barriers to employment, including individuals described in § 641.570(b) or § 641.520(a)(2) through (9), into unsubsidized employment;

(f) An ability to coordinate activities with other organizations at the State and local levels, including the One-Stop delivery system;

(g) An ability to properly manage the program, as reflected in its plan for fiscal management of the SCSEP;

(h) An ability to administer a project that provides community service;

(i) An ability to minimize program disruption for current participants and in community services provided if there is a change in project sponsor and/or location, and its plan for minimizing disruptions;

(j) Any additional criteria that the Department deems appropriate to minimize disruptions for current participants. (OAA § 514(c)).

[75 FR 53812, Sept. 1, 2010, as amended at 87 FR 8189, Feb. 14, 2022]

§ 641.430 What are the responsibility conditions that an applicant must meet?

Subject to § 641.440, each applicant must meet the listed responsibility ''tests'' by not having committed the following acts:

(a) The Department has been unable to recover a debt from the applicant, whether incurred by the applicant or by one of its sub-recipients, or the applicant has failed to comply with a debt repayment plan to which it agreed. In this context, a debt is established by final agency action, followed by three demand letters to the applicant, without payment in full by the applicant.

(b) Established fraud or criminal activity of a significant nature within the applicant's organization.

(c) Serious administrative deficiencies identified by the Department, such as failure to maintain a financial management system as required by Federal regulations.

(d) Willful obstruction of the auditing or monitoring process.

(e) Failure to provide services to applicants as agreed to in a current or recent grant or to meet applicable core performance measures or address other applicable indicators of performance.

(f) Failure to correct deficiencies brought to the grantee's attention in writing as a result of monitoring activities, reviews, assessments, or other activities.

(g) Failure to return a grant closeout package or outstanding advances within 90 days after the grant expiration date or receipt of closeout package, whichever is later, unless an extension has been requested and granted.

(h) Failure to submit required reports.

(i) Failure to properly report and dispose of Government property as instructed by the Department.

(j) Failure to have maintained effective cash management or cost controls resulting in excess cash on hand.

(k) Failure to ensure that a sub-recipient complies with applicable audit requirements, including OMB Circular A–133 and the audit requirements specified at § 641.821.

(l) Failure to audit a sub-recipient within the period required under § 641.821.

(m) Final disallowed costs in excess of five percent of the grant or contract award if, in the judgment of the Grant Officer, the disallowances are egregious findings.

(n) Failure to establish a mechanism to resolve a sub-recipient's audit in a timely fashion. (OAA § 514(d)(4)).

§ 641.440 Are there responsibility conditions that alone will disqualify an applicant?

(a) Yes, an applicant may be disqualified if

(1) Either of the first two responsibility tests, a or b, listed in § 641.430 is not met, or

(2) The applicant substantially, or persistently for two or more consecutive years, fails one of the other responsibility tests listed in § 641.430.

(b) The second responsibility test addresses ''fraud or criminal activity of a

significant nature.'' The Department will determine the existence of significant fraud or criminal activity which typically will include willful or grossly negligent disregard for the use or handling of, or other fiduciary duties concerning, Federal funding, where the grantee has no effective systems, checks, or safeguards to detect or prevent fraud or criminal activity. Additionally, significant fraud or criminal activity will typically include coordinated patterns or behaviors that pervade a grantee's administration or are committed by the higher levels of a grantee's management or authority. The Department will determine whether ''fraud or criminal activity of a significant nature'' has occurred on a case-by-case basis, regardless of what party identifies the alleged fraud or criminal activity.

§ 641.450 How will the Department examine the responsibility of eligible entities?

The Department will review available records to assess each applicant's overall fiscal and administrative ability to manage Federal funds. The Department's responsibility review may consider all relevant information, including the organization's history of managing other grants awarded by the Department or by other Federal agencies. (OAA § 514(d)(1) and (d)(2)).

§ 641.460 What factors will the Department consider in selecting national grantees?

The Department will select national grantees from among applicants that are able to meet the eligibility and responsibility review criteria at § 514 of the OAA. (Section 641.420 contains the eligibility criteria and §§ 641.430 and 641.440 contain the responsibility criteria.) The Department also will take the rating criteria described in the Solicitation for Grant Applications or other instrument into consideration. These rating criteria will include relevant past performance.

§ 641.465 Under what circumstances may the Department reject an application?

(a) The Department may question any proposed project component of an application if it believes that the component will not serve the purposes of the SCSEP. The Department may reject the application if the applicant does not submit or negotiate an acceptable alternative.

(b) The Department may reject any application that the Grant Officer determines unacceptable based on the content of the application, rating score, past performance, fiscal management, or any other factor the Grant Officer believes serves the best interest of the program, including the application's comparative rating in a competition.

§ 641.470 What happens if an applicant's application is rejected?

(a) Any entity whose application is rejected in whole or in part will be informed that it has not been selected. The non-selected entity may request an explanation of the Department's basis for its rejection. If requested, the Department will provide the entity with feedback on its proposal. The non-selected entity may follow the procedures in § 641.900.

(b) Incumbent grantees will not have an opportunity to obtain technical assistance provided by the Department under OAA § 513(d)(2)(B)(i) to cure, in an open competition, any deficiency in a proposal because that will create inequity in favor of incumbents. Nor, during an open competition, will the Department provide assistance to any applicant to improve its application.

(c) If the Administrative Law Judge (ALJ) rules, under § 641.900, that the organization should have been selected, in whole or in part, the matter must be remanded to the Grant Officer. The Grant Officer must, within 10 working days, determine whether the organization continues to meet the requirements of this part, and whether the positions which are the subject of the ALJ's decision will be awarded, in whole or in part, to the organization and the timing of the award. In making this determination, the Grant Officer must take into account disruption to participants, disruption to grantees, and the operational needs of the SCSEP.

(d) In the event that the Grant Officer determines that it is not feasible to award any positions to the appealing

applicant, the applicant will be awarded its bid preparation costs, or a pro rata share of those costs if the Grant Officer's finding applies to only a portion of the funds that would be awarded. If positions are awarded to the appealing applicant, that applicant is not entitled to the full grant amount but will only receive the funds remaining in the grant that have not been expended by the current grantee through its operation of the grant and its subsequent closeout. The available remedy in a SCSEP non-selection appeal is neither retroactive nor immediately effective selection; rather it is the potential to be selected as a SCSEP grantee as quickly as administratively feasible in the future, for the remainder of the grant cycle.

(e) In the event that any party notifies the Grant Officer that it is not satisfied with the Grant Officer's decision, the Grant Officer must return the decision to the ALJ for review.

(f) Any organization selected and/or funded as a SCSEP grantee is subject to having its positions reduced or to being removed as a SCSEP grantee if an ALJ decision so orders. The Grant Officer provides instructions on transition and closeout to both the newly designated grantee and to the grantee whose positions are affected or which is being removed. All parties must agree to the provisions of this paragraph as a condition of being a SCSEP grantee.

§ 641.480 May the Governor, or the highest government official, make recommendations to the Department on national grant applications?

(a) Yes, in accordance with § 641.410(b), each Governor, or highest government official, will have a reasonable opportunity to make comments on any application to operate a SCSEP project located in the Governor's, or the highest government official's, State before the Department makes a final decision on a grant award. The Governor's, or the highest government official's, comments should be directed to the Department and may include the anticipated effect of the proposal on the overall distribution of program positions within the State; recommendations for redistribution of positions to underserved areas as vacancies occur in previously encumbered positions in other areas; and recommendations for distributing any new positions that may become available as a result of an increase in funding for the State. The Governor's, or the highest government official's, recommendations should be consistent with the State Plan. (OAA § 503(a)(5)).

(b) The Governor, or the highest government official, has the option of making the authorized recommendations on all applications or only on those applications proposed for award following the rating process. It is incumbent on each Governor, or the highest government official, to inform the Department of his or her intent to review the applications before or after the rating process.

§ 641.490 When will the Department compete SCSEP grant awards?

(a)(1) The Department will hold a full and open competition for national grants every four years. (OAA § 514(a)(1)).

(2) If a national grantee meets the expected level of performance for each of the core indicators for each of the four years, the Department may provide an additional one-year grant to the national grantee. (OAA § 514(a)(2)).

§ 641.495 When must a State compete its SCSEP award?

If a State grantee fails to meet its expected levels of performance for three consecutive Program Years, the State must hold a full and open competition, under such conditions as the Secretary may provide, for the State SCSEP funds for the full Program Year following the determination of consecutive failure. (OAA § 513(d)(3)(B)(iii)). The incumbent (failed) grantee is not eligible to compete. Other states are also not eligible to compete for these funds. § 641.400(b)(2).

Subpart E—Services to Participants

§ 641.500 Who is eligible to participate in the SCSEP?

Anyone who is at least 55 years old, unemployed (as defined in § 641.140), and who is a member of a family with an

income that is not more than 125 percent of the family income levels prepared by the Department of Health and Human Services and approved by OMB (Federal poverty guidelines) is eligible to participate in the SCSEP. (OAA sec. 518(a)(3), (9).) A person with a disability may be treated as a ''family of one'' for income eligibility determination purposes at the option of the applicant.

[82 FR 56883, Dec. 17, 2017]

§ 641.505 When is eligibility determined?

Initial eligibility is determined at the time individuals apply to participate in the SCSEP. Once individuals become SCSEP participants, the grantee or sub-recipient is responsible for verifying their continued eligibility at least once every 12 months. Grantees and sub-recipients may also verify an individual's eligibility as circumstances require, including instances when enrollment is delayed.

§ 641.507 How is applicant income computed?

An applicant's income is computed by calculating the includable income received by the applicant during the 12-month period ending on the date an individual submits an application to participate in the SCSEP, or the annualized income for the 6-month period ending on the application date. The Department requires grantees to use whichever method is more favorable to the individual. (OAA § 518(a)(4)).

§ 641.510 What types of income are included and excluded for participant eligibility determinations?

(a) With certain exceptions, the Department will use the definition of income from the U.S. Census Bureau's Current Population Survey (CPS) as the standard for determining SCSEP applicant income eligibility.

(b) Any income that is unemployment compensation, a benefit received under title XVI of the Social Security Act (42 U.S.C. 1381 *et seq.*), a payment made to or on behalf of veterans or former members of the Armed Forces under the laws administered by the Secretary of Veterans Affairs, or 25 percent of a benefit received under title II of the Social Security Act (42 U.S.C. 401 *et seq.*), must be excluded from SCSEP income eligibility determinations. (OAA § 518(a)(3)(A)).

(c) The Department has issued administrative guidance on income inclusions and exclusions and procedures for determining SCSEP income eligibility. This guidance may be updated periodically.

§ 641.512 May grantees and sub-recipients enroll otherwise eligible job ready individuals and place them directly into unsubsidized employment?

No, grantees and sub-recipients may not enroll as SCSEP participants job-ready individuals who can be directly placed into unsubsidized employment. Such individuals should be referred to an employment provider, such as the One-Stop Center for job placement assistance under WIOA or another employment program.

[82 FR 56883, Dec. 1, 2017]

§ 641.515 How must grantees and sub-recipients recruit and select eligible individuals for participation in the SCSEP?

(a) Grantees and sub-recipients must develop methods of recruitment and selection that assure that the maximum number of eligible individuals have an opportunity to participate in the program. To the extent feasible, grantees and sub-recipients should seek to enroll minority and Indian eligible individuals, eligible individuals with limited English proficiency, and eligible individuals with greatest economic need, at least in proportion to their numbers in the area, taking into consideration their rates of poverty and unemployment. (OAA § 502(b)(1)(M)).

(b) Grantees and sub-recipients must use the One-Stop delivery system as one method in the recruitment and selection of eligible individuals to ensure that the maximum number of eligible individuals have an opportunity to participate in the project. (OAA § 502(b)(1)(H)).

(c) States may enter into agreements among themselves to permit cross-border enrollment of eligible participants. Such agreements should cover both State and national grantee positions

and must be submitted to the Department for approval in the grant application or a modification of the grant.

§ 641.520 Are there any priorities that grantees and sub-recipients must use in selecting eligible individuals for participation in the Senior Community Service Employment Program?

(a) Yes, in selecting eligible individuals for participation in the SCSEP, priority must be given to individuals who have one or more of the following characteristics:

(1) Are 65 years of age or older;

(2) Have a disability;

(3) Have limited English proficiency or low literacy skills;

(4) Reside in a rural area;

(5) Are veterans (or, in some cases, spouses of veterans) for purposes of §2(a) of the Jobs for Veterans Act, 38 U.S.C. 4215(a) as set forth in paragraph (b) of this section;

(6) Have low employment prospects;

(7) Have failed to find employment after using services provided through the one-stop delivery system;

(8) Are homeless or are at risk for homelessness; or

(9) Are formerly incarcerated individuals as defined in §641.140. (OAA sec. 518(b).)

(b) Section 2(a) of the Jobs for Veterans Act creates a priority for service for veterans (and, in some cases, spouses of veterans) who otherwise meet the program eligibility criteria for the SCSEP. 38 U.S.C. 4215(a). Priority is extended to veterans. Priority is also extended to the spouse of a veteran who died of a service-connected disability; the spouse of a member of the Armed Forces on active duty who has been listed for a total of more than 90 days as missing in action, captured in the line of duty by a hostile force, or forcibly detained by a foreign government or power; the spouse of any veteran who has a total disability resulting from a service-connected disability; and the spouse of any veteran who died while a disability so evaluated was in existence.

(c) Grantees and sub-recipients must apply these priorities in the following order:

(1) Persons who qualify as a veteran or qualified spouse under §2(a) of the Jobs for Veterans Act, 38 U.S.C. 4215(a), and who possess at least one of the other priority characteristics;

(2) Persons who qualify as a veteran or qualified spouse under §2(a) of the Jobs for Veterans Act, 38 U.S.C. 4215(a), who do not possess any other of the priority characteristics;

(3) Persons who do not qualify as a veteran or qualified spouse under §2(a) of the Jobs for Veterans Act (non-veterans), and who possess at least one of the other priority characteristics.

[75 FR 53812, Sept. 1, 2010, as amended at 87 FR 8190, Feb. 14, 2022]

§ 641.535 What services must grantees and sub-recipients provide to participants?

(a) When individuals are selected for participation in the SCSEP, the grantee or sub-recipient is responsible for:

(1) Providing orientation to the SCSEP, including information on project goals and objectives, community service assignments, training opportunities, available supportive services, the availability of a free physical examination, participant rights and responsibilities, and permitted and prohibited political activities;

(2)(i) Assessing participants' work history, skills and interests, talents, physical capabilities, aptitudes, needs for supportive services, occupational preferences, training needs, potential for performing community service assignments, and potential for transition to unsubsidized employment;

(ii) Performing an initial assessment upon program entry, unless an assessment has already been performed under title I of WIOA as provided in §641.230. Subsequent assessments may be made as necessary, but must be made no less frequently than two times during a 12-month period (including the initial assessment);

(3)(i) Using the information gathered during the initial assessment to develop an IEP that includes an appropriate employment goal for each participant, except that if an assessment has already been performed and an IEP developed under title I of WIOA, the WIOA assessment and IEP will satisfy the requirement for a SCSEP assessment and IEP as provided in §641.230;

(ii) Updating the IEP as necessary to reflect information gathered during the subsequent participant assessments (OAA § 502(b)(1)(N));

(iii) The initial IEP should include an appropriate employment goal for each participant. Thereafter, if the grantee determines that the participant is not likely to obtain unsubsidized employment, the IEP must reflect other approaches to help the participant achieve self-sufficiency, including the transition to other services or programs.

(4) Placing participants in appropriate community service assignments in the community in which they reside, or in a nearby community (OAA § 502(b)(1)(B));

(5) Providing or arranging for training identified in participants' IEPs and consistent with the SCSEP's goal of unsubsidized employment (OAA § 502(a)(1), 502(b)(1)(B), 502(b)(1)(I), 502(b)(1)(N)(ii));

(6) Assisting participants in obtaining needed supportive services identified in their IEPs (OAA § 502(b)(1)(N));

(7) Providing appropriate services for participants, or referring participants to appropriate services, through the One-Stop delivery system established under WIOA (OAA sec. 502(b)(1)(O));

(8) Providing counseling on participants' progress in meeting the goals and objectives identified in their IEPs, and in meeting their supportive service needs (OAA § 502(b)(1)(N)(iii));

(9) Providing participants with wages and benefits for time spent in the community service assignment, orientation, and training (OAA § 502(b)(1)(I), 502(b)(1)(J), 502(c)(6)(A)(i)) (see also §§ 641.565 and 641.540(f), addressing wages and benefits);

(10) Ensuring that participants have safe and healthy working conditions at their community service employment worksites (OAA § 502(b)(1)(J));

(11) Assisting participants in obtaining unsubsidized employment, including providing or arranging for employment counseling in support of their IEPs;

(b) The Department may issue administrative guidance that clarifies the requirements of paragraph (a).

(c) Grantees may not use SCSEP funds for job ready individuals who only need job search assistance or job referral services. Grantees may provide job search assistance and job club activities to participants who are enrolled in the SCSEP and are assigned to community service assignments. (See also § 641.512).

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56883, Dec. 1, 2017]

§ 641.540 What types of training may grantees and sub-recipients provide to SCSEP participants in addition to the training received at a community service assignment?

(a) In addition to the training provided in a community service assignment, grantees and sub-recipients may arrange skill training provided that it:

(1) Is realistic and consistent with the participants' IEP;

(2) Makes the most effective use of the participant's skills and talents; and

(3) Prepares the participant for unsubsidized employment.

(b) Training may be provided before or during a community service assignment.

(c) Training may be in the form of lectures, seminars, classroom instruction, individual instruction, online instruction, and on-the-job experiences. Training may be provided by the grantee or through other arrangements, including but not limited to, arrangements with other workforce development programs such as WIOA. (OAA sec. 502(c)(6)(A)(ii).)

(d) Grantees and sub-recipients are encouraged to obtain training through locally available resources, including host agencies, at no cost or reduced cost to the SCSEP.

(e) Grantees and sub-recipients may pay for participant training, including the payment of reasonable costs of instructors, classroom rental, training supplies, materials, equipment, and tuition. (OAA § 502(c)(6)(A)(ii)).

(f) Participants must be paid wages while in training, as described in § 641.565(a). (OAA § 502(b)(1)(I)).

(g) As provided in § 641.545, grantees and sub-recipients may pay for costs associated with supportive services, such as transportation, necessary to participate in training. (OAA § 502(b)(1)(L)).

(h) Nothing in this section prevents or limits participants from engaging in self-development training available through other sources, at their own expense, during hours when not performing their community service assignments.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56883, Dec. 1, 2017]

§ 641.545 What supportive services may grantees and sub-recipients provide to participants?

(a) Grantees and sub-recipients are required to assess all participants' need for supportive services and to make every effort to assist participants in obtaining needed supportive services. Grantees and sub-recipients may provide directly or arrange for supportive services that are necessary to enable an individual to successfully participate in a SCSEP project, including but not limited to payment of reasonable costs of transportation; health and medical services; special job-related or personal counseling; incidentals such as work shoes, badges, uniforms, eyeglasses, and tools; dependent care; housing, including temporary shelter; needs-related payments; and follow-up services. (OAA secs. 502(c)(6)(A)(iv), 518(a)(8).)

(b) To the extent practicable, the grantee or sub-recipient should arrange for the payment of these expenses from other resources.

(c) Grantees and sub-recipients are encouraged to contact placed participants throughout the first 12 months following placement to determine if they have the necessary supportive services to remain in the job and to provide or arrange to provide such services if feasible.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56883, Dec. 1, 2017]

§ 641.550 What responsibility do grantees and sub-recipients have to place participants in unsubsidized employment?

For those participants whose IEPs include a goal of unsubsidized employment, grantees and sub-recipients are responsible for working with participants to ensure that the participants are receiving services and taking actions designed to help them achieve this goal. Grantees and sub-recipients must contact private and public employers directly or through the One-Stop delivery system to develop or identify suitable unsubsidized employment opportunities. They must also encourage host agencies to assist participants in their transition to unsubsidized employment, including unsubsidized employment with the host agency.

§ 641.565 What policies govern the provision of wages and benefits to participants?

(a) *Wages.* (1)(i) Grantees and sub-recipients must pay participants the highest applicable required wage for time spent in orientation, training, and community service assignments.

(ii) SCSEP participants may be paid the highest applicable required wage while receiving WIOA career services.

(2) The highest applicable required wage is either the minimum wage applicable under the Fair Labor Standards Act of 1938; the State or local minimum wage for the most nearly comparable covered employment; or the prevailing rate of pay for persons employed in similar public occupations by the same employer.

(3) Grantees and sub-recipients must make any adjustments to minimum wage rates payable to participants as may be required by Federal, State, or local statute during the grant term.

(b) *Benefits*—(1) *Required benefits.* Except as provided in paragraph (b)(2) of this section, grantees and sub-recipients must ensure that participants receive such benefits as are required by law.

(i) Grantees and sub-recipients must provide benefits uniformly to all participants within a project or subproject, unless the Department agrees to waive this provision due to a determination that such a waiver is in the best interests of applicants, participants, and project administration.

(ii) Grantees and sub-recipients must offer participants the opportunity to receive physical examinations annually.

(A) Physical examinations are a benefit, and not an eligibility criterion. The examining physician must provide,

to the participant only, a written report of the results of the examination.

(B) Participants may choose not to accept the physical examination. In that case, the grantee or sub-recipient must document this refusal, through a signed statement, within 60 workdays after commencement of the community service assignment. Each year thereafter, grantees and sub-recipients must offer the physical examination and document the offer and any participant's refusal.

(C) Grantees and sub-recipients may use SCSEP funds to pay the costs of physical examinations.

(iii) When participants are not covered by the State workers' compensation law, the grantee or sub-recipient must provide participants with workers' compensation benefits equal to those provided by law for covered employment. OAA § 504(b).

(iv) If required by State law, grantees/sub-recipients must provide unemployment compensation coverage for participants.

(v) Grantees and sub-recipients must provide compensation for scheduled work hours during which a host agency's business is closed for a Federal holiday, which may be paid or in the form of rescheduled work time.

(vi) Grantees and sub-recipients must provide necessary sick leave that is not part of an accumulated sick leave program, which may be paid or in the form of rescheduled work time.

(2) *Prohibited wage and benefits costs.* (i) Participants may not carry over allowable benefits from one Program Year to the next;

(ii) Grantees and sub-recipients may not provide payment or otherwise compensate participants for unused benefits such as sick leave or holidays;

(iii) Grantees and sub-recipients may not use SCSEP funds to cover costs associated with the following participant benefits:

(A) Retirement. Grantees and sub-recipients may not use SCSEP funds to provide contributions into a retirement system or plan, or to pay the cost of pension benefits for program participants.

(B) Annual leave.

(C) Accumulated sick leave.

(D) Bonuses. (OAA § 502(c)(6)(A)(i)).

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56883, Dec. 1, 2017]

§ 641.570 Is there a time limit for participation in the program?

(a) *Individual time limit.* (1) Eligible individuals may participate in the program for a maximum duration of 48 months in the aggregate (whether or not consecutive), from the later of July 1, 2007, or the date of the individual's enrollment in the program.

(2) At the time of enrollment, the grantee or sub-recipient must inform the participant of this time limit and the possible extension available under paragraph (b) of this section, and the grantee or sub-recipient must provide for a system to transition participants to unsubsidized employment or other assistance before the maximum enrollment duration has expired. Provisions for transition must be reflected in the participant's IEP.

(3) If requested by a grantee or sub-recipient, the Department will authorize an extension for individuals who meet the criteria in paragraph (b) of this section. Notwithstanding any individual extensions granted, grantees and sub-recipients must ensure that projects do not exceed the overall average participation cap for all participants, as described in paragraph (c) of this section.

(b) *Increased periods of individual participation.* If requested by a grantee, the Department will authorize increased periods of participation for individuals who:

(1) Have a severe disability;

(2) Are frail or are age 75 or older;

(3) Meet the eligibility requirements related to age for, but do not receive, benefits under title II of the Social Security Act (42 U.S.C. 401 *et seq.*);

(4) Live in an area with persistent unemployment and are individuals with severely limited employment prospects;

(5) Have limited English proficiency or low literacy skills; or

(6) Are formerly incarcerated individuals as defined in § 641.140.

(c) *Average grantee participation cap.* (1) Notwithstanding any individual extension authorized under paragraph (b)

of this section, each grantee must manage its SCSEP project in such a way that the grantee does not exceed an average participation cap for all participants of 27 months (in the aggregate).

(2) A grantee may request, and the Department may authorize, an extended average participation period of up to 36 months (in the aggregate) for a particular project area in a given Program Year if the Department determines that extenuating circumstances exist to justify an extension, due to one more of the following factors:

(i) High rates of unemployment or of poverty or of participation in the program of block grants to States for temporary assistance for needy families established under part A of title IV of the Social Security Act, in the areas served by a grantee, relative to other areas of the State involved or the Nation;

(ii) Significant downturns in the economy of an area served by the grantee or in the national economy;

(iii) Significant numbers or proportions of participants with one or more barriers to employment, including ''most-in-need'' individuals described in §641.710(a)(6), served by a grantee relative to such numbers or proportions for grantees serving other areas of the State or Nation;

(iv) Changes in Federal, State, or local minimum wage requirements; or

(v) Limited economies of scale for the provision of community service employment and other authorized activities in the areas served by the grantee.

(3) For purposes of the average participation cap, each grantee will be considered to be one project.

(d) *Authorized break in participation.* On occasion a participant takes an authorized break in participation from the program, such as a formal leave of absence necessitated by personal circumstances or a break caused because a suitable community service assignment is not available. Such an authorized break, if taken under a formal grantee policy allowing such breaks and formally entered into the SCSEP Performance and Results Quarterly Performance Reporting (SPARQ) system, will not count toward the individual time limit described in paragraph (a) or the average participation cap described in paragraph (c) of this section.

(e) *Administrative guidance.* The Department will issue administrative guidance detailing the process by which a grantee may request increased periods of individual participation, and the process by which a grantee may request an extension of the average participation cap. The process will require that the determination of individual participant extension requests is made in a fair and equitable manner.

(f) *Grantee authority.* Grantees may limit the time of participation for individuals to less than the 48 months described in paragraph (a) of this section, if the grantee uniformly applies the lower participation limit, and if the grantee submits a description of the lower participation limit policy in its grant application or modification of the grant and the Department approves the policy. (OAA §§502(b)(1)(C), 518(a)(3)(B)).

[75 FR 53812, Sept. 1, 2010, as amended at 87 FR 8190, Feb. 14, 2022]

§641.575 May a grantee or sub-recipient establish a limit on the amount of time its participants may spend at a host agency?

Yes, grantees and sub-recipients may establish limits on the amount of time that participants spend at a particular host agency, and are encouraged to rotate participants among different host agencies, or to different assignments within the same host agency, as such rotations may increase participants' skills development and employment opportunities. Such limits must be established in the grant agreement or modification of the grant, and approved by the Department. The Department will not approve any limit that does not require an individualized determination that rotation is in the best interest of the participant and will further the acquisition of skills listed in the IEP. Host agency rotations have no effect on either the individual participation limit or the average participation cap.

§ 641.577 Is there a limit on community service assignment hours?

While there is no specific limit on the number of hours that may be worked in a community service assignment, a community service assignment must be a part-time position. However, the Department strongly encourages grantees to use 1,300 hours as a benchmark and good practice for monitoring community service hours.

§ 641.580 Under what circumstances may a grantee or sub-recipient terminate a participant?

(a) If, at any time, a grantee or sub-recipient determines that a participant was incorrectly declared eligible as a result of false information knowingly given by that individual, the grantee or sub-recipient must give the participant immediate written notice explaining the reason(s) for termination and may terminate the participant 30 days after it has provided the participant with written notice.

(b) If, during eligibility verification under § 641.505, a grantee or sub-recipient finds a participant to be no longer eligible for enrollment, the grantee or sub-recipient must give the participant written notice explaining the reason(s) for termination and may terminate the participant 30 days after it has provided the participant with written notice.

(c) If, at any time, the grantee or sub-recipient determines that it incorrectly determined a participant to be eligible for the program through no fault of the participant, the grantee or sub-recipient must give the participant immediate written notice explaining the reason(s) for termination and may terminate the participant 30 days after it has provided the participant with written notice.

(d) A grantee or sub-recipient may terminate a participant for cause. Grantees must include their policies concerning for-cause terminations in the grant application and obtain the Department's approval. The grantee or sub-recipient must give the participant written notice explaining the reason(s) for termination and may terminate the participant 30 days after it has provided the participant with written notice.

(e) A grantee or sub-recipient may terminate a participant if the participant refuses to accept a reasonable number of job offers or referrals to unsubsidized employment consistent with the IEP and there are no extenuating circumstances that would hinder the participant from moving to unsubsidized employment. The grantee or sub-recipient must give the participant written notice explaining the reason(s) for termination and may terminate the participant 30 days after it has provided the participant with written notice.

(f) When a grantee or sub-recipient makes an unfavorable determination of enrollment eligibility under paragraph (b) or (c) of this section, it should refer the individual to other potential sources of assistance, such as the One-Stop delivery system. When a grantee or sub-recipient terminates a participant under paragraph (d) or (e) of this section, it may refer the individual to other potential sources of assistance, such as the One-Stop delivery system.

(g) Grantees and sub-recipients must provide each participant at the time of enrollment with a written copy of its policies for terminating a participant for cause or otherwise, and must verbally review those policies with each participant.

(h) Any termination, as described in paragraphs (a) through (e) of this section, must be consistent with administrative guidelines issued by the Department and the termination notice must inform the participant of the grantee's grievance procedure, and the termination must be subject to the applicable grievance procedures described in § 641.910.

(i) Participants may not be terminated from the program solely on the basis of their age. Grantees and sub-recipients may not impose an upper age limit for participation in the SCSEP.

§ 641.585 What is the employment status of SCSEP participants?

(a) Participants are not considered Federal employees solely as a result of their participation in the SCSEP. (OAA § 504(a)).

(b) Grantees must determine whether or not a participant qualifies as an employee of the grantee, sub-recipient,

local project, or host agency, under applicable law. Responsibility for this determination rests with the grantee even when a Federal agency is a grantee or host agency.

Subpart F—Pilot, Demonstration, and Evaluation Projects

§ 641.600 What is the purpose of the pilot, demonstration, and evaluation projects authorized under § 502(e) of the OAA?

The purpose of the pilot, demonstration, and evaluation projects authorized under § 502(e) of the OAA is to develop and implement techniques and approaches, and to demonstrate the effectiveness of these techniques and approaches, in addressing the employment and training needs of individuals eligible for SCSEP.

§ 641.610 How are pilot, demonstration, and evaluation projects administered?

The Department may enter into agreements with States, public agencies, nonprofit private organizations, or private business concerns, as may be necessary, to conduct pilot, demonstration, and evaluation projects.

§ 641.620 How may an organization apply for pilot, demonstration, and evaluation project funding?

Organizations applying for pilot, demonstration, and evaluation project funding must follow the instructions issued by the Department. Instructions for these unique funding opportunities are published in TEGLs available at *http://www.doleta.gov/Seniors*.

§ 641.630 What pilot, demonstration, and evaluation project activities are allowable under the Older Americans Act?

Allowable pilot, demonstration and evaluation projects include:

(a) Activities linking businesses and eligible individuals, including activities providing assistance to participants transitioning from subsidized activities to private sector employment;

(b) Demonstration projects and pilot projects designed to:

(1) Attract more eligible individuals into the labor force;

(2) Improve the provision of services to eligible individuals under One-Stop delivery systems established under title I of WIOA;

(3) Enhance the technological skills of eligible individuals; and

(4) Provide incentives to SCSEP grantees for exemplary performance and incentives to businesses to promote their participation in the SCSEP;

(c) Demonstration projects and pilot projects, as described in paragraph (b) of this section, for workers who are older individuals (but targeted to eligible individuals) only if such demonstration projects and pilot projects are designed to assist in developing and implementing techniques and approaches in addressing the employment and training needs of eligible individuals;

(d) Provision of training and technical assistance to support a SCSEP project;

(e) Dissemination of best practices relating to employment of eligible individuals; and

(f) Evaluation of SCSEP activities.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56884, Dec. 1, 2017]

§ 641.640 Should pilot, demonstration, and evaluation project entities coordinate with SCSEP grantees and sub-recipients, including area agencies on aging?

(a) To the extent practicable, the Department will provide an opportunity, before the development of a demonstration or pilot project, for the appropriate area agency on aging and SCSEP grantees and sub-grantees to submit comments on the project in order to ensure coordination of SCSEP activities with activities carried out under this subpart.

(b) To the extent practicable, entities carrying out pilot, demonstration, and evaluation projects must consult with appropriate area agencies on aging, SCSEP grantees and sub-grantees, and other appropriate agencies and entities to promote coordination of SCSEP and pilot, demonstration, and evaluation activities. (OAA § 502(e)).

Subpart G—Performance Accountability

SOURCE: 82 FR 56884, Dec. 1, 2017, unless otherwise noted.

§ 641.700 What performance measures apply to Senior Community Service Employment Program grantees?

(a) *Measures of performance.* There are seven core performance measures. Core measures (defined in § 641.710) are subject to goal-setting and corrective action (described in § 641.720); that is, performance level goals for each core measure must be agreed upon between the Department and each grantee as described in § 641.720, and if a grantee fails to meet the performance level goals for the core measures, that grantee is subject to corrective action.

(b) *Core measures.* Section 513(b)(1) of the OAA establishes the following core measures of performance:

(1) Hours (in the aggregate) of community service employment;

(2) The percentage of project participants who are in unsubsidized employment during the second quarter after exit from the project;

(3) The percentage of project participants who are in unsubsidized employment during the fourth quarter after exit from the project;

(4) The median earnings of project participants who are in unsubsidized employment during the second quarter after exit from the project;

(5) Indicators of effectiveness in serving employers, host agencies, and project participants;

(6) The number of eligible individuals served; and

(7) The number of most-in-need individuals served (the number of participating individuals described in OAA sec. 518(a)(3)(B)(ii) or (b)(2)).

(c) *Affected entities.* The core measures of performance are applicable to each grantee without regard to whether such grantee operates the program directly or through sub-contracts, subgrants, or agreements with other entities. Grantees must assure that their sub-grantees and lower-tier sub-grantees are collecting and reporting program data.

(d) *Required evaluation and reporting.* An agreement to be evaluated on the core measures of performance is a requirement for application for, and is a condition of, all SCSEP grants.

§ 641.710 How are the performance measures defined?

The core measures are defined as follows:

(a) ''Hours of community service employment'' is defined as the total number of hours of community service provided by SCSEP participants divided by the number of hours of community service funded by the grantee's grant, after adjusting for differences in minimum wage among the States and areas. Paid training hours are excluded from this measure.

(b) ''The percentage of project participants who are in unsubsidized employment during the second quarter after exit from the project'' is defined by the formula: The number of participants who exited during the reporting period who are employed in unsubsidized employment during the second quarter after the exit quarter divided by the number of participants who exited during the reporting period multiplied by 100.

(c) ''The percentage of project participants who are in unsubsidized employment during the fourth quarter after exit from the project'' is defined by the formula: The number of participants who exited during the reporting period who are employed in unsubsidized employment during the fourth quarter after the exit quarter divided by the number of participants who exited during the reporting period multiplied by 100.

(d) ''The median earnings of project participants who are in unsubsidized employment during the second quarter after exit from the project'' is defined by the formula: For all participants who exited and are in unsubsidized employment during the second quarter after the exit quarter: The wage that is at the midpoint (of all the wages) between the highest and lowest wage earned in the second quarter after the exit quarter.

(e) ''Indicators of effectiveness in serving employers, host agencies, and project participants'' is defined as the

combined results of customer assessments of the services received by each of these three customer groups.

(f) ''The number of eligible individuals served'' is defined as the total number of participants served divided by a grantee's authorized number of positions, after adjusting for differences in minimum wage among the States and areas.

(g) ''Most-in-need'' or the number of participating individuals described in OAA sec. 518(a)(3)(B)(ii) or (b)(2) is defined by counting the total number of the following characteristics for all participants and dividing by the number of participants served. Participants are characterized as most-in-need if they:

(1) Have a severe disability;

(2) Are frail;

(3) Are age 75 or older;

(4) Meet the eligibility requirements related to age for, but do not receive, benefits under title II of the Social Security Act (42 U.S.C. 401 *et seq.*);

(5) Live in an area with persistent unemployment and are individuals with severely limited employment prospects;

(6) Have limited English proficiency;

(7) Have low literacy skills;

(8) Have a disability;

(9) Reside in a rural area;

(10) Are veterans;

(11) Have low employment prospects;

(12) Have failed to find employment after utilizing services provided under title I of the Workforce Innovation and Opportunity Act;

(13) Are homeless or at risk for homelessness; or

(14) Are formerly incarcerated individuals as defined in § 641.140.

[75 FR 53812, Sept. 1, 2010, as amended at 87 FR 8190, Feb. 14, 2022]

§ 641.720 How will the Department and grantees initially determine and then adjust expected levels of the core performance measures?

(a) *First 2 years.* Before the beginning of the first program year of the grant, each grantee must reach agreement with the Department on levels of performance for each measure listed in § 641.700 for each of the first 2 program years covered by the grant agreement. In reaching the agreement, the grantee and the Department must take into account the expected levels of performance proposed by the grantee and the factors described in paragraph (c) of this section.

The levels agreed to will be considered the expected levels of performance for the grantee for such program years. Funds may not be awarded under the grant until such agreement is reached. At the conclusion of negotiations concerning the performance levels with all grantees, the Department will make available for public review the final negotiated expected levels of performance for each grantee, including any comments submitted by the grantee regarding the grantee's satisfaction with the negotiated levels.

(b) *Third and fourth year.* Each grantee must reach agreement with the Department prior to the third program year covered by the grant agreement, on levels of performance for each measure listed in § 641.700, for each of the third and fourth program years so covered. In reaching the agreement, the grantee and the Department must take into account the expected levels of performance proposed by the grantee and the factors described in paragraph (c) of this section. The levels agreed to will be considered to be the expected levels of performance for the grantee for such program years. Funds may not be awarded under the grant until such agreement is reached. At the conclusion of negotiations concerning the performance levels with all grantees, the Department will make available for public review the final negotiated expected levels of performance for each grantee, including any comments submitted by the grantee regarding the grantee's satisfaction with the negotiated levels.

(c) *Factors.* In reaching the agreements described in paragraphs (a) and (b) of this section, each grantee and the Department must:

(1) Take into account how the levels involved compare with the expected levels of performance established for other grantees;

(2) Ensure that the levels involved are adjusted, using an objective statistical model based on the model established by the Secretary of Labor with

the Secretary of Education in accordance with sec. 116(b)(3)(A)(viii) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3141(b)(3)(A)(viii)); and

(3) Take into account the extent to which the levels involved promote continuous improvement in performance accountability on the core measures and ensure optimal return on the investment of Federal funds.

(d) *Adjustments based on economic conditions and individuals served during the program year.* The Department will, in accordance with the objective statistical model developed pursuant to paragraph (c)(2) of this section, adjust the expected levels of performance for a program year for grantees to reflect the actual economic conditions and characteristics of participants in the corresponding projects during such program year.

§ 641.730 How will the Department assist grantees in the transition to the new core performance measures?

As soon as practicable after January 2, 2018, the Department will determine if a SCSEP grantee's performance under the measures in effect prior to January 2, 2018 would have met the expected levels of performance for the Program Year 2018. If the Department determines that the grantee would have failed to meet the Program Year 2018 expected levels of performance, the Department will provide technical assistance to help the grantee to transition to eventually meet the expected levels of performance under the measures in § 641.700.

§ 641.740 How will the Department determine whether a grantee fails, meets, or exceeds the expected levels of performance and what will be the consequences of failing to meet expected levels of performance?

(a) *Aggregate calculation of performance.* Not later than 120 days after the end of each program year, the Department will determine if a grantee has met the expected levels of performance including any adjustments to such levels made in accordance with § 641.720(d) by aggregating the grantee's core measures. The aggregate is calculated by combining the percentage of goal achieved on each of the individual core measures to obtain an average score. A grantee will fail to meet its performance measures when it is does not meet 80 percent of the agreed-upon level of performance for the aggregate of all the core measures. Performance in the range of 80 to 100 percent constitutes meeting the level for the core performance measures. Performance in excess of 100 percent constitutes exceeding the level for the core performance measures.

(b) *Consequences*—(1) *National grantees.* (i) If the Department determines that a national grantee fails to meet the expected levels of performance in a program year, as described in paragraph (a) of this section, the Department, after each year of such failure, will provide technical assistance and will require such grantee to submit a corrective action plan not later than 160 days after the end of the program year.

(ii) The corrective action plan must detail the steps the grantee will take to meet the expected levels of performance in the next program year.

(iii) Any national grantee that has failed to meet the expected levels of performance for 4 consecutive years will not be allowed to compete in the subsequent grant competition, but may compete in the next grant competition after that subsequent competition.

(2) *State grantees.* (i) If the Department determines that a State fails to meet the expected levels of performance, as described in paragraph (a) of this section, the Department, after each year of such failure, will provide technical assistance and will require the State to submit a corrective action plan not later than 160 days after the end of the program year.

(ii) The corrective action plan must detail the steps the State will take to meet the expected levels of performance in the next program year.

(iii) If the Department determines that the State fails to meet the expected levels of performance for 3 consecutive program years the Department will require the State to conduct a competition to award the funds allotted to the State under sec. 506(e) of the OAA for the first full program year following the Department's determination. The new grantee will be responsible for administering the SCSEP in

the State and will be subject to the same requirements and responsibilities as had been the State grantee.

(c) *Evaluation.* The Department will annually evaluate, publish and make available for public review, information on the actual performance of each grantee with respect to the levels achieved for each of the core measures of performance, compared to the expected levels of performance established under § 641.720 (including any adjustments to such levels made in accordance with § 641.720(d)). The results of the Department's annual evaluation will be reported to Congress.

§ 641.750 Will there be performance-related incentives?

The Department is authorized by OAA secs. 502(e)(2)(B)(iv) and 517(c)(1) to use recaptured SCSEP funds to provide incentive awards. The Department will exercise this authority at its discretion.

Subpart H—Administrative Requirements

§ 641.800 What uniform administrative requirements apply to the use of SCSEP funds?

(a) SCSEP recipients and sub-recipients must follow the uniform administrative requirements and allowable cost requirements that apply to their type of organization. (OAA § 503(f)(2)).

(b) Governments, State, local, and Indian tribal organizations that receive SCSEP funds under grants or cooperative agreements must follow the common rule implementing OMB Circular A–102, ''Grants and Cooperative Agreements with State and Local Governments'' (10/07/1994) (further amended 08/29/1997), codified at 29 CFR part 97.

(c) Nonprofit and commercial organizations, institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations that receive SCSEP funds under grants or cooperative agreements must follow the common rule implementing OMB Circular A–110, codified at 29 CFR part 95.

§ 641.803 What is program income?

Program income, as described in 29 CFR 97.25 (State and local governments) and 29 CFR 95.2(bb) (non-profit and commercial organizations), is income earned by the recipient or sub-recipient during the grant period that is directly generated by an allowable activity supported by grant funds or earned as a result of the award of grant funds. Program income includes income earned from license fees and royalties for copyrighted material, patents, patent applications, trademarks, and inventions produced under an award. (*See* 29 CFR 95.24(e) (non-profit and commercial organizations) and 29 CFR 97.25(e) (State and local governments)). Costs of generating SCSEP program income may be deducted from gross income received by SCSEP recipients and sub-recipients to determine SCSEP program income earned or generated provided these costs have not been charged to the SCSEP.

§ 641.806 How must SCSEP program income be used?

(a) SCSEP recipients that earn or generate program income during the grant period must add the program income to the Federal and non-Federal funds committed to the SCSEP and must use it to further the purposes of the program and in accordance with the terms and conditions of the grant award. Program income may only be spent during the grant period in which it was earned (except as provided for in paragraph (b)), as provided in 29 CFR 95.24(a) (non-profit and commercial organizations) or 29 CFR 97.25(g) (2) (State and local governments), as applicable.

(b)(1) Except as provided for in paragraph (b)(2), recipients that continue to receive a SCSEP grant from the Department must spend program income earned from SCSEP-funded activities in the Program Year in which the earned income was received.

(2) Any program income remaining at the end of the Program Year in which it was earned will remain available for expenditure in the subsequent Program Year only. Any program income remaining after the second Program Year must be remitted to the Department.

(c) Recipients that do not continue to receive a SCSEP grant from the Department must remit unexpended program income earned during the grant

period from SCSEP funded activities to the Department at the end of the grant period. These recipients have no obligation to the Department for program income earned after the end of the grant period.

§ 641.809 What non-Federal share (matching) requirements apply to the use of SCSEP funds?

(a) The Department will pay no more than 90 percent of the total cost of activities carried out under a SCSEP grant. (OAA sec. 502(c)(1)).

(b) All SCSEP recipients, including Federal agencies if there is no statutory exemption, must provide or ensure that at least 10 percent of the total cost of activities carried out under a SCSEP grant (non-Federal share of costs) consists of allowable costs paid for with non-Federal funds, except as provided in paragraphs (e) and (f) of this section.

(c) Recipients must determine the non-Federal share of costs in accordance with 29 CFR 97.24 for governmental units, or 29 CFR 95.23 for nonprofit and commercial organizations.

(d) The non-Federal share of costs may be provided in cash, or in-kind, or a combination of the two. (OAA § 502(c)(2)).

(e) A recipient may not require a subrecipient or host agency to provide non-Federal resources for the use of the SCSEP project as a condition of entering into a sub-recipient or host agency relationship. This does not preclude a sub-recipient or host agency from voluntarily contributing non-Federal resources for the use of the SCSEP project.

(f) The Department may pay all of the costs of activities in an emergency or disaster project or a project in an economically distressed area. (OAA § 502(c)(1)(B)).

§ 641.812 What is the period of availability of SCSEP funds?

(a) Except as provided in § 641.815, recipients must expend SCSEP funds during the Program Year for which they are awarded (July 1–June 30). (OAA § 517(b)).

(b) SCSEP recipients must ensure that no sub-agreement provides for the expenditure of any SCSEP funds before the start of the grant year, or after the end of the grant period, except as provided in § 641.815.

§ 641.815 May the period of availability be extended?

SCSEP recipients may request in writing, and the Department may grant, an extension of the period during which SCSEP funds may be obligated or expended. SCSEP recipients requesting an extension must justify that an extension is necessary. (OAA § 517(b)). The Department will notify recipients in writing of the approval or disapproval of any such requests.

§ 641.821 What audit requirements apply to the use of SCSEP funds?

(a) Recipients and sub-recipients receiving Federal awards of SCSEP funds must follow the audit requirements in paragraphs (b) and (c) of this section that apply to their type of organization. As used here, Federal awards of SCSEP funds include Federal financial assistance and Federal cost-reimbursement contracts received directly from the Department or indirectly under awards by SCSEP recipients or higher-tier sub-recipients. (OAA § 503(f)(2)).

(b) All governmental and nonprofit organizations that are recipients or sub-recipients must follow the audit requirements of OMB Circular A–133. These requirements are codified at 29 CFR parts 96 and 99 and referenced in 29 CFR 97.26 for governmental organizations and in 29 CFR 95.26 for institutions of higher education, hospitals, and other nonprofit organizations.

(c)(1) The Department is responsible for audits of SCSEP recipients that are commercial organizations.

(2) Commercial organizations that are sub-recipients under the SCSEP and that expend more than the minimum level specified in OMB Circular A–133 ($500,000, for fiscal years ending after December 31, 2003) must have either an organization-wide audit or a program-specific financial and compliance audit conducted in accordance with OMB Circular A–133.

§ 641.824 What lobbying requirements apply to the use of SCSEP funds?

SCSEP recipients and sub-recipients must comply with the restrictions on

lobbying codified in the Department's regulations at 29 CFR part 93. (Also refer to § 641.850(c), ''Lobbying costs.'')

§ 641.827 What general nondiscrimination requirements apply to the use of SCSEP funds?

(a) SCSEP recipients, sub-recipients, and host agencies are required to comply with the nondiscrimination provisions codified in the Department's regulations at 29 CFR parts 31 and 32 and the provisions on the equal treatment of religious organizations at 29 CFR part 2 subpart D.

(b) Recipients and sub-recipients of SCSEP funds are required to comply with the nondiscrimination provisions codified in the Department's regulations at 29 CFR part 38 if:

(1) The recipient:

(i) Is a One-Stop partner listed in sec. 121(b) of WIOA, and

(ii) Operates programs and activities that are part of the One-Stop delivery system established under WIOA; or

(2) The recipient otherwise satisfies the definition of ''recipient'' in 29 CFR 38.4.

(c) Recipients must ensure that participants are provided informational materials relating to age discrimination and/or their rights under the Age Discrimination in Employment Act of 1975 that are distributed to recipients by the Department as required by § 503(b)(3) of the OAA.

(d) Questions about or complaints alleging a violation of the nondiscrimination requirements cited in this section may be directed or mailed to the Director, Civil Rights Center, U.S. Department of Labor, Room N–4123, 200 Constitution Avenue, NW., Washington, DC, 20210, for processing. (See § 641.910(d)).

(e) The specification of any right or protection against discrimination in paragraphs (a) through (d) of this section must not be interpreted to exclude or diminish any other right or protection against discrimination in connection with a SCSEP project that may be available to any participant, applicant for participation, or other individual under any applicable Federal, State, or local laws prohibiting discrimination, or their implementing regulations.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56886, Dec. 1, 2017]

§ 641.833 What policies govern political patronage?

(a) A recipient or sub-recipient must not select, reject, promote, or terminate an individual based on political services provided by the individual or on the individual's political affiliations or beliefs. In addition, as provided in § 641.827(b), certain recipients and sub-recipients of SCSEP funds are required to comply with WIOA nondiscrimination regulations in 29 CFR part 38. These regulations prohibit discrimination on the basis of political affiliation or belief.

(b) A recipient or sub-recipient must not provide, or refuse to provide, funds to any sub-recipient, host agency, or other entity based on political affiliation.

(c) SCSEP recipients must ensure that every entity that receives SCSEP funds through the recipient is applying the policies stated in paragraphs (a) and (b) of this section.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56886, Dec. 1, 2017]

§ 641.836 What policies govern political activities?

(a) No project under title V of the OAA may involve political activities. SCSEP recipients must ensure compliance with the requirements and prohibitions involving political activities described in paragraphs (b) and (c) of this section.

(b) State and local employees involved in the administration of SCSEP activities may not engage in political activities prohibited under the Hatch Act (5 U.S.C. chapter 15), including:

(1) Seeking partisan elective office;

(2) Using official authority or influence for the purpose of affecting elections, nominations for office, or fundraising for political purposes. (5 U.S.C. 1502).

(c) SCSEP recipients must provide all persons associated with SCSEP activities with a written explanation of allowable and unallowable political activities under the Hatch Act. A notice

explaining these allowable and unallowable political activities must be posted in every workplace in which SCSEP activities are conducted. The Department will provide the form and content of the notice and explanatory material by administrative issuance. (OAA § 502(b)(1)(P)).

(d) SCSEP recipients must ensure that:

(1) No SCSEP participants or staff persons engage in partisan or nonpartisan political activities during hours for which they are being paid with SCSEP funds.

(2) No participants or staff persons engage in partisan political activities in which such participants or staff persons represent themselves as spokespersons for the SCSEP.

(3) No participants are employed or out-stationed in the offices of a Member of Congress, a State or local legislator, or on the staff of any legislative committee.

(4) No participants are employed or out-stationed in the immediate offices of any elected chief executive officer of a State or unit of general government, except that:

(i) Units of local government may serve as host agencies for participants, provided that their assignments are non-political; and

(ii) While assignments may place participants in such offices, such assignments actually must be concerned with program and service activities and not in any way involved in political functions.

(5) No participants are assigned to perform political activities in the offices of other elected officials. Placement of participants in such offices in non-political assignments is permissible, however, provided that:

(i) SCSEP recipients develop safeguards to ensure that participants placed in these assignments are not involved in political activities; and

(ii) These safeguards are described in the grant agreement and are approved by the Department and are subject to review and monitoring by the SCSEP recipient and by the Department.

§ 641.839 What policies govern union organizing activities?

Recipients must ensure that SCSEP funds are not used in any way to assist, promote, or deter union organizing.

§ 641.841 What policies govern nepotism?

(a) SCSEP recipients must ensure that no recipient or sub-recipient hires, and no host agency serves as a worksite for, a person who works in a SCSEP community service assignment if a member of that person's immediate family is engaged in a decision-making capacity (whether compensated or not) for that project, subproject, recipient, sub-recipient, or host agency. The Department may exempt worksites on Native American reservations and in rural areas from this requirement provided that adequate justification can be documented, such as that no other persons are eligible and available for participation in the program.

(b) To the extent that an applicable State or local legal nepotism requirement is more restrictive than this provision, SCSEP recipients must ensure that the more restrictive requirement is followed.

(c) For purposes of this section, ''immediate family'' means wife, husband, son, daughter, mother, father, brother, sister, son-in-law, daughter-in-law, mother- in-law, father-in-law, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, stepparent, stepchild, grandparent, or grandchild.

§ 641.844 What maintenance of effort requirements apply to the use of SCSEP funds?

(a) A community service assignment for a participant under title V of the OAA is permissible only when specific maintenance of effort requirements are met.

(b) Each project funded under title V:

(1) Must not reduce the number of employment opportunities or vacancies that would otherwise be available to individuals not participating in the program;

(2) Must not displace currently employed workers (including partial displacement, such as a reduction in the hours of non-overtime work, wages, or employment benefits);

(3) Must not impair existing contracts or result in the substitution of Federal funds for other funds in connection with work that would otherwise be performed; and

(4) Must not employ or continue to employ any eligible individual to perform the same work or substantially the same work as that performed by any other individual who is on layoff. (OAA § 502(b)(1)(G)).

§ 641.847 What uniform allowable cost requirements apply to the use of SCSEP funds?

(a) *General.* Unless specified otherwise in this part or the grant agreement, recipients and sub-recipients must follow the uniform allowable cost requirements that apply to their type of organization. For example, a local government sub-recipient receiving SCSEP funds from a nonprofit organization must use the allowable cost requirements for governmental organizations in OMB Circular A–87. The Department's regulations at 29 CFR 95.27 (non-profit and commercial organizations) and 29 CFR 97.22 (State and local governments) identify the Federal principles for determining allowable costs that each kind of organization must follow. The applicable Federal principles for each kind of organization are described in paragraphs (b)(1) through (b)(5) of this section. (OAA § 503(f)(2)).

(b) *Allowable costs/cost principles.* (1) Allowable costs for State, local, and Indian tribal government organizations must be determined under OMB Circular A–87, ''Cost Principles for State, Local and Indian Tribal Governments.''

(2) Allowable costs for nonprofit organizations must be determined under OMB Circular A–122, ''Cost Principles for Non-Profit Organizations.''

(3) Allowable costs for institutions of higher education must be determined under OMB Circular A–21, ''Cost Principles for Educational Institutions.''

(4) Allowable costs for hospitals must be determined in accordance with appendix E of 45 CFR part 74, ''Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals.''

(5) Allowable costs for commercial organizations and those nonprofit organizations listed in Attachment C to OMB Circular A–122 must be determined under the provisions of the Federal Acquisition Regulation (FAR), at 48 CFR part 31.

§ 641.850 Are there other specific allowable and unallowable cost requirements for the SCSEP?

(a) Yes, in addition to the generally applicable cost principles in § 641.847(b), the cost principles in paragraphs (b) through (g) of this section apply to SCSEP grants.

(b) *Claims against the Government.* For all types of entities, legal expenses for the prosecution of claims against the Federal Government, including appeals to an Administrative Law Judge, are unallowable.

(c) *Lobbying costs.* In addition to the prohibition contained in 29 CFR part 93, SCSEP funds must not be used to pay any salaries or expenses related to any activity designed to influence legislation or appropriations pending before the Congress of the United States or any State legislature. (See § 641.824).

(d) *One-Stop costs.* Costs of participating as a required partner in the One-Stop delivery system established in accordance with sec. 121(e) of WIOA are allowable, provided that SCSEP services and funding are provided in accordance with the MOU required by WIOA and OAA sec. 502(b)(1)(O), and costs are determined in accordance with the applicable cost principles. The costs of services provided by the SCSEP, including those provided by participants/enrollees, may comprise a portion or the total of a SCSEP project's proportionate share of One-Stop costs.

(e) *Building repairs and acquisition costs.* Except as provided in this paragraph and as an exception to the allowable cost principles in § 641.847(b), no SCSEP funds may be used for the purchase, construction, or renovation of any building except for the labor involved in:

(1) Minor remodeling of a public building necessary to make it suitable for use for project purposes;

(2) Minor repair and rehabilitation of publicly used facilities for the general benefit of the community; and

(3) Repair and rehabilitation by participants of housing occupied by persons with low incomes who are declared eligible for such services by authorized local agencies.

(f) *Accessibility and reasonable accommodation.* Recipients and sub-recipients may use SCSEP funds to meet their obligations under § 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990, as amended, and any other applicable Federal disability nondiscrimination laws, to provide physical and programmatic accessibility and reasonable accommodation/modifications for, and effective communications with, individuals with disabilities. (29 U.S.C. 794).

(g) *Participants' benefit costs.* Recipients and sub-recipients may use SCSEP funds for participant benefit costs only under the conditions set forth in § 641.565.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56886, Dec. 1, 2017]

§ 641.853 How are costs classified?

(a) All costs must be classified as ''administrative costs'' or ''programmatic activity costs.'' (OAA § 502(c)(6)).

(b) Recipients and sub-recipients must assign participants' wage and benefit costs and other participant (enrollee) costs such as supportive services to the programmatic activity cost category. (See § 641.864). When a participant's community service assignment involves functions whose costs are normally classified as administrative costs, compensation provided to the participants must be charged as programmatic activity costs instead of administrative costs, since participant wage and benefit costs are always charged to the programmatic activity cost category.

§ 641.856 What functions and activities constitute administrative costs?

(a) Administrative costs are that allocable portion of necessary and reasonable allowable costs of recipients and program operators that are associated with those specific functions identified in paragraph (b) of this section and that are not related to the direct provision of programmatic activities specified in § 641.864. These costs may be both personnel and non-personnel and both direct and indirect costs.

(b) Administrative costs are the costs associated with:

(1) Performing general administrative and coordination functions, including:

(i) Accounting, budgeting, financial, and cash management functions;

(ii) Procurement and purchasing functions;

(iii) Property management functions;

(iv) Personnel management functions;

(v) Payroll functions;

(vi) Coordinating the resolution of findings arising from audits, reviews, investigations, and incident reports;

(vii) Audit functions;

(viii) General legal services functions;

(ix) Developing systems and procedures, including information systems, required for these administrative functions;

(x) Preparing administrative reports; and

(xi) Other activities necessary for general administration of government funds and associated programs.

(2) Oversight and monitoring responsibilities related to administrative functions;

(3) Costs of goods and services used for administrative functions of the program, including goods and services such as rental or purchase of equipment, utilities, office supplies, postage, and rental and maintenance of office space;

(4) Travel costs incurred for official business in carrying out administrative activities or the overall management of the program;

(5) Costs of information systems related to administrative functions (for example, personnel, procurement, purchasing, property management, accounting, and payroll systems) including the purchase, systems development, and operating costs of such systems and;

(6) Costs of technical assistance, professional organization membership dues, and evaluating results obtained by the project involved against stated objectives. (OAA § 502(c)(4)).

§ 641.859 What other special rules govern the classification of costs as administrative costs or programmatic activity costs?

(a) Recipients and sub-recipients must comply with the special rules for classifying costs as administrative costs or programmatic activity costs set forth in paragraphs (b) through (e) of this section.

(b)(1) Costs of awards by recipients and program operators that are solely for the performance of their own administrative functions are classified as administrative costs.

(2) Costs incurred by recipients and program operators for administrative functions listed in § 641.856(b) are classified as administrative costs.

(3) Costs incurred by vendors and sub-recipients performing the administrative functions of recipients and program operators are classified as administrative costs. (See 29 CFR 99.210 for a discussion of factors differentiating sub-recipients from vendors.)

(4) Except as provided in paragraph (b)(3) of this section, all costs incurred by all vendors, and only those sub-recipients below program operators, are classified as programmatic activity costs. (*See* 29 CFR 99.210 for a discussion of factors differentiating sub-recipients from vendors.)

(c) Personnel and related non-personnel costs of staff who perform both administrative functions specified in § 641.856(b) and programmatic services or activities must be allocated as administrative or programmatic activity costs to the benefiting cost objectives/categories based on documented distributions of actual time worked or other equitable cost allocation methods.

(d) The allocable share of indirect or overhead costs charged to the SCSEP grant are to be allocated to the administrative and programmatic activity cost categories in the same proportion as the costs in the overhead or indirect cost pool are classified as programmatic activity or administrative costs.

(e) Costs of the following information systems including the purchase, systems development and operating (e.g., data entry) costs are charged to the programmatic activity cost category:

(1) Tracking or monitoring of participant and performance information;

(2) Employment statistics information, including job listing information, job skills information, and demand occupation information; and

(3) Local area performance information.

§ 641.861 Must SCSEP recipients provide funding for the administrative costs of sub-recipients?

(a) Recipients and sub-recipients must obtain funding for administrative costs to the extent practicable from non-Federal sources. (OAA § 502(c)(5)).

(b) SCSEP recipients must ensure that sufficient funding is provided for the administrative activities of sub-recipients that receive SCSEP funding through the recipient. Each SCSEP recipient must describe in its grant application the methodology used to ensure that sub-recipients receive sufficient funding for their administrative activities. (OAA § 502(b)(1)(R)).

§ 641.864 What functions and activities constitute programmatic activity costs?

Programmatic activity costs include, but are not limited to, the costs of the following functions:

(a) Participant wages, such benefits as are required by law (such as workers' compensation or unemployment compensation), the costs of physical examinations, compensation for scheduled work hours during which a host agency is closed for a Federal holiday, and necessary sick leave that is not part of an accumulated sick leave program, except that no amounts provided under the grant may be used to pay the cost of pension benefits, annual leave, accumulated sick leave, or bonuses, as described in § 641.565;

(b) Outreach, recruitment and selection, intake, orientation, assessment, and preparation and updating of IEPs;

(c) Participant training, as described in § 641.540, which may be provided before commencing or during a community service assignment, and which may be provided at a host agency, in a classroom setting, or using other appropriate arrangements, which may include reasonable costs of instructors'

salaries, classroom space, training supplies, materials, equipment, and tuition;

(d) Subject to the restrictions in § 641.535(c), job placement assistance, including job development and job search assistance, job fairs, job clubs, and job referrals; and

(e) Participant supportive services, to enable an individual to successfully participate in a SCSEP project, as described in § 641.545. (OAA § 502(c)(6)(A)).

§ 641.867 What are the limitations on the amount of SCSEP administrative costs?

(a) Except as provided in paragraph (b), no more than 13.5 percent of the SCSEP funds received for a Program Year may be used for administrative costs.

(b) The Department may increase the amount available for administrative costs to not more than 15 percent, in accordance with § 641.870. (OAA § 502(c)(3)).

§ 641.870 Under what circumstances may the administrative cost limitation be increased?

(a) SCSEP recipients may request that the Department increase the amount available for administrative costs. The Department may honor the request if:

(1) The Department determines that it is necessary to carry out the project; and

(2) The recipient demonstrates that:

(i) Major administrative cost increases are being incurred in necessary program components, such as liability insurance, payments for workers' compensation for staff, costs associated with achieving unsubsidized placement goals, and other operation requirements imposed by the Department;

(ii) The number of community service assignment positions in the project or the number of minority eligible individuals participating in the project will decline if the amount available for paying the cost of administration is not increased; or

(iii) The size of the project is so small that the amount of administrative costs incurred to carry out the project necessarily exceeds 13.5 percent of the grant amount. (OAA § 502(c)(3)).

(b) A request by a recipient or prospective recipient for an increase in the amount available for administrative costs may be submitted as part of the grant application or as a separate submission at any time after the grant award.

§ 641.873 What minimum expenditure levels are required for participant wages and benefits?

(a) Except as provided in § 641.874 or in paragraph (c) of this section, not less than 75 percent of the SCSEP funds provided under a grant from the Department must be used to pay for wages and benefits of participants as described in § 641.864(a). (OAA § 502(c)(6)(B)).

(b) A SCSEP recipient is in compliance with this provision if at least 75 percent of the total expenditure of SCSEP funds provided to the recipient was for wages and benefits, even if one or more sub-recipients did not expend at least 75 percent of their SCSEP subrecipient award for wages and benefits.

(c) A SCSEP grantee may submit to the Department a request for approval to use not less than 65 percent of the grant funds to pay wages and benefits under § 641.874.

§ 641.874 What conditions apply to a SCSEP grantee request to use additional funds for training and supportive service costs?

(a) A grantee may submit to the Department a request for approval—

(1) To use not less than 65 percent of the grant funds to pay the wages and benefits described in § 641.864(a);

(2) To use the percentage of grant funds specified in § 641.867 to pay for administrative costs as described in § 641.856;

(3) To use the 10 percent of grant funds that would otherwise be devoted to wages and benefits under § 641.873 to provide participant training (as described in § 641.540(e)) and participant supportive services to enable participants to successfully participate in a SCSEP project (as described in § 641.545), in which case the grantee must provide (from the funds described in this paragraph) the wages for those individual participants who are receiving training from the funds described in this paragraph, but may not use the

funds described in this paragraph to pay for any administrative costs; and

(4) To use the remaining grant funds to provide participant training, job placement assistance, participant supportive services, and outreach, recruitment and selection, intake, orientation and assessment.

(b) In submitting the request the grantee must include in the request—

(1) A description of the activities for which the grantee will spend the grant funds described in paragraphs (a)(3) and (a)(4) of this section;

(2) An explanation documenting how the provision of such activities will improve the effectiveness of the project, including an explanation of whether any displacement of eligible individuals or elimination of positions for such individuals will occur, information on the number of such individuals to be displaced and of such positions to be eliminated, and an explanation of how the activities will improve employment outcomes for the individuals served, based on the assessment conducted under § 641.535(a)(2); and

(3) A proposed budget and work plan for the activities, including a detailed description of how the funds will be spent on the activities described in paragraphs (a)(3) and (a)(4) of this section.

(c)(1) If a grantee wishes to amend an existing grant agreement to use additional funds for training and supportive service costs, the grantee must submit such a request not later than 90 days before the proposed date of implementation contained in the request. Not later than 30 days before the proposed date of implementation, the Department will approve, approve as modified, or reject the request, on the basis of the information included in the request.

(2) If a grantee submits a request to use additional funds for training and supportive service costs in the grant application, the request will be accepted and processed as a part of the grant review process.

(d) Grantees may apply this provision to individual sub-recipients but need not provide this opportunity to all their sub-recipients.

§ 641.876 How will compliance with cost limitations and minimum expenditure levels be determined?

The Department will determine compliance by examining expenditures of SCSEP funds. The cost limitations and minimum expenditure level requirements must be met at the time all such funds have been expended or the period of availability of such funds has expired, whichever comes first.

§ 641.879 What are the financial and performance reporting requirements for recipients?

(a) In accordance with 29 CFR 97.41 (State and local governments) or 29 CFR 95.52 (non-profit and commercial organizations), each SCSEP recipient must submit a SCSEP Financial Status Report (FSR, ETA Form 9130) in electronic format to the Department via the Internet within 45 days after the ending of each quarter of the Program Year. Each SCSEP recipient must also submit a final closeout FSR to the Department via the Internet within 90 days after the end of the grant period. The Department will provide instructions for the preparation of this report. (OAA § 503(f)(3)).

(1) Financial data must be reported on an accrual basis, and cumulatively by funding year of appropriation. Financial data may also be required on specific program activities as required by the Department.

(2) If the SCSEP recipient's accounting records are not normally kept on the accrual basis of accounting, the SCSEP recipient must develop accrual information through an analysis of the documentation on hand.

(b) In accordance with 29 CFR 97.40 (State and local governments) or 29 CFR 95.51 (non-profit and commercial organizations), each SCSEP recipient must submit updated data on participants (including data on demographic characteristics and data regarding the performance measures), host agencies, and employers in an electronic format specified by the Department via the Internet within 30 days after the end of each of the first three quarters of the Program Year, on the last day of the fourth quarter of the Program Year, and within 90 days after the last day of the Program Year. Recipients wishing

to correct data errors or omissions for their final Program Year report must do so within 90 days after the end of the Program Year. The Department will generate SCSEP Quarterly Progress Reports (QPRs), as well as the final QPR, as soon as possible after receipt of the data. (OAA § 503(f)(3)).

(c) Each State agency receiving title V funds must annually submit an equitable distribution report of SCSEP positions by all recipients in the State. The Department will provide instructions for the preparation of this report. (OAA § 508).

(d) In addition to the data required to be submitted under paragraph (b) of this section, each SCSEP recipient may be required to collect data and submit reports on the performance measures. See subpart G. The Department will provide instructions detailing these measures and how recipients must prepare this report.

(e) In addition to the data required to be submitted under paragraph (b) of this section, each SCSEP recipient may be required to collect data and submit reports about the demographic characteristics of program participants. The Department will provide instructions detailing these measures and how recipients must prepare these reports.

(f) Federal agencies that receive and use SCSEP funds under interagency agreements must submit project financial and progress reports in accordance with this section. Federal recipients must maintain the necessary records that support required reports according to instructions provided by the Department. (OAA § 503(f)(3)).

(g) Recipients may be required to maintain records that contain any other information that the Department determines to be appropriate in support of any other reports that the Department may require. (OAA § 503(f)(3)).

(h) Grantees submitting reports that cannot be validated or verified as accurately counting and reporting activities in accordance with the reporting instructions may be treated as failing to submit reports, which may result in failing one of the responsibility tests outlined in § 641.430 and OAA § 514(d).

§ 641.881 What are the SCSEP recipient's responsibilities relating to awards to sub-recipients?

(a) Recipients are responsible for ensuring that all awards to sub-recipients are conducted in a manner to provide, to the maximum extent practicable, full and open competition in accordance with the procurement procedures in 29 CFR 95.43 (non-profit and commercial organizations) and 29 CFR 97.36 (State and local governments).

(b) The SCSEP recipient is responsible for all grant activities, including the performance of SCSEP activities by sub-recipients, and ensuring that sub-recipients comply with the OAA and this part. (See also OAA § 514(d) and § 641.430 of this part on responsibility tests).

(c) Recipients must follow their own procedures for allocating funds to other entities. The Department will not grant funds to another entity on the recipient's behalf.

(d)(1) National grantees that receive grants to provide services in an area where a substantial population of individuals with barriers to employment exists must, in selecting sub-recipients, give special consideration to organizations (including former national grant recipients) with demonstrated expertise in serving such individuals. (OAA § 514(e)(2)).

(2) For purposes of this section, the term ''individuals with barriers to employment'' means minority individuals, Indian individuals, individuals with greatest economic need, and most-in-need individuals. (OAA § 514(e)(1)).

§ 641.884 What are the grant closeout procedures?

SCSEP recipients must follow the grant closeout procedures at 29 CFR 97.50 (State and local governments) or 29 CFR 95.71 (non-profit and government organizations), as appropriate. The Department will issue supplementary closeout instructions to OAA title V recipients as necessary.

Subpart I—Grievance Procedures and Appeals Process

§ 641.900 What appeal process is available to an applicant that does not receive a grant?

(a) An applicant for financial assistance under title V of the OAA that is dissatisfied because it was not awarded financial assistance in whole or in part may request that the Grant Officer provide an explanation for not awarding financial assistance to that applicant. The request must be filed within 10 days of the date of notification indicating that financial assistance would not be awarded. The Grant Officer must provide the protesting applicant with feedback concerning its proposal within 21 days of the protest. Applicants may appeal to the U.S. Department of Labor, Office of Administrative Law Judges (OALJ), within 21 days of the date of the Grant Officer's feedback on the proposal, or within 21 days of the Grant Officer's notification that financial assistance would not be awarded if the applicant does not request feedback on its proposal. The appeal may be for a part or the whole of the denied funding. This appeal will not in any way interfere with the Department's decisions to fund other organizations to provide services during the appeal period.

(b) Failure to file an appeal within the 21 days provided in paragraph (a) of this section constitutes a waiver of the right to a hearing.

(c) A request for a hearing under this section must state specifically those issues in the Grant Officer's notification upon which review is requested. Those provisions of the Grant Officer's notification not specified for review are considered resolved and not subject to further review.

(d) A request for a hearing must be filed with the Chief Administrative Law Judge, U.S. Department of Labor, with one copy to the Departmental official who issued the determination.

(e) The decision of the ALJ constitutes final agency action unless, within 21 days of the decision, a party dissatisfied with the ALJ's decision, in whole or in part, has filed a petition for review with the Administrative Review Board (ARB) (established under Secretary's Order No. 01–2020), specifically identifying the procedure, fact, law, or policy to which exception is taken, in accordance with 29 CFR part 26. The Department will deem any exception not specifically urged to have been waived. A copy of the petition for review must be sent to the grant officer at that time. If, within 30 days of the filing of the petition for review, the ARB does not notify the parties that the case has been accepted for review, then the decision of the ALJ constitutes final agency action. In any case accepted by the ARB, a decision must be issued by the ARB within 180 days of acceptance. If a decision is not so issued, the decision of the ALJ constitutes final agency action.

(f) The Rules of Practice and Procedures for Administrative Hearings Before the Office of Administrative Law Judges, at 29 CFR part 18, govern the conduct of hearings under this section, except that:

(1) The appeal is not considered a complaint; and

(2) Technical rules of evidence, such as the Federal Rules of Evidence and subpart B of 29 CFR part 18, will not apply to any hearing conducted under this section. However, rules designed to assure production of the most credible evidence available and to subject testimony to test by cross-examination will be applied when the ALJ conducting the hearing considers them reasonably necessary. The certified copy of the administrative file transmitted to the ALJ by the official issuing the notification not to award financial assistance must be part of the evidentiary record of the case and need not be moved into evidence.

(g) The ALJ should render a written decision no later than 90 days after the closing of the record.

(h) The remedies available are provided in § 641.470.

[75 FR 53812, Sept. 1, 2010, as amended at 85 FR 13028, Mar. 6, 2020; 85 FR 30614, May 20, 2020; 86 FR 1777, Jan. 11, 2021]

§ 641.910 What grievance procedures must grantees make available to applicants, employees, and participants?

(a) Each grantee must establish, and describe in the grant agreement, grievance procedures for resolving complaints, other than those described by paragraph (d) of this section, arising between the grantee, employees of the grantee, sub-recipients, and applicants or participants.

(b) The Department will not review final determinations made under paragraph (a) of this section, except to determine whether the grantee's grievance procedures were followed, and according to paragraph (c) of this section.

(c) Allegations of violations of Federal law, other than those described in paragraph (d) of this section, which are not resolved within 60 days under the grantee's procedures, may be filed with the Chief, Division of Adult Services, Employment and Training Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. Allegations determined to be substantial and credible will be investigated and addressed.

(d) Questions about, or complaints alleging a violation of, the nondiscrimination requirements of title VI of the Civil Rights Act of 1964, sec. 504 of the Rehabilitation Act of 1973, sec. 188 of the Workforce Innovation and Opportunity Act (WIOA), or their implementing regulations, may be directed or mailed to the Director, Civil Rights Center, U.S. Department of Labor, Room N–4123, 200 Constitution Avenue NW., Washington, DC 20210. In the alternative, complaints alleging violations of WIOA sec. 188 may be filed initially at the grantee level. See 29 CFR 38.69, 38.72. In such cases, the grantee must use complaint processing procedures meeting the requirements of 29 CFR 38.69 through 38.76 to resolve the complaint.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56886, Dec. 1, 2017]

§ 641.920 What actions of the Department may a grantee appeal and what procedures apply to those appeals?

(a) Appeals from a final disallowance of costs as a result of an audit must be made under 29 CFR 96.63.

(b) Appeals of suspension or termination actions taken on the grounds of discrimination are processed under 29 CFR part 31 or 29 CFR part 38, as appropriate.

(c) Protests and appeals of decisions not to award a grant, in whole or in part, will be handled under § 641.900.

(d) Upon a grantee's receipt of the Department's final determination relating to costs (except final disallowance of costs as a result of an audit, as described in paragraph (a) of this section), payment, suspension or termination, or the imposition of sanctions, the grantee may appeal the final determination to the Department's Office of Administrative Law Judges, as follows:

(1) Within 21 days of receipt of the Department's final determination, the grantee may file a request for a hearing with the Chief Administrative Law Judge, United States Department of Labor, in accordance with 29 CFR part 18, with a copy to the Department official who signed the final determination.

(2) The request for hearing must be accompanied by a copy of the final determination, and must state specifically those issues of the determination upon which review is requested. Those provisions of the determination not specified for review, or the entire determination when no hearing has been requested within the 21 days, are considered resolved and not subject to further review.

(3) The Rules of Practice and Procedures for Administrative Hearings Before the Office of Administrative Law Judges, at 29 CFR part 18, govern the conduct of hearings under this section, except that:

(i) The appeal is not considered as a complaint; and

(ii) Technical rules of evidence, such as the Federal Rules of Evidence and subpart B of 29 CFR part 18, will not apply to any hearing conducted under this section. However, rules designed to assure production of the most credible

evidence available and to subject testimony to test by cross-examination will be applied when the Administrative Law Judge conducting the hearing considers them reasonably necessary. The certified copy of the administrative file transmitted to the Administrative Law Judge by the official issuing the final determination must be part of the evidentiary record of the case and need not be moved into evidence.

(4) The Administrative Law Judge should render a written decision no later than 90 days after the closing of the record. In ordering relief, the ALJ may exercise the full authority of the Secretary under the OAA.

(5) The decision of the ALJ constitutes final agency action unless, within 21 days of the decision, a party dissatisfied with the ALJ's decision, in whole or in part, has filed a petition for review with the ARB (established under Secretary's Order No. 01–2020), specifically identifying the procedure, fact, law, or policy to which exception is taken, in accordance with 29 CFR part 26. The Department will deem any exception not specifically argued to have been waived. A copy of the petition for review must be sent to the grant officer at that time. If, within 30 days of the filing of the petition for review, the ARB does not notify the parties that the case has been accepted for review, then the decision of the ALJ constitutes final agency action. In any case accepted by the ARB, a decision must be issued by the ARB within 180 days of acceptance. If a decision is not so issued, the decision of the ALJ constitutes final agency action.

[75 FR 53812, Sept. 1, 2010, as amended at 82 FR 56886, Dec. 1, 2017; 85 FR 13028, Mar. 6, 2020; 85 FR 30614, May 20, 2020; 86 FR 1777, Jan. 11, 2021]

§ 641.930 Is there an alternative dispute resolution process that may be used in place of an OALJ hearing?

(a) Parties to a complaint that has been filed according to the requirements of § 641.920 (a), (c), and (d) may choose to waive their rights to an administrative hearing before the OALJ. Instead, they may choose to transfer the settlement of their dispute to an individual acceptable to all parties who will conduct an informal review of the stipulated facts and render a decision in accordance with applicable law. A written decision must be issued within 60 days after submission of the matter for informal review.

(b) Unless the parties agree in writing to extend the period, the waiver of the right to request a hearing before the OALJ will automatically be revoked if a settlement has not been reached or a decision has not been issued within the 60 days provided in paragraph (a) of this section.

(c) The decision rendered under this informal review process will be treated as the final agency decision.

PART 646 [RESERVED]

PART 650—STANDARD FOR APPEALS PROMPTNESS—UNEMPLOYMENT COMPENSATION

Sec.

650.1 Nature and purpose of the standard.
650.2 Federal law requirements.
650.3 Secretary's interpretation of Federal law requirements.
650.4 Review of State law and criteria for review of State compliance.
650.5 Annual appeals performance plan.

AUTHORITY: Sec. 1102 of the Social Security Act, 42 U.S.C. 1302; Secretary's Order No. 4–75, dated April 16, 1975. Interpret and apply secs. 303(a)(1), 303(a)(3), and 303(b)(2) of the Social Security Act (42 U.S.C. 503(a)(1), 503(a)(3), 503(b)(2)).

SOURCE: 37 FR 16173, Aug. 11, 1972, unless otherwise noted.

§ 650.1 Nature and purpose of the standard.

(a) This standard is responsive to the overriding concern of the U.S. Supreme Court in California Department of Human Resources v. Java, 402 U.S. 121 (1971), and that of other courts with delay in payment of unemployment compensation to eligible individuals, including delays caused specifically by the adjudication process. The standard seeks to assure that all administrative appeals affecting benefit rights are heard and decided with the greatest promptness that is administratively feasible.

(b) Sections 303(a) (1) and (3) of the Social Security Act require, as a condition for the receipt of granted funds,

that State laws include provisions for methods of administration reasonably calculated to insure full payment of unemployment compensation when due, and opportunity for a fair hearing for all individuals whose claims for unemployment compensation are denied. The Secretary has construed these provisions to require, as a condition for receipt of granted funds, that State laws include provisions for hearing and deciding appeals for all unemployment insurance claimants who are parties to an administrative benefit appeal with the greatest promptness that is administratively feasible. What is the greatest promptness that is administratively feasible in an individual case depends on the facts and circumstances of that case. For example, the greatest promptness that is administratively feasible will be longer in cases that involve interstate appeals, complex issues of fact or law, reasonable requests by parties for continuances or rescheduling of hearings or other unforeseen and uncontrollable factors than it will be for other cases.

(c) In addition, the Secretary has construed section 303(b)(2) of the Social Security Act as requiring States to comply substantially with the required provisions of State law. The Secretary considers as substantial compliance the issuance of minimum percentages of first level benefit appeal decisions within the periods of time specified in § 650.4.

(d) Although the interpretation of Federal law requirements in § 650.3 below applies to both first and second level administrative benefit appeals, the criteria for review of State compliance in § 650.3(b) apply only to first level benefit appeals.

§ 650.2 Federal law requirements.

(a) Section 303(a)(1) of the Social Security Act requires that a State law include provision for:

> Such methods of administration * * * as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due.

(b) Section 303(a)(3) of the Social Security Act requires that a State law include provision for:

> Opportunity for a fair hearing, before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied.

(c) Section 303(b)(2) of the Social Security Act provides that:

> Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that in the administration of the law there is—
>
> (1) * * *
>
> (2) A failure to comply substantially with any provision specified in subsection (a) [303(a)]; the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such denial or failure to comply. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State * * *

§ 650.3 Secretary's interpretation of Federal law requirements.

(a) The Secretary interprets sections 303(a)(1) and 303(a)(3) above to require that a State law include provision for—

(1) Hearing and decision for claimants who are parties to an appeal from a benefit determination to an administrative tribunal with the greatest promptness that is administratively feasible, and

(2) Such methods of administration of the appeals process as will reasonably assure hearing and decision with the greatest promptness that is administratively feasible.

(b) The Secretary interprets section 303(b)(2) above to require a State to comply substantially with provisions specified in paragraph (a) of this section.

§ 650.4 Review of State law and criteria for review of State compliance.

(a) A State law will satisfy the requirements of § 650.3(a) if it contains a provision requiring, or is construed to require, hearing and decision for claimants who are parties to an administrative appeal affecting benefit rights with the greatest promptness that is administratively feasible.

(b) A State will be deemed to comply substantially with the State law requirements set forth in § 650.3(a) with respect to first level appeals, the State has issued at least 60 percent of all

first level benefit appeal decisions within 30 days of the date of appeal, and at least 80 percent of all first level benefit appeal decisions within 45 days. These computations will be derived from the State's regular reports required pursuant to the Unemployment Compensation Manual, part III, sections 4400–4450.[1]

[37 FR 16173, Aug. 11, 1972, as amended at 41 FR 6757, Feb. 13, 1976; 71 FR 35517, June 21, 2006]

§ 650.5 Annual appeals performance plan.

No later than December 15 of each year, each State shall submit an appeals performance plan showing how it will operate during the following calendar year so as to achieve or maintain the issuance of at least 60 percent of all first level benefit appeals decisions within 30 days of the date of appeal, and 80 percent within 45 days.

(Approved by the Office of Management and Budget under control number 1205–0132)

(Pub. L. No. 96–511)

[41 FR 6757, Feb. 13, 1976, as amended at 49 FR 18295, Apr. 30, 1984; 71 FR 35517, June 21, 2006]

PART 651—GENERAL PROVISIONS GOVERNING THE WAGNER-PEYSER ACT EMPLOYMENT SERVICE

AUTHORITY: 29 U.S.C. 49a and 49k; 38 U.S.C. 101, chapters 41 and 42; Secs. 3, 189 and 503, Pub. L. 113–128, 128 Stat. 1425 (Jul. 22, 2014).

§ 651.10 Definitions of terms used in this part and parts 652, 653, 654, and 658 of this chapter.

In addition to the definitions set forth in sec. 3 of the Workforce Innovation and Opportunity Act (WIOA), codified at 29 U.S.C. 3101 *et seq.*, the following definitions apply to the regulations in parts 652, 653, 654, and 658 of this chapter:

Act means the Wagner-Peyser Act (codified at 29 U.S.C. 49 *et seq.*).

Administrator, Office of Workforce Investment (OWI Administrator) means the chief official of the Office of Workforce Investment (OWI) or the Administrator's designee.

Agent means a legal entity or person, such as an association of employers, or an attorney for an association, that is authorized to act on behalf of the employer for purposes of recruitment of workers through the clearance system and is not itself an employer or joint employer, as defined in this section, with respect to a specific job order.

Agricultural employer means any employer as defined in this part who owns or operates a farm, ranch, processing establishment, cannery, gin, packing shed or nursery, or who produces or conditions seed, and who either recruits, solicits, hires, employs, furnishes, or transports any migrant or seasonal farmworker or any agricultural employer as described in 29 U.S.C. 1802(2).

Agricultural worker see *Farmworker*.

Apparent violation means a suspected violation of employment-related laws or employment service (ES) regulations by an employer, which an ES staff member observes, has reason to believe, or regarding which an ES staff member receives information (other than a *complaint* as defined in this part).

Applicant holding office means an ES office that is in receipt of a clearance order and has access to U.S. workers who may be willing and available to perform farmwork on less than year-round basis.

Applicant Holding State means a State Workforce Agency that is in receipt of a clearance order from another State and potentially has U.S. workers who may be willing and available to perform farmwork on a less than year-round basis.

Bona fide occupational qualification (BFOQ) means that an employment decision or request based on age, sex, national origin, or religion is based on a finding that such characteristic is necessary to the individual's ability to perform the job in question. Since a BFOQ is an exception to the general prohibition against discrimination on the basis of age, sex, national origin, or

[1] The Unemployment Compensation Manual is available at each regional office of the Department of Labor and at the headquarters' office of each State unemployment compensation agency.

religion, it must be interpreted narrowly in accordance with the Equal Employment Opportunity Commission regulations set forth at 29 CFR parts 1604, 1605, 1606, and 1625.

Career services means the services described in sec. 134(c)(2) of WIOA and § 678.430 of this chapter.

Clearance order means a job order that is processed through the clearance system under the Agricultural Recruitment System (ARS) at part 653, subpart F, of this chapter.

Clearance system means the orderly movement of U.S. job seekers as they are referred through the employment placement process by an ES office. This includes joint action of local ES offices in different labor market areas and/or States.

Complainant means the individual, employer, organization, association, or other entity filing a complaint.

Complaint means a representation made or referred to a State or ES office of an alleged violation of the ES regulations and/or other Federal laws enforced by the Department's Wage and Hour Division (WHD) or Occupational Safety and Health Administration (OSHA), as well as other Federal, State, or local agencies enforcing employment-related law.

Complaint System Representative means a trained ES staff individual who is responsible for processing complaints.

Criteria clearance order means a clearance order that is attached to an application for foreign temporary agricultural workers pursuant to part 655, subpart B, of this chapter.

Decertification means the rescission by the Secretary of Labor (Secretary) of the year-end certification made under sec. 7 of the Wagner-Peyser Act to the Secretary of the Treasury that the State agency may receive funds authorized by the Wagner-Peyser Act.

Department means the United States Department of Labor, including its agencies and organizational units.

Discontinuation of services means that an employer, agent, farm labor contractor, joint employer, or successor in interest, as defined in this section, cannot participate in or receive any Wagner-Peyser Act employment service provided by the ES to employers pursuant to parts 652 and 653 of this chapter.

Employer means a person, firm, corporation, or other association or organization which currently has a location within the United States to which U.S. workers may be referred for employment, and which proposes to employ a worker at a place within the United States and which has an employer relationship with respect to employees under this subpart as indicated by the fact that it hires, pays, fires, supervises, and otherwise controls the work of such employees. An association of employers is considered an employer if it has all of the indicia of an employer set forth in this definition. Such an association, however, is considered as a joint employer with the employer member if either shares in exercising one or more of the definitional indicia.

Employment and Training Administration (ETA) means the component of the Department that administers Federal government job training and worker dislocation programs, Federal grants to States for public ES programs, and unemployment insurance benefits. These services are provided primarily through State and local workforce development systems.

Employment-related laws means those laws and implementing rules, regulations, and standards that relate to the employment relationship, such as those enforced by the Department's WHD, OSHA, or by other Federal, State, or local agencies.

Employment Service (ES) office means a site that provides ES services as a one-stop partner program. A site must be colocated in a one-stop center consistent with the requirements of §§ 678.305 through 678.315 of this chapter.

Employment Service (ES) Office Manager means the ES staff person in charge of ES services provided in a one-stop center.

Employment Service (ES) regulations means the Federal regulations at this part and parts 652, 653, 654, 658 of this chapter, and 29 CFR part 75.

Employment Service (ES) staff means individuals who are funded, in whole or in part, by Wagner-Peyser Act funds to carry out activities authorized under the Wagner-Peyser Act.

Establishment means a public or private economic employing unit generally at a single physical location which produces and/or sells goods or services, for example, a mine, factory, store, farm, orchard or ranch. It is usually engaged in one, or predominantly one, type of commercial or governmental activity. Each branch or subsidiary unit of a large employer in a geographical area or community must be considered an individual establishment, except that all such units in the same physical location is considered a single establishment. A component of an establishment which may not be located in the same physical structure (such as the warehouse of a department store) also must be considered as part of the parent establishment. For the purpose of the ''seasonal farmworker'' definition, farm labor contractors and crew leaders are not considered establishments; it is the organizations to which they supply the workers that are the establishments.

Farm labor contractor means any person or entity, other than an agricultural employer, an agricultural association, or an employee of an agricultural employer or agricultural association, who, for any money or other valuable consideration paid or promised to be paid, recruits, solicits, hires, employs, furnishes, or transports any migrant or seasonal farmworker (MSFW).

Farmwork means the cultivation and tillage of the soil, dairying, the production, cultivation, growing, and harvesting of any agricultural or horticultural commodities. This includes the raising of livestock, bees, fur-bearing animals, or poultry, the farming of fish, and any practices (including any forestry or lumbering operations) performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market. It also includes the handling, planting, drying, packing, packaging, processing, freezing, or grading prior to delivery for storage of any agricultural or horticultural commodity in its unmanufactured state. For the purposes of this definition, agricultural commodities means all commodities produced on a farm including crude gum (oleoresin) from a living tree products processed by the original producer of the crude gum (oleoresin) from which they are derived, including gum spirits of turpentine and gum rosin. *Farmwork* also means any service or activity covered under §655.103(c) of this chapter and/or 29 CFR 500.20(e) and any service or activity so identified through official Department guidance such as a Training and Employment Guidance Letter.

Farmworker means an individual employed in farmwork, as defined in this section.

Field checks means unannounced appearances by ES staff and/or other State or Federal staff at agricultural worksites to which ES placements have been made through the intrastate or interstate clearance system to ensure that conditions are as stated on the clearance order and that the employer is not violating an employment-related law.

Field visits means announced appearances by State Monitor Advocates, Regional Monitor Advocates, the National Monitor Advocate (or National Monitor Advocate staff), or outreach staff to the working, living, and gathering areas of migrant and seasonal farmworkers (MSFWs), to perform the duties described at §§653.107(b) (outreach staff), 653.108(o) and (q) (State Monitor Advocates), 658.602(n) (National Monitor Advocates and National Monitor Advocate staff), and 658.603(p) (Regional Monitor Advocates). Monitor Advocates or outreach staff must keep records of each such visit.

Governor means the chief executive of a State or an outlying area.

Hearing Officer means a Department Administrative Law Judge, designated to preside at Department administrative hearings.

Individual with a disability means an individual with a disability as defined in sec. 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

Interstate clearance order means an agricultural clearance order for temporary employment (employment on a less than year-round basis) describing one or more hard-to-fill job openings, which an ES office uses to request recruitment assistance from other ES offices in a different State.

Intrastate clearance order means an agricultural clearance order for temporary employment (employment on a less than year-round basis) describing one or more hard-to-fill job openings, which an ES office uses to request recruitment assistance from all other ES offices within the State.

Job development means the process of securing a job interview with a public or private employer for a specific participant for whom the ES office has no suitable opening on file.

Job information means information derived from data compiled in the normal course of ES activities from reports, job orders, applications, and the like.

Job opening means a single job opportunity for which the ES office has on file a request to select and refer participants.

Job order means the document containing the material terms and conditions of employment relating to wages, hours, working conditions, worksite and other benefits, submitted by an employer.

Job referral means:

(1) The act of bringing to the attention of an employer a participant or group of participants who are available for specific job openings or for a potential job; and

(2) The record of such referral. ''Job referral'' means the same as ''referral to a job.''

Labor market area means an economically integrated geographic area within which individuals can reside and find employment within a reasonable distance or can readily change employment without changing their place of residence. Such an area must be identified in accordance with criteria used by the Department's Bureau of Labor Statistics in defining such areas or similar criteria established by a Governor.

Joint employer means where two or more employers each have sufficient definitional indicia of being an employer of a worker as defined in this section, they are, at all times, joint employers of that worker. An employer that submits a job order to the ES clearance system as a joint employer, is a joint employer of any worker placed and employed on the job order during the period of employment anticipated, amended, or otherwise extended in accordance with the order.

Local Workforce Development Board or *Local WDB* means a Local Workforce Development Board established under sec. 107 of WIOA.

Migrant farmworker means a seasonal farmworker (as defined in this section) who travels to the job site so that the farmworker is not reasonably able to return to their permanent residence within the same day.

MSFW means a migrant farmworker or a seasonal farmworker.

Non-criteria clearance order means a clearance order that is not attached to an application for foreign temporary agricultural workers pursuant to part 655, subpart B, of this chapter.

*Occupational Information Network (O*NET)* means the online reference database which contains detailed descriptions of U.S. occupations, distinguishing characteristics, classification codes, and information on tasks, knowledge, skills, abilities, and work activities as well as information on interests, work styles, and work values.

One-stop center means a physical center within the one-stop delivery system, as described in sec. 121(e)(2)(A) of WIOA.

One-stop delivery system means a one-stop delivery system described in sec. 121(e) of WIOA.

One-stop partner means an entity described in sec. 121(b) of WIOA and § 678.400 of this chapter that is participating in the operation of a one-stop delivery system.

*O*NET–SOC* means the occupational codes and titles used in the O*NET system, based on and grounded in the Standard Occupational Classification (SOC), which are the titles and codes utilized by Federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, and disseminating data. The SOC system is issued by the Office of Management and Budget and the Department is authorized to develop additional detailed O*NET occupations within existing SOC categories. The Department uses O*NET–SOC titles and codes for the purposes of collecting descriptive occupational information and for State reporting of data on training, credential attainment, and

placement in employment by occupation.

Onsite review means an appearance by the State Monitor Advocate and/or Federal staff at an ES office to monitor the delivery of services and protections afforded by ES regulations to MSFWs by the State Workforce Agency and local ES offices.

Order holding office means an ES office that has accepted a clearance order from an employer seeking U.S. workers to perform farmwork on a less than year-round basis through the Agricultural Recruitment System.

Outreach contact means each MSFW that receives the presentation of information, offering of assistance, or follow-up activity from outreach staff.

Outreach staff means ES staff with the responsibilities described in § 653.107(b) of this chapter. State Monitor Advocates are not considered outreach staff.

Participant means a reportable individual who has received services other than the services described in § 677.150(a)(3) of this chapter, after satisfying all applicable programmatic requirements for the provision of services, such as eligibility determination. (*See* § 677.150(a) of this chapter.)

(1) The following individuals are not participants, subject to § 677.150(a)(3)(ii) and (iii) of this chapter:

(i) Individuals who only use the self-service system; and

(ii) Individuals who receive information-only services or activities.

(2) ES participants must be included in the program's performance calculations.

Placement means the hiring by a public or private employer of an individual referred by the ES office for a job or an interview, provided that the ES office completed all the following steps:

(1) Prepared a job order form prior to referral, except in the case of a job development contact on behalf of a specific participant;

(2) Made prior arrangements with the employer for the referral of an individual or individuals;

(3) Referred an individual who had not been specifically designated by the employer, except for referrals on agricultural job orders for a specific crew leader or worker;

(4) Verified from a reliable source, preferably the employer, that the individual had entered on a job; and

(5) Appropriately recorded the placement.

Public housing means housing operated by or on behalf of any public agency.

Regional Administrator (RA) means the chief Department of Labor Employment and Training Administration (ETA) official in each Department regional office.

Reportable individual means an individual who has taken action that demonstrates an intent to use ES services and who meets specific reporting criteria of the Wagner-Peyser Act (*see* § 677.150(b) of this chapter), including:

(1) Individuals who provide identifying information;

(2) Individuals who only use the self-service system; or

(3) Individuals who only receive information-only services or activities.

Respondent means the individual or entity alleged to have committed the violation described in the complaint, such as the employer, service provider, or State agency.

Seasonal farmworker means an individual who is employed, or was employed in the past 12 months, in farmwork (as defined in this section) of a seasonal or other temporary nature and is not required to be absent overnight from their permanent place of residence. Labor is performed on a seasonal basis where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year. Workers who move from one seasonal activity to another, while employed in farmwork, are employed on a seasonal basis even though they may continue to be employed during a major portion of the year. Workers are employed on a temporary basis where they are employed for a limited time only or their performance is contemplated for a particular piece of work, usually of short duration. Generally, employment which is contemplated to continue indefinitely is not temporary.

Secretary means the Secretary of the U.S. Department of Labor or the Secretary's designee.

Significant MSFW States are those States designated by the Department and must include the 20 States with the highest estimated number of MSFWs.

Significant MSFW one-stop centers are those designated by the Department and include those ES offices where MSFWs account for 10 percent or more of annual participants or reportable individuals in ES and those local ES offices that the OWI Administrator determines must be included due to special circumstances such as an estimated large number of MSFWs in the service area. In no event may the number of significant MSFW one-stop centers be less than 100 centers on a nationwide basis.

Solicitor means the chief legal officer of the U.S. Department of Labor or the Solicitor's designee.

Standard Metropolitan Statistical Area (SMSA) means a metropolitan area designated by the Bureau of Census which contains:

(1) At least 1city of 50,000 inhabitants or more; or

(2) Twin cities with a combined population of at least 50,000.

State means any of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

State Administrator means the chief official of the SWA.

State agency or *State Workforce Agency (SWA)* means the State ES agency designated under sec. 4 of the Wagner-Peyser Act.

State hearing official means a State official designated to preside at State administrative hearings convened to resolve complaints involving ES regulations pursuant to subpart E of part 658 of this chapter.

State Workforce Agency (SWA) official means an individual employed by the State Workforce Agency or any of its subdivisions.

State Workforce Development Board or *State WDB* means the entity within a State appointed by the Governor under sec. 101 of WIOA.

Successor in interest—The following factors, including those as used under Title VII of the Civil Rights Act and the Vietnam Era Veterans' Readjustment Assistance Act, may be considered in determining whether an employer, agent, or farm labor contractor is a successor in interest; however, these factors are not exhaustive, and no one factor is dispositive, but all of the circumstances will be considered as a whole:

(1) Substantial continuity of the same business operations;

(2) Use of the same facilities;

(3) Continuity of the work force;

(4) Similarity of jobs and working conditions;

(5) Similarity of supervisory personnel;

(6) Whether the former management or owner retains a direct or indirect interest in the new enterprise;

(7) Similarity in machinery, equipment, and production methods;

(8) Similarity of products and services;

(9) The ability of the predecessor to provide relief; and

(10) For purposes of discontinuation of services, the involvement of the firm's ownership, management, supervisors, and others associated with the firm in the violation(s) at issue.

Supply State(s) means a State that potentially has U.S. workers who may be recruited for referral through the Agricultural Recruitment System to the area of intended employment in a different State.

Supportive services means services that are necessary to enable an individual to participate in activities authorized under WIOA or the Wagner-Peyser Act. These services may include, but are not limited to, the following:

(1) Linkages to community services;

(2) Assistance with transportation;

(3) Assistance with child care and dependent care;

(4) Assistance with housing;

(5) Needs-related payments;

(6) Assistance with educational testing;

(7) Reasonable accommodations for individuals with disabilities;

(8) Referrals to health care;

(9) Assistance with uniforms or other appropriate work attire and work-related tools, including such items as eyeglasses and protective eye gear;

(10) Assistance with books, fees, school supplies, and other necessary items for students enrolled in postsecondary education classes; and

(11) Payments and fees for employment and training-related applications, tests, and certifications.

Tests means a standardized method of measuring an individual's possession of, interest in, or ability to acquire, job skills and knowledge. Use of tests by one-stop staff must be in accordance with the provisions of:

(1) Title 41 CFR part 60–3, Uniform Guidelines on Employee Selection Procedures;

(2) Title 29 CFR part 1627, Records To Be Made or Kept Relating to Age; Notices To Be Posted; Administrative Exemptions; and

(3) The Department of Labor's regulations on Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance, which have been published as 29 CFR part 32.

Training services means services described in sec. 134(c)(3) of WIOA.

Unemployment insurance claimant means a person who files a claim for benefits under any State or Federal unemployment compensation law.

Veteran means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable, as defined under 38 U.S.C. 101 and sec. 3(63)(A) of WIOA.

Wagner-Peyser Act Employment Service (ES) also known as Employment Service (ES) means the national system of public ES offices described under the Wagner-Peyser Act. ES services are delivered through a nationwide system of one-stop centers, managed by SWAs and the various local offices of the SWAs, and funded by the United States Department of Labor.

Week means 7 consecutive calendar days.

WIOA means the Workforce Innovation and Opportunity Act (codified at 29 U.S.C. 3101 *et seq.*).

Workforce and Labor Market Information (WLMI) means the body of knowledge that describes the relationship between labor demand and supply. This includes identification and analysis of the socio-economic factors that influence employment, training, and business decisions, such as worker preparation, educational program offerings and related policy decisions within national, State, Substate, and local labor market areas. WLMI includes, but is not limited to:

(1) Employment numbers by occupation and industry;

(2) Unemployment numbers and rates;

(3) Short- and long-term industry and occupational employment projections;

(4) Information on business employment dynamics, including the number and nature of business establishments, and share and location of industrial production;

(5) Local employment dynamics, including business turnover rates; new hires, job separations, net job losses;

(6) Job vacancy counts;

(7) Job seeker and job posting data from the public labor exchange system;

(8) Identification of high growth and high demand industries, occupations, and jobs;

(9) Information on employment and earnings for wage and salary workers and for the self-employed;

(10) Information on work hours, benefits, unionization, trade disputes, conditions of employment, and retirement;

(11) Information on occupation-specific requirements regarding education, training, skills, knowledge, and experience;

WLMI also may include, as either source data or as outputs of analysis of source data:

(12) Population and workforce growth and decline, classified by age, sex, race, and other demographic characteristics;

(13) Identification of emerging occupations and evolving skill demands;

(14) Business skill and hiring requirements;

(15) Workforce characteristics, which may include skills, experience, education, credential attainment, competencies, etc.;

(16) Workforce available in geographic areas;

(17) Information on regional and local economic development activity, including job creation through business start-ups and expansions;

(18) Enrollments in and completers from educational programs, training and registered apprenticeship;

(19) Trends in industrial and occupational restructuring;

(20) Shifts in consumer demands;

(21) Data contained in governmental or administrative reporting including wage records as identified in § 652.301 of this chapter;

(22) Labor market intelligence gained from interaction with businesses, industry or trade associations, education agencies, government entities, and the public; and

(23) Other economic factors.

Workforce and Labor Market Information System (WLMIS) means the system that collects, analyzes, interprets, and disseminates workforce characteristics and employment-related data, statistics, and information at national, State, and local labor market areas and makes that information available to the public, workforce development system, one-stop partner programs, and the education and economic development communities.

Workforce development activity means an activity carried out through a workforce development program as defined in sec. 3 of WIOA.

Working days or *business days* means those days that the order-holding ES office is open for public business, for purposes of the Agricultural Recruitment System.

Work test means activities designed to ensure that an individual whom a State determines to be eligible for unemployment insurance benefits is able to work, available for work, and actively seeking work in accordance with the State's unemployment compensation law.

[81 FR 56333, Aug. 19, 2016, as amended at 85 FR 625, Jan. 6, 2020; 88 FR 82723, Nov. 24, 2023; 89 FR 14582, Feb. 28, 2024; 89 FR 34058, Apr. 29, 2024]

PART 652—ESTABLISHMENT AND FUNCTIONING OF STATE EMPLOYMENT SERVICE

Subpart A—Employment Service Operations

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AUTHORITY: 29 U.S.C. chapter 4B; 38 U.S.C. chapters 41 and 42; Secs. 189 and 503, Public Law 113–128, 128 Stat. 1425 (Jul. 22, 2014).

SOURCE: 81 FR 56337, Aug. 19, 2016, unless otherwise noted.

Subpart A—Employment Service Operations

§ 652.1 Introduction.

These regulations implement the provisions of the Wagner-Peyser Act, known hereafter as the Wagner-Peyser Act, as amended by title III of the Workforce Innovation and Opportunity Act (WIOA), Public Law 113–128. The Wagner-Peyser Act Employment Service (ES) is a core program under the WIOA, and an integral component of the one-stop delivery system. Congress intended that the States exercise broad authority in implementing provisions of the Wagner-Peyser Act.

§ 652.2 Scope and purpose of the Wagner-Peyser Act Employment Service.

The basic purpose of the ES is to improve the functioning of the nation's labor markets by bringing together individuals who are seeking employment and employers who are seeking workers.

§ 652.3 Public labor exchange services system.

At a minimum, each State must administer a labor exchange system which has the capacity, to:

(a) Assist job seekers in finding employment, including promoting their familiarity with the Department's electronic tools;

(b) Assist employers in filling jobs;

(c) Facilitate the match between job seekers and employers;

(d) Participate in a system for clearing labor among the States, including the use of standardized classification systems issued by the Secretary, under sec. 15 of the Wagner-Peyser Act;

(e) Meet the work test requirements of the State unemployment compensation system; and

(f) Provide labor exchange services as identified in § 678.430(a) of this chapter, sec. 7(a) of the Wagner-Peyser Act, and sec. 134(c)(2)(A)(iv) of WIOA.

§ 652.4 Allotment of funds and grant agreement.

(a) *Allotments.* The Secretary must provide planning estimates in accordance with sec. 6(b)(5) of the Wagner-Peyser Act. Within 30 days of receipt of planning estimates from the Secretary, the State must make public the sub-State resource distributions, and describe the process and schedule under which these resources will be issued, planned, and committed. This notification must include a description of the procedures by which the public may review and comment on the sub-State distributions, including a process by which the State will resolve any complaints.

(b) *Grant agreement.* To establish a continuing relationship under the Wagner-Peyser Act, the Governor and the Secretary must sign a grant agreement, including a statement assuring that the State must comply with the Wagner-Peyser Act and all applicable rules and regulations. Consistent with this agreement and sec. 6 of the Wagner-Peyser Act, State allotments will be obligated through a notification of obligation.

§ 652.5 Services authorized.

The funds allotted to each State under sec. 6 of the Wagner-Peyser Act must be expended consistent with an approved plan under §§ 676.100 through 676.145 of this chapter and § 652.211. At a minimum, each State must provide the minimum labor exchange elements listed at § 652.3.

§§ 652.6–652.7 [Reserved]

§ 652.8 Administrative provisions.

(a) *Administrative requirements.* The Employment Security Manual is not

applicable to funds appropriated under the Wagner-Peyser Act. Except as provided for in paragraph (f) of this section, administrative requirements and cost principles applicable to grants under this part are as specified in 2 CFR parts 200 and 2900 which govern the Uniform Guidelines, cost principles, and audit requirements for Federal awards.

(b) *Management systems, reporting, and recordkeeping.* (1) The State must ensure that a financial system provides fiscal control and accounting procedures sufficient to permit preparation of required reports, and the tracing of funds to a level of expenditure adequate to establish that funds have not been expended in violation of the restrictions on the use of such funds. (sec. 10(a) of the Wagner-Peyser Act)

(2) The financial management system and the program information system must provide Federally-required records and reports that are uniform in definition, accessible to authorized Federal and State staff, and verifiable for monitoring, reporting, audit and evaluation purposes. (sec. 10(c) of the Wagner-Peyser Act)

(c) *Reports required.* (1) Each State must make reports pursuant to instructions issued by the Secretary and in such format as the Secretary prescribes.

(2) The Secretary is authorized to monitor and investigate pursuant to sec. 10 of the Wagner-Peyser Act.

(d) *Special administrative and cost provisions.* (1) Neither the Department nor the State is a guarantor of the accuracy or truthfulness of information obtained from employers or applicants in the process of operating a labor exchange activity.

(2) Prior approval authority—as described in various sections of 29 CFR part 97, Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments, and Office of Management and Budget Circular A–87 (Revised)—is delegated to the State except that the Secretary reserves the right to require transfer of title on nonexpendable Automated Data Processing Equipment (ADPE), in accordance with provisions contained in 2 CFR parts 200 and 2900. The Secretary reserves the right to exercise prior approval authority in other areas, after providing advance notice to the State.

(3) Application for financial assistance and modification requirements must be as specified under this part.

(4) Cost of promotional and informational activities consistent with the provisions of the Wagner-Peyser Act, describing services offered by employment security agencies, job openings, labor market information, and similar items are allowable.

(5) Each State must retain basic documents for the minimum period specified below, consistent with 2 CFR parts 200 and 2900:

(i) Work application: 3 years.

(ii) Job order: 3 years.

(6) Payments from the State's Wagner-Peyser Act allotment made into a State's account in the Unemployment Trust Fund for the purpose of reducing charges against Reed Act funds (sec. 903(c) of the Social Security Act, as amended (42 U.S.C. 1103(c)) are allowable costs, provided that:

(i) The charges against Reed Act funds were for amounts appropriated, obligated, and expended for the acquisition of automatic data processing installations or for the acquisition or major renovation of State-owned office building; and

(ii) With respect to each acquisition of improvement of property pursuant to paragraph (d)(6)(i) of this section, the payments are accounted for in the State's records as credits against equivalent amounts of Reed Act funds used for administrative expenditures.

(e) *Disclosure of information.* (1) The State must assure the proper disclosure of information pursuant to sec. 3(b) of the Wagner-Peyser Act.

(2) The information specified in sec. 3(b) and other sections of the Wagner-Peyser Act, also must be provided to officers or any employee of the Federal government or of a State government lawfully charged with administration of unemployment compensation laws, ES activities under the Wagner-Peyser Act or other related legislation, but only for purposes reasonably necessary for the proper administration of such laws.

(f) *Audits.* (1) The State must follow the audit requirements found at

§ 683.210 of this chapter, except that funds expended pursuant to sec. 7(b) of the Wagner-Peyser Act must be audited annually.

(2) The Comptroller General and the Inspector General of the Department have the authority to conduct audits, evaluations or investigations necessary to meet their responsibilities under sec. 9(b)(1) and 9(b)(2), respectively, of the Wagner-Peyser Act.

(3) The audit, conducted pursuant to paragraph (f)(1) or (2) of this section, must be submitted to the Secretary who will follow the resolution process specified in §§ 683.420 through 683.440 of this chapter.

(g) *Sanctions for violation of the Wagner-Peyser Act.* (1) The Secretary may impose appropriate sanctions and corrective actions for violation of the Wagner-Peyser Act, regulations, or State Plan, including the following:

(i) Requiring repayment, for debts owed the government under the grant, from non-Federal funds;

(ii) Offsetting debts arising from the misexpenditure of grant funds, against amounts to which the State is or may be entitled under the Wagner-Peyser Act, provided that debts arising from gross negligence or willful misuse of funds may not be offset against future grants. When the Secretary reduces amounts allotted to the State by the amount of the misexpenditure, the debt must be fully satisfied;

(iii) Determining the amount of Federal cash maintained by the State or a subrecipient in excess of reasonable grant needs, establishing a debt for the amount of such excessive cash, and charging interest on that debt; and

(iv) Imposing other appropriate sanctions or corrective actions, except where specifically prohibited by the Wagner-Peyser Act or regulations.

(2) To impose a sanction or corrective action, the Secretary must utilize the initial and final determination procedures outlined in paragraph (f)(3) of this section and specified in the administrative provisions at §§ 683.420 through 683.440 of this chapter.

(h) *Other violations.* Violations or alleged violations of the Wagner-Peyser Act, regulations, or grant terms and conditions except those pertaining to audits or discrimination must be determined and processed in accordance with part 658, subpart H, of this chapter.

(i) *Fraud and abuse.* Any persons having knowledge of fraud, criminal activity or other abuse must report such information directly and immediately to the Secretary, including all complaints involving such matters.

(j) *Nondiscrimination requirements.* States must:

(1) Assure that no individual be excluded from participation in, denied the benefits of, subjected to discrimination under, or denied employment in the administration or in connection with any services or activities authorized under the Wagner-Peyser Act in violation of any applicable nondiscrimination law. All complaints alleging discrimination must be filed and processed according to the procedures in the applicable Department of Labor nondiscrimination regulations.

(2) Assure that discriminatory job orders will not be accepted, except where the stated requirement is a bona fide occupational qualification (BFOQ). *See generally* 42 U.S.C. 2000e–2(e) and 29 CFR parts 1604, 1605, 1606, and 1625.

(3) Assure that ES offices are in compliance with the veteran referral and job listing requirements at 41 CFR 60–300.84.

(4) Assure that employment testing programs will comply with 41 CFR part 60–3 and 29 CFR part 32 and 29 CFR 1627.3(b)(1)(iv).

(5) Nondiscrimination and equal opportunity requirements and procedures, including complaint processing and compliance reviews, will be governed by the applicable Department of Labor nondiscrimination regulations.

[81 FR 56337, Aug. 19, 2016, as amended at 88 FR 82725, Nov. 24, 2023]

§ 652.9 Labor disputes.

(a) State agencies may not make a job referral on job orders which will aid directly or indirectly in the filling of a job opening which is vacant because the former occupant is on strike, or is being locked out in the course of a labor dispute, or the filling of which is otherwise an issue in a labor dispute involving a work stoppage.

(b) Written notification must be provided to all applicants referred to jobs

not at issue in the labor dispute that a labor dispute exists in the employing establishment and that the job to which the applicant is being referred is not at issue in the dispute.

(c) When a job order is received from an employer reportedly involved in a labor dispute involving a work stoppage, State agencies must:

(1) Verify the existence of the labor dispute and determine its significance with respect to each vacancy involved in the job order; and

(2) Notify all potentially affected staff concerning the labor dispute.

(d) State agencies must resume full referral services when they have been notified of, and verified with the employer and workers' representative(s), that the labor dispute has been terminated.

(e) State agencies must notify the regional office in writing of the existence of labor disputes which:

(1) Result in a work stoppage at an establishment involving a significant number of workers; or

(2) Involve multi-establishment employers with other establishments outside the reporting State.

§ 652.10 Severability.

Should a court hold any portion of any provision of this part to be invalid, the provision will be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding is one of total invalidity or unenforceability, in which event the provision or subprovision will be severable from this part and will not affect the remainder thereof.

[88 FR 82725, Nov. 24, 2023]

Subpart B—Services for Veterans

§ 652.100 Services for veterans.

Veterans receive priority of service for all Department-funded employment and training programs as described in 20 CFR part 1010. The Department's Veterans' Employment and Training Service (VETS) administers the Jobs for Veterans State Grants (JVSG) program under chapter 41 of title 38 of the U.S. Code and other activities and training programs which provide services to specific populations of eligible veterans. VETS' general regulations are located in parts 1001, 1002, and 1010 of this title.

Subpart C—Employment Service Services in a One-Stop Delivery System Environment

§ 652.200 What is the purpose of this subpart?

(a) This subpart provides guidance to States to implement the services provided under the Wagner-Peyser Act, as amended by WIOA, in a one-stop delivery system environment.

(b) Except as otherwise provided, the definitions contained in part 651 of this chapter and sec. 2 of the Wagner-Peyser Act apply to this subpart.

§ 652.201 What is the role of the State Workforce Agency in the one-stop delivery system?

(a) The role of the State Workforce Agency (SWA) in the one-stop delivery system is to ensure the delivery of services authorized under sec. 7(a) of the Wagner-Peyser Act. The SWA is a required one-stop partner in each local one-stop delivery system and is subject to the provisions relating to such partners that are described at part 678 of this chapter.

(b) Consistent with those provisions, the State agency must:

(1) Participate in the one-stop delivery system in accordance with sec. 7(e) of the Wagner-Peyser Act;

(2) Be represented on the Workforce Development Boards (WDBs) that oversee the local and State one-stop delivery system and be a party to the Memorandum of Understanding, described at §678.500 of this chapter, addressing the operation of the one-stop delivery system; and

(3) Provide these services as part of the one-stop delivery system.

§ 652.202 May local Employment Service offices exist outside of the one-stop delivery system?

No. Local ES offices may not exist outside of the one-stop service delivery system. A State must colocate ES, as provided in §§678.310 through 678.315 of this chapter.

§ 652.203 Who is responsible for funds authorized under the Wagner-Peyser Act in the workforce development system?

The SWA retains responsibility for all funds authorized under the Wagner-Peyser Act, including those funds authorized under sec. 7(a) required for providing the services and activities delivered as part of the one-stop delivery system.

§ 652.204 Must funds authorized under the Wagner-Peyser Act Governor's Reserve flow through the one-stop delivery system?

No, sec. 7(b) of the Wagner-Peyser Act provides that 10 percent of the State's allotment under the Wagner-Peyser Act is reserved for use by the Governor for performance incentives, supporting exemplary models of service delivery, professional development and career advancement of SWA officials as applicable, and services for groups with special needs. However, these funds may flow through the one-stop delivery system.

[81 FR 56337, Aug. 19, 2016, as amended at 85 FR 626, Jan. 6, 2020; 88 FR 82725, Nov. 24, 2023]

§ 652.205 May funds authorized under the Wagner-Peyser Act be used to supplement funding for labor exchange programs authorized under separate legislation?

(a) Section 7(c) of the Wagner-Peyser Act enables States to use funds authorized under sec. 7(a) or 7(b) of the Wagner-Peyser Act to supplement funding of any workforce activity carried out under WIOA.

(b) Funds authorized under the Wagner-Peyser Act may be used under sec. 7(c) to provide additional funding to other activities authorized under WIOA if:

(1) The activity meets the requirements of the Wagner-Peyser Act, and its own requirements;

(2) The activity serves the same individuals as are served under the Wagner-Peyser Act;

(3) The activity provides services that are coordinated with ES services; and

(4) The funds supplement, rather than supplant, funds provided from non-Federal sources.

[81 FR 56337, Aug. 19, 2016, as amended at 88 FR 82725, Nov. 24, 2023]

§ 652.206 May a State use funds authorized under the Wagner-Peyser Act to provide applicable "career services," as defined in the Workforce Innovation and Opportunity Act?

Yes, funds authorized under sec. 7(a) of the Wagner-Peyser Act must be used to provide basic career services as identified in §678.430(a) of this chapter and secs. 134(c)(2)(A)(i)–(xi) of WIOA, and may be used to provide individualized career services as identified in §678.430(b) of this chapter and sec. 134(c)(2)(A)(xii) of WIOA. Funds authorized under sec. 7(b) of the Wagner-Peyser Act may be used to provide career services. Career services must be provided consistent with the requirements of the Wagner-Peyser Act.

§ 652.207 How does a State meet the requirement for universal access to Employment Service services?

(a) A State has discretion in how it meets the requirement for universal access to ES services. In exercising this discretion, a State must meet the Wagner-Peyser Act's requirements.

(b) These requirements are:

(1) Labor exchange services must be available to all employers and job seekers, including unemployment insurance (UI) claimants, veterans, migrant and seasonal farmworkers, and individuals with disabilities;

(2) The State must have the capacity to deliver labor exchange services to employers and job seekers, as described in the Wagner-Peyser Act, on a statewide basis through:

(i) Self-service, including virtual services;

(ii) Facilitated self-help service; and

(iii) Staff-assisted service;

(3) In each local area, in at least one comprehensive physical center, ES staff must provide labor exchange services (including staff-assisted labor exchange services) and career services as described in §652.206; and

(4) Those labor exchange services provided under the Wagner-Peyser Act in a local area must be described in the

Memorandum of Understanding (MOU) described in § 678.500 of this chapter.

[81 FR 56337, Aug. 19, 2016, as amended at 85 FR 626, Jan. 6, 2020; 88 FR 82726, Nov. 24, 2023]

§ 652.208 How are applicable career services related to the methods of service delivery described in in this part?

Career services may be delivered through any of the applicable three methods of service delivery described in § 652.207(b)(2). These methods are:

(a) Self-service, including virtual services;

(b) Facilitated self-help service; and

(c) Staff-assisted service.

§ 652.209 What are the requirements under the Wagner-Peyser Act for providing reemployment services and other activities to referred unemployment insurance claimants?

(a) In accordance with sec. 3(c)(3) of the Wagner-Peyser Act, the SWA, as part of the one-stop delivery system, must provide reemployment services to UI claimants for whom such services are required as a condition for receipt of UI benefits. Services must be appropriate to the needs of UI claimants who are referred to reemployment services under any Federal or State UI law.

(b) The SWA also must provide other activities, including:

(1) Coordination of labor exchange services with the provision of UI eligibility services as required by sec. 5(b)(2) of the Wagner-Peyser Act;

(2) Administration of the work test, conducting eligibility assessments, and registering UI claimants for employment services in accordance with a State's unemployment compensation law, and provision of job finding and placement services as required by sec. 3(c)(3) and described in sec. 7(a)(3)(F) of the Wagner-Peyser Act; and

(3) Referring UI claimants to, and providing application assistance for, training and education resources and programs, including Federal Pell grants and other student assistance under title IV of the Higher Education Act, the Montgomery GI Bill, Post–9/11 GI Bill, and other Veterans Educational Assistance, training provided for youth, and adult and dislocated workers, as well as other employment training programs under WIOA, and for Vocational Rehabilitation Services under title I of the Rehabilitation Act of 1973.

§ 652.210 What are the Wagner-Peyser Act's requirements for administration of the work test, including eligibility assessments, as appropriate, and assistance to unemployment insurance claimants?

(a) State UI law or rules establish the requirements under which UI claimants must register and search for work in order to fulfill the UI work test requirements.

(b) ES staff must assure that:

(1) UI claimants receive the full range of labor exchange services available under the Wagner-Peyser Act that are necessary and appropriate to facilitate their earliest return to work, including career services specified in § 652.206 and listed in sec. 134(c)(2)A) of WIOA;

(2) UI claimants requiring assistance in seeking work receive the necessary guidance and counseling to ensure they make a meaningful and realistic work search; and

(3) ES staff will provide UI program staff with information about UI claimants' ability or availability for work, or the suitability of work offered to them.

[81 FR 56337, Aug. 19, 2016, as amended at 85 FR 626, Jan. 6, 2020]

§ 652.211 What are State planning requirements under the Wagner-Peyser Act?

The ES is a core program identified in WIOA and must be included as part of each State's Unified or Combined State Plans. See §§ 676.105 through 676.125 of this chapter for planning requirements for the core programs.

§ 652.215 What staffing models must be used to deliver services in the Employment Service?

(a) Except as provided in paragraph (b) of this section, the Secretary requires that States deliver the labor exchange services described in § 652.3 using State merit-staff employees employed according to the merit-system principles described in 5 CFR part 900, subpart F—Standards for a Merit System of Personnel Administration. This

requirement also applies to the provision of services and activities under parts 653 and 658 of this chapter.

(b) States authorized prior to February 5, 2020, to use a staffing model other than that described in paragraph (a) of this section to deliver ES services may use the staffing model consistent with the model previously authorized for the State. These States may use merit-staffing flexibility only to the same extent that the Department had authorized it prior to February 5, 2020.

(c) States using staffing models under paragraph (b) of this section are required to participate in evaluations of their delivery of ES services conducted by the Department.

(d) All States must comply with the requirements in this section no later than January 22, 2026.

[88 FR 82726, Nov. 24, 2023]

§ 652.216 May the one-stop operator provide guidance to Employment Service staff in accordance with the Wagner-Peyser Act?

(a) Yes, the one-stop delivery system envisions a partnership in which Wagner-Peyser Act labor exchange services are coordinated with other activities provided by other partners in a one-stop setting. As part of the local MOU described in §678.500 of this chapter, the SWA, as a one-stop partner, may agree to have ES staff receive guidance from the one-stop operator regarding the provision of labor exchange services.

(b) The guidance given to ES staff must be consistent with the provisions of the Wagner-Peyser Act, the local MOU, and applicable collective bargaining agreements.

[85 FR 626, Jan. 6, 2020]

Subpart D—Workforce and Labor Market Information

§ 652.300 What role does the Secretary of Labor have concerning the Workforce and Labor Market Information System?

(a) The Secretary of Labor must oversee the development, maintenance, and continuous improvement of the workforce and labor market information system defined in Wagner-Peyser Act sec. 15 and §651.10 of this chapter. The Department also will identify parameters of continuous improvement. The Secretary will consult with the Workforce Information Advisory Council on these matters and consider the council's recommendations.

(b) With respect to data collection, analysis, and dissemination of workforce and labor market information as defined in Wagner-Peyser Act sec. 15 and §651.10 of this chapter, the Secretary must:

(1) Assign responsibilities within the Department of Labor for elements of the workforce and labor market information system described in sec. 15(a) of the Wagner-Peyser Act to ensure that the statistical and administrative data collected are consistent with appropriate Bureau of Labor Statistics standards and definitions, and that the information is accessible and understandable to users of such data;

(2) Actively seek the cooperation of heads of other Federal agencies to establish and maintain mechanisms for ensuring complementarity and non-duplication in the development and operation of statistical and administrative data collection activities;

(3) Solicit, receive, and evaluate the recommendations of the Workforce Information Advisory Council established by Wagner-Peyser Act sec. 15(d);

(4) Eliminate gaps and duplication in statistical undertakings;

(5) Through the Bureau of Labor Statistics and the Employment and Training Administration, and in collaboration with States, develop and maintain the elements of the workforce and labor market information system, including the development of consistent procedures and definitions for use by States in collecting and reporting the workforce and labor market information data described in Wagner-Peyser Act sec. 15 and defined in §651.10 of this chapter;

(6) Establish procedures for the system to ensure that the data and information are timely, and paperwork and reporting for the system are reduced to a minimum; and

(7) Prepare a 2-year plan for the workforce and labor market information system, as described in the Wagner-Peyser Act sec. 15(c), as amended by WIOA sec. 308(d).

§ 652.301 What are wage records for purposes of the Wagner-Peyser Act?

Wage records, for purposes of the Wagner-Peyser Act, are records that contain ''wage information'' as defined in § 603.2(k) of this chapter. In this part, ''State wage records'' refers to wage records produced or maintained by a State.

§ 652.302 How do the Secretary of Labor's responsibilities described in this part apply to State wage records?

(a) A significant portion of the workforce and labor market information—defined in § 651.10 of this chapter—are developed using State wage records.

(b) Based on the Secretary of Labor's responsibilities described in Wagner-Peyser Act sec. 15 and § 652.300, the Secretary of Labor will, in consultation with Federal agencies, and States, and considering recommendations from the Workforce Information Advisory Council described in Wagner-Peyser Act sec. 15(d), develop:

(1) Standardized definitions for the data elements comprising ''wage records'' as defined in § 652.301; and

(2) Improved processes and systems for the collection and reporting of wage records.

(c) In carrying out these activities, the Secretary also may consult with other stakeholders, such as employers.

§ 652.303 How do the requirements of part 603 of this chapter apply to wage records?

All information collected by the State in wage records referred to in § 652.302 is subject to the confidentiality regulations at part 603 of this chapter.

PART 653—SERVICES OF THE WAGNER-PEYSER ACT EMPLOYMENT SERVICE SYSTEM

Subpart A [Reserved]

Subpart B—Services for Migrant and Seasonal Farmworkers (MSFWs)

Sec.

653.100 Purpose and scope of subpart.
653.101 Provision of services to migrant and seasonal farmworkers.
653.102 Job information.
653.103 Process for migrant and seasonal farmworkers to participate in workforce development activities.
653.104–653.106 [Reserved]
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Subparts C–E [Reserved]

Subpart F—Agricultural Recruitment System for U.S. Workers (ARS)

653.500 Purpose and scope of subpart.
653.501 Requirements for processing clearance orders.
653.502 Conditional access to the Agricultural Recruitment System.
653.503 Field checks.
653.504 Severability.

AUTHORITY: Secs. 167, 189, 503, Public Law 113–128, 128 Stat. 1425 (Jul. 22, 2014); 29 U.S.C. chapter 4B; 38 U.S.C. part III, chapters 41 and 42.

SOURCE: 81 FR 56341, Aug. 19, 2016, unless otherwise noted.

Subpart A [Reserved]

Subpart B—Services for Migrant and Seasonal Farmworkers (MSFWs)

§ 653.100 Purpose and scope of subpart.

(a) This subpart sets forth the principal regulations of the Wagner-Peyser Act Employment Service (ES) concerning the provision of services for MSFWs consistent with the requirement that all services of the workforce development system be available to all job seekers in an equitable and nondiscriminatory fashion. This includes ensuring MSFWs have access to these services in a way that meets their unique needs. MSFWs must receive

services on a basis which is qualitatively equivalent and quantitatively proportionate to services provided to non-MSFWs.

(b) This subpart contains requirements that State Workforce Agencies (SWAs) establish a system to monitor their own compliance with ES regulations governing services to MSFWs.

(c) Established under this subpart are special services to ensure MSFWs receive the full range of career services as defined in WIOA sec. 134(c)(2).

[81 FR 56341, Aug. 19, 2016, as amended at 88 FR 82726, Nov. 24, 2023]

§ 653.101 Provision of services to migrant and seasonal farmworkers.

SWAs must ensure that ES staff at one-stop centers offer MSFWs the full range of career and supportive services, benefits and protections, and job and training referral services as are provided to non-MSFWs. SWAs must ensure ES staff at the one-stop centers tailor such ES services in a way that accounts for individual MSFW preferences, needs, skills, and the availability of job and training opportunities, so that MSFWs are reasonably able to participate in the ES.

[88 FR 82726, Nov. 24, 2023]

§ 653.102 Job information.

All SWAs must make job order information conspicuous and available to MSFWs by all reasonable means. Such information must, at minimum, be available through internet labor exchange systems and through the one-stop centers. SWAs must ensure ES staff at one-stop centers provide assistance to MSFWs to access job order information easily and efficiently.

[81 FR 56341, Aug. 19, 2016, as amended at 85 FR 626, Jan. 6, 2020; 88 FR 82726, Nov. 24, 2023]

§ 653.103 Process for migrant and seasonal farmworkers to participate in workforce development activities.

(a) Each ES office must determine whether participants and reportable individuals are MSFWs as defined at § 651.10 of this chapter.

(b) SWAs must comply with the language access and assistance requirements at 29 CFR 38.9 with regard to all individuals with limited English proficiency (LEP), including MSFWs who are limited English proficient individuals, as defined at 29 CFR 38.4(hh). This includes ensuring ES staff comply with these language access and assistance requirements.

(c) One-stop centers must provide MSFWs a list of available career and supportive services.

(d) One-stop centers must refer and/or register MSFWs for services, as appropriate, if the MSFW is interested in obtaining such services.

[81 FR 56341, Aug. 19, 2016, as amended at 85 FR 626, Jan. 6, 2020; 88 FR 82726, Nov. 24, 2023]

§§ 653.104–653.106 [Reserved]

§ 653.107 Outreach and Agricultural Outreach Plan.

(a) *State Workforce Agency (SWA) outreach responsibilities.* (1) Each SWA must ensure outreach staff conduct outreach as described in paragraph (b) of this section on an ongoing basis. State Administrators must ensure State Monitor Advocates (SMAs) and outreach staff coordinate activities with WIOA title I sec. 167 grantees as well as with public and private community service agencies and MSFW groups. WIOA title I sec. 167 grantees' activities involving MSFWs does not substitute for SWA outreach responsibilities.

(2) As part of their outreach, SWAs must ensure outreach staff:

(i) Communicate the full range of workforce development services to MSFWs; and

(ii) Conduct thorough outreach efforts with extensive follow-up activities identified at paragraph (b)(5) of this section.

(3) When hiring or assigning outreach staff, SWAs must ensure hiring officials:

(i) Seek and put a strong emphasis on hiring and assigning qualified candidates who speak the language of a significant proportion of the State MSFW population; and

(A) Who are from MSFW backgrounds; or

(B) Who have substantial work experience in farmworker activities.

(ii) Inform farmworker organizations and other organizations with expertise concerning MSFWs of job openings and

encourage them to refer qualified applicants to apply.

(4) Each SWA must ensure that there are an adequate number of outreach staff employed in the State to conduct MSFW outreach in each service area of the State and to contact a majority of MSFWs in the State annually. In the 20 States with the highest estimated year-round MSFW activity, as identified by the Department, there must be full-time, year-round outreach staff to conduct outreach duties. Full-time means each individual outreach staff person must spend 100 percent of their time on the outreach responsibilities described in paragraph (b) of this section. For the remainder of the States, there must be year-round part-time outreach staff, and during periods of the highest MSFW activity, there must be full-time outreach staff. These staffing levels must align with and be supported by information about the estimated number of farmworkers in the State and the farmworker activity in the State as demonstrated in the State's Agricultural Outreach Plan (AOP) pursuant to paragraph (d) of this section. All outreach staff must be multilingual, if warranted by the characteristics of the MSFW population in the State, and must spend a majority of their time in the field.

(5) The SWA must publicize the availability of ES services through such means as newspaper and electronic media publicity. Contacts with public and private community agencies, employers and/or employer organizations, and MSFW groups also must be utilized to facilitate the widest possible distribution of information concerning employment services.

(6) SWAs must ensure each outreach staff member is provided with an identification card or other materials identifying them as representatives of the State.

(b) *Outreach staff responsibilities.* Outreach staff must locate and contact MSFWs who are not being reached by the normal intake activities conducted by the ES offices. Outreach staff responsibilities include the activities identified in paragraphs (b)(1) through (11) of this section.

(1) Outreach staff must explain to MSFWs at their working, living, or gathering areas (including day-haul sites), by means of written and oral presentations either spontaneous or recorded, the following:

(i) The services available at the local one-stop center (which includes the availability of referrals to training, supportive services, and career services, as well as specific employment opportunities), and other related services;

(ii) Information on the Employment Service and Employment-related Law Complaint System;

(iii) Information on the other organizations serving MSFWs in the area; and

(iv) A basic summary of farmworker rights, including farmworker rights with respect to the terms and conditions of employment.

(2) Outreach staff must not enter work areas to perform outreach duties described in this section on an employer's property without permission of the employer unless otherwise authorized to enter by law; must not enter workers' living areas without the permission of the workers; and must comply with appropriate State laws regarding access.

(3) After making the presentation, outreach staff must urge the MSFWs to go to the local one-stop center to obtain the full range of employment and training services.

(4) If an MSFW cannot or does not wish to visit the local one-stop center, outreach staff must offer to provide onsite the following:

(i) Assistance in the preparation of applications for ES services;

(ii) Assistance in obtaining referral(s) to current and future employment opportunities;

(iii) Assistance in the preparation of either ES or employment-related law complaints;

(iv) Referral of complaints to the ES office Complaint System Representative or ES Office Manager;

(v) Referral to supportive services and/or career services in which the individual or a family member may be interested; and

(vi) As needed, assistance in making appointments and arranging transportation for individual MSFW(s) or members of their family to and from local one-stop centers or other appropriate agencies.

(5) Outreach staff must make follow-up contacts as necessary and appropriate to provide the assistance specified in paragraphs (b)(1) through (4) of this section.

(6) Outreach staff must be alert to observe the working and living conditions of MSFWs and if an outreach staff member observes or receives information about apparent violations, the outreach staff member must document and refer the information to the appropriate ES Office Manager (as described in § 658.419 of this chapter).

(7) Outreach staff must be trained in one-stop center procedures and in the services, benefits, and protections afforded MSFWs by the ES, including training on protecting farmworkers against sexual harassment, sexual coercion, assault, and human trafficking. Such trainings are intended to help outreach staff identify when such issues may be occurring in the fields and how to document and refer the cases to the appropriate enforcement agencies. Outreach staff also must be trained in the Complaint System procedures at part 658, subpart E, of this chapter and be aware of the local, State, regional, and national enforcement agencies that would be appropriate to receive referrals. The program for such training must be formulated by the State Administrator, pursuant to uniform guidelines developed by ETA. The SMA must be given an opportunity to review and comment on the State's program.

(8) Outreach staff must maintain complete records of their contacts with MSFWs and the services they perform. These records must include a daily log, a copy of which must be sent monthly to the ES Office Manager and maintained on file for at least 3 years. These records must include the number of contacts, the names of contacts (if available), and the services provided (e.g., whether a complaint was received and if the complaint or apparent violation was resolved informally or referred to the appropriate enforcement agency, and whether a request for career services was received). Outreach staff also must maintain records of each possible violation or complaint of which they have knowledge, and their actions in ascertaining the facts and referring the matters as provided herein. These records must include a description of the circumstances and names of any employers who have refused outreach staff access to MSFWs pursuant to paragraph (b)(2) of this section.

(9) Outreach staff must not engage in political, unionization, or anti-unionization activities during the performance of their duties.

(10) Outreach staff must be provided with, carry, and display, upon request, identification cards or other material identifying them as representatives of the State.

(11) Outreach staff in significant MSFW one-stop centers must conduct especially vigorous outreach in their service areas. Outreach activities must align with and be supported by information provided in the State's AOP pursuant to paragraph (d) of this section.

(c) *ES office outreach responsibilities.* Each ES Office Manager must file with the SMA a monthly summary report of outreach efforts. These reports must summarize information collected, pursuant to paragraph (b)(8) of this section. The ES Office Manager and/or other appropriate staff must assess the performance of outreach staff by examining the overall quality and productivity of their work, including the services provided and the methods and tools used to offer services. Performance must not be judged solely by the number of contacts made by the outreach staff. The monthly reports and daily outreach logs must be made available to the SMA and Federal onsite review teams.

(d) *State Agricultural Outreach Plan (AOP).* (1) Each SWA must develop an AOP every 4 years as part of the Unified or Combined State Plans required under sec. 102 or 103 of WIOA.

(2) The AOP must:

(i) Provide an assessment of the unique needs of MSFWs in the area based on past and projected agricultural and MSFW activity in the State;

(ii) Explain the materials, tools, and resources the State will use for outreach;

(iii) Describe the SWA's proposed outreach activities to contact MSFWs

who are not being reached by the normal intake activities conducted by the one-stop centers. The description must identify the number of full-time and part-time outreach staff positions in the State and must demonstrate that there are sufficient outreach staff to conduct MSFW outreach in each service area of the State to contact a majority of MSFWs in the State annually;

(iv) Describe the activities planned for providing the full range of ES services to the agricultural community, including both MSFWs and agricultural employers, through the one-stop centers; and

(v) Include a description of how the SWA intends to provide ES staff in significant MSFW one-stop centers in accordance with § 653.111.

(3) In developing the AOP, the SWA must solicit information and suggestions from WIOA sec. 167 National Farmworker Jobs Program (NFJP) grantees, other appropriate MSFW groups, public agencies, agricultural employer organizations, and other interested organizations. In addition, at least 45 calendar days before submitting its final AOP to the Department, the SWA must provide the proposed AOP to NFJP grantees, public agencies, agricultural employer organizations, and other organizations expressing an interest and allow at least 30 calendar days for review and comment. The SWA must:

(i) Consider any comments received in formulating its final proposed AOP.

(ii) Inform all commenting parties in writing whether their comments have been incorporated and, if not, the reasons therefore.

(iii) Transmit the comments and recommendations received and its responses to the Department with the submission of the AOP. (If the comments are received after the submission of the AOP, they may be sent separately to the Department.)

(4) The AOP must be submitted in accordance with paragraph (d)(1) of this section and planning guidance issued by the Department.

(5) The Annual Summaries required at § 653.108(u) must update the Department on the SWA's progress toward meeting the objectives set forth in the AOP.

[81 FR 56341, Aug. 19, 2016, as amended at 85 FR 626, Jan. 6, 2020; 88 FR 82726, Nov. 24, 2023]

§ 653.108 State Workforce Agency and State Monitor Advocate responsibilities.

(a) State Administrators must ensure their SWAs monitor their own compliance with ES regulations in serving MSFWs on an ongoing basis. The State Administrator has overall responsibility for SWA self-monitoring. The State Administrator and ES staff must not retaliate against staff, including the SMA, for self-monitoring or raising any issues or concerns regarding noncompliance with the ES regulations.

(b) The State Administrator must appoint an SMA who must be a SWA official. The State Administrator must inform farmworker organizations and other organizations with expertise concerning MSFWs of the opening and encourage them to refer qualified applicants to apply. Among qualified candidates, the SWAs must seek and put a strong emphasis on hiring persons:

(1) Who are from MSFW backgrounds; or

(2) Who speak the language of a significant proportion of the State MSFW population; or

(3) Who have substantial work experience in farmworker activities.

(c) The SMA must be an individual who:

(1) Is a senior-level ES staff employee;

(2) Reports directly to the State Administrator or State Administrator's designee, such as a director or other appropriately titled official in the State Administrator's office, who has the authority to act on behalf of the State Administrator, except that if a designee is selected, they must not be the individual who has direct program oversight of the ES; and

(3) Has the knowledge, skills, and abilities necessary to fulfill the responsibilities as described in this subpart.

(d) The SMA must have sufficient authority, staff, resources, and access to top management to monitor compliance with the ES regulations. Staff assigned to the SMA are intended to help the SMA carry out the duties set forth

in this section and must not perform work that conflicts with any of the SMA's duties, such as outreach responsibilities required by §653.107, ARS processing under subpart F of this part, and complaint processing under subpart E of part 658. The number of ES staff positions assigned to the SMA must be determined by reference to the number of MSFWs in the State, (as measured at the time of the peak MSFW population), and the need for monitoring activity in the State.

(e) The SMA must devote full-time staffing to the SMA functions described in this section. No State may dedicate less than full-time staffing for the SMA position, unless the Regional Administrator, with input from the Regional Monitor Advocate, provides written approval. Any State that proposes less than full-time dedication must demonstrate to the Regional Administrator and Regional Monitor Advocate that all SMA functions can be effectively performed with part-time staffing. The SMA must not perform work that conflicts with any of the SMA's duties, such as outreach responsibilities required by §653.107, ARS processing under subpart F of this part, and complaint processing under subpart E of part 658.

(f) All SMAs and their staff must attend training session(s) offered by the Regional Monitor Advocate(s) and National Monitor Advocate and their staff and those necessary to maintain competency and enhance the SMA's understanding of the unique needs of farmworkers. Such trainings must include those identified by the SMA's Regional Monitor Advocate and may include those offered by the Occupational Safety and Health Administration, the Department's Wage and Hour Division, U.S. Equal Employment Opportunity Commission, the Immigrant and Employee Rights Section of the Department of Justice's Civil Rights Division, the Department's Civil Rights Center, and other organizations offering farmworker-related information.

(g) The SMA must provide any relevant documentation requested from the SWA by the Regional Monitor Advocate or the National Monitor Advocate.

(h) The SMA must:

(1) Conduct an ongoing review of the delivery of services and protections afforded by the ES regulations to MSFWs by the SWA and ES offices. This includes:

(i) Monitoring compliance with §653.111;

(ii) Monitoring the ES services that the SWA and one-stop centers provide to MSFWs to assess whether they are qualitatively equivalent and quantitatively proportionate to the services that the SWA and one-stop centers provide to non-MSFWs; and

(iii) Reviewing the appropriateness of informal resolution of complaints and apparent violations as documented in the complaint logs.

(2) Without delay, must advise the SWA and ES offices of problems, deficiencies, or improper practices in the delivery of services and protections afforded by these regulations and, if warranted, specify the corrective action(s) necessary to address these deficiencies. When the SMA finds corrective action(s) necessary, the ES Office Manager or other appropriate ES staff must develop a corrective action plan in accordance with the requirements identified at paragraph (h)(3)(v) of this section. The SMA also must advise the SWA on means to improve the delivery of services.

(3) Participate in on-site reviews of one-stop centers on a regular basis (regardless of whether or not they are designated significant MSFW one-stop centers) using the procedures set forth in paragraphs (h)(3)(i) through (vii) of this section.

(i) Before beginning an onsite review, the SMA or review staff must study:

(A) Program performance data;

(B) Reports of previous reviews;

(C) Corrective action plans developed as a result of previous reviews;

(D) Complaint logs, as required by the regulations under part 658 of this chapter, including logs documenting the informal resolution of complaints and apparent violations; and

(E) Complaints elevated from the office or concerning the office.

(ii) The SMA must ensure that the onsite review format, developed by ETA, is used as a guideline for onsite reviews.

(iii) Upon completion of an onsite monitoring review, the SMA must hold one or more wrap-up sessions with the ES Office Manager and staff to discuss any findings and offer initial recommendations and appropriate technical assistance.

(iv) After each review, the SMA must conduct an in-depth analysis of the review data. The conclusions, including findings and areas of concern and recommendations of the SMA, must be put in writing and must be sent directly to the State Administrator, to the official of the SWA with authority over the ES office, and other appropriate SWA officials.

(v) If the review results in any findings of noncompliance with the regulations under this chapter, the SMA's report must include the necessary corrective action(s). To resolve the findings, the ES Office Manager or other appropriate ES staff must develop and propose a written corrective action plan. The plan must be approved or revised by SWA officials and the SMA. The plan must include the actions required to correct any compliance issues within 30 business days or, if the plan allows for more than 30 business days for full compliance, the length of and the reasons for the extended period and the major interim steps to correct the compliance issues must be specifically stated. SWAs are responsible for assuring and documenting that the ES office is in compliance within the time period designated in the plan.

(vi) SWAs must submit to the appropriate ETA regional office copies of the onsite review reports and corrective action plans for ES offices.

(vii) The SMA may delegate the review described in paragraph (h)(3) of this section to the SMA's staff, if the SMA finds such delegation necessary. In such event, the SMA is responsible for and must approve the written report of the review.

(4) Ensure all significant MSFW one-stop centers not reviewed onsite by Federal staff are reviewed at least once per year by the SMA or their staff, and that, if necessary, those ES offices in which significant problems are revealed by required reports, management information, the Complaint System, or other means are reviewed as soon as possible.

(5) Review and approve the SWA's AOP.

(6) On a regular basis, review outreach staff's daily logs and other reports including those showing or reflecting the outreach staff's activities.

(7) Write and submit annual summaries to the State Administrator with a copy to the Regional Administrator and the National Monitor Advocate.

(i) The SMA must participate in Federal reviews conducted pursuant to part 658, subpart G, of this chapter, as requested by the Regional or National Monitor Advocate.

(j) The SMA must monitor the performance of the Complaint System, as set forth at §§ 658.400 and 658.401 of this chapter. The SMA must review the ES office's informal resolution of complaints relating to MSFWs and must ensure that the ES Office Manager transmits copies of the Complaint System logs pursuant to part 658, subpart E, of this chapter to the SWA.

(k) The SMA must serve as an advocate to improve services for MSFWs.

(l) The SMA must establish an ongoing liaison with WIOA sec. 167 National Farmworker Jobs Program (NFJP) grantees and other organizations serving farmworkers, employers, and employer organizations in the State.

(m) The SMA must establish an ongoing liaison with the State-level Equal Opportunity (E.O.) Officer.

(n) The SMA must meet (either in person or by alternative means), at minimum, quarterly, with representatives of the organizations pursuant to paragraphs (l) and (m) of this section, to receive input on improving coordination with ES offices or improving the coordination of services to MSFWs. To foster such collaboration, the SMAs must communicate freely with these organizations. The SMA must also establish Memorandums of Understanding (MOUs) with the NFJP grantees and may establish MOUs with other organizations serving farmworkers as appropriate.

(o) The SMA must conduct frequent field visits to the working, living, and gathering areas of MSFWs, and must

discuss the SWA's provision of ES services and other employment-related programs with MSFWs, crew leaders, and employers. Records must be kept of each such field visit.

(p) The SMA must participate in the appropriate regional public meeting(s) held by the Department of Labor Regional Farm Labor Coordinated Enforcement Committee, other Occupational Safety and Health Administration and Wage and Hour Division task forces, and other committees as appropriate.

(q) The SMA must ensure that outreach efforts in all significant MSFW one-stop centers are reviewed at least yearly. This review will include accompanying at least one outreach staff from each significant MSFW one-stop center on field visits to MSFWs' working, living, and/or gathering areas. The SMA must review findings from these reviews with the ES Office Managers.

(r) The SMA must review on at least a quarterly basis all statistical and other MSFW-related data reported by ES offices in order:

(1) To determine the extent to which the SWA has complied with the ES regulations; and

(2) To identify the areas of non-compliance.

(s) The SMA must have full access to all statistical and other MSFW-related information gathered by SWAs and ES offices and may interview ES staff with respect to reporting methods. After each review, the SMA must consult, as necessary, with the SWA and ES offices and provide technical assistance to ensure accurate reporting.

(t) The SMA must review and comment on proposed State ES directives, manuals, and operating instructions relating to MSFWs and must ensure:

(1) That they accurately reflect the requirements of the regulations; and

(2) That they are clear and workable. The SMA also must explain and make available at the requestor's cost, pertinent directives and procedures to employers, employer organizations, farmworkers, farmworker organizations, and other parties expressing an interest in a readily identifiable directive or procedure issued and receive suggestions on how these documents can be improved.

(u) The SMA must prepare for the State Administrator, the Regional Monitor Advocate, and the National Monitor Advocate an Annual Summary describing how the State provided ES services to MSFWs within the State based on statistical data, reviews, and other activities as required in this chapter. The summary must include:

(1) A description of the activities undertaken during the program year by the SMA pertaining to their responsibilities set forth in this section and other applicable regulations in this chapter.

(2) An assurance that the SMA is a senior-level official who reports directly to the State Administrator or the State Administrator's designee as described at paragraph (c) of this section.

(3) An evaluation of SMA staffing levels, including:

(i) An assurance the SMA devotes all of their time to Monitor Advocate functions or, if the SMA conducts their functions on a part-time basis, an assessment of whether all SMA functions are able to be effectively performed on a part-time basis; and

(ii) An assessment of whether the performance of SMA functions requires increased time by the SMA (if part-time) or an increase in the number of ES staff assigned to assist the SMA in the performance of SMA functions, or both.

(4) A summary of the monitoring reviews conducted by the SMA, including:

(i) A description of any problems, deficiencies, or improper practices the SMA identified in the delivery of services;

(ii) A summary of the actions taken by the SWA to resolve the problems, deficiencies, or improper practices described in its service delivery; and

(iii) A summary of any technical assistance the SMA provided for the SWA, ES offices, and outreach staff.

(5) A summary and analysis of the outreach efforts undertaken by all significant and non-significant MSFW one-stop centers, as well as the results of those efforts, and an analysis of whether the outreach levels and results were adequate.

(6) A summary of the State's actions taken under the Complaint System described in part 658, subpart E, of this chapter, identifying any challenges, complaint trends, findings from reviews of the Complaint System, trainings offered throughout the year, and steps taken to inform MSFWs and employers, and farmworker advocacy groups about the Complaint System.

(7) A summary of how the SMA is working with WIOA sec. 167 NFJP grantees, the State-level E.O. Officer, and other organizations serving farmworkers, employers, and employer organizations in the State, and an assurance that the SMA is meeting at least quarterly with these individuals and representatives of these organizations.

(8) A summary of the statistical and other MSFW-related data and reports gathered by SWAs and ES offices for the year, including an overview of the SMA's involvement in the SWA's reporting systems.

(9) A summary of the training conducted for ES staff on techniques for accurately reporting data.

(10) A summary of activities related to the AOP and an explanation of whether those activities helped the State reach the objectives described in the AOP. At the end of the 4-year AOP cycle, the summary must include a synopsis of the SWA's achievements over the previous 4 years to accomplish the objectives set forth in the AOP, and a description of the objectives which were not achieved and the steps the SWA will take to address those deficiencies.

(11) For significant MSFW one-stop centers, a summary of the State's efforts to comply with § 653.111.

[88 FR 82727, Nov. 24, 2023]

§ 653.109 Data collection and performance accountability measures.

SWAs must:

(a) Collect career service indicator data for the career services specified in WIOA sec. 134(c)(2)(A)(xii).

(b) Collect data, in accordance with applicable ETA Reports and Guidance, on:

(1) The number of MSFWs contacted through outreach activities;

(2) The number of MSFWs and non-MSFWs registered for career services;

(3) The number of MSFWs referred to and placed in agricultural jobs;

(4) The number of MSFWs referred to and placed in non-agricultural jobs;

(5) The percentage of MSFW program participants who are in unsubsidized employment during the second quarter after exit from the program;

(6) The median earnings of MSFW program participants who are in unsubsidized employment during the second quarter after exit from the program;

(7) The percentage of MSFW program participants who are in unsubsidized employment during the fourth quarter after exit from the program;

(8) The number of MSFWs served who identified themselves as male, female, Hispanic or Latino, Black or African-American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, or White;

(9) Agricultural clearance orders (including field checks), MSFW complaints and apparent violations, and monitoring activities;

(10) The number of reportable individuals and participants who are MSFWs; and

(11) Any other data required by the Department.

(c) Provide necessary training to ES staff on techniques for accurately reporting data.

(d) Collect and submit data on MSFWs required by the Unified or Combined State Plan, as directed by the Department.

(e) Periodically verify data required to be collected under this section, take necessary steps to ensure its validity, and submit the data for verification to the Department, as directed by the Department.

(f) Submit additional reports to the Department as directed.

(g) Meet equity indicators that address ES controllable services and include, at a minimum, individuals referred to a job, receiving job development, and referred to supportive or career services.

(h) Meet minimum levels of service in significant MSFW States. That is, only significant MSFW States will be required to meet minimum levels of service to MSFWs. Minimum level of service indicators must include, at a minimum, individuals placed in a job,

individuals placed long-term (150 days or more) in a non-agricultural job, a review of significant MSFW one-stop centers, field checks conducted, outreach contacts per quarter, and processing of complaints. The determination of the minimum service levels required of significant MSFW States must be based on the following:

(1) Past SWA performance in serving MSFWs, as reflected in on-site reviews and data collected under paragraph (b) of this section.

(2) The need for services to MSFWs in the upcoming year, comparing prior and projected levels of MSFW activity.

[81 FR 56341, Aug. 19, 2016, as amended at 85 FR 628, Jan. 6, 2020; 88 FR 82729, Nov. 24, 2023]

§ 653.110 Disclosure of data.

(a) SWAs must disclose to the public, on written request, in conformance with applicable State and Federal law, the data collected by SWAs and ES offices pursuant to § 653.109, if possible within 10 business days after receipt of the request.

(b) If a request for data held by a SWA is made to the ETA national or regional office, ETA must forward the request to the SWA for response.

(c) If the SWA cannot supply the requested data within 10 business days after receipt of the request, the SWA must respond to the requestor in writing, giving the reason for the delay and specifying the date by which it expects to be able to comply.

(d) SWA intra-agency memoranda and reports (or parts thereof) and memoranda and reports (or parts thereof) between the SWA and the ETA, to the extent that they contain statements of opinion rather than facts, may be withheld from public disclosure provided the reason for withholding is given to the requestor in writing. Similarly, documents or parts thereof, which, if disclosed, would constitute an unwarranted invasion of personal or employer privacy, also may be withheld provided the reason is given to the requestor in writing.

[81 FR 56341, Aug. 19, 2016, as amended at 88 FR 82730, Nov. 24, 2023]

§ 653.111 State Workforce Agency staffing requirements for significant MSFW one-stop centers.

(a) The SWA must staff significant MSFW one-stop centers in a manner facilitating the delivery of ES services tailored to the unique needs of MSFWs. This includes recruiting qualified candidates who meet the criteria in § 653.107(a)(3).

(b) The SMA, Regional Monitor Advocate, or the National Monitor Advocate, as part of their regular reviews of SWA compliance with these regulations, must monitor the extent to which the SWA has complied with its obligations under paragraph (a) of this section.

(c) SWAs remain subject to all applicable Federal laws prohibiting discrimination and protecting equal employment opportunity.

[85 FR 628, Jan. 6, 2020, as amended at 88 FR 82730, Nov. 24, 2023]

Subparts C–E [Reserved]

Subpart F—Agricultural Recruitment System for U.S. Workers (ARS)

§ 653.500 Purpose and scope of subpart.

This subpart includes the requirements for the acceptance of intrastate and interstate job clearance orders which seek U.S. workers to perform farmwork on a temporary, less than year-round basis. Orders seeking workers to perform farmwork on a year-round basis are not subject to the requirements of this subpart. This subpart affects all job orders for workers who are recruited through the ES intrastate and interstate clearance systems for less than year-round farmwork, including both MSFWs and non-MSFW job seekers.

§ 653.501 Requirements for processing clearance orders.

(a) *Assessment of need.* No ES staff may place a job order seeking workers to perform farmwork into intrastate or interstate clearance unless:

(1) The ES office and employer have attempted and have not been able to

obtain sufficient workers within the local labor market area; or

(2) The ES office anticipates a shortage of local workers.

(b) *ES office responsibilities.* (1) Each ES office must ensure the agricultural clearance form prescribed by the Department (ETA Form 790 or its subsequently issued form), and its attachments are complete when placing intrastate or interstate clearance orders seeking workers.

(2) All clearance orders must be posted in accordance with applicable ETA guidance. If the job order for the ES office incorporates offices beyond the local office commuting area, the ES office must suppress the employer information in order to facilitate the orderly movement of workers within the ES.

(3) ES staff must determine, through a preoccupancy housing inspection performed by ES staff or an appropriate public agency, that the housing assured by the employer is either available and meets the applicable housing standards or has been approved for conditional access to the clearance system as set forth in § 653.502; except that mobile range housing for sheepherders and goatherders must meet existing Departmental guidelines and/or applicable regulations.

(4) Prior to placing a job order into intrastate or interstate clearance, ES staff must consult the Department's Office of Foreign Labor Certification and Wage and Hour Division debarment lists, and the Department's Office of Workforce Investment discontinuation of services list.

(i) If the employer requesting access to the clearance system is currently debarred from participating in the H–2A or H–2B foreign labor certification programs, the SWA must initiate discontinuation of services pursuant to part 658, subpart F, of this chapter.

(ii) If the employer requesting access to the clearance system is currently discontinued from receiving ES services under § 658.503 of this chapter by any State, the SWA must not approve the clearance order for placement into intrastate or interstate clearance. Employers may submit written requests to the OWI Administrator to determine whether they are on the OWI discontinuation of services list. If the OWI Administrator indicates that the employer is not on the discontinuation of services list then the SWA must approve the clearance order, as long as all other requirements have been met.

(iii) For purposes of this paragraph (b)(4), ''employer'' has the meaning given in § 658.500(b) of this chapter.

(c) *SWA responsibilities.* (1) SWAs must ensure intrastate and interstate clearance orders:

(i) Include the following language: ''In view of the statutorily established basic function of the ES as a no-fee labor exchange, that is, as a forum for bringing together employers and job seekers, neither the ETA nor the SWAs are guarantors of the accuracy or truthfulness of information contained on job orders submitted by employers. Nor does any job order accepted or recruited upon by the ES constitute a contractual job offer to which the ETA or a SWA is in any way a party;''

(ii) Do not contain an unlawful discriminatory specification including, for beneficiaries (as defined in 29 CFR 38.4) only, on the basis of citizenship status or participant status;

(iii) Are signed by the employer; and

(iv) State all the material terms and conditions of the employment, including:

(A) The crop;

(B) The nature of the work;

(C) The anticipated period and hours of employment;

(D) The anticipated starting and ending date of employment and the anticipated number of days and hours per week for which work will be available;

(E) The hourly wage rate, if applicable, and any non-hourly wage rate offered, including a piece rate or base rate and bonuses and, for any non-hourly wage rate, an estimate of its hourly wage rate equivalent for each activity and unit size;

(F) Any deductions to be made from wages;

(G) A specification of any non-monetary benefits to be provided by the employer;

(H) Any hours, days, or weeks for which work is guaranteed, and, for each guaranteed week of work except as provided in paragraph (c)(3)(i) of this section, the exclusive manner in which

the guarantee may be abated due to weather conditions or other acts of God beyond the employer's control; and

(I) Any bonus or work incentive payments or other expenses which will be paid by the employer in addition to the basic wage rate, including the anticipated time period(s) within which such payments will be made.

(2) SWAs must ensure:

(i) The wages offered are not less than the applicable prevailing wages, as defined in § 655.103(b) of this chapter, or the applicable Federal or State minimum wage, whichever is higher. The working conditions offered are not less than the prevailing working conditions among similarly employed farmworkers in the area of intended employment. If the wages offered are expressed as piece rates or as base rates and bonuses, the employer must make the method of calculating the wage and supporting materials available to ES staff who must check if the employer's calculation of the estimated hourly wage rate is reasonably accurate and is not less than the prevailing wage rate or applicable Federal or State minimum wage, whichever is higher; and

(ii) The employer has agreed to provide or pay for the transportation of the workers and their families at or before the end of the period of employment specified in the job order on at least the same terms as transportation is commonly provided by employers in the area of intended employment to farmworkers and their families recruited from the same area of supply. Under no circumstances may the payment or provision of transportation occur later than the departure time needed to return home to begin the school year, in the case of any worker with children 18 years old or younger, or be conditioned on the farmworker performing work after the period of employment specified in the job order.

(3) SWAs must ensure that the employer makes the following assurances in the clearance order:

(i) The employer will provide to workers placed through the clearance system the number of hours of work cited in paragraph (c)(1)(iv)(D) of this section for the 14 calendar days beginning with the anticipated date of need, unless the employer has amended the date of need at least 10 business days prior to the original date of need (pursuant to paragraph (c)(3)(iv) of this section).

(ii) No extension of employment beyond the period of employment specified in the clearance order may relieve the employer from paying the wages already earned, or if specified in the clearance order as a term of employment, providing transportation or paying transportation expenses to the worker's home.

(iii) The working conditions comply with applicable Federal and State minimum wage, child labor, social security, health and safety, farm labor contractor registration and other employment-related laws.

(iv) The employer will notify the order-holding office or SWA immediately upon learning that a crop is maturing earlier or later, or that weather conditions, over-recruitment, or other factors have changed the terms and conditions of employment. If there is a change to the date of need, the employer will notify the order-holding office or SWA, and each worker who has been placed on the clearance order using the contact information the worker provided to the employer, in writing (email and other forms of electronic written notification are acceptable) at least 10 business days prior to the original date of need. Notification to workers must be made in accordance with the language access requirements of 29 CFR 38.9 for workers with limited English proficiency. If a worker provides electronic contact information, such as an email address or telephone number, the employer will send notice using one of the electronic contact methods provided. If the employer provides non-written telephonic notice, such as a phone call, voice message, or an equivalent, the employer will also send written notice using the email or postal address provided by the worker at least 10 business days prior to the original date of need. The employer will maintain records of the notification and the date notification was sent to the order-holding office or SWA and workers for 3 years. Consistent with paragraph (c)(5) of this section, if the employer does not properly send notification to the order-holding office

or SWA and workers at least 10 business days prior to the original date of need, the employer will provide the housing described on the clearance order to all migrant workers placed on the clearance order who are already traveling to the place of employment, without cost to the workers, until work commences. The employer will pay all placed workers for the hours listed on the clearance order and will provide or pay all other benefits and expenses described on the clearance order for each day work is delayed up to 14 calendar days or provide alternative work.

(v) The employer, if acting as a farm labor contractor (''FLC'') or farm labor contractor employee (''FLCE'') on the order, has a valid Federal FLC certificate or Federal FLCE identification card and when appropriate, any required State farm labor contractor certificate.

(vi) The availability of no cost or public housing which meets the Federal standards and which is sufficient to house the specified number of workers requested through the clearance system. This assurance must cover the availability of housing for only those workers, and when applicable, family members who are not reasonably able to return to their residence in the same day.

(vii) Outreach staff must have reasonable access to the workers in the conduct of outreach activities pursuant to § 653.107.

(viii) The job order contains all the material terms and conditions of the job. The employer must assure this by signing the following statement in the clearance order: ''This clearance order describes the actual terms and conditions of the employment being offered by me and contains all the material terms and conditions of the job.''

(4) If a SWA discovers that an employer's clearance order contains a material misrepresentation, the SWA may initiate the Discontinuation of Services as set forth in part 658, subpart F of this chapter.

(5) If there is a change to the anticipated date of need and the employer fails to notify the order-holding office or SWA and all workers placed on the clearance order at least 10 business days prior to the original date of need, as assured in paragraph (c)(3)(iv) of this section, the employer must provide housing to all migrant workers placed on the clearance order who are already traveling to the place of employment, without cost to the workers, until work commences, and must pay all placed workers the specified hourly rate of pay, or if the pay is piece-rate, the higher of the Federal or State minimum wage, or an applicable prevailing wage, or for criteria orders the rate of pay required under part 655, subpart B, of this chapter, and must provide or pay all other benefits and expenses described on the clearance order for each day work is delayed up to 14 calendar days starting with the originally anticipated date of need or provide alternative work if such alternative work is stated on the approved clearance order. If an employer fails to comply under this paragraph (c)(5) the order-holding office must process the information as an apparent violation pursuant to § 658.419 of this chapter and may refer an apparent violation of the employer's payment obligation under this paragraph (c)(5) to the Department's Wage and Hour Division.

(d) *Processing clearance orders.* (1) The order-holding ES office must transmit an electronic copy of the approved clearance order to its SWA. The SWA must distribute additional electronic copies of the form with all attachments (except that the SWA may, at its discretion, delegate this distribution to the local office) as follows:

(i) At least one copy of the clearance order must be sent to each of the SWAs selected for recruitment (areas of supply);

(ii) At least one copy of the clearance order must be sent to each applicant-holding ETA regional office;

(iii) At least one copy of the clearance order must be sent to the order-holding ETA regional office; and

(iv) At least one copy of the clearance order must be sent to the Regional Farm Labor Coordinated Enforcement Committee and/or other Occupational Safety and Health Administration and Wage and Hour Division regional agricultural coordinators, and/or other committees as appropriate in the area of employment.

(2) The ES office may place an intrastate or interstate order seeking workers to perform farmwork for a specific farm labor contractor or for a worker preferred by an employer provided the order meets ES nondiscrimination criteria. The order would not meet such criteria, for example, if it requested a ''white male crew leader'' or ''any white male crew leader.''

(3) The approval process described in this paragraph (d)(3) does not apply to clearance orders that are attached to applications for foreign temporary agricultural workers pursuant to part 655, subpart B, of this chapter; such clearance orders must be sent to the processing center as directed by ETA in guidance. For noncriteria clearance orders (orders that are not attached to applications under part 655, subpart B, of this chapter), the ETA regional office must review and approve the order within 10 business days of its receipt of the order, and the Regional Administrator or their designee must approve the areas of supply to which the order will be extended. Any denial by the Regional Administrator or their designee must be in writing and state the reasons for the denial.

(4) The applicant holding office must notify all referred farmworkers, farm labor contractors on behalf of farmworkers, or family heads on behalf of farmworker family members, to contact an ES office, preferably the order-holding office, to verify the date of need cited in the clearance order between 9 and 5 business days prior to the original date of need cited in the clearance order; and that failure to do so will disqualify the referred farmworker from the first weeks' pay as described in paragraph (c)(3)(i) of this section. The SWA must make a record of this notification.

(5) If the worker referred through the clearance system contacts an ES office (in any State) other than the order holding office, that ES office must assist the referred worker in contacting the order holding office on a timely basis. Such assistance must include, if necessary, contacting the order holding office by telephone or other timely means on behalf of the worker referred through the clearance system.

(6) ES staff must assist all farmworkers to understand the terms and conditions of employment set forth in intrastate and interstate clearance orders and must provide such workers with checklists showing wage payment schedules, working conditions, and other material specifications of the clearance order.

(7) If an order holding office learns that a crop is maturing earlier than expected or that other material factors, including weather conditions and recruitment levels have changed since the date the clearance order was accepted, the SWA must contact immediately the applicant holding office which must inform immediately crews and families scheduled to report to the job site of the changed circumstances and must adjust arrangements on behalf of such crews and families.

(8) When there is a delay in the date of need, SWAs must document notifications by employers and contacts by individual farmworkers or crew leaders on behalf of farmworkers or family heads on behalf of farmworker family members to verify the date of need.

(9) If weather conditions, over-recruitment, or other conditions have eliminated the scheduled job opportunities, the SWAs involved must make every effort to place the workers in alternate job opportunities as soon as possible, especially if the worker(s) is/are already en route or at the job site. ES staff must keep records of actions under this section.

(10) Applicant-holding offices must provide workers referred on clearance orders with a checklist summarizing wages, working conditions and other material specifications in the clearance order. The checklist must include language notifying the worker that a copy of the original clearance order is available upon request.

(11) The applicant-holding office must give each referred worker a copy of the list of worker's rights described in Departmental guidance.

(12) If the labor supply SWA accepts a clearance order, the SWA must actively recruit workers for referral. In the event a potential labor supply SWA rejects a clearance order, the reasons for rejection must be documented and

submitted to the Regional Administrator having jurisdiction over the SWA. The Regional Administrator will examine the reasons for rejection, and, if the Regional Administrator agrees, will inform the Regional Administrator with jurisdiction over the order-holding SWA of the rejection and the reasons. If the Regional Administrator who receives the notification of rejection does not concur with the reasons for rejection, that Regional Administrator will inform the National Monitor Advocate, who, in consultation with the appropriate ETA higher authority, will make a final determination on the acceptance or rejection of the order.

[81 FR 56341, Aug. 19, 2016, as amended at 85 FR 628, Jan. 6, 2020; 87 FR 61791, Oct. 12, 2022; 88 FR 82730, Nov. 24, 2023; 89 FR 35048, Apr. 29, 2024]

§ 653.502 Conditional access to the Agricultural Recruitment System.

(a) *Filing requests for conditional access*—(1) *''Noncriteria'' employers.* Except as provided in paragraph (a)(2) of this section, an employer whose housing does not meet applicable standards may file with the ES office serving the area in which its housing is located, a written request for its clearance orders to be conditionally allowed into the intrastate or interstate clearance system, provided that the employer's request assures its housing will be in full compliance with the requirements of the applicable housing standards at least 20 calendar days (giving the specific date) before the housing is to be occupied.

(2) *''Criteria'' employers.* If the request for conditional access described in paragraph (a)(1) of this section is from an employer filing a clearance order pursuant to an application for temporary alien agricultural labor certification for H–2A workers under subpart B of part 655 of this chapter, the request must be filed with the Certifying Officer (CO) at the processing center designated by ETA in guidance to make determinations on applications for temporary employment certification under the H–2A program.

(3) *Assurance.* The employer's request pursuant to paragraph (a)(1) or (2) of this section must contain an assurance that the housing will be in full compliance with the applicable housing standards at least 20 calendar days (stating the specific date) before the housing is to be occupied.

(b) *Processing requests*—(1) *SWA processing.* Upon receipt of a written request for conditional access to the intrastate or interstate clearance system under paragraph (a)(1) of this section, the ES office must send the request to the SWA, which, in turn, must forward it to the Regional Administrator.

(2) *Regional office processing and determination.* Upon receipt of a request for conditional access pursuant to paragraph (b)(1) of this section, the Regional Administrator must review the matter and, as appropriate, must either grant or deny the request.

(c) *Authorization.* The authorization for conditional access to the intrastate or interstate clearance system must be in writing, and must state that although the housing does not comply with the applicable standards, the employer's job order may be placed into intrastate or interstate clearance until a specified date. The Regional Administrator must send the authorization to the employer and must send copies (hard copy or electronic) to the appropriate SWA and ES office. The employer must submit and the ES office must attach copies of the authorization to each of the employer's clearance orders which is placed into intrastate or interstate clearance.

(d) *Notice of denial.* If the Regional Administrator denies the request for conditional access to the intrastate or interstate clearance system they must provide written notice to the employer, the appropriate SWA, and the ES office, stating the reasons for the denial.

(e) *Inspection.* The ES office serving the area containing the housing of any employer granted conditional access to the intrastate or interstate clearance system must assure that the housing is inspected no later than the date by which the employer has promised to have its housing in compliance with the applicable housing standards. An employer however, may request an earlier preliminary inspection. If, on the date set forth in the authorization, the housing is not in full compliance with

the applicable housing standards as assured in the request for conditional access, the ES office must afford the employer 5 calendar days to bring the housing into full compliance. After the 5-calendar-day period, if the housing is not in full compliance with the applicable housing standards as assured in the request for conditional access, the ES office must immediately:

(1) Notify the RA or the NPC designated by the Regional Administrator;

(2) With the approval of an appropriate SWA official, remove the employer's clearance orders from intrastate and interstate clearance; and

(3) If workers have been recruited against these orders, in cooperation with the ES agencies in other States, make every reasonable attempt to locate and notify the appropriate crew leaders or workers, and to find alternative and comparable employment for the workers.

[81 FR 56341, Aug. 19, 2016, as amended at 85 FR 628, Jan. 6, 2020; 88 FR 82730, Nov. 24, 2023]

§ 653.503 Field checks.

(a) If a worker is placed on a clearance order, the SWA must notify the employer in writing that the SWA, through its ES offices, and/or Federal staff, must conduct unannounced field checks to determine and document whether wages, hours, transportation, and working and housing conditions are being provided as specified in the clearance order.

(b) Where the SWA has made placements on 10 or more agricultural clearance orders (pursuant to this subpart) during the quarter, the SWA must conduct field checks on at least 25 percent of the total of such orders. Where the SWA has made placements on nine or fewer job orders during the quarter (but at least one job order), the SWA must conduct field checks on 100 percent of all such orders. This requirement must be met on a quarterly basis.

(c) Field checks must include visit(s) to the worksite at a time when workers are present. When conducting field checks, ES staff must consult both the employees and the employer to ensure compliance with the full terms and conditions of employment.

(d) If the individual conducting the field check observes or receives information, or otherwise has reason to believe that conditions are not as stated in the clearance order or that an employer is violating an employment-related law, the individual must document the finding and attempt informal resolution where appropriate (for example, informal resolution must not be attempted in certain cases, such as E.O.-related issues and others identified by the Department through guidance). If the matter has not been resolved within 5 business days, the SWA must initiate the Discontinuation of Services as set forth at part 658, subpart F of this chapter and must refer apparent violations of employment-related laws to appropriate enforcement agencies in writing.

(e) SWA officials may enter into formal or informal arrangements with appropriate State and Federal enforcement agencies where the enforcement agency staff may conduct field checks instead of and on behalf of the SWA. The agreement may include the sharing of information and any actions taken regarding violations of the terms and conditions of the employment as stated in the clearance order and any other violations of employment-related laws. An enforcement agency field check must satisfy the requirement for SWA field checks where all aspects of wages, hours, and working and housing conditions have been reviewed by the enforcement agency. The SWA must supplement enforcement agency efforts with field checks focusing on areas not addressed by enforcement agencies.

(f) ES staff must keep records of all field checks.

[81 FR 56341, Aug. 19, 2016, as amended at 85 FR 628, Jan. 6, 2020; 88 FR 82730, Nov. 24, 2023]

§ 653.504 Severability.

Should a court hold any portion of any provision of this part to be invalid, the provision will be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding is one of total invalidity or unenforceability, in which event the provision or subprovision will be severable from this part and will not affect the remainder thereof.

[88 FR 82730, Nov. 24, 2023]

PART 654—SPECIAL RESPONSIBILITIES OF THE EMPLOYMENT SERVICE SYSTEM

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AUTHORITY: 29 U.S.C. 49k; 8 U.S.C. 1188(c)(4); 41 Op.A.G. 406 (1959).

SOURCE: 44 FR 1689, Jan. 5, 1979, unless otherwise noted.

Subpart A—Responsibilities Under Executive Order 12073

AUTHORITY: 41 U.S.C. 10a *et seq;* 29 U.S.C. 49 *et seq;* 15 U.S.C. 644(n); E.O. 12073; 10582, as amended by E.O. 11051 and 12148.

§ 654.1 Purpose of subpart.

This subpart implements the responsibilities of the Secretary of Labor in classifying labor surplus areas in accordance with Executive Order 12073 (Federal Procurement in Labor Surplus Areas). The Secretary of Labor has delegated responsibilities to the Assistant Secretary, Employment and Training Administration.

[44 FR 1689, Jan. 5, 1979, as amended at 48 FR 15616, Apr. 12, 1983]

§ 654.3 Description of Executive Order 12073.

Executive Order 12073 requires executive agencies to emphasize procurement set-asides in labor surplus areas. The Secretary of Labor is responsible under this order for classifying and designating labor surplus areas.

[44 FR 1689, Jan. 5, 1979, as amended at 48 FR 15616, Apr. 12, 1983]

§ 654.4 Definitions.

(a) *Assistant Secretary* shall mean Assistant Secretary for Employment and Training, U.S. Department of Labor.

(b) *Civil jurisdiction* shall mean:

(1) Cities of 25,000 or more population on the basis of the most recently available Bureau of the Census estimates; or

(2) Towns and townships in the States of New Jersey, New York, Michigan, and Pennsylvania of 25,000 or more population and which possess powers and functions similar to cities; or

(3) All counties, except those counties which contain any of the types of political jurisdictions defined in paragraphs (b) (1) and (2) of this section; or

(4) All other counties are defined as ''balance of county'' (*i.e.*, total county less component cities and townships identified in paragraphs (b) (1) and (2) of this section); or

(5) County equivalents which are towns in the States of Massachusetts, Rhode Island and Connecticut.

(c) *Labor surplus area* shall mean a civil jurisdiction that, in accordance with the criteria specified in § 654.5, has been classified as a labor surplus area.

(d) *Reference period* shall mean the two year period ending December 31 of the year prior to the October 1 annual date of eligibility determination.

[44 FR 1689, Jan. 5, 1979, as amended at 44 FR 26071, May 5, 1979; 48 FR 15616, Apr. 12, 1983; 53 FR 23347, June 21, 1988]

§ 654.5 Classification of labor surplus areas.

(a) *Basic criteria.* The Assistant Secretary shall classify a civil jurisdiction as a labor surplus area whenever, as determined by the Bureau of Labor Statistics, the average unemployment rate for all civilian workers in the civil jurisdiction for the reference period is (1) 120 percent of the national average unemployment rate for civilian workers or higher for the reference period as determined by the Bureau of Labor Statistics, or (2) 10 percent or higher. No civil jurisdiction shall be classified as a labor surplus area if the average unemployment rate for all civilian workers for the reference period is less than 6.0 percent.

(b) *Criteria for exceptional circumstances.* The Assistant Secretary, upon petition submitted by the appropriate State Workforce Agency, may classify a civil jurisdiction, a Metropolitan Statistical Area, or a Primary Metropolitan Statistical Area as a labor surplus area whenever such an area meets or is expected to meet the unemployment tests established under § 654.5(a) as a result of exceptional circumstances. For purposes of this paragraph ''exceptional circumstances'' shall mean catastrophic events, such as natural disasters, plant closings, and contract cancellations expected to have a long-term impact on labor market area conditions, discounting temporary or seasonal factors. For purposes of this paragraph, ''Metropolitan Statistical Area'' and ''Primary Metropolitan Statistical Area'' shall mean the areas officially defined and designated as such by the Office of Management and Budget.

(Approved by OMB under control number 1205–0207)

[48 FR 15616, Apr. 12, 1983, as amended at 53 FR 23347, June 21, 1988; 71 FR 35518, June 21, 2006]

§ 654.6 Termination of classification.

(a) *Basic procedure.* The Assistant Secretary shall terminate the classification of a civil jurisdiction as a labor surplus area after any year in which the Assistant Secretary determines that the criteria established under § 654.5 (a) are no longer met.

(b) *Procedure for exceptional circumstances.* The Assistant Secretary shall terminate the classification of a civil jurisdiction classified as a labor surplus area pursuant to the provisions of § 654.5(b) after any year in which the Assistant Secretary determines that the exceptional circumstances criteria of that paragraph are no longer met.

[44 FR 1689, Jan. 5, 1979, as amended at 48 FR 15616, Apr. 12, 1983]

§ 654.7 Publication of area classifications.

The Assistant Secretary shall publish annually a list of labor surplus areas together with geographic descriptions thereof. The Assistant Secretary periodically may cause these lists to be published in the FEDERAL REGISTER.

[44 FR 1689, Jan. 5, 1979, as amended at 48 FR 15616, Apr. 12, 1983]

§ 654.8 Services to firms and individuals in labor surplus areas.

To carry out the purposes and policy objectives of Executive Order 12073 and Executive Order 10582, the Assistant Secretary shall cooperate with and assist the State Workforce Agencies and the Secretary of Commerce, as appropriate, to:

(a) Provide relevant labor market data and related economic information to assist in the initiation of industrial expansion programs in labor surplus areas;

(b) Identify upon request the skills and numbers of unemployed persons available for work in labor surplus areas, providing such information to firms interested in establishing new

plants and facilities or expanding existing plants and facilities in such areas;

(c) Identify the occupational composition and skill requirements of industries contemplating locating in labor surplus areas and make such information available to training and apprenticeship agencies and resources in the community for purposes of appropriate training and skill development;

(d) Identify unemployed individuals in need of, and having the potential for, training in occupations and skills required by new or expanding industries and refer such individuals to appropriate training opportunities;

(e) Receive job openings on a voluntary basis and/or under the mandatory listing program provided by 38 U.S.C. 2012 and Executive Order 11701 and refer qualified unemployed workers to such openings, making appropriate efforts to refer to such openings qualified individuals who reside in the labor surplus area.

[44 FR 1689, Jan. 5, 1979, as amended at 48 FR 15616, Apr. 12, 1983; 71 FR 35518, June 21, 2006]

§ 654.9 Filing of complaints.

Complaints alleging that the Department of Labor has violated the labor surplus area regulations should be mailed to the Assistant Secretary for Employment and Training, U.S. Department of Labor, Washington, DC 20210. Such complaints should include: (a) The allegations of wrongdoing; (b) the date of the incident; and (c) any other relevant information available to the complainant. The Assistant Secretary shall make a determination and respond to the complainant after investigation of the incident. If the complaint is not resolved following this investigation, the Assistant Secretary, at his discretion, may offer, in writing by certified mail, the complainant a hearing before a Department of Labor Administrative Law Judge, provided that the complainant requests such a hearing from the Assistant Secretary within 20 working days of the certified date of receipt of the Assistant Secretary's offer of a hearing.

[48 FR 15616, Apr. 12, 1983]

§ 654.10 Transition provisions.

The annual list of labor surplus areas for the period June 1, 1982, through May 31, 1983, shall be extended through September 30, 1983.

[48 FR 15616, Apr. 12, 1983]

Subpart B—Responsibilities Under Executive Order 10582

AUTHORITY: 41 U.S.C. 10a *et seq.;* 29 U.S.C. 49 *et seq.;* 15 U.S.C. 644(n); E.O. 12073, E.O. 10582 as amended by E.O. 11051 and 12148.

§ 654.11 Purpose of subpart.

This subpart implements the responsibilities of the Secretary of Labor in determining areas of substantial unemployment in accordance with Executive Order 10582 issued pursuant to the Buy American Act, 41 U.S.C. 10a *et seq.*

§ 654.12 Description of Executive Order 10582.

(a) Under the Buy American Act, heads of executive agencies are required to determine, as a condition precedent to the purchase by their agencies of materials of foreign origin for public use within the United States, (1) that the price of like materials of domestic origin is unreasonable, or (2) that the purchase of like materials of domestic origin is inconsistent with the public interest.

(b) Section 3(c) of Executive Order 10582 issued pursuant to the Buy American Act permits executive agencies to reject a bid or offer to furnish materials of foreign origin in any situation in which the domestic supplier, offering the lowest price for furnishing the desired materials, undertakes to produce substantially all of the materials in areas of substantial unemployment, as determined by the Secretary of Labor.

§ 654.13 Determination of areas of substantial unemployment.

An area of substantial unemployment, for purposes of Executive Order 10582, shall be any area classified as a labor surplus area at § 654.5 of this part pursuant to the procedures set forth at subpart A of this part.

§ 654.14 Filing of complaints.

Complaints arising under subpart B of this part alleging that the Department of Labor has violated the labor surplus area regulations shall be made pursuant to the procedures set forth at § 654.9 of this part.

[48 FR 15616, Apr. 12, 1983]

Subparts C–D [Reserved]

Subpart E—Housing for Farmworkers

SOURCE: 81 FR 56349, Aug. 19, 2016, unless otherwise noted.

PURPOSE AND APPLICABILITY

§ 654.400 Scope and purpose.

(a) This subpart sets forth the Department's Employment and Training Administration (ETA) standards for agricultural housing and variances. Local Wagner-Peyser Act Employment Service (ES) offices, as part of the State ES agencies and in cooperation with the ES program, assist employers in recruiting farmworkers from places outside the area of intended employment. The experiences of the ES agencies indicate that employees so referred have on many occasions been provided with inadequate, unsafe, and unsanitary housing conditions. To discourage this practice, it is the policy of the Federal-State ES system to deny its intrastate and interstate recruitment services to employers until the State ES agency has ascertained that the employer's housing meets certain standards.

(b) To implement this policy, § 653.501 of this chapter provides that recruitment services must be denied unless the employer has signed an assurance that if the workers are to be housed, a preoccupancy inspection has been conducted, and the ES staff has ascertained that, with respect to intrastate or interstate clearance orders, the employer's housing meets the full set of standards set forth at 29 CFR 1910.142 or this subpart, except that mobile range housing for sheepherders or goatherders must meet existing Departmental guidelines and/or applicable regulations.

§ 654.401 Applicability.

(a) Employers whose housing was completed or under construction prior to April 3, 1980, or was under a signed contract for construction prior to March 4, 1980, may continue to follow the full set of the Department's ETA standards set forth in this subpart.

(b) The Department will consider agricultural housing which complies with ETA transitional standards set forth in this subpart also to comply with the Occupational Safety and Health Administration (OSHA) temporary labor camp standards at 29 CFR 1910.142.

§ 654.402 Variances.

(a) An employer may apply for a structural variance from a specific standard(s) in this subpart by filing a written application for such a variance with the local ES office serving the area in which the housing is located. This application must:

(1) Clearly specify the standard(s) from which the variance is desired;

(2) Adequately justify that the variance is necessary to obtain a beneficial use of an existing facility, and to prevent a practical difficulty or unnecessary hardship; and

(3) Clearly set forth the specific alternative measures which the employer has taken to protect the health and safety of workers and adequately show that such alternative measures have achieved the same result as the standard(s) from which the employer desires the variance.

(b) Upon receipt of a written request for a variance under paragraph (a) of this section, the local ES office must send the request to the State office which, in turn, must forward it to the ETA Regional Administrator (RA). The RA must review the matter and, after consultation with OSHA, must either grant or deny the request for a variance.

(c) The variance granted by the RA must be in writing, must state the particular standard(s) involved, and must state as conditions of the variance the specific alternative measures which have been taken to protect the health and safety of the workers. The RA must send the approved variance to the employer and must send copies to OSHA's Regional Administrator, the

Regional Administrator of the Wage and Hour Division (WHD), and the appropriate State Workforce Agency (SWA) and the local ES office. The employer must submit and the local ES office must attach copies of the approved variance to each of the employer's job orders which is placed into intrastate or interstate clearance.

(d) If the RA denies the request for a variance, the RA must provide written notice stating the reasons for the denial to the employer, the appropriate SWA, and the local ES office. The notice also must offer the employer an opportunity to request a hearing before a Department of Labor Hearing Officer, provided the employer requests such a hearing from the RA within 30 calendar days of the date of the notice. The request for a hearing must be handled in accordance with the complaint procedures set forth at §§ 658.424 and 658.425 of this chapter.

(e) The procedures of paragraphs (a) through (d) of this section only apply to an employer who has chosen, as evidenced by its written request for a variance, to comply with the ETA housing standards at §§ 654.404 through 654.417.

§ 654.403 [Reserved]

HOUSING STANDARDS

§ 654.404 Housing site.

(a) Housing sites must be well drained and free from depressions in which water may stagnate. They must be located where the disposal of sewage is provided in a manner which neither creates nor is likely to create a nuisance, or a hazard to health.

(b) Housing must not be subject to, or in proximity to, conditions that create or are likely to create offensive odors, flies, noise, traffic, or any similar hazards.

(c) Grounds within the housing site must be free from debris, noxious plants (poison ivy, etc.) and uncontrolled weeds or brush.

(d) The housing site must provide a space for recreation reasonably related to the size of the facility and the type of occupancy.

§ 654.405 Water supply.

(a) An adequate and convenient supply of water that meets the standards of the State health authority must be provided.

(b) A cold water tap must be available within 100 feet of each individual living unit when water is not provided in the unit. Adequate drainage facilities must be provided for overflow and spillage.

(c) Common drinking cups are not permitted.

§ 654.406 Excreta and liquid waste disposal.

(a) Facilities must be provided and maintained for effective disposal of excreta and liquid waste. Raw or treated liquid waste may not be discharged or allowed to accumulate on the ground surface.

(b) Where public sewer systems are available, all facilities for disposal of excreta and liquid wastes must be connected thereto.

(c) Where public sewers are not available, a subsurface septic tank-seepage system or other type of liquid waste treatment and disposal system, privies or portable toilets must be provided. Any requirements of the State health authority must be complied with.

§ 654.407 Housing.

(a) Housing must be structurally sound, in good repair, in a sanitary condition and must provide protection to the occupants against the elements.

(b) Housing must have flooring constructed of rigid materials, smooth finished, readily cleanable, and so located as to prevent the entrance of ground and surface water.

(c) The following space requirements must be provided:

(1) For sleeping purposes only in family units and in dormitory accommodations using single beds, not less than 50 square feet of floor space per occupant;

(2) For sleeping purposes in dormitory accommodations using double bunk beds only, not less than 40 square feet per occupant; and

(3) For combined cooking, eating, and sleeping purposes not less than 60 square feet of floor space per occupant.

(d) Housing used for families with one or more children over 6 years of

age must have a room or partitioned sleeping area for the husband and wife. The partition must be of rigid materials and installed so as to provide reasonable privacy.

(e) Separate sleeping accommodations must be provided for each sex or each family.

(f) Adequate and separate arrangements for hanging clothing and storing personal effects for each person or family must be provided.

(g) At least one-half of the floor area in each living unit must have a minimum ceiling height of 7 feet. No floor space may be counted toward minimum requirements where the ceiling height is less than 5 feet.

(h) Each habitable room (not including partitioned areas) must have at least one window or skylight opening directly to the out-of-doors. The minimum total window or skylight area, including windows in doors, must equal at least 10 percent of the usable floor area. The total openable area must equal at least 45 percent of the minimum window or skylight area required, except where comparably adequate ventilation is supplied by mechanical or some other method.

§ 654.408 Screening.

(a) All outside openings must be protected with screening of not less than 16 mesh.

(b) All screen doors must be tight fitting, in good repair, and equipped with self-closing devices.

§ 654.409 Heating.

(a) All living quarters and service rooms must be provided with properly installed, operable heating equipment capable of maintaining a temperature of at least 68 degrees Fahrenheit (°F) if during the period of normal occupancy the temperature in such quarters falls below 68 °F.

(b) Any stoves or other sources of heat utilizing combustible fuel must be installed and vented in such a manner as to prevent fire hazards and a dangerous concentration of gases. No portable heaters other than those operated by electricity may be provided. If a solid or liquid fuel stove is used in a room with wooden or other combustible flooring, there must be a concrete slab, insulated metal sheet, or other fireproof material on the floor under each stove, extending at least 18 inches beyond the perimeter of the base of the stove.

(c) Any wall or ceiling within 18 inches of a solid or liquid fuel stove or a stovepipe must be of fireproof material. A vented metal collar must be installed around a stovepipe, or vent passing through a wall, ceiling, floor, or roof.

(d) When a heating system has automatic controls, the controls must be of the type which cut off the fuel supply upon the failure or interruption of the flame or ignition, or whenever a predetermined safe temperature or pressure is exceeded.

§ 654.410 Electricity and lighting.

(a) All housing sites must be provided with electric service.

(b) Each habitable room and all common use rooms, and areas such as: laundry rooms, toilets, privies, hallways, stairways, etc., must contain adequate ceiling or wall-type light fixtures. At least one wall-type electrical convenience outlet must be provided in each individual living room.

(c) Adequate lighting must be provided for the yard area, and pathways to common use facilities.

(d) All wiring and lighting fixtures must be installed and maintained in a safe condition.

§ 654.411 Toilets.

(a) Toilets must be constructed, located, and maintained so as to prevent any nuisance or public health hazard.

(b) Water closets or privy seats for each sex must be in the ratio of not less than one such unit for each 15 occupants, with a minimum of one unit for each sex in common use facilities.

(c) Urinals, constructed of nonabsorbent materials, may be substituted for men's toilet seats on the basis of one urinal or 24 inches of trough-type urinal for one toilet seat up to a maximum of one-third of the required toilet seats.

(d) Except in individual family units, separate toilet accommodations for men and women must be provided. If toilet facilities for men and women are

in the same building, they must be separated by a solid wall from floor to roof or ceiling. Toilets must be distinctly marked ''men'' and ''women'' in English and in the native language of the persons expected to occupy the housing.

(e) Where common use toilet facilities are provided, an adequate and accessible supply of toilet tissue, with holders, must be furnished.

(f) Common use toilets and privies must be well lighted and ventilated and must be clean and sanitary.

(g) Toilet facilities must be located within 200 feet of each living unit.

(h) Privies may not be located closer than 50 feet from any living unit or any facility where food is prepared or served.

(i) Privy structures and pits must be fly-tight. Privy pits must have adequate capacity for the required seats.

§ 654.412 Bathing, laundry, and hand washing.

(a) Bathing and hand washing facilities, supplied with hot and cold water under pressure, must be provided for the use of all occupants. These facilities must be clean and sanitary and located within 200 feet of each living unit.

(b) There must be a minimum of 1 showerhead per 15 persons. Showerheads must be spaced at least 3 feet apart, with a minimum of 9 square feet of floor space per unit. Adequate, dry dressing space must be provided in common use facilities. Shower floors must be constructed of nonabsorbent nonskid materials and sloped to properly constructed floor drains. Except in individual family units, separate shower facilities must be provided each sex. When common use shower facilities for both sexes are in the same building they must be separated by a solid nonabsorbent wall extending from the floor to ceiling, or roof, and must be plainly designated ''men'' or ''women'' in English and in the native language of the persons expected to occupy the housing.

(c) Lavatories or equivalent units must be provided in a ratio of 1 per 15 persons.

(d) Laundry facilities, supplied with hot and cold water under pressure, must be provided for the use of all occupants. Laundry trays or tubs must be provided in the ratio of 1 per 25 persons. Mechanical washers may be provided in the ratio of 1 per 50 persons in lieu of laundry trays, although a minimum of 1 laundry tray per 100 persons must be provided in addition to the mechanical washers.

§ 654.413 Cooking and eating facilities.

(a) When workers or their families are permitted or required to cook in their individual unit, a space must be provided and equipped for cooking and eating. Such space must be provided with:

(1) A cookstove or hot plate with a minimum of two burners;

(2) Adequate food storage shelves and a counter for food preparation;

(3) Provisions for mechanical refrigeration of food at a temperature of not more than 45 °F;

(4) A table and chairs or equivalent seating and eating arrangements, all commensurate with the capacity of the unit; and

(5) Adequate lighting and ventilation.

(b) When workers or their families are permitted or required to cook and eat in a common facility, a room or building separate from the sleeping facilities must be provided for cooking and eating. Such room or building must be provided with:

(1) Stoves or hot plates, with a minimum equivalent of 2 burners, in a ratio of 1 stove or hot plate to 10 persons, or 1 stove or hot plate to 2 families;

(2) Adequate food storage shelves and a counter for food preparation;

(3) Mechanical refrigeration for food at a temperature of not more than 45 °F;

(4) Tables and chairs or equivalent seating adequate for the intended use of the facility;

(5) Adequate sinks with hot and cold water under pressure;

(6) Adequate lighting and ventilation; and

(7) Floors must be of nonabsorbent, easily cleaned materials.

(c) When central mess facilities are provided, the kitchen and mess hall

must be in proper proportion to the capacity of the housing and must be separate from the sleeping quarters. The physical facilities, equipment, and operation must be in accordance with provisions of applicable State codes.

(d) Wall surface adjacent to all food preparation and cooking areas must be of nonabsorbent, easily cleaned material. In addition, the wall surface adjacent to cooking areas must be of fire-resistant material.

§ 654.414 Garbage and other refuse.

(a) Durable, fly-tight, clean containers in good condition of a minimum capacity of 20 gallons, must be provided adjacent to each housing unit for the storage of garbage and other refuse. Such containers must be provided in a minimum ratio of 1 per 15 persons.

(b) Provisions must be made for collection of refuse at least twice a week, or more often if necessary. The disposal of refuse, which includes garbage, must be in accordance with State and local law.

§ 654.415 Insect and rodent control.

Housing and facilities must be free of insects, rodents, and other vermin.

§ 654.416 Sleeping facilities.

(a) Sleeping facilities must be provided for each person. Such facilities must consist of comfortable beds, cots, or bunks, provided with clean mattresses.

(b) Any bedding provided by the housing operator must be clean and sanitary.

(c) Triple deck bunks may not be provided.

(d) The clear space above the top of the lower mattress of a double deck bunk and the bottom of the upper bunk must be a minimum of 27 inches. The distance from the top of the upper mattress to the ceiling must be a minimum of 36 inches.

(e) Beds used for double occupancy may be provided only in family accommodations.

§ 654.417 Fire, safety, and first aid.

(a) All buildings in which people sleep or eat must be constructed and maintained in accordance with applicable State or local fire and safety laws.

(b) In family housing and housing units for less than 10 persons, of one story construction, two means of escape must be provided. One of the two required means of escape may be a readily accessible window with an openable space of not less than 24 × 24 inches.

(c) All sleeping quarters intended for use by 10 or more persons, central dining facilities, and common assembly rooms must have at least two doors remotely separated so as to provide alternate means of escape to the outside or to an interior hall.

(d) Sleeping quarters and common assembly rooms on the second story must have a stairway, and a permanent, affixed exterior ladder or a second stairway.

(e) Sleeping and common assembly rooms located above the second story must comply with the State and local fire and building codes relative to multiple story dwellings.

(f) Fire extinguishing equipment must be provided in a readily accessible place located not more than 100 feet from each housing unit. Such equipment must provide protection equal to a 2½ gallon stored pressure or 5-gallon pump-type water extinguisher.

(g) First aid facilities must be provided and readily accessible for use at all time. Such facilities must be equivalent to the 16 unit first aid kit recommended by the American Red Cross, and provided in a ratio of 1 per 50 persons.

(h) No flammable or volatile liquids or materials must be stored in or adjacent to rooms used for living purposes, except for those needed for current household use.

(i) Agricultural pesticides and toxic chemicals may not be stored in the housing area.

PART 655—TEMPORARY EMPLOYMENT OF FOREIGN WORKERS IN THE UNITED STATES

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(ii), 8 U.S.C. 1103(a)(6), 1182(m), (n), and (t), 1184(c), (g), and (j), 1188, and 1288(c) and (d); sec. 3(c)(1), Pub. L. 101–238, 103 Stat. 2099, 2102 (8 U.S.C. 1182 note); sec. 221(a), Pub. L. 101–649, 104 Stat. 4978, 5027 (8 U.S.C. 1184 note); sec. 303(a)(8), Pub. L. 102–232, 105 Stat. 1733, 1748 (8 U.S.C. 1101 note); sec. 323(c), Pub. L. 103–206, 107 Stat. 2428; sec. 412(e), Pub. L. 105–277, 112 Stat. 2681 (8 U.S.C. 1182 note); sec. 2(d), Pub. L. 106–95, 113 Stat. 1312, 1316 (8 U.S.C. 1182 note); 29 U.S.C. 49k; Pub. L. 107–296, 116 Stat. 2135, as amended; Pub. L. 109–423, 120 Stat. 2900; 8 CFR 214.2(h)(4)(i); 8 CFR 214.2(h)(6)(iii); and sec. 6, Pub. L. 115–218, 132 Stat. 1547 (48 U.S.C. 1806).

Subpart A issued under 8 CFR 214.2(h).

Subpart B issued under 8 U.S.C. 1101(a)(15)(H)(ii)(a), 1184(c), and 1188; and 8 CFR 214.2(h).

Subpart E issued under 48 U.S.C. 1806.

Subparts F and G issued under 8 U.S.C. 1288(c) and (d); sec. 323(c), Pub. L. 103–206, 107 Stat. 2428; and 28 U.S.C. 2461 note, Pub. L. 114–74 at section 701.

Subparts H and I issued under 8 U.S.C. 1101(a)(15)(H)(i)(b) and (b)(1), 1182(n), and (t), and 1184(g) and (j); sec. 303(a)(8), Pub. L. 102–232, 105 Stat. 1733, 1748 (8 U.S.C. 1101 note); sec. 412(e), Pub. L. 105–277, 112 Stat. 2681; 8 CFR 214.2(h); and 28 U.S.C. 2461 note, Pub. L. 114–74 at section 701.

Subparts L and M issued under 8 U.S.C. 1101(a)(15)(H)(i)(c) and 1182(m); sec. 2(d), Pub. L. 106–95, 113 Stat. 1312, 1316 (8 U.S.C. 1182 note); Pub. L. 109–423, 120 Stat. 2900; and 8 CFR 214.2(h).

SOURCE: 42 FR 45899, Sept. 13, 1977, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 655 appear at 71 FR 35521, 35522, June 21, 2006.

§ 655.0 Scope and purpose of part.

(a) *Subparts A, B, and C*—(1) *General.* Subparts A, B, and C of this part set out the procedures adopted by the Secretary to secure information sufficient to make factual determinations of: (i) Whether U.S. workers are available to perform temporary employment in the United States, for which an employer desires to employ nonimmigrant foreign workers, and (ii) whether the employment of aliens for such temporary work will adversely affect the wages or working conditions of similarly employed U.S. workers. These factual determinations (or a determination that there are not sufficient facts to make one or both of these determinations) are required to carry out the policies of the Immigration and Nationality Act (INA), that a nonimmigrant alien worker not be admitted to fill a particular temporary job opportunity unless no qualifed U.S. worker is available to fill the job opportunity, and unless the employment of the foreign worker in the job opportunity will not adversely affect the wages or working conditions of similarly employed U.S. workers.

(2) *The Secretary's determinations.* Before any factual determination can be made concerning the availability of U.S. workers to perform particular job opportunities, two steps must be taken. First, the minimum level of wages, terms, benefits, and conditions for the particular job opportunities, below which similarly employed U.S. workers would be adversely affected, must be established. (The regulations in this part establish such minimum levels for wages, terms, benefits, and conditions of employment.) Second, the wages, terms, benefits, and conditions offered and afforded to the aliens must be compared to the established minimum levels. If it is concluded that adverse effect would result, the ultimate determination of availability within the meaning of the INA cannot be made since U.S. workers cannot be expected to accept employment under conditions below the established minimum levels. *Florida Sugar Cane League, Inc.* v. *Usery,* 531 F. 2d 299 (5th Cir. 1976).

Once a determination of no adverse effect has been made, the availability of U.S. workers can be tested only if U.S. workers are actively recruited through the offer of wages, terms, benefits, and conditions at least at the minimum level or the level offered to the aliens, whichever is higher. The regulations in this part set forth requirements for recruiting U.S. workers in accordance with this principle.

(3) *Construction.* This part and its subparts shall be construed to effectuate the purpose of the INA that U.S. workers rather than aliens be employed wherever possible. *Elton Orchards, Inc.* v. *Brennan,* 508 F. 2d 493, 500 (1st Cir. 1974), *Flecha* v. *Quiros,* 567 F. 2d 1154 (1st Cir. 1977). Where temporary alien workers are admitted, the terms and conditions of their employment must not result in a lowering of the

terms and conditions of domestic workers similarly employed, *Williams* v. *Usery*, 531 F. 2d 305 (5th Cir. 1976); *Florida Sugar Cane League, Inc.* v. *Usery*, 531 F. 2d 299 (5th Cir. 1976), and the job benefits extended to any U.S. workers shall be at least those extended to the alien workers.

(b) *Subparts D and E.* Subparts D and E of this part set forth the process by which health care facilities can file attestations with the Department of Labor for the purpose of employing or otherwise using nonimmigrant registered nurses under H–1A visas.

(c) *Subparts F and G.* Subparts F and G of this part set forth the process by which employers can file attestations with the Department of Labor for the purpose of employing alien crewmembers in longshore work under D-visas and enforcement provisions relating thereto.

(d) *Subparts H and I of this part.* Subpart H of this part sets forth the process by which employers can file labor condition applications (LCAs) with, and the requirements for obtaining approval from, the Department of Labor to temporarily employ the following three categories of nonimmigrants in the United States: (1) H–1B visas for temporary employment in specialty occupations or as fashion models of distinguished merit and ability; (2) H–1B1 visas for temporary employment in specialty occupations of nonimmigrant professionals from countries with which the United States has entered into certain agreements identified in section 214(g)(8)(A) of the INA; and (3) E–3 visas for nationals of the Commonwealth of Australia for temporary employment in specialty occupations. Subpart I of this part establishes the enforcement provisions that apply to the H–1B, H–1B1, and E–3 visa programs.

(e) *Subparts J and K of this part.* Subparts J and K of this part set forth the process by which employers can file attestations with the Department of Labor for the purpose of employing nonimmigrant alien students on F-visas in off-campus employment and enforcement provisions relating thereto.

[43 FR 10312, Mar. 10, 1978, as amended at 52 FR 20507, June 1, 1987; 55 FR 50510, Dec. 6, 1990; 56 FR 24667, May 30, 1991; 56 FR 54738, Oct. 22, 1991; 56 FR 56875, Nov. 6, 1991; 57 FR 1337, Jan. 13, 1992; 57 FR 40989, Sept. 8, 1992; 69 FR 68226, Nov. 23, 2004; 73 FR 19947, Apr. 11, 2008]

§ 655.00 Authority of the Office of Foreign Labor Certification (OFLC) Administrator under subparts A, B, and C.

Pursuant to the regulations under this part, temporary labor certification determinations under subparts A, B, and C of this part are ordinarily made by the Office of Foreign Labor Certification (OFLC) Administrator (OFLC Administrator) of the Employment and Training Administration. The OFLC Administrator will informally advise the employer or agent of the name of the official who will make determinations with respect to the application.

[71 FR 35518, June 21, 2006]

Subpart A—Labor Certification Process for Temporary Non-Agricultural Employment in the United States (H–2B Workers)

SOURCE: 80 FR 24108, Apr. 29, 2015, unless otherwise noted.

§ 655.1 Scope and purpose of this subpart.

Section 214(c)(1) of the Immigration and Nationality Act (INA), 8 U.S.C. 1184(c)(1), requires the Secretary of Homeland Security to consult with appropriate agencies before authorizing the classification of aliens as H–2B workers. Department of Homeland Security (DHS) regulations at 8 CFR 214.2(h)(6)(iii)(D) designate the Secretary of Labor as an appropriate authority with whom DHS consults regarding the H–2B program, and specifies that the Secretary of Labor, in carrying out this consultative function, shall issue regulations regarding the issuance of temporary labor certifications. DHS regulations at 8 CFR 214.2(h)(6)(iv) further provide that an employer's petition to employ H–2B

nonimmigrant workers for temporary non-agricultural employment in the United States (U.S.), except for Guam, must be accompanied by an approved temporary labor certification from the Secretary of Labor (Secretary).

(a) *Purpose.* The temporary labor certification reflects a determination by the Secretary that:

(1) There are not sufficient U.S. workers who are qualified and who will be available to perform the temporary services or labor for which an employer desires to hire foreign workers, and that

(2) The employment of the H–2B worker(s) will not adversely affect the wages and working conditions of U.S. workers similarly employed.

(b) *Scope.* This subpart sets forth the procedures governing the labor certification process for the temporary employment of nonimmigrant foreign workers in the H–2B nonimmigrant classification, as defined in 8 U.S.C. 1101(a)(15)(H)(ii)(b), section 101(a)(15)(H)(ii)(b) of the INA. It also establishes obligations with respect to the terms and conditions of the temporary labor certification with which H–2B employers must comply, as well as their obligations to H–2B workers and workers in corresponding employment. Additionally, this subpart sets forth integrity measures for ensuring employers' continued compliance with the terms and conditions of the temporary labor certification.

§ 655.2 Authority of the agencies, offices, and divisions in the Department of Labor.

(a) *Authority and role of the Office of Foreign Labor Certification (OFLC).* The Secretary has delegated authority to make determinations under this subpart, pursuant to 8 CFR 214.2(h)(6)(iii)(D) and (h)(6)(iv), to the Assistant Secretary for the Employment and Training Administration (ETA), who in turn has delegated that authority to OFLC. Determinations on an *Application for Temporary Employment Certification* in the H–2B program are made by the Administrator, OFLC who, in turn, may delegate this responsibility to designated staff members, e.g., a Certifying Officer (CO).

(b) *Authority of the Wage and Hour Division (WHD).* Pursuant to its authority under section 214(c)(14)(B) of the INA, 8 U.S.C. 1184(c)(14)(B), DHS has delegated to the Secretary certain investigatory and enforcement functions with respect to terms and conditions of employment in the H–2B program. The Secretary has, in turn, delegated that authority to WHD. The regulations governing WHD investigation and enforcement functions, including those related to the enforcement of temporary labor certifications, issued under this subpart, may be found in 29 CFR part 503.

(c) *Concurrent authority.* OFLC and WHD have concurrent authority to impose a debarment remedy under § 655.73 or under 29 CFR 503.24.

§ 655.3 Territory of Guam.

This subpart does not apply to temporary employment in the Territory of Guam, except that an employer who applies for a temporary labor certification for a job opportunity on Guam will need to obtain a prevailing wage from the U.S. Department of Labor (DOL) in accordance with § 655.10, subject to the transfer of authority to set the prevailing wage for a job opportunity on Guam to DOL in title 8 of the Code of Federal Regulations. DOL does not certify to DHS the temporary employment of H–2B nonimmigrant foreign workers, or enforce compliance with the provisions of the H–2B visa program, in the Territory of Guam.

§ 655.4 Transition procedures.

(a) The NPWC shall continue to process an *Application for Prevailing Wage Determination* submitted prior to April 29, 2015, in accordance with the prevailing wage methodology at 20 CFR part 655, subpart A, revised as of April 1, 2009, except for § 655.10(b)(2), see 20 CFR part 655, subpart A, revised as of April 1, 2014. Employers with a pending *Application for Prevailing Wage Determination* who seek a prevailing wage based on an alternate wage source must submit a new *Application for Prevailing Wage Determination.*

(b) The NPWC shall process an *Application for a Prevailing Wage Determination* submitted on or after April 29, 2015, in accordance with the wage

methodology established in § 655.10 of the final prevailing wage rule.

(c) The NPC shall continue to process an *Application for Temporary Employment Certification* submitted prior to April 29, 2015, in accordance with 20 CFR part 655, subpart A, revised as of April 1, 2009.

(d) The NPC shall process an *Application for Temporary Employment Certification* submitted on or after April 29, 2015, and that has a start date of need prior to October 1, 2015, as follows:

(1) Employers will be permitted to file an *Application for Temporary Employment Certification* job order with the NPC using the emergency situations provision at § 655.17. The *Application for Temporary Employment Certification* must include a signed and dated copy of the new Appendix B associated with the ETA Form 9142B containing the requisite program assurances and obligations under this rule. In the case of a job contractor filing as a joint employer with its employer-client, the NPC must receive a separate attachment containing the employer-client's business and contact information (*i.e.*, sections C and D of the ETA Form 9142B) as well as a separate signed and dated copy of the Appendix B for its employer-client, as required by § 655.19.

(2) The NPC will waive the regulatory filing timeframe under § 655.15 and process the *Application for Temporary Employment Certification* and job order in a manner consistent with the handling of applications under § 655.17 for emergency situations, including the recruitment of U.S. workers on an expedited basis, and make a determination as required by § 655.50. The recruitment of U.S. workers on an expedited basis will consist of placing a new job order with the SWA serving the area of intended employment that contains the job assurances and contents set forth in § 655.18 for a period of not less than 10 calendar days. In addition, employers who have not placed any newspaper advertisements under the rule published at 20 CFR part 655, subpart A, revised as of April 1, 2009. must place one newspaper advertisement, which may be published on any day of the week, meeting the advertising requirements of § 655.41, during the period of time the SWA is actively circulating the job order for intrastate clearance.

(3) If the Chicago NPC grants a temporary labor certification, the employer will receive an original certified ETA Form 9142B and a Final Determination letter. Upon receipt of the original certified ETA Form 9142B, the employer or its agent or attorney, if applicable, must complete the footer on the original Appendix B of the *Application for Temporary Employment Certification,* retain the original Appendix B, and submit a signed copy of Appendix B, together with the original certified ETA Form 9142B directly to USCIS. Under the document retention requirements in § 655.56, the employer must retain a copy of the temporary labor certification and the original signed Appendix B.

(4) An employer who did not submit an *Application for a Prevailing Wage Determination* prior to April 29, 2015, but who has a start date of need prior to October 1, 2015 may submit a completed *Application for a Prevailing Wage Determination* to the NPC with its emergency *Application for Temporary Employment Certification* requesting a prevailing wage determination for the job opportunity. Upon receipt, the NPC will transmit, on behalf of the employer, a copy of the *Application for a Prevailing Wage Determination* to the NPWC for processing and issuance of a prevailing wage determination using the wage methodology established in § 655.10.

(e) The NPC shall process an *Application for Temporary Employment Certification* submitted on or after April 29, 2015, and that has a start date of need after October 1, 2015, in accordance with all application filing requirements under this rule, and the employer must obtain a valid prevailing wage determination under the wage methodology established in § 655.10 prior to filing the job order with the SWA under § 655.16.

(f) Employers with a prevailing wage determination issued by the NPWC, or

who have a pending or granted *Application for Temporary Employment Certification* on April 29, 2015, may seek a supplemental prevailing wage determination (SPWD) in order to obtain a prevailing wage based on an alternate wage source under this rule.

(1) The SPWD will apply during the validity period of the certification, except that such SPWD will be applicable only to those H–2B workers who are not yet employed in the certified position on the date of the issuance of the SPWD. The SPWD will not be applicable to H–2B workers who are already employed in the certified position at the time of the issuance of the SPWD, and it will not apply to U.S. workers recruited and hired under the original job order. For seafood employers whose workers' entry into the U.S. may be staggered under § 655.15(f), an SPWD issued under this provision will apply only to those H–2B workers who have not yet entered the U.S. and are therefore not yet employed in the certified position at the time of the issuance of the SPWD.

(2) In order to receive an SPWD under this provision, the employer must submit a new ETA Form 9141 to the NPWC that contains in Section E.a.5 Job Duties the original PWD tracking number (starting with P–400), the H–2B temporary employment certification application number (starting with H–400), and the words ''Request for a Supplemental Prevailing Wage Determination.'' Electronic submission through the iCERT Visa Portal System is preferred. Upon receipt of the request, the NPWC will issue to the employer, or if applicable, the employer's attorney or agent, an SPWD in an expedited manner and provide a copy to the Chicago NPC.

§ 655.5 Definition of terms.

For purposes of this subpart:

Act means the Immigration and Nationality Act or INA, as amended, 8 U.S.C. 1101 *et seq.*

Administrative Law Judge (ALJ) means a person within the Department's Office of Administrative Law Judges appointed under 5 U.S.C. 3105.

Administrator, Office of Foreign Labor Certification (OFLC) means the primary official of the Office of Foreign Labor Certification, ETA, or the Administrator's designee.

Administrator, Wage and Hour Division (WHD) means the primary official of the WHD, or the Administrator's designee.

Agent means:

(1) A legal entity or person who:

(i) Is authorized to act on behalf of an employer for temporary nonagricultural labor certification purposes;

(ii) Is not itself an employer, or a joint employer, as defined in this part with respect to a specific application; and

(iii) Is not an association or other organization of employers.

(2) No agent who is under suspension, debarment, expulsion, disbarment, or otherwise restricted from practice before any court, the Department of Labor, the Executive Office for Immigration Review under 8 CFR 1003.101, or DHS under 8 CFR 292.3 may represent an employer under this part.

Agricultural labor or services means those duties and occupations defined in subpart B of this part.

Applicant means a U.S. worker who is applying for a job opportunity for which an employer has filed an *Application for Temporary Employment Certification* (ETA Form 9142B and the appropriate appendices).

Application for Temporary Employment Certification means the Office of Management and Budget (OMB)-approved ETA Form 9142B and the appropriate appendices, a valid wage determination, as required by § 655.10, and a subsequently-filed U.S. worker recruitment report, submitted by an employer to secure a temporary labor certification determination from DOL.

Area of intended employment means the geographic area within normal commuting distance of the place (worksite address) of the job opportunity for which the certification is sought. There is no rigid measure of distance that constitutes a normal commuting distance or normal commuting area, because there may be widely varying factual circumstances among different areas (e.g., average commuting times, barriers to reaching the worksite, or quality of the regional transportation network). If the place of

intended employment is within a Metropolitan Statistical Area (MSA), including a multistate MSA, any place within the MSA is deemed to be within normal commuting distance of the place of intended employment. The borders of MSAs are not controlling in the identification of the normal commuting area; a location outside of an MSA may be within normal commuting distance of a location that is inside (e.g., near the border of) the MSA.

Area of substantial unemployment means a contiguous area with a population of at least 10,000 in which there is an average unemployment rate equal to or exceeding 6.5 percent for the 12 months preceding the determination of such areas made by the ETA.

Attorney means any person who is a member in good standing of the bar of the highest court of any State, possession, territory, or commonwealth of the U.S., or the District of Columbia. No attorney who is under suspension, debarment, expulsion, disbarment, or otherwise restricted from practice before any court, the Department of Labor, the Executive Office for Immigration Review under 8 CFR 1003.101, or DHS under 8 CFR 292.3 may represent an employer under this subpart.

Board of Alien Labor Certification Appeals (BALCA or Board) means the permanent Board established by part 656 of this chapter, chaired by the Chief Administrative Law Judge (Chief ALJ), and consisting of ALJs assigned to the Department of Labor and designated by the Chief ALJ to be members of BALCA.

Certifying Officer (CO) means an OFLC official designated by the Administrator, OFLC to make determinations on applications under the H–2B program. The Administrator, OFLC is the National CO. Other COs may also be designated by the Administrator, OFLC to make the determinations required under this subpart.

Chief Administrative Law Judge (Chief ALJ) means the chief official of the Department's Office of Administrative Law Judges or the Chief Administrative Law Judge's designee.

Corresponding employment means:

(1) The employment of workers who are not H–2B workers by an employer that has a certified H–2B *Application for Temporary Employment Certification* when those workers are performing either substantially the same work included in the job order or substantially the same work performed by the H–2B workers, except that workers in the following two categories are not included in corresponding employment:

(i) Incumbent employees continuously employed by the H–2B employer to perform substantially the same work included in the job order or substantially the same work performed by the H–2B workers during the 52 weeks prior to the period of employment certified on the *Application for Temporary Employment Certification* and who have worked or been paid for at least 35 hours in at least 48 of the prior 52 workweeks, and who have worked or been paid for an average of at least 35 hours per week over the prior 52 weeks, as demonstrated on the employer's payroll records, provided that the terms and working conditions of their employment are not substantially reduced during the period of employment covered by the job order. In determining whether this standard was met, the employer may take credit for any hours that were reduced by the employee voluntarily choosing not to work due to personal reasons such as illness or vacation; or

(ii) Incumbent employees covered by a collective bargaining agreement or an individual employment contract that guarantees both an offer of at least 35 hours of work each workweek and continued employment with the H–2B employer at least through the period of employment covered by the job order, except that the employee may be dismissed for cause.

(2) To qualify as corresponding employment, the work must be performed during the period of the job order, including any approved extension thereof.

Date of need means the first date the employer requires services of the H–2B workers as listed on the *Application for Temporary Employment Certification*.

Department of Homeland Security (DHS) means the Federal Department having jurisdiction over certain immigration-related functions, acting through its component agencies, including USCIS.

Employee means a person who is engaged to perform work for an employer, as defined under the general common law. Some of the factors relevant to the determination of employee status include: The hiring party's right to control the manner and means by which the work is accomplished; the skill required to perform the work; the source of the instrumentalities and tools for accomplishing the work; the location of the work; the hiring party's discretion over when and how long to work; and whether the work is part of the regular business of the hiring party. Other applicable factors may be considered and no one factor is dispositive. The terms employee and worker are used interchangeably in this subpart.

Employer means a person (including any individual, partnership, association, corporation, cooperative, firm, joint stock company, trust, or other organization with legal rights and duties) that:

(1) Has a place of business (physical location) in the U.S. and a means by which it may be contacted for employment;

(2) Has an employer relationship (such as the ability to hire, pay, fire, supervise or otherwise control the work of employees) with respect to an H–2B worker or a worker in corresponding employment; and

(3) Possesses, for purposes of filing an *Application for Temporary Employment Certification*, a valid Federal Employer Identification Number (FEIN).

Employer-client means an employer that has entered into an agreement with a job contractor and that is not an affiliate, branch or subsidiary of the job contractor, under which the job contractor provides services or labor to the employer on a temporary basis and will not exercise substantial, direct day-to-day supervision and control in the performance of the services or labor to be performed other than hiring, paying and firing the workers.

Employment and Training Administration (ETA) means the agency within the Department of Labor that includes OFLC and has been delegated authority by the Secretary to fulfill the Secretary's mandate under the DHS regulations for the administration and adjudication of an *Application for Temporary Employment Certification* and related functions.

Federal holiday means a legal public holiday as defined at 5 U.S.C. 6103.

Full-time means 35 or more hours of work per week.

H–2B Petition means the DHS Form I–129 *Petition for a Nonimmigrant Worker*, with H Supplement or successor form or supplement, and accompanying documentation required by DHS for employers seeking to employ foreign persons as H–2B nonimmigrant workers

H–2B Registration means the OMB-approved ETA Form 9155, submitted by an employer to register its intent to hire H–2B workers and to file an *Application for Temporary Employment Certification*.

H–2B worker means any temporary foreign worker who is lawfully present in the U.S. and authorized by DHS to perform nonagricultural labor or services of a temporary or seasonal nature under 8 U.S.C. 1101(a)(15)(H)(ii)(b), INA section 101(a)(15)(H)(ii)(b).

Job contractor means a person, association, firm, or a corporation that meets the definition of an employer and that contracts services or labor on a temporary basis to one or more employers, which is not an affiliate, branch or subsidiary of the job contractor and where the job contractor will not exercise substantial, direct day-to-day supervision and control in the performance of the services or labor to be performed other than hiring, paying and firing the workers.

Job offer means the offer made by an employer or potential employer of H–2B workers to both U.S. and H–2B workers describing all the material terms and conditions of employment, including those relating to wages, working conditions, and other benefits.

Job opportunity means one or more openings for full-time employment with the petitioning employer within a specified area(s) of intended employment for which the petitioning employer is seeking workers.

Job order means the document containing the material terms and conditions of employment relating to wages, hours, working conditions, worksite and other benefits, including obligations and assurances under 29 CFR part

503 and this subpart that is posted between and among the State Workforce Agencies (SWAs) on their job clearance systems.

Joint employment means that where two or more employers each have sufficient definitional indicia of being an employer to be considered the employer of a worker, those employers will be considered to jointly employ that worker. Each employer in a joint employment relationship to a worker is considered a joint employer of that worker.

Layoff means any involuntary separation of one or more U.S. employees without cause.

Metropolitan Statistical Area (MSA) means a geographic entity defined by OMB for use by Federal statistical agencies in collecting, tabulating, and publishing Federal statistics. A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but fewer than 50,000) population. Each metro or micro area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.

National Prevailing Wage Center (NPWC) means that office within OFLC from which employers, agents, or attorneys who wish to file an *Application for Temporary Employment Certification* receive a prevailing wage determination (PWD).

NPWC Director means the OFLC official to whom the Administrator, OFLC has delegated authority to carry out certain NPWC operations and functions.

National Processing Center (NPC) means the office within OFLC which is charged with the adjudication of an *Application for Temporary Employment Certification* or other applications. For purposes of this subpart, the NPC receiving a request for an *H–2B Registration* and an *Application for Temporary Employment Certification* is the Chicago NPC whose address is published in the FEDERAL REGISTER.

NPC Director means the OFLC official to whom the Administrator, OFLC has delegated authority for purposes of certain Chicago NPC operations and functions.

Non-agricultural labor and services means any labor or services not considered to be agricultural labor or services as defined in subpart B of this part. It does not include the provision of services as members of the medical profession by graduates of medical schools.

Occupational employment statistics (OES) survey means the program under the jurisdiction of the Bureau of Labor Statistics (BLS) that provides annual wage estimates for occupations at the State and MSA levels.

Offered wage means the wage offered by an employer in an H–2B job order. The offered wage must equal or exceed the highest of the prevailing wage or Federal, State or local minimum wage.

Office of Foreign Labor Certification (OFLC) means the organizational component of the ETA that provides national leadership and policy guidance and develops regulations to carry out the Secretary's responsibilities, including determinations related to an employer's request for *H–2B Regis*tration, *Application for Prevailing Wage Determination*, or *Application for Temporary Employment Certification*.

Prevailing wage determination (PWD) means the prevailing wage for the position, as described in § 655.10, that is the subject of the *Application for Temporary Employment Certification*. The PWD is made on ETA Form 9141, *Application for Prevailing Wage Determination*.

Professional athlete means an individual who is employed as an athlete by:

(1) A team that is a member of an association of six or more professional sports teams whose total combined revenues exceed $10,000,000 per year, if the association governs the conduct of its members and regulates the contests and exhibitions in which its member teams regularly engage; or

(2) Any minor league team that is affiliated with such an association.

Seafood is defined as fresh or saltwater finfish, crustaceans, other forms of aquatic animal life, including, but not limited to, alligator, frog, aquatic turtle, jellyfish, sea cucumber, and sea urchin and the roe of such animals, and all mollusks.

Secretary means the Secretary of Labor, the chief official of the U.S. Department of Labor, or the Secretary's designee.

Secretary of Homeland Security means the chief official of the U.S. Department of Homeland Security (DHS) or the Secretary of Homeland Security's designee.

Secretary of State means the chief official of the U.S. Department of State or the Secretary of State's designee.

State Workforce Agency (SWA) means a State government agency that receives funds under the Wagner-Peyser Act (29 U.S.C. 49 *et seq.*) to administer the State's public labor exchange activities.

Strike means a concerted stoppage of work by employees as a result of a labor dispute, or any concerted slowdown or other concerted interruption of operation (including stoppage by reason of the expiration of a collective bargaining agreement).

Successor in interest means:

(1) Where an employer has violated 29 CFR part 503, or this subpart, and has ceased doing business or cannot be located for purposes of enforcement, a successor in interest to that employer may be held liable for the duties and obligations of the violating employer in certain circumstances. The following factors, as used under Title VII of the Civil Rights Act and the Vietnam Era Veterans' Readjustment Assistance Act, may be considered in determining whether an employer is a successor in interest; no one factor is dispositive, but all of the circumstances will be considered as a whole:

(i) Substantial continuity of the same business operations;

(ii) Use of the same facilities;

(iii) Continuity of the work force;

(iv) Similarity of jobs and working conditions;

(v) Similarity of supervisory personnel;

(vi) Whether the former management or owner retains a direct or indirect interest in the new enterprise;

(vii) Similarity in machinery, equipment, and production methods;

(viii) Similarity of products and services; and

(ix) The ability of the predecessor to provide relief.

(2) For purposes of debarment only, the primary consideration will be the personal involvement of the firm's ownership, management, supervisors, and others associated with the firm in the violation(s) at issue.

United States (U.S.) means the continental United States, Alaska, Hawaii, the Commonwealth of Puerto Rico, Guam, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands (CNMI).

U.S. Citizenship and Immigration Services (USCIS) means the Federal agency within DHS that makes the determination under the INA whether to grant petitions filed by employers seeking H–2B workers to perform temporary non-agricultural work in the U.S.

United States worker (U.S. worker) means a worker who is:

(1) A citizen or national of the U.S.;

(2) An alien who is lawfully admitted for permanent residence in the U.S., is admitted as a refugee under 8 U.S.C. 1157, section 207 of the INA, is granted asylum under 8 U.S.C. 1158, section 208 of the INA, or is an alien otherwise authorized under the immigration laws to be employed in the U.S.; or

(3) An individual who is not an unauthorized alien (as defined in 8 U.S.C. 1324a(h)(3), section 274a(h)(3) of the INA) with respect to the employment in which the worker is engaging.

Wage and Hour Division (WHD) means the agency within the Department of Labor with investigatory and law enforcement authority, as delegated from DHS, to carry out the provisions under 8 U.S.C. 1184(c), section 214(c) of the INA.

Wages mean all forms of cash remuneration to a worker by an employer in payment for personal services.

§ 655.6 Temporary need.

(a) An employer seeking certification under this subpart must establish that its need for non-agricultural services or labor is temporary, regardless of whether the underlying job is permanent or temporary.

(b) The employer's need is considered temporary if justified to the CO as one of the following: A one-time occurrence; a seasonal need; a peakload

need; or an intermittent need, as defined by DHS regulations. Except where the employer's need is based on a one-time occurrence, the CO will deny a request for an *H–2B Registration* or an *Application for Temporary Employment Certification* where the employer has a need lasting more than 9 months.

(c) A job contractor will only be permitted to seek certification if it can demonstrate through documentation its own temporary need, not that of its employer-client(s). A job contractor will only be permitted to file applications based on a seasonal need or a one-time occurrence.

(d) Nothing in this paragraph (d) is intended to limit the authority of the Secretary of Homeland Security, in the course of adjudicating an H–2B petition, to make the final determination as to whether a prospective H–2B employer's need is temporary in nature.

§ 655.7 Persons and entities authorized to file.

(a) *Persons authorized to file.* In addition to the employer applicant, a request for an *H–2B Registration* or an *Application for Temporary Employment Certification* may be filed by an attorney or agent, as defined in § 655.5.

(b) *Employer's signature required.* Regardless of whether the employer is represented by an attorney or agent, the employer is required to sign the *H–2B Registration* and *Application for Temporary Employment Certification* and all documentation submitted to the Department of Labor.

§ 655.8 Requirements for agents.

An agent filing an *Application for Temporary Employment Certification* on behalf of an employer must provide:

(a) A copy of the agent agreement or other document demonstrating the agent's authority to represent the employer; and

(b) A copy of the Migrant and Seasonal Agricultural Worker Protection Act (MSPA) Farm Labor Contractor Certificate of Registration, if the agent is required under MSPA, at 29 U.S.C. 1801 *et seq.*, to have such a certificate, identifying the specific farm labor contracting activities the agent is authorized to perform.

§ 655.9 Disclosure of foreign worker recruitment.

(a) The employer, and its attorney or agent, as applicable, must provide a copy of all agreements with any agent or recruiter whom it engages or plans to engage in the recruitment of H–2B workers under this *Application for Temporary Employment Certification*. These agreements must contain the contractual prohibition against charging fees as set forth in § 655.20(p).

(b) The employer, and its attorney or agent, as applicable, must also provide the identity and location of all persons and entities hired by or working for the recruiter or agent referenced in paragraph (a) of this section, and any of the agents or employees of those persons and entities, to recruit prospective foreign workers for the H–2B job opportunities offered by the employer.

(c) The Department of Labor will maintain a publicly available list of agents and recruiters who are party to the agreements referenced in paragraph (a) of this section, as well as the persons and entities referenced in paragraph (b) of this section and the locations in which they are operating.

Prefiling Procedures

§ 655.10 Determination of prevailing wage for temporary labor certification purposes.

(a) *Offered wage.* The employer must advertise the position to all potential workers at a wage at least equal to the prevailing wage obtained from the NPWC, or the Federal, State or local minimum wage, whichever is highest. The employer must offer and pay this wage (or higher) to both its H–2B workers and its workers in corresponding employment. The issuance of a PWD under this section does not permit an employer to pay a wage lower than the highest wage required by any applicable Federal, State or local law.

(b) *Determinations.* Prevailing wages shall be determined as follows:

(1) Except as provided in paragraph (i) of this section, if the job opportunity is covered by a collective bargaining agreement (CBA) that was negotiated at arms' length between the union and the employer, the wage rate

set forth in the CBA is considered as not adversely affecting the wages of U.S. workers, that is, it is considered the ''prevailing wage'' for labor certification purposes.

(2) If the job opportunity is not covered by a CBA, the prevailing wage for labor certification purposes shall be the arithmetic mean of the wages of workers similarly employed in the area of intended employment using the wage component of the BLS Occupational Employment Statistics Survey (OES), unless the employer provides a survey acceptable to OFLC under paragraph (f) of this section.

(c) *Request for PWD.* (1) An employer must request and receive a PWD from the NPWC before filing the job order with the SWA.

(2) The PWD must be valid on the date the job order is posted.

(d) *Multiple worksites.* If the job opportunity involves multiple worksites within an area of intended employment and different prevailing wage rates exist for the opportunity within the area of intended employment, the prevailing wage is the highest applicable wage among all the worksites.

(e) *NPWC action.* The NPWC will provide the PWD, indicate the source, and return the Application for Prevailing Wage Determination (ETA Form 9141) with its endorsement to the employer.

(f) *Employer-provided survey.* (1) If the job opportunity is not covered by a CBA, or by a professional sports league's rules or regulations, the NPWC will consider a survey provided by the employer in making a Prevailing Wage Determination only if the employer submission demonstrates that the survey falls into one of the following categories:

(i) The survey was independently conducted and issued by a state, including any state agency, state college, or state university;

(ii) The survey is submitted for a geographic area where the OES does not collect data, or in a geographic area where the OES provides an arithmetic mean only at a national level for workers employed in the SOC;

(iii)(A) The job opportunity is not included within an occupational classification of the SOC system; or

(B) The job opportunity is within an occupational classification of the SOC system designated as an ''all other'' classification.

(2) The survey must provide the arithmetic mean of the wages of all workers similarly employed in the area of intended employment, except that if the survey provides a median but does not provide an arithmetic mean, the prevailing wage applicable to the employer's job opportunity shall be the median of the wages of workers similarly employed in the area of intended employment.

(3) Notwithstanding paragraph (f)(2) of this section, the geographic area surveyed may be expanded beyond the area of intended employment, but only as necessary to meet the requirements of paragraph (f)(4)(ii) of this section. Any geographic expansion beyond the area of intended employment must include only those geographic areas that are contiguous to the area of intended employment.

(4) In each case where the employer submits a survey under paragraph (f)(1) of this section, the employer must submit, concurrently with the ETA Form 9141, a completed Form ETA–9165 containing specific information about the survey methodology, including such items as sample size and source, sample selection procedures, and survey job descriptions, to allow a determination of the adequacy of the data provided and validity of the statistical methodology used in conducting the survey. In addition, the information provided by the employer must include the attestation that:

(i) The surveyor either made a reasonable, good faith attempt to contact all employers employing workers in the occupation and geographic area surveyed or conducted a randomized sampling of such employers;

(ii) The survey includes wage data from at least 30 workers and three employers;

(iii) If the survey is submitted under paragraph (f)(1)(ii) or (iii) of this section, the collection was administered by a bona fide third party. The following are not bona fide third parties under this rule: Any H–2B employer or any H–2B employer's agent, representative, or attorney;

(iv) The survey was conducted across industries that employ workers in the occupation; and

(v) The wage reported in the survey includes all types of pay, consistent with Form ETA–9165.

(5) The survey must be based upon recently collected data: The survey must be the most current edition of the survey and must be based on wages paid not more than 24 months before the date the survey is submitted for consideration.

(g) *Review of employer-provided surveys.* (1) If the NPWC finds an employer-provided survey not to be acceptable, the NPWC shall inform the employer in writing of the reasons the survey was not accepted.

(2) The employer, after receiving notification that the survey it provided for consideration is not acceptable, may request review under § 655.13.

(h) *Validity period.* The NPWC must specify the validity period of the prevailing wage, which in no event may be more than 365 days and no less than 90 days from the date that the determination is issued.

(i) *Professional athletes.* In computing the prevailing wage for a professional athlete when the job opportunity is covered by professional sports league rules or regulations, the wage set forth in those rules or regulations is considered the prevailing wage.

(j) *Retention of documentation.* The employer must retain the PWD for 3 years from the date of issuance or the date of a final determination on the *Application for Temporary Employment Certification,* whichever is later, and submit it to a CO if requested by a Notice of Deficiency, described in § 655.31, or audit, as described in § 655.70, or to a WHD representative during a WHD investigation.

(k) *Guam.* The requirements of this section apply to any request filed for an H–2B job opportunity on Guam, subject to the transfer of authority to set the prevailing wage for a job opportunity on Guam to DOL in Title 8 of the Code of Federal Regulations.

[80 FR 24108, Apr. 29, 2015, as amended at 80 FR 24184, Apr. 29, 2015]

§ 655.11 Registration of H–2B employers.

All employers, including job contractors, that desire to hire H–2B workers must establish their need for services or labor is temporary by filing an *H–2B Registration* with the Chicago NPC.

(a) *Registration filing.* An employer must file an *H–2B Registration.* The *H–2B Registration* must be accompanied by documentation evidencing:

(1) The number of positions that will be sought in the first year of registration;

(2) The time period of need for the workers requested;

(3) That the nature of the employer's need for the services or labor to be performed is non-agricultural and temporary, and is justified as either a one-time occurrence, a seasonal need, a peakload need, or an intermittent need, as defined by DHS regulations and § 655.6 (or in the case of job contractors, a seasonal need or one-time occurrence); and

(4) For job contractors, the job contractor's own seasonal need or one-time occurrence, such as through the provision of payroll records.

(b) *Original signature.* The *H–2B Registration* must bear the original signature of the employer (and that of the employer's attorney or agent if applicable). If and when the *H–2B Registration* is permitted to be filed electronically, the employer will satisfy this requirement by signing the *H–2B Registration* as directed by the CO.

(c) *Timeliness of registration filing.* A completed request for an *H–2B Registration* must be received by no less than 120 calendar days and no more than 150 calendar days before the employer's date of need, except where the employer submits the *H–2B Registration* in support of an emergency filing under § 655.17.

(d) *Temporary need.* (1) The employer must establish that its need for non-agricultural services or labor is temporary, regardless of whether the underlying job is permanent or temporary, consistent with DHS regulations. A job contractor must also demonstrate through documentation its own seasonal need or one-time occurrence.

(2) The employer's need will be assessed in accordance with the definitions provided by the Secretary of Homeland Security and as further defined in § 655.6.

(e) *NPC review.* The CO will review the *H–2B Registration* and its accompanying documentation for completeness and make a determination based on the following factors:

(1) The job classification and duties qualify as non-agricultural;

(2) The employer's need for the services or labor to be performed is temporary in nature, and for job contractors, demonstration of the job contractor's own seasonal need or one-time occurrence;

(3) The number of worker positions and period of need are justified; and

(4) The request represents a bona fide job opportunity.

(f) *Mailing and postmark requirements.* Any notice or request pertaining to an *H–2B Registration* sent by the CO to an employer requiring a response will be mailed to the address provided on the *H–2B Registration* using methods to assure next day delivery, including electronic mail. The employer's response to the notice or request must be mailed using methods to assure next day delivery, including electronic mail, and be sent by the due date specified by the CO or by the next business day if the due date falls on a Saturday, Sunday or Federal holiday.

(g) *Request for information (RFI).* If the CO determines the *H–2B Registration* cannot be approved, the CO will issue an RFI. The RFI will be issued within 7 business days of the CO's receipt of the *H–2B Registration.* The RFI will:

(1) State the reason(s) why the *H–2B Registration* cannot be approved and what supplemental information or documentation is needed to correct the deficiencies;

(2) Specify a date, no later than 7 business days from the date the RFI is issued, by which the supplemental information or documentation must be sent by the employer;

(3) State that, upon receipt of a response to the RFI, the CO will review the *H–2B Registration* as well as any supplemental information and documentation and issue a Notice of Decision on the *H–2B Registration.* The CO may, at his or her discretion, issue one or more additional RFIs before issuing a Notice of Decision on the *H–2B Registration;* and

(4) State that failure to comply with an RFI, including not responding in a timely manner or not providing all required documentation within the specified timeframe, will result in a denial of the *H–2B Registration.*

(h) *Notice of Decision.* The CO will notify the employer in writing of the final decision on the *H–2B Registration.*

(1) Approved *H–2B Registration.* If the *H–2B Registration* is approved, the CO will send a Notice of Decision to the employer, and a copy to the employer's attorney or agent, if applicable. The Notice of Decision will notify the employer that it is eligible to seek H–2B workers in the occupational classification for the anticipated number of positions and period of need stated on the approved *H–2B Registration.* The CO may approve the *H–2B Registration* for a period of up to 3 consecutive years.

(2) Denied *H–2B Registration.* If the *H–2B Registration* is denied, the CO will send a Notice of Decision to the employer, and a copy to the employer's attorney or agent, if applicable. The Notice of Decision will:

(i) State the reason(s) why the *H–2B Registration* is denied;

(ii) Offer the employer an opportunity to request administrative review under § 655.61 within 10 business days from the date the Notice of Decision is issued and state that if the employer does not request administrative review within that period the denial is final.

(i) *Retention of documents.* All employers filing an *H–2B Registration* are required to retain any documents and records not otherwise submitted proving compliance with this subpart. Such records and documents must be retained for a period of 3 years from the date of certification of the last *Application for Temporary Employment Certification* supported by the *H–2B Registration,* if approved, or 3 years from the date the decision is issued if the *H–2B Registration* is denied or 3 years from the day the Department of Labor receives written notification from the

employer withdrawing its pending *H–2B Registration*.

(j) *Transition period*. In order to allow OFLC to make the necessary changes to its program operations to accommodate the new registration process, OFLC will announce in the FEDERAL REGISTER a separate transition period for the registration process, and until that time, will continue to adjudicate temporary need during the processing of applications.

§ 655.12 Use of registration of H–2B employers.

(a) Upon approval of the *H–2B Registration*, the employer is authorized for the specified period of up to 3 consecutive years from the date the *H–2B Registration* is approved to file an *Application for Temporary Employment Certification*, unless:

(1) The number of workers to be employed has increased by more than 20 percent (or 50 percent for employers requesting fewer than 10 workers) from the initial year;

(2) The dates of need for the job opportunity have changed by more than a total of 30 calendar days from the initial year for the entire period of need;

(3) The nature of the job classification and/or duties has materially changed; or

(4) The temporary nature of the employer's need for services or labor to be performed has materially changed.

(b) If any of the changes in paragraphs (a)(1) through (4) of this section apply, the employer must file a new *H–2B Registration* in accordance with § 655.11.

(c) The *H–2B Registration* may not be transferred from one employer to another unless the employer to which it is transferred is a successor in interest to the employer to which it was issued.

§ 655.13 Review of PWDs.

(a) *Request for review of PWDs.* Any employer desiring review of a PWD must make a written request for such review to the NPWC Director within 7 business days from the date the PWD is issued. The request for review must clearly identify the PWD for which review is sought; set forth the particular grounds for the request; and include any materials submitted to the NPWC for purposes of securing the PWD.

(b) *NPWC review*. Upon the receipt of the written request for review, the NPWC Director will review the employer's request and accompanying documentation, including any supplementary material submitted by the employer, and after review shall issue a Final Determination letter; that letter may:

(1) Affirm the PWD issued by the NPWC; or

(2) Modify the PWD.

(c) *Request for review by BALCA*. Any employer desiring review of the NPWC Director's decision on a PWD must make a written request for review of the determination by BALCA within 10 business days from the date the Final Determination letter is issued.

(1) The request for BALCA review must be in writing and addressed to the NPWC Director who made the final determinations. Upon receipt of a request for BALCA review, the NPWC will prepare an appeal file and submit it to BALCA.

(2) The request for review, statements, briefs, and other submissions of the parties must contain only legal arguments and may refer to only the evidence that was within the record upon which the decision on the PWD was based.

(3) BALCA will handle appeals in accordance with § 655.61.

§ 655.14 [Reserved]

APPLICATION FOR TEMPORARY EMPLOYMENT CERTIFICATION FILING PROCEDURES

§ 655.15 Application filing requirements.

All registered employers that desire to hire H–2B workers must file an *Application for Temporary Employment Certification* with the NPC designated by the Administrator, OFLC. Except for employers that qualify for emergency procedures at § 655.17, employers that fail to register under the procedures in § 655.11 and/or that fail to submit a PWD obtained under § 655.10 will not be eligible to file an *Application for Temporary Employment Certification* and their applications will be returned without review.

(a) *What to file.* A registered employer seeking H–2B workers must file a completed *Application for Temporary Employment Certification* (ETA Form 9142B and the appropriate appendices and valid PWD), a copy of the job order being submitted concurrently to the SWA serving the area of intended employment, as set forth in § 655.16, and copies of all contracts and agreements with any agent and/or recruiter, executed in connection with the job opportunities and all information required, as specified in §§ 655.8 and 655.9.

(b) *Timeliness.* A completed *Application for Temporary Employment Certification* must be filed no more than 90 calendar days and no less than 75 calendar days before the employer's date of need.

(c) *Location and method of filing.* The employer must submit the *Application for Temporary Employment Certification* and all required supporting documentation to the NPC either electronically or by mail.

(d) *Original signature.* The *Application for Temporary Employment Certification* must bear the original signature of the employer (and that of the employer's authorized attorney or agent if the employer is so represented). If the *Application for Temporary Employment Certification* is filed electronically, the employer must satisfy this requirement by signing the *Application for Temporary Employment Certification* as directed by the CO.

(e) *Requests for multiple positions.* Certification of more than one position may be requested on the *Application for Temporary Employment Certification* as long as all H–2B workers will perform the same services or labor under the same terms and conditions, in the same occupation, in the same area of intended employment, and during the same period of employment.

(f) *Separate applications.* Except as otherwise permitted by this paragraph (f), only one *Application for Temporary Employment Certification* may be filed for worksite(s) within one area of intended employment for each job opportunity with an employer for each period of employment. Except where otherwise permitted under § 655.4, an association or other organization of employers is not permitted to file master applications on behalf of its employer-members under the H–2B program.

(1) Subject to paragraph (f)(2) of this section, if a petition for H–2B nonimmigrants filed by an employer in the seafood industry is granted, the employer may bring the nonimmigrants described in the petition into the United States at any time during the 120-day period beginning on the start date for which the employer is seeking the services of the nonimmigrants without filing another petition.

(2) An employer in the seafood industry may not bring H–2B nonimmigrants into the United States after the date that is 90 days after the start date for which the employer is seeking the services of the nonimmigrants unless the employer conducts new recruitment, that begins at least 45 days after, and ends before the 90th day after, the certified start date of need as follows:

(i) Completes a new assessment of the local labor market by—

(A) Listing the job orders in local newspapers on 2 separate Sundays; and

(B) Placing new job orders for the job opportunity with the State Workforce Agency serving the area of intended employment and posting the job opportunity at the place of employment for at least 10 days; and

(C) Offering the job to an equally or better qualified United States worker who—

(*1*) Applies for the job; and

(*2*) Will be available at the time and place of need.

(3) In order to comply with this provision, employers in the seafood industry must—

(*1*) Sign and date an attestation form stating the employer's compliance with this subparagraph. The attestation form is available at *http://www.foreignlaborcert.doleta.gov/form.cfm;*

(*2*) Provide each H–2B nonimmigrant worker seeking admission to the United States a copy of the signed and dated attestation, with instructions that the worker must present the documentation upon request to the Department of State's consular officers when they apply for a visa and/or the Department of Homeland Security's U.S Customs and Border Protection officers when seeking admission to the United States. Without this attestation, an H–

2B nonimmigrant may be denied a visa or admission to the United States if seeking to enter at any time other than the start date stated in the petition. (The attestation is not necessary when filing an amended petition based on a worker who is being substituted in accordance with DHS regulations.) The attestation presented by an H–2B nonimmigrant worker must be the official attestation downloaded from OFLC's Web site and may not be altered or revised in any manner; and

(*3*) Retain the additional recruitment documentation, together with their prefiling recruitment documentation, for a period of 3 years from the date of certification, consistent with the document retention requirements under § 655.56. Seafood industry employers who conduct the required additional recruitment should not submit proof of the additional recruitment to the Office of Foreign Labor Certification.

(g) *One-time occurrence.* Where a one-time occurrence lasts longer than 1 year, the CO will instruct the employer on any additional recruitment requirements with respect to the continuing validity of the labor market test or offered wage obligation.

(h) *Information dissemination.* Information received in the course of processing a request for an *H–2B Registration*, an *Application for Temporary Employment Certification* or program integrity measures such as audits may be forwarded from OFLC to WHD, or any other Federal agency as appropriate, for investigative and/or enforcement purposes.

§ 655.16 Filing of the job order at the SWA.

(a) *Submission of the job order.* (1) The employer must submit the job order to the SWA serving the area of intended employment at the same time it submits the *Application for Temporary Employment Certification* and a copy of the job order to the NPC in accordance with § 655.15. If the job opportunity is located in more than one State within the same area of intended employment, the employer may submit the job order to any one of the SWAs having jurisdiction over the anticipated worksites, but must identify the receiving SWA on the copy of the job order submitted to the NPC with its *Application for Temporary Employment Certification.* The employer must inform the SWA that the job order is being placed in connection with a concurrently submitted *Application for Temporary Employment Certification* for H–2B workers.

(2) In addition to complying with State-specific requirements governing job orders, the job order submitted to the SWA must satisfy the requirements set forth in § 655.18.

(b) *SWA review of the job order.* The SWA must review the job order and ensure that it complies with criteria set forth in § 655.18. If the SWA determines that the job order does not comply with the applicable criteria, the SWA must inform the CO at the NPC of the noted deficiencies within 6 business days of receipt of the job order.

(c) *Intrastate and interstate clearance.* Upon receipt of the Notice of Acceptance, as described in § 655.33, the SWA must promptly place the job order in intrastate clearance, and in interstate clearance by providing a copy of the job order to other states as directed by the CO.

(d) *Duration of job order posting and SWA referral of U.S. workers.* Upon receipt of the Notice of Acceptance, any SWA in receipt of the employer's job order must keep the job order on its active file until the end of the recruitment period, as set forth in § 655.40(c), and must refer to the employer in a manner consistent with § 655.47 all qualified U.S. workers who apply for the job opportunity or on whose behalf a job application is made.

(e) *Amendments to a job order.* The employer may amend the job order at any time before the CO makes a final determination, in accordance with procedures set forth in § 655.35.

§ 655.17 Emergency situations.

(a) *Waiver of time period.* The CO may waive the time period(s) for filing an *H–2B Registration* and/or an *Application for Temporary Employment Certification* for employers that have good and substantial cause, provided that the CO has sufficient time to thoroughly test the domestic labor market on an expedited basis and to make a final determination as required by § 655.50.

(b) *Employer requirements.* The employer requesting a waiver of the required time period(s) must submit to the NPC a request for a waiver of the time period requirement, a completed *Application for Temporary Employment Certification* and the proposed job order identifying the SWA serving the area of intended employment, and must otherwise meet the requirements of § 655.15. If the employer did not previously apply for an *H–2B Registration*, the employer must also submit a completed *H–2B Registration* with all supporting documentation, as required by § 655.11. If the employer did not previously apply for a PWD, the employer must also submit a completed PWD request. The employer's waiver request must include detailed information describing the good and substantial cause that has necessitated the waiver request. Good and substantial cause may include, but is not limited to, the substantial loss of U.S. workers due to Acts of God, or a similar unforeseeable man-made catastrophic event (such as an oil spill or controlled flooding) that is wholly outside of the employer's control, unforeseeable changes in market conditions, or pandemic health issues. A denial of a previously submitted *H–2B Registration* in accordance with the procedures set forth in § 655.11 does not constitute good and substantial cause necessitating a waiver under this section.

(c) *Processing of emergency applications.* The CO will process the emergency *H–2B Registration* and/or *Application for Temporary Employment Certification* and job order in a manner consistent with the provisions of this subpart and make a determination on the *Application for Temporary Employment Certification* in accordance with § 655.50. If the CO grants the waiver request, the CO will forward a Notice of Acceptance and the approved job order to the SWA serving the area of intended employment identified by the employer in the job order. If the CO determines that the certification cannot be granted because, under paragraph (a) of this section, the request for emergency filing is not justified and/or there is not sufficient time to make a determination of temporary need or ensure compliance with the criteria for certification contained in § 655.51, the CO will send a Final Determination letter to the employer in accordance with § 655.53.

§ 655.18 Job order assurances and contents.

(a) *General.* Each job order placed in connection with an *Application for Temporary Employment Certification* must at a minimum include the information contained in paragraph (b) of this section. In addition, by submitting the *Application for Temporary Employment Certification*, an employer agrees to comply with the following assurances with respect to each job order:

(1) *Prohibition against preferential treatment.* The employer's job order must offer to U.S. workers no less than the same benefits, wages, and working conditions that the employer is offering, intends to offer, or will provide to H–2B workers. Job offers may not impose on U.S. workers any restrictions or obligations that will not be imposed on the employer's H–2B workers. This does not relieve the employer from providing to H–2B workers at least the minimum benefits, wages, and working conditions which must be offered to U.S. workers consistent with this section.

(2) *Bona fide job requirements.* Each job qualification and requirement must be listed in the job order and must be bona fide and consistent with the normal and accepted qualifications and requirements imposed by non-H–2B employers in the same occupation and area of intended employment.

(b) *Contents.* In addition to complying with the assurances in paragraph (a) of this section, the employer's job order must meet the following requirements:

(1) State the employer's name and contact information;

(2) Indicate that the job opportunity is a temporary, full-time position, including the total number of job openings the employer intends to fill;

(3) Describe the job opportunity for which certification is sought with sufficient information to apprise U.S. workers of the services or labor to be performed, including the duties, the minimum education and experience requirements, the work hours and days,

and the anticipated start and end dates of the job opportunity;

(4) Indicate the geographic area of intended employment with enough specificity to apprise applicants of any travel requirements and where applicants will likely have to reside to perform the services or labor;

(5) Specify the wage that the employer is offering, intends to offer, or will provide to H–2B workers, or, in the event that there are multiple wage offers, the range of wage offers, and ensure that the wage offer equals or exceeds the highest of the prevailing wage or the Federal, State, or local minimum wage;

(6) If applicable, specify that overtime will be available to the worker and the wage offer(s) for working any overtime hours;

(7) If applicable, state that on-the-job training will be provided to the worker;

(8) State that the employer will use a single workweek as its standard for computing wages due;

(9) Specify the frequency with which the worker will be paid, which must be at least every 2 weeks or according to the prevailing practice in the area of intended employment, whichever is more frequent;

(10) If the employer provides the worker with the option of board, lodging, or other facilities, including fringe benefits, or intends to assist workers to secure such lodging, disclose the provision and cost of the board, lodging, or other facilities, including fringe benefits or assistance to be provided;

(11) State that the employer will make all deductions from the worker's paycheck required by law. Specify any deductions the employer intends to make from the worker's paycheck which are not required by law, including, if applicable, any deductions for the reasonable cost of board, lodging, or other facilities;

(12) Detail how the worker will be provided with or reimbursed for transportation and subsistence from the place from which the worker has come to work for the employer, whether in the U.S. or abroad, to the place of employment, if the worker completes 50 percent of the period of employment covered by the job order, consistent with § 655.20(j)(1)(i);

(13) State that the employer will provide or pay for the worker's cost of return transportation and daily subsistence from the place of employment to the place from which the worker, disregarding intervening employment, departed to work for the employer, if the worker completes the certified period of employment or is dismissed from employment for any reason by the employer before the end of the period, consistent with § 655.20(j)(1)(ii);

(14) If applicable, state that the employer will provide daily transportation to and from the worksite;

(15) State that the employer will reimburse the H–2B worker in the first workweek for all visa, visa processing, border crossing, and other related fees, including those mandated by the government, incurred by the H–2B worker (but need not include passport expenses or other charges primarily for the benefit of the worker);

(16) State that the employer will provide to the worker, without charge or deposit charge, all tools, supplies, and equipment required to perform the duties assigned, in accordance with § 655.20(k);

(17) State the applicability of the three-fourths guarantee, offering the worker employment for a total number of work hours equal to at least three-fourths of the workdays of each 12-week period, if the period of employment covered by the job order is 120 or more days, or each 6-week period, if the period of employment covered by the job order is less than 120 days, in accordance with § 655.20(f); and

(18) Instruct applicants to inquire about the job opportunity or send applications, indications of availability, and/or resumes directly to the nearest office of the SWA in the State in which the advertisement appeared and include the SWA contact information.

§ 655.19 Job contractor filing requirements.

(a) Provided that a job contractor and any employer-client are joint employers, a job contractor may submit an *Application for Temporary Employment Certification* on behalf of itself and that employer-client.

(b) A job contractor must have separate contracts with each different employer-client. Each contract or agreement may support only one *Application for Temporary Employment Certification* for each employer-client job opportunity within a single area of intended employment.

(c) Either the job contractor or its employer-client may submit an ETA Form 9141, *Application for Prevailing Wage Determination*, describing the job opportunity to the NPWC. However, each of the joint employers is separately responsible for ensuring that the wage offer listed on the *Application for Temporary Employment Certification*, ETA Form 9142B, and related recruitment at least equals the prevailing wage rate determined by the NPWC and that all other wage obligations are met.

(d)(1) A job contractor that is filing as a joint employer with its employer-client must submit to the NPC a completed *Application for Temporary Employment Certification*, ETA Form 9142, that clearly identifies the joint employers (the job contractor and its employer-client) and the employment relationship (including the actual worksite), in accordance with the instructions provided by the Department of Labor. The *Application for Temporary Employment Certification* must bear the original signature of the job contractor and the employer-client and be accompanied by the contract or agreement establishing the employers' relationship related to the workers sought.

(2) By signing the *Application for Temporary Employment Certification*, each employer independently attests to the conditions of employment required of an employer participating in the H–2B program and assumes full responsibility for the accuracy of the representations made in the application and for all of the responsibilities of an employer in the H–2B program.

(e)(1) Either the job contractor or its employer-client may place the required job order and conduct recruitment as described in §§ 655.16 and 655.43 through 655.46. Also, either one of the joint employers may assume responsibility for interviewing applicants. However, both of the joint employers must sign the recruitment report that is submitted to the NPC with the *Application for Temporary Employment Certification*, ETA Form 9142B.

(e)(1) Either the job contractor or its employer-client may place the required job order and conduct recruitment as described in § 655.16 and §§ 655.42 through 655.46. Also, either one of the joint employers may assume responsibility for interviewing applicants. However, both of the joint employers must sign the recruitment report that is submitted to the NPC with the *Application for Temporary Employment Certification*, ETA Form 9142B.

(2) The job order and all recruitment conducted by joint employers must satisfy the content requirements identified in §§ 655.18 and 655.41. Additionally, in order to fully apprise applicants of the job opportunity and avoid potential confusion inherent in a job opportunity involving two employers, joint employer recruitment must clearly identify both employers (the job contractor and its employer-client) by name and must clearly identify the worksite location(s) where workers will perform labor or services.

(3)(i) Provided that all of the employer-clients' job opportunities are in the same occupation and area of intended employment and have the same requirements and terms and conditions of employment, including dates of employment, a job contractor may combine more than one of its joint employer employer-clients' job opportunities in a single advertisement. Each advertisement must fully apprise potential workers of the job opportunity available with each employer-client and otherwise satisfy the advertising content requirements required for all H–2B-related advertisements, as identified in § 655.41. Such a shared advertisement must clearly identify the job contractor by name, the joint employment relationship, and the number of workers sought for each job opportunity, identified by employer-client name and location (e.g., 5 openings with Employer-Client 1 (worksite location), 3 openings with Employer-Client 2 (worksite location)).

(ii) In addition, the advertisement must contain the following statement: ''Applicants may apply for any or all of the jobs listed. When applying, please

identify the job(s) (by company and work location) you are applying to for the entire period of employment specified.'' If an applicant fails to identify one or more specific work location(s), that applicant is presumed to have applied to all work locations listed in the advertisement.

(f) If an application for joint employers is approved, the NPC will issue one certification and send it to the job contractor. In order to ensure notice to both employers, a courtesy copy of the certification cover letter will be sent to the employer-client. (g) When submitting a certified *Application for Temporary Employment Certification* to USCIS, the job contractor should submit the complete ETA Form 9142B containing the original signatures of both the job contractor and employer-client.

[42 FR 45899, Sept. 13, 1977, as amended at 84 FR 62446, Nov. 15, 2019]

ASSURANCES AND OBLIGATIONS

§ 655.20 Assurances and obligations of H–2B employers.

An employer employing H–2B workers and/or workers in corresponding employment under an *Application for Temporary Employment Certification* has agreed as part of the *Application for Temporary Employment Certification* that it will abide by the following conditions with respect to its H–2B workers and any workers in corresponding employment:

(a) *Rate of pay.* (1) The offered wage in the job order equals or exceeds the highest of the prevailing wage or Federal minimum wage, State minimum wage, or local minimum wage. The employer must pay at least the offered wage, free and clear, during the entire period of the *Application for Temporary Employment Certification* granted by OFLC.

(2) The offered wage is not based on commissions, bonuses, or other incentives, including paying on a piece-rate basis, unless the employer guarantees a wage earned every workweek that equals or exceeds the offered wage.

(3) If the employer requires one or more minimum productivity standards of workers as a condition of job retention, the standards must be specified in the job order and the employer must demonstrate that they are normal and usual for non-H–2B employers for the same occupation in the area of intended employment.

(4) An employer that pays on a piece-rate basis must demonstrate that the piece rate is no less than the normal rate paid by non-H–2B employers to workers performing the same activity in the area of intended employment. The average hourly piece rate earnings must result in an amount at least equal to the offered wage. If the worker is paid on a piece rate basis and at the end of the workweek the piece rate does not result in average hourly piece rate earnings during the workweek at least equal to the amount the worker would have earned had the worker been paid at the offered hourly wage, then the employer must supplement the worker's pay at that time so that the worker's earnings are at least as much as the worker would have earned during the workweek if the worker had instead been paid at the offered hourly wage for each hour worked.

(b) *Wages free and clear.* The payment requirements for wages in this section will be satisfied by the timely payment of such wages to the worker either in cash or negotiable instrument payable at par. The payment must be made finally and unconditionally and ''free and clear.'' The principles applied in determining whether deductions are reasonable and payments are received free and clear and the permissibility of deductions for payments to third persons are explained in more detail in 29 CFR part 531.

(c) *Deductions.* The employer must make all deductions from the worker's paycheck required by law. The job order must specify all deductions not required by law which the employer will make from the worker's pay; any such deductions not disclosed in the job order are prohibited. The wage payment requirements of paragraph (b) of this section are not met where unauthorized deductions, rebates, or refunds reduce the wage payment made to the worker below the minimum amounts required by the offered wage or where the worker fails to receive such amounts free and clear because the worker ''kicks back'' directly or indirectly to the employer or to another

person for the employer's benefit the whole or part of the wages delivered to the worker. Authorized deductions are limited to: Those required by law, such as taxes payable by workers that are required to be withheld by the employer and amounts due workers which the employer is required by court order to pay to another; deductions for the reasonable cost or fair value of board, lodging, and facilities furnished; and deductions of amounts which are authorized to be paid to third persons for the worker's account and benefit through his or her voluntary assignment or order or which are authorized by a collective bargaining agreement with bona fide representatives of workers which covers the employer. Deductions for amounts paid to third persons for the worker's account and benefit which are not so authorized or are contrary to law or from which the employer, agent or recruiter including any agents or employees of these entities, or any affiliated person derives any payment, rebate, commission, profit, or benefit directly or indirectly, may not be made if they reduce the actual wage paid to the worker below the offered wage indicated on the *Application for Temporary Employment Certification*.

(d) *Job opportunity is full-time.* The job opportunity is a full-time temporary position, consistent with § 655.5, and the employer must use a single workweek as its standard for computing wages due. An employee's workweek must be a fixed and regularly recurring period of 168 hours—seven consecutive 24-hour periods. It need not coincide with the calendar week but may begin on any day and at any hour of the day.

(e) *Job qualifications and requirements.* Each job qualification and requirement must be listed in the job order and must be bona fide and consistent with the normal and accepted qualifications and requirements imposed by non-H–2B employers in the same occupation and area of intended employment. The employer's job qualifications and requirements imposed on U.S. workers must not be less favorable than the qualifications and requirements that the employer is imposing or will impose on H–2B workers. A qualification means a characteristic that is necessary to the individual's ability to perform the job in question. A requirement means a term or condition of employment which a worker is required to accept in order to obtain the job opportunity. The CO may require the employer to submit documentation to substantiate the appropriateness of any job qualification and/or requirement specified in the job order.

(f) *Three-fourths guarantee.* (1) The employer must guarantee to offer the worker employment for a total number of work hours equal to at least three-fourths of the workdays in each 12-week period (each 6-week period if the period of employment covered by the job order is less than 120 days) beginning with the first workday after the arrival of the worker at the place of employment or the advertised first date of need, whichever is later, and ending on the expiration date specified in the job order or in its extensions, if any. See the exception in paragraph (y) of this section.

(2) For purposes of this paragraph (f) a workday means the number of hours in a workday as stated in the job order. The employer must offer a total number of hours of work to ensure the provision of sufficient work to reach the three-fourths guarantee in each 12-week period (each 6-week period if the period of employment covered by the job order is less than 120 days) during the work period specified in the job order, or during any modified job order period to which the worker and employer have mutually agreed and that has been approved by the CO.

(3) In the event the worker begins working later than the specified beginning date the guarantee period begins with the first workday after the arrival of the worker at the place of employment, and continues until the last day during which the job order and all extensions thereof are in effect.

(4) The 12-week periods (6-week periods if the period of employment covered by the job order is less than 120 days) to which the guarantee applies are based upon the workweek used by the employer for pay purposes. The first 12-week period (or 6-week period, as appropriate) also includes any partial workweek, if the first workday after the worker's arrival at the place

of employment is not the beginning of the employer's workweek, with the guaranteed number of hours increased on a pro rata basis (thus, the first period may include up to 12 weeks and 6 days (or 6 weeks and 6 days, as appropriate)). The final 12-week period (or 6-week period, as appropriate) includes any time remaining after the last full 12-week period (or 6-week period) ends, and thus may be as short as 1 day, with the guaranteed number of hours decreased on a pro rata basis.

(5) Therefore, if, for example, a job order is for a 32-week period (a period greater than 120 days), during which the normal workdays and work hours for the workweek are specified as 5 days a week, 7 hours per day, the worker would have to be guaranteed employment for at least 315 hours in the first 12-week period (12 weeks × 35 hours/week = 420 hours × 75 percent = 315), at least 315 hours in the second 12-week period, and at least 210 hours (8 weeks × 35 hours/week = 280 hours × 75 percent = 210) in the final partial period. If the job order is for a 16-week period (less than 120 days), during which the normal workdays and work hours for the workweek are specified as 5 days a week, 7 hours per day, the worker would have to be guaranteed employment for at least 157.5 hours (6 weeks × 35 hours/week = 210 hours × 75 percent = 157.5) in the first 6-week period, at least 157.5 hours in the second 6-week period, and at least 105 hours (4 weeks × 35 hours/week = 140 hours × 75 percent = 105) in the final partial period.

(6) If the worker is paid on a piece rate basis, the employer must use the worker's average hourly piece rate earnings or the offered wage, whichever is higher, to calculate the amount due under the guarantee.

(7) A worker may be offered more than the specified hours of work on a single workday. For purposes of meeting the guarantee, however, the worker will not be required to work for more than the number of hours specified in the job order for a workday. The employer, however, may count all hours actually worked in calculating whether the guarantee has been met. If during any 12-week period (6-week period if the period of employment covered by the job order is less than 120 days) during the period of the job order the employer affords the U.S. or H–2B worker less employment than that required under paragraph (f)(1) of this section, the employer must pay such worker the amount the worker would have earned had the worker, in fact, worked for the guaranteed number of days. An employer has not met the work guarantee if the employer has merely offered work on three-fourths of the workdays in an 12-week period (or 6-week period, as appropriate) if each workday did not consist of a full number of hours of work time as specified in the job order.

(8) Any hours the worker fails to work, up to a maximum of the number of hours specified in the job order for a workday, when the worker has been offered an opportunity to work in accordance with paragraph (f)(1) of this section, and all hours of work actually performed (including voluntary work over 8 hours in a workday), may be counted by the employer in calculating whether each 12-week period (or 6-week period, as appropriate) of guaranteed employment has been met. An employer seeking to calculate whether the guaranteed number of hours has been met must maintain the payroll records in accordance with this part.

(g) *Impossibility of fulfillment.* If, before the expiration date specified in the job order, the services of the worker are no longer required for reasons beyond the control of the employer due to fire, weather, or other Act of God, or similar unforeseeable man-made catastrophic event (such as an oil spill or controlled flooding) that is wholly outside the employer's control that makes the fulfillment of the job order impossible, the employer may terminate the job order with the approval of the CO. In the event of such termination of a job order, the employer must fulfill a three-fourths guarantee, as described in paragraph (f) of this section, for the time that has elapsed from the start date listed in the job order or the first workday after the arrival of the worker at the place of employment, whichever is later, to the time of its termination. The employer must make efforts to transfer the H–2B worker or worker in corresponding employment to other

comparable employment acceptable to the worker and consistent with the INA, as applicable. If a transfer is not effected, the employer must return the worker, at the employer's expense, to the place from which the worker (disregarding intervening employment) came to work for the employer, or transport the worker to the worker's next certified H–2B employer, whichever the worker prefers.

(h) *Frequency of pay.* The employer must state in the job order the frequency with which the worker will be paid, which must be at least every 2 weeks or according to the prevailing practice in the area of intended employment, whichever is more frequent. Employers must pay wages when due.

(i) *Earnings statements.* (1) The employer must keep accurate and adequate records with respect to the workers' earnings, including but not limited to: Records showing the nature, amount and location(s) of the work performed; the number of hours of work offered each day by the employer (broken out by hours offered both in accordance with and over and above the three-fourths guarantee in paragraph (f) of this section); the hours actually worked each day by the worker; if the number of hours worked by the worker is less than the number of hours offered, the reason(s) the worker did not work; the time the worker began and ended each workday; the rate of pay (both piece rate and hourly, if applicable); the worker's earnings per pay period; the worker's home address; and the amount of and reasons for any and all deductions taken from or additions made to the worker's wages.

(2) The employer must furnish to the worker on or before each payday in one or more written statements the following information:

(i) The worker's total earnings for each workweek in the pay period;

(ii) The worker's hourly rate and/or piece rate of pay;

(iii) For each workweek in the pay period the hours of employment offered to the worker (showing offers in accordance with the three-fourths guarantee as determined in paragraph (f) of this section, separate from any hours offered over and above the guarantee);

(iv) For each workweek in the pay period the hours actually worked by the worker;

(v) An itemization of all deductions made from or additions made to the worker's wages;

(vi) If piece rates are used, the units produced daily;

(vii) The beginning and ending dates of the pay period; and

(viii) The employer's name, address and FEIN.

(j) *Transportation and visa fees.* (1)(i) *Transportation to the place of employment.* The employer must provide or reimburse the worker for transportation and subsistence from the place from which the worker has come to work for the employer, whether in the U.S. or abroad, to the place of employment if the worker completes 50 percent of the period of employment covered by the job order (not counting any extensions). The employer may arrange and pay for the transportation and subsistence directly, advance at a minimum the most economical and reasonable common carrier cost of the transportation and subsistence to the worker before the worker's departure, or pay the worker for the reasonable costs incurred by the worker. When it is the prevailing practice of non-H–2B employers in the occupation in the area to do so or when the employer extends such benefits to similarly situated H–2B workers, the employer must advance the required transportation and subsistence costs (or otherwise provide them) to workers in corresponding employment who are traveling to the employer's worksite. The amount of the transportation payment must be no less (and is not required to be more) than the most economical and reasonable common carrier transportation charges for the distances involved. The amount of the daily subsistence must be at least the amount permitted in § 655.173. Where the employer will reimburse the reasonable costs incurred by the worker, it must keep accurate and adequate records of: The costs of transportation and subsistence incurred by the worker; the amount reimbursed; and the date(s) of reimbursement. Note that the FLSA applies independently of

the H–2B requirements and imposes obligations on employers regarding payment of wages.

(ii) *Transportation from the place of employment.* If the worker completes the period of employment covered by the job order (not counting any extensions), or if the worker is dismissed from employment for any reason by the employer before the end of the period, and the worker has no immediate subsequent H–2B employment, the employer must provide or pay at the time of departure for the worker's cost of return transportation and daily subsistence from the place of employment to the place from which the worker, disregarding intervening employment, departed to work for the employer. If the worker has contracted with a subsequent employer that has not agreed in the job order to provide or pay for the worker's transportation from the employer's worksite to such subsequent employer's worksite, the employer must provide or pay for that transportation and subsistence. If the worker has contracted with a subsequent employer that has agreed in the job order to provide or pay for the worker's transportation from the employer's worksite to such subsequent employer's worksite, the subsequent employer must provide or pay for such expenses.

(iii) *Employer-provided transportation.* All employer-provided transportation must comply with all applicable Federal, State, and local laws and regulations and must provide, at a minimum, the same vehicle safety standards, driver licensure requirements, and vehicle insurance as required under 49 CFR parts 390, 393, and 396.

(iv) *Disclosure.* All transportation and subsistence costs that the employer will pay must be disclosed in the job order.

(2) The employer must pay or reimburse the worker in the first workweek for all visa, visa processing, border crossing, and other related fees (including those mandated by the government) incurred by the H–2B worker, but not for passport expenses or other charges primarily for the benefit of the worker.

(k) *Employer-provided items.* The employer must provide to the worker, without charge or deposit charge, all tools, supplies, and equipment required to perform the duties assigned.

(l) *Disclosure of job order.* The employer must provide to an H–2B worker outside of the U.S. no later than the time at which the worker applies for the visa, or to a worker in corresponding employment no later than on the day work commences, a copy of the job order including any subsequent approved modifications. For an H–2B worker changing employment from an H–2B employer to a subsequent H–2B employer, the copy must be provided no later than the time an offer of employment is made by the subsequent H–2B employer. The disclosure of all documents required by this paragraph (l) must be provided in a language understood by the worker, as necessary or reasonable.

(m) *Notice of worker rights.* The employer must post and maintain in a conspicuous location at the place of employment a poster provided by the Department of Labor that sets out the rights and protections for H–2B workers and workers in corresponding employment. The employer must post the poster in English. To the extent necessary, the employer must request and post additional posters, as made available by the Department of Labor, in any language common to a significant portion of the workers if they are not fluent in English.

(n) *No unfair treatment.* The employer has not and will not intimidate, threaten, restrain, coerce, blacklist, discharge or in any manner discriminate against, and has not and will not cause any person to intimidate, threaten, restrain, coerce, blacklist, discharge, or in any manner discriminate against, any person who has:

(1) Filed a complaint under or related to 8 U.S.C. 1184(c), section 214(c) of the INA, 29 CFR part 503, or this subpart, or any other regulation promulgated thereunder;

(2) Instituted or caused to be instituted any proceeding under or related to 8 U.S.C. 1184(c), section 214(c) of the INA, 29 CFR part 503, or this subpart or any other regulation promulgated thereunder;

(3) Testified or is about to testify in any proceeding under or related to 8 U.S.C. 1184(c), section 214(c) of the INA,

29 CFR part 503, or this subpart or any other regulation promulgated thereunder;

(4) Consulted with a workers' center, community organization, labor union, legal assistance program, or an attorney on matters related to 8 U.S.C. 1184(c), section 214(c) of the INA, 29 CFR part 503, or this subpart or any other regulation promulgated thereunder; or

(5) Exercised or asserted on behalf of himself/herself or others any right or protection afforded by 8 U.S.C. 1184(c), section 214(c) of the INA, 29 CFR part 503, or this subpart or any other regulation promulgated thereunder.

(o) *Comply with the prohibitions against employees paying fees.* The employer and its attorney, agents, or employees have not sought or received payment of any kind from the worker for any activity related to obtaining H–2B labor certification or employment, including payment of the employer's attorney or agent fees, application and *H–2B Petition* fees, recruitment costs, or any fees attributed to obtaining the approved *Application for Temporary Employment Certification*. For purposes of this paragraph (o), payment includes, but is not limited to, monetary payments, wage concessions (including deductions from wages, salary, or benefits), kickbacks, bribes, tributes, in-kind payments, and free labor. All wages must be paid free and clear. This provision does not prohibit employers or their agents from receiving reimbursement for costs that are the responsibility and primarily for the benefit of the worker, such as government-required passport fees.

(p) *Contracts with third parties to comply with prohibitions.* The employer must contractually prohibit in writing any agent or recruiter (or any agent or employee of such agent or recruiter) whom the employer engages, either directly or indirectly, in recruitment of H–2B workers to seek or receive payments or other compensation from prospective workers. The contract must include the following statement: ''Under this agreement, [name of agent, recruiter] and any agent of or employee of [name of agent or recruiter] are prohibited from seeking or receiving payments from any prospective employee of [employer name] at any time, including before or after the worker obtains employment. Payments include but are not limited to, any direct or indirect fees paid by such employees for recruitment, job placement, processing, maintenance, attorneys' fees, agent fees, application fees, or petition fees.''

(q) *Prohibition against preferential treatment of foreign workers.* The employer's job offer must offer to U.S. workers no less than the same benefits, wages, and working conditions that the employer is offering, intends to offer, or will provide to H–2B workers. Job offers may not impose on U.S. workers any restrictions or obligations that will not be imposed on the employer's H–2B workers. This does not relieve the employer from providing to H–2B workers at least the minimum benefits, wages, and working conditions which must be offered to U.S. workers consistent with this section.

(r) *Non-discriminatory hiring practices.* The job opportunity is, and through the period set forth in paragraph (t) of this section must continue to be, open to any qualified U.S. worker regardless of race, color, national origin, age, sex, religion, disability, or citizenship. Rejections of any U.S. workers who applied or apply for the job must only be for lawful, job-related reasons, and those not rejected on this basis have been or will be hired. In addition, the employer has and will continue to retain records of all hired workers and rejected applicants as required by § 655.56.

(s) *Recruitment requirements.* The employer must conduct all required recruitment activities, including any additional employer-conducted recruitment activities as directed by the CO, and as specified in §§ 655.40 through 655.46.

(t) *Continuing requirement to hire U.S. workers.* The employer has and will continue to cooperate with the SWA by accepting referrals of all qualified U.S. workers who apply (or on whose behalf a job application is made) for the job opportunity, and must provide employment to any qualified U.S. worker who applies to the employer for the job opportunity, until 21 days before the date of need.

(u) *No strike or lockout.* There is no strike or lockout at any of the employer's worksites within the area of intended employment for which the employer is requesting H–2B certification at the time the *Application for Temporary Employment Certification* is filed.

(v) *No recent or future layoffs.* The employer has not laid off and will not lay off any similarly employed U.S. worker in the occupation that is the subject of the *Application for Temporary Employment Certification* in the area of intended employment within the period beginning 120 calendar days before the date of need through the end of the period of certification. A layoff for lawful, job-related reasons such as lack of work or the end of a season is permissible if all H–2B workers are laid off before any U.S. worker in corresponding employment.

(w) *Contact with former U.S. employees.* The employer will contact (by mail or other effective means) its former U.S. workers, including those who have been laid off within 120 calendar days before the date of need (except those who were dismissed for cause or who abandoned the worksite), employed by the employer in the occupation at the place of employment during the previous year, disclose the terms of the job order, and solicit their return to the job.

(x) *Area of intended employment and job opportunity.* The employer must not place any H–2B workers employed under the approved *Application for Temporary Employment Certification* outside the area of intended employment or in a job opportunity not listed on the approved *Application for Temporary Employment Certification* unless the employer has obtained a new approved *Application for Temporary Employment Certification.*

(y) *Abandonment/termination of employment.* Upon the separation from employment of worker(s) employed under the *Application for Temporary Employment Certification* or workers in corresponding employment, if such separation occurs before the end date of the employment specified in the *Application for Temporary Employment Certification,* the employer must notify OFLC in writing of the separation from employment not later than 2 work days after such separation is discovered by the employer. In addition, the employer must notify DHS in writing (or any other method specified by the Department of Labor or DHS in the FEDERAL REGISTER or the Code of Federal Regulations) of such separation of an H–2B worker. An abandonment or abscondment is deemed to begin after a worker fails to report for work at the regularly scheduled time for 5 consecutive working days without the consent of the employer. If the separation is due to the voluntary abandonment of employment by the H–2B worker or worker in corresponding employment, and the employer provides appropriate notification specified under this paragraph (y), the employer will not be responsible for providing or paying for the subsequent transportation and subsistence expenses of that worker under this section, and that worker is not entitled to the three-fourths guarantee described in paragraph (f) of this section. The employer's obligation to guarantee three-fourths of the work described in paragraph (f) ends with the last full 12-week period (or 6-week period, as appropriate) preceding the worker's voluntary abandonment or termination for cause.

(z) *Compliance with applicable laws.* During the period of employment specified on the *Application for Temporary Employment Certification,* the employer must comply with all applicable Federal, State and local employment-related laws and regulations, including health and safety laws. This includes compliance with 18 U.S.C. 1592(a), with respect to prohibitions against employers, the employer's agents or their attorneys knowingly holding, destroying or confiscating workers' passports, visas, or other immigration documents.

(aa) *Disclosure of foreign worker recruitment.* The employer, and its attorney or agent, as applicable, must comply with § 655.9 by providing a copy of all agreements with any agent or recruiter whom it engages or plans to engage in the recruitment of H–2B workers, and the identity and location of the persons or entities hired by or working for the agent or recruiter and any of the agents or employees of those persons and entities, to recruit foreign workers. Pursuant to § 655.15(a), the

agreements and information must be filed with the *Application for Temporary Employment Certification*.

(bb) *Cooperation with investigators*. The employer must cooperate with any employee of the Secretary who is exercising or attempting to exercise the Department's authority pursuant to 8 U.S.C. 1184(c)(14)(B), section 214(c)(14)(B) of the INA.

§§ 655.21–655.29 [Reserved]

PROCESSING OF AN APPLICATION FOR TEMPORARY EMPLOYMENT CERTIFICATION

§ 655.30 Processing of an application and job order.

(a) *NPC review*. The CO will review the *Application for Temporary Employment Certification* and job order for compliance with all applicable program requirements.

(b) *Mailing and postmark requirements*. Any notice or request sent by the CO to an employer requiring a response will be mailed to the address provided in the *Application for Temporary Employment Certification* using methods to assure next day delivery, including electronic mail. The employer's response to such a notice or request must be mailed using methods to assure next day delivery, including electronic mail, and be sent by the due date or the next business day if the due date falls on a Saturday, Sunday or Federal holiday.

(c) *Information dissemination*. OFLC may forward information received in the course of processing an *Application for Temporary Employment Certification* and program integrity measures to WHD, or any other Federal agency, as appropriate, for investigation and/or enforcement purposes.

§ 655.31 Notice of deficiency.

(a) *Notification timeline*. If the CO determines the *Application for Temporary Employment Certification* and/or job order is incomplete, contains errors or inaccuracies, or does not meet the requirements set forth in this subpart, the CO will notify the employer within 7 business days from the CO's receipt of the *Application for Temporary Employment Certification*. If applicable, the Notice of Deficiency will include job order deficiencies identified by the SWA under §655.16. The CO will send a copy of the Notice of Deficiency to the SWA serving the area of intended employment identified by the employer on its job order, and if applicable, to the employer's attorney or agent.

(b) *Notice content*. The Notice of Deficiency will:

(1) State the reason(s) why the *Application for Temporary Employment Certification* or job order fails to meet the criteria for acceptance and state the modification needed for the CO to issue a Notice of Acceptance;

(2) Offer the employer an opportunity to submit a modified *Application for Temporary Employment Certification* or job order within 10 business days from the date of the Notice of Deficiency. The Notice will state the modification needed for the CO to issue a Notice of Acceptance;

(3) Offer the employer an opportunity to request administrative review of the Notice of Deficiency before an ALJ under provisions set forth in §655.61. The Notice will inform the employer that it must submit a written request for review to the Chief ALJ of DOL within 10 business days from the date the Notice of Deficiency is issued by facsimile or other means normally assuring next day delivery, and that the employer must simultaneously serve a copy on the CO. The Notice will also state that the employer may submit any legal arguments that the employer believes will rebut the basis of the CO's action; and

(4) State that if the employer does not comply with the requirements of this section by either submitting a modified application within 10 business days or requesting administrative review before an ALJ under §655.61, the CO will deny the *Application for Temporary Employment Certification*. The Notice will inform the employer that the denial of the *Application for Temporary Employment Certification* is final, and cannot be appealed. The Department of Labor will not further consider that *Application for Temporary Employment Certification*.

§ 655.32 Submission of a modified application or job order.

(a) *Review of a modified Application for Temporary Employment Certification or*

job order. Upon receipt of a response to a Notice of Deficiency, including any modifications, the CO will review the response. The CO may issue one or more additional Notices of Deficiency before issuing a decision. The employer's failure to comply with a Notice of Deficiency, including not responding in a timely manner or not providing all required documentation, will result in a denial of the *Application for Temporary Employment Certification*.

(b) *Acceptance of a modified Application for Temporary Employment Certification or job order*. If the CO accepts the modification(s) to the *Application for Temporary Employment Certification* and/or job order, the CO will issue a Notice of Acceptance to the employer. The CO will send a copy of the Notice of Acceptance to the SWA instructing it to make any necessary modifications to the not yet posted job order and, if applicable, to the employer's attorney or agent, and follow the procedure set forth in § 655.33.

(c) *Denial of a modified Application for Temporary Employment Certification or job order*. If the CO finds the response to Notice of Deficiency unacceptable, the CO will deny the *Application for Temporary Employment Certification* in accordance with the labor certification determination provisions in § 655.51.

(d) *Appeal from denial of a modified Application for Temporary Employment Certification or job order*. The procedures for appealing a denial of a modified *Application for Temporary Employment Certification* and/or job order are the same as for appealing the denial of a non-modified *Application for Temporary Employment Certification* outlined in § 655.61.

(e) *Post acceptance modifications*. Irrespective of the decision to accept the *Application for Temporary Employment Certification*, the CO may require modifications to the job order at any time before the final determination to grant or deny the *Application for Temporary Employment Certification* if the CO determines that the offer of employment does not contain all the minimum benefits, wages, and working condition provisions as set forth in § 655.18. The employer must make such modification, or certification will be denied under § 655.53. The employer must provide all workers recruited in connection with the job opportunity in the *Application for Temporary Employment Certification* with a copy of the modified job order no later than the date work commences, as approved by the CO.

§ 655.33 Notice of acceptance.

(a) *Notification timeline*. If the CO determines the *Application for Temporary Employment Certification* and job order are complete and meet the requirements of this subpart, the CO will notify the employer in writing within 7 business days from the date the CO received the *Application for Temporary Employment Certification* and job order or modification thereof. A copy of the Notice of Acceptance will be sent to the SWA serving the area of intended employment identified by the employer on its job order and, if applicable, to the employer's attorney or agent.

(b) *Notice content*. The notice will:

(1) Direct the employer to engage in recruitment of U.S. workers as provided in §§ 655.40 through 655.46, including any additional recruitment ordered by the CO under § 655.46;

(2) State that such employer-conducted recruitment is in addition to the job order being circulated by the SWA(s) and that the employer must conduct recruitment within 14 calendar days from the date the Notice of Acceptance is issued, consistent with § 655.40;

(3) Direct the SWA to place the job order into intra- and interstate clearance as set forth in § 655.16 and to commence such clearance by:

(i) Sending a copy of the job order to other States listed as anticipated worksites in the *Application for Temporary Employment Certification* and job order, if applicable; and

(ii) Sending a copy of the job order to the SWAs for all States designated by the CO for interstate clearance;

(4) Instruct the SWA to keep the approved job order on its active file until the end of the recruitment period as defined in § 655.40(c), and to transmit the same instruction to other SWAs to which it circulates the job order in the course of interstate clearance;

(5) Where the occupation or industry is traditionally or customarily unionized, direct the SWA to circulate a copy of the job order to the following labor organizations:

(i) The central office of the State Federation of Labor in the State(s) in which work will be performed; and

(ii) The office(s) of local union(s) representing employees in the same or substantially equivalent job classification in the area(s) in which work will be performed;

(6) Advise the employer, as appropriate, that it must contact the appropriate designated community-based organization(s) with notice of the job opportunity; and

(7) Require the employer to submit a report of its recruitment efforts as specified in § 655.48.

§ 655.34 Electronic job registry.

(a) *Location of and placement in the electronic job registry.* Upon acceptance of the *Application for Temporary Employment Certification* under § 655.33, the CO will place for public examination a copy of the job order posted by the SWA on the Department's electronic job registry, including any amendments or required modifications approved by the CO.

(b) *Length of posting on electronic job registry.* The Department of Labor will keep the job order posted on the electronic job registry until the end of the recruitment period, as set forth in § 655.40(c).

(c) *Conclusion of active posting.* Once the recruitment period has concluded the job order will be placed in inactive status on the electronic job registry.

§ 655.35 Amendments to an application or job order.

(a) *Increases in number of workers.* The employer may request to increase the number of workers noted in the *H–2B Registration* by no more than 20 percent (50 percent for employers requesting fewer than 10 workers). All requests for increasing the number of workers must be made in writing and will not be effective until approved by the CO. In considering whether to approve the request, the CO will determine whether the proposed amendment(s) are sufficiently justified and must take into account the effect of the changes on the underlying labor market test for the job opportunity. Upon acceptance of an amendment, the CO will submit to the SWA any necessary changes to the job order and update the electronic job registry. The employer must promptly provide copies of any approved amendments to all U.S. workers hired under the original job order.

(b) *Minor changes to the period of employment.* The employer may request minor changes to the total period of employment listed on its *Application for Temporary Employment Certification* and job order, for a period of up to 14 days, but the period of employment may not exceed a total of 9 months, except in the event of a one-time occurrence. All requests for minor changes to the total period of employment must be made in writing and will not be effective until approved by the CO. In considering whether to approve the request, the CO will determine whether the proposed amendment(s) are sufficiently justified and must take into account the effect of the changes on the underlying labor market test for the job opportunity. Upon acceptance of an amendment, the CO will submit to the SWA any necessary changes to the job order and update the electronic job registry. The employer must promptly provide copies of any approved amendments to all U.S. workers hired under the original job order

(c) *Other amendments to the Application for Temporary Employment Certification and job order.* The employer may request other amendments to the *Application for Temporary Employment Certification* and job order. All such requests must be made in writing and will not be effective until approved by the CO. In considering whether to approve the request, the CO will determine whether the proposed amendment(s) are sufficiently justified and must take into account the effect of the changes on the underlying labor market test for the job opportunity. Upon acceptance of an amendment, the CO will submit to the SWA any necessary changes to the job order and update the electronic job registry.

(d) *Amendments after certification are not permitted.* The employer must

promptly provide copies of any approved amendments to all U.S. workers hired under the original job order.

§§ 655.36–655.39 [Reserved]

POST-ACCEPTANCE REQUIREMENTS

§ 655.40 Employer-conducted recruitment.

(a) *Employer obligations.* Employers must conduct recruitment of U.S. workers to ensure that there are not qualified U.S. workers who will be available for the positions listed in the *Application for Temporary Employment Certification*. U.S. Applicants can be rejected only for lawful job-related reasons.

(b) *Employer-conducted recruitment period.* Unless otherwise instructed by the CO, the employer must conduct the recruitment described in §§ 655.43 through 655.46 within 14 calendar days from the date the Notice of Acceptance is issued. All employer-conducted recruitment must be completed before the employer submits the recruitment report as required in § 655.48.

(c) *U.S. workers.* Employers must continue to accept referrals and applications of all U.S. applicants interested in the position until 21 days before the date of need.

(d) *Interviewing U.S. workers.* Employers that wish to require interviews must conduct those interviews by phone or provide a procedure for the interviews to be conducted in the location where the worker is being recruited so that the worker incurs little or no cost. Employers cannot provide potential H–2B workers with more favorable treatment with respect to the requirement for, and conduct of, interviews.

(e) *Qualified and available U.S. workers.* The employer must consider all U.S. applicants for the job opportunity. The employer must accept and hire any applicants who are qualified and who will be available.

(f) *Recruitment report.* The employer must prepare a recruitment report meeting the requirements of § 655.48.

[42 FR 45899, Sept. 13, 1977, as amended at 84 FR 62446, Nov. 15, 2019]

§ 655.41 Advertising requirements.

(a) All recruitment conducted under §§ 655.43 through 655.46 must contain terms and conditions of employment that are not less favorable than those offered to the H–2B workers and, at a minimum, must comply with the assurances applicable to job orders as set forth in § 655.18(a).

(b) All advertising must contain the following information:

(1) The employer's name and contact information;

(2) The geographic area of intended employment with enough specificity to apprise applicants of any travel requirements and where applicants will likely have to reside to perform the services or labor;

(3) A description of the job opportunity for which certification is sought with sufficient information to apprise U.S. workers of the services or labor to be performed, including the duties, the minimum education and experience requirements, the work hours and days, and the anticipated start and end dates of the job opportunity;

(4) A statement that the job opportunity is a temporary, full-time position including the total number of job openings the employer intends to fill;

(5) If applicable, a statement that overtime will be available to the worker and the wage offer(s) for working any overtime hours;

(6) If applicable, a statement indicating that on-the-job training will be provided to the worker;

(7) The wage that the employer is offering, intends to offer or will provide to the H–2B workers or, in the event that there are multiple wage offers, the range of applicable wage offers, each of which must equal or exceed the highest of the prevailing wage or the Federal, State, or local minimum wage;

(8) If applicable, any board, lodging, or other facilities the employer will offer to workers or intends to assist workers in securing;

(9) All deductions not required by law that the employer will make from the worker's paycheck, including, if applicable, reasonable deduction for board, lodging, and other facilities offered to the workers;

(10) A statement that transportation and subsistence from the place where

the worker has come to work for the employer to the place of employment and return transportation and subsistence will be provided, as required by § 655.20(j)(1);

(11) If applicable, a statement that work tools, supplies, and equipment will be provided to the worker without charge;

(12) If applicable, a statement that daily transportation to and from the worksite will be provided by the employer;

(13) A statement summarizing the three-fourths guarantee as required by § 655.20(f); and

(14) A statement directing applicants to apply for the job opportunity at the nearest office of the SWA in the State in which the advertisement appeared, the SWA contact information, and, if applicable, the job order number.

[42 FR 45899, Sept. 13, 1977, as amended at 84 FR 62446, Nov. 15, 2019]

§ 655.42 [Reserved]

§ 655.43 Contact with former U.S. employees.

The employer must contact (by mail or other effective means) its former U.S. workers, including those who have been laid off within 120 calendar days before the date of need, employed by the employer in the occupation at the place of employment during the previous year (except those who were dismissed for cause or who abandoned the worksite), disclose the terms of the job order, and solicit their return to the job. The employer must maintain documentation sufficient to prove such contact in accordance with § 655.56.

§ 655.44 [Reserved]

§ 655.45 Contact with bargaining representative, posting and other contact requirements.

(a) If there is a bargaining representative for any of the employer's employees in the occupation and area of intended employment, the employer must provide written notice of the job opportunity, by providing a copy of the *Application for Temporary Employment Certification* and the job order, and maintain documentation that it was sent to the bargaining representative(s). An employer governed by this paragraph (a) must include information in its recruitment report that confirms that the bargaining representative(s) was contacted and notified of the position openings and whether the organization referred qualified U.S. worker(s), including the number of referrals, or was non-responsive to the employer's requests.

(b) If there is no bargaining representative, the employer must post the availability of the job opportunity in at least 2 conspicuous locations at the place(s) of anticipated employment or in some other manner that provides reasonable notification to all employees in the job classification and area in which the work will be performed by the H–2B workers. Electronic posting, such as displaying the notice prominently on any internal or external Web site that is maintained by the employer and customarily used for notices to employees about terms and conditions of employment, is sufficient to meet this posting requirement as long as it otherwise meets the requirements of this section. The notice must meet the requirements under § 655.41 and be posted for at least 15 consecutive business days. The employer must maintain a copy of the posted notice and identify where and when it was posted in accordance with § 655.56.

(c) If appropriate to the occupation and area of intended employment, as indicated by the CO in the Notice of Acceptance, the employer must provide written notice of the job opportunity to a community-based organization, and maintain documentation that it was sent to any designated community-based organization. An employer governed by this paragraph (c) must include information in its recruitment report that confirms that the community-based organization was contacted and notified of the position openings and whether the organization referred qualified U.S. worker(s), including the number of referrals, or was non-responsive to the employer's requests.

§ 655.46 Additional employer-conducted recruitment.

(a) *Requirement to conduct additional recruitment.* The employer may be instructed by the CO to conduct additional reasonable recruitment. Such recruitment may be required at the discretion of the CO where the CO has determined that there is a likelihood that U.S. workers who are qualified and will be available for the work, including but not limited to where the job opportunity is located in an Area of Substantial Unemployment.

(b) *Nature of the additional employer-conducted recruitment.* The CO will describe the precise number and nature of the additional recruitment efforts. Additional recruitment may include, but is not limited to, posting on the employer's Web site or another Web site, contact with additional community-based organizations, additional contact with State One-Stop Career Centers, and other print advertising, such as using a professional, trade or ethnic publication where such a publication is appropriate for the occupation and the workers likely to apply for the job opportunity. When assessing the appropriateness of a particular recruitment method, the CO will consider the cost of the additional recruitment and the likelihood that the additional recruitment method(s) will identify qualified and available U.S. workers.

(c) *Proof of the additional employer-conducted recruitment.* The CO will specify the documentation or other supporting evidence that must be maintained by the employer as proof that the additional recruitment requirements were met. Documentation must be maintained as required in § 655.56.

§ 655.47 Referrals of U.S. workers.

SWAs may only refer for employment individuals who have been apprised of all the material terms and conditions of employment and who are qualified and will be available for employment.

§ 655.48 Recruitment report.

(a) *Requirements of the recruitment report.* The employer must prepare, sign, and date a recruitment report. Where recruitment was conducted by a job contractor or its employer-client, both joint employers must sign the recruitment report in accordance with § 655.19(e). The recruitment report must be submitted by a date specified by the CO in the Notice of Acceptance and contain the following information:

(1) The name of each recruitment activity or source (e.g., job order and the name of the newspaper);

(2) The name and contact information of each U.S. worker who applied or was referred to the job opportunity up to the date of the preparation of the recruitment report, and the disposition of each worker's application. The employer must clearly indicate whether the job opportunity was offered to the U.S. worker and whether the U.S. worker accepted or declined;

(3) Confirmation that former U.S. employees were contacted, if applicable, and by what means;

(4) Confirmation that the bargaining representative was contacted, if applicable, and by what means, or that the employer posted the availability of the job opportunity to all employees in the job classification and area in which the work will be performed by the H–2B workers;

(5) Confirmation that the community-based organization designated by the CO was contacted, if applicable;

(6) If applicable, confirmation that additional recruitment was conducted as directed by the CO; and

(7) If applicable, for each U.S. worker who applied for the position but was not hired, the lawful job-related reason(s) for not hiring the U.S. worker.

(b) *Duty to update recruitment report.* The employer must continue to update the recruitment report throughout the recruitment period. In a joint employment situation, either the job contractor or the employer-client may update the recruitment report. The updated report must be signed, dated and need not be submitted to the Department of Labor, but must be made available in the event of a post-certification audit or upon request by DOL.

§ 655.49 [Reserved]

Labor Certification Determinations

§ 655.50 Determinations.

(a) *Certifying Officers (COs).* The Administrator, OFLC is the Department's

National CO. The Administrator, OFLC and the CO(s), by virtue of delegation from the Administrator, OFLC, have the authority to certify or deny *Applications for Temporary Employment Certification* under the H–2B nonimmigrant classification. If the Administrator, OFLC directs that certain types of temporary labor certification applications or a specific *Application for Temporary Employment Certification* under the H–2B nonimmigrant classification be handled by the OFLC's National Office, the Director of the NPC will refer such applications to the Administrator, OFLC.

(b) *Determination.* Except as otherwise provided in this paragraph (b), the CO will make a determination either to certify or deny the *Application for Temporary Employment Certification.* The CO will certify the application only if the employer has met all the requirements of this subpart, including the criteria for certification in § 655.51, thus demonstrating that there is an insufficient number of U.S. workers who are qualified and who will be available for the job opportunity for which certification is sought and that the employment of the H–2B workers will not adversely affect the wages and working conditions of similarly employed U.S. workers.

§ 655.51 Criteria for certification.

(a) The criteria for certification include whether the employer has a valid *H–2B Registration* to participate in the H–2B program and has complied with all of the requirements necessary to grant the labor certification.

(b) In making a determination whether there are insufficient U.S. workers to fill the employer's job opportunity, the CO will count as available any U.S. worker referred by the SWA or any U.S. worker who applied (or on whose behalf an application is made) directly to the employer, but who was rejected by the employer for other than a lawful job-related reason.

(c) A certification will not be granted to an employer that has failed to comply with one or more sanctions or remedies imposed by final agency actions under the H–2B program.

§ 655.52 Approved certification.

If a temporary labor certification is granted, the CO will send the approved *Application for Temporary Employment Certification* and a Final Determination letter to the employer by means normally assuring next day delivery, including electronic mail, and a copy, if applicable, to the employer's attorney or agent. If the *Application for Temporary Employment Certification* is electronically filed, the employer must sign the certified *Application for Temporary Employment Certification* as directed by the CO. The employer must retain a signed copy of the *Application for Temporary Employment Certification* and the original signed Appendix B of the Application, as required by § 655.56.

§ 655.53 Denied certification.

If a temporary labor certification is denied, the CO will send the Final Determination letter to the employer by means normally assuring next day delivery, including electronic mail, and a copy, if applicable, to the employer's attorney or agent. The Final Determination letter will:

(a) State the reason(s) certification is denied, citing the relevant regulatory standards;

(b) Offer the employer an opportunity to request administrative review of the denial under § 655.61; and

(c) State that if the employer does not request administrative review in accordance with § 655.61, the denial is final and the Department of Labor will not accept any appeal on that *Application for Temporary Employment Certification.*

§ 655.54 Partial certification.

The CO may issue a partial certification, reducing either the period of need or the number of H–2B workers or both for certification, based upon information the CO receives during the course of processing the *Application for Temporary Employment Certification.* The number of workers certified will be reduced by one for each U.S. worker who is qualified and who will be available at the time and place needed to perform the services or labor and who has not been rejected for lawful job-related reasons. If a partial labor certification

is issued, the CO will amend the *Application for Temporary Employment Certification* and then return it to the employer with a Final Determination letter, with a copy to the employer's attorney or agent, if applicable. The Final Determination letter will:

(a) State the reason(s) why either the period of need and/or the number of H–2B workers requested has been reduced, citing the relevant regulatory standards;

(b) If applicable, address the availability of U.S. workers in the occupation;

(c) Offer the employer an opportunity to request administrative review of the partial certification under § 655.61; and

(d) State that if the employer does not request administrative review in accordance with § 655.61, the partial certification is final and the Department of Labor will not accept any appeal on that *Application for Temporary Employment Certification*.

§ 655.55 Validity of temporary labor certification.

(a) *Validity period.* A temporary labor certification is valid only for the period as approved on the *Application for Temporary Employment Certification*. The certification expires on the last day of authorized employment.

(b) *Scope of validity.* A temporary labor certification is valid only for the number of H–2B positions, the area of intended employment, the job classification and specific services or labor to be performed, and the employer specified on the approved *Application for Temporary Employment Certification*, including any approved modifications. The temporary labor certification may not be transferred from one employer to another unless the employer to which it is transferred is a successor in interest to the employer to which it was issued.

§ 655.56 Document retention requirements of H–2B employers.

(a) *Entities required to retain documents.* All employers filing an *Application for Temporary Employment Certification* requesting H–2B workers are required to retain the documents and records proving compliance with 29 CFR part 503 and this subpart, including but not limited to those specified in paragraph (c) of this section.

(b) *Period of required retention.* The employer must retain records and documents for 3 years from the date of certification of the *Application for Temporary Employment Certification*, or from the date of adjudication if the *Application for Temporary Employment Certification* is denied, or 3 years from the day the Department of Labor receives the letter of withdrawal provided in accordance with § 655.62. For the purposes of this section, records and documents required to be retained in connection with an *H–2B Registration* must be retained in connection with all of the *Applications for Temporary Employment Certification* that are supported by it.

(c) *Documents and records to be retained by all employer applicants.* All employers filing an *H–2B Registration* and an *Application for Temporary Employment Certification* must retain the following documents and records and must provide the documents and records to the Department of Labor and other Federal agencies in the event of an audit or investigation:

(1) Documents and records not previously submitted during the registration process that substantiate temporary need;

(2) Proof of recruitment efforts, as applicable, including:

(i) Job order placement as specified in § 655.16;

(ii) Contact with former U.S. workers as specified in § 655.43;

(iii) Contact with bargaining representative(s), or a copy of the posting of the job opportunity, if applicable, as specified in § 655.45(a) or (b); and

(iv) Additional employer-conducted recruitment efforts as specified in § 655.46;

(3) Substantiation of the information submitted in the recruitment report prepared in accordance with § 655.48, such as evidence of nonapplicability of contact with former workers as specified in § 655.43;

(4) The final recruitment report and any supporting resumes and contact information as specified in § 655.48;

(5) Records of each worker's earnings, hours offered and worked, location(s) of work performed, and other information as specified in § 655.20(i);

(6) If appropriate, records of reimbursement of transportation and subsistence costs incurred by the workers, as specified in § 655.20(j).

(7) Evidence of contact with U.S. workers who applied for the job opportunity in the *Application for Temporary Employment Certification*, including documents demonstrating that any rejections of U.S. workers were for lawful, job-related reasons, as specified in § 655.20(r);

(8) Evidence of contact with any former U.S. worker in the occupation at the place of employment in the *Application for Temporary Employment Certification*, including documents demonstrating that the U.S. worker had been offered the job opportunity in the *Application for Temporary Employment Certification*, as specified in § 655.20(w), and that the U.S. worker either refused the job opportunity or was rejected only for lawful, job-related reasons, as specified in § 655.20(r);

(9) The written contracts with agents or recruiters as specified in §§ 655.8 and 655.9, and the list of the identities and locations of persons hired by or working for the agent or recruiter and these entities' agents or employees, as specified in § 655.9;

(10) Written notice provided to and informing OFLC that an H–2B worker or worker in corresponding employment has separated from employment before the end date of employment specified in the *Application for Temporary Employment Certification*, as specified in § 655.20(y);

(11) The *H–2B Registration*, job order and a copy of the *Application for Temporary Employment Certification* and the original signed Appendix B of the Application. If the *Application for Temporary Employment Certification* and *H–2B Registration* is electronically filed, a printed copy of each adjudicated *Application for Temporary Employment Certification*, including any modifications, amendments or extensions must be signed by the employer as directed by the CO and retained;

(12) The *H–2B Petition*, including all accompanying documents; and

(13) Any collective bargaining agreement(s), individual employment contract(s), or payroll records from the previous year necessary to substantiate any claim that certain incumbent workers are not included in corresponding employment, as specified in § 655.5.

(d) *Availability of documents for enforcement purposes.* An employer must make available to the Administrator, WHD within 72 hours following a request by the WHD the documents and records required under 29 CFR part 503 and this section so that the Administrator, WHD may copy, transcribe, or inspect them.

[42 FR 45899, Sept. 13, 1977, as amended at 84 FR 62446, Nov. 15, 2019]

§ 655.57 Request for determination based on nonavailability of U.S. workers.

(a) *Standards for requests.* If a temporary labor certification has been partially granted or denied, based on the CO's determination that qualified U.S. workers are available, and, on or after 21 calendar days before the date of need, some or all of those qualified U.S. workers are, in fact no longer available, the employer may request a new temporary labor certification determination from the CO. Prior to making a new determination the CO will promptly ascertain (which may be through the SWA or other sources of information on U.S. worker availability) whether specific qualified replacement U.S. workers are available or can be reasonably expected to be present at the employer's establishment within 72 hours from the date the employer's request was received. The CO will expeditiously, but in no case later than 72 hours after the time a complete request (including the signed statement included in paragraph (b) of this section) is received, make a determination on the request. An employer may appeal a denial of such a determination in accordance with procedures contained in § 655.61.

(b) *Unavailability of U.S. workers.* The employer's request for a new determination must be made directly to the CO by electronic mail or other appropriate means and must be accompanied by a signed statement confirming the employer's assertion. In addition, unless the employer has provided to the CO notification of abandonment or termination of employment as required by

§ 655.20(y), the employer's signed statement must include the name and contact information of each U.S. worker who became unavailable and must supply the reason why the worker has become unavailable.

(c) *Notification of determination.* If the CO determines that U.S. workers have become unavailable and cannot identify sufficient available U.S. workers who are qualified or who are likely to become available, the CO will grant the employer's request for a new determination. However, this does not preclude an employer from submitting subsequent requests for new determinations, if warranted, based on subsequent facts concerning purported nonavailability of U.S. workers or referred workers not being qualified because of lawful job-related reasons.

§§ 655.58–655.59 [Reserved]

POST CERTIFICATION ACTIVITIES

§ 655.60 Extensions.

An employer may apply for extensions of the period of employment in the following circumstances. A request for extension must be related to weather conditions or other factors beyond the control of the employer (which may include unforeseeable changes in market conditions), and must be supported in writing, with documentation showing why the extension is needed and that the need could not have been reasonably foreseen by the employer. The CO will notify the employer of the decision in writing. Except in extraordinary circumstances, the CO will not grant an extension where the total work period under that *Application for Temporary Employment Certification* and the authorized extension would exceed 9 months for employers whose temporary need is seasonal, peakload, or intermittent, or 3 years for employers that have a one-time occurrence of temporary need. The employer may appeal a denial of a request for an extension by following the procedures in § 655.61. The H–2B employer's assurances and obligations under the temporary labor certification will continue to apply during the extended period of employment. The employer must immediately provide to its workers a copy of any approved extension.

§ 655.61 Administrative review.

(a) *Request for review.* Where authorized in this subpart, employers may request an administrative review before the BALCA of a determination by the CO. In such cases, the request for review:

(1) Must be sent to the BALCA, with a copy simultaneously sent to the CO who issued the determination, within 10 business days from the date of determination;

(2) Must clearly identify the particular determination for which review is sought;

(3) Must set forth the particular grounds for the request;

(4) Must include a copy of the CO's determination; and

(5) May contain only legal argument and such evidence as was actually submitted to the CO before the date the CO's determination was issued.

(b) *Appeal file.* Upon the receipt of a request for review, the CO will, within 7 business days, assemble and submit the Appeal File using means to ensure same day or next day delivery, to the BALCA, the employer, and the Associate Solicitor for Employment and Training Legal Services, Office of the Solicitor, U.S. Department of Labor.

(c) *Briefing schedule.* Within 7 business days of receipt of the Appeal File, the counsel for the CO may submit, using means to ensure same day or next day delivery, a brief in support of the CO's decision.

(d) *Assignment.* The Chief ALJ may designate a single member or a three member panel of the BALCA to consider a particular case.

(e) *Review.* The BALCA must review the CO's determination only on the basis of the Appeal File, the request for review, and any legal briefs submitted and must:

(1) Affirm the CO's determination; or

(2) Reverse or modify the CO's determination; or

(3) Remand to the CO for further action.

(f) *Decision.* The BALCA should notify the employer, the CO, and counsel for the CO of its decision within 7 business days of the submission of the CO's brief or 10 business days after receipt of the Appeal File, whichever is later,

using means to ensure same day or next day delivery.

§ 655.62 Withdrawal of an Application for Temporary Employment Certification.

Employers may withdraw an *Application for Temporary Employment Certification* after it has been accepted and before it is adjudicated. The employer must request such withdrawal in writing.

§ 655.63 Public disclosure.

The Department of Labor will maintain an electronic file accessible to the public with information on all employers applying for temporary nonagricultural labor certifications. The database will include such information as the number of workers requested, the date filed, the date decided, and the final disposition.

§ 655.64 Special application filing and eligibility provisions for Fiscal Year 2025 under the December 2, 2024, supplemental cap increase.

(a) An employer filing a petition with USCIS under 8 CFR 214.2(h)(6)(xv) to request H–2B workers with FY 2025 employment start dates on or before September 30, 2025, must meet the following requirements:

(1) The employer must attest on the Form ETA–9142–B–CAA–9 that its business is suffering irreparable harm or will suffer impending irreparable harm (that is, permanent and severe financial loss) without the ability to employ all of the H–2B workers requested on the petition filed pursuant to 8 CFR 214.2(h)(6)(xv). The employer's attestation must identify the types of evidence the employer is relying on and will retain to meet the irreparable harm standard. The employer must attest that it has created a detailed written statement describing how it is suffering irreparable harm or will suffer impending irreparable harm and describing how such evidence demonstrates irreparable harm. In addition, the employer must attest that it will provide to DHS and/or DOL upon request all of the documentation it relied upon and retained as evidence that it meets the irreparable harm standard, including all of the supporting documentation the employer committed to retain at the time of filing on the employer's attestation form by selecting a checkbox next to the applicable type of documentation in section C, and the written statement describing how such evidence demonstrates irreparable harm.

(2) The employer must attest on Form ETA–9142–B–CAA–9 that each of the workers requested and/or instructed to apply for a visa, whether named or unnamed, on a petition filed pursuant to 8 CFR 214.2(h)(6)(xv), have been issued an H–2B visa or otherwise granted H–2B status during one of the last three (3) fiscal years (fiscal year 2022, 2023, or 2024), unless the H–2B worker is a national of Guatemala, El Salvador, Honduras, Haiti, Colombia, Ecuador, or Costa Rica and is counted towards the 20,000 cap described in 8 CFR 214.2(h)(6)(xv)(A)(*2*).

(3) The employer must attest on Form ETA–9142–B–CAA–9 that the employer will comply with all the assurances, obligations, and conditions of employment set forth on its approved *Application for Temporary Employment Certification*.

(4) An employer that submits Form ETA–9142B–CAA–9 and the I–129 petition 30 or more days after the certified start date of work, as shown on its approved Form ETA–9142B, *Final Determination: H–2B Temporary Labor Certification Approval*, must conduct additional recruitment of U.S. workers as follows:

(i) Not later than the next business day after submitting the I–129 petition for H–2B worker(s), the employer must place a new job order for the job opportunity with the State Workforce Agency (SWA), serving the area of intended employment. The employer must follow all applicable SWA instructions for posting job orders, concurrently inform the SWA and NPC that the job order is being placed in connection with a previously certified *Application for Temporary Employment Certification* for H–2B workers by providing the unique temporary labor certification (TLC) identification number, and receive applications in all forms allowed by the SWA, including online applications (sometimes known as ''self-referrals'').

The job order must contain the job assurances and contents set forth in § 655.18 for recruitment of U.S. workers at the place of employment, and remain posted for at least 15 calendar days;

(ii) During the period of time the SWA is actively circulating the job order described in paragraph (a)(4)(i) of this section for intrastate clearance, the employer must contact, by email or other available electronic means, the nearest comprehensive American Job Center (AJC) serving the area of intended employment where work will commence, request staff assistance advertising and recruiting qualified U.S. workers for the job opportunity, and provide the AJC with the unique identification number associated with the job order placed with the SWA or, if unavailable, a copy of the job order. If a comprehensive AJC is not available, the employer must contact the nearest affiliate AJC serving the area of intended employment where work will commence to satisfy the requirements of this paragraph (a)(4)(ii);

(iii) Where the occupation or industry is traditionally or customarily unionized, during the period of time the SWA is actively circulating the job order described in paragraph (a)(4)(i) of this section for intrastate clearance, the employer must contact (by mail, email or other effective means) the nearest American Federation of Labor and Congress of Industrial Organizations office covering the area of intended employment and provide written notice of the job opportunity, by providing a copy of the job order placed pursuant to (a)(4)(i) of this section, and request assistance in recruiting qualified U.S. workers for the job;

(iv) During the period of time the SWA is actively circulating the job order described in paragraph (a)(4)(i) of this section for intrastate clearance, the employer must contact (by mail or other effective means) its former U.S. workers, including those who have been furloughed or laid off, during the period beginning January 1, 2023, until the date the I–129 petition required under 8 CFR 214.2(h)(6)(xv) is submitted, who were employed by the employer in the occupation at the place of employment (except those who were dismissed for cause or who abandoned the worksite), disclose the terms of the job order placed pursuant to (a)(4)(i) of this section, and solicit their return to the job. The contact and disclosures required by this paragraph (a)(4)(iv) must be provided in a language understood by the worker, as necessary or reasonable, and in writing;

(v) During the period of time the SWA is actively circulating the job order described in paragraph (a)(4)(i) of this section for intrastate clearance, the employer must engage in the recruitment of U.S. workers as provided in § 655.45(a) and (b). The contact and disclosures required by this paragraph (a)(4)(v) must be provided in a language understood by the worker, as necessary or reasonable, in writing; and

(vi) During the period of time the SWA is actively circulating the job order described in paragraph (a)(4)(i) of this section for intrastate clearance, the employer must contact (by mail or other effective written means) all U.S. workers currently employed at the place of employment, disclose the terms of the job order placed pursuant to (a)(4)(i) of this section, and request assistance in recruiting qualified U.S. workers for the job. The contact, disclosure, and request for assistance required by this paragraph (a)(4)(vi) must be provided in a language understood by the worker, as necessary or reasonable, and in writing;

(vii) Where the employer maintains a website for its business operations, during the period of time the SWA is actively circulating the job order described in paragraph (a)(4)(i) of this section for intrastate clearance, the employer must post the job opportunity in a conspicuous location on the website. The job opportunity posted on the website must disclose the terms of the job order placed pursuant to (a)(4)(i) of this section, and remain posted for at least 15 calendar days;

(viii) The employer must hire any qualified U.S. worker who applies or is referred for the job opportunity until the date on which the last H–2B worker departs for the place of employment, or 30 days after the last date on which the SWA job order is posted, whichever is

later. Consistent with § 655.40(a), applicants can be rejected only for lawful job-related reasons.

(5) The employer must attest on Form ETA–9142–B–CAA–9 that it will fully cooperate with any audit, investigation, compliance review, evaluation, verification, or inspection conducted by DOL, including an on-site inspection of the employer's facilities, interview of the employer's employees and any other individuals possessing pertinent information, and review of the employer's records related to the compliance with applicable laws and regulations, including but not limited to evidence pertaining to or supporting the eligibility criteria for the FY 2025 supplemental allocations outlined in this paragraph (a) and § 655.68(a), as a condition for the approval of the H–2B petition. Pursuant to this subpart A at § 655.73 and 29 CFR 503.25, the employer will not impede, interfere, or refuse to cooperate with an employee of the Secretary who is exercising or attempting to exercise DOL's audit or investigative authority. DOL may consider the failure to respond to and/or comply with an investigation or audit to be a willful misrepresentation of material fact or a substantial failure to meet the terms and conditions of the *H–2B Application for Prevailing Wage Determination,* or *Application for Temporary Employment Certification,* resulting in an adverse agency action on the employer, agent, or attorney, including assessment of a civil money penalty, revocation of the temporary labor certification, and/or program debarment for not less than 1 year or more than 5 years from the date of the final agency decision under 20 CFR 655.70, 655.72, 655.73 or 29 CFR part 503. A debarred party will be disqualified from filing any labor certification applications or labor condition applications with the Department of Labor by, or on behalf of, the debarred party for the same period of time set forth in the final debarment decision.

(b) This section expires on October 1, 2025.

(c) The requirements under paragraph (a) of this section are intended to be non-severable from the remainder of this section; in the event that paragraph (a)(1), (2), (3), (4), or (5) of this section is enjoined or held to be invalid by any court of competent jurisdiction, the remainder of this section is also intended to be enjoined or held to be invalid in such jurisdiction, without prejudice to workers already present in the United States under this part, as consistent with law.

[89 FR 95683, Dec. 2, 2024]

EFFECTIVE DATE NOTE: At 89 FR 95683, Dec. 2, 2024, § 655.64 was added, effective Dec. 2, 2024, through Sept. 30, 2025.

§ 655.65 Special document retention provisions for Fiscal Years 2024 through 2027 under the Consolidated Appropriations Act, 2023, as extended by Public Law 118–15.

(a) An employer that files a petition with USCIS to employ H–2B workers in fiscal year 2024 under authority of the temporary increase in the numerical limitation under section 303 of Division O, Public Law 117–328, as extended by Public Law 118–15 must maintain for a period of three (3) years from the date of certification, consistent with 20 CFR 655.56 and 29 CFR 503.17, the following:

(1) A copy of the attestation filed pursuant to the regulations in 8 CFR 214.2 governing that temporary increase;

(2) Evidence establishing, at the time of filing the I–129 petition, that the employer's business is suffering irreparable harm or will suffer impending irreparable harm (that is, permanent and severe financial loss) without the ability to employ all of the H–2B workers requested on the petition filed pursuant to 8 CFR 214.2(h)(6)(xiv), including a detailed written statement describing the irreparable harm and how such evidence shows irreparable harm;

(3) Documentary evidence establishing that each of the workers the employer requested and/or instructed to apply for a visa, whether named or unnamed on a petition filed pursuant to 8 CFR 214.2(h)(6)(xiv), have been issued an H–2B visa or otherwise granted H–2B status during one of the last three (3) fiscal years (fiscal year 2021, 2022, or 2023), unless the H–2B worker(s) is a national of El Salvador, Guatemala, Honduras, Haiti, Colombia, Ecuador, or Costa Rica and is counted towards the 20,000 cap described in 8 CFR 214.2(h)(6)(xiv)(A)(*2*). Alternatively, if

applicable, employers must maintain documentary evidence that the workers the employer requested and/or instructed to apply for visas are eligible nationals of El Salvador, Guatemala, Honduras, Haiti, Colombia, Ecuador, or Costa Rica as defined in 8 CFR 214.2(h)(6)(xiv)(A)(*2*); and

(4) If applicable, proof of recruitment efforts set forth in § 655.64(a)(4)(i) through (vii) and a recruitment report that meets the requirements set forth in § 655.48(a)(1) through (4) and (7), and maintained throughout the recruitment period set forth in § 655.64(a)(4)(viii).

(b) DOL and/or DHS may inspect the documents in paragraphs (a)(1) through (4) of this section upon request.

(c) This section expires on October 1, 2027.

[88 FR 80460, Nov. 17, 2023]

EFFECTIVE DATE NOTE: At 88 FR 80460, Nov. 17, 2023, § 655.65 was added, effective Nov. 17, 2023, until Sept. 30, 2027.

§ 655.66 Special document retention provisions for Fiscal Years 2022 through 2026 under the Consolidated Appropriations Act, 2022.

(a) An employer that files a petition with USCIS to employ H–2B workers in fiscal year 2022 under authority of the temporary increase in the numerical limitation under section 204 of Division O, Public Law 117–103 must maintain for a period of three (3) years from the date of certification, consistent with 20 CFR 655.56 and 29 CFR 503.17, the following:

(1) A copy of the attestation filed pursuant to the regulations in 8 CFR 214.2 governing that temporary increase;

(2) Evidence establishing, at the time of filing the I–129 petition, that the employer's business is suffering irreparable harm or will suffer impending irreparable harm (that is, permanent and severe financial loss) without the ability to employ all of the H–2B workers requested on the petition filed pursuant to 8 CFR 214.2(h)(6)(xii);

(3) Documentary evidence establishing that each of the workers the employer requested and/or instructed to apply for a visa, whether named or unnamed on a petition filed pursuant to 8 CFR 214.2(h)(6)(xii), have been issued an H–2B visa or otherwise granted H–2B status during one of the last three (3) fiscal years (fiscal year 2019, 2020, or 2021), unless the H–2B worker(s) is a national of El Salvador, Guatemala, Honduras, or Haiti and is counted towards the 11,500 cap described in 8 CFR 214.2(h)(6)(xii)(A)(*2*). Alternatively, if applicable, employers must maintain documentary evidence that the workers the employer requested and/or instructed to apply for visas are eligible nationals of El Salvador, Guatemala, Honduras, or Haiti as defined in 8 CFR 214.2(h)(6)(xii)(A)(*2*); and

(4) If applicable, proof of recruitment efforts set forth in § 655.65(a)(5)(i) through (v) and a recruitment report that meets the requirements set forth in § 655.48(a)(1) through (4) and (7), and maintained throughout the recruitment period set forth in § 655.65(a)(5)(vi).

(b) DOL or DHS may inspect the documents in paragraphs (a)(1) through (4) of this section upon request.

(c) This section expires on October 1, 2025.

[87 FR 30377, May 18, 2022]

EFFECTIVE DATE NOTE: At 87 FR 30378, May 18, 2022, § 655.66 was added, effective May 18, 2022, through Sept. 30, 2025.

§ 655.67 Special document retention provisions for Fiscal Years 2023 through 2026 under the Consolidated Appropriations Act, 2022, as extended by Public Law 117–180.

(a) An employer that files a petition with USCIS to employ H–2B workers in fiscal year 2023 under authority of the temporary increase in the numerical limitation under section 204 of Division O, Public Law 117–103 must maintain for a period of three (3) years from the date of certification, consistent with 20 CFR 655.56 and 29 CFR 503.17, the following: (1) A copy of the attestation filed pursuant to the regulations in 8 CFR 214.2 governing that temporary increase;

(2) Evidence establishing, at the time of filing the I–129 petition, that the employer's business is suffering irreparable harm or will suffer impending irreparable harm (that is, permanent and severe financial loss) without the

ability to employ all of the H–2B workers requested on the petition filed pursuant to 8 CFR 214.2(h)(6)(xiii), including a detailed written statement describing the irreparable harm and how such evidence shows irreparable harm;

(3) Documentary evidence establishing that each of the workers the employer requested and/or instructed to apply for a visa, whether named or unnamed on a petition filed pursuant to 8 CFR 214.2(h)(6)(xiii), have been issued an H–2B visa or otherwise granted H–2B status during one of the last three (3) fiscal years (fiscal year 2020, 2021, or 2022), unless the H–2B worker(s) is a national of El Salvador, Guatemala, Honduras, or Haiti and is counted towards the20,000 cap described in 8 CFR 214.2(h)(6)(xiii)(A)(*2*). Alternatively, if applicable, employers must maintain documentary evidence that the workers the employer requested and/or instructed to apply for visas are eligible nationals of El Salvador, Guatemala, Honduras, or Haiti as defined in 8 CFR 214.2(h)(6)(xiii)(A)(*2*); and

(4) If applicable, proof of recruitment efforts set forth in '4§ 655.65(a)(5)(i) through (viii) and a recruitment report that meets the requirements set forth in § 655.48(a)(1) through (4) and (7), and maintained throughout the recruitment period set forth in § 655.65(a)(5)(ix).

(b) DOL or DHS may inspect the documents in paragraphs (a)(1) through (4) of this section upon request.

(c) This section expires on October 1, 2026.

[87 FR 76878, Dec. 15, 2022]

EFFECTIVE DATE NOTE: At 87 FR 76878, Dec. 15, 2022, § 655.67 was added, effective Dec. 15, 2022, to Sept. 30, 2026.

§ 655.68 Special document retention provisions for Fiscal Years 2025 through 2028 under the Further Consolidated Appropriations Act, 2024, as extended by Public Law 118–83.

(a) An employer that files a petition with USCIS to employ H–2B workers in fiscal year 2025 under authority of the temporary increase in the numerical limitation under section 105 of Division G, Public Law 118–47, as extended by Public Law 118–83 must maintain for a period of three (3) years from the date of certification, consistent with 20 CFR 655.56 and 29 CFR 503.17, the following:

(1) A copy of the attestation filed pursuant to the regulations in 8 CFR 214.2 governing that temporary increase;

(2) Evidence establishing, at the time of filing the I–129 petition and as attested to in the attestation form, that the employer's business is suffering irreparable harm or will suffer impending irreparable harm (that is, permanent and severe financial loss) without the ability to employ all of the H–2B workers requested on the petition filed pursuant to 8 CFR 214.2(h)(6)(xv), including a detailed written statement describing the irreparable harm and how such evidence shows irreparable harm;

(3) Documentary evidence establishing that each of the workers the employer requested and/or instructed to apply for a visa, whether named or unnamed on a petition filed pursuant to 8 CFR 214.2(h)(6)(xv), have been issued an H–2B visa or otherwise granted H–2B status during one of the last three (3) fiscal years (fiscal year 2022, 2023, or 2024), unless the H–2B worker(s) is a national of El Salvador, Guatemala, Honduras, Haiti, Colombia, Ecuador, or Costa Rica and is counted towards the 20,000 cap described in 8 CFR 214.2(h)(6)(xv)(A)(*2*). Alternatively, if applicable, employers must maintain documentary evidence that the workers the employer requested and/or instructed to apply for visas are eligible nationals of El Salvador, Guatemala, Honduras, Haiti, Colombia, Ecuador, or Costa Rica as defined in 8 CFR 214.2(h)(6)(xv)(A)(*2*); and

(4) If applicable, proof of recruitment efforts set forth in § 655.64(a)(4)(i) through (vii) and a recruitment report that meets the requirements set forth in § 655.48(a)(1) through (4) and (7), and maintained throughout the recruitment period set forth in § 655.64(a)(4)(viii).

(b) DOL and/or DHS may inspect the documents in paragraphs (a)(1) through (4) of this section upon request.

(c) This section expires on October 1, 2028.

[89 FR 95685, Dec. 2, 2024]

EFFECTIVE DATE NOTE: At 89 FR 95685, Dec. 2, 2024, § 655.68 was added, effective Dec. 2, 2024, through Sept. 30, 2028.

§ 655.69 Special document retention provisions for Fiscal Years 2022 through 2026 under Public Laws 116–260, 117–43, and 117–70.

(a) An employer that files a petition with USCIS to employ H–2B workers in fiscal year 2022 under authority for the temporary increase in the numerical limitation provided by Public Law 117–43 and Public Law 117–70 on the same terms as section 105 of Division O, of Public Law 116–260, must maintain for a period of three (3) years from the date of certification, consistent with 20 CFR 655.56 and 29 CFR 503.17, the following:

(1) A copy of the attestation filed pursuant to the regulations in 8 CFR 214.2 governing that temporary increase;

(2) Evidence establishing, at the time of filing the I–129 petition, that the employer's business is suffering irreparable harm or will suffer impending irreparable harm (that is, permanent and severe financial loss) without the ability to employ all of the H–2B workers requested on the petition filed pursuant to 8 CFR 214.2(h)(6)(xi);

(3) Documentary evidence establishing that each of the workers the employer requested and/or instructed to apply for a visa, whether named or unnamed on a petition filed pursuant to 8 CFR 214.2(h)(6)(xi), have been issued an H–2B visa or otherwise granted H–2B status during one of the last three (3) fiscal years (fiscal year 2019, 2020, or 2021), unless the H–2B worker(s) is a national of El Salvador, Guatemala, Honduras, or Haiti and is counted towards the 6,500 cap described in 8 CFR 214.2(h)(6)(xi)(A)(*2*). Alternatively, if applicable, employers must maintain documentary evidence that the workers the employer requested and/or instructed to apply for visas are eligible nationals of El Salvador, Guatemala, Honduras, or Haiti as defined in 8 CFR 214.2(h)(6)(xi)(A)(*2*); and

(4) If applicable, proof of recruitment efforts set forth in § 655.64(a)(5)(i) through (iv) and a recruitment report that meets the requirements set forth in § 655.48(a)(1) through (4) and (7), and maintained throughout the recruitment period set forth in § 655.64(a)(5)(v).

(b) DOL or DHS may inspect the documents in paragraphs (a)(1) through (4) of this section upon request.

(c) This section expires on October 1, 2025.

[87 FR 4762, Jan. 28, 2022]

EFFECTIVE DATE NOTE: At 87 FR 4762, Jan. 28, 2022, § 655.69 was added, effective Jan. 28, 2022, until Sept. 30, 2025.

INTEGRITY MEASURES

§ 655.70 Audits.

The CO may conduct audits of adjudicated temporary employment certification applications.

(a) *Discretion*. The CO has the sole discretion to choose the applications selected for audit.

(b) *Audit letter*. Where an application is selected for audit, the CO will send an audit letter to the employer and a copy, if appropriate, to the employer's attorney or agent. The audit letter will:

(1) Specify the documentation that must be submitted by the employer;

(2) Specify a date, no more than 30 calendar days from the date the audit letter is issued, by which the required documentation must be sent to the CO; and

(3) Advise that failure to fully comply with the audit process may result:

(i) In the requirement that the employer undergo the assisted recruitment procedures in § 655.71 in future filings of H–2B temporary employment certification applications for a period of up to 2 years, or

(ii) In a revocation of the certification and/or debarment from the H–2B program and any other foreign labor certification program administered by the Department Labor.

(c) *Supplemental information request*. During the course of the audit examination, the CO may request supplemental information and/or documentation from the employer in order to complete the audit. If circumstances warrant, the CO can issue one or more requests for supplemental information.

(d) *Potential referrals*. In addition to measures in this subpart, the CO may decide to provide the audit findings and underlying documentation to DHS,

WHD, or other appropriate enforcement agencies. The CO may refer any findings that an employer discouraged a qualified U.S. worker from applying, or failed to hire, discharged, or otherwise discriminated against a qualified U.S. worker to the Department of Justice, Civil Rights Division, Office of Special Counsel for Unfair Immigration Related Employment Practices.

§ 655.71 CO-ordered assisted recruitment.

(a) *Requirement of assisted recruitment.* If, as a result of audit or otherwise, the CO determines that a violation has occurred that does not warrant debarment, the CO may require the employer to engage in assisted recruitment for a defined period of time for any future *Application for Temporary Employment Certification.*

(b) *Notification of assisted recruitment.* The CO will notify the employer (and its attorney or agent, if applicable) in writing of the assisted recruitment that will be required of the employer for a period of up to 2 years from the date the notice is issued. The notification will state the reasons for the imposition of the additional requirements, state that the employer's agreement to accept the conditions will constitute their inclusion as bona fide conditions and terms of an application for temporary employment certification, and offer the employer an opportunity to request an administrative review. If administrative review is requested, the procedures in § 655.61 apply.

(c) *Assisted recruitment.* The assisted recruitment process will be in addition to any recruitment required of the employer by §§ 655.41 through 655.46 and may consist of, but is not limited to, one or more of the following:

(1) Requiring the employer to submit a draft advertisement to the CO for review and approval at the time of filing the *Application for Temporary Employment Certification;*

(2) Designating the sources where the employer must recruit for U.S. workers and directing the employer to place the advertisement(s) in such sources;

(3) Extending the length of the placement of the advertisement and/or job order;

(4) Requiring the employer to notify the CO and the SWA in writing when the advertisement(s) are placed;

(5) Requiring an employer to perform any additional assisted recruitment directed by the CO;

(6) Requiring the employer to provide proof of the publication of all advertisements as directed by the CO, in addition to providing a copy of the job order;

(7) Requiring the employer to provide proof of all SWA referrals made in response to the job order;

(8) Requiring the employer to submit any proof of contact with all referrals and past U.S. workers; and/or

(9) Requiring the employer to provide any additional documentation verifying it conducted the assisted recruitment as directed by the CO.

(d) *Failure to comply.* If an employer materially fails to comply with requirements ordered by the CO under this section, the certification will be denied and the employer and/or its attorney or agent may be debarred under § 655.73.

[42 FR 45899, Sept. 13, 1977, as amended at 84 FR 62447, Nov. 15, 2019]

§ 655.72 Revocation.

(a) *Basis for DOL revocation.* The Administrator, OFLC may revoke a temporary labor certification approved under this subpart, if the Administrator, OFLC finds:

(1) The issuance of the temporary labor certification was not justified due to fraud or willful misrepresentation of a material fact in the application process, as defined in § 655.73(d);

(2) The employer substantially failed to comply with any of the terms or conditions of the approved temporary labor certification. A substantial failure is a willful failure to comply that constitutes a significant deviation from the terms and conditions of the approved certification and is further defined in § 655.73(d) and (e);

(3) The employer failed to cooperate with a DOL investigation or with a DOL official performing an investigation, inspection, audit (under § 655.73), or law enforcement function under 29 CFR part 503 or this subpart; or

(4) The employer failed to comply with one or more sanctions or remedies

imposed by WHD, or with one or more decisions or orders of the Secretary with the respect to the H–2B program.

(b) *DOL procedures for revocation*—(1) *Notice of Revocation*. If the Administrator, OFLC makes a determination to revoke an employer's temporary labor certification, the Administrator, OFLC will send to the employer (and its attorney or agent, if applicable) a Notice of Revocation. The notice will contain a detailed statement of the grounds for the revocation and inform the employer of its right to submit rebuttal evidence or to appeal. If the employer does not file rebuttal evidence or an appeal within 10 business days from the date the Notice of Revocation is issued, the notice is the final agency action and will take effect immediately at the end of the 10-day period.

(2) *Rebuttal*. If the employer timely submits rebuttal evidence, the Administrator, OFLC will inform the employer of the final determination on the revocation within 10 business days of receiving the rebuttal evidence. If the Administrator, OFLC determines that the certification should be revoked, the Administrator, OFLC will inform the employer of its right to appeal according to the procedures of § 655.61. If the employer does not appeal the final determination, it will become the final agency action.

(3) *Appeal*. An employer may appeal a Notice of Revocation, or a final determination of the Administrator, OFLC after the review of rebuttal evidence, according to the appeal procedures of § 655.61. The ALJ's decision is the final agency action.

(4) *Stay*. The timely filing of rebuttal evidence or an administrative appeal will stay the revocation pending the outcome of those proceedings.

(5) *Decision*. If the temporary labor certification is revoked, the Administrator, OFLC will send a copy of the final agency action to DHS and the Department of State.

(c) *Employer's obligations in the event of revocation*. If an employer's temporary labor certification is revoked, the employer is responsible for:

(1) Reimbursement of actual inbound transportation and other expenses;

(2) The workers' outbound transportation expenses;

(3) Payment to the workers of the amount due under the three-fourths guarantee; and

(4) Any other wages, benefits, and working conditions due or owing to the workers under this subpart.

§ 655.73 Debarment.

a) *Debarment of an employer*. The Administrator, OFLC may not issue future labor certifications under this subpart to an employer or any successor in interest to that employer, subject to the time limits set forth in paragraph (c) of this section, if the Administrator, OFLC finds that the employer committed the following violations:

(1) Willful misrepresentation of a material fact in its *H–2B Registration, Application for Prevailing Wage Determination, Application for Temporary Employment Certification,* or *H–2B Petition;*

(2) Substantial failure to meet any of the terms and conditions of its *H–2B Registration, Application for Prevailing Wage Determination, Application for Temporary Employment Certification,* or *H–2B Petition*. A substantial failure is a willful failure to comply that constitutes a significant deviation from the terms and conditions of such documents; or

(3) Willful misrepresentation of a material fact to the DOS during the visa application process.

(b) *Debarment of an agent or attorney*. If the Administrator, OFLC finds, under this section, that an attorney or agent committed a violation as described in paragraphs (a)(1) through (3) of this section or participated in an employer's violation, the Administrator, OFLC may not issue future labor certifications to an employer represented by such agent or attorney, subject to the time limits set forth in paragraph (c) of this section.

(c) *Period of debarment*. Debarment under this subpart may not be for less than 1 year or more than 5 years from the date of the final agency decision.

(d) *Determining whether a violation is willful*. A willful misrepresentation of a material fact or a willful failure to meet the required terms and conditions occurs when the employer, attorney, or agent knows a statement is false or that the conduct is in violation, or

shows reckless disregard for the truthfulness of its representation or for whether its conduct satisfies the required conditions.

(e) *Determining whether a violation is significant.* In determining whether a violation is a significant deviation from the terms and conditions of the *H–2B Registration, Application for Prevailing Wage Determination, Application for Temporary Employment Certification,* or *H–2B Petition,* the factors that the Administrator, OFLC may consider include, but are not limited to, the following:

(1) Previous history of violation(s) under the H–2B program;

(2) The number of H–2B workers, workers in corresponding employment, or improperly rejected U.S. applicants who were and/or are affected by the violation(s);

(3) The gravity of the violation(s);

(4) The extent to which the violator achieved a financial gain due to the violation(s), or the potential financial loss or potential injury to the worker(s); and

(5) Whether U.S. workers have been harmed by the violation.

(f) *Violations.* Where the standards set forth in paragraphs (d) and (e) in this section are met, debarrable violations would include but would not be limited to one or more acts of commission or omission which involve:

(1) Failure to pay or provide the required wages, benefits or working conditions to the employer's H–2B workers and/or workers in corresponding employment;

(2) Failure, except for lawful, job-related reasons, to offer employment to qualified U.S. workers who applied for the job opportunity for which certification was sought;

(3) Failure to comply with the employer's obligations to recruit U.S. workers;

(4) Improper layoff or displacement of U.S. workers or workers in corresponding employment;

(5) Failure to comply with one or more sanctions or remedies imposed by the Administrator, WHD for violation(s) of obligations under the job order or other H–2B obligations, or with one or more decisions or orders of the Secretary or a court under this subpart or 29 CFR part 503;

(6) Failure to comply with the Notice of Deficiency process under this subpart;

(7) Failure to comply with the assisted recruitment process under this subpart;

(8) Impeding an investigation of an employer under 29 CFR part 503 or an audit under this subpart;

(9) Employing an H–2B worker outside the area of intended employment, in an activity/activities not listed in the job order, or outside the validity period of employment of the job order, including any approved extension thereof;

(10) A violation of the requirements of § 655.20(o) or (p);

(11) A violation of any of the provisions listed in § 655.20(r);

(12) Any other act showing such flagrant disregard for the law that future compliance with program requirements cannot reasonably be expected;

(13) Fraud involving the *H–2B Registration, Application for Prevailing Wage Determination, Application for Temporary Employment Certification,* or the *H–2B Petition;* or

(14) A material misrepresentation of fact during the registration or application process.

(g) *Debarment procedure*—(1) *Notice of Debarment.* If the Administrator, OFLC makes a determination to debar an employer, attorney, or agent, the Administrator, OFLC will send the party a Notice of Debarment. The Notice will state the reason for the debarment finding, including a detailed explanation of the grounds for and the duration of the debarment and inform the party subject to the notice of its right to submit rebuttal evidence or to request a debarment hearing. If the party does not file rebuttal evidence or request a hearing within 30 calendar days of the date of the Notice of Debarment, the notice is the final agency action and the debarment will take effect at the end of the 30-day period. The timely filing of an rebuttal evidence or a request for a hearing stays the debarment pending the outcome of the appeal as provided in paragraphs (g)(2) through (6) of this section.

(2) *Rebuttal.* The party who received the Notice of Debarment may choose to submit evidence to rebut the grounds stated in the notice within 30 calendar days of the date the notice is issued. If rebuttal evidence is timely filed, the Administrator, OFLC will issue a final determination on the debarment within 30 calendar days of receiving the rebuttal evidence. If the Administrator, OFLC determines that the party should be debarred, the Administrator, OFLC will inform the party of its right to request a debarment hearing according to the procedures in this section. The party must request a hearing within 30 calendar days after the date of the Administrator, OFLC's final determination, or the Administrator OFLC's determination will be the final agency order and the debarment will take effect at the end of the 30-day period.

(3) *Hearing.* The recipient of a Notice of Debarment seeking to challenge the debarment must request a debarment hearing within 30 calendar days of the date of a Notice of Debarment or the date of a final determination of the Administrator, OFLC after review of rebuttal evidence submitted under paragraph (g)(2) of this section. To obtain a debarment hearing, the recipient must, within 30 days of the date of the Notice or the final determination, file a written request with the Chief ALJ, United States Department of Labor, 800 K Street NW., Suite 400–N, Washington, DC 20001–8002, and simultaneously serve a copy on the Administrator, OFLC. The debarment will take effect 30 calendar days from the date the Notice of Debarment or final determination is issued, unless a request for review is timely filed. Within 10 business days of receipt of the request for a hearing, the Administrator, OFLC will send a certified copy of the ETA case file to the Chief ALJ by means normally assuring next day delivery. The Chief ALJ will immediately assign an ALJ to conduct the hearing. The procedures in 29 CFR part 18 apply to such hearings, except that the request for a hearing will not be considered to be a complaint to which an answer is required.

(4) *Decision.* After the hearing, the ALJ must affirm, reverse, or modify the Administrator, OFLC's determination. The ALJ will prepare the decision within 60 calendar days after completion of the hearing and closing of the record. The ALJ's decision will be provided to the parties to the debarment hearing by means normally assuring next day delivery. The ALJ's decision is the final agency action, unless either party, within 30 calendar days of the ALJ's decision, seeks review of the decision with the Administrative Review Board (ARB).

(5) *Review by the ARB.* (i) Any party wishing review of the decision of an ALJ must, within 30 calendar days of the decision of the ALJ, petition the ARB to review the decision. Copies of the petition must be served on all parties and on the ALJ. The ARB will decide whether to accept the petition within 30 calendar days of receipt. If the ARB declines to accept the petition, or if the ARB does not issue a notice accepting a petition within 30 calendar days after the receipt of a timely filing of the petition, the decision of the ALJ is the final agency action. If a petition for review is accepted, the decision of the ALJ will be stayed unless and until the ARB issues an order affirming the decision. The ARB must serve notice of its decision to accept or not to accept the petition upon the ALJ and upon all parties to the proceeding.

(ii) Upon receipt of the ARB's notice to accept the petition, the Office of Administrative Law Judges will promptly forward a copy of the complete hearing record to the ARB.

(iii) Where the ARB has determined to review the decision and order, the ARB will notify each party of the issue(s) raised, the form in which submissions must be made (e.g., briefs or oral argument), and the time within which the presentation must be submitted.

(6) *ARB Decision.* The ARB's final decision must be issued within 90 calendar days from the notice granting the petition and served upon all parties and the ALJ.

(h) *Concurrent debarment jurisdiction.* OFLC and the WHD have concurrent jurisdiction to debar under this section or under 29 CFR 503.24. When considering debarment, OFLC and the WHD

will coordinate their activities. A specific violation for which debarment is imposed will be cited in a single debarment proceeding. Copies of final debarment decisions will be forwarded to DHS and DOS promptly.

(i) *Debarment from other foreign labor programs.* Upon debarment under this subpart or 29 CFR 503.24, the debarred party will be disqualified from filing any labor certification applications or labor condition applications with the Department of Labor by, or on behalf of, the debarred party for the same period of time set forth in the final debarment decision.

§§ 655.74–655.99 [Reserved]

Subpart B—Labor Certification Process for Temporary Agricultural Employment in the United States (H–2A Workers)

SOURCE: 87 FR 61791, Oct. 12, 2022, unless otherwise noted.

§ 655.100 Purpose and scope of this subpart.

(a) *Purpose.* (1) A temporary agricultural labor certification issued under this subpart reflects a determination by the Secretary of Labor (Secretary), pursuant to 8 U.S.C. 1188(a), that:

(i) There are not sufficient able, willing, and qualified United States (U.S.) workers available to perform the agricultural labor or services of a temporary or seasonal nature for which an employer desires to hire temporary foreign workers (H–2A workers); and

(ii) The employment of the H–2A worker(s) will not adversely affect the wages and working conditions of workers in the United States similarly employed.

(2) This subpart describes the process by which the Department of Labor (Department or DOL) makes such a determination and certifies its determination to the Department of Homeland Security (DHS).

(b) *Scope.* This subpart sets forth the procedures governing the labor certification process for the temporary employment of foreign workers in the H–2A nonimmigrant classification, as defined in 8 U.S.C. 1101(a)(15)(H)(ii)(a). It also establishes standards and obligations with respect to the terms and conditions of the temporary agricultural labor certification with which H–2A employers must comply, as well as the rights and obligations of H–2A workers and workers in corresponding employment. Additionally, this subpart sets forth integrity measures for ensuring employers' continued compliance with the terms and conditions of the temporary agricultural labor certification.

§ 655.101 Authority of the agencies, offices, and divisions in the Department of Labor.

(a) *Authority and role of the Office of Foreign Labor Certification.* The Secretary has delegated authority to the Assistant Secretary for the Employment and Training Administration (ETA), who in turn has delegated that authority to the Office of Foreign Labor Certification (OFLC), to issue certifications and carry out other statutory responsibilities as required by 8 U.S.C. 1188. Determinations on an *Application for Temporary Employment Certification* are made by the OFLC Administrator who, in turn, may delegate this responsibility to designated staff, e.g., a Certifying Officer (CO).

(b) *Authority of the Wage and Hour Division.* The Secretary has delegated authority to the Wage and Hour Division (WHD) to conduct certain investigatory and enforcement functions with respect to terms and conditions of employment under 8 U.S.C. 1188, 29 CFR part 501, and this subpart (''the H–2A program''), and to carry out other statutory responsibilities required by 8 U.S.C. 1188. The regulations governing WHD's investigatory and enforcement functions, including those related to the enforcement of temporary agricultural labor certifications issued under this subpart, are in 29 CFR part 501.

(c) *Concurrent authority.* OFLC and WHD have concurrent authority to impose a debarment remedy pursuant to § 655.182 and 29 CFR 501.20.

§ 655.102 Transition procedures.

(a) The National Processing Center (NPC) shall continue to process an *Application for Temporary Employment Certification* submitted prior to November 14, 2022, in accordance with 20 CFR part

655, subpart B, in effect as of November 13, 2022.

(b) The NPC shall process an *Application for Temporary Employment Certification* submitted on or after November 14, 2022, and that has a first date of need no later than February 12, 2023, in accordance with 20 CFR part 655, subpart B, in effect as of November 13, 2022.

(c) The NPC shall process an *Application for Temporary Employment Certification* submitted on or after November 14, 2022, and that has a first date of need later than February 12, 2023, in accordance with all job order and application filing requirements under this subpart.

§ 655.103 Overview of this subpart and definition of terms.

(a) *Overview.* In order to bring nonimmigrant workers to the United States to perform agricultural work, an employer must first demonstrate to the Secretary that there are not sufficient U.S. workers able, willing, and qualified to perform the work in the area of intended employment at the time needed and that the employment of foreign workers will not adversely affect the wages and working conditions of workers in the United States similarly employed. This subpart describes a process by which the DOL makes such a determination and certifies its determination to the DHS.

(b) *Definitions.* For the purposes of this subpart:

Act. The Immigration and Nationality Act, as amended (INA), 8 U.S.C. 1101 *et seq.*

Administrative Law Judge (ALJ). A person within the Department's Office of Administrative Law Judges appointed pursuant to 5 U.S.C. 3105.

Administrator. See definitions of OFLC Administrator and WHD Administrator in this paragraph (b).

Adverse effect wage rate (AEWR). The wage rate published by the OFLC Administrator in the FEDERAL REGISTER for non-range occupations as set forth in § 655.120(b) and range occupations as set forth in § 655.211(c).

Adverse effect wage rate (AEWR). The wage rate published by the OFLC Administrator in the FEDERAL REGISTER for non-range occupations as set forth in § 655.120(b) and range occupations as set forth in § 655.211(c).

Agent. A legal entity or person, such as an association of agricultural employers, or an attorney for an association, that:

(i) Is authorized to act on behalf of the employer for temporary agricultural labor certification purposes;

(ii) Is not itself an employer, or a joint employer, as defined in this subpart with respect to a specific application; and

(iii) Is not under suspension, debarment, expulsion, or disbarment from practice before any court, the Department, or the Executive Office for Immigration Review or DHS under 8 CFR 292.3 or 1003.101.

Agricultural association. Any nonprofit or cooperative association of farmers, growers, or ranchers (including, but not limited to, processing establishments, canneries, gins, packing sheds, nurseries, or other similar fixed-site agricultural employers), incorporated or qualified under applicable State law, that recruits, solicits, hires, employs, furnishes, houses, or transports any worker that is subject to 8 U.S.C. 1188. An agricultural association may act as the agent of an employer, or may act as the sole or joint employer of any worker subject to 8 U.S.C. 1188.

Applicant. A U.S. worker who is applying for a job opportunity for which an employer has filed an *Application for Temporary Employment Certification* and job order.

Application for Temporary Employment Certification. The Office of Management and Budget (OMB)-approved Form ETA–9142A and appropriate appendices submitted by an employer to secure a temporary agricultural labor certification determination from DOL.

Area of intended employment (AIE). The geographic area within normal commuting distance of the place of employment for which temporary agricultural labor certification is sought. There is no rigid measure of distance that constitutes a normal commuting distance or normal commuting area, because there may be widely varying factual circumstances among different areas (e.g., average commuting times,

barriers to reaching the place of employment, or quality of the regional transportation network). If a place of employment is within an MSA, including a multistate MSA, any place within the MSA is deemed to be within normal commuting distance of the place of employment. The borders of MSAs are not controlling in the identification of the normal commuting area; a place of employment outside of an MSA may be within normal commuting distance of a place of employment that is inside (e.g., near the border of) the MSA.

Attorney. Any person who is a member in good standing of the bar of the highest court of any State, possession, territory, or commonwealth of the United States, or the District of Columbia (DC). Such a person is also permitted to act as an agent under this subpart. No attorney who is under suspension, debarment, expulsion, or disbarment from practice before any court, the Department, or the Executive Office for Immigration Review or DHS under 8 CFR 292.3 or 1003.101, may represent an employer under this subpart.

Average adverse effect wage rate (average AEWR). The simple average of the adverse effect wage rates (AEWR) applicable to the SOC 45–2092 (Farmworkers and Laborers, Crop, Nursery, and Greenhouse) and published by the OFLC Administrator in accordance with § 655.120. An average AEWR remains valid until replaced with an adjusted average AEWR.

Board of Alien Labor Certification Appeals (BALCA or Board). The permanent Board established by part 656 of this chapter, chaired by the Chief Administrative Law Judge (Chief ALJ), and consisting of Administrative Law Judges (ALJs) appointed pursuant to 5 U.S.C. 3105 and designated by the Chief ALJ to be members of Board of Alien Labor Certification Appeals (BALCA or Board).

Certifying Officer (CO). The person who makes a determination on an *Application for Temporary Employment Certification* filed under the H–2A program. The OFLC Administrator is the national CO. Other COs may be designated by the OFLC Administrator to also make the determinations required under this subpart.

Chief Administrative Law Judge (Chief ALJ). The chief official of the Department's Office of Administrative Law Judges or the Chief ALJ's designee.

Corresponding employment. The employment of workers who are not H–2A workers by an employer who has an approved *Application for Temporary Employment Certification* in any work included in the job order, or in any agricultural work performed by the H–2A workers. To qualify as corresponding employment, the work must be performed during the validity period of the job order, including any approved extension thereof.

Department of Homeland Security (DHS). The Department of Homeland Security, as established by 6 U.S.C. 111.

Employee. A person who is engaged to perform work for an employer, as defined under the general common law of agency. Some of the factors relevant to the determination of employee status include: the hiring party's right to control the manner and means by which the work is accomplished; the skill required to perform the work; the source of the instrumentalities and tools for accomplishing the work; the location of the work; the hiring party's discretion over when and how long to work; and whether the work is part of the regular business of the hiring party. Other applicable factors may be considered and no one factor is dispositive.

Employer. A person (including any individual, partnership, association, corporation, cooperative, firm, joint stock company, trust, or other organization with legal rights and duties) that:

(i) Has an employment relationship (such as the ability to hire, pay, fire, supervise, or otherwise control the work of employee) with respect to an H–2A worker or a worker in corresponding employment; or

(ii) Files an *Application for Temporary Employment Certification* other than as an agent; or

(iii) Is a person on whose behalf an *Application for Temporary Employment Certification* is filed.

Employment and Training Administration (ETA). The agency within the Department that includes OFLC and has

been delegated authority by the Secretary to fulfill the Secretary's mandate under the INA and DHS' implementing regulations in 8 CFR chapter I, subchapter B, for the administration and adjudication of an *Application for Temporary Employment Certification* and related functions.

Federal holiday. Legal public holiday as defined at 5 U.S.C. 6103.

First date of need. The first date the employer requires the labor or services of H–2A workers as indicated in the *Application for Temporary Employment Certification*.

Fixed-site employer. Any person engaged in agriculture who meets the definition of an employer, as those terms are defined in this subpart; who owns or operates a farm, ranch, processing establishment, cannery, gin, packing shed, nursery, or other similar fixed-site location where agricultural activities are performed; and who recruits, solicits, hires, employs, houses, or transports any worker subject to 8 U.S.C. 1188, 29 CFR part 501, or this subpart as incident to or in conjunction with the owner's or operator's own agricultural operation.

H–2A labor contractor (H–2ALC). Any person who meets the definition of employer under this subpart and is not a fixed-site employer, an agricultural association, or an employee of a fixed-site employer or agricultural association, as those terms are used in this subpart, who recruits, solicits, hires, employs, furnishes, houses, or transports any worker subject to 8 U.S.C. 1188, 29 CFR part 501, or this subpart.

H–2A Petition. The USCIS Form I–129, Petition for a Nonimmigrant Worker, with H Supplement or successor form and/or supplement, and accompanying documentation required by DHS for employers seeking to employ foreign persons as H–2A nonimmigrant workers.

H–2A worker. Any temporary foreign worker who is lawfully present in the United States and authorized by DHS to perform agricultural labor or services of a temporary or seasonal nature pursuant to 8 U.S.C. 1101(a)(15)(H)(ii)(a), as amended.

Job offer. The offer made by an employer or potential employer of H–2A workers to both U.S. and H–2A workers describing all the material terms and conditions of employment, including those relating to wages, working conditions, and other benefits.

Job opportunity. Full-time employment at a place in the United States to which U.S. workers can be referred.

Job order. The document containing the material terms and conditions of employment that is posted by the State Workforce Agency (SWA) on its interstate and intrastate job clearance systems based on the employer's *Agricultural Clearance Order* (Form ETA–790/ETA–790A and all appropriate addenda), as submitted to the NPC.

Joint employment. (i) Where two or more employers each have sufficient definitional indicia of being a joint employer of a worker under the common law of agency, they are, at all times, joint employers of that worker.

(ii) An agricultural association that files an *Application for Temporary Employment Certification* as a joint employer is, at all times, a joint employer of all the H–2A workers sponsored under the *Application for Temporary Employment Certification* and all workers in corresponding employment. An employer-member of an agricultural association that files an *Application for Temporary Employment Certification* as a joint employer is a joint employer of the H–2A workers sponsored under the joint employer *Application for Temporary Employment Certification* along with the agricultural association during the period that the employer-member employs the H–2A workers sponsored under the *Application for Temporary Employment Certification*.

(iii) Employers that jointly file a joint employer *Application for Temporary Employment Certification* under § 655.131(b) are, at all times, joint employers of all the H–2A workers sponsored under the *Application for Temporary Employment Certification* and all workers in corresponding employment.

Key service provider. A health-care provider; a community health worker; an education provider; a translator or interpreter; an attorney, legal advocate, or other legal service provider; a government official, including a consular representative; a member of the clergy; an emergency services provider;

a law enforcement officer; and any other provider of similar services.

Labor organization. Any organization of any kind, or any agency or employee representation committee or plan, in which workers participate and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work.

Master application. An *Application for Temporary Employment Certification* filed by an association of agricultural producers as a joint employer with its employer-members. A master application must cover the same occupations or comparable agricultural employment; the first date of need for all employer-members listed on the *Application for Temporary Employment Certification* may be separated by no more than 14 calendar days; and may cover multiple areas of intended employment within a single State but no more than two contiguous States.

Metropolitan Statistical Area (MSA). A geographic entity defined by OMB for use by Federal statistical agencies in collecting, tabulating, and publishing Federal statistics. A Metropolitan Statistical Area contains a core urban area of 50,000 or more population, and a Micropolitan Statistical Area contains an urban core of at least 10,000 (but fewer than 50,000) population. Each metropolitan or micropolitan area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.

National Processing Center (NPC). The offices within OFLC in which the COs operate and which are charged with the adjudication of *Applications for Temporary Employment Certification.*

Office of Foreign Labor Certification (OFLC). OFLC means the organizational component of ETA that provides national leadership and policy guidance, and develops regulations and procedures to carry out the responsibilities of the Secretary under the INA concerning the admission of foreign workers to the United States to perform work described in 8 U.S.C. 1101(a)(15)(H)(ii)(a).

OFLC Administrator. The primary official of OFLC, or the OFLC Administrator's designee.

Period of employment. The time during which the employer requires the labor or services of H–2A workers as indicated by the first and last dates of need provided in the *Application for Temporary Employment Certification.*

Piece rate. A form of wage compensation based upon a worker's quantitative output or one unit of work or production for the crop or agricultural activity.

Place of employment. A worksite or physical location where work under the job order actually is performed by the H–2A workers and workers in corresponding employment.

Positive recruitment. The active participation of an employer or its authorized hiring agent, performed under the auspices and direction of OFLC, in recruiting and interviewing individuals in the area where the employer's job opportunity is located, and any other State designated by the Secretary as an area of traditional or expected labor supply with respect to the area where the employer's job opportunity is located, in an effort to fill specific job openings with U.S. workers.

Prevailing practice. A practice engaged in by employers, that:

(i) Fifty percent or more of employers in an area and for an occupation engage in the practice or offer the benefit; and

(ii) This 50 percent or more of employers also employs 50 percent or more of U.S. workers in the occupation and area (including H–2A and non-H–2A employers) for purposes of determinations concerning the provision of family housing, and frequency of wage payments, but non-H–2A employers only for determinations concerning the provision of advance transportation and the utilization of labor contractors.

Prevailing wage. A wage rate established by the OFLC Administrator for a crop activity or agricultural activity and, if applicable, a distinct work task or tasks performed in that activity and geographic area based on a survey conducted by a State that meets the requirements in § 655.120(c).

Secretary of Homeland Security. The chief official of DHS, or the Secretary of Homeland Security's designee.

Secretary of Labor (Secretary). The chief official of the Department, or the Secretary's designee.

State Workforce Agency (SWA). State government agency that receives funds pursuant to the Wagner-Peyser Act, 29 U.S.C. 49 et seq., to administer the State's public labor exchange activities.

Strike. A concerted stoppage of work by employees as a result of a labor dispute, or any concerted slowdown or other concerted interruption of operation (including stoppage by reason of the expiration of a collective bargaining agreement).

Successor in interest. (i) Where an employer, agent, or attorney has violated 8 U.S.C. 1188, 29 CFR part 501, or this subpart, and has ceased doing business or cannot be located for purposes of enforcement, a successor in interest to that employer, agent, or attorney may be held liable for the duties and obligations of the violating employer, agent, or attorney in certain circumstances. The following factors, as used under Title VII of the Civil Rights Act and the Vietnam Era Veterans' Readjustment Assistance Act, may be considered in determining whether an employer, agent, or attorney is a successor in interest; no one factor is dispositive, but all of the circumstances will be considered as a whole:

(A) Substantial continuity of the same business operations;

(B) Use of the same facilities;

(C) Continuity of the work force;

(D) Similarity of jobs and working conditions;

(E) Similarity of supervisory personnel;

(F) Whether the former management or owner retains a direct or indirect interest in the new enterprise;

(G) Similarity in machinery, equipment, and production methods;

(H) Similarity of products and services; and

(I) The ability of the predecessor to provide relief.

(ii) For purposes of debarment only, the primary consideration will be the personal involvement of the firm's ownership, management, supervisors, and others associated with the firm in the violation(s) at issue.

Temporary agricultural labor certification. Certification made by the OFLC Administrator, based on the *Application for Temporary Employment Certification*, job order, and all supporting documentation, with respect to an employer seeking to file an H–2A Petition with DHS to employ one or more foreign nationals as an H–2A worker, pursuant to 8 U.S.C. 1101(a)(15)(H)(ii)(a), 1184(a) and (c), and 1188, and this subpart.

United States. The continental United States, Alaska, Hawaii, the Commonwealth of Puerto Rico, and the territories of Guam, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

U.S. Citizenship and Immigration Services (USCIS). An operational component of DHS.

U.S. worker. A worker who is:

(i) A citizen or national of the United States;

(ii) An individual who is lawfully admitted for permanent residence in the United States, is admitted as a refugee under 8 U.S.C. 1157, is granted asylum under 8 U.S.C. 1158, or is an immigrant otherwise authorized by the INA or DHS to be employed in the United States; or

(iii) An individual who is not an unauthorized alien, as defined in 8 U.S.C. 1324a(h)(3), with respect to the employment in which the worker is engaging.

Wage and Hour Division (WHD). The agency within the Department with authority to conduct certain investigatory and enforcement functions, as delegated by the Secretary, under 8 U.S.C. 1188, 29 CFR part 501, and this subpart.

Wages. All forms of cash remuneration to a worker by an employer in payment for labor or services.

WHD Administrator. The primary official of WHD, or the WHD Administrator's designee.

Work contract. All the material terms and conditions of employment relating to wages, hours, working conditions, and other benefits, including those required by 8 U.S.C. 1188, 29 CFR part 501, or this subpart. The contract between the employer and the worker may be in the form of a separate written document. In the absence of a separate

written work contract incorporating the required terms and conditions of employment, agreed to by both the employer and the worker, the work contract at a minimum will be the terms and conditions of the job order and any obligations required under 8 U.S.C. 1188, 29 CFR part 501, or this subpart.

(c) *Definition of agricultural labor or services.* For the purposes of this subpart, agricultural labor or services, pursuant to 8 U.S.C. 1011(a)(15)(H)(ii)(a), is defined as: agricultural labor as defined and applied in sec. 3121(g) of the Internal Revenue Code of 1986 at 26 U.S.C. 3121(g); agriculture as defined and applied in sec. 3(f) of the Fair Labor Standards Act of 1938, as amended (FLSA), at 29 U.S.C. 203(f); the pressing of apples for cider on a farm; or logging employment. An occupation included in either statutory definition is agricultural labor or services, notwithstanding the exclusion of that occupation from the other statutory definition. For informational purposes, the statutory provisions are listed in paragraphs (c)(1) through (3) of this section.

(1) *Agricultural labor.* (i) For the purpose of paragraph (c) of this section, agricultural labor means all service performed:

(A) On a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife;

(B) In the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm;

(C) In connection with the production or harvesting of any commodity defined as an agricultural commodity in sec. 15(g) of the Agricultural Marketing Act, as amended, 12 U.S.C. 1141j, or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes;

(D) In the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed;

(E) In the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in paragraph (c)(1)(i)(D) of this section but only if such operators produced all of the commodity with respect to which such service is performed. For purposes of this paragraph (c)(1)(i)(E), any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than 20 at any time during the calendar year in which such service is performed;

(F) The provisions of paragraphs (c)(1)(i)(D) and (E) of this section shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption; or

(G) On a farm operated for profit if such service is not in the course of the employer's trade or business or is domestic service in a private home of the employer.

(ii) As used in this section, the term ''farm'' includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses, or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards.

(2) *Agriculture.* For purposes of paragraph (c) of this section, agriculture means farming in all its branches and

among other things includes the cultivation and tillage of the soil, dairying, the production, cultivation, growing, and harvesting of any agricultural or horticultural commodities (including commodities defined as agricultural commodities in 12 U.S.C. 1141j(g), the raising of livestock, bees, fur-bearing animals, or poultry, and any practices (including any forestry or lumbering operations) performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market. *See* 29 U.S.C. 203(f), as amended. Under 12 U.S.C. 1141j(g), agricultural commodities include, in addition to other agricultural commodities, crude gum (oleoresin) from a living tree, and the following products as processed by the original producer of the crude gum (oleoresin) from which derived: gum spirits of turpentine and gum rosin. In addition, as defined in 7 U.S.C. 92, gum spirits of turpentine means spirits of turpentine made from gum (oleoresin) from a living tree and gum rosin means rosin remaining after the distillation of gum spirits of turpentine.

(3) *Apple pressing for cider*. The pressing of apples for cider on a farm, as the term farm is defined and applied in sec. 3121(g) of the Internal Revenue Code at 26 U.S.C. 3121(g), or as applied in sec. 3(f) of the FLSA at 29 U.S.C. 203(f), pursuant to 29 CFR part 780.

(4) *Logging employment*. Logging employment is operations associated with felling and moving trees and logs from the stump to the point of delivery, such as, but not limited to, marking danger trees, marking trees or logs to be cut to length, felling, limbing, bucking, debarking, chipping, yarding, loading, unloading, storing, and transporting machines, equipment and personnel to, from, and between logging sites.

(5) *Employment as defined and specified in §§ 655.300 through 655.304*. For the purpose of paragraph (c) of this section, agricultural labor or services includes animal shearing, commercial beekeeping, and custom combining activities as defined and specified in §§ 655.300 through 655.304.

(d) *Definition of a temporary or seasonal nature*. For the purposes of this subpart, employment is of a seasonal nature where it is tied to a certain time of year by an event or pattern, such as a short annual growing cycle or a specific aspect of a longer cycle, and requires labor levels far above those necessary for ongoing operations. Employment is of a temporary nature where the employer's need to fill the position with a temporary worker will, except in extraordinary circumstances, last no longer than 1 year.

(e) *Definition of single employer for purposes of temporary or seasonal need and contractual obligations*. Separate entities will be deemed a single employer (sometimes referred to as an ''integrated employer'') for purposes of assessing temporary or seasonal need and for enforcement of contractual obligations if they meet the definition of single employer in this paragraph (e). Under the definition of single employer, a determination of whether separate entities are a single employer is not determined by a single factor, but rather the entire relationship is viewed in its totality. Factors considered in determining whether two or more entities consist of a single employer include:

(1) Common management;

(2) Interrelation between operations;

(3) Centralized control of labor relations; and

(4) Degree of common ownership/financial control.

[87 FR 61791, Oct. 12, 2022, as amended at 88 FR 12801, Feb. 28, 2023; 89 FR 34059, Apr. 29, 2024]

§ 655.104 Successors in interest.

(a) *Liability of successors in interest*. Where an employer, agent, or attorney has violated 8 U.S.C. 1188, 29 CFR part 501, or this subpart, a successor in interest to that employer, agent, or attorney may be held liable for the duties and obligations of the violating employer, agent, or attorney in certain circumstances, regardless of whether such successor in interest has succeeded to all the rights and liabilities of the predecessor employer, agent, or attorney.

(b) *Definition of successors in interest*. The following factors, including those

as used under Title VII of the Civil Rights Act and the Vietnam Era Veterans' Readjustment Assistance Act, may be considered in determining whether an employer, agent, or attorney is a successor in interest; however, these factors are not exhaustive, and no one factor is dispositive, but all of the circumstances will be considered as a whole:

(1) Substantial continuity of the same business operations;

(2) Use of the same facilities;

(3) Continuity of the work force;

(4) Similarity of jobs and working conditions;

(5) Similarity of supervisory personnel;

(6) Whether the former management or owner retains a direct or indirect interest in the new enterprise;

(7) Similarity in machinery, equipment, and production methods;

(8) Similarity of products and services;

(9) The ability of the predecessor to provide relief; and

(10) For purposes of debarment, the personal involvement of the firm's ownership, management, supervisors, and others associated with the firm in the violation(s) at issue.

(c) *Effect of debarment on successors in interest.* When an employer, agent, or attorney is debarred under § 655.182 or 29 CFR 501.20, any successor in interest to the debarred employer, agent, or attorney is also debarred. No application for H–2A workers may be filed by or on behalf of a successor in interest to a debarred employer, agent, or attorney, subject to the term limits set forth in § 655.182(c)(2). If the CO determines that an application for H–2A workers was filed by or on behalf of a successor in interest to a debarred employer, agent, or attorney during the period of debarment as set forth in § 655.182(c)(2), the CO will issue a Notice of Deficiency (NOD) pursuant to § 655.141 or deny the application pursuant to § 655.164, as appropriate depending upon the status of the H–2A application, solely on the basis that the entity is a successor in interest to a debarred employer, agent, or attorney. If the OFLC Administrator determines that a certification for H–2A workers was issued to a successor in interest to a debarred employer, the OFLC Administrator may revoke the certification pursuant to § 655.181(a). The employer, agent, or attorney may appeal its status as a successor in interest to the debarred entity, pursuant to the procedures for appeals of CO determinations at § 655.171.

[89 FR 34060, Apr. 29, 2024]

PRE-FILING PROCEDURES

§ 655.120 Offered wage rate.

(a) *Employer obligation.* (1) Except for occupations covered by §§ 655.200 through 655.235, to comply with its obligation under § 655.122(l), an employer must offer, advertise in its recruitment, and pay a wage that is at least the highest of:

(i) The AEWR;

(ii) A prevailing wage rate, whether expressed as a piece rate or other unit of pay, if the OFLC Administrator has approved a prevailing wage survey for the applicable crop activity or agricultural activity and, if applicable, a distinct work task or tasks performed in that activity, meeting the requirements of paragraph (c) of this section;

(iii) The agreed-upon collective bargaining wage;

(iv) The Federal minimum wage;

(v) The State minimum wage; or

(vi) Any other wage rate the employer intends to pay.

(2) Where the wage rates set forth in paragraph (a)(1) of this section are expressed in different units of pay (including piece rates or other pay structures), the employer must list the highest applicable wage rate for each unit of pay in its job order and must offer and advertise all of these wage rates in its recruitment. The employer's obligation to pay the highest of these wage rates is set forth at § 655.122(l)(2).

(b) *AEWR determinations.* (1) Except for occupations governed by the procedures in §§ 655.200 through 655.235, the OFLC Administrator will determine the AEWRs as follows:

(i) For occupations included in the Department of Agriculture's (USDA) Farm Labor Survey (FLS) field and livestock workers (combined) category:

(A) If an annual average hourly gross wage in the State or region is reported

by the FLS, that wage shall be the AEWR for the State; or

(B) If an annual average hourly gross wage in the State or region is not reported by the FLS, the AEWR for the occupations shall be the statewide annual average hourly gross wage in the State as reported by the Occupational Employment and Wage Statistics (OEWS) survey; or

(C) If a statewide annual average hourly gross wage in the State is not reported by the OEWS survey, the AEWR for the occupations shall be the national annual average hourly gross wage as reported by the OEWS survey.

(ii) For all other occupations:

(A) The AEWR for each occupation shall be the statewide annual average hourly gross wage for that occupation in the State as reported by the OEWS survey; or

(B) If a statewide annual average hourly gross wage in the State is not reported by the OEWS survey, the AEWR for each occupation shall be the national annual average hourly gross wage for that occupation as reported by the OEWS survey.

(iii) The AEWR methodologies described in paragraphs (b)(1)(i) and (ii) of this section shall apply to all job orders submitted, as set forth in § 655.121, on or after March 30, 2023, including job orders filed concurrently with an *Application for Temporary Employment Certification* to the NPC for emergency situations under § 655.134. For purposes of paragraphs (b)(1)(i) and (ii) of this section, the term *State* and *statewide* include the 50 States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.

(2) The OFLC Administrator will publish a notice in the FEDERAL REGISTER, at least once in each calendar year, on a date to be determined by the OFLC Administrator, establishing each AEWR. The updated AEWR will be effective as of the date of publication of the notice in the FEDERAL REGISTER.

(3) If an updated AEWR for the occupational classification and geographic area is published in the FEDERAL REGISTER during the work contract, and the updated AEWR is higher than the highest of the previous AEWR; a prevailing wage for the crop activity or agricultural activity and, if applicable, a distinct work task or tasks performed in that activity and geographic area; the agreed-upon collective bargaining wage; the Federal minimum wage; or the State minimum wage, the employer must pay at least the updated AEWR beginning on the date the updated AEWR is published in the FEDERAL REGISTER.

(4) If an updated AEWR for the occupational classification and geographic area is published in the FEDERAL REGISTER during the work contract, and the updated AEWR is lower than the rate guaranteed on the job order, the employer must continue to pay at least the rate guaranteed on the job order.

(5) If the job duties on the job order cannot be encompassed within a single occupational classification, the applicable AEWR shall be the highest AEWR for all applicable occupations.

(c) *Prevailing wage determinations.*

(1) The OFLC Administrator will issue a prevailing wage for a crop activity or agricultural activity and, if applicable, a distinct work task or tasks performed in that activity if all of the following requirements are met:

(i) The SWA submits to the Department a wage survey for the crop activity or agricultural activity and, if applicable, a distinct work task or tasks performed in that activity and a Form ETA–232 providing the methodology of the survey;

(ii) The survey was independently conducted by the State, including any State agency, State college, or State university;

(iii) The survey covers work performed in a single crop activity or agricultural activity and, if applicable, a distinct work task or tasks performed in that activity;

(iv) The surveyor either made a reasonable, good faith attempt to contact all employers employing workers in the crop activity or agricultural activity and distinct work task(s), if applicable, and geographic area surveyed or contacted a randomized sample of such employers, except where the estimated universe of employers is less than five. Where the estimated universe of employers is less than five, the surveyor contacted all employers in the estimated universe;

(v) The survey reports the average wage of U.S. workers in the crop activity or agricultural activity and distinct work task(s), if applicable, and geographic area using the unit of pay used to compensate the largest number of U.S. workers whose wages are reported in the survey;

(vi) The survey covers an appropriate geographic area based on available resources to conduct the survey, the size of the agricultural population covered by the survey, and any different wage structures in the crop activity or agricultural activity within the State;

(vii) Where the estimated universe of U.S. workers is at least 30, the survey includes the wages of at least 30 U.S. workers in the unit of pay used to compensate the largest number of U.S. workers whose wages are reported in the survey. Where the estimated universe of U.S. workers is less than 30, the survey includes the wages of all such U.S. workers;

(viii) Where the estimated universe of employers is at least five, the survey includes wages of U.S. workers employed by at least five employers in the unit of pay used to compensate the largest number of U.S. workers whose wages are reported in the survey. Where the estimated universe of employers is less than five, the survey includes wages of U.S. workers employed by all such employers; and

(ix) Where the estimated universe of employers is at least 4, the wages paid by a single employer represent no more than 25 percent of the sampled wages in the unit of pay used to compensate the largest number of U.S. workers whose wages are reported in the survey. This paragraph (c)(1)(ix) does not apply where the estimated universe of employers is less than four.

(2) A prevailing wage issued by the OFLC Administrator will remain valid for 1 year after the wage is posted on the OFLC website or until replaced with an adjusted prevailing wage, whichever comes first, except that if a prevailing wage that was guaranteed on the job order expires during the work contract, the employer must continue to guarantee at least the expired prevailing wage rate.

(3) If a prevailing wage for the geographic area and crop activity or agricultural activity and distinct work task(s), if applicable, is adjusted during a work contract, and is higher than the highest of the AEWR, a previous prevailing wage for the geographic area and crop activity or agricultural activity or, if applicable, a distinct work task or tasks performed in that activity, the agreed-upon collective bargaining wage, the Federal minimum wage, or the State minimum wage, the employer must pay at least that higher prevailing wage upon the Department's notice to the employer of the new prevailing wage.

(4) If a prevailing wage for the geographic area and crop activity or agricultural activity and distinct work task(s), if applicable, is adjusted during a work contract, and is lower than the rate guaranteed on the job order, the employer must continue to pay at least the rate guaranteed on the job order.

(d) *Appeals.* (1) If the employer does not include the appropriate offered wage rate on the *Application for Temporary Employment Certification,* the CO will issue a Notice of Deficiency (NOD) requiring the employer to correct the wage rate.

(2) If the employer disagrees with the wage rate required by the CO, the employer may appeal only after the *Application for Temporary Employment Certification* is denied, and the employer must follow the procedures in § 655.171.

[87 FR 61791, Oct. 12, 2022, as amended at 88 FR 12801, Feb. 28, 2023; 89 FR 34060, Apr. 29, 2024]

§ 655.121 Job order filing requirements.

(a) *What to file.* (1) Prior to filing an *Application for Temporary Employment Certification,* the employer must submit a completed job order, Form ETA–790/790A, including all required addenda, to the NPC designated by the OFLC Administrator, and must identify it as a job order to be placed in connection with a future *Application for Temporary Employment Certification* for H–2A workers. The employer must include in its submission to the NPC a valid Federal Employer Identification Number (FEIN) as well as a valid place of business (physical location) in the United States and a means by which it may be contacted for employment.

(2) Where the job order is being placed in connection with a future master application to be filed by an agricultural association as a joint employer with its employer-members, the agricultural association may submit a single job order to be placed in the name of the agricultural association on behalf of all employers named on the job order and the future *Application for Temporary Employment Certification*.

(3) Where the job order is being placed in connection with a future application to be jointly filed by two or more employers seeking to jointly employ a worker(s) (but is not a master application), any one of the employers may submit a single job order to be placed on behalf of all joint employers named on the job order and the future *Application for Temporary Employment Certification*.

(4) The job order must satisfy the requirements for agricultural clearance orders set forth in 20 CFR part 653, subpart F, and the requirements set forth in § 655.122.

(b) *Timeliness*. The employer must submit a completed job order to the NPC no more than 75 calendar days and no fewer than 60 calendar days before the employer's first date of need.

(c) *Location and method of filing*. The employer must submit a completed job order to the NPC using the electronic method(s) designated by the OFLC Administrator. The NPC will return without review any job order submitted using a method other than the designated electronic method(s), unless the employer submits the job order by mail as set forth in § 655.130(c)(2) or requests a reasonable accommodation as set forth in § 655.130(c)(3).

(d) *Original signature*. The job order must contain an electronic (scanned) copy of the original signature of the employer or a verifiable electronic signature method, as directed by the OFLC Administrator. If submitted by mail, the *Application for Temporary Employment Certification* must bear the original signature of the employer and, if applicable, the employer's authorized agent or attorney.

(e) *SWA review*. (1) Upon receipt of the job order, the NPC will transmit an electronic copy of the job order to the SWA serving the area of intended employment for intrastate clearance. If the job opportunity is located in more than one State within the same area of intended employment, the NPC will transmit the job order to any one of the SWAs having jurisdiction over the place(s) of employment.

(2) The SWA will review the contents of the job order for compliance with the requirements set forth in 20 CFR part 653, subpart F, and this subpart, and will work with the employer to address any noted deficiencies. The SWA must notify the employer in writing of any deficiencies in its job order not later than 7 calendar days from the date the SWA received the job order. The SWA notification will state the reason(s) the job order fails to meet the applicable requirements, state the modification(s) needed for the SWA to accept the job order, and offer the employer an opportunity to respond to the deficiencies within 5 calendar days from the date the notification was issued by the SWA. Upon receipt of a response, the SWA will review the response and notify the employer in writing of its acceptance or denial of the job order within 3 calendar days from the date the response was received by the SWA. If the employer's response is not received within 12 calendar days after the notification was issued, the SWA will notify the employer in writing that the job order is deemed abandoned, and the employer will be required to submit a new job order to the NPC meeting the requirements of this section. Any notice sent by the SWA to an employer that requires a response must be sent using methods to assure next day delivery, including email or other electronic methods, with a copy to the employer's representative, as applicable.

(3) If, after providing responses to the deficiencies noted by the SWA, the employer is not able to resolve the deficiencies with the SWA, the employer may file an *Application for Temporary Employment Certification* pursuant to the emergency filing procedures contained in § 655.134, with a statement describing the nature of the dispute and demonstrating compliance with its requirements under this section. In the event the SWA does not respond within the stated timelines, the employer may

use the emergency filing procedures noted in the preceding sentence. The CO will process the emergency *Application for Temporary Employment Certification* in a manner consistent with the provisions set forth in §§ 655.140 through 655.145 and make a determination on the *Application for Temporary Employment Certification* in accordance with §§ 655.160 through 655.167.

(f) *Intrastate clearance.* Upon its acceptance of the job order, the SWA must promptly place the job order in intrastate clearance and commence recruitment of U.S. workers. Where the employer's job order references an area of intended employment that falls within the jurisdiction of more than one SWA, the originating SWA will notify the NPC that a copy of the approved job order must be forwarded to the other SWAs serving the area of intended employment. Upon receipt of the SWA notification, the NPC will promptly transmit an electronic copy of the approved job order to the other SWAs serving the area of intended employment.

(g) *Duration of job order posting.* The SWA must keep the job order on its active file until the end of the recruitment period, as set forth in § 655.135(d), and must refer each U.S. worker who applies (or on whose behalf an application is made) for the job opportunity.

(h) *Modifications to the job order.* (1) Prior to the issuance of a final determination on an *Application for Temporary Employment Certification,* the CO may require modifications to the job order when the CO determines that the offer of employment does not contain all the minimum benefits, wages, and working condition provisions. Such modifications must be made, or certification will be denied pursuant to § 655.164.

(2) The employer may request a modification of the job order, Form ETA–790/790A, prior to the submission of an *Application for Temporary Employment Certification.* However, the employer may not reject referrals against the job order based upon a failure on the part of the applicant to meet the amended criteria, if such referral was made prior to the amendment of the job order. The employer may not request a modification of the job order on or after the date of filing an *Application for Temporary Employment Certification.*

(3) The employer must provide all workers recruited in connection with the *Application for Temporary Employment Certification* with a copy of the modified job order or work contract which reflects the amended terms and conditions, on the first day of employment, in accordance with § 655.122(q), or as soon as practicable, whichever comes first.

§ 655.122 Contents of job offers.

(a) *Prohibition against preferential treatment of H–2A workers.* The employer's job offer must offer to U.S. workers no less than the same benefits, wages, and working conditions that the employer is offering, intends to offer, or will provide to H–2A workers. Job offers may not impose on U.S. workers any restrictions or obligations that will not be imposed on the employer's H–2A workers. This does not relieve the employer from providing to H–2A workers at least the same level of minimum benefits, wages, and working conditions that must be offered to U.S. workers consistent with this section.

(b) *Job qualifications and requirements.* Each job qualification and requirement listed in the job offer must be bona fide and consistent with the normal and accepted qualifications required by employers that do not use H–2A workers in the same or comparable occupations and crops. Either the CO or the SWA may require the employer to submit documentation to substantiate the appropriateness of any job qualification specified in the job offer.

(c) *Minimum benefits, wages, and working conditions.* Every job order accompanying an *Application for Temporary Employment Certification* must include each of the minimum benefit, wage, and working condition provisions listed in paragraphs (d) through (q) of this section.

(d) *Housing*—(1) *Obligation to provide housing.* The employer must provide housing at no cost to the H–2A workers and those workers in corresponding employment who are not reasonably able to return to their residence within the same day. Housing must be provided through one of the following means:

(i) *Employer-provided housing.* Employer-provided housing must meet the full set of the DOL Occupational Safety and Health Administration (OSHA) standards set forth at 29 CFR 1910.142, or the full set of standards at §§ 654.404 through 654.417 of this chapter, whichever are applicable under § 654.401 of this chapter. Requests by employers whose housing does not meet the applicable standards for conditional access to the interstate clearance system will be processed under the procedures set forth at § 654.403 of this chapter; or

(ii) *Rental and/or public accommodations.* Rental or public accommodations or other substantially similar class of habitation must meet local standards for such housing. In the absence of applicable local standards addressing those health or safety concerns otherwise addressed by the DOL OSHA standards at 29 CFR 1910.142(b)(2) (minimum square footage); (b)(3) (beds, cots, or bunks, and suitable storage facilities); (b)(9) (minimum square footage in a room where workers cook, live, and sleep); (b)(10) (where the employer chooses to meet its meal obligations under paragraph (g) of this section by furnishing free and convenient cooking and kitchen facilities to the workers, the provision of stoves, sanitary kitchen facilities); (b)(11) (heating, cooking, and water heating equipment installed properly); (c) (water supply); (d)(1) (adequate toilet facilities); (d)(9) (adequate toilet paper); (d)(10) (toilets kept in sanitary condition); (f) (laundry, handwashing, and bathing facilities); (g) (lighting); (h)(2) (garbage containers kept clean); (h)(3) (garbage containers emptied when full, but at least twice a week); and (j) (insect and rodent control), State standards addressing such concerns will apply. In the absence of applicable local or State standards addressing such concerns, the relevant DOL OSHA standards at 29 CFR 1910.142(b)(2), (3), (9), (10), and (11), (c), (d)(1), (9), and (10), (f), (g), (h)(2) and (3), and (j) will apply. Any charges for rental housing must be paid directly by the employer to the owner or operator of the housing.

(2) *Standards for range and mobile housing.* An employer employing workers under §§ 655.200 through 655.235 must comply with the housing requirements in §§ 655.230 and 655.235. An employer employing workers under §§ 655.300 through 655.304 must comply with the housing standards in § 655.304.

(3) *Deposit charges.* Charges in the form of deposits for bedding or other similar incidentals related to housing must not be levied upon workers. However, employers may require workers to reimburse them for damage caused to housing by the individual worker(s) found to have been responsible for damage that is not the result of normal wear and tear related to habitation.

(4) *Charges for public housing.* If public housing provided for migrant agricultural workers under the auspices of a local, county, or State government is secured by the employer, the employer must pay any charges normally required for use of the public housing units directly to the housing's management.

(5) *Family housing.* When it is the prevailing practice in the area of intended employment and the occupation to provide family housing, it must be provided to workers with families who request it.

(6) *Compliance with applicable standards*—(i) *Timeliness.* The determination as to whether housing provided to workers under this section meets the applicable standards must be made not later than 30 calendar days before the first date of need identified in the *Application for Temporary Employment Certification.*

(ii) *Certification of employer-provided housing.* The SWA (or another local, State, or Federal authority acting on behalf of the SWA) with jurisdiction over the location of the employer-provided housing must inspect and provide to the employer and CO documentation certifying that the employer-provided housing is sufficient to accommodate the number of workers requested and meets all applicable standards under paragraph (d)(1)(i) of this section.

(iii) *Certification of rental and/or public accommodations.* The employer must provide to the CO a written statement, signed and dated, that attests that the accommodations are compliant with the applicable standards under paragraph (d)(1)(ii) of this section and are sufficient to accommodate the number of workers requested. This statement

must include the number of bed(s) and room(s) that the employer will secure for the worker(s). If applicable local or State rental or public accommodation standards under paragraph (d)(1)(ii) of this section require an inspection, the employer also must submit to the CO a copy of the inspection report or other official documentation from the relevant authority. If the applicable standards do not require an inspection, the employer's written statement must confirm that no inspection is required.

(iv) *Certified housing that becomes unavailable.* If after a request to certify housing, such housing becomes unavailable for reasons outside the employer's control, the employer may substitute other rental or public accommodation housing that is in compliance with the local, State, or Federal housing standards applicable under this section. The employer must promptly notify the SWA in writing of the change in accommodations and the reason(s) for such change and provide the SWA evidence of compliance with the applicable local, State, or Federal safety and health standards, in accordance with the requirements of this section. If, upon inspection, the SWA determines the substituted housing does not meet the applicable housing standards, the SWA must promptly provide written notification to the employer to cure the deficiencies with a copy to the CO. An employer's failure to provide housing that complies with the applicable standards will result in either a denial of a pending *Application for Temporary Employment Certification* or revocation of the temporary agricultural labor certification granted under this subpart.

(e) *Workers' compensation.* (1) The employer must provide workers' compensation insurance coverage in compliance with State law covering injury and disease arising out of and in the course of the worker's employment. If the type of employment for which the certification is sought is not covered by or is exempt from the State's workers' compensation law, the employer must provide, at no cost to the worker, insurance covering injury and disease arising out of and in the course of the worker's employment that will provide benefits at least equal to those provided under the State workers' compensation law for other comparable employment.

(2) Prior to issuance of the temporary agricultural labor certification, the employer must provide the CO with proof of workers' compensation insurance coverage meeting the requirements of this paragraph (e), including the name of the insurance carrier, the insurance policy number, and proof of insurance for the entire period of employment, or, if appropriate, proof of State law coverage.

(f) *Employer-provided items.* The employer must provide to the worker, without charge or deposit charge, all tools, supplies, and equipment required to perform the duties assigned.

(g) *Meals.* The employer either must provide each worker with three meals a day or must furnish free and convenient cooking and kitchen facilities to the workers that will enable the workers to prepare their own meals. Where the employer provides the meals, the job offer must state the charge, if any, to the worker for such meals. The amount of meal charges is governed by § 655.173. When a charge or deduction for the cost of meals would bring the employee's wage below the minimum wage set by the FLSA at 29 U.S.C. 206, the charge or deduction must meet the requirements of the FLSA at 29 U.S.C. 203(m), including the recordkeeping requirements found at 29 CFR 516.27.

(h) *Transportation; daily subsistence*—(1) *Transportation to place of employment.* If the employer has not previously advanced such transportation and subsistence costs to the worker or otherwise provided such transportation or subsistence directly to the worker by other means and if the worker completes 50 percent of the work contract period, the employer must pay the worker for reasonable costs incurred by the worker for transportation and daily subsistence from the place from which the worker has come to work for the employer, whether in the U.S. or abroad to the place of employment. When it is the prevailing practice of non-H–2A agricultural employers in the occupation in the area to do so, or

when the employer extends such benefits to similarly situated H–2A workers, the employer must advance the required transportation and subsistence costs (or otherwise provide them) to workers in corresponding employment who are traveling to the employer's worksite. The amount of the transportation payment must be no less (and is not required to be more) than the most economical and reasonable common carrier transportation charges for the distances involved. The amount of the daily subsistence payment must be at least as much as the employer would charge the worker for providing the worker with three meals a day during employment (if applicable), but in no event less than the amount permitted under § 655.173(a). Note that the FLSA applies independently of the H–2A requirements and imposes obligations on employers regarding payment of wages.

(2) *Transportation from place of employment.* If the worker completes the work contract period, or if the employee is terminated without cause, and the worker has no immediate subsequent H–2A employment, the employer must provide or pay for the worker's transportation and daily subsistence from the place of employment to the place from which the worker, disregarding intervening employment, departed to work for the employer. If the worker has contracted with a subsequent employer who has not agreed in such work contract to provide or pay for the worker's transportation and daily subsistence expenses from the employer's worksite to such subsequent employer's worksite, the employer must provide or pay for such expenses. If the worker has contracted with a subsequent employer who has agreed in such work contract to provide or pay for the worker's transportation and daily subsistence expenses from the employer's worksite to such subsequent employer's worksite, the subsequent employer must provide or pay for such expenses. The employer is not relieved of its obligation to provide or pay for return transportation and subsistence if an H–2A worker is displaced as a result of the employer's compliance with the 50 percent rule as described in § 655.135(d) with respect to the referrals made after the employer's date of need.

(3) *Transportation between living quarters and place of employment.* The employer must provide transportation between housing provided or secured by the employer and the employer's place of employment at no cost to the worker.

(4) *Employer-provided transportation.* (i) All employer-provided transportation must comply with all applicable local, State, or Federal laws and regulations, and must provide, at a minimum, the same transportation safety standards, driver's licensure, and vehicle insurance required under 29 U.S.C. 1841, 29 CFR 500.104 or 500.105, and 29 CFR 500.120 through 500.128.

(ii) The employer must not operate, or allow any other person to operate, any employer-provided transportation that is required by the U.S. Department of Transportation's Federal Motor Vehicle Safety Standards, including 49 CFR 571.208, to be manufactured with seat belts, unless all passengers and the driver are properly restrained by seat belts meeting standards established by the U.S. Department of Transportation, including 49 CFR 571.209 and 571.210.

(iii) The job offer must include a description of the modes of transportation (*e.g.*, type of vehicle) that will be used for inbound, outbound, daily, and any other transportation.

(iv) If workers' compensation is used to cover transportation in lieu of vehicle insurance, the employer must either ensure that the workers' compensation covers all travel or that vehicle insurance exists to provide coverage for travel not covered by workers' compensation and it must have property damage insurance.

(i) *Three-fourths guarantee*—(1) *Offer to worker.* The employer must guarantee to offer the worker employment for a total number of work hours equal to at least three-fourths of the workdays of the total period beginning with the first workday after the arrival of the worker at the place of employment or the advertised contractual first date of need, whichever is later, and ending on the expiration date specified in the work contract or in its extensions, if any.

(i) For purposes of this paragraph (i)(1), a workday means the number of hours in a workday as stated in the job order and excludes the worker's Sabbath and Federal holidays. The employer must offer a total number of hours to ensure the provision of sufficient work to reach the three-fourths guarantee. The work hours must be offered during the work period specified in the work contract.

(ii) In the event the worker begins working later than the specified beginning date of the contract, the guarantee period begins with the first workday after the arrival of the worker at the place of employment, and continues until the last day during which the work contract and all extensions thereof are in effect.

(iii) Therefore, if, for example, a work contract is for a 10-week period, during which a normal workweek is specified as 6 days a week, 8 hours per day, the worker would have to be guaranteed employment for at least 360 hours (10 weeks × 48 hours/week = 480 hours × 75 percent = 360). If a Federal holiday occurred during the 10-week span, the 8 hours would be deducted from the total hours for the work contract, before the guarantee is calculated. Continuing with the above example, the worker would have to be guaranteed employment for 354 hours (10 weeks × 48 hours/week = (480 hours − 8 hours (Federal holiday)) × 75 percent = 354 hours).

(iv) A worker may be offered more than the specified hours of work on a single workday. For purposes of meeting the guarantee, however, the worker will not be required to work for more than the number of hours specified in the job order for a workday, or on the worker's Sabbath or Federal holidays. However, all hours of work actually performed may be counted by the employer in calculating whether the period of guaranteed employment has been met. If during the total work contract period the employer affords the U.S. or H–2A worker less employment than that required under this paragraph (i)(1), the employer must pay such worker the amount the worker would have earned had the worker, in fact, worked for the guaranteed number of days. An employer will not be considered to have met the work guarantee if the employer has merely offered work on three-fourths of the workdays if each workday did not consist of a full number of hours of work time as specified in the job order.

(2) *Guarantee for piece rate paid worker.* If the worker is paid on a piece rate basis, the employer must use the worker's average hourly piece rate earnings or the required hourly wage rate, whichever is higher, to calculate the amount due under the guarantee.

(3) *Failure to work.* Any hours the worker fails to work, up to a maximum of the number of hours specified in the job order for a workday, when the worker has been offered an opportunity to work in accordance with paragraph (i)(1) of this section, and all hours of work actually performed (including voluntary work over 8 hours in a workday or on the worker's Sabbath or Federal holidays), may be counted by the employer in calculating whether the period of guaranteed employment has been met. An employer seeking to calculate whether the number of hours has been met must maintain the payroll records in accordance with this subpart.

(4) *Displaced H–2A worker.* The employer is not liable for payment of the three-fourths guarantee to an H–2A worker whom the CO certifies is displaced because of the employer's compliance with its obligation to hire U.S. workers who apply or are referred after the employer's date of need described in § 655.135(d) with respect to referrals made during that period.

(5) *Obligation to provide housing and meals.* Notwithstanding the three-fourths guarantee contained in this section, employers are obligated to provide housing and meals in accordance with paragraphs (d) and (g) of this section for each day of the contract period up until the day the workers depart for other H–2A employment, depart to the place outside of the United States from which the worker came, or, if the worker voluntarily abandons employment or is terminated for cause, the day of such abandonment or termination.

(j) *Earnings records.* (1) An employer must keep accurate and adequate records with respect to each worker's

earnings, including, but not limited to, field tally records, supporting summary payroll records, and records showing the nature and amount of the work performed; the number of hours of work offered each day by the employer (broken out by hours offered both in accordance with and over and above the three-fourths guarantee at paragraph (i)(3) of this section); the hours actually worked each day by the worker; the time the worker began and ended each workday; the rate of pay (both piece rate and hourly, if applicable); the worker's earnings per pay period; the worker's permanent address and, when available, the worker's permanent email address and phone number(s); and the amount of and reasons for any and all deductions taken from the worker's wages. In the case of H–2A workers, the permanent address must be the worker's permanent address in the worker's home country.

(2) Each employer must keep the records required by paragraph (j) of this section, including field tally records and supporting summary payroll records, safe and accessible at the place or places of employment, or at one or more established central recordkeeping offices where such records are customarily maintained. All records must be available for inspection and transcription by the Secretary or a duly authorized and designated representative, and by the worker and representatives designated by the worker as evidenced by appropriate documentation (an Entry of Appearance as Attorney or Representative, Form G–28, signed by the worker, or an affidavit signed by the worker confirming such representation). Where the records are maintained at a central recordkeeping office, other than in the place or places of employment, such records must be made available for inspection and copying within 72 hours following notice from the Secretary, or a duly authorized and designated representative, and by the worker and designated representatives as described in this paragraph (j)(2).

(3) To assist in determining whether the three-fourths guarantee in paragraph (i) of this section has been met, if the number of hours worked by the worker on a day during the work contract period is less than the number of hours offered, as specified in the job offer, the records must state the reason or reasons therefore.

(4) The employer must retain the records for not less than 3 years after the date of the certification.

(k) *Hours and earnings statements.* The employer must furnish to the worker on or before each payday in one or more written statements the following information:

(1) The worker's total earnings for the pay period;

(2) The worker's hourly rate and/or piece rate of pay;

(3) The hours of employment offered to the worker (showing offers in accordance with the three-fourths guarantee as determined in paragraph (i) of this section, separate from any hours offered over and above the guarantee);

(4) The hours actually worked by the worker;

(5) An itemization of all deductions made from the worker's wages;

(6) If piece rates are used, the units produced daily;

(7) Beginning and ending dates of the pay period; and

(8) The employer's name, address, and FEIN.

(l) *Rates of pay.* Except for occupations covered by §§ 655.200 through 655.235, the employer must pay the worker at least the highest wage rate set forth in § 655.120(a)(1).

(1) The employer must calculate workers' wages using the wage rate that will result in the highest wages for each worker in each pay period. When calculating wages based on an hourly wage rate, the calculation must reflect every hour or portion thereof worked during a pay period. The wages actually paid cannot be lower than the wages that would result from the wage rate(s) guaranteed in the job order.

(2) Where the wage rates set forth in § 655.120(a)(1) include both hourly and non-hourly wage rates, the employer must calculate each worker's wages, in each pay period, using the highest wage rate for each unit of pay, and pay the worker the highest of these wages for that pay period. The wage actually paid cannot be lower than the wages that would result from the wage rate(s) guaranteed in the job offer.

(3) If the employer requires one or more minimum productivity standards of workers as a condition of job retention, such standards must be specified in the job offer and be no more than those required by the employer in 1977, unless the OFLC Administrator approves a higher minimum, or, if the employer first applied for temporary agricultural labor certification after 1977, such standards must be no more than those normally required (at the time of the first *Application for Temporary Employment Certification*) by other employers for the activity in the area of intended employment.

(4) If applicable, the employer must state in the job order:

(i) That overtime hours may be available;

(ii) The wage rate(s) to be paid for any such overtime hours;

(iii) The circumstances under which the wage rate(s) for overtime hours will be paid, including, but not limited to, after how many hours in a day or workweek the overtime wage rate will be paid, and whether overtime wage rates will vary between places of employment; and

(iv) Where the overtime pay is required by law, the applicable Federal, State, or local law requiring the overtime pay.

(m) *Frequency of pay*. The employer must state in the job offer the frequency with which the worker will be paid, which must be at least twice monthly or according to the prevailing practice in the area of intended employment, whichever is more frequent. Employers must pay wages when due.

(n) *Termination for cause or abandonment of employment*. (1) If a worker is terminated for cause or voluntarily abandons employment before the end of the contract period, and the employer notifies the NPC, and DHS in the case of an H–2A worker, in writing or by any other method specified by the Department in a notice published in the FEDERAL REGISTER or specified by DHS not later than 2 working days after such termination for cause or abandonment occurs, the employer will not be responsible for providing or paying for the subsequent transportation and subsistence expenses of that worker under this section, and that worker is not entitled to the three-fourths guarantee described in paragraph (i) of this section, and, in the case of a U.S. worker, the employer will not be obligated to contact that worker under § 655.153.

(2) A worker is terminated for cause when the employer terminates the worker for failure to comply with employer policies or rules or to satisfactorily perform job duties in accordance with reasonable expectations based on criteria listed in the job offer.

(i) An employer may terminate a worker for cause only if all of the following conditions are satisfied:

(A) The employee has been informed (in a language understood by the worker), or reasonably should have known, of the policy, rule, or performance expectation;

(B) Compliance with the policy, rule, or performance expectation is within the worker's control;

(C) The policy, rule, or performance expectation is reasonable and applied consistently to the employer's H–2A workers and workers in corresponding employment;

(D) The employer undertakes a fair and objective investigation into the job performance or misconduct; and

(E) The employer corrects the worker's performance or behavior using progressive discipline, which is a system of graduated and reasonable responses to an employee's failure to satisfactorily perform job duties or comply with employer policies or rules. Disciplinary measures should be proportional to the misconduct or failure to meet performance expectations but may increase in severity if misconduct or failure to meet performance expectations is repeated, and may include immediate termination for egregious misconduct, meaning intentional or reckless conduct that is plainly illegal, poses imminent danger to physical safety, or that a reasonable person would understand as being outrageous. Prior to each disciplinary measure, the employer must notify the worker of the infraction and allow the worker to present evidence in their defense. Following each disciplinary measure, except where the appropriate disciplinary measure is termination, the employer

must provide relevant and adequate instruction to the worker, and must afford the worker reasonable time to correct the behavior or to meet the performance expectation following such instruction. The employer must document each infraction and corresponding disciplinary measure, evidence the worker presented in their defense, and resulting instruction, and provide a copy of this documentation to the worker (in a language understood by the worker) within 1 week of the implementation of the disciplinary measure.

(ii) A worker is not terminated for cause where the termination is: contrary to a Federal, State, or local law; for an employee's refusal to work under conditions that the employee reasonably believes will expose them or other employees to an unreasonable health or safety risk; because of discrimination on the basis of race, color, national origin, age, sex (including sexual orientation or gender identity), religion, disability, familial status or citizenship status; or, where applicable, where the employer failed to comply with its obligations under § 655.135(m) in an investigatory interview that contributed to the termination.

(iii) The employer bears the burden of demonstrating that any termination for cause meets the requirements in paragraph (n)(2).

(3) Abandonment will be deemed to begin after a worker fails to report to work at the regularly scheduled time for 5 consecutive working days without the consent of the employer.

(4) The employer is required to maintain records described in this section for not less than 3 years from the date of the certification.

(i) Records of notification to the NPC, and to DHS in the case of an H–2A worker, of termination for cause or abandonment.

(ii) Disciplinary records, including the infraction and each step of progressive discipline, any evidence the worker presented in their defense, any investigation related to the termination, and any subsequent instruction afforded the worker.

(iii) Records indicating the reason(s) for termination of any worker, including disciplinary records as described in paragraph (n)(4)(ii) of this section and § 655.167.

(o) *Contract impossibility*. If, before the expiration date specified in the work contract, the services of the worker are no longer required for reasons beyond the control of the employer due to fire, weather, or other Act of God that makes the fulfillment of the contract impossible, the employer may terminate the work contract. Whether such an event constitutes a contract impossibility will be determined by the CO. In the event of such termination of a contract, the employer must fulfill a three-fourths guarantee for the time that has elapsed from the start of the work contract to the time of its termination, as described in paragraph (i)(1) of this section. The employer must make efforts to transfer the worker to other comparable employment acceptable to the worker, consistent with existing immigration law, as applicable. If such transfer is not affected, the employer must:

(1) Return the worker, at the employer's expense, to the place from which the worker (disregarding intervening employment) came to work for the employer, or transport the worker to the worker's next certified H–2A employer, whichever the worker prefers;

(2) Reimburse the worker the full amount of any deductions made from the worker's pay by the employer for transportation and subsistence expenses to the place of employment; and

(3) Pay the worker for any costs incurred by the worker for transportation and daily subsistence to that employer's place of employment. Daily subsistence must be computed as set forth in paragraph (h) of this section. The amount of the transportation payment must not be less (and is not required to be more) than the most economical and reasonable common carrier transportation charges for the distances involved.

(p) *Deductions*. (1) The employer must make all deductions from the worker's paycheck required by law. The job offer must specify all deductions not required by law which the employer will make from the worker's paycheck. All deductions must be reasonable. The employer may deduct the cost of the

worker's transportation and daily subsistence expenses to the place of employment which were borne directly by the employer. In such circumstances, the job offer must state that the worker will be reimbursed the full amount of such deduction upon the worker's completion of 50 percent of the work contract period. However, an employer subject to the FLSA may not make deductions that would violate the FLSA.

(2) A deduction is not reasonable if it includes a profit to the employer or to any affiliated person. A deduction that is primarily for the benefit or convenience of the employer will not be recognized as reasonable and therefore the cost of such an item may not be included in computing wages. The wage requirements of §655.120 will not be met where undisclosed or unauthorized deductions, rebates, or refunds reduce the wage payment made to the employee below the minimum amounts required under this subpart, or where the employee fails to receive such amounts free and clear because the employee kicks back directly or indirectly to the employer or to another person for the employer's benefit the whole or part of the wage delivered to the employee. The principles applied in determining whether deductions are reasonable and payments are received free and clear, and the permissibility of deductions for payments to third persons are explained in more detail in 29 CFR part 531.

(q) *Disclosure of work contract.* The employer must provide to an H–2A worker not later than the time at which the worker applies for the visa, or to a worker in corresponding employment not later than on the day work commences, a copy of the work contract between the employer and the worker in a language understood by the worker as necessary or reasonable. For an H–2A worker going from an H–2A employer to a subsequent H–2A employer, the copy must be provided not later than the time an offer of employment is made by the subsequent H–2A employer. For an H–2A worker that does not require a visa for entry, the copy must be provided not later than the time of an offer of employment. At a minimum, the work contract must contain all of the provisions required by this section. In the absence of a separate, written work contract entered into between the employer and the worker, the work contract at a minimum will be the terms of the job order and any obligations required under 8 U.S.C. 1188, 29 CFR part 501, or this subpart.

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34060, Apr. 29, 2024]

§ 655.123 [Reserved]

§ 655.124 Withdrawal of a job order.

(a) The employer may withdraw a job order if the employer no longer plans to file an *Application for Temporary Employment Certification*. However, the employer is still obligated to comply with the terms and conditions of employment contained in the job order with respect to all workers recruited in connection with that job order.

(b) To request withdrawal, the employer must submit a request in writing to the NPC identifying the job order and stating the reason(s) for the withdrawal.

APPLICATION FOR TEMPORARY EMPLOYMENT CERTIFICATION FILING PROCEDURES

§ 655.130 Application filing requirements.

All employers who desire to hire H–2A foreign agricultural workers must apply for a certification from the Secretary by filing an *Application for Temporary Employment Certification* with the NPC designated by the OFLC Administrator. This section provides the procedures employers must follow when filing.

(a) *What to file.* (1) An employer that desires to apply for temporary agricultural labor certification of one or more nonimmigrant workers must file a completed *Application for Temporary Employment Certification*, all supporting documentation and information required at the time of filing under §§655.131 through 655.137, and, unless a specific exemption applies, a copy of Form ETA–790/790A, submitted as set forth in §655.121(a).

(2) The *Application for Temporary Employment Certification* must include the employer's legal name, trade name(s),

and a valid FEIN as well as a valid place of business (physical location) in the United States and a means by which it may be contacted by prospective U.S. applicants for employment. For each employer of any H–2A worker sponsored under the *Application for Temporary Employment Certification* or any worker in corresponding employment, the *Application for Temporary Employment Certification* must include the identity, location, and contact information of all persons who are the owners of that entity.

(3) For each place of employment identified in the job order, the *Application for Temporary Employment Certification* must include the identity, location, and contact information of all persons and entities, if different than the employer(s), who are the operators of the place of employment, and of all persons who manage or supervise any H–2A worker sponsored under the *Application for Temporary Employment Certification* or any worker in corresponding employment, regardless of whether those managers or supervisors are employed by the employer or another entity.

(4) If the information specified in paragraphs (a)(2) and (3) of this section changes during the work contract period, the employer must update its records to reflect the change. The employer must continue to keep this information up to date until the end of the work contract period, including any extensions. The employer must retain the updated information in accordance with § 655.167(c)(9) and must make this updated information available in the event of a post-certification audit or upon request by the Department. The Department may share the information it receives from employers with any other Federal agency, as appropriate for investigative or enforcement purpose, as set forth in paragraph (f) of this section.

(b) *Timeliness.* A completed *Application for Temporary Employment Certification* must be filed no less than 45 calendar days before the employer's first date of need.

(c) *Location and method of filing*—(1) *Electronic filing.* The employer must file the *Application for Temporary Employment Certification* and all required supporting documentation with the NPC using the electronic method(s) designated by the OFLC Administrator. The NPC will return without review any application submitted using a method other than the designated electronic method(s), unless the employer submits the application in accordance with paragraph (c)(2) or (3) of this section.

(2) *Filing by mail.* Employers that lack adequate access to electronic filing may file the application by mail. The employer must indicate that it is filing by mail due to lack of adequate access to electronic filing. The OFLC Administrator will identify the address to which such filing must be mailed by public notice(s) and by instructions on DOL's website.

(3) *Reasonable accommodation.* Employers who are unable or limited in their ability to use and/or access the electronic *Application for Temporary Employment Certification*, or any other form or documentation required under this subpart, as a result of a disability may request a reasonable accommodation to enable them to participate in the H–2A program. An employer in need of such an accommodation may contact the NPC in writing to the address designated in a notice published in the FEDERAL REGISTER or 202–513–7350 (this is not a toll-free number), or for individuals with hearing or speech impairments, 1–877–889–5627 (this is the TTY toll-free Federal Information Relay Service number) for assistance in using, accessing, or filing any form or documentation required under this subpart, including the *Application for Temporary Employment Certification*. All requests for an accommodation should include the employer's name, a detailed description of the accommodation needed, and the preferred method of contact. The NPC will respond to the request for a reasonable accommodation within 10 business days of the date of receipt.

(d) *Original signature.* The *Application for Temporary Employment Certification* must contain an electronic (scanned) copy of the original signature of the employer (and that of the employer's authorized attorney or agent if the employer is represented by an attorney or

agent) or a verifiable electronic signature method, as directed by the OFLC Administrator. If submitted by mail, the *Application for Temporary Employment Certification* must bear the original signature of the employer and, if applicable, the employer's authorized attorney or agent.

(e) *Scope of applications.* (1) Except as otherwise permitted by this subpart, all places of employment on an *Application for Temporary Employment Certification* must be within a single area of intended employment. Where a job opportunity involves work at multiple places of employment after the workday begins, the *Application for Temporary Employment Certification* may include places of employment outside of a single area of intended employment only as is necessary to perform the duties specified in the *Application for Temporary Employment Certification,* and provided that the worker can reasonably return to the worker's residence or the employer-provided housing within the same workday.

(2) An employer may file only one *Application for Temporary Employment Certification* covering the same area of intended employment, period of employment, and occupation or comparable work to be performed.

(f) *Information dissemination.* Information received in the course of processing *Applications for Temporary Employment Certification* or in the course of conducting program integrity measures such as audits may be forwarded from OFLC to WHD or any other Federal agency, as appropriate, for investigative or enforcement purposes.

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34062, Apr. 29, 2024]

§ 655.131 Agricultural association and joint employer filing requirements.

(a) *Agricultural association filing requirements.* If an agricultural association files an *Application for Temporary Employment Certification,* in addition to complying with all the assurances, guarantees, and other requirements contained in this subpart and in part 653, subpart F, of this chapter, the following requirements also apply.

(1) The agricultural association must identify in the *Application for Temporary Employment Certification* for H–2A workers whether it is filing as a sole employer, a joint employer, or an agent. The agricultural association must retain documentation substantiating the employer or agency status of the agricultural association and be prepared to submit such documentation in response to a NOD from the CO prior to issuing a Final Determination, or in the event of an audit or investigation.

(2) The agricultural association may file a master application on behalf of its employer-members. The master application is available only when the agricultural association is filing as a joint employer. An agricultural association may submit a master application covering the same occupation or comparable work available with a number of its employer-members in multiple areas of intended employment, as long as the first dates of need for each employer-member named in the *Application for Temporary Employment Certification* are separated by no more than 14 calendar days and all places of employment are located in no more than two contiguous States. The agricultural association must identify in the *Application for Temporary Employment Certification* by name, address, total number of workers needed, period of employment, first date of need, and the crops and agricultural work to be performed, each employer-member that will employ H–2A workers.

(3) An agricultural association filing a master application as a joint employer may sign the *Application for Temporary Employment Certification* on behalf of its employer-members. An agricultural association filing as an agent may not sign on behalf of its employer-members but must obtain each employer-member's signature on the *Application for Temporary Employment Certification* prior to filing.

(4) If the application is approved, the agricultural association, as appropriate, will receive a Final Determination certifying the *Application for Temporary Employment Certification* in accordance with the procedures contained in § 655.162.

(b) *Joint employer filing requirements.* (1) If an employer files an *Application for Temporary Employment Certification*

on behalf of one or more other employers seeking to jointly employ H–2A workers in the same area of intended employment, in addition to complying with all the assurances, guarantees, and other requirements contained in this subpart and in part 653, subpart F, of this chapter, the following requirements also apply:

(i) The *Application for Temporary Employment Certification* must identify the name, address, and the crop(s) and agricultural work to be performed for each employer seeking to jointly employ the H–2A workers;

(ii) No single joint employer may employ an H–2A worker, or any combination of H–2A workers, for more than a total of 34 hours in any workweek; and

(iii) The *Application for Temporary Employment Certification* must be signed and dated by each joint employer named in the application, in accordance with the procedures contained in § 655.130(e). By signing the *Application for Temporary Employment Certification,* each joint employer named in the application attests to the conditions of employment required of an employer participating in the H–2A program, and assumes full responsibility for the accuracy of the representations made in the *Application for Temporary Employment Certification* and for compliance with all of the assurances and obligations of an employer in the H–2A program at all times during the period the *Application for Temporary Employment Certification* is valid; and

(2) If the application is approved, the joint employer who submits the *Application for Temporary Employment Certification* will receive, on behalf of the other joint employers, a Final Determination certifying the *Application for Temporary Employment Certification* in accordance with the procedures contained in § 655.162.

§ 655.132 H–2A labor contractor filing requirements.

An H–2A labor contractor (H–2ALC) must meet all of the requirements of the definition of *employer* in § 655.103(b) and comply with all the assurances, guarantees, and other requirements contained in this part, including § 655.135, and in part 653, subpart F, of this chapter. The H–2ALC must include in or with its *Application for Temporary Employment Certification* at the time of filing the following:

(a) The name and location of each fixed-site agricultural business to which the H–2ALC expects to provide H–2A workers, the expected beginning and ending dates when the H–2ALC will be providing the workers to each fixed site, and a description of the crops and activities the workers are expected to perform at such fixed site.

(b) A copy of the Migrant and Seasonal Agricultural Worker Protection Act (MSPA) Farm Labor Contractor (FLC) Certificate of Registration, if required under MSPA at 29 U.S.C. 1801 *et seq.*, identifying the specific farm labor contracting activities the H–2ALC is authorized to perform as an FLC.

(c) Proof of its ability to discharge financial obligations under the H–2A program by including with the *Application for Temporary Employment Certification* an original surety bond meeting the following requirements.

(1) *Requirements for the bond.* The bond must be payable to the Administrator, Wage and Hour Division, United States Department of Labor, 200 Constitution Avenue NW, Room S–3502, Washington, DC 20210. Consistent with the enforcement procedure set forth at 29 CFR 501.9(b), the bond must obligate the surety to pay any sums to the WHD Administrator for wages and benefits, including any assessment of interest, owed to an H–2A worker or to a worker engaged in corresponding employment, or to a U.S. worker improperly rejected or improperly laid off or displaced, based on a final decision finding a violation or violations of this part or 29 CFR part 501 relating to the labor certification the bond is intended to cover. The aggregate liability of the surety shall not exceed the face amount of the bond. The bond must remain in full force and effect for all liabilities incurred during the period of the labor certification, including any extension thereof. The bond may not be cancelled absent a finding by the WHD Administrator that the labor certification has been revoked.

(2) *Amount of the bond.* Unless a higher amount is sought by the WHD Administrator pursuant to 29 CFR 501.9(a), the required bond amount is

the base amount adjusted to reflect the average AEWR, as defined in § 655.103, and further adjusted if the labor certification will be used for the employment of 150 or more workers.

(i) The base amounts are $5,000 for a labor certification for which an H–2ALC employs fewer than 25 workers; $10,000 for a labor certification for which an H–2ALC employs 25 to 49 workers; $20,000 for a labor certification for which an H–2ALC employs 50 to 74 workers; $50,000 for a labor certification for which an H–2ALC employs 75 to 99 workers; and $75,000 for a labor certification for which an H–2ALC employs 100 or more workers.

(ii) The bond amount is calculated by multiplying the base amount by the average AEWR in effect at the time of bond submission, as provided in paragraph (c)(3) of this section, and dividing by $9.25. Thus, the required bond amounts will vary based on changes in the average AEWR.

(iii) For a labor certification for which an H–2ALC employs 150 or more workers, the bond amount applicable to the certification of 100 or more workers is further adjusted for each additional 50 workers as follows: the bond amount is increased by a value which represents 2 weeks of wages for 50 workers, calculated using the average AEWR (*i.e.*, 80 hours × 50 workers × Average AEWR); this increase is applied to the bond amount for each additional group of 50 workers.

(iv) The required bond amounts shall be calculated and published in the FEDERAL REGISTER after the OFLC Administrator has calculated the average AEWR or any adjustment thereto.

(3) *Form of the bond and method of filing*. The bond shall consist of an executed Form ETA–9142A—Appendix B, and must contain the name, address, phone number, and contact person for the surety, and valid documentation of power of attorney. The bond must be filed using the method directed by the OFLC Administrator at the time of filing:

(i) *Electronic surety bonds*. When the OFLC Administrator directs the use of electronic surety bonds, this will be the required method of filing bonds for all applications subject to mandatory electronic filing. Consistent with the application filing requirements of § 655.130(c) and (d), the bond must be completed, signed by the employer and the surety using a verifiable electronic signature method, and submitted electronically with the *Application for Temporary Employment Certification* and supporting materials unless the employer is permitted to file by mail or a different accommodation under § 655.130(c)(2) or (3).

(ii) *Electronic submission of copy*. Until such time as the OFLC Administrator directs the use of electronic surety bonds, employers may submit an electronic (scanned) copy of the surety bond with the application, provided that the original bond is received within 30 days of the date that the labor certification is issued.

(iii) *Mailing original bond with application*. For applications not subject to mandatory electronic filing due under § 655.130(c)(2) or (3), employers may submit the original bond as part of its mailed, paper application package, or consistent with the accommodation provided.

(d) Copies of the fully-executed work contracts with each fixed-site agricultural business identified under paragraph (a) of this section.

(e) Where the fixed-site agricultural business will provide housing or transportation to the workers, proof that:

(1) All housing used by workers and owned, operated, or secured by the fixed-site agricultural business complies with the applicable standards as set forth in § 655.122(d) and certified by the SWA and that the fixed-site agricultural business has agreed to comply with the requirements at § 655.135(n); and

(2) All transportation between all places of employment and the workers' living quarters that is provided by the fixed-site agricultural business complies with all applicable local, State, or Federal laws and regulations and must provide, at a minimum, the same vehicle safety standards, driver licensure, and vehicle insurance as required under 29 U.S.C. 1841 and 29 CFR 500.104 or 500.105 and 500.120 through 500.128, except where workers' compensation is

used to cover such transportation as described in § 655.122(h).

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§ 655.133 Requirements for agents.

(a) An agent filing an *Application for Temporary Employment Certification* on behalf of an employer must provide a copy of the agent agreement or other document demonstrating the agent's authority to represent the employer.

(b) In addition the agent must provide a copy of the MSPA FLC Certificate of Registration, if required under MSPA at 29 U.S.C. 1801 *et seq.*, identifying the specific farm labor contracting activities the agent is authorized to perform.

§ 655.134 Emergency situations.

(a) *Waiver of time period.* The CO may waive the time period for filing for employers who did not make use of temporary foreign agricultural workers during the prior year's agricultural season or for any employer that has other good and substantial cause, provided the CO has sufficient time to test the domestic labor market on an expedited basis to make the determinations required by § 655.100.

(b) *Employer requirements.* The employer requesting a waiver of the required time period must submit to the NPC: all documentation required at the time of filing by § 655.130(a), except evidence of a job order submitted pursuant to § 655.121; a completed job order on the Form ETA–790/790A and all required addenda; and a statement justifying the request for a waiver of the time period requirement. The statement must indicate whether the waiver request is due to the fact that the employer did not use H–2A workers during the prior year's agricultural season or whether the request is for good and substantial cause. If the waiver is requested for good and substantial cause, the employer's statement must also include detailed information describing the good and substantial cause that has necessitated the waiver request. Good and substantial cause may include, but is not limited to, the substantial loss of U.S. workers due to Acts of God or similar unforeseeable man-made catastrophic events (e.g., a hazardous materials emergency or government-controlled flooding), unforeseeable changes in market conditions, pandemic health issues, or similar conditions that are wholly outside of the employer's control.

(c) *Processing of emergency applications.* (1) Upon receipt of a complete emergency situation(s) waiver request, the CO promptly will transmit a copy of the job order to the SWA serving the area of intended employment. The SWA will review the contents of the job order for compliance with the requirements set forth in 20 CFR part 653, subpart F, and § 655.122. If the SWA determines that the job order does not comply with the applicable criteria, the SWA must inform the CO of the noted deficiencies within 5 calendar days of the date the job order is received by the SWA.

(2) The CO will process emergency *Applications for Temporary Employment Certification* in a manner consistent with the provisions set forth in §§ 655.140 through 655.145 and make a determination on the *Application for Temporary Employment Certification* in accordance with §§ 655.160 through 655.167. The CO may notify the employer, in accordance with the procedures contained in § 655.141, that the application cannot be accepted because, pursuant to paragraph (a) of this section, the request for emergency filing was not justified and/or there is not sufficient time to test the availability of U.S. workers such that the CO can make a determination on the *Application for Temporary Employment Certification* in accordance with § 655.161. Such notification will so inform the employer of the opportunity to submit a modified *Application for Temporary Employment Certification* and/or job order in accordance with the procedures contained in § 655.142.

§ 655.135 Assurances and obligations of H–2A employers.

An employer seeking to employ H–2A workers must agree as part of the *Application for Temporary Employment Certification* and job offer that it will abide by the requirements of this subpart and of 29 CFR part 501 and must make each of the following additional assurances:

(a) *Non-discriminatory hiring practices.* The job opportunity is, and through the period set forth in paragraph (d) of this section must continue to be, open to any qualified U.S. worker regardless of race, color, national origin, age, sex, religion, handicap, or citizenship status. Rejections of any U.S. workers who applied or apply for the job must be only for lawful, job-related reasons, and those not rejected on this basis have been or will be hired. In addition, the employer has and will continue to retain records of all hires and rejections as required by § 655.167.

(b) *No strike or lockout.* The place(s) of employment for which the employer is requesting a temporary agricultural labor certification does not currently have employees on strike or being locked out in the course of a labor dispute.

(c) *Recruitment requirements*—(1) *General requirements.* The employer has and will continue to cooperate with the SWA by accepting referrals of all eligible U.S. workers who apply (or on whose behalf an application is made) for the job opportunity until the end of the period as specified in paragraph (d) of this section and must independently conduct the positive recruitment activities, as specified in § 655.154, until the date on which the H–2A workers depart for the place of employment. Unless the SWA is informed in writing of a different date, the date that is the third day preceding the employer's first date of need will be determined to be the date the H–2A workers departed for the employer's place of employment.

(2) *Interviewing U.S. workers.* Employers that wish to require interviews must conduct those interviews by phone or provide a procedure for the interviews to be conducted in the location where the U.S. worker is being recruited so that the worker incurs little or no cost due to the interview. Employers cannot provide potential H–2A workers with more favorable treatment than U.S. workers with respect to the requirement for, and conduct of, interviews.

(3) *Qualified and available U.S. workers.* The employer must consider all U.S. applicants for the job opportunity until the end of the recruitment period, as set forth in § 655.135(d). The employer must accept and hire all applicants who are qualified and who will be available for the job opportunity. U.S. applicants can be rejected only for lawful, job-related reasons, and those not rejected on this basis will be hired.

(d) *Fifty percent rule.* From the time the foreign workers depart for the employer's place of employment, the employer must provide employment to any qualified, eligible U.S. worker who applies to the employer until 50 percent of the period of the work contract has elapsed. Start of the work contract timeline is calculated from the first date of need stated on the *Application for Temporary Employment Certification*, under which the foreign worker who is in the job was hired. This paragraph (d) will not apply to any employer who certifies to in the *Application for Temporary Employment Certification* that the employer:

(1) Did not, during any calendar quarter during the preceding calendar year, use more than 500 man-days of agricultural labor, as defined in 29 U.S.C. 203(u);

(2) Is not an employer-member of an association that has petitioned for certification under this subpart for its employer-members; and

(3) Has not otherwise associated with other employers who are petitioning for temporary foreign workers under this subpart.

(e) *Compliance with applicable laws.* During the period of employment that is the subject of the *Application for Temporary Employment Certification*, the employer must comply with all applicable Federal, State, and local laws and regulations, including health and safety laws. In compliance with such laws, including the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Pub. L. 110–457, 18 U.S.C. 1592(a), the employer may not hold or confiscate workers' passports, visas, or other immigration documents. H–2A employers may also be subject to the FLSA. The FLSA operates independently of the H–2A program and has specific requirements that address payment of wages, including deductions from wages, the payment of Federal minimum wage and payment of overtime.

(f) *Job opportunity is full-time.* The job opportunity is a full-time temporary position, calculated to be at least 35 hours per workweek.

(g) *No recent or future layoffs.* The employer has not laid off and will not lay off any similarly employed U.S. worker in the occupation that is the subject of the *Application for Temporary Employment Certification* in the area of intended employment except for lawful, job-related reasons within 60 days of the first date of need, or if the employer has laid off such workers, it has offered the job opportunity that is the subject of the *Application for Temporary Employment Certification* to those laid-off U.S. worker(s) and the U.S. worker(s) refused the job opportunity, was rejected for the job opportunity for lawful, job-related reasons, or was hired. A layoff for lawful, job-related reasons such as lack of work or the end of the growing season is permissible if all H–2A workers are laid off before any U.S. worker in corresponding employment.

(h) *No unfair treatment.* (1) The employer has not and will not intimidate, threaten, restrain, coerce, blacklist, discharge or in any manner discriminate against, and has not and will not cause any person to intimidate, threaten, restrain, coerce, blacklist, or in any manner discriminate against, any person who has:

(i) Filed a complaint under or related to 8 U.S.C. 1188 or this subpart or any Department regulation in this chapter or 29 CFR part 501 promulgated under 8 U.S.C. 1188;

(ii) Instituted or caused to be instituted any proceeding under or related to 8 U.S.C. 1188 or this subpart or any Department regulation in this chapter or 29 CFR part 501 promulgated under 8 U.S.C. 1188;

(iii) Testified or is about to testify in any proceeding under or related to 8 U.S.C. 1188 or this subpart or any Department regulation in this chapter or 29 CFR part 501 promulgated under 8 U.S.C. 1188;

(iv) Consulted with an employee of a legal assistance program or an attorney on matters related to 8 U.S.C. 1188 or this subpart or any Department regulation in this chapter or 29 CFR part 501 promulgated under 8 U.S.C. 1188;

(v) Consulted with a key service provider on matters related to 8 U.S.C. 1188 or this subpart or any Department regulation in this chapter or 29 CFR part 501 promulgated under 8 U.S.C. 1188;

(vi) Exercised or asserted on behalf of themself or others any right or protection afforded by 8 U.S.C. 1188 or this subpart or any Department regulation in this chapter or 29 CFR part 501 promulgated under 8 U.S.C. 1188; or

(vii) Filed a complaint, instituted, or caused to be instituted any proceeding; or testified, assisted, or participated (or is about to testify, assist, or participate) in any investigation, proceeding, or hearing under or related to any applicable Federal, State, or local laws or regulations, including safety and health, employment, and labor laws.

(2) With respect to any person engaged in agriculture as defined and applied in 29 U.S.C. 203(f), the employer has not and will not intimidate, threaten, restrain, coerce, blacklist, discharge or in any manner discriminate against, and has not and will not cause any person to intimidate, threaten, restrain, coerce, blacklist, or in any manner discriminate against, any person because such person:

(i) Has engaged in activities related to self-organization, including any effort to form, join, or assist a labor organization; or has engaged in other concerted activities for the purpose of mutual aid or protection relating to wages or working conditions; or has refused to engage in any or all of such activities; or

(ii) Has refused to attend an employer-sponsored meeting with the employer or its agent, representative or designee, if the primary purpose of the meeting is to communicate the employer's opinion concerning any activity protected by this subpart; or has refused to listen to employer-sponsored speech or view employer-sponsored communications, the primary purpose of which is to communicate the employer's opinion concerning any activity protected by this subpart.

(i) *Notify workers of duty to leave United States.* (1) The employer must inform H–2A workers of the requirement that they leave the United States at

the end of the period certified by the Department or separation from the employer, whichever is earlier, as required under paragraph (i)(2) of this section, unless the H–2A worker is being sponsored by another subsequent H–2A employer.

(2) As explained further in the DHS regulations, a temporary agricultural labor certification limits the validity period of an H–2A Petition. *See* 8 CFR 214.2(h)(5)(vii). A foreign worker may not remain beyond their authorized period of stay, as determined by DHS, nor beyond separation from employment prior to completion of the H–2A contract, absent an extension or change of such worker's status under the DHS regulations. *See* 8 CFR 214.2(h)(5)(viii)(B).

(j) *Comply with the prohibition against employees paying fees.* The employer and its agents have not sought or received payment of any kind from any employee subject to 8 U.S.C. 1188 for any activity related to obtaining H–2A labor certification, including payment of the employer's attorney fees, application fees, or recruitment costs. For purposes of this paragraph (j), payment includes, but is not limited to, monetary payments, wage concessions (including deductions from wages, salary, or benefits), kickbacks, bribes, tributes, in kind payments, and free labor. The provision in this paragraph (j) does not prohibit employers or their agents from receiving reimbursement for costs that are the responsibility and primarily for the benefit of the worker, such as government-required passport fees.

(k) *Contracts with third parties to comply with prohibitions.* The employer must contractually prohibit in writing any foreign labor contractor or recruiter (or any agent of such foreign labor contractor or recruiter) whom the employer engages, either directly or indirectly, in international recruitment of H–2A workers to seek or receive payments or other compensation from prospective employees. The contract must include the following statement: ''Under this agreement, [name of foreign labor contractor or recruiter] and any agent or employee of [name of foreign labor contractor or recruiter] are prohibited from seeking or receiving payments from any prospective employee of [employer name] at any time, including before or after the worker obtains employment. Payments include but are not limited to any direct or indirect fees paid by such employees for recruitment, job placement, processing, maintenance, attorney fees, agent fees, application fees, or any fees related to obtaining H–2A labor certification.'' This documentation is to be made available upon request by the CO or another Federal party.

(l) *Notice of worker rights.* The employer must post and maintain in a conspicuous location at the place of employment, a poster provided by the Secretary in English, and, to the extent necessary, any language common to a significant portion of the workers if they are not fluent in English, which sets out the rights and protections for workers employed pursuant to 8 U.S.C. 1188.

(m) *Designation of representative.* With respect to any H–2A worker or worker in corresponding employment engaged in agriculture as defined and applied in 29 U.S.C. 203(f), employed at the place(s) of employment included in the *Application for Temporary Employment Certification*, the employer must permit a worker to designate a representative to attend any investigatory interview that the worker reasonably believes might result in disciplinary action and must permit the worker to receive advice and active assistance from the designated representative during any such investigatory interview. Where the designated representative is present at the worksite at the time of the investigatory interview, the employer must permit the representative to attend the investigatory interview in person. Where the designated representative is not present at the time and place of the investigatory interview, the employer must permit the representative to attend the investigatory interview remotely, including by telephone, videoconference, or other means.

(n) *Access to worker housing.* Workers residing in employer-furnished housing must be permitted to invite, or accept at their discretion, guests to their living quarters and/or the common areas or outdoor spaces near such housing during time that is outside of the

workers' workday subject only to reasonable restrictions designed to protect worker safety or prevent interference with other workers' enjoyment of these areas. Because workers' ability to accept guests at their discretion depends on the ability of potential guests to contact and seek an invitation from those workers, restrictions impeding this ability to contact and seek an invitation will be evaluated as restrictions on the workers' ability to accept guests.

(o) *Passport withholding.* During the period of employment that is the subject of the *Application for Temporary Labor Certification*, the employer may not hold or confiscate a worker's passport, visa, or other immigration or government identification document *except* where the worker states in writing that: the worker voluntarily requested that the employer keep these documents safe, the employer did not direct the worker to submit such a request, and the worker understands that the passport, visa, or other immigration or government identification document will be returned to the worker immediately upon the worker's request.

(p) *Foreign worker recruitment.* The employer, and its attorney or agent, as applicable, must comply with § 655.137(a) by providing a copy of all agreements with any agent or recruiter whom it engages or plans to engage in the recruitment of H–2A workers, and the identity and location of the persons and entities hired by or working for the agent or recruiter and any of the agents and employees of those persons and entities, to recruit foreign workers. Pursuant to § 655.130(a), the agreements and information must be filed with the *Application for Temporary Employment Certification*. The employer must update this documentation in accordance with § 655.137(c).

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34062, Apr. 29, 2024]

§ 655.136 Withdrawal of an *Application for Temporary Employment Certification* and job order.

(a) The employer may withdraw an *Application for Temporary Employment Certification* and the related job order at any time before the CO makes a determination under § 655.160. However, the employer is still obligated to comply with the terms and conditions of employment contained in the *Application for Temporary Employment Certification* and job order with respect to all workers recruited in connection with that application and job order.

(b) To request withdrawal, the employer must submit a request in writing to the NPC identifying the *Application for Temporary Employment Certification* and job order and stating the reason(s) for the withdrawal.

§ 655.137 Disclosure of foreign worker recruitment.

(a) If the employer engages or plans to engage an agent or foreign labor recruiter, directly or indirectly, in international recruitment, the employer, and its attorney or agent, as applicable, must provide copies of all contracts and agreements with any agent and/or recruiter, executed in connection with the job opportunity, as specified in § 655.135(p). These agreements must contain the contractual prohibition against charging fees as set forth in § 655.135(k).

(b) The employer, and its attorney or agent, as applicable, must provide all recruitment-related information required in the *Application for Temporary Employment Certification*, as defined in § 655.103(b), which includes the identity and location of all persons and entities hired by or working for the recruiter or agent, and any of the agents or employees of those persons and entities, to recruit prospective foreign workers for the H–2A job opportunity.

(c) The employer must continue to keep the foreign labor recruiter information referenced in paragraphs (a) and (b) of this section up to date until the end of the work contract period. The employer must retain the updated information in accordance with § 655.167(c)(8) and must make this updated information available in the event of a post-certification audit or upon request by the Department. The Department may share the foreign worker recruitment information it receives from employers with any other Federal agency, as appropriate for investigative or enforcement purpose, as set forth in § 655.130(f).

(d) The Department of Labor will maintain a publicly available list of agents and recruiters (including government registration numbers, if any) who are party to the agreements employers submit, as well as the persons and entities the employer identified as hired by or working for the recruiter and the locations in which they are operating.

[89 FR 34063, Apr. 29, 2024]

PROCESSING OF APPLICATIONS FOR TEMPORARY EMPLOYMENT CERTIFICATION

§ 655.140 Review of applications.

(a) *NPC review.* The CO will promptly review the *Application for Temporary Employment Certification* and job order for compliance with all applicable program requirements, including compliance with the requirements set forth in this subpart, and make a decision to issue a NOD under § 655.141, a Notice of Acceptance (NOA) under § 655.143, or a Final Determination under § 655.160.

(b) *Mailing and postmark requirements.* Any notice or request sent by the CO(s) to an employer requiring a response will be sent electronically or via traditional methods to assure next day delivery using the address, including electronic mail address, provided on the *Application for Temporary Employment Certification.* The employer's response to such a notice or request must be filed electronically or via traditional methods to assure next day delivery. The employer's response must be sent by the date due or the next business day if the due date falls on a Sunday or Federal holiday.

§ 655.141 Notice of deficiency.

(a) *Notification timeline.* If the CO determines the *Application for Temporary Employment Certification* or job order is incomplete, contains errors or inaccuracies, or does not meet the requirements set forth in this subpart, the CO will notify the employer within 7 calendar days of the CO's receipt of the *Application for Temporary Employment Certification.* A copy of this notification will be sent to the SWA serving the area of intended employment.

(b) *Notice content.* The notice will:

(1) State the reason(s) the *Application for Temporary Employment Certification* or job order fails to meet the criteria for acceptance;

(2) Offer the employer an opportunity to submit a modified *Application for Temporary Employment Certification* or job order within 5 business days from date of receipt stating the modification that is needed for the CO to issue the NOA;

(3) State that the CO's determination on whether to grant or deny the *Application for Temporary Employment Certification* will be made not later than 30 calendar days before the first date of need, provided that the employer submits the requested modification to the *Application for Temporary Employment Certification* or job order within 5 business days and in a manner specified by the CO; and

(4) State that if the employer does not comply with the requirements of § 655.142, the CO will deny the *Application for Temporary Employment Certification.*

§ 655.142 Submission of modified applications.

(a) *Submission requirements and certification delays.* If in response to a NOD the employer chooses to submit a modified *Application for Temporary Employment Certification* or job order, the CO's Final Determination will be postponed by 1 calendar day for each day that passes beyond the 5 business-day period allowed under § 655.141(b) to submit a modified *Application for Temporary Employment Certification* or job order, up to a maximum of 5 calendar days. The CO may issue one or more additional NODs before issuing a Final Determination. The *Application for Temporary Employment Certification* will be deemed abandoned if the employer does not submit a modified *Application for Temporary Employment Certification* or job order within 12 calendar days after the NOD was issued.

(b) *Provisions for denial of modified Application for Temporary Employment Certification.* If the modified *Application for Temporary Employment Certification* or job order does not cure the deficiencies cited in the NOD(s) or otherwise fails

to satisfy the criteria required for certification, the CO will deny the *Application for Temporary Employment Certification* in accordance with the labor certification determination provisions in § 655.164.

(c) *Appeal from denial of modified Application for Temporary Employment Certification*. The procedures for appealing a denial of a modified *Application for Temporary Employment Certification* are the same as for a non-modified *Application for Temporary Employment Certification* as long as the employer timely requests an expedited administrative review or de novo hearing before an ALJ by following the procedures set forth in § 655.171.

§ 655.143 Notice of acceptance.

(a) *Notification timeline*. When the CO determines the *Application for Temporary Employment Certification* and job order meet the requirements set forth in this subpart, the CO will notify the employer within 7 calendar days of the CO's receipt of the *Application for Temporary Employment Certification*. A copy of the notice will be sent to the SWA serving the area of intended employment.

(b) *Notice content*. The notice must:

(1) Authorize conditional access to the interstate clearance system and direct each SWA receiving a copy of the job order to commence recruitment of U.S. workers as specified in § 655.150;

(2) Direct the employer to engage in positive recruitment of U.S. workers under §§ 655.153 and 655.154 and to submit a report of its positive recruitment efforts meeting the requirements of § 655.156. If the OFLC Administrator's annual determination of labor supply States under § 655.154 requires the employer to engage in a specific additional positive recruitment activity in a labor supply State, the NOA will describe the precise nature of the additional positive recruitment required and will specify the documentation or other supporting evidence that must be maintained by the employer as proof that positive recruitment requirements were met;

(3) State that positive recruitment is in addition to and will occur during the period of time that the job order is being circulated by the SWA(s) for interstate clearance under § 655.150 and will terminate on the date specified in § 655.158;

(4) State any other documentation or assurances needed for the *Application for Temporary Employment Certification* to meet the requirements for certification under this subpart;

(5) State that the CO will make a determination either to grant or deny the *Application for Temporary Employment Certification* not later than 30 calendar days before the first date of need, except as provided for under § 655.142 for modified *Applications for Temporary Employment Certification* or when the *Application for Temporary Employment Certification* does not meet the requirements for certification but is expected to before the first date of need; and

(6) Where appropriate to the job opportunity and area of intended employment, direct the SWA to provide written notice of the job opportunity to organizations that provide employment and training services to workers likely to apply for the job and/or to place written notice of the job opportunity in other physical locations where such workers are likely to gather.

§ 655.144 Electronic job registry.

(a) *Location of and placement in the electronic job registry*. Upon acceptance of the *Application for Temporary Employment Certification* under § 655.143, the CO will promptly place for public examination a copy of the job order on an electronic job registry maintained by the Department, including any required modifications approved by the CO, as specified in § 655.142.

(b) *Length of posting on electronic job registry*. Unless otherwise provided, the Department will keep the job order posted on the electronic job registry in active status until the end of the recruitment period, as set forth in § 655.135(d).

§ 655.145 Pre-determination amendments to applications for temporary employment certification.

(a) *Increases in number of workers*. The *Application for Temporary Employment Certification* may be amended at any time before the CO's certification determination to increase the number of

workers requested in the initial *Application for Temporary Employment Certification* by not more than 20 percent (50 percent for employers requesting less than 10 workers) without requiring an additional recruitment period for U.S. workers. Requests for increases above the percent prescribed, without additional recruitment, may be approved by the CO only when the employer demonstrates that the need for additional workers could not have been foreseen, and the crops or commodities will be in jeopardy prior to the expiration of an additional recruitment period. All requests for increasing the number of workers must be made in writing.

(b) *Minor changes to the period of employment.* The *Application for Temporary Employment Certification* may be amended to make minor changes in the total period of employment before the CO issues a final determination. Changes will not be effective until submitted in writing and approved by the CO. In considering whether to approve the request, the CO will review the reason(s) for the request, determine whether the reason(s) are on the whole justified, and take into account the effect any change(s) would have on the adequacy of the underlying test of the domestic labor market for the job opportunity. An employer must demonstrate that the change to the period of employment could not have been foreseen, and the crops or commodities will be in jeopardy prior to the expiration of an additional recruitment period. Upon acceptance of an amendment, the CO will submit to the SWA any necessary modification to the job order.

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34063, Apr. 29, 2024]

POST-ACCEPTANCE REQUIREMENTS

§ 655.150 Interstate clearance of job order.

(a) *CO approves for interstate clearance.* The CO will promptly transmit a copy of the approved job order for interstate clearance, at minimum, to all States listed in the job order as anticipated place(s) of employment and all other States designated by the OFLC Administrator as States of traditional or expected labor supply for the anticipated place(s) of employment under § 655.154(d).

(b) *Duration of posting.* Each of the SWAs to which the CO transmits the job order must keep the job order on its active file until the end of the recruitment period, as set forth in § 655.135(d), and must refer each qualified U.S. worker who applies (or on whose behalf an application is made) for the job opportunity.

§§ 655.151–655.152 [Reserved]

§ 655.153 Contact with former U.S. workers.

The employer must contact, by mail or other effective means, U.S. workers employed by the employer in the occupation at the place of employment during the previous year and solicit their return to the job. This contact must occur during the period of time that the job order is being circulated by the SWA(s) for interstate clearance under § 655.150 and before the date specified in § 655.158. Documentation sufficient to prove contact must be maintained in the event of an audit or investigation. An employer has no obligation to contact U.S. workers it terminated for cause or who abandoned employment at any time during the previous year if the employer provided timely notice to the NPC of the termination or abandonment in the manner described in § 655.122(n).

§ 655.154 Additional positive recruitment.

(a) *Where to conduct additional positive recruitment.* In addition to the CO's posting of the job opportunity on an electronic job registry in accordance with § 655.144, the employer must conduct positive recruitment as required by the OFLC Administrator's determination of traditional or expected labor supply States, which is published annually in accordance with paragraph (d) of this section.

(b) *Additional requirements should be comparable to non-H–2A employers in the area.* The location(s) and method(s) of the positive recruitment required of the employer must be no less than the normal recruitment efforts of non-H–2A agricultural employers of comparable or smaller size in the area of

intended employment, taking into consideration the kind and degree of recruitment efforts which the employer may make to obtain foreign workers.

(c) *Nature of the additional positive recruitment.* The OFLC Administrator's labor supply State determination will identify areas of labor supply within a State, and the NOA issued under § 655.143 will describe the precise nature of the additional positive recruitment required of the employer, if any. The employer will not be required to conduct positive recruitment in more than three States for each area of intended employment listed on the employer's *Application for Temporary Employment Certification* and job order.

(d) *Determination of labor supply States.* (1) The OFLC Administrator will make an annual determination with respect to each State whether there are other traditional or expected labor supply States and, within a traditional or expected labor supply State, areas in which there are a significant number of qualified U.S. workers who, if recruited, would be willing to make themselves available for work in that State. The OFLC Administrator will publish the determination annually on OFLC's website.

(2) The determination will become effective on the date of publication on OFLC's website for employers who have not commenced positive recruitment under this subpart and will remain valid until the OFLC Administrator publishes a new determination.

(3) The determination as to whether any State is a source of traditional or expected labor supply to another State will be based primarily upon information provided by the SWAs to the OFLC Administrator within 120 calendar days preceding the determination.

§ 655.155 Referrals of U.S. workers.

SWAs may only refer for employment individuals who have been apprised of all the material terms and conditions of employment and have indicated, by accepting referral to the job opportunity, that they are qualified, able, willing, and available for employment.

§ 655.156 Recruitment report.

(a) *Requirements of a recruitment report.* The employer must prepare, sign, and date a written recruitment report. The recruitment report must be submitted on a date specified by the CO in the NOA set forth in § 655.143 and contain the following information:

(1) Identify the name of each recruitment source and date(s) of advertisement;

(2) State the name and contact information of each U.S. worker who applied or was referred to the job opportunity up to the date of the preparation of the recruitment report, and the disposition of each worker;

(3) Confirm that former U.S. workers were contacted, with a description by what means they were contacted and the date(s) of such contact, or state there are no former U.S. workers to contact; and

(4) If applicable, for each U.S. worker who applied for the position but was not hired, explain the lawful job-related reason(s) for not hiring the U.S. worker.

(b) *Duty to update recruitment report.* The employer must continue to update the recruitment report until the end of the recruitment period, as set forth in § 655.135(d). The updated report must be made available in the event of a post-certification audit or upon request by the Department. The Department may share recruitment report information with any other Federal agency, as set forth in § 655.130(f).

§ 655.157 Withholding of U.S. workers prohibited.

(a) *Filing a complaint.* Any employer who has reason to believe that a person or entity has willfully and knowingly withheld U.S. workers prior to the arrival at the place of employment of H–2A workers in order to force the hiring of U.S. workers during the recruitment period, as set forth in § 655.135(d), may submit a written complaint to the CO. The complaint must clearly identify the person or entity who the employer believes has withheld the U.S. workers, and must specify sufficient facts to support the allegation (e.g., dates, places, numbers and names of U.S. workers) which will permit an investigation to be conducted by the CO.

(b) *Duty to investigate.* Upon receipt, the CO must immediately investigate the complaint. The investigation must include interviews with the employer who has submitted the complaint, the person or entity named as responsible for withholding the U.S. workers, and the individual U.S. workers whose availability has purportedly been withheld.

(c) *Duty to suspend the recruitment period.* Where the CO determines, after conducting the interviews required by paragraph (b) of this section, that the employer's complaint is valid and justified, the CO will immediately suspend the applicable recruitment period, as set forth in §655.135(d), to the employer. The CO's determination is the final decision of the Secretary.

§ 655.158 Duration of positive recruitment.

Except as otherwise noted, the obligation to engage in positive recruitment described in §§655.150 through 655.154 will terminate on the date H–2A workers depart for the employer's place of employment. Unless the SWA is informed in writing of a different date, the date that is the third day preceding the employer's first date of need will be determined to be the date the H–2A workers departed for the employer's place of employment.

LABOR CERTIFICATION DETERMINATIONS

§ 655.160 Determinations.

Except as otherwise noted in this section, the CO will make a determination either to grant or deny the *Application for Temporary Employment Certification* not later than 30 calendar days before the first date of need identified in the *Application for Temporary Employment Certification*. An *Application for Temporary Employment Certification* that is modified under §655.142 or that otherwise does not meet the requirements for certification in this subpart is not subject to the 30-day timeframe for certification.

§ 655.161 Criteria for certification.

(a) The criteria for certification include whether the employer has complied with the applicable requirements of parts 653 and 654 of this chapter, and all requirements of this subpart, which are necessary to grant the labor certification.

(b) In making a determination as to whether there are insufficient U.S. workers to fill the employer's job opportunity, the CO will count as available any U.S. worker referred by the SWA or any U.S. worker who applied (or on whose behalf an application is made) directly to the employer, whom the employer has not rejected for a lawful, job-related reason.

§ 655.162 Approved certification.

If temporary agricultural labor certification is granted, the CO will send a Final Determination notice and a copy of the certified *Application for Temporary Employment Certification* and job order to the employer and a copy, if applicable, to the employer's agent or attorney using an electronic method(s) designated by the OFLC Administrator. For employers permitted to file by mail as set forth in §655.130(c), the CO will send the Final Determination notice and a copy of the certified *Application for Temporary Employment Certification* and job order by means normally assuring next day delivery. The CO will send the certified *Application for Temporary Employment Certification* and job order, including any approved modifications, directly to USCIS using an electronic method(s) designated by the OFLC Administrator.

§ 655.163 Certification fee.

A determination by the CO to grant an *Application for Temporary Employment Certification* in whole or in part will include a bill for the required certification fees. Each employer of H–2A workers under the *Application for Temporary Employment Certification* (except joint employer agricultural associations, which may not be assessed a fee in addition to the fees assessed to the employer-members of the agricultural association) must pay in a timely manner a non-refundable fee upon issuance of the certification granting the *Application for Temporary Employment Certification* (in whole or in part), as follows:

(a) *Amount.* The *Application for Temporary Employment Certification* fee for each employer receiving a temporary agricultural labor certification is $100

plus $10 for each H–2A worker certified under the *Application for Temporary Employment Certification*, provided that the fee to an employer for each temporary agricultural labor certification received will be no greater than $1,000. There is no additional fee to the association filing the *Application for Temporary Employment Certification*. The fees must be paid by check or money order made payable to United States Department of Labor. In the case of an agricultural association acting as a joint employer applying on behalf of its H–2A employer-members, the aggregate fees for all employers of H–2A workers under the *Application for Temporary Employment Certification* must be paid by one check or money order.

(b) *Timeliness.* Fees must be received by the CO no more than 30 calendar days after the date of the certification. Non-payment or untimely payment may be considered a substantial violation subject to the procedures in § 655.182.

§ 655.164 Denied certification.

If temporary agricultural labor certification is denied, the CO will send a Final Determination notice to the employer and a copy, if appropriate, to the employer's agent or attorney using an electronic method(s) designated by the OFLC Administrator. For employers permitted to file by mail as set forth in § 655.130(c), the CO will send the Final Determination notice by means normally assuring next day delivery. The Final Determination notice will:

(a) State the reason(s) certification is denied, citing the relevant regulatory standards;

(b) Offer the employer an opportunity to request an expedited administrative review or a de novo administrative hearing before an ALJ of the denial under § 655.171; and

(c) State that if the employer does not request an expedited administrative judicial review or a de novo hearing before an ALJ in accordance with § 655.171, the denial is final, and the Department will not accept any appeal on that *Application for Temporary Employment Certification*.

§ 655.165 Partial certification.

The CO may issue a partial certification, reducing either the period of employment or the number of H–2A workers being requested or both for certification, based upon information the CO receives during the course of processing the *Application for Temporary Employment Certification*, an audit, or otherwise. The number of workers certified will be reduced by one for each U.S. worker who is able, willing, and qualified, and who will be available at the time and place needed and has not been rejected for lawful, job-related reasons, to perform the labor or services. If a partial labor certification is issued, the CO will send the Final Determination notice approving partial certification using the procedures at § 655.162. The Final Determination notice will:

(a) State the reason(s) the period of employment and/or the number of H–2A workers requested has been reduced, citing the relevant regulatory standards;

(b) Offer the employer an opportunity to request an expedited administrative review or a de novo administrative hearing before an ALJ of the partial certification under § 655.171; and

(c) State that if the employer does not request an expedited administrative judicial review or a de novo hearing before an ALJ in accordance with § 655.171, the partial certification is final, and the Department will not accept any appeal on that *Application for Temporary Employment Certification*.

§ 655.166 Requests for determinations based on nonavailability of U.S. workers.

(a) *Standards for requests.* If a temporary agricultural labor certification has been partially granted or denied based on the CO's determination that able, willing, available, eligible, and qualified U.S. workers are available, and, on or after 30 calendar days before the first date of need, some or all of those U.S. workers are, in fact, no longer able, willing, eligible, qualified, or available, the employer may request a new temporary agricultural labor certification determination from the CO. Prior to making a new determination, the CO will promptly ascertain

(which may be through the SWA or other sources of information on U.S. worker availability) whether specific able, willing, eligible and qualified replacement U.S. workers are available or can be reasonably expected to be present at the employer's establishment within 72 hours from the date the employer's request was received. The CO will expeditiously, but in no case later than 72 hours after the time a complete request (including the signed statement included in paragraph (b) of this section) is received, make a determination on the request under paragraph (c) of this section. An employer may appeal a denial of such a determination in accordance with the procedures contained in § 655.171.

(b) *Unavailability of U.S. workers.* The employer's request for a new determination must be made directly to the CO in writing using an electronic method(s) designated by the OFLC Administrator, unless the employer requests to file the request by mail as set forth in § 655.130(c). If the employer requests the new determination by asserting solely that U.S. workers have become unavailable, the employer must submit to the CO a signed statement confirming such assertion. If such signed statement is not received by the CO within 72 hours of the CO's receipt of the request for a new determination, the CO will deny the request.

(c) *Notification of determination.* If the CO determines that U.S. workers have become unavailable and cannot identify sufficient available U.S. workers who are able, willing, eligible, and qualified or who are likely to become available, the CO will grant the employer's request for a new determination on the *Application for Temporary Employment Certification* in accordance with the procedures contained in § 655.162 or § 655.165. However, this does not preclude an employer from submitting subsequent requests for new determinations, if warranted, based on subsequent facts concerning purported nonavailability of U.S. workers or referred workers not being eligible workers or not able, willing, or qualified because of lawful, job-related reasons.

§ 655.167 Document retention requirements of H–2A employers.

(a) *Entities required to retain documents.* All employers must retain documents and records demonstrating compliance with this subpart.

(b) *Period of required retention.* Records and documents must be retained for a period of 3 years from the date of certification of the *Application for Temporary Employment Certification* or from the date of determination if the *Application for Temporary Employment Certification* is denied or withdrawn.

(c) *Documents and records to be retained by all employers.* All employers must retain:

(1) Proof of recruitment efforts, including:

(i) Job order placement as specified in § 655.121;

(ii) Contact with former U.S. workers as specified in § 655.153; and

(iii) Additional positive recruitment efforts as specified in § 655.154.

(2) Substantiation of information submitted in the recruitment report prepared in accordance with § 655.156, such as evidence of nonapplicability of contact of former employees as specified in § 655.153.

(3) The final recruitment report and any supporting resumes and contact information as specified in § 655.156(b).

(4) Proof of workers' compensation insurance or State law coverage as specified in § 655.122(e).

(5) Records of each worker's earnings as specified in § 655.122(j).

(6) The work contract or a copy of the *Application for Temporary Employment Certification* as defined in § 655.103(b) and specified in § 655.122(q).

(7) If applicable, records of notice to the NPC and to DHS of the abandonment of employment or termination for cause of a worker as set forth in § 655.122(n).

(8) Written contracts with agents or recruiters as specified in § 655.137(a) and the identities and locations of persons hired by or working for the agent or recruiter and the agents and employees of these agents and recruiters, as specified in § 655.137(b).

(9) The identity, location, and contact information of all persons who are

the owners of each employer, as specified in § 655.130(a)(2), and the identity, location, and contact information of all persons and entities who are the operators of the place of employment (if different than the employers) and of all persons who manage or supervise any H–2A worker sponsored under the *Application for Temporary Employment Certification* or any worker in corresponding employment, as specified in § 655.130(a)(3).

(10) If applicable, disciplinary records, including each step of progressive discipline, any evidence the worker presented in their defense, any investigation related to the termination, and any subsequent instruction afforded the worker.

(11) If applicable, records indicating the reason(s) for termination of any worker, including disciplinary records described in § 655.122(n)(4)(ii) and this section, relating to the termination as set forth in § 655.122(n).

(12) If applicable, evidence demonstrating the employer notified the SWA and each worker of an unforeseen minor delay in the start date of need, as specified in § 655.175(b)(2)(i).

(d) *Additional retention requirement for agricultural associations filing an Application for Temporary Employment Certification.* In addition to the documents specified in paragraph (c) of this section, associations must retain documentation substantiating their status as an employer or agent, as specified in § 655.131.

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34063, Apr. 29, 2024]

POST-CERTIFICATION

§ 655.170 Extensions.

An employer may apply for extensions of the period of employment in the following circumstances.

(a) *Short-term extension.* Employers seeking extensions of 2 weeks or less of the certified *Application for Temporary Employment Certification* must apply directly to DHS for approval. If granted, the *Application for Temporary Employment Certification* will be deemed extended for such period as is approved by DHS.

(b) *Long-term extension.* Employers seeking extensions of more than 2 weeks may apply to the CO. Such requests must be related to weather conditions or other factors beyond the control of the employer (which may include unforeseen changes in market conditions). Such requests must be supported in writing, with documentation showing that the extension is needed and that the need could not have been reasonably foreseen by the employer. The CO will notify the employer of the decision in writing if time allows, or will otherwise notify the employer of the decision. The CO will not grant an extension where the total work contract period under that *Application for Temporary Employment Certification* and extensions would last longer than 1 year, except in extraordinary circumstances. The employer may appeal a denial of a request for an extension by following the procedures in § 655.171.

(c) *Disclosure.* The employer must provide to the workers a copy of any approved extension in accordance with § 655.122(q), as soon as practicable.

§ 655.171 Appeals.

(a) *Request for review.* Where authorized in this subpart, an employer seeking review of a decision of the CO must request an administrative review or de novo hearing before an ALJ of that decision to exhaust its administrative remedies. In such cases, the request for review:

(1) Except as provided in § 655.181(b)(3), must be received by the Chief ALJ, and the CO who issued the decision, within 10 business days from the date of the CO's decision;

(2) Must clearly identify the particular decision for which review is sought;

(3) Must include a copy of the CO's decision;

(4) Must clearly state whether the employer is seeking administrative review or a de novo hearing. If the request does not clearly state the employer is seeking a de novo hearing, then the employer waives its right to a hearing, and the case will proceed as a request for administrative review;

(5) Must set forth the particular grounds for the request, including the specific factual issues the requesting party alleges needs to be examined in

connection with the CO's decision in question;

(6) May contain any legal argument that the employer believes will rebut the basis of the CO's action, including any briefing the employer wishes to submit where the request is for administrative review;

(7) May contain only such evidence as was actually before the CO at the time of the CO's decision, where the request is for administrative review; and

(8) May contain new evidence for the ALJ's consideration, where the request is for a de novo hearing, provided that the new evidence is introduced at the hearing.

(b) *Administrative file.* After the receipt of the request for review, the CO will send a copy of the OFLC administrative file to the Chief ALJ, the employer, the employer's attorney or agent (if applicable), and the Associate Solicitor for Employment and Training Legal Services, Office of the Solicitor, U.S. DOL (counsel), as soon as practicable by means normally assuring next-day delivery.

(c) *Assignment.* The Chief ALJ will immediately assign an ALJ to consider the particular case, which may be a single member or a three-member panel of the BALCA.

(d) *Administrative review*—(1) *Briefing schedule.* If the employer wishes to submit a brief on appeal, it must do so as part of its request for review. Within 7 business days of receipt of the OFLC administrative file, the counsel for the CO may submit a brief in support of the CO's decision and, if applicable, in response to the employer's brief.

(2) *Standard of review.* The ALJ must uphold the CO's decision unless shown by the employer to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(3) *Scope of review.* The ALJ will consider the documents in the OFLC administrative file that were before the CO at the time of the CO's decision and any written submissions from the parties or amici curiae that do not contain new evidence. The ALJ may not consider evidence not before the CO at the time of the CO's decision, even if such evidence is in the administrative file. After due consideration, the ALJ will affirm, reverse, or modify the CO's decision, or remand to the CO for further action, except in cases over which the Secretary has assumed jurisdiction pursuant to 29 CFR 18.95.

(4) *Decision.* The decision of the ALJ must specify the reasons for the action taken and must be immediately provided to the employer, the employer's attorney or agent (if applicable), the CO, and counsel for the CO within 7 business days of the submission of the CO's brief or 10 business days after receipt of the OFLC administrative file, whichever is later, using means normally assuring next-day delivery.

(e) *De novo hearing*—(1) *Conduct of hearing.* Where the employer has requested a de novo hearing the procedures in 29 CFR part 18 apply to such hearings, except that:

(i) The appeal will not be considered to be a complaint to which an answer is required;

(ii) The ALJ will ensure that the hearing is scheduled to take place within 14 business days after the ALJ's receipt of the OFLC administrative file, if the employer so requests, and will allow for the introduction of new evidence during the hearing as appropriate;

(iii) The ALJ may authorize discovery and the filing of pre-hearing motions, and so limit them to the types and quantities which in the ALJ's discretion will contribute to a fair hearing without unduly burdening the parties;

(iv) The ALJ's decision must be rendered within 10 calendar days after the hearing; and

(v) If the employer waives the right to a hearing, such as by asking for a decision on the record, or if the ALJ determines there are no disputed material facts to warrant a hearing, then the standard and scope of review for administrative review applies.

(2) *Standard and scope of review.* The ALJ will review the evidence presented during the hearing and the CO's decision de novo. The ALJ may determine that there are no issues of material fact, or only some issues of material fact, for which there is a genuine dispute, and may subsequently limit the hearing to only issues of material fact for which there is a genuine dispute. If

new evidence is submitted with a request for a de novo hearing, and the ALJ subsequently determines that a hearing is warranted, the new evidence provided with the request must be introduced at the hearing to be considered by the ALJ. After a de novo hearing, the ALJ must affirm, reverse, or modify the CO's decision, or remand to the CO for further action, except in cases over which the Secretary has assumed jurisdiction pursuant to 29 CFR 18.95.

(3) *Decision*. The decision of the ALJ must specify the reasons for the action taken and must be immediately provided to the employer, the employer's attorney or agent (if applicable), the CO, and counsel for the CO by means normally assuring next-day delivery.

§ 655.172 Post-certification withdrawals.

(a) The employer may withdraw an *Application for Temporary Employment Certification* and the related job order after the CO grants certification under § 655.160. However, the employer is still obligated to comply with the terms and conditions of employment contained in the *Application for Temporary Employment Certification* and job order with respect to all workers recruited in connection with that application and job order.

(b) To request withdrawal, the employer must submit a request in writing to the NPC identifying the certification and stating the reason(s) for the withdrawal.

§ 655.173 Setting meal charges; petition for higher meal charges.

(a) *Meal charges*. An employer may charge workers up to $14.00 per day for providing them with three meals. The maximum charge allowed by this paragraph (a) will be changed annually by the same percentage as the 12-month percentage change for the Consumer Price Index for all Urban Consumers for Food between December of the year just concluded and December of the year prior to that. The annual adjustments will be effective on the date of their publication by the OFLC Administrator in the FEDERAL REGISTER. When a charge or deduction for the cost of meals would bring the employee's wage below the minimum wage set by the FLSA at 29 U.S.C. 206, the charge or deduction must meet the requirements of the FLSA at 29 U.S.C. 203(m), including the recordkeeping requirements found at 29 CFR 516.27.

(b) *Petitions for higher meal charges*. The employer may file a petition with the CO to request approval to charge more than the applicable amount set under paragraph (a) of this section.

(1) *Filing a higher meal charge request*. To request approval to charge more than the applicable amount set under paragraph (a) of this section, the employer must submit the documentation required by either paragraph (b)(1)(i) or (ii) of this section. A higher meal charge request will be denied, in whole or in part, if the employer's documentation does not justify the higher meal charge requested.

(i) *Meals prepared directly by the employer*. Documentation submitted must include only the cost of goods and services directly related to the preparation and serving of meals, the number of workers fed, the number of meals served, and the number of days meals were provided. The cost of the following items may be included in the employer's charge to workers for providing prepared meals: food; kitchen supplies other than food, such as lunch bags and soap; labor costs that have a direct relation to food service operations, such as wages of cooks and dining hall supervisors; fuel, water, electricity, and other utilities used for the food service operation; and other costs directly related to the food service operation. Charges for transportation, depreciation, overhead, and similar charges may not be included. Receipts and other cost records for a representative pay period must be retained and must be available for inspection for a period of 3 years.

(ii) *Meals provided through a third party*. Documentation submitted must identify each third party that the employer will engage to prepare meals, describe how the employer will fulfill its obligation to provide three meals per day to workers through its agreement with the third party, and document the third party's charge(s) to the employer for the meals to be provided. Neither the third party's charge(s) to

the employer nor the employer's meal charge to workers may include a profit, kick back, or other direct or indirect benefit to the employer, a person affiliated with the employer, or to another person for the employer's benefit. Receipts and other cost records documenting payments made to the third party that prepared the meals and meal charge deductions from employee pay must be retained for the period provided in §655.167(b) and must be available for inspection by the CO and WHD during an investigation.

(2) *Effective date and scope of validity of a higher meal charge approval.* The employer may begin charging the higher rate upon receipt of approval from the CO, unless the CO sets a later effective date in the decision, and after disclosing to workers any change in the meal charge or deduction. A favorable decision from the CO is valid only for the meal provision arrangement documented under paragraph (b)(1) of this section and the approved higher meal charge amount. If the approved meal provision arrangement changes, the employer may charge no more than the maximum permitted under paragraph (a) of this section until a new petition for a higher meal charge based on the new arrangement is approved.

(3) *Appeal rights.* In the event the employer's petition for a higher meal charge is denied in whole or in part, the employer may appeal the denial. Appeals will be filed with the Chief ALJ, pursuant to §655.171.

§655.174 Public disclosure.

The Department will maintain an electronic file accessible to the public with information on all employers applying for temporary agricultural labor certifications. The database will include such information as the number of workers requested, the date filed, the date decided, and the final disposition.

§655.175 Post-certification changes to applications for temporary employment certification.

(a) *No post-certification changes.* The *Application for Temporary Employment Certification* may not be changed after certification, except where authorized in this subpart. The employer is obligated to comply with the terms and conditions of employment contained in the *Application for Temporary Employment Certification* and job order with respect to all workers recruited in connection with its certification.

(b) *Post-certification changes to the first date of work.* Where the work under the approved *Application for Temporary Employment Certification* will not begin on the first date of need certified and will be delayed for a period of no more than 14 calendar days, due to circumstances that could not have been foreseen, and the crops or commodities will be in jeopardy prior to the expiration of an additional recruitment period, the employer need not withdraw an approved *Application for Temporary Employment Certification,* provided the employer complies with the obligations at paragraphs (b)(1) and (2) of this section.

(1) In the event of a delay, the employer must provide to all workers who are already traveling to the place of employment, upon their arrival and without cost to the workers until work commences, daily subsistence in the same amount required during travel under §655.122(h)(1), except for days for which the worker receives compensation under paragraph (b)(2)(ii) of this section. The employer must fulfill this subsistence obligation to the worker no later than the first date the worker would have been paid had they begun employment on time. Employers must comply with all other requirements of the certified *Application for Temporary Employment Certification* beginning on the first date of need certified, including but not limited to housing under §655.122(d).

(2)(i) In the event of a delay, the employer must notify the SWA and each worker to be employed under the job order associated with the approved *Application for Temporary Employment Certification* of the delay at least 10 business days before the certified start date of need. The employer must notify the worker in writing, in a language understood by the worker, as necessary or reasonable, using the contact information the worker provided to the employer. If the worker provides electronic contact information, such as an email address or telephone number, the

employer must send notice using that email address and telephone number. The employer may provide telephonic notice, provided the employer also sends written notice using the email or postal address provided by the worker. The employer must retain evidence of such notification under § 655.167(c)(12).

(ii) If the employer fails to provide timely notification required under paragraph (b)(2)(i) of this section to any worker(s), the employer must pay such worker(s) the highest of the hourly rates of pay at § 655.120(a), or, if applicable, the rate required under § 655.211(a)(1), for each hour of the offered work schedule in the job order, for each day that work is delayed, for a period up to 14 calendar days. The employer must fulfill this obligation to the worker no later than the first date the worker would have been paid had they begun employment on time.

(iii) For purposes of an employer's compliance with the three-fourths guarantee under § 655.122(i), any compensation paid to a worker under paragraph (b)(2)(ii) of this section for any workday included within the time period described in § 655.122(i) will be considered hours offered to the worker.

[89 FR 34064, Apr. 29, 2024]

INTEGRITY MEASURES

§ 655.180 Audit.

The CO may conduct audits of applications for which certifications have been granted.

(a) *Discretion.* The CO has the sole discretion to choose the certified applications selected for audit.

(b) *Audit letter.* Where an application is selected for audit, the CO will issue an audit letter to the employer and a copy, if appropriate, to the employer's agent or attorney. The audit letter will:

(1) Specify the documentation that must be submitted by the employer;

(2) Specify a date, no more than 30 calendar days from the date the audit letter is issued, by which the required documentation must be sent to the CO; and

(3) Advise that failure to fully comply with the audit process may result in the revocation of the certification or program debarment.

(c) *Supplemental information request.* During the course of the audit examination, the CO may request supplemental information and/or documentation from the employer in order to complete the audit. If circumstances warrant, the CO can issue one or more requests for supplemental information.

(d) *Potential referrals.* In addition to measures in this subpart, the CO may decide to provide the audit findings and underlying documentation to DHS, WHD, or other appropriate enforcement agencies. The CO may refer any findings that an employer discouraged an eligible U.S. worker from applying, or failed to hire, discharged, or otherwise discriminated against an eligible U.S. worker, to the Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section.

§ 655.181 Revocation.

(a) *Basis for DOL revocation.* The OFLC Administrator may revoke a temporary agricultural labor certification approved under this subpart, if the OFLC Administrator finds:

(1) The issuance of the temporary agricultural labor certification was not justified due to fraud or misrepresentation in the application process, including because the certification was issued in error to a debarred employer, including a successor in interest, during the period of debarment as set forth in § 655.182(c)(2);

(2) The employer substantially violated a material term or condition of the approved temporary agricultural labor certification, as defined in § 655.182;

(3) The employer failed to cooperate with a DOL investigation or with a DOL official performing an investigation, inspection, audit (as discussed in § 655.180), or law enforcement function under 8 U.S.C. 1188, 29 CFR part 501, or this subpart; or

(4) The employer failed to comply with one or more sanctions or remedies imposed by WHD, or with one or more decisions or orders of the Secretary or a court order secured by the Secretary under 8 U.S.C. 1188, 29 CFR part 501, or this subpart.

(b) *DOL procedures for revocation*—(1) *Notice of Revocation.* If the OFLC Administrator makes a determination to

revoke an employer's temporary agricultural labor certification, the OFLC Administrator will send to the employer (and its attorney or agent) a Notice of Revocation. The Notice will contain a detailed statement of the grounds for the revocation, and it will inform the employer of its right to submit rebuttal evidence or to appeal as provided in this paragraph (b)(1) and in paragraph (b)(3) of this section. If the employer does not file rebuttal evidence or an appeal within 14 calendar days of the date of the Notice of Revocation, the Notice is the final agency action and will take effect immediately at the end of the 14-day period.

(2) *Rebuttal.* The employer may submit evidence to rebut the grounds stated in the Notice of Revocation within 14 calendar days of the date the Notice is issued. If rebuttal evidence is timely filed by the employer, the OFLC Administrator will inform the employer of the OFLC Administrator's final determination on the revocation within 14 calendar days of receiving the rebuttal evidence. If the OFLC Administrator determines that the certification should be revoked, the OFLC Administrator will inform the employer of its right to appeal as provided in this paragraph (b)(2) and in paragraph (b)(3) of this section. If the employer does not appeal the OFLC Administrator's final determination within 10 calendar days, it will become the final agency action.

(3) *Appeal.* An employer may appeal a Notice of Revocation, or a final determination of the OFLC Administrator after the review of rebuttal evidence, according to the appeal procedures of § 655.171. In such cases, the appeal must be received by the Chief ALJ, and the OFLC Administrator, within the time periods established in paragraphs (b)(1) and (2) of this section.

(4) *Stay.* The timely filing of rebuttal evidence or an administrative appeal will stay the revocation pending the outcome of those proceedings.

(5) *Decision.* If the temporary agricultural labor certification is revoked, the OFLC Administrator will send a copy of the final agency action to DHS and the Department of State (DOS).

(c) *Employer's obligations in the event of revocation.* If an employer's temporary agricultural labor certification is revoked, the employer is responsible for:

(1) Reimbursement of actual inbound transportation and subsistence expenses, as if the worker meets the requirements for payment under § 655.122(h)(1);

(2) The worker's outbound transportation and subsistence expenses, as if the worker meets the requirements for payment under § 655.122(h)(2);

(3) Payment to the worker of the amount due under the three-fourths guarantee as required by § 655.122(i); and

(4) Any other wages, benefits, and working conditions due or owing to the worker under this subpart.

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34064, Apr. 29, 2024]

§ 655.182 Debarment.

(a) *Debarment of an employer, agent, or attorney.* The OFLC Administrator may debar an employer, agent, or attorney from participating in any action under 8 U.S.C. 1188, this subpart, or 29 CFR part 501 subject to the time limits set forth in paragraph (c) of this section, if the OFLC Administrator finds that the employer, agent, or attorney substantially violated a material term or condition of the temporary agricultural labor certification, with respect to H–2A workers; workers in corresponding employment; or U.S. workers improperly rejected for employment, or improperly laid off or displaced.

(b) *Effect on future applications.* (1) No application for H–2A workers may be filed by or on behalf of a debarred employer, or by an employer represented by a debarred agent or attorney, subject to the term limits set forth in paragraph (c)(2) of this section. If such an application is filed, it will be denied without review.

(2) No application for H–2A workers may be filed by or on behalf of a successor in interest to a debarred employer, agent, or attorney, subject to the term limits set forth in paragraph (c)(2) of this section. If the CO determines that such an application is filed, the CO will issue a NOD pursuant to § 655.141 or deny the application pursuant to § 655.164, as appropriate depending upon the status of the *Application*

for Temporary Employment Certification, solely on the basis that the entity is a successor in interest to a debarred employer, agent, or attorney. The employer, agent, or attorney may appeal its status as a successor in interest to the debarred entity, pursuant to the procedures for appeals of CO determinations at § 655.171.

(c) *Statute of limitations and period of debarment.* (1) The OFLC Administrator must issue any Notice of Debarment not later than 2 years after the occurrence of the violation.

(2) No employer, agent, or attorney may be debarred under this subpart for more than 3 years from the date of the final agency decision.

(d) *Definition of violation.* For the purposes of this section, a violation includes:

(1) One or more acts of commission or omission on the part of the employer or the employer's agent which involve:

(i) Failure to pay or provide the required wages, benefits, or working conditions to the employer's H–2A workers and/or workers in corresponding employment;

(ii) Failure, except for lawful, job-related reasons, to offer employment to qualified U.S. workers who applied for the job opportunity for which certification was sought;

(iii) Failure to comply with the employer's obligations to recruit U.S. workers;

(iv) Improper layoff or displacement of U.S. workers or workers in corresponding employment;

(v) Failure to comply with one or more sanctions or remedies imposed by the WHD Administrator for violation(s) of contractual or other H–2A obligations, or with one or more decisions or orders of the Secretary or a court under 8 U.S.C. 1188, 29 CFR part 501, or this subpart;

(vi) Impeding an investigation of an employer under 8 U.S.C. 1188 or 29 CFR part 501, or an audit under § 655.180;

(vii) Employing an H–2A worker outside the area of intended employment, in an activity/activities not listed in the job order or outside the validity period of employment of the job order, including any approved extension thereof;

(viii) A violation of the requirements of § 655.135(j), (k), or (o);

(ix) A violation of any of the provisions listed in 29 CFR 501.4(a); or

(x) A single heinous act showing such flagrant disregard for the law that future compliance with program requirements cannot reasonably be expected;

(2) The employer's failure to pay a necessary certification fee in a timely manner;

(3) The H–2ALC's failure to submit an original surety bond meeting the requirements of § 655.132(c) within 30 days of the date the temporary agricultural labor certification was issued or failure to submit additional surety within 30 days of a finding under 20 CFR 501.9(a) that the face value of the bond is insufficient;

(4) Fraud involving the *Application for Temporary Employment Certification;* or

(5) A material misrepresentation of fact during the application process.

(e) *Determining whether a violation is substantial.* In determining whether a violation is so substantial as to merit debarment, the factors the OFLC Administrator may consider include, but are not limited to, the following:

(1) Previous history of violation(s) of 8 U.S.C. 1188, 29 CFR part 501, or this subpart;

(2) The number of H–2A workers, workers in corresponding employment, or U.S. workers who were and/or are affected by the violation(s);

(3) The gravity of the violation(s);

(4) Efforts made in good faith to comply with 8 U.S.C. 1188, 29 CFR part 501, and this subpart;

(5) Explanation from the person charged with the violation(s);

(6) Commitment to future compliance, taking into account the public health, interest, or safety, and whether the person has previously violated 8 U.S.C. 1188; and

(7) The extent to which the violator achieved a financial gain due to the violation(s), or the potential financial loss or potential injury to the worker(s).

(f) *Debarment procedure*—(1) *Notice of Debarment.* If the OFLC Administrator makes a determination to debar an employer, agent, or attorney, the OFLC Administrator will send the party a Notice of Debarment. The Notice will

state the reason for the debarment finding, including a detailed explanation of the grounds for and the duration of the debarment, and it will inform the party subject to the Notice of its right to submit rebuttal evidence or to request a debarment hearing. If the party does not file rebuttal evidence or request a hearing within 30 calendar days of the date of the Notice of Debarment, the Notice will be the final agency action and the debarment will take effect at the end of the 30-day period.

(2) *Rebuttal.* The party who received the Notice of Debarment may choose to submit evidence to rebut the grounds stated in the Notice within 30 calendar days of the date the Notice is issued. If rebuttal evidence is timely filed, the OFLC Administrator will issue a final determination on the debarment within 30 calendar days of receiving the rebuttal evidence. If the OFLC Administrator determines that the party should be debarred, the OFLC Administrator will inform the party of its right to request a debarment hearing according to the procedures of paragraph (f)(3) of this section. The party must request a hearing within 30 calendar days after the date of the OFLC Administrator's final determination, or the OFLC Administrator's determination will be the final agency action and the debarment will take effect at the end of the 30-calendar-day period.

(3) *Hearing.* The recipient of a Notice of Debarment may request a debarment hearing within 30 calendar days of the date of a Notice of Debarment or the date of a final determination of the OFLC Administrator after review of rebuttal evidence submitted pursuant to paragraph (f)(2) of this section. To obtain a debarment hearing, the debarred party must, within 30 calendar days of the date of the Notice or the final determination, file a written request to the Chief Administrative Law Judge, United States Department of Labor, 800 K Street NW, Suite 400–N, Washington, DC 20001–8002, and simultaneously serve a copy to the OFLC Administrator. The debarment will take effect 30 calendar days from the date the Notice of Debarment or final determination is issued, unless a request for review is properly filed within 30 calendar days from the issuance of the Notice of Debarment or final determination. The timely filing of a request for a hearing stays the debarment pending the outcome of the hearing. Within 10 calendar days of receipt of the request for a hearing, the OFLC Administrator will send a certified copy of the ETA case file to the Chief ALJ by means normally assuring next day delivery. The Chief ALJ will immediately assign an ALJ to conduct the hearing. The procedures in 29 CFR part 18 apply to such hearings, except that the request for a hearing will not be considered to be a complaint to which an answer is required.

(4) *Decision.* After the hearing, the ALJ must affirm, reverse, or modify the OFLC Administrator's determination. The ALJ will prepare the decision within 60 calendar days after completion of the hearing and closing of the record. The ALJ's decision will be provided immediately to the parties to the debarment hearing by means normally assuring next day delivery. The ALJ's decision is the final agency action, unless either party, within 30 calendar days of the ALJ's decision, seeks review of the decision with the Administrative Review Board (ARB).

(5) *Review by the ARB.* (i) Any party wishing review of the decision of an ALJ must, within 30 calendar days of the decision of the ALJ, petition the ARB to review the decision. Copies of the petition must be served on all parties and on the ALJ. The ARB will decide whether to accept the petition within 30 calendar days of receipt. If the ARB declines to accept the petition, or if the ARB does not issue a notice accepting a petition within 30 calendar days after the receipt of a timely filing of the petition, the decision of the ALJ will be deemed the final agency action. If a petition for review is accepted, the decision of the ALJ will be stayed unless and until the ARB issues an order affirming the decision. The ARB must serve notice of its decision to accept or not to accept the petition upon the ALJ and upon all parties to the proceeding.

(ii) Upon receipt of the ARB's notice to accept the petition, the Office of Administrative Law Judges will promptly forward a copy of the complete hearing record to the ARB.

(iii) Where the ARB has determined to review such decision and order, the ARB will notify each party of the issue(s) raised, the form in which submissions must be made (e.g., briefs or oral argument), and the time within which such presentation must be submitted.

(6) *ARB decision.* The ARB's decision must be issued within 90 calendar days from the notice granting the petition and served upon all parties and the ALJ. If the ARB fails to issue a decision within 90 calendar days from the notice granting the petition, the ALJ's decision will be the final agency decision.

(g) *Concurrent debarment jurisdiction.* OFLC and WHD have concurrent jurisdiction to impose a debarment remedy under this section or under 29 CFR 501.20. When considering debarment, OFLC and WHD may inform one another and may coordinate their activities. A specific violation for which debarment is imposed will be cited in a single debarment proceeding. Copies of final debarment decisions will be forwarded to DHS promptly.

(h) *Debarment of associations, employer-members of associations, and joint employers.* If the OFLC Administrator determines that an individual employer-member of an agricultural association, or a joint employer under § 655.131(b), has committed a substantial violation, the debarment determination will apply only to that employer-member unless the OFLC Administrator determines that the agricultural association or another agricultural association member or joint employer under § 655.131(b), participated in the violation, in which case the debarment will be invoked against the agricultural association or other complicit agricultural association member(s) or joint employer(s) under § 655.131(b), as well.

(i) *Debarment involving agricultural associations acting as joint employers.* If the OFLC Administrator determines that an agricultural association acting as a joint employer with its employer-members has committed a substantial violation, the debarment determination will apply only to the agricultural association, and will not be applied to any individual employer-member of the agricultural association. However, if the OFLC Administrator determines that the employer-member participated in, had knowledge of, or had reason to know of the violation, the debarment may be invoked against the complicit agricultural association member as well. An agricultural association debarred from the H–2A temporary labor certification program will not be permitted to continue to file as a joint employer with its employer-members during the period of the debarment.

(j) *Debarment involving agricultural associations acting as sole employers.* If the OFLC Administrator determines that an agricultural association acting as a sole employer has committed a substantial violation, the debarment determination will apply only to the agricultural association and any successor in interest to the debarred agricultural association.

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34064, Apr. 29, 2024]

§ 655.183 Less than substantial violations.

(a) *Requirement of special procedures.* If the OFLC Administrator determines that a less than substantial violation has occurred but has reason to believe that past actions on the part of the employer (or agent or attorney) may have had and may continue to have a chilling or otherwise negative effect on the recruitment, employment, and retention of U.S. workers, the OFLC Administrator may require the employer to conform to special procedures before and after the temporary agricultural labor certification determination. These special procedures may include special on-site positive recruitment and streamlined interviewing and referral techniques. The special procedures are designed to enhance U.S. worker recruitment and retention in the next year as a condition for receiving a temporary agricultural labor certification. Such requirements will be reasonable; will not require the employer to offer better wages, working conditions, and benefits than those specified in § 655.122; and will be no more than deemed necessary to assure employer compliance with the test of

U.S. worker availability and adverse effect criteria of this subpart.

(b) *Notification of required special procedures.* The OFLC Administrator will notify the employer (or agent or attorney) in writing of the special procedures that will be required in the coming year. The notification will state the reasons for the imposition of the requirements, state that the employer's agreement to accept the conditions will constitute inclusion of them as bona fide conditions and terms of a temporary agricultural labor certification, and will offer the employer an opportunity to request an administrative review or a de novo hearing before an ALJ. If an administrative review or de novo hearing is requested, the procedures prescribed in § 655.171 will apply.

(c) *Failure to comply with special procedures.* If the OFLC Administrator determines that the employer has failed to comply with special procedures required pursuant to paragraph (a) of this section, the OFLC Administrator will send a written notice to the employer, stating that the employer's otherwise affirmative H–2A certification determination will be reduced by 25 percent of the total number of H–2A workers requested (which cannot be more than those requested in the previous year) for a period of 1 year. Notice of such a reduction in the number of workers requested will be conveyed to the employer by the OFLC Administrator in a written temporary agricultural labor certification determination. The notice will offer the employer an opportunity to request administrative review or a de novo hearing before an ALJ. If administrative review or a de novo hearing is requested, the procedures prescribed in § 655.171 will apply, provided that if the ALJ affirms the OFLC Administrator's determination that the employer has failed to comply with special procedures required by paragraph (a) of this section, the reduction in the number of workers requested will be 25 percent of the total number of H–2A workers requested (which cannot be more than those requested in the previous year) for a period of 1 year.

§ 655.184 Applications involving fraud or willful misrepresentation.

(a) *Referral for investigation.* If the CO discovers possible fraud or willful misrepresentation involving an *Application for Temporary Employment Certification*, the CO may refer the matter to DHS and the Department's Office of the Inspector General for investigation.

(b) *Sanctions.* If WHD, a court, or DHS determines that there was fraud or willful misrepresentation involving an *Application for Temporary Employment Certification* and certification has been granted, a finding under this paragraph (b) will be cause to revoke the certification. The finding of fraud or willful misrepresentation may also constitute a debarrable violation under § 655.182.

§ 655.185 Job service complaint system; enforcement of work contracts.

(a) *Filing with DOL.* Complaints arising under this subpart must be filed through the Job Service Complaint System, as described in 20 CFR part 658, subpart E. Complaints involving allegations of fraud or misrepresentation must be referred by the SWA to the CO for appropriate handling and resolution. Complaints that involve work contracts must be referred by the SWA to WHD for appropriate handling and resolution, as described in 29 CFR part 501. As part of this process, WHD may report the results of its investigation to the OFLC Administrator for consideration of employer penalties or such other action as may be appropriate.

(b) *Filing with the Department of Justice.* Complaints alleging that an employer discouraged an eligible U.S. worker from applying, failed to hire, discharged, or otherwise discriminated against an eligible U.S. worker, or discovered violations involving the same, will be referred to the U.S. Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section, in addition to any activity, investigation, and/or enforcement action taken by ETA or a SWA. Likewise, if the Immigrant and Employee Rights Section becomes aware of a violation of the regulations in this subpart, it may provide such information to the appropriate SWA and the CO.

§ 655.190 Severability.

If any provision of this subpart is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, the provision will be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding is one of total invalidity or unenforceability, in which event the provision will be severable from this part and shall not affect the remainder thereof.

[89 FR 34065, Apr. 29, 2024]

Labor Certification Process for Temporary Agricultural Employment in Range Sheep Herding, Goat Herding, and Production of Livestock Occupations

§ 655.200 Scope and purpose of herding and range livestock regulations in this section and §§ 655.201 through 655.235.

(a) *Purpose.* The purpose of this section and §§ 655.201 through 655.235 is to establish certain procedures for employers who apply to the Department to obtain labor certifications to hire temporary agricultural foreign workers to perform herding or production of livestock on the range, as defined in § 655.201. Unless otherwise specified in this section and §§ 655.201 through 655.235, employers whose job opportunities meet the qualifying criteria under this section and §§ 655.201 through 655.235 must fully comply with all of the requirements of §§ 655.100 through 655.185; part 653, subparts B and F, of this chapter; and part 654 of this chapter.

(b) *Jobs subject to this section and §§ 655.201 through 655.235.* The procedures in this section and §§ 655.201 through 655.235 apply to job opportunities with the following unique characteristics:

(1) The work activities involve the herding or production of livestock (which includes work that is closely and directly related to herding and/or the production of livestock), as defined under § 655.201;

(2) The work is performed on the range for the majority (meaning more than 50 percent) of the workdays in the work contract period. Any additional work performed at a place other than the range must constitute the production of livestock (which includes work that is closely and directly related to herding and/or the production of livestock); and

(3) The work activities generally require the workers to be on call 24 hours per day, 7 days a week.

§ 655.201 Definition of herding and range livestock terms.

The following are terms that are not defined in §§ 655.100 through 655.185 and are specific to applications for labor certifications involving the herding or production of livestock on the range.

Herding. Activities associated with the caring, controlling, feeding, gathering, moving, tending, and sorting of livestock on the range.

Livestock. An animal species or species group such as sheep, cattle, goats, horses, or other domestic hooved animals. In the context of §§ 655.200 through 655.235, livestock refers to those species raised on the range.

Production of livestock. The care or husbandry of livestock throughout one or more seasons during the year, including guarding and protecting livestock from predatory animals and poisonous plants; feeding, fattening, and watering livestock; examining livestock to detect diseases, illnesses, or other injuries; administering medical care to sick or injured livestock; applying vaccinations and spraying insecticides on the range; and assisting with the breeding, birthing, raising, weaning, castration, branding, and general care of livestock. This term also includes duties performed off the range that are closely and directly related to herding and/or the production of livestock. The following are non-exclusive examples of ranch work that is closely and directly related: repairing fences used to contain the herd; assembling lambing jugs; cleaning out lambing jugs; feeding and caring for the dogs that the workers use on the range to assist with herding or guarding the flock; feeding and caring for the horses that the workers use on the range to help with herding or to move the sheep camps and supplies; and loading animals into livestock trucks for movement to the range or to market. The

following are examples of ranch work that is not closely and directly related: working at feedlots; planting, irrigating and harvesting crops; operating or repairing heavy equipment; constructing wells or dams; digging irrigation ditches; applying weed control; cutting trees or chopping wood; constructing or repairing the bunkhouse or other ranch buildings; and delivering supplies from the ranch to the herders on the range.

Range. The range is any area located away from the ranch headquarters used by the employer. The following factors are indicative of the range: it involves land that is uncultivated; it involves wide expanses of land, such as thousands of acres; it is located in a remote, isolated area; and typically range housing is required so that the herder can be in constant attendance to the herd. No one factor is controlling, and the totality of the circumstances is considered in determining what should be considered range. The range does not include feedlots, corrals, or any area where the stock involved would be near ranch headquarters. Ranch headquarters, which is a place where the business of the ranch occurs and is often where the owner resides, is limited and does not embrace large acreage; it only includes the ranchhouse, barns, sheds, pen, bunkhouse, cookhouse, and other buildings in the vicinity. The range also does not include any area where a herder is not required to be available constantly to attend to the livestock and to perform tasks, including but not limited to, ensuring the livestock do not stray, protecting them from predators, and monitoring their health.

Range housing. Range housing is housing located on the range that meets the standards articulated under § 655.235.

§ 655.205 Herding and range livestock job orders.

An employer whose job opportunity has been determined to qualify for the procedures in §§ 655.200 through 655.235 is not required to comply with the job order filing timeframe requirements in § 655.121(a) and (b) or the job order review process in § 655.121(e) and (f). Rather, the employer must submit the job order along with a completed *Application for Temporary Employment Certification*, as required in § 655.215, to the designated NPC for the NPC's review.

§ 655.210 Contents of herding and range livestock job orders.

(a) *Content of job offers.* Unless otherwise specified in §§ 655.200 through 655.235, the employer must satisfy the requirements for job orders established under § 655.121 and for the content of job offers established under part 653, subpart F, of this chapter and § 655.122.

(b) *Job qualifications and requirements.* The job offer must include a statement that the workers are on call for up to 24 hours per day, 7 days per week and that the workers spend the majority (meaning more than 50 percent) of the workdays during the contract period in the herding or production of livestock on the range. Duties may include activities performed off the range only if such duties constitute the production of livestock (which includes work that is closely and directly related to herding and/or the production of livestock). All such duties must be specifically disclosed on the job order. The job offer may also specify that applicants must possess up to 6 months of experience in similar occupations involving the herding or production of livestock on the range and require reference(s) for the employer to verify applicant experience. An employer may specify other appropriate job qualifications and requirements for its job opportunity. Job offers may not impose on U.S. workers any restrictions or obligations that will not be imposed on the employer's H–2A workers engaged in herding or the production of livestock on the range. Any such requirements must be applied equally to both U.S. and foreign workers. Each job qualification and requirement listed in the job offer must be bona fide, and the CO may require the employer to submit documentation to substantiate the appropriateness of any other job qualifications and requirements specified in the job offer.

(c) *Range housing.* The employer must specify in the job order that range housing will be provided. The range housing must meet the requirements set forth in § 655.235.

(d) *Employer-provided items.* (1) The employer must provide to the worker, without charge or deposit charge, all tools, supplies, and equipment required by law, by the employer, or by the nature of the work to perform the duties assigned in the job offer safely and effectively. The employer must specify in the job order which items it will provide to the worker.

(2) Because of the unique nature of the herding or production of livestock on the range, this equipment must include effective means of communicating with persons capable of responding to the worker's needs in case of an emergency including, but not limited to, satellite phones, cell phones, wireless devices, radio transmitters, or other types of electronic communication systems. The employer must specify in the job order:

(i) The type(s) of electronic communication device(s) and that such device(s) will be provided without charge or deposit charge to the worker during the entire period of employment; and

(ii) If there are periods of time when the workers are stationed in locations where electronic communication devices may not operate effectively, the employer must specify in the job order, the means and frequency with which the employer plans to make contact with the workers to monitor the worker's well-being. This contact must include either arrangements for the workers to be located, on a regular basis, in geographic areas where the electronic communication devices operate effectively, or arrangements for regular, pre-scheduled, in-person visits between the workers and the employer, which may include visits between the workers and other persons designated by the employer to resupply the workers' camp.

(e) *Meals.* The employer must specify in the job offer and provide to the worker, without charge or deposit charge:

(1) Either three sufficient meals a day, or free and convenient cooking facilities and adequate provision of food to enable the worker to prepare their own meals. To be sufficient or adequate, the meals or food provided must include a daily source of protein, vitamins, and minerals; and

(2) Adequate potable water, or water that can be easily rendered potable and the means to do so. Standards governing the provision of water to range workers are also addressed in § 655.235(e).

(f) *Hours and earnings statements.* (1) The employer must keep accurate and adequate records with respect to the worker's earnings and furnish to the worker on or before each payday a statement of earnings. The employer is exempt from recording the hours actually worked each day, the time the worker begins and ends each workday, as well as the nature and amount of work performed, but all other regulatory requirements in § 655.122(j) and (k) apply.

(2) The employer must keep daily records indicating whether the site of the employee's work was on the range or off the range. If the employer prorates a worker's wage pursuant to paragraph (g)(2) of this section because of the worker's voluntary absence for personal reasons, it must also keep a record of the reason for the worker's absence.

(g) *Rates of pay.* (1) The employer must offer, advertise in its recruitment, and pay a wage that is at least the highest of the following rates in effect at the time work is performed, whichever is highest, for every month of the job order period or portion thereof:

(i) The monthly AEWR, as specified in § 655.211;

(ii) The agreed-upon collective bargaining wage;

(iii) The applicable minimum wage imposed by Federal or State law or judicial action; or

(iv) Any other wage rate the employer intends to pay.

(2) The offered wage shall not be based on commissions, bonuses, or other incentives, unless the employer guarantees a wage that equals or exceeds the monthly AEWR, the agreed-upon collective bargaining wage, the applicable minimum wage imposed by Federal or State law or judicial action, any agreed-upon collective bargaining rate, or any other wage rate the employer intends to pay, whichever is highest, and must be paid to each

worker free and clear without any unauthorized deductions.

(3) The employer may prorate the wage for the initial and final pay periods of the job order period if its pay period does not match the beginning or ending dates of the job order. The employer also may prorate the wage if a worker is voluntarily unavailable to work for personal reasons.

(4) If applicable, the employer must state in the job order:

(i) That overtime hours may be available;

(ii) The wage rate(s) to be paid for any such overtime hours;

(iii) The circumstances under which the wage rate(s) for overtime hours will be paid, including, but not limited to, after how many hours in a day or workweek the overtime wage rate will be paid, and whether overtime wage rates will vary between-place(s) of employment; and

(iv) Where the overtime pay is required by law, the applicable Federal, State, or local law requiring the overtime pay.

(h) *Frequency of pay.* The employer must state in the job offer the frequency with which the worker will be paid, which must be at least twice monthly. Employers must pay wages when due.

[87 FR 61791, Oct. 12, 2022, as amended at 89 FR 34065, Apr. 29, 2024]

§ 655.211 Herding and range livestock wage rate.

(a) *Compliance with rates of pay.* (1) To comply with its obligation under § 655.210(g), an employer must offer, advertise in its recruitment, and pay each worker employed under §§ 655.200 through 655.235 a wage that is at least the highest of the monthly AEWR established under this section, the agreed-upon collective bargaining wage, the applicable minimum wage imposed by Federal or State law or judicial action, or any other wage rate the employer intends to pay. The employer must list all potentially applicable wage rates in the job order and must offer and advertise all of these wage rates in its recruitment.

(2) If the monthly AEWR established under this section is adjusted during a work contract, and is higher than the agreed-upon collective bargaining wage, the applicable minimum wage imposed by Federal or State law or judicial action in effect at the time the work is performed, and any other wage rate the employer offered to pay, the employer must pay at least that adjusted monthly AEWR upon the effective date of the updated monthly AEWR published by the Department in the FEDERAL REGISTER.

(b) *Publication of the monthly AEWR.* The OFLC Administrator will publish, at least once in each calendar year, on a date to be determined by the OFLC Administrator, an update to the monthly AEWR as a document in the FEDERAL REGISTER.

(c) *Monthly AEWR rate.* (1) The monthly AEWR shall be $7.25 multiplied by 48 hours, and then multiplied by 4.333 weeks per month; and

(2) Beginning for calendar year 2017, the monthly AEWR shall be adjusted annually based on the Employment Cost Index (ECI) for wages and salaries published by the Bureau of Labor Statistics (BLS) for the preceding October-October period.

(d) *Transition rates.* (1) For the period from November 16, 2015, through calendar year 2016, the Department shall set the monthly AEWR at 80 percent of the result of the formula in paragraph (c) of this section.

(2) For calendar year 2017, the Department shall set the monthly AEWR at 90 percent of the result of the formula in paragraph (c) of this section.

(3) For calendar year 2018 and beyond, the Department shall set the monthly AEWR at 100 percent of the result of the formula in paragraph (c) of this section.

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§ 655.215 Procedures for filing herding and range livestock *Applications for Temporary Employment Certification.*

(a) *Compliance with §§ 655.130 through 655.132.* Unless otherwise specified in §§ 655.200 through 655.235, the employer must satisfy the requirements for filing an *Application for Temporary Employment Certification* with the NPC designated by the OFLC Administrator as

required under §§ 655.130 through 655.132.

(b) *What to file.* An employer must file a completed *Application for Temporary Employment Certification* and job order.

(1) The *Application for Temporary Employment Certification* and job order may cover multiple areas of intended employment in one or more contiguous States.

(2) An agricultural association filing as a joint employer may submit a single job order and master *Application for Temporary Employment Certification* on behalf of its employer-members located in more than two contiguous States with different first dates of need. Unless modifications to a sheep or goat herding or production of livestock job order are required by the CO or requested by the employer, pursuant to § 655.121(h), the agricultural association is not required to re-submit the job order during the calendar year with its *Application for Temporary Employment Certification*.

§ 655.220 Processing herding and range livestock *Applications for Temporary Employment Certification.*

(a) *NPC review.* Unless otherwise specified in §§ 655.200 through 655.235, the CO will review and process the *Application for Temporary Employment Certification* and job order in accordance with the requirements outlined in §§ 655.140 through 655.145, and will work with the employer to address any deficiencies in the job order in a manner consistent with §§ 655.140 through 655.141.

(b) *Notice of acceptance.* Once the job order is determined to meet all regulatory requirements, the NPC will issue a NOA consistent with § 655.143(b), provide notice to the employer authorizing conditional access to the interstate clearance system, and transmit an electronic copy of the approved job order to each SWA with jurisdiction over the anticipated place(s) of employment. The CO will direct the SWA to place the job order promptly in clearance and commence recruitment of U.S. workers. Where an agricultural association files as a joint employer and submits a single job order on behalf of its employer-members, the CO will transmit a copy of the job order to the SWA having jurisdiction over the location of the agricultural association, those SWAs having jurisdiction over other States where the work will take place, and to the SWAs in all States designated under § 655.154(d), directing each SWA to place the job order in intrastate clearance and commence recruitment of U.S. workers.

(c) *Electronic job registry.* Under § 655.144(b), where a single job order is approved for an agricultural association filing as a joint employer on behalf of its employer-members with different first dates of need, the Department will keep the job order posted on the OFLC electronic job registry until the end of the recruitment period, as set forth in § 655.135(d), has elapsed for all employer-members identified on the job order.

§ 655.225 Post-acceptance requirements for herding and range livestock.

(a) Unless otherwise specified in this section, the requirements for recruiting U.S. workers by the employer and SWA must be satisfied, as specified in §§ 655.150 through 655.158.

(b) Pursuant to § 655.150(b), where a single job order is approved for an agricultural association filing as a joint employer on behalf of its employer-members with different first dates of need, each of the SWAs to which the job order was transmitted by the CO or the SWA having jurisdiction over the location of the agricultural association must keep the job order on its active file the end of the recruitment period, as set forth in § 655.135(d), has elapsed for all employer-members identified on the job order, and must refer to the agricultural association each qualified U.S. worker who applies (or on whose behalf an application is made) for the job opportunity.

(c) Any eligible U.S. worker who applies (or on whose behalf an application is made) for the job opportunity and is hired will be placed at the location nearest to them absent a request for a different location by the U.S. worker. Employers must make reasonable efforts to accommodate such placement requests by the U.S. worker.

(d) An agricultural association that fulfills the recruitment requirements for its employer-members is required to maintain a written recruitment report containing the information required by § 655.156 for each individual employer-member identified in the application or job order, including any approved modifications.

§ 655.230 Range housing.

(a) Housing for work performed on the range must meet the minimum standards contained in §§ 655.235 and 655.122(d)(2).

(b) The SWA with jurisdiction over the location of the range housing must inspect and certify that such housing used on the range is sufficient to accommodate the number of certified workers and meets all applicable standards contained in § 655.235. The SWA must conduct a housing inspection no less frequently than once every three calendar years after the initial inspection and provide documentation to the employer certifying the housing for a period lasting no more than 36 months. If the SWA determines that an employer's housing cannot be inspected within a 3-year timeframe or, when it is inspected, the housing does not meet all the applicable standards in § 655.235, the CO may deny the H–2A application in full or in part or require additional inspections, to be carried out by the SWA, in order to satisfy the regulatory requirement.

(c)(1) The employer may self-certify its compliance with the standards contained in § 655.235 only when the employer has received a certification from the SWA for the range housing it seeks to use within the past 36 months.

(2) To self-certify the range housing, the employer must submit a copy of the valid SWA housing certification and a written statement, signed and dated by the employer, to the SWA and the CO assuring that the housing is available, sufficient to accommodate the number of workers being requested for temporary agricultural labor certification, and meets all the applicable standards for range housing contained in § 655.235.

(d) The use of range housing at a location other than the range, where fixed-site employer-provided housing would otherwise be required, is permissible only when the worker occupying the housing is performing work that constitutes the production of livestock (which includes work that is closely and directly related to herding and/or the production of livestock). In such a situation, workers must be granted access to facilities, including but not limited to toilets and showers with hot and cold water under pressure, as well as cooking and cleaning facilities, that would satisfy the requirements contained in § 655.122(d)(1)(i). When such work does not constitute the production of livestock, workers must be housed in housing that meets all the requirements of § 655.122(d).

§ 655.235 Standards for range housing.

An employer employing workers under this section and §§ 655.200 through 655.230 may use a mobile unit, camper, or other similar mobile housing vehicle, tents, and remotely located stationary structures along herding trails, which meet the following standards:

(a) *Housing site.* Range housing sites must be well drained and free from depressions where water may stagnate.

(b) *Water supply.* (1) An adequate and convenient supply of water that meets the standards of the State or local health authority must be provided.

(2) The employer must provide each worker at least 4.5 gallons of potable water, per day, for drinking and cooking, delivered on a regular basis, so that the workers will have at least this amount available for their use until this supply is next replenished. Employers must also provide an additional amount of water sufficient to meet the laundry and bathing needs of each worker. This additional water may be non-potable, and an employer may require a worker to rely on natural sources of water for laundry and bathing needs if these sources are available and contain water that is clean and safe for these purposes. If an employer relies on alternate water sources to meet any of the workers' needs, it must take precautionary measures to protect the worker's health where these sources are also used to water the herd, dogs, or horses, to prevent contamination of the sources if they

collect runoff from areas where these animals excrete.

(3) The water provided for use by the workers may not be used to water dogs, horses, or the herd.

(4) In situations where workers are located in areas that are not accessible by motorized vehicle, an employer may request a variance from the requirement that it deliver potable water to workers, provided the following conditions are satisfied:

(i) It seeks the variance at the time it submits its *Application for Temporary Employment Certification*;

(ii) It attests that it has identified natural sources of water that are potable or may be easily rendered potable in the area in which the housing will be located, and that these sources will remain available during the period the worker is at that location;

(iii) It attests that it shall provide each worker an effective means to test whether the water is potable and, if not potable, the means to easily render it potable; and

(iv) The CO approves the variance.

(5) Individual drinking cups must be provided.

(6) Containers appropriate for storing and using potable water must be provided and, in locations subject to freezing temperatures, containers must be small enough to allow storage in the housing unit to prevent freezing.

(c) *Excreta and liquid waste disposal.* (1) Facilities, including shovels, must be provided and maintained for effective disposal of excreta and liquid waste in accordance with the requirements of the State health authority or involved Federal agency; and

(2) If pits are used for disposal by burying of excreta and liquid waste, they must be kept fly-tight when not filled in completely after each use. The maintenance of disposal pits must be in accordance with State and local health and sanitation requirements.

(d) *Housing structure.* (1) Housing must be structurally sound, in good repair, in a sanitary condition and must provide shelter against the elements to occupants;

(2) Housing, other than tents, must have flooring constructed of rigid materials easy to clean and so located as to prevent ground and surface water from entering;

(3) Each housing unit must have at least one window that can be opened or skylight opening directly to the outdoors; and

(4) Tents appropriate to weather conditions may be used only where the terrain and/or land use regulations do not permit the use of other more substantial housing.

(e) *Heating.* (1) Where the climate in which the housing will be used is such that the safety and health of a worker requires heated living quarters, all such quarters must have properly installed operable heating equipment that supplies adequate heat. Where the climate in which the housing will be used is mild and the low temperature for any day in which the housing will be used is not reasonably expected to drop below 50 degrees Fahrenheit, no separate heating equipment is required as long as proper protective clothing and bedding are made available, free of charge or deposit charge, to the workers.

(2) Any stoves or other sources of heat using combustible fuel must be installed and vented in such a manner as to prevent fire hazards and a dangerous concentration of gases. If a solid or liquid fuel stove is used in a room with wooden or other combustible flooring, there must be a concrete slab, insulated metal sheet, or other fireproof material on the floor under each stove, extending at least 18 inches beyond the perimeter of the base of the stove.

(3) Any wall or ceiling within 18 inches of a solid or liquid fuel stove or stove pipe must be made of fireproof material. A vented metal collar must be installed around a stovepipe or vent passing through a wall, ceiling, floor, or roof.

(4) When a heating system has automatic controls, the controls must be of the type that cuts off the fuel supply when the flame fails or is interrupted or whenever a predetermined safe temperature or pressure is exceeded.

(5) A heater may be used in a tent if the heater is approved by a testing service and if the tent is fireproof.

(f) *Lighting.* (1) In areas where it is not feasible to provide electrical service to range housing units, including

tents, lanterns must be provided (kerosene wick lights meet the definition of lantern); and

(2) Lanterns, where used, must be provided in a minimum ratio of one per occupant of each unit, including tents.

(g) *Bathing, laundry, and hand washing.* Bathing, laundry, and hand washing facilities must be provided when it is not feasible to provide hot and cold water under pressure.

(h) *Food storage.* When mechanical refrigeration of food is not feasible, the worker must be provided with another means of keeping food fresh and preventing spoilage, such as a butane or propane gas refrigerator. Other proven methods of safeguarding fresh foods, such as dehydrating or salting, are acceptable.

(i) *Cooking and eating facilities.* (1) When workers or their families are permitted or required to cook in their individual unit, a space must be provided with adequate lighting and ventilation; and

(2) Wall surfaces next to all food preparation and cooking areas must be of nonabsorbent, easy to clean material. Wall surfaces next to cooking areas must be made of fire-resistant material.

(j) *Garbage and other refuse.* (1) Durable, fly-tight, clean containers must be provided to each housing unit, including tents, for storing garbage and other refuse; and

(2) Provision must be made for collecting or burying refuse, which includes garbage, at least twice a week or more often if necessary, except where the terrain in which the housing is located cannot be accessed by motor vehicle and the refuse cannot be buried, in which case the employer must provide appropriate receptacles for storing the refuse and for removing the trash when the employer next transports supplies to the location.

(k) *Insect and rodent control.* Appropriate materials, including sprays, and sealed containers for storing food, must be provided to aid housing occupants in combating insects, rodents, and other vermin.

(l) *Sleeping facilities.* A separate comfortable and clean bed, cot, or bunk, with a clean mattress, must be provided for each person, except in a family arrangement, unless a variance is requested from and granted by the CO. When filing an application for certification and only where it is demonstrated to the CO that it is impractical to provide a comfortable and clean bed, cot, or bunk, with a clean mattress, for each range worker, the employer may request a variance from this requirement to allow for a second worker to join the range operation. Such a variance must be used infrequently, and the period of the variance will be temporary (*i.e.,* the variance shall be for no more than 3 consecutive days). Should the CO grant the variance, the employer must supply a sleeping bag or bed roll for the second occupant free of charge or deposit charge.

(m) *Fire, safety, and first aid.* (1) All units in which people sleep or eat must be constructed and maintained according to applicable State or local fire and safety law.

(2) No flammable or volatile liquid or materials may be stored in or next to rooms used for living purposes, except for those needed for current household use.

(3) Housing units for range use must have a second means of escape through which the worker can exit the unit without difficulty.

(4) Tents are not required to have a second means of escape, except when large tents with walls of rigid material are used.

(5) Adequate, accessible fire extinguishers in good working condition and first aid kits must be provided in the range housing.

LABOR CERTIFICATION PROCESS FOR TEMPORARY AGRICULTURAL EMPLOYMENT IN ANIMAL SHEARING, COMMERCIAL BEEKEEPING, CUSTOM COMBINING, AND REFORESTATION OCCUPATIONS

§ 655.300 Scope and purpose.

(a) *Purpose.* The purpose of this section and §§ 655.301 through 655.304 is to establish certain procedures for employers who apply to the DOL to obtain labor certifications to hire temporary agricultural foreign workers to perform animal shearing, commercial beekeeping, and custom combining, as defined in this subpart. Unless otherwise

specified in this section and §§ 655.301 through 655.304, employers whose job opportunities meet the qualifying criteria under this section and §§ 655.301 through 655.304 must fully comply with all of the requirements of §§ 655.100 through 655.185; part 653, subparts B and F, of this chapter; and part 654 of this chapter.

(b) *Jobs subject to this section and §§ 655.301 through 655.304.* The procedures in this section and §§ 655.301 through 655.304 apply to job opportunities for animal shearing, commercial beekeeping, and custom combining, as defined under § 655.301, where workers are required to perform agricultural work on a scheduled itinerary covering multiple areas of intended employment.

§ 655.301 Definition of terms.

The following terms are specific to applications for labor certifications involving animal shearing, commercial beekeeping, and custom combining.

Animal shearing. Activities associated with the shearing and crutching of sheep, goats, or other animals producing wool or fleece, including gathering, moving, and sorting animals into shearing yards, stations, or pens; placing animals into position, whether loose, tied, or otherwise immobilized, prior to shearing; selecting and using suitable handheld or power-driven equipment and tools for shearing; shearing animals with care according to industry standards; marking, sewing, or disinfecting any nicks and cuts on animals due to shearing; cleaning and washing animals after shearing is complete; gathering, storing, loading, and delivering wool or fleece to storage yards, trailers or other containers; and maintaining, oiling, sharpening, and repairing equipment and other tools used for shearing. Transporting equipment and other tools used for shearing qualifies as an activity associated with animal shearing for the purposes of this definition only where such activities are performed by workers who are employed by the same employer as the animal shearing crew and who travel and work with the animal shearing crew. Wool or fleece grading, which involves examining, sorting, and placing unprocessed wool or fleece into containers according to government or industry standards, qualifies as activity associated with animal shearing for the purposes of this definition only where such activity is performed by workers who are employed by the same employer as the animal shearing crew and who travel and work with the animal shearing crew.

Commercial beekeeping. Activities associated with the care or husbandry of bee colonies for producing and collecting honey, wax, pollen, and other products for commercial sale or providing pollination services to agricultural producers, including assembling, maintaining, and repairing hives, frames, or boxes; inspecting and monitoring colonies to detect diseases, illnesses, or other health problems; feeding and medicating bees to maintain the health of the colonies; installing, raising, and moving queen bees; splitting or dividing colonies, when necessary, and replacing combs; preparing, loading, transporting, and unloading colonies and equipment; forcing bees from hives, inserting honeycomb of bees into hives, or inducing swarming of bees into hives of prepared honeycomb frames; uncapping, extracting, refining, harvesting, and packaging honey, beeswax, or other products for commercial sale; cultivating bees to produce bee colonies and queen bees for sale; and maintaining and repairing equipment and other tools used to work with bee colonies.

Custom combining. Activities for agricultural producers consisting of: operating self-propelled combine equipment (*i.e.,* equipment that reaps or harvests, threshes, and swath or winnow the crop); performing manual or mechanical adjustments to combine equipment, including cutters, blowers and conveyers; performing safety checks on self-propelled combine equipment; and maintaining and repairing equipment and other tools for performing swathing or combining work; and, where performed by workers employed by the same employer as the custom combining crew and who work and travel with the custom combining crew: transporting harvested crops to elevators, silos, or other storage areas, and transporting combine equipment

and other tools used for custom combining work from one field to another. Neither the planting and cultivation of crops and related activities, nor component parts of custom combining not performed by the harvesting entity (e.g., grain cleaning), are considered custom combining for the purposes of this definition.

§ 655.302 Contents of job orders.

(a) *Content of job offers.* Unless otherwise specified in §§ 655.300 through 655.304, the employer must satisfy the requirements for job orders established under § 655.121 and for the content of job offers established under part 653, subpart F, of this chapter and § 655.122.

(b) *Job qualifications and requirements.* (1) For job opportunities involving animal shearing, the job offer may specify that applicants must possess up to 6 months of experience in similar occupations and require reference(s) for the employer to verify applicant experience. The job offer may also specify that applicants must possess experience with an industry shearing method or pattern, must be willing to join the employer at the time the job opportunity is available and at the place the employer is located, and must be available to complete the scheduled itinerary under the job order. U.S. applicants whose experience is based on a similar or related industry shearing method or pattern must be afforded a break-in period of no less than 5 working days to adapt to the employer's preferred shearing method or pattern.

(2) For job opportunities involving commercial beekeeping, the job offer may specify that applicants must possess up to 3 months of experience in similar occupations and require reference(s) for the employer to verify applicant experience. The job offer may also specify that applicants must not have bee, pollen, or honey-related allergies, must possess a valid commercial U.S. driver's license or be able to obtain such license not later than 30 days after the first workday after the arrival of the worker at the place of employment, must be willing to join the employer at the time and place the employer is located, and must be available to complete the scheduled itinerary under the job order.

(3) For job opportunities involving custom combining, the job offer may specify that applicants must possess up to 6 months of experience in similar occupations and require reference(s) for the employer to verify applicant experience. The job offer may also specify that applicants must be willing to join the employer at the time and place the employer is located and must be available to complete the scheduled itinerary under the job order.

(4) An employer may specify other appropriate job qualifications and requirements for its job opportunity, subject to § 655.122(a) and (b).

(c) *Employer-provided communication devices.* For job opportunities involving animal shearing and custom combining, the employer must provide to at least one worker per crew, without charge or deposit charge, effective means of communicating with persons capable of responding to the workers' needs in case of an emergency, including, but not limited to, satellite phones, cell phones, wireless devices, radio transmitters, or other types of electronic communication systems. The employer must specify in the job order the type(s) of electronic communication device(s) and that such devices will be provided without charge or deposit charge to at least one worker per crew during the entire period of employment.

(d) *Housing.* For job opportunities involving animal shearing and custom combining, the employer must specify in the job order that housing will be provided as set forth in § 655.304.

§ 655.303 Procedures for filing *Applications for Temporary Employment Certification.*

(a) *Compliance with §§ 655.130 through 655.132.* Unless otherwise specified in §§ 655.300 through 655.304, the employer must satisfy the requirements for filing an *Application for Temporary Employment Certification* with the NPC designated by the OFLC Administrator as required under §§ 655.130 through 655.132.

(b) *What to file.* An employer must file a completed *Application for Temporary Employment Certification.* The employer must identify each place of employment with as much geographic

specificity as possible, including the names of each farm or ranch, their physical locations, and the estimated period of employment at each place of employment where work will be performed under the job order.

(c) *Scope of applications.* The *Application for Temporary Employment Certification* and job order may cover multiple areas of intended employment in one or more contiguous States. An *Application for Temporary Employment Certification* and job order for opportunities involving commercial beekeeping may include one noncontiguous State at the beginning and end of the period of employment for the overwintering of bee colonies.

(d) *Agricultural association filings.* An agricultural association filing as a joint employer may submit a single job order and master *Application for Temporary Employment Certification* on behalf of its employer-members located in more than two contiguous States. An agricultural association filing as a joint employer may file an *Application for Temporary Employment Certification* and job order for opportunities involving commercial beekeeping including one noncontiguous State at the beginning and end of the period of employment for the overwintering of bee colonies.

§ 655.304 Standards for mobile housing.

(a) *Use of mobile housing.* An employer employing workers engaged in animal shearing or custom combining under this section and §§ 655.301 through 655.303 may use a mobile unit, camper, or other similar mobile housing unit that complies with all of the following standards, except as provided in paragraph (a)(1) or (2) of this section:

(1) In situations where the mobile housing unit will be located on the range (as defined in § 655.201) to enable work to be performed on the range, and where providing housing that meets each of the standards for mobile housing in this section is not feasible, an employer may request a variance from the particular mobile housing standard(s) with which compliance is not feasible. The CO will specify the locations, dates, and specific variances, if approved. The following conditions must be satisfied for an employer to obtain a variance:

(i) The employer seeks the variance at the time it submits its *Application for Temporary Employment Certification;*

(ii) The employer identifies the particular mobile housing standard(s), and attests that compliance with the standard(s) is not feasible;

(iii) The employer identifies the location(s) in which the particular mobile housing standard(s) cannot be met;

(iv) The employer identifies the anticipated dates that the mobile housing unit will be in those location(s);

(v) The employer identifies the corresponding range housing standard(s) in § 655.235 that will be met instead, and attests that it will comply with such standard(s);

(vi) The employer attests to the reason why the particular mobile housing(s) standard cannot be met; and,

(vii) The CO approves the variance.

(2) A Canadian employer performing custom combining operations in the United States whose mobile housing unit is located in Canada when not in use must have the housing unit inspected and approved by an authorized representative of the Federal or provincial government of Canada, in accordance with inspection procedures and applicable standards for such housing under Canadian law or regulation.

(b) *Compliance with mobile housing standards.* The employer may comply with the standards for mobile housing in this section in one of two ways:

(1) The employer may provide a mobile housing unit that complies with all applicable standards; or

(2) The employer may provide a mobile housing unit and supplemental facilities (e.g., located at a fixed housing site) if workers are afforded access to all facilities contained in these standards.

(c) *Housing site.* (1) Mobile housing sites must be well drained and free from depressions where water may stagnate. They shall be located where the disposal of sewage is provided in a manner that neither creates, nor is likely to create, a nuisance or a hazard to health.

(2) Mobile housing sites shall not be in proximity to conditions that create or are likely to create offensive odors,

flies, noise, traffic, or any similar hazards.

(3) Mobile housing sites shall be free from debris, noxious plants (e.g., poison ivy, etc.), and uncontrolled weeds or brush.

(d) *Drinking water supply.* (1) An adequate and convenient supply of potable water that meets the standards of the local or State health authority must be provided.

(2) Individual drinking cups must be provided.

(3) A cold water tap shall be available within a reasonable distance of each individual living unit when water is not provided in the unit.

(4) Adequate drainage facilities shall be provided for overflow and spillage.

(e) *Excreta and liquid waste disposal.* (1) Toilet facilities, such as portable toilets, recreational vehicle (RV) or trailer toilets, privies, or flush toilets, must be provided and maintained for effective disposal of excreta and liquid waste in accordance with the requirements of the applicable local, State, or Federal health authority, whichever is most stringent.

(2) Where mobile housing units contain RV or trailer toilets, such facilities must be connected to sewage hookups whenever feasible (*i.e.,* in campgrounds or RV parks).

(3) If wastewater tanks are used, the employer must make provisions to regularly empty the wastewater tanks.

(4) If pits are used for disposal by burying of excreta and liquid waste, they shall be kept fly-tight when not filled in completely after each use. The maintenance of disposal pits must be in accordance with local and State health and sanitation requirements.

(f) *Housing structure.* (1) Housing must be structurally sound, in good repair, in a sanitary condition, and must provide shelter against the elements to occupants.

(2) Housing must have flooring constructed of rigid materials easy to clean and so located as to prevent ground and surface water from entering.

(3) Each housing unit must have at least one window or a skylight that can be opened directly to the outdoors.

(g) *Heating.* (1) Where the climate in which the housing will be used is such that the safety and health of a worker requires heated living quarters, all such quarters must have properly installed operable heating equipment that supplies adequate heat. Where the climate in which the housing will be used is mild and the low temperature for any day in which the housing will be used is not reasonably expected to drop below 50 degrees Fahrenheit, no separate heating equipment is required as long as proper protective clothing and bedding are made available, free of charge or deposit charge, to the workers.

(2) Any stoves or other sources of heat using combustible fuel must be installed and vented in such a manner as to prevent fire hazards and a dangerous concentration of gases. If a solid or liquid fuel stove is used in a room with wooden or other combustible flooring, there must be a concrete slab, insulated metal sheet, or other fireproof material on the floor under each stove, extending at least 18 inches beyond the perimeter of the base of the stove.

(3) Any wall or ceiling within 18 inches of a solid or liquid fuel stove or stove pipe must be made of fireproof material. A vented metal collar must be installed around a stovepipe or vent passing through a wall, ceiling, floor, or roof.

(4) When a heating system has automatic controls, the controls must be of the type that cuts off the fuel supply when the flame fails or is interrupted or whenever a predetermined safe temperature or pressure is exceeded.

(h) *Electricity and lighting.* (1) Barring unusual circumstances that prevent access, electrical service or generators must be provided.

(2) In areas where it is not feasible to provide electrical service to mobile housing units, lanterns must be provided (e.g., battery operated lights).

(3) Lanterns, where used, must be provided in a minimum ratio of one per occupant of each unit.

(i) *Bathing, laundry, and hand washing.* (1) Bathing facilities, supplied with hot and cold water under pressure, shall be provided to all occupants no less frequently than once per day.

(2) Laundry facilities, supplied with hot and cold water under pressure,

shall be provided to all occupants no less frequently than once per week.

(3) Alternative bathing and laundry facilities must be available to occupants at all times when water under pressure is unavailable.

(4) Hand washing facilities must be available to all occupants at all times.

(j) *Food storage.* (1) Provisions for mechanical refrigeration of food at a temperature of not more than 45 degrees Fahrenheit must be provided.

(2) When mechanical refrigeration of food is not feasible, the employer must provide another means of keeping food fresh and preventing spoilage (e.g., a butane or propane gas refrigerator).

(k) *Cooking and eating facilities.* (1) When workers or their families are permitted or required to cook in their individual unit, a space must be provided with adequate lighting and ventilation, and stoves or hotplates.

(2) Wall surfaces next to all food preparation and cooking areas must be of nonabsorbent, easy to clean material. Wall surfaces next to cooking areas must be made of fire-resistant material.

(l) *Garbage and other refuse.* (1) Durable, fly-tight, clean containers must be provided to each housing unit, for storing garbage and other refuse.

(2) Provision must be made for collecting refuse, which includes garbage, at least twice a week or more often if necessary for proper disposal in accordance with applicable local, State, or Federal law, whichever is most stringent.

(m) *Insect and rodent control.* Appropriate materials, including sprays, and sealed containers for storing food, must be provided to aid housing occupants in combating insects, rodents, and other vermin.

(n) *Sleeping facilities.* (1) A separate comfortable and clean bed, cot, or bunk, with a clean mattress, must be provided for each person, except in a family arrangement.

(2) Clean and sanitary bedding must be provided for each person.

(3) No more than two deck bunks are permissible.

(o) *Fire, safety, and first aid.* (1) All units in which people sleep or eat must be constructed and maintained according to applicable local or State fire and safety law.

(2) No flammable or volatile liquid or materials may be stored in or next to rooms used for living purposes, except for those needed for current household use.

(3) Mobile housing units must have a second means of escape through which the worker can exit the unit without difficulty.

(4) Adequate, accessible fire extinguishers in good working condition and first aid kits must be provided in the mobile housing.

(p) *Maximum occupancy.* The number of occupants housed in each mobile housing unit must not surpass the occupancy limitations set forth in the manufacturer specifications for the unit.

Subparts C–D [Reserved]

Subpart E—Labor Certification Process for Temporary Employment in the Commonwealth of the Northern Marianas Islands (CW–1 Workers)

SOURCE: 84 FR 12431, Apr. 1, 2019, unless otherwise noted.

§ 655.400 Scope and purpose of this subpart.

(a) *Purpose.* (1) A temporary labor certification (TLC) issued under this subpart reflects a determination by the Secretary of Labor (Secretary), pursuant to 48 U.S.C. 1806(d)(2)(A), that:

(i) There are not sufficient U.S. workers in the Commonwealth who are able, willing, and qualified and who will be available at the time and place needed to perform the services or labor for which an employer desires to hire foreign workers; and

(ii) The employment of the CNMI-Only Transitional Worker visa program (CW–1) nonimmigrant worker(s) will not adversely affect the wages and working conditions of U.S. workers similarly employed.

(2) This subpart describes the process by which the Department of Labor (Department or DOL) makes such a determination and certifies its determination to the Department of Homeland Security (DHS).

(b) *Scope.* This subpart sets forth the procedures governing the labor certification process for the employment of foreign workers in the CW–1 nonimmigrant classification, as defined in 48 U.S.C. 1806(d). It also establishes standards and obligations with respect to the terms and conditions of the temporary labor certification (TLC) with which CW–1 employers must comply, as well as the rights and obligations of CW–1 workers and workers in corresponding employment. Additionally, this subpart sets forth integrity measures for ensuring employers' continued compliance with the terms and conditions of the TLC.

§ 655.401 Authority of the agencies, offices, and divisions in the Department of Labor.

The Secretary has delegated authority to the Assistant Secretary for the Employment and Training Administration (ETA), who in turn has delegated that authority to the Office of Foreign Labor Certification (OFLC), to issue certifications and carry out other statutory responsibilities as required by 48 U.S.C. 1806. Determinations on a *CW–1 Application for Temporary Employment Certification* are made by the OFLC Administrator who, in turn, may delegate this responsibility to designated staff members, e.g., a Certifying Officer (CO).

§ 655.402 Definition of terms.

For purposes of this subpart:

Administrative Law Judge (ALJ) means a person within the Department's Office of Administrative Law Judges appointed under 5 U.S.C. 3105.

Agent means a person or a legal entity, such as an association or other organization of employers, or an attorney for an association or other organization of employers, that:

(1) Is authorized to act on behalf of the employer for Temporary Labor Certification (TLC) purposes;

(2) Is not itself an employer, or a joint employer, as defined in this subpart with respect to the specific application; and

(3) Is not under suspension, debarment, expulsion, disbarment, or otherwise restricted from practice before any court, the Department, the Executive Office for Immigration Review or DHS under 8 CFR 292.3 or 1003.101.

Applicant (or U.S. applicant) means a U.S. worker who is applying for a job opportunity for which an employer has filed a *CW–1 Application for Temporary Employment Certification*.

Application for Prevailing Wage Determination means the Office of Management and Budget (OMB)-approved Form ETA–9141C (or successor form) and the appropriate appendices, submitted by an employer to secure a prevailing wage determination (PWD) from the National Prevailing Wage Center (NPWC).

CW–1 Application for Temporary Employment Certification means the OMB-approved Form ETA–9142C (or successor form) and the appropriate appendices, a valid wage determination, as required by § 655.410, and all supporting documentation submitted by an employer to secure a TLC determination from the OFLC Administrator.

Attorney means any person who is a member in good standing of the bar of the highest court of any State, possession, territory, or commonwealth of the United States, or the District of Columbia. Such a person is also permitted to act as an agent under this subpart. No attorney who is under suspension, debarment, expulsion, or disbarment from practice before any court, the Department, the Executive Office for Immigration Review, or DHS under 8 CFR 1003.101 or 292.3, may represent an employer under this subpart.

Board of Alien Labor Certification Appeals (BALCA or Board) means the permanent Board established by part 656 of this chapter, chaired by the Chief Administrative Law Judge (Chief ALJ), and consisting of ALJs appointed pursuant to 5 U.S.C. 3105 and designated by the Chief ALJ to be members of BALCA.

Certifying Officer or CO means the person who makes determination on a *CW–1 Application for Temporary Employment Certification* filed under the CW–1

program. The OFLC Administrator is the national CO. Other COs may also be designated by the OFLC Administrator to make the determinations required under this subpart, including making PWDs.

Chief Administrative Law Judge or Chief ALJ means the chief official of the Department's Office of Administrative Law Judges or the Chief ALJ's designee.

CNMI Department of Labor means the executive Department of the Commonwealth Government that administers employment and job training activities for employers and U.S. workers in the Commonwealth.

Commonwealth or CNMI means the Commonwealth of the Northern Mariana Islands.

Corresponding employment means the employment of U.S. workers who are not CW–1 workers by an employer who has an approved *CW–1 Application for Temporary Employment Certification* in any work included in the approved job offer, or in any work performed by the CW–1 workers. To qualify as corresponding employment the work must be performed during the validity period of the *CW–1 Application for Temporary Employment Certification* and approved job offer, including any approved extension thereof.

CW–1 Petition means the U.S. Citizenship and Immigration Services (USCIS) Form I–129CW, *Petition for a CNMI–Only Nonimmigrant Transitional Worker*, a successor form, other form, or electronic equivalent, any supplemental information requested by USCIS, and additional evidence as may be prescribed or requested by USCIS.

CW–1 worker means any foreign worker who is lawfully present in the Commonwealth and authorized by DHS to perform temporary labor or services under 48 U.S.C. 1806(d).

Date of need means the first date the employer requires services of the CW–1 workers as indicated on the *CW–1 Application for Temporary Employment Certification*.

Department of Homeland Security or DHS means the Federal Department having jurisdiction over certain immigration-related functions, acting through its component agencies, including USCIS.

Employee means a person who is engaged to perform work for an employer, as defined under the general common law of agency. Some of the factors relevant to the determination of employee status include: The hiring party's right to control the manner and means by which the work is accomplished; the skill required to perform the work; the source of the instrumentalities and tools for accomplishing the work; the location of the work; the hiring party's discretion over when and how long to work; and whether the work is part of the regular business of the hiring party. Other applicable factors may be considered and no one factor is dispositive. The terms employee and worker are used interchangeably in this subpart.

Employer means a person (including any individual, partnership, association, corporation, cooperative, firm, joint stock company, trust, or other organization with legal rights and duties) that:

(1) Has a place of business (physical location) in the Commonwealth and a means by which it may be contacted for employment;

(2) Has an employer relationship (such as the ability to hire, pay, fire, supervise or otherwise control the work of employees) with respect to a CW–1 worker or a worker in corresponding employment, as defined under the common law of agency; and

(3) Possesses, for purposes of filing a *CW–1 Application for Temporary Employment Certification,* a valid Federal Employer Identification Number (FEIN).

Employer-client means an employer that has entered into an agreement with a job contractor and that is not an affiliate, branch, or subsidiary of the job contractor, under which the job contractor provides services or labor to the employer-client on a temporary basis and will not exercise substantial, direct day-to-day supervision and control in the performance of the services or labor to be performed other than hiring, paying, and firing the workers.

Employment and Training Administration or ETA means the agency within the Department that includes OFLC and has been delegated authority by the Secretary to fulfill the Secretary's mandate under for the administration

and adjudication of a *CW–1 Application for Temporary Employment Certification* and related functions.

Federal holiday means a legal public holiday as defined at 5 U.S.C. 6103.

Full-time means 35 or more hours of work per week.

Governor means the Governor of the Commonwealth of the Northern Mariana Islands.

Job contractor means a person, association, firm, or a corporation that meets the definition of an employer and that contracts services or labor on a temporary basis to one or more employers that are not an affiliate, branch, or subsidiary of the job contractor and where the job contractor will not exercise substantial, direct day-to-day supervision and control in the performance of the services or labor to be performed other than hiring, paying, and releasing the workers.

Job offer means the offer made by an employer or potential employer of CW–1 workers to both U.S. and CW–1 workers describing all the material terms and conditions of employment, including those relating to wages, working conditions, and other benefits.

Job opportunity means full-time employment at a place in the Commonwealth to which U.S. workers can be referred.

Joint employment means that where two or more employers each have sufficient definitional indicia of being a joint employer of a worker under the common law of agency, they are, at all times, joint employers of that worker.

Layoff means any involuntary separation of one or more U.S. employees other than for cause.

Long-term worker means an alien who was admitted to the CNMI as a CW–1 nonimmigrant during fiscal year (FY) 2015, and who was granted CW–1 nonimmigrant status during each of FYs 2016 through 2018, as defined by DHS.

National Prevailing Wage Center or NPWC means that office within OFLC from which employers, agents, or attorneys who wish to file a *CW–1 Application for Temporary Employment Certification* receive a PWD.

NPWC Director means the OFLC official to whom the OFLC Administrator has delegated authority to carry out certain NPWC operations and functions.

National Processing Center (NPC) means the office within OFLC in which the COs operate, and which are charged with the adjudication of *CW–1 Applications for Temporary Employment Certification.*

NPC Director means the OFLC official to whom the OFLC Administrator has delegated authority for purposes of certain NPC operations and functions.

Occupational employment statistics (OES) survey means the program under the jurisdiction of the Bureau of Labor Statistics (BLS) that reports annual wage estimates, including those for Guam, based on standard occupational classifications (SOCs).

Offered wage means the wage offered by an employer in the *CW–1 Application for Temporary Employment Certification* and job offer. The offered wage must equal or exceed the highest of the prevailing wage, or the Federal minimum wage, or the Commonwealth minimum wage.

Office of Foreign Labor Certification or OFLC means the organizational component of the ETA that provides national leadership and policy guidance and develops regulations to carry out the Secretary's responsibilities, including determinations related to an employer's request for an *Application for Prevailing Wage Determination* or *CW–1 Application for Temporary Employment Certification.*

Place of employment means the worksite (or physical location) where work under the *CW–1 Application for Temporary Employment Certification* and job offer actually is performed by the CW–1 workers and workers in corresponding employment.

Prevailing wage (PW) means the official wage issued by the NPWC on the Form ETA 9141C, *Application for Prevailing Wage Determination for the CW–1 Program,* or successor form. At least that amount must be paid to all CW–1 workers and U.S. workers in corresponding employment.

Prevailing wage determination (PWD) means the prevailing wage issued by the OFLC NPWC on the Form ETA–9141C, *Application for Prevailing Wage Determination for the CW–1 Program,* or successor form. The PWD is used in

support of the *CW–1 Application for Temporary Employment Certification*.

Secretary of Labor or Secretary means the chief official of the U.S. DOL, or the Secretary's designee.

Secretary of Homeland Security means the chief official of DHS or the Secretary of Homeland Security's designee.

Secretary of State means the chief official of the U.S. Department of State or the Secretary of State's designee.

Strike means a concerted stoppage of work by employees as a result of a labor dispute, or any concerted slowdown or other concerted interruption of operation (including stoppage by reason of the expiration of a collective bargaining agreement).

Successor in interest means an employer, agent, or attorney that is controlling and carrying on the business of a previous employer.

(1) Where an employer, agent, or attorney has violated 48 U.S.C. 1806 or the regulations in this subpart and has ceased doing business or cannot be located for purposes of enforcement, a successor in interest to that employer, agent, or attorney may be held liable for the duties and obligations of the violating employer in certain circumstances. The following factors, as used under Title VII of the Civil Rights Act and the Vietnam Era Veterans' Readjustment Assistance Act, may be considered in determining whether an employer, agent, or attorney is a successor in interest; no one factor is dispositive, and all the circumstances will be considered as a whole:

(i) Substantial continuity of the same business operations;

(ii) Use of the same facilities;

(iii) Continuity of the work force;

(iv) Similarity of jobs and working conditions;

(v) Similarity of supervisory personnel;

(vi) Whether the former management or owner retains a direct or indirect interest in the new enterprise;

(vii) Similarity in machinery, equipment, and production methods;

(viii) Similarity of products and services; and

(ix) The ability of the predecessor to provide relief.

(2) For purposes of debarment only, the primary consideration will be the personal involvement of the firm's ownership, management, supervisors, and others associated with the firm in the violation(s) at issue.

Temporary labor certification or TLC means the certification made by the OFLC Administrator, based on the *CW–1 Application for Temporary Employment Certification*, job offer, and all supporting documentation, with respect to an employer seeking to file with DHS a visa petition to employ one or more foreign nationals as a CW–1 worker.

United States means the continental United States, Alaska, Hawaii, the Commonwealth of Puerto Rico, Guam, the U.S. Virgin Islands, and the Commonwealth.

United States worker (U.S. worker) means a worker who is:

(1) A citizen or national of the United States;

(2) An alien lawfully admitted for permanent residence; or

(3) A citizen of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau, who is eligible for nonimmigrant admission and is employment-authorized under the Compacts of Free Association between the United States and those nations.

U.S. Citizenship and Immigration Services or USCIS means the Federal agency within DHS that makes the determination whether to grant petitions filed by employers seeking CW–1 workers to perform temporary work in the Commonwealth.

Wages mean all forms of cash remuneration to a worker by an employer in payment for labor or services.

Work contract means the document containing all the material terms and conditions of employment relating to wages, hours, working conditions, places of employment, and other benefits, including all assurances and obligations required to be included under this subpart. The contract between the employer and the worker may be in the form of a separate written document containing the advertised terms and conditions of the job offer. In the absence of a separate, written work contract incorporating the required terms and conditions of employment, agreed

to by both the employer and the worker, the required terms of the certified *CW–1 Application for Temporary Employment Certification* will be the work contract.

§ 655.403 Persons and entities authorized to file.

(a) *Persons authorized to file.* In addition to the employer, a request for a PWD or TLC under this subpart may be filed by an attorney or agent, as defined in § 655.402.

(b) *Employer's signature required.* Regardless of whether the employer is represented by an attorney or agent, the employer is required to sign the *CW–1 Application for Temporary Employment Certification* and all documentation submitted to the Department.

§ 655.404 Requirements for agents.

An agent filing a *CW–1 Application for Temporary Employment Certification* on behalf of an employer must provide a copy of the agent agreement or other document demonstrating the agent's authority to represent the employer to the NPC at the time of filing the application.

§§ 655.405–655.409 [Reserved]

PREFILING PROCEDURES

§ 655.410 Offered wage rate and determination of prevailing wage.

(a) *Offered wage.* (1) The employer must advertise the position to all potential workers at a wage that is at least the highest of the following:

(i) The prevailing wage for the job opportunity obtained from the NPWC;

(ii) The Federal minimum wage; or

(iii) The Commonwealth minimum wage.

(2) The employer must offer and pay at least the wage provided in paragraph (a)(1) of this section to both its CW–1 workers and its workers in corresponding employment. The issuance of a PWD under this section does not permit an employer to pay a wage lower than the highest wage required by any applicable Federal or Commonwealth law.

(b) *Determinations*—(1) *Methods.* The OFLC Administrator will determine prevailing wages in the Commonwealth and occupational classification as follows:

(i) If the mean hourly wage for the occupational classification in the Commonwealth is reported by the Governor, annually, and meets the requirements set forth in paragraph (e) of this section, as determined by the OFLC Administrator, that wage must be the prevailing wage for the occupational classification;

(ii) If the OFLC Administrator has not approved a survey, as reported by the Governor, for the occupational classification under paragraph (b)(1)(i) of this section, and the BLS OES survey reports a mean wage paid to workers in the SOC in Guam, the prevailing wage must be the mean wage paid to workers in the SOC in Guam from the BLS OES survey; and

(iii) If the OFLC Administrator has not approved a survey, as reported by the Governor, for the occupational classification under paragraph (b)(1)(i) of this section and the BLS OES survey does not report the mean wage paid to workers in the SOC in Guam under paragraph (b)(1)(ii) of this section, the prevailing wage must be the mean wage paid to workers in the SOC in the United States from the BLS OES Survey, adjusted based on the ratio of the mean wage paid to workers in all SOCs in Guam compared to the mean wage paid to workers in all SOCs in the United States from the BLS OES survey.

(2) *Multiple occupations.* If the job duties on the *Application for Prevailing Wage Determination* do not fall within a single occupational classification, the NPC will determine the applicable prevailing wage based on the highest prevailing wage for all applicable occupational classifications.

(c) *Request for PWD*—(1) *Filing requirement.* An employer must electronically request and receive a PWD from the NPWC then electronically file the *CW–1 Application for Temporary Employment Certification* with the NPC.

(2) *Location and methods of filing*—(i) *Electronic filing.* The employer must file the *Application for Prevailing Wage Determination* and all required supporting documentation with the NPWC using the electronic method(s) designated by the OFLC Administrator. The NPWC

will return without review any application submitted using a method other than the designated electronic method(s), unless the employer submits with the application a statement of the need to file by mail.

(ii) *Filing by mail.* Employers that are unable to file electronically, either due to lack of internet access or physical disability precluding electronic filing, may file the application by mail. The mailed application must include a statement indicating the need to file by mail. The NPWC will return, without review, mailed applications that do not contain such a statement. OFLC will publish the address for mailed applications in the instructions to Form ETA–9141C.

(d) *NPWC action.* The NPWC will provide the PWD, indicate the source of the PWD, and return the *Application for Prevailing Wage Determination* with its endorsement to the employer.

(e) *Wage survey reported by the Governor.* The OFLC Administrator will issue a prevailing wage for the occupational classification in the Commonwealth based on a wage survey reported by the Governor if all of the following requirements are met:

(1) The survey was independently conducted and issued by the Governor of the Commonwealth, including through any Commonwealth agency, Commonwealth college, or Commonwealth university;

(2) The survey provides the arithmetic mean of the wages of workers in the occupational classification in the Commonwealth;

(3) The surveyor either made a reasonable, good faith attempt to contact all employers in the Commonwealth employing workers in the occupation or conducted a randomized sampling of such employers;

(4) The survey includes the wages of at least 30 workers in the Commonwealth;

(5) The survey includes the wages of workers in the Commonwealth employed by at least three employers;

(6) The survey was conducted across industries that employ workers in the occupational classification;

(7) The wage reported in the survey includes all types of pay;

(8) The survey is based on wages paid to workers in the occupational classification not more than 12 months before the date the survey is submitted to the OFLC Administrator for consideration; and

(9) The Governor submits the survey to the OFLC Administrator, with specific information about the survey methodology, including such items as sample size and source, sample selection procedures, and survey job descriptions, to allow a determination of the adequacy of the data provided and validity of the statistical methodology used in conducting the survey.

(f) *Review of wage survey reported by the Governor.* (1) If the OFLC Administrator finds the wage reported for any occupational classification not to be acceptable, the OFLC Administrator must inform the Governor in writing of the reasons the wage reported in the survey was not accepted.

(2) The Governor, after receiving notification from the OFLC Administrator that the wage reported in the survey it provided for consideration is not acceptable, may submit corrected wage data or conduct a new wage survey and submit revised wage data to the OFLC Administrator for consideration under this section.

(g) *Validity period.* The NPWC will specify the validity period of the prevailing wage, which in no event may be more than 365 days or fewer than 90 days from the date that the determination is issued.

(h) *Retention of documentation.* The employer must retain the PWD for 3 years from the date of issuance if not used in support of a TLC application or if it is used in support of a TLC application that is denied, and 3 years from the date on which the certification of the *CW–1 Application for Temporary Employment Certification* expires, whichever is later. The employer must submit the PWD to a CO if requested by a Notice of Deficiency (NOD), described in § 655.431, or audit, as described in § 655.470, or to any Federal Government Official performing an investigation, inspection, audit, or law enforcement function.

§ 655.411 Review of prevailing wage determinations.

(a) *Request for review of PWDs.* Any employer desiring review of a PWD must make a written request for such review to the NPWC Director. The written request must be received by the NPWC Director within 7 business days from the date the PWD was issued. The request for review must clearly identify the PWD for which review is sought; set forth the particular grounds for the request; and include any materials submitted to the NPWC for purposes of securing the PWD.

(b) *NPWC review.* Upon the receipt of the written request for review, the NPWC Director will review the employer's request and accompanying documentation, including any supplementary material submitted by the employer, and after review must issue a Final Determination letter; that letter may:

(1) Affirm the PWD issued by the NPWC; or

(2) Modify the PWD.

(c) *Request for review by BALCA.* Any employer desiring review of the NPWC Director's decision on a PWD must make a written request to BALCA for review of the determination, with a copy simultaneously sent to the NPWC Director who issued the final determination. The written request must be received by BALCA within 10 business days from the date the Final Determination letter was issued.

(1) Upon receipt of a request for BALCA review, the NPWC will prepare an Appeal File and submit it to BALCA.

(2) The request for review, statements, briefs, and other submissions of the parties must contain only legal arguments and may refer to only the evidence that was within the record upon which the decision on the PWD by the NPWC Director was based.

(3) BALCA will handle appeals in accordance with § 655.461.

§§ 655.412–655.419 [Reserved]

CW–1 Application for Temporary Employment Certification Filing Procedures

§ 655.420 Application filing requirements.

An employer seeking to hire CW–1 workers must electronically file a *CW–1 Application for Temporary Employment Certification* with the NPC designated by the OFLC Administrator. This section provides the procedures an employer must follow when filing.

(a) *What to file.* An employer seeking a TLC must file a completed *CW–1 Application for Temporary Employment Certification* (Form ETA–9142C and the appropriate appendices and valid PWD), and all supporting documentation and information required at the time of filing under this subpart. Applications that are incomplete at the time of submission will be returned to the employer without review.

(b) *Timeliness.* (1) Except as provided in paragraph (b)(2) of this section, a completed *CW–1 Application for Temporary Employment Certification* must be filed no more than 120 calendar days before the employer's date of need.

(2) If the employer is seeking a TLC to extend the employment of a CW–1 worker, a completed *CW–1 Application for Temporary Employment Certification* must be filed no more than 180 calendar days before the date on which the CW–1 status expires.

(c) *Location and methods of filing*—(1) *Electronic filing.* The employer must file the *CW–1 Application for Temporary Employment Certification* and all required supporting documentation with the NPC using the electronic method(s) designated by the OFLC Administrator. The NPC will return, without review, any application submitted using a method other than the designated electronic method(s), unless the employer submits with the application a statement of the need to file by mail or indicates that it already submitted such a statement to NPWC during the same fiscal year.

(2) *Filing by mail.* Employers that are unable to file electronically, either due to lack of internet access or physical disability precluding electronic filing,

may file the application by mail. The mailed application must include a statement indicating the need to file by mail as indicated above. The NPC will return, without review, mailed applications that do not contain such a statement. OFLC will publish the address for mailed applications in the instructions to Form ETA–9142C.

(d) *Original signature and acceptance of electronic signatures.* An electronically filed *CW–1 Application for Temporary Employment Certification* must contain an electronic (scanned) copy of the original signature of the employer (and that of the employer's authorized attorney or agent, if the employer is represented by an attorney or agent) or, in the alternative, use a verifiable electronic signature method, as directed by the OFLC Administrator. If submitted by mail, the *CW–1 Application for Temporary Employment Certification* must bear the original signature of the employer and, if applicable, the employer's authorized attorney or agent.

(e) *Requests for multiple positions.* An employer may request certification of more than one position on its *CW–1 Application for Temporary Employment Certification* as long as all CW–1 workers will perform the same services or labor under the same terms and conditions, in the same occupation, during the same period of employment, and at a location (or locations) covered by the application.

(f) *Scope of application.* (1) A *CW–1 Application for Temporary Employment Certification* must be limited to places of employment within the Commonwealth.

(2) In a single application filing, an association or other organization of employers is not permitted to file a *CW–1 Application for Temporary Employment Certification* on behalf of more than one employer-member under the CW–1 program.

(g) *Period of employment.* (1) Except as provided in paragraph (g)(2) of this section, the period of need identified in the *CW–1 Application for Temporary Employment Certification* must not exceed 1 year.

(2) If the employer is seeking TLC to employ a long-term CW–1 worker, the period of need identified in the *CW–1 Application for Temporary Employment Certification* must not exceed 3 years.

(h) *Return of applications based on USCIS CW–1 cap notice.* (1) Except as provided in paragraph (h)(3) of this section, if USCIS issues a public notice stating that it has received a sufficient number of CW–1 petitions to meet the statutory numerical limit on the total number of foreign nationals who may be issued a CW–1 permit or otherwise granted CW–1 status for the fiscal year, the OFLC Administrator must return without review any *CW–1 Applications for Temporary Employment Certification* with dates of need in that fiscal year received on or after the date that the OFLC Administrator provides the notice in paragraph (h)(2) of this section.

(2) The OFLC Administrator will announce the return of future *CW–1 Applications for Temporary Employment Certification* with dates of need in the fiscal year for which the cap is met with a notice on the OFLC's website. This notice will be effective on the date of its publication on the OFLC's website and will remain valid for the fiscal year unless:

(i) USCIS issues a public notice stating additional CW–1 permits are available for the fiscal year; and

(ii) The OFLC Administrator publishes a new notice announcing that additional TLCs may be granted in the fiscal year.

(3) After the notice that OFLC will return future *CW–1 Applications for Temporary Employment Certification,* the OFLC Administrator will continue to process *CW–1 Applications for Temporary Employment Certification* filed before the effective date of the suspension notice and will continue to permit the filing of *CW–1 Applications for Temporary Employment Certification* by employers who identify in the *CW–1 Application for Temporary Employment Certification* that the employment of all CW–1 workers employed under the *CW–1 Application for Temporary Employment Certification* will be exempt from the statutory numerical limit on the total number of foreign nationals who may be issued a CW–1 permit or otherwise granted CW–1 status.

§ 655.421 Job contractor filing requirements.

(a) A job contractor may submit a *CW–1 Application for Temporary Employment Certification* on behalf of itself and that employer-client. By doing so, the Department deems the job contractor a joint employer.

(b) A job contractor must have separate contracts with each different employer-client. A single contract or agreement may support only one *CW–1 Application for Temporary Employment Certification* for each employer-client job opportunity in the Commonwealth.

(c) Either the job contractor or its employer-client may submit an *Application for Prevailing Wage Determination* describing the job opportunity to the NPWC. However, each of the joint employers is separately responsible for ensuring that the wage offer(s) listed in the *CW–1 Application for Temporary Employment Certification* and related recruitment at least equals the prevailing wage obtained from the NPWC, or the Federal or Commonwealth minimum wage, whichever is highest, and that all other wage obligations are met.

(d)(1) A job contractor that is filing as a joint employer with its employer-client must submit to the NPC a completed *CW–1 Application for Temporary Employment Certification* that clearly identifies the joint employers (the job contractor and its employer-client) and the employment relationship (including the places of employment), in accordance with instructions provided by the OFLC Administrator. The *CW–1 Application for Temporary Employment Certification* must bear the original signature of the job contractor and the employer-client or use a verifiable electronic signature method, consistent with the requirements set forth at § 655.420(d), and be accompanied by the contract or agreement establishing the employers' relationships related to the workers sought.

(2) By signing the *CW–1 Application for Temporary Employment Certification*, each employer independently attests to the conditions of employment required of an employer participating in the CW–1 program and assumes full responsibility for the accuracy of the representations made in the application and for all of the responsibilities of an employer in the CW–1 program.

(e)(1) Either the job contractor or its employer-client may place the required advertisements and conduct recruitment as described in §§ 655.442 through 655.445. Also, either one of the joint employers may assume responsibility for interviewing applicants. However, both of the joint employers must sign the recruitment report that is submitted to the NPC meeting the requirement set forth in § 655.446.

(2) All recruitment conducted by the joint employers must satisfy the job offer assurance and advertising content requirements identified in § 655.441. Additionally, in order to fully inform applicants of the job opportunity and avoid potential confusion inherent in a job opportunity involving two employers, joint employer recruitment must clearly identify both employers (the job contractor and its employer-client) by name and must clearly identify the place(s) of employment where workers will perform labor or services.

(3)(i) Provided that all of the employer-clients' job opportunities are in the same occupation located in the Commonwealth and have the same requirements and terms and conditions of employment, including dates of employment, a job contractor may combine more than one of its joint employer employer-clients' job opportunities in a single advertisement. Each advertisement must fully inform potential workers of the job opportunity available with each employer-client and otherwise satisfy the job offer assurances and advertising content requirements identified in § 655.441. Such a shared advertisement must clearly identify the job contractor by name, the joint employment relationship, and the number of workers sought for each job opportunity, identified by employer-client names and locations (e.g., five openings with Employer-Client A (place of employment location), three openings with Employer-Client B (place of employment location)).

(ii) In addition, the advertisement must contain the following statement: ''Applicants may apply for any or all of the jobs listed. When applying, please identify the job(s) (by company and work location) you are applying to for

the entire period of employment specified.'' If an applicant fails to identify one or more specific work location(s), that applicant is presumed to have applied to all work locations listed in the advertisement.

(f) If a TLC for the joint employers is granted, the Final Determination certifying the *CW–1 Application for Temporary Employment Certification* will be sent to both the job contractor and employer-client.

§ 655.422 Emergency situations.

(a) *Waiver of PWD requirement prior to application filing.* The CO may waive the requirement to obtain a PWD, as required under § 655.410(c), prior to filing a *CW–1 Application for Temporary Employment Certification* for employers that have good and substantial cause, provided that the CO has sufficient time to thoroughly test the labor market and to make a final determination as required by § 655.450. The requirement to obtain a PWD prior to filing the *CW–1 Application for Temporary Employment Certification,* under § 655.410(c), is the only provision of this subpart which will be waived under these emergency situation procedures.

(b) *Employer requirements.* The employer requesting a waiver of the requirement to obtain a PWD must submit to the NPC a completed *Application for Prevailing Wage Determination,* a completed *CW–1 Application for Temporary Employment Certification,* and a statement justifying the waiver request. The employer's waiver request must include detailed information describing the good and substantial cause that has necessitated the waiver request. Good and substantial cause may include, but is not limited to, the substantial loss of U.S. workers due to an Act of God, or similar unforeseeable man-made catastrophic events (such as a hazardous materials emergency or government-controlled flooding), unforeseeable changes in market conditions, pandemic health issues, or similar conditions that are wholly outside of the employer's control. Issues related to the CW–1 visa cap are not good and substantial cause for a waiver of the filing requirements. Further, a denial of a previously submitted *CW–1 Application for Temporary Employment Certification* or CW–1 petition with USCIS does not constitute good and substantial cause necessitating a waiver under this section.

(c) *Processing of emergency applications.* The CO will process the emergency *CW–1 Application for Temporary Employment Certification,* including the *Application for Prevailing Wage Determination for the CW–1 Program,* in a manner consistent with the provisions of this subpart and make a determination in accordance with § 655.450. The CO will notify the employer, if the application cannot be processed because, pursuant to paragraph (a) of this section, the request for emergency filing was not justified and/or the filing does not meet the requirements set forth in this subpart.

§ 655.423 Assurances and obligations of CW–1 employers.

An employer employing CW–1 workers and/or workers in corresponding employment under a *CW–1 Application for Temporary Employment Certification* has agreed as part of the *CW–1 Application for Temporary Employment Certification* that it will abide by the following conditions with respect to its CW–1 workers and any workers in corresponding employment:

(a) *Rate of pay.* (1) The offered wage in the work contract equals or exceeds the highest of the prevailing wage, Federal minimum wage, or Commonwealth minimum wage. The employer must pay at least the offered wage, free and clear, during the entire period of the *CW–1 Application for Temporary Employment Certification* granted by OFLC.

(2) The offered wage is not based on commissions, bonuses, or other incentives, including paying on a piece-rate basis, unless the employer guarantees a wage earned every workweek that equals or exceeds the offered wage.

(3) If the employer requires one or more minimum productivity standards of workers as a condition of job retention, the standards must be specified in the work contract and the employer must demonstrate that they are normal and usual for non-CW–1 employers for the same occupation in the Commonwealth.

(4) An employer that pays on a piece-rate basis must demonstrate that the

piece-rate is no less than the normal rate paid by non-CW–1 employers to workers performing the same activity in the Commonwealth. The average hourly piece-rate earnings must result in an amount at least equal to the offered wage. If the worker is paid on a piece-rate basis and at the end of the workweek the piece-rate does not result in average hourly piece-rate earnings during the workweek at least equal to the amount the worker would have earned had the worker been paid at the offered hourly wage, then the employer must supplement the worker's pay at that time so that the worker's earnings are at least as much as the worker would have earned during the workweek if the worker had instead been paid at the offered hourly wage for each hour worked.

(b) *Wages free and clear.* The payment requirements for wages in this section will be satisfied by the timely payment of such wages to the worker either in cash or in negotiable instrument payable at par. The payment must be made finally and unconditionally and ''free and clear.'' The principles applied in determining whether deductions are reasonable and payments are received free and clear, and the permissibility of deductions for payments to third persons are explained in more detail in 29 CFR part 531.

(c) *Deductions.* The employer must make all deductions from the worker's paycheck required by law. The work contract must specify all deductions not required by law that the employer will make from the worker's pay; any such deductions not disclosed in the work contract are prohibited. The wage payment requirements of paragraph (b) of this section are not met where unauthorized deductions, rebates, or refunds reduce the wage payment made to the worker below the minimum amounts required by the offered wage or where the worker fails to receive such amounts free and clear because the worker ''kick backs'' directly or indirectly to the employer or to another person for the employer's benefit the whole or part of the wages delivered to the worker. Authorized deductions are limited to: Those required by law, such as taxes payable by workers that are required to be withheld by the employer and amounts due workers which the employer is required by court order to pay to another; deductions for the reasonable cost or fair value of board, lodging, and facilities furnished; and deductions of amounts which are authorized to be paid to third persons for the worker's account and benefit through his or her voluntary assignment or order or which are authorized by a collective bargaining agreement with bona fide representatives of workers which covers the employer. Deductions for amounts paid to third persons for the worker's account and benefit which are not so authorized or are contrary to law or from which the employer, agent, or recruiter, including any agents or employees of these entities or any affiliated person, derives any payment, rebate, commission, profit, or benefit directly or indirectly, may not be made if they reduce the actual wage paid to the worker below the offered wage indicated on the *CW–1 Application for Temporary Employment Certification*.

(d) *Job opportunity is full time.* The job opportunity is a full-time position, consistent with § 655.402, and the employer must use a single workweek as its standard for computing wages due. An employee's workweek must be a fixed and regularly recurring period of 168 hours—7 consecutive 24-hour periods. It need not coincide with the calendar week but may begin on any day and at any hour of the day.

(e) *Job qualifications and requirements.* Each job qualification and requirement must be listed in the work contract and must be bona fide and consistent with the normal and accepted qualifications and requirements imposed by non-CW–1 employers in the same occupation and in the Commonwealth. The employer's job qualifications and requirements imposed on U.S. workers must not be less favorable than the qualifications and requirements that the employer is imposing or will impose on CW–1 workers. A qualification means a characteristic that is necessary to the individual's ability to perform the job in question. A requirement means a term or condition of employment that a worker is required to

accept in order to obtain the job opportunity. The CO may require the employer to submit documentation to substantiate the appropriateness of any job qualification and/or requirement.

(f) *Three-fourths guarantee*—(1) *Offer to worker.* The employer must guarantee to offer the worker employment for a total number of work hours equal to at least three-fourths of the workdays of the total period of employment specified in the work contract, beginning with the first workday after the arrival of the worker at the place of employment or the advertised contractual first date of need, whichever is later, and ending on the expiration date specified in the work contract or in its extensions, if any. See the exception in paragraph (f)(1)(iv) of this section.

(i) For purposes of this paragraph (f), a workday means the number of hours in a workday as stated in the work contract. The employer must offer a total number of hours to ensure the provision of sufficient work to reach the three-fourths guarantee. The work hours must be offered during the work period specified in the work contract, or during any modified work contract period to which the worker and employer have mutually agreed and that has been approved by the CO.

(ii) In the event the worker begins working later than the start date of need specified in the application, the guarantee period begins with the first workday after the arrival of the worker at the place of employment and continues until the last day during which the work contract and all extensions thereof are in effect.

(iii) Therefore, if, for example, a work contract is for a 10-week period, during which a normal workweek is specified as 6 days a week, 8 hours per day, the worker would have to be guaranteed employment for at least 360 hours (10 weeks × 48 hours/week = 480 hours × 75 percent = 360). If a Federal holiday occurred during the 10-week period, the 8 hours would be deducted from the total hours for the work contract, before the guarantee is calculated. Continuing with the above example, the worker would have to be guaranteed employment for 354 hours (10 weeks × 48 hours/week = 480 hours − 8 hours (Federal holiday) = 472 hours × 75 percent = 354 hours).

(iv) A worker may be offered more than the specified hours of work on a single workday. For purposes of meeting the guarantee, the worker will not be required to work more than the number of hours specified in the work contract for a workday but all hours of work actually performed may be counted by the employer in calculating whether the period of guaranteed employment has been met. If during the total work contract period the employer affords the U.S. or CW–1 worker less employment than that required under this paragraph (f)(1)(iv), the employer must pay such worker the amount the worker would have earned had the worker, in fact, worked for the guaranteed number of days. An employer will not be considered to have met the work guarantee if the employer has merely offered work on three-fourths of the workdays of the work contract period if each workday did not consist of a full number of hours of work time as specified in the work contract.

(2) *Guarantee for piece-rate paid worker.* If the worker is paid on a piece-rate basis, the employer must use the worker's average hourly piece-rate earnings or the offered wage, whichever is higher, to calculate the amount due under the guarantee in accordance with paragraph (f)(1) of this section.

(3) *Failure to work.* Any hours the worker fails to work, up to a maximum of the number of hours specified in the work contract for a workday, when the worker has been offered an opportunity to work in accordance with paragraph (f)(1) of this section, and all hours of work actually performed (including voluntary work over 8 hours in a workday), may be counted by the employer in calculating whether the period of guaranteed employment has been met. An employer seeking to calculate whether the guaranteed number of hours has been met must maintain the payroll records in accordance with this subpart.

(g) *Impossibility of fulfillment.* If before the expiration date specified in the work contract, the services of the

worker are no longer required for reasons beyond the control of the employer due to fire, weather, or other Act of God, or similar unforeseeable man-made catastrophic event (such as an oil spill or controlled flooding) that is wholly outside the employer's control that makes the fulfillment of the work contract impossible, the employer may terminate the work contract with the approval of the CO. In the event of such termination, the employer must fulfill a three-fourths guarantee, as described in paragraph (f) of this section, for the time that has elapsed from the start date listed in the work contract or the first workday after the arrival of the worker at the place of employment, whichever is later, to the time of its termination. The employer must make efforts to transfer the CW–1 worker or worker in corresponding employment to other comparable employment acceptable to the worker and consistent with immigration laws, as applicable. If a transfer is not affected, the employer must return the worker, at the employer's expense, to the place from which the worker (disregarding intervening employment) came to work for the employer, or transport the worker to the worker's next certified CW–1 employer, whichever the worker prefers.

(h) *Frequency of pay*. The employer must state in the work contract the frequency with which the worker will be paid, which must be at least every 2 weeks. Employers must pay wages when due.

(i) *Earnings statements*. (1) The employer must keep accurate and adequate records with respect to the workers' earnings, including but not limited to: Records showing the nature, amount, and location(s) of the work performed; the number of hours of work offered each day by the employer (broken out by hours offered both in accordance with and over and above the three-fourths guarantee in paragraph (f) of this section); the hours actually worked each day by the worker; if the number of hours worked by the worker is less than the number of hours offered, the reason(s) the worker did not work; the time the worker began and ended each workday; the rate of pay (both piece-rate and hourly, if applicable); the worker's earnings per pay period; the worker's home address; and the amount of and reasons for any and all deductions taken from or additions made to the worker's wages.

(2) The employer must furnish to the worker on or before each payday in one or more written statements the following information:

(i) The worker's total earnings for each workweek in the pay period;

(ii) The worker's hourly rate or piece-rate of pay;

(iii) For each workweek in the pay period the hours of employment offered to the worker (showing offers in accordance with the three-fourths guarantee as determined in paragraph (f) of this section, separate from any hours offered over and above the guarantee);

(iv) For each workweek in the pay period the hours actually worked by the worker;

(v) An itemization of all deductions made from or additions made to the worker's wages;

(vi) If piece-rates are used, the units produced daily;

(vii) The beginning and ending dates of the pay period; and

(viii) The employer's name, address, and FEIN.

(j) *Transportation and visa fees*—(1)(i) *Transportation to the place of employment*. The employer must provide or reimburse the worker for transportation and subsistence from the place from which the worker has come to work for the employer, whether in the United States, including another part of the Commonwealth, or abroad, to the place of employment if the worker completes 50 percent of the period of employment covered by the work contract (not counting any extensions). The employer may arrange and pay for the transportation and subsistence directly, advance at a minimum the most economical and reasonable common carrier cost of the transportation and subsistence to the worker before the worker's departure, or pay the worker for the reasonable costs incurred by the worker. When it is the prevailing practice of non-CW–1 employers in the occupation and in the Commonwealth to do so or when the employer extends such benefits to similarly situated CW–

1 workers, the employer must advance the required transportation and subsistence costs (or otherwise provide them) to workers in corresponding employment who are traveling to the employer's place of employment from such a distance that the worker is not reasonably able to return to their residence each day. The amount of the transportation payment must be no less (and is not required to be more) than the most economical and reasonable common carrier transportation charges for the distances involved. The amount of the daily subsistence must be at least the amount permitted in § 655.173. Where the employer will reimburse the reasonable costs incurred by the worker, it must keep accurate and adequate records of: The costs of transportation and subsistence incurred by the worker; the amount reimbursed; and the date(s) of reimbursement. Note that the Fair Labor Standards Act applies independently of the CW–1 requirements and imposes obligations on employers regarding payment of wages.

(ii) *Transportation from the place of employment.* If the worker completes the period of employment covered by the work contract (not counting any extensions), or if the worker is dismissed from employment for any reason by the employer before the end of the period, and the worker has no immediate subsequent CW–1 employment, the employer must provide or pay at the time of departure for the worker's cost of return transportation and daily subsistence from the place of employment to the place from which the worker, disregarding intervening employment, departed to work for the employer. If the worker has contracted with a subsequent employer that has not agreed in the work contract to provide or pay for the worker's transportation from the former employer's place of employment to such subsequent employer's place of employment, the former employer must provide or pay for that transportation and subsistence. If the worker has contracted with a subsequent employer that has agreed in the work contract to provide or pay for the worker's transportation from the former employer's place of employment to such subsequent employer's place of employment, the subsequent employer must provide or pay for such expenses.

(iii) *Employer-provided transportation.* All employer-provided transportation must comply with all applicable Federal and Commonwealth laws and regulations including, but not limited to, vehicle safety standards, driver licensure requirements, and vehicle insurance coverage.

(2) The employer must pay or reimburse the worker in the first workweek for all visa, visa processing, border crossing, and other related fees (including those mandated by the government) incurred by the CW–1 worker, but not for passport expenses or other charges primarily for the benefit of the worker.

(k) *Employer-provided items.* The employer must provide to the worker, without charge or deposit charge, all tools, supplies, and equipment required to perform the duties assigned.

(l) *Disclosure of work contract.* The employer must provide to a CW–1 worker outside of the United States no later than the time at which the worker applies for the visa, or to a worker in corresponding employment no later than on the day work commences, a copy of the work contract including any subsequent approved modifications. For a CW–1 worker changing employment from a CW–1 employer to a subsequent CW–1 employer, the copy must be provided no later than the time an offer of employment is made by the subsequent CW–1 employer. The disclosure of all documents required by this paragraph (l) must be provided in a language understood by the worker. At a minimum, the work contract must contain all of the provisions required to be included by this section. In the absence of a separate, written work contract entered into between the employer and the worker, the required terms of the certified *CW–1 Application for Temporary Employment Certification* will be the work contract.

(m) *No unfair treatment.* The employer has not and will not intimidate, threaten, restrain, coerce, blacklist, discharge, or in any manner discriminate against, and has not and will not cause any person to intimidate, threaten, restrain, coerce, blacklist, discharge, or in any manner discriminate against,

any person who has, related to the CW–1 program:

(1) Filed a complaint under or related to any applicable Federal or Commonwealth laws and regulations;

(2) Instituted or caused to be instituted any proceeding under or related to any applicable Federal or Commonwealth laws and regulations;

(3) Testified or is about to testify in any proceeding under or related to any applicable Federal or Commonwealth laws and regulations;

(4) Consulted with a workers' center, community organization, labor union, legal assistance program, or an attorney on matters related to any applicable Federal or Commonwealth laws and regulations; or

(5) Exercised or asserted on behalf of himself/herself or others any right or protection afforded by any applicable Federal or Commonwealth laws and regulations.

(n) *Comply with the prohibitions against employees paying fees.* The employer and its attorney, agents, or employees have not sought or received payment of any kind from the worker for any activity related to obtaining CW–1 labor certification or employment, including payment of the employer's attorney or agent fees, application and *CW–1 Petition* fees, recruitment costs, or any fees attributed to obtaining the approved *CW–1 Application for Temporary Employment Certification.* For purposes of this paragraph (n), payment includes, but is not limited to, monetary payments, wage concessions (including deductions from wages, salary, or benefits), kickbacks, bribes, tributes, in-kind payments, and free labor. All wages must be paid free and clear. This paragraph (n) does not prohibit employers or their agents from receiving reimbursement for costs that are the responsibility and primarily for the benefit of the worker, such as government-required passport fees.

(o) *Contracts with third parties to comply with prohibitions.* The employer must contractually prohibit in writing any agent or recruiter (or any agent or employee of such agent or recruiter) whom the employer engages, either directly or indirectly, in recruitment of CW–1 workers to seek or receive payments or other compensation from prospective workers. The contract must include the following statement: ''Under this agreement, [name of agent, recruiter] and any agent of or employee of [name of agent or recruiter] are prohibited from seeking or receiving payments from any prospective employee of [employer name] at any time, including before or after the worker obtains employment. Payments include but are not limited to, any direct or indirect fees paid by such employees for recruitment, job placement, processing, maintenance, attorneys' fees, agent fees, application fees, or petition fees.''

(p) *Prohibition against preferential treatment of foreign workers.* The employer's job offer must offer to U.S. workers no less than the same benefits, wages, and working conditions that the employer is offering, intends to offer, or will provide to CW–1 workers. Job offers may not impose on U.S. workers any restrictions or obligations that will not be imposed on the employer's CW–1 workers. This does not relieve the employer from providing to CW–1 workers at least the minimum benefits, wages, and working conditions which must be offered to U.S. workers consistent with this section.

(q) *Nondiscriminatory hiring practices.* The job opportunity is open to any qualified U.S. worker as defined in § 655.402, regardless of race, color, national origin, age, sex, religion, disability, or citizenship. Rejections of any U.S. workers who applied or apply for the job must only be for lawful, job-related reasons, and those not rejected on this basis have been or will be hired. In addition, the employer has and will continue to retain records of all hired workers and rejected applicants as required by § 655.456.

(r) *Recruitment requirements.* The employer must conduct all required recruitment activities, including any additional employer-conducted recruitment activities as directed by the CO, and as specified in §§ 655.442 through 655.445.

(s) *No strike or lockout.* There is no strike or lockout at any of the employer's place(s) of employment within the Commonwealth for which the employer is requesting CW–1 certification at the

time the *CW–1 Application for Temporary Employment Certification* is filed.

(t) *No recent or future layoffs.* The employer has not laid off and will not lay off any similarly employed U.S. worker in the occupation that is the subject of the *CW–1 Application for Temporary Employment Certification* in the Commonwealth within the period beginning 270 calendar days before the date of need and through the end of the TLC's period of certification. A layoff for lawful, job-related reasons such as lack of work or the end of a season is permissible if all CW–1 workers are laid off before any U.S. worker in corresponding employment.

(u) *No work performed outside the Commonwealth and job opportunity.* The employer must not place any CW–1 workers employed under the approved *CW–1 Application for Temporary Employment Certification* outside the Commonwealth or in a job opportunity not listed on the approved *CW–1 Application for Temporary Employment Certification*.

(v) *Abandonment/termination of employment.* Upon the separation from employment of any worker employed under the *CW–1 Application for Temporary Employment Certification* or workers in corresponding employment, if such separation occurs before the end date of the employment period specified in the *CW–1 Application for Temporary Employment Certification*, the employer must notify OFLC in writing of the separation from employment not later than 2 working days after such separation is discovered by the employer. An abandonment or abscondment is deemed to begin after a worker fails to report for work at the regularly scheduled time for 5 consecutive working days without the consent of the employer. If the separation is due to the voluntary abandonment of employment by the CW–1 worker or worker in corresponding employment or is terminated for cause, and the employer provides appropriate notification specified under this paragraph (v), the employer will not be responsible for providing or paying for the subsequent transportation and subsistence costs of that worker under this section, and that worker is not entitled to the three-fourths guarantee described in paragraph (f) of this section.

(w) *Compliance with applicable laws.* During the period of employment specified on the *CW–1 Application for Temporary Employment Certification*, the employer must comply with all applicable Federal and Commonwealth employment-related laws and regulations, including health and safety laws. This includes compliance with 18 U.S.C. 1592(a), with respect to prohibitions against employers, the employer's agents, or their attorneys knowingly holding, destroying or confiscating workers' passports, visas, or other immigration documents.

§§ 655.424–655.429 [Reserved]

PROCESSING OF AN CW–1 APPLICATION FOR TEMPORARY EMPLOYMENT CERTIFICATION

§ 655.430 Review of applications.

(a) *NPC review.* The CO will review the *CW–1 Application for Temporary Employment Certification* for compliance with all applicable program requirements, including compliance with the requirements set forth in this subpart, and make a decision as to whether to issue a NOD under § 655.431 or a Notice of Acceptance (NOA) under § 655.433.

(b) *Mailing and postmark requirements.* Any notice or request sent by the CO to an employer requiring a response will be sent electronically or via first class mail using the address, including electronic mail address, provided on the *CW–1 Application for Temporary Employment Certification*. The employer's response to such a notice or request must be filed electronically or via first class mail. The employer's response must be filed electronically or postmarked by the date due or the next business day if the due date falls on a Saturday, Sunday, or Federal Holiday.

(c) *Information dissemination.* OFLC may forward, to DHS or any other Federal Government Official performing an investigation, inspection, audit, or law enforcement function, information OFLC receives in the course of processing a request for a *CW–1 Application for Temporary Employment Certification* or of administering program integrity measures such as audits.

§ 655.431 Notice of Deficiency.

(a) *Notification.* If the CO determines the *CW–1 Application for Temporary Employment Certification* contains errors or inaccuracies, or does not meet the requirements set forth in this subpart, the CO will issue a NOD to the employer and, if applicable, the employer's attorney or agent.

(b) *Notice content.* The NOD will:

(1) State the reason(s) the *CW–1 Application for Temporary Employment Certification* fails to meet the criteria for acceptance;

(2) Offer the employer an opportunity to submit a modified *CW–1 Application for Temporary Employment Certification* within 10 business days from the date of the NOD, and state the modification that is required for the CO to issue a NOA; and

(3) State that if the employer does not comply with the requirements of § 655.432 for submitting a modified application, the CO will deny the *CW–1 Application for Temporary Employment Certification.*

§ 655.432 Submission of modified applications.

(a) *Review of a modified CW–1 Application for Temporary Employment Certification.* Upon receipt of a response to a NOD, including any modifications, the CO will review the response. The CO may issue one or more additional NODs before issuing a decision. The employer's failure to comply with a NOD, including not responding in a timely manner or not providing all required documentation, will result in a denial of the *CW–1 Application for Temporary Employment Certification.*

(b) *Acceptance of a modified CW–1 Application for Temporary Employment Certification.* If the CO accepts the modification(s) to the *CW–1 Application for Temporary Employment Certification,* the CO will issue a NOA to the employer and, if applicable, the employer's attorney or agent.

(c) *Denial of modified CW–1 Application for Temporary Employment Certification.* If the modified *CW–1 Application for Temporary Employment Certification* does not cure the deficiencies cited in the NOD(s) or otherwise fails to satisfy the criteria required for certification, the CO will, at its discretion, either send a second NOD or deny the *CW–1 Application for Temporary Employment Certification* in accordance with the labor certification determination provisions in § 655.453.

(d) *Appeal from denial of modified CW–1 Application for Temporary Employment Certification.* The procedures for appealing a denial of a modified *CW–1 Application for Temporary Employment Certification* are the same as for appealing the denial of a nonmodified *CW–1 Application for Temporary Employment Certification,* outlined in § 655.461.

(e) *Post acceptance modifications.* Notwithstanding the decision to accept the *CW–1 Application for Temporary Employment Certification,* the CO may require modifications to the *CW–1 Application for Temporary Employment Certification* at any time before the final determination to grant or deny the *CW–1 Application for Temporary Employment Certification* if the CO determines that the job offer does not contain the minimum benefits, wages, and working conditions set forth in § 655.441. The employer must make such modifications, or the application will be denied under § 655.453. The employer must provide all workers recruited in connection with the job opportunity in the *CW–1 Application for Temporary Employment Certification* with a copy of the modified *CW–1 Application for Temporary Employment Certification,* as approved by the CO, no later than the date work commences.

§ 655.433 Notice of Acceptance.

(a) *Notification.* When the CO determines the *CW–1 Application for Temporary Employment Certification* contains no errors or inaccuracies, and meets the requirements set forth in this subpart, the CO will issue a NOA to the employer and, if applicable, the employer's attorney or agent.

(b) *Notice content.* The NOA must:

(1) Direct the employer to engage in recruitment of U.S. workers as provided in §§ 655.442 through 655.444, including any additional recruitment ordered by the CO under § 655.445;

(2) State that such employer-conducted recruitment must begin within 14 calendar days from the date the NOA is issued, consistent with § 655.440(b);

(3) Require the employer to submit a report of its recruitment efforts, by the

date required by the CO in the NOA, as specified in § 655.446; and

(4) Advise the employer that failure to submit a complete recruitment report by the deadline will lead to denial of the application.

§ 655.434 Amendments to an application.

(a) *Increases in number of workers.* The *CW–1 Application for Temporary Employment Certification* may be amended at any time before the CO's certification determination to increase the number of workers requested in the initial *CW–1 Application for Temporary Employment Certification* by not more than 20 percent (50 percent for employers requesting less than 10 workers) without requiring an additional recruitment period for U.S. workers. Requests for increases above the percent prescribed, without additional recruitment, may be approved by the CO only when the employer demonstrates that the need for additional workers could not have been foreseen and is wholly outside of the employer's control. All requests to increase the number of workers must be made in writing and will not be effective until approved by the CO. Upon acceptance of an amendment, the employer must promptly provide copies of any approved amendments to all U.S. workers recruited and hired under the original job offer.

(b) *Minor changes to the period of employment.* The *CW–1 Application for Temporary Employment Certification* may be amended at any time before the CO's certification determination to make minor changes (meaning a change of up to 14 calendar days) in the total period of employment, without requiring an additional recruitment period for U.S. workers. Changes will not be effective until submitted in writing and approved by the CO. In considering whether to approve the request, the CO will review the reason(s) for the request, determine whether the reason(s) are on the whole justified, and take into account the effect any change(s) would have on the adequacy of the underlying test of the domestic labor market for the job opportunity. An employer must demonstrate that the change to the period of employment could not have been foreseen and is wholly outside of the employer's control. The CO will deny any request to change the period of employment where the total amended period of employment will exceed the maximum applicable duration permitted under § 655.420(g). Upon acceptance of an amendment, the employer must promptly provide copies of any approved amendments to all U.S. workers recruited and hired under the original job offer.

(c) *Other minor amendments to the CW–1 Application for Temporary Employment Certification.* The employer may request other minor amendments to the *CW–1 Application for Temporary Employment Certification* at any time before the CO's certification determination is issued. In considering whether to approve the request, the CO will determine whether the proposed amendment(s) are sufficiently justified and must take into account the effect of the changes on the underlying labor market test for the job opportunity. All requests for minor changes must be made in writing and will not be effective until approved by the CO. Upon acceptance of an amendment, the employer must promptly provide copies of any approved amendments to all U.S. workers recruited and hired under the original job offer.

(d) *Amendments after certification are not permitted.* After the CO has made a determination to certify the *CW–1 Application for Temporary Employment Certification*, the employer may no longer request amendments.

§§ 655.435–655.439 [Reserved]

Post Acceptance Requirements

§ 655.440 Employer-conducted recruitment.

(a) *Employer obligations.* Employers must conduct recruitment of U.S. workers to ensure that there are not qualified U.S. workers who will be available for the positions listed in the *CW–1 Application for Temporary Employment Certification.*

(b) *Period to begin employer-conducted recruitment.* Unless otherwise instructed by the CO, the employer must begin the recruitment required in §§ 655.442 through 655.445 within 14 calendar days from the date the NOA is

issued. All employer-conducted recruitment must be completed before the employer submits the recruitment report as required in § 655.446.

(c) *Interviewing U.S. workers.* Employers that wish to require interviews must conduct those interviews by phone or provide a procedure for the interviews to be conducted in the location where the worker is being recruited so that the worker incurs little or no cost. Employers cannot provide potential CW–1 workers with more favorable treatment with respect to the requirement for, and conduct of, interviews.

(d) *Qualified and available U.S. workers.* The employer must consider all U.S. applicants for the job opportunity and must hire all U.S. applicants who are qualified and who will be available for the job opportunity. U.S. applicants may be rejected only for lawful, job-related reasons, and those not rejected on this basis will be hired.

(e) *Recruitment report.* The employer must prepare a recruitment report meeting the requirements of § 655.446, by the date specified by the CO in the NOA.

§ 655.441 Job offer assurances and advertising contents.

(a) *General.* All recruitment conducted under §§ 655.442 through 655.445 in connection with an *CW–1 Application for Temporary Employment Certification* must contain terms and conditions of employment that are not less favorable than those offered to the CW–1 workers and must comply with the assurances applicable to job offers as set forth in § 655.423.

(b) *Contents.* All advertising must contain the following information:

(1) The employer's name and contact information;

(2) A statement that the job opportunity is a temporary, full-time position and identify the job title and total number of job openings the employer intends to fill;

(3) A description of the job opportunity with sufficient information to apprise applicants of the services or labor to be performed, including the job duties, the minimum education and experience requirements, the work hours and days, and the anticipated start and end dates of the job opportunity;

(4) The place(s) of employment with enough specificity to apprise applicants of any travel requirements and where applicants will likely have to reside to perform the services or labor;

(5) The wage that the employer is offering, intends to offer or will provide to the CW–1 workers or, in the event that there are multiple wage offers, the range of applicable wage offers, each of which must equal or exceed the highest of the prevailing wage or the Federal or Commonwealth minimum wage;

(6) If applicable, a statement that overtime will be available to the worker and specify the wage offer(s) for working any overtime hours;

(7) The frequency with which the worker will be paid as required by § 655.423(h);

(8) A statement that the employer will make all deductions from the worker's paycheck required by law, and must specify any deductions the employer intends to make from the worker's paycheck which are not required by law, including, if applicable, any deductions for the reasonable cost of board, lodging, or other facilities;

(9) A statement summarizing the three-fourths guarantee as required by § 655.423(f);

(10) A statement that transportation and subsistence will be provided to the worker while traveling from the worker's origin to the place of employment as will the return transportation and subsistence at the conclusion of the job opportunity, as required by § 655.423(j)(1);

(11) If applicable, a statement that daily transportation to and from the place(s) of employment will be provided by the employer;

(12) If applicable, a statement that the employer will provide to the worker, without charge or deposit charge, all tools, supplies, and equipment required to perform the duties assigned, in accordance with § 655.423(k);

(13) If applicable, any board, lodging, or other facilities the employer will offer to workers or intends to assist workers in securing;

(14) If applicable, a statement indicating that on-the-job training will be provided to the worker; and

(15) A statement that directs applicants to apply for the job opportunity directly with the employer, and that indicates at least two verifiable methods by which applicants may apply for the job opportunity, one of which must be via electronic means, and that provides the days and hours during which applicants may be interviewed for the job opportunity.

§ 655.442 Place advertisement with CNMI Department of Labor.

(a) The employer must place an advertisement with the CNMI Department of Labor for a period of 21 consecutive calendar days satisfying the requirements set forth in § 655.441.

(b) Documentation of this step must include:

(1) Either printouts of web pages in which the advertisement appeared on the CNMI Department of Labor job listing system, or other verifiable evidence from the CNMI Department of Labor containing the text of the advertisement; and

(2) The dates of publication demonstrating compliance with the requirement of this section.

§ 655.443 Contact with former U.S. workers.

The employer must contact (by mail or other effective means) its former U.S. workers, including those who have been laid off within 270 calendar days before the date of need, employed by the employer in the occupation at the place(s) of employment during the previous year (except those who were dismissed for cause or who abandoned the place(s) of employment), provide a copy of the *CW–1 Application for Temporary Employment Certification*, and solicit their return to the job. This contact must occur during the period of time that the job offer is being advertised on the CNMI Department of Labor's job listing system under § 655.442. The employer must retain documentation sufficient to prove such contact in accordance with § 655.456. An employer has no obligation to contact U.S. workers it terminated for cause or who abandoned employment at any time during the previous year, if the employer provided timely notice to the NPC of the termination or abandonment in the manner described in § 655.423(v).

§ 655.444 Notice of posting requirement.

The employer must post a copy of the *CW–1 Application for Temporary Employment Certification* in at least two conspicuous locations at the place(s) of employment or in some other manner that provides reasonable notification to all employees in the job classification and area in which the work will be performed by the CW–1 workers. Electronic posting, such as displaying an electronic copy of the *CW–1 Application for Temporary Employment Certification* prominently on any internal or external website that is maintained by the employer and customarily used for notices to employees about terms and conditions of employment, is sufficient to meet this posting requirement as long as it otherwise meets the requirements of this section. The notice must be posted for a period of 21 consecutive calendar days. The employer must maintain proof the *CW–1 Application for Temporary Employment Certification* was posted and identify where and during what period of time it was posted in accordance with § 655.456.

§ 655.445 Additional employer-conducted recruitment.

(a) *Requirement to conduct additional recruitment.* The employer may be instructed by the CO to conduct additional reasonable recruitment. Such recruitment may be required at the discretion of the CO where the CO has determined that there is a likelihood that U.S. workers who are qualified will be available for the work.

(b) *Nature of the additional employer-conducted recruitment.* The CO will describe the precise number and nature of the additional recruitment efforts. Additional recruitment may include, but is not limited to, advertising the job offer on the employer's website or another electronic job search website; advertising with community-based organizations, local unions, or trade unions; or other advertising using a professional, trade, or other publication where such a publication is appropriate for the workers likely to apply for the job opportunity. When assessing

the appropriateness of a particular recruitment method, the CO will consider the cost of the additional recruitment and the likelihood that the additional recruitment method(s) will identify qualified and available U.S. workers.

(c) *Proof of the additional employer-conducted recruitment.* The CO will specify the documentation or other supporting evidence that must be retained by the employer as proof that the additional recruitment requirements were met. Documentation must be retained as required in § 655.456.

§ 655.446 Recruitment report.

(a) *Requirements of the recruitment report.* No fewer than 2 calendar days after the last date on which the last advertisement appeared, as required by the NOA issued under § 655.433, the employer must prepare, sign, and date a recruitment report. Where recruitment was conducted by a job contractor or its employer-client, both joint employers must sign the recruitment report in accordance with § 655.421(e)(1). The recruitment report must be submitted to the NPC, by the date specified in the NOA, and contain the following information:

(1) The name of each recruitment activity or source;

(2) The name and contact information of each U.S. worker who applied or was referred to the job opportunity up to the date of the preparation of the recruitment report, and the disposition of each worker's application. The employer must clearly indicate whether the job opportunity was offered to the U.S. worker and whether the U.S. worker accepted or declined;

(3) Confirmation that the advertisement was posted on the CNMI Department of Labor's job listing system and the dates of advertising;

(4) Confirmation that former U.S. employees were contacted, if applicable, and by what means and the date(s) of contact;

(5) Confirmation the employer posted the availability of the job opportunity to all employees in the job classification and area in which the work will be performed by the CW–1 workers and the dates of advertising;

(6) If applicable, confirmation that additional recruitment was conducted as directed by the CO and the date(s) of advertising; and

(7) If applicable, for each U.S. worker who applied for the position but was not hired, the lawful job-related reason(s) for not hiring the U.S. worker.

(b) *Duty to update and retain the recruitment report.* The employer must update the recruitment report throughout the recruitment period. In a joint employment situation, either the job contractor or the employer-client may update the recruitment report throughout the recruitment period. The employer must retain the recruitment report as required in § 655.456.

§§ 655.447–655.449 [Reserved]

Labor Certification Determinations

§ 655.450 Determinations.

Except as otherwise noted in this section, the OFLC Administrator and CO(s), by virtue of delegation from the OFLC Administrator, have the authority to certify or deny *CW–1 Applications for Temporary Employment Certification*. The CO will certify the application only if the employer has met all the requirements of this subpart, including the criteria for certification in § 655.451, thus demonstrating that there is an insufficient number of U.S. workers in the Commonwealth who are able, willing, qualified and who will be available at the time and place of the job opportunity for which certification is sought and that the employment of the CW–1 workers will not adversely affect the wages and working conditions of similarly employed U.S. workers.

§ 655.451 Criteria for temporary labor certification.

(a) The criteria for TLC include whether the employer has complied with all of the requirements of this subpart, which are required to grant the labor certification.

(b) In determining whether there are insufficient U.S. workers in the Commonwealth to fill the employer's job opportunity, the CO will count as available any U.S. worker who applied (or on whose behalf an application is made) directly to the employer, but who was rejected by the employer for other than a lawful job-related reason. In making this determination, the CO

will also consider the employer's contacts with its former U.S. workers, including workers that have been laid off within 270 calendar days before the date of need.

§ 655.452 Approved certification.

If the TLC is granted, the CO will send a Final Determination notice and a copy of the certified *CW–1 Application for Temporary Employment Certification* to the employer and a copy, if applicable, to the employer's agent or attorney using an electronic method(s) designated by the OFLC Administrator. For employers permitted to file by mail as set forth in § 655.420(c), the CO will send the Final Determination notice and a copy of the certified *CW–1 Application for Temporary Employment Certification* by first class mail. The CO will send the certified *CW–1 Application for Temporary Employment Certification*, including approved modifications, on behalf of the employer, directly to USCIS using an electronic method(s) designated by the OFLC Administrator. The employer must retain a copy of the certified *CW–1 Application for Temporary Employment Certification*, including the original signed Appendix C, as required by § 655.456.

§ 655.453 Denied certification.

If an electronically filed TLC is denied, the CO will send the Final Determination notice to the employer and a copy, if applicable, to the employer's agent or attorney using an electronic method(s) designated by the OFLC Administrator. For employers permitted to file by mail as set forth in § 655.420(c), the CO will send the Final Determination notice by first class mail. The Final Determination notice will:

(a) State the reason(s) certification is denied, citing the relevant regulatory standards;

(b) Offer the employer an opportunity to request administrative review of the denial under § 655.461; and

(c) State that if the employer does not request administrative review in accordance with § 655.461, the denial is final, and the Department will not accept any appeal on that *CW–1 Application for Temporary Employment Certification*.

§ 655.454 Partial certification.

The CO may issue a partial certification, reducing either the period of need or the number of CW–1 workers or both, based upon information the CO receives during the course of processing the *CW–1 Application for Temporary Employment Certification*, an audit, or otherwise. The number of workers certified will be reduced by one for each U.S. worker who is able, willing, and qualified, and who will be available at the time and place needed and who has not been rejected for lawful, job-related reasons, to perform the labor or services. If a partial labor certification is issued, the CO will send the Final Determination notice approving partial certification using the procedures at § 655.452.

The Final Determination notice will:

(a) State the reason(s) the period of employment or the number of CW–1 workers requested has been reduced, citing the relevant regulatory standards;

(b) Offer the employer an opportunity to request administrative review of the partial certification under § 655.461; and

(c) State that if the employer does not request administrative judicial review in accordance with § 655.461, the partial certification is final, and the Department will not accept any appeal on that *CW–1 Application for Temporary Employment Certification*.

§ 655.455 Validity of temporary labor certification.

(a) *Validity period.* A TLC is valid only for the period of employment as approved on the *CW–1 Application for Temporary Employment Certification*. The certification expires after the last day of authorized employment, including any approved extensions thereof.

(b) *Scope of validity.* A TLC is valid only for the number of CW–1 positions, the places of employment located in the Commonwealth, the job classification and specific services or labor to be performed, and the employer(s) specified on the approved *CW–1 Application for Temporary Employment Certification*, including any approved modifications. The TLC may not be transferred from one employer to another unless the employer to which it is transferred is a

successor in interest to the employer to which it was issued.

§ 655.456 Document retention requirements for CW–1 employers.

(a) *Entities required to retain documents.* All CW–1 employers filing a *CW–1 Application for Temporary Employment Certification* are required to retain the documents and records establishing compliance with this subpart, including but not limited to those specified in paragraph (c) of this section.

(b) *Period of record retention.* The employer must retain records and documents for 3 years from the date on which the certification of the *CW–1 Application for Temporary Employment Certification* expires, or 3 years from the date of the final determination if the *CW–1 Application for Temporary Employment Certification* is denied, or 3 years from the date the Department receives the request for withdrawal of a *CW–1 Application for Temporary Employment Certification* under § 655.462.

(c) *Documents and records to be retained by all employers.* All employers filing a *CW–1 Application for Temporary Employment Certification* must retain the following documents and records and must provide the documents and records to the Department and any other Federal Government Official in the event of an audit or investigation:

(1) Proof of recruitment efforts, including:

(i) Placement of the job offer with the CNMI Department of Labor as specified in § 655.442;

(ii) Contact with former U.S. employees as specified in § 655.443, including documents demonstrating that each such U.S. worker had been offered the job opportunity listed in the *CW–1 Application for Temporary Employment Certification,* and that the U.S. worker either refused the job opportunity or was rejected only for lawful, job-related reasons;

(iii) Posting notice of the job opportunity to all employees in the job classification and area in which the work will be performed by the CW–1 workers as specified in § 655.444; and

(iv) All additional employer-conducted recruitment required by the CO as specified in § 655.445.

(2) Documentation supporting the information submitted in the recruitment report prepared in accordance with § 655.446, such as evidence of nonapplicability of contact with former workers as specified in § 655.443 and any supporting resumes and contact information as specified in § 655.446.

(3) Records of each worker's earnings, hours offered and worked, location(s) where work is performed, and other information as specified in § 655.423(i).

(4) If applicable, records of reimbursement of transportation and subsistence costs incurred by the workers, as specified in § 655.423(j).

(5) Copies of written contracts with third parties demonstrating compliance with the prohibition of seeking or receiving payments or other compensation of any kind from prospective workers as specified in § 655.423(o).

(6) Evidence of the employer's contact with U.S. workers who applied for the job opportunity in the *CW–1 Application for Temporary Employment Certification,* including, but not limited to, documents demonstrating that any rejections of U.S. workers were for lawful, job-related reasons, as specified in § 655.423(q).

(7) Written notice provided to and informing OFLC that a CW–1 worker or worker in corresponding employment has separated from employment before the end date of employment specified in the *CW–1 Application for Temporary Employment Certification,* as specified in § 655.423(v).

(8) A copy of the *CW–1 Application for Temporary Employment Certification* and all accompanying appendices, including any modifications, amendments, or extensions, signed by the employer as directed by the CO.

(d) *Availability of documents and records for enforcement purposes.* The employer must make available to the Department, DHS or to any Federal Government Official performing an investigation, inspection, audit, or law enforcement function all documents and records required to be retained under this subpart for purposes of copying, transcribing, or inspecting them.

§§ 655.457–655.459 [Reserved]

POST CERTIFICATION ACTIVITIES

§ 655.460 Extensions.

(a) *Basis for extension.* Under certain circumstances an employer may apply for extensions of the period of employment. A request for extension must be related to weather conditions or other factors beyond the control of the employer (which may include unforeseen changes in market conditions). Such requests must be supported in writing, with documentation showing that the extension is needed and that the need could not have been reasonably foreseen by the employer. The CO will not grant an extension where the total period of employment under that *CW–1 Application for Temporary Employment Certification* and the authorized extension would exceed the maximum applicable duration permitted under § 655.420(g).

(b) *Decision by the CO.* The CO will notify the employer of the decision in writing. The employer may appeal a denial of a request for an extension by following the appeal procedures in § 655.461.

(c) *Obligations during period of extension.* The CW–1 employer's assurances and obligations under the TLC will continue to apply during the extended period of employment. The employer must immediately provide to its CW–1 workers and workers in corresponding employment a copy of any approved extension.

§ 655.461 Administrative review.

(a) *Request for review.* Where authorized in this subpart, an employer wishing review of a determination by the CO must request an administrative review before BALCA of that determination to exhaust its administrative remedies. In such cases, the request for review:

(1) Must be received by BALCA, and the CO who issued the determination, within 10 business days from the date of the determination;

(2) Must clearly identify the particular determination for which review is sought;

(3) Must include a copy of the CO's determination;

(4) Must set forth the particular grounds for the request, including the specific factual issues the requesting party alleges needs to be examined in connection with the CO's determination;

(5) May contain any legal argument that the employer believes will rebut the basis for the CO's determination, including any briefing the employer wishes to submit; and

(6) May contain only such evidence as was actually before the CO at the time of the CO's determination.

(b) *Appeal File.* After the receipt of a request for review, the CO will send a copy of the Appeal File, as soon as practicable by means normally assuring next-day delivery, to BALCA, the employer, the employer's attorney or agent (if applicable), and the Associate Solicitor for Employment and Training Legal Services, Office of the Solicitor, U.S. Department of Labor (counsel).

(c) *Assignment.* The Chief ALJ will immediately, upon receipt of the appeal file from the CO, assign either a single member or a three-member panel of BALCA to consider a particular case.

(d) *Administrative review*—(1) *Briefing schedule.* If the employer wishes to submit a brief on appeal, it must do so as part of its request for review. Within 7 business days of receipt of the Appeal File, the counsel for the CO may submit a brief in support of the CO's decision and, if applicable, in response to the employer's brief.

(2) *Standard of review.* The ALJ must uphold the CO's decision unless shown by the employer to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(e) *Scope of review.* BALCA will, except in cases over which the Secretary has assumed jurisdiction pursuant to 29 CFR 18.95, affirm, reverse, or modify the CO's determination, or remand to the CO for further action. BALCA will reach this decision after due consideration of the documents in the Appeal File that were before the CO at the time of the CO's determination, the request for review, and any legal briefs submitted. BALCA may not consider evidence not before the CO at the time of the CO's determination, even if such

evidence is in the Appeal File, request for review, or legal briefs.

(f) *Decision.* The decision of BALCA must specify the reasons for the action taken and must be provided to the employer, the CO, and counsel for the CO within 7 business days of the submission of the CO's brief or 10 business days after receipt of the Appeal File, whichever is later, using means normally assuring expedited delivery.

[84 FR 12431, Apr. 1, 2019, as amended at 85 FR 13029, Mar. 6, 2020; 85 FR 30615, May 20, 2020]

§ 655.462 Withdrawal of a CW–1 Application for Temporary Employment Certification.

(a) The employer may withdraw a *CW–1 Application for Temporary Employment Certification* after it has been submitted to the NPC for processing, including after the CO grants certification under § 655.450. However, the employer is still obligated to comply with the terms and conditions of employment contained in the *CW–1 Application for Temporary Employment Certification* and work contract with respect to all workers recruited and hired in connection with that application.

(b) To request withdrawal, the employer must submit a request in writing to the NPC identifying the *CW–1 Application for Temporary Employment Certification* and stating the reason(s) for the withdrawal.

§ 655.463 Public disclosure.

The Department will maintain an electronic file accessible to the public with information on all employers applying for TLCs. The database will include such information as the number of workers requested, the date filed, the date decided, and the final disposition.

§§ 655.464–655.469 [Reserved]

INTEGRITY MEASURES

§ 655.470 Audits.

The CO may conduct audits of certified *CW–1 Applications for Temporary Employment Certification.*

(a) *Discretion.* The CO has the sole discretion to choose the certified applications selected for audit.

(b) *Audit letter.* Where an application is selected for audit, the CO will issue an audit letter to the employer and a copy, if appropriate, to the employer's attorney or agent. The audit letter will:

(1) Specify the documentation that must be submitted by the employer;

(2) Specify a date, no more than 30 calendar days from the date the audit letter is issued, by which the required documentation must be sent to the CO; and

(3) Advise that failure to comply fully with the audit process may result:

(i) In the requirement that the employer undergo the assisted recruitment procedures in § 655.471 in future filings of *CW–1 Applications for Temporary Employment Certification* for a period of up to 2 years; or

(ii) In a revocation of the certification or debarment from the CW–1 program and any other foreign labor certification program administered by the Department.

(c) *Supplemental information request.* During the course of the audit examination, the CO may request supplemental information or documentation from the employer in order to complete the audit. If circumstances warrant, the CO can issue one or more requests for supplemental information.

(d) *Potential referrals.* In addition to measures in this subpart, the CO may decide to provide the audit findings and underlying documentation to DHS or other appropriate enforcement agencies. The CO may refer any findings that an employer discouraged a qualified U.S. worker from applying, or failed to hire, discharged, or otherwise discriminated against a qualified U.S. worker, to the Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section.

§ 655.471 Assisted recruitment.

(a) *Requirement of assisted recruitment.* If, as a result of audit or otherwise, the CO determines that a violation has occurred that does not warrant debarment, the CO may require the employer to engage in assisted recruitment for a defined period of time for any future *CW–1 Application for Temporary Employment Certification.*

(b) *Notification of assisted recruitment.* The CO will notify the employer (and its attorney or agent, if applicable) in writing of the assisted recruitment that will be required of the employer for a period of up to 2 years from the date the notice is issued. The notification will state the reasons for the imposition of the additional requirements, state that the employer's agreement to accept the conditions will constitute their inclusion as bona fide conditions and terms of a *CW–1 Application for Temporary Employment Certification*, and offer the employer an opportunity to request an administrative review. If administrative review is requested, the procedures in § 655.461 apply.

(c) *Assisted recruitment.* The assisted recruitment process will be in addition to any recruitment required of the employer by §§ 655.442 through 655.445 and may consist of, but is not limited to, one or more of the following:

(1) Requiring the employer to submit a draft advertisement to the CO for review and approval at the time of filing the *CW–1 Application for Temporary Employment Certification*;

(2) Designating the sources where the employer must recruit for U.S. workers in the Commonwealth and directing the employer to place the advertisement(s) in such sources;

(3) Extending the length of the placement of the advertisements;

(4) Requiring the employer to notify the CO in writing when the advertisement(s) are placed;

(5) Requiring an employer to perform any additional assisted recruitment directed by the CO;

(6) Requiring the employer to provide proof of the publication of all advertisements as directed by the CO;

(7) Requiring the employer to provide proof of all U.S. workers who applied (or on whose behalf an application is made) in response to the employer's recruitment efforts;

(8) Requiring the employer to submit any proof of contact with all referrals and former U.S. workers; or

(9) Requiring the employer to provide any additional documentation verifying it conducted the assisted recruitment as directed by the CO.

(d) *Failure to comply.* If an employer materially fails to comply with requirements ordered by the CO under this section, the certification will be denied and the employer and its attorney or agent may be debarred under § 655.473.

§ 655.472 Revocation.

(a) *Basis for revocation.* The OFLC Administrator may revoke a TLC approved under this subpart, if the OFLC Administrator finds:

(1) The issuance of the TLC was not justified due to fraud or misrepresentation of a material fact in the application process;

(2) The employer substantially failed to comply with any of the terms or conditions of the approved TLC. A substantial failure is a failure to comply that constitutes a significant deviation from the terms and conditions of the approved certification and is further defined in § 655.473(d); or

(3) The employer impeded the audit process, as set forth in § 655.470, or impeded any Federal Government Official performing an investigation, inspection, audit, or law enforcement function.

(b) *DOL procedures for revocation*—(1) *Notice of Revocation.* If the OFLC Administrator makes a determination to revoke an employer's TLC, the OFLC Administrator will issue a Notice of Revocation to the employer (and its attorney or agent, if applicable). The notice will contain a detailed statement of the grounds for the revocation and inform the employer of its right to submit rebuttal evidence to the OFLC Administrator or to request administrative review of the Notice of Revocation by BALCA. If the employer does not submit rebuttal evidence or request administrative review within 10 business days from the date the Notice of Revocation is issued, the notice will become the final agency action and will take effect immediately at the end of the 10 business days.

(2) *Rebuttal.* If the employer timely submits rebuttal evidence, the OFLC Administrator will inform the employer of the final determination on the revocation within 10 business days of receiving the rebuttal evidence. If the OFLC Administrator determines that the certification must be revoked, the OFLC Administrator will inform

the employer of its right to appeal the final determination to BALCA according to the procedures of § 655.461. If the employer does not appeal the final determination, it will become the final agency action.

(3) *Request for review.* An employer may appeal a Notice of Revocation or a final determination of the OFLC Administrator after the review of rebuttal evidence to BALCA, according to the appeal procedures of § 655.461.

(4) *Stay.* The timely submission of rebuttal evidence or a request for administrative review will stay the revocation pending the outcome of the proceeding.

(5) *Decision.* If the TLC is revoked, the OFLC Administrator will provide copies of final revocation decisions to DHS and DOS promptly.

(c) *Employer's obligations in the event of revocation.* If an employer's TLC is revoked, the employer is responsible for:

(1) Reimbursement of actual inbound transportation and other required expenses;

(2) The workers' outbound transportation and other required expenses;

(3) Payment to the workers of the amount due under the three-fourths guarantee; and

(4) Any other wages, benefits, and working conditions due or owing to the workers under this subpart.

[84 FR 12431, Apr. 1, 2019, as amended at 85 FR 13029, Mar. 6, 2020; 85 FR 30615, May 20, 2020]

§ 655.473 Debarment.

(a) *Debarment of an employer, agent, or attorney.* The OFLC Administrator may debar an employer, agent, attorney, or any successor in interest to that employer, agent, or attorney, from participating in any action under this subpart, subject to the time limits set forth in paragraph (c) of this section, if the OFLC Administrator finds that the employer, agent, or attorney substantially violated a material term or condition of the *Application for Prevailing Wage Determination* or *CW–1 Application for Temporary Employment Certification*, as defined in paragraph (d) of this section. The OFLC Administrator will provide copies of final debarment decisions to DHS and DOS promptly.

(b) *Effect on future applications in all foreign labor programs.* The debarred employer, or a debarred agent or attorney, or any successor in interest to any debarred employer, agent, or attorney, will be disqualified from filing any labor certification applications or labor condition applications with the Department subject to the term limits set forth in paragraph (c) of this section. If such an application is filed, it will be denied without review.

(c) *Period of debarment.* No employer, agent, or attorney may be debarred under this subpart for more than 5 years for a single violation.

(d) *Definition of violation.* For the purposes of this section, a violation of a material term or condition of the *Application for Prevailing Wage Determination* or *CW–1 Application for Temporary Employment Certification* includes:

(1) One or more acts of commission or omission on the part of the employer or the employer's agent or attorney that involve:

(i) Failure to pay or provide the required wages, benefits, or working conditions to the employer's CW–1 workers or workers in corresponding employment;

(ii) Failure, except for lawful, job-related reasons, to offer employment to qualified U.S. workers who applied for the job opportunity for which certification was sought;

(iii) Failure to comply with the employer's obligations to recruit U.S. workers;

(iv) Improper layoff or displacement of U.S. workers or workers in corresponding employment;

(v) Failure to comply with the NOD process, as set forth in § 655.431, or the assisted recruitment process, as set forth in § 655.471;

(vi) Impeding the audit process, as set forth in § 655.470, or impeding any Federal Government Official performing an investigation, inspection, audit, or law enforcement function;

(vii) Employing a CW–1 worker outside of the Commonwealth, in an activity not listed in the work contract, or outside the validity period of employment of the work contract, including any approved extension thereof;

(viii) A violation of the requirements of § 655.423(n) or (o);

(ix) A violation of any of the provisions listed in § 655.423(q); or

(x) Any other act showing such flagrant disregard for the law that future compliance with program requirements cannot reasonably be expected;

(2) Fraud involving the *Application for Prevailing Wage Determination* or the *CW–1 Application for Temporary Employment Certification* under this subpart; or

(3) A material misrepresentation of fact during the course of processing the *CW–1 Application for Temporary Employment Certification*.

(e) *Determining whether a violation is substantial.* In determining whether a violation is substantial as to merit debarment, the factors the OFLC Administrator may consider include, but are not limited to, the following:

(1) Previous history of violation(s) under the CW–1 program;

(2) The number of CW–1 workers, workers in corresponding employment, or U.S. workers who were or are affected by the violation(s);

(3) The gravity of the violation(s); or

(4) The extent to which the violator achieved a financial gain due to the violation(s), or the potential financial loss or potential injury to the worker(s).

(f) *Debarment procedure*—(1) *Notice of Debarment.* If the OFLC Administrator makes a determination to debar an employer, agent, attorney, or any successor in interest to that employer, agent, or attorney, the OFLC Administrator will issue the party a Notice of Debarment. The notice will state the reason(s) for the debarment finding, including a detailed explanation of the grounds for and the duration of the debarment, and it will inform the party subject to the notice of its right to submit rebuttal evidence to the OFLC Administrator, or to request administrative review of the decision by BALCA. If the party does not file rebuttal evidence or a request for review within 30 calendar days of the date of the Notice of Debarment, the notice is the final agency action and the debarment will take effect on the date specified in the notice or if no date is specified, at the end of 30 calendar days The timely filing of rebuttal evidence or a request for review stays the debarment pending the outcome of the appeal as provided in paragraphs (f)(2) through (6) of this section.

(2) *Rebuttal.* The party who received the Notice of Debarment may choose to submit evidence to rebut the grounds stated in the notice within 30 calendar days of the date the notice is issued. If rebuttal evidence is timely filed, the OFLC Administrator will issue a Final Determination on the debarment within 30 calendar days of receiving the rebuttal evidence. If the OFLC Administrator determines that the party must be debarred, the OFLC Administrator will issue a Final Determination and inform the party of its right to request administrative review of the debarment by BALCA according to the procedures in this section. The party must request review within 30 calendar days after the date of the Final Determination, or the Final Determination will be the final agency order and the debarment will take effect on the date specified in the Final Determination or if no date is specified, at the end of 30 calendar days.

(3) *Request for review.* (i) The recipient of a Notice of Debarment or Final Determination seeking to challenge the debarment must request review of the debarment within 30 calendar days of the date of the Notice of Debarment or the date of the Final Determination by the OFLC Administrator after review of rebuttal evidence submitted under paragraph (f)(2) of this section. A request for review of debarment must be filed in writing with the Chief ALJ, United States Department of Labor, in accordance with 29 CFR part 18, with a simultaneous copy served on the OFLC Administrator; the request must clearly identify the particular debarment determination for which review is sought; and must set forth the particular grounds for the request. If no timely request for review is filed, the debarment will take effect on the date specified in the Notice of Debarment or Final Determination, or if no date is specified, 30 calendar days from the date the Notice of Debarment or Final Determination is issued.

(ii) Upon receipt of a request for review, the OFLC Administrator will promptly send a certified copy of the ETA case file to the Chief ALJ by

means normally assuring expedited delivery. The Chief ALJ will immediately assign an ALJ to conduct the review.

(iii) Statements, briefs, and other submissions of the parties must contain only legal argument and only such evidence that was within the record upon which the debarment was based, including any rebuttal evidence submitted pursuant to paragraph (f)(2) of this section.

(4) *Review by the ALJ.* (i) In considering requests for review, the ALJ must afford all parties 30 days to submit or decline to submit any appropriate Statement of Position or legal brief. The ALJ must review the debarment determination on the basis of the record upon which the decision was made, the request for review, and any Statements of Position or legal briefs submitted.

(ii) The ALJ's final decision must affirm, reverse, or modify the OFLC Administrator's determination. The ALJ's decision will be provided to the parties by expedited mail. The ALJ's decision is the final agency action, unless either party, within 30 calendar days of the ALJ's decision, seeks review of the decision with the Administrative Review Board (ARB).

(5) *Review by the ARB.* (i) Any party wishing review of the decision of an ALJ must, within 30 calendar days of the decision of the ALJ, petition the ARB to review the decision in accordance with 29 CFR part 26. Copies of the petition must be served on all parties and on the ALJ. The ARB will decide whether to accept the petition within 30 calendar days of receipt. If the ARB declines to accept the petition, or if the ARB does not issue a notice accepting a petition within 30 calendar days after the receipt of a timely filing of the petition, the decision of the ALJ is the final agency action. If a petition for review is accepted, the decision of the ALJ will be stayed unless and until the ARB issues an order affirming the decision. The ARB must serve notice of its decision to accept or not to accept the petition upon the ALJ and upon all parties to the proceeding.

(ii) Upon receipt of the ARB's notice to accept the petition, the Office of Administrative Law Judges will promptly forward a copy of the complete appeal record to the ARB.

(iii) Where the ARB has determined to review the decision and order, the ARB will notify each party of the issue(s) raised, the form in which submissions must be made (e.g., briefs or oral argument), and the time within which the presentation must be submitted.

(6) *ARB decision.* The ARB's decision must be issued within 90 calendar days from the notice granting the petition and served upon all parties and the ALJ.

[84 FR 12431, Apr. 1, 2019, as amended at 85 FR 13029, Mar. 6, 2020; 85 FR 30615, May 20, 2020; 86 FR 1778, Jan. 11, 2021]

§§ 655.474–655.499 [Reserved]

Subpart F—Attestations by Employers Using Alien Crewmembers for Longshore Activities in U.S. Ports

SOURCE: 60 FR 3956, 3976, Jan. 19, 1995, unless otherwise noted.

GENERAL PROVISIONS

§ 655.500 Purpose, procedure and applicability of subparts F and G of this part.

(a) *Purpose.* (1) Section 258 of the Immigration and Nationality Act (''Act'') prohibits nonimmigrant alien crewmembers admitted to the United States on D-visas from performing longshore work at U.S. ports except in five specific instances:

(i) Where the vessel's country of registration does not prohibit U.S. crewmembers from performing longshore work in that country's ports and nationals of a country (or countries) which does not prohibit U.S. crewmembers from performing longshore work in that country's ports hold a majority of the ownership interest in the vessel, as determined by the Secretary of State (henceforth referred to as the ''reciprocity exception'');

(ii) Where there is in effect in a local port one or more collective bargaining agreement(s), each covering at least thirty percent of the longshore workers, and each permitting the activity

to be performed under the terms of such agreement(s);

(iii) Where there is no collective bargaining agreement covering at least thirty percent of the longshore workers at the particular port and an attestation with accompanying documentation has been filed with the Department of Labor attesting that, among other things, the use of alien crewmembers to perform a particular activity of longshore work is permitted under the prevailing practice of the particular port (henceforth referred to as the ''prevailing practice exception'');

(iv) Where the longshore work is to be performed at a particular location in the State of Alaska and an attestation with accompanying documentation has been filed with the Department of Labor attesting that, among other things, before using alien crewmembers to perform the activity specified in the attestation, the employer will make a bona fide request for and employ United States longshore workers who are qualified and available in sufficient numbers from contract stevedoring companies, labor organizations recognized as exclusive bargaining representatives of United States longshore workers, and private dock operators (henceforth referred to as the ''Alaska exception''); or

(v) Where the longshore work involves an automated self-unloading conveyor belt or vacuum-actuated system on a vessel and the Administrator has not previously determined that an attestation must be filed pursuant to this part as a basis for performing those functions (henceforth referred to as the ''automated vessel exception'').

(2) The term ''longshore work'' does not include the loading or unloading of hazardous cargo, as determined by the Secretary of Transportation, for safety and environmental protection. The Department of Homeland Security (DHS) through the United States Citizenship and Immigration Services (USCIS), determines whether an employer may use alien crewmembers for longshore work at U.S. ports. In those cases where an employer must file an attestation in order to perform such work, the Department of Labor shall be responsible for accepting the filing of such attestations. Subpart F of this part sets forth the procedure for filing attestations with the Department of Labor for employers proposing to use alien crewmembers for longshore work at U.S. ports under the prevailing practice exception, the Alaska exception, and where it has been determined that an attestation is required under the automated vessel exception listed in paragraph (a)(1)(iv) of this section. Subpart G of this part sets forth complaint, investigation, and penalty provisions with respect to such attestations.

(b) *Procedure.* (1) Under the prevailing practice exception in sec. 258(c) of the Act, and in those cases where it has been determined that an attestation is required under the automated vessel exception for longshore work to be performed at locations other than in the State of Alaska, the procedure involves filing an attestation with the Department of Labor attesting that:

(i) The use of alien crewmembers for a particular activity of longshore work is the prevailing practice at the particular port;

(ii) The use of alien crewmembers is not during a strike or lockout nor designed to influence the election of a collective bargaining representative; and

(iii) Notice of the attestation has been provided to the bargaining representative of longshore workers in the local port, or, where there is none, notice has been provided to longshore workers employed at the local port.

(2) Under the automated vessel exception in sec. 258(c) of the Act, no attestation is required in cases where longshore activity consists of the use of an automated self-unloading conveyor belt or vacuum-actuated system on a vessel. The legislation creates a rebuttable presumption that the use of alien crewmembers for the operation of such automated systems is the prevailing practice. In order to overcome such presumption, it must be shown by the preponderance of the evidence submitted by any interested party, that the use of alien crewmembers for such activity is not the prevailing practice at the particular port, that it is during

a strike or lockout, or that it is intended or designed to influence an election of a bargaining representative for workers in the local port.

(3) Under the Alaska exception in sec. 258(d) of the Act, and in those cases where it has been determined that an attestation is required under the automated vessel exception consisting of the use of such equipment for longshore work to be performed in the State of Alaska, the procedure involves filing an attestation with the Department of Labor attesting that:

(i) The employer will make a bona fide request for United States longshore workers who are qualified and available in sufficient numbers to perform the activity at the particular time and location from the parties to whom notice has been provided under paragraph (b)(3)(iv) (B) and (C) of this section, except that:

(A) Wherever two or more contract stevedoring companies which meet the requirements of section 32 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 932) have signed a joint collective bargaining agreement with a single labor organization recognized as an exclusive bargaining representative of United States longshore workers within the meaning of the National Labor Relations Act (29 U.S.C. 141 *et seq.*), the employer may request longshore workers from only one such contract stevedoring company, and

(B) A request for longshore workers to an operator of a private dock may be made only for longshore work to be performed at that dock and only if the operator meets the requirements of section 32 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 932);

(ii) The employer will employ all United States longshore workers made available in response to the request made pursuant to paragraph (b)(3)(i) of this section who are qualified and available in sufficient numbers and who are needed to perform the longshore activity at the particular time and location attested to;

(iii) The use of alien crewmembers for such activity is not intended or designed to influence and election of a bargaining representative for workers in the State of Alaska; and

(iv) Notice of the attestation has been provided to:

(A) Labor organizations which have been recognized as exclusive bargaining representatives of United States longshore workers within the meaning of the National Labor Relations Act (29 U.S.C. 141 *et seq.*) and which make available or intend to make available workers to the particular location where the longshore work is to be performed;

(B) Contract stevedoring companies which employ or intend to employ United States longshore workers at that location; and

(C) Operators of private docks at which the employer will use longshore workers.

(c) *Applicability.* Subparts F and G of this part apply to all employers who seek to employ alien crewmembers for longshore work at U.S. ports under the prevailing practice exception, to all employers who seek to employ alien crewmembers for longshore work at locations in the State of Alaska under the Alaska exception, to all employers claiming the automated vessel exception, and to those cases where it has been determined that an attestation is required under the automated vessel exception.

[60 FR 3956, 3976, Jan. 19, 1995, as amended at 71 FR 35520, June 21, 2006]

§ 655.501 Overview of responsibilities.

This section provides a context for the attestation process, to facilitate understanding by employers that may seek to employ alien crewmembers for longshore work under the prevailing practice exception, under the Alaska exception, and in those cases where an attestation is necessary under the automated vessel exception.

(a) *Department of Labor's responsibilities.* The United States Department of Labor (DOL) administers the attestation process. Within DOL, the Employment and Training Administration (ETA) shall have responsibility for setting up and operating the attestation process; the Employment Standards

Administration's Wage and Hour Division shall be responsible for investigating and resolving any complaints filed concerning such attestations.

(b) *Employer attestation responsibilities.* (1) Each employer seeking to use alien crewmembers for longshore work at a local U.S. port pursuant to the prevailing practice exception or where an attestation is required under the automated vessel exception for longshore work to be performed at locations other than in the State of Alaska shall, as the first step, submit an attestation on Form ETA 9033, as described in § 655.510 of this part, to ETA at the address set forth at § 655.510(b) of this part. If ETA accepts the attestation for filing, pursuant to § 655.510 of this part, ETA shall return the cover form of the accepted attestation to the employer, and, at the same time, shall provide notice of the filing to the United States Citizenship and Immigration Services of the Department of Homeland Security (DHS) office having jurisdiction over the port where longshore work will be performed.

(2) Each employer seeking to use alien crewmembers for longshore work at a particular location in the State of Alaska pursuant to the Alaska exception or where an attestation is required under the automated vessel exception for longshore work to be performed at a particular location in Alaska shall submit, as a first step, an attestation on Form ETA 9033–A, as described in § 655.533 of this part, to ETA at the address of the Seattle regional office as set forth at § 655.532 of this part. The address appears in the instructions to Form ETA 9033–A. ETA shall return the cover form of the accepted attestation to the employer, and, at the same time, shall provide notice of the filing to the DHS office having jurisdiction over the location where longshore work will be performed.

(c) *Complaints.* Complaints concerning misrepresentation in the attestation, failure of the employer to carry out the terms of the attestation, or complaints that an employer is required to file an attestation under the automated vessel exception, may be filed with the Wage and Hour Division, according to the procedures set forth in subpart G of this part. Complaints of ''misrepresentation'' may include assertions that an employer has attested to the use of alien crewmembers only for a particular activity of longshore work and has thereafter used such alien crewmembers for another activity of longshore work. If the Division determines that the complaint presents reasonable cause to warrant an investigation, the Division shall then investigate, and, where appropriate, after an opportunity for a hearing, assess sanctions and penalties. Subpart G of this part further provides that interested parties may obtain an administrative law judge hearing on the Division's determination after an investigation and may seek the Secretary's review of the administrative law judge's decision. Subpart G of this part also provides that a complainant may request that the Wage and Hour Administrator issue a cease and desist order in the case of either alleged violation(s) of an attestation or longshore work by alien crewmember(s) employed by an employer allegedly not qualified for the claimed automated vessel exception. Upon the receipt of such a request, the Division shall notify the employer, provide an opportunity for a response and an informal meeting, and then rule on the request, which shall be granted if the preponderance of the evidence submitted supports the complainant's position.

[60 FR 3956, 3976, Jan. 19, 1995, as amended at 71 FR 35521, June 21, 2006]

§ 655.502 Definitions.

For the purposes of subparts F and G of this part:

Accepted for filing means that a properly completed attestation on Form ETA 9033, including accompanying documentation for each of the requirements in § 655.510 (d) through (f) of this part, or a properly completed attestation on Form ETA 9033–A, including accompanying documentation for the requirement in § 655.537 of this part in the case of an attestation under the Alaska exception, submitted by the employer or its designated agent or representative has been received and filed by the Employment and Training Administration of the Department of Labor (DOL). (Unacceptable attestations under the

prevailing practice exception are described at § 655.510(g)(2) of this part. Unacceptable attestations under the Alaska exception are described at § 655.538(b) of this part.)

Act and *INA* mean the Immigration and Nationality Act, as amended, 8 U.S.C. 1101 *et seq.*

Activity means any activity relating to loading cargo; unloading cargo; operation of cargo-related equipment; or handling of mooring lines on the dock when a vessel is made fast or let go.

Administrative law judge means an official appointed pursuant to 5 U.S.C. 3105.

Administrator means the Administrator of the Wage and Hour Division, Employment Standards Administration, Department of Labor, or such authorized representatives as may be designated to perform any of the functions of the Administrator under subparts F and G of this part.

Administrator, Office of Foreign Labor Certification (OFLC Administrator) means the primary official of the Office of Foreign Labor Certification (OFLC Administrator), or the OFLC Administrator's designee.

Attestation means documents submitted by an employer attesting to and providing accompanying documentation to show that, under the prevailing practice exception, the use of alien crewmembers for a particular activity of longshore work at a particular U.S. port is the prevailing practice, and is not during a strike or lockout nor intended to influence an election of a bargaining representative for workers; and that notice of the attestation has been provided to the bargaining representative, or, where there is none, to the longshore workers at the local port. Under the Alaska exception, such documents shall show that, before using alien crewmen to perform longshore work, the employer will make bona fide requests for dispatch of United States longshore workers who are qualified and available in sufficient numbers and that the employer will employ all such United States longshore workers in response to such a request for dispatch; that the use of alien crewmembers is not intended or designed to influence an election of a bargaining representative for workers in the State of Alaska; and that notice of the attestation has been provided to labor organizations recognized as exclusive bargaining representatives of United States longshore workers, contract stevedoring companies, and operators of private docks at which the employer will use longshore workers.

Attesting employer means an employer who has filed an attestation.

Attorney General means the chief official of the U.S. Department of Justice or the Attorney General's designee.

Automated vessel means a vessel equipped with an automated self-unloading conveyor belt or vacuum-actuated system which is utilized for loading or unloading cargo between the vessel and the dock.

Certifying Officer (CO) means a Department of Labor official, or the CO's designee, who makes determinations about whether or not to grant applications for labor certification. The National Certifying Officer, which is the OFLC Administrator, makes such determinations in the national office of the OFLC.

Chief Administrative Law Judge means the chief official of the Office of the Administrative Law Judges of the Department of Labor or the Chief Administrative Law Judge's designee.

Contract stevedoring company means a stevedoring company which is licensed to do business in the State of Alaska and which meets the requirements of section 32 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 932).

Crewmember means any nonimmigrant alien admitted to the United States to perform services under sec. 101(a)(15)(D)(i) of the Act (8 U.S.C. 1101(a)(15)(D)(i)).

Date of filing means the date an attestation is *accepted for filing* by ETA.

Department and *DOL* mean the United States Department of Labor.

Department of Homeland Security (DHS) through the United States Citizenship and Immigration Services (USCIS) makes the determination under the Act on whether an employer of alien crewmembers may use such crewmembers for longshore work at a U.S. port.

Division means the Wage and Hour Division of the Employment Standards Administration, DOL.

Employer means a person, firm, corporation, or other association or organization, which suffers or permits, or proposes to suffer or permit, alien crewmembers to perform longshore work at a port within the U.S. For purposes of §§ 655.530 through 655.541, which govern the performance of longshore activities by alien crewmembers under the Alaska exception, ''employer'' includes any agent or representative designated by the employer.

Employment and Training Administration (ETA) means the agency within the Department of Labor (DOL) which includes the Office of Foreign Labor (OFLC).

Employment Standards Administration (ESA) means the agency within the Department of Labor (DOL) which includes the Wage and Hour Division.

Lockout means a labor dispute involving a work stoppage, wherein an employer withholds work from its employees in order to gain a concession from them.

Longshore work means any activity (except safety and environmental protection work as described in sec. 258(b)(2) of the Act) relating to the loading or unloading of cargo, the operation of cargo related equipment (whether or not integral to the vessel), or the handling of mooring lines on the dock when the vessel is made fast or let go, in the United States or the coastal waters thereof.

Longshore worker means a U.S. worker who performs longshore work.

Office of Foreign Labor Certification (OFLC) means the organizational component within the ETA that provides national leadership and policy guidance and develops regulations and procedures to carry out the responsibilities of the Secretary of Labor under the INA concerning alien workers seeking admission to the United States in order to work under the Immigration and Nationality Act, as amended.

Port means a geographic area, either on a seacoast, lake, river or any other navigable body of water, which contains one or more publicly or privately owned terminals, piers, docks, or maritime facilities, which is commonly thought of as a port by other government maritime-related agencies, such as the Maritime Administration. U.S. ports include, but are not limited to, those listed in Appendix A to this subpart.

Qualified and available in sufficient numbers means the full complement of qualified longshore workers needed to perform the longshore activity, as determined by industry standards in the State of Alaska, including safety considerations.

Secretary means the Secretary of Labor or the Secretary's designee.

Strike means a labor dispute wherein employees engage in a concerted stoppage of work (including stoppage by reason of the expiration of a collective-bargaining agreement) or engage in any concerted slowdown or other concerted interruption of operations.

Unanticipated emergency means an unexpected and unavoidable situation, such as one involving severe weather conditions, natural disaster, or mechanical breakdown, where cargo must be immediately loaded on, or unloaded from, a vessel.

United States is defined at 8 U.S.C. 1101(a)(38).

United States (U.S.) worker means a worker who is a U.S. citizen, a U.S. national, a permanent resident alien, or any other worker legally permitted to work indefinitely in the United States.

[60 FR 3956, 3976, Jan. 19, 1995, as amended at 71 FR 35520, June 21, 2006]

§ 655.510 Employer attestations.

(a) *Who may submit attestations?* An employer (or the employer's designated U.S. agent or representative) seeking to employ alien crewmembers for a particular activity of longshore work under the prevailing practice exception shall submit an attestation, provided there is not in effect in the local port any collective bargaining agreement covering at least 30 percent of the longshore workers. An attestation is required for each port at which the employer intends to use alien crewmembers for longshore work. The attestation shall include: A completed Form ETA 9033, which shall be signed by the employer (or the employer's designated agent or representative); and

facts and evidence prescribed in paragraphs (d) through (f) of this section. This § 655.510 shall not apply in the case of longshore work performed at a particular location in the State of Alaska. The procedures governing the filing of attestations under the Alaska exception are set forth at §§ 655.530 through 655.541.

(b) *Where and when should attestations be submitted?* (1) Attestations must be submitted, by U.S. mail, private carrier, or facsimile transmission to the U.S. Department of Labor office(s) which are designated by the OFLC Administrator. Attestations must be received and date-stamped by DOL at least 14 calendar days prior to the date of the first performance of the intended longshore activity, and shall be accepted for filing or returned by ETA in accordance with paragraph (g) of this section within 14 calendar days of the date received by ETA. An attestation which is accepted by ETA solely because it was not reviewed within 14 days is subject to subsequent invalidation pursuant to paragraph (i) of this section. Every employer filing an attestation shall have an agent or representative with a United States address. Such address shall be clearly indicated on the Form ETA 9033. In order to ensure that an attestation has been accepted for filing prior to the date of the performance of the longshore activity, employers are advised to take mailing time into account to make sure that ETA receives the attestation at least 14 days prior to the first performance of the longshore activity.

(2) *Unanticipated Emergencies.* ETA may accept for filing attestations received after the 14-day deadline when due to an unanticipated emergency, as defined in § 655.502 of this part. When an employer is claiming an unanticipated emergency, it shall submit documentation to support such a claim. ETA shall then make a determination on the validity of the claim, and shall accept the attestation for filing or return it in accordance with paragraph (g) of this section. ETA shall in no case accept an attestation received later than the date of the first performance of the activity.

(c) *What should be submitted?*—(1) *Form ETA 9033 with accompanying documentation.* For each port, a completed and dated original Form ETA 9033, or facsimile transmission thereof, containing the required attestation elements and the original signature of the employer (or the employer's designated agent or representative) shall be submitted, along with two copies of the completed, signed, and dated Form ETA 9033. (If the attestation is submitted by facsimile transmission, the attestation containing the original signature shall be maintained at the U.S. business address of the employer's designated agent or representative). Copies of Form ETA 9033 are available at the National Processing Centers and at the National Office. In addition, the employer shall submit two sets of all facts and evidence to show compliance with each of the attestation elements as prescribed by the regulatory standards in paragraphs (d) through (f) of this section. In the case of an investigation pursuant to subpart G of this part, the employer shall have the burden of proof to establish the validity of each attestation. The employer shall maintain in its records at the office of its U.S. agent, for a period of at least 3 years from the date of filing, sufficient documentation to meet its burden of proof, which shall at a minimum include the documentation described in this § 655.510, and shall make the documents available to Department of Labor officials upon request.

Whenever any document is submitted to a Federal agency or retained in the employer's records pursuant to this part, the document either shall be in the English language or shall be accompanied by a written translation into the English language certified by the translator as to the accuracy of the translation and his/her competency to translate.

(2) *Statutory precondition regarding collective bargaining agreements.* (i) The employer may file an attestation only when there is no collective bargaining agreement in effect in the port covering 30 percent or more of the longshore workers in the port. The employer shall attest on the Form ETA 9033 that no such collective bargaining agreement exists at the port at the time that the attestation is filed.

(ii) The employer is not required to submit with the Form ETA 9033 documentation substantiating that there is no collective bargaining agreement in effect in the port covering 30 percent or more of the longshore workers. If a complaint is filed which presents reasonable cause to believe that such an agreement exists, the Department shall conduct an investigation. In such an investigation, the employer shall have the burden of proving that no such collective bargaining agreement exists.

(3) *Ports for which attestations may be filed.* Employers may file an attestation for a port which is listed in appendix A (U.S. Seaports) to this subpart. Employers may also file an attestation for a particular location not in appendix A to this subpart if additional facts and evidence are submitted with the attestation to demonstrate that the location is a port, meeting all of the criteria as defined by § 655.502 of this part.

(4) *Attestation elements.* The attestation elements referenced in paragraph (c)(1) of this section are mandated by sec. 258(c)(1)(B) of the Act (8 U.S.C. 1288(c)(1)(B)). Section 258(c)(1)(B) of the Act requires employers who seek to have alien crewmembers engage in a longshore activity to attest as follows:

(i) The performance of the activity by alien crewmembers is permitted under the prevailing practice of the particular port as of the date of filing of the attestation;

(ii) The use of the alien crewmembers for such activity is not during a strike or lockout in the course of a labor dispute, and is not intended or designed to influence an election of a bargaining representative for workers in the local port; and

(iii) Notice of the attestation has been provided by the owner, agent, consignee, master, or commanding officer to the bargaining representative of longshore workers in the local port, or, where there is no such bargaining representative, notice has been provided to longshore workers employed at the local port.

(d) *The first attestation element: prevailing practice.* For an employer to be in compliance with the first attestation element, it is required to have been the prevailing practice during the 12-month period preceding the filing of the attestation, for a particular activity of longshore work at the particular port to be performed by alien crewmembers. For each port, a prevailing practice can exist for any of four different types of longshore work: loading of cargo, unloading of cargo, operation of cargo-related equipment, or handling of mooring lines. It is thus possible that at a particular port it is the prevailing practice for alien crewmembers to unload vessels but not the prevailing practice to load them. An employer shall indicate on the attestation form which of the four longshore activities it is claiming is the prevailing practice for such work to be performed by alien crewmembers.

(1) *Establishing a prevailing practice.* (i) In establishing that a particular activity of longshore work is the prevailing practice at a particular port, an employer shall submit facts and evidence to show that in the 12-month period preceding the filing of the attestation, one of the following conditions existed:

(A) Over fifty percent of vessels docking at the port used alien crewmembers for the activity; or

(B) Alien crewmembers made up over fifty percent of the workers in the port who engaged in the activity.

(ii) *Prevailing practice after Secretary of State determination of non-reciprocity.* Section 258(d) of the Act provides a reciprocity exception (separate from the prevailing practice exception) to the prohibition on performance of longshore work by alien crewmembers in U.S. ports. However, this reciprocity exception becomes nonapplicable where the Secretary of State determines that, for a particular activity of longshore work, a particular country (by law, regulation, or practice) prohibits such activity by U.S. crewmembers in its ports. When the Secretary of State places a country on the non-reciprocity list (which means, for the purposes of this section, *Prohibitions on longshore work by U.S. nationals; listing by country* at 22 CFR 89.1), crewmembers on vessels from that country (that is, vessels that are registered in that country or vessels whose majority ownership interest is held by nationals of that country) are not permitted to perform longshore work in U.S. waters, absent

applicability of some exception other than the reciprocity exception. The Secretary of State's determination has the following effects in the establishment of a prevailing practice for a particular longshore activity at a particular U.S. port for purposes of the prevailing practice exception.

(A) An employer from any country, other than the country which is placed on the non-reciprocity list, may include the longshore activities performed by alien crewmembers on all vessels in establishing the prevailing practice for a particular longshore activity in a particular port.

(B) An employer from a country which is placed on the non-reciprocity list may file an attestation for the prevailing practice exception under the standards and requirements established in this subpart F (except as provided in paragraph (d)(1)(ii)(C) of this section), provided that the attestation is filed at least 12 months after the date on which the employer's country is placed on the list.

(C) An employer from a country which is placed on the non-reciprocity list may file an attestation pursuant to the prevailing practice exception earlier than 12 months from the date on which the employer's country is placed on the list, except that the following restrictions shall apply to such attestation:

(*1*) The employer shall submit facts and evidence to show that, for the 12-month period preceding the date of the attestation, the use of alien crewmembers to perform a particular activity of longshore work was permitted by the prevailing practice in the port (as defined in paragraph (d)(1)(i) of this section) without considering or including such activity by crewmembers on vessels from the employer's country; or

(*2*) The employer shall submit facts and evidence (including data on activities performed by crewmembers on vessels from the employer's country) to show that the use of alien crewmembers to perform a particular activity of longshore work was permitted by the prevailing practice in the port (as defined in paragraph (d)(1)(i) of this section) for one of two periods—

(*i*) For the employer whose country has not previously been on the non-reciprocity list, the period is the continuous 12-month period prior to May 28, 1991 (the effective date of section 258 of the Act); or

(*ii*) For the employer whose country was at some time on the non-reciprocity list, but was subsequently removed from the non-reciprocity list and then restored to the non-reciprocity list (on one or more occasions), the period is the last continuous 12-month period during which the employer's country was not under the reciprocity exception (that is, was listed on the non-reciprocity list).

(*iii*) For purposes of this paragraph (d)(1):

(A) ''Workers in the port engaged in the activity'' means any person who performed the activity in any calendar day;

(B) Vessels shall be counted each time they dock at the particular port):

(C) Vessels exempt from section 258 of the INA for safety and environmental protection shall not be included in counting the number of vessels which dock at the port (see Department of Transportation Regulations); and

(D) Automated vessels shall not be included in counting the number of vessels which dock at the port. For establishing a prevailing practice under the automated vessel exception see § 655.520 of this part.

(2) *Documentation.* In assembling the facts and evidence required by paragraph (d)(1) of this section, the employer may consult with the port authority which has jurisdiction over the local port, the collective bargaining representative(s) of longshore workers at the local port, other employers, or any other entity which is familiar with the practices at the port. Such documentation shall include a written summary of a survey of the experience of shipmasters who entered the local port in the previous year; or a letter, affidavit, or other written statement from an appropriate local port authority regarding the use of alien crewmembers to perform the longshore activity at the port in the previous year; or other documentation of comparable weight. Written statements from collective bargaining representatives and/or shipping agents with direct knowledge of

practices regarding the use of alien crewmembers in the local port may also be pertinent. Such documentation shall accompany the Form ETA 9033, and any underlying documentation which supports the employer's burden of proof shall be maintained in the employer's records at the office of the U.S. agent as required by paragraph (c)(1) of this section.

(e) *The second attestation element: no strike or lockout; no intention or design to influence bargaining representative election.* (1) The employer shall attest that, at the time of submitting the attestation, there is not a strike or lockout in the course of a labor dispute covering the employer's activity, and that it will not use alien crewmembers during a strike or lockout after filing the attestation. The employer shall also attest that the employment of such aliens is not intended or designed to influence an election for a bargaining representative for workers in the local port. Labor disputes for purposes of this attestation element relate only to those involving longshore workers at the port of intended employment. This attestation element applies to strikes and lockouts and elections of bargaining representatives at the local port where the use of alien crewmembers for longshore work is intended.

(2) *Documentation.* As documentation to substantiate the requirement in paragraph (e)(1) of this section, an employer may submit a statement of the good faith efforts made to determine whether there is a strike or lockout at the particular port, as, for example, by contacting the port authority or the collective bargaining representative for longshore workers at the particular port.

(f) *The third attestation element: notice of filing.* The employer of alien crewmembers shall attest that at the time of filing the attestation, notice of filing has been provided to the bargaining representative of the longshore workers in the local port, or, where there is no such bargaining representative, notice of the filing has been provided to longshore workers employed at the local port through posting in conspicuous locations and through other appropriate means.

(1) *Notification of bargaining representative.* No later than the date the attestation is received by DOL to be considered for filing, the employer of alien crewmembers shall notify the bargaining representative (if any) of longshore workers at the local port that the attestation is being submitted to DOL. The notice shall include a copy of the Form ETA 9033, shall state the activity(ies) for which the attestation is submitted, and shall state in that notice that the attestation and accompanying documentation are available at the national office of ETA for review by interested parties. The employer may have its owner, agent, consignee, master, or commanding officer provide such notice. Notices under this paragraph (f)(1) shall include the following statement: ''Complaints alleging misrepresentation of material facts in the attestation and/or failure to comply with the terms of the attestation may be filed with any office of the Wage and Hour Division of the United States Department of Labor.''

(2) *Posting notice where there is no bargaining representative.* If there is no bargaining representative of longshore workers at the local port when the employer submits an attestation to ETA, the employer shall provide written notice to the port authority for distribution to the public on request. In addition, the employer shall post one or more written notices at the local port, stating that the attestation with accompanying documentation has been submitted, the activity(ies) for which the attestation has been submitted, and that the attestation and accompanying documentation are available at the national office of ETA for review by interested parties. Such posted notice shall be clearly visible and unobstructed, and shall be posted in conspicuous places where the longshore workers readily can read the posted notice on the way to or from their duties. Appropriate locations for posting such notices include locations in the immediate proximity of mandatory Fair Labor Standards Act wage and hour notices and Occupational Safety and Health Act occupational safety and health notices. The notice shall include a copy of the Form ETA 9033 filed with

DOL, shall provide information concerning the availability of supporting documents for examination at the national office of ETA, and shall include the following statement: ''Complaints alleging misrepresentation of material facts in the attestation and/or failure to comply with the terms of the attestation may be filed with any office of the Wage and Hour Division of the United States Department of Labor.''

(3) *Documentation.* The employer shall provide a statement setting forth the name and address of the person to whom the notice was provided and where and when the notice was posted and shall attach a copy of the notice.

(g) *Actions on attestations submitted for filing.* Once an attestation has been received from an employer, a determination shall be made by the Certifying Officer whether to accept the attestation for filing or return it. The Certifying Officer may request additional explanation and/or documentation from the employer in making this determination. An attestation which is properly filled out and which includes accompanying documentation for each of the requirements set forth at § 655.510(d) through (f) shall be accepted for filing by ETA on the date it is signed by the Certifying Officer unless it falls within one of the categories set forth in paragraph (g)(2) of this section. Once an attestation is accepted for filing, ETA shall then follow the procedures set forth in paragraph (g)(1) of this section. Upon acceptance of the employer's attestation by ETA, the attestation and accompanying documentation will be forwarded and shall be available in a timely manner for public examination at the ETA national office. ETA shall not consider information contesting an attestation received by ETA prior to the determination to accept or return the attestation for filing. Such information shall not be made part of ETA's administrative record on the attestation, but shall be referred to ESA to be processed as a complaint pursuant to subpart G of this part if the attestation is accepted by ETA for filing.

(1) *Acceptance.* (i) If the attestation is properly filled out and includes accompanying documentation for each of the requirements at § 655.510(d) through (f), and does not fall within one of the categories set forth at paragraph (g)(2) of this section, ETA shall accept the attestation for filing, provide notification to the DHS office having jurisdiction over the port where longshore work will be performed, and return to the employer, or the employer's agent or representative at a U.S. address, one copy of the attestation form submitted by the employer, with ETA's acceptance indicated thereon. The employer may then use alien crewmembers for the particular activity of longshore work at the U.S. port cited in the attestation in accordance with DHS regulations.

(ii) DOL is not the guarantor of the accuracy, truthfulness or adequacy of an attestation accepted for filing.

(2) *Unacceptable attestations.* ETA shall not accept an attestation for filing and shall return such attestation to the employer, or the employer's agent or representative at a U.S. address, when one of the following conditions exists:

(i) When the Form ETA 9033 is not properly filled out. Examples of improperly filled out Form ETA 9033's include instances where the employer has neglected to check all the necessary boxes, or where the employer has failed to include the name of the port where it intends to use the alien crewmembers for longshore work, or where the employer has named a port that is not listed in appendix A and has failed to submit facts and evidence to support a showing that the location is a port as defined by § 655.502, or when the employer has failed to sign the attestation or to designate an agent in the United States;

(ii) When the Form ETA 9033 with accompanying documentation is not received by ETA at least 14 days prior to the date of performance of the first activity indicated on the Form ETA 9033; unless the employer is claiming an unanticipated emergency, has included documentation which supports such claim, and ETA has found the claim to be valid;

(iii) When the Form ETA 9033 does not include accompanying documentation for each of the requirements set forth at § 655.510 (d) through (f);

(iv) When the accompanying documentation required by paragraph (c) of this section submitted by the employer, on its face, is inconsistent with the requirements set forth at § 655.510 (d) through (f). Examples of such a situation include instances where the Form ETA 9033 pertains to one port and the accompanying documentation to another; where the Form ETA 9033 pertains to one activity of longshore work and the accompanying documentation obviously refers to another; or where the documentation clearly indicates that only thirty percent, instead of the required fifty percent, of the activity attested to is performed by alien crewmembers;

(v) When the Administrator, Wage and Hour Division, has notified ETA, in writing, after an investigation pursuant to subpart G of this part, that the particular activity of longshore work which the employer has attested is the prevailing practice at a particular port, is not, in fact, the prevailing practice at the particular port;

(vi) When the Administrator, Wage and Hour Division, has notified ETA, in writing, that a cease and desist order has been issued pursuant to subpart G of this part, with respect to the attesting employer's performance of the particular activity and port, in violation of a previously accepted attestation;

(vii) When the Administrator, Wage and Hour Division, has notified ETA, in writing, after an investigation pursuant to subpart G of this part, that the particular employer has misrepresented or failed to comply with an attestation previously submitted and accepted for filing, but in no case for a period of more than one year after the date of the Administrator's notice and provided that DHS has not advised ETA that the prohibition is in effect for a lesser period; or

(viii) When the Administrator, Wage and Hour Division, has notified ETA, in writing, that the employer has failed to comply with any penalty, sanction, or other remedy assessed in a final agency action following an investigation by the Wage and Hour Division pursuant to subpart G of this part.

(3) *Resubmission.* If the attestation is not accepted for filing pursuant to the categories set forth in paragraph (g)(2) of this section, ETA shall return to the employer, or the employer's agent or representative, at a U.S. address, the attestation form and accompanying documentation submitted by the employer. ETA shall notify the employer, in writing, of the reason(s) that the attestation is unacceptable. When an attestation is found to be unacceptable pursuant to paragraphs (g)(2) (i) through (iv) of this section, the employer may resubmit the attestation with the proper documentation. When an attestation is found to be unacceptable pursuant to paragraphs (g)(2) (v) through (viii) of this section and returned, such action shall be the final decision of the Secretary of Labor.

(h) *Effective date and validity of filed attestations.* An attestation is filed and effective as of the date it is accepted and signed by the Certifying Officer. Such attestation is valid for the 12-month period beginning on the date of acceptance for filing, unless suspended or invalidated pursuant to subpart G of this part or paragraph (i) of this section. The filed attestation expires at the end of the 12-month period of validity.

(i) *Suspension or invalidation of filed attestations.* Suspension or invalidation of an attestation may result from enforcement action(s) under subpart G of this part (*i.e.*, investigation(s) conducted by the Administrator or cease and desist order(s) issued by the Administrator regarding the employer's misrepresentation in or failure to carry out its attestation); or from a discovery by ETA that it made an error in accepting the attestation because such attestation falls within one of the categories set forth in paragraph (g)(2) of this section.

(1) *Result of Wage and Hour Division action.* Upon the determination of a violation under subpart G of this part, the Administrator shall, pursuant to § 655.660(b), notify the DHS of the violation and of the Administrator's notice to ETA.

(2) *Result of ETA action.* If, after accepting an attestation for filing, ETA finds that the attestation is unacceptable because it falls within one of the categories set forth at paragraph (g)(2) of this section, and as a result, ETA suspends or invalidates the attestation,

ETA shall notify the DHS of such suspension or invalidation and shall return a copy of the attestation form to the employer, or the employer's agent or representative, at a U.S. address. ETA shall notify the employer, in writing, of the reason(s) that the attestation is suspended or invalidated. When an attestation is found to be suspended or invalidated pursuant to paragraphs (g)(2) (i) through (iv) of this section, the employer may resubmit the attestation with the proper documentation. When an attestation is suspended or invalidated because it falls within one of the categories in paragraphs (g)(2) (v) through (viii) of this section, such action shall be the final decision of the Secretary of Labor, except as set forth in subpart G of this part.

(j) *Withdrawal of accepted attestations.* (1) An employer who has submitted an attestation which has been accepted for filing may withdraw such attestation at any time before the 12-month period of its validity terminates, unless the Administrator has found reasonable cause under subpart G to commence an investigation of the particular attestation. Such withdrawal may be advisable, for example, when the employer learns that the particular activity(ies) of longshore work which it has attested is the prevailing practice to perform with alien crewmembers may not, in fact, have been the prevailing practice at the particular port at the time of filing. Requests for such withdrawals shall be in writing and shall be directed to the Certifying Officer.

(2) Withdrawal of an attestation shall not affect an employer's liability with respect to any failure to meet the conditions attested to which took place before the withdrawal, or for misrepresentations in an attestation. However, if an employer has not yet performed the particular longshore activity(ies) at the port in question, the Administrator will not find reasonable cause to investigate unless it is alleged, and there is reasonable cause to believe, that the employer has made misrepresentations in the attestation or documentation thereof, or that the employer has not in fact given the notice attested to.

(Approved by the Office of Management and Budget under Control No. 1205–0309)

[60 FR 3956, 3976, Jan. 19, 1995, as amended at 71 FR 35520, June 21, 2006]

§ 655.520 Special provisions regarding automated vessels.

In general, an attestation is not required in the case of a particular activity of longshore work consisting of the use of automated self-unloading conveyor belt or vacuum-actuated systems on a vessel. The legislation creates a rebuttable presumption that the use of alien crewmembers for the operation of such automated systems is the prevailing practice. In order to overcome such presumption, it must be shown by the preponderance of the evidence submitted by any interested party, that the use of alien crewmembers for such activity is not the prevailing practice. Longshore work involving the use of such equipment shall be exempt from the attestation requirement only if the activity consists of using that equipment. If the automated equipment is not used in the particular activity of longshore work, an attestation is required as described under § 655.510 of this part if it is the prevailing practice in the port to use alien crewmembers for this work, except that in all cases, where an attestation is required for longshore work to be performed at a particular location in the State of Alaska, an employer shall file such attestation under the Alaska exception pursuant to §§ 655.530 through 655.541 on Form ETA 9033–A. When automated equipment is used in the particular activity of longshore work, an attestation is required only if the Administrator finds, based on a preponderance of the evidence which may be submitted by any interested party, that the performance of the particular activity of longshore work is not the prevailing practice at the port, or was during a strike or lockout or intended to influence an election of a bargaining representative for workers in the local port, or if the Administrator issues a cease and desist order against use of the automated equipment without such attestation.

(a) *Procedure when attestation is required.* If it is determined pursuant to subpart G of this part that an attestation is required for longshore work consisting of the use of automated equipment at a location other than in the State of Alaska, the employer shall comply with all the requirements set forth at § 655.510 of this part except paragraph (d) of § 655.510. In lieu of complying with § 655.510(d) of this part, the employer shall comply with paragraph (b) of this section. If it is determined pursuant to subpart G of this part that an attestation is required for longshore work consisting of the use of automated equipment at a particular location in the State of Alaska, the employer shall comply with all the requirements set forth at §§ 655.530 through 655.541 of this part.

(b) *The first attestation element: prevailing practice for automated vessels.* For an employer to be in compliance with the first attestation element, it is required to have been the prevailing practice that over fifty percent (as described in paragraph (b)(1) of this section) of a particular activity of longshore work which was performed through the use of automated self-unloading conveyor belt or vacuum-actuated equipment at the particular port during the 12-month period preceding the filing of the attestation, was performed by alien crewmembers. For purposes of this paragraph (b), only automated vessels shall be included in counting the number of vessels which dock at the port.

(1) *Establishing a prevailing practice.* (i) In establishing that the use of alien crewmembers to perform a particular activity of longshore work consisting of the use of self-unloading conveyor belt or vacuum-actuated systems on a vessel is the prevailing practice at a particular port, an employer shall submit facts and evidence to show that in the 12-month period preceding the filing of the attestation, one of the following conditions existed:

(A) Over fifty percent of the automated vessels docking at the port used alien crewmembers for the activity (for purposes of this paragraph (b)(1), a vessel shall be counted each time it docks at the particular port); or

(B) Alien crewmembers made up over fifty percent of the workers who performed the activity with respect to such automated vessels.

(ii) *Prevailing practice after Secretary of State determination of non-reciprocity.* Section 258(d) of the Act provides a reciprocity exception (separate from the prevailing practice exception) to the prohibition on performance of longshore work by alien crewmembers in U.S. ports. However, this reciprocity exception becomes nonapplicable where the Secretary of State determines that, for a particular activity of longshore work, a particular country (by law, regulation, or practice) prohibits such activity by U.S. crewmembers in its ports. When the Secretary of State places a country on the non-reciprocity list (which means, for the purposes of this section, *Prohibitions on longshore work by U.S. nationals; listing by country* at 22 CFR 89.1), crewmembers on vessels from that country (that is, vessels that are registered in that country or vessels whose majority ownership interest is held by nationals of that country) are not permitted to perform longshore work in U.S. waters, absent applicability of some exception other than the reciprocity exception. The Secretary of State's determination has the following effects in the establishment of a prevailing practice for a particular longshore activity at a particular U.S. port for purposes of the prevailing practice exception.

(A) An employer from any country, other than the country which is placed on the non-reciprocity list, may include the longshore activities performed by alien crewmembers on all vessels in establishing the prevailing practice for a particular longshore activity in a particular port.

(B) An employer from a country which is placed on the non-reciprocity list may file an attestation for the prevailing practice exception under the standards and requirements established in this subpart F (except as provided in paragraph (b)(1)(ii)(C) of this section), provided that the attestation is filed at least 12 months after the date on which the employer's country is placed on the list.

(C) An employer from a country which is placed on the non-reciprocity

list may file an attestation pursuant to the prevailing practice exception earlier than 12 months from the date on which the employer's country is placed on the list, except that the following restrictions shall apply to such attestation:

(*1*) The employer shall submit facts and evidence to show that, for the 12-month period preceding the date of the attestation, the use of alien crewmembers to perform a particular activity of longshore work was permitted by the prevailing practice in the port (as defined in paragraph (d)(1)(i) of this section) without considering or including such activity by crewmembers on vessels from the employer's country; or

(*2*) The employer shall submit facts and evidence (including data on activities performed by crewmembers on vessels from the employer's country) to show that the use of alien crewmembers to perform a particular activity of longshore work was permitted by the prevailing practice in the port (as defined in paragraph (b)(1)(i) of this section) for one of two periods—

(*i*) For the employer whose country has not previously been on the non-reciprocity list, the period is the continuous 12-month period prior to May 28, 1991 (the effective date of section 258 of the Act); or

(*ii*) For the employer whose country was at some time on the non-reciprocity list, but was subsequently removed from the non-reciprocity list and then restored to the non-reciprocity list (on one or more occasions), the period is the last continuous 12-month period during which the employer's country was not under the reciprocity exception (that is, was listed on the non-reciprocity list).

(2) *Documentation.* In assembling the documentation described in paragraph (b)(1) of this section, the employer may consult with the port authority which has jurisdiction over the local port, the collective bargaining representative(s) of longshore workers at the local port, other employers, or any other entity which is familiar with the practices at the port. The documentation shall include a written summary of a survey of the experience of shipmasters who entered the local port in the previous year; or a letter, affidavit, or other written statement from an appropriate local port authority regarding the use of alien crewmembers to perform the longshore activity at the port in the previous year; or other documentation of comparable weight. Written statements from collective bargaining representatives and/or shipping agents with direct knowledge of practices regarding the use of alien crewmembers may also be pertinent. Such documentation shall accompany the Form ETA 9033, and any underlying documentation which supports the employer's burden of proof shall be maintained in the employer's records at the office of the U.S. agent as required under § 655.510(c)(1) of this part.

(Approved by the Office of Management and Budget under Control No. 1205–0309)

ALASKA EXCEPTION

§ 655.530 Special provisions regarding the performance of longshore activities at locations in the State of Alaska.

Applicability. Section § 655.510 of this part shall not apply to longshore work performed at locations in the State of Alaska. The performance of longshore work by alien crewmembers at locations in the State of Alaska shall instead be governed by §§ 655.530 through 655.541. The use of alien crewmembers to perform longshore work in Alaska consisting of the use of an automated self-unloading conveyor belt or vacuum-actuated system on a vessel shall continue to be governed by the provisions of § 655.520 of this part, except that, if the Administrator finds, based on a preponderance of the evidence which may be submitted by any interested party, that an attestation is required because the performance of the particular activity of longshore work is not the prevailing practice at the location in the State of Alaska, or was during a strike or lockout or intended to influence an election of a bargaining representative for workers at that location, or if the Administrator issues a cease and desist order against use of the automated equipment without such an attestation, the required attestation shall be filed pursuant to the Alaska exception at §§ 655.530 through

655.541 and not the prevailing practice exception at § 655.510.

§ 655.531 Who may submit attestations for locations in Alaska?

In order to use alien crewmembers to perform longshore activities at a particular location in the State of Alaska an employer shall submit an attestation on Form ETA 9033–A. As noted at § 655.502, ''Definitions,'' for purposes of §§ 655.530 through 655.541, which govern the performance of longshore activities by alien crewmembers under the Alaska exception, ''employer'' includes any agent or representative designated by the employer. An employer may file a single attestation for multiple locations in the State of Alaska.

§ 655.532 Where and when should attestations be submitted for locations in Alaska?

(a) Attestations shall be submitted, by U.S. mail, private carrier, or facsimile transmission to the U.S. Department of Labor regional office of the Employment and Training Administration in Seattle, Washington. Except as provided in paragraph (b) of this section, attestations shall be received and date-stamped by the Department at least 30 calendar days prior to the date of the first performance of the longshore activity. The attestation shall be accepted for filing or returned by ETA in accordance with § 655.538 within 14 calendar days of the date received by ETA. An attestation which is accepted by ETA solely because it was not reviewed within 14 days is subject to subsequent invalidation pursuant to § 655.540 of this part. An employer filing an attestation shall have an agent or representative with a United States address. Such address shall be clearly indicated on the Form ETA 9033–A. In order to ensure that an attestation has been accepted for filing prior to the date of the first performance of the longshore activity, employers are advised to take mailing time into account to make sure that ETA receives the attestation at least 30 days prior to the first performance of the longshore activity.

(b) *Late filings.* ETA may accept for filing attestations received after the 30-day deadline where the employer could not have reasonably anticipated the need to file an attestation for the particular location at that time. When an employer states that it could not have reasonably anticipated the need to file the attestation at that time, it shall submit documentation to ETA to support such a claim. ETA shall then make a determination on the validity of the claim and shall accept the attestation for filing or return it in accordance with § 655.538 of this part. ETA in no case shall accept an attestation received less than 24 hours prior to the first performance of the activity.

§ 655.533 What should be submitted for locations in Alaska?

(a) *Form ETA 9033–A with accompanying documentation.* A completed and dated original Form ETA 9033–A, or facsimile transmission thereof, containing the required attestation elements and the original signature of the employer or the employer's agent or designated representative, along with two copies of the completed, signed, and dated Form ETA 9033–A shall be submitted to ETA. (If the attestation is submitted by facsimile transmission, the attestation containing the original signature shall be maintained at the U.S. business address of the employer's designated agent or representative). Copies of Form ETA 9033–A are available at the National Processing Centers and at the National office. In addition, the employer shall submit two sets of facts and evidence to show compliance with the fourth attestation element at § 655.537 of this part. In the case of an investigation pursuant to subpart G of this part, the employer has the burden of proof to establish the validity of each attestation. The employer shall maintain in its records at the office of its U.S. agent, for a period of at least 3 years from the date of filing, sufficient documentation to meet its burden of proof, which shall at a minimum include the documentation described in §§ 655.530 through 655.541, and shall make the documents available to Department of Labor officials upon request. Whenever any document is submitted to a Federal agency or retained in the employer's records pursuant to this part, the document shall either be in the English language or shall

be accompanied by a written translation into the English language certified by the translator as to the accuracy of the translation and his/her competency to translate.

(b) *Attestation elements.* The attestation elements referenced in §§ 655.534 through 655.537 of this part are mandated by Sec. 258(d)(1) of the Act (8 U.S.C. 1288(d)(1)). Section 258(d)(1) of the Act requires employers who seek to have alien crewmembers engage in longshore activity at locations in the State of Alaska to attest as follows:

(1) The employer will make a bona fide request for United States longshore workers who are qualified and available in sufficient numbers to perform the activity at the particular time and location from the parties to whom notice has been provided under § 655.537(a)(1) (ii) and (iii), except that:

(i) Wherever two or more contract stevedoring companies have signed a joint collective bargaining agreement with a single labor organization recognized as an exclusive bargaining representative of United States longshore workers within the meaning of the National Labor Relations Act (29 U.S.C. 141 *et seq.*), the employer may request longshore workers from only one such contract stevedoring company, and

(ii) A request for longshore workers to an operator of a private dock may be made only for longshore work to be performed at that dock and only if the operator meets the requirements of section 32 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 932);

(2) The employer will employ all United States longshore workers made available in response to the request made pursuant to § 655.534(a)(1) who are qualified and available in sufficient numbers and who are needed to perform the longshore activity at the particular time and location to which the employer has attested;

(3) The use of alien crewmembers for such activity is not intended or designed to influence an election of a bargaining representative for workers in the State of Alaska; and

(4) Notice of the attestation has been provided to:

(i) Labor organizations which have been recognized as exclusive bargaining representatives of United States longshore workers within the meaning of the National Labor Relations Act (29 U.S.C. 141 *et seq.*) and which make available or intend to make available workers to the particular location where the longshore work is to be performed;

(ii) Contract stevedoring companies which employ or intend to employ United States longshore workers at that location; and

(iii) Operators of private docks at which the employer will use longshore workers.

[60 FR 3956, 3976, Jan. 19, 1995, as amended at 71 FR 35520, June 21, 2006]

§ 655.534 The first attestation element for locations in Alaska: Bona fide request for dispatch of United States longshore workers.

(a) The first attestation element shall be satisfied when the employer signs Form ETA 9033–A, attesting that, before using alien crewmembers to perform longshore work during the validity period of the attestation, the employer will make a bona fide request for United States longshore workers who are qualified and available in sufficient numbers to perform the specified longshore activity from the parties to whom notice is provided under § 655.537(a)(1) (ii) and (iii). Although an employer is required to provide notification of filing to labor organizations recognized as exclusive bargaining representatives of United States longshore workers pursuant to § 655.537(a)(1)(i) of this part, an employer need not request dispatch of United States longshore workers directly from such parties. The requests for dispatch of United States longshore workers pursuant to this section shall be directed to contract stevedoring companies which employ or intend to employ United States longshore workers at that location, and to operators of private docks at which the employer will use longshore workers. An employer is not required to request dispatch of United States longshore workers from private dock operators or contract stevedoring companies which do not meet the requirements of section 32 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 932) or, in the case of

contract stevedoring companies, which are not licensed to do business in the State of Alaska.

(1) Wherever two or more contract stevedoring companies have signed a joint collective bargaining agreement with a single qualified labor organization, the employer may request longshore workers from only one of such contract stevedoring companies. A qualified labor organization is one which has been recognized as an exclusive bargaining representative of United States longshore workers within the meaning of the National Labor Relations Act (29 U.S.C. 141 *et seq.*) and which makes available or intends to make available workers to the particular location where the longshore work is to be performed.

(2) A request for longshore workers to an operator of a private dock may be made only for longshore work to be performed at that dock.

(3) An employer shall not be required to request longshore workers from a party if that party has notified the employer in writing that it does not intend to make available United States longshore workers who are qualified and available in sufficient numbers to the time and location at which the longshore work is to be performed.

(4) A party that has provided such written notice to the employer under paragraph (a)(3) of this section may subsequently notify the employer in writing that it is prepared to make available United States longshore workers who are qualified and available in sufficient numbers to perform the longshore activity at the time and location where the longshore work is to be performed. In that event, the employer's obligations to that party under §§ 655.534 and 655.535 of this part shall recommence 60 days after its receipt of such notice.

(5) When a party has provided written notice to the employer under paragraph (a)(3) of this section that it does not intend to dispatch United States longshore workers to perform the longshore work attested to by the employer, such notice shall expire upon the earliest of the following events:

(i) When the terms of such notice specify an expiration date at which time the employer's obligation to that party under §§ 655.534 and 655.535 of this part shall recommence;

(ii) When retracted pursuant to paragraph (a)(4) of this section; or

(iii) Upon the expiration of the validity of the attestation.

(b) *Documentation.* To substantiate the requirement in paragraph (a) of this section, an employer shall develop and maintain documentation to meet the employer's burden of proof under the first attestation element. The employer shall retain records of all requests for dispatch of United States longshore workers to perform the longshore work attested to. Such documentation shall consist of letters, telephone logs, facsimiles or other memoranda to show that, before using alien crewmembers to perform longshore work, the employer made a bona fide request for United States longshore workers who are qualified and available in sufficient numbers to perform the longshore activity. At a minimum, such documentation shall include the date the request was made, the name and telephone number of the particular individual(s) to whom the request for dispatch was directed, and the number and composition of full work units requested. Further, whenever any party has provided written notice to the employer under paragraph (a)(3) of this section, the employer shall retain the notice for the period of time specified in § 655.533 of this part, and, if appropriate, any subsequent notice by that party that it is prepared to make available United States longshore workers at the times and locations attested to.

§ 655.535 The second attestation element for locations in Alaska: Employment of United States longshore workers.

(a) The second attestation element shall be satisfied when the employer signs Form ETA 9033–A, attesting that during the validity period of the attestation, the employer will employ all United States longshore workers made available in response to the request for dispatch who, in compliance with applicable industry standards in the State of Alaska, including safety considerations, are qualified and available in sufficient numbers and are needed to perform the longshore activity at the

particular time and location attested to.

(1) In no case shall an employer filing an attestation be required to hire less than a full work unit of United States longshore workers needed to perform the longshore activity nor be required to provide overnight accommodations for the longshore workers while employed. For purposes of this section, ''full work unit'' means the full complement of longshore workers needed to perform the longshore activity, as determined by industry standards in the State of Alaska, including safety considerations. Where the makeup of a full work unit is covered by one or more collective bargaining agreements in effect at the time and location where longshore work is to be performed, the provisions of such agreement(s) shall be deemed to be in conformance with industry standards in the State of Alaska.

(2) In no case shall an employer be required to provide transportation to the vessel where the longshore work is to be performed, except where:

(i) Surface transportation is available; for purposes of this section, ''surface transportation'' means a tugboat or other vessel which is appropriately insured, operated by licensed personnel, and capable of safely transporting U.S. longshore workers from shore to a vessel on which longshore work is to be performed;

(ii) Such transportation may be safely accomplished; and

(iii)(A) Travel time to the vessel does not exceed one-half hour each way; and

(B) Travel distance to the vessel from the point of embarkation does not exceed 5 miles; for purposes of this section, ''point of embarkation'' means a dock or landing at which U.S. longshore workers may be safely boarded for transport from shore to a vessel on which longshore work is to be performed; or

(C) In the cases of Wide Bay, Alaska, and Klawock/Craig, Alaska, travel time does not exceed 45 minutes each way and travel distance to the vessel from the point of embarkation does not exceed 7.5 miles, unless the party responding to the request for dispatch agrees to lesser time and distance specifications.

(3) If a United States longshore worker is capable of getting to and from the vessel where longshore work is to be performed when the vessel is beyond the time and distance limitations specified in paragraph (a)(2)(iii) of this section, and where all of the other criteria governing the employment of United States longshore workers under this subpart are met (e.g., ''qualified and available in sufficient numbers''), the employer is still obligated to employ the worker to perform the longshore activity. In such instance, however, the employer shall not be required to provide such transportation nor to reimburse the longshore worker for the cost incurred in transport to and from the vessel.

(4) Where an employer is required to provide transportation to the vessel because it is within the time and distance limitations specified in (a)(2)(iii) of this section, the employer also shall be required to provide return transportation to the point of embarkation.

(b) *Documentation.* To substantiate the requirement in paragraph (a) of this section, an employer shall develop and maintain documentation to meet the employer's burden of proof. Such documentation shall include records of payments to contract stevedoring companies or private dock operators, payroll records for United States longshore workers employed, or other documentation to show clearly that the employer has met its obligation to employ all United States longshore workers made available in response to a request for dispatch who are qualified and available in sufficient numbers. The documentation shall specify the number of full work units employed pursuant to this section, the composition of such full work units (*i.e.*, number of workers by job title), and the date(s) and location(s) where the longshore work was performed. The employer also shall develop and maintain documentation concerning the provision of transportation from the point of embarkation to the vessel on which longshore work is to be performed. Each time one or more United States longshore workers are dispatched in response to the request

under § 655.534, the employer shall retain a written record of whether transportation to the vessel was provided and the time and distance from the point of embarkation to the vessel.

§ 655.536 The third attestation element for locations in Alaska: No intention or design to influence bargaining representative election.

(a) The employer shall attest that use of alien crewmembers to perform the longshore activity specified on the Form ETA 9033–A is not intended or designed to influence an election of a bargaining representative for workers in the State of Alaska.

(b) *Documentation.* The employer need not develop nor maintain documentation to substantiate the statement referenced in paragraph (a) of this section. In the case of an investigation, however, the employer has the burden of proof to show that the use of alien crewmembers to perform the longshore activity specified on the Form ETA 9033–A was not intended nor designed to influence an election of a bargaining representative for workers in the State of Alaska.

§ 655.537 The fourth attestation element for locations in Alaska: Notice of filing.

(a)(1) The employer shall attest that at the time of filing the attestation, notice of filing has been provided to:

(i) Labor organizations which have been recognized as exclusive bargaining representatives of United States longshore workers within the meaning of the National Labor Relations Act (29 U.S.C. 141 *et seq.*) and which make available or intend to make available workers to the particular location where the longshore work is to be performed;

(ii) Contract stevedoring companies which employ or intend to employ United States longshore workers at the location where the longshore work is to be performed; and

(iii) Operators of private docks at which the employer will use longshore workers.

(2) The notices provided under paragraph (a)(1) of this section shall include a copy of the Form ETA 9033–A to be submitted to ETA, shall provide information concerning the availability of supporting documents for public examination at the national office of ETA, and shall include the following statement: ''Complaints alleging a misrepresentation of material facts in the attestation and/or failure to comply with the terms of the attestation may be filed with any office of the Wage and Hour Division of the United States Department of Labor.''

(b) The employer shall request a copy of the Certificate of Compliance issued by the district director of the Office of Workers' Compensation Programs under section 37 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 932) from the parties to whom notice is provided pursuant to paragraphs (a)(1) (ii) and (iii) of this section. An employer's obligation to make a bona fide request for dispatch of U.S. longshore workers under § 655.534 of this part before using alien crewmembers to perform the longshore work attested to shall commence upon receipt of the copy of the Certificate of Compliance.

(c) *Documentation.* The employer shall develop and maintain documentation sufficient to meet its burden of proving the validity of the statement referenced in paragraphs (a) and (b) of this section and attested to on the Form ETA 9033–A. Such documentation shall include a copy of the notices provided, as required by paragraph (a)(1) of this section, and shall be submitted to ETA along with the Form ETA 9033–A.

§ 655.538 Actions on attestations submitted for filing for locations in Alaska.

Once an attestation has been received from an employer, a determination shall be made by the Certifying Officer whether to accept the attestation for filing or return it. The Certifying Officer may request additional explanation and/or documentation from the employer in making this determination. An attestation which is properly filled out and which includes accompanying documentation for the requirement set forth at § 655.537 of this part shall be accepted for filing by ETA on the date it is signed by the Certifying Officer unless it falls within one of the categories set forth in paragraph (b) of this section. Once an attestation

is accepted for filing, ETA shall then follow the procedures set forth in paragraph (a)(1) of this section. Upon acceptance of the employer's attestation by ETA, the attestation and accompanying documentation shall be forwarded to and be available for public examination at the ETA national office in a timely manner. ETA shall not consider information contesting an attestation received by ETA prior to the determination to accept or return the attestation for filing. Such information shall not be made a part of ETA's administrative record on the attestation, but shall be referred to ESA to be processed as a complaint pursuant to subpart G of this part if the attestation is accepted by ETA for filing.

(a) *Acceptance.* (1) If the attestation is properly filled out and includes accompanying documentation for the requirement set forth at § 655.537, and does not fall within one of the categories set forth at paragraph (b) of this section, ETA shall accept the attestation for filing, provide notification to the DHS office having jurisdiction over the location where longshore work will be performed, and return to the employer, or the employer's agent or representative at a U.S. address, one copy of the attestation form submitted by the employer, with ETA's acceptance indicated thereon. Before using alien crewmembers to perform the longshore work attested to on Form ETA 9033–A, the employer shall make a bona fide request for and employ United States longshore workers who are qualified and available in sufficient numbers pursuant to §§ 655.534 and 655.535. Where such a request for dispatch of United States longshore workers is unsuccessful, either in whole or in part, any use of alien crewmembers to perform longshore activity shall be in accordance with DHS regulations.

(2) DOL is not the guarantor of the accuracy, truthfulness or adequacy of an attestation accepted for filing.

(b) *Unacceptable attestations.* ETA shall not accept an attestation for filing and shall return such attestation to the employer, or the employer's agent or representative at a U.S. address, when any one of the following conditions exists:

(1) When the Form ETA 9033–A is not properly filled out. Examples of improperly filled out Form ETA 9033–A's include instances where the employer has neglected to check all the necessary boxes, where the employer has failed to include the name of any port, city, or other geographical reference point where longshore work is to be performed, or where the employer has failed to sign the attestation or to designate an agent in the United States.

(2) When the Form ETA 9033–A with accompanying documentation is not received by ETA at least 30 days prior to the first performance of the longshore activity, unless the employer is claiming that it could not have reasonably anticipated the need to file the attestation for that location at that time, and has included documentation which supports this contention, and ETA has found the claim to be valid.

(3) When the Form ETA 9033–A does not include accompanying documentation for the requirement set forth at § 655.537.

(4) When the accompanying documentation submitted by the employer and required by § 655.537, on its face, is inconsistent with that section. Examples of such a situation include an instance where the Form ETA 9033–A indicates that the longshore work will be performed at a particular private dock and the documentation required under the notice attestation element indicates that notice was provided to an operator of a different private dock, or where the longshore work is to be performed at a particular time and location in the State of Alaska and the notice of filing provided to qualified labor organizations and contract stevedoring companies indicates that the longshore work is to be performed at a different time and/or location.

(5) When the Administrator, Wage and Hour Division, has notified ETA, in writing, after an investigation pursuant to subpart G of this part, that a cease and desist order has been issued pursuant to subpart G of this part, with respect to the attesting employer's performance of longshore work at a particular location in the State of Alaska, in violation of a previously accepted attestation.

(6) When the Administrator, Wage and Hour Division, has notified ETA, in writing, after an investigation pursuant to subpart G of this part, that the particular employer has misrepresented or failed to comply with an attestation previously submitted and accepted for filing, but in no case for a period of more than one year after the date of the Administrator's notice and provided that DHS has not advised ETA that the prohibition is in effect for a lesser period.

(7) When the Administrator, Wage and Hour Division, has notified ETA, in writing, that the employer has failed to comply with any penalty, sanction, or other remedy assessed in a final agency action following an investigation by the Wage and Hour Division pursuant to subpart G of this part.

(c) *Resubmission.* If the attestation is not accepted for filing pursuant to paragraph (b) of this section, ETA shall return to the employer, or the employer's agent or representative, at a U.S. address, the attestation form and accompanying documentation submitted by the employer. ETA shall notify the employer, in writing, of the reason(s) that the attestation is unacceptable. When an attestation is found to be unacceptable pursuant to paragraph (b)(1), (2), (3), or (4) of this section, the employer may resubmit the corrected attestation with the proper documentation. When an attestation is found to be unacceptable pursuant to paragraph (b) (5), (6), or (7) of this section and returned, such action shall be the final decision of the Secretary of Labor.

§ 655.539 Effective date and validity of filed attestations for locations in Alaska.

An attestation is filed and effective as of the date it is accepted and signed by the Certifying Officer. Such attestation is valid for the 12-month period beginning on the date of acceptance for filing, unless suspended or invalidated pursuant to § 655.540 of this part. The filed attestation expires at the end of the 12-month period of validity.

§ 655.540 Suspension or invalidation of filed attestations for locations in Alaska.

Suspension or invalidation of an attestation may result from enforcement action(s) under subpart G of this part (*i.e.*, investigation(s) conducted by the Administrator or cease and desist order(s) issued by the Administrator regarding the employer's misrepresentation in or failure to carry out its attestation); or from a discovery by ETA that it made an error in accepting the attestation because such attestation falls within one of the categories set forth in § 655.538(b).

(a) *Result of Wage and Hour Division action.* Upon the determination of a violation under subpart G of this part, the Administrator shall, pursuant to § 655.665(b), notify the DHS of the violation and of the Administrator's notice to ETA.

(b) *Result of ETA action.* If, after accepting an attestation for filing, ETA finds that the attestation is unacceptable because it falls within one of the categories set forth at § 655.538(b) and, as a result, ETA suspends or invalidates the attestation, ETA shall notify the DHS of such suspension or invalidation and shall return a copy of the attestation form to the employer, or the employer's agent or representative at a U.S. address. ETA shall notify the employer, in writing, of the reason(s) that the attestation is suspended or invalidated.

§ 655.541 Withdrawal of accepted attestations for locations in Alaska.

(a) An employer who has submitted an attestation which has been accepted for filing may withdraw such attestation at any time before the 12-month period of its validity terminates, unless the Administrator has found reasonable cause under subpart G to commence an investigation of the particular attestation. Such withdrawal may be advisable, for example, when the employer learns that the country in which the vessel is registered and of which nationals of such country hold a majority of the ownership interest in the vessel has been removed from the non-reciprocity list (which means, for purposes of this section, *Prohibitions on longshore work by U.S. nationals; listing*

by country at 22 CFR 89.1). In that event, an attestation would no longer be required under subpart F of this part, since upon being removed from the non-reciprocity list the performance of longshore work by alien crewmembers would be permitted under the reciprocity exception at sec. 258(e) of the Act (8 U.S.C. 1288(e)). Requests for withdrawals shall be in writing and shall be directed to the Certifying Officer.

(b) Withdrawal of an attestation shall not affect an employer's liability with respect to any failure to meet the conditions attested to which took place before the withdrawal, or for misrepresentations in an attestation. However, if an employer has not yet performed the longshore activities at the location(s) in question, the Administrator shall not find reasonable cause to investigate unless it is alleged, and there is reasonable cause to believe, that the employer has made misrepresentations in the attestation or documentation thereof, or that the employer has not in fact given the notice attested to.

PUBLIC ACCESS

§ 655.550 Public access.

(a) *Public examination at ETA.* ETA shall make available for public examination in Washington, DC, a list of employers which have filed attestations under this subpart, and for each such employer, a copy of the employer's attestation and accompanying documentation it has received.

(b) *Notice to public.* ETA periodically shall publish a list in the FEDERAL REGISTER identifying under this subpart employers which have submitted attestations; employers which have attestations on file; and employers which have submitted attestations which have been found unacceptable for filing.

(Approved by the Office of Management and Budget under Control No. 1205–0309)

APPENDIX A TO SUBPART F OF PART 655—U.S. SEAPORTS

The list of 224 seaports includes all major and most smaller ports serving ocean and Great Lakes commerce.

NORTH ATLANTIC RANGE

Bucksport, ME
Eastport, ME
Portland, ME
Searsport, ME
Portsmouth, NH
Boston, MA
Fall River, MA
New Bedford, MA
Providence, RI
Bridgeport, CT
New Haven, CT
New London, CT
Albany, NY
New York, NY/NJ
Camden, NJ
Gloucester City, NJ
Paulsboro, NJ
Chester, PA
Marcus Hook, PA
Philadelphia, PA
Delaware City, DE
Wilmington, DE
Baltimore, MD
Cambridge, MD
Alexandria, VA
Chesapeake, VA
Hopewell, VA
Newport News, VA
Norfolk, VA
Portsmouth, VA
Richmond, VA

SOUTH ATLANTIC RANGE

Morehead City, NC
Southport, NC
Wilmington, NC
Charleston, SC
Georgetown, SC
Port Royal, SC
Brunswick, GA
Savannah, GA
St. Mary, GA
Cocoa, FL
Fernandina Beach, FL
Fort Lauderdale, FL
Fort Pierce, FL
Jacksonville, FL
Miami, FL
Palm Beach, FL
Port Canaveral, FL
Port Everglades, FL
Riviera, FL
Aguadilla, PR
Ceiba, PR
Guanica, PR
Guayanilla, PR
Humacao, PR
Jobos, PR
Mayaguez, PR
Ponce, PR
San Juan, PR
Vieques, PR
Yabucoa, PR
Alucroix, VI
Charlotte Amalie, VI
Christiansted, VI
Frederiksted, VI
Limetree Bay, VI

NORTH PACIFIC RANGE

Astoria, OR
Bandon, OR
Columbia City, OR
Coos Bay, OR
Mapleton, OR
Newport, OR
Portland, OR
Rainier, OR
Reedsport, OR
St. Helens, OR
Toledo, OR
Anacortes, WA
Bellingham, WA
Edmonds (Edwards Point), WA
Everett, WA
Ferndale, WA
Friday Harbor, WA
Grays Harbor, WA
Kalama, WA
Longview, WA
Olympia, WA
Point Wells, WA
Portage, WA
Port Angeles, WA
Port Gamble, WA
Port Townsend, WA
Raymond, WA
Seattle, WA
Tacoma, WA
Vancouver, WA
Willapa Harbor, WA
Winslow, WA

GREAT LAKES RANGE

Duluth, MN
Silver Bay, MN
Green Bay, WI
Kenosha, WI
Manitowoc, WI
Milwaukee, WI
Sheboygan, WI
Superior, WI
Alpena, MI
Bay City, MI
Detroit, MI
De Tour Village, MI
Essexville, MI
Ferrysburg, MI

Grand Haven, MI	Fairport, OH
Marine City, MI	Huron, OH
Muskegon, MI	Lorain, OH
Port Huron, MI	Sandusky, OH
Presque Isle, MI	Toledo, OH
Rogers City, MI	Erie, PA
Saginaw, MI	Buffalo, NY
Sault Ste Marie, MI	Odgensburg, NY
Chicago, IL	Oswego, NY
Ashtabula, OH	Rochester, NY
Cincinnati, OH	Burns Harbor, IN
Cleveland, OH	E. Chicago, IN
Conneaut, OH	Gary, IN

GULF COAST RANGE

Panama City, FL	Beaumont, TX
Pensacola, FL	Brownsville, TX
Port Manatee, FL	Corpus Christi, TX
Port St. Joe, FL	Freeport, TX
Tampa, FL	Galveston, TX
Mobile, AL	Harbor Island, TX
Gulfport, MS	Houston, TX
Pascagoula, MS	Orange, TX
Baton Rouge, LA	Port Arthur, TX
Gretna, LA	Port Isabel, TX
Lake Charles, LA	Port Lavaca, TX
Louisiana Offshore Oil Port, LA	Port Neches, TX
New Orleans, LA	Sabine, TX
	Texas City, TX

SOUTH PACIFIC RANGE

Alameda, CA	Port Hueneme, CA
Antioch, CA	Port San Luis, CA
Benicia, CA	Redwood City, CA
Carlsbad, CA	Richmond, CA
Carpinteria, CA	Sacramento, CA
Crockett, CA	San Diego, CA
El Segundo, CA	San Francisco, CA
Eureka, CA	Selby, CA
Estero Bay, CA	Stockton, CA
Gaviota, CA	Vallejo, CA
Huntington Beach, CA	Ventura, CA
Long Beach, CA	Barbers Point, HI
Los Angeles, CA	Hilo, HI
Mandalay Beach, CA	Honolulu, HI
Martinez, CA	Kahului, HI
Moss Landing, CA	Kaunakakai, HI
Oakland, CA	Kawaihae, HI
Pittsburg, CA	Nawiliwili, HI
Port Costa, CA	Port Allen, HI

Subpart G—Enforcement of the Limitations Imposed on Employers Using Alien Crewmembers for Longshore Activities in U.S. Ports

SOURCE: 60 FR 3969, 3977, Jan. 19, 1995, unless otherwise noted.

§ 655.600 Enforcement authority of Administrator, Wage and Hour Division.

(a) The Administrator shall perform all the Secretary's investigative and enforcement functions under section 258 of the INA (8 U.S.C. 1288) and subparts F and G of this part.

(b) The Administrator, pursuant to a complaint, shall conduct such investigations as may be appropriate and, in connection therewith, enter and inspect such places and such records (and make transcriptions or copies thereof), question such persons and gather such information as deemed necessary by the Administrator to determine compliance regarding the matters which are the subject of the investigation.

(c) An employer being investigated shall make available to the Administrator such records, information, persons, and places as the Administrator deems appropriate to copy, transcribe, question, or inspect. No employer subject to the provisions of section 258 of the INA (8 U.S.C. 1288) and subparts F and G of this part shall interfere with any official of the Department of Labor performing an investigation, inspection or law enforcement function pursuant to 8 U.S.C. 1288 or subpart F or G of this part. Any such interference shall be a violation of the attestation and subparts F and G of this part, and the Administrator may take such further actions as the Administrator considers appropriate. (NOTE: Federal criminal statutes prohibit certain interference with a Federal officer in the performance of official duties. 18 U.S.C. 111 and 18 U.S.C. 1114.)

(d)(1) An employer subject to subparts F and G of this part shall at all times cooperate in administrative and enforcement proceedings. No employer shall intimidate, threaten, restrain, coerce, blacklist, discharge, retaliate, or in any manner discriminate against any person because such person has:

(i) Filed a complaint or appeal under or related to section 258 of the INA (8 U.S.C. 1288) or subpart F or G of this part;

(ii) Testified or is about to testify in any proceeding under or related to section 258 of the INA (8 U.S.C. 1288) or subpart F or G of this part;

(iii) Exercised or asserted on behalf of himself or herself or others any right or protection afforded by section 258 of the INA (8 U.S.C. 1288) or subpart F or G of this part.

(iv) Consulted with an employee of a legal assistance program or an attorney on matters related to section 258 of the Act or to subpart F or G of this part or any other DOL regulation promulgated pursuant to 8 U.S.C. 1288.

(2) In the event of such intimidation or restraint as are described in paragraph (d)(1) of this section, the conduct shall be a violation of the attestation and subparts F and G of this part, and the Administrator may take such further actions as the Administrator considers appropriate.

(e) The Administrator shall, to the extent possible under existing law, protect the confidentiality of any person who provides information to the Department in confidence in the course of an investigation or otherwise under subpart F or G of this part. However, confidentiality will not be afforded to the complainant or to information provided by the complainant.

§ 655.605 Complaints and investigative procedures.

(a) The Administrator, through an investigation, shall determine whether a basis exists to make a finding that:

(1) An attesting employer has—

(i) Failed to meet conditions attested to; or

(ii) Misrepresented a material fact in an attestation.

(NOTE: Federal criminal statutes provide penalties of up to $10,000 and/or imprisonment of up to 5 years for knowing and willful submission of false statements to the Federal Government. 18 U.S.C. 1001; see also 18 U.S.C. 1546.); or

(2) In the case of an employer operating under the automated vessel exception to the prohibition on utilizing alien crewmembers to perform longshore activity(ies) at a U.S. port, the employer—

(i) Is utilizing alien crewmember(s) to perform longshore activity(ies) at a port where the prevailing practice has not been to use such workers for such activity(ies); or

(ii) Is utilizing alien crewmember(s) to perform longshore activities:

(A) During a strike or lockout in the course of a labor dispute at the U.S. port; and/or

(B) With intent or design to influence an election of a bargaining representative for workers at the U.S. port; or

(3) An employer failed to comply in any other manner with the provisions of subpart F or G of this part.

(b) Any aggrieved person or organization may file a complaint of a violation of the provisions of subpart F or G of this part.

(1) No particular form of complaint is required, except that the complaint shall be written or, if oral, shall be reduced to writing by the Wage and Hour Division official who receives the complaint.

(2) The complaint shall set forth sufficient facts for the Administrator to determine—

(i) Whether, in the case of an attesting employer, there is reasonable cause to believe that particular part or parts of the attestation or regulations have been violated; or

(ii) Whether, in the case of an employer claiming the automated vessel exception, the preponderance of the evidence submitted by any interested party shows that conditions exist that would require the employer to file an attestation.

(3) The complaint may be submitted to any local Wage and Hour Division office; the addresses of such offices are found in local telephone directories. The office or person receiving such a complaint shall refer it to the office of the Wage and Hour Division administering the area in which the reported violation is alleged to have occurred.

(c) The Administrator shall determine whether there is reasonable cause to believe that the complaint warrants investigation. If the Administrator determines that the complaint fails to present reasonable cause for an investigation, the Administrator shall so notify the complainant, who may submit a new complaint, with such additional information as may be necessary. There shall be no hearing pursuant to § 655.625 for the Administrator's determination not to conduct an investigation. If the Administrator determines that an investigation on the

complaint is warranted, the investigation shall be conducted and a determination issued within 180 calendar days of the Administrator's receipt of the complaint, or later for good cause shown.

(d) In conducting an investigation, the Administrator may consider and make part of the investigation file any evidence or materials that have been compiled in any previous investigation regarding the same or a closely related matter.

(e) In conducting an investigation under an attestation, the Administrator shall take into consideration the employer's burden to provide facts and evidence to establish the matters asserted. In conducting an investigation regarding an employer's eligibility for the automated vessel exception, the Administrator shall not impose the burden of proof on the employer, but shall consider all evidence from any interested party in determining whether the employer is not eligible for the exception.

(f) In an investigation regarding the use of alien crewmembers to perform longshore activity(ies) in a U.S. port (whether by an attesting employer or by an employer claiming the automated vessel exception), the Administrator shall accept as conclusive proof a previous Departmental determination, published in the FEDERAL REGISTER pursuant to § 655.670, establishing that such use of alien crewmembers is not the prevailing practice for the activity(ies) and U.S. port at issue. The Administrator shall give appropriate weight to a previous Departmental determination published in the FEDERAL REGISTER pursuant to § 655.670, establishing that at the time of such determination, such use of alien crewmembers was the prevailing practice for the activity(ies) and U.S. port at issue.

(g) When an investigation has been conducted, the Administrator shall, within the time period specified in paragraph (c) of this section, issue a written determination as to whether a basis exists to make a finding stated in paragraph (a) of this section. The determination shall be issued and an opportunity for a hearing shall be afforded in accordance with the procedures specified in § 655.625(d) of this part.

§ 655.610 Automated vessel exception to prohibition on utilization of alien crewmember(s) to perform longshore activity(ies) at a U.S. port.

(a) The Act establishes a rebuttable presumption that the prevailing practice in U.S. ports is for automated vessels (*i.e.*, vessels equipped with automated self- unloading conveyor belts or vacuum-actuated systems) to use alien crewmembers to perform longshore activity(ies) through the use of the self-unloading equipment. An employer claiming the automated vessel exception does not have the burden of establishing eligibility for the exception.

(b) In the event of a complaint asserting that an employer claiming the automated vessel exception is not eligible for such exception, the Administrator shall determine whether the preponderance of the evidence submitted by any interested party shows that:

(1) It is not the prevailing practice at the U.S. port to use alien crewmember(s) to perform the longshore activity(ies) through the use of the self-unloading equipment; or

(2) The employer is using alien crewmembers to perform longshore activity(ies)—

(i) During a strike or lockout in the course of a labor dispute at the U.S. port; and/or

(ii) With intent or design to influence an election of a bargaining representative for workers at the U.S. port.

(c) In making the prevailing practice determination required by paragraph (b)(1) of this section, the Administrator shall determine whether, in the 12-month period preceding the date of the Administrator's receipt of the complaint, one of the following conditions existed:

(1) Over fifty percent of the automated vessels docking at the port used alien crewmembers for the activity (for purposes of this paragraph (c)(1) of this section, a vessel shall be counted each time it docks at the particular port); or

(2) Alien crewmembers made up over fifty percent of the workers who performed the activity with respect to such automated vessels.

(d) An interested party, complaining that the automated vessel exception is not applicable to a particular employer, shall provide to the Administrator evidence such as:

(1) A written summary of a survey of the experience of masters of automated vessels which entered the local port in the previous year, describing the practice in the port as to the use of alien crewmembers;

(2) A letter, affidavit, or other written statement from an appropriate local port authority regarding the use of alien crewmembers to perform the longshore activity at the port in the previous year;

(3) Written statements from collective bargaining representatives and/or shipping agents with direct knowledge of practices regarding the use of alien crewmembers at the port in the previous year.

§ 655.615 Cease and desist order.

(a) If the Administrator determines that reasonable cause exists to conduct an investigation with respect to an attestation, the complainant may request that the Administrator enter a cease and desist order against the employer against whom the complaint is lodged.

(1) The request for a cease and desist order may be filed along with the complaint, or may be filed subsequently. The request, including all accompanying documents, shall be filed in duplicate with the same Wage and Hour Division office that received the complaint.

(2) No particular form is prescribed for a request for a cease and desist order pursuant to this paragraph (a). However, any such request shall:

(i) Be dated;

(ii) Be typewritten or legibly written;

(iii) Specify the attestation provision(s) with respect to which the employer allegedly failed to comply and/or submitted misrepresentation(s) of material fact(s);

(iv) Be accompanied by evidence to substantiate the allegation(s) of noncompliance and/or misrepresentation;

(v) Be signed by the complaining party making the request or by the authorized representative of such party;

(vi) Include the address at which such complaining party or authorized representative desires to receive further communications relating thereto.

(3) Upon receipt of a request for a cease and desist order, the Administrator shall promptly notify the employer of the request. The Administrator's notice shall:

(i) Inform the employer that it may respond to the request and meet with a Wage and Hour Division official within 14 calendar days of the date of the notice;

(ii) Be served upon the employer by facsimile transmission, in person, or by certified or regular mail, at the address of the U.S. agent stated on the employer's attestation;

(iii) Be accompanied by copies of the complaint, the request for a cease and desist order, the evidence submitted by the complainant, and any evidence from other investigation(s) of the same or a closely related matter which the Administrator may incorporate into the record. (Any such evidence from other investigation(s) shall also be made available for examination by the complaining party at the Wage and Hour Division office which issued the notice.)

(4) No particular form is prescribed for the employer's response to the complaining party's request for a cease and desist order under this paragraph (a), however, any such response shall:

(i) Be dated;

(ii) Be submitted by facsimile transmission, in person, by certified or regular mail, or by courier service to the Wage and Hour Division office which issued the notice of the request;

(iii) Be received by the appropriate Wage and Hour Division office no later than 14 calendar days from the date of the notice of the request;

(iv) Be typewritten or legibly written;

(v) Explain, in any detail desired by the employer, the employer's grounds or reasons as to why the Administrator should deny the requested cease and desist order;

(vi) Be accompanied by evidence to substantiate the employer's grounds or reasons as to why the Administrator should deny the requested cease and desist order;

(vii) Specify whether the employer desires an informal meeting with a Wage and Hour Division official;

(viii) Be signed by the employer or its authorized representative; and

(ix) Include the address at which the employer or its authorized representative desires to receive further communications relating thereto, if such address is different from the address of the U.S. agent stated on the attestation.

(5) In the event the employer requests a meeting with a Wage and Hour Division official, the Administrator shall provide the employer and the complaining party, or their authorized representatives, an opportunity for such a meeting to present their views regarding the evidence and arguments submitted by the parties. This shall be an informal meeting, not subject to any procedural rules. The meeting shall be held within the 14 calendar days permitted for the employer's response to the request for the cease and desist order, and shall be held at a time and place set by the Wage and Hour Division official, who shall notify the parties.

(6) After receipt of the employer's timely response and after any informal meeting which may have been held with the parties, the Administrator shall promptly issue a written determination, either denying the request or issuing a cease and desist order. In making the determination, the Administrator shall consider all the evidence submitted, including any evidence from the same or a closely related matter which the Administrator has incorporated into the record and provided to the employer. If the Administrator determines that the complaining party's position is supported by a preponderance of the evidence submitted, the Administrator shall order that the employer cease the activities specified in the determination, until the completion of the Administrator's investigation and any subsequent proceedings pursuant to § 655.625 of this part, unless the prohibition is lifted by subsequent order of the Administrator because it is later determined that the employer's position was correct. While the cease and desist order is in effect, ETA shall suspend the subject attestation, either in whole or in part, and shall not accept any subsequent attestation from the employer for the activity(ies) and U.S. port or location in the State of Alaska at issue.

(7) The Administrator's cease and desist order shall be served on the employer at the address of its designated U.S. based representative or at the address specified in the employer's response, by facsimile transmission, personal service, or certified mail.

(b) If the Administrator determines that reasonable cause exists to conduct an investigation with respect to a complaint that a non-attesting employer is not entitled to the automated vessel exception to the requirement for the filing of an attestation, a complaining party may request that the Administrator enter a cease and desist order against the employer against whom the complaint is lodged.

(1) The request for a cease and desist order may be filed along with the complaint, or may be filed subsequently. The request, including all accompanying documents, shall be filed in duplicate with the same Wage and Hour Division office that received the complaint.

(2) No particular form is prescribed for a request for a cease and desist order pursuant to this paragraph. However, any such request shall:

(i) Be dated;

(ii) Be typewritten or legibly written;

(iii) Specify the circumstances which allegedly require that the employer be denied the use of the automated vessel exception;

(iv) Be accompanied by evidence to substantiate the allegation(s);

(v) Be signed by the complaining party making the request or by the authorized representative of such party; and

(vi) Include the address at which such complaining party or authorized representative desires to receive further communications relating thereto.

(3) Upon receipt of a request for a cease and desist order, the Administrator shall notify the employer of the request. The Administrator's notice shall:

(i) Inform the employer that it may respond to the request and meet with a Wage and Hour Division official within

14 calendar days of the date of the notice;

(ii) Be served upon the employer by facsimile transmission, in person, or by certified or regular mail, at the employer's last known address; and

(iii) Be accompanied by copies of the complaint, the request for a cease and desist order, the evidence submitted by the complainant, and any evidence from other investigation(s) of the same or a closely related matter which the Administrator may incorporate into the record. (Any such evidence from other investigation(s) shall also be made available for examination by the complaining party at the Wage and Hour Division office which issued the notice.)

(4) No particular form is prescribed for the employer's response to the complaining party's request for a cease and desist order under this paragraph (b). However, any such response shall:

(i) Be dated;

(ii) Be submitted by facsimile transmission, in person, by certified or regular mail, or by courier service to the Wage and Hour Division office which issued the notice of the request;

(iii) Be received by the appropriate Wage and Hour Division office no later than 14 calendar days from the date of the notice of the request;

(iv) Be typewritten or legibly written;

(v) Explain, in any detail desired by the employer, the employer's grounds or reasons as to why the Administrator should deny the requested cease and desist order;

(vi) Be accompanied by evidence to substantiate the employer's grounds or reasons as to why the Administrator should deny the requested cease and desist order;

(vii) Specify whether the employer desires an informal meeting with a Wage and Hour Division official;

(viii) Be signed by the employer or its authorized representative; and

(ix) Include the address at which the employer or its authorized representative desires to receive further communications relating thereto.

(5) In the event the employer requests a meeting with a Wage and Hour Division official, the Administrator shall provide the employer and the complaining party, or their authorized representatives, an opportunity for such a meeting to present their views regarding the evidence and arguments submitted by the parties. This shall be an informal meeting, not subject to any procedural rules. The meeting shall be held within the 14 calendar days permitted for the employer's response to the request for the cease and desist order, and shall be held at a time and place set by the Wage and Hour Division official, who shall notify the parties.

(6) After receipt of the employer's timely response and after any informal meeting which may have been held with the parties, the Administrator shall promptly issue a written determination, either denying the request or issuing a cease and desist order. If the Administrator determines that the complaining party's position is supported by a preponderance of the evidence submitted, the Administrator shall order that the employer cease the use of alien crewmembers to perform the longshore activity(ies) specified in the order. In making the determination, the Administrator shall consider all the evidence submitted, including any evidence from the same or a closely related matter which the Administrator has incorporated into the record and provided to the employer. The order shall remain in effect until the completion of the investigation and any subsequent hearing proceedings pursuant to § 655.625 of this part, unless the employer files and maintains on file with ETA an attestation pursuant to § 655.520 of this part or unless the prohibition is lifted by subsequent order of the Administrator because it is later determined that the employer's position was correct.

(7) The Administrator's cease and desist order shall be served on the employer or its designated representative by facsimile transmission, personal service, or by certified mail at the address specified in the employer's response or, if no such address was specified, at the employer's last known address.

§ 655.620 Civil money penalties and other remedies.

(a) The Administrator may assess a civil money penalty not to exceed $11,823 for each alien crewmember with respect to whom there has been a violation of the attestation or subpart F or G of this part. The Administrator may also impose appropriate remedy(ies).

(b) In determining the amount of civil money penalty to be assessed, the Administrator shall consider the type of violation committed and other relevant factors. The factors which may be considered include, but are not limited to, the following:

(1) Previous history of violation, or violations, by the employer under the Act and subpart F or G of this part;

(2) The number of workers affected by the violation or violations;

(3) The gravity of the violation or violations;

(4) Efforts made by the violator in good faith to comply with the provisions of 8 U.S.C. 1288(c) and subparts F and G of this part;

(5) The violator's explanation of the violation or violations;

(6) The violator's commitment to future compliance; and/or

(7) The extent to which the violator achieved a financial gain due to the violation, or the potential financial loss, potential injury or adverse effect with respect to other parties.

(c) The civil money penalty, and any other remedy determined by the Administrator to be appropriate, are immediately due for payment or performance upon the assessment by the Administrator, or the decision by an administrative law judge where a hearing is requested, or the decision by the Secretary where review is granted. The employer shall remit the amount of the civil money penalty, by certified check or money order made payable to the order of ''Wage and Hour Division, Labor.'' The remittance shall be delivered or mailed to the Wage and Hour Division office for the area in which the violations occurred. The performance of any other remedy prescribed by the Administrator shall follow procedures established by the Administrator. The employer's failure to pay the civil money penalty, or to perform any other remedy prescribed by the Administrator, shall result in the rejection by ETA of any future attestation submitted by the employer, until such payment or performance is accomplished.

[60 FR 3969, 3977, Jan. 19, 1995, as amended at 81 FR 43448, July 1, 2016; 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2214, Jan. 13, 2023; 89 FR 1814, Jan. 11, 2024; 90 FR 1858, Jan. 10, 2025]

§ 655.625 Written notice, service and Federal Register publication of Administrator's determination.

(a) The Administrator's determination, issued pursuant to § 655.605 of this part, shall be served on the complainant, the employer, and other known interested parties by personal service or by certified mail at the parties' last known addresses. Where service by certified mail is not accepted by the party, the Administrator may exercise discretion to serve the determination by regular mail.

(b) Where the Administrator determines the prevailing practice regarding the use of alien crewmember(s) to perform longshore activity(ies) in a U.S. port (whether the Administrator's investigation involves an employer operating under an attestation, or under the automated vessel exception), the Administrator shall, simultaneously with issuance of the determination, publish in the FEDERAL REGISTER a notice of the determination. The notice shall identify the activity(ies), the U.S. port, and the prevailing practice regarding the use of alien crewmembers. The notice shall also inform interested parties that they may request a hearing pursuant to § 655.630 of this part, within 15 days of the date of the determination.

(c) The Administrator shall file with the Chief Administrative Law Judge, U.S. Department of Labor, a copy of the complaint and the Administrator's determination.

(d) The Administrator's written determination required by § 655.605 of this part shall:

(1) Set forth the determination of the Administrator and the reason or reasons therefor, and in the case of a finding of violation(s) by an attesting employer, prescribe any remedies, including the amount of any civil money penalties assessed and the reason therefor, and/or any other remedies required for compliance with the employer's attestation.

(2) Inform the interested parties that they may request a hearing pursuant to § 655.625 of this part.

(3) Inform the interested parties that in the absence of a timely request for a hearing, received by the Chief Administrative Law Judge within 15 calendar days of the date of the determination, the determination of the Administrator shall become final and not appealable.

(4) Set forth the procedure for requesting a hearing, and give the address of the Chief Administrative Law Judge (with whom the request must be filed) and the representative(s) of the Solicitor of Labor (upon whom copies of the request must be served).

(5) Inform the parties that, pursuant to § 655.665, the Administrator shall notify ETA and the DHS of the occurrence of a violation by the attesting employer or of the non-attesting employer's ineligibility for the automated vessel exception.

§ 655.630 Request for hearing.

(a) Any interested party desiring to request an administrative hearing on a determination issued pursuant to §§ 655.605 and 655.625 of this part shall make such request in writing to the Chief Administrative Law Judge at the address stated in the notice of determination.

(b) Interested parties may request a hearing in the following circumstances:

(1) The complainant or any other interested party may request a hearing where the Administrator determines, after investigation, that there is no basis for a finding that an attesting employer has committed violation(s) or that the employer is eligible for the automated vessel exception. In such a proceeding, the requesting party and the employer shall be parties; the Administrator may intervene as a party or appear as *amicus curiae* at any time in the proceeding, at the Administrator's discretion.

(2) The employer or any other interested party may request a hearing where the Administrator determines, after investigation, that there is a basis for a finding that an attesting employer has committed violation(s) or that a non- attesting employer is not eligible for the automated vessel exception. In such a proceeding, the Administrator and the employer shall be parties.

(c) No particular form is prescribed for any request for hearing permitted by this section. However, any such request shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) Specify the issue or issues stated in the notice of determination giving rise to such request;

(4) State the specific reason or reasons why the party requesting the hearing believes such determination is in error;

(5) Be signed by the party making the request or by an authorized representative of such party; and

(6) Include the address at which such party or authorized representative desires to receive further communications relating thereto.

(d) The request for such hearing must be received by the Chief Administrative Law Judge, at the address stated in the Administrator's notice of determination, no later than 15 calendar days after the date of the determination. An interested party that fails to meet this 15-day deadline for requesting a hearing may thereafter participate in the proceedings only by consent of the administrative law judge, either through intervention as a party pursuant to 29 CFR 18.10 (b) through (d) or through participation as an amicus curiae pursuant to 18 CFR 18.12.

(e) The request may be filed in person, by facsimile transmission, by certified or regular mail, or by courier service. For the requesting party's protection, if the request is filed by mail, it should be by certified mail. If the request is filed by facsimile transmission, the original of the request, signed by the requestor or authorized

representative, shall be filed within ten days.

(f) Copies of the request for a hearing shall be sent by the requestor to the Wage and Hour Division official who issued the Administrator's notice of determination, to the representative(s) of the Solicitor of Labor identified in the notice of determination, and to all known interested parties.

§ 655.635 Rules of practice for administrative law judge proceedings.

(a) Except as specifically provided in this subpart, and to the extent they do not conflict with the provisions of this subpart, the ''Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges'' established by the Secretary at 29 CFR part 18 shall apply to administrative proceedings under this subpart.

(b) As provided in the Administrative Procedure Act, 5 U.S.C. 556, any oral or documentary evidence may be received in proceedings under this part. The Federal Rules of Evidence and subpart B of the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges (29 CFR part 18, subpart B) shall not apply, but principles designed to ensure production of relevant and probative evidence shall guide the admission of evidence. The administrative law judge may exclude evidence which is immaterial, irrelevant, or unduly repetitive.

§ 655.640 Service and computation of time.

(a) Under this subpart, a party may serve any pleading or document by regular mail. Service on a party is complete upon mailing to the last known address or, in the case of the attesting employer, to the employer's designated representative in the U.S. No additional time for filing or response is authorized where service is by mail. In the interest of expeditious proceedings, the administrative law judge may direct the parties to serve pleadings or documents by a method other than regular mail.

(b) Two (2) copies of all pleadings and other documents in any administrative law judge proceeding shall be served on the attorneys for the Administrator. One copy shall be served on the Associate Solicitor, Division of Fair Labor Standards, Office of the Solicitor, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, and one copy on the attorney representing the Administrator in the proceeding.

(c) Time will be computed beginning with the day following the action and includes the last day of the period unless it is a Saturday, Sunday, or federally-observed holiday, in which case the time period includes the next business day.

§ 655.645 Administrative law judge proceedings.

(a) Upon receipt of a timely request for a hearing filed pursuant to and in accordance with § 655.630 of this part, the Chief Administrative Law Judge shall promptly appoint an administrative law judge to hear the case.

(b) Within seven calendar days following the assignment of the case, the administrative law judge shall notify all interested parties of the date, time and place of the hearing. All parties shall be given at least fourteen calendar days' notice of such hearing.

(c) The date of the hearing shall be not more than 60 calendar days from the date of the Administrator's determination. Because of the time constraints imposed by the Act, no requests for postponement shall be granted except for compelling reasons. Even if such reasons are shown, no extension of the hearing date beyond 60 days from the date of the Administrator's determination shall be granted except by consent of all the parties to the proceeding.

(d) The administrative law judge may prescribe a schedule by which the parties are permitted to file a prehearing brief or other written statement of fact or law. Any such brief or statement shall be served upon each other party in accordance with § 655.640 of this part. Posthearing briefs will not be permitted except at the request of the administrative law judge. When permitted, any such brief shall be limited to the issue or issues specified by the administrative law judge, shall be due within the time prescribed by the administrative law judge, and shall be

served on each other party in accordance with § 655.640 of this part.

(e) In reaching a decision, the administrative law judge shall, in accordance with the Act, impose the following burden of proof—

(1) The attesting employer shall have the burden of producing facts and evidence to establish the matters required by the attestation at issue;

(2) The burden of proof as to the applicability of the automated vessel exception shall be on the party to the hearing who is asserting that the employer is not eligible for the exception.

(f) The administrative law judge proceeding shall not be an appeal or review of the Administrator's ruling on a request for a cease and desist order pursuant to § 655.615.

§ 655.650 Decision and order of administrative law judge.

(a) Within 90 calendar days after receipt of the transcript of the hearing, the administrative law judge shall issue a decision. If any party desires review of the decision, including judicial review, a petition for Secretary's review thereof shall be filed as provided in § 655.655 of this subpart. If a petition for review is filed, the decision of the administrative law judge shall be inoperative unless and until the Secretary issues an order affirming the decision, or, unless and until 30 calendar days have passed after the Secretary's receipt of the petition for review and the Secretary has not issued notice to the parties that the Secretary will review the administrative law judge's decision.

(b) The decision of the administrative law judge shall include a statement of findings and conclusions, with reasons and basis therefor, upon each material issue presented on the record. The decision shall also include an appropriate order which may affirm, deny, reverse, or modify, in whole or in part, the determination of the Administrator; the reason or reasons for such order shall be stated in the decision. The administrative law judge shall not render determinations as to the legality of a regulatory provision or the constitutionality of a statutory provision.

(c) The decision shall be served on all parties in person or by certified or regular mail.

§ 655.655 Secretary's review of administrative law judge's decision.

(a) The Administrator or any interested party desiring review of the decision and order of an administrative law judge shall petition the Secretary to review the decision and order. To be effective, such petition shall be received by the Secretary within 30 calendar days of the date of the decision and order. Copies of the petition shall be served on all parties and on the administrative law judge.

(b) No particular form is prescribed for any petition for Secretary's review permitted by this subpart. However, any such petition shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) Specify the issue or issues stated in the administrative law judge decision and order giving rise to such petition;

(4) State the specific reason or reasons why the party petitioning for review believes such decision and order are in error;

(5) Be signed by the party filing the petition or by an authorized representative of such party;

(6) Include the address at which such party or authorized representative desires to receive further communications relating thereto; and

(7) Attach copies of the administrative law judge's decision and order, and any other record documents which would assist the Secretary in determining whether review is warranted.

(c) Whenever the Secretary determines to review the decision and order of an administrative law judge, a notice of the Secretary's determination shall be served upon the administrative law judge and upon all parties to the proceeding within 30 calendar days after the Secretary's receipt of the petition for review.

(d) Upon receipt of the Secretary's notice, the Office of Administrative Law Judges shall within fifteen calendar days forward the complete hearing record to the Secretary.

(e) The Secretary's notice may specify:

(1) The issue or issues to be reviewed;
(2) The form in which submissions shall be made by the parties (e.g., briefs); and
(3) The time within which such submissions shall be made.

(f) All documents submitted to the Secretary shall be filed with the Secretary of Labor, U.S. Department of Labor, Washington, DC 20210, Attention: Executive Director, Office of Administrative Appeals, room S–4309. An original and two copies of all documents shall be filed. Documents are not deemed filed with the Secretary until actually received by the Secretary. All documents, including documents filed by mail, shall be received by the Secretary either on or before the due date.

(g) Copies of all documents filed with the Secretary shall be served upon all other parties involved in the proceeding. Service upon the Administrator shall be in accordance with § 655.640(b) of this part.

(h) The Secretary's final decision shall be issued within 180 calendar days from the date of the notice of intent to review. The Secretary's decision shall be served upon all parties and the administrative law judge.

(i) Upon issuance of the Secretary's decision, the Secretary shall transmit the entire record to the Chief Administrative Law Judge for custody pursuant to § 655.660 of this part.

§ 655.660 Administrative record.

The official record of every completed administrative hearing procedure provided by subparts F and G of this part shall be maintained and filed under the custody and control of the Chief Administrative Law Judge. Upon receipt of a complaint seeking review of the final agency action in a United States District Court, the Chief Administrative Law Judge shall certify the official record and shall transmit such record to the clerk of the court.

§ 655.665 Notice to the Department of Homeland Security and the Employment and Training Administration.

(a) The Administrator shall promptly notify the DHS and ETA of the entry of a cease and desist order pursuant to § 655.615 of this part. The order shall remain in effect until the completion of the Administrator's investigation and any subsequent proceedings pursuant to § 655.630 of this part, unless the Administrator notifies the DHS and ETA of the entry of a subsequent order lifting the prohibition.

(1) The DHS, upon receipt of notification from the Administrator that a cease and desist order has been entered against an employer:

(i) Shall not permit the vessels owned or chartered by the attesting employer to use alien crewmembers to perform the longshore activity(ies) at the port or location in the State of Alaska specified in the cease and desist order; and

(ii) Shall, in the case of an employer seeking to utilize the automated vessel exception, require that such employer not use alien crewmembers to perform the longshore activity(ies) at the port or location in the State of Alaska specified in the cease and desist order, without having on file with ETA an attestation pursuant to § 655.520 of this part.

(2) ETA, upon receipt of the Administrator's notice shall, in the case of an attesting employer, suspend the employer's attestation, either in whole or in part, for the activity(ies) and port or location in the State of Alaska specified in the cease and desist order.

(b) The Administrator shall notify the DHS and ETA of the final determination of a violation by an attesting employer or of the ineligibility of an employer for the automated vessel exception, upon the earliest of the following events:

(1) Where the Administrator determines that there is a basis for a finding of violation by an attesting employer or a finding of nonapplicability of the automated vessel exception, and no timely request for hearing is made pursuant to § 655.630 of this part;

(2) Where, after a hearing, the administrative law judge issues a decision and order finding a violation by an attesting employer or finding inapplicable the automated vessel exception, and no timely petition for review to the Secretary is made pursuant to § 655.655 of this part; or

(3) Where a petition for review is taken from an administrative law

judge's decision finding a violation or finding inapplicable the automated vessel exception, and the Secretary either declines within thirty days to entertain the appeal, pursuant to § 655.655(c) of this part, or the Secretary affirms the administrative law judge's determination; or

(4) Where the administrative law judge finds that there was no violation by an attesting employer or that the automated vessel exception does apply, and the Secretary, upon review, issues a decision pursuant to § 655.655 of this part, holding that a violation was committed by an attesting employer or holding that the automated vessel exception does not apply.

(c) The DHS, upon receipt of notification from the Administrator pursuant to paragraph (b) of this section:

(1) Shall not permit the vessels owned or chartered by the attesting employer to enter any port of the U.S. for a period of up to one year;

(2) Shall, in the case of an employer determined to be ineligible for the automated vessel exception, thereafter require that such employer not use alien crewmembers(s) to perform the longshore activity(ies) at the specified port or location in the State of Alaska without having on file with ETA an attestation pursuant to § 655.520 of this part; and

(3) Shall, in the event that the Administrator's notice constitutes a conclusive determination (pursuant to § 655.670) that the prevailing practice at a particular U.S. port does not permit the use of nonimmigrant alien crewmembers for particular longshore activity(ies), thereafter permit no employer to use alien crewmembers for the particular longshore activity(ies) at that port.

(d) ETA, upon receipt of the Administrator's notice pursuant to paragraph (b) of this section:

(1) Shall, in the case of an attesting employer, suspend the employer's attestation, either in whole or in part, for the port or location at issue and for any other U.S. port, and shall not accept for filing any attestation submitted by the employer for a period of 12 months or for a shorter period if such is specified for that employer by the DHS; and

(2) Shall, if the Administrator's notice constitutes a conclusive determination (pursuant to § 655.670) that the prevailing practice at a particular U.S. port does not permit the use of alien crewmembers for the longshore activity(ies), thereafter accept no attestation under the prevailing practice exception on Form ETA 9033 from any employer for the performance of the activity(ies) at that port, and shall invalidate any current attestation under the prevailing practice exception on Form ETA 9033 for any employer for the performance of the activity(ies) at that port.

[60 FR 3969, 3977, Jan. 19, 1995, as amended at 71 FR 35520, June 21, 2006]

§ 655.670 Federal Register notice of determination of prevailing practice.

(a) Pursuant to § 655.625(b), the Administrator shall publish in the FEDERAL REGISTER a notice of the Administrator's determination of any investigation regarding the prevailing practice for the use of alien crewmembers for particular longshore activity(ies) in a particular U.S. port (whether under an attestation or under the automated vessel exception). Where the Administrator has determined that the prevailing practice in that U.S. port does not permit such use of alien crewmembers, and no timely request for a hearing is filed pursuant to § 655.630, the Administrator's determination shall be the conclusive determination for purposes of the Act and subparts F and G of this part; the DHS and ETA shall, upon notice from the Administrator, take the actions specified in § 655.665. Where the Administrator has determined that the prevailing practice in that U.S. port at the time of the investigation permits such use of alien crewmembers, the Administrator shall, in any subsequent investigation, give that determination appropriate weight, unless the determination is reversed in proceedings under § 655.630 or § 655.655.

(b) Where an interested party, pursuant to § 655.630, requests a hearing on the Administrator's determination, the Administrator shall, upon the issuance of the decision of the administrative law judge, publish in the FEDERAL REGISTER a notice of the judge's decision as to the prevailing practice for the

longshore activity(ies) and U.S. port at issue, if the administrative law judge:

(1) Reversed the determination of the Administrator published in the FEDERAL REGISTER pursuant to paragraph (a) of this section; or

(2) Determines that the prevailing practice for the particular activity in the port does not permit the use of alien crewmembers.

(c) If the administrative law judge determines that the prevailing practice in that port does not permit such use of alien crewmembers, the judge's decision shall be the conclusive determination for purposes of the Act and subparts F and G of this part (unless and until reversed by the Secretary on discretionary review pursuant to § 655.655). The DHS and ETA shall upon notice from the Administrator, take the actions specified in § 655.665.

(d) In the event that the Secretary, upon discretionary review pursuant to § 655.655, issues a decision that reverses the administrative law judge on a matter on which the Administrator has published notices in the FEDERAL REGISTER pursuant to paragraphs (a) and (b) of this section, the Administrator shall publish in the FEDERAL REGISTER a notice of the Secretary's decision and shall notify the DHS and ETA.

(1) Where the Secretary reverses the administrative law judge and determines that, contrary to the judge's decision, the prevailing practice for the longshore activity(ies) in the U.S. port at issue does not permit the use of alien crewmembers, the Secretary's decision shall be the conclusive determination for purposes of the Act and subparts F and G of this part. Upon notice from the Administrator, the DHS and ETA shall take the actions specified in § 655.665.

(2) Where the Secretary reverses the administrative law judge and determines that, contrary to the judge's decision, the use of alien crewmembers is permitted by the prevailing practice for the longshore activity(ies) in the U.S. port at issue, the judge's decision shall no longer have the conclusive effect specified in paragraph (b) of this section. Upon notice from the Administrator, the DHS and ETA shall cease the actions specified in § 655.665.

§ 655.675 Non-applicability of the Equal Access to Justice Act.

A proceeding under subpart G of this part is not subject to the Equal Access to Justice Act, as amended, 5 U.S.C. 504. In such a proceeding, the administrative law judge shall have no authority to award attorney fees and/or other litigation expenses pursuant to the provisions of the Equal Access to Justice Act.

Subpart H—Labor Condition Applications and Requirements for Employers Seeking To Employ Nonimmigrants on H–1b Visas in Specialty Occupations and as Fashion Models, and Requirements for Employers Seeking To Employ Nonimmigrants on H–1b1 and E–3 Visas in Specialty Occupations

SOURCE: 59 FR 65659, 65676, Dec. 20, 1994, unless otherwise noted.

§ 655.700 What statutory provisions govern the employment of H–1B, H–1B1, and E–3 nonimmigrants and how do employers apply for H–1B, H–1B1, and E–3 visas?

Under the E–3 visa program, the Immigration and Nationality Act (INA), as amended, permits certain nonimmigrant treaty aliens to be admitted to the United States solely to perform services in a specialty occupation (INA section 101(a)(15)(E)(iii)). Under the H–1B1 visa program, the INA permits nonimmigrant professionals in specialty occupations from countries with which the United States has entered into certain agreements that are identified in section 214(g)(8)(A) of the INA to temporarily enter the United States for employment in a specialty occupation. Employers seeking to employ nonimmigrant workers in specialty occupations under H–1B, H–1B1, or E–3 visas must file a labor condition application with the Department of Labor as described in § 655.730(c) and (d). Certain procedures described in this subpart H for obtaining a visa and entering the U.S. after the Department of Labor attestation process, including procedures

in § 655.705, apply only to H–1B nonimmigrants. The procedures for receiving an E–3 or H–1B1 visa and entering the U.S. on an E–3 or H–1B1 visa after the attestation process is certified by the Department of Labor are identified in the regulations and procedures of the Department of State and the United States Citizenship and Immigration Services (USCIS) of the Department of Homeland Security. Consult the Department of State (*http://www.state.gov/*) and USCIS (*http://www.uscis.gov/*) Web sites and regulations for specific instructions regarding the E–3 and H–1B1 visas.

(a) *Statutory provisions regarding H–1B visas.* With respect to nonimmigrant workers entering the U.S. on H–1B visas, which are available to nonimmigrant aliens in specialty occupations or certain fashion models from any country, the INA, as amended, provides as follows:

(1) Establishes an annual ceiling (exclusive of spouses and children) on the number of foreign workers who may be issued H–1B visas—

(i) 195,000 in fiscal year 2001;

(ii) 195,000 in fiscal year 2002;

(iii) 195,000 in fiscal year 2003; and

(iv) 65,000 in each succeeding fiscal year;

(2) Defines the scope of eligible occupations for which nonimmigrants may be issued H–1B visas and specifies the qualifications that are required for entry as an H–1B nonimmigrant ;

(3) Requires an employer seeking to employ H–1B nonimmigrants to file a labor condition application (LCA) agreeing to various attestation requirements and have it certified by the Department of Labor (DOL) before a nonimmigrant may be provided H–1B status by the United States Citizenship and Immigration Services of the Department of Homeland Security (DHS); and

(4) Establishes an enforcement system under which DOL is authorized to determine whether an employer has engaged in misrepresentation or failed to meet a condition of the LCA, and is authorized to impose fines and penalties.

(b) *Procedure for obtaining an H–1B visa classification.* Before a nonimmigrant may be admitted to work in a ''specialty occupation'' or as a fashion model of distinguished merit and ability in the United States under the H–1B visa classification, there are certain steps which must be followed:

(1) First, an employer shall submit to the Department of Labor (DOL), and obtain DOL certification of, a labor condition application (LCA). The requirements for obtaining a certified LCA are provided in this subpart. The electronic LCA (Form ETA 9035E) is available at *http://www.lca.doleta.gov*. The paper-version LCA (Form ETA 9035) and the LCA cover pages (Form ETA 9035CP), which contain the full attestation statements incorporated by reference into Form ETA 9035 and Form ETA 9035E, may be obtained from *http://ows.doleta.gov* and from the Employment and Training Administration (ETA) National Office. Employers must file LCAs in the manner prescribed in § 655.720.

(2) After obtaining DOL certification of an LCA, the employer may submit a nonimmigrant visa petition (DHS Form I–129), together with the certified LCA, to DHS, requesting H–1B classification for the foreign worker. The requirements concerning the submission of a petition to, and its processing by, DHS are set forth in DHS regulations. The DHS petition (Form I–129) may be obtained from an DHS district or area office.

(3) If DHS approves the H–1B classification, the nonimmigrant then may apply for an H–1B visa abroad at a consular office of the Department of State. If the nonimmigrant is already in the United States in a status other than H–1B, he/she may apply to the DHS for a change of visa status.

(c) *Applicability.* (1) This subpart H and subpart I of this part apply to all employers seeking to employ foreign workers under the H–1B visa classification in specialty occupations or as fashion models of distinguished merit and ability.

(2) During the period that the provisions of Appendix 1603.D.4 of Annex 1603 of the North American Free Trade Agreement (NAFTA) apply, this subpart H and subpart I of this part shall apply (except for the provisions relating to the recruitment and displacement of U.S. workers (see §§ 655.738 and 655.739)) to the entry and employment

of a nonimmigrant who is a citizen of Mexico under and pursuant to the provisions of section D or Annex 1603 of NAFTA in the case of all professions set out in Appendix 1603.D.1 of Annex 1603 of NAFTA other than registered nurses. Therefore, the references in this part to ''H–1B nonimmigrant'' apply to any Mexican citizen nonimmigrant who is classified by DHS as ''TN.'' In the case of a registered nurse, the following provisions shall apply: subparts D and E of this part or the Nursing Relief for Disadvantaged Areas Act of 1999 (Public Law 106–95) and the regulations issued thereunder, 20 CFR part 655, subparts L and M.

(3) *E–3 visas:* Except as provided in paragraph (d) of this section, this subpart H and subpart I of this part apply to all employers seeking to employ foreign workers under the E–3 visa classification in specialty occupations under INA section 101(a)(15)(E)(iii) (8 U.S.C. 1101(a)(15)(E)(iii)). This paragraph (c)(3) applies to labor condition applications filed on or after April 11, 2008. E–3 labor condition applications filed prior to that date but on or after May 11, 2005 (*i.e.*, the effective date of the statute), will be processed according to the E–3 statutory terms and the E–3 processing procedures published on July 19, 2005 in the FEDERAL REGISTER at 74 FR 41434.

(4) *H–1B1 visas:* Except as provided in paragraph (d) of this section, subparts H and I of this part apply to all employers seeking to employ foreign workers under the H–1B1 visa classification in specialty occupations described in INA section 101(a)(15)(H)(i)(b1) (8 U.S.C. 1101(a)(15)(H)(i)(b1)), under the U.S.-Chile and U.S.-Singapore Free Trade Agreements as long as the Agreements are in effect. (INA section 214(g)(8)(A) (8 U.S.C. 1184(g)(8)(A)). This paragraph (c)(4) applies to H–1B1 labor condition applications filed on or after November 23, 2004. Further, H–1B1 labor condition applications filed prior to that date but on or after January 1, 2004, the effective date of the H–1B1 program, will be handled according to the H–1B1 statutory terms and the H–1B1 processing procedures as described in paragraph (d)(3) of this section.

(d) *Nonimmigrants on E–3 or H–1B1 visas*—(1) *Exclusions.* The following sections in this subpart and in subpart I of this part do not apply to E–3 and H–1B1 nonimmigrants, but apply only to H–1B nonimmigrants: §§ 655.700(a), (b), (c)(1) and (2); 655.710(b); 655.730(d)(5) and (e); 655.735; 655.736; 655.737; 655.738; 655.739; 655.760(a)(7), (8), (9), and (10); and 655.805(a)(7), (8), and (9). Further, the following references in subparts H or I of this part, whether in the excluded sections listed above or elsewhere, do not apply to E–3 and H–1B1 nonimmigrants, but apply only to H–1B nonimmigrants: references to fashion models of distinguished merit and ability (H–1B visas, but not H–1B1 and E–3 visas, are available to such fashion models); references to a petition process before USCIS (the petition process applies only to H–1B, but not to initial H–1B1 and E–3 visas unless it is a petition to accord a change of status); references to additional attestation obligations of H–1B-dependent employers and employers found to have willfully violated the H–1B program requirements (these provisions do not apply to the H–1B1 and E–3 programs); and references in § 655.750(a) or elsewhere in this part to the provision in INA section 214(n) (formerly INA section 214(m)) (8 U.S.C. 1184(n)) regarding increased portability of H–1B status (by the statutory terms, the portability provision is inapplicable to H–1B1 and E–3 nonimmigrants).

(2) *Terminology.* For purposes of subparts H and I of this part, except in those sections identified in paragraph (d)(1) of this section as inapplicable to E–3 and H–1B1 nonimmigrants and as otherwise excluded:

(i) The term ''H–1B'' includes ''E–3'' and ''H–1B1'' (INA section 101(a)(15)(E)(iii) and (a)(15)(H)(i)(b1)) (8 U.S.C. 1101(a)(15)(E)(iii) and (a)(15)(H)(i)(b1)); and

(ii) The term ''labor condition application'' or ''LCA'' includes a labor attestation made under section 212(t)(1) of the INA for an E–3 or H–1B1 nonimmigrant professional classified under INA section 101(a)(15)(E)(iii) and (a)(15)(H)(i)(b1) (8 U.S.C. 1101(a)(15)(E)(iii) and (a)(15)(H)(i)(b1)).

(3) *Filing procedures for E–3 and H–1B1 labor attestations.* Employers seeking to employ an E–3 or H–1B1 nonimmigrant must submit a completed ETA Form

9035 or ETA Form 9035E (electronic) to DOL in the manner prescribed in §§ 655.720 and 655.730. Employers must indicate on the form whether the labor condition application is for an ''E–3 Australia,'' ''H–1B1 Chile,'' or ''H–1B1 Singapore'' nonimmigrant. Any changes in the procedures and instructions for submitting labor condition applications will be provided in a notice published in the FEDERAL REGISTER and posted on the ETA Web site at *http://www.foreignlaborcert.doleta.gov/*.

(4) *Employer's responsibilities regarding E–3 and H–1B1 labor attestation.* Each employer seeking an E–3 or H–1B1 nonimmigrant in a specialty occupation has several responsibilities, as described more fully in subparts H and I of this part, including the following:

(i) By submitting a signed and completed LCA, the employer makes certain representations and agrees to several attestations regarding the employer's responsibilities, including the wages, working conditions, and benefits to be provided to the E–3 or H–1B1 nonimmigrant. These attestations are specifically identified and incorporated in the LCA, and are fully described on Form ETA 9035CP (cover pages).

(ii) The employer reaffirms its acceptance of all of the attestation obligations by transmitting the certified labor attestation to the nonimmigrant, the Department of State, and/or the USCIS according to the procedures of those agencies.

(iii) The employer shall maintain the original signed and certified LCA in its files, and shall make a copy of the filed LCA, as well as necessary supporting documentation (as identified under this subpart), available for public examination in a public access file at the employer's principal place of business in the U.S. or at the place of employment within one working day after the date on which the LCA is filed with ETA.

(iv) The employer shall develop sufficient documentation to meet its burden of proof, in the event that such statement or information is challenged, with respect to the validity of the statements made in its LCA and the accuracy of information provided. The employer shall also maintain such documentation at its principal place of business in the U.S. and shall make such documentation available to DOL for inspection and copying upon request.

(5) *Application to Chile.* During the period that the provisions of Chapter 14 and Section D of Annex 14.3 of the United States-Chile Free Trade Agreement (Chile FTA) are in effect, this subpart H and subpart I of this part shall apply (except for the provisions excluded under paragraph (d)(1) of this section) to the temporary entry and employment of a nonimmigrant who is a national of Chile under the provisions of Article 14.9 and Annex 2.1 of the Chile FTA and who is a professional under the provisions of Annex 14.3(D) of the Chile FTA.

(6) *Application to Singapore.* During the period that the provisions of Section IV of Annex 11A of the United States-Singapore Free Trade Agreement (Singapore FTA) are in effect, this subpart H and subpart I of this part shall apply (except for the provisions excluded under paragraph (d)(1) of this section) to the temporary entry and employment of a nonimmigrant who is a national of Singapore under the provisions of Chapter 11 and Section IV of Annex 11A of the Singapore FTA and who is a professional under the provisions of Annex 11A(IV) of the Singapore FTA.

[65 FR 80209, Dec. 20, 2000, as amended at 66 FR 63300, Dec. 5, 2001; 69 FR 68226, Nov. 23, 2004; 70 FR 72560, Dec. 5, 2005; 71 FR 35520, 35521, June 21, 2006; 71 FR 37804, June 30, 2006; 73 FR 19947, Apr. 11, 2008]

§ 655.705 What Federal agencies are involved in the H–1B and H–1B1 programs, and what are the responsibilities of those agencies and of employers?

Four federal agencies (Department of Labor, Department of State, Department of Justice, and Department of Homeland Security) are involved in the process relating to H–1B nonimmigrant classification and employment. The employer also has continuing responsibilities under the process. This section briefly describes the responsibilities of each of these entities.

(a) *Department of Labor (DOL) responsibilities.* DOL administers the labor

condition application process and enforcement provisions (exclusive of complaints regarding non-selection of U.S. workers, as described in 8 U.S.C. 1182(n)(1)(G)(i)(II) and 1182(n)(5)). Two DOL agencies have responsibilities:

(1) The Employment and Training Administration (ETA) is responsible for receiving and certifying labor condition applications (LCAs) in accordance with this subpart H. ETA is also responsible for compiling and maintaining a list of LCAs and makes such list available for public examination at the Department of Labor, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210.

(2) The Wage and Hour Division of the Employment Standards Administration (ESA) is responsible, in accordance with subpart I of this part, for investigating and determining an employer's misrepresentation in or failure to comply with LCAs in the employment of H–1B nonimmigrants.

(b) *Department of Justice (DOJ), Department of Homeland Security (DHS) and Department of State (DOS) responsibilities.* The Department of State, through U.S. Embassies and Consulates, is responsible for issuing H–1B, H–1B1, and E–3 visas. For H–1B visas, the following agencies are involved: DHS accepts the employer's petition (DHS Form I–129) with the DOL-certified LCA attached. In doing so, the DHS determines whether the petition is supported by an LCA which corresponds with the petition, whether the occupation named in the labor condition application is a specialty occupation or whether the individual is a fashion model of distinguished merit and ability, and whether the qualifications of the nonimmigrant meet the statutory requirements for H–1B visa classification. If the petition is approved, DHS will notify the U.S. Consulate where the nonimmigrant intends to apply for the visa unless the nonimmigrant is in the U.S. and eligible to adjust status without leaving this country. See 8 U.S.C. 1255(h)(2)(B)(i). The Department of Justice administers the system for the enforcement and disposition of complaints regarding an H–1B-dependent employer's or willful violator employer's failure to offer a position filled by an H–1B nonimmigrant to an equally or better qualified United States worker (8 U.S.C. 1182(n)(1)(E), 1182(n)(5)), or such employer's willful misrepresentation of material facts relating to this obligation. DHS, is responsible for disapproving H–1B and other petitions filed by an employer found to have engaged in misrepresentation or failed to meet certain conditions of the labor condition application (8 U.S.C. 1182(n)(2)(C)(i)–(iii); 1182(n)(5)(E)). DOL and DOS are involved in the process relating to the initial issuance of H–1B1 and E–3 visas. DHS is involved in change of status and extension of stays for the H–1B1 and E–3 category.

(c) *Employer's responsibilities.* This paragraph applies only to the H–1B program; employer's responsibilities under the H–1B1 and E–3 programs are found at § 655.700(d)(4). Each employer seeking an H–1B nonimmigrant in a specialty occupation or as a fashion model of distinguished merit and ability has several responsibilities, as described more fully in this subpart and subpart I of this part, including:

(1) The employer shall submit a completed labor condition application (LCA) on Form ETA 9035E or Form ETA 9035 in the manner prescribed in § 655.720. By completing and submitting the LCA, and by signing the LCA, the employer makes certain representations and agrees to several attestations regarding its responsibilities, including the wages, working conditions, and benefits to be provided to the H–1B nonimmigrants (8 U.S.C. 1182(n)(1)); these attestations are specifically identified and incorporated by reference in the LCA, as well as being set forth in full on Form ETA 9035CP. The LCA contains additional attestations for certain H–1B-dependent employers and employers found to have willfully violated the H–1B program requirements; these attestations impose certain obligations to recruit U.S. workers, to offer the job to U.S. applicants who are equally or better qualified than the H–1B nonimmigrant(s) sought for the job, and to avoid the displacement of U.S. workers (either in the employer's workforce, or in the workforce of a second employer with whom the H–1B nonimmigrant(s) is placed, where there

are indicia of employment with a second employer (8 U.S.C. 1182(n)(1)(E)–(G)). These additional attestations are specifically identified and incorporated by reference in the LCA, as well as being set forth in full on Form ETA 9035CP. If ETA certifies the LCA, notice of the certification will be sent to the employer by the same means the employer used to submit the LCA (that is, electronically where the Form ETA 9035E was submitted electronically, and by U.S. Mail where the Form ETA 9035 was submitted by U.S. Mail). The employer reaffirms its acceptance of all of the attestation obligations by submitting the LCA to the U.S. Citizenship and Immigration Services (formerly the Immigration and Naturalization Service or INS) in support of the Petition for Nonimmigrant Worker, Form I–129, for an H–1B nonimmigrant. See 8 CFR 214.2(h)(4)(iii)(B)(2), which specifies the employer will comply with the terms of the LCA for the duration of the H–1B nonimmigrant's authorized period of stay.

(2) The employer shall maintain the original signed and certified LCA in its files, and shall make a copy of the LCA, as well as necessary supporting documentation (as identified under this subpart), available for public examination in a public access file at the employer's principal place of business in the U.S. or at the place of employment within one working day after the date on which the LCA is filed with ETA.

(3) The employer then may submit a copy of the certified, signed LCA to DHS with a completed petition (Form I–129) requesting H–1B classification.

(4) The employer shall not allow the nonimmigrant worker to begin work until DHS grants the alien authorization to work in the United States for that employer or, in the case of a nonimmigrant previously afforded H–1B status who is undertaking employment with a new H–1B employer, until the new employer files a nonfrivolous petition (Form I–129) in accordance with DHS requirements.

(5) The employer shall develop sufficient documentation to meet its burden of proof with respect to the validity of the statements made in its LCA and the accuracy of information provided, in the event that such statement or information is challenged. The employer shall also maintain such documentation at its principal place of business in the U.S. and shall make such documentation available to DOL for inspection and copying upon request.

[65 FR 80210, Dec. 20, 2000, as amended at 66 FR 63300, Dec. 5, 2001; 70 FR 72560, Dec. 5, 2005; 71 FR 35520, June 21, 2006; 73 FR 19948, Apr. 11, 2008]

§ 655.710 What is the procedure for filing a complaint?

(a) Except as provided in paragraph (b) of this section, complaints concerning misrepresentation in the labor condition application or failure of the employer to meet a condition specified in the application shall be filed with the Administrator, Wage and Hour Division (Administrator), ESA, according to the procedures set forth in subpart I of this part. The Administrator shall investigate where appropriate, and after an opportunity for a hearing, assess appropriate sanctions and penalties, as described in subpart I of this part.

(b) Complaints arising under section 212(n)(1)(G)(i)(II) of the INA, 8 U.S.C. 1182(n)(1)(G)(i)(II), alleging failure of the employer to offer employment to an equally or better qualified U.S. applicant, or an employer's misrepresentation regarding such offer(s) of employment, may be filed with the Department of Justice, Civil Rights Division, Office of Special Counsel for Immigration-Related Unfair Employment Practices, 950 Pennsylvania Avenue, NW., Washington, DC 20530, Telephone: 1–800–255–8155 (employers), 1–800–255–7688 (employees); Web address: *http://www.usdoj.gov/crt/osc*. The Department of Justice shall investigate where appropriate, and take action as appropriate under that Department's regulations and procedures.

[65 FR 80210, Dec. 20, 2000, as amended at 70 FR 72561, Dec. 5, 2005]

§ 655.715 Definitions.

For the purposes of subparts H and I of this part:

Actual wage means the wage rate paid by the employer to all individuals with experience and qualifications similar to the H–1B nonimmigant's experience

and qualifications for the specific employment in question at the place of employment. The actual wage established by the employer is *not* an average of the wage rates paid to all workers employed in the occupation.

Administrative Law Judge (ALJ) means an official appointed pursuant to 5 U.S.C. 3105.

Administrator means the Administrator of the Wage and Hour Division, Employment Standards Administration, Department of Labor, and such authorized representatives as may be designated to perform any of the functions of the Administrator under subpart H or I of this part.

Aggrieved party means a person or entity whose operations or interests are adversely affected by the employer's alleged non-compliance with the labor condition application and includes, but is not limited to:

(1) A worker whose job, wages, or working conditions are adversely affected by the employer's alleged noncompliance with the labor condition application;

(2) A bargaining representative for workers whose jobs, wages, or working conditions are adversely affected by the employer's alleged non-compliance with the labor condition application;

(3) A competitor adversely affected by the employer's alleged non-compliance with the labor condition application; and

(4) A government agency which has a program that is impacted by the employer's alleged non-compliance with the labor condition application.

Area of intended employment means the area within normal commuting distance of the place (address) of employment where the H–1B nonimmigrant is or will be employed. There is no rigid measure of distance which constitutes a normal commuting distance or normal commuting area, because there may be widely varying factual circumstances among different areas (e.g., normal commuting distances might be 20, 30, or 50 miles). If the place of employment is within a Metropolitan Statistical Area (MSA) or a Primary Metropolitan Statistical Area (PMSA), any place within the MSA or PMSA is deemed to be within normal commuting distance of the place of employment; however, all locations within a Consolidated Metropolitan Statistical Area (CMSA) will not automatically be deemed to be within normal commuting distance. The borders of MSAs and PMSAs are not controlling with regard to the identification of the normal commuting area; a location outside of an MSA or PMSA (or a CMSA) may be within normal commuting distance of a location that is inside (e.g., near the border of) the MSA or PMSA (or CMSA).

Attorney General means the chief official of the U.S. Department of Justice or the Attorney General's designee.

Authorized agent and *authorized representative* mean an official of the employer who has the legal authority to commit the employer to the statements in the labor condition application.

Center Director means the Department official to whom the Administrator has delegated his authority for purposes of NPC operations and functions.

Certification means the determination by a certifying officer that a labor condition application is not incomplete and does not contain obvious inaccuracies.

Certify means the act of making a certification.

Certifying Officer means a Department of Labor official, or such official's designee, who makes determinations about whether or not to certify labor condition applications.

Chief Administrative Law Judge (Chief ALJ) means the chief official of the Office of the Administrative Law Judges of the Department of Labor or the Chief Administrative Law Judge's designee.

Department and *DOL* mean the United States Department of Labor.

Department of Homeland Security (DHS) through the United States Citizenship and Immigration Services (USCIS) makes the determination under the INA on whether to grant visa petitions of employers seeking the admission of non-immigrants under H–1B visa for the purpose of employment.

Division means the Wage and Hour Division of the Employment Standards Administration, DOL.

Employed, employed by the employer, or employment relationship means the employment relationship as determined under the common law, under which the key determinant is the putative employer's right to control the means and manner in which the work is performed. Under the common law, ''no shorthand formula or magic phrase * * * can be applied to find the answer * * *. [A]ll of the incidents of the relationship must be assessed and weighed with no one factor being decisive.'' *NLRB* v. *United Ins. Co. of America*, 390 U.S. 254, 258 (1968).

Employer means a person, firm, corporation, contractor, or other association or organization in the United States that has an employment relationship with H–1B, H–1B1, or E–3 nonimmigrants and/or U.S. worker(s). In the case of an H–1B nonimmigrant (not including E–3 and H–1B1 nonimmigrants), the person, firm, contractor, or other association or organization in the United States that files a petition with the United States Citizenship and Immigration Services (USCIS) of the Department of Homeland Security (DHS) on behalf of the nonimmigrant is deemed to be the employer of that nonimmigrant. In the case of an E–3 and H–1B1 nonimmigrant, the person, firm, contractor, or other association or organization in the United States that files an LCA with the Department of Labor on behalf of the nonimmigrant is deemed to be the employer of that nonimmigrant.

Employment and Training Administration (ETA) means the agency within the Department which includes the Office of Foreign Labor Certification (OFLC).

Employment Standards Administration (ESA) means the agency within the Department which includes the Wage and Hour Division.

INA means the Immigration and Nationality Act, as amended, 8 U.S.C. 1101 *et seq.*

Independent authoritative source means a professional, business, trade, educational or governmental association, organization, or other similar entity, not owned or controlled by the employer, which has recognized expertise in an occupational field.

Independent authoritative source survey means a survey of wages conducted by an independent authoritative source and published in a book, newspaper, periodical, loose-leaf service, newsletter, or other similar medium, within the 24-month period immediately preceding the filing of the employer's application. Such survey shall:

(1) Reflect the average wage paid to workers similarly employed in the area of intended employment;

(2) Be based upon recently collected data—e.g., within the 24-month period immediately preceding the date of publication of the survey; and

(3) Represent the latest published prevailing wage finding by the authoritative source for the occupation in the area of intended employment.

Interested party means a person or entity who or which may be affected by the actions of an H–1B employer or by the outcome of a particular investigation and includes any person, organization, or entity who or which has notified the Department of his/her/its interest or concern in the Administrator's determination.

Lockout means a labor dispute involving a work stoppage, wherein an employer withholds work from its employees in order to gain a concession from them.

Occupation means the occupational or job classification in which the H–1B nonimmigrant is to be employed.

Office of Foreign Labor Certification (OFLC) means the organizational component within the ETA that provides national leadership and policy guidance and develops regulations and procedures to carry out the responsibilities of the Secretary of Labor under the INA concerning alien workers seeking admission to the United States in order to work under the Immigration and Nationality Act, as amended.

Period of intended employment means the time period between the starting and ending dates inclusive of the H–1B nonimmigrant's intended period of employment in the occupational classification at the place of employment as set forth in the labor condition application.

Place of employment means the worksite or physical location where the

work actually is performed by the H–1B, H–1B1, or E–3 nonimmigrant.

(1) The term does not include any location where either of the following criteria—paragraph (1)(i) or (ii)—is satisfied:

(i) *Employee developmental activity.* An H–1B worker who is stationed and regularly works at one location may temporarily be at another location for a particular individual or employer-required developmental activity such as a management conference, a staff seminar, or a formal training course (other than ''on-the-job-training'' at a location where the employee is stationed and regularly works). For the H–1B worker participating in such activities, the location of the activity would not be considered a ''place of employment'' or ''worksite,'' and that worker's presence at such location—whether owned or controlled by the employer or by a third party—would not invoke H–1B program requirements with regard to that employee at that location. However, if the employer uses H–1B nonimmigrants as instructors or resource or support staff who continuously or regularly perform their duties at such locations, the locations would be ''places of employment'' or ''worksites'' for any such employees and, thus, would be subject to H–1B program requirements with regard to those employees.

(ii) *Particular worker's job functions.* The nature and duration of an H–1B nonimmigrant's job functions may necessitate frequent changes of location with little time spent at any one location. For such a worker, a location would not be considered a ''place of employment'' or ''worksite'' if the following three requirements (*i.e.,* paragraphs (1)(ii)(A) through (C)) are all met—

(A) The nature and duration of the H–1B worker's job functions mandates his/her short-time presence at the location. For this purpose, either:

(*1*) The H–1B nonimmigrant's job must be peripatetic in nature, in that the normal duties of the worker's occupation (rather than the nature of the employer's business) requires frequent travel (local or non-local) from location to location; or

(*2*) The H–1B worker's duties must require that he/she spend most work time at one location but occasionally travel for short periods to work at other locations; and

(B) The H–1B worker's presence at the locations to which he/she travels from the ''home'' worksite is on a casual, short-term basis, which can be recurring but not excessive (*i.e.,* not exceeding five consecutive workdays for any one visit by a peripatetic worker, or 10 consecutive workdays for any one visit by a worker who spends most work time at one location and travels occasionally to other locations); and

(C) The H–1B nonimmigrant is not at the location as a ''strikebreaker'' (*i.e.,* the H–1B nonimmigrant is not performing work in an occupation in which workers are on strike or lockout).

(2) Examples of ''non-worksite'' locations based on worker's job functions: A computer engineer sent out to customer locations to ''troubleshoot'' complaints regarding software malfunctions; a sales representative making calls on prospective customers or established customers within a ''home office'' sales territory; a manager monitoring the performance of out-stationed employees; an auditor providing advice or conducting reviews at customer facilities; a physical therapist providing services to patients in their homes within an area of employment; an individual making a court appearance; an individual lunching with a customer representative at a restaurant; or an individual conducting research at a library.

(3) Examples of ''worksite'' locations based on worker's job functions: A computer engineer who works on projects or accounts at different locations for weeks or months at a time; a sales representative assigned on a continuing basis in an area away from his/her ''home office;'' an auditor who works for extended periods at the customer's offices; a physical therapist who ''fills in'' for full-time employees of health care facilities for extended periods; or a physical therapist who works for a contractor whose business is to provide staffing on an ''as needed'' basis at hospitals, nursing homes, or clinics.

(4) Whenever an H–1B worker performs work at a location which is not a ''worksite'' (under the criterion in paragraph (1)(i) or (1)(ii) of this definition), that worker's ''place of employment'' or ''worksite'' for purposes of H–1B obligations is the worker's home station or regular work location. The employer's obligations regarding notice, prevailing wage and working conditions are focused on the home station ''place of employment'' rather than on the above-described location(s) which do not constitute worksite(s) for these purposes. However, whether or not a location is considered to be a ''worksite''/''place of employment'' for an H–1B nonimmigrant, the employer is required to provide reimbursement to the H–1B nonimmigrant for expenses incurred in traveling to that location on the employer's business, since such expenses are considered to be ordinary business expenses of employers (§§ 655.731(c)(7)(iii)(C); 655.731(c)(9)). In determining the worker's ''place of employment'' or ''worksite,'' the Department will look carefully at situations which appear to be contrived or abusive; the Department would seriously question any situation where the H–1B nonimmigrant's purported ''place of employment'' is a location other than where the worker spends most of his/her work time, or where the purported ''area of employment'' does not include the location(s) where the worker spends most of his/her work time.

Required wage rate means the rate of pay which is the higher of:

(1) The actual wage for the specific employment in question; or

(2) The prevailing wage rate (determined as of the time of filing the LCA application) for the occupation in which the H–1B, H–1B1, or E–3 nonimmigrant is to be employed in the geographic area of intended employment. The prevailing wage rate must be no less than the minimum wage required by Federal, State, or local law.

Secretary means the Secretary of Labor or the Secretary's designee.

Specialty occupation:

(1) For purposes of the E–3 and H–1B programs (but not the H–1B1 program), *specialty occupation* means an occupation that requires theoretical and practical application of a body of specialized knowledge, and attainment of a bachelor's or higher degree (or its equivalent) in the specific specialty as a minimum for entry into the occupation in the United States. The nonimmigrant in a specialty occupation shall possess the following qualifications:

(i) Full state licensure to practice in the occupation, if licensure is required for the occupation;

(ii) Completion of the required degree; or

(iii) Experience in the specialty equivalent to the completion of such degree and recognition of expertise in the specialty through progressively responsible positions relating to the specialty. INA, 8 U.S.C. 1184(i)(1) and (2).

(2) For purposes of the H–1B1 program, *specialty occupation* means an occupation that requires theoretical and practical application of a body of specialized knowledge, and attainment of a bachelor's or higher degree (or its equivalent) in the specific specialty as a minimum for entry into the occupation in the United States. INA, 8 U.S.C. 1184(i)(3). For H–1B1 nonimmigrants from Chile, additional occupations that qualify as specialty occupations are Disaster Relief Claims Adjuster, Management Consultant, Agricultural Manager, and Physical Therapist, as defined in Appendix 14.3(D)(2) of the United States-Chile Free Trade Agreement. For H–1B1 nonimmigrants from Singapore, additional occupations that qualify as specialty occupations are Disaster Relief Claims Adjuster and Management Consultant, as defined in Appendix 11A.2 of the United States-Singapore Free Trade Agreement.

(3) Determinations of specialty occupation and of nonimmigrant qualifications for the H–1B and H–1B1 programs are not made by the Department of Labor, but by the Department of State and/or United States Citizenship and Immigration Services (USCIS) of the Department of Homeland Security in accordance with the procedures of those agencies for processing visas, petitions, extensions of stay, or requests for change of nonimmigrant status for H–1B or H–1B1 nonimmigrants.

Specific employment in question means the set of duties and responsibilities performed or to be performed by the H–

1B nonimmigrant at the place of employment.

State means one of the 50 States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.

State Workforce Agency, formerly State Employment Security Agency or SESA means the State agency which, under the State Administrator, is designated by the Governor to administer Wagner-Peyser Act funded employment and workforce information services (State agency) and the State unemployment compensation program.

Strike means a labor dispute wherein employees engage in a concerted stoppage of work (including stoppage by reason of the expiration of a collective-bargaining agreement) or engage in any concerted slowdown or other concerted interruption of operation.

United States worker (''U.S. worker'') means an employee who is either

(1) A citizen or national of the United States, or

(2) An alien who is lawfully admitted for permanent residence in the United States, is admitted as a refugee under section 207 of the INA, is granted asylum under section 208 of the INA, or is an immigrant otherwise authorized (by the INA or by DHS) to be employed in the United States.

Wage rate means the remuneration (exclusive of fringe benefits) to be paid, stated in terms of amount per hour, day, month or year (see definition of ''Required Wage Rate'').

[59 FR 65659, 65676, Dec. 20, 1994, as amended at 65 FR 80211, Dec. 20, 2000; 69 FR 68228, Nov. 23, 2004; 70 FR 72561, Dec. 5, 2005; 71 FR 35520, June 21, 2006; 73 FR 19948, Apr. 11, 2008; 73 FR 78067, Dec. 19, 2008]

§ 655.720 Where are labor condition applications (LCAs) to be filed and processed?

(a) Employers must file all LCAs regarding H–1B, H–1B1, and E–3 nonimmigrants through the electronic submission procedure identified in paragraph (b) of this section except as provided in the next sentence. If a physical disability or lack of access to the Internet prevents an employer from using the electronic filing system, an LCA may be filed by U.S. Mail in accordance with paragraphs (c) and (d) of this section. Requirements for signing, providing public access to, and use of certified LCAs are identified in § 655.730(c). If the LCA is certified by DOL, notice of the certification will be sent to the employer by the same means that the employer used to submit the LCA, that is, electronically where the Form ETA 9035E was submitted electronically, and by U.S. Mail where the Form ETA 9035 was submitted by U.S. Mail.

(b) *Electronic submission.* Employers must file the electronic LCA, Form ETA 9035E, through the Department of Labor's Web site at *http://www.lca.doleta.gov*. The employer must follow instructions for electronic submission posted on the Web site. In the event ETA implements the Government Paperwork Elimination Act (44 U.S.C.A. 3504 n.) and/or the Electronic Records and Signatures in Global and National Commerce Act (E–SIGN) (15 U.S.C. 7001–7006) for the submission and certification of the Form ETA 9035E, instructions will be provided (by public notice(s) and by instructions on the Department's Web site) to employers as to how the requirements of these statutes will be met in the Form ETA 9035E procedures.

(c) *Approval to file LCAs by U.S. Mail.* (1) Employers with physical disabilities or lacking Internet access and wishing to file LCAs by U.S. Mail may submit a written request to the Chief, Division of Foreign Labor Certification in accordance with paragraphs (c)(2) through (c)(4) of this section. The ETA shall identify the address to which such written request shall be mailed in a Notice in the FEDERAL REGISTER and on the Department's Web site at *http://www.lca.doleta.gov*.

(2) The written request must establish the employer's need to file by U.S. Mail, including providing an explanation of how physical disability or lack of access to the Internet prevents the employer from using the electronic filing system. No particular form or format is required for this request.

(3) ETA will review the submitted justification, and may require the employer to submit supporting documentation. In the case of employers asserting a lack of Internet access, supporting documentation could, for example, consist of documentation that

the Internet cannot be accessed from the employer's worksite or physical location (for example because no Internet service provider serves the site), and there is no publicly available Internet access, at public libraries or elsewhere, within a reasonable distance of the employer. In the case of employers with physical disabilities supporting documentation could, for example, consist of physicians' statements or invoices for medical devices or aids relevant to the employer's disability.

(4) ETA may approve or deny employers' requests to submit LCAs by U.S. Mail. Approvals shall be valid for 1 year from the date of approval.

(d) *U.S. Mail.* If an employer has a valid approval to file by U.S. Mail in accordance with paragraph (c) of this section, the employer may use Form ETA 9035 and send it by U.S. Mail to ETA. ETA shall publish a Notice in the FEDERAL REGISTER identifying the address, and any future address changes, to which paper LCAs must be mailed, and shall also post these addresses on the DOL Internet Web site at *http://www.lca.doleta.gov*. When Form ETA 9035 is submitted by U.S. Mail, the form must bear the original signature of the employer (or that of the employer's authorized agent or representative) at the time it is submitted to ETA.

(e) The ETA National Office is responsible for policy questions and other issues regarding LCAs. Prevailing wage challenges are handled in accordance with the procedures identified in § 655.731(a)(2).

[70 FR 72561, Dec. 5, 2005, as amended at 73 FR 19949, Apr. 11, 2008]

§ 655.721 [Reserved]

§ 655.730 What is the process for filing a labor condition application?

This section applies to the filing of labor condition applications for H–1B, H–1B1, and E–3 nonimmigrants. The term H–1B is meant to apply to all three categories unless exceptions are specifically noted.

(a) *Who must submit labor condition applications?* An employer, or the employer's authorized agent or representative, which meets the definition of ''employer'' set forth in § 655.715 and intends to employ an H–1B nonimmigrant in a specialty occupation or as a fashion model of distinguished merit and ability shall submit an LCA to the Department.

(b) *Where and when is an LCA to be submitted?* An LCA shall be submitted by the employer to ETA in accordance with the procedure prescribed in § 655.720 no earlier than six months before the beginning date of the period of intended employment shown on the LCA. It is the employer's responsibility to ensure ETA receives a complete and accurate LCA. Incomplete or obviously inaccurate LCAs will not be certified by ETA. ETA will process all LCAs sequentially and will usually make a determination to certify or not certify an LCA within seven working days of the date ETA receives the LCA. LCAs filed by U.S. Mail may not be processed as quickly as those filed electronically.

(c) *What is to be submitted and what are its contents?* Form ETA 9035 or ETA 9035E.

(1) *General.* The employer (or the employer's authorized agent or representative) must submit to ETA one completed and dated LCA as prescribed in § 655.720. The electronic LCA, Form ETA 9035E, is found on the DOL Web site where the electronic submission is made, at *http://www.lca.doleta.gov*. Copies of the paper form, Form ETA 9035, and cover pages Form ETA 9035CP are available on the DOL Web site at *http://www.ows.doleta.gov* and from the ETA National Office, and may be used by employers with approval under § 655.720 to file by U.S. Mail during the approval's validity period.

(2) *Undertaking of the Employer.* In submitting the LCA, and by affixing the signature of the employer or its authorized agent or representative on Form ETA 9035E or Form ETA 9035, the employer (or its authorized agent or representative on behalf of the employer) attests the statements in the LCA are true and promises to comply with the labor condition statements (attestations) specifically identified in Forms ETA 9035E and ETA 9035, as well as set forth in full in the Form ETA 9035CP. The labor condition statements (attestations) are described in detail in §§ 655.731 through 655.734, and the additional attestations for LCAs filed by

certain H–1B-dependent employers and employers found to have willfully violated the H–1B program requirements are described in §§ 655.736 through 655.739.

(3) *Signed Originals, Public Access, and Use of Certified LCAs.* In accordance with § 655.760(a) and (a)(1), the employer must maintain in its files and make available for public examination the LCA as submitted to ETA and as certified by ETA. When Form ETA 9035E is submitted electronically, a signed original is created by the employer (or by the employer's authorized agent or representative) printing out and signing the form immediately upon certification by ETA. When Form ETA 9035 is submitted by U.S. Mail as permitted by § 655.720(a), the form must bear the original signature of the employer (or of the employer's authorized agent or representative) when submitted to ETA. For H–1B visas only, the employer must submit a copy of the signed, certified Form ETA 9035 or ETA 9035E to the U.S. Citizenship and Immigration Services (USCIS, formerly INS) in support of the Form I–129 petition, thereby reaffirming the employer's acceptance of all of the attestation obligations in accordance with 8 CFR 214.2(h)(4)(iii)(B)(2).

(4) *Contents of LCA.* Each LCA shall identify the occupational classification for which the LCA is being submitted and shall state:

(i) The occupation, by Dictionary of Occupational Titles (DOT) Three-Digit Occupational Groups code and by the employer's own title for the job;

(ii) The number of nonimmigrants sought;

(iii) The gross wage rate to be paid to each nonimmigrant, expressed on an hourly, weekly, biweekly, monthly, or annual basis;

(iv) The starting and ending dates of the nonimmigrants' employment;

(v) The place(s) of intended employment;

(vi) The prevailing wage for the occupation in the area of intended employment and the specific source (e.g., name of published survey) relied upon by the employer to determine the wage. If the wage is obtained from a SESA, now known as a State Workforce Agency (SWA), the appropriate box must be checked and the wage must be stated; the source for a wage obtained from a source other than a SWA must be identified along with the wage; and

(vii) For applications filed regarding H–1B nonimmigrants only (and not applications regarding H–1B1 and E–3 nonimmigrants), the employer's status as to whether or not the employer is H–1B-dependent and/or a willful violator, and, if the employer is H–1B-dependent and/or a willful violator, whether the employer will use the application only in support of petitions for exempt H–1B nonimmigrants.

(5) *Multiple positions and/or places of employment.* The employer shall file a separate LCA for each occupation in which the employer intends to employ one or more nonimmigrants, but the LCA may cover more than one intended position (employment opportunity) within that occupation. All intended places of employment shall be identified on the LCA; the employer may file one or more additional LCAs to identify additional places of employment. Separate LCAs must be filed for H–1B, H–1B1, and E–3 nonimmigrants.

(6) *Full-time and part-time jobs.* The position(s) covered by the LCA may be either full-time or part-time; full-time and part-time positions can not be combined on a single LCA.

(d) *What attestations does the LCA contain?* An employer's LCA shall contain the labor condition statements referenced in §§ 655.731 through 655.734, and § 655.736 through 655.739 (if applicable), which provide that no individual may be admitted or provided status as an H–1B nonimmigrant in an occupational classification unless the employer has filed with the Secretary an application stating that:

(1) The employer is offering and will offer during the period of authorized employment to H–1B nonimmigrants no less than the greater of the following wages (such offer to include benefits and eligibility for benefits provided as compensation for services, which are to be offered to the nonimmigrants on the same basis and in accordance with the same criteria as the employer offers such benefits to U.S. workers):

(i) The actual wage paid to the employer's other employees at the worksite with similar experience and qualifications for the specific employment in question; or

(ii) The prevailing wage level for the occupational classification in the area of intended employment;

(2) The employer will provide working conditions for such nonimmigrants that will not adversely affect the working conditions of workers similarly employed (including benefits in the nature of working conditions, which are to be offered to the nonimmigrants on the same basis and in accordance with the same criteria as the employer offers such benefits to U.S. workers);

(3) There is not a strike or lockout in the course of a labor dispute in the occupational classification at the place of employment;

(4) The employer has provided and will provide notice of the filing of the labor condition application to:

(i)(A) The bargaining representative of the employer's employees in the occupational classification in the area of intended employment for which the H–1B nonimmigrants are sought, in the manner described in §655.734(a)(1)(i); or

(B) If there is no such bargaining representative, affected workers by providing electronic notice of the filing of the LCA or by posting notice in conspicuous locations at the place(s) of employment, in the manner described in §655.734(a)(1)(ii); and

(ii) H–1B nonimmigrants by providing a copy of the LCA to each H–1B nonimmigrant at the time that such nonimmigrant actually reports to work, in the manner described in §655.734(a)(2).

(5) For applications filed regarding H–1B nonimmigrants only (and not applications regarding H–1B1 or E–3 nonimmigrants), the employer has determined its status concerning H–1B-dependency and/or willful violator (as described in §655.736), has indicated such status, and if either such status is applicable to the employer, has indicated whether the LCA will be used only for exempt H–1B nonimmigrant(s), as described in §655.737.

(6) The employer has provided the information about the occupation required in paragraph (c) of this section.

(e) *Change in employer's corporate structure or identity.* (1) Where an employer corporation changes its corporate structure as the result of an acquisition, merger, ''spin-off,'' or other such action, the new employing entity is not required to file new LCAs and H–1B petitions with respect to the H–1B nonimmigrants transferred to the employ of the new employing entity (regardless of whether there is a change in the Federal Employer Identification Number (FEIN)), *provided that* the new employing entity maintains in its records a list of the H–1B nonimmigrants transferred to the employ of the new employing entity, and maintains in the public access file(s) (see §655.760) a document containing all of the following:

(i) Each affected LCA number and its date of certification;

(ii) A description of the new employing entity's actual wage system applicable to H–1B nonimmigrant(s) who become employees of the new employing entity;

(iii) The Federal Employer Identification Number (FEIN) of the new employing entity (whether or not different from that of the predecessor entity); and

(iv) A sworn statement by an authorized representative of the new employing entity expressly acknowledging such entity's assumption of all obligations, liabilities and undertakings arising from or under attestations made in each certified and still effective LCA filed by the predecessor entity. Unless such statement is executed and made available in accordance with this paragraph, the new employing entity shall not employ any of the predecessor entity's H–1B nonimmigrants without filing new LCAs and petitions for such nonimmigrants. The new employing entity's statement shall include such entity's explicit agreement to:

(A) Abide by the DOL's H–1B regulations applicable to the LCAs;

(B) Maintain a copy of the statement in the public access file (see §655.760); and

(C) Make the document available to any member of the public or the Department upon request.

(2) Notwithstanding the provisions of paragraph (e)(1) of this section, the new

employing entity must file new LCA(s) and H–1B petition(s) when it hires any new H–1B nonimmigrant(s) or seeks extension(s) of H–1B status for existing H–1B nonimmigrant(s). In other words, the new employing entity may not utilize the predecessor entity's LCA(s) to support the hiring or extension of any H–1B nonimmigrant after the change in corporate structure.

(3) A change in an employer's H–1B-dependency status which results from the change in the corporate structure has no effect on the employer's obligations with respect to its current H–1B nonimmigrant employees. However, the new employing entity shall comply with § 655.736 concerning H–1B-dependency and/or willful-violator status and § 655.737 concerning exempt H–1B nonimmigrants, in the event that such entity seeks to hire new H–1B nonimmigrant(s) or to extend the H–1B status of existing H–1B nonimmigrants. (See § 655.736(d)(6).)

[65 FR 80212, Dec. 20, 2000, as amended at 66 FR 63301, Dec. 5, 2001; 69 FR 68228, Nov. 23, 2004; 70 FR 72562, Dec. 5, 2005; 71 FR 35521, June 21, 2006; 73 FR 19949, Apr. 11, 2008]

§ 655.731 What is the first LCA requirement, regarding wages?

An employer seeking to employ H–1B nonimmigrants in a specialty occupation or as a fashion model of distinguished merit and ability shall state on Form ETA 9035 or 9035E that it will pay the H–1B nonimmigrant the required wage rate. For the purposes of this section, ''H–1B'' includes ''E–3 and H–1B1'' as well.

(a) *Establishing the wage requirement.* The first LCA requirement shall be satisfied when the employer signs Form ETA 9035 or 9035E attesting that, for the entire period of authorized employment, the required wage rate will be paid to the H–1B nonimmigrant(s); that is, that the wage shall be the greater of the actual wage rate (as specified in paragraph (a)(1) of this section) or the prevailing wage (as specified in paragraph (a)(2) of this section). The wage requirement includes the employer's obligation to offer benefits and eligibility for benefits provided as compensation for services to H–1B nonimmigrants on the same basis, and in accordance with the same criteria, as the employer offers to U.S. workers.

(1) The *actual wage* is the wage rate paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question. In determining such wage level, the following factors may be considered: Experience, qualifications, education, job responsibility and function, specialized knowledge, and other legitimate business factors. ''Legitimate business factors,'' for purposes of this section, means those that it is reasonable to conclude are necessary because they conform to recognized principles or can be demonstrated by accepted rules and standards. Where there are other employees with substantially similar experience and qualifications in the specific employment in question—*i.e.*, they have substantially the same duties and responsibilities as the H–1B nonimmigrant—the actual wage shall be the amount paid to these other employees. Where no such other employees exist at the place of employment, the actual wage shall be the wage paid to the H–1B nonimmigrant by the employer. Where the employer's pay system or scale provides for adjustments during the period of the LCA—e.g., cost of living increases or other periodic adjustments, or the employee moves to a more advanced level in the same occupation—such adjustments shall be provided to similarly employed H–1B nonimmigrants (unless the prevailing wage is higher than the actual wage).

(2) The prevailing wage for the occupational classification in the area of intended employment must be determined as of the time of filing the application. The employer shall base the prevailing wage on the best information available as of the time of filing the application. Except as provided in this section, the employer is not required to use any specific methodology to determine the prevailing wage and may utilize a wage obtained from an OFLC NPC (OES), an independent authoritative source, or other legitimate sources of wage data. One of the following sources shall be used to establish the prevailing wage:

(i) A collective bargaining agreement which was negotiated at arms-length

between a union and the employer which contains a wage rate applicable to the occupation;

(ii) If the job opportunity is in an occupation which is not covered by paragraph (a)(2)(i) of this section, the prevailing wage shall be the arithmetic mean of the wages of workers similarly employed, except that the prevailing wage shall be the median when provided by paragraphs (a)(2)(ii)(A), (b)(3)(iii)(B)(*2*), and (b)(3)(iii)(C)(*2*) of this section. The prevailing wage rate shall be based on the best information available. The following prevailing wage sources may be used:

(A) *OFLC National Processing Center (NPC) determination.* Prior to January 1, 2010, the SWA having jurisdiction over the area of intended employment shall continue to receive and process prevailing wage determination requests, but shall do so in accordance with these regulatory provisions and Department guidance. On or after January 1, 2010, the NPC shall receive and process prevailing wage determination requests in accordance with these regulations and with Department guidance. Upon receipt of a written request for a PWD on or after January 1, 2010, the NPC will determine whether the occupation is covered by a collective bargaining agreement which was negotiated at arm's length, and, if not, determine the arithmetic mean of wages of workers similarly employed in the area of intended employment. The wage component of the Bureau of Labor Statistics Occupational Employment Statistics survey shall be used to determine the arithmetic mean, unless the employer provides an acceptable survey. The NPC shall determine the wage in accordance with secs. 212(n) and 212(t) of the INA. If an acceptable employer-provided wage survey provides a median and does not provide an arithmetic mean, the median shall be the prevailing wage applicable to the employer's job opportunity. In making a PWD, the Chicago NPC will follow 20 CFR 656.40 and other administrative guidelines or regulations issued by ETA. The Chicago NPC shall specify the validity period of the PWD, which in no event shall be for less than 90 days or more than 1 year from the date of the determination.

(*1*) An employer who chooses to utilize an NPC PWD shall file the labor condition application within the validity period of the prevailing wage as specified in the PWD. Any employer desiring review of an NPC PWD, including judicial review, shall follow the appeal procedures at 20 CFR 656.41. Employers which challenge an NPC PWD under 20 CFR 656.41 must obtain a ruling prior to filing an LCA. In any challenge, the Department and the NPC shall not divulge any employer wage data collected under the promise of confidentiality. Once an employer obtains a PWD from the NPC and files an LCA supported by that PWD, the employer is deemed to have accepted the PWD (as to the amount of the wage) and thereafter may not contest the legitimacy of the PWD by filing an appeal with the CO (see 20 CFR 656.41) or in an investigation or enforcement action.

(*2*) If the employer is unable to wait for the NPC to produce the requested prevailing wage for the occupation in question, or for the CO and/or the BALCA to issue a decision, the employer may rely on other legitimate sources of available wage information as set forth in paragraphs (a)(2)(ii)(B) and (C) of this section. If the employer later discovers, upon receipt of the PWD from the NPC, that the information relied upon produced a wage below the final PWD and the employer was paying the NPC-determined wage, no wage violation will be found if the employer retroactively compensates the H–2B nonimmigrant(s) for the difference between the wage paid and the prevailing wage, within 30 days of the employer's receipt of the PWD.

(*3*) In all situations where the employer obtains the PWD from the NPC, the Department will deem that PWD as correct as to the amount of the wage. Nevertheless, the employer must maintain a copy of the NPC PWD. A complaint alleging inaccuracy of an NPC PWD, in such cases, will not be investigated.

(B) *An independent authoritative source.* The employer may use an independent authoritative wage source in lieu of an NPC PWD. The independent authoritative source survey must meet

all the criteria set forth in paragraph (b)(3)(iii)(B) of this section.

(C) *Another legitimate source of wage information.* The employer may rely on other legitimate sources of wage data to obtain the prevailing wage. The other legitimate source survey must meet all the criteria set forth in paragraph (b)(3)(iii)(C) of this section. The employer will be required to demonstrate the legitimacy of the wage in the event of an investigation.

(iii) For purposes of this section, ''similarly employed'' means ''having substantially comparable jobs in the occupational classification in the area of intended employment,'' except that if a representative sample of workers in the occupational category can not be obtained in the area of intended employment, ''similarly employed'' means:

(A) Having jobs requiring a substantially similar level of skills within the area of intended employment; or

(B) If there are no substantially comparable jobs in the area of intended employment, having substantially comparable jobs with employers outside of the area of intended employment.

(iv) A prevailing wage determination for LCA purposes made pursuant to this section shall not permit an employer to pay a wage lower than required under any other applicable Federal, state or local law.

(v) Where a range of wages is paid by the employer to individuals in an occupational classification or among individuals with similar experience and qualifications for the specific employment in question, a range is considered to meet the prevailing wage requirement so long as the bottom of the wage range is at least the prevailing wage rate.

(vi) The employer shall enter the prevailing wage on the LCA in the form in which the employer will pay the wage (e.g., an annual salary or an hourly rate), except that in all cases the prevailing wage must be expressed as an hourly wage if the H–1B nonimmigrant will be employed part-time. Where an employer obtains a prevailing wage determination (from any of the sources identified in paragraphs (a)(2)(i) and (ii) of this section) that is expressed as an hourly rate, the employer may convert this determination to a yearly salary by multiplying the hourly rate by 2080. Conversely, where an employer obtains a prevailing wage (from any of these sources) that is expressed as a yearly salary, the employer may convert this determination to an hourly rate by dividing the salary by 2080.

(vii) In computing the prevailing wage for a job opportunity in an occupational classification in an area of intended employment in the case of an employee of an institution of higher education or an affiliated or related nonprofit entity, a nonprofit research organization, or a Governmental research organization as these terms are defined in 20 CFR 656.40(e), the prevailing wage level shall only take into account employees at such institutions and organizations in the area of intended employment.

(viii) An employer may file more than one LCA for the same occupational classification in the same area of employment and, in such circumstances, the employer could have H–1B employees in the same occupational classification in the same area of employment, brought into the U.S. (or accorded H–1B status) based on petitions approved pursuant to different LCAs (filed at different times) with different prevailing wage determinations. Employers are advised that the prevailing wage rate as to any particular H–1B nonimmigrant is prescribed by the LCA which supports that nonimmigrant's H–1B petition. The employer is required to obtain the prevailing wage at the time that the LCA is filed (see paragraph (a)(2) of this section). The LCA is valid for the period certified by ETA, and the employer must satisfy all the LCA's requirements (including the required wage which encompasses both prevailing and actual wage rates) for as long as any H–1B nonimmigrants are employed pursuant to that LCA (§ 655.750). Where new nonimmigrants are employed pursuant to a new LCA, that new LCA prescribes the employer's obligations as to those new nonimmigrants. The prevailing wage determination on the later/subsequent LCA does not ''relate back'' to operate as an ''update'' of the prevailing wage for the previously-filed

LCA for the same occupational classification in the same area of employment. However, employers are cautioned that the actual wage component to the required wage may, as a practical matter, eliminate any wage-payment differentiation among H–1B employees based on different prevailing wage rates stated in applicable LCAs. Every H–1B nonimmigrant is to be paid in accordance with the employer's actual wage system, and thus is to receive any pay increases which that system provides.

(3) Once the prevailing wage rate is established, the H–1B employer then shall compare this wage with the actual wage rate for the specific employment in question at the place of employment and must pay the H–1B nonimmigrant at least the higher of the two wages.

(b) *Documentation of the wage statement.* (1) The employer shall develop and maintain documentation sufficient to meet its burden of proving the validity of the wage statement required in paragraph (a) of this section and attested to on Form ETA 9035 or 9035E. The documentation shall be made available to DOL upon request. Documentation shall also be made available for public examination to the extent required by § 655.760. The employer shall also document that the wage rate(s) paid to H–1B nonimmigrant(s) is(are) no less than the required wage rate(s). The documentation shall include information about the employer's wage rate(s) for all other employees for the specific employment in question at the place of employment, beginning with the date the labor condition application was submitted and continuing throughout the period of employment. The records shall be retained for the period of time specified in § 655.760. The payroll records for each such employee shall include:

(i) Employee's full name;

(ii) Employee's home address;

(iii) Employee's occupation;

(iv) Employee's rate of pay;

(v) Hours worked each day and each week by the employee if:

(A) The employee is paid on other than a salary basis (e.g., hourly, piecerate; commission); or

(B) With respect only to H–1B nonimmigrants, the worker is a part-time employee (whether paid a salary or an hourly rate).

(vi) Total additions to or deductions from pay each pay period, by employee; and

(vii) Total wages paid each pay period, date of pay and pay period covered by the payment, by employee.

(viii) Documentation of offer of benefits and eligibility for benefits provided as compensation for services on the same basis, and in accordance with the same criteria, as the employer offers to U.S. workers (see paragraph (c)(3) of this section):

(A) A copy of any document(s) provided to employees describing the benefits that are offered to employees, the eligibility and participation rules, how costs are shared, etc. (e.g., summary plan descriptions, employee handbooks, any special or employee-specific notices that might be sent);

(B) A copy of all benefit plans or other documentation describing benefit plans and any rules the employer may have for differentiating benefits among groups of workers;

(C) Evidence as to what benefits are actually provided to U.S. workers and H–1B nonimmigrants, including evidence of the benefits selected or declined by employees where employees are given a choice of benefits;

(D) For multinational employers who choose to provide H–1B nonimmigrants with ''home country'' benefits, evidence of the benefits provided to the nonimmigrant before and after he/she went to the United States. See paragraph (c)(3)(iii)(C) of this section.

(2) *Actual wage.* In addition to payroll data required by paragraph (b)(1) of this section (and also by the Fair Labor Standards Act), the employer shall retain documentation specifying the basis it used to establish the actual wage. The employer shall show how the wage set for the H–1B nonimmigrant relates to the wages paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question at the place of employment. Where adjustments are made in the employer's pay system or scale during

the validity period of the LCA, the employer shall retain documentation explaining the change and clearly showing that, after such adjustments, the wages paid to the H–1B nonimmigrant are at least the greater of the adjusted actual wage or the prevailing wage for the occupation and area of intended employment.

(3) *Prevailing wage.* The employer also shall retain documentation regarding its determination of the prevailing wage. This source documentation shall not be submitted to ETA with the labor condition application, but shall be retained at the employer's place of business for the length of time required in § 655.760(c). Such documentation shall consist of the documentation described in paragraph (b)(3)(i), (ii), or (iii) of this section and the documentation described in paragraph (b)(1) of this section.

(i) If the employer used a wage determination issued pursuant to the provisions of the Davis-Bacon Act, 40 U.S.C. 276a *et seq.* (*see* 29 CFR part 1), or the McNamara-O'Hara Service Contract Act, 41 U.S.C. 351 *et seq.* (*see* 29 CFR part 4), the documentation shall include a copy of the determination showing the wage rate for the occupation in the area of intended employment.

(ii) If the employer used an applicable wage rate from a union contract which was negotiated at arms-length between a union and the employer, the documentation shall include an excerpt from the union contract showing the wage rate(s) for the occupation.

(iii) If the employer did not use a wage covered by the provisions of paragraph (b)(3)(i) or (b)(3)(ii) of this section, the employer's documentation shall consist of:

(A) A copy of the prevailing wage finding from the NPC for the occupation within the area of intended employment.

(B) A copy of the prevailing wage survey for the occupation within the area of intended employment published by an independent authoritative source. For purposes of this paragraph (b)(3)(iii)(B), a prevailing wage survey for the occupation in the area of intended employment published by an independent authoritative source shall mean a survey of wages published in a book, newspaper, periodical, loose-leaf service, newsletter, or other similar medium, within the 24-month period immediately preceding the filing of the employer's application. Such survey shall:

(*1*) Reflect the weighted average wage paid to workers similarly employed in the area of intended employment;

(*2*) Reflect the median wage of workers similarly employed in the area of intended employment if the survey provides such a median and does not provide a weighted average wage of workers similarly employed in the area of intended employment;

(*3*) Be based upon recently collected data—e.g., within the 24-month period immediately preceding the date of publication of the survey; and

(*4*) Represent the latest published prevailing wage finding by the independent authoritative source for the occupation in the area of intended employment; or

(C) A copy of the prevailing wage survey or other source data acquired from another legitimate source of wage information that was used to make the prevailing wage determination. For purposes of this paragraph (b)(3)(iii)(C), a prevailing wage provided by another legitimate source of such wage information shall be one which:

(*1*) Reflects the weighted average wage paid to workers similarly employed in the area of intended employment;

(*2*) Reflect the median wage of workers similarly employed in the area of intended employment if the survey provides such a median and does not provide a weighted average wage of workers similarly employed in the area of intended employment;

(*3*) Is based on the most recent and accurate information available; and

(*4*) Is reasonable and consistent with recognized standards and principles in producing a prevailing wage.

(c) *Satisfaction of required wage obligation.* (1) The required wage must be paid to the employee, cash in hand, free and clear, when due, *except that* deductions made in accordance with paragraph (c)(9) of this section may reduce the cash wage below the level of

the required wage. Benefits and eligibility for benefits provided as compensation for services must be offered in accordance with paragraph (c)(3) of this section.

(2) ''Cash wages paid,'' for purposes of satisfying the H–1B required wage, shall consist only of those payments that meet all the following criteria:

(i) Payments shown in the employer's payroll records as earnings for the employee, and disbursed to the employee, cash in hand, free and clear, when due, except for deductions authorized by paragraph (c)(9) of this section;

(ii) Payments reported to the Internal Revenue Service (IRS) as the employee's earnings, with appropriate withholding for the employee's tax paid to the IRS (in accordance with the Internal Revenue Code of 1986, 26 U.S.C. 1, *et seq.*);

(iii) Payments of the tax reported and paid to the IRS as required by the Federal Insurance Contributions Act, 26 U.S.C. 3101, *et seq.* (FICA). The employer must be able to document that the payments have been so reported to the IRS and that both the employer's and employee's taxes have been paid *except that* when the H–1B nonimmigrant is a citizen of a foreign country with which the President of the United States has entered into an agreement as authorized by section 233 of the Social Security Act, 42 U.S.C. 433 (*i.e.*, an agreement establishing a totalization arrangement between the social security system of the United States and that of the foreign country), the employer's documentation shall show that all appropriate reports have been filed and taxes have been paid in the employee's home country.

(iv) Payments reported, and so documented by the employer, as the employee's earnings, with appropriate employer and employee taxes paid to all other appropriate Federal, State, and local governments in accordance with any other applicable law.

(v) Future bonuses and similar compensation (*i.e.*, unpaid but to-be-paid) may be credited toward satisfaction of the required wage obligation if their payment is assured (*i.e.*, they are not conditional or contingent on some event such as the employer's annual profits). Once the bonuses or similar compensation are paid to the employee, they must meet the requirements of paragraphs (c)(2)(i) through (iv) of this section (*i.e.*, recorded and reported as ''earnings'' with appropriate taxes and FICA contributions withheld and paid).

(3) *Benefits and eligibility for benefits* provided as compensation for services (e.g., cash bonuses; stock options; paid vacations and holidays; health, life, disability and other insurance plans; retirement and savings plans) shall be offered to the H–1B nonimmigrant(s) on the same basis, and in accordance with the same criteria, as the employer offers to U.S. workers.

(i) For purposes of this section, the offer of benefits ''on the same basis, and in accordance with the same criteria'' means that the employer shall offer H–1B nonimmigrants the same benefit package as it offers to U.S. workers, and may not provide more strict eligibility or participation requirements for the H–1B nonimmigrant(s) than for similarly employed U.S. workers(s) (e.g., full-time workers compared to full-time workers; professional staff compared to professional staff). H–1B nonimmigrants are not to be denied benefits on the basis that they are ''temporary employees'' by virtue of their nonimmigrant status. An employer may offer greater or additional benefits to the H–1B nonimmigrant(s) than are offered to similarly employed U.S. worker(s), *provided* that such differing treatment is consistent with the requirements of all applicable nondiscrimination laws (e.g., Title VII of the 1964 Civil Rights Act, 42 U.S.C. 2000e–2000e17). Offers of benefits by employers shall be made in good faith and shall result in the H–1B nonimmigrant(s)'s actual receipt of the benefits that are offered by the employer and elected by the H–1B nonimmigrant(s).

(ii) The benefits received by the H–1B nonimmigrant(s) need not be identical to the benefits received by similarly employed U.S. workers(s), *provided that* the H–1B nonimmigrant is offered the same benefits package as those workers but voluntarily chooses to receive different benefits (e.g., elects to receive

cash payment rather than stock option, elects not to receive health insurance because of required employee contributions, or elects to receive different benefits among an array of benefits) or, in those instances where the employer is part of a multinational corporate operation, the benefits received by the H–1B nonimmigrant are provided in accordance with an employer's practice that satisfies the requirements of paragraph (c)(3)(iii)(B) or (C) of this section. In all cases, however, an employer's practice must comply with the requirements of any applicable nondiscrimination laws (e.g., Title VII of the 1964 Civil Rights Act, 42 U.S.C. 2000e–2000e17).

(iii) If the employer is part of a multinational corporate operation (*i.e.*, operates in affiliation with business entities in other countries, whether as subsidiaries or in some other arrangement), the following three options (*i.e.*, (A), (B) or (C)) are available to the employer with respect to H–1B nonimmigrants who remain on the ''home country'' payroll.

(A) The employer may offer the H–1B nonimmigrant(s) benefits in accordance with paragraphs (c)(3)(i) and (ii) of this section.

(B) Where an H–1B nonimmigrant is in the U.S. for no more than 90 consecutive calendar days, the employer during that period may maintain the H–1B nonimmigrant on the benefits provided to the nonimmigrant in his/her permanent work station (ordinarily the home country), and not offer the nonimmigrant the benefits that are offered to similarly employed U.S. workers, *provided that* the employer affords reciprocal benefits treatment for any U.S. workers (*i.e.*, allows its U.S. employees, while working out of the country on a temporary basis away from their permanent work stations in the United States, or while working in the United States on a temporary basis away from their permanent work stations in another country, to continue to receive the benefits provided them at their permanent work stations). Employers are cautioned that this provision is available only if the employer's practices do not constitute an evasion of the benefit requirements, such as where the H–1B nonimmigrant remains in the United States for most of the year, but briefly returns to the ''home country'' before any 90-day period would expire.

(C) Where an H–1B nonimmigrant is in the U.S. for more than 90 consecutive calendar days (or from the point where the worker is transferred to the U.S. or it is anticipated that the worker will likely remain in the U.S. more than 90 consecutive days), the employer may maintain the H–1B nonimmigrant on the benefits provided in his/her home country (*i.e.*, ''home country benefits'') (and not offer the nonimmigrant the benefits that are offered to similarly employed U.S. workers) *provided that* all of the following criteria are satisfied:

(*1*) The H–1B nonimmigrant continues to be employed in his/her home country (either with the H–1B employer or with a corporate affiliate of the employer);

(*2*) The H–1B nonimmigrant is enrolled in benefits in his/her home country (in accordance with any applicable eligibility standards for such benefits);

(*3*) The benefits provided in his/her home country are equivalent to, or equitably comparable to, the benefits offered to similarly employed U.S. workers (*i.e.*, are no less advantageous to the nonimmigrant);

(*4*) The employer affords reciprocal benefits treatment for any U.S. workers while they are working out of the country, away from their permanent work stations (whether in the United States or abroad), on a temporary basis (*i.e.*, maintains such U.S. workers on the benefits they received at their permanent work stations);

(*5*) If the employer offers health benefits to its U.S. workers, the employer offers the same plan on the same basis to its H–1B nonimmigrants in the United States where the employer does not provide the H–1B nonimmigrant with health benefits in the home country, or the employer's home-country health plan does not provide full coverage (*i.e.*, coverage comparable to what he/she would receive at the home work station) for medical treatment in the United States; and

(*6*) The employer offers H–1B nonimmigrants who are in the United States more than 90 continuous days

those U.S. benefits which are paid directly to the worker (e.g., paid vacation, paid holidays, and bonuses).

(iv) Benefits provided as compensation for services may be credited toward the satisfaction of the employer's required wage obligation only if the requirements of paragraph (c)(2) of this section are met (e.g., recorded and reported as ''earnings'' with appropriate taxes and FICA contributions withheld and paid).

(4) For *salaried employees,* wages will be due in prorated installments (e.g., annual salary divided into 26 bi-weekly pay periods, where employer pays bi-weekly) paid no less often than monthly *except that,* in the event that the employer intends to use some other form of nondiscretionary payment to supplement the employee's regular/pro-rata pay in order to meet the required wage obligation (e.g., a quarterly production bonus), the employer's documentation of wage payments (including such supplemental payments) must show the employer's commitment to make such payment and the method of determining the amount thereof, and must show unequivocally that the required wage obligation was met for prior pay periods and, upon payment and distribution of such other payments that are pending, will be met for each current or future pay period. An employer that is a school or other educational institution may apply an established salary practice under which the employer pays to H–1B nonimmigrants and U.S. workers in the same occupational classification an annual salary in disbursements over fewer than 12 months, *provided that* the nonimmigrant agrees to the compressed annual salary payments prior to the commencement of the employment and the application of the salary practice to the nonimmigrant does not otherwise cause him/her to violate any condition of his/her authorization under the INA to remain in the U.S.

(5) For *hourly-wage employees,* the required wages will be due for all hours worked and/or for any nonproductive time (as specified in paragraph (c)(7) of this section) at the end of the employee's ordinary pay period (e.g., weekly) but in no event less frequently than monthly.

(6) Subject to the standards specified in paragraph (c)(7) of this section (regarding nonproductive status), an H–1B nonimmigrant shall receive the required pay beginning on the date when the nonimmigrant ''enters into employment'' with the employer.

(i) For purposes of this paragraph (c)(6), the H–1B nonimmigrant is considered to ''enter into employment'' when he/she first makes him/herself available for work or otherwise comes under the control of the employer, such as by waiting for an assignment, reporting for orientation or training, going to an interview or meeting with a customer, or studying for a licensing examination, and includes all activities thereafter.

(ii) Even if the H–1B nonimmigrant has not yet ''entered into employment'' with the employer (as described in paragraph (c)(6)(i) of this section), the employer that has had an LCA certified and an H–1B petition approved for the H–1B nonimmigrant shall pay the nonimmigrant the required wage beginning 30 days after the date the nonimmigrant first is admitted into the U.S. pursuant to the petition, or, if the nonimmigrant is present in the United States on the date of the approval of the petition, beginning 60 days after the date the nonimmigrant becomes eligible to work for the employer. For purposes of this latter requirement, the H–1B nonimmigrant is considered to be eligible to work for the employer upon the date of need set forth on the approved H–1B petition filed by the employer, or the date of adjustment of the nonimmigrant's status by DHS, whichever is later. Matters such as the worker's obtaining a State license would not be relevant to this determination.

(7) *Wage obligation(s) for H–1B nonimmigrant in nonproductive status*—(i) *Circumstances where wages must be paid.* If the H–1B nonimmigrant is not performing work and is in a nonproductive status due to a decision by the employer (e.g., because of lack of assigned work), lack of a permit or license, or any other reason except as specified in paragraph (c)(7)(ii) of this section, the employer is required to pay the salaried employee the full pro-rata amount

due, or to pay the hourly-wage employee for a full-time week (40 hours or such other number of hours as the employer can demonstrate to be full-time employment for hourly employees, or the full amount of the weekly salary for salaried employees) at the required wage for the occupation listed on the LCA. If the employer's LCA carries a designation of ''part-time employment,'' the employer is required to pay the nonproductive employee for at least the number of hours indicated on the I–129 petition filed by the employer with the DHS and incorporated by reference on the LCA. If the I–129 indicates a range of hours for part-time employment, the employer is required to pay the nonproductive employee for at least the average number of hours normally worked by the H–1B nonimmigrant, provided that such average is within the range indicated; in no event shall the employee be paid for fewer than the minimum number of hours indicated for the range of part-time employment. In all cases the H–1B nonimmigrant must be paid the required wage for all hours performing work within the meaning of the Fair Labor Standards Act, 29 U.S.C. 201 *et seq.*

(ii) *Circumstances where wages need not be paid.* If an H–1B nonimmigrant experiences a period of nonproductive status due to conditions unrelated to employment which take the nonimmigrant away from his/her duties at his/her voluntary request and convenience (e.g., touring the U.S., caring for ill relative) or render the nonimmigrant unable to work (e.g., maternity leave, automobile accident which temporarily incapacitates the nonimmigrant), then the employer shall not be obligated to pay the required wage rate during that period, *provided that* such period is not subject to payment under the employer's benefit plan or other statutes such as the Family and Medical Leave Act (29 U.S.C. 2601 *et seq.*) or the Americans with Disabilities Act (42 U.S.C. 12101 *et seq.*). Payment need not be made if there has been a *bona fide* termination of the employment relationship. DHS regulations require the employer to notify the DHS that the employment relationship has been terminated so that the petition is canceled (8 CFR 214.2(h)(11)), and require the employer to provide the employee with payment for transportation home under certain circumstances (8 CFR 214.2(h)(4)(iii)(E)).

(8) If the employee works in an occupation other than that identified on the employer's LCA, the employer's required wage obligation is based on the occupation identified on the LCA, and not on whatever wage standards may be applicable in the occupation in which the employee may be working.

(9) ''Authorized deductions,'' for purposes of the employer's satisfaction of the H–1B required wage obligation, means a deduction from wages in complete compliance with one of the following three sets of criteria (*i.e.*, paragraph (c)(9)(i), (ii), or (iii))—

(i) Deduction which is required by law (e.g., income tax; FICA); or

(ii) Deduction which is authorized by a collective bargaining agreement, or is reasonable and customary in the occupation and/or area of employment (e.g., union dues; contribution to premium for health insurance policy covering all employees; savings or retirement fund contribution for plan(s) in compliance with the Employee Retirement Income Security Act, 29 U.S.C. 1001, *et seq.), except that* the deduction may not recoup a business expense(s) of the employer (including attorney fees and other costs connected to the performance of H–1B program functions which are required to be performed by the employer, e.g., preparation and filing of LCA and H–1B petition); the deduction must have been revealed to the worker prior to the commencement of employment and, if the deduction was a condition of employment, had been clearly identified as such; and the deduction must be made against wages of U.S. workers as well as H–1B nonimmigrants (where there are U.S. workers); or

(iii) Deduction which meets the following requirements:

(A) Is made in accordance with a voluntary, written authorization by the employee (Note to paragraph (c)(9)(iii)(A): an employee's mere acceptance of a job which carries a deduction as a condition of employment does

not constitute voluntary authorization, even if such condition were stated in writing);

(B) Is for a matter principally for the benefit of the employee (Note to paragraph (c)(9)(iii)(B): housing and food allowances would be considered to meet this ''benefit of employee'' standard, unless the employee is in travel status, or unless the circumstances indicate that the arrangements for the employee's housing or food are principally for the convenience or benefit of the employer (e.g., employee living at worksite in ''on call'' status));

(C) Is not a recoupment of the employer's business expense (e.g., tools and equipment; transportation costs where such transportation is an incident of, and necessary to, the employment; living expenses when the employee is traveling on the employer's business; attorney fees and other costs connected to the performance of H–1B program functions which are required to be performed by the employer (e.g., preparation and filing of LCA and H–1B petition)). (For purposes of this section, initial transportation from, and end-of-employment travel, to the worker's home country shall not be considered a business expense.);

(D) Is an amount that does not exceed the fair market value or the actual cost (whichever is lower) of the matter covered (Note to paragraph (c)(9)(iii)(D): The employer must document the cost and value); and

(E) Is an amount that does not exceed the limits set for garnishment of wages in the Consumer Credit Protection Act, 15 U.S.C. 1673, and the regulations of the Secretary pursuant to that Act, 29 CFR part 870, under which garnishment(s) may not exceed 25 percent of an employee's disposable earnings for a workweek.

(10) A deduction from or reduction in the payment of the required wage is not authorized (and is therefore prohibited) for the following purposes (*i.e.*, paragraphs (c)(10) (i) and (ii)):

(i) A penalty paid by the H–1B nonimmigrant for ceasing employment with the employer prior to a date agreed to by the nonimmigrant and the employer.

(A) The employer is not permitted to require (directly or indirectly) that the nonimmigrant pay a penalty for ceasing employment with the employer prior to an agreed date. Therefore, the employer shall not make any deduction from or reduction in the payment of the required wage to collect such a penalty.

(B) The employer is permitted to receive *bona fide* liquidated damages from the H–1B nonimmigrant who ceases employment with the employer prior to an agreed date. However, the requirements of paragraph (c)(9)(iii) of this section must be fully satisfied, if such damages are to be received by the employer via deduction from or reduction in the payment of the required wage.

(C) The distinction between liquidated damages (which are permissible) and a penalty (which is prohibited) is to be made on the basis of the applicable State law. In general, the laws of the various States recognize that *liquidated damages* are amounts which are fixed or stipulated by the parties at the inception of the contract, and which are reasonable approximations or estimates of the anticipated or actual damage caused to one party by the other party's breach of the contract. On the other hand, the laws of the various States, in general, consider that penalties are amounts which (although fixed or stipulated in the contract by the parties) are not reasonable approximations or estimates of such damage. The laws of the various States, in general, require that the relation or circumstances of the parties, and the purpose(s) of the agreement, are to be taken into account, so that, for example, an agreement to a payment would be considered to be a prohibited penalty where it is the result of fraud or where it cloaks oppression. Furthermore, as a general matter, the sum stipulated must take into account whether the contract breach is total or partial (*i.e.*, the percentage of the employment contract completed). (*See*, e.g., *Vanderbilt University* v. *DiNardo*, 174 F.3d 751 (6th Cir. 1999) (applying Tennessee law); *Overholt Crop Insurance Service Co*. v. *Travis*, 941 F.2d 1361 (8th Cir. 1991) (applying Minnesota and South Dakota law); *BDO Seidman* v. *Hirshberg*, 712 N.E.2d 1220 (N.Y. 1999); *Guiliano* v. *Cleo, Inc.*, 995 S.W.2d 88

(Tenn. 1999); *Wojtowicz* v. *Greeley Anesthesia Services, P.C.*, 961 P.2d 520 (Colo.Ct.App. 1998); *see generally*, Restatement (Second) Contracts § 356 (comment b); 22 Am.Jur.2d Damages §§ 683, 686, 690, 693, 703). In an enforcement proceeding under subpart I of this part, the Administrator shall determine, applying relevant State law (including consideration where appropriate to actions by the employer, if any, contributing to the early cessation, such as the employer's constructive discharge of the nonimmigrant or non-compliance with its obligations under the INA and its regulations) whether the payment in question constitutes liquidated damages or a penalty. (Note to paragraph (c)(10)(i)(C): The $500/$1,000 filing fee, if any, under section 214(c) of the INA can never be included in any liquidated damages received by the employer. *See* paragraph (c)(10)(ii), which follows.)

(ii) *A rebate of the $500/$1,000 filing fee paid by the employer, if any, under section 214(c) of the INA.* The employer may not receive, and the H–1B nonimmigrant may not pay, any part of the $500 additional filing fee (for a petition filed prior to December 18, 2000) or $1,000 additional filing fee (for a petition filed on or subsequent to December 18, 2000), whether directly or indirectly, voluntarily or involuntarily. Thus, no deduction from or reduction in wages for purposes of a rebate of any part of this fee is permitted. Further, if liquidated damages are received by the employer from the H–1B nonimmigrant upon the nonimmigrant's ceasing employment with the employer prior to a date agreed to by the nonimmigrant and the employer, such liquidated damages shall not include any part of the $500/$1,000 filing fee (*see* paragraph (c)(10)(i) of this section). If the filing fee is paid by a third party and the H–1B nonimmigrant reimburses all or part of the fee to such third party, the employer shall be considered to be in violation of this prohibition since the employer would in such circumstances have been spared the expense of the fee which the H–1B nonimmigrant paid.

(11) Any unauthorized deduction taken from wages is considered by the Department to be non-payment of that amount of wages, and in the event of an investigation, will result in back wage assessment (plus civil money penalties and/or disqualification from H–1B and other immigration programs, if willful).

(12) Where the employer depresses the employee's wages below the required wage by imposing on the employee any of the employer's business expenses(s), the Department will consider the amount to be an unauthorized deduction from wages even if the matter is not shown in the employer's payroll records as a deduction.

(13) Where the employer makes deduction(s) for repayment of loan(s) or wage advance(s) made to the employee, the Department, in the event of an investigation, will require the employer to establish the legitimacy and purpose(s) of the loan(s) or wage advance(s), with reference to the standards set out in paragraph (c)(9)(iii) of this section.

(d) *Enforcement actions.* (1) In the event that a complaint is filed pursuant to subpart I of this part, alleging a failure to meet the ''prevailing wage'' condition or a material misrepresentation by the employer regarding the payment of the required wage, or pursuant to such other basis for investigation as the Administrator may find, the Administrator shall determine whether the employer has the documentation required in paragraph (b)(3)of this section, and whether the documentation supports the employer's wage attestation. Where the documentation is either nonexistent or is insufficient to determine the prevailing wage (e.g., does not meet the criteria specified in this section, in which case the Administrator may find a violation of paragraph (b)(1), (2), or (3), of this section); or where, based on significant evidence regarding wages paid for the occupation in the area of intended employment, the Administrator has reason to believe that the prevailing wage finding obtained from an independent authoritative source or another legitimate source varies substantially from the wage prevailing for the occupation in the area of intended employment; or where the employer has been unable to demonstrate that

the prevailing wage determined by another legitimate source is in accordance with the regulatory criteria, the Administrator may contact ETA, which shall provide the Administrator with a prevailing wage determination, which the Administrator shall use as the basis for determining violations and for computing back wages, if such wages are found to be owed. The 30-day investigatory period shall be suspended while ETA makes the prevailing wage determination and, in the event that the employer timely challenges the determination (see § 655.731(d)(2)), shall be suspended until the challenge process is completed and the Administrator's investigation can be resumed.

(2) In the event the Administrator obtains a prevailing wage from ETA pursuant to paragraph (d)(1) of this section, and the employer desires review, including judicial review, the employer shall challenge the ETA prevailing wage only by filing a request for review under § 656.41 of this chapter within 30 days of the employer's receipt of the PWD from the Administrator. If the request is timely filed, the decision of OFLC is suspended until the Center Director issues a determination on the employer's appeal. If the employer desires review, including judicial review, of the decision of the NPC Center Director, the employer shall make a request for review of the determination by the Board of Alien Labor Certification Appeals (BALCA) under § 656.41(e) of this chapter within 30 days of the receipt of the decision of the Center Director. If a request for review is timely filed with the BALCA, the determination by the Center Director is suspended until the BALCA issues a determination on the employer's appeal. In any challenge to the wage determination, neither ETA nor the NPC shall divulge any employer wage data collected under the promise of confidentiality.

(i) Where an employer timely challenges an OFLC PWD obtained by the Administrator, the 30-day investigative period shall be suspended until the employer obtains a final ruling. Upon such a final ruling, the investigation and any subsequent enforcement proceeding shall continue, with the PWD as determined by the BALCA serving as the conclusive determination for all purposes.

(ii) [Reserved]

(3) For purposes of this paragraph (d), OFLC may consult with the NPC to ascertain the prevailing wage applicable under the circumstances of the particular complaint.

[65 FR 80214, Dec. 20, 2000, as amended at 66 FR 63302, Dec. 5, 2001; 69 FR 68228, Nov. 23, 2004; 69 FR 77384, Dec. 27, 2004; 71 FR 35521, June 21, 2006; 73 FR 19949, Apr. 11, 2008; 73 FR 78067, Dec. 19, 2008; 74 FR 45561, Sept. 3, 2009; 85 FR 63914, Oct. 8, 2020; 86 FR 70730, Dec. 13, 2021]

§ 655.732 What is the second LCA requirement, regarding working conditions?

An employer seeking to employ H–1B nonimmigrants in specialty occupations or as fashion models of distinguished merit and ability shall state on Form ETA 9035 or 9035E that the employment of H–1B nonimmigrants will not adversely affect the working conditions of workers similarly employed in the area of intended employment. For the purposes of this section, ''H–1B'' includes ''E–3 and H–1B1'' as well.

(a) *Establishing the working conditions requirement.* The second LCA requirement shall be satisfied when the employer affords working conditions to its H–1B nonimmigrant employees on the same basis and in accordance with the same criteria as it affords to its U.S. worker employees who are similarly employed, and without adverse effect upon the working conditions of such U.S. worker employees. Working conditions include matters such as hours, shifts, vacation periods, and benefits such as seniority-based preferences for training programs and work schedules. The employer's obligation regarding working conditions shall extend for the longer of two periods: the validity period of the certified LCA, or the period during which the H–1B nonimmigrant(s) is(are) employed by the employer.

(b) *Documentation of the working condition statement.* In the event of an enforcement action pursuant to subpart I of this part, the employer shall produce documentation to show that it has afforded its H–1B nonimmigrant employees working conditions on the same basis and in accordance with the same

criteria as it affords its U.S. worker employees who are similarly employed.

[65 FR 80221, Dec. 20, 2000, as amended at 66 FR 63302, Dec. 5, 2001; 73 FR 19949, Apr. 11, 2008]

§ 655.733 What is the third LCA requirement, regarding strikes and lockouts?

An employer seeking to employ H–1B nonimmigrants shall state on Form ETA 9035 or 9035E that there is not at that time a strike or lockout in the course of a labor dispute in the occupational classification at the place of employment. A strike or lockout which occurs after the labor condition application is filed by the employer with DOL is covered by DHS regulations at 8 CFR 214.2(h)(17). For the purposes of this section, ''H–1B'' includes ''E–3 and H–1B1'' as well.

(a) *Establishing the no strike or lockout requirement.* The third labor condition application requirement shall be satisfied when the employer signs the labor condition application attesting that, as of the date the application is filed, the employer is not involved in a strike, lockout, or work stoppage in the course of a labor dispute in the occupational classification in the area of intended employment. Labor disputes for the purpose of this section relate only to those disputes involving employees of the employer working at the place of employment in the occupational classification named in the labor condition application. See also DHS regulations at 8 CFR 214.2(h)(17) for effects of strikes or lockouts in general on the H–1B nonimmigrant's employment.

(1) *Strike or lockout subsequent to certification of labor condition application.* In order to remain in compliance with the no strike or lockout labor condition statement, if a strike or lockout of workers in the same occupational classification as the H–1B nonimmigrant occurs at the place of employment during the validity of the labor condition application, the employer, within three days of the occurrence of the strike or lockout, shall submit to ETA, by U.S. mail, facsimile (FAX), or private carrier, written notice of the strike or lockout. Further, the employer shall not place, assign, lease, or otherwise contract out an H–1B nonimmigrant, during the entire period of the labor condition application's validity, to any place of employment where there is a strike or lockout in the course of a labor dispute in the same occupational classification as the H–1B nonimmigrant. Finally, the employer shall not use the labor condition application in support of any petition filings for H–1B nonimmigrants to work in such occupational classification at such place of employment until ETA determines that the strike or lockout has ended.

(2) *ETA notice to DHS.* Upon receiving from an employer a notice described in paragraph (a)(1) of this section, ETA shall examine the documentation, and may consult with the union at the employer's place of business or other appropriate entities. If ETA determines that the strike or lockout is covered under DHS's ''*Effect of strike*'' regulation for ''H'' visa holders, ETA shall certify to DHS, in the manner set forth in that regulation, that a strike or other labor dispute involving a work stoppage of workers in the same occupational classification as the H–1B nonimmigrant is in progress at the place of employment. See 8 CFR 214.2(h)(17).

(b) *Documentation of the third labor condition statement.* The employer need not develop nor maintain documentation to substantiate the statement referenced in paragraph (a) of this section. In the case of an investigation, however, the employer has the burden of proof to show that there was no strike or lockout in the course of a labor dispute for the occupational classification in which an H–1B nonimmigrant is employed, either at the time the application was filed or during the validity period of the LCA.

[59 FR 65659, 65676, Dec. 20, 1994, as amended at 66 FR 63302, Dec. 5, 2001; 73 FR 19949, Apr. 11, 2008]

§ 655.734 What is the fourth LCA requirement, regarding notice?

An employer seeking to employ H–1B nonimmigrants shall state on Form ETA 9035 or 9035E that the employer has provided notice of the filing of the labor condition application to the bargaining representative of the employer's employees in the occupational

classification in which the H–1B nonimmigrants will be employed or are intended to be employed in the area of intended employment, or, if there is no such bargaining representative, has posted notice of filing in conspicuous locations in the employer's establishment(s) in the area of intended employment, in the manner described in this section. For the purposes of this section, ''H–1B'' includes ''E–3 and H–1B1'' as well.

(a) *Establishing the notice requirement.* The fourth labor condition application requirement shall be established when the conditions of paragraphs (a)(1) and (a)(2) of this section are met.

(1)(i) Where there is a collective bargaining representative for the occupational classification in which the H–1B nonimmigrants will be employed, on or within 30 days before the date the labor condition application is filed with ETA, the employer shall provide notice to the bargaining representative that a labor condition application is being, or will be, filed with ETA. The notice shall identify the number of H–1B nonimmigrants the employer is seeking to employ; the occupational classification in which the H–1B nonimmigrants will be employed; the wages offered; the period of employment; and the location(s) at which the H–1B nonimmigrants will be employed. Notice under this paragraph (a)(1)(i) shall include the following statement: ''Complaints alleging misrepresentation of material facts in the labor condition application and/or failure to comply with the terms of the labor condition application may be filed with any office of the Wage and Hour Division of the United States Department of Labor.''

(ii) Where there is no collective bargaining representative, the employer shall, on or within 30 days before the date the LCA is filed with ETA, provide a notice of the filing of the LCA. The notice shall indicate that H–1B nonimmigrants are sought; the number of such nonimmigrants the employer is seeking; the occupational classification; the wages offered; the period of employment; the location(s) at which the H–1B nonimmigrants will be employed; and that the LCA is available for public inspection at the H–1B employer's principal place of business in the U.S. or at the worksite. The notice shall also include the statement: ''Complaints alleging misrepresentation of material facts in the labor condition application and/or failure to comply with the terms of the labor condition application may be filed with any office of the Wage and Hour Division of the United States Department of Labor.'' If the employer is an H–1B-dependent employer or a willful violator, and the LCA is not being used only for exempt H–1B nonimmigrants, the notice shall also set forth the nondisplacement and recruitment obligations to which the employer has attested, and shall include the following additional statement: ''Complaints alleging failure to offer employment to an equally or better qualified U.S. applicant or an employer's misrepresentation regarding such offers of employment may be filed with the Department of Justice, Civil Rights Division, Office of Special Counsel for Immigration-Related Unfair Employment Practices, 950 Pennsylvania Avenue, NW., Washington, DC 20530, Telephone: 1 (800) 255–8155 (employers), 1 (800) 255–7688 (employees); Web address: *http://www.usdoj.gov/crt/osc.*'' The notice shall be provided in one of the two following manners:

(A) *Hard copy notice,* by posting a notice in at least two conspicuous locations at each place of employment where any H–1B nonimmigrant will be employed (whether such place of employment is owned or operated by the employer or by some other person or entity).

(*1*) The notice shall be of sufficient size and visibility, and shall be posted in two or more conspicuous places so that workers in the occupational classification at the place(s) of employment can easily see and read the posted notice(s).

(*2*) Appropriate locations for posting the notices include, but are not limited to, locations in the immediate proximity of wage and hour notices required by 29 CFR 516.4 or occupational safety and health notices required by 29 CFR 1903.2(a).

(*3*) The notices shall be posted on or within 30 days before the date the labor

condition application is filed and shall remain posted for a total of 10 days.

(B) *Electronic notice*, by providing electronic notification to employees in the occupational classification (including both employees of the H–1B employer and employees of another person or entity which owns or operates the place of employment) for which H–1B nonimmigrants are sought, at each place of employment where any H–1B nonimmigrant will be employed. Such notification shall be given on or within 30 days before the date the labor condition application is filed, and shall be available to the affected employees for a total of 10 days, except that if employees are provided individual, direct notice (as by e-mail), notification only need be given once during the required time period. Notification shall be readily available to the affected employees. An employer may accomplish this by any means it ordinarily uses to communicate with its workers about job vacancies or promotion opportunities, including through its ''home page'' or ''electronic bulletin board'' to employees who have, as a practical matter, direct access to these resources; or through e-mail or an actively circulated electronic message such as the employer's newsletter. Where affected employees at the place of employment are not on the ''intranet'' which provides direct access to the home page or other electronic site but do have computer access readily available, the employer may provide notice to such workers by direct electronic communication such as e-mail (*i.e.*, a single, personal e-mail message to each such employee) or by arranging to have the notice appear for 10 days on an intranet which includes the affected employees (e.g., contractor arranges to have notice on customer's intranet accessible to affected employees). Where employees lack practical computer access, a hard copy must be posted in accordance with paragraph (a)(1)(ii)(A) of this section, or the employer may provide employees individual copies of the notice.

(2) Where the employer places any H–1B nonimmigrant(s) at one or more worksites not contemplated at the time of filing the application, but which are within the area of intended employment listed on the LCA, the employer is required to post electronic or hard-copy notice(s) at such worksite(s), in the manner described in paragraph (a)(1) of this section, on or before the date any H–1B nonimmigrant begins work.

(3) The employer shall, no later than the date the H–1B nonimmigrant reports to work at the place of employment, provide the H–1B nonimmigrant with a copy of the LCA (Form ETA 9035, or Form ETA 9035E) certified by ETA and signed by the employer (or by the employer's authorized agent or representative). Upon request, the employer shall provide the H–1B nonimmigrant with a copy of the cover pages, Form ETA 9035CP.

(b) *Documentation of the fourth labor condition statement.* The employer shall develop and maintain documentation sufficient to meet its burden of proving the validity of the statement referenced in paragraph (a) of this section and attested to on Form ETA 9035 or 9035E. Such documentation shall include a copy of the dated notice and the name and address of the collective bargaining representative to whom the notice was provided. Where there is no collective bargaining representative, the employer shall note and retain the dates when, and locations where, the notice was posted and shall retain a copy of the posted notice.

(c) *Records retention; records availability.* The employer's documentation shall not be submitted to ETA with the labor condition application, but shall be retained for the period of time specified in § 655.760(c) of this part. The documentation shall be made available for public examination as required in § 655.760(a) of this part, and shall be made available to DOL upon request.

[65 FR 65659, 65676, Dec. 20, 1994, as amended at 65 FR 80221, Dec. 20, 2000; 66 FR 63302, Dec. 5, 2001; 70 FR 72563, Dec. 5, 2005; 73 FR 19949, Apr. 11, 2008]

§ 655.735 What are the special provisions for short-term placement of H–1B nonimmigrants at place(s) of employment outside the area(s) of intended employment listed on the LCA?

This section does not apply to E–3 and H–1B1 nonimmigrants.

(a) Subject to the conditions specified in this section, an employer may make short-term placements or assignments of H–1B nonimmigrant(s) at worksite(s) (place(s) of employment) in areas not listed on the employer's approved LCA(s) without filing new labor condition application(s) for such area(s).

(b) The following conditions must be fully satisfied by an employer during all short-term placement(s) or assignment(s) of H–1B nonimmigrant(s) at worksite(s) (place(s) of employment) in areas not listed on the employer's approved LCA(s):

(1) The employer has fully satisfied the requirements of §§ 655.730 through 655.734 with regard to worksite(s) located within the area(s) of intended employment listed on the employer's LCA(s).

(2) The employer shall not place, assign, lease, or otherwise contract out any H–1B nonimmigrant(s) to any worksite where there is a strike or lockout in the course of a labor dispute in the same occupational classification(s) as that of the H–1B nonimmigrant(s).

(3) For every day the H–1B nonimmigrant(s) is placed or assigned outside the area(s) of employment listed on the approved LCA(s) for such worker(s), the employer shall:

(i) Continue to pay such worker(s) the required wage (based on the prevailing wage at such worker's(s') permanent worksite, or the employer's actual wage, whichever is higher);

(ii) Pay such worker(s) the actual cost of lodging (for both workdays and non-workdays); and

(iii) Pay such worker(s) the actual cost of travel, meals and incidental or miscellaneous expenses (for both workdays and non-workdays).

(c) An employer's short-term placement(s) or assignment(s) of H–1B nonimmigrant(s) at any worksite(s) in an area of employment not listed on the employer's approved LCA(s) shall not exceed a total of 30 workdays in a one-year period for any H–1B nonimmigrant at any worksite or combination of worksites in the area, *except that* such placement or assignment of an H–1B nonimmigrant may be for longer than 30 workdays but for no more than a total of 60 workdays in a one-year period where the employer is able to show the following:

(1) The H–1B nonimmigrant continues to maintain an office or work station at his/her permanent worksite (e.g., the worker has a dedicated workstation and telephone line(s) at the permanent worksite);

(2) The H–1B nonimmigrant spends a substantial amount of time at the permanent worksite in a one-year period; and

(3) The H–1B nonimmigrant's U.S. residence or place of abode is located in the area of the permanent worksite and not in the area of the short-term worksite(s) (e.g., the worker's personal mailing address; the worker's lease for an apartment or other home; the worker's bank accounts; the worker's automobile driver's license; the residence of the worker's dependents).

(d) For purposes of this section, the term *workday* shall mean any day on which an H–1B nonimmigrant performs any work at any worksite(s) within the area of short-term placement or assignment. For example, three workdays would be counted where a nonimmigrant works three non-consecutive days at three different worksites (whether or not the employer owns or controls such worksite(s)), within the same area of employment. Further, for purposes of this section, the term *one-year period* shall mean the calendar year (*i.e.,* January 1 through December 31) or the employer's fiscal year, whichever the employer chooses.

(e) The employer may not make short-term placement(s) or assignment(s) of H–1B nonimmigrant(s) under this section at worksite(s) in any area of employment for which the employer has a certified LCA for the occupational classification. Further, an H–1B nonimmigrant entering the U.S. is required to be placed at a worksite in accordance with the approved petition and supporting LCA; thus, the nonimmigrant's initial placement or assignment cannot be a short-term placement under this section. In addition, the employer may not continuously rotate H–1B nonimmigrants on short-term placement or assignment to an area of employment in a manner that would defeat the purpose of the short-

term placement option, which is to provide the employer with flexibility in assignments to afford enough time to obtain an approved LCA for an area where it intends to have a continuing presence (e.g., an employer may not rotate H–1B nonimmigrants to an area of employment for 20-day periods, with the result that nonimmigrants are continuously or virtually continuously employed in the area of employment, in order to avoid filing an LCA; such an employer would violate the short-term placement provisions).

(f) Once any H–1B nonimmigrant's short-term placement or assignment has reached the workday limit specified in paragraph (c) of this section in an area of employment, the employer shall take one of the following actions:

(1) File an LCA and obtain ETA certification, and thereafter place any H–1B nonimmigrant(s) in that occupational classification at worksite(s) in that area pursuant to the LCA (*i.e.*, the employer shall perform all actions required in connection with such LCA, including determination of the prevailing wage and notice to workers); or

(2) Immediately terminate the placement of any H–1B nonimmigrant(s) who reaches the workday limit in an area of employment. No worker may exceed the workday limit within the one-year period specified in paragraph (d) of this section, unless the employer first files an LCA for the occupational classification for the area of employment. Employers are cautioned that if any worker exceeds the workday limit within the one-year period, then the employer has violated the terms of its LCA(s) and the regulations in the subpart, and thereafter the short-term placement option cannot be used by the employer for H–1B nonimmigrants in that occupational classification in that area of employment.

(g) An employer is not required to use the short-term placement option provided by this section, but may choose to make each placement or assignment of an H–1B nonimmigrant at worksite(s) in a new area of employment pursuant to a new LCA for such area. Further, an employer which uses the short-term placement option is not required to continue to use the option. Such an employer may, at any time during the period identified in paragraphs (c) and (d) of this section, file an LCA for the new area of employment (performing all actions required in connection with such LCA); upon certification of such LCA, the employer's obligation to comply with this section concerning short-term placement shall terminate. (However, see § 655.731(c)(9)(iii)(C) regarding payment of business expenses for employee's travel on employer's business.)

[65 FR 80222, Dec. 20, 2000, as amended at 73 FR 19949, Apr. 11, 2008]

§ 655.736 What are H–1B-dependent employers and willful violators?

Two attestation obligations apply only to two types of employers: H–1B-dependent employers (as described in paragraphs (a) through (e) of this section) and employers found to have willfully violated their H–1B obligations within a certain five-year period (as described in paragraph (f) of this section). These obligations apply only to certain labor condition applications filed by such employers (as described in paragraph (g) of this section), and do not apply to LCAs filed by such employers solely for the employment of ''exempt'' H–1B nonimmigrants (as described in paragraph (g) of this section and § 655.737). These obligations require that such employers not displace U.S. workers from jobs (as described in § 655.738) and that such employers recruit U.S. workers before hiring H–1B nonimmigrants (as described in § 655.739).

(a) *What constitutes an ''H–1B-dependent'' employer?* (1) ''H–1B-dependent employer,'' for purposes of THIS subpart H and subpart I of this part, means an employer that meets one of the three following standards, which are based on the ratio between the employer's total work force employed in the U.S. (including both U.S. workers and H–1B nonimmigrants, and measured according to full-time equivalent employees) and the employer's H–1B nonimmigrant employees (a ''head count'' including both full-time and part-time H–1B employees)—

(i)(A) The employer has 25 or fewer full-time equivalent employees who are employed in the U.S.; and

(B) Employs more than seven H–1B nonimmigrants;

(ii)(A) The employer has at least 26 but not more than 50 full-time equivalent employees who are employed in the U.S.; and

(B) Employs more than 12 H–1B nonimmigrant; or

(iii)(A) The employer has at least 51 full-time equivalent employees who are employed in the U.S.; and

(B) Employs H–1B nonimmigrants in a number that is equal to at least 15 percent of the number of such full-time equivalent employees.

(2) *''Full-time equivalent employees'' (FTEs),* for purposes of paragraph (a) of this section are to be determined according to the following standards:

(i) The determination of FTEs is to include only persons employed by the employer (as defined in § 655.715), and does not include *bona fide* consultants and independent contractors. For purposes of this section, the Department will accept the employer's designation of persons as ''employees,'' provided that such persons are consistently treated as ''employees'' for all purposes including FICA, FLSA, etc.

(ii) The determination of FTEs is to be based on the following records:

(A) To determine the number of employees, the employer's quarterly tax statement (or similar document) is to be used (assuming there is no issue as to whether all employees are listed on the tax statement); and

(B) To determine the number of hours of work by part-time employees, for purposes of aggregating such employees to FTEs, the last payroll (or the payrolls over the previous quarter, if the last payroll is not representative) is to be used, or where hours of work records are not maintained, other available information is to be used to make a reasonable approximation of hours of work (such as a standard work schedule). (But see paragraph (a)(2)(iii)(B)(*1*) of this section regarding the determination of FTEs for part-time employees without a computation of the hours worked by such employees.)

(iii) *The FTEs employed by the employer* means the total of the two numbers yielded by paragraphs (a)(2)(iii)(A) and (B), which follow:

(A) The number of full-time employees. A full-time employee is one who works 40 or more hours per week, unless the employer can show that less than 40 hours per week is full-time employment in its regular course of business (however, in no event would less than 35 hours per week be considered to be full-time employment). Each full-time employee equals one FTE (e.g., 50 full-time employees would yield 50 FTEs). (Note to paragraph (a)(2)(iii)(A): An employee who commonly works more than the number of hours constituting full-time employment cannot be counted as more than one FTE.); plus

(B) The part-time employees aggregated to a number of full-time equivalents, if the employer has part-time employees. For purposes of this determination, a part-time employee is one who regularly works fewer than the number of hours per week which constitutes full-time employment (e.g., employee regularly works 20 hours, where full-time employment is 35 hours per week). The aggregation of part-time employees to FTEs may be performed by either of the following methods (*i.e.,* paragraphs (a)(2)(iii)(B)(*1*) or (*2*)):

(*1*) Each employee working fewer than full-time hours counted as one-half of an FTE, with the total rounded to the next higher whole number (e.g., three employees working fewer than 35 hours per week, where full-time employment is 35 hours, would yield two FTEs (*i.e.,* 1.5 rounded to 2)); or

(*2*) The total number of hours worked by all part-time employees in the representative pay period, divided by the number of hours per week that constitute full-time employment, with the quotient rounded to the nearest whole number (e.g., 72 total hours of work by three part-time employees, divided by 40 (hours per week constituting full-time employment), would yield two FTEs (*i.e.,* 1.8 rounded to 2)).

(iv) *Examples of determinations of FTEs:* Employer A has 100 employees, 70 of whom are full-time (with full-time employment shown to be 44 hours of work per week) and 30 of whom are part-time (with a total of 1004 hours of work by all 30 part-time employees during the representative pay period). Utilizing the method in paragraph

(a)(2)(iii)(B)(*1*) of this section, this employer would have 85 FTEs: 70 FTEs for full-time employees, plus 15 FTEs for part-time employees (*i.e.*, each of the 30 part-time employees counted as one-half of a full-time employee, as described in paragraph (a)(2)(iii)(B)(*1*) of this section). (This employer would have 23 FTEs for part-time employees, if these FTEs were computed as described in paragraph (a)(2)(iii)(B)(*2*) of this section: 1004 total hours of work by part-time employees, divided by 44 (full-time employment), yielding 22.8, rounded to 23)). Employer B has 100 employees, 80 of whom are full-time (with full-time employment shown to be 40 hours of work per week) and 20 of whom are part-time (with a total of 630 hours of work by all 30 part-time employees during the representative pay period). This employer would have 90 FTEs: 80 FTEs for full-time employees, plus 10 FTEs for part-time employees (*i.e.*, each of the 20 part-time employees counted as one-half of a full-time employee, as described in paragraph (a)(2)(iii)(B)(*1*) of this section) (This employer would have 16 FTEs for part-time employees, if these FTEs were computed as described in paragraph (a)(2)(iii)(B)(*2*) of this section: 630 total hours of work by part-time employees, divided by 40 (full-time employment), yielding 15.7, rounded to 16)).

(b) *What constitutes an ''employer'' for purposes of determining H–1B-dependency status?* Any group treated as a single employer under the Internal Revenue Code (IRC) at 26 U.S.C. 414(b), (c), (m) or (o) shall be treated as a single employer for purposes of the determination of H–1B-dependency. Therefore, if an employer satisfies the requirements of the IRC and relevant regulations with respect to the following groups of employees, those employees will be treated as employees of a single employer for purposes of determining whether that employer is an H–1B-dependent employer.

(1) Pursuant to section 414(b) of the IRC and related regulations, all employees ''within a controlled group of corporations'' (within the meaning of section 1563(a) of the IRC, determined without regard to section 1563(a)(4) and (e)(3)(C)), will be treated as employees of a single employer. A *controlled group of corporations* is a parent-subsidiary-controlled group, a brother-sister-controlled group, or a combined group. 26 U.S.C. 1563(a), 26 CFR 1.414(b)–1(a).

(i) A *parent-subsidiary-controlled group* is one or more chains of corporations connected through stock ownership with a common parent corporation where at least 80 percent of the stock (by voting rights or value) of each subsidiary corporation is owned by one or more of the other corporations (either another subsidiary or the parent corporation), and the common parent corporation owns at least 80 percent of the stock of at least one subsidiary.

(ii) A *brother-sister-controlled group* is a group of corporations in which five or fewer persons (individuals, estates, or trusts) own 80 percent or more of the stock of the corporations and certain other ownership criteria are satisfied.

(iii) A *combined group* is a group of three or more corporations, each of which is a member of a parent-subsidiary controlled group or a brother-sister-controlled group and one of which is a common parent corporation of a parent-subsidiary-controlled group and is also included in a brother-sister-controlled group.

(2) Pursuant to section 414(c) of the IRC and related regulations, all employees of trades or businesses (whether or not incorporated) that are under common control are treated as employees of a single employer. 26 U.S.C. 414(c), 26 CFR 1.414(c)–2.

(i) Trades or businesses are under common control if they are included in:

(A) A parent-subsidiary group of trades or businesses;

(B) A brother-sister group of trades or businesses; or

(C) A combined group of trades or businesses.

(ii) Trades or businesses include sole proprietorships, partnerships, estates, trusts or corporations.

(iii) The standards for determining whether trades or businesses are under common control are similar to standards that apply to controlled groups of corporations. However, pursuant to 26 CFR 1.414(c)–2(b)(2), ownership of at least an 80 percent interest in the profits or capital interest of a partnership

or the actuarial value of a trust or estate constitutes a controlling interest in a trade or business.

(3) Pursuant to section 414(m) of the IRC and related regulations, all employees of the members of an affiliated service group are treated as employees of a single employer. 26 U.S.C. 414(m).

(i) An *affiliated service group* is, generally, a group consisting of a service organization (the ''first organization''), such as a health care organization, a law firm or an accounting firm, and one or more of the following:

(A) A second service organization that is a shareholder or partner in the first organization and that regularly performs services for the first organization (or is regularly associated with the first organization in performing services for third persons); or

(B) Any other organization if :

(*1*) A significant portion of the second organization's business is the performance of services for the first organization (or an organization described in paragraph (b)(3)(i) of this section or for both) of a type historically performed in such service field by employees, and

(*2*) Ten percent or more of the interest in the second organization is held by persons who are highly compensated employees of the first organization (or an organization described in paragraph (b)(3)(i) of this section).

(ii) [Reserved]

(4) Section 414(o) of the IRC provides that the Department of the Treasury may issue regulations addressing other business arrangements, including employee leasing, in which a group of employees are treated as employed by the same employer. However, the Department of the Treasury has not issued any regulations under this provision. Therefore, that section of the IRC will not be taken into account in determining what groups of employees are considered employees of a single employer for purposes of H–1B dependency determinations, unless regulations are issued by the Treasury Department during the period the dependency provisions of the ACWIA are effective.

(5) The definitions of ''single employer'' set forth in paragraphs (b)(1) through (b)(3) of this section are established by the Internal Revenue Service (IRS) in regulations located at 26 CFR 1.414(b)–1(a), (c)–2 and (m)–5. Guidance on these definitions should be sought from those regulations or from the IRS.

(c) *Which employers are required to make determinations of H–1B-dependency status?* Every employer that intends to file an LCA regarding H–1B nonimmigrants or to file H–1B petition(s) or request(s) for extension(s) of H–1B status from January 19, 2001 through September 30, 2003, and after March 7, 2005, is required to determine whether it is an H–1B-dependent employer or a willful violator which, except as provided in § 655.737, will be subject to the additional obligations for H–1B-dependent employers (see paragraph (g) of this section). No H–1B-dependent employer or willful violator may use an LCA filed before January 19, 2001, and during the period of October 1, 2003 through March 7, 2005, to support a new H–1B petition or request for an extension of status. Furthermore, on all H–1B LCAs filed from January 19, 2001 through September 30, 2003, and on or after March 8, 2005, an employer will be required to attest whether it is an H–1B-dependent employer or willful violator. An employer that attests it is non-H–1B-dependent but does not meet the ''snap shot'' test set forth in paragraph (c)(2) of this section shall make and document a full calculation of its status. However, as explained in paragraphs (c)(1) and (2) of this section, which follow, most employers would not be required to make any calculations or to create any documentation as to the determination of their H–1B status.

(1) *Employers with readily apparent status concerning H–1B-dependency need not calculate that status.* For most employers, regardless of their size, H–1B-dependency status (*i.e.*, H–1B-dependent or non-H–1B-dependent) is readily apparent and would require no calculations, in that the ratio of H–1B employees to the total workforce is obvious and can easily be compared to the definition of ''H–1B-dependency'' (see definition set out in paragraph (a)(1) of this section).

For example: Employer A with 20 employees, only one of whom is an H–1B non-immigrant, would obviously not be H–1B-dependent and would not need to make calculations

to confirm that status. Employer B with 45 employees, 30 of whom are H–1B nonimmigrants, would obviously be H–1B-dependent and would not need to make calculations. Employer C with 500 employees, only 30 of whom are H–1B nonimmigrants, would obviously not be H–1B-dependent and would not need to make calculations. Employer D with 1,000 employees, 850 of whom are H–1B nonimmigrants, would obviously be H–1B-dependent and would not have to make calculations.

(2) *Employers with borderline H–1B-dependency status may use a ''snap-shot'' test to determine whether calculation of that status is necessary.* Where an employer's H–1B-dependency status (*i.e.*, H–1B-dependent or non-H–1B-dependent) is not readily apparent, the employer may use one of the following tests to determine whether a full calculation of the status is needed:

(i) *Small employer* (50 or fewer employees). If the employer has 50 or fewer employees (both full-time and part-time, including H–1B nonimmigrants and U.S. workers), then the employer may compare the number of its H–1B nonimmigrant employees (both full-time and part-time) to the numbers specified in the definition set out in paragraph (a)(1) of this section, and shall fully calculate its H–1B-dependency status (*i.e.*, calculate FTEs) where the number of its H–1B nonimmigrant employees is above the number specified in the definition. In other words, if the employer has 25 or fewer employees, and more than seven of them are H–1B nonimmigrants, then the employer shall fully calculate its status; if the employer has at least 26 but no more than 50 employees, and more than 12 of them are H–1B nonimmigrants, then the employer shall fully calculate its status.

(ii) *Large employer* (51 or more employees). If the number of H–1B nonimmigrant employees (both full-time and part-time), divided by the number of full-time employees (including H–1B nonimmigrants and U.S. workers), is 0.15 or more, then an employer which believes itself to be non-H–1B-dependent shall fully calculate its H–1B-dependency status (including the calculation of FTEs). In other words, if the number of full-time employees (including H–1B nonimmigrants and U.S. workers) multiplied by 0.15 yields a number that is equal to or less than the number of H–1B nonimmigrant employees (both full-time and part-time), then the employer shall attest that it is H–1B-dependent or shall fully calculate its H–1B dependency status (including the calculation of FTEs).

(d) *What documentation is the employer required to make or maintain, concerning its determination of H–1B-dependency status?* All employers are required to retain copies of H–1B petitions and requests for extensions of H–1B status filed with the DHS, as well as the payroll records described in § 655.731(b)(1). The nature of any additional documentation would depend upon the general characteristics of the employer's workforce, as described in paragraphs (d)(1) through (4), which follow.

(1) *Employer with readily apparent status concerning H–1B-dependency.* If an employer's H–1B-dependency status (*i.e.*, H–1B-dependent or non-H–1B-dependent) is readily apparent (as described in paragraph (c)(1) of this section), then that status must be reflected on the employer's LCA but the employer is not required to make or maintain any particular documentation. The public access file maintained in accordance with § 655.760 would show the H–1B-dependency status, by means of copy(ies) of the LCA(s). In the event of an enforcement action pursuant to subpart I of this part, the employer's readily apparent status could be verified through records to be made available to the Administrator (e.g., copies of H–1B petitions; payroll records described in § 655.731(b)(1)).

(2) *Employer with borderline H–1B-dependency status.* An employer which uses a ''snap-shot'' test to determine whether it should undertake a calculation of its H–1B-dependency status (as described in paragraph (c)(2) of this section) is not required to make or maintain any documentation of that ''snap-shot'' test. The employer's status must be reflected on the LCA(s), which would be available in the public access file. In the event of an enforcement action pursuant to subpart I of this part, the employer's records to be made available to the Administrator would enable the employer to show and the Administrator to verify the ''snap-

shot'' test (e.g., copies of H–1B petitions; payroll records described in § 655.731(b)(1)) .

(3) *Employer with H–1B-dependent status.* An employer which attests that it is H–1B-dependent—whether that status is readily apparent or is determined through calculations—is not required to make or maintain any documentation of the calculation. The employer's status must be reflected on the LCA(s), which would be available in the public access file. In the event of an enforcement action pursuant to subpart I of this part, the employer's designation of H–1B-dependent status on the LCA(s) would be conclusive and sufficient documentation of that status (except where the employer's status had altered to non-H–1B-dependent and had been appropriately documented, as described in paragraph (d)(5)(ii) of this section).

(4) *Employer with non-H–1B-dependent status who is required to perform full calculation.* An employer which attests that it is non-H–1B-dependent and does not meet the ''snap shot'' test set forth in paragraph (c)(2) of this section shall retain in its records a dated copy of its calculation that it is not H–1B-dependent. In the event of an enforcement action pursuant to subpart I of this part, the employer's records to be made available to the Administrator would enable the employer to show and the Administrator to verify the employer's determination (e.g., copies of H–1B petitions; payroll records described in § 655.731(b)(1)).

(5) *Employer which changes its H–1B-dependency status due to changes in workforce.* An employer may experience a change in its H–1B-dependency status, due to changes in the ratio of H–1B nonimmigrant to U.S. workers in its workforce. Thus it is important that employers who wish to file a new LCA or a new H–1B petition or request for extension of status remain cognizant of their dependency status and do a recheck of such status if the make-up of their workforce changes sufficiently that their dependency status might possibly change. In the event of such a change of status, the following standards will apply:

(i) Change from non-H–1B-dependent to H–1B-dependent. An employer which experiences this change in its workforce is not required to make or maintain any record of its determination of the change of its H–1B-dependency status. The employer is not required to file new LCA(s) (which would accurately state its H–1B-dependent status), unless it seeks to hire new H–1B nonimmigrants or extend the status of existing H–1B nonimmigrants (see paragraph (g) of this section).

(ii) Change from H–1B-dependent to non-H–1B-dependent. An employer which experiences this change in its workforce is required to perform a full calculation of its status (as described in paragraph (c) of this section) and to retain a copy of such calculation in its records. If the employer seeks to hire new H–1B nonimmigrants or extend the status of existing H–1B nonimmigrants (see paragraph (g) of this section), the employer shall either file new LCAs reflecting its non-H–1B-dependent status or use its existing certified LCAs reflecting an H–1B-dependency status, in which case it shall continue to be bound by the dependent-employer attestations on such LCAs. In the event of an enforcement action pursuant to subpart I of this part, the employer's records to be made available to the Administrator would enable the employer to show and the Administrator to verify the employer's determination (e.g., copies of H–1B petitions; payroll records described in § 655.731(b)(1)).

(6) *Change in corporate structure or identity of employer.* If an employer which experiences a change in its corporate structure as the result of an acquisition, merger, ''spin-off,'' or other such action wishes to file a new LCA or a new H–1B petition or request for extension of status, the new employing entity shall redetermine its H–1B-dependency status in accordance with paragraphs (a) and (c) of this section (see paragraph (g) of this section). (See § 655.730(e), regarding change in corporate structure or identity of employer.) In the event of an enforcement action pursuant to subpart I of this part, the employer's calculations where required under paragraph (c) of this section and its records to be made available to the Administrator would enable the employer to show and the Administrator to verify the employer's

determination (e.g., copies of H–1B petitions; payroll records described in § 655.731(b)(1)).

(7) *''Single employer'' under IRC test.* If an employer utilizes the IRC single-employer definition and concludes that it is non-H–1B-dependent, the employer shall perform the ''snap-shot'' test set forth in paragraph (c)(2) of this section, and if it fails to meet that test, shall attest that it is H–1B-dependent or shall perform the full calculation of dependency status in accordance with paragraph (a) of this section. The employer shall place a list of the entities included as a ''single employer'' in the public access file maintained in accordance with § 766.760. In addition, the employer shall retain in its records the ''snap-shot'' or full calculation of its status, as appropriate (showing the number of employees of each entity who are included in the numerator and denominator of the equation, whether the employer utilizes the ''snap shot'' test or a complete calculation as described in paragraph (c) of this section). In the event of an enforcement action pursuant to subpart I of this part, the employer's records to be made available to the Administrator would enable the employer to show and the Administrator to verify the employer's determination (e.g., copies of H–1B petitions; payroll records described in § 655.731(b)(1)).

(e) *How is an employer's H–1B-dependency status to be shown on the LCA?* The employer is required to designate its status by marking the appropriate box on the Form ETA–9035 or 9035E (*i.e.*, either H–1B-dependent or non-H–1B-dependent). An employer which marks the designation of ''H–1B-dependent'' may also mark the designation of its intention to seek only ''exempt'' H–1B nonimmigrants on the LCA (see paragraph (g) of this section, and § 655.737). In the event that an employer has filed an LCA designating its H–1B-dependency status (either H–1B-dependent or non-H–1B-dependent) and thereafter experiences a change of status, the employer cannot use that LCA to support H–1B petitions for new nonimmigrants or requests for extension of H–1B status for existing nonimmigrants. Similarly, an employer that is or becomes H–1B-dependent cannot continue to use an LCA filed before January 19, 2001 to support new H–1B petitions or requests for extension of status. In such circumstances, the employer shall file a new LCA accurately designating its status and shall use that new LCA to support new petitions or requests for extensions of status.

(f) *What constitutes a ''willful violator'' employer and what are its special obligations?* (1) *''Willful violator''* or *''willful violator employer,''* for purposes of this subpart H and subpart I of this part means an employer that meets all of the following standards (*i.e.*, paragraphs (f)(1)(i) through (iii))—

(i) A finding of violation by the employer (as described in paragraph (f)(1)(ii)) is entered in either of the following two types of enforcement proceeding:

(A) A Department of Labor proceeding under section 212(n)(2) of the Act (8 U.S.C. 1182(n)(2)(C) and subpart I of this part; or

(B) A Department of Justice proceeding under section 212(n)(5) of the Act (8 U.S.C. 1182(n)(5).

(ii) The agency finds that the employer has committed either a willful failure or a misrepresentation of a material fact during the five-year period preceding the filing of the LCA; and

(iii) The agency's finding is entered on or after October 21, 1998.

(2) For purposes of this paragraph, ''willful failure'' means a violation which is a ''willful failure'' as defined in § 655.805(c).

(g) *What LCAs are subject to the additional attestation obligations?* (1) An employer that is ''H–1B-dependent'' (under the standards described in paragraphs (a) through (e) of this section) or is a ''willful violator'' (under the standards described in paragraph (f) of this section) is subject to the attestation obligations regarding displacement of U.S. workers and recruitment of U.S. workers (under the standards described in §§ 655.738 and 655.739, respectively) for all LCAs that are filed during the time period specified in paragraph (g)(2) of this section, to be used to support any petitions for new H–1B nonimmigrants or any requests for extensions of status for existing H–1B nonimmigrants. An LCA which does not accurately indicate the employer's H–1B-dependency

status or willful violator status shall not be used to support H–1B petitions or requests for extensions. Further, an employer which falsely attests to non-H–1B-dependency status, or which experiences a change of status to H–1B-dependency but continues to use the LCA to support new H–1B petitions or requests for extension of status shall—despite the LCA designation of non-H–1B-dependency—be held to its obligations to comply with the attestation requirements concerning nondisplacement of U.S. workers and recruitment of U.S. workers (as described in §§ 655.738 and 655.739, respectively), as explicitly acknowledged and agreed on the LCA.

(2) During the period between January 19, 2001 through September 30, 2003, and on or after March 8, 2005, any employer that is ''H–1B-dependent'' (under the standards described in paragraphs (a) through (e) of this section) or is a ''willful violator'' (under the standards described in paragraph (f) of this section) shall file a new LCA accurately indicating that status in order to be able to file petition(s) for new H–1B nonimmigrant(s) or request(s) for extension(s) of status for existing H–1B nonimmigrant(s). An LCA filed during a period when the special attestation obligations for H–1B dependent employers and willful violators were not in effect (that is before January 19, 2001, and from October 1, 2003 through March 7, 2005) may not be used by an H–1B dependent employer or willful violator to support petition(s) for new H–1B nonimmigrant(s) or request(s) for extension(s) of status for existing H–1B nonimmigrants.

(3) An employer that files an LCA indicating ''H–1B-dependent'' and/or ''willful violator'' status may also indicate on the LCA that all the H–1B nonimmigrants to be employed pursuant to that LCA will be ''exempt H–1B nonimmigrants'' as described in § 655.737. Such an LCA is not subject to the additional LCA attestation obligations, *provided that* all H–1B nonimmigrants employed under it are, in fact, exempt. An LCA which indicates that it will be used only for exempt H–1B nonimmigrants shall not be used to support H–1B petitions or requests for extensions of status for H–1B nonimmigrants who are not, in fact, exempt. Further, an employer which attests that the LCA will be used only for exempt H–1B nonimmigrants but uses the LCA to employ non-exempt H–1B nonimmigrants (through petitions and/or extensions of status) shall—despite the LCA designation of exempt H–1B nonimmigrants—be held to its obligations to comply with the attestation requirements concerning nondisplacement of U.S. workers and recruitment of U.S. workers (as described in §§ 655.738 and 655.739, respectively), as explicitly acknowledged and agreed on the LCA.

(4) The special provisions for H–1B-dependent employers and willful violator employers do not apply to LCAs filed from October 1, 2003 through March 7, 2005, or before January 19, 2001. However, all LCAs filed before October 1, 2003, and containing the additional attestation obligations described in this section and §§ 655.737 through 655.739, will remain in effect with regard to those obligations, for so long as any H–1B nonimmigrant(s) employed pursuant to the LCA(s) remain employed by the employer.

[65 FR 80223, Dec. 20, 2000; 66 FR 1375, Jan. 8, 2001, as amended at 66 FR 63302, Dec. 5, 2001; 70 FR 72563, Dec. 5, 2005]

§ 655.737 What are "exempt" H–1B nonimmigrants, and how does their employment affect the additional attestation obligations of H–1B-dependent employers and willful violator employers?

(a) An employer that is H–1B-dependent or a willful violator of the H-1B program requirements (as described in § 655.736) is subject to the attestation obligations regarding displacement of U.S. workers and recruitment of U.S. workers (as described in §§ 655.738 and 655.739, respectively) for all LCAs that are filed during the time period specified in § 655.736(g). However, these additional obligations do not apply to an LCA filed by such an employer if the LCA is used only for the employment of ''exempt'' H–1B nonimmigrants (through petitions and/or extensions of status) as described in this section.

(b) *What is the test or standard for determining an H–1B nonimmigrant's ''exempt'' status?* An H–1B nonimmigrant is

''exempt'' for purposes of this section if the nonimmigrant meets either of the two following criteria:

(1) Receives wages (including cash bonuses and similar compensation) at an annual rate equal to at least $60,000; or

(2) Has attained a master's or higher degree (or its equivalent) in a specialty related to the intended employment.

(c) *How is the $60,000 annual wage to be determined?* The H–1B nonimmigrant can be considered to be an ''exempt'' worker, for purposes of this section, if the nonimmigrant actually receives hourly wages or annual salary totaling at least $60,000 in the calendar year. The standards applicable to the employer's satisfaction of the required wage obligation are applicable to the determination of whether the $60,000 wages or salary are received (see § 655.731(c)(2) and (3)). Thus, employer contributions or costs for benefits such as health insurance, life insurance, and pension plans cannot be counted toward this $60,000. The compensation to be counted or credited for these purposes could include cash bonuses and similar payments, *provided that* such compensation is paid to the worker ''cash in hand, free and clear, when due'' (§ 655.731(c)(1)), meaning that the compensation has readily determinable market value, is readily convertible to cash tender, and is actually received by the employee when due (which must be within the year for which the employer seeks to count or credit the compensation toward the employee's $60,000 earnings to qualify for exempt status). Cash bonuses and similar compensation can be counted or credited toward the $60,000 for ''exempt'' status only if payment is assured (*i.e.*, if the payment is contingent or conditional on some event such as the employer's annual profits, the employer must guarantee payment even if the contingency is not met). The full $60,000 annual wages or salary must be received by the employee in order for the employee to have ''exempt'' status. The wages or salary required for ''exempt'' status cannot be decreased or *pro rated* based on the employee's part-time work schedule; an H–1B nonimmigrant working part-time, whose actual annual compensation is less than $60,000, would not qualify as exempt on the basis of wages, even if the worker's earnings, if projected to a full-time work schedule, would theoretically exceed $60,000 in a year. Where an employee works for less than a full year, the employee must receive at least the appropriate *pro rata* share of the $60,000 in order to be ''exempt'' (e.g., an employee who resigns after three months must be paid at least $15,000). In the event of an investigation pursuant to subpart I of this part, the Administrator will determine whether the employee has received the required $60,000 per year, using the employee's anniversary date to determine the one-year period; for an employee who had worked for less than a full year (either at the beginning of employment, or after his/her last anniversary date), the determination as to the $60,000 annual wages will be on a *pro rata* basis (*i.e.*, whether the employee had been paid at a rate of $60,000 per year (or $5,000 per month) including any unpaid, guaranteed bonuses or similar compensation).

(d) *How is the ''master's or higher degree (or its equivalent) in a specialty related to the intended employment'' to be determined?* (1) ''Master's or higher degree (or its equivalent),'' for purposes of this section means a foreign academic degree from an institution which is accredited or recognized under the law of the country where the degree was obtained, and which is equivalent to a master's or higher degree issued by a U.S. academic institution. The equivalence to a U.S. academic degree cannot be established through experience or through demonstration of expertise in the academic specialty (*i.e.*, no ''time equivalency'' or ''performance equivalency'' will be recognized as substituting for a degree issued by an academic institution). The DHS and the Department will consult appropriate sources of expertise in making the determination of equivalency between foreign and U.S. academic degrees. Upon the request of the DHS or the Department, the employer shall provide evidence to establish that the H–1B nonimmigrant has received the degree, that the degree was earned in the asserted field of study, including an academic transcript of courses, and

that the institution from which the degree was obtained was accredited or recognized.

(2) ''Specialty related to the intended employment,'' for purposes of this section, means that the academic degree is in a specialty which is generally accepted in the industry or occupation as an appropriate or necessary credential or skill for the person who undertakes the employment in question. A ''specialty'' which is not generally accepted as appropriate or necessary to the employment would not be considered to be sufficiently ''related' to afford the H–1B nonimmigrant status as an ''exempt H–1B nonimmigrant.''

(e) *When and how is the determination of the H–1B nonimmigrant's ''exempt'' status to be made?* An employer that is H–1B-dependent or a willful violator (as described in §655.736) may designate on the LCA that the LCA will be used only to support H–1B petition(s) and/or request(s) for extension of status for ''exempt'' H–1B nonimmigrants.

(1) If the employer makes the designation of ''exempt'' H–1B nonimmigrant(s) on the LCA, then the DHS—as part of the adjudication of the H–1B petition or request for extension of status—will determine the worker's ''exempt'' status, since an H–1B petition must be supported by an LCA consistent with the petition (*i.e.*, occupation, area of intended employment, exempt status). The employer shall maintain, in the public access file maintained in accordance with §755.760, a list of the H–1B nonimmigrant(s) whose petition(s) and/or request(s) are supported by LCA(s) which the employer has attested will be used only for exempt H–1B nonimmigrants. In the event of an investigation under subpart I of this part, the Administrator will give conclusive effect to an DHS determination of ''exempt'' status based on the nonimmigrant's educational attainments (*i.e.*, master's or higher degree (or its equivalent) in a specialty related to the intended employment) unless the determination was based on false information. If the DHS determination of ''exempt'' status was based on the assertion that the nonimmigrant would receive wages (including cash bonuses and similar compensation) at an annual rate equal to at least $60,000, the employer shall provide evidence to show that such wages actually were received by the nonimmigrant (consistent with paragraph (c) of this section and the regulatory standards for satisfaction or payment of the required wages as described in §655.731(c)(3)).

(2) If the employer makes the designation of ''exempt'' H–1B nonimmigrants on the LCA, but is found in an enforcement action under subpart I of this part to have used the LCA to employ nonimmigrants who are, in fact, not exempt, then the employer will be subject to a finding that it failed to comply with the nondisplacement and recruitment obligations (as described in §§655.738 and 655.739, respectively) and may be assessed appropriate penalties and remedies.

(3) If the employer does not make the designation of ''exempt'' H–1B nonimmigrants on the LCA, then the employer has waived the option of not being subject to the additional LCA attestation obligations on the basis of employing only exempt H–1B nonimmigrants under the LCA. In the event of an investigation under subpart I of this part, the Administrator will not consider the question of the nonimmigrant(s)'s ''exempt'' status in determining whether an H–1B-dependent employer or willful violator employer has complied with such additional LCA attestation obligations.

[65 FR 80227, Dec. 20, 2000]

§655.738 What are the "non-displacement of U.S. workers" obligations that apply to H–1B-dependent employers and willful violators, and how do they operate?

An employer that is subject to these additional attestation obligations (under the standards described in §655.736) is prohibited from displacement of any U.S. worker(s)—whether directly (in its own workforce) or secondarily (at a worksite of a second employer)—under the standards set out in this section.

(a) *United States worker* (*U.S. worker*) is defined in §655.715.

(b) *Displacement*, for purposes of this section, has two components: ''lay off'' of U.S. worker(s), and ''essentially

equivalent jobs'' held by U.S. worker(s) and H–1B nonimmigrant(s).

(1) *Lay off* of a U.S. worker means that the employer has caused the worker's loss of employment, other than through—

(i) Discharge of a U.S. worker for inadequate performance, violation of workplace rules, or other cause related to the worker's performance or behavior on the job;

(ii) A U.S. worker's voluntary departure or voluntary retirement (to be assessed in light of the totality of the circumstances, under established principles concerning ''constructive discharge'' of workers who are pressured to leave employment);

(iii) Expiration of a grant or contract under which a U.S. worker is employed, other than a temporary employment contract entered into in order to evade the employer's non-displacement obligation. The question is whether the loss of the contract or grant has caused the worker's loss of employment. It would not be a layoff where the job loss results from the expiration of a grant or contract without which there is no alternative funding or need for the U.S. worker's position on that or any other grant or contract (e.g., the expiration of a research grant that funded a project on which the worker was employed at an academic or research institution; the expiration of a staffing firm's contract with a customer where the U.S. worker was hired expressly to work pursuant to that contract and the employer has no practice of moving workers to other customers or projects upon the expiration of contract(s)). On the other hand, it would be a layoff where the employer's normal practice is to move the U.S. worker from one contract to another when a contract expires, and work on another contract for which the worker is qualified is available (e.g., staffing firm's contract with one customer ends and another contract with a different customer begins); or

(iv) A U.S. worker who loses employment is offered, as an alternative to such loss, a similar employment opportunity with the same employer (or, in the case of secondary displacement at a worksite of a second employer, as described in paragraph (d) of this section, a similar employment opportunity with either employer) at equivalent or higher compensation and benefits than the position from which the U.S. worker was discharged, regardless of whether or not the U.S. worker accepts the offer. The validity of the offer of a similar employment opportunity will be assessed in light of the following factors:

(A) The offer is a *bona fide* offer, rather than an offer designed to induce the U.S. worker to refuse or an offer made with the expectation that the worker will refuse;

(B) The offered job provides the U.S. worker an opportunity similar to that provided in the job from which he/she is discharged, in terms such as a similar level of authority, discretion, and responsibility, a similar opportunity for advancement within the organization, and similar tenure and work scheduling;

(C) The offered job provides the U.S. worker equivalent or higher compensation and benefits to those provided in the job from which he/she is discharged. The comparison of compensation and benefits includes all forms of remuneration for employment, whether or not called wages and irrespective of the time of payment (e.g., salary or hourly wage rate; profit sharing; retirement plan; expense account; use of company car). The comparison also includes such matters as cost of living differentials and relocation expenses (e.g., a New York City ''opportunity'' at equivalent or higher compensation and benefits offered to a worker discharged from a job in Kansas City would provide a wage adjustment from the Kansas City pay scale and would include relocation costs).

(2) *Essentially equivalent jobs.* For purposes of the displacement prohibition, the job from which the U.S. worker is laid off must be essentially equivalent to the job for which an H–1B nonimmigrant is sought. To determine whether the jobs of the laid off U.S. worker(s) and the H–1B nonimmigrant(s) are essentially equivalent, the comparison(s) shall be on a one-to-one basis where appropriate (*i.e.*, one U.S. worker left employment and one H–1B nonimmigrant joined the workforce) but shall be broader in

focus where appropriate (e.g., an employer, through reorganization, eliminates an entire department with several U.S. workers and then staffs this department's function(s) with H–1B nonimmigrants). The following comparisons are to be made:

(i) *Job responsibilities.* The job of the H–1B nonimmigrant must involve essentially the same duties and responsibilities as the job from which the U.S. worker was laid off. The comparison focuses on the core elements of and competencies for the job, such as supervisory duties, or design and engineering functions, or budget and financial accountability. Peripheral, non-essential duties that could be tailored to the particular abilities of the individual workers would not be determinative in this comparison. The job responsibilities must be similar and both workers capable of performing those duties.

(ii) *Qualifications and experience of the workers.* The qualifications of the laid off U.S. worker must be substantially equivalent to the qualifications of the H–1B nonimmigrant. The comparison is to be confined to the experience and qualifications (e.g., training, education, ability) of the workers which are directly relevant to the actual performance requirements of the job, including the experience and qualifications that would materially affect a worker's relative ability to perform the job better or more efficiently. While it would be appropriate to compare whether the workers in question have ''substantially equivalent'' qualifications and experience, the workers need not have identical qualifications and experience (e.g., a bachelor's degree from one accredited university would be considered to be substantially equivalent to a bachelor's degree from another accredited university; 15 years experience in an occupation would be substantially equivalent to 10 years experience in that occupation). It would not be appropriate to compare the workers' relative ages, their sexes, or their ethnic or religious identities.

(iii) *Area of employment.* The job of the H–1B nonimmigrant must be located in the same area of employment as the job from which the U.S. worker was laid off. The comparison of the locations of the jobs is confined to the area within normal commuting distance of the worksite or physical location where the work of the H–1B nonimmigrant is or will be performed. For purposes of this comparison, if both such worksites or locations are within a Metropolitan Statistical Area or a Primary Metropolitan Statistical Area, they will be deemed to be within the same area of employment.

(3) The worker's rights under a collective bargaining agreement or other employment contract are not affected by the employer's LCA obligations as to non-displacement of such worker.

(c) *Direct displacement.* An H–1B-dependent or willful-violator employer (as described in § 655.736) is prohibited from displacing a U.S. worker in its own workforce (*i.e.*, a U.S. worker ''employed by the employer'') within the period beginning 90 days before and ending 90 days after the filing date of an H–1B petition supported by an LCA described in § 655.736(g). The following standards and guidance apply under the direct displacement prohibition:

(1) *Which U.S. workers are protected against ''direct displacement''?* This prohibition covers the H–1B employer's own workforce—U.S. workers ''employed by the employer''—who are employed in jobs that are essentially equivalent to the jobs for which the H–1B nonimmigrant(s) are sought (as described in paragraph (b)(2) of this section). The term ''employed by the employer'' is defined in § 655.715.

(2) *When does the ''direct displacement'' prohibition apply?* The H–1B employer is prohibited from displacing a U.S. worker during a specific period of time before and after the date on which the employer files any H-1B petition supported by the LCA which is subject to the non-displacement obligation (as described in § 655.736(g)). This protected period is from 90 days before until 90 days after the petition filing date.

(3) *What constitutes displacement of a U.S. worker?* The H–1B employer is prohibited from laying off a U.S. worker from a job that is essentially the equivalent of the job for which an H–1B nonimmigrant is sought (as described in paragraph (b)(1) of this section).

(d) *Secondary displacement.* An H–1B-dependent or willful-violator employer

(as described in § 655.736) is prohibited from placing certain H–1B nonimmigrant(s) with another employer where there are indicia of an employment relationship between the nonimmigrant and that other employer (thus possibly affecting the jobs of U.S. workers employed by that other employer), unless and until the H–1B employer makes certain inquiries and/or has certain information concerning that other employer's displacement of similarly employed U.S. workers in its workforce. Employers are cautioned that even if the required inquiry of the secondary employer is made, the H–1B-dependent or willful violator employer shall be subject to a finding of a violation of the secondary displacement prohibition if the secondary employer, in fact, displaces any U.S. worker(s) during the applicable time period (see § 655.810(d)). The following standards and guidance apply under the secondary displacement prohibition:

(1) *Which U.S. workers are protected against ''secondary displacement''?* This provision applies to U.S. workers employed by the other or ''secondary'' employer (not those employed by the H–1B employer) in jobs that are essentially equivalent to the jobs for which certain H–1B nonimmigrants are placed with the other/secondary employer (as described in paragraph (b)(2) of this section). The term ''employed by the employer'' is defined in § 655.715.

(2) *Which H–1B nonimmigrants activate the secondary displacement prohibition?* Not every placement of an H–1B nonimmigrant with another employer will activate the prohibition and—depending upon the particular facts—an H–1B employer (such as a service provider) may be able to place H–1B nonimmigrant(s) at a client or customer's worksite without being subject to the prohibition. The prohibition applies to the placement of an H–1B nonimmigrant whose H–1B petition is supported by an LCA described in § 655.736(g) and whose placement with the other/secondary employer meets both of the following criteria:

(i) The nonimmigrant performs duties in whole or in part at one or more worksites owned, operated, or controlled by the other/secondary employer; and

(ii) There are indicia of an employment relationship between the nonimmigrant and the other/secondary employer. The relationship between the H–1B-nonimmigrant and the other/secondary need not constitute an ''employment'' relationship (as defined in § 655.715), and the applicability of the secondary displacement provision does not establish such a relationship. Relevant indicia of an employment relationship include:

(A) The other/secondary employer has the right to control when, where, and how the nonimmigrant performs the job (the presence of this indicia would suggest that the relationship between the nonimmigrant and the other/secondary employer approaches the relationship which triggers the secondary displacement provision);

(B) The other/secondary employer furnishes the tools, materials, and equipment;

(C) The work is performed on the premises of the other/secondary employer (this indicia alone would not trigger the secondary displacement provision);

(D) There is a continuing relationship between the nonimmigrant and the other/secondary employer;

(E) The other/secondary employer has the right to assign additional projects to the nonimmigrant;

(F) The other/secondary employer sets the hours of work and the duration of the job;

(G) The work performed by the nonimmigrant is part of the regular business (including governmental, educational, and non-profit operations) of the other/secondary employer;

(H) The other/secondary employer is itself in business; and

(I) The other/secondary employer can discharge the nonimmigrant from providing services.

(3) *What other/secondary employers are included in the prohibition on secondary displacement of U.S. workers by the H–1B employer?* The other/secondary employer who accepts the placement and/or services of the H–1B employer's nonimmigrant employee(s) need not be an H–1B employer. The other/secondary employer would often be (but is not limited to) the client or customer of an H–1B employer that is a staffing firm

or a service provider which offers the services of H–1B nonimmigrants under a contract (e.g., a medical staffing firm under contract with a nursing home provides H–1B nonimmigrant physical therapists; an information technology staffing firm under contract with a bank provides H–1B nonimmigrant computer engineers). Only the H–1B employer placing the nonimmigrant with the secondary employer is subject to the non-displacement obligation on the LCA, and only that employer is liable in an enforcement action pursuant to subpart I of this part if the other/secondary employer, in fact, displaces any of its U.S. worker(s) during the applicable time period. The other/secondary employer will not be subject to sanctions in an enforcement action pursuant to subpart I of this part (except in circumstances where such other/secondary employer is, in fact, an H–1B employer and is found to have failed to comply with its own obligations). (Note to paragraph (d)(3): Where the other/secondary employer's relationship to the H–1B nonimmigrant constitutes ''employment'' for purposes of a statute other than the H–1B provision of the INA, such as the Fair Labor Standards Act (29 U.S.C. 201 *et seq.*), the other/secondary employer would be subject to all obligations of an employer of the nonimmigrant under such other statute.)

(4) *When does the ''secondary displacement'' prohibition apply?* The H–1B employer's obligation of inquiry concerns the actions of the other/secondary employer during the specific period beginning 90 days before and ending 90 days after the date of the placement of the H–1B nonimmigrant(s) with such other/secondary employer.

(5) *What are the H–1B employer's obligations concerning inquiry and/or information as to the other/secondary employer's displacement of U.S. workers?* The H–1B employer is prohibited from placing the H–1B nonimmigrant with another employer, unless the H–1B employer has inquired of the other/secondary employer as to whether, and has no knowledge that, within the period beginning 90 days before and ending 90 days after the date of such placement, the other/secondary employer has displaced or intends to displace a similarly-employed U.S. worker employed by such other/secondary employer. The following standards and guidance apply to the H–1B employer's obligation:

(i) The H–1B employer is required to exercise due diligence and to make a reasonable effort to enquire about potential secondary displacement, through methods which may include (but are not limited to)—

(A) Securing and retaining a written assurance from the other/secondary employer that it has not and does not intend to displace a similarly-employed U.S. worker within the prescribed period;

(B) Preparing and retaining a memorandum to the file, prepared at the same time or promptly after receiving the other/secondary employer's oral statement that it has not and does not intend to displace a similarly-employed U.S. worker within the prescribed period (such memorandum shall include the substance of the conversation, the date of the communication, and the names of the individuals who participated in the conversation, including the person(s) who made the inquiry on behalf of the H–1B employer and made the statement on behalf of the other/secondary employer); or

(C) including a secondary displacement clause in the contract between the H–1B employer and the other/secondary employer, whereby the other/secondary employer would agree that it has not and will not displace similarly-employed U.S. workers within the prescribed period.

(ii) The employer's exercise of due diligence may require further, more particularized inquiry of the other/secondary employer in circumstances where there is information which indicates that U.S. worker(s) have been or will be displaced (e.g., where the H–1B nonimmigrants will be performing functions that the other/secondary employer performed with its own workforce in the past). The employer is not permitted to disregard information which would provide knowledge about potential secondary displacement (e.g., newspaper reports of relevant lay-offs by the other/secondary employer) if such information becomes available before the H–1B employer's placement of

H–1B nonimmigrants with such employer. Under such circumstances, the H–1B employer would be expected to recontact the other/secondary employer and receive credible assurances that no lay-offs of similarly-employed U.S. workers are planned or have occurred within the prescribed period.

(e) *What documentation is required of H–1B employers concerning the non-displacement obligation?* The H–1B employer is responsible for demonstrating its compliance with the non-displacement obligation (whether direct or indirect), if applicable.

(1) Concerning *direct displacement* (as described in paragraph (c) of this section), the employer is required to retain all records the employer creates or receives concerning the circumstances under which each U.S. worker, in the same locality and same occupation as any H–1B nonimmigrant(s) hired, left its employ in the period from 90 days before to 90 days after the filing date of the employer's petition for the H–1B nonimmigrant(s), and for any such U.S. worker(s) for whom the employer has taken any action during the period from 90 days before to 90 days after the filing date of the H–1B petition to cause the U.S. worker's termination (e.g., a notice of future termination of the employee's job). For all such employees, the H–1B employer shall retain at least the following documents: the employee's name, last-known mailing address, occupational title and job description; any documentation concerning the employee's experience and qualifications, and principal assignments; all documents concerning the departure of such employees, such as notification by the employer of termination of employment prepared by the employer or the employee and any responses thereto, and evaluations of the employee's job performance. Finally, the employer is required to maintain a record of the terms of any offers of similar employment to such U.S. workers and the employee's response thereto.

(2) Concerning *secondary displacement* (as described in paragraph (d) of this section), the H–1B employer is required to maintain documentation to show the manner in which it satisfied its obligation to make inquiries as to the displacement of U.S. workers by the other/secondary employer with which the H–1B employer places any H–1B nonimmigrants (as described in paragraph (d)(5) of this section).

[65 FR 80228, Dec. 20, 2000]

§ 655.739 What is the "recruitment of U.S. workers" obligation that applies to H–1B-dependent employers and willful violators, and how does it operate?

An employer that is subject to this additional attestation obligation (under the standards described in § 655.736) is required—prior to filing the LCA or any petition or request for extension of status supported by the LCA—to take good faith steps to recruit U. S. workers in the United States for the job(s) in the United States for which the H–1B nonimmigrant(s) is/are sought. The recruitment shall use procedures that meet industry-wide standards and offer compensation that is at least as great as the required wage to be paid to H–1B nonimmigrants pursuant to § 655.731(a) (*i.e.*, the higher of the local prevailing wage or the employer's actual wage). The employer may use legitimate selection criteria relevant to the job that are normal or customary to the type of job involved, so long as such criteria are not applied in a discriminatory manner. This section provides guidance for the employer's compliance with the recruitment obligation.

(a) ''*United States worker*'' (''U.S. worker'') is defined in § 655.715.

(b) ''*Industry,*'' for purposes of this section, means the set of employers which primarily compete for the same types of workers as those who are the subjects of the H–1B petitions to be filed pursuant to the LCA. Thus, a hospital, university, or computer software development firm is to use the recruitment standards utilized by the health care, academic, or information technology industries, respectively, in hiring workers in the occupations in question. Similarly, a staffing firm, which places its workers at job sites of other employers, is to use the recruitment standards of the industry which primarily employs such workers (e.g., the health care industry, if the staffing firm is placing physical therapists

(whether in hospitals, nursing homes, or private homes); the information technology industry, if the staffing firm is placing computer programmers, software engineers, or other such workers).

(c) ''*Recruitment,*'' for purposes of this section, means the process by which an employer seeks to contact or to attract the attention of person(s) who may apply for employment, solicits applications from person(s) for employment, receives applications, and reviews and considers applications so as to present the appropriate candidates to the official(s) who make(s) the hiring decision(s) (*i.e.*, pre-selection treatment of applications and applicants).

(d) ''*Solicitation methods,*'' for purposes of this section, means the techniques by which an employer seeks to contact or to attract the attention of potential applicants for employment, and to solicit applications from person(s) for employment.

(1) Solicitation methods may be either external or internal to the employer's workforce (with internal solicitation to include current and former employees).

(2) Solicitation methods may be either active (where an employer takes positive, proactive steps to identify potential applicants and to get information about its job openings into the hands of such person(s)) or passive (where potential applicants find their way to an employer's job announcements).

(i) Active solicitation methods include direct communication to incumbent workers in the employer's operation and to workers previously employed in the employer's operation and elsewhere in the industry; providing training to incumbent workers in the employer's organization; contact and outreach through collective bargaining organizations, trade associations and professional associations; participation in job fairs (including at minority-serving institutions, community/junior colleges, and vocational/technical colleges); use of placement services of colleges, universities, community/junior colleges, and business/trade schools; use of public and/or private employment agencies, referral agencies, or recruitment agencies (''headhunters'').

(ii) Passive solicitation methods include advertising in general distribution publications, trade or professional journals, or special interest publications (e.g., student-oriented; targeted to underrepresented groups, including minorities, persons with disabilities, and residents of rural areas); America's Job Bank or other Internet sites advertising job vacancies; notices at the employer's worksite(s) and/or on the employer's Internet ''home page.''

(e) *How are ''industry-wide standards for recruitment'' to be identified?* An employer is not required to utilize any particular number or type of recruitment methods, and may make a determination of the standards for the industry through methods such as trade organization surveys, studies by consultative groups, or reports/statements from trade organizations. An employer which makes such a determination should be prepared to demonstrate the industry-wide standards in the event of an enforcement action pursuant to subpart I of this part. An employer's recruitment shall be at a level and through methods and media which are normal, common or prevailing in the industry, including those strategies that have been shown to be successfully used by employers in the industry to recruit U.S. workers. An employer may not utilize only the lowest common denominator of recruitment methods used in the industry, or only methods which could reasonably be expected to be likely to yield few or no U.S. worker applicants, even if such unsuccessful recruitment methods are commonly used by employers in the industry. An employer's recruitment methods shall include, at a minimum, the following:

(1) Both internal and external recruitment (*i.e.*, both within the employer's workforce (former as well as current workers) and among U.S. workers elsewhere in the economy); and

(2) At least some active recruitment, whether internal (e.g., training the employer's U.S. worker(s) for the position(s)) or external (e.g., use of recruitment agencies or college placement services).

(f) *How are ''legitimate selection criteria relevant to the job that are normal or customary to the type of job involved'' to be*

identified? In conducting recruitment of U.S. workers (*i.e.*, in soliciting applications and in pre-selection screening or considering of applicants), an employer shall apply selection criteria which satisfy all of the following three standards (*i.e.*, paragraph (b) (1) through (3)). Under these standards, an employer would not apply spurious criteria that discriminate against U.S. worker applicants in favor of H–1B nonimmigrants. An employer that uses criteria which fail to meet these standards would be considered to have failed to conduct its recruitment of U.S. workers in good faith.

(1) *Legitimate criteria,* meaning criteria which are legally cognizable and not violative of any applicable laws (e.g., employer may not use age, sex, race or national origin as selection criteria);.

(2) *Relevant to the job,* meaning criteria which have a nexus to the job's duties and responsibilities; and

(3) *Normal and customary to the type of job involved,* meaning criteria which would be necessary or appropriate based on the practices and expectations of the industry, rather than on the preferences of the particular employer.

(g) *What actions would constitute a prohibited ''discriminatory manner'' of recruitment?* The employer shall not apply otherwise-legitimate screening criteria in a manner which would skew the recruitment process in favor of H–1B nonimmigrants. In other words, the employer's application of its screening criteria shall provide full and fair solicitation and consideration of U.S. applicants. The recruitment would be considered to be conducted in a discriminatory manner if the employer applied its screening criteria in a disparate manner (whether between H–1B and U.S. workers, or between jobs where H–1B nonimmigrants are involved and jobs where such workers are not involved). The employer would also be considered to be recruiting in a discriminatory manner if it used screening criteria that are prohibited by any applicable discrimination law (e.g., sex, race, age, national origin). The employer that conducts recruitment in a discriminatory manner would be considered to have failed to conduct its recruitment of U.S. workers in good faith.

(h) *What constitute ''good faith steps'' in recruitment of U.S. workers?* The employer shall perform its recruitment, as described in paragraphs (d) through (g) of this section, so as to offer fair opportunities for employment to U.S. workers, without skewing the recruitment process against U.S. workers or in favor of H–1B nonimmigrants. No specific regimen is required for solicitation methods seeking applicants or for pre-selection treatment screening applicants. The employer's recruitment process, including pre-selection treatment, must assure that U.S. workers are given a fair chance for consideration for a job, rather than being ignored or rejected through a process that serves the employer's preferences with respect to the make up of its workforce (e.g., the Department would look with disfavor on a practice of interviewing H–1B applicants but not U.S. applicants, or a practice of screening the applications of H–1B nonimmigrants differently from the applications of U.S. workers). The employer shall not exercise a preference for its incumbent nonimmigrant workers who do not yet have H–1B status (e.g., workers on student visas). The employer shall recruit in the United States, seeking U.S. worker(s), for the job(s) in the United States for which H–1B nonimmigrant(s) are or will be sought.

(i) What documentation is the employer required to make or maintain, concerning its recruitment of U.S. workers?

(1) The employer shall maintain documentation of the recruiting methods used, including the places and dates of the advertisements and postings or other recruitment methods used, the content of the advertisements and postings, and the compensation terms (if such are not included in the content of the advertisements and postings). The documentation may be in any form, including copies of advertisements or proofs from the publisher, the order or confirmation from the publisher, an electronic or printed copy of the Internet posting, or a memorandum to the file.

(2) The employer shall retain any documentation it has received or prepared concerning the treatment of applicants, such as copies of applications and/or related documents, test papers, rating forms, records regarding interviews, and records of job offers and applicants' responses. To comply with this requirement, the employer is not required to create any documentation it would not otherwise create.

(3) The documentation maintained by the employer shall be made available to the Administrator in the event of an enforcement action pursuant to subpart I of this part. The documentation shall be maintained for the period of time specified in § 655.760.

(4) The employer's public access file maintained in accordance with § 655.760 shall contain information summarizing the principal recruitment methods used and the time frame(s) in which such recruitment methods were used. This may be accomplished either through a memorandum or through copies of pertinent documents.

(j) In addition to conducting good faith recruitment of U.S. workers (as described in paragraphs (a) through (h) of this section), the employer is required to have offered the job to any U.S. worker who applies and is equally or better qualified for the job than the H–1B nonimmigrant (see 8 U.S.C. 1182(n)(1)(G)(i)(II)); this requirement is enforced by the Department of Justice (see 8 U.S.C. 1182(n)(5); 20 CFR 655.705(c)).

[65 FR 80231, Dec. 20, 2000]

§ 655.740 What actions are taken on labor condition applications?

(a) *Actions on labor condition applications submitted for filing.* Once a labor condition application has been received from an employer, a determination shall be made by the ETA Certifying Officer whether to certify the labor condition application or return it to the employer not certified.

(1) *Certification of labor condition application.* Where all items on Form ETA 9035 or Form ETA 9035E have been completed, the form is not obviously inaccurate, and in the case of Form ETA 9035, it contains the signature of the employer or its authorized agent or representative, the Certifying Officer shall certify the labor condition application unless it falls within one of the categories set forth in paragraph (a)(2) of this section. The Certifying Officer shall make a determination to certify or not certify the labor condition application within 7 working days of the date the application is received and date-stamped by the Department. If the labor condition application is certified, the Certifying Officer shall return a certified copy of the labor condition application to the employer or the employer's authorized agent or representative. The employer shall file the certified labor condition application with the appropriate DHS office in the manner prescribed by DHS. The DHS shall determine whether each occupational classification named in the certified labor condition application is a specialty occupation or is a fashion model of distinguished merit and ability.

(2) *Determinations not to certify labor condition applications.* ETA shall not certify a labor condition application and shall return such application to the employer or the employer's authorized agent or representative, when either or both of the following two conditions exists:

(i) *When the Form ETA 9035 or 9035E is not properly completed.* Examples of a Form ETA 9035 or 9035E which is not properly completed include instances where the employer has failed to check all the necessary boxes; or where the employer has failed to state the occupational classification, number of nonimmigrants sought, wage rate, period of intended employment, place of intended employment, or prevailing wage and its source; or, in the case of Form ETA 9035, where the application does not contain the signature of the employer or the employer's authorized representative.

(ii) *When the Form ETA 9035 or ETA 9035E contains obvious inaccuracies.* An obvious inaccuracy will be found if the employer files an application in error—e.g., where the Administrator, Wage and Hour Division, after notice and opportunity for a hearing pursuant to subpart I of this part, has notified ETA in writing that the employer has been disqualified from employing H–1B nonimmigrants under section 212(n)(2) of

the INA (8 U.S.C. 1182(n)(2)) or from employing H–1B1 or E–3 nonimmigrants under section 212(t)(3) of the INA (8 U.S.C. 1182(t)(3)). Examples of other obvious inaccuracies include stating a wage rate below the FLSA minimum wage, submitting an LCA earlier than six months before the beginning date of the period of intended employment, identifying multiple occupations on a single LCA, identifying a wage which is below the prevailing wage listed on the LCA, or identifying a wage range where the bottom of such wage range is lower than the prevailing wage listed on the LCA.

(3) *Correction and resubmission of labor condition application.* If the labor condition application is not certified pursuant to paragraph (a)(2) (i) or (ii) of this section, ETA shall return it to the employer, or the employer's authorized agent or representative, explaining the reasons for such return without certification. The employer may immediately submit a corrected application to ETA. A ''resubmitted'' or ''corrected'' labor condition application shall be treated as a new application by ETA (*i.e.*, on a ''first come, first served'' basis) *except that* if the labor condition application is not certified pursuant to paragraph (a)(2)(ii) of this section because of notification by the Administrator of the employer's disqualification, such action shall be the final decision of the Secretary and no application shall be resubmitted by the employer.

(b) *Challenges to labor condition applications.* ETA shall not consider information contesting a labor condition application received by ETA prior to the determination on the application. Such information shall not be made part of ETA's administrative record on the application, but shall be referred to ESA to be processed as a complaint pursuant to subpart I of this part, and, if such application is certified by ETA, the complaint will be handled by ESA under subpart I of this part.

(c) *Truthfulness and adequacy of information.* DOL is not the guarantor of the accuracy, truthfulness or adequacy of a certified labor condition application. The burden of proof is on the employer to establish the truthfulness of the information contained on the labor condition application.

[59 FR 65659, 65676, Dec. 20, 1994, as amended at 65 FR 80232, Dec. 20, 2000; 66 FR 63302, Dec. 5, 2001; 69 FR 68228, Nov. 23, 2004; 70 FR 72563, Dec. 5, 2005; 73 FR 19949, Apr. 11, 2008]

§ 655.750 What is the validity period of the labor condition application?

(a) *Validity of certified labor condition applications.* A labor condition application (LCA) certified under § 655.740 is valid for the period of employment indicated by the authorized DOL official on Form ETA 9035E or ETA 9035. The validity period of an LCA will not begin before the application is certified. If the approved LCA is the initial LCA issued for the nonimmigrant, the period of authorized employment must not exceed 3 years for an LCA issued on behalf of an H–1B or H–1B1 nonimmigrant and must not exceed 2 years for an LCA issued on behalf of an E–3 nonimmigrant. If the approved LCA is for an extension of an H–1B1 it must not exceed two years. The period of authorized employment in the aggregate is based on the first date of employment and ends:

(1) In the case of an H–1B or initial H–1B1 LCA, on the latest date indicated or three years after the employment start date under the LCA, whichever comes first; or

(2) In the case of an E–3 or an H–1B1 extension LCA, on the latest date indicated or two years after the employment start date under the LCA, whichever comes first.

(b) *Withdrawal of certified labor condition applications.* (1) An employer who has filed a labor condition application which has been certified pursuant to § 655.740 of this part may withdraw such labor condition application at any time before the expiration of the validity period of the application, provided that:

(i) H–1B, H–1B1, and E–3 nonimmigrants are not employed at the place of employment pursuant to the LCA; and

(ii) The Administrator has not commenced an investigation of the particular application. Any such request for withdrawal shall be null and void; and the employer shall remain bound by the labor condition application until the enforcement proceeding is

completed, at which time the application may be withdrawn.

(2) Requests for withdrawals must be in writing and must be sent to ETA, Office of Foreign Labor Certification. ETA will publish the mailing address, and any future mailing address changes, in the FEDERAL REGISTER, and will also post the address on the DOL Web site at *http://www.foreignlaborcert.doleta.gov/*.

(3) An employer shall comply with the ''required wage rate'' and ''prevailing working conditions'' statements of its labor condition application required under §§ 655.731 and 655.732 of this part, respectively, even if such application is withdrawn, at any time H–1B nonimmigrants are employed pursuant to the application, unless the application is superseded by a subsequent application which is certified by ETA.

(4) An employer's obligation to comply with the ''no strike or lockout'' and ''notice'' statements of its labor condition application (required under §§ 655.733 and 655.734 of this part, respectively), shall remain in effect and the employer shall remain subject to investigation and sanctions for misrepresentation on these statements even if such application is withdrawn, regardless of whether H–1B nonimmigrants are actually employed, unless the application is superseded by a subsequent application which is certified by ETA.

(5) Only for the purpose of assuring the labor standards protections afforded under the H–1B program, where an employer files a petition with DHS under the H–1B classification pursuant to a certified LCA that had been withdrawn by the employer, such petition filing binds the employer to all obligations under the withdrawn LCA immediately upon receipt of such petition by DHS.

(c) *Invalidation or suspension of a labor condition application.* (1) Invalidation of a labor condition application shall result from enforcement action(s) by the Administrator, Wage and Hour Division, under subpart I of this part—e.g., a final determination finding the employer's failure to meet the application's condition regarding strike or lockout; or the employer's willful failure to meet the wage and working conditions provisions of the application; or the employer's substantial failure to meet the notice of specification requirements of the application; see §§ 655.734 and 655.760 of this part; or the misrepresentation of a material fact in an application. Upon notice by the Administrator of the employer's disqualification, ETA shall invalidate the application and notify the employer, or the employer's authorized agent or representative. ETA shall notify the employer in writing of the reason(s) that the application is invalidated. When a labor condition application is invalidated, such action shall be the final decision of the Secretary.

(2) Suspension of a labor condition application may result from a discovery by ETA that it made an error in certifying the application because such application is incomplete, contains one or more obvious inaccuracies, or has not been signed. In such event, ETA shall immediately notify DHS and the employer. When an application is suspended, the employer may immediately submit to the certifying officer a corrected or completed application. If ETA does not receive a corrected application within 30 days of the suspension, or if the employer was disqualified by the Administrator, the application shall be immediately invalidated as described in paragraph (c) of this section.

(3) An employer shall comply with the ''required wages rate'' and ''prevailing working conditions'' statements of its labor condition application required under §§ 655.731 and 655.732 of this part, respectively, even if such application is suspended or invalidated, at any time H–1B nonimmigrants are employed pursuant to the application, unless the application is superseded by a subsequent application which is certified by ETA.

(4) An employer's obligation to comply with the ''no strike or lockout'' and ''notice'' statements of its labor condition application (required under §§ 655.733 and 655.734 of this part, respectively), shall remain in effect and the employer shall remain subject to investigation and sanctions for misrepresentation on these statements even if such application is suspended or invalidated, regardless of whether H–1B nonimmigrants are actually employed, unless the application is superseded by a

subsequent application which is certified by ETA.

(d) *Employers subject to disqualification.* No labor condition application shall be certified for an employer which has been found to be disqualified from participation, in the H–1B program as determined in a final agency action following an investigation by the Wage and Hour Division pursuant to subpart I of this part.

[59 FR 65659, 65676, Dec. 20, 1994, as amended at 65 FR 80232, Dec. 20, 2000; 66 FR 63302, Dec. 5, 2001; 70 FR 72563, Dec. 5, 2005; 73 FR 19949, Apr. 11, 2008]

§ 655.760 What records are to be made available to the public, and what records are to be retained?

Paragraphs (a)(1) thru (a)(6) and paragraphs (b) and (c) of this section also apply to the H–1B1 and E–3 visa categories.

(a) *Public examination.* The employer shall make a filed labor condition application and necessary supporting documentation available for public examination at the employer's principal place of business in the U.S. or at the place of employment within one working day after the date on which the labor condition application is filed with DOL. The following documentation shall be necessary:

(1) A copy of the certified labor condition application (Form ETA 9035E or Form ETA 9035) and cover pages (Form ETA 9035CP). If the Form ETA 9035E is submitted electronically, a printout of the certified application shall be signed by the employer and maintained in its files and included in the public examination file.

(2) Documentation which provides the wage rate to be paid the H–1B nonimmigrant;

(3) A full, clear explanation of the system that the employer used to set the ''actual wage'' the employer has paid or will pay workers in the occupation for which the H–1B nonimmigrant is sought, including any periodic increases which the system may provide—e.g., memorandum summarizing the system or a copy of the employer's pay system or scale (payroll records are not required, although they shall be made available to the Department in an enforcement action).

(4) A copy of the documentation the employer used to establish the ''prevailing wage'' for the occupation for which the H–1B nonimmigrant is sought (a general description of the source and methodology is all that is required to be made available for public examination; the underlying individual wage data relied upon to determine the prevailing wage is not a public record, although it shall be made available to the Department in an enforcement action); and

(5) A copy of the document(s) with which the employer has satisfied the union/employee notification requirements of § 655.734 of this part.

(6) A summary of the benefits offered to U.S. workers in the same occupational classifications as H–1B nonimmigrants, a statement as to how any differentiation in benefits is made where not all employees are offered or receive the same benefits (such summary need not include proprietary information such as the costs of the benefits to the employer, or the details of stock options or incentive distributions), and/or, where applicable, a statement that some/all H–1B nonimmigrants are receiving ''home country'' benefits (*see* § 655.731(c)(3));

(7) Where the employer undergoes a change in corporate structure, a sworn statement by a responsible official of the new employing entity that it accepts all obligations, liabilities and undertakings under the LCAs filed by the predecessor employing entity, together with a list of each affected LCA and its date of certification, and a description of the actual wage system and FEIN of the new employing entity (*see* § 655.730(e)(1)).

(8) Where the employer utilizes the definition of ''single employer''in the IRC, a list of any entities included as part of the single employer in making the determination as to its H–1B-dependency status (*see* § 655.736(d)(7));

(9) Where the employer is H–1B-dependent and/or a willful violator, and indicates on the LCA(s) that only ''exempt'' H–1B nonimmigrants will be employed, a list of such ''exempt'' H–1B nonimmigrants (*see* § 655.737(e)(1));

(10) Where the employer is H–1B-dependent or a willful violator, a summary of the recruitment methods used

and the time frames of recruitment of U.S. workers (or copies of pertinent documents showing this information) (*see* § 655.739(i)(4).

(b) *National lists of applications and attestations.* ETA shall compile and maintain on a current basis a list of the labor condition applications filed under INA section 212(n) regarding H–1B nonimmigrants and a list of labor attestations filed under INA section 212(t) regarding H–1B1 nonimmigrants. Each list shall be by employer, showing the occupational classification, wage rate(s), number of nonimmigrants sought, period(s) of intended employment, and date(s) of need for each employer's application. The list shall be available for public examination at the Office of Foreign Labor Certification, Department of Labor, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210.

(c) *Retention of records.* Either at the employer's principal place of business in the U.S. or at the place of employment, the employer shall retain copies of the records required by this subpart for a period of one year beyond the last date on which any H–1B nonimmigrant is employed under the labor condition application or, if no nonimmigrants were employed under the labor condition application, one year from the date the labor condition application expired or was withdrawn. Required payroll records for the H–1B employees and other employees in the occupational classification shall be retained at the employer's principal place of business in the U.S. or at the place of employment for a period of three years from the date(s) of the creation of the record(s), except that if an enforcement action is commenced, all payroll records shall be retained until the enforcement proceeding is completed through the procedures set forth in subpart I of this part.

(Approved by the Office of Management and Budget under control number 1205–0310)

[59 FR 65659, 65676, Dec. 20, 1994, as amended at 60 FR 4029, Jan. 19, 1995; 65 FR 80232, Dec. 20, 2000; 66 FR 63302, Dec. 5, 2001; 69 FR 68228, Nov. 23, 2004; 70 FR 72563, Dec. 5, 2005; 71 FR 35521, June 21, 2006; 73 FR 19950, Apr. 11, 2008]

Subpart I—Enforcement of H–1B Labor Condition Applications and H–1B1 and E–3 Labor Attestations

SOURCE: 59 FR 65672, 65676, Dec. 20, 1994, unless otherwise noted.

§ 655.800 Who will enforce the LCAs and how will they be enforced?

(a) *Authority of Administrator.* Except as provided in § 655.807, the Administrator shall perform all the Secretary's investigative and enforcement functions under sections 212(n) and (t) of the INA (8 U.S.C. 1182(n) and (t)) and this subpart I and subpart H of this part.

(b) *Conduct of investigations.* The Administrator, either pursuant to a complaint or otherwise, shall conduct such investigations as may be appropriate and, in connection therewith, enter and inspect such places and such records (and make transcriptions or copies thereof), question such persons and gather such information as deemed necessary by the Administrator to determine compliance regarding the matters which are the subject of the investigation.

(c) *Employer cooperation/availability of records.* An employer shall at all times cooperate in administrative and enforcement proceedings. An employer being investigated shall make available to the Administrator such records, information, persons, and places as the Administrator deems appropriate to copy, transcribe, question, or inspect. No employer subject to the provisions of sections 212(n) or (t) of the INA and/or this subpart I or subpart H of this part shall interfere with any official of the Department of Labor performing an investigation, inspection or law enforcement function pursuant to 8 U.S.C. 1182(n) or (t) or this subpart I or subpart H of this part. Any such interference shall be a violation of the labor condition application and this subpart I and subpart H of this part, and the Administrator may take such further actions as the Administrator considers appropriate. (Federal criminal statutes prohibit certain interference with a Federal officer in the performance of official duties. 18 U.S.C. 111 and 18 U.S.C. 1114.)

(d) *Confidentiality.* The Administrator shall, to the extent possible under existing law, protect the confidentiality of any person who provides information to the Department in confidence in the course of an investigation or otherwise under this subpart I or subpart H of this part.

[65 FR 80233, Dec. 20, 2000, as amended at 69 FR 68228, Nov. 23, 2004]

§ 655.801 What protection do employees have from retaliation?

(a) No employer subject to this subpart I or subpart H of this part shall intimidate, threaten, restrain, coerce, blacklist, discharge or in any other manner discriminate against an employee (which term includes a former employee or an applicant for employment) because the employee has—

(1) Disclosed information to the employer, or to any other person, that the employee reasonably believes evidences a violation of sections 212(n) or (t) of the INA or any regulation relating to sections 212(n) or (t), including this subpart I and subpart H of this part and any pertinent regulations of DHS or the Department of Justice; or

(2) Cooperated or sought to cooperate in an investigation or other proceeding concerning the employer's compliance with the requirements of sections 212(n) or (t) of the INA or any regulation relating to sections 212(n) or (t).

(b) It shall be a violation of this section for any employer to engage in the conduct described in paragraph (a) of this section. Such conduct shall be subject to the penalties prescribed by sections 212(n)(2)(C)(ii) or (t)(3)(C)(ii) of the INA and § 655.810(b)(2), *i.e.*, a fine of up to $9,624, disqualification from filing petitions under section 204 or section 214(c) of the INA for at least two years, and such further administrative remedies as the Administrator considers appropriate.

(c) Pursuant to sections 212(n)(2)(C)(v) and (t)(3)(C)(v) of the INA, an H–1B nonimmigrant who has filed a complaint alleging that an employer has discriminated against the employee in violation of paragraph (a)(1) of this section may be allowed to seek other appropriate employment in the United States, provided the employee is otherwise eligible to remain and work in the United States. Such employment may not exceed the maximum period of stay authorized for a nonimmigrant classified under sections 212(n) or (t) of the INA, as applicable. Further information concerning this provision should be sought from the United States Citizenship and Immigration Services of the Department of Homeland Security.

[65 FR 80233, Dec. 20, 2000, as amended at 69 FR 68229, Nov. 23, 2004; 71 FR 35521, June 21, 2006; 81 FR 43448, July 1, 2016; 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2214, Jan. 13, 2023; 89 FR 1814, Jan. 11, 2024; 90 FR 1858, Jan. 10, 2025]

§ 655.805 What violations may the Administrator investigate?

(a) The Administrator, through investigation, shall determine whether an H–1B employer has—

(1) Filed a labor condition application with ETA which misrepresents a material fact (Note to paragraph (a)(1): Federal criminal statutes provide penalties of up to $10,000 and/or imprisonment of up to five years for knowing and willful submission of false statements to the Federal Government. 18 U.S.C. 1001; see also 18 U.S.C. 1546);

(2) Failed to pay wages (including benefits provided as compensation for services), as required under § 655.731 (including payment of wages for certain nonproductive time);

(3) Failed to provide working conditions as required under § 655.732;

(4) Filed a labor condition application for H–1B nonimmigrants during a strike or lockout in the course of a labor dispute in the occupational classification at the place of employment, as prohibited by § 655.733;

(5) Failed to provide notice of the filing of the labor condition application, as required in § 655.734;

(6) Failed to specify accurately on the labor condition application the number of workers sought, the occupational classification in which the H–1B nonimmigrant(s) will be employed, or the wage rate and conditions under which the H–1B nonimmigrant(s) will be employed;

(7) Displaced a U.S. worker (including displacement of a U.S. worker employed by a secondary employer at the

worksite where an H–1B worker is placed), as prohibited by § 655.738 (if applicable);

(8) Failed to make the required displacement inquiry of another employer at a worksite where H–1B nonimmigrant(s) were placed, as set forth in § 655.738 (if applicable);

(9) Failed to recruit in good faith, as required by § 655.739 (if applicable);

(10) Displaced a U.S. worker in the course of committing a willful violation of any of the conditions in paragraphs (a)(2) through (9) of this section, or willful misrepresentation of a material fact on a labor condition application;

(11) Required or accepted from an H–1B nonimmigrant payment or remittance of the additional $500/$1,000 fee incurred in filing an H–1B petition with the DHS, as prohibited by § 655.731(c)(10)(ii);

(12) Required or attempted to require an H–1B nonimmigrant to pay a penalty for ceasing employment prior to an agreed upon date, as prohibited by § 655.731(c)(10)(i);

(13) Discriminated against an employee for protected conduct, as prohibited by § 655.801;

(14) Failed to make available for public examination the application and necessary document(s) at the employer's principal place of business or worksite, as required by § 655.760(a);

(15) Failed to maintain documentation, as required by this part; and

(16) Failed otherwise to comply in any other manner with the provisions of this subpart I or subpart H of this part.

(b) The determination letter setting forth the investigation findings (see § 655.815) shall specify if the violations were found to be substantial or willful. Penalties may be assessed and disqualification ordered for violation of the provisions in paragraphs (a)(5), (6), or (9) of this section only if the violation was found to be substantial or willful. The penalties may be assessed and disqualification ordered for violation of the provisions in paragraphs (a)(2) or (3) of this section only if the violation was found to be willful, but the Secretary may order payment of back wages (including benefits) due for such violation whether or not the violation was willful.

(c) For purposes of this part, ''*willful failure*'' means a knowing failure or a reckless disregard with respect to whether the conduct was contrary to sections 212(n)(1)(A)(i) or (ii), or 212(t)(1)(A)(i) or (ii) of the INA, or §§ 655.731 or 655.732. See *McLaughlin* v. *Richland Shoe Co.*, 486 U.S. 128 (1988); see also *Trans World Airlines* v. *Thurston,* 469 U.S. 111 (1985).

(d) The provisions of this part become applicable upon the date that the employer's LCA is certified pursuant to §§ 655.740 and 655.750, or upon the date employment commences pursuant to section 214(m) of the INA, whichever is earlier. The employer's submission and signature on the LCA (whether Form ETA 9035 or Form ETA 9035E) each constitutes the employer's representation that the statements on the LCA are accurate and its acknowledgment and acceptance of the obligations of the program. The employer's acceptance of these obligations is re-affirmed by the employer's submission of the petition (Form I–129) to the DHS, supported by the LCA. See 8 CFR 214.2(h)(4)(iii)(B)(*2*), which specifies that the employer will comply with the terms of the LCA for the duration of the H–1B nonimmigrant's authorized period of stay. If the period of employment specified in the LCA expires or the employer withdraws the application in accordance with § 655.750(b), the provisions of this part will no longer apply with respect to such application, except as provided in § 655.750(b)(3) and (4).

[65 FR 80233, Dec. 20, 2000, as amended at 66 FR 63302, Dec. 5, 2001; 69 FR 68229, Nov. 23, 2004]

§ 655.806 Who may file a complaint and how is it processed?

(a) Any aggrieved party, as defined in § 655.715, may file a complaint alleging a violation described in § 655.805(a). The procedures for filing a complaint by an aggrieved party and its processing by the Administrator are set forth in this section. The procedures for filing and processing information alleging violations from persons or organizations that are not aggrieved parties are set

forth in § 655.807. With regard to complaints filed by any aggrieved person or organization—

(1) No particular form of complaint is required, except that the complaint shall be written or, if oral, shall be reduced to writing by the Wage and Hour Division official who receives the complaint.

(2) The complaint shall set forth sufficient facts for the Administrator to determine whether there is reasonable cause to believe that a violation as described in § 655.805 has been committed, and therefore that an investigation is warranted. This determination shall be made within 10 days of the date that the complaint is received by a Wage and Hour Division official. If the Administrator determines that the complaint fails to present reasonable cause for an investigation, the Administrator shall so notify the complainant, who may submit a new complaint, with such additional information as may be necessary. No hearing or appeal pursuant to this subpart shall be available where the Administrator determines that an investigation on a complaint is not warranted.

(3) If the Administrator determines that an investigation on a complaint is warranted, the complaint shall be accepted for filing; an investigation shall be conducted and a determination issued within 30 calendar days of the date of filing. The time for the investigation may be increased with the consent of the employer and the complainant, or if, for reasons outside of the control of the Administrator, the Administrator needs additional time to obtain information needed from the employer or other sources to determine whether a violation has occurred. No hearing or appeal pursuant to this subpart shall be available regarding the Administrator's determination that an investigation on a complaint is warranted.

(4) In the event that the Administrator seeks a prevailing wage determination from ETA pursuant to § 655.731(d), or advice as to prevailing working conditions from ETA pursuant to § 655.732(c)(2), the 30-day investigation period shall be suspended from the date of the Administrator's request to the date of the Administrator's receipt of the wage determination (or, in the event that the employer challenges the wage determination through the Employment Service complaint system, to the date of the completion of such complaint process).

(5) A complaint must be filed not later than 12 months after the latest date on which the alleged violation(s) were committed, which would be the date on which the employer allegedly failed to perform an action or fulfill a condition specified in the LCA, or the date on which the employer, through its action or inaction, allegedly demonstrated a misrepresentation of a material fact in the LCA. This jurisdictional bar does not affect the scope of the remedies which may be assessed by the Administrator. Where, for example, a complaint is timely filed, back wages may be assessed for a period prior to one year before the filing of a complaint.

(6) A complaint may be submitted to any local Wage and Hour Division office. The addresses of such offices are found in local telephone directories, and on the Department's informational site on the Internet at *http://www.dol.gov/dol/esa/public/contacts/whd/america2.htm.* The office or person receiving such a complaint shall refer it to the office of the Wage and Hour Division administering the area in which the reported violation is alleged to have occurred.

(b) When an investigation has been conducted, the Administrator shall, pursuant to § 655.815, issue a written determination as described in § 655.805(a).

[65 FR 80234, Dec. 20, 2000]

§ 655.807 How may someone who is not an "aggrieved party" allege violations, and how will those allegations be processed?

(a) Persons who are not aggrieved parties may submit information concerning possible violations of the provisions described in § 655.805(a)(1) through (4) and (a)(7) through (9). No particular form is required to submit the information, except that the information shall be submitted in writing or, if oral, shall be reduced to writing by the Wage and Hour Division official who receives the information. An optional form shall be available to be

used in setting forth the information. The information provided shall include:

(1) The identity of the person submitting the information and the person's relationship, if any, to the employer or other information concerning the person's basis for having knowledge of the employer's employment practices or its compliance with the requirements of this subpart I and subpart H of this part; and

(2) A description of the possible violation, including a description of the facts known to the person submitting the information, in sufficient detail for the Secretary to determine if there is reasonable cause to believe that the employer has committed a willful violation of the provisions described in § 655.805(a)(1), (2), (3), (4), (7), (8), or (9).

(b) The Administrator may interview the person submitting the information as appropriate to obtain further information to determine whether the requirements of this section are met. In addition, the person submitting information under this section shall be informed that his or her identity will not be disclosed to the employer without his or her permission.

(c) Information concerning possible violations must be submitted not later than 12 months after the latest date on which the alleged violation(s) were committed. The 12-month period shall be applied in the manner described in § 655.806(a)(5).

(d) Upon receipt of the information, the Administrator shall promptly review the information submitted and determine:

(1) Does the source likely possess knowledge of the employer's practices or employment conditions or the employer's compliance with the requirements of subpart H of this part?

(2) Has the source provided specific credible information alleging a violation of the requirements of the conditions described in § 655.805(a)(1), (2), (3), (4), (7), (8), or (9)?

(3) Does the information in support of the allegations appear to provide reasonable cause to believe that the employer has committed a violation of the provisions described in § 655.805(a)(1), (2), (3), (4), (7), (8), or (9), and that

(i) The alleged violation is willful?

(ii) The employer has engaged in a pattern or practice of violations? or

(iii) The employer has committed substantial violations, affecting multiple employees?

(e) ''Information'' within the meaning of this section does not include information from an officer or employee of the Department of Labor unless it was obtained in the course of a lawful investigation, and does not include information submitted by the employer to the DHS or the Secretary in securing the employment of an H–1B nonimmigrant.

(f)(1) Except as provided in paragraph (f)(2) of this section, where the Administrator has received information from a source other than an aggrieved party which satisfies all of the requirements of paragraphs (a) through (d) of this section, or where the Administrator or another agency of the Department obtains such information in a lawful investigation under this or any other section of the INA or any other Act, the Administrator (by mail or facsimile transmission) shall promptly notify the employer that the information has been received, describe the nature of the allegation in sufficient detail to permit the employer to respond, and request that the employer respond to the allegation within 10 days of its receipt of the notification. The Administrator shall not identify the source or information which would reveal the identity of the source without his or her permission.

(2) The Administrator may dispense with notification to the employer of the alleged violations if the Administrator determines that such notification might interfere with an effort to secure the employer's compliance. This determination shall not be subject to review in any administrative proceeding and shall not be subject to judicial review.

(g) After receipt of any response to the allegations provided by the employer, the Administrator will promptly review all of the information received and determine whether the allegations should be referred to the Secretary for a determination whether an investigation should be commenced by the Administrator.

(h) If the Administrator refers the allegations to the Secretary, the Secretary shall make a determination as to whether to authorize an investigation under this section.

(1) No investigation shall be commenced unless the Secretary (or the Deputy Secretary or other Acting Secretary in the absence or disability) personally authorizes the investigation and certifies—

(i) That the information provided under paragraph (a) of this section or obtained pursuant to a lawful investigation by the Department of Labor provides reasonable cause to believe that the employer has committed a violation of the provisions described in § 655.805(a)(1), (2), (3), (4), (7), (8), or (9);

(ii) That there is reasonable cause to believe the alleged violations are willful, that the employer has engaged in a pattern or practice of such violations, or that the employer has committed substantial violations, affecting multiple employees; and

(iii) That the other requirements of paragraphs (a) through (d) of this section have been met.

(2) No hearing shall be available from a decision by the Administrator declining to refer allegations addressed by this section to the Secretary, and none shall be available from a decision by the Secretary certifying or declining to certify that an investigation is warranted.

(i) If the Secretary issues a certification, an investigation shall be conducted and a determination issued within 30 days after the certification is received by the local Wage and Hour office undertaking the investigation. The time for the investigation may be increased upon the agreement of the employer and the Administrator or, if for reasons outside of the control of the Administrator, additional time is necessary to obtain information needed from the employer or other sources to determine whether a violation has occurred.

(j) In the event that the Administrator seeks a prevailing wage determination from ETA pursuant to § 655.731(d), or advice as to prevailing working conditions from ETA pursuant to § 655.732(c)(2), the 30-day investigation period shall be suspended from the date of the Administrator's request to the date of the Administrator's receipt of the wage determination (or, in the event that the employer challenges the wage determination through the Employment Service complaint system, to the date of the completion of such complaint process).

(k) Following the investigation, the Administrator shall issue a determination in accordance with to § 655.815.

(l) This section shall expire on September 30, 2003 unless section 212(n)(2)(G) of the INA is extended by future legislative action. Absent such extension, no investigation shall be certified by the Secretary under this section after that date; however, any investigation certified on or before September 30, 2003 may be completed.

[65 FR 80234, Dec. 20, 2000]

§ 655.808 Under what circumstances may random investigations be conducted?

(a) The Administrator may conduct random investigations of an employer during a five-year period beginning with the date of any of the following findings, provided such date is on or after October 21, 1998:

(1) A finding by the Secretary that the employer willfully violated

any of the provisions described in § 655.805(a)(1) through (9);

(2) A finding by the Secretary that the employer willfully misrepresented material fact(s) in a labor condition application filed pursuant to § 655.730; or

(3) A finding by the Attorney General that the employer willfully failed to meet the condition of section 212(n)(1)(G)(i)(II) of the INA (pertaining to an offer of employment to an equally or better qualified U.S. worker).

(b) A finding within the meaning of this section is a final, unappealed decision of the agency. See §§ 655.520(a), 655.845(c), and 655.855(b).

(c) An investigation pursuant to this section may be made at any time the Administrator, in the exercise of discretion, considers appropriate, without regard to whether the Administrator has reason to believe a violation of the provisions of this subpart I and subpart

H of this part has been committed. Following an investigation, the Administrator shall issue a determination in accordance with § 655.815.

[65 FR 80236, Dec. 20, 2000]

§ 655.810 What remedies may be ordered if violations are found?

(a) Upon determining that an employer has failed to pay wages or provide fringe benefits as required by § 655.731 and § 655.732, the Administrator shall assess and oversee the payment of back wages or fringe benefits to any H–1B nonimmigrant who has not been paid or provided fringe benefits as required. The back wages or fringe benefits shall be equal to the difference between the amount that should have been paid and the amount that actually was paid to (or with respect to) such nonimmigrant(s).

(b) *Civil money penalties.* The Administrator may assess civil money penalties for violations as follows:

(1) An amount not to exceed $2,364 per violation for:

(i) A violation pertaining to strike/lockout (§ 655.733) or displacement of U.S. workers (§ 655.738);

(ii) A substantial violation pertaining to notification (§ 655.734), labor condition application specificity (§ 655.730), or recruitment of U.S. workers (§ 655.739);

(iii) A misrepresentation of material fact on the labor condition application;

(iv) An early-termination penalty paid by the employee (§ 655.731(c)(10)(i));

(v) Payment by the employee of the additional $500/$1,000 filing fee (§ 655.731(c)(10)(ii)); or

(vi) Violation of the requirements of the regulations in this subpart I and subpart H of this part or the provisions regarding public access (§ 655.760) where the violation impedes the ability of the Administrator to determine whether a violation of sections 212(n) or (t) of the INA has occurred or the ability of members of the public to have information needed to file a complaint or information regarding alleged violations of sections 212(n) or (t) of the INA;

(2) An amount not to exceed $9,624 per violation for:

(i) A willful failure pertaining to wages/working conditions (§§ 655.731, 655.732), strike/lockout, notification, labor condition application specificity, displacement (including placement of an H–1B nonimmigrant at a worksite where the other/secondary employer displaces a U.S. worker), or recruitment;

(ii) A willful misrepresentation of a material fact on the labor condition application; or

(iii) Discrimination against an employee (§ 655.801(a)); or

(3) An amount not to exceed $67,367 per violation where an employer (whether or not the employer is an H–1B-dependent employer or willful violator) displaced a U.S. worker employed by the employer in the period beginning 90 days before and ending 90 days after the filing of an H–1B petition in conjunction with any of the following violations:

(i) A willful violation of any of the provisions described in § 655.805(a)(2) through (9) pertaining to wages/working condition, strike/lockout, notification, labor condition application specificity, displacement, or recruitment; or

(ii) A willful misrepresentation of a material fact on the labor condition application (§ 655.805(a)(1)).

(c) In determining the amount of the civil money penalty to be assessed, the Administrator shall consider the type of violation committed and other relevant factors. The factors which may be considered include, but are not limited to, the following:

(1) Previous history of violation, or violations, by the employer under the INA and this subpart I or subpart H of this part;

(2) The number of workers affected by the violation or violations;

(3) The gravity of the violation or violations;

(4) Efforts made by the employer in good faith to comply with the provisions of 8 U.S.C. 1182(n) or (t) and this subparts H and I of this part;

(5) The employer's explanation of the violation or violations;

(6) The employer's commitment to future compliance; and

(7) The extent to which the employer achieved a financial gain due to the violation, or the potential financial loss, potential injury or adverse effect with respect to other parties.

(d) *Disqualification from approval of petitions.* The Administrator shall notify the DHS pursuant to § 655.855 that the employer shall be disqualified from approval of any petitions filed by, or on behalf of, the employer pursuant to section 204 or section 214(c) of the INA for the following periods:

(1) At least one year for violation(s) of any of the provisions specified in paragraph (b)(1)(i) through (iii) of this section;

(2) At least two years for violation(s) of any of the provisions specified in paragraph (b)(2) of this section; or

(3) At least three years, for violation(s) specified in paragraph (b)(3) of this section.

(e) *Other administrative remedies.* (1) If the Administrator finds a violation of the provisions specified in paragraph (b)(1)(iv) or (v) of this section, the Administrator may issue an order requiring the employer to return to the employee (or pay to the U.S. Treasury if the employee cannot be located) any money paid by the employee in violation of those provisions.

(2) If the Administrator finds a violation of the provisions specified in paragraph (b)(1)(i) through (iii), (b)(2), or (b)(3) of this section, the Administrator may impose such other administrative remedies as the Administrator determines to be appropriate, including but not limited to reinstatement of workers who were discriminated against in violation of § 655.805(a), reinstatement of displaced U.S. workers, back wages to workers who have been displaced or whose employment has been terminated in violation of these provisions, or other appropriate legal or equitable remedies.

(f) The civil money penalties, back wages, and/or any other remedy(ies) determined by the Administrator to be appropriate are immediately due for payment or performance upon the assessment by the Administrator, or upon the decision by an administrative law judge where a hearing is timely requested, or upon the decision by the Secretary where review is granted. The employer shall remit the amount of the civil money penalty by certified check or money order made payable to the order of ''Wage and Hour Division, Labor.'' The remittance shall be delivered or mailed to the Wage and Hour Division office in the manner directed in the Administrator's notice of determination. The payment or performance of any other remedy prescribed by the Administrator shall follow procedures established by the Administrator. Distribution of back wages shall be administered in accordance with existing procedures established by the Administrator.

(g) The Federal Civil Penalties Inflation Adjustment Act of 1990 (Pub. L. 101–410), as amended by the Debt Collection Improvement Act of 1996 (Pub. L. 104–134, section 31001(s)) and the Federal Civil Penalties Inflation Adjustment Act Improvement Act of 2015 (Pub. L. 114–74, section 701), requires that Federal agencies annually adjust their civil money penalties for inflation according to a specified cost-of-living formula.

[65 FR 80236, Dec. 20, 2000, as amended at 69 FR 68229, Nov. 23, 2004; 81 FR 43448, July 1, 2016; 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2019; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2214, Jan. 13, 2023; 89 FR 1814, Jan. 11, 2024; 90 FR 1858, Jan. 10, 2025]

§ 655.815 What are the requirements for the Administrator's determination?

(a) The Administrator's determination, issued pursuant to § 655.806, 655.807, or 655.808, shall be served on the complainant, the employer, and other known interested parties by personal service or by certified mail at the parties' last known addresses. Where service by certified mail is not accepted by the party, the Administrator may exercise discretion to serve the determination by regular mail.

(b) The Administrator shall file with the Chief Administrative Law Judge, U.S. Department of Labor, a copy of the complaint and the Administrator's determination.

(c) The Administrator's written determination required by § 655.805 of this part shall:

(1) Set forth the determination of the Administrator and the reason or reasons therefor, and in the case of a finding of violation(s) by an employer, prescribe any remedies, including the amount of any back wages assessed,

the amount of any civil money penalties assessed and the reason therefor, and/or any other remedies assessed.

(2) Inform the interested parties that they may request a hearing pursuant to § 655.820 of this part.

(3) Inform the interested parties that in the absence of a timely request for a hearing, received by the Chief Administrative Law Judge within 15 calendar days of the date of the determination, the determination of the Administrator shall become final and not appealable.

(4) Set forth the procedure for requesting a hearing, give the addresses of the Chief Administrative Law Judge (with whom the request must be filed) and the representative(s) of the Solicitor of labor (upon whom copies of the request must be served).

(5) Where appropriate, inform the parties that, pursuant to § 655.855, the Administrator shall notify ETA and the DHS of the occurrence of a violation by the employer.

[59 FR 65672, 65676, Dec. 20, 1994, as amended at 65 FR 80237, Dec. 20, 2000]

§ 655.820 How is a hearing requested?

(a) Any interested party desiring review of a determination issued under §§ 655.805 and 655.815, including judicial review, shall make a request for such an administrative hearing in writing to the Chief Administrative Law Judge at the address stated in the notice of determination. If such a request for an administrative hearing is timely filed, the Administrator's determination shall be inoperative unless and until the case is dismissed or the Administrative Law Judge issues an order affirming the decision.

(b) Interested parties may request a hearing in the following circumstances:

(1) The complainant or any other interested party may request a hearing where the Administrator determines, after investigation, that there is no basis for a finding that an employer has committed violation(s). In such a proceeding, the party requesting the hearing shall be the prosecuting party and the employer shall be the respondent; the Administrator may intervene as a party or appear as *amicus curiae* at any time in the proceeding, at the Administrator's discretion.

(2) The employer or any other interested party may request a hearing where the Administrator determines, after investigation, that the employer has committed violation(s). In such a proceeding, the Administrator shall be the prosecuting party and the employer shall be the respondent.

(c) No particular form is prescribed for any request for hearing permitted by this section. However, any such request shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) Specify the issue or issues stated in the notice of determination giving rise to such request;

(4) State the specific reason or reasons why the party requesting the hearing believes such determination is in error;

(5) Be signed by the party making the request or by an authorized representative of such party; and

(6) Include the address at which such party or authorized representative desires to receive further communications relating thereto.

(d) The request for such hearing shall be received by the Chief Administrative Law Judge, at the address stated in the Administrator's notice of determination, no later than 15 calendar days after the date of the determination. An interested party which fails to meet this 15-day deadline for requesting a hearing may thereafter participate in the proceedings only by consent of the administrative law judge, either through intervention as a party pursuant to 29 CFR 18.10 (b) through (d) or through participation as an *amicus curiae* pursuant to 29 CFR 18.12.

(e) The request may be filed in person, by facsimile transmission, by certified or regular mail, or by courier service. For the requesting party's protection, if the request is by mail, it should be by certified mail. If the request is by facsimile transmission, the original of the request, signed by the requestor or authorized representative, shall be filed within ten days.

(f) Copies of the request for a hearing shall be sent by the requestor to the Wage and Hour Division official who

issued the Administrator's notice of determination, to the representative(s) of the Solicitor of Labor identified in the notice of determination, and to all known interested parties.

[59 FR 65672, 65676, Dec. 20, 1994, as amended at 65 FR 80237, Dec. 20, 2000]

§ 655.825 What rules of practice apply to the hearing?

(a) Except as specifically provided in this subpart, and to the extent they do not conflict with the provisions of this subpart, the ''Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges'' established by the Secretary at 29 CFR part 18 shall apply to administrative proceedings under this subpart.

(b) As provided in the Administrative Procedure Act, 5 U.S.C. 556, any oral or documentary evidence may be received in proceedings under this part. The Federal Rules of Evidence and subpart B of the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges (29 CFR part 18, subpart B) shall not apply, but principles designed to ensure production of relevant and probative evidence shall guide the admission of evidence. The administrative law judge may exclude evidence which is immaterial, irrelevant, or unduly repetitive.

§ 655.830 What rules apply to service of pleadings?

(a) Under this subpart, a party may serve any pleading or document by regular mail. Service on a party is complete upon mailing to the last known address. No additional time for filing or response is authorized where service is by mail. In the interest of expeditious proceedings, the administrative law judge may direct the parties to serve pleadings or documents by a method other than regular mail.

(b) Two (2) copies of all pleadings and other documents in any administrative law judge proceeding shall be served on the attorneys for the Administrator. One copy shall be served on the Associate Solicitor, Division of Fair Labor Standards, Office of the Solicitor, U.S. Department of Labor, 200 Constitution Avenue NW., Room N–2716, Washington, DC 20210, and one copy shall be served on the attorney representing the Administrator in the proceeding.

(c) Time will be computed beginning with the day following the action and includes the last day of the period unless it is a Saturday, Sunday, or federally-observed holiday, in which case the time period includes the next business day.

§ 655.835 How will the administrative law judge conduct the proceeding?

(a) Upon receipt of a timely request for a hearing filed pursuant to and in accordance with § 655.820 of this part, the Chief Administrative Law Judge shall promptly appoint an administrative law judge to hear the case.

(b) Within 7 calendar days following the assignment of the case, the administrative law judge shall notify all interested parties of the date, time and place of the hearing. All parties shall be given at least fourteen calendar days notice of such hearing.

(c) The date of the hearing shall be not more than 60 calendar days from the date of the Administrator's determination. Because of the time constraints imposed by the INA, no request for postponement shall be granted except for compelling reasons. Even where such reasons are shown, no request for postponement of the hearing beyond the 60-day deadline shall be granted except by consent of all the parties to the proceeding.

(d) The administrative law judge may prescribe a schedule by which the parties are permitted to file a prehearing brief or other written statement of fact or law. Any such brief or statement shall be served upon each other party in accordance with § 655.830 of this part. Posthearing briefs will not be permitted except at the request of the administrative law judge. When permitted, any such brief shall be limited to the issue or issues specified by the administrative law judge, shall be due within the time prescribed by the administrative law judge, and shall be served on each other party in accordance with § 655.830 of this part.

§ 655.840 What are the requirements for a decision and order of the administrative law judge?

(a) Within 60 calendar days after the date of the hearing, the administrative law judge shall issue a decision. If any party desires review of the decision, including judicial review, a petition for Secretary's review thereof shall be filed as provided in § 655.845 of this subpart. If a petition for review is filed, the decision of the administrative law judge shall be inoperative unless and until the Secretary issues an order affirming the decision, or, unless and until 30 calendar days have passed after the Secretary's receipt of the petition for review and the Secretary has not issued notice to the parties that the Secretary will review the administrative law judge's decision.

(b) The decision of the administrative law judge shall include a statement of findings and conclusions, with reasons and basis therefor, upon each material issue presented on the record. The decision shall also include an appropriate order which may affirm, deny, reverse, or modify, in whole or in part, the determination of the Administrator; the reason or reasons for such order shall be stated in the decision.

(c) In the event that the Administrator's determination of wage violation(s) and computation of back wages are based upon a wage determination obtained by the Administrator from ETA during the investigation (pursuant to § 655.731(d)) and the administrative law judge determines that the Administrator's request was not warranted (under the standards in § 655.731(d)), the administrative law judge shall remand the matter to the Administrator for further proceedings on the existence of wage violations and/or the amount(s) of back wages owed. If there is no such determination and remand by the administrative law judge, the administrative law judge shall accept as final and accurate the wage determination obtained from ETA or, in the event either the employer or another interested party filed a timely complaint through the Employment Service complaint system, the final wage determination resulting from that process. See § 655.731; see also 20 CFR 658.420 through 658.426. Under no circumstances shall the administrative law judge determine the validity of the wage determination or require submission into evidence or disclosure of source data or the names of establishments contacted in developing the survey which is the basis for the prevailing wage determination.

(d) The administrative law judge shall not render determinations as to the legality of a regulatory provision or the constitutionality of a statutory provision.

(e) The decision shall be served on all parties in person or by certified or regular mail.

[59 FR 65672, 65676, Dec. 20, 1994, as amended at 65 FR 80237, Dec. 20, 2000]

§ 655.845 What rules apply to appeal of the decision of the administrative law judge?

(a) The Administrator or any interested party desiring review of the decision and order of an administrative law judge, including judicial review, shall petition the Department's Administrative Review Board (Board) to review the decision and order. To be effective, such petition shall be received by the Board within 30 calendar days of the date of the decision and order. Copies of the petition shall be served on all parties and on the administrative law judge.

(b) No particular form is prescribed for any petition for the Board's review permitted by this subpart. However, any such petition shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) Specify the issue or issues stated in the administrative law judge decision and order giving rise to such petition;

(4) State the specific reason or reasons why the party petitioning for review believes such decision and order are in error;

(5) Be signed by the party filing the petition or by an authorized representative of such party;

(6) Include the address at which such party or authorized representative desires to receive further communications relating thereto; and

(7) Attach copies of the administrative law judge's's decision and order, and any other record documents which

would assist the Board in determining whether review is warranted.

(c) Whenever the Board determines to review the decision and order of an administrative law judge, a notice of the Board's determination shall be served upon the administrative law judge, upon the Office of Administrative Law Judges, and upon all parties to the proceeding within 30 calendar days after the Board's receipt of the petition for review. If the Board determines that it will review the decision and order, the order shall be inoperative unless and until the Board issues an order affirming the decision and order.

(d) Upon receipt of the Board's notice, the Office of Administrative Law Judges shall within 15 calendar days forward the complete hearing record to the Board.

(e) The Board's notice shall specify:

(1) The issue or issues to be reviewed;

(2) The form in which submissions shall be made by the parties (e.g., briefs);

(3) The time within which such submissions shall be made.

(f) All documents submitted to the Board shall be filed with the Administrative Review Board in accordance with 29 CFR part 26. Documents are not deemed filed with the Board until actually received by the Board. All documents, including documents filed by mail, shall be received by the Board either on or before the due date.

(g) Copies of all documents filed with the Board shall be served upon all other parties involved in the proceeding. Service upon the Administrator shall be in accordance with § 655.830(b).

(h) The Board's decision shall be issued within 180 calendar days from the date of the notice of intent to review. The Board's decision shall be served upon all parties and the administrative law judge.

(i) After the Board's decision becomes final, the Board shall transmit the entire record to the Chief Administrative Law Judge for custody pursuant to § 655.850.

[65 FR 80237, Dec. 20, 2000, as amended at 85 FR 13029, Mar. 6, 2020; 85 FR 30615, May 20, 2020; 86 FR 1778, Jan. 11, 2021]

§ 655.850 Who has custody of the administrative record?

The official record of every completed administrative hearing procedure provided by subparts H and I of this part shall be maintained and filed under the custody and control of the Chief Administrative Law Judge. Upon receipt of a complaint seeking review of the final agency action in a United States District Court, the Chief Administrative Law Judge shall certify the official record and shall transmit such record to the clerk of the court.

§ 655.855 What notice shall be given to the Employment and Training Administration and the DHS of the decision regarding violations?

(a) The Administrator shall notify the DHS and ETA of the final determination of any violation requiring that the DHS not approve petitions filed by an employer. The Administrator's notification will address the type of violation committed by the employer and the appropriate statutory period for disqualification of the employer from approval of petitions. Violations requiring notification to the DHS are identified in § 655.810(f).

(b) The Administrator shall notify the DHS and ETA upon the earliest of the following events:

(1) Where the Administrator determines that there is a basis for a finding of violation by an employer, and no timely request for hearing is made pursuant to § 655.820; or

(2) Where, after a hearing, the administrative law judge issues a decision and order finding a violation by an employer, and no timely petition for review is filed with the Department's Administrative Review Board (Board) pursuant to § 655.845; or

(3) Where a timely petition for review is filed from an administrative law judge's decision finding a violation and the Board either declines within 30 days to entertain the appeal, pursuant to § 655.845(c), or the Board reviews and affirms the administrative law judge's determination; or

(4) Where the administrative law judge finds that there was no violation by an employer, and the Board, upon review, issues a decision pursuant to

§ 655.845, holding that a violation was committed by an employer.

(c) The DHS, upon receipt of notification from the Administrator pursuant to paragraph (a) of this section, shall not approve petitions filed with respect to that employer under sections 204 or 214(c) of the INA (8 U.S.C. 1154 and 1184(c)) for nonimmigrants to be employed by the employer, for the period of time provided by the Act and described in § 655.810(f).

(d) ETA, upon receipt of the Administrator's notice pursuant to paragraph (a) of this section, shall invalidate the employer's labor condition application(s) under this subpart I and subpart H of this part, and shall not accept for filing any application or attestation submitted by the employer under 20 CFR part 656 or subparts A, B, C, D, E, H, or I of this part, for the same calendar period as specified by the DHS.

[65 FR 80238, Dec. 20, 2000]

Subparts J–K [Reserved]

Subpart L—What Requirements Must a Facility Meet to Employ H–1C Nonimmigrant Workers as Registered Nurses?

SOURCE: 65 FR 51149, Aug. 22, 2000, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to subpart L of part 655 appear at 75 FR 10403, Mar. 5, 2010.

§ 655.1100 What are the purposes, procedures and applicability of these regulations in subparts L and M of this part?

(a) *Purpose.* The Immigration and Nationality Act (INA), as amended by the Nursing Relief for Disadvantaged Areas Act of 1999, establishes the H–1C nonimmigrant visa program to provide qualified nursing professionals for narrowly defined health professional shortage areas. Subpart L of this part sets forth the procedure by which facilities seeking to use nonimmigrant registered nurses must submit attestations to the Department of Labor demonstrating their eligibility to participate as facilities, their wages and working conditions for nurses, their efforts to recruit and retain United States workers as registered nurses, the absence of a strike/lockout or layoff, notification of nurses, and the numbers of and worksites where H–1C nurses will be employed. Subpart M of this part sets forth complaint, investigation, and penalty provisions with respect to such attestations.

(b) *Procedure.* The INA establishes a procedure for facilities to follow in seeking admission to the United States for, or use of, nonimmigrant nurses under H–1C visas. The procedure is designed to reduce reliance on nonimmigrant nurses in the future, and calls for the facility to attest, and be able to demonstrate in the course of an investigation, that it is taking timely and significant steps to develop, recruit, and retain U.S. nurses. Subparts L and M of this part set forth the specific requirements of those procedures.

(c) *Applicability.* (1) Subparts L and M of this part apply to all facilities that seek the temporary admission or use of H–1C nonimmigrants as registered nurses.

(2) During the period that the provisions of Appendix 1603.D.4 of Annex 1603 of the North American Free Trade Agreement (NAFTA) apply, subparts L and M of this part shall apply to the entry of a nonimmigrant who is a citizen of Mexico under the provisions of section D of Annex 1603 of NAFTA. Therefore, the references in this part to ''H–1C nurse'' apply to such nonimmigrants who are classified by USCIS as ''TN.''

§ 655.1101 What are the responsibilities of the government agencies and the facilities that participate in the H–1C program?

(a) *Federal agencies' responsibilities.* The Department of Labor (DOL), Department of Homeland Security, and Department of State are involved in the H–1C visa process. Within DOL, the Employment and Training Administration (ETA) and the Wage and Hour Division have responsibility for different aspects of the process.

(b) *Facility's attestation responsibilities.* Each facility seeking one or more H–1C nurse(s) must, as the first step, submit an attestation on Form ETA 9081, as described in § 655.1110 of this part, to

the U.S. Department of Labor, Employment and Training Administration, Office of Foreign Labor Certification, Chicago National Processing Center, 536 South Clark Street, Chicago, IL 60605–1509. If the attestation satisfies the criteria stated in § 655.1130 and includes the supporting information required by § 655.1110 and by § 655.1114, ETA shall accept the attestation form for filing, and return the accepted attestation to the facility.

(c) *H–1C petitions.* Upon ETA's acceptance of the attestation, the facility may then file petitions with U.S. Citizenship and Immigration Services (USCIS) for the admission of, change to, or extension of status of H–1C nurses. The facility must attach a copy of the accepted attestation (Form ETA 9081) to the petition or the request for adjustment or extension of status, filed with USCIS. At the same time that the facility files an H–1C petition with USCIS, it must also send a copy of the petition to the Employment and Training Administration, Administrator, Office of Foreign Labor Certification, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210. The facility must also send to this same ETA address a copy of the USCIS petition approval notice within 5 days after it is received from USCIS.

(d) *Visa issuance.* USCIS makes determinations, in adjudicating an H–1C petition, whether the foreign worker possesses the required qualifications and credentials to be employed as an H–1C nurse. The Department of State is subsequently responsible for determining visa eligibility.

(e) *Board of Alien Labor Certification Appeals (BALCA) review of Attestations accepted and not accepted for filing.* Any interested party may seek review by the BALCA of an Attestation accepted or not accepted for filing by ETA. However, such appeals are limited to ETA actions on the three Attestation matters on which ETA conducts a substantive review (*i.e.*, the employer's eligibility as a facility; the facility's attestation to alternative timely and significant steps; and the facility's assertion that taking a second timely and significant step would not be reasonable).

(f) *Complaints.* Complaints concerning misrepresentation of material fact(s) in the Attestation or failure of the facility to carry out the terms of the Attestation may be filed with the Wage and Hour Division of DOL, according to the procedures set forth in subpart M of this part. The Wage and Hour Administrator shall investigate and, where appropriate, after an opportunity for a hearing, assess remedies and penalties. Subpart M of this part also provides that interested parties may obtain an administrative law judge hearing and may seek review of the administrative law judge's decision at the Department's Administrative Review Board.

[75 FR 10403, Mar. 5, 2010]

§ 655.1102 What are the definitions of terms that are used in these regulations?

For the purposes of subparts L and M of this part:

Accepted for filing means that the Attestation and any supporting documentation submitted by the facility have been received by the Employment and Training Administration of the Department of Labor and have been found to be complete and acceptable for purposes of Attestation requirements in §§ 655.1110 through 655.1118.

Administrative Law Judge means an official appointed under 5 U.S.C. 3105.

Administrator means the Administrator of the Wage and Hour Division, Employment Standards Administration, Department of Labor, and such authorized representatives as may be designated to perform any of the functions of the Administrator under subparts L and M of this part.

Administrator, Office of Foreign Labor Certification (OFLC) means the primary official of the Office of Foreign Labor Certification (OFLC Administrator), or the OFLC Administrator's designee.

Aggrieved party means a person or entity whose operations or interests are adversely affected by the employer's alleged misrepresentation of material fact(s) or non-compliance with the Attestation and includes, but is not limited to:

(1) A worker whose job, wages, or working conditions are adversely affected by the facility's alleged misrepresentation of material fact(s) or non-compliance with the attestation;

(2) A bargaining representative for workers whose jobs, wages, or working conditions are adversely affected by the facility's alleged misrepresentation of material fact(s) or non-compliance with the attestation;

(3) A competitor adversely affected by the facility's alleged misrepresentation of material fact(s) or non-compliance with the attestation; and

(4) A government agency which has a program that is impacted by the facility's alleged misrepresentation of material fact(s) or non-compliance with the attestation.

Attorney General means the chief official of the U.S. Department of Justice or the Attorney General's designee.

Board of Alien Labor Certification Appeals (BALCA) means a panel of one or more administrative law judges who serve on the permanent Board of Alien Labor Certification Appeals established by 20 CFR part 656. BALCA consists of administrative law judges assigned to the Department of Labor and designated by the Chief Administrative Law Judge to be members of the Board of Alien Labor Certification Appeals.

Certifying Officer means a Department of Labor official, or such official's designee, who makes determinations about whether or not H–1C attestations are acceptable for certification.

Chief Administrative Law Judge means the chief official of the Office of the Administrative Law Judges of the Department of Labor or the Chief Administrative Law Judge's designee.

Date of filing means the date an Attestation is ''accepted for filing'' by ETA.

Department and *DOL* mean the United States Department of Labor.

Division means the Wage and Hour Division of the Employment

Standards Administration, DOL.

Employed or *employment* means the employment relationship as determined under the common law, except that a facility which files a petition on behalf of an H–1C nonimmigrant is deemed to be the employer of that H–1C nonimmigrant without the necessity of the application of the common law test. Under the common law, the key determinant is the putative employer's right to control the means and manner in which the work is performed. Under the common law, ''no shorthand formula or magic phrase * * * can be applied to find the answer * * *. [A]ll of the incidents of the relationship must be assessed and weighed with no one factor being decisive.'' *NLRB* v. *United Ins. Co. of America*, 390 U.S. 254, 258 (1968). The determination should consider the following factors and any other relevant factors that would indicate the existence of an employment relationship:

(1) The firm has the right to control when, where, and how the worker performs the job;

(2) The work does not require a high level of skill or expertise;

(3) The firm rather than the worker furnishes the tools, materials, and equipment;

(4) The work is performed on the premises of the firm or the client;

(5) There is a continuing relationship between the worker and the firm;

(6) The firm has the right to assign additional projects to the worker;

(7) The firm sets the hours of work and the duration of the job;

(8) The worker is paid by the hour, week, month or an annual salary, rather than for the agreed cost of performing a particular job;

(9) The worker does not hire or pay assistants;

(10) The work performed by the worker is part of the regular business (including governmental, educational and nonprofit operations) of the firm;

(11) The firm is itself in business;

(12) The worker is not engaged in his or her own distinct occupation or business;

(13) The firm provides the worker with benefits such as insurance, leave, or workers' compensation;

(14) The worker is considered an employee of the firm for tax purposes (*i.e.*, the entity withholds federal, state, and Social Security taxes);

(15) The firm can discharge the worker; and

(16) The worker and the firm believe that they are creating an employer-employee relationship.

Employment and Training Administration (ETA) means the agency within the Department of Labor (DOL) which includes the Office of Foreign Labor Certification (OFLC).

Facility means a ''subsection (d) hospital'' (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) that meets the following requirements:

(1) As of March 31, 1997, the hospital was located in a health professional shortage area (as defined in section 332 of the Public Health Service Act (42 U.S.C. 245e)); and

(2) Based on its settled cost report filed under Title XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*) for its cost reporting period beginning during fiscal year 1994—

(i) The hospital has not less than 190 licensed acute care beds;

(ii) The number of the hospital's inpatient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of such title is not less than 35 percent of the total number of such hospital's acute care inpatient days for such period; and

(iii) The number of the hospital's inpatient days for such period which were made up of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX of the Social Security Act, is not less than 28 percent of the total number of such hospital's acute care inpatient days for such period.

(3) The requirements of paragraph (2) of this definition shall not apply to a facility in Guam, the Commonwealth of the Northern Mariana Islands, or the Virgin Islands.

Full-time employment means work where the nurse is regularly scheduled to work 40 hours or more per week, unless the facility documents that it is common practice for the occupation at the facility or for the occupation in the geographic area for full-time nurses to work fewer hours per week.

Geographic area means the area within normal commuting distance of the place (address) of the intended worksite. If the geographic area does not include a sufficient number of facilities to make a prevailing wage determination, the term ''geographic area'' shall be expanded with respect to the attesting facility to include a sufficient number of facilities to permit a prevailing wage determination to be made. If the place of the intended worksite is within a Metropolitan Statistical Area (MSA) or Primary Metropolitan Statistical Area (PMSA), any place within the MSA or PMSA will be deemed to be within normal commuting distance of the place of intended employment.

H–1C nurse means any nonimmigrant alien admitted to the United States to perform services as a nurse under section 101(a)(15)(H)(i)(c) of the Act (8 U.S.C. 1101(a)(15)(H)(i)(c)).

INA means the Immigration and Nationality Act, as amended, 8

U.S.C. 1101 *et seq.*

Lockout means a labor dispute involving a work stoppage in which an employer withholds work from its employees in order to gain a concession from them.

Nurse means a person who is or will be authorized by a State Board of Nursing to engage in registered nursing practice in a State or U.S. territory or possession at a facility which provides health care services. A staff nurse means a nurse who provides nursing care directly to patients. In order to qualify under this definition of ''nurse'' the alien must:

(1) Have obtained a full and unrestricted license to practice nursing in the country where the alien obtained nursing education, or have received nursing education in the United States;

(2) Have passed the examination given by the Commission on Graduates for Foreign Nursing Schools (CGFNS), or have obtained a full and unrestricted (permanent) license to practice as a registered nurse in the state of intended employment, or have obtained a full and unrestricted (permanent) license in any state or territory of the United States and received temporary authorization to practice as a registered nurse in the state of intended employment; and,

(3) Be fully qualified and eligible under the laws (including such temporary or interim licensing requirements which authorize the nurse to be employed) governing the place of intended employment to practice as a

registered nurse immediately upon admission to the United States, and be authorized under such laws to be employed by the employer. For purposes of this paragraph, the temporary or interim licensing may be obtained immediately after the alien enters the United States and registers to take the first available examination for permanent licensure.

Office of Foreign Labor Certification (OFLC) means the organizational component within the ETA that provides national leadership and policy guidance and develops regulations and procedures to carry out the responsibilities of the Secretary of Labor under the INA concerning foreign workers seeking admission to the United States.

Prevailing wage means the weighted average wage paid to similarly employed registered nurses within the geographic area.

Secretary means the Secretary of Labor or the Secretary's designee.

Similarly employed means employed by the same type of facility (acute care or long-term care) and working under like conditions, such as the same shift, on the same days of the week, and in the same specialty area.

State means one of the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

Strike means a labor dispute in which employees engage in a concerted stoppage of work (including stoppage by reason of the expiration of a collective-bargaining agreement) or engage in any concerted slowdown or other concerted interruption of operations.

United States (U.S.) means the continental U.S., Alaska, Hawaii, the Commonwealth of Puerto Rico, and the territories of Guam, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

U.S. Citizenship and Immigration Services (USCIS) means the bureau within the Department of Homeland Security that makes determinations under the INA on whether to approve petitions seeking classification and/or admission of nonimmigrant nurses under the H–1C program.

United States (U.S.) nurse means any nurse who: is a U.S. citizen; is a U.S. national; is lawfully admitted for permanent residence; is admitted as a refugee under 8 U.S.C. 1157; or is granted asylum under 8 U.S.C. 1158.

Worksite means the location where the nurse is involved in the practice of nursing.

[65 FR 51149, Aug. 22, 2000, as amended at 73 FR 78068, Dec. 19, 2008; 75 FR 10404, Mar. 5, 2010]

§ 655.1110 What requirements are imposed in the filing of an attestation?

(a) *Who may file Attestations?* (1) Any hospital which meets the definition of facility in §§ 655.1102 and 655.1111 may file an Attestation.

(2) ETA shall determine the hospital's eligibility as a facility through a review of this attestation element on the first Attestation filed by the hospital. ETA's determination on this point is subject to a hearing before the BALCA upon the request of any interested party. The BALCA proceeding shall be limited to the point.

(3) Upon the hospital's filing of a second or subsequent Attestation, its eligibility as a facility shall be controlled by the determination made on this point in the ETA review (and BALCA proceeding, if any) of the hospital's first Attestation.

(b) *Where and when should attestations be submitted?* (1) Attestations shall be submitted, by U.S. mail or private carrier, to ETA at the following address: U.S. Department of Labor, Employment and Training Administration, Office of Foreign Labor Certification, Chicago National Processing Center, 536 South Clark Street, Chicago, IL 60605–1509.

(2) Attestations shall be reviewed and accepted for filing or rejected by ETA within 30 calendar days of the date they are received by ETA. Therefore, it is recommended that attestations be submitted to ETA at least 35 calendar days prior to the planned date for filing an H–1C visa petition with USCIS.

(c) *What shall be submitted?* (1) Form ETA 9081 and required supporting documentation, as described in paragraphs (c)(1)(i) through (iv) of this section.

(i) A completed and dated original Form ETA 9081, containing the required attestation elements and the

original signature of the chief executive officer of the facility, shall be submitted, along with one copy of the completed, signed, and dated Form ETA 9081. Copies of the form and instructions are available at the address listed in paragraph (b) of this section.

(ii) If the Attestation is the first filed by the hospital, it shall be accompanied by copies of pages from the hospital's Form HCFA 2552 filed with the Department of Health and Human Services (pursuant to title XVIII of the Social Security Act) for its 1994 cost reporting period, showing the number of its acute care beds and the percentages of Medicaid and Medicare reimbursed acute care inpatient days (*i.e.*, Form HCFA–2552–92, Worksheet S–3, Part I; Worksheet S, Parts I and II).

(iii) If the facility attests that it will take one or more timely and significant steps other than the steps identified on Form ETA 9081, then the facility must submit (in duplicate) an explanation of the proposed step(s) and an explanation of how the proposed step(s) is/are of comparable significance to those set forth on the Form and in § 655.1114. (*See* § 655.1114(b)(2)(v).)

(iv) If the facility attests that taking more than one timely and significant step is unreasonable, then the facility must submit (in duplicate) an explanation of this attestation. (*See* § 655.1114(c).)

(2) Filing fee of $250 per Attestation. Payment must be in the form of a check or money order, payable to the ''U.S. Department of Labor.'' Remittances must be drawn on a bank or other financial institution located in the U.S. and be payable in U.S. currency.

(3) Copies of H–1C petitions and USCIS approval notices. After ETA has approved the attestation used by the facility to support any H–1C petition, the facility must send copies of each H–1C petition and USCIS approval notice on such petition to Employment and Training Administration, Administrator, Office of Foreign Labor Certification, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210.

(d) *Attestation elements.* The attestation elements referenced in paragraph (c)(1) of this section are mandated by section 212(m)(2)(A) of the INA (8 U.S.C. 1182(m)(2)(A)). Section 212(m)(2)(A) requires a prospective employer of H–1C nurses to attest to the following:

(1) That it qualifies as a facility (*See* § 655.1111);

(2) That employment of H–1C nurses will not adversely affect the wages or working conditions of similarly employed nurses (*See* § 655.1112);

(3) That the facility will pay the H–1C nurse the facility wage rate (*See* § 655.1113);

(4) That the facility has taken, and is taking, timely and significant steps to recruit and retain U.S. nurses (*See* § 655.1114);

(5) That there is not a strike or lockout at the facility, that the employment of H–1C nurses is not intended or designed to influence an election for a bargaining representative for RNs at the facility, and that the facility did not lay off and will not lay off a registered nurse employed by the facility 90 days before and after the date of filing a visa petition (*See* § 655.1115);

(6) That the facility will notify its workers and give a copy of the Attestation to every nurse employed at the facility (*See* § 655.1116);

(7) That no more than 33 percent of nurses employed by the facility will be H–1C nonimmigrants (*See* § 655.1117); and

(8) That the facility will not authorize H–1C nonimmigrants to work at a worksite not under its control, and will not transfer an H–1C nonimmigrant from one worksite to another (*See* § 655.1118).

[75 FR 10404, Mar. 5, 2010]

§ 655.1111 Element I—What hospitals are eligible to participate in the H–1C program?

(a) The first attestation element requires that the employer be a ''facility'' for purposes of the H–1C program, as defined in INA Section 212(m)(6), 8 U.S.C. 1182 (2)(m)(6).

(b) A qualifying facility under that section is a ''subpart (d) hospital,'' as defined in Section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B), which:

(1) Was located in a health professional shortage area (HPSA), as determined by the Department of Health

and Human Services, on March 31, 1997. A list of HPSAs, as of March 31, 1997, was published in the FEDERAL REGISTER on May 30, 1997 (62 FR 29395);

(2) Had at least 190 acute care beds, as determined by its settled cost report, filed under Title XVIII of the Social Security Act, (42 U.S.C. 1395 *et seq.*), for its fiscal year 1994 cost reporting period (*i.e.*, Form HCFA–2552–92, Worksheet S–3, Part I, column 1, line 8);

(3) Had at least 35% of its acute care inpatient days reimbursed by Medicare, as determined by its settled cost report, filed under Title XVIII of the Social Security Act, for its fiscal year 1994 cost reporting period (*i.e.*, Form HCFA–2552–92, Worksheet S–3, Part I, column 4, line 8 as a percentage of column 6, line 8); and

(4) Had at least 28% of its acute care inpatient days reimbursed by Medicaid, as determined by its settled cost report, filed under Title XVIII of the Social Security Act, for its fiscal year 1994 cost reporting period (*i.e.*, Form HCFA–2552–92, Worksheet S–3, Part I, column 5, line 8 as a percentage of column 6, line 8).

(c) The FEDERAL REGISTER notice containing the controlling list of HPSAs (62 FR 29395), can be found in federal depository libraries and on the Government Printing Office Internet website at *http://www.access.gpo.gov*.

(d) To make a determination about information in the settled cost report, the employer shall examine its own Worksheet S–3, Part I, Hospital and Hospital Health Care Complex Statistical Data, in the Hospital and Hospital Health Care Complex Cost Report, Form HCFA 2552, filed for the fiscal year 1994 cost reporting period.

(e) The facility must maintain a copy of the portions of Worksheet S–3, Part I and Worksheet S, Parts I and II of HCFA Form 2552 which substantiate the attestation of eligibility as a ''facility.'' One set of copies of this document must be kept in the facility's public access file. The full Form 2552 for fiscal year 1994 must be made available to the Department upon request.

§ 655.1112 Element II—What does "no adverse effect on wages and working conditions" mean?

(a) The second attestation element requires that the facility attest that ''the employment of the alien will not adversely affect the wages and working conditions of registered nurses similarly employed.''

(b) For purposes of this program, ''employment'' is full-time employment as defined in § 655.1102; part-time employment of H–1C nurses is not authorized.

(c) *Wages.* To meet the requirement of no adverse effect on wages, the facility must attest that it will pay each nurse employed by the facility at least the prevailing wage for the occupation in the geographic area. The facility must pay the higher of the wage required under this paragraph or the wage required under § 655.1113 (*i.e.*, the third attestation element: facility wage).

(1) *Collectively bargained wage rates.* Where wage rates for nurses at a facility are the result of arms-length collective bargaining, those rates shall be considered ''prevailing'' for that facility for the purposes of this subpart.

(2) Determination of prevailing wage for H–1C purposes. In the absence of collectively bargained wage rates, the National Processing Center (NPC) having jurisdiction as determined by OFLC shall determine the prevailing wage for similarly employed nurses in the geographic area in accordance with administrative guidelines issued by ETA for prevailing wage determination requests submitted on or after the effective date of these regulations.

(i) Prior to the effective date of these regulations, the SWA having jurisdiction over the area of intended employment shall continue to receive and process prevailing wage determination requests in accordance with the regulatory provisions and Department guidance in effect prior to January 1, 2009. On or after the effective date of these regulations, the NPC shall receive and process prevailing wage determination requests in accordance with these regulations and with Department guidance. A facility seeking to determine the prevailing wage must request a prevailing wage determination from the

NPC having jurisdiction for providing the prevailing wage over the proposed area of intended employment not more than 90 days prior to the date the attestation is submitted to the Department. The NPC must enter its wage determination on the form it uses and return the form with its endorsement to the employer. Once a facility obtains a prevailing wage determination from the NPC and files an attestation supported by that prevailing wage determination, the facility shall be deemed to have accepted the prevailing wage determination as accurate and appropriate (as to both the occupational classification and the wage rate) and thereafter shall not contest the legitimacy of that prevailing wage determination in an investigation or enforcement action pursuant to subpart M of this part.

(ii) A facility may challenge the prevailing wage determination with the NPC having provided such determination according to administrative guidelines issued by ETA, but must obtain a final ruling prior to filing an attestation.

(3) *Total compensation package.* The prevailing wage under this paragraph relates to wages only. Employers are cautioned that each item in the total compensation package for U.S. nurses, H–1C, and other nurses employed by the facility must be the same within a given facility, including such items as housing assistance and fringe benefits.

(4) *Documentation of pay and total compensation.* The facility must maintain in its public access file a copy of the prevailing wage, which shall be either the collective bargaining agreement or the determination that was obtained from the NPC. The facility must maintain payroll records, as specified in § 655.1113, and make such records available to the Administrator in the event of an enforcement action pursuant to subpart M.

(d) *Working conditions.* To meet the requirement of no adverse effect on working conditions, the facility must attest that it will afford equal treatment to U.S. and H–1C nurses with the same seniority, with respect to such working conditions as the number and scheduling of hours worked (including shifts, straight days, weekends); vacations; wards and clinical rotations; and overall staffing-patient patterns. In the event of an enforcement action pursuant to subpart M, the facility must provide evidence substantiating compliance with this attestation.

[65 FR 51149, Aug. 22, 2000, as amended at 73 FR 78068, Dec. 19, 2008]

§ 655.1113 Element III—What does "facility wage rate" mean?

(a) The third attestation element requires that the facility employing or seeking to employ the alien must attest that ''the alien employed by the facility will be paid the wage rate for registered nurses similarly employed by the facility.''

(b) The facility must pay the higher of the wage required in this section (*i.e.* facility wage), or the wage required in § 655.1112 (*i.e.*, prevailing wage).

(c) *Wage obligations for H–1C nurses in nonproductive status*—(1) *Circumstances where wages must be paid.* If the H–1C nurse is not performing work and is in a nonproductive status due to a decision by the facility (e.g., because of lack of assigned work), because the nurse has not yet received a license to work as a registered nurse, or any other reason except as specified in paragraph (c)(2) of this section, the facility is required to pay the salaried H–1C nurse the full amount of the weekly salary, or to pay the hourly-wage H–1C nurse for a full-time week (40 hours or such other number of hours as the facility can demonstrate to be full-time employment) at the applicable wage rate.

(2) *Circumstances where wages need not be paid.* If an H–1C nurse experiences a period of nonproductive status due to conditions unrelated to employment which take the nurse away from his/her duties at his/her voluntary request and convenience (e.g., touring the U.S., caring for ill relative) or render the nonimmigrant unable to work (e.g., maternity leave, automobile accident which temporarily incapacitates the nonimmigrant), then the facility is not obligated to pay the required wage rate during that period, *provided that* such period is not subject to payment under the facility's benefit plan. Payment need not be made if there has been a

bona fide termination of the employment relationship, as demonstrated by notification to USCIS that the employment relationship has been terminated and the petition should be canceled.

(d) *Documentation.* The facility must maintain documentation substantiating compliance with this attestation element. The public access file shall contain the facility pay schedule for nurses or a description of the factors taken into consideration by the facility in making compensation decisions for nurses, if either of these documents exists. Categories of nursing positions not covered by the public access file documentation shall not be covered by the Attestation, and, therefore, such positions shall not be filled or held by H–1C nurses. The facility must maintain the payroll records, as required under the Fair Labor Standards Act at 29 CFR part 516, and make such records available to the Administrator in the event of an enforcement action pursuant to subpart M of this part.

§ 655.1114 Element IV—What are the timely and significant steps an H–1C employer must take to recruit and retain U.S. nurses?

(a) The fourth attestation element requires that the facility attest that it ''has taken and is taking timely and significant steps designed to recruit and retain sufficient registered nurses who are United States citizens or immigrants who are authorized to perform nursing services, in order to remove as quickly as reasonably possible the dependence of the facility on nonimmigrant registered nurses.'' The facility must take at least two such steps, unless it demonstrates that taking a second step is not reasonable. The steps described in this section shall not be considered to be an exclusive list of the significant steps that may be taken to meet the conditions of this section. Nothing in this subpart or subpart M of this part shall require a facility to take more than one step, if the facility can demonstrate that taking a second step is not reasonable. A facility choosing to take timely and significant steps other than those specifically described in this section must submit with its Attestation a description of the step(s) it is proposing to take and an explanation of how the proposed step(s) are of comparable timeliness and significance to those described in this section (*See* § 655.1110(c)(1)(iii)). A facility claiming that a second step is unreasonable must submit an explanation of why such second step would be unreasonable (*See* § 655.1110(c)(1)(iv)).

(b) *Descriptions of steps.* Each of the actions described in this section shall be considered a significant step reasonably designed to recruit and retain U.S. nurses. A facility choosing any of these steps shall designate such step on Form ETA 9081, thereby attesting that its program(s) meets the regulatory requirements set forth for such step. Section 212(m)(2)(E)(ii) of the INA provides that a violation shall be found if a facility fails to meet a condition attested to. Thus, a facility shall be held responsible for all timely and significant steps to which it attests.

(1) *Statutory steps*—(i) *Operating a training program for registered nurses at the facility or financing (or providing participation in) a training program for registered nurses elsewhere.* Training programs may include either courses leading to a higher degree (*i.e.*, beyond an associate or a baccalaureate degree), or continuing education courses. If the program includes courses leading to a higher degree, they must be courses which are part of a program accepted for degree credit by a college or university and accredited by a State Board of Nursing or a State Board of Higher Education (or its equivalent), as appropriate. If the program includes continuing education courses, they must be courses which meet criteria established to qualify the nurses taking the courses to earn continuing education units accepted by a State Board of Nursing (or its equivalent). In either type of program, financing by the facility (either directly or arranged through a third party) shall cover the total costs of such training. The number of U.S. nurses for whom such training actually is provided shall be no less than half of the number of nurses who left the facility during the 12-month period prior to submission of the Attestation. U.S. nurses to whom such training was offered, but who rejected such training, may be counted towards those provided training.

(ii) *Providing career development programs and other methods of facilitating health care workers to become registered nurses.* This may include programs leading directly to a degree in nursing, or career ladder/career path programs which could ultimately lead to a degree in nursing. Any such degree program shall be, at a minimum, through an accredited community college (leading to an associate's degree), 4-year college (a bachelor's degree), or diploma school, and the course of study must be one accredited by a State Board of Nursing (or its equivalent). The facility (either directly or arranged through a third party) must cover the total costs of such programs. U.S. workers participating in such programs must be working or have worked in health care occupations or facilities. The number of U.S. workers for whom such training is provided must be equal to no less than half the average number of vacancies for nurses during the 12–month period prior to the submission of the Attestation. U.S. nurses to whom such training was offered, but who rejected such training, may be counted towards those provided training.

(iii) *Paying registered nurses wages at a rate higher than currently being paid to registered nurses similarly employed in the geographic area.* The facility's entire schedule of wages for nurses shall be at least 5 percent higher than the prevailing wage as determined by the NPC, and such differentials shall be maintained throughout the period of the Attestation's effectiveness.

(iv) *Providing reasonable opportunities for meaningful salary advancement by registered nurses.* This may include salary advancement based on factors such as merit, education, and specialty, and/or salary advancement based on length of service, with other bases for wage differentials remaining constant.

(A) *Merit, education, and specialty.* Salary advancement may be based on factors such as merit, education, and specialty, or the facility may provide opportunities for professional development of its nurses which lead to salary advancement (e.g., participation in continuing education or in-house educational instruction; service on special committees, task forces, or projects considered of a professional development nature; participation in professional organizations; and writing for professional publications). Such opportunities must be available to all the facility's nurses.

(B) *Length of service.* Salary advancement may be based on length of service using clinical ladders which provide, annually, salary increases of 3 percent or more for a period of no less than 10 years, over and above the costs of living and merit, education, and specialty increases and differentials.

(2) *Other possible steps.* The Act indicates that the four steps described in the statute (and set out in paragraph (b)(1) of this section) are not an exclusive list of timely and significant steps which might qualify. The actions described in paragraphs (b)(2)(i) through (iv) of this section, are also deemed to be qualified; in paragraph (b)(2)(v) of this section, the facility is afforded the opportunity to identify a timely and significant step of its own devising.

(i) *Monetary incentives.* The facility provides monetary incentives to nurses, through bonuses and merit pay plans not included in the base compensation package, for additional education, and for efforts by the nurses leading to increased recruitment and retention of U.S. nurses. Such monetary incentives may be based on actions by nurses such as: Instituting innovations to achieve better patient care, increased productivity, reduced waste, and/or improved workplace safety; obtaining additional certification in a nursing specialty; accruing unused sick leave; recruiting other U.S. nurses; staying with the facility for a given number of years; taking less desirable assignments (other than shift differential); participating in professional organizations; serving on task forces and on special committees; or contributing to professional publications.

(ii) *Special perquisites.* The facility provides nurses with special perquisites for dependent care or housing assistance of a nature and/or extent that constitute a ''significant'' factor in inducing employment and retention of U.S. nurses.

(iii) *Work schedule options.* The facility provides nurses with non-mandatory work schedule options for part-time work, job-sharing, compressed work week or non-rotating shifts (provided, however, that H–1C nurses are employed only in full-time work) of a nature and/or extent that constitute a ''significant'' factor in inducing employment and retention of U.S. nurses.

(iv) *Other training options.* The facility provides training opportunities to U.S. workers not currently in health care occupations to become registered nurses by means of financial assistance (e.g., scholarship, loan or pay-back programs) to such persons.

(v) *Alternative but significant steps.* Facilities are encouraged to be innovative in devising timely and significant steps other than those described in paragraphs (b)(1) and (b)(2)(i) through (iv) of this section. To qualify, an alternative step must be of a timeliness and significance comparable to those in this section. A facility may designate on Form ETA 9081 that it has taken and is taking such alternate step(s), thereby attesting that the step(s) meet the statutory test of timeliness and significance comparable to those described in paragraphs (b)(1) and (b)(2)(i) through (iv) in promoting the development, recruitment, and retention of U.S. nurses. If such a designation is made on Form ETA 9081, the submission of the Attestation to ETA must include an explanation and appropriate documentation of the alternate step(s), and of the manner in which they satisfy the statutory test in comparison to the steps described in paragraphs (b)(1) and (b)(2)(i) through (iv). ETA will review the explanation and documentation and determine whether the alternate step(s) qualify under this subsection. The ETA determination is subject to review by the BALCA, upon the request of an interested party; such review shall be limited to this matter.

(c) *Unreasonableness of second step.* Nothing in this subpart or subpart M of this part requires a facility to take more than one step, if the facility can demonstrate that taking a second step is not reasonable. However, a facility shall make every effort to take at least two steps. The taking of a second step may be considered unreasonable if it would result in the facility's financial inability to continue providing the same quality and quantity of health care or if the provision of nursing services would otherwise be jeopardized by the taking of such a step.

(1) A facility may designate on Form ETA 9081 that the taking of a second step is not reasonable. If such a designation is made on Form ETA 9081, the submission of the Attestation to ETA shall include an explanation and appropriate documentation with respect to each of the steps described in paragraph (b) of this section (other than the step designated as being taken by the facility), showing why it would be unreasonable for the facility to take each such step and why it would be unreasonable for the facility to take any other step designed to recruit, develop and retain sufficient U.S. nurses to meet its staffing needs.

(2) ETA will review the explanation and documentation, and will determine whether the taking of a second step would not be reasonable. The ETA determination is subject to review by the BALCA, upon the request of an interested party; such review shall be limited to this matter.

(d) *Performance-based alternative to criteria for specific steps.* Instead of complying with the specific criteria for one or more of the steps in the second and/or succeeding years of participation in the H–1C program, a facility may include in its *prior* year's Attestation, in addition to the actions taken under specifically attested steps, that it will reduce the number of H–1C nurses it utilizes within one year from the date of the Attestation by at least 10 percent, without reducing the quality or quantity of services provided. If this goal is achieved, the facility shall so indicate on its subsequent year's Attestation. Further, the facility need not attest to any ''timely and significant step'' on that subsequent attestation, if it again indicates that it shall again reduce the number of H–1C nurses it utilizes within one year from the date of the Attestation by at least 10 percent. This performance-based alternative is designed to permit a facility to achieve the objectives of the Act, without subjecting the facility to detailed requirements and criteria as to

the specific means of achieving that objective.

(e) *Documentation.* The facility must include in the public access file a description of the activities which constitute its compliance with each timely and significant step which is attested on Form ETA 9081 (e.g., summary of a training program for registered nurses; description of a career ladder showing meaningful opportunities for pay advancements for nurses). If the facility has attested that it will take an alternative step or that taking a second step is unreasonable, then the public access file must include the documentation which was submitted to ETA under paragraph (c) of this section. The facility must maintain in its non-public files, and must make available to the Administrator in the event of an enforcement action pursuant to subpart M of this part, documentation which provides a complete description of the nature and operation of its program(s) sufficient to substantiate its full compliance with the requirements of each timely and significant step which is attested to on Form ETA 9081. This documentation should include information relating to all of the requirements for the step in question.

§ 655.1115 Element V—What does "no strike/lockout or layoff" mean?

(a) The fifth attestation element requires that the facility attest that ''there is not a strike or lockout in the course of a labor dispute, the facility did not lay off and will not lay off a registered nurse employed by the facility within the period beginning 90 days before and ending 90 days after the date of filing of any visa petition, and the employment of such an alien is not intended or designated to influence an election for a bargaining representative for registered nurses of the facility.'' Labor disputes for purposes of this attestation element relate only to those involving nurses providing nursing services; other health service occupations are not included. A facility which has filed a petition for H–1C nurses is also prohibited from interfering with the right of the nonimmigrant to join or organize a union.

(b) *Notice of strike or lockout.* In order to remain in compliance with the no strike or lockout portion of this attestation element, the facility must notify ETA if a strike or lockout of nurses at the facility occurs during the 1 year validity period of the attestation. Within 3 days of the occurrence of such strike or lockout, the facility must submit to the Administrator, Office of Foreign Labor Certification, Employment and Training Administration, Department of Labor, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210, by U.S. mail or private carrier, written notice of the strike or lockout. Upon receiving a notice described in this section from a facility, ETA will examine the documentation, and may consult with the union at the facility or other appropriate entities. If ETA determines that the strike or lockout is covered under USCIS regulation 8 CFR 214.2(h)(17), *Effect of a strike*, for ''H'' nonimmigrants, ETA must certify to USCIS, in the manner set forth in that regulation, that a strike or other labor dispute involving a work stoppage of nurses is in progress at the facility.

(c) *Lay off* of a U.S. nurse means that the employer has caused the nurse's loss of employment in circumstances *other than* where—

(1) A U.S. nurse has been discharged for inadequate performance, violation of workplace rules, or other reasonable work-related cause;

(2) A U.S. nurse's departure or retirement is voluntary (to be assessed in light of the totality of the circumstances, under established principles concerning ''constructive discharge'' of workers who are pressured to leave employment);

(3) The grant or contract under which the work performed by the U.S. nurse is required and funded has expired, and without such grant or contract the nurse would not continue to be employed because there is no alternative funding or need for the position; or

(4) A U.S. nurse who loses employment is offered, as an alternative to such loss, a similar employment opportunity with the same employer. The validity of the offer of a similar employment opportunity will be assessed in light of the following factors:

(i) The offer is a *bona fide* offer, rather than an offer designed to induce the

U.S. nurse to refuse or an offer made with the expectation that the worker will refuse;

(ii) The offered job provides the U.S. nurse an opportunity similar to that provided in the job from which he/she is discharged, in terms such as a similar level of authority, discretion, and responsibility, a similar opportunity for advancement within the organization, and similar tenure and work scheduling;

(iii) The offered job provides the U.S. nurse equivalent or higher compensation and benefits to those provided in the job from which he/she is discharged.

(d) *Documentation.* The facility must include in its public access file, copies of all notices of strikes or other labor disputes involving a work stoppage of nurses at the facility (submitted to ETA under paragraph (b) of this section). The facility must retain in its non-public files, and make available in the event of an enforcement action pursuant to subpart M of this part, any existing documentation with respect to the departure of each U.S. nurse who left his/her employment with the facility in the period from 90 days before until 90 days after the facility's petition for H–1C nurse(s). The facility is also required to have a record of the terms of any offer of alternative employment to such a U.S. nurse and the nurse's response to the offer (which may be a note to the file or other record of the nurse's response), and to make such record available in the event of an enforcement action pursuant to subpart M.

[65 FR 51149, Aug. 22, 2000, as amended at 75 FR 10405, Mar. 5, 2010]

§ 655.1116 Element VI—What notification must facilities provide to registered nurses?

(a) The sixth attestation element requires the facility to attest that at the time of filing of the petition for registered nurses under section 101(a)(15)(H)(i)(c) of the INA, notice of filing has been provided by the facility to the bargaining representative of the registered nurses at the facility or, where there is no such bargaining representative, notice of the filing has been provided to registered nurses at the facility through posting in conspicuous locations, and individual copies of the Attestation have been provided to registered nurses employed at the facility.

(b) *Notification of bargaining representative.* (1) At a time no later than the date the attestation is transmitted to ETA, on ETA Form 9081, Attestation for H–1C Nonimmigrant Nurses, the facility must notify the bargaining representative (if any) for nurses at the facility that the attestation is being submitted. This notice may be either a copy of the attestation (ETA Form 9081) or a document stating that the attestations are available for review by interested parties at the facility (explaining how they can be inspected or obtained) and at the Office of Foreign Labor Certification, Employment and Training Administration, Department of Labor, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210. The notice must include the following statement: ''Complaints alleging misrepresentation of material facts in the attestation or failure to comply with the terms of the attestation may be filed with any office of the Wage and Hour Division, United States Department of Labor.''

(2) No later than the date the facility transmits a petition for H–1C nurses to USCIS, the facility must notify the bargaining representative (if any) for nurses at the facility that the H–1C petition is being submitted. This notice may be either a copy of petition, or a document stating that the attestations and H–1C petition are available for review by interested parties at the facility (explaining how they can be inspected or obtained) and at the Office of Foreign Labor Certification, Employment and Training Administration, Department of Labor, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210. The notice must include the following statement: ''Complaints alleging misrepresentation of material facts in the attestation or failure to comply with the terms of the attestation may be filed with any office of the Wage and Hour Division, United States Department of Labor.''

(c) *Posting notice.* If there is no bargaining representative for nurses at

the facility, the facility must post a written notice in two or more conspicuous locations at the facility. Such notices shall be clearly visible and unobstructed while posted, and shall be posted in conspicuous places where nurses can easily read the notices on their way to or from their duties. Appropriate locations for posting hard copy notices include locations in the immediate proximity of mandatory Fair Labor Standards Act wage and hour notices and Occupational Safety and Health Act occupational safety and health notices. In the alternative, the facility may use electronic means it ordinarily uses to communicate with its nurses about job vacancies or promotion opportunities, including through its ''home page'' or ''electronic bulletin board,'' provided that the nurses have, as a practical matter, direct access to those sites; or, where the nurses have individual e-mail accounts, the facility may use e-mail. This must be accomplished no later than the date when the facility transmits an Attestation to ETA and the date when the facility transmits an H–1C petition to the USCIS. The notice may be either a copy of the Attestation or petition, or a document stating that the Attestation or petition has been filed and is available for review by interested parties at the facility (explaining how these documents can be inspected or obtained) and at the national office of ETA. The notice shall include the following statement: ''Complaints alleging misrepresentation of material facts in the Attestation or failure to comply with the terms of the Attestation may be filed with any office of the Wage and Hour Division of the United States Department of Labor.'' Unless it is sent to an individual e-mail address, the Attestation notice shall remain posted during the validity period of the Attestation; the petition notice shall remain posted for ten days. Copies of all notices shall be available for examination in the facility's public access file.

(d) *Individual notice to RNs.* In addition to notifying the bargaining representative or posting notice as described in paragraphs (b) and (c) of this section, the facility must provide a copy of the Attestation, within 30 days of the date of filing, to every registered nurse employed at the facility. This requirement may be satisfied by electronic means if an individual e-mail message, with the Attestation as an attachment, is sent to every RN at the facility. This notification includes not only the RNs employed by the facility, but also includes any RN who is providing service at the facility as an employee of another entity, such as a nursing contractor.

(e) Where RNs lack practical computer access, a hard copy must be posted in accordance with paragraph (c) of this section and a hard copy of the Attestation delivered, within 30 days of the date of filing, to every RN employed at the facility in accordance with paragraph (d) of this section.

(f) The facility must maintain, in its public access file, copies of the notices required by this section. The facility must make such documentation available to the Administrator in the event of an enforcement action pursuant to subpart M of this part.

[65 FR 51149, Aug. 22, 2000, as amended at 75 FR 10405, Mar. 5, 2010]

§ 655.1117 Element VII—What are the limitations as to the number of H–1C nonimmigrants that a facility may employ?

(a) The seventh attestation element requires that the facility attest that it will not, at any time, employ a number of H–1C nurses that exceeds 33% of the total number of registered nurses employed by the facility. The calculation of the population of nurses for purposes of this attestation includes only nurses who have an employer-employee relationship with the facility (as defined in § 655.1102).

(b) The facility must maintain documentation (e.g., payroll records, copies of H–1C petitions) that demonstrates its compliance with this attestation. The facility must make such documentation available to the Administrator in the event of an enforcement action pursuant to subpart M of this part.

§ 655.1118 Element VIII—What are the limitations as to where the H–1C nonimmigrant may be employed?

The eighth attestation element requires that the facility attest that it

will not authorize any H–1C nurse to perform services at any worksite not controlled by the facility or transfer any H–1C nurse from one worksite to another worksite, even if all of the worksites are controlled by the facility.

§ 655.1130 What criteria does the Department use to determine whether or not to certify an Attestation?

(a) An Attestation form which is complete and has no obvious inaccuracies will be accepted for filing by ETA without substantive review, *except that* ETA will conduct a substantive review on particular attestation elements in the following limited circumstances:

(1) Determination of whether the hospital submitting the Attestation is a qualifying ''facility'' (*see* § 655.1110(c)(ii), regarding the documentation required, and the process for review);

(2) Where the facility attests that it is taking or will take a ''timely and significant step'' other than those identified on the Form ETA 9081 (*see* § 655.1114(b)(2)(v), regarding the documentation required, and the process for review);

(3) Where the facility asserts that taking a second ''timely and significant step'' is unreasonable (*see* § 655.1114(c), regarding the documentation required, and the process for review).

(b) The certifying officer will act on the Attestation in a timely manner. If the officer does not contact the facility for information or make any determination within 30 days of receiving the Attestation, the Attestation shall be accepted for filing. If ETA receives information contesting the truth of the statements attested to or compliance with an Attestation prior to the determination to accept or reject the Attestation for filing, such information shall not be made part of ETA's administrative record on the Attestation but shall be referred to the Administrator to be processed as a complaint pursuant to subpart M of this part if such Attestation is accepted by ETA for filing.

(c) When the facility submits the attestation to ETA and provides the notice required by § 655.1116, the attestation must be made available for public examination at the facility. When ETA accepts the attestation for filing, the attestation will be made available, upon request, for public examination in the Office of Foreign Labor Certification, Employment Training Administration, U.S. Department of Labor, Room C–4312, 200 Constitution Avenue, NW., Washington, DC 20210.

(d) *Standards for acceptance of Attestation*. ETA will accept the Attestation for filing under the following standards:

(1) The Attestation is complete and contains no obvious inaccuracies.

(2) The facility's explanation and documentation are sufficient to satisfy the requirements for the Attestation elements on which substantive review is conducted (as described in paragraph (a) of this section).

(3) The facility has no outstanding ''insufficient funds'' check(s) in connection with filing fee(s) for prior Attestation(s).

(4) The facility has no outstanding civil money penalties and/or has not failed to satisfy a remedy assessed by the Wage and Hour Administrator, under subpart M of this part, where that penalty or remedy assessment has become the final agency action.

(5) The facility has not been disqualified from approval of any petitions filed by, or on behalf of, the facility under section 204 or section 212(m) of the INA.

(e) *DOL not the guarantor*. DOL is not the guarantor of the accuracy, truthfulness or adequacy of an Attestation accepted for filing.

(f) *Attestation Effective and Expiration Dates.* An Attestation becomes filed and effective as of the date it is accepted and signed by the ETA certifying officer. Such Attestation is valid until the date that is the later of the end of the 12-month period beginning on the date of acceptance for filing with the Secretary, or the end of the period of admission (under INA section 101(a)(15)(H)(i)(c)) of the last alien with respect to whose admission the Attestation was applied, unless the Attestation is suspended or invalidated earlier than such date pursuant to § 655.1132.

[65 FR 51149, Aug. 22, 2000, as amended at 75 FR 10406, Mar. 5, 2010]

§ 655.1132 When will the Department suspend or invalidate an approved Attestation?

(a) Suspension or invalidation of an Attestation may result where: the facility's check for the filing fee is not honored by a financial institution; a Board of Alien Labor Certification Appeals (BALCA) decision reverses an ETA certification of the Attestation; ETA finds that it made an error in its review and certification of the Attestation; an enforcement proceeding has finally determined that the facility failed to meet a condition attested to, or that there was a misrepresentation of material fact in an Attestation; the facility has failed to pay civil money penalties and/or failed to satisfy a remedy assessed by the Wage and Hour Administrator, where that penalty or remedy assessment has become the final agency action. If an Attestation is suspended or invalidated, ETA will notify USCIS.

(b) *BALCA decision or final agency action in an enforcement proceeding.* If an Attestation is suspended or invalidated as a result of a BALCA decision overruling an ETA acceptance of the Attestation for filing, or is suspended or invalidated as a result of an enforcement action by the Administrator under subpart M of this part, such suspension or invalidation may not be separately appealed, but shall be merged with appeals on the underlying matter.

(c) *ETA action.* If, after accepting an Attestation for filing, ETA discovers that it erroneously accepted that Attestation for filing and, as a result, ETA suspends or invalidates that acceptance, the facility may appeal such suspension or invalidation under § 655.1135 as if that suspension or invalidation were a decision to reject the Attestation for filing.

(d) A facility must comply with the terms of its Attestation, even if such Attestation is suspended, invalidated or expired, as long as any H–1C nurse is at the facility, unless the Attestation is superseded by a subsequent Attestation accepted for filing by ETA.

§ 655.1135 What appeals procedures are available concerning ETA's actions on a facility's Attestation?

(a) *Appeals of acceptances or rejections.* Any interested party may appeal ETA's acceptance or rejection of an Attestation submitted by a facility for filing. However, such an appeal shall be limited to ETA's determination on one or more of the attestation elements for which ETA conducts a substantive review (as described in § 655.1130(a)). Such appeal must be filed no later than 30 days after the date of the acceptance or rejection, and will be considered under the procedures set forth at paragraphs (d) and (f) of this section.

(b) *Appeal of invalidation or suspension.* An interested party may appeal ETA's invalidation or suspension of a filed Attestation due to a discovery by ETA that it made an error in its review of the Attestation, as described in § 655.1132.

(c) *Parties to the appeal.* In the case of an appeal of an acceptance, the facility will be a party to the appeal; in the case of the appeal of a rejection, invalidation, or suspension, the collective bargaining representative (if any) representing nurses at the facility shall be a party to the appeal. Appeals shall be in writing; shall set forth the grounds for the appeal; shall state if *de novo* consideration by BALCA is requested; and shall be mailed by certified mail within 30 calendar days of the date of the action from which the appeal is taken (*i.e.*, the acceptance, rejection, suspension or invalidation of the Attestation).

(d) *Where to file appeals.* Appeals made under this section must be in writing and must be mailed by certified mail to: U.S. Department of Labor, Employment and Training Administration, Office of Foreign Labor Certification, Chicago National Processing Center, 536 South Clark Street, Chicago, IL 60605–1509.

(e) *Transmittal of the case file to BALCA.* Upon receipt of an appeal under this section, the Certifying Office shall send to BALCA a certified copy of the ETA case file, containing the Attestation and supporting documentation and any other information or data considered by ETA in taking

the action being appealed. The administrative law judge chairing BALCA shall assign a panel of one or more administrative law judges who serve on BALCA to review the record for legal sufficiency and to consider and rule on the appeal.

(f) *Consideration on the record; de novo hearings.* BALCA may not remand, dismiss, or stay the case, except as provided in paragraph (h) of this section, but may otherwise consider the appeal on the record or in a *de novo* hearing (on its own motion or on a party's request). Interested parties and *amici* curiae may submit briefs in accordance with a schedule set by BALCA. The ETA official who made the determination which was appealed will be represented by the Associate Solicitor for Employment and Training Legal Services, Office of the Solicitor, Department of Labor, or the Associate Solicitor's designee. If BALCA determines to hear the appeal on the record without a *de novo* hearing, BALCA shall render a decision within 30 calendar days after BALCA's receipt of the case file. If BALCA determines to hear the appeal through a *de novo* hearing, the procedures contained in 29 CFR part 18 will apply to such hearings, except that:

(1) The appeal will not be considered to be a complaint to which an answer is required.

(2) BALCA shall ensure that, at the request of the appellant, the hearing is scheduled to take place within a reasonable period after BALCA's receipt of the case file (see also the time period described in paragraph (f)(4) of this section).

(3) Technical rules of evidence, such as the Federal Rules of Evidence and subpart B of the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges (29 CFR part 18, subpart B), will not apply to any hearing conducted pursuant to this subpart, but rules or principles designed to assure production of the most credible evidence available, and to subject testimony to test by cross-examination, shall be applied where reasonably necessary by BALCA in conducting the hearing. BALCA may exclude irrelevant, immaterial, or unduly repetitious evidence. The certified copy of the case file transmitted to BALCA by the Certifying Officer must be made part of the evidentiary record of the case and need not be moved into evidence.

(4) BALCA's decision shall be rendered within 120 calendar days after BALCA's receipt of the case file.

(g) *Dismissals and stays.* If BALCA determines that the appeal is solely a question of misrepresentation by the facility or is solely a complaint of the facility's nonperformance of the Attestation, BALCA shall dismiss the case and refer the matter to the Administrator, Wage and Hour Division, for action under subpart M. If BALCA determines that the appeal is partially a question of misrepresentation by the facility, or is partially a complaint of the facility's nonperformance of the Attestation, BALCA shall refer the matter to the Administrator, Wage and Hour Division, for action under subpart M of this part and shall stay BALCA consideration of the case pending final agency action on such referral. During such stay, the 120-day period described in paragraph (f)(1)(iv) of this section shall be suspended.

(h) *BALCA's decision.* After consideration on the record or a *de novo* hearing, BALCA shall either affirm or reverse ETA's decision, and shall so notify the appellant; and any other parties.

(i) *Decisions on Attestations.* With respect to an appeal of the acceptance, rejection, suspension or invalidation of an Attestation, the decision of BALCA shall be the final decision of the Secretary, and no further review shall be given to the matter by any DOL official.

[65 FR 51149, Aug. 22, 2000, as amended at 75 FR 10406, Mar. 5, 2010]

§ 655.1150 What materials must be available to the public?

(a) *Public examination at ETA.* ETA will make available, upon request, for public examination at the Office of Foreign Labor Certification, Employment Training Administration, U.S. Department of Labor, Room C–4312, 200 Constitution Avenue, NW., Washington, DC 20210, a list of facilities which have filed attestations; a copy of the facility's attestation(s) and any supporting documentation; and a copy

of each of the facility's H–1C petitions (if any) to USCIS along with the USCIS approval notices (if any).

(b) *Public examination at facility.* For the duration of the Attestation's validity and thereafter for so long as the facility employs any H–1C nurse under the Attestation, the facility must maintain a separate file containing a copy of the Attestation, a copy of the prevailing wage determination, a description of the facility pay system or a copy of the facility's pay schedule if either document exists, copies of the notices provided under § 655.1115 and § 655.1116, a description of the ''timely and significant steps'' as described in § 655.1114, and any other documentation required by this part to be contained in the public access file. The facility must make this file available to any interested parties within 72 hours upon written or oral request. If a party requests a copy of the file, the facility shall provide it and any charge for such copy shall not exceed the cost of reproduction.

(c) *ETA Notice to public.* ETA will periodically publish a notice in the FEDERAL REGISTER announcing the names and addresses of facilities which have submitted Attestations; facilities which have Attestations on file; facilities which have submitted Attestations which have been rejected for filing; and facilities which have had Attestations suspended.

[65 FR 51149, Aug. 22, 2000, as amended at 75 FR 10406, Mar. 5, 2010]

Subpart M—What are the Department's enforcement obligations with respect to H–1C Attestations?

SOURCE: 65 FR 51149, Aug. 22, 2000, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to subpart M of part 655 appear at 75 FR 10403, Mar. 5, 2010.

§ 655.1200 What enforcement authority does the Department have with respect to a facility's H–1C Attestations?

(a) The Administrator shall perform all the Secretary's investigative and enforcement functions under 8 U.S.C. 1182(m) and subparts L and M of this part.

(b) The Administrator, either because of a complaint or otherwise, shall conduct such investigations as may be appropriate and, in connection therewith, enter and inspect such places and such records (and make transcriptions thereof), question such persons and gather such information as deemed necessary by the Administrator to determine compliance with the matters to which a facility has attested under section 212(m) of the INA (8 U.S.C. 1182(m)) and subparts L and M of this part.

(c) A facility being investigated must make available to the Administrator such records, information, persons, and places as the Administrator deems appropriate to copy, transcribe, question, or inspect. A facility must fully cooperate with any official of the Department of Labor performing an investigation, inspection, or law enforcement function under 8 U.S.C. 1182(m) or subparts L or M of this part. Such cooperation shall include producing documentation upon request. The Administrator may deem the failure to cooperate to be a violation, and take such further actions as the Administrator considers appropriate.

(NOTE: Federal criminal statutes prohibit certain interference with a Federal officer in the performance of official duties. 18 U.S.C. 111 and 1114.)

(d) No facility may intimidate, threaten, restrain, coerce, blacklist, discharge, or in any manner discriminate against any person because such person has:

(1) Filed a complaint or appeal under or related to section 212(m) of the INA (8 U.S.C. 1182(m)) or subpart L or M of this part;

(2) Testified or is about to testify in any proceeding under or related to section 212(m) of the INA (8 U.S.C. 1182(m)) or subpart L or M of this part.

(3) Exercised or asserted on behalf of himself/herself or others any right or protection afforded by section 212(m) of the INA (8 U.S.C. 1182(m)) or subpart L or M of this part.

(4) Consulted with an employee of a legal assistance program or an attorney on matters related to the Act or to subparts L or M of this part or any

other DOL regulation promulgated under 8 U.S.C. 1182(m).

(5) In the event of such intimidation or restraint as are described in this paragraph, the Administrator may deem the conduct to be a violation and take such further actions as the Administrator considers appropriate.

(e) A facility subject to subparts L and M of this part must maintain a separate file containing its Attestation and required documentation, and must make that file or copies thereof available to interested parties, as required by §655.1150. In the event of a facility's failure to maintain the file, to provide access, or to provide copies, the Administrator may deem the conduct to be a violation and take such further actions as the Administrator considers appropriate.

(f) No facility may seek to have an H–1C nurse, or any other nurse similarly employed by the employer, or any other employee waive rights conferred under the Act or under subpart L or M of this part. In the event of such waiver, the Administrator may deem the conduct to be a violation and take such further actions as the Administrator considers appropriate. This prohibition of waivers does not prevent agreements to settle litigation among private parties, and a waiver or modification of rights or obligations in favor of the Secretary shall be valid for purposes of enforcement of the provisions of the Act or subpart L and M of this part.

(g) The Administrator shall, to the extent possible under existing law, protect the confidentiality of any complainant or other person who provides information to the Department.

§655.1205 What is the Administrator's responsibility with respect to complaints and investigations?

(a) The Administrator, through investigation, shall determine whether a facility has failed to perform any attested conditions, misrepresented any material facts in an Attestation (including misrepresentation as to compliance with regulatory standards), or otherwise violated the Act or subpart L or M of this part. The Administrator's authority applies whether an Attestation is expired or unexpired at the time a complaint is filed. (Note: Federal criminal statutes provide for fines and/or imprisonment for knowing and willful submission of false statements to the Federal Government. 18 U.S.C. 1001; *see also* 18 U.S.C. 1546.)

(b) Any aggrieved person or organization may file a complaint of a violation of the provisions of section 212(m) of the INA (8 U.S.C. 1182(m)) or subpart L or M of this part. No particular form of complaint is required, except that the complaint shall be written or, if oral, shall be reduced to writing by the Wage and Hour Division official who receives the complaint. The complaint must set forth sufficient facts for the Administrator to determine what part or parts of the Attestation or regulations have allegedly been violated. Upon the request of the complainant, the Administrator shall, to the extent possible under existing law, maintain confidentiality about the complainant's identity; if the complainant wishes to be a party to the administrative hearing proceedings under this subpart, the complainant shall then waive confidentiality. The complaint may be submitted to any local Wage and Hour Division office; the addresses of such offices are found in local telephone directories. Inquiries concerning the enforcement program and requests for technical assistance regarding compliance may also be submitted to the local Wage and Hour Division office.

(c) The Administrator shall determine whether there is reasonable cause to believe that the complaint warrants investigation and, if so, shall conduct an investigation, within 180 days of the receipt of a complaint. If the Administrator determines that the complaint fails to present reasonable cause for an investigation, the Administrator shall so notify the complainant, who may submit a new complaint, with such additional information as may be necessary.

(d) When an investigation has been conducted, the Administrator shall, within 180 days of the receipt of a complaint, issue a written determination, stating whether a basis exists to make a finding that the facility failed to meet a condition of its Attestation, made a misrepresentation of a material fact therein, or otherwise violated the

Act or subpart L or M. The determination shall specify any sanctions imposed due to violations. The Administrator shall provide a notice of such determination to the interested parties and shall inform them of the opportunity for a hearing pursuant to § 655.1220.

§ 655.1210 What penalties and other remedies may the Administrator impose?

(a) The Administrator may assess a civil money penalty not to exceed $1,000 per nurse per violation, with the total penalty not to exceed $10,000 per violation. The Administrator also may impose appropriate remedies, including the payment of back wages, the performance of attested obligations such as providing training, and reinstatement and/or wages for laid off U.S. nurses.

(b) In determining the amount of civil money penalty to be assessed for any violation, the Administrator will consider the type of violation committed and other relevant factors. The matters which may be considered include, but are not limited to, the following:

(1) Previous history of violation, or violations, by the facility under the Act and subpart L or M of this part;

(2) The number of workers affected by the violation or violations;

(3) The gravity of the violation or violations;

(4) Efforts made by the violator in good faith to comply with the Attestation as provided in the Act and subparts L and M of this part;

(5) The violator's explanation of the violation or violations;

(6) The violator's commitment to future compliance, taking into account the public health, interest, or safety; and

(7) The extent to which the violator achieved a financial gain due to the violation, or the potential financial loss or potential injury or adverse effect upon the workers.

(c) The civil money penalty, back wages, and any other remedy determined by the Administrator to be appropriate, are immediately due for payment or performance upon the assessment by the Administrator, or the decision by an administrative law judge where a hearing is requested, or the decision by the Secretary where review is granted. The facility must remit the amount of the civil money penalty, by certified check or money order made payable to the order of ''Wage and Hour Division, Labor.'' The remittance must be delivered or mailed to the Wage and Hour Division Regional Office for the area in which the violation(s) occurred. The payment of back wages, monetary relief, and/or the performance or any other remedy prescribed by the Administrator will follow procedures established by the Administrator. The facility's failure to pay the civil money penalty, back wages, or other monetary relief, or to perform any other assessed remedy, will result in the rejection by ETA of any future Attestation submitted by the facility until such payment or performance is accomplished.

(d) The Federal Civil Penalties Inflation Adjustment Act of 1990, as amended (28 U.S.C. 2461 note), requires that inflationary adjustments to civil money penalties in accordance with a specified cost-of-living formula be made, by regulation, at least every four years. The adjustments are to be based on changes in the Consumer Price Index for all Urban Consumers (CPI-U) for the U.S. City Average for All Items. The adjusted amounts will be published in the FEDERAL REGISTER. The amount of the penalty in a particular case will be based on the amount of the penalty in effect at the time the violation occurs.

§ 655.1215 How are the Administrator's investigation findings issued?

(a) The Administrator's determination, issued under § 655.1205(d), shall be served on the complainant, the facility, and other interested parties by personal service or by certified mail at the parties' last known addresses. Where service by certified mail is not accepted by the party, the Administrator may exercise discretion to serve the determination by regular mail. Where the complainant has requested confidentiality, the Administrator shall serve the determination in a manner which will not breach that confidentiality.

(b) The Administrator's written determination required by § 655.1205(c) shall:

(1) Set forth the determination of the Administrator and the reason or reasons therefore; prescribe any remedies or penalties including the amount of any unpaid wages due, the actions required for compliance with the facility Attestation, and the amount of any civil money penalty assessment and the reason or reasons therefore.

(2) Inform the interested parties that they may request a hearing under § 655.1220.

(3) Inform the interested parties that if a request for a hearing is not received by the Chief Administrative Law Judge within 15 days of the date of the determination, the determination of the Administrator shall become final and not appealable.

(4) Set forth the procedure for requesting a hearing, and give the address of the Chief Administrative Law Judge.

(5) Inform the parties that, under § 655.1255, the Administrator shall notify the Department of Homeland Security and ETA of the occurrence of a violation by the employer.

[75 FR 10406, Mar. 5, 2010]

§ 655.1220 Who can appeal the Administrator's findings and what is the process?

(a) Any interested party desiring review of a determination issued under § 655.1205(d), including judicial review, must make a request for an administrative hearing in writing to the Chief Administrative Law Judge at the address stated in the notice of determination. If such a request for an administrative hearing is timely filed, the Administrator's determination shall be inoperative unless and until the case is dismissed or the Administrative Law Judge issues an order affirming the decision.

(b) An interested party may request a hearing in the following circumstances:

(1) Where the Administrator determines that there is no basis for a finding of violation, the complainant or other interested party may request a hearing. In such a proceeding, the party requesting the hearing shall be the prosecuting party and the facility shall be the respondent; the Administrator may intervene as a party or appear as *amicus curiae* at any time in the proceeding, at the Administrator's discretion.

(2) Where the Administrator determines that there is a basis for a finding of violation, the facility or other interested party may request a hearing. In such a proceeding, the Administrator shall be the prosecuting party and the facility shall be the respondent.

(c) No particular form is prescribed for any request for hearing permitted by this part. However, any such request shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) Specify the issue or issues stated in the notice of determination giving rise to such request;

(4) State the specific reason or reasons why the party requesting the hearing believes such determination is in error;

(5) Be signed by the party making the request or by an authorized representative of such party; and

(6) Include the address at which such party or authorized representative desires to receive further communications relating thereto.

(d) The request for such hearing must be received by the Chief Administrative Law Judge, at the address stated in the Administrator's notice of determination, no later than 10 days after the date of the determination. An interested party which fails to meet this 10-day deadline for requesting a hearing may thereafter participate in the proceedings only by consent of the administrative law judge, either through intervention as a party under 29 CFR 18.10 (b) through (d) or through participation as an *amicus curiae* under 29 CFR 18.12.

(e) The request may be filed in person, by facsimile transmission, by certified or regular mail, or by courier service. For the requesting party's protection, if the request is filed by mail, it should be certified mail. If the request is filed by facsimile transmission, the original of the request, signed by the requestor or authorized representative, must be filed within 10

days of the date of the Administrator's notice of determination.

(f) Copies of the request for a hearing must be sent by the requestor to the Wage and Hour Division official who issued the Administrator's notice of determination, to the representative(s) of the Solicitor of Labor identified in the notice of determination, and to all known interested parties.

§ 655.1225 What are the rules of practice before an ALJ?

(a) Except as specifically provided in this subpart, and to the extent they do not conflict with the provisions of this subpart, the ''Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges'' established by the Secretary at 29 CFR part 18 shall apply to administrative proceedings under this subpart.

(b) As provided in the Administrative Procedure Act, 5 U.S.C. 556, any oral or documentary evidence may be received in proceedings under this part. The Federal Rules of Evidence and subpart B of the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges (29 CFR part 18, subpart B) do not apply, but principles designed to ensure production of relevant and probative evidence shall guide the admission of evidence. The administrative law judge may exclude evidence which is immaterial, irrelevant, or unduly repetitive.

§ 655.1230 What time limits are imposed in ALJ proceedings?

(a) Under this subpart, a party may serve any pleading or document by regular mail. Service is complete upon mailing to the last known address. No additional time for filing or response is authorized where service is by mail. In the interest of expeditious proceedings, the administrative law judge may direct the parties to serve pleadings or documents by a method other than regular mail.

(b) Two (2) copies of all pleadings and other documents in any administrative law judge proceeding shall be served on the attorneys for the Administrator. One copy must be served on the Associate Solicitor, Division of Fair Labor Standards, Office of the Solicitor, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, and one copy on the attorney representing the Administrator in the proceeding.

(c) Time will be computed beginning with the day following the action and includes the last day of the period unless it is a Saturday, Sunday, or Federally-observed holiday, in which case the time period includes the next business day.

§ 655.1235 What are the ALJ proceedings?

(a) Upon receipt of a timely request for a hearing filed in accordance with § 655.1220, the Chief Administrative Law Judge shall appoint an administrative law judge to hear the case.

(b) Within seven (7) days following the assignment of the case, the administrative law judge shall notify all interested parties of the date, time, and place of the hearing. All parties shall be given at least five (5) days notice of such hearing.

(c) The date of the hearing shall be not more than 60 days from the date of the Administrator's determination. Because of the time constraints imposed by the Act, no requests for postponement shall be granted except for compelling reasons and by consent of all the parties to the proceeding.

(d) The administrative law judge may prescribe a schedule by which the parties are permitted to file a pre-hearing brief or other written statement of fact or law. Any such brief or statement shall be served upon each other party in accordance with § 655.1230. Posthearing briefs will not be permitted except at the request of the administrative law judge. When permitted, any such brief shall be limited to the issue or issues specified by the administrative law judge, shall be due within the time prescribed by the administrative law judge, and shall be served on each other party in accordance with § 655.1230.

§ 655.1240 When and how does an ALJ issue a decision?

(a) Within 90 days after receipt of the transcript of the hearing, the administrative law judge shall issue a decision.

(b) The decision of the administrative law judge shall include a statement of findings and conclusions, with reasons and basis therefore, upon each material issue presented on the record. The decision shall also include an appropriate order which may affirm, deny, reverse, or modify, in whole or in part, the determination of the Administrator; the reason or reasons for such order shall be stated in the decision. The administrative law judge shall not render determinations as to the legality of a regulatory provision or the constitutionality of a statutory provision.

(c) The decision shall be served on all parties in person or by certified or regular mail.

§ 655.1245 Who can appeal the ALJ's decision and what is the process?

(a) The Administrator or any interested party desiring review of the decision and order of an administrative law judge, including judicial review, must petition the Department's Administrative Review Board (Board) to review the ALJ's decision and order. To be effective, such petition must be received by the Board within 30 days of the date of the decision and order. Copies of the petition must be served on all parties and on the administrative law judge.

(b) No particular form is prescribed for any petition for the Board's review permitted by this subpart. However, any such petition must:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) Specify the issue or issues stated in the administrative law judge's decision and order giving rise to such petition;

(4) State the specific reason or reasons why the party petitioning for review believes such decision and order are in error;

(5) Be signed by the party filing the petition or by an authorized representative of such party;

(6) Include the address at which such party or authorized representative desires to receive further communications relating thereto; and

(7) Attach copies of the administrative law judge's decision and order, and any other record documents which would assist the Board in determining whether review is warranted.

(c) Whenever the Board determines to review the decision and order of an administrative law judge, a notice of the Board's determination must be served upon the administrative law judge and upon all parties to the proceeding within 30 days after the Board's receipt of the petition for review. If the Board determines that it will review the decision and order, the order shall be inoperative unless and until the Board issues an order affirming the decision and order.

(d) Within 15 days of receipt of the Board's notice, the Office of Administrative Law Judges shall forward the complete hearing record to the Board.

(e) The Board's notice shall specify:

(1) The issue or issues to be reviewed;

(2) The form in which submissions must be made by the parties (e.g., briefs, oral argument);

(3) The time within which such submissions must be made.

(f) All documents submitted to the Board shall be filed with the Administrative Review Board in accordance with 29 CFR part 26. Documents are not deemed filed with the Board until actually received by the Board. All documents, including documents filed by mail, shall be received by the Board either on or before the due date.

(g) Copies of all documents filed with the Board must be served upon all other parties involved in the proceeding. Service upon the Administrator must be in accordance with § 655.1230(b).

(h) The Board's final decision shall be issued within 180 days from the date of the notice of intent to review. The Board's decision shall be served upon all parties and the administrative law judge.

(i) Upon issuance of the Board's decision, the Board shall transmit the entire record to the Chief Administrative Law Judge for custody in accordance with § 655.1250.

[65 FR 51149, Aug. 22, 2000, as amended at 86 FR 1776, Jan. 11, 2021]

§ 655.1250 Who is the official record keeper for these administrative appeals?

The official record of every completed administrative hearing procedure provided by subparts L and M of this part shall be maintained and filed under the custody and control of the Chief Administrative Law Judge. Upon receipt of a complaint seeking review of the final agency action in a United States District Court, the Chief Administrative Law Judge shall certify the official record and shall transmit such record to the clerk of the court.

§ 655.1255 What are the procedures for debarment of a facility based on a finding of violation?

(a) The Administrator shall notify the Department of Homeland Security and ETA of the final determination of a violation by a facility upon the earliest of the following events:

(1) Where the Administrator determines that there is a basis for a finding of violation by a facility, and no timely request for hearing is made under § 655.1220; or

(2) Where, after a hearing, the administrative law judge issues a decision and order finding a violation by a facility, and no timely petition for review to the Board is made under § 655.1245; or

(3) Where a petition for review is taken from an administrative law judge's decision and the Board either declines within 30 days to entertain the appeal, under § 655.1245(c), or the Board affirms the administrative law judge's determination; or

(4) Where the administrative law judge finds that there was no violation by a facility, and the Board, upon review, issues a decision under § 655.1245(h), holding that a violation was committed by a facility.

(b) U.S. Citizenship and Immigration Services, upon receipt of the Administrator's notice under paragraph (a) of this section, shall not approve petitions filed with respect to that employer under section 212(m) of the INA (8 U.S.C. 1182(m)) during a period of at least 12 months from the date of receipt of the Administrator's notification. The Administrator must provide USCIS with a recommendation as to the length of the debarment.

(c) ETA, upon receipt of the Administrator's notice under paragraph (a) of this section, shall suspend the employer's attestation(s) under subparts L and M of this part, and shall not accept for filing any attestation submitted by the employer under subparts L and M of this part, for a period of 12 months from the date of receipt of the Administrator's notification or for a longer period if one is specified by the Department of Homeland Security for visa petitions filed by that employer under section 212(m) of the INA.

[75 FR 10406, Mar. 5, 2010]

§ 655.1260 Can Equal Access to Justice Act attorney fees be awarded?

A proceeding under subpart L or M of this part is not subject to the Equal Access to Justice Act, as amended, 5 U.S.C. 504. In such a proceeding, the administrative law judge shall have no authority to award attorney fees and/or other litigation expenses under the provisions of the Equal Access to Justice Act.

Subpart N—Labor Certification Process for Temporary Agricultural Employment in the United States (H–2A Workers)

SOURCE: 73 FR 77207, Dec. 18, 2008, unless otherwise noted. Redesignated at 74 FR 25985, May 29, 2009.

EFFECTIVE DATE NOTE: At 74 FR 25985, May 29, 2009, subpart B, consisting of §§ 655.90, 655.92, 655.93, and 655.100 through 655.119, was redesignated as subpart N, consisting of §§ 655.1290, 655.1292, 655.1293, and 655.1300 through 655.1319, and newly designated subpart N was suspended, effective June 29, 2009.

§ 655.1290 Purpose and scope of subpart B.

This subpart sets out the procedures established by the Secretary of the United States Department of Labor (the Secretary) to acquire information sufficient to make factual determinations of:

(a) Whether there are sufficient able, willing, and qualified U.S. workers available to perform the temporary and seasonal agricultural employment for which an employer desires to import nonimmigrant foreign workers (H–2A workers); and

(b) Whether the employment of H–2A workers will adversely affect the wages and working conditions of workers in the U.S. similarly employed.

§ 655.1292 Authority of ETA–OFLC.

Temporary agricultural labor certification determinations are made by the Administrator, Office of Foreign Labor Certification (OFLC) in the Department of Labor's (the Department or DOL) Employment & Training Administration (ETA), who, in turn, may delegate this responsibility to a designated staff member; e.g., a Certifying Officer (CO).

§ 655.1293 Special procedures.

(a) *Systematic process.* This subpart provides procedures for the processing of applications from agricultural employers and associations of employers for the certification of employment of nonimmigrant workers in agricultural employment.

(b) *Establishment of special procedures.* To provide for a limited degree of flexibility in carrying out the Secretary's responsibilities under the Immigration and Nationality Act (INA), while not deviating from statutory requirements, the Administrator, OFLC has the authority to establish or to devise, continue, revise, or revoke special procedures in the form of variances for processing certain H–2A applications when employers can demonstrate upon written application to the Administrator, OFLC that special procedures are necessary. These include special procedures in effect for the handling of applications for sheepherders in the Western States (and adaptation of such procedures to occupations in the range production of other livestock), and for custom combine crews. In a like manner, for work in occupations characterized by other than a reasonably regular workday or workweek, such as the range production of sheep or other livestock, the Administrator, OFLC has the authority to establish monthly, weekly, or bi-weekly adverse effect wage rates (AEWR) for those occupations for a statewide or other geographical area. Prior to making determinations under this section, the Administrator, OFLC will consult with employer and worker representatives.

§ 655.1300 Overview of subpart B and definition of terms.

(a) *Overview*—(1) *Application filing process.* (i) This subpart provides guidance to employers desiring to apply for a labor certification for the employment of H–2A workers to perform agricultural employment of a temporary or seasonal nature. The regulations in this subpart provide that such employers must file with the Administrator, OFLC an H–2A application on forms prescribed by the ETA that describe the material terms and conditions of employment to be offered and afforded to U.S. and H–2A workers. The application must be filed with the Administrator, OFLC at least 45 calendar days before the first date the employer requires the services of the H–2A workers. The application must contain attestations of the employer's compliance or promise to comply with program requirements regarding recruitment of eligible U.S. workers, the payment of an appropriate wage, and terms and conditions of employment.

(ii) No more than 75 and no fewer than 60 calendar days before the first date the employer requires the services of the H–2A workers, and as a precursor to the filing of an *Application for Temporary Employment Certification*, the employer must initiate positive recruitment of eligible U.S. workers and cooperate with the local office of the State Workforce Agency (SWA) which serves the area of intended employment to place a job order into intrastate and interstate recruitment. Prior to commencing recruitment an employer must obtain the appropriate wage for the position directly from the ETA National Processing Center (NPC). The employer must then place a job order with the SWA; place print advertisements meeting the requirements of this regulation; contact former U.S. employees; and, when so designated by the Secretary, recruit in other States of traditional or expected labor supply with a significant number of U.S. workers who, if recruited, would be willing to make themselves available at the time and place needed. The SWA will post the job order locally, as well as in all States listed in the application as anticipated work sites, and in any additional States designated by

the Secretary as States of traditional or expected labor supply. The SWA will keep the job order open until the end of the designated recruitment period. No more than 50 days prior to the first date the employer requires the services of the H–2A workers, the employer will prepare and sign an initial written recruitment report that it must submit with its *Application for Temporary Employment Certification* (*www.foreignlaborcert.doleta.gov*). The recruitment report must contain information regarding the original number of openings for which the employer recruited. The employer's obligation to engage in positive recruitment will end on the actual date on which the H–2A workers depart for the place of work, or 3 days prior to the first date the employer requires the services of the H–2A workers, whichever occurs first.

(iii) The *Application for Temporary Employment Certification* must be filed by mail unless the Department publishes a Notice in the FEDERAL REGISTER requiring that applications be filed electronically. Applications that meet threshold requirements for completeness and accuracy will be processed by NPC staff, who will review each application for compliance with the criteria for certification. Each application must meet requirements for timeliness and temporary need and must provide assurances and other safeguards against adverse impact on the wages and working conditions of U.S. workers. Employers receiving a labor certification must continue to cooperate with the SWA by accepting referrals—and have the obligation to hire qualified and eligible U.S. workers who apply—until the end of the designated recruitment period.

(2) *Deficient applications.* The CO will promptly review the application and notify the applicant in writing if there are deficiencies that render the application not acceptable for certification, and afford the applicant a 5 calendar day period (from date of the employer's receipt) to resubmit a modified application or to file an appeal of the CO's decision not to approve the application as acceptable for consideration. Modified applications that fail to cure deficiencies will be denied.

(3) *Amendment of applications.* This subpart provides for the amendment of applications. Where the recruitment is not materially affected by such amendments, additional positive recruitment will not be required.

(4) *Determinations*—(i) *Determinations.* If the employer has complied with the criteria for certification, including recruitment of eligible U.S. workers, the CO must make a determination on the application by 30 days before the first date the employer requires the services of the H–2A workers. An employer's failure to comply with any of the certification criteria or to cure deficiencies identified by the CO may lengthen the time required for processing, resulting in a final determination less than 30 days prior to the stated date of need.

(ii) *Certified applications.* This subpart provides that an application for temporary agricultural labor certification will be certified if the CO finds that the employer has not offered and does not intend to offer foreign workers higher wages, better working conditions, or fewer restrictions than those offered and afforded to U.S. workers; that sufficient U.S. workers who are able, willing, qualified, and eligible will not be available at the time and place needed to perform the work for which H–2A workers are being requested; and that the employment of such nonimmigrants will not adversely affect the wages and working conditions of similarly employed U.S. workers.

(iii) *Fees*—(A) *Amount.* This subpart provides that each employer (except joint employer associations) of H–2A workers will pay the appropriate fees to the Department for each temporary agricultural labor certification received.

(B) *Timeliness of payment.* The fee must be received by the CO no later than 30 calendar days after the granting of each temporary agricultural labor certification. Fees received any later are untimely. A persistent or prolonged failure to pay fees in a timely manner is a substantial program violation which may result in the denial of future temporary agricultural labor certifications and/or program debarment.

(iv) *Denied applications.* This subpart provides that if the application for temporary agricultural labor certification is denied, in whole or in part, the employer may seek expedited review of the denial, or a de novo hearing, by an administrative law judge as provided in this subpart.

(b) *Transition of filing procedures from current regulations*—(1) *Compliance with these regulations.* Employers with a date of need for H–2A workers for temporary or seasonal agricultural services on or after January 1, 2010 must comply with all of the obligations and assurances required in this subpart.

(2) *Transition from former regulations.* Employers with a date of need for H–2A workers for temporary or seasonal agricultural services prior to January 1, 2010 will file applications in the following manner:

(i) *Obtaining required wage rate.* An employer will not obtain an offered wage rate through the NPC prior to filing an application, but will complete and submit Form ETA–9142, *Application for Temporary Employment Certification* no less than 45 days prior to their date of need. The employer will simultaneously submit Form ETA–790 *Agricultural and Food Processing Clearance Order*, along with the *Application for Temporary Employment Certification*, directly to the NPC having jurisdiction over H–2A applications.

(ii) *Pre-filing activities.* Activities required to be conducted prior to filing under the final rule will be conducted post-filing during this transition period. The employer will be expected to make attestations in its application applicable to its future activities concerning recruitment, payment of the offered wage rate, etc. Employers will not be required to complete an initial recruitment report for submission with the application, but will be required to complete a recruitment report for submission to the NPC prior to certification, and will also be required to complete a final recruitment report covering the entire recruitment period.

(iii) *Acceptance of application.* Upon receipt, the NPC will provide the employer with the wage rate to be offered, at a minimum, by the employer, and will process the application in a manner consistent with new § 655.107, issuing a notification of deficiencies for any curable deficiencies within 7 calendar days.

(iv) *Processing of application.* Once the application and job order have been accepted, the NPC will transmit a copy of the job order to the SWA(s) serving the area of intended employment to initiate intrastate and interstate clearance, request that the SWA(s) schedule an inspection of the housing, and provide instructions to the employer to commence positive recruitment in a manner consistent with § 655.102(d)(2) through (4). The NPC will designate labor supply States during this period on a case-by-case basis. Such designations must be based on information provided by State agencies or by other sources, and will to the extent information is available take into account the success of recent efforts by out-of-State employers to recruit in that State.

(c) *Definitions of terms used in this subpart.* For the purposes of this subpart:

Administrative Law Judge (ALJ) means a person within the DOL's Office of Administrative Law Judges appointed pursuant to 5 U.S.C. 3105, or a panel of such persons designated by the Chief Administrative Law Judge from the Board of Alien Labor Certification Appeals (BALCA) established by part 656 of this chapter, which will hear and decide appeals as set forth in § 655.115.

Administrator, OFLC means the primary official of the Office of Foreign Labor Certification (*OFLC*), or the Administrator, OFLC 's designee.

Adverse effect wage rate (AEWR) means the minimum wage rate that the Administrator, OFLC has determined must be offered and paid to every H–2A worker employed under the DOL-approved *Application for Temporary Employment Certification* in a particular occupation and/or area, as well as to U.S. workers hired by employers into corresponding employment during the H–2A recruitment period, to ensure that the wages of similarly employed U.S. workers will not be adversely affected.

Agent means a legal entity or person, such as an association of agricultural employers, or an attorney for an association, that:

(1) Is authorized to act on behalf of the employer for temporary agricultural labor certification purposes;

(2) Is not itself an employer, or a joint employer, as defined in this paragraph (c) of this section with respect to a specific application; and

(3) Is not under suspension, debarment, expulsion, or disbarment from practice before any court or the Department, the Board of Immigration Appeals, the immigration judges, or the Department of Homeland Security (DHS) under 8 CFR 292.3 or 1003.101.

Agricultural association means any nonprofit or cooperative association of farmers, growers, or ranchers (including but not limited to processing establishments, canneries, gins, packing sheds, nurseries, or other fixed-site agricultural employers), incorporated or qualified under applicable State law, that recruits, solicits, hires, employs, furnishes, houses or transports any worker that is subject to sec. 218 of the INA. An agricultural association may act as the agent of an employer for purposes of filing an *Application for Temporary Employment Certification*, and may also act as the sole or joint employer of H–2A workers.

Application for Temporary Employment Certification means the Office of Management and Budget (OMB)-approved form submitted by an employer to secure a temporary agricultural labor certification determination from DOL. A complete submission of the *Application for Temporary Employment Certification* includes both the form and the employer's initial recruitment report.

Area of intended employment means the geographic area within normal commuting distance of the place (worksite address) of the job opportunity for which the certification is sought. There is no rigid measure of distance which constitutes a normal commuting distance or normal commuting area, because there may be widely varying factual circumstances among different areas (e.g., average commuting times, barriers to reaching the worksite, quality of the regional transportation network, etc.). If the place of intended employment is within a Metropolitan Statistical Area (MSA), including a multistate MSA, any place within the MSA is deemed to be within normal commuting distance of the place of intended employment. The borders of MSAs are not controlling in the identification of the normal commuting area; a location outside of an MSA may be within normal commuting distance of a location that is inside (e.g., near the border of) the MSA.

Attorney means any person who is a member in good standing of the bar of the highest court of any State, possession, territory, or commonwealth of the U.S., or the District of Columbia, and who is not under suspension, debarment, expulsion, or disbarment from practice before any court or the Department, the Board of Immigration Appeals, the immigration judges, or DHS under 8 CFR. 292.3 or 1003.101. Such a person is permitted to act as an agent or attorney for an employer and/or foreign worker under this subpart.

Certifying Officer (CO) means the person designated by the Administrator, OFLC to make determinations on applications filed under the H–2A program.

Chief Administrative Law Judge means the chief official of the DOL Office of Administrative Law Judges or the Chief Administrative Law Judge's designee.

Date of need means the first date the employer requires the services of H–2A worker as indicated in the employer's *Application for Temporary Employment Certification*.

Department of Homeland Security (DHS) means the Federal agency having control over certain immigration functions that, through its sub-agency, *United States Citizenship and Immigration Services* (USCIS), makes the determination under the INA on whether to grant visa petitions filed by employers seeking H–2A workers to perform temporary agricultural work in the U.S.

DOL or Department means the United States Department of Labor.

Eligible worker means an individual who is not an unauthorized alien (as defined in sec. 274A(h)(3) of the INA, 8 U.S.C. 1324a(h)(3)) with respect to the employment in which the worker is engaging.

Employee means employee as defined under the general common law of agency. Some of the factors relevant to the

determination of employee status include: the hiring party's right to control the manner and means by which the work is accomplished; the skill required to perform the work; the source of the instrumentalities and tools for accomplishing the work; the location of the work; the hiring party's discretion over when and how long to work; and whether the work is part of the regular business of the hiring party. Other applicable factors may be considered and no one factor is dispositive.

Employer means a person, firm, corporation or other association or organization that:

(1) Has a place of business (physical location) in the U.S. and a means by which it may be contacted for employment;

(2) Has an employer relationship with respect to H–2A employees or related U.S. workers under this subpart; and

(3) Possesses, for purposes of filing an *Application for Temporary Employment Certification*, a valid Federal Employer Identification Number (FEIN).

Employment Standards Administration (ESA) means the agency within DOL that includes the Wage and Hour Division (WHD), and which is charged with carrying out certain investigative and enforcement functions of the Secretary under the INA.

Employment Service (ES) refers to the system of Federal and State entities responsible for administration of the labor certification process for temporary and seasonal agricultural employment of nonimmigrant foreign workers. This includes the SWAs and the OFLC, including the NPCs.

Employment and Training Administration (ETA) means the agency within the DOL that includes OFLC.

Federal holiday means a legal public holiday as defined at 5 U.S.C. 6103.

Fixed-site employer means any person engaged in agriculture who meets the definition of an employer as those terms are defined in this subpart who owns or operates a farm, ranch, processing establishment, cannery, gin, packing shed, nursery, or other similar fixed-site location where agricultural activities are performed and who recruits, solicits, hires, employs, houses, or transports any worker subject to sec. 218 of the INA or these regulations as incident to or in conjunction with the owner's or operator's own agricultural operation. For purposes of this subpart, *person* includes any individual, partnership, association, corporation, cooperative, joint stock company, trust, or other organization with legal rights and duties.

H–2A Labor Contractor (H–2ALC) means any person who meets the definition of employer under this paragraph (c) of this section and is not a fixed-site employer, an agricultural association, or an employee of a fixed-site employer or agricultural association, as those terms are used in this part, who recruits, solicits, hires, employs, furnishes, houses, or transports any worker subject to sec. 218 of the INA or these regulations.

H–2A worker means any temporary foreign worker who is lawfully present in the U.S. to perform agricultural labor or services of a temporary or seasonal nature pursuant to sec. 101(a)(15)(H)(ii)(a) of the INA, as amended.

INA means the Immigration and Nationality Act, as amended, 8 U.S.C. 1101 *et seq*.

Job offer means the offer made by an employer or potential employer of H–2A workers to eligible workers describing all the material terms and conditions of employment, including those relating to wages, working conditions, and other benefits.

Job opportunity means a job opening for temporary, full-time employment at a place in the U.S. to which a U.S. worker can be referred.

Joint employment means that where two or more employers each have sufficient definitional indicia of employment to be considered the employer of an employee, those employers will be considered to jointly employ that employee. Each employer in a joint employment relationship to an employee is considered a joint employer of that employee.

Occupational Safety and Health Administration (OSHA) means the organizational component of the Department that assures the safety and health of America's workers by setting and enforcing standards; providing training, outreach, and education; establishing

partnerships; and encouraging continual improvement in workplace safety and health under the Occupational Safety and Health Act, as amended.

Office of Foreign Labor Certification (OFLC) means the organizational component of the ETA that provides national leadership and policy guidance and develops regulations and procedures to carry out the responsibilities of the Secretary under the INA concerning the admission of foreign workers to the U.S. to perform work described in sec. 101(a)(15)(H)(ii)(a) of the INA, as amended.

Positive recruitment means the active participation of an employer or its authorized hiring agent in recruiting and interviewing qualified and eligible individuals in the area where the employer's job opportunity is located and any other State designated by the Secretary as an area of traditional or expected labor supply with respect to the area where the employer's job opportunity is located, in an effort to fill specific job openings with U.S. workers.

Prevailing means, with respect to practices engaged in by employers and benefits other than wages provided by employers, that:

(1) Fifty percent or more of employers in an area and for an occupation engage in the practice or offer the benefit; but only if

(2) This 50 percent or more of employers also employs in aggregate 50 percent or more of U.S. workers in the occupation and area (including H–2A and non-H–2A employers for purposes of determinations concerning the provision of family housing, frequency of wage payments, and workers supplying their own bedding, but non-H–2A employers only for determinations concerning the provision of advance transportation).

Prevailing piece rate means that amount that is typically paid to an agricultural worker per piece (which includes, but is not limited to, a load, bin, pallet, bag, bushel, etc.), to be determined by the SWA according to a methodology published by the Department. As is currently the case, the unit of production will be required to be clearly described; e.g., a field box of oranges (1½ bushels), a bushel of potatoes, and Eastern apple box (1½ metric bushels), a flat of strawberries (twelve quarts), etc.

Prevailing hourly wage means the hourly wage determined by the SWA to be prevailing in the area in accordance with State-based wage surveys.

Representative means a person or entity employed by, or duly authorized to act on behalf of, the employer with respect to activities entered into for, and/or attestations made with respect to, the *Application for Temporary Employment Certification*.

Secretary means the Secretary of the United States Department of Labor, or the Secretary's designee.

Secretary of Homeland Security means the chief official of the United States Department of Homeland Security (DHS) or the Secretary of Homeland Security's designee.

Secretary of State means the chief official of the United States Department of State (DOS) or the Secretary of State's designee.

State Workforce Agency (SWA) means the State government agency that receives funds pursuant to the Wagner-Peyser Act to administer the public labor exchange delivered through the State's One-Stop delivery system in accordance with the Wagner-Peyser Act at 29 U.S.C. 49 *et seq*. Separately, SWAs receive ETA grants, administered by OFLC, to assist them in performing certain activities related to foreign labor certification, including conducting housing inspections.

Strike means a labor dispute wherein employees engage in a concerted stoppage of work (including stoppage by reason of the expiration of a collective-bargaining agreement) or engage in any concerted slowdown or other concerted interruption of operation. Whether a job opportunity is vacant by reason of a strike or lock out will be determined by evaluating for each position identified as vacant in the *Application for Temporary Employment Certification* whether the specific vacancy has been caused by the strike or lock out.

Successor in interest means that, in determining whether an employer is a successor in interest, the factors used under Title VII of the Civil Rights Act

and the Vietnam Era Veterans' Readjustment Assistance Act will be considered. When considering whether an employer is a successor for purposes of § 655.118, the primary consideration will be the personal involvement of the firm's ownership, management, supervisors, and others associated with the firm in the violations resulting in a debarment recommendation. Normally, wholly new management or ownership of the same business operation, one in which the former management or owner does not retain a direct or indirect interest, will not be deemed to be a successor in interest for purposes of debarment. A determination of whether or not a successor in interest exists is based on the entire circumstances viewed in their totality. The factors to be considered include:

(1) Substantial continuity of the same business operations;

(2) Use of the same facilities;

(3) Continuity of the work force;

(4) Similarity of jobs and working conditions;

(5) Similarity of supervisory personnel;

(6) Similarity in machinery, equipment, and production methods;

(7) Similarity of products and services; and

(8) The ability of the predecessor to provide relief.

Temporary agricultural labor certification means the certification made by the Secretary with respect to an employer seeking to file with DHS a visa petition to employ one or more foreign nationals as an H–2A worker, pursuant to secs. 101(a)(15)(H)(ii)(a), 214(a) and (c), and 218 of the INA that:

(1) There are not sufficient workers who are able, willing, and qualified, and who will be available at the time and place needed, to perform the agricultural labor or services involved in the petition, and

(2) The employment of the foreign worker in such agricultural labor or services will not adversely affect the wages and working conditions of workers in the U.S. similarly employed (8 U.S.C. 1101(a)(15)(H)(ii)(a), 1184(a) and (c), and 1188).

United States (U.S.), when used in a geographic sense, means the continental United States, Alaska, Hawaii, the Commonwealth of Puerto Rico, and the territories of Guam, the Virgin Islands, and, as of the transition program effective date, as defined in the Consolidated Natural Resources Act of 2008, Public Law 110–229, Title VII, the Commonwealth of the Northern Mariana Islands.

United States Citizenship and Immigration Services (USCIS) means the Federal agency making the determination under the INA whether to grant petitions filed by employers seeking H–2A workers to perform temporary agricultural work in the U.S.

United States worker (U.S. worker) means a worker who is

(1) A citizen or national of the U.S., or

(2) An alien who is lawfully admitted for permanent residence in the U.S., is admitted as a refugee under sec. 207 of the INA, is granted asylum under sec. 208 of the INA, or is an immigrant otherwise authorized (by the INA or by DHS) to be employed in the U.S.

Wages means all forms of cash remuneration to a worker by an employer in payment for personal services.

Within [number and type] days means, for purposes of determining an employer's compliance with the timing requirements for appeals and requests for review, a period that begins to run on the first business day after the Department sends a notice to the employer by means normally assuring next-day delivery, and will end on the day that the employer sends whatever communication is required by these rules back to the Department, as evidenced by a postal mark or other similar receipt.

Work contract means all the material terms and conditions of employment relating to wages, hours, working conditions, and other benefits, required by the applicable regulations in Subpart B of 20 CFR part 655, *Labor Certification for Temporary Agricultural Employment of H–2A Aliens in the U.S. (H–2A Workers),* or these regulations, including those terms and conditions attested to by the H–2A employer, which contract between the employer and the worker may be in the form of a separate written document. In the absence of a separate written work contract incorporating the required terms and conditions of employment, agreed to by both

the employer and the worker, the work contract at a minimum shall be the terms of the job order, as provided in 20 CFR part 653, Subpart F, and covered provisions of the work contract shall be enforced in accordance with these regulations.

(d) *Definition of agricultural labor or services of a temporary or seasonal nature.* For the purposes of this subpart means the following:

(1) *Agricultural labor or services*, pursuant to sec. 101(a)(15)(H)(ii)(a) of the INA at 8 U.S.C. 1101(a)(15)(H)(ii)(a), is defined as:

(i) Agricultural labor as defined and applied in sec. 3121(g) of the Internal Revenue Code of 1954 at 26 U.S.C. 3121(g);

(ii) Agriculture as defined and applied in sec. 3(f) of the Fair Labor Standards Act of 1938 (FLSA) at 29 U.S.C. 203(f). Work performed by H–2A workers, or workers in corresponding employment, that is not defined as agriculture in sec. 3(f) is subject to the provisions of the FLSA as provided therein, including the overtime provisions in sec. 7(a) 29 U.S.C. 207(a);

(iii) The pressing of apples for cider on a farm;

(iv) Logging employment; or

(v) Handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity while in the employ of the operator of a farm where no H–2B workers are employed to perform the same work at the same establishment; or

(vi) Other work typically performed on a farm that is not specifically listed on the *Application for Temporary Employment Certification* and is minor (*i.e.*, less than 20 percent of the total time worked on the job duties and activities that are listed on the *Application for Temporary Employment Certification*) and incidental to the agricultural labor or services for which the H–2A worker was sought.

(2) An occupation included in either of the statutory definitions cited in paragraphs (d)(1)(i) and (ii) of this section is *agricultural labor or services*, notwithstanding the exclusion of that occupation from the other statutory definition.

(i) *Agricultural labor.* For purposes of paragraph (d)(1)(i) of this section means all services performed:

(A) On a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and furbearing animals and wildlife;

(B) In the employ of the owner or tenant or other operator of a farm, in connection with the operation or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm;

(C) In connection with the production or harvesting of any commodity defined as an agricultural commodity in sec. 15(g) of the Agricultural Marketing Act, as amended at 12 U.S.C. 1141j, or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes;

(D)(*1*) In the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity, but only if such operator produced more than one-half of the commodity with respect to which such service is performed;

(*2*) In the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in paragraph (d)(2)(i)(D)(*1*) of this section, but only if such operators produced all of the commodity with respect to which such service is performed. For purposes of this paragraph, any unincorporated group of operators will be deemed a cooperative organization if the number of operators comprising such group is more than 20 at any time during the

calendar quarter in which such service is performed;

(*3*) The provisions of paragraphs (d)(2)(i)(D)(*1*) and (*2*) of this section do not apply to services performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption; or

(*4*) On a farm operated for profit if such service is not in the course of the employer's trade or business and is not domestic service in a private home of the employer.

(E) For purposes of (d)(2)(i) of this section, the term farm includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards. See sec. 3121(g) of the Internal Revenue Code of 1986 at 26 U.S.C. 3121(g).

(ii) *Agriculture*. For purposes of paragraph (d)(1)(ii) of this section agriculture means farming in all its branches and among other things includes the cultivation and tillage of the soil, dairying, the production, cultivation, growing, and harvesting of any agricultural or horticultural commodities (including commodities as defined as agricultural commodities in 12 U.S.C. 1141j(g)), the raising of livestock, bees, fur-bearing animals, or poultry, and any practices (including any forestry or lumbering operations) performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market. See 29 U.S.C. 203(f), as amended.

(iii) *Agricultural commodity*. For purposes of paragraph (d)(2)(ii) of this section agricultural commodity includes, in addition to other agricultural commodities, crude gum (oleoresin) from a living tree, and gum spirits of turpentine and gum rosin as processed by the original producer of the crude gum (oleoresin) from which derived. *Gum spirits of turpentine* means spirits of turpentine made from gum (oleoresin) from a living tree and *gum rosin* means rosin remaining after the distillation of gum spirits of turpentine. See 12 U.S.C. 1141j(g), sec. 15(g) of the Agricultural Marketing Act, as amended, and 7 U.S.C. 92.

(3) *Of a temporary or seasonal nature*—(i) *On a seasonal or other temporary basis*. For the purposes of this subpart, of a temporary or seasonal nature means on a seasonal or other temporary basis, as defined in the WHD's regulation at 29 CFR 500.20 under the Migrant and Seasonal Agricultural Worker Protection Act (MSPA).

(ii) *MSPA definition*. The definition of *on a seasonal or other temporary basis* found in MSPA is summarized as follows:

(A) Labor is performed on a seasonal basis where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year. A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though the worker may continue to be employed during a major portion of the year.

(B) A worker is employed on other temporary basis where he or she is employed for a limited time only or the worker's performance is contemplated for a particular piece of work, usually of short duration. Generally, employment which is contemplated to continue indefinitely is not temporary.

(C) On a seasonal or other temporary basis does not include (i) the employment of any foreman or other supervisory employee who is employed by a specific agricultural employer or agricultural association essentially on a year round basis; or (ii) the employment of any worker who is living at his or her permanent place of residence, when that worker is employed by a specific agricultural employer or agricultural association on essentially a year round basis to perform a variety of tasks for his or her employer and is not primarily employed to do field work.

(iii) *Temporary.* For the purposes of this subpart, the definition of ''temporary'' in paragraph (d)(3) of this section refers to any job opportunity covered by this subpart where the employer needs a worker for a position for a limited period of time, including, but not limited to, a peakload need, which is generally less than 1 year, unless the original temporary agricultural labor certification is extended pursuant to § 655.110.

[73 FR 77207, Dec. 18, 2008, as amended at 74 FR 17601, Apr. 16, 2009]

§ 655.1301 Applications for temporary employment certification in agriculture.

(a) *Application filing requirements.* (1) An employer that desires to apply for temporary employment certification of one or more nonimmigrant foreign workers must file a completed DOL *Application for Temporary Employment Certification* form and, unless a specific exemption applies, the initial recruitment report. If an association of agricultural producers files the application, the association must identify whether it is the sole employer, a joint employer with its employer-member employers, or the agent of its employer-members. The association must retain documentation substantiating the employer or agency status of the association and be prepared to submit such documentation to the CO in the event of an audit.

(2) If an H–2ALC intends to file an application, the H–2ALC must meet all of the requirements of the definition of employer in § 655.100(b), and comply with all the assurances, guarantees, and other requirements contained in this part and in part 653, subpart F, of this chapter. The H–2ALC must have a place of business (physical location) in the U.S. and a means by which it may be contacted for employment. H–2A workers employed by an H–2ALC may not perform services for a fixed-site employer unless the H–2ALC is itself providing the housing and transportation required by § 655.104(d) and (h), or has filed a statement confirming that the fixed-site employer will provide compliant housing and/or transportation, as required by § 655.106, with the OFLC, for each fixed-site employer listed on the application. The H–2ALC must retain a copy of the statement of compliance required by § 655.106(b)(6).

(3) An association of agricultural producers may submit a master application covering a variety of job opportunities available with a number of employers in multiple areas of intended employment, just as though all of the covered employers were in fact a single employer, as long as a single date of need is provided for all workers requested by the application and the combination of job opportunities is supported by an explanation demonstrating a business reason for the combination. The association must identify on the *Application for Temporary Employment Certification,* by name and address, each employer that will employ H–2A workers. If the association is acting solely as an agent, each employer will receive a separate labor certification.

(b) *Filing.* The employer may send the *Application for Temporary Employment Certification* and all supporting documentation by U.S. Mail or private mail courier to the NPC. The Department will publish a Notice in the FEDERAL REGISTER identifying the address(es), and any future address changes, to which applications must be mailed, and will also post these addresses on the DOL Internet Web site at *http://www.foreignlaborcert.doleta.gov/.* The form must bear the original signature of the employer (and that of the employer's authorized attorney or agent if the employer is represented by an attorney or agent). An association filing a master application as a joint employer may sign on behalf of its employer members. The Department may also require applications to be filed electronically in addition to or instead of by mail.

(c) *Timeliness.* A completed *Application for Temporary Employment Certification* must be filed no less than 45 calendar days before date of need.

(d) *Emergency situations*—(1) *Waiver of time period and required pre-filing activity.* The CO may waive the time period for filing and pre-filing wage and recruitment requirements set forth in § 655.102, along with their associated attestations, for employers who did not

make use of temporary alien agricultural workers during the prior year's agricultural season or for any employer that has other good and substantial cause (which may include unforeseen changes in market conditions), provided that the CO can timely make the determinations required by § 655.109(b).

(2) *Employer requirements.* The employer requesting a waiver of the required time period and pre-filing wage and recruitment requirements must submit to the NPC a completed *Application for Temporary Employment Certification*, a completed job offer on the ETA Form 790 *Agricultural and Food Processing Clearance Order*, and a statement justifying the request for a waiver of the time period requirement. The statement must indicate whether the waiver request is due to the fact that the employer did not use H–2A workers during the prior agricultural season or whether the request is for other good and substantial cause. If the waiver is requested for good and substantial cause, the employer's statement must also include detailed information describing the good and substantial cause which has necessitated the waiver request. Good and substantial cause may include, but is not limited to, such things as the substantial loss of U.S. workers due to weather-related activities or other reasons, unforeseen events affecting the work activities to be performed, pandemic health issues, or similar conditions.

(3) *Processing of applications.* The CO shall promptly transmit the job order, on behalf of the employer, to the SWA serving the area of intended employment and request an expedited review of the job order in accordance with § 655.102(e) and an inspection of housing in accordance with § 655.104(d)(6)(iii). The CO shall process the application and job order in accordance with § 655.107, issue a wage determination in accordance with § 655.108 and, upon acceptance, require the employer to engage in positive recruitment consistent with § 655.102(d)(2), (3), and (4). The CO shall require the SWA to transmit the job order for interstate clearance consistent with § 655.102(f). The CO shall specify a date on which the employer will be required to submit a recruitment report in accordance with § 655.102(k). The CO will make a determination on the application in accordance with § 655.109.

§ 655.1302 Required pre-filing activity.

(a) *Time of filing of application.* An employer may not file an *Application for Temporary Employment Certification* before all of the pre-filing recruitment steps set forth in this section have been fully satisfied, except where specifically exempted from some or all of those requirements by these regulations. Modifications to these requirements for H–2ALCs are set forth in § 655.106.

(b) *General attestation obligation.* An employer must attest on the *Application for Temporary Employment Certification* that it will comply with all of the assurances and obligations of this subpart and to performing all necessary steps of the recruitment process as specified in this section.

(c) *Retention of documentation.* An employer filing an *Application for Temporary Employment Certification* must maintain documentation of its advertising and recruitment efforts as required in this subpart and be prepared to submit this documentation in response to a Notice of Deficiency from the CO prior to the CO rendering a Final Determination, or in the event of an audit. The documentation required in this subpart must be retained for a period of no less than 3 years from the date of the certification. There is no record retention requirement for any application (and supporting documentation) after the Secretary has made a final decision to deny the application.

(d) *Positive recruitment steps.* An employer filing an application must:

(1) Submit a job order to the SWA serving the area of intended employment;

(2) Run two print advertisements (one of which must be on a Sunday, except as provided in paragraph (g) of this section);

(3) Contact former U.S. employees who were employed within the last year as described in paragraph (h) of this section; and

(4) Based on an annual determination made by the Secretary, as described in

paragraph (i) of this section, recruit in all States currently designated as a State of traditional or expected labor supply with respect to each area of intended employment in which the employer's work is to be performed as required in paragraph (i)(2) of this section.

(e) *Job order.* (1) The employer must submit a job order to the SWA serving the area of intended employment no more than 75 calendar days and no fewer than 60 calendar days before the date of need for intrastate and interstate clearance, identifying it as a job order to be placed in connection with a future application for H–2A workers. If the job opportunity is located in more than one State, the employer may submit a job order to any one of the SWAs having jurisdiction over the anticipated worksites. Where a future master application will be filed by an association of agricultural employers, the SWA will prepare a single job order in the name of the association on behalf of all employers that will be duly named on the *Application for Temporary Employment Certification.* Documentation of this step by the applicant is satisfied by maintaining proof of posting from the SWA identifying the job order number(s) with the start and end dates of the posting of the job order.

(2) The job order submitted to the SWA must satisfy all the requirements for newspaper advertisements contained in § 655.103 and comply with the requirements for agricultural clearance orders in 20 CFR part 653 Subpart F and the requirements set forth in § 655.104.

(3) The SWA will review the contents of the job order as provided in 20 CFR part 653 Subpart F and will work with the employer to address any deficiencies, except that the order may be placed prior to completion of the housing inspection required by 20 CFR 653.501(d)(6) where necessary to meet the timeframes required by statute and regulation. However, the SWA must ensure that housing within its jurisdiction is inspected as expeditiously as possible thereafter. Any issue with regard to whether a job order may properly be placed in the job service system that cannot be resolved with the applicable SWA may be brought to the attention of the NPC, which may direct that the job order be placed in the system where the NPC determines that the applicable program requirements have been met. If the NPC concludes that the job order is not acceptable, it shall so inform the employer using the procedures applicable to a denial of certification set forth in § 655.109(e).

(f) *Intrastate/Interstate recruitment.* (1) Upon receipt and acceptance of the job order, the SWA must promptly place the job order in intrastate clearance on its active file and begin recruitment of eligible U.S. workers. The SWA receiving the job order under paragraph (e) of this section will promptly transmit, on behalf of the employer, a copy of its active job order to all States listed in the job order as anticipated worksites. The SWA must also transmit a copy of all active job orders to no fewer than three States, which must include those States, if any, designated by the Secretary as traditional or expected labor supply States (''out-of-State recruitment States'') for the area of intended employment in which the employer's work is to be performed as defined in paragraph (i) of this section.

(2) Unless otherwise directed by the CO, the SWA must keep the job order open for interstate clearance until the end of the recruitment period, as set forth in § 655.102(f)(3). Each of the SWAs to which the job order was referred must keep the job order open for that same period of time and must refer each eligible U.S. worker who applies (or on whose behalf an application is made) for the job opportunity.

(3)(i) For the first 5 years after the effective date of this rule, the recruitment period shall end 30 days after the first date the employer requires the services of the H–2A workers, or on the last day the employer requires the services of H–2A workers in the applicable area of intended employment, whichever is sooner (the 30-day rule). During that 5-year period, the Department will endeavor to study the costs and benefits of providing for continuing recruitment of U.S. workers after the H–2A workers have already entered the country. Unless prior to the expiration of the 5-year period the Department conducts a study and publishes a notice determining that the

economic benefits of such extended recruitment period outweigh its costs, the recruitment period will, after the expiration of the 5-year period, end on the first date the employer requires the services of the H–2A worker.

(ii) *Withholding of U.S. workers prohibited.* The provisions of this paragraph shall apply so as long as the 30-day rule is in place.

(A) *Complaints.* Any employer who has reason to believe that a person or entity has willfully and knowingly withheld U.S. workers prior to the arrival at the job site of H–2A workers in order to force the hiring of U.S. workers during the 30-day rule under paragraph (f)(3)(i) of this section may submit a written complaint to the CO. The complaint must clearly identify the person or entity who the employer believes has withheld the U.S. workers, and must specify sufficient facts to support the allegation (e.g., dates, places, numbers and names of U.S. workers) which will permit an investigation to be conducted by the CO.

(B) *Investigations.* The CO must immediately investigate the complaint. The investigation must include interviews with the employer who has submitted the complaint, the person or entity named as responsible for withholding the U.S. workers, and the individual U.S. workers whose availability has purportedly been withheld.

(C) *Written findings.* Where the CO determines, after conducting the interviews required by this paragraph, that the employer's complaint is valid and justified, the CO shall immediately suspend the application of the 30-day rule under paragraph (f)(3)(i) of this section to the employer. The CO's determination shall be the final decision of the Secretary.

(g) *Newspaper advertisements.* (1) During the period of time that the job order is being circulated by the SWA(s) for interstate clearance under paragraph (f) of this section, the employer must place an advertisement on 2 separate days, which may be consecutive, one of which must be a Sunday (except as provided in paragraph (g)(2) of this section), in a newspaper of general circulation serving the area of intended employment that has a reasonable distribution and is appropriate to the occupation and the workers likely to apply for the job opportunity. Both newspaper advertisements must be published only after the job order is accepted by the SWA for intrastate/interstate clearance.

(2) If the job opportunity is located in a rural area that does not have a newspaper with a Sunday edition, the employer must, in place of a Sunday edition, advertise in the regularly published daily edition with the widest circulation in the area of intended employment.

(3) The newspaper advertisements must satisfy the requirements of §§ 655.103 and 655.104. The employer must maintain copies of newspaper pages (with date of publication and full copy of ad), or tear sheets of the pages of the publication in which the advertisements appeared, or other proof of publication containing the text of the printed advertisements and the dates of publication furnished by the newspaper.

(4) If a professional, trade or ethnic publication is more appropriate for the occupation and the workers likely to apply for the job opportunity than a general circulation newspaper, and is the most likely source to bring responses from able, willing, qualified, and available U.S. workers, the employer may use a professional, trade or ethnic publication in place of one of the newspaper advertisements, but may not replace the Sunday advertisement (or the substitute required by paragraph (g)(2) of this section).

(h) *Contact with former U.S. employees.* The employer must contact by mail or other effective means its former U.S. employees (except those who were dismissed for cause, abandoned the worksite, or were provided documentation at the end of their previous period of employment explaining the lawful, job-related reasons they would not be re-contacted) employed by the employer in the occupation at the place of employment during the previous year and solicit their return to the job. The employer must maintain copies of correspondence signed and dated by the employer or, if other means are used, maintain dated logs demonstrating

that each worker was contacted, including the phone number, e-mail address, or other means that was used to make contact. The employer must list in the recruitment report any workers who did not return to the employ of the employer because they were either unable or unwilling to return to the job or did not respond to the employer's request, and must retain documentation, if provided by the worker, showing evidence of their inability, unwillingness, or non-responsiveness.

(i) *Additional positive recruitment.* (1) Each year, the Secretary will make a determination with respect to each State whether there are other States (''traditional or expected labor supply States'') in which there are a significant number of able and qualified workers who, if recruited, would be willing to make themselves available for work in that State, as well as which newspapers in each traditional or expected labor supply State that the employer may use to fulfill its obligation to run a newspaper advertisement in that State. Such determination must be based on information provided by State agencies or by other sources within the 120 days preceding the determination (which will be solicited by notice in the FEDERAL REGISTER), and will to the extent information is available take into account the success of recent efforts by out-of-State employers to recruit in that State. The Secretary will not designate a State as a traditional or expected labor supply State if the State has a significant number of employers that are recruiting for U.S. workers for the same types of occupations and comparable work. The Secretary's annual determination as to traditional or expected labor supply States, if any, from which applicants from each State must recruit will be published in the FEDERAL REGISTER and made available through the ETA Web site.

(2) Each employer must engage in positive recruitment in those States designated in accordance with paragraph (i)(1) with respect to the State in which the employer's work is to be performed. Such recruitment will consist of one newspaper advertisement in each State in one of the newspapers designated by the Secretary, published within the same period of time as the newspaper advertisements required under paragraph (g) of this section. An employer will not be required to conduct positive recruitment in more than three States designated in accordance with paragraph (i)(1) for each area of intended employment listed on the employer's application. The advertisement must refer applicants to the SWA nearest the area in which the advertisement was placed.

(j) *Referrals of U.S. workers.* SWAs may only refer for employment individuals for whom they have verified identity and employment authorization through the process for employment verification of all workers that is established by INA sec. 274A(b). SWAs must provide documentation certifying the employment verification that satisfies the standards of INA sec. 274A(a)(5) and its implementing regulations at 8 CFR 274a.6.

(k) *Recruitment report.* (1) No more than 50 days before the date of need the employer must prepare, sign, and date a written recruitment report. The recruitment report must be submitted with the *Application for Temporary Employment Certification.* The recruitment report must:

(i) List the original number of openings for which the employer recruited;

(ii) Identify each recruitment source by name;

(iii) State the name and contact information of each U.S. worker who applied or was referred to the job opportunity up to the date of the preparation of the recruitment report, and the disposition of each worker;

(iv) Confirm that former employees were contacted and by what means; and

(v) If applicable, explain the lawful job-related reason(s) for not hiring any U.S. workers who applied for the position.

(2) The employer must update the recruitment report within 48 hours of the date that is the end of the recruitment period as specified in § 655.102(f)(3). This supplement to the recruitment report must meet the requirements of paragraph (k)(1) of this section. The employer must sign and date this supplement to the recruitment report and retain it for a period of no less than 3

years. The supplement to the recruitment report must be provided in the event of an audit.

(3) The employer must retain resumes (if provided) of, and evidence of contact with (which may be in the form of an attestation), each U.S. worker who applied or was referred to the job opportunity. Such resumes and evidence of contact must be retained along with the recruitment report and the supplemental recruitment report for a period of no less than 3 years, and must be provided in response to a Notice of Deficiency or in the event of an audit.

§ 655.1303 Advertising requirements.

All advertising conducted to satisfy the required recruitment steps under § 655.102 before filing the *Application for Temporary Employment Certification* must meet the requirements set forth in this section and at § 655.104 and must contain terms and conditions of employment which are not less favorable than those that will be offered to the H–2A workers. All advertising must contain the following information:

(a) The employer's name and location(s) of work, or in the event that a master application will be filed by an association, a statement indicating that the name and location of each member of the association can be obtained from the SWA of the State in which the advertisement is run;

(b) The geographic area(s) of employment with enough specificity to apprise applicants of any travel requirements and where applicants will likely have to reside to perform the services or labor;

(c) A description of the job opportunity for which certification is sought with sufficient information to apprise U.S. workers of services or labor to be performed and the anticipated period of employment of the job opportunity;

(d) The wage offer, or in the event that there are multiple wage offers (such as where a master application will be filed by an association and/or where there are multiple crop activities for a single employer), the range of applicable wage offers and, where a master application will be filed by an association, a statement indicating that the rate(s) applicable to each employer can be obtained from the SWA;

(e) The three-fourths guarantee specified in § 655.104(i);

(f) If applicable, a statement that work tools, supplies, and equipment will be provided at no cost to the worker;

(g) A statement that housing will be made available at no cost to workers, including U.S. workers, who cannot reasonably return to their permanent residence at the end of each working day;

(h) If applicable, a statement that transportation and subsistence expenses to the worksite will be provided by the employer;

(i) A statement that the position is temporary and a specification of the total number of job openings the employer intends to fill;

(j) A statement directing applicants to report or send resumes to the SWA of the State in which the advertisement is run for referral to the employer;

(k) Contact information for the applicable SWA and the job order number.

§ 655.1304 Contents of job offers.

(a) *Preferential treatment of aliens prohibited.* The employer's job offer must offer to U.S. workers no less than the same benefits, wages, and working conditions that the employer is offering, intends to offer, or will provide to H–2A workers. Except where otherwise permitted under this section, no job offer may impose on U.S. workers any restrictions or obligations that will not be imposed on the employer's H–2A workers.

(b) *Job qualifications.* Each job qualification listed in the job offer must not substantially deviate from the normal and accepted qualifications required by employers that do not use H–2A workers in the same or comparable occupations and crops.

(c) *Minimum benefits, wages, and working conditions.* Every job offer accompanying an H–2A application must include each of the minimum benefit, wage, and working condition provisions listed in paragraphs (d) through (q) of this section.

(d) *Housing*—(1) *Obligation to provide housing.* The employer must provide housing at no cost to the worker, except for those U.S. workers who are reasonably able to return to their permanent residence at the end of the work day. Housing must be provided through one of the following means:

(i) *Employer-provided housing.* Employer-provided housing that meets the full set of DOL OSHA standards set forth at 29 CFR 1910.142, or the full set of standards at §§ 654.404 through 654.417 of this chapter, whichever are applicable under § 654.401; or

(ii) *Rental and/or public accommodations.* Rental or public accommodations or other substantially similar class of habitation that meets applicable local standards for such housing. In the absence of applicable local standards, State standards will apply. In the absence of applicable local or State standards, DOL OSHA standards at 29 CFR 1910.142 will apply. Any charges for rental housing must be paid directly by the employer to the owner or operator of the housing. The employer must document that the housing complies with the local, State, or Federal housing standards. Such documentation may include but is not limited to a certificate from a State Department of Health or other State or local agency or a statement from the manager or owner of the housing.

(2) *Standards for range housing.* Housing for workers principally engaged in the range production of livestock shall meet standards of DOL OSHA for such housing. In the absence of such standards, range housing for sheepherders and other workers engaged in the range production of livestock must meet guidelines issued by ETA.

(3) *Deposit charges.* Charges in the form of deposits for bedding or other similar incidentals related to housing must not be levied upon workers. However, employers may require workers to reimburse them for damage caused to housing, bedding, or other property by the individual workers found to have been responsible for damage which is not the result of normal wear and tear related to habitation.

(4) *Charges for public housing.* If public housing provided for migrant agricultural workers under the auspices of a local, county, or State government is secured by the employer, the employer must pay any charges normally required for use of the public housing units (but need not pay for optional, extra services) directly to the housing's management.

(5) *Family housing.* When it is the prevailing practice in the area of intended employment and the occupation to provide family housing, family housing must be provided to workers with families who request it.

(6) *Housing inspection.* In order to ensure that the housing provided by an employer under this section meets the relevant standard:

(i) An employer must make the required attestation, which may include an attestation that the employer is complying with the procedures set forth in § 654.403, at the time of filing the *Application for Temporary Employment Certification* pursuant to § 655.105(e)(2).

(ii) The employer must make a request to the SWA for a housing inspection no less than 60 days before the date of need, except where otherwise provided under this part.

(iii) The SWA must make its determination that the housing meets the statutory criteria applicable to the type of housing provided prior to the date on which the Secretary is required to make a certification determination under INA sec. 218(c)(3)(A), which is 30 days before the employer's date of need. SWAs must not adopt rules or restrictions on housing inspections that unreasonably prevent inspections from being completed in the required time frame, such as rules that no inspections will be conducted where the housing is already occupied or is not yet leased. If the employer has attested to and met all other criteria for certification, and the employer has made a timely request for a housing inspection under this paragraph, and the SWA has failed to complete a housing inspection by the statutory deadline of 30 days prior to date of need, the certification will not be withheld on account of the SWA's failure to meet the statutory deadline. The SWA must in such cases inspect the housing prior to or during

occupation to ensure it meets applicable housing standards. If, upon inspection, the SWA determines the supplied housing does not meet the applicable housing standards, the SWA must promptly provide written notification to the employer and the CO. The CO will take appropriate action, including notice to the employer to cure deficiencies. An employer's failure to cure substantial violations can result in revocation of the temporary labor certification.

(7) *Certified housing that becomes unavailable.* If after a request to certify housing (but before certification), or after certification of housing, such housing becomes unavailable for reasons outside the employer's control, the employer may substitute other rental or public accommodation housing that is in compliance with the local, State, or Federal housing standards applicable under paragraph (d)(1)(ii) of this section and for which the employer is able to submit evidence of such compliance. The employer must notify the SWA in writing of the change in accommodations and the reason(s) for such change and provide the SWA evidence of compliance with the applicable local, State or Federal safety and health standards, in accordance with the requirements of paragraph (d)(1)(ii) of this section. The SWA must notify the CO of all housing changes and of any noncompliance with the standards set forth in paragraph (d)(1)(ii) of this section. Substantial noncompliance can result in revocation of the temporary labor certification under § 655.117.

(e) *Workers' compensation.* The employer must provide workers' compensation insurance coverage in compliance with State law covering injury and disease arising out of and in the course of the worker's employment. If the type of employment for which the certification is sought is not covered by or is exempt from the State's workers' compensation law, the employer must provide, at no cost to the worker, insurance covering injury and disease arising out of and in the course of the worker's employment that will provide benefits at least equal to those provided under the State workers' compensation law for other comparable employment. The employer must retain for 3 years from the date of certification of the application, the name of the insurance carrier, the insurance policy number, and proof of insurance for the dates of need, or, if appropriate, proof of State law coverage.

(f) *Employer-provided items.* Except as provided in this paragraph, the employer must provide to the worker, without charge or deposit charge, all tools, supplies, and equipment required to perform the duties assigned. The employer may charge the worker for reasonable costs related to the worker's refusal or negligent failure to return any property furnished by the employer or due to such worker's willful damage or destruction of such property. Where it is a common practice in the particular area, crop activity and occupation for workers to provide tools and equipment, with or without the employer reimbursing the workers for the cost of providing them, such an arrangement will be permitted, provided that the requirements of sec. 3(m) of the FLSA at 29 U.S.C. 203(m) are met. Section 3(m) does not permit deductions for tools or equipment primarily for the benefit of the employer that reduce an employee's wage below the wage required under the minimum wage, or, where applicable, the overtime provisions of the FLSA.

(g) *Meals.* The employer either must provide each worker with three meals a day or must furnish free and convenient cooking and kitchen facilities to the workers that will enable the workers to prepare their own meals. Where the employer provides the meals, the job offer must state the charge, if any, to the worker for such meals. The amount of meal charges is governed by § 655.114.

(h) *Transportation; daily subsistence—*(1) *Transportation to place of employment.* If the employer has not previously advanced such transportation and subsistence costs to the worker or otherwise provided such transportation or subsistence directly to the worker by other means and if the worker completes 50 percent of the work contract period, the employer must pay the worker for reasonable costs incurred by the worker for transportation and daily subsistence from the place from

which the worker has departed to the employer's place of employment. For an H–2A worker coming from outside of the U.S., the place from which the worker has departed is the place of recruitment, which the Department interprets to mean the appropriate U.S. consulate or port of entry. When it is the prevailing practice of non-H–2A agricultural employers in the occupation in the area to do so, or when the employer extends such benefits to similarly situated H–2A workers, the employer must advance the required transportation and subsistence costs (or otherwise provide them) to U.S. workers. The amount of the transportation payment must be no less (and is not required to be more) than the most economical and reasonable common carrier transportation charges for the distances involved. The amount of the daily subsistence payment must be at least as much as the employer would charge the worker for providing the worker with three meals a day during employment (if applicable), but in no event less than the amount permitted under paragraph (g) of this section.

(2) *Transportation from last place of employment to home country.* If the worker completes the work contract period, and the worker has no immediately subsequent H–2A employment, the employer must provide or pay for the worker's transportation and daily subsistence from the place of employment to the place from which the worker, disregarding intervening employment, departed to work for the employer. For an H–2A worker coming from outside of the U.S., the place from which the worker has departed will be considered to be the appropriate U.S. consulate or port of entry.

(3) *Transportation between living quarters and worksite.* The employer must provide transportation between the worker's living quarters (*i.e.*, housing provided or secured by the employer pursuant to paragraph (d) of this section) and the employer's worksite at no cost to the worker, and such transportation must comply with all applicable Federal, State or local laws and regulations, and must provide, at a minimum, the same vehicle safety standards, driver licensure, and vehicle insurance as required under 29 U.S.C. 1841 and 29 CFR part 500, subpart D. If workers' compensation is used to cover such transportation, in lieu of vehicle insurance, the employer must either ensure that the workers' compensation covers all travel or that vehicle insurance exists to provide coverage for travel not covered by workers' compensation.

(i) *Three-fourths guarantee*—(1) *Offer to worker.* The employer must guarantee to offer the worker employment for a total number of work hours equal to at least three-fourths of the workdays of the total period beginning with the first workday after the arrival of the worker at the place of employment or the advertised contractual first date of need, whichever is later, and ending on the expiration date specified in the work contract or in its extensions, if any. For purposes of this paragraph a workday means the number of hours in a workday as stated in the job order and excludes the worker's Sabbath and Federal holidays. The employer must offer a total number of hours to ensure the provision of sufficient work to reach the three-fourths guarantee. The work hours must be offered during the work period specified in the work contract, or during any modified work contract period to which the worker and employer have mutually agreed and has been approved by the CO. The work contract period can be shortened by agreement of the parties only with the approval of the CO. In the event the worker begins working later than the specified beginning date of the contract, the guarantee period begins with the first workday after the arrival of the worker at the place of employment, and continues until the last day during which the work contract and all extensions thereof are in effect. Therefore, if, for example, a work contract is for a 10-week period, during which a normal workweek is specified as 6 days a week, 8 hours per day, the worker would have to be guaranteed employment for at least 360 hours (e.g., 10 weeks × 48 hours/week = 480-hours × 75 percent = 360). If a Federal holiday occurred during the 10-week span, the 8 hours would be deducted from the total guaranteed. A worker may be offered more than the specified hours of work on a single workday. For purposes of

meeting the guarantee, however, the worker will not be required to work for more than the number of hours specified in the job order for a workday, or on the worker's Sabbath or Federal holidays. However, all hours of work actually performed may be counted by the employer in calculating whether the period of guaranteed employment has been met. If the employer affords the U.S. or H–2A worker during the total work contract period less employment than that required under this paragraph, the employer must pay such worker the amount the worker would have earned had the worker, in fact, worked for the guaranteed number of days.

(2) *Guarantee for piece rate paid worker.* If the worker will be paid on a piece rate basis, the employer must use the worker's average hourly piece rate earnings or the AEWR, whichever is higher, to calculate the amount due under the guarantee.

(3) *Failure to work.* Any hours the worker fails to work, up to a maximum of the number of hours specified in the job order for a workday, when the worker has been offered an opportunity to do so in accordance with paragraph (i)(1) of this section, and all hours of work actually performed (including voluntary work over 8 hours in a workday or on the worker's Sabbath or Federal holidays), may be counted by the employer in calculating whether the period of guaranteed employment has been met. An employer seeking to calculate whether the number of hours has been met must maintain the payroll records in accordance with paragraph (j)(2) of this section.

(4) *Displaced H–2A worker.* The employer is not liable for payment under paragraph (i)(1) of this section to an H–2A worker whom the CO certifies is displaced because of the employer's compliance with § 655.105(d) with respect to referrals made after the employer's date of need. The employer is, however, liable for return transportation for any such displaced worker in accordance with paragraph (h)(2) of this section.

(5) *Obligation to provide housing and meals.* Notwithstanding the three-fourths guarantee contained in this section, employers are obligated to provide housing and subsistence for each day of the contract period up until the day the workers depart for other H–2A employment, depart to the place outside of the U.S. from which the worker came, or, if the worker voluntarily abandons employment or is terminated for cause, the day of such abandonment or termination.

(j) *Earnings records.* (1) The employer must keep accurate and adequate records with respect to the workers' earnings, including but not limited to field tally records, supporting summary payroll records, and records showing the nature and amount of the work performed; the number of hours of work offered each day by the employer (broken out by hours offered both in accordance with and over and above the three-fourths guarantee at paragraph (i)(3) of this section); the hours actually worked each day by the worker; the time the worker began and ended each workday; the rate of pay (both piece rate and hourly, if applicable); the worker's earnings per pay period; the worker's home address; and the amount of and reasons for any and all deductions taken from the worker's wages.

(2) Each employer must keep the records required by this part, including field tally records and supporting summary payroll records, safe and accessible at the place or places of employment, or at one or more established central recordkeeping offices where such records are customarily maintained. All records must be available for inspection and transcription by the Secretary or a duly authorized and designated representative, and by the worker and representatives designated by the worker as evidenced by appropriate documentation (an Entry of Appearance as Attorney or Representative, Form G–28, signed by the worker, or an affidavit signed by the worker confirming such representation). Where the records are maintained at a central recordkeeping office, other than in the place or places of employment, such records must be made available for inspection and copying within 72 hours following notice from the Secretary, or a duly authorized and designated representative, and by the worker and designated representatives as described in this paragraph.

(3) To assist in determining whether the three-fourths guarantee in paragraph (i) of this section has been met, if the number of hours worked by the worker on a day during the work contract period is less than the number of hours offered, as specified in the job offer, the records must state the reason or reasons therefore.

(4) The employer must retain the records for not less than 3 years after the completion of the work contract.

(k) *Hours and earnings statements.* The employer must furnish to the worker on or before each payday in one or more written statements the following information:

(1) The worker's total earnings for the pay period;

(2) The worker's hourly rate and/or piece rate of pay;

(3) The hours of employment offered to the worker (broken out by offers in accordance with, and over and above, the guarantee);

(4) The hours actually worked by the worker;

(5) An itemization of all deductions made from the worker's wages; and

(6) If piece rates are used, the units produced daily.

(l) *Rates of pay.* (1) If the worker is paid by the hour, the employer must pay the worker at least the AEWR in effect at the time recruitment for the position was begun, the prevailing hourly wage rate, the prevailing piece rate, or the Federal or State minimum wage rate, whichever is highest, for every hour or portion thereof worked during a pay period; or

(2)(i) If the worker is paid on a piece rate basis and the piece rate does not result at the end of the pay period in average hourly piece rate earnings during the pay period at least equal to the amount the worker would have earned had the worker been paid at the appropriate hourly rate, the worker's pay must be supplemented at that time so that the worker's earnings are at least as much as the worker would have earned during the pay period if the worker had instead been paid at the appropriate hourly wage rate for each hour worked;

(ii) The piece rate must be no less than the piece rate prevailing for the activity in the area of intended employment; and

(iii) If the employer who pays by the piece rate requires one or more minimum productivity standards of workers as a condition of job retention, such standards must be specified in the job offer and must be normal, meaning that they may not be unusual for workers performing the same activity in the area of intended employment.

(m) *Frequency of pay.* The employer must state in the job offer the frequency with which the worker will be paid, which must be at least twice monthly.

(n) *Abandonment of employment or termination for cause.* If the worker voluntarily abandons employment before the end of the contract period, fails to report for employment at the beginning of the contract period, or is terminated for cause, and the employer notifies the Department and DHS in writing or by any other method specified by the Department or DHS in a manner specified in a notice published in the FEDERAL REGISTER not later than 2 working days after such abandonment or abscondment occurs, the employer will not be responsible for providing or paying for the subsequent transportation and subsistence expenses of that worker under paragraph (h) of this section, and that worker is not entitled to the three-fourths guarantee described in paragraph (i) of this section. An abandonment or abscondment shall be deemed to begin after a worker fails to report for work at the regularly scheduled time for 5 consecutive working days without the consent of the employer. Employees may be terminated for cause, however, for shorter unexcused periods of time that shall not be considered abandonment or abscondment.

(o) *Contract impossibility.* If, before the expiration date specified in the work contract, the services of the worker are no longer required for reasons beyond the control of the employer due to fire, weather, or other Act of God that makes the fulfillment of the contract impossible, the employer may terminate the work contract. Whether such an event constitutes a contract impossibility will be determined by the CO. In the event of such termination of a

contract, the employer must fulfill a three-fourths guarantee for the time that has elapsed from the start of the work contract to the time of its termination as described in paragraph (i)(1) of this section. The employer must:

(1) Return the worker, at the employer's expense, to the place from which the worker (disregarding intervening employment) came to work for the employer, or transport the worker to the worker's next certified H–2A employer (but only if the worker can provide documentation supporting such employment), whichever the worker prefers. For an H–2A worker coming from outside of the U.S., the place from which the worker (disregarding intervening employment) came to work for the employer is the appropriate U.S. consulate or port of entry;

(2) Reimburse the worker the full amount of any deductions made from the worker's pay by the employer for transportation and subsistence expenses to the place of employment; and

(3) Pay the worker for any costs incurred by the worker for transportation and daily subsistence to that employer's place of employment. Daily subsistence will be computed as set forth in paragraph (h) of this section. The amount of the transportation payment will be no less (and is not required to be more) than the most economical and reasonable common carrier transportation charges for the distances involved.

(p) *Deductions.* The employer must make all deductions from the worker's paycheck that are required by law. The job offer must specify all deductions not required by law which the employer will make from the worker's paycheck. All deductions must be reasonable. However, an employer subject to the FLSA may not make deductions that would violate the FLSA.

(q) *Copy of work contract.* The employer must provide to the worker, no later than on the day the work commences, a copy of the work contract between the employer and the worker. The work contract must contain all of the provisions required by paragraphs (a) through (p) of this section. In the absence of a separate, written work contract entered into between the employer and the worker, the job order, as provided in 20 CFR part 653, Subpart F, will be the work contract.

§ 655.1305 Assurances and obligations of H–2A employers.

An employer seeking to employ H–2A workers must attest as part of the *Application for Temporary Employment Certification* that it will abide by the following conditions of this subpart:

(a) The job opportunity is and will continue through the recruitment period to be open to any qualified U.S. worker regardless of race, color, national origin, age, sex, religion, handicap, or citizenship, and the employer has conducted and will continue to conduct the required recruitment, in accordance with regulations, and has been unsuccessful in locating sufficient numbers of qualified U.S. applicants for the job opportunity for which certification is sought. Any U.S. workers who applied or apply for the job were or will be rejected only for lawful, job-related reasons, and those not rejected on this basis have been or will be hired. In addition, the employer attests that it will retain records of all rejections as required by § 655.119.

(b) The employer is offering terms and working conditions which are not less favorable than those offered to the H–2A worker(s) and are not less than the minimum terms and conditions required by this subpart.

(c) The specific job opportunity for which the employer is requesting H–2A certification is not vacant because the former occupant is on strike or being locked out in the course of a labor dispute.

(d) The employer will continue to cooperate with the SWA by accepting referrals of all eligible U.S. workers who apply (or on whose behalf an application is made) for the job opportunity until the end of the recruitment period as specified in § 655.102(f)(3).

(e) During the period of employment that is the subject of the labor certification application, the employer will:

(1) Comply with applicable Federal, State and local employment-related laws and regulations, including employment-related health and safety laws;

(2) Provide for or secure housing for those workers who are not reasonably

able to return to their permanent residence at the end of the work day, without charge to the worker, that complies with the applicable standards as set forth in § 655.104(d);

(3) Where required, has timely requested a preoccupancy inspection of the housing and, if one has been conducted, received certification;

(4) Provide insurance, without charge to the worker, under a State workers' compensation law or otherwise, that meets the requirements of § 655.104(e); and

(5) Provide transportation in compliance with all applicable Federal, State or local laws and regulations between the worker's living quarters (*i.e.*, housing provided by the employer under § 655.104(d)) and the employer's worksite without cost to the worker.

(f) Upon the separation from employment of H–2A worker(s) employed under the labor certification application, if such separation occurs prior to the end date of the employment specified in the application, the employer will notify the Department and DHS in writing (or any other method specified by the Department or DHS) of the separation from employment not later than 2 work days after such separation is discovered by the employer. The procedures for reporting abandonments and abscondments are outlined in § 655.104(n) of this subpart.

(g) The offered wage rate is the highest of the AEWR in effect at the time recruitment is initiated, the prevailing hourly wage or piece rate, or the Federal or State minimum wage, and the employer will pay the offered wage during the entire period of the approved labor certification.

(h) The offered wage is not based on commission, bonuses, or other incentives, unless the employer guarantees a wage paid on a weekly, bi-weekly, or monthly basis that equals or exceeds the AEWR, prevailing hourly wage or piece rate, or the legal Federal or State minimum wage, whichever is highest.

(i) The job opportunity is a full-time temporary position, calculated to be at least 30 hours per work week, the qualifications for which do not substantially deviate from the normal and accepted qualifications required by employers that do not use H–2A workers in the same or comparable occupations or crops.

(j) The employer has not laid off and will not lay off any similarly employed U.S. worker in the occupation that is the subject of the *Application for Temporary Employment Certification* in the area of intended employment except for lawful, job related reasons within 60 days of the date of need, or if the employer has laid off such workers, it has offered the job opportunity that is the subject of the application to those laid-off U.S. worker(s) and the U.S. worker(s) either refused the job opportunity or was rejected for the job opportunity for lawful, job-related reasons.

(k) The employer has not and will not intimidate, threaten, restrain, coerce, blacklist, or in any manner discriminate against, and has not and will not cause any person to intimidate, threaten, restrain, coerce, blacklist, or in any manner discriminate against, any person who has with just cause:

(1) Filed a complaint under or related to sec. 218 of the INA at 8 U.S.C. 1188, or this subpart or any other Department regulation promulgated under sec. 218 of the INA;

(2) Instituted or caused to be instituted any proceeding under or related to sec. 218 of the INA, or this subpart or any other Department regulation promulgated under sec. 218 of the INA;

(3) Testified or is about to testify in any proceeding under or related to sec. 218 of the INA or this subpart or any other Department regulation promulgated under sec. 218 of the INA;

(4) Consulted with an employee of a legal assistance program or an attorney on matters related to sec. 218 of the INA or this subpart or any other Department regulation promulgated under sec. 218 of the INA; or

(5) Exercised or asserted on behalf of himself/herself or others any right or protection afforded by sec. 218 of the INA, or this subpart or any other Department regulation promulgated under sec. 218 of the INA.

(l) The employer shall not discharge any person because of that person's taking any action listed in paragraphs (k)(1) through (k)(5) of this section.

(m) All fees associated with processing the temporary labor certification will be paid in a timely manner.

(n) The employer will inform H–2A workers of the requirement that they leave the U.S. at the end of the period certified by the Department or separation from the employer, whichever is earlier, as required under § 655.111, unless the H–2A worker is being sponsored by another subsequent employer.

(o) The employer and its agents have not sought or received payment of any kind from the employee for any activity related to obtaining labor certification, including payment of the employer's attorneys' fees, application fees, or recruitment costs. For purposes of this paragraph, payment includes, but is not limited to, monetary payments, wage concessions (including deductions from wages, salary, or benefits), kickbacks, bribes, tributes, in kind payments, and free labor. This provision does not prohibit employers or their agents from receiving reimbursement for costs that are the responsibility of the worker, such as government required passport or visa fees.

(p) The employer has contractually forbidden any foreign labor contractor or recruiter whom the employer engages in international recruitment of H–2A workers to seek or receive payments from prospective employees, except as provided for in DHS regulations at 8 CFR 214.2(h)(5)(xi)(A).

(q) The applicant is either a fixed-site employer, an agent or recruiter, an H–2ALC (as defined in these regulations), or an association.

§ 655.1306 Assurances and obligations of H–2A Labor Contractors.

(a) The pre-filing activity requirements set forth in § 655.102 are modified as follows for H–2ALCs:

(1) The job order for an H–2ALC may contain work locations in multiple areas of intended employment, and may be submitted to any one of the SWAs having jurisdiction over the anticipated work areas. The SWA receiving the job order shall promptly transmit, on behalf of the employer, a copy of its active job order to all States listed in the application as anticipated worksites, as well as those States, if any, designated by the Secretary as traditional or expected labor supply States for each area in which the employer's work is to be performed. Each SWA shall keep the H–2ALC's job order posted until the end of the recruitment period, as set forth in § 655.102(f)(3), for the area of intended employment that is covered by the SWA. SWAs in States that have been designated as traditional or expected labor supply States for more than one area of intended of employment that are listed on an application shall keep the H–2ALC's job order posted until the end of the applicable recruitment period that is last in time, and may make referrals for job opportunities in any area of intended employment that is still in an active recruitment period, as defined by § 655.102(f)(3).

(2) The H–2ALC must conduct separate positive recruitment under § 655.102(g) through (i) for each area of intended employment in which the H–2ALC intends to perform work, but need not conduct separate recruitment for each work location within a single area of intended employment. The positive recruitment for each area of intended employment must list the name and location of each fixed-site agricultural business to which the H–2ALC expects to provide H–2A workers, the expected beginning and ending dates when the H–2ALC will be providing the workers to each fixed site, and a description of the crops and activities the workers are expected to perform at such fixed site. Such positive recruitment must be conducted pre-filing for the first area of intended employment, but must be started no more than 75 and no fewer than 60 days before the listed arrival date (or the amended date, if applicable) for each subsequent area of intended employment. For each area of intended employment, the advertising that must be placed in any applicable States designated as traditional or expected labor supply States must be placed at the same time as the placement of other positive recruitment for the area of intended employment in accordance with § 655.102(i)(2).

(3) The job order and the positive recruitment in each area of intended employment may require that workers

complete the remainder of the H–2ALC's itinerary.

(4) An H–2ALC who hires U.S. workers during the course of its itinerary, and accordingly releases one or more of its H–2A workers, is eligible for the release from the three-quarters guarantee with respect to the released H–2A workers that is provided for in § 655.104(i)(4).

(5) An H–2ALC may amend its application subsequent to submission in accordance with § 655.107(d)(3) to account for new or changed worksites or areas of intended employment during the course of the itinerary in the following manner:

(i) If the additional worksite(s) are in the same area(s) of intended employment as represented on the *Application for Temporary Employment Certification*, the H–2ALC is not required to re-recruit in those areas of intended employment if that recruitment has been completed and if the job duties at the new work sites are similar to those already covered by the application.

(ii) If the additional worksite(s) are outside the area(s) of intended employment represented on the *Application for Temporary Employment Certification*, the H–2ALC must submit in writing the new area(s) of intended employment and explain the reasons for the amendment of the labor certification itinerary. The CO will order additional recruitment in accordance with § 655.102(d).

(iii) For any additional worksite not included on the original application that necessitates a change in housing of H–2A workers, the H–2ALC must secure the statement of housing as described in paragraph (b)(6) of this section and obtain an inspection of such housing from the SWA in the area of intended employment.

(iv) Where additional recruitment is required under paragraphs (a)(5)(i) or (a)(5)(ii) of this section, the CO shall allow it to take place on an expedited basis, where possible, so as to allow the amended dates of need to be met.

(6) Consistent with paragraph (a)(5) of this section, no later than 30 days prior to the commencement of employment in each area of intended employment in the itinerary of an H–2ALC, the SWA having jurisdiction over that area of intended employment must complete the housing inspections for any employer-provided housing to be used by the employees of the H–2ALC.

(7) To satisfy the requirements of § 655.102(h), the H–2ALC must contact all U.S employees that worked for the H–2ALC during the previous season, except those excluded by that section, before filing its application, and must advise those workers that a separate job opportunity exists for each area of intended employment that is covered by the application. The employer may advise contacted employees that for any given job opportunity, workers may be required to complete the remainder of the H–2ALC's itinerary.

(b) In addition to the assurances and obligations listed in § 655.105, H–2ALC applicants are also required to:

(1) Provide the MSPA Farm Labor Contractor (FLC) certificate of registration number and expiration date if required under MSPA at 29 U.S.C. 1801 *et seq.*, to have such a certificate;

(2) Identify the farm labor contracting activities the H–2ALC is authorized to perform as an FLC under MSPA as shown on the FLC certificate of registration, if required under MSPA at 29 U.S.C. 1801 *et seq.*, to have such a certificate of registration;

(3) List the name and location of each fixed-site agricultural business to which the H–2A Labor Contractor expects to provide H–2A workers, the expected beginning and ending dates when the H–2ALC will be providing the workers to each fixed site, and a description of the crops and activities the workers are expected to perform at such fixed site;

(4) Provide proof of its ability to discharge financial obligations under the H–2A program by attesting that it has obtained a surety bond as required by 29 CFR 501.8, stating on the application the name, address, phone number, and contact person for the surety, and providing the amount of the bond (as calculated pursuant to 29 CFR 501.8) and any identifying designation utilized by the surety for the bond;

(5) Attest that it has engaged in, or will engage in within the timeframes required by § 655.102 as modified by § 655.106(a), recruitment efforts in each area of intended employment in which

it has listed a fixed-site agricultural business; and

(6) Attest that it will be providing housing and transportation that complies with the applicable housing standards in § 655.104(d) or that it has obtained from each fixed-site agricultural business that will provide housing or transportation to the workers a written statement stating that:

(i) All housing used by workers and owned, operated or secured by the fixed-site agricultural business complies with the applicable housing standards in § 655.104(d); and

(ii) All transportation between the worksite and the workers' living quarters that is provided by the fixed-site agricultural business complies with all applicable Federal, State, or local laws and regulations and will provide, at a minimum, the same vehicle safety standards, driver licensure, and vehicle insurance as required under 29 U.S.C. 1841 and 29 CFR part 500, subpart D, except where workers' compensation is used to cover such transportation as described in § 655.104(h)(3).

§ 655.1307 Processing of applications.

(a) *Processing.* (1) Upon receipt of the application, the CO will promptly review the application for completeness and an absence of errors that would prevent certification, and for compliance with the criteria for certification. The CO will make a determination to certify, deny, or issue a Notice of Deficiency prior to making a Final Determination on the application. Applications requesting that zero job opportunities be certified for H–2A employment because the employer has been able to recruit a sufficient number of U.S. workers must comply with other requirements for H–2A applications and must be supported by a recruitment report, in which case the application will be accepted but will then be denied. Criteria for certification, as used in this subpart, include, but are not limited to, whether the employer has established the need for the agricultural services or labor to be performed on a temporary or seasonal basis; made all the assurances and met all the obligations required by § 655.105, and/or, if an H–2ALC, by § 655.106; complied with the timeliness requirements in § 655.102; and complied with the recruitment obligations required by §§ 655.102 and 655.103.

(2) Unless otherwise noted, any notice or request sent by the CO or OFLC to an applicant requiring a response shall be sent by means normally assuring next-day delivery, to afford the applicant sufficient time to respond. The employer's response shall be considered filed with the Department when sent (by mail, certified mail, or any other means indicated to be acceptable by the CO) to the Department, which may be demonstrated, for example, by a postmark.

(b) *Notice of deficiencies.* (1) If the CO determines that the employer has made all necessary attestations and assurances, but the application fails to comply with one or more of the criteria for certification in paragraph (a) of this section, the CO will promptly notify the employer within 7 calendar days of the CO's receipt of the application.

(2) The notice will:

(i) State the reason(s) why the application fails to meet the criteria for temporary labor certification, citing the relevant regulatory standard(s);

(ii) Offer the employer an opportunity to submit a modified application within 5 business days from date of receipt, stating the modification that is needed for the CO to accept the application for consideration;

(iii) Except as provided for under paragraph (b)(2)(iv) of this section, state that the CO's determination on whether to grant or deny the *Application for Temporary Employment Certification* will be made no later than 30 calendar days before the date of need, provided that the employer submits the requested modification to the application within 5 business days and in a manner specified by the CO;

(iv) Where the CO determines the employer failed to comply with the recruitment obligations required by §§ 655.102 and 655.103, offer the employer an opportunity to correct its recruitment and conduct it on an expedited schedule. The CO shall specify the positive recruitment requirements, request the employer submit proof of corrected advertisement and an initial recruitment report meeting the requirements

of § 655.102(k) no earlier than 48 hours after the last corrected advertisement is printed, and state that the CO's determination on whether to grant or deny the *Application for Temporary Employment Certification* will be made within 5 business days of receiving the required documentation, which may be a date later than 30 days before the date of need:

(v) Offer the employer an opportunity to request an expedited administrative review or a de novo administrative hearing before an ALJ, of the *Notice of Deficiency*. The notice will state that in order to obtain such a review or hearing, the employer, within 5 business days of the receipt of the notice, must file by facsimile or other means normally assuring next day delivery, a written request to the Chief Administrative Law Judge of DOL and simultaneously serve a copy on the CO. The notice will also state that the employer may submit any legal arguments that the employer believes will rebut the basis of the CO's action; and

(vi) State that if the employer does not comply with the requirements under paragraphs (b)(2)(ii) and (iv) of this section or request an expedited administrative judicial review or a de novo hearing before an ALJ within the 5 business days the CO will deny the application in accordance with the labor certification determination provisions in § 655.109.

(c) *Submission of modified applications.* (1) If the CO notifies the employer of any deficiencies within the 7 calendar day timeframe set forth in paragraph (b)(1) of this section, the date by which the CO's Final Determination is required by statute to be made will be postponed by 1 day for each day that passes beyond the 5 business-day period allowed under paragraph (b)(2)(ii) of this section to submit a modified application.

(2) Where the employer submits a modified application as required by the CO, and the CO approves the modified application, the CO will not deny the application based solely on the fact that it now does not meet the timeliness requirements for filing applications.

(3) If the modified application is not approved, the CO will deny the application in accordance with the labor certification determination provisions in § 655.109.

(d) *Amendments to applications.* (1) Applications may be amended at any time before the CO's certification determination to increase the number of workers requested in the initial application by not more than 20 percent (50 percent for employers requesting less than 10 workers) without requiring an additional recruitment period for U.S. workers. Requests for increases above the percent prescribed, without additional recruitment, may be approved by the CO only when the request is submitted in writing, the need for additional workers could not have been foreseen, and the crops or commodities will be in jeopardy prior to the expiration of an additional recruitment period.

(2) Applications may be amended to make minor changes in the total period of employment, but only if a written request is submitted to the CO and approved in advance. In considering whether to approve the request, the CO will review the reason(s) for the request, determine whether the reason(s) are on the whole justified, and take into account the effect(s) of a decision to approve on the adequacy of the underlying test of the domestic labor market for the job opportunity. If a request for a change in the start date of the total period of employment is made after workers have departed for the employer's place of work, the CO may only approve the change if the request is accompanied by a written assurance signed and dated by the employer that all such workers will be provided housing and subsistence, without cost to the workers, until work commences. Upon acceptance of an amendment, the CO will submit to the SWA any necessary modification to the job order.

(3) Other amendments to the application, including elements of the job offer and the place of work, may be approved by the CO if the CO determines the proposed amendment(s) are justified by a business reason and will not prevent the CO from making the labor certification determination required under § 655.109. Requested amendments will be reviewed as quickly as possible, taking into account revised dates of

need for work locations associated with the amendment.

(e) *Appeal procedures.* With respect to either a Notice of Deficiency issued under paragraph (b) of this section, the denial of a requested amendment under paragraph (d) of this section, or a notice of denial issued under § 655.109(e), if the employer timely requests an expedited administrative review or *de novo* hearing before an ALJ, the procedures set forth in § 655.115 will be followed.

§ 655.1308 Offered wage rate.

(a) *Highest wage.* To comply with its obligation under § 655.105(g), an employer must offer a wage rate that is the highest of the AEWR in effect at the time recruitment for a position is begun, the prevailing hourly wage or piece rate, or the Federal or State minimum wage.

(b) *Wage rate request.* The employer must request and obtain a wage rate determination from the NPC, on a form prescribed by ETA, before commencing any recruitment under this subpart, except where specifically exempted from this requirement by these regulations.

(c) *Validity of wage rate.* The recruitment must begin within the validity period of the wage determination obtained from the NPC. Recruitment for this purpose begins when the job order is accepted by the SWA for posting.

(d) *Wage offer.* The employer must offer and advertise in its recruitment a wage at least equal to the wage rate required by paragraph (a) of this section.

(e) *Adverse effect wage rate.* The AEWR will be based on published wage data for the occupation, skill level, and geographical area from the Bureau of Labor Statistics (BLS), Occupational Employment Statistics (OES) survey. The NPC will obtain wage information on the AEWR using the On-line Wage Library (OWL) found on the Foreign Labor Certification Data Center Web site (*http://www.flcdatacenter.com/*). This wage shall not be less than the July 24, 2009 Federal minimum wage of $7.25.

(f) *Wage determination.* The NPC must enter the wage rate determination on a form it uses, indicate the source, and return the form with its endorsement to the employer.

(g) *Skill level.* (1) Level I wage rates are assigned to job offers for beginning level employees who have a basic understanding of the occupation. These employees perform routine tasks that require limited, if any, exercise of judgment. The tasks provide experience and familiarization with the employer's methods, practices, and programs. The employees may perform higher level work for training and developmental purposes. These employees work under close supervision and receive specific instructions on required tasks and results expected. Their work is closely monitored and reviewed for accuracy.

(2) Level II wage rates are assigned to job offers for employees who have attained, through education or experience, a good understanding of the occupation. These employees perform moderately complex tasks that require limited judgment. An indicator that the job request warrants a wage determination at Level II would be a requirement for years of education and/or experience that are generally required as described in the O*NET Job Zones.

(3) Level III wage rates are assigned to job offers for employees who have a sound understanding of the occupation and have attained, either through education or experience, special skills or knowledge. These employees perform tasks that require exercising judgment and may coordinate the activities of other staff. They may have supervisory authority over those staff. A requirement for years of experience or educational degrees that are at the higher ranges indicated in the O*NET Job Zones would be an indicator that a Level III wage should be considered. Frequently, key words in the job title can be used as indicators that an employer's job offer is for an experienced worker. Words such as lead, senior, crew chief, or journeyman would be indicators that a Level III wage should be considered.

(4) Level IV wage rates are assigned to job offers for employees who have sufficient experience in the occupation to plan and conduct work requiring judgment and the independent evaluation, selection, modification, and application of standard procedures and techniques. Such employees receive only

minimal guidance and their work is reviewed only for application of sound judgment and effectiveness in meeting the establishment's procedures and expectations. They generally have management and/or supervisory responsibilities.

(h) *Retention of documentation.* An employer filing an *Application for Temporary Employment Certification* must maintain documentation of its wage determination from the NPC as required in this subpart and be prepared to submit this documentation with the filing of its application. The documentation required in this subpart must be retained for a period of no less than 3 years from the date of the certification. There is no record retention requirement for applications (and supporting documentation) that are denied.

§ 655.1309 Labor certification determinations.

(a) *COs.* The Administrator, OFLC is the Department's National CO. The Administrator, OFLC, and the CO(s) in the NPC(s) (by virtue of delegation from the Administrator, OFLC), have the authority to certify or deny applications for temporary employment certification under the H–2A nonimmigrant classification. If the Administrator, OFLC has directed that certain types of temporary labor certification applications or specific applications under the H–2A nonimmigrant classification be handled by the National OFLC, the Director(s) of the NPC(s) will refer such applications to the Administrator, OFLC.

(b) *Determination.* No later than 30 calendar days before the date of need, as identified in the *Application for Temporary Employment Certification*, except as provided for under § 655.107(c) for modified applications, or applications not otherwise meeting certification criteria by that date, the CO will make a determination either to grant or deny the *Application for Temporary Employment Certification.* The CO will grant the application if and only if: the employer has met the requirements of this subpart, including the criteria for certification set forth in § 655.107(a), and thus the employment of the H–2A workers will not adversely affect the wages and working conditions of similarly employed U.S. workers.

(c) *Notification.* The CO will notify the employer in writing (either electronically or by mail) of the labor certification determination.

(d) *Approved certification.* If temporary labor certification is granted, the CO must send the certified *Application for Temporary Employment Certification* and a Final Determination letter to the employer, or, if appropriate, to the employer's agent or attorney. The Final Determination letter will notify the employer to file the certified application and any other documentation required by USCIS with the appropriate USCIS office and to continue to cooperate with the SWA by accepting all referrals of eligible U.S. workers who apply (or on whose behalf an application is made) for the job opportunity until the end of the recruitment period as set forth in § 655.102(f)(3). However, the employer will not be required to accept referrals of eligible U.S. workers once it has hired or extended employment offers to eligible U.S. workers equal to the number of H–2A workers sought.

(e) *Denied certification.* If temporary labor certification is denied, the Final Determination letter will be sent to the employer by means normally assuring next-day delivery. The Final Determination Letter will:

(1) State the reasons certification is denied, citing the relevant regulatory standards and/or special procedures;

(2) If applicable, address the availability of U.S. workers in the occupation as well as the prevailing benefits, wages, and working conditions of similarly employed U.S. workers in the occupation and/or any applicable special procedures;

(3) Offer the applicant an opportunity to request an expedited administrative review, or a *de novo* administrative hearing before an ALJ, of the denial. The notice must state that in order to obtain such a review or hearing, the employer, within 7 calendar days of the date of the notice, must file by facsimile (fax), telegram, or other means normally assuring next day delivery, a written request to the Chief Administrative Law Judge of DOL (giving the address) and simultaneously serve a

copy on the CO. The notice will also state that the employer may submit any legal arguments which the employer believes will rebut the basis of the CO's action; and

(4) State that if the employer does not request an expedited administrative judicial review or a *de novo* hearing before an ALJ within the 7 calendar days, the denial is final and the Department will not further consider that application for temporary alien agricultural labor certification.

(f) *Partial certification.* The CO may, to ensure compliance with all regulatory requirements, issue a partial certification, reducing either the period of need or the number of H–2A workers being requested or both for certification, based upon information the CO receives in the course of processing the temporary labor certification application, an audit, or otherwise. The number of workers certified shall be reduced by one for each referred U.S. worker who is qualified, able, available and willing. If a partial labor certification is issued, the Final Determination letter will:

(1) State the reasons for which either the period of need and/or the number of H–2A workers requested has been reduced, citing the relevant regulatory standards and/or special procedures;

(2) If applicable, address the availability of U.S. workers in the occupation;

(3) Offer the applicant an opportunity to request an expedited administrative review, or a *de novo* administrative hearing before an ALJ, of the decision. The notice will state that in order to obtain such a review or hearing, the employer, within 7 calendar days of the date of the notice, will file by facsimile or other means normally assuring next day delivery a written request to the Chief Administrative Law Judge of DOL (giving the address) and simultaneously serve a copy on the CO. The notice will also state that the employer may submit any legal arguments which the employer believes will rebut the basis of the CO's action; and

(4) State that if the employer does not request an expedited administrative judicial review or a *de novo* hearing before an ALJ within the 7 calendar days, the denial is final and the Department will not further consider that application for temporary alien agricultural labor certification.

(g) *Appeal procedures.* If the employer timely requests an expedited administrative review or *de novo* hearing before an ALJ under paragraph (e)(3) or (f)(3) of this section, the procedures at § 655.115 will be followed.

(h) *Payment of processing fees.* A determination by the CO to grant an *Application for Temporary Employment Certification* in whole or in part under paragraph (d) or (f) of this section will include a bill for the required fees. Each employer of H–2A workers under the *Application for Temporary Employment Certification* (except joint employer associations, which shall not be assessed a fee in addition to the fees assessed to the members of the association) must pay in a timely manner a non-refundable fee upon issuance of the certification granting the application (in whole or in part), as follows:

(1) *Amount.* The application fee for each employer receiving a temporary agricultural labor certification is $100 plus $10 for each H–2A worker certified under the *Application for Temporary Employment Certification*, provided that the fee to an employer for each temporary agricultural labor certification received will be no greater than $1,000. There is no additional fee to the association filing the application. The fees must be paid by check or money order made payable to ''United States Department of Labor.'' In the case of H–2A employers that are members of an agricultural association acting as a joint employer applying on their behalf, the aggregate fees for all employers of H–2A workers under the application must be paid by one check or money order.

(2) *Timeliness.* Fees received by the CO no more than 30 days after the date the temporary labor certification is granted will be considered timely. Nonpayment of fees by the date that is 30 days after the issuance of the certification will be considered a substantial program violation and subject to the procedures in § 655.115.

§ 655.1310 Validity and scope of temporary labor certifications.

(a) *Validity period.* A temporary labor certification is valid for the duration of the job opportunity for which certification is granted to the employer. Except as provided in paragraph and (d) of this section, the validity period is that time between the beginning and ending dates of certified employment, as listed on the *Application for Temporary Employment Certification*. The certification expires on the last day of authorized employment.

(b) *Scope of validity.* Except as provided in paragraphs (c) and (d) of this section, a temporary labor certification is valid only for the number of H–2A workers, the area of intended employment, the specific occupation and duties, and the employer(s) specified on the certified *Application for Temporary Employment Certification* (as originally filed or as amended) and may not be transferred from one employer to another.

(c) *Scope of validity—associations*—(1) *Certified applications.* If an association is requesting temporary labor certification as a joint employer, the certified *Application for Temporary Employment Certification* will be granted jointly to the association and to each of the association's employer members named on the application. Workers authorized by the temporary labor certification may be transferred among its certified employer members to perform work for which the temporary labor certification was granted, provided the association controls the assignment of such workers and maintains a record of such assignments. All temporary agricultural labor certifications to associations may be used for the certified job opportunities of any of its employer members named on the application. If an association is requesting temporary labor certification as a sole employer, the certified *Application for Temporary Employment Certification* is granted to the association only.

(2) *Ineligible employer-members.* Workers may not be transferred or referred to an association's employer member if that employer member has been debarred from participation in the H–2A program.

(d) *Extensions on period of employment*—(1) *Short-term extension.* An employer who seeks an extension of 2 weeks or less of the certified *Application for Temporary Employment Certification* must apply for such extension to DHS. If DHS grants the extension, the corresponding *Application for Temporary Employment Certification* will be deemed extended for such period as is approved by DHS.

(2) *Long-term extension.* For extensions beyond 2 weeks, an employer may apply to the CO at any time for an extension of the period of employment on the certified *Application for Temporary Employment Certification* for reasons related to weather conditions or other factors beyond the control of the employer (which may include unforeseen changes in market conditions), provided that the employer's need for an extension is supported in writing, with documentation showing that the extension is needed and that the need could not have been reasonably foreseen by the employer. The CO will grant or deny the request for extension of the period of employment on the *Application for Temporary Employment Certification* based on the available information, and will notify the employer of the decision in writing. The employer may appeal a denial for a request of an extension in accordance with the procedures contained in § 655.115. The CO will not grant an extension where the total work contract period under that application and extensions would be 12 months or more, except in extraordinary circumstances.

(e) *Requests for determinations based on nonavailability of able, willing, available, eligible, and qualified U.S. workers*—(1) *Standards for requests.* If a temporary labor certification has been partially granted or denied based on the CO's determination that able, willing, available, eligible, and qualified U.S. workers are available, and, on or after 30 calendar days before the date of need, some or all of those U.S. workers are, in fact, no longer able, willing, eligible, qualified, or available, the employer may request a new temporary labor certification determination from the CO. Prior to making a new determination the CO will promptly ascertain (which may be through the SWA or

other sources of information on U.S. worker availability) whether specific able, willing, eligible and qualified replacement U.S. workers are available or can be reasonably expected to be present at the employer's establishment within 72 hours from the date the employer's request was received. The CO will expeditiously, but in no case later than 72 hours after the time a complete request (including the signed statement included in paragraph (e)(2) of this section) is received, make a determination on the request. An employer may appeal a denial of such a determination in accordance with the procedures contained in § 655.115.

(2) *Unavailability of U.S. workers.* The employer's request for a new determination must be made directly to the CO by telephone or electronic mail, and must be confirmed by the employer in writing as required by this paragraph. If the employer telephonically or via electronic mail requests the new determination by asserting solely that U.S. workers have become unavailable, the employer must submit to the CO a signed statement confirming such assertion. If such signed statement is not received by the CO within 72 hours of the CO's receipt of the request for a new determination, the CO will deny the request.

(3) *Notification of determination.* If the CO determines that U.S. workers have become unavailable and cannot identify sufficient specific able, willing, eligible, and qualified U.S. workers who are or who are likely to be available, the CO will grant the employer's request for a new determination. However, this does not preclude an employer from submitting subsequent requests for new determinations, if warranted, based on subsequent facts concerning purported nonavailability of U.S. workers or referred workers not being eligible workers or not able, willing, or qualified because of lawful job-related reasons.

§ 655.1311 Required departure.

(a) *Limit to worker's stay.* As defined further in DHS regulations, a temporary labor certification limits the authorized period of stay for an H–2A worker. *See* 8 CFR 214.2(h). A foreign worker may not remain beyond his or her authorized period of stay, as established by DHS, which is based upon the validity period of the labor certification under which the H–2A worker is employed, nor beyond separation from employment prior to completion of the H–2A contract, absent an extension or change of such worker's status under DHS regulations.

(b) *Notice to worker.* Upon establishment of a program by DHS for registration of departure, an employer must notify any H–2A worker that when the worker departs the U.S. by land at the conclusion of employment as provided in paragraph (a) of this section, the worker must register such departure at the place and in the manner prescribed by DHS.

§ 655.1312 Audits.

(a) *Discretion.* The Department will conduct audits of temporary labor certification applications for which certification has been granted. The applications selected for audit will be chosen within the sole discretion of the Department.

(b) *Audit letter.* Where an application is selected for audit, the CO will issue an audit letter to the employer/applicant. The audit letter will:

(1) State the documentation that must be submitted by the employer;

(2) Specify a date, no fewer than 14 days and no more than 30 days from the date of the audit letter, by which the required documentation must be received by the CO; and

(3) Advise that failure to comply with the audit process may result in a finding by the CO to:

(i) Revoke the labor certification as provided in § 655.117 and/or

(ii) Debar the employer from future filings of H–2A temporary labor certification applications as provided in § 655.118.

(c) *Supplemental information request.* During the course of the audit examination, the CO may request supplemental information and/or documentation from the employer in order to complete the audit.

(d) *Audit violations.* If, as a result of the audit, the CO determines the employer failed to produce required documentation, or determines that the employer violated the standards set forth

in § 655.117(a) with respect to the application, the employer's labor certification may be revoked under § 655.117 and/or the employer may be referred for debarment under § 655.118. The CO may determine to provide the audit findings and underlying documentation to DHS or another appropriate enforcement agency. The CO shall refer any findings that an employer discouraged an eligible U.S. worker from applying, or failed to hire, discharged, or otherwise discriminated against an eligible U.S. worker, to the Department of Justice, Civil Rights Division, Office of Special Counsel for Unfair Immigration Related Employment Practices.

§ 655.1313 H–2A applications involving fraud or willful misrepresentation.

(a) *Referral for investigation.* If the CO discovers possible fraud or willful misrepresentation involving an *Application for Temporary Employment Certification* the CO may refer the matter to the DHS and the Department's Office of the Inspector General for investigation.

(b) *Terminated processing.* If a court or the DHS determines that there was fraud or willful misrepresentation involving an *Application for Temporary Employment Certification,* the application will be deemed invalid. The determination is not appealable. If a certification has been granted, a finding under this paragraph will be cause to revoke the certification.

§ 655.1314 Setting meal charges; petition for higher meal charges.

(a) *Meal charges.* Until a new amount is set under this paragraph an employer may charge workers up to $9.90 for providing them with three meals per day. The maximum charge allowed by this paragraph (a) will be changed annually by the same percentage as the 12 month percentage change for the Consumer Price Index for all Urban Consumers for Food between December of the year just concluded and December of the year prior to that. The annual adjustments will be effective on the date of their publication by the Administrator, OFLC, as a Notice in the FEDERAL REGISTER. When a charge or deduction for the cost of meals would bring the employee's wage below the minimum wage set by the FLSA at 29 U.S.C. 206 (FLSA), the charge or deduction must meet the requirements of 29 U.S.C. 203(m) of the FLSA, including the recordkeeping requirements found at 29 CFR 516.27.

(b) *Filing petitions for higher meal charges.* The employer may file a petition with the CO to charge more than the applicable amount for meal charges if the employer justifies the charges and submits to the CO the documentation required by paragraph (b)(1) of this section.

(1) *Required documentation.* Documentation submitted must include the cost of goods and services directly related to the preparation and serving of meals, the number of workers fed, the number of meals served and the number of days meals were provided. The cost of the following items may be included: Food; kitchen supplies other than food, such as lunch bags and soap; labor costs that have a direct relation to food service operations, such as wages of cooks and dining hall supervisors; fuel, water, electricity, and other utilities used for the food service operation; and other costs directly related to the food service operation. Charges for transportation, depreciation, overhead and similar charges may not be included. Receipts and other cost records for a representative pay period must be retained and must be available for inspection by the CO for a period of 1 year.

(2) *Effective date for higher charge.* The employer may begin charging the higher rate upon receipt of a favorable decision from the CO unless the CO sets a later effective date in the decision.

(c) *Appeal.* In the event the employer's petition for a higher meal charge is denied in whole or in part, the employer may appeal the denial. Appeals will be filed with the Chief Administrative Law Judge. ALJ's will hear such appeals according to the procedures in 29 CFR part 18, except that the appeal will not be considered as a complaint to which an answer is required. The decision of the ALJ is the final decision of the Secretary.

§ 655.1315 Administrative review and de novo hearing before an administrative law judge.

(a) *Administrative review*—(1) *Consideration.* Whenever an employer has requested an administrative review before an ALJ of a decision by the CO: Not to accept for consideration an *Application for Temporary Employment Certification;* to deny an *Application for Temporary Employment Certification;* to deny an amendment of an *Application for Temporary Employment Certification;* or to deny an extension of an *Application for Temporary Employment Certification,* the CO will send a certified copy of the ETA case file to the Chief Administrative Law Judge by means normally assuring next-day delivery. The Chief Administrative Law Judge will immediately assign an ALJ (which may be a panel of such persons designated by the Chief Administrative Law Judge from BALCA established by 20 CFR part 656, which will hear and decide the appeal as set forth in this section) to review the record for legal sufficiency. The ALJ may not remand the case and may not receive evidence in addition to what the CO used to make the determination.

(2) *Decision.* Within 5 business days after receipt of the ETA case file the ALJ will, on the basis of the written record and after due consideration of any written submissions (which may not include new evidence) from the parties involved or amici curiae, either affirm, reverse, or modify the CO's decision by written decision. The decision of the ALJ must specify the reasons for the action taken and must be immediately provided to the employer, the CO, the Administrator, OFLC, and DHS by means normally assuring next-day delivery. The ALJ's decision is the final decision of the Secretary.

(b) *De novo hearing.* (1) *Request for hearing; conduct of hearing.* Whenever an employer has requested a de novo hearing before an ALJ of a decision by the CO: Not to accept for consideration an *Application for Temporary Employment Certification;* to deny an *Application for Temporary Employment Certification;* to deny an amendment of an *Application for Temporary Employment Certification;* or to deny an extension of an *Application for Temporary Employment Certification,* the CO will send a certified copy of the ETA case file to the Chief Administrative Law Judge by means normally assuring next-day delivery. The Chief Administrative Law Judge will immediately assign an ALJ (which may be a panel of such persons designated by the Chief Administrative Law Judge from BALCA established by 20 CFR part 656 of this chapter, but which will hear and decide the appeal as provided in this section) to conduct the *de novo* hearing. The procedures in 29 CFR part 18 apply to such hearings, except that:

(i) The appeal will not be considered to be a complaint to which an answer is required;

(ii) The ALJ will ensure that the hearing is scheduled to take place within 5 calendar days after the ALJ's receipt of the ETA case file, if the employer so requests, and will allow for the introduction of new evidence; and

(iii) The ALJ's decision must be rendered within 10 calendar days after the hearing.

(2) *Decision.* After a *de novo* hearing, the ALJ must affirm, reverse, or modify the CO's determination, and the ALJ's decision must be provided immediately to the employer, CO, Administrator, OFLC, and DHS by means normally assuring next-day delivery. The ALJ's decision is the final decision of the Secretary.

§ 655.1316 Job Service Complaint System; enforcement of work contracts.

(a) Complaints arising under this subpart may be filed through the Job Service Complaint System, as described in 20 CFR part 658, Subpart E. Complaints which involve worker contracts must be referred by the SWA to ESA for appropriate handling and resolution, as described in 29 CFR part 501. As part of this process, ESA may report the results of its investigation to the Administrator, OFLC for consideration of employer penalties or such other action as may be appropriate.

(b) Complaints alleging that an employer discouraged an eligible U.S. worker from applying, failed to hire, discharged, or otherwise discriminated against an eligible U.S. worker, or discovered violations involving the same,

may be referred to the U.S. Department of Justice, Civil Rights Division, Office of Special Counsel for Unfair Immigration Related Employment Practices (OSC), in addition to any activity, investigation, and/or enforcement action taken by ETA or an SWA. Likewise, if OSC becomes aware of a violation of these regulations, it may provide such information to the appropriate SWA and the CO.

§ 655.1317 Revocation of approved labor certifications.

(a) *Basis for DOL revocation.* The CO, in consultation with the Administrator, OFLC, may revoke a temporary agricultural labor certification approved under this subpart, if, after notice and opportunity for a hearing (or failure to file rebuttal evidence), it is found that any of the following violations were committed with respect to that temporary agricultural labor certification:

(1) The CO finds that issuance of the temporary agricultural labor certification was not justified due to a willful misrepresentation on the application;

(2) The CO finds that the employer:

(i) Willfully violated a material term or condition of the approved temporary agricultural labor certification or the H–2A regulations, unless otherwise provided under paragraphs (a)(2)(ii) through (iv) of this section; or

(ii) Failed, after notification, to cure a substantial violation of the applicable housing standards set out in 20 CFR 655.104(d); or

(iii) Significantly failed to cooperate with a DOL investigation or with a DOL official performing an investigation, inspection, or law enforcement function under sec. 218 of the INA at 8 U.S.C. 1188, this subpart, or 29 CFR part 501 (ESA enforcement of contractual obligations); or

(iv) Failed to comply with one or more sanctions or remedies imposed by the ESA for violation(s) of obligations found by that agency, or with one or more decisions or orders of the Secretary or a court order secured by the Secretary under sec. 218 of the INA at 8 U.S.C. 1188, this subpart, or 29 CFR part 501 (ESA enforcement of contractual obligations).

(3) The CO determines after a recommendation is made by the WHD ESA in accordance with 29 CFR 501.20, which governs when a recommendation of revocation may be made to ETA, that the conduct complained of upon examination meets the standards of paragraph (a)(1) or (2) of this section; or

(4) If a court or the DHS, or, as a result of an audit, the CO, determines that there was fraud or willful misrepresentation involving the *Application for Temporary Employment Certification*.

(b) *DOL procedures for revocation.* (1) The CO will send to the employer (and his attorney or agent) a *Notice of Intent to Revoke* by means normally ensuring next-day delivery, which will contain a detailed statement of the grounds for the proposed revocation and the time period allowed for the employer's rebuttal. The employer may submit evidence in rebuttal within 14 calendar days of the date the notice is issued. The CO must consider all relevant evidence presented in deciding whether to revoke the temporary agricultural labor certification.

(2) If rebuttal evidence is not timely filed by the employer, the *Notice of Intent to Revoke* will become the final decision of the Secretary and take effect immediately at the end of the 14-day period.

(3) If, after reviewing the employer's timely filed rebuttal evidence, the CO finds that the employer more likely than not meets one or more of the bases for revocation under § 655.117(a), the CO will notify the employer, by means normally ensuring next-day delivery, within 14 calendar days after receiving such timely filed rebuttal evidence, of his/her final determination that the temporary agricultural labor certification should be revoked. The CO's notice will contain a detailed statement of the bases for the decision, and must offer the employer an opportunity to request a hearing. The notice must state that, to obtain such a hearing, the employer must, within 10 calendar days of the date of the notice file a written request to the Chief Administrative Law Judge, United States Department of Labor, 800 K Street, NW., Suite 400–N, Washington, DC 20001–8002, and simultaneously serve a copy to the

Administrator, OFLC. The timely filing of a request for a hearing will stay the revocation pending the outcome of the hearing.

(c) *Hearing*. (1) Within 5 business days of receipt of the request for a hearing, the CO will send a certified copy of the ETA case file to the Chief Administrative Law Judge by means normally assuring next-day delivery. The Chief Administrative Law Judge will immediately assign an ALJ to conduct the hearing. The procedures in 29 CFR part 18 apply to such hearings, except that:

(i) The request for a hearing will not be considered to be a complaint to which an answer is required;

(ii) The ALJ will ensure that the hearing is scheduled to take place within 15 calendar days after the ALJ's receipt of the ETA case file, if the employer so requests, and will allow for the introduction of new evidence; and

(iii) The ALJ's decision must be rendered within 20 calendar days after the hearing.

(2) *Decision*. After the hearing, the ALJ must affirm, reverse, or modify the CO's determination. The ALJ's decision must be provided immediately to the employer, CO, Administrator, OFLC, DHS, and DOS by means normally assuring next-day delivery. The ALJ's decision is the final decision of the Secretary.

(d) *Employer's obligations in the event of revocation*. If an employer's temporary agricultural labor certification is revoked under this section, and the workers have departed the place of recruitment, the employer will be responsible for:

(1) Reimbursement of actual inbound transportation and subsistence expenses, as if the worker meets the requirements for payment under § 655.104(h)(1);

(2) The worker's outbound transportation expenses, as if the worker meets the requirements for payment under § 655.104(h)(2);

(3) Payment to the worker of the amount due under the three-fourths guarantee as required by § 655.104(i); and

(4) Any other wages, benefits, and working conditions due or owing to the worker under these regulations.

§ 655.1318 Debarment.

(a) The Administrator, OFLC may not issue future labor certifications under this subpart to an employer and any successor in interest to the debarred employer, subject to the time limits set forth in paragraph (c) of this section, if:

(1) The Administrator, OFLC finds that the employer substantially violated a material term or condition of its temporary labor certification with respect to the employment of domestic or nonimmigrant workers; and

(2) The Administrator, OFLC issues a *Notice of Intent to Debar* no later than 2 years after the occurrence of the violation.

(b) The Administrator, OFLC may not issue future labor certifications under this subpart to an employer represented by an agent or attorney, subject to the time limits set forth in paragraph (c) of this section, if:

(1) The Administrator, OFLC finds that the agent or attorney participated in, had knowledge of, or had reason to know of, an employer's substantial violation; and

(2) The Administrator, OFLC issues the agent or attorney a *Notice of Intent to Debar* no later than 2 years after the occurrence of the violation.

(c) No employer, attorney, or agent may be debarred under this subpart for more than 3 years.

(d) For the purposes of this section, a substantial violation includes:

(1) A pattern or practice of acts of commission or omission on the part of the employer or the employer's agent which:

(i) Are significantly injurious to the wages or benefits required to be offered under the H–2A program, or working conditions of a significant number of the employer's U.S. or H–2A workers; or

(ii) Reflect a significant failure to offer employment to all qualified domestic workers who applied for the job opportunity for which certification was being sought, except for lawful job-related reasons; or

(iii) Reflect a willful failure to comply with the employer's obligations to recruit U.S. workers as set forth in this subpart; or

(iv) Reflect a significant failure to comply with the audit process in violation of § 655.112; or

(v) Reflect the employment of an H–2A worker outside the area of intended employment, or in an activity/activities, not listed in the job order (other than an activity minor and incidental to the activity/activities listed in the job order), or after the period of employment specified in the job order and any approved extension;

(2) The employer's persistent or prolonged failure to pay the necessary fee in a timely manner, following the issuance of a deficiency notice to the applicant and allowing for a reasonable period for response;

(3) Fraud involving the *Application for Temporary Employment Certification* or a response to an audit;

(4) A significant failure to cooperate with a DOL investigation or with a DOL official performing an investigation, inspection, or law enforcement function under sec. 218 of the INA at 8 U.S.C. 1188, this subpart, or 29 CFR part 501 (ESA enforcement of contractual obligations); or

(5) A significant failure to comply with one or more sanctions or remedies imposed by the ESA for violation(s) of obligations found by that agency (if applicable), or with one or more decisions or orders of the Secretary or a court order secured by the Secretary under sec. 218 of the INA at 8 U.S.C. 1188, this subpart, or 29 CFR part 501 (ESA enforcement of contractual obligations); or

(6) A single heinous act showing such flagrant disregard for the law that future compliance with program requirements cannot reasonably be expected.

(e) DOL procedures for debarment under this section will be as follows:

(1) The Administrator, OFLC will send to the employer, attorney, or agent a *Notice of Intent to Debar* by means normally ensuring next-day delivery, which will contain a detailed statement of the grounds for the proposed debarment. The employer, attorney or agent may submit evidence in rebuttal within 14 calendar days of the date the notice is issued. The Administrator, OFLC must consider all relevant evidence presented in deciding whether to debar the employer, attorney, or agent.

(2) If rebuttal evidence is not timely filed by the employer, attorney, or agent, the *Notice of Intent to Debar* will become the final decision of the Secretary and take effect immediately at the end of the 14-day period.

(3) If, after reviewing the employer's timely filed rebuttal evidence, the Administrator, OFLC determines that the employer, attorney, or agent more likely than not meets one or more of the bases for debarment under § 655.118(d), the Administrator, OFLC will notify the employer, by means normally ensuring next-day delivery, within 14 calendar days after receiving such timely filed rebuttal evidence, of his/her final determination of debarment and of the employer, attorney, or agent's right to appeal.

(4) The *Notice of Debarment* must be in writing, must state the reason for the debarment finding, including a detailed explanation of the grounds for and the duration of the debarment, and must offer the employer, attorney, or agent an opportunity to request a hearing. The notice must state that, to obtain such a hearing, the debarred party must, within 30 calendar days of the date of the notice, file a written request to the Chief Administrative Law Judge, United States Department of Labor, 800 K Street, NW., Suite 400–N, Washington, DC 20001–8002, and simultaneously serve a copy to the Administrator, OFLC. The debarment will take effect 30 days from the date the *Notice of Debarment* is issued unless a request for a hearing is properly filed within 30 days from the date the *Notice of Debarment* is issued. The timely filing of the request for a hearing stays the debarment pending the outcome of the hearing.

(5)(i) *Hearing*. Within 10 days of receipt of the request for a hearing, the Administrator, OFLC will send a certified copy of the ETA case file to the Chief Administrative Law Judge by means normally assuring next-day delivery. The Chief Administrative Law Judge will immediately assign an ALJ to conduct the hearing. The procedures in 29 CFR part 18 apply to such hearings, except that the request for a hearing will not be considered to be a

complaint to which an answer is required;

(ii) *Decision.* After the hearing, the ALJ must affirm, reverse, or modify the Administrator, OFLC 's determination. The ALJ's decision must be provided immediately to the employer, Administrator, OFLC, DHS, and DOS by means normally assuring next-day delivery. The ALJ's decision is the final decision of the Secretary, unless either party, within 30 calendar days of the ALJ's decision, seeks review of the decision with the Administrative Review Board (ARB).

(iii) Review by the ARB.

(A) Any party wishing review of the decision of an ALJ must, within 30 days of the decision of the ALJ, petition the ARB to review the decision. Copies of the petition must be served on all parties and on the ALJ. The ARB must decide whether to accept the petition within 30 days of receipt. If the ARB declines to accept the petition or if the ARB does not issue a notice accepting a petition within 30 days after the receipt of a timely filing of the petition, the decision of the ALJ shall be deemed the final agency action. If a petition for review is accepted, the decision of the ALJ shall be stayed unless and until the ARB issues an order affirming the decision. The ARB must serve notice of its decision to accept or not to accept the petition upon the ALJ and upon all parties to the proceeding in person or by certified mail.

(B) Upon receipt of the ARB's notice to accept the petition, the Office of Administrative Law Judges shall promptly forward a copy of the complete hearing record to the ARB.

(C) Where the ARB has determined to review such decision and order, the ARB shall notify each party of:

(*1*) The issue or issues raised;

(*2*) The form in which submissions shall be made (*i.e.*, briefs, oral argument, etc.); and

(*3*) The time within which such presentation shall be submitted.

(D) The ARB's final decision must be issued within 90 days from the notice granting the petition and served upon all parties and the ALJ, in person or by certified mail. If the ARB fails to provide a decision within 90 days from the notice granting the petition, the ALJ's decision will be the final decision of the Secretary.

(f) *Debarment involving members of associations.* If the Administrator, OFLC determines a substantial violation has occurred, and if an individual employer-member of an agricultural association acting as a joint employer is determined to have committed the violation, the debarment determination will apply only to that member of the association unless the Administrator, OFLC determines that the association or other association members participated in the violation, in which case the debarment will be invoked against the complicit association or other association members.

(g) *Debarment involving agricultural associations acting as joint employers.* If the Administrator, OFLC determines a substantial violation has occurred, and if an agricultural association acting as a joint employer with its members is found to have committed the violation, the debarment determination will apply only to the association, and will not be applied to any individual employer-member of the association unless the Administrator, OFLC determines that the member participated in the violation, in which case the debarment will be invoked against any complicit association members as well. An association debarred from the H–2A temporary labor certification program will not be permitted to continue to file as a joint employer with its members during the period of the debarment.

(h) *Debarment involving agricultural associations acting as sole employers.* If the Administrator, OFLC determines a substantial violation has occurred, and if an agricultural association acting as a sole employer is determined to have committed the violation, the debarment determination will apply only to the association and any successor in interest to the debarred association.

§ 655.1319 Document retention requirements.

(a) *Entities required to retain documents.* All employers receiving a certification of the *Application for Temporary Employment Certification* for agricultural workers under this subpart are required to retain the documents and

records as provided in the regulations cited in paragraph (c) of this section.

(b) *Period of required retention.* Records and documents must be retained for a period of 3 years from the date of certification of the *Application for Temporary Employment Certification.*

(c) *Documents and records to be retained.* (1) All applicants must retain the following documentation:

(i) Proof of recruitment efforts including:

(A) Job order placement as specified in §655.102(e)(1);

(B) Advertising as specified in §655.102(g)(3), or, if used, professional, trade, or ethnic publications;

(C) Contact with former U.S. workers as specified in §655.102(h);

(D) Multi-state recruitment efforts (if required under §655.102(i)) as specified in §655.102(g)(3);

(ii) Substantiation of information submitted in the recruitment report prepared in accordance with §655.102(k)(2), such as evidence of nonapplicability of contact of former employees as specified in §655.102(h);

(iii) The supplemental recruitment report as specified in §655.102(k) and any supporting resumes and contact information as specified in §655.102(k)(3);

(iv) Proof of workers' compensation insurance or State law coverage as specified in §655.104(e);

(v) Records of each worker's earnings as specified in §655.104(j);

(vi) The work contract or a copy of the *Application for Temporary Employment Certification* as defined in 29 CFR 501.10 and specified in §655.104(q);

(vii) The wage determination provided by the NPC as specified in §655.108;

(viii) Copy of the request for housing inspection submitted to the SWA as specified in §655.104(d); and

(2) In addition to the documentation specified in paragraph (c)(1) of this section, H–2ALCs must also retain:

(i) Statements of compliance with the housing and transportation obligations for each fixed-site employer which provided housing or transportation and to which the H–2ALC provided workers during the validity period of the certification, unless such housing and transportation obligations were met by the H–2ALC itself, in which case proof of compliance by the H–2ALC must be retained, as specified in §655.101(a)(5);

(ii) Proof of surety bond coverage which includes the name, address, and phone number of the surety, the bond number of other identifying designation, the amount of coverage, and the payee, as specified in 29 CFR 501.8; and

(3) Associations filing must retain documentation substantiating their status as an employer or agent, as specified in §655.101(a)(1).

PART 656—LABOR CERTIFICATION PROCESS FOR PERMANENT EMPLOYMENT OF ALIENS IN THE UNITED STATES

Subpart A—Purpose and Scope of Part 656

Sec.

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656.40 Determination of prevailing wage for labor certification purposes.
656.41 Review of prevailing wage determinations.

AUTHORITY: 8 U.S.C. 1182(a)(5)(A), 1182(p)(1); sec.122, Public Law 101–649, 109 Stat. 4978; and Title IV, Public Law 105–277, 112 Stat. 2681.

SOURCE: 69 FR 77386, Dec. 27, 2004, unless otherwise noted.

Subpart A—Purpose and Scope of Part 656

§ 656.1 Purpose and scope of part 656.

(a) Under section 212(a)(5)(A) of the Immigration and Nationality Act (INA or Act) (8 U.S.C. 1182(a)(5)(A)), certain aliens may not obtain immigrant visas for entrance into the United States in order to engage in permanent employment unless the Secretary of Labor has first certified to the Secretary of State and to the Secretary of Homeland Security that:

(1) There are not sufficient United States workers who are able, willing, qualified and available at the time of application for a visa and admission into the United States and at the place where the alien is to perform the work; and

(2) The employment of the alien will not adversely affect the wages and working conditions of United States workers similarly employed.

(b) The regulations under this part set forth the procedures through which such immigrant labor certifications may be applied for, and granted or denied.

(c) Correspondence and questions about the regulations in this part should be addressed to: Office of Foreign Labor Certification, Employment and Training Administration, 200 Constitution Avenue, NW., Room C–4312, Washington, DC 20210.

[69 FR 77386, Dec. 27, 2004, as amended at 71 FR 35522, June 21, 2006]

§ 656.2 Description of the Immigration and Nationality Act and of the Department of Labor's role thereunder.

(a) *Description of the Act.* The Act (8 U.S.C. 1101 *et seq.*) regulates the admission of aliens into the United States. The Act designates the Secretary of Homeland Security and the Secretary of State as the principal administrators of its provisions.

(b) *Burden of proof under the Act.* Section 291 of the Act (8 U.S.C. 1361) provides, in pertinent part, that:

> Whenever any person makes application for a visa or any other documentation required for entry, or makes application for admission, or otherwise attempts to enter the United States, the burden of proof shall be upon such person to establish that he is eligible to receive such visa or such document, or is not subject to exclusion under any provision of this Act * * *.

(c)(1) *Role of the Department of Labor.* The permanent labor certification role of the Department of Labor under the Act derives from section 212(a)(5)(A) (8 U.S.C. 1182(a)(5)(A)), which provides that any alien who seeks admission or status as an immigrant for the purpose of employment under paragraph (2) or (3) of section 203(b) of the Act may not be admitted unless the Secretary of Labor has first certified to the Secretary of State and to the Secretary of Homeland Security that:

(i) There are not sufficient United States workers who are able, willing, qualified, and available at the time of application for a visa and admission to the United States and at the place where the alien is to perform such skilled or unskilled labor; and

(ii) The employment of such alien will not adversely affect the wages and working conditions of workers in the United States similarly employed.

(2) This certification is referred to in this part 656 as a ''labor certification.''

(3) We certify the employment of aliens in several instances: For the permanent employment of aliens under this part; and for temporary employment of aliens for agricultural and nonagricultural employment in the United States classified under 8 U.S.C. 1101(a)(15)(H)(ii), under the DHS regulation at 8 CFR 214.2(h)(5) and (6) and sections 101(a)(15)(H)(ii), 214, and 218 of the

Act. See 8 U.S.C. 1101(a)(15)(H)(ii), 1184, and 1188. We also administer labor attestation and labor condition application programs for the admission and/or work authorization of the following nonimmigrants: Specialty occupations and fashion models (H–1B visas), specialty occupations from countries with which the U.S. has entered agreements listed in the INA (H–1B1 visas), registered nurses (H–1C visas), and crewmembers performing longshore work (D visas), classified under 8 U.S.C. 1101(a)(15)(H)(i)(b), 1101(a)(15)(H)(i)(b1), 1101(a)(15)(H)(i)(c), and 1101(a)(15)(D), respectively. See also 8 U.S.C. 1184(c), (m), and (n), and 1288.

§ 656.3 Definitions, for purposes of this part, of terms used in this part.

Act means the Immigration and Nationality Act, as amended, 8 U.S.C. 1101 *et seq*.

Agent means a person who is not an employee of an employer, and who has been designated in writing to act on behalf of an alien or employer in connection with an application for labor certification.

Applicant means a U.S. worker (see definition of U.S. worker below) who is applying for a job opportunity for which an employer has filed an *Application for Permanent Employment Certification* (ETA Form 9089).

Application means an *Application for Permanent Employment Certification* submitted by an employer (or its agent or attorney) in applying for a labor certification under this part.

Area of intended employment means the area within normal commuting distance of the place (address) of intended employment. There is no rigid measure of distance which constitutes a normal commuting distance or normal commuting area, because there may be widely varying factual circumstances among different areas (e.g., normal commuting distances might be 20, 30, or 50 miles). If the place of intended employment is within a Metropolitan Statistical Area (MSA) or a Primary Metropolitan Statistical Area (PMSA), any place within the MSA or PMSA is deemed to be within normal commuting distance of the place of intended employment; however, not all locations within a Consolidated Metropolitan Statistical Area (CMSA) will be deemed automatically to be within normal commuting distance. The borders of MSA's and PMSA's are not controlling in the identification of the normal commuting area; a location outside of an MSA or PMSA (or a CMSA) may be within normal commuting distance of a location that is inside (e.g., near the border of) the MSA or PMSA (or CMSA). The terminology CMSAs and PMSAs are being replaced by the Office of Management and Budget (OMB). However, ETA will continue to recognize the use of these area concepts as well as their replacements.

Attorney means any person who is a member in good standing of the bar of the highest court of any state, possession, territory, or commonwealth of the United States, or the District of Columbia, and who is not under suspension or disbarment from practice before any court or before DHS or the United States Department of Justice's Executive Office for Immigration Review. Such a person is permitted to act as an agent, representative, or attorney for an employer and/or alien under this part.

Barter, for purposes of an Application for Permanent Employment Certification (Form ETA 9089) or an Application for Alien Labor Certification (Form ETA 750), means the transfer of ownership of a labor certification application or certification from one person to another by voluntary act or agreement in exchange for a commodity, service, property or other valuable consideration.

Board of Alien Labor Certification Appeals (BALCA or Board) means the permanent Board established by this part, chaired by the Chief Administrative Law Judge, and consisting of Administrative Law Judges assigned to the Department of Labor and designated by the Chief Administrative Law Judge to be members of the Board of Alien Labor Certification Appeals. The Board of Alien Labor Certification Appeals is located in Washington, DC, and reviews and decides appeals in Washington, DC.

Certifying Officer (CO) means a Department of Labor official who makes determinations about whether or not to grant applications for labor certifications.

Closely-held Corporation means a corporation that typically has relatively few shareholders and whose shares are not generally traded in the securities market.

Employer means:

(1) A person, association, firm, or a corporation that currently has a location within the United States to which U.S. workers may be referred for employment and that proposes to employ a full-time employee at a place within the United States, or the authorized representative of such a person, association, firm, or corporation. An employer must possess a valid Federal Employer Identification Number (FEIN). For purposes of this definition, an ''authorized representative'' means an employee of the employer whose position or legal status authorizes the employee to act for the employer in labor certification matters. A labor certification can not be granted for an *Application for Permanent Employment Certification* filed on behalf of an independent contractor.

(2) Persons who are temporarily in the United States, including but not limited to, foreign diplomats, intracompany transferees, students, and exchange visitors, visitors for business or pleasure, and representatives of foreign information media can not be employers for the purpose of obtaining a labor certification for permanent employment.

Employment means:

(1) Permanent, full-time work by an employee for an employer other than oneself. For purposes of this definition, an investor is not an employee. In the event of an audit, the employer must be prepared to document the permanent and full-time nature of the position by furnishing position descriptions and payroll records for the job opportunity involved in the *Application for Permanent Employment Certification*.

(2) Job opportunities consisting solely of job duties that will be performed totally outside the United States, its territories, possessions, or commonwealths can not be the subject of an *Application for Permanent Employment Certification*.

Employment and Training Administration (ETA) means the agency within the Department of Labor (DOL) that includes the Office of Foreign Labor Certification (OFLC).

Immigration Officer means an official of the Department of Homeland Security, United States Citizenship and Immigration Services (USCIS) who handles applications for labor certifications under this part.

Job opportunity means a job opening for employment at a place in the United States to which U.S. workers can be referred.

Nonprofessional occupation means any occupation for which the attainment of a bachelor's or higher degree is not a usual requirement for the occupation.

Non-profit or tax-exempt organization for the purposes of § 656.40 means an organization that:

(1) Is defined as a tax exempt organization under the Internal Revenue Code of 1986, section 501(c)(3), (c)(4), or (c)(6) (26 U.S.C. 501(c)(3), (c)(4) or (c)(6)); and

(2) Has been approved as a tax-exempt organization for research or educational purposes by the Internal Revenue Service.

Office of Foreign Labor Certification means the organizational component within the Employment and Training Administration that provides national leadership and policy guidance and develops regulations and procedures to carry out the responsibilities of the Secretary of Labor under the Immigration and Nationality Act, as amended, concerning alien workers seeking admission to the United States in order to work under section 212(a)(5)(A) of the Immigration and Nationality Act, as amended.

*O*NET* means the system developed by the Department of Labor, Employment and Training Administration, to provide to the general public information on skills, abilities, knowledge, work activities, interests and specific vocational preparation levels associated with occupations. O*NET is based on the Standard Occupational Classification system. Further information about O*NET can be found at *http://www.onetcenter.org*.

Prevailing wage determination (PWD) means the prevailing wage provided or approved by an OFLC National Processing Center (NPC), in accordance with OFLC guidance governing foreign

labor certification programs. This includes PWD requests processed for purposes of employer petitions filed with DHS under Schedule A or for sheepherders.

Professional occupation means an occupation for which the attainment of a bachelor's or higher degree is a usual education requirement. A beneficiary of an application for permanent alien employment certification involving a professional occupation need not have a bachelor's or higher degree to qualify for the professional occupation. However, if the employer is willing to accept work experience in lieu of a baccalaureate or higher degree, such work experience must be attainable in the U.S. labor market and must be stated on the application form. If the employer is willing to accept an equivalent foreign degree, it must be clearly stated on the *Application for Permanent Employment Certification form.*

Purchase, for purposes of an Application for Permanent Employment Certification (Form ETA 9089) or an Application for Alien Labor Certification (Form ETA 750), means the transfer of ownership of a labor certification application or certification from one person to another by voluntary act and agreement, based on a valuable consideration.

Sale, for purposes of an Application for Permanent Employment Certification (Form ETA 9089) or an Application for Alien Labor Certification (Form ETA 750), means an agreement between two parties, called, respectively, the seller (or vendor) and the buyer (or purchaser) by which the seller, in consideration of the payment or promise of payment of a certain price in money terms, transfers ownership of a labor certification application or certification to the buyer.

Secretary means the Secretary of Labor, the chief official of the U.S. Department of Labor, or the Secretary's designee.

Secretary of Homeland Security means the chief official of the U.S. Department of Homeland Security or the Secretary of Homeland Security's designee.

Secretary of State means the chief official of the U.S. Department of State or the Secretary of State's designee.

Specific vocational preparation (SVP) means the amount of lapsed time required by a typical worker to learn the techniques, acquire the information, and develop the facility needed for average performance in a specific job-worker situation. Lapsed time is not the same as work time. For example, 30 days is approximately 1 month of lapsed time and not six 5-day work weeks, and 3 months refers to 3 calendar months and not 90 work days. The various levels of specific vocational preparation are provided below.

Level	Time
1	Short demonstration.
2	Anything beyond short demonstration up to and including 30 days.
3	Over 30 days up to and including 3 months.
4	Over 3 months up to and including 6 months.
5	Over 6 months up to and including 1 year.
6	Over 1 year up to and including 2 years.
7	Over 2 years up to and including 4 years.
8	Over 4 years up to and including 10 years.
9	Over 10 years.

State Workforce Agency (SWA), formerly known as State Employment Security Agency (SESA), means the state agency that receives funds under the Wagner-Peyser Act to provide employment-related services to U.S. workers and employers and/or administers the public labor exchange delivered through the state's one-stop delivery system in accordance with the Wagner-Peyser Act.

United States, when used in a geographic sense, means the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

United States worker means any worker who is:

(1) A U.S. citizen;

(2) A U.S. national;

(3) Lawfully admitted for permanent residence;

(4) Granted the status of an alien lawfully admitted for temporary residence under 8 U.S.C. 1160(a), 1161(a), or 1255a(a)(1);

(5) Admitted as a refugee under 8 U.S.C. 1157; or

(6) Granted asylum under 8 U.S.C. 1158.

[69 FR 77386, Dec. 27, 2004, as amended at 71 FR 35522, June 21, 2006; 72 FR 27944, May 17, 2007; 73 FR 78068, Dec. 19, 2008]

Subpart B—Occupational Labor Certification Determinations

§ 656.5 Schedule A.

We have determined there are not sufficient United States workers who are able, willing, qualified, and available for the occupations listed below on *Schedule A* and the wages and working conditions of United States workers similarly employed will not be adversely affected by the employment of aliens in *Schedule A* occupations. An employer seeking a labor certification for an occupation listed on *Schedule A* may apply for that labor certification under § 656.15.

SCHEDULE A

(a) Group I:

(1) Persons who will be employed as physical therapists, and who possess all the qualifications necessary to take the physical therapist licensing examination in the state in which they propose to practice physical therapy.

(2) Aliens who will be employed as professional nurses; and

(i) Who have received a Certificate from the Commission on Graduates of Foreign Nursing Schools (CGFNS);

(ii) Who hold a permanent, full and unrestricted license to practice professional nursing in the state of intended employment; or

(iii) Who have passed the National Council Licensure Examination for Registered Nurses (NCLEX–RN), administered by the National Council of State Boards of Nursing.

(3) Definitions of Group I occupations:

(i) *Physical therapist* means a person who applies the art and science of physical therapy to the treatment of patients with disabilities, disorders and injuries to relieve pain, develop or restore function, and maintain performance, using physical means, such as exercise, massage, heat, water, light, and electricity, as prescribed by a physician (or a surgeon).

(ii) *Professional nurse* means a person who applies the art and science of nursing which reflects comprehension of principles derived from the physical, biological and behavioral sciences. Professional nursing generally includes making clinical judgments involving the observation, care and counsel of persons requiring nursing care; administering of medicines and treatments prescribed by the physician or dentist; and participation in the activities for the promotion of health and prevention of illness in others. A program of study for professional nurses generally includes theory and practice in clinical areas such as obstetrics, surgery, pediatrics, psychiatry, and medicine.

(b) Group II:

(1) *Sciences or arts (except performing arts).* Aliens (except for aliens in the performing arts) of exceptional ability in the sciences or arts including college and university teachers of exceptional ability who have been practicing their science or art during the year prior to application and who intend to practice the same science or art in the United States. For purposes of this group, the term ''science or art'' means any field of knowledge and/or skill with respect to which colleges and universities commonly offer specialized courses leading to a degree in the knowledge and/or skill. An alien, however, need not have studied at a college or university in order to qualify for the Group II occupation.

(2) *Performing arts.* Aliens of exceptional ability in the performing arts whose work during the past 12 months did require, and whose intended work in the United States will require, exceptional ability.

Subpart C—Labor Certification Process

§ 656.10 General instructions.

(a) *Filing of applications.* A request for a labor certification on behalf of any alien who is required by the Act to be a beneficiary of a labor certification in order to obtain permanent resident status in the United States may be filed as follows:

(1) Except as provided in paragraphs (a)(2), (3), and (4) of this section, an employer seeking a labor certification must file under this section and § 656.17.

(2) An employer seeking a labor certification for a college or university teacher must apply for a labor certification under this section and must also file under either § 656.17 or § 656.18.

(3) An employer seeking labor certification for an occupation listed on *Schedule A* must apply for a labor certification under this section and § 656.15.

(4) An employer seeking labor certification for a sheepherder must apply for a labor certification under this section and must also choose to file under either § 656.16 or § 656.17.

(b) *Representation.* (1) Employers may have agents or attorneys represent them throughout the labor certification process. If an employer intends to be represented by an agent or attorney, the employer must sign the statement set forth on the *Application for Permanent Employment Certification* form: That the attorney or agent is representing the employer and the employer takes full responsibility for the accuracy of any representations made by the attorney or agent. Whenever, under this part, any notice or other document is required to be sent to the employer, the document will be sent to the attorney or agent who has been authorized to represent the employer on the *Application for Permanent Employment Certification* form.

(2)(i) It is contrary to the best interests of U.S. workers to have the alien and/or agents or attorneys for either the employer or the alien participate in interviewing or considering U.S. workers for the job offered the alien. As the beneficiary of a labor certification application, the alien can not represent the best interests of U.S. workers in the job opportunity. The alien's agent and/or attorney can not represent the alien effectively and at the same time truly be seeking U.S. workers for the job opportunity. Therefore, the alien and/or the alien's agent and/or attorney may not interview or consider U.S. workers for the job offered to the alien, unless the agent and/or attorney is the employer's representative, as described in paragraph (b)(2)(ii) of this section.

(ii) The employer's representative who interviews or considers U.S. workers for the job offered to the alien must be the person who normally interviews or considers, on behalf of the employer, applicants for job opportunities such as that offered the alien, but which do not involve labor certifications.

(3) No person under suspension or disbarment from practice before any court or before the DHS or the United States Department of Justice's Executive Office for Immigration Review is permitted to act as an agent, representative, or attorney for an employer and/or alien under this part.

(c) *Attestations.* The employer must certify to the conditions of employment listed below on the *Application for Permanent Employment Certification* under penalty of perjury under 18 U.S.C. 1621 (2). Failure to attest to any of the conditions listed below results in a denial of the application.

(1) The offered wage equals or exceeds the prevailing wage determined pursuant to § 656.40 and § 656.41, and the wage the employer will pay to the alien to begin work will equal or exceed the prevailing wage that is applicable at the time the alien begins work or from the time the alien is admitted to take up the certified employment;

(2) The wage offered is not based on commissions, bonuses or other incentives, unless the employer guarantees a prevailing wage paid on a weekly, biweekly, or monthly basis that equals or exceeds the prevailing wage;

(3) The employer has enough funds available to pay the wage or salary offered the alien;

(4) The employer will be able to place the alien on the payroll on or before the date of the alien's proposed entrance into the United States;

(5) The job opportunity does not involve unlawful discrimination by race, creed, color, national origin, age, sex, religion, handicap, or citizenship;

(6) The employer's job opportunity is not:

(i) Vacant because the former occupant is on strike or locked out in the course of a labor dispute involving a work stoppage;

(ii) At issue in a labor dispute involving a work stoppage.

(7) The job opportunity's terms, conditions and occupational environment are not contrary to Federal, state or local law;

(8) The job opportunity has been and is clearly open to any U.S. worker;

(9) The U.S. workers who applied for the job opportunity were rejected for lawful job-related reasons;

(10) The job opportunity is for full-time, permanent employment for an employer other than the alien.

(d) *Notice.* (1) In applications filed under §§ 656.15 (*Schedule A*), 656.16 (Sheepherders), 656.17 (Basic Process), 656.18 (College and University Teachers), and 656.21 (Supervised Recruitment), the employer must give notice of the filing of the *Application for Permanent Employment Certification* and be able to document that notice was provided, if requested by the Certifying Officer, as follows:

(i) To the bargaining representative(s) (if any) of the employer's employees in the occupational classification for which certification of the job opportunity is sought in the employer's location(s) in the area of intended employment. Documentation may consist of a copy of the letter and a copy of the *Application for Permanent Employment Certification* form that was sent to the bargaining representative.

(ii) If there is no such bargaining representative, by posted notice to the employer's employees at the facility or location of the employment. The notice must be posted for at least 10 consecutive business days. The notice must be clearly visible and unobstructed while posted and must be posted in conspicuous places where the employer's U.S. workers can readily read the posted notice on their way to or from their place of employment. Appropriate locations for posting notices of the job opportunity include locations in the immediate vicinity of the wage and hour notices required by 29 CFR 516.4 or occupational safety and health notices required by 29 CFR 1903.2(a). In addition, the employer must publish the notice in any and all in-house media, whether electronic or printed, in accordance with the normal procedures used for the recruitment of similar positions in the employer's organization. The documentation requirement may be satisfied by providing a copy of the posted notice and stating where it was posted, and by providing copies of all the in-house media, whether electronic or print, that were used to distribute notice of the application in accordance with the procedures used for similar positions within the employer's organization.

(2) In the case of a private household, notice is required under this paragraph (d) only if the household employs one or more U.S. workers at the time the application for labor certification is filed. The documentation requirement may be satisfied by providing a copy of the posted notice to the Certifying Officer.

(3) The notice of the filing of an *Application for Permanent Employment Certification* must:

(i) State the notice is being provided as a result of the filing of an application for permanent alien labor certification for the relevant job opportunity;

(ii) State any person may provide documentary evidence bearing on the application to the Certifying Officer of the Department of Labor;

(iii) Provide the address of the appropriate Certifying Officer; and

(iv) Be provided between 30 and 180 days before filing the application.

(4) If an application is filed under § 656.17, the notice must contain the information required for advertisements by § 656.17(f), must state the rate of pay (which must equal or exceed the prevailing wage entered by the SWA on the prevailing wage request form), and must contain the information required by paragraph (d)(3) of this section.

(5) If an application is filed on behalf of a college and university teacher selected in a competitive selection and recruitment process, as provided by § 656.18, the notice must include the information required for advertisements by § 656.18(b)(3), and must include the information required by paragraph (d)(3) of this section.

(6) If an application is filed under the *Schedule A* procedures at § 656.15, or the procedures for sheepherders at § 656.16, the notice must contain a description of the job and rate of pay, and must meet the requirements of this section.

(e)(1)(i) *Submission of evidence.* Any person may submit to the Certifying Officer documentary evidence bearing on an application for permanent alien labor certification filed under the basic labor certification process at § 656.17 or an application involving a college and university teacher selected in a competitive recruitment and selection process under § 656.18.

(ii) Documentary evidence submitted under paragraph (e)(1)(i) of this section may include information on available workers, information on wages and working conditions, and information on the employer's failure to meet the terms and conditions for the employment of alien workers and co-workers. The Certifying Officer must consider this information in making his or her determination.

(2)(i) Any person may submit to the appropriate DHS office documentary evidence of fraud or willful misrepresentation in a *Schedule A* application filed under § 656.15 or a sheepherder application filed under § 656.16.

(ii) Documentary evidence submitted under paragraph (e)(2) of this section is limited to information relating to possible fraud or willful misrepresentation. The DHS may consider this information under § 656.31.

(f) *Retention of documents.* Copies of applications for permanent employment certification filed with the Department of Labor and all supporting documentation must be retained by the employer for 5 years from the date of filing the *Application for Permanent Employment Certification.*

[69 FR 77386, Dec. 27, 2004, as amended at 71 FR 35523, June 21, 2006]

§ 656.11 Substitutions and modifications to applications.

(a) Substitution or change to the identity of an alien beneficiary on any application for permanent labor certification, whether filed under this part or 20 CFR part 656 in effect prior to March 28, 2005, and on any resulting certification, is prohibited for any request to substitute submitted after July 16, 2007.

(b) Requests for modifications to an application will not be accepted for applications submitted after July 16, 2007.

[72 FR 27944, May 17, 2007]

§ 656.12 Improper commerce and payment.

The following provision applies to applications filed under both this part and 20 CFR part 656 in effect prior to March 28, 2005, and to any certification resulting from those applications:

(a) Applications for permanent labor certification and approved labor certifications are not articles of commerce. They shall not be offered for sale, barter or purchase by individuals or entities. Any evidence that an application for permanent labor certification or an approved labor certification has been sold, bartered, or purchased shall be grounds for investigation under this part and may be grounds for denial under § 656.24, revocation under § 656.32, debarment under § 656.31(f), or any combination thereof.

(b) An employer must not seek or receive payment of any kind for any activity related to obtaining permanent labor certification, including payment of the employer's attorneys' fees, whether as an incentive or inducement to filing, or as a reimbursement for costs incurred in preparing or filing a permanent labor certification application, except when work to be performed by the alien in connection with the job opportunity would benefit or accrue to the person or entity making the payment, based on that person's or entity's established business relationship with the employer. An alien may pay his or her own costs in connection with a labor certification, including attorneys' fees for representation of the alien, except that where the same attorney represents both the alien and the employer, such costs shall be borne by the employer. For purposes of this paragraph (b), payment includes, but is not limited to, monetary payments; wage concessions, including deductions from wages, salary, or benefits; kickbacks, bribes, or tributes; in kind payments; and free labor.

(c) Evidence that an employer has sought or received payment from any source in connection with an application for permanent labor certification or an approved labor certification, except for a third party to whose benefit work to be performed in connection with the job opportunity would accrue, based on that person's or entity's established business relationship with the employer, shall be grounds for investigation under this part or any appropriate Government agency's procedures, and may be grounds for denial under § 656.32, revocation under § 656.32,

debarment under § 656.31(f), or any combination thereof.

[72 FR 27945, May 17, 2007]

§ 656.15 Applications for labor certification for *Schedule A* occupations.

(a) *Filing application.* An employer must apply for a labor certification for a *Schedule A* occupation by filing an application with the appropriate DHS office, and not with an ETA application processing center.

(b) *General documentation requirements.* A *Schedule A* application must include:

(1) An *Application for Permanent Employment Certification* form, which includes a prevailing wage determination in accordance with §§ 656.40 and 656.41.

(2) Evidence that notice of filing the *Application for Permanent Employment Certification* was provided to the bargaining representative or the employer's employees as prescribed in § 656.10(d).

(c) *Group I documentation.* An employer seeking labor certification under Group I of *Schedule A* must file with DHS, as part of its labor certification application, documentary evidence of the following:

(1) An employer seeking *Schedule A* labor certification for an alien to be employed as a physical therapist (§ 656.5(a)(1)) must file as part of its labor certification application a letter or statement, signed by an authorized state physical therapy licensing official in the state of intended employment, stating the alien is qualified to take that state's written licensing examination for physical therapists. Application for certification of permanent employment as a physical therapist may be made only under this § 656.15 and not under § 656.17.

(2) An employer seeking a *Schedule A* labor certification for an alien to be employed as a professional nurse (§ 656.5(a)(2)) must file as part of its labor certification application documentation that the alien has received a Certificate from the Commission on Graduates of Foreign Nursing Schools (CGFNS); that the alien holds a full and unrestricted (permanent) license to practice nursing in the state of intended employment; or that the alien has passed the National Council Licensure Examination for Registered Nurses (NCLEX–RN). Application for certification of employment as a professional nurse may be made only under this § 656.15(c) and not under § 656.17.

(d) *Group II documentation.* An employer seeking a *Schedule A* labor certification under Group II of *Schedule A* must file with DHS, as part of its labor certification application, documentary evidence of the following:

(1) An employer seeking labor certification on behalf of an alien to be employed as an alien of exceptional ability in the sciences or arts (excluding those in the performing arts) must file documentary evidence showing the widespread acclaim and international recognition accorded the alien by recognized experts in the alien's field; and documentation showing the alien's work in that field during the past year did, and the alien's intended work in the United States will, require exceptional ability. In addition, the employer must file documentation about the alien from at least two of the following seven groups:

(i) Documentation of the alien's receipt of internationally recognized prizes or awards for excellence in the field for which certification is sought;

(ii) Documentation of the alien's membership in international associations, in the field for which certification is sought, which require outstanding achievement of their members, as judged by recognized international experts in their disciplines or fields;

(iii) Published material in professional publications about the alien, about the alien's work in the field for which certification is sought, which shall include the title, date, and author of such published material;

(iv) Evidence of the alien's participation on a panel, or individually, as a judge of the work of others in the same or in an allied field of specialization to that for which certification is sought;

(v) Evidence of the alien's original scientific or scholarly research contributions of major significance in the field for which certification is sought;

(vi) Evidence of the alien's authorship of published scientific or scholarly

articles in the field for which certification is sought, in international professional journals or professional journals with an international circulation;

(vii) Evidence of the display of the alien's work, in the field for which certification is sought, at artistic exhibitions in more than one country.

(2) An employer seeking labor certification on behalf of an alien of exceptional ability in the performing arts must file documentary evidence that the alien's work experience during the past twelve months did require, and the alien's intended work in the United States will require, exceptional ability; and must submit documentation to show this exceptional ability, such as:

(i) Documentation attesting to the current widespread acclaim and international recognition accorded to the alien, and receipt of internationally recognized prizes or awards for excellence;

(ii) Published material by or about the alien, such as critical reviews or articles in major newspapers, periodicals, and/or trade journals (the title, date, and author of such material shall be indicated);

(iii) Documentary evidence of earnings commensurate with the claimed level of ability;

(iv) Playbills and star billings;

(v) Documents attesting to the outstanding reputation of theaters, concert halls, night clubs, and other establishments in which the alien has appeared or is scheduled to appear; and/or

(vi) Documents attesting to the outstanding reputation of theaters or repertory companies, ballet troupes, orchestras, or other organizations in which or with which the alien has performed during the past year in a leading or starring capacity.

(e) *Determination.* An Immigration Officer determines whether the employer and alien have met the applicable requirements of § 656.10 and of *Schedule A* (§ 656.5); reviews the application; and determines whether or not the alien is qualified for and intends to pursue the *Schedule A* occupation. The *Schedule A* determination of DHS is conclusive and final. The employer, therefore, may not appeal from any such determination under the review procedures at § 656.26.

(f) *Refiling after denial.* If an application for a *Schedule A* occupation is denied, the employer, except where the occupation is as a physical therapist or a professional nurse, may at any time file for a labor certification on the alien beneficiary's behalf under § 656.17. Labor certifications for professional nurses and for physical therapists shall not be considered under § 656.17.

[69 FR 77386, Dec. 27, 2004, as amended at 73 FR 78068, Dec. 19, 2008]

§ 656.16 Labor certification applications for sheepherders.

(a) *Filing requirements and required documentation.* (1) An employer may apply for a labor certification to employ an alien (who has been employed legally as a nonimmigrant sheepherder in the United States for at least 33 of the preceding 36 months) as a sheepherder by filing an *Application for Permanent Employment Certification* form directly with DHS, not with an office of DOL.

(2) A signed letter or letters from each U.S. employer who has employed the alien as a sheepherder during the immediately preceding 36 months, attesting the alien has been employed in the United States lawfully and continuously as a sheepherder for at least 33 of the immediately preceding 36 months, must be filed with the application.

(b) *Determination.* An Immigration Officer reviews the application and the letters attesting to the alien's previous employment as a sheepherder in the United States, and determines whether or not the alien and the employer(s) have met the requirements of this section.

(1) The determination of the Immigration Officer under this paragraph (b) is conclusive and final. The employer(s) and the alien, therefore, may not make use of the review procedures set forth at §§ 656.26 and 656.27 to appeal such a determination.

(2) If the alien and the employer(s) have met the requirements of this section, the Immigration Officer must indicate on the *Application for Permanent Employment Certification* form the occupation, the immigration office that made the determination, and the date of the determination (see § 656.30 for

the significance of this date). The Immigration Officer must then promptly forward a copy of the *Application for Permanent Employment Certification* form, without attachments, to the Office of Foreign Labor Certification (OFLC) Administrator.

(c) *Alternative filing.* If an application for a sheepherder does not meet the requirements of this section, the application may be filed under § 656.17.

[69 FR 77386, Dec. 27, 2004, as amended at 71 FR 35523, June 21, 2006]

§ 656.17 Basic labor certification process.

(a) *Filing applications.* (1) Except as otherwise provided by §§ 656.15, 656.16, and 656.18, an employer who desires to apply for a labor certification on behalf of an alien must file a completed Department of Labor *Application for Permanent Employment Certification* form (ETA Form 9089). The application must be filed with an ETA application processing center. Incomplete applications will be denied. Applications filed and certified electronically must, upon receipt of the labor certification, be signed immediately by the employer in order to be valid. Applications submitted by mail must contain the original signature of the employer, alien, attorney, and/or agent when they are received by the application processing center. DHS will not process petitions unless they are supported by an original certified ETA Form 9089 that has been signed by the employer, alien, attorney and/or agent.

(2) The Department of Labor may issue or require the use of certain identifying information, including user identifiers, passwords, or personal identification numbers (PINS). The purpose of these personal identifiers is to allow the Department of Labor to associate a given electronic submission with a single, specific individual. Personal identifiers can not be issued to a company or business. Rather, a personal identifier can only be issued to specific individual. Any personal identifiers must be used solely by the individual to whom they are assigned and can not be used or transferred to any other individual. An individual assigned a personal identifier must take all reasonable steps to ensure that his or her personal identifier can not be compromised. If an individual assigned a personal identifier suspects, or becomes aware, that his or her personal identifier has been compromised or is being used by someone else, then the individual must notify the Department of Labor immediately of the incident and cease the electronic transmission of any further submissions under that personal identifier until such time as a new personal identifier is provided. Any electronic transmissions submitted with a personal identifier will be presumed to be a submission by the individual assigned that personal identifier. The Department of Labor's system will notify those making submissions of these requirements at the time of each submission.

(3) Documentation supporting the application for labor certification should not be filed with the application, however in the event the Certifying Officer notifies the employer that its application is to be audited, the employer must furnish required supporting documentation prior to a final determination.

(b) *Processing.* (1) Applications are screened and are certified, are denied, or are selected for audit.

(2) Employers will be notified if their applications have been selected for audit by the issuance of an audit letter under § 656.20.

(3) Applications may be selected for audit in accordance with selection criteria or may be randomly selected.

(c) *Filing date.* Non-electronically filed applications accepted for processing shall be date stamped. Electronically filed applications will be considered filed when submitted.

(d) *Refiling procedures.* (1) Employers that filed applications under the regulations in effect prior to March 28, 2005, may, if a job order has not been placed pursuant to those regulations, refile such applications under this part without loss of the original filing date by:

(i) Submitting an application for an identical job opportunity after complying with all of the filing and recruiting requirements of this part 656; and

(ii) Withdrawing the original application in accordance with ETA procedures. Filing an application under this

part stating the employer's desire to use the original filing date will be deemed to be a withdrawal of the original application. The original application will be deemed withdrawn regardless of whether the employer's request to use the original filing date is approved.

(2) Refilings under this paragraph must be made within 210 days of the withdrawal of the prior application.

(3) A copy of the original application, including amendments, must be sent to the appropriate ETA application processing center when requested by the CO under § 656.20.

(4) For purposes of paragraph (d)(1)(i) of this section, a job opportunity shall be considered identical if the employer, alien, job title, job location, job requirements, and job description are the same as those stated in the original application filed under the regulations in effect prior to March 28, 2005. For purposes of determining identical job opportunity, the original application includes all accepted amendments up to the time the application was withdrawn, including amendments in response to an assessment notice from a SWA pursuant to § 656.21(h) of the regulations in effect prior to March 28, 2005.

(e) *Required pre-filing recruitment.* Except for labor certification applications involving college or university teachers selected pursuant to a competitive recruitment and selection process (§ 656.18), *Schedule A* occupations (§§ 656.5 and 656.15), and sheepherders (§ 656.16), an employer must attest to having conducted the following recruitment prior to filing the application:

(1) *Professional occupations.* If the application is for a professional occupation, the employer must conduct the recruitment steps within 6 months of filing the application for alien employment certification. The employer must maintain documentation of the recruitment and be prepared to submit this documentation in the event of an audit or in response to a request from the Certifying Officer prior to rendering a final determination.

(i) *Mandatory steps.* Two of the steps, a job order and two print advertisements, are mandatory for all applications involving professional occupations, except applications for college or university teachers selected in a competitive selection and recruitment process as provided in § 656.18. The mandatory recruitment steps must be conducted at least 30 days, but no more than 180 days, before the filing of the application.

(A) *Job order.* Placement of a job order with the SWA serving the area of intended employment for a period of 30 days. The start and end dates of the job order entered on the application shall serve as documentation of this step.

(B) *Advertisements in newspaper or professional journals.* (*1*) Placing an advertisement on two different Sundays in the newspaper of general circulation in the area of intended employment most appropriate to the occupation and the workers likely to apply for the job opportunity and most likely to bring responses from able, willing, qualified, and available U.S. workers.

(*2*) If the job opportunity is located in a rural area of intended employment that does not have a newspaper with a Sunday edition, the employer may use the edition with the widest circulation in the area of intended employment.

(*3*) The advertisements must satisfy the requirements of paragraph (f) of this section. Documentation of this step can be satisfied by furnishing copies of the newspaper pages in which the advertisements appeared or proof of publication furnished by the newspaper.

(*4*) If the job involved in the application requires experience and an advanced degree, and a professional journal normally would be used to advertise the job opportunity, the employer may, in lieu of one of the Sunday advertisements, place an advertisement in the professional journal most likely to bring responses from able, willing, qualified, and available U.S. workers. Documentation of this step can be satisfied by providing a copy of the page in which the advertisement appeared.

(ii) *Additional recruitment steps.* The employer must select three additional recruitment steps from the alternatives listed in paragraphs (e)(1)(ii)(A)–(J) of this section. Only one of the additional steps may consist

solely of activity that took place within 30 days of the filing of the application. None of the steps may have taken place more than 180 days prior to filing the application.

(A) *Job fairs.* Recruitment at job fairs for the occupation involved in the application, which can be documented by brochures advertising the fair and newspaper advertisements in which the employer is named as a participant in the job fair.

(B) *Employer's Web site.* The use of the employer's Web site as a recruitment medium can be documented by providing dated copies of pages from the site that advertise the occupation involved in the application.

(C) *Job search Web site other than the employer's.* The use of a job search Web site other than the employer's can be documented by providing dated copies of pages from one or more website(s) that advertise the occupation involved in the application. Copies of web pages generated in conjunction with the newspaper advertisements required by paragraph (e)(1)(i)(B) of this section can serve as documentation of the use of a Web site other than the employer's.

(D) *On-campus recruiting.* The employer's on-campus recruiting can be documented by providing copies of the notification issued or posted by the college's or university's placement office naming the employer and the date it conducted interviews for employment in the occupation.

(E) *Trade or professional organizations.* The use of professional or trade organizations as a recruitment source can be documented by providing copies of pages of newsletters or trade journals containing advertisements for the occupation involved in the application for alien employment certification.

(F) *Private employment firms.* The use of private employment firms or placement agencies can be documented by providing documentation sufficient to demonstrate that recruitment has been conducted by a private firm for the occupation for which certification is sought. For example, documentation might consist of copies of contracts between the employer and the private employment firm and copies of advertisements placed by the private employment firm for the occupation involved in the application.

(G) *Employee referral program with incentives.* The use of an employee referral program with incentives can be documented by providing dated copies of employer notices or memoranda advertising the program and specifying the incentives offered.

(H) *Campus placement offices.* The use of a campus placement office can be documented by providing a copy of the employer's notice of the job opportunity provided to the campus placement office.

(I) *Local and ethnic newspapers.* The use of local and ethnic newspapers can be documented by providing a copy of the page in the newspaper that contains the employer's advertisement.

(J) *Radio and television advertisements.* The use of radio and television advertisements can be documented by providing a copy of the employer's text of the employer's advertisement along with a written confirmation from the radio or television station stating when the advertisement was aired.

(2) *Nonprofessional occupations.* If the application is for a nonprofessional occupation, the employer must at a minimum, place a job order and two newspaper advertisements within 6 months of filing the application. The steps must be conducted at least 30 days but no more that 180 days before the filing of the application.

(i) *Job order.* Placing a job order with the SWA serving the area of intended employment for a period of 30 days. The start and end dates of the job order entered on the application serve as documentation of this step.

(ii) *Newspaper advertisements.* (A) Placing an advertisement on two different Sundays in the newspaper of general circulation in the area of intended employment most appropriate to the occupation and the workers likely to apply for the job opportunity.

(B) If the job opportunity is located in a rural area of intended employment that does not have a newspaper that publishes a Sunday edition, the employer may use the newspaper edition with the widest circulation in the area of intended employment.

(C) Placement of the newspaper advertisements can be documented in the

same way as provided in paragraph (e)(1)(i)(B)(*3*) of this section for professional occupations.

(D) The advertisements must satisfy the requirements of paragraph (f) of this section.

(f) *Advertising requirements.* Advertisements placed in newspapers of general circulation or in professional journals before filing the *Application for Permanent Employment Certification* must:

(1) Name the employer;

(2) Direct applicants to report or send resumes, as appropriate for the occupation, to the employer;

(3) Provide a description of the vacancy specific enough to apprise the U.S. workers of the job opportunity for which certification is sought;

(4) Indicate the geographic area of employment with enough specificity to apprise applicants of any travel requirements and where applicants will likely have to reside to perform the job opportunity;

(5) Not contain a wage rate lower than the prevailing wage rate;

(6) Not contain any job requirements or duties which exceed the job requirements or duties listed on the ETA Form 9089; and

(7) Not contain wages or terms and conditions of employment that are less favorable than those offered to the alien.

(g) *Recruitment report.* (1) The employer must prepare a recruitment report signed by the employer or the employer's representative noted in § 656.10(b)(2)(ii) describing the recruitment steps undertaken and the results achieved, the number of hires, and, if applicable, the number of U.S. workers rejected, categorized by the lawful job related reasons for such rejections. The Certifying Officer, after reviewing the employer's recruitment report, may request the U.S. workers' resumes or applications, sorted by the reasons the workers were rejected.

(2) A U.S. worker is able and qualified for the job opportunity if the worker can acquire the skills necessary to perform the duties involved in the occupation during a reasonable period of on-the-job training. Rejecting U.S. workers for lacking skills necessary to perform the duties involved in the occupation, where the U.S. workers are capable of acquiring the skills during a reasonable period of on-the-job training is not a lawful job-related reason for rejection of the U.S. workers.

(h) *Job duties and requirements.* (1) The job opportunity's requirements, unless adequately documented as arising from business necessity, must be those normally required for the occupation and must not exceed the Specific Vocational Preparation level assigned to the occupation as shown in the O*NET Job Zones. To establish a business necessity, an employer must demonstrate the job duties and requirements bear a reasonable relationship to the occupation in the context of the employer's business and are essential to perform the job in a reasonable manner.

(2) A foreign language requirement can not be included, unless it is justified by business necessity. Demonstrating business necessity for a foreign language requirement may be based upon the following:

(i) The nature of the occupation, e.g., translator; or

(ii) The need to communicate with a large majority of the employer's customers, contractors, or employees who can not communicate effectively in English, as documented by:

(A) The employer furnishing the number and proportion of its clients, contractors, or employees who can not communicate in English, and/or a detailed plan to market products or services in a foreign country; and

(B) A detailed explanation of why the duties of the position for which certification is sought requires frequent contact and communication with customers, employees or contractors who can not communicate in English and why it is reasonable to believe the allegedly foreign-language-speaking customers, employees, and contractors can not communicate in English.

(3) If the job opportunity involves a combination of occupations, the employer must document that it has normally employed persons for that combination of occupations, and/or workers customarily perform the combination of occupations in the area of intended employment, and/or the combination job opportunity is based on a business necessity. Combination occupations

can be documented by position descriptions and relevant payroll records, and/or letters from other employers stating their workers normally perform the combination of occupations in the area of intended employment, and/or documentation that the combination occupation arises from a business necessity.

(4)(i) Alternative experience requirements must be substantially equivalent to the primary requirements of the job opportunity for which certification is sought; and

(ii) If the alien beneficiary already is employed by the employer, and the alien does not meet the primary job requirements and only potentially qualifies for the job by virtue of the employer's alternative requirements, certification will be denied unless the application states that any suitable combination of education, training, or experience is acceptable.

(i) *Actual minimum requirements.* DOL will evaluate the employer's actual minimum requirements in accordance with this paragraph (i).

(1) The job requirements, as described, must represent the employer's actual minimum requirements for the job opportunity.

(2) The employer must not have hired workers with less training or experience for jobs substantially comparable to that involved in the job opportunity.

(3) If the alien beneficiary already is employed by the employer, in considering whether the job requirements represent the employer's actual minimums, DOL will review the training and experience possessed by the alien beneficiary at the time of hiring by the employer, including as a contract employee. The employer can not require domestic worker applicants to possess training and/or experience beyond what the alien possessed at the time of hire unless:

(i) The alien gained the experience while working for the employer, including as a contract employee, in a position not substantially comparable to the position for which certification is being sought, or

(ii) The employer can demonstrate that it is no longer feasible to train a worker to qualify for the position.

(4) In evaluating whether the alien beneficiary satisfies the employer's actual minimum requirements, DOL will not consider any education or training obtained by the alien beneficiary at the employer's expense unless the employer offers similar training to domestic worker applicants.

(5) For purposes of this paragraph (i):

(i) The term ''employer'' means an entity with the same Federal Employer Identification Number (FEIN), provided it meets the definition of an employer at § 656.3.

(ii) A ''substantially comparable'' job or position means a job or position requiring performance of the same job duties more than 50 percent of the time. This requirement can be documented by furnishing position descriptions, the percentage of time spent on the various duties, organization charts, and payroll records.

(j) *Conditions of employment.* (1) Working conditions must be normal to the occupation in the area and industry.

(2) Live-in requirements are acceptable for household domestic service workers only if the employer can demonstrate the requirement is essential to perform, in a reasonable manner, the job duties as described by the employer and there are not cost-effective alternatives to a live-in household requirement. Mere employer assertions do not constitute acceptable documentation. For example, a live-in requirement could be supported by documenting two working parents and young children in the household, and/or the existence of erratic work schedules requiring frequent travel and a need to entertain business associates and clients on short notice. Depending upon the situation, acceptable documentation could consist of travel vouchers, written estimates of costs of alternatives such as babysitters, or a detailed listing of the frequency and length of absences of the employer from the home.

(k) *Layoffs.* (1) If there has been a layoff by the employer applicant in the area of intended employment within 6 months of filing an application involving the occupation for which certification is sought or in a related occupation, the employer must document it

has notified and considered all potentially qualified laid off (employer applicant) U.S. workers of the job opportunity involved in the application and the results of the notification and consideration. A layoff shall be considered any involuntary separation of one or more employees without cause or prejudice.

(2) For the purposes of paragraph (k)(1) of this section, a related occupation is any occupation that requires workers to perform a majority of the essential duties involved in the occupation for which certification is sought.

(l) *Alien influence and control over job opportunity.* If the employer is a closely held corporation or partnership in which the alien has an ownership interest, or if there is a familial relationship between the stockholders, corporate officers, incorporators, or partners, and the alien, or if the alien is one of a small number of employees, the employer in the event of an audit must be able to demonstrate the existence of a bona fide job opportunity, *i.e.*, the job is available to all U.S. workers, and must provide to the Certifying Officer, the following supporting documentation:

(1) A copy of the articles of incorporation, partnership agreement, business license or similar documents that establish the business entity;

(2) A list of all corporate/company officers and shareholders/partners of the corporation/firm/business, their titles and positions in the business' structure, and a description of the relationships to each other and to the alien beneficiary;

(3) The financial history of the corporation/company/partnership, including the total investment in the business entity and the amount of investment of each officer, incorporator/partner and the alien beneficiary; and

(4) The name of the business' official with primary responsibility for interviewing and hiring applicants for positions within the organization and the name(s) of the business' official(s) having control or influence over hiring decisions involving the position for which labor certification is sought.

(5) If the alien is one of 10 or fewer employees, the employer must document any family relationship between the employees and the alien.

§ 656.18 Optional special recruitment and documentation procedures for college and university teachers.

(a) *Filing requirements.* Applications for certification of employment of college and university teachers must be filed by submitting a completed *Application for Permanent Employment Certification* form to the appropriate ETA application processing center.

(b) *Recruitment.* The employer may recruit for college and university teachers under § 656.17 or must be able to document the alien was selected for the job opportunity in a competitive recruitment and selection process through which the alien was found to be more qualified than any of the United States workers who applied for the job. For purposes of this paragraph (b), documentation of the ''competitive recruitment and selection process'' must include:

(1) A statement, signed by an official who has actual hiring authority from the employer outlining in detail the complete recruitment procedures undertaken; and which must set forth:

(i) The total number of applicants for the job opportunity;

(ii) The specific lawful job-related reasons why the alien is more qualified than each U.S. worker who applied for the job; and

(2) A final report of the faculty, student, and/or administrative body making the recommendation or selection of the alien, at the completion of the competitive recruitment and selection process;

(3) A copy of at least one advertisement for the job opportunity placed in a national professional journal, giving the name and the date(s) of publication; and which states the job title, duties, and requirements;

(4) Evidence of all other recruitment sources utilized; and

(5) A written statement attesting to the degree of the alien's educational or professional qualifications and academic achievements.

(c) *Time limit for filing.* Applications for permanent alien labor certification for job opportunities as college and

university teachers must be filed within 18 months after a selection is made pursuant to a competitive recruitment and selection process.

(d) *Alternative procedure*. An employer that can not or does not choose to satisfy the special recruitment procedures for a college or university teacher under this section may avail itself of the basic process at § 656.17. An employer that files for certification of employment of college and university teachers under § 656.17 or this section must be able to document, if requested by the Certifying Officer, in accordance with § 656.24(a)(2)(ii), the alien was found to be more qualified than each U.S. worker who applied for the job opportunity.

§ 656.19 Live-in household domestic service workers.

(a) *Processing*. Applications on behalf of live-in household domestic service occupations are processed pursuant to the requirements of the basic process at § 656.17.

(b) *Required documentation*. Employers filing applications on behalf of live-in household domestic service workers must provide, in event of an audit, the following documentation:

(1) A statement describing the household living accommodations, including the following:

(i) Whether the residence is a house or apartment;

(ii) The number of rooms in the residence;

(iii) The number of adults and children, and ages of the children, residing in the household; and

(iv) That free board and a private room not shared with any other person will be provided to the alien.

(2) Two copies of the employment contract, each signed and dated prior to the filing of the application by both the employer and the alien (not by their attorneys or agents). The contract must clearly state:

(i) The wages to be paid on an hourly and weekly basis;

(ii) Total hours of employment per week, and exact hours of daily employment;

(iii) That the alien is free to leave the employer's premises during all nonwork hours except the alien may work overtime if paid for the overtime at no less than the legally required hourly rate;

(iv) That the alien will reside on the employer's premises;

(v) Complete details of the duties to be performed by the alien;

(vi) The total amount of any money to be advanced by the employer with details of specific items, and the terms of repayment by the alien of any such advance by the employer;

(vii) That in no event may the alien be required to give more than two weeks' notice of intent to leave the employment contracted for and the employer must give the alien at least two weeks' notice before terminating employment;

(viii) That a duplicate contract has been furnished to the alien;

(ix) That a private room and board will be provided at no cost to the worker; and

(x) Any other agreement or conditions not specified on the *Application for Permanent Employment Certification* form.

(3) Documentation of the alien's paid experience in the form of statements from past or present employers setting forth the dates (month and year) employment started and ended, hours of work per day, number of days worked per week, place where the alien worked, detailed statement of duties performed on the job, equipment and appliances used, and the amount of wages paid per week or month. The total paid experience must be equal to one full year's employment on a full-time basis. For example, two year's experience working half-days is the equivalent of one year's full time experience. Time spent in a household domestic service training course can not be included in the required one year of paid experience. Each statement must contain the name and address of the person who signed it and show the date on which the statement was signed. A statement not in English shall be accompanied by a written translation into English certified by the translator as to the accuracy of the translation, and as to the translator's competency to translate.

§ 656.20 Audit procedures.

(a) Review of the labor certification application may lead to an audit of the application. Additionally, certain applications may be selected randomly for audit and quality control purposes. If an application is selected for audit, the Certifying Officer shall issue an audit letter. The audit letter will:

(1) State the documentation that must be submitted by the employer;

(2) Specify a date, 30 days from the date of the audit letter, by which the required documentation must be submitted; and

(3) Advise that if the required documentation has not been sent by the date specified the application will be denied.

(i) Failure to provide documentation in a timely manner constitutes a refusal to exhaust available administrative remedies; and

(ii) The administrative-judicial review procedure provided in § 656.26 is not available.

(b) A substantial failure by the employer to provide required documentation will result in that application being denied under § 656.24 and may result in a determination by the Certifying Officer pursuant to § 656.24 to require the employer to conduct supervised recruitment under § 656.21 in future filings of labor certification applications for up to 2 years.

(c) The Certifying Officer may in his or her discretion provide one extension, of up to 30 days, to the 30 days specified in paragraph (a)(2) of this section.

(d) Before making a final determination in accordance with the standards in § 656.24, whether in course of an audit or otherwise, the Certifying Officer may:

(1) Request supplemental information and/or documentation; or

(2) Require the employer to conduct supervised recruitment under § 656.21.

[69 FR 77386, Dec. 27, 2004, as amended at 71 FR 35523, June 21, 2006]

§ 656.21 Supervised recruitment.

(a) *Supervised recruitment.* Where the Certifying Officer determines it appropriate, post-filing supervised recruitment may be required of the employer for the pending application or future applications pursuant to § 656.20(b).

(b) *Requirements.* Supervised recruitment shall consist of advertising for the job opportunity by placing an advertisement in a newspaper of general circulation or in a professional, trade, or ethnic publication, and any other measures required by the CO. If placed in a newspaper of general circulation, the advertisement must be published for 3 consecutive days, one of which must be a Sunday; or, if placed in a professional, trade, or ethnic publication, the advertisement must be published in the next available published edition. The advertisement must be approved by the Certifying Officer before publication, and the CO will direct where the advertisement is to be placed.

(1) The employer must supply a draft advertisement to the CO for review and approval within 30 days of being notified that supervised recruitment is required.

(2) The advertisement must:

(i) Direct applicants to send resumes or applications for the job opportunity to the CO for referral to the employer;

(ii) Include an identification number and an address designated by the Certifying Officer;

(iii) Describe the job opportunity;

(iv) Not contain a wage rate lower than the prevailing wage rate;

(v) Summarize the employer's minimum job requirements, which can not exceed any of the requirements entered on the application form by the employer;

(vi) Offer training if the job opportunity is the type for which employers normally provide training; and

(vii) Offer wages, terms and conditions of employment no less favorable than those offered to the alien.

(c) *Timing of advertisement.* (1) The advertisement shall be placed in accordance with the guidance provided by the CO.

(2) The employer will notify the CO when the advertisement will be placed.

(d) *Additional or substitute recruitment.* The Certifying Officer may designate other appropriate sources of workers from which the employer must recruit

for U.S. workers in addition to the advertising described in paragraph (b) of this section.

(e) *Recruitment report.* The employer must provide to the Certifying Officer a signed, detailed written report of the employer's supervised recruitment, signed by the employer or the employer's representative described in § 656.10(b)(2)(ii), within 30 days of the Certifying Officer's request for such a report. The recruitment report must:

(1) Identify each recruitment source by name and document that each recruitment source named was contacted. This can include, for example, copies of letters to recruitment sources such as unions, trade associations, colleges and universities and any responses received to the employer's inquiries. Advertisements placed in newspapers, professional, trade, or ethnic publications can be documented by furnishing copies of the tear sheets of the pages of the publication in which the advertisements appeared, proof of publication furnished by the publication, or dated copies of the web pages if the advertisement appeared on the web as well as in the publication in which the advertisement appeared.

(2) State the number of U.S. workers who responded to the employer's recruitment.

(3) State the names, addresses, and provide resumes (other than those sent to the employer by the CO) of the U.S. workers who applied for the job opportunity, the number of workers interviewed, and the job title of the person who interviewed the workers.

(4) Explain, with specificity, the lawful job-related reason(s) for not hiring each U.S. worker who applied. Rejection of one or more U.S. workers for lacking skills necessary to perform the duties involved in the occupation, where the U.S. workers are capable of acquiring the skills during a reasonable period of on-the-job training, is not a lawful job-related reason for rejecting the U.S. workers. For the purpose of this paragraph (e)(4), a U.S. worker is able and qualified for the job opportunity if the worker can acquire the skills necessary to perform the duties involved in the occupation during a reasonable period of on-the-job training.

(f) The employer shall supply the CO with the required documentation or information within 30 days of the date of the request. If the employer does not do so, the CO shall deny the application.

(g) The Certifying Officer in his or her discretion, for good cause shown, may provide one extension to any request for documentation or information.

§ 656.24 Labor certification determinations.

(a)(1) The Office of Foreign Labor Certification Administrator (OFLC Administrator) is the National Certifying Officer. The OFLC Administrator and the certifying officers in the ETA application processing centers have the authority to certify or deny labor certification applications.

(2) If the labor certification presents a special or unique problem, the Director of an ETA application processing center may refer the matter to the Office of Foreign Labor Certification Administrator (OFLC Administrator). If the OFLC Administrator has directed that certain types of applications or specific applications be handled in the ETA national office, the Directors of the ETA application processing centers shall refer such applications to the OFLC Administrator.

(b) The Certifying Officer makes a determination either to grant or deny the labor certification on the basis of whether or not:

(1) The employer has met the requirements of this part.

(2) There is in the United States a worker who is able, willing, qualified, and available for and at the place of the job opportunity.

(i) The Certifying Officer must consider a U.S. worker able and qualified for the job opportunity if the worker, by education, training, experience, or a combination thereof, is able to perform in the normally accepted manner the duties involved in the occupation as customarily performed by other U.S. workers similarly employed. For the purposes of this paragraph (b)(2)(i), a U.S. worker is able and qualified for the job opportunity if the worker can acquire the skills necessary to perform the duties involved in the occupation

during a reasonable period of on-the-job training.

(ii) If the job involves a job opportunity as a college or university teacher, the U.S. worker must be at least as qualified as the alien.

(3) The employment of the alien will not have an adverse effect upon the wages and working conditions of U.S. workers similarly employed. In making this determination, the Certifying Officer considers such things as: labor market information, the special circumstances of the industry, organization, and/or occupation, the prevailing wage in the area of intended employment, and prevailing working conditions, such as hours, in the occupation.

(c) The Certifying Officer shall notify the employer in writing (either electronically or by mail) of the labor certification determination.

(d) If a labor certification is granted, except for a labor certification for an occupation on *Schedule A* (§ 656.5) or for employment as a sheepherder under § 656.16, the Certifying Officer must send the certified application and complete Final Determination form to the employer, or, if appropriate, to the employer's agent or attorney, indicating the employer may file all the documents with the appropriate DHS office.

(e) If the labor certification is denied, the Final Determination form will:

(1) State the reasons for the determination;

(2) Quote the request for review procedures at § 656.26 (a) and (b);

(3) Advise that failure to request review within 30 days of the date of the determination, as specified in § 656.26(a), constitutes a failure to exhaust administrative remedies;

(4) Advise that, if a request for review is not made within 30 days of the date of the determination, the denial shall become the final determination of the Secretary;

(5) Advise that if an application for a labor certification is denied, and a request for review is not made in accordance with the procedures at § 656.26(a) and (b), a new application may be filed at any time; and

(6) Advise that a new application in the same occupation for the same alien can not be filed while a request for review is pending with the Board of Alien Labor Certification Appeals.

(f) If the Certifying Officer determines the employer substantially failed to produce required documentation, or the documentation was inadequate, or determines a material misrepresentation was made with respect to the application, or if the Certifying Officer determines it is appropriate for other reasons, the employer may be required to conduct supervised recruitment pursuant to § 656.21 in future filings of labor certification applications for up to two years from the date of the Final Determination.

(g)(1) The employer may request reconsideration within 30 days from the date of issuance of the denial.

(2) For applications submitted after July 16, 2007, a request for reconsideration may include only:

(i) Documentation that the Department actually received from the employer in response to a request from the Certifying Officer to the employer; or

(ii) Documentation that the employer did not have an opportunity to present previously to the Certifying Officer, but that existed at the time the Application for Permanent Labor Certification was filed, and was maintained by the employer to support the application for permanent labor certification in compliance with the requirements of § 656.10(f).

(3) Paragraphs (g)(1) and (2) of this section notwithstanding, the Certifying Officer will not grant any request for reconsideration where the deficiency that caused denial resulted from the applicant's disregard of a system prompt or other direct instruction.

(4) The Certifying Officer may, in his or her discretion, reconsider the determination or treat it as a request for review under § 656.26(a).

[69 FR 77386, Dec. 27, 2004, as amended at 71 FR 35523, June 21, 2006; 72 FR 27945, May 17, 2007]

§ 656.26 Board of Alien Labor Certification Appeals review of denials of labor certification.

(a) *Request for review.* (1) If a labor certification is denied, if a labor certification is revoked pursuant to § 656.32, or if a debarment is issued

under § 656.31(f), a request for review of the denial, revocation, or debarment may be made to the Board of Alien Labor Certification Appeals by the employer or debarred person or entity by making a request for such an administrative review in accordance with the procedures provided in paragraph (a) of this section. In the case of a finding of debarment, receipt by the Department of a request for review, if made in accordance with this section, shall stay the debarment until such time as the review has been completed and a decision rendered thereon.

(2) A request for review of a denial or revocation:

(i) Must be sent within 30 days of the date of the determination to the Certifying Officer who denied the application or revoked the certification;

(ii) Must clearly identify the particular labor certification determination for which review is sought;

(iii) Must set forth the particular grounds for the request; and

(iv) Must include a copy of the Final Determination.

(3) A request for review of debarment:

(i) Must be sent to the Administrator, Office of Foreign Labor Certification, within 30 days of the date of the debarment determination;

(ii) Must clearly identify the particular debarment determination for which review is sought;

(iii) Must set forth the particular grounds for the request; and

(iv) Must include a copy of the Notice of Debarment.

(4)(i) With respect to a denial of the request for review, statements, briefs, and other submissions of the parties and amicus curiae must contain only legal argument and only such evidence that was within the record upon which the denial of labor certification was based.

(ii) With respect to a revocation or a debarment determination, the BALCA proceeding may be de novo.

(b) Upon the receipt of a request for review, the Certifying Officer immediately must assemble an indexed Appeal File:

(1) The Appeal File must be in chronological order, must have the index on top followed by the most recent document, and must have consecutively numbered pages. The Appeal File must contain the request for review, the complete application file, and copies of all the written material, such as pertinent parts and pages of surveys and/or reports upon which the denial was based.

(2) The Certifying Officer must send the Appeal File to the Board of Alien Labor Certification Appeals, Office of Administrative Law Judges, 800 K Street, NW., Suite 400–N, Washington, DC 20001–8002.

(3) The Certifying Officer must send a copy of the Appeal File to the employer. The employer may furnish or suggest directly to the Board of Alien Labor Certification Appeals the addition of any documentation that is not in the Appeal File, but that was submitted to DOL before the issuance of the Final Determination. The employer must submit such documentation in writing, and must send a copy to the Associate Solicitor for Employment and Training Legal Services, Office of the Solicitor, U.S. Department of Labor, Washington, DC 20210.

(c) *Debarment Appeal File.* Upon the receipt of a request for review of debarment, the Administrator, Office of Foreign Labor Certification, immediately must assemble an indexed Appeal File:

(1) The Appeal File must be in chronological order, must have the index on top followed by the most recent document, and must have consecutively numbered pages. The Appeal File must contain the request for review, the complete application file(s), and copies of all written materials, such as pertinent parts and pages of surveys and/or reports or documents received from any court, DHS, or the Department of State, upon which the debarment was based.

(2) The Administrator, Office of Foreign Labor Certification, must send the Appeal File to the Board of Alien Labor Certification Appeals, Office of Administrative Law Judges, 800 K St., NW., Suite 400–N, Washington, DC 20001–8002.

(3) The Administrator, Office of Foreign Labor Certification, must send a copy of the Appeal File to the debarred person or entity. The debarred person

or entity may furnish or suggest directly to the Board of Alien Labor Certification Appeals the addition of any documentation that is not in the Appeal File. The debarred person or entity must submit such documentation in writing, and must send a copy to the Associate Solicitor for Employment and Training Legal Services, Office of the Solicitor, U.S. Department of Labor, 200 Constitution Ave., NW., Washington, DC 20210.

[69 FR 77386, Dec. 27, 2004, as amended at 72 FR 27945, May 17, 2007]

§ 656.27 Consideration by and decisions of the Board of Alien Labor Certification Appeals.

(a) *Panel designations.* In considering requests for review before it, the Board of Alien Labor Certification Appeals may sit in panels of three members. The Chief Administrative Law Judge may designate any Board of Alien Labor Certification Appeals member to submit proposed findings and recommendations to the Board of Alien Labor Certification Appeals or to any duly designated panel thereof to consider a particular case.

(b) *Briefs and Statements of Position.* In considering the requests for review before it, the Board of Alien Labor Certification Appeals must afford all parties 30 days to submit or decline to submit any appropriate Statement of Position or legal brief. The Certifying Officer is to be represented solely by the Solicitor of Labor or the Solicitor's designated representative.

(c) *Review on the record.* The Board of Alien Labor Certification Appeals must review a denial of labor certification under § 656.24, a revocation of a certification under § 656.32, or an affirmation of a prevailing wage determination under § 656.41 on the basis of the record upon which the decision was made, the request for review, and any Statements of Position or legal briefs submitted and, except in cases over which the Secretary has assumed jurisdiction pursuant to 29 CFR 18.95, must:

(1) Affirm the denial of the labor certification, the revocation of certification, or the affirmation of the PWD; or

(2) Direct the Certifying Officer to grant the certification, overrule the revocation of certification, or overrule the affirmation of the PWD; or

(3) Direct that a hearing on the case be held under paragraph (e) of this section.

(d) *Notifications of decisions.* The Board of Alien Labor Certification Appeals must notify the employer, the Certifying Officer, and the Solicitor of Labor of its decision, and must return the record to the Certifying Officer unless the case has been set for hearing under paragraph (e) of this section.

(e) *Hearings*—(1) *Notification of hearing.* If the case has been set for a hearing, the Board of Alien Labor Certification Appeals must notify the employer, the alien, the Certifying Officer, and the Solicitor of Labor of the date, time, and place of the hearing, and that the hearing may be rescheduled upon written request and for good cause shown.

(2) *Hearing procedure.* (i) The ''Rules of Practice and Procedure For Administrative Hearings Before the Office of Administrative Law Judges,'' at 29 CFR part 18, apply to hearings under this paragraph (e).

(ii) For the purposes of this paragraph (e)(2), references in 29 CFR part 18 to: ''administrative law judge'' mean the Board of Alien Labor Certification Appeals member or the Board of Alien Labor Certification Appeals panel duly designated under § 656.27(a); ''Office of Administrative Law Judges'' means the Board of Alien Labor Certification Appeals; and ''Chief Administrative Law Judge'' means the Chief Administrative Law Judge in that official's function of chairing the Board of Alien Labor Certification Appeals.

[69 FR 77386, Dec. 27, 2004, as amended at 85 FR 13029, Mar. 6, 2020; 85 FR 30615, May 20, 2020]

§ 656.30 Validity of and invalidation of labor certifications.

(a) *Priority date.* (1) The filing date for a Schedule A occupation or sheepherders is the date the application was dated by the Immigration Officer.

(2) The filing date, established under § 656.17(c), of an approved labor certification may be used as a priority date by the Department of Homeland Security and the Department of State, as appropriate.

(b) *Expiration of labor certifications.* For certifications resulting from applications filed under this part and 20 CFR part 656 in effect prior to March 28, 2005, the following applies:

(1) An approved permanent labor certification granted on or after July 16, 2007 expires if not filed in support of a Form I–140 petition with the Department of Homeland Security within 180 calendar days of the date the Department of Labor granted the certification.

(2) An approved permanent labor certification granted before July 16, 2007 expires if not filed in support of a Form I–140 petition with the Department of Homeland Security within 180 calendar days of July 16, 2007.

(c) *Scope of validity.* For certifications resulting from applications filed under this part or 20 CFR part 656 in effect prior to March 28, 2005, the following applies:

(1) A permanent labor certification for a Schedule A occupation or sheepherders is valid only for the occupation set forth on the *Application for Alien Employment Certification* (Form ETA 750) or the *Application for Permanent Employment Certification* (Form ETA 9089) and only for the alien named on the original application, unless a substitution was approved prior to July 16, 2007. The certification is valid throughout the United States unless the certification contains a geographic limitation.

(2) A permanent labor certification involving a specific job offer is valid only for the particular job opportunity, the alien named on the original application (unless a substitution was approved prior to July 16, 2007), and the area of intended employment stated on the *Application for Alien Employment Certification* (Form ETA 750) or the *Application for Permanent Employment Certification* (Form ETA 9089).

(d) *Invalidation of labor certifications.* After issuance, a labor certification may be revoked by ETA using the procedures described in § 656.32. Additionally, after issuance, a labor certification is subject to invalidation by the DHS or by a Consul of the Department of State upon a determination, made in accordance with those agencies' procedures or by a court, of fraud or willful misrepresentation of a material fact involving the labor certification application. If evidence of such fraud or willful misrepresentation becomes known to the CO or to the Chief, Division of Foreign Labor Certification, the CO, or the Chief of the Division of Foreign Labor Certification, as appropriate, shall notify in writing the DHS or Department of State, as appropriate. A copy of the notification must be sent to the regional or national office, as appropriate, of the Department of Labor's Office of Inspector General.

(e) *Duplicate labor certifications.* (1) The Certifying Officer shall issue a duplicate labor certification at the written request of a Consular or Immigration Officer. The Certifying Officer shall issue such duplicate labor certifications only to the Consular or Immigration Officer who initiated the request.

(2) The Certifying Officer shall issue a duplicate labor certification to a Consular or Immigration Officer at the written request of an alien, employer, or an alien's or employer's attorney/agent. Such request for a duplicate labor certification must be addressed to the Certifying Officer who issued the labor certification; must include documentary evidence from a Consular or Immigration Officer that a visa application or visa petition, as appropriate, has been filed; and must include a Consular Office or DHS tracking number.

(3) A duplicate labor certification shall be issued by the Certifying Officer with the same filing and expiration dates, as described in paragraphs (a) and (b) of this section, as the original approved labor certification.

[69 FR 77386, Dec. 27, 2004, as amended at 72 FR 27946, May 17, 2007]

§ 656.31 Labor certification applications involving fraud, willful misrepresentation, or violations of this part.

The following provisions apply to applications filed under both this part and 20 CFR part 656 in effect prior to March 28, 2005, and to any certifications resulting from those applications.

(a) *Denial.* A Certifying Officer may deny any application for permanent labor certification if the officer finds

the application contains false statements, is fraudulent, or was otherwise submitted in violation of the Department's permanent labor certification regulations.

(b) *Possible fraud or willful misrepresentation.* (1) If the Department learns an employer, attorney, or agent is involved in possible fraud or willful misrepresentation in connection with the permanent labor certification program, the Department will refer the matter to the Department of Justice, Department of Homeland Security, or other government entity, as appropriate, for investigation, and send a copy of the referral to the Department of Labor's Office of Inspector General (OIG). In these cases, or if the Department learns an employer, attorney, or agent is under investigation by the Department of Justice, Department of Homeland Security, or other government entity for possible fraud or willful misrepresentation in connection with the permanent labor certification program, the Department may suspend processing of any permanent labor certification application involving such employer, attorney, or agent until completion of any investigation and/or judicial proceedings. Unless the investigatory agency, in writing, requests the Department to do otherwise, the Department shall provide written notification to the employer of the suspension in processing.

(2) A suspension pursuant to paragraph (b)(1) of this section may last initially for up to 180 days. No later than 180 days after the suspension began, if no criminal indictment or information has been issued, or judicial proceedings have not been concluded, the National Certifying Officer may resume processing some or all of the applications, or may extend the suspension in processing until completion of any investigation and/or judicial proceedings.

(c) *Criminal indictment or information.* If the Department learns that an employer, attorney, or agent is named in a criminal indictment or information in connection with the permanent labor certification program, the processing of applications related to that employer, attorney, or agent may be suspended until the judicial process is completed. Unless the investigatory or prosecutorial agency, in writing, requests the Department to do otherwise, the Department shall provide written notification to the employer of the suspension in processing.

(d) *No finding of fraud or willful misrepresentation.* If an employer, attorney, or agent is acquitted of fraud or willful misrepresentation charges, or if such criminal charges are withdrawn or otherwise fail to result in a finding of fraud or willful misrepresentation, the Certifying Officer shall decide each pending permanent labor certification application related to that employer, attorney, or agent on the merits of the application.

(e) *Finding of fraud or willful misrepresentation.* If an employer, attorney, or agent is found to have committed fraud or willful misrepresentation involving the permanent labor certification program, whether by a court, the Department of State or DHS, as referenced in § 656.30(d), or through other proceedings:

(1) Any suspension of processing of pending applications related to that employer, attorney, or agent will terminate.

(2) The Certifying Officer will decide each such application on its merits, and may deny any such application as provided in § 656.24 and in paragraph (a) of this section.

(3) In the case of a pending application involving an attorney or agent found to have committed fraud or willful misrepresentation, DOL will notify the employer associated with that application of the finding and require the employer to notify DOL in writing, within 30 days of the notification, whether the employer will withdraw the application, designate a new attorney or agent, or continue the application without representation. Failure of the employer to respond within 30 days of the notification will result in a denial. If the employer elects to continue representation by the attorney or agent, DOL will suspend processing of affected applications while debarment proceedings are conducted under paragraph (f) of this section.

(f) *Debarment.* (1) No later than six years after the date of filing of the labor certification application that is

the basis for the finding, or, if such basis requires a pattern or practice as provided in paragraphs (f)(1)(iii), (iv), and (v) of this section, no later than six years after the date of filing of the last labor certification application which constitutes a part of the pattern or practice, the Administrator, Office of Foreign Labor Certification, may issue to an employer, attorney, agent, or any combination thereof a Notice of Debarment from the permanent labor certification program for a reasonable period of no more than three years, based upon any action that was prohibited at the time the action occurred, upon determining the employer, attorney, or agent has participated in or facilitated one or more of the following:

(i) The sale, barter, or purchase of permanent labor applications or certifications, or any other action prohibited under § 656.12;

(ii) The willful provision or willful assistance in the provision of false or inaccurate information in applying for permanent labor certification;

(iii) A pattern or practice of a failure to comply with the terms of the Form ETA 9089 or Form ETA 750;

(iv) A pattern or practice of failure to comply in the audit process pursuant to § 656.20;

(v) A pattern or practice of failure to comply in the supervised recruitment process pursuant to § 656.21; or

(vi) Conduct resulting in a determination by a court, DHS or the Department of State of fraud or willful misrepresentation involving a permanent labor certification application, as referenced in § 656.31(e).

(2) The Notice of Debarment shall be in writing; shall state the reason for the debarment finding, including a detailed explanation of how the employer, attorney or agent has participated in or facilitated one or more of the actions listed in paragraphs (f)(1)(i) through (v) of this section; shall state the start date and term of the debarment; and shall identify appeal opportunities under § 656.26. The debarment shall take effect on the start date identified in the Notice of Debarment unless a request for review is filed within the time permitted by § 656.26. DOL will notify DHS and the Department of State regarding any Notice of Debarment.

(g) *False statements.* To knowingly and willfully furnish any false information in the preparation of the *Application for Permanent Employment Certification* (Form ETA 9089) or the *Application for Alien Employment Certification* (Form ETA 750) and any supporting documentation, or to aid, abet, or counsel another to do so is a Federal offense, punishable by fine or imprisonment up to five years, or both under 18 U.S.C. 2 and 1001. Other penalties apply as well to fraud or misuse of ETA immigration documents and to perjury with respect to such documents under 18 U.S.C. 1546 and 1621.

[72 FR 27946, May 17, 2007]

§ 656.32 Revocation of approved labor certifications.

(a) *Basis for DOL revocation.* The Certifying Officer in consultation with the Chief, Division of Foreign Labor Certification may take steps to revoke an approved labor certification, if he/she finds the certification was not justified. A labor certification may also be invalidated by DHS or the Department of State as set forth in § 656.30(d).

(b) *Department of Labor procedures for revocation.* (1) The Certifying Officer sends to the employer a *Notice of Intent to Revoke* an approved labor certification which contains a detailed statement of the grounds for the revocation and the time period allowed for the employer's rebuttal. The employer may submit evidence in rebuttal within 30 days of receipt of the notice. The Certifying Officer must consider all relevant evidence presented in deciding whether to revoke the labor certification.

(2) If rebuttal evidence is not filed by the employer, the *Notice of Intent to Revoke* becomes the final decision of the Secretary.

(3) If the employer files rebuttal evidence and the Certifying Officer determines the certification should be revoked, the employer may file an appeal under § 656.26.

(4) The Certifying Officer will inform the employer within 30 days of receiving any rebuttal evidence whether or not the labor certification will be revoked.

(5) If the labor certification is revoked, the Certifying Officer will also send a copy of the notification to the DHS and the Department of State.

Subpart D—Determination of Prevailing Wage

§ 656.40 Determination of prevailing wage for labor certification purposes.

(a) *Application process.* The employer must request a PWD from the NPC, on a form or in a manner prescribed by OFLC. Prior to January 1, 2010, the SWA having jurisdiction over the area of intended employment shall continue to receive and process prevailing wage determination requests in accordance with the regulatory provisions and Department guidance in effect prior to January 1, 2009. On or after January 1, 2010, the NPC shall receive and process prevailing wage determination requests in accordance with these regulations and with Department guidance. The NPC will provide the employer with an appropriate prevailing wage rate. The NPC shall determine the wage in accordance with sec. 212(t) of the INA. Unless the employer chooses to appeal the center's PWD under § 656.41(a) of this part, it files the Application for Permanent Employment Certification either electronically or by mail with the processing center of jurisdiction and maintains the PWD in its files. The determination shall be submitted to the CO, if requested.

(b) *Determinations.* The National Processing Center will determine the appropriate prevailing wage as follows:

(1) Except as provided in paragraphs (e) and (f) of this section, if the job opportunity is covered by a collective bargaining agreement (CBA) that was negotiated at arms-length between the union and the employer, the wage rate set forth in the CBA agreement is considered as not adversely affecting the wages of U.S. workers similarly employed, that is, it is considered the ''prevailing wage'' for labor certification purposes.

(2) If the job opportunity is not covered by a CBA, the prevailing wage for labor certification purposes shall be the arithmetic mean, except as provided in paragraph (b)(3) of this section, of the wages of workers similarly employed in the area of intended employment. The wage component of the DOL Occupational Employment Statistics Survey shall be used to determine the arithmetic mean, unless the employer provides an acceptable survey under paragraph (g) of this section.

(3) If the employer provides a survey acceptable under paragraph (g) of this section that provides a median and does not provide an arithmetic mean, the prevailing wage applicable to the employer's job opportunity shall be the median of the wages of workers similarly employed in the area of intended employment.

(4) The employer may utilize a current wage determination in the area under the Davis-Bacon Act, 40 U.S.C. 276a *et seq.*, 29 CFR part 1, or the McNamara-O'Hara Service Contract Act, 41 U.S.C. 351 *et seq.*

(c) *Validity period.* The National Processing Center must specify the validity period of the prevailing wage, which in no event may be less than 90 days or more than 1 year from the determination date. To use a prevailing wage rate provided by the NPC, employers must file their applications or begin the recruitment period required by §§ 656.17(e) or 656.21 of this part within the validity period specified by the NPC.

(d) *Similarly employed.* For purposes of this section, similarly employed means having substantially comparable jobs in the occupational category in the area of intended employment, except that, if a representative sample of workers in the occupational category can not be obtained in the area of intended employment, similarly employed means:

(1) Having jobs requiring a substantially similar level of skills within the area of intended employment; or

(2) If there are no substantially comparable jobs in the area of intended employment, having substantially comparable jobs with employers outside of the area of intended employment.

(e) *Institutions of higher education and research entities.* In computing the prevailing wage for a job opportunity in an occupational classification in an area of intended employment for an employee of an institution of higher

education, or an affiliated or related nonprofit entity, a nonprofit research organization, or a Governmental research organization, the prevailing wage level takes into account the wage levels of employees only at such institutions and organizations in the area of intended employment.

(1) The organizations listed in this paragraph (e) are defined as follows:

(i) *Institution of higher education* means an institution of higher education as defined in section 101(a) of the Higher Education Act of 1965. Section 101(a) of that Act, 20 U.S.C. 1001(a)(2000), provides an institution of higher education is an educational institution in any state that:

(A) Admits as regular students only persons having a certificate of graduation from a school providing secondary education, or the recognized equivalent of such a certificate;

(B) Is legally authorized within such state to provide a program of education beyond secondary education;

(C) Provides an educational program for which the institution awards a bachelor's degree or provides not less than a two-year program that is acceptable for full credit toward such a degree;

(D) Is a public or other nonprofit institution; and

(E) Is accredited by a nationally recognized accrediting agency or association or, if not so accredited, is an institution that has been granted preaccreditation status by such an agency or association that has been recognized by the Secretary of Education for the granting of preaccreditation status, and the Secretary of Education has determined there is satisfactory assurance the institution will meet the accreditation standards of such an agency or association within a reasonable time.

(ii) *Affiliated or related nonprofit entity* means a nonprofit entity (including but not limited to a hospital and a medical or research institution) connected or associated with an institution of higher education, through shared ownership or control by the same board or federation, operated by an institution of higher education, or attached to an institution of higher education as a member, branch, cooperative, or subsidiary.

(iii) *Nonprofit research organization or Governmental research organization* means a research organization that is either a nonprofit organization or entity primarily engaged in basic research and/or applied research, or a United States Government entity whose primary mission is the performance or promotion of basic research and/or applied research. Basic research is general research to gain more comprehensive knowledge or understanding of the subject under study, without specific applications in mind. Basic research is also research that advances scientific knowledge, but does not have specific immediate commercial objectives although it may be in fields of present or commercial interest. It may include research and investigation in the sciences, social sciences, or humanities. Applied research is research to gain knowledge or understanding to determine the means by which a specific, recognized need may be met. Applied research includes investigations oriented to discovering new scientific knowledge that has specific commercial objectives with respect to products, processes, or services. It may include research and investigation in the sciences, social sciences, or humanities.

(2) *Nonprofit organization or entity*, for the purpose of this paragraph (e), means an organization qualified as a tax exempt organization under the Internal Revenue Code of 1986, section 501(c)(3), (c)(4), or (c)(6) (26 U.S.C. 501(c)(3), (c)(4) or (c)(6)), and which has received approval as a tax exempt organization from the Internal Revenue Service, as it relates to research or educational purposes.

(f) *Professional athletes.* In computing the prevailing wage for a professional athlete (defined in Section 212(a)(5)(A)(iii)(II) of the Act) when the job opportunity is covered by professional sports league rules or regulations, the wage set forth in those rules or regulations is considered the prevailing wage (see Section 212(p)(2) of the Act). INA Section 212(a)(5)(A)(iii)(II), 8 U.S.C.

1182(a)(5)(A)(iii)(II) (1999), defines ''professional athlete'' as an individual who is employed as an athlete by—

(1) A team that is a member of an association of six or more professional sports teams whose total combined revenues exceed $10,000,000 per year, if the association governs the conduct of its members and regulates the contests and exhibitions in which its member teams regularly engage; or

(2) Any minor league team that is affiliated with such an association.

(g) *Employer-provided wage information.* (1) If the job opportunity is not covered by a CBA, or by a professional sports league's rules or regulations, the NPC will consider wage information provided by the employer in making a PWD. An employer survey can be submitted either initially or after NPC issuance of a PWD derived from the OES survey. In the latter situation, the new employer survey submission will be deemed a new PWD request.

(2) In each case where the employer submits a survey or other wage data for which it seeks acceptance, the employer must provide the NPC with enough information about the survey methodology, including such items as sample size and source, sample selection procedures, and survey job descriptions, to allow the NPC to make a determination about the adequacy of the data provided and validity of the statistical methodology used in conducting the survey in accordance with guidance issued by the OFLC national office.

(3) The survey submitted to the NPC must be based upon recently collected data.

(i) A published survey must have been published within 24 months of the date of submission to the NPC, must be the most current edition of the survey, and the data upon which the survey is based must have been collected within 24 months of the publication date of the survey.

(ii) A survey conducted by the employer must be based on data collected within 24 months of the date it is submitted to the NPC.

(4) If the employer-provided survey is found not to be acceptable, the NPC will inform the employer in writing of the reasons the survey was not accepted.

(5) The employer, after receiving notification that the survey it provided for NPC consideration is not acceptable, may file supplemental information as provided by paragraph (h) of this section, file a new request for a PWD, or appeal under § 656.41.

(h) *Submittal of supplemental information by employer.* (1) If the employer disagrees with the skill level assigned to its job opportunity, or if the NPC informs the employer its survey is not acceptable, or if there are other legitimate bases for such a review, the employer may submit supplemental information to the NPC.

(2) The NPC will consider one supplemental submission about the employer's survey or the skill level the NPC assigned to the job opportunity or any other legitimate basis for the employer to request such a review. If the NPC does not accept the employer's survey after considering the supplemental information, or affirms its determination concerning the skill level, it will inform the employer of the reasons for its decision.

(3) The employer may then apply for a new wage determination or appeal under § 656.41 of this part.

(i) *Frequent users.* The Secretary will issue guidance regarding the process by which employers may obtain a wage determination to apply to a subsequent application, when the wage is for the same occupation, skill level, and area of intended employment. In no case may the wage rate the employer provides the NPC be lower than the highest wage required by any applicable Federal, State, or local law.

(j) *Fees prohibited.* No SWA or SWA employee may charge a fee in connection with the filing of a request for a PWD, responding to such a request, or responding to a request for a review of a SWA prevailing wage determination under § 656.41.

[69 FR 77386, Dec. 27, 2004, as amended at 73 FR 78068, Dec. 19, 2008; 85 FR 63915, Oct. 8, 2020; 86 FR 70731, Dec. 13, 2021]

§ 656.41 Review of prevailing wage determinations.

(a) *Review of NPC PWD.* Any employer desiring review of a PWD made

by a CO must make a request for such review within 30 days of the date from when the PWD was issued. The request for review must be sent to the director of the NPC that issued the PWD within 30 days of the date of the PWD; clearly identify the PWD from which review is sought; set forth the particular grounds for the request; and include all the materials pertaining to the PWD submitted to the NPC up to the date of the PWD received from the NPC.

(b) *Processing of request by NPC.* Upon the receipt of a request for review, the NPC will review the employer's request and accompanying documentation, and add any material that may have been omitted by the employer, including any material the NPC sent the employer up to the date of the PWD.

(c) *Review on the record.* The director will review the PWD solely on the basis upon which the PWD was made and, upon the request for review, may either affirm or modify the PWD.

(d) *Request for review by BALCA.* Any employer desiring review of the director's determination must make a request for review by the BALCA within 30 days of the date of the Director's decision.

(1) The request for review, statements, briefs, and other submissions of the parties and amicus curiae must contain only legal arguments and only such evidence that was within the record upon which the director made his/her affirmation of the PWD.

(2) The request for review must be in writing and addressed to the director of the NPC making the determination. Upon receipt of a request for a review, the director will assemble an indexed appeal file in reverse chronological order, with the index on top followed by the most recent document.

(3) The director will send the Appeal File to the Office of Administrative Law Judges, BALCA. The BALCA handles the appeals in accordance with §§ 656.26 and 656.27.

[73 FR 78069, Dec. 19, 2008]

FINDING AIDS

A list of CFR titles, subtitles, chapters, subchapters and parts and an alphabetical list of agencies publishing in the CFR are included in the CFR Index and Finding Aids volume to the Code of Federal Regulations which is published separately and revised annually.

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For changes to this volume of the CFR prior to this listing, consult the annual edition of the monthly List of CFR Sections Affected (LSA). The LSA is available at *www.govinfo.gov*. For changes to this volume of the CFR prior to 2001, see the ''List of CFR Sections Affected, 1949–1963, 1964–1972, 1973–1985, and 1986–2000'' published in 11 separate volumes. The ''List of CFR Sections Affected 1986–2000'' is available at *www.govinfo.gov*.

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617 Authority citation revised 51972
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641.900 (e) revised; eff. 4–20–20 13028
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641.920 (d)(5) revised; eff. 4–20–20 13028
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645 Removed 65694
651.10 Amended 625
652.204 Amended 626
652.207 (b)(3) revised 626
652.210 (b) introductory text revised 626
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653.103 (c) and (d) 626
653.107 (a)(1), (2) introductory text, (3), (4), (b) introductory text, (2), (4)(iv), (5) through (11), and (c) revised; (a)(6) added 626

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653.108 (b) introductory text, (2), (c), (d), (g)(2)(i)(D), (vii), (3), (s)(2), (3), (9), and (11) revised; (g)(1), (2)(v), (i), and (o) amended 627
653.109 (c) revised 628
653.111 Revised 628
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653.502 (e)(2) revised 628
653.503 (d) and (e) revised 628
655 Authority citation revised 63914
655.103 (b) amended 70477
655.120 (c) removed; (b) redesignated as new (c); new (b) added 70477
655.171 (a) and (b)(2) revised; eff. 4–20–20 13028
(a) and (b)(2) revised 30614
655.181 (b)(3) revised; eff. 4–20–20 13029
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655.182 (f)(6) revised; eff. 4–20–20 13029
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655.183 (c) revised; eff. 4–20–20 13029
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655.461 (e) revised; eff. 4–20–20 13029
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655.472 (b)(3) revised; eff. 4–20–20 13029

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(b)(3) revised 30615
655.473 (f)(6) revised; eff. 4–20–20 13029
(f)(6) revised 30615
655.620 (a) amended 2296
655.731 (a)(2)(ii) introductory text, (A), and (A)(*2*) revised; interim 63914
655.801 (b) amended 2296
655.810 (b)(1) introductory text, (2) introductory text, and (3) introductory text amended 2296
655.845 (h) and (i) revised; eff. 4–20–20 13029
(h) and (i) revised 30615
656 Authority citation revised 63915
656.27 (c) revised; eff. 4–20–20 13029
(c) revised 30615
656.40 (a), (b)(2), and (3) revised; interim 63915

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501.3 (a), (b), (c)(2), (6), (f), and (h) revised 1771
501.4 (e) removed 1771
501.5 (c) and (f) revised 1771

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641.920 (d)(1) and (5) revised 1777
655 Authority citation revised 3672, 70730
655.61 (e) revised 4
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655.64 Added (temporary) 28232
655.68 Added (temporary) 28233
655.72 (b)(3) revised 4
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655.801 (b) amended 2967
655.810 (b)(1) introductory text, (2) introductory text, and (3) introductory text amended 2967
655.845 (f) revised 1778
655.1245 (f) revised 1778
656 Authority citation revised 3672, 26177, 70731
656.40 (a), (b)(2), and (3) revised 3672
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641 Authority citation revised 8189
641.140 Amended; eff. 4-15-22 8189
641.325 (b)(4) and (5) revised; (b)(6) added; eff. 4-15-22 8189
641.420 (e) revised; eff. 4-15-22 8189
641.520 Heading, (a)(7), and (8) revised; (a)(9) added; eff. 4-15-22 8190
641.570 (b)(4) and (5) revised; (b)(6) added; eff. 4-15-22 8190
641.710 (g)(12) and (13) revised; (g)(14) added; eff. 4-15-22 8190
641 Regulation at 87 FR 8189 eff. date confirmed 26988
653.501 (c)(2)(i) amended 61791
655 Technical correction 6017
655.64 Added (temporary) 4761
655.65 Added (temporary) 30377
655.65 Added; eff. through 9-30-23 76877

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652 Authority citation revised 82725
652.8 (h), (j) introductory text, (2), and (3) revised 82725
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652.200—652.216 (Subpart C) Heading revised 82725
652.204 Heading revised 82725
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652.207 Heading and (a) revised 82726
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653.102 Amended 82726
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653.504 Added 82730

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655.65 Added; eff. 9-3-27 80460
655.103 (b) amended 12801
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655.68 Added; eff. through 9-30-28 95685
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655.122 (h)(4), (i)(1)(i), (ii), (l), and (n) revised 34060
655.130 (a) revised 34062
655.132 (e)(1) revised 34062
655.135 Introductory text and (h) revised; (m) through (p) added 34062
655.137 Added 34063
655.145 Heading and (b) revised 34063
655.167 (c)(6) and (7) revised; (c)(8) through (12) added 34063
655.175 Added 34064
655.181 (a)(1) revised 34064
655.182 (a), (b), and (d)(1)(viii) revised 34064
655.190 Added 34065
655.210 (g) revised 34065
655.211 (a) revised 34065
655.620 (a) amended 1814
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655.620 (a) amended 1858
655.801 (b) amended 1858
655.810 (b)(1) introductory text, (2) introductory text, and (3) introductory text amended; (g) revised 1858

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CODE OF FEDERAL REGULATIONS

Title 20
Employees' Benefits

Part 657 to End

Revised as of April 1, 2025

Containing a codification of documents
of general applicability and future effect

As of April 1, 2025

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Title 1 through Title 16.....as of January 1
Title 17 through Title 27.....as of April 1
Title 28 through Title 41.....as of July 1
Title 42 through Title 50.....as of October 1

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An index to the text of ''Title 3—The President'' is carried within that volume.

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OLIVER A. POTTS,
Director,
Office of the Federal Register
April 1, 2025

THIS TITLE

Title 20—EMPLOYEES' BENEFITS is composed of four volumes. The first volume, containing parts 1–399, includes current regulations issued by the Office of Workers' Compensation Programs, Department of Labor and the Railroad Retirement Board. The second volume, containing parts 400–499, includes all current regulations issued by the Social Security Administration. The third volume, containing parts 500 to 656, includes current regulations issued by the Employees' Compensation Appeals Board, and the Employment and Training Administration. The fourth volume, containing part 657 to End, includes the current regulations issued by the Office of Workers' Compensation Programs, the Benefits Review Board, the Office of the Assistant Secretary for Veterans' Employment and Training Service (all of the Department of Labor) and the Joint Board for the Enrollment of Actuaries. The contents of these volumes represent all current regulations codified under this title of the CFR as of April 1, 2025.

An index to chapter III appears in the second volume.

For this volume, Michele Bugenhagen was Chief Editor. The Code of Federal Regulations publication program is under the direction of the John Hyrum Martinez, assisted by Stephen J. Frattini.

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AUTHORITY: Pub. L. 113–128, 128 Stat. 1425 (July 22, 2014); 29 U.S.C. chapter 4B.

SOURCE: 81 FR 56352, Aug. 19, 2016, unless otherwise noted.

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Subpart E—Employment Service and Employment-Related Law Complaint System (Complaint System)

§ 658.400 Purpose and scope of subpart.

(a) This subpart sets forth the regulations governing the Complaint System for the Wagner-Peyser Act Employment Service (ES) at the State and Federal levels. Specifically, the Complaint System processes complaints against an employer about the specific job to which the applicant was referred through the ES and complaints involving the failure to comply with the ES regulations under parts 651, 652, 653, and 654 of this chapter and this part. As noted in §658.411(d)(6), this subpart only covers ES-related complaints made within 2 years of the alleged violation.

(b) Any complaints alleging violations under the Unemployment Insurance program, under Workforce Innovation and Opportunity Act (WIOA) title I programs, or complaints by veterans alleging employer violations of the mandatory listing requirements under 38 U.S.C. 4212 are not covered by this subpart and must be referred to the appropriate administering agency which would follow the procedures set forth in the respective regulations.

(c) The Complaint System also accepts, refers, and, under certain circumstances, tracks complaints involving employment-related laws as defined in § 651.10 of this chapter.

(d) A complainant may designate an individual to act as their representative.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82731, Nov. 24, 2023]

COMPLAINTS FILED AT THE LOCAL AND STATE LEVEL

§ 658.410 Establishment of local and State complaint systems.

(a) Each State Workforce Agency (SWA) must establish and maintain a Complaint System pursuant to this subpart.

(b) The State Administrator must have overall responsibility for the operation of the Complaint System; this includes responsibility for the informal resolution of complaints. In the ES office, the ES Office Manager is responsible for the operation of the Complaint System.

(c) SWAs must ensure centralized control procedures are established for the processing of complaints and apparent violations. The ES Office Manager and the State Administrator must ensure a central complaint log is maintained, listing all complaints taken by the ES office or the SWA and apparent violations identified by ES staff, and specifying for each complaint or apparent violation:

(1) The name of the complainant (for complaints);

(2) The name of the respondent (employer or State agency);

(3) The date the complaint is filed or the apparent violation was identified;

(4) Whether the complaint is made by or on behalf of a migrant and seasonal farmworker (MSFW) or whether the apparent violation affects an MSFW;

(5) Whether the complaint or apparent violation concerns an employment-related law or the ES regulations; and

(6) The actions taken (including any documents the SWA sent or received and the date the SWA took such action(s)), and whether the complaint or apparent violation has been resolved, including informally.

(d) State agencies must ensure information pertaining to the use of the Complaint System is publicized, which must include, but is not limited to, the prominent display of an Employment and Training Administration (ETA)-approved Complaint System poster in each one-stop center.

(e) Each one-stop center must ensure there is appropriate staff available during regular office hours to take complaints.

(f) Complaints may be accepted in any one-stop center, or by a SWA, or elsewhere by outreach staff.

(g) All complaints filed through the ES office must be processed by a trained Complaint System Representative.

(h) All complaints received by a SWA must be assigned to a trained Complaint System Representative designated by the State Administrator. Complaints must not be assigned to the State Monitor Advocate (SMA).

(i) State agencies must ensure any action taken by the Complaint System Representative, including referral on a complaint from an MSFW, is fully documented and contains all relevant information, including a notation of the type of each complaint pursuant to Department guidance, a copy of the original complaint form, a copy of any ES-related reports, any relevant correspondence, a list of actions taken, a record of pertinent telephone calls, and all correspondence relating thereto.

(j) Within 1 month after the end of the calendar quarter, the ES office manager must transmit an electronic copy of the quarterly Complaint System log described in paragraph (c) of this section to the SMA. These logs must be made available to the Department upon request.

(k) The appropriate ES staff processing a complaint must offer to assist

the complainant through the provision of appropriate services.

(l) The State Administrator must establish a referral system for cases where a complaint is filed alleging a violation that occurred in the same State but through a different ES office.

(m) Follow-up on unresolved complaints. When an MSFW submits a complaint, the Complaint System Representative must follow up monthly on the processing of the complaint and must inform the complainant of the status of the complaint. No follow-up with the complainant is required for non-MSFW complaints.

(n) A complainant may designate an individual to act as their representative throughout the filing and processing of a complaint.

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 628, Jan. 6, 2020; 88 FR 82731, Nov. 24, 2023]

§ 658.411 Action on complaints.

(a) *Filing complaints.*

(1) Whenever an individual indicates an interest in filing a complaint under this subpart with an ES office, the SWA, or outreach staff, the individual receiving the complaint must offer to explain the operation of the Complaint System and must offer to take the complaint in writing.

(2) During the initial discussion with the complainant, the staff taking the complaint must:

(i) Make every effort to obtain all the information they perceive to be necessary to investigate the complaint;

(ii) Request that the complainant indicate all of the physical addresses, email addresses, telephone numbers, and any other helpful means by which they might be contacted during the investigation of the complaint; and

(iii) Request that the complainant contact the Complaint System Representative before leaving the area if possible, and explain the need to maintain contact during the investigation.

(3) The staff must ensure the complainant (or their representative) submits the complaint on the Complaint/Referral Form or another complaint form prescribed or approved by the Department or submits complaint information which satisfies paragraph (a)(4) of this section. The Complaint/Referral Form must be used for all complaints, including complaints about unlawful discrimination, except as provided in paragraph (a)(4) of this section. The staff must offer to assist the complainant in filling out the form and submitting all necessary information and must do so if the complainant desires such assistance. If the complainant also represents several other complainants, all such complainants must be named. The complainant, or their representative, must sign the completed form in writing or electronically. The identity of the complainant(s) and any persons who furnish information relating to, or assisting in, an investigation of a complaint must be kept confidential to the maximum extent possible, consistent with applicable law and a fair determination of the complaint. A copy of the completed complaint submission must be given to the complainant(s), and the complaint form must be given to the appropriate Complaint System Representative described in § 658.410(g).

(4) Any complaint in a reasonable form (letter or email) which is signed by the complainant, or their representative, and includes sufficient information to initiate an investigation must be treated as if it were a properly completed Complaint/Referral Form filed in person. A letter (via hard copy or email) confirming the complaint was received must be sent to the complainant and the document must be sent to the appropriate Complaint System Representative. The Complaint System Representative must request additional information from the complainant if the complainant has not provided sufficient information to investigate the matter expeditiously.

(b) *Complaints regarding an employment-related law.* (1) When a complaint is filed regarding an employment-related law with an ES office or a SWA, and paragraph (c) of this section does not apply, the office must determine if the complainant is an MSFW.

(i) If the complainant is a non-MSFW, the office must immediately refer the complainant to the appropriate enforcement agency, another public agency, a legal aid organization, and/or a consumer advocate organization, as appropriate, for assistance. Upon completing the referral, the local

or State representative is not required to follow up with the complainant.

(ii) If the complainant is a MSFW, the ES office or SWA Complaint System Representative must:

(A) Take from the MSFW or their representative, in writing (hard copy or electronic), the complaint(s) describing the alleged violation(s) of the employment-related law(s); and

(B) Attempt to resolve the issue informally at the local level, except in cases where the complaint was submitted to the SWA and the Complaint System Representative determines that they must take immediate action or in cases where informal resolution at the local level would be detrimental to the complainant(s). In cases where informal resolution at the local level would be detrimental to the complainant(s), the Complaint System Representative must immediately refer the complaint to the appropriate enforcement agency. Concurrently, the Complaint System Representative must offer to refer the MSFW to other ES services should the MSFW be interested.

(C) If the issue is not resolved within 5 business days, the Complaint System Representative must refer the complaint to the appropriate enforcement agency (or another public agency, a legal aid organization, or a consumer advocate organization, as appropriate) for further assistance.

(D) If the ES office or SWA Complaint System Representative determines that the complaint must be referred to a State or Federal agency, they must refer the complaint immediately to the appropriate enforcement agency for prompt action.

(E) If the complaint was referred under paragraph (b)(1)(ii)(D) of this section, the representative must notify the complainant of the enforcement agency to which the complaint was referred.

(F) When a complaint alleges an employer in a different State from where the complaint is filed has violated an employment-related law:

(*1*) The ES office or SWA receiving the complaint must ensure the Complaint/Referral Form is adequately completed and then immediately send a copy of the Complaint/Referral Form and copies of any relevant documents to the SWA in the other State. Copies of the referral letter must be sent to the complainant, and copies of the complaint and referral letter must be sent to the ETA Regional Office(s) with jurisdiction over the transferring and receiving State agencies. All such copies must be sent via hard copy or electronic mail.

(*2*) The SWA receiving the complaint must process the complaint as if it had been initially filed with that SWA.

(*3*) The ETA Regional Office with jurisdiction over the receiving SWA must follow up with it to ensure the complaint is processed in accordance with these regulations.

(2) If an enforcement agency makes a final determination that the employer violated an employment-related law and the complaint is connected to a job order, the SWA must initiate procedures for discontinuation of services immediately in accordance with subpart F of this part. If this occurs, the SWA must notify the complainant and the employer of this action.

(c) *Complaints alleging unlawful discrimination or reprisal for protected activity*. All complaints received under this subpart by an ES office or a SWA alleging unlawful discrimination or reprisal for protected activity in violation of nondiscrimination laws, such as those enforced by the Equal Employment Opportunity Commission (EEOC) or the Department of Labor's Civil Rights Center (CRC), or in violation of the Immigration and Nationality Act's antidiscrimination provision found at 8 U.S.C. 1324b, must be logged and immediately referred to the State-level E.O. Officer. The Complaint System Representative must notify the complainant of the referral in writing.

(2) Any complaints received either at the local and State level or at the ETA regional office, that allege violations of civil rights laws and regulations such as those under title VI of the Civil Rights Act or sec. 188 of WIOA, including for beneficiaries (as defined in 29 CFR 38.4) only, on the basis of citizenship status or participant status, as well as reprisal for protected activity, must immediately be logged and directed or forwarded to the recipient's Equal Opportunity Officer or the CRC.

(d) *Complaints regarding the ES regulations (ES complaints).* (1) When an ES complaint is filed with an ES office or a SWA, and paragraph (c) of this section does not apply, the following procedures apply:

(i) When an ES complaint is filed against an employer, the proper office to process the complaint is the ES office serving the area in which the employer is located.

(ii) When a complaint is against an employer in another State or against another SWA:

(A) The ES office or SWA receiving the complaint must ensure the Complaint/Referral Form is adequately completed, and then immediately send a copy of the Complaint/Referral Form and copies of any relevant documents to the SWA in the other State. Copies of the referral letter must be sent to the complainant, and copies of the complaint and referral letter must be sent to the ETA Regional Office(s) with jurisdiction over the transferring and receiving State agencies. All such copies must be sent via hard copy or electronic mail.

(B) The SWA receiving the complaint must process the complaint as if it had been initially filed with that SWA.

(C) The ETA Regional Office with jurisdiction over the receiving SWA must follow up with it to ensure the complaint is processed in accordance with these regulations.

(D) If the complaint is against more than one SWA, the complaint must so clearly state. Additionally, the complaints must be processed as separate complaints and must be processed according to procedures in this paragraph (d).

(iii) When an ES complaint is filed against an ES office, the proper office to process the complaint is the ES office serving the area in which the alleged violation occurred.

(iv) When an ES complaint is filed against more than one ES offices and is in regard to an alleged agency-wide violation, the SWA representative or their designee must process the complaint.

(v) When a complaint is filed alleging a violation that occurred in the same State but through a different ES office, the ES office where the complaint is filed must ensure that the Complaint/Referral Form is adequately completed and send the form to the appropriate local ES office for tracking, further referral if necessary, and follow-up. A copy of the referral letter must be sent to the complainant via hard copy or electronic mail.

(2)(i) If a complaint regarding an alleged violation of the ES regulations is filed in a ES office by either a non-MSFW or MSFW, or their representative(s) (or if all necessary information has been submitted to the office pursuant to paragraph (a)(4) of this section), the appropriate ES office Complaint System Representative must investigate and attempt to resolve the complaint immediately upon receipt.

(ii) If resolution has not been achieved to the satisfaction of the complainant within 15 working days after receipt of the complaint, or 5 working days with respect to complaints filed by or on behalf of MSFWs, (or after all necessary information has been submitted to the ES office pursuant to paragraph (a)(4) of this section), the Complaint System Representative must send the complaint to the SWA for resolution or further action.

(iii) The ES office must notify the complainant and the respondent, in writing (via hard copy or electronic mail), of the determination (pursuant to paragraph (d)(5) of this section) of its investigation under paragraph (d)(2)(i) of this section, or of the referral to the SWA (if referred).

(3) When a non-MSFW or their representative files a complaint regarding the ES regulations with a SWA, or when a non-MSFW complaint is referred from an ES office the following procedures apply:

(i) If the complaint is not transferred to an enforcement agency under paragraph (b)(1)(i) of this section the Complaint System Representative must investigate and attempt to resolve the complaint immediately upon receipt.

(ii) If resolution at the SWA level has not been accomplished within 30 working days after the complaint was received by the SWA (or after all necessary information has been submitted to the SWA pursuant to paragraph (a)(4) of this section), whether the complaint was received directly or from an

ES office pursuant to paragraph (d)(2)(ii) of this section, the SWA official must make a written determination regarding the complaint and must send electronic copies to the complainant and the respondent. The determination must follow the procedures set forth in paragraph (d)(5) of this section.

(4)(i) When a MSFW or their representative files a complaint regarding the ES regulations directly with a SWA, or when a MSFW complaint is referred from an ES office, the Complaint System Representative must investigate and attempt to resolve the complaint immediately upon receipt and may, if necessary, conduct a further investigation.

(ii) If resolution at the SWA level has not been accomplished within 20 business days after the complaint was received by the SWA (or after all necessary information has been submitted to the SWA pursuant to paragraph (a)(4) of this section), the Complaint System Representative must make a written determination regarding the complaint and must send electronic copies to the complainant and the respondent. The determination must follow the procedures set forth in paragraph (d)(5) of this section.

(5)(i) All written determinations by the SWA on complaints under the ES regulations must be sent by certified mail (or another legally viable method) and a copy of the determination may be sent via electronic mail. The determination must include all the following:

(A) The results of any SWA investigation;

(B) The conclusions reached on the allegations of the complaint;

(C) If a resolution was not reached, an explanation of why the complaint was not resolved; and

(D) If the complaint is against the SWA, an offer to the complainant of the opportunity to request, in writing, a hearing within 20 business days after the certified date of receipt of the notification.

(ii) If the SWA determines that the employer has not violated the ES regulations, the SWA must offer to the complainant the opportunity to request, in writing, a hearing within 20 business days after the certified date of receipt of the notification.

(iii) If the SWA, within 20 business days from the certified date of receipt of the notification provided for in paragraph (d)(5) of this section, receives a written request (via hard copy or electronic mail) for a hearing, the SWA must refer the complaint to a State hearing official for hearing. The SWA must, in writing (via hard copy or electronic mail), notify the respective parties to whom the determination was sent that:

(A) The parties will be notified of the date, time, and place of the hearing;

(B) The parties may be represented at the hearing by an attorney or other representative;

(C) The parties may bring witnesses and/or documentary evidence to the hearing;

(D) The parties may cross-examine opposing witnesses at the hearing;

(E) The decision on the complaint will be based on the evidence presented at the hearing;

(F) The State hearing official may reschedule the hearing at the request of a party or its representative; and

(G) With the consent of the SWA and of the State hearing official, the party who requested the hearing may withdraw the request for the hearing in writing before the hearing.

(iv) If the State agency makes a final determination that the employer who has or is currently using the ES has violated the ES regulations, the determination, pursuant to paragraph (d)(5) of this section, must state that the State will initiate procedures for discontinuation of services to the employer in accordance with subpart F of this part.

(6) A complaint regarding the ES regulations must be processed to resolution by these regulations only if it is made within 2 years of the alleged occurrence.

(e) *Resolution of complaints.* A complaint is considered resolved when:

(1) The complainant indicates satisfaction with the outcome via written correspondence;

(2) The complainant chooses not to elevate the complaint to the next level of review;

(3) The complainant or the complainant's authorized representative fails to respond to a request for information under paragraph (a)(4) of this section within 20 working days or, in cases where the complainant is an MSFW, 40 working days of a written request by the appropriate ES office or State agency;

(4) The complainant exhausts all available options for review; or

(5) A final determination has been made by the enforcement agency to which the complaint was referred.

(f) *Reopening of case after resolution.* If the complainant or the complainant's authorized representative fails to respond pursuant to paragraph (e)(3) of this section, the complainant or the complainant's authorized representative may reopen the case within 1 year after the SWA has closed the case.

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 629, Jan. 6, 2020; 88 FR 82731, Nov. 24, 2023]

§ 658.417 State hearings.

(a) The hearing described in § 658.411(d)(5) must be held by State hearing officials. A State hearing official may be any State official authorized to hold hearings under State law. Examples of hearing officials are referees in State unemployment compensation hearings and officials of the State agency authorized to preside at State administrative hearings.

(b) The State hearing official may decide to conduct hearings on more than one complaint concurrently if they determine that the issues are related or that the complaints will be processed more expeditiously if conducted together.

(c) The State hearing official, upon the referral of a case for a hearing, must:

(1) Notify all involved parties of the date, time, and place of the hearing; and

(2) Reschedule the hearing, as appropriate.

(d) In conducting a hearing, the State hearing official must:

(1) Regulate the course of the hearing;

(2) Issue subpoenas if necessary, provided the official has the authority to do so under State law;

(3) Ensure that all relevant issues are considered;

(4) Rule on the introduction of evidence and testimony; and

(5) Take all actions necessary to ensure an orderly proceeding.

(e) All testimony at the hearing must be recorded and may be transcribed when appropriate.

(f) The parties must be afforded the opportunity to present, examine, and cross-examine witnesses.

(g) The State hearing official may elicit testimony from witnesses, but may not act as advocate for any party.

(h) The State hearing official must receive and include in the record, documentary evidence offered by any party and accepted at the hearing. Copies thereof must be made available by the party submitting the document to other parties to the hearing upon request.

(i) Federal and State rules of evidence do not apply to hearings conducted pursuant to this section; however rules or principles designed to assure production of the most credible evidence available and to subject testimony to test by cross-examination, must be applied where reasonably necessary by the State hearing official. The State hearing official may exclude irrelevant, immaterial, or unduly repetitious evidence.

(j) The case record, or any portion thereof, must be available for inspection and copying by any party at, prior to, or subsequent to the hearing upon request. Special procedures may be used for disclosure of medical and psychological records such as disclosure to a physician designated by the individual.

(k) The State hearing official must, if feasible, resolve the dispute at any time prior to the conclusion of the hearing.

(l) At the State hearing official's discretion, other appropriate individuals, organizations, or associations may be permitted to participate in the hearing as amicus curiae (friends of the court) with respect to any legal or factual issues relevant to the complaint. Any documents submitted by the amicus curiae must be included in the record.

(m) If the parties to the hearing are located in more than one State or are

located in the same State but access to the hearing location is extremely inconvenient for one or more parties as determined by the State hearing official, the hearing official must:

(1) Whenever possible, hold a single hearing at a location convenient to all parties or their representatives wishing to appear and present evidence, with all such parties and/or their representatives present.

(2) If a hearing location cannot be established by the State hearing official under paragraph (m)(1) of this section, the State hearing official may conduct, with the consent of the parties, the hearing by a telephone conference call from a State agency office. If the hearing is conducted via telephone conference call the parties and their representatives must have the option to participate in person or via telephone.

(3) Where the State agency is not able, for any reason, to conduct a telephonic hearing under paragraph (m)(2) of this section, the State agencies in the States where the parties are located must take evidence and hold the hearing in the same manner as used for appealed interstate unemployment claims in those States, to the extent that such procedures are consistent with this section.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82732, Nov. 24, 2023]

§ 658.418 Decision of the State hearing official.

(a) The State hearing official may:

(1) Rule that it lacks jurisdiction over the case;

(2) Rule that the complaint has been withdrawn properly in writing;

(3) Rule that reasonable cause exists to believe that the request has been abandoned; or

(4) Render such other rulings as are appropriate to resolve the issues in question.

However, the State hearing official does not have authority or jurisdiction to consider the validity or constitutionality of the ES regulations or of the Federal statutes under which they are promulgated.

(b) Based on the entire record, including the investigations and determinations of the ES offices and State agencies and any evidence provided at the hearing, the State hearing official must prepare a written decision. The State hearing official must send a copy of the decision stating the findings of fact and conclusions of law, and the reasons therefor to the complainant, the respondent, entities serving as amicus capacity (if any), the State agency, the Regional Administrator, and the Solicitor of Labor, Attn: Associate Solicitor for Employment and Training Legal Services, Department of Labor, Room N2101, 200 Constitution Avenue NW., Washington, DC 20210. The notification to the complainant and respondent must be sent by certified mail or by other legally viable means.

(c) All decisions of a State hearing official must be accompanied by a written notice informing the parties (not including the Regional Administrator, the Solicitor of Labor, or entities serving in an amicus capacity) that they may appeal the judge's decision within 20 working days of the certified date of receipt of the decision, and they may file an appeal in writing with the Regional Administrator. The notice must give the address of the Regional Administrator.

§ 658.419 Apparent violations.

(a) If an ES staff member observes, has reason to believe, or is in receipt of information regarding an apparent violation, except as part of a field check under § 653.503 of this chapter, the staff member must document the apparent violation and refer it to the ES Office Manager, who must ensure the apparent violation is documented in the Complaint System log, as described at § 658.410.

(b) If the employer has filed a job order with the ES office within the past 12 months, the ES office must attempt informal resolution provided at § 658.411.

(c) If the employer has not filed a job order with the ES office during the past 12 months, the suspected violation of an employment-related law must be referred to the appropriate enforcement agency in writing.

(d) Apparent violations of nondiscrimination laws must be processed

according to the procedures described in § 658.411(c).

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 629, Jan. 6, 2020; 88 FR 82732, Nov. 24, 2023]

WHEN A COMPLAINT RISES TO THE FEDERAL LEVEL

§ 658.420 Responsibilities of the Employment and Training Administration regional office.

(a) Each Regional Administrator must establish and maintain a Complaint System within each ETA regional office.

(b) The Regional Administrator must designate Department of Labor officials to process ES regulation-related complaints as follows:

(1) All complaints received at the ETA regional office under this subpart that allege unlawful discrimination or reprisal for protected activity in violation of nondiscrimination laws, such as those enforced by the EEOC or CRC, or in violation of the Immigration and Nationality Act's anti-discrimination provision found at 8 U.S.C. 1324b, must be logged and immediately referred to the appropriate State-level E.O. Officer(s).

(2) All complaints other than those described in paragraph (b)(1) of this section must be assigned to a regional office official designated by the Regional Administrator, provided that the regional office official designated to process MSFW complaints must be the Regional Monitor Advocate (RMA).

(c) Except for those complaints under paragraph (b)(1) of this section, the Regional Administrator must designate Department of Labor officials to process employment-related law complaints in accordance with § 658.422, provided that the regional official designated to process MSFW employment-related law complaints must be the RMA. The RMA must follow up monthly on all complaints filed by MSFWs including complaints under paragraph (b)(1) of this section.

(d) The Regional Administrator must ensure that all complaints and all related documents and correspondence are logged with a notation of the nature of each item.

[81 FR 56352, Aug. 19, 2016, as amended 88 FR 82733, Nov. 24, 2023]

§ 658.421 Processing of Wagner-Peyser Act Employment Service regulation-related complaints.

(a)(1) Except as provided below in paragraph (a)(2) of this section, no complaint alleging a violation of the ES regulations may be processed at the ETA regional office level until the complainant has exhausted the SWA administrative remedies set forth at §§ 658.411 through 658.418. If the Regional Administrator determines that a complaint has been prematurely filed with an ETA regional office, the Regional Administrator must inform the complainant within 10 working days in writing that the complainant must first exhaust those remedies before the complaint may be filed in the regional office. A copy of this letter and a copy of the complaint also must be sent to the State Administrator.

(2) If a complaint is submitted directly to the Regional Administrator and if they determine that the nature and scope of a complaint described in paragraph (a) of this section is such that the time required to exhaust the administrative procedures at the SWA level would adversely affect a significant number of individuals, the RA must accept the complaint and take the following action:

(i) If the complaint is filed against an employer, the regional office must process the complaint in a manner consistent with the requirements imposed upon State agencies by §§ 658.411 and 658.418. A hearing must be offered to the parties once the Regional Administrator makes a determination on the complaint.

(ii) If the complaint is filed against a SWA, the regional office must follow procedures established at § 658.411(d).

(b) The ETA regional office is responsible for processing appeals of determinations made on complaints at the SWA level. An appeal includes any letter or other writing which the Regional Administrator reasonably understands to be requesting review if it is received by the regional office and signed by a party to the complaint.

(c)(1) Once the Regional Administrator receives a timely appeal, they must request the complete SWA file, including the original Complaint/Referral Form from the appropriate SWA.

(2) The Regional Administrator must review the file in the case and must determine within 10 business days whether any further investigation or action is appropriate; however, if the Regional Administrator determines that they need to request legal advice from the Office of the Solicitor at the U.S. Department of Labor, then the Regional Administrator is allowed 20 business days to make this determination.

(d) If the Regional Administrator determines that no further action is warranted, the Regional Administrator will send their determination in writing to the appellant within 5 days of the determination, with a notification that the appellant may request a hearing before a Department of Labor Administrative Law Judge (ALJ) by filing a hearing request in writing with the Regional Administrator within 20 working days of the appellant's receipt of the notification.

(e) If the Regional Administrator determines that further investigation or other action is warranted, the Regional Administrator must undertake such an investigation or other action necessary to resolve the complaint.

(f) After taking the actions described in paragraph (e) of this section, the Regional Administrator must either affirm, reverse, or modify the decision of the State hearing official, and must notify each party to the State hearing official's hearing or to whom the State office determination was sent, notice of the determination and notify the parties that they may appeal the determination to the Department of Labor's Office of Administrative Law Judges within 20 business days of the party's receipt of the notice.

(g) If the Regional Administrator finds reason to believe that a SWA or one of its ES offices has violated ES regulations, the Regional Administrator must follow the procedures set forth at subpart H of this part.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82733, Nov. 24, 2023]

§ 658.422 Processing of employment-related law complaints by the Regional Administrator.

(a) This section applies to all complaints submitted directly to the Regional Administrator or their representative.

(b) Each complaint filed by an MSFW alleging violation(s) of employment-related laws must be taken in writing, logged, and referred to the appropriate enforcement agency for prompt action. If such a complaint alleges a violation of nondiscrimination laws or reprisal for protected activity, it must be referred to the appropriate State-level E.O. Officer in accordance with § 658.420(b)(1).

(c) Each complaint submitted by a non-MSFW alleging violation(s) of employment-related laws must be logged and referred to the appropriate enforcement agency for prompt action. If such a complaint alleges a violation of nondiscrimination laws or reprisal for protected activity, it must be referred to the appropriate State-level E.O. Officer in accordance with § 658.420(b)(1).

(d) Upon referring the complaint in accordance with paragraphs (b) and (c) of this section, the regional official must inform the complainant of the enforcement agency (and individual, if known) to which the complaint was referred.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82733, Nov. 24, 2023]

§ 658.424 Proceedings before the Office of Administrative Law Judges.

(a) If a party requests a hearing pursuant to § 658.421 or § 658.707, the Regional Administrator must:

(1) Send the party requesting the hearing, and all other parties to the prior State level hearing, a written notice (hard copy or electronic) that the matter will be referred to the Office of Administrative Law Judges for a hearing;

(2) Compile four hearing files (hard copy or electronic) containing copies of all documents relevant to the case, indexed and compiled chronologically; and

(3) Send simultaneously one hearing file to the Department of Labor Chief Administrative Law Judge, 800 K Street NW., Suite 400N, Washington, DC 20001–8002, one hearing file to the OWI Administrator, and one hearing file to the Solicitor of Labor, Attn: Associate Solicitor for Employment and

Training Legal Services, and retain one hearing file.

(b) Proceedings under this section are governed by the rules of practice and procedure at subpart A of 29 CFR part 18, Rule of Practice and Procedure for Administrative Hearings before the Office of Administrative Law Judges, except where otherwise specified in this section or at § 658.425.

(c) Upon receipt of a hearing file, the ALJ designated to the case must notify the party requesting the hearing, all parties to the prior State hearing official hearing (if any), the State agency, the Regional Administrator, the OWI Administrator, and the Solicitor of Labor of the receipt of the case. After conferring all the parties, the ALJ may decide to make a determination on the record in lieu of scheduling a hearing.

(d) The ALJ may decide to consolidate cases and conduct hearings on more than one complaint concurrently if they determine that the issues are related or that the complaints will be processed more expeditiously.

(e) If the parties to the hearing are located in more than one State or are located in the same State but access to the hearing location is extremely inconvenient for one or more parties as determined by the ALJ, the ALJ must:

(1) Whenever possible, hold a single hearing, at a location convenient to all parties or their representatives wishing to appear and present evidence, with all such parties and/or their representatives present.

(2) If a hearing location cannot be established by the ALJ at a location pursuant to paragraph (e)(1) of this section, the ALJ may conduct, with the consent of the parties, the hearing by a telephone conference call. If the hearing is conducted via telephone conference call the parties and their representatives must have the option to participate in person or via telephone.

(3) Where the ALJ is unable, for any reason, to conduct a telephonic hearing under paragraph (e)(2) of this section, the ALJ must confer with the parties on how to proceed.

(f) Upon deciding to hold a hearing, the ALJ must notify all involved parties of the date, time, and place of the hearing.

(g) The parties to the hearing must be afforded the opportunity to present, examine, and cross-examine witnesses. The ALJ may elicit testimony from witnesses, but may not act as advocate for any party. The ALJ has the authority to issue subpoenas.

(h) The ALJ must receive, and make part of the record, documentary evidence offered by any party and accepted at the hearing, provided that copies of such evidence is provided to the other parties to the proceeding prior to the hearing at the time required by the ALJ.

(i) Technical rules of evidence do not apply to hearings conducted pursuant to this part, but rules or principles designed to assure production of the most credible evidence available and to subject testimony to test by cross-examination must be applied where reasonably necessary by the ALJ conducting the hearing. The ALJ may exclude irrelevant, immaterial, or unduly repetitious evidence.

(j) The case record, or any portion thereof, must be available for inspection and copying by any party to the hearing at, prior to, or subsequent to the hearing upon request. Special procedures may be used for disclosure of medical and psychological records such as disclosure to a physician designated by the individual concerned.

(k) The ALJ must, if feasible, encourage resolution of the dispute by conciliation at any time prior to the conclusion of the hearing.

[81 FR 56352, Aug. 19, 2016, as amended at 88 82733, Nov. 24, 2023]

§ 658.425 Decision of Department of Labor Administrative Law Judge.

(a) The ALJ may:

(1) Rule that they lack jurisdiction over the case:

(2) Rule that the appeal has been withdrawn, with the written consent of all parties;

(3) Rule that reasonable cause exists to believe that the appeal has been abandoned; or

(4) Render such other rulings as are appropriate to the issues in question. However, the ALJ does not have jurisdiction to consider the validity or constitutionality of the ES regulations or

of the Federal statutes under which they are promulgated.

(b) Based on the entire record, including any legal briefs, the record before the State agency, the investigation (if any) and determination of the Regional Administrator, and evidence provided at the hearing, the ALJ must prepare a written decision. The ALJ must send a copy of the decision stating the findings of fact and conclusions of law to the parties to the hearing, including the State agency, the Regional Administrator, the OWI Administrator, and the Solicitor, and to entities filing amicus briefs (if any).

(c) The decision of the ALJ serves as the final decision of the Secretary.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82733, Nov. 24, 2023]

§ 658.426 Complaints against the United States Employment Service.

(a) Complaints alleging that an ETA regional office or the National Office has violated ES regulations must be mailed to the Assistant Secretary for Employment and Training, U.S. Department of Labor, Washington, DC 20210. Such complaints must include:

(1) A specific allegation of the violation;

(2) The date of the incident;

(3) Location of the incident;

(4) The individual alleged to have committed the violation; and

(5) Any other relevant information available to the complainant.

(b) The Assistant Secretary or the Regional Administrator as designated must make a determination and respond to the complainant after investigation of the complaint.

§ 658.427 Severability.

Should a court hold any portion of any provision of this part to be invalid, the provision will be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding is one of total invalidity or unenforceability, in which event the provision or subprovision will be severable from this part and will not affect the remainder thereof.

[88 FR 82733, Nov. 24, 2023]

Subpart F—Discontinuation of Services to Employers by the Wagner-Peyser Act Employment Service

§ 658.500 Scope and purpose of subpart.

(a) This subpart contains the regulations governing the discontinuation of services provided by the ES to employers pursuant to parts 652 and 653 of this chapter.

(b) For purposes of this subpart only, where the term ''employer'' is used, it refers to employers, agents, farm labor contractors, joint employers, and successors in interest to any employer, agent, farm labor contractor, or joint employer, as defined at § 651.10 of this chapter. A successor in interest to an employer, agent, or farm labor contractor may be held liable for the duties and obligations of that employer, agent, or farm labor contractor for purposes of recruitment of workers through the ES clearance system or enforcement of ES regulations, regardless of whether such successor in interest has succeeded to all the rights and liabilities of the predecessor entity.

[89 FR 34065, Apr. 29, 2024]

§ 658.501 Basis for discontinuation of services.

(a) SWA officials must initiate procedures for discontinuation of services to employers who:

(1) Submit and refuse to correct or withdraw job orders containing terms and conditions that are contrary to employment-related laws;

(2) Submit job orders and refuse to provide assurances, or refuse to withdraw job orders that do not contain assurances, required pursuant to the Agricultural Recruitment System for U.S. Workers at part 653, subpart F, of this chapter;

(3) Are found through field checks or otherwise to have either misrepresented the terms or conditions of employment specified on job orders or failed to comply fully with assurances made on job orders;

(4) Are found by a final determination by an appropriate enforcement agency to have violated any employment-related laws and notification of

this final determination has been provided to the Department or the SWA by that enforcement agency, including those who are currently debarred from participating in the H–2A or H–2B foreign labor certification programs pursuant to § 655.73 or § 655.182 of this chapter or 29 CFR 501.20 or 503.24;

(5) Are found to have violated ES regulations pursuant to § 658.411 or § 658.419;

(6) Refuse to accept qualified workers referred through the clearance system for criteria clearance orders filed pursuant to part 655, subpart B, of this chapter;

(7) Refuse to cooperate in field checks conducted pursuant to § 653.503 of this chapter; or

(8) Repeatedly cause the initiation of the procedures for discontinuation of services pursuant to paragraphs (a)(1) through (7) of this section.

(b) If an ES office or SWA has information that an employer participating in the ES may have committed fraud or misrepresentation in connection with its current or prior temporary labor certification or may not have complied with the terms of such certification, under, for example the H–2A and H–2B visa programs, SWA officials must notify the OFLC National Processing Center and the Wage and Hour Division of the alleged noncompliance as applicable under § 655.185 and 29 CFR 501.2, 501.6, 503.3, and 503.7. If the circumstances occurred within the previous 3 years, SWA officials must determine whether there is a basis under paragraph (a) of this section for which the SWA must initiate procedures for discontinuation of services.

(c) [Reserved]

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 629, Jan. 6, 2020; 89 FR 34065, Apr. 29, 2024]

§ 658.502 Notification to employers of intent to discontinue services.

(a) Except as provided in paragraph (b) of this section, where the SWA determines that there is an applicable basis for discontinuation of services under § 658.501(a)(1) through (8), the SWA must notify the employer in writing that it intends to discontinue the provision of ES services in accordance with this section and must provide the reasons for proposing discontinuation of services.

(1) Where the decision is based on § 658.501(a)(1), the SWA must specify the date the order was submitted, the job order involved, and the terms and conditions contrary to employment-related laws and the laws involved. The SWA must notify the employer in writing that all ES services will be terminated unless the employer within 20 working days:

(i) Provides adequate evidence that the terms and conditions are not contrary to employment-related laws;

(ii) Withdraws the terms and conditions and resubmits the job order in compliance with all employment-related laws; or

(iii) If the job is no longer available, makes assurances that all future job orders submitted will be in compliance with all employment-related laws.

(2) Where the decision is based on § 658.501(a)(2), the SWA must specify the date the order was submitted, the job order involved, the assurances involved, and explain how the employer refused to provide the assurances. The SWA must notify the employer that all ES services will be terminated unless the employer within 20 working days:

(i) Resubmits the order with the required assurances; or

(ii) If the job is no longer available, makes assurances that all future job orders submitted will contain all assurances required pursuant to the Agricultural Recruitment System for U.S. Workers at part 653, subpart F, of this chapter.

(3) Where the decision is based on § 658.501(a)(3), the SWA must specify the terms and conditions the employer misrepresented or the assurances with which the employer did not fully comply, and explain how the employer misrepresented the terms or conditions or failed to comply with assurances on the job order. The SWA must notify the employer that all ES services will be terminated unless the employer within 20 working days:

(i) Provides adequate evidence that terms and conditions of employment were not misrepresented;

(ii) Provides adequate evidence that there was full compliance with the assurances made on the job orders; or

(iii) Provides adequate evidence that it has resolved the misrepresentation of terms and conditions of employment or noncompliance with assurances and provides adequate assurance that specifications on future orders will accurately represent the terms and conditions of employment and that there will be full compliance with all job order assurances.

(4) Where the decision is based on §658.501(a)(4), the SWA must provide evidence of the final determination, including debarment. For final determinations, the SWA must specify the enforcement agency's findings of facts and conclusions of law as to the employment-related law violation(s). For final debarment orders, the SWA must specify the time period for which the employer is debarred from participating in one of the Department's foreign labor certification programs. The SWA must notify the employer that all ES services will be terminated unless the employer within 20 working days:

(i) Provides adequate evidence that the enforcement agency's determination is not final because, for example, it has been stayed pending appeal, overturned, or reversed; or

(ii) Provides adequate evidence that, as applicable:

(A) The Department's debarment is no longer in effect; and

(B) The employer has completed all required actions imposed by the enforcement agency as a consequence of the violation, including payment of any fines or restitution to remediate the violation; and

(iii) Provides assurances that any policies, procedures, or conditions responsible for the violation have been corrected and the same or similar violations are not likely to occur in the future.

(5) Where the decision is based on §658.501(a)(5), the SWA must specify which ES regulation, as defined in §651.10, the employer has violated and must provide basic facts to explain the violation. The SWA must notify the employer that all ES services will be terminated unless the employer within 20 working days:

(i) Provides adequate evidence that the employer did not violate ES regulations; or

(ii) Provides adequate evidence that appropriate restitution has been made or remedial action taken; and

(iii) Provides assurances that any policies, procedures, or conditions responsible for the violation have been corrected and the same or similar violations are not likely to occur in the future.

(6) Where the decision is based on §658.501(a)(6), the SWA must indicate that the employer filed the job order pursuant to part 655, subpart B, of this chapter, and specify the name of each worker the SWA referred and the employer did not accept. The SWA must notify the employer that all ES services will be terminated unless the employer within 20 working days:

(i) Provides adequate evidence that the workers were accepted; or

(ii) Provides adequate evidence that the workers were not available to accept the job; or

(iii) Provides adequate evidence that the workers were not qualified; or

(iv) Provides adequate evidence that the workers were referred after the time period described in §655.135(d) of this chapter elapsed; or

(v) Provides adequate evidence that:

(A) After refusal, the employer accepted the qualified workers referred; or

(B) Appropriate restitution has been made or other remedial action taken; and

(vi) Provides assurances that qualified workers referred in the future will be accepted or, if the time period described in §655.135(d) of this chapter has lapsed, provides assurances that qualified workers referred on all future criteria clearance orders will be accepted.

(7) Where the decision is based on §658.501(a)(7), the SWA must explain how the employer did not cooperate in the field check. The SWA must notify the employer that all ES services will be terminated unless the employer within 20 working days:

(i) Provides adequate evidence that it did cooperate; or

(ii) Immediately cooperates in the conduct of field checks; and

(iii) Provides assurances that it will cooperate in future field checks.

(8) Where the decision is based on § 658.501(a)(8), the SWA must list and provide basic facts explaining the prior instances where the employer has repeatedly caused initiation of discontinuation proceedings. The SWA must notify the employer that all ES services will be terminated unless the employer within 20 working days provides adequate evidence that the SWA's initiation of discontinuation in prior proceedings was unfounded.

(b) SWA officials must discontinue services immediately in accordance with § 658.503, without providing the notice described in this section, if an employer has met any of the bases for discontinuation of services under § 658.501(a) and, in the judgment of the State Administrator, exhaustion of the administrative procedures set forth in this section would cause substantial harm to workers.

[89 FR 34066, Apr. 29, 2024]

§ 658.503 Discontinuation of services.

(a) Within 20 working days of receipt of the employer's response to the SWA's notification under § 658.502(a), or at least 20 working days after the SWA's notification has been received by the employer if the SWA does not receive a response, the SWA must notify the employer in writing of its final determination. If the SWA determines that the employer did not provide a satisfactory response in accordance with § 658.502(a), the SWA's notification must specify the reasons for its determination and state that the discontinuation of services is effective 20 working days from the date of the notification. The notification must also state that the employer may request reinstatement or appeal the determination by requesting a hearing pursuant to § 658.504, and that a request for a hearing stays the discontinuation pending the outcome of the hearing. If the employer does not request a hearing, the SWA must also notify the ETA Office of Workforce Investment of any final determination to discontinue ES services within 10 working days of the date the determination becomes effective.

(b) Where the SWA discontinues services immediately under § 658.502(b), the SWA's written notification must specify the facts supporting the applicable basis for discontinuation under § 658.501(a), the reasons that exhaustion of the administrative procedures would cause substantial harm to workers, and that services are discontinued as of the date of the notification. The notification must also state that the employer may request reinstatement or appeal the determination by requesting a hearing pursuant to § 658.504, and that a request for a hearing relating to immediate discontinuation does not stay the discontinuation pending the outcome of the hearing. Within 10 working days of the date of issuance, the SWA must also notify the ETA Office of Workforce Investment of any determination to immediately discontinue ES services.

(c) If the SWA discontinues services to an employer that is subject to Federal Contractor Job Listing Requirements, the SWA must notify the ETA regional office immediately.

(d) If the SWA discontinues services to an employer based on a complaint filed pursuant to § 658.411, the SWA must notify the complainant of the employer's discontinuation of services.

(e) If the SWA discontinues services to an employer, the employer cannot participate in or receive Wagner-Peyser Act ES Services provided by the ES, including by any SWA, to employers pursuant to parts 652 and 653 of this chapter. From the date of discontinuance, the SWA that issued the determination must remove the employer's active job orders from the clearance system. No SWA may process any future job orders from the employer or provide any other services pursuant to parts 652 and 653 of this chapter to the employer unless services have been reinstated under § 658.504.

(f) SWAs must continue to provide the full range of ES and other appropriate services to workers whose employers experience discontinuation of services under this subpart.

[89 FR 34067, Apr. 29, 2024]

§ 658.504 Reinstatement of services.

(a) Where the SWA discontinues services to an employer under § 658.502(b) or § 658.503, the employer may submit a written request for reinstatement of services to the SWA or may, within 20

working days of receiving notice of the SWA's final determination, appeal the discontinuation by submitting a written request for a hearing.

(b) If the employer submits a written request for reinstatement of services to the SWA:

(1) Within 20 working days of receipt of the employer's request for reinstatement, the SWA must notify the employer of its decision to grant or deny the request. If the SWA denies the request for reinstatement, it must specify the reasons for the denial and notify the employer that it may request a hearing, in accordance with paragraph (c) of this section, within 20 working days.

(2) The SWA must reinstate services if:

(i) The employer provides adequate evidence that the policies, procedures, or conditions responsible for the previous discontinuation of services have been corrected and that the same or similar circumstances are not likely to occur in the future; and

(ii) The employer provides adequate evidence that it has responded to all findings of an enforcement agency, SWA, or ETA, including payment of any fines or restitution to remediate the violation, that were the basis of the discontinuation of services, if applicable.

(c) If the employer submits a timely request for a hearing:

(1) The SWA must follow the procedures set forth in § 658.417; and

(2) The SWA must reinstate services to the employer if ordered to do so by a State hearing official, Regional Administrator, or Federal Administrative Law Judge as a result of a hearing offered pursuant to paragraph (c)(1) of this section.

(d) Within 10 working days of the date of issuance, the SWA must notify the ETA Office of Workforce Investment of any determination to reinstate ES services, or any decision on appeal upholding a SWA's determination to discontinue services.

[89 FR 34067, Apr. 29, 2024]

Subpart G—Review and Assessment of State Workforce Agency Compliance With Employment Service Regulations

§ 658.600 Scope and purpose of subpart.

This subpart sets forth the regulations governing review and assessment of State Workforce Agency (SWA) compliance with the ES regulations at this part and parts 651, 652, 653, and 654 of this chapter. All recordkeeping and reporting requirements contained in this part and part 653 of this chapter have been approved by the Office of Management and Budget as required by the Paperwork Reduction Act of 1980.

§ 658.601 State Workforce Agency responsibility.

(a) Each SWA must establish and maintain a self-appraisal system for ES operations to determine success in reaching goals and to correct deficiencies in performance. The self-appraisal system must include numerical (quantitative) appraisal and non-numerical (qualitative) appraisal.

(1) Numerical appraisal at the ES office level must be conducted as follows:

(i) Performance must be measured on a quarterly-basis against planned service levels as stated in the Unified or Combined State Plan (''State Plan''). The State Plan must be consistent with numerical goals contained in ES office plans.

(ii) To appraise numerical activities/indicators, actual results as shown on the Department's ETA Form 9172, or any successor report required by the Department must be compared to planned levels. Differences between achievement and plan levels must be identified.

(iii) When the numerical appraisal of required activities/indicators identifies significant differences from planned levels, additional analysis must be conducted to isolate possible contributing factors. This data analysis must include, as appropriate, comparisons to past performance, attainment of State Plan goals and consideration of pertinent non-numerical factors.

(iv) Results of ES office numerical reviews must be documented and significant deficiencies identified. A corrective action plan as described in paragraph (a)(6) of this section must be developed to address these deficiencies.

(v) The result of ES office appraisal, including corrective action plans, must be communicated in writing to the next higher level of authority for review. This review must cover adequacy of analysis, appropriateness of corrective actions, and need for higher level involvement. When this review is conducted at an area or district office, a report describing ES office performance within the area or district jurisdiction must be communicated to the SWA on a quarterly basis.

(2) Numerical appraisal at the SWA level must be conducted as follows:

(i) Performance must be measured on a quarterly basis against planned service levels as stated in the State Plan. The State Plan must be consistent with numerical goals contained in ES office plans.

(ii) To appraise these key numerical activities/indicators, actual results as shown on ETA Form 9172, or any successor report required by the Department must be compared to planned levels. Differences between achievement and plan levels must be identified.

(iii) The SWA must review statewide data and performance against planned service levels as stated in the State Plan on at least a quarterly basis to identify significant statewide deficiencies and to determine the need for additional analysis, including identification of trends, comparisons to past performance, and attainment of State Plan goals.

(iv) Results of numerical reviews must be documented and significant deficiencies identified. A corrective action plan as described in paragraph (a)(5) of this section must be developed to address these deficiencies. These plans must be submitted to the ETA Regional Office as part of the periodic performance process described at § 658.603(d)(2).

(3) Non-numerical (qualitative) appraisal of ES office activities must be conducted at least annually as follows:

(i) Each ES office must assess the quality of its services to applicants, employers, and the community and its compliance with Federal regulations.

(ii) At a minimum, non-numerical review must include an assessment of the following factors:

(A) Appropriateness of services provided to participants and employers;

(B) Timely delivery of services to participants and employers;

(C) Staff responsiveness to individual participants and employer needs;

(D) Thoroughness and accuracy of documents prepared in the course of service delivery; and

(E) Effectiveness of ES interface with external organizations, such as other ETA-funded programs, community groups, etc.

(iii) Non-numerical review methods must include:

(A) Observation of processes;

(B) Review of documents used in service provisions; and

(C) Solicitation of input from applicants, employers, and the community.

(iv) The result of non-numerical reviews must be documented and deficiencies identified. A corrective action plan addressing these deficiencies as described in paragraph (a)(6) of this section must be developed.

(v) The result of ES office non-numerical appraisal, including corrective actions, must be communicated in writing to the next higher level of authority for review. This review must cover thoroughness and adequacy of ES office appraisal, appropriateness of corrective actions, and need for higher level involvement. When this review is conducted at an area or district level, a report summarizing local ES office performance within that jurisdiction must be communicated to the SWA on an annual basis.

(4) As part of its oversight responsibilities, the SWA must conduct onsite reviews in those ES offices which show continuing internal problems or deficiencies in performance as indicated by such sources as data analysis, non-numerical appraisal, or other sources of information.

(5) Non-numerical (qualitative) review of SWA ES activities must be conducted as follows:

(i) SWA operations must be assessed annually to determine compliance with Federal regulations.

(ii) Results of non-numerical reviews must be documented and deficiencies identified. A corrective action plan addressing these deficiencies must be developed.

(6) Corrective action plans developed to address deficiencies uncovered at any administrative level within the State as a result of the self-appraisal process must include:

(i) Specific descriptions of the type of action to be taken, the time frame involved, and the assignment of responsibility.

(ii) Provision for the delivery of technical assistance as needed.

(iii) A plan to conduct follow-up on a timely basis to determine if action taken to correct the deficiencies has been effective.

(7)(i) The provisions of the ES regulations which require numerical and non-numerical assessment of service to special applicant groups (*e.g.*, services to veterans at 20 CFR part 1001—Services for Veterans and services to MSFWs at this part and part 653 of this chapter), are supplementary to the provisions of this section.

(ii) Each State Administrator and ES office manager must ensure their staff know and carry out ES regulations, including regulations on performance standards and program emphases, and any corrective action plans imposed by the SWA or by the Department.

(iii) Each State Administrator must ensure the SWA complies with its approved State Plan.

(iv) Each State Administrator must ensure to the maximum extent feasible the accuracy of data entered by the SWA into Department-required management information systems. Each SWA must establish and maintain a data validation system pursuant to Department instructions. The system must review every local ES office at least once every 4 years. The system must include the validation of time distribution reports and the review of data gathering procedures.

(b) [Reserved]

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 629, Jan. 6, 2020]

§ 658.602 Employment and Training Administration National Office responsibility.

The ETA National Office must:

(a) Monitor ETA Regional Offices' operations under ES regulations;

(b) From time to time, conduct such special reviews and audits as necessary to monitor ETA regional office and SWA compliance with ES regulations;

(c) Offer technical assistance to the ETA regional offices and SWAs in carrying out ES regulations and programs;

(d) Have report validation surveys conducted in support of resource allocations; and

(e) Develop tools and techniques for reviewing and assessing SWA performance and compliance with ES regulations.

(f) ETA must appoint a National Monitor Advocate (NMA), who must devote full time to the duties set forth in this subpart. The NMA must:

(1) Review the effective functioning of the Regional Monitor Advocates (RMAs) and SMAs;

(2) Review the performance of SWAs in providing the full range of ES services to MSFWs;

(3) Take steps to resolve or refer ES-related problems of MSFWs which come to their attention;

(4) Take steps to refer non-ES-related problems of MSFWs which come to their attention;

(5) Recommend to the Administrator changes in policy toward MSFWs; and

(6) Serve as an advocate to improve services for MSFWs within the ES system. The NMA must be a member of the National Farm Labor Coordinated Enforcement Staff Level Working Committee and other Occupational Safety and Health Administration (OSHA) and Wage and Hour Division (WHD) task forces, and other committees as appropriate.

(g) The NMA must be appointed by the Office of Workforce Investment Administrator (Administrator) after informing farmworker organizations and other organizations with expertise concerning MSFWs of the opening and encouraging them to refer qualified applicants to apply through the Federal

merit system. Among qualified candidates, determined through merit systems procedures, individuals must be sought who meet the criteria used in the selection of the SMAs, as provided in SWA self-monitoring requirements at § 653.108(a) of this chapter.

(h) The NMA must be assigned staff necessary to fulfill effectively all the responsibilities set forth in this subpart.

(i) The NMA must submit the Annual Report to the OWI Administrator, the ETA Assistant Secretary, and the National Farm Labor Coordinated Enforcement Committee covering the matters set forth in this subpart.

(j) The NMA must monitor and assess SWA compliance with ES regulations affecting MSFWs on a continuing basis. Their assessment must consider:

(1) Information from RMAs and SMAs;

(2) Program performance data, including the service indicators;

(3) Periodic reports from regional offices;

(4) All Federal on-site reviews;

(5) Selected State on-site reviews;

(6) Other relevant reports prepared by the ES;

(7) Information received from farmworker organizations and employers; and

(8) Their personal observations from visits to SWAs, ES offices, agricultural work sites, and migrant camps. In the Annual Report, the NMA must include both a quantitative and qualitative analysis of their findings and the implementation of their recommendations by State and Federal officials, and must address the information obtained from all of the foregoing sources.

(k) The NMA must review the activities of the State/Federal monitoring system as it applies to services to MSFWs and the Complaint System including the effectiveness of the regional monitoring function in each region and must recommend any appropriate changes in the operation of the system. The NMA's findings and recommendations must be fully set forth in the Annual Report.

(l) If the NMA finds the effectiveness of any RMA has been substantially impeded by the Regional Administrator or other regional office official, they must, if unable to resolve such problems informally, report and recommend appropriate actions directly to the OWI Administrator. If the NMA receives information that the effectiveness of any SMA has been substantially impeded by the State Administrator, a State or Federal ES official, or other ES staff, they must, in the absence of a satisfactory informal resolution at the regional level, report and recommend appropriate actions directly to the OWI Administrator.

(m) The NMA must be informed of all proposed changes in policy and practice within the ES, including ES regulations, which may affect the delivery of services to MSFWs. The NMA must advise the OWI Administrator concerning all such proposed changes which may adversely affect MSFWs. The NMA must propose directly to the OWI Administrator changes in ES policy and administration which may substantially improve the delivery of services to MSFWs. They also must recommend changes in the funding of SWAs and/or adjustment or reallocation of the discretionary portions of funding formulae.

(n) The NMA must participate in the review and assessment activities required in this section and §§ 658.700 through 658.711. As part of such participation, the NMA, or if they are unable to participate, an RMA must accompany the National Office review team on National Office on-site reviews. The NMA must engage in the following activities during each State on-site review:

(1) They must accompany selected outreach staff on their field visits.

(2) They must participate in field check(s) of migrant camps or work site(s) where MSFWs have been placed on inter or intrastate clearance orders.

(3) They must contact local WIOA sec. 167 National Farmworker Jobs Program grantees or other farmworker organizations as part of the on-site review and discuss with representatives of these organizations current trends and any other pertinent information concerning MSFWs.

(4) They must meet with the SMA and discuss the full range of the ES

services to MSFWs, including monitoring and the Complaint System.

(o) In addition to the duties specified in paragraph (f) of this section, the NMA each year during the harvest season must visit the four States with the highest level of MSFW activity during the prior fiscal year, if they are not scheduled for a National Office on-site review during the current fiscal year, and must:

(1) Meet with the SMA and other ES staff to discuss MSFW service delivery; and

(2) Contact representatives of MSFW organizations and interested employer organizations to obtain information concerning ES delivery and coordination with other agencies.

(p) The NMA must perform duties specified in §§ 658.700 through 765.711. As part of this function, they must monitor the performance of regional offices in imposing corrective action. The NMA must report any deficiencies in performance to the Administrator.

(q) The NMA must establish routine and regular contacts with WIOA sec. 167 National Farmworker Jobs Program grantees, other farmworker organizations and agricultural employers and/or employer organizations. The NMA must attend conferences or meetings of these groups wherever possible and must report to the Administrator and the National Farm Labor Coordinated Enforcement Committee on these contacts when appropriate. The NMA must include in the Annual Report recommendations about how the Department might better coordinate ES and WIOA sec. 167 National Farmworker Jobs Program services as they pertain to MSFWs.

(r) In the event that any SMA or RMA, enforcement agency, or MSFW group refers a matter to the NMA which requires emergency action, the NMA must assist them in obtaining action by appropriate agencies and staff, inform the originating party of the action taken, and, upon request, provide written confirmation.

(s) Through all the mechanisms provided in this subpart, the NMA must aggressively seek to ascertain and remedy, if possible, systemic deficiencies in the provisions of ES services and protections afforded by these regulations to MSFWs. The NMA must:

(1) Use the regular reports on complaints submitted by SWAs and ETA regional offices to assess the adequacy of these systems and to determine the existence of systemic deficiencies.

(2) Provide technical assistance to ETA regional office and ES staff for administering the Complaint System, and any other ES services as appropriate.

(3) Recommend to the Regional Administrator specific instructions for action by regional office staff to correct any ES-related systemic deficiencies. Prior to any ETA review of regional office operations concerning ES services to MSFWs, the NMA must provide to the Regional Administrator a brief summary of ES-related services to MSFWs in that region and their recommendations for incorporation in the regional review materials as the Regional Administrator and ETA reviewing organization deem appropriate.

(4) Recommend to the National Farm Labor Coordinated Enforcement Committee specific instructions for action by WHD and OSHA regional office staff to correct any non-ES-related systemic deficiencies of which he/she is aware.

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 629, Jan. 6, 2020; 88 FR 82733, Nov. 24, 2023]

§ 658.603 Employment and Training Administration regional office responsibility.

(a) The Regional Administrator must have responsibility for the regular review and assessment of SWA performance and compliance with ES regulations.

(b) The Regional Administrator must participate with the National Office staff in reviewing and approving the State Plan for the SWAs within the region. In reviewing the State Plans the Regional Administrator and appropriate National Office staff must consider relevant factors including the following:

(1) State Workforce Agency compliance with ES regulations;

(2) State Workforce Agency performance against the goals and objectives established in the previous State Plan;

(3) The effect which economic conditions and other external factors considered by the ETA in the resource allocation process may have had or are expected to have on the SWA's performance;

(4) SWA adherence to national program emphasis; and

(5) The adequacy and appropriateness of the State Plan for carrying out ES programs.

(c) The Regional Administrator must assess the overall performance of SWAs on an ongoing basis through desk reviews and the use of required reporting systems and other available information.

(d) As appropriate, Regional Administrators must conduct or have conducted:

(1) Comprehensive on-site reviews of SWAs and their offices to review SWA organization, management, and program operations;

(2) Periodic performance reviews of SWA operation of ES programs to measure actual performance against the State Plan, past performance, the performance of other SWAs, etc.;

(3) Audits of SWA programs to review their program activity and to assess whether the expenditure of grant funds has been in accordance with the approved budget. Regional Administrators also may conduct audits through other agencies or organizations or may require the SWA to have audits conducted;

(4) Validations of data entered into management information systems to assess:

(i) The accuracy of data entered by the SWAs into the management information system;

(ii) Whether the SWAs' data validating and reviewing procedures conform to Department instructions; and

(iii) Whether SWAs have implemented any corrective action plans required by the Department to remedy deficiencies in their validation programs;

(5) Technical assistance programs to assist SWAs in carrying out ES regulations and programs;

(6) Reviews to assess whether the SWA has complied with corrective action plans imposed by the Department or by the SWA itself; and

(7) Unannounced field checks of a sample of agricultural work sites to which ES placements have been made through the clearance system to determine and document whether wages, hours, and working and housing conditions are as specified on the clearance order. If regional office staff find reason to believe that conditions vary from clearance order specifications, findings must be documented on the Complaint/Apparent Violation Referral Form and provided to the State Workforce Agency to be processed as an apparent violation under § 658.419.

(e) The Regional Administrator must provide technical assistance to SWAs to assist them in carrying out ES regulations and programs.

(f) The Regional Administrator must appoint a RMA who must carry out the duties set forth in this subpart. The RMA must:

(1) Review the effective functioning of the SMAs in their region;

(2) Review the performance of SWAs in providing the full range of ES services to MSFWs;

(3) Take steps to resolve ES-related problems of MSFWs which come to their attention;

(4) Recommend to the Regional Administrator changes in policy towards MSFWs;

(5) Review the operation of the Complaint System; and

(6) Serve as an advocate to improve service for MSFWs within the ES. The RMA must be a member of the Regional Farm Labor Coordinated Enforcement Committee.

(g) The RMA must be appointed by the Regional Administrator after informing farmworker organizations and other organizations in the region with expertise concerning MSFWs of the opening and encouraging them to refer qualified applicants to apply through the Federal merit system. The RMA must have direct personal access to the Regional Administrator wherever they find it necessary. Among qualified candidates, individuals must be sought who meet the criteria used in the selection of the SMAs, as provided in § 653.108(b) of this chapter.

(h) The Regional Administrator must ensure that staff necessary to fulfill effectively all the regional office responsibilities set forth in this section are assigned.

(i) The RMA must participate in training sessions including those offered by the National Office and those necessary to maintain competency and enhance their understanding of issues farmworkers face (including trainings offered by OSHA, WHD, EEOC, CRC, and other organizations offering farmworker-related information).

(j) At the regional level, the RMA must have primary responsibility for:

(1) Monitoring the effectiveness of the Complaint System set forth at subpart E of this part;

(2) Apprising appropriate State and ETA officials of deficiencies in the Complaint System; and

(3) Providing technical assistance to SMAs in the region.

(k) At the ETA regional level, the RMA must have primary responsibility for ensuring SWA compliance with ES regulations as it pertains to services to MSFWs is monitored by the regional office. They must independently assess on a continuing basis the provision of ES services to MSFWs, seeking out and using:

(1) Information from SMAs, including all reports and other documents;

(2) Program performance data;

(3) The periodic and other required reports from SWAs;

(4) Federal on-site reviews;

(5) Other reports prepared by the National Office;

(6) Information received from farmworker organizations and employers; and

(7) Any other pertinent information which comes to their attention from any possible source.

(8) In addition, the RMA must consider their personal observations from visits to ES offices, agricultural work sites, and migrant camps.

(l) The RMA must assist the Regional Administrator and other line officials in applying appropriate corrective and remedial actions to State agencies.

(m) The Regional Administrator's quarterly report to the National Office must include the RMA's summary of their independent assessment as required in paragraph (f)(5) of this section. The fourth quarter summary must include an Annual Summary from the region. The summary also must include both a quantitative and a qualitative analysis of their reviews and must address all the matters with respect to which they have responsibilities under these regulations.

(n) The RMA must review the activities and performance of the SMAs and the State monitoring system in the region, and must recommend any appropriate changes in the operation of the system to the Regional Administrator. The RMA's review must include a determination whether the SMA:

(1) Does not have adequate access to information;

(2) Is being impeded in fulfilling their duties; or

(3) Is making recommendations that are being consistently ignored by SWA officials. If the RMA believes that the effectiveness of any SMA has been substantially impeded by the State Administrator, other State agency officials, any Federal officials, or other ES staff, the RMA must report and recommend appropriate actions to the Regional Administrator. Copies of the recommendations must be provided to the NMA electronically or in hard copy.

(o)(1) The RMA must be informed of all proposed changes in policy and practice within the ES, including ES regulations, which may affect the delivery of services to MSFWs. They must advise the Regional Administrator on all such proposed changes which, in their opinion, may adversely affect MSFWs or which may substantially improve the delivery of services to MSFWs.

(2) The RMA also may recommend changes in ES policy or regulations, as well as changes in the funding of State Workforce Agencies and/or adjustments of reallocation of the discretionary portions of funding formulae as they pertain to MSFWs.

(p) The RMA must participate in the review and assessment activities required in this section and §§ 658.700 through 658.711. The RMA, an assistant, or another RMA must participate in National Office and regional office onsite statewide reviews of ES services to

MSFWs in States in the region. The RMA must engage in the following activities in the course of participating in an on-site SWA review:

(1) Accompany selected outreach staff on their field visits;

(2) Participate in a field check of migrant camps or work sites where MSFWs have been placed on intrastate or interstate clearance orders;

(3) Contact local WIOA sec. 167 National Farmworker Jobs Program grantees or other farmworker organizations as part of the on-site review, and must discuss with representatives of these organizations perceived trends, and/or other relevant information concerning MSFWs in the area; and

(4) Meet with the SMA and discuss the full range of the ES services to MSFWs, including monitoring and the Complaint System.

(q) During the calendar quarter preceding the time of peak MSFW activity in each State, the RMA must meet with the SMA and must review in detail the State Workforce Agency's capability for providing the full range of services to MSFWs as required by ES regulations, during the upcoming harvest season. The RMA must offer technical assistance and recommend to the SWA and/or the Regional Administrator any changes in State policy or practice that the RMA finds necessary.

(r) As appropriate, each year during the peak harvest season, the RMA must visit each State in the region not scheduled for an onsite review during that fiscal year and must:

(1) Meet with the SMA and other ES staff to discuss MSFW service delivery; and

(2) Contact representatives of MSFW organizations to obtain information concerning ES delivery and coordination with other agencies and interested employer organizations.

(s) The RMA must initiate and maintain regular and personal contacts, including informal contacts in addition to those specifically required by these regulations, with SMAs in the region. In addition, the RMA must have personal and regular contact with the NMA. The RMA also must establish routine and regular contacts with WIOA sec. 167 National Farmworker Jobs Program grantees, other farmworker organizations and agricultural employers and/or employer organizations in the RMA's region. The RMA must attend conferences or meetings of these groups wherever possible and must report to the Regional Administrator and the Regional Farm Labor Coordinated Enforcement Committee on these contacts when appropriate. The RMA also must make recommendations as to how the Department might better coordinate ES and WIOA sec. 167 National Farmworker Jobs Program services to MSFWs.

(t) The RMA must attend MSFW-related public meeting(s) conducted in the region, as appropriate. Following such meetings or hearings, the RMA must take such steps or make such recommendations to the Regional Administrator, as the RMA deems necessary to remedy problem(s) or condition(s) identified or described therein.

(u) The RMA must attempt to achieve regional solutions to any problems, deficiencies, or improper practices concerning services to MSFWs which are regional in scope. Further, the RMA must recommend policies, offer technical assistance, or take any other necessary steps as they deem desirable or appropriate on a regional, rather than State-by-State, basis to promote region-wide improvement in the delivery of ES services to MSFWs. The RMA must facilitate region-wide coordination and communication regarding provision of ES services to MSFWs among SMAs, State Administrators, and Federal ETA officials to the greatest extent possible. In the event that any SWA or other RMA, enforcement agency, or MSFW group refers a matter to the RMA which requires emergency action, the RMA must assist them in obtaining action by appropriate agencies and staff, inform the originating party of the action taken, and, upon request, provide written confirmation.

(v) The RMA must initiate and maintain such contacts as they deem necessary with RMAs in other regions to seek to resolve problems concerning MSFWs who work, live, or travel through the region. The RMA must recommend to the Regional Administrator and/or the National Office interregional cooperation on any particular

matter, problem, or policy with respect to which inter-regional action is desirable.

(w) The RMA must establish regular contacts with the regional agricultural coordinators from WHD and OSHA and any other regional staff from other Federal enforcement agencies and must establish contacts with the staff of other Department agencies represented on the Regional Farm Labor Coordinated Enforcement Committee and to the extent necessary, on other pertinent task forces or committees.

(x) The RMA must participate in the regional reviews of the State Plans, and must comment to the Regional Administrator as to the SWA compliance with the ES regulations as they pertain to services to MSFWs, including the staffing of ES offices.

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 630, Jan. 6, 2020; 88 FR 82734, Nov. 24, 2023]

§ 658.604 Assessment and evaluation of program performance data.

(a) State Workforce Agencies must compile program performance data required by the Department, including statistical information on program operations.

(b) The Department must use the program performance data in assessing and evaluating whether each SWA has complied with ES regulations and its State Plan.

(c) In assessing and evaluating program performance data, the Department must act in accordance with the following general principles:

(1) The fact that the program performance data from a SWA, whether overall or relative to a particular program activity, indicate poor program performance does not by itself constitute a violation of ES regulations or of the State Workforce Agency's responsibilities under its State Plan;

(2) Program performance data, however, may so strongly indicate that a SWA's performance is so poor that the data may raise a presumption (*prima facie* case) that a SWA is violating ES regulations or the State Plan. A SWA's failure to meet the operational objectives set forth in the State Plan raises a presumption that the agency is violating ES regulations and/or obligations under its State Plan. In such cases, the Department must afford the SWA an opportunity to rebut the presumption of a violation pursuant to the procedures at subpart H of this part.

(3) The Department must take into account that certain program performance data may measure items over which SWAs have direct or substantial control while other data may measure items over which the SWA has indirect or minimal control.

(i) Generally, for example, a SWA has direct and substantial control over the delivery of ES services such as referrals to jobs, job development contacts, counseling, referrals to career and supportive services, and the conduct of field checks.

(ii) State Workforce Agencies, however, have only indirect control over the outcome of services. For example, SWAs cannot guarantee that an employer will hire a referred applicant, nor can they guarantee that the terms and conditions of employment will be as stated on a job order.

(iii) Outside forces, such as a sudden heavy increase in unemployment rates, a strike by SWA employees, or a severe drought or flood, may skew the results measured by program performance data.

(4) The Department must consider a SWA's failure to keep accurate and complete program performance data required by ES regulations as a violation of the ES regulations.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82736, Nov. 24, 2023]

§ 658.605 Communication of findings to State agencies.

(a) The Regional Administrator must inform SWAs in writing of the results of review and assessment activities and, as appropriate, must discuss with the State Administrator the impact or action required by the Department as a result of review and assessment activities.

(b) The ETA National Office must transmit the results of any review and assessment activities it conducted to the Regional Administrator who must send the information to the SWA.

(c) Whenever the review and assessment indicates a SWA violation of ES regulations or its State Plan, the Regional Administrator must follow the

procedures set forth at subpart H of this part.

(d) Regional Administrators must follow-up any corrective action plan imposed on a SWA under subpart H of this part by further review and assessment of the State Workforce Agency pursuant to this subpart.

Subpart H—Federal Application of Remedial Action to State Workforce Agencies

§ 658.700 Scope and purpose of subpart.

This subpart sets forth the procedures which the Department must follow upon either discovering independently or receiving from other(s) information indicating that SWAs may not be adhering to ES regulations.

§ 658.701 Statements of policy.

(a) It is the policy of the Department to take all necessary action, including the imposition of the full range of sanctions set forth in this subpart, to ensure State Workforce Agencies comply with all requirements established by ES regulations.

(b) It is the policy of the Department to initiate decertification procedures against SWAs in instances of serious or continual violations of ES regulations if less stringent remedial actions taken in accordance with this subpart fail to resolve noncompliance.

(c) It is the policy of the Department to act on information concerning alleged violations by SWAs of the ES regulations received from any person or organization.

§ 658.702 Initial action by the Regional Administrator.

(a) The ETA Regional Administrator is responsible for ensuring that all SWAs in their region are in compliance with ES regulations.

(b) Wherever a Regional Administrator discovers or is apprised of possible SWA violations of ES regulations by the review and assessment activities under subpart G of this part, or through required reports or written complaints from individuals, organizations, or employers which are elevated to the Department after the exhaustion of SWA administrative remedies, the Regional Administrator must conduct an investigation. Within 10 business days after receipt of the report or other information, the Regional Administrator must make a determination whether there is probable cause to believe that a SWA has violated ES regulations.

(c) The Regional Administrator must accept complaints regarding possible SWA violations of ES regulations from employee organizations, employers or other groups, without exhaustion of the complaint process described at subpart E of this part, if the Regional Administrator determines that the nature and scope of the complaint are such that the time required to exhaust the administrative procedures at the State level would adversely affect a significant number of applicants. In such cases, the Regional Administrator must investigate the matter within 10 business days, may provide the SWA 10 business days for comment, and must make a determination within an additional 10 business days whether there is probable cause to believe that the SWA has violated ES regulations.

(d) If the Regional Administrator determines that there is no probable cause to believe that a SWA has violated ES regulations, they must retain all reports and supporting information in Department files. In all cases where the Regional Administrator has insufficient information to make a probable cause determination, they must so notify the Administrator in writing and the time for the investigation must be extended 20 additional business days.

(e) If the Regional Administrator determines there is probable cause to believe a SWA has violated ES regulations, they must issue a Notice of Initial Findings of Non-compliance by registered mail (or other legally viable means) to the offending SWA. The notice will specify the nature of the violation, cite the regulations involved, and indicate corrective action which may be imposed in accordance with paragraphs (g) and (h) of this section. If the non-compliance involves services to MSFWs or the Complaint System, a copy of said notice must be sent to the NMA.

(f)(1) The SWA may have 20 business days to comment on the findings, or up

to 20 additional days, if the Regional Administrator determines a longer period is appropriate. The SWA's comments must include agreement or disagreement with the findings and suggested corrective actions, where appropriate.

(2) After the period elapses, the Regional Administrator must prepare within 20 business days, written final findings which specify whether the SWA has violated ES regulations. If in the final findings the Regional Administrator determines the SWA has not violated ES regulations, the Regional Administrator must notify the State Administrator of this finding and retain supporting documents in their files. If the final finding involves services to MSFWs or the Complaint System, the Regional Administrator also must notify the RMA and the NMA. If the Regional Administrator determines a SWA has violated ES regulations, the Regional Administrator must prepare a Final Notice of Noncompliance which must specify the violation(s) and cite the regulations involved. The Final Notice of Noncompliance must be sent to the SWA by registered mail or other legally viable means. If the noncompliance involves services to MSFWs or the Complaint System, a copy of the Final Notice must be sent to the RMA and the NMA.

(g) If the violation involves the misspending of grant funds, the Regional Administrator may order in the Final Notice of Noncompliance a disallowance of the expenditure and may either demand repayment or withhold future funds in the amount in question. If the Regional Administrator disallows costs, the Regional Administrator must give the reasons for the disallowance, inform the SWA that the disallowance is effective immediately and that no more funds may be spent in the disallowed manner, and offer the SWA the opportunity to request a hearing pursuant to § 658.707. The offer, or the acceptance of an offer of a hearing, however, does not stay the effectiveness of the disallowance. The Regional Administrator must keep complete records of the disallowance.

(h) If the violation does not involve misspending of grant funds or the Regional Administrator determines that the circumstances warrant other action:

(1) The Final Notice of Noncompliance must direct the SWA to implement a specific corrective action plan to correct all violations. If the SWA's comment demonstrates with supporting evidence (except where inappropriate) that all violations have already been corrected, the Regional Administrator need not impose a corrective action plan and instead may cite the violation(s) and accept the SWA's resolution, subject to follow-up review, if necessary. If the Regional Administrator determines that the violation(s) cited had been found previously and that the corrective action(s) taken had not corrected the violation(s) contrary to the findings of previous follow-up reviews, the Regional Administrator must apply remedial actions to the SWA pursuant to § 658.704.

(2) The Final Notice of Noncompliance must specify the time by which each corrective action must be taken. This period may not exceed 40 business days unless the Regional Administrator determines that exceptional circumstances necessitate corrective actions requiring a longer time period. In such cases, and if the violations involve services to MSFWs or the Complaint System, the Regional Administrator must notify the Administrator in writing of the exceptional circumstances which necessitate more time, and must specify the additional time period. The specified time must commence with the date of signature on the registered mail receipt.

(3) When the time provided for in paragraph (h)(2) of this section elapses, Department staff must review the SWA's efforts as documented by the SWA to determine if the corrective action(s) has been taken and if the SWA has achieved compliance with ES regulations. If necessary, Department staff must conduct a follow-up visit as part of this review.

(4) If, as a result of this review, the Regional Administrator determines the SWA has corrected the violation(s), the Regional Administrator must record the basis for this determination, notify the SWA, send a copy to the Administrator, and retain a copy in Department files.

(5) If, as a result of this review, the Regional Administrator determines the SWA has taken corrective action but is unable to determine if the violation has been corrected due to seasonality or other factors, the Regional Administrator must notify in writing the SWA and the Administrator of their findings. The Regional Administrator must conduct further follow-up at an appropriate time to make a final determination if the violation has been corrected. If the Regional Administrator's follow-up reveals that violations have not been corrected, the Regional Administrator must apply remedial actions to the SWA pursuant to § 658.704.

(6) If, as a result of the review the Regional Administrator determines the SWA has not corrected the violations and has not made good faith efforts and adequate progress toward the correction of the violations, the Regional Administrator must apply remedial actions to the SWA pursuant to § 658.704.

(7) If, as a result of the review, the Regional Administrator determines the SWA has made good faith efforts and adequate progress toward the correction of the violation and it appears the violation will be fully corrected within a reasonable amount of time, the SWA must be advised by registered mail or other legally viable means (with a copy sent to the Administrator) of this conclusion, of remaining differences, of further needed corrective action, and that all deficiencies must be corrected within a specified time period. This period may not exceed 40 business days unless the Regional Administrator determines exceptional circumstances necessitate corrective action requiring more time. In such cases, the Regional Administrator must notify the Administrator in writing of the exceptional circumstances which necessitate more time, and must specify that time period. The specified time commences with the date of signature on the registered mail receipt.

(8)(i) If the SWA has been given additional time pursuant to paragraph (h)(7) of this section, Department staff must review the SWA's efforts as documented by the SWA at the end of the time period. If necessary, the Department must conduct a follow-up visit as part of this review.

(ii) If the SWA has corrected the violation(s), the Regional Administrator must document that finding, notify in writing the SWA and the Administrator, and retain supporting documents in Department files. If the SWA has not corrected the violation(s), the Regional Administrator must apply remedial actions pursuant to § 658.704.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82736, Nov. 24, 2023]

§ 658.703 Emergency corrective action.

In critical situations as determined by the Regional Administrator, where it is necessary to protect the integrity of the funds, or ensure the proper operation of the program, the Regional Administrator may impose immediate corrective action. Where immediate corrective action is imposed, the Regional Administrator must notify the SWA of the reason for imposing the emergency corrective action prior to providing the SWA an opportunity to comment.

§ 658.704 Remedial actions.

(a) If a SWA fails to correct violations as determined pursuant to § 658.702, the Regional Administrator must apply one or more of the following remedial actions to the SWA:

(1) Imposition of special reporting requirements for a specified time;

(2) Restrictions of obligational authority within one or more expense classifications;

(3) Implementation of specific operating systems or procedures for a specified time;

(4) Requirement of special training for ES staff;

(5) With the approval of the Assistant Secretary and after affording the State Administrator the opportunity to request a conference with the Assistant Secretary, the elevation of specific decision-making functions from the State Administrator to the Regional Administrator;

(6) With the approval of the Assistant Secretary and after affording the State Administrator the opportunity to request a conference with the Assistant Secretary, the imposition of Federal staff in key SWA positions;

(7) With the approval of the Assistant Secretary and after affording the State

Administrator the opportunity to request a conference with the Assistant Secretary, funding of the SWA on a short-term basis or partial withholding of funds for a specific function or for a specific geographical area;

(8) Holding of public hearings in the State on the SWA's deficiencies;

(9) Disallowance of funds pursuant to § 658.702(g); or

(10) If the matter involves a serious or continual violation, the initiation of decertification procedures against the State Workforce Agency, as set forth in paragraph (e) of this section.

(b) The Regional Administrator must send, by registered mail, a Notice of Remedial Action to the SWA. The Notice of Remedial Action must set forth the reasons for the remedial action. When such a notice is the result of violations of regulations governing services to MSFWs (§§ 653.100 *through 653.113* of this chapter) or the Complaint System (§§ 658.400 through 658.426), a copy of said notice must be sent to the Administrator, who must publish the notice promptly in the FEDERAL REGISTER.

(c) If the remedial action is other than decertification, the notice must state the remedial action must take effect immediately. The notice also must state the SWA may request a hearing pursuant to § 658.707 by filing a request in writing with the Regional Administrator pursuant to § 658.707 within 20 business days of the SWA's receipt of the notice. The offer of hearing, or the acceptance thereof, however, does not stay or otherwise delay the implementation of remedial action.

(d) Within 60 business days after the initial application of remedial action, the Regional Administrator must conduct a review of the SWA's compliance with ES regulations unless the Regional Administrator determines more time is necessary. In such cases, the Regional Administrator must notify the Administrator in writing of the circumstances which necessitate more time, and specify that time period. If necessary, Department staff must conduct a follow-up visit as part of this review. If the SWA is in compliance with the ES regulations, the Regional Administrator must fully document these facts and must terminate the remedial actions. The Regional Administrator must notify the SWA of their findings. When the case involves violations of regulations governing services to MSFWs or the Complaint System, a copy of said notice must be sent to the Administrator, who must promptly publish the notice in the FEDERAL REGISTER. The Regional Administrator must conduct, within a reasonable time after terminating the remedial actions, a review of the SWA's compliance to determine whether any remedial actions must be reapplied.

(e) If, upon conducting the on-site review referred to in paragraph (c) of this section, the Regional Administrator finds the SWA remains in noncompliance, the Regional Administrator must continue the remedial action and/or impose different additional remedial actions. The Regional Administrator must fully document all such decisions and, when the case involves violations of regulations governing services to MSFWs or the Complaint System, must send copies to the Administrator, who must promptly publish the notice in the FEDERAL REGISTER.

(f)(1) If the SWA has not brought itself into compliance with ES regulations within 120 business days of the initial application of remedial action, the Regional Administrator must initiate decertification unless the Regional Administrator determines the circumstances necessitate continuing remedial action for more time. In such cases, the Regional Administrator must notify the Administrator in writing of the circumstances which necessitate the extended time, and specify the time period.

(2) The Regional Administrator must notify the SWA by registered mail or by other legally viable means of the decertification proceedings, and must state the reasons therefor. Whenever such a notice is sent to a SWA, the Regional Administrator must prepare five copies (hard copies or electronic copies) containing, in chronological order, all the documents pertinent to the case along with a request for decertification stating the grounds therefor. One copy must be retained. Two must be sent to the ETA National Office, one must be

sent to the Solicitor of Labor, Attention: Associate Solicitor for Employment and Training, and, if the case involves violations of regulations governing services to MSFWs or the Complaint System, copies must be sent to the RMA and the NMA.All copies also must be sent electronically to each respective party. The notice sent by the Regional Administrator must be published promptly in the FEDERAL REGISTER.

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 630, Jan. 6, 2020; 88 FR 82736, Nov. 24, 2023]

§ 658.705 Decision to decertify.

(a) Within 30 business days of receiving a request for decertification, the ETA Assistant Secretary must review the case and must decide whether to proceed with decertification.

(b) The Assistant Secretary must grant the request for decertification unless they make a finding that:

(1) The violations of ES regulations are neither serious nor continual;

(2) The SWA is in compliance; or

(3) The Assistant Secretary has reason to believe the SWA will achieve compliance within 80 business days unless exceptional circumstances necessitate more time, pursuant to the remedial action already applied or to be applied. (In the event the Assistant Secretary does not have sufficient information to act upon the request, they may postpone the determination for up to an additional 20 business days to obtain any available additional information.) In making a determination whether violations are ''serious'' or ''continual,'' as required by paragraph (b)(1) of this section, the Assistant Secretary must consider:

(i) Statewide or multiple deficiencies as shown by performance data and/or on-site reviews;

(ii) Recurrent violations, even if they do not persist over consecutive reporting periods, and

(iii) The good faith efforts of the State to achieve full compliance with ES regulations as shown by the record.

(c) If the Assistant Secretary denies a request for decertification, they must write a complete report documenting their findings and, if appropriate, instructing an alternate remedial action or actions be applied. Electronic copies of the report must be sent to the Regional Administrator. Notice of the Assistant Secretary's decision must be published promptly in the FEDERAL REGISTER and the report of the Assistant Secretary must be made available for public inspection and copying.

(d) If the Assistant Secretary decides decertification is appropriate, they must submit the case to the Secretary providing written explanation for their recommendation of decertification.

(e) Within 30 business days after receiving the Assistant Secretary's report, the Secretary must determine whether to decertify the SWA. The Secretary must grant the request for decertification unless they make one of the three findings set forth in paragraph (b) of this section. If the Secretary decides not to decertify, they must then instruct that remedial action be continued or that alternate actions be applied. The Secretary must write a report explaining their reasons for not decertifying the SWA and copies (hard copy and electronic) will be sent to the SWA. Notice of the Secretary's decision must be published promptly in the FEDERAL REGISTER, and the report of the Secretary must be made available for public inspection and copy.

(f) Where either the Assistant Secretary or the Secretary denies a request for decertification and orders further remedial action, the Regional Administrator must continue to monitor the SWA's compliance. If the SWA achieves compliance within the time established pursuant to paragraph (b) of this section, the Regional Administrator must terminate the remedial actions. If the SWA fails to achieve full compliance within that time period after the Secretary's decision not to decertify, the Regional Administrator must submit a report of their findings to the Assistant Secretary who must reconsider the request for decertification pursuant to the requirements of paragraph (b) of this section.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82736, Nov. 24, 2023]

§ 658.706 Notice of decertification.

If the Secretary decides to decertify a SWA, they must send a Notice of Decertification to the SWA stating the

reasons for this action and providing a 10-business-day period during which the SWA may request an administrative hearing in writing to the Secretary. The document must be published promptly in the FEDERAL REGISTER.

[88 FR 82737, Nov. 24, 2023]

§ 658.707 Requests for hearings.

(a) Any SWA which received a Notice of Decertification under § 658.706 or a notice of disallowance under § 658.702(g) may request a hearing on the issue by filing a written request for hearing with the Secretary within 10 business days of receipt of the notice. Additionally, any SWA that has received a Notice of Remedial Action under § 658.704(c) may request a hearing by filing a written request with the Regional Administrator within 20 business days of the SWA's receipt of the notice. This request must state the reasons the SWA believes the basis of the decision to be wrong, and it must be signed by the State Administrator (electronic signatures may be accepted).

(b) When the Secretary or Regional Administrator receives a request for a hearing from a SWA, they must send copies of a file containing all materials and correspondence relevant to the case to the Assistant Secretary, the Regional Administrator, the Solicitor of Labor, and the Department of Labor Chief Administrative Law Judge. When the case involves violations of regulations governing services to MSFWs or the Complaint System, a copy must be sent to the NMA.

(c) The Secretary must publish notice of hearing in the FEDERAL REGISTER. This notice must invite all interested parties to attend and to present evidence at the hearing. All interested parties who make written request to participate must thereafter receive copies (hard copy and/or electronic) of all documents filed in said proceedings.

[81 FR 56352, Aug. 19, 2016, as amended at 88 FR 82737, Nov. 24, 2023]

§ 658.708 Hearings.

(a) Upon receipt of a hearing file by the Chief Administrative Law Judge, the case must be docketed and notice sent by electronic mail, other means of electronic service, or registered mail, return receipt requested, to the Solicitor of Labor, Attention: Associate Solicitor for Employment and Training, the Administrator, the Regional Administrator and the State Administrator. The notice must set a time, place, and date for a hearing on the matter and must advise the parties that:

(1) They may be represented at the hearing;

(2) They may present oral and documentary evidence at the hearing;

(3) They may cross-examine opposing witnesses at the hearing; and

(4) They may request rescheduling of the hearing if the time, place, or date set are inconvenient.

(b) The Solicitor of Labor or the Solicitor's designee will represent the Department at the hearing.

§ 658.709 Conduct of hearings.

(a) Proceedings under this section are governed by secs. 5 through 8 of the Administrative Procedure Act, 5 U.S.C. 553 *et seq.* and the rules of practice and procedure at subpart A of 29 CFR part 18, except as otherwise specified in this section.

(b) Technical rules of evidence do not apply, but rules or principles designed to assure production of the most credible evidence available and to subject testimony to test by cross-examination, must be applied if necessary by the ALJ conducting the hearing. The ALJ may exclude irrelevant, immaterial, or unduly repetitious evidence. All documents and other evidence offered or taken for the record must be open to examination by the parties. Opportunity must be given to refute facts and arguments advanced on either side of the issue. A transcript must be made of the oral evidence except to the extent the substance thereof is stipulated for the record.

(c) Discovery may be conducted as provided in the rules of practice and procedure at 29 CFR 18.50 through 18.65.

(d) When a public officer is a respondent in a hearing in an official capacity and during its pendency dies, resigns, or otherwise ceases to hold office, the

proceeding does not abate and the officer's successor is automatically substituted as a party. Proceedings following the substitution must be in the name of the substituted party, but any misnomer not affecting the substantive rights of the parties must be disregarded. An order of substitution may be entered at any time, but the omission to enter such an order may not affect the substitution.

§ 658.710 Decision of the Administrative Law Judge.

(a) The ALJ has jurisdiction to decide all issues of fact and related issues of law and to grant or deny appropriate motions, but does not have jurisdiction to decide upon the validity of Federal statutes or regulations.

(b) The decision of the ALJ must be based on the hearing record, must be in writing, and must state the factual and legal basis of the decision. The ALJ's decision must be available for public inspection and copying.

(c) Except when the case involves the decertification of a SWA, the decision of the ALJ will be considered the final decision of the Secretary.

(d) If the case involves the decertification of an appeal to the SWA, the decision of the ALJ must contain a notice stating that, within 30 calendar days of the decision, the SWA or the Administrator may appeal to the Administrative Review Board, United States Department of Labor, by filing an appeal with the Administrative Review Board in accordance with 29 CFR part 26.

[81 FR 56352, Aug. 19, 2016, as amended at 86 FR 1778, Jan. 11, 2021]

§ 658.711 Decision of the Administrative Review Board.

(a) Upon the receipt of an appeal to the Administrative Review Board, United States Department of Labor, the ALJ must certify the record in the case to the Administrative Review Board, which must make a decision to decertify or not on the basis of the hearing record.

(b) The decision of the Administrative Review Board must be in writing, and must set forth the factual and legal basis for the decision. After the Board's decision becomes final, notice of the decision must be published in the FEDERAL REGISTER, and copies must be made available for public inspection and copying.

[81 FR 56352, Aug. 19, 2016, as amended at 85 FR 13030, Mar. 6, 2020; 85 FR 30615, May 20, 2020]

PART 660—INTRODUCTION TO THE REGULATIONS FOR WORKFORCE INVESTMENT SYSTEMS UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

Sec.

660.100 What is the purpose of title I of the Workforce Investment Act of 1998?
660.200 What do the regulations for workforce investment systems under title I of the Workforce Investment Act cover?
660.300 What definitions apply to the regulations for workforce investment systems under title I of WIA?

AUTHORITY: Sec. 506(c), Pub. L. 105–220; 20 U.S.C. 9276(c).

SOURCE: 65 FR 49388, Aug. 11, 2000, unless otherwise noted.

§ 660.100 What is the purpose of title I of the Workforce Investment Act of 1998?

The purpose of title I of the Workforce Investment Act of 1998 (WIA) is to provide workforce investment activities that increase the employment, retention and earnings of participants, and increase occupational skill attainment by participants, which will improve the quality of the workforce, reduce welfare dependency, and enhance the productivity and competitiveness of the Nation's economy. These goals are achieved through the workforce investment system. (WIA sec. 106.)

§ 660.200 What do the regulations for workforce investment systems under title I of the Workforce Investment Act cover?

The regulations found in 20 CFR parts 660 through 671 set forth the regulatory requirements that are applicable to programs operated with funds provided under title I of WIA. This part 660 describes the purpose of that Act, explains the format of these regulations and sets forth definitions for terms that apply to each part. Part 661 contains regulations relating to Statewide

and local governance of the workforce investment system. Part 662 describes the One-Stop system and the roles of One-Stop partners. Part 663 sets forth requirements applicable to WIA title I programs serving adults and dislocated workers. Part 664 sets forth requirements applicable to WIA title I programs serving youth. Part 665 contains regulations relating to Statewide activities. Part 666 describes the WIA title I performance accountability system. Part 667 sets forth the administrative requirements applicable to programs funded under WIA title I. Parts 668 and 669 contain the particular requirements applicable to programs serving Indians and Native Americans and Migrant and Seasonal Farmworkers, respectively. Parts 670 and 671 describe the particular requirements applicable to the Job Corps and other national programs, respectively. In addition, part 652 describes the establishment and functioning of State Employment Services under the Wagner-Peyser Act, and 29 CFR part 37 contains the Department's nondiscrimination regulations implementing WIA section 188.

§ 660.300 What definitions apply to the regulations for workforce investment systems under title I of WIA?

In addition to the definitions set forth at WIA section 101, the following definitions apply to the regulations in 20 CFR parts 660 through 671:

Department or DOL means the U.S. Department of Labor, including its agencies and organizational units.

Designated region means a combination of local areas that are partly or completely in a single labor market area, economic development region, or other appropriate contiguous subarea of a State, that is designated by the State under WIA section 116(c), or a similar interstate region that is designated by two or more States under WIA section 116(c)(4).

Employment and training activity means a workforce investment activity that is carried out for an adult or dislocated worker.

EO data means data on race and ethnicity, age, sex, and disability required by 29 CFR part 37 of the DOL regulations implementing section 188 of WIA, governing nondiscrimination.

ETA means the Employment and Training Administration of the U.S. Department of Labor.

Grant means an award of WIA financial assistance by the U.S. Department of Labor to an eligible WIA recipient.

Grantee means the direct recipient of grant funds from the Department of Labor. A grantee may also be referred to as a recipient.

Individual with a disability means an individual with any disability (as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102)). For purposes of WIA section 188, this term is defined at 29 CFR 37.4.

Labor Federation means an alliance of two or more organized labor unions for the purpose of mutual support and action.

Literacy means an individual's ability to read, write, and speak in English, and to compute, and solve problems, at levels of proficiency necessary to function on the job, in the family of the individual, and in society.

Local Board means a Local Workforce Investment Board established under WIA section 117, to set policy for the local workforce investment system.

Obligations means the amounts of orders placed, contracts and subgrants awarded, goods and services received, and similar transactions during a funding period that will require payment by the recipient or subrecipient during the same or a future period. For purposes of the reallotment process described at 20 CFR 667.150, the Secretary also treats as State obligations any amounts allocated by the State under WIA sections 128(b) and 133(b) to a single area State or to a balance of State local area administered by a unit of the State government, and inter-agency transfers and other actions treated by the State as encumbrances against amounts reserved by the State under WIA sections 128(a) and 133(a) for Statewide workforce investment activities.

Outlying area means the United States Virgin Islands, Guam, American Samoa, the Commonwealth of the

Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau.

Participant means an individual who has registered under 20 CFR 663.105 or 664.215 and has been determined to be eligible to participate in and who is receiving services (except for follow up services) under a program authorized by WIA title I. Participation commences on the first day, following determination of eligibility, on which the individual begins receiving core, intensive, training or other services provided under WIA title I.

Recipient means an entity to which a WIA grant is awarded directly from the Department of Labor to carry out a program under title I of WIA. The State is the recipient of funds awarded under WIA sections 127(b)(1)(C)(I)(II), 132(b)(1)(B) and 132(b)(2)(B). The recipient is the entire legal entity that received the award and is legally responsible for carrying out the WIA program, even if only a particular component of the entity is designated in the grant award document.

Register means the process for collecting information to determine an individual's eligibility for services under WIA title I. Individuals may be registered in a variety ways, as described in 20 CFR 663.105 and 20 CFR 664.215.

Secretary means the Secretary of the U.S. Department of Labor.

Self certification means an individual's signed attestation that the information he/she submits to demonstrate eligibility for a program under title I of WIA is true and accurate.

State means each of the several States of the United States, the District of Columbia and the Commonwealth of Puerto Rico. The term ''State'' does not include outlying areas.

State Board means a State Workforce Investment Board established under WIA section 111.

Subgrant means an award of financial assistance in the form of money, or property in lieu of money made under a grant by a grantee to an eligible subrecipient. The term includes financial assistance when provided by contractual legal agreement, but does not include procurement purchases, nor does it include any form of assistance which is excluded from the definition of *Grant* in this part.

Subrecipient means an entity to which a subgrant is awarded and which is accountable to the recipient (or higher tier subrecipient) for the use of the funds provided. DOL's audit requirements for States, local governments, and non-profit organizations provides guidance on distinguishing between a subrecipient and a vendor at 29 CFR 99.210.

Unobligated balance means the portion of funds authorized by the Federal agency that has not been obligated by the grantee and is determined by deducting the cumulative obligations from the cumulative funds authorized.

Vendor means an entity responsible for providing generally required goods or services to be used in the WIA program. These goods or services may be for the recipient's or subrecipient's own use or for the use of participants in the program. DOL's audit requirements for States, local governments, and non-profit organizations provides guidance on distinguishing between a subrecipient and a vendor at 29 CFR 99.210.

Wagner-Peyser Act means the Act of June 6, 1933, as amended, codified at 29 U.S.C. 49 *et seq*.

WIA regulations mean the regulations in 20 CFR parts 660 through 671, the Wagner-Peyser Act regulations in 20 CFR part 652, subpart C, and the regulations implementing WIA section 188 in 29 CFR part 37.

Workforce investment activities mean the array of activities permitted under title I of WIA, which include employment and training activities for adults and dislocated workers, as described in WIA section 134, and youth activities, as described in WIA section 129.

Youth activity means a workforce investment activity that is carried out for youth.

PART 661—STATEWIDE AND LOCAL GOVERNANCE OF THE WORKFORCE INVESTMENT SYSTEM UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

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AUTHORITY: Sec. 506(c), Pub. L. 105–220; 20 U.S.C. 9276(c).

SOURCE: 65 FR 49390, Aug. 11, 2000, unless otherwise noted.

Subpart A—General Governance Provisions

§ 661.100 What is the workforce investment system?

Under title I of WIA, the workforce investment system provides the framework for delivery of workforce investment activities at the State and local levels to individuals who need those services, including job seekers, dislocated workers, youth, incumbent workers, new entrants to the workforce, veterans, persons with disabilities, and employers. Each State's Governor is required, in accordance with the requirements of this part, to establish a State Board; to designate local workforce investment areas; and to oversee the creation of Local Boards and One-Stop service delivery systems in the State.

§ 661.110 What is the role of the Department of Labor as the Federal governmental partner in the governance of the workforce investment system?

(a) Successful governance of the workforce investment system will be achieved through cooperation and coordination of Federal, State and local governments.

(b) The Department of Labor sees as one of its primary roles providing leadership and guidance to support a system that meets the objectives of title I of WIA, and in which State and local partners have flexibility to design systems and deliver services in a manner designed to best achieve the goals of WIA based on their particular needs. The WIA regulations provide the framework in which State and local officials can exercise such flexibility within the confines of the statutory requirements. Wherever possible, system features such as design options and categories of services are broadly defined, and are subject to State and local interpretation.

(c) The Secretary, in consultation with other Federal Agencies, as appropriate, may publish guidance on interpretations of statutory and regulatory provisions. State and local policies, interpretations, guidelines and definitions that are consistent with interpretations contained in such guidance will be considered to be consistent with the Act for purposes of § 661.120.

§ 661.120 What are the roles of the local and State governmental partner in the governance of the workforce investment system?

(a) Local areas should establish policies, interpretations, guidelines and definitions to implement provisions of title I of WIA to the extent that such policies, interpretations, guidelines and definitions are not inconsistent with the Act and the regulations issued under the Act, Federal statutes and regulations governing One-Stop partner programs, and with State policies.

(b) States should establish policies, interpretations, guidelines and definitions to implement provisions of title I of WIA to the extent that such policies, interpretations, guidelines and definitions are not inconsistent with the Act and the regulations issued under the Act, as well as Federal statutes and regulations governing One-Stop partner programs.

Subpart B—State Governance Provisions

§ 661.200 What is the State Workforce Investment Board?

(a) The State Board is a board established by the Governor in accordance with the requirements of WIA section 111 and this section.

(b) The membership of the State Board must meet the requirements of WIA section 111(b). The State Board must contain two or more members representing the categories described in WIA section 111(b)(1)(C)(iii)–(v), and special consideration must be given to chief executive officers of community colleges and community based organizations in the selection of members representing the entities identified in WIA section 111(b)(1)(C)(v).

(c) The Governor may appoint any other representatives or agency officials, such as agency officials responsible for economic development, child support and juvenile justice programs in the State.

(d) Members who represent organizations, agencies or other entities must be individuals with optimum policy making authority within the entities they represent.

(e) A majority of members of the State Board must be representatives of business. Members who represent business must be individuals who are owners, chief executive officers, chief operating officers, or other individuals with optimum policy making or hiring authority, including members of Local Boards.

(f) The Governor must appoint the business representatives from among individuals who are nominated by State business organizations and business trade associations. The Governor must appoint the labor representatives from among individuals who are nominated by State labor federations.

(g) The Governor must select a chairperson of the State Board from the business representatives on the board.

(h) The Governor may establish terms of appointment or other conditions governing appointment or membership on the State Board.

(i) For the programs and activities carried out by One-Stop partners, as described in WIA section 121(b) and 20 CFR 662.200 and 662.210, the State Board must include:

(1) The lead State agency officials with responsibility for such program, or

(2) In any case in which no lead State agency official has responsibility for such a program service, a representative in the State with expertise relating to such program, service or activity.

(3) If the director of the designated State unit, as defined in section 7(8)(B) of the Rehabilitation Act, does not represent the State Vocational Rehabilitation Services program (VR program) on the State Board, then the State must describe in its State plan how the member of the State Board representing the VR program will effectively represent the interests, needs, and priorities of the VR program and how the employment needs of individuals with disabilities in the State will be addressed.

(j) An individual may be appointed as a representative of more than one entity if the individual meets all the criteria for representation, including the criteria described in paragraphs (d) through (f) of this section, for each entity. (WIA sec. 111)

§ 661.203 What is meant by the terms "optimum policy making authority" and "expertise relating to [a] program, service or activity"?

For purposes of selecting representatives to State and local workforce investment boards:

(a) A representative with ''optimum policy making authority'' is an individual who can reasonably be expected to speak affirmatively on behalf of the entity he or she represents and to commit that entity to a chosen course of action.

(b) A representative with ''expertise relating to [a] program, service or activity'' includes a person who is an official with a One-stop partner program and a person with documented expertise relating to the One-stop partner program.

§ 661.205 What is the role of the State Board?

The State Board must assist the Governor in the:

(a) Development of the State Plan;

(b) Development and continuous improvement of a Statewide system of activities that are funded under subtitle B of title I of WIA, or carried out through the One-Stop delivery system, including—

(1) Development of linkages in order to assure coordination and nonduplication among the programs and activities carried out by One-Stop partners, including, as necessary, addressing any impasse situations in the development of the local Memorandum of Understanding; and

(2) Review of local plans;

(c) Commenting at least once annually on the measures taken under section 113(b)(14) of the Carl D. Perkins Vocational and Technical Education Act;

(d) Designation of local workforce investment areas,

(e) Development of allocation formulas for the distribution of funds for adult employment and training activities and youth activities to local areas,

as permitted under WIA sections 128(b)(3)(B) and 133(b)(3)(B);

(f) Development and continuous improvement of comprehensive State performance measures, including State adjusted levels of performance, to assess the effectiveness of the workforce investment activities in the State, as required under WIA section 136(b);

(g) Preparation of the annual report to the Secretary described in WIA section 136(d);

(h) Development of the Statewide employment statistics system described in section 15(e) of the Wagner-Peyser Act; and

(i) Development of an application for an incentive grant under WIA section 503. (WIA sec. 111(d).)

§ 661.207 How does the State Board meet its requirement to conduct business in an open manner under the "sunshine provision" of WIA section 111(g)?

The State Board must conduct its business in an open manner as required by WIA section 111(g), by making available to the public, on a regular basis through open meetings, information about the activities of the State Board. This includes information about the State Plan prior to submission of the plan; information about membership; the development of significant policies, interpretations, guidelines and definitions; and, on request, minutes of formal meetings of the State Board.

§ 661.210 Under what circumstances may the Governor select an alternative entity in place of the State Workforce Investment Board?

(a) The State may use any State entity that meets the requirements of WIA section 111(e) to perform the functions of the State Board.

(b) If the State uses an alternative entity, the State workforce investment plan must demonstrate that the alternative entity meets all three of the requirements of WIA section 111(e). Section 111(e) requires that such entity:

(1) Was in existence on December 31, 1997;

(2)(i) Was established under section 122 (relating to State Job Training Coordinating Councils) or title VII (relating to State Human Resource Investment Councils) of the Job Training Partnership Act (29 U.S.C.1501 *et seq.*), as in effect on December 31, 1997, or

(ii) Is substantially similar to the State Board described in WIA section 111(a), (b), and (c) and § 661.200; and

(3) Includes, at a minimum, two or more representatives of business in the State and two or more representatives of labor organizations in the State.

(c) If the alternative entity does not provide for representative membership of each of the categories of required State Board membership under WIA section 111(b), the State Plan must explain the manner in which the State will ensure an ongoing role for any unrepresented membership group in the workforce investment system. The State Board may maintain an ongoing role for an unrepresented membership group, including entities carrying out One-stop partner programs, by means such as regularly scheduled consultations with entities within the unrepresented membership groups, by providing an opportunity for input into the State Plan or other policy development by unrepresented membership groups, or by establishing an advisory committee of unrepresented membership groups.

(d) If the membership structure of the alternative entity is significantly changed after December 31, 1997, the entity will no longer be eligible to perform the functions of the State Board. In such case, the Governor must establish a new State Board which meets all of the criteria of WIA section 111(b).

(e) A significant change in the membership structure includes any significant change in the organization of the alternative entity or in the categories of entities represented on the alternative entity which requires a change to the alternative entity's charter or a similar document that defines the formal organization of the alternative entity, regardless of whether the required change to the document has or has not been made. A significant change in the membership structure is considered to have occurred when members are added to represent groups not previously represented on the entity. A significant change in the membership structure is not considered to have occurred when additional members are added to an existing membership category, when non-

voting members are added, or when a member is added to fill a vacancy created in an existing membership category.

(f) In 20 CFR parts 660 through 671, all references to the State Board also apply to an alternative entity used by a State.

§ 661.220 What are the requirements for the submission of the State Workforce Investment Plan?

(a) The Governor of each State must submit a State Workforce Investment Plan (State Plan) in order to be eligible to receive funding under title I of WIA and the Wagner-Peyser Act. The State Plan must outline the State's five year strategy for the workforce investment system.

(b) The State Plan must be submitted in accordance with planning guidelines issued by the Secretary of Labor. The planning guidelines set forth the information necessary to document the State's vision, goals, strategies, policies and measures for the workforce investment system (that were arrived at through the collaboration of the Governor, chief elected officials, business and other parties), as well as the information required to demonstrate compliance with WIA, and the information detailed by WIA and the WIA regulations, including 29 CFR part 37, and the Wagner-Peyser Act and the Wagner-Peyser regulations at 20 CFR part 652:

(c) The State Plan must contain a description of the State's performance accountability system, and the State performance measures in accordance with the requirements of WIA section 136 and 20 CFR part 666.

(d) The State must provide an opportunity for public comment on and input into the development of the State Plan prior to its submission. The opportunity for public comment must include an opportunity for comment by representatives of business, representatives of labor organizations, and chief elected official(s) and must be consistent with the requirement, at WIA section 111(g), that the State Board makes information regarding the State Plan and other State Board activities available to the public through regular open meetings. The State Plan must describe the State's process and timeline for ensuring a meaningful opportunity for public comment.

(e) The Secretary reviews completed plans and must approve all plans within ninety days of their submission, unless the Secretary determines in writing that:

(1) The plan is inconsistent with the provisions of title I of WIA or the WIA regulations, including 29 CFR part 37. For example, a finding of inconsistency would be made if the Secretary and the Governor have not reached agreement on the adjusted levels of performance under WIA section 136(b)(3)(A), or there is not an effective strategy in place to ensure development of a fully operational One-Stop delivery system in the State; or

(2) The portion of the plan describing the detailed Wagner-Peyser plan does not satisfy the criteria for approval of such plans as provided in section 8(d) of the Wagner-Peyser Act or the Wagner-Peyser regulations at 20 CFR part 652.

(3) A plan which is incomplete, or which does not contain sufficient information to determine whether it is consistent with the statutory or regulatory requirements of title I of WIA or of section 8(d) of the Wagner-Peyser Act, will be considered to be inconsistent with those requirements.

§ 661.230 What are the requirements for modification of the State Workforce Investment Plan?

(a) The State may submit a modification of its workforce investment plan at any time during the five-year life of the plan.

(b) Modifications are required when:

(1) Changes in Federal or State law or policy substantially change the assumptions upon which the plan is based.

(2) There are changes in the Statewide vision, strategies, policies, performance indicators, the methodology used to determine local allocation of funds, reorganizations which change the working relationship with system employees, changes in organizational responsibilities, changes to the membership structure of the State Board or alternative entity and similar substantial changes to the State's workforce investment system.

(3) The State has failed to meet performance goals, and must adjust service strategies.

(c) Modifications are required in accordance with the Wagner-Peyser provisions at 20 CFR 652.212.

(d) Modifications to the State Plan are subject to the same public review and comment requirements that apply to the development of the original State Plan.

(e) State Plan modifications will be approved by the Secretary based on the approval standard applicable to the original State Plan under § 661.220(e).

§ 661.240 How do the unified planning requirements apply to the five-year strategic WIA and Wagner-Peyser plan and to other Department of Labor plans?

(a) A State may submit to the Secretary a unified plan for any of the programs or activities described in WIA section 501(b)(2). This includes the following DOL programs and activities:

(1) The five-year strategic WIA and Wagner-Peyser plan;

(2) Trade adjustment assistance activities and NAFTA-TAA;

(3) Veterans' programs under 38 U.S.C. Chapter 41;

(4) Programs authorized under State unemployment compensation laws;

(5) [Reserved]

(6) Senior Community Service Employment Programs under title V of the Older Americans Act.

(b) For purposes of paragraph (a) of this section:

(1) A State may submit, as part of the unified plan, any plan, application form or any other similar document, that is required as a condition for the approval of Federal funding under the applicable program. These plans include such things as the WIA plan. They do not include jointly executed funding instruments, such as grant agreements, or Governor/Secretary Agreements or items such as corrective actions plans.

(2) A state may submit a unified plan meeting the requirements of the Interagency guidance entitled *State Unified Plan, Planning Guidance for State Unified Plans Under Section 501 of the Workforce Investment Act of 1998*, in lieu of completing the individual State planning guidelines of the programs covered by the unified plan.

(c) A State which submits a unified plan covering an activity or program described in subsection 501(b) of WIA that is approved under subsection 501(d) of the Act will not be required to submit any other plan or application in order to receive Federal funds to carry out the activity or program.

(d) Each portion of a unified plan submitted under paragraph (a) of this section is subject to the particular requirements of Federal law authorizing the program. All grantees are still subject to such things as reporting and record-keeping requirements, corrective action plan requirements and other generally applicable requirements.

(e) A unified plan must contain the information required by WIA section 501(c) and will be approved in accordance with the requirements of WIA section 501(d).

[65 FR 49390, Aug. 11, 2000, as amended at 71 FR 35525, June 21, 2006]

§ 661.250 What are the requirements for designation of local workforce investment areas?

(a) The Governor must designate local workforce investment areas in order for the State to receive funding under title I of WIA.

(b) The Governor must take into consideration the factors described in WIA section 116(a)(1)(B) in making designations of local areas. Such designation must be made in consultation with the State Board, and after consultation with chief elected officials. The Governor must also consider comments received through the public comment process described in the State workforce investment plan under § 661.220(d).

(c) The Governor may approve a request for designation as a workforce investment area from any unit of general local government, including a combination of such units, if the State Board determines that the area meets the requirements of WIA section 116(a)(1)(B) and recommends designation.

(d) The Governor of any State that was a single service delivery area State under the Job Training Partnership Act as of July 1, 1998, and only those

States, may designate the State as a single local workforce investment area State. (WIA sec.116.)

§ 661.260 What are the requirements for automatic designation of workforce investment areas relating to units of local government with a population of 500,000 or more?

The requirements for automatic designation relating to units of local government with a population of 500,000 or more and to rural concentrated employment programs are contained in WIA section 116(a)(2). The Governor has authority to determine the source of population data to use in making these designations.

§ 661.270 What are the requirements for temporary and subsequent designation of workforce investment areas relating to areas that had been designated as service delivery areas under JTPA?

The requirements for temporary and subsequent designation relating to areas that had been designated as service delivery areas under JTPA are contained in WIA section 116(a)(3).

§ 661.280 What right does an entity have to appeal the Governor's decision rejecting a request for designation as a workforce investment area?

(a) A unit of local government (or combination of units) or a rural concentrated employment program grant recipient (as described at WIA section 116(a)(2)(B), which has requested but has been denied its request for designation as a workforce investment area under §§ 661.260 through 661.270, may appeal the decision to the State Board, in accordance with appeal procedures established in the State Plan.

(b) If a decision on the appeal is not rendered in a timely manner or if the appeal to the State Board does not result in designation, the entity may request review by the Secretary of Labor, under the procedures set forth at 20 CFR 667.640(a).

(c) The Secretary may require that the area be designated as a workforce investment area, if the Secretary determines that:

(1) The entity was not accorded procedural rights under the State appeals process; or

(2) The area meets the automatic designation requirements at WIA section 116(a)(2) or the temporary and subsequent designation requirements at WIA section 116(a)(3), as appropriate.

§ 661.290 Under what circumstances may States require Local Boards to take part in regional planning activities?

(a) The State may require Local Boards within a designated region (as defined at 20 CFR 660.300) to:

(1) Participate in a regional planning process that results in regional performance measures for workforce investment activities under title I of WIA. Regions that meet or exceed the regional performance measures may receive regional incentive grants;

(2) Share, where feasible, employment and other types of information that will assist in improving the performance of all local areas in the designated region on local performance measures; and

(3) Coordinate the provision of WIA title I services, including supportive services such as transportation, across the boundaries of local areas within the designated region.

(b) Two or more States may designate a labor market area, economic development region, or other appropriate contiguous subarea of the States as an interstate region. In such cases, the States may jointly exercise the State's functions described in this section.

(c) Designation of intrastate regions and interstate regions and their corresponding performance measures must be described in the respective State Plan(s). For interstate regions, the roles of the respective Governors, State Boards and Local Boards must be described in the respective State Plans.

(d) Unless agreed to by all affected chief elected officials and the Governor, these regional planning activities may not substitute for or replace the requirements applicable to each local area under other provisions of the WIA. (WIA sec. 116(a).)

Subpart C—Local Governance Provisions

§ 661.300 What is the Local Workforce Investment Board?

(a) The Local Workforce Investment Board (Local Board) is appointed by the chief elected official in each local area in accordance with State criteria established under WIA section 117(b), and is certified by the Governor every two years, in accordance with WIA section 117(c)(2).

(b) In partnership with the chief elected official(s), the Local Board sets policy for the portion of the Statewide workforce investment system within the local area.

(c) The Local Board and the chief elected official(s) may enter into an agreement that describes the respective roles and responsibilities of the parties.

(d) The Local Board, in partnership with the chief elected official, develops the local workforce investment plan and performs the functions described in WIA section 117(d). (WIA sec.117 (d).)

(e) If a local area includes more than one unit of general local government in accordance with WIA section 117 (c)(1)(B), the chief elected officials of such units may execute an agreement to describe their responsibilities for carrying out the roles and responsibilities. If, after a reasonable effort, the chief elected officials are unable to reach agreement, the Governor may appoint the members of the local board from individuals nominated or recommended as specified in WIA section 117(b).

(f) If the State Plan indicates that the State will be treated as a local area under WIA title I, the Governor may designate the State Board to carry out any of the roles of the Local Board.

§ 661.305 What is the role of the Local Workforce Investment Board?

(a) WIA section 117(d) specifies that the Local Board is responsible for:

(1) Developing the five-year local workforce investment plan (Local Plan) and conducting oversight of the One-Stop system, youth activities and employment and training activities under title I of WIA, in partnership with the chief elected official;

(2) Selecting One-Stop operators with the agreement of the chief elected official;

(3) Selecting eligible youth service providers based on the recommendations of the youth council, and identifying eligible providers of adult and dislocated worker intensive services and training services, and maintaining a list of eligible providers with performance and cost information, as required in 20 CFR part 663, subpart E;

(4) Developing a budget for the purpose of carrying out the duties of the Local Board, subject to the approval of the chief elected official;

(5) Negotiating and reaching agreement on local performance measures with the chief elected official and the Governor;

(6) Assisting the Governor in developing the Statewide employment statistics system under the Wagner-Peyser Act;

(7) Coordinating workforce investment activities with economic development strategies and developing employer linkages; and

(8) Promoting private sector involvement in the Statewide workforce investment system through effective connecting, brokering, and coaching activities through intermediaries such as the One-Stop operator in the local area or through other organizations, to assist employers in meeting hiring needs.

(b) The Local Board, in cooperation with the chief elected official, appoints a youth council as a subgroup of the Local Board and coordinates workforce and youth plans and activities with the youth council, in accordance with WIA section 117(h) and § 661.335.

(c) Local Boards which are part of a State designated region for regional planning must carry out the regional planning responsibilities required by the State in accordance with WIA section 116(c) and § 661.290. (WIA sec. 117.)

§ 661.307 How does the Local Board meet its requirement to conduct business in an open manner under the "sunshine provision" of WIA section 117(e)?

The Local Board must conduct its business in an open manner as required by WIA section 117(e), by making available to the public, on a regular basis

through open meetings, information about the activities of the Local Board. This includes information about the Local Plan prior to submission of the plan; information about membership; the development of significant policies, interpretations, guidelines and definitions; and, on request, minutes of formal meetings of the Local Board.

§ 661.310 Under what limited conditions may a Local Board directly be a provider of core services, intensive services, or training services, or act as a One-Stop Operator?

(a) A Local Board may not directly provide core services, or intensive services, or be designated or certified as a One-Stop operator, unless agreed to by the chief elected official and the Governor.

(b) A Local Board is prohibited from providing training services, unless the Governor grants a waiver in accordance with the provisions in WIA section 117(f)(1). The waiver shall apply for not more than one year. The waiver may be renewed for additional periods, but for not more than one additional year at a time.

(c) The restrictions on the provision of core, intensive, and training services by the Local Board, and designation or certification as One-Stop operator, also apply to staff of the Local Board. (WIA sec. 117(f)(1) and (f)(2).)

§ 661.315 Who are the required members of the Local Workforce Investment Boards?

(a) The membership of Local Board must be selected in accordance with criteria established under WIA section 117(b)(1) and must meet the requirements of WIA section 117(b)(2). The Local Board must contain two or more members representing the categories described in WIA section 117(b)(2)(A)(ii)–(v), and special consideration must be given to the entities identified in WIA section 117(b)(2)(A)(ii), (iv) and (v) in the selection of members representing those categories. The Local Board must contain at least one member representing each One-Stop partner.

(b) The membership of Local Boards may include individuals or representatives of other appropriate entities, including entities representing individuals with multiple barriers to employment and other special populations, as determined by the chief elected official.

(c) Members who represent organizations, agencies or other entities must be individuals with optimum policy making authority within the entities they represent.

(d) A majority of the members of the Local Board must be representatives of business in the local area. Members representing business must be individuals who are owners, chief executive officers, chief operating officers, or other individuals with optimum policy-making or hiring authority. Business representatives serving on Local Boards may also serve on the State Board.

(e) Chief elected officials must appoint the business representatives from among individuals who are nominated by local business organizations and business trade associations. Chief elected officials must appoint the labor representatives from among individuals who are nominated by local labor federations (or, for a local area in which no employees are represented by such organizations, other representatives of employees). (WIA sec. 117(b).)

(f) An individual may be appointed as a representative of more than one entity if the individual meets all the criteria for representation, including the criteria described in paragraphs (c) through (e) of this section, for each entity.

§ 661.317 Who may be selected to represent a particular One-Stop partner program on the Local Board when there is more than one partner program entity in the local area?

When there is more than one grant recipient, administrative entity or organization responsible for administration of funds of a particular One-stop partner program in the local area, the chief elected official may appoint one or more members to represent all of those particular partner program entities. In making such appointments, the local elected official may solicit nominations from the partner program entities.

§ 661.320 Who must chair a Local Board?

The Local Board must elect a chairperson from among the business representatives on the board. (WIA sec. 117(b)(5).)

§ 661.325 What criteria will be used to establish the membership of the Local Board?

The Local Board is appointed by the chief elected official(s) in the local area in accordance with State criteria established under WIA section 117(b), and is certified by the Governor every two years, in accordance with WIA section 117(c)(2). The criteria for certification must be described in the State Plan. (WIA sec. 117(c).)

§ 661.330 Under what circumstances may the State use an alternative entity as the Local Workforce Investment Board?

(a) The State may use any local entity that meets the requirements of WIA section 117(i) to perform the functions of the Local Board. WIA section 117(i) requires that such entity:

(1) Was established to serve the local area (or the service delivery area that most closely corresponds to the local area);

(2) Was in existence on December 31, 1997;

(3)(i) Is a Private Industry Council established under section 102 of the Job Training Partnership Act, as in effect on December 31, 1997; or

(ii) Is substantially similar to the Local Board described in WIA section 117 (a), (b), and (c) and (h)(1) and (2); and,

(4) Includes, at a minimum, two or more representatives of business in the local area and two or more representatives of labor organizations nominated by local labor federations or employees in the local area.

(b)(1) If the Governor certifies an alternative entity to perform the functions of the Local Board; the State workforce investment plan must demonstrate that the alternative entity meets the requirements of WIA section 117(i), set forth in paragraph (a) of this section.

(2) If the alternative entity does not provide for representative membership of each of the categories of required Local Board membership under WIA section 117(b), including all of the One-stop partner programs, the local workforce investment plan must explain the manner in which the Local Board will ensure an ongoing role for the unrepresented membership group in the local workforce investment system.

(3) The Local Board may provide an ongoing role for an unrepresented membership group, including entities carrying out One-stop partner programs, by means such as regularly scheduled consultations with entities within the unrepresented membership groups, by providing an opportunity for input into the local plan or other policy development by unrepresented membership groups, or by establishing an advisory committee of unrepresented membership groups. The Local Board must enter into good faith negotiations over the terms of the MOU with all entities carrying out One-stop partner programs, including programs not represented on the alternative entity.

(c) If the membership structure of an alternative entity is significantly changed after December 31, 1997, the entity will no longer be eligible to perform the functions of the Local Board. In such case, the chief elected official(s) must establish a new Local Board which meets all of the criteria of WIA section 117(a), (b), and (c) and (h)(1) and (2).

(d) A significant change in the membership structure includes any significant change in the organization of the alternative entity or in the categories of entities represented on the alternative entity which requires a change to the alternative entity's charter or a similar document that defines the formal organization of the alternative entity, regardless of whether the required change to the document has or has not been made. A significant change in the membership structure is considered to have occurred when members are added to represent groups not previously represented on the entity. A significant change in the membership structure is not considered to have occurred when additional members are added to an existing membership category, when nonvoting members (including a Youth

Council) are added, or when a member is added to fill a vacancy created in an existing membership category.

(e) In 20 CFR parts 660 through 671, all references to the Local Board must be deemed to also apply to an alternative entity used by a local area. (WIA sec. 117(i).)

§ 661.335 What is a youth council, and what is its relationship to the Local Board?

(a) A youth council must be established as a subgroup within each Local Board.

(b) The membership of each youth council must include:

(1) Members of the Local Board, such as educators, which may include special education personnel, employers, and representatives of human service agencies, who have special interest or expertise in youth policy;

(2) Members who represent service agencies, such as juvenile justice and local law enforcement agencies;

(3) Members who represent local public housing authorities;

(4) Parents of eligible youth seeking assistance under subtitle B of title I of WIA;

(5) Individuals, including former participants, and members who represent organizations, that have experience relating to youth activities; and

(6) Members who represent the Job Corps, if a Job Corps Center is located in the local area represented by the council.

(c) Youth councils may include other individuals, who the chair of the Local Board, in cooperation with the chief elected official, determines to be appropriate.

(d) Members of the youth council who are not members of the Local Board must be voting members of the youth council and nonvoting members of the Local Board.

§ 661.340 What are the responsibilities of the youth council?

The youth council is responsible for:

(a) Coordinating youth activities in a local area;

(b) Developing portions of the local plan related to eligible youth, as determined by the chairperson of the Local Board;

(c) Recommending eligible youth service providers in accordance with WIA section 123, subject to the approval of the Local Board;

(d) Conducting oversight with respect to eligible providers of youth activities in the local area, subject to the approval of the Local Board; and

(e) Carrying out other duties, as authorized by the chairperson of the Local Board, such as establishing linkages with educational agencies and other youth entities.

§ 661.345 What are the requirements for the submission of the local workforce investment plan?

(a) WIA section 118 requires that each Local Board, in partnership with the appropriate chief elected officials, develops and submits a comprehensive five-year plan to the Governor which identifies and describes certain policies, procedures and local activities that are carried out in the local area, and that is consistent with the State Plan.

(b) The Local Board must provide an opportunity for public comment on and input into the development of the local workforce investment plan prior to its submission, and the opportunity for public comment on the local plan must:

(1) Make copies of the proposed local plan available to the public (through such means as public hearings and local news media);

(2) Include an opportunity for comment by members of the Local Board and members of the public, including representatives of business and labor organizations;

(3) Provide at least a thirty (30) day period for comment, beginning on the date on which the proposed plan is made available, prior to its submission to the Governor; and

(4) Be consistent with the requirement, in WIA section 117(e), that the Local Board make information about the plan available to the public on a regular basis through open meetings.

(c) The Local Board must submit any comments that express disagreement with the plan to the Governor along with the plan.

§ 661.350 What are the contents of the local workforce investment plan?

(a) The local workforce investment plan must meet the requirements of WIA section 118(b). The plan must include:

(1) An identification of the workforce investment needs of businesses, jobseekers, and workers in the local area;

(2) An identification of current and projected employment opportunities and job skills necessary to obtain such opportunities;

(3) A description of the One-Stop delivery system to be established or designated in the local area, including:

(i) How the Local Board will ensure continuous improvement of eligible providers of services and ensure that such providers meet the employment needs of local employers and participants; and

(ii) A copy of the local Memorandum(s) of Understanding between the Local Board and each of the One-Stop partners concerning the operation of the local One-Stop delivery system;

(4) A description of the local levels of performance negotiated with the Governor and the chief elected official(s) to be used by the Local Board for measuring the performance of the local fiscal agent (where appropriate), eligible providers, and the local One-Stop delivery system;

(5) A description and assessment of the type and availability of adult and dislocated worker employment and training activities in the local area, including a description of the local ITA system and the procedures for ensuring that exceptions to the use of ITA's, if any, are justified under WIA section 134(d)(4)(G)(ii) and 20 CFR 663.430;

(6) A description of how the Local Board will coordinate local activities with Statewide rapid response activities;

(7) A description and assessment of the type and availability of youth activities in the local area, including an identification of successful providers of such activities;

(8) A description of the process used by the Local Board to provide opportunity for public comment, including comment by representatives of business and labor organizations, and input into the development of the local plan, prior to the submission of the plan;

(9) An identification of the fiscal agent, or entity responsible for the disbursal of grant funds;

(10) A description of the competitive process to be used to award grants and contracts for activities carried out under this subtitle I of WIA, including the process to be used to procure training services that are made as exceptions to the Individual Training Account process (WIA section 134(d)(4)(G)),

(11) A description of the criteria to be used by the Governor and the Local Board, under 20 CFR 663.600, to determine whether funds allocated to a local area for adult employment and training activities under WIA sections 133(b)(2)(A) or (3) are limited, and the process by which any priority will be applied by the One-Stop operator;

(12) In cases where an alternate entity functions as the Local Board, the information required at § 661.330(b), and

(13) Such other information as the Governor may require.

(b) The Governor must review completed plans and must approve all such plans within ninety days of their submission, unless the Governor determines in writing that:

(1) There are deficiencies identified in local workforce investment activities carried out under this subtitle that have not been sufficiently addressed; or

(2) The plan does not comply with title I of WIA and the WIA regulations, including the required consultations, the public comment provisions, and the nondiscrimination requirements of 29 CFR part 37.

(c) In cases where the State is a single local area:

(1) The Secretary performs the roles assigned to the Governor as they relate to local planning activities.

(2) The Secretary issues planning guidance for such States.

(3) The requirements found in WIA and in the WIA regulations for consultation with chief elected officials apply to the development of State and local plans and to the development and operation of the One-Stop delivery system.

(d) During program year 2000, if a local plan does not contain all of the

elements described in paragraph (a) of this section, the Governor may approve a local plan on a transitional basis. A transitional approval under this paragraph is considered to be a written determination that the local plan is not approved under paragraph (b) of this section.

§ 661.355 When must a local plan be modified?

The Governor must establish procedures governing the modification of local plans. Situations in which modifications may be required by the Governor include significant changes in local economic conditions, changes in the financing available to support WIA title I and partner-provided WIA services, changes to the Local Board structure, or a need to revise strategies to meet performance goals.

Subpart D—Waivers and Work-Flex Waivers

§ 661.400 What is the purpose of the General Statutory and Regulatory Waiver Authority provided at section 189(i)(4) of the Workforce Investment Act?

(a) The purpose of the general statutory and regulatory waiver authority is to provide flexibility to States and local areas and enhance their ability to improve the statewide workforce investment system.

(b) A waiver may be requested to address impediments to the implementation of a strategic plan, including the continuous improvement strategy, consistent with the key reform principles of WIA. These key reform principles include:

(1) Streamlining services and information to participants through a One-Stop delivery system;

(2) Empowering individuals to obtain needed services and information to enhance their employment opportunities;

(3) Ensuring universal access to core employment-related services;

(4) Increasing accountability of States, localities and training providers for performance outcomes;

(5) Establishing a stronger role for Local Boards and the private sector;

(6) Providing increased State and local flexibility to implement innovative and comprehensive workforce investment systems; and

(7) Improving youth programs through services which emphasize academic and occupational learning.

§ 661.410 What provisions of WIA and the Wagner-Peyser Act may be waived, and what provisions may not be waived?

(a) The Secretary may waive any of the statutory or regulatory requirements of subtitles B and E of title I of WIA, except for requirements relating to:

(1) Wage and labor standards;

(2) Non-displacement protections;

(3) Worker rights;

(4) Participation and protection of workers and participants;

(5) Grievance procedures and judicial review;

(6) Nondiscrimination;

(7) Allocation of funds to local areas;

(8) Eligibility of providers or participants;

(9) The establishment and functions of local areas and local boards;

(10) Procedures for review and approval of State and Local plans; and

(b) The Secretary may waive any of the statutory or regulatory requirements of sections 8 through 10 of the Wagner-Peyser Act (29 U.S.C. 49g–49i) except for requirements relating to:

(1) The provision of services to unemployment insurance claimants and veterans; and

(2) Universal access to the basic labor exchange services without cost to job seekers.

(c) The Secretary does not intend to waive any of the statutory or regulatory provisions essential to the key reform principles embodied in the Workforce Investment Act, described in §661.400, except in extremely unusual circumstances where the provision can be demonstrated as impeding reform. (WIA sec. 189(i).)

§ 661.420 Under what conditions may a Governor request, and the Secretary approve, a general waiver of statutory or regulatory requirements under WIA section 189(i)(4)?

(a) A Governor may request a general waiver in consultation with appropriate chief elected officials:

(1) By submitting a waiver plan which may accompany the State's WIA 5-year strategic Plan; or

(2) After a State's WIA Plan is approved, by directly submitting a waiver plan.

(b) A Governor's waiver request may seek waivers for the entire State or for one or more local areas.

(c) A Governor requesting a general waiver must submit to the Secretary a plan to improve the Statewide workforce investment system that:

(1) Identifies the statutory or regulatory requirements for which a waiver is requested and the goals that the State or local area, as appropriate, intends to achieve as a result of the waiver and how those goals relate to the Strategic Plan goals;

(2) Describes the actions that the State or local area, as appropriate, has undertaken to remove State or local statutory or regulatory barriers;

(3) Describes the goals of the waiver and the expected programmatic outcomes if the request is granted;

(4) Describes the individuals affected by the waiver; and

(5) Describes the processes used to:

(i) Monitor the progress in implementing the waiver;

(ii) Provide notice to any Local Board affected by the waiver;

(iii) Provide any Local Board affected by the waiver an opportunity to comment on the request; and

(iv) Ensure meaningful public comment, including comment by business and organized labor, on the waiver.

(d) The Secretary issues a decision on a waiver request within 90 days after the receipt of the original waiver request.

(e) The Secretary will approve a waiver request if and only to the extent that:

(1) The Secretary determines that the requirements for which a waiver is requested impede the ability of either the State or local area to implement the State's plan to improve the Statewide workforce investment system;

(2) The Secretary determines that the waiver plan meets all of the requirements of WIA section 189(i)(4) and §§ 661.400 through 661.420; and

(3) The State has executed a Memorandum of Understanding with the Secretary requiring the State to meet, or ensure that the local area meets, agreed-upon outcomes and to implement other appropriate measures to ensure accountability.

(f) The Secretary will issue guidelines under which the States may request general waivers of WIA and Wagner-Peyser requirements. (WIA sec. 189(i).)

§ 661.430 Under what conditions may the Governor submit a Workforce Flexibility Plan?

(a) A State may submit to the Secretary, and the Secretary may approve, a workforce flexibility (work-flex) plan under which the State is authorized to waive, in accordance with the plan:

(1) Any of the statutory or regulatory requirements under title I of WIA applicable to local areas, if the local area requests the waiver in a waiver application, except for:

(i) Requirements relating to the basic purposes of title I of WIA;

(ii) Wage and labor standards;

(iii) Grievance procedures and judicial review;

(iv) Nondiscrimination;

(v) Eligibility of participants;

(vi) Allocation of funds to local areas;

(vii) Establishment and functions of local areas and local boards;

(viii) Review and approval of local plans;

(ix) Worker rights, participation, and protection; and

(x) Any of the statutory provisions essential to the key reform principles embodied in the Workforce Investment Act, described in § 661.400.

(2) Any of the statutory or regulatory requirements applicable to the State under section 8 through 10 of the Wagner-Peyser Act (29 U.S.C. 49g–49i), except for requirements relating to:

(i) The provision of services to unemployment insurance claimants and veterans; and

(ii) Universal access to basic labor exchange services without cost to job seekers; and

(3) Any of the statutory or regulatory requirements under the Older Americans Act of 1965 (OAA) (42 U.S.C. 3001 *et seq.*), applicable to State agencies on aging with respect to activities carried

out using funds allotted under OAA section 506(a)(3) (42 U.S.C. 3056d(a)(3)), except for requirements relating to:

(i) The basic purposes of OAA;

(ii) Wage and labor standards;

(iii) Eligibility of participants in the activities; and

(iv) Standards for agreements.

(b) A State's workforce flexibility plan may accompany the State's five-year Strategic Plan or may be submitted separately. If it is submitted separately, the workforce flexibility plan must identify related provisions in the State's five-year Strategic Plan.

(c) A workforce flexibility plan submitted under paragraph (a) of this section must include descriptions of:

(1) The process by which local areas in the State may submit and obtain State approval of applications for waivers;

(2) The statutory and regulatory requirements of title I of WIA that are likely to be waived by the State under the workforce flexibility plan;

(3) The statutory and regulatory requirements of sections 8 through 10 of the Wagner-Peyser Act that are proposed for waiver, if any;

(4) The statutory and regulatory requirements of the Older Americans Act of 1965 that are proposed for waiver, if any;

(5) The outcomes to be achieved by the waivers described in paragraphs (c)(1) to (4) of this section including, where appropriate, revisions to adjusted levels of performance included in the State or local plan under title I of WIA; and

(6) The measures to be taken to ensure appropriate accountability for Federal funds in connection with the waivers.

(d) The Secretary may approve a workforce flexibility plan for a period of up to five years.

(e) Before submitting a workforce flexibility plan to the Secretary for approval, the State must provide adequate notice and a reasonable opportunity for comment on the proposed waiver requests under the workforce flexibility plan to all interested parties and to the general public.

(f) The Secretary will issue guidelines under which States may request designation as a work-flex State.

§ 661.440 What limitations apply to the State's Workforce Flexibility Plan authority under WIA?

(a)(1) Under work-flex waiver authority a State must not waive the WIA, Wagner-Peyser or Older Americans Act requirements which are excepted from the work-flex waiver authority and described in § 661.430(a).

(2) Requests to waive statutory and regulatory requirements of title I of WIA applicable at the State level may not be granted under work-flex waiver authority granted to a State. Such requests may only be granted by the Secretary under the general waiver authority described at §§ 661.410 through 661.420.

(b) As required in § 661.430(c)(5), States must address the outcomes to result from work-flex waivers as part of its workforce flexibility plan. Once approved, a State's work-flex designation is conditioned on the State demonstrating it has met the agreed-upon outcomes contained in its workforce flexibility plan.

PART 662—DESCRIPTION OF THE ONE-STOP SYSTEM UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

Subpart A—General Description of the One-Stop Delivery System

Sec.

662.100 What is the One-Stop delivery system?

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662.220 What entity serves as the One-Stop partner for a particular program in the local area?
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Subpart C—Memorandum of Understanding for the One-Stop Delivery System

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Subpart D—One-Stop Operators

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662.410 How is the One-Stop operator selected?
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662.430 Under what conditions may One-Stop operators designated to operate in a One-Stop delivery system established prior to the enactment of WIA be designated to continue to act as a One-Stop operator under WIA without meeting the requirements of § 662.410(b)?

AUTHORITY: Sec. 506(c), Pub. L. 105–220; 20 U.S.C. 9276(c).

SOURCE: 65 FR 49398, Aug. 11, 2000, unless otherwise noted.

Subpart A—General Description of the One-Stop Delivery System

§ 662.100 What is the One-Stop delivery system?

(a) In general, the One-Stop delivery system is a system under which entities responsible for administering separate workforce investment, educational, and other human resource programs and funding streams (referred to as One-Stop partners) collaborate to create a seamless system of service delivery that will enhance access to the programs' services and improve long-term employment outcomes for individuals receiving assistance.

(b) Title I of WIA assigns responsibilities at the local, State and Federal level to ensure the creation and maintenance of a One-Stop delivery system that enhances the range and quality of workforce development services that are accessible to individuals seeking assistance.

(c) The system must include at least one comprehensive physical center in each local area that must provide the core services specified in WIA section 134(d)(2), and must provide access to other programs and activities carried out by the One-Stop partners.

(d) While each local area must have at least one comprehensive center (and may have additional comprehensive centers), WIA section 134(c) allows for arrangements to supplement the center. These arrangements may include:

(1) A network of affiliated sites that can provide one or more partners' programs, services and activities at each site;

(2) A network of One-Stop partners through which each partner provides services that are linked, physically or technologically, to an affiliated site that assures individuals are provided information on the availability of core services in the local area; and

(3) Specialized centers that address specific needs, such as those of dislocated workers.

(e) The design of the local area's One-Stop delivery system, including the number of comprehensive centers and the supplementary arrangements, must be described in the local plan and be consistent with the Memorandum of Understanding executed with the One-Stop partners.

Subpart B—One-Stop Partners and the Responsibilities of Partners

§ 662.200 Who are the required One-Stop partners?

(a) WIA section 121(b)(1) identifies the entities that are required partners in the local One-Stop systems.

(b) The required partners are the entities that are responsible for administering the following programs and activities in the local area:

(1) Programs authorized under title I of WIA, serving:

(i) Adults;

(ii) Dislocated workers;

(iii) Youth;

(iv) Job Corps;

(v) Native American programs;

(vi) Migrant and seasonal farmworker programs; and

(vii) Veterans' workforce programs; (WIA sec. 121(b)(1)(B)(i));

(2) Programs authorized under the Wagner-Peyser Act (29 U.S.C. 49 *et seq.*); (WIA sec. 121(b)(1)(B)(ii));

(3) Adult education and literacy activities authorized under title II of WIA; (WIA sec. 121(b)(1)(B)(iii));

(4) Programs authorized under parts A and B of title I of the Rehabilitation Act (29 U.S.C. 720 *et seq.*); (WIA sec. 121(b)(1)(B)(iv));

(5) [Reserved]

(6) Senior community service employment activities authorized under title V of the Older Americans Act of 1965 (42 U.S.C. 3056 *et seq.*); (WIA sec. 121(b)(1)(B)(vi));

(7) Postsecondary vocational education activities under the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2301 *et seq.*); (WIA sec. 121(b)(1)(B)(vii));

(8) Trade Adjustment Assistance and NAFTA Transitional Adjustment Assistance activities authorized under chapter 2 of title II of the Trade Act of 1974, as amended (19 U.S.C. 2271 *et seq.*) and Section 123(c)(2) of the Trade Adjustment Assistance Reform Act of 2002 (Pub. L. 107–210), respectively; see (WIA sec. 121(b)(1)(B)(viii));

(9) Activities authorized under chapter 41 of title 38, U.S.C. (local veterans' employment representatives and disabled veterans outreach programs); (WIA sec. 121(b)(1)(B)(ix));

(10) Employment and training activities carried out under the Community Services Block Grant (42 U.S.C. 9901 *et seq.*); (WIA sec. 121(b)(1)(B)(x));

(11) Employment and training activities carried out by the Department of Housing and Urban Development; (WIA sec. 121(b)(1)(B)(xi)); and

(12) Programs authorized under State unemployment compensation laws (in accordance with applicable Federal law); (WIA sec. 121(b)(1)(B)(xii).)

[65 FR 49398, Aug. 11, 2000, as amended at 71 FR 35523, June 21, 2006]

§ 662.210 What other entities may serve as One-Stop partners?

(a) WIA provides that other entities that carry out a human resource program, including Federal, State, or local programs and programs in the private sector may serve as additional partners in the One-Stop system if the Local Board and chief elected official(s) approve the entity's participation.

(b) Additional partners may include:

(1) TANF programs authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 *et seq.*);

(2) Employment and training programs authorized under section 6(d)(4) of the Food Stamp Act of 1977 (7 U.S.C. 2015(d)(4));

(3) Work programs authorized under section 6(o) of the Food Stamp Act of 1977 (7 U.S.C. 2015(o));

(4) Programs authorized under the National and Community Service Act of 1990 (42 U.S.C. 12501 *et seq.*); and

(5) Other appropriate Federal, State or local programs, including programs related to transportation and housing and programs in the private sector. (WIA sec. 121(b)(2).)

(c) The State may require that one or more of the programs identified in paragraph (b) of this section be included as a partner in all of the local One-Stop delivery systems in the State.

§ 662.220 What entity serves as the One-Stop partner for a particular program in the local area?

(a) The ''entity'' that carries out the program and activities listed in §§ 662.200 and 662.210 and, therefore, serves as the One-Stop partner is the grant recipient, administrative entity or organization responsible for administering the funds of the specified program in the local area. The term ''entity'' does not include the service providers that contract with or are subrecipients of the local administrative entity. For programs that do not include local administrative entities, the responsible State Agency should be the partner. Specific entities for particular programs are identified in paragraph (b) of this section. If a program or activity listed in § 662.200 is not carried out in a local area, the requirements relating to a required One-Stop partner are not applicable to such program or activity in that local One-Stop system.

(b)(1) For title II of WIA, the entity that carries out the program for the

purposes of paragraph (a) is the State eligible entity. The State eligible entity may designate an eligible provider, or a consortium of eligible providers, as the ''entity'' for this purpose;

(2) For title I, Part A, of the Rehabilitation Act, the entity that carries out the program for the purposes of paragraph (a) of this section is the designated State agency or designated unit specified under section 101(a)(2) that is primarily concerned with vocational rehabilitation, or vocational and other rehabilitation, of individuals with disabilities; and

(3) Under WIA, the national programs, including Job Corps, the WIA Indian and Native American program, the Migrant and Seasonal Farmworkers program, and the Veterans' Workforce Investment program, are required One-Stop partners. Local Boards must include them in the One-Stop delivery system where they are present in their local area. In local areas where the national programs are not present, States and Local Boards should take steps to ensure that customer groups served by these programs have access to services through the One-Stop delivery system.

§ 662.230 What are the responsibilities of the required One-Stop partners?

All required partners must:

(a) Make available to participants through the One-Stop delivery system the core services that are applicable to the partner's programs; (WIA sec. 121(b)(1)(A).)

(b) Use a portion of funds made available to the partner's program, to the extent not inconsistent with the Federal law authorizing the partner's program, to:

(1) Create and maintain the One-Stop delivery system; and

(2) Provide core services; (WIA sec. 134(d)(1)(B).)

(c) Enter into a memorandum of understanding (MOU) with the Local Board relating to the operation of the One-Stop system that meets the requirements of § 662.300, including a description of services, how the cost of the identified services and operating costs of the system will be funded, and methods for referrals (WIA sec. 121(c));

(d) Participate in the operation of the One-Stop system consistent with the terms of the MOU and requirements of authorizing laws; (WIA sec. 121(b)(1)(B).) and

(e) Provide representation on the Local Workforce Investment Board. (WIA sec. 117(b)(2)(A)(vi).)

§ 662.240 What are a program's applicable core services?

(a) The core services applicable to any One-Stop partner program are those services described in paragraph (b) of this section, that are authorized and provided under the partner's program.

(b) The core services identified in section 134(d)(2) of the WIA are:

(1) Determinations of whether the individuals are eligible to receive assistance under subtitle B of title I of WIA;

(2) Outreach, intake (which may include worker profiling), and orientation to the information and other services available through the One-Stop delivery system;

(3) Initial assessment of skill levels, aptitudes, abilities, and supportive service needs;

(4) Job search and placement assistance, and where appropriate, career counseling;

(5) Provision of employment statistics information, including the provision of accurate information relating to local, regional, and national labor market areas, including—

(i) Job vacancy listings in such labor market areas;

(ii) Information on job skills necessary to obtain the listed jobs; and

(iii) Information relating to local occupations in demand and the earnings and skill requirements for such occupations;

(6) Provision of program performance information and program cost information on:

(i) Eligible providers of training services described in WIA section 122;

(ii) Eligible providers of youth activities described in WIA section 123;

(iii) Providers of adult education described in title II;

(iv) Providers of postsecondary vocational education activities and vocational education activities available to

school dropouts under the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2301 *et seq.*); and

(v) Providers of vocational rehabilitation program activities described in title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 *et seq.*);

(7) Provision of information on how the local area is performing on the local performance measures and any additional performance information with respect to the One-Stop delivery system in the local area;

(8) Provision of accurate information relating to the availability of supportive services, including, at a minimum, child care and transportation, available in the local area, and referral to such services, as appropriate;

(9) Provision of information regarding filing claims for unemployment compensation;

(10) Assistance in establishing eligibility for programs of financial aid assistance for training and education programs that are not funded under this Act and are available in the local area; and

(11) Followup services, including counseling regarding the workplace, for participants in workforce investment activities authorized under subtitle (B) of title I of WIA who are placed in unsubsidized employment, for not less than 12 months after the first day of the employment, as appropriate.

[65 FR 49398, Aug. 11, 2000, as amended at 71 FR 35523, June 21, 2006]

§ 662.250 Where and to what extent must required One-Stop partners make core services available?

(a) At a minimum, the core services that are applicable to the program of the partner under § 662.220, and that are in addition to the basic labor exchange services traditionally provided in the local area under the Wagner-Peyser program, must be made available at the comprehensive One-Stop center. These services must be made available to individuals attributable to the partner's program who seek assistance at the center. The adult and dislocated worker program partners are required to make all of the core services listed in § 662.240 available at the center in accordance with 20 CFR 663.100(b)(1).

(b) The applicable core services may be made available by the provision of appropriate technology at the comprehensive One-Stop center, by co-locating personnel at the center, cross-training of staff, or through a cost reimbursement or other agreement between service providers at the comprehensive One-Stop center and the partner, as described in the MOU.

(c) The responsibility of the partner for the provision of core services must be proportionate to the use of the services at the comprehensive One-Stop center by the individuals attributable to the partner's program. The specific method of determining each partner's proportionate responsibility must be described in the MOU.

(d) For purposes of this part, individuals attributable to the partner's program may include individuals who are referred through the comprehensive One-Stop center and enrolled in the partner's program after the receipt of core services, who have been enrolled in the partner's program prior to receipt of the applicable core services at the center, who meet the eligibility criteria for the partner's program and who receive an applicable core service, or who meet an alternative definition described in the MOU.

(e) Under the MOU, the provision of applicable core services at the center by the One-Stop partner may be supplemented by the provision of such services through the networks of affiliated sites and networks of One-Stop partners described in WIA section 134(c)(2).

§ 662.260 What services, in addition to the applicable core services, are to be provided by One-Stop partners through the One-Stop delivery system?

In addition to the provision of core services, One-Stop partners must provide access to the other activities and programs carried out under the partner's authorizing laws. The access to these services must be described in the local MOU. 20 CFR part 663 describes the specific requirements relating to the provision of core, intensive, and training services through the One-Stop system that apply to the adult and the dislocated worker programs authorized

under title I of WIA. Additional requirements apply to the provision of all labor exchange services under the Wagner-Peyser Act. (WIA sec. 134(c)(1)(D).)

§ 662.270 How are the costs of providing services through the One-Stop delivery system and the operating costs of the system to be funded?

The MOU must describe the particular funding arrangements for services and operating costs of the One-Stop delivery system. Each partner must contribute a fair share of the operating costs of the One-Stop delivery system proportionate to the use of the system by individuals attributable to the partner's program. There are a number of methods, consistent with the equirements of the relevant OMB circulars, that may be used for allocating costs among the partners. Some of these methodologies include allocations based on direct charges, cost pooling, indirect cost rates and activity-based cost allocation plans. Additional guidance relating to cost allocation methods may be issued by the Department in consultation with the other appropriate Federal agencies.

§ 662.280 Does title I require One-Stop partners to use their funds for individuals who are not eligible for the partner's program or for services that are not authorized under the partner's program?

No, the requirements of the partner's program continue to apply. The Act intends to create a seamless service delivery system for individuals seeking workforce development services by linking the One-Stop partners in the One-Stop delivery system. While the overall effect is to provide universal access to core services, the resources of each partner may only be used to provide services that are authorized and provided under the partner's program to individuals who are eligible under such program. (WIA sec. 121(b)(1).)

Subpart C—Memorandum of Understanding for the One-Stop Delivery System

§ 662.300 What is the Memorandum of Understanding (MOU)?

(a) The Memorandum of Understanding (MOU) is an agreement developed and executed between the Local Board, with the agreement of the chief elected official, and the One-Stop partners relating to the operation of the One-Stop delivery system in the local area.

(b) The MOU must contain the provisions required by WIA section 121(c)(2). These provisions cover services to be provided through the One-Stop delivery system; the funding of the services and operating costs of the system; and methods for referring individuals between the One-Stop operators and partners. The MOU's provisions also must determine the duration and procedures for amending the MOU, and may contain any other provisions that are consistent with WIA title I and the WIA regulations agreed to by the parties. (WIA sec. 121(c).)

§ 662.310 Is there a single MOU for the local area or are there to be separate MOU's between the Local Board and each partner?

(a) A single ''umbrella'' MOU may be developed that addresses the issues relating to the local One-Stop delivery system for the Local Board, chief elected official and all partners, or the Local Board, chief elected official and the partners may decide to enter into separate agreements between the Local Board (with the agreement of the chief elected official) and one or more partners. Under either approach, the requirements described in this subpart apply. Since funds are generally appropriated annually, financial agreements may be negotiated with each partner annually to clarify funding of services and operating costs of the system under the MOU.

(b) WIA emphasizes full and effective partnerships between Local Boards, chief elected officials and One-Stop partners. Local Boards and partners

must enter into good-faith negotiations. Local Boards, chief elected officials and partners may request assistance from a State agency responsible for administering the partner program, the Governor, State Board, or other appropriate parties. The State agencies, the State Board, and the Governor may also consult with the appropriate Federal agencies to address impasse situations after exhausting other alternatives. The Local Board and partners must document the negotiations and efforts that have taken place. Any failure to execute an MOU between a Local Board and a required partner must be reported by the Local Board and the required partner to the Governor or State Board, and the State agency responsible for administering the partner's program, and by the Governor or the State Board and the responsible State agency to the Secretary of Labor and to the head of any other Federal agency with responsibility for oversight of a partner's program. (WIA sec. 121(c).)

(c) If an impasse has not been resolved through the alternatives available under this section any partner that fails to execute an MOU may not be permitted to serve on the Local Board. In addition, any local area in which a Local Board has failed to execute an MOU with all of the required partners is not eligible for State incentive grants awarded on the basis of local coordination of activities under 20 CFR 665.200(d)(2). These sanctions are in addition to, not in lieu of, any other remedies that may be applicable to the Local Board or to each partner for failure to comply with the statutory requirement.

Subpart D—One-Stop Operators

§ 662.400 Who is the One-Stop operator?

(a) The One-Stop operator is the entity that performs the role described in paragraph (c) of this section. The types of entities that may be selected to be the One-Stop operator include:

(1) A postsecondary educational institution;

(2) An Employment Service agency established under the Wagner-Peyser Act on behalf of the local office of the agency;

(3) A private, nonprofit organization (including a community-based organization);

(4) A private for-profit entity;

(5) A government agency; and

(6) Another interested organization or entity.

(b) One-Stop operators may be a single entity or a consortium of entities and may operate one or more One-Stop centers. In addition, there may be more than one One-Stop operator in a local area.

(c) The agreement between the Local Board and the One-Stop operator shall specify the operator's role. That role may range between simply coordinating service providers within the center, to being the primary provider of services within the center, to coordinating activities throughout the One-Stop system. (WIA sec. 121(d).)

§ 662.410 How is the One-Stop operator selected?

(a) The Local Board, with the agreement of the chief elected official, must designate and certify One-Stop operators in each local area.

(b) The One-Stop operator is designated or certified:

(1) Through a competitive process,

(2) Under an agreement between the Local Board and a consortium of entities that includes at least three or more of the required One-Stop partners.identified at § 662.200, or

(3) Under the conditions described in §§ 662.420 or 662.430. (WIA sec.121(d), 121(e) and 117(f)(2))

(c) The designation or certification of the One-Stop operator must be carried out in accordance with the ''sunshine provision'' at 20 CFR 661.307.

§ 662.420 Under what limited conditions may the Local Board be designated or certified as the One-Stop operator?

(a) The Local Board may be designated or certified as the One-Stop operator only with the agreement of the chief elected official and the Governor.

(b) The designation or certification must be reviewed whenever the biennial certification of the Local Board is made under 20 CFR 663.300(a). (WIA sec. 117(f)(2).)

§ 662.430 Under what conditions may One-Stop operators designated to operate in a One-Stop delivery system established prior to the enactment of WIA be designated to continue as a One-Stop operator under WIA without meeting the requirements of § 662.410(b)?

Under WIA section 121(e), the Local Board, the chief elected official and the Governor may agree to certify an entity that has been serving as a One-Stop operator in a One-Stop delivery system established prior to the enactment of WIA (August 7, 1998) to continue to serve as a One-Stop operator without meeting the requirements for designation under § 662.410(b) if the local One-Stop delivery system is modified, as necessary, to meet the other requirements of this part, including the requirements relating to the inclusion of One-Stop partners, the execution of the MOU, and the provision of services.(WIA sec. 121(e).)

PART 663—ADULT AND DISLOCATED WORKER ACTIVITIES UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

Subpart A—Delivery of Adult and Dislocated Worker Services Through the One-Stop Delivery System

Sec.

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Subpart A—Delivery of Adult and Dislocated Worker Services Through the One-Stop Delivery System

§ 663.100 What is the role of the adult and dislocated worker programs in the One-Stop delivery system?

(a) The One-Stop system is the basic delivery system for adult and dislocated worker services. Through this system, adults and dislocated workers can access a continuum of services. The services are organized into three levels: core, intensive, and training.

(b) The chief elected official or his/her designee(s), as the local grant recipient(s) for the adult and dislocated worker programs, is a required One-Stop partner and is subject to the provisions relating to such partners described in 20 CFR part 662. Consistent with those provisions:

(1) Core services for adults and dislocated workers must be made available in at least one comprehensive One-Stop center in each local workforce investment area. Services may also be available elsewhere, either at affiliated sites or at specialized centers. For example, specialized centers may be established to serve workers being dislocated from a particular employer or industry, or to serve residents of public housing.

(2) The One-Stop centers also make intensive services available to adults and dislocated workers, as needed, either by the One-Stop operator directly or through contracts with service providers that are approved by the Local Board.

(3) Through the One-Stop system, adults and dislocated workers needing training are provided Individual Training Accounts (ITA's) and access to lists of eligible providers and programs of training. These lists contain quality consumer information, including cost and performance information for each of the providers' programs, so that participants can make informed choices

on where to use their ITA's. (ITA's are more fully discussed in subpart D of this part.)

§ 663.105 When must adults and dislocated workers be registered?

(a) Registration is the process for collecting information to support a determination of eligibility. This information may be collected through methods that include electronic data transfer, personal interview, or an individual's application.

(b) Adults and dislocated workers who receive services funded under title I other than self-service or informational activities must be registered and determined eligible.

(c) EO data must be collected on every individual who is interested in being considered for WIA title I financially assisted aid, benefits, services, or training by a recipient, and who has signified that interest by submitting personal information in response to a request from the recipient.

§ 663.110 What are the eligibility criteria for core services for adults in the adult and dislocated worker programs?

To be eligible to receive core services as an adult in the adult and dislocated worker programs, an individual must be 18 years of age or older. To be eligible for the dislocated worker programs, an eligible adult must meet the criteria of § 663.115. Eligibility criteria for intensive and training services are found at §§ 663.220 and 663.310.

§ 663.115 What are the eligibility criteria for core services for dislocated workers in the adult and dislocated worker programs?

(a) To be eligible to receive core services as a dislocated worker in the adult and dislocated worker programs, an individual must meet the definition of ''dislocated worker'' at WIA section 101(9). Eligibility criteria for intensive and training services are found at §§ 663.220 and 663.310.

(b) Governors and Local Boards may establish policies and procedures for One-Stop operators to use in determining an individual's eligibility as a dislocated worker, consistent with the definition at WIA section 101(9). These policies and procedures may address such conditions as:

(1) What constitutes a ''general announcement'' of plant closing under WIA section 101(9)(B)(ii) or (iii); and

(2) What constitutes ''unemployed as a result of general economic conditions in the community in which the individual resides or because of natural disasters'' for determining the eligibility of self-employed individuals, including family members and farm or ranch hands, under WIA section 101(9)(C).

§ 663.120 Are displaced homemakers eligible for dislocated worker activities under WIA?

(a) Yes, there are two significant differences from the eligibility requirements under the Job Training Partnership Act.

(b) Under the dislocated worker program in JTPA, displaced homemakers are defined as ''additional dislocated workers'' and are only eligible to receive services if the Governor determines that providing such services would not adversely affect the delivery of services to the other eligible dislocated workers. Under WIA section 101(9), displaced homemakers who meet the definition at WIA section 101(10) are eligible dislocated workers without any additional determination.

(c) The definition of displaced homemaker under JTPA included individuals who had been dependent upon public assistance under Aid for Families with Dependent Children (AFDC) as well as those who had been dependent on the income of another family member. The definition in WIA section 101(10) includes only those individuals who were dependent on a family member's income. Those individuals who have been dependent on public assistance may be served in the adult program.

§ 663.145 What services are WIA title I adult and dislocated workers formula funds used to provide?

(a) WIA title I formula funds allocated to local areas for adults and dislocated workers must be used to provide core, intensive and training services through the One-Stop delivery system. Local Boards determine the most appropriate mix of these services, but

all three types must be available for both adults and dislocated workers. There are different eligibility criteria for each of these types of services, which are described at §§ 663.110, 663.115, 663.220 and 663.310.

(b) WIA title I funds may also be used to provide the other services described in WIA section 134(e):

(1) Discretionary One-Stop delivery activities, including:

(i) Customized screening and referral of qualified participants in training services to employment; and

(ii) Customized employment-related services to employers on a fee-for-service basis that are in addition to labor exchange services available to employers under the Wagner-Peyser Act.

(2) Supportive services, including needs-related payments, as described in subpart H of this part.

§ 663.150 What core services must be provided to adults and dislocated workers?

(a) At a minimum, all of the core services described in WIA section 134(d)(2) and 20 CFR 662.240 must be provided in each local area through the One-Stop delivery system.

(b) Followup services must be made available, as appropriate, for a minimum of 12 months following the first day of employment, to registered participants who are placed in unsubsidized employment.

§ 663.155 How are core services delivered?

Core services must be provided through the One-Stop delivery system. Core services may be provided directly by the One-Stop operator or through contracts with service providers that are approved by the Local Board. The Local Board may only be a provider of core services when approved by the chief elected official and the Governor in accordance with the requirements of WIA section 117(f)(2) and 20 CFR 661.310.

§ 663.160 Are there particular core services an individual must receive before receiving intensive services under WIA section 134(d)(3)?

(a) Yes, at a minimum, an individual must receive at least one core service, such as an initial assessment or job search and placement assistance, before receiving intensive services. The initial assessment provides preliminary information about the individual's skill levels, aptitudes, interests, and supportive services needs. The job search and placement assistance helps the individual determine whether he or she is unable to obtain employment, and thus requires more intensive services to obtain employment. The decision on which core services to provide, and the timing of their delivery, may be made on a case-by-case basis at the local level depending upon the needs of the participant.

(b) A determination of the need for intensive services under § 663.220, as established by the initial assessment or the individual's inability to obtain employment through the core services provided, must be contained in the participant's case file.

§ 663.165 How long must an individual be in core services in order to be eligible for intensive services?

There is no Federally-required minimum time period for participation in core services before receiving intensive services. (WIA sec. 134(d)(3).)

Subpart B—Intensive Services

§ 663.200 What are intensive services for adults and dislocated workers?

(a) Intensive services are listed in WIA section 134(d)(3)(C). The list in the Act is not all-inclusive and other intensive services, such as out-of-area job search assistance, literacy activities related to basic workforce readiness, relocation assistance, internships, and work experience may be provided, based on an assessment or individual employment plan.

(b) For the purposes of paragraph (a) of this section, work experience is a planned, structured learning experience that takes place in a workplace for a limited period of time. Work experience may be paid or unpaid, as appropriate. A work experience workplace may be in the private for profit sector, the non-profit sector, or the public sector. Labor standards apply in any work experience where an employee/employer relationship, as defined by the Fair Labor Standards Act, exists.

§ 663.210 How are intensive services delivered?

(a) Intensive services must be provided through the One-Stop delivery system, including specialized One-Stop centers. Intensive services may be provided directly by the One-Stop operator or through contracts with service providers, which may include contracts with public, private for-profit, and private non-profit service providers (including specialized service providers), that are approved by the Local Board. (WIA secs. 117(d)(2)(D) and 134(d)(3)(B).)

(b) The Local Board may only be a provider of intensive services when approved by the chief elected official and the Governor in accordance with WIA section 117(f)(2) and 20 CFR 661.310.

§ 663.220 Who may receive intensive services?

There are two categories of adults and dislocated workers who may receive intensive services:

(a) Adults and dislocated workers who are unemployed, have received at least one core service and are unable to obtain employment through core services, and are determined by a One-Stop operator to be in need of more intensive services to obtain employment; and

(b) Adults and dislocated workers who are employed, have received at least one core service, and are determined by a One-Stop operator to be in need of intensive services to obtain or retain employment that leads to self-sufficiency, as described in § 663.230.

§ 663.230 What criteria must be used to determine whether an employed worker needs intensive services to obtain or retain employment leading to "self-sufficiency"?

State Boards or Local Boards must set the criteria for determining whether employment leads to self-sufficiency. At a minimum, such criteria must provide that self-sufficiency means employment that pays at least the lower living standard income level, as defined in WIA section 101(24). Self-sufficiency for a dislocated worker may be defined in relation to a percentage of the layoff wage. The special needs of individuals with disabilities or other barriers to employment should be taken into account when setting criteria to determine self-sufficiency.

§ 663.240 Are there particular intensive services an individual must receive before receiving training services under WIA section 134(d)(4)(A)(i)?

(a) Yes, at a minimum, an individual must receive at least one intensive service, such as development of an individual employment plan with a case manager or individual counseling and career planning, before the individual may receive training services.

(b) The case file must contain a determination of need for training services under § 663.310, as identified in the individual employment plan, comprehensive assessment, or through any other intensive service received.

§ 663.245 What is the individual employment plan?

The individual employment plan is an ongoing strategy jointly developed by the participant and the case manager that identifies the participant's employment goals, the appropriate achievement objectives, and the appropriate combination of services for the participant to achieve the employment goals.

§ 663.250 How long must an individual participant be in intensive services to be eligible for training services?

There is no Federally-required minimum time period for participation in intensive services before receiving training services. The period of time an individual spends in intensive services should be sufficient to prepare the individual for training or employment. (WIA sec. 134(d)(4)(A)(i).)

Subpart C—Training Services

§ 663.300 What are training services for adults and dislocated workers?

Training services are listed in WIA section 134(d)(4)(D). The list in the Act is not all-inclusive and additional training services may be provided.

§ 663.310 Who may receive training services?

Training services may be made available to employed and unemployed adults and dislocated workers who:

(a) Have met the eligibility requirements for intensive services, have received at least one intensive service under § 663.240, and have been determined to be unable to obtain or retain employment through such services;

(b) After an interview, evaluation, or assessment, and case management, have been determined by a One-Stop operator or One-Stop partner, to be in need of training services and to have the skills and qualifications to successfully complete the selected training program;

(c) Select a program of training services that is directly linked to the employment opportunities either in the local area or in another area to which the individual is willing to relocate;

(d) Are unable to obtain grant assistance from other sources to pay the costs of such training, including such sources as Welfare-to-Work, State-funded training funds, Trade Adjustment Assistance and Federal Pell Grants established under title IV of the Higher Education Act of 1965, or require WIA assistance in addition to other sources of grant assistance, including Federal Pell Grants (provisions relating to fund coordination are found at § 663.320 and WIA section 134(d)(4)(B)); and

(e) For individuals whose services are provided through the adult funding stream, are determined eligible in accordance with the State and local priority system, if any, in effect for adults under WIA section 134(d)(4)(E) and § 663.600. (WIA sec. 134(d)(4)(A).)

§ 663.320 What are the requirements for coordination of WIA training funds and other grant assistance?

(a) WIA funding for training is limited to participants who:

(1) Are unable to obtain grant assistance from other sources to pay the costs of their training; or

(2) Require assistance beyond that available under grant assistance from other sources to pay the costs of such training. Program operators and training providers must coordinate funds available to pay for training as described in paragraphs (b) and (c) of this section.

(b) Program operators must coordinate training funds available and make funding arrangements with One-Stop partners and other entities to apply the provisions of paragraph (a) of this section. Training providers must consider the availability of other sources of grants to pay for training costs such as Welfare-to-Work, State-funded training funds, and Federal Pell Grants, so that WIA funds supplement other sources of training grants.

(c) A WIA participant may enroll in WIA-funded training while his/her application for a Pell Grant is pending as long as the One-Stop operator has made arrangements with the training provider and the WIA participant regarding allocation of the Pell Grant, if it is subsequently awarded. In that case, the training provider must reimburse the One-Stop operator the WIA funds used to underwrite the training for the amount the Pell Grant covers. Reimbursement is not required from the portion of Pell Grant assistance disbursed to the WIA participant for education-related expenses. (WIA sec. 134(d)(4)(B).)

Subpart D—Individual Training Accounts

§ 663.400 How are training services provided?

Except under the three conditions described in WIA section 134(d)(4)(G)(ii) and § 663.430(a), the Individual Training Account (ITA) is established for eligible individuals to finance training services. Local Boards may only provide training services under § 663.430 if they receive a waiver from the Governor and meet the requirements of 20 CFR 661.310 and WIA section 117(f)(1). (WIA sec. 134(d)(4)(G).)

§ 663.410 What is an Individual Training Account (ITA)?

The ITA is established on behalf of a participant. WIA title I adult and dislocated workers purchase training services from eligible providers they select in consultation with the case manager. Payments from ITA's may be made in a variety of ways, including

the electronic transfer of funds through financial institutions, vouchers, or other appropriate methods. Payments may also be made incrementally; through payment of a portion of the costs at different points in the training course. (WIA sec. 134(d)(4)(G).)

§ 663.420 Can the duration and amount of ITA's be limited?

(a) Yes, the State or Local Board may impose limits on ITA's, such as limitations on the dollar amount and/or duration.

(b) Limits to ITA's may be established in different ways:

(1) There may be a limit for an individual participant that is based on the needs identified in the individual employment plan; or

(2) There may be a policy decision by the State Board or Local Board to establish a range of amounts and/or a maximum amount applicable to all ITA's.

(c) Limitations established by State or Local Board policies must be described in the State or Local Plan, respectively, but should not be implemented in a manner that undermines the Act's requirement that training services are provided in a manner that maximizes customer choice in the selection of an eligible training provider. ITA limitations may provide for exceptions to the limitations in individual cases.

(d) An individual may select training that costs more than the maximum amount available for ITAs under a State or local policy when other sources of funds are available to supplement the ITA. These other sources may include: Pell Grants; scholarships; severance pay; and other sources.

§ 663.430 Under what circumstances may mechanisms other than ITA's be used to provide training services?

(a) Contracts for services may be used instead of ITA's only when one of the following three exceptions applies:

(1) When the services provided are on-the-job training (OJT) or customized training;

(2) When the Local Board determines that there are an insufficient number of eligible providers in the local area to accomplish the purpose of a system of ITA's. The Local Plan must describe the process to be used in selecting the providers under a contract for services. This process must include a public comment period for interested providers of at least 30 days;

(3) When the Local Board determines that there is a training services program of demonstrated effectiveness offered in the area by a community-based organization (CBO) or another private organization to serve special participant populations that face multiple barriers to employment, as described in paragraph (b) in this section. The Local Board must develop criteria to be used in determining demonstrated effectiveness, particularly as it applies to the special participant population to be served. The criteria may include:

(i) Financial stability of the organization;

(ii) Demonstrated performance in the delivery of services to hard to serve participant populations through such means as program completion rate; attainment of the skills, certificates or degrees the program is designed to provide; placement after training in unsubsidized employment; and retention in employment; and

(iii) How the specific program relates to the workforce investment needs identified in the local plan.

(b) Under paragraph (a)(3) of this section, special participant populations that face multiple barriers to employment are populations of low-income individuals that are included in one or more of the following categories:

(1) Individuals with substantial language or cultural barriers;

(2) Offenders;

(3) Homeless individuals; and

(4) Other hard-to-serve populations as defined by the Governor.

§ 663.440 What are the requirements for consumer choice?

(a) Training services, whether under ITA's or under contract, must be provided in a manner that maximizes informed consumer choice in selecting an eligible provider.

(b) Each Local Board, through the One-Stop center, must make available to customers the State list of eligible providers required in WIA section

122(e). The list includes a description of the programs through which the providers may offer the training services, the information identifying eligible providers of on-the-job training and customized training required under WIA section 122(h) (where applicable), and the performance and cost information about eligible providers of training services described in WIA sections 122 (e) and (h).

(c) An individual who has been determined eligible for training services under § 663.310 may select a provider described in paragraph (b) of this section after consultation with a case manager. Unless the program has exhausted training funds for the program year, the operator must refer the individual to the selected provider, and establish an ITA for the individual to pay for training. For purposes of this paragraph, a referral may be carried out by providing a voucher or certificate to the individual to obtain the training.

(d) The cost of referral of an individual with an ITA to a training provider is paid by the applicable adult or dislocated worker program under title I of WIA.

Subpart E—Eligible Training Providers

§ 663.500 What is the purpose of this subpart?

The workforce investment system established under WIA emphasizes informed customer choice, system performance, and continuous improvement. The eligible provider process is part of the strategy for achieving these goals. Local Boards, in partnership with the State, identify training providers and programs whose performance qualifies them to receive WIA funds to train adults and dislocated workers. In order to maximize customer choice and assure that all significant population groups are served, States and local areas should administer the eligible provider process in a manner to assure that significant numbers of competent providers, offering a wide variety of training programs and occupational choices, are available to customers. After receiving core and intensive services and in consultation with case managers, eligible participants who need training use the list of these eligible providers to make an informed choice. The ability of providers to successfully perform, the procedures State and Local Boards use to establish eligibility, and the degree to which information, including performance information, on those providers is made available to customers eligible for training services, are key factors affecting the successful implementation of the Statewide workforce investment system. This subpart describes the process for determining eligible training providers.

§ 663.505 What are eligible providers of training services?

(a) Eligible providers of training services are described in WIA section 122. They are those entities eligible to receive WIA title I-B funds to provide training services to eligible adult and dislocated worker customers.

(b) In order to provide training services under WIA title I-B, a provider must meet the requirements of this subpart and WIA section 122.

(1) These requirements apply to the use of WIA title I adult and dislocated worker funds to provide training:

(i) To individuals using ITA's to access training through the eligible provider list; and

(ii) To individuals for training provided through the exceptions to ITA's described at § 663.430 (a)(2) and (a)(3).

(2) These requirements apply to all organizations providing training to adult and dislocated workers, including:

(i) Postsecondary educational institutions providing a program described in WIA section 122(a)(2)(A)(ii);

(ii) Entities that carry out programs under the National Apprenticeship Act (29 U.S.C. 50 *et seq.*);

(iii) Other public or private providers of a program of training services described in WIA section 122(a)(2)(C);

(iv) Local Boards, if they meet the conditions of WIA section 117(f)(1); and

(v) Community-based organizations and other private organizations providing training under § 663.430.

(c) Provider eligibility procedures must be established by the Governor, as required by this subpart. Different

procedures are described in WIA for determinations of ''initial'' and ''subsequent'' eligibility. Because the processes are different, they are discussed separately.

§ 663.508 What is a "program of training services"?

A program of training services is one or more courses or classes, or a structured regimen, that upon successful completion, leads to:

(a) A certificate, an associate degree, baccalaureate degree, or

(b) The skills or competencies needed for a specific job or jobs, an occupation, occupational group, or generally, for many types of jobs or occupations, as recognized by employers and determined prior to training.

§ 663.510 Who is responsible for managing the eligible provider process?

(a) The State and the Local Boards each have responsibilities for managing the eligible provider process.

(b) The Governor must establish eligibility criteria for certain providers to become initially eligible and must set minimum levels of performance for all providers to remain subsequently eligible.

(c) The Governor must designate a State agency (called the ''designated State agency'') to assist in carrying out WIA section 122. The designated State agency is responsible for:

(1) Developing and maintaining the State list of eligible providers and programs, which is comprised of lists submitted by Local Boards;

(2) Determining if programs meet performance levels, including verifying the accuracy of the information on the State list in consultation with the Local Boards, removing programs that do not meet program performance levels, and taking appropriate enforcement actions, against providers in the case of the intentional provision of inaccurate information, as described in WIA section 122(f)(1), and in the case of a substantial violation of the requirements of WIA, as described in WIA section 122(f)(2);

(3) Disseminating the State list, accompanied by performance and cost information relating to each provider, to One-Stop operators throughout the State.

(d) The Local Board must:

(1) Accept applications for initial eligibility from certain postsecondary institutions and entities providing apprenticeship training;

(2) Carry out procedures prescribed by the Governor to assist in determining the initial eligibility of other providers;

(3) Carry out procedures prescribed by the Governor to assist in determining the subsequent eligibility of all providers;

(4) Compile a local list of eligible providers, collect the performance and cost information and any other required information relating to providers;

(5) Submit the local list and information to the designated State agency;

(6) Ensure the dissemination and appropriate use of the State list through the local One-Stop system;

(7) Consult with the designated State agency in cases where termination of an eligible provider is contemplated because inaccurate information has been provided; and

(8) Work with the designated State agency in cases where the termination of an eligible provider is contemplated because of violations of the Act.

(e) The Local Board may:

(1) Make recommendations to the Governor on the procedures to be used in determining initial eligibility of certain providers;

(2) Increase the levels of performance required by the State for local providers to maintain subsequent eligibility;

(3) Require additional verifiable program-specific information from local providers to maintain subsequent eligibility.

§ 663.515 What is the process for initial determination of provider eligibility?

(a) To be eligible to receive adult or dislocated worker training funds under title I of WIA, all providers must submit applications to the Local Boards in the areas in which they wish to provide services. The application must describe each program of training services to be offered.

(b) For programs eligible under title IV of the Higher Education Act and apprenticeship programs registered under the National Apprenticeship Act (NAA), and the providers or such programs, Local Boards determine the procedures to use in making an application. The procedures established by the Local Board must specify the timing, manner, and contents of the required application.

(c) For programs not eligible under title IV of the HEA or registered under the NAA, and for providers not eligible under title IV of the HEA or carrying out apprenticeship programs under NAA:

(1) The Governor must develop a procedure for use by Local Boards for determining the eligibility of other providers, after

(i) Soliciting and taking into consideration recommendations from Local Boards and providers of training services within the State;

(ii) Providing an opportunity for interested members of the public, including representatives of business and labor organizations, to submit comments on the procedure; and

(iii) Designating a specific time period for soliciting and considering the recommendations of Local Boards and provider, and for providing an opportunity for public comment.

(2) The procedure must be described in the State Plan.

(3)(i) The procedure must require that the provider must submit an application to the Local Board at such time and in such manner as may be required, which contains a description of the program of training services;

(ii) If the provider provides a program of training services on the date of application, the procedure must require that the application include an appropriate portion of the performance information and program cost information described in § 663.540, and that the program meet appropriate levels of performance;

(iii) If the provider does not provide a program of training services on that date, the procedure must require that the provider meet appropriate requirements specified in the procedure. (WIA sec. 122(b)(2)(D).)

(d) The Local Board must include providers that meet the requirements of paragraphs (b) and (c) of this section on a local list and submit the list to the designated State agency. The State agency has 30 days to determine that the provider or its programs do not meet the requirements relating to the providers under paragraph (c) of this section. After the agency determines that the provider and its programs meet(s) the criteria for initial eligibility, or 30 days have elapsed, whichever occurs first, the provider and its programs are initially eligible. The programs and providers submitted under paragraph (b) of this section are initially eligible without State agency review. (WIA sec. 122(e).)

§ 663.530 Is there a time limit on the period of initial eligibility for training providers?

Yes, under WIA section 122(c)(5), the Governor must require training providers to submit performance information and meet performance levels annually in order to remain eligible providers. States may require that these performance requirements be met one year from the date that initial eligibility was determined, or may require all eligible providers to submit performance information by the same date each year. If the latter approach is adopted, the Governor may exempt eligible providers whose determination of initial eligibility occurs within six months of the date of submissions. The effect of this requirement is that no training provider may have a period of initial eligibility that exceeds eighteen months. In the limited circumstance when insufficient data is available, initial eligibility may be extended for a period of up to six additional months, if the Governor's procedures provide for such an extension.

§ 663.535 What is the process for determining the subsequent eligibility of a provider?

(a) The Governor must develop a procedure for the Local Board to use in determining the subsequent eligibility of all eligible training providers determined initially eligible under § 663.515 (b) and (c), after:

(1) Soliciting and taking into consideration recommendations from Local Boards and providers of training services within the State;

(2) Providing an opportunity for interested members of the public, including representatives of business and labor organizations, to submit comments on such procedure; and

(3) Designating a specific time period for soliciting and considering the recommendations of Local Boards and providers, and for providing an opportunity for public comment.

(b) The procedure must be described in the State Plan.

(c) The procedure must require that:

(1) Providers annually submit performance and cost information as described at WIA section 122(d)(1) and (2), for each program of training services for which the provider has been determined to be eligible, in a time and manner determined by the Local Board;

(2) Providers and programs annually meet minimum performance levels described at WIA section 122(c)(6), as demonstrated utilizing UI quarterly wage records where appropriate.

(d) The program's performance information must meet the minimum acceptable levels established under paragraph (c)(2) of this section to remain eligible;

(e) Local Boards may require higher levels of performance for local programs than the levels specified in the procedures established by the Governor. (WIA sec.122(c)(5) and (c)(6).)

(f) The State procedure must require Local Boards to take into consideration:

(1) The specific economic, geographic and demographic factors in the local areas in which providers seeking eligibility are located, and

(2) The characteristics of the populations served by programs seeking eligibility, including the demonstrated difficulties in serving these populations, where applicable.

(g) The Local Board retains those programs on the local list that meet the required performance levels and other elements of the State procedures and submits the list, accompanied by the performance and cost information, and any additional required information, to the designated State agency. If the designated State agency determines within 30 days from the receipt of the information that the program does not meet the performance levels established under paragraph (c)(2) of this section, the program may be removed from the list. A program retained on the local list and not removed by the designated State agency is considered an eligible program of training services.

§ 663.540 What kind of performance and cost information is required for determinations of subsequent eligibility?

(a) Eligible providers of training services must submit, at least annually, under procedures established by the Governor under § 663.535(c):

(1) Verifiable program-specific performance information, including:

(i) The information described in WIA section 122(d)(1)(A)(i) for all individuals participating in the programs of training services, including individuals who are not receiving assistance under WIA section 134 and individuals who are receiving such assistance; and

(ii) The information described in WIA section 122(d)(1)(A)(ii) relating only to individuals receiving assistance under the WIA adult and dislocated worker program who are participating in the applicable program of training services; and

(2) Information on program costs (such as tuition and fees) for WIA participants in the program.

(b) Governors may require any additional verifiable performance information (such as the information described at WIA section 122(d)(2)) that the Governor determines to be appropriate to obtain subsequent eligibility, including information regarding all participating individuals as well as individuals receiving assistance under the WIA adult and dislocated worker program.

(c) Governors must establish procedures by which providers can demonstrate if the additional information required under paragraph (b) of this section imposes extraordinary costs on providers, or if providers experience extraordinary costs in the collection of

information. If, through these procedures, providers demonstrate that they experience such extraordinary costs:

(1) The Governor or Local Board must provide access to cost-effective methods for the collection of the information; or

(2) The Governor must provide additional resources to assist providers in the collection of the information from funds for Statewide workforce investment activities reserved under WIA sections 128(a) and 133(a)(1).

(d) The Local Board and the designated State agency may accept program-specific performance information consistent with the requirements for eligibility under title IV of the Higher Education Act of 1965 from a provider for purposes of enabling the provider to fulfill the applicable requirements of this section, if the information is substantially similar to the information otherwise required under this section.

§ 663.550 How is eligible provider information developed and maintained?

(a) The designated State agency must maintain a list of all eligible training programs and providers in the State (the ''State list'').

(b) The State list is a compilation of the eligible programs and providers identified or retained by local areas and that have not been removed under §§ 663.535(g) and 663.565.

(c) The State list must be accompanied by the performance and cost information contained in the local lists as required by § 663.535(e). (WIA sec. 122(e)(4)(A).)

§ 663.555 How is the State list disseminated?

(a) The designated State agency must disseminate the State list and accompanying performance and cost information to the One-Stop delivery systems within the State.

(b) The State list and information must be updated at least annually.

(c) The State list and accompanying information form the primary basis of the One-Stop consumer reports system that provides for informed customer choice. The list and information must be widely available, through the One-Stop delivery system, to customers seeking information on training outcomes, as well as participants in employment and training activities funded under WIA and other programs.

(1) The State list must be made available to individuals who have been determined eligible for training services under § 663.310.

(2) The State list must also be made available to customers whose training is supported by other One-Stop partners.

§ 663.565 May an eligible training provider lose its eligibility?

(a) Yes. A training provider must deliver results and provide accurate information in order to retain its status as an eligible training provider.

(b) If the provider's programs do not meet the established performance levels, the programs will be removed from the eligible provider list.

(1) A Local Board must determine, during the subsequent eligibility determination process, whether a provider's programs meet performance levels. If the program fails to meet such levels, the program must be removed from the local list. If all of the provider's programs fail to meet such levels, the provider must be removed from the local list.

(2) The designated State agency upon receipt of the performance information accompanying the local list, may remove programs from the State list if the agency determines the program failed to meet the levels of performance prescribed under § 663.535(c). If all of the provider's programs are determined to have failed to meet the levels, the designated State agency may remove the provider from the State list.

(3) Providers determined to have intentionally supplied inaccurate information or to have subsequently violated any provision of title I of WIA or the WIA regulations, including 29 CFR part 37, may be removed from the list in accordance with the enforcement provisions of WIA section 122(f). A provider whose eligibility is terminated under these conditions is liable to repay all adult and dislocated worker training funds it received during the period of noncompliance.

(4) The Governor must establish appeal procedures for providers of training to appeal a denial of eligibility under this subpart according to the requirements of 20 CFR 667.640(b).

§ 663.570 What is the consumer reports system?

The consumer reports system, referred to in WIA as performance information, is the vehicle for informing the customers of the One-Stop delivery system about the performance of training providers and programs in the local area. It is built upon the State list of eligible providers and programs developed through the procedures described in WIA section 122 and this subpart. The consumer reports system must contain the information necessary for an adult or dislocated worker customer to fully understand the options available to him or her in choosing a program of training services. Such program-specific factors may include overall performance, performance for significant customer groups (including wage replacement rates for dislocated workers), performance of specific provider sites, current information on employment and wage trends and projections, and duration of training programs.

§ 663.575 In what ways can a Local Board supplement the information available from the State list?

(a) Local Boards may supplement the information available from the State list by providing customers with additional information to assist in supporting informed customer choice and the achievement of local performance measures (as described in WIA section 136).

(b) This additional information may include:

(1) Information on programs of training services that are linked to occupations in demand in the local area;

(2) Performance and cost information, including program-specific performance and cost information, for the local outlet(s) of multi-site eligible providers; and

(3) Other appropriate information related to the objectives of WIA, which may include the information described in § 663.570.

§ 663.585 May individuals choose training providers located outside of the local area?

Yes, individuals may choose any of the eligible providers and programs on the State list. A State may also establish a reciprocal agreement with another State(s) to permit providers of eligible training programs in each State to accept individual training accounts provided by the other State. (WIA secs. 122(e)(4) and (e)(5).)

§ 663.590 May a community-based organization (CBO) be included on an eligible provider list?

Yes, CBO's may apply and they and their programs may be determined eligible providers of training services, under WIA section 122 and this subpart. As eligible providers, CBO's provide training through ITA's and may also receive contracts for training special participant populations when the requirements of § 663.430 are met.

§ 663.595 What requirements apply to providers of OJT and customized training?

For OJT and customized training providers, One-Stop operators in a local area must collect such performance information as the Governor may require, determine whether the providers meet such performance criteria as the Governor may require, and disseminate a list of providers that have met such criteria, along with the relevant performance information about them, through the One-Stop delivery system. Providers determined to meet the criteria are considered to be identified as eligible providers of training services. These providers are not subject to the other requirements of WIA section 122 or this subpart.

Subpart F—Priority and Special Populations

§ 663.600 What priority must be given to low-income adults and public assistance recipients served with adult funds under title I?

(a) WIA states, in section 134(d)(4)(E), that in the event that funds allocated to a local area for adult employment

and training activities are limited, priority for intensive and training services funded with title I adult funds must be given to recipients of public assistance and other low-income individuals in the local area.

(b) Since funding is generally limited, States and local areas must establish criteria by which local areas can determine the availability of funds and the process by which any priority will be applied under WIA section 134(d)(2)(E). Such criteria may include the availability of other funds for providing employment and training-related services in the local area, the needs of the specific groups within the local area, and other appropriate factors.

(c) States and local areas must give priority for adult intensive and training services to recipients of public assistance and other low-income individuals, unless the local area has determined that funds are not limited under the criteria established under paragraph (b) of this section.

(d) The process for determining whether to apply the priority established under paragraph (b) of this section does not necessarily mean that only the recipients of public assistance and other low income individuals may receive WIA adult funded intensive and training services when funds are determined to be limited in a local area. The Local Board and the Governor may establish a process that gives priority for services to the recipients of public assistance and other low income individuals and that also serves other individuals meeting eligibility requirements.

§ 663.610 Does the statutory priority for use of adult funds also apply to dislocated worker funds?

No, the statutory priority applies to adult funds for intensive and training services only. Funds allocated for dislocated workers are not subject to this requirement.

§ 663.620 How do the Welfare-to-Work program and the TANF program relate to the One-Stop delivery system?

(a) The local Welfare-to-Work (WtW) program operator is a required partner in the One-Stop delivery system. 20 CFR part 662 describes the roles of such partners in the One-Stop delivery system and applies to the Welfare-to-Work program operator. WtW programs serve individuals who may also be served by the WIA programs and, through appropriate linkages and referrals, these customers will have access to a broader range of services through the cooperation of the WtW program in the One-Stop system. WtW participants, who are determined to be WIA eligible, and who need occupational skills training may be referred through the One-Stop system to receive WIA training, when WtW grant and other grant funds are not available in accordance with § 663.320(a). WIA participants who are also determined WtW eligible, may be referred to the WtW operator for job placement and other WtW assistance.

(b) The local TANF agency is specifically suggested under WIA as an additional partner in the One-Stop system. TANF recipients will have access to more information about employment opportunities and services when the TANF agency participates in the One-Stop delivery system. The Governor and Local Board should encourage the TANF agency to become a One-Stop partner to improve the quality of services to the WtW and TANF-eligible populations. In addition, becoming a One-Stop partner will ensure that the TANF agency is represented on the Local Board and participates in developing workforce investment strategies that help cash assistance recipients secure lasting employment.

§ 663.630 How does a displaced homemaker qualify for services under title I?

Displaced homemakers may be eligible to receive assistance under title I in a variety of ways, including:

(a) Core services provided by the One-Stop partners through the One-Stop delivery system;

(b) Intensive or training services for which an individual qualifies as a dislocated worker/displaced homemaker if the requirements of this part are met;

(c) Intensive or training services for which an individual is eligible if the requirements of this part are met;

(d) Statewide employment and training projects conducted with reserve

funds for innovative programs for displaced homemakers, as described in 20 CFR 665.210(f).

§ 663.640 May an individual with a disability whose family does not meet income eligibility criteria under the Act be eligible for priority as a low-income adult?

Yes, even if the family of an individual with a disability does not meet the income eligibility criteria, the individual with a disability is to be considered a low-income individual if the individual's own income:

(a) Meets the income criteria established in WIA section 101(25)(B); or

(b) Meets the income eligibility criteria for cash payments under any Federal, State or local public assistance program. (WIA sec. 101(25)(F).)

Subpart G—On-the-Job Training (OJT) and Customized Training

§ 663.700 What are the requirements for on-the-job training (OJT)?

(a) On-the-job training (OJT) is defined at WIA section 101(31). OJT is provided under a contract with an employer in the public, private non-profit, or private sector. Through the OJT contract, occupational training is provided for the WIA participant in exchange for the reimbursement of up to 50 percent of the wage rate to compensate for the employer's extraordinary costs. (WIA sec. 101(31)(B).)

(b) The local program must not contract with an employer who has previously exhibited a pattern of failing to provide OJT participants with continued long-term employment with wages, benefits, and working conditions that are equal to those provided to regular employees who have worked a similar length of time and are doing the same type of work. (WIA sec. 195(4).)

(c) An OJT contract must be limited to the period of time required for a participant to become proficient in the occupation for which the training is being provided. In determining the appropriate length of the contract, consideration should be given to the skill requirements of the occupation, the academic and occupational skill level of the participant, prior work experience, and the participant's individual employment plan. (WIA sec. 101(31)(C).)

§ 663.705 What are the requirements for OJT contracts for employed workers?

OJT contracts may be written for eligible employed workers when:

(a) The employee is not earning a self-sufficient wage as determined by Local Board policy;

(b) The requirements in § 663.700 are met; and

(c) The OJT relates to the introduction of new technologies, introduction to new production or service procedures, upgrading to new jobs that require additional skills, workplace literacy, or other appropriate purposes identified by the Local Board.

§ 663.710 What conditions govern OJT payments to employers?

(a) On-the-job training payments to employers are deemed to be compensation for the extraordinary costs associated with training participants and the costs associated with the lower productivity of the participants.

(b) Employers may be reimbursed up to 50 percent of the wage rate of an OJT participant for the extraordinary costs of providing the training and additional supervision related to the OJT. (WIA sec. 101(31)(B).)

(c) Employers are not required to document such extraordinary costs.

§ 663.715 What is customized training?

Customized training is training:

(a) That is designed to meet the special requirements of an employer (including a group of employers);

(b) That is conducted with a commitment by the employer to employ, or in the case of incumbent workers, continue to employ, an individual on successful completion of the training; and

(c) For which the employer pays for not less than 50 percent of the cost of the training. (WIA sec. 101(8).)

§ 663.720 What are the requirements for customized training for employed workers?

Customized training of an eligible employed individual may be provided for an employer or a group of employers when:

(a) The employee is not earning a self-sufficient wage as determined by Local Board policy;

(b) The requirements in § 663.715 are met; and

(c) The customized training relates to the purposes described in § 663.705(c) or other appropriate purposes identified by the Local Board.

§ 663.730 May funds provided to employers for OJT of customized training be used to assist, promote, or deter union organizing?

No, funds provided to employers for OJT or customized training must not be used to directly or indirectly assist, promote or deter union organizing.

Subpart H—Supportive Services

§ 663.800 What are supportive services for adults and dislocated workers?

Supportive services for adults and dislocated workers are defined at WIA sections 101(46) and 134(e)(2) and (3). They include services such as transportation, child care, dependent care, housing, and needs-related payments, that are necessary to enable an individual to participate in activities authorized under WIA title I. Local Boards, in consultation with the One-Stop partners and other community service providers, must develop a policy on supportive services that ensures resource and service coordination in the local area. Such policy should address procedures for referral to such services, including how such services will be funded when they are not otherwise available from other sources. The provision of accurate information about the availability of supportive services in the local area, as well as referral to such activities, is one of the core services that must be available to adults and dislocated workers through the One-Stop delivery system. (WIA sec. 134(d)(2)(H).)

§ 663.805 When may supportive services be provided to participants?

(a) Supportive services may only be provided to individuals who are:

(1) Participating in core, intensive or training services; and

(2) Unable to obtain supportive services through other programs providing such services. (WIA sec. 134(e)(2)(A) and (B).)

(b) Supportive services may only be provided when they are necessary to enable individuals to participate in title I activities. (WIA sec. 101(46).)

§ 663.810 Are there limits on the amounts or duration of funds for supportive services?

(a) Local Boards may establish limits on the provision of supportive services or provide the One-Stop operator with the authority to establish such limits, including a maximum amount of funding and maximum length of time for supportive services to be available to participants.

(b) Procedures may also be established to allow One-Stop operators to grant exceptions to the limits established under paragraph (a) of this section.

§ 663.815 What are needs-related payments?

Needs-related payments provide financial assistance to participants for the purpose of enabling individuals to participate in training and are one of the supportive services authorized by WIA section 134(e)(3).

§ 663.820 What are the eligibility requirements for adults to receive needs-related payments?

Adults must:

(a) Be unemployed,

(b) Not qualify for, or have ceased qualifying for, unemployment compensation; and

(c) Be enrolled in a program of training services under WIA section 134(d)(4).

§ 663.825 What are the eligibility requirements for dislocated workers to receive needs-related payments?

To receive needs related payments, a dislocated worker must:

(a) Be unemployed, and:

(1) Have ceased to qualify for unemployment compensation or trade readjustment allowance under TAA or NAFTA-TAA; and

(2) Be enrolled in a program of training services under WIA section 134(d)(4) by the end of the 13th week after the most recent layoff that resulted in a

determination of the worker's eligibility as a dislocated worker, or, if later, by the end of the 8th week after the worker is informed that a short-term layoff will exceed 6 months; or

(b) Be unemployed and did not qualify for unemployment compensation or trade readjustment assistance under TAA or NAFTA-TAA.

§ 663.830 May needs-related payments be paid while a participant is waiting to start training classes?

Yes, payments may be provided if the participant has been accepted in a training program that will begin within 30 calendar days. The Governor may authorize local areas to extend the 30 day period to address appropriate circumstances.

§ 663.840 How is the level of needs-related payments determined?

(a) The payment level for adults must be established by the Local Board.

(b) For dislocated workers, payments must not exceed the greater of either of the following levels:

(1) For participants who were eligible for unemployment compensation as a result of the qualifying dislocation, the payment may not exceed the applicable weekly level of the unemployment compensation benefit; or

(2) For participants who did not qualify for unemployment compensation as a result of the qualifying layoff, the weekly payment may not exceed the poverty level for an equivalent period. The weekly payment level must be adjusted to reflect changes in total family income as determined by Local Board policies. (WIA sec. 134(e)(3)(C).)

PART 664—YOUTH ACTIVITIES UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

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Subpart A—Youth Councils

§ 664.100 What is the youth council?

(a) The duties and membership requirements of the youth council are described in WIA section 117(h) and 20 CFR 661.335 and 661.340.

(b) The purpose of the youth council is to provide expertise in youth policy and to assist the Local Board in:

(1) Developing and recommending local youth employment and training policy and practice;

(2) Broadening the youth employment and training focus in the community to incorporate a youth development perspective;

(3) Establishing linkages with other organizations serving youth in the local area; and

(4) Taking into account a range of issues that can have an impact on the success of youth in the labor market. (WIA sec. 117(h).)

§ 664.110 Who is responsible for oversight of youth programs in the local area?

(a) The Local Board, working with the youth council, is responsible for conducting oversight of local youth programs operated under the Act, to ensure both fiscal and programmatic accountability.

(b) Local program oversight is conducted in consultation with the local area's chief elected official.

(c) The Local Board may, after consultation with the CEO, delegate its responsibility for oversight of eligible youth providers, as well as other youth program oversight responsibilities, to the youth council, recognizing the advantage of delegating such responsibilities to the youth council whose members have expertise in youth issues. (WIA sec. 117(d); 117(h)(4).)

Subpart B—Eligibility for Youth Services

§ 664.200 Who is eligible for youth services?

An eligible youth is defined, under WIA sec. 101(13), as an individual who:

(a) Is age 14 through 21;

(b) Is a low income individual, as defined in the WIA section 101(25); and

(c) Is within one or more of the following categories:

(1) Deficient in basic literacy skills;

(2) School dropout;

(3) Homeless, runaway, or foster child;

(4) Pregnant or parenting;

(5) Offender; or

(6) Is an individual (including a youth with a disability) who requires additional assistance to complete an educational program, or to secure and hold employment. (WIA sec. 101(13).)

§ 664.205 How is the "deficient in basic literacy skills" criterion in § 664.200(c)(1) defined and documented?

(a) Definitions and eligibility documentation requirements regarding the ''deficient in basic literacy skills'' criterion in § 664.200(c)(1) may be established at the State or local level. These

definitions may establish such criteria as are needed to address State or local concerns, and must include a determination that an individual:

(1) Computes or solves problems, reads, writes, or speaks English at or below the 8th grade level on a generally accepted standardized test or a comparable score on a criterion-referenced test; or

(2) Is unable to compute or solve problems, read, write, or speak English at a level necessary to function on the job, in the individual's family or in society. (WIA secs. 101(19), 203(12).)

(b) In cases where the State Board establishes State policy on this criterion, the policy must be included in the State plan. (WIA secs. 101(13)(C)(i), 101(19).)

§ 664.210 How is the "requires additional assistance to complete an educational program, or to secure and hold employment" criterion in § 664.200(c)(6) defined and documented?

Definitions and eligibility documentation requirements regarding the ''requires additional assistance to complete an educational program, or to secure and hold employment'' criterion of § 664.200(c)(6) may be established at the State or local level. In cases where the State Board establishes State policy on this criterion, the policy must be included in the State Plan. (WIA sec. 101(13)(C)(iv).)

§ 664.215 Must youth participants be registered to participate in the youth program?

(a) Yes, all youth participants must be registered.

(b) Registration is the process of collecting information to support a determination of eligibility.

(c) Equal opportunity data must be collected during the registration process on any individual who has submitted personal information in response to a request by the recipient for such information.

§ 664.220 Is there an exception to permit youth who are not low-income individuals to receive youth services?

Yes, up to five percent of youth participants served by youth programs in a local area may be individuals who do not meet the income criterion for eligible youth, provided that they are within one or more of the following categories:

(a) School dropout;

(b) Basic skills deficient, as defined in WIA section 101(4);

(c) Are one or more grade levels below the grade level appropriate to the individual's age;

(d) Pregnant or parenting;

(e) Possess one or more disabilities, including learning disabilities;

(f) Homeless or runaway;

(g) Offender; or

(h) Face serious barriers to employment as identified by the Local Board. (WIA sec. 129(c)(5).)

§ 664.230 Are the eligibility barriers for eligible youth the same as the eligibility barriers for the five percent of youth participants who do not have to meet income eligibility requirements?

No, the barriers listed in §§ 664.200 and 664.220 are not the same. Both lists of eligibility barriers include school dropout, homeless or runaway, pregnant or parenting, and offender, but each list contains barriers not included on the other list.

§ 664.240 May a local program use eligibility for free lunches under the National School Lunch Program as a substitute for the income eligibility criteria under title I of WIA?

No, the criteria for income eligibility under the National School Lunch Program are not the same as the Act's income eligibility criteria. Therefore, the school lunch list may not be used as a substitute for income eligibility to determine who is eligible for services under the Act.

§ 664.250 May a disabled youth whose family does not meet income eligibility criteria under the Act be eligible for youth services?

Yes, even if the family of a disabled youth does not meet the income eligibility criteria, the disabled youth may be considered a low-income individual if the youth's own income:

(a) Meets the income criteria established in WIA section 101(25)(B); or

(b) Meets the income eligibility criteria for cash payments under any Federal, State or local public assistance program. (WIA sec. 101(25)(F).)

Subpart C—Out-of-School Youth

§ 664.300 Who is an "out-of-school youth"?

An out-of-school youth is an individual who:

(a) Is an eligible youth who is a school dropout; or

(b) Is an eligible youth who has either graduated from high school or holds a GED, but is basic skills deficient, unemployed, or underemployed. (WIA sec. 101(33).)

§ 664.310 When is dropout status determined, particularly for youth attending alternative schools?

A school dropout is defined as an individual who is no longer attending any school and who has not received a secondary school diploma or its recognized equivalent. A youth's dropout status is determined at the time of registration. A youth attending an alternative school at the time of registration is not a dropout. An individual who is out-of school at the time of registration and subsequently placed in an alternative school, may be considered an out-of-school youth for the purposes of the 30 percent expenditure requirement for out-of-school youth. (WIA sec. 101(39).)

§ 664.320 Does the requirement that at least 30 percent of youth funds be used to provide activities to out-of-school youth apply to all youth funds?

(a) Yes, the 30 percent requirement applies to the total amount of all funds allocated to a local area under WIA section 128(b)(2)(A) or (b)(3), except for local area expenditures for administrative purposes under 20 CFR 667.210(a)(2).

(b) Although it is not necessary to ensure that 30 percent of such funds spent on summer employment opportunities (or any other particular element of the youth program) are spent on out-of-school youth, the funds spent on these activities are included in the total to which the 30 percent requirement applies.

(c) There is a limited exception, at WIA section 129(c)(4)(B), under which certain small States may apply to the Secretary to reduce the minimum amount that must be spent on out-of-school youth. (WIA sec. 129(c)(4).)

Subpart D—Youth Program Design, Elements, and Parameters

§ 664.400 What is a local youth program?

A local youth program is defined as those youth activities offered by a Local Workforce Investment Board for a designated local workforce investment area, as specified in 20 CFR part 661.

§ 664.405 How must local youth programs be designed?

(a) The design framework of local youth programs must:

(1) Provide an objective assessment of each youth participant, that meets the requirements of WIA section 129(c)(1)(A), and includes a review of the academic and occupational skill levels, as well as the service needs, of each youth;

(2) Develop an individual service strategy for each youth participant that meets the requirements of WIA section 129(c)(1)(B), including identifying an age-appropriate career goal and consideration of the assessment results for each youth; and

(3) Provide preparation for postsecondary educational opportunities, provide linkages between academic and occupational learning, provide preparation for employment, and provide effective connections to intermediary organizations that provide strong links to the job market and employers.

(4) The requirement in WIA section 123 that eligible providers of youth services be selected by awarding a grant or contract on a competitive basis does not apply to the design framework component, such as services for intake, objective assessment and the development of individual service strategy, when these services are provided by the grant recipient/fiscal agent.

(b) The local plan must describe the design framework for youth program design in the local area, and how the ten program elements required in § 664.410 are provided within that framework.

(c) Local Boards must ensure appropriate links to entities that will foster the participation of eligible local area youth. Such links may include connections to:

(1) Local area justice and law enforcement officials;

(2) Local public housing authorities;

(3) Local education agencies;

(4) Job Corps representatives; and

(5) Representatives of other area youth initiatives, including those that serve homeless youth and other public and private youth initiatives.

(d) Local Boards must ensure that the referral requirements in WIA section 129(c)(3) for youth who meet the income eligibility criteria are met, including:

(1) Providing these youth with information regarding the full array of applicable or appropriate services available through the Local Board or other eligible providers, or One-Stop partners; and

(2) Referring these youth to appropriate training and educational programs that have the capacity to serve them either on a sequential or concurrent basis.

(e) In order to meet the basic skills and training needs of eligible applicants who do not meet the enrollment requirements of a particular program or who cannot be served by the program, each eligible youth provider must ensure that these youth are referred:

(1) For further assessment, as necessary, and

(2) To appropriate programs, in accordance with paragraph (d)(2) of this section.

(f) Local Boards must ensure that parents, youth participants, and other members of the community with experience relating to youth programs are involved in both the design and implementation of its youth programs.

(g) The objective assessment required under paragraph (a)(1) of this section or the individual service strategy required under paragraph (a)(2) of this section is not required if the program provider determines that it is appropriate to use a recent objective assessment or individual service strategy that was developed under another education or training program. (WIA section 129(c)(1).)

§ 664.410 Must local programs include each of the ten program elements listed in WIA section 129(c)(2) as options available to youth participants?

(a) Yes, local programs must make the following services available to youth participants:

(1) Tutoring, study skills training, and instruction leading to secondary school completion, including dropout prevention strategies;

(2) Alternative secondary school offerings;

(3) Summer employment opportunities directly linked to academic and occupational learning;

(4) Paid and unpaid work experiences, including internships and job shadowing, as provided in §§ 664.460 and 664.470;

(5) Occupational skill training;

(6) Leadership development opportunities, which include community service and peer-centered activities encouraging responsibility and other positive social behaviors;

(7) Supportive services, which may include the services listed in § 664.440;

(8) Adult mentoring for a duration of at least twelve (12) months, that may occur both during and after program participation;

(9) Followup services, as provided in § 664.450; and

(10) Comprehensive guidance and counseling, including drug and alcohol abuse counseling, as well as referrals to counseling, as appropriate to the needs of the individual youth.

(b) Local programs have the discretion to determine what specific program services will be provided to a youth participant, based on each participant's objective assessment and individual service strategy. (WIA sec. 129(c)(2).)

§ 664.420 What are leadership development opportunities?

Leadership development opportunities are opportunities that encourage

responsibility, employability, and other positive social behaviors such as:

(a) Exposure to postsecondary educational opportunities;

(b) Community and service learning projects;

(c) Peer-centered activities, including peer mentoring and tutoring;

(d) Organizational and team work training, including team leadership training;

(e) Training in decision-making, including determining priorities; and

(f) Citizenship training, including life skills training such as parenting, work behavior training, and budgeting of resources. (WIA sec. 129(c)(2)(F).)

§ 664.430 What are positive social behaviors?

Positive social behaviors are outcomes of leadership opportunities, often referred to as soft skills, which are incorporated by many local programs as part of their menu of services. Positive social behaviors focus on areas that may include the following:

(a) Positive attitudinal development;

(b) Self esteem building;

(c) Openness to working with individuals from diverse racial and ethnic backgrounds;

(d) Maintaining healthy lifestyles, including being alcohol and drug free;

(e) Maintaining positive relationships with responsible adults and peers, and contributing to the well being of one's community, including voting;

(f) Maintaining a commitment to learning and academic success;

(g) Avoiding delinquency;

(h) Postponed and responsible parenting; and

(i) Positive job attitudes and work skills. (WIA sec. 129(c)(2)(F).)

§ 664.440 What are supportive services for youth?

Supportive services for youth, as defined in WIA section 101(46), may include the following:

(a) Linkages to community services;

(b) Assistance with transportation;

(c) Assistance with child care and dependent care;

(d) Assistance with housing;

(e) Referrals to medical services; and

(f) Assistance with uniforms or other appropriate work attire and work-related tools, including such items as eye glasses and protective eye gear. (WIA sec. 129(c)(2)(G).)

§ 664.450 What are follow-up services for youth?

(a) Follow-up services for youth may include:

(1) The leadership development and supportive service activities listed in §§ 664.420 and 664.440;

(2) Regular contact with a youth participant's employer, including assistance in addressing work-related problems that arise;

(3) Assistance in securing better paying jobs, career development and further education;

(4) Work-related peer support groups;

(5) Adult mentoring; and

(6) Tracking the progress of youth in employment after training.

(b) All youth participants must receive some form of follow-up services for a minimum duration of 12 months. Follow-up services may be provided beyond twelve (12) months at the State or Local Board's discretion. The types of services provided and the duration of services must be determined based on the needs of the individual. The scope of these follow-up services may be less intensive for youth who have only participated in summer youth employment opportunities. (WIA sec. 129(c)(2)(I).)

§ 664.460 What are work experiences for youth?

(a) Work experiences are planned, structured learning experiences that take place in a workplace for a limited period of time. As provided in WIA section 129(c)(2)(D) and § 664.470, work experiences may be paid or unpaid.

(b) Work experience workplaces may be in the private, for-profit sector; the non-profit sector; or the public sector.

(c) Work experiences are designed to enable youth to gain exposure to the working world and its requirements. Work experiences are appropriate and desirable activities for many youth throughout the year. Work experiences should help youth acquire the personal attributes, knowledge, and skills needed to obtain a job and advance in employment. The purpose is to provide

the youth participant with the opportunities for career exploration and skill development and is not to benefit the employer, although the employer may, in fact, benefit from the activities performed by the youth. Work experiences may be subsidized or unsubsidized and may include the following elements:

(1) Instruction in employability skills or generic workplace skills such as those identified by the Secretary's Commission on Achieving Necessary Skills (SCANS);

(2) Exposure to various aspects of an industry;

(3) Progressively more complex tasks;

(4) Internships and job shadowing;

(5) The integration of basic academic skills into work activities;

(6) Supported work, work adjustment, and other transition activities;

(7) Entrepreneurship;

(8) Service learning;

(9) Paid and unpaid community service; and

(10) Other elements designed to achieve the goals of work experiences.

(d) In most cases, on-the-job training is not an appropriate work experiences activity for youth participants under age 18. Local program operators may choose, however, to use this service strategy for eligible youth when it is appropriate based on the needs identified by the objective assessment of an individual youth participant. (WIA sec. 129(c)(2)(D).)

§ 664.470 Are paid work experiences allowable activities?

Funds under the Act may be used to pay wages and related benefits for work experiences in the public; private, for-profit or non-profit sectors where the objective assessment and individual service strategy indicate that work experiences are appropriate. (WIA sec. 129(c)(2)(D).)

Subpart E—Concurrent Enrollment

§ 664.500 May youth participate in both youth and adult/dislocated worker programs concurrently?

(a) Yes, under the Act, eligible youth are 14 through 21 years of age. Adults are defined in the Act as individuals age 18 and older. Thus, individuals ages 18 through 21 may be eligible for both adult and youth programs. There is no specified age for the dislocated worker program.

(b) Individuals who meet the respective eligibility requirements may participate in adult and youth programs concurrently. Concurrent enrollment is allowable for youth served in programs under WIA titles I or II. Such individuals must be eligible under the youth or adult/dislocated worker eligibility criteria applicable to the services received. Local program operators may determine, for individuals in this age group, the appropriate level and balance of services under the youth, adult, dislocated worker, or other services.

(c) Local program operators must identify and track the funding streams which pay the costs of services provided to individuals who are participating in youth and adult/dislocated worker programs concurrently, and ensure that services are not duplicated.

§ 664.510 Are Individual Training Accounts allowed for youth participants?

No, however, individuals age 18 and above, who are eligible for training services under the adult and dislocated worker programs, may receive Individual Training Accounts through those programs. Requirements for concurrent participation requirements are set forth in § 664.500. To the extent possible, in order to enhance youth participant choice, youth participants should be involved in the selection of educational and training activities.

Subpart F—Summer Employment Opportunities

§ 664.600 Are Local Boards required to offer summer employment opportunities in the local youth program?

(a) Yes, Local Boards are required to offer summer youth employment opportunities that link academic and occupational learning as part of the menu of services required in § 664.410(a).

(b) Summer youth employment must provide direct linkages to academic and occupational learning, and may provide other elements and strategies

as appropriate to serve the needs and goals of the participants.

(c) Local Boards may determine how much of available youth funds will be used for summer and for year-round youth activities.

(d) The summer youth employment opportunities element is not intended to be a stand-alone program. Local programs should integrate a youth's participation in that element into a comprehensive strategy for addressing the youth's employment and training needs. Youths who participate in summer employment opportunities must be provided with a minimum of twelve months of followup services, as required in §664.450. (WIA sec. 129(c)(2)(C).)

§ 664.610 How is the summer employment opportunities element administered?

Chief elected officials and Local Boards are responsible for ensuring that the local youth program provides summer employment opportunities to youth. The chief elected officials (which may include local government units operating as a consortium) are the grant recipients for local youth funds, unless another entity is chosen to be grant recipient or fiscal agent under WIA section 117(d)(3)(B). If, in the administration of the summer employment opportunities element of the local youth program, providers other than the grant recipient/fiscal agent, are used to provide summer youth employment opportunities, these providers must be selected by awarding a grant or contract on a competitive basis, based on the recommendation of the youth council and on criteria contained in the State Plan. However, the selection of employers who are providing unsubsidized employment opportunities may be excluded from the competitive process. (WIA sec. 129(c)(2)(C).)

§ 664.620 Do the core indicators described in 20 CFR 666.100(a)(3) apply to participation in summer employment activities?

Yes, the summer employment opportunities element is one of a number of activities authorized by the WIA youth program. WIA section 136(b)(2) (A)(ii) and(B) provides specific core indicators of performance for youth, and requires that all participating youth be included in the determination of whether the local levels of performance are met. Program operators can help ensure positive outcomes for youth participants by providing them with continuity of services.

Subpart G—One-Stop Services to Youth

§ 664.700 What is the connection between the youth program and the One-Stop service delivery system?

(a) The chief elected official (or designee, under WIA section 117(d)(3)(B)), as the local grant recipient for the youth program is a required One-Stop partner and is subject to the requirements that apply to such partners, described in 20 CFR part 662.

(b) In addition to the provisions of 20 CFR part 662, connections between the youth program and the One-Stop system may include those that facilitate:

(1) The coordination and provision of youth activities;

(2) Linkages to the job market and employers;

(3) Access for eligible youth to the information and services required in §§664.400 and 664.410; and

(4) Other activities designed to achieve the purposes of the youth program and youth activities as described in WIA section 129(a). (WIA secs. 121(b)(1)(B)(i); 129.)

§ 664.710 Do Local Boards have the flexibility to offer services to area youth who are not eligible under the youth program through the One-Stop centers?

Yes, however, One-Stop services for non-eligible youth must be funded by programs that are authorized to provide services to such youth. For example, basic labor exchange services under the Wagner-Peyser Act may be provided to any youth.

Subpart H—Youth Opportunity Grants

§ 664.800 How are the recipients of Youth Opportunity Grants selected?

(a) Youth Opportunity Grants are awarded through a competitive selection process. The Secretary establishes appropriate application procedures, selection criteria, and an approval process for awarding Youth Opportunity Grants to applicants which can accomplish the purpose of the Act and use available funds in an effective manner in the Solicitation for Grant Applications announcing the competition.

(b) The Secretary distributes grants equitably among urban and rural areas by taking into consideration such factors as the following:

(1) The poverty rate in urban and rural communities;

(2) The number of people in poverty in urban and rural communities; and

(3) The quality of proposals received. (WIA sec.169(a) and (e).)

§ 664.810 How does a Local Board or other entity become eligible to receive a Youth Opportunity Grant?

(a) A Local Board is eligible to receive a Youth Opportunity Grant if it serves a community that:

(1) Has been designated as an empowerment zone (EZ) or enterprise community (EC) under section 1391 of the Internal Revenue Code of 1986;

(2) Is located in a State that does not have an EZ or an EC and that has been designated by its Governor as a high poverty area; or

(3) Is one of two areas in a State that has been designated by the Governor as an area for which a local board may apply for a Youth Opportunity Grant, and that meets the poverty rate criteria in section 1392 (a)(4), (b), and (d) of the Internal Revenue Code of 1986.

(b) An entity other than a Local Board is eligible to receive a grant if that entity:

(1) Is a WIA Indian and Native American grant recipient under WIA section 166; and

(2) Serves a community that:

(i) Meets the poverty rate criteria in section 1392(a)(4), (b), and (d) of the Internal Revenue Code of 1986; and

(ii) Is located on an Indian reservation or serves Oklahoma Indians or Alaska Native villages or Native groups, as provided in WIA section 169 (d)(2)(B). (WIA sec. 169(c) and (d).)

§ 664.820 Who is eligible to receive services under Youth Opportunity Grants?

All individuals ages 14 through 21 who reside in the community identified in the grant are eligible to receive services under the grant. (WIA sec. 169(a).)

§ 664.830 How are performance measures for Youth Opportunity Grants determined?

(a) The Secretary negotiates performance measures, including appropriate performance levels for each indicator, with each selected grantee, based on information contained in the application.

(b) Performance indicators for the measures negotiated under Youth Opportunity Grants are the indicators of performance provided in WIA sections 136(b)(2)(A) and (B). (WIA sec. 169(f).).

PART 665—STATEWIDE WORKFORCE INVESTMENT ACTIVITIES UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

Subpart A—General Description

Sec.

665.100 What are the Statewide workforce investment activities under title I of WIA?

665.110 How are Statewide workforce investment activities funded?

Subpart B—Required and Allowable Statewide Workforce Investment Activities

665.200 What are required Statewide workforce investment activities?

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665.220 Who is an ''incumbent worker'' for purposes of Statewide workforce investment activities?

Subpart C—Rapid Response Activities

665.300 What are rapid response activities and who is responsible for providing them?

665.310 What rapid response activities are required?

665.320 May other activities be undertaken as part of rapid response?
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665.340 What is meant by ''provision of additional assistance'' in WIA section 134(a)(2)(A)(ii)?

AUTHORITY: Section 506(c), Pub. L. 105–220; 20 U.S.C. 9276(c).

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Subpart A—General Description

§ 665.100 What are the Statewide workforce investment activities under title I of WIA?

Statewide workforce investment activities include Statewide employment and training activities for adults and dislocated workers, as described in WIA section 134(a), and Statewide youth activities, as described in WIA section 129(b). They include both required and allowable activities. In accordance with the requirements of this subpart, the State may develop policies and strategies for use of Statewide workforce investment funds. Descriptions of these policies and strategies must be included in the State Plan. (WIA secs. 129(b), 134(a).)

§ 665.110 How are Statewide workforce investment activities funded?

(a) Except for the Statewide rapid response activities described in paragraph (c) of this section, Statewide workforce investment activities are supported by funds reserved by the Governor under WIA section 128(a).

(b) Funds reserved by the Governor for Statewide workforce investment activities may be combined and used for any of the activities authorized in WIA sections 129(b), 134(a)(2)(B) or 134(a)(3)(A) (which are described in §§ 665.200 and 665.210), regardless of whether the funds were allotted through the youth, adult, or dislocated worker funding streams.

(c) Funds for Statewide rapid response activities are reserved under WIA section 133(a)(2) and may be used to provide the activities authorized at section 134(a)(2)(A) (which are described in §§ 665.310 through 665.330). (WIA secs. 129(b), 133(a)(2), 134(a)(2)(B), and 134(a)(3)(A).)

Subpart B—Required and Allowable Statewide Workforce Investment Activities

§ 665.200 What are required Statewide workforce investment activities?

Required Statewide workforce investment activities are:

(a) Required rapid response activities, as described in § 665.310;

(b) Disseminating:

(1) The State list of eligible providers of training services (including those providing non-traditional training services), for adults and dislocated workers;

(2) Information identifying eligible providers of on-the-job training (OJT) and customized training;

(3) Performance and program cost information about these providers, as described in 20 CFR 663.540; and

(4) A list of eligible providers of youth activities as described in WIA section 123;

(c) States must assure that the information listed in paragraphs (b)(1) through (4) of this section is widely available.

(d) Conducting evaluations, under WIA section 136(e), of workforce investment activities for adults, dislocated workers and youth, in order to establish and promote methods for continuously improving such activities to achieve high-level performance within, and high-level outcomes from, the Statewide workforce investment system. Such evaluations must be designed and conducted in conjunction with the State and Local Boards, and must include analysis of customer feedback, outcome and process measures in the workforce investment system. To the maximum extent practicable, these evaluations should be conducted in coordination with Federal evaluations carried out under WIA section 172.

(e) Providing incentive grants:

(1) To local areas for regional cooperation among Local Boards (including Local Boards for a designated region, as described in 20 CFR 661.290);

(2) For local coordination of activities carried out under WIA; and

(3) For exemplary performance by local areas on the performance measures.

(f) Providing technical assistance to local areas that fail to meet local performance measures.

(g) Assisting in the establishment and operation of One-Stop delivery systems, in accordance with the strategy described in the State workforce investment plan. (WIA sec. 112(b)(14).)

(h) Providing additional assistance to local areas that have high concentrations of eligible youth.

(i) Operating a fiscal and management accountability information system, based on guidelines established by the Secretary after consultation with the Governors, chief elected officials, and One-Stop partners, as required by WIA section 136(f). (WIA secs. 129(b)(2), 134(a)(2), and 136(e)(2).)

§ 665.210 What are allowable Statewide workforce investment activities?

Allowable Statewide workforce investment activities include:

(a) State administration of the adult, dislocated worker and youth workforce investment activities, consistent with the five percent administrative cost limitation at 20 CFR 667.210(a)(1).

(b) Providing capacity building and technical assistance to local areas, including Local Boards, One-Stop operators, One-Stop partners, and eligible providers, which may include:

(1) Staff development and training; and

(2) The development of exemplary program activities.

(c) Conducting research and demonstrations.

(d) Establishing and implementing:

(1) Innovative incumbent worker training programs, which may include an employer loan program to assist in skills upgrading; and

(2) Programs targeted to Empowerment Zones and Enterprise Communities.

(e) Providing support to local areas for the identification of eligible training providers.

(f) Implementing innovative programs for displaced homemakers, and programs to increase the number of individuals trained for and placed in nontraditional employment.

(g) Carrying out such adult and dislocated worker employment and training activities as the State determines are necessary to assist local areas in carrying out local employment and training activities.

(h) Carrying out youth activities Statewide.

(i) Preparation and submission to the Secretary of the annual performance progress report as described in 20 CFR 667.300(e). (WIA secs. 129(b)(3) and 134(a)(3).)

§ 665.220 Who is an "incumbent worker" for purposes of Statewide workforce investment activities?

States may establish policies and definitions to determine which workers, or groups of workers, are eligible for incumbent worker services under this subpart. An incumbent worker is an individual who is employed, but an incumbent worker does not necessarily have to meet the eligibility requirements for intensive and training services for employed adults and dislocated workers at 20 CFR 663.220(b) and 663.310. (WIA sec. 134(a)(3)(A)(iv)(I).)

Subpart C—Rapid Response Activities

§ 665.300 What are rapid response activities and who is responsible for providing them?

(a) Rapid response activities are described in §§ 665.310 through 665.330. They encompass the activities necessary to plan and deliver services to enable dislocated workers to transition to new employment as quickly as possible, following either a permanent closure or mass layoff, or a natural or other disaster resulting in a mass job dislocation.

(b) The State is responsible for providing rapid response activities. Rapid response is a required activity carried out in local areas by the State, or an entity designated by the State, in conjunction with the Local Board and chief elected officials. The State must establish methods by which to provide additional assistance to local areas that experience disasters, mass layoffs, plant closings, or other dislocation events when such events substantially increase the number of unemployed individuals.

(c) States must establish a rapid response dislocated worker unit to carry

out Statewide rapid response activities. (WIA secs. 101(38), 112(b)(17)(A)(ii) and 134(a)(2)(A).)

§ 665.310 What rapid response activities are required?

Rapid response activities must include:

(a) Immediate and on-site contact with the employer, representatives of the affected workers, and the local community, which may include an assessment of the:

(1) Layoff plans and schedule of the employer;

(2) Potential for averting the layoff(s) in consultation with State or local economic development agencies, including private sector economic development entities;

(3) Background and probable assistance needs of the affected workers;

(4) Reemployment prospects for workers in the local community; and

(5) Available resources to meet the short and long-term assistance needs of the affected workers.

(b) The provision of information and access to unemployment compensation benefits, comprehensive One-Stop system services, and employment and training activities, including information on the Trade Adjustment Assistance (TAA) program and the NAFTA-TAA program (19 U.S.C. 2271 *et seq.*);

(c) The provision of guidance and/or financial assistance in establishing a labor-management committee voluntarily agreed to by labor and management, or a workforce transition committee comprised of representatives of the employer, the affected workers and the local community. The committee may devise and oversee an implementation strategy that responds to the reemployment needs of the workers. The assistance to this committee may include:

(1) The provision of training and technical assistance to members of the committee;

(2) Funding the operating costs of a committee to enable it to provide advice and assistance in carrying out rapid response activities and in the design and delivery of WIA-authorized services to affected workers. Typically, such support will last no longer than six months; and

(3) Providing a list of potential candidates to serve as a neutral chairperson of the committee.

(d) The provision of emergency assistance adapted to the particular closing, layoff or disaster.

(e) The provision of assistance to the local board and chief elected official(s) to develop a coordinated response to the dislocation event and, as needed, obtain access to State economic development assistance. Such coordinated response may include the development of an application for National Emergency Grant under 20 CFR part 671. (WIA secs. 101(38) and 134(a)(2)(A).)

§ 665.320 May other activities be undertaken as part of rapid response?

Yes, a State or designated entity may provide rapid response activities in addition to the activities required to be provided under § 665.310. In order to provide effective rapid response upon notification of a permanent closure or mass layoff, or a natural or other disaster resulting in a mass job dislocation, the State or designated entity may:

(a) In conjunction, with other appropriate Federal, State and Local agencies and officials, employer associations, technical councils or other industry business councils, and labor organizations:

(1) Develop prospective strategies for addressing dislocation events, that ensure rapid access to the broad range of allowable assistance;

(2) Identify strategies for the aversion of layoffs; and

(3) Develop and maintain mechanisms for the regular exchange of information relating to potential dislocations, available adjustment assistance, and the effectiveness of rapid response strategies.

(b) In collaboration with the appropriate State agency(ies), collect and analyze information related to economic dislocations, including potential closings and layoffs, and all available resources in the State for dislocated workers in order to provide an adequate basis for effective program management, review and evaluation of rapid response and layoff aversion efforts in the State.

(c) Participate in capacity building activities, including providing information about innovative and successful strategies for serving dislocated workers, with local areas serving smaller layoffs.

(d) Assist in devising and overseeing strategies for:

(1) Layoff aversion, such as prefeasibility studies of avoiding a plant closure through an option for a company or group, including the workers, to purchase the plant or company and continue it in operation;

(2) Incumbent worker training, including employer loan programs for employee skill upgrading; and

(3) Linkages with economic development activities at the Federal, State and local levels, including Federal Department of Commerce programs and available State and local business retention and recruitment activities.

§ 665.330 Are the NAFTA-TAA program requirements for rapid response also required activities?

The Governor must ensure that rapid response activities under WIA are made available to workers who, under the NAFTA Implementation Act (Public Law 103–182), are members of a group of workers (including those in any agricultural firm or subdivision of an agricultural firm) for which the Governor has made a preliminary finding that:

(a) A significant number or proportion of the workers in such firm or an appropriate subdivision of the firm have become totally or partially separated, or are threatened to become totally or partially separated; and

(b) Either:

(1) The sales or production, or both, of such firm or subdivision have decreased absolutely; and

(2) Imports from Mexico or Canada of articles like or directly competitive with those produced by such firm or subdivision have increased; or

(c) There has been a shift in production by such workers' firm or subdivision to Mexico or Canada of articles which are produced by the firm or subdivision.

§ 665.340 What is meant by "provision of additional assistance" in WIA section 134(a)(2)(A)(ii)?

Up to 25 percent of dislocated worker funds may be reserved for rapid response activities. Once the State has reserved adequate funds for rapid response activities, such as those described in §§ 665.310 and 665.320, the remainder of the funds may be used by the State to provide funds to local areas, that experience increased numbers of unemployed individuals due to natural disasters, plant closings, mass layoffs or other events, for provision of direct services to participants (such as intensive, training, and other services) if there are not adequate local funds available to assist the dislocated workers.

PART 666—PERFORMANCE ACCOUNTABILITY UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

Subpart A—State Measures of Performance

Sec.

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666.120 What are the procedures for negotiating annual levels of performance?
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Subpart C—Local Measures of Performance

666.300 What performance indicators apply to local areas?
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Subpart D—Incentives and Sanctions for Local Performance

666.400 Under what circumstances are local areas eligible for State Incentive Grants?
666.410 How may local incentive awards be used?
666.420 Under what circumstances may a sanction be applied to local areas for poor performance?

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Subpart A—State Measures of Performance

§ 666.100 What performance indicators must be included in a State's plan?

(a) All States submitting a State Plan under WIA title I, subtitle B must propose expected levels of performance for each of the core indicators of performance for the adult, dislocated worker and youth programs, respectively and the two customer satisfaction indicators.

(1) For the Adult program, these indicators are:

(i) Entry into unsubsidized employment;

(ii) Retention in unsubsidized employment six months after entry into the employment;

(iii) Earnings received in unsubsidized employment six months after entry into the employment; and

(iv) Attainment of a recognized credential related to achievement of educational skills (such as a secondary school diploma or its recognized equivalent), or occupational skills, by participants who enter unsubsidized employment.

(2) For the Dislocated Worker program, these indicators are:

(i) Entry into unsubsidized employment;

(ii) Retention in unsubsidized employment six months after entry into the employment;

(iii) Earnings received in unsubsidized employment six months after entry into the employment; and

(iv) Attainment of a recognized credential related to achievement of educational skills (such as a secondary school diploma or its recognized equivalent), or occupational skills, by participants who enter unsubsidized employment.

(3) For the Youth program, these indicators are:

(i) For eligible youth aged 14 through 18:

(A) Attainment of basic skills goals, and, as appropriate, work readiness or occupational skills goals, up to a maximum of three goals per year;

(B) Attainment of secondary school diplomas and their recognized equivalents; and

(C) Placement and retention in post-secondary education, advanced training, military service, employment, or qualified apprenticeships.

(ii) For eligible youth aged 19 through 21:

(A) Entry into unsubsidized employment;

(B) Retention in unsubsidized employment six months after entry into the employment;

(C) Earnings received in unsubsidized employment six months after entry into the employment; and

(D) Attainment of a recognized credential related to achievement of educational skills (such as a secondary school diploma or its recognized equivalent), or occupational skills, by participants who enter post-secondary education, advanced training, or unsubsidized employment.

(4) A single customer satisfaction measure for employers and a single customer satisfaction indicator for participants must be used for the WIA title I, subtitle B programs for adults, dislocated workers and youth. (WIA sec. 136(b)(2).)

(b) After consultation with the representatives identified in WIA sections 136(i) and 502(b), the Departments of

Labor and Education will issue definitions for the performance indicators established under title I and title II of WIA. (WIA sec. 136 (b), (f) and (i).)

§ 666.110 May a Governor require additional indicators of performance?

Yes, Governors may develop additional indicators of performance for adults, youth and dislocated worker activities. These indicators must be included in the State Plan. (WIA sec. 136(b)(2)(C).)

§ 666.120 What are the procedures for negotiating annual levels of performance?

(a) We issue instructions on the specific information that must accompany the State Plan and that is used to review the State's expected levels of performance. The instructions may require that levels of performance for years two and three be expressed as a percentage improvement over the immediately preceding year's performance, consistent with the objective of continuous improvement.

(b) States must submit expected levels of performance for the required indicators for each of the first three program years covered by the Plan.

(c) The Secretary and the Governor must reach agreement on levels of performance for each core indicator and the customer satisfaction indicators. In negotiating these levels, the following must be taken into account:

(1) The expected levels of performance identified in the State Plan;

(2) The extent to which the levels of performance for each core indicator assist in achieving high customer satisfaction;

(3) The extent to which the levels of performance promote continuous improvement and ensure optimal return on the investment of Federal funds; and

(4) How the levels compare with those of other States, taking into account factors including differences in economic conditions, participant characteristics, and the proposed service mix and strategies.

(d) The levels of performance agreed to under paragraph (c) of this section will be the State's negotiated levels of performance for the first three years of the State Plan. These levels will be used to determine whether sanctions will be applied or incentive grant funds will be awarded.

(e) Before the fourth year of the State Plan, the Secretary and the Governor must reach agreement on levels of performance for each core indicator and the customer satisfaction indicators for the fourth and fifth years covered by the plan. In negotiating these levels, the factors listed in paragraph (c) of this section must be taken into account.

(f) The levels of performance agreed to under paragraph (e) of this section will be the State negotiated levels of performance for the fourth and fifth years of the plan and must be incorporated into the State Plan.

(g) Levels of performance for the additional indicators developed by the Governor, including additional indicators to demonstrate and measure continuous improvement toward goals identified by the State, are not part of the negotiations described in paragraphs (c) and (e) of this section. (WIA sec. 136(b)(3).)

(h) State negotiated levels of performance may be revised in accordance with § 666.130.

§ 666.130 Under what conditions may a State or DOL request revisions to the State negotiated levels of performance?

(a) The DOL guidelines describe when and under what circumstances a Governor may request revisions to negotiated levels. These circumstances include significant changes in economic conditions, in the characteristics of participants entering the program, or in the services to be provided from when the initial plan was submitted and approved. (WIA sec. 136(b)(3)(A)(vi).)

(b) The guidelines will establish the circumstances under which a State will be required to submit revisions under specified circumstances.

§ 666.140 Which individuals receiving services are included in the core indicators of performance?

(a)(1) The core indicators of performance apply to all individuals who are registered under 20 CFR 663.105 and 664.215 for the adult, dislocated worker

and youth programs, except for those adults and dislocated workers who participate exclusively in self-service or informational activities. (WIA sec. 136(b)(2)(A).)

(2) Self-service and informational activities are those core services that are made available and accessible to the general public, that are designed to inform and educate individuals about the labor market and their employment strengths, weaknesses, and the range of services appropriate to their situation, and that do not require significant staff involvement with the individual in terms of resources or time.

(b) For registered participants, a standardized record that includes appropriate performance information must be maintained in accordance with WIA section 185(a)(3).

(c) Performance will be measured on the basis of results achieved by registered participants, and will reflect services provided under WIA title I, subtitle B programs for adults, dislocated workers and youth. Performance may also take into account services provided to participants by other One-Stop partner programs and activities, to the extent that the local MOU provides for the sharing of participant information.

§ 666.150 What responsibility do States have to use quarterly wage record information for performance accountability?

(a) States must, consistent with State laws, use quarterly wage record information in measuring the progress on State and local performance measures. In order to meet this requirement the use of social security numbers from registered participants and such other information as is necessary to measure the progress of those participants through quarterly wage record information is authorized.

(b) The State must include in the State Plan a description of the State's performance accountability system, and a description of the State's strategy for using quarterly wage record information to measure the progress on State and local performance measures. The description must identify the entities that may have access to quarterly wage record information for this purpose.

(c) ''Quarterly wage record information'' means information regarding wages paid to an individual, the social security account number (or numbers, if more than one) of the individual and the name, address, State, and (when known) the Federal employer identification number of the employer paying the wages to the individual. (WIA sec. 136(f)(2).)

Subpart B—Incentives and Sanctions for State Performance

§ 666.200 Under what circumstances is a State eligible for an Incentive Grant?

A State is eligible to apply for an Incentive Grant if its performance for the immediately preceding year exceeds:

(a) The State's negotiated levels of performance for the required core indicators for the adult, dislocated worker and youth programs under title I of WIA as well as the customer satisfaction indicators for WIA title I programs;

(b) The adjusted levels of performance for title II Adult Education and Family Literacy programs; and

(c) The adjusted levels of performance under section 113 of the Carl D. Perkins Vocational and Technical Education Act (20 U.S.C. 2301 *et seq.*). (WIA sec. 503.)

§ 666.205 What are the time frames under which States submit performance progress reports and apply for incentive grants?

(a) State performance progress reports must be filed by the due date established in reporting instructions issued by the Department.

(b) Based upon the reports filed under paragraph (a) of this section, we will determine the amount of funds available, under WIA title I, to each eligible State for incentive grants, in accordance with the criteria of § 666.230. We will publish the award amounts for each eligible State, after consultation with the Secretary of Education, within ninety (90) days after the due date for performance progress reports established under paragraph (a) of this section.

(c) Within forty-five (45) days of the publication of award amounts under paragraph (b) of this section, States may apply for incentive grants in accordance with the requirements of § 666.220.

§ 666.210 How may Incentive Grant funds be used?

Incentive grant funds are awarded to States to carry out any one or more innovative programs under titles I or II of WIA or the Carl D. Perkins Vocational and Technical Education Act, regardless of which Act is the source of the incentive funds. (WIA sec. 503(a).)

§ 666.220 What information must be included in a State Board's application for an Incentive Grant?

(a) After consultation with the Secretary of Education, we will issue instructions annually which will include the amount of funds available to be awarded for each State and provide instructions for submitting applications for an Incentive Grant.

(b) Each State desiring an incentive grant must submit to the Secretary an application, developed by the State Board, containing the following assurances:

(1) The State legislature was consulted regarding the development of the application.

(2) The application was approved by the Governor, the eligible agency (as defined in WIA section 203), and the State agency responsible for vocational and technical programs under the Carl D. Perkins Vocational and Technical Education Act.

(3) The State exceeded the State negotiated levels of performance for title I, the levels of performance under title II and the levels for vocational and technical programs under the Carl D. Perkins Vocational and Technical Education Act. (WIA sec. 503(b).)

§ 666.230 How does the Department determine the amounts for Incentive Grant awards?

(a) We determine the total amount to be allocated from funds available under WIA section 174(b) for Incentive Grants taking into consideration such factors as:

(1) The availability of funds under section 174(b) for technical assistance, demonstration and pilot projects, evaluations, and Incentive Grants and the needs for these activities;

(2) The number of States that are eligible for Incentive Grants and their relative program formula allocations under title I;

(3) The availability of funds under WIA section 136(g)(2) resulting from funds withheld for poor performance by States; and

(4) The range of awards established in WIA section 503(c).

(b) We will publish the award amount for eligible States, after consultation with the Secretary of Education, within 90 days after the due date, established under § 666.205(a), for the latest State performance progress report providing the annual information needed to determine State eligibility.

(c) In determining the amount available to an eligible State, the Secretary, with the Secretary of Education, may consider such factors as:

(1) The relative allocations of the eligible State compared to other States;

(2) The extent to which the negotiated levels of performance were exceeded;

(3) Performance improvement relative to previous years;

(4) Changes in economic conditions, participant characteristics and proposed service design since the negotiated levels of performance were agreed to;

(5) The eligible State's relative performance for each of the indicators compared to other States; and

(6) The performance on those indicators considered most important in terms of accomplishing national goals established by each of the respective Secretaries.

§ 666.240 Under what circumstances may a sanction be applied to a State that fails to achieve negotiated levels of performance for title I?

(a) If a State fails to meet the negotiated levels of performance agreed to under § 666.120 for core indicators of performance or customer satisfaction indicators for the adult, dislocated worker or youth programs under title I

of WIA, the Secretary must, upon request, provide technical assistance, as authorized under WIA sections 136(g) and 170.

(b) If a State fails to meet the negotiated levels of performance for core indicators of performance or customer satisfaction indicators for the same program in two successive years, the amount of the succeeding year's allocation for the applicable program may be reduced by up to five percent.

(c) The exact amount of any allocation reduction will be based upon the degree of failure to meet the negotiated levels of performance for core indicators. In making a determination of the amount, if any, of such a sanction, we may consider factors such as:

(1) The State's performance relative to other States;

(2) Improvement efforts underway;

(3) Incremental improvement on the performance measures;

(4) Technical assistance previously provided;

(5) Changes in economic conditions and program design;

(6) The characteristics of participants served compared to the participant characteristics described in the State Plan; and

(7) Performance on other core indicators of performance and customer satisfaction indicators for that program. (WIA sec. 136(g).)

(d) Only performance that is less than 80 percent of the negotiated levels will be deemed to be a failure to achieve negotiated levels of performance.

(e) In accordance with 20 CFR 667.300(e), a State grant may be reduced for failure to submit an annual performance progress report.

(f) A State may request review of a sanction we impose in accordance with the provisions of 20 CFR 667.800.

Subpart C—Local Measures of Performance

§ 666.300 What performance indicators apply to local areas?

(a) Each local workforce investment area in a State is subject to the same core indicators of performance and the customer satisfaction indicators that apply to the State under § 666.100(a).

(b) In addition to the indicators described in paragraph (a) of this section, under § 666.110, the Governor may apply additional indicators of performance to local areas in the State. (WIA sec. 136(c)(1).)

§ 666.310 What levels of performance apply to the indicators of performance in local areas?

(a) The Local Board and the chief elected official must negotiate with the Governor and reach agreement on the local levels of performance for each indicator identified under § 666.300. The levels must be based on the State negotiated levels of performance established under § 666.120 and take into account the factors described in paragraph (b) of this section.

(b) In determining the appropriate local levels of performance, the Governor, Local Board and chief elected official must take into account specific economic, demographic and other characteristics of the populations to be served in the local area.

(c) The performance levels agreed to under paragraph (a) of this section must be incorporated in the local plan. (WIA secs. 118(b)(3) and 136(c).)

Subpart D—Incentives and Sanctions for Local Performance

§ 666.400 Under what circumstances are local areas eligible for State Incentive Grants?

(a) States must use a portion of the funds reserved for Statewide workforce investment activities under WIA sections 128(a) and 133(a)(1) to provide Incentive Grants to local areas for regional cooperation among local boards (including local boards for a designated region, as described in WIA section 116(c)), for local coordination of activities carried out under this Act, and for exemplary performance on the local performance measures established under subpart C of this part.

(b) The amount of funds used for Incentive Grants under paragraph (a) of this section and the criteria used for determining exemplary local performance levels to qualify for the incentive grants are determined by the Governor. (WIA sec. 134(a)(2)(B)(iii).)

§ 666.410 How may local incentive awards be used?

The local incentive grant funds may be used for any activities allowed under WIA title I-B.

§ 666.420 Under what circumstances may a sanction be applied to local areas for poor performance?

(a) If a local area fails to meet the levels of performance agreed to under § 666.310 for the core indicators of performance or customer satisfaction indicators for a program in any program year, technical assistance must be provided. The technical assistance must be provided by the Governor with funds reserved for Statewide workforce investment activities under WIA sections 128(a) and 133(a)(1), or, upon the Governor's request, by the Secretary. The technical assistance may include the development of a performance improvement plan, a modified local plan, or other actions designed to assist the local area in improving performance.

(b) If a local area fails to meet the levels of performance agreed to under § 666.310 for the core indicators of performance or customer satisfaction indicators for a program for two consecutive program years, the Governor must take corrective actions. The corrective actions may include the development of a reorganization plan under which the Governor:

(1) Requires the appointment and certification of a new Local Board;

(2) Prohibits the use of particular service providers or One-Stop partners that have been identified as achieving poor levels of performance; or

(3) Requires other appropriate measures designed to improve the performance of the local area.

(c) A local area may appeal to the Governor to rescind or revise a reorganization plan imposed under paragraph (b) of this section not later than thirty (30) days after receiving notice of the plan. The Governor must make a final decision within 30 days after receipt of the appeal. The Governor's final decision may be appealed by the Local Board to the Secretary under 20 CFR 667.650(b) not later than thirty (30) days after the local area receives the decision. The decision by the Governor to impose a reorganization plan becomes effective at the time it is issued, and remains effective unless the Secretary rescinds or revises the reorganization plan. Upon receipt of the appeal from the local area, the Secretary must make a final decision within thirty (30) days. (WIA sec. 136(h).)

PART 667—ADMINISTRATIVE PROVISIONS UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

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Sec.

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SOURCE: 65 FR 49421, Aug. 11, 2000, unless otherwise noted.

Subpart A—Funding

§ 667.100 When do Workforce Investment Act grant funds become available?

(a) *Program year.* Except as provided in paragraph (b) of this section, fiscal year appropriations for programs and activities carried out under title I of WIA are available for obligation on the basis of a program year. A program year begins on July 1 in the fiscal year for which the appropriation is made and ends on June 30 of the following year.

(b) *Youth fund availability.* Fiscal year appropriations for a program year's youth activities, authorized under chapter 4, subtitle B, title I of WIA, may be made available for obligation beginning on April 1 of the fiscal year for which the appropriation is made.

§ 667.105 What award document authorizes the expenditure of Workforce Investment Act funds under title I of the Act?

(a) *Agreement.* All WIA title I funds that are awarded by grant, contract or cooperative agreement are issued under an agreement between the Grant Officer/Contracting Officer and the recipient. The agreement describes the terms and conditions applicable to the award of WIA title I funds.

(b) *Grant funds awarded to States.* Under the Governor/Secretary Agreement described in §667.110, each program year, the grant agreement described in paragraph (a) of this section will be executed and signed by the Governor or the Governor's designated representative and Secretary or the Grant Officer. The grant agreement and associated Notices of Obligation are the basis for Federal obligation of funds allotted to the States in accordance with WIA sections 127(b) and 132(b) for each program year.

(c) *Indian and Native American Programs.* (1) Awards of grants, contracts or cooperative agreements for the WIA Indian and Native American program will be made to eligible entities on a competitive basis every two program years for a two-year period, in accordance with the provisions of 20 CFR part 668. An award for the succeeding two-year period may be made to the same recipient on a non-competitive basis if the recipient:

(i) Has performed satisfactorily; and

(ii) Submits a satisfactory two-year program plan for the succeeding two-year grant, contract or agreement period.

(2) A grant, contract or cooperative agreement may be renewed under the authority of paragraph (c)(1) of this section no more than once during any four-year period for any single recipient.

(d) *National Farmworker Jobs programs.* (1) Awards of grants or contracts for the National Farmworker Jobs program will be made to eligible entities on a competitive basis every two program years for a two-year period, in accordance with the provisions of 20 CFR part 669. An award for the succeeding two-year period may be made to the same recipient if the recipient:

(i) Has performed satisfactorily; and

(ii) Submits a satisfactory two-year program plan for the succeeding two-year period.

(2) A grant or contract may be renewed under the authority of paragraph (d)(1) of this section no more than once during any four-year period for any single recipient.

(e) *Job Corps.* (1) Awards of contracts will be made on a competitive basis between the Contracting Officer and eligible entities to operate contract centers and provide operational support services.

(2) The Secretary may enter into interagency agreements with Federal agencies for funding, establishment, and operation of Civilian Conservation Centers for Job Corps programs.

(f) [Reserved]

(g) *Awards under WIA sections 171 and 172.* (1) Awards of grants, contracts or cooperative agreements will be made to eligible entities for programs or activities authorized under WIA sections 171 or 172. These funds are for:

(i) Demonstration;

(ii) Pilot;

(iii) Multi-service;

(iv) Research;

(v) Multi-State projects; and

(vi) Evaluations

(2) Grants and contracts under paragraphs (g)(1)(i) and (ii) of this section

will be awarded on a competitive basis, except that a noncompetitive award may be made in the case of a project that is funded jointly with other public or private entities that provide a portion of the funding.

(3) Contracts and grants under paragraphs (g)(1)(iii), (iv), and (v) of this section in amounts that exceed $100,000 will be awarded on a competitive basis, except that a noncompetitive award may be made in the case of a project that is funded jointly with other public or private sector entities that provide a substantial portion of the assistance under the grant or contract for the project.

(4) Grants or contracts for carrying out projects in paragraphs (g)(1)(iii), (iv), and (v) of this section may not be awarded to the same organization for more than three consecutive years, unless the project is competitively reevaluated within that period.

(5) Entities with nationally recognized expertise in the methods, techniques and knowledge of workforce investment activities will be provided priority in awarding contracts or grants for the projects under paragraphs (g)(1)(iii), (iv), and (v) of this section.

(6) A peer review process will be used for projects under paragraphs (g)(1)(iii), (iv), and (v) of this section for grants that exceed $500,000, and to designate exemplary and promising programs.

(h) *Termination.* Each grant terminates when the period of fund availability has expired. The grant must be closed in accordance with the closeout provisions at 29 CFR 95.71 or 97.50, as appropriate.

[65 FR 49421, Aug. 11, 2000, as amended at 71 FR 35525, June 21, 2006]

§ 667.107 What is the period of availability for expenditure of WIA funds?

(a) *Grant funds expended by States.* Funds allotted to States under WIA sections 127(b) and 132(b) for any program year are available for expenditure by the State receiving the funds only during that program year and the two succeeding program years.

(b) *Grant funds expended by local areas.* (1) Funds allocated by a State to a local area under WIA sections 128(b) and 133(b), for any program year are available for expenditure only during that program year and the succeeding program year.

(2) Funds which are not expended by a local area in the two-year period described in paragraph (b)(1) of this section, must be returned to the State. Funds so returned are available for expenditure by State and local recipients and subrecipients only during the third program year of availability. These funds may:

(i) Be used for Statewide projects, or

(ii) Be distributed to other local areas which had fully expended their allocation of funds for the same program year within the two-year period.

(c) *Job Corps.* Funds obligated for any program year for any Job Corps activity carried out under title I, subtitle C, of WIA may be expended during that program year and the two succeeding program years.

(d) *Funds awarded under WIA sections 171 and 172.* Funds obligated for any program year for a program or activity authorized under sections 171 or 172 of WIA remain available until expended.

(e) *Other programs under title I of WIA.* For all other grants, contracts and cooperative agreements issued under title I of WIA the period of availability for expenditure is set in the terms and conditions of the award document.

§ 667.110 What is the Governor/Secretary Agreement?

(a) To establish a continuing relationship under the Act, the Governor and the Secretary will enter into a Governor/Secretary Agreement. The Agreement will consist of a statement assuring that the State will comply with:

(1) The Workforce Investment Act and all applicable rules and regulations, and

(2) The Wagner-Peyser Act and all applicable rules and regulations.

(b) The Governor/Secretary Agreement may be modified, revised or terminated at any time, upon the agreement of both parties.

§ 667.120 What planning information must a State submit in order to receive a formula grant?

Each State seeking financial assistance under WIA sections 127 (youth) or 132 (adults and dislocated workers) or under the Wagner-Peyser Act must submit a single State Plan. The requirements for the plan content and the plan review process are described in WIA section 112, Wagner-Peyser Act section 8, and 20 CFR 661.220, 661.240 and 652.211 through 652.214.

§ 667.130 How are WIA title I formula funds allocated to local workforce investment areas?

(a) *General.* The Governor must allocate WIA formula funds allotted for services to youth, adults and dislocated workers in accordance with WIA sections 128 and 133, and this section.

(1) State Boards must assist Governors in the development of any discretionary within-State allocation formulas. (WIA sec. 111(d)(5).)

(2) Within-State allocations must be made:

(i) In accordance with the allocation formulas contained in WIA sections 128(b) and 133(b) and in the State workforce investment plan, and

(ii) After consultation with chief elected officials in each of the workforce investment areas.

(b) *State reserve.* (1) Of the WIA formula funds allotted for services to youth, adults and dislocated workers, the Governor must reserve funds from each of these sources for Statewide workforce investment activities. In making these reservations, the Governor may reserve up to fifteen (15) percent from each of these sources. Funds reserved under this paragraph may be combined and spent on Statewide employment and training activities, for adults and dislocated workers, and Statewide youth activities, as described in 20 CFR 665.200 and 665.210, without regard to the funding source of the reserved funds.

(2) The Governor must reserve a portion of the dislocated worker funds for Statewide rapid response activities, as described in WIA section 134(a)(2)(A) and 20 CFR 665.310 through 665.330. In making this reservation, the Governor may reserve up to twenty-five (25) percent of the dislocated worker funds.

(c) *Youth allocation formula.* (1) Unless the Governor elects to distribute funds in accordance with the discretionary allocation formula described in paragraph (c)(2) of this section, the remainder of youth funds not reserved under paragraph (b)(1) of this section must be allocated:

(i) 33⅓ percent on the basis of the relative number of unemployed individuals in areas of substantial unemployment in each workforce investment area, compared to the total number of unemployed individuals in all areas of substantial unemployment in the State;

(ii) 33⅓ percent on the basis of the relative excess number of unemployed individuals in each workforce investment area, compared to the total excess number of unemployed individuals in the State; and

(iii) 33⅓ percent on the basis of the relative number of disadvantaged youth in each workforce investment area, compared to the total number of disadvantaged youth in the State. (WIA sec. 128(b)(2)(A)(i))

(2) *Discretionary youth allocation formula.* In lieu of making the formula allocation described in paragraph (c)(1) of this section, the State may allocate youth funds under a discretionary formula. Under that formula, the State must allocate a minimum of 70 percent of youth funds not reserved under paragraph (b)(1) of this section on the basis of the formula in paragraph (c)(1) of this section, and may allocate up to 30 percent on the basis of a formula that:

(i) Incorporates additional factors (other than the factors described in paragraph (c)(1) of this section) relating to:

(A) Excess youth poverty in urban, rural and suburban local areas; and

(B) Excess unemployment above the State average in urban, rural and suburban local areas; and

(ii) Was developed by the State Board and approved by the Secretary of Labor as part of the State workforce investment plan. (WIA sec. 128(b)(3).)

(d) *Adult allocation formula.* (1) Unless the Governor elects to distribute funds in accordance with the discretionary

allocation formula described in paragraph (d)(2) of this section, the remainder of adult funds not reserved under paragraph (b)(1) of this section must be allocated:

(i) 33⅓ percent on the basis of the relative number of unemployed individuals in areas of substantial unemployment in each workforce investment area, compared to the total number of unemployed individuals in areas of substantial unemployment in the State;

(ii) 33⅓ percent on the basis of the relative excess number of unemployed individuals in each workforce investment area, compared to the total excess number of unemployed individuals in the State; and

(iii) 33⅓ percent on the basis of the relative number of disadvantaged adults in each workforce investment area, compared to the total number of disadvantaged adults in the State. (WIA sec. 133(b)(2)(A)(i))

(2) *Discretionary adult allocation formula.* In lieu of making the formula allocation described in paragraph (d)(1) of this section, the State may allocate adult funds under a discretionary formula. Under that formula, the State must allocate a minimum of 70 percent of adult funds on the basis of the formula in paragraph (d)(1) of this section, and may allocate up to 30 percent on the basis of a formula that:

(i) Incorporates additional factors (other than the factors described in paragraph (d)(1) of this section) relating to:

(A) Excess poverty in urban, rural and suburban local areas; and

(B) Excess unemployment above the State average in urban, rural and suburban local areas; and

(ii) Was developed by the State Board and approved by the Secretary of Labor as part of the State workforce investment plan. (WIA sec. 133(b)(3).)

(e) *Dislocated worker allocation formula.* (1) The remainder of dislocated worker funds not reserved under paragraph (b)(1) or (b)(2) of this section must be allocated on the basis of a formula prescribed by the Governor that distributes funds in a manner that addresses the State's worker readjustment assistance needs. Funds so distributed must not be less than 60 percent of the State's formula allotment.

(2)(i) The Governor's dislocated worker formula must use the most appropriate information available to the Governor, including information on:

(A) Insured unemployment data,

(B) Unemployment concentrations,

(C) Plant closings and mass layoff data,

(D) Declining industries data,

(E) Farmer-rancher economic hardship data, and

(F) Long-term unemployment data.

(ii) The State Plan must describe the data used for the formula and the weights assigned, and explain the State's decision to use other information or to omit any of the information sources set forth in paragraph (e)(2)(i) of this section.

(3) The Governor may not amend the dislocated worker formula more than once for any program year.

(4)(i) Dislocated worker funds initially reserved by the Governor for Statewide rapid response activities in accordance with paragraph (b)(2) of this section may be:

(A) Distributed to local areas, and

(B) Used to operate projects in local areas in accordance with the requirements of WIA section 134(a)(2)(A) and 20 CFR 665.310 through 665.330.

(ii) The State Plan must describe the procedures for any distribution to local areas, including the timing and process for determining whether a distribution will take place.

§ 667.135 What "hold harmless" provisions apply to WIA adult and youth allocations?

(a)(1) For the first two fiscal years after the date on which a local area is designated under section 116 of WIA, the State may elect to apply the ''hold harmless'' provisions specified in paragraph (b) of this section to local area allocations of WIA youth funds under § 667.130(c) and to allocations of WIA adult funds under § 667.130(d).

(2) Effective at the end of the second full fiscal year after the date on which a local area is designated under section 116 of WIA the State must apply the ''hold harmless'' specified in paragraph (b) of this section to local area allocations of WIA youth funds under § 667.130(c) and to allocations of WIA adult funds under § 667.130(d).

(3) There are no ''hold harmless'' provisions that apply to local area allocations of WIA dislocated worker funds.

(b)(1) If a State elects to apply a ''hold-harmless'' under paragraph (a)(1) of this section, a local area must not receive an allocation amount for a fiscal year that is less than 90 percent of the average allocation of the local area for the two preceding fiscal years.

(2) In applying the ''hold harmless'' under paragraph (a)(2) of this section, a local area must not receive an allocation amount for a fiscal year that is less than 90 percent of the average allocation of the local area for the two preceding fiscal years.

(3) Amounts necessary to increase allocations to local areas must be obtained by ratably reducing the allocations to be made to other local areas.

(4) If the amounts of WIA funds appropriated in a fiscal year are not sufficient to provide the amount specified in paragraph (b)(1) of this section to all local areas, the amounts allocated to each local area mustbe ratably reduced. (WIA secs. 128(b)(2)(A)(ii), 133(b)(2)(A)(ii), 506.)

§ 667.140 Does a Local Board have the authority to transfer funds between programs?

(a) A Local Board may transfer up to 20 percent of a program year allocation for adult employment and training activities, and up to 20 percent of a program year allocation for dislocated worker employment and training activities between the two programs.

(b) Before making any such transfer, a Local Board must obtain the Governor's approval.

(c) Local Boards may not transfer funds to or from the youth program.

§ 667.150 What reallotment procedures does the Secretary use?

(a) The first reallotment of funds among States will occur during PY 2001 based on obligations in PY 2000.

(b) The Secretary determines, during the first quarter of the program year, whether a State has obligated its required level of at least 80 percent of the funds allotted under WIA sections 127 and 132 for programs serving youth, adults, and dislocated workers for the prior year, as separately determined for each of the three funding streams. Unobligated balances are determined based on allotments adjusted for any allowable transfer between the adult and dislocated worker funding streams. The amount to be recaptured from each State for reallotment, if any, is based on State obligations of the funds allotted to each State under WIA sections 127 and 132 for programs serving youth, adults, or dislocated workers, less any amount reserved (up to 5 percent at the State level and up to 10 percent at the local level) for the costs of administration. This amount, if any, is separately determined for each funding stream.

(c) The Secretary reallots youth, adult and dislocated worker funds among eligible States in accordance with the provisions of WIA sections 127(c) and 132(c), respectively. To be eligible to receive a reallotment of youth, adult, or dislocated worker funds under the reallotment procedures, a State must have obligated at least 80 percent of the prior program year's allotment, less any amount reserved for the costs of administration of youth, adult, or dislocated worker funds. A State's eligibility to receive a reallotment is separately determined for each funding stream.

(d) The term ''obligation'' is defined at 20 CFR 660.300. For purposes of this section, the Secretary will also treat as State obligations:

(1) Amounts allocated by the State, under WIA sections 128(b) and 133(b), to the single State local area if the State has been designated as a single local area under WIA section 116(b) or to a balance of State local area administered by a unit of the State government, and

(2) Inter-agency transfers and other actions treated by the State as encumbrances against amounts reserved by the State under WIA sections 128(a) and 133(a) for Statewide workforce investment activities.

§ 667.160 What reallocation procedures must the Governors use?

(a) The Governor may reallocate youth, adult, and dislocated worker funds among local areas within the State in accordance with the provisions of sections 128(c) and 133(c) of the

Act. If the Governor chooses to reallocate funds, the provisions in paragraphs (b) and (c) of this section apply.

(b) For the youth, adult and dislocated worker programs, the amount to be recaptured from each local area for purposes of reallocation, if any, must be based on the amount by which the prior year's unobligated balance of allocated funds exceeds 20 percent of that year's allocation for the program, less any amount reserved (up to 10 percent) for the costs of administration. Unobligated balances must be determined based on allocations adjusted for any allowable transfer between funding streams. This amount, if any, must be separately determined for each funding stream.

(c) To be eligible to receive youth, adult or dislocated worker funds under the reallocation procedures, a local area must have obligated at least 80 percent of the prior program year's allocation, less any amount reserved (up to 10 percent) for the costs of administration, for youth, adult, or dislocated worker activities, as separately determined. A local area's eligibility to receive a reallocation must be separately determined for each funding stream.

§ 667.170 What responsibility review does the Department conduct for awards made under WIA title I, subtitle D?

(a) Before final selection as a potential grantee, we conduct a review of the available records to assess the organization's overall responsibility to administer Federal funds. As part of this review, we may consider any information that has come to our attention and will consider the organization's history with regard to the management of other grants, including DOL grants. The failure to meet any one responsibility test, except for those listed in paragraphs (a)(1) and (a)(2) of this section, does not establish that the organization is not responsible unless the failure is substantial or persistent (for two or more consecutive years). The responsibility tests include:

(1) The organization's efforts to recover debts (for which three demand letters have been sent) established by final agency action have been unsuccessful, or that there has been failure to comply with an approved repayment plan;

(2) Established fraud or criminal activity of a significant nature within the organization.

(3) Serious administrative deficiencies that we identify, such as failure to maintain a financial management system as required by Federal regulations;

(4) Willful obstruction of the audit process;

(5) Failure to provide services to applicants as agreed to in a current or recent grant or to meet applicable performance standards;

(6) Failure to correct deficiencies brought to the grantee's attention in writing as a result of monitoring activities, reviews, assessments, or other activities;

(7) Failure to return a grant closeout package or outstanding advances within 90 days of the grant expiration date or receipt of closeout package, whichever is later, unless an extension has been requested and granted; final billings reflecting serious cost category or total budget cost overrun;

(8) Failure to submit required reports;

(9) Failure to properly report and dispose of government property as instructed by DOL;

(10) Failure to have maintained effective cash management or cost controls resulting in excess cash on hand;

(11) Failure to ensure that a subrecipient complies with its OMB Circular A–133 audit requirements specified at § 667.200(b);

(12) Failure to audit a subrecipient within the required period;

(13) Final disallowed costs in excess of five percent of the grant or contract award if, in the judgement of the grant officer, the disallowances are egregious findings and;

(14) Failure to establish a mechanism to resolve a subrecipient's audit in a timely fashion.

(b) This responsibility review is independent of the competitive process. Applicants which are determined to be not responsible will not be selected as potential grantees irrespective of their standing in the competition.

Subpart B—Administrative Rules, Costs and Limitations

§ 667.200 What general fiscal and administrative rules apply to the use of WIA title I funds?

(a) *Uniform fiscal and administrative requirements.* (1) Except as provided in paragraphs (a)(3) through (6) of this section, State, local, and Indian tribal government organizations that receive grants or cooperative agreements under WIA title I must follow the common rule ''Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments'' which is codified at 29 CFR part 97.

(2) Except as provided in paragraphs (a)(3) through (7) of this section, institutions of higher education, hospitals, other non-profit organizations, and commercial organizations must the follow the common rule implementing OMB Circular A–110 which is codified at 2 CFR part 215 and 29 CFR part 95.

(3) In addition to the requirements at 29 CFR 95.48 or 29 CFR 97.36(i) (as appropriate), all procurement contracts and other transactions between Local Boards and units of State or local governments must be conducted only on a cost reimbursement basis. No provision for profit is allowed. (WIA sec. 184(a)(3)(B).)

(4) In addition to the requirements at 29 CFR 95.42 or 29 CFR 97.36(b)(3) (as appropriate), which address codes of conduct and conflict of interest issues related to employees:

(i) A State Board member or a Local Board member or a Youth Council member must neither cast a vote on, nor participate in any decision-making capacity, on the provision of services by such member (or any organization which that member directly represents), nor on any matter which would provide any direct financial benefit to that member or a member of his immediate family.

(ii) Neither membership on the State Board, the Local Board, the Youth Council nor the receipt of WIA funds to provide training and related services, by itself, violates these conflict of interest provisions.

(5) The addition method, described at 29 CFR 95.24 or 29 CFR 97.25(g)(2) (as appropriate), must be used for the all program income earned under WIA title I grants. When the cost of generating program income has been charged to the program, the gross amount earned must be added to the WIA program. However, the cost of generating program income must be subtracted from the amount earned to establish the net amount of program income available for use under the grants when these costs have not been charged to the WIA program.

(6) Any excess of revenue over costs incurred for services provided by a governmental or non-profit entity must be included in program income. (WIA sec. 195(7)(A) and (B).)

(7) Interest income earned on funds received under WIA title I must be included in program income. (WIA sec. 195(7)(B)(iii).)

(8) On a fee-for-service basis, employers may use local area services, facilities, or equipment funded under title I of WIA to provide employment and training activities to incumbent workers:

(i) When the services, facilities, or equipment are not being used by eligible participants;

(ii) If their use does not affect the ability of eligible participants to use the services, facilities, or equipment; and

(iii) If the income generated from such fees is used to carry out programs authorized under this title.

(b) *Audit requirements.* (1) All governmental and non-profit organizations must follow the audit requirements of OMB Circular A–133. These requirements are found at 29 CFR 97.26 for governmental organizations and at 29 CFR 95.26 for institutions of higher education, hospitals, and other non-profit organizations.

(2)(i) We are responsible for audits of commercial organizations which are direct recipients of Federal financial assistance under WIA title I.

(ii) Commercial organizations which are subrecipients under WIA title I and which expend more than the minimum level specified in OMB Circular A–133 ($300,000 ($500,000 for years ending after December 21, 2003)) must have either an organization-wide audit conducted in accordance with A–133 or a program

specific financial and compliance audit.

(c) *Allowable costs/cost principles.* All recipients and subrecipients must follow the Federal allowable cost principles that apply to their kind of organizations. The DOL regulations at 29 CFR 95.27 and 29 CFR 97.22 identify the Federal principles for determining allowable costs which each kind of recipient and subrecipient must follow. The applicable Federal principles for each kind of recipient are described in paragraphs (c)(1) through (5) of this section; all recipients must comply with paragraphs (c)(6) and (c)(7) of this section. For those selected items of cost requiring prior approval, the authority to grant or deny approval is delegated to the Governor for programs funded under sections 127 or 132 of the Act.

(1) Allowable costs for State, local, and Indian tribal government organizations must be determined under OMB Circular A–87, ''Cost Principles for State, Local and Indian Tribal Governments.''

(2) Allowable costs for non-profit organizations must be determined under OMB Circular A–122, ''Cost Principles for Non-Profit Organizations.''

(3) Allowable costs for institutions of higher education must be determined under OMB Circular A–21, ''Cost Principles for Educational Institutions.''

(4) Allowable costs for hospitals must be determined in accordance under appendix E of 45 CFR part 74, ''Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals.''

(5) Allowable costs for commercial organizations and those non-profit organizations listed in Attachment C to OMB Circular A–122 must be determined under the provisions of the Federal Acquisition Regulation (FAR), at 48 CFR part 31.

(6) For all types of entities, legal expenses for the prosecution of claims against the Federal Government, including appeals to an Administrative Law Judge, are unallowable.

(d) *Government-wide debarment and suspension, and government-wide drug-free workplace requirements.* All WIA title I grant recipients and subrecipients must comply with the government-wide requirements for debarment and suspension, and the government-wide requirements for a drug-free workplace, codified at 29 CFR part 98.

(e) *Restrictions on lobbying.* All WIA title I grant recipients and subrecipients must comply with the restrictions on lobbying which are codified in the DOL regulations at 29 CFR part 93.

(f) *Nondiscrimination.* All WIA title I recipients, as the term is defined in 29 CFR 37.4, must comply with the nondiscrimination and equal opportunity provisions of WIA section 188 and its implementing regulations found at 29 CFR part 37. Information on the handling of discrimination complaints by participants and other interested parties may be found in 29 CFR 37.70 through 37.80, and in § 667.600(g).

(g) *Nepotism.* (1) No individual may be placed in a WIA employment activity if a member of that person's immediate family is directly supervised by or directly supervises that individual.

(2) To the extent that an applicable State or local legal requirement regarding nepotism is more restrictive than this provision, such State or local requirement must be followed.

[65 FR 49421, Aug. 11, 2000, as amended at 71 FR 35523, June 21, 2006]

§ 667.210 What administrative cost limits apply to Workforce Investment Act title I grants?

(a) Formula grants to States:

(1) As part of the 15 percent that a State may reserve for Statewide activities, the State may spend up to five percent (5%) of the amount allotted under sections 127(b)(1), 132(b)(1) and 132(b)(2) of the Act for the administrative costs of Statewide workforce investment activities.

(2) Local area expenditures for administrative purposes under WIA formula grants are limited to no more than ten percent (10%) of the amount allocated to the local area under sections 128(b) and 133(b) of the Act.

(3) Neither the five percent (5%) of the amount allotted that may be reserved for Statewide administrative costs nor the ten percent (10%) of the amount allotted that may be reserved for local administrative costs needs to be allocated back to the individual funding streams.

(b) Limits on administrative costs for programs operated under subtitle D of title I will be identified in the grant or contract award document.

(c) In a One-Stop environment, administrative costs borne by other sources of funds, such as the Wagner-Peyser Act, are not included in the administrative cost limit calculation. Each program's administrative activities area chargeable to its own grant and subject to its own administrative cost limitations.

§ 667.220 What Workforce Investment Act title I functions and activities constitute the costs of administration subject to the administrative cost limit?

(a) The costs of administration are that allocable portion of necessary and reasonable allowable costs of State and local workforce investment boards, direct recipients, including State grant recipients under subtitle B of title I and recipients of awards under subtitle D of title I, as well as local grant recipients, local grant subrecipients, local fiscal agents and one-stop operators that are associated with those specific functions identified in paragraph (b) of this section and which are not related to the direct provision of workforce investment services, including services to participants and employers. These costs can be both personnel and non-personnel and both direct and indirect.

(b) The costs of administration are the costs associated with performing the following functions:

(1) Performing the following overall general administrative functions and coordination of those functions under WIA title I:

(i) Accounting, budgeting, financial and cash management functions;

(ii) Procurement and purchasing functions;

(iii) Property management functions;

(iv) Personnel management functions;

(v) Payroll functions;

(vi) Coordinating the resolution of findings arising from audits, reviews, investigations and incident reports;

(vii) Audit functions;

(viii) General legal services functions; and

(ix) Developing systems and procedures, including information systems, required for these administrative functions;

(2) Performing oversight and monitoring responsibilities related to WIA administrative functions;

(3) Costs of goods and services required for administrative functions of the program, including goods and services such as rental or purchase of equipment, utilities, office supplies, postage, and rental and maintenance of office space;

(4) Travel costs incurred for official business in carrying out administrative activities or the overall management of the WIA system; and

(5) Costs of information systems related to administrative functions (for example, personnel, procurement, purchasing, property management, accounting and payroll systems) including the purchase, systems development and operating costs of such systems.

(c)(1) Awards to subrecipients or vendors that are solely for the performance of administrative functions are classified as administrative costs.

(2) Personnel and related non-personnel costs of staff who perform both administrative functions specified in paragraph (b) of this section and programmatic services or activities must be allocated as administrative or program costs to the benefitting cost objectives/categories based on documented distributions of actual time worked or other equitable cost allocation methods.

(3) Specific costs charged to an overhead or indirect cost pool that can be identified directly as a program cost are to be charged as a program cost. Documentation of such charges must be maintained.

(4) Except as provided at paragraph (c)(1), all costs incurred for functions and activities of subrecipients and vendors are program costs.

(5) Costs of the following information systems including the purchase, systems development and operating (e.g., data entry) costs are charged to the program category:

(i) Tracking or monitoring of participant and performance information;

(ii) Employment statistics information, including job listing information,

job skills information, and demand occupation information;

(iii) Performance and program cost information on eligible providers of training services, youth activities, and appropriate education activities;

(iv) Local area performance information; and

(v) Information relating to supportive services and unemployment insurance claims for program participants;

(6) Continuous improvement activities are charged to administration or program category based on the purpose or nature of the activity to be improved. Documentation of such charges must be maintained.

§ 667.250 What requirements relate to the enforcement of the Military Selective Service Act?

The requirements relating to the enforcement of the Military Selective Service Act are found at WIA section 189(h).

§ 667.255 Are there special rules that apply to veterans when income is a factor in eligibility determinations?

Yes, under 38 U.S.C. 4213, when past income is an eligibility determinant for Federal employment or training programs, any amounts received as military pay or allowances by any person who served on active duty, and certain other specified benefits must be disregarded. This applies when determining if a person is a ''low-income individual'' for eligibility purposes, (for example, in the WIA youth, Job Corps, or NFJP programs) and applies if income is used as a factor in applying the priority provision, under 20 CFR 663.600, when WIA adult funds are limited. Questions regarding the application of 38 U.S.C. 4213 should be directed to the Veterans Employment and Training Service.

§ 667.260 May WIA title I funds be spent for construction?

WIA title I funds must not be spent on construction or purchase of facilities or buildings except:

(a) To meet a recipient's, as the term is defined in 29 CFR 37.4, obligation to provide physical and programmatic accessibility and reasonable accommodation, as required by section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990, as amended;

(b) To fund repairs, renovations, alterations and capital improvements of property, including:

(1) SESA real property, identified at WIA section 193, using a formula that assesses costs proportionate to space utilized;

(2) JTPA owned property which is transferred to WIA title I programs;

(c) Job Corps facilities, as authorized by WIA section 160(3)(B); and

(d) To fund disaster relief employment on projects for demolition, cleaning, repair, renovation, and reconstruction of damaged and destroyed structures, facilities, and lands located within a disaster area. (WIA sec. 173(d).)

§ 667.262 Are employment generating activities, or similar activities, allowable under WIA title I?

(a) Under WIA section 181(e), WIA title I funds may not be spent on employment generating activities, economic development, and other similar activities, unless they are directly related to training for eligible individuals. For purposes of this section, employer outreach and job development activities are directly related to training for eligible individuals.

(b) These employer outreach and job development activities include:

(1) Contacts with potential employers for the purpose of placement of WIA participants;

(2) Participation in business associations (such as chambers of commerce); joint labor management committees, labor associations, and resource centers;

(3) WIA staff participation on economic development boards and commissions, and work with economic development agencies, to:

(i) Provide information about WIA programs,

(ii) Assist in making informed decisions about community job training needs, and

(iii) Promote the use of first source hiring agreements and enterprise zone vouchering services,

(4) Active participation in local business resource centers (incubators) to provide technical assistance to small and new business to reduce the rate of business failure;

(5) Subscriptions to relevant publications;

(6) General dissemination of information on WIA programs and activities;

(7) The conduct of labor market surveys;

(8) The development of on-the-job training opportunities; and

(9) Other allowable WIA activities in the private sector. (WIA sec. 181(e).)

§ 667.264 What other activities are prohibited under title I of WIA?

(a) WIA title I funds must not be spent on:

(1) The wages of incumbent employees during their participation in economic development activities provided through a Statewide workforce investment system, (WIA sec. 181(b)(1).);

(2) Public service employment, except to provide disaster relief employment, as specifically authorized in section 173(d) of WIA, (WIA sec. 195(10));

(3) Expenses prohibited under any other Federal, State or local law or regulation.

(b) WIA formula funds available to States and local areas under subtitle B, title I of WIA must not be used for foreign travel. (WIA sec. 181(e).)

§ 667.266 What are the limitations related to religious activities?

(a) Limitations related to sectarian activities are set forth at WIA section 188(a)(3) and 29 CFR 37.6(f).

(b)(1) 29 CFR part 2, subpart D governs the circumstances under which DOL support, including WIA Title I financial assistance, may be used to employ or train participants in religious activities. Under that subpart, such assistance may be used for such employment or training only when the assistance is provided indirectly within the meaning of the Establishment Clause of the U.S. Constitution, and not when the assistance is provided directly. As explained in that subpart, assistance provided through an Individual Training Account is generally considered indirect, and other mechanisms may also be considered indirect. *See also* 20 CFR 667.275 and 29 CFR 37.6(f)(1). 29 CFR part 2, subpart D also contains requirements related to equal treatment in Department of Labor programs for religious organizations, and to protecting the religious liberty of Department of Labor social service providers and beneficiaries.

(2) Limitations on the employment of participants under WIA Title I to carry out the construction, operation, or maintenance of any part of any facility used or to be used for religious instruction or as a place for religious worship are described at 29 CFR 37.6(f)(2).

[65 FR 49421, Aug. 11, 2000, as amended at 69 FR 41891, July 12, 2004]

§ 667.268 What prohibitions apply to the use of WIA title I funds to encourage business relocation?

(a) WIA funds may not be used or proposed to be used for:

(1) The encouragement or inducement of a business, or part of a business, to relocate from any location in the United States, if the relocation results in any employee losing his or her job at the original location;

(2) Customized training, skill training, or on-the-job training or company specific assessments of job applicants or employees of a business or a part of a business that has relocated from any location in the United States, until the company has operated at that location for 120 days, if the relocation has resulted in any employee losing his or her jobs at the original location.

(b) *Pre-award review.* To verify that an establishment which is new or expanding is not, in fact, relocating employment from another area, standardized pre-award review criteria developed by the State must be completed and documented jointly by the local area with the establishment as a prerequisite to WIA assistance.

(1) The review must include names under which the establishment does business, including predecessors and successors in interest; the name, title, and address of the company official certifying the information, and whether WIA assistance is sought in connection with past or impending job losses at other facilities, including a review of whether WARN notices relating to the employer have been filed.

(2) The review may include consultations with labor organizations and others in the affected local area(s). (WIA sec. 181(d).)

§ 667.269 What procedures and sanctions apply to violations of §§ 667.260 through 667.268?

(a) We will promptly review and take appropriate action on alleged violations of the provisions relating to:

(1) Employment generating activities (§ 667.262);

(2) Other prohibited activities (§ 667.264);

(3) The limitation related to sectarian activities (§ 667.266);

(4) The use of WIA title I funds to encourage business relocation (§ 667.268).

(b) Procedures for the investigation and resolution of the violations are provided for under the Grant Officer's resolution process at § 667.510. Sanctions and remedies are provided for under WIA section 184(c) for violations of the provisions relating to:

(1) Construction (§ 667.260);

(2) Employment generating activities (§ 667.262);

(3) Other prohibited activities (§ 667.264); and

(4) The limitation related to sectarian activities (§ 667.266(b)(1)).

(c) Sanctions and remedies are provided for in WIA section 181(d)(3) for violations of § 667.268, which addresses business relocation.

(d) Violations of § 667.266(b)(2) will be handled in accordance with the DOL nondiscrimination regulations implementing WIA section 188, codified at 29 CFR part 37.

§ 667.270 What safeguards are there to ensure that participants in Workforce Investment Act employment and training activities do not displace other employees?

(a) A participant in a program or activity authorized under title I of WIA must not displace (including a partial displacement, such as a reduction in the hours of non-overtime work, wages, or employment benefits) any currently employed employee (as of the date of the participation).

(b) A program or activity authorized under title I of WIA must not impair existing contracts for services or collective bargaining agreements. When a program or activity authorized under title I of WIA would be inconsistent with a collective bargaining agreement, the appropriate labor organization and employer must provide written concurrence before the program or activity begins.

(c) A participant in a program or activity under title I of WIA may not be employed in or assigned to a job if:

(1) Any other individual is on layoff from the same or any substantially equivalent job;

(2) The employer has terminated the employment of any regular, unsubsidized employee or otherwise caused an involuntary reduction in its workforce with the intention of filling the vacancy so created with the WIA participant; or

(3) The job is created in a promotional line that infringes in any way on the promotional opportunities of currently employed workers.

(d) Regular employees and program participants alleging displacement may file a complaint under the applicable grievance procedures found at § 667.600. (WIA sec. 181.)

§ 667.272 What wage and labor standards apply to participants in activities under title I of WIA?

(a) Individuals in on-the-job training or individuals employed in activities under title I of WIA must be compensated at the same rates, including periodic increases, as trainees or employees who are similarly situated in similar occupations by the same employer and who have similar training, experience and skills. Such rates must be in accordance with applicable law, but may not be less than the higher of the rate specified in section 6(a)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a)(1)) or the applicable State or local minimum wage law.

(b) Individuals in on-the-job training or individuals employed in programs and activities under Title I of WIA must be provided benefits and working conditions at the same level and to the same extent as other trainees or employees working a similar length of time and doing the same type of work.

(c) Allowances, earnings, and payments to individuals participating in programs under Title I of WIA are not

considered as income for purposes of determining eligibility for and the amount of income transfer and in-kind aid furnished under any Federal or Federally assisted program based on need other than as provided under the Social Security Act (42 U.S.C. 301 *et seq.*). (WIA sec. 181(a)(2).)

§ 667.274 What health and safety standards apply to the working conditions of participants in activities under title I of WIA?

(a) Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees are equally applicable to working conditions of participants engaged in programs and activities under Title I of WIA.

(b)(1) To the extent that a State workers' compensation law applies, workers' compensation must be provided to participants in programs and activities under Title I of WIA on the same basis as the compensation is provided to other individuals in the State in similar employment.

(2) If a State workers' compensation law applies to a participant in work experience, workers' compensation benefits must be available for injuries suffered by the participant in such work experience. If a State workers' compensation law does not apply to a participant in work experience, insurance coverage must be secured for injuries suffered by the participant in the course of such work experience.

§ 667.275 What are a recipient's obligations to ensure nondiscrimination and equal opportunity, and what are a recipient's obligations with respect to religious activities?

(a)(1) Recipients, as defined in 29 CFR 37.4, must comply with the nondiscrimination and equal opportunity provisions of WIA section 188 and its implementing regulations, codified at 29 CFR part 37. Under that definition, the term ''recipients'' includes State and Local Workforce Investment Boards, One-Stop operators, service providers, vendors, and subrecipients, as well as other types of individuals and entitites.

(2) Nondiscrimination and equal opportunity requirements and procedures, including complaint processing and compliance reviews, are governed by the regulations implementing WIA section 188, codified at 29 CFR part 37, and are administered and enforced by the DOL Civil Rights Center.

(3) As described in § 667.260(a), financial assistance provided under WIA title I may be used to meet a recipient's obligation to provide physical and programmatic accessibility and reasonable accommodation/modification in regard to the WIA program, as required by section 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act of 1990, as amended, section 188 of WIA, and the regulations implementing these statutory provisions.

(b) 29 CFR part 2, subpart D governs the circumstances under which recipients may use DOL support, including WIA Title I financial assistance, to employ or train participants in religious activities. Under that subpart, such assistance may be used for such employment or training only when the assistance is provided indirectly within the meaning of the Establishment Clause of the U.S. Constitution, and not when the assistance is provided directly. As explained in that subpart, assistance provided through an Individual Training Account is generally considered indirect, and other mechanisms may also be considered indirect. *See also* 20 CFR 667.266 and 29 CFR 37.6(f)(1). 29 CFR part 2, subpart D also contains requirements related to equal treatment of religious organizations in Department of Labor programs, and to protection of religious liberty of Department of Labor social service providers and beneficiaries. Limitations on the employment of participants under WIA Title I to carry out the construction, operation, or maintenance of any part of any facility used or to be used for religious instruction or as a place of religious worship are described at 29 CFR 37.6(f)(2). *See* section 188(a)(3) of the Workforce Investment Act of 1998, 29 U.S.C. 2938(a)(3).

[65 FR 49421, Aug. 11, 2000, as amended at 69 FR 41891, July 12, 2004]

Subpart C—Reporting Requirements

§ 667.300 What are the reporting requirements for Workforce Investment Act programs?

(a) *General.* All States and other direct grant recipients must report financial, participant, and performance data in accordance with instructions issued by DOL. Required reports must be submitted no more frequently than quarterly within a time period specified in the reporting instructions.

(b) *Subrecipient reporting.* (1) A State or other direct grant recipient may impose different forms or formats, shorter due dates, and more frequent reporting requirements on subrecipients. However, the recipient is required to meet the reporting requirements imposed by DOL.

(2) If a State intends to impose different reporting requirements, it must describe those reporting requirements in its State WIA plan.

(c) *Financial reports.* (1) Each grant recipient must submit financial reports.

(2) Reports must include any income or profits earned, including such income or profits earned by subrecipients, and any costs incurred (such as stand-in costs) that are otherwise allowable except for funding limitations. (WIA sec. 185(f)(2))

(3) Reported expenditures and program income, including any profits earned, must be on the accrual basis of accounting and cumulative by fiscal year of appropriation. If the recipient's accounting records are not normally kept on the accrual basis of accounting, the recipient must develop accrual information through an analysis of the documentation on hand.

(d) *Due date.* Financial reports and participant data reports are due no later than 45 days after the end of each quarter unless otherwise specified in reporting instructions. A final financial report is required 90 days after the expiration of a funding period or the termination of grant support.

(e) *Annual performance progress report.* An annual performance progress report for each of the three programs under title I, subpart B is required by WIA section 136(d).

(1) A State failing to submit any of these annual performance progress reports within 45 days of the due date may have its grant (for that program or all title I, subpart B programs) for the succeeding year reduced by as much as five percent, as provided by WIA section 136(g)(1)(B).

(2) States submitting annual performance progress reports that cannot be validated or verified as accurately counting and reporting activities in accordance with the reporting instructions, may be treated as failing to submit annual reports, and be subject to sanction. Sanctions related to State performance or failure to submit these reports timely cannot result in a total grant reduction of more than five percent. Any sanction would be in addition to having to repay the amount of any incentive funds granted based on the invalid report.

Subpart D—Oversight and Monitoring

§ 667.400 Who is responsible for oversight and monitoring of WIA title I grants?

(a) The Secretary is authorized to monitor all recipients and subrecipients of all grants awarded and funds expended under WIA title I to determine compliance with the Act and the WIA regulations, and may investigate any matter deemed necessary to determine such compliance. Federal oversight will be conducted primarily at the recipient level.

(b) In each fiscal year, we will also conduct in-depth reviews in several States, including financial and performance audits, to assure that funds are spent in accordance with the Act. Priority for such in-depth reviews will be given to States not meeting annual adjusted levels of performance.

(c)(1) Each recipient and subrecipient must continuously monitor grant-supported activities in accordance with the uniform administrative requirements at 29 CFR parts 95 and 97, as applicable, including the applicable cost principles indicated at 29 CFR 97.22(b) or 29 CFR 95.27, for all entities receiving WIA title I funds. For governmental units, the applicable requirements are at 29 CFR part 97. For non-

profit organizations, the applicable requirements are at 29 CFR part 95.

(2) In the case of grants under WIA sections 127 and 132, the Governor must develop a State monitoring system that meets the requirements of § 667.410(b). The Governor must monitor Local Boards annually for compliance with applicable laws and regulations in accordance with the State monitoring system. Monitoring must include an annual review of each local area's compliance with the uniform administrative requirements.

§ 667.410 What are the oversight roles and responsibilities of recipients and subrecipients?

(a) *Roles and responsibilities for all recipients and subrecipients of funds under WIA title I in general.* Each recipient and subrecipient must conduct regular oversight and monitoring of its WIA activities and those of its subrecipients and contractors in order to:

(1) Determine that expenditures have been made against the cost categories and within the cost limitations specified in the Act and the regulations in this part;

(2) Determine whether or not there is compliance with other provisions of the Act and the WIA regulations and other applicable laws and regulations; and

(3) Provide technical assistance as necessary and appropriate.

(b) *State roles and responsibilities for grants under WIA sections 127 and 132.* (1) The Governor is responsible for the development of the State monitoring system. The Governor must be able to demonstrate, through a monitoring plan or otherwise, that the State monitoring system meets the requirements of paragraph (b)(2) of this section.

(2) The State monitoring system must:

(i) Provide for annual on-site monitoring reviews of local areas' compliance with DOL uniform administrative requirements, as required by WIA section 184(a)(4);

(ii) Ensure that established policies to achieve program quality and outcomes meet the objectives of the Act and the WIA regulations, including policies relating to: the provision of services by One-Stop Centers; eligible providers of training services; and eligible providers of youth activities;

(iii) Enable the Governor to determine if subrecipients and contractors have demonstrated substantial compliance with WIA requirements; and

(iv) Enable the Governor to determine whether a local plan will be disapproved for failure to make acceptable progress in addressing deficiencies, as required in WIA section 118(d)(1).

(v) Enable the Governor to ensure compliance with the nondiscrimination and equal opportunity requirements of WIA section 188 and 29 CFR part 37. Requirements for these aspects of the monitoring system are set forth in 29 CFR 37.54(d)(2)(ii).

(3) The State must conduct an annual on-site monitoring review of each local area's compliance with DOL uniform administrative requirements, including the appropriate administrative requirements for subrecipients and the applicable cost principles indicated at § 667.200 for all entities receiving WIA title I funds.

(4) The Governor must require that prompt corrective action be taken if any substantial violation of standards identified in paragraphs (b) (2) or (3) of this section is found. (WIA sec. 184(a)(5).)

(5) The Governor must impose the sanctions provided in WIA section 184 (b) and (c) in the event of a subrecipient's failure to take required corrective action required under paragraph (b)(4) of this section.

(6) The Governor may issue additional requirements and instructions to subrecipients on monitoring activities.

(7) The Governor must certify to the Secretary every two years that:

(i) The State has implemented uniform administrative requirements;

(ii) The State has monitored local areas to ensure compliance with uniform administrative requirements; and

(iii) The State has taken appropriate corrective action to secure such compliance. (WIA sec. 184(a)(6)(A), (B), and (C).)

Subpart E—Resolution of Findings From Monitoring and Oversight Reviews

§ 667.500 What procedures apply to the resolution of findings arising from audits, investigations, monitoring and oversight reviews?

(a) *Resolution of subrecipient-level findings.* (1) The Governor is responsible for resolving findings that arise from the State's monitoring reviews, investigations and audits (including OMB Circular A–133 audits) of subrecipients.

(2) A State must utilize the audit resolution, debt collection and appeal procedures that it uses for other Federal grant programs.

(3) If a State does not have such procedures, it must prescribe standards and procedures to be used for this grant program.

(b) *Resolution of State and other direct recipient level findings.* (1) The Secretary is responsible for resolving findings that arise from Federal audits, monitoring reviews, investigations, incident reports, and recipient level OMB Circular A–133 audits.

(2) The Secretary uses the DOL audit resolution process, consistent with the Single Audit Act of 1996 and OMB Circular A–133, and Grant Officer Resolution provisions of § 667.510, as appropriate.

(3) A final determination issued by a Grant Officer under this process may be appealed to the DOL Office of Administrative Law Judges under the procedures at § 667.800.

(c) *Resolution of nondiscrimination findings.* Findings arising from investigations or reviews conducted under nondiscrimination laws will be resolved in accordance with WIA section 188 and the Department of Labor nondiscrimination regulations implementing WIA section 188, codified at 29 CFR part 37.

§ 667.505 How do we resolve investigative and monitoring findings?

(a) As a result of an investigation, on-site visit or other monitoring, we notify the recipient of the findings of the investigation and gives the recipient a period of time (not more than 60 days) to comment and to take appropriate corrective actions.

(b) The Grant Officer reviews the complete file of the investigation or monitoring report and the recipient's actions under paragraph (a) of this section. The Grant Officer's review takes into account the sanction provisions of WIA section 184(b) and (c). If the Grant Officer agrees with the recipient's handling of the situation, the Grant Officer so notifies the recipient. This notification constitutes final agency action.

(c) If the Grant Officer disagrees with the recipient's handling of the matter, the Grant Officer proceeds under § 667.510.

§ 667.510 What is the Grant Officer resolution process?

(a) *General.* When the Grant Officer is dissatisfied with the State's disposition of an audit or other resolution of violations (including those arising out of incident reports or compliance reviews), or with the recipient's response to findings resulting from investigations or monitoring report, the initial and final determination process, set forth in this section, is used to resolve the matter.

(b) *Initial determination.* The Grant Officer makes an initial determination on the findings for both those matters where there is agreement and those where there is disagreement with the recipient's resolution, including the allowability of questioned costs or activities. This initial determination is based upon the requirements of the Act and regulations, and the terms and conditions of the grants, contracts, or other agreements under the Act.

(c) *Informal resolution.* Except in an emergency situation, when the Secretary invokes the authority described in WIA section 184(e), the Grant Officer may not revoke a recipient's grant in whole or in part, nor institute corrective actions or sanctions, without first providing the recipient with an opportunity to present documentation or arguments to resolve informally those matters in controversy contained in the initial determination. The initial determination must provide for an informal resolution period of at least 60 days from issuance of the initial determination. If the matters are resolved informally, the Grant Officer must

issue a final determination under paragraph (d) of this section which notifies the parties in writing of the nature of the resolution and may close the file.

(d) *Grant Officer's final determination.* (1) If the matter is not fully resolved informally, the Grant Officer provides each party with a written final determination by certified mail, return receipt requested. For audits of recipient-level entities and other recipients which receive WIA funds directly from DOL, ordinarily, the final determination is issued not later than 180 days from the date that the Office of Inspector General (OIG) issues the final approved audit report to the Employment and Training Administration. For audits of subrecipients conducted by the OIG, ordinarily the final determination is issued not later than 360 days from the date the OIG issues the final approved audit report to ETA.

(2) A final determination under this paragraph (d) must:

(i) Indicate whether efforts to informally resolve matters contained in the initial determination have been unsuccessful;

(ii) List those matters upon which the parties continue to disagree;

(iii) List any modifications to the factual findings and conclusions set forth in the initial determination and the rationale for such modifications;

(iv) Establish a debt, if appropriate;

(v) Require corrective action, when needed;

(vi) Determine liability, method of restitution of funds and sanctions; and

(vii) Offer an opportunity for a hearing in accordance with § 667.800 of this part.

(3) Unless a hearing is requested, a final determination under this paragraph (d) is final agency action and is not subject to further review.

(e) Nothing in this subpart precludes the Grant Officer from issuing an initial determination and/or final determination directly to a subrecipient, in accordance with section 184(d)(3) of the Act. In such a case, the Grant Officer will inform the recipient of this action.

Subpart F—Grievance Procedures, Complaints, and State Appeals Processes

§ 667.600 What local area, State and direct recipient grievance procedures must be established?

(a) Each local area, State and direct recipient of funds under title I of WIA, except for Job Corps, must establish and maintain a procedure for grievances and complaints according to the requirements of this section. The grievance procedure requirements applicable to Job Corps are set forth at 20 CFR 670.990.

(b) Each local area, State, and direct recipient must:

(1) Provide information about the content of the grievance and complaint procedures required by this section to participants and other interested parties affected by the local Workforce Investment System, including One-Stop partners and service providers;

(2) Require that every entity to which it awards Title I funds must provide the information referred to in paragraph (b)(1) of this section to participants receiving Title I-funded services from such entities; and

(3) Must make reasonable efforts to assure that the information referred to in paragraph (b)(1) of this section will be understood by affected participants and other individuals, including youth and those who are limited-English speaking individuals. Such efforts must comply with the language requirements of 29 CFR 37.35 regarding the provision of services and information in languages other than English.

(c) Local area procedures must provide:

(1) A process for dealing with grievances and complaints from participants and other interested parties affected by the local Workforce Investment System, including One-Stop partners and service providers;

(2) An opportunity for an informal resolution and a hearing to be completed within 60 days of the filing of the grievance or complaint;

(3) A process which allows an individual alleging a labor standards violation to submit the grievance to a binding arbitration procedure, if a collective bargaining agreement covering the

parties to the grievance so provides; and

(4) An opportunity for a local level appeal to a State entity when:

(i) No decision is reached within 60 days; or

(ii) Either party is dissatisfied with the local hearing decision.

(d) State procedures must provide:

(1) A process for dealing with grievances and complaints from participants and other interested parties affected by the Statewide Workforce Investment programs;

(2) A process for resolving appeals made under paragraph (c)(4) of this section;

(3) A process for remanding grievances and complaints related to the local Workforce Investment Act programs to the local area grievance process; and

(4) An opportunity for an informal resolution and a hearing to be completed within 60 days of the filing of the grievance or complaint.

(e) Procedures of direct recipients must provide:

(1) A process for dealing with grievance and complaints from participants and other interested parties affected by the recipient's Workforce Investment Act programs; and

(2) An opportunity for an informal resolution and a hearing to be completed within 60 days of the filing of the grievance or complaint.

(f) The remedies that may be imposed under local, State and direct recipient grievance procedures are enumerated at WIA section 181(c)(3).

(g)(1) The provisions of this section on grievance procedures do not apply to discrimination complaints brought under WIA section 188 and/or 29 CFR part 37. Such complaints must be handled in accordance with the procedures set forth in that regulatory part.

(2) Questions about or complaints alleging a violation of the nondiscrimination provisions of WIA section 188 may be directed or mailed to the Director, Civil Rights Center, U.S. Department of Labor, Room N4123, 200 Constitution Avenue, NW, Washington, D.C. 20210, for processing.

(h) Nothing in this subpart precludes a grievant or complainant from pursuing a remedy authorized under another Federal, State or local law.

§ 667.610 What processes do we use to review State and local grievances and complaints?

(a) We investigate allegations arising through the grievance procedures described in § 667.600 when:

(1) A decision on a grievance or complaint under § 667.600(d) has not been reached within 60 days of receipt of the grievance or complaint or within 60 days of receipt of the request for appeal of a local level grievance and either party appeals to the Secretary; or

(2) A decision on a grievance or complaint under § 667.600(d) has been reached and the party to which such decision is adverse appeals to the Secretary.

(b) We must make a final decision on an appeal under paragraph (a) of this section no later than 120 days after receiving the appeal.

(c) Appeals made under paragraph (a)(2) of this section must be filed within 60 days of the receipt of the decision being appealed. Appeals made under paragraph (a)(1) of this section must be filed within 120 days of the filing of the grievance with the State, or the filing of the appeal of a local grievance with the State. All appeals must be submitted by certified mail, return receipt requested, to the Secretary, U.S. Department of Labor, Washington, DC 20210, Attention: ASET. A copy of the appeal must be simultaneously provided to the appropriate ETA Regional Administrator and the opposing party.

(d) Except for complaints arising under WIA section 184(f) or section 188, grievances or complaints made directly to the Secretary will be referred to the appropriate State or local area for resolution in accordance with this section, unless we notify the parties that the Department of Labor will investigate the grievance under the procedures at § 667.505. Discrimination complaints brought under WIA section 188 or 29 CFR part 37 will be referred to the Director of the Civil Rights Center.

§ 667.630 How are complaints and reports of criminal fraud and abuse addressed under WIA?

Information and complaints involving criminal fraud, waste, abuse or other criminal activity must be reported immediately through the Department's Incident Reporting System to the DOL Office of Inspector General, Office of Investigations, Room S5514, 200 Constitution Avenue NW., Washington, D.C. 20210, or to the corresponding Regional Inspector General for Investigations, with a copy simultaneously provided to the Employment and Training Administration. The Hotline number is 1–800–347–3756. Complaints of a non-criminal nature are handled under the procedures set forth in § 667.505 or through the Department's Incident Reporting System.

§ 667.640 What additional appeal processes or systems must a State have for the WIA program?

(a) *Non-designation of local areas:* (1) The State must establish, and include in its State Plan, due process procedures which provide expeditious appeal to the State Board for a unit or combination of units of general local government or a rural concentrated employment program grant recipient (as described at WIA section 116(a)(2)(B)) that requests, but is not granted, automatic or temporary and subsequent designation as a local workforce investment area under WIA section 116(a)(2) or 116(a)(3).

(2) These procedures must provide an opportunity for a hearing and prescribe appropriate time limits to ensure prompt resolution of the appeal.

(3) If the appeal to the State Board does not result in designation, the appellant may request review by the Secretary under § 667.645.

(4) If the Secretary determines that the appellant was not accorded procedural rights under the appeal process established in paragraph (a)(1) of this section, or that the area meets the requirements for designation at WIA section 116(a)(2) or 116(a)(3), the Secretary may require that the area be designated as a workforce investment area.

(b) *Denial or termination of eligibility as a training provider.* (1) A State must establish procedures which allow providers of training services the opportunity to appeal:

(i) Denial of eligibility by a Local Board or the designated State agency under WIA section 122 (b), (c) or (e);

(ii) Termination of eligibility or other action by a Local Board or State agency under WIA section 122(f); or

(iii) Denial of eligibility as a provider of on-the-job training (OJT) or customized training by a One-Stop operator under WIA section 122(h).

(2) Such procedures must provide an opportunity for a hearing and prescribe appropriate time limits to ensure prompt resolution of the appeal.

(3) A decision under this State appeal process may not be appealed to the Secretary.

(c) *Testing and sanctioning for use of controlled substances.* (1) A State must establish due process procedures which provide expeditious appeal for:

(i) WIA participants subject to testing for use of controlled substances, imposed under a State policy established under WIA section 181(f); and

(ii) WIA participants who are sanctioned after testing positive for the use of controlled substances, under the policy described in paragraph (c)(1)(i) of this section.

(2) A decision under this State appeal process may not be appealed to the Secretary.

§ 667.645 What procedures apply to the appeals of non-designation of local areas?

(a) A unit or combination of units of general local government or rural concentrated employment program grant recipient (as described in WIA section 116(a)(2)(B)) whose appeal of the denial of a request for automatic or temporary and subsequent designation as a local workforce investment area to the State Board has not resulted in designation may appeal the denial of local area designation to the Secretary.

(b) Appeals made under paragraph (a) of this section must be filed no later than 30 days after receipt of written notification of the denial from the State Board, and must be submitted by certified mail, return receipt requested, to the Secretary, U.S. Department of Labor, Washington, DC 20210,

Attention: ASET. A copy of the appeal must be simultaneously provided to the State Board.

(c) The appellant must establish that it was not accorded procedural rights under the appeal process set forth in the State Plan, or establish that it meets the requirements for designation in WIA section 116(a)(2) or (a)(3). The Secretary may consider any comments submitted in response by the State Board.

(d) If the Secretary determines that the appellant has met its burden of establishing that it was not accorded procedural rights under the appeal process set forth in the State Plan, or that it meets the requirements for designation in WIA section 116(a)(2) or (a)(3), the Secretary may require that the area be designated as a local workforce investment area.

(e) The Secretary must issue a written decision to the Governor and the appellant.

§ 667.650 What procedures apply to the appeals of the Governor's imposition of sanctions for substantial violations or performance failures by a local area?

(a) A local area which has been found in substantial violation of WIA title I, and has received notice from the Governor that either all or part of the local plan will be revoked or that a reorganization will occur, may appeal such sanctions to the Secretary under WIA section 184(b). The sanctions do not become effective until:

(1) The time for appeal has expired; or

(2) The Secretary has issued a decision.

(b) A local area which has failed to meet local performance measures for two consecutive years, and has received the Governor's notice of intent to impose a reorganization plan, may appeal such sanctions to the Secretary under WIA section 136(h)(1)(B).

(c) Appeals made under paragraph (a) or (b) of this section must be filed no later than 30 days after receipt of written notification of the revoked plan or imposed reorganization, and must be submitted by certified mail, return receipt requested, to the Secretary, U.S. Department of Labor, Washington, DC 20210, Attention: ASET. A copy of the appeal must be simultaneously provided to the Governor.

(d) The Secretary may consider any comments submitted in response by the Governor.

(e) The Secretary will notify the Governor and the appellant in writing of the Secretary's decision under paragraph (a) of this section within 45 days after receipt of the appeal. The Secretary will notify the Governor and the appellant in writing of the Secretary's decision under paragraph (b) of this section within 30 days after receipt of the appeal.

Subpart G—Sanctions, Corrective Actions, and Waiver of Liability

§ 667.700 What procedure do we use to impose sanctions and corrective actions on recipients and subrecipients of WIA grant funds?

(a)(1) Except for actions under WIA section 188(a) or 29 CFR part 37 (relating to nondiscrimination requirements), the Grant Officer uses the initial and final determination procedures outlined in § 667.510 to impose a sanction or corrective action.

(2) To impose a sanction or corrective action for a violation of WIA section 188(a) or 29 CFR part 37, the Department will use the procedures set forth in that regulatory part.

(b) To impose a sanction or corrective action for noncompliance with the uniform administrative requirements set forth at section 184(a)(3) of WIA, and § 667.200(a), when the Grant Officer determines that the Governor has not taken corrective action to remedy the violation as required by WIA section 184(a)(5), the Grant Officer, under the authority of WIA section 184(a)(7) and § 667.710(c), must require the Governor to impose any of the corrective actions set forth at WIA section 184(b)(1). If the Governor fails to impose the corrective actions required by the Grant Officer, the Secretary may immediately suspend or terminate financial assistance in accordance with WIA section 184(e).

(c) For substantial violations of WIA statutory and regulatory requirements, if the Governor fails to promptly take the actions specified in WIA section 184(b)(1), the Grant Officer may impose

such actions directly against the local area.

(d) The Grant Officer may also impose a sanction directly against a subrecipient, as authorized in section 184(d)(3) of the Act. In such a case, the Grant Officer will inform the recipient of the action.

§ 667.705 Who is responsible for funds provided under title I of WIA?

(a) The recipient is responsible for all funds under its grant(s).

(b) The political jurisdiction(s) of the chief elected official(s) in a local workforce investment area is liable for any misuse of the WIA grant funds allocated to the local area under WIA sections 128 and 133, unless the chief elected official(s) reaches an agreement with the Governor to bear such liability.

(c) When a local workforce area is composed of more than one unit of general local government, the liability of the individual jurisdictions must be specified in a written agreement between the chief elected officials.

§ 667.710 What actions are required to address the failure of a local area to comply with the applicable uniform administrative provisions?

(a) If, as part of the annual on-site monitoring of local areas, the Governor determines that a local area is not in compliance with the uniform administrative requirements found at 29 CFR part 95 or part 97, as appropriate, the Governor must:

(1) Require corrective action to secure prompt compliance; and

(2) Impose the sanctions provided for at section 184(b) if the Governor finds that the local area has failed to take timely corrective action.

(b) An action by the recipient to impose a sanction against a local area, in accordance with this section, may be appealed to the Secretary in accordance with § 667.650, and will not become effective until:

(1) The time for appeal has expired; or

(2) The Secretary has issued a decision.

(c)(1) If the Secretary finds that the Governor has failed to monitor and certify compliance of local areas with the administrative requirements, under WIA section 184(a), or that the Governor has failed to promptly take the actions required upon a determination under paragraph (a) of this section that a local area is not in compliance with the uniform administrative requirements, the Secretary will require the Governor to take corrective actions against the State recipient or the local area, as appropriate to ensure prompt compliance.

(2) If the Governor fails to take the corrective actions required by the Secretary under paragraph (c)(1) of this section, the Secretary may immediately suspend or terminate financial assistance under WIA section 184(e).

§ 667.720 How do we handle a recipient's request for waiver of liability under WIA section 184(d)(2)?

(a) A recipient may request a waiver of liability, as described in WIA section 184(d)(2), and a Grant Officer may approve such a waiver under WIA section 184(d)(3).

(b)(1) When the debt for which a waiver of liability is desired was established in a non-Federal resolution proceeding, the resolution report must accompany the waiver request.

(2) When the waiver request is made during the ETA Grant Officer resolution process, the request must be made during the informal resolution period described in § 667.510(c).

(c) A waiver of the recipient's liability shall be considered by the Grant Officer only when:

(1) The misexpenditure of WIA funds occurred at a subrecipient's level;

(2) The misexpenditure was not due to willful disregard of the requirements of title I of the Act, gross negligence, failure to observe accepted standards of administration, or did not constitute fraud;

(3) If fraud did exist, it was perpetrated against the recipient/subrecipients; and

(i) The recipient/subrecipients discovered, investigated, reported, and cooperated in any prosecution of the perpetrator of the fraud; and

(ii) After aggressive debt collection action, it has been documented that further attempts at debt collection from the perpetrator of the fraud would be inappropriate or futile;

(4) The recipient has issued a final determination which disallows the misexpenditure, the recipient's appeal process has been exhausted, and a debt has been established; and

(5) The recipient requests such a waiver and provides documentation to demonstrate that it has substantially complied with the requirements of section 184(d)(2) of the Act, and this section.

(d) The recipient will not be released from liability for misspent funds under the determination required by section 184(d) of the Act unless the Grant Officer determines that further collection action, either by the recipient or subrecipients, would be inappropriate or would prove futile.

§ 667.730 What is the procedure to handle a recipient's request for advance approval of contemplated corrective actions?

(a) The recipient may request advance approval from the Grant Officer for contemplated corrective actions, including debt collection actions, which the recipient plans to initiate or to forego. The recipient's request must include a description and an assessment of all actions taken by the subrecipients to collect the misspent funds.

(b) Based on the recipient's request, the Grant Officer may determine that the recipient may forego certain collection actions against a subrecipient when:

(1) The subrecipient meets the criteria set forth in section 184(d)(2) of the Act;

(2) The misexpenditure of funds:

(i) Was not made by that subrecipient but by an entity that received WIA funds from that subrecipient;

(ii) Was not a violation of section 184(d)(1) of the Act, and did not constitute fraud; or

(iii) If fraud did exist,

(A) It was perpetrated against the subrecipient; and:

(B) The subrecipient discovered, investigated, reported, and cooperated in any prosecution of the perpetrator of the fraud; and

(C) After aggressive debt collection action, it has been documented that further attempts at debt collection from the perpetrator of the fraud would be inappropriate or futile;

(3) A final determination which disallows the misexpenditure and establishes a debt has been issued at the appropriate level;

(4) Final action within the recipient's appeal system has been completed; and

(5) Further debt collection action by that subrecipient or the recipient would be either inappropriate or futile.

§ 667.740 What procedure must be used for administering the offset/deduction provisions at section 184(c) of the Act?

(a)(1) For recipient level misexpenditures, we may determine that a debt, or a portion thereof, may be offset against amounts that are allotted to the recipient. Recipients must submit a written request for an offset to the Grant Officer. Generally, we will apply the offset against amounts that are available at the recipient level for administrative costs.

(2) The Grant Officer may approve an offset request, under paragraph (a)(1) of this section, if the misexpenditures were not due to willful disregard of the requirements of the Act and regulations, gross negligence, failure to observe accepted standards of administration or a pattern of misexpenditure.

(b) For subrecipient level misexpenditures that were not due to willful disregard of the requirements of the Act and regulations, gross negligence, failure to observe accepted standards of administration or a pattern of misexpenditure, if we have required the State to repay such amount the State may deduct an amount equal to the misexpenditure from its subsequent year's allocations to the local area from funds available for the administrative costs of the local programs involved.

(c) If offset is granted, the debt will not be fully satisfied until the Grant Officer reduces amounts allotted to the State by the amount of the misexpenditure.

(d) A State may not make a deduction under paragraph (b) of this section until the State has taken appropriate corrective action to ensure full compliance within the local area with regard

to appropriate expenditure of WIA funds.

Subpart H—Administrative Adjudication and Judicial Review

§ 667.800 What actions of the Department may be appealed to the Office of Administrative Law Judges?

(a) An applicant for financial assistance under title I of WIA which is dissatisfied because we have issued a determination not to award financial assistance, in whole or in part, to such applicant; or a recipient, subrecipient, or a vendor against which the Grant Officer has directly imposed a sanction or corrective action, including a sanction against a State under 20 CFR part 666, may appeal to the U.S. Department of Labor, Office of Administrative Law Judges (OALJ) within 21 days of receipt of the final determination.

(b) Failure to request a hearing within 21 days of receipt of the final determination constitutes a waiver of the right to a hearing.

(c) A request for a hearing under this subpart must state specifically those issues in the final determination upon which review is requested. Those provisions of the final determination not specified for review, or the entire final determination when no hearing has been requested within the 21 days, are considered resolved and not subject to further review. Only alleged violations of the Act, its regulations, grant or other agreement under the Act fairly raised in the determination, and the request for hearing are subject to review.

(d) A request for a hearing must be filed with the Chief Administrative Law Judge, U.S. Department of Labor, in accordance with 29 CFR part 18, with one copy to the Departmental official who issued the determination.

(e) The procedures in this subpart apply in the case of a complainant who has not had a dispute adjudicated under the alternative dispute resolution process set forth in § 667.840 within the 60 days, except that the request for hearing before the OALJ must be filed within 15 days of the conclusion of the 60-day period provided in § 667.840. In addition to including the final determination upon which review is requested, the complainant must include a copy of any Stipulation of Facts and a brief summary of proceedings.

[65 FR 49421, Aug. 11, 2000, as amended at 86 FR 1779, Jan. 11, 2021]

§ 667.810 What rules of procedure apply to hearings conducted under this subpart?

(a) *Rules of practice and procedure.* The rules of practice and procedure promulgated by the OALJ at subpart A of 29 CFR part 18, govern the conduct of hearings under this subpart. However, a request for hearing under this subpart is not considered a complaint to which the filing of an answer by DOL or a DOL agency or official is required. Technical rules of evidence will not apply to hearings conducted pursuant to this part. However, rules or principles designed to assure production of the most credible evidence available and to subject testimony to cross-examination will apply.

(b) *Prehearing procedures.* In all cases, the Administrative Law Judge (ALJ) should encourage the use of prehearing procedures to simplify and clarify facts and issues.

(c) *Subpoenas.* Subpoenas necessary to secure the attendance of witnesses and the production of documents or other items at hearings must be obtained from the ALJ and must be issued under the authority contained in section 183(c) of the Act, incorporating 15 U.S.C. 49.

(d) *Timely submission of evidence.* The ALJ must not permit the introduction at the hearing of any documentation if it has not been made available for review by the other parties to the proceeding either at the time ordered for any prehearing conference, or, in the absence of such an order, at least 3 weeks prior to the hearing date.

(e) *Burden of production.* The Grant Officer has the burden of production to support her or his decision. To this end, the Grant Officer prepares and files an administrative file in support of the decision which must be made part of the record. Thereafter, the party or parties seeking to overturn the Grant Officer's decision has the burden of persuasion.

§ 667.820 What authority does the Administrative Law Judge have in ordering relief as an outcome of an administrative hearing?

In ordering relief, the ALJ has the full authority of the Secretary under the Act.

§ 667.825 What special rules apply to reviews of NFJP and WIA INA grant selections?

(a) An applicant whose application for funding as a WIA INA grantee under 20 CFR part 668 or as an NFJP grantee under 20 CFR part 669 is denied in whole or in part may request an administrative review under § 667.800(a) with to determine whether there is a basis in the record to support the decision. This appeal will not in any way interfere with the designation and funding of another organization to serve the area in question during the appeal period. The available remedy in such an appeal is the right to be designated in the future as the WIA INA or NFJP grantee for the remainder of the current grant cycle. Neither retroactive nor immediately effective selection status may be awarded as relief in a non-selection appeal under this section.

(b) If the ALJ rules that the organization should have been selected and the organization continues to meet the requirements of 20 CFR part 668 or part 669, we will select and fund the organization within 90 days of the ALJ's decision unless the end of the 90-day period is within six (6) months of the end of the funding period. An applicant so selected is not entitled to the full grant amount, but will only receive the funds remaining in the grant that have not been expended by the current grantee through its operation of the grant and its subsequent closeout.

(c) Any organization selected and/or funded as a WIA INA or NFJP grantee is subject to being removed as grantee in the event an ALJ decision so orders. The Grant Officer provides instructions on transition and close-out to a grantee which is removed. All parties must agree to the provisions of this paragraph as a condition for WIA INA or NFJP funding.

(d) A successful appellant which has not been awarded relief because of the application of paragraph (b) of this section is eligible to compete for funds in the immediately subsequent two-year grant cycle. In such a situation, we will not issue a waiver of competition and for the area and will select a grantee through the normal competitive process.

§ 667.830 When will the Administrative Law Judge issue a decision?

(a) The ALJ should render a written decision not later than 90 days after the closing of the record.

(b) The decision of the ALJ constitutes final agency action unless, within 20 days of the decision, a party dissatisfied with the ALJ's decision has filed a petition for review with the Administrative Review Board (ARB) (established under Secretary's Order No. 01–2020), specifically identifying the procedure, fact, law, or policy to which exception is taken, in accordance with 29 CFR part 26. Any exception not specifically urged is deemed to have been waived. A copy of the petition for review must be sent to the opposing party at that time. Thereafter, the decision of the ALJ constitutes final agency action unless the ARB, within 30 days of the filing of the petition for review, notifies the parties that the case has been accepted for review. In any case accepted by the ARB, a decision must be issued by the ARB within 180 days of acceptance. If a decision is not so issued, the decision of the ALJ constitutes final agency action.

[65 FR 49421, Aug. 11, 2000, as amended at 85 FR 13030, Mar. 6, 2020; 85 FR 30615, May 20, 2020; 86 FR 1779, Jan. 11, 2021]

§ 667.840 Is there an alternative dispute resolution process that may be used in place of an OALJ hearing?

(a) Parties to a complaint which has been filed according to the requirements of § 667.800 may choose to waive their rights to an administrative hearing before the OALJ. Instead, they may choose to transfer the settlement of their dispute to an individual acceptable to all parties who will conduct an informal review of the stipulated facts and render a decision in accordance with applicable law. A written decision must be issued within 60 days after

submission of the matter for informal review.

(b) The waiver of the right to request a hearing before the OALJ will automatically be revoked if a settlement has not been reached or a decision has not been issued within the 60 days provided in paragraph (a) of this section.

(c) The decision rendered under this informal review process will be treated as a final decision of an Administrative Law Judge under section 186(b) of the Act.

§ 667.850 Is there judicial review of a final order of the Secretary issued under section 186 of the Act?

(a) Any party to a proceeding which resulted in a Secretary's final order under section 186 of the Act may obtain a review in the United States Court of Appeals having jurisdiction over the applicant or recipient of funds involved, by filing a review petition within 30 days of the issuance of the Secretary's final order.

(b) The court has jurisdiction to make and enter a decree affirming, modifying, or setting aside the order of the Secretary, in whole or in part.

(c) No objection to the Secretary's order may be considered by the court unless the objection was specifically urged, in a timely manner, before the Secretary. The review is limited to questions of law, and the findings of fact of the Secretary are conclusive if supported by substantial evidence.

(d) The judgment of the court is final, subject to certiorari review by the United States Supreme Court.

§ 667.860 Are there other remedies available outside of the Act?

Nothing contained in this subpart prejudices the separate exercise of other legal rights in pursuit of remedies and sanctions available outside the Act.

PART 668—INDIAN AND NATIVE AMERICAN PROGRAMS UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

Subpart A—Purposes and Policies

Sec.

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Subpart A—Purposes and Policies

§ 668.100 What is the purpose of the programs established to serve Native American peoples (INA programs) under section 166 of the Workforce Investment Act?

(a) The purpose of WIA INA programs is to support comprehensive employment and training activities for Indian, Alaska Native and Native Hawaiian individuals in order to:

(1) Develop more fully their academic, occupational, and literacy skills;

(2) Make them more competitive in the workforce;

(3) Promote the economic and social development of Indian, Alaska Native, and Native Hawaiian communities according to the goals and values of such communities; and

(4) Help them achieve personal and economic self-sufficiency.

(b) The principal means of accomplishing these purposes is to enable tribes and Native American organizations to provide employment and training services to Native American peoples and their communities. Services should be provided in a culturally appropriate manner, consistent with the principles of Indian self-determination. (WIA sec. 166(a)(1).)

§ 668.120 How must INA programs be administered?

(a) We will administer INA programs to maximize the Federal commitment to support the growth and development of Native American people and communities as determined by representatives of such communities.

(b) In administering these programs, we will observe the Congressional declaration of policy set forth in the Indian Self-Determination and Education Assistance Act, at 25 U.S.C. section 450a, as well as the Department of Labor's ''American Indian and Alaska Native Policy,'' dated July 29, 1998.

(c) The regulations in this part are not intended to abrogate the trust responsibilities of the Federal Government to Native American bands, tribes, or groups in any way.

(d) We will administer INA programs through a single organizational unit and consistent with the requirements in section 166(h) of the Act. We have designated the Division of Indian and Native American Programs (DINAP) within the Employment and Training Administration (ETA) as this single organizational unit required by WIA section 166(h)(1).

(e) We will establish and maintain administrative procedures for the selection, administration, monitoring, and evaluation of Native American employment and training programs authorized under this Act. We will utilize staff who have a particular competence in this field to administer these programs. (WIA sec. 166(h).)

§ 668.130 What obligation do we have to consult with the INA grantee community in developing rules, regulations, and standards of accountability for INA programs?

We will consult with the Native American grantee community as a full partner in developing policies for the INA programs. We will actively seek and consider the views of all INA grantees, and will discuss options with the grantee community prior to establishing policies and program regulations. The primary consultation vehicle is the Native American Employment and Training Council. (WIA sec. 166(h)(2).)

§ 668.140 What WIA regulations apply to the INA program?

(a) The regulations found in this subpart.

(b) The general administrative requirements found in 20 CFR part 667, including the regulations concerning Complaints, Investigations and Hearings found at 20 CFR part 667, subpart E through subpart H.

(c) The Department's regulations codifying the common rules implementing Office of Management and Budget (OMB) Circulars which generally apply to Federal programs carried out by Indian tribal governments and nonprofit organizations, at 29 CFR parts 95, 96, 97, and 99 as applicable.

(d) The Department's regulations at 29 CFR part 37, which implement the nondiscrimination provisions of WIA section 188, apply to recipients of financial assistance under WIA section 166.

§ 668.150 What definitions apply to terms used in the regulations in this part?

In addition to the definitions found in WIA sections 101 and 166 and 20 CFR 660.300, the following definitions apply:

DINAP means the Division of Indian and Native American Programs within the Employment and Training Administration of the Department.

Governing body means a body of representatives who are duly elected, appointed by duly elected officials, or selected according to traditional tribal means. A governing body must have the authority to provide services to and to enter into grants on behalf of the organization that selected or designated it.

Grant Officer means a Department of Labor official authorized to obligate Federal funds. Indian or Native American (INA) *Grantee* means an entity which is formally designated under subpart B of this part to operate an INA program and which has a grant agreement under § 668.292.

NEW means the Native Employment Works Program, the tribal work program authorized under section 412(a)(2) of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act (Public Law 104–193).

Underemployed means an individual who is working part time but desires full time employment, or who is working in employment not commensurate with the individual's demonstrated level of educational and/or skill achievement.

Subpart B—Service Delivery Systems Applicable to Section 166 Programs

§ 668.200 What are the requirements for designation as an "Indian or Native American (INA) grantee"?

(a) To be designated as an INA grantee, an entity must have:

(1) A legal status as a government or as an agency of a government, private non-profit corporation, or a consortium which contains at least one of these entities;

(2) The ability to administer INA program funds, as defined at § 668.220; and

(3) A new (non-incumbent) entity must have a population within the designated geographic service area which would provide funding under the funding formula found at § 668.296(b) in the amount of at least $100,000, including any amounts received for supplemental youth services under the funding formula at § 668.440(a). Incumbent grantees which do not meet this dollar threshold for Program Year (PY) 2000 and beyond will be grandfathered in. We will make an exception for grantees wishing to participate in the demonstration program under Public Law 102–477 if all resources to be consolidated under the Public Law 102–477 plan total at least $100,000, with at least $20,000 derived from section 166 funds as determined by the most recent Census data. Exceptions to this $20,000 limit may be made for those entities which are close to the limit and which have demonstrated the capacity to administer Federal funds and operate a successful employment and training program.

(b) To be designated as a Native American grantee, a consortium or its members must meet the requirements of paragraph (a) of this section and must:

(1) Be in close proximity to one another, but they may operate in more than one State;

(2) Have an administrative unit legally authorized to run the program and to commit the other members to contracts, grants, and other legally-binding agreements; and

(3) Be jointly and individually responsible for the actions and obligations of the consortium, including debts.

(c) Entities potentially eligible for designation under paragraph (a)(1) or (b)(1) of this section are:

(1) Federally-recognized Indian tribes;

(2) Tribal organizations, as defined in 25 U.S.C. 450b;

(3) Alaska Native-controlled organizations representing regional or village areas, as defined in the Alaska Native Claims Settlement Act;

(4) Native Hawaiian-controlled entities;

(5) Native American-controlled organizations serving Indians; and

(6) Consortia of eligible entities which individually meets the legal requirements for a consortium described in paragraph (c) of this section.

(d) Under WIA section 166(d)(2)(B), individuals who were eligible to participate under section 401 of JTPA on August 6, 1998, remain eligible to participate under section 166 of WIA. State-recognized tribal organizations serving such individuals are considered to be

''Native American controlled'' for WIA section 166 purposes.

§ 668.210 What priority for designation is given to eligible organizations?

(a) Federally-recognized Indian tribes, Alaska Native entities, or consortia that include a tribe or entity will have the highest priority for designation. To be designated, the organizations must meet the requirements in this subpart. These organizations will be designated for those geographic areas and/or populations over which they have legal jurisdiction. (WIA sec. 166(c)(1).)

(b) If we decide not to designate Indian tribes or Alaska Native entities to serve their service areas, we will enter into arrangements to provide services with entities which the tribes or Alaska Native entities involved approve.

(c) In geographic areas not served by Indian tribes or Alaska Native entities, entities with a Native American-controlled governing body and which are representative of the Native American community or communities involved will have priority for designation.

§ 668.220 What is meant by the "ability to administer funds" for designation purposes?

An organization has the ''ability to administer funds'' if it:

(a) Is in compliance with Departmental debt management procedures, if applicable;

(b) Has not been found guilty of fraud or criminal activity which would affect the entity's ability to safeguard Federal funds or deliver program services;

(c) Can demonstrate that it has or can acquire the necessary program and financial management personnel to safeguard Federal funds and effectively deliver program services; and

(d) Can demonstrate that it has successfully carried out, or has the capacity to successfully carry out activities that will strengthen the ability of the individuals served to obtain or retain unsubsidized employment.

§ 668.230 How will we determine an entity's "ability to administer funds"?

(a) Before determining which entity to designate for a particular service area, we will conduct a review of the entity's ability to administer funds.

(b) The review for an entity that has served as a grantee in either of the two designation periods before the one under consideration, also will consider the extent of compliance with the WIA regulations. Evidence of the ability to administer funds may be established by a satisfactory Federal audit record. It may also be established by a recent record showing substantial compliance with Federal record keeping, reporting, program performance standards, or similar standards imposed on grantees by this or other public sector supported programs.

(c) For other entities, the review includes the experience of the entity's management in administering funds for services to Native American people. This review also includes an assessment of the relationship between the entity and the Native American community or communities to be served.

[65 FR 49435, Aug. 11, 2000, as amended at 71 FR 35524, June 21, 2006]

§ 668.240 What is the process for applying for designation as an INA grantee?

(a) Every entity seeking designation must submit a Notice of Intent (NOI) which complies with the requirements of the Solicitation for Grant Application (SGA). An SGA will be issued every two years, covering all areas except for those for which competition is waived for the incumbent grantee under WIA section 166(c)(2).

(b) NOI's must be submitted to the Chief of DINAP, bearing a U.S. Postal Service postmark indicating its submission no later than October 1st of the year which precedes the first year of a new designation cycle (unless the SGA provides a later date). For NOI's received after October 1, only a timely official U.S. Postal Service postmark is acceptable as proof of timely submission. Dates indicating submission by private express delivery services or metered mail are unacceptable as proof of the timely submission of designation documents.

(c) NOI's must include the following:

(1) Documentation of the legal status of the entity, as described in § 668.200(a)(1);

(2) A Standard Form (SF) 424b;
(3) The assurances required by 29 CFR 37.20;
(4) A specific description, by State, county, reservation or similar area, or service population, of the geographic area for which the entity requests designation;
(5) A brief summary of the employment and training or human resource development programs serving Native Americans that the entity currently operates or has operated within the previous two-year period;
(6) A description of the planning process used by the entity, including the involvement of the governing body and local employers;
(7) Evidence to establish an entity's ability to administer funds under §§ 668.220 through 668.230.

§ 668.250 What happens if two or more entities apply for the same area?

(a) Every two years, unless there has been a waiver of competition for the area, we issue a Solicitation for Grant Application (SGA) seeking applicants for INA program grants.
(b) If two or more entities apply for grants for the same service area, or for overlapping service areas, and a waiver of competition under WIA section 166(c)(2) is not granted to the incumbent grantee, the following additional procedures apply:
(1) The Grant Officer will follow the regulations for priority designation at § 668.210.
(2) If no applicant is entitled to priority designation, DINAP will inform each entity which submitted a NOI, including the incumbent grantee, in writing, of all the competing Notices of Intent no later than November 15 of the year the NOI's are received.
(3) Each entity will have an opportunity to describe its service plan, and may submit additional information addressing the requirements of § 668.240(c) or such other information as the applicant determines is appropriate. Revised Notices must be received or contain an official U.S. Postal Service postmark, no later than January 5th (unless a later date is provided in DINAP's information notice).
(4) The Grant Officer selects the entity that demonstrates the ability to produce the best outcomes for its customers.

§ 668.260 How are INA grantees designated?

(a) On March 1 of each designation year, we designate or conditionally designate Native American grantees for the coming two program years. The Grant Officer informs, in writing, each entity which submitted a Notice of Intent that the entity has been:
(1) Designated;
(2) Conditionally designated;
(3) Designated for only a portion of its requested area or population; or
(4) Denied designation.
(b) Designated Native American entities must ensure and provide evidence to DOL that a system is in place to afford all members of the eligible population within their service area an equitable opportunity to receive employment and training activities and services.

§ 668.270 What appeal rights are available to entities that are denied designation?

Any entity that is denied designation in whole or in part for the area or population that it requested may appeal the denial to the Office of the Administrative Law Judges using the procedures at 20 CFR 667.800 or the alternative dispute resolution procedures at 20 CFR 667.840. The Grant Officer will provide an entity whose request for designation was denied, in whole or in part, with a copy of the appeal procedures.

§ 668.280 Are there any other ways in which an entity may be designated as an INA grantee?

Yes, for an area which would otherwise go unserved. The Grant Officer may designate an entity, which has not submitted an NOI, but which meets the qualifications for designation, to serve the particular geographic area. Under such circumstances, DINAP will seek the views of Native American leaders in the area involved about the decision to designate the entity to serve that community. DINAP will inform the Grant Officer of their views. The Grant Officer will accommodate their views to the extent possible.

§ 668.290 Can an INA grantee's designation be terminated?

(a) Yes, the Grant Officer can terminate a grantee's designation for cause, or the Secretary or another DOL official confirmed by the Senate can terminate a grantee's designation in emergency circumstances where termination is necessary to protect the integrity of Federal funds or ensure the proper operation of the program. (WIA sec. 184(e).)

(b) The Grant Officer may terminate a grantee's designation for cause only if there is a substantial or persistent violation of the requirements in the Act or the WIA regulations. The grantee must be provided with written notice 60 days before termination, stating the specific reasons why termination is proposed. The appeal procedures at 20 CFR 667.800 apply.

(c) The Secretary must give a grantee terminated in emergency circumstances prompt notice of the termination and an opportunity for a hearing within 30 days of the termination.

§ 668.292 How does a designated entity become an INA grantee?

A designated entity becomes a grantee on the effective date of an executed grant agreement, signed by the authorized official of the grantee organization and the Grant Officer. The grant agreement includes a set of certifications and assurances that the grantee will comply with the terms of the Act, the WIA regulations, and other appropriate requirements. Funds are released to the grantee upon approval of the required planning documents, as described in §§ 668.710 through 668.740.

§ 668.294 Do we have to designate an INA grantee for every part of the country?

No, beginning with the PY 2000 grant awards, if there are no entities meeting the requirements for designation in a particular area, or willing to serve that area, we will not allocate funds for that service area. The funds allocated to that area will be distributed to the remaining INA grantees, or used for other program purposes such as technical assistance and training (TAT). Unawarded funds used for technical assistance and training are in addition to, and not subject to the limitations on, amounts reserved under § 668.296(e). Areas which are unserved by the INA program may be restored during a subsequent designation cycle, when and if a current grantee or other eligible entity applies for and is designated to serve that area.

§ 668.296 How are WIA funds allocated to INA grantees?

(a) Except for reserved funds described in paragraph (e) of this section and funds used for program purposes under § 668.294, all funds available for WIA section 166(d)(2)(A)(i) comprehensive workforce investment services program at the beginning of a Program Year will be allocated to Native American grantees for their designated geographic service areas.

(b) Each INA grantee will receive the sum of the funds calculated under the following formula:

(1) One-quarter of the funds available will be allocated on the basis of the number of unemployed Native American persons in the grantee's designated INA service area(s) compared to all such persons in all such areas in the United States.

(2) Three-quarters of the funds available will be allocated on the basis of the number of Native American persons in poverty in the grantee's designated INA service area(s) as compared to all such persons in all such areas in the United States.

(3) The data and definitions used to implement these formulas is provided by the U.S. Bureau of the Census.

(c) In years immediately following the use of new data in the formula described in paragraph (b) of this section, based upon criteria to be described in the SGA, we may utilize a hold harmless factor to reduce the disruption in grantee services which would otherwise result from changes in funding levels. This factor will be determined in consultation with the grantee community and the Native American Employment and Training Council.

(d) We may reallocate funds from one INA grantee to another if a grantee is unable to serve its area for any reason, such as audit or debt problems, criminal activity, internal (political) strife,

or lack of ability or interest. Funds may also be reallocated if a grantee has carry-in excess of 20 percent of the total funds available to it. Carry-in amounts greater than 20 percent but less than 25 percent of total funds available may be allowed under an approved waiver issued by DINAP.

(e) We may reserve up to one percent (1 percent) of the funds appropriated under WIA section 166(d)(2)(A)(i) for any Program Year for TAT purposes. Technical assistance will be provided in consultation with the Native American Employment and Training Council.

Subpart C—Services to Customers

§ 668.300 Who is eligible to receive services under the INA program?

(a) A person is eligible to receive services under the INA program if that person is:

(1) An Indian, as determined by a policy of the Native American grantee. The grantee's definition must at least include anyone who is a member of a Federally-recognized tribe; or

(2) An Alaska Native, as defined in section 3(b) of the Alaska Native Claims Settlement Act (ANCSA), 43 U.S.C. 1602(b); or

(3) A Native Hawaiian, as defined in WIA section 166(b)(3).

(b) The person must also be any one of the following:

(1) Unemployed; or

(2) Underemployed, as defined in § 668.150; or

(3) A low-income individual, as defined in WIA section 101(25); or

(4) The recipient of a bona fide lay-off notice which has taken effect in the last six months or will take effect in the following six month period, who is unlikely to return to a previous industry or occupation, and who is in need of retraining for either employment with another employer or for job retention with the current employer; or

(5) An individual who is employed, but is determined by the grantee to be in need of employment and training services to obtain or retain employment that allows for self-sufficiency.

(c) If applicable, male applicants must also register or be registered for the Selective Service.

(d) For purposes of determining whether a person is a low-income individual under paragraph (b)(3) of this section, we will issue guidance for the determination of family income. (WIA sec. 189(h).)

§ 668.340 What are INA grantee allowable activities?

(a) The INA grantee may provide any services consistent with the purposes of this section that are necessary to meet the needs of Native Americans preparing to enter, reenter, or retain unsubsidized employment. (WIA sec. 166(d)(1)(B).) Comprehensive workforce investment activities authorized under WIA section 166(d)(2) include:

(b) Core services, which must be delivered in partnership with the One-Stop delivery system, include:

(1) Outreach;

(2) Intake;

(3) Orientation to services available;

(4) Initial assessment of skill levels, aptitudes, abilities and supportive service needs;

(5) Eligibility certification;

(6) Job Search and placement assistance;

(7) Career counseling;

(8) Provision of employment statistics information and local, regional, and national Labor Market Information;

(9) Provision of information about filing of Unemployment Insurance claims;

(10) Assistance in establishing eligibility for Welfare-to-Work programs;

(11) Assistance in establishing eligibility for financial assistance for training;

(12) Provision of information about supportive services;

(13) Provision of performance and cost information relating to training providers and training services; and

(14) Follow-up services.

(c) Allowable intensive services which include:

(1) Comprehensive and specialized testing and assessment;

(2) Development of an individual employment plan;

(3) Group counseling;

(4) Individual counseling and career planning;

(5) Case Management for seeking training services;
(6) Short term pre-vocational services;
(7) Work experience in the public or private sector;
(8) Tryout employment;
(9) Dropout prevention activities;
(10) Supportive services; and
(11) Other services identified in the approved Two Year Plan.
(d) Allowable training services which include:
(1) Occupational skill training;
(2) On-the-job training;
(3) Programs that combine workplace training with related instruction, which may include cooperative education programs;
(4) Training programs operated by the private sector;
(5) Skill upgrading and retraining;
(6) Entrepreneurial and small business development technical assistance and training;
(7) Job readiness training;
(8) Adult basic education, GED attainment, literacy training, and English language training, provided alone or in combination with training or intensive services described paragraphs (c)(1) through (11) and (d)(1) through (10) of this section;
(9) Customized training conducted with a commitment by an employer or group of employers to employ an individual upon successful completion of training; and
(10) Educational and tuition assistance.
(e) Allowable activities specifically designed for youth are identified in section 129 of the Act and include:
(1) Improving educational and skill competencies;
(2) Adult mentoring;
(3) Training opportunities;
(4) Supportive services, as defined in WIA section 101(46);
(5) Incentive programs for recognition and achievement;
(6) Opportunities for leadership development, decision-making, citizenship and community service;
(7) Preparation for postsecondary education, academic and occupational learning, unsubsidized employment opportunities, and other effective connections to intermediaries with strong links to the job market and local and regional employers;
(8) Tutoring, study skills training, and other drop-out prevention strategies;
(9) Alternative secondary school services;
(10) Summer employment opportunities that are directly linked to academic and occupational learning;
(11) Paid and unpaid work experiences, including internships and job shadowing;
(12) Occupational skill training;
(13) Leadership development opportunities, as defined in 20 CFR 664.420;
(14) Follow-up services, as defined in 20 CFR 664.450;
(15) Comprehensive guidance and counseling, which may include drug and alcohol abuse counseling and referral; and
(16) Information and referral.
(f) In addition, allowable activities include job development and employment outreach, including:
(1) Support of the Tribal Employment Rights Office (TERO) program;
(2) Negotiation with employers to encourage them to train and hire participants;
(3) Establishment of linkages with other service providers to aid program participants;
(4) Establishment of management training programs to support tribal administration or enterprises; and
(5) Establishment of linkages with remedial education, such as Adult Basic Education (ABE), basic literacy training, and English-as-a-second-language (ESL) training programs, as necessary.
(g) Participants may be enrolled in more than one activity at a time and may be sequentially enrolled in multiple activities.
(h) INA grantees may provide any services which may be carried out by fund recipients under any provisions of the Act. (WIA sec. 166(d).)
(i) In addition, INA grantees must develop programs which contribute to occupational development, upward mobility, development of new careers, and opportunities for nontraditional employment. (WIA sec. 195(1).)

§ 668.350 Are there any restrictions on allowable activities?

(a) All occupational training must be for occupations for which there are employment opportunities in the local area or another area to which the participant is willing to relocate. (WIA sec. 134(d)(4)(A)(iii).)

(b) INA grantees must provide OJT services consistent with the definition provided in WIA section 101(31) and other limitations in the Act. Individuals in OJT must:

(1) Be compensated at the same rates, including periodic increases, as trainees or employees who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills (WIA sec. 181(a)(1)); and

(2) Be provided benefits and working conditions at the same level and to the same extent as other trainees or employees working a similar length of time and doing the same type of work. (WIA sec. 181(b)(5).)

(c) In addition, OJT contracts under this title must not be entered into with employers who have:

(1) Received payments under previous contracts and have exhibited a pattern of failing to provide OJT participants with continued, long-term employment as regular employees with wages and employment benefits and working conditions at the same level and to the same extent as other employees working a similar length of time and doing the same work; or

(2) Who have violated paragraphs (b)(1) and/or (2) of this section. (WIA sec. 195(4).)

(d) INA grantees are prohibited from using funds to encourage the relocation of a business, as described in WIA section 181(d) and 20 CFR 667.268.

(e) INA grantees must only use WIA funds for activities which are in addition to those that would otherwise be available to the Native American population in the area in the absence of such funds. (WIA sec. 195(2).)

(f) INA grantees must not spend funds on activities that displace currently employed individuals, impair existing contracts for services, or in any way affect union organizing.

(g) Under 20 CFR 667.266, sectarian activities involving WIA financial assistance or participants are limited in accordance with the provisions of 29 CFR 37.6(f). (WIA sec. 181(b).)

§ 668.360 What is the role of INA grantees in the One-Stop system?

(a) In those local workforce investment areas where an INA grantee conducts field operations or provides substantial services, the INA grantee is a required partner in the local One-Stop delivery system and is subject to the provisions relating to such partners described in 20 CFR part 662. Consistent with those provisions, a Memorandum of Understanding (MOU) between the INA grantee and the Local Board over the operation of the One-Stop Center(s) in the Local Board's workforce investment area also must be executed. Where the Local Board is an alternative entity under 20 CFR 661.330, the INA grantee must negotiate with the alternative entity on the terms of its MOU and the scope of its on-going role in the local workforce investment system, as specified in 20 CFR 661.310(b)(2). In local areas with a large concentration of potentially eligible INA participants, which are in an INA grantee's service area but in which the grantee does not conduct operations or provide substantial services, the INA grantee should encourage such individuals to participate in the One-Stop system in that area in order to receive WIA services.

(b) At a minimum, the MOU must contain provisions related to:

(1) The services to be provided through the One-Stop Service System;

(2) The methods for referral of individuals between the One-Stop operator and the INA grantee which take into account the services provided by the INA grantee and the other One-Stop partners;

(3) The exchange of information on the services available and accessible through the One-Stop system and the INA program;

(4) As necessary to provide referrals and case management services, the exchange of information on Native American participants in the One-Stop system and the INA program;

(5) Arrangements for the funding of services provided by the One-Stop(s), consistent with the requirements at 20

CFR 662.280 that no expenditures may be made with INA program funds for individuals who are not eligible or for services not authorized under this part.

(c) The INA grantee's Two Year Plan must describe the efforts the grantee has made to negotiate MOU's consistent with paragraph (b) of this section, for each planning cycle during which Local Boards are operating under the terms of WIA.

§ 668.370 What policies govern payments to participants, including wages, training allowances or stipends, or direct payments for supportive services?

(a) INA grantees may pay training allowances or stipends to participants for their successful participation in and completion of education or training services (except such allowance may not be provided to participants in OJT). Allowances or stipends may not exceed the Federal or State minimum wage, whichever is higher.

(b) INA grantees may not pay a participant in a training activity when the person fails to participate without good cause.

(c) If a participant in a WIA-funded activity, including participants in OJT, is involved in an employer-employee relationship, that participant must be paid wages and fringe benefits at the same rates as trainees or employees who have similar training, experience and skills and which are not less than the higher of the applicable Federal, State or local minimum wage. (WIA sec. 181(a)(1).)

(d) In accordance with the policy described in the two-year plan, INA grantees may pay incentive bonuses to participants who meet or exceed individual employability or training goals established in writing in the individual employment plan.

(e) INA grantees must comply with other restrictions listed in WIA sections 181 through 199, which apply to all programs funded under title I of WIA.

(f) INA grantees must comply with the provisions on labor standards in WIA section 181(b).

§ 668.380 What will we do to strengthen the capacity of INA grantees to deliver effective services?

We will provide appropriate TAT, as necessary, to INA grantees. This TAT will assist INA grantees to improve program performance and enhance services to the target population(s), as resources permit. (WIA sec. 166(h)(5).)

Subpart D—Supplemental Youth Services

§ 668.400 What is the purpose of the supplemental youth services program?

The purpose of this program is to provide supplemental employment and training and related services to Native American youth on or near Indian reservations, or in Oklahoma, Alaska, and Hawaii. (WIA sec. 166(d)(2)(A)(ii).)

§ 668.410 What entities are eligible to receive supplemental youth services funding?

Eligible recipients for supplemental youth services funding are limited to those tribal, Alaska Native, Native Hawaiian and Oklahoma tribal grantees funded under WIA section 166(d)(2)(A)(i), or other grantees serving those areas and/or populations specified in § 668.400, that received funding under title II-B of the Job Training Partnership Act, or that are designated to serve an eligible area as specified in WIA section 166(d)(2)(A)(ii).

§ 668.420 What are the planning requirements for receiving supplemental youth services funding?

Beginning with PY 2000, eligible INA grantees must describe the supplemental youth services which they intend to provide in their Two Year Plan (described more fully in §§ 668.710 and 668.720). This Plan includes the target population the grantee intends to serve, for example, drop-outs, juvenile offenders, and/or college students. It also includes the performance measures/standards to be utilized to measure program progress.

§ 668.430 What individuals are eligible to receive supplemental youth services?

(a) Participants in supplemental youth services activities must be Native Americans, as determined by the INA grantee according to § 668.300(a), and must meet the definition of Eligible Youth, as defined in WIA section 101(13).

(b) Youth participants must be low-income individuals, except that not more than five percent (5%) who do not meet the minimum income criteria, may be considered eligible youth if they meet one or more of the following categories:

(1) School dropouts;

(2) Basic skills deficient as defined in WIA section 101(4);

(3) Have educational attainment that is one or more grade levels below the grade level appropriate to their age group;

(4) Pregnant or parenting;

(5) Have disabilities, including learning disabilities;

(6) Homeless or runaway youth;

(7) Offenders; or

(8) Other eligible youth who face serious barriers to employment as identified by the grantee in its Plan. (WIA sec. 129(c)(5).)

§ 668.440 How is funding for supplemental youth services determined?

(a) Beginning with PY 2000, supplemental youth funding will be allocated to eligible INA grantees on the basis of the relative number of Native American youth between the ages of 14 and 21, inclusive, in the grantee's designated INA service area as compared to the number of Native American youth in other eligible INA service areas. We reserve the right to redetermine this youth funding stream in future program years, in consultation with the Native American Employment and Training Council, as program experience warrants and as appropriate data become available.

(b) The data used to implement this formula is provided by the U.S. Bureau of the Census.

(c) The hold harmless factor described in § 668.296(c) also applies to supplemental youth services funding. This factor also will be determined in consultation with the grantee community and the Native American Employment and Training Council.

(d) The reallocation provisions of § 668.296(d) also apply to supplemental youth services funding.

(e) Any supplemental youth services funds not allotted to a grantee or refused by a grantee may be used for the purposes outlined in § 668.296(e), as described in § 668.294. Any such funds are in addition to, and not subject to the limitations on, amounts reserved under § 668.296(e).

§ 668.450 How will supplemental youth services be provided?

(a) INA grantees may offer supplemental services to youth throughout the school year, during the summer vacation, and/or during other breaks during the school year at their discretion;

(b) We encourage INA grantees to work with Local Educational Agencies to provide academic credit for youth activities whenever possible;

(c) INA grantees may provide participating youth with the activities listed in 20 CFR 668.340(e).

§ 668.460 Are there performance measures and standards applicable to the supplemental youth services program?

Yes, WIA section 166(e)(5) requires that the program plan contain a description of the performance measures to be used to assess the performance of grantees in carrying out the activities assisted under this section. We will develop specific indicators of performance and levels of performance for supplemental youth services activities in partnership with the Native American Employment and Training Council, and will transmit them to INA grantees as an administrative issuance.

Subpart E—Services to Communities

§ 668.500 What services may INA grantees provide to or for employers under section 166?

(a) INA grantees may provide a variety of services to employers in their areas. These services may include:

(1) Workforce planning which involves the recruitment of current or

potential program participants, including job restructuring services;

(2) Recruitment and assessment of potential employees, with priority given to potential employees who are or who might become eligible for program services;

(3) Pre-employment training;

(4) Customized training;

(5) On-the-Job training (OJT);

(6) Post-employment services, including training and support services to encourage job retention and upgrading;

(7) Work experience for public or private sector work sites;

(8) Other innovative forms of worksite training.

(b) In addition to the services listed in paragraph (a) of this section, other grantee-determined services (as described in the grantee's Two Year Plan) which are intended to assist eligible participants to obtain or retain employment may also be provided to or for employers.

§ 668.510 What services may INA grantees provide to the community at large under section 166?

(a) INA grantees may provide services to the Native American communities in their designated service areas by engaging in program development and service delivery activities which:

(1) Strengthen the capacity of Native American-controlled institutions to provide education and work-based learning services to Native American youth and adults, whether directly or through other Native American institutions such as tribal colleges;

(2) Increase the community's capacity to deliver supportive services, such as child care, transportation, housing, health, and similar services needed by clients to obtain and retain employment;

(3) Use program participants engaged in education, training, work experience, or similar activities to further the economic and social development of Native American communities in accordance with the goals and values of those communities; and

(4) Engage in other community-building activities described in the INA grantee's Two Year Plan.

(b) INA grantees should develop their Two Year Plan in conjunction with, and in support of, strategic tribal planning and community development goals.

§ 668.520 Must INA grantees give preference to Indian/Native American entities in the selection of contractors or service providers?

Yes, INA grantees must give as much preference as possible to Indian organizations and to Indian-owned economic enterprises, as defined in section 3 of the Indian Financing Act of 1974 (25 U.S.C. 1452), when awarding any contract or subgrant.

§ 668.530 What rules govern the issuance of contracts and/or subgrants?

In general, INA grantees must follow the rules of OMB Circulars A–102 (for tribes) or A–110 (for private non-profits) when awarding contracts and/or subgrants under WIA section 166. The common rules implementing those circulars are codified for DOL-funded programs at 29 CFR part 97 (A–102) or 29 CFR part 95 (A–110), and covered in the WIA regulations at 20 CFR 667.200. These rules do not apply to OJT contract awards.

Subpart F—Accountability for Services and Expenditures

§ 668.600 To whom is the INA grantee accountable for the provision of services and the expenditure of INA funds?

(a) The INA grantee is responsible to the Native American community to be served by INA funds.

(b) The INA grantee is also responsible to the Department of Labor, which is charged by law with ensuring that all WIA funds are expended:

(1) According to applicable laws and regulations;

(2) For the benefit of the identified Native American client group; and

(3) For the purposes approved in the grantee's plan and signed grant document.

§ 668.610 How is this accountability documented and fulfilled?

(a) Each INA grantee must establish its own internal policies and procedures to ensure accountability to the

INA grantee's governing body, as the representative of the Native American community(ies) served by the INA program. At a minimum, these policies and procedures must provide a system for governing body review and oversight of program plans and measures and standards for program performance.

(b) Accountability to the Department is accomplished in part through on-site program reviews (monitoring), which strengthen the INA grantee's capability to deliver effective services and protect the integrity of Federal funds.

(c) In addition to audit information, as described at §668.850 and program reviews, accountability to the Department is documented and fulfilled by the submission of reports. For the purposes of report submission, a postmark or date indicating receipt by a private express delivery service is acceptable proof of timely submission. These report requirements are as follows:

(1) Each INA grantee must submit an annual report on program participants and activities. This report must be received no later than 90 days after the end of the Program Year, and may be combined with the report on program expenditures. The reporting format is developed by DINAP, in consultation with the Native American Advisory Council, and published in the FEDERAL REGISTER.

(2) Each INA grantee must submit an annual report on program expenditures. This report must be received no later than 90 days after the end of the Program Year, and may be combined with the report on program participants and activities.

(3) INA grantees are encouraged, but not required, to submit a descriptive narrative with their annual reports describing the barriers to successful plan implementation they have encountered. This narrative should also discuss program successes and other notable occurrences that effected the INA grantee's overall performance that year.

(4) Each INA grantee may be required to submit interim reports on program participants and activities and/or program expenditures during the Program Year. Interim reports must be received no later than 45 days after the end of the reporting period.

§ 668.620 What performance measures are in place for the INA program?

Indicators of performance measures and levels of performance in use for INA program will be those indicators and standards proposed in individual grantee plans and approved by us, in accordance with guidelines we will develop in consultation with INA grantees under WIA section 166(h)(2)(A).

§ 668.630 What are the requirements for preventing fraud and abuse under section 166?

(a) Each INA grantee must implement program and financial management procedures to prevent fraud and abuse. Such procedures must include a process which enables the grantee to take action against contractors or subgrantees to prevent any misuse of funds. (WIA sec. 184.)

(b) Each INA grantee must have rules to prevent conflict of interest by its governing body. These conflict of interest rules must include a rule prohibiting any member of any governing body or council associated with the INA grantee from voting on any matter which would provide a direct financial benefit to that member, or to a member of his or her immediate family, in accordance with 20 CFR 667.200(a)(4) and 29 CFR 97.36(b) or 29 CFR 95.42.

(c) Officers or agents of the INA grantee must not solicit or personally accept gratuities, favors, or anything of monetary value from any actual or potential contractor, subgrantee, vendor or participant. This rule must also apply to officers or agents of the grantee's contractors and/or subgrantees. This prohibition does not apply to:

(1) Any rebate, discount or similar incentive provided by a vendor to its customers as a regular feature of its business;

(2) Items of nominal monetary value distributed consistent with the cultural practices of the Native American community served by the grantee.

(d) No person who selects program participants or authorizes the services provided to them may select or authorize services to any participant who is such a person's husband, wife, father,

mother, brother, sister, son, or daughter unless:

(1)(i) The participant involved is a low income individual; or

(ii) The community in which the participant resides has a population of less than 1,000 Native American people; and

(2) The INA grantee has adopted and implemented the policy described in the Two Year Plan to prevent favoritism on behalf of such relatives.

(e) INA grantees are subject to the provisions of 41 U.S.C. 53 relating to kickbacks.

(f) No assistance provided under this Act may involve political activities. (WIA sec. 195(6).)

(g) INA grantees may not use funds under this Act for lobbying, as provided in 29 CFR part 93.

(h) The provisions of 18 U.S.C. 665 and 666 prohibiting embezzlement apply to programs under WIA.

(i) Recipients of financial assistance under WIA section 168 are prohibited from discriminatory practices as outlined at WIA section 188, and the regulations implementing WIA section 188, at 29 CFR part 37. However, this does not affect the legal requirement that all INA participants be Native American. Also, INA grantees are not obligated to serve populations other than those for which they were designated.

§ 668.640 What grievance systems must a section 166 program provide?

INA grantees must establish grievance procedures consistent with the requirements of WIA section 181(c) and 20 CFR 667.600.

§ 668.650 Can INA grantees exclude segments of the eligible population?

(a) No, INA grantees cannot exclude segments of the eligible population. INA grantees must document in their Two Year Plan that a system is in place to afford all members of the eligible population within the service area for which the grantee was designated an equitable opportunity to receive WIA services and activities.

(b) Nothing in this section restricts the ability of INA grantees to target subgroups of the eligible population (for example, the disabled, substance abusers, TANF recipients, or similar categories), as outlined in an approved Two Year Plan. However, it is unlawful to target services to subgroups on grounds prohibited by WIA section 188 and 29 CFR part 37, including tribal affilitation (which is considered national origin). Outreach efforts, on the other hand, may be targeted to any subgroups.

Subpart G—Section 166 Planning/ Funding Process

§ 668.700 What process must an INA grantee use to plan its employment and training services?

(a) An INA grantee may utilize the planning procedures it uses to plan other activities and services.

(b) However, in the process of preparing its Two Year Plan for Native American WIA services, the INA grantee must consult with:

(1) Customers or prospective customers of such services;

(2) Prospective employers of program participants or their representatives;

(3) Service providers, including local educational agencies, which can provide services which support or are complementary to the grantee's own services; and

(4) Tribal or other community officials responsible for the development and administration of strategic community development efforts.

§ 668.710 What planning documents must an INA grantee submit?

Each grantee receiving funds under WIA section 166 must submit to DINAP a comprehensive services plan and a projection of participant services and expenditures covering the two-year planning cycle. We will, in consultation with the Native American Advisory Council, issue budget and planning instructions which grantees must use when preparing their plan.

§ 668.720 What information must these planning documents contain?

(a) The comprehensive services plan must cover the two Program Years included within a designation cycle. According to planning instructions issued by the Department, the comprehensive services plan must describe in narrative form:

(1) The specific goals of the INA grantee's program for the two Program Years involved;

(2) The method the INA grantee will use to target its services to specific segments of its service population;

(3) The array of services which the INA grantee intends to make available;

(4) The system the INA grantee will use to be accountable for the results of its program services. Such results must be judged in terms of the outcomes for individual participants and/or the benefits the program provides to the Native American community(ies) which the INA grantee serves. Plans must include the performance information required by § 668.620;

(5) The ways in which the INA grantee will seek to integrate or coordinate and ensure nonduplication of its employment and training services with:

(i) The One-Stop delivery system in its local workforce investment area, including a description of any MOU's which affect the grantee's participation;

(ii) Other services provided by Local Workforce Investment Boards;

(iii) Other program operators;

(iv) Other services available within the grantee organization; and

(v) Other services which are available to Native Americans in the community, including planned participation in the One-Stop system.

(b) Eligible INA grantees must include in their plan narratives a description of activities planned under the supplemental youth program, including items described in paragraphs (a)(1) through (5) of this section.

(c) INA grantees must be prepared to justify the amount of proposed Administrative Costs, utilizing the definition at 20 CFR 667.220.

(d) INA grantees' plans must contain a projection of participant services and expenditures for each Program Year, consistent with guidance issued by the Department.

§ 668.730 When must these plans be submitted?

(a) The two-year plans are due at a date specified by DINAP in the year in which the two-year designation cycle begins. We will announce exact submission dates in the biennial planning instructions.

(b) Plans from INA grantees who are eligible for supplemental youth services funds must include their supplemental youth plans as part of their regular Two Year Plan.

(c) INA grantees must submit modifications for the second year reflecting exact funding amounts, after the individual allotments have been determined. We will announce the time for their submission, which will be no later than June 1 prior to the beginning of the second year of the designation cycle.

§ 668.740 How will we review and approve such plans?

(a) We will approve a grantee's planning documents before the date on which funds for the program become available unless:

(1) The planning documents do not contain the information specified in the regulations in this part and Departmental planning guidance; or

(2) The services which the INA grantee proposes are not permitted under WIA or applicable regulations.

(b) We may approve a portion of the plan, and disapprove other portions. The grantee also has the right to appeal the decision to the Office of the Administrative Law Judges under the procedures at 20 CFR 667.800 or 667.840. While the INA grantee exercises its right to appeal, the grantee must implement the approved portions of the plan.

(c) If we disapprove all or part of an INA grantee's plan, and that disapproval is sustained in the appeal process, the INA grantee will be given the opportunity to amend its plan so that it can be approved.

(d) If an INA grantee's plan is amended but is still disapproved, the grantee will have the right to appeal the decision to the Offices of the Administrative Law Judges under the procedures at 20 CFR 667.800 or 667.840.

§ 668.750 Under what circumstances can we or the INA grantee modify the terms of the grantee's plan(s)?

(a) We may unilaterally modify the INA grantee's plan to add funds or, if

required by Congressional action, to reduce the amount of funds available for expenditure.

(b) The INA grantee may request approval to modify its plan to add, expand, delete, or diminish any service allowable under the regulations in this part. The INA grantee may modify its plan without our approval, unless the modification reduces the total number of participants to be served annually under the grantee's program by a number which exceeds 25 percent of the participants previously proposed to be served, or by 25 participants, whichever is larger.

(c) We will act upon any modification within thirty (30) calendar days of receipt of the proposed modification. In the event that further clarification or modification is required, we may extend the thirty (30) day time frame to conclude appropriate negotiations.

Subpart H—Administrative Requirements

§ 668.800 What systems must an INA grantee have in place to administer an INA program?

(a) Each INA grantee must have a written system describing the procedures the grantee uses for:

(1) The hiring and management of personnel paid with program funds;

(2) The acquisition and management of property purchased with program funds;

(3) Financial management practices;

(4) A participant grievance system which meets the requirements in section 181(c) of WIA and 20 CFR 667.600; and

(5) A participant records system.

(b) Participant records systems must include:

(1) A written or computerized record containing all the information used to determine the person's eligibility to receive program services;

(2) The participant's signature certifying that all the eligibility information he or she provided is true to the best of his/her knowledge; and

(3) The information necessary to comply with all program reporting requirements.

§ 668.810 What types of costs are allowable expenditures under the INA program?

Rules relating to allowable costs under WIA are covered in 20 CFR 667.200 through 667.220.

§ 668.820 What rules apply to administrative costs under the INA program?

The definition and treatment of administrative costs are covered in 20 CFR 667.210(b) and 667.220.

§ 668.825 Does the WIA administrative cost limit for States and local areas apply to section 166 grants?

No, under 20 CFR 667.210(b), limits on administrative costs for section 166 grants will be negotiated with the grantee and identified in the grant award document.

§ 668.830 How should INA program grantees classify costs?

Cost classification is covered in the WIA regulations at 20 CFR 667.200 through 667.220. For purposes of the INA program, program costs also include costs associated with other activities such as Tribal Employment Rights Office (TERO), and supportive services, as defined in WIA section 101(46).

§ 668.840 What cost principles apply to INA funds?

The cost principles described in OMB Circulars A–87 (for tribal governments), A–122 (for private non-profits), and A–21 (for educational institutions), and the regulations at 20 CFR 667.200(c), apply to INA grantees, depending on the nature of the grantee organization.

§ 668.850 What audit requirements apply to INA grants?

The audit requirements established under the Department's regulations at 29 CFR part 99, which implement OMB Circular A–133, apply to all Native American WIA grants. These regulations, for all of WIA title I, are cited at 20 CFR 667.200(b). Audit resolution procedures are covered at 20 CFR 667.500 and 667.510.

§ 668.860 What cash management procedures apply to INA grant funds?

INA grantees must draw down funds only as they actually need them. The U.S. Department of Treasury regulations which implement the Cash Management Improvement Act, found at 31 CFR part 205, apply by law to most recipients of Federal funds. Special rules may apply to those grantees required to keep their funds in interest-bearing accounts, and to grantees participating in the demonstration under Public Law 102–477.

§ 668.870 What is "program income" and how is it regulated in the INA program?

(a) Program income is defined and regulated by WIA section 195(7), 20 CFR 667.200(a)(5) and the applicable rules in 29 CFR parts 95 and 97.

(b) For grants made under this part, program income does not include income generated by the work of a work experience participant in an enterprise, including an enterprise owned by an Indian tribe or Alaska Native entity, whether in the public or private sector.

(c) Program income does not include income generated by the work of an OJT participant in an establishment under paragraph (b) of this section.

Subpart I—Miscellaneous Program Provisions

§ 668.900 Does WIA provide regulatory and/or statutory waiver authority?

Yes, WIA section 166(h)(3) permits waivers of any statutory or regulatory requirement imposed upon INA grantees (except for the areas cited in § 668.920). Such waivers may include those necessary to facilitate WIA support of long term community development goals.

§ 668.910 What information is required to document a requested waiver?

To request a waiver, an INA grantee must submit a plan indicating how the waiver will improve the grantee's WIA program activities. We will provide further guidance on the waiver process, consistent with the provisions of WIA section 166(h)(3).

§ 668.920 What provisions of law or regulations may not be waived?

Requirements relating to:

(a) Wage and labor standards;

(b) Worker rights;

(c) Participation and protection of workers and participants;

(d) Grievance procedures;

(e) Judicial review; and

(f) Non-discrimination may not be waived. (WIA sec. 166(h)(3)(A).)

§ 668.930 May INA grantees combine or consolidate their employment and training funds?

Yes, INA grantees may consolidate their employment and training funds under WIA with assistance received from related programs in accordance with the provisions of the Indian Employment, Training and Related Services Demonstration Act of 1992 (Public Law 102–477) (25 U.S.C. 3401 *et seq.*). Also, Federally-recognized tribes that administer INA funds and funds provided by more than one State under other sections of WIA title I may enter into an agreement with the Governors to transfer the State funds to the INA program. (WIA sec. 166(f) and (h)(6).)

§ 668.940 What is the role of the Native American Employment and Training Council?

The Native American Employment and Training Council is a body composed of representatives of the grantee community which advises the Secretary on all aspects of Native American employment and training program implementation. WIA section 166(h)(4) continues the Council essentially as it is currently constituted, with the exception that all the Council members no longer have to be Native American. However, the nature of the consultative process remains essentially unchanged. We continue to support the Council.

PART 669—NATIONAL FARMWORKER JOBS PROGRAM UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

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Sec.
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AUTHORITY: Section 506(c), Pub. L. 105–220; 20 U.S.C. 9276(c).

SOURCE: 65 FR 49445, Aug. 11, 2000, unless otherwise noted.

Subpart A—Purpose and Definitions

§ 669.100 What is the purpose of the National Farmworker Jobs Program (NFJP) and the other services and activities established under WIA section 167?

The purpose of the NFJP, and the other services and activities established under WIA section 167, is to strengthen the ability of eligible migrant and seasonal farmworkers and their families to achieve economic self-sufficiency. This part provides the regulatory requirements applicable to the expenditure of WIA section 167 funds for such programs, services and activities.

§ 669.110 What definitions apply to this program?

In addition to the definitions found in WIA sections 101 and 167 and in 20 CFR 660.300, the following definitions apply to programs under this part:

Allowances means direct payments, which must not exceed the higher of the State or Federal minimum wage, made to NFJP participants during their enrollment to enable them to participate in intensive or training services.

Capacity enhancement means the technical assistance we provide to grantees and grantee staff by the Department to improve the quality of the program and the delivery of program services to NFJP participants.

Dependent means an individual who:

(1) Was claimed as a dependent on the qualifying farmworker's federal income tax return for the previous year; or

(2) Is the spouse of the qualifying farmworker; or

(3) If not claimed as a dependent for federal income tax purposes, is able to establish:

(i) A relationship as the farmworker's

(A) Child, grandchild, great grandchild, including legally adopted children;

(B) Stepchild;

(C) Brother, sister, half brother, half sister, stepbrother, or stepsister;

(D) Parent, grandparent, or other direct ancestor but not foster parent;

(E) Foster child;

(F) Stepfather or stepmother;

(G) Uncle or aunt;

(H) Niece or nephew;

(I) Father-in-law, mother-in-law, son-in-law; or

(J) Daughter-in-law, brother-in-law, or sister-in-law; and

(ii) The receipt of over half of his/her total support from the eligible farmworker's family during the eligibility determination period.

Disadvantaged means a farmworker whose income, for any 12 consecutive months out of the 24 months immediately before the farmworker applies for the program, does not exceed the higher of either the poverty line or 70 percent of the lower living standard income level, adjusted for the farmworker's family size and including the income of all wage earners, except when its inclusion would be unjust due to unstable conditions of the family unit.

DSFP means the Division of Seasonal Farmworker Programs within the Employment and Training Administration of the Department, or a successor organizational unit.

Eligibility determination period means any consecutive 12-month period within the 24-month period immediately preceding the date of application for the NFJP by the applicant farmworker.

Emergency assistance means assistance that addresses immediate needs of farmworkers and their families, provided by NFJP grantees. Except for evidence to support legal working status in the United States and Selective Service registration, where applicable, the applicant's self-attestation is accepted as eligibility for emergency assistance.

Farmwork means those occupations and industries within agricultural production and agricultural services that we identify for the National Farmworker Jobs Program.

Housing development assistance within the NFJP, is a type of related assistance consisting of an organized program of education and on-site demonstrations about the basic elements of family housing and may include financing, site selection, permits and construction skills, leading towards home ownership.

MOU means Memorandum of Understanding.

MSFW means a Migrant or Seasonal Farmworker under WIA section 167.

MSFW program grantee means an entity to which we directly award a WIA grant to carry out the MSFW program in one or more designated States or substate areas.

National Farmworker Jobs Program (NFJP) is the nationally administered workforce investment program for farmworkers established by WIA section 167 as a required partner of the One-Stop system.

Related assistance means short-term forms of direct assistance designed to assist farmworkers and their families to retain or stabilize their agricultural employment or enrollment in the NFJP.

Self-certification means a farmworker's signed attestation that the information he/she submits to demonstrate eligibility for the NFJP is true and accurate.

Service area means the geographical jurisdiction in which a WIA section 167 grantee is designated to operate.

Work experience means a planned, structured learning experience that takes place in a workplace for a limited period of time. Work experience may be paid or unpaid, as appropriate.

§ 669.120 How do we administer the NFJP program?

This program is centrally administered by the Department of Labor in a manner consistent with the requirements of WIA section 167. As described in § 669.210, we designate grantees using procedures consistent with standard Federal government competitive procedures. We award other grants and contracts using similar competitive procedures.

§ 669.130 What unit within the Department administers the National Farmworker Jobs Program funded under WIA section 167?

We have designated the Division of Seasonal Farmworker Programs (DSFP), or its successor organization, within the Employment and Training Administration, as the organizational unit that administers the NFJP and other MSFW programs at the Federal level.

§ 669.140 How does the Division of Seasonal Farmworker Programs (DSFP) assist the MSFW grantee organizations to serve farmworker customers?

We provide technical assistance and training to MSFW grantees for the purposes of program implementation and program performance management leading to enhancement of services to and continuous improvement in the employment outcomes of farmworkers.

§ 669.150 How are regulations established for this program?

In developing regulations for WIA section 167, we consult with the Migrant and Seasonal Farmworker Employment and Training Advisory Committee. The regulations and program guidance consider the economic circumstances and demographics of eligible migrant and seasonal farmworkers.

§ 669.160 How do we consult with NFJP organizations in developing rules, regulations and standards of accountability, and other policy guidance for the NFJP?

(a) We consider the NFJP grantee community as a full partner in the development of policies for the NFJPs under the Act.

(b) We have established and continue to support the Federal MSFW Employment and Training Advisory Committee. Through the Advisory Committee, we actively seek and consider the views of the grantee community before establishing policies and/or program regulations, according to the requirements of WIA section 167.

§ 669.170 What WIA regulations apply to the programs funded under WIA section 167?

(a) The regulations found in this part;

(b) The general administrative requirements found in 20 CFR part 667, including the regulations concerning Complaints, Investigations and Hearings found at 20 CFR part 667, subpart E through subpart H, which cover programs under WIA section 167;

(c) The Department's regulations codifying the common rules implementing Office of Management and Budget (OMB) Circulars, which generally apply to Federal programs carried out by State and local governments and nonprofit organizations at 29 CFR parts 95, 96, 97, and 99, as applicable.

(d) The regulations on partnership responsibilities contained in 20 CFR parts 661 (Statewide and Local Governance) and 662 (the One-Stop System).

(e) The Department's regulations at 29 CFR part 37, which implement the nondiscrimination provisions of WIA section 188, apply to recipients of financial assistance under WIA section 167.

Subpart B—The Service Delivery System for the National Farmworker Jobs Program

§ 669.200 Who is eligible to receive a NFJP grant?

(a) To be eligible to receive a grant under this section, an entity must have:

(1) An understanding of the problems of eligible migrant and seasonal farmworkers and their dependents;

(2) A familiarity with the agricultural industry and the labor market needs of the geographic area to be served;

(3) The capacity to effectively administer a diversified program of workforce investment activities and related assistance for eligible migrant and seasonal farmworkers (including farmworker youth) as described in paragraph (b) of this section;

(4) The capacity to work effectively as a One-Stop partner.

(b) For purposes of paragraph (a)(3) of this section, an entity's ''capacity to effectively administer'' a program may be demonstrated by:

(1) Organizational experience; or

(2) Significant experience of its key staff in administering similar programs.

(c) For purposes of paragraph (a)(4) of this section, an applicant may demonstrate its capacity to work effectively as a One-Stop partner through its existing relationships with Local Workforce Investment Boards and other One-Stop partners, as evidenced through One-Stop system participation and successful MOU negotiations.

(d) As part of the evaluation of the applicant's capacity to work effectively as a One-Stop partner under paragraph (a)(4) of this section:

(1) The Grant Officer must determine whether the policies or actions of any Local Board established under the authorty of the alternative entity provision of WIA section 117(i) and 20 CFR 661.330:

(i) Preclude One-Stop system participation by the applicant or existing NFJP grantee; or

(ii) For the prior program year, contributed to a failure to reach agreement on the terms of the MOU required under § 669.220; and

(2) If the Grant Officer's determinations under paragraph (d)(1) of this section are affirmative, then the Grant Officer may consider this fact when weighing the capacity of the competitors.

§ 669.210 How does an eligible entity become an NFJP grantee?

To become an NFJP grantee and receive a grant under this subpart, an applicant must respond to a Solicitation for Grant Applications (SGA). The SGA may contain additional requirements for the grant application or the grantee's two-year plan. Under the SGA, grantees will be selected using standard Federal Government competitive procedures. The entity's proposal must describe a two-year strategy for meeting the needs of eligible migrant and seasonal farmworkers in the geographic area the entity seeks to serve.

§ 669.220 What is the role of the NFJP grantee in the One-Stop delivery system?

(a) In those local workforce investment areas where the grantee operates its NFJP, the grantee is a required partner of the local One-Stop delivery system and is subject to the provisions relating to such partners described in 20 CFR part 662. Consistent with those provisions, the grantee and the Local Board must negotiate an MOU which meets the requirements of 20 CFR 662.300 and sets forth their respective responsibilities for making the full range of services available through the One-Stop system available to farmworkers. Where the Local Board is an alternative entity under 20 CFR 661.330, the NFJP grantee must negotiate with the Board on the terms of its MOU and the scope of its on-going role in the local workforce investment system, as specified in 20 CFR 661.310(b)(2). In local areas where the grantee does not operate its NFJP and there is a large concentration of MSFW's, the grantee may consider the availability of electronic connections and other means to participate in the One-stop system in that area, in order to serve those individuals.

(b) The MOU must provide for appropriate and equitable services to MSFW's, and may include costs of services to MSFW's incurred by the One-Stop that extend beyond Wagner-Peyser funded services and activities.

§ 669.230 Can an NFJP grantee's designation be terminated?

Yes, a grantee's designation may be terminated for cause:

(a) By the Secretary, in emergency circumstances when such action is necessary to protect the integrity of Federal funds or ensure the proper operation of the program. Any grantee so terminated will be provided with written notice and an opportunity for a hearing within 30 days after the termination (WIA sec. 184(e)); or

(b) By the Grant Officer, if there is a substantial or persistent violation of the requirements in the Act or the WIA regulations. In such a case, the Grant Officer must provide the grantee with 60 days prior written notice, stating the reasons why termination is proposed, and the applicable appeal procedures.

§ 669.240 How do we use funds appropriated under WIA section 167 for the NFJP?

(a) At least 94 percent of the funds appropriated each year for WIA section 167 activities must be allocated to State service areas, based on the distribution of the eligible MSFW population determined under a formula which has been published in the FEDERAL REGISTER. Grants are awarded under a competitive process for the provision of services to eligible farmworkers within each service area.

(b) The balance, up to 6 percent of the appropriated funds, will be used for discretionary purposes, for such activities as grantee technical assistance and support of farmworker housing activities.

Subpart C—The National Farmworker Jobs Program Customers and Available Program Services

§ 669.300 What are the general responsibilities of the NFJP grantees?

Each grantee is responsible for providing needed services in accordance with a service delivery strategy described in its approved grant plan. These services must reflect the needs of the MSFW population in the service area and include the services and training activities that are necessary to achieve each participant's employment goals.

§ 669.310 What are the basic components of an NFJP service delivery strategy?

The NFJP service delivery strategy must include:

(a) A customer-centered case management approach;

(b) The provision of workforce investment activities, which include core services, intensive services, and training services, as described in WIA section 134, as appropriate;

(c) The arrangements under the MOU's with the applicable Local Workforce Investment Boards for the delivery of the services available through the One-Stop system to MSFW's; and

(d) Related assistance services.

§ 669.320 Who is eligible to receive services under the NFJP?

Disadvantaged migrant and seasonal farmworkers, as defined in § 669.110, and their dependents are eligible for services funded by the NFJP.

§ 669.330 How are services delivered to the customer?

To ensure that all services are focused on the customer's needs, services are provided through a case-management approach and may include: Core, intensive and training services; and related assistance, which includes emergency assistance and supportive services. The basic services and delivery of case-management activities are further described at §§ 669.340 through 669.410. Consistent with 20 CFR part 663, before receiving intensive services, a participant must receive at least one core service, and, prior to receiving training services, a participant must receive at least one intensive service.

§ 669.340 What core services are available to eligible MSFW's?

The core services identified in WIA section 134(d)(2) are available to eligible MSFW's.

§ 669.350 How are core services delivered to MSFW's?

(a) The full range of core services are available to MSFW's, as well as other individuals, at One-Stop Centers, as described in 20 CFR part 662.

(b) Core services must be made available through the One-Stop delivery system. The delivery of core services to MSFW's, by the NFJP grantee and through the One-Stop system, must be discussed in the required MOU between the Local Board and the NFJP grantee.

§ 669.360 May grantees provide emergency assistance to MSFW's?

(a) Yes, Emergency Assistance (as defined in § 669.110) is a form of the related assistance that is authorized under WIA section 167(d) and may be provided by a grantee as described in the grant plan.

(b) In providing emergency assistance, the NFJP grantee may use an abbreviated eligibility determination process that accepts the applicant's self-attestation as final evidence of eligibility, except that self-attestation may not be used to establish the requirements of legal working status in the United States, and Selective Service registration, where applicable.

§ 669.370 What intensive services may be provided to eligible MSFW's?

(a) Intensive services available to farmworkers include those described in WIA section 134(d)(3)(C).

(b) Intensive services may also include:

(1) Dropout prevention activities;

(2) Allowance payments;

(3) Work experience, which:

(i) Is designed to promote the development of good work habits and basic work skills at the work-site (work experience may be conducted with the public and private non-profit sectors and with the private for-profit sector when the design for this service is described in the approved grant plan); and which:

(ii)(A) May be paid. Paid work experience must compensate participants at no less than the higher of the applicable State or Federal minimum wage; or

(B) May be unpaid. Unpaid work experience must provide tangible benefits, in lieu of wages, to those who participate in unpaid work experience and the strategy for ensuring that tangible benefits are received must be described in the approved grant plan. The benefits to the participant must be commensurate with the participant's contribution to the hosting organization;

(4) Literacy and English-as-a-Second language; and

(5) Other services identified in the approved grant plan.

§ 669.380 What is the objective assessment that is authorized as an intensive service?

(a) An objective assessment is a procedure designed to comprehensively assess the skills, abilities, and interests of each employment and training participant through the use of diagnostic testing and other assessment tools. The methods used by the grantee in conducting the objective assessment may include:

(1) Structured in-depth interviews;

(2) Skills and aptitude assessments;

(3) Performance assessments (for example, skills or work samples, including those that measure interest and capability to train in nontraditional employment);

(4) Interest or attitude inventories;

(5) Career guidance instruments;

(6) Aptitude tests; and

(7) Basic skills tests.

(b) The objective assessment is an ongoing process that requires the grantee staff to remain in close consultation with each participant to continuously obtain current information about the participant's progress that may be relevant to his/her Individual Employment Plan (IEP).

§ 669.400 What are the elements of the Individual Employment Plan that is authorized as an intensive service?

The elements of the Individual Employment Plan (IEP) are:

(a) *Joint development:* The grantee develops the IEP in partnership with the participant;

(b) *Customer focus:* The combination of services chosen with the participant must be consistent with the results of any objective assessment, responsive to the expressed goals of the participant, and must include periodic evaluation of planned goals and a record of accomplishments in consultation with the participant;

(c) *Length/type of service:* The type and duration of intensive or training services must be based upon:

(1) The employment/career goal;

(2) Referrals to other programs for specified activities; and

(3) The delivery agents and schedules for intensive services, training and training-related supportive services; and

(d) *Privacy:* As a customer-centered case management tool, an IEP is a personal record and must receive confidential treatment.

§ 669.410 What training services may be provided to eligible MSFW's?

(a) Training services include those described in WIA sections 134(d)(4)(D) and 167(d), and may be described in the IEP and may include:

(1) On-the-job training activities under a contract between the participating employer and the grantee;

(2) Training-related supportive services; and

(b) Other training activities identified in the approved grant plan such as training in self-employment skills and micro-enterprise development.

§ 669.420 What must be included in an on-the-job training contract?

At a minimum, an on-the-job training contract must comply with the requirements of WIA sections 195(4) and 101(31) and must include:

(a) The occupation(s) for which training is to be provided;

(b) The duration of training;

(c) The wage rate to be paid to the trainee;

(d) The rate of reimbursement;

(e) The maximum amount of reimbursement;

(f) A training outline that reflects the work skills required for the position;

(g) An outline of any other separate classroom training that may be provided by the employer; and

(h) The employer's agreement to maintain and make available time and attendance, payroll and other records to support amounts claimed by the employer for reimbursement under the OJT contract.

§ 669.430 What Related Assistance services may be provided to eligible farmworkers?

Related Assistance may include such services and activities as:

(a) Emergency Assistance;

(b) Workplace safety and farmworker pesticide safety instruction;

(c) Housing development assistance;

(d) Other supportive services described in the grant plan; and

(e) English language classes and basic education classes for participants not enrolled in intensive or training services.

§ 669.440 When may farmworkers receive related assistance?

Farmworkers may receive related assistance services when the need for the related assistance is documented for any eligible farmworker or dependent

in a determination made by the grantee or in a statement by the farmworker.

Subpart D—Performance Accountability, Planning and Waiver Provision

§ 669.500 What performance measures and standards apply to the NFJP?

(a) The NFJP will use the core indicators of performance common to the adult and youth programs, described in 20 CFR part 666. The levels of performance for the farmworker indicators will be established in a negotiation between the Department and the grantee. The levels must take into account the characteristics of the population to be served and the economic conditions in the service area. Proposed levels of performance must be included in the grantee plan submission, and the agreed-upon levels must be included in the approved plan.

(b) We may develop additional performance indicators with appropriate levels of performance for evaluating programs that serve farmworkers and which reflect the State service area economy and local demographics of eligible MSFW's. The levels of performance for these additional indicators must be negotiated with the grantee and included in the approved plan.

§ 669.510 What planning documents must an NFJP grantee submit?

Each grantee receiving WIA section 167 program funds must submit to DSFP a comprehensive service delivery plan and a projection of participant services and expenditures covering the two-year designation cycle.

§ 669.520 What information is required in the NFJP grant plans?

An NFJP grantee's biennial plan must describe:

(a) The employment and education needs of the farmworker population to be served;

(b) The manner in which proposed services to farmworkers and their families will strengthen their ability to obtain or retain employment or stabilize their agricultural employment;

(c) The related assistance and supportive services to be provided and the manner in which such assistance and services are to be coordinated with other available services;

(d) The performance indicators and proposed levels of performance used to assess the performance of such entity, including the specific goals of the grantee's program for the two Program Years involved;

(e) The method the grantee will use to target its services on specific segments of the eligible population, as appropriate;

(f) The array of services which the grantee intends to make available, with costs specified on forms we prescribe. These forms will indicate how many participants the grantee expects to serve, by activity, the results expected under the grantee's plan, and the anticipated expenditures by cost category; and

(g) Its response to any other requirements set forth in the SGA issued under § 669.210.

§ 669.530 What are the submission dates for these plans?

We will announce plan submission dates in the SGA issued under § 669.220.

§ 669.540 Under what circumstances are the terms of the grantee's plan modified by the grantee or the Department?

(a) Plans must be modified to reflect the funding level for the second year of the designation cycle. We will provide instructions for when to submit modifications for second year funding, which will generally be no later than June 1 prior to the beginning of the second year of the designation cycle.

(b) We may unilaterally modify the grantee's plan to add funds or, if the total amount of funds available for allotment is reduced by Congress, to reduce each grantee's grant amount.

(c) The grantee may modify its plan to add, delete, expand, or reduce any part of the program plan or allowable activities. Such modifications may be made by the grantee without our approval except where the modification reduces the total number of participants to be served annually under intensive and/or training services by 15 percent or more, in which case the plan

may only be modified with Grant Officer approval.

(d) If the grantee is approved for a regulatory waiver under §§ 669.560 and 669.570, the grantee must submit a modification of its service delivery plan to reflect the effect of the waiver.

§ 669.550 How are costs classified under the NFJP?

(a) Costs are classified as follows:

(1) Administrative costs, as defined in 20 CFR 667.220; and

(2) Program costs, which are all other costs not defined as administrative.

(b) Program costs must be classified and reported in the following categories:

(1) Related assistance, including emergency assistance and supportive services, including allocated staff costs; and

(2) All other program services, including allocated staff costs.

§ 669.555 Do the WIA administrative cost limits for States and local areas apply to NFJP grants?

No, under 20 CFR 667.210(b), limits on administrative costs for NFJP grants will be negotiated with the grantee and identified in the grant award document.

§ 669.560 Are there regulatory and/or statutory waiver provisions that apply to WIA section 167?

(a) The statutory waiver provision at WIA section 189(i) does not apply to WIA section 167.

(b) NFJP grantees may request waiver of any regulatory provisions only when such regulatory provisions are:

(1) Not required by WIA;

(2) Not related to wage and labor standards, nondisplacement protection, worker rights, participation and protection of workers and participants, and eligibility of participants, grievance procedures, judicial review, nondiscrimination, allocation of funds, procedures for review and approval of plans; and

(3) Not related to the key reform principles embodied in WIA, described in 20 CFR 661.400.

§ 669.570 What information is required to document a requested waiver?

To request a waiver, a grantee must submit a waiver plan that:

(a) Describes the goals of the waiver, the expected programmatic outcomes, and how the waiver will improve the provision of WIA activities;

(b) Is consistent with guidelines we establish and the waiver provisions at 20 CFR 661.400 through 661.420; and

(c) Includes a modified service delivery plan reflecting the effect of requested waiver.

Subpart E—The MSFW Youth Program

§ 669.600 What is the purpose of the WIA section 167 MSFW Youth Program?

The purpose of the MSFW youth program is to provide an effective and comprehensive array of educational opportunities, employment skills, and life enhancement activities to at-risk and out-of-school MSFW youth that lead to success in school, economic stability and development into productive members of society.

§ 669.610 What is the relationship between the MSFW youth program and the NFJP authorized at WIA section 167?

The MSFW youth program is funded under WIA section 127(b)(1)(A)(iii) to provide farmworker youth activities under the auspices of WIA section 167. These funds are specifically earmarked for MSFW youth. Funds provided for the section 167 program may also be used for youth, but are not limited to this age group.

§ 669.620 How do the MSFW youth program regulations apply to the NFJP program authorized under WIA section 167?

(a) This subpart applies only to the administration of grants for MSFW youth programs funded under WIA section 127(b)(1)(A)(iii).

(b) The regulations for the NFJP in this part apply to the administration of the MSFW youth program, except as modified in this subpart.

§ 669.630 What are the requirements for designation as an "MSFW youth program grantee"?

Any entity that meets the requirements described in the SGA may apply for designation as an ''MSFW youth program grantee'' consistent with requirements described in the SGA. The Department gives special consideration to an entity in any service area for which the entity has been designated as a WIA section 167 NFJP program grantee.

§ 669.640 What is the process for applying for designation as an MSFW youth program grantee?

(a) To apply for designation as an MSFW youth program grantee, entities must respond to an SGA by submitting a plan that meets the requirements of WIA section 167(c)(2) and describes a two-year strategy for meeting the needs of eligible MSFW youth in the service area the entity seeks to serve.

(b) The designation process is conducted competitively (subject to § 669.210) through a selection process distinct from the one used to select WIA section 167 NFJP grantees.

§ 669.650 How are MSFW youth funds allocated to section 167 youth grantees?

The allocation of funds among entities designated as WIA section 167 MSFW Youth Program grantees is based on the comparative merits of the applications, in accordance with criteria set forth in the SGA. However, we may include criteria in the SGA that promote a geographical distribution of funds and that encourages both large- and small-scale programs.

§ 669.660 What planning documents and information are required in the application for MSFW youth grants and when must they be filed?

The required planning documents and other required information and the submission dates for filing are described in the SGA.

§ 669.670 Who is eligible to receive services under the section 167 MSFW youth program?

Disadvantaged youth, ages 14 through 21, who are individually eligible or are members of eligible families under the WIA section 167 NFJP may receive these services.

§ 669.680 What activities and services may be provided under the MSFW youth program?

(a) Based on an evaluation and assessment of the needs of MSFW youth participants, grantees may provide activities and services to MSFW youth that include:

(1) Intensive services and training services, as described in §§ 669.400 and 669.410;

(2) Life skills activities which may include self and interpersonal skills development;

(3) Community service projects;

(4) Small business development technical assistance and training in conjunction with entrepreneurial training;

(5) Supportive services including the related assistance services, described in § 669.430; and

(b) Other activities and services that conform to the use of funds for youth activities described in 20 CFR part 664.

PART 670—THE JOB CORPS UNDER TITLE I OF THE WORKFORCE INVESTMENT ACT

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Sec.

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SOURCE: 65 FR 49450, Aug. 11, 2000, unless otherwise noted.

Subpart A—Scope and Purpose

§ 670.100 What is the scope of this part?

The regulations in this part are an outline of the requirements that apply to the Job Corps program. More detailed policies and procedures are contained in a Policy and Requirements Handbook issued by the Secretary. Throughout this part, phrases like ''according to instructions (procedures) issued by the Secretary'' refer to the Policy and Requirements Handbook and other Job Corps directives.

§ 670.110 What is the Job Corps program?

Job Corps is a national program that operates in partnership with States and communities, local Workforce Investment Boards, youth councils, One-Stop Centers and partners, and other youth programs to provide education and training, primarily in a residential setting, for low income young people. The objective of Job Corps is to provide young people with the skills they need to obtain and hold a job, enter the Armed Forces, or enroll in advanced training or further education.

§ 670.120 What definitions apply to this part?

The following definitions apply to this part:

Absent Without Official Leave (AWOL) means an adverse enrollment status to which a student is assigned based on extended, unapproved absence from his/her assigned center or off-center place of duty. Students do not earn Job Corps allowances while in AWOL status.

Applicable local board means a local Workforce Investment Board that:

(1) Works with a Job Corps center and provides information on local demand occupations, employment opportunities, and the job skills needed to obtain the opportunities, and

(2) Serves communities in which the graduates of the Job Corps seek employment when they leave the program.

Capital improvement means any modification, addition, restoration or other improvement:

(1) Which increases the usefulness, productivity, or serviceable life of an existing site, facility, building, structure, or major item of equipment;

(2) Which is classified for accounting purposes as a ''fixed asset;'' and

(3) The cost of which increases the recorded value of the existing building, site, facility, structure, or major item of equipment and is subject to depreciation.

Center means a facility and an organizational entity, including all of its parts, providing Job Corps training and designated as a Job Corps center.

Center operator means a Federal, State or local agency, or a contractor that runs a center under an agreement or contract with DOL.

Civilian conservation center (CCC) means a center operated on public land under an agreement between DOL and another Federal agency, which provides, in addition to other training and

assistance, programs of work-based learning to conserve, develop, or manage public natural resources or public recreational areas or to develop community projects in the public interest.

Contract center means a Job Corps center operated under a contract with DOL.

Contracting officer means the Regional Director or other official authorized to enter into contracts or agreements on behalf of DOL.

Enrollee means an individual who has voluntarily applied for, been selected for, and enrolled in the Job Corps program, and remains with the program, but has not yet become a graduate. Enrollees are also referred to as ''students'' in this part.

Enrollment means the process by which individual formally becomes a student in the Job Corps program.

Graduate means an enrollee who has:

(1) Completed the requirements of a vocational training program, or received a secondary school diploma or its equivalent as a result of participating in the Job Corps program; and

(2) Achieved job readiness and employment skills as a result of participating in the Job Corps program.

Individual with a disability means an individual with a disability as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

Interagency agreement means a formal agreement between DOL and another Federal agency administering and operating centers. The agreement establishes procedures for the funding, administration, operation, and review of those centers as well as the resolution of any disputes.

Job Corps means the agency of the Department established by section 143 of the Workforce Investment Act of 1998 (WIA) (20 U.S.C. 9201 *et seq.*) to perform those functions of the Secretary of Labor set forth in subtitle C of WIA Title I.

Job Corps Director means the chief official of the Job Corps or a person authorized to act for the Job Corps Director.

Low income individual means an individual who meets the definition in WIA section 101(25).

National Office means the national office of Job Corps.

National training contractor means a labor union, union-affiliated organization, business organization, association or a combination of such organizations, which has a contract with the national office to provide vocational training, placement, or other services.

Operational support services means activities or services required to support the operation of Job Corps, including:

(1) Outreach and admissions services;

(2) Contracted vocational training and off-center training;

(3) Placement services;

(4) Continued services for graduates;

(5) Certain health services; and

(6) Miscellaneous logistical and technical support.

Outreach and admissions agency means an organization that performs outreach, and screens and enrolls youth under a contract or other agreement with Job Corps.

Placement means student employment, entry into the Armed Forces, or enrollment in other training or education programs following separation from Job Corps.

Placement agency means an organization acting under a contract or other agreement with Job Corps to provide placement services for graduates and, to the extent possible, for former students.

Regional appeal board means the board designated by the Regional Director to consider student appeals of disciplinary discharges.

Regional Director means the chief Job Corps official of a regional office or a person authorized to act for the Regional Director.

Regional Office means a regional office of Job Corps.

Regional Solicitor means the chief official of a regional office of the DOL Office of the Solicitor, or a person authorized to act for the Regional Solicitor.

Separation means the action by which an individual ceases to be a student in the Job Corps program, either voluntarily or involuntarily.

Student means an individual enrolled in the Job Corps.

Unauthorized goods means:

(1) Firearms and ammunition;

(2) Explosives and incendiaries;

(3) Knives with blades longer than 2 inches;
(4) Homemade weapons;
(5) All other weapons and instruments used primarily to inflict personal injury;
(6) Stolen property;
(7) Drugs, including alcohol, marijuana, depressants, stimulants, hallucinogens, tranquilizers, and drug paraphernalia except for drugs and/or paraphernalia that are prescribed for medical reasons; and
(8) Any other goods prohibited by the center operator in a student handbook.

§ 670.130 What is the role of the Job Corps Director?

The Job Corps Director has been delegated the authority to carry out the responsibilities of the Secretary under Subtitle I-C of the Act. Where the term ''Secretary'' is used in this part 670 to refer to establishment or issuance of guidelines and standards directly relating to the operation of the Job Corps program, the Job Corps Director has that responsibility.

Subpart B—Site Selection and Protection and Maintenance of Facilities

§ 670.200 Who decides where Job Corps centers will be located?

(a) The Secretary must approve the location and size of all Job Corps centers.
(b) The Secretary establishes procedures for making decisions concerning the establishment, relocation, expansion, or closing of contract centers.

§ 670.210 How are center facility improvements and new construction handled?

The Secretary issues procedures for requesting, approving, and initiating capital improvements and new construction on Job Corps centers.

§ 670.220 Are we responsible for the protection and maintenance of center facilities?

(a) Yes, the Secretary establishes procedures for the protection and maintenance of contract center facilities owned or leased by the Department of Labor, that are consistent with Federal Property Management Regulations at 41 CFR Chapter 101.
(b) Federal agencies operating civilian conservation centers (CCC's) on public land are responsible for protection and maintenance of CCC facilities.
(c) The Secretary issues procedures for conducting periodic facility surveys of centers to determine their condition and to identify needs such as correction of safety and health deficiencies, rehabilitation, and/or new construction.

Subpart C—Funding and Selection of Service Providers

§ 670.300 What entities are eligible to receive funds to operate centers and provide training and operational support services?

(a) Entities eligible to receive funds under this subpart to operate centers include:
(1) Federal, State, and local agencies;
(2) Private for-profit and non-profit corporations;
(3) Indian tribes and organizations; and
(4) Area vocational education or residential vocational schools. (WIA sec. 147(a)(1)(A) and (d)).
(b) Entities eligible to receive funds to provide outreach and admissions, placement and other operational support services include:
(1) One-Stop Centers and partners;
(2) Community action agencies;
(3) Business organizations;
(4) Labor organizations;
(5) Private for-profit and non-profit corporations; and
(6) Other agencies, and individuals that have experience and contact with youth. (WIA sec. 145(a)(3)).

§ 670.310 How are entities selected to receive funding?

(a) The Secretary selects eligible entities to operate contract centers and operational support service providers on a competitive basis in accordance with the Federal Property and Administrative Services Act of 1949 unless section 303 (c) and (d) of that Act apply. In selecting an entity, Job Corps issues requests for proposals (RFP) for the operation of all contract centers

and for provision of operational support services according to Federal Acquisition Regulation (48 CFR Chapter 1) and DOL Acquisition Regulation (48 CFR Chapter 29). Job Corps develops RFP's for center operators in consultation with the Governor, the center industry council (if established), and the Local Board for the workforce investment area in which the center is located.

(b) The RFP for each contract center and each operational support service contract describes uniform specifications and standards, as well as specifications and requirements that are unique to the operation of the specific center or to the specific required operational support services.

(c) The Contracting Officer selects and funds Job Corps contract center operators on the basis of an evaluation of the proposals received using criteria established by the Secretary, and set forth in the RFP. The criteria include the following:

(1) The offeror's ability to coordinate the activities carried out through the Job Corps center with activities carried out under the appropriate State and local workforce investment plans;

(2) The degree to which the offeror proposes vocational training that reflects employment opportunities in the local areas in which most of the students intend to seek employment;

(3) The degree to which the offeror is familiar with the surrounding community, including the applicable One-Stop Centers, and the State and region in which the center is located; and

(4) The offeror's past performance.

(d) The Contracting Officer selects and funds operational support service contractors on the basis of an evaluation of the proposals received using criteria established by the Secretary and set forth in the RFP.

(e) The Secretary enters into interagency agreements with Federal agencies for the funding, establishment, and operation of CCC's which include provisions to ensure that the Federal agencies comply with the regulations under this part.

§ 670.320 What are the requirements for award of contracts and payments to Federal agencies?

(a) The requirements of the Federal Property and Administrative Services Act of 1949, as amended; the Federal Grant and Cooperative Agreement Act of 1977; the Federal Acquisition Regulation (48 CFR Chapter 1); and the DOL Acquisition Regulation (48 CFR Chapter 29) apply to the award of contracts and to payments to Federal agencies.

(b) Job Corps funding of Federal agencies that operate CCC's are made by a transfer of obligational authority from DOL to the respective operating agency.

Subpart D—Recruitment, Eligibility, Screening, Selection and Assignment, and Enrollment

§ 670.400 Who is eligible to participate in the Job Corps program?

To be eligible to participate in the Job Corps, an individual must be:

(a) At least 16 and not more than 24 years of age at the time of enrollment, except

(1) There is no upper age limit for an otherwise eligible individual with a disability; and

(2) Not more than 20% of individuals enrolled nationwide may be individuals who are aged 22 to 24 years old;

(b) A low-income individual;

(c) An individual who is facing one or more of the following barriers to education and employment:

(1) Is basic skills deficient, as defined in WIA sec. 101(4); or

(2) Is a school dropout; or

(3) Is homeless, or a runaway, or a foster child; or

(4) Is a parent; or

(5) Requires additional education, vocational training, or intensive counseling and related assistance in order to participate successfully in regular schoolwork or to secure and hold meaningful employment; and

(d) Meets the requirements of § 670.420, if applicable.

§ 670.410 Are there additional factors which are considered in selecting an eligible applicant for enrollment?

Yes, in accordance with procedures issued by the Secretary, an eligible applicant may be selected for enrollment, only if:

(a) A determination is made, based on information relating to the background, needs and interests of the applicant, that the applicant's educational and vocational needs can best be met through the Job Corps program;

(b) A determination is made that there is a reasonable expectation the applicant can participate successfully in group situations and activities, and is not likely to engage in actions that would potentially:

(1) Prevent other students from receiving the benefit of the program;

(2) Be incompatible with the maintenance of sound discipline; or

(3) Impede satisfactory relationships between the center to which the student is assigned and surrounding local communities;

(c) The applicant is made aware of the center's rules and what the consequences are for failure to observe the rules, as described in procedures issued by the Secretary;

(d) The applicant passes a background check conducted according to procedures established by the Secretary. The background check must find that the applicant is not on probation, parole, under a suspended sentence or under the supervision of any agency as a result of court action or institutionalization, unless the court or appropriate agency certifies in writing that it will approve of the applicant's release from its supervision and that the applicant's release does not violate applicable laws and regulations. No one will be denied enrollment in Job Corps solely on the basis of contact with the criminal justice system. (WIA secs. 145(b)(1)(C) and 145(b)(2));

(e) Suitable arrangements are made for the care of any dependent children for the proposed period of enrollment.

§ 670.420 Are there any special requirements for enrollment related to the Military Selective Service Act?

(a) Yes, each male applicant 18 years of age or older must present evidence that he has complied with section 3 of the Military Selective Service Act (50 U.S.C. App. 451 *et seq.*) if required; and

(b) When a male student turns 18 years of age, he must submit evidence to the center that he has complied with the requirements of the Military Selective Service Act (50 U.S.C. App. 451 *et seq*).

§ 670.430 What entities conduct outreach and admissions activities for the Job Corps program?

The Regional Director makes arrangements with outreach and admissions agencies to perform Job Corps recruitment, screening and admissions functions according to standards and procedures issued by the Secretary. One-Stop Centers or partners, community action organizations, private for-profit and non-profit businesses, labor organizations, or other entities that have contact with youth over substantial periods of time and are able to offer reliable information about the needs of youth, conduct outreach and admissions activities. The Regional Director awards contracts for provision of outreach and screening services on a competitive basis in accordance with the requirements in § 670.310.

§ 670.440 What are the responsibilities of outreach and admissions agencies?

(a) Outreach and admissions agencies are responsible for:

(1) Developing outreach and referral sources;

(2) Actively seeking out potential applicants;

(3) Conducting personal interviews with all applicants to identify their needs and eligibility status; and

(4) Identifying youth who are interested and likely Job Corps participants.

(b) Outreach and admissions agencies are responsible for completing all Job Corps application forms and determining whether applicants meet the eligibility and selection criteria for

participation in Job Corps as provided in §§ 670.400 and 670.410.

(c) The Secretary may decide that determinations with regard to one or more of the eligibility criteria will be made by the Regional Director.

§ 670.450 How are applicants who meet eligibility and selection criteria assigned to centers?

(a) Each applicant who meets the application and selection requirements of §§ 670.400 and 670.410 is assigned to a center based on an assignment plan developed by the Secretary. The assignment plan identifies a target for the maximum percentage of students at each center who come from the State or region nearest the center, and the regions surrounding the center. The assignment plan is based on an analysis of:

(1) The number of eligible individuals in the State and region where the center is located and the regions surrounding where the center is located;

(2) The demand for enrollment in Job Corps in the State and region where the center is located and in surrounding regions; and

(3) The size and enrollment level of the center.

(b) Eligible applicants are assigned to centers closest to their homes, unless it is determined, based on the special needs of applicants, including vocational interests and English literacy needs, the unavailability of openings in the closest center, or parent or guardian concerns, that another center is more appropriate.

(c) A student who is under the age of 18 must not be assigned to a center other than the center closest to home if a parent or guardian objects to the assignment.

§ 670.460 What restrictions are there on the assignment of eligible applicants for nonresidential enrollment in Job Corps?

(a) No more than 20 percent of students enrolled in Job Corps nationwide may be nonresidential students.

(b) In enrolling individuals who are to be nonresidential students, priority is given to those eligible individuals who are single parents with dependent children. (WIA sec 147(b).)

§ 670.470 May a person who is determined to be ineligible or an individual who is denied enrollment appeal that decision?

(a) A person who is determined to be ineligible to participate in Job Corps under § 670.400 or a person who is not selected for enrollment under § 670.410 may appeal the determination to the outreach and admissions agency or to the center within 60 days of the determination. The appeal will be resolved according to the procedures in §§ 670.990 and 670.991. If the appeal is denied by the outreach/admissions contractor or the center, the person may appeal the decision in writing to the Regional Director within 60 days the date of the denial. The Regional Director will decide within 60 days whether to reverse or approve the appealed decision. The decision by the Regional Director is the Department's final decision.

(b) If an applicant believes that he or she has been determined ineligible or not selected for enrollment based upon a factor prohibited by WIA section 188, the individual may proceed under the applicable DOL nondiscrimination regulations implementing WIA section 188. These regulations may be found at 29 CFR part 37.

(c) An applicant who is determined to be ineligible or a person who is denied enrollment must be referred to the appropriate One-Stop Center or other local service provider.

§ 670.480 At what point is an applicant considered to be enrolled in Job Corps?

(a) To become enrolled as a Job Corps student, an applicant selected for enrollment must physically arrive at the assigned Job Corps center on the appointed date. However, applicants selected for enrollment who arrive at their assigned centers by government furnished transportation are considered to be enrolled on their dates of departure by such transportation.

(b) Center operators must document the enrollment of new students according to procedures issued by the Secretary.

§ 670.490 How long may a student be enrolled in Job Corps?

(a) Except as provided in paragraph (b) of this section, a student may remain enrolled in Job Corps for no more than two years.

(b)(1) An extension of a student's enrollment may be authorized in special cases according to procedures issued by the Secretary; and

(2) A student's enrollment in an advanced career training program may be extended in order to complete the program for a period not to exceed one year.

Subpart E—Program Activities and Center Operations

§ 670.500 What services must Job Corps centers provide?

(a) Job Corps centers must provide:

(1) Academic, vocational, employability and social skills training;

(2) Work-based learning; and

(3) Recreation, counseling and other residential support services.

(b) In addition, centers must provide students with access to the core services described in WIA section 134(d)(2) and the intensive services described in WIA section 134(d)(3).

§ 670.505 What types of training must Job Corps centers provide?

(a) Job Corps centers must provide basic education, vocational and social skills training. The Secretary provides curriculum standards and guidelines.

(b) Each center must provide students with competency-based or individualized training in an occupational area that will best contribute to the students' opportunities for permanent long-term employment.

(1) Specific vocational training programs offered by individual centers must be approved by the Regional Director according to policies issued by the Secretary.

(2) Center industry councils described in § 670.800 must review appropriate labor market information, identify employment opportunities in local areas where students will look for employment, determine the skills and education necessary for those jobs, and as appropriate, recommend changes in the center's vocational training program to the Secretary.

(c) Each center must implement a system to evaluate and track the progress and achievements of each student at regular intervals.

(d) Each center must develop a training plan that must be available for review and approval by the appropriate Regional Director.

§ 670.510 Are Job Corps center operators responsible for providing all vocational training?

No, in order to facilitate students' entry into the workforce, the Secretary may contract with national business, union, or union-affiliated organizations for vocational training programs at specific centers. Contractors providing such vocational training will be selected in accordance with the requirements of § 670.310.

§ 670.515 What responsibilities do the center operators have in managing work-based learning?

(a) The center operator must emphasize and implement work-based learning programs for students through center program activities, including vocational skills training, and through arrangements with employers. Work-based learning must be under actual working conditions and must be designed to enhance the employability, responsibility, and confidence of the students. Work-based learning usually occurs in tandem with students' vocational training.

(b) The center operator must ensure that students are assigned only to workplaces that meet the safety standards described in § 670.935.

§ 670.520 Are students permitted to hold jobs other than work-based learning opportunities?

Yes, a center operator may authorize a student to participate in gainful leisure time employment, as long as the employment does not interfere with required scheduled activities.

§ 670.525 What residential support services must Job Corps center operators provide?

Job Corps center operators must provide the following services according to procedures issued by the Secretary:

(a) A quality living and learning environment that supports the overall training program and includes a safe, secure, clean and attractive physical and social environment, seven days a week, 24 hours a day;

(b) An ongoing, structured counseling program for students;

(c) Food service, which includes provision of nutritious meals for students;

(d) Medical services, through provision or coordination of a wellness program which includes access to basic medical, dental and mental health services, as described in the Policy and Requirements Handbook, for all students from the date of enrollment until separation from the Job Corps program;

(e) A recreation/avocational program;

(f) A student leadership program and an elected student government; and

(g) A student welfare association for the benefit of all students that is funded by non-appropriated funds which come from sources such as snack bars, vending machines, disciplinary fines, and donations, and is run by an elected student government, with the help of a staff advisor.

§ 670.530 Are Job Corps centers required to maintain a student accountability system?

Yes, each Job Corps center must establish and operate an effective system to account for and document the whereabouts, participation, and status of students during their Job Corps enrollment. The system must enable center staff to detect and respond to instances of unauthorized or unexplained student absence. Each center must operate its student accountability system according to requirements and procedures issued by the Secretary.

§ 670.535 Are Job Corps centers required to establish behavior management systems?

(a) Yes, each Job Corps center must establish and maintain its own student incentives system to encourage and reward students' accomplishments.

(b) The Job Corps center must establish and maintain a behavior management system, according to procedures established by the Secretary. The behavior management system must include a zero tolerance policy for violence and drugs policy as described in § 670.540.

§ 670.540 What is Job Corps' zero tolerance policy?

(a) Each Job Corps center must have a zero tolerance policy for:

(1) An act of violence, as defined in procedures issued by the Secretary;

(2) Use, sale, or possession of a controlled substance, as defined at 21 U.S.C. 802;

(3) Abuse of alcohol;

(4) Possession of unauthorized goods; or

(5) Other illegal or disruptive activity.

(b) As part of this policy, all students must be tested for drugs as a condition of enrollment. (WIA sec. 145(a)(1) and 152(b)(2).)

(c) According to procedures issued by the Secretary, the policy must specify the offenses that result in the automatic separation of a student from the Job Corps. The center director is responsible for determining when there is a violation of a specified offense.

§ 670.545 How does Job Corps ensure that students receive due process in disciplinary actions?

The center operator must ensure that all students receive due process in disciplinary proceedings according to procedures developed by the Secretary. These procedures must include, at a minimum, center fact-finding and behavior review boards, a code of sanctions under which the penalty of separation from Job Corps might be imposed, and procedures for students to appeal a center's decision to discharge them involuntarily from Job Corps to a regional appeal board.

§ 670.550 What responsibilities do Job Corps centers have in assisting students with child care needs?

(a) Job Corps centers are responsible for coordinating with outreach and admissions agencies to assist students with making arrangements for child care for their dependent children.

(b) Job Corps centers may operate on center child development programs with the approval of the Secretary.

§ 670.555 What are the center's responsibilities in ensuring that students' religious rights are respected?

(a) Centers must ensure that a student has the right to worship or not worship as he or she chooses.

(b) Students who believe their religious rights have been violated may file complaints under the procedures set forth in 29 CFR part 37.

(c) Requirements related to equal treatment of religious organizations in Department of Labor programs, and to protection of religious liberty of Department of Labor social service providers and beneficiaries, are found at subpart D of 29 CFR part 2. *See also* §§ 667.266 and 667.275 of 20 CFR; 29 CFR part 37.

[65 FR 49450, Aug. 11, 2000, as amended at 69 FR 41891, July 12, 2004]

§ 670.560 Is Job Corps authorized to conduct pilot and demonstration projects?

(a) Yes, the Secretary may undertake experimental, research and demonstration projects related to the Job Corps program according to WIA section 156.

(b) The Secretary establishes policies and procedures for conducting such projects.

(c) All studies and evaluations produced or developed with Federal funds become the property of the United States.

Subpart F—Student Support

§ 670.600 Is government-paid transportation provided to Job Corps students?

Yes, Job Corps provides for the transportation of students between their homes and centers as described in policies and procedures issued by the Secretary.

§ 670.610 When are students authorized to take leaves of absence from their Job Corps centers?

Job Corps students are eligible for annual leaves, emergency leaves and other types of leaves of absence from their assigned centers according to criteria and requirements issued by the Secretary. Center operators and other service providers must account for student leave according to procedures issued by the Secretary.

§ 670.620 Are Job Corps students eligible to receive cash allowances and performance bonuses?

(a) Yes, according to criteria and rates established by the Secretary, Job Corps students receive cash living allowances, performance bonuses, and allotments for care of dependents, and graduates receive post-separation readjustment allowances and placement bonuses. The Secretary may provide former students with post-separation allowances.

(b) In the event of a student's death, any amount due under this section is paid according to the provisions of 5 U.S.C. 5582 governing issues such as designation of beneficiary, order of precedence and related matters.

§ 670.630 Are student allowances subject to Federal Payroll Taxes?

Yes, Job Corps student allowances are subject to Federal payroll tax withholding and social security taxes. Job Corps students are considered to be Federal employees for purposes of Federal payroll taxes. (WIA sec. 157(a)(2).)

§ 670.640 Are students provided with clothing?

Yes, Job Corps students are provided cash clothing allowances and/or articles of clothing, including safety clothing, when needed for their participation in Job Corps and their successful entry into the work force. Center operators and other service providers must issue clothing and clothing assistance to students according to rates, criteria, and procedures issued by the Secretary.

Subpart G—Placement and Continued Services

§ 670.700 What are Job Corps centers' responsibilities in preparing students for placement services?

Job Corps centers must test and counsel students to assess their competencies and capabilities and determine their readiness for placement.

§ 670.710 What placement services are provided for Job Corps students?

(a) Job Corps placement services focus on placing program graduates in:

(1) Full-time jobs that are related to their vocational training and that pay wages that allow for self-sufficiency;

(2) Higher education; or

(3) Advanced training programs, including apprenticeship programs.

(b) Placement service levels for students may vary, depending on whether the student is a graduate or a former student.

(c) Procedures relating to placement service levels are issued by the Secretary.

§ 670.720 Who provides placement services?

The One-Stop system must be used to the fullest extent possible in placing graduates and former students in jobs. Job Corps placement agencies provide placement services under a contract or other agreement with the Department of Labor.

§ 670.730 What are the responsibilities of placement agencies?

(a) Placement agencies are responsible for:

(1) Contacting graduates;

(2) Assisting them in improving skills in resume preparation, interviewing techniques and job search strategies;

(3) Identifying job leads or educational and training opportunities through coordination with local Workforce Investment Boards, One-Stop operators and partners, employers, unions and industry organizations; and

(4) Placing graduates in jobs, apprenticeship, the Armed Forces, or higher education or training, or referring former students for additional services in their local communities as appropriate. Placement services may be provided for former students according to procedures issued by the Secretary.

(b) Placement agencies must record and submit all Job Corps placement information according to procedures established by the Secretary.

§ 670.740 Must continued services be provided for graduates?

Yes, according to procedures issued by the Secretary, continued services, including transition support and workplace counseling, must be provided to program graduates for 12 months after graduation.

§ 670.750 Who may provide continued services for graduates?

Placement agencies, centers or other agencies, including One-Stop partners, may provide post-program services under a contract or other agreement with the Regional Director. In selecting a provider for continued services, priority is given to One-Stop partners. (WIA sec. 148(d)).

§ 670.760 How will Job Corps coordinate with other agencies?

(a) The Secretary issues guidelines for the National Office, Regional Offices, Job Corps centers and operational support providers to use in developing and maintaining cooperative relationships with other agencies and institutions, including law enforcement, educational institutions, communities, and other employment and training programs and agencies.

(b) The Secretary develops polices and requirements to ensure linkages with the One-Stop delivery system to the greatest extent practicable, as well as with other Federal, State, and local programs, and youth programs funded under this title. These linkages enhance services to youth who face multiple barriers to employment and must include, where appropriate:

(1) Referrals of applicants and students;

(2) Participant assessment;

(3) Pre-employment and work maturity skills training;

(4) Work-based learning;

(5) Job search, occupational, and basic skills training; and

(6) Provision of continued services for graduates.

Subpart H—Community Connections

§ 670.800 How do Job Corps centers and service providers become involved in their local communities?

(a) Job Corps representatives serve on Youth Councils operating under applicable Local Boards wherever geographically feasible.

(b) Each Job Corps center must have a Business and Community Liaison designated by the director of the center to establish relationships with local and distant employers, applicable One-Stop centers and local boards, and members of the community according to procedures established by the Secretary. (WIA sec. 153(a).)

(c) Each Job Corps center must implement an active community relations program.

(d) Each Job Corps center must establish an industry advisory council, according to procedures established by the Secretary. The industry advisory council must include:

(1) Distant and local employers;

(2) Representatives of labor organizations (where present) and employees; and

(3) Job Corps students and graduates.

(e) A majority of the council members must be local and distant business owners, chief executives or chief operating officers of nongovernmental employers or other private sector employers, who have substantial management, hiring or policy responsibility and who represent businesses with employment opportunities in the local area and the areas to which students will return.

(f) The council must work with Local Boards and must review labor market information to provide recommendations to the Secretary regarding the center's vocational training offerings, including identification of emerging occupations suitable for training. (WIA sec.154(b)(1).)

(g) Job Corps is identified as a required One-Stop partner. Wherever practicable, Job Corps centers and operational support contractors must establish cooperative relationships and partnerships with One-Stop centers and other One-Stop partners, Local Boards, and other programs for youth.

Subpart I—Administrative and Management Provisions

§ 670.900 Are damages caused by the acts or omissions of students eligible for payment under the Federal Tort Claims Act?

Yes, students are considered Federal employees for purposes of the FTCA (28 U.S.C. 2671 *et seq.*). Claims for such damage should be filed pursuant to the procedures found in 29 CFR part 15, subpart D.

[77 FR 22207, Apr. 13, 2012]

§ 670.905 Are loss and damages that occur to persons or personal property of students at Job Corps centers eligible for reimbursement?

Yes, the Job Corps may pay students for valid claims under the procedures found in 29 CFR part 15, subpart D.

[77 FR 22207, Apr. 13, 2012]

§ 670.910 If a student is injured in the performance of duty as a Job Corps Student, what benefits may they receive?

(a) Job Corps students are considered Federal employees for purposes of the Federal Employees' Compensation Act (FECA) as specified in 29 U.S.C. 2897.

(b) Job Corps students may be entitled to benefits under FECA as provided by 5 U.S.C. 8143 for injuries occurring in the performance of duty.

(c) Job Corps students must meet the same eligibility tests for FECA benefits that apply to all other Federal employees. The requirements for FECA benefits may be found at 5 U.S.C. 8101, *et seq.* and part 10 of this title. The Department of Labor's Office of Workers' Compensation Programs (OWCP) administers the FECA program; all FECA determinations are within the exclusive authority of the OWCP, subject to appeal to the Employees' Compensation Appeals Board.

(d) Whenever a student is injured, develops an occupationally related illness, or dies while in the performance of duty, the procedures of the OWCP, at part 10 of this title, must be followed. To assist OWCP in determining FECA eligibility, a thorough investigation of the circumstances and a medical evaluation must be completed and required forms must be timely filed by the center operator with the DOL's OWCP. Additional information regarding Job Corps FECA claims may be found in OWCP's regulations and procedures available on DOL's Web site located at *www.dol.gov*.

[77 FR 22207, Apr. 13, 2012]

§ 670.915 When is a Job Corps student considered to be in the performance of duty?

(a) Performance of duty is a determination that must be made by the OWCP under FECA, and is based on the individual circumstances in each claim.

(b) In general, residential students may be considered to be in the ''performance of duty'' when:

(1) They are on center under the supervision and control of Job Corps officials;

(2) They are engaged in any authorized Job Corps activity;

(3) They are in authorized travel status; or

(4) They are engaged in any authorized offsite activity.

(c) Non-resident students are generally considered to be ''in performance of duty'' as Federal employees when they are engaged in any authorized Job Corps activity, from the time they arrive at any scheduled center activity until they leave the activity. The standard rules governing coverage of Federal employees during travel to and from work apply. These rules are described in guidance issued by the Secretary.

(d) Students are generally considered to be not in the performance of duty when:

(1) They are Absent Without Leave (AWOL);

(2) They are at home, whether on pass or on leave;

(3) They are engaged in an unauthorized offsite activity; or

(4) They are injured or ill due to their own willful misconduct, intent to cause injury or death to oneself or another or through intoxication or illegal use of drugs.

[77 FR 22207, Apr. 13, 2012]

§ 670.935 How are students protected from unsafe or unhealthy situations?

(a) The Secretary establishes procedures to ensure that students are not required or permitted to work, be trained, reside in, or receive services in buildings or surroundings or under conditions that are unsanitary or hazardous. Whenever students are employed or in training for jobs, they must be assigned only to jobs or training which observe applicable Federal, State and local health and safety standards.

(b) The Secretary develops procedures to ensure compliance with applicable DOL Occupational Safety and Health Administration regulations.

§ 670.940 What are the requirements for criminal law enforcement jurisdiction on center property?

(a) All Job Corps property which would otherwise be under exclusive Federal legislative jurisdiction is considered under concurrent jurisdiction with the appropriate State and locality with respect to criminal law enforcement. Concurrent jurisdiction extends to all portions of the property, including housing and recreational facilities, in addition to the portions of the property used for education and training activities.

(b) Centers located on property under concurrent Federal-State jurisdiction must establish agreements with Federal, State and local law enforcement agencies to enforce criminal laws.

(c) The Secretary develops procedures to ensure that any searches of a student's person, personal area or belongings for unauthorized goods follow applicable right-to-privacy laws.

§ 670.945 Are Job Corps operators and service providers authorized to pay State or local taxes on gross receipts?

(a) A private for-profit or a nonprofit Job Corps service provider is not liable, directly or indirectly, to any State or subdivision for any gross receipts taxes, business privilege taxes measured by gross receipts, or any similar taxes in connection with any payments made to or by such service provider for operating a center or other Job Corps program or activity. The service provider is not liable to any State or subdivision to collect or pay any sales, excise, use, or similar tax imposed upon the sale to or use by such deliverer of any property, service, or other item in connection with the operation of a center or other Job Corps program or activity. (WIA sec. 158(d).)

(b) If a State or local authority compels a center operator or other service provider to pay such taxes, the center

operator or service provider may pay the taxes with Federal funds, but must document and report the State or local requirement according to procedures issued by the Secretary.

§ 670.950 What are the financial management responsibilities of Job Corps center operators and other service providers?

(a) Center operators and other service providers must manage Job Corps funds using financial management information systems that meet the specifications and requirements of the Secretary.

(b) These financial management systems must:

(1) Provide accurate, complete, and current disclosures of the costs of their Job Corps activities;

(2) Ensure that expenditures of funds are necessary, reasonable, allocable and allowable in accordance with applicable cost principles;

(3) Use account structures specified by the Secretary;

(4) Ensure the ability to comply with cost reporting requirements and procedures issued by the Secretary; and

(5) Maintain sufficient cost data for effective planning, monitoring, and evaluation of program activities and for determining the allowability of reported costs.

§ 670.955 Are center operators and service providers subject to Federal audits?

(a) Yes, Center operators and service providers are subject to Federal audits.

(b) The Secretary arranges for the survey, audit, or evaluation of each Job Corps center and service provider at least once every three years, by Federal auditors or independent public accountants. The Secretary may arrange for more frequent audits. (WIA sec. 159(b)(2).)

(c) Center operators and other service providers are responsible for giving full cooperation and access to books, documents, papers and records to duly appointed Federal auditors and evaluators. (WIA sec. 159(b)(1).)

§ 670.960 What are the procedures for management of student records?

The Secretary issues guidelines for a system for maintaining records for each student during enrollment and for disposition of such records after separation.

§ 670.965 What procedures apply to disclosure of information about Job Corps students and program activities?

(a) The Secretary develops procedures to respond to requests for information or records or other necessary disclosures pertaining to students.

(b) DOL disclosure of Job Corps information must be handled according to the Freedom of Information Act and according to DOL regulations at 29 CFR part 70.

(c) Job Corps contractors are not ''agencies'' for Freedom of Information Act purposes. Therefore, their records are not subject to disclosure under the Freedom of Information Act or 29 CFR part 70.

(d) The regulations at 29 CFR part 71 apply to a system of records covered by the Privacy Act of 1974 maintained by DOL or to a similar system maintained by a contractor, such as a screening agency, contract center operator, or placement agency on behalf of the Job Corps.

§ 670.970 What are the reporting requirements for center operators and operational support service providers?

The Secretary establishes procedures to ensure the timely and complete reporting of necessary financial and program information to maintain accountability. Center operators and operational support service providers are responsible for the accuracy and integrity of all reports and data they provide.

§ 670.975 How is the performance of the Job Corps program assessed?

The performance of the Job Corps program as a whole, and the performance of individual program components, is assessed on an ongoing basis, in accordance with the regulations in this part and procedures and standards, including a national performance measurement system, issued by the

Secretary. Annual performance assessments are done for each center operator and other service providers, including screening and admissions and placement agencies.

§ 670.980 What are the indicators of performance for Job Corps?

(a) At a minimum, the performance assessment system established under § 670.975 will include expected levels of performance established for each of the indicators of performance contained in WIA section 159(c). These are:

(1) The number of graduates and rate of graduation, analyzed by the type of vocational training received and the training provider;

(2) The job placement rate of graduates into unsubsidized employment, analyzed by the vocational training received, whether or not the job placement is related to the training received, the vocational training provider, and whether the placement is made by a local or national service provider;

(3) The average placement wage of graduates in training-related and non-training related unsubsidized jobs;

(4) The average wage of graduates on the first day of employment and at 6 and 12 months following placement, analyzed by the type of vocational training received;

(5) The number of and retention rate of graduates in unsubsidized employment after 6 and 12 months;

(6) The number of graduates who entered unsubsidized employment for 32 hours per week or more, for 20 to 32 hours per week, and for less than 20 hours per week.

(7) The number of graduates placed in higher education or advanced training; and

(8) The number of graduates who attained job readiness and employment skills.

(b) The Secretary issues the expected levels of performance for each indicator. To the extent practicable, the levels of performance will be continuous and consistent from year to year.

§ 670.985 What happens if a center operator, screening and admissions contractor or other service provider fails to meet the expected levels of performance?

(a) The Secretary takes appropriate action to address performance issues through a specific performance plan.

(b) The plan may include the following actions:

(1) Providing technical assistance to a Job Corps center operator or support service provider, including a screening and admissions contractor;

(2) Changing the management staff of a center;

(3) Changing the vocational training offered at a center;

(4) Contracting out or recompeting the contract for a center or operational support service provider;

(5) Reducing the capacity of a Job Corps center;

(6) Relocating a Job Corps center; or

(7) Closing a Job Corps center. (WIA sec. 159 (f).)

§ 670.990 What procedures are available to resolve complaints and disputes?

(a) Each Job Corps center operator and service provider must establish and maintain a grievance procedure for filing complaints and resolving disputes from applicants, students and/or other interested parties about its programs and activities. A hearing on each complaint or dispute must be conducted within 30 days of the filing of the complaint or dispute. A decision on the complaint must be made by the center operator or service provider, as appropriate, within 60 days after the filing of the complaint, and a copy of the decision must be immediately served, by first-class mail, on the complainant and any other party to the complaint. Except for complaints under § 670.470 or complaints alleging fraud or other criminal activity, complaints may be filed within one year of the occurrence that led to the complaint.

(b) The procedure established under paragraph (a) of this section must include procedures to process complaints alleging violations of WIA section 188, consistent with DOL nondiscrimination regulations implementing WIA

section 188 at 29 CFR part 37 and § 670.995.

§ 670.991 How does Job Corps ensure that complaints or disputes are resolved in a timely fashion?

(a) If a complaint is not resolved by the center operator or service provider in the time frames described in § 670.990, the person making the complaint may request that the Regional Director determine whether reasonable cause exists to believe that the Act or regulations for this part of the Act have been violated. The request must be filed with the Regional Director within 60 days from the date that the center operator or service provider should have issued the decision.

(b) Following the receipt of a request for review under paragraph (a) of this section, the Regional Director must determine within 60 days whether there has been a violation of the Act or the WIA regulations. If the Regional Director determines that there has been a violation of the Act or Regulations, (s)he may direct the operator or service provider to remedy the violation or direct the service provider to issue a decision to resolve the dispute according to the service provider's grievance procedures. If the service provider does not comply with the Regional Director's decision within 30 days, the Regional Director may impose a sanction on the center operator or service provider for violating the Act or regulations, and/or for failing to issue a decision. Decisions imposing sanctions upon a center operator or service provider may be appealed to the DOL Office of Administrative Law Judges under 20 CFR 667.800 or 667.840.

§ 670.992 How does Job Corps ensure that centers or other service providers comply with the Act and the WIA regulations?

(a) If DOL receives a complaint or has reason to believe that a center or other service provider is failing to comply with the requirements of the Act or regulations, the Regional Director must investigate the allegation and determine within 90 days after receiving the complaint or otherwise learning of the alleged violation, whether such allegation or complaint is true.

(b) As a result of such a determination, the Regional Director may:

(1) Direct the center operator or service provider to handle a complaint through the grievance procedures established under § 670.990; or

(2) Investigate and determine whether the center operator or service provider is in compliance with the Act and regulations. If the Regional Director determines that the center or service provider is not in compliance with the Act or regulations, the Regional Director may take action to resolve the complaint under § 670.991(b), or will report the incident to the DOL Office of the Inspector General, as described in 20 CFR 667.630.

§ 670.993 How does Job Corps ensure that contract disputes will be resolved?

A dispute between DOL and a Job Corps contractor will be handled according to the Contract Disputes Act and applicable regulations.

§ 670.994 How does Job Corps resolve disputes between DOL and other Federal Agencies?

Disputes between DOL and a Federal Agency operating a center will be handled according to the interagency agreement with the agency which is operating the center.

§ 670.995 What DOL equal opportunity and nondiscrimination regulations apply to Job Corps?

Nondiscrimination requirements, procedures, complaint processing, and compliance reviews are governed by, as applicable, provisions of the following Department of Labor regulations:

(a) Regulations implementing WIA section 188 for programs receiving Federal financial assistance under WIA found at 29 CFR part 37.

(b) 29 CFR part 33 for programs conducted by the Department of Labor; and

(c) 41 CFR Chapter 60 for entities that have a Federal government contract.

PART 671—NATIONAL EMERGENCY GRANTS FOR DISLOCATED WORKERS

Sec.

671.100 What is the purpose of national emergency grants under WIA section 173?
671.105 What funds are available for national emergency grants?
671.110 What are major economic dislocations or other events which may qualify for a national emergency grant?
671.120 Who is eligible to apply for national emergency grants?
671.125 What are the requirements for submitting applications for national emergency grants?
671.130 When should applications for national emergency grants be submitted to the Department?
671.140 What are the allowable activities and what dislocated workers may be served under national emergency grants?
671.150 How do statutory and workflex waivers apply to national emergency grants?
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671.170 What are the program and administrative requirements that apply to national emergency grants?

AUTHORITY: Sec. 506(c), Pub. L. 105–220; 20 U.S.C. 9276(c).

SOURCE: 65 FR 49460, Aug. 11, 2000, unless otherwise noted.

§ 671.100 What is the purpose of national emergency grants under WIA section 173?

The purpose of national emergency grants is to provide supplemental dislocated worker funds to States, Local Boards and other eligible entities in order to respond to the needs of dislocated workers and communities affected by major economic dislocations and other worker dislocation events which cannot be met with formula allotments.

§ 671.105 What funds are available for national emergency grants?

We use funds reserved under WIA section 132(a)(2)(A) to provide financial assistance to eligible applicant for grants under WIA section 173.

§ 671.110 What are major economic dislocations or other events which may qualify for a national emergency grant?

These include:

(a) Plant closures;

(b) Mass layoffs affecting 50 or more workers at a single site of employment;

(c) Closures and realignments of military installations;

(d) Multiple layoffs in a single local community that have significantly increased the total number of unemployed individuals in a community;

(e) Emergencies or natural disasters, as defined in paragraphs (1) and (2) respectively, of section 102 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122(1) and (2)) which have been declared eligible for public assistance by the Federal Emergency Management Agency (FEMA); and

(f) Other events, as determined by the Secretary.

§ 671.120 Who is eligible to apply for national emergency grants?

(a) *For projects within a State.* A State, a Local Board or another entity determined to be appropriate by the Governor of the State in which the project is located may apply for a national emergency grant. Also, Indian tribes, tribal organizations, Alaska Native entities, Indian-controlled organizations serving Indians, or Native Hawaiian organizations which are recipients of funds under section 166 of the Act (Indian and Native American Programs) may apply for a national emergency grant.

(b) *For inter-State projects.* Consortia of States and/or Local Boards may apply. Other private entities which can demonstrate, in the application for assistance, that they possess unique capabilities to effectively respond to the circumstances of the major economic dislocation(s) covered in the application may apply.

(c) *Other entities.* The Secretary may consider applications from other entities, to ensure that appropriate assistance is provided in response to major economic dislocations.

§ 671.125 What are the requirements for submitting applications for national emergency grants?

We publish instructions for submitting applications for National Emergency Grants in the FEDERAL REGISTER. The instructions specify application procedures, selection criteria and the approval process.

§ 671.130 When should applications for national emergency grants be submitted to the Department?

(a) Applications for national emergency grants to respond to mass layoffs and plant closures may be submitted to the Department as soon as:

(1) The State receives a notification of a mass layoff or a closure as a result of a WARN notice, a general announcement or some other means determined by the Governor to be sufficient to respond;

(2) Rapid response assistance has been initiated; and

(3) A determination has been made, in collaboration with the applicable Local Board(s) and chief elected official(s), that State and local formula dislocated worker funds are inadequate to provide the level of services needed by the workers being laid off.

(b) An eligible entity may apply for a national emergency grant at any time during the year.

(c) Applications for national emergency grants to respond to a declared emergency or natural disaster as described in § 671.110(e), cannot be considered until FEMA has declared that the affected area is eligible for disaster-related public assistance.

§ 671.140 What are the allowable activities and what dislocated workers may be served under national emergency grants?

(a) National emergency grants may provide adjustment assistance for eligible dislocated workers, described at WIA section 173(c)(2) or (d)(2).

(b) Adjustment assistance includes the core, intensive, and training services authorized at WIA sections 134(d) and 173. The scope of services to be provided in a particular project are negotiated between the Department and the grantee, taking into account the needs of the target population covered by the grant. The scope of services may be changed through grant modifications, if necessary.

(c) National emergency grants may provide for supportive services to help workers who require such assistance to participate in activities provided for in the grant. Needs-related payments, in support of other employment and training assistance, may be available for the purpose of enabling dislocated workers who are eligible for such payments to participate in programs of training services. Generally, the terms of a grant must be consistent with Local Board policies governing such financial assistance with formula funds (including the payment levels and duration of payments). However, the terms of the grant agreement may diverge from established Local Board policies, in the following instances:

(1) If unemployed dislocated workers served by the project are not able to meet the 13 or 8 weeks enrollment in training requirement at WIA section 134(e)(3)(B) because of the lack of formula or emergency grant funds in the State or local area at the time of dislocation, such individuals may be eligible for needs-related payments if they are enrolled in training by the end of the 6th week following the date of the emergency grant award;

(2) Trade-impacted workers who are not eligible for trade readjustment assistance under NAFTA-TAA may be eligible for needs-related payments under a national emergency grant if the worker is enrolled in training by the end of the 16th week following layoff; and

(3) Under other circumstances as specified in the national emergency grant application guidelines.

(d) A national emergency grant to respond to a declared emergency or natural disaster, as defined at § 671.110(e), may provide short-term disaster relief employment for:

(1) Individuals who are temporarily or permanently laid off as a consequence of the disaster;

(2) Dislocated workers; and

(3) Long-term unemployed individuals.

(e) Temporary employment assistance is authorized on disaster projects that provide food, clothing, shelter and

other humanitarian assistance for disaster victims; and on projects that perform demolition, cleaning, repair, renovation and reconstruction of damaged and destroyed structures, facilities and lands located within the disaster area. For such temporary jobs, each eligible worker is limited to no more than six months of employment for each single disaster. The amounts, duration and other limitations on wages will be negotiated for each grant.

(f) Additional requirements that apply to national emergency grants, including natural disaster grants, are contained in the application instructions.

§ 671.150 How do statutory and workflex waivers apply to national emergency grants?

(a) State and Local Board grantees may request and we may approve the application of existing general statutory or regulatory waivers and workflex waivers to a National Emergency Grant award. The application for grant funds must describe any statutory waivers which the applicant wishes to apply to the project that the State and/or Local Board, as applicable, have been granted under its waiver plan, or that the State has approved for implementation in the applicable local area under workflex waivers. We will consider such requests as part of the overall application review and decision process.

(b) If, during the operation of the project, the grantee wishes to apply a waiver not identified in the application, the grantee must request a modification which includes the provision to be waived, the operational barrier to be removed and the effect upon the outcome of the project.

§ 671.160 What rapid response activities are required before a national emergency grant application is submitted?

(a) Rapid response is a required Statewide activity under WIA section 134(a)(2)(A), to be carried out by the State or its designee in collaboration with the Local Board(s) and chief elected official(s). Under 20 CFR 665.310, rapid response encompasses, among other activities, an assessment of the general needs of the affected workers and the resources available to them.

(b) In accordance with national emergency grant application guidelines published by the Department, each applicant must demonstrate that:

(1) The rapid response activities described in 20 CFR 665.310 have been initiated and carried out, or are in the process of being carried out;

(2) State and local funds, including those made available under section 132(b)(2)(B) of the Act, have been used to initiate appropriate services to the eligible workers;

(3) There is a need for additional funds to effectively respond to the assistance needs of the workers and, in the case of declared emergencies and natural disasters, the community; and

(4) The application has been developed by or in conjunction with the Local Board(s) and chief elected official(s) of the local area(s) in which the proposed project is to operate.

§ 671.170 What are the program and administrative requirements that apply to national emergency grants?

(a) In general, the program requirements and administrative standards set forth at 20 CFR parts 663 and 667 will apply.

(b) Exceptions include:

(1) Funds provided in response to a natural disaster may be used for temporary job creation in areas declared eligible for public assistance by FEMA, subject to the limitations of WIA section 173(d), this part and the application guidelines issued by the Department;

(2) National emergency grant funds may be used to pay an appropriate level of administrative costs based on the design and complexity of the project. We will negotiate administration costs with the applicant as part of the application review and grant award and modification processes;

(3) The period of availability for expenditure of funds under a national emergency grant is specified in the grant agreement.

(4) We may establish supplemental reporting, monitoring and oversight requirements for national emergency

grants. The requirements will be identified in the grant application instructions or the grant document.

(5) We may negotiate and fund projects under terms other than those specified in this part where it can be clearly demonstrated that such adjustments will achieve a greater positive benefit for the workers and/or communities being assisted.

PART 672—PROVISIONS GOVERNING THE YOUTHBUILD PROGRAM

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Subpart A—Purpose and Definitions

§ 672.100 What is YouthBuild?

(a) YouthBuild is a workforce development program that provides employment, education, leadership development, and training opportunities to disadvantaged and low-income youth between the ages of 16 and 24, most of whom are secondary school drop outs and are either a member of a low-income family, a foster care youth, a youth offender, a youth with a disability, a child of an incarcerated parent, or a migrant youth.

(b) Program participants receive education services that may lead to either

a high school diploma or General Educational Development (GED). Further, they receive occupational skills training and are encouraged to pursue a post- secondary education or additional training, including registered apprenticeship programs. The program is designed to create a skilled workforce either in the construction industry, through the rehabilitation and construction of housing for homeless individuals and families and low- income families, as well as public facilities, or in other high wage, high-demand jobs. The program also benefits the larger community because it provides more new and rehabilitated affordable housing.

§ 672.105 What are the purposes of the YouthBuild program?

(a) The overarching goal of the YouthBuild program is to provide disadvantaged and low-income youth the opportunity to obtain education and employment skills in local in-demand and high-demand jobs to achieve economic self-sufficiency. Additionally, the YouthBuild program has as goals:

(1) To promote leadership skills development and community service activities. YouthBuild programs will foster the development of leadership skills and a commitment to community improvement among youth in low-income communities.

(2) To enable youth to further their education and training. YouthBuild programs will provide counseling and assistance in obtaining post-secondary education and/or employment and training placements that allow youth to further their education and training.

(3) To expand the supply of permanent affordable housing and reduce the rate of homelessness in communities with YouthBuild programs. The program seeks to increase the number of affordable housing units available and to decrease the number of homeless individuals and families in their communities.

(b) Through these educational and occupational opportunities, to enable youth participants to provide a valuable contribution to their communities. The YouthBuild program will add skilled workers to the workforce by educating and training youth who might have otherwise succumbed to the negative influences within their environments.

§ 672.110 What definitions apply to this part?

Alternative school. The term ''alternative school'' means a school or program that is set up by a State, school district, or other community-based entity to serve young people who are not succeeding in a traditional public school environment. In order for an ''alternative school'' to qualify as of part of a ''sequential service strategy'' it must be recognized by the authorizing entity designated by the State, award a high school diploma or both a high school diploma and a GED and, must be affiliated with a YouthBuild program.

Community or other public facility. The term ''community or other public facility'' means those facilities which are either privately owned by non-profit organizations, including faith-based and community-based organizations, and publicly used for the benefit of the community, or publicly owned and publicly used for the benefit of the community.

Core construction. The term ''core construction'' means activities that are directly related to the construction or rehabilitation of residential, community, or other public facilities. These activities include, but are not limited to, job skills that can be found under the Standard Occupational Classification System (SOC) major group 47, Construction and Extraction Occupations, in codes 47–1011 through 47–4099. These activities may also include, but are not limited to, construction skills that may be required by green building and weatherization industries but are not yet standardized. A full list of the SOC's can be found at the Bureau of Labor Statistics (BLS) Web site, *http://www.bls.gov/soc.*

Eligible entity. The term ''eligible entity'' means a public or private nonprofit agency or organization (including a consortium of such agencies or organizations), including—

(1) A community-based organization;

(2) A faith-based organization;

(3) An entity carrying out activities under this Title, such as a local school board;

(4) A community action agency;

(5) A State or local housing development agency;

(6) An Indian tribe or other agency primarily serving Indians;

(7) A community development corporation;

(8) A State or local youth service or conservation corps; and

(9) Any other entity eligible to provide education or employment training under a Federal program (other than the program carried out under this part).

Homeless individual. For purposes of YouthBuild, the definition of ''homeless individual'' at Section 103 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302) applies.

Housing development agency. The term ''housing development agency'' means any agency of a Federal, State or local government, or any private nonprofit organization, that is engaged in providing housing for homeless individuals or low-income families.

Income. As defined in 42 U.S.C. 1437a(b), ''income'' is: Income from all sources of each member of the household, as determined in accordance with the criteria prescribed by the Secretary of Labor, in consultation with the Secretary of Agriculture, except that any amounts not actually received by the family and any amounts which would be eligible for exclusion under sec. 1382b(a)(7) of the United States Housing Act of 1937, may not be considered as income under this paragraph.

Indian; Indian tribe. As defined in 25 U.S.C. 450b of sec. 4 of the Indian Self-Determination and Education Assistance Act, the term ''Indian'' is a person who is a member of an Indian tribe; and the term ''Indian tribe'' is any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) (43 U.S.C. 1601 *et seq.*), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual of limited English proficiency. As defined in 20 U.S.C. 9202(10), an ''individual of limited English proficiency'' is: An adult or out- of-school youth who has limited ability in speaking, reading, writing, or understanding the English language, and:

(1) Whose native language is a language other than English; or

(2) Who lives in a family or community environment where a language other than English is the dominant language.

Low-income family. As defined in 42 U.S.C. 1437a(b)(2), a ''low-income family'' is: A family whose income does not exceed 80 percent of the median income for the area, as determined by the Secretary of Labor with adjustments for smaller and larger families, except that the Secretary of Labor may establish income ceilings higher or lower than 80 percent of the median for the area if the Secretary finds that such variations are necessary because of prevailing levels of construction costs or unusually high or low family incomes. Further, as defined by 42 U.S.C. 1437a(b)(2)(3), the term families includes families consisting of one person.

Migrant youth. The term ''migrant youth'' means a youth, or a youth who is the dependent of someone who, during the previous 12 months has:

(1) Worked at least 25 days in agricultural labor that is characterized by chronic unemployment or underemployment;

(2) Made at least $800 from agricultural labor that is characterized by chronic unemployment or underemployment, if at least 50 percent of his or her income came from such agricultural labor;

(3) Was employed at least 50 percent of his or her total employment in agricultural labor that is characterized by chronic unemployment or underemployment; or

(4) Was employed in agricultural labor that requires travel to a jobsite such that the farmworker is unable to return to a permanent place of residence within the same day.

Needs-based stipend. The term ''Needs-based stipends'' means additional payments (beyond regular stipends for program participation) that are based on defined needs that enable youth to participate in the program. To provide needs-based stipends the grantee must have a written policy in place, which defines: Eligibility; the amounts; and the required documentation and criteria for payments. This policy must be applied consistently to all program participants.

Occupational skills training. The term ''Occupational skills training'' means an organized program of study that provides specific vocational skills that lead to proficiency in performing the actual tasks and technical functions required by certain occupational fields at entry, intermediate, or advanced levels. The occupational skills training offered in YouthBuild programs must begin upon program enrollment and be tied to the award of an industry-recognized credential.

Partnership. The term ''partnership'' means an agreement that involves a Memorandum of Understanding (MOU) or letter of commitment submitted by each organization and applicant, as defined in the YouthBuild Transfer Act, that plan on working together as partners in a YouthBuild program. Each partner must have a clearly defined role. These roles must be verified through a letter of commitment, not just a letter of support, or an MOU submitted by each partner. The letter of commitment or MOU must detail the role the partner will play in the YouthBuild Program, including the partner's specific responsibilities and resources committed, if appropriate. These letters or MOUs must clearly indicate the partnering organization's unique contribution and commitment to the YouthBuild Program.

Public housing agency. As defined in 42 U.S.C. 1437a(b), a ''public housing agency'' is: Any State, county, municipality or other government entity or public body, or agency or instrumentality of these entities, that is authorized to engage or assist in the development or operation of low- income housing.

Registered apprenticeship program. The term ''registered apprenticeship program'' means:

(1) Registered under the Act of August 16, 1937 (commonly known as the ''National Apprenticeship Act''; 50 Stat. 664, chapter 663; 20 U.S.C. 50 *et seq.*); and

(2) A program with a plan containing all terms and conditions for the qualification, recruitment, selection, employment and training of apprentices, as required under 29 CFR parts 29 and 30, including such matters as the requirement for a written apprenticeship agreement.

Sequential service strategy. The term ''sequential service strategy'' means the educational and occupational skills training plan developed for individuals who have dropped out of high school and want to enroll in a YouthBuild program. The plan is designed so that the individual sequentially enrolls in an alternative school, and after receiving a year or more of educational services, enrolls in the YouthBuild program.

Transitional housing. The term ''transitional housing'' means housing provided for the purpose of facilitating the movement of homeless individuals to independent living within a reasonable amount of time. The term includes housing primarily designed to serve deinstitutionalized homeless individuals and other homeless individuals who are individuals with disabilities or are members of families with children.

Youth in foster care. The term ''youth in foster care'' means youth currently in foster care or youth who have ever been in foster care.

Youth who is an individual with a disability. The term youth who is an individual with a disability means a youth with any disability (as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102)) or a student receiving special education and related services under the Individuals with Disabilities Education Act (IDEA).

Subpart B—Funding and Grant Applications

§ 672.200 How are YouthBuild grants funded and administered?

The Secretary uses funds authorized for appropriation under sec. 173A of the Workforce Investment Act (WIA) to administer YouthBuild as a national program under Title I, Subtitle D of the Act. YouthBuild grants are awarded to eligible entities, as defined in § 672.110, through a competitive selection process described in § 672.205.

§ 672.205 How does an eligible entity apply for grant funds to operate a YouthBuild program?

The Secretary announces the availability of grant funds through a Solicitation for Grant Applications (SGA). The SGA contains instructions for what is required in the grant application, describes eligibility requirements, the rating criteria that will be used in reviewing grant applications, and special reporting requirements to operate a YouthBuild project.

§ 672.210 How are eligible entities selected to receive grant funds?

In order to receive funds under the YouthBuild program, an eligible entity applying for funds (applicant) must meet selection criteria established by the Secretary which include:

(a) The qualifications or potential capabilities of an applicant;

(b) An applicant's potential to develop a successful YouthBuild program;

(c) The need for an applicant's proposed program, as determined by the degree of economic distress of the community from which participants would be recruited (measured by indicators such as poverty, youth unemployment, and the number of individuals who have dropped out of secondary school) and of the community in which the housing and public facilities proposed to be rehabilitated or constructed are located (measured by indicators such as incidence of homelessness, shortage of affordable housing, and poverty);

(d) The commitment of an applicant to provide skills training, leadership development, counseling and case management, and education to participants;

(e) The focus of a proposed program on preparing youth for postsecondary education and training opportunities or local in-demand occupations;

(f) The extent of an applicant's coordination of activities to be carried out through the proposed program with:

(1) Local boards, One-Stop Career Center operators, and One-Stop partners participating in the operation of the One-Stop delivery system involved, or the extent of the applicant's good faith efforts, as determined by the Secretary, in achieving such coordination;

(2) Public education, criminal justice, housing and community development, national service, or postsecondary education or other systems that relate to the goals of the proposed program; and

(3) Employers in the local area.

(g) The extent to which a proposed program provides for inclusion of tenants who were previously homeless individuals or families in the rental of housing provided through the program;

(h) The commitment of additional resources to the proposed program (in addition to the funds made available through the grant) by:

(1) An applicant;

(2) Recipients of other Federal, State, or local housing and community development assistance who will sponsor any part of the rehabilitation, construction, operation and maintenance, or other housing and community development activities undertaken as part of the proposed program; or

(3) Entities carrying out other Federal, State, or local activities or activities conducted by Indian tribes, including vocational education programs, adult and language instruction educational programs, and job training using funds provided under WIA,

(i) An applicant's ability to enter partnerships with:

(1) Education and training providers including:

(i) The kindergarten through twelfth grade educational system;

(ii) Adult education programs;

(iii) Community and technical colleges;

(iv) Four-year colleges and universities;

(v) Registered apprenticeship programs; and

(vi) Other training entities.

(2) Employers, including professional organizations and associations. An applicant will be evaluated on the extent to which employers participate in:

(i) Defining the program strategy and goals;

(ii) Identifying needed skills and competencies;

(iii) Designing training approaches and curricula;

(iv) Contributing financial support; and

(v) Hiring qualified YouthBuild graduates.

(3) The workforce investment system which may include:

(i) State and local workforce investment boards;

(ii) State workforce agencies; and

(iii) One-Stop Career Centers and their cooperating partners.

(4) The juvenile and adult justice systems, and the extent to which they provide:

(i) Support and guidance for YouthBuild participants with court involvement;

(ii) Assistance in the reporting of recidivism rates among YouthBuild participants; and

(iii) Referrals of eligible participants through diversion or re-entry from incarceration.

(5) Faith-based and community organizations, and the extent to which they provide a variety of grant services such as:

(i) Case management;

(ii) Mentoring;

(iii) English as a Second Language courses; and

(iv) Other comprehensive supportive services, when appropriate.

(j) The applicant's potential to serve different regions, including rural areas and States that may not have previously received grants for YouthBuild programs; and

(k) Such other factors as the Secretary determines to be appropriate for purposes of evaluating an applicant's potential to carry out the proposed program in an effective and efficient manner.

(l) The weight to be given to these factors will be described in the SGA issued under § 672.205.

§ 672.215 How are eligible entities notified of approval for grant funds?

The Secretary will, to the extent practicable, notify each eligible entity applying for funds no later than 5 months from the date the application is received, whether the application is approved or disapproved. In the event additional funds become available, ETA reserves the right to use such funds to select additional grantees from applications submitted in response to an SGA.

Subpart C—Program Requirements

§ 672.300 Who is an eligible participant?

(a) *Eligibility criteria.* Except as provided in paragraph (b) of this section, an individual is eligible to participate in a YouthBuild program if the individual is:

(1) Not less than age 16 and not more than age 24 on the date of enrollment; and

(2) A school dropout or an individual who has dropped out of school and reenrolled in an alternative school, if that reenrollment is part of a sequential service strategy; and

(3) Is one or more of the following:

(i) A member of a low-income family as defined in § 672.110;

(ii) A youth in foster care;

(iii) A youth offender;

(iv) A youth who is an individual with a disability;

(v) The child of a current or formerly incarcerated parent; or

(vi) A migrant youth as defined in § 672.110.

(b) *Exceptions.* Not more than 25 percent of the participants in a program, under this section, may be individuals who do not meet the requirements of paragraph (a)(2) or (3) of this section, if such individuals:

(1) Are basic skills deficient as defined in section 101(4) of WIA, even if they have their high school diploma, GED credential, or other State-recognized equivalent; or

(2) Have been referred by a local secondary school for participation in a YouthBuild program leading to the attainment of a secondary school diploma.

§ 672.305 Are there special rules that apply to veterans?

Special rules for determining income for veterans are found in 20 CFR 667.255 and for the priority of service provisions for qualified persons are found in 20 CFR part 1010. Those special rules apply to covered persons who are eligible to participate in the YouthBuild program.

§ 672.310 What eligible activities may be funded under the YouthBuild program?

Grantees may provide one or more of the following education and workforce investment and other activities to YouthBuild participants—

(a) Eligible education activities include:

(1) Services and activities designed to meet the educational needs of participants, including:

(i) Basic skills instruction and remedial education;

(ii) Language instruction educational programs for individuals with limited English proficiency;

(iii) Secondary education services and activities, including tutoring, study skills training, and dropout prevention activities, designed to lead to the attainment of a secondary school diploma, GED credential, or other State- recognized equivalent (including recognized alternative standards for individuals with disabilities);

(iv) Counseling and assistance in obtaining post-secondary education and required financial aid; and

(v) Alternative secondary school services;

(2) Counseling services and related activities, such as comprehensive guidance and counseling on drug and alcohol abuse and referral to appropriate treatment;

(3) Activities designed to develop employment and leadership skills, which may include community service and peer-centered activities encouraging responsibility and other positive social behaviors, and activities related to youth policy committees that participate in decisionmaking related to the program; and

(4) Supportive services, as defined under Title I of WIA Section 101(46), and provision of need-based stipends, as defined in § 672.110.

(b) Eligible workforce investment activities include:

(1) Work experience and skills training (coordinated, to the maximum extent feasible, with registered apprenticeship programs) in housing rehabilitation and construction activities described in paragraphs (c)(1) and (2) of this section;

(2) Occupational skills training;

(3) Other paid and unpaid work experiences, including internships and job shadowing; and

(4) Job search assistance.

(c) Other eligible activities include:

(1) Supervision and training for participants in the rehabilitation or construction of housing, including residential housing for homeless individuals and families or low-income families, or transitional housing for homeless individuals and families;

(2) Supervision and training for participants in the rehabilitation or construction of community or other public facilities, except that, as provided in § 672.505(b), not more than 10 percent of the funds awarded for each grant may be used for such supervision and training;

(3) Ongoing training and technical assistance for staff of grant recipients that is related to developing and carrying out the YouthBuild program;

(4) Payment of a portion of the administrative costs of the program as provided in § 672.505(a);

(5) Adult mentoring;

(6) Provision of wages, stipends, or additional benefits to participants in the program as provided in § 672.530; and

(7) Follow-up services as provided in § 672.325.

§ 672.315 What timeframes apply to participation?

An eligible individual selected for participation in the program must be offered full-time participation in the program for not less than 6 months and not more than 24 months.

§ 672.320 What timeframes must be devoted to education and workforce investment or other activities?

YouthBuild grantees must structure programs so that participants in the program are offered:

(a) Eligible education activities, as specified in § 672.310(a), during at least 50 percent of the time during which they participate in the program; and

(b) Eligible workforce investment activities, as specified in § 672.310(b), during at least 40 percent of the time during which they participate in the program. Grantees must provide the eligible workforce investment activities described in § 672.310(b)(1) as part of their program of eligible workforce investment activities.

(c) The remaining 10 percent of the time of participation can be used for the activities described in paragraphs (a) and (b) of this section and/or for leadership development and community service activities.

§ 672.325 What timeframes apply for follow-up services?

Follow-up services must be provided to all YouthBuild participants for a period of not less than 9 months but no more than 12 months after participants exit a YouthBuild program. These are services that assist participants in obtaining or retaining employment, or applying for and transitioning to postsecondary education or training.

Subpart D—Performance Indicators

§ 672.400 What are the performance indicators for YouthBuild grants?

(a) The performance indicators for YouthBuild grants are:

(1) Placement in employment or education;

(2) Attainment of a degree or certificate;

(3) Literacy and numeracy gains; and

(4) Such other indicators of performance as may be required by the Secretary.

(b) We will provide the details of the performance indicators in administrative guidance.

§ 672.405 What are the required levels of performance for the performance indicators?

(a) Expected levels of performance for each of the common performance indicators are national standards that are provided in separately issued guidance. Short-term or other performance indicators will be provided in separately issued guidance or as part of the SGA or grant agreement. Performance level expectations are based on available YouthBuild data and data from similar WIA Youth programs and may change between grant competitions. The expected national levels of performance will take into account the extent to which the levels promote continuous improvement in performance.

(b) The levels of performance established will, at a minimum:

(1) Be expressed in an objective, quantifiable, and measurable form; and

(2) Indicate continuous improvement in performance.

§ 672.410 What are the reporting requirements for YouthBuild grantees?

Each grantee must provide such reports as are required by the Secretary in separately issued guidance, including:

(a) The Quarterly Performance Report;

(b) The quarterly narrative progress report;

(c) The financial report; and

(d) Such other reports as may be required by the grant agreement.

§ 672.415 What are the due dates for quarterly reporting?

(a) Quarterly reports are due no later than 45 days after the end of the reporting quarter, unless otherwise specified in the reporting guidance issued under § 672.410; and

(b) A final financial report is required 90 days after the expiration of a funding period or the termination of grant support.

Subpart E—Administrative Rules, Costs, and Limitations

§ 672.500 What administrative regulations apply to the YouthBuild program?

Each YouthBuild grantee must comply with the following:

(a) The regulations found in this part.

(b) The general administrative requirements found in 20 CFR part 667, except those that apply only to the WIA Title I–B program and those that have been modified by this section.

(c) The Department's regulations on government-wide requirements, which include:

(1) The regulations codifying the Office of Management and Budget's government-wide grants requirements: Circular A–110 (codified at 2 CFR part 215), and Circular A–102 at 29 CFR parts 95 and 97, as applicable;

(2) The Department's regulations at 29 CFR part 37, which implement the nondiscrimination provisions of WIA section 188;

(3) The Department's regulations at 29 CFR parts 93, 94, and 98 relating to restrictions on lobbying, drug free workplace, and debarment and suspension; and

(4) The audit requirements of OMB Circular A–133 stated at 29 CFR part 99, as required by 29 CFR 96.11, 95.26, and 97.26, as applicable.

§ 672.505 How may grantees provide services under the YouthBuild program?

Each recipient of a grant under the YouthBuild program may provide the services and activities described in these regulations either directly or through subgrants, contracts, or other arrangements with local educational agencies, postsecondary educational institutions, State or local housing development agencies, other public agencies, including agencies of Indian tribes, or private organizations.

§ 672.510 What cost limits apply to the use of YouthBuild program funds?

(a) Administrative costs for programs operated under YouthBuild are limited to no more than 15 percent of the grant award. The definition of administrative costs can be found in 20 CFR 667.220.

(b) The cost of supervision and training for participants involved in the rehabilitation or construction of community and other public facilities is limited to no more than 10 percent of the grant award.

§ 672.515 What are the cost-sharing or matching requirements of the YouthBuild program?

(a) The cost-sharing or matching requirements applicable to a YouthBuild grant will be addressed in the grant agreement.

(b) The value of construction materials used in the YouthBuild program is an allowable cost for the purposes of the required non-Federal share or match.

(c) The value of land acquired for the YouthBuild program is not an allowable cost-sharing or match.

(d) Federal funds may not be used as cost-sharing or match resources except as provided by Federal law.

(e) The value of buildings acquired for the YouthBuild program is an allowable match, provided that the following conditions apply:

(1) The purchase cost of buildings used solely for training purposes is allowable; and

(2) For buildings used for training and other purposes, the allowable amount is determined based on the proportionate share of the purchase price related to direct training activities.

(f) Grantees must follow the requirements of 29 CFR 95.23 or 29 CFR 97.24 in the accounting, valuation, and reporting of the required non-Federal share.

§ 672.520 What are considered to be leveraged funds?

(a) Leveraged funds may be used to support allowable YouthBuild program activities and consist of payments made for allowable costs funded by both non-YouthBuild Federal, and non-Federal, resources which include:

(1) Costs which meet the criteria for cost-sharing or match in § 672.515 and are in excess of the amount of cost-sharing or match resources required;

(2) Costs which would meet the criteria in § 672.515 except that they are

paid for with other Federal resources; and

(3) Costs which benefit the grant program and are otherwise allowable under the cost principles but are not allowable under the grant because of some statutory, regulatory, or grant provision, whether paid for with Federal or non-Federal resources.

(b) The use of leveraged funds must be reported in accordance with Departmental instructions.

§ 672.525 How are the costs associated with real property treated in the YouthBuild program?

(a) As provided in paragraphs (b) and (c) of this section, the costs of the following activities associated with real property are allowable solely for the purpose of training YouthBuild participants:

(1) Rehabilitation of existing structures for use by homeless individuals and families or low-income families or for use as transitional housing.

(2) Construction of buildings for use by homeless individuals and families or low-income families or for use as transitional housing.

(3) Construction or rehabilitation of community or other public facilities, except, as provided in § 672.510(b), only 10 percent of the grant award is allowable for such construction and rehabilitation.

(b) The costs for acquisition of buildings that are used for activities described in paragraph (a) of this section are allowable with prior grant officer approval and only under the following conditions:

(1) The purchase cost of buildings used solely for training purposes is allowable; and

(2) For buildings used for training and other purposes, the allowable amount is determined based on the proportionate share of the purchase cost related to direct training.

(c) The following costs are allowable to the extent allocable to training YouthBuild participants in the construction and rehabilitation activities specified in paragraph (a) of this section:

(1) Trainees' tools and clothing including personal protective equipment (PPE);

(2) On-site trainee supervisors;

(3) Construction management;

(4) Relocation of buildings; and

(5) Clearance and demolition.

(d) Architectural fees, or a proportionate share thereof, are allowable when such fees can be related to items such as architectural plans or blueprints on which participants will be trained.

(e) The following costs are unallowable:

(1) The costs of acquisition of land.

(2) Brokerage fees.

§ 672.530 What participant costs are allowable under the YouthBuild program?

Allowable participant costs include:

(a) The costs of payments to participants engaged in eligible work-related YouthBuild activities.

(b) The costs of payments provided to participants engaged in non-work- related YouthBuild activities.

(c) The costs of needs-based stipends.

(d) The costs of supportive services.

(e) The costs of providing additional benefits to participants or individuals who have exited the program and are receiving follow-up services, which may include:

(1) Tuition assistance for obtaining college education credits;

(2) Scholarships to an Apprenticeship, Technical, or Secondary Education program; and

(3) Sponsored health programs.

§ 672.535 What effect do payments to YouthBuild participants have on eligibility for other Federal need-based benefits?

Under 20 CFR 667.272(c), allowances, earnings, and payments to individuals participating in programs under Title I of WIA are not considered as income for purposes of determining eligibility for and the amount of income transfer and in-kind aid furnished under any Federal or Federally-assisted program based on need other than as provided under the Social Security Act (42 U.S.C. 301).

§ 672.540 What program income requirements apply under the YouthBuild program?

(a) Except as provided in paragraph (b) of this section, program income requirements, as specified in the applicable Uniform Administrative Requirements at 29 CFR 95.24 and 97.25, apply to YouthBuild grants.

(b) Revenue from the sale of buildings rehabilitated or constructed under the YouthBuild program to homeless individuals and families and low-income families is not considered program income. Grantees are encouraged to use that revenue for the long-term sustainability of the YouthBuild program.

§ 672.545 Are YouthBuild programs subject to the Davis-Bacon Act labor standards?

(a) YouthBuild programs and grantees are subject to Davis-Bacon labor standards requirements under the circumstances set forth in paragraph (b) of this section. In those instances where a grantee is subject to Davis-Bacon requirements, the grantee must follow applicable requirements in the Department's regulations at 29 CFR parts 1, 3, and 5, including the requirements contained in the Davis-Bacon contract provisions set forth in 29 CFR 5.5.

(b) YouthBuild participants are subject to Davis-Bacon Act labor standards when they perform Davis-Bacon-covered laborer or mechanic work, defined at 29 CFR 5.2, on Federal or Federally-assisted projects that are subject to the Davis-Bacon Act labor standards. The Davis-Bacon prevailing wage requirements apply to hours worked on the site of the work.

(c) YouthBuild participants who are not registered and participating in a training program approved by the Employment and Training Administration must be paid not less than the applicable wage rate on the wage determination for the classification of work actually performed.

§ 672.550 What are the recordkeeping requirements for YouthBuild programs?

(a) Grantees must follow the recordkeeping requirements specified in the Uniform Administrative Requirements, at 29 CFR 95.53 and 29 CFR 97.42, as appropriate.

(b) Grantees must maintain such additional records related to the use of buildings constructed or rehabilitated with YouthBuild funds as specified in the grant agreement or in the Department's guidance.

Subpart F—Additional Requirements

§ 672.600 What are the safety requirements for the YouthBuild program?

(a) YouthBuild Grantees must comply with 20 CFR 667.274, which applies Federal and State health and safety standards to the working conditions under WIA-funded projects and programs. These health and safety standards include ''hazardous orders'' governing child labor under 29 CFR part 570 prohibiting youth ages 16 and 17 from working in identified hazardous occupations.

(b) YouthBuild grantees are required to:

(1) Provide comprehensive safety training for youth working on YouthBuild construction projects;

(2) Have written, jobsite-specific, safety plans overseen by an on-site supervisor with authority to enforce safety procedures;

(3) Provide necessary personal protective equipment to youth working on YouthBuild projects; and

(4) Submit required injury incident reports.

§ 672.605 What are the reporting requirements for youth safety?

YouthBuild grantees must ensure that YouthBuild program sites comply with the Occupational Safety and Health Administration's (OSHA) reporting requirements in 29 CFR part 1904. A YouthBuild grantee is responsible for sending a copy of OSHA's injury incident report form, to U.S. Department of Labor, Employment and Training Administration within 7 days of any reportable injury suffered by a YouthBuild participant. The injury incident report form is available from OSHA and can be downloaded at *http://www.osha.gov/recordkeeping/*

RKforms.html. Reportable injuries include those that result in death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness.

§ 672.610 What environmental protection laws apply to the YouthBuild program?

YouthBuild Program grantees are required, where applicable, to comply with all environmental protection statutes and regulations.

§ 672.615 What requirements apply to YouthBuild housing?

(a) YouthBuild grantees must ensure that all residential housing units which are constructed or rehabilitated using YouthBuild funds must be available solely for:

(1) Sale to homeless individuals and families or low-income families;

(2) Rental by homeless individuals and families or low-income families;

(3) Use as transitional or permanent housing for the purpose of assisting in the movement of homeless individuals and families to independent living; or

(4) Rehabilitation of homes for low-income homeowners.

(b) For rentals of residential units located on the property which are constructed or rehabilitated using YouthBuild funds:

(1) The property must maintain at least a 90 percent level of occupancy for low-income families. The income test will be conducted only at the time of entry for each available unit or rehabilitation of occupant-owned home. If the grantee cannot find a qualifying tenant to lease the unit, the unit may be leased to a family whose income is above the income threshold to qualify as a low-income family but below the median income for the area. Leases for tenants with higher incomes will be limited to not more than two years. The leases provided to tenants with higher incomes are not subject to the termination clause that is described in paragraph (b)(2) of this section.

(2) The property owner must not terminate the tenancy or refuse to renew the lease of a tenant occupying a residential rental housing unit constructed or rehabilitated using YouthBuild funds except for serious or repeated violations of the terms and conditions of the lease, for violation of applicable Federal, State or local laws, or for good cause. Any termination or refusal to renew the lease must be preceded by not less than a 30-day written notice to the tenant specifying the grounds for the action. The property owner may waive the written notice requirement for termination in dangerous or egregious situations involving the tenant.

(c) All transitional or permanent housing for homeless individuals or families or low-income families must be safe and sanitary. The housing must meet all applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located.

(d) For sales or rentals of residential housing units constructed or rehabilitated using YouthBuild funds, YouthBuild grantees must ensure that owners of the property record a restrictive covenant at the time that an occupancy permit is issued against such property which includes the use restrictions set forth in paragraphs (a), (b), and (c) of this section and incorporates the following definitions at § 672.110: Homeless Individual; Low- Income Housing; and Transitional Housing. The term of the restrictive covenant must be at least 10 years from the time of the issuance of the occupancy permit, unless a time period of more than 10 years has been established by the grantee. Any additional stipulations imposed by a grantee or property owner should be clearly stated in the covenant.

(e) Any conveyance document prepared in the 10-year period of the restrictive covenant must inform the buyer of the property that all residential housing units constructed or rehabilitated using YouthBuild funds are subject to the restrictions set forth in paragraphs (a), (b), (c), and (d) of this section.

PARTS 673–674 [RESERVED]

PART 675—INTRODUCTION TO THE REGULATIONS FOR THE WORKFORCE DEVELOPMENT SYSTEMS UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

Sec.

675.100 What are the purposes of title I of the Workforce Innovation and Opportunity Act?
675.200 What do the regulations for workforce development systems under title I of the Workforce Innovation and Opportunity Act cover?
675.300 What definitions apply to these regulations?

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§ 675.100 What are the purposes of title I of the Workforce Innovation and Opportunity Act?

The purposes of title I of the Workforce Innovation and Opportunity Act (WIOA) include:

(a) Increasing access to, and opportunities for individuals to receive, the employment, education, training, and support services necessary to succeed in the labor market, with a particular focus on those individuals with disabilities or other barriers to employment including out of school youth with the goal of improving their outcomes;

(b) Enhancing the strategic role for States and elected officials, and Local Workforce Development Boards (WDBs) in the public workforce system by increasing flexibility to tailor services to meet employer and worker needs at State, regional, and local levels;

(c) Streamlining service delivery across multiple programs by requiring colocation, coordination, and integration of activities and information to make the system understandable and accessible for individuals, including individuals with disabilities and those with other barriers to employment, and businesses.

(d) Supporting the alignment of the workforce investment, education, and economic development systems in support of a comprehensive, accessible, and high-quality workforce development system at the Federal, State, and local and regional levels;

(e) Improving the quality and labor market relevance of workforce investment, education, and economic development efforts by promoting the use of industry and sector partnerships, career pathways, and regional service delivery strategies in order to both provide America's workers with the skills and credentials that will enable them to secure and advance in employment with family-sustaining wages, and to provide America's employers with the skilled workers the employers need to succeed in a global economy;

(f) Promoting accountability using core indicators of performance measured across all WIOA authorized programs, sanctions, and high quality evaluations to improve the structure and delivery of services through the workforce development system to address and improve the employment and skill needs of workers, job seekers, and employers;

(g) Increasing the prosperity and economic growth of workers, employers, communities, regions, and States; and

(h) Providing workforce development activities through statewide and local workforce development systems to increase employment, retention and earnings of participants and to increase industry-recognized postsecondary credential attainment to improve the quality of the workforce, reduce welfare dependency, increase economic self-sufficiency, meet skill requirements of employers, and enhance productivity and competitiveness of the nation.

§ 675.200 What do the regulations for workforce development systems under title I of the Workforce Innovation and Opportunity Act cover?

(a) The regulations found in parts 675 through 688 of this chapter set forth the regulatory requirements that are applicable to programs operated with funds provided under title I of WIOA. This part describes the purpose of that Act, explains the format of these regulations, and sets forth definitions for terms that apply to each part. Parts 676, 677 and 678 of this chapter contain regulations relating to Unified and

Combined State Plans, performance accountability, and the one-stop delivery system and the roles of one-stop partners, respectively. Part 679 of this chapter contains regulations relating to statewide and local governance of the workforce development system. Part 680 of this chapter sets forth requirements applicable to WIOA title I programs serving adults and dislocated workers. Part 681 of this chapter sets forth requirements applicable to WIOA title I programs serving youth. Part 682 of this chapter contains regulations relating to statewide activities. Part 683 of this chapter sets forth the administrative requirements applicable to programs funded under WIOA title I. Parts 684 and 685 of this chapter contain the particular requirements applicable to programs serving Indians and Native Americans and Migrant and Seasonal Farmworkers, respectively. Parts 686 and 687 of this chapter describe the particular requirements applicable to the Job Corps and the national dislocated worker grant programs, respectively. Part 688 of this chapter contains the regulations governing the YouthBuild program. In addition, part 603 of this chapter provides the requirements regarding confidentiality and disclosure of State Unemployment Compensation program data under WIOA.

(b) Finally, parts 651 through 658 of this chapter address provisions for the Wagner-Peyser Act Employment Service, as amended by WIOA title III. Specifically, part 651 of this chapter contains general provisions and definitions of terms used in parts 651 through 658 of this chapter; part 652 of this chapter establishes the State Employment Service and describes its operation and services; part 653 of this chapter describes employment services to migrant and seasonal farmworkers and the role of the State Monitor Advocate; part 654 of this chapter addresses the special responsibilities of the Employment Service regarding housing for farmworkers; and part 658 of this chapter contains the administrative provisions that apply to the Wagner-Peyser Act Employment Service.

(c) Title 29 CFR part 38 contains the Department's nondiscrimination regulations implementing WIOA sec. 188.

§ 675.300 What definitions apply to these regulations?

In addition to the definitions set forth in WIOA and those set forth in specific parts of this chapter, the following definitions apply to the regulations in parts 675 through 688 of this chapter:

Consultation means the process by which State and/or local stakeholders convene to discuss changes to the public workforce system and constitutes a robust conversation in which all parties are given an opportunity to share their thoughts and opinions.

Contract means a legal instrument by which a non-Federal entity purchases property or services needed to carry out the project or program under a Federal award. The term as used in this part does not include a legal instrument, even if the non-Federal entity considers it a contract, when the substance of the transaction meets the definition of a Federal award or subaward as defined in this section.

Contractor means an entity that receives a contract as defined in this section.

Cooperative agreement means a legal instrument of financial assistance between a Federal awarding agency or pass-through entity and a non-Federal entity that, consistent with 31 U.S.C. 6302–6305:

(1) Is used to enter into a relationship the principal purpose of which is to transfer anything of value from the Federal awarding agency or pass-through entity to the non-Federal entity to carry out a public purpose authorized by a law of the United States (see 31 U.S.C. 6101(3)); and not to acquire property or services for the Federal government or pass-through entity's direct benefit or use;

(2) Is distinguished from a grant in that it provides for substantial involvement between the Federal awarding agency or pass-through entity and the non-Federal entity in carrying out the activity contemplated by the Federal award.

(3) The term does not include:

(i) A cooperative research and development agreement as defined in 15 U.S.C. 3710a; or

(ii) An agreement that provides only:

(A) Direct United States Government cash assistance to an individual;
(B) A subsidy;
(C) A loan;
(D) A loan guarantee; or
(E) Insurance.

Department means the U.S. Department of Labor, including its agencies and organizational units.

Employment and training activity means a workforce investment activity that is carried out for an adult or dislocated worker under part 678 of this chapter.

Equal opportunity data or *EO data* means data on race and ethnicity, age, sex, and disability required by 29 CFR part 38 of the Department of Labor regulations implementing sec. 188 of WIOA, governing nondiscrimination.

Employment and Training Administration or *ETA* means the Employment and Training Administration of the U.S. Department of Labor.

Family means two or more persons related by blood, marriage, or decree of court, who are living in a single residence, and are included in one or more of the following categories:
(1) A married couple and dependent children;
(2) A parent or guardian and dependent children; or
(3) A married couple.

Federal award means:
(1) The Federal financial assistance that a non-Federal entity receives directly from a Federal awarding agency or indirectly from a pass-through entity, as described in 2 CFR 200.101 (Applicability);
(2) The cost-reimbursement contract under the Federal Acquisition Regulations that a non-Federal entity receives directly from a Federal awarding agency or indirectly from a pass-through entity, as described in 2 CFR 200.101 (Applicability); and
(3) The instrument setting forth the terms and conditions. The instrument is the grant agreement, cooperative agreement, other agreement for assistance covered in paragraph (b) of 2 CFR 200.40 (Federal financial assistance), or the cost-reimbursement contract awarded under the Federal Acquisition Regulations.
(4) Federal award does not include other contracts that a Federal agency uses to buy goods or services from a contractor or a contract to operate Federal government owned, contractor operated facilities (GOCOs).

Federal financial assistance means:
(1) For grants and cooperative agreements, assistance in the form of:
(i) Grants;
(ii) Cooperative agreements;
(iii) Non-cash contributions or donations of property (including donated surplus property);
(iv) Direct appropriations;
(v) Food commodities; and
(vi) Other financial assistance, except assistance listed in paragraph (2) of this definition.
(2) For purposes of the audit requirements at 2 CFR part 200, subpart F, Federal financial assistance includes assistance that non-Federal entities receive or administer in the form of:
(i) Loans;
(ii) Loan Guarantees;
(iii) Interest subsidies; and
(iv) Insurance.
(3) Federal financial assistance does not include amounts received as reimbursement for services rendered to individuals as described in 2 CFR 200.502, which outlines the basis for determining Federal awards expended.

Grant or *grant agreement* means a legal instrument of financial assistance between a Federal awarding agency and a non-Federal entity that, consistent with 31 U.S.C. 6302, 6304:
(1) Is used to enter into a relationship the principal purpose of which is to transfer anything of value from the Federal awarding agency to carry out a public purpose authorized by a law of the United States (see 31 U.S.C. 6101(3)); and not to acquire property or services for the Federal awarding agency's direct benefit or use;
(2) Is distinguished from a cooperative agreement in that it does not provide for substantial involvement between the Federal awarding agency or pass-through entity and the non-Federal entity in carrying out the activity contemplated by the Federal award.
(3) Grant agreement does not include an agreement that provides only:
(i) Direct United States Government cash assistance to an individual;
(ii) A subsidy;
(iii) A loan;

(iv) A loan guarantee; or

(v) Insurance.

Grantee means the direct recipient of grant funds from the Department of Labor under a grant or grant agreement. A grantee also may be referred to as a recipient.

Individual with a disability means an individual with any disability as defined in sec. 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102). For purposes of WIOA sec. 188, this term is defined at 29 CFR 38.4.

Labor Federation means an alliance of two or more organized labor unions for the purpose of mutual support and action.

Literacy means an individual's ability to read, write, and speak in English, and to compute, and solve problems, at levels of proficiency necessary to function on the job, in the family of the individual, and in society.

Local WDB means a Local Workforce Development Board (WDB) established under WIOA sec. 107, to set policy for the local workforce development system.

Non-Federal entity, as defined in 2 CFR 2900.2, means a State, local government, Indian tribe, institution of higher education (IHE), for-profit entity, foreign public entity, foreign organization or nonprofit organization that carries out a Federal award as a recipient or subrecipient.

Obligations when used in connection with a non-Federal entity's utilization of funds under a Federal award, means orders placed for property and services, contracts and subawards made, and similar transactions during a given period that require payment by the non-Federal entity during the same or a future period.

Outlying area means:

(1) The United States Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands; and

(2) The Republic of Palau, except during a period that the Secretaries determine both that a Compact of Free Association is in effect and that the Compact contains provisions for training and education assistance prohibiting the assistance provided under WIOA.

Pass-through entity means a non-Federal entity that provides a subaward to a subrecipient to carry out part of a Federal program.

Recipient means a non-Federal entity that receives a Federal award directly from a Federal awarding agency to carry out an activity under a Federal program. The term recipient does not include subrecipients.

Register means the process for collecting information, including identifying information, to determine an individual's eligibility for services under WIOA title I. Individuals may be registered in a variety ways, as described in § 680.110 of this chapter.

Secretary means the Secretary of the U.S. Department of Labor, or their designee.

Secretaries means the Secretaries of the U.S. Department Labor and the U.S. Department of Education, or their designees.

Self-certification means an individual's signed attestation that the information they submit to demonstrate eligibility for a program under title I of WIOA is true and accurate.

State means each of the several States of the United States, the District of Columbia, and the Commonwealth of Puerto Rico. The term ''State'' does not include outlying areas.

State WDB means a State Workforce Development Board (WDB) established under WIOA sec. 101.

Subgrant or *subaward* means an award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a Federal award received by the pass-through entity. It does not include payments to a contractor or payments to an individual that is a beneficiary of a Federal program. A subaward may be provided through any form of legal agreement, including an agreement that the pass-through entity considers a contract.

Subrecipient means a non-Federal entity that receives a subaward from a pass-through entity to carry out part of a Federal program, but does not include an individual that is a beneficiary of such program. A subrecipient also may be a recipient of other Federal awards directly from a Federal awarding agency.

Unliquidated obligations means, for financial reports prepared on a cash

basis, obligations incurred by the non-Federal entity that have not been paid (liquidated). For reports prepared on an accrual expenditure basis, these are obligations incurred by the non-Federal entity for which an expenditure has not been recorded.

Unobligated balance means the amount of funds under a Federal award that the non-Federal entity has not obligated. The amount is computed by subtracting the cumulative amount of the non-Federal entity's unliquidated obligations and expenditures of funds under the Federal award from the cumulative amount of the funds that the Federal awarding agency or pass-through entity authorized the non-Federal entity to obligate.

Wagner-Peyser Act means the Act of June 6, 1933, as amended, codified at 29 U.S.C. 49 *et seq*.

WIA regulations mean the regulations in parts 660 through 672 of this chapter, the Wagner-Peyser Act regulations in part 652, subpart C, of this chapter, and the regulations implementing WIA sec. 188 in 29 CFR part 37.

WIOA regulations mean the regulations in parts 675 through 687 of this chapter, the Wagner-Peyser Act regulations in part 652, subpart C, of this chapter, and the regulations implementing WIA sec. 188 in 29 CFR part 38.

Workforce investment activities mean the array of activities permitted under title I of WIOA, which include employment and training activities for adults and dislocated workers, as described in WIOA sec. 134, and youth activities, as described in WIOA sec. 129.

Youth workforce investment activity means a workforce investment activity that is carried out for eligible youth under part 679 of this chapter.

PART 676—UNIFIED AND COMBINED STATE PLANS UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

Sec.

676.100 What are the purposes of the Unified and Combined State Plans?
676.105 What are the general requirements for the Unified State Plan?
676.110 What are the program-specific requirements in the Unified State Plan for the adult, dislocated worker, and youth programs authorized under Workforce Innovation and Opportunity Act title I?
676.115 What are the program-specific requirements in the Unified State Plan for the Adult Education and Family Literacy Act program authorized under Workforce Innovation and Opportunity Act title II?
676.120 What are the program-specific requirements in the Unified State Plan for the Employment Service program authorized under the Wagner-Peyser Act, as amended by Workforce Innovation and Opportunity Act title III?
676.125 What are the program-specific requirements in the Unified State Plan for the State Vocational Rehabilitation program authorized under title I of the Rehabilitation Act of 1973, as amended by Workforce Innovation and Opportunity Act title IV?
676.130 What is the development, submission, and approval process of the Unified State Plan?
676.135 What are the requirements for modification of the Unified State Plan?
676.140 What are the general requirements for submitting a Combined State Plan?
676.143 What is the development, submission, and approval process of the Combined State Plan?
676.145 What are the requirements for modifications of the Combined State Plan?

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§ 676.100 What are the purposes of the Unified and Combined State Plans?

(a) The Unified and Combined State Plans provide the framework for States to outline a strategic vision of, and goals for, how their workforce development systems will achieve the purposes of the Workforce Innovation and Opportunity Act (WIOA).

(b) The Unified and Combined State Plans serve as 4-year action plans to develop, align, and integrate the State's systems and provide a platform to achieve the State's vision and strategic and operational goals. A Unified or Combined State Plan is intended to:

(1) Align, in strategic coordination, the six core programs required in the Unified State Plan pursuant to §676.105(b), and additional Combined State Plan partner programs that may be part of the Combined State Plan pursuant to §676.140;

(2) Direct investments in economic, education, and workforce training programs to focus on providing relevant education and training to ensure that individuals, including youth and individuals with barriers to employment, have the skills to compete in the job market and that employers have a ready supply of skilled workers;

(3) Apply strategies for job-driven training consistently across Federal programs; and

(4) Enable economic, education, and workforce partners to build a skilled workforce through innovation in, and alignment of, employment, training, and education programs.

§ 676.105 What are the general requirements for the Unified State Plan?

(a) The Unified State Plan must be submitted in accordance with § 676.130 and WIOA sec. 102(c), as explained in joint planning guidelines issued by the Secretaries of Labor and Education.

(b) The Governor of each State must submit, at a minimum, in accordance with § 676.130, a Unified State Plan to the Secretary of Labor to be eligible to receive funding for the workforce development system's six core programs:

(1) The adult, dislocated worker, and youth programs authorized under subtitle B of title I of WIOA and administered by the U.S. Department of Labor (DOL);

(2) The Adult Education and Family Literacy Act (AEFLA) program authorized under title II of WIOA and administered by the U.S. Department of Education (ED);

(3) The Employment Service program authorized under the Wagner-Peyser Act of 1933, as amended by WIOA title III and administered by DOL; and

(4) The Vocational Rehabilitation program authorized under title I of the Rehabilitation Act of 1973, as amended by title IV of WIOA and administered by ED.

(c) The Unified State Plan must outline the State's 4-year strategy for the core programs described in paragraph (b) of this section and meet the requirements of sec. 102(b) of WIOA, as explained in the joint planning guidelines issued by the Secretaries of Labor and Education.

(d) The Unified State Plan must include strategic and operational planning elements to facilitate the development of an aligned, coordinated, and comprehensive workforce development system. The Unified State Plan must include:

(1) Strategic planning elements that describe the State's strategic vision and goals for preparing an educated and skilled workforce under sec. 102(b)(1) of WIOA. The strategic planning elements must be informed by and include an analysis of the State's economic conditions and employer and workforce needs, including education and skill needs.

(2) Strategies for aligning the core programs and Combined State Plan partner programs as described in § 676.140(d), as well as other resources available to the State, to achieve the strategic vision and goals in accordance with sec. 102(b)(1)(E) of WIOA.

(3) Operational planning elements in accordance with sec. 102(b)(2) of WIOA that support the strategies for aligning the core programs and other resources available to the State to achieve the State's vision and goals and a description of how the State Workforce Development Board (WDB) will implement its functions, in accordance with sec. 101(d) of WIOA. Operational planning elements must include:

(i) A description of how the State strategy will be implemented by each core program's lead State agency;

(ii) State operating systems, including data systems, and policies that will support the implementation of the State's strategy identified in paragraph (d)(1) of this section;

(iii) Program-specific requirements for the core programs required by WIOA sec. 102(b)(2)(D);

(iv) Assurances required by sec. 102(b)(2)(E) of WIOA, including an assurance that the lead State agencies responsible for the administration of the core programs reviewed and commented on the appropriate operational planning of the Unified State Plan and approved the elements as serving the needs of the population served by such programs, and other assurances deemed necessary by the Secretaries of Labor and Education under sec. 102(b)(2)(E)(x) of WIOA;

(v) A description of joint planning and coordination across core programs, required one-stop partner programs, and other programs and activities in the Unified State Plan; and

(vi) Any additional operational planning requirements imposed by the Secretary of Labor or the Secretary of Education under sec. 102(b)(2)(C)(viii) of WIOA.

(e) All of the requirements in this part that apply to States also apply to outlying areas.

§ 676.110 What are the program-specific requirements in the Unified State Plan for the adult, dislocated worker, and youth programs authorized under Workforce Innovation and Opportunity Act title I?

The program-specific requirements for the adult, dislocated worker, and youth programs that must be included in the Unified State Plan are described in sec. 102(b)(2)(D) of WIOA. Additional planning requirements may be explained in joint planning guidelines issued by the Secretaries of Labor and Education.

§ 676.115 What are the program-specific requirements in the Unified State Plan for the Adult Education and Family Literacy Act program authorized under Workforce Innovation and Opportunity Act title II?

The program-specific requirements for the AEFLA program in title II that must be included in the Unified State Plan are described in secs. 102(b)(2)(C) and 102(b)(2)(D)(ii) of WIOA.

(a) With regard to the description required in sec. 102(b)(2)(D)(ii)(I) of WIOA pertaining to content standards, the Unified State Plan must describe how the eligible agency will, by July 1, 2016, align its content standards for adult education with State-adopted challenging academic content standards under the Elementary and Secondary Education Act of 1965, as amended.

(b) With regard to the description required in sec. 102(b)(2)(C)(iv) of WIOA pertaining to the methods and factors the State will use to distribute funds under the core programs, for title II of WIOA, the Unified State Plan must include—

(1) How the eligible agency will award multi-year grants on a competitive basis to eligible providers in the State; and

(2) How the eligible agency will provide direct and equitable access to funds using the same grant or contract announcement and application procedure.

§ 676.120 What are the program-specific requirements in the Unified State Plan for the Employment Service program authorized under the Wagner-Peyser Act, as amended by Workforce Innovation and Opportunity Act title III?

The Employment Service program authorized under the Wagner-Peyser Act of 1933, as amended by WIOA title III, is subject to requirements in sec. 102(b) of WIOA, including any additional requirements imposed by the Secretary of Labor under secs. 102(b)(2)(C)(viii) and 102(b)(2)(D)(iv) of WIOA, as explained in joint planning guidelines issued by the Secretaries of Labor and Education.

§ 676.125 What are the program-specific requirements in the Unified State Plan for the State Vocational Rehabilitation program authorized under title I of the Rehabilitation Act of 1973, as amended by Workforce Innovation and Opportunity Act title IV?

The program specific-requirements for the vocational rehabilitation services portion of the Unified or Combined State Plan are set forth in sec. 101(a) of the Rehabilitation Act of 1973, as amended. All submission requirements for the vocational rehabilitation services portion of the Unified or Combined State Plan are in addition to the jointly developed strategic and operational content requirements prescribed by sec. 102(b) of WIOA.

§ 676.130 What is the development, submission, and approval process of the Unified State Plan?

(a) The Unified State Plan described in § 676.105 must be submitted in accordance with WIOA sec. 102(c), as explained in joint planning guidelines issued jointly by the Secretaries of Labor and Education.

(b) A State must submit its Unified State Plan to the Secretary of Labor pursuant to a process identified by the Secretary.

(1) The initial Unified State Plan must be submitted no later than 120 days prior to the commencement of the second full program year of WIOA.

(2) Subsequent Unified State Plans must be submitted no later than 120 days prior to the end of the 4-year period covered by a preceding Unified State Plan.

(3) For purposes of paragraph (b) of this section, ''program year'' means July 1 through June 30 of any year.

(c) The Unified State Plan must be developed with the assistance of the State WDB, as required by § 679.130(a) of this chapter and WIOA sec. 101(d), and must be developed in coordination with administrators with optimum policy-making authority for the core programs and required one-stop partners.

(d) The State must provide an opportunity for public comment on and input into the development of the Unified State Plan prior to its submission.

(1) The opportunity for public comment must include an opportunity for comment by representatives of Local WDBs and chief elected officials, businesses, representatives of labor organizations, community-based organizations, adult education providers, institutions of higher education, other stakeholders with an interest in the services provided by the six core programs, and the general public, including individuals with disabilities.

(2) Consistent with the ''Sunshine Provision'' of WIOA in sec. 101(g), the State WDB must make information regarding the Unified State Plan available to the public through electronic means and regularly occurring open meetings in accordance with State law. The Unified State Plan must describe the State's process and timeline for ensuring a meaningful opportunity for public comment.

(e) Upon receipt of the Unified State Plan from the State, the Secretary of Labor will ensure that the entire Unified State Plan is submitted to the Secretary of Education pursuant to a process developed by the Secretaries.

(f) The Unified State Plan is subject to the approval of both the Secretary of Labor and the Secretary of Education.

(g) Before the Secretaries of Labor and Education approve the Unified State Plan, the vocational rehabilitation services portion of the Unified State Plan described in WIOA sec. 102(b)(2)(D)(iii) must be approved by the Commissioner of the Rehabilitation Services Administration.

(h) The Secretaries of Labor and Education will review and approve the Unified State Plan within 90 days of receipt by the Secretary of Labor, unless the Secretary of Labor or the Secretary of Education determines in writing within that period that:

(1) The plan is inconsistent with a core program's requirements;

(2) The Unified State Plan is inconsistent with any requirement of sec. 102 of WIOA; or

(3) The plan is incomplete or otherwise insufficient to determine whether it is consistent with a core program's requirements or other requirements of WIOA.

(i) If neither the Secretary of Labor nor the Secretary of Education makes the written determination described in paragraph (h) of this section within 90 days of the receipt by the Secretaries, the Unified State Plan will be considered approved.

§ 676.135 What are the requirements for modification of the Unified State Plan?

(a) In addition to the required modification review set forth in paragraph (b) of this section, a Governor may submit a modification of its Unified State Plan at any time during the 4-year period of the plan.

(b) Modifications are required, at a minimum:

(1) At the end of the first 2-year period of any 4-year State Plan, wherein the State WDB must review the Unified State Plan, and the Governor must submit modifications to the plan to reflect changes in labor market and economic conditions or other factors affecting the implementation of the Unified State Plan;

(2) When changes in Federal or State law or policy substantially affect the strategies, goals, and priorities upon which the Unified State Plan is based;

(3) When there are changes in the statewide vision, strategies, policies, State negotiated levels of performance

as described in § 677.170(b) of this chapter, the methodology used to determine local allocation of funds, reorganizations that change the working relationship with system employees, changes in organizational responsibilities, changes to the membership structure of the State WDB or alternative entity, and similar substantial changes to the State's workforce development system.

(c) Modifications to the Unified State Plan are subject to the same public review and comment requirements in § 676.130(d) that apply to the development of the original Unified State Plan.

(d) Unified State Plan modifications must be approved by the Secretaries of Labor and Education, based on the approval standards applicable to the original Unified State Plan under § 676.130. This approval must come after the approval of the Commissioner of the Rehabilitation Services Administration for modification of any portion of the plan described in sec. 102(b)(2)(D)(iii) of WIOA.

§ 676.140 What are the general requirements for submitting a Combined State Plan?

(a) A State may choose to develop and submit a 4-year Combined State Plan in lieu of the Unified State Plan described in §§ 676.105 through 676.125.

(b) A State that submits a Combined State Plan covering an activity or program described in paragraph (d) of this section that is, in accordance with WIOA sec. 103(c), approved or deemed complete under the law relating to the program will not be required to submit any other plan or application in order to receive Federal funds to carry out the core programs or the program or activities described under paragraph (d) of this section that are covered by the Combined State Plan.

(c) If a State develops a Combined State Plan, it must be submitted in accordance with the process described in § 676.143.

(d) If a State chooses to submit a Combined State Plan, the plan must include the six core programs and one or more of the Combined State Plan partner programs and activities described in sec. 103(a)(2) of WIOA. The Combined State Plan partner programs and activities that may be included in the Combined State Plan are:

(1) Career and technical education programs authorized under the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 *et seq.*);

(2) Temporary Assistance for Needy Families or TANF, authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 *et seq.*);

(3) Employment and training programs authorized under sec. 6(d)(4) of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(d)(4));

(4) Work programs authorized under sec. 6(o) of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(o));

(5) Trade adjustment assistance activities under chapter 2 of title II of the Trade Act of 1974 (19 U.S.C. 2271 *et seq.*);

(6) Services for veterans authorized under chapter 41 of title 38 United States Code;

(7) Programs authorized under State unemployment compensation laws (in accordance with applicable Federal law);

(8) Senior Community Service Employment Programs under title V of the Older Americans Act of 1965 (42 U.S.C. 3056 *et seq.*);

(9) Employment and training activities carried out by the Department of Housing and Urban Development (HUD);

(10) Employment and training activities carried out under the Community Services Block Grant Act (42 U.S.C. 9901 *et seq.*); and

(11) Reintegration of offenders programs authorized under sec. 212 of the Second Chance Act of 2007 (42 U.S.C. 17532).

(e) A Combined State Plan must contain:

(1) For the core programs, the information required by sec. 102(b) of WIOA and §§ 676.105 through 676.125, as explained in the joint planning guidelines issued by the Secretaries;

(2) For the Combined State Plan partner programs and activities, except as described in paragraph (h) of this section, the information required by the law authorizing and governing that

program to be submitted to the appropriate Secretary, any other applicable legal requirements, and any common planning requirements described in sec. 102(b) of WIOA, as explained in the joint planning guidelines issued by the Secretaries;

(3) A description of the methods used for joint planning and coordination among the core programs, and with the required one-stop partner programs and other programs and activities included in the State Plan; and

(4) An assurance that all of the entities responsible for planning or administering the programs described in the Combined State Plan have had a meaningful opportunity to review and comment on all portions of the plan.

(f) Each Combined State Plan partner program included in the Combined State Plan remains subject to the applicable program-specific requirements of the Federal law and regulations, and any other applicable legal or program requirements, governing the implementation and operation of that program.

(g) For purposes of §§ 676.140 through 676.145 the term ''appropriate Secretary'' means the head of the Federal agency who exercises either plan or application approval authority for the program or activity under the Federal law authorizing the program or activity or, if there are no planning or application requirements, who exercises administrative authority over the program or activity under that Federal law.

(h) States that include employment and training activities carried out under the Community Services Block Grant (CSBG) Act (42 U.S.C. 9901 *et seq.*) under a Combined State Plan would submit all other required elements of a complete CSBG State Plan directly to the Federal agency that administers the program, according to the requirements of Federal law and regulations.

(i) States that submit employment and training activities carried out by HUD under a Combined State Plan would submit any other required planning documents for HUD programs directly to HUD, according to the requirements of Federal law and regulations.

§ 676.143 What is the development, submission, and approval process of the Combined State Plan?

(a) For purposes of § 676.140(a), if a State chooses to develop a Combined State Plan it must submit the Combined State Plan in accordance with the requirements described below and sec. 103 of WIOA, as explained in the joint planning guidelines issued by the Secretaries of Labor and Education.

(b) The Combined State Plan must be developed with the assistance of the State WDB, as required by § 679.130(a) of this chapter and WIOA sec. 101(d), and must be developed in coordination with administrators with optimum policy-making authority for the core programs and required one-stop partners.

(c) The State must provide an opportunity for public comment on and input into the development of the Combined State Plan prior to its submission.

(1) The opportunity for public comment for the portions of the Combined State Plan that cover the core programs must include an opportunity for comment by representatives of Local WDBs and chief elected officials, businesses, representatives of labor organizations, community-based organizations, adult education providers, institutions of higher education, other stakeholders with an interest in the services provided by the six core programs, and the general public, including individuals with disabilities.

(2) Consistent with the ''Sunshine Provision'' of WIOA in sec. 101(g), the State WDB must make information regarding the Combined State Plan available to the public through electronic means and regularly occurring open meetings in accordance with State law. The Combined State Plan must describe the State's process and timeline for ensuring a meaningful opportunity for public comment on the portions of the plan covering core programs.

(3) The portions of the plan that cover the Combined State Plan partner programs are subject to any public comment requirements applicable to those programs.

(d) The State must submit to the Secretaries of Labor and Education and

to the Secretary of the agency with responsibility for approving the program's plan or deeming it complete under the law governing the program, as part of its Combined State Plan, any plan, application, form, or any other similar document that is required as a condition for the approval of Federal funding under the applicable program or activity. Such submission must occur in accordance with a process identified by the relevant Secretaries in paragraph (a) of this section.

(e) The Combined State Plan will be approved or disapproved in accordance with the requirements of sec. 103(c) of WIOA.

(1) The portion of the Combined State Plan covering programs administered by the Departments of Labor and Education must be reviewed, and approved or disapproved, by the appropriate Secretary within 90 days beginning on the day the Combined State Plan is received by the appropriate Secretary from the State, consistent with paragraph (f) of this section. Before the Secretaries of Labor and Education approve the Combined State Plan, the vocational rehabilitation services portion of the Combined State Plan described in WIOA sec. 102(b)(2)(D)(iii) must be approved by the Commissioner of the Rehabilitation Services Administration.

(2) If an appropriate Secretary other than the Secretary of Labor or the Secretary of Education has authority to approve or deem complete a portion of the Combined State Plan for a program or activity described in §676.140(d), that portion of the Combined State Plan must be reviewed, and approved, disapproved, or deemed complete, by the appropriate Secretary within 120 days beginning on the day the Combined State Plan is received by the appropriate Secretary from the State consistent with paragraph (f) of this section.

(f) The appropriate Secretaries will review and approve or deem complete the Combined State Plan within 90 or 120 days, as appropriate, as described in paragraph (e) of this section, unless the Secretaries of Labor and Education or appropriate Secretary have determined in writing within that period that:

(1) The Combined State Plan is inconsistent with the requirements of the six core programs or the Federal laws authorizing or applicable to the program or activity involved, including the criteria for approval of a plan or application, or deeming the plan complete, if any, under such law;

(2) The portion of the Combined State Plan describing the six core programs or the program or activity described in paragraph (a) of this section involved does not satisfy the criteria as provided in sec. 102 or 103 of WIOA, as applicable; or

(3) The Combined State Plan is incomplete, or otherwise insufficient to determine whether it is consistent with a core program's requirements, other requirements of WIOA, or the Federal laws authorizing, or applicable to, the program or activity described in §676.140(d), including the criteria for approval of a plan or application, if any, under such law.

(g) If the Secretary of Labor, the Secretary of Education, or the appropriate Secretary does not make the written determination described in paragraph (f) of this section within the relevant period of time after submission of the Combined State Plan, that portion of the Combined State Plan over which the Secretary has jurisdiction will be considered approved.

(h) The Secretaries of Labor and Education's written determination of approval or disapproval regarding the portion of the plan for the six core programs may be separate from the written determination of approval, disapproval, or completeness of the program-specific requirements of Combined State Plan partner programs and activities described in §676.140(d) and included in the Combined State Plan.

(i) *Special rule.* In paragraphs (f)(1) and (3) of this section, the term ''criteria for approval of a plan or application,'' with respect to a State or a core program or a program under the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 *et seq.*), includes a requirement for agreement between the State and the appropriate Secretaries regarding State performance measures or State performance accountability measures, as the

case may be, including levels of performance.

§ 676.145 What are the requirements for modifications of the Combined State Plan?

(a) For the core program portions of the Combined State Plan, modifications are required, at a minimum:

(1) By the end of the first 2-year period of any 4-year State Plan. The State WDB must review the Combined State Plan, and the Governor must submit modifications to the Combined State Plan to reflect changes in labor market and economic conditions or other factors affecting the implementation of the Combined State Plan;

(2) When changes in Federal or State law or policy substantially affect the strategies, goals, and priorities upon which the Combined State Plan is based;

(3) When there are changes in the statewide vision, strategies, policies, State negotiated levels of performance as described in § 677.170(b) of this chapter, the methodology used to determine local allocation of funds, reorganizations that change the working relationship with system employees, changes in organizational responsibilities, changes to the membership structure of the State WDB or alternative entity, and similar substantial changes to the State's workforce development system.

(b) In addition to the required modification review described in paragraph (a)(1) of this section, a State may submit a modification of its Combined State Plan at any time during the 4-year period of the plan.

(c) For any Combined State Plan partner programs and activities described in § 676.140(d) that are included in a State's Combined State Plan, the State—

(1) May decide if the modification requirements under WIOA sec. 102(c)(3) that apply to the core programs will apply to the Combined State Plan partner programs, as long as consistent with any other modification requirements for the programs, or may comply with the requirements applicable to only the particular program or activity; and

(2) Must submit, in accordance with the procedure described in § 676.143, any modification, amendment, or revision required by the Federal law authorizing, or applicable to, the Combined State Plan partner program or activity.

(i) If the underlying programmatic requirements change (*e.g.*, the authorizing statute is reauthorized) for Federal laws authorizing such programs, a State must either modify its Combined State Plan or submit a separate plan to the appropriate Federal agency in accordance with the new Federal law authorizing the Combined State Plan partner program or activity and other legal requirements applicable to such program or activity.

(ii) If the modification, amendment, or revision affects the administration of only that particular Combined State Plan partner program and has no impact on the Combined State Plan as a whole or the integration and administration of the core and other Combined State Plan partner programs at the State level, modifications must be submitted for approval to only the appropriate Secretary, based on the approval standards applicable to the original Combined State Plan under § 676.143, if the State elects, or in accordance with the procedures and requirements applicable to the particular Combined State Plan partner program.

(3) A State also may amend its Combined State Plan to add a Combined State Plan partner program or activity described in § 676.140(d).

(d) Modifications of the Combined State Plan are subject to the same public review and comment requirements that apply to the development of the original Combined State Plan as described in § 676.143(c) except that, if the modification, amendment, or revision affects the administration of a particular Combined State Plan partner program and has no impact on the Combined State Plan as a whole or the integration and administration of the core and other Combined State Plan partner programs at the State level, a State may comply instead with the procedures and requirements applicable to the particular Combined State Plan partner program.

(e) Modifications for the core program portions of the Combined State Plan must be approved by the Secretaries of Labor and Education, based on the approval standards applicable to the original Combined State Plan under §676.143. This approval must come after the approval of the Commissioner of the Rehabilitation Services Administration for modification of any portion of the Combined State Plan described in sec. 102(b)(2)(D)(iii) of WIOA.

PART 677—PERFORMANCE ACCOUNTABILITY UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

Sec.

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§677.150 What definitions apply to Workforce Innovation and Opportunity Act performance accountability provisions?

(a) *Participant.* A reportable individual who has received services other than the services described in paragraph (a)(3) of this section, after satisfying all applicable programmatic requirements for the provision of services, such as eligibility determination.

(1) For the Vocational Rehabilitation (VR) program, a participant is a reportable individual who has an approved and signed Individualized Plan for Employment (IPE) and has begun to receive services.

(2) For the Workforce Innovation and Opportunity Act (WIOA) title I youth program, a participant is a reportable individual who has satisfied all applicable program requirements for the provision of services, including eligibility determination, an objective assessment, and development of an individual service strategy, and received 1 of the 14 WIOA youth program elements identified in sec. 129(c)(2) of WIOA.

(3) The following individuals are not participants:

(i) Individuals in an Adult Education and Family Literacy Act (AEFLA) program who have not completed at least 12 contact hours;

(ii) Individuals who only use the self-service system.

(A) Subject to paragraph (a)(3)(ii)(B) of this section, self-service occurs when individuals independently access any workforce development system program's information and activities in either a physical location, such as a one-stop center resource room or partner agency, or remotely via the use of electronic technologies.

(B) Self-service does not uniformly apply to all virtually accessed services. For example, virtually accessed services that provide a level of support beyond independent job or information seeking on the part of an individual would not qualify as self-service.

(iii) Individuals who receive information-only services or activities, which provide readily available information that does not require an assessment by a staff member of the individual's skills, education, or career objectives.

(4) Programs must include participants in their performance calculations.

(b) *Reportable individual.* An individual who has taken action that demonstrates an intent to use program services and who meets specific reporting criteria of the program, including:

(1) Individuals who provide identifying information;

(2) Individuals who only use the self-service system; or

(3) Individuals who only receive information-only services or activities.

(c) *Exit.* As defined for the purpose of performance calculations, exit is the point after which a participant who has received services through any program meets the following criteria:

(1) For the adult, dislocated worker, and youth programs authorized under WIOA title I, the AEFLA program authorized under WIOA title II, and the Employment Service program authorized under the Wagner-Peyser Act, as amended by WIOA title III, exit date is the last date of service.

(i) The last day of service cannot be determined until at least 90 days have elapsed since the participant last received services; services do not include self-service, information-only services or activities, or follow-up services. This also requires that there are no plans to provide the participant with future services.

(ii) [Reserved].

(2)(i) For the VR program authorized under title I of the Rehabilitation Act of 1973, as amended by WIOA title IV (VR program):

(A) The participant's record of service is closed in accordance with 34 CFR 361.56 because the participant has achieved an employment outcome; or

(B) The participant's service record is closed because the individual has not achieved an employment outcome or the individual has been determined ineligible after receiving services in accordance with 34 CFR 361.43.

(ii) Notwithstanding any other provision of this section, a participant will not be considered as meeting the definition of exit from the VR program if the participant's service record is closed because the participant has achieved a supported employment outcome in an integrated setting but not in competitive integrated employment.

(3)(i) A State may implement a common exit policy for all or some of the core programs in WIOA title I and the Employment Service program authorized under the Wagner-Peyser Act, as amended by WIOA title III, and any additional required partner program(s) listed in sec. 121(b)(1)(B) of WIOA that

is under the authority of the U.S. Department of Labor (DOL).

(ii) If a State chooses to implement a common exit policy, the policy must require that a participant is exited only when all of the criteria in paragraph (c)(1) of this section are met for the WIOA title I core programs and the Employment Service program authorized under the Wagner-Peyser Act, as amended by WIOA title III, as well as any additional required partner programs listed in sec. 121(b)(1)(B) of WIOA under the authority of DOL to which the common exit policy applies in which the participant is enrolled.

(d) *State.* For purposes of this part, other than in regard to sanctions or the statistical adjustment model, all references to ''State'' include the outlying areas of American Samoa, Guam, Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, and, as applicable, the Republic of Palau.

Subpart A—State Indicators of Performance for Core Programs

§ 677.155 What are the primary indicators of performance under the Workforce Innovation and Opportunity Act?

(a) All States submitting either a Unified or Combined State Plan under §§ 676.130 and 676.143 of this chapter, must propose expected levels of performance for each of the primary indicators of performance for the adult, dislocated worker, and youth programs authorized under WIOA title I; the AEFLA program authorized under WIOA title II; the Employment Service program authorized under the Wagner-Peyser Act, as amended by WIOA title III; and the VR program authorized under title I of the Rehabilitation Act of 1973, as amended by WIOA title IV.

(1) *Primary indicators of performance.* The six primary indicators of performance for the adult and dislocated worker programs, the AEFLA program, and the VR program are:

(i) The percentage of participants who are in unsubsidized employment during the second quarter after exit from the program;

(ii) The percentage of participants who are in unsubsidized employment during the fourth quarter after exit from the program;

(iii) Median earnings of participants who are in unsubsidized employment during the second quarter after exit from the program;

(iv)(A) The percentage of those participants enrolled in an education or training program (excluding those in on-the-job training [OJT] and customized training) who attained a recognized postsecondary credential or a secondary school diploma, or its recognized equivalent, during participation in or within 1 year after exit from the program.

(B) A participant who has attained a secondary school diploma or its recognized equivalent is included in the percentage of participants who have attained a secondary school diploma or recognized equivalent only if the participant also is employed or is enrolled in an education or training program leading to a recognized postsecondary credential within 1 year after exit from the program;

(v) The percentage of participants who, during a program year, are in an education or training program that leads to a recognized postsecondary credential or employment and who are achieving measurable skill gains, defined as documented academic, technical, occupational, or other forms of progress, towards such a credential or employment. Depending upon the type of education or training program, documented progress is defined as one of the following:

(A) Documented achievement of at least one educational functioning level of a participant who is receiving instruction below the postsecondary education level;

(B) Documented attainment of a secondary school diploma or its recognized equivalent;

(C) Secondary or postsecondary transcript or report card for a sufficient number of credit hours that shows a participant is meeting the State unit's academic standards;

(D) Satisfactory or better progress report, towards established milestones, such as completion of OJT or completion of 1 year of an apprenticeship program or similar milestones, from an

employer or training provider who is providing training; or

(E) Successful passage of an exam that is required for a particular occupation or progress in attaining technical or occupational skills as evidenced by trade-related benchmarks such as knowledge-based exams.

(vi) The percentage of participants in unsubsidized employment during the second quarter after exit from the program who were employed by the same employer in the second and fourth quarters after exit. For the six core programs, this indicator is a statewide indicator reported by one core program on behalf of all six core programs in the State, as described in guidance.

(2) *Participants.* For purposes of the primary indicators of performance in paragraph (a)(1) of this section, ''participant'' will have the meaning given to it in § 677.150(a), except that—

(i) For purposes of determining program performance levels under indicators set forth in paragraphs (a)(1)(i) through (iv) and (vi) of this section, a ''participant'' does not include a participant who received services under sec. 225 of WIOA and exits such program while still in a correctional institution as defined in sec. 225(e)(1) of WIOA; and

(ii) The Secretaries of Labor and Education may, as needed and consistent with the Paperwork Reduction Act (PRA), make further determinations as to the participants to be included in calculating program performance levels for purposes of any of the performance indicators set forth in paragraph (a)(1) of this section.

(b) The primary indicators in paragraphs (a)(1)(i) through (iii) and (vi) of this section apply to the Employment Service program authorized under the Wagner-Peyser Act, as amended by WIOA title III.

(c) For the youth program authorized under WIOA title I, the primary indicators are:

(1) Percentage of participants who are in education or training activities, or in unsubsidized employment, during the second quarter after exit from the program;

(2) Percentage of participants in education or training activities, or in unsubsidized employment, during the fourth quarter after exit from the program;

(3) Median earnings of participants who are in unsubsidized employment during the second quarter after exit from the program;

(4) The percentage of those participants enrolled in an education or training program (excluding those in OJT and customized training) who obtained a recognized postsecondary credential or a secondary school diploma, or its recognized equivalent, during participation in or within 1 year after exit from the program, except that a participant who has attained a secondary school diploma or its recognized equivalent is included as having attained a secondary school diploma or recognized equivalent only if the participant is also employed or is enrolled in an education or training program leading to a recognized postsecondary credential within 1 year from program exit;

(5) The percentage of participants who during a program year, are in an education or training program that leads to a recognized postsecondary credential or employment and who are achieving measurable skill gains, defined as documented academic, technical, occupational or other forms of progress towards such a credential or employment. Depending upon the type of education or training program, documented progress is defined as one of the following:

(i) Documented achievement of at least one educational functioning level of a participant who is receiving instruction below the postsecondary education level;

(ii) Documented attainment of a secondary school diploma or its recognized equivalent;

(iii) Secondary or postsecondary transcript or report card for a sufficient number of credit hours that shows a participant is achieving the State unit's academic standards;

(iv) Satisfactory or better progress report, towards established milestones, such as completion of OJT or completion of 1 year of an apprenticeship program or similar milestones, from an employer or training provider who is providing training; or

(v) Successful passage of an exam that is required for a particular occupation or progress in attaining technical or occupational skills as evidenced by trade-related benchmarks such as knowledge-based exams.

(6) The percentage of participants in unsubsidized employment during the second quarter after exit from the program who were employed by the same employer in the second and fourth quarters after exit. For the six core programs, this indicator is a statewide indicator reported by one core program on behalf of all six core programs in the State, as described in guidance.

[81 FR 56002, Aug. 19, 2016, as amended at 89 FR 13847, Feb. 23, 2024]

§ 677.160 What information is required for State performance reports?

(a) The State performance report required by sec. 116(d)(2) of WIOA must be submitted annually using a template the Departments of Labor and Education will disseminate, and must provide, at a minimum, information on the actual performance levels achieved consistent with § 677.175 with respect to:

(1) The total number of participants served, and the total number of participants who exited each of the core programs identified in sec. 116(b)(3)(A)(ii) of WIOA, including disaggregated counts of those who participated in and exited a core program, by:

(i) Individuals with barriers to employment as defined in WIOA sec. 3(24); and

(ii) Co-enrollment in any of the programs in WIOA sec. 116(b)(3)(A)(ii).

(2) Information on the performance levels achieved for the primary indicators of performance for all of the core programs identified in § 677.155 including disaggregated levels for:

(i) Individuals with barriers to employment as defined in WIOA sec. 3(24);

(ii) Age;

(iii) Sex; and

(iv) Race and ethnicity.

(3) The total number of participants who received career services and the total number of participants who exited from career services for the most recent program year and the 3 preceding program years, and the total number of participants who received training services and the total number of participants who exited from training services for the most recent program year and the 3 preceding program years, as applicable to the program;

(4) Information on the performance levels achieved for the primary indicators of performance consistent with § 677.155 for career services and training services for the most recent program year and the 3 preceding program years, as applicable to the program;

(5) The percentage of participants in a program who attained unsubsidized employment related to the training received (often referred to as training-related employment) through WIOA title I, subtitle B programs;

(6) The amount of funds spent on career services and the amount of funds spent on training services for the most recent program year and the 3 preceding program years, as applicable to the program;

(7) The average cost per participant for those participants who received career services and training services, respectively, during the most recent program year and the 3 preceding program years, as applicable to the program;

(8) The percentage of a State's annual allotment under WIOA sec. 132(b) that the State spent on administrative costs; and

(9) Information that facilitates comparisons of programs with programs in other States.

(10) For WIOA title I programs, a State performance narrative, which, for States in which a local area is implementing a pay-for-performance contracting strategy, at a minimum provides:

(i) A description of pay-for-performance contract strategies being used for programs;

(ii) The performance of service providers entering into contracts for such strategies, measured against the levels of performance specified in the contracts for such strategies; and

(iii) An evaluation of the design of the programs and performance strategies and, when available, the satisfaction of employers and participants who received services under such strategies.

(b) The disaggregation of data for the State performance report must be done

in compliance with WIOA sec. 116(d)(6)(C).

(c) The State performance reports must include a mechanism of electronic access to the State's local area and eligible training provider (ETP) performance reports.

(d) States must comply with these requirements from sec. 116 of WIOA as explained in joint guidance issued by the Departments of Labor and Education, which may include information on reportable individuals as determined by the Secretaries of Labor and Education.

§ 677.165 May a State establish additional indicators of performance?

States may identify additional indicators of performance for the six core programs. If a State does so, these indicators must be included in the Unified or Combined State Plan.

§ 677.170 How are State levels of performance for primary indicators established?

(a) A State must submit in the State Plan expected levels of performance on the primary indicators of performance for each core program as required by sec. 116(b)(3)(A)(iii) of WIOA as explained in joint guidance issued by the Secretaries of Labor and Education.

(1) The initial State Plan submitted under WIOA must contain expected levels of performance for the first 2 years of the State Plan.

(2) States must submit expected levels of performance for the third and fourth year of the State Plan before the third program year consistent with §§ 676.135 and 676.145 of this chapter.

(b) States must reach agreement on levels of performance with the Secretaries of Labor and Education for each indicator for each core program. These are the negotiated levels of performance. The negotiated levels must be based on the following factors:

(1) How the negotiated levels of performance compare with State levels of performance established for other States;

(2) The application of an objective statistical model established by the Secretaries of Labor and Education, subject to paragraph (d) of this section;

(3) How the negotiated levels promote continuous improvement in performance based on the primary indicators and ensure optimal return on investment of Federal funds; and

(4) The extent to which the negotiated levels assist the State in meeting the performance goals established by the Secretaries of Labor and Education for the core programs in accordance with the Government Performance and Results Act of 1993, as amended.

(c) An objective statistical adjustment model will be developed and disseminated by the Secretaries of Labor and Education. The model will be based on:

(1) Differences among States in actual economic conditions, including but not limited to unemployment rates and job losses or gains in particular industries; and

(2) The characteristics of participants, including but not limited to:

(i) Indicators of poor work history;

(ii) Lack of work experience;

(iii) Lack of educational or occupational skills attainment;

(iv) Dislocation from high-wage and high-benefit employment;

(v) Low levels of literacy;

(vi) Low levels of English proficiency;

(vii) Disability status;

(viii) Homelessness;

(ix) Ex-offender status; and

(x) Welfare dependency.

(d) The objective statistical adjustment model developed under paragraph (c) of this section will be:

(1) Applied to the core programs' primary indicators upon availability of data which are necessary to populate the model and apply the model to the local core programs;

(2) Subject to paragraph (d)(1) of this section, used before the beginning of a program year in order to reach agreement on State negotiated levels for the upcoming program year; and

(3) Subject to paragraph (d)(1) of this section, used to revise negotiated levels at the end of a program year based on actual economic conditions and characteristics of participants served, consistent with sec. 116(b)(3)(A)(vii) of WIOA.

(e) The negotiated levels revised at the end of the program year, based on the statistical adjustment model, are the adjusted levels of performance.

(f) States must comply with these requirements from sec. 116 of WIOA as explained in joint guidance issued by the Departments of Labor and Education.

§ 677.175 What responsibility do States have to use quarterly wage record information for performance accountability?

(a)(1) States must, consistent with State laws, use quarterly wage record information in measuring a State's performance on the primary indicators of performance outlined in § 677.155 and a local area's performance on the primary indicators of performance identified in § 677.205.

(2) The use of social security numbers from participants and such other information as is necessary to measure the progress of those participants through quarterly wage record information is authorized.

(3) To the extent that quarterly wage records are not available for a participant, States may use other information as is necessary to measure the progress of those participants through methods other than quarterly wage record information.

(b) ''Quarterly wage record information'' means intrastate and interstate wages paid to an individual, the social security number (or numbers, if more than one) of the individual, and the name, address, State, and the Federal employer identification number of the employer paying the wages to the individual.

(c) The Governor may designate a State agency (or appropriate State entity) to assist in carrying out the performance reporting requirements for WIOA core programs and ETPs. The Governor or such agency (or appropriate State entity) is responsible for:

(1) Facilitating data matches;

(2) Data quality reliability; and

(3) Protection against disaggregation that would violate applicable privacy standards.

Subpart B—Sanctions for State Performance and the Provision of Technical Assistance

§ 677.180 When is a State subject to a financial sanction under the Workforce Innovation and Opportunity Act?

A State will be subject to financial sanction under WIOA sec. 116(f) if it fails to:

(a) Submit the State annual performance report required under WIOA sec. 116(d)(2); or

(b) Meet adjusted levels of performance for the primary indicators of performance in accordance with sec. 116(f) of WIOA.

§ 677.185 When are sanctions applied for a State's failure to submit an annual performance report?

(a) Sanctions will be applied when a State fails to submit the State annual performance report required under sec. 116(d)(2) of WIOA. A State fails to report if the State either:

(1) Does not submit a State annual performance report by the date for timely submission set in performance reporting guidance; or

(2) Submits a State annual performance report by the date for timely submission, but the report is incomplete.

(b) Sanctions will not be applied if the reporting failure is due to exceptional circumstances outside of the State's control. Exceptional circumstances may include, but are not limited to:

(1) Natural disasters;

(2) Unexpected personnel transitions; and

(3) Unexpected technology related issues.

(c) In the event that a State may not be able to submit a complete and accurate performance report by the deadline for timely reporting:

(1) The State must notify the Secretary of Labor or Secretary of Education as soon as possible, but no later than 30 days prior to the established deadline for submission, of a potential impact on the State's ability to submit its State annual performance report in order to not be considered failing to report.

(2) In circumstances where unexpected events occur less than 30 days before the established deadline for submission of the State annual performance reports, the Secretaries of Labor and Education will review requests for extending the reporting deadline in accordance with the Departments of Labor and Education's procedures that will be established in guidance.

§ 677.190 When are sanctions applied for failure to achieve adjusted levels of performance?

(a) States' negotiated levels of performance will be adjusted through the application of the statistical adjustment model established under § 677.170 to account for actual economic conditions experienced during a program year and characteristics of participants, annually at the close of each program year.

(b) Any State that fails to meet adjusted levels of performance for the primary indicators of performance outlined in § 677.155 for any year will receive technical assistance, including assistance in the development of a performance improvement plan provided by the Secretary of Labor or Secretary of Education.

(c) Whether a State has failed to meet adjusted levels of performance will be determined using the following criteria:

(1) The overall State program score, which is expressed as the percent achieved, compares the actual results achieved by a core program on the primary indicators of performance, except for the effectiveness in serving employers indicator described in § 677.155(a)(1)(vi), to the adjusted levels of performance for that core program. The average of the percentages achieved of the adjusted level of performance for each of the primary indicators, except for the effectiveness in serving employers indicator described in § 677.155(a)(1)(vi), by a core program will constitute the overall State program score.

(2) However, until all indicators for the core program have at least 2 years of complete data, the overall State program score will be based on a comparison of the actual results achieved to the adjusted level of performance for each of the primary indicators that have at least 2 years of complete data for that program.

(3) The overall State indicator score, which is expressed as the percent achieved, compares the actual results achieved on a primary indicator of performance by all core programs in a State to the adjusted levels of performance for that primary indicator.

(i) The average of the percentages achieved of the adjusted level of performance by all of the core programs on that indicator will constitute the overall State indicator score, except for the effectiveness in serving employers indicator described in § 677.155(a)(1)(vi).

(ii) The overall State indicator score for effectiveness in serving employers, as reported by one core program on behalf of all six core programs in the State, as described in guidance, is a statewide indicator that reflects the performance for all core programs. It is calculated as the statewide percentage achieved of the statewide adjusted level of performance.

(4) However, until all indicators for the State have at least 2 years of complete data, the overall State indicator score will be based on a comparison of the actual results achieved to the adjusted level of performance for each of the primary indicators that have at least 2 years of complete data in a State.

(5) The individual indicator score, which is expressed as the percent achieved, compares the actual results achieved by each core program on each of the individual primary indicators to the adjusted levels of performance for each of the program's primary indicators of performance, except for the effectiveness in serving employers indicator described in § 677.155(a)(1)(vi).

(d) A performance failure occurs when:

(1) Any overall State program score or overall State indicator score falls below 90 percent for the program year; or

(2) Any of the States' individual indicator scores fall below 50 percent for the program year.

(e) Sanctions based on performance failure will be applied to States if, for

2 consecutive years, the State fails to meet:

(1) 90 percent of the overall State program score for the same core program;

(2) 90 percent of the overall State indicator score for the same primary indicator; or

(3) 50 percent of the same indicator score for the same program.

[81 FR 56002, Aug. 19, 2016 as amended at 89 FR 13848, Feb. 23, 2024]

§ 677.195 What should States expect when a sanction is applied to the Governor's Reserve Allotment?

(a) The Secretaries of Labor and Education will reduce the Governor's Reserve Allotment by five percent of the maximum available amount for the immediately succeeding program year if:

(1) The State fails to submit the State annual performance reports as required under WIOA sec. 116(d)(2), as defined in § 677.185;

(2) The State fails to meet State adjusted levels of performance for the same primary performance indicator(s) under either § 677.190(d)(1) for the second consecutive year as defined in § 677.190; or

(3) The State's score on the same indicator for the same program falls below 50 percent under § 677.190(d)(2) for the second consecutive year as defined in § 677.190.

(b) If the State fails under paragraphs (a)(1) and either (a)(2) or (3) of this section in the same program year, the Secretaries of Labor and Education will reduce the Governor's Reserve Allotment by 10 percent of the maximum available amount for the immediately succeeding program year.

(c) If a State's Governor's Reserve Allotment is reduced:

(1) The reduced amount will not be returned to the State in the event that the State later improves performance or submits its annual performance report; and

(2) The Governor's Reserve will continue to be set at the reduced level in each subsequent year until the Secretary of Labor or the Secretary of Education, depending on which program is impacted, determines that the State met the State adjusted levels of performance for the applicable primary performance indicators and has submitted all of the required performance reports.

(d) A State may request review of a sanction the Secretary of Labor imposes in accordance with the provisions of § 683.800 of this chapter.

§ 677.200 What other administrative actions will be applied to States' performance requirements?

(a) In addition to sanctions for failure to report or failure to meet adjusted levels of performance, States will be subject to administrative actions in the case of poor performance.

(b) States' performance achievement on the individual primary indicators will be assessed in addition to the overall State program score and overall State indicator score. Based on this assessment, as clarified and explained in guidance, for performance on any individual primary indicator, the Secretary of Labor or the Secretary of Education will require the State to establish a performance risk plan to address continuous improvement on the individual primary indicator.

Subpart C—Local Performance Accountability for Workforce Innovation and Opportunity Act Title I Programs

§ 677.205 What performance indicators apply to local areas and what information must be included in local area performance reports?

(a) Each local area in a State under WIOA title I is subject to the same primary indicators of performance for the core programs for WIOA title I under § 677.155(a)(1) and (c) that apply to the State.

(b) In addition to the indicators described in paragraph (a) of this section, under § 677.165, the Governor may apply additional indicators of performance to local areas in the State.

(c) States must annually make local area performance reports available to the public using a template that the Departments of Labor and Education will disseminate in guidance, including by electronic means. The State must provide electronic access to the public local area performance report in its annual State performance report.

(d) The local area performance report must include:

(1) The actual results achieved under § 677.155 and the information required under § 677.160(a);

(2) The percentage of a local area's allotment under WIOA secs. 128(b) and 133(b) that the local area spent on administrative costs; and

(3) Other information that facilitates comparisons of programs with programs in other local areas (or planning regions if the local area is part of a planning region).

(e) The disaggregation of data for the local area performance report must be done in compliance with WIOA sec. 116(d)(6)(C).

(f) States must comply with any requirements from sec. 116(d)(3) of WIOA as explained in guidance, including the use of the performance reporting template, issued by DOL.

§ 677.210 How are local performance levels established?

(a) The objective statistical adjustment model required under sec. 116(b)(3)(A)(viii) of WIOA and described in § 677.170(c) must be:

(1) Applied to the core programs' primary indicators upon availability of data which are necessary to populate the model and apply the model to the local core programs;

(2) Used in order to reach agreement on local negotiated levels of performance for the upcoming program year; and

(3) Used to establish adjusted levels of performance at the end of a program year based on actual conditions, consistent with WIOA sec. 116(c)(3).

(b) Until all indicators for the core program in a local area have at least 2 years of complete data, the comparison of the actual results achieved to the adjusted levels of performance for each of the primary indicators only will be applied where there are at least 2 years of complete data for that program.

(c) The Governor, Local Workforce Development Board (WDB), and chief elected official must reach agreement on local negotiated levels of performance based on a negotiations process before the start of a program year with the use of the objective statistical model described in paragraph (a) of this section. The negotiations will include a discussion of circumstances not accounted for in the model and will take into account the extent to which the levels promote continuous improvement. The objective statistical model will be applied at the end of the program year based on actual economic conditions and characteristics of the participants served.

(d) The negotiations process described in paragraph (c) of this section must be developed by the Governor and disseminated to all Local WDBs and chief elected officials.

(e) The Local WDBs may apply performance measures to service providers that differ from the performance indicators that apply to the local area. These performance measures must be established after considering:

(1) The established local negotiated levels;

(2) The services provided by each provider; and

(3) The populations the service providers are intended to serve.

Subpart D—Incentives and Sanctions for Local Performance for Workforce Innovation and Opportunity Act Title I Programs

§ 677.215 Under what circumstances are local areas eligible for State Incentive Grants?

(a) The Governor is not required to award local incentive funds, but is authorized to provide incentive grants to local areas for performance on the primary indicators of performance consistent with WIOA sec. 134(a)(3)(A)(xi).

(b) The Governor may use non-Federal funds to create incentives for the Local WDBs to implement pay-for-performance contract strategies for the delivery of training services described in WIOA sec. 134(c)(3) or activities described in WIOA sec. 129(c)(2) in the local areas served by the Local WDBs. Pay-for-performance contract strategies must be implemented in accordance with part 683, subpart E of this chapter and § 677.160.

§ 677.220 Under what circumstances may a corrective action or sanction be applied to local areas for poor performance?

(a) If a local area fails to meet the adjusted levels of performance agreed to under § 677.210 for the primary indicators of performance in the adult, dislocated worker, and youth programs authorized under WIOA title I in any program year, technical assistance must be provided by the Governor or, upon the Governor's request, by the Secretary of Labor.

(1) A State must establish the threshold for failure to meet adjusted levels of performance for a local area before coming to agreement on the negotiated levels of performance for the local area.

(i) A State must establish the adjusted level of performance for a local area, using the statistical adjustment model described in § 677.170(c).

(ii) At least 2 years of complete data on any indicator for any local core program are required in order to establish adjusted levels of performance for a local area.

(2) The technical assistance may include:

(i) Assistance in the development of a performance improvement plan;

(ii) The development of a modified local or regional plan; or

(iii) Other actions designed to assist the local area in improving performance.

(b) If a local area fails to meet the adjusted levels of performance agreed to under § 677.210 for the same primary indicators of performance for the same core program authorized under WIOA title I for a third consecutive program year, the Governor must take corrective actions. The corrective actions must include the development of a reorganization plan under which the Governor:

(1) Requires the appointment and certification of a new Local WDB, consistent with the criteria established under § 679.350 of this chapter;

(2) Prohibits the use of eligible providers and one-stop partners that have been identified as achieving poor levels of performance; or

(3) Takes such other significant actions as the Governor determines are appropriate.

§ 677.225 Under what circumstances may local areas appeal a reorganization plan?

(a) The Local WDB and chief elected official for a local area that is subject to a reorganization plan under WIOA sec. 116(g)(2)(A) may appeal to the Governor to rescind or revise the reorganization plan not later than 30 days after receiving notice of the reorganization plan. The Governor must make a final decision within 30 days after receipt of the appeal.

(b) The Local WDB and chief elected official may appeal the final decision of the Governor to the Secretary of Labor not later than 30 days after receiving the decision from the Governor. Any appeal of the Governor's final decision must be:

(1) Appealed jointly by the Local WDB and chief elected official to the Secretary of Labor under § 683.650 of this chapter; and

(2) Must be submitted by certified mail, return receipt requested, to the Secretary of Labor, U.S. Department of Labor, 200 Constitution Ave. NW., Washington, DC 20210, Attention: ASET. A copy of the appeal must be simultaneously provided to the Governor.

(c) Upon receipt of the joint appeal from the Local WDB and chief elected official, the Secretary of Labor must make a final decision within 30 days. In making this determination the Secretary of Labor may consider any comments submitted by the Governor in response to the appeals.

(d) The decision by the Governor on the appeal becomes effective at the time it is issued and remains effective unless the Secretary of Labor rescinds or revises the reorganization plan under WIOA sec. 116(g)(2)(C).

Subpart E—Eligible Training Provider Performance for Workforce Innovation and Opportunity Act Title I Programs

§ 677.230 What information is required for the eligible training provider performance reports?

(a) States are required to make available and publish annually using a template the Departments of Labor and Education will disseminate including through electronic means, the ETP performance reports for ETPs who provide services under sec. 122 of WIOA that are described in §§ 680.400 through 680.530 of this chapter. These reports at a minimum must include, consistent with § 677.175 and with respect to each program of study that is eligible to receive funds under WIOA:

(1) The total number of participants as defined by § 677.150(a) who received training services under the adult and dislocated worker programs authorized under WIOA title I for the most recent year and the 3 preceding program years, including:

(i) The number of participants under the adult and dislocated worker programs disaggregated by barriers to employment;

(ii) The number of participants under the adult and dislocated worker programs disaggregated by race, ethnicity, sex, and age;

(iii) The number of participants under the adult and dislocated worker programs disaggregated by the type of training entity for the most recent program year and the 3 preceding program years;

(2) The total number of participants who exit a program of study or its equivalent, including disaggregate counts by the type of training entity during the most recent program year and the 3 preceding program years;

(3) The average cost-per-participant for participants who received training services for the most recent program year and the 3 preceding program years disaggregated by type of training entity;

(4) The total number of individuals exiting from the program of study (or the equivalent) with respect to all individuals engaging in the program of study (or the equivalent); and

(5) The levels of performance achieved for the primary indicators of performance identified in § 677.155(a)(1)(i) through (iv) with respect to all individuals engaging in a program of study (or the equivalent).

(b) Apprenticeship programs registered under the National Apprenticeship Act are not required to submit ETP performance information. If a registered apprenticeship program voluntarily submits performance information to a State, the State must include this information in the report.

(c) The State must provide a mechanism of electronic access to the public ETP performance report in its annual State performance report.

(d) States must comply with any requirements from sec. 116(d)(4) of WIOA as explained in guidance issued by DOL.

(e) The Governor may designate one or more State agencies such as a State Education Agency or other State Educational Authority to assist in overseeing ETP performance and facilitating the production and dissemination of ETP performance reports. These agencies may be the same agencies that are designated as responsible for administering the ETP list as provided under § 680.500 of this chapter. The Governor or such agencies, or authorities, is responsible for:

(1) Facilitating data matches between ETP records and unemployment insurance (UI) wage data in order to produce the report;

(2) The creation and dissemination of the reports as described in paragraphs (a) through (d) of this section;

(3) Coordinating the dissemination of the performance reports with the ETP list and the information required to accompany the list, as provided in § 680.500 of this chapter.

Subpart F—Performance Reporting Administrative Requirements

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(a) On a quarterly basis, each State must submit to the Secretary of Labor or the Secretary of Education, as appropriate, individual records that include demographic information, information on services received, and information on resulting outcomes, as appropriate, for each reportable individual in either of the following programs administered by the Secretary of Labor or Secretary of Education: A WIOA title I core program; the Employment Service program authorized under the Wagner-Peyser Act, as amended by WIOA title III; or the VR program authorized under title I of the Rehabilitation Act of 1973, as amended by WIOA title IV.

(b) For individual records submitted to the Secretary of Labor, those records may be required to be integrated across all programs administered by the Secretary of Labor in one single file.

(c) States must comply with the requirements of sec. 116(d)(2) of WIOA as explained in guidance issued by the Departments of Labor and Education.

§ 677.240 What are the requirements for data validation of State annual performance reports?

(a) States must establish procedures, consistent with guidelines issued by the Secretary of Labor or the Secretary of Education, to ensure that they submit complete annual performance reports that contain information that is valid and reliable, as required by WIOA sec. 116(d)(5).

(b) If a State fails to meet standards in paragraph (a) of this section as determined by the Secretary of Labor or the Secretary of Education, the appropriate Secretary will provide technical assistance and may require the State to develop and implement corrective actions, which may require the State to provide training for its subrecipients.

(c) The Secretaries of Labor and Education will provide training and technical assistance to States in order to implement this section. States must comply with the requirements of sec. 116(d)(5) of WIOA as explained in guidance.

PART 678—DESCRIPTION OF THE ONE-STOP DELIVERY SYSTEM UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

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Subpart A—General Description of the One-Stop Delivery System

§ 678.300 What is the one-stop delivery system?

(a) The one-stop delivery system brings together workforce development, educational, and other human

resource services in a seamless customer-focused service delivery network that enhances access to the programs' services and improves long-term employment outcomes for individuals receiving assistance. One-stop partners administer separately funded programs as a set of integrated streamlined services to customers.

(b) Title I of the Workforce Innovation and Opportunity Act (WIOA) assigns responsibilities at the local, State, and Federal level to ensure the creation and maintenance of a one-stop delivery system that enhances the range and quality of education and workforce development services that employers and individual customers can access.

(c) The system must include at least one comprehensive physical center in each local area as described in § 678.305.

(d) The system may also have additional arrangements to supplement the comprehensive center. These arrangements include:

(1) An affiliated site or a network of affiliated sites, where one or more partners make programs, services, and activities available, as described in § 678.310;

(2) A network of eligible one-stop partners, as described in §§ 678.400 through 678.410, through which each partner provides one or more of the programs, services, and activities that are linked, physically or technologically, to an affiliated site or access point that assures customers are provided information on the availability of career services, as well as other program services and activities, regardless of where they initially enter the public workforce system in the local area; and

(3) Specialized centers that address specific needs, including those of dislocated workers, youth, or key industry sectors, or clusters.

(e) Required one-stop partner programs must provide access to programs, services, and activities through electronic means if applicable and practicable. This is in addition to providing access to services through the mandatory comprehensive physical one-stop center and any affiliated sites or specialized centers. The provision of programs and services by electronic methods such as Web sites, telephones, or other means must improve the efficiency, coordination, and quality of one-stop partner services. Electronic delivery must not replace access to such services at a comprehensive one-stop center or be a substitute to making services available at an affiliated site if the partner is participating in an affiliated site. Electronic delivery systems must be in compliance with the nondiscrimination and equal opportunity provisions of WIOA sec. 188 and its implementing regulations at 29 CFR part 38.

(f) The design of the local area's one-stop delivery system must be described in the Memorandum of Understanding (MOU) executed with the one-stop partners, described in § 678.500.

§ 678.305 What is a comprehensive one-stop center and what must be provided there?

(a) A comprehensive one-stop center is a physical location where job seeker and employer customers can access the programs, services, and activities of all required one-stop partners. A comprehensive one-stop center must have at least one title I staff person physically present.

(b) The comprehensive one-stop center must provide:

(1) Career services, described in § 678.430;

(2) Access to training services described in § 680.200 of this chapter;

(3) Access to any employment and training activities carried out under sec. 134(d) of WIOA;

(4) Access to programs and activities carried out by one-stop partners listed in §§ 678.400 through 678.410, including the Employment Service program authorized under the Wagner-Peyser Act, as amended by WIOA title III (Wagner-Peyser Act Employment Service program); and

(5) Workforce and labor market information.

(c) Customers must have access to these programs, services, and activities during regular business days at a comprehensive one-stop center. The Local Workforce Development Board (WDB) may establish other service hours at other times to accommodate the schedules of individuals who work on regular business days. The State WDB will

evaluate the hours of access to service as part of the evaluation of effectiveness in the one-stop certification process described in § 678.800(b).

(d) ''Access'' to each partner program and its services means:

(1) Having a program staff member physically present at the one-stop center;

(2) Having a staff member from a different partner program physically present at the one-stop center appropriately trained to provide information to customers about the programs, services, and activities available through partner programs; or

(3) Making available a direct linkage through technology to program staff who can provide meaningful information or services.

(i) A ''direct linkage'' means providing direct connection at the one-stop center, within a reasonable time, by phone or through a real-time Web-based communication to a program staff member who can provide program information or services to the customer.

(ii) A ''direct linkage'' cannot exclusively be providing a phone number or computer Web site or providing information, pamphlets, or materials.

(e) All comprehensive one-stop centers must be physically and programmatically accessible to individuals with disabilities, as described in 29 CFR part 38, the implementing regulations of WIOA sec. 188.

§ 678.310 What is an affiliated site and what must be provided there?

(a) An affiliated site, or affiliate one-stop center, is a site that makes available to job seeker and employer customers one or more of the one-stop partners' programs, services, and activities. An affiliated site does not need to provide access to every required one-stop partner program. The frequency of program staff's physical presence in the affiliated site will be determined at the local level. Affiliated sites are access points in addition to the comprehensive one-stop center(s) in each local area. If used by local areas as a part of the service delivery strategy, affiliate sites must be implemented in a manner that supplements and enhances customer access to services.

(b) As described in § 678.315, Wagner-Peyser Act employment services cannot be a stand-alone affiliated site.

(c) States, in conjunction with the Local WDBs, must examine lease agreements and property holdings throughout the one-stop delivery system in order to use property in an efficient and effective way. Where necessary and appropriate, States and Local WDBs must take expeditious steps to align lease expiration dates with efforts to consolidate one-stop operations into service points where Wagner-Peyser Act employment services are colocated as soon as reasonably possible. These steps must be included in the State Plan.

(d) All affiliated sites must be physically and programmatically accessible to individuals with disabilities, as described in 29 CFR part 38, the implementing regulations of WIOA sec. 188.

§ 678.315 Can a stand-alone Wagner-Peyser Act Employment Service office be designated as an affiliated one-stop site?

(a) Separate stand-alone Wagner-Peyser Act Employment Service offices are not permitted under WIOA, as also described in § 652.202 of this chapter.

(b) If Wagner-Peyser Act employment services are provided at an affiliated site, there must be at least one or more other partners in the affiliated site with a physical presence of combined staff more than 50 percent of the time the center is open. Additionally, the other partner must not be the partner administering local veterans' employment representatives, disabled veterans' outreach program specialists, or unemployment compensation programs. If Wagner-Peyser Act employment services and any of these 3 programs are provided at an affiliated site, an additional partner or partners must have a presence of combined staff in the center more than 50 percent of the time the center is open.

§ 678.320 Are there any requirements for networks of eligible one-stop partners or specialized centers?

Any network of one-stop partners or specialized centers, as described in § 678.300(d)(3), must be connected to the

comprehensive one-stop center and any appropriate affiliate one-stop centers, for example, by having processes in place to make referrals to these centers and the partner programs located in them. Wagner-Peyser Act employment services cannot stand alone in a specialized center. Just as described in § 678.315 for an affiliated site, a specialized center must include other programs besides Wagner-Peyser Act employment services, local veterans' employment representatives, disabled veterans' outreach program specialists, and unemployment compensation.

Subpart B—One-Stop Partners and the Responsibilities of Partners

§ 678.400 Who are the required one-stop partners?

(a) Section 121(b)(1)(B) of WIOA identifies the entities that are required partners in the local one-stop delivery systems.

(b) The required partners are the entities responsible for administering the following programs and activities in the local area:

(1) Programs authorized under title I of WIOA, including:

(i) Adults;

(ii) Dislocated workers;

(iii) Youth;

(iv) Job Corps;

(v) YouthBuild;

(vi) Native American programs; and

(vii) Migrant and seasonal farmworker programs;

(2) The Wagner-Peyser Act Employment Service program authorized under the Wagner-Peyser Act (29 U.S.C. 49 *et seq.*), as amended by WIOA title III;

(3) The Adult Education and Family Literacy Act (AEFLA) program authorized under title II of WIOA;

(4) The Vocational Rehabilitation (VR) program authorized under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 *et seq.*), as amended by WIOA title IV;

(5) The Senior Community Service Employment Program authorized under title V of the Older Americans Act of 1965 (42 U.S.C. 3056 *et seq.*);

(6) Career and technical education programs at the postsecondary level authorized under the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 *et seq.*);

(7) Trade Adjustment Assistance activities authorized under chapter 2 of title II of the Trade Act of 1974 (19 U.S.C. 2271 *et seq.*);

(8) Jobs for Veterans State Grants programs authorized under chapter 41 of title 38, U.S.C.;

(9) Employment and training activities carried out under the Community Services Block Grant (42 U.S.C. 9901 *et seq.*);

(10) Employment and training activities carried out by the Department of Housing and Urban Development;

(11) Programs authorized under State unemployment compensation laws (in accordance with applicable Federal law);

(12) Programs authorized under sec. 212 of the Second Chance Act of 2007 (42 U.S.C. 17532); and

(13) Temporary Assistance for Needy Families (TANF) authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 *et seq.*), unless exempted by the Governor under § 678.405(b).

§ 678.405 Is Temporary Assistance for Needy Families a required one-stop partner?

(a) Yes, TANF, authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 *et seq.*), is a required partner.

(b) The Governor may determine that TANF will not be a required partner in the State, or within some specific local areas in the State. In this instance, the Governor must notify the Secretaries of the U.S. Departments of Labor and Health and Human Services in writing of this determination.

(c) In States, or local areas within a State, where the Governor has determined that TANF is not required to be a partner, local TANF programs may still work in collaboration or partnership with the local one-stop centers to deliver employment and training services to the TANF population unless inconsistent with the Governor's direction.

§ 678.410 What other entities may serve as one-stop partners?

(a) Other entities that carry out a workforce development program, including Federal, State, or local programs and programs in the private sector, may serve as additional partners in the one-stop delivery system if the Local WDB and chief elected official(s) approve the entity's participation.

(b) Additional partners may include, but are not limited to:

(1) Employment and training programs administered by the Social Security Administration, including the Ticket to Work and Self-Sufficiency Program established under sec. 1148 of the Social Security Act (42 U.S.C. 1320b-19);

(2) Employment and training programs carried out by the Small Business Administration;

(3) Supplemental Nutrition Assistance Program (SNAP) employment and training programs, authorized under secs. 6(d)(4) and 6(o) of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(d)(4));

(4) Client Assistance Program authorized under sec. 112 of the Rehabilitation Act of 1973 (29 U.S.C. 732);

(5) Programs authorized under the National and Community Service Act of 1990 (42 U.S.C. 12501 *et seq.*); and

(6) Other appropriate Federal, State or local programs, including, but not limited to, employment, education, and training programs provided by public libraries or in the private sector.

§ 678.415 What entity serves as the one-stop partner for a particular program in the local area?

(a) The entity that carries out the program and activities listed in § 678.400 or § 678.410, and therefore serves as the one-stop partner, is the grant recipient, administrative entity, or organization responsible for administering the funds of the specified program in the local area. The term ''entity'' does not include the service providers that contract with, or are subrecipients of, the local administrative entity. For programs that do not include local administrative entities, the responsible State agency must be the partner. Specific entities for particular programs are identified in paragraphs (b) through (e) of this section. If a program or activity listed in § 678.400 is not carried out in a local area, the requirements relating to a required one-stop partner are not applicable to such program or activity in that local one-stop delivery system.

(b) For title II of WIOA, the entity or agency that carries out the program for the purposes of paragraph (a) of this section is the sole entity or agency in the State or outlying area responsible for administering or supervising policy for adult education and literacy activities in the State or outlying area. The State eligible entity or agency may delegate its responsibilities under paragraph (a) of this section to one or more eligible providers or consortium of eligible providers.

(c) For the VR program, authorized under title I of the Rehabilitation Act of 1973, as amended by WIOA title IV, the entity that carries out the program for the purposes of paragraph (a) of this section is the designated State agencies or designated State units specified under sec. 101(a)(2) of the Rehabilitation Act that is primarily concerned with vocational rehabilitation, or vocational and other rehabilitation, of individuals with disabilities.

(d) Under WIOA title I, the national programs, including Job Corps, the Native American program, YouthBuild, and Migrant and Seasonal Farmworker programs are required one-stop partners. The entity for the Native American program, YouthBuild, and Migrant and Seasonal Farmworker programs is the grantee of those respective programs. The entity for Job Corps is the Job Corps center.

(e) For the Carl D. Perkins Career and Technical Education Act of 2006, the entity that carries out the program for the purposes of paragraph (a) of this section is the eligible recipient or recipients at the postsecondary level, or a consortium of eligible recipients at the postsecondary level in the local area. The eligible recipient at the postsecondary level may also request assistance from the State eligible agency in completing its responsibilities under paragraph (a) of this section.

§ 678.420 What are the roles and responsibilities of the required one-stop partners?

Each required partner must:

(a) Provide access to its programs or activities through the one-stop delivery system, in addition to any other appropriate locations;

(b) Use a portion of funds made available to the partner's program, to the extent consistent with the Federal law authorizing the partner's program and with Federal cost principles in 2 CFR parts 200 and 2900 (requiring, among other things, that costs are allowable, reasonable, necessary, and allocable), to:

(1) Provide applicable career services; and

(2) Work collaboratively with the State and Local WDBs to establish and maintain the one-stop delivery system. This includes jointly funding the one-stop infrastructure through partner contributions that are based upon:

(i) A reasonable cost allocation methodology by which infrastructure costs are charged to each partner based on proportionate use and relative benefit received;

(ii) Federal cost principles; and

(iii) Any local administrative cost requirements in the Federal law authorizing the partner's program. (This is further described in § 678.700.)

(c) Enter into an MOU with the Local WDB relating to the operation of the one-stop delivery system that meets the requirements of § 678.500(b);

(d) Participate in the operation of the one-stop delivery system consistent with the terms of the MOU, requirements of authorizing laws, the Federal cost principles, and all other applicable legal requirements; and

(e) Provide representation on the State and Local WDBs as required and participate in Board committees as needed.

§ 678.425 What are the applicable career services that must be provided through the one-stop delivery system by required one-stop partners?

(a) The applicable career services to be delivered by required one-stop partners are those services listed in § 678.430 that are authorized to be provided under each partner's program.

(b) One-stop centers provide services to individual customers based on individual needs, including the seamless delivery of multiple services to individual customers. There is no required sequence of services.

§ 678.430 What are career services?

Career services, as identified in sec. 134(c)(2) of WIOA, consist of three types:

(a) Basic career services must be made available and, at a minimum, must include the following services, as consistent with allowable program activities and Federal cost principles:

(1) Determinations of whether the individual is eligible to receive assistance from the adult, dislocated worker, or youth programs;

(2) Outreach, intake (including worker profiling), and orientation to information and other services available through the one-stop delivery system. For the TANF program, States must provide individuals with the opportunity to initiate an application for TANF assistance and non-assistance benefits and services, which could be implemented through the provision of paper application forms or links to the application Web site;

(3) Initial assessment of skill levels including literacy, numeracy, and English language proficiency, as well as aptitudes, abilities (including skills gaps), and supportive services needs;

(4) Labor exchange services, including—

(i) Job search and placement assistance, and, when needed by an individual, career counseling, including—

(A) Provision of information on in-demand industry sectors and occupations (as defined in sec. 3(23) of WIOA); and

(B) Provision of information on non-traditional employment; and

(ii) Appropriate recruitment and other business services on behalf of employers, including information and referrals to specialized business services other than those traditionally offered through the one-stop delivery system;

(5) Provision of referrals to and coordination of activities with other programs and services, including programs and services within the one-stop delivery system and, when appropriate, other workforce development programs;

(6) Provision of workforce and labor market employment statistics information, including the provision of accurate information relating to local, regional, and national labor market areas, including—

(i) Job vacancy listings in labor market areas;

(ii) Information on job skills necessary to obtain the vacant jobs listed; and

(iii) Information relating to local occupations in demand and the earnings, skill requirements, and opportunities for advancement for those jobs;

(7) Provision of performance information and program cost information on eligible providers of education, training, and workforce services by program and type of providers;

(8) Provision of information, in usable and understandable formats and languages, about how the local area is performing on local performance accountability measures, as well as any additional performance information relating to the area's one-stop delivery system;

(9) Provision of information, in usable and understandable formats and languages, relating to the availability of supportive services or assistance, and appropriate referrals to those services and assistance, including: Child care; child support; medical or child health assistance available through the State's Medicaid program and Children's Health Insurance Program; benefits under SNAP; assistance through the earned income tax credit; and assistance under a State program for TANF, and other supportive services and transportation provided through that program;

(10) Provision of information and meaningful assistance to individuals seeking assistance in filing a claim for unemployment compensation.

(i) ''Meaningful assistance'' means:

(A) Providing assistance on-site using staff who are well-trained in unemployment compensation claims filing and the rights and responsibilities of claimants; or

(B) Providing assistance by phone or via other technology, as long as the assistance is provided by trained and available staff and within a reasonable time.

(ii) The costs associated in providing this assistance may be paid for by the State's unemployment insurance program, or the WIOA adult or dislocated worker programs, or some combination thereof.

(11) Assistance in establishing eligibility for programs of financial aid assistance for training and education programs not provided under WIOA.

(b) Individualized career services must be made available if determined to be appropriate in order for an individual to obtain or retain employment. These services include the following services, as consistent with program requirements and Federal cost principles:

(1) Comprehensive and specialized assessments of the skill levels and service needs of adults and dislocated workers, which may include—

(i) Diagnostic testing and use of other assessment tools; and

(ii) In-depth interviewing and evaluation to identify employment barriers and appropriate employment goals;

(2) Development of an individual employment plan, to identify the employment goals, appropriate achievement objectives, and appropriate combination of services for the participant to achieve his or her employment goals, including the list of, and information about, the eligible training providers (as described in § 680.180 of this chapter);

(3) Group counseling;

(4) Individual counseling;

(5) Career planning;

(6) Short-term pre-vocational services including development of learning skills, communication skills, interviewing skills, punctuality, personal maintenance skills, and professional conduct services to prepare individuals for unsubsidized employment or training;

(7) Internships and work experiences that are linked to careers (as described in § 680.170 of this chapter);

(8) Workforce preparation activities;

(9) Financial literacy services as described in sec. 129(b)(2)(D) of WIOA and § 681.500 of this chapter;

(10) Out-of-area job search assistance and relocation assistance; and

(11) English language acquisition and integrated education and training programs.

(c) Follow-up services must be provided, as appropriate, including: Counseling regarding the workplace, for participants in adult or dislocated worker workforce investment activities who are placed in unsubsidized employment, for up to 12 months after the first day of employment.

(d) In addition to the requirements in paragraph (a)(2) of this section, TANF agencies must identify employment services and related support being provided by the TANF program (within the local area) that qualify as career services and ensure access to them via the local one-stop delivery system.

§ 678.435 What are the business services provided through the one-stop delivery system, and how are they provided?

(a) Certain career services must be made available to local employers, specifically labor exchange activities and labor market information described in § 678.430(a)(4)(ii) and (a)(6). Local areas must establish and develop relationships and networks with large and small employers and their intermediaries. Local areas also must develop, convene, or implement industry or sector partnerships.

(b) Customized business services may be provided to employers, employer associations, or other such organizations. These services are tailored for specific employers and may include:

(1) Customized screening and referral of qualified participants in training services to employers;

(2) Customized services to employers, employer associations, or other such organizations, on employment-related issues;

(3) Customized recruitment events and related services for employers including targeted job fairs;

(4) Human resource consultation services, including but not limited to assistance with:

(i) Writing/reviewing job descriptions and employee handbooks;

(ii) Developing performance evaluation and personnel policies;

(iii) Creating orientation sessions for new workers;

(iv) Honing job interview techniques for efficiency and compliance;

(v) Analyzing employee turnover;

(vi) Creating job accommodations and using assistive technologies; or

(vii) Explaining labor and employment laws to help employers comply with discrimination, wage/hour, and safety/health regulations;

(5) Customized labor market information for specific employers, sectors, industries or clusters; and

(6) Other similar customized services.

(c) Local areas may also provide other business services and strategies that meet the workforce investment needs of area employers, in accordance with partner programs' statutory requirements and consistent with Federal cost principles. These business services may be provided through effective business intermediaries working in conjunction with the Local WDB, or through the use of economic development, philanthropic, and other public and private resources in a manner determined appropriate by the Local WDB and in cooperation with the State. Allowable activities, consistent with each partner's authorized activities, include, but are not limited to:

(1) Developing and implementing industry sector strategies (including strategies involving industry partnerships, regional skills alliances, industry skill panels, and sectoral skills partnerships);

(2) Customized assistance or referral for assistance in the development of a registered apprenticeship program;

(3) Developing and delivering innovative workforce investment services and strategies for area employers, which may include career pathways, skills upgrading, skill standard development and certification for recognized post-secondary credential or other employer use, and other effective initiatives for meeting the workforce investment needs of area employers and workers;

(4) Assistance to area employers in managing reductions in force in coordination with rapid response activities and with strategies for the aversion of layoffs, which may include strategies

such as early identification of firms at risk of layoffs, use of feasibility studies to assess the needs of and options for at-risk firms, and the delivery of employment and training activities to address risk factors;

(5) The marketing of business services to appropriate area employers, including small and mid-sized employers; and

(6) Assisting employers with accessing local, State, and Federal tax credits.

(d) All business services and strategies must be reflected in the local plan, described in § 679.560(b)(3) of this chapter.

§ 678.440 When may a fee be charged for the business services in this subpart?

(a) There is no requirement that a fee-for-service be charged to employers.

(b) No fee may be charged for services provided in § 678.435(a).

(c) A fee may be charged for services provided under § 678.435(b) and (c). Services provided under § 678.435(c) may be provided through effective business intermediaries working in conjunction with the Local WDB and may also be provided on a fee-for-service basis or through the leveraging of economic development, philanthropic, and other public and private resources in a manner determined appropriate by the Local WDB. The Local WDB may examine the services provided compared with the assets and resources available within the local one-stop delivery system and through its partners to determine an appropriate cost structure for services, if any.

(d) Any fees earned are recognized as program income and must be expended by the partner in accordance with the partner program's authorizing statute, implementing regulations, and Federal cost principles identified in Uniform Guidance.

Subpart C—Memorandum of Understanding for the One-Stop Delivery System

§ 678.500 What is the Memorandum of Understanding for the one-stop delivery system and what must be included in the Memorandum of Understanding?

(a) The MOU is the product of local discussion and negotiation, and is an agreement developed and executed between the Local WDB and the one-stop partners, with the agreement of the chief elected official and the one-stop partners, relating to the operation of the one-stop delivery system in the local area. Two or more local areas in a region may develop a single joint MOU, if they are in a region that has submitted a regional plan under sec. 106 of WIOA.

(b) The MOU must include:

(1) A description of services to be provided through the one-stop delivery system, including the manner in which the services will be coordinated and delivered through the system;

(2) Agreement on funding the costs of the services and the operating costs of the system, including:

(i) Funding of infrastructure costs of one-stop centers in accordance with §§ 678.700 through 678.755; and

(ii) Funding of the shared services and operating costs of the one-stop delivery system described in § 678.760;

(3) Methods for referring individuals between the one-stop operators and partners for appropriate services and activities;

(4) Methods to ensure that the needs of workers, youth, and individuals with barriers to employment, including individuals with disabilities, are addressed in providing access to services, including access to technology and materials that are available through the one-stop delivery system;

(5) The duration of the MOU and procedures for amending it; and

(6) Assurances that each MOU will be reviewed, and if substantial changes have occurred, renewed, not less than once every 3-year period to ensure appropriate funding and delivery of services.

(c) The MOU may contain any other provisions agreed to by the parties that

are consistent with WIOA title I, the authorizing statutes and regulations of one-stop partner programs, and the WIOA regulations.

(d) When fully executed, the MOU must contain the signatures of the Local WDB, one-stop partners, the chief elected official(s), and the time period in which the agreement is effective. The MOU must be updated not less than every 3 years to reflect any changes in the signatory official of the Board, one-stop partners, and chief elected officials, or one-stop infrastructure funding.

(e) If a one-stop partner appeal to the State regarding infrastructure costs, using the process described in § 678.750, results in a change to the one-stop partner's infrastructure cost contributions, the MOU must be updated to reflect the final one-stop partner infrastructure cost contributions.

§ 678.505 Is there a single Memorandum of Understanding for the local area, or must there be different Memoranda of Understanding between the Local Workforce Development Board and each partner?

(a) A single ''umbrella'' MOU may be developed that addresses the issues relating to the local one-stop delivery system for the Local WDB, chief elected official and all partners. Alternatively, the Local WDB (with agreement of chief elected official) may enter into separate agreements between each partner or groups of partners.

(b) Under either approach, the requirements described in § 678.500 apply. Since funds are generally appropriated annually, the Local WDB may negotiate financial agreements with each partner annually to update funding of services and operating costs of the system under the MOU.

§ 678.510 How must the Memorandum of Understanding be negotiated?

(a) WIOA emphasizes full and effective partnerships between Local WDBs, chief elected officials, and one-stop partners. Local WDBs and partners must enter into good-faith negotiations. Local WDBs, chief elected officials, and one-stop partners may also request assistance from a State agency responsible for administering the partner program, the Governor, State WDB, or other appropriate parties on other aspects of the MOU.

(b) Local WDBs and one-stop partners must establish, in the MOU, how they will fund the infrastructure costs and other shared costs of the one-stop centers. If agreement regarding infrastructure costs is not reached when other sections of the MOU are ready, an interim infrastructure funding agreement may be included instead, as described in § 678.715(c). Once agreement on infrastructure funding is reached, the Local WDB and one-stop partners must amend the MOU to include the infrastructure funding of the one-stop centers. Infrastructure funding is described in detail in subpart E of this part.

(c) The Local WDB must report to the State WDB, Governor, and relevant State agency when MOU negotiations with one-stop partners have reached an impasse.

(1) The Local WDB and partners must document the negotiations and efforts that have taken place in the MOU. The State WDB, one-stop partner programs, and the Governor may consult with the appropriate Federal agencies to address impasse situations related to issues other than infrastructure funding after attempting to address the impasse. Impasses related to infrastructure cost funding must be resolved using the State infrastructure cost funding mechanism described in § 678.730.

(2) The Local WDB must report failure to execute an MOU with a required partner to the Governor, State WDB, and the State agency responsible for administering the partner's program. Additionally, if the State cannot assist the Local WDB in resolving the impasse, the Governor or the State WDB must report the failure to the Secretary of Labor and to the head of any other Federal agency with responsibility for oversight of a partner's program.

Subpart D—One-Stop Operators

§ 678.600 Who may operate one-stop centers?

(a) One-stop operators may be a single entity (public, private, or nonprofit) or a consortium of entities. If the consortium of entities is one of one-stop partners, it must include a minimum of three of the one-stop partners described in § 678.400.

(b) The one-stop operator may operate one or more one-stop centers. There may be more than one one-stop operator in a local area.

(c) The types of entities that may be a one-stop operator include:

(1) An institution of higher education;

(2) An Employment Service State agency established under the Wagner-Peyser Act;

(3) A community-based organization, nonprofit organization, or workforce intermediary;

(4) A private for-profit entity;

(5) A government agency;

(6) A Local WDB, with the approval of the chief elected official and the Governor; or

(7) Another interested organization or entity, which is capable of carrying out the duties of the one-stop operator. Examples may include a local chamber of commerce or other business organization, or a labor organization.

(d) Elementary schools and secondary schools are not eligible as one-stop operators, except that a nontraditional public secondary school such as a night school, adult school, or an area career and technical education school may be selected.

(e) The State and Local WDBs must ensure that, in carrying out WIOA programs and activities, one-stop operators:

(1) Disclose any potential conflicts of interest arising from the relationships of the operators with particular training service providers or other service providers (further discussed in § 679.430 of this chapter);

(2) Do not establish practices that create disincentives to providing services to individuals with barriers to employment who may require longer-term career and training services; and

(3) Comply with Federal regulations and procurement policies relating to the calculation and use of profits, including those at § 683.295 of this chapter, the Uniform Guidance at 2 CFR part 200, and other applicable regulations and policies.

§ 678.605 How is the one-stop operator selected?

(a) Consistent with paragraphs (b) and (c) of this section, the Local WDB must select the one-stop operator through a competitive process, as required by sec. 121(d)(2)(A) of WIOA, at least once every 4 years. A State may require, or a Local WDB may choose to implement, a competitive selection process more than once every 4 years.

(b) In instances in which a State is conducting the competitive process described in paragraph (a) of this section, the State must follow the same policies and procedures it uses for procurement with non-Federal funds.

(c) All other non-Federal entities, including subrecipients of a State (such as local areas), must use a competitive process based on local procurement policies and procedures and the principles of competitive procurement in the Uniform Guidance set out at 2 CFR 200.318 through 200.326. All references to ''noncompetitive proposals'' in the Uniform Guidance at 2 CFR 200.320(f) will be read as ''sole source procurement'' for the purposes of implementing this section.

(d) Entities must prepare written documentation explaining the determination concerning the nature of the competitive process to be followed in selecting a one-stop operator.

§ 678.610 When is the sole-source selection of one-stop operators appropriate, and how is it conducted?

(a) States may select a one-stop operator through sole source selection when allowed under the same policies and procedures used for competitive procurement with non-Federal funds, while other non-Federal entities including subrecipients of a State (such as local areas) may select a one-stop operator through sole selection when consistent with local procurement policies and procedures and the Uniform Guidance set out at 2 CFR 200.320.

(b) In the event that sole source procurement is determined necessary and reasonable, in accordance with § 678.605(c), written documentation must be prepared and maintained concerning the entire process of making such a selection.

(c) Such sole source procurement must include appropriate conflict of interest policies and procedures. These policies and procedures must conform to the specifications in § 679.430 of this chapter for demonstrating internal controls and preventing conflict of interest.

(d) A Local WDB may be selected as a one-stop operator through sole source procurement only with agreement of the chief elected official in the local area and the Governor. The Local WDB must establish sufficient conflict of interest policies and procedures and these policies and procedures must be approved by the Governor.

§ 678.615 May an entity currently serving as one-stop operator compete to be a one-stop operator under the procurement requirements of this subpart?

(a) Local WDBs may compete for and be selected as one-stop operators, as long as appropriate firewalls and conflict of interest policies and procedures are in place. These policies and procedures must conform to the specifications in § 679.430 of this chapter for demonstrating internal controls and preventing conflict of interest.

(b) State and local agencies may compete for and be selected as one-stop operators by the Local WDB, as long as appropriate firewalls and conflict of interest policies and procedures are in place. These policies and procedures must conform to the specifications in § 679.430 of this chapter for demonstrating internal controls and preventing conflict of interest.

(c) In the case of single-area States where the State WDB serves as the Local WDB, the State agency is eligible to compete for and be selected as operator as long as appropriate firewalls and conflict of interest policies are in place and followed for the competition. These policies and procedures must conform to the specifications in § 679.430 of this chapter for demonstrating internal controls and preventing conflicts of interest.

§ 678.620 What is the one-stop operator's role?

(a) At a minimum, the one-stop operator must coordinate the service delivery of required one-stop partners and service providers. Local WDBs may establish additional roles of one-stop operator, including, but not limited to: Coordinating service providers across the one-stop delivery system, being the primary provider of services within the center, providing some of the services within the center, or coordinating service delivery in a multi-center area, which may include affiliated sites. The competition for a one-stop operator must clearly articulate the role of the one-stop operator.

(b)(1) Subject to paragraph (b)(2) of this section, a one-stop operator may not perform the following functions: Convene system stakeholders to assist in the development of the local plan; prepare and submit local plans (as required under sec. 107 of WIOA); be responsible for oversight of itself; manage or significantly participate in the competitive selection process for one-stop operators; select or terminate one-stop operators, career services, and youth providers; negotiate local performance accountability measures; or develop and submit budget for activities of the Local WDB in the local area.

(2) An entity serving as a one-stop operator, that also serves a different role within the one-stop delivery system, may perform some or all of these functions when it is acting in its other role, if it has established sufficient firewalls and conflict of interest policies and procedures. The policies and procedures must conform to the specifications in § 679.430 of this chapter for demonstrating internal controls and preventing conflict of interest.

§ 678.625 Can a one-stop operator also be a service provider?

Yes, but there must be appropriate firewalls in place in regards to the competition, and subsequent oversight,

monitoring, and evaluation of performance of the service provider. The operator cannot develop, manage, or conduct the competition of a service provider in which it intends to compete. In cases where an operator is also a service provider, there must be firewalls and internal controls within the operator-service provider entity, as well as specific policies and procedures at the Local WDB level regarding oversight, monitoring, and evaluation of performance of the service provider. The firewalls must conform to the specifications in § 679.430 of this chapter for demonstrating internal controls and preventing conflicts of interest.

§ 678.630 Can State merit staff still work in a one-stop center where the operator is not a governmental entity?

Yes. State merit staff can continue to perform functions and activities in the one-stop center. The Local WDB and one-stop operator must establish a system for management of merit staff in accordance with State policies and procedures. Continued use of State merit staff for the provision of Wagner-Peyser Act services or services from other programs with merit staffing requirements must be included in the competition for and final contract with the one-stop operator when Wagner-Peyser Act services or services from other programs with merit staffing requirements are being provided.

§ 678.635 What is the compliance date of the provisions of this subpart?

(a) No later than July 1, 2017, one-stop operators selected under the competitive process described in this subpart must be in place and operating the one-stop center.

(b) By November 17, 2016, every Local WDB must demonstrate it is taking steps to prepare for competition of its one-stop operator. This demonstration may include, but is not limited to, market research, requests for information, and conducting a cost and price analysis.

Subpart E—One-Stop Operating Costs

§ 678.700 What are the one-stop infrastructure costs?

(a) Infrastructure costs of one-stop centers are nonpersonnel costs that are necessary for the general operation of the one-stop center, including:

(1) Rental of the facilities;

(2) Utilities and maintenance;

(3) Equipment (including assessment-related products and assistive technology for individuals with disabilities); and

(4) Technology to facilitate access to the one-stop center, including technology used for the center's planning and outreach activities.

(b) Local WDBs may consider common identifier costs as costs of one-stop infrastructure.

(c) Each entity that carries out a program or activities in a local one-stop center, described in §§ 678.400 through 678.410, must use a portion of the funds available for the program and activities to maintain the one-stop delivery system, including payment of the infrastructure costs of one-stop centers. These payments must be in accordance with this subpart; Federal cost principles, which require that all costs must be allowable, reasonable, necessary, and allocable to the program; and all other applicable legal requirements.

§ 678.705 What guidance must the Governor issue regarding one-stop infrastructure funding?

(a) The Governor, after consultation with chief elected officials, the State WDB, and Local WDBs, and consistent with guidance and policies provided by the State WDB, must develop and issue guidance for use by local areas, specifically:

(1) Guidelines for State-administered one-stop partner programs for determining such programs' contributions to a one-stop delivery system, based on such programs' proportionate use of such system, and relative benefit received, consistent with Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for

Federal Awards in 2 CFR part 200, including determining funding for the costs of infrastructure; and

(2) Guidance to assist Local WDBs, chief elected officials, and one-stop partners in local areas in determining equitable and stable methods of funding the costs of infrastructure at one-stop centers based on proportionate use and relative benefit received, and consistent with Federal cost principles contained in the Uniform Guidance at 2 CFR part 200.

(b) The guidance must include:

(1) The appropriate roles of the one-stop partner programs in identifying one-stop infrastructure costs;

(2) Approaches to facilitate equitable and efficient cost allocation that results in a reasonable cost allocation methodology where infrastructure costs are charged to each partner based on its proportionate use of the one-stop centers and relative benefit received, consistent with Federal cost principles at 2 CFR part 200; and

(3) The timelines regarding notification to the Governor for not reaching local agreement and triggering the State funding mechanism described in § 678.730, and timelines for a one-stop partner to submit an appeal in the State funding mechanism.

§ 678.710 How are infrastructure costs funded?

Infrastructure costs are funded either through the local funding mechanism described in § 678.715 or through the State funding mechanism described in § 678.730.

§ 678.715 How are one-stop infrastructure costs funded in the local funding mechanism?

(a) In the local funding mechanism, the Local WDB, chief elected officials, and one-stop partners agree to amounts and methods of calculating amounts each partner will contribute for one-stop infrastructure funding, include the infrastructure funding terms in the MOU, and sign the MOU. The local funding mechanism must meet all of the following requirements:

(1) The infrastructure costs are funded through cash and fairly evaluated non-cash and third-party in-kind partner contributions and include any funding from philanthropic organizations or other private entities, or through other alternative financing options, to provide a stable and equitable funding stream for ongoing one-stop delivery system operations;

(2) Contributions must be negotiated between one-stop partners, chief elected officials, and the Local WDB and the amount to be contributed must be included in the MOU;

(3) The one-stop partner program's proportionate share of funding must be calculated in accordance with the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards in 2 CFR part 200 based upon a reasonable cost allocation methodology whereby infrastructure costs are charged to each partner in proportion to its use of the one-stop center, relative to benefits received. Such costs must also be allowable, reasonable, necessary, and allocable;

(4) Partner shares must be periodically reviewed and reconciled against actual costs incurred, and adjusted to ensure that actual costs charged to any one-stop partners are proportionate to the use of the one-stop center and relative to the benefit received by the one-stop partners and their respective programs or activities.

(b) In developing the section of the MOU on one-stop infrastructure funding described in § 678.755, the Local WDB and chief elected officials will:

(1) Ensure that the one-stop partners adhere to the guidance identified in § 678.705 on one-stop delivery system infrastructure costs.

(2) Work with one-stop partners to achieve consensus and informally mediate any possible conflicts or disagreements among one-stop partners.

(3) Provide technical assistance to new one-stop partners and local grant recipients to ensure that those entities are informed and knowledgeable of the elements contained in the MOU and the one-stop infrastructure costs arrangement.

(c) The MOU may include an interim infrastructure funding agreement, including as much detail as the Local WDB has negotiated with one-stop partners, if all other parts of the MOU have been negotiated, in order to allow

the partner programs to operate in the one-stop centers. The interim infrastructure funding agreement must be finalized within 6 months of when the MOU is signed. If the interim infrastructure funding agreement is not finalized within that timeframe, the Local WDB must notify the Governor, as described in § 678.725.

§ 678.720 What funds are used to pay for infrastructure costs in the local one-stop infrastructure funding mechanism?

(a) In the local funding mechanism, one-stop partner programs may determine what funds they will use to pay for infrastructure costs. The use of these funds must be in accordance with the requirements in this subpart, and with the relevant partner's authorizing statutes and regulations, including, for example, prohibitions against supplanting non-Federal resources, statutory limitations on administrative costs, and all other applicable legal requirements. In the case of partners administering programs authorized by title I of WIOA, these infrastructure costs may be considered program costs. In the case of partners administering adult education and literacy programs authorized by title II of WIOA, these funds must include Federal funds made available for the local administration of adult education and literacy programs authorized by title II of WIOA. These funds may also include non-Federal resources that are cash, in-kind or third-party contributions. In the case of partners administering the Carl D. Perkins Career and Technical Education Act of 2006, funds used to pay for infrastructure costs may include funds available for local administrative expenses, non-Federal resources that are cash, in-kind or third-party contributions, and may include other funds made available by the State.

(b) There are no specific caps on the amount or percent of overall funding a one-stop partner may contribute to fund infrastructure costs under the local funding mechanism, except that contributions for administrative costs may not exceed the amount available for administrative costs under the authorizing statute of the partner program. However, amounts contributed for infrastructure costs must be allowable and based on proportionate use of the one-stop centers and relative benefit received by the partner program, taking into account the total cost of the one-stop infrastructure as well as alternate financing options, and must be consistent with 2 CFR part 200, including the Federal cost principles.

(c) Cash, non-cash, and third-party in-kind contributions may be provided by one-stop partners to cover their proportionate share of infrastructure costs.

(1) Cash contributions are cash funds provided to the Local WDB or its designee by one-stop partners, either directly or by an interagency transfer.

(2) Non-cash contributions are comprised of—

(i) Expenditures incurred by one-stop partners on behalf of the one-stop center; and

(ii) Non-cash contributions or goods or services contributed by a partner program and used by the one-stop center.

(3) Non-cash contributions, especially those set forth in paragraph (c)(2)(ii) of this section, must be valued consistent with 2 CFR 200.306 to ensure they are fairly evaluated and meet the partners' proportionate share.

(4) Third-party in-kind contributions are:

(i) Contributions of space, equipment, technology, non-personnel services, or other like items to support the infrastructure costs associated with one-stop operations, by a non-one-stop partner to support the one-stop center in general, not a specific partner; or

(ii) Contributions by a non-one-stop partner of space, equipment, technology, non-personnel services, or other like items to support the infrastructure costs associated with one-stop operations, to a one-stop partner to support its proportionate share of one-stop infrastructure costs.

(iii) In-kind contributions described in paragraphs (c)(4)(i) and (ii) of this section must be valued consistent with 2 CFR 200.306 and reconciled on a regular basis to ensure they are fairly evaluated and meet the proportionate share of the partner.

(5) All partner contributions, regardless of the type, must be reconciled on

a regular basis (*i.e.*, monthly or quarterly), comparing actual expenses incurred to relative benefits received, to ensure each partner program is contributing its proportionate share in accordance with the terms of the MOU.

§ 678.725 What happens if consensus on infrastructure funding is not reached at the local level between the Local Workforce Development Board, chief elected officials, and one-stop partners?

With regard to negotiations for infrastructure funding for Program Year (PY) 2017 and for each subsequent program year thereafter, if the Local WDB, chief elected officials, and one-stop partners do not reach consensus on methods of sufficiently funding local infrastructure through the local funding mechanism in accordance with the Governor's guidance issued under § 678.705 and consistent with the regulations in §§ 678.715 and 678.720, and include that consensus agreement in the signed MOU, then the Local WDB must notify the Governor by the deadline established by the Governor under § 678.705(b)(3). Once notified, the Governor must administer funding through the State funding mechanism, as described in §§ 678.730 through 678.738, for the program year impacted by the local area's failure to reach consensus.

§ 678.730 What is the State one-stop infrastructure funding mechanism?

(a) Consistent with sec. 121(h)(1)(A)(i)(II) of WIOA, if the Local WDB, chief elected official, and one-stop partners in a local area do not reach consensus agreement on methods of sufficiently funding the costs of infrastructure of one-stop centers for a program year, the State funding mechanism is applicable to the local area for that program year.

(b) In the State funding mechanism, the Governor, subject to the limitations in paragraph (c) of this section, determines one-stop partner contributions after consultation with the chief elected officials, Local WDBs, and the State WDB. This determination involves:

(1) The application of a budget for one-stop infrastructure costs as described in § 678.735, based on either agreement reached in the local area negotiations or the State WDB formula outlined in § 678.745;

(2) The determination of each local one-stop partner program's proportionate use of the one-stop delivery system and relative benefit received, consistent with the Uniform Guidance at 2 CFR part 200, including the Federal cost principles, the partner programs' authorizing laws and regulations, and other applicable legal requirements described in § 678.736; and

(3) The calculation of required statewide program caps on contributions to infrastructure costs from one-stop partner programs in areas operating under the State funding mechanism as described in § 678.738.

(c) In certain situations, the Governor does not determine the infrastructure cost contributions for some one-stop partner programs under the State funding mechanism.

(1) The Governor will not determine the contribution amounts for infrastructure funds for Native American program grantees described in part 684 of this chapter. The appropriate portion of funds to be provided by Native American program grantees to pay for one-stop infrastructure must be determined as part of the development of the MOU described in § 678.500 and specified in that MOU.

(2) In States in which the policymaking authority is placed in an entity or official that is independent of the authority of the Governor with respect to the funds provided for adult education and literacy activities authorized under title II of WIOA, postsecondary career and technical education activities authorized under the Carl D. Perkins Career and Technical Education Act of 2006, or VR services authorized under title I of the Rehabilitation Act of 1973 (other than sec. 112 or part C), as amended by WIOA title IV, the determination of the amount each of the applicable partners must contribute to assist in paying the infrastructure costs of one-stop centers must be made by the official or chief officer of the entity with such authority, in consultation with the Governor.

(d) Any duty, ability, choice, responsibility, or other action otherwise related to the determination of infrastructure costs contributions that is

assigned to the Governor in §§ 678.730 through 678.745 also applies to this decision-making process performed by the official or chief officer described in paragraph (c)(2) of this section.

§ 678.731 What are the steps to determine the amount to be paid under the State one-stop infrastructure funding mechanism?

(a) To initiate the State funding mechanism, a Local WDB that has not reached consensus on methods of sufficiently funding local infrastructure through the local funding mechanism as provided in § 678.725 must notify the Governor by the deadline established by the Governor under § 678.705(b)(3).

(b) Once a Local WDB has informed the Governor that no consensus has been reached:

(1) The Local WDB must provide the Governor with local negotiation materials in accordance with § 678.735(a).

(2) The Governor must determine the one-stop center budget by either:

(i) Accepting a budget previously agreed upon by partner programs in the local negotiations, in accordance with § 678.735(b)(1); or

(ii) Creating a budget for the one-stop center using the State WDB formula (described in § 678.745) in accordance with § 678.735(b)(3).

(3) The Governor then must establish a cost allocation methodology to determine the one-stop partner programs' proportionate shares of infrastructure costs, in accordance with § 678.736.

(4)(i) Using the methodology established under paragraph (b)(2)(ii) of this section, and taking into consideration the factors concerning individual partner programs listed in § 678.737(b)(2), the Governor must determine each partner's proportionate share of the infrastructure costs, in accordance with § 678.737(b)(1), and

(ii) In accordance with § 678.730(c), in some instances, the Governor does not determine a partner program's proportionate share of infrastructure funding costs, in which case it must be determined by the entities named in § 678.730(c)(1) and (2).

(5) The Governor must then calculate the statewide caps on the amounts that partner programs may be required to contribute toward infrastructure funding, according to the steps found at § 678.738(a)(1) through (4).

(6) The Governor must ensure that the aggregate total of the infrastructure contributions according to proportionate share required of all local partner programs in local areas under the State funding mechanism do not exceed the cap for that particular program, in accordance with § 678.738(b)(1). If the total does not exceed the cap, the Governor must direct each one-stop partner program to pay the amount determined under § 678.737(a) toward the infrastructure funding costs of the one-stop center. If the total does exceed the cap, then to determine the amount to direct each one-stop program to pay, the Governor may:

(i) Ascertain, in accordance with § 678.738(b)(2)(i), whether the local partner or partners whose proportionate shares are calculated above the individual program caps are willing to voluntarily contribute above the capped amount to equal that program's proportionate share; or

(ii) Choose from the options provided in § 678.738(b)(2)(ii), including having the local area re-enter negotiations to reassess each one-stop partner's proportionate share and make adjustments or identify alternate sources of funding to make up the difference between the capped amount and the proportionate share of infrastructure funding of the one-stop partner.

(7) If none of the solutions given in paragraphs (b)(6)(i) and (ii) of this section prove to be viable, the Governor must reassess the proportionate shares of each one-stop partner so that the aggregate amount attributable to the local partners for each program is less than that program's cap amount. Upon such reassessment, the Governor must direct each one-stop partner program to pay the reassessed amount toward the infrastructure funding costs of the one-stop center.

§ 678.735 How are infrastructure cost budgets for the one-stop centers in a local area determined in the State one-stop infrastructure funding mechanism?

(a) Local WDBs must provide to the Governor appropriate and relevant materials and documents used in the negotiations under the local funding

mechanism, including but not limited to: The local WIOA plan, the cost allocation method or methods proposed by the partners to be used in determining proportionate share, the proposed amounts or budget to fund infrastructure, the amount of total partner funds included, the type of funds or non-cash contributions, proposed one-stop center budgets, and any agreed upon or proposed MOUs.

(b)(1) If a local area has reached agreement as to the infrastructure budget for the one-stop centers in the local area, it must provide this budget to the Governor as required by paragraph (a) of this section. If, as a result of the agreed upon infrastructure budget, only the individual programmatic contributions to infrastructure funding based upon proportionate use of the one-stop centers and relative benefit received are at issue, the Governor may accept the budget, from which the Governor must calculate each partner's contribution consistent with the cost allocation methodologies contained in the Uniform Guidance found in 2 CFR part 200, as described in § 678.736.

(2) The Governor may also take into consideration the extent to which the partners in the local area have agreed in determining the proportionate shares, including any agreements reached at the local level by one or more partners, as well as any other element or product of the negotiating process provided to the Governor as required by paragraph (a) of this section.

(3) If a local area has not reached agreement as to the infrastructure budget for the one-stop centers in the local area, or if the Governor determines that the agreed upon budget does not adequately meet the needs of the local area or does not reasonably work within the confines of the local area's resources in accordance with the Governor's one-stop budget guidance (which is required to be issued by WIOA sec. 121(h)(1)(B) and under § 678.705), then, in accordance with § 678.745, the Governor must use the formula developed by the State WDB based on at least the factors required under § 678.745, and any associated weights to determine the local area budget.

§ 678.736 How does the Governor establish a cost allocation methodology used to determine the one-stop partner programs' proportionate shares of infrastructure costs under the State one-stop infrastructure funding mechanism?

Once the appropriate budget is determined for a local area through either method described in § 678.735 (by acceptance of a budget agreed upon in local negotiation or by the Governor applying the formula detailed in § 678.745), the Governor must determine the appropriate cost allocation methodology to be applied to the one-stop partners in such local area, consistent with the Federal cost principles permitted under 2 CFR part 200, to fund the infrastructure budget.

§ 678.737 How are one-stop partner programs' proportionate shares of infrastructure costs determined under the State one-stop infrastructure funding mechanism?

(a) The Governor must direct the one-stop partners in each local area that have not reached agreement under the local funding mechanism to pay what the Governor determines is each partner program's proportionate share of infrastructure funds for that area, subject to the application of the caps described in § 678.738.

(b)(1) The Governor must use the cost allocation methodology—as determined under § 678.736—to determine each partner's proportionate share of the infrastructure costs under the State funding mechanism, subject to considering the factors described in paragraph (b)(2) of this section.

(2) In determining each partner program's proportionate share of infrastructure costs, the Governor must take into account the costs of administration of the one-stop delivery system for purposes not related to one-stop centers for each partner (such as costs associated with maintaining the Local WDB or information technology systems), as well as the statutory requirements for each partner program, the partner program's ability to fulfill such requirements, and all other applicable legal requirements. The Governor may also take into consideration the extent to which the partners in the local area have agreed in determining

the proportionate shares, including any agreements reached at the local level by one or more partners, as well as any other materials or documents of the negotiating process, which must be provided to the Governor by the Local WDB and described in § 678.735(a).

§ 678.738 How are statewide caps on the contributions for one-stop infrastructure funding determined in the State one-stop infrastructure funding mechanism?

(a) The Governor must calculate the statewide cap on the contributions for one-stop infrastructure funding required to be provided by each one-stop partner program for those local areas that have not reached agreement. The cap is the amount determined under paragraph (a)(4) of this section, which the Governor derives by:

(1) First, determining the amount resulting from applying the percentage for the corresponding one-stop partner program provided in paragraph (d) of this section to the amount of Federal funds provided to carry out the one-stop partner program in the State for the applicable fiscal year;

(2) Second, selecting a factor (or factors) that reasonably indicates the use of one-stop centers in the State, applying such factor(s) to all local areas in the State, and determining the percentage of such factor(s) applicable to the local areas that reached agreement under the local funding mechanism in the State;

(3) Third, determining the amount resulting from applying the percentage determined in paragraph (a)(2) of this section to the amount determined under paragraph (a)(1) of this section for the one-stop partner program; and

(4) Fourth, determining the amount that results from subtracting the amount determined under paragraph (a)(3) of this section from the amount determined under paragraph (a)(1) of this section. The outcome of this final calculation results in the partner program's cap.

(b)(1) The Governor must ensure that the funds required to be contributed by each partner program in the local areas in the State under the State funding mechanism, in aggregate, do not exceed the statewide cap for each program as determined under paragraph (a) of this section.

(2) If the contributions initially determined under § 678.737 would exceed the applicable cap determined under paragraph (a) of this section, the Governor may:

(i) Ascertain if the one-stop partner whose contribution would otherwise exceed the cap determined under paragraph (a) of this section will voluntarily contribute above the capped amount, so that the total contributions equal that partner's proportionate share. The one-stop partner's contribution must still be consistent with the program's authorizing laws and regulations, the Federal cost principles in 2 CFR part 200, and other applicable legal requirements; or

(ii) Direct or allow the Local WDB, chief elected officials, and one-stop partners to: Re-enter negotiations, as necessary; reduce the infrastructure costs to reflect the amount of funds that are available for such costs without exceeding the cap levels; reassess the proportionate share of each one-stop partner; or identify alternative sources of financing for one-stop infrastructure funding, consistent with the requirement that each one-stop partner pay an amount that is consistent with the proportionate use of the one-stop center and relative benefit received by the partner, the program's authorizing laws and regulations, the Federal cost principles in 2 CFR part 200, and other applicable legal requirements.

(3) If applicable under paragraph (b)(2)(ii) of this section, the Local WDB, chief elected officials, and one-stop partners, after renegotiation, may come to agreement, sign an MOU, and proceed under the local funding mechanism. Such actions do not require the redetermination of the applicable caps under paragraph (a) of this section.

(4) If, after renegotiation, agreement among partners still cannot be reached or alternate financing cannot be identified, the Governor may adjust the specified allocation, in accordance with the amounts available and the limitations

described in paragraph (d) of this section. In determining these adjustments, the Governor may take into account information relating to the renegotiation as well as the information described in § 678.735(a).

(c) *Limitations.* Subject to paragraph (a) of this section and in accordance with WIOA sec. 121(h)(2)(D), the following limitations apply to the Governor's calculations of the amount that one-stop partners in local areas that have not reached agreement under the local funding mechanism may be required under § 678.736 to contribute to one-stop infrastructure funding:

(1) *WIOA formula programs and Wagner-Peyser Act Employment Service.* The portion of funds required to be contributed under the WIOA youth, adult, or dislocated worker programs, or under the Wagner-Peyser Act (29 U.S.C. 49 *et seq.*) must not exceed three percent of the amount of the program in the State for a program year.

(2) *Other one-stop partners.* For required one-stop partners other than those specified in paragraphs (c)(1), (3), (5), and (6) of this section, the portion of funds required to be contributed must not exceed 1.5 percent of the amount of Federal funds provided to carry out that program in the State for a fiscal year. For purposes of the Carl D. Perkins Career and Technical Education Act of 2006, the cap on contributions is determined based on the funds made available by the State for postsecondary level programs and activities under sec. 132 of the Carl D. Perkins Career and Technical Education Act and the amount of funds used by the State under sec. 112(a)(3) of the Perkins Act during the prior year to administer postsecondary level programs and activities, as applicable.

(3) *Vocational rehabilitation.* (i) Within a State, for the entity or entities administering the programs described in WIOA sec. 121(b)(1)(B)(iv) and § 678.400, the allotment is based on the one State Federal fiscal year allotment, even in instances where that allotment is shared between two State agencies, and the cumulative portion of funds required to be contributed must not exceed—

(A) 0.75 percent of the amount of Federal funds provided to carry out such program in the State for Fiscal Year 2016 for purposes of applicability of the State funding mechanism for PY 2017;

(B) 1.0 percent of the amount provided to carry out such program in the State for Fiscal Year 2017 for purposes of applicability of the State funding mechanism for PY 2018;

(C) 1.25 percent of the amount provided to carry out such program in the State for Fiscal Year 2018 for purposes of applicability of the State funding mechanism for PY 2019;

(D) 1.5 percent of the amount provided to carry out such program in the State for Fiscal Year 2019 and following years for purposes of applicability of the State funding mechanism for PY 2020 and subsequent years.

(ii) The limitations set forth in paragraph (d)(3)(i) of this section for any given fiscal year must be based on the final VR allotment to the State in the applicable Federal fiscal year.

(4) *Federal direct spending programs.* For local areas that have not reached a one-stop infrastructure funding agreement by consensus, an entity administering a program funded with direct Federal spending, as defined in sec. 250(c)(8) of the Balanced Budget and Emergency Deficit Control Act of 1985, as in effect on February 15, 2014 (2 U.S.C. 900(c)(8)), must not be required to provide more for infrastructure costs than the amount that the Governor determined (as described in § 678.737).

(5) *TANF programs.* For purposes of TANF, the cap on contributions is determined based on the total Federal TANF funds expended by the State for work, education, and training activities during the prior Federal fiscal year (as reported to the Department of Health and Human Services (HHS) on the quarterly TANF Financial Report form), plus any additional amount of Federal TANF funds that the State TANF agency reasonably determines was expended for administrative costs in connection with these activities but that was separately reported to HHS as an administrative cost. The State's contribution to the one-stop infrastructure must not exceed 1.5 percent of these combined expenditures.

(6) *Community Services Block Grant (CSBG) programs.* For purposes of

CSBG, the cap on contributions will be based on the total amount of CSBG funds determined by the State to have been expended by local CSBG-eligible entities for the provision of employment and training activities during the prior Federal fiscal year for which information is available (as reported to HHS on the CSBG Annual Report) and any additional amount that the State CSBG agency reasonably determines was expended for administrative purposes in connection with these activities and was separately reported to HHS as an administrative cost. The State's contribution must not exceed 1.5 percent of these combined expenditures.

(d) For programs for which it is not otherwise feasible to determine the amount of Federal funding used by the program until the end of that program's operational year—because, for example, the funding available for education, employment, and training activities is included within funding for the program that may also be used for other unrelated activities—the determination of the Federal funds provided to carry out the program for a fiscal year under paragraph (a)(1) of this section may be determined by:

(1) The percentage of Federal funds available to the one-stop partner program that were used by the one-stop partner program for education, employment, and training activities in the previous fiscal year for which data are available; and

(2) Applying the percentage determined under paragraph (d)(1) of this section to the total amount of Federal funds available to the one-stop partner program for the fiscal year for which the determination under paragraph (a)(1) of this section applies.

§ 678.740 What funds are used to pay for infrastructure costs in the State one-stop infrastructure funding mechanism?

(a) In the State funding mechanism, infrastructure costs for WIOA title I programs, including Native American Programs described in part 684 of this chapter, may be paid using program funds, administrative funds, or both. Infrastructure costs for the Senior Community Service Employment Program under title V of the Older Americans Act (42 U.S.C. 3056 *et seq.*) may also be paid using program funds, administrative funds, or both.

(b) In the State funding mechanism, infrastructure costs for other required one-stop partner programs (listed in §§ 678.400 through 678.410) are limited to the program's administrative funds, as appropriate.

(c) In the State funding mechanism, infrastructure costs for the adult education program authorized by title II of WIOA must be paid from the funds that are available for local administration and may be paid from funds made available by the State or non-Federal resources that are cash, in-kind, or third-party contributions.

(d) In the State funding mechanism, infrastructure costs for the Carl D. Perkins Career and Technical Education Act of 2006 must be paid from funds available for local administration of postsecondary level programs and activities to eligible recipients or consortia of eligible recipients and may be paid from funds made available by the State or non-Federal resources that are cash, in-kind, or third-party contributions.

§ 678.745 What factors does the State Workforce Development Board use to develop the formula described in Workforce Innovation and Opportunity Act, which is used by the Governor to determine the appropriate one-stop infrastructure budget for each local area operating under the State infrastructure funding mechanism, if no reasonably implementable locally negotiated budget exists?

The State WDB must develop a formula, as described in WIOA sec. 121(h)(3)(B), to be used by the Governor under § 678.735(b)(3) in determining the appropriate budget for the infrastructure costs of one-stop centers in the local areas that do not reach agreement under the local funding mechanism and are, therefore, subject to the State funding mechanism. The formula identifies the factors and corresponding weights for each factor that the Governor must use, which must include: The number of one-stop centers in a local area; the population served by such centers; the services provided

by such centers; and any factors relating to the operations of such centers in the local area that the State WDB determines are appropriate. As indicated in §678.735(b)(1), if the local area has agreed on such a budget, the Governor may accept that budget in lieu of applying the formula factors.

§ 678.750 When and how can a one-stop partner appeal a one-stop infrastructure amount designated by the State under the State infrastructure funding mechanism?

(a) The Governor must establish a process, described under sec. 121(h)(2)(E) of WIOA, for a one-stop partner administering a program described in §§678.400 through 678.410 to appeal the Governor's determination regarding the one-stop partner's portion of funds to be provided for one-stop infrastructure costs. This appeal process must be described in the Unified State Plan.

(b) The appeal may be made on the ground that the Governor's determination is inconsistent with proportionate share requirements in §678.735(a), the cost contribution limitations in §678.735(b), the cost contribution caps in §678.738, consistent with the process described in the State Plan.

(c) The process must ensure prompt resolution of the appeal in order to ensure the funds are distributed in a timely manner, consistent with the requirements of §683.630 of this chapter.

(d) The one-stop partner must submit an appeal in accordance with State's deadlines for appeals specified in the guidance issued under §678.705(b)(3), or if the State has not set a deadline, within 21 days from the Governor's determination.

§ 678.755 What are the required elements regarding infrastructure funding that must be included in the one-stop Memorandum of Understanding?

The MOU, fully described in §678.500, must contain the following information whether the local areas use either the local one-stop or the State funding method:

(a) The period of time in which this infrastructure funding agreement is effective. This may be a different time period than the duration of the MOU.

(b) Identification of an infrastructure and shared services budget that will be periodically reconciled against actual costs incurred and adjusted accordingly to ensure that it reflects a cost allocation methodology that demonstrates how infrastructure costs are charged to each partner in proportion to its use of the one-stop center and relative benefit received, and that complies with 2 CFR part 200 (or any corresponding similar regulation or ruling).

(c) Identification of all one-stop partners, chief elected officials, and Local WDB participating in the infrastructure funding arrangement.

(d) Steps the Local WDB, chief elected officials, and one-stop partners used to reach consensus or an assurance that the local area followed the guidance for the State funding process.

(e) Description of the process to be used among partners to resolve issues during the MOU duration period when consensus cannot be reached.

(f) Description of the periodic modification and review process to ensure equitable benefit among one-stop partners.

§ 678.760 How do one-stop partners jointly fund other shared costs under the Memorandum of Understanding?

(a) In addition to jointly funding infrastructure costs, one-stop partners listed in §§678.400 through 678.410 must use a portion of funds made available under their programs' authorizing Federal law (or fairly evaluated in-kind contributions) to pay the additional costs relating to the operation of the one-stop delivery system. These other costs must include applicable career services and may include other costs, including shared services.

(b) For the purposes of paragraph (a) of this section, shared services' costs may include the costs of shared services that are authorized for and may be commonly provided through the one-stop partner programs to any individual, such as initial intake, assessment of needs, appraisal of basic skills, identification of appropriate services to meet such needs, referrals to other one-stop partners, and business services. Shared operating costs may also

include shared costs of the Local WDB's functions.

(c) Contributions to the additional costs related to operation of the one-stop delivery system may be cash, non-cash, or third-party in-kind contributions, consistent with how these are described in § 678.720(c).

(d) The shared costs described in paragraph (a) of this section must be allocated according to the proportion of benefit received by each of the partners, consistent with the Federal law authorizing the partner's program, and consistent with all other applicable legal requirements, including Federal cost principles in 2 CFR part 200 (or any corresponding similar regulation or ruling) requiring that costs are allowable, reasonable, necessary, and allocable.

(e) Any shared costs agreed upon by the one-stop partners must be included in the MOU.

Subpart F—One-Stop Certification

§ 678.800 How are one-stop centers and one-stop delivery systems certified for effectiveness, physical and programmatic accessibility, and continuous improvement?

(a) The State WDB, in consultation with chief elected officials and Local WDBs, must establish objective criteria and procedures for Local WDBs to use when certifying one-stop centers.

(1) The State WDB, in consultation with chief elected officials and Local WDBs, must review and update the criteria every 2 years as part of the review and modification of State Plans pursuant to § 676.135 of this chapter.

(2) The criteria must be consistent with the Governor's and State WDB's guidelines, guidance, and policies on infrastructure funding decisions, described in § 678.705. The criteria must evaluate the one-stop centers and one-stop delivery system for effectiveness, including customer satisfaction, physical and programmatic accessibility, and continuous improvement.

(3) When the Local WDB is the one-stop operator as described in § 679.410 of this chapter, the State WDB must certify the one-stop center.

(b) Evaluations of effectiveness must include how well the one-stop center integrates available services for participants and businesses, meets the workforce development needs of participants and the employment needs of local employers, operates in a cost-efficient manner, coordinates services among the one-stop partner programs, and provides access to partner program services to the maximum extent practicable, including providing services outside of regular business hours where there is a workforce need, as identified by the Local WDB. These evaluations must take into account feedback from one-stop customers. They must also include evaluations of how well the one-stop center ensures equal opportunity for individuals with disabilities to participate in or benefit from one-stop center services. These evaluations must include criteria evaluating how well the centers and delivery systems take actions to comply with the disability-related regulations implementing WIOA sec. 188, set forth at 29 CFR part 38. Such actions include, but are not limited to:

(1) Providing reasonable accommodations for individuals with disabilities;

(2) Making reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination against persons with disabilities;

(3) Administering programs in the most integrated setting appropriate;

(4) Communicating with persons with disabilities as effectively as with others;

(5) Providing appropriate auxiliary aids and services, including assistive technology devices and services, where necessary to afford individuals with disabilities an equal opportunity to participate in, and enjoy the benefits of, the program or activity; and

(6) Providing for the physical accessibility of the one-stop center to individuals with disabilities.

(c) Evaluations of continuous improvement must include how well the one-stop center supports the achievement of the negotiated local levels of performance for the indicators of performance for the local area described in sec. 116(b)(2) of WIOA and part 677 of this chapter. Other continuous improvement factors may include a regular process for identifying and responding to technical assistance needs,

a regular system of continuing professional staff development, and having systems in place to capture and respond to specific customer feedback.

(d) Local WDBs must assess at least once every 3 years the effectiveness, physical and programmatic accessibility, and continuous improvement of one-stop centers and the one-stop delivery systems using the criteria and procedures developed by the State WDB. The Local WDB may establish additional criteria, or set higher standards for service coordination, than those set by the State criteria. Local WDBs must review and update the criteria every 2 years as part of the Local Plan update process described in § 676.580 of this chapter. Local WDBs must certify one-stop centers in order to be eligible to use infrastructure funds in the State funding mechanism described in § 678.730.

(e) All one-stop centers must comply with applicable physical and programmatic accessibility requirements, as set forth in 29 CFR part 38, the implementing regulations of WIOA sec. 188.

Subpart G—Common Identifier

§ 678.900 What is the common identifier to be used by each one-stop delivery system?

(a) The common one-stop delivery system identifier is ''American Job Center.''

(b) As of November 17, 2016, each one-stop delivery system must include the ''American Job Center'' identifier or ''a proud partner of the American Job Center network'' on all primary electronic resources used by thONTENTS≤ e one-stop delivery system, and on any newly printed, purchased, or created materials.

(c) As of July 1, 2017, each one-stop delivery system must include the ''American Job Center'' identifier or ''a proud partner of the American Job Center network'' on all products, programs, activities, services, electronic resources, facilities, and related property and new materials used in the one-stop delivery system.

(d) One-stop partners, States, or local areas may use additional identifiers on their products, programs, activities, services, facilities, and related property and materials.

PART 679—STATEWIDE AND LOCAL GOVERNANCE OF THE WORKFORCE DEVELOPMENT SYSTEM UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

Subpart A—State Workforce Development Board

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Subpart A—State Workforce Development Board

§ 679.100 What is the purpose of the State Workforce Development Board?

The purpose of the State Workforce Development Board (WDB) is to convene State, regional, and local workforce system and partners, to—

(a) Enhance the capacity and performance of the workforce development system;

(b) Align and improve the outcomes and effectiveness of Federally-funded and other workforce programs and investments; and

(c) Through these efforts, promote economic growth.

(d) Engage public workforce system representatives, including businesses, education providers, economic development, labor representatives, and other

stakeholders to help the workforce development system achieve the purpose of the Workforce Innovation and Opportunity Act (WIOA); and

(e) Assist to achieve the State's strategic and operational vision and goals as outlined in the State Plan.

§ 679.110 What is the State Workforce Development Board?

(a) The State WDB is a board established by the Governor in accordance with the requirements of WIOA sec. 101 and this section.

(b) The membership of the State WDB must meet the requirements of WIOA sec. 101(b) and must represent diverse geographic areas of the State, including urban, rural, and suburban areas. The WDB membership must include:

(1) The Governor;

(2) A member of each chamber of the State legislature, appointed by the appropriate presiding officers of such chamber, as appropriate under State law; and

(3) Members appointed by the Governor, which must include:

(i) A majority of representatives of businesses or organizations in the State who:

(A) Are the owner or chief executive officer for the business or organization, or is an executive with the business or organization with optimum policy-making or hiring authority, and also may be members of a Local WDB as described in WIOA sec. 107(b)(2)(A)(i);

(B) Represent businesses, or organizations that represent businesses described in paragraph (b)(3)(i) of this section, that, at a minimum, provide employment and training opportunities that include high-quality, work-relevant training and development in in-demand industry sectors or occupations in the State; and

(C) Are appointed from a list of potential members nominated by State business organizations and business trade associations; and

(D) At a minimum, one member representing small businesses as defined by the U.S. Small Business Administration.

(ii) Not less than 20 percent who are representatives of the workforce within the State, which:

(A) Must include two or more representatives of labor organizations nominated by State labor federations;

(B) Must include one representative who must be a member of a labor organization or training director from a joint labor-management registered apprenticeship program, or, if no such joint program exists in the State, a member of a labor organization or training director who is a representative of an registered apprenticeship program;

(C) May include one or more representatives of community-based organizations that have demonstrated experience and expertise in addressing the employment, training, or education needs of individuals with barriers to employment, including organizations that serve veterans or provide or support competitive, integrated employment for individuals with disabilities; and

(D) May include one or more representatives of organizations that have demonstrated experience and expertise in addressing the employment, training, or education needs of eligible youth, including representatives of organizations that serve out-of-school youth.

(iii) The balance of the members:

(A) Must include representatives of the Government including:

(*1*) The lead State officials with primary responsibility for the following core programs—

(*i*) The adult, dislocated worker, and youth programs authorized under title I of WIOA and the Wagner-Peyser Act;

(*ii*) The Adult Education and Family Literacy Act (AEFLA) program authorized under title II of WIOA; and

(*iii*) The State Vocational Rehabilitation (VR) program authorized under the Rehabilitation Act of 1973, as amended by title IV of WIOA.

(*iv*) Where the lead official represents more than one core program, that official must ensure adequate representation of the needs of all core programs under his or her jurisdiction.

(*2*) Two or more chief elected officials (collectively representing both cities and counties, where appropriate).

(B) May include other appropriate representatives and officials designated

by the Governor, such as, but not limited to, State agency officials responsible for one-stop partner programs, economic development or juvenile justice programs in the State, individuals who represent an Indian tribe or tribal organization as defined in WIOA sec. 166(b), and State agency officials responsible for education programs in the State, including chief executive officers of community colleges and other institutions of higher education.

(c) The Governor must select a chairperson for the State WDB from the business representatives on the WDB described in paragraph (b)(3)(i) of this section).

(d) The Governor must establish bylaws that at a minimum address:

(1) The nomination process used by the Governor to select the State WDB chair and members;

(2) The term limitations and how the term appointments will be staggered to ensure only a portion of membership expire in a given year;

(3) The process to notify the Governor of a WDB member vacancy to ensure a prompt nominee;

(4) The proxy and alternative designee process that will be used when a WDB member is unable to attend a meeting and assigns a designee as per the following requirements:

(i) If the alternative designee is a business representative, he or she must have optimum policy-making hiring authority.

(ii) Other alternative designees must have demonstrated experience and expertise and optimum policy-making authority.

(5) The use of technology, such as phone and Web-based meetings, that must be used to promote WDB member participation;

(6) The process to ensure members actively participate in convening the workforce development system's stakeholders, brokering relationships with a diverse range of employers, and leveraging support for workforce development activities; and

(7) Other conditions governing appointment or membership on the State WDB as deemed appropriate by the Governor.

(e) Members who represent organizations, agencies or other entities described in paragraphs (b)(3)(ii) through (iii) of this section must be individuals who have optimum policy-making authority in the organization or for the core program that they represent.

(f)(1) A State WDB member may not represent more than one of the categories described in:

(i) Paragraph (b)(3)(i) of this section (business representatives);

(ii) Paragraph (b)(3)(ii) of this section (workforce representatives); or

(iii) Paragraph (b)(3)(iii) of this section (government representatives).

(2) A State WDB member may not serve as a representative of more than one subcategory under paragraph (b)(3)(ii) of this section.

(3) A State WDB member may not serve as a representative of more than one subcategory under paragraph (b)(3)(iii) of this section, except that where a single government agency is responsible for multiple required programs, the head of the agency may represent each of the required programs.

(g) All required WDB members must have voting privileges. The Governor also may convey voting privileges to non-required members.

§ 679.120 What is meant by the terms "optimum policy-making authority" and "demonstrated experience and expertise"?

For purposes of § 679.110:

(a) A representative with ''optimum policy-making authority'' is an individual who can reasonably be expected to speak affirmatively on behalf of the entity he or she represents and to commit that entity to a chosen course of action.

(b) A representative with ''demonstrated experience and expertise'' means an individual with documented leadership in developing or implementing workforce development, human resources, training and development, or a core program function. Demonstrated experience and expertise may include individuals with experience in education or training of job seekers with barriers to employment as described in § 679.110(b)(3)(ii)(C) and (D).

§ 679.130 What are the functions of the State Workforce Development Board?

Under WIOA sec. 101(d), the State WDB must assist the Governor in the:

(a) Development, implementation, and modification of the 4-year State Plan;

(b) Review of statewide policies, programs, and recommendations on actions that must be taken by the State to align workforce development programs to support a comprehensive and streamlined workforce development system. Such review of policies, programs, and recommendations must include a review and provision of comments on the State Plans, if any, for programs and activities of one-stop partners that are not core programs;

(c) Development and continuous improvement of the workforce development system, including—

(1) Identification of barriers and means for removing barriers to better coordinate, align, and avoid duplication among programs and activities;

(2) Development of strategies to support career pathways for the purpose of providing individuals, including low-skilled adults, youth, and individuals with barriers to employment, including individuals with disabilities, with workforce investment activities, education, and supportive services to enter or retain employment;

(3) Development of strategies to provide effective outreach to and improved access for individuals and employers who could benefit from workforce development system;

(4) Development and expansion of strategies to meet the needs of employers, workers, and job seekers particularly through industry or sector partnerships related to in-demand industry sectors and occupations;

(5) Identification of regions, including planning regions for the purposes of WIOA sec. 106(a), and the designation of local areas under WIOA sec. 106, after consultation with Local WDBs and chief elected officials;

(6) Development and continuous improvement of the one-stop delivery system in local areas, including providing assistance to Local WDBs, one-stop operators, one-stop partners, and providers. Such assistance includes assistance with planning and delivering services, including training and supportive services, to support effective delivery of services to workers, job seekers, and employers; and

(7) Development of strategies to support staff training and awareness across the workforce development system and its programs;

(d) Development and updating of comprehensive State performance and accountability measures to assess core program effectiveness under WIOA sec. 116(b);

(e) Identification and dissemination of information on best practices, including best practices for—

(1) The effective operation of one-stop centers, relating to the use of business outreach, partnerships, and service delivery strategies, including strategies for serving individuals with barriers to employment;

(2) The development of effective Local WDBs, which may include information on factors that contribute to enabling Local WDBs to exceed negotiated local levels of performance, sustain fiscal integrity, and achieve other measures of effectiveness; and

(3) Effective training programs that respond to real-time labor market analysis, that effectively use direct assessment and prior learning assessment to measure an individual's prior knowledge, skills, competencies, and experiences for adaptability, to support efficient placement into employment or career pathways;

(f) Development and review of statewide policies affecting the coordinated provision of services through the State's one-stop delivery system described in WIOA sec. 121(e), including the development of—

(1) Objective criteria and procedures for use by Local WDBs in assessing the effectiveness, physical and programmatic accessibility and continuous improvement of one-stop centers. Where a Local WDB serves as the one-stop operator, the State WDB must use such criteria to assess and certify the one-stop center;

(2) Guidance for the allocation of one-stop center infrastructure funds under WIOA sec. 121(h); and

(3) Policies relating to the appropriate roles and contributions of entities carrying out one-stop partner programs within the one-stop delivery system, including approaches to facilitating equitable and efficient cost allocation in the system;

(g) Development of strategies for technological improvements to facilitate access to, and improve the quality of services and activities provided through the one-stop delivery system, including such improvements to—

(1) Enhance digital literacy skills (as defined in sec. 202 of the Museum and Library Service Act, 20 U.S.C. 9101);

(2) Accelerate acquisition of skills and recognized postsecondary credentials by participants;

(3) Strengthen professional development of providers and workforce professionals; and

(4) Ensure technology is accessible to individuals with disabilities and individuals residing in remote areas;

(h) Development of strategies for aligning technology and data systems across one-stop partner programs to enhance service delivery and improve efficiencies in reporting on performance accountability measures, including design implementation of common intake, data collection, case management information, and performance accountability measurement and reporting processes and the incorporation of local input into such design and implementation to improve coordination of services across one-stop partner programs;

(i) Development of allocation formulas for the distribution of funds for employment and training activities for adults and youth workforce investment activities, to local areas as permitted under WIOA secs. 128(b)(3) and 133(b)(3);

(j) Preparation of the annual reports described in paragraphs (1) and (2) of WIOA sec. 116(d);

(k) Development of the statewide workforce and labor market information system described in sec. 15(e) of the Wagner-Peyser Act; and

(l) Development of other policies as may promote statewide objectives for and enhance the performance of the workforce development system in the State.

§ 679.140 How does the State Workforce Development Board meet its requirement to conduct business in an open manner under the "sunshine provision" of the Workforce Innovation and Opportunity Act?

(a) The State WDB must conduct business in an open manner as required by WIOA sec. 101(g).

(b) The State WDB must make available to the public, on a regular basis through electronic means and open meetings, information about the activities and functions of the State WDB, including:

(1) The State Plan, or modification to the State Plan, prior to submission of the State Plan or modification of the State Plan;

(2) Information regarding membership;

(3) Minutes of formal meetings of the State WDB upon request;

(4) State WDB by-laws as described at § 679.110(d).

§ 679.150 Under what circumstances may the Governor select an alternative entity in place of the State Workforce Development Board?

(a) The State may use any State entity that meets the requirements of WIOA sec. 101(e) to perform the functions of the State WDB. This may include:

(1) A State council;

(2) A State WDB within the meaning of the Workforce Investment Act of 1998, as in effect on the day before the date of enactment of WIOA; or

(3) A combination of regional WDBs or similar entity.

(b) If the State uses an alternative entity, the State Plan must demonstrate that the alternative entity meets all three of the requirements of WIOA sec. 101(e)(1):

(1) Was in existence on the day before the date of enactment of the Workforce Investment Act of 1998 (WIA);

(2) Is substantially similar to the State WDB described in WIOA secs. 101(a)–(c) and § 679.110; and

(3) Includes representatives of business and labor organizations in the State.

(c) If the alternative entity does not provide representatives for each of the categories required under WIOA sec. 101(b), the State Plan must explain the

manner in which the State will ensure an ongoing role for any unrepresented membership group in the workforce development system. The State WDB must maintain an ongoing and meaningful role for an unrepresented membership group, including entities carrying out the core programs, by such methods as:

(1) Regularly scheduled consultations with entities within the unrepresented membership groups;

(2) Providing an opportunity for input into the State Plan or other policy development by unrepresented membership groups; and

(3) Establishing an advisory committee of unrepresented membership groups.

(d) In parts 675 through 687 of this chapter, all references to the State WDB also apply to an alternative entity used by a State.

§ 679.160 Under what circumstances may the State Workforce Development Board hire staff?

(a) The State WDB may hire a director and other staff to assist in carrying out the functions described in WIOA sec. 101(d) and § 679.130 using funds described in WIOA sec. 129(b)(3) or sec. 134(a)(3)(B)(i).

(b) The State WDB must establish and apply a set of objective qualifications for the position of director that ensures the individual selected has the requisite knowledge, skills, and abilities to meet identified benchmarks and to assist in effectively carrying out the functions of the State WDB.

(c) The director and staff must be subject to the limitations on the payment of salary and bonuses described in WIOA sec. 194(15).

Subpart B—Workforce Innovation and Opportunity Act Local Governance (Workforce Development Areas)

§ 679.200 What is the purpose of requiring States to identify regions?

The purpose of identifying regions is to align workforce development activities and resources with larger regional economic development areas and available resources to provide coordinated and efficient services to both job seekers and employers.

§ 679.210 What are the requirements for identifying a region?

(a) The Governor must assign local areas to a region prior to submission of the State Unified or Combined Plan, in order for the State to receive WIOA title I, subtitle B adult, dislocated worker, and youth allotments.

(b) The Governor must develop a policy and process for identifying regions. Such policy must include:

(1) Consultation with the Local WDBs and chief elected officials (CEOs) in the local area(s) as required in WIOA sec. 102(b)(2)(D)(i)(II) and WIOA sec. 106(a)(1); and

(2) Consideration of the extent to which the local areas in a proposed region:

(i) Share a single labor market;

(ii) Share a common economic development area; and

(iii) Possess the Federal and non-Federal resources, including appropriate education and training institutions, to administer activities under WIOA subtitle B.

(c) In addition to the required criteria described in paragraph (b)(2) of this section, other factors the Governor also may consider include:

(1) Population centers;

(2) Commuting patterns;

(3) Land ownership;

(4) Industrial composition;

(5) Location quotients;

(6) Labor force conditions;

(7) Geographic boundaries; and

(8) Additional factors as determined by the Secretary.

(d) Regions must consist of:

(1) One local area;

(2) Two or more contiguous local areas in a single State; or

(3) Two or more contiguous local areas in two or more States.

(e) Planning regions are those regions described in paragraph (d)(2) or (3) of this section. Planning regions are subject to the regional planning requirements in § 679.510.

§ 679.220 What is the purpose of the local area?

(a) The purpose of a local area is to serve as a jurisdiction for the administration of workforce development activities and execution of adult, dislocated worker, and youth funds allocated by the State. Such areas may be aligned with a region identified in WIOA sec. 106(a)(1) or may be components of a planning region, each with its own Local WDB. Also, significantly, local areas are the areas within which Local WDBs oversee their functions, including strategic planning, operational alignment and service delivery design, and a jurisdiction where partners align resources at a sub-State level to design and implement overall service delivery strategies.

(b) The Governor must designate local areas (local areas) in order for the State to receive adult, dislocated worker, and youth funding under title I, subtitle B of WIOA.

§ 679.230 What are the general procedural requirements for designation of local areas?

As part of the process of designating or redesignating a local area, the Governor must develop a policy for designation of local areas that must include:

(a) Consultation with the State WDB;

(b) Consultation with the chief elected officials and affected Local WDBs; and

(c) Consideration of comments received through a public comment process which must:

(1) Offer adequate time for public comment prior to designation of the local area; and

(2) Provide an opportunity for comment by representatives of Local WDBs, chief elected officials, businesses, institutions of higher education, labor organizations, other primary stakeholders, and the general public regarding the designation of the local area.

§ 679.240 What are the substantive requirements for designation of local areas that were not designated as local areas under the Workforce Investment Act of 1998?

(a) Except as provided in § 679.250, the Governor may designate or redesignate a local area in accordance with policies and procedures developed by the Governor, which must include at a minimum consideration of the extent to which the proposed area:

(1) Is consistent with local labor market areas;

(2) Has a common economic development area; and

(3) Has the Federal and non-Federal resources, including appropriate education and training institutions, to administer activities under WIOA subtitle B.

(b) The Governor may approve a request at any time for designation as a workforce development area from any unit of general local government, including a combination of such units, if the State WDB determines that the area meets the requirements of paragraph (a)(1) of this section and recommends designation.

(c) Regardless of whether a local area has been designated under this section or § 679.250, the Governor may redesignate a local area if the redesignation has been requested by a local area and the Governor approves the request.

§ 679.250 What are the requirements for initial and subsequent designation of workforce development areas that had been designated as local areas under the Workforce Investment Act of 1998?

(a) If the chief elected official and Local WDB in a local area submits a request for initial designation, the Governor must approve the request if, for the 2 program years preceding the date of enactment of WIOA, the following criteria are met:

(1) The local area was designated as a local area for purposes of WIA;

(2) The local area performed successfully; and

(3) The local area sustained fiscal integrity.

(b) Subject to paragraph (c) of this section, after the period of initial designation, if the chief elected official and Local WDB in a local area submits

a request for subsequent designation, the Governor must approve the request if the following criteria are met for the 2 most recent program years of initial designation:

(1) The local area performed successfully;

(2) The local area sustained fiscal integrity; and

(3) In the case of a local area in a planning region, the local area met the regional planning requirements described in WIOA sec. 106(c)(1).

(c) No determination of subsequent eligibility may be made before the conclusion of Program Year (PY) 2017.

(d) The Governor:

(1) May review a local area designated under paragraph (b) of this section at any time to evaluate whether that the area continues to meet the requirements for subsequent designation under that paragraph; and

(2) Must review a local area designated under paragraph (b) of this section before submitting its State Plan during each 4-year State planning cycle to evaluate whether the area continues to meet the requirements for subsequent designation under that paragraph.

(e) For purposes of subsequent designation under paragraphs (b) and (d) of this section, the local area and chief elected official must be considered to have requested continued designation unless the local area and chief elected official notify the Governor that they no longer seek designation.

(f) Local areas designated under §679.240 or States designated as single-area States under §679.270 are not subject to the requirements described in paragraph (b) of this section related to the subsequent designation of a local area.

(g) The Governor may approve, under paragraph (c) of this section, a request for designation as a local area from areas served by rural concentrated employment programs as described in WIOA sec. 107(c)(1)(C).

§679.260 What do the terms "performed successfully" and "sustained fiscal integrity" mean for purposes of designating local areas?

(a) For the purpose of initial local area designation, the term ''performed successfully'' means that the local area met or exceeded the levels of performance the Governor negotiated with the Local WDB and chief elected official under WIA sec. 136(c) for the last 2 full program years before the enactment of WIOA, and that the local area has not failed any individual measure for the last 2 consecutive program years before the enactment of WIOA.

(b) For the purpose of determining subsequent local area designation, the term ''performed successfully'' means that the local area met or exceeded the levels of performance the Governor negotiated with the Local WDB and chief elected official for core indicators of performance as provided in paragraphs (b)(1) and (2) of this section as appropriate, and that the local area has not failed any individual measure for the last 2 consecutive program years in accordance with a State-established definition, provided in the State Plan, of met or exceeded performance.

(1) For subsequent designation determinations made at the conclusion of PY 2017, a finding of whether a local area performed successfully must be limited to having met or exceeded the negotiated levels for the Employment Rate 2nd Quarter after Exit and the Median Earnings indicators of performance, as described at §677.155(a)(1)(i) and (iii) of this chapter respectively, for PY 2016 and PY 2017.

(2) For subsequent designation determinations made at the conclusion of PY 2018, or at any point thereafter, a finding of whether a local area performed successfully must be based on all six of the WIOA indicators of performance as described at §677.155(a)(1)(i) through (vi) of this chapter for the 2 most recently completed program years.

(c) For the purpose of determining initial and subsequent local area designation under §679.250(a) and (b), the term ''sustained fiscal integrity'' means that the Secretary has not made a formal determination that either the grant recipient or the administrative entity of the area misexpended funds due to willful disregard of the requirements of the provision involved, gross negligence, or failure to comply with accepted standards of administration for the 2-year period preceding the determination.

§ 679.270 What are the special designation provisions for single-area States?

(a) The Governor of any State that was a single-State local area under the WIA as in effect on July 1, 2013 may designate the State as a single-State local area under WIOA.

(b) The Governor of a State local area under paragraph (a) of this section who seeks to designate the State as a single-State local area under WIOA must:

(1) Identify the State as a single-area State in the Unified or Combined State Plan; and

(2) Include the local plan for approval as part of the Unified or Combined State Plan.

(c) The State WDB for a single-area State must act as the Local WDB and carry out the functions of the Local WDB in accordance with WIOA sec. 107 and § 679.370, except that the State is not required to meet and report on a set of local performance accountability measures.

(d) Single-area States must conduct the functions of the Local WDB as outlined in paragraph (c) of this section to achieve the incorporation of local interests but may do so in a manner that reduces unnecessary burden and duplication of processes.

(e) States must carry out the duties of State and Local WDBs in accordance with guidance issued by the Secretary of Labor.

§ 679.280 How does the State fulfill the requirement to provide assistance to local areas within a planning region that wish to redesignate into a single local area?

(a) When the chief elected officials and Local WDBs of each local area within a planning region make a request to the Governor to redesignate into a single local area, the State WDB must authorize statewide adult, dislocated worker, and youth program funds to facilitate such redesignation.

(b) When statewide funds are not available, the State may provide funds for redesignation in the next available program year.

(c) Redesignation activities that may be carried out by the local areas include:

(1) Convening sessions and conferences;

(2) Renegotiation of contracts and agreements; and

(3) Other activities directly associated with the redesignation as deemed appropriate by the State WDB.

§ 679.290 What right does an entity have to appeal the Governor's decision rejecting a request for designation as a workforce development area?

(a) A unit of local government (or combination of units) or a local area which has requested but has been denied its request for designation as a workforce development area under § 679.250 may appeal the decision to the State WDB, in accordance with appeal procedures established in the State Plan and § 683.630(a) of this chapter.

(b) If a decision on the appeal is not rendered in a timely manner or if the appeal to the State WDB does not result in designation, the entity may request review by the Secretary of Labor, under the procedures set forth at § 683.640 of this chapter.

Subpart C—Local Workforce Development Boards

§ 679.300 What is the vision and purpose of the Local Workforce Development Board?

(a) The vision for the Local WDB is to serve as a strategic leader and convener of local workforce development system stakeholders. The Local WDB partners with employers and the workforce development system to develop policies and investments that support public workforce system strategies that support regional economies, the development of effective approaches including local and regional sector partnerships and career pathways, and high quality, customer centered service delivery and service delivery approaches;

(b) The purpose of the Local WDB is to—

(1) Provide strategic and operational oversight in collaboration with the required and additional partners and workforce stakeholders to help develop a comprehensive and high-quality workforce development system in the local area and larger planning region;

(2) Assist in the achievement of the State's strategic and operational vision and goals as outlined in the Unified State Plan or Combined State Plan; and

(3) Maximize and continue to improve the quality of services, customer satisfaction, effectiveness of the services provided.

§ 679.310 What is the Local Workforce Development Board?

(a) The Local WDB is appointed by the chief elected official(s) in each local area in accordance with State criteria established under WIOA sec. 107(b), and is certified by the Governor every 2 years, in accordance with WIOA sec. 107(c)(2).

(b) In partnership with the chief elected official(s), the Local WDB sets policy for the portion of the statewide workforce development system within the local area and consistent with State policies.

(c) The Local WDB and the chief elected official(s) may enter into an agreement that describes the respective roles and responsibilities of the parties.

(d) The Local WDB, in partnership with the chief elected official(s), develops the local plan and performs the functions described in WIOA sec. 107(d) and § 679.370.

(e) If a local area includes more than one unit of general local government in accordance with WIOA sec. 107(c)(1)(B), the chief elected officials of such units may execute an agreement to describe their responsibilities for carrying out the roles and responsibilities. If the chief elected officials are unable to reach agreement after a reasonable effort, the Governor may appoint the members of the Local WDB from individuals nominated or recommended as specified in WIOA sec. 107(b).

(f) If the State Plan indicates that the State will be treated as a local area under WIOA, the State WDB must carry out the roles of the Local WDB in accordance with WIOA sec. 107, except that the State is not required to meet and report on a set of local performance accountability measures.

(g) The CEO must establish by-laws, consistent with State policy for Local WDB membership, that at a minimum address:

(1) The nomination process used by the CEO to select the Local WDB chair and members;

(2) The term limitations and how the term appointments will be staggered to ensure only a portion of membership expire in a given year;

(3) The process to notify the CEO of a WDB member vacancy to ensure a prompt nominee;

(4) The proxy and alternative designee process that will be used when a WDB member is unable to attend a meeting and assigns a designee as per the requirements at § 679.110(d)(4);

(5) The use of technology, such as phone and Web-based meetings, that will be used to promote WDB member participation;

(6) The process to ensure WDB members actively participate in convening the workforce development system's stakeholders, brokering relationships with a diverse range of employers, and leveraging support for workforce development activities; and

(7) A description of any other conditions governing appointment or membership on the Local WDB as deemed appropriate by the CEO.

§ 679.320 Who are the required members of the Local Workforce Development Board?

(a) For each local area in the State, the members of Local WDB must be selected by the chief elected official consistent with criteria established under WIOA sec. 107(b)(1) and criteria established by the Governor, and must meet the requirements of WIOA sec. 107(b)(2).

(b) A majority of the members of the Local WDB must be representatives of business in the local area. At a minimum, two members must represent small business as defined by the U.S. Small Business Administration. Business representatives serving on Local WDBs also may serve on the State WDB. Each business representative must meet the following criteria:

(1) Be an owner, chief executive officer, chief operating officer, or other individual with optimum policy-making or hiring authority; and

(2) Provide employment opportunities in in-demand industry sectors or

occupations, as those terms are defined in WIOA sec. 3(23).

(c) At least 20 percent of the members of the Local WDB must be workforce representatives. These representatives:

(1) Must include two or more representatives of labor organizations, where such organizations exist in the local area. Where labor organizations do not exist, representatives must be selected from other employee representatives;

(2) Must include one or more representatives of a joint labor-management, or union affiliated, registered apprenticeship program within the area who must be a training director or a member of a labor organization. If no union affiliated registered apprenticeship programs exist in the area, a representative of a registered apprenticeship program with no union affiliation must be appointed, if one exists;

(3) May include one or more representatives of community-based organizations that have demonstrated experience and expertise in addressing the employment, training or education needs of individuals with barriers to employment, including organizations that serve veterans or provide or support competitive integrated employment for individuals with disabilities; and

(4) May include one or more representatives of organizations that have demonstrated experience and expertise in addressing the employment, training, or education needs of eligible youth, including representatives of organizations that serve out-of-school youth.

(d) The Local WDB also must include:

(1) At least one eligible training provider administering adult education and literacy activities under WIOA title II;

(2) At least one representative from an institution of higher education providing workforce investment activities, including community colleges; and

(3) At least one representative from each of the following governmental and economic and community development entities:

(i) Economic and community development entities;

(ii) The State Employment Service office under the Wagner-Peyser Act (29 U.S.C. 49 *et seq.*) serving the local area; and

(iii) The programs carried out under title I of the Rehabilitation Act of 1973, other than sec. 112 or part C of that title;

(e) The membership of Local WDBs may include individuals or representatives of other appropriate entities in the local area, including:

(1) Entities administering education and training activities who represent local educational agencies or community-based organizations with demonstrated expertise in addressing the education or training needs for individuals with barriers to employment;

(2) Governmental and economic and community development entities who represent transportation, housing, and public assistance programs;

(3) Philanthropic organizations serving the local area; and

(4) Other appropriate individuals as determined by the chief elected official.

(f) Members must be individuals with optimum policy-making authority within the entities they represent.

(g) Chief elected officials must establish a formal nomination and appointment process, consistent with the criteria established by the Governor and State WDB under sec. 107(b)(1) of WIOA for appointment of members of the Local WDBs, that ensures:

(1) Business representatives are appointed from among individuals who are nominated by local business organizations and business trade associations;

(2) Labor representatives are appointed from among individuals who are nominated by local labor federations (or, for a local area in which no employees are represented by such organizations, other representatives of employees); and

(3) When there is more than one local area provider of adult education and literacy activities under title II, or multiple institutions of higher education providing workforce investment activities as described in WIOA sec. 107(b)(2)(C)(i) or (ii), nominations are solicited from those particular entities.

(h) An individual may be appointed as a representative of more than one entity if the individual meets all the criteria for representation, including the criteria described in paragraphs (c) through (g) of this section, for each entity.

(i) All required WDB members must have voting privilege. The chief elected official may convey voting privileges to non-required members.

§ 679.330 Who must chair a Local Workforce Development Board?

The Local WDB must elect a chairperson from among the business representatives on the WDB.

§ 679.340 What is meant by the terms "optimum policy-making authority" and "demonstrated experience and expertise"?

For purposes of selecting representatives to Local WDBs:

(a) A representative with ''optimum policy-making authority'' is an individual who can reasonably be expected to speak affirmatively on behalf of the entity he or she represents and to commit that entity to a chosen course of action.

(b) A representative with ''demonstrated experience and expertise'' means an individual who:

(1) Is a workplace learning advisor as defined in WIOA sec. 3(70);

(2) Contributes to the field of workforce development, human resources, training and development, or a core program function; or

(3) The Local WDB recognizes for valuable contributions in education or workforce development related fields.

§ 679.350 What criteria will be used to establish the membership of the Local Workforce Development Board?

The Local WDB is appointed by the chief elected official(s) in the local area in accordance with State criteria established under WIOA sec. 107(b), and is certified by the Governor every 2 years, in accordance with WIOA sec. 107(c)(2).

§ 679.360 What is a standing committee, and what is its relationship to the Local Workforce Development Board?

(a) Standing committees may be established by the Local WDB to provide information and assist the Local WDB in carrying out its responsibilities under WIOA sec. 107. Standing committees must be chaired by a member of the Local WDB, may include other members of the Local WDB, and must include other individuals appointed by the Local WDB who are not members of the Local WDB and who have demonstrated experience and expertise in accordance with § 679.340(b) and as determined by the Local WDB. Standing committees may include each of the following:

(1) A standing committee to provide information and assist with operational and other issues relating to the one-stop delivery system, which may include representatives of the one-stop partners.

(2) A standing committee to provide information and to assist with planning, operational, and other issues relating to the provision of services to youth, which must include community-based organizations with a demonstrated record of success in serving eligible youth.

(3) A standing committee to provide information and to assist with operational and other issues relating to the provision of services to individuals with disabilities, including issues relating to compliance with WIOA sec. 188, if applicable, and applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*) regarding providing programmatic and physical access to the services, programs, and activities of the one-stop delivery system, as well as appropriate training for staff on providing supports for or accommodations to, and finding employment opportunities for, individuals with disabilities.

(b) The Local WDB may designate other standing committees in addition to those specified in paragraph (a) of this section.

(c) Local WDBs may designate an entity in existence as of the date of the

enactment of WIOA, such as an effective youth council, to serve as a standing committee as long as the entity meets the requirements of WIOA sec. 107(b)(4).

§ 679.370 What are the functions of the Local Workforce Development Board?

As provided in WIOA sec. 107(d), the Local WDB must:

(a) Develop and submit a 4-year local plan for the local area, in partnership with the chief elected official and consistent with WIOA sec. 108;

(b) If the local area is part of a planning region that includes other local areas, develop and submit a regional plan in collaboration with other local areas. If the local area is part of a planning region, the local plan must be submitted as a part of the regional plan;

(c) Conduct workforce research and regional labor market analysis to include:

(1) Analyses and regular updates of economic conditions, needed knowledge and skills, workforce, and workforce development (including education and training) activities to include an analysis of the strengths and weaknesses (including the capacity to provide) of such services to address the identified education and skill needs of the workforce and the employment needs of employers;

(2) Assistance to the Governor in developing the statewide workforce and labor market information system under the Wagner-Peyser Act for the region; and

(3) Other research, data collection, and analysis related to the workforce needs of the regional economy as the WDB, after receiving input from a wide array of stakeholders, determines to be necessary to carry out its functions;

(d) Convene local workforce development system stakeholders to assist in the development of the local plan under § 679.550 and in identifying non-Federal expertise and resources to leverage support for workforce development activities. Such stakeholders may assist the Local WDB and standing committees in carrying out convening, brokering, and leveraging functions at the direction of the Local WDB;

(e) Lead efforts to engage with a diverse range of employers and other entities in the region in order to:

(1) Promote business representation (particularly representatives with optimum policy-making or hiring authority from employers whose employment opportunities reflect existing and emerging employment opportunities in the region) on the Local WDB;

(2) Develop effective linkages (including the use of intermediaries) with employers in the region to support employer utilization of the local workforce development system and to support local workforce investment activities;

(3) Ensure that workforce investment activities meet the needs of employers and support economic growth in the region by enhancing communication, coordination, and collaboration among employers, economic development entities, and service providers; and

(4) Develop and implement proven or promising strategies for meeting the employment and skill needs of workers and employers (such as the establishment of industry and sector partnerships), that provide the skilled workforce needed by employers in the region, and that expand employment and career advancement opportunities for workforce development system participants in in-demand industry sectors or occupations;

(f) With representatives of secondary and postsecondary education programs, lead efforts to develop and implement career pathways within the local area by aligning the employment, training, education, and supportive services that are needed by adults and youth, particularly individuals with barriers to employment;

(g) Lead efforts in the local area to identify and promote proven and promising strategies and initiatives for meeting the needs of employers, workers and job seekers, and identify and disseminate information on proven and promising practices carried out in other local areas for meeting such needs;

(h) Develop strategies for using technology to maximize the accessibility and effectiveness of the local workforce development system for employers, and workers and job seekers, by:

(1) Facilitating connections among the intake and case management information systems of the one-stop partner programs to support a comprehensive workforce development system in the local area;

(2) Facilitating access to services provided through the one-stop delivery system involved, including access in remote areas;

(3) Identifying strategies for better meeting the needs of individuals with barriers to employment, including strategies that augment traditional service delivery, and increase access to services and programs of the one-stop delivery system, such as improving digital literacy skills; and

(4) Leveraging resources and capacity within the local workforce development system, including resources and capacity for services for individuals with barriers to employment;

(i) In partnership with the chief elected official for the local area:

(1) Conduct oversight of youth workforce investment activities authorized under WIOA sec. 129(c), adult and dislocated worker employment and training activities under WIOA secs. 134(c) and (d), and the entire one-stop delivery system in the local area;

(2) Ensure the appropriate use and management of the funds provided under WIOA subtitle B for the youth, adult, and dislocated worker activities and one-stop delivery system in the local area; and

(3) Ensure the appropriate use management, and investment of funds to maximize performance outcomes under WIOA sec. 116;

(j) Negotiate and reach agreement on local performance indicators with the chief elected official and the Governor;

(k) Negotiate with CEO and required partners on the methods for funding the infrastructure costs of one-stop centers in the local area in accordance with §678.715 of this chapter or must notify the Governor if they fail to reach agreement at the local level and will use a State infrastructure funding mechanism;

(l) Select the following providers in the local area, and where appropriate terminate such providers in accordance with 2 CFR part 200:

(1) Providers of youth workforce investment activities through competitive grants or contracts based on the recommendations of the youth standing committee (if such a committee is established); however, if the Local WDB determines there is an insufficient number of eligible training providers in a local area, the Local WDB may award contracts on a sole-source basis as per the provisions at WIOA sec. 123(b);

(2) Providers of training services consistent with the criteria and information requirements established by the Governor and WIOA sec. 122;

(3) Providers of career services through the award of contracts, if the one-stop operator does not provide such services; and

(4) One-stop operators in accordance with §§678.600 through 678.635 of this chapter;

(m) In accordance with WIOA sec. 107(d)(10)(E) work with the State to ensure there are sufficient numbers and types of providers of career services and training services serving the local area and providing the services in a manner that maximizes consumer choice, as well as providing opportunities that lead to competitive integrated employment for individuals with disabilities;

(n) Coordinate activities with education and training providers in the local area, including:

(1) Reviewing applications to provide adult education and literacy activities under WIOA title II for the local area to determine whether such applications are consistent with the local plan;

(2) Making recommendations to the eligible agency to promote alignment with such plan; and

(3) Replicating and implementing cooperative agreements to enhance the provision of services to individuals with disabilities and other individuals, such as cross training of staff, technical assistance, use and sharing of information, cooperative efforts with employers, and other efforts at cooperation, collaboration, and coordination;

(o) Develop a budget for the activities of the Local WDB, with approval of the chief elected official and consistent with the local plan and the duties of the Local WDB;

(p) Assess, on an annual basis, the physical and programmatic accessibility of all one-stop centers in the local area, in accordance with WIOA sec. 188, if applicable, and applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*); and

(q) Certification of one-stop centers in accordance with § 678.800 of this chapter.

§ 679.380 How does the Local Workforce Development Board satisfy the consumer choice requirements for career services and training services?

(a) In accordance with WIOA sec. 122 and in working with the State, the Local WDB satisfies the consumer choice requirement for training services by:

(1) Determining the initial eligibility of entities providing a program of training services, renewing the eligibility of providers, and considering the possible termination of an eligible training provider due to the provider's submission of inaccurate eligibility and performance information or the provider's substantial violation of WIOA;

(2) Working with the State to ensure there are sufficient numbers and types of providers of training services, including eligible training providers with expertise in assisting individuals with disabilities and eligible training providers with expertise in assisting adults in need of adult education and literacy activities described under WIOA sec. 107(d)(10)(E), serving the local area;

(3) Ensuring the dissemination and appropriate use of the State list through the local one-stop delivery system;

(4) Receiving performance and cost information from the State and disseminating this information through the one-stop delivery systems within the State; and

(5) Providing adequate access to services for individuals with disabilities.

(b) Working with the State, the Local WDB satisfies the consumer choice requirement for career services by:

(1) Determining the career services that are best performed by the one-stop operator consistent with §§ 678.620 and 678.625 of this chapter and career services that require contracting with a career service provider; and

(2) Identifying a wide-array of potential career service providers and awarding contracts where appropriate including to providers to ensure:

(i) Sufficient access to services for individuals with disabilities, including opportunities that lead to integrated, competitive employment for individuals with disabilities; and

(ii) Sufficient access for adult education and literacy activities.

§ 679.390 How does the Local Workforce Development Board meet its requirement to conduct business in an open manner under the "sunshine provision" of the Workforce Innovation and Opportunity Act?

The Local WDB must conduct its business in an open manner as required by WIOA sec. 107(e), by making available to the public, on a regular basis through electronic means and open meetings, information about the activities of the Local WDB. This includes:

(a) Information about the Local Plan, or modification to the Local Plan, before submission of the plan;

(b) List and affiliation of Local WDB members;

(c) Selection of one-stop operators;

(d) Award of grants or contracts to eligible training providers of workforce investment activities including providers of youth workforce investment activities;

(e) Minutes of formal meetings of the Local WDB; and

(f) Local WDB by-laws, consistent with § 679.310(g).

§ 679.400 Who are the staff to the Local Workforce Development Board and what is their role?

(a) WIOA sec. 107(f) grants Local WDBs authority to hire a director and other staff to assist in carrying out the functions of the Local WDB.

(b) Local WDBs must establish and apply a set of qualifications for the position of director that ensures the individual selected has the requisite knowledge, skills, and abilities to meet identified benchmarks and to assist in carrying out the functions of the Local WDB.

(c) The Local WDB director and staff must be subject to the limitations on the payment of salary and bonuses described in WIOA sec. 194(15).

(d) In general, Local WDB staff only may assist the Local WDB fulfill the required functions at WIOA sec. 107(d).

(e) Should the WDB select an entity to staff the WDB that provides additional workforce functions beyond the functions described at WIOA sec. 107(d), such an entity is required to enter into a written agreement with the Local WDB and chief elected official(s) to clarify their roles and responsibilities as required by § 679.430.

§ 679.410 Under what conditions may a Local Workforce Development Board directly be a provider of career services, or training services, or act as a one-stop operator?

(a)(1) A Local WDB may be selected as a one-stop operator:

(i) Through sole source procurement in accordance with § 678.610 of this chapter; or

(ii) Through successful competition in accordance with § 678.615 of this chapter.

(2) The chief elected official in the local area and the Governor must agree to the selection described in paragraph (a)(1) of this section.

(3) Where a Local WDB acts as a one-stop operator, the State must ensure certification of one-stop centers in accordance with § 678.800 of this chapter.

(b) A Local WDB may act as a provider of career services only with the agreement of the chief elected official in the local area and the Governor.

(c) A Local WDB is prohibited from providing training services, unless the Governor grants a waiver in accordance with the provisions in WIOA sec. 107(g)(1).

(1) The State must develop a procedure for approving waivers that includes the criteria at WIOA sec. 107(g)(1)(B)(i):

(i) Satisfactory evidence that there is an insufficient number of eligible training providers of such a program of training services to meet local demand in the local area;

(ii) Information demonstrating that the WDB meets the requirements for eligible training provider services under WIOA sec. 122; and

(iii) Information demonstrating that the program of training services prepares participants for an in-demand industry sector or occupation in the local area.

(2) The local area must make the proposed request for a waiver available to eligible training providers and other interested members of the public for a public comment period of not less than 30 days and includes any comments received during this time in the final request for the waiver.

(3) The waiver must not exceed the duration of the local plan and may be renewed by submitting a new waiver request consistent with paragraphs (c)(1) and (2) of this section for additional periods, not to exceed the durations of such subsequent plans.

(4) The Governor may revoke the waiver if the Governor determines the waiver is no longer needed or that the Local WDB involved has engaged in a pattern of inappropriate referrals to training services operated by the Local WDB.

(d) The restrictions on the provision of career and training services by the Local WDB, as one-stop operator, also apply to staff of the Local WDB.

§ 679.420 What are the functions of the local fiscal agent?

(a) In order to assist in administration of the grant funds, the chief elected official or the Governor, where the Governor serves as the local grant recipient for a local area, may designate an entity to serve as a local fiscal agent. Designation of a fiscal agent does not relieve the chief elected official or Governor of liability for the misuse of grant funds. If the CEO designates a fiscal agent, the CEO must ensure this agent has clearly defined roles and responsibilities.

(b) In general the fiscal agent is responsible for the following functions:

(1) Receive funds.

(2) Ensure sustained fiscal integrity and accountability for expenditures of funds in accordance with Office of Management and Budget circulars, WIOA and the corresponding Federal Regulations and State policies.

(3) Respond to audit financial findings.

(4) Maintain proper accounting records and adequate documentation.

(5) Prepare financial reports.

(6) Provide technical assistance to subrecipients regarding fiscal issues.

(c) At the direction of the Local WDB or the State WDB in single-area States, the fiscal agent may have the following additional functions:

(1) Procure contracts or obtain written agreements.

(2) Conduct financial monitoring of service providers.

(3) Ensure independent audit of all employment and training programs.

§ 679.430 How do entities performing multiple functions in a local area demonstrate internal controls and prevent conflict of interest?

Local organizations often function simultaneously in a variety of roles, including local fiscal agent, Local WDB staff, one-stop operator, and direct provider of services. Any organization that has been selected or otherwise designated to perform more than one of these functions must develop a written agreement with the Local WDB and CEO to clarify how the organization will carry out its responsibilities while demonstrating compliance with WIOA and corresponding regulations, relevant Office of Management and Budget circulars, and the State's conflict of interest policy.

Subpart D—Regional and Local Plan

§ 679.500 What is the purpose of the regional and local plan?

(a) The local plan serves as 4-year action plan to develop, align, and integrate service delivery strategies and to support the State's vision and strategic and operational goals. The local plan sets forth the strategy to:

(1) Direct investments in economic, education, and workforce training programs to focus on providing relevant education and training to ensure that individuals, including youth and individuals with barriers to employment, have the skills to compete in the job market and that employers have a ready supply of skilled workers;

(2) Apply job-driven strategies in the one-stop delivery system;

(3) Enable economic, education, and workforce partners to build a skilled workforce through innovation in, and alignment of, employment, training, and education programs; and

(4) Incorporate the local plan into the regional plan per § 679.540.

(b) In the case of planning regions, a regional plan is required to meet the purposes described in paragraph (a) of this section and to coordinate resources among multiple WDBs in a region.

(c) The Governor must establish and disseminate to Local WDBs and regional planning areas a policy for the submission of local and regional plans. The policy must set a deadline for the submission of the regional and local plans that accounts for the activities required in plan development outlined in §§ 679.510 and 679.550.

§ 679.510 What are the requirements for regional planning?

(a) Local WDBs and chief elected officials within an identified planning region (as defined in WIOA secs. 106(a)(2)(B)–(C) and § 679.200) must:

(1) Participate in a regional planning process that results in:

(i) The preparation of a regional plan, as described in paragraph (a)(2) of this section and consistent with any guidance issued by the Department;

(ii) The establishment of regional service strategies, including use of cooperative service delivery agreements;

(iii) The development and implementation of sector initiatives for in-demand industry sectors or occupations for the planning region;

(iv) The collection and analysis of regional labor market data (in conjunction with the State) which must include the local planning requirements at § 679.560(a)(1)(i) and (ii);

(v) The coordination of administrative cost arrangements, including the pooling of funds for administrative costs, as appropriate;

(vi) The coordination of transportation and other supportive services as appropriate;

(vii) The coordination of services with regional economic development services and providers; and

(viii) The establishment of an agreement concerning how the planning region will collectively negotiate and reach agreement with the Governor on local levels of performance for, and report on, the performance accountability measures described in WIOA sec. 116(c) for local areas or the planning region.

(2) Prepare, submit, and obtain approval of a single regional plan that:

(i) Includes a description of the activities described in paragraph (a)(1) of this section; and

(ii) Incorporates local plans for each of the local areas in the planning region, consistent with § 679.540(a).

(b) Consistent with § 679.550(b), the Local WDBs representing each local area in the planning region must provide an opportunity for public comment on the development of the regional plan or subsequent plan modifications before submitting the plan to the Governor. To provide adequate opportunity for public comment, the Local WDBs must:

(1) Make copies of the proposed regional plan available to the public through electronic and other means, such as public hearings and local news media;

(2) Include an opportunity for comment by members of the public, including representatives of business, labor organizations, and education;

(3) Provide no more than a 30-day period for comment on the plan before its submission to the Governor, beginning on the date on which the proposed plan is made available; and

(4) The Local WDBs must submit any comments that express disagreement with the plan to the Governor along with the plan.

(5) Consistent with WIOA sec. 107(e), the Local WDB must make information about the plan available to the public on a regular basis through electronic means and open meetings.

(c) The State must provide technical assistance and labor market data, as requested by local areas, to assist with regional planning and subsequent service delivery efforts.

(d) As they relate to regional areas and regional plans, the terms local area and local plan are defined in WIOA secs. 106(c)(3)(A)–(B).

§ 679.520 What are the requirements for approval of a regional plan?

Consistent with the requirements of § 679.570, the Governor must review completed plans (including a modification to the plan). Such plans will be considered approved 90 days after receipt of the plan unless the Governor determines in writing that:

(a) There are deficiencies in workforce investment activities that have been identified through audits and the local area has not made acceptable progress in implementing plans to address deficiencies; or

(b) The plan does not comply with applicable provisions of WIOA and the WIOA regulations, including the required consultations and public comment provisions, and the nondiscrimination requirements of 29 CFR part 38.

(c) The plan does not align with the State Plan, including with regard to the alignment of the core programs to support the strategy identified in the State Plan in accordance with WIOA sec. 102(b)(1)(E) and § 676.105 of this chapter.

§ 679.530 When must the regional plan be modified?

(a) Consistent with § 679.580, the Governor must establish procedures governing the modification of regional plans.

(b) At the end of the first 2-year period of the 4-year local plan, the Local WDBs within a planning region, in partnership with the appropriate chief elected officials, must review the regional plan and prepare and submit modifications to the regional plan to reflect changes:

(1) In regional labor market and economic conditions; and

(2) Other factors affecting the implementation of the local plan, including but not limited to changes in the financing available to support WIOA title I and partner-provided WIOA services.

§ 679.540 How are local planning requirements reflected in a regional plan?

(a) The regional plan must address the requirements at WIOA secs. 106(c)(1)(A)–(H), and incorporate the

local planning requirements identified for local plans at WIOA secs. 108(b)(1)–(22).

(b) The Governor may issue regional planning guidance that allows Local WDBs and chief elected officials in a planning region to address any local plan requirements through the regional plan where there is a shared regional responsibility.

§ 679.550 What are the requirements for the development of the local plan?

(a) Under WIOA sec. 108, each Local WDB must, in partnership with the appropriate chief elected officials, develop and submit a comprehensive 4-year plan to the Governor.

(1) The plan must identify and describe the policies, procedures, and local activities that are carried out in the local area, consistent with the State Plan.

(2) If the local area is part of a planning region, the Local WDB must comply with WIOA sec. 106(c) and §§ 679.510 through 679.540 in the preparation and submission of a regional plan.

(b) Consistent with § 679.510(b), the Local WDB must provide an opportunity for public comment on the development of the local plan or subsequent plan modifications before submitting the plan to the Governor. To provide adequate opportunity for public comment, the Local WDB must:

(1) Make copies of the proposed local plan available to the public through electronic and other means, such as public hearings and local news media;

(2) Include an opportunity for comment by members of the public, including representatives of business, labor organizations, and education;

(3) Provide no more than a 30-day period for comment on the plan before its submission to the Governor, beginning on the date on which the proposed plan is made available, prior to its submission to the Governor; and

(4) The Local WDB must submit any comments that express disagreement with the plan to the Governor along with the plan.

(5) Consistent WIOA sec. 107(e), the Local WDB must make information about the plan available to the public on a regular basis through electronic means and open meetings.

§ 679.560 What are the contents of the local plan?

(a) The local workforce investment plan must describe strategic planning elements, including:

(1) A regional analysis of:

(i) Economic conditions including existing and emerging in-demand industry sectors and occupations; and

(ii) Employment needs of employers in existing and emerging in-demand industry sectors and occupations.

(iii) As appropriate, a local area may use an existing analysis, which is a timely current description of the regional economy, to meet the requirements of paragraphs (a)(1)(i) and (ii) of this section;

(2) Knowledge and skills needed to meet the employment needs of the employers in the region, including employment needs in in-demand industry sectors and occupations;

(3) An analysis of the regional workforce, including current labor force employment and unemployment data, information on labor market trends, and educational and skill levels of the workforce, including individuals with barriers to employment;

(4) An analysis of workforce development activities, including education and training, in the region. This analysis must include the strengths and weaknesses of workforce development activities and capacity to provide the workforce development activities to address the education and skill needs of the workforce, including individuals with barriers to employment, and the employment needs of employers;

(5) A description of the Local WDB's strategic vision to support regional economic growth and economic self-sufficiency. This must include goals for preparing an educated and skilled workforce (including youth and individuals with barriers to employment), and goals relating to the performance accountability measures based on performance indicators described in § 677.155(a)(1) of this chapter; and

(6) Taking into account analyses described in paragraphs (a)(1) through (4) of this section, a strategy to work with the entities that carry out the core

programs and required partners to align resources available to the local area, to achieve the strategic vision and goals described in paragraph (a)(5) of this section.

(b) The plan must include a description of the following requirements at WIOA secs. 108(b)(2)–(21):

(1) The workforce development system in the local area that identifies:

(i) The programs that are included in the system; and

(ii) How the Local WDB will support the strategy identified in the State Plan under § 676.105 of this chapter and work with the entities carrying out core programs and other workforce development programs, including programs of study authorized under the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 *et seq.*) to support service alignment;

(2) How the Local WDB will work with entities carrying out core programs to:

(i) Expand access to employment, training, education, and supportive services for eligible individuals, particularly eligible individuals with barriers to employment;

(ii) Facilitate the development of career pathways and co-enrollment, as appropriate, in core programs; and

(iii) Improve access to activities leading to a recognized postsecondary credential (including a credential that is an industry-recognized certificate or certification, portable, and stackable);

(3) The strategies and services that will be used in the local area:

(i) To facilitate engagement of employers in workforce development programs, including small employers and employers in in-demand industry sectors and occupations;

(ii) To support a local workforce development system that meets the needs of businesses in the local area;

(iii) To better coordinate workforce development programs and economic development;

(iv) To strengthen linkages between the one-stop delivery system and unemployment insurance programs; and

(v) That may include the implementation of initiatives such as incumbent worker training programs, on-the-job training programs, customized training programs, industry and sector strategies, career pathways initiatives, utilization of effective business intermediaries, and other business services and strategies designed to meet the needs of regional employers. These initiatives must support the strategy described in paragraph (b)(3) of this section;

(4) An examination of how the Local WDB will coordinate local workforce investment activities with regional economic development activities that are carried out in the local area and how the Local WDB will promote entrepreneurial skills training and microenterprise services;

(5) The one-stop delivery system in the local area, including:

(i) How the Local WDB will ensure the continuous improvement of eligible providers through the system and that such providers will meet the employment needs of local employers, workers, and job seekers;

(ii) How the Local WDB will facilitate access to services provided through the one-stop delivery system, including in remote areas, through the use of technology and other means;

(iii) How entities within the one-stop delivery system, including one-stop operators and the one-stop partners, will comply with WIOA sec. 188, if applicable, and applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*) regarding the physical and programmatic accessibility of facilities, programs and services, technology, and materials for individuals with disabilities, including providing staff training and support for addressing the needs of individuals with disabilities; and

(iv) The roles and resource contributions of the one-stop partners;

(6) A description and assessment of the type and availability of adult and dislocated worker employment and training activities in the local area;

(7) A description of how the Local WDB will coordinate workforce investment activities carried out in the local area with statewide rapid response activities;

(8) A description and assessment of the type and availability of youth workforce investment activities in the local area including activities for

youth who are individuals with disabilities, which must include an identification of successful models of such activities;

(9) How the Local WDB will coordinate relevant secondary and postsecondary education programs and activities with education and workforce investment activities to coordinate strategies, enhance services, and avoid duplication of services;

(10) How the Local WDB will coordinate WIOA title I workforce investment activities with the provision of transportation and other appropriate supportive services in the local area;

(11) Plans, assurances, and strategies for maximizing coordination, improving service delivery, and avoiding duplication of Wagner-Peyser Act (29 U.S.C. 49 *et seq.*) services and other services provided through the one-stop delivery system;

(12) How the Local WDB will coordinate WIOA title I workforce investment activities with adult education and literacy activities under WIOA title II. This description must include how the Local WDB will carry out the review of local applications submitted under title II consistent with WIOA secs. 107(d)(11)(A) and (B)(i) and WIOA sec. 232;

(13) Copies of executed cooperative agreements which define how all local service providers, including additional providers, will carry out the requirements for integration of and access to the entire set of services available in the local one-stop delivery system. This includes cooperative agreements (as defined in WIOA sec. 107(d)(11)) between the Local WDB or other local entities described in WIOA sec. 101(a)(11)(B) of the Rehabilitation Act of 1973 (29 U.S.C. 721(a)(11)(B)) and the local office of a designated State agency or designated State unit administering programs carried out under title I of the Rehabilitation Act (29 U.S.C. 720 *et seq.*) (other than sec. 112 or part C of that title (29 U.S.C. 732, 741) and subject to sec. 121(f)) in accordance with sec. 101(a)(11) of the Rehabilitation Act (29 U.S.C. 721(a)(11)) with respect to efforts that will enhance the provision of services to individuals with disabilities and to other individuals, such as cross training of staff, technical assistance, use and sharing of information, cooperative efforts with employers, and other efforts at cooperation, collaboration, and coordination;

(14) An identification of the entity responsible for the disbursal of grant funds described in WIOA sec. 107(d)(12)(B)(i)(III), as determined by the chief elected official or the Governor under WIOA sec. 107(d)(12)(B)(i);

(15) The competitive process that will be used to award the subgrants and contracts for WIOA title I activities;

(16) The local levels of performance negotiated with the Governor and chief elected official consistent with WIOA sec. 116(c), to be used to measure the performance of the local area and to be used by the Local WDB for measuring the performance of the local fiscal agent (where appropriate), eligible providers under WIOA title I subtitle B, and the one-stop delivery system in the local area;

(17) The actions the Local WDB will take toward becoming or remaining a high-performing WDB, consistent with the factors developed by the State WDB;

(18) How training services outlined in WIOA sec. 134 will be provided through the use of individual training accounts, including, if contracts for training services will be used, how the use of such contracts will be coordinated with the use of individual training accounts under that chapter, and how the Local WDB will ensure informed customer choice in the selection of training programs regardless of how the training services are to be provided;

(19) The process used by the Local WDB, consistent with WIOA sec. 108(d), to provide a 30-day public comment period prior to submission of the plan, including an opportunity to have input into the development of the local plan, particularly for representatives of businesses, education, and labor organizations;

(20) How one-stop centers are implementing and transitioning to an integrated, technology-enabled intake and case management information system for programs carried out under WIOA and by one-stop partners; and

(21) The direction given by the Governor and the Local WDB to the one-

stop operator to ensure priority for adult career and training services will be given to recipients of public assistance, other low-income individuals, and individuals who are basic skills deficient consistent with WIOA sec. 134(c)(3)(E) and § 680.600 of this chapter.

(c) The local plan must include any additional information required by the Governor.

(d) The local plan must identify the portions that the Governor has designated as appropriate for common response in the regional plan where there is a shared regional responsibility, as permitted by § 679.540(b).

(e) Comments submitted during the public comment period that represent disagreement with the plan must be submitted with the local plan.

§ 679.570 What are the requirements for approval of a local plan?

(a) Consistent with the requirements at § 679.520 the Governor must review completed plans (including a modification to the plan). Such plans will be considered approved 90 days after the Governor receives the plan unless the Governor determines in writing that:

(1) There are deficiencies in workforce investment activities that have been identified through audits and the local area has not made acceptable progress in implementing plans to address deficiencies; or

(2) The plan does not comply with applicable provisions of WIOA and the WIOA regulations, including the required consultations and public comment provisions, and the nondiscrimination requirements of 29 CFR part 38.

(3) The plan does not align with the State Plan, including with regard to the alignment of the core programs to support the strategy identified in the State Plan in accordance with WIOA sec. 102(b)(1)(E) and § 676.105 of this chapter.

(b) In cases where the State is a single local area:

(1) The State must incorporate the local plan into the State's Unified or Combined State Plan and submit it to the U.S. Department of Labor in accordance with the procedures described in § 676.105 of this chapter.

(2) The Secretary of Labor performs the roles assigned to the Governor as they relate to local planning activities.

(3) The Secretary of Labor will issue planning guidance for such States.

§ 679.580 When must the local plan be modified?

(a) Consistent with the requirements at § 679.530, the Governor must establish procedures governing the modification of local plans.

(b) At the end of the first 2-year period of the 4-year local plan, each Local WDB, in partnership with the appropriate chief elected officials, must review the local plan and prepare and submit modifications to the local plan to reflect changes:

(1) In labor market and economic conditions; and

(2) Other factors affecting the implementation of the local plan, including but not limited to:

(i) Significant changes in local economic conditions;

(ii) Changes in the financing available to support WIOA title I and partner-provided WIOA services;

(iii) Changes to the Local WDB structure; and

(iv) The need to revise strategies to meet local performance goals.

Subpart E—Waivers/WorkFlex (Workforce Flexibility Plan)

§ 679.600 What is the purpose of the general statutory and regulatory waiver authority in the Workforce Innovation and Opportunity Act?

(a) The purpose of the general statutory and regulatory waiver authority provided at sec. 189(i)(3) of the WIOA is to provide flexibility to States and local areas and enhance their ability to improve the statewide workforce development system to achieve the goals and purposes of WIOA.

(b) A waiver may be requested to address impediments to the implementation of a Unified or Combined State Plan, including the continuous improvement strategy, consistent with the purposes of title I of WIOA as identified in § 675.100 of this chapter.

§ 679.610 What provisions of the Workforce Innovation and Opportunity Act and the Wagner-Peyser Act may be waived, and what provisions may not be waived?

(a) The Secretary may waive for a State, or local area in a State, any of the statutory or regulatory requirements of subtitles A, B and E of title I of WIOA, except for requirements relating to:

(1) Wage and labor standards;

(2) Non-displacement protections;

(3) Worker rights;

(4) Participation and protection of workers and participants;

(5) Grievance procedures and judicial review;

(6) Nondiscrimination;

(7) Allocation of funds to local areas;

(8) Eligibility of providers or participants;

(9) The establishment and functions of local areas and Local WDBs;

(10) Procedures for review and approval of State and Local plans;

(11) The funding of infrastructure costs for one-stop centers; and

(12) Other requirements relating to the basic purposes of title I of WIOA described in § 675.100 of this chapter.

(b) The Secretary may waive for a State, or local area in a State, any of the statutory or regulatory requirements of secs. 8 through 10 of the Wagner- Peyser Act (29 U.S.C. 49g–49i) except for requirements relating to:

(1) The provision of services to unemployment insurance claimants and veterans; and

(2) Universal access to the basic labor exchange services without cost to job seekers.

§ 679.620 Under what conditions may a Governor request, and the Secretary approve, a general waiver of statutory or regulatory requirements under the Workforce Innovation and Opportunity Act?

(a) The Secretary will issue guidelines under which the States may request general waivers of WIOA and Wagner-Peyser Act requirements.

(b) A Governor may request a general waiver in consultation with appropriate chief elected officials:

(1) By submitting a waiver plan which may accompany the State's WIOA 4-year Unified or Combined State Plan or 2-year modification; or

(2) After a State's WIOA Plan is approved, by separately submitting a waiver plan.

(c) A Governor's waiver request may seek waivers for the entire State or for one or more local areas within the State.

(d) A Governor requesting a general waiver must submit to the Secretary a plan to improve the statewide workforce development system that:

(1) Identifies the statutory or regulatory requirements for which a waiver is requested and the goals that the State or local area, as appropriate, intends to achieve as a result of the waiver and how those goals relate to the Unified or Combined State Plan;

(2) Describes the actions that the State or local area, as appropriate, has undertaken to remove State or local statutory or regulatory barriers;

(3) Describes the goals of the waiver and the expected programmatic outcomes if the request is granted;

(4) Describes how the waiver will align with the Department's policy priorities, such as:

(i) Supporting employer engagement;

(ii) Connecting education and training strategies;

(iii) Supporting work-based learning;

(iv) Improving job and career results; and

(v) Other priorities as articulated in guidance;

(5) Describes the individuals affected by the waiver, including how the waiver will impact services for disadvantaged populations or individuals with multiple barriers to employment; and

(6) Describes the processes used to:

(i) Monitor the progress in implementing the waiver;

(ii) Provide notice to any Local WDB affected by the waiver;

(iii) Provide any Local WDB affected by the waiver an opportunity to comment on the request;

(iv) Ensure meaningful public comment, including comment by business and organized labor, on the waiver; and

(v) Collect and report information about waiver outcomes in the State's WIOA Annual Report.

(7) The Secretary may require that States provide the most recent data

available about the outcomes of the existing waiver in cases where the State seeks renewal of a previously approved waiver.

(e) The Secretary will issue a decision on a waiver request within 90 days after the receipt of the original waiver request.

(f) The Secretary will approve a waiver request if and only to the extent that:

(1) The Secretary determines that the requirements for which a waiver is requested impede the ability of either the State or local area to implement the State's Plan to improve the statewide workforce development system;

(2) The Secretary determines that the waiver plan meets all of the requirements of WIOA sec. 189(i)(3) and §§ 679.600 through 679.620; and

(3) The State has executed a memorandum of understanding (MOU) with the Secretary requiring the State to meet, or ensure that the local area meets, agreed-upon outcomes and to implement other appropriate measures to ensure accountability.

(g) A waiver may be approved for as long as the Secretary determines appropriate, but for not longer than the duration of the State's existing Unified or Combined State Plan.

(h) The Secretary may revoke a waiver granted under this section if the Secretary determines that the State has failed to meet the agreed upon outcomes, measures, failed to comply with the terms and conditions in the MOU described in paragraph (f) of this section or any other document establishing the terms and conditions of the waiver, or if the waiver no longer meets the requirements of §§ 679.600 through 679.620.

§ 679.630 Under what conditions may the Governor submit a workforce flexibility plan?

(a) A State may submit to the Secretary, and the Secretary may approve, a workforce flexibility (workflex) plan under which the State is authorized to waive, in accordance with the plan:

(1) Any of the statutory or regulatory requirements under title I of WIOA applicable to local areas, if the local area requests the waiver in a waiver application, except for:

(i) Requirements relating to the basic purposes of title I of WIOA described in § 675.100 of this chapter;

(ii) Wage and labor standards;

(iii) Grievance procedures and judicial review;

(iv) Nondiscrimination;

(v) Eligibility of participants;

(vi) Allocation of funds to local areas;

(vii) Establishment and functions of local areas and Local WDBs;

(viii) Procedures for review and approval of local plans; and

(ix) Worker rights, participation, and protection.

(2) Any of the statutory or regulatory requirements applicable to the State under secs. 8 through 10 of the Wagner-Peyser Act (29 U.S.C. 49g-49i), except for requirements relating to:

(i) The provision of services to unemployment insurance claimants and veterans; and

(ii) Universal access to basic labor exchange services without cost to job seekers.

(3) Any of the statutory or regulatory requirements applicable under the Older Americans Act of 1965 (OAA) (42 U.S.C. 3001 *et seq.*), to State agencies on aging with respect to activities carried out using funds allotted under OAA sec. 506(b) (42 U.S.C. 3056d(b)), except for requirements relating to:

(i) The basic purposes of OAA;

(ii) Wage and labor standards;

(iii) Eligibility of participants in the activities; and

(iv) Standards for grant agreements.

(b) A workforce flexibility plan submitted under paragraph (a) of this section must include descriptions of:

(1) The process by which local areas in the State may submit and obtain State approval of applications for waivers of requirements under title I of WIOA;

(2) A description of the criteria the State will use to approve local area waiver requests and how such requests support implementation of the goals identified State Plan;

(3) The statutory and regulatory requirements of title I of WIOA that are likely to be waived by the State under the workforce flexibility plan;

(4) The statutory and regulatory requirements of secs. 8 through 10 of the

Wagner-Peyser Act that are proposed for waiver, if any;

(5) The statutory and regulatory requirements of the OAA that are proposed for waiver, if any;

(6) The outcomes to be achieved by the waivers described in paragraphs (b)(1) through (5) of this section including, where appropriate, revisions to adjusted levels of performance included in the State or local plan under title I of WIOA, and a description of the data or other information the State will use to track and assess outcomes; and

(7) The measures to be taken to ensure appropriate accountability for Federal funds in connection with the waivers.

(c) A State's workforce flexibility plan may accompany the State's Unified or Combined State Plan, 2-year modification, or may be submitted separately as a modification to that plan.

(d) The Secretary may approve a workforce flexibility plan consistent with the period of approval of the State's Unified or Combined State Plan, and not for more than 5 years.

(e) Before submitting a workforce flexibility plan to the Secretary for approval, the State must provide adequate notice and a reasonable opportunity for comment on the proposed waiver requests under the workforce flexibility plan to all interested parties and to the general public.

(f) The Secretary will issue guidelines under which States may request designation as a work-flex State. These guidelines may require a State to implement an evaluation of the impact of work-flex in the State.

§ 679.640 What limitations apply to the State's workforce flexibility plan authority under the Workforce Innovation and Opportunity Act?

(a)(1) Under work-flex waiver authority a State must not waive the WIOA, Wagner-Peyser Act or OAA requirements which are excepted from the work-flex waiver authority and described in § 679.630(a).

(2) Requests to waive statutory and regulatory requirements of title I of WIOA applicable at the State level may not be granted under work-flex waiver authority granted to a State. Such requests only may be granted by the Secretary under the general waiver authority described at §§ 679.610 through 679.620.

(b) As required in § 679.630(b)(6), States must address the outcomes to result from work-flex waivers as part of its workforce flexibility plan. The Secretary may terminate a State's work-flex designation if the State fails to meet agreed-upon outcomes or other terms and conditions contained in its workforce flexibility plan.

PART 680—ADULT AND DISLOCATED WORKER ACTIVITIES UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

Subpart A—Delivery of Adult and Dislocated Worker Activities Under Title I of the Workforce Innovation and Opportunity Act

Sec.

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Subpart A—Delivery of Adult and Dislocated Worker Activities Under Title I of the Workforce Innovation and Opportunity Act

§ 680.100 What is the role of the adult and dislocated worker programs in the one-stop delivery system?

(a) The one-stop delivery system is the basic delivery system for adult and dislocated worker services. Through this system, adults and dislocated workers can access a continuum of services. The services are classified as career and training services.

(b) The chief elected official or his/her designee(s), as the local grant recipient(s) for the adult and dislocated worker programs, is a required one-stop partner and is subject to the provisions relating to such partners described in part 678 of this chapter. Consistent with those provisions:

(1) Career services for adults and dislocated workers must be made available in at least one one-stop center in each local area. Services also may be available elsewhere, either at affiliated sites or at specialized centers. For example, specialized centers may be established to serve workers being dislocated from a particular employer or industry, or to serve residents of public housing.

(2) Through the one-stop delivery system, adults and dislocated workers needing training are provided Individual Training Accounts (ITAs) and access to lists of eligible training providers and programs of training. These lists contain quality consumer information, including cost and performance information for each of the providers' programs, so that participants can make informed choices on where to use their ITAs. (ITAs are more fully discussed in subpart C of this part.)

§ 680.110 When must adults and dislocated workers be registered and considered a participant?

(a) Registration is the process for collecting information to support a determination of eligibility. This information may be collected through methods that include electronic data transfer, personal interview, or an individual's application. Individuals are considered participants when they have received a Workforce Innovation and Opportunity Act (WIOA) service other than self-service or information-only activities and have satisfied all applicable programmatic requirements for the provision of services, such as eligibility determination (*see* § 677.150(a) of this chapter).

(b) Adults and dislocated workers who receive services funded under WIOA title I other than self-service or information-only activities must be registered and must be a participant.

(c) EO data, as defined in § 675.300 of this chapter, must be collected on every individual who is interested in being considered for WIOA title I financially assisted aid, benefits, services, or training by a recipient, and who has signified that interest by submitting personal information in response to a

request from the grant recipient or designated service provider.

§ 680.120 What are the eligibility criteria for career services for adults in the adult and dislocated worker programs?

To be eligible to receive career services as an adult in the adult and dislocated worker programs, an individual must be 18 years of age or older. To be eligible for any dislocated worker programs, an eligible adult must meet the criteria of § 680.130. Eligibility criteria for training services are found at § 680.210.

§ 680.130 What are the eligibility criteria for career services for dislocated workers in the adult and dislocated worker programs?

(a) To be eligible to receive career services as a dislocated worker in the adult and dislocated worker programs, an individual must meet the definition of ''dislocated worker'' at WIOA sec. 3(15). Eligibility criteria for training services are found at § 680.210.

(b) Governors and Local Workforce Development Boards (WDBs) may establish policies and procedures for one-stop centers to use in determining an individual's eligibility as a dislocated worker, consistent with the definition at WIOA sec. 3(15). These policies and procedures may address such conditions as:

(1) What constitutes a ''general announcement'' of plant closing under WIOA sec. 3(15)(B)(ii) or (iii);

(2) What constitutes ''unemployed as a result of general economic conditions in the community in which the individual resides or because of natural disasters'' for determining the eligibility of self-employed individuals, including family members and farm workers or ranch hands, under WIOA sec. 3(15)(C); and

(3) What constitutes ''unlikely to return to a previous industry or occupation'' under WIOA sec. 3(15)(A)(iii), consistent with § 680.660.

§ 680.140 What Workforce Innovation and Opportunity Act title I adult and dislocated worker services are Local Workforce Development Boards required and permitted to provide?

(a) WIOA title I formula funds allocated to local areas for adults and dislocated workers must be used to provide career and training services through the one-stop delivery system. Local WDBs determine the most appropriate mix of these services, but both types must be available for eligible adults and dislocated workers. Different eligibility criteria apply for each type of services. *See* §§ 680.120, 680.130, and 680.210.

(b) WIOA title I funds also may be used to provide the additional services described in WIOA sec. 134(d), including:

(1) Job seeker services, such as:

(i) Customer support to enable individuals with barriers to employment (including individuals with disabilities) and veterans, to navigate among multiple services and activities;

(ii) Training programs for displaced homemakers and for individuals training for nontraditional employment (as defined in WIOA sec. 3(37) as occupations or fields of work in which individuals of one gender comprise less than 25 percent of the individuals so employed), in conjunction with programs operated in the local area;

(iii) Work support activities for low-wage workers, in coordination with one-stop partners, which will provide opportunities for these workers to retain or enhance employment. These activities may include any activities available under the WIOA adult and dislocated worker programs in coordination with activities and resources available through partner programs. These activities may be provided in a manner that enhances the worker's ability to participate, for example by providing them at nontraditional hours or providing on-site child care;

(iv) Supportive services, including needs-related payments, as described in subpart G of this part; and

(v) Transitional jobs, as described in § 680.190, to individuals with barriers to

employment who are chronically unemployed or have an inconsistent work history;

(2) Employer services, such as:

(i) Customized screening and referral of qualified participants in training services to employers;

(ii) Customized employment-related services to employers, employer associations, or other such organization on a fee-for-service basis that are in addition to labor exchange services available to employers under the Wagner-Peyser Act Employment Service;

(iii) Activities to provide business services and strategies that meet the workforce investment needs of area employers, as determined by the Local WDB and consistent with the local plan (*see* § 678.435 of this chapter and WIOA sec. 134(d)(1)(A)(ix)); and

(3) Coordination activities, such as:

(i) Employment and training activities in coordination with child support enforcement activities, as well as child support services and assistance activities, of the State and local agencies carrying out part D of title IV of the Social Security Act (42 U.S.C. 651 *et seq.*);

(ii) Employment and training activities in coordination with cooperative extension programs carried out by the Department of Agriculture;

(iii) Employment and training activities in coordination with activities to facilitate remote access to services provided through a one-stop delivery system, including facilitating access through the use of technology;

(iv) Improving coordination between workforce investment activities and economic development activities carried out within the local area involved, and to promote entrepreneurial skills training and microenterprise services;

(v) Improving services and linkages between the local workforce development system (including the local one-stop delivery system) and employers, including small employers, in the local area;

(vi) Strengthening linkages between the one-stop delivery system and the unemployment insurance programs; and

(vii) Improving coordination between employment and training activities and programs carried out in the local area for individuals with disabilities, including programs carried out by State agencies relating to intellectual disabilities and developmental disabilities, activities carried out by Statewide Independent Living Councils established under sec. 705 of the Rehabilitation Act of 1973 (29 U.S.C. 796d), programs funded under part B of chapter 1 of title VII of such Act (29 U.S.C. 796e *et seq.*), and activities carried out by centers for independent living, as defined in sec. 702 of such Act (29 U.S.C. 796a);

(4) Implementing a Pay-for-Performance contract strategy for training services in accordance with §§ 683.500 through 683.530 of this chapter for which up to 10 percent of the Local WDB's total adult and dislocated worker funds may be used;

(5) Technical assistance for one-stop centers, partners, and eligible training providers (ETPs) on the provision of service to individuals with disabilities in local areas, including staff training and development, provision of outreach and intake assessments, service delivery, service coordination across providers and programs, and development of performance accountability measures;

(6) Activities to adjust the economic self-sufficiency standards referred to in WIOA sec. 134(a)(3)(A)(xii) for local factors or activities to adopt, calculate or commission for approval, economic self-sufficiency standards for the local areas that specify the income needs of families, by family size, the number and ages of children in the family, and sub-State geographical considerations;

(7) Implementing promising service to workers and businesses, which may include support for education, training, skill upgrading, and statewide networking for employees to become workplace learning advisors and maintain proficiency in carrying out the activities associated with such advising; and

(8) Incumbent worker training programs, as described in subpart F of this part.

§ 680.150 What career services must be provided to adults and dislocated workers?

(a) At a minimum, all of the basic career services described in WIOA secs. 134(c)(2)(A)(i)–(xi) and § 678.430(a) of this chapter must be provided in each local area through the one-stop delivery system.

(b) Individualized career services described in WIOA sec. 134(c)(2)(A)(xii) and § 678.430(b) of this chapter must be made available, if determined appropriate in order for an individual to obtain or retain employment.

(c) Follow-up services, as described in WIOA sec. 134(c)(2)(A)(xiii) and § 678.430(c) of this chapter, must be made available, as determined appropriate by the Local WDB, for a minimum of 12 months following the first day of employment, to participants who are placed in unsubsidized employment.

§ 680.160 How are career services delivered?

Career services must be provided through the one-stop delivery system. Career services may be provided directly by the one-stop operator or through contracts with service providers that are approved by the Local WDB. The Local WDB only may be a provider of career services when approved by the chief elected official and the Governor in accordance with the requirements of WIOA sec. 107(g)(2) and § 679.410 of this chapter.

§ 680.170 What is the individual employment plan?

The individual employment plan (IEP) is an individualized career service, under WIOA sec. 134(c)(2)(A)(xii)(II), that is developed jointly by the participant and career planner when determined appropriate by the one-stop center or one-stop partner. The plan is an ongoing strategy to identify employment goals, achievement objectives, and an appropriate combination of services for the participant to achieve the employment goals.

§ 680.180 What is an internship or work experience for adults and dislocated workers?

For the purposes of WIOA sec. 134(c)(2)(A)(xii)(VII), an internship or work experience is a planned, structured learning experience that takes place in a workplace for a limited period of time. Internships and other work experience may be paid or unpaid, as appropriate and consistent with other laws, such as the Fair Labor Standards Act. An internship or other work experience may be arranged within the private for profit sector, the non-profit sector, or the public sector. Labor standards apply in any work experience setting where an employee/employer relationship, as defined by the Fair Labor Standards Act, exists. Transitional jobs are a type of work experience, as described in §§ 680.190 and 680.195.

§ 680.190 What is a transitional job?

A transitional job is one that provides a time-limited work experience, that is wage-paid and subsidized, and is in the public, private, or non-profit sectors for those individuals with barriers to employment who are chronically unemployed or have inconsistent work history, as determined by the Local WDB. These jobs are designed to enable an individual to establish a work history, demonstrate work success in an employee-employer relationship, and develop the skills that lead to unsubsidized employment.

§ 680.195 What funds may be used for transitional jobs?

The local area may use up to 10 percent of their combined total of adult and dislocated worker allocations for transitional jobs as described in § 680.190. Transitional jobs must be combined with comprehensive career services (*see* § 680.150) and supportive services (*see* § 680.900).

Subpart B—Training Services

§ 680.200 What are training services for adults and dislocated workers?

Types of training services are listed in WIOA sec. 134(c)(3)(D) and in paragraphs (a) through (k) of this section.

This list is not all-inclusive and additional training services may be provided.

(a) Occupational skills training, including training for nontraditional employment;

(b) On-the-job training (OJT) (*see* §§ 680.700, 680.710, 680.720, and 680.730);

(c) Incumbent worker training, in accordance with WIOA sec. 134(d)(4) and §§ 680.780, 680.790, 680.800, 680.810, and 680.820;

(d) Programs that combine workplace training with related instruction, which may include cooperative education programs;

(e) Training programs operated by the private sector;

(f) Skills upgrading and retraining;

(g) Entrepreneurial training;

(h) Transitional jobs in accordance with WIOA sec 134(d)(5) and §§ 680.190 and 680.195;

(i) Job readiness training provided in combination with services listed in paragraphs (a) through (h) of this section;

(j) Adult education and literacy activities, including activities of English language acquisition and integrated education and training programs, provided concurrently or in combination with training services listed in paragraphs (a) through (g) of this section; and

(k) Customized training conducted with a commitment by an employer or group of employers to employ an individual upon successful completion of the training (*see* §§ 680.760 and 680.770).

§ 680.210 Who may receive training services?

Under WIOA sec. 134(c)(3)(A) training services may be made available to employed and unemployed adults and dislocated workers who:

(a) A one-stop center or one-stop partner determines, after an interview, evaluation, or assessment, and career planning, are:

(1) Unlikely or unable to obtain or retain employment that leads to economic self-sufficiency or wages comparable to or higher than wages from previous employment through career services;

(2) In need of training services to obtain or retain employment leading to economic self-sufficiency or wages comparable to or higher than wages from previous employment; and

(3) Have the skills and qualifications to participate successfully in training services;

(b) Select a program of training services that is directly linked to the employment opportunities in the local area or the planning region, or in another area to which the individuals are willing to commute or relocate;

(c) Are unable to obtain grant assistance from other sources to pay the costs of such training, including such sources as State-funded training funds, Trade Adjustment Assistance (TAA), and Federal Pell Grants established under title IV of the Higher Education Act of 1965, or require WIOA assistance in addition to other sources of grant assistance, including Federal Pell Grants (provisions relating to fund coordination are found at § 680.230 and WIOA sec. 134(c)(3)(B)); and

(d) If training services are provided through the adult funding stream, are determined eligible in accordance with the State and local priority system in effect for adults under WIOA sec. 134(c)(3)(E) and § 680.600.

§ 680.220 Are there particular career services an individual must receive before receiving training services under the Workforce Innovation and Opportunity Act?

(a) Yes, except as provided by paragraph (b) of this section, an individual must at a minimum receive either an interview, evaluation, or assessment, and career planning or any other method through which the one-stop center or partner can obtain enough information to make an eligibility determination to be determined eligible for training services under WIOA sec. 134(c)(3)(A)(i) and § 680.210. Where appropriate, a recent interview, evaluation, or assessment, may be used for the assessment purpose.

(b) The case file must contain a determination of need for training services under § 680.210 as determined through the interview, evaluation, or assessment, and career planning informed by local labor market information and training provider performance

information, or through any other career service received. There is no requirement that career services be provided as a condition to receipt of training services; however, if career services are not provided before training, the Local WDB must document the circumstances that justified its determination to provide training without first providing the services described in paragraph (a) of this section.

(c) There is no Federally required minimum time period for participation in career services before receiving training services.

§ 680.230 What are the requirements for coordination of Workforce Innovation and Opportunity Act training funds and other grant assistance?

(a) WIOA funding for training is limited to participants who:

(1) Are unable to obtain grant assistance from other sources to pay the costs of their training; or

(2) Require assistance beyond that available under grant assistance from other sources to pay the costs of such training. Programs and training providers must coordinate funds available to pay for training as described in paragraphs (b) and (c) of this section. In making the determination under this paragraph (a), one-stop centers may take into account the full cost of participating in training services, including the cost of support services and other appropriate costs.

(b) One-stop centers must coordinate training funds available and make funding arrangements with one-stop partners and other entities to apply the provisions of paragraph (a) of this section. One-stop centers must consider the availability of other sources of grants to pay for training costs such as Temporary Assistance for Needy Families (TANF), State-funded training funds, and Federal Pell Grants, so that WIOA funds supplement other sources of training grants.

(c) A WIOA participant may enroll in WIOA-funded training while his/her application for a Pell Grant is pending as long as the one-stop center has made arrangements with the training provider and the WIOA participant regarding allocation of the Pell Grant, if it is subsequently awarded. In that case, the training provider must reimburse the one-stop center the WIOA funds used to underwrite the training for the amount the Pell Grant covers, including any education fees the training provider charges to attend training. Reimbursement is not required from the portion of Pell Grant assistance disbursed to the WIOA participant for education-related expenses.

Subpart C—Individual Training Accounts

§ 680.300 How are training services provided?

Training services for eligible individuals are typically provided by training providers who receive payment for their services through an ITA. The ITA is a payment agreement established on behalf of a participant with a training provider. WIOA title I adult and dislocated workers purchase training services from State eligible training providers they select in consultation with the career planner, which includes discussion of program quality and performance information on the available eligible training providers. Payments from ITAs may be made in a variety of ways, including the electronic transfer of funds through financial institutions, vouchers, or other appropriate methods. Payments also may be made incrementally, for example, through payment of a portion of the costs at different points in the training course. Under limited conditions, as provided in § 680.320 and WIOA sec. 134(d)(3)(G), a Local WDB may contract for these services, rather than using an ITA for this purpose. In some limited circumstances, the Local WDB may itself provide the training services, but only if it obtains a waiver from the Governor for this purpose, and the Local WDB meets the other requirements of § 679.410 of this chapter and WIOA sec. 107(g)(1).

§ 680.310 Can the duration and amount of Individual Training Accounts be limited?

(a) Yes, the State or Local WDB may impose limits on ITAs, such as limitations on the dollar amount and/or duration.

(b) Limits to ITAs may be established in different ways:

(1) There may be a limit for an individual participant that is based on the needs identified in the IEP, such as the participant's occupational choice or goal and the level of training needed to succeed in that goal; or

(2) There may be a policy decision by the State WDB or Local WDB to establish a range of amounts and/or a maximum amount applicable to all ITAs.

(c) Limitations established by State or Local WDB policies must be described in the State or Local Plan, respectively, but must not be implemented in a manner that undermines WIOA's requirement that training services are provided in a manner that maximizes customer choice in the selection of an ETP. Exceptions to ITA limitations may be provided for individual cases and must be described in State or Local WDB policies.

(d) An individual may select training that costs more than the maximum amount available for ITAs under a State or local policy when other sources of funds are available to supplement the ITA. These other sources may include: Pell Grants; scholarships; severance pay; and other sources.

§ 680.320 Under what circumstances may mechanisms other than Individual Training Accounts be used to provide training services?

(a) Contracts for services may be used instead of ITAs only when one or more of the following five exceptions apply, and the local area has fulfilled the consumer choice requirements of § 680.340:

(1) When the services provided are on-the-job-training (OJT), customized training, incumbent worker training, or transitional jobs.

(2) When the Local WDB determines that there are an insufficient number of eligible training providers in the local area to accomplish the purpose of a system of ITAs. The determination process must include a public comment period for interested providers of at least 30 days, and be described in the Local Plan.

(3) When the Local WDB determines that there is a training services program of demonstrated effectiveness offered in the area by a community-based organization or another private organization to serve individuals with barriers to employment, as described in paragraph (b) of this section. The Local WDB must develop criteria to be used in determining demonstrated effectiveness, particularly as it applies to the individuals with barriers to employment to be served. The criteria may include:

(i) Financial stability of the organization;

(ii) Demonstrated performance in the delivery of services to individuals with barriers to employment through such means as program completion rate; attainment of the skills, certificates or degrees the program is designed to provide; placement after training in unsubsidized employment; and retention in employment; and

(iii) How the specific program relates to the workforce investment needs identified in the local plan.

(4) When the Local WDB determines that it would be most appropriate to contract with an institution of higher education (*see* WIOA sec. 3(28)) or other provider of training services in order to facilitate the training of multiple individuals in in-demand industry sectors or occupations, provided that the contract does not limit consumer choice.

(5) When the Local WDB is considering entering into a Pay-for-Performance contract, and the Local WDB ensures that the contract is consistent with § 683.510 of this chapter.

(b) Under paragraph (a)(3) of this section, individuals with barriers to employment include those individuals in one or more of the following categories, as prescribed by WIOA sec. 3(24):

(1) Displaced homemakers;

(2) Low-income individuals;

(3) Indians, Alaska Natives, and Native Hawaiians;

(4) Individuals with disabilities;

(5) Older individuals, *i.e.*, those aged 55 or over;

(6) Ex-offenders;

(7) Homeless individuals;

(8) Youth who are in or have aged out of the foster care system;

(9) Individuals who are English language learners, individuals who have

low levels of literacy, and individuals facing substantial cultural barriers;

(10) Eligible migrant and seasonal farmworkers, defined in WIOA sec. 167(i);

(11) Individuals within 2 years of exhausting lifetime eligibility under TANF (part A of title IV of the Social Security Act);

(12) Single-parents (including single pregnant women);

(13) Long-term unemployed individuals; or

(14) Other groups determined by the Governor to have barriers to employment.

(c) The Local Plan must describe the process to be used in selecting the providers under a contract for services.

§ 680.330 How can Individual Training Accounts, supportive services, and needs-related payments be used to support placing participating adults and dislocated workers into a registered apprenticeship program and support participants once they are in a registered apprenticeship program?

Registered apprenticeships automatically qualify to be a on a State's eligible training provider list (ETPL) as described in § 680.470.

(a) ITAs can be used to support placing participants in registered apprenticeship through:

(1) Pre-apprenticeship training, as defined in § 681.480 of this chapter; and

(2) Training services provided under a registered apprenticeship program.

(b) Supportive services may be provided as described in §§ 680.900 and 680.910.

(c) Needs-related payments may be provided as described in §§ 680.930, 680.940, 680.950, 680.960, and 680.970.

(d) Work-based training options also may be used to support participants in registered apprenticeship programs (*see* §§ 680.740 and 680.750).

§ 680.340 What are the requirements for consumer choice?

(a) Training services, whether under ITAs or under contract, must be provided in a manner that maximizes informed consumer choice in selecting an eligible provider.

(b) Each Local WDB, through the one-stop center, must make available to customers the State list of eligible training providers required in WIOA sec. 122(d). The list includes a description of the programs through which the providers may offer the training services, and the performance and cost information about those providers described in WIOA sec. 122(d). Additionally, the Local WDB must make available information identifying eligible providers as may be required by the Governor under WIOA sec. 122(h) (where applicable).

(c) An individual who has been determined eligible for training services under § 680.210 may select a provider described in paragraph (b) of this section after consultation with a career planner. Unless the program has exhausted training funds for the program year, the one-stop center must refer the individual to the selected provider, and establish an ITA for the individual to pay for training. For purposes of this paragraph (c), a referral may be carried out by providing a voucher or certificate to the individual to obtain the training.

(d) The cost of referral of an individual with an ITA to a training provider is paid by the applicable adult or dislocated worker program under title I of WIOA.

(e) Each Local WDB, through the one-stop center, may coordinate funding for ITAs with funding from other Federal, State, local, or private job training programs or sources to assist the individual in obtaining training services.

(f) Consistent with paragraph (a) of this section, priority consideration must be given to programs that lead to recognized postsecondary credentials (defined at WIOA sec. 3(52)) that are aligned with in-demand industry sectors or occupations in the local area.

§ 680.350 May Workforce Innovation and Opportunity Act title I adult and dislocated worker funds be used to directly support adult education and literacy activities?

Yes, under WIOA sec. 134(c)(3)(D)(x), title I funds may provide adult education and literacy activities if they are provided concurrently or in combination with one or more of the following training services:

(a) Occupational skills training, including training for nontraditional employment;
(b) OJT;
(c) Incumbent worker training (as described in §§ 680.780, 680.790, 680.800, 680.810, and 680.820);
(d) Programs that combined workplace training and related instruction, which may include cooperative education programs;
(e) Training programs operated by the private sector;
(f) Skill upgrading and retraining; or
(g) Entrepreneurial training.

Subpart D—Eligible Training Providers

§ 680.400 What is the purpose of this subpart?

(a) This subpart describes the process for determining eligible training providers and programs for WIOA title I, subtitle B adult, dislocated worker, and out-of-school youth (OSY) aged 16–24 training participants and for publicly disseminating the list of these providers with relevant information about their programs. The workforce development system established under WIOA emphasizes informed consumer choice, job-driven training, provider performance, and continuous improvement. The quality and selection of providers and programs of training services is vital to achieving these core principles.

(b) The State list of eligible training providers and programs and the related eligibility procedures ensure the accountability, quality and labor-market relevance of programs of training services that receive funds through WIOA title I, subtitle B. The State list of eligible training providers and programs also is a means for ensuring informed customer choice for individuals eligible for training. In administering the eligible training provider eligibility process, States and local areas must work to ensure that qualified providers offering a wide variety of job-driven programs of training services are available. The State list of eligible training providers and programs is made publicly available online through Web sites and searchable databases as well as any other means the State uses to disseminate information to consumers, including formats accessible to individuals with disabilities. The list must be accompanied by relevant performance and cost information and must be presented in a way that is easily understood, in order to maximize informed consumer choice and serve all significant population groups, and also must be available in an electronic format. The State eligible training provider performance reports, as required under WIOA sec. 116(d)(4), are addressed separately in § 677.230 of this chapter.

§ 680.410 What is an eligible training provider?

An ETP:
(a) Is the only type of entity that receives funding for training services, as defined in § 680.200, through an individual training account;
(b) Must be included on the State list of eligible training providers and programs under this subpart;
(c) Must provide a program of training services; and
(d) Must be one of the following types of entities:
(1) Institutions of higher education that provide a program which leads to a recognized postsecondary credential;
(2) Entities that carry out programs registered under the National Apprenticeship Act (29 U.S.C. 50 *et seq.*); or
(3) Other public or private providers of training services, which may include:
(i) Community-based organizations;
(ii) Joint labor-management organizations; and
(iii) Eligible providers of adult education and literacy activities under title II of WIOA if such activities are provided in combination with training services described at § 680.350.

§ 680.420 What is a "program of training services"?

A program of training services is one or more courses or classes, or a structured regimen, that provides the services in § 680.200 and leads to:
(a) An industry-recognized certificate or certification, a certificate of completion of a registered apprenticeship, a license recognized by the State involved or the Federal government, an associate or baccalaureate degree;

(b) Consistent with § 680.350, a secondary school diploma or its equivalent;

(c) Employment; or

(d) Measurable skill gains toward a credential described in paragraph (a) or (b) of this section or employment.

§ 680.430 Who is responsible for managing the training provider eligibility process?

(a) The Governor, in consultation with the State WDB, establishes the criteria, information requirements, and procedures, including procedures identifying the respective roles of the State and local areas, governing the eligibility of providers and programs of training services to receive funds through ITAs.

(b) The Governor may designate a State agency (or appropriate State entity) to assist in carrying out the process and procedures for determining the eligibility of training providers and programs of training services. The Governor or such agency (or appropriate State entity) is responsible for:

(1) Ensuring the development and maintenance of the State list of eligible training providers and programs, as described in §§ 680.450 (initial eligibility), 680.460 (continued eligibility), and 680.490 (performance and cost information reporting requirements);

(2) Ensuring that programs meet eligibility criteria and performance levels established by the State, including verifying the accuracy of the information;

(3) Removing programs that do not meet State-established program criteria or performance levels, as described in § 680.480(c);

(4) Taking appropriate enforcement actions against providers that intentionally provide inaccurate information, or that substantially violate the requirements of WIOA, as described in § 680.480(a) and (b); and

(5) Disseminating the State list of eligible training providers and programs, accompanied by performance and cost information relating to each program, to the public and the Local WDBs throughout the State, as further described in § 680.500.

(c) The Local WDB must:

(1) Carry out the procedures assigned to the Local WDB by the State, such as determining the initial eligibility of entities providing a program of training services, renewing the eligibility of providers and programs, and considering the possible termination of an eligible training provider due to the provider's submission of inaccurate eligibility and performance information or the provider's substantial violation of WIOA requirements;

(2) Work with the State to ensure there are sufficient numbers and types of providers of training services, including eligible providers with expertise in assisting individuals with disabilities and eligible providers with expertise in assisting adults in need of adult education and literacy activities described under WIOA sec. 107(d)(10)(E), serving the local area; and

(3) Ensure the dissemination and appropriate use of the State list of eligible training providers and programs through the local one-stop delivery system, including formats accessible to individuals with disabilities.

(d) The Local WDB may make recommendations to the Governor on the procedure used in determining eligibility of providers and programs.

(e) The Local WDB may, except with respect to registered apprenticeship programs:

(1) Require additional criteria and information from local providers as criteria to become or remain eligible in that local area; and

(2) Set higher levels of performance than those required by the State as criteria for local programs to become or remain eligible to provide services in that local area.

§ 680.440 [Reserved]

§ 680.450 What is the initial eligibility process for new providers and programs?

(a) All providers and programs that have not previously been eligible to provide training services under WIOA sec. 122 or WIA sec. 122, except for registered apprenticeship programs, must submit required information to be considered for initial eligibility in accordance with the Governor's procedures.

(b) Apprenticeship programs registered under the National Apprenticeship Act are exempt from initial eligibility procedures. Registered apprenticeship programs must be included and maintained on the State list of eligible training providers and programs as long as the program remains registered, unless the registered apprenticeship program is removed from the list for a reason set forth in § 680.470. Procedures for registered apprenticeship programs to be included and maintained on the list are described in § 680.470.

(c) In establishing the State requirements described in paragraph (e) of this section, the Governor must, in consultation with the State WDB, develop a procedure for determining the eligibility of training providers and programs. This procedure, which must be described in the State Plan, must be developed after:

(1) Soliciting and taking into consideration recommendations from Local WDBs and providers of training services within the State;

(2) Providing an opportunity for interested members of the public, including representatives of business and labor organizations, to submit comments on the procedure; and

(3) Designating a specific time period for soliciting and considering the recommendations of Local WDBs and providers, and for providing an opportunity for public comment.

(d) For institutions of higher education that provide a program that leads to a recognized postsecondary credential and for other public or private providers of programs of training services, including joint labor-management organizations, and providers of adult education and literacy activities, the Governor must establish criteria and State requirements for providers and programs seeking initial eligibility.

(e) The Governor must require providers and programs seeking initial eligibility to provide verifiable program specific performance information. At a minimum, these criteria must require applicant providers to:

(1) Describe each program of training services to be offered;

(2) Provide information addressing a factor related to the indicators of performance, as described in WIOA secs. 116(b)(2)(A)(i)(I)–(IV) and § 680.460(g)(1) through (4) which include unsubsidized employment during the second quarter after exit, unsubsidized employment during the fourth quarter after exit, median earnings and credentials attainment;

(3) Describe whether the provider is in a partnership with a business;

(4) Provide other information the Governor may require in order to demonstrate high quality programs of training services, which may include information related to training services that lead to a recognized postsecondary credential; and

(5) Provide information that addresses alignment of the training services with in-demand industry sectors and occupations, to the extent possible.

(f) In establishing the initial eligibility procedures and criteria, the Governor may establish minimum performance standards, based on the performance information described in paragraph (e) of this section.

(g) Under WIOA sec. 122(b)(4)(B), eligible training providers receive initial eligibility for only 1 year for a particular program.

(h) After the initial eligibility expires, these initially eligible training providers are subject to the Governor's application procedures for continued eligibility, described at § 680.460, in order to remain eligible.

§ 680.460 What is the application procedure for continued eligibility?

(a) The Governor must establish an application procedure for eligible training providers and programs to maintain their continued eligibility. The application procedure must take into account the program's prior eligibility status.

(1) Training providers and programs that were previously eligible under WIA will be subject to the application procedure for continued eligibility after the close of the Governor's transition period for implementation.

(2) Training providers and programs that were not previously eligible under WIA and have been determined to be initially eligible under WIOA, under

the procedures described at § 680.450, will be subject to the application procedure for continued eligibility after their initial eligibility expires.

(b) The Governor must develop this procedure after:

(1) Soliciting and taking into consideration recommendations from Local WDBs and providers of training services within the State;

(2) Providing an opportunity for interested members of the public, including representatives of business and labor organizations, to submit comments on such procedure; and

(3) Designating a specific time period for soliciting and considering the recommendations of Local WDBs and providers, and for providing an opportunity for public comment.

(c) Procedures for registered apprenticeship programs to be included and maintained on the list are described in § 680.470. Apprenticeship programs registered under the National Apprenticeship Act must be included and maintained on the State list of eligible training providers and programs as long as the program remains registered, unless the registered apprenticeship program is removed from the list for a reason set forth in § 680.470.

(d) The application procedure must describe the roles of the State and local areas in receiving and reviewing provider applications and in making eligibility determinations.

(e) The application procedure must be described in the State Plan.

(f) In establishing eligibility criteria, the Governor must take into account:

(1) The performance of the eligible training provider's program on:

(i) The performance accountability measures described in WIOA secs. 116(b)(2)(A)(i)(I)–(IV) and the other matters required by WIOA sec. 122(b)(2);

(ii) Other appropriate measures of performance outcomes determined by the Governor for program participants receiving training services under WIOA title I, subtitle B, taking into consideration the characteristics of the population served and relevant economic conditions; and

(iii) Outcomes of the program for students in general with respect to employment and earnings as defined in WIOA sec. 116(b)(2).

(iv) All of these measures may include minimum performance standards.

(v) Until data from the conclusion of each performance indicator's first data cycle are available, the Governor may take into account alternate factors related to the measures described in paragraphs (f)(1)(i) through (iv) of this section.

(2) Ensuring access to training services throughout the State, including in rural areas, and through the use of technology;

(3) Information reported to State agencies on Federal and State training programs other than programs within WIOA title I, subtitle B;

(4) The degree to which programs of training services relate to in-demand industry sectors and occupations in the State;

(5) State licensure requirements of training providers;

(6) Encouraging the use of industry-recognized certificates and credentials;

(7) The ability of providers to offer programs of training services that lead to postsecondary credentials;

(8) The quality of the program of training services including a program that leads to a recognized postsecondary credential;

(9) The ability of the providers to provide training services to individuals who are employed and individuals with barriers to employment;

(10) Whether the providers timely and accurately submitted all of the information required for completion of eligible training provider performance reports required under WIOA sec. 116(d)(4) and all of the information required for initial and continued eligibility in this subpart; and

(11) Other factors that the Governor determines are appropriate in order to ensure: The accountability of providers; that one-stop centers in the State will meet the needs of local employers and participants; and, that participants will be given an informed choice among providers.

(g) The information requirements that the Governor establishes under

paragraph (f)(1) of this section must require eligible training providers to submit appropriate, accurate, and timely information for participants receiving training under WIOA title I, subtitle B. That information must include:

(1) The percentage of program participants who are in unsubsidized employment during the second quarter after exit from the program;

(2) The percentage of program participants who are in unsubsidized employment during the fourth quarter after exit from the program;

(3) The median earnings of program participants who are in unsubsidized employment during the second quarter after exit from the program;

(4) The percentage of program participants who obtain a recognized postsecondary credential, or a secondary school diploma or its recognized equivalent during participation in or within 1 year after exit from the program;

(5) Information on recognized postsecondary credentials received by program participants;

(6) Information on cost of attendance, including costs of tuition and fees, for program participants;

(7) Information on the program completion rate for such participants.

(h) The eligibility criteria must require that:

(1) Providers submit performance and cost information as described in paragraph (g) of this section and in the Governor's procedures for each program of training services for which the provider has been determined to be eligible, in a timeframe and manner determined by the State, but at least every 2 years; and

(2) That the collection of information required to demonstrate compliance with the criteria is not unduly burdensome or costly to providers.

(i) The procedure for continued eligibility also must provide for the State biennially to review provider eligibility information to assess the renewal of training provider eligibility. Such procedures may establish minimum levels of training provider performance as criteria for continued eligibility.

(j) The procedure for biennial review of the provider eligibility must include verification of the registration status of registered apprenticeship programs and removal of any registered apprenticeship programs as described in § 680.470.

(k) The Governor may establish procedures and timeframes for providing technical assistance to eligible training providers who are not intentionally supplying inaccurate information or who have not substantially violated any of the requirements under this section but are failing to meet the criteria and information requirements due to undue cost or burden.

(l) The Governor's procedures must include what the Governor considers to be a substantial violation of the requirement to timely and accurately submit all of the information required for completion of the eligible training provider performance reports required under WIOA sec. 116(d)(4) and all of the information required for initial and continued eligibility in this subpart.

(1) The Governor's procedures on determining a substantial violation must take into account exceptional circumstances beyond the provider's control, such as natural disasters, unexpected personnel transitions, and unexpected technology-related issues.

(2) Providers who substantially violate the requirement in paragraph (g) of this section to timely and accurately submit all required information must be removed from the State list of eligible training providers and programs, as provided in § 680.480(b).

§ 680.470 What are the procedures for including and removing registered apprenticeship programs on a State list of eligible training providers and programs?

(a) All registered apprenticeship programs that are registered with the U.S. Department of Labor, Office of Apprenticeship, or a recognized State apprenticeship agency, are automatically eligible to be included in the State list of eligible training providers and programs. All registered apprenticeship programs must be informed of their automatic eligibility to be included on the list, and must be provided an opportunity to consent to their inclusion, before being placed on the State list of eligible training providers and programs. The Governor must establish a

mechanism for registered apprenticeship program sponsors in the State to be informed of their automatic eligibility and to indicate that the program sponsor wishes to be included on the State list of eligible training providers and programs. This mechanism must place minimal burden on registered apprenticeship program sponsors and must be developed in accordance with guidance from the U.S. Department of Labor Office of Apprenticeship or with the assistance of the recognized State apprenticeship agency, as applicable.

(b) Once on the State list of eligible training providers and programs, registered apprenticeship programs will remain on the list:

(1) Until they are deregistered;

(2) Until the registered apprenticeship program notifies the State that it no longer wants to be included on the list; or

(3) Until the registered apprenticeship program is determined to have intentionally supplied inaccurate information or to have substantially violated any provision of title I of WIOA or the WIOA regulations, including 29 CFR part 38.

(c) A registered apprenticeship program whose eligibility is terminated under paragraph (b)(3) of this section must be terminated for not less than 2 years and is liable to repay all youth, adult, and dislocated worker training funds it received during the period of noncompliance. The Governor must specify in the procedures required by § 680.480 which individual or entity is responsible for making these determinations and the process by which the determination will be made, which must include an opportunity for a hearing that meets the requirements of § 683.630(b) of this chapter.

(d) Inclusion of a registered apprenticeship in the State list of eligible training providers and programs allows an individual who is eligible to use WIOA title I, subtitle B funds to use those funds toward registered apprenticeship training, consistent with their availability and limitations as prescribed by § 680.300. The use of ITAs and other WIOA title I, subtitle B funds toward registered apprenticeship training is further described in § 680.330.

(e) The Governor is encouraged to consult with the State and Local WDBs, ETA's Office of Apprenticeship, recognized State apprenticeship agencies (where they exist in the Governor's State) or other State agencies, to establish voluntary reporting of performance information.

(f) Pre-apprenticeship providers that wish to provide training services to participants using WIOA title I, subtitle B funds are subject to the eligibility procedures of this subpart.

§ 680.480 May an eligible training provider lose its eligibility?

(a) Yes. A training provider must meet the Governors requirements for eligibility and provide accurate information in order to retain its status as an eligible training provider.

(b) Providers determined to have intentionally supplied inaccurate information or to have substantially violated any provision of title I of WIOA or the WIOA regulations, including 29 CFR part 38, must be removed from the State list of eligible training providers and programs in accordance with the enforcement provisions of WIOA sec. 122(f). A provider whose eligibility is terminated under these conditions must be terminated for not less than 2 years and is liable to repay all youth, adult, and dislocated worker training funds it received during the period of noncompliance. The Governor must specify in the procedures which individual or entity is responsible for making these determinations and the process by which the determination will be made, which must include an opportunity for a hearing that meets the requirements of § 683.630(b) of this chapter.

(c) As a part of the biennial review of eligibility established by the Governor, the State must remove programs of training services that fail to meet criteria established by the Governor to remain eligible, which may include failure to meet established minimum performance levels. Registered apprenticeship programs only may be removed for the reasons set forth in § 680.470.

(d) The Governor must establish an appeals procedure for providers of training services to appeal a denial of eligibility under this subpart that

meets the requirements of § 683.630(b) of this chapter, which explains the appeals process for denial or termination of eligibility of a provider of training services.

(e) Where a Local WDB has established higher minimum performance standards, according to § 680.430(e), the Local WDB may remove a program of training services from the eligible programs in that local area for failure to meet those higher performance standards. Training providers may appeal a denial of eligibility under § 683.630(b) of this chapter.

§ 680.490 What kind of performance and cost information must eligible training providers other than registered apprenticeship programs provide for each program of training services?

(a) In accordance with the State procedure under § 680.460(i), eligible training providers, except registered apprenticeship programs, must submit, at least every 2 years, appropriate, timely, and accurate performance and cost information.

(b) Program-specific performance information must include:

(1) The information described in WIOA sec. 122(b)(2)(A) for individuals participating in the programs of training services who are receiving assistance under WIOA. This information includes indicators of performance as described in WIOA secs. 116(b)(2)(I)–(IV) and § 680.460(g)(1) through (4);

(2) Information identifying the recognized postsecondary credentials received by such participants in § 680.460(g)(5);

(3) Program cost information, including tuition and fees, for WIOA participants in the program in § 680.460(g)(6); and

(4) Information on the program completion rate for WIOA participants in § 680.460(g)(7).

(c) Governors may require any additional performance information (such as the information described at WIOA sec. 122(b)(1)) that the Governor determines to be appropriate to determine, maintain eligibility, or better to inform consumers.

(d) Governors must establish a procedure by which a provider can demonstrate that providing additional information required under this section would be unduly burdensome or costly. If the Governor determines that providers have demonstrated such extraordinary costs or undue burden:

(1) The Governor must provide access to cost-effective methods for the collection of the information;

(2) The Governor may provide additional resources to assist providers in the collection of the information from funds for statewide workforce investment activities reserved under WIOA secs. 128(a) and 133(a)(1); or

(3) The Governor may take other steps to assist eligible training providers in collecting and supplying required information such as offering technical assistance.

§ 680.500 How is the State list of eligible training providers and programs disseminated?

(a) In order to assist participants in choosing employment and training activities, the Governor or State agency must disseminate the State list of eligible training providers and programs and accompanying performance and cost information to Local WDBs in the State and to members of the public online, including through Web sites and searchable databases, and through whatever other means the State uses to disseminate information to consumers, including the one-stop delivery system and its program partners throughout the State.

(b) The State list of eligible training providers and programs and information must be updated regularly and provider and program eligibility must be reviewed biennially according to the procedures established by the Governor in § 680.460(i).

(c) In order to ensure informed consumer choice, the State list of eligible training providers and programs and accompanying information must be widely available to the public through electronic means, including Web sites and searchable databases, as well as through any other means the State uses to disseminate information to consumers. The list and accompanying information must be available through the one-stop delivery system and its partners including the State's secondary and postsecondary education

systems. The list must be accessible to individuals seeking information on training outcomes, as well as participants in employment and training activities funded under WIOA, including those under § 680.210, and other programs. In accordance with WIOA sec. 188, the State list also must be accessible to individuals with disabilities.

(d) The State list of eligible training providers and programs must be accompanied by appropriate information to assist participants in choosing employment and programs of training services. Such information must include:

(1) Recognized postsecondary credential(s) offered;

(2) Provider information supplied to meet the Governor's eligibility procedure as described in §§ 680.450 and 680.460;

(3) Performance and cost information as described in § 680.490; and

(4) Additional information as the Governor determines appropriate.

(e) The State list of eligible training providers and programs and accompanying information must be made available in a manner that does not reveal personally identifiable information about an individual participant. In addition, in developing the information to accompany the State list described in § 680.490(b), disclosure of personally identifiable information from an education record must be carried out in accordance with the Family Educational Rights and Privacy Act, including the circumstances relating to prior written consent.

§ 680.510 In what ways can a Local Workforce Development Board supplement the information available from the State list of eligible training providers and programs?

(a) Local WDBs may supplement the criteria and information requirements established by the Governor in order to support informed consumer choice and the achievement of local performance indicators. However, the Local WDB may not do so for registered apprenticeship programs.

(b) This additional information may include:

(1) Information on programs of training services that are linked to occupations in demand in the local area;

(2) Performance and cost information, including program-specific performance and cost information, for the local outlet(s) of multi-site eligible training providers;

(3) Information that shows how programs are responsive to local requirements; and

(4) Other appropriate information related to the objectives of WIOA.

§ 680.520 May individuals choose training providers and programs located outside of the local area or outside of the State?

(a) An individual may choose training providers and programs outside of the local area provided the training program is on the State list, in accordance with local policies and procedures.

(b) An individual may choose eligible training providers and programs outside of the State consistent with State and local policies and procedures. State policies and procedures may provide for reciprocal or other agreements established with another State to permit eligible training providers in a State to accept ITAs provided by the other State.

§ 680.530 What eligibility requirements apply to providers of on-the-job-training, customized training, incumbent worker training, and other training exceptions?

(a) Providers of on-the-job training, customized training, incumbent worker training, internships, paid or unpaid work experience, or transitional jobs are not subject to the requirements applicable to entities listed on the eligible training provider list, and are not included on the State list of eligible training providers and programs.

(b) For providers of training described in paragraph (a) of this section, the Governor may establish performance criteria those providers must meet to receive funds under the adult or dislocated worker programs pursuant to a contract as provided in § 680.320.

(c) One-stop operators in a local area must collect such performance information as the Governor may require and determine whether the providers meet any performance criteria the

Governor may establish under paragraph (b) of this section.

(d) One-stop operators must disseminate information identifying providers and programs that have met the Governor's performance criteria, along with the relevant performance information about them, through the one-stop delivery system.

Subpart E—Priority and Special Populations

§ 680.600 What priority must be given to low-income adults and public assistance recipients and individuals who are basic skills deficient served with adult funds under title I of the Workforce Innovation and Opportunity Act?

(a) WIOA sec. 134(c)(3)(E) states that priority for individualized career services (*see* § 678.430(b) of this chapter) and training services funded with title I adult funds must be given to recipients of public assistance, other low-income individuals, and individuals who are basic skills deficient (as defined in WIOA sec. 3(5)(B)) in the local area.

(b) States and local areas must establish criteria by which the one-stop center will apply the priority under WIOA sec. 134(c)(3)(E). Such criteria may include the availability of other funds for providing employment and training-related services in the local area, the needs of the specific groups within the local area, and other appropriate factors.

(c) The priority established under paragraph (a) of this section does not necessarily mean that these services only may be provided to recipients of public assistance, other low-income individuals, and individuals who are basic skills deficient. The Local WDB and the Governor may establish a process that also gives priority to other individuals eligible to receive such services, provided that it is consistent with priority of service for veterans (*see* § 680.650) and the priority provisions of WIOA sec. 134(c)(3)(E), discussed above in paragraphs (a) and (b) of this section.

§ 680.610 Does the statutory priority for use of adult funds also apply to dislocated worker funds?

No, the statutory priority only applies to adult funds and only applies to providing individualized career services, as described in § 680.150(b), and training services. Funds allocated for dislocated workers are not subject to this requirement.

§ 680.620 How does the Temporary Assistance for Needy Families program relate to the one-stop delivery system?

The local TANF program is a required partner in the one-stop delivery system. Part 678 of this chapter describes the roles of such partners in the one-stop delivery system and it applies to the TANF program. TANF serves individuals who also may be served by the WIOA programs and, through appropriate linkages and referrals, these customers will have access to a broader range of services through the cooperation of the TANF program in the one-stop delivery system. TANF participants, who are determined to be WIOA eligible, and who need occupational skills training may be referred through the one-stop delivery system to receive WIOA training, when TANF grant and other grant funds are not available to the individual in accordance with § 680.230(a). WIOA participants who also are determined TANF eligible may be referred to the TANF program for assistance.

§ 680.630 How does a displaced homemaker qualify for services under title I of the Workforce Innovation and Opportunity Act?

(a) Individuals who meet the definitions of a ''displaced homemaker'' (*see* WIOA sec. 3(16)) qualify for career and training services with dislocated worker title I funds.

(b) Displaced homemakers also may qualify for career and training services with adult funds under title I if the requirements of this part are met (*see* §§ 680.120 and 680.600).

(c) Displaced homemakers also may be served in statewide employment and training projects conducted with reserve funds for innovative programs for

displaced homemakers, as described in § 682.210(c) of this chapter.

(d) The definition of displaced homemaker includes the dependent spouse of a member of the Armed Forces on active duty (as defined in sec. 101(d)(1) of title 10, United States Code) and whose family income is significantly reduced because of a deployment, a call or order to active duty under a provision of law referred to in sec. 101(a)(13)(B) of title 10, United State Code, a permanent change of station, or the service-connected death or disability of the member.

§ 680.640 May an individual with a disability whose family does not meet income eligibility criteria under the Workforce Innovation and Opportunity Act be eligible for priority as a low-income adult?

Yes, even if the family of an individual with a disability does not meet the income eligibility criteria, the individual with a disability is to be considered a low-income individual if the individual's own income:

(a) Meets the income criteria established in WIOA sec. 3(36)(A)(vi); or

(b) Meets the income eligibility criteria for payments under any Federal, State or local public assistance program (see WIOA sec. 3(36)(A)(i)).

§ 680.650 Do veterans receive priority of service under the Workforce Innovation and Opportunity Act?

Yes, veterans, as defined under WIOA sec. 3(63)(A) and 38 U.S.C. 101, receive priority of service in all Department of Labor-funded training programs under 38 U.S.C. 4215 and described in 20 CFR part 1010. A veteran still must meet each program's eligibility criteria to receive services under the respective employment and training program. For income-based eligibility determinations, amounts paid while on active duty or paid by the Department of Veterans Affairs (VA) for vocational rehabilitation, disability payments, or related VA-funded programs are not to be considered as income, in accordance with 38 U.S.C. 4213 and § 683.230 of this chapter.

§ 680.660 Are separating military service members eligible for dislocated worker activities under the Workforce Innovation and Opportunity Act?

If the separating service member is separating from the Armed Forces with a discharge that is anything other than dishonorable, the separating service member qualifies for dislocated worker activities based on the following criteria:

(a) The separating service member has received a notice of separation, a DD–214 from the Department of Defense, or other documentation showing a separation or imminent separation from the Armed Forces to satisfy the termination or layoff part of the dislocated worker eligibility criteria in WIOA sec. 3(15)(A)(i);

(b) The separating service member qualifies for the dislocated worker eligibility criteria on eligibility for or exhaustion of unemployment compensation in WIOA sec. 3(15)(A)(ii)(I) or (II); and,

(c) As a separating service member, the individual meets the dislocated worker eligibility criteria that the individual is unlikely to return to a previous industry or occupation in WIOA sec. 3(15)(A)(iii).

Subpart F—Work-Based Training

§ 680.700 What are the requirements for on-the-job training?

(a) OJT is defined at WIOA sec. 3(44). OJT is provided under a contract with an employer or registered apprenticeship program sponsor in the public, private non-profit, or private sector. Through the OJT contract, occupational training is provided for the WIOA participant in exchange for the reimbursement, typically up to 50 percent of the wage rate of the participant, for the extraordinary costs of providing the training and supervision related to the training. In limited circumstances, as provided in WIOA sec. 134(c)(3)(h) and § 680.730, the reimbursement may be up to 75 percent of the wage rate of the participant.

(b) OJT contracts under WIOA title I, must not be entered into with an employer who has received payments under previous contracts under WIOA

or WIA if the employer has exhibited a pattern of failing to provide OJT participants with continued long-term employment as regular employees with wages and employment benefits (including health benefits) and working conditions at the same level and to the same extent as other employees working a similar length of time and doing the same type of work.

(c) An OJT contract must be limited to the period of time required for a participant to become proficient in the occupation for which the training is being provided. In determining the appropriate length of the contract, consideration should be given to the skill requirements of the occupation, the academic and occupational skill level of the participant, prior work experience, and the participant's IEP.

§ 680.710 What are the requirements for on-the-job training contracts for employed workers?

OJT contracts may be written for eligible employed workers when:

(a) The employee is not earning a self-sufficient wage or wages comparable to or higher than wages from previous employment, as determined by Local WDB policy;

(b) The requirements in § 680.700 are met; and

(c) The OJT relates to the introduction of new technologies, introduction to new production or service procedures, upgrading to new jobs that require additional skills, workplace literacy, or other appropriate purposes identified by the Local WDB.

§ 680.720 What conditions govern on-the-job training payments to employers?

(a) OJT payments to employers are deemed to be compensation for the extraordinary costs associated with training participants and potentially lower productivity of the participants while in the OJT.

(b) Employers may be reimbursed up to 50 percent of the wage rate of an OJT participant, and up to 75 percent using the criteria in § 680.730, for the extraordinary costs of providing the training and additional supervision related to the OJT.

(c) Employers are not required to document such extraordinary costs.

§ 680.730 Under what conditions may a Governor or Local Workforce Development Board raise the on-the-job training reimbursement rate up to 75 percent of the wage rate?

(a) The Governor may increase the reimbursement rate for OJT contracts funded through the statewide employment and training activities described in § 682.210 of this chapter up to 75 percent, and the Local WDB also may increase the reimbursement rate for OJT contracts described in § 680.320(a)(1) up to 75 percent, when taking into account the following factors:

(1) The characteristics of the participants taking into consideration whether they are ''individuals with barriers to employment,'' as defined in WIOA sec. 3(24);

(2) The size of the employer, with an emphasis on small businesses;

(3) The quality of employer-provided training and advancement opportunities, for example if the OJT contract is for an in-demand occupation and will lead to an industry-recognized credential; and

(4) Other factors the Governor or Local WDB may determine to be appropriate, which may include the number of employees participating, wage and benefit levels of the employees (both at present and after completion), and relation of the training to the competitiveness of the participant.

(b) Governors or Local WDBs must document the factors used when deciding to increase the wage reimbursement levels above 50 percent up to 75 percent.

§ 680.740 How can on-the-job training funds be used to support placing participants into a registered apprenticeship program?

(a) OJT contracts may be entered into with registered apprenticeship program sponsors or participating employers in registered apprenticeship programs for the OJT portion of the registered apprenticeship program consistent with § 680.700. Depending on the length of the registered apprenticeship and State and local OJT policies, these funds may cover some or all of the registered apprenticeship training.

(b) If the apprentice is unemployed at the time of participation, the OJT must be conducted as described in § 680.700. If the apprentice is employed at the time of participation, the OJT must be conducted as described in § 680.710.

§ 680.750 Can Individual Training Account and on-the-job training funds be combined to support placing participants into a registered apprenticeship program?

There is no Federal prohibition on using both ITA and OJT funds when placing participants into a registered apprenticeship program. See § 680.330 on using ITAs to support participants in registered apprenticeship.

§ 680.760 What is customized training?

Customized training is training:

(a) That is designed to meet the special requirements of an employer (including a group of employers);

(b) That is conducted with a commitment by the employer to employ an individual upon successful completion of the training; and

(c) For which the employer pays for a significant cost of the training, as determined by the Local WDB in accordance with the factors identified in WIOA sec. 3(14).

§ 680.770 What are the requirements for customized training for employed workers?

Customized training of an eligible employed individual may be provided for an employer or a group of employers when:

(a) The employee is not earning a self-sufficient wage or wages comparable to or higher than wages from previous employment, as determined by Local WDB policy;

(b) The requirements in § 680.760 are met; and

(c) The customized training relates to the purposes described in § 680.710(c) or other appropriate purposes identified by the Local WDB.

§ 680.780 Who is an "incumbent worker" for purposes of statewide and local employment and training activities?

States and local areas must establish policies and definitions to determine which workers, or groups of workers, are eligible for incumbent worker services. To qualify as an incumbent worker, the incumbent worker needs to be employed, meet the Fair Labor Standards Act requirements for an employer-employee relationship, and have an established employment history with the employer for 6 months or more, with the following exception: In the event that the incumbent worker training is being provided to a cohort of employees, not every employee in the cohort must have an established employment history with the employer for 6 months or more as long as a majority of those employees being trained do meet the employment history requirement. An incumbent worker does not have to meet the eligibility requirements for career and training services for adults and dislocated workers under WIOA, unless they also are enrolled as a participant in the WIOA adult or dislocated worker program.

§ 680.790 What is incumbent worker training?

Incumbent worker training must satisfy the requirements in WIOA sec. 134(d)(4) and increase the competitiveness of the employee or employer. For purposes of WIOA sec. 134(d)(4)(B), incumbent worker training is training:

(a) Designed to meet the special requirements of an employer (including a group of employers) to retain a skilled workforce or avert the need to lay off employees by assisting the workers in obtaining the skills necessary to retain employment.

(b) Conducted with a commitment by the employer to retain or avert the layoffs of the incumbent worker(s) trained.

§ 680.800 What funds may be used for incumbent worker training?

(a) The local area may reserve up to 20 percent of their combined total of adult and dislocated worker allocations for incumbent worker training as described in § 680.790;

(b) The State may use their statewide activities funds (per WIOA sec. 134(a)(3)(A)(i)) and Rapid Response funds for statewide incumbent worker training activities (*see* §§ 682.210(b) and 682.320(b)(4) of this chapter).

§ 680.810 What criteria must be taken into account for an employer to be eligible to receive local incumbent worker training funds?

The Local WDB must consider under WIOA sec. 134(d)(4)(A)(ii):

(a) The characteristics of the individuals in the program;

(b) The relationship of the training to the competitiveness of an individual and the employer; and

(c) Other factors the Local WDB determines appropriate, including number of employees trained, wages and benefits including post training increases, and the existence of other training opportunities provided by the employer.

§ 680.820 Are there cost sharing requirements for local area incumbent worker training?

Yes. Under WIOA secs. 134(d)(4)(C) and 134(d)(4)(D)(i)–(iii), employers participating in incumbent worker training are required to pay the non-Federal share of the cost of providing training to their incumbent workers. The amount of the non-Federal share depends upon the limits established under WIOA secs. 134(d)(4)(ii)(C) and (D).

§ 680.830 May funds provided to employers for work-based training be used to assist, promote, or deter union organizing?

No. Funds provided to employers for work-based training, as described in this subpart, must not be used to directly or indirectly assist, promote, or deter union organizing.

§ 680.840 May funds provided to employers for work-based training and other work experiences be used to fill job openings as a result of a labor dispute?

No. Funds provided to employers for work-based training, as described in this subpart and in subpart A of this part, may not be used to directly or indirectly aid in the filling of a job opening which is vacant because the former occupant is on strike, or is being locked out in the course of a labor dispute, or the filling of which is otherwise an issue in a labor dispute involving a work stoppage.

Subpart G—Supportive Services

§ 680.900 What are supportive services for adults and dislocated workers?

Supportive services for adults and dislocated workers are defined at WIOA sec. 3(59) and secs. 134(d)(2) and (3). Local WDBs, in consultation with the one-stop partners and other community service providers, must develop a policy on supportive services that ensures resource and service coordination in the local area. The policy should address procedures for referral to such services, including how such services will be funded when they are not otherwise available from other sources. The provision of accurate information about the availability of supportive services in the local area, as well as referral to such activities, is one of the career services that must be available to adults and dislocated workers through the one-stop delivery system. (WIOA sec. 134(c)(2)(A)(ix) and § 678.430 of this chapter). Local WDBs must ensure that needs-related payments are made in a manner consistent with §§ 680.930, 680.940, 680.950, 680.960, and 680.970. Supportive services are services that are necessary to enable an individual to participate in activities authorized under WIOA sec. 134(c)(2) and (3). These services may include, but are not limited to, the following:

(a) Linkages to community services;

(b) Assistance with transportation;

(c) Assistance with child care and dependent care;

(d) Assistance with housing;

(e) Needs-related payments, as described at §§ 680.930, 680.940, 680.950, 680.960, and 680.970;

(f) Assistance with educational testing;

(g) Reasonable accommodations for individuals with disabilities;

(h) Legal aid services;

(i) Referrals to health care;

(j) Assistance with uniforms or other appropriate work attire and work-related tools, including such items as eyeglasses and protective eye gear;

(k) Assistance with books, fees, school supplies, and other necessary items for students enrolled in postsecondary education classes; and

(l) Payments and fees for employment and training-related applications, tests, and certifications.

§ 680.910 When may supportive services be provided to participants?

(a) Supportive services may only be provided to individuals who are:

(1) Participating in career or training services as defined in WIOA secs. 134(c)(2) and (3); and

(2) Unable to obtain supportive services through other programs providing such services.

(b) Supportive services only may be provided when they are necessary to enable individuals to participate in career service or training activities.

§ 680.920 Are there limits on the amount or duration of funds for supportive services?

(a) Local WDBs may establish limits on the provision of supportive services or provide the one-stop center with the authority to establish such limits, including a maximum amount of funding and maximum length of time for supportive services to be available to participants.

(b) Procedures also may be established to allow one-stop centers to grant exceptions to the limits established under paragraph (a) of this section.

§ 680.930 What are needs-related payments?

Needs-related payments provide financial assistance to participants for the purpose of enabling them to participate in training and are a supportive service authorized by WIOA sec. 134(d)(3). Unlike other supportive services, in order to qualify for needs-related payments a participant must be enrolled in training.

§ 680.940 What are the eligibility requirements for adults to receive needs-related payments?

Adults must:

(a) Be unemployed;

(b) Not qualify for, or have ceased qualifying for, unemployment compensation; and

(c) Be enrolled in a program of training services under WIOA sec. 134(c)(3).

§ 680.950 What are the eligibility requirements for dislocated workers to receive needs-related payments?

To receive needs-related payments, a dislocated worker must:

(a) Be unemployed, and:

(1) Have ceased to qualify for unemployment compensation or trade readjustment allowance under TAA; and

(2) Be enrolled in a program of training services under WIOA sec. 134(c)(3) by the end of the 13th week after the most recent layoff that resulted in a determination of the worker's eligibility as a dislocated worker, or, if later, by the end of the 8th week after the worker is informed that a short-term layoff will exceed 6 months; or

(b) Be unemployed and did not qualify for unemployment compensation or trade readjustment assistance under TAA and be enrolled in a program of training services under WIOA sec. 134(c)(3).

§ 680.960 May needs-related payments be paid while a participant is waiting to start training classes?

Yes, payments may be provided if the participant has been accepted in a training program that will begin within 30 calendar days. The Governor may authorize local areas to extend the 30-day period to address appropriate circumstances.

§ 680.970 How is the level of needs-related payments determined?

(a) The payment level for adults must be established by the Local WDB. For statewide projects, the payment level for adults must be established by the State WDB.

(b) For dislocated workers, payments must not exceed the greater of either of the following levels:

(1) The applicable weekly level of the unemployment compensation benefit, for participants who were eligible for unemployment compensation as a result of the qualifying dislocation; or

(2) The poverty level for an equivalent period, for participants who did not qualify for unemployment compensation as a result of the qualifying layoff. The weekly payment level must be adjusted to reflect changes in total family income, as determined by Local WDB policies.

PART 681—YOUTH ACTIVITIES UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

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Subpart A—Standing Youth Committees

§ 681.100 What is a standing youth committee?

The Workforce Innovation and Opportunity Act (WIOA) eliminates the requirement for Local Workforce Development Boards (WDBs) to establish a youth council. However, the Department encourages Local WDBs to establish a standing committee to provide information and to assist with planning, operational, oversight, and other issues relating to the provision of services to youth. If the Local WDB does not designate a standing youth committee, it retains responsibility for all aspects of youth formula programs.

§ 681.110 Who is included on a standing youth committee?

(a) If a Local WDB decides to form a standing youth committee, the committee must include a member of the Local WDB, who chairs the committee, members of community-based organizations with a demonstrated record of success in serving eligible youth, and other individuals with appropriate expertise and experience who are not members of the Local WDB.

(b) The committee must reflect the needs of the local area. The committee members appointed for their experience and expertise may bring their expertise to help the committee address the employment, training, education, human and supportive service needs of eligible youth including out-of-school youth (OSY). Members may represent agencies such as secondary and post-secondary education, training, health, disability, mental health, housing, public assistance, and justice, or be representatives of philanthropic or economic and community development organizations, and employers. The committee may also include parents, participants, and youth.

(c) A Local WDB may designate an existing entity such as an effective youth council as the standing youth committee if it fulfills the requirements above in paragraph (a) of this section.

§ 681.120 What does a standing youth committee do?

Under the direction of the Local WDB, a standing youth committee may:

(a) Recommend policy direction to the Local WDB for the design, development, and implementation of programs that benefit all youth;

(b) Recommend the design of a comprehensive community workforce development system to ensure a full range of services and opportunities for all youth, including disconnected youth;

(c) Recommend ways to leverage resources and coordinate services among schools, public programs, and community-based organizations serving youth;

(d) Recommend ways to coordinate youth services and recommend eligible youth service providers;

(e) Provide on-going leadership and support for continuous quality improvement for local youth programs;

(f) Assist with planning, operational, and other issues relating to the provision of services to youth; and

(g) If so delegated by the Local WDB after consultation with the chief elected official (CEO), oversee eligible youth providers, as well as other youth program oversight responsibilities.

Subpart B—Eligibility for Youth Services

§ 681.200 Who is eligible for youth services?

Both in-school youth (ISY) and OSY are eligible for youth services.

§ 681.210 Who is an "out-of-school youth"?

An OSY is an individual who is:

(a) Not attending any school (as defined under State law);

(b) Not younger than age 16 or older than age 24 at time of enrollment. Because age eligibility is based on age at enrollment, participants may continue to receive services beyond the age of 24 once they are enrolled in the program; and

(c) One or more of the following:

(1) A school dropout;

(2) A youth who is within the age of compulsory school attendance, but has not attended school for at least the most recent complete school year calendar quarter. School year calendar quarter is based on how a local school district defines its school year quarters. In cases where schools do not use quarters, local programs must use calendar year quarters;

(3) A recipient of a secondary school diploma or its recognized equivalent who is a low-income individual and is either basic skills deficient or an English language learner;

(4) An offender;

(5) A homeless individual aged 16 to 24 who meets the criteria defined in sec. 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2(6)), a homeless child or youth aged 16 to 24 who meets the criteria defined in sec. 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)) or a runaway;

(6) An individual in foster care or who has aged out of the foster care system or who has attained 16 years of age and left foster care for kinship guardianship or adoption, a child eligible for assistance under sec. 477 of the Social Security Act (42 U.S.C. 677), or in an out-of-home placement;

(7) An individual who is pregnant or parenting;

(8) An individual with a disability; or

(9) A low-income individual who requires additional assistance to enter or complete an educational program or to secure or hold employment.

§ 681.220 Who is an "in-school youth"?

An ISY is an individual who is:

(a) Attending school (as defined by State law), including secondary and postsecondary school;

(b) Not younger than age 14 or (unless an individual with a disability who is attending school under State law) older than age 21 at time of enrollment. Because age eligibility is based on age at enrollment, participants may continue to receive services beyond the age of 21 once they are enrolled in the program;

(c) A low-income individual; and

(d) One or more of the following:

(1) Basic skills deficient;

(2) An English language learner;

(3) An offender;

(4) A homeless individual aged 14 to 21 who meets the criteria defined in sec. 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2(6)), a homeless child or youth aged 14 to 21 who meets the criteria defined in sec. 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), or a runaway;

(5) An individual in foster care or who has aged out of the foster care system or who has attained 16 years of age and left foster care for kinship guardianship or adoption, a child eligible for assistance under sec. 477 of the Social Security Act (42 U.S.C. 677), or in an out-of-home placement;

(6) An individual who is pregnant or parenting;

(7) An individual with a disability; or

(8) An individual who requires additional assistance to complete an educational program or to secure or hold employment.

§ 681.230 What does "school" refer to in the "not attending or attending any school" in the out-of-school and in-school eligibility criteria?

In general, the applicable State law for secondary and postsecondary institutions defines ''school.'' However, for purposes of WIOA, the Department does not consider providers of adult education under title II of WIOA, YouthBuild programs, the Job Corps program, high school equivalency programs, or dropout re-engagement programs to be schools. Therefore, in all cases except the one provided below, WIOA youth programs may consider a youth to be an OSY for purposes of WIOA youth program eligibility if he or she attend adult education provided

under title II of WIOA, YouthBuild, Job Corps, high school equivalency programs, or dropout re-engagement programs regardless of the funding source of those programs. Youth attending high school equivalency programs funded by the public K–12 school system who are classified by the school system as still enrolled in school are an exception; they are considered ISY.

§ 681.240 When do local youth programs verify dropout status?

Local WIOA youth programs must verify a youth's dropout status at the time of WIOA youth program enrollment. An individual who is out of school at the time of enrollment, and subsequently placed in any school, is an OSY for the purposes of the 75 percent expenditure requirement for OSY throughout his/her participation in the program.

§ 681.250 Who does the low-income eligibility requirement apply to?

(a) For OSY, only those youth who are the recipient of a secondary school diploma or its recognized equivalent and are either basic skills deficient or an English language learner, and youth who require additional assistance to enter or complete an educational program or to secure or hold employment, must be low-income. All other OSY meeting OSY eligibility under § 681.210(c)(1), (2), (4), (5), (6), (7), and (8) are not required to be low-income.

(b) All ISY must be low-income to meet the ISY eligibility criteria, except those that fall under the low-income exception.

(c) WIOA allows a low-income exception where five percent of WIOA youth may be participants who ordinarily would be required to be low-income for eligibility purposes and meet all other eligibility criteria for WIOA youth except the low-income criteria. A program must calculate the five percent based on the percent of newly enrolled youth in the local area's WIOA youth program in a given program year who would ordinarily be required to meet the low-income criteria.

(d) In addition to the criteria in the definition of ''low-income individual'' in WIOA sec. 3(36), a youth is low-income if he or she receives or is eligible to receive a free or reduced price lunch under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 *et seq.* or if he or she lives in a high poverty area.

§ 681.260 How does the Department define "high poverty area" for the purposes of the special regulation for low-income youth in the Workforce Innovation and Opportunity Act?

A youth who lives in a high poverty area is automatically considered to be a low-income individual. A high poverty area is a Census tract, a set of contiguous Census tracts, an American Indian Reservation, Oklahoma Tribal Statistical Area (as defined by the U.S. Census Bureau), Alaska Native Village Statistical Area or Alaska Native Regional Corporation Area, Native Hawaiian Homeland Area, or other tribal land as defined by the Secretary in guidance or county that has a poverty rate of at least 25 percent as set every 5 years using American Community Survey 5-Year data.

§ 681.270 May a local program use eligibility for free or reduced price lunches under the National School Lunch Program as a substitute for the income eligibility criteria under title I of the Workforce Innovation and Opportunity Act?

Yes, WIOA sec. 3(36) defines a low-income individual to include an individual who receives (or is eligible to receive) a free or reduced price lunch under the Richard B. Russell National School Lunch Act.

§ 681.280 Is a youth with a disability eligible for youth services under the Workforce Innovation and Opportunity Act if his or her family income exceeds the income eligibility criteria?

Yes, for an individual with a disability, income level for eligibility purposes is based on the individual's own income rather than his or her family's income. WIOA sec. 3(36)(A)(vi) states that an individual with a disability whose own income meets the low-income definition in clause (ii) (income that does not exceed the higher of the poverty line or 70 percent of the lower living standard income level), but who is a member of a family whose income

exceeds this income requirement is eligible for youth services. Furthermore, only ISY with a disability must be low income. OSY with a disability are not required to be low-income.

§ 681.290 How does the Department define the "basic skills deficient" criterion in this part?

(a) As used in § 681.210(c)(3), a youth is ''basic skills deficient'' if he or she:

(1) Have English reading, writing, or computing skills at or below the 8th grade level on a generally accepted standardized test; or

(2) Are unable to compute or solve problems, or read, write, or speak English at a level necessary to function on the job, in the individual's family, or in society.

(b) The State or Local WDB must establish its policy on paragraph (a)(2) of this section in its respective State or local plan.

(c) In assessing basic skills, local programs must use assessment instruments that are valid and appropriate for the target population, and must provide reasonable accommodation in the assessment process, if necessary, for individuals with disabilities.

§ 681.300 How does the Department define the "requires additional assistance to enter or complete an educational program, or to secure and hold employment" criterion in this part for OSY?

Either the State or the local level may establish definitions and eligibility documentation requirements for the ''requires additional assistance to enter or complete an educational program, or to secure and hold employment'' criterion of § 681.210(c)(9). In cases where the State WDB establishes State policy on this criterion, the State WDB must include the definition in the State Plan. In cases where the State WDB does not establish a policy, the Local WDB must establish a policy in its local plan if using this criterion.

§ 681.310 How does the Department define the "requires additional assistance to complete an educational program, or to secure and hold employment" criterion in this part for ISY?

(a) Either the State or the local level may establish definitions and eligibility documentation requirements for the ''requires additional assistance to complete an educational program, or to secure and hold employment'' criterion of § 681.220(d)(8). In cases where the State WDB establishes State policy on this criterion, the State WDB must include the definition in the State Plan. In cases where the State WDB does not establish a policy, the Local WDB must establish a policy in its local plan if using this criterion.

(b) In each local area, not more than five percent of the ISY newly enrolled in a given program year may be eligible based on the ''requires additional assistance to complete an educational program or to secure or hold employment'' criterion.

§ 681.320 Must youth participants enroll to participate in the youth program?

(a) Yes, to participate in youth programs, participants must enroll in the WIOA youth program.

(b) In order to be a participant in the WIOA youth program, all of the following must occur:

(1) An eligibility determination;

(2) The provision of an objective assessment;

(3) Development of an individual service strategy; and

(4) Participation in any of the 14 WIOA youth program elements.

Subpart C—Youth Program Design, Elements, and Parameters

§ 681.400 What is the process used to select eligible youth service providers?

(a) The grant recipient/fiscal agent has the option to provide directly some or all of the youth workforce investment activities.

(b) However, as provided in WIOA sec. 123, if a Local WDB chooses to award grants or contracts to youth service providers to carry out some or all of

the youth workforce investment activities, the Local WDB must award such grants or contracts on a competitive basis, subject to the exception explained in paragraph (b)(4) of this section:

(1) The Local WDB must identify youth service providers based on criteria established in the State Plan (including such quality criteria established by the Governor for a training program that leads to a recognized postsecondary credential) and take into consideration the ability of the provider to meet performance accountability measures based on the primary indicators of performance for youth programs.

(2) The Local WDB must procure the youth service providers in accordance with the Uniform Guidance at 2 CFR parts 200 and 2900, in addition to applicable State and local procurement laws.

(3) If the Local WDB establishes a standing youth committee under § 681.100 it may assign the committee the function of selecting of grants or contracts.

(4) Where the Local WDB determines there are an insufficient number of eligible youth providers in the local area, such as a rural area, the Local WDB may award grants or contracts on a sole source basis.

§ 681.410 Does the requirement that a State and local area expend at least 75 percent of youth funds to provide services to out-of-school youth apply to all youth funds?

Yes. The 75 percent requirement applies to both statewide youth activities funds and local youth funds with 2 exceptions.

(a) Only statewide funds spent on direct services to youth are subject to the OSY expenditure requirement. Funds spent on statewide youth activities that do not provide direct services to youth, such as most of the required statewide youth activities listed in WIOA sec. 129(b)(1), are not subject to the OSY expenditure requirement. For example, administrative costs, monitoring, and technical assistance are not subject to OSY expenditure requirement; while funds spent on direct services to youth such as statewide demonstration projects, are subject to the OSY expenditure requirement.

(b) For a State that receives a small State minimum allotment under WIOA sec. 127(b)(1)(C)(iv)(II) for youth or WIOA sec. 132(b)(1)(B)(iv)(II) for adults, the State may submit a request to the Secretary to decrease the percentage to not less than 50 percent for a local area in the State, and the Secretary may approve such a request for that program year, if the State meets the following requirements:

(1) After an analysis of the ISY and OSY populations in the local area, the State determines that the local area will be unable to use at least 75 percent of the local area WIOA youth funds to serve OSY due to a low number of OSY; and

(2) The State submits to the Secretary, for the local area, a request including a proposed percentage decreased to not less than 50 percent to provide workforce investment activities for OSY.

(c) In the exercise of discretion afforded by WIOA sec. 129(a)(4), the Secretary has determined that requests to decrease the percentage of funds used to provide youth workforce investment activities for OSY will not be granted to States that received 90 percent of the allotment percentage for the past year. Therefore, when the Secretary receives such a request from a State, the request will be denied.

(d) For local area funds, the administrative costs of carrying out local workforce investment activities described in WIOA sec. 128(b)(4) are not subject to the OSY expenditure requirement. All other local area youth funds beyond the administrative costs are subject to the OSY expenditure requirement.

§ 681.420 How must Local Workforce Development Boards design Workforce Innovation and Opportunity Act youth programs?

(a) The design framework services of local youth programs must:

(1) Provide for an objective assessment of each youth participant that meets the requirements of WIOA sec. 129(c)(1)(A), and includes a review of the academic and occupational skill levels, as well as the service needs and

strengths, of each youth for the purpose of identifying appropriate services and career pathways for participants and informing the individual service strategy;

(2) Develop, and update as needed, an individual service strategy based on the needs of each youth participant that is directly linked to one or more indicators of performance described in WIOA sec. 116(b)(2)(A)(ii), that identifies career pathways that include education and employment goals, that considers career planning and the results of the objective assessment and that prescribes achievement objectives and services for the participant; and

(3) Provide case management of youth participants, including follow-up services.

(b) The local plan must describe the design framework for youth programs in the local area, and how the 14 program elements required in § 681.460 are to be made available within that framework.

(c) Local WDBs must ensure appropriate links to entities that will foster the participation of eligible local area youth. Such links may include connections to:

(1) Local area justice and law enforcement officials;

(2) Local public housing authorities;

(3) Local education agencies;

(4) Local human service agencies;

(5) WIOA title II adult education providers;

(6) Local disability-serving agencies and providers and health and mental health providers;

(7) Job Corps representatives; and

(8) Representatives of other area youth initiatives, such as YouthBuild, and including those that serve homeless youth and other public and private youth initiatives.

(d) Local WDBs must ensure that WIOA youth service providers meet the referral requirements in WIOA sec. 129(c)(3)(A) for all youth participants, including:

(1) Providing these participants with information about the full array of applicable or appropriate services available through the Local WDBs or other eligible providers, or one-stop partners; and

(2) Referring these participants to appropriate training and educational programs that have the capacity to serve them either on a sequential or concurrent basis.

(e) If a youth applies for enrollment in a program of workforce investment activities and either does not meet the enrollment requirements for that program or cannot be served by that program, the eligible training provider of that program must ensure that the youth is referred for further assessment, if necessary, or referred to appropriate programs to meet the skills and training needs of the youth.

(f) In order to meet the basic skills and training needs of applicants who do not meet the eligibility requirements of a particular program or who cannot be served by the program, each youth provider must ensure that these youth are referred:

(1) For further assessment, as necessary; and

(2) To appropriate programs, in accordance with paragraph (d)(2) of this section.

(g) Local WDBs must ensure that parents, youth participants, and other members of the community with experience relating to youth programs are involved in both the design and implementation of its youth programs.

(h) The objective assessment required under paragraph (a)(1) of this section or the individual service strategy required under paragraph (a)(2) of this section is not required if the program provider determines that it is appropriate to use a recent objective assessment or individual service strategy that was developed under another education or training program.

(i) The Local WDBs may implement a WIOA Pay-for-Performance contract strategy for program elements described at § 681.460, for which the Local WDB may reserve and use not more than 10 percent of the total funds allocated to the local area under WIOA sec. 128(b). For additional regulations on WIOA Pay-for-Performance contract strategies, see § 683.500 of this chapter.

§ 681.430 May youth participate in both the Workforce Innovation and Opportunity Act (WIOA) youth and adult programs concurrently, and how do local program operators track concurrent enrollment in the WIOA youth and adult programs?

(a) Yes, individuals who meet the respective program eligibility requirements may participate in adult and youth programs concurrently. Such individuals must be eligible under the youth or adult eligibility criteria applicable to the services received. Local program operators may determine, for these individuals, the appropriate level and balance of services under the youth and adult programs.

(b) Local program operators must identify and track the funding streams which pay the costs of services provided to individuals who are participating in youth and adult programs concurrently, and ensure no duplication of services.

(c) Individuals who meet the respective program eligibility requirements for WIOA youth title I and title II may participate in title I youth and title II concurrently.

§ 681.440 How does a local youth program determine if an 18 to 24 year old is enrolled in the Workforce Innovation and Opportunity Act (WIOA) youth program or the WIOA adult program?

A local program must determine the appropriate program for the participant based on the service needs of the participant and if the participant is career-ready based on an assessment of their occupational skills, prior work experience, employability, and the participant's needs.

§ 681.450 For how long must a local Workforce Innovation and Opportunity Act youth program serve a participant?

Local youth programs must provide service to a participant for the amount of time necessary to ensure successful preparation to enter postsecondary education and/or unsubsidized employment. While there is no minimum or maximum time a youth can participate in the WIOA youth program, programs must link participation to the individual service strategy and not the timing of youth service provider contracts or program years.

§ 681.460 What services must local programs offer to youth participants?

(a) Local programs must make each of the following 14 services available to youth participants:

(1) Tutoring, study skills training, instruction and evidence-based dropout prevention and recovery strategies that lead to completion of the requirements for a secondary school diploma or its recognized equivalent (including a recognized certificate of attendance or similar document for individuals with disabilities) or for a recognized postsecondary credential;

(2) Alternative secondary school services, or dropout recovery services, as appropriate;

(3) Paid and unpaid work experiences that have academic and occupational education as a component of the work experience, which may include the following types of work experiences:

(i) Summer employment opportunities and other employment opportunities available throughout the school year;

(ii) Pre-apprenticeship programs;

(iii) Internships and job shadowing; and

(iv) On-the-job training opportunities;

(4) Occupational skill training, which includes priority consideration for training programs that lead to recognized postsecondary credentials that align with in-demand industry sectors or occupations in the local area involved, if the Local WDB determines that the programs meet the quality criteria described in WIOA sec. 123;

(5) Education offered concurrently with and in the same context as workforce preparation activities and training for a specific occupation or occupational cluster;

(6) Leadership development opportunities, including community service and peer-centered activities encouraging responsibility and other positive social and civic behaviors;

(7) Supportive services, including the services listed in § 681.570;

(8) Adult mentoring for a duration of at least 12 months, that may occur

both during and after program participation;

(9) Follow-up services for not less than 12 months after the completion of participation, as provided in § 681.580;

(10) Comprehensive guidance and counseling, which may include drug and alcohol abuse counseling, as well as referrals to counseling, as appropriate to the needs of the individual youth;

(11) Financial literacy education;

(12) Entrepreneurial skills training;

(13) Services that provide labor market and employment information about in-demand industry sectors or occupations available in the local area, such as career awareness, career counseling, and career exploration services; and

(14) Activities that help youth prepare for and transition to postsecondary education and training.

(b) Local programs have the discretion to determine what specific program services a youth participant receives, based on each participant's objective assessment and individual service strategy. Local programs are not required to provide every program service to each participant.

(c) When available, the Department encourages local programs to partner with existing local, State, or national entities that can provide program element(s) at no cost to the local youth program.

§ 681.470 Does the Department require local programs to use Workforce Innovation and Opportunity Act funds for each of the 14 program elements?

No. The Department does not require local programs to use WIOA youth funds for each of the program elements. Local programs may leverage partner resources to provide some of the readily available program elements. However, the local area must ensure that if a program element is not funded with WIOA title I youth funds, the local program has an agreement in place with a partner organization to ensure that the program element will be offered. The Local WDB must ensure that the program element is closely connected and coordinated with the WIOA youth program.

§ 681.480 What is a pre-apprenticeship program?

A pre-apprenticeship is a program designed to prepare individuals to enter and succeed in an apprenticeship program registered under the Act of August 16, 1937 (commonly known as the ''National Apprenticeship Act''; 50 Stat. 664, chapter 663; 29 U.S.C. 50 *et. seq.*) (referred to in this part as a ''registered apprenticeship'' or ''registered apprenticeship program'') and includes the following elements:

(a) Training and curriculum that aligns with the skill needs of employers in the economy of the State or region involved;

(b) Access to educational and career counseling and other supportive services, directly or indirectly;

(c) Hands-on, meaningful learning activities that are connected to education and training activities, such as exploring career options, and understanding how the skills acquired through coursework can be applied toward a future career;

(d) Opportunities to attain at least one industry-recognized credential; and

(e) A partnership with one or more registered apprenticeship programs that assists in placing individuals who complete the pre-apprenticeship program in a registered apprenticeship program.

§ 681.490 What is adult mentoring?

(a) Adult mentoring for youth must:

(1) Last at least 12 months and may take place both during the program and following exit from the program;

(2) Be a formal relationship between a youth participant and an adult mentor that includes structured activities where the mentor offers guidance, support, and encouragement to develop the competence and character of the mentee; and

(3) While group mentoring activities and mentoring through electronic means are allowable as part of the mentoring activities, at a minimum, the local youth program must match the youth with an individual mentor with whom the youth interacts on a face-to-face basis.

(b) Mentoring may include workplace mentoring where the local program

matches a youth participant with an employer or employee of a company.

§ 681.500 What is financial literacy education?

The financial literacy education program element may include activities which:

(a) Support the ability of participants to create budgets, initiate checking and savings accounts at banks, and make informed financial decisions;

(b) Support participants in learning how to effectively manage spending, credit, and debt, including student loans, consumer credit, and credit cards;

(c) Teach participants about the significance of credit reports and credit scores; what their rights are regarding their credit and financial information; how to determine the accuracy of a credit report and how to correct inaccuracies; and how to improve or maintain good credit;

(d) Support a participant's ability to understand, evaluate, and compare financial products, services, and opportunities and to make informed financial decisions;

(e) Educate participants about identity theft, ways to protect themselves from identify theft, and how to resolve cases of identity theft and in other ways understand their rights and protections related to personal identity and financial data;

(f) Support activities that address the particular financial literacy needs of non-English speakers, including providing the support through the development and distribution of multilingual financial literacy and education materials;

(g) Support activities that address the particular financial literacy needs of youth with disabilities, including connecting them to benefits planning and work incentives counseling;

(h) Provide financial education that is age appropriate, timely, and provides opportunities to put lessons into practice, such as by access to safe and affordable financial products that enable money management and savings; and

(i) Implement other approaches to help participants gain the knowledge, skills, and confidence to make informed financial decisions that enable them to attain greater financial health and stability by using high quality, age-appropriate, and relevant strategies and channels, including, where possible, timely and customized information, guidance, tools, and instruction.

§ 681.510 What is comprehensive guidance and counseling?

Comprehensive guidance and counseling provides individualized counseling to participants. This includes drug and alcohol abuse counseling, mental health counseling, and referral to partner programs, as appropriate. When referring participants to necessary counseling that cannot be provided by the local youth program or its service providers, the local youth program must coordinate with the organization it refers to in order to ensure continuity of service.

§ 681.520 What are leadership development opportunities?

Leadership development opportunities are opportunities that encourage responsibility, confidence, employability, self-determination, and other positive social behaviors such as:

(a) Exposure to postsecondary educational possibilities;

(b) Community and service learning projects;

(c) Peer-centered activities, including peer mentoring and tutoring;

(d) Organizational and team work training, including team leadership training;

(e) Training in decision-making, including determining priorities and problem solving;

(f) Citizenship training, including life skills training such as parenting and work behavior training;

(g) Civic engagement activities which promote the quality of life in a community; and

(h) Other leadership activities that place youth in a leadership role such as serving on youth leadership committees, such as a Standing Youth Committee.

§ 681.530 What are positive social and civic behaviors?

Positive social and civic behaviors are outcomes of leadership opportunities, which are incorporated by local programs as part of their menu of services. Positive social and civic behaviors focus on areas that may include the following:

(a) Positive attitudinal development;

(b) Self-esteem building;

(c) Openness to work with individuals from diverse backgrounds;

(d) Maintaining healthy lifestyles, including being alcohol- and drug-free;

(e) Maintaining positive social relationships with responsible adults and peers, and contributing to the well-being of one's community, including voting;

(f) Maintaining a commitment to learning and academic success;

(g) Avoiding delinquency; and

(h) Positive job attitudes and work skills.

§ 681.540 What is occupational skills training?

(a) The Department defines occupational skills training as an organized program of study that provides specific vocational skills that lead to proficiency in performing actual tasks and technical functions required by certain occupational fields at entry, intermediate, or advanced levels. Local areas must give priority consideration to training programs that lead to recognized postsecondary credentials that align with in-demand industry sectors or occupations in the local area. Such training must:

(1) Be outcome-oriented and focused on an occupational goal specified in the individual service strategy;

(2) Be of sufficient duration to impart the skills needed to meet the occupational goal; and

(3) Lead to the attainment of a recognized postsecondary credential.

(b) The chosen occupational skills training must meet the quality standards in WIOA sec. 123.

§ 681.550 Are Individual Training Accounts permitted for youth participants?

Yes. In order to enhance individual participant choice in their education and training plans and provide flexibility to service providers, the Department allows WIOA Individual Training Accounts (ITAs) for OSY, ages 16 to 24 using WIOA youth funds when appropriate.

§ 681.560 What is entrepreneurial skills training and how is it taught?

Entrepreneurial skills training provides the basics of starting and operating a small business.

(a) Such training must develop the skills associated with entrepreneurship. Such skills may include, but are not limited to, the ability to:

(1) Take initiative;

(2) Creatively seek out and identify business opportunities;

(3) Develop budgets and forecast resource needs;

(4) Understand various options for acquiring capital and the trade-offs associated with each option; and

(5) Communicate effectively and market oneself and one's ideas.

(b) Approaches to teaching youth entrepreneurial skills include, but are not limited to, the following:

(1) Entrepreneurship education that provides an introduction to the values and basics of starting and running a business. Entrepreneurship education programs often guide youth through the development of a business plan and also may include simulations of business start-up and operation.

(2) Enterprise development which provides supports and services that incubate and help youth develop their own businesses. Enterprise development programs go beyond entrepreneurship education by helping youth access small loans or grants that are needed to begin business operation and by providing more individualized attention to the development of viable business ideas.

(3) Experiential programs that provide youth with experience in the day-to-day operation of a business. These programs may involve the development of a youth-run business that young people participating in the program work in and manage. Or, they may facilitate placement in apprentice or internship positions with adult entrepreneurs in the community.

§ 681.570 What are supportive services for youth?

Supportive services for youth, as defined in WIOA sec. 3(59), are services that enable an individual to participate in WIOA activities. These services include, but are not limited to, the following:

(a) Linkages to community services;

(b) Assistance with transportation;

(c) Assistance with child care and dependent care;

(d) Assistance with housing;

(e) Needs-related payments;

(f) Assistance with educational testing;

(g) Reasonable accommodations for youth with disabilities;

(h) Legal aid services;

(i) Referrals to health care;

(j) Assistance with uniforms or other appropriate work attire and work-related tools, including such items as eyeglasses and protective eye gear;

(k) Assistance with books, fees, school supplies, and other necessary items for students enrolled in postsecondary education classes; and

(l) Payments and fees for employment and training-related applications, tests, and certifications.

§ 681.580 What are follow-up services for youth?

(a) Follow-up services are critical services provided following a youth's exit from the program to help ensure the youth is successful in employment and/or postsecondary education and training. Follow-up services may include regular contact with a youth participant's employer, including assistance in addressing work-related problems that arise.

(b) Follow-up services for youth also may include the following program elements:

(1) Supportive services;

(2) Adult mentoring;

(3) Financial literacy education;

(4) Services that provide labor market and employment information about in-demand industry sectors or occupations available in the local area, such as career awareness, career counseling, and career exploration services; and

(5) Activities that help youth prepare for and transition to postsecondary education and training.

(c) All youth participants must be offered an opportunity to receive follow-up services that align with their individual service strategies. Furthermore, follow-up services must be provided to all participants for a minimum of 12 months unless the participant declines to receive follow-up services or the participant cannot be located or contacted. Follow-up services may be provided beyond 12 months at the State or Local WDB's discretion. The types of services provided and the duration of services must be determined based on the needs of the individual and therefore, the type and intensity of follow-up services may differ for each participant. Follow-up services must include more than only a contact attempted or made for securing documentation in order to report a performance outcome.

§ 681.590 What is the work experience priority and how will local youth programs track the work experience priority?

(a) Local youth programs must expend not less than 20 percent of the funds allocated to them to provide ISY and OSY with paid and unpaid work experiences that fall under the categories listed in § 681.460(a)(3) and further defined in § 681.600.

(b) Local WIOA youth programs must track program funds spent on paid and unpaid work experiences, including wages and staff costs for the development and management of work experiences, and report such expenditures as part of the local WIOA youth financial reporting. The percentage of funds spent on work experience is calculated based on the total local area youth funds expended for work experience rather than calculated separately for ISY and OSY. Local area administrative costs are not subject to the 20 percent minimum work experience expenditure requirement.

§ 681.600 What are work experiences?

(a) Work experiences are a planned, structured learning experience that takes place in a workplace for a limited period of time. Work experience may be paid or unpaid, as appropriate. A work experience may take place in the private for-profit sector, the nonprofit sector, or the public sector.

Labor standards apply in any work experience where an employee/employer relationship, as defined by the Fair Labor Standards Act or applicable State law, exists. Consistent with § 680.840 of this chapter, funds provided for work experiences may not be used to directly or indirectly aid in the filling of a job opening that is vacant because the former occupant is on strike, or is being locked out in the course of a labor dispute, or the filling of which is otherwise an issue in a labor dispute involving a work stoppage. Work experiences provide the youth participant with opportunities for career exploration and skill development.

(b) Work experiences must include academic and occupational education. The educational component may occur concurrently or sequentially with the work experience. Further academic and occupational education may occur inside or outside the work site.

(c) The types of work experiences include the following categories:

(1) Summer employment opportunities and other employment opportunities available throughout the school year;

(2) Pre-apprenticeship programs;

(3) Internships and job shadowing; and

(4) On-the-job training (OJT) opportunities as defined in WIOA sec. 3(44) and in § 680.700 of this chapter.

§ 681.610 Does the Workforce Innovation and Opportunity Act require Local Workforce Development Boards to offer summer employment opportunities in the local youth program?

No, WIOA does not require Local WDBs to offer summer youth employment opportunities as summer employment is no longer its own program element under WIOA. However, WIOA does require Local WDBs to offer work experience opportunities using at least 20 percent of their funding, which may include summer employment.

§ 681.620 How are summer employment opportunities administered?

Summer employment opportunities are a component of the work experience program element. If youth service providers administer the work experience program element, they must be selected by the Local WDB according to the requirements of WIOA sec. 123 and § 681.400, based on criteria contained in the State Plan. However, the summer employment administrator does not need to select the employers who are providing the employment opportunities through a competitive process.

§ 681.630 What does education offered concurrently with and in the same context as workforce preparation activities and training for a specific occupation or occupational cluster mean?

This program element reflects an integrated education and training model and describes how workforce preparation activities, basic academic skills, and hands-on occupational skills training are to be taught within the same time frame and connected to training in a specific occupation, occupational cluster, or career pathway.

§ 681.640 Are incentive payments to youth participants permitted?

Yes, incentive payments to youth participants are permitted for recognition and achievement directly tied to training activities and work experiences. The local program must have written policies and procedures in place governing the award of incentives and must ensure that such incentive payments are:

(a) Tied to the goals of the specific program;

(b) Outlined in writing before the commencement of the program that may provide incentive payments;

(c) Align with the local program's organizational policies; and

(d) Are in accordance with the requirements contained in 2 CFR part 200.

§ 681.650 How can parents, youth, and other members of the community get involved in the design and implementation of local youth programs?

Local WDBs and programs must provide opportunities for parents, participants, and other members of the community with experience working with youth to be involved in the design and implementation of youth programs. Parents, youth participants, and other

members of the community can get involved in a number of ways, including serving on youth standing committees, if they exist and they are appointed by the Local WDB. They also can get involved by serving as mentors, serving as tutors, and providing input into the design and implementation of other program design elements. Local WDBs also must make opportunities available to successful participants to volunteer to help participants as mentors, tutors, or in other activities.

Subpart D—One-Stop Services to Youth

§ 681.700 What is the connection between the youth program and the one-stop delivery system?

(a) WIOA sec. 121(b)(1)(B)(i) requires that the youth program function as a required one-stop partner and fulfill the roles and responsibilities of a one-stop partner described in WIOA sec. 121(b)(1)(A).

(b) In addition to the provisions of part 678 of this chapter, connections between the youth program and the one-stop delivery system may include those that facilitate:

(1) The coordination and provision of youth activities;

(2) Linkages to the job market and employers;

(3) Access for eligible youth to the information and services required in § 681.460;

(4) Services for non-eligible youth such as basic labor exchange services, other self-service activities such as job searches, career exploration, use of one-stop center resources, and referral as appropriate; and

(5) Other activities described in WIOA sec. 129(b)–(c).

(c) Local WDBs must either colocate WIOA youth program staff at one-stop centers and/or ensure one-stop centers and staff are trained to serve youth and equipped to advise youth to increase youth access to services and connect youth to the program that best aligns with their needs.

§ 681.710 Do Local Workforce Development Boards have the flexibility to offer services to area youth who are not eligible under the youth program through the one-stop centers?

Yes. However, Local WDBs must ensure one-stop centers fund services for non-eligible youth through programs authorized to provide services to such youth. For example, one-stop centers may provide basic labor exchange services under the Wagner-Peyser Act to any youth.

PART 682—STATEWIDE ACTIVITIES UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

Subpart A—General Description

Sec.

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Subpart A—General Description

§ 682.100 What are the statewide employment and training activities under title I of the Workforce Innovation and Opportunity Act?

Statewide employment and training activities include those activities for adults and dislocated workers, as described in WIOA sec. 134(a), and statewide youth activities, as described in the Workforce Innovation and Opportunity Act (WIOA) sec. 129(b). They include both required and allowable activities. In accordance with the requirements of this subpart, the State may develop policies and strategies for use of statewide employment and training funds. Descriptions of these policies and strategies must be included in the State Plan.

§ 682.110 How are statewide employment and training activities funded?

(a) Except for the statewide rapid response activities described in paragraph (c) of this section, statewide employment and training activities are supported by funds reserved by the Governor under WIOA sec. 128(a).

(b) Funds reserved by the Governor for statewide workforce investment activities may be combined and used for any of the activities authorized in WIOA sec. 129(b), 134(a)(2)(B), or 134(a)(3)(A) (which are described in §§ 682.200 and 682.210), regardless of whether the funds were allotted through the youth, adult, or dislocated worker funding streams.

(c) Funds for statewide rapid response activities are reserved under WIOA sec.133(a)(2) and may be used to provide the activities authorized at WIOA sec. 134(a)(2)(A) (which are described in §§ 682.310 through 682.330).

Subpart B—Required and Allowable Statewide Employment and Training Activities

§ 682.200 What are required statewide employment and training activities?

Required statewide employment and training activities are:

(a) Required rapid response activities, as described in § 682.310;

(b) Disseminating by various means, as provided by WIOA sec. 134(a)(2)(B):

(1) The State list of eligible training providers (including those providing non-traditional training services), for adults and dislocated workers and eligible training providers of registered apprenticeship programs;

(2) Information identifying eligible providers of on-the-job training (OJT), customized training, incumbent worker training (see § 680.790 of this chapter), internships, paid or unpaid work experience opportunities (see § 680.180 of this chapter) and transitional jobs (see § 680.190 of this chapter);

(3) Information on effective outreach and partnerships with business;

(4) Information on effective service delivery strategies and promising practices to serve workers and job seekers;

(5) Performance information and information on the cost of attendance, including tuition and fees, consistent with the requirements of §§ 680.490 and 680.530 of this chapter;

(6) A list of eligible providers of youth activities as described in WIOA sec. 123; and

(7) Information of physical and programmatic accessibility for individuals with disabilities;

(c) States must assure that the information listed in paragraphs (b)(1) through (7) of this section is widely available;

(d) Conducting evaluations under WIOA sec. 116(e), consistent with the requirements found under § 682.220;

(e) Providing technical assistance to State entities and agencies, local areas, and one-stop partners in carrying out activities described in the State Plan, including coordination and alignment of data systems used to carry out the requirements of this Act;

(f) Assisting local areas, one-stop operators, one-stop partners, and eligible providers, including development of staff, including staff training to provide opportunities for individuals with barriers to employment to enter in-demand industry sectors or occupations and nontraditional occupations, and the development of exemplary program activities;

(g) Assisting local areas for carrying out the regional planning and service delivery efforts required under WIOA sec. 106(c);

(h) Assisting local areas by providing information on and support for the effective development, convening, and implementation of industry and sector partnerships;

(i) Providing technical assistance to local areas that fail to meet the adjusted levels of performance agreed to under § 677.210 of this chapter;

(j) Carrying out monitoring and oversight of activities for services to youth, adults, and dislocated workers under WIOA title I, and which may include a review comparing the services provided to male and female youth;

(k) Providing additional assistance to local areas that have a high concentration of eligible youth; and

(l) Operating a fiscal and management accountability information system, based on guidelines established by the Secretary.

§ 682.210 What are allowable statewide employment and training activities?

Allowable statewide employment and training activities may include:

(a) State administration of the adult, dislocated worker and youth workforce investment activities, consistent with the five percent administrative cost limitation at WIOA sec. 134(a)(3)(B) and § 683.205(a)(1) of this chapter;

(b) Developing and implementing innovative programs and strategies designed to meet the needs of all employers (including small employers) in the State, including the programs and strategies referenced in WIOA sec. 134(a)(3)(A)(i);

(c) Developing strategies for serving individuals with barriers to employment, and for coordinating programs and services among one-stop partners;

(d) Development or identification of education and training programs that have the characteristics referenced in WIOA sec. 134(a)(3)(A)(iii);

(e) Implementing programs to increase the number of individuals training for and placed in non-traditional employment;

(f) Conducting research and demonstrations related to meeting the employment and education needs of youth, adults and dislocated workers;

(g) Supporting the development of alternative, evidence-based programs, and other activities that enhance the choices available to eligible youth and which encourage youth to reenter and complete secondary education, enroll in postsecondary education and advanced training, progress through a career pathway, and enter into unsubsidized employment that leads to economic self-sufficiency;

(h) Supporting the provision of career services in the one-stop delivery system in the State as described in § 678.430 of this chapter and WIOA secs. 129(b)(2)(C) and 134(c)(2);

(i) Supporting financial literacy activities as described in § 681.500 of this chapter and WIOA sec. 129(b)(2)(D);

(j) Providing incentive grants to local areas for performance by the local areas on local performance accountability measures;

(k) Providing technical assistance to Local Workforce Development Boards (WDBs), chief elected officials, one-stop operators, one-stop partners, and eligible providers in local areas on the development of exemplary program activities and on the provision of technology to facilitate remote access to services provided through the one-stop delivery system in the State;

(l) Providing technical assistance to local areas that are implementing WIOA Pay-for-Performance contract strategies and conducting evaluations of such strategies. Technical assistance may include providing assistance with data collections, meeting data entry requirements, and identifying level of performance;

(m) Carrying out activities to facilitate remote access to training services provided through the one-stop delivery system;

(n) Activities that include:

(1) Activities to improve coordination of workforce investment activities, with economic development activities; and

(2) Activities to improve coordination of employment and training activities with child support services and activities, cooperative extension programs carried out by the Department of Agriculture, programs carried out by local areas for individuals with disabilities (including the programs identified in WIOA sec. 134(a)(3)(A)(viii)(II)(cc)), adult education and literacy activities including those provided by public libraries, activities in the correction systems to assist ex-offenders in reentering the workforce and financial literacy activities; and

(3) Developing and disseminating workforce and labor market information;

(o) Implementation of promising practices for workers and businesses as described in WIOA sec. 134(a)(3)(A)(x);

(p) Adopting, calculating, or commissioning for approval an economic self-sufficiency standard for the State that specifies the income needs of families, by family size, the number and ages of children in the family, and sub-State geographical considerations;

(q) Developing and disseminating common intake procedures and related items, including registration processes, across core and partner programs; and

(r) Coordinating activities with the child welfare system to facilitate provision of services for children and youth who are eligible for assistance under sec. 477 of the Social Security Act.

§ 682.220 What are States' responsibilities in regard to evaluations?

(a) As required by § 682.200(d), States must use funds reserved by the Governor for statewide activities to conduct evaluations of activities under the WIOA title I core programs in order to promote continuous improvement, research and test innovative services and strategies, and achieve high levels of performance and outcomes.

(b) Evaluations conducted under paragraph (a) of this section must:

(1) Be coordinated with and designed in conjunction with State and Local WDBs and with State agencies responsible for the administration of all core programs;

(2) When appropriate, include analysis of customer feedback and outcome and process measures in the statewide workforce development system;

(3) Use designs that employ the most rigorous analytical and statistical methods that are reasonably feasible, such as the use of control groups; and

(4) To the extent feasible, be coordinated with the evaluations provided for by the Secretary of Labor and the Secretary of Education under WIOA sec. 169 (regarding title I programs and other employment-related programs), WIOA sec. 242(c)(2)(D) (regarding adult education), sec. 12(a)(5), 14, and 107 of the Rehabilitation Act of 1973 (29 U.S.C. 709(a)(5), 711, 727) (applied with respect to programs carried out under title I of that Act (29 U.S.C. 720 *et seq.*)), and the investigations provided by the Secretary of Labor under sec. 10(b) of the Wagner-Peyser Act (29 U.S.C. 49i(b)).

(c) States must annually prepare, submit to the State WDB and Local WDBs in the State, and make available to the public (including by electronic means) reports containing the results, as available, of the evaluations described in paragraph (a) of this section.

(d) States must cooperate, to the extent practicable, in evaluations and related research projects conducted by the Secretaries of Labor and Education under the laws cited in paragraph (b)(4) of this section. Such cooperation must, at a minimum, meet the following requirements:

(1) The timely provision of:

(i) Data, in accordance with appropriate privacy protections established by the Secretary of Labor;

(ii) Responses to surveys;

(iii) Site visits; and

(iv) Data and survey responses from local subgrantees and State and Local WDBs, and assuring that subgrantees and WDBs allow timely site visits;

(2) Encouraging other one-stop partners at local level to cooperate in timely provision of data, survey responses and site visits as listed in paragraphs (d)(1)(i) through (iv) of this section; and

(3) If a State determines that timely cooperation in data provision as described in paragraph (d)(1) of this section is not practicable, the Governor must inform the Secretary in writing and explain the reasons why it is not practicable. In such circumstances, the State must cooperate with the Department in developing a plan or strategy to mitigate or overcome the problems preventing timely provision of data, survey responses, and site visits.

(e) In fulfilling the requirements under paragraphs (a) through (c) of this section, States are permitted, but not required, to:

(1) Conduct evaluations that jointly examine title I core program activities and activities under other core programs in WIOA titles II–IV, as determined through the processes associated with paragraph (b)(1) of this section;

(2) Conduct any type of evaluation similar to those authorized for, or conducted by, the Department of Labor or the Department of Education under the laws cited in paragraph (b)(4) of this section, including process and outcome studies, pilot and demonstration projects that have an evaluative component, analyses of administrative and programmatic data, impact and benefit-cost analyses, and use of rigorous designs to test the efficacy of various interventions; and

(3) Conduct evaluations over multiple program years, involving multiple phases and such tasks and activities as necessary for an evaluation, such as a literature or evidence review, feasibility study, planning, research, coordination, design, data collection, analysis, and report preparation, clearance, and dissemination.

(f) In funding evaluations conducted under paragraph (a) of this section, States are permitted, but not required to:

(1) Use funds from any WIOA title I–IV core program to conduct evaluations, as determined through the processes associated with paragraph (b)(1) of this section; and

(2) Use or combine funds, consistent with Federal and State law, regulation and guidance, from other public or private sources, to conduct evaluations relating to activities under the WIOA title I–IV core programs. Such projects may include those funded by the Department of Labor and other Federal agencies, among other sources.

Subpart C—Rapid Response Activities

§ 682.300 What is rapid response, and what is its purpose?

(a) Rapid response is described in §§ 682.300 through 682.370, and encompasses the strategies and activities necessary to:

(1) Plan for and respond to as quickly as possible following an event described in § 682.302; and

(2) Deliver services to enable dislocated workers to transition to new employment as quickly as possible.

(b) The purpose of rapid response is to promote economic recovery and vitality by developing an ongoing, comprehensive approach to identifying, planning for, responding to layoffs and dislocations, and preventing or minimizing their impacts on workers, businesses, and communities. A successful rapid response system includes:

(1) Informational and direct reemployment services for workers, including but not limited to information and support for filing unemployment insurance claims, information on the impacts of layoff on health coverage or other benefits, information on and referral to career services, reemployment-focused workshops and services, and training;

(2) Delivery of solutions to address the needs of businesses in transition, provided across the business lifecycle (expansion and contraction), including comprehensive business engagement and layoff aversion strategies and activities designed to prevent or minimize the duration of unemployment;

(3) Convening, brokering, and facilitating the connections, networks and partners to ensure the ability to provide assistance to dislocated workers and their families such as home heating assistance, legal aid, and financial advice; and

(4) Strategic planning, data gathering and analysis designed to anticipate, prepare for, and manage economic change.

§ 682.302 Under what circumstances must rapid response services be delivered?

Rapid response must be delivered when one or more of the following circumstances occur:

(a) Announcement or notification of a permanent closure, regardless of the number of workers affected;

(b) Announcement or notification of a mass layoff as defined in § 682.305;

(c) A mass job dislocation resulting from a natural or other disaster; or

(d) The filing of a Trade Adjustment Assistance (TAA) petition.

§ 682.305 How does the Department define the term "mass layoff" for the purposes of rapid response?

For the purposes of rapid response, the term ''mass layoff'' used throughout this subpart will have occurred when at least one of the following conditions have been met:

(a) A layoff meets the State's definition of mass layoff, as long as the definition does not exceed a minimum threshold of 50 affected workers;

(b) Where a State has not defined a minimum threshold for mass layoff meeting the requirements of paragraph (a) of this section, layoffs affecting 50 or more workers; or

(c) When a Worker Adjustment and Retraining Notification (WARN) Act notice has been filed, regardless of the number of workers affected by the layoff announced.

§ 682.310 Who is responsible for carrying out rapid response activities?

(a) Rapid response activities must be carried out by the State or an entity designated by the State, in conjunction with the Local WDBs, chief elected officials, and other stakeholders, as provided by WIOA secs. 133(a)(2) and 134(a)(2)(A).

(b) States must establish and maintain a rapid response unit to carry out statewide rapid response activities and to oversee rapid response activities undertaken by a designated State entity, Local WDB, or the chief elected officials for affected local areas, as provided under WIOA sec. 134(a)(2)(A)(i)(I).

§ 682.320 What is layoff aversion, and what are appropriate layoff aversion strategies and activities?

(a) Layoff aversion consists of strategies and activities, including those provided in paragraph (b) of this section and §§ 682.330 and 682.340, to prevent or minimize the duration of unemployment resulting from layoffs.

(b) Layoff aversion activities may include:

(1) Providing assistance to employers in managing reductions in force, which may include early identification of firms at risk of layoffs, assessment of the needs of and options for at-risk firms, and the delivery of services to address these needs, as provided by WIOA sec. 134(d)(1)(A)(ix)(II)(cc);

(2) Ongoing engagement, partnership, and relationship-building activities with businesses in the community, in order to create an environment for successful layoff aversion efforts and to enable the provision of assistance to dislocated workers in obtaining reemployment as soon as possible;

(3) Funding feasibility studies to determine if a company's operations may be sustained through a buyout or other means to avoid or minimize layoffs;

(4) Developing, funding, and managing incumbent worker training programs or other worker upskilling approaches as part of a layoff aversion strategy or activity;

(5) Connecting companies to:

(i) Short-time compensation or other programs designed to prevent layoffs or to reemploy dislocated workers quickly, available under Unemployment Insurance programs;

(ii) Employer loan programs for employee skill upgrading; and

(iii) Other Federal, State, and local resources as necessary to address other business needs that cannot be funded with resources provided under this title;

(6) Establishing linkages with economic development activities at the Federal, State, and local levels, including Federal Department of Commerce programs and available State and local business retention and expansion activities;

(7) Partnering or contracting with business-focused organizations to assess risks to companies, propose strategies to address those risks, implement services, and measure impacts of services delivered;

(8) Conducting analyses of the suppliers of an affected company to assess their risks and vulnerabilities from a potential closing or shift in production of their major customer;

(9) Engaging in proactive measures to identify opportunities for potential economic transition and training needs in growing industry sectors or expanding businesses; and

(10) Connecting businesses and workers to short-term, on-the-job, or customized training programs and registered apprenticeships before or after layoff to help facilitate rapid reemployment.

§ 682.330 What rapid response activities are required?

Rapid response activities must include:

(a) Layoff aversion activities as described in § 682.320, as applicable.

(b) Immediate and on-site contact with the employer, representatives of the affected workers, and the local community, including an assessment of and plans to address the:

(1) Layoff plans and schedule of the employer;

(2) Background and probable assistance needs of the affected workers;

(3) Reemployment prospects for workers; and

(4) Available resources to meet the short and long-term assistance needs of the affected workers.

(c) The provision of information and access to unemployment compensation benefits and programs, such as Short-Time Compensation, comprehensive one-stop delivery system services, and employment and training activities, including information on the TAA program (19 U.S.C. 2271 *et seq.*), Pell Grants, the GI Bill, and other resources.

(d) The delivery of other necessary services and resources including workshops and classes, use of worker transition centers, and job fairs, to support reemployment efforts for affected workers.

(e) Partnership with the Local WDB(s) and chief elected official(s) to ensure a coordinated response to the dislocation event and, as needed, obtain access to State or local economic development assistance. Such coordinated response may include the development of an application for a national dislocated worker grant as provided under part 687 of this chapter.

(f) The provision of emergency assistance adapted to the particular layoff or disaster.

(g) As appropriate, developing systems and processes for:

(1) Identifying and gathering information for early warning of potential layoffs or opportunities for layoff aversion;

(2) Analyzing, and acting upon, data and information on dislocations and other economic activity in the State, region, or local area; and

(3) Tracking outcome and performance data and information related to the activities of the rapid response program.

(h) Developing and maintaining partnerships with other appropriate Federal, State and local agencies and officials, employer associations, technical councils, other industry business councils, labor organizations, and other public and private organizations, as applicable, in order to:

(1) Conduct strategic planning activities to develop strategies for addressing dislocation events and ensuring timely access to a broad range of necessary assistance; and

(2) Develop mechanisms for gathering and exchanging information and data relating to potential dislocations, resources available, and the customization of layoff aversion or rapid response activities, to ensure the ability to provide rapid response services as early as possible.

(i) Delivery of services to worker groups for which a petition for Trade Adjustment Assistance has been filed.

(j) The provision of additional assistance, as described in § 682.350, to local areas that experience disasters, mass layoffs, or other dislocation events when such events exceed the capacity of the local area to respond with existing resources as provided under WIOA sec. 134(a)(2)(A)(i)(II).

(k) Provision of guidance and financial assistance as appropriate, in establishing a labor-management committee if voluntarily agreed to by the employee's bargaining representative and management. The committee may devise and oversee an implementation strategy that responds to the reemployment needs of the workers. The assistance to this committee may include:

(1) The provision of training and technical assistance to members of the committee; and

(2) Funding the operating costs of a committee to enable it to provide advice and assistance in carrying out rapid response activities and in the design and delivery of WIOA-authorized services to affected workers.

§ 682.340 May other activities be undertaken as part of rapid response?

(a) Yes, in order to conduct layoff aversion activities, or to prepare for and respond to dislocation events, in addition to the activities required under § 682.330, a State or designated entity may devise rapid response strategies or conduct activities that are intended to minimize the negative impacts of dislocation on workers, businesses, and communities and ensure rapid reemployment for workers affected by layoffs.

(b) When circumstances allow, rapid response may provide guidance and/or financial assistance to establish community transition teams to assist the impacted community in organizing support for dislocated workers and in meeting the basic needs of their families, including heat, shelter, food, clothing and other necessities and services that are beyond the resources and ability of the one-stop delivery system to provide.

§ 682.350 What is meant by "provision of additional assistance" in the Workforce Innovation and Opportunity Act?

As stated in WIOA sec. 133(a)(2), a State may reserve up to 25 percent of its allotted dislocated worker funds for rapid response activities. Once the State has reserved adequate funds for rapid response activities, such as those described in §§ 682.310, 682.320, and 682.330, any of the remaining funds reserved may be provided to local areas that experience increases of unemployment due to natural disasters, mass layoffs or other events, for provision of direct career services to participants if there are not adequate local funds available to assist the dislocated workers. States may wish to establish the policies or procedures governing the provision of additional assistance as described in § 682.340.

§ 682.360 What rapid response, layoff aversion, or other information will States be required to report to the Employment and Training Administration?

(a) Where a WIOA individual record exists for an individual served under programs reporting through the WIOA individual record, States must report information regarding the receipt of services under this subpart for such an individual. This information must be reported in the WIOA individual record.

(b) States must comply with these requirements as explained in guidance issued by the Department of Labor.

§ 682.370 What are the statewide activities for which rapid response funds remaining unobligated after the first program year for which the funds were allotted may be used by the State?

Funds reserved by the Governor for rapid response activities that remain unobligated after the first program year for which such funds were allotted may be used by the Governor to carry out statewide activities under §§ 682.200 and 682.210. Statewide activities for which these funds may be used include prioritizing the planning for and delivery of activities designed to prevent job loss, increasing the rate of reemployment, building relationships with businesses and other stakeholders, building and maintaining early warning networks and systems, and otherwise supporting efforts to allow long-term unemployed workers to return to work.

PART 683—ADMINISTRATIVE PROVISIONS UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

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Sec.

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Subpart A—Funding and Closeout

§ 683.100 When do Workforce Innovation and Opportunity Act grant funds become available for obligation?

(a) WIOA *title I.* Except as provided in paragraph (b) of this section or in the applicable fiscal year appropriation,

fiscal year appropriations for programs and activities carried out under title I are available for obligation on the basis of a program year. A program year begins on July 1 in the fiscal year for which the appropriation is made and ends on June 30 of the following year.

(b) *Youth funds.* Fiscal year appropriations for a program year's youth activities, authorized under chapter 2, subtitle B, title I of WIOA may be made available for obligation beginning on April 1 of the fiscal year for which the appropriation is made.

(c) *Wagner-Peyser Act employment service.* Fiscal year appropriations for activities authorized under sec. 6 of the Wagner-Peyser Act, 29 U.S.C. 49e, are available for obligation on the basis of a program year. A program year begins July 1 in the fiscal year for which the appropriation is made and ends on June 30 of the following year.

(d) *Discretionary grants.* Discretionary grant funds are available for obligation in accordance with the fiscal year appropriation.

§ 683.105 What award document authorizes the expenditure of funds under title I of the Workforce Innovation and Opportunity Act and the Wagner-Peyser Act?

(a) *Agreement.* All WIOA title I and Wagner-Peyser Act funds are awarded by grant or cooperative agreement, as defined in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards regulations at 2 CFR 200.51 and 200.24 respectively, or contract, as defined in 2 CFR 200.22. All grant or cooperative agreements are awarded by the Grant Officer through negotiation with the recipient (the non-Federal entity). The agreement describes the terms and conditions applicable to the award of WIOA title I and Wagner-Peyser Act funds and will conform to the requirements of 2 CFR 200.210. Contracts are issued by the Contracting Officer in compliance with the Federal Acquisition Regulations.

(b) *Grant funds awarded to States and outlying areas.* The Federal funds allotted to the States and outlying areas each program year in accordance with secs. 127(b) and 132(b) of WIOA will be obligated by grant agreement.

(c) *Native American programs.* Awards of grants, contracts, or cooperative agreements for the WIOA Native American program will be made to eligible entities on a competitive basis every 4 program years for a 4-year period, in accordance with the provisions of sec. 166 of WIOA.

(d) *Migrant and seasonal farmworker programs.* Awards of grants or contracts for the Migrant and Seasonal Farmworker Program will be made to eligible entities on a competitive basis every 4 program years for a 4-year period, in accordance with the provisions of sec. 167 of WIOA.

(e) *Awards for evaluation and research under sec. 169 of WIOA.* (1) Awards of grants, contracts, or cooperative agreements will be made to eligible entities for programs or activities authorized under WIOA sec. 169. These funds are for:

(i) Evaluations;

(ii) Research;

(iii) Studies;

(iv) Multi-State projects; and

(v) Dislocated worker projects.

(2) Awards of grants, contracts, or cooperative agreements under paragraphs (e)(1)(ii) through (iv) of this section in amounts that exceed $100,000 will be awarded on a competitive basis, except that a noncompetitive award may be made in the case of a project that is funded jointly with other public or private sector entities that provide a substantial portion of the assistance under the grant, contract, or cooperative agreement for the project.

(3) Awards of grants, contracts, or cooperative agreements for carrying out projects in paragraphs (e)(1)(ii) through (iv) of this section may not be awarded to the same organization for more than 3 consecutive years unless:

(i) Such grant, contract, or cooperative agreement is competitively reevaluated within such period;

(ii) The initial grant, contract, or cooperative agreement was issued on a non-competitive basis because it was for less than $100,000, and:

(A) The non-competitive continuation is for less than $100,000;

(B) The scope of work is essentially the same as the initial grant, contract, or cooperative agreement;

(C) Progress in meeting performance objectives is satisfactory; and

(D) Other terms and conditions established by the Department have been met; or

(iii) The initial grant, contract, or cooperative agreement was issued on a non-competitive basis because the project was funded jointly with other public or private sector entities that provide a substantial portion of the assistance, and:

(A) The non-competitive continuation maintains a substantial portion of joint funding;

(B) The scope of work is essentially the same as the initial grant, contract, or cooperative agreement;

(C) Progress in meeting performance objectives is satisfactory; and

(D) Other terms and conditions established by the Department have been met.

(4) Entities with recognized expertise in the methods, techniques, and knowledge of workforce investment activities will be provided priority in awarding funds for the projects under paragraphs (e)(1)(ii) through (iv) of this section. The duration of such projects will be specified in the grant, contract, or cooperative agreement.

(5) A peer review process will be used to review and evaluate projects under this paragraph (e) for grants, contracts, or cooperative agreements that exceed $500,000, and to designate exemplary and promising programs.

(f) *Termination.* Each grant, cooperative agreement, or contract terminates as indicated in the terms of the agreement or when the period of performance has expired. The grants and cooperative agreements must be closed in accordance with the closeout provisions at 2 CFR 200.343 and 2 CFR part 2900 as applicable.

§ 683.110 What is the period of performance of Workforce Innovation and Opportunity Act title I and Wagner-Peyser Act funds?

(a) The statutory period of availability for expenditure for WIOA title I grants will be established as the period of performance for such grants unless otherwise provided in the grant agreement or cooperative agreement. All funds must be fully expended by the expiration of the period of performance or they risk losing their availability. Unless otherwise authorized in a grant or cooperative agreement or subsequent modification, recipients must expend funds with the shortest period of availability first.

(b) *Grant funds expended by States.* Funds allotted to States under WIOA secs. 127(b) and 132(b) for any program year are available for expenditure by the State receiving the funds only during that program year and the 2 succeeding program years as identified in § 683.100.

(c) *Grant funds expended by local areas as defined in WIOA sec. 106.* (1)(i) Funds allocated by a State to a local area under WIOA secs. 128(b) and 133(b), for any program year are available for expenditure only during that program year and the succeeding program year;

(ii) *Pay-for-Performance exception.* Funds used to carry out WIOA Pay-for-Performance contract strategies will remain available until expended in accordance with WIOA sec. 189(g)(2)(D).

(2) Funds which are not expended by a local area(s) in the 2-year period described in paragraph (c)(1)(i) of this section, must be returned to the State. Funds so returned are available for expenditure by State and local recipients and subrecipients only during the third program year of availability in accordance with WIOA secs. 128(c) and 132(c). These funds are available for only the following purposes:

(i) For statewide projects; or

(ii) For distribution to local areas which had fully expended their allocation of funds for the same program year within the 2-year period.

(d) *Native American programs.* Funds awarded by the Department under WIOA sec. 166(c) are available for expenditure for the period identified in the grant or contract award document, which will not exceed 4 years.

(e) *Migrant and seasonal farmworker programs.* Funds awarded by the Department under WIOA sec. 167 are available for expenditure for the period identified in the grant award document, which will not exceed 4 years.

(f) *Evaluations and research.* Funds awarded by the Department under

WIOA sec. 169 are available for expenditure for any program or activity authorized under sec. 169 of WIOA and will remain available until expended or as specified in the award document.

(g) *Other programs under title I of WIOA, including secs. 170 and 171, and all other grants, contracts and cooperative agreements.* Funds are available for expenditure for a period of performance identified in the grant or contract agreement.

(h) *Wagner-Peyser Act.* Funds allotted to States for grants under secs. 3 and 15 of the Wagner-Peyser Act for any program year are available for expenditure by the State receiving the funds only during that program year and the 2 succeeding program years. The program year begins on July 1 of the fiscal year for which the appropriation is made.

§ 683.115 What planning information must a State submit in order to receive a formula grant?

Each State seeking financial assistance under subtitle B, chapter 2 (youth) or chapter 3 (adults and dislocated workers), of title I of WIOA, or under the Wagner-Peyser Act must submit a Unified State Plan under sec. 102 of WIOA or a Combined State Plan under WIOA sec. 103. The requirements for the plan content and the plan review process are described in secs. 102 and 103 of WIOA, sec. 8 of Wagner-Peyser Act, and §§ 676.100 through 676.145 of this chapter and §§ 652.211 through 652.214 of this chapter.

§ 683.120 How are Workforce Innovation and Opportunity Act title I formula funds allocated to local areas?

(a) *General.* The Governor must allocate WIOA formula funds allotted for services to youth, adults and dislocated workers in accordance with secs. 128 and 133 of WIOA and this section.

(1) State WDBs must assist Governors in the development of any youth or adult discretionary within-State allocation formulas.

(2) Within-State allocations must be made:

(i) In accordance with the allocation formulas contained in secs. 128(b) and 133(b) of WIOA and in the State Plan;

(ii) After consultation with chief elected officials and Local WDBs in each of the local areas; and

(iii) In accordance with sec. 182(e) of WIOA, available to local areas not later than 30 days after the date funds are made available to the State or 7 days after the date the local plan for the area is approved, whichever is later.

(b) *State reserve.* Of the WIOA formula funds allotted for services to youth, adults and dislocated workers, the Governor must reserve not more than 15 percent of the funds from each of these sources to carry out statewide activities. Funds reserved under this paragraph may be combined and spent on statewide activities under WIOA sec. 129(b) and statewide employment and training activities under WIOA sec. 134(a), for adults and dislocated workers, and youth activities, as described in §§ 682.200 and 682.210 of this chapter, without regard to the funding source of the reserved funds.

(c) *Youth allocation formula.* (1) Unless the Governor elects to distribute funds in accordance with the discretionary allocation formula described in paragraph (c)(2) of this section, the remainder of youth funds not reserved under paragraph (b) of this section must be allocated:

(i) 33⅓ percent on the basis of the relative number of unemployed individuals in areas of substantial unemployment in each local area, compared to the total number of unemployed individuals in all areas of substantial unemployment in the State;

(ii) 33⅓ percent on the basis of the relative excess number of unemployed individuals in each local area, compared to the total excess number of unemployed individuals in the State; and

(iii) 33⅓ percent on the basis of the relative number of disadvantaged youth in each local area, compared to the total number of disadvantaged youth in the State except for local areas as described in sec. 107(c)(1)(C) of WIOA where the allotment must be based on the greater of either the number of individuals aged 16 to 21 in families with an income below the low-income level for the area or the number of disadvantaged youth in the area.

(2) *Discretionary youth allocation formula.* In lieu of making the formula allocation described in paragraph (c)(1) of this section, the State may allocate youth funds under a discretionary formula. Under this discretionary formula, the State must allocate a minimum of 70 percent of youth funds not reserved under paragraph (b) of this section on the basis of the formula in paragraph (c)(1) of this section, and may allocate up to 30 percent on the basis of a formula that:

(i) Incorporates additional factors (other than the factors described in paragraph (c)(1) of this section) relating to:

(A) Excess youth poverty in urban, rural and suburban local areas; and

(B) Excess unemployment above the State average in urban, rural and suburban local areas; and

(ii) Was developed by the State WDB and approved by the Secretary of Labor as part of the State Plan.

(d) *Adult allocation formula.* (1) Unless the Governor elects to distribute funds in accordance with the discretionary allocation formula described in paragraph (d)(2) of this section, the remainder of adult funds not reserved under paragraph (b) of this section must be allocated:

(i) 33⅓ percent on the basis of the relative number of unemployed individuals in areas of substantial unemployment in each local area, compared to the total number of unemployed individuals in areas of substantial unemployment in the State;

(ii) 33⅓ percent on the basis of the relative excess number of unemployed individuals in each local area, compared to the total excess number of unemployed individuals in the State; and

(iii) 33⅓ percent on the basis of the relative number of disadvantaged adults in each local area, compared to the total number of disadvantaged adults in the State. Except for local areas as described in sec. 107(c)(1)(C) of WIOA where the allotment must be based on the higher of either the number of adults with an income below the low-income level for the area or the number of disadvantaged adults in the area.

(2) *Discretionary adult allocation formula.* In lieu of making the formula allocation described in paragraph (d)(1) of this section, the State may allocate adult funds under a discretionary formula, Under this discretionary formula, the State must allocate a minimum of 70 percent of adult funds not reserved under paragraph (b) of this section on the basis of the formula in paragraph (d)(1), and may allocate up to 30 percent on the basis of a formula that:

(i) Incorporates additional factors (other than the factors described in paragraph (d)(1) of this section) relating to:

(A) Excess poverty in urban, rural and suburban local areas; and

(B) Excess unemployment above the State average in urban, rural and suburban local areas; and

(ii) Was developed by the State WDB and approved by the Secretary of Labor as part of the State Plan.

(e) *Dislocated worker allocation formula.* (1) The remainder of dislocated worker funds not reserved under paragraph (b) of this section must be allocated on the basis of a formula prescribed by the Governor that distributes funds in a manner that addresses the State's dislocated worker needs. Funds so distributed must not be less than 60 percent of the State's formula allotment.

(2) The Governor's dislocated worker formula must use the most appropriate information available to the Governor, including information on:

(i) Insured unemployment data;

(ii) Unemployment concentrations;

(iii) Plant closings and mass layoff data;

(iv) Declining industries data;

(v) Farmer-rancher economic hardship data; and

(vi) Long-term unemployment data.

(3) The Governor may not amend the dislocated worker formula more than once for any program year.

(f) *Rapid response.* (1) Of the WIOA formula funds allotted for services to dislocated workers in sec. 132(b)(2)(B) of WIOA, the Governor must reserve not more than 25 percent of the funds for statewide rapid response activities described in WIOA sec. 134(a)(2)(A) and §§ 682.300 through 682.370 of this chapter.

(2) *Unobligated funds.* Funds reserved by a Governor for rapid response activities under sec. 133(a)(2) of WIOA, and sec. 133(a)(2) of the Workforce Investment Act (as in effect on the day before the date of enactment of WIOA), to carry out sec. 134(a)(2)(A) of WIOA that remain unobligated after the first program year for which the funds were allotted, may be used by the Governor to carry out statewide activities authorized under paragraph (b) of this section and §§ 682.200 and 682.210 of this chapter.

(g) *Special rule.* For the purpose of the formula in paragraphs (c)(1) and (d)(1) of this section, the State must, as appropriate and to the extent practicable, exclude college students and members of the Armed Forces from the determination of the number of disadvantaged youth and disadvantaged adults.

§ 683.125 What minimum funding provisions apply to Workforce Innovation and Opportunity Act adult, dislocated worker, and youth allocations?

(a) For funding authorized by secs. 128(b)(2), 133(b)(2)(A), and 133(b)(2)(B) of WIOA, which are youth, adult, and dislocated worker funds, a local area must not receive an allocation percentage for a fiscal year that is less than 90 percent of the average allocation percentage of the local area for the 2 preceding fiscal years.

(b) The Department's annual fiscal year appropriation provides funding for programs and activities described in paragraph (a) of this section under separate appropriations with various periods of availability. These periods of availability are described in § 683.100 as a program year. A program year for funds allocated under secs. 133(b)(2)(A) and 133(b)(2)(B) of WIOA begins on July 1 in the fiscal year for which the appropriation is made and ends on June 30 of the following year. A program year for funds available under WIOA sec. 128(b)(2) is available from April 1 of the fiscal year in which the appropriation is made and ends on June 30 of the following year. Therefore, when grantees are calculating the minimum funding percentage they must do so on a program year basis.

(c) When a new local area is designated under sec. 106 of WIOA the State must develop a methodology to apply the minimum funding provision specified in paragraph (a) of this section to local area allocations of WIOA youth, adult, and dislocated worker funds.

(d) Amounts necessary to increase allocations to local areas to comply with paragraph (a) of this section must be obtained by ratably reducing the allocations to be made to other local areas.

(e) If the amounts of WIOA funds appropriated in a fiscal year are not sufficient to provide the amount specified in paragraph (a) of this section to all local areas, the amounts allocated to each local area must be ratably reduced.

§ 683.130 Does a Local Workforce Development Board have the authority to transfer funds between the adult employment and training activities allocation and the dislocated worker employment and training activities allocation?

(a) A Local WDB may transfer up to 100 percent of a program year allocation for adult employment and training activities, and up to 100 percent of a program year allocation for dislocated worker employment and training activities between the two programs.

(b) Local WDBs may not transfer funds to or from the youth program.

(c) Before making any transfer described in paragraph (a) of this section, a Local WDB must obtain the Governor's written approval. The Governor's written approval must be based on criteria or factors that the Governor must establish in a written policy, such as the State Unified or Combined Plan or other written policy.

§ 683.135 What reallotment procedures does the Secretary use?

(a) The Secretary determines, during the second quarter of each program year, whether a State has obligated its required level of at least 80 percent of the funds allotted under secs. 127 and 132 of WIOA for programs serving youth, adults, and dislocated workers for the prior program year, as separately determined for each of the three funding streams. The amount to be recaptured from each State for reallotment, if any, is based on State obligations of the funds allotted to each

State under secs. 127 and 132 of WIOA for programs serving youth, adults, or dislocated workers, less any amount reserved (up to five percent at the State level) for the costs of administration. The recapture amount, if any, is separately determined for each funding stream.

(b) The Secretary reallots youth, adult and dislocated worker funds among eligible States in accordance with the provisions of secs. 127(c) and 132(c) of WIOA, respectively. To be eligible to receive a reallotment of youth, adult, or dislocated worker funds under the reallotment procedures, a State must have obligated at least 80 percent of the prior program year's allotment, less any amount reserved for the costs of administration at the State level of youth, adult, or dislocated worker funds. A State's eligibility to receive a reallotment is separately determined for each funding stream.

(c) The term ''obligation'' is defined at 2 CFR 200.71.

(d) Obligations must be reported on the required Department of Labor (the Department) financial form, such as the ETA–9130 form, unless otherwise noted in guidance.

§ 683.140 What reallocation procedures must the Governors use?

(a) The Governor, after consultation with the State WDB, may reallocate youth, adult, and dislocated worker funds among local areas within the State in accordance with the provisions of secs. 128(c) and 133(c) of WIOA. If the Governor chooses to reallocate funds, the provisions in paragraphs (b) and (c) of this section apply.

(b) For the youth, adult and dislocated worker programs, the amount to be recaptured from each local area for purposes of reallocation, if any, must be based on the amount by which the prior year's unobligated balance of allocated funds exceeds 20 percent of that year's allocation for the program, less any amount reserved (up to 10 percent) for the costs of administration. Unobligated balances must be determined based on allocations adjusted for any allowable transfer between funding streams. The amount to be recaptured, if any, must be separately determined for each funding stream. The term ''obligation'' is defined at 2 CFR 200.71.

(c) To be eligible to receive youth, adult or dislocated worker funds under the reallocation procedures, a local area must have obligated at least 80 percent of the prior program year's allocation, less any amount reserved (up to 10 percent) for the costs of administration, for youth, adult, or dislocated worker activities, as separately determined. A local area's eligibility to receive a reallocation must be separately determined for each funding stream.

§ 683.145 What merit review and risk assessment does the Department conduct for Federal financial assistance awards made under Workforce Innovation and Opportunity Act title I, subtitle D?

(a) For competitive awards, the Department will design and execute a merit review process for applications as prescribed under 2 CFR 200.204 when issuing Federal financial assistance awards made under WIOA title I, subtitle D. This process will be described in the applicable funding opportunity announcement.

(b) Prior to issuing a Federal financial assistance award under WIOA title I, subtitle D, the Department will conduct a risk assessment to assess the organization's overall ability to administer Federal funds as required under 2 CFR 200.205. As part of this assessment, the Department may consider any information that has come to its attention and will consider the organization's history with regard to the management of other grants, including Department of Labor grants.

(c) In evaluating risks posed by applicants, the Department will consider the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded

amounts will be expended prior to future awards;

(4) Reports and findings from audits; and

(5) The applicant's ability to implement effectively statutory, regulatory, or other requirements imposed on non-Federal entities.

§ 683.150 What closeout requirements apply to grants funded with Workforce Innovation and Opportunity Act title I and Wagner-Peyser Act funds?

(a) After the expiration of the period of performance, the Department will closeout the Federal award when it determines that all applicable administrative actions and all required work of the Federal award have been completed by the grant recipient. This section specifies the actions the grant recipient and the Department must take to complete this process.

(1) The grant recipient must submit, no later than 90 calendar days after the end date of the period of performance, all financial, performance, and other reports as required by the terms and conditions of the Federal award.

(2) The Department may approve extensions when requested by the grant recipient.

(b) Unless otherwise noted in the terms and conditions of the award or an extension, grant recipients must comply with 2 CFR 200.343(b) and 2900.15 in regards to closeout.

(c) The Department must make prompt payments to the grant recipient for allowable reimbursable costs under the Federal award being closed out.

(d) The grant recipient must promptly refund any balances of unobligated cash that the Department paid in advance or paid and that is not authorized to be retained by the grant recipient. See Office of Management and Budget Circular A–129, 2 CFR 200.345, and 2 CFR part 2900 for requirements regarding unreturned amounts that become delinquent debts.

(e) Consistent with the terms and conditions of the Federal award, the Department must make a settlement for any upward or downward adjustments to the Federal share of costs after closeout reports are received.

(f) The grant recipient must account for any real and personal property acquired with Federal funds or received from the Federal government in accordance with 2 CFR 200.310 through 200.316, and 200.329.

(g) The Department should complete all closeout actions for Federal awards no later than 1 year after receipt and acceptance of all required final reports.

(h) The closeout of an award does not affect any of the following:

(1) The right of the Department to disallow costs and recover funds on the basis of a later audit or other review.

(2) The obligation of the grant recipient to return any funds due as a result of later refunds, corrections, or other transactions.

(3) Audit requirements as described in 2 CFR part 200, subpart F.

(4) Property management requirements in 2 CFR 200.310 through 200.316.

(5) Records retention as required in 2 CFR 200.333 through 200.337.

(i) After closeout of an award, a relationship created under the award may be modified or ended in whole or in part with the consent of the Department and the grant recipient, provided the responsibilities of the grant recipient referred to in 2 CFR 200.344(a) and 200.310 through 200.316 are considered, and provisions are made for continuing responsibilities of the grant recipient, as appropriate.

(j) Grant recipients that award WIOA funds to subrecipients must institute a timely closeout process after the end of performance to ensure a timely closeout in accordance with 2 CFR 200.343 and 200.344.

Subpart B—Administrative Rules, Costs, and Limitations

§ 683.200 What general fiscal and administrative rules apply to the use of Workforce Innovation and Opportunity Act title I and Wagner-Peyser Act funds?

(a) *Uniform Guidance.* Recipients and subrecipients of a Federal award under title I of WIOA and the Wagner-Peyser Act must follow the Uniform Guidance at 2 CFR parts 200, 215, 225, 230, including any exceptions identified by the Department at 2 CFR part 2900.

(1) Commercial organizations, for-profit entities, and foreign entities that are recipients and subrecipients of a Federal award must adhere to 2 CFR part 200, including any exceptions identified by the Department under 2 CFR part 2900;

(2) Commercial organizations, for-profit entities, and foreign entities that are contractors or subcontractors must adhere to the Federal Acquisition Regulations (FAR), including 48 CFR part 31.

(b) *Allowable costs and cost principles.* (1) Recipients and subrecipients of a Federal award under title I of WIOA and the Wagner-Peyser Act must follow the cost principles at subpart E and appendices III through IX of 2 CFR part 200, including any exceptions identified by the Department at 2 CFR part 2900.

(2) Unless specified in the grant agreement, for those items requiring prior approval in the Uniform Guidance (*e.g.*, selected items of cost, budget realignment), the authority to grant or deny approval is delegated to the Governor for programs funded under sec. 127 or 132 of WIOA or under the Wagner-Peyser Act.

(3) Costs of workforce councils, advisory councils, Native American Employment and Training Councils, and Local WDB committees established under title I of WIOA are allowable.

(c) *Uniform administrative requirements.* (1) Except as provided in paragraphs (c)(3) through (6) of this section, all recipients and subrecipients of a Federal award under title I of WIOA and under the Wagner-Peyser Act must follow 2 CFR part 200, including any exceptions identified by the Department at 2 CFR part 2900.

(2) Unless otherwise specified in the grant agreement, expenditures must be reported on accrual basis.

(3) In accordance with the requirements at 2 CFR 200.400(g), subrecipients may not earn or keep any profit resulting from Federal financial assistance, unless expressly authorized by the terms and conditions of the Federal award.

(4) In addition to the requirements at 2 CFR 200.317 through 200.326 (as appropriate), all procurement contracts between Local WDBs and units of State or local governments must be conducted only on a cost reimbursement basis.

(5) In addition to the requirements at 2 CFR 200.318, which address codes of conduct and conflict of interest the following applies:

(i) A State WDB member, Local WDB member, or WDB standing committee member must neither cast a vote on, nor participate in any decision-making capacity, on the provision of services by such member (or any organization which that member directly represents), nor on any matter which would provide any direct financial benefit to that member or that member's immediate family.

(ii) Neither membership on the State WDB, the Local WDB, or a WDB standing committee, nor the receipt of WIOA funds to provide training and related services, by itself, violates these conflict of interest provisions.

(iii) In accordance with the requirements at 2 CFR 200.112, recipients of Federal awards must disclose in writing any potential conflict of interest to the Department. Subrecipients must disclose in writing any potential conflict of interest to the recipient of grant funds.

(6) The addition method, described at 2 CFR 200.307, must be used for all program income earned under title I of WIOA and Wagner-Peyser Act grants. When the cost of generating program income has been charged to the program, the gross amount earned must be added to the program in which it was earned. However, the cost of generating program income must be subtracted from the amount earned to establish the net amount of program income available for use under the grants when these costs have not been charged to the program.

(7) Any excess of revenue over costs incurred for services provided by a governmental or non-profit entity must be included in program income.

(8) Interest income earned on funds received under title I of WIOA and the Wagner-Peyser Act must be included in program income.

(9) On a fee-for-service basis, employers may use local area services, facilities, or equipment funded under title I of WIOA to provide employment and

training activities to incumbent workers:

(i) When the services, facilities, or equipment are not being used by eligible participants;

(ii) If their use does not affect the ability of eligible participants to use the services, facilities, or equipment; and

(iii) If the income generated from such fees is used to carry out programs authorized under this title.

(d) *Government-wide debarment and suspension, and government-wide drug-free workplace requirements.* All WIOA title I and Wagner-Peyser Act grant recipients and subrecipients must comply with the government-wide requirements for debarment and suspension, and the government-wide requirements for a drug-free workplace in accordance with the Drug-Free Workplace Act of 1988, 41 U.S.C. 8103 *et seq.*, and 2 CFR part 182.

(e) *Restrictions on lobbying.* All WIOA title I and Wagner-Peyer grant recipients and subrecipients must comply with the restrictions on lobbying specified in WIOA sec. 195 and codified in the Department regulations at 29 CFR part 93.

(f) *Buy-American.* As stated in sec. 502 of WIOA, all funds authorized in title I of WIOA and the Wagner-Peyser Act must be expended in compliance with secs. 8301 through 8303 of the Buy American Act (41 U.S.C. 8301–8305).

(g) *Nepotism.* (1) No individual may be placed in a WIOA employment activity if a member of that person's immediate family is directly supervised by or directly supervises that individual.

(2) To the extent that an applicable State or local legal requirement regarding nepotism is more restrictive than this provision, such State or local requirement must be followed.

(h) *Mandatory disclosures.* All WIOA title I and Wagner-Peyser Act recipients of Federal awards must disclose as required at 2 CFR 200.113, in a timely manner, in writing to the Federal awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures can result in any of the remedies described in 2 CFR 200.338 (Remedies for noncompliance), including suspension or debarment.

§ 683.205 What administrative cost limitations apply to Workforce Innovation and Opportunity Act title I grants?

(a) *State formula grants.* (1) As part of the 15 percent that a State may reserve for statewide activities, the State may spend up to 5 percent of the amount allotted under secs. 127(b)(1), 132(b)(1), and 132(b)(2) of WIOA for the administrative costs of statewide activities.

(2) Local area expenditures for administrative purposes under WIOA formula grants are limited to no more than 10 percent of the amount allocated to the local area under secs. 128(b) and 133(b) of WIOA.

(3) The 5 percent reserved for statewide administrative costs and the 10 percent reserved for local administrative costs may be used for administrative costs for any of the statewide youth workforce investment activities or statewide employment and training activities under secs. 127(b)(1), 128(b), 132(b), and 133(b) of WIOA.

(4) In a one-stop environment, administrative costs borne by other sources of funds, such as the Wagner-Peyser Act, are not included in the administrative cost limit calculation. Each program's administrative activities are chargeable to its own grant and subject to its own administrative cost limitations.

(5) Costs of negotiating a MOU or infrastructure funding agreement under title I of WIOA are excluded from the administrative cost limitations.

(b) *Discretionary grants.* Limits on administrative costs, if any, for programs operated under subtitle D of title I of WIOA will be identified in the grant or cooperative agreement.

§ 683.210 What audit requirements apply to the use of Workforce Innovation and Opportunity Act title I and Wagner-Peyser Act funds?

All recipients of WIOA title I and Wagner-Peyser Act funds that expend more than the minimum amounts specified in 2 CFR part 200, subpart F, in Federal awards during their fiscal year must have a program specific or single audit conducted in accordance with 2 CFR part 200, subpart F.

(a) *Commercial or for-profit.* Grant recipients and subrecipients of title I and Wagner-Peyser Act funds that are commercial or for-profit entities must adhere to the requirements contained in 2 CFR part 200, subpart F.

(b) *Subrecipients and contractors.* An auditee may simultaneously be a recipient, a subrecipient, and a contractor depending on the substance of its agreements with Federal awarding agencies and pass-through entities. Federal awards expended as a recipient or subrecipient are subject to audit requirements under 2 CFR part 200, subpart F.

(c) *Contractors.* The payments received for goods or services provided as a contractor are not Federal awards. Subrecipient and contractor determinations made under 2 CFR 200.330 must be considered in determining whether payments constitute a Federal award or a payment for goods and services provided as a contractor.

§ 683.215 What Workforce Innovation and Opportunity Act title I functions and activities constitute the costs of administration subject to the administrative cost limitation?

(a) The costs of administration are expenditures incurred by State and Local WDBs, Regions, direct grant recipients, including State grant recipients under subtitle B of title I of WIOA, and recipients of awards under subtitle D of title I, as well as local grant recipients, local grant subrecipients, local fiscal agents and one-stop operators that are associated with those specific functions identified in paragraph (b) of this section and which are not related to the direct provision of workforce investment services, including services to participants and employers. These costs can be both personnel and non-personnel and both direct and indirect.

(b) The costs of administration are the costs associated with performing the following functions:

(1) Performing the following overall general administrative functions and coordination of those functions under title I of WIOA:

(i) Accounting, budgeting, financial and cash management functions;

(ii) Procurement and purchasing functions;

(iii) Property management functions;

(iv) Personnel management functions;

(v) Payroll functions;

(vi) Coordinating the resolution of findings arising from audits, reviews, investigations and incident reports;

(vii) Audit functions;

(viii) General legal services functions;

(ix) Developing systems and procedures, including information systems, required for these administrative functions; and

(x) Fiscal agent responsibilities;

(2) Performing oversight and monitoring responsibilities related to WIOA administrative functions;

(3) Costs of goods and services required for administrative functions of the program, including goods and services such as rental or purchase of equipment, utilities, office supplies, postage, and rental and maintenance of office space;

(4) Travel costs incurred for official business in carrying out administrative activities; and

(5) Costs of information systems related to administrative functions (for example, personnel, procurement, purchasing, property management, accounting, and payroll systems) including the purchase, systems development and operating costs of such systems.

(c)(1) Awards to subrecipients or contractors that are solely for the performance of administrative functions are classified as administrative costs.

(2) Personnel and related non-personnel costs of staff that perform both administrative functions specified in paragraph (b) of this section and programmatic services or activities must be allocated as administrative or program costs to the benefitting cost objectives/categories.

(3) Specific costs charged to an overhead or indirect cost pool that can be identified directly as a program cost are to be charged as a program cost. Documentation of such charges must be maintained.

(4) Except as provided at paragraph (c)(1) of this section, all costs incurred

for functions and activities of subrecipients, other than those subrecipients listed in paragraph (a) of this section, and contractors are program costs.

(5) Continuous improvement activities are charged to administration or program category based on the purpose or nature of the activity to be improved. Documentation of such charges must be maintained.

(6) Costs of the following information systems including the purchase, systems development, and operational costs (*e.g.,* data entry) are charged to the program category:

(i) Tracking or monitoring of participant and performance information;

(ii) Employment statistics information, including job listing information, job skills information, and demand occupation information;

(iii) Performance and program cost information on eligible training providers, youth activities, and appropriate education activities;

(iv) Local area performance information; and

(v) Information relating to supportive services and unemployment insurance claims for program participants.

(d) Where possible, entities identified in paragraph (a) of this section must make efforts to streamline the services in paragraphs (b)(1) through (5) of this section to reduce administrative costs by minimizing duplication and effectively using information technology to improve services.

§ 683.220 What are the internal controls requirements for recipients and subrecipients of Workforce Innovation and Opportunity Act title I and Wagner-Peyser Act funds?

(a) Recipients and subrecipients of WIOA title I and Wagner-Peyser Act funds must have an internal control structure and written policies in place that provide safeguards to protect personally identifiable information, records, contracts, grant funds, equipment, sensitive information, tangible items, and other information that is readily or easily exchanged in the open market, or that the Department or the recipient or subrecipient considers to be sensitive, consistent with applicable Federal, State and local privacy and confidentiality laws. Internal controls also must include reasonable assurance that the entity is:

(1) Managing the award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award;

(2) Complying with Federal statutes, regulations, and the terms and conditions of the Federal awards;

(3) Evaluating and monitoring the recipient's and subrecipient's compliance with WIOA, regulations and the terms and conditions of Federal awards; and

(4) Taking prompt action when instances of noncompliance are identified.

(b) Internal controls should be in compliance with the guidance in ''Standards for Internal Control in the Federal Government'' issued by the Comptroller General of the United States and the ''Internal Control Integrated Framework'', issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). See 2 CFR 200.303.

§ 683.225 What requirements relate to the enforcement of the Military Selective Service Act?

The requirements relating to the enforcement of the Military Selective Service Act are found at WIOA sec. 189(h).

§ 683.230 Are there special rules that apply to veterans when income is a factor in eligibility determinations?

Yes, under 38 U.S.C. 4213, when past income is an eligibility determinant for Federal employment or training programs, any amounts received as military pay or allowances by any person who served on active duty, and certain other specified benefits must be disregarded for the veteran and for other individuals for whom those amounts would normally be applied in making an eligibility determination. This applies when determining if a person is a ''low-income individual'' for eligibility purposes (for example, in the WIOA youth, or NFJP programs). Also, it applies when income is used as a factor when a local area provides priority of service for ''low-income individuals'' with title I WIOA funds (*see* §§ 680.600 and 680.650 of this chapter). A veteran

must still meet each program's eligibility criteria to receive services under the respective employment and training program.

§ 683.235 May Workforce Innovation and Opportunity Act title I funds be spent for construction?

WIOA title I funds must not be spent on construction, purchase of facilities or buildings, or other capital expenditures for improvements to land or buildings, except with the prior written approval of the Secretary.

§ 683.240 What are the instructions for using real property with Federal equity?

(a) *SESA properties.* Federal equity acquired in real property through grants to States awarded under title III of the Social Security Act or the Wagner-Peyser Act, including State Employment Security Agency (SESA) real property, is transferred to the States that used the grant to acquire such equity.

(1) The portion of any real property that is attributable to the Federal equity transferred under this section must be used to carry out activities authorized under WIOA, title III of the Social Security Act (Unemployment Compensation program), or the Wagner-Peyser Act.

(2) When such real property is no longer needed for the activities described in paragraph (a)(1) of this section, the States must request disposition instructions from the Grant Officer prior to disposition or sale of the property. The portion of the proceeds from the disposition of the real property that is attributable to the Federal equity transferred under this section must be used to carry out activities authorized under WIOA, title III of the Social Security Act, or the Wagner-Peyser Act.

(3) States must not use funds awarded under WIOA, title III of the Social Security Act, or the Wagner-Peyser Act to amortize the costs of real property that is purchased by any State on or after February 15, 2007, the date of enactment of the Revised Continuing Appropriations Resolution, 2007.

(4) Properties occupied by the Wagner-Peyser Act Employment Service must be colocated with one-stop centers.

(b) *Reed Act-funded properties.* Properties with Reed Act equity may be used for the one-stop service delivery system to the extent that the proportionate share of Reed Act equity is less than or equal to the proportionate share of occupancy by the Unemployment Compensation and Wagner-Peyser Act programs in such properties. When such real property is no longer needed for authorized purposes, the State must request disposition instructions from the Grant Officer prior to disposition or sale. The portion of the proceeds from the disposition or sale of the real property that is attributable to the Reed Act equity must be returned to the State's account in the Unemployment Trust Fund (UTF) and used in accordance with Department-issued guidance.

(c) *Job Training Partnership Act and Workforce Investment Act-funded properties.* Real property that was purchased with WIA funds or that was transferred to WIA now is transferred to the WIOA title I programs and must be used for WIOA purposes. When such real property is no longer needed for the activities of WIOA, the recipient or subrecipient must seek instructions from the Grant Officer or State (in the case of a subrecipient) prior to disposition or sale.

§ 683.245 Are employment generating activities, or similar activities, allowable under title I of the Workforce Innovation and Opportunity Act?

(a) Under sec. 181(e) of WIOA, title I funds must not be spent on employment generating activities, investment in revolving loan funds, capitalization of businesses, investment in contract bidding resource centers, economic development activities, or similar activities, unless they are directly related to training for eligible individuals. For purposes of this prohibition, employer outreach and job development activities are directly related to training for eligible individuals.

(b) These employer outreach and job development activities may include:

(1) Contacts with potential employers for the purpose of placement of WIOA participants;

(2) Participation in business associations (such as chambers of commerce); joint labor management committees, labor associations, and resource centers;

(3) WIOA staff participation on economic development boards and commissions, and work with economic development agencies to:

(i) Provide information about WIOA programs;

(ii) Coordinate activities in a region or local area to promote entrepreneurial training and microenterprise services;

(iii) Assist in making informed decisions about community job training needs; and

(iv) Promote the use of first source hiring agreements and enterprise zone vouchering services;

(4) Active participation in local business resource centers (incubators) to provide technical assistance to small businesses and new businesses to reduce the rate of business failure;

(5) Subscriptions to relevant publications;

(6) General dissemination of information on WIOA programs and activities;

(7) The conduct of labor market surveys;

(8) The development of on-the-job training opportunities; and

(9) Other allowable WIOA activities in the private sector.

§ 683.250 What other activities are prohibited under title I of the Workforce Innovation and Opportunity Act?

(a) WIOA title I funds must not be spent on:

(1) The wages of incumbent employees during their participation in economic development activities provided through a statewide workforce development system.

(2) Public service employment, except as specifically authorized under title I of WIOA.

(3) Expenses prohibited under any other Federal, State or local law or regulation.

(4) Subawards or contracts with parties that are debarred, suspended, or otherwise excluded from or ineligible for participation in Federal programs or activities.

(5) Contracts with persons falsely labeling products made in America.

(b) WIOA formula funds available to States and local areas under title I, subtitle B must not be used for foreign travel.

§ 683.255 What are the limitations related to religious activities of title I of the Workforce Innovation and Opportunity Act?

(a) Section 188(a)(3) of WIOA prohibits the use of funds to employ participants to carry out the construction, operation, or maintenance of any part of any facility used for sectarian instruction or as a place for religious worship with the exception of maintenance of facilities that are not primarily used for instruction or worship and are operated by organizations providing services to WIOA participants.

(b) 29 CFR part 2, subpart D, governs the circumstances under which Department support, including WIOA title I financial assistance, may be used to employ or train participants in religious activities. Under that subpart, such assistance may be used for such employment or training only when the assistance is provided indirectly within the meaning of the Establishment Clause of the U.S. Constitution, and not when the assistance is provided directly. That subpart also contains requirements related to equal treatment in Department of Labor programs for religious organizations, and to protecting the religious liberty of Department of Labor social service providers and beneficiaries. (29 CFR part 2, subpart D—Equal Treatment in Department of Labor Programs for Religious Organizations, Protection of Religious Liberty of Department of Labor Social Service Providers and Beneficiaries).

§ 683.260 What prohibitions apply to the use of Workforce Innovation and Opportunity Act title I funds to encourage business relocation?

(a) *Prohibition.* Section 181(d) of WIOA states that funds must not be used or proposed to be used for:

(1) The encouragement or inducement of a business, or part of a business, to relocate from any location in the United States, if the relocation results in any employee losing his or her job at the original location;

(2) Customized training, skill training, on-the-job training, incumbent worker training, transitional employment, or company specific assessments of job applicants for or employees of any business or part of a business that has relocated from any location in the United States, until the company has operated at that location for 120 days, if the relocation has resulted in any employee losing his or her jobs at the original location.

(b) *Pre-award review.* To verify that a business establishment which is new or expanding is not, in fact, relocating employment from another area, standardized pre-award review criteria developed by the State must be completed and documented jointly by the local area and the business establishment as a prerequisite to WIOA assistance.

(1) The review must include names under which the establishment does business, including predecessors and successors in interest; the name, title, and address of the company official certifying the information, and whether WIOA assistance is sought in connection with past or impending job losses at other facilities, including a review of whether WARN notices relating to the employer have been filed.

(2) The review may include consultations with labor organizations and others in the affected local area(s).

§ 683.265 What procedures and sanctions apply to violations of this part?

(a) The Grant Officer will promptly review and take appropriate action on alleged violations of the provisions relating to:

(1) Construction (§ 683.235);

(2) Employment generating activities (§ 683.245);

(3) Other prohibited activities (§ 683.250);

(4) The limitation related to religious activities (§ 683.255); and

(5) The use of WIOA title I funds to encourage business relocation (§ 683.260).

(b) Procedures for the investigation and resolution of the violations are provided under the Grant Officer's resolution process at § 683.440.

(c) Sanctions and remedies are provided for under sec. 184(c) of WIOA for violations of the provisions relating to:

(1) Construction (§ 683.235);

(2) Employment generating activities (§ 683.245);

(3) Other prohibited activities (§ 683.250); and

(4) The limitation related to religious activities (§ 683.255(b)).

(d) Sanctions and remedies are provided for in sec. 181(d)(3) of WIOA for violations of § 683.260, which addresses business relocation.

(e) Violations of § 683.255(a) will be handled in accordance with the Department's nondiscrimination regulations implementing sec. 188 of WIOA, codified at 29 CFR part 38.

§ 683.270 What safeguards are there to ensure that participants in Workforce Innovation and Opportunity Act employment and training activities do not displace other employees?

(a) A participant in a program or activity authorized under title I of WIOA must not displace (including a partial displacement, such as a reduction in the hours of non-overtime work, wages, or employment benefits) any currently employed employee (as of the date of the participation).

(b) A program or activity authorized under title I of WIOA must not impair existing contracts for services or collective bargaining agreements. When a program or activity authorized under title I of WIOA would be inconsistent with a collective bargaining agreement, the appropriate labor organization and employer must provide written concurrence before the program or activity begins.

(c) A participant in a program or activity under title I of WIOA may not be employed in or assigned to a job if:

(1) Any other individual is on layoff from the same or any substantially equivalent job;

(2) The employer has terminated the employment of any regular, unsubsidized employee or otherwise caused an involuntary reduction in its workforce with the intention of filling the vacancy so created with the WIOA participant; or

(3) The job is created in a promotional line that infringes in any way

on the promotional opportunities of currently employed workers as of the date of the participation.

(d) Regular employees and program participants alleging displacement may file a complaint under the applicable grievance procedures found at § 683.600.

§ 683.275 What wage and labor standards apply to participants in activities under title I of the Workforce Innovation and Opportunity Act?

(a) Individuals in on-the-job training or individuals employed in activities under title I of WIOA must be compensated at the same rates, including periodic increases, as trainees or employees who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills. Such rates must be in accordance with applicable law, but may not be less than the higher of the rate specified in sec. 6(a)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a)(1)) or the applicable State or local minimum wage law.

(b) The reference in paragraph (a) of this section to sec. 6(a)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a)(1)) is not applicable for individuals in territorial jurisdictions in which sec. 6(a)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a)(1)) does not apply.

(c) Individuals in on-the-job training or individuals employed in programs and activities under title I of WIOA must be provided benefits and working conditions at the same level and to the same extent as other trainees or employees working a similar length of time and doing the same type of work.

(d) Allowances, earnings, and payments to individuals participating in programs under title I of WIOA are not considered as income for purposes of determining eligibility for and the amount of income transfer and in-kind aid furnished under any Federal or Federally-assisted program based on need, other than as provided under the Social Security Act (42 U.S.C. 301 *et seq.*).

§ 683.280 What health and safety standards apply to the working conditions of participants in activities under title I of the Workforce Innovation and Opportunity Act?

(a) Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees are equally applicable to working conditions of participants engaged in programs and activities under title I of WIOA.

(b)(1) To the extent that a State workers' compensation law applies, workers' compensation must be provided to participants in programs and activities under title I of WIOA on the same basis as the compensation is provided to other individuals in the State in similar employment.

(2) If a State workers' compensation law applies to a participant in work experience, workers' compensation benefits must be available for injuries suffered by the participant in such work experience. If a State workers' compensation law does not apply to a participant in work experience, insurance coverage must be secured for injuries suffered by the participant in the course of such work experience.

§ 683.285 What are a recipient's obligations to ensure nondiscrimination and equal opportunity, and what are a recipient's obligations with respect to religious activities?

(a)(1) Recipients, as defined in 29 CFR 37.4, must comply with the nondiscrimination and equal opportunity provisions of WIOA sec. 188 and its implementing regulations, codified at 29 CFR part 38. Under that definition, the term ''recipients'' includes State and Local WDBs, one-stop operators, service providers, Job Corps contractors, and subrecipients, as well as other types of individuals and entities.

(2) Nondiscrimination and equal opportunity requirements and procedures, including complaint processing and compliance reviews, are governed by the regulations implementing sec. 188 of WIOA, codified at 29 CFR part 38, and are administered and enforced by the Department of Labor Civil Rights Center.

(3) Financial assistance provided under title I of WIOA may be used to meet a recipient's obligation to provide

physical and programmatic accessibility and reasonable accommodation/modification in regard to the WIOA program, as required by sec. 504 of the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; sec. 188 of WIOA; and the regulations implementing these statutory provisions.

(4) No person may discriminate against an individual who is a participant in a program or activity that receives funds under title I of WIOA, with respect to the terms and conditions affecting, or rights provided to, the individual, solely because of the status of the individual as a participant.

(5) Participation in programs and activities or receiving funds under title I of WIOA must be available to citizens and nationals of the United States, lawfully admitted permanent resident aliens, refugees, asylees, and parolees, and other immigrants authorized by the Secretary of Homeland Security or the Secretary's designee to work in the United States.

(b)(1) Title 29 CFR part 2, subpart D, governs the circumstances under which recipients may use Department support, including WIOA title I and Wagner-Peyser Act financial assistance, to employ or train participants in religious activities. As explained in that subpart, such assistance may be used for such employment or training only when the assistance is provided indirectly within the meaning of the Establishment Clause of the U.S. Constitution, and not when the assistance is provided directly. As explained in that subpart, assistance provided through an Individual Training Account is generally considered indirect, and other mechanisms also may be considered indirect. *See also* § 683.255 and 29 CFR 37.6(f)(1).

(2) Title 29 CFR part 2, subpart D, also contains requirements related to equal treatment of religious organizations in Department of Labor programs, and to protection of religious liberty for Department of Labor social service providers and beneficiaries. Limitations on the employment of participants under WIOA title I to carry out the construction, operation, or maintenance of any part of any facility used or to be used for religious instruction or as a place of religious worship are described at 29 CFR 37.6(f)(2). *See also* WIOA sec. 188(a)(3).

§ 683.290 Are there salary and bonus restrictions in place for the use of title I of Workforce Innovation and Opportunity Act and Wagner-Peyser Act funds?

(a) No funds available under title I of WIOA or the Wagner-Peyser Act may be used by a recipient or subrecipient of such funds to pay the salary and bonuses of an individual, either as direct costs or indirect costs, at a rate in excess of the annual rate of basic pay prescribed for level II of the Executive Schedule under 5 U.S.C. 5313, which can be found at *https://www.opm.gov/*.

(b) In instances where funds awarded under title I of WIOA or the Wagner-Peyser Act pay only a portion of the salary or bonus, the WIOA title I or Wagner-Peyser Act funds may only be charged for the share of the employee's salary or bonus attributable to the work performed on the WIOA title I or Wagner-Peyser Act grant. That portion cannot exceed the proportional Executive level II rate. The restriction applies to the sum of salaries and bonuses charged as either direct costs or indirect costs under title I of WIOA and the Wagner-Peyser Act.

(c) The limitation described in paragraph (a) of this section will not apply to contractors (as defined in 2 CFR 200.23) providing goods and services. In accordance with 2 CFR 200.330, characteristics indicative of contractor are the following:

(1) Provides the goods and services within normal business operations;

(2) Provides similar goods or services to many different purchasers;

(3) Normally operates in a competitive environment;

(4) Provides goods or services that are ancillary to the operation of the Federal program; and

(5) Is not subject to compliance requirements of the Federal program as a result of the agreement, though similar requirements may apply for other reasons.

(d) If a State is a recipient of such funds, the State may establish a lower limit than is provided in paragraph (a) of this section for salaries and bonuses of those receiving salaries and bonuses

from a subrecipient of such funds, taking into account factors including the relative cost of living in the State, the compensation levels for comparable State or local government employees, and the size of the organizations that administer the Federal programs involved.

(e) When an individual is working for the same recipient or subrecipient in multiple offices that are funded by title I of WIOA or the Wagner-Peyser Act, the recipient or subrecipient must ensure that the sum of the individual's salary and bonus does not exceed the prescribed limit in paragraph (a) of this section.

§ 683.295 Is earning of profit allowed under the Workforce Innovation and Opportunity Act?

(a)(1) Under secs. 121(d), 122(a) and 134(b) of WIOA, for-profit entities are eligible to be one-stop operators, service providers, and eligible training providers.

(2) Where for-profit entities are one-stop operators, service providers, and eligible training providers, and those entities are recipients of Federal financial assistance, the recipient or subrecipient and the for-profit entity must follow 2 CFR 200.323.

(b) For programs authorized by other sections of WIOA, 2 CFR 200.400(g) prohibits earning and keeping of profit in Federal financial assistance unless expressly authorized by the terms and conditions of the Federal award.

(c) Income earned by a public or private nonprofit entity may be retained by such entity only if such income is used to continue to carry out the program.

Subpart C—Reporting Requirements

§ 683.300 What are the reporting requirements for programs funded under the Workforce Innovation and Opportunity Act?

(a) *General.* All States and other direct grant recipients must report financial, participant, and other performance data in accordance with instructions issued by the Secretary. Reports, records, plans, or any other data required to be submitted or made available must, to the extent practicable, be submitted or made available through electronic means. Reports will not be required to be submitted more frequently than quarterly within a time period specified in the reporting instructions.

(b) *Subrecipient reporting.* (1) For the annual eligible training provider performance reports described in § 677.230 of this chapter and local area performance reports described in § 677.205 of this chapter, the State must require the template developed under WIOA sec. 116(d)(1) to be used.

(2) For financial reports and performance reports other than those described in paragraph (b)(1) of this section, a State or other grant recipient may impose different forms or formats, shorter due dates, and more frequent reporting requirements on subrecipients.

(3) If a State intends to impose different reporting requirements on subrecipients, it must describe those reporting requirements in its State WIOA Plan.

(c) *Financial reports.* (1) Each grant recipient must submit financial reports on a quarterly basis.

(2) Local WDBs will submit quarterly financial reports to the Governor.

(3) Each State will submit to the Secretary a summary of the reports submitted to the Governor pursuant to paragraph (c)(2) of this section.

(4) Reports must include cash on hand, obligations, expenditures, any income or profits earned, including such income or profits earned by subrecipients, indirect costs, recipient share of expenditures and any expenditures incurred (such as stand-in costs) by the recipient that are otherwise allowable except for funding limitations.

(5) Reported expenditures, matching funds, and program income, including any profits earned, must be reported on the accrual basis of accounting and cumulative by fiscal year of appropriation. If the recipient's accounting records are not normally kept on the accrual basis of accounting, the recipient must develop accrual information through an analysis of the documentation on hand.

(d) *Performance reports.* (1) States must submit an annual performance report for each of the core workforce programs administered under WIOA as required by sec. 116(d) of WIOA and in accordance with part 677, subpart A, of this chapter.

(2) For all programs authorized under subtitle D of WIOA, each grant recipient must complete reports on performance indicators or goals specified in its grant agreement.

(e) *Due date.* (1) For the core programs, performance reports are due on the date set forth in guidance.

(2) Financial reports and all performance and data reports not described in paragraph (e)(1) of this section are due no later than 45 days after the end of each quarter unless otherwise specified in reporting instructions. Closeout financial reports are required no later than 90 calendar days after the expiration of a period of performance or period of fund availability (whichever comes first) and/or termination of the grant. If required by the terms and conditions of the grant, closeout performance reports are required no later than 90 calendar days after the expiration of a period of performance or period of fund availability (whichever comes first) and/or termination of the grant.

(f) *Format.* All reports whenever practicable should be collected, transmitted, and stored in open and machine readable formats.

(g) *Systems compatibility.* States and grant recipients will develop strategies for aligning data systems based upon guidelines issued by the Secretary of Labor and the Secretary of Education.

(h) *Additional reporting.* At the Grant Officer's or Secretary's discretion, reporting may be required more frequently of its grant recipients. Such requirement is consistent with 2 CFR parts 200 and 2900.

Subpart D—Oversight and Resolution of Findings

§ 683.400 What are the Federal and State monitoring and oversight responsibilities?

(a) The Secretary is authorized to monitor all recipients and subrecipients of all Federal financial assistance awarded and funds expended under title I of WIOA and the Wagner-Peyser Act to determine compliance with these statutes and Department regulations, and may investigate any matter deemed necessary to determine such compliance. Federal oversight will be conducted primarily at the recipient level.

(b) As funds allow, in each fiscal year, the Secretary also will conduct in-depth reviews in several States, including financial and performance monitoring, to assure that funds are spent in accordance with WIOA and the Wagner-Peyser Act.

(c)(1) Each recipient and subrecipient must monitor grant-supported activities in accordance with 2 CFR part 200.

(2) In the case of grants under secs. 128 and 133 of WIOA, the Governor must develop a State monitoring system that meets the requirements of § 683.410(b). The Governor must monitor Local WDBs and regions annually for compliance with applicable laws and regulations in accordance with the State monitoring system. Monitoring must include an annual review of each local area's compliance with 2 CFR part 200.

(d) Documentation of monitoring, including monitoring reports and audit work papers, conducted under paragraph (c) of this section, along with corrective action plans, must be made available for review upon request of the Secretary, Governor, or a representative of the Federal government authorized to request the information.

§ 683.410 What are the oversight roles and responsibilities of recipients and subrecipients of Federal financial assistance awarded under title I of the Workforce Innovation and Opportunity Act and the Wagner-Peyser Act?

(a) Each recipient and subrecipient of funds under title I of WIOA and under the Wagner-Peyser Act must conduct regular oversight and monitoring of its WIOA and Wagner-Peyser Act program(s) and those of its subrecipients and contractors as required under title I of WIOA and the Wagner-Peyser Act, as well as under 2 CFR part 200, including 2 CFR 200.327, 200.328, 200.330, 200.331, and Department exceptions at 2 CFR part 2900, in order to:

(1) Determine that expenditures have been made against the proper cost categories and within the cost limitations specified in WIOA and the regulations in this part;

(2) Determine whether there is compliance with other provisions of WIOA and the WIOA regulations and other applicable laws and regulations;

(3) Assure compliance with 2 CFR part 200; and

(4) Determine compliance with the nondiscrimination, disability, and equal opportunity requirements of sec. 188 of WIOA, including the Assistive Technology Act of 1998 (29 U.S.C. 3003).

(b) State roles and responsibilities for grants under secs. 128 and 133 of WIOA:

(1) The Governor is responsible for the development of the State monitoring system. The Governor must be able to demonstrate, through a monitoring plan or otherwise, that the State monitoring system meets the requirements of paragraph (b)(2) of this section.

(2) The State monitoring system must:

(i) Provide for annual on-site monitoring reviews of local areas' compliance with 2 CFR part 200, as required by sec. 184(a)(3) of WIOA;

(ii) Ensure that established policies to achieve program performance and outcomes meet the objectives of WIOA and the WIOA regulations;

(iii) Enable the Governor to determine if subrecipients and contractors have demonstrated substantial compliance with WIOA and Wagner-Peyser Act requirements;

(iv) Enable the Governor to determine whether a local plan will be disapproved for failure to make acceptable progress in addressing deficiencies, as required in sec. 108(e) of WIOA; and

(v) Enable the Governor to ensure compliance with the nondiscrimination, disability, and equal opportunity requirements of sec. 188 of WIOA, including the Assistive Technology Act of 1998 (29 U.S.C. 3003).

(3) The State must conduct an annual on-site monitoring review of each local area's compliance with 2 CFR part 200, as required by sec. 184(a)(4) of WIOA.

(4) The Governor must require that prompt corrective action be taken if any substantial violation of standards identified in paragraph (b)(2) or (3) of this section is found.

(5) The Governor must impose the sanctions provided in secs. 184(b)–(c) of WIOA in the event of a subrecipient's failure to take required corrective action required under paragraph (b)(4) of this section.

(6) The Governor may issue additional requirements and instructions to subrecipients on monitoring activities.

(7) The Governor must certify to the Secretary every 2 years that:

(i) The State has implemented 2 CFR part 200;

(ii) The State has monitored local areas to ensure compliance with 2 CFR part 200, including annual certifications and disclosures as outlined in 2 CFR 200.113, Mandatory Disclosures. Failure to do so may result in remedies described under 2 CFR 200.338, including suspension and debarment; and

(iii) The State has taken appropriate corrective action to secure such compliance.

§ 683.420 What procedures apply to the resolution of findings arising from audits, investigations, monitoring, and oversight reviews?

(a) *Resolution of subrecipient-level findings.* (1) The Governor or direct grant recipient is responsible for resolving findings that arise from the monitoring reviews, investigations, other Federal monitoring reviews, and audits (including under 2 CFR part 200) of subrecipients awarded funds through title I of WIOA or the Wagner-Peyser Act.

(i) A State or direct grant recipient must utilize the written monitoring and audit resolution, debt collection and appeal procedures that it uses for other Federal grant programs.

(ii) If a State or direct grant recipient does not have such written procedures, it must prescribe standards and procedures to be used for this grant program.

(2) For subrecipients awarded funds through a recipient of grant funds under subtitle D of title I of WIOA, the direct recipient of the grant funds

must have written monitoring and resolution procedures in place that are consistent with 2 CFR part 200.

(b) *Resolution of State and other direct recipient-level findings.* (1) The Secretary is responsible for resolving findings that arise from Federal audits, monitoring reviews, investigations, incident reports, and audits under 2 CFR part 200 for direct recipients of Federal awards under title I of WIOA and the Wagner-Peyser Act, as amended by WIOA title III.

(2) The Secretary will use the Department audit resolution process, consistent with 2 CFR part 200 (and Department modifications at 2 CFR part 2900), and Grant Officer Resolution provisions of § 683.440, as appropriate.

(3) A final determination issued by a Grant Officer under this process may be appealed to the Department of Labor Office of Administrative Law Judges under the procedures at § 683.800.

(c) *Resolution of nondiscrimination findings.* Findings arising from investigations or reviews conducted under nondiscrimination laws will be resolved in accordance with WIOA sec. 188 of WIOA and the Department of Labor nondiscrimination regulations implementing sec. 188 of WIOA, codified at 29 CFR part 38.

§ 683.430 How does the Secretary resolve investigative and monitoring findings?

(a) As a result of an investigation, on-site visit, other monitoring, or an audit (*i.e.*, Single Audit, OIG Audit, GAO Audit, or other audit), the Secretary will notify the direct recipient of the Federal award of the findings of the investigation and give the direct recipient a period of time (not more than 60 days) to comment and to take appropriate corrective actions.

(1) *Adequate resolution.* The Grant Officer in conjunction with the Federal project officer, reviews the complete file of the monitoring review, monitoring report, or final audit report and the recipient's response and actions under paragraph (a) of this section. The Grant Officer's review takes into account the sanction provisions of secs. 184(b)–(c) of WIOA. If the Grant Officer agrees with the recipient's handling of the situation, the Grant Officer so notifies the recipient. This notification constitutes final agency action.

(2) *Inadequate resolution.* If the direct recipient's response and actions to resolve the findings are found to be inadequate, the Grant Officer will begin the Grant Officer resolution process under § 683.440.

(b) Audits from 2 CFR part 200 will be resolved through the Grant Officer resolution process, as discussed in § 683.440.

§ 683.440 What is the Grant Officer resolution process?

(a) *General.* When the Grant Officer is dissatisfied with the a recipient's disposition of an audit or other resolution of findings (including those arising out of site visits, incident reports or compliance reviews), or with the recipient's response to findings resulting from investigations or monitoring reports, the initial and final determination process as set forth in this section is used to resolve the matter.

(b) *Initial determination.* The Grant Officer makes an initial determination on the findings for both those matters where there is agreement and those where there is disagreement with the recipient's resolution, including the allowability of questioned costs or activities. This initial determination is based upon the requirements of WIOA, the Wagner-Peyser Act, and applicable regulations, and the terms and conditions of the grants or other agreements under the award.

(c) *Informal resolution.* Except in an emergency situation, when the Secretary invokes the authority described in sec. 184(e) of WIOA, the Grant Officer may not revoke a recipient's grant in whole or in part, nor institute corrective actions or sanctions, without first providing the recipient with an opportunity to present documentation or arguments to resolve informally those matters in dispute contained in the initial determination. The initial determination must provide for an informal resolution period of at least 60 days from issuance of the initial determination. If the matters are resolved informally, the Grant Officer must issue a final determination under paragraph (d) of this section which notifies

the parties in writing of the nature of the resolution and may close the file.

(d) *Final determination.* (1) Upon completion of the informal resolution process, the Grant Officer provides each party with a written final determination by certified mail, return receipt requested. For audits of recipient-level entities and other recipients which receive WIOA funds directly from the Department, ordinarily, the final determination is issued not later than 180 days from the date that the Office of Inspector General (OIG) issues the final approved audit report to the Employment and Training Administration. For audits of subrecipients conducted by the OIG, ordinarily the final determination is issued not later than 360 days from the date the OIG issues the final approved audit report to ETA.

(2) A final determination under this paragraph (d) must:

(i) Indicate whether efforts to resolve informally matters contained in the initial determination have been unsuccessful;

(ii) List those matters upon which the parties continue to disagree;

(iii) List any modifications to the factual findings and conclusions set forth in the initial determination and the rationale for such modifications;

(iv) Establish a debt, if appropriate;

(v) Require corrective action, when needed;

(vi) Determine liability, method of restitution of funds, and sanctions; and

(vii) Offer an opportunity for a hearing in accordance with § 683.800.

(3) Unless a hearing is requested, a final determination under this paragraph (d) is final agency action and is not subject to further review.

Subpart E—Pay-for-Performance Contract Strategies

§ 683.500 What is a Workforce Innovation and Opportunity Act Pay-for-Performance contract strategy?

(a) A WIOA Pay-for-Performance contract strategy is a specific type of performance-based contract strategy that has four distinct characteristics:

(1) It is a strategy to use WIOA Pay-for-Performance contracts as they are described in § 683.510;

(2) It must include the identification of the workforce development problem and target populations for which a local area will pursue a WIOA Pay-for-Performance contract strategy; the outcomes the local area would hope to achieve through a Pay-for-Performance contract relative to baseline performance; and the acceptable cost to government associated with achieving these outcomes;

(3) It must include a strategy for independently validating the performance outcomes achieved under each contract within the strategy prior to payment occurring; and

(4) It must include a description of how the State or local area will reallocate funds to other activities under the contract strategy in the event a service provider does not achieve performance benchmarks under a WIOA Pay-for-Performance contract.

(b) Prior to the implementation of a WIOA Pay-for-Performance contract strategy, a local area must conduct a feasibility study to determine whether the intervention is suitable for a WIOA Pay-for-Performance contract strategy.

(c) The WIOA Pay-for-Performance contract strategy must be developed in accordance with guidance issued by the Secretary.

§ 683.510 What is a Workforce Innovation and Opportunity Act Pay-for-Performance contract?

(a) *Pay-for-Performance contract.* A WIOA Pay-for-Performance contract is a type of Performance-Based contract.

(b) *Applicability.* WIOA Pay-for-Performance contracts may only be entered into when they are a part of a WIOA Pay-for-Performance contract strategy described in § 683.500.

(c) *Cost-plus a percentage of cost contracts.* Use of cost plus a percentage of cost contracts is prohibited. (2 CFR 200.323.)

(d) *Services provided.* WIOA Pay-for-Performance contracts must be used to provide adult training services described in sec. 134(c)(3) of WIOA or youth activities described in sec. 129(c)(2) of WIOA.

(e) *Structure of payment.* WIOA Pay-for-Performance contracts must specify a fixed amount that will be paid to

the service provider based on the achievement of specified levels of performance on the performance outcomes in sec. 116(b)(2)(A) of WIOA for target populations within a defined timetable. Outcomes must be independently validated, as described in paragraph (j) of this section and § 683.500, prior to disbursement of funds.

(f) *Eligible service providers.* WIOA Pay-for-Performance contracts may be entered into with eligible service providers, which may include local or national community-based organizations or intermediaries, community colleges, or other training providers that are eligible under sec. 122 or 123 of WIOA (as appropriate).

(g) *Target populations.* WIOA Pay-for-Performance contracts must identify target populations as specified by the Local WDB, which may include individuals with barriers to employment.

(h) *Bonus payments.* WIOA Pay-for-Performance contracts may include bonus payments for the contractor based on achievement of specified levels of performance. Bonus payments for achieving outcomes above and beyond those specified in the contract must be used by the service provider to expand capacity to provide effective training.

(i) *Performance reporting.* Performance outcomes achieved under the WIOA Pay-for-Performance contract, measured against the levels of performance specified in the contract, must be tracked by the local area and reported to the State pursuant to WIOA sec. 116(d)(2)(K) and § 677.160 of this chapter.

(j) *Validation.* WIOA Pay-for-Performance contracts must include independent validation of the contractor's achievement of the performance benchmarks specified in the contract. This validation must be based on high-quality, reliable, and verified data.

(k) *Guidance.* The Secretary may issue additional guidance related to use of WIOA Pay-for-Performance contracts.

§ 683.520 What funds can be used to support Workforce Innovation and Opportunity Act Pay-for-Performance contract strategies?

(a) For WIOA Pay-for-Performance contract strategies providing adult and dislocated worker training services, funds allocated under secs. 133(b)(2)–(3) of WIOA can be used. For WIOA Pay-for-Performance contract strategies providing youth activities, funds allocated under WIOA sec. 128(b) can be used.

(b) No more than 10 percent of the total local adult and dislocated worker allocations can be reserved and used on the implementation of WIOA Pay-for-Performance contract strategies for adult training services described in sec. 134(c)(3) of WIOA. No more than 10 percent of the local youth allocation can be reserved and used on the implementation of WIOA Pay-for-Performance contract strategies for youth training services and other activities described in secs. 129(c)(2) of WIOA.

§ 683.530 How long are funds used for Workforce Innovation and Opportunity Act Pay-for-Performance contract strategies available?

Section 189(g)(2)(D) of WIOA authorizes funds used for WIOA Pay-for-Performance contract strategies to be available until expended. Under WIOA sec. 3(47)(C), funds that are obligated but not expended due to a contractor not achieving the levels of performance specified in a WIOA Pay-for-Performance contract may be reallocated for further activities related to WIOA Pay-for-Performance contract strategies only. The Secretary will issue additional guidance related to the funds availability and reallocation.

§ 683.540 What is the State's role in assisting local areas in using Workforce Innovation and Opportunity Act Pay-for-Performance contract strategies?

(a) Using funds from the Governor's Reserve the State may:

(1) Provide technical assistance to local areas including assistance with structuring WIOA Pay-for-Performance contracting strategies, performance data collection, meeting performance data entry requirements, and identifying levels of performance.

(2) Conduct evaluations of local WIOA Pay-for-Performance contracting strategies, if appropriate.

(3) Conduct other activities that comply with limitations on the use of the Governor's Reserve.

(b) Using non-Federal funds, Governors may establish incentives for Local WDBs to implement WIOA Pay-for-Performance contract strategies as described in this subpart.

(c) In the case of a State in which local areas are implementing WIOA Pay-for-Performance contract strategies, the State must:

(1) Collect and report to the Department data on the performance of service providers entering into WIOA Pay-for-Performance contracts, measured against the levels of performance benchmarks specified in the contracts, pursuant to sec. 116(d)(2)(K) of WIOA and § 677.160 of this chapter and in accordance with any additional guidance issued by the Secretary.

(2) Collect and report to the Department State and/or local evaluations of the design and performance of the WIOA Pay-for-Performance contract strategies, and, where possible, the level of satisfaction with the strategies among employers and participants benefitting from the strategies, pursuant to sec. 116(d)(2)(K) of WIOA and § 677.160 of this chapter, and in accordance with any guidance issued by the Secretary.

(3) Monitor local areas' use of WIOA Pay-for-Performance contract strategies to ensure compliance with § 683.500 and the contract specifications in § 683.510, and State procurement policies.

(4) Monitor local areas' expenditures to ensure that no more than 10 percent of a local area's adult and dislocated worker allotments and no more than 10 percent of a local area's youth allotment is reserved and used on WIOA Pay-for-Performance contract strategies.

(d) The Secretary will issue additional guidance on State roles in WIOA Pay-for-Performance contract strategies.

Subpart F—Grievance Procedures, Complaints, and State Appeals Processes

§ 683.600 What local area, State, and direct recipient grievance procedures must be established?

(a) Each local area, State, outlying area, and direct recipient of funds under title I of WIOA, except for Job Corps, must establish and maintain a procedure for participants and other interested parties to file grievances and complaints alleging violations of the requirements of title I of WIOA, according to the requirements of this section. The grievance procedure requirements applicable to Job Corps are set forth at §§ 686.960 and 686.965 of this chapter.

(b) Each local area, State, and direct recipient must:

(1) Provide information about the content of the grievance and complaint procedures required by this section to participants and other interested parties affected by the local workforce development system, including one-stop partners and service providers;

(2) Require that every entity to which it awards title I funds provide the information referred to in paragraph (b)(1) of this section to participants receiving title I-funded services from such entities; and

(3) Must make reasonable efforts to assure that the information referred to in paragraph (b)(1) of this section will be understood by affected participants and other individuals, including youth and those who are limited-English speaking individuals. Such efforts must comply with the language requirements of 29 CFR 37.35 regarding the provision of services and information in languages other than English.

(c) Local area procedures must provide:

(1) A process for dealing with grievances and complaints from participants and other interested parties affected by the local workforce development system, including one-stop partners and service providers;

(2) An opportunity for an informal resolution and a hearing to be completed within 60 days of the filing of the grievance or complaint;

(3) A process which allows an individual alleging a labor standards violation to submit the grievance to a binding arbitration procedure, if a collective bargaining agreement covering the parties to the grievance so provides; and

(4) An opportunity for a local level appeal to a State entity when:

(i) No decision is reached within 60 days; or

(ii) Either party is dissatisfied with the local hearing decision.

(d) State procedures must provide:

(1) A process for dealing with grievances and complaints from participants and other interested parties affected by the statewide Workforce Investment programs;

(2) A process for resolving appeals made under paragraph (c)(4) of this section;

(3) A process for remanding grievances and complaints related to the local Workforce Innovation and Opportunity Act programs to the local area grievance process; and

(4) An opportunity for an informal resolution and a hearing to be completed within 60 days of the filing of the grievance or complaint; and

(5) An opportunity for appeal to the Secretary under the circumstances described in § 683.610(a).

(e) Procedures of direct recipients must provide:

(1) A process for dealing with grievance and complaints from participants and other interested parties affected by the recipient's Workforce Innovation and Opportunity Act programs; and

(2) An opportunity for an informal resolution and a hearing to be completed within 60 days of the filing of the grievance or complaint.

(f) The remedies that may be imposed under local, State, and direct recipient grievance procedures are enumerated at WIOA sec. 181(c)(3).

(g)(1) The provisions of this section on grievance procedures do not apply to discrimination complaints brought under WIOA sec. 188 and/or 29 CFR part 38. Such complaints must be handled in accordance with the procedures set forth in that regulatory part.

(2) Questions about or complaints alleging a violation of the nondiscrimination provisions of WIOA sec. 188 may be directed or mailed to the Director, Civil Rights Center, U.S. Department of Labor, Room N4123, 200 Constitution Avenue NW., Washington, DC 20210, for processing.

(h) Nothing in this subpart precludes a grievant or complainant from pursuing a remedy authorized under another Federal, State, or local law.

§ 683.610 What processes does the Secretary use to review grievances and complaints of Workforce Innovation and Opportunity Act title I recipients?

(a) The Secretary investigates allegations arising through the grievance procedures described in § 683.600 when:

(1) A decision on a grievance or complaint under § 683.600(d) has not been reached within 60 days of receipt of the grievance or complaint or within 60 days of receipt of the request for appeal of a local level grievance and either party appeals to the Secretary; or

(2) A decision on a grievance or complaint under § 683.600(d) has been reached and the party to which such decision is adverse appeals to the Secretary.

(b) The Secretary must make a final decision on an appeal under paragraph (a) of this section no later than 120 days after receiving the appeal.

(c) Appeals made under paragraph (a)(2) of this section must be filed within 60 days of the receipt of the decision being appealed. Appeals made under paragraph (a)(1) of this section must be filed within 120 days of the filing of the grievance with the State, or the filing of the appeal of a local grievance with the State. All appeals must be submitted by certified mail, return receipt requested, to the Secretary, U.S. Department of Labor, 200 Constitution Ave. NW., Washington, DC 20210, Attention: ASET. A copy of the appeal must be simultaneously provided to the appropriate ETA Regional Administrator and the opposing party.

(d) Except for complaints arising under WIOA sec. 184(f) or sec. 188, grievances or complaints made directly to the Secretary will be referred to the appropriate State or local area for resolution in accordance with this section, unless the Department notifies the parties that the Department of Labor will investigate the grievance under the procedures at § 683.430. Discrimination complaints brought under WIOA sec. 184(f) or sec. 188 or 29 CFR part 38 will be referred to the Director of the Civil Rights Center.

(e) Complaints and grievances from participants receiving services under the Wagner-Peyser Act will follow the

procedures outlined at part 658 of this chapter.

§ 683.620 How are complaints and reports of criminal fraud and abuse addressed under the Workforce Innovation and Opportunity Act?

(a) Information and complaints involving criminal fraud, waste, abuse or other criminal activity must be reported immediately through the Department's Incident Reporting System to the Department of Labor Office of Inspector General, Office of Investigations, Room S5514, 200 Constitution Avenue NW., Washington, DC 20210, or to the corresponding Regional Inspector General for Investigations, with a copy simultaneously provided to the Employment and Training Administration. The Hotline number is 1–800–347–3756. The Web site is *http://www.oig.dol.gov/contact.htm*.

(b) Complaints of a non-criminal nature may be handled under the procedures set forth in § 683.600 or through the Department's Incident Reporting System.

§ 683.630 What additional appeal processes or systems must a State have for the Workforce Innovation and Opportunity Act program?

(a) Non-designation of local areas:

(1) The State must establish, and include in its State Plan, due process procedures which provide expeditious appeal to the State WDB for a unit of general local government (including a combination of such units) or grant recipient that requests, but is not granted, initial or subsequent designation of an area as a local area under WIOA sec. 106(b)(2) or 106(b)(3) and § 679.250 of this chapter.

(2) These procedures must provide an opportunity for a hearing and prescribe appropriate time limits to ensure prompt resolution of the appeal.

(3) If the appeal to the State WDB does not result in designation, the appellant may request review by the Secretary under § 683.640.

(b) Denial or termination of eligibility as a training provider:

(1) A State must establish procedures which allow providers of training services the opportunity to appeal:

(i) Denial of eligibility by a Local WDB or the designated State agency under WIOA sec. 122(b), 122(c), or 122(d).

(ii) Termination of eligibility or other action by a Local WDB or State agency under WIOA sec. 122(f); or

(iii) Denial of eligibility as a provider of on-the-job training (OJT) or customized training by a one-stop operator under WIOA sec. 122(h).

(2) Such procedures must provide an opportunity for a hearing and prescribe appropriate time limits to ensure prompt resolution of the appeal.

(3) A decision under this State appeal process may not be appealed to the Secretary.

(c) Testing and sanctioning for use of controlled substances.

(1) A State must establish due process procedures, in accordance with WIOA sec. 181(f), which provide expeditious appeal for:

(i) Participants in programs under title I, subtitle B of WIOA subject to testing for use of controlled substances, imposed under a State policy established under WIOA sec. 181(f)(1); and

(ii) Participants in programs under title I, subtitle B of WIOA who are sanctioned, in accordance with WIOA sec. 181(f)(2), after testing positive for the use of controlled substances, under the policy described in paragraph (c)(1)(i) of this section.

(2) A decision under this State appeal process may not be appealed to the Secretary.

§ 683.640 What procedures apply to the appeals of non-designation of local areas?

(a) A unit of general local government (including a combination of such units) or grant recipient whose appeal of the denial of a request for initial or subsequent designation as a local area to the State WDB has not resulted in such designation, may appeal the State WDB's denial to the Secretary.

(b) Appeals made under paragraph (a) of this section must be filed no later than 30 days after receipt of written notification of the denial from the State WDB, and must be submitted by certified mail, return receipt requested, to the Secretary, U.S. Department of Labor, 200 Constitution Ave.

NW., Washington, DC 20210, Attention: ASET. A copy of the appeal must be simultaneously provided to the State WDB.

(c) The appellant must establish that it was not accorded procedural rights under the appeal process set forth in the State Plan, or establish that it meets the requirements for designation in WIOA sec. 106(b)(2) or 106(b)(3) and § 679.250 of this chapter.

(d) If the Secretary determines that the appellant has met its burden of establishing that it was not accorded procedural rights under the appeal process set forth in the State Plan, or that it meets the requirements for designation in WIOA sec. 106(b)(2) or 106(b)(3) and § 679.250 of this chapter, the Secretary may require that the area be designated as a local area. In making this determination, the Secretary may consider any comments submitted by the State WDB in response to the appeal made under paragraph (a) of this section.

(e) The Secretary must issue a written decision to the Governor and the appellant.

§ 683.650 What procedures apply to the appeals of the Governor's imposition of sanctions for substantial violations or performance failures by a local area?

(a) A local area which has been found in substantial violation of WIOA title I, and has received notice from the Governor that either all or part of the local plan will be revoked or that a reorganization will occur, may appeal such sanctions to the Secretary under WIOA sec. 184(b). The appeal must be filed no later than 30 days after receipt of written notification of the revoked plan or imposed reorganization.

(b) The sanctions described in paragraph (a) of this section do not become effective until:

(1) The time for appeal has expired; or

(2) The Secretary has issued the decision described in paragraph (e) of this section.

(c) A local area which has failed to meet local performance indicators for 3 consecutive program years, and has received the Governor's notice of intent to impose a reorganization plan, may appeal to the Governor to rescind or revise such plan, in accordance with § 677.225 of this chapter.

(d) Appeals to the Secretary made under paragraph (a) of this section must be submitted by certified mail, return receipt requested, to the Secretary, U.S. Department of Labor, 200 Constitution Ave. NW., Washington, DC 20210, Attention: ASET. A copy of the appeal must be simultaneously provided to the Governor.

(e) The Secretary will notify the Governor and the appellant in writing of the Secretary's decision under paragraph (a) of this section within 45 days after receipt of the appeal. In making this determination, the Secretary may consider any comments submitted by the Governor in response to the appeals.

Subpart G—Sanctions, Corrective Actions, and Waiver of Liability

§ 683.700 When can the Secretary impose sanctions and corrective actions on recipients and subrecipients of title I Workforce Innovation and Opportunity Act funds?

(a) *Applicability*. (1) Except for actions under WIOA secs. 116 and 188(a) or 29 CFR parts 31, 32, 35, and 38 and 49 CFR part 25, the Grant Officer must use the procedures outlined in § 683.440 before imposing a sanction on, or requiring corrective action by, recipients of funds under title I of WIOA.

(2) To impose a sanction or corrective action for a violation of WIOA sec. 188(a) the Department will use the procedures set forth in 29 CFR part 38.

(3) To impose a sanction or corrective action for a violation of WIOA sec. 116 the Department will use the procedures set forth in part 677 of this chapter.

(b) *States*. When a Grant Officer determines that the Governor has not fulfilled its requirements under 2 CFR part 200, an audit, or a monitoring compliance review set forth at sec. 184(a)(4) of WIOA and § 683.410, or has not taken corrective action to remedy a violation as required by WIOA secs. 184(a)(5) and 184(b)(1), the Grant Officer must require the Governor to impose the necessary corrective actions set forth at WIOA secs. 184(a)(5) and 184(b)(1), or may require repayment of funds under WIOA sec. 184(c). If the

Secretary determines it is necessary to protect the funds or ensure the proper operation of a program or activity, the Secretary may immediately suspend or terminate financial assistance in accordance with WIOA sec. 184(e).

(c) *Local areas.* If the Governor fails to promptly take the actions specified in WIOA sec. 184(b)(1) when it determines that a local area has failed to comply with the requirements described in § 683.720(a), and that the local area has not taken the necessary corrective action, the Grant Officer may impose such actions directly against the local area.

(d) *Direct grant recipients.* When the Grant Officer determines that a direct grant recipient of subtitle D of title I of WIOA has not taken corrective action to remedy a substantial violation as the result of noncompliance with 2 CFR part 200, the Grant Officer may impose sanctions against the grant recipient.

(e) *Subrecipients.* The Grant Officer may impose a sanction directly against a subrecipient, as authorized in WIOA sec. 184(d)(3) and 2 CFR 200.338. In such a case, the Grant Officer will inform the direct grant recipient of the action.

§ 683.710 Who is responsible for funds provided under title I of the Workforce Innovation and Opportunity Act and the Wagner-Peyser Act?

(a) The recipient of the funds is responsible for all funds under its grant(s) awarded under WIOA title I and the Wagner-Peyser Act.

(b)(1) The local government's chief elected official(s) in a local area is liable for any misuse of the WIOA grant funds allocated to the local area under WIOA secs. 128 and 133, unless the chief elected official(s) reaches an agreement with the Governor to bear such liability.

(2) When a local workforce area or region is composed of more than one unit of general local government, the liability of the individual jurisdictions must be specified in a written agreement between the chief elected officials.

(3) When there is a change in the chief elected official(s), the Local WDB is required to inform the new chief elected official(s), in a timely manner, of their responsibilities and liabilities as well as the need to review and update any written agreements among the chief elected official(s).

(4) The use of a fiscal agent does not relieve the chief elected official, or Governor if designated under paragraph (b)(1) of this section, of responsibility for any misuse of grant funds allocated to the local area under WIOA secs. 128 and 133.

§ 683.720 What actions are required to address the failure of a local area to comply with the applicable uniform administrative provisions?

(a) If, as part of the annual on-site monitoring of local areas, the Governor determines that a local area is not in compliance with 2 CFR part 200, including the failure to make the required disclosures in accordance with 2 CFR 200.113 or the failure to disclose all violations of Federal criminal law involving fraud, bribery or gratuity violations, the Governor must:

(1) Require corrective action to secure prompt compliance; and

(2) Impose the sanctions provided for at WIOA sec. 184(b) if the Governor finds that the local area has failed to take timely corrective action.

(b) An action by the Governor to impose a sanction against a local area, in accordance with this section, may be appealed to the Secretary in accordance with § 683.650.

(c)(1) If the Secretary finds that the Governor has failed to monitor and certify compliance of local areas with the administrative requirements under WIOA sec. 184(a), or that the Governor has failed to take the actions promptly required upon a determination under paragraph (a) of this section, the Secretary must take the action described in § 683.700(b).

(2) If the Governor fails to take the corrective actions required by the Secretary under paragraph (c)(1) of this section, the Secretary may immediately suspend or terminate financial assistance under WIOA sec. 184(e).

§ 683.730 When can the Secretary waive the imposition of sanctions?

(a)(1) A recipient of title I funds may request that the Secretary waive the imposition of sanctions authorized under WIOA sec. 184.

(2) A Grant officer may approve the waiver described in paragraph (a)(1) of this section if the grant officer finds that the recipient has demonstrated substantial compliance with the requirements of WIOA sec. 184(d)(2).

(b)(1) When the debt for which a waiver request was established in a non-Federal resolution proceeding, the resolution report must accompany the waiver request.

(2) When the waiver request is made during the ETA Grant Officer resolution process, the request must be made during the informal resolution period described in § 683.440(c).

(c) A waiver of the recipient's liability must be considered by the Grant Officer only when:

(1) The misexpenditure of WIOA funds occurred at a subrecipient's level;

(2) The misexpenditure was not due to willful disregard of the requirements of title I of WIOA, gross negligence, failure to observe accepted standards of administration, and did not constitute fraud or failure to make the required disclosures in accordance with 2 CFR 200.113 addressing all violations of Federal criminal law involving fraud, bribery or gratuity violations (2 CFR part 180 and 31 U.S.C. 3321)

(3) If fraud did exist, was perpetrated against the recipient/subrecipients, and:

(i) The recipient/subrecipients discovered, investigated, reported, and cooperated in any prosecution of the perpetrator of the fraud; and

(ii) After aggressive debt collection action, it has been documented that further attempts at debt collection from the perpetrator of the fraud would be inappropriate or futile;

(4) The recipient has issued a final determination which disallows the misexpenditure, the recipient's appeal process has been exhausted, and a debt has been established; and

(5) The recipient provides documentation to demonstrate that it has substantially complied with the requirements of WIOA sec. 184(d)(2) and this section.

(d) The recipient will not be released from liability for misspent funds under the determination required by WIOA sec. 184(d) unless the Grant Officer determines that further collection action, either by the recipient or subrecipient(s), would be inappropriate or would prove futile.

§ 683.740 What is the procedure to handle a recipient of title I Workforce Innovation and Opportunity Act funds' request for advance approval of contemplated corrective actions?

(a) The recipient may request advance approval from the Grant Officer for contemplated corrective actions, including debt collection actions, which the recipient plans to initiate or to forego. The recipient's request must include a description and an assessment of all actions taken to collect the misspent funds.

(b) Based on the recipient's request, the Grant Officer may determine that the recipient may forego certain debt collection actions against a subrecipient when:

(1) The subrecipient meets the criteria set forth in WIOA sec. 184(d)(2);

(2) The misexpenditure of funds:

(i) Was not made by that subrecipient but by an entity that received WIOA funds from that subrecipient;

(ii) Was not a violation of WIOA sec. 184(d)(1), did not constitute fraud, or failure to disclose, in a timely manner, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award; or

(iii) If fraud did exist:

(A) It was perpetrated against the subrecipient;

(B) The subrecipient discovered, investigated, reported, and cooperated in any prosecution of the perpetrator of the fraud; and

(C) After aggressive debt collection action, it has been documented that further attempts at debt collection from the perpetrator of the fraud would be inappropriate or futile;

(3) A determination which disallows the misexpenditure and establishes a debt has been issued at the appropriate level; and,

(4) Further debt collection action by that subrecipient or the recipient would be either inappropriate or futile.

§ 683.750 What procedure must be used for administering the offset/deduction provisions of the Workforce Innovation and Opportunity Act?

(a)(1) For misexpenditures by direct recipients of title I and Wagner-Peyser Act formula funds the Grant Officer may determine that a debt, or a portion thereof, may be offset against amounts that are allotted to the recipient. Recipients must submit a written request for an offset to the Grant Officer. Generally, the Grant Officer will apply the offset against amounts that are available at the recipient level for administrative costs.

(2) The Grant Officer may approve an offset request, under paragraph (a)(1) of this section, if the misexpenditures were not due to willful disregard of the requirements of WIOA and regulations, fraud, gross negligence, failure to observe accepted standards of administration or a pattern of misexpenditure.

(b) For subrecipient misexpenditures that were not due to willful disregard of the requirements of WIOA and regulations, fraud, gross negligence, failure to observe accepted standards of administration or a pattern of misexpenditure, if the Grant Officer has required the State to repay or offset such amount, the State may deduct an amount equal to the misexpenditure from the subrecipient's allocation of the program year after the determination was made. Deductions are to be made from funds reserved for the administrative costs of the local programs involved, as appropriate.

(c) If offset is granted, the debt will not be fully satisfied until the Grant Officer reduces amounts allotted to the recipient by the amount of the misexpenditure.

(d) For recipients of funds under title I and Wagner-Peyser Act funds, a direct recipient may not make a deduction under paragraph (b) of this section until the State has taken appropriate corrective action to ensure full compliance within the local area with regard to appropriate expenditure of WIOA funds.

Subpart H—Administrative Adjudication and Judicial Review

§ 683.800 What actions of the Department may be appealed to the Office of Administrative Law Judges?

(a) An applicant for financial assistance under title I of WIOA who is dissatisfied by a determination not to award Federal financial assistance, in whole or in part, to such applicant; or a recipient, subrecipient, or a contractor against which the Grant Officer has directly imposed a sanction or corrective action under sec. 184 of WIOA, including a sanction against a State under part 677 of this chapter, may appeal to the U.S. Department of Labor, Office of Administrative Law Judges (OALJ) within 21 days of receipt of the final determination.

(b) Failure to request a hearing within 21 days of receipt of the final determination constitutes a waiver of the right to a hearing.

(c) A request for a hearing under this subpart must specifically state those issues or findings in the final determination upon which review is requested. Issues or findings in the final determination not specified for review, or the entire final determination when no hearing has been requested within the 21 days, are considered resolved and not subject to further review. Only alleged violations of WIOA, its regulations, the grant or other agreement under WIOA raised in the final determination and the request for hearing are subject to review.

(d) A request for a hearing must be filed with the Chief Administrative Law Judge, U.S. Department of Labor, in accordance with 29 CFR part 18, with one copy to the Departmental official who issued the determination.

(e) The procedures in this subpart apply in the case of a complainant who has engaged in the alternative dispute resolution process set forth in § 683.840, if neither a settlement was reached nor a decision issued within the 60 days, except that the request for hearing before the OALJ must be filed within 15 days of the conclusion of the 60-day period provided in § 683.840. In addition to including the final determination upon which review is requested, the complainant must include a copy of any

Stipulation of Facts and a brief summary of proceedings.

[81 FR 56410, Aug. 19, 2016, as amended at 86 FR 1779, Jan. 11, 2021]

§ 683.810 What rules of procedure apply to hearings conducted under this subpart?

(a) *Rules of practice and procedure.* The rules of practice and procedure promulgated by the OALJ at subpart A of 29 CFR part 18, govern the conduct of hearings under this subpart. However, a request for hearing under this subpart is not considered a complaint to which the filing of an answer by the Department or a Department agency or official is required. Technical rules of evidence will not apply to hearings conducted pursuant to this part. However, rules or principles designed to assure production of the most credible evidence available and to subject testimony to cross-examination will apply.

(b) *Prehearing procedures.* In all cases, the Administrative Law Judge (ALJ) should encourage the use of prehearing procedures to simplify and clarify facts and issues.

(c) *Subpoenas.* Subpoenas necessary to secure the attendance of witnesses and the production of documents or other items at hearings must be obtained from the ALJ and must be issued under the authority contained in WIOA sec. 183(c), incorporating 15 U.S.C. 49.

(d) *Timely submission of evidence.* The ALJ must not permit the introduction at the hearing of any documentation if it has not been made available for review by the other parties to the proceeding either at the time ordered for any prehearing conference, or, in the absence of such an order, at least 3 weeks prior to the hearing date.

(e) *Burden of production.* The Grant Officer has the burden of production to support her or his decision. This burden is satisfied once the Grant Officer prepares and files an administrative file in support of the decision which must be made part of the record. Thereafter, the party or parties seeking to overturn the Grant Officer's decision has the burden of persuasion.

§ 683.820 What authority does the Administrative Law Judge have in ordering relief as an outcome of an administrative hearing?

(a) In ordering relief the ALJ has the full authority of the Secretary under WIOA, except as described in paragraph (b) of this section.

(b) In grant selection appeals of awards funded under WIOA title I, subtitle D:

(1) If the Administrative Law Judge rules, under § 683.800, that the appealing organization should have been selected for an award, the matter must be remanded to the Grant Officer. The Grant Officer must, within 10 working days, determine whether the organization continues to meet the requirements of the applicable solicitation, whether the funds which are the subject of the ALJ's decision will be awarded to the organization, and the timing of the award. In making this determination, the Grant Officer must take into account disruption to participants, disruption to grantees, and the operational needs of the program.

(2) If the Administrative Law Judge rules that additional application review is required, the Grant Officer must implement that review and, if a new organization is selected, follow the steps laid out in paragraph (b)(1) of this section to determine whether the grant funds will be awarded to that organization.

(3) In the event that the Grant Officer determines that the funds will not be awarded to the appealing organization for the reasons discussed in paragraph (b)(1) of this section, an organization which does not have an approved Negotiated Indirect Cost Rate Agreement will be awarded its reasonable application preparation costs.

(4) If funds are awarded to the appealing organization, the Grant Officer will notify the current grantee within 10 days. In addition, the appealing organization is not entitled to the full grant amount but only will receive the funds remaining in the grant that have not been obligated by the current grantee through its operation of the grant and its subsequent closeout.

(5) In the event that an organization, other than the appealing organization,

is adversely effected by the Grant Officer's determination upon completion of the additional application review under paragraph (b)(2) of this section, that organization may appeal that decision to the Office of Administrative Law Judges by following the procedures set forth in § 683.800.

(6) Any organization selected and/or funded under WIOA title I, subtitle D, is subject to having its award removed if an ALJ decision so orders. As part of this process, the Grant Officer will provide instructions on transition and closeout to both the newly selected grantee and to the grantee whose position is affected or which is being removed. All awardees must agree to the provisions of this paragraph (b) as a condition of accepting a grant award.

§ 683.830 When will the Administrative Law Judge issue a decision?

(a) The ALJ should render a written decision not later than 90 days after the closing of the record.

(b) The decision of the ALJ constitutes final agency action unless, within 20 days of the decision, a party dissatisfied with the ALJ's decision has filed a petition for review with the Administrative Review Board (ARB) (established under Secretary's Order No. 01–2020), specifically identifying the procedure, fact, law, or policy to which exception is taken, in accordance with 29 CFR part 26. Any exception not specifically raised in the petition is deemed to have been waived. A copy of the petition for review also must be sent to the opposing party and if an applicant or recipient, to the Grant Officer and the Grant Officer's Counsel at the time of filing. Unless the ARB, within 30 days of the filing of the petition for review, notifies the parties that the case has been accepted for review, the decision of the ALJ constitutes final agency action. In any case accepted by the ARB, a decision must be issued by the ARB within 180 days of acceptance. If a decision is not so issued, the decision of the ALJ constitutes final agency action.

[81 FR 56410, Aug. 19, 2016, as amended at 85 FR 13030, Mar. 6, 2020; 85 FR 30616, May 20, 2020; 86 FR 1779, Jan. 11, 2021]

§ 683.840 Is there an alternative dispute resolution process that may be used in place of an Office of Administrative Law Judges hearing?

(a) The parties to a complaint which has been filed according to the requirements of § 683.800 may choose to waive their rights to an administrative hearing before the OALJ. Instead, they may choose to transfer the settlement of their dispute to an individual acceptable to all parties who will conduct an informal review of the stipulated facts and render a decision in accordance with applicable law. A written decision must be issued within 60 days after submission of the matter for informal review.

(b) The waiver of the right to request a hearing before the OALJ described in paragraph (a) of this section will automatically be revoked if a settlement has not been reached or a written decision has not been issued within the 60 days provided in paragraph (a) of this section.

(c) The decision rendered under this informal review process will be treated as a final decision of an Administrative Law Judge under WIOA sec. 186(b).

§ 683.850 Is there judicial review of a final order of the Secretary issued under WIOA?

(a) Any party to a proceeding which resulted in a Secretary's final order under WIOA sec. 186 in which the Secretary awards, declines to award, or only conditionally awards financial assistance or with respect to a corrective action or sanction imposed under WIOA sec. 184 may obtain a review in the United States Court of Appeals having jurisdiction over the applicant or recipient of funds involved, by filing a review petition within 30 days of the issuance of the Secretary's final order in accordance with WIOA sec. 187.

(b) The court has jurisdiction to make and enter a decree affirming, modifying, or setting aside the order of the Secretary, in whole or in part.

(c) No objection to the Secretary's order may be considered by the court unless the objection was specifically urged, in a timely manner, before the Secretary. The review is limited to questions of law, and the findings of

fact of the Secretary are conclusive if supported by substantial evidence.

(d) The judgment of the court is final, subject to certiorari review by the United States Supreme Court.

PART 684—INDIAN AND NATIVE AMERICAN PROGRAMS UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

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Sec.

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684.920 What provisions of law or regulations may not be waived?
684.930 May Indian and Native American program grantees combine or consolidate their employment and training funds?
684.940 What is the role of the Native American Employment and Training Council?
684.950 Does the Workforce Innovation and Opportunity Act provide any additional assistance to unique populations in Alaska and Hawaii?

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SOURCE: 81 FR 56428, Aug. 19, 2016, unless otherwise noted.

Subpart A—Purposes and Policies

§ 684.100 What is the purpose of the programs established to serve Indians and Native Americans under the Workforce Innovation and Opportunity Act?

(a) The purpose of WIOA Indian and Native American (INA) programs in sec. 166 is to support employment and training activities for INAs in order to:

(1) Develop more fully the academic, occupational, and literacy skills of such individuals;

(2) Make such individuals more competitive in the workforce and to equip them with entrepreneurial skills necessary for successful self-employment; and

(3) Promote the economic and social development of INA communities in accordance with the goals and values of such communities.

(b) The principal means of accomplishing these purposes is to enable tribes and Native American organizations to provide employment and training services to INAs and their communities. Services should be provided in a culturally appropriate manner, consistent with the principles of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 *et seq.*).

§ 684.110 How must Indian and Native American programs be administered?

(a) INA programs will be administered to maximize the Federal commitment to support the growth and development of INAs and their communities as determined by representatives of such communities.

(b) In administering these programs, the Department will follow the Congressional declaration of policy set forth in the Indian Self-Determination and Education Assistance Act, at 25 U.S.C. 450a, as well as the Department of Labor's ''American Indian and Alaska Native Policies.''

(c) The regulations in this part are not intended to abrogate the trust responsibilities of the Federal government to Federally recognized tribes in any way.

(d) The Department will administer INA programs through a single organizational unit and consistent with the requirements in sec. 166(i) of WIOA. The Division of Indian and Native American Programs (DINAP) within the Employment and Training Administration (ETA) is designated as this single organizational unit as required by sec. 166(i)(1) of WIOA.

(e) The Department will establish and maintain administrative procedures for the selection, administration, monitoring, and evaluation of INA employment and training programs authorized under this Act.

§ 684.120 What obligation does the Department have to consult with the Indian and Native American grantee community in developing rules, regulations, and standards of accountability for Indian and Native American programs?

The Department's primary consultation vehicle for INA programs is the Native American Employment and Training Council. In addition, the Department will consult with the INA program grantee community in developing policies for the INA programs, actively seeking and considering the views of INA program grantees prior to establishing INA program policies and regulations. The Department will follow the Department of Labor's tribal consultation policy and Executive Order 13175 of November 6, 2000.

§ 684.130 What definitions apply to terms used in this part?

In addition to the definitions found in secs. 3 and 166 of WIOA, and § 675.300 of this chapter, the following definitions apply:

Alaska Native-Controlled Organization means an organization whose governing board is comprised of 51 percent or more of individuals who are Alaska Native as defined in secs. 3(b) and 3(r) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b), (r)).

Carry-in means the total amount of funds unobligated by a grantee at the end of a program year. If the amount of funds unobligated by a grantee at the end of a program year is more than 20 percent of the grantee's ''total funds available'' for that program year, such excess amount is considered ''excess carry-in.''

DINAP means the Division of Indian and Native American Programs within the Employment and Training Administration of the U.S. Department of Labor.

Governing body means a body of representatives who are duly elected, appointed by duly elected officials, or selected according to traditional tribal means. A governing body must have the authority to provide services to and to enter into grants on behalf of the organization that selected or designated it.

Grant Officer means a U.S. Department of Labor official authorized to obligate Federal funds.

High-poverty area means a Census tract, a set of contiguous Census tracts, an American Indian Reservation, Oklahoma Tribal Statistical Area, Alaska Native Village Statistical Area, or Alaska Native Regional Corporation Area, Native Hawaiian Homeland Area or county where the poverty rate for the INA population is at least 25 percent of the total INA population of such area using the most recent ACS 5-Year data. Alternatively, high-poverty also can mean, a Census tract, a set of contiguous Census tracts, an American Indian Reservation, Oklahoma Tribal Statistical Area, Alaska Native Village Statistical Area, or Alaska Native Regional Corporation Area, Native Hawaiian Homeland Area or county where the poverty rate for the total population is at least 25 percent of such area using the most recent ACS 5-Year data. INA program grantees may use either definition when determining if a Census tract is a high-poverty area.

INA program grantee means an entity which is formally selected under subpart B of this part to operate an INA program and which has a grant agreement.

Incumbent grantee means an entity that is currently receiving a grant under sec. 166 of WIOA.

Indian and Native American or INA means, for the purpose of this part, an

individual that is an American Indian, Native American, Native Hawaiian, or Alaska Native.

Indian-Controlled Organization means an organization whose governing board is comprised of 51 percent or more individuals who are members of one or more Federally recognized tribes. Incumbent grantees who were receiving INA funding as of October 18, 2016 and met the 51 percent threshold with the inclusion of members of ''State recognized tribes'' continue to be eligible for WIOA sec. 166 funds as an Indian-Controlled Organization, as long as they have been continuously funded under WIOA as recipients of INA program grantees since October 18, 2016. Tribal Colleges and Universities meet the definition of Indian-Controlled Organization for the purposes of this regulation.

Native Hawaiian-Controlled Organization means an organization whose governing board is comprised of 51 percent or more individuals who are Native Hawaiian as defined in sec. 7207 of the Native Hawaiian Education Act (20 U.S.C. 7517).

Total funds available means all funds that a grantee had ''available'' at the beginning of a program year.

Underemployed means an individual who is working part-time but desires full-time employment, or who is working in employment not commensurate with the individual's demonstrated level of educational and/or skill achievement.

Subpart B—Service Delivery Systems Applicable to Section 166 Programs

§ 684.200 What are the requirements to apply for a Workforce Innovation and Opportunity Act grant?

(a) To be eligible to apply for a WIOA, sec. 166 grant, an entity must have legal status as a government or as an agency of a government, private non-profit corporation, or a consortium whose members all qualify as one of these entities.

(b) A new entity (which is not an incumbent grantee) must have a population within the designated geographic service area which would receive at least $100,000 under the funding formula found at § 684.270(b), including any amounts received for supplemental youth services under the funding formula at § 684.440(a).

(c) Incumbent grantees which do not meet this dollar threshold and were receiving INA funding of less than $100,000 as of October 18, 2016 will be grandfathered into the program and are eligible to be awarded less than $100,000 so long as the grantees have continuously received less than $100,000 since October 18, 2016.

(d) The Department will make an exception to the $100,000 minimum for applicants that apply for WIOA funding through Public Law 102–477, the Indian, Employment, Training, and Related Services demonstration program, if all resources to be consolidated under the Public Law 102–477 plan total at least $100,000, with at least $20,000 derived from sec. 166 funds. However, incumbent Public Law 102–477 grantees that were receiving INA funding of less than $20,000 as of October 18, 2016 will be grandfathered into the program and are eligible to be awarded less than $20,000 so long as the grantees have continuously received less than $20,000 since October 18, 2016.

(e) To be eligible to apply as a consortium, each member of the consortium must meet the requirements of paragraph (a) of this section and must:

(1) Be in close proximity to one another, but may operate in more than one State;

(2) Have an administrative unit legally authorized to run the program and to commit the other members to contracts, grants, and other legally-binding agreements; and

(3) Be jointly and individually responsible for the actions and obligations of the consortium, including debts.

(f) Entities eligible under paragraph (a)(1) of this section are:

(1) Federally recognized Indian tribes;

(2) Tribal organizations, as defined in 25 U.S.C. 450b;

(3) Alaska Native-controlled organizations;

(4) Native Hawaiian-controlled organizations;

(5) Indian-controlled organizations serving INAs; and

(6) A consortium of eligible entities which meets the legal requirements for a consortium described in paragraph (b) of this section.

(g) State-recognized tribal organizations that meet the definition of an Indian-controlled organization are eligible to apply for WIOA sec. 166 grant funds. State-recognized tribes that do not meet this definition but were grantees under WIA as of July 1, 2015 will be grandfathered into WIOA as Indian-controlled organizations provided they meet the definition of Indian-controlled organization in § 684.130.

§ 684.210 What priority for awarding grants is given to eligible organizations?

(a) Federally recognized Indian tribes, Alaska Native entities, or a consortium of such entities will have priority to receive grants under this part for those geographic service areas in which they have legal jurisdiction, such as an Indian reservation, Oklahoma Tribal Service Area (OTSA), or Alaska Native Village Service Area (ANVSA).

(b) If the Department decides not to make an award to an Indian tribe or Alaska Native entity that has legal jurisdiction over a service area, it will consult with such tribe or Alaska Native entity that has jurisdiction before selecting another entity to provide services for such areas.

(c) The priority described in paragraphs (a) and (b) of this section does not apply to service areas outside the legal jurisdiction of an Indian tribe or Alaska Native entity.

§ 684.220 What is the process for applying for a Workforce Innovation and Opportunity Act grant?

(a) Entities seeking a WIOA sec. 166 grant, including incumbent grantees, will be provided an opportunity to apply for a WIOA sec. 166 grant every 4 years through a competitive grant process.

(b) As part of the competitive application process, applicants will be required to submit a 4-year plan as described at § 684.710. The requirement to submit a 4-year plan does not apply to entities that have been granted approval to transfer their WIOA funds to the Department of the Interior pursuant to Public Law 102–477.

§ 684.230 What appeal rights are available to entities that are denied a grant award?

Any entity that is denied a grant award for which it applied in whole or in part may appeal the denial to the Office of the Administrative Law Judges using the procedures at § 683.800 of this chapter or the alternative dispute resolution procedures at § 683.840 of this chapter. The Grant Officer will provide an entity whose request for a grant award was denied, in whole or in part, with a copy of the appeal procedures.

§ 684.240 Are there any other ways in which an entity may be awarded a Workforce Innovation and Opportunity Act grant?

Yes. For areas that would otherwise go unserved, the Grant Officer may designate an entity, which has not submitted a competitive application, but which meets the qualifications for a grant award, to serve the particular geographic area. Under such circumstances, DINAP will seek the views of INA leaders in the community that would otherwise go unserved before making the decision to designate the entity that would serve the community. DINAP will inform the Grant Officer of the INA leaders' views. The Grant Officer will accommodate views of INA leaders in such areas to the extent possible.

§ 684.250 Can an Indian and Native American grantee's grant award be terminated?

(a) Yes, the Grant Officer can terminate a grantee's award for cause, or the Secretary or another Department of Labor official confirmed by the Senate can terminate a grantee's award in emergency circumstances where termination is necessary to protect the integrity of Federal funds or ensure the proper operation of the program under sec. 184(e) of WIOA.

(b) The Grant Officer may terminate a grantee's award for cause only if there is a substantial or persistent violation of the requirements in WIOA or the WIOA regulations. The grantee must be provided with written notice

60 days before termination, stating the specific reasons why termination is proposed. The appeal procedures at § 683.800 of this chapter apply.

§ 684.260 Does the Department have to award a grant for every part of the country?

No, if there are no entities meeting the requirements for a grant award in a particular area, or willing to serve that area, the Department will not award funds for that service area. The funds that otherwise would have been allocated to that area under § 684.270 will be distributed to other INA program grantees, or used for other program purposes such as technical assistance and training (TAT). Unawarded funds used for TAT are in addition to, and not subject to the limitations on, amounts reserved under § 684.270(e). Areas which are unserved by the INA program may be restored during a subsequent grant award cycle, when and if a current grantee or other eligible entity applies for a grant award to serve that area.

§ 684.270 How are Workforce Innovation and Opportunity Act funds allocated to Indian and Native American program grantees?

(a) Except for reserved funds described in paragraph (e) of this section and funds used for other program purposes under § 684.260, all funds available for WIOA sec. 166(d)(2)(A)(i) comprehensive workforce investment services program at the beginning of a program year will be allocated to INA program grantees for the geographic service area(s) awarded to them through the grant competition.

(b) Each INA program grantee will receive the sum of the funds calculated using the following formula:

(1) One-quarter of the funds available will be allocated on the basis of the number of unemployed American Indian, Alaska Native, and Native Hawaiian individuals in the grantee's geographic service area(s) compared to all such unemployed persons in the United States.

(2) Three-quarters of the funds available will be allocated on the basis of the number of American Indian, Alaska Native, and Native Hawaiian individuals in poverty in the grantee's geographic service area(s) as compared to all such persons in poverty in the United States.

(3) The data and definitions used to implement these formulas are provided by the U.S. Bureau of the Census.

(c) In years immediately following the use of new data in the formula described in paragraph (b) of this section, based upon criteria to be described in the Funding Opportunity Announcement (FOA), the Department may utilize a hold harmless factor to reduce the disruption in grantee services which would otherwise result from changes in funding levels. This factor will be determined in consultation with the grantee community and the Native American Employment and Training Council.

(d) The Department may reallocate funds from one INA program grantee to another if a grantee is unable to serve its area for any reason, such as audit or debt problems, criminal activity, internal (political) strife, failure to adhere to or meet grant terms and conditions, or lack of ability or interest. If a grantee has excess carry-in for a program year, the Department also may readjust the awards granted under the funding formula so that an amount that equals the previous program year's carry-in will be allocated to another INA program grantee(s).

(e) The Department may reserve up to one percent of the funds appropriated under WIOA sec. 166(d)(2)(A)(i) for any program year for TAT purposes. It will consult with the Native American Employment and Training Council in planning how the TAT funds will be used, designating activities to meet the unique needs of the INA communities served by the INA program. INA program grantees also will have access to resources available to other Department programs to the extent permitted under other law.

Subpart C—Services to Customers

§ 684.300 Who is eligible to receive services under the Indian and Native American program?

(a) A person is eligible to receive services under the INA program if that person is:

(1) An Indian, as determined by a policy of the INA program grantee. The grantee's definition must at least include anyone who is a member of a Federally-recognized tribe; or

(2) An Alaska Native, as defined in WIOA sec. 166(b)(1); or

(3) A Native Hawaiian, as defined in WIOA sec. 166(b)(3).

(b) The person also must be any one of the following:

(1) Unemployed; or

(2) Underemployed, as defined in § 684.130; or

(3) A low-income individual, as defined in sec. 3(36) of WIOA; or

(4) The recipient of a bona fide lay-off notice which has taken effect in the last 6 months or will take effect in the following 6-month period, who is unlikely to return to a previous industry or occupation, and who is in need of retraining for either employment with another employer or for job retention with the current employer; or

(5) An individual who is employed, but is determined by the grantee to be in need of employment and training services to obtain or retain employment that allows for self-sufficiency.

(c) If applicable, male applicants also must register or be registered for the Selective Service.

§ 684.310 What are Indian and Native American program grantee allowable activities?

(a) Generally, INA program grantees must make efforts to provide employment and training opportunities to eligible individuals (as described in § 684.300) who can benefit from, and who are most in need of, such opportunities. In addition, INA program grantees must make efforts to develop programs that contribute to occupational development, upward mobility, development of new careers, and opportunities for nontraditional employment.

(b) Allowable activities for INA program grantees are any services consistent with the purposes of this part that are necessary to meet the needs of INAs preparing to enter, reenter, or retain unsubsidized employment leading to self-sufficiency.

(c) Examples of career services, which may be delivered in partnership with the one-stop delivery system, are described in sec. 134(c)(2) of WIOA and § 678.430 of this chapter.

(d) Follow-up services, including counseling and supportive services for up to 12 months after the date of exit to assist participants in obtaining and retaining employment.

(e) Training services include the activities described in WIOA sec. 134(c)(3)(D).

(f) Allowable activities specifically designed for youth, as listed in sec. 129 of WIOA, include:

(1) Tutoring, study skills training, instruction, and evidence-based dropout prevention and recovery strategies that lead to completion of the requirements for a secondary school diploma or its recognized equivalent (including a recognized certificate of attendance or similar document for individuals with disabilities) or for a recognized postsecondary credential;

(2) Alternative secondary school services, or dropout recovery services, as appropriate;

(3) Paid and unpaid work experiences that have as a component academic and occupational education, which may include:

(i) Summer employment opportunities and other employment opportunities available throughout the school year;

(ii) Pre-apprenticeship programs;

(iii) Internships and job shadowing; and

(iv) On-the-job training opportunities;

(4) Occupational skill training, which must include priority consideration for training programs that lead to recognized postsecondary credentials that are aligned with in-demand industry sectors or occupations in the local area involved;

(5) Education offered concurrently with and in the same context as workforce preparation activities and training for a specific occupation or occupational cluster;

(6) Leadership development opportunities, which may include community service and peer-centered activities encouraging responsibility and other positive social and civic behaviors, as appropriate;

(7) Supportive services as defined in WIOA sec. 3(59);

(8) Adult mentoring for the period of participation and a subsequent period, for a total of not less than 12 months;

(9) Follow-up services for not less than 12 months after the completion of participation, as appropriate;

(10) Comprehensive guidance and counseling, which may include drug and alcohol abuse counseling and referral, as appropriate;

(11) Financial literacy education;

(12) Entrepreneurial skills training;

(13) Services that provide labor market and employment information about in-demand industry sectors or occupations available in the local area, such as career awareness, career counseling, and career exploration services; and

(14) Activities that help youth prepare for and transition to postsecondary education and training.

(g) In addition, allowable activities include job development and employment outreach, including:

(1) Support of the Tribal Employment Rights Office (TERO) program;

(2) Negotiation with employers to encourage them to train and hire participants;

(3) Establishment of linkages with other service providers to aid program participants;

(4) Establishment of management training programs to support tribal administration or enterprises; and

(5) Establishment of linkages with remedial education, such as adult basic education, basic literacy training, and training programs for limited English proficient (LEP) individuals, as necessary.

(h) Participants may be enrolled in more than one activity at a time and may be sequentially enrolled in multiple activities.

(i) Services may be provided to a participant in any sequence based on the particular needs of the participant.

§ 684.320 Are there any restrictions on allowable activities?

(a) Training services must be directly linked to an in-demand industry sector or occupation in the service area, or in another area to which a participant receiving such services is willing to relocate.

(b) INA program grantees must provide on-the-job training (OJT) services consistent with the definition provided in WIOA sec. 3(44) and other limitations in WIOA. Individuals in OJT must:

(1) Be compensated at the same rates, including periodic increases, as trainees or employees who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; and

(2) Be provided benefits and working conditions at the same level and to the same extent as other trainees or employees working a similar length of time and doing the same type of work.

(c) In addition, OJT contracts under this title must not be entered into with employers who have:

(1) Received payments under previous contracts under WIOA or the Workforce Investment Act of 1998 and have exhibited a pattern of failing to provide OJT participants with continued, long-term employment as regular employees with wages and employment benefits (including health benefits) and working conditions at the same level and to the same extent as other employees working a similar length of time and doing the same type of work; or

(2) Have exhibited a pattern of violating paragraphs (b)(1) and/or (2) of this section.

(d) INA program grantees are prohibited from using funds to encourage the relocation of a business, as described in WIOA sec. 181(d) and § 683.260 of this chapter.

(e) INA program grantees must only use WIOA funds for activities that are in addition to those that would otherwise be available to the INA population in the area in the absence of such funds.

(f) INA program grantees must not spend funds on activities that displace currently employed individuals, impair existing contracts for services, or in any way affect union organizing.

(g) Under § 683.255 of this chapter, sectarian activities involving WIOA financial assistance or participants are limited in accordance with the provisions of sec. 188(a)(3) of WIOA.

§ 684.330 What is the role of Indian and Native American program grantees in the one-stop delivery system?

(a) In those local areas where an INA program grantee conducts field operations or provides substantial services, the INA program grantee is a required partner in the local one-stop delivery system and is subject to the provisions relating to such partners described in part 678 of this chapter. Consistent with those provisions, a Memorandum of Understanding (MOU) between the INA program grantee and the Local Workforce Development Board (WDB) over the operation of the one-stop center(s) in the Local WDB's workforce development area also must be executed. Where the Local WDB is an alternative entity under § 679.150 of this chapter, the INA program grantee must negotiate with the alternative entity on the terms of its MOU and the scope of its on-going role in the local workforce development system, as specified in §§ 678.420 and 678.500 through 678.510 of this chapter. In local areas with a large concentration of potentially eligible INA participants, which are in an INA program grantee's service area but in which the grantee does not conduct operations or provide substantial services, the INA program grantee should encourage such individuals to participate in the one-stop delivery system in that area in order to receive WIOA services.

(b) At a minimum, the MOU must contain the provisions listed in WIOA sec. 121(c) and:

(1) The exchange of information on the services available and accessible through the one-stop delivery system and the INA program;

(2) As necessary to provide referrals and case management services, the exchange of information on INA participants in the one-stop delivery system and the INA program; and

(3) Arrangements for the funding of services provided by the one-stop(s), consistent with the requirements that no expenditures may be made with INA program funds for individuals who are not eligible or for services not authorized under this part.

(c) Where the INA program grantee has failed to enter into a MOU with the Local WDB, the INA program grantee must describe in its 4-year plan the good-faith efforts made in order to negotiate an MOU with the Local WDB.

(d) Pursuant to WIOA sec. 121(h)(2)(D)(iv), INA program grantees will not be subject to the funding of the one-stop infrastructure unless otherwise agreed upon in the MOU under subpart C of part 678 of this chapter.

§ 684.340 What policies govern payments to participants, including wages, training allowances or stipends, or direct payments for supportive services?

(a) INA program grantees may pay training allowances or stipends to participants for their successful participation in and completion of education or training services (except such allowance may not be provided to participants in OJT). Allowances or stipends may not exceed the Federal or State minimum wage, whichever is higher.

(b) INA program grantees may not pay a participant in a training activity when the person fails to participate without good cause.

(c) If a participant in a WIOA-funded activity, including participants in OJT, is involved in an employer-employee relationship, that participant must be paid wages and fringe benefits at the same rates as trainees or employees who have similar training, experience and skills and which are not less than the higher of the applicable Federal, State, or local minimum wage.

(d) In accordance with the policy described in the 4-year plan submitted as part of the competitive process, INA program grantees may pay incentive bonuses to participants who meet or exceed individual employability or training goals established in writing in the individual employment plan.

(e) INA program grantees must comply with other restrictions listed in WIOA secs. 181 through 195, which apply to all programs funded under title I of WIOA, including the provisions on labor standards in WIOA sec. 181(b).

§ 684.350 What will the Department do to strengthen the capacity of Indian and Native American program grantees to deliver effective services?

The Department will provide appropriate TAT, as necessary, to INA program grantees. This TAT will assist INA program grantees to improve program performance and improve the quality of services to the target population(s), as resources permit.

Subpart D—Supplemental Youth Services

§ 684.400 What is the purpose of the supplemental youth services program?

The purpose of this program is to provide supplemental employment and training and related services to low-income INA youth on or near Indian reservations and in Oklahoma, Alaska, or Hawaii.

§ 684.410 What entities are eligible to receive supplemental youth services funding?

Entities eligible to receive supplemental youth services funding are limited to: Those tribal, Alaska Native, Native Hawaiian and Oklahoma tribal grantees funded under WIOA sec. 166(d)(2)(A)(i) or other grantees serving those areas, and entities serving the populations specified in § 684.400 that received funding under sec. 166(d)(2)(A)(ii) of the Workforce Investment Act.

§ 684.420 What are the planning requirements for receiving supplemental youth services funding?

Applicants eligible to apply for supplemental youth funding must describe the supplemental youth services they intend to provide in the 4-year plan that they will submit as part of the competitive application process. The information on youth services will be incorporated into the overall 4-year plan, which is more fully described in §§ 684.700 and 684.710, and is required for both adult and youth funds. As indicated in § 684.710(c), additional planning information required for applicants requesting supplemental youth funding will be provided in the FOA. The Department envisions that the strategy for youth funds will not be extensive; however, grantees will be required to provide the number of youth it plans to serve and projected performance outcomes. The Department also supports youth activities that preserve INA culture and will support strategies that promote INA values.

§ 684.430 What individuals are eligible to receive supplemental youth services?

(a) Participants in supplemental youth services activities must be:

(1) American Indian, Alaska Native or Native Hawaiian as determined by the INA program grantee according to § 684.300(a);

(2) Between the age of 14 and 24; and

(3) A low-income individual as defined at WIOA sec. 3(36) except up to five percent of the participants during a program year in an INA youth program may not be low-income individuals provided they meet the eligibility requirements of paragraphs (a)(1) and (2) of this section.

(b) For the purpose of this section, the term ''low-income,'' used with respect to an individual, also includes a youth living in a high-poverty area.

§ 684.440 How is funding for supplemental youth services determined?

(a) Supplemental youth funding will be allocated to eligible INA program grantees on the basis of the relative number of INA youth between the ages of 14 and 24 living in poverty in the grantee's geographic service area compared to the number of INA youth between the ages of 14 and 24 living in poverty in all eligible geographic service areas. The Department reserves the right to redefine the supplemental youth funding stream in future program years, in consultation with the Native American Employment and Training Council, as program experience warrants and as appropriate data become available.

(b) The data used to implement this formula are provided by the U.S. Bureau of the Census.

(c) The hold harmless factor described in § 684.270(c) also applies to supplemental youth services funding. This factor also will be determined in

consultation with the grantee community and the Native American Employment and Training Council.

(d) The reallocation provisions of § 684.270(d) also apply to supplemental youth services funding.

(e) Any supplemental youth services funds not allotted to a grantee or refused by a grantee may be used for the purposes outlined in § 684.270(e), as described in § 684.260. Any such funds are in addition to, and not subject to the limitations on, amounts reserved under § 684.270(e).

§ 684.450 How will supplemental youth services be provided?

(a) INA program grantees may offer supplemental services to youth throughout the school year, during the summer vacation, and/or during other breaks during the school year at their discretion.

(b) The Department encourages INA program grantees to work with local educational agencies to provide academic credit for youth activities whenever possible.

(c) INA program grantees may provide participating youth with the activities referenced in § 684.310(e).

§ 684.460 What performance indicators are applicable to the supplemental youth services program?

(a) Pursuant to WIOA secs. 166(e)(5) and 166(h), the performance indicators at WIOA sec. 116(b)(2)(A)(ii) apply to the INA youth program, which must include:

(1) The percentage of program participants who are in education or training activities, or in unsubsidized employment, during the second quarter after exit from the program;

(2) The percentage of program participants who are in education or training activities, or in unsubsidized employment, during the fourth quarter after exit from the program;

(3) The median earnings of program participants who are in unsubsidized employment during the second quarter after exit from the program;

(4) The percentage of program participants who obtain a recognized postsecondary credential, or a secondary school diploma or its recognized equivalent (subject to WIOA sec. 116(b)(2)(A)(iii)) during participation in or within 1 year after exit from the program;

(5) The percentage of program participants who, during a program year, are in an education or training program that leads to a recognized postsecondary credential or employment and who are achieving measurable skill gains toward such a credential or employment; and

(6) The percentage of participants in unsubsidized employment during the second quarter after exit from the program who were employed by the same employer in the second and fourth quarters after exit.

(b) In addition to the performance indicators in paragraphs (a)(1) through (6) of this section, the Secretary, in consultation with the Native American Employment and Training Council, must develop a set of performance indicators and standards that is in addition to the primary indicators of performance that are applicable to the INA program under this section.

[81 FR 56428, Aug. 19, 2016, as amended at 89 FR 13613, Feb. 23, 2024]

Subpart E—Services to Communities

§ 684.500 What services may Indian and Native American grantees provide to or for employers under the Workforce Innovation and Opportunity Act?

(a) INA program grantees may provide a variety of services to employers in their areas. These services may include:

(1) Workforce planning which involves the recruitment of current or potential program participants, including job restructuring services;

(2) Recruitment and assessment of potential employees, with priority given to potential employees who are or who might become eligible for program services;

(3) Pre-employment training;

(4) Customized training;

(5) OJT;

(6) Post-employment services, including training and support services to encourage job retention and upgrading;

(7) Work experience for public or private sector work sites; and

(8) Other innovative forms of worksite training.

(b) In addition to the services listed in paragraph (a) of this section, other grantee-determined services (as described in the grantee's 4-year plan), which are intended to assist eligible participants to obtain or retain employment also may be provided to or for employers.

§ 684.510 What services may Indian and Native American grantees provide to the community at large under the Workforce Innovation and Opportunity Act?

(a) INA program grantees may provide services to the INA communities in their service areas by engaging in program development and service delivery activities which:

(1) Strengthen the capacity of Indian-controlled institutions to provide education and work-based learning services to INA youth and adults, whether directly or through other INA institutions such as tribal colleges;

(2) Increase the community's capacity to deliver supportive services, such as child care, transportation, housing, health, and similar services needed by clients to obtain and retain employment;

(3) Use program participants engaged in education, training, work experience, or similar activities to further the economic and social development of INA communities in accordance with the goals and values of those communities; and

(4) Engage in other community-building activities described in the INA program grantee's 4-year plan.

(b) INA program grantees should develop their 4-year plan in conjunction with, and in support of, strategic tribal planning and community development goals.

§ 684.520 Must Indian and Native American program grantees give preference to Indian and Native American entities in the selection of contractors or service providers?

Yes, INA program grantees must give as much preference as possible to Indian organizations and to Indian-owned economic enterprises, as defined in sec. 3 of the Indian Financing Act of 1974 (25 U.S.C. 1452), when awarding any contract or subgrant.

§ 684.530 What rules govern the issuance of contracts and/or subgrants?

In general, INA program grantees must follow the rules of Uniform Administrative Requirements, Cost Principles, & Audit Requirements for Federal Awards when awarding contracts and/or subgrants under WIOA sec. 166. These requirements are codified at 2 CFR part 200, subpart E (and Department modifications at 2 CFR part 2900), and covered in WIOA regulations at § 683.200 of this chapter. These rules do not apply to OJT contract awards.

Subpart F—Accountability for Services and Expenditures

§ 684.600 To whom is the Indian and Native American program grantee accountable for the provision of services and the expenditure of Indian and Native American funds?

(a) The INA program grantee is responsible to the INA community to be served by INA funds.

(b) The INA program grantee also is responsible to the Department of Labor, which is charged by law with ensuring that all WIOA funds are expended:

(1) According to applicable laws and regulations;

(2) For the benefit of the identified INA client group; and

(3) For the purposes approved in the grantee's plan and signed grant document.

§ 684.610 How is this accountability documented and fulfilled?

(a) Each INA program grantee must establish its own internal policies and procedures to ensure accountability to the INA program grantee's governing body, as the representative of the INA community(ies) served by the INA program. At a minimum, these policies and procedures must provide a system for governing body review and oversight of program plans and measures and standards for program performance.

(b) Accountability to the Department is accomplished in part through on-site

program reviews (monitoring), which strengthen the INA program grantee's capability to deliver effective services and protect the integrity of Federal funds.

(c) In addition to audit information, as described at § 684.860 and program reviews, accountability to the Department is documented and fulfilled by the submission of quarterly financial and program reports, and compliance with the terms and conditions of the grant award.

§ 684.620 What performance indicators are in place for the Indian and Native American program?

(a) Pursuant to WIOA secs. 166(e)(5) and 166(h), the performance indicators at WIOA sec. 116(b)(2)(A)(i) apply to the INA program which must include:

(1) The percentage of program participants who are in unsubsidized employment during the second quarter after exit from the program;

(2) The percentage of program participants who are in unsubsidized employment during the fourth quarter after exit from the program;

(3) The median earnings of program participants who are in unsubsidized employment during the second quarter after exit from the program;

(4) The percentage of program participants who obtain a recognized postsecondary credential, or a secondary school diploma or its recognized equivalent (subject to WIOA sec. 116(b)(2)(A)(iii)) during participation in or within 1 year after exit from the program;

(5) The percentage of program participants who, during a program year, are in an education or training program that leads to a recognized postsecondary credential or employment and who are achieving measurable skill gains toward such a credential or employment; and

(6) The percentage of participants in unsubsidized employment during the second quarter after exit from the program who were employed by the same employer in the second and fourth quarters after exit.

(b) In addition to the performance indicators at WIOA sec. 116(b)(2)(A)(i), the Department, in consultation with the Native American Employment and Training Council, must develop a set of performance indicators and standards that are applicable to the INA program.

[81 FR 56428, Aug. 19, 2016, as amended at 89 FR 13613, Feb. 23, 2024]

§ 684.630 What are the requirements for preventing fraud and abuse under the WIOA?

(a) INA program grantees must establish such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursal of, and accounting for, Federal funds. Such procedures must ensure that all financial transactions are conducted and records maintained in accordance with generally accepted accounting principles.

(b) Each INA program grantee must have rules to prevent conflict of interest by its governing body. These conflict of interest rules must include a rule prohibiting any member of any governing body or council associated with the INA program grantee from voting on any matter which would provide a direct financial benefit to that member, or to a member of his or her immediate family, in accordance with § 683.200(c)(5)(iii) of this chapter and 2 CFR parts 200 and 2900.

(c) Officers or agents of the INA program grantee must not solicit or personally accept gratuities, favors, or anything of monetary value from any actual or potential contractor, subgrantee, vendor, or participant. This rule also must apply to officers or agents of the grantee's contractors and/or subgrantees. This prohibition does not apply to:

(1) Any rebate, discount, or similar incentive provided by a vendor to its customers as a regular feature of its business; and

(2) Items of nominal monetary value distributed consistent with the cultural practices of the INA community served by the grantee.

(d) No person who selects program participants or authorizes the services provided to them may select or authorize services to any participant who is such a person's spouse, parent, sibling, or child unless:

(1)(i) The participant involved is a low-income individual; or

(ii) The community in which the participant resides has a population of less than 1,000 INAs combined; and

(2) The INA program grantee has adopted and implemented the policy described in the 4-year plan to prevent favoritism on behalf of such relatives.

(e) INA program grantees are subject to the provisions of 41 U.S.C. 8702 relating to kickbacks.

(f) No assistance provided under WIOA may involve political activities.

(g) INA program grantees must comply with the restrictions on lobbying activities pursuant to sec. 195 of WIOA and the restrictions on lobbying codified in the Department regulations at 29 CFR part 93.

(h) The provisions of 18 U.S.C. 665 and 666 prohibiting embezzlement apply to programs under WIOA.

(i) Recipients of financial assistance under WIOA sec. 166 are prohibited from discriminatory practices as outlined at WIOA sec. 188, and the regulations implementing WIA sec. 188, at 29 CFR part 38. However, this does not affect the legal requirement that all INA participants be INAs. Also, INA program grantees are not obligated to serve populations outside the geographic boundaries for which they receive funds. However, INA program grantees are not precluded from serving eligible individuals outside their geographic boundaries if the INA program grantee chooses to do so.

§ 684.640 What grievance systems must an Indian and Native American program grantee provide?

INA program grantees must establish grievance procedures consistent with the requirements of WIOA sec. 181(c) and § 683.600 of this chapter.

§ 684.650 Can Indian and Native American grantees exclude segments of the eligible population?

(a) No, INA program grantees cannot exclude segments of the eligible population except as otherwise provided in this part. INA program grantees must document in their 4-year plan that a system is in place to afford all members of the eligible population within the service area for which the grantee was designated an equitable opportunity to receive WIOA services and activities.

(b) Nothing in this section restricts the ability of INA program grantees to target subgroups of the eligible population (for example, the disabled, substance abusers, TANF recipients, or similar categories), as outlined in an approved 4-year plan. However, it is unlawful to target services to subgroups on grounds prohibited by WIOA sec. 188 and 29 CFR part 38, including tribal affiliation (which is considered national origin). Outreach efforts, on the other hand, may be targeted to any subgroups.

Subpart G—Section 166 Planning/Funding Process

§ 684.700 What is the process for submitting a 4-year plan?

Every 4 years, INA program grantees must submit a 4-year strategy for meeting the needs of INAs in accordance with WIOA sec. 166(e). This plan will be part of, and incorporated with, the 4-year competitive process described in WIOA sec. 166(c) and § 684.220. Accordingly, specific requirements for the submission of a 4-year plan will be provided in a FOA and will include the information described at § 684.710.

§ 684.710 What information must be included in the 4-year plans as part of the competitive application?

(a) The 4-year plan, which will be submitted as part of the competitive process, must include the information required at WIOA secs. 166(e)(2)–(5) which are:

(1) The population to be served;

(2) The education and employment needs of the population to be served and the manner in which the activities to be provided will strengthen the ability of the individuals served to obtain or retain unsubsidized employment leading to self-sufficiency;

(3) A description of the activities to be provided and the manner in which such activities are to be integrated with other appropriate activities; and

(4) A description of the performance indicators and expected levels of performance.

(b) The 4-year plan also must include any additional information requested in the FOA.

(c) INA program grantees receiving supplemental youth funds will be required to provide additional information (at a minimum the number of youth it plans to serve and the projected performance outcomes) in the 4-year plan that describes a strategy for serving low-income, INA youth. Additional information required for supplemental youth funding will be identified in the FOA.

§ 684.720 When must the 4-year plan be submitted?

The 4-year plans will be submitted as part of the competitive FOA process described at § 684.220. Accordingly, the due date for the submission of the 4-year plan will be specified in the FOA.

§ 684.730 How will the Department review and approve such plans?

(a) It is the Department's intent to approve a grantee's 4-year strategic plan before the date on which funds for the program become available unless:

(1) The planning documents do not contain the information specified in the regulations in this part and/or the FOA; or

(2) The services which the INA program grantee proposes are not permitted under WIOA or applicable regulations.

(b) After competitive grant selections have been made, the DINAP office will assist INA program grantees in resolving any outstanding issues with the 4-year plan. However, the Department may delay funding to grantees until all issues have been resolved. If the issues with the application of an incumbent grantee cannot be solved, the Department will reallocate funds from the grantee to other grantees that have an approved 4-year plan. The Grant Officer may delay executing a grant agreement and obligating funds to an entity selected through the competitive process until all the required documents—including the 4-year plan—are in place and satisfactory.

(c) The Department may approve a portion of the plan and disapprove other portions.

(d) The grantee also has the right to appeal a nonselection decision or a decision by the Department to deny or reallocate funds based on unresolved issues with the applicant's application or 4-year plan. Such an appeal would go to the Office of the Administrative Law Judges under procedures at § 683.800 or § 683.840 of this chapter in the case of a nonelection.

§ 684.740 Under what circumstances can the Department or the Indian and Native American grantee modify the terms of the grantee's plan(s)?

(a) The Department may unilaterally modify the INA program grantee's plan to add funds or, if required by Congressional action, to reduce the amount of funds available for expenditure.

(b) The INA program grantee may request approval to modify its plan to add, expand, delete, or diminish any service allowable under the regulations in this part. The INA program grantee may modify its plan without our approval, unless the modification reduces the total number of participants to be served annually under the grantee's program by a number which exceeds 25 percent of the participants previously proposed to be served, or by 25 participants, whichever is larger.

Subpart H—Administrative Requirements

§ 684.800 What systems must an Indian and Native American program grantee have in place to administer an Indian and Native American program?

(a) Each INA program grantee must have a written system describing the procedures the grantee uses for:

(1) The hiring and management of personnel paid with program funds;

(2) The acquisition and management of property purchased with program funds;

(3) Financial management practices;

(4) A participant grievance system which meets the requirements in sec. 181(c) of WIOA and § 683.600 of this chapter; and

(5) A participant records system.

(b) Participant records systems must include:

(1) A written or computerized record containing all the information used to determine the person's eligibility to receive program services;

(2) The participant's signature certifying that all the eligibility information he or she provided is true to the best of his/her knowledge; and

(3) The information necessary to comply with all program reporting requirements.

§ 684.810 What types of costs are allowable expenditures under the Indian and Native American program?

Rules relating to allowable costs under WIOA are covered in §§ 683.200 through 683.215 of this chapter.

§ 684.820 What rules apply to administrative costs under the Indian and Native American program?

The definition and treatment of administrative costs are covered in §§ 683.205(b) and 683.215 of this chapter.

§ 684.830 Does the Workforce Innovation and Opportunity Act administrative cost limit for States and local areas apply to WIOA grants?

No, under § 683.205(b) of this chapter, limits on administrative costs for sec. 166 grants will be negotiated with the grantee and identified in the grant award document.

§ 684.840 How must Indian and Native American program grantees classify costs?

Cost classification is covered in the WIOA regulations at §§ 683.200 through 683.215 of this chapter. For purposes of the INA program, program costs also include costs associated with other activities such as TERO, and supportive services, as defined in WIOA sec. 3(59).

§ 684.850 What cost principles apply to Indian and Native American funds?

The cost principles at 2 CFR part 200, subpart E, Uniform Administrative Requirements, Cost Principles, & Audit Requirements for Federal Awards, and the Department's modifications to 2 CFR part 200, subpart E, at 2 CFR part 2900, apply to INA program grantees.

§ 684.860 What audit requirements apply to Indian and Native American grants?

(a) WIOA sec. 166 grantees must follow the audit requirements at 2 CFR part 200, subpart F, Uniform Administrative Requirements, Cost Principles, & Audit Requirements for Federal Awards, and the Department's modifications to 2 CFR part 200 at 2 CFR part 2900.

(b) Grants made and contracts and cooperative agreements entered into under sec. 166 of WIOA are subject to the requirements of chapter 75 of subtitle V of title 31, United States Code, and charging of costs under this section are subject to appropriate circulars issued by the Office of Management and Budget and to 2 CFR part 200 and the Department's modifications to 2 CFR part 200 at 2 CFR part 2900.

§ 684.870 What is "program income" and how is it regulated in the Indian and Native American program?

(a) Program income is regulated by WIOA sec. 194(7)(A), §§ 683.200(c)(6) through (8) and 683.300(c)(5) of this chapter, and the applicable rules in 2 CFR parts 200 and 2900.

(b) For grants made under this part, program income does not include income generated by the work of a work experience participant in an enterprise, including an enterprise owned by an INA entity, whether in the public or private sector.

(c) Program income does not include income generated by the work of an OJT participant in an establishment under paragraph (b) of this section.

Subpart I—Miscellaneous Program Provisions

§ 684.900 Does the Workforce Innovation and Opportunity Act provide regulatory and/or statutory waiver authority?

Yes, WIOA sec. 166(i)(3) permits waivers of any statutory or regulatory requirement of title I of WIOA that are inconsistent with the specific needs of the INA program grantee (except for

the areas cited in § 684.920). Such waivers may include those necessary to facilitate WIOA support of long-term community development goals.

§ 684.910 What information is required in a waiver request?

(a) To request a waiver, an INA program grantee must submit a waiver request indicating how the waiver will improve the grantee's WIOA program activities. The waiver process will be generally consistent with, but not identical to, the waiver requirements under sec. 189(i)(3)(B) of WIOA. INA program grantees may submit a waiver request as part of the 4-year strategic plan.

(b) A waiver may be requested at the beginning of a 4-year grant award cycle or anytime during a 4-year award cycle. However, all waivers expire at the end of the 4-year award cycle. INA program grantees seeking to continue an existing waiver in a new 4-year grant cycle must submit a new waiver request in accordance with paragraph (a) of this section.

§ 684.920 What provisions of law or regulations may not be waived?

Requirements relating to:

(a) Wage and labor standards;

(b) Worker rights;

(c) Participation and protection of workers and participants;

(d) Grievance procedures;

(e) Judicial review; and

(f) Non-discrimination may not be waived.

§ 684.930 May Indian and Native American program grantees combine or consolidate their employment and training funds?

Yes. INA program grantees may consolidate their employment and training funds under WIOA with assistance received from related programs in accordance with the provisions of the Public Law 102–477, the Indian Employment, Training, and Related Services Demonstration Act of 1992, as amended by Public Law 106–568, the Omnibus Indian Advancement Act of 2000 (25 U.S.C. 3401 *et seq.*). WIOA funds consolidated under Public Law 102–477 are administered by Department of the Interior (DOI). Accordingly, the administrative oversight for funds transferred to DOI, including the reporting of financial expenditures and program outcomes are the responsibility of DOI. However, the Department must review the initial 477 plan and ensure that all Departmental programmatic and financial obligations have been met before WIOA funds are approved to be transferred to DOI and consolidated with other related programs. The initial plan must meet the statutory requirements of WIOA. After approval of the initial plan, all subsequent plans that are renewed or updated from the initial plan may be approved by DOI without further review by the Department.

§ 684.940 What is the role of the Native American Employment and Training Council?

The Native American Employment and Training Council is a body composed of representatives of the grantee community which advises the Secretary on the operation and administration of the INA employment and training program. WIOA sec. 166(i)(4) continues the Council essentially as it is currently constituted. The Department continues to support the Council.

§ 684.950 Does the Workforce Innovation and Opportunity Act provide any additional assistance to unique populations in Alaska and Hawaii?

Yes. Notwithstanding any other provision of law, the Secretary is authorized to award grants, on a competitive basis, to entities with demonstrated experience and expertise in developing and implementing programs for the unique populations who reside in Alaska or Hawaii, including public and private nonprofit organizations, tribal organizations, American Indian tribal colleges or universities, institutions of higher education, or consortia of such organizations or institutions, to improve job training and workforce investment activities for such unique populations.

PART 685—NATIONAL FARMWORKER JOBS PROGRAM UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

Subpart A—Purpose and Definitions

Sec.

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Subpart A—Purpose and Definitions

§ 685.100 What is the purpose of the National Farmworker Jobs Program and the other services and activities established under the Workforce Innovation and Opportunity Act?

The purpose of the NFJP and the other services and activities established under WIOA sec. 167 is to strengthen the ability of eligible migrant and seasonal farmworkers (MSFWs) and their dependents to obtain or retain unsubsidized employment, stabilize their unsubsidized employment and achieve economic self-sufficiency, including upgraded employment in agriculture. This part provides the regulatory requirements applicable to the expenditure of WIOA secs. 167 and 127(a)(1) funds for such programs, services, and activities.

§ 685.110 What definitions apply to this program?

In addition to the definitions found in § 675.300 of this chapter, the following definitions apply to programs under this part:

Allowances means direct payments made to participants during their enrollment to enable them to participate in the career services described in WIOA sec. 134(c)(2)(A)(xii) or training services as appropriate.

Dependent means an individual who:

(1) Was claimed as a dependent on the eligible MSFW's Federal income tax return for the previous year; or

(2) Is the spouse of the eligible MSFW; or

(3) If not claimed as a dependent for Federal income tax purposes, is able to establish:

(i) A relationship as the eligible MSFW's;

(A) Child, grandchild, great grandchild, including legally adopted children;

(B) Stepchild;

(C) Brother, sister, half-brother, half-sister, stepbrother, or stepsister;

(D) Parent, grandparent, or other direct ancestor but not foster parent;

(E) Foster child;

(F) Stepfather or stepmother;

(G) Uncle or aunt;

(H) Niece or nephew;

(I) Father-in-law, mother-in-law, son-in-law; or

(J) Daughter-in-law, brother-in-law, or sister-in-law; and

(ii) The receipt of over half of his/her total support from the eligible MSFW's family during the eligibility determination period.

Eligibility determination period means any consecutive 12-month period within the 24-month period immediately preceding the date of application for the MSFW program by the applicant MSFW.

Eligible migrant farmworker means an eligible seasonal farmworker as defined in WIOA sec. 167(i)(3) whose agricultural labor requires travel to a job site such that the farmworker is unable to return to a permanent place of residence within the same day; and dependents of the migrant farmworker, as described in WIOA sec. 167(i)(2).

Eligible migrant and seasonal farmworker means an eligible migrant farmworker or an eligible seasonal farmworker, also referred to in this regulation as an ''*eligible MSFW*,'' as defined in WIOA sec. 167(i).

Eligible MSFW youth means an eligible MSFW aged 14–24 who is individually eligible or is a dependent of an eligible MSFW. The term *eligible MSFW youth* is a subset of the term *eligible MSFW* defined in this section.

Eligible seasonal farmworker means a low-income individual who for 12 consecutive months out of the 24 months prior to application for the program involved, has been primarily employed in agricultural or fish farming labor that is characterized by chronic unemployment or underemployment; and faces multiple barriers to economic self-sufficiency; and dependents of the seasonal farmworker as described in WIOA sec. 167(i)(3).

Emergency assistance is a form of ''related assistance'' and means assistance provided by grantees that addresses immediate needs of eligible MSFWs and their dependents. An applicant's self-certification is accepted as sufficient documentation of eligibility for emergency assistance.

Family, for the purpose of reporting housing assistance grantee indicators of performance as described in in

§ 685.400, means the eligible MSFW(s) and all the individuals identified under the definition of *dependent* in this section who are living together in one physical residence.

Farmwork means work while employed in the occupations described in § 651.10 of this chapter.

Grantee means an entity to which the Department directly awards a WIOA grant to carry out programs to serve eligible MSFWs in a service area, with funds made available under WIOA sec. 167 or 127(a)(1).

Housing assistance means housing services which contribute to safe and sanitary temporary and permanent housing constructed, supplied, or maintained with NFJP funding.

Lower living standard income level means the income level as defined in WIOA sec. 3(36)(B).

Low-income individual means an individual as defined in WIOA sec. 3(36)(A).

MOU means Memorandum of Understanding.

National Farmworker Jobs Program (NFJP) is the Department of Labor-administered workforce investment program for eligible MSFWs established by WIOA sec. 167 as a required partner of the one-stop delivery system and includes both career services and training grants, and housing grants.

Recognized postsecondary credential means a credential as defined in WIOA sec. 3(52).

Related assistance means short-term forms of direct assistance designed to assist eligible MSFWs retain or stabilize their agricultural employment. Examples of related assistance may include, but are not limited to, services such as transportation assistance or providing work clothing.

Self-certification means an eligible MSFW's signed attestation that the information he/she submits to demonstrate eligibility for the NFJP is true and accurate.

Service area means the geographical jurisdiction, which may be comprised of one or more designated State or sub-State areas, in which a WIOA sec. 167 grantee is designated to operate.

Supportive services means the services defined in WIOA sec. 3(59).

Technical assistance means the guidance provided to grantees and grantee staff by the Department to improve the quality of the program and the delivery of program services to eligible MSFWs.

§ 685.120 How does the Department administer the National Farmworker Jobs Program?

The Department's Employment and Training Administration (ETA) administers NFJP activities required under WIOA sec. 167 for eligible MSFWs. As described in § 685.210, the Department designates grantees using procedures consistent with standard Federal government competitive procedures.

§ 685.130 How does the Department assist grantees to serve eligible migrant and seasonal farmworkers?

The Department provides guidance, administrative support, technical assistance, and training to grantees for the purposes of program implementation, and program performance management to enhance services and promote continuous improvement in the employment outcomes of eligible MSFWs.

§ 685.140 What Workforce Innovation and Opportunity Act (WIOA) regulations apply to the programs authorized under WIOA?

The regulations that apply to programs authorized under WIOA sec. 167 include but are not limited to:

(a) The regulations found in this part;

(b) The general administrative requirements found in part 683 of this chapter, including the regulations concerning Complaints, Investigations and Hearings found at part 683, subparts D through H, of this chapter, which cover programs under WIOA sec. 167;

(c) Uniform Guidance at 2 CFR part 200 and the Department's exceptions at 2 CFR part 2900 pursuant to the effective dates in 2 CFR parts 200 and 2900;

(d) The regulations on partnership responsibilities contained in parts 679 (Statewide and Local Governance) and 678 (the One-Stop System) of this chapter; and

(e) The Department's regulations at 29 CFR part 38, which implement the nondiscrimination provisions of WIOA sec. 188.

Subpart B—The Service Delivery System for the National Farmworker Jobs Program

§ 685.200 Who is eligible to receive a National Farmworker Jobs Program grant?

To be eligible to receive a grant under this section, an entity must have:

(a) An understanding of the problems of eligible MSFWs;

(b) A familiarity with the agricultural industries and the labor market needs of the proposed service area; and

(c) The ability to demonstrate a capacity to administer and deliver effectively a diversified program of workforce investment activities, including youth workforce investment activities, and related assistance for eligible MSFWs.

§ 685.210 How does an eligible entity become a grantee?

To become a grantee and receive a grant under this subpart, an applicant must respond to a Funding Opportunity Announcement (FOA). Under the FOA, grantees will be selected using standard Federal government competitive procedures. The entity's proposal must include a program plan, which is a 4-year strategy for meeting the needs of eligible MSFWs in the proposed service area, and a description of the entities experience working with the broader workforce delivery system. Unless specified otherwise in the FOA, grantees may serve eligible MSFWs, including eligible MSFW youth, under the grant. An applicant whose application for funding as a grantee under this section is denied in whole or in part may request an administrative review under § 683.800 of this chapter.

§ 685.220 What is the role of the grantee in the one-stop delivery system?

In those local areas where the grantee operates its NFJP as described in its grant agreement, the grantee is a required one-stop partner, and is subject to the provisions relating to such partners described in part 678 of this chapter. Consistent with those provisions, the grantee and Local Workforce Development Board (WDB) must develop and enter into an MOU which meets the requirements of § 678.500 of this chapter, and which sets forth their respective responsibilities for providing access to the full range of NFJP services through the one-stop delivery system to eligible MSFWs.

§ 685.230 Can a grantee's designation be terminated?

Yes, a grantee's designation may be terminated by the Department for cause:

(a) In emergency circumstances when such action is necessary to protect the integrity of Federal funds or to ensure the proper operation of the program. Any grantee so terminated will be provided with written notice and an opportunity for a hearing within 30 days after the termination; or

(b) By the Department's Grant Officer, if the recipient materially fails to comply with the terms and conditions of the award. In such a case, the Grant Officer will follow the administrative regulations at § 683.440 of this chapter.

§ 685.240 How does the Department use funds appropriated under the Workforce Innovation and Opportunity Act for the National Farmworker Jobs Program?

At least 99 percent of the funds appropriated each year for WIOA sec. 167 activities must be allocated to service areas, based on the distribution of the eligible MSFW population determined under a formula established by the Secretary. The Department will award grants pursuant to § 685.210 for the provision of services to eligible MSFWs within each service area. The Department will use a percentage of the funds allocated for State service areas for housing grants, specified in a FOA issued by the Department. The Department will use up to one percent of the appropriated funds for discretionary purposes, such as technical assistance to eligible entities and other activities prescribed by the Secretary.

Subpart C—The National Farmworker Jobs Program Services to Eligible Migrant and Seasonal Farmworkers

§ 685.300 What are the general responsibilities of grantees?

(a) The Department awards career services and training grants and housing grants through the FOA process described in § 685.210. Career services and training grantees are responsible for providing appropriate career services, training, and related assistance to eligible MSFWs. Housing grantees are responsible for providing housing assistance to eligible MSFWs.

(b) Grantees will provide these services in accordance with the service delivery strategy meeting the requirements of § 685.310 and as described in their approved program plan described in § 685.420. These services must reflect the needs of the MSFW population in the service area and include the services that are necessary to achieve each participant's employment goals or housing needs.

(c) Grantees are responsible for coordinating services, particularly outreach to MSFWs, with the State Workforce Agency as defined in § 651.10 of this chapter and the State's Monitor Advocate.

(d) Grantees are responsible for fulfilling the responsibilities of one-stop partners described in § 678.420 of this chapter.

§ 685.310 What are the basic components of a National Farmworker Jobs Program service delivery strategy?

The NFJP service delivery strategy must include:

(a) A customer-focused case management approach;

(b) The provision of workforce investment activities to eligible MSFWs which include career services and training, as described in WIOA secs. 167(d) and 134, and part 680 of this chapter;

(c) The provision of youth workforce investment activities described in WIOA sec. 129 and part 681 of this chapter may be provided to eligible MSFW youth;

(d) The arrangements under the MOUs with the applicable Local WDBs for the delivery of the services available through the one-stop delivery system to MSFWs; and

(e) Related assistance services.

§ 685.320 Who is eligible to receive services under the National Farmworker Jobs Program?

Eligible migrant farmworkers (including eligible MSFW youth) and eligible seasonal farmworkers (including eligible MSFW youth) as defined in § 685.110 are eligible for services funded by the NFJP.

§ 685.330 How are services delivered to eligible migrant and seasonal farmworkers?

To ensure that all services are focused on the customer's needs, services are provided through a case-management approach emphasizing customer choice and may include: Appropriate career services and training; related assistance, which includes emergency assistance; and supportive services, which includes allowance payments. The basic services and delivery of case-management activities are further described in §§ 685.340 through 685.390.

§ 685.340 What career services may grantees provide to eligible migrant and seasonal farmworkers?

(a) Grantees may provide the career services described in WIOA secs. 167(d) and 134(c)(2), and part 680 of this chapter to eligible MSFWs.

(b) Grantees may provide other services identified in the approved program plan.

(c) The delivery of career services to eligible MSFWs by the grantee and through the one-stop delivery system must be discussed in the required MOU between the Local WDB and the grantee.

§ 685.350 What training services may grantees provide to eligible migrant and seasonal farmworkers?

(a) Grantees may provide the training activities described in WIOA secs. 167(d) and 134(c)(3)(D), and part 680 of this chapter to eligible MSFWs. These activities include, but are not limited to, occupational-skills training and on-the-job training (OJT). Eligible MSFWs

are not required to receive career services prior to receiving training services.

(1) When providing OJT services NFJP grantees may reimburse employers for the extraordinary costs of training by up to 50 percent of the wage rate of the participant for OJT.

(2) Grantees also may increase the OJT reimbursement rate up to 75 percent of the wage rate of a participant under certain conditions, provided that such reimbursement is being provided consistent with the reimbursement rates used under WIOA sec. 134(c)(3)(H)(i) for the local area(s) in which the grantee operates its program.

(b) Training services must be directly linked to an in-demand industry sector or occupation in the service area, or in another area to which an eligible MSFW receiving such services is willing to relocate.

(c) Training activities must encourage the attainment of recognized post-secondary credentials as defined in § 685.110 when appropriate for an eligible MSFW.

§ 685.360 What housing services may grantees provide to eligible migrant and seasonal farmworkers?

(a) Housing grantees must provide housing services to eligible MSFWs.

(b) Career services and training grantees may provide housing services to eligible MSFWs as described in their program plan.

(c) Housing services may include the following:

(1) Permanent housing that is owner-occupied, or occupied on a permanent, year-round basis (notwithstanding ownership) as the eligible MSFW's primary residence to which he/she returns at the end of the work or training day.

(i) Types of permanent housing may include rental units, single family homes, duplexes, and other multi-family structures, dormitories, group homes, and other housing types that provide short-term, seasonal, or year-round housing opportunities in permanent structures. Modular structures, manufactured housing, or mobile units placed on permanent foundations and supplied with appropriate utilities, and other infrastructure also are considered permanent housing.

(ii) Permanent housing services include but are not limited to: Investments in development services, project management, and resource development to secure acquisition, construction/renovation and operating funds, property management services, and program management. New construction, purchase of existing structures, and rehabilitation of existing structures, as well as the infrastructure, utilities, and other improvements necessary to complete or maintain those structures also may be considered part of managing permanent housing.

(2) Temporary housing that is not owner-occupied and is used by MSFWs whose employment requires occasional travel outside their normal commuting area.

(i) Types of temporary housing may include: Housing units intended for temporary occupancy located in permanent structures, such as rental units in an apartment complex or in mobile structures that provide short-term, seasonal housing opportunities; temporary structures that may be moved from site to site, dismantled and re-erected when needed for farmworker occupancy, closed during the off-season, or handled through other similar arrangements; off-farm housing operated independently of employer interest in, or control of, the housing; or on-farm housing located on property owned by an agricultural employer and operated by an entity such as an agricultural employer or a nonprofit organization; and other housing types that provide short-term, seasonal, or temporary housing opportunities in temporary structures.

(ii) Temporary housing services include but are not limited to: Managing temporary housing which may involve property management of temporary housing facilities, case management, and referral services, and emergency housing payments, including vouchers and cash payments for rent/lease and utilities.

(d) Permanent housing developed with NFJP funds must be promoted and made widely available to eligible MSFWs, but occupancy is not restricted to eligible MSFWs. Temporary

housing services must only be provided to eligible MSFWs.

(e) Except as provided in paragraph (f) of this section, NFJP funds used for housing assistance must ensure the provision of safe and sanitary temporary and permanent housing that meets the Federal housing standards at part 654 of this chapter (ETA housing for farmworkers) or 29 CFR 1910.10 (OSHA housing standards).

(f) When NFJP grantees provide temporary housing assistance that allows the participant to select the housing, including vouchers and cash payments for rent, lease, and utilities, NFJP grantees are not required to ensure that such housing meets the Federal housing standards at part 654 of this chapter or 29 CFR 1910.10.

§ 685.370 What services may grantees provide to eligible migrant and seasonal farmworkers youth participants aged 14–24?

(a) Based on an evaluation and assessment of the needs of eligible MSFW youth, grantees may provide activities and services that include but are not limited to:

(1) Career services and training as described in §§ 685.340 and 685.350;

(2) Youth workforce investment activities specified in WIOA sec. 129;

(3) Life skills activities which may include self- and interpersonal skills development;

(4) Community service projects; and

(5) Other activities and services that conform to the use of funds for youth activities described in part 681 of this chapter.

(b) Grantees may provide these services to any eligible MSFW youth, regardless of the participant's eligibility for WIOA title I youth activities as described in WIOA sec. 129(a).

§ 685.380 What related assistance services may be provided to eligible migrant and seasonal farmworkers?

Related assistance may include short-term direct services and activities. Examples include emergency assistance, as defined in § 685.110, and those activities identified in WIOA sec. 167(d), such as: English language and literacy instruction; pesticide and worker safety training; housing (including permanent housing), as described in § 685.360 and as provided in the approved program plan; and school dropout prevention and recovery activities. Related assistance may be provided to eligible MSFWs not enrolled in career services, youth services, or training services.

§ 685.390 When may eligible migrant and seasonal farmworkers receive related assistance?

Eligible MSFWs may receive related assistance services when the grantee identifies and documents the need for the related assistance, which may include a statement by the eligible MSFW.

Subpart D—Performance Accountability, Planning, and Waiver Provisions

§ 685.400 What are the indicators of performance that apply to the National Farmworker Jobs Program?

(a) For grantees providing career services and training, the Department will use the indicators of performance common to the adult and youth programs, described in WIOA sec. 116(b)(2)(A).

(b) For grantees providing career services and training, the Department will reach agreement with individual grantees on the levels of performance for each of the primary indicators of performance, taking into account economic conditions, characteristics of the individuals served, and other appropriate factors, and using, to the extent practicable, the statistical adjustment model under WIOA sec. 116(b)(3)(A)(viii). Once agreement on the levels of performance for each of the primary indicators of performance is reached with individual grantees, the Department will incorporate the adjusted levels of performance in the grant plan. For the purposes of performance reporting, eligible MSFWs who receive any career services, youth services, training, or certain related assistance are considered participants as defined in § 677.150 of this chapter and must be included in performance calculations for the indicators of performance. Eligible MSFWs who receive only those services identified in § 677.150(a)(3)(ii) or (iii) of this chapter

are not included in performance calculations for the indicators of performance described in WIOA sec. 116(b)(2)(A).

(c) For grantees providing housing services only, grantees will use the total number of eligible MSFWs served and the total number of eligible MSFW families served as indicators of performance. Additionally, grantees providing permanent housing development activities will use the total number of individuals served and the total number of families served as indicators of performance.

(d) The Department may develop additional performance indicators with appropriate levels of performance for evaluating programs that serve eligible MSFWs and which reflect the State service area economy, local demographics of eligible MSFWs, and other appropriate factors. If additional performance indicators are developed, the levels of performance for these additional indicators must be negotiated with the grantee and included in the approved program plan.

(e) Grantees may develop additional performance indicators and include them in the program plan or in periodic performance reports.

§ 685.410 What planning documents must a grantee submit?

Each grantee receiving WIOA sec. 167 program funds must submit to the Department a comprehensive program plan and a projection of participant services and expenditures in accordance with instructions issued by the Secretary.

§ 685.420 What information is required in the grantee program plan?

A grantee's 4-year program plan must describe:

(a) The service area that the applicant proposes to serve;

(b) The population to be served and the education and employment needs of the MSFW population to be served;

(c) The manner in which proposed services to eligible MSFWs will strengthen their ability to obtain or retain unsubsidized employment or stabilize their unsubsidized employment, including upgraded employment in agriculture;

(d) The related assistance and supportive services to be provided and the manner in which such assistance and services are to be integrated and coordinated with other appropriate services;

(e) The performance accountability measures that will be used to assess the performance of the entity in carrying out the NFJP program activities, including the expected levels of performance for the primary indicators of performance described in § 685.400;

(f) The availability and accessibility of local resources, such as supportive services, services provided through one-stop delivery systems, and education and training activities, and how the resources can be made available to the population to be served;

(g) The plan for providing services including strategies and systems for outreach, career planning, assessment, and delivery through one-stop delivery systems;

(h) The methods the grantee will use to target its services on specific segments of the eligible population, as appropriate; and

(i) Such other information as required by the Secretary in instructions issued under § 685.410.

§ 685.430 Under what circumstances are the terms of the grantee's program plan modified by the grantee or the Department?

(a) Plans must be modified to reflect the funding level for each year of the grant. The Department will provide instructions annually on when to submit modifications for each year of funding, which will generally be no later than June 1 prior to the start of the subsequent year of the grant cycle.

(b) The grantee must submit a request to the Department for any proposed modifications to its plan to add, delete, expand, or reduce any part of the program plan or allowable activities. The Department will consider the cost principles, uniform administrative requirements, and terms and conditions of award when reviewing modifications to program plans.

(c) If the grantee is approved for a regulatory waiver under §§ 685.460 and 685.470, the grantee must submit a

modification of its grant plan to reflect the effect of the waiver.

§ 685.440 How are costs classified under the National Farmworker Jobs Program?

(a) Costs are classified as follows:

(1) Administrative costs, as defined in § 683.215 of this chapter; and

(2) Program costs, which are all other costs not defined as administrative.

(b) Program costs must be classified and reported in the following categories:

(1) Related assistance (including emergency assistance);

(2) Supportive services; and

(3) All other program services.

§ 685.450 What is the Workforce Innovation and Opportunity Act administrative cost limit for National Farmworker Jobs Program grants?

Under § 683.205(b) of this chapter, limits on administrative costs for programs operated under subtitle D of WIOA title I will be identified in the grant or contract award document. Administrative costs will not exceed 15 percent of total grantee funding.

§ 685.460 Are there regulatory and/or statutory waiver provisions that apply to the National Farmworker Jobs Program?

(a) The statutory waiver provision at WIOA sec. 189(i) and discussed in § 679.600 of this chapter does not apply to any NFJP grant under WIOA sec. 167.

(b) Grantees may request waiver of any regulatory provisions only when such regulatory provisions are:

(1) Not required by WIOA;

(2) Not related to wage and labor standards, non-displacement protection, worker rights, participation and protection of workers and participants, and eligibility of participants, grievance procedures, judicial review, nondiscrimination, allocation of funds, procedures for review and approval of plans; and

(3) Not related to the basic purposes of WIOA, described in § 675.100 of this chapter.

§ 685.470 How can grantees request a waiver?

To request a waiver, a grantee must submit to the Department a waiver plan that:

(a) Describes the goals of the waiver, the expected programmatic outcomes, and how the waiver will improve the provision of program activities;

(b) Is consistent with any guidelines the Department establishes;

(c) Describes the data that will be collected to track the impact of the waiver; and

(d) Includes a modified program plan reflecting the effect of the requested waiver.

Subpart E—Supplemental Youth Workforce Investment Activity Funding Under the Workforce Innovation and Opportunity Act

§ 685.500 What is supplemental youth workforce investment activity funding?

Pursuant to WIOA sec. 127(a)(1), if Congress appropriates more than $925 million for WIOA youth workforce investment activities in a fiscal year, 4 percent of the excess amount must be used by the Department to provide workforce investment activities for eligible MSFW youth under WIOA sec. 167.

§ 685.510 What requirements apply to grants funded by the Workforce Innovation and Opportunity Act?

The requirements in subparts A through D of this part apply to grants funded by WIOA sec. 127(a)(1), except that grants described in this subpart must be used only for workforce investment activities for eligible MSFW youth, as described in § 685.370 and WIOA sec. 167(d) (including related assistance and supportive services).

§ 685.520 What is the application process for obtaining a grant funded by the Workforce Innovation and Opportunity Act?

The Department will issue a separate FOA for grants funded by WIOA sec. 127(a)(1). The selection will be made in

accordance with the procedures described in §685.210, except that the Department reserves the right to provide priority to applicants that are WIOA sec. 167 grantees.

§685.530 What planning documents are required for grants funded by the Workforce Innovation and Opportunity Act?

The required planning documents will be described in the FOA.

§685.540 How are funds allocated to grants funded by the Workforce Innovation and Opportunity Act?

The allocation of funds will be based on the comparative merits of the applications, in accordance with criteria set forth in the FOA.

§685.550 Who is eligible to receive services through grants funded by the Workforce Innovation and Opportunity Act?

Eligible MSFW youth as defined in §685.110 are eligible to receive services through grants funded by WIOA sec. 127(a)(1).

PART 686—THE JOB CORPS UNDER TITLE I OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

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Subpart A—Scope and Purpose

§ 686.100 What is the scope of this part?

The regulations in this part outline the requirements that apply to the Job Corps program. More detailed policies and procedures are contained in a Policy and Requirements Handbook issued by the Secretary. Throughout this part, ''instructions (procedures) issued by the Secretary'' and similar references refer to the Policy and Requirements Handbook and other Job Corps directives.

§ 686.110 What is the Job Corps program?

Job Corps is a national program that operates in partnership with States and communities, Local Workforce Development Boards (WDBs), Youth Standing Committees where established, one-stop centers and partners, and other youth programs to provide academic, career and technical education, service-learning, and social opportunities primarily in a residential setting, for low-income young people. The objective of Job Corps is to support responsible citizenship and provide young people with the skills they need to lead to successful careers that will result in economic self-sufficiency and opportunities for advancement in in-demand industry sectors or occupations or the Armed Forces, or to enrollment in postsecondary education.

§ 686.120 What definitions apply to this part?

The following definitions apply to this part:

Absent Without Official Leave (AWOL) means an adverse enrollment status to which a student is assigned based on extended, unapproved absence from his/her assigned center or off-center place of duty. Students do not earn Job Corps allowances while in AWOL status.

Applicable Local WDB means a Local WDB that:

(1) Works with a Job Corps center and provides information on local employment opportunities and the job skills and credentials needed to obtain the opportunities; and

(2) Serves communities in which the graduates of the Job Corps seek employment.

Applicable one-stop center means a one-stop center that provides career transition services, such as referral, assessment, recruitment, and placement, to support the purposes of the Job Corps.

Capital improvement means any modification, addition, restoration or other improvement:

(1) Which increases the usefulness, productivity, or serviceable life of an existing site, facility, building, structure, or major item of equipment;

(2) Which is classified for accounting purposes as a ''fixed asset;'' and

(3) The cost of which increases the recorded value of the existing building, site, facility, structure, or major item of equipment and is subject to depreciation.

Career technical training means career and technical education and training.

Career transition service provider means an organization acting under a contract or other agreement with Job Corps to provide career transition services for graduates and, to the extent possible, for former students.

Civilian Conservation Center (CCC) means a center operated on public land under an agreement between the Department of Labor (the Department) and the Department of Agriculture, which provides, in addition to other training and assistance, programs of

work-based learning to conserve, develop, or manage public natural resources or public recreational areas or to develop community projects in the public interest.

Contract center means a Job Corps center operated under a contract with the Department.

Contracting officer means an official authorized to enter into contracts or agreements on behalf of the Department.

Enrollee means an individual who has voluntarily applied for, been selected for, and enrolled in the Job Corps program, and remains with the program, but has not yet become a graduate. Enrollees also are referred to as ''students'' in this part.

Enrollment means the process by which an individual formally becomes a student in the Job Corps program.

Former enrollee means an individual who has voluntarily applied for, been selected for, and enrolled in the Job Corps program, but left the program prior to becoming a graduate.

Graduate means an individual who has voluntarily applied for, been selected for, and enrolled in the Job Corps program and who, as a result of participation in the program, has received a secondary school diploma or recognized equivalent, or has completed the requirements of a career technical training program that prepares individuals for employment leading to economic self-sufficiency or entrance into postsecondary education or training.

Individual with a disability means an individual with a disability as defined in sec. 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

Interagency agreement means a formal agreement between the Department and another Federal agency administering and operating centers. The agreement establishes procedures for the funding, administration, operation, and review of those centers as well as the resolution of any disputes.

Job Corps means the Job Corps program established within the Department of Labor and described in sec. 143 of the Workforce Innovation and Opportunity Act (WIOA).

Job Corps center means a facility and an organizational entity, including all of its parts, providing Job Corps training and designated as a Job Corps center, as described in sec. 147 of WIOA.

Job Corps Director means the chief official of the Job Corps or a person authorized to act for the Job Corps Director.

Low-income individual means an individual who meets the definition in WIOA sec. 3(36).

National Office means the national office of Job Corps.

National training contractor means a labor union, union-affiliated organization, business organization, association, or a combination of such organizations, which has a contract with the national office to provide career technical training, career transition services, or other services.

Operational support services means activities or services required to support the operation of Job Corps, including:

(1) Outreach and admissions services;

(2) Contracted career technical training and off-center training;

(3) Career transition services;

(4) Continued services for graduates;

(5) Certain health services; and

(6) Miscellaneous logistical and technical support.

Operator means a Federal, State or local agency, or a contractor selected under this subtitle to operate a Job Corps center under an agreement or contract with the Department.

Outreach and admissions provider means an organization that performs recruitment services, including outreach activities, and screens and enrolls youth under a contract or other agreement with Job Corps.

Participant, as used in this part, includes both graduates and enrollees and former enrollees that have completed their career preparation period. It also includes all enrollees and former enrollees who have remained in the program for at least 60 days.

Placement means student employment, entry into the Armed Forces, or enrollment in other training or education programs following separation from Job Corps.

Regional appeal board means the board designated by the Regional Director to consider student appeals of disciplinary discharges.

Regional Director means the chief Job Corps official of a regional office or a person authorized to act for the Regional Director.

Regional office means a regional office of Job Corps.

Regional Solicitor means the chief official of a regional office of the Department of Labor Office of the Solicitor, or a person authorized to act for the Regional Solicitor.

Separation means the action by which an individual ceases to be a student in the Job Corps program, either voluntarily or involuntarily.

Service provider means an entity selected under this subtitle to provide operational support services described in this subtitle to a Job Corps center.

Student means an individual enrolled in the Job Corps.

Unauthorized goods means:

(1) Firearms and ammunition;

(2) Explosives and incendiaries;

(3) Knives;

(4) Homemade weapons;

(5) All other weapons and instruments used primarily to inflict personal injury;

(6) Stolen property;

(7) Drugs, including alcohol, marijuana, depressants, stimulants, hallucinogens, tranquilizers, and drug paraphernalia except for drugs and/or paraphernalia that are prescribed for medical reasons; and

(8) Any other goods prohibited by the Secretary, center director, or center operator in a student handbook.

Subpart B—Site Selection and Protection and Maintenance of Facilities

§ 686.200 How are Job Corps center locations and sizes determined?

(a) The Secretary must approve the location and size of all Job Corps centers based on established criteria and procedures.

(b) The Secretary establishes procedures for making decisions concerning the establishment, relocation, expansion, or closing of contract centers.

§ 686.210 How are center facility improvements and new construction handled?

The Secretary establishes procedures for requesting, approving, and initiating capital improvements and new construction on Job Corps centers.

§ 686.220 Who is responsible for the protection and maintenance of center facilities?

(a) The Secretary establishes procedures for the protection and maintenance of contract center facilities owned or leased by the Department of Labor, that are consistent with the current Federal Property Management Regulations.

(b) The U.S. Department of Agriculture, when operating Civilian Conservation Centers (CCC) on public land, is responsible for the protection and maintenance of CCC facilities.

(c) The Secretary issues procedures for conducting periodic facility surveys of centers to determine their condition and to identify needs such as correction of safety and health deficiencies, rehabilitation, and/or new construction.

Subpart C—Funding and Selection of Center Operators and Service Providers

§ 686.300 What entities are eligible to receive funds to operate centers and provide training and operational support services?

(a) *Center operators.* Entities eligible to receive funds under this subpart to operate centers include:

(1) Federal, State, and local agencies;

(2) Private organizations, including for-profit and non-profit corporations;

(3) Indian tribes and organizations; and

(4) Area career and technical education or residential career and technical schools.

(b) *Service providers.* Entities eligible to receive funds to provide outreach and admissions, career transition services and other operational support services are local or other entities with the necessary capacity to provide activities described in this part to a Job Corps center, including:

(1) Applicable one-stop centers and partners;

(2) Organizations that have a demonstrated record of effectiveness in serving at-risk youth and placing them into employment, including community action agencies; business organizations, including private for-profit and non-profit corporations; and labor organizations; and

(3) Child welfare agencies that are responsible for children and youth eligible for benefits and services under sec. 477 of the Social Security Act (42 U.S.C. 677).

§ 686.310 How are entities selected to receive funding to operate centers?

(a) The Secretary selects eligible entities to operate contract centers on a competitive basis in accordance with applicable statutes and regulations. In selecting an entity, the Secretary issues requests for proposals (RFPs) for the operation of all contract centers according to the Federal Acquisition Regulation (48 CFR chapter 1) and Department of Labor Acquisition Regulation (48 CFR chapter 29). The Secretary develops RFPs for center operators in consultation with the Governor, the center workforce council (if established), and the Local WDB for the workforce development area in which the center is located.

(b) The RFP for each contract center describes uniform specifications and standards, as well as specifications and requirements that are unique to the operation of the specific center.

(c) The contracting officer selects and funds Job Corps contract center operators on the basis of an evaluation of the proposals received using criteria established by the Secretary, and set forth in the RFP. The criteria include the following:

(1) The offeror's ability to coordinate the activities carried out through the Job Corps center with activities carried out under the appropriate State and local workforce investment plans;

(2) The offeror's ability to offer career technical training that has been proposed by the workforce council and the degree to which the training reflects employment opportunities in the local areas in which most of the enrollees intend to seek employment;

(3) The degree to which the offeror demonstrates relationships with the surrounding communities, including employers, labor organizations, State WDBs, Local WDBs, applicable one-stop centers, and the State and region in which the center is located;

(4) The offeror's past performance, if any, relating to operating or providing activities to a Job Corps center, including information regarding the offeror in any reports developed by the Office of the Inspector General of the Department of Labor and the offeror's demonstrated effectiveness in assisting individuals in achieving the indicators of performance for eligible youth described in sec. 116(b)(2)(A)(ii) of WIOA, listed in § 686.1010; and

(5) The offeror's ability to demonstrate a record of successfully assisting at-risk youth to connect to the workforce, including providing them with intensive academics and career technical training.

(d) In order to be eligible to operate a Job Corps center, the offeror also must submit the following information at such time and in such manner as required by the Secretary:

(1) A description of the program activities that will be offered at the center and how the academics and career technical training reflect State and local employment opportunities, including opportunities in in-demand industry sectors and occupations recommended by the workforce council;

(2) A description of the counseling, career transition, and support activities that will be offered at the center, including a description of the strategies and procedures the offeror will use to place graduates into unsubsidized employment or education leading to a recognized postsecondary credential upon completion of the program;

(3) A description of the offeror's demonstrated record of effectiveness in placing at-risk youth into employment and postsecondary education, including past performance of operating a Job Corps center and as appropriate, the entity's demonstrated effectiveness in assisting individuals in achieving the indicators of performance for eligible youth described in sec. 116(b)(2)(A)(ii) of WIOA, listed in § 686.1010;

(4) A description of the relationships that the offeror has developed with State WDBs, Local WDBs, applicable one-stop centers, employers, labor organizations, State and local educational agencies, and the surrounding communities in which the center is located;

(5) A description of the offeror's ability to coordinate the activities carried out through the Job Corps center with activities carried out under the appropriate State Plan and local plans;

(6) A description of the strong fiscal controls the offeror has in place to ensure proper accounting of Federal funds and compliance with the Financial Management Information System established by the Secretary under sec. 159(a) of WIOA;

(7) A description of the steps to be taken to control costs in accordance with the Financial Management Information System established by the Secretary;

(8) A detailed budget of the activities that will be supported using Federal funds provided under this part and non-Federal resources;

(9) An assurance the offeror is licensed to operate in the State in which the center is located;

(10) An assurance that the offeror will comply with basic health and safety codes, including required disciplinary measures and Job Corps' Zero Tolerance Policy; and

(11) Any other information on additional selection factors required by the Secretary.

[81 FR 56443, Aug. 19, 2016, as amended at 84 FR 64740, Nov. 25, 2019]

§ 686.320 What if a current center operator is deemed to be an operator of a high-performing center?

(a) If an offeror meets the requirements as an operator of a high-performing center as applied to a particular Job Corps center, that operator will be allowed to compete in any competitive selection process carried out for an award to operate that center.

(b) An offeror is considered to be an operator of a high-performing center if the Job Corps center operated by the offeror:

(1) Is ranked among the top 20 percent of Job Corps centers for the most recent preceding program year according to the rankings calculated under § 686.1060; and

(2) Meets the expected levels of performance established under § 686.1050 with respect to each of the primary indicators of performance for Job Corps centers:

(i) For the period of the most recent preceding 3 program years for which information is available at the time the determination is made, achieved an average of 100 percent, or higher, of the expected level of performance for the indicator; and

(ii) For the most recent preceding program year for which information is available at the time the determination is made, achieved 100 percent, or higher, of the expected level of performance established for the indicator.

(c) If any of the program years described in paragraphs (b)(2)(i) and (ii) of this section precedes the implementation of the establishment of the expected levels of performance under § 686.1050 and the application of the primary indicators of performance for Job Corps centers identified in § 686.1010, an entity is considered an operator of a high-performing center during that period if the Job Corps center operated by the entity:

(1) Meets the requirements of paragraph (b)(2) of this section with respect to such preceding program years using the performance of the Job Corps center regarding the national goals or targets established by the Office of the Job Corps under the previous performance accountability system for—

(i) The 6-month follow-up placement rate of graduates in employment, the military, education, or training;

(ii) The 12-month follow-up placement rate of graduates in employment, the military, education, or training;

(iii) The 6-month follow-up average weekly earnings of graduates;

(iv) The rate of attainment of secondary school diplomas or their recognized equivalent;

(v) The rate of attainment of completion certificates for career technical training;

(vi) Average literacy gains; and

(vii) Average numeracy gains; or

(2) Is ranked among the top five percent of Job Corps centers for the most

recent preceding program year according to the rankings calculated under § 686.1060.

§ 686.330 What is the length of an agreement entered into by the Secretary for operation of a Job Corps center and what are the conditions for renewal of such an agreement?

(a) Agreements are for not more than a 2-year period. The Secretary may exercise any contractual option to renew the agreement in 1-year increments for not more than 3 additional years.

(b) The Secretary will establish procedures for evaluating the option to renew an agreement that includes: An assessment of the factors described in paragraph (c) of this section; a review of contract performance and financial reporting compliance; a review of the program management and performance data described in §§ 686.1000 and 686.1010; an assessment of whether the center is on a performance improvement plan as described § 686.1070 and if so, whether the center is making measureable progress in completing the actions described in the plan; and an evaluation of the factors described in paragraph (d) of this section.

(c) The Secretary only will renew the agreement of an entity to operate a Job Corps center if the entity:

(1) Has a satisfactory record of integrity and business ethics;

(2) Has adequate financial resources to perform the agreement;

(3) Has the necessary organization, experience, accounting and operational controls, and technical skills; and

(4) Is otherwise qualified and eligible under applicable laws and regulations, including that the contractor is not under suspension or debarred from eligibility for Federal contractors.

(d) The Secretary will not renew an agreement for an entity to operate a Job Corps center for any additional 1-year period if, for both of the 2 most recent preceding program years for which information is available at the time the determination is made, or if a second program year is not available, the preceding year for which information is available, such center:

(1) Has been ranked in the lowest 10 percent of Job Corps centers according to the rankings calculated under § 686.1060; and

(2) Failed to achieve an average of 50 percent or higher of the expected level of performance established under § 686.1050 with respect to each of the primary indicators of performance for eligible youth described in sec. 116(b)(2)(A)(ii) of WIOA, listed in § 686.1010.

(e)(1) Information will be considered to be available for a program year for purposes of paragraph (d) of this section if for each of the primary indicators of performance, all of the students included in the cohort being measured either began their participation under the current center operator or, if they began their participation under the previous center operator, were on center for at least 6 months under the current operator. If an operator assumes operation of a center that meets the criteria under paragraphs (d)(1) and (2) of this section, the first contractual option year will not be denied based on the application of paragraph (d) of this section provided that the operator otherwise meets the requirements for renewal described in paragraphs (a) through (c) of this section.

(2) If complete information for any of the indicators of performance described in paragraph (d)(2) of this section is not available for either of the 2 program years described in paragraph (d) of this section, the Secretary will review partial program year data from the most recent program year for those indicators, if at least two quarters of data are available, when making the determination required under paragraph (d)(2) of this section.

(f) If any of the program years described in paragraph (d) of this section precede the implementation of the establishment of the expected levels of performance under § 686.1050 and the application of the primary indicators of performance for Job Corps centers described in § 686.1010, the evaluation described in paragraph (d) of this section will be based on whether in its operation of the center the entity:

(1) Is ranked among the lowest 10 percent of Job Corps centers for the most recent preceding program year according to the ranking calculated under § 686.1060; and

(2) Meets the requirement of paragraph (d)(2) of this section with respect

to such preceding program years using the performance of the Job Corps center regarding the national goals or targets established by the Office of the Job Corps under the previous performance accountability system for—

(i) The 6-month follow-up placement rate of graduates in employment, the military, education, or training;

(ii) The 12-month follow-up placement rate of graduates in employment, the military, education, or training;

(iii) The 6-month follow-up average weekly earnings of graduates;

(iv) The rate of attainment of secondary school diplomas or their recognized equivalent;

(v) The rate of attainment of completion certificates for career technical training;

(vi) Average literacy gains; and

(vii) Average numeracy gains.

(g) The Secretary can exercise an option to renew the agreement with an entity notwithstanding the requirements in paragraph (d) of this section for no more than 2 additional years if the Secretary determines that a renewal would be in the best interest of the Job Corps program, taking into account factors including:

(1) Significant improvements in program performance in carrying out a performance improvement plan;

(2) That the performance is due to circumstances beyond the control of the entity, such as an emergency or disaster;

(3) A significant disruption in the operations of the center, including in the ability to continue to provide services to students, or significant increase in the cost of such operations; or

(4) A significant disruption in the procurement process with respect to carrying out a competition for the selection of a center operator.

(h) If the Secretary does make an exception and exercises the option to renew per paragraph (g) of this section, the Secretary will provide a detailed explanation of the rationale for exercising the option to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.

§ 686.340 How are entities selected to receive funding to provide outreach and admission, career transition and other operations support services?

(a) The Secretary selects eligible entities to provide outreach and admission, career transition, and operational services on a competitive basis in accordance with applicable statutes and regulations. In selecting an entity, the Secretary issues requests for proposals (RFP) for operational support services according to the Federal Acquisition Regulation (48 CFR chapter 1) and Department of Labor Acquisition Regulation (48 CFR chapter 29). The Secretary develops RFPs for operational support services in consultation with the Governor, the center workforce council (if established), and the Local WDB for the workforce development area in which the center is located.

(b) The RFP for each support service contract describes uniform specifications and standards, as well as specifications and requirements that are unique to the specific required operational support services.

(c) The contracting officer selects and funds operational support service contracts on the basis of an evaluation of the proposals received using criteria established by the Secretary and set forth in the RFP. The criteria may include the following, as applicable:

(1) The ability of the offeror to coordinate the activities carried out in relation to the Job Corps center with related activities carried out under the appropriate State Plan and local plans;

(2) The ability of the entity to offer career technical training that has been proposed by the workforce council and the degree to which the training reflects employment opportunities in the local areas in which most of the students intend to seek employment;

(3) The degree to which the offeror demonstrates relationships with the surrounding communities, including employers, labor organizations, State WDBs, Local WDBs, applicable one-stop centers, and the State and region in which the services are provided;

(4) The offeror's past performance, if any, relating to providing services to a

Job Corps center, including information regarding the offeror in any reports developed by the Office of the Inspector General of the Department of Labor and the offeror's demonstrated effectiveness in assisting individuals in achieving the indicators of performance for eligible youth described in sec. 116(b)(2)(A)(ii) of WIOA, listed in § 686.1010;

(5) The offeror's ability to demonstrate a record of successfully assisting at-risk youth to connect to the workforce; and

(6) Any other information on additional selection factors required by the Secretary.

[81 FR 56443, Aug. 19, 2016, as amended at 84 FR 64740, Nov. 25, 2019]

§ 686.350 What conditions apply to the operation of a Civilian Conservation Center?

(a) The Secretary of Labor may enter into an agreement with the Secretary of Agriculture to operate Job Corps centers located on public land, which are called Civilian Conservation Centers (CCCs). Located primarily in rural areas, in addition to academics, career technical training, and workforce preparation skills training, CCCs provide programs of work experience to conserve, develop, or manage public natural resources or public recreational areas or to develop community projects in the public interest.

(b) When the Secretary of Labor enters into an agreement with the Secretary of Agriculture for the funding, establishment, and operation of CCCs, provisions are included to ensure that the Department of Agriculture complies with the regulations under this part.

(c) Enrollees in CCCs may provide assistance in addressing national, State, and local disasters, consistent with current child labor laws. The Secretary of Agriculture must ensure that enrollees are properly trained, equipped, supervised, and dispatched consistent with the standards for the conservation and rehabilitation of wildlife established under the Fish and Wildlife Coordination Act (16 U.S.C. 661 *et seq.*).

(d) The Secretary of Agriculture must designate a Job Corps National Liaison to support the agreement between the Departments of Labor and Agriculture to operate CCCs.

(e) The Secretary of Labor, in consultation with the Secretary of Agriculture, may select an entity to operate a CCC in accordance with the requirements of § 686.310 if the Secretary of Labor determines appropriate.

(f) The Secretary of Labor has the discretion to close CCCs if the Secretary determines appropriate.

§ 686.360 What are the requirements for award of contracts and payments to Federal agencies?

(a) The requirements of the Federal Property and Administrative Services Act of 1949, as amended; the Federal Grant and Cooperative Agreement Act of 1977; the Federal Acquisition Regulation (48 CFR chapter 1); and the Department of Labor Acquisition Regulation (48 CFR chapter 29) apply to the award of contracts and to payments to Federal agencies.

(b) Job Corps funding of Federal agencies that operate CCCs are made by a transfer of obligational authority from the Department to the respective operating agency.

Subpart D—Recruitment, Eligibility, Screening, Selection and Assignment, and Enrollment

§ 686.400 Who is eligible to participate in the Job Corps program?

(a) To be eligible to participate in the Job Corps, an individual must be:

(1) At least 16 and not more than 24 years of age at the time of enrollment, except that:

(i) The Job Corps Director may waive the maximum age limitation described in paragraph (a)(1) of this section, and the requirement in paragraph (a)(1)(ii) of this section for an individual with a disability if he or she is otherwise eligible according to the requirements listed in this section and § 686.410; and

(ii) Not more than 20 percent of individuals enrolled nationwide may be individuals who are aged 22 to 24 years old;

(2) A low-income individual;

(3) An individual who is facing one or more of the following barriers to education and employment:

(i) Is basic skills deficient, as defined in WIOA sec. 3;

(ii) Is a school dropout;

(iii) Is homeless as defined in sec. 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)); is a homeless child or youth, as defined in sec. 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)); or is a runaway, an individual in foster care; or an individual who was in foster care and has aged out of the foster care system.

(iv) Is a parent; or

(v) Requires additional education, career technical training, or workforce preparation skills in order to obtain and retain employment that leads to economic self-sufficiency; and

(4) Meets the requirements of § 686.420, if applicable.

(b) Notwithstanding paragraph (a)(2) of this section, a veteran is eligible to become an enrollee if the individual:

(1) Meets the requirements of paragraphs (a)(1) and (3) of this section; and

(2) Does not meet the requirement of paragraph (a)(2) of this section because the military income earned by the individual within the 6-month period prior to the individual's application for Job Corps prevents the individual from meeting that requirement.

§ 686.410 Are there additional factors which are considered in selecting an eligible applicant for enrollment?

Yes, in accordance with procedures issued by the Secretary, an eligible applicant may be selected for enrollment only if:

(a) A determination is made, based on information relating to the background, needs, and interests of the applicant, that the applicant's educational and career and technical needs can best be met through the Job Corps program;

(b) A determination is made that there is a reasonable expectation the applicant can participate successfully in group situations and activities, and is not likely to engage in actions that would potentially:

(1) Prevent other students from receiving the benefit of the program;

(2) Be incompatible with the maintenance of sound discipline; or

(3) Impede satisfactory relationships between the center to which the student is assigned and surrounding local communities;

(c) The applicant is made aware of the center's rules, what the consequences are for failure to observe the rules, and agrees to comply with such rules, as described in procedures issued by the Secretary;

(d) The applicant has not been convicted of a felony consisting of murder, child abuse, or a crime involving rape or sexual assault. Other than these felony convictions, no one will be denied enrollment in Job Corps solely on the basis of contact with the criminal justice system. All applicants must submit to a background check conducted according to procedures established by the Secretary and in accordance with applicable State and local laws. If the background check finds that the applicant is on probation, parole, under a suspended sentence, or under the supervision of any agency as a result of court action or institutionalization, the court or appropriate supervising agency may certify in writing that it will approve of the applicant's participation in Job Corps, and provide full release from its supervision, and that the applicant's participation and release does not violate applicable laws and regulations; and

(e) Suitable arrangements are made for the care of any dependent children for the proposed period of enrollment.

§ 686.420 Are there any special requirements for enrollment related to the Military Selective Service Act?

(a) Yes, each male applicant 18 years of age or older must present evidence that he has complied with sec. 3 of the Military Selective Service Act (50 U.S.C. App. 451 *et seq.*) if required; and

(b) When a male student turns 18 years of age, he must submit evidence to the center that he has complied with the requirements of the Military Selective Service Act (50 U.S.C. App. 451 *et seq.*).

§ 686.430 What entities conduct outreach and admissions activities for the Job Corps program?

The Secretary makes arrangements with outreach and admissions providers to perform Job Corps recruitment, screening and admissions functions according to standards and procedures issued by the Secretary. Entities eligible to receive funds to provide outreach and admissions services are identified in § 686.300.

§ 686.440 What are the responsibilities of outreach and admissions providers?

(a) Outreach and admissions agencies are responsible for:

(1) Developing outreach and referral sources;

(2) Actively seeking out potential applicants;

(3) Conducting personal interviews with all applicants to identify their needs and eligibility status; and

(4) Identifying youth who are interested and likely Job Corps participants.

(b) Outreach and admissions providers are responsible for completing all Job Corps application forms and determining whether applicants meet the eligibility and selection criteria for participation in Job Corps as provided in §§ 686.400 and 686.410.

(c) The Secretary may decide that determinations with regard to one or more of the eligibility criteria will be made by the National Director or his or her designee.

§ 686.450 How are applicants who meet eligibility and selection criteria assigned to centers?

(a) Each applicant who meets the application and selection requirements of §§ 686.400 and 686.410 is assigned to a center based on an assignment plan developed by the Secretary in consultation with the operators of Job Corps centers. The assignment plan identifies a target for the maximum percentage of students at each center who come from the State or region nearest the center, and the regions surrounding the center. The assignment plan is based on an analysis of the following non-exclusive list of factors that will be analyzed in consultation with center operators:

(1) The number of eligible individuals in the State and region where the center is located and the regions surrounding where the center is located;

(2) The demand for enrollment in Job Corps in the State and region where the center is located and in surrounding regions;

(3) The size and enrollment level of the center, including the education, training, and supportive services provided through the center; and

(4) The performance of the Job Corps center relating to the expected levels of performance for indicators described in WIOA sec. 159(c)(1), and whether any actions have been taken with respect to the center under secs. 159(f)(2) and 159(f)(3) of WIOA.

(b) Eligible applicants are assigned to the center that offers the type of career technical training selected by the individual, and among the centers that offer such career technical training, is closest to the home of the individual. The Secretary may waive this requirement if:

(1) The enrollee would be unduly delayed in participating in the Job Corps program because the closest center is operating at full capacity; or

(2) The parent or guardian of the enrollee requests assignment of the enrollee to another Job Corps center due to circumstances in the community that would impair prospects for successful completion by the enrollee.

(c) If a parent or guardian objects to the assignment of a student under the age of 18 to a center other than the center closest to home that offers the desired career technical training, the Secretary must not make such an assignment.

§ 686.460 What restrictions are there on the assignment of eligible applicants for nonresidential enrollment in Job Corps?

No more than 20 percent of students enrolled in Job Corps nationwide may be nonresidential students.

§ 686.470 May an individual who is determined to be ineligible or an individual who is denied enrollment appeal that decision?

(a) A person who is determined to be ineligible to participate in Job Corps under § 686.400 or a person who is not selected for enrollment under § 686.410 may appeal the determination to the outreach and admissions agency within 60 days of the determination. The appeal will be resolved according to the procedures in §§ 686.960 and 686.965. If the appeal is denied by the outreach/admissions contractor or the center, the person may appeal the decision in writing to the Regional Director within 60 days of the date of the denial. The Regional Director will decide within 60 days whether to reverse or approve the appealed decision. The decision by the Regional Director is the Department's final decision.

(b) If an applicant believes that he or she has been determined ineligible or not selected for enrollment based upon a factor prohibited by sec. 188 of WIOA, the individual may proceed under the applicable Department nondiscrimination regulations implementing WIOA sec. 188 at 29 CFR part 38.

(c) An applicant who is determined to be ineligible or a person who is denied enrollment must be referred to the appropriate one-stop center or other local service provider.

§ 686.480 At what point is an applicant considered to be enrolled in Job Corps?

(a) To be considered enrolled as a Job Corps student, an applicant selected for enrollment must physically arrive at the assigned Job Corps center on the appointed date. However, applicants selected for enrollment who arrive at their assigned centers by government furnished transportation are considered to be enrolled on their dates of departure by such transportation.

(b) Center operators must document the enrollment of new students according to procedures issued by the Secretary.

§ 686.490 How long may a student be enrolled in Job Corps?

(a) Except as provided in paragraph (b) of this section, a student may remain enrolled in Job Corps for no more than 2 years.

(b)(1) An extension of a student's enrollment may be authorized in special cases according to procedures issued by the Secretary;

(2) A student's enrollment in an advanced career training program may be extended in order to complete the program for a period not to exceed 1 year;

(3) An extension of a student's enrollment may be authorized in the case of a student with a disability who would reasonably be expected to meet the standards for a Job Corps graduate if allowed to participate in the Job Corps for not more than 1 additional year; and

(4) An enrollment extension may be granted to a student who participates in national service, as authorized by a Civilian Conservation Center, for the amount of time equal to the period of national service.

Subpart E—Program Activities and Center Operations

§ 686.500 What services must Job Corps centers provide?

(a) Job Corps centers must provide an intensive, well-organized, and fully supervised program including:

(1) Educational activities, including:

(i) Career technical training;

(ii) Academic instruction;

(iii) Employability and skills training; and

(iv) Independent learning and living skills development.

(2) Work-based learning and experience;

(3) Residential support services; and

(4) Other services as required by the Secretary.

(b) In addition, centers must provide students with access to the career services described in secs. 134(c)(2)(A)(i)–(xi) of WIOA.

§ 686.505 What types of training must Job Corps centers provide?

(a) Job Corps centers must provide students with a career technical training program that is:

(1) Aligned with industry-recognized standards and credentials and with program guidance; and

(2) Linked to employment opportunities in in-demand industry sectors and occupations both in the area in which the center is located and, if practicable, in the area the student plans to reside after graduation.

(b) Each center must provide education programs, including: An English language acquisition program, high school diploma or high school equivalency certification program, and academic skills training necessary for students to master skills in their chosen career technical training programs.

(c) Each center must provide programs for students to learn and practice employability and independent learning and living skills including: job search and career development, interpersonal relations, driver's education, study and critical thinking skills, financial literacy and other skills specified in program guidance.

(d) All Job Corps training programs must be based on industry and academic skills standards leading to recognized industry and academic credentials, applying evidence-based instructional approaches, and resulting in:

(1) Students' employment in unsubsidized, in-demand jobs with the potential for advancement opportunities;

(2) Enrollment in advanced education and training programs or apprenticeships, including registered apprenticeship; or

(3) Enlistment in the Armed Services.

(e) Specific career technical training programs offered by individual centers must be approved by the Regional Director according to policies issued by the Secretary.

(f) Center workforce councils described in § 686.810 must review appropriate labor market information, identify in-demand industry sectors and employment opportunities in local areas where students will look for employment, determine the skills and education necessary for those jobs, and as appropriate, recommend changes in the center's career technical training program to the Secretary.

(g) Each center must implement a system to evaluate and track the progress and achievements of each student at regular intervals.

(h) Each center must develop a training plan that must be available for review and approval by the appropriate Regional Director.

§ 686.510 Are entities other than Job Corps center operators permitted to provide academic and career technical training?

(a) The Secretary may arrange for the career technical and academic education of Job Corps students through local public or private educational agencies, career and technical educational institutions or technical institutes, or other providers such as business, union or union-affiliated organizations with demonstrated effectiveness, as long as the entity can provide education and training substantially equivalent in cost and quality to that which the Secretary could provide through other means.

(b) Entities providing these services will be selected in accordance with the requirements of § 686.310.

§ 686.515 What are advanced career training programs?

(a) The Secretary may arrange for programs of advanced career training (ACT) for selected students, which may be provided through the eligible training providers identified in WIOA sec. 122 in which the students continue to participate in the Job Corps program for a period not to exceed 1 year in addition to the period of participation to which these students would otherwise be limited.

(b) Students participating in an ACT program are eligible to receive:

(1) All of the benefits provided to a residential Job Corps student; or

(2) A monthly stipend equal to the average value of the benefits described in paragraph (b)(1) of this section.

(c) Any operator may enroll more students than otherwise authorized by the Secretary in an ACT program if, in accordance with standards developed by the Secretary, the operator demonstrates:

(1) Participants in such a program have achieved a satisfactory rate of completion and placement in training-related jobs; and

(2) For the most recently preceding 2 program years, the operator has, on average, met or exceeded the expected levels of performance under WIOA sec.

159(c)(1) for each of the primary indicators described in WIOA sec. 116(b)(2)(A)(ii), listed in § 686.1010.

§ 686.520 What responsibilities do the center operators have in managing work-based learning?

(a) The center operator must emphasize and implement work-based learning programs for students through center program activities, including career and technical skills training, and through arrangements with employers. Work-based learning must be under actual working conditions and must be designed to enhance the employability, responsibility, and confidence of the students. Work-based learning usually occurs in tandem with students' career technical training.

(b) The center operator must ensure that students are assigned only to workplaces that meet the safety standards described in § 686.920.

§ 686.525 Are students permitted to hold jobs other than work-based learning opportunities?

Yes, a center operator may authorize a student to participate in gainful leisure time employment, as long as the employment does not interfere with required scheduled activities.

§ 686.530 What residential support services must Job Corps center operators provide?

Job Corps center operators must provide the following services according to procedures issued by the Secretary:

(a) A center-wide quality living and learning environment that supports the overall training program and includes a safe, secure, clean and attractive physical and social environment, 7 days a week, 24 hours a day;

(b) An ongoing, structured personal counseling program for students provided by qualified staff;

(c) A quality, safe and clean food service, to provide nutritious meals for students;

(d) Medical services, through provision or coordination of a wellness program which includes access to basic medical, dental and mental health services, as described in the Policy and Requirements Handbook, for all students from the date of enrollment until separation from the Job Corps program;

(e) A recreation/avocational program that meets the needs of all students;

(f) A student leadership program and an elected student government; and

(g) A student welfare association for the benefit of all students that is funded by non-appropriated funds that come from sources such as snack bars, vending machines, disciplinary fines, donations, and other fundraising activities, and is run by an elected student government, with the help of a staff advisor.

§ 686.535 Are Job Corps centers required to maintain a student accountability system?

Yes, each Job Corps center must establish and implement an effective system to account for and document the daily whereabouts, participation, and status of students during their Job Corps enrollment. The system must enable center staff to detect and respond to instances of unauthorized or unexplained student absence. Each center must operate its student accountability system according to requirements and procedures issued by the Secretary.

§ 686.540 Are Job Corps centers required to establish behavior management systems?

(a) Yes, each Job Corps center must establish and maintain its own student incentives system to encourage and reward students' accomplishments.

(b) The Job Corps center must establish and maintain a behavior management system, based on a behavior management plan, according to standards of conduct and procedures established by the Secretary. The behavior management plan must be approved by the Job Corps regional office and reviewed annually. The behavior management system must include a zero tolerance policy for violence and drugs as described in § 686.545. All criminal incidents will be promptly reported to local law enforcement.

§ 686.545 What is Job Corps' zero tolerance policy?

(a) All center operators must comply with Job Corps' zero tolerance policy

as established by the Secretary. Job Corps has a zero tolerance policy for infractions including but not limited to:

(1) Acts of violence, as defined by the Secretary;

(2) Use, sale, or possession of a controlled substance, as defined at 21 U.S.C. 802;

(3) Abuse of alcohol;

(4) Possession of unauthorized goods; or

(5) Other illegal or disruptive activity.

(b) As part of this policy, all students must be tested for drugs as a condition of participation.

(c) The zero tolerance policy specifies the offenses that result in the separation of students from the Job Corps. The center director is expressly responsible for determining when there is a violation of this policy.

§ 686.550 How does Job Corps ensure that students receive due process in disciplinary actions?

The center operator must ensure that all students receive due process in disciplinary proceedings according to procedures developed by the Secretary. These procedures must include center fact-finding and behavior review boards, a code of sanctions under which the penalty of separation from Job Corps might be imposed, and procedures for students to submit an appeal to a Job Corps regional appeal board following a center's decision to discharge involuntarily the student from Job Corps.

§ 686.555 What responsibilities do Job Corps centers have in assisting students with child care needs?

(a) Job Corps centers are responsible for coordinating with outreach and admissions agencies to assist applicants, whenever feasible, with making arrangements for child care. Prior to enrollment, a program applicant with dependent children who provides primary or custodial care must certify that suitable arrangements for child care have been established for the proposed period of enrollment.

(b) Child development programs may be located at Job Corps centers with the approval of the Secretary.

§ 686.560 What are the center's responsibilities in ensuring that students' religious rights are respected?

(a) Centers must ensure that a student has the right to worship or not worship as he or she chooses.

(b) Students who believe their religious rights have been violated may file complaints under the procedures set forth in 29 CFR part 38.

(c) Requirements related to equal treatment of religious organizations in Department of Labor programs, and to protection of religious liberty of Department of Labor social service providers and beneficiaries, are found at subpart D of 29 CFR part 2. *See also* §§ 683.255 and 683.285 of this chapter; 29 CFR part 38.

§ 686.565 Is Job Corps authorized to conduct pilot and demonstration projects?

Yes, the Secretary may undertake experimental, research and demonstration projects related to the Job Corps program according to WIOA sec. 156(a), provided that such projects are developed, approved, and conducted in accordance with policies and procedures developed by the Secretary.

Subpart F—Student Support

§ 686.600 Are students provided with government-paid transportation to and from Job Corps centers?

Yes, Job Corps provides for the transportation of students between their homes and centers as described in policies and procedures issued by the Secretary.

§ 686.610 When are students authorized to take leaves of absence from their Job Corps centers?

(a) Job Corps students are eligible for annual leaves, emergency leaves and other types of leaves of absence from their assigned centers according to criteria and requirements issued by the Secretary. Additionally, enrollees in Civilian Conservation Centers may take leave to provide assistance in addressing national, State, and local disasters, consistent with current laws and regulations, including child labor laws and regulations.

(b) Center operators and other service providers must account for student leave according to procedures issued by the Secretary.

§ 686.620 Are Job Corps students eligible to receive cash allowances and performance bonuses?

(a) Yes, according to criteria and rates established by the Secretary, Job Corps students receive cash living allowances, performance bonuses, and allotments for care of dependents. Graduates receive post-separation transition allowances according to § 686.750.

(b) In the event of a student's death, any amount due under this section is paid according to the provisions of 5 U.S.C. 5582 governing issues such as designation of beneficiary, order of precedence, and related matters.

§ 686.630 Are student allowances subject to Federal payroll taxes?

Yes, Job Corps student allowances are subject to Federal payroll tax withholding and social security taxes. Job Corps students are considered to be Federal employees for purposes of Federal payroll taxes.

§ 686.640 Are students provided with clothing?

Yes, Job Corps students are provided cash clothing allowances and/or articles of clothing, including safety clothing, when needed for their participation in Job Corps and their successful entry into the work force. Center operators and other service providers must issue clothing and clothing assistance to students according to rates, criteria, and procedures issued by the Secretary.

Subpart G—Career Transition and Graduate Services

§ 686.700 What are a Job Corps center's responsibilities in preparing students for career transition services?

Job Corps centers must assess and counsel students to determine their competencies, capabilities, and readiness for career transition services.

§ 686.710 What career transition services are provided for Job Corps enrollees?

Job Corps career transition services focus on placing program graduates in:

(a) Full-time jobs that are related to their career technical training and career pathway that lead to economic self-sufficiency;

(b) Postsecondary education;

(c) Advanced training programs, including registered apprenticeship programs; or

(d) The Armed Forces.

§ 686.720 Who provides career transition services?

The one-stop delivery system must be used to the maximum extent practicable in placing graduates and former enrollees in jobs. Multiple other resources also may provide post-program services, including but not limited to Job Corps career transition service providers under a contract or other agreement with the Department of Labor, and State vocational rehabilitation agencies for individuals with disabilities.

§ 686.730 What are the responsibilities of career transition service providers?

(a) Career transition service providers are responsible for:

(1) Contacting graduates;

(2) Assisting them in improving skills in resume preparation, interviewing techniques and job search strategies;

(3) Identifying job leads or educational and training opportunities through coordination with Local WDBs, one-stop operators and partners, employers, unions and industry organizations;

(4) Placing graduates in jobs, registered apprenticeship, the Armed Forces, or postsecondary education or training, or referring former students for additional services in their local communities as appropriate; and

(5) Providing placement services for former enrollees according to procedures issued by the Secretary.

(b) Career transition service providers must record and submit all Job Corps placement information according to procedures established by the Secretary.

§ 686.740 What services are provided for program graduates?

According to procedures issued by the Secretary, career transition and support services must be provided to program graduates for up to 12 months after graduation.

§ 686.750 Are graduates provided with transition allowances?

Yes, graduates receive post-separation transition allowances according to policies and procedures established by the Secretary. Transition allowances are incentive-based to reflect a graduate's attainment of academic credentials and those associated with career technical training such as industry-recognized credentials.

§ 686.760 What services are provided to former enrollees?

(a) Up to 3 months of employment services, including career services offered through a one-stop center, may be provided to former enrollees.

(b) According to procedures issued by the Secretary, other career transition services as determined appropriate may be provided to former enrollees.

Subpart H—Community Connections

§ 686.800 How do Job Corps centers and service providers become involved in their local communities?

(a) The director of each Job Corps center must ensure the establishment and development of mutually beneficial business and community relationships and networks. Establishing and developing networks includes relationships with:

(1) Local and distant employers;

(2) Applicable one-stop centers and Local WDBs:

(3) Entities offering apprenticeship opportunities, including registered apprenticeships, and youth programs;

(4) Labor-management organizations and local labor organizations;

(5) Employers and contractors that support national training programs and initiatives; and

(6) Community-based organizations, non-profit organizations, and intermediaries providing workforce development-related services.

(b) Each Job Corps center also must establish and develop relationships with members of the community in which it is located. Members of the community must be informed of the projects of the Job Corps center and changes in the rules, procedures, or activities of the center that may affect the community. Events of mutual interest to the community and the Job Corps center must be planned to create and maintain community relations and community support.

§ 686.810 What is the makeup of a workforce council and what are its responsibilities?

(a) Each Job Corps center must establish a workforce council, according to procedures established by the Secretary. The workforce council must include:

(1) Non-governmental and private sector employers;

(2) Representatives of labor organizations (where present) and of employees;

(3) Job Corps enrollees and graduates; and

(4) In the case of a single-State local area, the workforce council must include a representative of the State WDB constituted under § 679.110 of this chapter.

(b) A majority of the council members must be business owners, chief executives or chief operating officers of nongovernmental employers or other private sector employers, or their designees, who have substantial management, hiring or policy responsibility and who represent businesses with employment opportunities in the local area and the areas in which students will seek employment.

(c) The workforce council may include, or otherwise provide for consultation with, employers from outside the local area who are likely to hire a significant number of enrollees from the Job Corps center.

(d) The workforce council must:

(1) Work with all applicable Local WDBs and review labor market information to determine and provide recommendations to the Secretary regarding the center's career technical training offerings, including identification of emerging occupations suitable for training;

(2) Review all relevant labor market information, including related information in the State Plan or the local plan, to:

(i) Recommend in-demand industry sectors or occupations in the area in which the center operates;

(ii) Determine employment opportunities in the areas in which enrollees intend to seek employment;

(iii) Determine the skills and education necessary to obtain the identified employment; and

(iv) Recommend to the Secretary the type of career technical training that must be implemented at the center to enable enrollees to obtain the employment opportunities identified; and

(3) Meet at least once every 6 months to reevaluate the labor market information, and other relevant information, to determine and recommend to the Secretary any necessary changes in the career technical training provided at the center.

§ 686.820 How will Job Corps coordinate with other agencies?

(a) The Secretary issues guidelines for the national office, regional offices, Job Corps centers and operational support providers to use in developing and maintaining cooperative relationships with other agencies and institutions, including law enforcement, educational institutions, communities, and other employment and training programs and agencies.

(b) The Secretary develops polices and requirements to ensure linkages with the one-stop delivery system to the greatest extent practicable, as well as with other Federal, State, and local programs, and youth programs funded under title I of WIOA. These linkages enhance services to youth who face multiple barriers to employment and must include, where appropriate:

(1) Referrals of applicants and students;

(2) Participant assessment;

(3) Pre-employment and work maturity skills training;

(4) Work-based learning;

(5) Job search, occupational, and basic skills training; and

(6) Provision of continued services for graduates.

(c) Job Corps is identified as a required one-stop partner. Wherever practicable, Job Corps centers and operational support contractors must establish cooperative relationships and partnerships with one-stop centers and other one-stop partners, Local WDBs, and other programs for youth.

Subpart I—Administrative and Management Provisions

§ 686.900 Are damages caused by the acts or omissions of students eligible for payment under the Federal Tort Claims Act?

Yes, students are considered Federal employees for purposes of the FTCA. (28 U.S.C. 2671 *et seq.*) Claims for such damage must be filed pursuant to the procedures found in 29 CFR part 15, subpart D.

§ 686.905 Are loss and damages that occur to persons or personal property of students at Job Corps centers eligible for reimbursement?

Yes, the Job Corps may pay students for valid claims under the procedures found in 29 CFR part 15, subpart D.

§ 686.910 If a student is injured in the performance of duty as a Job Corps student, what benefits may the student receive?

(a) Job Corps students are considered Federal employees for purposes of the Federal Employees' Compensation Act (FECA) as specified in sec. 157(a)(3) of WIOA. (29 U.S.C. 2897(a)(3))

(b) Job Corps students may be entitled to benefits under FECA as provided by 5 U.S.C. 8143 for injuries occurring in the performance of duty.

(c) Job Corps students must meet the same eligibility tests for FECA benefits that apply to all other Federal employees. The requirements for FECA benefits may be found at 5 U.S.C. 8101, *et seq.* and part 10 of this title. The Department of Labor's Office of Workers' Compensation Programs (OWCP) administers the FECA program; all FECA determinations are within the exclusive authority of the OWCP, subject to appeal to the Employees' Compensation Appeals Board.

(d) Whenever a student is injured, develops an occupationally related illness, or dies while in the performance

of duty, the procedures of the OWCP, at part 10 of this title, must be followed. To assist OWCP in determining FECA eligibility, a thorough investigation of the circumstances and a medical evaluation must be completed and required forms must be timely filed by the center operator with the Department's OWCP. Additional information regarding Job Corps FECA claims may be found in OWCP's regulations and procedures available on the Department's Web site located at *https://www.dol.gov/*.

§ 686.915 When is a Job Corps student considered to be in the performance of duty?

(a) Performance of duty is a determination that must be made by the OWCP under FECA, and is based on the individual circumstances in each claim.

(b) In general, residential students may be considered to be in the ''performance of duty'' when:

(1) They are on center under the supervision and control of Job Corps officials;

(2) They are engaged in any authorized Job Corps activity;

(3) They are in authorized travel status; or

(4) They are engaged in any authorized offsite activity.

(c) Non-resident students are generally considered to be ''in performance of duty'' as Federal employees when they are engaged in any authorized Job Corps activity, from the time they arrive at any scheduled center activity until they leave the activity. The standard rules governing coverage of Federal employees during travel to and from work apply. These rules are described in guidance issued by the Secretary.

(d) Students are generally considered to be not in the performance of duty when:

(1) They are Absent Without Leave (AWOL);

(2) They are at home, whether on pass or on leave;

(3) They are engaged in an unauthorized offsite activity; or

(4) They are injured or ill due to their own willful misconduct, intent to cause injury or death to oneself or another, or through intoxication or illegal use of drugs.

§ 686.920 How are students protected from unsafe or unhealthy situations?

(a) The Secretary establishes procedures to ensure that students are not required or permitted to work, be trained, reside in, or receive services in buildings or surroundings or under conditions that are unsanitary or hazardous. Whenever students are employed or in training for jobs, they must be assigned only to jobs or training which observe applicable Federal, State and local health and safety standards.

(b) The Secretary develops procedures to ensure compliance with applicable Department of Labor Occupational Safety and Health Administration regulations and Wage and Hour Division regulations.

§ 686.925 What are the requirements for criminal law enforcement jurisdiction on center property?

(a) All Job Corps property which would otherwise be under exclusive Federal legislative jurisdiction is considered under concurrent jurisdiction with the appropriate State and locality with respect to criminal law enforcement. Concurrent jurisdiction extends to all portions of the property, including housing and recreational facilities, in addition to the portions of the property used for education and training activities.

(b) Centers located on property under concurrent Federal-State jurisdiction must establish agreements with Federal, State and local law enforcement agencies to enforce criminal laws.

(c) The Secretary develops procedures to ensure that any searches of a student's person, personal area, or belongings for unauthorized goods follow applicable right-to-privacy laws.

§ 686.930 Are Job Corps operators and service providers authorized to pay State or local taxes on gross receipts?

(a) A private for-profit or a non-profit Job Corps service provider is not liable, directly or indirectly, to any State or subdivision for any gross receipts

taxes, business privilege taxes measured by gross receipts, or any similar taxes in connection with any payments made to or by such service provider for operating a center or other Job Corps program or activity. The service provider is not liable to any State or subdivision to collect or pay any sales, excise, use, or similar tax imposed upon the sale to or use by such deliverer of any property, service, or other item in connection with the operation of a center or other Job Corps program or activity.

(b) If a State or local authority compels a center operator or other service provider to pay such taxes, the center operator or service provider may pay the taxes with Federal funds, but must document and report the State or local requirement according to procedures issued by the Secretary.

§ 686.935 What are the financial management responsibilities of Job Corps center operators and other service providers?

(a) Center operators and other service providers must manage Job Corps funds using financial management information systems that meet the specifications and requirements of the Secretary.

(b) These financial management systems must:

(1) Provide accurate, complete, and current disclosures of the costs of their Job Corps activities;

(2) Ensure that expenditures of funds are necessary, reasonable, allocable, and allowable in accordance with applicable cost principles;

(3) Use account structures specified by the Secretary;

(4) Ensure the ability to comply with cost reporting requirements and procedures issued by the Secretary; and

(5) Maintain sufficient cost data for effective planning, monitoring, and evaluation of program activities and for determining the allowability of reported costs.

§ 686.940 Are center operators and service providers subject to Federal audits?

(a) Yes, Center operators and service providers are subject to Federal audits.

(b) The Secretary arranges for the survey, audit, or evaluation of each Job Corps center and service provider at least once every 3 years, by Federal auditors or independent public accountants. The Secretary may arrange for more frequent audits.

(c) Center operators and other service providers are responsible for giving full cooperation and access to books, documents, papers and records to duly appointed Federal auditors and evaluators.

§ 686.945 What are the procedures for management of student records?

The Secretary issues guidelines for a system for maintaining records for each student during enrollment and for disposition of such records after separation.

§ 686.950 What procedures apply to disclosure of information about Job Corps students and program activities?

(a) The Secretary develops procedures to respond to requests for information or records or other necessary disclosures pertaining to students.

(b) Department disclosure of Job Corps information must be handled according to the Freedom of Information Act and according to Department regulations at 29 CFR part 70.

(c) Job Corps contractors are not ''agencies'' for Freedom of Information Act purposes. Therefore, their records are not subject to disclosure under the Freedom of Information Act or 29 CFR part 70.

(d) The regulations at 29 CFR part 71 apply to a system of records covered by the Privacy Act of 1974 maintained by the Department or to a similar system maintained by a contractor, such as a screening agency, contract center operator, or career transition service provider on behalf of the Job Corps.

§ 686.955 What are the reporting requirements for center operators and operational support service providers?

The Secretary establishes procedures to ensure the timely and complete reporting of necessary financial and program information to maintain accountability. Center operators and operational support service providers are

responsible for the accuracy and integrity of all reports and data they provide.

§ 686.960 What procedures are available to resolve complaints and disputes?

(a) Each Job Corps center operator and service provider must establish and maintain a grievance procedure for filing complaints and resolving disputes from applicants, students and/or other interested parties about its programs and activities. A hearing on each complaint or dispute must be conducted within 30 days of the filing of the complaint or dispute. A decision on the complaint must be made by the center operator or service provider, as appropriate, within 60 days after the filing of the complaint, and a copy of the decision must be immediately served, by first-class mail, on the complainant and any other party to the complaint. Except for complaints under § 686.470 or complaints alleging fraud or other criminal activity, complaints may be filed within 1 year of the occurrence that led to the complaint.

(b) The procedure established under paragraph (a) of this section must include procedures to process complaints alleging violations of sec. 188 of WIOA, consistent with Department nondiscrimination regulations implementing sec. 188 of WIOA at 29 CFR part 38 and § 686.985.

§ 686.965 How does Job Corps ensure that complaints or disputes are resolved in a timely fashion?

(a) If a complaint is not resolved by the center operator or service provider in the time frames described in § 686.960, the person making the complaint may request that the Regional Director determine whether reasonable cause exists to believe that WIOA or regulations for this part of WIOA have been violated. The request must be filed with the Regional Director within 60 days from the date that the center operator or service provider should have issued the decision.

(b) Following the receipt of a request for review under paragraph (a) of this section, the Regional Director must determine within 60 days whether there has been a violation of WIOA or the WIOA regulations. If the Regional Director determines that there has been a violation of WIOA or WIOA regulations, (s)he may direct the operator or service provider to remedy the violation or direct the service provider to issue a decision to resolve the dispute according to the service provider's grievance procedures. If the service provider does not comply with the Regional Director's decision within 30 days, the Regional Director may impose a sanction on the center operator or service provider for violating WIOA or WIOA regulations, and/or for failing to issue a decision. Decisions imposing sanctions upon a center operator or service provider may be appealed to the Department of Labor Office of Administrative Law Judges under § 683.800 or § 683.840 of this chapter.

§ 686.970 How does Job Corps ensure that centers or other service providers comply with the Workforce Innovation and Opportunity Act and the WIOA regulations?

(a) If the Department receives a complaint or has reason to believe that a center or other service provider is failing to comply with the requirements of WIOA or WIOA regulations, the Regional Director must investigate the allegation and determine within 90 days after receiving the complaint or otherwise learning of the alleged violation, whether such allegation or complaint is true.

(b) As a result of such a determination, the Regional Director may:

(1) Direct the center operator or service provider to handle a complaint through the grievance procedures established under § 686.960; or

(2) Investigate and determine whether the center operator or service provider is in compliance with WIOA and WIOA regulations. If the Regional Director determines that the center or service provider is not in compliance with WIOA or WIOA regulations, the Regional Director may take action to resolve the complaint under § 686.965(b), or will report the incident to the Department of Labor Office of the Inspector General, as described in § 683.620 of this chapter.

§ 686.975 How does Job Corps ensure that contract disputes will be resolved?

A dispute between the Department and a Job Corps contractor will be handled according to the Contract Disputes Act and applicable regulations.

§ 686.980 How does Job Corps resolve disputes between the U.S. Department of Labor and the U.S. Department of Agriculture regarding the operation of Job Corps centers?

Disputes between the U.S. Department of Labor and the U.S. Department of Agriculture regarding operating a center will be handled according to the interagency agreement between the two agencies.

§ 686.985 What Department of Labor equal opportunity and nondiscrimination regulations apply to Job Corps?

Nondiscrimination requirements, procedures, complaint processing, and compliance reviews are governed by, as applicable, provisions of the following Department of Labor regulations:

(a) Regulations implementing sec. 188 of WIOA for programs receiving Federal financial assistance under WIOA found at 29 CFR part 38;

(b) Title 29 CFR part 33 for programs conducted by the Department of Labor; and

(c) Title 41 CFR chapter 60 for entities that have a Federal government contract.

Subpart J—Performance

§ 686.1000 How is the performance of the Job Corps program assessed?

(a) The performance of the Job Corps program as a whole, and the performance of individual centers, outreach and admissions providers, and career transition service providers, is assessed in accordance with the regulations in this part and procedures and standards issued by the Secretary, through a national performance management system, including the Outcome Measurement System (OMS).

(b) The national performance management system will include measures that reflect the primary indicators of performance described in § 686.1010, the information needed to complete the Annual Report described in § 686.1040, and any other information the Secretary determines is necessary to manage and evaluate the effectiveness of the Job Corps program. The Secretary will issue annual guidance describing the performance management system and outcome measurement system.

(c) Annual performance assessments based on the measures described in paragraph (b) of this section are done for each center operator and other service providers, including outreach and admissions providers and career transition providers.

§ 686.1010 What are the primary indicators of performance for Job Corps centers and the Job Corps program?

The primary indicators of performance for eligible youth are described in sec. 116(b)(2)(A)(ii) of WIOA. They are:

(a) The percentage of program participants who are in education or training activities, or in unsubsidized employment, during the second quarter after exit from the program;

(b) The percentage of program participants who are in education or training activities, or in unsubsidized employment, during the fourth quarter after exit from the program;

(c) The median earnings of program participants who are in unsubsidized employment during the second quarter after exit from the program;

(d) The percentage of program participants who obtain a recognized postsecondary credential, or a secondary school diploma or its recognized equivalent during participation in or within 1 year after exit from the program. Program participants who obtain a secondary school diploma or its recognized equivalent will be included in the percentage only if they also have obtained or retained employment, or are in an education or training program leading to a recognized postsecondary credential, within 1 year after exit from the program;

(e) The percentage of program participants who, during a program year, are in an education or training program that leads to a recognized postsecondary credential or employment and who are achieving measurable skill

gains toward such a credential or employment; and

(f) The percentage of participants in unsubsidized employment during the second quarter after exit from the program who were employed by the same employer in the second and fourth quarters after exit.

[81 FR 56428, Aug. 19, 2016, as amended at 89 FR 13613, Feb. 23, 2024]

§ 686.1020 What are the indicators of performance for Job Corps outreach and admissions providers?

The Secretary establishes performance indicators for outreach and admission service providers serving the Job Corps program. They include, but are not limited to:

(a) The number of enrollees recruited, compared to the established goals for such recruitment, and the number of enrollees who remain committed to the program for 90 days after enrollment;

(b) The percentage and number of former enrollees, including the number dismissed under the zero tolerance policy described in sec. 152(b) of WIOA and § 686.545;

(c) The maximum attainable percent of enrollees at the Job Corps center that reside in the State in which the center is located, and the maximum attainable percentage of enrollees at the Job Corps center that reside in the State in which the center is located and in surrounding regions, as compared to the percentage targets established by the Secretary for the center for each of those measures;

(d) The cost per enrollee, calculated by comparing the number of enrollees at the center in a program year to the total budget for such center in the same program year; and

(e) Additional indicators of performance, as necessary.

§ 686.1030 What are the indicators of performance for Job Corps career transition service providers?

The Secretary establishes performance indicators for career transition service providers serving the Job Corps program. These include, but are not limited to, the following:

(a) The primary indicators of performance for eligible youth in WIOA sec. 116(b)(2)(A)(ii), as listed in § 686.1010;

(b) The number of graduates who entered the Armed Forces;

(c) The number of graduates who entered registered apprenticeship programs;

(d) The number of graduates who entered unsubsidized employment related to the career technical training received through the Job Corps program;

(e) The number of graduates who entered unsubsidized employment not related to the education and training received through the Job Corps program;

(f) The percentage and number of graduates who enter postsecondary education;

(g) The average wage of graduates who entered unsubsidized employment:

(1) On the first day of such employment; and

(2) On the day that is 6 months after such first day; and

(h) Additional indicators of performance, as necessary.

§ 686.1040 What information will be collected for use in the Annual Report?

The Secretary will collect and submit in the Annual Report described in sec. 159(c)(4) of WIOA, which will include the following information on each Job Corps center, and the Job Corps program as a whole:

(a) Information on the performance, based on the performance indicators described § 686.1010, as compared to the expected level of performance established under § 686.1050 for each performance indicator;

(b) Information on the performance of outreach service providers and career transition service providers on the performance indicators established under §§ 686.1020 and 686.1030, as compared to the expected levels of performance established under § 686.1050 for each of those indicators;

(c) The number of enrollees served;

(d) Demographic information on the enrollees served, including age, race, gender, and education and income level;

(e) The number of graduates of a Job Corps center;

(f) The number of graduates who entered the Armed Forces;

(g) The number of graduates who entered registered apprenticeship programs;

(h) The number of graduates who received a regular secondary school diploma;

(i) The number of graduates who received a State recognized equivalent of a secondary school diploma;

(j) The number of graduates who entered unsubsidized employment related to the career technical training received through the Job Corps program and the number who entered unsubsidized employment not related to the education and training received;

(k) The percentage and number of former enrollees, including the number dismissed under the zero tolerance policy described in § 686.545;

(l) The percentage and number of graduates who enter postsecondary education;

(m) The average wage of graduates who enter unsubsidized employment:

(1) On the first day of such employment; and

(2) On the day that is 6 months after such first day;

(n) The maximum attainable percent of enrollees at a Job Corps center that reside in the State in which the center is located, and the maximum attainable percentage of enrollees at a Job Corps center that reside in the State in which the center is located and in surrounding regions, as compared to the percentage targets established by the Secretary for the center for each of those measures;

(o) The cost per enrollee, which is calculated by comparing the number of enrollees at the center in a program year to the total budget for such center in the same program year;

(p) The cost per graduate, which is calculated by comparing the number of graduates of the center in a program year compared to the total budget for such center in the same program year;

(q) Information regarding the state of Job Corps buildings and facilities, including a review of requested construction, rehabilitation, and acquisition projects, by each Job Corps center, and a review of new facilities under construction;

(r) Available information regarding the national and community service activities of enrollees, particularly those enrollees at Civilian Conservation Centers; and

(s) Any additional information required by the Secretary.

§ 686.1050 How are the expected levels of performance for Job Corps centers, outreach and admissions providers and career transition service providers established?

(a) The Secretary establishes expected levels of performance for Job Corps centers, outreach and admissions providers and career transition service providers and the Job Corps program relating to each of the primary indicators of performance described in §§ 686.1010, 686.1020, and 686.1030.

(b) As described in § 686.1000, the Secretary will issue annual guidance describing the national performance management system and outcomes measurement system, which will communicate the expected levels of performance for each primary indicator of performance for each center, and each indicator of performance for each outreach and admission provider, and for each career transition service provider. Such guidance also will describe how the expected levels of performance were calculated.

§ 686.1060 How are center rankings established?

(a) The Secretary calculates annual rankings of center performance based on the performance management system described in § 686.1000 as part of the annual performance assessment described in § 686.1000(c).

(b) The Secretary will issue annual guidance that communicates the methodology for calculating the performance rankings for the year.

§ 686.1070 How and when will the Secretary use performance improvement plans?

(a) The Secretary establishes standards and procedures for developing and implementing performance improvement plans.

(1) The Secretary will develop and implement a performance improvement plan for a center when that center fails to meet the expected levels of performance described in § 686.1050.

(i) The Secretary will consider a center to have failed to meet the expected level of performance if the center:

(A) Is ranked among the lowest 10 percent of Job Corps centers for the most recent preceding program year according to the rankings calculated under §686.1060; and

(B) The center fails to achieve an average of 90 percent of the expected level of performance for all of the primary indicators.

(ii) For any program year that precedes the implementation of the establishment of the expected levels of performance under §686.1050 and the application of the primary indicators of performance for Job Corps centers identified in §686.1010, the Secretary will consider a center to have failed to meet the expected levels of performance if the center:

(A) Is ranked among the lowest 10 percent of Job Corps centers for the most recent preceding program year according to the rankings calculated under §686.1060; and

(B) The center's composite OMS score for the program year is 88 percent or less of the year's OMS national average.

(2) The Secretary also may develop and implement additional performance improvement plans, which will require improvements for a Job Corps center that fails to meet criteria established by the Secretary other than the expected levels of performance.

(b) A performance improvement plan will require action be taken to correct identified performance issues within 1 year of the implementation of the plan, and it will identify criteria that must be met for the center to complete the performance improvement plan.

(1) The center operator must implement the actions outlined in the performance improvement plan.

(2) If the center fails to take the steps outlined in the performance improvement plan or fails to meet the criteria established to complete the performance improvement plan after 1 year, the center will be considered to have failed to improve performance under a performance improvement plan detailed in paragraph (a) of this section.

(i) Such a center will remain on a performance improvement plan and the Secretary will take action as described in paragraph (c) of this section.

(ii) If a Civilian Conservation Center fails to meet expected levels of performance relating to the primary indicators of performance specified in §686.1010, or fails to improve performance under a performance improvement plan detailed in paragraph (a) of this section after 3 program years, the Secretary, in consultation with the Secretary of Agriculture, must select an entity to operate the Civilian Conservation Center on a competitive basis, in accordance with the requirements of §686.310.

(c) Under a performance improvement plan, the Secretary may take the following actions, as necessary:

(1) Providing technical assistance to the center;

(2) Changing the management staff of a center;

(3) Changing the career technical training offered at the center;

(4) Replacing the operator of the center;

(5) Reducing the capacity of the center;

(6) Relocating the center; or

(7) Closing the center in accordance with the criteria established under §686.200(b).

PART 687—NATIONAL DISLOCATED WORKER GRANTS

Sec.

687.100 What are the types and purposes of National Dislocated Worker Grants under the Workforce Innovation and Opportunity Act?

687.110 What are major economic dislocations or other events which may qualify for a National Dislocated Worker Grant?

687.120 Who is eligible to apply for National Dislocated Worker Grants?

687.130 When must applications for National Dislocated Worker Grants be submitted to the Department?

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687.150 What are the requirements for submitting applications for National Dislocated Worker Grants?

687.160 What is the timeframe for the Department to issue decisions on National Dislocated Worker Grant applications?
687.170 Who is eligible to be served under National Dislocated Worker Grants?
687.180 What are the allowable activities under National Dislocated Worker Grants?
687.190 How do statutory and regulatory waivers apply to National Dislocated Worker Grants?
687.200 What are the program and administrative requirements that apply to National Dislocated Worker Grants?

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§ 687.100 What are the types and purposes of National Dislocated Worker Grants under the Workforce Innovation and Opportunity Act?

There are two types and purposes of National Dislocated Worker Grants (DWGs) under sec. 170 of WIOA: Employment Recovery DWGs and Disaster Recovery DWGs.

(a) Employment Recovery DWGs provide employment and training activities for dislocated workers and other eligible populations. They are intended to expand service capacity temporarily at the State and local levels, by providing time-limited funding assistance in response to major economic dislocations or other events that affect the U.S. workforce that cannot be accommodated with WIOA formula funds or other relevant existing resources.

(b) Disaster Recovery DWGs allow for the creation of disaster relief employment to assist with clean-up and recovery efforts from emergencies or major disasters and the provision of employment and training activities, in accordance with § 687.180(b).

§ 687.110 What are major economic dislocations or other events which may qualify for a National Dislocated Worker Grant?

(a) Qualifying events for Employment Recovery DWGs include:

(1) Plant closures or mass layoffs affecting 50 or more workers from one employer in the same area;

(2) Closures and realignments of military installations;

(3) Plant closures or layoffs that have significantly increased the total number of unemployed individuals in a community;

(4) Situations where higher-than-average demand for employment and training activities for dislocated members of the Armed Forces, dislocated spouses of members of the Armed Forces on active duty (as defined in 10 U.S.C. 101(d)(1)), or members of the Armed Forces described in § 687.170(a)(1)(iii), exceeds State and local resources for providing such activities; and

(5) Other events, as determined by the Secretary.

(b) Qualifying events for Disaster Recovery DWGs include:

(1) Emergencies or major disasters, as defined in paragraphs (1) and (2), respectively, of sec. 102 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122(1) and (2)) which have been declared eligible for public assistance by the Federal Emergency Management Agency (FEMA);

(2) An emergency or disaster situation of national significance, natural or man-made, that could result in a potentially large loss of employment, as declared or otherwise recognized and issued in writing by the chief official of a Federal Agency with jurisdiction over the Federal response to the emergency or disaster situation; and

(3) Situations where a substantial number of workers from a State, tribal area, or outlying area in which an emergency or disaster has occurred relocate to another State, tribal area, or outlying area.

§ 687.120 Who is eligible to apply for National Dislocated Worker Grants?

(a) For Employment Recovery DWGs, the following entities are eligible to apply:

(1) States or outlying areas, or a consortium of States;

(2) Local Workforce Development Boards (WDBs), or a consortium of WDBs;

(3) An entity described in sec. 166(c) of WIOA (relating to Indian and Native American programs);

(4) Other entities determined to be appropriate by the Governor of the State or outlying area involved; and

(5) Other entities that demonstrate to the Secretary the capability to respond effectively to circumstances relating to particular dislocations.

(b) For Disaster Recovery DWGs, the following entities are eligible to apply:

(1) States;

(2) Outlying areas; and

(3) Indian tribal governments as defined by the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122(6)).

§ 687.130 When must applications for National Dislocated Worker Grants be submitted to the Department?

(a) Applications for Employment Recovery DWGs may be submitted at any time during the year and must be submitted to respond to eligible events as soon as possible when:

(1) The applicant receives a notification of a mass layoff or a closure as a result of a Worker Adjustment and Retraining Notification (WARN) Act notice, a general announcement, or some other means, or in the case of applications to address situations described in § 687.110(a)(4), when higher-than-average demand for employment and training activities for those members of the Armed Forces and military spouses exceeds State and local resources for providing such activities;

(2) Worker need and interest in services has been determined through Rapid Response, or other means, and is sufficient to justify the need for a DWG; and

(3) A determination has been made, in collaboration with the applicable local area, that State and local formula funds are inadequate to provide the level of services needed by the affected workers.

(b) Applications for Disaster Recovery DWGs to respond to an emergency or major disaster must be submitted as soon as possible when:

(1) As described in § 687.110(b)(1), FEMA has declared that the affected area is eligible for public assistance;

(2) A situation as described in § 687.110(b)(2) occurs. The applications must indicate the applicable Federal agency declaration, describe the impact on the local and/or State economy, and describe the proposed activities; or

(3) A situation as described in § 687.110(b)(3) occurs, and interest in services has been determined and is sufficient to justify the need for a DWG.

§ 687.140 What activities are applicants expected to conduct before a National Dislocated Worker Grant Application is submitted?

Prior to submitting an application for DWG funds, applicants must:

(a) For Employment Recovery DWGs:

(1) Collect information to identify the needs and interests of the affected workers through rapid response activities (described in § 682.330 of this chapter), or other means;

(2) Provide appropriate services to eligible workers including other rapid response activities, based on information gathered as described in paragraph (a)(1) of this section; and

(3) Coordinate with the Local WDB and chief elected official(s) of the local area(s) in which the proposed DWG project is to operate.

(b) For Disaster DWGs:

(1) Conduct a preliminary assessment of the clean-up and humanitarian needs of the affected areas;

(2) Reasonably ascertain that there is a sufficient population of eligible individuals to conduct the planned work; and

(3) Coordinate with the Local WDB and chief elected official(s) of the local area(s) in which the proposed project is to operate.

§ 687.150 What are the requirements for submitting applications for National Dislocated Worker Grants?

The Department will publish guidance on the requirements for submitting applications for DWGs. Requirements may vary depending on the DWG. A project implementation plan must be submitted after receiving the DWG award, unless otherwise specified.

§ 687.160 What is the timeframe for the Department to issue decisions on National Dislocated Worker Grant applications?

The Department will issue a final decision on a DWG application within 45 calendar days of receipt of an application that meets the requirements of this part. Applicants are encouraged to

review their DWG application submissions carefully and consult with the appropriate Employment and Training Administration Regional Office to ensure their applications meet the requirements established in this part and those that may be set forth in guidance.

§ 687.170 Who is eligible to be served under National Dislocated Worker Grants?

(a) For Employment Recovery DWGs:

(1) In order to receive employment and training activities, an individual must be:

(i) A dislocated worker within the meaning of sec. 3(15) of WIOA;

(ii) A person who is either:

(A) A civilian employee of the Department of Defense or the Department of Energy employed at a military installation that is being closed or will undergo realignment within 24 months after the date of determination of eligibility; or

(B) An individual employed in a nonmanagerial position with a Department of Defense contractor determined by the Secretary of Defense to be at risk of termination from employment as a result of reductions in defense expenditures and whose employer is converting from defense to non-defense applications in order to prevent worker layoffs; or

(iii) A member of the Armed Forces who:

(A) Was on active duty or full-time National Guard duty;

(B) Is involuntarily separated from active duty or full-time National Guard duty (as defined in 10 U.S.C. 1141), or is separated from active duty or full-time National Guard duty pursuant to a special separation benefits program under 10 U.S.C. 1174a, or the voluntary separation incentive program under 10 U.S.C. 1175;

(C) Is not entitled to retired or retained pay incident to the separation described in paragraph (a)(1)(iii)(B) of this section; and

(D) Applies for employment and training assistance under this part before the end of the 180-day period beginning on the date of the separation described in paragraph (a)(1)(iii)(B) of this section.

(iv) For Employment Recovery DWGs awarded for situations described in § 687.110(a)(4), a person who is:

(A) A dislocated member of the Armed Forces or member of the Armed Forces described in paragraph (a)(1)(iii) of this section; or

(B) The dislocated spouse of a member of the Armed Forces on active duty (as defined in 10 U.S.C. 101(d)(1)).

(2) [Reserved]

(b) For Disaster Recovery DWGs:

(1) In order to be eligible to receive disaster relief employment under sec. 170(b)(1)(B)(i) of WIOA, an individual must be:

(i) A dislocated worker;

(ii) A long-term unemployed individual;

(iii) An individual who is temporarily or permanently laid off as a consequence of the emergency or disaster; or

(iv) An individual who is self-employed and becomes unemployed or significantly underemployed as a result of the emergency or disaster.

(2) In order to be eligible to receive employment and training activities and in rare instances, disaster relief employment under sec. 170(b)(1)(B)(ii) of WIOA, an individual must have relocated or evacuated from an area as a result of a disaster that has been declared or otherwise recognized, and be:

(i) A dislocated worker;

(ii) A long-term unemployed individual;

(iii) An individual who is temporarily or permanently laid off as a consequence of the emergency or disaster; or

(iv) An individual who is self-employed and becomes unemployed or significantly underemployed as a result of the emergency or disaster.

(c) For Disaster Recovery DWG funds, individuals described in paragraph (b)(2) of this section are eligible to receive services provided with DWG funds in the State, tribal area, or outlying area in which the disaster occurred or the State, tribal area, or outlying area to which they have relocated. In certain cases determined by the Secretary, individuals described in paragraph (b)(2) of this section are eligible to receive services in both the State, tribal area, or outlying area in

which the disaster occurred and the State, tribal area, or outlying area to which they have relocated.

§ 687.180 What are the allowable activities under National Dislocated Worker Grants?

(a) For Employment Recovery DWGs:

(1) Employment and training assistance, including those activities authorized at secs. 134(c) through (d) and 170(b)(1) of WIOA. The services to be provided in a particular project are negotiated between the Department and the grantee, taking into account the needs of the target population covered by the grant, and may be changed through grant modifications, if necessary.

(2) DWGs may provide for supportive services, including needs-related payments (subject to the restrictions in sec. 134(d)(3) of WIOA, where applicable, and the terms and conditions of the grant) to help workers who require such assistance to participate in the activities provided for in the grant. Generally, the terms of a grant must be consistent with local policies governing such financial assistance under its formula funds (including the payment levels and duration of payments). The terms of the grant agreement may diverge from established local policies, in the following instances:

(i) If unemployed dislocated workers served by the project are not able to meet the 13 or 8 weeks enrollment in training requirement established by sec. 134(d)(3)(B) of WIOA because of the lack of formula or DWG funds in the State or local area at the time of the dislocation, such individuals may be eligible for needs-related payments if they are enrolled in training by the end of the 6th week following the date of the DWG award; or

(ii) Under other circumstances as specified in guidance governing DWG application requirements.

(b) For Disaster DWGs: Funds provided under sec. 170(b)(1)(B) of WIOA can support a different array of activities, depending on the circumstances surrounding the situation for which the grant was awarded:

(1) For DWGs serving individuals in an emergency or disaster area declared eligible for public assistance by FEMA, disaster relief employment is authorized to support projects that provide food, clothing, shelter, and other humanitarian assistance for emergency and disaster victims, and projects regarding demolition, cleaning, repair, renovation, and reconstruction of damaged and destroyed structures, facilities, and lands located within the disaster area and in offshore areas related to the emergency or disaster in coordination with the Administrator of FEMA. Employment and training activities also may be provided, as appropriate. An individual's disaster relief employment is limited to 12 months or less for work related to recovery from a single emergency or disaster. The Secretary may extend an individual's disaster relief employment for up to an additional 12 months, if it is requested and sufficiently justified by an entity described in § 687.120(b).

(2) For DWGs serving individuals who have relocated from an emergency or disaster area, only employment and training activities will be authorized, except where disaster relief employment is appropriate.

(3) For DWGs awarded to States for events that have designations from Federal agencies (other than FEMA) that recognize an emergency or disaster situation as one of national significance that could result in a potentially large loss of employment, disaster relief employment and/or employment and training activities may be authorized, depending on the circumstances associated with the specific event.

(c) Disaster Recovery DWG funds may be expended through public and private agencies and organizations engaged in the activities described in this paragraph (b) of this section.

§ 687.190 How do statutory and regulatory waivers apply to National Dislocated Worker Grants?

(a) For DWGs, utilization of statutory or regulatory waivers is limited to waivers already approved by the Department under sec. 189(i) of WIOA, separate from the DWG process. WIOA

sec. 189(i) gives the Department the authority to waive provisions under subtitles A, B, and/or E of WIOA; requirements of DWGs in WIOA subtitle D cannot and will not be waived.

(b) A grant application must include a description of the approved waiver and request that the waiver be applied to the DWG. The Department will consider such requests as part of the overall DWG application review and decision process; however, applicants may not use this process to request new waivers.

(c) If during the operation of a DWG, the grantee wishes to utilize a statutory or regulatory waiver that the Department has already approved under sec. 189(i), but it was not included in the grantee's original DWG application, the grantee must submit a grant modification that describes the waiver and requests application of the waiver to the DWG. Grantees may not use this process to request new waivers.

§ 687.200 What are the program and administrative requirements that apply to National Dislocated Worker Grants?

(a) Unless otherwise authorized in a DWG agreement, the financial and administrative rules contained in part 683 of this chapter apply to awards under this part.

(b) Exceptions include:

(1) Funds provided in response to a disaster may be used for temporary job creation in areas declared eligible for public assistance by FEMA, and, in some instances, areas impacted by an emergency or disaster situation of national significance, as provided in § 687.110(b)(2), and subject to the limitations of sec. 170(d) of WIOA, this part, and any guidance issued by the Department;

(2) Per sec. 170(d)(4) of WIOA, in extremely limited instances, as determined by the Secretary or the Secretary's designee, any Disaster Recovery DWG funds that are available for expenditure under any grant awarded under this part may be used for additional disasters or situations of national significance experienced by an entity described in § 687.120(b) in the same program year the funds were awarded;

(3) DWG funds may be used to pay an appropriate level of administrative costs based on the design and complexity of the project. The Department will negotiate administrative costs with the applicant as part of the application review and grant award and modification processes. Administrative cost limits will be calculated against the amount of the grant awarded;

(4) The period of availability for expenditure of funds under a DWG is specified in the grant agreement;

(5) The Department may establish supplemental reporting, monitoring, and oversight requirements for DWGs. The requirements will be identified in the grant application instructions or the grant document; and

(6) The Department may negotiate and fund projects under terms other than those specified in this part where it can be clearly demonstrated that such adjustments will achieve a greater positive benefit for the workers and/or communities being assisted.

PART 688—PROVISIONS GOVERNING THE YOUTHBUILD PROGRAM

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Subpart A—Purpose and Definitions

§ 688.100 What is YouthBuild?

(a) YouthBuild is a workforce development program that provides employment, education, leadership development, and training opportunities to disadvantaged and low-income youth between the ages of 16 and 24, most of whom are secondary school drop outs and are either a member of a low-income family, a foster care youth, a youth who is homeless, an offender, a youth with a disability, a child of an incarcerated parent, or a migrant youth.

(b) Program participants receive education services that may lead to either a high school diploma or its State-recognized equivalent. Further, they receive occupational skills training and are encouraged to pursue postsecondary education or additional training, including registered apprenticeship and pre-apprenticeship programs. The program is designed to create a skilled workforce either in the construction industry, through the rehabilitation and construction of housing for homeless and low-income individuals and families, as well as public facilities, or in other in-demand industries or occupations. The program also benefits the larger community because it provides increased access to affordable housing.

§ 688.110 What are the purposes of the YouthBuild program?

The overarching goal of the YouthBuild program is to provide disadvantaged and low-income youth the opportunity to obtain education and employment skills in local in-demand jobs to achieve economic self-sufficiency. Additionally, the YouthBuild program has as goals to:

(a) Enable disadvantaged youth to obtain the education and employment skills necessary to achieve economic self-sufficiency through employment in

in-demand occupations and pursuit of postsecondary education and training opportunities;

(b) Provide disadvantaged youth with opportunities for meaningful work and service to their communities;

(c) Foster the development of employment and leadership skills and commitment to community development among youth in low-income communities;

(d) Expand the supply of permanent affordable housing for homeless individuals and families, homeless youth, and low-income families by utilizing the talents of disadvantaged youth. The program seeks to increase the number of affordable and transitional housing units available to decrease the rate of homelessness in communities with YouthBuild programs; and

(e) Improve the quality and energy efficiency of community and other non-profit and public facilities, including those that are used to serve homeless and low-income families.

§ 688.120 What definitions apply to this part?

In addition to the definitions at sec. 3 of the Workforce Innovation and Opportunity Act (WIOA) and § 675.300 of this chapter, the following definitions apply:

Adjusted income means, with respect to a family, the amount (as determined by the Housing Development Agency) of the income of the members of the family residing in a dwelling unit or the persons on a lease, after any income exclusions as follows:

(1) *Mandatory exclusions.* In determining adjusted income, a Housing Development Agency must exclude from the annual income of a family the following amounts:

(i) *Elderly and disabled families.* $400 for any elderly or disabled family.

(ii) *Medical expenses.* The amount by which three percent of the annual family income is exceeded by the sum of:

(A) Unreimbursed medical expenses of any elderly family or disabled family;

(B) Unreimbursed medical expenses of any family that is not covered under paragraph (1)(ii)(A) of this definition, except that this paragraph (1)(ii)(B) only applies to the extent approved in appropriation Acts; and

(C) Unreimbursed reasonable attendant care and auxiliary apparatus expenses for each handicapped member of the family, to the extent necessary to enable any member of such family (including such handicapped member) to be employed.

(iii) *Child care expenses.* Any reasonable child care expenses necessary to enable a member of the family to be employed or to further his or her education.

(iv) *Minors, students, and persons with disabilities.* $480 for each member of the family residing in the household (other than the head of the household or his or her spouse) who is less than 18 years of age or is attending school or vocational training on a full-time basis, or who is 18 years of age or older and is a person with disabilities.

(v) *Child support payments.* Any payment made by a member of the family for the support and maintenance of any child who does not reside in the household, except that the amount excluded under this clause may not exceed $480 for each child for whom such payment is made; except that this clause only applies to the extent approved in appropriations Acts.

(vi) *Spousal support expenses.* Any payment made by a member of the family for the support and maintenance of any spouse or former spouse who does not reside in the household, except that the amount excluded under this clause must not exceed the lesser of the amount that such family member has a legal obligation to pay, or $550 for each individual for whom such payment is made; except that this clause only applies to the extent approved in appropriations Acts.

(vii) *Earned income of minors.* The amount of any earned income of a member of the family who is not:

(A) 18 years of age or older; and

(B) The head of the household (or the spouse of the head of the household).

(2) *Permissive exclusions for public housing.* In determining adjusted income, a Housing Development Agency may, at the discretion of the agency, establish exclusions from the annual income of a family residing in a public

housing dwelling unit. Such exclusions may include the following amounts:

(i) *Excessive travel expenses.* Excessive travel expenses in an amount not to exceed $25 per family per week, for employment or education-related travel.

(ii) *Earned income.* An amount of any earned income of the family, established at the discretion of the Housing Development Agency, which may be based on:

(A) All earned income of the family,

(B) The amount earned by particular members of the family;

(C) The amount earned by families having certain characteristics; or

(D) The amount earned by families or members during certain periods or from certain sources.

(iii) *Others.* Such other amounts for other purposes, as the Housing Development Agency may establish.

Applicant means an eligible entity that has submitted an application under § 688.210.

Basic skills deficient means an individual:

(1) Who is a youth, and who has English reading, writing, or computing skills at or below the eighth grade level on a generally accepted standardized test; or

(2) Who is a youth or adult, and who is unable to compute or solve problems, or read, write, or speak English, at a level necessary to function on the job, in the individual's family, or in society.

Community or other public facility means those facilities which are either privately owned by non-profit organizations, including faith-based and community-based organizations, and publicly used for the benefit of the community, or publicly owned and publicly used for the benefit of the community.

Construction Plus means the inclusion of occupational skills training for YouthBuild participants in in-demand occupations other than construction.

Eligible entity means a public or private non-profit agency or organization (including a consortium of such agencies or organizations), including:

(1) A community-based organization;

(2) A faith-based organization;

(3) An entity carrying out activities under this title, such as a Local Workforce Development Board (WDB);

(4) A community action agency;

(5) A State or local Housing Development Agency;

(6) An Indian tribe or other agency primarily serving Indians;

(7) A community development corporation;

(8) A State or local youth service or conservation corps; and

(9) Any other entity eligible to provide education or employment training under a Federal program (other than the program carried out under this section).

English language learner, when used with respect to a participant, means an eligible individual who has limited ability in reading, writing, speaking, or comprehending the English language, and:

(1) Whose native language is a language other than English; or

(2) Who lives in a family or community environment where a language other than English is the dominant language.

Exit, as used in § 688.400, has the same meaning as in § 677.150(c) of this chapter.

Follow-up services include:

(1) The leadership development and supportive service activities listed in §§ 681.520 and 681.570 of this chapter;

(2) Regular contact with a youth participant's employer, including assistance in addressing work-related problems that arise;

(3) Assistance in securing better paying jobs, career development, and further education;

(4) Work-related peer support groups;

(5) Adult mentoring; and

(6) Services necessary to ensure the success of youth participants in employment and/or postsecondary education.

Homeless child or youth means an individual who lacks a fixed, regular, and adequate nighttime residence and includes a child or youth who:

(1) Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;

(2) Is living in a motel, hotel, trailer park, or campground due to the lack of alternative adequate accommodations;

(3) Is living in an emergency or transitional shelter, is abandoned in a hospital, or is awaiting foster care placement;

(4) Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

(5) Is living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; or

(6) Is a migratory child living in circumstances described in this definition.

Homeless individual means an individual who lacks a fixed, regular, and adequate nighttime residence and includes an individual who:

(1) Is sharing the housing of other persons due to loss of housing, economic hardship, or similar reason;

(2) Is living in a motel, hotel, trailer park, or campground due to the lack of alternative adequate accommodations;

(3) Is living in an emergency or transitional shelter;

(4) Is abandoned in a hospital, or is awaiting foster care placement;

(5) Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as regular sleeping accommodation for human beings; or

(6) Is a migratory child living in circumstances described in this definition.

Housing Development Agency means any agency of a Federal, State or local government, or any private non-profit organization, that is engaged in providing housing for homeless individuals or low-income families.

Income, as defined in the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(2)), means income is from all sources of each member of the household, as determined in accordance with the criteria prescribed by the Secretary of Labor, in consultation with the Secretary of Agriculture, except that any amounts not actually received by the family and any amounts which would be eligible for exclusion under sec. 1382b(a)(7) of the United States Housing Act of 1937, may not be considered as income under this definition.

In-Demand Industry Sector or Occupation means:

(1) An industry sector that has a substantial current or potential impact (including through jobs that lead to economic self-sufficiency and opportunities for advancement) on the State, regional, or local economy, as appropriate, and that contributes to the growth or stability of other supporting business, or the growth of other industry sectors; or

(2) An occupation that currently has or is projected to have a number of positions (including positions that lead to economic self-sufficiency and opportunities for advancement) in an industry sector so as to have a significant impact on the State, regional, or local economy, as appropriate.

Indian, as defined in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b), means a person who is a member of an Indian tribe.

Indian tribe means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 *et seq.*), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual with a disability means an individual with a disability as defined in sec. 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

Low-income family means a family whose income does not exceed 80 percent of the median income for the area unless the Secretary determines that a higher or lower ceiling is warranted. This definition includes families consisting of one person as defined by 42 U.S.C. 1437a(b)(3).

Migrant youth means a youth, or a youth who is the dependent of someone who, during the previous 12 months, has:

(1) Worked at least 25 days in agricultural labor that is characterized by chronic unemployment or underemployment;

(2) Made at least $800 from agricultural labor that is characterized by

chronic unemployment or underemployment, if at least 50 percent of his or her income came from such agricultural labor;

(3) Was employed at least 50 percent of his or her total employment in agricultural labor that is characterized by chronic unemployment or underemployment; or

(4) Was employed in agricultural labor that requires travel to a jobsite such that the farmworker is unable to return to a permanent place of residence within the same day.

Needs-based payments means additional payments beyond regular stipends for program participation that are based on defined needs that enable a youth to participate in the program.

Occupational skills training means an organized program of study that provides specific vocational skills that lead to proficiency in performing actual tasks and technical functions required by certain occupational fields at entry, intermediate, or advanced levels. Occupational skills training includes training programs that lead to recognized postsecondary credentials that align with in-demand industry sectors or occupations in the local area. Such training must:

(1) Be outcome-oriented and focused on an occupational goal specified in the individual service strategy;

(2) Be of sufficient duration to impart the skills needed to meet the occupational goal; and

(3) Result in attainment of a recognized postsecondary credential.

Offender means an adult or juvenile who:

(1) Is or has been subject to any stage of the criminal justice process, and who may benefit from WIOA services; or

(2) Requires assistance in overcoming artificial barriers to employment resulting from a record of arrest or conviction.

Participant means an individual who has been determined eligible to participate in the YouthBuild program, and who enrolls in the program and receives services or training described in § 688.320.

Pre-apprenticeship, as defined in § 681.480 of this chapter, means a program designed to prepare individuals to enter and succeed in an apprenticeship program registered under the Act of August 16, 1937 (commonly known as the ''National Apprenticeship Act''; 50 Stat. 664, chapter 663; 29 U.S.C. 50 *et seq.*) (referred to in this part as a ''registered apprenticeship'' or ''registered apprenticeship program'') and includes the following elements:

(1) Training and curriculum that aligns with the skill needs of employers in the economy of the State or region involved;

(2) Access to educational and career counseling and other supportive services, directly or indirectly;

(3) Hands-on, meaningful learning activities that are connected to education and training activities, such as exploring career options, and understanding how the skills acquired through coursework can be applied toward a future career;

(4) Opportunities to attain at least one industry-recognized credential; and

(5) A partnership with one or more registered apprenticeship programs that assists in placing individuals who complete the pre-apprenticeship program in a registered apprenticeship program.

(6) YouthBuild programs that receive funding under this part are considered pre-apprenticeship programs under this definition.

Recognized postsecondary credential means a credential consisting of an industry-recognized certificate or certification, a certificate of completion of a registered apprenticeship, a license recognized by the State involved or Federal government, or an associate or baccalaureate degree.

Registered apprenticeship program means an apprenticeship program that:

(1) Is registered under the Act of August 16, 1937 (commonly known as the ''National Apprenticeship Act'' (50 Stat. 664; 20 U.S.C. 50 *et seq.*)); and

(2) Meets such other criteria as the Secretary may establish.

School dropout means an individual who no longer attends any school and who has not received a secondary school diploma or its State-recognized equivalent.

Secondary school means a nonprofit institutional day or residential school, including a public secondary charter

school, that provides secondary education, as determined under State law, except that the term does not include any education beyond grade 12.

Section 3 means a program described in sec. 3 of the Housing and Urban Development Act of 1968, as amended by the Housing and Community Development Act of 1992.

Supportive services for youth, as defined in § 681.570 of this chapter, are services that enable an individual to participate in WIOA activities. These services include, but are not limited to, the following:

(1) Linkages to community services;

(2) Assistance with transportation;

(3) Assistance with child care and dependent care;

(4) Referrals to child support;

(5) Assistance with housing;

(6) Needs-related payments;

(7) Assistance with educational testing;

(8) Reasonable accommodations for youth with disabilities;

(9) Referrals to health care;

(10) Assistance with uniforms or other appropriate work attire and work-related tools, including such items as eyeglasses and protective eye gear;

(11) Assistance with books, fees, school supplies, and other necessary items for students enrolled in postsecondary education classes; and

(12) Payments and fees for employment and training-related applications, tests, and certifications.

Transitional housing means housing provided to ease the movement of individuals and families experiencing homelessness to permanent housing within 24 months or such longer period.

YouthBuild program means any program that receives assistance under this part and provides disadvantaged youth with opportunities for employment, education, leadership development, service to the community, and training through the rehabilitation (which, for purposes of this part, includes energy efficiency enhancements) or construction of housing for homeless individuals and low-income families, and public facilities.

Youth in foster care, as defined in § 681.210 of this chapter, means an individual in foster care or who has aged out of the foster care system or who has attained 16 years of age and left foster care for kinship, guardianship, or adoption; or a child eligible for assistance under sec. 477 of the Social Security Act (42 U.S.C. 677), or in an out-of-home placement.

Subpart B—Funding and Grant Applications

§ 688.200 How are YouthBuild grants funded and administered?

The Secretary uses funds authorized for appropriation under WIOA sec. 171(i) to administer YouthBuild as a national program under title I, subtitle D of WIOA. YouthBuild grants are awarded to eligible entities, as defined in § 688.120, through the competitive selection process described in § 688.210.

§ 688.210 How does an eligible entity apply for grant funds to operate a YouthBuild program?

The Secretary announces the availability of grant funds through a Funding Opportunity Announcement (FOA). The FOA contains instructions for what the Department requires in the grant application, describes eligibility requirements, the rating criteria that the Department will use in reviewing grant applications, and special reporting requirements to operate a YouthBuild project. The FOA, along with the requisite forms needed to apply for grant funds, can be found at *http://www.doleta.gov/grants/find_grants.cfm.*

§ 688.220 How are eligible entities selected to receive grant funds?

In order to receive funds under the YouthBuild program, an eligible entity must meet selection criteria established by the Secretary which include:

(a) The qualifications or potential capabilities of an applicant;

(b) An applicant's potential to develop a successful YouthBuild program;

(c) The need for an applicant's proposed program, as determined by the degree of economic distress of the community from which participants would be recruited (measured by indicators such as poverty, youth unemployment, and the number of individuals who have dropped out of secondary school)

and of the community in which the housing and community and public facilities proposed to be rehabilitated or constructed are located (measured by indicators such as incidence of homelessness, shortage of affordable housing, and poverty);

(d) The commitment of an applicant to provide skills training, leadership development, counseling and case management, and education to participants;

(e) The focus of a proposed program on preparing youth for local in-demand sectors or occupations, or postsecondary education and training opportunities;

(f) The extent of an applicant's coordination of activities to be carried out through the proposed program with:

(1) Local WDBs, one-stop center operators, and one-stop partners participating in the operation of the one-stop delivery system involved, or the extent of the applicant's good faith efforts, as determined by the Secretary, in achieving such coordination;

(2) Public education, criminal justice, housing and community development, national service, or postsecondary education or other systems that relate to the goals of the proposed program; and

(3) Employers in the local area;

(g) The extent to which a proposed program provides for inclusion of tenants who were previously homeless individuals or families in the rental of housing provided through the program;

(h) The commitment of additional resources to the proposed program (in addition to the funds made available through the grant) by:

(1) An applicant;

(2) Recipients of other Federal, State, or local housing and community development assistance who will sponsor any part of the rehabilitation, construction, operation and maintenance, or other housing and community development activities undertaken as part of the proposed program; or

(3) Entities carrying out other Federal, State, or local activities or activities conducted by Indian tribes, including vocational education programs, adult and language instruction educational programs, and job training using funds provided under WIOA;

(i) An applicant's ability to enter partnerships with:

(1) Education and training providers including:

(i) The kindergarten through twelfth grade educational system;

(ii) Adult education programs;

(iii) Community and technical colleges;

(iv) Four-year colleges and universities;

(v) Registered apprenticeship programs; and

(vi) Other training entities;

(2) Employers, including professional organizations and associations. An applicant will be evaluated on the extent to which employers participate in:

(i) Defining the program strategy and goals;

(ii) Identifying needed skills and competencies;

(iii) Designing training approaches and curricula;

(iv) Contributing financial support; and

(v) Hiring qualified YouthBuild graduates;

(3) The workforce development system which may include:

(i) State and Local WDBs;

(ii) State workforce agencies; and

(iii) One-stop centers and their partner programs;

(4) The juvenile and adult justice systems, and the extent to which they provide:

(i) Support and guidance for YouthBuild participants with court involvement;

(ii) Assistance in the reporting of recidivism rates among YouthBuild participants; and

(iii) Referrals of eligible participants through diversion or reentry from incarceration;

(5) Faith-based and community organizations, and the extent to which they provide a variety of grant services such as:

(i) Case management;

(ii) Mentoring;

(iii) English as a Second Language courses; and

(iv) Other comprehensive supportive services, when appropriate;

(j) The applicant's potential to serve different regions, including rural areas and States that may not have previously received grants for YouthBuild programs; and

(k) Such other factors as the Secretary determines to be appropriate for purposes of evaluating an applicant's potential to carry out the proposed program in an effective and efficient manner.

(l) The weight to be given to these factors will be described in a FOA issued under § 688.210.

§ 688.230 What are the minimum requirements to apply for YouthBuild funds?

At minimum, applications for YouthBuild funds must include the following elements:

(a) Labor market information for the relevant labor market area, including both current data (as of the date of submission of the application) and projections on career opportunities in construction and in-demand industry sectors or occupations;

(b) A request for the grant, specifying the amount of the grant requested and its proposed uses;

(c) A description of the applicant and a statement of its qualifications, including a description of the applicant's relationship with Local WDBs, one-stop operators, employers, local unions, entities carrying out registered apprenticeship programs, other community groups, and the applicant's past experience with rehabilitation or construction of housing or public facilities (including experience with programs through the U.S. Department of Housing and Urban Development (HUD) under sec. 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u)), and with youth education and employment training programs);

(d) A description of the proposed site for the proposed program;

(e) A description of the educational and job training activities, work opportunities, postsecondary education and training opportunities, and other services that will be provided to participants, and how those activities, opportunities, and services will prepare youth for employment in in-demand industry sectors or occupations in the labor market area described in paragraph (a) of this section;

(1) A description of the proposed activities to be undertaken under the grant related to rehabilitation or construction, and, in the case of an applicant requesting approval from the Secretary to carry out additional activities related to in-demand industry sectors or occupations, a description of such additional activities.

(2) The anticipated schedule for carrying out all activities proposed under paragraph (f) of this section;

(f) A description of the manner in which eligible youth will be recruited and selected as participants, including a description of arrangements that will be made with Local WDBs, one-stop operators, faith and community-based organizations, State education agencies or local education agencies (including agencies of Indian tribes), public assistance agencies, the courts of jurisdictions, agencies that serve youth who are homeless individuals (including those that operate shelters), foster care agencies, and other appropriate public and private agencies;

(g) A description of the special outreach efforts that will be undertaken to recruit eligible young women (including young women with dependent children) as participants;

(h) A description of the specific role of employers in the proposed program, such as their role in developing the proposed program and assisting in service provision and placement activities;

(i) A description of how the proposed program will be coordinated with other Federal, State, and local activities conducted by Indian tribes, such as workforce investment activities, career and technical education and training programs, adult and language instruction educational programs, activities conducted by public schools, activities conducted by community colleges, national service programs, and other job training provided with funds available under WIOA, in particular how programs will coordinate with local Workforce Development funds outlined in WIOA sec. 129(c)(2);

(j) Assurances that there will be a sufficient number of adequately trained supervisory personnel in the proposed program;

(k) A description of the level of performance to be achieved with respect to primary indicators of performance for eligible youth as described in § 688.410;

(l) The organization's past performance under a grant issued by the Secretary to operate a YouthBuild program;

(m) A description of the applicant's relationship with local building trade unions regarding their involvement in training to be provided through the proposed program, the relationship of the proposed program to established registered apprenticeship programs and employers, the ability of the applicant to grant an industry-recognized certificate or certification through the program, and the quality of the program leading to the certificate or certification;

(n) A description of activities that will be undertaken to develop leadership skills of participants;

(o) A detailed budget and description of the system of fiscal controls, and auditing and accounting procedures, that will be used to ensure fiscal soundness for the proposed program;

(p) A description of the commitments for any additional resources (in addition to funds made available through the grant) to be made available to the proposed program from:

(1) The applicant;

(2) Recipients of other Federal, State, or local housing and community development assistance that will sponsor any part of the rehabilitation or construction, operation or maintenance, or other housing and community development activities undertaken as part of the proposed program; or

(3) Entities carrying out other Federal, State or local activities conducted by Indian tribes, including career and technical education and training programs, and job training provided with funds under WIOA;

(q) Information identifying and describing of, the financing proposed for any:

(1) Rehabilitation of the property involved;

(2) Acquisition of the property; or

(3) Construction of the property;

(r) Information identifying and describing of, the entity that will manage and operate the property;

(s) Information identifying and describing of, the data collection systems to be used;

(t) A certification, by a public official responsible for the housing strategy for the State or unit of general local government within which the proposed program is located, that the proposed program is consistent with the housing strategy;

(u) A certification that the applicant will comply with requirements of the Fair Housing Act (42 U.S.C. 3601 *et seq.*) and will affirmatively further fair housing; and

(v) Any additional requirements that the Secretary determines are appropriate.

§ 688.240 How are eligible entities notified of approval for grant funds?

The Secretary will, to the extent practicable, notify each eligible entity applying for funds no later than 5 months from the date the application is received, whether the application is approved or disapproved. In the event additional funds become available, the Employment and Training Administration (ETA) reserves the right to use such funds to select additional grantees from applications submitted in response to a FOA.

Subpart C—Program Requirements

§ 688.300 Who is an eligible participant?

(a) *Eligibility criteria.* Except as provided in paragraph (b) of this section, an individual is eligible to participate in a YouthBuild program if the individual is:

(1) Not less than age 16 and not more than age 24 on the date of enrollment;

(2) A school dropout or an individual who has dropped out of school and has subsequently reenrolled; and

(3) Is one or more of the following:

(i) A member of a low-income family;

(ii) A youth in foster care;

(iii) An offender;

(iv) A youth who is an individual with a disability;

(v) The child of a current or formerly incarcerated parent; or

(vi) A migrant youth.

(b) *Exceptions.* Not more than 25 percent of the participants in a program, under this section, may be individuals who do not meet the requirements of paragraph (a)(2) or (3) of this section, if such individuals:

(1) Are basic skills deficient, as defined in § 688.120, despite attainment of a secondary school diploma or its recognized State equivalent (including recognized certificates of attendance or similar documents for individuals with disabilities); or

(2) Have been referred by a local secondary school for participation in a YouthBuild program leading to the attainment of a secondary school diploma if such referral is to a YouthBuild program offering a secondary school diploma.

§ 688.310 Are there special rules that apply to veterans?

Special rules for determining income for veterans are found in § 683.230 of this chapter and for the priority of service provisions for qualified persons are found in 20 CFR part 1010. Those special rules apply to covered persons who are eligible to participate in the YouthBuild program.

§ 688.320 What eligible activities may be funded under the YouthBuild program?

Grantees may provide one or more of the following education and workforce investment and other activities to YouthBuild participants:

(a) Eligible education and workforce activities including:

(1) Work experience and skills training (coordinated, to the maximum extent feasible, with registered apprenticeship programs), including:

(i) Supervision and training for participants in the rehabilitation or construction of housing, including residential housing for homeless individuals or low-income families, or transitional housing for homeless individuals and in additional in-demand industry sectors or occupations in the region in which the program operates (as approved by the Secretary);

(ii) Supervision and training for participants in the rehabilitation or construction of community and other public facilities, except that not more than 15 percent of grant funds-appropriated to carry out this section may be used for this activity; and

(iii) Supervision and training for participants in in-demand industry sectors or occupations in the region in which the program operates, if such activity is approved by the Secretary;

(2) Occupational skills training;

(3) Other paid and unpaid work experiences, including internships and job shadowing;

(4) Services and activities designed to meet the educational needs of participants, including:

(i) Basic skills instruction and remedial education;

(ii) Language instruction educational programs for participants who are English language learners;

(iii) Secondary education services and activities, including tutoring, study skills training, and school dropout prevention and recovery activities, designed to lead to the attainment of a secondary school diploma or its recognized equivalent (including recognized certificates of attendance or similar documents for individuals with disabilities);

(iv) Counseling and assistance in obtaining postsecondary education and required financial aid; and

(v) Alternative secondary school services;

(5) Counseling services and related activities, such as comprehensive guidance and counseling on drug and alcohol abuse, referrals to mental health services, and referrals to victim services;

(6) Activities designed to develop employment and leadership skills, which may include community service and peer-centered activities encouraging responsibility, interpersonal skills, and other positive social behaviors, and activities related to youth policy committees that participate in decision-making related to the program;

(7)(i) Supportive services and needs-based payments necessary to enable individuals to participate in the program and to assist individuals, for a period of time not to exceed 12 months after the

completion of training, in obtaining or retaining employment or applying for and transitioning to postsecondary education or training;

(ii) To provide needs-based payments, a grantee must have a written policy which:

(A) Establishes participant eligibility for such payments;

(B) Establishes the amounts to be provided;

(C) Describes the required documentation and criteria for payments; and

(D) Applies consistently to all program participants; and

(8) Job search and assistance;

(b) Payment of the administrative costs of the applicant, including recruitment and selection of participants, except that not more than 10 percent of the amount awarded under § 688.210 may be used for such costs;

(c) Adult mentoring;

(d) Provision of wages, stipends, or benefits to participants in the program;

(e) Ongoing training and technical assistance that is related to developing and carrying out the program; and

(f) Follow-up services.

§ 688.330 What level of training qualifies a construction project as a qualifying work site under the YouthBuild program?

At a minimum, in order to qualify as a work site for the purposes of the YouthBuild program, a work site must:

(a) Provide participants with the opportunity to have hands-on training and experience in two or more modules, each within a different skill area, in a construction skills training program that offers an industry-recognized credential;

(b) Be built or renovated for low-income individuals or families;

(c) Have a restrictive covenant in place that only allows for rental or resale to low-income participants as required by § 688.730; and

(d) Adhere to the allowable construction and other capital asset costs applicable to the YouthBuild program.

§ 688.340 What timeframes apply to participation?

An eligible individual selected for participation in the program must be offered full-time participation in the program for not less than 6 months and not more than 24 months.

§ 688.350 What timeframes must be devoted to education and workforce investment or other activities?

YouthBuild grantees must structure programs so that participants in the program are offered:

(a) Education and related services and activities designed to meet educational needs, such as those specified in § 688.320(a)(4) through (7), during at least 50 percent of the time during which they participate in the program; and

(b) Workforce and skills development activities, such as those specified in § 688.320(a)(1) through (3), during at least 40 percent of the time during which they participate in the program.

(c) The remaining 10 percent of the time of participation may be used for the activities described in paragraphs (a) and (b) of this section and/or for leadership development and community service activities.

§ 688.360 What timeframes apply to follow-up services?

Grantees must provide follow-up services to all YouthBuild participants for a period of 12 months after a participant successfully exits a YouthBuild program.

§ 688.370 What are the requirements for exit from the YouthBuild program?

At a minimum, to be a successful exit, the Department of Labor requires that:

(a) Participants receive hands-on construction training or hands-on training in another industry or occupation, in the case of Construction Plus grantees; and

(b) Participants meet the exit policies established by the grantee.

(1) Such policies must describe the program outcomes and/or individual goals that must be met by each participant in order to successfully complete the program; and

(2) Grantees must apply the policies consistently to determine when a successful exit has occurred.

§ 688.380 What is the role of the YouthBuild grantee in the one-stop delivery system?

In those local areas where the grantee operates its YouthBuild program, the grantee is a required partner of the local one-stop delivery system and is subject to the provisions relating to such partners described in part 678 of this chapter.

Subpart D—Performance Indicators

§ 688.400 What are the performance indicators for YouthBuild grants?

The performance indicators for YouthBuild grants include:

(a) The percentage of program participants who are in education and training activities, or in unsubsidized employment, during the second quarter after exit from the program;

(b) The percentage of program participants who are in education or training activities, or in unsubsidized employment, during the fourth quarter after exit from the program;

(c) The median earnings of program participants who are in unsubsidized employment during the second quarter after exit from the program;

(d) The percentage of program participants who obtain a recognized postsecondary credential or secondary school diploma or its recognized equivalent (and for those achieving the secondary diploma or its recognized equivalent, such participants also have obtained or retained employment or are in an education or training program leading to a recognized postsecondary credential within 1 year after exit from the program);

(e) The percentage of program participants who, during a program year, are in an education and training program that leads to a recognized postsecondary credential or employment and who are achieving measurable skill gains toward such a credential or employment;

(f) The percentage of participants in unsubsidized employment during the second quarter after exit from the program who were employed by the same employer in the second and fourth quarters after exit; and

(g) Other indicators of performance as may be required by the Secretary.

[81 FR 56460, Aug. 19, 2016, as amended at 89 FR 13614, Feb. 23, 2024]

§ 688.410 What are the required levels of performance for the performance indicators?

(a) The Secretary must annually establish expected levels of performance for YouthBuild programs relating to each of the primary indicators of performance. The expected levels of performance for each of the performance indicators are national standards that are provided in separately issued guidance. Short-term or other performance indicators will be provided in separately issued guidance or as part of the FOA or grant agreement. Performance level expectations will be based on available YouthBuild data and data from similar WIOA youth programs and may change from one grant competition to another. The expected national levels of performance will take into account the extent to which the levels promote continuous improvement in performance.

(b) The levels of performance established will at a minimum:

(1) Be expressed in an objective, quantifiable, and measurable form; and

(2) Indicate continuous improvement in performance.

§ 688.420 What are the reporting requirements for YouthBuild grantees?

Each grantee must provide such reports as are required by the Secretary in separately issued guidance, including:

(a) The quarterly performance report;

(b) The quarterly narrative progress report;

(c) The financial report; and

(d) Such other reports as may be required by the grant agreement.

§ 688.430 What are the due dates for quarterly reporting?

(a) Quarterly reports are due no later than 45 days after the end of the reporting quarter, unless otherwise specified in the reporting guidance issued under § 688.420; and

(b) A final financial report is required 90 days after the expiration of a

funding period or the termination of grant support.

Subpart E—Administrative Rules, Costs, and Limitations

§ 688.500 What administrative regulations apply to the YouthBuild program?

Each YouthBuild grantee must comply with the following:

(a) The regulations found in this part;

(b) The general administrative requirements found in part 683 of this chapter, except those that apply only to the WIOA title I, subtitle B program and those that have been modified by this section;

(c) The Department's regulations on government-wide requirements, which include:

(1) The regulations codifying the Office of Management and Budget's (OMB) government-wide grants requirements at 2 CFR parts 200 and 2900, as applicable;

(2) The Department's regulations at 29 CFR part 38, which implement the nondiscrimination provisions of WIOA sec. 188;

(3) The Department's regulations at 29 CFR parts 93, 94, and 98 relating to restrictions on lobbying, drug free workplace, and debarment and suspension; and

(4) The audit requirements of the Office of Management and Budget at 2 CFR parts 200 and 2900, as applicable; and

(d) Relevant State and local educational standards.

§ 688.510 How may grantees provide services under the YouthBuild program?

Each recipient of a grant under the YouthBuild program may provide the services and activities described in these regulations either directly or through subgrants, contracts, or other arrangements with local educational agencies, postsecondary educational institutions, State or local housing development agencies, other public agencies, including agencies of Indian tribes, or private organizations.

§ 688.520 What cost limits apply to the use of YouthBuild program funds?

(a) Administrative costs for programs operated under YouthBuild are limited to 10 percent of the grant award. The definition of administrative costs can be found in § 683.215 of this chapter.

(b) The cost of supervision and training for participants involved in the rehabilitation or construction of community and other public facilities is limited to no more than 15 percent of the grant award.

§ 688.530 What are the cost-sharing or matching requirements of the YouthBuild program?

(a) In addition to the rules described in paragraphs (b) through (f) of this section, the cost-sharing or matching requirements applicable to a YouthBuild grant will be addressed in the grant agreement.

(b) The value of construction materials used in the YouthBuild program is an allowable cost for the purposes of the required non-Federal share or match.

(c) The value of land acquired for the YouthBuild program is not an allowable cost-sharing or match.

(d) Federal funds may not be used as cost-sharing or match resources except as provided by Federal law.

(e) The value of buildings acquired for the YouthBuild program is an allowable match, provided that the following conditions apply:

(1) The purchase cost of buildings used solely for training purposes is allowable; and

(2) For buildings used for training and other purposes, the allowable amount is determined based on the proportionate share of the purchase price related to direct training activities.

(f) Grantees must follow the requirements of Uniform Guidance at 2 CFR parts 200 and 2900 in the accounting, valuation, and reporting of the required non-Federal share.

§ 688.540 What are considered to be leveraged funds?

(a) Leveraged funds may be used to support allowable YouthBuild program activities and consist of payments made for allowable costs funded by

both non-YouthBuild Federal, and non-Federal, resources which include:

(1) Costs which meet the criteria for cost-sharing or match in § 688.530 and are in excess of the amount of cost-sharing or match resources required;

(2) Costs which would meet the criteria in § 688.530 except that they are paid for with other Federal resources; and

(3) Costs which benefit the grant program and are otherwise allowable under the cost principles but are not allowable under the grant because of some statutory, regulatory, or grant provision, whether paid for with Federal or non-Federal resources.

(b) The use of leveraged funds must be reported in accordance with Departmental instructions.

§ 688.550 How are the costs associated with real property treated in the YouthBuild program?

(a) As provided in paragraphs (b) and (c) of this section, the costs of the following activities associated with real property are allowable solely for the purpose of training YouthBuild participants:

(1) Rehabilitation of existing structures for use by homeless individuals and families or low-income families or for use as transitional housing;

(2) Construction of buildings for use by homeless individuals and families or low-income families or for use as transitional housing; and

(3) Construction or rehabilitation of community or other public facilities, except, as provided in § 688.520(b), only 15 percent of the grant award is allowable for such construction and rehabilitation.

(b) The costs for acquisition of buildings that are used for activities described in paragraph (a) of this section are allowable with prior grant officer approval and only under the following conditions:

(1) The purchase cost of buildings used solely for training purposes is allowable; and

(2) For buildings used for training and other purposes, the allowable amount is determined based on the proportionate share of the purchase cost related to direct training.

(c) The following costs are allowable to the extent allocable to training YouthBuild participants in the construction and rehabilitation activities specified in paragraph (a) of this section:

(1) Trainees' tools and clothing including personal protective equipment (PPE);

(2) On-site trainee supervisors;

(3) Construction management;

(4) Relocation of buildings; and

(5) Clearance and demolition.

(d) Architectural fees, or a proportionate share thereof, are allowable when such fees can be related to items such as architectural plans or blueprints on which participants will be trained.

(e) The following costs are unallowable:

(1) The costs of acquisition of land; and

(2) Brokerage fees.

§ 688.560 What participant costs are allowable under the YouthBuild program?

Allowable participant costs include:

(a) The costs of payments to participants engaged in eligible work-related YouthBuild activities;

(b) The costs of payments provided to participants engaged in non-work-related YouthBuild activities;

(c) The costs of needs-based payments;

(d) The costs of supportive services; and

(e) The costs of providing additional benefits to participants or individuals who have exited the program and are receiving follow-up services, which may include:

(1) Tuition assistance for obtaining college education credits;

(2) Scholarships to a registered apprenticeship or technical education program; and

(3) Employer- or Government-sponsored health programs.

§ 688.570 Does the Department allow incentive payments in the YouthBuild program?

(a) Grantees are permitted to provide incentive payments to youth participants for recognition and achievement directly tied to training activities and work experiences. Grantees must tie

the incentive payments to the goals of the specific grant program and outline such goals in writing prior to starting the program that makes incentive payments.

(b) Prior to providing incentive payments, the organization must have written policies and procedures in place governing the awarding of incentives, and the incentives provided under the grant must align with these organizational policies.

(c) All incentive payments must comply with the requirements in Uniform Guidance at 2 CFR part 200.

§ 688.580 What effect do payments to YouthBuild participants have on eligibility for other Federal needs-based benefits?

Under § 683.275(d) of this chapter, the Department does not consider allowances, earnings, and payments to individuals participating in programs under title I of WIOA as income for purposes of determining eligibility for and the amount of income transfer and in-kind aid furnished under any Federal or Federally-assisted program based on need other than as provided under the Social Security Act (42 U.S.C. 301).

§ 688.590 What program income requirements apply under the YouthBuild program?

(a) Except as provided in paragraph (b) of this section, program income requirements, as specified in the applicable Uniform Administrative Requirements at 2 CFR parts 200 and 2900, apply to YouthBuild grants.

(b) Revenue from the sale of buildings rehabilitated or constructed under the YouthBuild program to homeless individuals and families and low-income families is not considered program income. Grantees are encouraged to use that revenue for the long-term sustainability of the YouthBuild program.

§ 688.600 Are YouthBuild programs subject to the Davis-Bacon Act labor standards?

(a) YouthBuild programs and grantees are subject to Davis-Bacon labor standards requirements under the circumstances set forth in paragraph (b) of this section. In those instances where a grantee is subject to Davis-Bacon requirements, the grantee must follow applicable requirements in the Department's regulations at 29 CFR parts 1, 3, and 5, including the requirements contained in the Davis-Bacon contract provisions set forth in 29 CFR 5.5.

(b) YouthBuild participants are subject to Davis-Bacon Act labor standards when they perform Davis-Bacon-covered laborer or mechanic work, defined at 29 CFR 5.2(m), on Federal or Federally-assisted projects that are subject to the Davis-Bacon Act labor standards. The Davis-Bacon prevailing wage requirements apply to hours worked on the site of the work.

(c) YouthBuild participants who are not registered and participating in a training program approved by the ETA must be paid not less than the applicable wage rate on the wage determination for the classification of work actually performed.

§ 688.610 What are the recordkeeping requirements for YouthBuild programs?

(a) Grantees must follow the recordkeeping requirements specified in the Uniform Administrative Requirements, at 29 CFR 95.53 and 97.42, as appropriate.

(b) Grantees must maintain such additional records related to the use of buildings constructed or rehabilitated with YouthBuild funds as specified in the grant agreement or in the Department's guidance.

Subpart F—Additional Requirements

§ 688.700 What are the safety requirements for the YouthBuild program?

(a) YouthBuild Grantees must comply with § 683.280 of this chapter, which applies Federal and State health and safety standards to the working conditions under WIOA-funded projects and programs. These health and safety standards include ''hazardous orders'' governing child labor at 29 CFR part 570.

(b) YouthBuild grantees are required to:

(1) Provide comprehensive safety training for youth working on YouthBuild construction projects;

(2) Have written, jobsite-specific safety plans overseen by an on-site supervisor with authority to enforce safety procedures;

(3) Provide necessary personal protective equipment to youth working on YouthBuild projects; and

(4) Submit required injury incident reports.

§ 688.710 What are the reporting requirements for youth safety?

YouthBuild grantees must ensure that YouthBuild program sites comply with the Occupational Safety and Health Administration's (OSHA) reporting requirements in 29 CFR part 1904. A YouthBuild grantee is responsible for sending a copy of OSHA's injury incident report form to the ETA within 7 days of any reportable injury suffered by a YouthBuild participant. The injury incident report form is available from OSHA and can be downloaded at *http://www.osha.gov/recordkeeping/RKforms.html*. Reportable injuries include those that result in death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness.

§ 688.720 What environmental protection laws apply to the YouthBuild program?

YouthBuild program grantees are required, where applicable, to comply with all environmental protection statutes and regulations.

§ 688.730 What requirements apply to YouthBuild housing?

(a) YouthBuild grantees must ensure that all residential housing units which are constructed or rehabilitated using YouthBuild funds must be available solely for:

(1) Sale to homeless individuals and families or low-income families;

(2) Rental by homeless individuals and families or low-income families;

(3) Use as transitional or permanent housing for the purpose of assisting in the movement of homeless individuals and families to independent living. In the case of transitional housing, the unit(s) must be occupied no more than 24 months by the same individual(s); or

(4) Rehabilitation of homes for low-income homeowners.

(b) For rentals of residential units located on the property which are constructed or rehabilitated using YouthBuild funds:

(1) The property must maintain at least a 90 percent level of occupancy for low-income families. The income test will be conducted only at the time of entry for each available unit or rehabilitation of occupant-owned home. If the grantee cannot find a qualifying tenant to lease the unit, the unit may be leased to a family whose income is above the income threshold to qualify as a low-income family but below the median income for the area. Leases for tenants with higher incomes will be limited to not more than 2 years. The leases provided to tenants with higher incomes are not subject to the termination clause that is described in paragraph (b)(2) of this section.

(2) The property owner must not terminate the tenancy or refuse to renew the lease of a tenant occupying a residential rental housing unit constructed or rehabilitated using YouthBuild funds except for serious or repeated violations of the terms and conditions of the lease, for violation of applicable Federal, State, or local laws, or for good cause. Any termination or refusal to renew the lease must be preceded by not less than a 30-day written notice to the tenant specifying the grounds for the action. The property owner may waive the written notice requirement for termination in dangerous or egregious situations involving the tenant.

(c) All transitional or permanent housing for homeless individuals or families or low-income families must be safe and sanitary. The housing must meet all applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located.

(d) For sales or rentals of residential housing units constructed or rehabilitated using YouthBuild funds, YouthBuild grantees must ensure that owners of the property record a restrictive covenant at the time that an occupancy permit is issued against such

property which includes the use restrictions set forth in paragraphs (a), (b), and (c) of this section and incorporates the following definitions at § 688.120: Homeless individual, Low-income family, and Transitional housing. The term of the restrictive covenant must be at least 5 years from the time of the issuance of the occupancy permit, unless a time period of more than 5 years has been established by the grantee. The Department advises that any additional stipulations imposed by a grantee or property owner be clearly stated in the covenant.

(e) Any conveyance document prepared in the 5-year period of the restrictive covenant must inform the buyer of the property that all residential housing units constructed or rehabilitated using YouthBuild funds are subject to the restrictions set forth in paragraphs (a) through (d) of this section.

PARTS 689–699 [RESERVED]

CHAPTER VI—OFFICE OF WORKERS' COMPENSATION PROGRAMS, DEPARTMENT OF LABOR

SUBCHAPTER A—LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT AND RELATED STATUTES

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SUBCHAPTER A—LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT AND RELATED STATUTES

PART 700 [RESERVED]

PART 701—GENERAL; ADMINISTERING AGENCY; DEFINITIONS AND USE OF TERMS

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701.302 Who is an employee?

COVERAGE UNDER STATE COMPENSATION PROGRAMS

701.401 Coverage under State compensation programs.

SPECIAL RULES FOR THE RECREATIONAL VESSEL EXCLUSION FROM THE DEFINITION OF ''EMPLOYEE''

701.501 What is a recreational vessel?

701.502 What types of work may exclude a recreational-vessel worker from the definition of ''employee''?

701.503 Did the American Recovery and Reinvestment Act of 2009 amend the recreational vessel exclusion?

701.504 When does the recreational vessel exclusion in the American Recovery and Reinvestment Act of 2009 apply?

701.505 May an employer stop paying benefits awarded before February 17, 2009 if the employee would now fall within the exclusion?

AUTHORITY: 5 U.S.C. 301, 8171 *et seq.;* 33 U.S.C. 939; 36 D.C. Code 501 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; Reorganization Plan No. 6 of 1950, 15 FR 3174, 3 CFR, 1949–1953 Comp., p. 1004, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 38 FR 26860, Sept. 26, 1973, unless otherwise noted.

RULES IN THIS SUBCHAPTER

§ 701.101 Scope of this subchapter and subchapter B.

(a) This subchapter contains the regulations governing the administration of the Longshore and Harbor Workers' Compensation Act, as amended (LHWCA), 33 U.S.C. 901 *et seq.*, except activities, pursuant to 33 U.S.C. 941, assigned to the Assistant Secretary of Labor for Occupational Safety and Health. It also contains the regulations governing the administration of the direct extensions of the LHWCA: the Defense Base Act (DBA), 42 U.S.C. 1651 *et seq.;* the Outer Continental Shelf Lands Act (OCSLA), 43 U.S.C. 1331; and the Nonappropriated Fund Instrumentalities Act (NFIA), 5 U.S.C. 8171 *et seq.*

(b) The regulations in this subchapter also apply to claims filed under the District of Columbia Workmen's Compensation Act (DCCA), 36 D.C. Code 501 *et seq.* That law applies to all claims for injuries or deaths based on employment events that occurred prior to July 26, 1982, the effective date of the District of Columbia Workers' Compensation Act, as amended (D.C. Code 32–1501 *et seq.*).

(c) The regulations governing the administration of the Black Lung Benefits Program are in subchapter B of this chapter.

[70 FR 43232, July 26, 2005]

§ 701.102 Organization of this subchapter.

Part 701 provides a general description of the regulations in this subchapter; sets forth information regarding the persons and agencies within the Department of Labor authorized by the Secretary of Labor to administer the Longshore and Harbor Workers' Compensation Act, its extensions and the regulations in this subchapter; and defines and clarifies use of specific terms in the several parts of this subchapter. Part 702 of this subchapter contains the general administrative regulations governing claims filed under the LHWCA. Part 703 of this subchapter

contains the regulations governing insurance carrier authorizations, insurance carrier security deposits, self-insurer authorizations, and certificates of compliance with the insurance regulations, as required by sections 32 and 37 of the LHWCA (33 U.S.C. 932, 937). Because the extensions of the LHWCA (*see* §701.101) incorporate by reference nearly all the provisions of the LHWCA, the regulations in parts 701, 702 and 703 also apply to the administration of the extensions (DBA, DCCA, OCSLA, and NFIA), unless otherwise noted. Part 704 of this subchapter contains the exceptions to the general applicability of parts 702 and 703 for the DBA, the DCCA, the OCSLA, and the NFIA.

[70 FR 43232, July 26, 2005]

OFFICE OF WORKERS' COMPENSATION PROGRAMS

§701.201 Office of Workers' Compensation Programs.

The Office of Workers' Compensation Programs is responsible for administering the LHWCA and its extensions.

[75 FR 63380, Oct. 15, 2010]

§§701.202–701.203 [Reserved]

DEFINITIONS AND USE OF TERMS

§701.301 What do certain terms in this subchapter mean?

(a) As used in this subchapter, except where the context clearly indicates otherwise:

(1) *Act* or *LHWCA* means the Longshore and Harbor Workers' Compensation Act, as amended (33 U.S.C. 901 *et seq.*), and includes the provisions of any statutory extension of such Act (*see* §701.101(a) and (b)) pursuant to which compensation on account of an injury is sought.

(2) *Secretary* means the Secretary of Labor, United States Department of Labor, or his authorized representative.

(3)–(4) [Reserved]

(5) *Office of Workers' Compensation Programs* or *OWCP* or *the Office* means the Office of Workers' Compensation Programs, referred to in §701.201. The term *Office of Workmen's Compensation Programs* shall have the same meaning as *Office of Workers' Compensation Programs* (*see* 20 CFR 1.6(b)).

(6) *Director* means the Director of OWCP, or his or her authorized representative.

(7) *District Director* means a person appointed as provided in sections 39 and 40 of the LHWCA or his or her designee, authorized to perform functions with respect to the processing and determination of claims for compensation under the LHWCA and its extensions as provided therein and under this subchapter. The term District Director is substituted for the term *Deputy Commissioner* used in the statute. This substitution is for administrative purposes only and in no way affects the power or authority of the position as established in the statute.

(8) *Administrative Law Judge* means a person appointed as provided in 5 U.S.C. 3105 and subpart B of 5 CFR part 930, who is qualified to preside at hearings under 5 U.S.C. 557 and is empowered by the Secretary to conduct formal hearings whenever necessary in respect of any claim for compensation arising under the LHWCA and its extensions.

(9) *Chief Administrative Law Judge* means the Chief Judge of the Office of Administrative Law Judges, United States Department of Labor, whose office is at the location set forth in 29 CFR 18.3(a).

(10) *Board or Benefits Review Board* means the Benefits Review Board established by section 21 of the LHWCA (33 U.S.C. 921) as amended and constituted and functioning pursuant to the provisions of chapter VII of this title and Secretary of Labor's Order No. 38–72 (38 FR 90), whose office is at the location set forth in 20 CFR 802.204.

(11) *Department* means the United States Department of Labor.

(12) *Employer* includes any employer who may be obligated as an employer under the provisions of the LHWCA as amended or any of its extensions to pay and secure compensation as provided therein.

(13) *Carrier* means an insurance carrier or self-insurer meeting the requirements of section 32 of the LHWCA as amended and of this subchapter with respect to authorization to provide insurance fulfilling the obligation of an

employer to secure the payment of compensation due his employees under the LHWCA as amended or a statutory extension thereof.

(14) The terms *wages*, *national average weekly wage*, *injury*, *disability*, *death*, and *compensation* shall have the meanings set forth in section 2 of the LHWCA.

(15) *Claimant* includes any person claiming compensation or benefits under the provisions of the LHWCA as amended or a statutory extension thereof on account of the injury or death of an employee.

(b) The definitions contained in paragraph (a) of this section shall not be considered to derogate from any definitions or delimitations of terms in the LHWCA as amended or any of its statutory extensions in any case where such statutory definitions or delimitations would be applicable.

(c) As used in this subchapter, the singular includes plural and the masculine includes the feminine.

[38 FR 26860, Sept. 26, 1973, as amended at 42 FR 3848, Jan. 21, 1977; 50 FR 391, Jan. 3, 1985; 51 FR 4281, Feb. 3, 1986; 55 FR 28606, July 12, 1990; 70 FR 43233, July 26, 2005; 76 FR 82127, Dec. 30, 2011; 77 FR 37286, June 21, 2012]

§ 701.302 Who is an employee?

(a) *Employee* means any person engaged in maritime employment, including:

(1) Any longshore worker or other person engaged in longshoring operations;

(2) Any harbor worker, including a ship repairer, shipbuilder and shipbreaker; and

(3) Any other individual to whom an injury may be the basis for a compensation claim under the LHWCA as amended, or any of its extensions;

(b) The term does not include:

(1) A master or member of a crew of any vessel; or

(2) Any person engaged by a master to load or unload or repair any small vessel under eighteen tons net.

(c) Nor does this term include the following individuals (whether or not the injury occurs over the navigable waters of the United States) where it is first determined that they are covered by a state workers' compensation act:

(1) Individuals employed exclusively to perform office clerical, secretarial, security, or data processing work (but not longshore cargo checkers and cargo clerks);

(2) Individuals employed by a club (meaning a social or fraternal organization whether profit or nonprofit), camp, recreational operation (meaning any recreational activity, including but not limited to scuba diving, commercial rafting, canoeing or boating activities operated for pleasure of owners, members of a club or organization, or renting, leasing or chartering equipment to another for the latter's pleasure), restaurant, museum or retail outlet;

(3) Individuals employed by a marina, provided they are not engaged in its construction, replacement or expansion, except for routine maintenance such as cleaning, painting, trash removal, housekeeping and small repairs;

(4) Employees of suppliers, vendors and transporters temporarily doing business on the premises of a covered employer, provided they are not performing work normally performed by employees of the covered employer;

(5) Aquaculture workers, meaning those employed by commercial enterprises involved in the controlled cultivation and harvest of aquatic plants and animals, including the cleaning, processing or canning of fish and fish products, the cultivation and harvesting of shellfish, and the controlled growing and harvesting of other aquatic species; or

(6) Individuals employed to build any recreational vessel under sixty-five feet in length, or individuals employed to repair any recreational vessel, or to dismantle any part of a recreational vessel in connection with the repair of such vessel. For purposes of this paragraph, the special rules set forth at §§ 701.501 through 701.505 apply.

[76 FR 82127, Dec. 30, 2011]

COVERAGE UNDER STATE COMPENSATION PROGRAMS

§ 701.401 Coverage under state compensation programs.

(a) Exclusions from the definition of ''employee'' under § 701.301(a)(12), and the employees of small vessel facilities

otherwise covered which are exempted from coverage under §702.171, are dependent upon coverage under a state workers' compensation program. For these purposes, a worker or dependent must first claim compensation under the appropriate state program and receive a final decision on the merits of the claim, denying coverage, before any claim may be filed under this Act.

(b) The intent of the Act is that state law will apply to those categories of employees if it otherwise would. Accordingly, not withstanding any contrary state law, claims by any of the categories of workers excluded under §701.301 or 702.171 must be made to and processed by the state and a merit decision denying coverage on jurisdictional grounds must be made before coverage or benefits under the Act may be sought.

(c) The time for filing notice and claim under the Act (see subpart B of part 702) does not begin to run for purposes of claims by those workers or dependents described in §701.301(a)(12) and §702.171, until a final adverse decision denying coverage under a state compensation act is received.

[50 FR 392, Jan. 3, 1985]

SPECIAL RULES FOR THE RECREATIONAL VESSEL EXCLUSION FROM THE DEFINITION OF ''EMPLOYEE''

§ 701.501 What is a recreational vessel?

(a) *Recreational vessel* means a vessel—

(1) Being manufactured or operated primarily for pleasure; or

(2) Leased, rented, or chartered to another for the latter's pleasure.

(b) In applying the definition in paragraph (a) of this section, the following rules apply:

(1) A vessel being *manufactured* or *built*, or being repaired under warranty by its manufacturer or builder, is a *recreational vessel* if the vessel appears intended, based on its design and construction, to be for ultimate recreational uses. The manufacturer or builder bears the burden of establishing that a vessel is recreational under this standard.

(2) A vessel being *repaired*, *dismantled for repair*, or *dismantled at the end of its life* is not a *recreational vessel* if the vessel had been operating, around the time of its repair or dismantling, in one or more of the following categories on more than an infrequent basis—

(A) ''Passenger vessel'' as defined by 46 U.S.C. 2101(22);

(B) ''Small passenger vessel'' as defined by 46 U.S.C. 2101(35);

(C) ''Uninspected passenger vessel'' as defined by 46 U.S.C. 2101(42);

(D) Vessel routinely engaged in ''commercial service'' as defined by 46 U.S.C. 2101(5); or

(E) Vessel that routinely carries ''passengers for hire'' as defined by 46 U.S.C. 2101(21a).

(3) Notwithstanding paragraph (b)(2) of this section, a vessel will be deemed recreational if it is a *public vessel*, *i.e.*, a vessel owned or bareboat-chartered and operated by the United States, or by a State or political subdivision thereof, at the time of repair, dismantling for repair, or dismantling, provided that such vessel shares elements of design and construction with traditional recreational vessels and is not normally engaged in a military, commercial or traditionally commercial undertaking.

(c) All subsequent amendments to the statutes referenced in paragraph (b)(2) of this section and the regulations implementing those provisions in Title 46 of the Code of Federal Regulations will apply when determining whether a vessel is recreational.

[76 FR 82128, Dec. 30, 2011]

§ 701.502 What types of work may exclude a recreational-vessel worker from the definition of "employee"?

(a) An individual who works on recreational vessels may be excluded from the definition of ''employee'' when:

(1) The individual's date of injury is before February 17, 2009, the injury is covered under a State workers' compensation law, and the individual is employed to:

(i) Build any recreational vessel under sixty-five feet in length; or

(ii) Repair any recreational vessel under sixty-five feet in length; or

(iii) Dismantle any recreational vessel under sixty-five feet in length.

(2) The individual's date of injury is on or after February 17, 2009, the injury

is covered under a State workers' compensation law, and the individual is employed to:

(i) Build any recreational vessel under sixty-five feet in length; or

(ii) Repair any recreational vessel; or

(iii) Dismantle any recreational vessel to repair it.

(b) In applying paragraph (a) of this section, the following principles apply:

(1) ''Length'' means a straight line measurement of the overall length from the foremost part of the vessel to the aftmost part of the vessel, measured parallel to the center line. The measurement must be from end to end over the deck, excluding sheer. Bow sprits, bumpkins, rudders, outboard motor brackets, handles, and other similar fittings, attachments, and extensions are not included in the measurement.

(2) ''Repair'' means any repair of a vessel including installations, painting and maintenance work. Repair does not include alterations or conversions that render the vessel a non-recreational vessel under § 701.501. For example, a worker who installs equipment on a private yacht to convert it to a passenger-carrying whale-watching vessel is not employed to ''repair'' a recreational vessel. Repair also does not include alterations or conversions that render a non-recreational vessel recreational under § 701.501.

(3) ''Dismantle'' means dismantling any part of a vessel to complete a repair but does not include dismantling any part of a vessel to complete alterations or conversions that render the vessel a non-recreational vessel under § 701.501, or render the vessel recreational under § 701.501, or, if the date of injury is on or after February 17, 2009, to scrap or dispose of the vessel at the end of the vessel's life.

[76 FR 82128, Dec. 30, 2011]

§ 701.503 Did the American Recovery and Reinvestment Act of 2009 amend the recreational vessel exclusion?

Yes. The amended exclusion was effective February 17, 2009, the effective date of the American Recovery and Reinvestment Act of 2009.

[76 FR 82128, Dec. 30, 2011]

§ 701.504 When does the recreational vessel exclusion in the American Recovery and Reinvestment Act of 2009 apply?

(a) *Date of injury.* Whether the amended version applies depends on the date of the injury for which compensation is claimed. The following rules apply to determining the date of injury:

(1) *Traumatic injury.* If the individual claims compensation for a traumatic injury, the date of injury is the date the employee suffered harm. For example, if the individual injures an arm or leg in the course of his or her employment, the date of injury is the date on which the individual was hurt.

(2) *Occupational disease or infection.* Occupational illnesses and infections generally involve delayed onset of symptoms following exposure to a harmful workplace substance or condition. If the individual claims compensation for an occupational illness or infection, the date of injury is the date the individual was exposed to the substance or condition.

(3) *Hearing loss.* If the individual claims compensation for hearing loss, the date of injury is the date the individual was exposed to harmful workplace noise or other stimulus that is capable of causing hearing loss.

(4) *Death-benefit claims.* If the individual claims compensation for an employee's death, the date of injury is the date of the workplace event or incident that caused, hastened, or contributed to the death.

(5) *Cumulative trauma.* If the individual claims compensation for cumulative trauma, in which multiple traumas contribute to an overall medical condition, such as a neck condition resulting from repetitive motion, the date of injury is any date on which a workplace trauma worsened the individual's condition. A workplace event will not be deemed a contributing trauma if a corresponding worsening of the condition is due solely to its natural progression, rather than the workplace event.

(b) If the date of injury is before February 17, 2009, the individual's entitlement is governed by section 2(3)(F) as it existed prior to the 2009 amendment.

(c) If the date of injury is on or after February 17, 2009, the individual's entitlement is governed by the 2009 amendment to section 2(3)(F).

[76 FR 82128, Dec. 30, 2011]

§ 701.505 May an employer stop paying benefits awarded before February 17, 2009 if the employee would now fall within the exclusion?

No. If an individual was awarded compensation for an injury occurring before February 17, 2009, the employer must still pay all benefits awarded, including disability compensation and medical benefits, even if the employee would be excluded from coverage under the amended exclusion.

[76 FR 82129, Dec. 30, 2011]

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AUTHORITY: 5 U.S.C. 301, and 8171 *et seq.;* 33 U.S.C. 901 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; 28 U.S.C. 2461 note (Federal Civil Penalties Inflation Adjustment Act of 1990); Pub. L. 114–74 at sec. 701; Reorganization Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 38 FR 26861, Sept. 26, 1973, unless otherwise noted.

Subpart A—General Provisions

ADMINISTRATION

§ 702.101 Exchange of documents and information.

(a) Except as otherwise required by the regulations in this subchapter, all documents and information sent to OWCP under this subchapter must be submitted—

(1) In hard copy by postal mail, commercial delivery service (such as Federal Express or United Parcel Service), or hand delivery;

(2) Electronically through an OWCP-authorized system; or

(3) As otherwise allowed by OWCP.

(b) Except as otherwise required by the regulations in this subchapter, all documents and information sent under this subchapter by OWCP to parties and their representatives or from any party or representative to another party or representative must be sent—

(1) In hard copy by postal mail, commercial delivery service (such as Federal Express or United Parcel Service), or hand delivery;

(2) Electronically by a reliable electronic method if the receiving party or representative agrees in writing to receive documents and information by that method; or

(3) Electronically through an OWCP-authorized system that provides service of documents on the parties and their representatives.

(c) Reliable electronic methods for delivering documents include, but are not limited to, email, facsimile and web portal.

(d) Any party or representative may revoke his or her agreement to receive documents and information electronically by giving written notice to OWCP, the party, or the representative with whom he or she had agreed to receive documents and information electronically, as appropriate.

(e) The provisions in paragraphs (a) through (d) of this section apply when parties are directed by the regulations in this subchapter to: Advise; apply; approve; authorize; demand; file; forward; furnish; give; give notice; inform; issue; make; notice, notify; provide; publish; receive; recommend; refer; release; report; request; respond; return; send; serve; service; submit; or transmit.

(f) Any reference in this subchapter to an application, copy, filing, form, letter, written notice, or written request includes both hard-copy and electronic documents.

(g) Any requirement in this subchapter that a document or information be submitted in writing, or that it be signed, executed, or certified does not preclude its submission or exchange electronically.

(h) Any reference in this subchapter to transmitting information to an entity's address may include that entity's electronic address or electronic portal.

(i) Any requirement in this subchapter that a document or information—

(1) Be sent to a specific district director means that the document or information should be sent to the physical or electronic address provided by OWCP for that district director; and

(2) Be filed by a district director in his or her office means that the document or information may be filed in a physical or electronic location specified by OWCP for that district director.

[80 FR 12928, Mar. 12, 2015]

§ 702.102 Establishment and modification of compensation districts, establishment of suboffices and jurisdictional areas.

(a) The Director has, pursuant to section 39(b) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 939(b), established compensation districts as required for improved administration or as otherwise determined by the Director (see 51 FR 4282, Feb. 3, 1986). The boundaries of the compensation districts may be modified at any time, and the Director will notify all interested parties directly of the modifications.

(b) As administrative exigencies from time to time may require, the Director

may, by administrative order, establish special areas outside the continental United States, Alaska, and Hawaii, or change or modify any areas so established, notwithstanding their inclusion within an established compensation district. Such areas will be designated ''jurisdictional areas.'' The Director will also designate which of his district directors will be in charge thereof.

(c) To further aid in the efficient administration of the OWCP, the Director may from time to time establish suboffices within compensation districts or jurisdictional areas, and will designate a person to be in charge thereof.

[80 FR 12928, Mar. 12, 2015]

§ 702.103 Effect of establishment of suboffices and jurisdictional areas.

Whenever the Director establishes a suboffice or jurisdictional area, those reports, records, or other documents with respect to processing of claims that are required to be filed with the district director of the compensation district in which the injury or death occurred, may instead be required to be filed with the suboffice, or office established for the jurisdictional area.

[80 FR 12928, Mar. 12, 2015

§ 702.104 Transfer of individual case file.

(a) At any time after a claim is filed, the district director having jurisdiction thereof may, with the prior or subsequent approval of the Director, transfer such case to the district director in another compensation district for the purpose of making an investigation, ordering medical examinations, or taking such other action as may be necessary or appropriate to further develop the claim. If, after filing a claim, the claimant moves to another compensation district, the district director may, upon request by the claimant or the employer and with the approval of the Director, transfer the case to such other compensation district.

(b) The district director making the transfer may by letter or memorandum to the district director to whom the case is transferred give advice, comments, suggestions, or directions if appropriate to the particular case. All interested parties will be advised of the transfer.

[42 FR 45301, Sept. 9, 1977, as amended at 80 FR 12928, Mar. 12, 2015]

§ 702.105 Use of the title District Director in place of Deputy Commissioner.

Wherever the statute refers to Deputy Commissioner, these regulations have substituted the term District Director. The substitution is purely an administrative one, and in no way effects the authority of or the powers granted and responsibilities imposed by the statute on that position.

[55 FR 28606, July 12, 1990]

RECORDS

§ 702.111 Employer's records.

Every employer shall maintain adequate records of injury sustained by employees while in his employ, and which shall also contain information of disease, other impairments or disabilities, or death relating to said injury. Such records shall be available for inspection by the OWCP or by any State authority. Records required by this section shall be retained by the employer for three years following the date of injury; this applies to records for lost-time and no-lost-time injuries.

(Approved by the Office of Management and Budget under control number 1215–0160)

(Pub. L. No. 96–511, 94 Stat. 2812 (44 U.S.C. 3501 *et seq.*))

[38 FR 26861, Sept. 26, 1973, as amended at 47 FR 145, Jan. 5, 1982; 50 FR 393, Jan. 3, 1985]

§ 702.112 Records of the OWCP.

All reports, records, or other documents filed with the OWCP with respect to claims are the records of the OWCP. The Director shall be the official custodian of those records maintained by the OWCP at its national office, and the district director shall be the official custodian of those records maintained at the headquarters office in each compensation district.

§ 702.113 Inspection of records of the OWCP.

Any party in interest may be permitted to examine the record of the

case in which he is interested. The official custodian of the record sought to be inspected shall permit or deny inspection in accordance with the Department of Labor's regulations pertaining thereto (see 29 CFR part 70). The original record in any such case shall not be removed from the office of the custodian for such inspection. The custodian may, in his discretion, deny inspection of any record or part thereof which is of a character specified in 5 U.S.C. 552(b) if in his opinion such inspection may result in damage, harm, or harassment to the beneficiary or to any other person. For special provisions concerning release of information regarding injured employees undergoing vocational rehabilitation, see § 702.508.

§ 702.114 Copying of records of OWCP.

Any party in interest may request copies of records he has been permitted to inspect. Such requests shall be addressed to the official custodian of the records sought to be copied. The official custodian shall provide the requested copies under the terms and conditions specified in the Department of Labor's regulations relating thereto (see 29 CFR part 70).

FORMS

§ 702.121 Forms.

The Director may from time to time prescribe, and require the use of, forms for the reporting of any information required to be reported by the regulations in this subchapter, or by the Act or any of its extensions.

REPRESENTATION

§ 702.131 Representation of parties in interest.

(a) Claimants, employers and insurance carriers may be represented in any proceeding under the Act by an attorney or other person previously authorized in writing by such claimant, employer or carrier to so act.

(b) The Secretary shall annually publish a list of individuals who are disqualified from representing claimants under the Act. Individuals on this list are not authorized to represent claimants under the Act subject to the provision of section 31(b)(2)(C) of the Act, 33 U.S.C. 931(b)(2)(C), and they shall not have their representation fee approved as provided in section 28(e), 33 U.S.C. 928(e).

(c) Individuals shall be included on the list mentioned in (b) if the Secretary determines, after proceedings under §§ 702.432(b) through 702.434, that such individual:

(1) Has been convicted (without regard to pending appeal) of any crime in connection with the representation of a claimant under this Act or any workers' compensation statute;

(2) Has engaged in fraud in connection with the presentation of a claim under this or any workers' compensation statute, including, but not limited to, knowingly making false representations, concealing or attempting to conceal material facts with respect to a claim, or soliciting or otherwise procuring false testimony;

(3) Has been prohibited from representing claimants before any other workers' compensation agency for reasons of professional misconduct which are similar in nature to those which would be grounds for disqualification under this section; or

(4) Has accepted fees for representing claimants under the Act which were not approved, or which were in excess of the amount approved pursuant to section 28 of the Act, 33 U.S.C. 928.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 394, Jan. 3, 1985]

§ 702.132 Fees for services.

(a) Any person seeking a fee for services performed on behalf of a claimant with respect to claims filed under the Act shall make application therefor to the district director, administrative law judge, Board, or court, as the case may be, before whom the services were performed (See 33 U.S.C. 928(c)). The application shall be filed and serviced upon the other parties within the time limits specified by such district director, administrative law judge, Board, or court. The application shall be supported by a complete statement of the extent and character of the necessary work done, described with particularity as to the professional status (e.g., attorney, paralegal, law clerk, or other person assisting an attorney) of

each person performing such work, the normal billing rate for each such person, and the hours devoted by each such person to each category of work. Any fee approved shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the complexity of the legal issues involved, and the amount of benefits awarded, and when the fee is to be assessed against the claimant, shall also take into account the financial circumstances of the claimant. No contract pertaining to the amount of a fee shall be recognized.

(b) No fee shall be approved for a representative whose name appears on the Secretary's list of disqualified representatives under § 702.131(b).

(c) Where fees are included in a settlement agreement submitted under § 702.241, *et seq*. approval of that agreement shall be deemed approval of attorney fees for purposes of this subsection for work performed before the Administrative Law Judge or district director approving the settlement.

[50 FR 394, Jan. 3, 1985]

§ 702.133 Unapproved fees; solicitation of claimants; penalties.

Under the provisions of section 28(e) of the Act, 33 U.S.C. 928(e), any person who receives any fees, other consideration, or any gratuity on account of services rendered as a representative of a claimant, unless such consideration or gratuity is approved under § 702.132, or who makes it a business to solicit employment for an attorney, or for himself in respect of any claim under the Act, shall upon conviction thereof, for each offense be punished by a fine of not more than $1,000 or by imprisonment for not more than 1 year, or by both fine and imprisonment.

§ 702.134 Payment of claimant's attorney's fees in disputed claims.

(a) If the employer or carrier declines to pay any compensation on or before the 30th day after receiving written notice from the district director of a claim for compensation having been filed, on the ground that there is no liability for compensation within the provisions of this Act, and the person seeking benefits shall thereafter have utilized the services of an attorney at law in the successful prosecution of his claim, there shall be awarded, in addition to the award of compensation, in a compensation order, a reasonable attorney's fee against the employer or carrier in an amount approved by the person, administrative body or court before whom the service was performed, which shall be paid directly by the employer or carrier to the attorney for the claimant in a lump sum after the compensation order becomes final (Act, section 28(a)).

(b) If the employer or carrier pays or tenders payment of compensation without an award pursuant to § 702.231 and section 14 (a) and (b) of this Act, and thereafter a controversy develops over the amount of additional compensation, if any, to which the employee may be entitled, the district director, administrative law judge, or Board shall set the matter for an informal conference and following such conference the district director, administrative law judge, or Board shall recommend in writing a disposition of the controversy. If the employer or carrier refuses to accept such written recommendation, within 14 days after its receipt by them, they shall pay or tender to the employee in writing the additional compensation, if any, to which they believe the employee is entitled. If the employee refuses to accept such payment or tender of compensation, and thereafter utilizes the services of an attorney at law, and if the compensation thereafter awarded is greater than the amount paid or tendered by the employer or carrier, a reasonable attorney's fee based solely upon the difference between the amount awarded and the amount tendered or paid shall be awarded in addition to the amount of compensation. The foregoing sentence shall not apply if the controversy relates to degree or length of disability, and if the employer or carrier offers to submit the case for evaluation by physicians employed or selected by the district director, as authorized by section 7(e) of the Act and § 702.408, and offers to tender an amount of compensation based upon the degree or length of disability found by the independent medical report at such time as an evaluation of disability can be

made. If the claimant is successful in review proceedings before the Board or court in any such case an award may be made in favor of the claimant and against the employer or carrier for a reasonable attorney's fee for claimant's counsel in accord with the above provisions. In all other cases any claim for legal services shall not be assessed against the employer or carrier (see Act, section 28(b)).

§ 702.135 Payment of claimant's witness fees and mileage in disputed claims.

In cases where an attorney's fee is awarded against an employer or carrier there may be further assessed against such employer or carrier as costs, fees and mileage for necessary witnesses attending the hearing at the instance of claimant. Both the necessity for the witness and the reasonableness of the fees of expert witnesses must be approved by the hearing officer, the Board, or the court, as the case may be. The amounts awarded against an employer or carrier as attorney's fees, costs, fees and mileage for witnesses shall not in any respect affect or diminish the compensation payable under this Act (see Act, section 28 (d)).

INFORMATION AND ASSISTANCE FOR CLAIMANTS

§ 702.136 Requests for information and assistance.

(a) *General assistance.* The Director shall, upon request, provide persons covered by the Act with information and assistance relating to the Act's coverage and compensation and the procedures for obtaining such compensation including assistance in processing a claim.

(b) *Legal assistance to claimants.* The Secretary may, upon request, provide a claimant with legal assistance in processing a claim under the Act. Such assistance may be made available to a claimant in the discretion of the Solicitor of Labor or his designee at any time prior to or during which the claim is being processed and shall be furnished without charge to the claimant. Legal representation of the claimant in adjudicatory proceedings may be furnished in cases in which the Secretary's interest in the case is not adverse to that of the claimant.

(c) *Other assistance.* The district directors and their staff, as designees of the Director, shall promptly and fully comply with the request of a claimant receiving compensation for information about, and assistance in obtaining, medical, manpower, and vocational rehabilitation services (see also subparts D and E of this part).

COMMUTATION OF PAYMENTS AND SPECIAL FUND

§ 702.142 Commutation of payments; aliens not residents or about to become nonresidents.

(a) Pursuant to section 9(g) of the Act, 33 U.S.C. 909(g), compensation paid to aliens not residents, or about to become nonresidents, of the United States or Canada shall be in the same amount as provided for residents except that dependents in any foreign country shall be limited to surviving spouse and child or children, or if there be no surviving spouse or child or children, to surviving father or mother whom the employee has supported, either wholly or in part, for the period of 1 year prior to the date of injury, and except that the Director, OWCP, may, at his option, or upon the application of the insurance carrier he shall, commute all future installments of compensation to be paid to such aliens by paying or causing to be paid to them one-half of the commuted amount of such future installments of compensation as determined by the Director.

(b) Applications for commutation under this section shall be made in writing to the district director having jurisdiction, and forwarded by the district director to the Director, for final action.

(c) Applications for commutations shall be made effective, if approved by the Director, on the date received by the district director, or on a later date if shown to be appropriate on the application.

(d) Commutations shall not be made with respect to a person journeying abroad for a visit who has previously declared an intention to return and has stated a time for returning, nor shall any commutation be made except upon

the basis of a compensation order fixing the right of the beneficiary to compensation.

[50 FR 394, Jan. 3, 1985]

§ 702.143 Establishment of special fund.

Congress, by section 44 of the Act, 33 U.S.C. 944, established in the U.S. Treasury a special fund, to be administered by the Secretary. The Treasurer of the United States is the custodian of such fund, and all monies and securities in such fund shall be held in trust by the Treasurer and shall not be money or property of the United States. The Treasurer shall make disbursements from such funds only upon the order of the Director, OWCP, as delegatee of the Secretary. The Act requires that the Treasurer give bond, in an amount to be fixed and with securities to be approved by the Secretary of the Treasury and the Comptroller General of the United States, conditioned upon the faithful performance of his duty as custodian of such fund.

§ 702.144 Purpose of the special fund.

This special fund was established to give effect to a congressional policy determination that, under certain circumstances, the employer of a particular employee should not be required to bear the entire burden of paying for the compensation benefits due that employee under the Act. Instead, a substantial portion of such burden should be borne by the industry generally. Section 702.145 describes this special circumstance under which the particular employer is relieved of some of his burden. Section 702.146 describes the manner and circumstances of the input into the fund.

§ 702.145 Use of the special fund.

(a) *Under section 10 of the Act.* This section provides for initial and subsequent annual adjustments in compensation and continuing payments to beneficiaries in cases of permanent total disability or death which commenced or occurred prior to enactment of the 1972 Amendments to this Act (Pub. L. 92–576, approved Oct. 27, 1972). At the discretion of the Director, such payments may be paid directly by him to eligible beneficiaries as the obligation accrues, one-half from the special fund and one-half from appropriations, or he may require insurance carriers or self-insured employers already making payments to such beneficiaries to pay such additional compensation as the amended Act requires. In the latter case such carriers and self-insurers shall be reimbursed by the Director for such additional amounts paid, in the proportion of one-half the amount from the special fund and one-half the amount from appropriations. To obtain reimbursement, the carriers and self-insurers shall submit claims for payments made by them during previous periods at intervals of not less than 6 months. A form has been prescribed for such purpose and shall be used. No administrative claims service expense incurred by the carrier or self-insurer shall be included in the claim and no such expense shall be allowed. The amounts reimbursed to such carrier or self-insurer shall be limited to amounts actually due and previously paid to beneficiaries.

(b) Under section 8(f) of the Act (Second Injuries). In any case in which an employee having an existing permanent partial disability suffers injury, the employer shall provide compensation for such disability as is found to be attributable to that injury based upon the average weekly wages of the employee at the time of injury. If, following an injury falling within the provisions of section 8(c)(1)–(20), the employee with the pre-existing permanent partial disability becomes permanently and totally disabled after the second injury, but such total disability is found not to be due solely to his second injury, the employer (or carrier) shall be liable for compensation as provided by the provisions of section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20) or for 104 weeks, whichever is greater. However, if the injury is a loss of hearing covered by section 8(c)(13), 33 U.S.C. 908(c)(13), the liability shall be the lesser of these periods. In all other cases of a second injury causing permanent total disability (or death), wherein it is found that such disability (or death) is not due solely to the second injury, and wherein the employee had a pre-existing permanent partial disability, the employer (or carrier) shall first pay

compensation under section 8(b) or (e) of the Act, 33 U.S.C. 908(b) or (e), if any is payable thereunder, and shall then pay 104 weeks compensation for such total disability or death, and none otherwise. If the second injury results in permanent partial disability, and if such disability is compensable under section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20), but the disability so compensable did not result solely from such second injury, and the disability so compensable is materially and substantially greater than that which would have resulted from the second injury alone, then the employer (or carrier) shall only be liable for the amount of compensation provided for in section 8(c)(1)–(20) that is attributable to such second injury, or for 104 weeks, whichever is greater. However, if the injury is a loss of hearing covered by section 8(c)(13), 33 U.S.C. 908(c)(13), the liability shall be the lesser of these periods. In all other cases wherein the employee is permanently and partially disabled following a second injury, and wherein such disability is not attributable solely to that second injury, and wherein such disability is materially and substantially greater than that which would have resulted from the second injury alone, and wherein such disability following the second injury is not compensable under section 8(c)(1)–(20) of the Act, then the employer (or carrier) shall be liable for such compensation as may be appropriate under section 8(b) or (e) of the Act, 33 U.S.C. 908(b) or (e), if any, to be followed by a payment of compensation for 104 weeks, and none other. The term ''compensation'' herein means money benefits only, and does not include medical benefits. The procedure for determining the extent of the employer's (or carrier's) liability under this paragraph shall be as provided for in the adjudication of claims in subpart C of this part 702. Thereafter, upon cessation of payments which the employer is required to make under this paragraph, if any additional compensation is payable in the case, the district director shall forward such case to the Director for consideration of an award to the person or persons entitled thereto out of the special fund. Any such award from the special fund shall be by order of the Director or Acting Director.

(c) *Under sections 8(g) and 39(c)(2) of the Act.* These sections, 33 U.S.C. 908(g) and 939(c)(2), respectively, provide for vocational rehabilitation of disabled employees, and authorize, under appropriate circumstances, a maintenance allowance for the employee (not to exceed $25 a week) in additional to other compensation benefits otherwise payable for his injury-related disability. Awards under these sections are made from the special fund upon order of the Director or his designee. The district directors may be required to make investigations with respect to any case and forward to the Director their recommendations as to the propriety and need for such maintenance.

(d) *Under section 39(c)(2) of the Act.* In addition to the maintenance allowance for the employee discussed in paragraph (c) of this section, the Director is further authorized to use the fund in such amounts as may be necessary to procure the vocational training services.

(e) *Under section 7(e) of the Act.* This provision, 33 U.S.C. 907(e), authorizes payment by the Director from the special fund for special medical examinations, *i.e.*, those obtained from impartial specialists to resolve disputes, when such special examinations are deemed necessary under that statutory provision. The Director has the discretionary power, however, to charge the cost of such examination to the insurance carrier or self-insured employer.

(f) *Under section 18(b) of the Act.* This section, 33 U.S.C. 918(b), provides a source for payment of compensation benefits in cases where the employer is insolvent, or other circumstances preclude the payment of benefits due in any case. In such situations, the district director shall forward the case to the Director for consideration of an award from the special fund, together with evidence with respect to the employer's insolvency or other reasons for nonpayment of benefits due. Benefits, as herein used, means medical care or supplies within the meaning of section 7 of the Act, 33 U.S.C. 907, and subpart D of this part 702, as well as monetary benefits. Upon receipt of the case, the Director shall promptly determine

whether an award from the special fund is appropriate and advisable in the case, having due regard for all other current commitments from the special fund. If such an award is made, the employer shall be liable for the repayment into the fund of the amounts paid therefrom, as provided in 33 U.S.C. 918(b).

(The information collection requirements contained in paragraph (a) were approved by the Office of Management and Budget under control number 1215–0065. The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 1215–0073)

(Pub. L. No. 96–511)

[38 FR 26861, Sept. 26, 1973, as amended at 49 FR 18294, Apr. 30, 1984; 51 FR 4282, Feb. 3, 1986]

§ 702.146 Source of the special fund.

(a) All amounts collected as fines and penalties under the several provisions of the Act shall be paid into the special fund (33 U.S.C. 44(c)(3)).

(b) Whenever an employee dies under circumstances creating a liability on an employer to pay death benefits to the employee's beneficiaries, and whenever there are no such beneficiaries entitled to such payments, the employer shall pay $5,000 into the special fund (Act, section 44(c)(1)). In such cases, the compensation order entered in the case shall specifically find that there is such liability and that there are no beneficiaries entitled to death benefits, and shall order payment by the employer into the fund. Compensation orders shall be made and filed in accordance with the regulations in subpart C of this part 702, except that for this purpose the district director settling the case under § 702.315 shall formalize the memorandum of conference in a compensation order, and shall file such order as provided for in § 702.349.

(c) The Director annually shall assess an amount against insurance carriers and self-insured employers authorized under the Act and part 703 of this subchapter to replenish the fund. That total amount to be charged all carriers and self-insurers to be assessed shall be based upon an estimate of the probable expenses of the fund during the calendar year. The assessment against each carrier and self-insurer shall be based upon (1) the ratio of the amount each paid during the prior calendar year for compensation in relation to the amount all such carriers of self-insurers paid during that period for compensation, and (2) the ratio of the amount of payments made by the special fund for all cases being paid under section 8(f) of the Act, 33 U.S.C. 908(f), during the preceding calendar year which are attributable to the carrier or self-insurer in relation to the total of such payments during such year attributable to all carriers and self-insurers. The resulting sum of the percentages from paragraphs (c) (1) and (2) of this section will be divided by two, and the resulting percentage multiplied by the probable expenses of the fund. The Director may, in his or her discretion, condition continuance or renewal of authorization under part 703 upon prompt payment of the assessment. However, no action suspending or revoking such authorization shall be taken without affording such carrier or self-insurer a hearing before the Director or his/her designee.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 395, Jan. 3, 1985; 51 FR 4282, Feb. 3, 1986]

§ 702.147 Enforcement of special fund provisions.

(a) As provided in section 44(d)(1) of the Act, 33 U.S.C. 944(d)(1), for the purpose of making rules, regulations, and determinations under the special fund provisions in section 44 and for providing enforcement thereof, the Director may investigate and gather appropriate data from each carrier and self-insured employer, and may enter and inspect such places and records (and make such transcriptions of records), question such employees, and investigate such facts, conditions, practices, or other matters as he may deem necessary or appropriate. The Director may require the employer to have audits performed of claims activity relating to this Act. The Director may also require detailed reports of payments made under the Act, and of estimated future liabilities under the Act, from any or all carriers of self-insurers. The Director may require that such reports be certified and verified in whatever manner is considered appropriate.

(b) Pursuant to section 44(d)(3) of the Act, 33 U.S.C. 944(d)(3), for the purpose of any hearing or investigation related to determinations or the enforcement of the provisions of section 44 with respect to the special fund, the provisions of 15 U.S.C. 49 and 50 as amended (the Federal Trade Commission Act provisions relating to attendance of witnesses and the production of books, papers, and documents) are made applicable to the jurisdiction, powers, and duties of the Director, OWCP, as the Secretary's delegatee.

(c) Civil penalties and unpaid assessments shall be collected by civil suits brought by and in the name of the Secretary.

(Approved by the Office of Management and Budget under control number 1215–0160)

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 395, Jan. 3, 1985]

§ 702.148 Insurance carriers' and self-insured employers' responsibilities.

(a) Each carrier and self-insured employer shall make, keep, and preserve such records, and make such reports and provide such additional information as the Director prescribes or orders, which he considers necessary or appropriate to effectively carry out his responsibilities.

(b) Consistent with their greater direct liability stemming from the amended assessment formula, employers and insurance carriers are given the authority to monitor their claims in the special fund as outlined in paragraph (c) of this section. For purposes of monitoring these claims, employers and insurance carriers remain parties in interest to the claim and are allowed access to all records relating to the claim. Similarly, employers and insurance carriers can initiate proceeding to modify an award of compensation after the special fund has assumed the liability to pay benefits. It is intended that employers and insurance carriers have neither a greater nor a lesser responsibility in this new role that they not have with regard to cases that remain their sole liability. (See § 702.373(d).)

(c) An employer or insurance carrier may conduct any reasonable investigation regarding cases placed into the special fund by the employer or insurance carrier. Such investigation may include, but shall not be limited to, a semi-annual request for earnings information pursuant to section 8(j) of the Act, 33 U.S.C. 908(j) (See § 702.285) periodic medical examinations, vocational rehabilitation evaluations, and requests for any additional information needed to effectively monitor such a case.

(Approved by the Office of Management and Budget under control number 1215–0118)

(Pub. L. No. 96–511, 94 Stat. 2812 (44 U.S.C. 3501 *et seq.*))

[38 FR 26861, Sept. 26, 1973, as amended at 47 FR 145, Jan. 5, 1982; 50 FR 395, Jan. 3, 1985]

LIENS ON COMPENSATION

§ 702.161 Liens against assets of insurance carriers and employers.

Where payments have been made from the special fund pursuant to section 18(b) of the Act, 33 U.S.C. 918(b) and § 704.145(f) the Secretary of Labor shall, for the benefit of the fund, be subrogated to all the rights of the person receiving such payments. The Secretary may institute proceedings under either section 18 or 21(d) of the Act, 33 U.S.C. 918 or 921(d), or both, to recover the amount expended by the fund or so much as in the judgement of the Secretary is possible, or the Secretary may settle or compromise any such claim.

[50 FR 395, Jan. 3, 1985]

§ 702.162 Liens on compensation authorized under special circumstances.

(a) Pursuant to section 17 of the Act, 33 U.S.C. 917, when a trust fund which complies with section 302(c) of the Labor-Management Relations Act of 1947, 29 U.S.C. 186(c) [LMRA], established pursuant to a collective bargaining agreement in effect between an employer and an employee entitled to compensation under this Act, has paid disability benefits to an employee which the employee is legally obligated to repay by reason of his entitlement to compensation under this Act, a lien shall be authorized on such compensation in favor of the trust fund for the amount of such payments.

(b)(1) An application for such a lien shall be filed on behalf of the trust

fund with the district director for the compensation district where the claim for compensation has been filed, 20 CFR 702.101. Such application shall include a certified statement by an authorized official of the trust fund that:

(i) The trust fund is entitled to a lien in its favor by reason of its payment of disability payments to a claimant-employee (including his name therein);

(ii) The trust fund was created pursuant to a collective bargaining agreement covering the claimant-employee;

(iii) The trust fund complies with section 302(c) of the Labor-Management Relations Act of 1947, 29 U.S.C. 186(c);

(iv) The trust agreement contains a subrogation provision entitling the fund to reimbursement for disability benefits paid to the claimant-employee who is entitled to compensation under the Longshoremen's Act;

(2) The statement shall also state the amount paid to the named claimant-employee and whether such disability benefit payments are continuing to be paid.

(3) If the claimant has signed a statement acknowledging receipt of disability benefits from the trust fund and/or a statement recognizing the trust fund's entitlement to a lien against compensation payments which may be received under the Longshoremen's and Harbor Worker's Compensation Act as a result of his present claim and for which the fund is providing disability payments, such statement(s) shall also be included with or attached to the application.

(c) Upon receipt of this application, the district director shall, within a reasonable time, notify the claimant, the employer and/or its compensation insurance carrier that the request for a lien has been filed and each shall be provided with a copy of the application. If the claimant disputes the right of the trust fund to the lien or the amount stated, if any, he shall, within 30 days after receipt of the application or such other longer period as the district director may set, notify the district director and he shall be given an opportunity to challenge the right of the trust fund to, or the amount of, the asserted lien; notice to either the employer or its compensation insurance carrier shall constitute notice to both of them.

(d) If the claim for compensation benefits is resolved without a formal hearing and if there is no dispute over the amount of the lien or the right of the trust fund to the lien, the district director may order and impose the lien and he shall notify all parties of the amount of the lien and manner in which it is to be paid.

(e) If the claimant's claim for compensation cannot be resolved informally, the district director shall transfer the case to the Office of the Chief Administrative Law Judge for a formal hearing, pursuant to section 19(d) of the Act, 33 U.S.C. 919(d), and 20 CFR 702.317. The district director shall also submit therewith the application for the lien and all documents relating thereto.

(f) If the administrative law judge issues a compensation order in favor of the claimant, such order shall establish a lien in favor of the trust fund if it is determined that the trust fund has satisfied all of the requirements of the Act and regulations.

(g) If the claim for compensation is not in dispute, but there is a dispute as to the right of the trust fund to a lien, or the amount of the lien, the district director shall transfer the matter together with all documents relating thereto to the Office of the Chief Administrative Law Judge for a formal hearing pursuant to section 19(d) of the Act, 33 U.S.C. 919(d), and 20 CFR 702.317.

(h) In the event that either the district director or the administrative law judge is not satisfied that the trust fund qualifies for a lien under section 17, the district director or administrative law judge may require further evidence including but not limited to the production of the collective bargaining agreement, trust agreement or portions thereof.

(i) Before any such lien is approved, if the trust fund has provided continued disability payments after the application for a lien has been filed, the trust fund shall submit a further certified statement showing the total amount paid to the claimant as disability payments. The claimant shall likewise be given an opportunity to

contest the amount alleged in this subsequent statement.

(j) In approving a lien on compensation, the district director or administrative law judge shall not order an initial payment to the trust fund in excess of the amount of the past due compensation. The remaining amount to which the trust fund is entitled shall thereafter be deducted from the affected employee's subsequent compensation payments and paid to the trust fund, but any such payment to the trust fund shall not exceed 10 percent of the claimant-employee's biweekly compensation payments.

(Approved by the Office of Management and Budget under control number 1215–0160)

[42 FR 45301, Sept. 9, 1977, as amended at 50 FR 395, Jan. 3, 1985; 51 FR 4282, Feb. 3, 1986]

CERTIFICATION OF EXEMPTION

§ 702.171 Certification of exemption, general.

An employer may apply to the Director or his/her designee to certify a particular facility as one engaged in the building, repairing or dismantling of exclusively small vessels, as defined. Once certified, injuries sustained at that facility would not be covered under the Act except for injuries which occur over the navigable waters of the United States including any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels. A facility otherwise covered under the Act remains covered until certification of exemption is issued; a certification will be granted only upon submission of a complete application (described in § 702.174), and only for as long as a facility meets the requirements detailed in section 3(d) of the Act, 33 U.S.C. 903(d). This exemption from coverage is not intended to be used by employers whose facilities from time to time may temporarily meet the criteria for qualification but only for facilities which work on exclusively small vessels, as defined.

[50 FR 396, Jan. 3, 1985]

§ 702.172 Certification; definitions.

For purposes of §§ 702.171 through 702.175 dealing with certification of small vessel facilities, the following definitions are applicable.

(a)(1) ''Small vessel'' means only those vessels described in section 3(d)(3) of the Act, 33 U.S.C. 903(d)(3), that is:

(i) A commercial barge which is under 900 lightship displacement tons (long); or

(ii) A commercial tugboat, towboat, crewboat, supply boat, fishing vessel or other work vessel which is under 1,600 tons gross.

(2) For these purposes: (i) One gross ton equals 100 cubic feet, as measured by the current formula contained in the Act of May 6, 1894 as amended through 1974 (46 U.S.C. 77); (ii) one long ton equals 2,240 lbs; and (iii) ''Commercial'' as it applies to ''vessel'' means any vessel engaged in commerce but does not include military vessels or Coast Guard vessels.

(b) ''Federal Maritime Subsidy'' means the construction differential subsidy (CDS) or operating differential subsidy under the Merchant Marine Act of 1936 (46 U.S.C. 1101 *et seq.*).

(c) *facility* means an operation of an employer at a particular contiguous geographic location.

[51 FR 4283, Feb. 3, 1986]

§ 702.173 Exemptions; requirements, limitations.

(a) Injuries at a facility otherwise covered by the Act are exempted only upon certification that the facility is: (1) Engaged in the building, repairing or dismantling of exclusively small commercial vessels; and (2) does not receive a Federal maritime subsidy.

(b) The exemption does not apply to: (1) Injuries at any facility which occur over the navigable waters of the United States or upon any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels; or (2) where the employee at such facility is not subject to a State workers' compensation law.

[50 FR 396, Jan. 3, 1985]

§ 702.174 Exemptions; necessary information.

(a) *Application.* Before any facility is exempt from coverage under the Act, the facility must apply for and receive

a certificate of exemption from the Director or his/her designee. The application must be made by the owner of the facility; where the owner is a partnership it must be made by a partner and where a corporation by an officer of the corporation or the manager in charge of the facility for which an exemption is sought. The information submitted must include the following:

(1) Name, location, physical description and a site plan or aerial photograph of the facility for which an exemption is sought.

(2) Description of the nature of the business.

(3) An affidavit (signed by a partner if the facility is owned by a partnership or an officer if owned by a corporation) vertifying and/or acknowledging that:

(i) the facility is, as of the date of the application, engaged in the business of building, repairing or dismantling exclusively small commercial vessels and that it does not then nor foreseeably will it engage in the building, repairing or dismantling of other than small vessels.

(ii) The facility does not receive any Federal maritime subsidy.

(iii) The signator has the duty to immediately inform the district director of any change in these or other conditions likely to result in a termination of an exemption.

(iv) the employer has secured appropriate compensation liability under a State workers' compensation law.

(v) Any false, relevant statements relating to the application or the failure to notify the district director of any changes in circumstances likely to result in termination of the exemption will be grounds for revocation of the exemption certificate and will subject the employer to all provisions of the Act, including all duties, responsibilities and penalties, retroactive to the date of application or date of change in circumstances, as appropriate.

(b) *Action by the Director*. The Director or his/her designee must review the application within thirty (30) days of its receipt.

(1) Where the application is complete and shows that all requirements under §702.173 are met, the Director must promptly notify the employer that certification has been approved and will be effective on the date specified. The employer is required to post notice of the exemption at a conspicuous location.

(2) Where the application is incomplete or does not substantiate that all requirements of section 3(d) of the Act, 33 U.S.C. 903(d), have been met, or evidence shows the facility is not eligible for exemption, the Director must promptly notify the employer by issuing a letter which details the reasons for the deficiency or the rejection. The employer/applicant may reapply for certification, correcting deficiencies and/or responding to the reasons for the Director's denial. The Director or his/her designee must issue a new decision within a reasonable time of reapplication following denial. Such action will be the final administrative review and is not appealable to the Administrative Law Judge or the Benefits Review Board.

(c) The Director or another designated individual at any time has the right to enter on and inspect any facility seeking exemption for purposes of verifying information provided on the application form.

(d) *Action by the employer*. Immediately upon receipt of the certificate of exemption from coverage under the Act the employer must post:

(1) A general notice in a conspicuous place that the Act does not cover injuries sustained at the facility in question, the basis of the exemption, the effective date of the exemption and grounds for termination of the exemption.

(2) A notice, where applicable, at the entrances to all areas to which the exemption does not apply.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 396, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986; 80 FR 12928, Mar. 12, 2015]

§702.175 Effect of work on excluded vessels; reinstatement of certification.

(a) When a vessel other than a small commercial vessel, as defined in §702.172, enters a facility which has been certified as exempt from coverage, the exemption shall automatically terminate as of the date such a

vessel enters the facility. The exemption shall also terminate on the date a contract for a Federal maritime subsidy is entered into, and, in the situation where the facility undertakes to build a vessel other than a small vessel, when the construction first takes on the characteristics of a vessel, *i.e.*, when the keel is laid. All duties, obligations and requirements imposed by the Act, including the duty to secure compensation liability as required by sections 4 and 32 of the Act, 33 U.S.C. 904 and 932, and to keep records and forward reports, are effective immediately. The employer shall notify the Director or his/her designee immediately where this occurs.

(b) Where an exemption certification is terminated because of circumstances described in (a), the employer may apply for reinstatement of the exemption once the event resulting in termination of the exemption ends. The reapplication shall consist of a reaffirmation of the nature of the business, an explanation of the circumstances leading to the termination of exemption, and an affidavit by the appropriate person affirming that the circumstances prompting the termination no longer exists nor will they reoccur in the forseeable future and that the facility is engaged in building, repairing or dismantling exclusively small vessels. The Director or the Director's designee shall respond to the complete reapplication within ten working days of receipt.

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

Subpart B—Claims Procedures

EMPLOYER'S REPORTS

§ 702.201 Reports from employers of employee's injury or death.

(a) Within 10 days from the date of an employee's injury or death, or 10 days from the date an employer has knowledge of an employee's injury or death, including any disease or death proximately caused by the employment, the employer shall furnish a report thereof to the district director for the compensation district in which the injury or death occurred, and shall thereafter furnish such additional or supplemental reports as the district director may request.

(b) No report shall be filed unless the injury causes the employee to lose one or more shifts from work. However, the employer shall keep a record containing the information specified in § 702.202. Compliance with the current OSHA injury record keeping requirements at 29 CFR part 1904 will satisfy the record keeping requirements of this section for no lost time injuries.

(Approved by the Office of Management and Budget under control number 1215–0160)

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 397, Jan. 3, 1985; 51 FR 4283, Feb. 3, 1986]

§ 702.202 Employer's report; form and contents.

The employer's report of an employee's injury or death shall be in writing and on a form prescribed by the Director for this purpose, and shall contain:

(a) The name, address and business of the employer;

(b) The name, address, occupation and Social Security Number (SSN) of the employee;

(c) The cause, nature, and other relevant circumstances of the injury or death;

(d) The year, month, day, and hour when, and the particular locality where, the injury or death occurred;

(e) Such other information as the Director may require.

(Approved by the Office of Management and Budget under control numbers 1215–0031 and 1215–0063)

[58 FR 68032, Dec. 23, 1993]

§ 702.203 Employer's report; how given.

(a) The employer must file its report of injury with the district director.

(b) If the employer sends its report of injury by U.S. postal mail or commercial delivery service, the report will be considered filed on the date that the employer mails the document or gives it to the commercial delivery service. If the employer sends its report of injury by a permissible electronic method, the report will be considered filed on the date that the employer completes all steps necessary for the transmission.

[80 FR 12929, Mar. 12, 2015]

§ 702.204 Employer's report; penalty for failure to furnish and or falsifying.

Any employer, insurance carrier, or self-insured employer who knowingly and willfully fails or refuses to send any report required by § 702.201, or who knowingly or willfully makes a false statement or misrepresentation in any report, shall be subject to a civil penalty not to exceed $29,980for each such failure, refusal, false statement, or misrepresentation for which penalties are assessed after January 15, 2025. The district director has the authority and responsibility for assessing a civil penalty under this section.

[81 FR 43449, July 1, 2016, as amended at 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2215, Jan. 13, 2023; 89 FR 1814, Jan. 11, 2023; 90 FR 1858, Jan. 10, 2025]

§ 702.205 Employer's report; effect of failure to report upon time limitations.

Where the employer, or agent in charge of the business, or carrier has been given notice or has knowledge of an employee's injury or death, and fails, neglects, or refuses to file a report thereof as required by § 702.201, the time limitations provisions with respect to the filing of claims for compensation for disability or death (33 U.S.C. 913(a), and see § 702.221) shall not begin to run until such report shall have been furnished as required herein.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 397, Jan. 3, 1985]

NOTICE

§ 702.211 Notice of employee's injury or death; designation of responsible official.

(a) In order to claim compensation under the Act, an employee or claimant must first give notice of the fact of an injury or death to the employer and also may give notice to the district director for the compensation district in which the injury or death occurred. Notice to the employer must be given to that individual whom the employer has designated to receive such notices. If no individual has been so designated notice may be given to: (1) The first line supervisor (including foreman, hatchboss or timekeeper), local plant manager or personnel office official; (2) to any partner if the employer is a partnership; or (3) if the employer is a corporation, to any authorized agent, to an officer or to the person in charge of the business at the place where the injury occurred. In the case of a retired employee, the employee/claimant may submit the notice to any of the above persons, whether or not the employer has designated an official to receive such notice.

(b) In order to facilitate the filing of notices, each employer shall designate at least one individual responsible for receiving notices of injury or death; this requirement applies to all employers. The designation shall be by position and the employer shall provide the name and/or position, exact location and telephone number of the individual to all employees by the appropriate method described below.

(1) *Type of individual.* Designees must be a first line supervisor (including a foreman, hatchboss or timekeeper), local plant manager, personnel office official, company nurse or other individual traditionally entrusted with this duty, who is located full-time on the premises of the covered facility. The employer must designate at least one individual at each place of employment or one individual for each work crew where there is no fixed place of employment (in that case, the designation should always be the same position for all work crews).

(2) *How designated.* The name and/or title, the location and telephone number of the individual who is selected by the employer to receive all notices shall be given to the district director for the compensation district in which the facility is located; posting on the worksite in a conspicuous place shall fulfill this requirement. A redesignation shall be effected by a change in posting.

(3) *Publication.* Every employer shall post the name and/or position, the exact location and telephone number of the designated official. The posting shall be part of the general posting requirement, done on a form prescribed

by the Director, and placed in a conspicuous location. Posting must be done at each worksite.

(4) *Effect of failure to designate.* Where an employer fails to properly designate and to properly publish the name and/or position of the individual authorized to receive notices of injury or death, such failure shall constitute satisfactory reasons for excusing the employee/claimant's failure to give notice as authorized by section 12(d)(3)(ii) of the Act, 33 U.S.C. 912(d)(3)(ii).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

§ 702.212 Notice; when given; when given for certain occupational diseases.

(a) For other than occupational diseases described in (b), the employee must give notice within thirty (30) days of the date of the injury or death. For this purpose the date of injury or death is:

(1) The day on which a traumatic injury occurs;

(2) The date on which the employee or claimant is or by the exercise of reasonable diligence or by reason of medical advice, should have been aware of a relationship between the injury or death and the employment; or

(3) In the case of claims for loss of hearing, the date the employee receives an audiogram, with the accompanying report which indicates the employee has suffered a loss of hearing that is related to his or her employment. (See § 702.441).

(b) In the case of an occupational disease which does not immediately result in disability or death, notice must be given within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware, of the relationship between the employment, the disease and the death or disability. For purposes of these occupational diseases, therefore, the notice period does not begin to run until the employee is disabled, or in the case of a retired employee, until a permanent impairment exists.

(c) For purposes of workers whose coverage under this Act is dependent on denial of coverage under a State compensation program, as described in § 701.401, the time limitations set forth above do not begin to run until a final decision denying State coverage is issued under the State compensation act.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

§ 702.213 Notice; by whom given.

Notice shall be given by the injured employee or someone on his behalf, or in the case of death, by the deceased employee's beneficiary or someone on his behalf.

[38 FR 26861, Sept. 26, 1973. Redesignated at 50 FR 397, Jan. 3, 1985]

§ 702.214 Notice; form and content.

Notice shall be in writing on a form prescribed by the Director for this purpose; such form shall be made available to the employee or beneficiary by the employer. The notice shall be signed by the person authorized to give notice, and shall contain the name, address and Social Security Number (SSN) of the employee and, in death cases, also the SSN of the person seeking survivor benefits, and a statement of the time, place, nature and cause of the injury or death.

[58 FR 68032, Dec. 23, 1993]

§ 702.215 Notice; how given.

Notice must be effected by delivering it to the individual designated to receive such notices at the physical or electronic address designated by the employer. Notice may be given to the district director by submitting a copy of the form supplied by OWCP to the district director, or orally in person or by telephone.

[80 FR 12929, Mar. 12, 2015]

§ 702.216 Effect of failure to give notice.

Failure to give timely notice to the employer's designated official shall not bar any claim for compensation if: (a) The employer, carrier, or designated

official had actual knowledge of the injury or death; or (b) the district director or ALJ determines the employer or carrier has not been prejudiced: or (c) the district director excuses failure to file notice. For purposes of this subsection, actual knowledge shall be deemed to exist if the employee's immediate supervisor was aware of the injury and/or in the case of a hearing loss, where the employer has furnished to the employee an audiogram and report which indicates a loss of hearing. Failure to give notice shall be excused by the district director if: a) Notice, while not given to the designated official, was given to an official of the employer or carrier, and no prejudice resulted; or b) for some other satisfactory reason, notice could not be given. Failure to properly designate and post the individual so designated shall be considered a satisfactory reason. In any event, such defense to a claim must be raised by the employer/carrier at the first hearing on the claim.

[51 FR 4283, Feb. 3, 1986]

§ 702.217 Penalty for false statement, misrepresentation.

(a) Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

(b) Any person including, but not limited to, an employer, its duly authorized agent or an employee of an insurance carrier, who knowingly and willingly makes a false statement or representation for the purpose of reducing, denying or terminating benefits to an injured employee, or his dependents pursuant to section 9, 33 U.S.C. 909, if the injury results in death, shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or both.

[50 FR 398, Jan. 3, 1985]

CLAIMS

§ 702.221 Claims for compensation; time limitations.

(a) Claims for compensation for disability or death shall be in writing and filed with the district director for the compensation district in which the injury or death occurred. The Social Security Number (SSN) of the injured employee and, in cases of death, the SSN of the person seeking survivor benefits shall also be set forth on each claim. Claims may be filed anytime after the seventh day of disability or anytime following the death of the employee. Except as provided below, the right to compensation is barred unless a claim is filed within one year of the injury or death, or (where payment is made without an award) within one year of the date on which the last compensation payment was made.

(b) In the case of a hearing loss claim, the time for filing a claim does not begin to run until the employee receives an audiogram with the accompanying report which indicates the employee has sustained a hearing loss that is related to his or her employment. (See § 702.441).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 398, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986; 58 FR 68032, Dec. 23, 1993]

§ 702.222 Claims; exceptions to time limitations.

(a) Where a person entitled to compensation under the Act is mentally incompetent or a minor, the time limitation provision of § 702.221 shall not apply to a mentally incompetent person so long as such person has no guardian or other authorized representative, but § 702.221 shall be applicable from the date of appointment of such guardian or other representative. In the case of minor who has no guardian before he or she becomes of age, time begins to run from the date he or she becomes of age.

(b) Where a person brings a suit at law or in admiralty to recover damages in respect of an injury or death, or files a claim under a State workers' compensation act because such person is excluded from this Act's coverage by reason of section 2(3) or 3(d) of the Act

(33 U.S.C. 902(3) or 903(d)), and recovery is denied because the person was an employee and defendant was an employer within the meaning of the Act, and such employer had secured compensation to such employee under the Act, the time limitation in § 702.221 shall not begin to run until the date of termination of such suit or proceeding.

(c) Notwithstanding the provisions in paragraph (a) of this section, where the claim is one based on disability or death due to an occupational disease which does not immediately result in death or disability, it must be filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware of the relationship between the employment, the disease and the death or disability, or within one year of the date of last payment of compensation, whichever is later. For purposes of occupational disease, therefore, the time limitation for filing a claim does not begin to run until the employee is disabled, or in the case of a retired employee, where a permanent impairment exists.

(d) The time limitations set forth above do not apply to claims filed under section 49 of the Act, 33 U.S.C. 949.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 398, Jan. 3, 1985]

§ 702.223 Claims; time limitations; time to object.

Notwithstanding the requirements of § 702.221, failure to file a claim within the period prescribed in such section shall not be a bar to such right unless objection to such failure is made at the first hearing of such claim in which all parties in interest are given reasonable notice and opportunity to be heard.

[38 FR 26861, Sept. 26, 1973. Redesignated and amended at 50 FR 397, Jan. 3, 1985]

§ 702.224 Claims; notification of employer of filing by employee.

Within 10 days after the filing of a claim for compensation for injury or death under the Act, the district director must give written notice thereof to the employer or carrier.

[80 FR 12929, Mar. 12, 2015]

§ 702.225 Withdrawal of a claim.

(a) *Before adjudication of claim.* A claimant (or an individual who is authorized to execute a claim on his behalf) may withdraw his previously filed claim: *Provided*, That:

(1) He files with the district director with whom the claim was filed a written request stating the reasons for withdrawal;

(2) The claimant is alive at the time his request for withdrawal is filed;

(3) The district director approves the request for withdrawal as being for a proper purpose and in the claimant's best interest; and

(4) The request for withdrawal is filed, on or before the date the OWCP makes a determination on the claim.

(b) *After adjudication of claim.* A claim for benefits may be withdrawn by a written request filed after the date the OWCP makes a determination on the claim: *Provided*, That:

(1) The conditions enumerated in paragraphs (a) (1) through (3) of this section are met; and

(2) There is repayment of the amount of benefits previously paid because of the claim that is being withdrawn or it can be established to the satisfaction of the Office that repayment of any such amount is assured.

(c) *Effect of withdrawal of claim.* Where a request for withdrawal of a claim is filed and such request for withdrawal is approved, such withdrawal shall be without prejudice to the filing of another claim, subject to the time limitation provisions of section 13 of the Act and of the regulations in this part.

[38 FR 26861, Sept. 26, 1973. Redesignated at 50 FR 397, Jan. 3, 1985]

NONCONTROVERTED CLAIMS

§ 702.231 Noncontroverted claims; payment of compensation without an award.

Unless the employer controverts its liability to pay compensation under this Act, the employer or insurance carrier shall pay periodically, promptly and directly to the person entitled

thereto benefits prescribed by the Act. For this purpose, where the employer furnishes to an employee a copy of an audiogram with a report thereon, which indicates the employee has sustained a hearing loss causally related to factors of that employment, the employer or insurance carrier shall pay appropriate compensation or at that time controvert the liability to pay compensation under this Act.

[50 FR 399, Jan. 3, 1985]

§ 702.232 Payments without an award; when; how paid.

The first installment of compensation shall become due by the fourteenth (14th) day after the employer has been notified, through the designated official or by any other means described in § 702.211 *et seq.*, or has actual knowledge of the injury or death. All compensation due on that fourteenth (14th) day shall be paid then and appropriate compensation due thereafter must be paid in semi-monthly installments, unless the district director determines otherwise.

[50 FR 399, Jan. 3, 1985]

§ 702.233 Penalty for failure to pay without an award.

If any installment of compensation payable without an award is not paid within 14 days after it becomes due, there shall be added to such unpaid installment an amount equal to 10 per centum thereof which shall be paid at the same time as, but in addition to, such installment unless the employer files notice of controversion in accordance with § 702.261, or unless such nonpayment is excused by the district director after a showing by the employer that owing to conditions over which he had no control such installment could not be paid within the period prescribed for the payment.

§ 702.234 Report by employer of commencement and suspension of payments.

Immediately upon making the first payment of compensation, and upon the suspension of payments once begun, the employer must notify the district director who is administering the claim of the commencement or suspension of payments, as the case may be.

[80 FR 12929, Mar. 12, 2015]

§ 702.235 Report by employer of final payment of compensation.

(a) Within 16 days after the final payment of compensation has been made, the employer, the insurance carrier, or where the employer is self-insured, the employer shall notify the district director on a form prescribed by the Secretary, stating that such final payment has been made, the total amount of compensation paid, the name and address of the person(s) to whom payments were made, the date of the injury or death and the name of the injured or deceased employee, and the inclusive dates during which compensation was paid.

(b) A ''final payment of compensation'' for the purpose of applying the penalty provision of § 702.236 shall be deemed any one of the following:

(1) The last payment of compensation made in accordance with a compensation order awarding disability or death benefits, issued by either a district director or an administrative law judge;

(2) The payment of an agreed settlement approved under section 8(i) (A) or (B), of the Act, 33 U.S.C. 908(i);

(3) The last payment made pursuant to an agreement reached by the parties through informal proceedings;

(4) Any other payment of compensation which anticipates no further payments under the Act.

(Approved by the Office of Management and Budget under control number 1215–0024)

(Pub. L. No. 96–511)

[42 FR 45302, Sept. 9, 1977, as amended at 49 FR 18294, Apr. 30, 1984; 50 FR 399, Jan. 3, 1985]

§ 702.236 Penalty for failure to report termination of payments.

Any employer failing to notify the district director that the final payment of compensation has been made as required by § 702.235 shall be assessed a civil penalty in the amount of $365 for any violation for which penalties are

assessed after January 15, 2025. The district director has the authority and responsibility for assessing a civil penalty under this section.

[81 FR 43449, July 1, 2016, as amended at 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2215, Jan. 13, 2023; 89 FR 1814, Jan. 11, 2024; 90 FR 1858, Jan. 10, 2025]

AGREED SETTLEMENTS

§ 702.241 Definitions and supplementary information.

(a) As used hereinafter, the term *adjudicator* shall mean district director or administrative law judge (ALJ).

(b) If a settlement application is submitted to an adjudicator and the case is pending at the Office of Administrative Law Judges, the Benefits Review Board, or any Federal circuit court of appeals, the parties may request that the case be remanded to the adjudicator for consideration of the application. The thirty day period as described in paragraph (f) of this section begins when the remanded case is received by the adjudicator.

(c) If a settlement application is first submitted to an ALJ, the thirty day period mentioned in paragraph (f) of this section does not begin until five days before the date the formal hearing is set. This rule does not preclude the parties from submitting the application at any other time such as (1) after the case is referred for hearing, (2) at the hearing, or (3) after the hearing but before the ALJ issues a decision and order. Where a case is pending before the ALJ but not set for a hearing, the parties may request the case be remanded to the district director for consideration of the settlement.

(d) A settlement agreement between parties represented by counsel, which is deemed approved when not disapproved within thirty days, as described in paragraph (f) of this section, shall be considered to have been filed in the office of the district director on the thirtieth day for purposes of sections 14 and 21 of the Act, 33 U.S.C. 914 and 921.

(e) A fee for representation which is included in an agreement that is approved in the manner described in paragraph (d) of this section, shall also be considered approved within the meaning of section 28(e) of the Act, 33 U.S.C. 928(e).

(f) The thirty day period for consideration of a settlement agreement shall be calculated from the day after receipt unless the parties are advised otherwise by the adjudicator. (See § 702.243(b)). If the last day of this period is a holiday or occurs during a weekend, the next business day shall be considered the thirtieth day.

(g) An agreement among the parties to settle a claim is limited to the rights of the parties and to claims then in existence; settlement of disability compensation or medical benefits shall not be a settlement of survivor benefits nor shall the settlement affect, in any way, the right of survivors to file a claim for survivor's benefits.

(h) For purposes of this section and § 702.243 the term *counsel* means any attorney admitted to the bar of any State, territory or the District of Columbia.

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986]

§ 702.242 Information necessary for a complete settlement application.

(a) The settlement application shall be a self-sufficient document which can be evaluated without further reference to the administrative file. The application shall be in the form of a stipulation signed by all parties and shall contain a brief summary of the facts of the case to include: a description of the incident, a description of the nature of the injury to include the degree of impairment and/or disability, a description of the medical care rendered to date of settlement, and a summary of compensation paid and the compensation rate or, where benefits have not been paid, the claimant's average weekly wage.

(b) The settlement application shall contain the following:

(1) A full description of the terms of the settlement which clearly indicates, where appropriate, the amounts to be paid for compensation, medical benefits, survivor benefits and representative's fees which shall be itemized as required by § 702.132.

(2) The reason for the settlement, and the issues which are in dispute, if any.

(3) The claimant's date of birth and, in death claims, the names and birth dates of all dependents.

(4) Information on whether or not the claimant is working or is capable of working. This should include, but not be limited to, a description of the claimant's educational background and work history, as well as other factors which could impact, either favorably or unfavorably, on future employability.

(5) A current medical report which fully describes any injury related impairment as well as any unrelated conditions. This report shall indicate whether maximum medical improvement has been reached and whether further disability or medical treatment is anticipated. If the claimant has already reached maximum medical improvement, a medical report prepared at the time the employee's condition stabilized will satisfy the requirement for a current medical report. A medical report need not be submitted with agreements to settle survivor benefits unless the circumstances warrant it.

(6) A statement explaining how the settlement amount is considered adequate.

(7) If the settlement application covers medical benefits an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application. An estimate of the claimant's need for future medical treatment as well as an estimate of the cost of such medical treatment shall also be submitted which indicates the inflation factor and/or the discount rate used, if any. The adjudicator may waive these requirements for good cause.

(8) Information on any collateral source available for the payment of medical expenses.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986]

§ 702.243 Settlement application; how submitted, how approved, how disapproved, criteria.

(a) When the parties to a claim for compensation, including survivor benefits and medical benefits, agree to a settlement they must submit a complete application to the adjudicator. The application must contain all the information outlined in § 702.242 and must be sent by certified mail with return receipt requested, commercial delivery service with tracking capability that provides reliable proof of delivery to the adjudicator, or electronically through an OWCP-authorized system. Failure to submit a complete application will toll the thirty day period mentioned in section 8(i) of the Act, 33 U.S.C. 908(i), until a complete application is received.

(b) The adjudicator must consider the settlement application within thirty days and either approve or disapprove the application. The liability of an employer/insurance carrier is not discharged until the settlement is specifically approved by a compensation order issued by the adjudicator. However, if the parties are represented by counsel, the settlement will be deemed approved unless specifically disapproved within thirty days after receipt of a complete application. This thirty day period does not begin until all the information described in § 702.242 has been submitted. The adjudicator will examine the settlement application within thirty days and must immediately serve on all parties notice of any deficiency. This notice must also indicate that the thirty day period will not commence until the deficiency is corrected.

(c) If the adjudicator disapproves a settlement application, the adjudicator must serve on all parties a written statement or order containing the reasons for disapproval. This statement must be served within thirty days of receipt of a complete application (as described in § 702.242) if the parties are represented by counsel. If the disapproval was made by a district director, any party to the settlement may request a hearing before an ALJ as provided in sections 8 and 19 of the Act, 33 U.S.C. 908 and 919, or an amended application may be submitted to the district director. If, following the hearing, the ALJ disapproves the settlement, the parties may: (1) Submit a new application, (2) file an appeal with the Benefits Review Board as provided in section 21 of the Act, 33 U.S.C. 921, or (3) proceed with a hearing on the merits of the claim. If the application is initially

disapproved by an ALJ, the parties may (1) submit a new application or (2) proceed with a hearing on the merits of the claim.

(d) The parties may submit a settlement application solely for compensation, or solely for medical benefits or for compensation and medical benefits combined.

(e) If either portion of a combined compensation and medical benefits settlement application is disapproved the entire application is disapproved unless the parties indicate on the face of the application that they agree to settle either portion independently.

(f) When presented with a settlement, the adjudicator must review the application and determine whether, considering all of the circumstances, including, where appropriate, the probability of success if the case were formally litigated, the amount is adequate. The criteria for determining the adequacy of the settlement application will include, but not be limited to:

(1) The claimant's age, education and work history;

(2) The degree of the claimant's disability or impairment;

(3) The availability of the type of work the claimant can do;

(4) The cost and necessity of future medical treatment (where the settlement includes medical benefits).

(g) In cases being paid pursuant to a final compensation order, where no substantive issues are in dispute, a settlement amount which does not equal the present value of future compensation payments commuted, computed at the discount rate specified below, must be considered inadequate unless the parties to the settlement show that the amount is adequate. The probability of the death of the beneficiary before the expiration of the period during which he or she is entitled to compensation will be determined according to the most current United States Life Table, as developed by the United States Department of Health and Human Services, which will be updated from time to time. The discount rate will be equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average accepted auction price for the last auction of 52 weeks U.S. Treasury Bills settled immediately prior to the date of the submission of the settlement application.

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986; 60 FR 51348, Oct. 2, 1995; 80 FR 12929, Mar. 12, 2015]

CONTROVERTED CLAIMS

§ 702.251 Employer's controversion of the right to compensation.

Where the employer controverts the right to compensation after notice or knowledge of the injury or death, or after receipt of a written claim, he must give notice thereof, stating the reasons for controverting the right to compensation, using the form prescribed by the Director. Such notice, or answer to the claim, must be filed with the district director within 14 days from the date the employer receives notice or has knowledge of the injury or death. A copy of the notice must also be given to the claimant.

[80 FR 12929, Mar. 12, 2015]

§ 702.252 Action by district director upon receipt of notice of controversion.

Upon receiving the employer's notice of controversion, the district director shall forthwith commence proceedings for the adjudication of the claim in accordance with the procedures set forth in subpart C of this part.

CONTESTED CLAIMS

§ 702.261 Claimant's contest of actions taken by employer or carrier with respect to the claim.

Where the claimant contests an action by the employer or carrier reducing, suspending, or terminating benefits, including medical care, he should immediately notify the office of the district director who is administering the claim and set forth the facts pertinent to his complaint.

[80 FR 12929, Mar. 12, 2015]

§ 702.262 Action by district director upon receipt of notice of contest.

Upon receipt of the claimant's notice of contest, the district director shall forthwith commence proceedings for adjudication of the claim in accordance with the procedures set forth in subpart C of this part.

DISCRIMINATION

§ 702.271 Discrimination; against employees who bring proceedings, prohibition and penalty.

(a)(1) No employer or its duly authorized agent may discharge or in any manner discriminate against an employee as to his/her employment because that employee: (i) Has claimed or attempted to claim compensation under this Act; or (ii) has testified or is about to testify in a proceeding under this Act. To discharge or refuse to employ a person who has been adjudicated to have filed a fraudulent claim for compensation or otherwise made a false statement or misrepresentation under section 31(a)(1) of the Act, 33 U.S.C. 931(a)(1), is not a violation of this section.

(2) Any employer who violates this section, and has penalties assessed for such violation after January 15, 2025, shall be liable for a penalty of not less than $2,998 or more than $14,988 to be paid (by the employer alone, and not by a carrier) to the district director for deposit in the special fund described in section 44 of the Act, 33 U.S.C. 944; and shall restore the employee to his or her employment along with all wages lost due to the discrimination unless the employee has ceased to be qualified to perform the duties of employment.

(b) When a district director receives a complaint from an employee alleging discrimination as defined under section 49, he or she shall notify the employer, and within five working days, initiate specific inquiry to determine all the facts and circumstances pertaining thereto. This may be accomplished by interviewing the employee, employer representatives and other parties who may have information about the matter. Interviews may be conducted by written correspondence, telephone or personal interview.

(c) If circumstances warrant, the district director may also conduct an informal conference on the issue as described in §§ 702.312 through 702.314.

(d) Any employee discriminated against is entitled to be restored to his employment and to be compensated by the employer for any loss of wages arising out of such discrimination provided that the employee is qualified to perform the duties of the employment. If it is determined that the employee has been discriminated against, the district director shall also determine whether the employee is qualified to perform the duties of the employment. The district director may use medical evidence submitted by the parties or he may arrange to have the employee examined by a physician selected by the district director. The cost of the medical examination arranged for by the district director may be charged to the special fund established by section 44, 33 U.S.C. 944.

[42 FR 45302, Sept. 9, 1977, as amended at 50 FR 400, Jan. 3, 1985; 62 FR 53956, Oct. 17, 1997; 81 FR 43449, July 1, 2016; 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2215, Jan. 13, 2023; 89 FR 1814, Jan. 11, 2024; 90 FR 1851, Jan. 10, 2025]

§ 702.272 Informal recommendation by district director.

(a) If the district director determines that the employee has been discharged or suffered discrimination and is able to resume his or her duties, the district director will recommend that the employer reinstate the employee and/or make such restitution as is indicated by the circumstances of the case, including compensation for any wage loss suffered as the result of the discharge or discrimination. The district director may also assess the employer an appropriate penalty, as determined under authority vested in the district director by the Act. If the district director determines that no violation occurred he must notify the parties of his findings and the reasons for recommending that the complaint be denied. If the employer and employee accept the district director's recommendation, within 10 days it will be incorporated in an order, to be filed and served in accordance with § 702.349.

(b) If the parties do not agree to the recommendation, the district director must, within 10 days after receipt of the rejection, prepare a memorandum summarizing the disagreement, send a copy to all interested parties, and within 14 days thereafter, refer the

case to the Office of the Chief Administrative Law Judge for hearing pursuant to § 702.317.

[42 FR 45302, Sept. 9, 1977, as amended at 80 FR 12929, Mar. 12, 2015]

§ 702.273 Adjudication by Office of the Chief Administrative Law Judge.

The Office of Administrative Law Judges is responsible for final determinations of all disputed issues connected with the discrimination complaint, including the amount of penalty to be assessed, and shall proceed with a formal hearing as described in §§ 702.331 to 702.394.

[42 FR 45302, Sept. 9, 1977]

§ 702.274 Employer's refusal to pay penalty.

In the event the employer refuses to pay the penalty assessed, the district director shall refer the complete administrative file to the Associate Director, Division of Longshore and Harbor Workers' Compensation, for subsequent transmittal to the Associate Solicitor for Employee Benefits, with the request that appropriate legal action be taken to recover the penalty.

[42 FR 45302, Sept. 9, 1977]

THIRD PARTY

§ 702.281 Third party action.

(a) Every person claiming benefits under this Act (or the representative) must promptly notify the employer and the district director when:

(1) A claim is made that someone other than the employer or person or persons in its employ, is liable in damages to the claimant because of the injury or death and identify such party by name and address.

(2) Legal action is instituted by the claimant or the representative against some person or party other than the employer or a person or persons in his employ, on the ground that such other person is liable in damages to the claimant on account of the compensable injury and/or death; specify the amount of damages claimed and identify the person or party by name and address.

(3) Any settlement, compromise or any adjudication of such claim has been effected and report the terms, conditions and amounts of such resolution of claim.

(b) Where the claim or legal action instituted against a third party results in a settlement agreement which is for an amount less than the compensation to which a person would be entitled under this Act, the person (or the person's representative) must obtain the prior, written approval of the settlement from the employer and the employer's carrier before the settlement is executed. Failure to do so relieves the employer and/or carrier of liability for compensation described in section 33(f) of Act, 33 U.S.C. 933(f) and for medical benefits otherwise due under section 7 of the Act, 33 U.S.C. 907, regardless of whether the employer or carrier has made payments of acknowledged entitlement to benefits under the Act. The approval must be on a form provided by OWCP and must be filed, within thirty days after the settlement is entered into, with the district director who is administering the claim.

[42 FR 45303, Sept. 9, 1977, as amended at 50 FR 400, Jan. 3, 1985; 51 FR 4284, Feb. 3, 1986; 80 FR 12930, Mar. 12, 2015]

REPORT OF EARNINGS

§ 702.285 Report of earnings.

(a) An employer, carrier or the Director (for those cases being paid from the Special Fund) may require an employee to whom it is paying compensation to submit a report on earnings from employment or self-employment. This report may not be required any more frequently than semi-annually. The report shall be made on a form prescribed by the Director and shall include all earnings from employment and self-employment and the periods for which the earnings apply. The employee must return the complete report on earnings even where he or she has no earnings to report.

(b) For these purposes the term ''earnings'' is defined as all monies received from any employment and includes but is not limited to wages, salaries, tips, sales commissions, fees for services provided, piecework and all revenue received from self-employment

even if the business or enterprise operated at a loss of if the profits were reinvested.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 400, Jan. 3, 1985]

§ 702.286 Report of earnings; forfeiture of compensation.

(a) Any employee who fails to submit the report on earnings from employment or self-employment under § 702.285 or, who knowingly and willingly omits or understates any part of such earnings, shall upon a determination by the district director forfeit all right to compensation with respect to any period during which the employee was required to file such a report. The employee must return the completed report on earnings (even where he or she reports no earnings) within thirty (30) days of the date of receipt; this period may be extended for good cause, by the district director, in determining whether a violation of this requirement has occurred.

(b) Any employer or carrier who believes that a violation of paragraph (a) of this section has occurred may file a charge with the district director. The allegation shall be accompanied by evidence which includes a copy of the report, with proof of service requesting the information from the employee and clearly stating the dates for which the employee was required to report income. Where the employer/carrier is alleging an omission or understatement of earnings, it shall, in addition, present evidence of earnings by the employee during that period, including copies of checks, affidavits from employers who paid the employee earnings, receipts of income from self-employment or any other evidence showing earnings not reported or underreported for the period in question. Where the district director finds the evidence sufficient to support the charge he or she shall convene an informal conference as described in subpart C and shall issue a compensation order affiming or denying the charge and setting forth the amount of compensation for the specified period. If there is a conflict over any issue relating to this matter any party may request a formal hearing before an Administrative Law Judge as described in subpart C.

(c) Compensation forfeited under paragraph (b) of this section, if already paid, shall be recovered by a deduction from the compensation payable to the employee if any, on such schedule as determined by the district director. The district director's discretion in such cases extends only to rescheduling repayment by crediting future compensation and not to whether and in what amounts compensation is forfeited. For this purpose, the district director shall consider the employee's essential expenses for living, income from whatever source, and assets, including cash, savings and checking accounts, stocks, bonds, and other securities.

[50 FR 400, Jan. 3, 1985]

Subpart C—Adjudication Procedures

GENERAL

§ 702.301 Scope of this subpart.

The regulations in this subpart govern the adjudication of claims in which the employer has filed a notice of controversion under § 702.251, or the employee has filed notice of contest under § 702.261. In the vast majority of cases, the problem giving rise to the controversy results from misunderstandings, clerical or mechanical errors, or mistakes of fact or law. Such problems seldom require resolution through formal hearings, with the attendant production of expert witnesses. Accordingly, by § 702.311 *et seq.*, the district directors are empowered to amicably and promptly resolve such problems by informal procedures. Where there is a genuine dispute of fact or law which cannot be so disposed of informally, resort must be had to the formal hearing procedures as set forth beginning at § 702.331. Supplementary compensation orders, modifications, and interlocutory matters are governed by regulations beginning with § 702.371. Thereafter, appeals from compensation orders are discussed beginning with § 702.391 (the regulations of the Benefits Review Board are set forth in full in part 802 of this title).

ACTION BY DISTRICT DIRECTORS

§ 702.311 Handling of claims matters by district directors; informal conferences.

The district director is empowered to resolve disputes with respect to claims in a manner designed to protect the rights of the parties and also to resolve such disputes at the earliest practicable date. This will generally be accomplished by informal discussions by telephone or by conferences at the district director's office. Some cases will be handled by written correspondence. The regulations governing informal conferences at the district director's office with all parties present are set forth below. When handling claims by telephone, or at the office with only one of the parties, the district director and his staff shall make certain that a full written record be made of the matters discussed and that such record be placed in the administrative file. When claims are handled by correspondence, copies of all communications shall constitute the administrative file.

§ 702.312 Informal conferences; called by and held before whom.

Informal conferences shall be called by the district director or his designee assigned or reassigned the case and held before that same person, unless such person is absent or unavailable. When so assigned, the designee shall perform the duties set forth below assigned to the district director, except that a compenstion order following an agreement shall be issued only by a person so designated by the Director to perform such duty.

[42 FR 45303, Sept. 9, 1977]

§ 702.313 Informal conferences; how called; when called.

Informal conferences may be called upon not less than 10 days' notice to the parties, unless the parties agree to meet at an earlier date. The notice may be given by telephone, but shall be confirmed by use of a written notice on a form prescribed by the Director. The notice shall indicate the date, time and place of the conference, and shall also specify the matters to be discussed. For good cause shown conferences may be rescheduled. A copy of such notice shall be placed in the administrative file.

§ 702.314 Informal conferences; how conducted; where held.

(a) No stenographic report shall be taken at informal conferences and no witnesses shall be called. The district director shall guide the discussion toward the achievement of the purpose of such conference, recommending courses of action where there are disputed issues, and giving the parties the benefit of his experience and specialized knowledge in the field of workmen's compensation.

(b) Conferences generally shall be held at the district director's office. However, such conferences may be held at any place which, in the opinion of the district director, will be of greater convenience to the parties or to their representatives.

§ 702.315 Conclusion of conference; agreement on all matters with respect to the claim.

(a) Following an informal conference at which agreement is reached on all issues, the district director must (within 10 days after conclusion of the conference), embody the agreement in a memorandum or within 30 days issue a formal compensation order, to be filed and served in accordance with § 702.349. If either party requests that a formal compensation order be issued, the district director must, within 30 days of such request, prepare, file, and serve such order in accordance with § 702.349. Where the problem was of such nature that it was resolved by telephone discussion or by exchange of written correspondence, the district director must prepare a memorandum or order setting forth the terms agreed upon and notify the parties either by telephone or in writing, as appropriate. In either instance, when the employer or carrier has agreed to pay, reinstate or increase monetary compensation benefits, or to restore or appropriately change medical care benefits, such action must be commenced immediately upon becoming aware of the agreement, and without awaiting receipt of the memorandum or the formal compensation order.

(b) Where there are several conferences or discussions, the provisions of paragraph (a) of this section do not apply until the last conference. The district director must, however, prepare and place in his administrative file a short, succinct memorandum of each preceding conference or discussion.

[80 FR 12930, Mar. 12, 2015]

§ 702.316 Conclusion of conference; no agreement on all matters with respect to the claim.

When it becomes apparent during the course of the informal conference that agreement on all issues cannot be reached, the district director shall bring the conference to a close, shall evaluate all evidence available to him or her, and after such evaluation shall prepare a memorandum of conference setting forth all outstanding issues, such facts or allegations as appear material and his or her recommendations and rationale for resolution of such issues. Copies of this memorandum shall then be sent to each of the parties or their representatives, who shall then have 14 days within which to signify in writing to the district director whether they agree or disagree with his or her recommendations. If they agree, the district director shall proceed as in § 702.315(a). If they disagree (Caution: See § 702.134), then the district director may schedule such further conference or conferences as, in his or her opinion, may bring about agreement; if he or she is satisfied that any further conference would be unproductive, or if any party has requested a hearing, the district director shall prepare the case for transfer to the Office of the Chief Administrative Law Judge (See § 702.317, §§ 702.331–702.351).

[42 FR 42551, Aug. 23, 1977, as amended at 60 FR 51348, Oct. 2, 1995]

§ 702.317 Preparation and transfer of the case for hearing.

A case is prepared for transfer in the following manner:

(a) The district director will furnish each of the parties or their representatives with a copy of a prehearing statement form.

(b) Each party must, within 21 days after receipt of such form, complete it and return it to the district director and serve copies on all other parties. Extensions of time for good cause may be granted by the district director.

(c) Upon receipt of the completed forms, the district director, after checking them for completeness and after any further conferences that, in his or her opinion, are warranted, will transmit them to the Office of the Chief Administrative Law Judge by letter of transmittal together with all available evidence which the parties intend to submit at the hearings (exclusive of X-rays, slides and other materials not suitable for transmission which may be offered into evidence at the time of the hearing); the materials transmitted must not include any recommendations expressed or memoranda prepared by the district director pursuant to § 702.316.

(d) If the completed pre-hearing statement forms raise new or additional issues not previously considered by the district director or indicate that material evidence will be submitted that could reasonably have been made available to the district director before he or she prepared the last memorandum of conference, the district director will transfer the case to the Office of the Chief Administrative Law Judge only after having considered such issues or evaluated such evidence or both and having issued an additional memorandum of conference in conformance with § 702.316.

(e) If a party fails to complete or return his or her pre-hearing statement form within the time allowed, the district director may, at his or her discretion, transmit the case without that party's form. However, such transmittal must include a statement from the district director setting forth the circumstances causing the failure to include the form, and such party's failure to submit a pre-hearing statement form may, subject to rebuttal at the formal hearing, be considered by the administrative law judge, to the extent intransigence is relevant, in subsequent rulings on motions which may be made in the course of the formal hearing.

[80 FR 12930, Mar. 12, 2015]

§ 702.318 The record; what constitutes; nontransferability of the administrative file.

For the purpose of any further proceedings under the Act, the formal record of proceedings shall consist of the hearing record made before the administrative law judge (see § 702.344). When transferring the case for hearing pursuant to § 702.317, the district director shall not transfer the administrative file under any circumstances.

§ 702.319 Obtaining documents from the administrative file for reintroduction at formal hearings.

Whenever any party considers any document in the administrative file essential to any further proceedings under the Act, it is the responsibility of such party to obtain such document from the district director and reintroduce it for the record before the administrative law judge. The type of document that may be obtained will be limited to documents previously submitted to the district director, including documents or forms with respect to notices, claims, controversions, contests, progress reports, medical services or supplies, etc. The work products of the district director or his staff will not be subject to retrieval. The procedure for obtaining documents will be for the requesting party to inform the district director in writing of the documents he wishes to obtain, specifying them with particularity. Upon receipt, the district director must promptly forward a copy of the requested materials to the requesting party. A copy of the letter of request and a statement of whether it has been satisfied must be kept in the case file.

[80 FR 12930, Mar. 12, 2015]

SPECIAL FUND

§ 702.321 Procedures for determining applicability of section 8(f) of the Act.

(a) *Application: filing, service, contents.* (1) An employer or insurance carrier which seeks to invoke the provisions of section 8(f) of the Act must request limitation of its liability and file a fully documented application with the district director. A fully documented application must contain a specific description of the pre-existing condition relied upon as constituting an existing permanent partial disability and the reasons for believing that the claimant's permanent disability after the injury would be less were it not for the pre-existing permanent partial disability or that the death would not have ensued but for that disability. These reasons must be supported by medical evidence as specified in this paragraph. The application must also contain the basis for the assertion that the pre-existing condition relied upon was manifest in the employer and documentary medical evidence relied upon in support of the request for section 8(f) relief. This medical evidence must include, but not be limited to, a current medical report establishing the extent of all impairments and the date of maximum medical improvement. If the claimant has already reached maximum medical improvement, a report prepared at that time will satisfy the requirement for a current medical report. If the current disability is total, the medical report must explain why the disability is not due solely to the second injury. If the current disability is partial, the medical report must explain why the disability is not due solely to the second injury and why the resulting disability is materially and substantially greater than that which would have resulted from the subsequent injury alone. If the injury is loss of hearing, the pre-existing hearing loss must be documented by an audiogram which complies with the requirements of § 702.441. If the claim is for survivor's benefits, the medical report must establish that the death was not due solely to the second injury. Any other evidence considered necessary for consideration of the request for section 8(f) relief must be submitted when requested by the district director or Director.

(2) If claim is being paid by the special fund and the claimant dies, an employer need not reapply for section 8(f) relief. However, survivor benefits will not be paid until it has been established that the death was due to the accepted injury and the eligible survivors have been identified. The district director will issue a compensation order

after a claim has been filed and entitlement of the survivors has been verified. Since the employer remains a party in interest to the claim, a compensation order will not be issued without the agreement of the employer.

(b) *Application: Time for filing.* (1) A request for section 8(f) relief should be made as soon as the permanency of the claimant's condition becomes known or is an issue in dispute. This could be when benefits are first paid for permanent disability, or at an informal conference held to discuss the permanency of the claimant's condition. Where the claim is for death benefits, the request should be made as soon as possible after the date of death. Along with the request for section 8(f) relief, the applicant must also submit all the supporting documentation required by this section, described in paragraph (a) of this section. Where possible, this documentation should accompany the request, but may be submitted separately, in which case the district director must, at the time of the request, fix a date for submission of the fully documented application. The date must be fixed as follows:

(i) Where notice is given to all parties that permanency will be an issue at an informal conference, the fully documented application must be submitted at or before the conference. For these purposes, notice means when the issue of permanency is noted on the form LS–141, Notice of Informal Conference. All parties are required to list issues reasonably anticipated to be discussed at the conference when the initial request for a conference is made and to notify all parties of additional issues which arise during the period before the conference is actually held.

(ii) Where the issue of permanency is first raised at the informal conference and could not have reasonably been anticipated by the parties prior to the conference, the district director must adjourn the conference and establish the date by which the fully documented application must be submitted and so notify the employer/carrier. The date will be set by the district director after reviewing the circumstances of the case.

(2) At the request of the employer or insurance carrier, and for good cause, the district director, at his/her discretion, may grant an extension of the date for submission of the fully documented application. In fixing the date for submission of the application under circumstances other than described above or in considering any request for an extension of the date for submitting the application, the district director must consider all the circumstances of the case, including but not limited to: Whether the claimant is being paid compensation and the hardship to the claimant of delaying referral of the case to the Office of Administrative Law Judges (OALJ); the complexity of the issues and the availability of medical and other evidence to the employer; the length of time the employer was or should have been aware that permanency is an issue; and, the reasons listed in support of the request. If the employer/carrier requested a specific date, the reasons for selection of that date will also be considered. Neither the date selected for submission of the fully documented application nor any extension therefrom can go beyond the date the case is referred to the OALJ for formal hearing.

(3) Where the claimant's condition has not reached maximum medical improvement and no claim for permanency is raised by the date the case is referred to the OALJ, an application need not be submitted to the district director to preserve the employer's right to later seek relief under section 8(f) of the Act. In all other cases, failure to submit a fully documented application by the date established by the district director will be an absolute defense to the liability of the special fund. This defense is an affirmative defense which must be raised and pleaded by the Director. The absolute defense will not be raised where permanency was not an issue before the district director. In all other cases, where permanency has been raised, the failure of an employer to submit a timely and fully documented application for section 8(f) relief will not prevent the district director, at his/her discretion, from considering the claim for compensation and transmitting the case for formal hearing. The failure of an employer to present a timely and fully documented application for section 8(f) relief may

be excused only where the employer could not have reasonably anticipated the liability of the special fund prior to the consideration of the claim by the district director. Relief under section 8(f) is not available to an employer who fails to comply with section 32(a) of the Act, 33 U.S.C. 932(a).

(c) *Application: Approval, disapproval.* If all the evidence required by paragraph (a) of this section was submitted with the application for section 8(f) relief and the facts warrant relief under this section, the district director must award such relief after concurrence by the Associate Director, DLHWC, or his or her designee. If the district director or the Associate Director or his or her designee finds that the facts do not warrant relief under section 8(f) the district director must advise the employer of the grounds for the denial. The application for section 8(f) relief may then be considered by an administrative law judge. When a case is transmitted to the Office of Administrative Law Judges the district director must also attach a copy of the application for section 8(f) relief submitted by the employer, and notwithstanding § 702.317(c), the district director's denial of the application.

(Approved by the Office of Management and Budget under control number 1215–0160)

[51 FR 4285, Feb. 3, 1986, as amended at 80 FR 12930, Mar. 12, 2015]

FORMAL HEARINGS

§ 702.331 Formal hearings; procedure initiating.

Formal hearings are initiated by transmitting to the Office of the Chief Administrative Law Judge the prehearing statement forms, the available evidence which the parties intend to submit at the formal hearing, and the letter of transmittal from the district director as provided in § 702.316 and § 702.317.

[42 FR 42552, Aug. 23, 1977]

§ 702.332 Formal hearings; how conducted.

Formal hearings shall be conducted by the administrative law judge assigned the case by the Office of the Chief Administrative Law Judge in accordance with the provisions of the Administrative Procedure Act, 5 U.S.C. 554 *et seq.* All hearings shall be transcribed.

§ 702.333 Formal hearings; parties.

(a) The necessary parties for a formal hearing are the claimant and the employer or insurance carrier, and the administrative law judge assigned the case.

(b) The Solicitor of Labor or his designee may appear and participate in any formal hearing held pursuant to these regulations on behalf of the Director as an interested party.

§ 702.334 Formal hearings; representatives of parties.

The claimant and the employer or carrier may be represented by persons of their choice.

§ 702.335 Formal hearings; notice.

On a form prescribed for this purpose, the Office of the Chief Administrative Law Judge shall notify the parties (See § 702.333) of the place and time of the formal hearing not less than 30 days in advance thereof.

[42 FR 42552, Aug. 23, 1977]

§ 702.336 Formal hearings; new issues.

(a) If, during the course of the formal hearing, the evidence presented warrants consideration of an issue or issues not previously considered, the hearing may be expanded to include the new issue. If in the opinion of the administrative law judge the new issue requires additional time for preparation, the parties shall be given a reasonable time within which to prepare for it. If the new issue arises from evidence that has not been considered by the district director, and such evidence is likely to resolve the case without the need for a formal hearing, the administrative law judge may remand the case to the district director for his or her evaluation and recommendation pursuant to, § 702.316.

(b) At any time prior to the filing of the compensation order in the case, the administrative law judge may in his discretion, upon the application of a party or upon his own motion, give notice that he will consider any new

issue. The parties shall be given not less than 10 days' notice of the hearing on such new issue. The parties may stipulate that the issue may be heard at an earlier time and shall proceed to a hearing on the new issue in the same manner as on an issue initially considered.

[38 FR 26861, Sept. 26, 1973, as amended at 42 FR 42552, Aug. 23, 1977]

§ 702.337 Formal hearings; change of time or place for hearings; postponements.

(a) Except for good cause shown, hearings shall be held at convenient locations not more than 75 miles from the claimant's residence.

(b) Once a formal hearing has been scheduled, continuances shall not be granted except in cases of extreme hardship or where attendance of a party or his or her representative is mandated at a previously scheduled judicial proceeding. Unless the ground for the request arises thereafter, requests for continuances must be received by the Chief Administrative Law Judge at least 10 days before the scheduled hearing date, must be served upon the other parties and must specify the extreme hardship or previously scheduled judicial proceeding claimed.

(c) The Chief Administrative Law Judge or the administrative law judge assigned to the case may change the time and place of the hearing, or temporarily adjourn a hearing, on his own motion or for good cause shown by a party. The parties shall be given not less than 10 days' notice of the new time and place of the hearing, unless they agree to such change without notice.

[42 FR 42552, Aug. 23, 1977]

§ 702.338 Formal hearings; general procedures.

All hearings shall be attended by the parties or their representatives and such other persons as the administrative law judge deems necessary and proper. The administrative law judge shall inquire fully into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material to such matters. If the administrative law judge believes that there is relevant and material evidence available which has not been presented at the hearing, he may adjourn the hearing or, at any time, prior to the filing of the compensation order, reopen the hearing for the receipt of such evidence. The order in which evidence and allegations shall be presented and the procedures at the hearings generally, except as these regulations otherwise expressly provide, shall be in the discretion of the administrative law judge and of such nature as to afford the parties a reasonable opportunity for a fair hearing.

§ 702.339 Formal hearings; evidence.

In making an investigation or inquiry or conducting a hearing, the administrative law judge shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by 5 U.S.C. 554 and these regulations; but may make such investigation or inquiry or conduct such hearing in such a manner as to best ascertain the rights of the parties.

§ 702.340 Formal hearings; witnesses.

(a) Witnesses at the hearing shall testify under oath or affirmation. The administrative law judge may examine the witnesses and shall allow the parties or their representatives to do so.

(b) No person shall be required to attend as a witness in any proceeding before an administrative law judge at a place more than 100 miles from his place of residence, unless his lawful mileage and fees for one day's attendance shall be paid or tendered to him in advance of the hearing date.

§ 702.341 Formal hearings; depositions; interrogatories.

The testimony of any witness, including any party represented by counsel, may be taken by deposition or interrogatory according to the Federal Rules of Civil Procedure as supplemented by local rules of practice for the Federal district court for the judicial district in which the case is pending. However, such depositions or interrogatories must be completed within reasonable times to be fixed by the Chief Administrative Law Judge or the

administrative law judge assigned to the case.

[42 FR 42552, Aug. 23, 1977]

§ 702.342 Formal hearings; witness fees.

Witnesses summoned in a formal hearing before an administrative law judge or whose depositions are taken shall receive the same fees and mileage as witnesses in courts of the United States (33 U.S.C. 925).

§ 702.343 Formal hearings; oral argument and written allegations.

Any party upon request shall be allowed a reasonable time for presentation of oral argument and shall be permitted to file a pre-hearing brief or other written statement of fact or law. A copy of any such pre-hearing brief or other written statement shall be filed with the Chief Administrative Law Judge or the administrative law judge assigned to the case before or during the proceeding at which evidence is submitted to the administrative law judge and shall be served upon each other party. Post-hearing briefs will not be permitted except at the request of the administrative law judge or upon averment on the record of a party that the case presents a specific novel or difficult legal or factual issue (or issues) that cannot be adequately addressed in oral summation. When permitted, any such brief shall be limited to the issue or issues specified by the administrative law judge or by the party in his or her averment and shall be due from any party desiring to address such issue or issues within 15 days of the conclusion of the proceeding at which evidence is submitted to the administrative law judge. Enlargement of the time for filing such briefs shall be granted only if the administrative law judge is persuaded that the brief will be helpful to him or her and that the enlargement granted will not delay decision of the case.

[42 FR 42552, Aug. 23, 1977]

§ 702.344 Formal hearings; record of hearing.

All formal hearings shall be open to the public and shall be stenographically reported. All evidence upon which the administrative law judge relies for his final decision shall be contained in the transcript of testimony either directly or by appropriate reference. All medical reports, exhibits, and any other pertinent document or record, in whole or in material part, shall be incorporated into the record either by reference or as an appendix.

§ 702.345 Formal hearings; consolidated issues; consolidated cases.

(a) When one or more additional issues are raised by the administrative law judge pursuant to § 702.336, such issues may, in the discretion of the administrative law judge, be consolidated for hearing and decision with other issues pending before him.

(b) When two or more cases are transferred for formal hearings and have common questions of law or which arose out of a common accident, the Chief Administrative Law Judge may consolidate such cases for hearing.

§ 702.346 Formal hearings; waiver of right to appear.

If all parties waive their right to appear before the administrative law judge or to present evidence or argument personally or by representative, it shall not be necessary for the administrative law judge to give notice of and conduct an oral hearing. A waiver of the right to appear and present evidence and allegations as to facts and law shall be made in writing and filed with the Chief Administrative Law Judge or the administrative law judge. Where such a waiver has been filed by all parties, and they do not appear before the administrative law judge personally or by representative, the administrative law judge shall make a record of the relevant written evidence submitted by the parties, together with any pleadings they may submit with respect to the issues in the case. Such documents shall be considered as all of the evidence in the case and the decision shall be based on them.

§ 702.347 Formal hearings; termination.

(a) Formal hearings are normally terminated upon the conclusion of the proceeding at which evidence is submitted to the administrative law judge.

(b) In exceptional cases the Chief Administrative Law Judge or the administrative law judge assigned to the case may, in his or her discretion, extend the time for official termination of the hearing.

[42 FR 42552, Aug. 23, 1977]

§ 702.348 Formal hearings; preparation of final decision and order; content.

Within 20 days after the official termination of the hearing as defined by § 702.347, the administrative law judge shall have prepared a final decision and order, in the form of a compensation order, with respect to the claim, making an award to the claimant or rejecting the claim. The compensation order shall contain appropriate findings of facts and conclusions of law with respect thereto, and shall be concluded with one or more paragraphs containing the order of the administrative law judge, his signature, and the date of issuance.

§ 702.349 Formal hearings; filing and mailing of compensation orders; waiver of service; disposition of transcripts.

(a) An administrative law judge must, within 20 days after the official termination of the hearing, deliver by mail, or otherwise, to the district director that administered the claim, the transcript of the hearing, other documents or pleadings filed with him with respect to the claim, and his signed compensation order. Upon receipt thereof, the district director, being the official custodian of all records with respect to claims he administers, must formally date and file the transcript, pleadings, and compensation order in his office. Such filing must be accomplished by the close of business on the next succeeding working day, and the district director must, on the same day as the filing was accomplished, serve a copy of the compensation order on the parties and on the representatives of the parties, if any. Service on the parties and their representatives must be made by certified mail unless a party has previously waived service by this method under paragraph (b) of this section.

(b) All parties and their representatives are entitled to be served with compensation orders via registered or certified mail. Parties and their representatives may waive this right and elect to be served with compensation orders electronically by filing the appropriate waiver form with the district director responsible for administering the claim. To waive service by registered or certified mail, employers, insurance carriers, and their representatives must file form LS–801 (Waiver of Service by Registered or Certified Mail for Employers and/or Insurance Carriers), and claimants and their representatives must file form LS–802 (Waiver of Service by Registered or Certified Mail for Claimants and/or Authorized Representatives). A signature on a waiver form represents a knowing and voluntary waiver of that party's or representative's right to receive compensation orders via registered or certified mail.

(1) Waiving parties and representatives must provide a valid electronic address on the waiver form.

(2) Parties and representatives must submit a separate waiver form for each case in which they intend to waive the right to certified or registered mail service.

(3) A representative may not sign a waiver form on a party's behalf.

(4) All compensation orders issued in a claim after receipt of the waiver form will be sent to the electronic address provided on the waiver form. Any changes to the address must be made by submitting another waiver form. Individuals may revoke their service waiver at any time by submitting a new waiver form that specifies that the service waiver is being revoked.

(5) If it appears that service in the manner selected by the individual has not been effective, the district director will serve the individual by certified mail.

[80 FR 12931, Mar. 12, 2015]

§ 702.350 Finality of compensation orders.

Compensation orders shall become effective when filed in the office of the district director, and unless proceedings for suspension or setting aside of such orders are instituted within 30 days of such filing, shall become final at the expiration of the 30th day after

such filing, as provided in section 21 of the Act 33 U.S.C. 921. If any compensation payable under the terms of such order is not paid within 10 days after it becomes due, section 14(f) of the Act requires that there be added to such unpaid compensation an amount equal to 20 percent thereof which shall be paid at the same time as, but in addition to, such compensation unless review of the compensation order is had as provided in such section 21 and an order staying payment has been issued by the Benefits Review Board or the reviewing court.

§ 702.351 Withdrawal of controversion of issues set for formal hearing; effect.

Whenever a party withdraws his controversion of the issues set for a formal hearing, the administrative law judge shall halt the proceedings upon receipt from said party of a signed statement to that effect and forthwith notify the district director who shall then proceed to dispose of the case as provided for in § 702.315.

INTERLOCUTORY MATTERS, SUPPLEMENTARY ORDERS, AND MODIFICATIONS

§ 702.371 Interlocutory matters.

Compensation orders shall not be made or filed with respect to interlocutory matters of a procedural nature arising during the pendency of a compensation case.

§ 702.372 Supplementary compensation orders.

(a) In any case in which the employer or insurance carrier is in default in the payment of compensation due under any award of compensation, for a period of 30 days after the compensation is due and payable, the person to whom such compensation is payable may, within 1 year after such default, apply in writing to the district director for a supplementary compensation order declaring the amount of the default. Upon receipt of such application, the district director will institute proceedings with respect to such application as if such application were an original claim for compensation, and the matter will be disposed of as provided for in § 702.315, or if agreement on the issue is not reached, then as in §§ 702.316 through 702.319.

(b) If, after disposition of the application as provided for in paragraph (a) of this section, a supplementary compensation order is entered declaring the amount of the default, which amount may be the whole of the award notwithstanding that only one or more installments is in default, a copy of such supplementary order must be filed and served in accordance with § 702.349. Thereafter, the applicant may obtain and file with the clerk of the Federal district court for the judicial district where the injury occurred or the district in which the employer has his principal place of business or maintains an office, a certified copy of said order and may seek enforcement thereof as provided for by section 18 of the Act, 33 U.S.C. 918.

[80 FR 12932, Mar. 12, 2015]

§ 702.373 Modification of awards.

(a) Upon his/her own initiative, or upon application of any party in interest (including an employer or carrier which has been granted relief under section 8(f) of the Act, 33 U.S.C. 908(f)), the district director may review any compensation case (including a case under which payments are made pursuant to section 44(i) of the Act, 33 U.S.C. 944(i)) in accordance with the procedure in subpart C of this part, and after such review of the case under § 702.315, or review at formal hearings under the regulations governing formal hearings in subpart C of this part, file a new compensation order terminating, continuing, reinstating, increasing or decreasing such compensation, or awarding compensation. Such new order shall not affect any compensation previously paid, except that an award increasing the compensation rate may be made retroactive from the date of injury, and if any part of the compensation due or to become due is unpaid, an award decreasing the compensation rate may be made effective from the date of the injury, and any payment made prior thereto in excess of such decreased rate shall be deducted from any unpaid compensation, in such manner and by such method as may be determined by the district director or the

administrative law judge. Settlements cannot be modified.

(b) Review of a compensation case under this section may be made at any time prior to 1 year after the date of the last payment of compensation, whether or not a compensation order has been issued, or at any time prior to 1 year after the rejection of a claim.

(c) Review of a compensation case may be had only for the reason that there is a change in conditions or that there was a mistake in the determination of facts.

(d) If the investigation, described in §702.148(c), discloses a change in conditions and the employer or insurance carrier intends to pursue modification of the award of compensation the district director and claimant shall be notified through an informal conference. At the conclusion of the informal conference the district director shall issue a recommendation either for or against the modification. This recommendation shall also be sent to the Associate Director, Division of Longshoremen's and Harbor Workers' Compensation (DLHWC) for a determination on whether or not to participate in the modification proceeding on behalf of the special fund. Lack of concurrence of the Associate Director, DLHWC or lack of participation by a representative of the special fund shall not be a bar to the modification proceeding.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 401, Jan. 3, 1985]

APPEALS

§ 702.391 Appeals; where.

Appeals may be taken to the Benefits Review Board, U.S. Department of Labor, Washington, D.C. 20210, by filing a notice of appeals with the office of the district director for the compensation district in which the decision or order appealed from was filed and by submitting to the Board a petition for review of such decision or order, in accordance with the provisions of part 802 of this title 20.

§ 702.392 Appeals; what may be appealed.

An appeal raising a substantial question of law or fact may be taken from a decision with respect to a claim under the Act. Such appeals may be taken from compensation orders when they have been filed as provided for in §702.349.

§ 702.393 Appeals; time limitations.

The notice of appeal (see §702.391) shall be filed with the district director within 30 days of the filing of the decision or order complained of, as defined and described in §§802.205 and 802.206 of this title. A petition for review of the decision or order is required to be filed within 30 days after receipt of the Board's acknowledgment of the notice of appeal, as provided in §802.210 of this title.

§ 702.394 Appeals; procedure.

The procedure for appeals to the Benefits Review Board shall be as provided by the Board in its Rules of Practice and Procedure, set forth in part 802 of this title.

Subpart D—Medical Care and Supervision

§ 702.401 Medical care defined.

(a) Medical care shall include medical, surgical, and other attendance or treatment, nursing and hospital services, laboratory, X-ray and other technical services, medicines, crutches, or other apparatus and prosthetic devices, and any other medical service or supply, including the reasonable and necessary cost of travel incident thereto, which is recognized as appropriate by the medical profession for the care and treatment of the injury or disease.

(b) An employee may rely on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by an accredited practitioner of such recognized church or religious denomination, and nursing services rendered in accordance with such tenets and practice without loss or diminution of compensation or benefits under the Act. For purposes of this section, a recognized church or religious denomination shall be any religious organization: (1) That is recognized by the Social Security Administration for purposes of reimbursements for treatment under Medicare and Medicaid or (2) that is

recognized by the Internal Revenue Service for purposes of tax exempt status.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.402 Employer's duty to furnish; duration.

It is the duty of the employer to furnish appropriate medical care (as defined in § 702.401(a)) for the employee's injury, and for such period as the nature of the injury or the process of recovery may require.

[50 FR 402, Jan. 3, 1985]

§ 702.403 Employee's right to choose physician; limitations.

The employee shall have the right to choose his/her attending physician from among those authorized by the Director, OWCP, to furnish such care and treatment, except those physicians included on the Secretary's list of debarred physicians. In determining the choice of a physician, consideration must be given to availability, the employee's condition and the method and means of transportation. Generally 25 miles from the place of injury, or the employee's home is a reasonable distance to travel, but other pertinent factors must also be taken into consideration.

[50 FR 402, Jan. 3, 1985]

§ 702.404 Physician defined.

The term *physician* includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The term includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation shown by X-ray or clinical findings. Physicians defined in this part may interpret their own X-rays. All physicians in these categories are authorized by the Director to render medical care under the Act. Naturopaths, faith healers, and other practitioners of the healing arts which are not listed herein are not included within the term ''physician'' as used in this part.

[42 FR 45303, Sept. 9, 1977]

§ 702.405 Selection of physician; emergencies.

Whenever the nature of the injury is such that immediate medical care is required and the injured employee is unable to select a physician, the employer shall select a physician. Thereafter the employee may change physicians when he is able to make a selection. Such changes shall be made upon obtaining written authorization from the employer or, if consent is withheld, from the district director. The Director will direct reimbursement of medical claims for services rendered by physicians or health care providers who are on the list of those excluded from providing care under the Act, if such services were rendered in an emergency. (See §§ 702.417 and 702.435(b)).

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.406 Change of physicians; nonemergencies.

(a) Whenever the employee has made his initial, free choice of an attending physician, he may not thereafter change physicians without the prior written consent of the employer (or carrier) or the district director. Such consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, and appropriate to, the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

(b) The district director for the appropriate compensation district may order a change of physicians or hospitals when such a change is found to be necessary or desirable or where the fees charged exceed those prevailing within the community for the same or similar services or exceed the provider's customary charges.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.407 Supervision of medical care.

The Director, OWCP, through the district directors and their designees,

shall actively supervise the medical care of an injured employee covered by the Act. Such supervision shall include:

(a) The requirement that periodic reports on the medical care being rendered be filed in the office of the district director, the frequency thereof being determined by order of the district director or sound judgment of the attending physician as the nature of the injury may dictate;

(b) The determination of the necessity, character and sufficiency of any medical care furnished or to be furnished the employee, including whether the charges made by any medical care provider exceed those permitted under the Act;

(c) The determination of whether a change of physicians, hospitals or other persons or locales providing treatment should be made or is necessary;

(d) The further evaluation of medical questions arising in any case under the Act, with respect to the nature and extent of the covered injury, and the medical care required therefor.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.408 Evaluation of medical questions; impartial specialists.

In any case in which medical questions arise with respect to the appropriate diagnosis, extent, effect of, appropriate treatment, and the duration of any such care or treatment, for an injury covered by the Act, the Director, OWCP, through the district directors having jurisdiction, shall have the power to evaluate such questions by appointing one or more especially qualified physicians to examine the employee, or in the case of death to make such inquiry as may be appropriate to the facts and circumstances of the case. The physician or physicians, including appropriate consultants, should report their findings with respect to the questions raised as expeditiously as possible. Upon receipt of such report, action appropriate therewith shall be taken.

§ 702.409 Evaluation of medical questions; results disputed.

Any party who is dissatisfied with such report may request a review or reexamination of the employee by one or more different physicians employed by or selected by the Director, and such review or reexamination shall be granted unless it is found that it is clearly unwarranted. Such review shall be completed within 2 weeks from the date ordered unless it is impossible to complete the review and render a report thereon within such time period. Upon receipt of the report of this additional review and reexamination, such action as may be appropriate shall forthwith be taken.

§ 702.410 Duties of employees with respect to special examinations.

(a) For any special examination required of an employee by §§ 702.408 and 702.409, the employee shall submit to such examination at such place as is designated in the order to report, but the place so selected shall be reasonably convenient for the employee.

(b) Where an employee fails to submit to an examination required by §§ 702.408 and 702.409, the district director or administrative law judge may order that no compensation otherwise payable shall be paid for any period during which the employee refuses to submit to such examination unless circumstances justified the refusal.

(c) Where an employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the district director or administrative law judge may by order suspend the payment of further compensation during such time as the refusal continues. Except that refusal to submit to medical treatment because of adherence to the tenets of a recognized church or religious denomination as described in § 702.401(b) shall not cause the suspension of compensation.

[42 FR 45303, Sept. 9, 1977, as amended at 50 FR 402, Jan. 3, 1985; 51 FR 4286, Feb. 3, 1986]

§ 702.411 Special examinations; nature of impartiality of specialists.

(a) The special examinations required by § 702.408 shall be accomplished in a

manner designed to preclude prejudgment by the impartial examiner. No physician previously connected with the case shall be present, nor may any other physician selected by the employer, carrier, or employee be present. The impartial examiner may be made aware, by any party or by the OWCP, of the opinions, reports, or conclusions of any prior examining physician with respect to the nature and extent of the impairment, its cause, or its effect upon the wage-earning capacity of the injured employee, if the district director determines that, for good cause, such opinions, reports, or conclusions shall be made available. Upon request, any party shall be given a copy of all materials made available to the impartial examiner.

(b) The impartiality of the specialists shall not be considered to have been compromised if the district director deems it advisable to, and does, apprise the specialist by memorandum of those undisputed facts pertaining to the nature of the employee's employment, of the nature of the injury, of the post-injury employment activity, if any, and of any other facts which are not disputed and are deemed pertinent to the type of injury and/or the type of examination being conducted.

(c) No physician selected to perform impartial examinations shall be, or shall have been for a period of 2 years prior to the examination, an employee of an insurance carrier or self-insured employer, or who has accepted or participated in any fee from an insurance carrier or self-insured employer, unless the parties in interest agree thereto.

[38 FR 26861, Sept. 26, 1973, as amended at 42 FR 45303, Sept. 9, 1977]

§ 702.412 Special examinations; costs chargeable to employer or carrier.

(a) The Director or his designee ordering the special examination shall have the power, in the exercise of his discretion, to charge the cost of the examination or review to the employer, to the insurance carrier, or to the special fund established by section 44 of the Act, 33 U.S.C. 944.

(b) The Director or his designee may also order the employer or the insurance carrier to provide the employee with the services of an attendant, where the district director considers such services necessary, because the employee is totally blind, has lost the use of both hands, or both feet or is paralyzed and unable to walk, or because of other disability making the employee so helpless as to require constant attendance in the discretion of the district director. Fees payable for such services shall be in accord with the provisions of § 702.413.

[42 FR 45303, Sept. 9, 1977]

§ 702.413 Fees for medical services; prevailing community charges.

All fees charged by medical care providers for persons covered by this Act shall be limited to such charges for the same or similar care (including supplies) as prevails in the community in which the medical care provider is located and shall not exceed the customary charges of the medical care provider for the same or similar services. Where a dispute arises concerning the amount of a medical bill, the Director shall determine the prevailing community rate using the OWCP Medical Fee Schedule (as described in 20 CFR 10.805 *through 10.810*) to the extent appropriate, and where not appropriate, may use other state or federal fee schedules. The opinion of the Director that a charge by a medical care provider disputed under the provisions of section 702.414 exceeds the charge which prevails in the community in which said medical care provider is located shall constitute sufficient evidence to warrant further proceedings pursuant to section 702.414 and to permit the Director to direct the claimant to select another medical provider for care to the claimant.

[60 FR 51348, Oct. 2, 1995, as amended at 77 FR 37286, June 21, 2012]

§ 702.414 Fees for medical services; unresolved disputes on prevailing charges.

(a) The Director may, upon written complaint of an interested party, or upon the Director's own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies that appears to exceed prevailing community charges for similar treatment, services or supplies or the provider's customary charges.

The OWCP medical fee schedule (see section 702.413) shall be used by the Director, where appropriate, to determine the prevailing community charges for a medical procedure by a physician or hospital (to the extent such procedure is covered by the OWCP fee schedule). The Director's investigation may initially be conducted informally through contact of the medical care provider by the district director. If this informal investigation is unsuccessful further proceedings may be undertaken. These proceedings may include, but not be limited to: an informal conference involving all interested parties; agency interrogatories to the pertinent medical care provider; and issuance of subpoenas duces tecum for documents having a bearing on the dispute.

(1) A claim by the provider that the OWCP fee schedule does not represent the prevailing community rate will be considered only where the following circumstances are presented:

(i) where the actual procedure performed was incorrectly identified by medical procedure code;

(ii) that the presence of a severe or concomitant medical condition made treatment especially difficult;

(iii) the provider possessed unusual qualifications (board certification in a specialty is not sufficient evidence in itself of unusual qualifications); or

(iv) the provider or service is not one covered by the OWCP fee schedule as described by 20 CFR 10.805 *through 10.810*.

(2) The circumstances listed in paragraph (a)(1) of this section are the only ones which will justify reevaluation of the amount calculated under the OWCP fee schedule.

(b) The failure of any medical care provider to present any evidence required by the Director pursuant to this section without good cause shall not prevent the Director from making findings of fact.

(c) After any proceeding under this section the Director shall make specific findings on whether the fee exceeded the prevailing community charges (as established by the OWCP fee schedule, where appropriate) or the provider's customary charges and provide notice of these findings to the affected parties.

(d) The Director may suspend any such proceedings if after receipt of the written complaint the affected parties agree to withdraw the controversy from agency consideration on the basis that such controversy has been resolved by the affected parties. Such suspension, however, shall be at the discretion of the Director.

[51 FR 4286, Feb. 3, 1986, as amended at 60 FR 51348, Oct. 2, 1995; 77 FR 37286, June 21, 2012]

§ 702.415 Fees for medical services; unresolved disputes on charges; procedure.

After issuance of specific findings of fact and proposed action by the Director as provided in § 702.414 any affected provider employer or other interested party has the right to seek a hearing pursuant to section 556 of title 5, United States Code. Upon written request for such a hearing, the matter shall be referred by the District Director to the OALJ for formal hearing in accordance with the procedures in subpart C of this part. If no such request for a hearing is filed with the district director within thirty (30) days the findings issued pursuant to § 702.414 shall be final.

[51 FR 4286, Feb. 3, 1986]

§ 702.416 Fees for medical services; disputes; hearings; necessary parties.

At formal hearings held pursuant to § 702.415, the necessary parties shall be the person whose fee or cost charge is in question and the Director, or their representatives. The employer or carrier may also be represented, and other parties, or associations having an interest in the proceedings, may be heard, in the discretion of the administrative law judge.

§ 702.417 Fees for medical services; disputes; effect of adverse decision.

If the final decision and order upholds the finding of the Director that the fee or charge in dispute was not in accordance with prevailing community charges or the provider's customary charges, the person claiming such fee or cost charge shall be given thirty (30) days after filing of such decision and order to make the necessary adjustment. If such person still refuses to

make the required readjustment, such person shall not be authorized to conduct any further treatments or examinations (if a physician) or to provide any other services or supplies (if by other than a physician). Any fee or cost charge subsequently incurred for services performed or supplies furnished shall not be a reimbursable medical expense under this subpart. This prohibition shall apply notwithstanding the fact that the services performed or supplies furnished were in all other respects necessary and appropriate within the provision of these regulations. However, the Director may direct reimbursement of medical claims for services rendered if such services were rendered in an emergency (see § 702.435(b)). At the termination of the proceedings provided for in this section the district director shall determine whether further proceedings under § 702.432 should be initiated.

[50 FR 403, Jan. 3, 1985]

MEDICAL PROCEDURES

§ 702.418 Procedure for requesting medical care; employee's duty to notify employer.

(a) As soon as practicable, but within 30 days after occurrence of an injury covered by the Act, or within 30 days after an employee becomes aware, or in the exercise of reasonable diligence should be aware, of the relationship between an injury or disease and his employment, the injured employee or someone on his behalf shall give written notice thereof to the district director having jurisdiction over the place where the injury occurred and to the employer. If a form has been prescribed for such purpose it shall be used, if available and practicable under the circumstances. Notices filed under subpart B of this part, if on the form prescribed by the Director for such purpose, satisfy the written notice requirements of this subpart.

(b) In the case of an occupational disease which does not immediately result in a disability or death, such notice shall be given within one year after the employee becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability. Notice shall be given: (1) To the district director in the compensation district in which the injury or death occurred, and (2) to the employer.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 403, Jan. 3, 1985]

§ 702.419 Action by employer upon acquiring knowledge or being given notice of injury.

Whenever an employer acquires knowledge of an employee's injury, through receipt of a written notice or otherwise, said employer shall forthwith authorize, in writing, appropriate medical care. If a form is prescribed for this purpose it shall be used whenever practicable. Authorization shall also be given in cases where an employee's initial choice was not of a specialist whose services are necessary for and appropriate to the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

[50 FR 403, Jan. 3, 1985]

§ 702.420 Issuance of authorization; binding effect upon insurance carrier.

The issuance of an authorization for treatment by the employer shall bind his insurance carrier to furnish and pay for such care and services.

§ 702.421 Effect of failure to obtain initial authorization.

An employee shall not be entitled to recover for medical services and supplies unless:

(a) The employer shall have refused or neglected a request to furnish such services and the employee has complied with sections 7 (b) and (c) of the Act, 33 U.S.C. 907 (b) and (c) and these regulations; or

(b) The nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize same.

[50 FR 403, Jan. 3, 1985]

§ 702.422 Effect of failure to report on medical care after initial authorization.

(a) Notwithstanding that medical care is properly obtained in accordance with these regulations, a finding by the Director that a medical care provider has failed to comply with the reporting requirements of the Act shall operate as a mandatory revocation of authorization of such medical care provider. The effect of a final finding to this effect operates to release the employer/carrier from liability of the expenses of such care. In addition to this, when such a finding is made by the Director, the claimant receiving treatment will be directed by the district director to seek authorization for medical care from another source.

(b) For good cause shown, the Director may excuse the failure to comply with the reporting requirements of the Act and further, may make an award for the reasonable value of such medical care.

[50 FR 403, Jan. 3, 1985]

DEBARMENT OF PHYSICIANS AND OTHER PROVIDERS OF MEDICAL SERVICES AND SUPPLIERS AND CLAIMS REPRESENTATIVES

§ 702.431 Grounds for debarment.

A physician or health care provider shall be debarred if it is found, after appropriate investigation as described in § 702.414 and proceedings under §§ 702.432 and 702.433, that such physician or health care provider has:

(a) Knowingly and willfully made, or caused to be made, any false statement or misrepresentation of a material fact for use in a claim for compensation or claim for reimbursement of medical expenses under this Act;

(b) Knowingly and willfully submitted, or caused to be submitted, a bill or request for payment under this Act containing a charge which the Director finds to be substantially in excess of the charge for the service, appliance, or supply prevailing within the community or in excess of the provider's customary charges, unless the Director finds there is good cause for the bill or request containing the charge;

(c) Knowingly and willfully furnished a service, appliance, or supply which is determined by the Director to be substantially in excess of the need of the recipient thereof or to be of a quality which substantially fails to meet professionally recognized standards;

(d) Been convicted under any criminal statute, without regard to pending appeal thereof, for fraudulent activities in connection with federal or state program for which payments are made to physicians or providers of similar services, appliances, or supplies; or has otherwise been excluded from participation in such program.

(e) The fact that a physician or health care provider has been convicted of a crime previously described in (d), or excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any program as described in (d), shall be a prima facie finding of fact for purposes of section 7(j)(2) of the Act, 33 U.S.C. 907(j)(2).

[50 FR 404, Jan. 3, 1985]

§ 702.432 Debarment process.

(a) *Pertaining to health care providers.* Upon receipt of information indicating that a physician or health care provider has engaged in activities enumerated in subparagraphs (a) through (c) of § 702.431, the Director, through the Director's designees, may evaluate the information (as described in § 702.414) to ascertain whether proceedings should be initiated against the physician or health care provider to remove authorization to render medical care or service under the Longshore and Harbor Workers' Compensation Act.

(b) *Pertaining to health care providers and claims representatives.* If after appropriate investigation the Director determines that proceedings should be initiated, written notice thereof must be provided to the physician, health care provider or claims representative. Notice must contain the following:

(1) A concise statement of the grounds upon which debarment will be based;

(2) A summary of the information upon which the director has relied in reaching an initial decision that debarment proceedings should be initiated;

(3) An invitation to the physician, health care provider or claims representative to: (i) Resign voluntarily from participation in the program without admitting or denying the allegations presented in the written notice; or (ii) request a decision on debarment to be based upon the existing agency record and any other information the physician, health care provider or claims representative may wish to provide;

(4) A notice of the physician's, health care provider's or claims representative's right, in the event of an adverse ruling by the Director, to request a formal hearing before an administrative law judge;

(5) A notice that should the physician, health care provider or claims representative fail to provide written answer to the written notice described in this section within thirty (30) days of receipt, the Director may deem the allegations made therein to be true and may order exclusion of the physician, health care provider or claims representative without conducting any further proceedings; and

(6) The name and address of the district director who will be responsible for receiving the answer from the physician, health care provider or claims representative.

(c) Should the physician, health care provider or claims representative fail to file a written answer to the notice described in this section within thirty (30) days of receipt thereof, the Director may deem the allegations made therein to be true and may order debarment of the physician, health care provider or claims representative.

(d) The physician, health care provider or claims representative may inspect or request copies of information in the agency records at any time prior to the Director's decision.

(e) The Director must issue a decision in writing, and must send a copy of the decision to the physician, health care provider or claims representative. The decision must advise the physician, health care provider or claims representative of the right to request, within thirty (30) days of the date of an adverse decision, a formal hearing before an administrative law judge under the procedures set forth herein. The filing of such a request for hearing within the time specified will operate to stay the effectiveness of the decision to debar.

[50 FR 404, Jan. 3, 1985, as amended at 80 FR 12932, Mar. 12, 2015]

§ 702.433 Requests for hearing.

(a) A request for hearing must be sent to the district director and contain a concise notice of the issues on which the physician, health care provider or claims representative desires to give evidence at the hearing with identification of witnesses and documents to be submitted at the hearing.

(b) If a request for hearing is timely received by the district director, the matter must be referred to the Chief Administrative Law Judge who must assign it for hearing with the assigned administrative law judge issuing a notice of hearing for the conduct of the hearing. A copy of the hearing notice must be served on the physician, health care provider or claims representative.

(c) If a request for hearing contains identification of witnesses or documents not previously considered by the Director, the Director may make application to the assigned administrative law judge for an offer of proof from the physician, health care provider or claims representative for the purpose of discovery prior to hearing. If the offer of proof indicates injection of new issues or new material evidence not previously considered by the Director, the Director may request a remand order for purposes of reconsideration of the decision made pursuant to § 702.432 of these regulations.

(d) The parties may make application for the issuance of subpoenas upon a showing of good cause therefore to the administrative law judge.

(e) The administrative law judge will issue a recommended decision after the termination of the hearing. The recommended decision must contain appropriate findings, conclusions, and a recommended order and be forwarded, together with the record of the hearing, to the Administrative Review Board for a decision. The recommended decision must be served upon all parties to the proceeding.

(f) Based upon a review of the record and the recommended decision of the administrative law judge, the Administrative Review Board will issue a decision.

[50 FR 404, Jan. 3, 1985, as amended at 55 FR 28606, July 12, 1990; 61 FR 19984, May 3, 1996; 80 FR 12932, Mar. 12, 2015; 85 FR 13030, Mar. 6, 2020; 85 FR 30616, May 20, 2020]

§ 702.434 Judicial review.

(a) Any physician, health care provider, or claims representative who participated as a party in the hearing may obtain review of the Department's final decision made by the Administrative Review Board or the Secretary, as appropriate, regardless of the amount of controversy, by commencing a civil action within sixty (60) days after the decision is transmitted to him or her. The pendency of such review will not stay the effect of the decision. Such action must be brought in the Court of Appeals of the United States for the judicial circuit in which the plaintiff resides or has his or her principal place of business, or the Court of Appeals for the District of Columbia pursuant to section 7(j)(4) of the Act, 33 U.S.C. 907(j)(4).

(b) As part of the Department's answer, the Administrative Review Board must file a certified copy of the transcript of the record of the hearing, including all evidence submitted in connection therewith.

(c) The findings of fact contained in the Department's final decision, if based on substantial evidence in the record as a whole, shall be conclusive.

[85 FR 30616, May 20, 2020]

§ 702.435 Effects of debarment.

(a) The Director shall give notice of the debarment of a physician, hospital, or provider of medical support services or supplies to:

(1) All OWCP district offices;

(2) The Health Care Financing Administration;

(3) The State or Local authority responsible for licensing or certifying the debarred party;

(4) The employers and authorized insurers under the Act by means of an annual bulletin sent to them by the Director; and

(5) The general public by posting in the district office in the jurisdiction where the debarred party maintains a place of business.

If a claims representative is debarred, the Director shall give notice to those groups listed in paragraphs (a) (1), (3), (4), and (5) of this section.

(b) Notwithstanding any debarment under this subpart, the Director shall not refuse a claimant reimbursement for any otherwise reimbursable medical expense if the treatment, service or supply was rendered by debarred provider in an emergency situation. However, such claimant will be directed by the Director to select a duly qualified provider upon the earliest opportunity.

[50 FR 405, Jan. 3, 1985]

§ 702.436 Reinstatement.

(a) If a physician or health care provider has been debarred or pursuant to § 702.431(d) or if a claims representative has been debarred pursuant to § 702.131(c) (1) or (3) the person debarred will be automatically reinstated upon notice to the Director that the conviction or exclusion has been reversed or withdrawn. However, such reinstatement will not preclude the Director from instituting debarment proceedings based upon the subject matter involved.

(b) A physician, health care provider or claims representative otherwise debarred by the Director may apply for reinstatement to participate in the program by application to the Director after three years from the date of entry of the order of exclusion. Such application for reinstatement shall be addressed to the Associate Director for the Longshore program, and shall contain a statement of the basis of the application along with any supporting documentation.

(c) The Director may further investigate the merits of the reinstatement application by requiring special reporting procedures from the applicant for a probationary period not to exceed six months to be monitored by the district office where the provider maintains a place of business.

(d) At the end of aforesaid probationary period, the Director may order

full reinstatement of the physician, health care provider or claims representative if such reinstatement is clearly consistent with the program goal to protect itself against fraud and abuse and, further, if the physician, health care provider or claims representative has given reasonable assurances that the basis for the debarment will not be repeated.

[50 FR 405, Jan. 3, 1985]

HEARING LOSS CLAIMS

§ 702.441 Claims for loss of hearing.

(a) Claims for hearing loss pending on or filed after September 28, 1984 (the date of enactment of Pub. L. 98–426) shall be adjudicated with respect to the determination of the degree of hearing impairment in accordance with these regulations.

(b) An audiogram shall be presumptive evidence of the amount of hearing loss on the date administered if the following requirements are met:

(1) The audiogram was administered by a licensed or certified audiologist, by a physician certified by the American Board of Otolaryngology, or by a technician, under an audiologist's or physician's supervision, certified by the Council of Accreditation on Occupational Hearing Conservation, or by any other person considered qualified by a hearing conservation program authorized pursuant to 29 CFR 1910.95(g)(3) promulgated under the Occupational Safety and Health Act of 1970 (29 U.S.C. 667). Thus, either a professional or trained technician may conduct audiometric testing. However, to be acceptable under this subsection, a licensed or certified audiologist or otolaryngologist, as defined, must ultimately interpret and certify the results of the audiogram. The accompanying report must set forth the testing standards used and describe the method of evaluating the hearing loss as well as providing an evaluation of the reliability of the test results.

(2) The employee was provided the audiogram and a report thereon at the time it was administered or within thirty (30) days thereafter.

(3) No one produces a contrary audiogram of equal probative value (meaning one performed using the standards described herein) made at the same time. ''Same time'' means within thirty (30) days thereof where noise exposure continues or within six (6) months where exposure to excessive noise levels does not continue. Audiometric tests performed prior to the enactment of Public Law 98–426 will be considered presumptively valid if the employer complied with the procedures in this section for administering audiograms.

(c) In determining the amount of preemployment hearing loss, an audiogram must be submitted which was performed prior to employment or within thirty (30) days of the date of the first employment-related noise exposure. Audiograms performed after December 27, 1984 must comply with the standards described in paragraph (d) of this section.

(d) In determining the loss of hearing under the Act, the evaluators shall use the criteria for measuring and calculating hearing impairment as published and modified from time-to-time by the American Medical Association in the *Guides to the Evaluation of Permanent Impairment*, using the most currently revised edition of this publication. In addition, the audiometer used for testing the individual's threshold of hearing must be calibrated according to current American National Standard Specifications for Audiometers. Audiometer testing procedures required by hearing conservation programs pursuant to the Occupational Safety and Health Act of 1970 should be followed (as described at 29 CFR 1910.95 and appendices).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 405, Jan. 3, 1985]

Subpart E—Vocational Rehabilitation

§ 702.501 Vocational rehabilitation; objective.

The objective of vocational rehabilitation is the return of permanently disabled persons to gainful employment commensurate with their physical or mental impairments, or both, through a program of reevaluation or redirection of their abilities, or retraining in

another occupation, or selective job placement assistance.

§ 702.502 Vocational rehabilitation; action by district directors.

All injury cases which are likely to result in, or have resulted in, permanent disability, and which are of a character likely to require review by a vocational rehabilitation adviser on the staff of the Director, shall promptly be referred to such adviser by the district director or his designee having charge of the case. A form has been prescribed for such purpose and shall be used. Medical data and other pertinent information shall accompany the referral.

(Approved by the Office of Management and Budget under control number 1215–0051)

(Pub. L. No. 96–511)

[38 FR 26861, Sept. 26, 1973, as amended at 49 FR 18294, Apr. 30, 1984]

§ 702.503 Vocational rehabilitation; action by adviser.

The vocational rehabilitation adviser, upon receipt of the referral, shall promptly consider the feasibility of a vocational referral or request for cooperative services from available resources or facilities, to include counseling, vocational survey, selective job placement assistance, and retraining. Public or private agencies may be utilized in arranging necessary vocational rehabilitation services under the Federal Vocational Rehabilitation Act, 29 U.S.C. 31 *et seq.*

§ 702.504 Vocational rehabilitation; referrals to State Employment Agencies.

Vocational rehabilitation advisers will arrange referral procedures with State Employment Service units within their assigned geographical districts for the purpose of securing employment counseling, job classification, and selective placement assistance. Referrals shall be made to State Employment Offices based upon the following:

(a) Vocational rehabilitation advisers will screen cases so as to refer only those disabled employees who are considered to have employment potential;

(b) Only employees will be referred who have permanent, compensable disabilities resulting in a significant vocational handicap and loss of wage earning capacity;

(c) Disabled employees, whose initial referral to former private employers did not result in a job reassignment or in a job retention, shall be referred for employment counseling and/or selective placement unless retraining services consideration is requested;

(d) The vocational rehabilitation advisers shall arrange for employees' referrals if it is ascertained that they may benefit from registering with the State Employment Service;

(e) Referrals will be made to appropriate State Employment Offices by letter, including all necessary information and a request for a report on the services provided the employee when he registers;

(f) The injured employee shall be advised of available job counseling services and informed that he is being referred for employment and selective placement;

(g) A followup shall be made within 60 days on all referrals to assure uniform reporting by State agencies on cases referred for a vocational survey.

§ 702.505 Vocational rehabilitation; referrals to other public and private agencies.

Referrals to such other public and private agencies providing assistance to disabled persons such as public welfare agencies, Public Health Services facilities, social services units of the Veterans Administration, the Social Security Administration, and other such agencies, shall be made by the vocational rehabilitation adviser, where appropriate, on an individual basis when requested by disabled employees. Such referrals do not provide for a service cost reimbursement by the Department of Labor.

§ 702.506 Vocational rehabilitation; training.

Vocational rehabilitation training shall be planned in anticipation of a short, realistic, attainable vocational objective terminating in remunerable employment, and in restoring wage-earning capacity or increasing it materially. The following procedures shall

apply in arranging for or providing training:

(a) The vocational rehabilitation adviser shall arrange for and develop all vocational training programs.

(b) Training programs shall be developed to meet the varying needs of eligible beneficiaries, and may include courses at colleges, technical schools, training at rehabilitation centers, on-the-job training, or tutorial courses. The courses shall be pertinent to the occupation for which the employee is being trained.

(c) Training may be terminated if the injured employee fails to cooperate with the Department of Labor or with the agency supervising his course of training. The employee shall be counseled before training is terminated.

(d) Reports shall be required at periodic intervals on all persons in approved training programs.

§ 702.507 Vocational rehabilitation; maintenance allowance.

(a) An injured employee who, as a result of injury, is or may be expected to be totally or partially incapacitated for a remunerative occupation and who, under the direction of the Director is being rendered fit to engage in a remunerative occupation, shall be paid additional compensation necessary for this maintenance, not exceeding $25 a week. The expense shall be paid out of the special fund established in section 44 of the Act, 33 U.S.C. 944. The maximum maintenance allowance shall not be provided on an automatic basis, but shall be based on the recommendation of a State agency that a claimant is unable to meet additional costs by reason of being in training.

(b) When required by reason of personal illness or hardship, limited periods of absence from training may be allowed without terminating the maintenance allowance. A maintenance allowance shall be terminated when it is shown to the satisfaction of the Director that a trainee is not complying reasonably with the terms of the training plan or is absenting himself without good cause from training so as to materially interfere with the accomplishment of the training objective.

§ 702.508 Vocational rehabilitation; confidentiality of information.

The following safeguards will be observed to protect the confidential character of information released regarding an individual undergoing rehabilitation:

(a) Information will be released to other agencies from which an injured employee has requested services only if such agencies have established regulations assuring that such information will be considered confidential and will be used only for the purpose for which it is provided;

(b) Interested persons and agencies have been advised that any information concerning rehabilitation program employees is to be held confidential;

(c) A rehabilitation employee's written consent is secured for release of information regarding disability to a person, agency, or establishment seeking the information for purposes other than the approved rehabilitation planning with such employee.

Subpart F—Occupational Disease Which Does Not Immediately Result in Death or Disability

SOURCE: 50 FR 406, Jan. 3, 1985, unless otherwise noted.

§ 702.601 Definitions.

(a) *Time of injury.* For purposes of this subpart and with respect to an occupational disease which does not immediately result in death or disability, the time of injury shall be deemed to be the date on which the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.

(b) *Disability.* With regard to an occupational disease for which the time of injury, as defined in § 702.601(a), occurs after the employee was retired, disability shall mean permanent impairment as determined according to the *Guides to the Evaluation of Permanent Impairment* which is prepared and modified from time-to-time by the American Medical Association, using the most currently revised edition of this

publication. If this guide does not evaluate the impairment, other professionally recognized standards may be utilized. The disability described in this paragraph shall be limited to permanent partial disability. For that reason they are not subject to adjustments under section 10(f) of the Act, 33 U.S.C. 910(f).

(c) *Retirement.* For purposes of this subpart, retirement shall mean that the claimant, or decedent in cases involving survivor's benefits, has voluntarily withdrawn from the workforce and that there is no realistic expectation that such person will return to the workforce.

[50 FR 406, Jan. 3, 1985, as amended at 51 FR 4286, Feb. 3, 1986]

§ 702.602 Notice and claims.

(a) *Time for giving notice of injury or death.* Refer to § 702.207.

(b) *Time for filing of claims.* Refer to § 702.212.

§ 702.603 Determining the payrate for compensating occupational disease claims which become manifest after retirement.

(a) If the time of injury occurs within the first year after the employee has retired, the payrate for compensation purposes shall be one fifty-second part of the employee's average annual earnings during the fifty-two week period preceding retirement.

(b) If the time of injury occurs more than one year after the employee has retired the payrate for compensation purposes shall be the national average weekly wage, determined according to section 6(b)(3) of the Act, 33 U.S.C. 906(b)(3), at the time of injury.

§ 702.604 Determining the amount of compensation for occupational disease claims which become manifest after retirement.

(a) If the claim is for disability benefits and the time of injury occurs after the employee has retired, compensation shall be 66⅔ percent of the payrate, as determined under § 702.603, times the disability, as determined according to § 702.601(b).

(b) If the claim is for death benefits and the time of injury occurs after the decedent has retired, compensation shall be the percent specified in section 9 of the Act, 33 U.S.C. 909, times the payrate determined according to § 702.603. Total weekly death benefits shall not exceed one fifty-second part of the decedent's average annual earnings during the fifty-two week period preceding retirement, such benefits shall be subject to the limitation provided for in section 6(b)(1) of the Act, 33 U.S.C. 906(b)(1).

[50 FR 406, Jan. 3, 1985, as amended at 51 FR 4286, Feb. 3, 1986]

Subpart G—Section 10(f) Adjustments

SOURCE: 83 FR 17290, Apr. 19, 2018, unless otherwise noted.

§ 702.701 What is an annual section 10(f) adjustment and how is it calculated?

(a) Claimants receiving compensation for permanent total disability or death benefits are entitled to section 10(f) adjustments each fiscal year. A section 10(f) adjustment cannot decrease the compensation or death benefits payable to any claimant.

(b) The section 10(f) adjustment for a given fiscal year is the lower of:

(1) The percentage by which the new fiscal year's national average weekly wage exceeds the prior fiscal year's national average weekly wage as determined by the Department (*see* § 702.804(b)); or

(2) 5 percent.

(c) Section 10(f) percentage increases are applied each October 1 to the amount of compensation or death benefits payable in the prior fiscal year.

(d) In applying section 10(f) adjustments—

(1) Calculations are rounded to the nearest dollar; and

(2) No adjustment is made if the calculated amount is less than one dollar.

(e) A section 10(f) adjustment must not increase a claimant's weekly compensation or death benefits beyond the applicable fiscal year's maximum rate.

(f) Section 10(f) adjustments do not apply to compensation for temporary or partial disability.

Subpart H—Maximum and Minimum Compensation Rates

SOURCE: 83 FR 17290, Apr. 19, 2018 unless otherwise noted.

GENERAL

§ 702.801 Scope and intent of this subpart.

(a) This subpart implements the Act's provisions that affect the maximum and minimum rates of compensation and death benefits payable to employees and survivors. These statutory provisions include sections 6(b) and (c), and 9(e). 33 U.S.C. 906(b), (c); 909(e). It is intended that these statutory provisions be construed as provided in this subpart.

(b) These regulations implement section 6(c), 33 U.S.C. 906(c), based on the following concepts:

(1) An employee is ''newly awarded compensation'' when he or she first becomes disabled due to an injury;

(2) A survivor is ''newly awarded compensation'' on the date the employee died; and

(3) An employee or survivor is ''currently receiving compensation'' when compensation for permanent total disability or death benefits is payable, regardless of when payment is actually made.

§ 702.802 Applicability of this subpart.

(a) This subpart applies to all compensation and death benefits paid under the Act as a result of injuries or deaths occurring on or after May 21, 2018 with the following exceptions:

(1) Amounts payable under an approved settlement (*see* 33 U.S.C. 908(i));

(2) Amounts paid for an employee's death to the Special Fund (*see* 33 U.S.C. 944(c)(1));

(3) Any payments for medical expenses (*see* 33 U.S.C. 907); and

(4) Any other lump sum payment of compensation or death benefits, including aggregate death benefits paid when a survivor remarries (*see* 33 U.S.C. 909(b)) or aggregate compensation paid under a commutation (*see* 33 U.S.C. 909(g)).

(b) The rules in this subpart governing minimum disability compensation and death benefits do not apply to claims arising under the Defense Base Act, 42 U.S.C. 1651 (*see* 42 U.S.C. 1652(a); 20 CFR 704.103).

§ 702.803 Definitions.

The following definitions apply to this subpart:

Calculated compensation rate means the amount of weekly compensation for total disability or death that a claimant would be entitled to if there were no maximum rates, minimum rates, or section 10(f) adjustments.

Date of disability. (1) Except as provided in paragraph (2) of this definition, the date of disability is the date on which the employee first became incapable, because of an injury, of earning the same wages the employee was receiving at the time of the injury.

(2) Exceptions:

(i) For scheduled permanent partial disability benefits under 33 U.S.C. 908(c)(1)–(20) that are not preceded by a permanent total, temporary total, or temporary partial disability resulting from the same injury, the date of disability is the date on which the employee first becomes permanently impaired by the injury to the scheduled member.

(ii) For an occupational disease that does not immediately result in disability, the date of disability is the date on which the employee becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between his or her employment, the disease, and the disability.

(iii) For any disability lasting 14 or fewer days, the date of disability is 4 days after the date on which the employee first became incapable, because of an injury, of earning the same wages the employee was receiving at the time of the injury.

Fiscal year or *FY* means the period from October 1 of a calendar year until September 30 of the following calendar year.

Maximum rate means the maximum weekly compensation rate calculated by the Department for a given fiscal year as described in § 702.804(b).

Minimum rate means the minimum weekly compensation rate calculated by the Department for a given fiscal year as described in § 702.804(c).

Section 10(f) adjustment means the annual increase that certain claimants receiving compensation for permanent total disability or death are entitled to each fiscal year under 33 U.S.C. 910(f) and as calculated by the Department as described in § 702.701(b).

§ 702.804 What are the weekly maximum and minimum rates for each fiscal year and how are they calculated?

(a) For each fiscal year, the Department must determine a weekly maximum and minimum compensation rate. These amounts are called the maximum and minimum rates in this subchapter. In combination with other factors, these rates are used to determine compensation payments under the Act.

(b) The maximum compensation rate in effect for a given fiscal year is 200% of the national average weekly earnings of production or nonsupervisory workers on private, nonagricultural payrolls, as calculated by the Department, for the first three quarters of the preceding fiscal year.

(c) The minimum compensation rate in effect for a given fiscal year is 50% of the national average weekly earnings of production or nonsupervisory workers on private, nonagricultural payrolls, as calculated by the Department, for the first three quarters of the preceding fiscal year.

MAXIMUM RATES

§ 702.805 What weekly maximum rates apply to compensation for permanent partial disability, temporary total disability, and temporary partial disability?

(a) The maximum rate in effect on the date of disability applies to all compensation payable for permanent partial disability, temporary partial disability, and temporary total disability.

(b) Examples:

(1) Employee *A* suffers a covered workplace injury on April 1, 2000, is temporarily totally disabled from that day through June 4, 2002, and is thereafter permanently partially disabled. All compensation payable for *A's* disability is subject to the FY 2000 maximum rate.

(2) Employee *B* suffers a covered workplace injury on August 25, 2010, and is temporarily totally disabled until September 25, 2010, when he returns to work. On January 3, 2011, he again becomes temporarily totally disabled from the same injury. He ceases work and is unable to return until November 22, 2012. All compensation payable for *B's* disability is subject to the FY 2010 maximum rate.

(3) Employee *C* retires on May 6, 2011. She discovers on November 10, 2012, that she has a compensable occupational disease. All compensation payable for *C's* occupational disease is subject to the FY 2013 maximum rate. *See* § 702.601(b) (occupational diseases discovered post-retirement are compensated as permanent partial disabilities).

§ 702.806 What weekly maximum rates apply to compensation for permanent total disability?

(a) The maximum rate in effect on the date that the employee became totally and permanently disabled applies to all compensation payable for permanent total disability during that fiscal year.

(b) For all periods the employee is permanently and totally disabled in subsequent fiscal years, the weekly compensation payable is subject to each subsequent year's maximum rate.

(c) If a claimant is receiving compensation for permanent total disability at the maximum rate for the current fiscal year, but the next fiscal year's maximum rate will be higher than the claimant's calculated compensation rate, the claimant's compensation for the next fiscal year will increase by the amount of the 10(f) adjustment, subject to the maximum rate for the next fiscal year.

(d) Examples:

(1) Employee *A* suffers a covered workplace injury on April 1, 2000, and is permanently and totally disabled from that date forward. *A's* compensation for the period from April 1, 2000, until September 30, 2000, is subject to the FY 2000 maximum rate. Beginning October 1, 2000, *A's* compensation for FY 2001 is subject to the FY 2001 maximum rate, compensation for FY 2002 is

subject to the FY 2002 maximum rate, *etc.*

(2) Employee *B* suffers a covered workplace injury on April 1, 2000, is temporarily totally disabled from that day through June 3, 2002, and is thereafter permanently totally disabled. *B's* compensation for the period from April 1, 2000, through June 3, 2002, is subject to the FY 2000 maximum rate (*see* § 702.805(a)). *B's* compensation for the period from June 4, 2002, through September 30, 2002, is subject to the FY 2002 maximum rate. Beginning October 1, 2002, *B's* compensation for FY 2003 is subject to the FY 2003 maximum rate, compensation for FY 2004 is subject to the FY 2004 maximum rate, *etc.*

(3) Employee *C* suffers a covered workplace injury in FY 2009 and is permanently totally disabled from that day forward. He was earning $1,950.00 a week when he was injured, making his calculated compensation rate $1,300.00 ($1,950.00 × 2 ÷ 3). His calculated compensation rate exceeds the maximum rate from FY 2009–2012; thus, his compensation is limited to each year's maximum rate. In FY 2013, *C's* calculated compensation rate of $1,300.00 is, for the first time, less than the FY 2013 maximum rate of $1,325.18. Applying the FY 2013 2.31% section 10(f) adjustment to *C's* FY 2012 compensation rate of $1,295.20 results in a compensation rate of $1,325.00 ($1,295.20 × .0231 = $29.92, rounded to the nearest cent; $1,295.20 + $29.92 = $1,325.12, rounded to the nearest dollar). This amount falls just below the FY 2013 maximum rate of $1,325.18. Thus, *C's* benefit rate for FY 2013 is $1,325.00, and is not limited by the maximum rate.

§ 702.807 What weekly maximum rates apply to death benefits?

(a) The maximum rate in effect on the date that the employee died applies to all death benefits payable during that fiscal year.

(b) Aggregate weekly death benefits paid to all eligible survivors during the fiscal year in which the employee died must not exceed the lower of—

(1) The maximum rate for that fiscal year; or

(2) The employee's average weekly wages.

(c) For subsequent fiscal years—

(1) Aggregate weekly death benefits paid during each subsequent fiscal year are subject to each subsequent year's maximum rate.

(2) If death benefits were paid in the first year at the employee's full average weekly wage under paragraph (b)(2) of this section, the aggregate weekly death benefits paid for each subsequent year may not exceed the current benefit rate plus the subsequent year's section 10(f) adjustment (*see* § 702.701).

(d) Post-retirement occupational diseases: Notwithstanding paragraphs (a) through (c) of this section, if an employee's death results from an occupational disease where the date of disability occurred after the employee voluntarily retired—

(1) Aggregate weekly death benefits paid to all eligible survivors during the fiscal year in which the employee died must not exceed the lower of:

(i) The maximum rate for that fiscal year; or

(ii) One fifty-second part of the employee's average annual earnings during the 52-week period preceding retirement.

(2) For subsequent fiscal years—

(i) Aggregate weekly death benefits paid during each subsequent fiscal year are subject to each subsequent year's maximum rate.

(ii) If death benefits were paid in the first year at 1/52 part of the employee's average annual earnings prior to retirement under paragraph (d)(1)(ii) of this section, the aggregate weekly death benefits paid for each subsequent year may not exceed the current benefit rate plus the subsequent year's section 10(f) adjustment (*see* § 702.701).

(e) Examples:

(1) Employee *A* suffers a covered workplace injury on May 1, 2013, and is permanently and totally disabled from that date until August 1, 2014, when he dies due to the injury. He has one eligible survivor and his average weekly wage at the time of injury was $3,000.00. The calculated compensation rate for *A's* survivor is $1,500.00 (*i.e.*, 50% of *A's* average weekly wage). *A's* weekly survivor's benefits for the period from August 2, 2014, to September 30, 2014, are limited to the FY 2014 maximum rate of $1,346.68. Beginning October 1, 2014, *A's* survivor's benefits for FY 2015 are

subject to the FY 2015 maximum rate, benefits for FY 2016 are subject to the FY 2016 maximum rate, *etc.*

(2) Employee *B* suffers a covered workplace injury and dies on December 1, 2012. She has one eligible survivor and her average weekly wage was $300.00. Because *B's* average weekly wage of $300.00 falls below the FY 2013 national average weekly wage of $662.59, death benefits are calculated at 50% of that national average wage (*see* 33 U.S.C. 909(e)). This yields a calculated compensation rate of $331.30. But because this rate exceeds *B's* actual average weekly wages, weekly death benefits payable during FY 2013 are limited to $300.00. In FY 2014, *B's* survivor is entitled to a 1.62% section 10(f) adjustment, resulting in weekly death benefits of $305.00 ($300.00 × .0162 = $4.86; $300.00 + $4.86 = $304.86, rounded to the nearest dollar). *B's* survivor would continue to receive section 10(f) adjustments in subsequent fiscal years.

(3) Employee *C* retired on February 1, 1998. During his last year of employment, he earned $23,000. He discovers on April 15, 2002, that he has a compensable occupational disease resulting in a 50% permanent impairment. *See* § 702.601(b). Because he retired more than one year before this date, his payrate for calculating compensation is the FY 2002 national average weekly wage, or $483.04. *See* § 702.603(b). He is entitled to weekly compensation of $161.01 ($483.04 × 2 ÷ 3 × 50%). *C* dies from the disease on June 1, 2015, leaving two survivors. The payrate for calculating death benefits is the FY 2015 national average weekly wage, or $688.51. *See* § 702.604(b). The survivors' aggregate calculated compensation rate is $459.01 ($688.51 × 2 ÷ 3). But because compensation cannot exceed 1/52 part of *C's* last year of earnings, aggregate weekly death benefits payable for FY 2015 are limited to $442.31 ($23,000 ÷ 52). For FY 2016, *C's* survivors are entitled to a 2.10% section 10(f) adjustment resulting in weekly death benefits of $452.00 ($442.31 × .021 = $9.29, rounded to the nearest cent; $442.31 + $9.29 = $451.60, rounded to the nearest dollar). *C's* survivors would continue to receive section 10(f) adjustments in subsequent fiscal years.

MINIMUM RATES

§ 702.808 What weekly minimum rates apply to compensation for partial disability?

There is no minimum rate for compensation paid for partial disability, whether temporary or permanent.

§ 702.809 What weekly minimum rates apply to compensation for temporary total disability?

(a) The minimum compensation payable for temporary total disability is the lower of:

(1) The minimum rate in effect on the date of disability, or

(2) The employee's average weekly wage on the date of disability.

(b) Example: Employee *A* suffers a covered workplace injury on May 6, 2014. He is temporarily totally disabled until November 6, 2015, when he returns to work. His average weekly wages at the time of disability were $500.00. Because his calculated compensation rate (*i.e.*, 66 and 2/3% of $500.00, or $333.34) is lower than the $336.67 FY 2014 minimum rate, *A's* compensation is raised to $336.67 for the entire period of his disability.

§ 702.810 What weekly minimum rates apply to compensation for permanent total disability?

(a) The weekly minimum compensation payable for the fiscal year in which the employee became permanently and totally disabled is the lower of:

(1) The minimum rate in effect on the date of disability, or

(2) The employee's average weekly wage on the date of disability.

(b) For all periods the employee is permanently and totally disabled in subsequent fiscal years, the weekly minimum compensation payable is the lower of:

(1) Each subsequent fiscal year's minimum rate, or

(2) The employee's average weekly wage on the date of disability.

(c) Example: Employee *A* suffers a covered workplace injury on April 1, 2003, and is permanently totally disabled from that day forward. He was earning $250.00 a week when he was injured. His calculated compensation rate is $166.67 ($250 × 2 ÷ 3). The FY 2003

minimum rate is $249.14. Because *A's* calculated compensation rate is below the FY 2003 minimum rate, and his actual weekly wage is above that rate, he is entitled to compensation at the minimum rate of $249.14 from April 1, 2003, to September 30, 2003. The FY 2004 minimum rate is $257.70. Because *A's* actual weekly wages on the date of disability are lower than the FY 2004 minimum rate, *A's* minimum weekly compensation rate for FY 2004 is $250.00. His weekly compensation rate for FY 2004, however, is higher because of a section 10(f) adjustment. For FY 2004, *A's* compensation rate is increased by a 3.44% section 10(f) adjustment, raising his compensation level to $258.00 ($249.14 × .0344 = $8.57; $249.14 + $8.57 = $257.71, rounded to the nearest dollar).

§ 702.811 What weekly minimum rates apply to death benefits?

(a) The average weekly wage used to compute death benefits is the greater of—

(1) The deceased employee's average weekly wages; or

(2) The national average weekly wage in effect at the time of the employee's death.

(b) The weekly minimum rate does not apply to death benefits.

PART 703—INSURANCE REGULATIONS

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AUTHORITY: 5 U.S.C. 301, and 8171 *et seq.;* 33 U.S.C. 901 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; Reorganization Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 38 FR 26873, Sept. 26, 1973, unless otherwise noted.

Subpart A—General

SOURCE: 70 FR 43233, July 26, 2005, unless otherwise noted.

§ 703.1 Scope of part.

Part 703 governs insurance carrier authorizations, insurance carrier security deposits, self-insurer authorizations, and certificates of compliance with the insurance regulations. These provisions are required by the LHWCA and apply to the extensions of the LHWCA except as otherwise provided in part 704 of this subchapter.

§ 703.2 Forms.

(a) Any information required by the regulations in this part to be submitted to OWCP must be submitted on forms the Director authorizes from time to time for such purpose. Persons submitting forms may not modify the forms or use substitute forms without OWCP's approval. These forms must be submitted, sent, or filed in the manner prescribed by OWCP.

Form No.	Title
(1) LS–271	Application for Self-Insurance.
(2) LS–274	Report of Injury Experience.
(3) LS–275 SI	Self-Insurer's Agreement and Undertaking.
(4) LS–275 IC	Insurance Carrier's Agreement and Undertaking.
(5) LS–276	Application for Security Deposit Determination.
(6) LS–405	Indemnity Bond.
(7) LS–570	Card Report of Insurance.

(b) Copies of the forms listed in this section are available for public inspection at the Office of Workers' Compensation Programs, U.S. Department of Labor, Washington, DC 20210. They may also be obtained from OWCP district offices and on the Internet at *http://www.dol.gov/owcp/dlhwc.*

[70 FR 43233, July 26, 2005, as amended at 77 FR 37286, June 21, 2012; 80 FR 12932, Mar. 12, 2015]

§ 703.3 Failure to secure coverage; penalties.

(a) Each employer must secure the payment of compensation under the Act either through an authorized insurance carrier or by becoming an authorized self-insurer under section 32(a)(1) or (2) of the Act (33 U.S.C. 932(a)(1) or (2)). An employer who fails to comply with these provisions is subject, upon conviction, to a fine of not more than $10,000, or by imprisonment for not more than one year, or both. Where the employer is a corporation, the president, secretary and treasurer each will also be subject to this fine and/or imprisonment, in addition to the fine against the corporation, and each is severally personally liable, jointly with the corporation, for all compensation or other benefits payable under the Act while the corporation fails to secure the payment of compensation.

(b) Any employer who willingly and knowingly transfers, sells, encumbers, assigns or in any manner disposes of, conceals, secretes, or destroys any property belonging to the employer after an employee sustains an injury covered by the Act, with the intent to avoid payment of compensation under

the Act to that employee or his/her dependents, shall be guilty of a misdemeanor and punished, upon conviction, by a fine of not more than $10,000 and/or imprisonment for one year. Where the employer is a corporation, the president, secretary and treasurer are also severally liable to imprisonment and, along with the corporation, jointly liable for the fine.

Subpart B—Authorization of Insurance Carriers

§ 703.101 Types of companies which may be authorized by the OWCP.

The OWCP will consider for the granting of authority to write insurance under the Longshoremen's and Harbor Workers' Compensation Act and its extensions the application of any stock company, mutual company or association, or any other person or fund, while authorized under the laws of the United States or for any State to insure workmen's compensation. The term ''carrier'' as used in this part means any person or fund duly authorized to insure workmen's compensation benefits under said Act, or its extensions.

§ 703.102 Applications for authority to write insurance; how filed; evidence to be submitted; other requirements.

An application for authority to write insurance under this Act shall be made in writing, signed by an officer of the applicant duly authorized to make such application, and transmitted to the Office of Workmen's Compensation Programs, U.S. Department of Labor, Washington, DC 20210. Such application shall be accompanied by full and complete information regarding the history and experience of such applicant in the writing of workmen's compensation insurance, together with evidence that it has authority in its charter or form of organization to write such insurance, and evidence that the applicant is currently authorized to insure workmen's compensation liability under the laws of the United States or of any State. The statements of fact in each application and in the supporting evidence shall be verified by the oath of the officer of the applicant who signs such application. Each applicant shall state in its application the area or areas, in which it intends to do business. In connection with any such application the following shall be submitted, the Office reserving the right to call for such additional information as it may deem necessary in any particular case:

(a) A copy of the last annual report made by the applicant to the insurance department or other authority of the State in which it is incorporated, or the State in which its principal business is done.

(b) A certified copy from the proper State authorities of the paper purporting to show the action taken upon such report, or such other evidence as the applicant desires to submit in respect of such report, which may obviate delay caused by an inquiry of the OWCP of the State authorities relative to the standing and responsibility of the applicant.

(c) A full and complete statement of its financial condition, if not otherwise shown, and, if a stock company, shall show specifically its capital stock and surplus.

(d) A copy of its charter or other formal outline of its organization, its rules, its bylaws, and other documents, writings, or agreements by and under which it does business, and such other evidence as it may deem proper to make a full exposition of its affairs and financial condition.

[38 FR 26873, Sept. 26, 1973; 50 FR 406, Jan. 3, 1985]

§ 703.103 Stock companies holding Treasury certificates of authority.

A stock company furnishing evidence that it is authorized to write workmen's compensation insurance under the laws of the United States or of any State, which holds a certificate of authority from the Secretary of the Treasury as an acceptable surety on Federal bonds, unless requested to do so, need not transmit to the Office with its application copies of such financial reports as are on file in the Department of the Treasury. The acceptance by that Department of such a company will be considered by the Office in conjunction with the application of such

company, provided there has been compliance with the other requirements of the regulations in this part.

§ 703.104 Applicants currently authorized to write insurance under the extensions of the LHWCA.

Any applicant currently authorized by the Office to write insurance under any extension of the LHWCA need not support its application under the LHWCA or any other LHWCA extension with the evidence required by the regulations in this part, except the form of policy and endorsement which it proposes to use, unless specifically requested by the Office, but instead its application may refer to the fact that it has been so authorized.

§ 703.105 Copies of forms of policies to be submitted with application.

With each application for authority to write insurance there shall be submitted for the approval of the Office copies of the forms of policies which the applicant proposes to issue in writing insurance under the LHWCA, or its extensions, to which shall be attached the appropriate endorsement to be used in connection therewith.

§ 703.106 Certificate of authority to write insurance.

No corporation, company, association, person, or fund shall write insurance under this Act without first having received from the OWCP a certificate of authority to write such insurance. Any such certificate issued by the Office, after application therefor in accordance with these regulations, may authorize the applicant to write such insurance in a limited territory as determined by the Office. Any such certificate may be suspended or revoked by the Office prior to its expiration for good cause shown, but no suspension or revocation shall affect the liability of any carrier already incurred. Good cause shall include, without limitation, the failure to maintain in such limited territory a regular business office with full authority to act on all matters falling within the Act, and the failure to promptly and properly perform the carrier's responsibilities under the Act and these regulations, with special emphasis upon lack of promptness in making payments when due, upon failure to furnish appropriate medical care, and upon attempts to offer to, or urge upon, claimants inequitable settlements. A hearing may be requested by the aggrieved party and shall be held before the Director or his representative prior to the taking of any adverse action under this section.

§ 703.108 Period of authority to write insurance.

Effective with the end of the authorization period July 1, 1983, through June 30, 1984, annual reauthorization of authority to write insurance coverage under the Act is no longer necessary. Beginning July 1, 1984, and thereafter, newly issued Certificates of Authority will show no expiration date. Certificates of Authority will remain in force for so long as the carrier complies with the requirements of the OWCP.

[50 FR 406, Jan. 3, 1985]

§ 703.109 Longshoremen's endorsement; see succeeding parts for endorsements for extensions.

(a) The following form of endorsement application to the standard workmen's compensation and employer's liability policy, shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. ___,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, 33 U.S.C. 901 *et seq.*, and all laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of this Act, and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, U.S. Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Act.

This endorsement shall not be cancelled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has

been sent to the District Director and to this employer.

All terms, conditions, requirements, and obligations, expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

§ 703.110 Other forms of endorsements and policies.

Where the form of endorsement prescribed by § 703.109 is not appropriate when used in conjunction with a form of policy approved for use by the Office no modification thereof shall be used unless specifically approved by the Office. Where the form of policy is designed to include therein the obligations of the insurer under said Act without the use of the appropriate endorsements, the policy shall contain the provisions required to be included in any of the endorsements. Such a policy, however, shall not be used until expressly approved by the Office.

§ 703.111 Submission of new forms of policies for approval; other endorsements.

No new forms of policies or modification of existing forms of policies shall be used by an insurer authorized by the Office under the regulations in this part to write insurance under said Act except after submission to and approval by the Office. No endorsement altering any provisions of a policy approved by the Office shall be used except after submission to and approval by the Office.

§ 703.112 Terms of policies.

A policy or contract of insurance shall be issued for the term of not less than 1 year from the date that it becomes effective, but if such insurance be not needed except for a particular contract or operation, the term of the policy may be limited to the period of such contract or operation.

§ 703.113 Marine insurance contracts.

A longshoremen's policy, or the longshoremen's endorsement provided for by § 703.109 for attachment to a marine policy, may specify the particular vessel or vessels in respect of which the policy applies and the address of the employer at the home port thereof. The report of the issuance of a policy or endorsement required by § 703.116 must be made to DLHWC and must show the name and address of the owner as well as the name or names of such vessel or vessels.

[80 FR 12933, Mar. 12, 2015]

§ 703.114 Notice of cancellation.

Cancellation of a contract or policy of insurance issued under authority of the Act will not become effective otherwise than as provided by 33 U.S.C. 936(b); 30 days before such cancellation is intended to be effective, notice of a proposed cancellation must be given to the district director and the employer in accordance with the provisions of 33 U.S.C. 912(c). The notice requirements of 33 U.S.C. 912(c) will be considered met when:

(a) Notice to the district director is given by a method specified in § 702.101(a) of this chapter or in the same manner that reports of issuance of policies and endorsements are reported under § 703.116; and

(b) Notice to the employer is given by a method specified in § 702.101(b) of this chapter.

[80 FR 12933, Mar. 12, 2015]

§ 703.115 Discharge by the carrier of obligations and duties of employer.

Every obligation and duty in respect of payment of compensation, the providing of medical and other treatment and care, the payment or furnishing of any other benefit required by said Act and in respect of the carrying out of the administrative procedure required or imposed by said Act or the regulations in this part upon an employer shall be discharged and carried out by the carrier except that the prescribed report of injury or death shall be sent by the employer to the district director and to the insurance carrier as required by 33 U.S.C. 930. Such carrier shall be jointly responsible with the employer for the submission of all reports, notices, forms, and other administrative papers required by the district director or the Office in the administration of said Act to be submitted by the employer, but any form

or paper so submitted where required therein shall contain in addition to the name and address of the carrier, the full name and address of the employer on whose behalf it is submitted. Notice to or knowledge of an employer of the occurrence of the injury or death shall be notice to or knowledge of such carrier. Jurisdiction of the employer by a district director, the Office, or appropriate appellate authority under said Act shall be jurisdiction of such carrier. Any requirement under any compensation order, finding, or decision shall be binding upon such carrier in the same manner and to the same extent as upon the employer.

§ 703.116 Report by carrier of issuance of policy or endorsement.

Each carrier must report to DLHWC each policy and endorsement issued by it to an employer whose employees are engaging in work subject to the Act and its extensions. Such reports must be made in a manner prescribed by OWCP. Reports made to an OWCP-authorized intermediary, such as an industry data collection organization, satisfy this reporting requirement.

[80 FR 12933, Mar. 12, 2015]

§ 703.117 Report; by whom sent.

The report of issuance of a policy and endorsement provided for in § 703.116 or notice of cancellation provided for in § 703.114 must be sent by the home office of the carrier, except that any carrier may authorize its agency or agencies in any compensation district to make such reports, provided the carrier notifies DLHWC of the agencies so duly authorized.

[80 FR 12933, Mar. 12, 2015]

§ 703.118 Agreement to be bound by report.

Every applicant for the authority to write insurance under the provisions of this Act, will be deemed to have included in its application an agreement that the acceptance by DLHWC of a report of insurance, as provided for by § 703.116, binds the carrier to full liability for the obligations under this Act of the employer named in said report, and every certificate of authority to write insurance under this Act will be deemed to have been issued by the Office upon consideration of the carrier's agreement to become so bound. It will be no defense to this agreement that the carrier failed or delayed to issue the policy to the employer covered by this report.

[80 FR 12933, Mar. 12, 2015]

§ 703.119 [Reserved]

§ 703.120 Name of one employer only in each report.

For policies that are reported to DLHWC on Form LS–570 (Carrier's Report of Issuance of Policy), a separate report of the issuance of a policy and endorsement, provided for by § 703.116, must be made for each employer covered by a policy. If a policy is issued insuring more than one employer, a separate form LS–570 for each employer so covered must be sent to DLHWC in the manner described in § 703.116, with the name of only one employer on each form.

[80 FR 12933, Mar. 12, 2015]

Subpart C—Insurance Carrier Security Deposit Requirements

SOURCE: 70 FR 43234, July 26, 2005, unless otherwise noted.

§ 703.201 Deposits of security by insurance carriers.

The regulations in this subpart require certain insurance carriers to deposit security in the form of indemnity bonds, letters of credit or negotiable securities (chosen at the option of the carrier) of a kind and in an amount determined by the Office, and prescribe the conditions under which deposits must be made. Security deposits secure the payment of compensation and medical benefits when an insurance carrier defaults on any of its obligations under the LHWCA, regardless of the date such obligations arose. They also secure the payment of compensation and medical benefits when a carrier becomes insolvent and such obligations are not otherwise fully secured by a State guaranty fund. Any gap in State guaranty fund coverage will have a direct effect on the amount of security the Office will require a carrier to post.

As used in this subpart, the terms ''obligations under the Act'' and ''LHWCA obligations'' mean a carrier's liability for compensation payments and medical benefits arising under the Longshore and Harbor Workers' Compensation Act and any of its extensions.

§ 703.202 Identification of significant gaps in State guaranty fund coverage for LHWCA obligations.

(a) In determining the amount of a carrier's required security deposit, the Office will consider the extent to which a State guaranty fund secures the insurance carrier's LHWCA obligations in that State. When evaluating State guaranty funds, the Office may consider a number of factors including, but not limited to—

(1) Limits on weekly benefit amounts;

(2) Limits on aggregate maximum benefit amounts;

(3) Time limits on coverage;

(4) Ocean marine exclusions;

(5) Employer size and viability provisions; and

(6) Financial strength of the State guaranty fund itself.

(b) OWCP will identify States without guaranty funds and States with guaranty funds that do not fully and immediately secure LHWCA obligations and will post its findings on the Internet at *http://www.dol.gov/owcp/dlhwc*. These findings will indicate the extent of any partial or total gap in coverage provided by a State guaranty fund, and they will be open for inspection and comment by all interested parties. If the extent of coverage a particular State guaranty fund provides either cannot be determined or is ambiguous, OWCP will deem one third (33⅓ percent) of a carrier's LHWCA obligations in that State to be unsecured. OWCP will revise its findings from time to time, in response to substantiated public comments it receives or for any other reasons it considers relevant.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.203 Application for security deposit determination; information to be submitted; other requirements.

(a) Each insurance carrier authorized by OWCP to write insurance under the LHWCA or any of its extensions, and each insurance carrier seeking initial authorization to write such insurance, must apply annually, on a schedule set by OWCP, for a determination of the extent of its unsecured obligations and the security deposit required. The application must be addressed to the Branch of Financial Management and Insurance (Branch) within OWCP's Division of Longshore and Harbor Workers' Compensation, and be made on a form provided by OWCP. The application must contain the following:

(1) Any carrier seeking an exemption from the security deposit requirements based on its financial standing (*see* § 703.204(c)(1)) must submit documentation establishing the carrier's current rating and its rating for the immediately preceding year from each insurance rating service designated by the Branch and posted on the Internet at *http://www.dol.gov/owcp/dlhwc*.

(2) All other carriers, and any carrier whose exemption request under paragraph (a)(1) of this section has been denied, must provide—

(i) A statement of the carrier's outstanding liabilities under the LHWCA or any of its extensions for its LHWCA obligations for each State in which the obligations arise; and

(ii) Any other information the Branch requests to enable it to give the application adequate consideration including, but not limited to, the reports set forth at § 703.212.

(b) If the carrier disagrees with any of OWCP's findings regarding State guaranty funds made under § 703.202(b) as they exist when it submits its application, the carrier may submit a statement of its unsecured obligations based on a different conclusion regarding the extent of coverage afforded by one or more State guaranty funds. The carrier must submit evidence and/or argument with its application sufficient to establish that such conclusion is correct.

(c) The carrier must sign and swear to the application. If the carrier is not an individual, the carrier's duly authorized officer must sign and swear to

the application and list his or her official designation. If the carrier is a corporation, the officer must also affix the corporate seal.

(d) At any time after filing an application, the carrier must inform the Branch immediately of any material changes that may have rendered its application incomplete, inaccurate or misleading.

(e) By filing an application, the carrier consents to be bound by and to comply with the regulations and requirements in this part.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.204 Decision on insurance carrier's application; minimum amount of deposit.

(a) The Branch will issue a decision on the application determining the extent of an insurance carrier's unsecured LHWCA obligations and fixing the amount of security the carrier must deposit to fully secure payment of its unsecured obligations. The Branch will transmit its decision to the applicant in a way it considers appropriate.

(b) The Branch may consider a number of factors in setting the security deposit amount including, but not limited to, the—

(1) Financial strength of the carrier as determined by private insurance rating organizations;

(2) Financial strength of the carrier's insureds in the Longshore industry;

(3) Extent to which State guaranty funds secure the carrier's LHWCA obligations in the event the carrier defaults on its obligations or becomes insolvent;

(4) Carrier's longevity in writing LHWCA or other workers' compensation coverage;

(5) Extent of carrier's exposure for LHWCA coverage; and

(6) Carrier's payment history in satisfying its LHWCA obligations.

(c) In setting the security deposit amount, the Branch will follow these criteria:

(1) Carriers who hold the highest rating awarded by each of the three insurance rating services designated by the Branch and posted on the Internet at *http://www.dol.gov/owcp/dlhwc* for both the current rating year and the immediately preceding year will not be required to deposit security.

(2) Carriers whose LHWCA obligations are fully secured by one or more State guaranty funds, as evaluated by OWCP under § 703.202 of this subpart, will not be required to deposit security.

(3) The Branch will require all carriers not meeting the requirements of paragraphs (c)(1) or (2) of this section to deposit security for their LHWCA obligations not secured by a State guaranty fund, as evaluated by OWCP under § 703.202 of this subpart. For carriers that write only an insignificant or incidental amount of LHWCA insurance, the Branch will require a deposit in an amount determined by the Branch from time to time. For all other carriers, the Branch will require a minimum deposit of one third (33⅓ percent) of a carrier s outstanding LHWCA obligations not secured by a State guaranty fund, but may require a deposit up to an amount equal to the carrier's total outstanding LHWCA obligations (100 percent) not secured by a State guaranty fund.

(d) If a carrier believes that a lesser deposit would fully secure its LHWCA obligations, the carrier may request a hearing before the Director of the Division of Longshore and Harbor Workers' Compensation (Longshore Director) or the Longshore Director's representative. Requests for hearing must be in writing and sent to the Branch within 10 days of the date of the Branch's decision. The carrier may submit new evidence and/or argument in support of its challenge to the Branch's decision and must provide any additional documentation OWCP requests. The Longshore Director or his representative will notify the carrier of the hearing date within 10 days of receiving the request. The Longshore Director or his representative will issue the final agency decision on the application within 60 days of the hearing date, or, where evidence is submitted after the hearing, within 60 days of the receipt of such evidence, but no later than 180 days after receiving the carrier's request for a hearing.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.205 Filing of Agreement and Undertaking; deposit of security.

Within 45 days of the date on which the insurance carrier receives the Branch's decision (or, if the carrier requests a hearing, a period set by the Longshore Director or the Longshore Director's representative) determining the extent of its unsecured LHWCA obligations and fixing the required security deposit amount (*see* § 703.204), the carrier must:

(a) Execute and file with the Branch an Agreement and Undertaking, in a form prescribed and provided by OWCP, in which the carrier shall agree to—

(1) Deposit with the Branch indemnity bonds or letters of credit in the amount fixed by the Office, or deposit negotiable securities under §§ 703.207 and 703.208 in that amount;

(2) Authorize the Branch, at its discretion, to bring suit under any deposited indemnity bond or to draw upon any deposited letters of credit, as appropriate under the terms of the security instrument, or to collect the interest and principal as they become due on any deposited negotiable securities and to sell or otherwise liquidate such negotiable securities or any part thereof when—

(i) The carrier defaults on any of its LHWCA obligations;

(ii) The carrier fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(iii) The carrier fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place;

(iv) State insolvency proceedings are initiated against the carrier; or

(v) The carrier fails to comply with any of the terms of the Agreement and Undertaking; and

(3) Authorize the Branch, at its discretion, to pay such ongoing claims of the carrier as it may find to be due and payable from the proceeds of the deposited security;

(b) Give security in the amount fixed in the Office's decision:

(1) In the form of an indemnity bond with sureties satisfactory to the Branch and in such form, and containing such provisions, as the Branch may prescribe: *Provided*, That only surety companies approved by the United States Treasury Department under the laws of the United States and the rules and regulations governing bonding companies may act as sureties on such indemnity bonds (*see* Department of Treasury's Circular–570), and that a surety company that is a corporate subsidiary of an insurance carrier may not act as surety on such carrier's indemnity bond;

(2) In the form of letters of credit issued by a financial institution satisfactory to the Branch and upon which the Branch may draw; or

(3) By a deposit of negotiable securities with a Federal Reserve Bank or the Treasurer of the United States in compliance with §§ 703.207 and 703.208.

§ 703.206 [Reserved]

§ 703.207 Kinds of negotiable securities that may be deposited; conditions of deposit; acceptance of deposits.

An insurance carrier electing to deposit negotiable securities to secure its obligations under the Act in the amount fixed by the Office under the regulations in this part shall deposit any negotiable securities acceptable as security for the deposit of public monies of the United States under regulations issued by the Secretary of the Treasury. (*See* 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 703.208 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; interest thereon.

Deposits of negotiable securities provided for by the regulations in this part must be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by the Branch, or the Treasurer of the United States, and must be held subject to the order of the Branch. The Branch will authorize the insurance carrier to collect interest on the securities it deposits unless any of the conditions set forth at § 703.211(a) occur.

§ 703.209 Substitution and withdrawal of indemnity bond, letters of credit or negotiable securities.

(a) A carrier may not substitute other security for any indemnity bond or letters of credit deposited under the regulations in this part except when authorized by the Branch. A carrier may, however, substitute negotiable securities acceptable under the regulations in this part for previously-deposited negotiable securities without the Branch's prior approval.

(b) A carrier that has ceased to write insurance under the Act may apply to the Branch for withdrawal of its security deposit. The carrier must file with its application a sworn statement setting forth—

(1) A list of all cases in each State in which the carrier is paying compensation, together with the names of the employees and other beneficiaries, a description of causes of injury or death, and a statement of the amount of compensation paid;

(2) A similar list of all pending cases in which the carrier has not yet paid compensation; and

(3) A similar list of all cases in which injury or death has occurred within one year before such application or in which the last payment of compensation was made within one year before such application.

(c) The Branch may authorize withdrawal of previously-deposited indemnity bonds, letters of credit and negotiable securities that, in the opinion of the Branch, are not necessary to provide adequate security for the payment of the carrier's outstanding and potential LHWCA liabilities. No withdrawals will be authorized unless there has been no claim activity involving the carrier for a minimum of five years, and the Branch is reasonably certain that no further claims will arise.

§ 703.210 Increase or reduction in security deposit amount.

(a) Whenever the Office considers the security deposited by an insurance carrier insufficient to fully secure the carrier's LHWCA obligations, the carrier must, upon demand by the Branch, deposit additional security in accordance with the regulations in this part in an amount fixed by the Branch. The Branch will issue its decision requiring additional security in accordance with § 703.204, and the procedures set forth at §§ 703.204(d) and 703.205 for requesting a hearing and complying with the Office's decision will apply as appropriate.

(b) The Branch may reduce the required security at any time on its own initiative, or upon application of a carrier, when in the Branch's opinion the facts warrant a reduction. A carrier seeking a reduction must furnish any information the Office requests regarding its outstanding LHWCA obligations for any State in which it does business, its obligations not secured by a State guaranty fund in each of these States, and any other evidence as the Branch considers necessary.

§ 703.211 Authority to seize security deposit; use and/or return of proceeds.

(a) The Office may take any of the actions set forth in paragraph (b) of this section when an insurance carrier—

(1) Defaults on any of its LHWCA obligations;

(2) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(3) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place;

(4) Has State insolvency proceedings initiated against it; or

(5) Fails to comply with any of the terms of the Agreement and Undertaking.

(b) When any of the conditions set forth in paragraph (a) of this section occur, the Office may, within its discretion and as appropriate to the security instrument—

(1) Bring suit under any indemnity bond;

(2) Draw upon any letters of credit;

(3) Seize any negotiable securities, collect the interest and principal as they may become due, and sell or otherwise liquidate the negotiable securities or any part thereof.

(c) When the Office, within its discretion, determines that it no longer

needs to collect the interest and principal of any negotiable securities seized pursuant to paragraphs (a) and (b) of this section, or to retain the proceeds of their sale, it must return any of the carrier's negotiable securities still in its possession and any remaining proceeds of their sale.

§ 703.212 Required reports; examination of insurance carrier accounts.

(a) Upon the Office's request, each insurance carrier must submit the following reports:

(1) A certified financial statement of the carrier's assets and liabilities, or a balance sheet.

(2) A sworn statement showing the extent of the carrier's unsecured LHWCA obligations for each State in which it is authorized to write insurance under the LHWCA or any of its extensions.

(3) A sworn statement reporting the carrier's open cases as of the date of such report, listing by State all death and injury cases, together with a report of the status of all outstanding claims.

(b) Whenever it considers necessary, the Office may inspect or examine a carrier's books of account, records, and other papers to verify any financial statement or other information the carrier furnished to the Office in any statement or report required by this section, or any other section of the regulations in this part. The carrier must permit the Office or its duly authorized representative to make the inspection or examination. Alternatively, the Office may accept an adequate independent audit by a certified public accountant.

§ 703.213 Failure to comply.

The Office may suspend or revoke a carrier's certificate of authority to write LHWCA insurance under § 703.106 when the carrier fails to comply with any of the requirements of this part.

Subpart D—Authorization of Self-Insurers

SOURCE: 70 FR 43234, July 26, 2005, unless otherwise noted.

§ 703.301 Employers who may be authorized as self-insurers.

The regulations in this subpart set forth procedures for authorizing employers to self-insure the payment of compensation under the Longshore and Harbor Workers' Compensation Act, or its extensions. The Office may authorize any employer to self-insure who, pursuant to the regulations in this part, furnishes to the Office satisfactory proof of its ability to pay compensation directly, and who agrees to immediately cancel any existing insurance policy covering its Longshore obligations (except for excess or catastrophic workers' compensation insurance, *see* §§ 703.302(a)(6), 703.304(a)(6)) when OWCP approves the employer's application to be self-insured. The regulations require self-insurers to deposit security in the form of an indemnity bond, letters of credit or negotiable securities (at the option of the employer) of a kind and in an amount determined by the Office, and prescribe the conditions under which such deposits shall be made. The term ''self-insurer'' as used in these regulations means any employer securing the payment of compensation under the LHWCA or its extensions in accordance with the provisions of 33 U.S.C. 932(a)(2) and these regulations.

§ 703.302 Application for authority to become a self-insurer; how filed; information to be submitted; other requirements.

(a) Any employer may apply to become an authorized self-insurer. The application must be addressed to the Branch of Financial Management and Insurance (Branch) within OWCP's Division of Longshore and Harbor Workers' Compensation, and be made on a form provided by OWCP. The application must contain—

(1) A statement of the employer's total payroll for the 12 months before the application date;

(2) A statement of the average number of employees engaged in employment within the purview of the LHWCA or any of its extensions for the 12 months before the application date;

(3) A statement of the number of injuries to such employees resulting in

disability of more than 7 days' duration, or in death, during each of the 5 years before the application date;

(4) A certified financial report for each of the three years before the application date;

(5) A description of the facilities maintained or the arrangements made for the medical and hospital care of injured employees;

(6) A statement describing the provisions and maximum amount of any excess or catastrophic insurance; and

(7) Any other information the Branch requests to enable it to give the application adequate consideration including, but not limited to, the reports set forth at § 703.310.

(b) The employer must sign and swear to the application. If the employer is not an individual, the employer's duly authorized officer must sign and swear to the application and list his or her official designation. If the employer is a corporation, the officer must also affix the corporate seal.

(c) At any time after filing an application, the employer must inform the Branch immediately of any material changes that may have rendered its application incomplete, inaccurate or misleading.

(d) By filing an application, the employer consents to be bound by and to comply with the regulations and requirements in this part.

§ 703.303 Decision on employer's application.

(a) The Branch will issue a decision granting or denying the employer's application to be an authorized self-insurer. If the Branch grants the application, the decision will fix the amount of security the employer must deposit. The Branch will transmit its decision to the employer in a way it considers appropriate.

(b) The employer is authorized to self-insure beginning with the date of the Branch's decision. Each grant of authority to self-insure is conditioned, however, upon the employer's execution and filing of an Agreement and Undertaking and deposit of the security fixed in the decision in the form and within the time limits required by § 703.304. In the event the employer fails to comply with the requirements set forth in § 703.304, its authorization to self-insure will be considered never to have been effective, and the employer will be subject to appropriate penalties for failure to secure its LHWCA obligations.

(c) The Branch will require security in the amount it considers necessary to fully secure the employer's LHWCA obligations. When fixing the amount of security, the Branch may consider a number of factors including, but not limited to, the—

(1) Employer's overall financial standing;

(2) Nature of the employer's work;

(3) Hazard of the work in which the employees are employed;

(4) Employer's payroll amount for employees engaged in employment within the purview of the Act; and

(5) Employer's accident record as shown in the application and the Office's records.

(d) If an employer believes that the Branch incorrectly denied its application to self-insure, or that a lesser security deposit would fully secure its LHWCA obligations, the employer may request a hearing before the Director of the Division of Longshore and Harbor Workers' Compensation (Longshore Director) or the Longshore Director's representative. Requests for hearing must be in writing and sent to the Branch within ten days of the date of the Branch's decision. The employer may submit new evidence and/or argument in support of its challenge to the Branch's decision and must provide any additional documentation OWCP requests. The Longshore Director or his representative will notify the employer of the hearing date within 10 days of receiving the request. The Longshore Director or his representative will issue the final agency decision on the application within 60 days of the hearing date, or, where evidence is submitted after the hearing, within 60 days of the receipt of such evidence, but no later than 180 days after receiving the employer's request for a hearing.

§ 703.304 Filing of Agreement and Undertaking; deposit of security.

Within 45 days of the date on which the employer receives the Branch's decision (or, if the employer requests a hearing, a period set by the Longshore Director or the Longshore Director's representative) granting its application to self-insure and fixing the required security deposit amount (*see* § 703.303), the employer must:

(a) Execute and file with the Branch an Agreement and Undertaking, in a form prescribed and provided by OWCP, in which the employer shall agree to:

(1) Pay when due, as required by the provisions of the Act, all compensation payable on account of injury or death of any of its employees injured within the purview of the Act;

(2) Furnish medical, surgical, hospital, and other attendance, treatment and care as required by the Act;

(3) Deposit with the Branch indemnity bonds or letters of credit in the amount fixed by the Office, or deposit negotiable securities under §§ 703.306 and 703.307 in that amount;

(4) Authorize the Branch, at its discretion, to bring suit under any deposited indemnity bond or to draw upon any deposited letters of credit, as appropriate under the terms of the security instrument, or to collect the interest and principal as they become due on any deposited negotiable securities and to seize and sell or otherwise liquidate such negotiable securities or any part thereof when the employer:

(i) Defaults on any of its LHWCA obligations;

(ii) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(iii) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place; or

(iv) Fails to comply with any of the terms of the Agreement and Undertaking;

(5) Authorize the Branch, at its discretion, to pay such compensation, medical, and other expenses and any accrued penalties imposed by law as it may find to be due and payable from the proceeds of the deposited security; and

(6) Obtain and maintain, if required by the Office, excess or catastrophic insurance in amounts to be determined by the Office.

(b) Give security in the amount fixed in the Office's decision:

(1) In the form of an indemnity bond with sureties satisfactory to the Office, and in such form and containing such provisions as the Office may prescribe: *Provided*, That only surety companies approved by the United States Treasury Department under the laws of the United States and the rules and regulations governing bonding companies may act as sureties on such indemnity bonds (*see* Department of Treasury's Circular–570);

(2) In the form of letters of credit issued by a financial institution satisfactory to the Branch and upon which the Branch may draw; or,

(3) By a deposit of negotiable securities with a Federal Reserve Bank or the Treasurer of the United States in compliance with §§ 703.306 and 703.307.

§ 703.305 [Reserved]

§ 703.306 Kinds of negotiable securities that may be deposited; conditions of deposit; acceptance of deposits.

A self-insurer or a self-insurer applicant electing to deposit negotiable securities to secure its obligations under the Act in the amount fixed by the Office under the regulations in this part shall deposit any negotiable securities acceptable as security for the deposit of public monies of the United States under regulations issued by the Secretary of the Treasury. (*See* 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 703.307 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; interest thereon.

Deposits of negotiable securities provided for by the regulations in this part shall be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by the Office, or the Treasurer of the United

States, and shall be held subject to the order of the Office. The Office will authorize the self-insurer to collect interest on the securities deposited by it unless any of the conditions set forth at §703.304(a)(4) occur.

§703.308 Substitution and withdrawal of indemnity bond, letters of credit or negotiable securities.

(a) A self-insurer may not substitute other security for any indemnity bond or letters of credit deposited under the regulations in this part except when authorized by the Office. A self-insurer may, however, substitute negotiable securities acceptable under the regulations in this part for previously-deposited negotiable securities without the Office's prior approval.

(b) A self-insurer discontinuing business, discontinuing operations within the purview of the Act, or securing the payment of compensation by commercial insurance under the provisions of the Act may apply to the Office for the withdrawal of the security it provided under the regulations in this part. The self-insurer must file with its application a sworn statement setting forth—

(1) A list of all cases in each compensation district in which the self-insurer is paying compensation, together with the names of the employees and other beneficiaries, a description of causes of injury or death, and a statement of the amount of compensation paid;

(2) A similar list of all pending cases in which the self-insurer has not yet paid compensation; and

(3) A similar list of all cases in which injury or death has occurred within one year before such application or in which the last payment of compensation was made within one year before such application.

(c) The Office may authorize withdrawal of previously-deposited indemnity bonds, letters of credit and negotiable securities that, in the opinion of the Office, are not necessary to provide adequate security for the payment of the self-insurer's outstanding and potential LHWCA obligations. No withdrawals will be authorized unless there has been no claim activity involving the self-insurer for a minimum of five years, and the Office is reasonably certain no further claims will arise.

§703.309 Increase or reduction in the amount of indemnity bond, letters of credit or negotiable securities.

(a) Whenever the Office considers the principal sum of the indemnity bond or letters of credit filed or the amount of the negotiable securities deposited by a self-insurer insufficient to fully secure the self-insurer's LHWCA obligations, the self-insurer must, upon demand by the Office, deposit additional security in accordance with the regulations in this part in an amount fixed by the Branch. The Branch will issue its decision requiring additional security in accordance with §703.303, and the procedures set forth at §§703.303(d) and 703.304 for requesting a hearing and complying with the Office's decision will apply as appropriate.

(b) The Office may reduce the required security at any time on its own initiative, or upon application of a self-insurer, when in the Office's opinion the facts warrant a reduction. A self-insurer seeking a reduction must furnish any information the Office requests regarding its current affairs, the nature and hazard of the work of its employees, the amount of its payroll for employees engaged in maritime employment within the purview of the Act, its financial condition, its accident experience, a record of compensation payments it has made, and any other evidence the Branch considers necessary.

§703.310 Authority to seize security deposit; use and/or return of proceeds.

(a) The Office may take any of the actions set forth in paragraph (b) of this section when a self-insurer—

(1) Defaults on any of its LHWCA obligations;

(2) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(3) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place; or

(4) Fails to comply with any of the terms of the Agreement and Undertaking.

(b) When any of the conditions set forth in paragraph (a) of this section occur, the Office may, within its discretion and as appropriate to the security instrument—

(1) Bring suit under any indemnity bond;

(2) Draw upon any letters of credit;

(3) Seize any negotiable securities, collect the interest and principal as they may become due, and sell or otherwise liquidate the negotiable securities or any part thereof.

(c) When the Office, within its discretion, determines that it no longer needs to collect the interest and principal of any negotiable securities seized pursuant to paragraphs (a) and (b) of this section, or to retain the proceeds of their sale, it must return any of the employer's negotiable securities still in its possession and any remaining proceeds of their sale.

§ 703.311 Required reports; examination of self-insurer accounts.

(a) Upon the Office's request, each self-insurer must submit the following reports:

(1) A certified financial statement of the self-insurer's assets and liabilities, or a balance sheet.

(2) A sworn statement showing by classifications the payroll of employees of the self-insurer who are engaged in employment within the purview of the LHWCA or any of its extensions.

(3) A sworn statement covering the six-month period preceding the date of such report, listing by compensation districts all death and injury cases which have occurred during such period, together with a report of the status of all outstanding claims showing the particulars of each case.

(b) Whenever it considers necessary, the Office may inspect or examine a self-insurer's books of account, records, and other papers to verify any financial statement or other information the self-insurer furnished to the Office in any report required by this section, or any other section of the regulations in this part. The self-insurer must permit the Office or its duly authorized representative to make the inspection or examination. Alternatively, the Office may accept an adequate report of a certified public accountant.

§ 703.312 Period of authorization as self-insurer.

(a) Self-insurance authorizations will remain in effect for so long as the self-insurer complies with the requirements of the Act, the regulations in this part, and OWCP.

(b) A self-insurer who has secured its liability by depositing an indemnity bond with the Office will, on or about May 10 of each year, receive from the Office a form for executing a bond that will continue its self-insurance authorization. The submission of such bond, duly executed in the amount indicated by the Office, will be deemed a condition of the continuing authorization.

§ 703.313 Revocation of authorization to self-insure.

The Office may for good cause shown suspend or revoke the authorization of any self-insurer. Failure by a self-insurer to comply with any provision or requirement of law or of the regulations in this part, or with any lawful order or communication of the Office, or the failure or insolvency of the surety on its indemnity bond, or impairment of financial responsibility of such self-insurer, shall be deemed good cause for suspension or revocation.

Subpart E—Issuance of Certificates of Compliance

§ 703.501 Issuance of certificates of compliance.

Every employer who has secured the payment of compensation as required by 33 U.S.C. 932 and by the regulations in this part may request a certificate from the district director in the compensation district in which he has operations, and for which a certificate is required by 33 U.S.C. 937, showing that such employer has secured the payment of compensation. Only one such certificate will be issued to an employer in a compensation district, and it will be valid only during the period for which such employer has secured such payment. An employer so desiring may have photocopies of such a certificate made for use in different places

within the compensation district. Two forms of such certificates have been provided by the Office, one form for use where the employer has obtained insurance generally under these regulations, and one for use where the employer has been authorized as a self-insurer.

§ 703.502 [Reserved]

§ 703.503 Return of certificates of compliance.

Upon the termination by expiration, cancellation or otherwise, of a policy of insurance issued under the provisions of law and these regulations, or the revocation or termination of the privilege of self-insurance granted by the Office, all certificates of compliance issued on the basis of such insurance or self-insurance shall be void and shall be returned by the employer to the district director issuing them with a statement of the reason for such return. An employer holding certificate of compliance under an insurance policy which has expired, pending renewal of such insurance need not return such certificate of compliance if such expired insurance is promptly replaced. An employer who has secured renewal of insurance upon the expiration of policy under said Act or whose self-insurance thereunder is reauthorized without a break in the continuity thereof need not return an expired certificate of compliance.

PART 704—SPECIAL PROVISIONS FOR LHWCA EXTENSIONS

Sec.

704.001 Extensions covered by this part.
704.002 Scope of part.

DEFENSE BASE ACT

704.101 Administration; compensation districts.
704.102 Commutation of payments to aliens and nonresidents.
704.103 Removal of certain minimums when computing or paying compensation.
704.151 DBA endorsement.

DISTRICT OF COLUMBIA WORKMEN'S COMPENSATION ACT

704.201 Administration; compensation districts.
704.251 DCCA endorsement.

OUTER CONTINENTAL SHELF LANDS ACT

704.301 Administration; compensation districts.
704.351 OCSLA endorsement.

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT

704.401 Administration; compensation districts.
704.451 NFIA endorsement.

AUTHORITY: 5 U.S.C. 301; Reorg. Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; 33 U.S.C. 939; 36 D.C. Code 501 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1331; 5 U.S.C. 6171 *et seq.;* Secretary's Order 1–89; Employment Standards Order No. 90–02.

SOURCE: 38 FR 26877, Sept. 26, 1973, unless otherwise noted.

§ 704.001 Extensions covered by this part.

(a) Defense Base Act (DBA).

(b) District of Columbia Workmen's Compensation Act (DCCA).

(c) Outer Continental Shelf Lands Act (OCSLA).

(d) Nonappropriated Fund Instrumentalities Act (NFIA).

§ 704.002 Scope of part.

The regulations governing the administration of the LHWCA as set forth in parts 702 and 703 of this subchapter govern the administration of the LHWCA extensions (see §704.001) in nearly every respect, and are not repeated in this part 704. Such special provisions as are necessary to the proper administration of each of the extensions are set forth in this part. To the extent of any inconsistency between regulations in parts 702 and 703 of this subchapter and those in this part, the latter supersedes those in parts 702 and 703 of this subchapter.

DEFENSE BASE ACT

§ 704.101 Administration; compensation districts.

For the purpose of administration of this Act areas assigned to the compensation districts established for administration of the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter shall be extended in the following manner to include:

(a) Canada, east of the 75th degree west longitude, Newfoundland, and

Greenland are assigned to District No. 1.

(b) Canada, west of the 75th degree and east of the 110th degree west longitude, is assigned to District No. 10.

(c) Canada, west of the 110th degree west longitude, and all areas in the Pacific Ocean north of the 45th degree north latitude are assigned to District No. 14.

(d) All areas west of the continents of North and South America (except coastal islands) to the 60th degree east longitude, except for Iran, are assigned to District No. 15.

(e) Mexico, Central and South America (including coastal islands); areas east of the continents of North and South America to the 60th degree east longitude, including Iran, and any other areas or locations not covered under any other district office, are assigned to District No. 2.

§ 704.102 Commutation of payments to aliens and nonresidents.

Authority to commute payments to aliens and nonnationals who are not residents of the United States and Canada, section 2(b) of the Defense Base Act, 42 U.S.C. 1652(b), though separately stated in this Act, is identical in language to section 9(g) of the Longshoremen's Act. Thus, except for the different statutory citation, the LHWCA regulation at §702.142 of this subchapter shall apply.

§ 704.103 Removal of certain minimums when computing or paying compensation.

The minimum limitation on weekly compensation for disability established by section 6 of the LHWCA, 33 U.S.C. 906, and the minimum limit on the average weekly wages on which death benefits are to be computed under section 9 of the LHWCA, 33 U.S.C. 909, shall not apply in computing compensation and death benefits under this Act; section 2(a), 42 U.S.C. 1652(a).

§ 704.151 DBA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employers' liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the provisions of the Defense Base Act, and all laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The Company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the Company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The Company agrees to abide by all the provisions of said Acts and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to this employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

DISTRICT OF COLUMBIA WORKMEN'S COMPENSATION ACT

§ 704.201 Administration; compensation districts.

For the purpose of administration of this Act, the District of Columbia shall be the compensation district and is designated as District No. 40.

§ 704.251 DCCA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the District of Columbia Workmen's Compensation Act, and the applicable provisions of the Longshoremen's and Harbor Workers' Compensation Act, and all laws amendatory of

either of said Acts or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said District of Columbia Workmen's Compensation Act and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Act.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director for the District of Columbia and to this employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

OUTER CONTINENTAL SHELF LANDS ACT

§ 704.301 Administration; compensation districts.

For the purpose of administration of this Act, the compensation districts established under the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter shall administer this Act, and their jurisdiction for this purpose is extended, where appropriate, to include those parts of the Outer Continental Shelf adjacent to the State or States in such districts having adjacent shelf areas.

§ 704.351 OCSLA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the Outer Continental Shelf Lands Act, and all the laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said laws and all the lawful rules, regulations, orders and decisions of the Office of Workmen's Compensation Programs, Department of Labor, until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to his employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT

§ 704.401 Administration; compensation districts.

For the purpose of administration of this Act within the continental United States, Hawaii, and Alaska, the compensation districts established for administration of the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter are established as the administrative districts under this Act. For the purpose of administration of this Act outside the continental United States, Alaska, and Hawaii, the compensation districts established for such overseas administration of the Defense Base Act as set forth in § 704.101 are established as the administrative districts under this Act.

§ 704.451 NFIA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the Nonappropriated Fund Instrumentalities Act, and all of the laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said Acts and all the lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to the within named employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

SUBCHAPTER B—FEDERAL COAL MINE HEALTH AND SAFETY ACT OF 1969, AS AMENDED

PART 718—STANDARDS FOR DETERMINING COAL MINERS' TOTAL DISABILITY OR DEATH DUE TO PNEUMOCONIOSIS

Subpart A—General

Sec.
718.1 Statutory provisions.
718.2 Applicability of this part.
718.3 Scope and intent of this part.
718.4 Definitions and use of terms.
718.5 Incorporations by reference.

Subpart B—Criteria for the Development of Medical Evidence

718.101 General.
718.102 Chest radiographs (X-rays).
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718.105 Arterial blood-gas studies.
718.106 Autopsy; biopsy.
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Subpart C—Determining Entitlement to Benefits

718.201 Definition of pneumoconiosis.
718.202 Determining the existence of pneumoconiosis.
718.203 Establishing relationship of pneumoconiosis to coal mine employment.
718.204 Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis.
718.205 Death due to pneumoconiosis.
718.206 Effect of findings by persons or agencies.

Subpart D—Presumptions Applicable to Eligibility Determinations

718.301 Establishing length of employment as a miner.
718.302 Relationship of pneumoconiosis to coal mine employment.
718.303 [Reserved]
718.304 Irrebuttable presumption of total disability or death due to pneumoconiosis.
718.305 Presumption of pneumoconiosis.
718.306 [Reserved]

APPENDIX A TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF CHEST RADIOGRAPHS (X-RAYS)

APPENDIX B TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF PULMONARY FUNCTION TESTS. TABLES B1, B2, B3, B4, B5, B6

APPENDIX C TO PART 718—BLOOD-GAS TABLES

AUTHORITY: 5 U.S.C. 301; Reorganization Plan No. 6 of 1950, 15 FR 3174; 30 U.S.C. 901 *et seq.*, 902(f), 934, 936; 33 U.S.C. 901 *et seq.*; 42 U.S.C. 405; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 45 FR 13678, Feb. 29, 1980, unless otherwise noted.

Subpart A—General

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.1 Statutory provisions.

Section 402(f) of the Act authorizes the Secretary of Labor to establish criteria for determining total disability or death due to pneumoconiosis to be applied in the processing and adjudication of claims filed under Part C of the Act. Section 402(f) further authorizes the Secretary of Labor, in consultation with the National Institute for Occupational Safety and Health, to establish criteria for all appropriate medical tests administered in connection with a claim for benefits. Section 413(b) of the Act authorizes the Secretary of Labor to establish criteria for the techniques used to take chest roentgenograms (x-rays) in connection with a claim for benefits under the Act.

[78 FR 59114, Sept. 25, 2013]

§ 718.2 Applicability of this part.

(a) With the exception of the second sentence of §718.204(a), this part is applicable to the adjudication of all claims filed on or after June 30, 1982 under Part C of the Act. It provides standards for establishing entitlement to benefits under the Act and describes the criteria for the development of medical evidence used in establishing such entitlement. The second sentence of §718.204(a) is applicable to the adjudication of all claims filed after January 19, 2001.

(b) Publication of certain provisions or parts of certain provisions that apply only to claims filed prior to June 30, 1982, or to claims subject to Section

435 of the Act, has been discontinued because those provisions affect an increasingly smaller number of claims. The version of Part 718 set forth in 20 CFR, parts 500 to end, edition revised as of April 1, 2010, applies to the adjudication of all claims filed prior to June 30, 1982, as appropriate.

(c) The provisions of this part must, to the extent appropriate, be construed together in the adjudication of claims.

[78 FR 59114, Sept. 25, 2013]

§ 718.3 Scope and intent of this part.

(a) This part sets forth the standards to be applied in determining whether a coal miner is or was totally disabled due to pneumoconiosis or died due to pneumoconiosis. It also specifies the procedures and requirements to be followed in conducting medical examinations and in administering various tests relevant to such determinations.

(b) This part is designed to interpret the presumptions contained in section 411(c) of the Act, evidentiary standards and criteria contained in section 413(b) of the Act and definitional requirements and standards contained in section 402(f) of the Act within a coherent framework for the adjudication of claims. It is intended that these enumerated provisions of the Act be construed as provided in this part.

[65 FR 80045, Dec. 20, 2000, as amended at 78 FR 59114, Sept. 25, 2013]

§ 718.4 Definitions and use of terms.

Except as is otherwise provided by this part, the definitions and usages of terms contained in § 725.101 of subpart A of part 725 of this title shall be applicable to this part.

§ 718.5 Incorporations by reference.

(a) The materials listed in paragraphs (b) through (f) of this section are incorporated by reference in this part. The Director of the Federal Register has approved these incorporations by reference under 5 U.S.C. 522(a) and 1 CFR part 51. To enforce any edition other than that specified in these regulations, OWCP must publish notice of change in the FEDERAL REGISTER. All approved material is available from the sources listed below. You may inspect a copy of the approved material at the Division of Coal Mine Workers' Compensation, OWCP, U.S. Department of Labor, Washington, DC. To arrange for an inspection at OWCP, call 202–693–0046. These materials are also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030 or go to *http://www.archives.gov/federalregister/codeoffederalregulations/ibrlocations.html*.

(b) American Association of Physicists in Medicine, Order Department, Medical Physics Publishing, 4513 Vernon Blvd., Madison, WI 53705, *http://www.aapm.org/pubs/reports:*

(1) AAPM On-Line Report No. 03, Assessment of Display Performance for Medical Imaging Systems, April 2005, IBR approved for Appendix A to part 718, paragraph (d).

(2) AAPM Report No. 93, Acceptance Testing and Quality Control of Photostimulable Storage Phosphor Imaging Systems, October 2006, IBR approved for Appendix A to part 718, paragraph (d).

(c) American College of Radiology, 1891 Preston White Dr., Reston, VA 20191, *http://www.acr.org/~/media/ACR/Documents/PGTS/guidelines/Reference_Levels.pdf:*

(1) ACR Practice Guideline for Diagnostic Reference Levels in Medical X-Ray Imaging, Revised 2008 (Resolution 3), IBR approved for Appendix A to part 718, paragraph (d).

(2) [Reserved]

(d) International Labour Office, CH–1211 Geneva 22, Switzerland, *http://www.ilo.org/publns:* (1) Occupational Safety and Health Series No. 22, Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, Revised edition 2011, IBR approved for § 718.102(d) and Appendix A to part 718, paragraph (d).

(2) Occupational Safety and Health Series No. 22 (Rev. 2000), Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, Revised edition 2000, IBR approved for § 718.102(d).

(3) Occupational Safety and Health Series No. 22 (Rev. 80), Guidelines for the Use of ILO International Classification of Radiographs of

Pneumoconioses, Revised edition 1980, IBR approved for § 718.102(d).

(e) National Council on Radiation Protection and Measurements, NCRP Publications, 7910 Woodmont Avenue, Suite 400, Bethesda, MD 20814–3095, Telephone (800) 229–2652, *http://www.ncrppublications.org:*

(1) NCRP Report No. 102, Medical X–Ray, Electron Beam, and Gamma–Ray Protection for Energies Up to 50 MeV (Equipment Design, Performance, and Use), issued June 30, 1989, IBR approved for Appendix A to part 718, paragraph (b).

(2) NCRP Report No. 105, Radiation Protection for Medical and Allied Health Personnel, issued October 30, 1989, IBR approved for Appendix A to part 718, paragraph (b).

(3) NCRP Report No. 147, Structural Shielding Design for Medical X–Ray Imaging Facilities, revised March 18, 2005, IBR approved for Appendix A to part 718, paragraph (b).

(f) National Electrical Manufacturers Association, 1300 N. 17th Street, Rosslyn, VA 22209, *http://medical.nema.org:*

(1) DICOM Standard PS 3.3–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 3: Information Object Definitions, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(2) DICOM Standard PS 3.4–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 4: Service Class Specifications, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(3) DICOM Standard PS 3.10–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 10: Media Storage and File Format for Media Interchange, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(4) DICOM Standard PS 3.11–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 11: Media Storage Application Profiles, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(5) DICOM Standard PS 3.12–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 12: Media Formats and Physical Media for Media Interchange, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(6) DICOM Standard PS 3.14–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 14: Grayscale Standard Display Function, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(7) DICOM Standard PS 3.16–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 16: Content Mapping Resource, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

[79 FR 21611, Apr. 17, 2014]

Subpart B—Criteria for the Development of Medical Evidence

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.101 General.

(a) The Office of Workers' Compensation Programs (hereinafter OWCP or the Office) must develop the medical evidence necessary to determine each claimant's entitlement to benefits. Each miner who files a claim for benefits under the Act must be provided an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation including, but not limited to, a chest radiograph (X-ray), physical examination, pulmonary function tests, and a blood-gas study.

(b) The standards for the administration of clinical tests and examinations contained in this subpart shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part (see §§ 725.406(b), 725.414(a), 725.456(d)). These standards shall also apply to claims governed by part 727 (see 20 CFR 725.4(d)), but only for clinical tests or examinations conducted after January 19, 2001. Any clinical test or examination subject to these standards shall be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. Unless otherwise provided, any evidence which is not in substantial

compliance with the applicable standard is insufficient to establish the fact for which it is proffered.

[65 FR 80045, Dec. 20, 2000, as amended at 78 FR 35555, June 13, 2013; 79 FR 21611, Apr. 17, 2014]

§ 718.102 Chest radiographs (X-rays).

(a) A chest radiograph (X-ray) must be of suitable quality for proper classification of pneumoconiosis and must conform to the standards for administration and interpretation of chest X-rays as described in Appendix A.

(b) Chest X-rays may be produced by either film or digital radiography systems as defined in Appendix A to this part.

(c) The images described in paragraphs (c)(1) and (2) of this section will not be considered of suitable quality for proper classification of pneumoconiosis under this section:

(1) Digital images derived from film screen chest X-rays (e.g., by scanning or digital photography); and

(2) Images that were acquired using digital systems and then printed on transparencies for back-lighted display (e.g., using traditional view boxes).

(d) Standards for classifying radiographs:

(1) To establish the existence of pneumoconiosis, a film chest X-ray must be classified as Category 1, 2, 3, A, B, or C, in accordance with the International Labour Organization (ILO) classification system established in one of the following:

(i) Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, revised edition 2011 (incorporated by reference, *see* § 718.5).

(ii) Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, revised edition 2000 (incorporated by reference, *see* § 718.5).

(iii) Guidelines for the Use of ILO International Classification of Radiographs of Pneumoconioses, revised edition 1980 (incorporated by reference, *see* § 718.5).

(2) To establish the existence of pneumoconiosis, a digital chest radiograph must be classified as Category 1, 2, 3, A, B, or C, in accordance with the ILO classification system established in Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, revised edition 2011.

(3) A chest radiograph classified under any of the foregoing ILO classification systems as Category 0, including subcategories 0-, 0/0, or 0/1, does not constitute evidence of pneumoconiosis.

(e) An X-ray report must include the following:

(1) The name and qualifications of the person who took the X-ray.

(2) The name and qualifications of the physician who interpreted the X-ray. The interpreting physician must indicate whether he or she was a Board-certified radiologist, a Board-eligible radiologist, or a Certified B Reader as defined below on the date the interpretation was made.

(i) *Board-certified radiologist* means that the physician is certified in radiology or diagnostic radiology by the American Board of Radiology, Inc., or the American Osteopathic Association.

(ii) *Board-eligible radiologist* means that the physician has successfully completed a formal accredited residency program in radiology or diagnostic radiology.

(iii) *Certified B Reader* means that the physician has demonstrated ongoing proficiency in evaluating chest radiographs for radiographic quality and in the use of the ILO classification for interpreting chest radiographs for pneumoconiosis and other diseases by taking and passing a specially designed proficiency examination given on behalf of or by the National Institute for Occupational Safety and Health (NIOSH), and has maintained that certification through the date the interpretation is made. *See* 42 CFR 37.52(b).

(3) A description and interpretation of the findings in terms of the ILO classification described in paragraph (d) of this section.

(4) A statement that the X-ray was interpreted in compliance with this section.

(f) Radiograph Submission: For film X-rays, the original film on which the X-ray report is based must be supplied to OWCP. For digital X-rays, a copy of the original digital object upon which the X-ray report is based, formatted to meet the standards for transmission of

diagnostic chest images set forth in Appendix A, paragraph (d), must be provided to OWCP on a DVD or other media specified by OWCP. In cases where the law prohibits the parties or a physician from supplying the original film or a copy of the digital image, the report will be considered as evidence only if the original film or digital image is otherwise available to OWCP and the other parties.

(g) Where the chest X-ray of a deceased miner has been lost or destroyed, or is otherwise unavailable, a report of the chest X-ray submitted by any party may be considered in connection with the claim.

(h) Except as provided in this paragraph (h), no chest X-ray may constitute evidence of the presence or absence of pneumoconiosis unless it is conducted and reported in accordance with the requirements of this section and Appendix A. In the absence of evidence to the contrary, compliance with the requirements of Appendix A must be presumed. In the case of a deceased miner where the only available X-ray does not substantially comply with paragraphs (a) through (e) of this section, the X-ray may form the basis for a finding of the presence or absence of pneumoconiosis if it is of sufficient quality for determining whether pneumoconiosis is present and it was interpreted by a Board-certified radiologist, Board-eligible radiologist, or Certified B Reader.

[79 FR 21612, Apr. 17, 2014]

§ 718.103 Pulmonary function tests.

(a) Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop). The instrument shall simultaneously provide records of volume versus time (spirometric tracing). The report shall provide the results of the forced expiratory volume in one second (FEV1) and the forced vital capacity (FVC). The report shall also provide the FEV1/FVC ratio, expressed as a percentage. If the maximum voluntary ventilation (MVV) is reported, the results of such test shall be obtained independently rather than calculated from the results of the FEV1.

(b) All pulmonary function test results submitted in connection with a claim for benefits shall be accompanied by three tracings of the flow versus volume and the electronically derived volume versus time tracings. If the MVV is reported, two tracings of the MVV whose values are within 10% of each other shall be sufficient. Pulmonary function test results developed in connection with a claim for benefits shall also include a statement signed by the physician or technician conducting the test setting forth the following:

(1) Date and time of test;

(2) Name, DOL claim number, age, height, and weight of claimant at the time of the test;

(3) Name of technician;

(4) Name and signature of physician supervising the test;

(5) Claimant's ability to understand the instructions, ability to follow directions and degree of cooperation in performing the tests. If the claimant is unable to complete the test, the person executing the report shall set forth the reasons for such failure;

(6) Paper speed of the instrument used;

(7) Name of the instrument used;

(8) Whether a bronchodilator was administered. If a bronchodilator is administered, the physician's report must detail values obtained both before and after administration of the bronchodilator and explain the significance of the results obtained; and

(9) That the requirements of paragraphs (b) and (c) of this section have been complied with.

(c) Except as provided in this paragraph, no results of a pulmonary function study shall constitute evidence of the presence or absence of a respiratory or pulmonary impairment unless it is conducted and reported in accordance with the requirements of this section and Appendix B to this part. In the absence of evidence to the contrary, compliance with the requirements of Appendix B shall be presumed. In the case of a deceased miner, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for

a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner.

§ 718.104 Report of physical examinations.

(a) A report of any physical examination conducted in connection with a claim shall be prepared on a medical report form supplied by the Office or in a manner containing substantially the same information. Any such report shall include the following information and test results:

(1) The miner's medical and employment history;

(2) All manifestations of chronic respiratory disease;

(3) Any pertinent findings not specifically listed on the form;

(4) If heart disease secondary to lung disease is found, all symptoms and significant findings;

(5) The results of a chest X-ray conducted and interpreted as required by § 718.102; and

(6) The results of a pulmonary function test conducted and reported as required by § 718.103. If the miner is physically unable to perform a pulmonary function test or if the test is medically contraindicated, in the absence of evidence establishing total disability pursuant to § 718.304, the report must be based on other medically acceptable clinical and laboratory diagnostic techniques, such as a blood gas study.

(b) In addition to the requirements of paragraph (a), a report of physical examination may be based on any other procedures such as electrocardiogram, blood-gas studies conducted and reported as required by § 718.105, and other blood analyses which, in the physician's opinion, aid in his or her evaluation of the miner.

(c) In the case of a deceased miner, where no report is in substantial compliance with paragraphs (a) and (b), a report prepared by a physician who is unavailable may nevertheless form the basis for a finding if, in the opinion of the adjudication officer, it is accompanied by sufficient indicia of reliability in light of all relevant evidence.

(d) *Treating physician.* In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) *Nature of relationship.* The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) *Duration of relationship.* The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) *Frequency of treatment.* The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) *Extent of treatment.* The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

§ 718.105 Arterial blood-gas studies.

(a) Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. No blood-gas study shall be performed if medically contraindicated.

(b) A blood-gas study shall initially be administered at rest and in a sitting position. If the results of the blood-gas test at rest do not satisfy the requirements of Appendix C to this part, an exercise blood-gas test shall be offered to the miner unless medically contraindicated. If an exercise blood-gas test is administered, blood shall be drawn during exercise.

(c) Any report of a blood-gas study submitted in connection with a claim shall specify:

(1) Date and time of test;

(2) Altitude and barometric pressure at which the test was conducted;

(3) Name and DOL claim number of the claimant;

(4) Name of technician;

(5) Name and signature of physician supervising the study;

(6) The recorded values for PC02, P02, and PH, which have been collected simultaneously (specify values at rest and, if performed, during exercise);

(7) Duration and type of exercise;

(8) Pulse rate at the time the blood sample was drawn;

(9) Time between drawing of sample and analysis of sample; and

(10) Whether equipment was calibrated before and after each test.

(d) If one or more blood-gas studies producing results which meet the appropriate table in Appendix C is administered during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report will prevent reliance on the blood-gas study as evidence that the miner was totally disabled at death. (e) In the case of a deceased miner, where no blood gas tests are in substantial compliance with paragraphs (a), (b), and (c), noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the only available tests demonstrate technically valid results. This provision shall not excuse compliance with the requirements in paragraph (d) for any blood gas study administered during a hospitalization which ends in the miner's death.

§ 718.106 Autopsy; biopsy.

(a) A report of an autopsy or biopsy submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure has been performed to obtain a portion of a lung, the evidence shall include a copy of the surgical note and the pathology report of the gross and microscopic examination of the surgical specimen. If an autopsy has been performed, a complete copy of the autopsy report shall be submitted to the Office.

(b) In the case of a miner who died prior to March 31, 1980, an autopsy or biopsy report shall be considered even when the report does not substantially comply with the requirements of this section. A noncomplying report concerning a miner who died prior to March 31, 1980, shall be accorded the appropriate weight in light of all relevant evidence.

(c) A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis.

§ 718.107 Other medical evidence.

(a) The results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis, the sequelae of pneumoconiosis or a respiratory or pulmonary impairment, may be submitted in connection with a claim and shall be given appropriate consideration.

(b) The party submitting the test or procedure pursuant to this section bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits.

Subpart C—Determining Entitlement to Benefits

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.201 Definition of pneumoconiosis.

(a) For the purpose of the Act, ''pneumoconiosis'' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or ''clinical'', pneumoconiosis and statutory, or ''legal'', pneumoconiosis.

(1) *Clinical Pneumoconiosis.* ''Clinical pneumoconiosis'' consists of those diseases recognized by the medical community as pneumoconioses, *i.e.,* the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* ''Legal pneumoconiosis'' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease ''arising out of coal mine employment'' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, ''pneumoconiosis'' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§ 718.202 Determining the existence of pneumoconiosis.

(a) A finding of the existence of pneumoconiosis may be made as follows in paragraphs (a)(1) through (4) of this section:

(1) A chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. Except as otherwise provided in this section, where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration must be given to the radiological qualifications of the physicians interpreting such X-rays (*see* § 718.102(d)).

(2) A biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis. A finding in an autopsy or biopsy of anthracotic pigmentation, however, must not be considered sufficient, by itself, to establish the existence of pneumoconiosis. A report of autopsy must be accepted unless there is evidence that the report is not accurate or that the claim has been fraudulently represented.

(3) If the presumptions described in § 718.304 or § 718.305 are applicable, it must be presumed that the miner is or was suffering from pneumoconiosis.

(4) A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding must be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding must be supported by a reasoned medical opinion.

(b) A claim for benefits must not be denied solely on the basis of a negative chest X-ray.

(c) A determination of the existence of pneumoconiosis must not be made—

(1) Solely on the basis of a living miner's statements or testimony; or

(2) In a claim involving a deceased miner, solely on the basis of the affidavit(s) (or equivalent testimony) of

the claimant and/or his or her dependents who would be eligible for augmentation of the claimant's benefits if the claim were approved.

[79 FR 21612, Apr. 17, 2014]

§ 718.203 Establishing relationship of pneumoconiosis to coal mine employment.

(a) In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. The provisions in this section set forth the criteria to be applied in making such a determination.

(b) If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

(c) If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship.

§ 718.204 Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis.

(a) *General.* Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

(b)(1) *Total disability defined.* A miner shall be considered totally disabled if the irrebuttable presumption described in §718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:

(i) From performing his or her usual coal mine work; and

(ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time.

(2) *Medical criteria.* In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:

(i) Pulmonary function tests showing values equal to or less than those listed in Table B1 (Males) or Table B2 (Females) in Appendix B to this part for an individual of the miner's age, sex, and height for the FEV1 test; if, in addition, such tests also reveal the values specified in either paragraph (b)(2)(i)(A) or (B) or (C) of this section:

(A) Values equal to or less than those listed in Table B3 (Males) or Table B4 (Females) in Appendix B of this part, for an individual of the miner's age, sex, and height for the FVC test, or

(B) Values equal to or less than those listed in Table B5 (Males) or Table B6 (Females) in Appendix B to this part, for an individual of the miner's age, sex, and height for the MVV test, or

(C) A percentage of 55 or less when the results of the FEV1 test are divided by the results of the FVC test (FEV1/FVC equal to or less than 55%), or

(ii) Arterial blood-gas tests show the values listed in Appendix C to this part, or

(iii) The miner has pneumoconiosis and has been shown by the medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure, or

(iv) Where total disability cannot be shown under paragraphs (b)(2)(i), (ii), or (iii) of this section, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may nevertheless be

found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b)(1) of this section.

(c)(1) *Total disability due to pneumoconiosis defined.* A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a ''substantially contributing cause'' of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

(2) Except as provided in §718.305 and paragraph (b)(2)(iii) of this section, proof that the miner suffers or suffered from a totally disabling respiratory or pulmonary impairment as defined in paragraphs (b)(2)(i), (b)(2)(ii), (b)(2)(iv) and (d) of this section shall not, by itself, be sufficient to establish that the miner's impairment is or was due to pneumoconiosis. Except as provided in paragraph (d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report.

(d) *Lay evidence.* In establishing total disability, lay evidence may be used in the following cases:

(1) In a case involving a deceased miner in which the claim was filed prior to January 1, 1982, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total (or under §718.306 partial) disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition.

(2) In a case involving a survivor's claim filed on or after January 1, 1982, but prior to June 30, 1982, which is subject to §718.306, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total or partial disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination shall not be based solely upon the affidavits or testimony of the claimant and/or his or her dependents who would be eligible for augmentation of the claimant's benefits if the claim were approved.

(3) In a case involving a deceased miner whose claim was filed on or after January 1, 1982, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination shall not be based solely upon the affidavits or testimony of any person who would be eligible for benefits (including augmented benefits) if the claim were approved.

(4) Statements made before death by a deceased miner about his or her physical condition are relevant and shall be considered in making a determination as to whether the miner was totally disabled at the time of death.

(5) In the case of a living miner's claim, a finding of total disability due to pneumoconiosis shall not be made solely on the miner's statements or testimony.

(e) In determining total disability to perform usual coal mine work, the following shall apply in evaluating the miner's employment activities:

(1) In the case of a deceased miner, employment in a mine at the time of death shall not be conclusive evidence that the miner was not totally disabled. To disprove total disability, it must be shown that at the time the miner died, there were no changed circumstances of employment indicative of his or her reduced ability to perform his or her usual coal mine work.

(2) In the case of a living miner, proof of current employment in a coal mine

shall not be conclusive evidence that the miner is not totally disabled unless it can be shown that there are no changed circumstances of employment indicative of his or her reduced ability to perform his or her usual coal mine work.

(3) Changed circumstances of employment indicative of a miner's reduced ability to perform his or her usual coal mine work may include but are not limited to:

(i) The miner's reduced ability to perform his or her customary duties without help; or

(ii) The miner's reduced ability to perform his or her customary duties at his or her usual levels of rapidity, continuity or efficiency; or

(iii) The miner's transfer by request or assignment to less vigorous duties or to duties in a less dusty part of the mine.

§ 718.205 Death due to pneumoconiosis.

(a) Benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits based on a showing of death due to pneumoconiosis, a claimant must prove that:

(1) The miner had pneumoconiosis (*see* § 718.202);

(2) The miner's pneumoconiosis arose out of coal mine employment (*see* § 718.203); and

(3) The miner's death was due to pneumoconiosis as provided by this section.

(b) Death will be considered to be due to pneumoconiosis if any of the following criteria is met:

(1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or

(2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at § 718.304 is applicable, or

(4) For survivors' claims filed after January 1, 2005, and pending on or after March 23, 2010, where the presumption at § 718.305 is invoked and not rebutted.

(5) However, except where the § 718.304 presumption is invoked, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury (including suicide) or the principal cause of death was a medical condition not related to pneumoconiosis, unless the claimant establishes (by proof or presumption) that pneumoconiosis was a substantially contributing cause of death.

(6) Pneumoconiosis is a ''substantially contributing cause'' of a miner's death if it hastens the miner's death.

[78 FR 59114, Sept. 25, 2013]

§ 718.206 Effect of findings by persons or agencies.

Decisions, statements, reports, opinions, or the like, of agencies, organizations, physicians or other individuals, about the existence, cause, and extent of a miner's disability, or the cause of a miner's death, are admissible. If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

Subpart D—Presumptions Applicable to Eligibility Determinations

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.301 Establishing length of employment as a miner.

The presumptions set forth in §§ 718.302 and 718.305 apply only if a miner worked in one or more coal mines for the number of years required to invoke the presumption. The length of the miner's coal mine work history must be computed as provided by 20 CFR 725.101(a)(32).

[78 FR 59114, Sept. 25, 2013]

§ 718.302 Relationship of pneumoconiosis to coal mine employment.

If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. (See § 718.203.)

§ 718.303 [Reserved]

§ 718.304 Irrebuttable presumption of total disability or death due to pneumoconiosis.

There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, that a miner's death was due to pneumoconiosis or that a miner was totally disabled due to pneumoconiosis at the time of death, if such miner is suffering or suffered from a chronic dust disease of the lung which:

(a) When diagnosed by chest X-ray (*see* § 718.202 concerning the standards for X-rays and the effect of interpretations of X-rays by physicians) yields one or more large opacities (greater than one centimeter in diameter) and would be classified in Category A, B, or C in accordance with the classification system established in Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses as provided in § 718.102(d); or

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or

(c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: *Provided, however,* that any diagnosis made under this paragraph must accord with acceptable medical procedures.

[79 FR 21613, Apr. 17, 2014]

§ 718.305 Presumption of pneumoconiosis.

(a) *Applicability.* This section applies to all claims filed after January 1, 2005, and pending on or after March 23, 2010.

(b) *Invocation.* (1) The claimant may invoke the presumption by establishing that—

(i) The miner engaged in coal-mine employment for fifteen years, either in one or more underground coal mines, or in coal mines other than underground mines in conditions substantially similar to those in underground mines, or in any combination thereof; and

(ii) The miner or survivor cannot establish entitlement under § 718.304 by means of chest x-ray evidence; and

(iii) The miner has, or had at the time of his death, a totally disabling respiratory or pulmonary impairment established pursuant to § 718.204, except that § 718.204(d) does not apply.

(2) The conditions in a mine other than an underground mine will be considered ''substantially similar'' to those in an underground mine if the claimant demonstrates that the miner was regularly exposed to coal-mine dust while working there.

(3) In a claim involving a living miner, a miner's affidavit or testimony, or a spouse's affidavit or testimony, may not be used by itself to establish the existence of a totally disabling respiratory or pulmonary impairment.

(4) In the case of a deceased miner, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition must be considered sufficient to establish total disability due to a respiratory or pulmonary impairment if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination must not be based solely upon the affidavits or testimony of any person who would be eligible for benefits (including augmented benefits) if the claim were approved.

(c) *Facts presumed.* Once invoked, there will be rebuttable presumption—

(1) In a miner's claim, that the miner is totally disabled due to pneumoconiosis, or was totally disabled due to pneumoconiosis at the time of death; or

(2) In a survivor's claim, that the miner's death was due to pneumoconiosis.

(d) *Rebuttal*—(1) *Miner's claim.* In a claim filed by a miner, the party opposing entitlement may rebut the presumption by—

(i) Establishing both that the miner does not, or did not, have:

(A) Legal pneumoconiosis as defined in § 718.201(a)(2); and

(B) Clinical pneumoconiosis as defined in § 718.201(a)(1), arising out of coal mine employment (*see* § 718.203); or

(ii) Establishing that no part of the miner's respiratory or pulmonary total disability was caused by pneumoconiosis as defined in § 718.201.

(2) *Survivor's claim.* In a claim filed by a survivor, the party opposing entitlement may rebut the presumption by—

(i) Establishing both that the miner did not have:

(A) Legal pneumoconiosis as defined in § 718.201(a)(2); and

(B) Clinical pneumoconiosis as defined in § 718.201(a)(1), arising out of coal mine employment (*see* § 718.203); or

(ii) Establishing that no part of the miner's death was caused by pneumoconiosis as defined in § 718.201.

(3) The presumption must not be considered rebutted on the basis of evidence demonstrating the existence of a totally disabling obstructive respiratory or pulmonary disease of unknown origin.

[78 FR 59114, Sept. 25, 2013]

§ 718.306 [Reserved]

APPENDIX A TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF CHEST RADIOGRAPHS (X-RAYS)

The following standards are established in accordance with sections 402(f)(1)(D) and 413(b) of the Act. They were developed in consultation with the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention in the Department of Health and Human Services. These standards are promulgated for the guidance of physicians and medical technicians to ensure that uniform procedures are used in administering and interpreting X-rays and that the best available medical evidence will be submitted in connection with a claim for black lung benefits. If it is established that one or more standards have not been met, the claims adjudicator may consider such fact in determining the evidentiary weight to be assigned to the physician's report of an X-ray.

(a) *Definitions.* (1) *Digital radiography systems,* as used in this context, include both digital radiography (DR) and computed radiography (CR). Digital radiography is the term used for digital X-ray image acquisition systems in which the X-ray signals received by the image detector are converted nearly instantaneously to electronic signals without moveable cassettes. Computed radiography is the term for digital X-ray image acquisition systems that detect X-ray signals using a cassette-based photostimulable storage phosphor. Subsequently, the cassette is processed using a stimulating laser beam to convert the latent radiographic image to electronic signals which are then processed and stored so they can be displayed.

(2) *Qualified medical physicist* means an individual who is trained in evaluating the performance of radiographic equipment including radiation controls and facility quality assurance programs, and has the relevant current certification by a competent U.S. national board, or unrestricted license or approval from a U.S. State or Territory.

(3) *Radiographic technique chart* means a table that specifies the types of cassette, intensifying screen, film or digital detector, grid, filter, and lists X-ray machine settings (timing, kVp, mA) that enables the radiographer to select the correct settings based on the body habitus or the thickness of the chest tissue.

(4) *Radiologic technologist* means an individual who has met the requirements for privileges to perform general radiographic procedures and for competence in using the equipment and software employed by the examining facility to obtain chest images as specified by the State or Territory and examining facility in which such services are provided. Optimally, such an individual will have completed a formal training program in radiography leading to a certificate, an associate's degree, or a bachelor's degree and participated in the voluntary initial certification and annual renewal of registration for radiologic technologists offered by the American Registry of Radiologic Technologists.

(5) *Soft copy* means the image of a coal miner's chest radiograph acquired using a digital radiography system, viewed at the full resolution of the image acquisition system using an electronic medical image display device.

(b) *General provisions.* (1) Facilities must maintain ongoing licensure and certification under relevant local, State, and Federal laws and regulations for all digital equipment and related processes covered by this Appendix. Radiographic equipment, its use and the facilities (including mobile facilities) in which such equipment is used must conform to applicable State or Territorial and Federal regulations. Where no applicable regulations exist regarding reducing the risk from ionizing radiation exposure in the clinical setting, radiographic equipment, its use and the facilities (including mobile facilities) in which such equipment is used should conform to the recommendations in NCRP Report No. 102, NCRP Report No. 105, and NCRP Report No. 147 (incorporated by reference, *see* § 718.5).

(2) Chest radiographs of miners must be performed:

(i) By or under the supervision of a physician who makes chest radiographs in the

normal course of practice and who has demonstrated ability to make chest radiographs of a quality to best ascertain the presence of pneumoconiosis; or

(ii) By a radiologic technologist.

(3) Miners must be disrobed from the waist up at the time the radiograph is given. The facility must provide a dressing area and for those miners who wish to use one, the facility will provide a clean gown. Facilities must be heated to a comfortable temperature.

(4) Before the miner is advised that the examination is concluded, the radiograph must be processed and inspected and accepted for quality standards by the physician, or if the physician is not available, acceptance may be made by the radiologic technologist. In a case of a substandard radiograph, another must be made immediately.

(c) *Chest radiograph specifications—film.* (1) Every chest radiograph must be a single posteroanterior projection at full inspiration on a film being no less than 14 by 17 inch film. Additional chest films or views must be obtained if they are necessary for clarification and classification. The film and cassette must be capable of being positioned both vertically and horizontally so that the chest radiograph will include both apices and costophrenic angles. If a miner is too large to permit the above requirements, then a projection with minimum loss of costophrenic angle must be made.

(2) Radiographs must be made with a diagnostic X-ray machine having a rotating anode tube with a maximum of a 2 mm source (focal spot).

(3) Except as provided in paragraph (c)(4) of this appendix, radiographs must be made with units having generators that comply with the following:

(i) Generators of existing radiographic units acquired by the examining facility prior to July 27, 1973, must have a minimum rating of 200 mA at 100 kVp;

(ii) Generators of units acquired subsequent to that date must have a minimum rating of 300 mA at 125 kVp. A generator with a rating of 150 kVp is recommended.

(4) Radiographs made with battery-powered mobile or portable equipment must be made with units having a minimum rating of 100 mA at 110 kVp at 500 Hz, or 200 mA at 110 kVp at 60 Hz.

(5) Capacitor discharge and field emission units may be used.

(6) Radiographs must be given only with equipment having a beam-limiting device that does not cause large unexposed boundaries. The use of such a device must be discernible from an examination of the radiograph.

(7) To ensure high quality chest radiographs:

(i) The maximum exposure time must not exceed 50 milliseconds except that with single phase units with a rating less than 300 mA at 125 kVp and subjects with chests over 28 cm postero-anterior, the exposure may be increased to not more than 100 milliseconds;

(ii) The source or focal spot to film distance must be at least 6 feet.

(iii) Medium-speed film and medium-speed intensifying screens are recommended. However, any film-screen combination, the rated ''speed'' of which is at least 100 and does not exceed 300, which produces radiographs with spatial resolution, contrast, latitude and quantum mottle similar to those of systems designated as ''medium speed'' may be employed;

(iv) Film-screen contact must be maintained and verified at 6-month or shorter intervals.

(v) Intensifying screens must be inspected at least once a month and cleaned when necessary by the method recommended by the manufacturer;

(vi) All intensifying screens in a cassette must be of the same type and made by the same manufacturer;

(vii) When using over 90 kV, a suitable grid or other means of reducing scattered radiation must be used;

(viii) The geometry of the radiographic system must ensure that the central axis (ray) of the primary beam is perpendicular to the plane of the film surface and impinges on the center of the film.

(8) Radiographic processing:

(i) Either automatic or manual film processing is acceptable. A constant time-temperature technique must be meticulously employed for manual processing.

(ii) If mineral or other impurities in the processing water introduce difficulty in obtaining a high-quality radiograph, a suitable filter or purification system must be used.

(9) An electric power supply must be used that complies with the voltage, current, and regulation specified by the manufacturer of the machine.

(10) A test object may be required on each radiograph for an objective evaluation of film quality at the discretion of the Department of Labor.

(11) Each radiograph made under this Appendix must be permanently and legibly marked with the name and address of the facility at which it is made, the miner's DOL claim number, the date of the radiograph, and left and right side of the film. No other identifying markings may be recorded on the radiograph.

(d) *Chest radiograph specifications—digital radiography systems.* (1) Every digital chest radiograph must be a single posteroanterior projection at full inspiration on a digital detector with sensor area being no less than 1505 square centimeters with a minimum width of 35 cm. The imaging plate must have a maximum pixel pitch of 200 μm, with a minimum bit depth of 10. Spatial resolution

must be at least 2.5 line pairs per millimeter. The storage phosphor cassette or digital image detector must be positioned either vertically or horizontally so that the image includes the apices and costophrenic angles of both right and left lungs. If the detector cannot include the apices and costophrenic angles of both lungs as described, then the two side-by-side images can be obtained that together include the apices and costophrenic angles of both right and left lungs.

(2) Radiographs must be made with a diagnostic X-ray machine with a maximum actual (not nominal) source (focal spot) of 2 mm, as measured in two orthogonal directions.

(3) Radiographs must be made with units having generators which have a minimum rating of 300 mA at 125 kVp. Exposure kilovoltage must be at least the minimum as recommended by the manufacturer for chest radiography.

(4) An electric power supply must be used that complies with the voltage, current, and regulation specified by the manufacturer of the machine. If the manufacturer or installer of the radiographic equipment recommends equipment for control of electrical power fluctuations, such equipment must be used as recommended.

(5) Radiographs must be obtained only with equipment having a beam-limiting device that does not cause large unexposed boundaries. The beam limiting device must provide rectangular collimation. Electronic post-image acquisition ''shutters'' available on some CR or DR systems that limit the size of the final image and that simulate collimator limits must not be used. The use and effect of the beam limiting device must be discernible on the resulting image.

(6) Radiographic technique charts must be used that are developed specifically for the X-ray system and detector combinations used, indicating exposure parameters by anatomic measurements.

(7) To ensure high quality chest radiographs:

(i) The maximum exposure time must not exceed 50 milliseconds except for subjects with chests over 28 cm posteroanterior, for whom the exposure time must not exceed 100 milliseconds.

(ii) The distance from source or focal spot to detector must be at least 70 inches (or 180 centimeters if measured in centimeters).

(iii) The exposure setting for chest images must be within the range of 100–300 equivalent exposure speeds and must comply with ACR Practice Guidelines for Diagnostic Reference Levels in Medical X-ray Imaging, Section V—Diagnostic Reference Levels for Imaging with Ionizing Radiation and Section VII-Radiation Safety in Imaging (incorporated by reference, *see* §718.5). Radiation exposures should be periodically measured and patient radiation doses estimated by the medical physicist to assure doses are as low as reasonably achievable.

(iv) Digital radiography system performance, including resolution, modulation transfer function (MTF), image signal-to-noise and detective quantum efficiency must be evaluated and judged acceptable by a qualified medical physicist using the specifications in AAPM Report No. 93, pages 1–68 (incorporated by reference, *see* §718.5). Image management software and settings for routine chest imaging must be used, including routine amplification of digital detector signal as well as standard image post-processing functions. Image or edge enhancement software functions must not be employed unless they are integral to the digital radiography system (not elective); in such cases, only the minimum image enhancement permitted by the system may be employed.

(v)(A) The image object, transmission and associated data storage, film format, and transmissions of associated information must conform to the following components of the Digital Imaging and Communications in Medicine (DICOM) standard (incorporated by reference, *see* §718.5):

(*1*) DICOM Standard PS 3.3–2011, Annex A—Composite Information Object Definitions, sections: Computed Radiographic Image Information Object Definition; Digital X-Ray Image Information Object Definition; X-Ray Radiation Dose SR Information Object Definition; and Grayscale Softcopy Presentation State Information Object Definition.

(*2*) DICOM Standard PS 3.4–2011: Annex B—Storage Service Class; Annex N—Softcopy Presentation State Storage SOP Classes; Annex O—Structured Reporting Storage SOP Classes.

(*3*) DICOM Standard PS 3.10–2011.

(*4*) DICOM Standard PS 3.11–2011.

(*5*) DICOM Standard PS 3.12–2011.

(*6*) DICOM Standard PS 13.14–2011.

(*7*) DICOM Standard PS 3.16–2011.

(B) Identification of each miner, chest image, facility, date and time of the examination must be encoded within the image information object, according to DICOM Standard PS 3.3–2011, Information Object Definitions, for the DICOM ''DX'' object. If data compression is performed, it must be lossless. Exposure parameters (kVp, mA, time, beam filtration, scatter reduction, radiation exposure) must be stored in the DX information object.

(C) Exposure parameters as defined in the DICOM Standard PS 3.16–2011 must additionally be provided when such parameters are available from the facility digital image acquisition system or recorded in a written report or electronic file and transmitted to OWCP.

(8) A specific test object may be required on each radiograph for an objective evaluation of image quality at the Department of Labor's discretion.

(9) CR imaging plates must be inspected at least once a month and cleaned when necessary by the method recommended by the manufacturer.

(10) A grid or air gap for reducing scattered radiation must be used; grids must not be used that cause Moiré interference patterns in either horizontal or vertical images.

(11) The geometry of the radiographic system must ensure that the central axis (ray) of the primary beam is perpendicular to the plane of the CR imaging plate or DR detector and is correctly aligned to the grid.

(12) Radiographs must not be made when the environmental temperatures and humidity in the facility are outside the manufacturer's recommended range of the CR and DR equipment to be used.

(13) All interpreters, whenever classifying digitally acquired chest radiographs, must have immediately available for reference a complete set of ILO standard digital chest radiographic images provided for use with the Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses (2011 Revision) (incorporated by reference, *see* §718.5). Modification of the appearance of the standard images using software tools is not permitted.

(14) Viewing systems should enable readers to display the coal miner's chest image at the full resolution of the image acquisition system, side-by-side with the selected ILO standard images for comparison.

(i)(A) Image display devices must be flat panel monitors displaying at least 3 MP at 10 bit depth. Image displays and associated graphics cards must meet the calibration and other specifications of the Digital Imaging and Communications in Medicine (DICOM) standard PS 3.14–2011 (incorporated by reference, *see* §718.5).

(B) Image displays and associated graphics cards must not deviate by more than 10 percent from the grayscale standard display function (GSDF) when assessed according to the AAPM On-Line Report No. 03, pages 1–146 (incorporated by reference, *see* §718.5).

(ii) Display system luminance (maximum and ratio), relative noise, linearity, modulation transfer function (MTF), frequency, and glare should meet or exceed recommendations listed in AAPM On-Line Report No. 03, pages 1–146 (incorporated by reference, *see* §718.5). Viewing displays must have a maximum luminance of at least 171 cd/m^2, a ratio of maximum luminance to minimum luminance of at least 250, and a glare ratio greater than 400. The contribution of ambient light reflected from the display surface, after light sources have been minimized, must be included in luminance measurements.

(iii) Displays must be situated so as to minimize front surface glare. Readers must minimize reflected light from ambient sources during the performance of classifications.

(iv) Measurements of the width and length of pleural shadows and the diameter of opacities must be taken using calibrated software measuring tools. If permitted by the viewing software, a record must be made of the presentation state(s), including any noise reduction and edge enhancement or restoration functions that were used in performing the classification, including any annotations and measurements.

(15) Quality control procedures for devices used to display chest images for classification must comply with the recommendations of the American Association of Physicists in Medicine AAPM On-Line Report No. 03, pages 1–146 (incorporated by reference, *see* §718.5). If automatic quality assurance systems are used, visual inspection must be performed using one or more test patterns recommended by the medical physicist every 6 months, or more frequently, to check for defects that automatic systems may not detect.

(16) Classification of CR and DR digitally-acquired chest radiographs under this Part must be performed based on the viewing images displayed as soft copies using the viewing workstations specified in this section. Classification of radiographs must not be based on the viewing of hard copy printed transparencies of images that were digitally-acquired.

(17) The classification of chest radiographs based on digitized copies of chest radiographs that were originally acquired using film-screen techniques is not permissible.

[79 FR 21613, Apr. 17, 2014]

APPENDIX B TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF PULMONARY FUNCTION TESTS. TABLES B1, B2, B3, B4, B5, B6.

The following standards are established in accordance with section 402(f)(1)(D) of the Act. They were developed in consultation with the National Institute for Occupational Safety and Health (NIOSH). These standards are promulgated for the guidance of physicians and medical technicians to insure that uniform procedures are used in administering and interpreting ventilatory function tests and that the best available medical evidence will be submitted in support of a claim for black lung benefits. If it is established that one or more standards have not been met, the claims adjudicator may consider such fact in determining the evidentiary weight to be given to the results of the ventilatory function tests.

(1) Instruments to be used for the administration of pulmonary function tests shall be approved by NIOSH and shall conform to the following criteria:

(i) The instrument shall be accurate within ±50 ml or within ±3 percent of reading, whichever is greater.

(ii) The instrument shall be capable of measuring vital capacity from 0 to 7 liters BTPS.

(iii) The instrument shall have a low inertia and offer low resistance to airflow such that the resistance to airflow at 12 liters per second must be less than 1.5 cm H20/liter/sec.

(iv) The instrument or user of the instrument must have a means of correcting volumes to body temperature saturated with water vapor (BTPS) under conditions of varying ambient spirometer temperatures and barometric pressures.

(v) The instrument used shall provide a tracing of flow versus volume (flow-volume loop) which displays the entire maximum inspiration and the entire maximum forced expiration. The instrument shall, in addition, provide tracings of the volume versus time tracing (spirogram) derived electronically from the flow-volume loop. Tracings are necessary to determine whether maximum inspiratory and expiratory efforts have been obtained during the FVC maneuver. If maximum voluntary ventilation is measured, the tracing shall record the individual breaths volumes versus time.

(vi) The instrument shall be capable of accumulating volume for a minimum of 10 seconds after the onset of exhalation.

(vii) The instrument must be capable of being calibrated in the field with respect to the FEV1. The volume calibration shall be accomplished with a 3 L calibrating syringe and should agree to within 1 percent of a 3 L calibrating volume. The linearity of the instrument must be documented by a record of volume calibrations at three different flow rates of approximately 3 L/6 sec, 3 L/3 sec, and 3 L/sec.

(viii) For measuring maximum voluntary ventilation (MVV) the instrument shall have a response which is flat within ±10 percent up to 4 Hz at flow rates up to 12 liters per second over the volume range.

(ix) The spirogram shall be recorded at a speed of at least 20 mm/sec and a volume excursion of at least 10mm/L. Calculation of the FEVl from the flow-volume loop is not acceptable. Original tracings shall be submitted.

(2) The administration of pulmonary function tests shall conform to the following criteria:

(i) Tests shall not be performed during or soon after an acute respiratory illness.

(ii) For the FEV1 and FVC, use of a nose clip is required. The procedures shall be explained in simple terms to the patient who shall be instructed to loosen any tight clothing and stand in front of the apparatus. The subject may sit, or stand, but care should be taken on repeat testing that the same position be used. Particular attention shall be given to insure that the chin is slightly elevated with the neck slightly extended. The subject shall be instructed to expire completely, momentarily hold his breath, place the mouthpiece in his mouth and close the mouth firmly about the mouthpiece to ensure no air leak. The subject will than make a maximum inspiration from the instrument and when maximum inspiration has been attained, without interruption, blow as hard, fast and completely as possible for at least 7 seconds or until a plateau has been attained in the volume-time curve with no detectable change in the expired volume during the last 2 seconds of maximal expiratory effort. A minimum of three flow-volume loops and derived spirometric tracings shall be carried out. The patient shall be observed throughout the study for compliance with instructions. Inspiration and expiration shall be checked visually for reproducibility. The effort shall be judged unacceptable when the patient:

(A) Has not reached full inspiration preceding the forced expiration; or

(B) Has not used maximal effort during the entire forced expiration; or

(C) Has not continued the expiration for least 7 sec. or until an obvious plateau for at least 2 sec. in the volume-time curve has occurred; or

(D) Has coughed or closed his glottis; or

(E) Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

(F) Has an unsatisfactory start of expiration, one characterized by excessive hesitation (or false starts). Peak flow should be attained at the start of expiration and the volume-time tracing (spirogram) should have a smooth contour revealing gradually decreasing flow throughout expiration; or

(G) Has an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test.

(iii) For the MVV, the subject shall be instructed before beginning the test that he or she will be asked to breathe as deeply and as rapidly as possible for approximately 15 seconds. The test shall be performed with the subject in the standing position, if possible. Care shall be taken on repeat testing that the same position be used. The subject shall breathe normally into the mouthpiece of the

apparatus for 10 to 15 seconds to become accustomed to the system. The subject shall then be instructed to breathe as deeply and as rapidly as possible, and shall be continually encouraged during the remainder of the maneuver. Subject shall continue the maneuver for 15 seconds. At least 5 minutes of rest shall be allowed between maneuvers. At least three MVV's shall be carried out. (*But see* §718.103(b).) During the maneuvers the patient shall be observed for compliance with instructions. The effort shall be judged unacceptable when the patient:

(A) Has not maintained consistent effort for at least 12 to 15 seconds; or

(B) Has coughed or closed his glottis; or

(C) Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

(D) Has an excessive variability between the three acceptable curves. The variation between the two largest MVVs of the three satisfactory tracings shall not exceed 10 percent.

(iv) A calibration check shall be performed on the instrument each day before use, using a volume source of at least three liters, accurate to within ±1 percent of full scale. The volume calibration shall be performed in accordance with the method described in paragraph (1)(vii) of this Appendix. Accuracy of the time measurement used in determining the FEV1 shall be checked using the manufacturer's stated procedure and shall be within ±3 percent of actual. The procedure described in the Appendix shall be performed as well as any other procedures suggested by the manufacturer of the spirometer being used.

(v)(A) The first step in evaluating a spirogram for the FVC and FEV1 shall be to determine whether or not the patient has performed the test properly or as described in (2)(ii) of this Appendix. The largest recorded FVC and FEV1, corrected to BTPS, shall be used in the analysis.

(B) Only MVV maneuvers which demonstrate consistent effort for at least 12 seconds shall be considered acceptable. The largest accumulated volume for a 12 second period corrected to BTPS and multiplied by five or the largest accumulated volume for a 15 second period corrected to BTPS and multiplied by four is to be reported as the MVV.

PREDICTION EQUATIONS FOR FEV1 MALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS)																								
	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
59.1	1.85	1.88	1.90	1.75	1.74	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.58	1.56	1.54	1.53	1.51	1.49	1.48	1.46	1.45	1.43	1.41
59.4	1.88	1.90	1.93	1.78	1.77	1.75	1.74	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.61	1.59	1.57	1.56	1.54	1.53	1.51	1.49	1.48	1.46	1.44
59.8	1.90	1.93	1.96	1.80	1.78	1.77	1.75	1.74	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.61	1.59	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48
60.2	1.93	1.96	1.99	1.83	1.81	1.80	1.78	1.77	1.75	1.73	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49
60.6	1.96	1.99	2.01	1.86	1.85	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.60	1.59	1.57	1.55	1.54	1.52
61.0	1.99	2.01	2.04	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.68	1.67	1.65	1.63	1.62	1.60	1.59	1.57	1.55
61.4	2.01	2.04	2.07	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67	1.65	1.63	1.62	1.60	1.58
61.8	2.04	2.07	2.10	1.95	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.83	1.81	1.79	1.78	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.65	1.63	1.62
62.2	2.07	2.10	2.12	2.00	1.99	1.97	1.95	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.74	1.73	1.71	1.70	1.68	1.66
62.6	2.10	2.12	2.15	2.03	2.02	2.00	1.99	1.97	1.95	1.94	1.92	1.90	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.77	1.76	1.74	1.73	1.71	1.69
63.0	2.13	2.15	2.18	2.07	2.05	2.03	2.02	2.00	1.98	1.97	1.95	1.94	1.92	1.90	1.89	1.87	1.85	1.84	1.82	1.81	1.79	1.77	1.76	1.74	1.73
63.4	2.15	2.18	2.21	2.10	2.08	2.06	2.05	2.03	2.02	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.89	1.87	1.85	1.84	1.82	1.80	1.79	1.77	1.76
63.8	2.18	2.21	2.23	2.13	2.11	2.10	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.88	1.87	1.85	1.84	1.82	1.80	1.79
64.2	2.21	2.24	2.26	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.92	1.90	1.88	1.87	1.85	1.83	1.82
64.6	2.24	2.26	2.29	2.19	2.17	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.04	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.91	1.90	1.88	1.87	1.85
65.0	2.26	2.29	2.32	2.22	2.20	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.08	2.06	2.04	2.03	2.01	1.99	1.98	1.96	1.95	1.93	1.91	1.90	1.88
65.4	2.29	2.32	2.34	2.25	2.24	2.22	2.20	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.03	2.01	1.99	1.98	1.96	1.94	1.93	1.91
65.7	2.32	2.35	2.37	2.28	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.02	2.01	1.99	1.98	1.96	1.94
66.1	2.35	2.37	2.40	2.31	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.06	2.04	2.02	2.01	1.99	1.97
66.5	2.37	2.40	2.43	2.33	2.31	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.05	2.04	2.02	2.01	1.99
66.9	2.40	2.43	2.46	2.36	2.34	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.09	2.07	2.05	2.04	2.02
67.3	2.43	2.46	2.48	2.38	2.36	2.34	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.08	2.07	2.05	2.04
67.7	2.46	2.48	2.51	2.41	2.39	2.37	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.08	2.07
68.1	2.48	2.51	2.54	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.20	2.18	2.16	2.15	2.13	2.12	2.10
68.5	2.51	2.54	2.57	2.47	2.45	2.44	2.42	2.40	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.20	2.18	2.16	2.15	2.13
68.9	2.54	2.57	2.59	2.50	2.48	2.47	2.45	2.44	2.42	2.40	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.23	2.21	2.19	2.18	2.16
69.3	2.57	2.59	2.62	2.52	2.50	2.49	2.47	2.46	2.44	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.23	2.21	2.19	2.18
69.7	2.59	2.62	2.65	2.55	2.53	2.51	2.50	2.48	2.47	2.45	2.43	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.22	2.21
70.1	2.62	2.65	2.68	2.58	2.56	2.55	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.30	2.29	2.27	2.25	2.24
70.5	2.65	2.68	2.70	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.42	2.40	2.38	2.37	2.35	2.34	2.32	2.30	2.29	2.27
70.9	2.68	2.70	2.73	2.64	2.62	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.41	2.40	2.38	2.37	2.35	2.33	2.32	2.30
71.3	2.70	2.73	2.76	2.67	2.65	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.41	2.40	2.38	2.37	2.35	2.33
71.7	2.73	2.76	2.79	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.41	2.40	2.38	2.37	2.35
72.1	2.76	2.79	2.81	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.48	2.46	2.44	2.43	2.41	2.40	2.38
72.4	2.79	2.81	2.84	2.75	2.73	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.48	2.46	2.44	2.43	2.41
72.8	2.82	2.84	2.87	2.78	2.76	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.59	2.57	2.55	2.54	2.52	2.51	2.49	2.47	2.46	2.44
73.2	2.84	2.87	2.90	2.80	2.78	2.76	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.59	2.57	2.55	2.54	2.52	2.51	2.49	2.47	2.46
73.6	2.87	2.90	2.92	2.83	2.81	2.80	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.59	2.57	2.55	2.54	2.52	2.51	2.49
74.0	2.90	2.92	2.95	2.86	2.84	2.83	2.81	2.79	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.58	2.57	2.55	2.54	2.52
74.4	2.92	2.95	2.98	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.78	2.76	2.74	2.73	2.71	2.70	2.68	2.66	2.65	2.63	2.62	2.60	2.58	2.57	2.55
74.8	2.95	2.98	3.01	2.92	2.90	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.73	2.71	2.69	2.68	2.66	2.65	2.63	2.61	2.60	2.58
75.2	2.98	3.01	3.03	2.95	2.93	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.72	2.71	2.69	2.68	2.66	2.64	2.63	2.61
75.6	3.01	3.04	3.06	2.98	2.96	2.95	2.93	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.72	2.71	2.69	2.68	2.66	2.64
76.0	3.04	3.06	3.09	3.01	2.99	2.98	2.97	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.84	2.82	2.80	2.79	2.77	2.76	2.74	2.72	2.71	2.69	2.67
76.4	3.06	3.09	3.12	3.04	3.02	3.01	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.83	2.82	2.80	2.79	2.77	2.75	2.74	2.72	2.71
76.8	3.09	3.12	3.15	3.07	3.05	3.04	3.02	3.01	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.83	2.82	2.80	2.78	2.77	2.75	2.74
77.2	3.12	3.15	3.17	3.10	3.08	3.07	3.05	3.04	3.02	3.01	2.99	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.87	2.85	2.83	2.82	2.80	2.78	2.77
77.6	3.15	3.17	3.20	3.12	3.11	3.09	3.08	3.07	3.05	3.04	3.02	3.01	2.99	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.87	2.85	2.83	2.82	2.80
78.0	3.17	3.20	3.23	3.15	3.14	3.12	3.11	3.09	3.08	3.07	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.94	2.93	2.91	2.90	2.88	2.86	2.85	2.83
78.3	3.20	3.23	3.26	3.18	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07	3.06	3.04	3.02	3.01	2.99	2.98	2.96	2.94	2.93	2.91	2.90	2.88	2.86
78.7	3.23	3.26	3.28	3.21	3.20	3.18	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07	3.06	3.04	3.02	3.01	2.99	2.98	2.96	2.94	2.93	2.91	2.90
79.1	3.26	3.28	3.31	3.24	3.23	3.21	3.20	3.18	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.94	2.93
79.5	3.28	3.31	3.34	3.26	3.25	3.23	3.22	3.20	3.19	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.94
79.9	3.31	3.34	3.36	3.29	3.27	3.26	3.24	3.23	3.21	3.20	3.18	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07	3.06	3.04	3.03	3.01	2.99	2.98
80.3	3.34	3.37	3.39	3.31	3.30	3.28	3.27	3.25	3.24	3.22	3.21	3.19	3.18	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07	3.06	3.04	3.03	3.01
80.7	3.37	3.39	3.42	3.34	3.32	3.31	3.29	3.28	3.26	3.25	3.23	3.22	3.21	3.19	3.18	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07	3.06	3.04
81.1	3.39	3.42	3.45	3.37	3.35	3.34	3.32	3.31	3.29	3.28	3.26	3.25	3.23	3.22	3.21	3.19	3.18	3.17	3.15	3.14	3.12	3.11	3.10	3.09	3.07
81.5	3.42	3.45	3.48	3.40	3.38	3.37	3.35	3.34	3.32	3.31	3.29	3.28	3.26	3.25	3.24	3.22	3.21	3.19	3.18	3.17	3.15	3.14	3.12	3.11	3.10
81.9	3.45	3.48	3.50	3.43	3.42	3.40	3.38	3.37	3.35	3.34	3.32	3.31	3.29	3.28	3.26	3.25	3.24	3.22	3.21	3.19	3.18	3.17	3.15	3.14	3.12
82.3	3.48	3.50	3.53	3.45	3.43	3.42	3.40	3.39	3.37	3.35	3.34	3.32	3.30	3.29	3.27	3.26	3.24	3.23	3.21	3.20	3.18	3.17	3.15	3.14	3.13
82.7	3.51	3.53	3.56	3.48	3.46	3.45	3.43	3.42	3.40	3.38	3.37	3.35	3.33	3.32	3.30	3.29	3.27	3.26	3.24	3.23	3.21	3.20	3.18	3.17	3.15

PREDICTION EQUATIONS FOR FEV1 MALES * 60% OF PREDICTED **

AGE (YEARS)

HEIGHT (IN)	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
59.1	1.40	1.38	1.36	1.35	1.33	1.32	1.30	1.28	1.27	1.25	1.23	1.22	1.20	1.19	1.17	1.15	1.14	1.12	1.11	1.09	1.07	1.06	1.04	1.02	1.01
59.4	1.43	1.41	1.40	1.38	1.36	1.35	1.33	1.31	1.30	1.28	1.27	1.25	1.24	1.22	1.20	1.18	1.17	1.15	1.14	1.12	1.10	1.09	1.07	1.06	1.04
59.8	1.46	1.44	1.43	1.41	1.39	1.38	1.36	1.35	1.33	1.31	1.30	1.28	1.26	1.25	1.23	1.22	1.20	1.18	1.17	1.15	1.14	1.12	1.10	1.09	1.07
60.2	1.49	1.47	1.46	1.44	1.43	1.41	1.39	1.38	1.36	1.34	1.33	1.31	1.30	1.28	1.26	1.25	1.23	1.22	1.20	1.18	1.17	1.15	1.14	1.12	1.10
60.6	1.52	1.51	1.49	1.47	1.46	1.44	1.43	1.41	1.39	1.38	1.36	1.34	1.33	1.31	1.30	1.28	1.26	1.25	1.23	1.22	1.20	1.18	1.17	1.15	1.13
61.0	1.55	1.54	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.39	1.38	1.36	1.34	1.33	1.31	1.30	1.28	1.26	1.25	1.23	1.22	1.20	1.18	1.16
61.4	1.58	1.57	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.39	1.38	1.36	1.34	1.33	1.31	1.30	1.28	1.26	1.25	1.23	1.22	1.20
61.8	1.62	1.60	1.58	1.57	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.40	1.38	1.36	1.34	1.33	1.31	1.30	1.28	1.26	1.25	1.23
62.2	1.65	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.40	1.38	1.36	1.34	1.33	1.31	1.30	1.28	1.26
62.6	1.68	1.66	1.65	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.40	1.38	1.36	1.34	1.33	1.31	1.30
63.0	1.71	1.69	1.68	1.66	1.65	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.40	1.38	1.36	1.34	1.33
63.4	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.40	1.38	1.36
63.8	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43	1.41	1.40
64.2	1.80	1.79	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.63	1.62	1.60	1.58	1.57	1.55	1.53	1.52	1.50	1.49	1.47	1.46	1.44	1.43
64.6	1.83	1.82	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.64	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.49	1.47	1.46
65.0	1.86	1.85	1.83	1.82	1.80	1.78	1.77	1.75	1.74	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.50	1.49
65.4	1.90	1.88	1.86	1.85	1.83	1.81	1.80	1.78	1.77	1.75	1.73	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52
65.7	1.93	1.91	1.89	1.88	1.86	1.85	1.83	1.81	1.80	1.78	1.77	1.75	1.73	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.58	1.56	1.54
66.1	1.96	1.94	1.93	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.57
66.5	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.60
66.9	2.02	2.00	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.69	1.67	1.66	1.64
67.3	2.05	2.04	2.02	2.00	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.69	1.67
67.7	2.08	2.07	2.05	2.03	2.02	2.00	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70
68.1	2.11	2.10	2.08	2.07	2.05	2.03	2.02	2.00	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73
68.5	2.15	2.13	2.11	2.10	2.08	2.06	2.05	2.03	2.02	2.00	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76
68.9	2.18	2.16	2.14	2.13	2.11	2.10	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.82	1.81	1.79
69.3	2.21	2.19	2.18	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.82
69.7	2.24	2.22	2.21	2.19	2.17	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.04	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.92	1.90	1.89	1.87	1.85
70.1	2.27	2.26	2.24	2.22	2.21	2.19	2.17	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.04	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.92	1.90	1.88
70.5	2.30	2.29	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.91
70.9	2.33	2.32	2.30	2.28	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.03	2.01	1.99	1.98	1.96	1.94
71.3	2.36	2.35	2.33	2.32	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.06	2.04	2.02	2.01	1.99	1.98
71.7	2.40	2.38	2.36	2.35	2.33	2.31	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.05	2.04	2.02	2.01
72.0	2.43	2.41	2.40	2.38	2.36	2.35	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.09	2.07	2.05	2.04
72.4	2.46	2.44	2.43	2.41	2.39	2.38	2.36	2.34	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.08	2.07
72.8	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.38	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.17	2.15	2.13	2.12	2.10
73.2	2.52	2.50	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.20	2.18	2.17	2.15	2.13
73.6	2.55	2.54	2.52	2.50	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.20	2.18	2.16
74.0	2.58	2.57	2.55	2.53	2.52	2.50	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.19
74.4	2.61	2.60	2.58	2.57	2.55	2.53	2.52	2.50	2.48	2.47	2.45	2.44	2.42	2.40	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.28	2.26	2.24	2.23
74.8	2.64	2.63	2.61	2.60	2.58	2.56	2.55	2.53	2.52	2.50	2.49	2.47	2.45	2.43	2.42	2.40	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.28	2.26
75.2	2.68	2.66	2.64	2.63	2.61	2.60	2.58	2.56	2.55	2.53	2.51	2.50	2.48	2.47	2.45	2.43	2.42	2.40	2.39	2.37	2.36	2.34	2.33	2.31	2.29
75.6	2.71	2.69	2.67	2.66	2.64	2.63	2.61	2.59	2.58	2.56	2.55	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.42	2.40	2.39	2.37	2.36	2.34	2.32
76.0	2.74	2.72	2.71	2.69	2.67	2.66	2.64	2.63	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.42	2.40	2.39	2.37	2.35
76.4	2.77	2.75	2.74	2.72	2.70	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.42	2.40	2.38
76.8	2.80	2.78	2.77	2.75	2.74	2.72	2.70	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.41
77.2	2.83	2.82	2.80	2.78	2.77	2.75	2.73	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.48	2.46	2.44
77.6	2.86	2.85	2.83	2.81	2.80	2.78	2.77	2.75	2.73	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.47
78.0	2.89	2.88	2.86	2.85	2.83	2.81	2.80	2.78	2.76	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.56	2.54	2.52	2.51
78.3	2.92	2.91	2.89	2.88	2.86	2.84	2.83	2.81	2.79	2.78	2.76	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.59	2.57	2.56	2.54
78.7	2.96	2.94	2.92	2.91	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.58	2.57
79.1	2.99	2.97	2.96	2.94	2.92	2.91	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.66	2.65	2.63	2.62	2.60
79.5	3.02	3.00	2.99	2.97	2.95	2.94	2.92	2.90	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.78	2.76	2.74	2.73	2.71	2.70	2.68	2.66	2.65	2.63
79.9	3.05	3.03	3.02	3.00	2.99	2.97	2.95	2.94	2.92	2.90	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.73	2.71	2.70	2.68	2.66
80.3	3.08	3.07	3.05	3.03	3.02	3.00	2.98	2.97	2.95	2.94	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.73	2.71	2.69
80.7	3.11	3.10	3.08	3.06	3.05	3.03	3.02	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.80	2.79	2.77	2.76	2.74	2.72
81.1	3.14	3.13	3.11	3.10	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.84	2.82	2.80	2.79	2.77	2.76
81.5	3.18	3.16	3.14	3.13	3.11	3.09	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.96	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.84	2.82	2.80	2.79
81.9	3.21	3.19	3.17	3.16	3.14	3.13	3.11	3.09	3.08	3.06	3.04	3.03	3.01	3.00	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.87	2.85	2.83	2.82
82.3	3.24	3.22	3.21	3.19	3.17	3.16	3.14	3.12	3.11	3.09	3.08	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.86	2.85
82.7	3.27	3.25	3.24	3.22	3.20	3.19	3.17	3.16	3.14	3.12	3.11	3.09	3.07	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.94	2.93	2.91	2.90	2.88

PREDICTION EQUATIONS FOR MEN

FEMALES

* 90% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS)																							
	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
51.2	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05
51.6	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.12	1.10	1.09	1.08	1.07
52.0	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.18	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08
52.4	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10
52.8	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.11
53.1	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.16	1.14	1.13
53.5	1.45	1.44	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.15
53.9	1.47	1.45	1.44	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.16
54.3	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.18
54.7	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20
55.1	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21
55.5	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23
55.9	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24
56.3	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26
56.7	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28
57.1	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39	1.38	1.37	1.36	1.34	1.33	1.32	1.31	1.29
57.5	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31
57.9	1.63	1.62	1.60	1.59	1.58	1.56	1.54	1.53	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.33
58.3	1.64	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.40	1.39	1.38	1.37	1.35	1.34
58.7	1.66	1.65	1.64	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.36
59.1	1.68	1.66	1.65	1.64	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.37
59.4	1.69	1.68	1.67	1.65	1.64	1.62	1.61	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.39
59.8	1.71	1.70	1.68	1.67	1.66	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.41	1.41
60.2	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42
60.6	1.74	1.73	1.72	1.70	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.46	1.45	1.44
61.0	1.76	1.74	1.73	1.72	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.46
61.4	1.77	1.76	1.74	1.73	1.72	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47
61.8	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.61	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.49
62.2	1.81	1.79	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.65	1.63	1.62	1.60	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.50
62.6	1.82	1.81	1.80	1.78	1.77	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.52
63.0	1.84	1.83	1.81	1.80	1.79	1.78	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.54
63.4	1.85	1.84	1.83	1.82	1.80	1.79	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.55
63.8	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59	1.58	1.57
64.2	1.89	1.87	1.86	1.85	1.84	1.82	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.58
64.6	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.61	1.60	1.60
65.0	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.65	1.63	1.63	1.62
65.4	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65	1.63
65.7	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65
66.1	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67
66.5	1.98	1.97	1.96	1.95	1.93	1.92	1.91	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68
66.9	2.00	1.98	1.97	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.84	1.82	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70
67.3	2.02	2.00	1.99	1.97	1.96	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71
67.7	2.03	2.02	2.01	1.99	1.98	1.97	1.96	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73
68.1	2.05	2.04	2.02	2.01	2.00	1.99	1.97	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75
68.5	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.78	1.76
68.9	2.08	2.07	2.06	2.04	2.03	2.02	2.01	1.99	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78
69.3	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96	1.95	1.93	1.92	1.91	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80
69.7	2.11	2.10	2.09	2.08	2.06	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.84	1.82	1.81
70.1	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.02	2.00	1.99	1.98	1.97	1.95	1.94	1.93	1.92	1.90	1.89	1.88	1.87	1.85	1.84	1.83
70.5	2.15	2.13	2.12	2.11	2.10	2.08	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.90	1.88	1.87	1.86	1.86
70.9	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.04	2.02	2.01	2.00	1.99	1.97	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86
71.3	2.18	2.17	2.15	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.93	1.91	1.90	1.89	1.88
71.7	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.11	2.09	2.08	2.07	2.06	2.04	2.03	2.02	2.01	1.99	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89
72.0	2.21	2.20	2.19	2.17	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.04	2.02	2.01	2.00	1.99	1.98	1.96	1.95	1.93	1.92	1.91
72.4	2.23	2.21	2.20	2.19	2.18	2.16	2.15	2.14	2.13	2.11	2.10	2.09	2.08	2.06	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.92
72.8	2.24	2.23	2.22	2.21	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.02	2.00	1.99	1.98	1.97	1.95	1.94
73.2	2.26	2.25	2.23	2.22	2.21	2.20	2.18	2.17	2.16	2.15	2.13	2.12	2.11	2.09	2.08	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96
73.6	2.28	2.26	2.25	2.24	2.23	2.21	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.04	2.02	2.01	2.00	1.99	1.97
74.0	2.29	2.28	2.27	2.25	2.24	2.23	2.22	2.20	2.19	2.18	2.17	2.15	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.99
74.4	2.31	2.30	2.28	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.11	2.09	2.08	2.07	2.06	2.04	2.03	2.02	2.01
74.8	2.32	2.31	2.30	2.29	2.27	2.26	2.25	2.24	2.22	2.21	2.20	2.19	2.17	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02

PREDICTION EQUATIONS FOR FEV1 FEMALES * 60% OF PREDICTED **

HEIGHT	AGE (YEARS)																								
(IN)	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
51.2	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.94	0.92	0.91	0.90	0.89	0.87	0.86	0.85	0.84	0.82	0.81	0.80	0.79	0.77	0.76	0.75	0.73
51.6	1.05	1.04	1.03	1.02	1.00	0.99	0.98	0.97	0.95	0.94	0.93	0.92	0.90	0.89	0.88	0.86	0.85	0.84	0.83	0.81	0.80	0.79	0.78	0.76	0.75
52.0	1.07	1.06	1.04	1.03	1.02	1.01	0.99	0.98	0.96	0.97	0.94	0.93	0.92	0.91	0.89	0.88	0.87	0.86	0.84	0.83	0.82	0.81	0.79	0.78	0.77
52.4	1.08	1.07	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.93	0.92	0.91	0.90	0.88	0.87	0.86	0.85	0.83	0.82	0.81	0.80	0.78
52.8	1.10	1.09	1.08	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.94	0.93	0.91	0.90	0.89	0.88	0.86	0.85	0.83	0.82	0.81	0.80
53.1	1.12	1.11	1.09	1.08	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.98	0.97	0.95	0.94	0.93	0.92	0.90	0.89	0.88	0.87	0.85	0.84	0.83	0.82
53.5	1.13	1.12	1.11	1.10	1.08	1.06	1.05	1.03	1.02	1.01	1.00	0.98	0.97	0.96	0.95	0.93	0.92	0.91	0.90	0.88	0.87	0.86	0.84	0.83	0.83
53.9	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.94	0.92	0.91	0.90	0.89	0.87	0.86	0.85
54.3	1.17	1.15	1.14	1.13	1.12	1.10	1.09	1.08	1.07	1.05	1.04	1.03	1.02	1.00	0.99	0.98	0.97	0.95	0.94	0.93	0.92	0.90	0.89	0.88	0.86
54.7	1.18	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.01	0.99	0.98	0.97	0.96	0.94	0.93	0.92	0.91	0.89	0.88
55.1	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10	1.09	1.07	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.93	0.92	0.91	0.90
55.5	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.03	1.01	1.00	0.99	0.98	0.96	0.95	0.94	0.93	0.91
55.9	1.23	1.22	1.21	1.19	1.18	1.17	1.16	1.14	1.13	1.12	1.11	1.09	1.08	1.07	1.06	1.04	1.03	1.02	1.00	0.99	0.98	0.96	0.95	0.94	0.93
56.3	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.05	1.03	1.02	1.01	1.00	0.98	0.97	0.96	0.95
56.7	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96
57.1	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.12	1.10	1.09	1.08	1.07	1.05	1.04	1.03	1.02	1.00	0.99	0.98
57.5	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.01	0.99
57.9	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10	1.09	1.07	1.06	1.05	1.04	1.02	1.01
58.3	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.03
58.7	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.16	1.14	1.13	1.12	1.11	1.10	1.09	1.08	1.07	1.06
59.1	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06
59.4	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.15	1.14	1.13	1.11	1.10	1.09	1.08
59.8	1.39	1.38	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.12	1.10	1.09
60.2	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11
60.6	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.14	1.12
61.0	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14
61.4	1.46	1.45	1.43	1.42	1.41	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.16
61.8	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17
62.2	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.41	1.39	1.38	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19
62.6	1.50	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20
63.0	1.52	1.51	1.49	1.48	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.38	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22
63.4	1.54	1.53	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24
63.8	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25
64.2	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27
64.6	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29
65.0	1.60	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30
65.4	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.34	1.33
65.7	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.53	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35
66.1	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.52	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36
66.5	1.67	1.66	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.52	1.51	1.50	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.40	1.38
66.9	1.69	1.67	1.66	1.65	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.52	1.51	1.50	1.49	1.48	1.47	1.46	1.45	1.44	1.42	1.41	1.40
67.3	1.70	1.69	1.68	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.41
67.7	1.72	1.71	1.69	1.68	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42
68.1	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43
68.5	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45
68.9	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.48	1.46
69.3	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48
69.7	1.80	1.79	1.77	1.76	1.74	1.73	1.72	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50
70.1	1.82	1.80	1.78	1.77	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.61	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.51
70.5	1.83	1.82	1.81	1.79	1.78	1.76	1.75	1.74	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.57	1.55	1.54	1.53	1.52
70.9	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55
71.3	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56
71.7	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58
72.0	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59
72.4	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61
72.8	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.63
73.2	1.94	1.93	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.64
73.6	1.95	1.94	1.92	1.91	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65
74.0	1.96	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.78	1.76	1.75	1.74	1.72	1.71	1.70	1.69	1.67	1.67
74.4	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68
74.8	2.01	2.00	1.98	1.97	1.96	1.95	1.93	1.92	1.91	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71

PREDICTION EQUATIONS FOR FVC MALES * 60% OF PREDICTED **

AGE (YEARS)

HEIGHT (IN)	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
59.1	2.22	2.27	2.32	2.14	2.12	2.10	2.09	2.07	2.05	2.04	2.02	2.00	1.98	1.97	1.95	1.93	1.91	1.90	1.88	1.86	1.84	1.83	1.81	1.79	1.77
59.4	2.25	2.30	2.35	2.18	2.16	2.14	2.13	2.11	2.09	2.07	2.06	2.04	2.02	2.00	1.99	1.97	1.95	1.93	1.92	1.90	1.88	1.87	1.85	1.83	1.81
59.8	2.28	2.33	2.38	2.22	2.20	2.18	2.17	2.15	2.13	2.11	2.10	2.08	2.06	2.04	2.03	2.01	1.99	1.97	1.96	1.94	1.92	1.90	1.89	1.87	1.85
60.2	2.31	2.36	2.41	2.26	2.24	2.22	2.20	2.19	2.17	2.15	2.13	2.12	2.10	2.08	2.07	2.05	2.03	2.01	2.00	1.98	1.96	1.94	1.93	1.91	1.89
60.6	2.34	2.39	2.44	2.30	2.28	2.26	2.24	2.23	2.21	2.19	2.17	2.16	2.14	2.12	2.10	2.09	2.07	2.05	2.03	2.02	2.00	1.98	1.96	1.95	1.93
61.0	2.37	2.42	2.47	2.33	2.32	2.30	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.16	2.14	2.13	2.11	2.09	2.07	2.06	2.04	2.02	2.00	1.99	1.97
61.4	2.40	2.45	2.50	2.37	2.36	2.34	2.32	2.30	2.29	2.27	2.25	2.23	2.22	2.20	2.18	2.16	2.15	2.13	2.11	2.10	2.08	2.06	2.04	2.03	2.01
61.8	2.43	2.48	2.53	2.41	2.40	2.38	2.36	2.34	2.33	2.31	2.29	2.27	2.26	2.24	2.22	2.20	2.19	2.17	2.15	2.13	2.12	2.10	2.08	2.06	2.05
62.2	2.46	2.51	2.56	2.45	2.43	2.42	2.40	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.19	2.17	2.16	2.14	2.12	2.10	2.09
62.6	2.49	2.54	2.59	2.49	2.47	2.46	2.44	2.42	2.40	2.39	2.37	2.35	2.33	2.32	2.30	2.28	2.26	2.25	2.23	2.21	2.19	2.18	2.16	2.14	2.13
63.0	2.52	2.57	2.62	2.52	2.51	2.49	2.48	2.46	2.44	2.43	2.41	2.39	2.37	2.36	2.34	2.32	2.30	2.29	2.27	2.25	2.23	2.22	2.20	2.18	2.16
63.4	2.55	2.60	2.65	2.55	2.53	2.52	2.50	2.48	2.46	2.45	2.43	2.41	2.39	2.38	2.36	2.34	2.32	2.31	2.29	2.27	2.25	2.24	2.22	2.20	2.20
63.8	2.58	2.63	2.68	2.61	2.59	2.57	2.56	2.54	2.52	2.50	2.49	2.47	2.45	2.43	2.42	2.40	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24
64.2	2.61	2.66	2.71	2.65	2.63	2.61	2.59	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.46	2.44	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.30	2.28
64.6	2.64	2.69	2.74	2.68	2.67	2.65	2.63	2.62	2.60	2.58	2.56	2.55	2.53	2.51	2.49	2.48	2.46	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.32
65.0	2.67	2.72	2.77	2.72	2.71	2.69	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.55	2.53	2.52	2.50	2.48	2.46	2.45	2.43	2.41	2.39	2.38	2.36
65.4	2.70	2.75	2.80	2.76	2.75	2.73	2.71	2.69	2.68	2.66	2.64	2.62	2.61	2.59	2.57	2.55	2.54	2.52	2.50	2.49	2.47	2.45	2.43	2.42	2.40
65.7	2.73	2.78	2.83	2.80	2.79	2.77	2.75	2.73	2.72	2.70	2.68	2.66	2.65	2.63	2.61	2.59	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.45	2.44
66.1	2.76	2.81	2.86	2.84	2.82	2.81	2.79	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.58	2.56	2.55	2.53	2.51	2.49	2.48
66.5	2.79	2.84	2.89	2.88	2.86	2.85	2.83	2.81	2.79	2.77	2.76	2.74	2.72	2.71	2.69	2.67	2.65	2.64	2.62	2.60	2.58	2.57	2.55	2.53	2.52
66.9	2.82	2.87	2.92	2.92	2.90	2.88	2.87	2.85	2.83	2.82	2.80	2.78	2.76	2.75	2.73	2.71	2.69	2.68	2.66	2.64	2.62	2.61	2.59	2.57	2.55
67.3	2.85	2.90	2.95	2.96	2.94	2.92	2.91	2.89	2.87	2.85	2.84	2.82	2.80	2.78	2.77	2.75	2.73	2.71	2.70	2.68	2.66	2.65	2.63	2.61	2.59
67.7	2.88	2.93	2.98	3.00	2.98	2.96	2.95	2.93	2.91	2.89	2.88	2.86	2.84	2.82	2.81	2.79	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63
68.1	2.91	2.96	3.01	3.04	3.02	3.00	2.98	2.97	2.95	2.93	2.91	2.90	2.88	2.86	2.85	2.83	2.81	2.79	2.78	2.76	2.74	2.72	2.71	2.69	2.67
68.5	2.94	2.99	3.04	3.08	3.06	3.04	3.02	3.01	2.99	2.97	2.95	2.94	2.92	2.90	2.88	2.87	2.85	2.83	2.81	2.80	2.78	2.76	2.74	2.73	2.71
68.9	2.97	3.02	3.07	3.11	3.10	3.08	3.06	3.05	3.03	3.01	2.99	2.98	2.96	2.94	2.92	2.91	2.89	2.87	2.85	2.84	2.82	2.80	2.78	2.77	2.75
69.3	3.00	3.05	3.10	3.15	3.12	3.10	3.08	3.07	3.05	3.03	3.01	3.00	2.98	2.96	2.94	2.93	2.91	2.89	2.88	2.86	2.84	2.82	2.81	2.79	2.79
69.7	3.03	3.08	3.13	3.19	3.16	3.14	3.12	3.11	3.09	3.07	3.05	3.04	3.02	3.00	2.98	2.97	2.95	2.93	2.91	2.90	2.88	2.86	2.84	2.84	2.82
70.1	3.06	3.11	3.16	3.23	3.21	3.20	3.18	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02	3.01	2.99	2.97	2.95	2.94	2.92	2.90	2.88	2.87
70.5	3.09	3.14	3.19	3.27	3.25	3.24	3.22	3.20	3.18	3.17	3.15	3.13	3.11	3.10	3.08	3.06	3.04	3.03	3.01	2.99	2.97	2.96	2.94	2.92	2.91
70.9	3.12	3.17	3.22	3.31	3.29	3.27	3.26	3.24	3.22	3.21	3.19	3.17	3.15	3.14	3.12	3.10	3.08	3.07	3.05	3.03	3.01	3.00	2.98	2.96	2.94
71.3	3.15	3.20	3.25	3.35	3.33	3.31	3.30	3.28	3.26	3.24	3.23	3.21	3.19	3.17	3.16	3.14	3.12	3.10	3.09	3.07	3.05	3.04	3.02	3.00	2.98
71.7	3.18	3.23	3.28	3.39	3.37	3.35	3.34	3.32	3.30	3.28	3.27	3.25	3.23	3.21	3.20	3.18	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02
72.0	3.21	3.26	3.31	3.43	3.41	3.39	3.37	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.24	3.22	3.20	3.18	3.17	3.15	3.13	3.11	3.10	3.08	3.06
72.4	3.24	3.29	3.34	3.47	3.45	3.43	3.41	3.40	3.38	3.36	3.34	3.33	3.31	3.29	3.27	3.26	3.24	3.22	3.20	3.19	3.17	3.15	3.13	3.12	3.10
72.8	3.27	3.32	3.37	3.50	3.49	3.47	3.45	3.43	3.42	3.40	3.38	3.37	3.35	3.33	3.31	3.30	3.28	3.26	3.24	3.23	3.21	3.19	3.17	3.16	3.14
73.2	3.30	3.35	3.40	3.54	3.53	3.51	3.49	3.47	3.46	3.44	3.42	3.40	3.39	3.37	3.35	3.33	3.32	3.30	3.28	3.27	3.25	3.23	3.21	3.20	3.18
73.6	3.33	3.38	3.43	3.58	3.57	3.55	3.53	3.51	3.50	3.48	3.46	3.44	3.43	3.41	3.39	3.37	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.23	3.22
74.0	3.36	3.41	3.46	3.62	3.60	3.59	3.57	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41	3.40	3.38	3.36	3.34	3.33	3.31	3.29	3.27	3.26
74.4	3.39	3.44	3.49	3.66	3.64	3.63	3.61	3.59	3.57	3.56	3.54	3.52	3.50	3.49	3.47	3.45	3.43	3.42	3.40	3.38	3.36	3.35	3.33	3.31	3.30
74.8	3.42	3.47	3.52	3.70	3.68	3.66	3.65	3.63	3.61	3.60	3.58	3.56	3.54	3.53	3.51	3.49	3.47	3.46	3.44	3.42	3.40	3.39	3.37	3.35	3.33
75.2	3.45	3.50	3.55	3.74	3.72	3.70	3.69	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53	3.51	3.50	3.48	3.46	3.44	3.43	3.41	3.39	3.37
75.6	3.48	3.53	3.58	3.78	3.76	3.74	3.73	3.71	3.69	3.67	3.66	3.64	3.62	3.60	3.59	3.57	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41
76.0	3.51	3.56	3.61	3.82	3.80	3.78	3.76	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.63	3.61	3.59	3.57	3.56	3.54	3.52	3.50	3.49	3.47	3.45
76.4	3.54	3.59	3.64	3.86	3.84	3.82	3.80	3.79	3.77	3.75	3.73	3.72	3.70	3.68	3.66	3.65	3.63	3.61	3.59	3.58	3.56	3.54	3.52	3.51	3.49
76.8	3.57	3.62	3.67	3.89	3.88	3.86	3.84	3.82	3.81	3.79	3.77	3.76	3.74	3.72	3.70	3.69	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53
77.2	3.60	3.65	3.70	3.93	3.92	3.90	3.88	3.86	3.85	3.83	3.81	3.79	3.78	3.76	3.74	3.72	3.71	3.69	3.67	3.66	3.64	3.62	3.60	3.59	3.57
77.6	3.63	3.68	3.73	3.97	3.96	3.94	3.92	3.90	3.89	3.87	3.85	3.84	3.82	3.80	3.78	3.76	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.62	3.61
78.0	3.66	3.71	3.76	4.01	3.99	3.98	3.96	3.94	3.92	3.91	3.89	3.87	3.86	3.84	3.82	3.80	3.79	3.77	3.75	3.73	3.72	3.70	3.68	3.66	3.65
78.3	3.69	3.74	3.79	4.05	4.03	4.02	4.00	3.98	3.96	3.95	3.93	3.91	3.89	3.88	3.86	3.84	3.82	3.81	3.79	3.77	3.75	3.74	3.72	3.74	3.72
78.7	3.72	3.77	3.82	4.09	4.07	4.05	4.04	4.02	4.00	3.99	3.97	3.95	3.93	3.92	3.90	3.88	3.86	3.85	3.83	3.81	3.79	3.78	3.76	3.74	3.73
79.1	3.75	3.80	3.85	4.13	4.11	4.09	4.08	4.06	4.04	4.02	4.01	3.99	3.97	3.95	3.94	3.92	3.90	3.88	3.87	3.85	3.83	3.82	3.80	3.78	3.76
79.5	3.78	3.83	3.88	4.17	4.15	4.13	4.12	4.10	4.08	4.06	4.05	4.03	4.01	3.99	3.98	3.96	3.94	3.92	3.91	3.89	3.87	3.85	3.84	3.82	3.80
79.9	3.81	3.86	3.91	4.21	4.19	4.17	4.15	4.14	4.12	4.10	4.08	4.07	4.05	4.03	4.02	4.00	3.98	3.96	3.95	3.93	3.91	3.89	3.88	3.86	3.84
80.3	3.84	3.89	3.94	4.25	4.23	4.21	4.19	4.18	4.16	4.14	4.12	4.11	4.09	4.07	4.05	4.04	4.02	4.00	3.98	3.97	3.95	3.93	3.91	3.90	3.88
80.7	3.87	3.92	3.97	4.28	4.27	4.25	4.23	4.22	4.20	4.18	4.16	4.15	4.13	4.11	4.09	4.08	4.06	4.04	4.02	4.01	3.99	3.97	3.95	3.94	3.92
81.1	3.90	3.95	4.00	4.32	4.31	4.29	4.27	4.25	4.24	4.22	4.20	4.18	4.17	4.15	4.13	4.11	4.10	4.08	4.06	4.05	4.03	4.01	3.99	3.98	3.96
81.5	3.93	3.98	4.03	4.36	4.35	4.33	4.31	4.29	4.28	4.26	4.24	4.22	4.21	4.19	4.17	4.15	4.14	4.12	4.10	4.08	4.07	4.05	4.03	4.01	4.00
81.9	3.96	4.01	4.06	4.40	4.38	4.37	4.35	4.33	4.31	4.30	4.28	4.26	4.24	4.23	4.21	4.19	4.18	4.16	4.14	4.12	4.11	4.09	4.07	4.05	4.04
82.3	3.99	4.04	4.09	4.44	4.42	4.41	4.39	4.37	4.35	4.34	4.32	4.30	4.28	4.27	4.25	4.23	4.21	4.20	4.18	4.16	4.14	4.13	4.11	4.09	4.08
82.7	4.02	4.07	4.12	4.48	4.46	4.44	4.43	4.41	4.39	4.38	4.36	4.34	4.32	4.31	4.29	4.27	4.25	4.24	4.22	4.20	4.18	4.17	4.15	4.13	4.11

PREDICTION EQUATIONS FOR FVC

MALES * 60% OF PREDICTED **

HEIGHT (IN.)	AGE (YEARS) 47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
59.1	1.76	1.74	1.72	1.70	1.69	1.67	1.65	1.63	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.50	1.48	1.46	1.44	1.43	1.41	1.39	1.37	1.36	1.34
59.4	1.80	1.78	1.76	1.74	1.73	1.71	1.69	1.67	1.66	1.64	1.62	1.60	1.59	1.57	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.43	1.41	1.40	1.38
59.8	1.83	1.82	1.80	1.78	1.77	1.75	1.73	1.71	1.70	1.68	1.66	1.64	1.63	1.61	1.59	1.57	1.56	1.54	1.52	1.50	1.49	1.47	1.45	1.43	1.42
60.2	1.87	1.86	1.84	1.82	1.80	1.79	1.77	1.75	1.73	1.72	1.70	1.68	1.66	1.65	1.63	1.61	1.60	1.58	1.56	1.54	1.53	1.51	1.49	1.47	1.46
60.6	1.91	1.90	1.88	1.86	1.84	1.83	1.81	1.79	1.77	1.76	1.74	1.72	1.70	1.69	1.67	1.65	1.63	1.62	1.60	1.58	1.56	1.55	1.53	1.51	1.50
61.0	1.95	1.93	1.92	1.90	1.88	1.86	1.85	1.83	1.81	1.80	1.78	1.76	1.74	1.73	1.71	1.69	1.67	1.66	1.64	1.62	1.60	1.59	1.57	1.55	1.53
61.4	1.99	1.97	1.96	1.94	1.92	1.90	1.89	1.87	1.85	1.83	1.82	1.80	1.78	1.76	1.75	1.73	1.71	1.69	1.68	1.66	1.65	1.63	1.61	1.59	1.57
61.8	2.03	2.01	2.00	1.98	1.96	1.94	1.93	1.91	1.89	1.87	1.86	1.84	1.82	1.80	1.79	1.77	1.75	1.73	1.72	1.70	1.68	1.66	1.65	1.63	1.61
62.2	2.07	2.05	2.04	2.02	2.00	1.98	1.97	1.95	1.93	1.91	1.90	1.88	1.86	1.84	1.83	1.81	1.79	1.77	1.76	1.74	1.72	1.70	1.69	1.67	1.65
62.6	2.11	2.09	2.08	2.06	2.04	2.02	2.01	1.99	1.97	1.96	1.94	1.92	1.90	1.89	1.87	1.85	1.83	1.81	1.80	1.78	1.76	1.74	1.73	1.71	1.69
63.0	2.15	2.13	2.12	2.10	2.08	2.06	2.05	2.03	2.01	1.99	1.98	1.96	1.94	1.92	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73
63.4	2.19	2.17	2.16	2.14	2.12	2.10	2.09	2.07	2.05	2.03	2.02	2.00	1.98	1.96	1.95	1.93	1.91	1.89	1.88	1.86	1.84	1.82	1.81	1.79	1.77
63.8	2.22	2.21	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.02	2.00	1.99	1.97	1.95	1.93	1.92	1.90	1.88	1.86	1.84	1.82	1.81
64.2	2.26	2.25	2.23	2.21	2.19	2.18	2.16	2.14	2.13	2.11	2.09	2.07	2.06	2.04	2.02	2.00	1.99	1.97	1.95	1.93	1.92	1.90	1.88	1.86	1.85
64.6	2.30	2.29	2.27	2.25	2.23	2.22	2.20	2.18	2.16	2.15	2.13	2.11	2.09	2.08	2.06	2.04	2.02	2.01	1.99	1.97	1.96	1.94	1.92	1.90	1.89
65.0	2.34	2.33	2.31	2.29	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.15	2.13	2.12	2.10	2.08	2.06	2.05	2.03	2.01	1.99	1.98	1.96	1.94	1.92
65.4	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24	2.22	2.21	2.19	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.05	2.03	2.02	2.00	1.98	1.96
65.7	2.42	2.40	2.38	2.37	2.35	2.33	2.32	2.30	2.28	2.26	2.25	2.23	2.21	2.19	2.18	2.16	2.14	2.12	2.11	2.09	2.07	2.05	2.04	2.02	2.00
66.1	2.46	2.44	2.42	2.41	2.39	2.37	2.35	2.34	2.32	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.18	2.16	2.15	2.13	2.11	2.09	2.08	2.06	2.04
66.5	2.50	2.48	2.46	2.45	2.43	2.41	2.39	2.38	2.36	2.34	2.32	2.31	2.29	2.27	2.25	2.24	2.22	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.08
66.9	2.54	2.52	2.50	2.48	2.47	2.45	2.43	2.41	2.40	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24	2.22	2.21	2.19	2.17	2.15	2.14	2.12
67.3	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.45	2.44	2.42	2.40	2.38	2.37	2.35	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.21	2.19	2.18	2.16
67.7	2.61	2.60	2.58	2.56	2.55	2.53	2.51	2.49	2.48	2.46	2.44	2.42	2.41	2.39	2.37	2.35	2.34	2.32	2.30	2.28	2.27	2.25	2.23	2.21	2.20
68.1	2.65	2.64	2.62	2.60	2.58	2.57	2.55	2.53	2.51	2.50	2.48	2.46	2.44	2.43	2.41	2.39	2.38	2.36	2.34	2.32	2.31	2.29	2.27	2.25	2.24
68.5	2.69	2.68	2.66	2.64	2.62	2.61	2.59	2.57	2.55	2.54	2.52	2.50	2.48	2.47	2.45	2.43	2.41	2.40	2.38	2.36	2.34	2.33	2.31	2.29	2.28
68.9	2.73	2.71	2.70	2.68	2.66	2.64	2.63	2.61	2.59	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.45	2.44	2.42	2.40	2.38	2.37	2.35	2.33	2.31
69.3	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63	2.61	2.60	2.58	2.56	2.54	2.53	2.51	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.37	2.35
69.7	2.81	2.79	2.77	2.76	2.74	2.72	2.71	2.69	2.67	2.65	2.64	2.62	2.60	2.58	2.57	2.55	2.53	2.51	2.50	2.48	2.46	2.44	2.43	2.41	2.39
70.1	2.85	2.83	2.81	2.80	2.78	2.76	2.74	2.73	2.71	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.57	2.55	2.54	2.52	2.50	2.48	2.47	2.45	2.43
70.5	2.89	2.87	2.85	2.84	2.82	2.80	2.78	2.77	2.75	2.73	2.71	2.70	2.68	2.66	2.64	2.63	2.61	2.59	2.57	2.56	2.54	2.52	2.50	2.49	2.47
70.9	2.93	2.91	2.89	2.87	2.86	2.84	2.82	2.80	2.79	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63	2.61	2.60	2.58	2.56	2.54	2.53	2.51
71.3	2.97	2.95	2.93	2.92	2.90	2.88	2.86	2.84	2.83	2.81	2.79	2.77	2.76	2.74	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.60	2.58	2.57	2.55
71.7	3.00	2.99	2.97	2.95	2.94	2.92	2.90	2.88	2.87	2.85	2.83	2.81	2.80	2.78	2.76	2.74	2.73	2.71	2.69	2.67	2.66	2.64	2.62	2.60	2.59
72.0	3.04	3.03	3.01	2.99	2.97	2.96	2.94	2.92	2.90	2.89	2.87	2.85	2.83	2.82	2.80	2.78	2.77	2.75	2.73	2.71	2.70	2.68	2.66	2.64	2.63
72.4	3.08	3.07	3.05	3.03	3.01	3.00	2.98	2.96	2.94	2.93	2.91	2.89	2.87	2.86	2.84	2.82	2.80	2.79	2.77	2.75	2.73	2.72	2.70	2.68	2.67
72.8	3.12	3.10	3.09	3.07	3.05	3.03	3.02	3.00	2.98	2.97	2.95	2.93	2.91	2.90	2.88	2.86	2.84	2.83	2.81	2.79	2.77	2.76	2.74	2.72	2.70
73.2	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02	3.00	2.99	2.97	2.95	2.93	2.92	2.90	2.88	2.86	2.85	2.83	2.81	2.80	2.78	2.76	2.74
73.6	3.20	3.18	3.16	3.15	3.13	3.11	3.10	3.08	3.06	3.04	3.03	3.01	2.99	2.97	2.96	2.94	2.92	2.90	2.89	2.87	2.85	2.83	2.82	2.80	2.78
74.0	3.24	3.22	3.20	3.19	3.17	3.15	3.13	3.12	3.10	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.96	2.94	2.93	2.91	2.89	2.87	2.86	2.84	2.82
74.4	3.28	3.26	3.24	3.23	3.21	3.19	3.17	3.16	3.14	3.12	3.10	3.09	3.07	3.05	3.03	3.02	3.00	2.98	2.96	2.95	2.93	2.91	2.89	2.88	2.86
74.8	3.32	3.30	3.28	3.26	3.25	3.23	3.21	3.19	3.18	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02	3.00	2.99	2.97	2.95	2.93	2.92	2.90
75.2	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.23	3.22	3.20	3.18	3.16	3.15	3.13	3.11	3.09	3.08	3.06	3.04	3.03	3.01	2.99	2.97	2.96	2.94
75.6	3.39	3.38	3.36	3.34	3.33	3.31	3.29	3.27	3.26	3.24	3.22	3.20	3.19	3.17	3.15	3.13	3.12	3.10	3.08	3.06	3.05	3.03	3.01	2.99	2.98
76.0	3.43	3.42	3.40	3.38	3.36	3.35	3.33	3.31	3.29	3.28	3.26	3.24	3.22	3.21	3.19	3.17	3.16	3.14	3.12	3.10	3.09	3.07	3.05	3.03	3.02
76.4	3.47	3.46	3.44	3.42	3.40	3.39	3.37	3.35	3.33	3.32	3.30	3.28	3.26	3.25	3.23	3.21	3.19	3.18	3.16	3.14	3.12	3.11	3.09	3.07	3.06
76.8	3.51	3.49	3.48	3.46	3.44	3.42	3.41	3.39	3.37	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.23	3.22	3.20	3.18	3.16	3.15	3.13	3.11	3.09
77.2	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41	3.39	3.38	3.36	3.34	3.32	3.31	3.29	3.27	3.25	3.24	3.22	3.20	3.19	3.17	3.15	3.13
77.6	3.59	3.57	3.55	3.54	3.52	3.50	3.49	3.47	3.45	3.43	3.42	3.40	3.38	3.36	3.35	3.33	3.31	3.29	3.28	3.26	3.24	3.22	3.21	3.19	3.17
78.0	3.63	3.61	3.59	3.58	3.56	3.54	3.52	3.51	3.49	3.47	3.45	3.44	3.42	3.41	3.39	3.37	3.35	3.33	3.32	3.30	3.28	3.26	3.25	3.23	3.21
78.3	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53	3.51	3.49	3.48	3.46	3.44	3.42	3.41	3.39	3.37	3.35	3.34	3.32	3.30	3.28	3.27	3.25
78.7	3.71	3.69	3.67	3.65	3.64	3.62	3.60	3.59	3.57	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41	3.39	3.38	3.36	3.34	3.32	3.31	3.29
79.1	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.62	3.61	3.59	3.57	3.55	3.54	3.52	3.50	3.48	3.47	3.45	3.43	3.42	3.40	3.38	3.36	3.35	3.33
79.5	3.78	3.77	3.75	3.73	3.72	3.70	3.68	3.66	3.65	3.63	3.61	3.59	3.58	3.56	3.54	3.52	3.51	3.49	3.47	3.45	3.44	3.42	3.40	3.38	3.37
79.9	3.82	3.81	3.79	3.77	3.75	3.74	3.72	3.70	3.68	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53	3.51	3.49	3.48	3.46	3.44	3.42	3.41
80.3	3.86	3.85	3.83	3.81	3.79	3.78	3.76	3.74	3.72	3.71	3.69	3.67	3.65	3.64	3.62	3.60	3.58	3.57	3.55	3.53	3.51	3.50	3.48	3.46	3.45
80.7	3.90	3.88	3.87	3.85	3.83	3.81	3.80	3.78	3.76	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.62	3.61	3.59	3.57	3.55	3.54	3.52	3.50	3.48
81.1	3.94	3.92	3.91	3.89	3.87	3.85	3.84	3.82	3.80	3.78	3.77	3.75	3.73	3.71	3.70	3.68	3.66	3.64	3.63	3.61	3.59	3.58	3.56	3.54	3.52
81.5	3.98	3.96	3.94	3.93	3.91	3.89	3.88	3.86	3.84	3.82	3.81	3.79	3.77	3.75	3.74	3.72	3.70	3.68	3.67	3.65	3.63	3.61	3.60	3.58	3.56
81.9	4.02	4.00	3.98	3.97	3.95	3.93	3.91	3.90	3.88	3.86	3.84	3.83	3.81	3.79	3.78	3.76	3.74	3.72	3.71	3.69	3.67	3.65	3.64	3.62	3.60
82.3	4.06	4.04	4.02	4.01	3.99	3.97	3.95	3.94	3.92	3.90	3.88	3.87	3.85	3.83	3.81	3.80	3.78	3.76	3.74	3.73	3.71	3.69	3.67	3.66	3.64
82.7	4.10	4.08	4.06	4.04	4.03	4.01	3.99	3.97	3.96	3.94	3.92	3.91	3.89	3.87	3.85	3.84	3.82	3.80	3.78	3.77	3.75	3.73	3.71	3.70	3.68

PREDICTION EQUATIONS FOR FVC FEMALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS)																								
	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
51.2	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.25	1.24	1.23	1.21
51.6	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.34	1.33	1.32	1.30	1.29	1.28	1.26	1.25	1.24
52.0	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.31	1.30	1.29	1.27	1.26
52.4	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.32	1.31	1.29	1.28
52.8	1.60	1.58	1.57	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.33	1.32	1.31	1.30
53.2	1.61	1.60	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.34	1.33	1.33	1.32	1.30
53.5	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.37	1.36	1.35	1.34	1.33
53.9	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.39	1.37	1.36	1.35	1.34
54.3	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35
54.7	1.67	1.65	1.64	1.63	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.38	1.37
55.1	1.68	1.67	1.65	1.64	1.63	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.44	1.43	1.42	1.41	1.40	1.39
55.5	1.70	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.45	1.44	1.43	1.42	1.41	1.40
55.9	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.42	1.41
56.3	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.42
56.7	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43
57.1	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.46	1.45
57.5	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48	1.46
57.9	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.49	1.48
58.3	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.49
58.7	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50
59.1	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51
59.4	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52
59.8	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53
60.2	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56	1.55
60.6	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57	1.56
61.0	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.78	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59	1.57
61.4	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.59
61.8	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60
62.2	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61
62.6	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62
63.0	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65	1.63
63.4	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66	1.65
63.8	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67	1.66
64.2	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68	1.67
64.6	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70	1.68
65.0	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71	1.70
65.4	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73	1.71
65.7	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74	1.73
66.1	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76	1.74
66.5	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77	1.76
66.9	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79	1.77
67.4	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80	1.79
67.7	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82	1.80
68.1	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83	1.82
68.5	2.19	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85	1.83
68.9	2.21	2.19	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86	1.85
69.3	2.22	2.21	2.19	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88	1.86
69.7	2.24	2.22	2.21	2.19	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89	1.88
70.1	2.25	2.24	2.22	2.21	2.19	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91	1.89
70.5	2.27	2.25	2.24	2.22	2.21	2.19	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92	1.91
70.9	2.28	2.27	2.25	2.24	2.22	2.21	2.19	2.18	2.16	2.15	2.13	2.12	2.10	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.92
71.3	2.30	2.28	2.27	2.25	2.24	2.22	2.21	2.19	2.18	2.16	2.15	2.13	2.12	2.11	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.98	1.97	1.96
71.7	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02	2.00	1.99
72.0	2.33	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.13	2.12	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02	2.00
72.4	2.34	2.33	2.31	2.30	2.28	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.04	2.03
72.8	2.36	2.34	2.33	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.04
73.2	2.37	2.36	2.34	2.33	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05
73.6	2.39	2.37	2.36	2.34	2.33	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.21	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.11	2.09	2.08	2.07
74.0	2.40	2.39	2.37	2.36	2.34	2.33	2.31	2.30	2.28	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.11	2.09	2.08
74.4	2.42	2.40	2.39	2.37	2.36	2.34	2.33	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.13	2.12	2.11	2.09
74.8	2.43	2.42	2.40	2.39	2.37	2.36	2.34	2.33	2.31	2.30	2.29	2.27	2.26	2.25	2.23	2.22	2.21	2.20	2.19	2.17	2.16	2.15	2.14	2.12	2.11

PREDICTION EQUATIONS FOR FVC

FEMALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS)																							
	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
51.2	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.11	1.10	1.06	1.07	1.06	1.04	1.03	1.02	1.00	0.99	0.98	0.96	0.95	0.94	0.92	0.91	0.90	0.88
51.6	1.22	1.21	1.20	1.18	1.17	1.16	1.14	1.13	1.12	1.10	1.09	1.08	1.07	1.05	1.04	1.03	1.01	1.00	0.99	0.97	0.96	0.95	0.93	0.92	0.91	0.91
52.0	1.23	1.22	1.21	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.07	1.06	1.05	1.03	1.02	1.01	0.99	0.98	0.97	0.96	0.94	0.93	0.92	0.91
52.4	1.25	1.24	1.22	1.21	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.07	1.06	1.05	1.03	1.02	1.01	0.99	0.98	0.97	0.96	0.94	0.93	0.93
52.8	1.26	1.25	1.24	1.22	1.21	1.20	1.18	1.17	1.16	1.14	1.13	1.12	1.11	1.09	1.08	1.07	1.06	1.04	1.03	1.02	1.00	0.99	0.98	0.96	0.95	0.94
53.2	1.28	1.27	1.25	1.24	1.23	1.21	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10	1.09	1.08	1.07	1.05	1.04	1.03	1.01	1.00	0.99	0.98	0.96
53.5	1.29	1.28	1.27	1.25	1.24	1.22	1.21	1.20	1.18	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.09	1.07	1.06	1.05	1.03	1.02	1.01	1.00	0.99	0.97
53.9	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.01	1.00	0.98
54.3	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.16	1.15	1.14	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.01	1.00
54.7	1.34	1.33	1.31	1.30	1.29	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.07	1.06	1.05	1.04	1.03	1.02
55.1	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.12	1.11	1.10	1.08	1.07	1.06	1.05	1.04	1.03
55.5	1.37	1.36	1.34	1.33	1.32	1.30	1.29	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.18	1.17	1.16	1.14	1.13	1.12	1.10	1.09	1.08	1.06	1.05	1.04
55.9	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.09	1.08	1.06
56.3	1.40	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.09	1.08
56.7	1.41	1.40	1.38	1.37	1.36	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.09
57.1	1.43	1.42	1.41	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11
57.5	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12
57.9	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13
58.3	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.18	1.17	1.16	1.14
58.7	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.15
59.1	1.50	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17
59.4	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18
59.8	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20
60.2	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22	1.21
60.6	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.25	1.24	1.23
61.0	1.57	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24
61.4	1.59	1.57	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.28	1.27	1.26	1.25
61.8	1.60	1.58	1.57	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26
62.2	1.62	1.61	1.59	1.58	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27
62.6	1.63	1.62	1.61	1.59	1.58	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.33	1.32	1.31	1.30	1.28
63.0	1.65	1.64	1.62	1.61	1.59	1.58	1.56	1.54	1.53	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.33	1.32	1.31	1.30
63.4	1.66	1.65	1.64	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32
63.8	1.68	1.66	1.65	1.64	1.62	1.61	1.59	1.58	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33
64.2	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36
64.6	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37
65.0	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39
65.4	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40
65.8	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45	1.44	1.42	1.41
66.2	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45	1.44	1.42
66.5	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45	1.44
66.9	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45
67.3	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46
67.7	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48
68.1	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49
68.5	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50
68.9	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52
69.3	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53
69.7	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54
70.1	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56
70.5	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57
70.9	1.95	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.59
71.3	1.96	1.94	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.59
71.7	1.98	1.96	1.95	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.62	1.61
72.0	1.99	1.97	1.96	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.62
72.4	2.00	1.99	1.97	1.96	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.67	1.65	1.64
72.8	2.02	2.00	1.99	1.97	1.96	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.67	1.65
73.2	2.03	2.01	2.00	1.98	1.97	1.95	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68	1.67
73.6	2.04	2.03	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69	1.68
74.0	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71	1.69
74.4	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72	1.71
74.8	2.09	2.07	2.06	2.04	2.03	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90	1.89	1.87	1.86	1.84	1.83	1.81	1.80	1.78	1.77	1.75	1.74	1.72

PREDICTION EQUATIONS FOR MVV MALES * 66% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
59.1	74.	75.	76.	70.	69.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.	58.	58.	57.	57.
59.4	75.	76.	77.	71.	70.	70.	69.	69.	68.	67.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.	58.	58.
59.8	76.	77.	78.	72.	71.	71.	70.	69.	69.	68.	67.	67.	67.	66.	65.	65.	64.	63.	63.	62.	62.	61.	60.	60.	59.
60.2	77.	78.	79.	74.	73.	73.	72.	71.	70.	69.	69.	68.	68.	67.	67.	66.	65.	65.	64.	64.	63.	62.	62.	61.	60.
60.6	78.	79.	81.	75.	74.	74.	73.	72.	71.	71.	70.	69.	69.	68.	68.	67.	67.	66.	65.	65.	64.	63.	63.	62.	62.
61.0	79.	81.	82.	76.	76.	75.	74.	73.	72.	72.	71.	70.	70.	69.	69.	68.	67.	67.	66.	66.	65.	64.	64.	63.	63.
61.4	81.	82.	83.	78.	77.	76.	75.	74.	73.	73.	72.	71.	71.	70.	70.	69.	68.	68.	67.	67.	66.	65.	65.	64.	64.
61.8	82.	83.	84.	79.	78.	77.	76.	75.	74.	74.	73.	72.	72.	71.	71.	70.	69.	69.	68.	68.	67.	67.	66.	65.	65.
62.2	83.	84.	85.	80.	79.	78.	77.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	69.	68.	68.	67.	67.	67.
62.6	84.	85.	86.	81.	80.	79.	78.	77.	76.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	69.	68.	68.	68.
63.0	85.	86.	87.	83.	81.	80.	79.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.	70.	70.	69.	69.
63.4	86.	87.	88.	84.	83.	81.	80.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	73.	73.	72.	72.	71.	71.	71.	70.
63.8	87.	88.	89.	85.	84.	82.	81.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	73.	73.	72.	72.	72.	71.
64.2	88.	89.	90.	86.	85.	83.	82.	81.	81.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	73.
64.6	89.	91.	92.	88.	86.	84.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.
65.0	91.	92.	93.	89.	88.	86.	85.	84.	84.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.
65.4	92.	93.	94.	90.	89.	87.	86.	86.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	76.
65.7	93.	94.	95.	91.	90.	89.	88.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	78.	78.
66.1	94.	95.	96.	92.	91.	90.	89.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	82.	81.	81.	80.	79.
66.5	95.	96.	97.	93.	92.	91.	90.	89.	89.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	83.	82.	82.	81.	80.
66.9	96.	97.	98.	94.	93.	92.	91.	90.	90.	89.	89.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	83.	82.	81.
67.3	97.	98.	99.	96.	94.	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	87.	87.	86.	85.	85.	85.	84.	84.	83.	83.
67.7	98.	99.	100.	97.	96.	94.	94.	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	87.	87.	86.	86.	85.	85.	84.	84.
68.1	99.	100.	102.	98.	97.	96.	95.	94.	94.	93.	92.	92.	91.	91.	90.	90.	89.	88.	88.	87.	87.	86.	86.	85.	85.
68.5	100.	102.	103.	100.	98.	97.	96.	95.	95.	94.	94.	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	86.	86.
68.9	102.	103.	104.	101.	100.	99.	98.	97.	96.	96.	95.	94.	94.	93.	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.
69.3	103.	104.	105.	103.	102.	101.	100.	99.	98.	97.	97.	96.	95.	95.	94.	94.	93.	93.	92.	92.	91.	91.	90.	90.	89.
69.7	104.	105.	106.	104.	103.	102.	101.	100.	99.	99.	98.	97.	97.	96.	96.	95.	95.	94.	94.	93.	93.	92.	92.	91.	90.
70.1	105.	106.	107.	105.	104.	103.	102.	101.	101.	100.	99.	99.	98.	98.	97.	97.	96.	96.	95.	95.	94.	94.	93.	92.	91.
70.5	106.	107.	108.	106.	106.	104.	103.	102.	102.	101.	100.	100.	99.	99.	98.	98.	97.	97.	96.	96.	95.	95.	94.	93.	93.
70.9	107.	108.	109.	108.	107.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	99.	98.	98.	97.	97.	96.	96.	95.	95.	94.
71.3	108.	109.	110.	109.	108.	106.	106.	105.	104.	104.	103.	102.	102.	101.	101.	100.	100.	99.	99.	98.	98.	97.	97.	96.	95.
71.7	109.	110.	111.	110.	109.	108.	107.	106.	106.	105.	104.	104.	103.	103.	102.	102.	101.	100.	100.	100.	99.	98.	98.	97.	96.
72.0	110.	111.	113.	111.	110.	109.	108.	107.	107.	106.	105.	105.	104.	104.	103.	103.	102.	102.	101.	101.	100.	100.	99.	98.	98.
72.4	112.	113.	114.	113.	111.	111.	109.	109.	108.	107.	107.	106.	105.	105.	104.	104.	103.	103.	102.	102.	102.	101.	100.	100.	99.
72.8	113.	114.	115.	114.	113.	112.	111.	110.	109.	109.	108.	107.	107.	106.	106.	105.	105.	104.	104.	103.	103.	102.	102.	101.	100.
73.2	114.	115.	116.	115.	114.	113.	112.	111.	111.	110.	109.	109.	108.	108.	107.	107.	106.	106.	105.	105.	104.	104.	103.	103.	101.
73.6	115.	116.	117.	116.	115.	114.	113.	113.	112.	111.	111.	110.	110.	109.	109.	108.	108.	107.	107.	106.	106.	105.	105.	104.	103.
74.0	116.	117.	118.	117.	116.	115.	114.	114.	113.	112.	112.	111.	111.	110.	110.	109.	109.	108.	108.	107.	107.	106.	106.	105.	104.
74.4	117.	118.	119.	118.	117.	116.	115.	115.	114.	113.	113.	112.	112.	111.	111.	110.	110.	109.	109.	108.	108.	107.	107.	106.	105.
74.8	118.	119.	120.	119.	118.	117.	116.	116.	115.	114.	114.	113.	113.	112.	112.	111.	111.	110.	110.	109.	109.	108.	108.	107.	106.
75.2	119.	120.	121.	120.	119.	118.	117.	117.	116.	115.	115.	114.	114.	113.	113.	112.	112.	111.	111.	110.	110.	109.	109.	108.	108.
75.6	120.	121.	122.	121.	120.	119.	118.	118.	117.	116.	116.	115.	115.	114.	114.	113.	113.	112.	112.	111.	111.	110.	110.	110.	109.
76.0	121.	122.	123.	122.	121.	120.	119.	119.	118.	117.	117.	116.	116.	115.	115.	114.	114.	113.	113.	112.	112.	111.	111.	111.	110.
76.4	122.	123.	124.	123.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	116.	115.	115.	114.	114.	113.	113.	112.	112.	112.	111.
76.8	123.	124.	125.	124.	123.	122.	122.	121.	120.	120.	119.	119.	118.	118.	117.	117.	116.	115.	115.	114.	114.	113.	113.	113.	112.
77.2	124.	125.	126.	125.	124.	123.	123.	122.	122.	121.	120.	120.	119.	119.	118.	118.	117.	117.	116.	116.	115.	115.	114.	114.	113.
77.6	125.	126.	127.	126.	125.	124.	124.	123.	123.	122.	122.	121.	121.	120.	120.	119.	119.	118.	118.	118.	117.	116.	116.	115.	115.
78.0	126.	127.	128.	127.	126.	125.	125.	124.	124.	123.	123.	122.	122.	121.	121.	120.	120.	119.	119.	118.	118.	117.	117.	116.	116.
78.3	127.	128.	129.	128.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	121.	121.	120.	120.	119.	119.	118.	118.	117.	117.
78.7	128.	129.	130.	129.	128.	127.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	121.	121.	120.	120.	119.	119.	118.	118.
79.1	129.	130.	131.	130.	129.	128.	128.	127.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	121.	121.	120.	120.	119.	118.
79.5	130.	131.	132.	131.	130.	129.	129.	128.	128.	127.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	121.	121.	120.	119.
79.9	131.	132.	134.	132.	131.	130.	130.	129.	129.	128.	128.	127.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	121.	120.
80.3	132.	134.	135.	134.	132.	131.	131.	130.	130.	129.	129.	128.	128.	127.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	121.
80.7	134.	135.	136.	135.	134.	132.	132.	131.	131.	130.	130.	129.	129.	128.	128.	127.	127.	126.	126.	125.	125.	124.	124.	123.	122.
81.1	135.	136.	138.	136.	135.	134.	133.	132.	132.	131.	131.	130.	130.	129.	129.	128.	128.	127.	127.	126.	126.	125.	125.	124.	123.
81.5	136.	138.	139.	138.	136.	135.	134.	134.	133.	132.	132.	131.	131.	130.	130.	129.	129.	128.	128.	127.	127.	126.	126.	125.	124.
81.9	138.	139.	140.	139.	138.	136.	135.	135.	134.	133.	133.	132.	132.	131.	131.	130.	130.	129.	129.	128.	128.	127.	127.	126.	125.
82.3	139.	140.	141.	140.	139.	138.	137.	136.	135.	135.	134.	133.	133.	132.	132.	131.	131.	130.	130.	129.	129.	128.	128.	127.	126.
82.7	140.	141.	142.	141.	140.	139.	138.	137.	136.	136.	135.	134.	134.	133.	133.	132.	132.	131.	131.	130.	130.	129.	129.	128.	127.
83.1	141.	142.	144.	142.	141.	140.	139.	138.	137.	137.	136.	135.	135.	134.	134.	133.	133.	132.	132.	131.	131.	130.	130.	129.	128.
83.5	142.	144.	145.	144.	142.	141.	140.	139.	138.	138.	137.	136.	136.	135.	135.	134.	134.	133.	133.	132.	132.	131.	131.	130.	129.
83.9	144.	145.	146.	145.	144.	142.	141.	140.	139.	139.	138.	137.	137.	136.	136.	135.	135.	134.	134.	133.	133.	132.	132.	131.	130.
84.3	145.	146.	148.	146.	145.	144.	142.	141.	140.	140.	139.	138.	138.	137.	137.	136.	136.	135.	135.	134.	134.	133.	133.	132.	131.
84.7	146.	148.	149.	148.	146.	145.	144.	143.	142.	141.	140.	140.	139.	139.	138.	138.	137.	137.	136.	136.	135.	135.	134.	133.	133.
85.1	148.	149.	150.	149.	148.	146.	145.	144.	143.	142.	142.	141.	140.	140.	139.	139.	138.	138.	137.	137.	136.	136.	135.	135.	134.
85.5	149.	150.	152.	150.	149.	148.	147.	146.	145.	144.	143.	142.	142.	141.	141.	140.	140.	139.	139.	138.	138.	137.	137.	136.	135.
85.9	150.	152.	153.	152.	150.	149.	148.	147.	146.	145.	144.	144.	143.	142.	142.	141.	141.	140.	140.	139.	139.	138.	138.	137.	137.
86.3	152.	153.	154.	153.	152.	151.	149.	148.	147.	147.	146.	145.	144.	144.	143.	142.	142.	141.	141.	140.	140.	139.	139.	138.	138.
86.7	153.	154.	156.	154.	153.	152.	151.	150.	149.	148.	147.	146.	146.	145.	144.	144.	143.	142.	142.	141.	141.	140.	140.	139.	139.
87.1	154.	156.	157.	156.	154.	153.	152.	151.	150.	149.	149.	148.	147.	146.	146.	145.	144.	144.	143.	142.	142.	141.	141.	140.	140.
87.5	156.	157.	158.	157.	156.	154.	153.	152.	152.	151.	150.	149.	148.	148.	147.	146.	146.	145.	144.	144.	143.	142.	142.	141.	141.
87.9	157.	158.	160.	158.	157.	156.	155.	154.	153.	152.	151.	150.	150.	149.	148.	148.	147.	146.	146.	145.	144.	144.	143.	142.	142.
88.3	158.	160.	161.	160.	158.	157.	156.	155.	154.	153.	153.	152.	151.	150.	150.	149.	148.	148.	147.	146.	146.	145.	144.	144.	143.
88.7	160.	161.	162.	161.	160.	158.	157.	156.	156.	155.	154.	153.	152.	152.	151.	150.	150.	149.	148.	148.	147.	146.	146.	145.	144.
89.1	161.	162.	164.	162.	161.	160.	159.	158.	157.	156.	155.	154.	154.	153.	152.	152.	151.	150.	150.	149.	148.	148.	147.	146.	146.
89.5	162.	164.	165.	164.	162.	161.	160.	159.	158.	157.	157.	156.	155.	154.	154.	153.	152.	152.	151.	150.	150.	149.	148.	148.	147.
89.9	164.	165.	166.	165.	164.	162.	161.	160.	160.	159.	158.	157.	156.	156.	155.	154.	154.	153.	152.	152.	151.	150.	150.	149.	148.
90.3	165.	166.	168.	166.	165.	164.	163.	162.	161.	160.	159.	158.	158.	157.	156.	156.	155.	154.	154.	153.	152.	152.	151.	150.	150.
90.7	166.	168.	169.	168.	166.	165.	164.	163.	162.	161.	161.	160.	159.	158.	158.	157.	156.	156.	155.	154.	154.	153.	152.	152.	151.
91.1	168.	169.	170.	169.	168.	166.	165.	164.	164.	163.	162.	161.	160.	160.	159.	158.	158.	157.	156.	156.	155.	154.	154.	153.	152.
91.5	169.	170.	172.	170.	169.	168.	167.	166.	165.	164.	163.	162.	162.	161.	160.	160.	159.	158.	158.	157.	156.	156.	155.	154.	154.
91.9	170.	172.	173.	172.	170.	169.	168.	167.	166.	165.	165.	164.	163.	162.	162.	161.	160.	160.	159.	158.	158.	157.	156.	156.	155.
92.3	172.	173.	174.	173.	172.	170.	169.	168.	168.	167.	166.	165.	164.	164.	163.	162.	162.	161.	160.	160.	159.	158.	158.	157.	156.
92.7	173.	174.	176.	174.	173.	172.	171.	170.	169.	168.	167.	166.	166.	165.	164.	164.	163.	162.	162.	161.	160.	160.	159.	158.	158.
93.1	174.	176.	177.	176.	174.	173.	172.	171.	170.	169.	169.	168.	167.	166.	166.	165.	164.	164.	163.	162.	162.	161.	160.	160.	159.
93.5	176.	177.	178.	177.	176.	174.	173.	172.	172.	171.	170.	169.	168.	168.	167.	166.	166.	165.	164.	164.	163.	162.	162.	161.	160.
93.9	177.	178.	180.	178.	177.	176.	175.	174.	173.	172.	171.	170.	170.	169.	168.	168.	167.	166.	166.	165.	164.	164.	163.	162.	162.
94.3	178.	180.	181.	180.	178.	177.	176.	175.	174.	173.	173.	172.	171.	170.	170.	169.	168.	168.	167.	166.	166.	165.	164.	164.	163.
94.7	180.	181.	182.	181.	180.	178.	177.	176.	176.	175.	174.	173.	172.	172.	171.	170.	170.	169.	168.	168.	167.	166.	166.	165.	164.
95.1	181.	182.	184.	182.	181.	180.	179.	178.	177.	176.	175.	174.	174.	173.	172.	172.	171.	170.	170.	169.	168.	168.	167.	166.	166.
95.5	182.	184.	185.	184.	182.	181.	180.	179.	178.	177.	177.	176.	175.	174.	174.	173.	172.	172.	171.	170.	170.	169.	168.	168.	167.
95.9	184.	185.	186.	185.	184.	182.	181.	180.	180.	179.	178.	177.	176.	176.	175.	174.	174.	173.	172.	172.	171.	170.	170.	169.	168.
96.3	185.	186.	188.	186.	185.	184.	183.	182.	181.	180.	179.	178.	178.	177.	176.	176.	175.	174.	174.	173.	172.	172.	171.	170.	170.
96.7	186.	188.	189.	188.	186.	185.	184.	183.	182.	181.	181.	180.	179.	178.	178.	177.	176.	176.	175.	174.	174.	173.	172.	172.	171.
97.1	188.	189.	190.	189.	188.	186.	185.	184.	184.	183.	182.	181.	180.	180.	179.	178.	178.	177.	176.	176.	175.	174.	174.	173.	172.
97.5	189.	190.	192.	190.	189.	188.	187.	186.	185.	184.	183.	182.	182.	181.	180.	180.	179.	178.	178.	177.	176.	176.	175.	174.	174.
97.9	190.	192.	193.	192.	190.	189.	188.	187.	186.	185.	185.	184.	183.	182.	182.	181.	180.	180.	179.	178.	178.	177.	176.	176.	175.
98.3	192.	193.	194.	193.	192.	190.	189.	188.	188.	187.	186.	185.	184.	184.	183.	182.	182.	181.	180.	180.	179.	178.	178.	177.	176.
98.7	193.	194.	196.	194.	193.	192.	191.	190.	189.	188.	187.	186.	186.	185.	184.	184.	183.	182.	182.	181.	180.	180.	179.	178.	178.
99.1	194.	196.	197.	196.	194.	193.	192.	191.	190.	189.	189.	188.	187.	186.	186.	185.	184.	184.	183.	182.	182.	181.	180.	180.	179.
99.5	196.	197.	198.	197.	196.	194.	193.	192.	192.	191.	190.	189.	188.	188.	187.	186.	186.	185.	184.	184.	183.	182.	182.	181.	180.
99.9	197.	198.	200.	198.	197.	196.	195.	194.	193.	192.	191.	190.	190.	189.	188.	188.	187.	186.	186.	185.	184.	184.	183.	182.	182.
100.3	198.	200.	201.	200.	198.	197.	196.	195.	194.	193.	193.	192.	191.	190.	190.	189.	188.	188.	187.	186.	186.	185.	184.	184.	183.
100.7	200.	201.	202.	201.	200.	198.	197.	196.	196.	195.	194.	193.	192.	192.	191.	190.	190.	189.	188.	188.	187.	186.	186.	185.	184.
101.1	201.	202.	204.	202.	201.	200.	199.	198.	197.	196.	195.	194.	194.	193.	192.	192.	191.	190.	190.	189.	188.	188.	187.	186.	186.
101.5	202.	204.	205.	204.	202.	201.	200.	199.	198.	197.	197.	196.	195.	194.	194.	193.	192.	192.	191.	190.	190.	189.	188.	188.	187.
101.9	204.	205.	206.	205.	204.	202.	201.	200.	200.	199.	198.	197.	196.	196.	195.	194.	194.	193.	192.	192.	191.	190.	190.	189.	188.
102.3	205.	206.	208.	206.	205.	204.	203.	202.	201.	200.	199.	198.	198.	197.	196.	196.	195.	194.	194.	193.	192.	192.	191.	190.	190.
102.7	206.	208.	209.	208.	206.	205.	204.	203.	202.	201.	201.	200.	199.	198.	198.	197.	196.	196.	195.	194.	194.	193.	192.	192.	191.
103.1	208.	209.	210.	209.	208.	206.	205.	204.	204.	203.	202.	201.	200.	200.	199.	198.	198.	197.	196.	196.	195.	194.	194.	193.	192.
103.5	209.	210.	212.	210.	209.	208.	207.	206.	205.	204.	203.	202.	202.	201.	200.	200.	199.	198.	198.	197.	196.	196.	195.	194.	194.
103.9	210.	212.	213.	212.	210.	209.	208.	207.	206.	205.	205.	204.	203.	202.	202.	201.	200.	200.	199.	198.	198.	197.	196.	196.	195.
104.3	212.	213.	214.	213.	212.	210.	209.	208.	208.	207.	206.	205.	204.	204.	203.	202.	202.	201.	200.	200.	199.	198.	198.	197.	196.
104.7	213.	214.	216.	214.	213.	212.	211.	210.	209.	208.	207.	206.	206.	205.	204.	204.	203.	202.	202.	201.	200.	200.	199.	198.	198.
105.1	214.	216.	217.	216.	214.	213.	212.	211.	210.	209.	209.	208.	207.	206.	206.	205.	204.	204.	203.	202.	202.	201.	200.	200.	199.
105.5	216.	217.	218.	217.	216.	214.	213.	212.	212.	211.	210.	209.	208.	208.	207.	206.	206.	205.	204.	204.	203.	202.	202.	201.	200.
105.9	217.	218.	220.	218.	217.	216.	215.	214.	213.	212.	211.	210.	210.	209.	208.	208.	207.	206.	206.	205.	204.	204.	203.	202.	202.
106.3	218.	220.	221.	220.	218.	217.	216.	215.	214.	213.	213.	212.	211.	210.	210.	209.	208.	208.	207.	206.	206.	205.	204.	204.	203.
106.7	220.	221.	222.	221.	220.	218.	217.	216.	216.	215.	214.	213.	212.	212.	211.	210.	210.	209.	208.	208.	207.	206.	206.	205.	204.
107.1	221.	222.	224.	222.	221.	220.	219.	218.	217.	216.	215.	214.	214.	213.	212.	212.	211.	210.	210.	209.	208.	208.	207.	206.	206.
107.5	222.	224.	225.	224.	222.	221.	220.	219.	218.	217.	217.	216.	215.	214.	214.	213.	212.	212.	211.	210.	210.	209.	208.	208.	207.
107.9	224.	225.	226.	225.	224.	222.	221.	220.	220.	219.	218.	217.	216.	216.	215.	214.	214.	213.	212.	212.	211.	210.	210.	209.	208.
108.3	225.	226.	228.	226.	225.	224.	223.	222.	221.	220.	219.	218.	218.	217.	216.	216.	215.	214.	214.	213.	212.	212.	211.	210.	210.
108.7	226.	228.	229.	228.	226.	225.	224.	223.	222.	221.	221.	220.	219.	218.	218.	217.	216.	216.	215.	214.	214.	213.	212.	212.	211.
109.1	228.	229.	230.	229.	228.	226.	225.	224.	224.	223.	222.	221.	220.	220.	219.	218.	218.	217.	216.	216.	215.	214.	214.	213.	212.
109.5	229.	230.	232.	230.	229.	228.	227.	226.	225.	224.	223.	222.	222.	221.	220.	220.	219.	218.	218.	217.	216.	216.	215.	214.	214.
109.9	230.	232.	233.	232.	230.	229.	228.	227.	226.	225.	225.	224.	223.	222.	222.	221.	220.	220.	219.	218.	218.	217.	216.	216.	215.
110.3	232.	233.	234.	233.	232.	230.	229.	228.	228.	227.	226.	225.	224.	224.	223.	222.	222.	221.	220.	220.	219.	218.	218.	217.	216.
110.7	233.	234.	236.	234.	233.	232.	231.	230.	229.	228.	227.	226.	226.	225.	224.	224.	223.	222.	222.	221.	220.	220.	219.	218.	218.
111.1	234.	236.	237.	236.	234.	233.	232.	231.	230.	229.	229.	228.	227.	226.	226.	225.	224.	224.	223.	222.	222.	221.	220.	220.	219.
111.5	236.	237.	238.	237.	236.	234.	233.	232.	232.	231.	230.	229.	228.	228.	227.	226.	226.	225.	224.	224.	223.	222.	222.	221.	220.
111.9	237.	238.	240.	238.	237.	236.	235.	234.	233.	232.	231.	230.	230.	229.	228.	228.	227.	226.	226.	225.	224.	224.	223.	222.	222.
112.3	238.	240.	241.	240.	238.	237.	236.	235.	234.	233.	233.	232.	231.	230.	230.	229.	228.	228.	227.	226.	226.	225.	224.	224.	223.
112.7	240.	241.	242.	241.	240.	238.	237.	236.	236.	235.	234.	233.	232.	232.	231.	230.	230.	229.	228.	228.	227.	226.	226.	225.	224.
113.1	241.	242.	244.	242.	241.	240.	239.	238.	237.	236.	235.	234.	234.	233.	232.	232.	231.	230.	230.	229.	228.	228.	227.	226.	226.
113.5	242.	244.	245.	244.	242.	241.	240.	239.	238.	237.	237.	236.	235.	234.	234.	233.	232.	232.	231.	230.	230.	229.	228.	228.	227.
113.9	244.	245.	246.	245.	244.	242.	241.	240.	240.	239.	238.	237.	236.	236.	235.	234.	234.	233.	232.	232.	231.	230.	230.	229.	228.
114.3	245.	246.	248.	246.	245.	244.	243.	242.	241.	240.	239.	238.	238.	237.	236.	236.	235.	234.	234.	233.	232.	232.	231.	230.	230.
114.7	246.	248.	249.	248.	246.	245.	244.	243.	242.	241.	241.	240.	239.	238.	238.	237.	236.	236.	235.	234.	234.	233.	232.	232.	231.
115.1	248.	249.	250.	249.	248.	246.	245.	244.	244.	243.	242.	241.	240.	240.	239.	238.	238.	237.	236.	236.	235.	234.	234.	233.	232.
115.5	249.	250.	252.	250.	249.	248.	247.	246.	245.	244.	243.	242.	242.	241.	240.	240.	239.	238.	238.	237.	236.	236.	235.	234.	234.
115.9	250.	252.	253.	252.	250.	249.	248.	247.	246.	245.	245.	244.	243.	242.	242.	241.	240.	240.	239.	238.	238.	237.	236.	236.	235.
116.3	252.	253.	254.	253.	252.	250.	249.	248.	248.	247.	246.	245.	244.	244.	243.	242.	242.	241.	240.	240.	239.	238.	238.	237.	236.
116.7	253.	254.	256.	254.	253.	252.	251.	250.	249.	248.	247.	246.	246.	245.	244.	244.

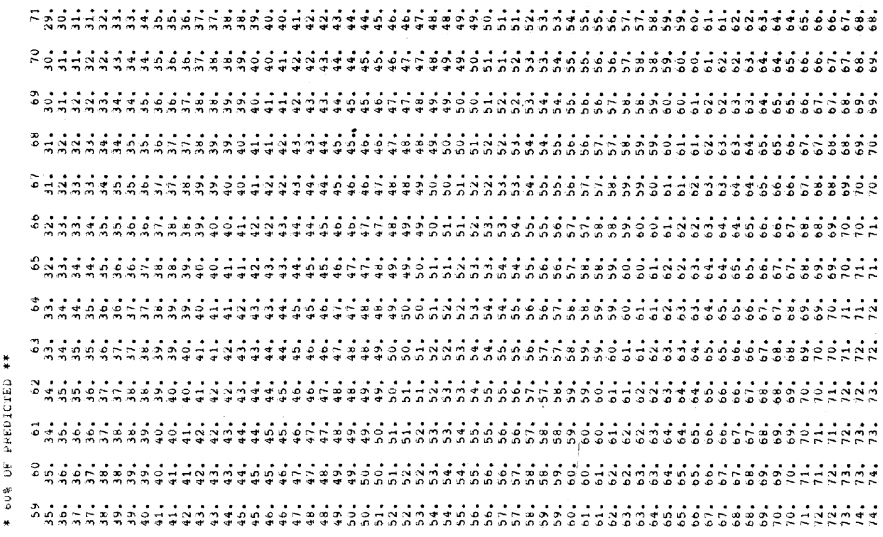
PREDICTION EQUATIONS FOR MVV — MALES — AGE (YEARS) — * 60% OF PREDICTED **

HEIGHT (CM)	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
59.1	56.	55.	55.	54.	54.	53.	52.	51.	51.	50.	49.	49.	48.	47.	47.	46.	46.	45.	44.	44.	43.	42.	42.	42.	40.
59.4	57.	56.	55.	55.	54.	53.	53.	52.	52.	51.	51.	50.	49.	49.	48.	47.	47.	46.	45.	45.	44.	43.	42.	42.	42.
59.8	58.	56.	56.	55.	54.	54.	53.	53.	52.	51.	51.	50.	49.	49.	48.	47.	47.	46.	46.	45.	44.	43.	43.	43.	43.
60.2	59.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	49.	49.	48.	47.	47.	46.	46.	45.	44.	44.	43.	43.
60.6	60.	59.	58.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.	48.	47.	47.	46.	45.	45.	44.	44.
61.0	61.	60.	59.	59.	58.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	49.	49.	48.	47.	47.	46.	46.	45.
61.4	62.	61.	61.	60.	59.	59.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.	48.	48.	47.	47.	46.
61.8	63.	62.	62.	61.	61.	60.	59.	59.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.	48.	48.	47.
62.2	64.	63.	63.	62.	62.	61.	61.	60.	59.	59.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.	48.
62.6	65.	65.	64.	64.	63.	62.	62.	61.	61.	60.	59.	59.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.
63.0	66.	66.	66.	65.	64.	64.	63.	63.	62.	61.	61.	60.	59.	59.	58.	57.	57.	56.	55.	54.	54.	53.	52.	52.	51.
63.4	68.	67.	67.	66.	66.	65.	64.	64.	63.	63.	62.	61.	61.	60.	59.	59.	58.	57.	57.	56.	55.	54.	54.	53.	52.
63.8	69.	68.	68.	67.	67.	66.	66.	65.	64.	64.	63.	63.	62.	61.	61.	60.	60.	59.	58.	57.	57.	56.	55.	54.	54.
64.2	70.	70.	69.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	60.	60.	59.	58.	58.	57.	56.	55.
64.6	72.	71.	71.	70.	70.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	60.	60.	59.	58.	58.	57.
65.0	73.	73.	72.	72.	71.	70.	70.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	60.	60.	59.	58.
65.4	75.	74.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	64.	63.	62.	62.	61.	60.	60.
65.7	77.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.	68.	67.	67.	66.	65.	65.	64.	63.	63.	62.	62.
66.1	78.	78.	77.	76.	76.	75.	74.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	64.	63.
66.5	80.	79.	79.	78.	78.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.
66.9	81.	81.	80.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.	68.	67.	67.
67.3	83.	82.	82.	81.	81.	80.	80.	79.	78.	78.	77.	77.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.
67.7	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	77.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.
68.1	85.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	76.	76.	75.	74.	74.	73.	72.
68.5	87.	86.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	76.	76.	75.	74.
68.9	88.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	77.	77.	76.
69.3	89.	89.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	78.	78.
69.7	90.	90.	90.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	79.
70.1	91.	91.	91.	91.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.
70.5	92.	92.	92.	92.	92.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.
70.9	93.	93.	93.	93.	93.	93.	93.	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.
71.3	95.	94.	94.	94.	94.	94.	94.	94.	94.	93.	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.
71.7	96.	96.	95.	95.	95.	95.	95.	95.	95.	95.	94.	94.	93.	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.
72.0	97.	97.	96.	96.	96.	96.	96.	96.	96.	96.	96.	95.	95.	94.	94.	93.	93.	92.	92.	91.	91.	90.	90.	89.	89.
72.4	98.	98.	98.	97.	97.	97.	97.	97.	97.	97.	97.	97.	96.	96.	95.	95.	94.	94.	93.	93.	92.	92.	91.	91.	90.
72.8	100.	99.	99.	99.	98.	98.	98.	98.	98.	98.	98.	98.	98.	97.	97.	96.	96.	95.	95.	94.	94.	93.	93.	92.	91.
73.2	101.	100.	100.	100.	99.	99.	99.	99.	99.	99.	99.	99.	99.	98.	98.	97.	97.	96.	96.	95.	95.	94.	94.	93.	93.
73.6	102.	102.	101.	101.	101.	100.	100.	100.	100.	100.	100.	100.	100.	99.	99.	98.	98.	97.	97.	96.	96.	95.	95.	94.	94.
74.0	103.	103.	103.	102.	102.	102.	101.	101.	101.	101.	101.	101.	101.	100.	100.	100.	99.	99.	98.	98.	97.	97.	96.	96.	95.
74.4	105.	104.	104.	104.	103.	103.	103.	102.	102.	102.	102.	102.	102.	101.	101.	101.	100.	100.	100.	99.	99.	98.	98.	97.	96.
74.8	106.	106.	105.	105.	105.	104.	104.	104.	103.	103.	103.	103.	103.	102.	102.	102.	101.	101.	101.	100.	100.	99.	99.	98.	98.
75.2	107.	107.	106.	106.	106.	106.	105.	105.	105.	104.	104.	104.	104.	103.	103.	103.	102.	102.	102.	101.	101.	100.	100.	99.	99.
75.6	108.	108.	108.	107.	107.	107.	106.	106.	106.	106.	105.	105.	105.	104.	104.	104.	103.	103.	103.	102.	102.	101.	101.	100.	100.
76.0	110.	109.	109.	108.	108.	108.	107.	107.	107.	106.	106.	106.	105.	105.	105.	104.	104.	104.	103.	103.	102.	102.	101.	101.	100.
76.4	111.	110.	110.	109.	109.	108.	108.	108.	107.	107.	107.	106.	106.	106.	105.	105.	105.	104.	104.	103.	103.	102.	102.	101.	101.
76.8	112.	111.	111.	110.	110.	109.	109.	109.	108.	108.	107.	107.	107.	106.	106.	106.	105.	105.	104.	104.	104.	103.	103.	102.	102.
77.2	113.	113.	112.	112.	111.	111.	110.	110.	109.	109.	109.	108.	108.	107.	107.	107.	106.	106.	105.	105.	105.	104.	104.	103.	103.
77.6	115.	114.	114.	113.	113.	112.	112.	111.	111.	111.	110.	110.	109.	109.	109.	108.	108.	107.	107.	107.	106.	106.	105.	105.	104.
78.0	116.	116.	115.	115.	114.	114.	113.	113.	112.	112.	112.	111.	111.	110.	110.	110.	109.	109.	109.	108.	108.	107.	107.	106.	106.
78.3	117.	117.	116.	116.	116.	115.	115.	114.	114.	114.	113.	113.	112.	112.	112.	111.	111.	111.	110.	110.	109.	109.	109.	108.	108.
78.7	118.	118.	117.	117.	116.	116.	116.	115.	115.	114.	114.	114.	113.	113.	112.	112.	112.	111.	111.	111.	110.	110.	109.	109.	109.
79.1	120.	119.	118.	118.	118.	117.	117.	116.	116.	116.	115.	115.	114.	114.	114.	113.	113.	112.	112.	112.	111.	111.	110.	110.	110.
79.5	121.	120.	119.	119.	119.	118.	118.	117.	117.	117.	116.	116.	116.	115.	115.	114.	114.	114.	113.	113.	112.	112.	112.	111.	110.
79.9	122.	121.	121.	120.	120.	119.	119.	119.	118.	118.	117.	117.	117.	116.	116.	115.	115.	115.	114.	114.	113.	113.	113.	112.	112.
80.3	123.	123.	122.	122.	121.	121.	120.	120.	120.	119.	119.	118.	118.	118.	117.	117.	116.	116.	116.	115.	115.	114.	114.	113.	113.
80.7	125.	124.	124.	123.	123.	122.	122.	121.	121.	121.	120.	120.	119.	119.	119.	118.	118.	117.	117.	117.	116.	116.	115.	115.	114.
81.1	126.	125.	125.	124.	124.	123.	123.	122.	122.	122.	121.	121.	120.	120.	120.	119.	119.	118.	118.	118.	117.	117.	116.	116.	115.
81.5	127.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	122.	121.	121.	120.	120.	120.	119.	119.	118.	118.	117.	117.	116.
81.9	128.	128.	128.	127.	127.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	122.	121.	121.	120.	120.	119.	119.	118.	118.	117.
82.3	130.	129.	129.	128.	128.	127.	127.	126.	126.	125.	125.	124.	124.	124.	123.	123.	122.	122.	121.	121.	120.	120.	119.	119.	118.
82.7	131.	130.	130.	129.	129.	128.	128.	127.	127.	126.	126.	126.	125.	125.	124.	124.	123.	123.	122.	122.	121.	121.	120.	120.	119.

HEIGHT (CM)	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101
59.1	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.	40.
59.4	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.	42.
59.8	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.	43.
60.2	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.	44.
60.6	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.	45.
61.0	47.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.	46.
61.4	48.	48.	48.	48.	48.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.	47.
61.8	49.	49.	49.	49.	49.	49.	49.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.	48.
62.2	50.	50.	50.	50.	50.	50.	50.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.	49.
62.6	51.	51.	51.	51.	51.	51.	51.	51.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.	50.
63.0	52.	52.	52.	52.	52.	52.	52.	52.	52.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.	51.
63.4	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.	52.
63.8	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.	53.
64.2	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.	54.
64.6	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.	55.
65.0	58.	58.	58.	58.	58.	58.	57.	57.	57.	57.	57.	57.	57.	57.	57.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.	56.
65.4	59.	59.	59.	59.	59.	59.	59.	59.	59.	58.	58.	58.	58.	58.	58.	58.	57.	57.	57.	57.	57.	57.	57.	57.	57.	57.	57.	57.	57.	57.
65.7	60.	60.	60.	60.	60.	60.	60.	60.	60.	60.	60.	60.	60.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.	59.
66.1	62.	62.	62.	62.	62.	62.	62.	62.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.	61.
66.5	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.	63.
66.9	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.	65.
67.3	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.	67.
67.7	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.	68.
68.1	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.	70.
68.5	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.	72.
68.9	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.	73.
69.3	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.	75.
69.7	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.	76.
70.1	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.	78.
70.5	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.	79.
70.9	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.	81.
71.3	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.	82.
71.7	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.	84.
72.0	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.	85.
72.4	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.	87.
72.8	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.	88.
73.2	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.	90.
73.6	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.	91.
74.0	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.	93.
74.4	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.	94.
74.8	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.	96.
75.2	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.	97.
75.6	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.	99.
76.0	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.
76.4	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.	102.
76.8	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.	103.
77.2	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.	105.
77.6	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.	106.
78.0	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.	108.
78.3	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.	109.
78.7	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.	111.
79.1	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.	112.
79.5	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.	114.
79.9	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.	115.
80.3	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.	117.
80.7	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.	118.
81.1	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.	120.
81.5	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.	121.
81.9	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.	123.
82.3	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.	124.
82.7	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.	126.

PREDICTION EQUATIONS FOR AVE FEMALES * 80% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
51.2	54.	54.	54.	53.	53.	52.	51.	51.	50.	50.	49.	49.	49.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.
51.6	55.	54.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.
52.0	55.	55.	54.	54.	54.	53.	53.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.
52.4	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.
52.8	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.
53.1	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.
53.5	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.
53.9	59.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.
54.3	59.	59.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.
54.7	60.	59.	59.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.
55.1	61.	60.	59.	59.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.
55.5	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.
55.9	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.
56.3	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.
56.7	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.
57.1	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.
57.5	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.
57.9	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.
58.3	66.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.
58.7	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.
59.1	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.
59.4	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.
59.8	68.	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.
60.2	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.
60.6	70.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.
61.0	70.	70.	69.	68.	68.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.
61.4	71.	70.	69.	69.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.
61.8	72.	71.	70.	69.	69.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.
62.2	72.	72.	71.	70.	69.	69.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.
62.6	73.	72.	72.	71.	70.	69.	69.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.
63.0	74.	73.	72.	72.	71.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.
63.4	74.	74.	73.	72.	72.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.
63.8	75.	74.	73.	73.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.
64.2	75.	75.	74.	73.	73.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.
64.6	76.	76.	75.	74.	74.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.
65.0	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.
65.4	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.
65.7	78.	78.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.
66.1	79.	78.	78.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.
66.5	79.	79.	78.	78.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.
66.9	80.	80.	79.	78.	78.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.
67.3	81.	80.	80.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.
67.7	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.
68.1	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.
68.5	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.
68.9	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.
69.3	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.
69.7	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.
70.1	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.
70.5	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.
70.9	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.
71.3	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.
71.7	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.
72.0	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.
72.4	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.
72.8	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.
73.2	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.
73.6	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.
74.0	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.
74.4	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.
74.8	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.



APPENDIX C TO PART 718—BLOOD-GAS TABLES

The following tables set forth the values to be applied in determining whether total disability may be established in accordance with §718.204(b)(2)(ii). The values contained in the tables are indicative of impairment only. They do not establish a degree of disability except as provided in §718.204(b)(2)(ii) of this subchapter, nor do they establish standards for determining normal alveolar gas exchange values for any particular individual. Tests must not be performed during or soon after an acute respiratory or cardiac illness. A miner who meets the following medical specifications must be found to be totally disabled, in the absence of rebutting evidence, if the values specified in one of the following tables are met:

(1) For arterial blood-gas studies performed at test sites up to 2,999 feet above sea level:

Arterial PCO2 (mm Hg)	Arterial PO2 equal to or less than (mm Hg)
25 or below	75
26	74
27	73
28	72
29	71
30	70
31	69
32	68
33	67
34	66
35	65
36	64
37	63
38	62
39	61
40–49	60
Above 50	(1)

[1] Any value.

(2) For arterial blood-gas studies performed at test sites 3,000 to 5,999 feet above sea level:

Arterial PCO2 (mm Hg)	Arterial PO2 equal to or less than (mm Hg)
25 or below	70
26	69
27	68
28	67
29	66
30	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40–49	55
Above 50	(2)

[2] Any value.

(3) For arterial blood-gas studies performed at test sites 6,000 feet or more above sea level:

Arterial PCO2 (mm Hg)	Arterial PO2 equal to or less than (mm Hg)
25 or below	65
26	64
27	63
28	62
29	61
30	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40–49	50
Above 50	(3)

[3] Any value.

[65 FR 80045, Dec. 20, 2000, as amended at 78 FR 59115, Sept. 25, 2013]

PART 722—CRITERIA FOR DETERMINING WHETHER STATE WORKERS' COMPENSATION LAWS PROVIDE ADEQUATE COVERAGE FOR PNEUMOCONIOSIS AND LISTING OF APPROVED STATE LAWS

Sec.
722.1 Purpose.
722.2 Definitions.
722.3 General criteria; inclusion in and removal from the Secretary's list.
722.4 The Secretary's list.

AUTHORITY: 5 U.S.C. 301, Reorganization Plan No. 6 of 1950, 15 FR 3174, 30 U.S.C. 901 *et seq.*, 921, 932, 936; 33 U.S.C. 901 *et seq.*, Secretary's Order 7–87, 52 FR 48466, Employment Standards Order No. 90–02.

SOURCE: 65 FR 80053, Dec. 20, 2000, unless otherwise noted.

§ 722.1 Purpose.

Section 421 of the Black Lung Benefits Act provides that a claim for benefits based on the total disability or death of a coal miner due to pneumoconiosis must be filed under a State workers' compensation law where such law provides adequate coverage for pneumoconiosis. A State workers' compensation law may be deemed to provide adequate coverage only when it is included on a list of such laws maintained by the Secretary. The purpose of this part is to set forth the procedures and criteria for inclusion on that list, and to provide that list.

§ 722.2 Definitions.

(a) The definitions and use of terms contained in subpart A of part 725 of this title shall be applicable to this part.

(b) For purposes of this part, the following definitions apply:

(1) *State agency* means, with respect to any State, the agency, department or officer designated by the workers' compensation law of the State to administer such law. In any case in which more than one agency participates in the administration of a State workers' compensation law, the Governor of the State may designate which of the agencies shall be the State agency for purposes of this part.

(2) *The Secretary's list* means the list published by the Secretary of Labor in the FEDERAL REGISTER (see §722.4) containing the names of those States which have in effect a workers' compensation law which provides adequate coverage for death or total disability due to pneumoconiosis.

§722.3 General criteria; inclusion in and removal from the Secretary's list.

(a) The Governor of any State or any duly authorized State agency may, at any time, request that the Secretary include such State's workers' compensation law on his list of those State workers' compensation laws providing adequate coverage for total disability or death due to pneumoconiosis. Each such request shall include a copy of the State workers' compensation law and any other pertinent State laws; a copy of any regulations, either proposed or promulgated, implementing such laws; and a copy of any relevant administrative or court decision interpreting such laws or regulations, or, if such decisions are published in a readily available report, a citation to such decision.

(b) Upon receipt of a request that a State be included on the Secretary's list, the Secretary shall include the State on the list if he finds that the State's workers' compensation law guarantees the payment of monthly and medical benefits to all persons who would be entitled to such benefits under the Black Lung Benefits Act at the time of the request, at a rate no less than that provided by the Black Lung Benefits Act. The criteria used by the Secretary in making such determination shall include, but shall not be limited to, the criteria set forth in section 421(b)(2) of the Act.

(c) The Secretary may require each State included on the list to submit reports detailing the extent to which the State's workers' compensation laws, as reflected by statute, regulation, or administrative or court decision, continues to meet the requirements of paragraph (b) of this section. If the Secretary concludes that the State's workers' compensation law does not provide adequate coverage at any time, either because of changes to the State workers' compensation law or the Black Lung Benefits Act, he shall remove the State from the Secretary's list after providing the State with notice of such removal and an opportunity to be heard.

§722.4 The Secretary's list.

(a) The Secretary has determined that publication of the Secretary's list in the Code of Federal Regulations is appropriate. Accordingly, in addition to its publication in the FEDERAL REGISTER as required by section 421 of the Black Lung Benefits Act, the list shall also appear in paragraph (b) of this section.

(b) Upon review of all requests filed with the Secretary under section 421 of the Black Lung Benefits Act and this part, and examination of the workers' compensation laws of the States making such requests, the Secretary has determined that the workers' compensation law of each of the following listed States, for the period from the date shown in the list until such date as the Secretary may make a contrary determination, provides adequate coverage for pneumoconiosis.

State	Period commencing
None	

PART 725—CLAIMS FOR BENEFITS UNDER PART C OF TITLE IV OF THE FEDERAL MINE SAFETY AND HEALTH ACT, AS AMENDED

Subpart A—General

Sec.

725.1 Statutory provisions.
725.2 Purpose and applicability of this part.
725.3 Contents of this part.
725.4 Applicability of other parts in this title.
725.101 Definitions and use of terms.

725.102 Disclosure of program information.
725.103 Burden of proof.

Subpart B—Persons Entitled to Benefits, Conditions, and Duration of Entitlement

725.201 Who is entitled to benefits; contents of this subpart.

CONDITIONS AND DURATION OF ENTITLEMENT: MINER

725.202 Miner defined; conditions of entitlement, miner.
725.203 Duration and cessation of entitlement, miner.

CONDITIONS AND DURATION OF ENTITLEMENT: MINER'S DEPENDENTS (AUGMENTED BENEFITS)

725.204 Determination of relationship; spouse.
725.205 Determination of dependency; spouse.
725.206 Determination of relationship; divorced spouse.
725.207 Determination of dependency; divorced spouse.
725.208 Determination of relationship; child.
725.209 Determination of dependency; child.
725.210 Duration of augmented benefits.
725.211 Time of determination of relationship and dependency of spouse or child for purposes of augmentation of benefits.

CONDITIONS AND DURATION OF ENTITLEMENT: MINER'S SURVIVORS

725.212 Conditions of entitlement; surviving spouse or surviving divorced spouse.
725.213 Duration of entitlement; surviving spouse or surviving divorced spouse.
725.214 Determination of relationship; surviving spouse.
725.215 Determination of dependency; surviving spouse.
725.216 Determination of relationship; surviving divorced spouse.
725.217 Determination of dependency; surviving divorced spouse.
725.218 Conditions of entitlement; child.
725.219 Duration of entitlement; child.
725.220 Determination of relationship; child.
725.221 Determination of dependency; child.
725.222 Conditions of entitlement; parent, brother or sister.
725.223 Duration of entitlement; parent, brother or sister.
725.224 Determination of relationship; parent, brother or sister.
725.225 Determination of dependency; parent, brother or sister.
725.226 ''Good cause'' for delayed filing of proof of support.
725.227 Time of determination of relationship and dependency of survivors.
725.228 Effect of conviction of felonious and intentional homicide on entitlement to benefits.

TERMS USED IN THIS SUBPART

725.229 Intestate personal property.
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AUTHORITY: 5 U.S.C. 301; 28 U.S.C. 2461 note (Federal Civil Penalties Inflation Adjustment Act of 1990); Pub. L. 114–74 at sec. 701; Reorganization Plan No. 6 of 1950, 15 FR 3174; 30 U.S.C. 901 *et seq.*, 902(f), 921, 932, 936; 33 U.S.C. 901 *et seq.;* 42 U.S.C. 405; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 65 FR 80054, Dec. 20, 2000, unless otherwise noted.

Subpart A—General

§ 725.1 Statutory provisions.

(a) *General.* Subchapter IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972, the Federal Mine Safety and Health Amendments Act of 1977, the Black Lung Benefits Reform Act of 1977, the Black Lung Benefits Revenue Act of 1977, the Black Lung Benefits Amendments of 1981, the Black Lung Benefits Revenue Act of 1981, the Black Lung Consolidation of Responsibility Act of 2002, and the Patient Protection and Affordable Care Act of 2010 (together comprising the Black Lung Benefits Act (*see* § 725.101(a)(1)) provides for the payment of benefits to certain disabled coal miners and their survivors. *See* § 725.201.

(b) *Part B.* Part B of subchapter IV of the Act provided that claims filed before July 1, 1973 were to be filed with, and adjudicated and administered by, the Social Security Administration (SSA). If awarded, these claims were paid by SSA out of appropriated funds. The Black Lung Consolidation of Administrative Responsibility Act (*see* paragraph (h) of this section) transferred all responsibility for continued administration of these claims to the Department of Labor.

(c) *Part C.* Claims filed by a miner or survivor on or after January 1, 1974, are filed, adjudicated, and paid under the provisions of part C of subchapter IV of the Act. Part C requires that a claim filed on or after January 1, 1974, shall be filed under an applicable approved State workers' compensation law, or if no such law has been approved by the Secretary of Labor, the claim may be filed with the Secretary of Labor under Section 422 of the Act. Claims filed with the Secretary of Labor under part

C are processed and adjudicated by the Secretary. Individual coal mine operators are primarily liable for benefits; however, if the miner's last coal mine employment terminated before January 1, 1970, or if no responsible operator can be identified, benefits are paid by the Black Lung Disability Trust Fund. Claims adjudicated under part C are subject to certain incorporated provisions of the Longshore and Harbor Workers' Compensation Act.

(d) *Changes made by the Black Lung Benefits Reform Act of 1977.* The Black Lung Benefits Reform Act of 1977 contains a number of significant amendments to the Act's standards for determining eligibility for benefits. Among these are:

(1) A provision which clarifies the definition of ''pneumoconiosis'' to include any ''chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment'';

(2) A provision which defines ''miner'' to include any person who works or has worked in or around a coal mine or coal preparation facility, and in coal mine construction or coal transportation under certain circumstances;

(3) A provision that continued employment in a coal mine is not conclusive proof that a miner is not or was not totally disabled;

(4) A provision which authorizes the Secretary of Labor to establish standards and develop criteria for determining total disability or death due to pneumoconiosis with respect to a part C claim;

(5) Provisions relating to the treatment to be accorded a survivor's affidavit, certain X-ray interpretations, and certain autopsy reports in the development of a claim; and

(6) Other clarifying, procedural, and technical amendments.

(e) *Changes made by the Black Lung Benefits Revenue Act of 1977.* The Black Lung Benefits Revenue Act of 1977 established the Black Lung Disability Trust Fund which is financed by a specified tax imposed upon each ton of coal (except lignite) produced and sold or used in the United States after March 31, 1978. The Secretary of the Treasury is the managing trustee of the fund and benefits are paid from the fund upon the direction of the Secretary of Labor. The fund was made liable for the payment of all claims approved under part C of the Act for all periods of eligibility occurring on or after January 1, 1974, with respect to claims where the miner's last coal mine employment terminated before January 1, 1970, or where individual liability can not be assessed against a coal mine operator due to bankruptcy, insolvency, or the like. The fund was also authorized to pay certain claims which a responsible operator has refused to pay within a reasonable time, and to seek reimbursement from such operator. The purpose of the fund and the Black Lung Benefits Revenue Act of 1977 was to insure that coal mine operators, or the coal industry, will fully bear the cost of black lung disease for the present time and in the future. The Black Lung Benefits Revenue Act of 1977 also contained other provisions relating to the fund and authorized a coal mine operator to establish its own trust fund for the payment of certain claims.

(f) *Changes made by the Black Lung Benefits Amendments of 1981.* The Black Lung Benefits Amendments of 1981 made a number of significant changes in the Act's standards for determining eligibility for benefits and concerning the payment of such benefits, and applied the changes to claims filed on or after January 1, 1982. Among these are:

(1) The Secretary of Labor may reread any X-ray submitted in support of a claim and may rely upon a second opinion concerning such an X-ray as a means of auditing the validity of the claim;

(2) The rebuttable presumption that the total disability of a miner with fifteen or more years employment in the coal mines, who has demonstrated a totally disabling respiratory or pulmonary impairment, is due to pneumoconiosis is no longer applicable (but the presumption was reinstated for claims filed after January 1, 2005, and pending on or after March 23, 2010, by the Patient Protection and Affordable Care Act of 2010 (*see* paragraph (i) of this section));

(3) In the case of deceased miners, where no medical or other relevant evidence is available, only affidavits from

persons not eligible to receive benefits as a result of the adjudication of the claim will be considered sufficient to establish entitlement to benefits;

(4) Unless the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982, benefits are payable on survivors' claims filed on and after January 1, 1982, only when the miner's death was due to pneumoconiosis (but for survivors' claims filed after January 1, 2005, and pending on or after March 23, 2010, an award of a miner's claim may form the basis for a survivor's entitlement under the Patient Protection and Affordable Care Act of 2010 (*see* paragraph (i) of this section));

(5) Benefits payable under this part are subject to an offset on account of excess earnings by the miner; and

(6) Other technical amendments.

(g) *Changes made by the Black Lung Benefits Revenue Act of 1981.* The Black Lung Benefits Revenue Act of 1981 temporarily doubles the amount of the tax upon coal until the fund has repaid all advances received from the United States Treasury and the interest on all such advances. With respect to claims filed on or after January 1, 1982, the fund's authorization for the payment of interim benefits is limited to the payment of prospective benefits only. These changes also define the rates of interest to be paid to and by the fund.

(h) *Changes made by the Black Lung Consolidation of Administrative Responsibility Act.* The Black Lung Consolidation of Administrative Responsibility Act of 2002 transferred administrative responsibility for all claims previously filed with or administered by the Social Security Administration to the Department of Labor, effective January 31, 2003. As a result, certain obsolete provisions in the BLBA (30 U.S.C. 904, 924a, and 945) were repealed. Various technical changes were made to other statutory provisions.

(i) *Changes made by the Patient Protection and Affordable Care Act of 2010.* The Patient Protection and Affordable Care Act of 2010 (the ACA) changed the entitlement criteria for miners' and survivors' claims filed after January 1, 2005, and pending on or after March 23, 2010, by reinstating two provisions made inapplicable by the Black Lung Benefits Amendments of 1981.

(1) For miners' claims meeting these date requirements, the ACA reinstated the rebuttable presumption that the miner is (or was) totally disabled due to pneumoconiosis if the miner has (or had) 15 or more years of qualifying coal mine employment and a totally disabling respiratory or pulmonary impairment.

(2) For survivors' claims meeting these date requirements, the ACA made two changes. First, it reinstated the rebuttable presumption that the miner's death was due to pneumoconiosis if the miner had 15 years or more of qualifying coal mine employment and was totally disabled by a respiratory or pulmonary impairment at the time of death. Second, it reinstituted derivative survivors' entitlement. As a result, an eligible survivor will be entitled to benefits if the miner is or was found entitled to benefits on his or her lifetime claim based on total disability due to pneumoconiosis arising out of coal-mine employment.

(j) *Longshore Act provisions.* The adjudication of claims filed under part C of the Act (*i.e.*, claims filed on or after January 1, 1974) is governed by various procedural and other provisions contained in the Longshore and Harbor Workers' Compensation Act (LHWCA), as amended from time to time, which are incorporated within the Act by section 422. The incorporated LHWCA provisions are applicable under the Act except as is otherwise provided by the Act or as provided by regulations of the Secretary. Although occupational disease benefits are also payable under the LHWCA, the primary focus of the procedures set forth in that Act is upon a time-definite-traumatic injury or death. Because of this and other significant differences between a black lung and longshore claim, it is determined, in accordance with the authority set forth in Section 422 of the Act, that certain of the incorporated procedures prescribed by the LHWCA must be altered to fit the circumstances ordinarily confronted in the adjudication of a black lung claim. The changes made are based upon the Department's experience in processing black lung claims since July 1, 1973, and all such changes are specified in this part. No

other departure from the incorporated provisions of the LHWCA is intended.

(k) *Social Security Act provisions.* Section 402 of Part A of the Act incorporates certain definitional provisions from the Social Security Act, 42 U.S.C. 301 *et seq.* Section 430 provides that the 1972, 1977 and 1981 amendments to part B of the Act shall also apply to part C ''to the extent appropriate.'' Sections 412 and 413 incorporate various provisions of the Social Security Act into part B of the Act. To the extent appropriate, therefore, these provisions also apply to part C. In certain cases, the Department has varied the terms of the Social Security Act provisions to accommodate the unique needs of the black lung benefits program. Parts of the Longshore and Harbor Workers' Compensation Act are also incorporated into part C. Where the incorporated provisions of the two acts are inconsistent, the Department has exercised its broad regulatory powers to choose the extent to which each incorporation is appropriate. Finally, Section 422(g), contained in part C of the Act, incorporates 42 U.S.C. 403(b)–(l).

[78 FR 59115, Sept. 25, 2013]

§ 725.2 Purpose and applicability of this part.

(a) This part sets forth the procedures to be followed and standards to be applied in filing, processing, adjudicating, and paying claims filed under part C of subchapter IV of the Act.

(b) This part applies to all claims filed under part C of subchapter IV of the Act on or after June 30, 1982. Publication of certain provisions or parts of certain provisions that apply only to claims filed prior to June 30, 1982, or to claims subject to Section 435 of the Act, has been discontinued because those provisions affect an increasingly smaller number of claims. The version of Part 725 set forth in 20 CFR, parts 500 to end, edition revised as of April 1, 2010, applies to the adjudication of all claims filed prior to June 30, 1982, as appropriate.

(c) The provisions of this part reflect revisions that became effective on January 19, 2001. This part applies to all claims filed after January 19, 2001 and all benefits payments made on such claims. With the exception of the following sections, this part also applies to the adjudication of claims that were pending on January 19, 2001 and all benefits payments made on such claims: §§ 725.101(a)(31), 725.204, 725.212(b), 725.213(c), 725.214(d), 725.219(d), 725.309, 725.310, 725.351, 725.360, 725.367, 725.406, 725.407, 725.408, 725.409, 725.410, 725.411, 725.412, 725.414, 725.415, 725.416, 725.417, 725.418, 725.421(b), 725.423, 725.454, 725.456, 725.457, 725.458, 725.459, 725.465, 725.491, 725.492, 725.493, 725.494, 725.495, 725.547, 725.701(e). The version of those sections set forth in 20 CFR, parts 500 to end, edition revised as of April 1, 1999, apply to the adjudications of claims that were pending on January 19, 2001. For purposes of construing the provisions of this section, a claim will be considered pending on January 19, 2001 if it was not finally denied more than one year prior to that date.

[78 FR 59117, Sept. 25, 2013]

§ 725.3 Contents of this part.

(a) This subpart describes the statutory provisions which relate to claims considered under this part, the purpose and scope of this part, definitions and usages of terms applicable to this part, and matters relating to the availability of information collected by the Department of Labor in connection with the processing of claims.

(b) Subpart B contains criteria for determining who may be found entitled to benefits under this part and other provisions relating to the conditions and duration of eligibility of a particular individual.

(c) Subpart C describes the procedures to be followed and action to be taken in connection with the filing of a claim under this part.

(d) Subpart D sets forth the duties and powers of the persons designated by the Secretary of Labor to adjudicate claims and provisions relating to the rights of parties and representatives of parties.

(e) Subpart E contains the procedures for developing evidence and adjudicating entitlement and liability issues by the district director.

(f) Subpart F describes the procedures to be followed if a hearing before the Office of Administrative Law Judges is required.

(g) Subpart G contains provisions governing the identification of a coal mine operator which may be liable for the payment of a claim.

(h) Subpart H contains provisions governing the payment of benefits with respect to an approved claim.

(i) Subpart I describes the statutory mechanisms provided for the enforcement of a coal mine operator's liability, sets forth the penalties which may be applied in the case of a defaulting coal mine operator, and describes the obligation of coal operators and their insurance carriers to file certain reports.

(j) Subpart J describes the right of certain beneficiaries to receive medical treatment benefits and vocational rehabilitation under the Act.

§ 725.4 Applicability of other parts in this title.

(a) Part 718. Part 718 of this subchapter, which contains the criteria and standards to be applied in determining whether a miner is or was totally disabled due to pneumoconiosis, or whether a miner died due to pneumoconiosis, shall be applicable to the determination of claims under this part. Claims filed after March 31, 1980, are subject to part 718 as promulgated by the Secretary in accordance with section 402(f)(1) of the Act on February 29, 1980 (see § 725.2(c)). The criteria contained in subpart C of part 727 of this subchapter are applicable in determining claims filed prior to April 1, 1980, under this part, and such criteria shall be applicable at all times with respect to claims filed under this part and under section 11 of the Black Lung Benefits Reform Act of 1977.

(b) *Parts 715, 717, and 720.* Pertinent and significant provisions of Parts 715, 717, and 720 of this subchapter (formerly contained in 20 CFR, parts 500 to end, edition revised as of April 1, 1978), which established the procedures for the filing, processing, and payment of claims filed under section 415 of the Act, are included within this part as appropriate.

(c) *Part 726.* Part 726 of this subchapter, which sets forth the obligations imposed upon a coal operator to insure or self-insure its liability for the payment of benefits to certain eligible claimants, is applicable to this part as appropriate.

(d) *Part 727.* Part 727 of this subchapter, which governs the review, adjudication and payment of pending and denied claims under section 435 of the Act, is applicable with respect to such claims. The criteria contained in subpart C of part 727 for determining a claimant's eligibility for benefits are applicable under this part with respect to all claims filed before April 1, 1980, and to all claims filed under this part and under section 11 of the Black Lung Benefits Reform Act of 1977. Because the part 727 regulations affect an increasingly smaller number of claims, however, the Department has discontinued publication of the criteria in the Code of Federal Regulations. The part 727 criteria may be found at 43 FR 36818, Aug. 18, 1978 or 20 CFR, parts 500 to end, edition revised as of April 1, 1999.

(e) *Part 410.* Part 410 of this title, which sets forth provisions relating to a claim for black lung benefits under part B of title IV of the Act, is inapplicable to this part except as is provided in this part, or in part 718 of this subchapter.

§ 725.101 Definition and use of terms.

(a) *Definitions.* For purposes of this subchapter, except where the content clearly indicates otherwise, the following definitions apply:

(1) The *Act* means the Black Lung Benefits Act, 30 U.S.C. 901–44, as amended.

(2) The *Longshore Act* or *LHWCA* means the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901–950, as amended from time to time.

(3) The *Social Security Act* means the Social Security Act, Act of August 14, 1935, c. 531, 49 Stat. 620, 42 U.S.C. 301–431, as amended from time to time.

(4) *Administrative law judge* means a person qualified under *5 U.S.C. 3105* to conduct hearings and adjudicate claims for benefits filed pursuant to section 415 and part C of the Act. Until March 1, 1979, it also means an individual appointed to conduct such hearings and adjudicate such claims under Public Law 94–504.

(5) *Beneficiary* means a miner or any surviving spouse, divorced spouse,

child, parent, brother or sister, who is entitled to benefits under either section 415 or part C of title IV of the Act.

(6) *Benefits* means all money or other benefits paid or payable under section 415 or part C of title IV of the Act on account of disability or death due to pneumoconiosis, including augmented benefits (see § 725.520(c)). The term also includes any expenses related to the medical examination and testing authorized by the district director pursuant to § 725.406.

(7) *Benefits Review Board* or *Board* means the Benefits Review Board, U.S. Department of Labor, an appellate tribunal appointed by the Secretary of Labor pursuant to the provisions of section 21(b)(1) of the LHWCA. See parts 801 and 802 of this title.

(8) *Black Lung Disability Trust Fund* or the *fund* means the Black Lung Disability Trust Fund established by the Black Lung Benefits Revenue Act of 1977, as amended by the Black Lung Benefits Revenue Act of 1981, for the payment of certain claims adjudicated under this part (see subpart G of this part).

(9) *Chief Administrative Law Judge* means the Chief Administrative Law Judge of the Office of Administrative Law Judges, U.S. Department of Labor, 800 K Street, NW., suite 400, Washington, DC 20001–8002.

(10) *Claim* means a written assertion of entitlement to benefits under section 415 or part C of title IV of the Act, submitted in a form and manner authorized by the provisions of this subchapter.

(11) *Claimant* means an individual who files a claim for benefits under this part.

(12) *Coal mine* means an area of land and all structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, placed upon, under or above the surface of such land by any person, used in, or to be used in, or resulting from, the work of extracting in such area bituminous coal, lignite or anthracite from its natural deposits in the earth by any means or method, and in the work of preparing the coal so extracted, and includes custom coal preparation facilities.

(13) *Coal preparation* means the breaking, crushing, sizing, cleaning, washing, drying, mixing, storing and loading of bituminous coal, lignite or anthracite, and such other work of preparing coal as is usually done by the operator of a coal mine.

(14) *Department* means the United States Department of Labor.

(15) *Director* means the Director, OWCP, or his or her designee.

(16) *District Director* means a person appointed as provided in sections 39 and 40 of the LHWCA, or his or her designee, who is authorized to develop and adjudicate claims as provided in this subchapter (see § 725.350). The term District Director is substituted for the term Deputy Commissioner wherever that term appears in the regulations. This substitution is for administrative purposes only and in no way affects the power or authority of the position as established in the statute. Any action taken by a person under the authority of a district director will be considered the action of a deputy commissioner.

(17) *Division* or *DCMWC* means the Division of Coal Mine Workers' Compensation in the OWCP, United States Department of Labor.

(18) *Insurer* or *carrier* means any private company, corporation, mutual association, reciprocal or interinsurance exchange, or any other person or fund, including any State fund, authorized under the laws of a State to insure employers' liability under workers' compensation laws. The term also includes the Secretary of Labor in the exercise of his or her authority under section 433 of the Act.

(19) *Miner* or *coal miner* means any individual who works or has worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal. The term also includes an individual who works or has worked in coal mine construction or transportation in or around a coal mine, to the extent such individual was exposed to coal mine dust as a result of such employment (see § 725.202). For purposes of this definition, the term does not include coke oven workers.

(20) *The Nation's coal mines* means all coal mines located in any State.

(21) *Office* or *OWCP* means the Office of Workers' Compensation Programs, United States Department of Labor.

(22) *Office of Administrative Law Judges* means the Office of Administrative Law Judges, U.S. Department of Labor.

(23) *Operator* means any owner, lessee, or other person who operates, controls or supervises a coal mine, including a prior or successor operator as defined in section 422 of the Act and certain transportation and construction employers (see subpart G of this part).

(24) *Person* means an individual, partnership, association, corporation, firm, subsidiary or parent of a corporation, or other organization or business entity.

(25) *Pneumoconiosis* means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment (see part 718 of this subchapter).

(26) *Responsible operator* means an operator which has been determined to be liable for the payment of benefits to a claimant for periods of eligibility after December 31, 1973, with respect to a claim filed under section 415 or part C of title IV of the Act or reviewed under section 435 of the Act.

(27) *Secretary* means the Secretary of Labor, United States Department of Labor, or a person, authorized by him or her to perform his or her functions under title IV of the Act.

(28) *State* includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, and prior to January 3, 1959, and August 21, 1959, respectively, the territories of Alaska and Hawaii.

(29) *Total disability* and *partial disability*, for purposes of this part, have the meaning given them as provided in part 718 of this subchapter.

(30) *Underground coal mine* means a coal mine in which the earth and other materials which lie above and around the natural deposit of coal (*i.e.*, overburden) are not removed in mining; including all land, structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, appurtenant thereto.

(31) A *workers' compensation law* means a law providing for payment of benefits to employees, and their dependents and survivors, for disability on account of injury, including occupational disease, or death, suffered in connection with their employment. A payment funded wholly out of general revenues shall not be considered a payment under a workers' compensation law.

(32) *Year* means a period of one calendar year (365 days, or 366 days if one of the days is February 29), or partial periods totaling one year, during which the miner worked in or around a coal mine or mines for at least 125 ''working days.'' A ''working day'' means any day or part of a day for which a miner received pay for work as a miner, but shall not include any day for which the miner received pay while on an approved absence, such as vacation or sick leave. In determining whether a miner worked for one year, any day for which the miner received pay while on an approved absence, such as vacation or sick leave, may be counted as part of the calendar year and as partial periods totaling one year.

(i) If the evidence establishes that the miner worked in or around coal mines at least 125 working days during a calendar year or partial periods totaling one year, then the miner has worked one year in coal mine employment for all purposes under the Act. If a miner worked fewer than 125 working days in a year, he or she has worked a fractional year based on the ratio of the actual number of days worked to 125. Proof that the miner worked more than 125 working days in a calendar year or partial periods totaling a year, does not establish more than one year.

(ii) To the extent the evidence permits, the beginning and ending dates of all periods of coal mine employment must be ascertained. The dates and length of employment may be established by any credible evidence including (but not limited to) company records, pension records, earnings statements, coworker affidavits, and sworn testimony. If the evidence establishes that the miner's employment

lasted for a calendar year or partial periods totaling a 365-day period amounting to one year, it must be presumed, in the absence of evidence to the contrary, that the miner spent at least 125 working days in such employment.

(iii) If the evidence is insufficient to establish the beginning and ending dates of the miner's coal mine employment, or the miner's employment lasted less than a calendar year, then the adjudication officer may use the following formula: divide the miner's yearly income from work as a miner by the coal mine industry's average daily earnings for that year, as reported by the Bureau of Labor Statistics (BLS). A copy of the BLS table must be made a part of the record if the adjudication officer uses this method to establish the length of the miner's work history.

(iv) Periods of coal mine employment occurring outside the United States must not be considered in computing the miner's work history.

(b) *Statutory terms.* The definitions contained in this section must not be construed in derogation of terms of the Act.

(c) *Dependents and survivors.* Dependents and survivors are those persons described in subpart B of this part.

[65 FR 80054, Dec. 20, 2000, as amended at 77 FR 37286, June 21, 2012; 78 FR 59117, Sept. 25, 2013]

§ 725.102 Disclosure of program information.

(a) All reports, records, or other documents filed with the OWCP with respect to claims are the records of the OWCP. The Director or his or her designee shall be the official custodian of those records maintained by the OWCP at its national office. The District Director shall be the official custodian of those records maintained at a district office.

(b) The official custodian of any record sought to be inspected shall permit or deny inspection in accordance with the Department of Labor's regulations pertaining thereto (see 29 CFR Part 70). The original record in any such case shall not be removed from the Office of the custodian for such inspection. The custodian may, in his or her discretion, deny inspection of any record or part thereof which is of a character specified in 5 U.S.C. 552(b) if in his or her opinion such inspection may result in damage, harm, or harassment to the beneficiary or to any other person. For special provisions concerning release of information regarding injured employees undergoing vocational rehabilitation, see § 702.508 of this chapter.

(c) Any person may request copies of records he or she has been permitted to inspect. Such requests shall be addressed to the official custodian of the records sought to be copied. The official custodian shall provide the requested copies under the terms and conditions specified in the Department of Labor's regulations relating thereto (see 29 CFR Part 70).

(d) Any party to a claim (§ 725.360) or his or her duly authorized representative shall be permitted upon request to inspect the file which has been compiled in connection with such claim. Any party to a claim or representative of such party shall upon request be provided with a copy of any or all material contained in such claim file. A request for information by a party or representative made under this paragraph shall be answered within a reasonable time after receipt by the Office. Internal documents prepared by the district director which do not constitute evidence of a fact which must be established in connection with a claim shall not be routinely provided or presented for inspection in accordance with a request made under this paragraph.

§ 725.103 Burden of proof.

Except as otherwise provided in this part and part 718, the burden of proving a fact alleged in connection with any provision shall rest with the party making such allegation.

Subpart B—Persons Entitled to Benefits, Conditions, and Duration of Entitlement

§ 725.201 Who is entitled to benefits; contents of this subpart.

(a) Part C of the Act provides for the payment of periodic benefits in accordance with this part to:

(1) A miner who meets the conditions of entitlement set forth in § 725.202(d); or

(2) The surviving spouse or surviving divorced spouse of a deceased miner who meets the conditions of entitlement set forth in § 725.212; or,

(3) Where neither exists, the child of a deceased miner who meets the conditions of entitlement set forth in § 725.218; or

(4) The surviving dependent parents, where there is no surviving spouse or child, or the surviving dependent brothers or sisters, where there is no surviving spouse, child, or parent, of a miner, who meet the conditions of entitlement set forth in § 725.222; or

(5) The child of a miner's surviving spouse who was receiving benefits under Part C of the Act at the time of such spouse's death.

(b) The provisions contained in this subpart describe the conditions of entitlement to benefits applicable to a miner, or a surviving spouse, child, parent, brother, or sister, and the events which establish or terminate entitlement to benefits.

(c) In order for an entitled miner or surviving spouse to qualify for augmented benefits because of one or more dependents, such dependents must meet relationship and dependency requirements with respect to such beneficiary prescribed by or pursuant to the Act. Such requirements are also set forth in this subpart.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

CONDITIONS AND DURATION OF ENTITLEMENT: MINER

§ 725.202 Miner defined; condition of entitlement, miner.

(a) *Miner defined.* A ''miner'' for the purposes of this part is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner. This presumption may be rebutted by proof that:

(1) The person was not engaged in the extraction, preparation or transportation of coal while working at the mine site, or in maintenance or construction of the mine site; or

(2) The individual was not regularly employed in or around a coal mine or coal preparation facility.

(b) *Coal mine construction and transportation workers; special provisions.* A coal mine construction or transportation worker shall be considered a miner to the extent such individual is or was exposed to coal mine dust as a result of employment in or around a coal mine or coal preparation facility. A transportation worker shall be considered a miner to the extent that his or her work is integral to the extraction or preparation of coal. A construction worker shall be considered a miner to the extent that his or her work is integral to the building of a coal or underground mine (see § 725.101(a)(12), (30)).

(1) There shall be a rebuttable presumption that such individual was exposed to coal mine dust during all periods of such employment occurring in or around a coal mine or coal preparation facility for purposes of:

(i) Determining whether such individual is or was a miner;

(ii) Establishing the applicability of any of the presumptions described in section 411(c) of the Act and part 718 of this subchapter; and

(iii) Determining the identity of a coal mine operator liable for the payment of benefits in accordance with § 725.495.

(2) The presumption may be rebutted by evidence which demonstrates that:

(i) The individual was not regularly exposed to coal mine dust during his or her work in or around a coal mine or coal preparation facility; or

(ii) The individual did not work regularly in or around a coal mine or coal preparation facility.

(c) A person who is or was a self-employed miner or independent contractor, and who otherwise meets the requirements of this paragraph, shall be considered a miner for the purposes of this part.

(d) *Conditions of entitlement; miner.* An individual is eligible for benefits under this subchapter if the individual:

(1) Is a miner as defined in this section; and

(2) Has met the requirements for entitlement to benefits by establishing that he or she:

(i) Has pneumoconiosis (see § 718.202), and

(ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

(iii) Is totally disabled (see § 718.204(c)), and

(iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

(3) Has filed a claim for benefits in accordance with the provisions of this part.

§ 725.203 Duration and cessation of entitlement; miner.

(a) An individual is entitled to benefits as a miner for each month beginning with the first month on or after January 1, 1974, in which the miner is totally disabled due to pneumoconiosis arising out of coal mine employment.

(b) The last month for which such individual is entitled to benefits is the month before the month during which either of the following events first occurs:

(1) The miner dies; or

(2) The miner's total disability ceases (see § 725.504).

(c) An individual who has been finally adjudged to be totally disabled due to pneumoconiosis and is receiving benefits under the Act shall promptly notify the Office and the responsible coal mine operator, if any, if he or she engages in his or her usual coal mine work or comparable and gainful work.

(d) Upon reasonable notice, an individual who has been finally adjudged entitled to benefits shall submit to any additional tests or examinations the Office deems appropriate, and shall submit medical reports and other relevant evidence the Office deems necessary, if an issue arises pertaining to the validity of the original award.

CONDITIONS AND DURATION OF ENTITLEMENT: MINER'S DEPENDENTS (AUGMENTED BENEFITS)

§ 725.204 Determination of relationship; spouse.

(a) For the purpose of augmenting benefits, an individual will be considered to be the spouse of a miner if:

(1) The courts of the State in which the miner is domiciled would find that such individual and the miner validly married; or

(2) The courts of the State in which the miner is domiciled would find, under the law they would apply in determining the devolution of the miner's intestate personal property, that the individual is the miner's spouse; or

(3) Under State law, such individual would have the right of a spouse to share in the miner's intestate personal property; or

(4) Such individual went through a marriage ceremony with the miner resulting in a purported marriage between them and which, but for a legal impediment, would have been a valid marriage, unless the individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the miner were not living in the same household in the month in which a request is filed that the miner's benefits be augmented because such individual qualifies as the miner's spouse.

(b) The qualification of an individual for augmentation purposes under this section shall end with the month before the month in which:

(1) The individual dies, or

(2) The individual who previously qualified as a spouse for purposes of § 725.520(c), entered into a valid marriage without regard to this section, with a person other than the miner.

§ 725.205 Determination of dependency; spouse.

For the purposes of augmenting benefits, an individual who is the miner's spouse (see § 725.204) will be determined to be dependent upon the miner if:

(a) The individual is a member of the same household as the miner (see § 725.232); or

(b) The individual is receiving regular contributions from the miner for support (see § 725.233(c)); or

(c) The miner has been ordered by a court to contribute to such individual's support (see § 725.233(e)); or

(d) The individual is the natural parent of the son or daughter of the miner; or

(e) The individual was married to the miner (see § 725.204) for a period of not less than 1 year.

§ 725.206 Determination of relationship; divorced spouse.

For the purposes of augmenting benefits with respect to any claim considered or reviewed under this part or part 727 of this subchapter (see § 725.4(d)), an individual will be considered to be the divorced spouse of a miner if the individual's marriage to the miner has been terminated by a final divorce on or after the 10th anniversary of the marriage unless, if such individual was married to and divorced from the miner more than once, such individual was married to the miner in each calendar year of the period beginning 10 years immediately before the date on which any divorce became final.

§ 725.207 Determination of dependency; divorced spouse.

For the purpose of augmenting benefits, an individual who is the miner's divorced spouse (§ 725.206) will be determined to be dependent upon the miner if:

(a) The individual is receiving at least one-half of his or her support from the miner (see § 725.233(g)); or

(b) The individual is receiving substantial contributions from the miner pursuant to a written agreement (see § 725.233(c) and (f)); or

(c) A court order requires the miner to furnish substantial contributions to the individual's support (see § 725.233(c) and (e)).

§ 725.208 Determination of relationship; child.

As used in this section, the term ''beneficiary'' means only a surviving spouse entitled to benefits at the time of death (see § 725.212), or a miner. An individual will be considered to be the child of a beneficiary if:

(a) The courts of the State in which the beneficiary is domiciled (see § 725.231) would find, under the law they would apply, that the individual is the beneficiary's child; or

(b) The individual is the legally adopted child of such beneficiary; or

(c) The individual is the stepchild of such beneficiary by reason of a valid marriage of the individual's parent or adopting parent to such beneficiary; or

(d) The individual does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, but would, under State law, have the same right as a child to share in the beneficiary's intestate personal property; or

(e) The individual is the natural son or daughter of a beneficiary but is not a child under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) of this section if the beneficiary and the mother or the father, as the case may be, of the individual went through a marriage ceremony resulting in a purported marriage between them which but for a legal impediment (see § 725.230) would have been a valid marriage; or

(f) The individual is the natural son or daughter of a beneficiary but is not a child under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of the beneficiary if:

(1) The beneficiary, prior to his or her entitlement to benefits, has acknowledged in writing that the individual is his or her son or daughter, or has been decreed by a court to be the parent of the individual, or has been ordered by a court to contribute to the support of the individual (see § 725.233(e)) because the individual is his or her son or daughter; or

(2) Such beneficiary is shown by satisfactory evidence to be the father or mother of the individual and was living with or contributing to the support of the individual at the time the beneficiary became entitled to benefits.

§ 725.209 Determination of dependency; child.

(a) For purposes of augmenting the benefits of a miner or surviving spouse, the term ''beneficiary'' as used in this section means only a miner or surviving spouse entitled to benefits (see § 725.202 and § 725.212). An individual who is the beneficiary's child (§ 725.208) will be determined to be, or to have been, dependent on the beneficiary, if the child:

(1) Is unmarried; and

(2)(i) Is under 18 years of age; or

(ii) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d); or

(iii) Is 18 years of age or older and is a student.

(b)(1) The term ''student'' means a ''full-time student'' as defined in section 202(d)(7) of the Social Security Act, 42 U.S.C. 402(d)(7) (see §§ 404.367–404.369 of this title), or an individual under 23 years of age who has not completed 4 years of education beyond the high school level and who is regularly pursuing a full-time course of study or training at an institution which is:

(i) A school, college, or university operated or directly supported by the United States, or by a State or local government or political subdivision thereof; or

(ii) A school, college, or university which has been accredited by a State or by a State-recognized or nationally-recognized accrediting agency or body; or

(iii) A school, college, or university not so accredited but whose credits are accepted, on transfer, by at least three institutions which are so accredited; or

(iv) A technical, trade, vocational, business, or professional school accredited or licensed by the Federal or a State government or any political subdivision thereof, providing courses of not less than 3 months' duration that prepare the student for a livelihood in a trade, industry, vocation, or profession.

(2) A student will be considered to be ''pursuing a full-time course of study or training at an institution'' if the student is enrolled in a noncorrespondence course of at least 13 weeks duration and is carrying a subject load which is considered full-time for day students under the institution's standards and practices. A student beginning or ending a full-time course of study or training in part of any month will be considered to be pursuing such course for the entire month.

(3) A child is considered not to have ceased to be a student:

(i) During any interim between school years, if the interim does not exceed 4 months and the child shows to the satisfaction of the Office that he or she has a bona fide intention of continuing to pursue a full-time course of study or training; or

(ii) During periods of reasonable duration in which, in the judgment of the Office, the child is prevented by factors beyond the child's control from pursuing his or her education.

(4) A student whose 23rd birthday occurs during a semester or the enrollment period in which such student is pursuing a full-time course of study or training shall continue to be considered a student until the end of such period, unless eligibility is otherwise terminated.

§ 725.210 Duration of augmented benefits.

Augmented benefits payable on behalf of a spouse or divorced spouse, or a child, shall begin with the first month in which the dependent satisfies the conditions of relationship and dependency set forth in this subpart. Augmentation of benefits on account of a dependent continues through the month before the month in which the dependent ceases to satisfy these conditions, except in the case of a child who qualifies as a dependent because such child is a student. In the latter case, benefits continue to be augmented through the month before the first month during no part of which such child qualifies as a student.

§ 725.211 Time of determination of relationship and dependency of spouse or child for purposes of augmentation of benefits.

With respect to the spouse or child of a miner entitled to benefits, and with respect to the child of a surviving spouse entitled to benefits, the determination as to whether an individual

purporting to be a spouse or child is related to or dependent upon such miner or surviving spouse shall be based on the facts and circumstances present in each case, at the appropriate time.

CONDITIONS AND DURATION OF ENTITLEMENT: MINER'S SURVIVORS

§ 725.212 Conditions of entitlement; surviving spouse or surviving divorced spouse.

(a) An individual who is the surviving spouse or surviving divorced spouse of a miner is eligible for benefits if such individual:

(1) Is not married;

(2) Was dependent on the miner at the pertinent time; and

(3) The deceased miner either:

(i) Is determined to have died due to pneumoconiosis; or

(ii) Filed a claim for benefits on or after January 1, 1982, which results or resulted in a final award of benefits, and the surviving spouse or surviving divorced spouse filed a claim for benefits after January 1, 2005 which was pending on or after March 23, 2010.

(b) If more than one spouse meets the conditions of entitlement prescribed in paragraph (a), then each spouse will be considered a beneficiary for purposes of section 412(a)(2) of the Act without regard to the existence of any other entitled spouse or spouses.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

§ 725.213 Duration of entitlement; surviving spouse or surviving divorced spouse.

(a) An individual is entitled to benefits as a surviving spouse, or as a surviving divorced spouse, for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 725.212 are satisfied.

(b) The last month for which such individual is entitled to such benefits is the month before the month in which either of the following events first occurs:

(1) The surviving spouse or surviving divorced spouse marries; or

(2) The surviving spouse or surviving divorced spouse dies.

(c) A surviving spouse or surviving divorced spouse whose entitlement to benefits has been terminated pursuant to § 725.213(b)(1) may thereafter again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after the marriage ends and such individual meets the requirements of § 725.212. The individual shall not be required to reestablish the miner's entitlement to benefits (§ 725.212(a)(3)(i)) or the miner's death due to pneumoconiosis (§ 725.212(a)(3)(ii)).

§ 725.214 Determination of relationship; surviving spouse.

An individual shall be considered to be the surviving spouse of a miner if:

(a) The courts of the State in which the miner was domiciled (see § 725.231) at the time of his or her death would find that the individual and the miner were validly married; or

(b) The courts of the State in which the miner was domiciled (see § 725.231) at the time of the miner's death would find that the individual was the miner's surviving spouse; or

(c) Under State law, such individual would have the right of the spouse to share in the miner's intestate personal property; or

(d) Such individual went through a marriage ceremony with the miner, resulting in a purported marriage between them which, but for a legal impediment (see § 725.230), would have been a valid marriage, unless such individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the miner were not living in the same household at the time of the miner's death.

§ 725.215 Determination of dependency; surviving spouse.

An individual who is the miner's surviving spouse (see § 725.214) shall be determined to have been dependent on the miner if, at the time of the miner's death:

(a) The individual was living with the miner (see § 725.232); or

(b) The individual was dependent upon the miner for support or the miner has been ordered by a court to

contribute to such individual's support (see § 725.233); or

(c) The individual was living apart from the miner because of the miner's desertion or other reasonable cause; or

(d) The individual is the natural parent of the miner's son or daughter; or

(e) The individual had legally adopted the miner's son or daughter while the individual was married to the miner and while such son or daughter was under the age of 18; or

(f) The individual was married to the miner at the time both of them legally adopted a child under the age of 18; or

(g)(1) The individual was married to the miner for a period of not less than 9 months immediately before the day on which the miner died, unless the miner's death:

(i) Is accidental (as defined in paragraph (g)(2) of this section), or

(ii) Occurs in line of duty while the miner is a member of a uniformed service serving on active duty (as defined in § 404.1019 of this title), and the surviving spouse was married to the miner for a period of not less than 3 months immediately prior to the day on which such miner died.

(2) For purposes of paragraph (g)(1)(i) of this section, the death of a miner is accidental if such individual received bodily injuries solely through violent, external, and accidental means, and as a direct result of the bodily injuries and independently of all other causes, dies not later than 3 months after the day on which such miner receives such bodily injuries. The term ''accident'' means an event that was unpremeditated and unforeseen from the standpoint of the deceased individual. To determine whether the death of an individual did, in fact, result from an accident the adjudication officer will consider all the circumstances surrounding the casualty. An intentional and voluntary suicide will not be considered to be death by accident; however, suicide by an individual who is so incompetent as to be incapable of acting intentionally and voluntarily will be considered to be a death by accident. In no event will the death of an individual resulting from violent and external causes be considered a suicide unless there is direct proof that the fatal injury was self-inflicted.

(3) The provisions of paragraph (g) shall not apply if the adjudication officer determines that at the time of the marriage involved, the miner would not reasonably have been expected to live for 9 months.

§ 725.216 Determination of relationship; surviving divorced spouse.

An individual will be considered to be the surviving divorced spouse of a deceased miner in a claim considered under this part or reviewed under part 727 of this subchapter (see § 725.4(d)), if such individual's marriage to the miner had been terminated by a final divorce on or after the 10th anniversary of the marriage unless, if such individual was married to and divorced from the miner more than once, such individual was married to such miner in each calendar year of the period beginning 10 years immediately before the date on which any divorce became final and ending with the year in which the divorce became final.

§ 725.217 Determination of dependency; surviving divorced spouse.

An individual who is the miner's surviving divorced spouse (see § 725.216) shall be determined to have been dependent on the miner if, for the month before the month in which the miner died:

(a) The individual was receiving at least one-half of his or her support from the miner (see § 725.233(g)); or

(b) The individual was receiving substantial contributions from the miner pursuant to a written agreement (see § 725.233(c) and (f)); or

(c) A court order required the miner to furnish substantial contributions to the individual's support (see § 725.233(c) and (e)).

§ 725.218 Conditions of entitlement; child.

(a) An individual is entitled to benefits where he or she meets the required standards of relationship and dependency under this subpart (see § 725.220 and § 725.221) and is the child of a deceased miner who:

(1) Is determined to have died due to pneumoconiosis; or

(2) Filed a claim for benefits on or after January 1, 1982, which results or resulted in a final award of benefits, and the surviving child filed a claim for benefits after January 1, 2005 which was pending on or after March 23, 2010.

(b) A child is not entitled to benefits for any month for which a miner, or the surviving spouse or surviving divorced spouse of a miner, establishes entitlement to benefits.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

§ 725.219 Duration of entitlement; child.

(a) An individual is entitled to benefits as a child for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 725.218 are satisfied.

(b) The last month for which such individual is entitled to such benefits is the month before the month in which any one of the following events first occurs:

(1) The child dies;

(2) The child marries;

(3) The child attains age 18; and

(i) Is not a student (as defined in § 725.209(b)) during any part of the month in which the child attains age 18; and

(ii) Is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(4) If the child's entitlement beyond age 18 is based on his or her status as a student, the earlier of:

(i) The first month during no part of which the child is a student; or

(ii) The month in which the child attains age 23 and is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(5) If the child's entitlement beyond age 18 is based on disability, the first month in no part of which such individual is under a disability.

(c) A child whose entitlement to benefits terminated with the month before the month in which the child attained age 18, or later, may thereafter (provided such individual is not married) again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after termination of benefits in which such individual is a student and has not attained the age of 23.

(d) A child whose entitlement to benefits has been terminated pursuant to § 725.219(b)(2) may thereafter again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after the marriage ends and such individual meets the requirements of § 725.218. The individual shall not be required to reestablish the miner's entitlement to benefits (§ 725.218(a)(1)) or the miner's death due to pneumoconiosis (§ 725.212(a)(2)).

§ 725.220 Determination of relationship; child.

For purposes of determining whether an individual may qualify for benefits as the child of a deceased miner, the provisions of § 725.208 shall be applicable. As used in this section, the term ''beneficiary'' means only a surviving spouse entitled to benefits at the time of such surviving spouse's death (see § 725.212), or a miner. For purposes of a survivor's claim, an individual will be considered to be a child of a beneficiary if:

(a) The courts of the State in which such beneficiary is domiciled (see § 725.231) would find, under the law they would apply in determining the devolution of the beneficiary's intestate personal property, that the individual is the beneficiary's child; or

(b) Such individual is the legally adopted child of such beneficiary; or

(c) Such individual is the stepchild of such beneficiary by reason of a valid marriage of such individual's parent or adopting parent to such beneficiary; or

(d) Such individual does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, but would, under State law, have the same right as a child to share in the beneficiary's intestate personal property; or

(e) Such individual is the natural son or daughter of a beneficiary but does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if the beneficiary and the mother or father, as the case may be,

of such individual went through a marriage ceremony resulting in a purported marriage between them which but for a legal impediment (see § 725.230) would have been a valid marriage; or

(f) Such individual is the natural son or daughter of a beneficiary but does not have the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if:

(1) Such beneficiary, prior to his or her entitlement to benefits, has acknowledged in writing that the individual is his or her son or daughter, or has been decreed by a court to be the father or mother of the individual, or has been ordered by a court to contribute to the support of the individual (see § 725.233(a)) because the individual is a son or daughter; or

(2) Such beneficiary is shown by satisfactory evidence to be the father or mother of the individual and was living with or contributing to the support of the individual at the time such beneficiary became entitled to benefits.

§ 725.221 Determination of dependency; child.

For the purposes of determining whether a child was dependent upon a deceased miner, the provisions of § 725.209 shall be applicable, except that for purposes of determining the eligibility of a child who is under a disability as defined in section 223(d) of the Social Security Act, such disability must have begun before the child attained age 22, or in the case of a student, before the child ceased to be a student.

§ 725.222 Conditions of entitlement; parent, brother, or sister.

(a) An individual is eligible for benefits as a surviving parent, brother or sister if all of the following requirements are met:

(1) The individual is the parent, brother, or sister of a deceased miner;

(2) The individual was dependent on the miner at the pertinent time;

(3) Proof of support is filed within 2 years after the miner's death, unless the time is extended for good cause (§ 725.226);

(4) In the case of a brother or sister, such individual also:

(i) Is under 18 years of age; or

(ii) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d), which began before such individual attained age 22, or in the case of a student, before the student ceased to be a student; or

(iii) Is a student (see § 725.209(b)); or

(iv) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d), at the time of the miner's death;

(5) The deceased miner:

(i) Is determined to have died due to pneumoconiosis; or

(ii) Filed a claim for benefits on or after January 1, 1982, which results or resulted in a final award of benefits, and the surviving parent, brother or sister filed a claim for benefits after January 1, 2005 which was pending on or after March 23, 2010.

(b)(1) A parent is not entitled to benefits if the deceased miner was survived by a spouse or child at the time of such miner's death.

(2) A brother or sister is not entitled to benefits if the deceased miner was survived by a spouse, child, or parent at the time of such miner's death.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

§ 725.223 Duration of entitlement; parent, brother, or sister.

(a) A parent, sister, or brother is entitled to benefits beginning with the month all the conditions of entitlement described in § 725.222 are met.

(b) The last month for which such parent is entitled to benefits is the month in which the parent dies.

(c) The last month for which such brother or sister is entitled to benefits is the month before the month in which any of the following events first occurs:

(1) The individual dies;

(2)(i) The individual marries or remarries; or

(ii) If already married, the individual received support in any amount from his or her spouse;

(3) The individual attains age 18; and

(i) Is not a student (as defined in §725.209(b)) during any part of the month in which the individual attains age 18; and

(ii) Is not under a disability (as defined in §725.209(a)(2)(ii)) at that time;

(4) If the individual's entitlement beyond age 18 is based on his or her status as a student, the earlier of:

(i) The first month during no part of which the individual is a student; or

(ii) The month in which the individual attains age 23 and is not under a disability (as defined in §725.209(a)(2)(ii)) at that time;

(5) If the individual's entitlement beyond age 18 is based on disability, the first month in no part of which such individual is under a disability.

§ 725.224 Determination of relationship; parent, brother, or sister.

(a) An individual will be considered to be the parent, brother, or sister of a miner if the courts of the State in which the miner was domiciled (see §225.231) at the time of death would find, under the law they would apply, that the individual is the miner's parent, brother, or sister.

(b) Where, under State law, the individual is not the miner's parent, brother, or sister, but would, under State law, have the same status (*i.e.*, right to share in the miner's intestate personal property) as a parent, brother, or sister, the individual will be considered to be the parent, brother, or sister as appropriate.

§ 725.225 Determination of dependency; parent, brother, or sister.

An individual who is the miner's parent, brother, or sister will be determined to have been dependent on the miner if, during the 1–year period immediately prior to the miner's death:

(a) The individual and the miner were living in the same household (see §725.232); and

(b) The individual was totally dependent on the miner for support (see §725.233(h)).

§ 725.226 "Good cause" for delayed filing of proof of support.

(a) *What constitutes ''good cause.''* ''Good cause'' may be found for failure to file timely proof of support where the parent, brother, or sister establishes to the satisfaction of the Office that such failure to file was due to:

(1) Circumstances beyond the individual's control, such as extended illness, mental, or physical incapacity, or communication difficulties; or

(2) Incorrect or incomplete information furnished the individual by the Office; or

(3) Efforts by the individual to secure supporting evidence without a realization that such evidence could be submitted after filing proof of support.

(b) *What does not constitute ''good cause.''* ''Good cause'' for failure to file timely proof of support (see §725.222(a)(3)) does not exist when there is evidence of record in the Office that the individual was informed that he or she should file within the prescribed period and he or she failed to do so deliberately or through negligence.

§ 725.227 Time of determination of relationship and dependency of survivors.

The determination as to whether an individual purporting to be an entitled survivor of a miner or beneficiary was related to, or dependent upon, the miner is made after such individual files a claim for benefits as a survivor. Such determination is based on the facts and circumstances with respect to a reasonable period of time ending with the miner's death. A prior determination that such individual was, or was not, a dependent for the purposes of augmenting the miner's benefits for a certain period, is not determinative of the issue of whether the individual is a dependent survivor of such miner.

§ 725.228 Effect of conviction of felonious and intentional homicide on entitlement to benefits.

An individual who has been convicted of the felonious and intentional homicide of a miner or other beneficiary shall not be entitled to receive any benefits payable because of the death of such miner or other beneficiary, and such person shall be considered nonexistent in determining the entitlement to benefits of other individuals.

TERMS USED IN THIS SUBPART

§ 725.229 Intestate personal property.

References in this subpart to the ''same right to share in the intestate personal property'' of a deceased miner (or surviving spouse) refer to the right of an individual to share in such distribution in the individual's own right and not the right of representation.

§ 725.230 Legal impediment.

For purposes of this subpart, ''legal impediment'' means an impediment resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution or resulting from a defect in the procedure followed in connection with the purported marriage ceremony—for example, the solemnization of a marriage only through a religious ceremony in a country which requires a civil ceremony for a valid marriage.

§ 725.231 Domicile.

(a) For purposes of this subpart, the term ''domicile'' means the place of an individual's true, fixed, and permanent home.

(b) The domicile of a deceased miner or surviving spouse is determined as of the time of death.

(c) If an individual was not domiciled in any State at the pertinent time, the law of the District of Columbia is applied.

§ 725.232 Member of the same household—"living with," "living in the same household," and "living in the miner's household," defined.

(a) *Defined.* (1) The term ''member of the same household'' as used in section 402(a)(2) of the Act (with respect to a spouse); the term ''living with'' as used in section 402(e) of the Act (with respect to a surviving spouse); and the term ''living in the same household'' as used in this subpart, means that a husband and wife were customarily living together as husband and wife in the same place.

(2) The term ''living in the miner's household'' as used in section 412(a)(5) of the Act (with respect to a parent, brother, or sister) means that the miner and such parent, brother, or sister were sharing the same residence.

(b) *Temporary absence.* The temporary absence from the same residence of either the miner, or the miner's spouse, parent, brother, or sister (as the case may be), does not preclude a finding that one was ''living with'' the other, or that they were ''members of the same household.'' The absence of one such individual from the residence in which both had customarily lived shall, in the absence of evidence to the contrary, be considered temporary:

(1) If such absence was due to service in the Armed Forces of the United States; or

(2) If the period of absence from his or her residence did not exceed 6 months and the absence was due to business or employment reasons, or because of confinement in a penal institution or in a hospital, nursing home, or other curative institution; or

(3) In any other case, if the evidence establishes that despite such absence they nevertheless reasonably expected to resume physically living together.

(c) *Relevant period of time.* (1) The determination as to whether a surviving spouse had been ''living with'' the miner shall be based upon the facts and circumstances as of the time of the death of the miner.

(2) The determination as to whether a spouse is a ''member of the same household'' as the miner shall be based upon the facts and circumstances with respect to the period or periods of time as to which the issue of membership in the same household is material.

(3) The determination as to whether a parent, brother, or sister was ''living in the miner's household'' shall take account of the 1-year period immediately prior to the miner's death.

§ 725.233 Support and contributions.

(a) *Support* defined. The term ''support'' includes food, shelter, clothing, ordinary medical expenses, and other ordinary and customary items for the maintenance of the person supported.

(b) *Contributions* defined. The term ''contributions'' refers to contributions actually provided by the contributor from such individual's property, or the use thereof, or by the use of such individual's own credit.

(c) *Regular contributions* and *substantial contributions* defined. The terms

''regular contributions'' and ''substantial contributions'' mean contributions that are customary and sufficient to constitute a material factor in the cost of the individual's support.

(d) *Contributions and community property.* When a spouse receives and uses for his or her support income from services or property, and such income, under applicable State law, is the community property of the wife and her husband, no part of such income is a ''contribution'' by one spouse to the other's support regardless of the legal interest of the donor. However, when a spouse receives and uses for support, income from the services and the property of the other spouse and, under applicable State law, such income is community property, all of such income is considered to be a contribution by the donor to the spouse's support.

(e) *Court order for support* defined. References to a support order in this subpart means any court order, judgment, or decree of a court of competent jurisdiction which requires regular contributions that are a material factor in the cost of the individual's support and which is in effect at the applicable time. If such contributions are required by a court order, this condition is met whether or not the contributions were actually made.

(f) *Written agreement* defined. The term ''written agreement'' in the phrase ''substantial contributions pursuant to a written agreement'', as used in this subpart means an agreement signed by the miner providing for substantial contributions by the miner for the individual's support. It must be in effect at the applicable time but it need not be legally enforceable.

(g) *One-half support* defined. The term ''one-half support'' means that the miner made regular contributions, in cash or in kind, to the support of a divorced spouse at the specified time or for the specified period, and that the amount of such contributions equalled or exceeded one-half the total cost of such individual's support at such time or during such period.

(h) *Totally dependent for support* defined. The term ''totally dependent for support'' as used in §725.225(b) means that the miner made regular contributions to the support of the miner's parents, brother, or sister, as the case may be, and that the amount of such contributions at least equalled the total cost of such individual's support.

Subpart C—Filing of Claims

§725.301 Who may file a claim.

(a) Any person who believes he or she may be entitled to benefits under the Act may file a claim in accordance with this subpart.

(b) A claimant who has attained the age of 18, is mentally competent and physically able, may file a claim on his or her own behalf.

(c) If a claimant is unable to file a claim on his or her behalf because of a legal or physical impairment, the following rules shall apply:

(1) A claimant between the ages of 16 and 18 years who is mentally competent and not under the legal custody or care of another person, or a committee or institution, may upon filing a statement to the effect, file a claim on his or her own behalf. In any other case where the claimant is under 18 years of age, only a person, or the manager or principal officer of an institution having legal custody or care of the claimant may file a claim on his or her behalf.

(2) If a claimant over 18 years of age has a legally appointed guardian or committee, only the guardian or committee may file a claim on his or her behalf.

(3) If a claimant over 18 years of age is mentally incompetent or physically unable to file a claim and is under the care of another person, or an institution, only the person, or the manager or principal officer of the institution responsible for the care of the claimant, may file a claim on his or her behalf.

(4) For good cause shown, the Office may accept a claim executed by a person other than one described in paragraphs (c)(2) or (3) of this section.

(d) Except as provided in §725.305, in order for a claim to be considered, the claimant must be alive at the time the claim is filed.

§ 725.302 Evidence of authority to file a claim on behalf of another.

A person filing a claim on behalf of a claimant shall submit evidence of his or her authority to so act at the time of filing or at a reasonable time thereafter in accordance with the following:

(a) A legally appointed guardian or committee shall provide the Office with certification of appointment by a proper official of the court.

(b) Any other person shall provide a statement describing his or her relationship to the claimant, the extent to which he or she has care of the claimant, or his or her position as an officer of the institution of which the claimant is an inmate. The Office may, at any time, require additional evidence to establish the authority of any such person.

§ 725.303 Date and place of filing of claims.

(a)(1) Claims for benefits shall be delivered, mailed to, or presented at, any of the various district offices of the Social Security Administration, or any of the various offices of the Department of Labor authorized to accept claims, or, in the case of a claim filed by or on behalf of a claimant residing outside the United States, mailed or presented to any office maintained by the Foreign Service of the United States. A claim shall be considered filed on the day it is received by the office in which it is first filed.

(2) A claim submitted to a Foreign Service Office or any other agency or subdivision of the U.S. Government shall be forwarded to the Office and considered filed as of the date it was received at the Foreign Service Office or other governmental agency or unit.

(b) A claim submitted by mail shall be considered filed as of the date of delivery unless a loss or impairment of benefit rights would result, in which case a claim shall be considered filed as of the date of its postmark. In the absence of a legible postmark, other evidence may be used to establish the mailing date.

§ 725.304 Forms and initial processing.

(a) Claims shall be filed on forms prescribed and approved by the Office. The district office at which the claim is filed will assist claimants in completing their forms.

(b) If the place at which a claim is filed is an office of the Social Security Administration, such office shall forward the completed claim form to an office of the DCMWC, which is authorized to process the claim.

§ 725.305 When a written statement is considered a claim.

(a) The filing of a statement signed by an individual indicating an intention to claim benefits shall be considered to be the filing of a claim for the purposes of this part under the following circumstances:

(1) The claimant or a proper person on his or her behalf (see § 725.301) executes and files a prescribed claim form with the Office during the claimant's lifetime within the period specified in paragraph (b) of this section.

(2) Where the claimant dies within the period specified in paragraph (b) of this section without filing a prescribed claim form, and a person acting on behalf of the deceased claimant's estate executes and files a prescribed claim form within the period specified in paragraph (c) of this section.

(b) Upon receipt of a written statement indicating an intention to claim benefits, the Office shall notify the signer in writing that to be considered the claim must be executed by the claimant or a proper party on his or her behalf on the prescribed form and filed with the Office within six months from the date of mailing of the notice.

(c) If before the notice specified in paragraph (b) of this section is sent, or within six months after such notice is sent, the claimant dies without having executed and filed a prescribed form, or without having had one executed and filed in his or her behalf, the Office shall upon receipt of notice of the claimant's death advise his or her estate, or those living at his or her last known address, in writing that for the claim to be considered, a prescribed claim form must be executed and filed by a person authorized to do so on behalf of the claimant's estate within six months of the date of the later notice.

(d) Claims based upon written statements indicating an intention to claim benefits not perfected in accordance

with this section shall not be processed.

§ 725.306 Withdrawal of a claim.

(a) A claimant or an individual authorized to execute a claim on a claimant's behalf or on behalf of claimant's estate under § 725.305, may withdraw a previously filed claim provided that:

(1) He or she files a written request with the appropriate adjudication officer indicating the reasons for seeking withdrawal of the claim;

(2) The appropriate adjudication officer approves the request for withdrawal on the grounds that it is in the best interests of the claimant or his or her estate, and;

(3) Any payments made to the claimant in accordance with § 725.522 are reimbursed.

(b) When a claim has been withdrawn under paragraph (a) of this section, the claim will be considered not to have been filed.

§ 725.307 Cancellation of a request for withdrawal.

At any time prior to approval, a request for withdrawal may be canceled by a written request of the claimant or a person authorized to act on the claimant's behalf or on behalf of the claimant's estate.

§ 725.308 Time limits for filing claims.

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Reform Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.

(b) There shall be a rebuttable presumption that every claim for benefits is timely filed. The time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

[65 FR 80054, Dec. 20, 2000, as amended at 83 FR 27695, June 14, 2018]

§ 725.309 Additional claims; effect of prior denial of benefits.

(a) If a claimant files a claim under this part while another claim filed by the claimant under this part is still pending, the later claim must be merged with the earlier claim for all purposes. For purposes of this section, a claim must be considered pending if it has not yet been finally denied.

(b) If a claimant files a claim under this part within one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim must be considered a request for modification of the prior denial and will be processed and adjudicated under § 725.310.

(c) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim must be considered a subsequent claim for benefits. A subsequent claim will be processed and adjudicated in accordance with the provisions of subparts E and F of this part. Except as provided in paragraph (1) below, a subsequent claim must be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see §§ 725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules apply to the adjudication of a subsequent claim:

(1) The requirement to establish a change in an applicable condition of entitlement does not apply to a survivor's claim if the requirements of §§ 725.212(a)(3)(ii), 725.218(a)(2), or 725.222(a)(5)(ii) are met, and the survivor's prior claim was filed—

(i) On or before January 1, 2005, or

(ii) After January 1, 2005 and was finally denied prior to March 23, 2010.

(2) Any evidence submitted in connection with any prior claim must be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(3) For purposes of this section, the applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(4) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister must be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(5) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see §725.463), will be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim will be binding on that party in the adjudication of the subsequent claim.

(6) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

(d) In any case involving more than one claim filed by the same claimant, under no circumstances are duplicate benefits payable for concurrent periods of eligibility. Any duplicate benefits paid will be subject to collection or offset under subpart H of this part.

[78 FR 59118, Sept. 25, 2013]

§725.310 Modification of awards and denials.

(a) Upon his or her own initiative, or upon the request of any party on grounds of a change in conditions or because of a mistake in a determination of fact, the district director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

(b) Modification proceedings must be conducted in accordance with the provisions of this part as appropriate, except that the claimant and the operator, or group of operators or the fund, as appropriate, are each entitled to submit no more than one additional chest X-ray interpretation, one additional pulmonary function test, one additional arterial blood gas study, and one additional medical report in support of its affirmative case along with such rebuttal evidence and additional statements as are authorized by paragraphs (a)(2)(ii) and (a)(3)(ii) of §725.414. Modification proceedings may not be initiated before an administrative law judge or the Benefits Review Board.

(c) At the conclusion of modification proceedings before the district director, the district director may issue a proposed decision and order (§725.418) or, if appropriate, deny the claim by reason of abandonment (§725.409). In any case in which the district director has initiated modification proceedings on his own initiative to alter the terms of an award or denial of benefits issued by an administrative law judge, the district director must, at the conclusion of modification proceedings, forward the claim for a hearing (§725.421). In any case forwarded for a hearing, the administrative law judge assigned to hear such case must consider whether any additional evidence submitted by the parties demonstrates a change in condition and, regardless of whether the parties have submitted new evidence, whether the evidence of record demonstrates a mistake in a determination of fact.

(d) An order issued following the conclusion of modification proceedings may terminate, continue, reinstate, increase or decrease benefit payments or

award benefits. Such order must not affect any benefits previously paid, except that an order increasing the amount of benefits payable based on a finding of a mistake in a determination of fact may be made effective on the date from which benefits were determined payable by the terms of an earlier award. In the case of an award which is decreased, no payment made in excess of the decreased rate prior to the date upon which the party requested reconsideration under paragraph (a) of this section will be subject to collection or offset under subpart H of this part, provided the claimant is without fault as defined by §725.543. In the case of an award which is decreased following the initiation of modification by the district director, no payment made in excess of the decreased rate prior to the date upon which the district director initiated modification proceedings under paragraph (a) will be subject to collection or offset under subpart H of this part, provided the claimant is without fault as defined by §725.543. In the case of an award which has become final and is thereafter terminated, no payment made prior to the date upon which the party requested reconsideration under paragraph (a) will be subject to collection or offset under subpart H of this part. In the case of an award which has become final and is thereafter terminated following the initiation of modification by the district director, no payment made prior to the date upon which the district director initiated modification proceedings under paragraph (a) will be subject to collection or offset under subpart H of this part.

(e)(1) In this paragraph, an order is ''effective'' as described in §725.502(a) and ''final'' as described in §§725.419(d), 725.479(a) or 802.406.

(2) Any modification request by an operator must be denied unless the operator proves that at the time of the request, the operator has:

(i) Paid to the claimant all monetary benefits, including retroactive benefits and interest under §725.502(b)(2), due under any effective order;

(ii) Paid to the claimant all additional compensation (*see* §725.607) due under an effective order;

(iii) Paid all medical benefits (*see* §725.701 *et seq.*) due under any effective award, but only if the order awards payment of specific medical expenses;

(iv) Paid all final orders awarding attorney's fees and expenses under §725.367 and witness fees under §725.459, but only if the underlying benefits order is final (*see* §725.367(b)); and

(v) Reimbursed the Black Lung Disability Trust Fund, with interest, for all benefits paid under the orders described in paragraphs (e)(2)(i) or (iii) of this section and the costs for the medical examination under §725.406.

(3) The requirements of paragraph (e)(2) of this section are inapplicable to any benefits owed pursuant to an effective but non-final order if the payment of such benefits has been stayed by the Benefits Review Board or appropriate court under 33 U.S.C. 921.

(4) Except as provided by paragraph (e)(5) of this section, the operator must submit all documentary evidence pertaining to its compliance with the requirements of paragraph (e)(2) of this section to the district director concurrently with its request for modification. The claimant is also entitled to submit any relevant evidence to the district director. Absent extraordinary circumstances, no documentary evidence pertaining to the operator's compliance with the requirements of paragraph (e)(2) at the time of the modification request will be admitted into the hearing record or otherwise considered at any later stage of the proceeding.

(5) The requirements imposed by paragraph (e)(2) of this section are continuing in nature. If at any time during the modification proceedings the operator fails to meet the payment obligations described, the adjudication officer must issue an order to show cause why the operator's modification request should not be denied and afford all parties time to respond to such order. Responses may include evidence pertaining to the operator's continued compliance with the requirements of paragraph (e)(2). If, after the time for response has expired, the adjudication officer determines that the operator is not meeting its obligations, the adjudication officer must deny the operator's modification request.

(6) The denial of a request for modification under this section will not bar any future modification request by the operator, so long as the operator satisfies the requirements of paragraph (e)(2) of this section with each future modification petition.

(7) The provisions of this paragraph apply to all modification requests filed on or after May 26, 2016.

[65 FR 80054, Dec. 20, 2000, as amended at 81 FR 24479, Apr. 26, 2016]

§ 725.311 Communications with respect to claims; time computations.

(a) Unless otherwise specified by this part, all requests, responses, notices, decisions, orders, or other communications required or permitted by this part shall be in writing.

(b) If required by this part, any document, brief, or other statement submitted in connection with the adjudication of a claim under this part shall be sent to each party to the claim by the submitting party. If proof of service is required with respect to any communication, such proof of service shall be submitted to the appropriate adjudication officer and filed as part of the claim record.

(c) In computing any period of time described in this part, by any applicable statute, or by the order of any adjudication officer, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period extends until the next day which is not a Saturday, Sunday, or legal holiday. ''Legal holiday'' includes New Year's Day, Birthday of Martin Luther King, Jr., Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

(d) In computing any period of time described in this part in which the period within which to file a response commences upon receipt of a document, it shall be presumed, in the absence of evidence to the contrary, that the document was received on the seventh day after it was mailed. In any case in which a provision of this part requires a document to be sent to a person or party by certified mail, and the document is not sent by certified mail, but the person or party actually received the document, the document shall be deemed to have been sent in compliance with the provisions of this part. In such a case, any time period which commences upon the service of the document shall commence on the date the document was received.

Subpart D—Adjudication Officers; Parties and Representatives

§ 725.350 Who are the adjudication officers?

(a) *General.* The persons authorized by the Secretary of Labor to accept evidence and decide claims on the basis of such evidence are called ''adjudication officers.'' This section describes the status of black lung claims adjudication officers.

(b) *District Director.* The district director is that official of the DCMWC or his designee who is authorized to perform functions with respect to the development, processing, and adjudication of claims in accordance with this part.

(c) *Administrative law judge.* An administrative law judge is that official appointed pursuant to 5 U.S.C. 3105 (or Public Law 94–504) who is qualified to preside at hearings under 5 U.S.C. 557 and is empowered by the Secretary to conduct formal hearings with respect to, and adjudicate, claims in accordance with this part. A person appointed under Public Law 94–504 shall not be considered an administrative law judge for purposes of this part for any period after March 1, 1979.

§ 725.351 Powers of adjudication officers.

(a) *District Director.* The district director is authorized to:

(1) Make determinations with respect to claims as is provided in this part;

(2) Conduct conferences and informal discovery proceedings as provided in this part;

(3) Compel the production of documents by the issuance of a subpoena;

(4) Prepare documents for the signature of parties;

(5) Issue appropriate orders as provided in this part; and

(6) Do all other things necessary to enable him or her to discharge the duties of the office.

(b) Administrative Law Judge. An administrative law judge is authorized to:

(1) Conduct formal hearings in accordance with the provisions of this part;

(2) Administer oaths and examine witnesses;

(3) Compel the production of documents and appearance of witnesses by the issuance of subpoenas;

(4) Issue decisions and orders with respect to claims as provided in this part; and

(5) Do all other things necessary to enable him or her to discharge the duties of the office.

(c) If any person in proceedings before an adjudication officer disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the same, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to be examined according to law, the district director, or the administrative law judge responsible for the adjudication of the claim, shall certify the facts to the Federal district court having jurisdiction in the place in which he or she is sitting (or to the U.S. District Court for the District of Columbia if he or she is sitting in the District) which shall thereupon in a summary manner hear the evidence as to the acts complained of, and, if the evidence so warrants, punish such person in the same manner and to the same extent as for a contempt committed before the court, or commit such person upon the same condition as if the doing of the forbidden act had occurred with reference to the process or in the presence of the court.

§ 725.352 Disqualification of adjudication officer.

(a) No adjudication officer shall conduct any proceedings in a claim in which he or she is prejudiced or partial, or where he or she has any interest in the matter pending for decision. A decision to withdraw from the consideration of a claim shall be within the discretion of the adjudication officer. If that adjudication officer withdraws, another officer shall be designated by the Director or the Chief Administrative Law Judge, as the case may be, to complete the adjudication of the claim.

(b) No adjudication officer shall be permitted to appear or act as a representative of a party under this part while such individual is employed as an adjudication officer. No adjudication officer shall be permitted at any time to appear or act as a representative in connection with any case or claim in which he or she was personally involved. No fee or reimbursement shall be awarded under this part to an individual who acts in violation of this paragraph.

(c) No adjudication officer shall act in any claim involving a party which employed such adjudication officer within one year before the adjudication of such claim.

(d) Notwithstanding paragraph (a) of this section, no adjudication officer shall be permitted to act in any claim involving a party who is related to the adjudication officer by consanguinity or affinity within the third degree as determined by the law of the place where such party is domiciled. Any action taken by an adjudication officer in knowing violation of this paragraph shall be void.

§ 725.360 Parties to proceedings.

(a) Except as provided in § 725.361, no person other than the Secretary of Labor and authorized personnel of the Department of Labor shall participate at any stage in the adjudication of a claim for benefits under this part, unless such person is determined by the appropriate adjudication officer to qualify under the provisions of this section as a party to the claim. The following persons shall be parties:

(1) The claimant;

(2) A person other than a claimant, authorized to execute a claim on such claimant's behalf under § 725.301;

(3) Any coal mine operator notified under § 725.407 of its possible liability for the claim;

(4) Any insurance carrier of such operator; and

(5) The Director in all proceedings relating to a claim for benefits under this part.

(b) A widow, child, parent, brother, or sister, or the representative of a decedent's estate, who makes a showing in writing that his or her rights with respect to benefits may be prejudiced by a decision of an adjudication officer, may be made a party.

(c) Any coal mine operator or prior operator or insurance carrier which has not been notified under § 725.407 and which makes a showing in writing that its rights may be prejudiced by a decision of an adjudication officer may be made a party.

(d) Any other individual may be made a party if that individual's rights with respect to benefits may be prejudiced by a decision to be made.

§ 725.361 Party amicus curiae.

At the discretion of the Chief Administrative Law Judge or the administrative law judge assigned to the case, a person or entity which is not a party may be allowed to participate amicus curiae in a formal hearing only as to an issue of law. A person may participate amicus curiae in a formal hearing upon written request submitted with supporting arguments prior to the hearing. If the request is granted, the administrative law judge hearing the case will inform the party of the extent to which participation will be permitted. The request may, however, be denied summarily and without explanation.

§ 725.362 Representation of parties.

(a) Except for the Secretary of Labor, whose interests shall be represented by the Solicitor of Labor or his or her designee, each of the parties may appoint an individual to represent his or her interest in any proceeding for determination of a claim under this part. Such appointment shall be made in writing or on the record at the hearing. An attorney qualified in accordance with § 725.363(a) shall file a written declaration that he or she is authorized to represent a party, or declare his or her representation on the record at a formal hearing. Any other person (see § 725.363(b)) shall file a written notice of appointment signed by the party or his or her legal guardian, or enter his or her appearance on the record at a formal hearing if the party he or she seeks to represent is present and consents to the representation. Any written declaration or notice required by this section shall include the OWCP number assigned by the Office and shall be sent to the Office or, for representation at a formal hearing, to the Chief Administrative Law Judge. In any case, such representative must be qualified under § 725.363. No authorization for representation or agreement between a claimant and representative as to the amount of a fee, filed with the Social Security Administration in connection with a claim under part B of title IV of the Act, shall be valid under this part. A claimant who has previously authorized a person to represent him or her in connection with a claim originally filed under part B of title IV may renew such authorization by filing a statement to such effect with the Office or appropriate adjudication officer.

(b) Any party may waive his or her right to be represented in the adjudication of a claim. If an adjudication officer determines, after an appropriate inquiry has been made, that a claimant who has been informed of his or her right to representation does not wish to obtain the services of a representative, such adjudication officer shall proceed to consider the claim in accordance with this part, unless it is apparent that the claimant is, for any reason, unable to continue without the help of a representative. However, it shall not be necessary for an adjudication officer to inquire as to the ability of a claimant to proceed without representation in any adjudication taking place without a hearing. The failure of a claimant to obtain representation in an adjudication taking place without a hearing shall be considered a waiver of the claimant's right to representation. However, at any time during the processing or adjudication of a claim, any claimant may revoke such waiver and obtain a representative.

§ 725.363 Qualification of representative.

(a) *Attorney.* Any attorney in good standing who is admitted to practice before a court of a State, territory, district, or insular possession, or before the Supreme Court of the United States or other Federal court and is not, pursuant to any provision of law, prohibited from acting as a representative, may be appointed as a representative.

(b) *Other person.* With the approval of the adjudication officer, any other person may be appointed as a representative so long as that person is not, pursuant to any provision of law, prohibited from acting as a representative.

§ 725.364 Authority of representative.

A representative, appointed and qualified as provided in §§ 725.362 and 725.363, may make or give on behalf of the party he or she represents, any request or notice relative to any proceeding before an adjudication officer, including formal hearing and review, except that such representative may not execute a claim for benefits, unless he or she is a person designated in § 725.301 as authorized to execute a claim. A representative shall be entitled to present or elicit evidence and make allegations as to facts and law in any proceeding affecting the party represented and to obtain information with respect to the claim of such party to the same extent as such party. Notice given to any party of any administrative action, determination, or decision, or request to any party for the production of evidence shall be sent to the representative of such party and such notice or request shall have the same force and effect as if it had been sent to the party represented.

§ 725.365 Approval of representative's fees; lien against benefits.

No fee charged for representation services rendered to a claimant with respect to any claim under this part shall be valid unless approved under this subpart. No contract or prior agreement for a fee shall be valid. In cases where the obligation to pay the attorney's fee is upon the claimant, the amount of the fee awarded may be made a lien upon the benefits due under an award and the adjudication officer shall fix, in the award approving the fee, such lien and the manner of payment of the fee. Any representative who is not an attorney may be awarded a fee for services under this subpart, except that no lien may be imposed with respect to such representative's fee.

§ 725.366 Fees for representatives.

(a) A representative seeking a fee for services performed on behalf of a claimant shall make application therefor to the district director, administrative law judge, or appropriate appellate tribunal, as the case may be, before whom the services were performed. The application shall be filed and served upon the claimant and all other parties within the time limits allowed by the district director, administrative law judge, or appropriate appellate tribunal. The application shall be supported by a complete statement of the extent and character of the necessary work done, and shall indicate the professional status (e.g., attorney, paralegal, law clerk, lay representative or clerical) of the person performing such work, and the customary billing rate for each such person. The application shall also include a listing of reasonable unreimbursed expenses, including those for travel, incurred by the representative or an employee of a representative in establishing the claimant's case. Any fee requested under this paragraph shall also contain a description of any fee requested, charged, or received for services rendered to the claimant before any State or Federal court or agency in connection with a related matter.

(b) Any fee approved under paragraph (a) of this section shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the qualifications of the representative, the complexity of the legal issues involved, the level of proceedings to which the claim was raised, the level at which the representative entered the proceedings, and any other information which may be relevant to the amount of fee requested. No fee approved shall include payment for time spent in preparation of a fee application. No fee

shall be approved for work done on claims filed between December 30, 1969, and June 30, 1973, under part B of title IV of the Act, except for services rendered on behalf of the claimant in regard to the review of the claim under section 435 of the Act and part 727 of this subchapter (see § 725.4(d)).

(c) In awarding a fee, the appropriate adjudication officer shall consider, and shall add to the fee, the amount of reasonable and unreimbursed expenses incurred in establishing the claimant's case. Reimbursement for travel expenses incurred by an attorney shall be determined in accordance with the provisions of § 725.459(a). No reimbursement shall be permitted for expenses incurred in obtaining medical or other evidence which has previously been submitted to the Office in connection with the claim.

(d) Upon receipt of a request for approval of a fee, such request shall be reviewed and evaluated by the appropriate adjudication officer and a fee award issued. Any party may request reconsideration of a fee awarded by the adjudication officer. A revised or modified fee award may then be issued, if appropriate.

(e) Each request for reconsideration or review of a fee award shall be in writing and shall contain supporting statements or information pertinent to any increase or decrease requested. If a fee awarded by a district director is disputed, such award shall be appealable directly to the Benefits Review Board. In such a fee dispute case, the record before the Board shall consist of the order of the district director awarding or denying the fee, the application for a fee, any written statement in opposition to the fee and the documentary evidence contained in the file which verifies or refutes any item claimed in the fee application.

§ 725.367 Payment of a claimant's attorney's fee by responsible operator or fund.

(a) An attorney who represents a claimant in the successful prosecution of a claim for benefits may be entitled to collect a reasonable attorney's fee from the responsible operator that is ultimately found liable for the payment of benefits, or, in a case in which there is no operator who is liable for the payment of benefits, from the fund. Generally, the operator or fund liable for the payment of benefits shall be liable for the payment of the claimant's attorney's fees where the operator or fund, as appropriate, took action, or acquiesced in action, that created an adversarial relationship between itself and the claimant. The fees payable under this section shall include reasonable fees for necessary services performed prior to the creation of the adversarial relationship. Circumstances in which a successful attorney's fees shall be payable by the responsible operator or the fund include, but are not limited to, the following:

(1) The responsible operator designated by the district director (see § 725.410(a)(3)) fails to accept the claimant's entitlement to benefits within the 30-day period provided by § 725.412(b) and is ultimately determined to be liable for benefits. The operator shall be liable for an attorney's fee with respect to all necessary services performed by the claimant's attorney;

(2) There is no operator that may be held liable for the payment of benefits, and the district director issues a schedule for the submission of additional evidence under § 725.410. The fund shall be liable for an attorney's fee with respect to all necessary services performed by the claimant's attorney;

(3) The claimant submits a bill for medical treatment, and the party liable for the payment of benefits declines to pay the bill on the grounds that the treatment is unreasonable, or is for a condition that is not compensable. The responsible operator or fund, as appropriate, shall be liable for an attorney's fee with respect to all necessary services performed by the claimant's attorney;

(4) A beneficiary seeks an increase in the amount of benefits payable, and the responsible operator or fund contests the claimant's right to that increase. If the beneficiary is successful in securing an increase in the amount of benefits payable, the operator or fund shall be liable for an attorney's fee with respect to all necessary services performed by the beneficiary's attorney;

(5) The responsible operator or fund seeks a decrease in the amount of benefits payable. If the beneficiary is successful in resisting the request for a decrease in the amount of benefits payable, the operator or fund shall be liable for an attorney's fee with respect to all necessary services performed by the beneficiary's attorney. A request for information clarifying the amount of benefits payable shall not be considered a request to decrease that amount.

(b) Any fee awarded under this section shall be in addition to the award of benefits, and shall be awarded, in an order, by the district director, administrative law judge, Board or court, before whom the work was performed. The operator or fund shall pay such fee promptly and directly to the claimant's attorney in a lump sum after the award of benefits becomes final.

(c) Section 205(a) of the Black Lung Benefits Amendments of 1981, Public Law 97–119, amended section 422 of the Act and relieved operators and carriers from liability for the payment of benefits on certain claims. Payment of benefits on those claims was made the responsibility of the fund. The claims subject to this transfer of liability are described in §725.496. On claims subject to the transfer of liability described in this paragraph the fund will pay all fees and costs which have been or will be awarded to claimant's attorneys which were or would have become the liability of an operator or carrier but for the enactment of the 1981 Amendments and which have not already been paid by such operator or carrier. Section 9501(d)(7) of the Internal Revenue Code (26 U.S.C.), which was also enacted as a part of the 1981 Amendments to the Act, expressly prohibits the fund from reimbursing an operator or carrier for any attorney fees or costs which it has paid on cases subject to the transfer of liability provisions.

Subpart E—Adjudication of Claims by the District Director

§ 725.401 Claims development—general.

After a claim has been received by the district director, the district director shall take such action as is necessary to develop, process, and make determinations with respect to the claim as provided in this subpart.

§ 725.402 Approved State workers' compensation law.

If a district director determines that any claim filed under this part is one subject to adjudication under a workers' compensation law approved under part 722 of this subchapter, he or she shall advise the claimant of this determination and of the Act's requirement that the claim must be filed under the applicable State workers' compensation law. The district director shall then prepare a proposed decision and order dismissing the claim for lack of jurisdiction pursuant to §725.418 and proceed as appropriate.

§ 725.403 [Reserved]

§ 725.404 Development of evidence—general.

(a) *Employment history.* Each claimant shall furnish the district director with a complete and detailed history of the coal miner's employment and, upon request, supporting documentation.

(b) *Matters of record.* Where it is necessary to obtain proof of age, marriage or termination of marriage, death, family relationship, dependency (see subpart B of this part), or any other fact which may be proven as a matter of public record, the claimant shall furnish such proof to the district director upon request.

(c) *Documentary evidence.* If a claimant is required to submit documents to the district director, the claimant shall submit either the original, a certified copy or a clear readable copy thereof. The district director or administrative law judge may require the submission of an original document or certified copy thereof, if necessary.

(d) *Submission of insufficient evidence.* In the event a claimant submits insufficient evidence regarding any matter, the district director shall inform the claimant of what further evidence is necessary and request that such evidence be submitted within a specified reasonable time which may, upon request, be extended for good cause.

§ 725.405 Development of medical evidence; scheduling of medical examinations and tests.

(a) Upon receipt of a claim, the district director shall ascertain whether the claim was filed by or on account of a miner as defined in § 725.202, and in the case of a claim filed on account of a deceased miner, whether the claim was filed by an eligible survivor of such miner as defined in subpart B of this part.

(b) In the case of a claim filed by or on behalf of a miner, the district director shall, where necessary, schedule the miner for a medical examination and testing under § 725.406.

(c) In the case of a claim filed by or on behalf of a survivor of a miner, the district director shall obtain whatever medical evidence is necessary and available for the development and evaluation of the claim.

(d) The district director shall, where appropriate, collect other evidence necessary to establish:

(1) The nature and duration of the miner's employment; and

(2) All other matters relevant to the determination of the claim.

(e) If at any time during the processing of the claim by the district director, the evidence establishes that the claimant is not entitled to benefits under the Act, the district director may terminate evidentiary development of the claim and proceed as appropriate.

§ 725.406 Medical examinations and tests.

(a) The Act requires the Department to provide each miner who applies for benefits with the opportunity to undergo a complete pulmonary evaluation at no expense to the miner. A complete pulmonary evaluation includes a report of physical examination, a pulmonary function study, a chest radiograph, and, unless medically contraindicated, a blood gas study.

(b) As soon as possible after a miner files an application for benefits, the district director will provide the miner with a list of medical facilities and physicians in the state of the miner's residence and states contiguous to the state of the miner's residence that the Office has authorized to perform complete pulmonary evaluations. The miner must select one of the facilities or physicians on the list, provided that the miner may not select any physician to whom the miner or the miner's spouse is related to the fourth degree of consanguinity, and the miner may not select any physician who has examined or provided medical treatment to the miner within the twelve months preceding the date of the miner's application. The district director will make arrangements for the miner to be given a complete pulmonary evaluation by that facility or physician. The results of the complete pulmonary evaluation must not be counted as evidence submitted by the miner under § 725.414.

(c) If any medical examination or test conducted under paragraph (a) of this section is not administered or reported in substantial compliance with the provisions of part 718 of this subchapter, or does not provide sufficient information to allow the district director to decide whether the miner is eligible for benefits, the district director must schedule the miner for further examination and testing. Where the deficiencies in the report are the result of a lack of effort on the part of the miner, the miner will be afforded one additional opportunity to produce a satisfactory result. In order to determine whether any medical examination or test was administered and reported in substantial compliance with the provisions of part 718 of this subchapter, the district director may have any component of such examination or test reviewed by a physician selected by the district director.

(d) After the physician completes the report authorized by paragraph (a), the district director will inform the miner that he may elect to have the results of the objective testing sent to his treating physician for use in preparing a medical opinion. The district director will also inform the claimant that any medical opinion submitted by his treating physician will count as one of the two medical opinions that the miner may submit under § 725.414 of this part.

(e) The cost of any medical examination or test authorized under this section, including the cost of travel to and from the examination, must be paid by

the fund. Reimbursement for overnight accommodations must not be authorized unless the district director determines that an adequate testing facility is unavailable within one day's round trip travel by automobile from the miner's residence. The fund must be reimbursed for such payments by an operator, if any, found liable for the payment of benefits to the claimant. If an operator fails to repay such expenses, with interest, upon request of the Office, the entire amount may be collected in an action brought under section 424 of the Act and § 725.603.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 35558, June 13, 2013; 79 FR 21615, Apr. 17, 2014]

§ 725.407 Identification and notification of responsible operator.

(a) Upon receipt of the miner's employment history, the district director shall investigate whether any operator may be held liable for the payment of benefits as a responsible operator in accordance with the criteria contained in Subpart G of this part.

(b) The district director may identify one or more operators potentially liable for the payment of benefits in accordance with the criteria set forth in § 725.495 of this part. The district director shall notify each such operator of the existence of the claim. Where the records maintained by the Office pursuant to part 726 of this subchapter indicate that the operator had obtained a policy of insurance, and the claim falls within such policy, the notice provided pursuant to this section shall also be sent to the operator's carrier. Any operator or carrier notified of the claim shall thereafter be considered a party to the claim in accordance with § 725.360 of this part unless it is dismissed by an adjudication officer and is not thereafter notified again of its potential liability.

(c) The notification issued pursuant to this section shall include a copy of the claimant's application and a copy of all evidence obtained by the district director relating to the miner's employment. The district director may request the operator to answer specific questions, including, but not limited to, questions related to the nature of its operations, its relationship with the miner, its financial status, including any insurance obtained to secure its obligations under the Act, and its relationship with other potentially liable operators. A copy of any notification issued pursuant to this section shall be sent to the claimant by regular mail.

(d) If at any time before a case is referred to the Office of Administrative Law Judges, the district director determines that an operator which may be liable for the payment of benefits has not been notified under this section or has been incorrectly dismissed pursuant to § 725.410(a)(3), the district director shall give such operator notice of its potential liability in accordance with this section. The adjudication officer shall then take such further action on the claim as may be appropriate. There shall be no time limit applicable to a later identification of an operator under this paragraph if the operator fraudulently concealed its identity as an employer of the miner. The district director may not notify additional operators of their potential liability after a case has been referred to the Office of Administrative Law Judges, unless the case was referred for a hearing to determine whether the claim was properly denied as abandoned pursuant to § 725.409.

§ 725.408 Operator's response to notification.

(a)(1) An operator which receives notification under § 725.407 shall, within 30 days of receipt, file a response indicating its intent to accept or contest its identification as a potentially liable operator. The operator's response shall also be sent to the claimant by regular mail.

(2) If the operator contests its identification, it shall, on a form supplied by the district director, state the precise nature of its disagreement by admitting or denying each of the following assertions. In answering these assertions, the term ''operator'' shall include any operator for which the identified operator may be considered a successor operator pursuant to § 725.492.

(i) That the named operator was an operator for any period after June 30, 1973;

(ii) That the operator employed the miner as a miner for a cumulative period of not less than one year;

(iii) That the miner was exposed to coal mine dust while working for the operator;

(iv) That the miner's employment with the operator included at least one working day after December 31, 1969; and

(v) That the operator is capable of assuming liability for the payment of benefits.

(3) An operator which receives notification under §725.407, and which fails to file a response within the time limit provided by this section, shall not be allowed to contest its liability for the payment of benefits on any of the grounds set forth in paragraph (a)(2).

(b)(1) Within 90 days of the date on which it receives notification under §725.407, an operator may submit documentary evidence in support of its position.

(2) No documentary evidence relevant to the grounds set forth in paragraph (a)(2) may be admitted in any further proceedings unless it is submitted within the time limits set forth in this section.

§725.409 Denial of a claim by reason of abandonment.

(a) A claim may be denied at any time by the district director by reason of abandonment where the claimant fails:

(1) To undergo a required medical examination without good cause; or,

(2) To submit evidence sufficient to make a determination of the claim; or,

(3) To pursue the claim with reasonable diligence; or,

(4) To attend an informal conference without good cause.

(b)(1) If the district director determines that a denial by reason of abandonment under paragraphs (a)(1) through (3) of this section is appropriate, he or she shall notify the claimant of the reasons for such denial and of the action which must be taken to avoid a denial by reason of abandonment. If the claimant completes the action requested within the time allowed, the claim shall be developed, processed and adjudicated as specified in this part. If the claimant does not fully comply with the action requested by the district director, the district director shall notify the claimant that the claim has been denied by reason of abandonment. Such notification shall be served on the claimant and all other parties to the claim by certified mail.

(2) In any case in which a claimant has failed to attend an informal conference and has not provided the district director with his reasons for failing to attend, the district director shall ask the claimant to explain his absence. In considering whether the claimant had good cause for his failure to attend the conference, the district director shall consider all relevant circumstances, including the age, education, and health of the claimant, as well as the distance between the claimant's residence and the location of the conference. If the district director concludes that the claimant had good cause for failing to attend the conference, he may continue processing the claim, including, where appropriate under §725.416, the scheduling of an informal conference. If the claimant does not supply the district director with his reasons for failing to attend the conference within 30 days of the date of the district director's request, or the district director concludes that the reasons supplied by the claimant do not establish good cause, the district director shall notify the claimant that the claim has been denied by reason of abandonment. Such notification shall be served on the claimant and all other parties to the claim by certified mail.

(c) The denial of a claim by reason of abandonment shall become effective and final unless, within 30 days after the denial is issued, the claimant requests a hearing. Following the expiration of the 30-day period, a new claim may be filed at any time pursuant to §725.309. For purposes of §725.309, a denial by reason of abandonment shall be deemed a finding that the claimant has not established any applicable condition of entitlement. If the claimant timely requests a hearing, the district director shall refer the case to the Office of Administrative Law Judges in accordance with §725.421. Except upon the motion or written agreement of the Director, the hearing will be limited to the issue of whether the claim was

properly denied by reason of abandonment. If the hearing is limited to the issue of abandonment and the administrative law judge determines that the claim was not properly denied by reason of abandonment, he shall remand the claim to the district director for the completion of administrative processing.

§ 725.410 Submission of additional evidence.

(a) After the district director completes the development of medical evidence under § 725.405 of this part, including the complete pulmonary evaluation authorized by § 725.406, and receives the responses and evidence submitted pursuant to § 725.408, he shall issue a schedule for the submission of additional evidence. The schedule shall contain the following information:

(1) If the claim was filed by, or on behalf of, a miner, the schedule shall contain a summary of the complete pulmonary evaluation administered pursuant to § 725.406. If the claim was filed by, or on behalf of, a survivor, the schedule shall contain a summary of any medical evidence developed by the district director pursuant to § 725.405(c).

(2) The schedule shall contain the district director's preliminary analysis of the medical evidence. If the district director believes that the evidence fails to establish any necessary element of entitlement, he shall inform the claimant of the element of entitlement not established and the reasons for his conclusions and advise the claimant that, unless he submits additional evidence, the district director will issue a proposed decision and order denying the claim.

(3) The schedule shall contain the district director's designation of a responsible operator liable for the payment of benefits. In the event that the district director has designated as the responsible operator an employer other than the employer who last employed the claimant as a miner, the district director shall include, with the schedule, a copy of the statements required by § 725.495(d) of this part. The district director may, in his discretion, dismiss as parties any of the operators notified of their potential liability pursuant to § 725.407. If the district director thereafter determines that the participation of a party dismissed pursuant to this section is required, he may once again notify the operator in accordance with § 725.407(d).

(4) The schedule shall notify the claimant and the designated responsible operator that they have the right to obtain further adjudication of the claim in accordance with this subpart, and that they have the right to submit additional evidence in accordance with this subpart. The schedule shall also notify the claimant that he has the right to obtain representation, under the terms set forth in subpart D, in order to assist him. In a case in which the district director has designated a responsible operator pursuant to paragraph (a)(3), the schedule shall further notify the claimant that if the operator fails to accept the claimant's entitlement to benefits within the time limit provided by § 725.412, the cost of obtaining additional medical and other necessary evidence, along with a reasonable attorney's fee, shall be reimbursed by the responsible operator in the event that the claimant establishes his entitlement to benefits payable by that operator. In a case in which there is no operator liable for the payment of benefits, the schedule shall notify the claimant that the cost of obtaining additional medical and other necessary evidence, along with a reasonable attorney's fee, shall be reimbursed by the fund.

(b) The schedule shall allow all parties not less than 60 days within which to submit additional evidence, including evidence relevant to the claimant's eligibility for benefits and evidence relevant to the liability of the designated responsible operator, and shall provide not less than an additional 30 days within which the parties may respond to evidence submitted by other parties. Any such evidence must meet the requirements set forth in § 725.414 in order to be admitted into the record.

(c) The district director shall serve a copy of the schedule, together with a copy of all of the evidence developed, on the claimant, the designated responsible operator, and all other operators which received notification pursuant to

§ 725.407. The schedule shall be served on each party by certified mail.

§ 725.411 Initial adjudication in Trust Fund cases.

Notwithstanding the requirements of § 725.410 of this part, if the district director concludes that the results of the complete pulmonary evaluation support a finding of eligibility, and that there is no operator responsible for the payment of benefits, the district director shall issue a proposed decision and order in accordance with § 725.418 of this part.

§ 725.412 Operator's response.

(a)(1) Within 30 days after the district director issues a schedule pursuant to § 725.410 of this part containing a designation of the responsible operator liable for the payment of benefits, that operator shall file a response with regard to its liability. The response shall specifically indicate whether the operator agrees or disagrees with the district director's designation.

(2) If the responsible operator designated by the district director does not file a timely response, it shall be deemed to have accepted the district director's designation with respect to its liability, and to have waived its right to contest its liability in any further proceeding conducted with respect to the claim.

(b) The responsible operator designated by the district director may also file a statement accepting claimant's entitlement to benefits. If that operator fails to file a timely response to the district director's designation, the district director shall, upon receipt of such a statement, issue a proposed decision and order in accordance with § 725.418 of this part. If the operator fails to file a statement accepting the claimant's entitlement to benefits within 30 days after the district director issues a schedule pursuant to § 725.410 of this part, the operator shall be deemed to have contested the claimant's entitlement.

§ 725.413 Disclosure of medical information.

(a) For purposes of this section, medical information is any written medical data, including data in electronic format, about the miner that a party develops in connection with a claim for benefits, including medical data developed with any prior claim that has not been disclosed previously to the other parties. Medical information includes, but is not limited to—

(1) Any examining physician's written or testimonial assessment of the miner, including the examiner's findings, diagnoses, conclusions, and the results of any tests;

(2) Any other physician's written or testimonial assessment of the miner's respiratory or pulmonary condition;

(3) The results of any test or procedure related to the miner's respiratory or pulmonary condition, including any information relevant to the test or procedure's administration; and

(4) Any physician's or other medical professional's interpretation of the results of any test or procedure related to the miner's respiratory or pulmonary condition.

(b) For purposes of this section, medical information does not include—

(1) Any record of a miner's hospitalization or other medical treatment; or

(2) Communications from a party's representative to a medical expert.

(c) Each party must disclose medical information the party or the party's agent receives by sending a complete copy of the information to all other parties in the claim within 30 days after receipt. If the information is received after the claim is already scheduled for hearing before an administrative law judge, the disclosure must be made at least 20 days before the scheduled hearing is held (*see* § 725.456(b)).

(d) Medical information disclosed under this section must not be considered in adjudicating any claim unless a party designates the information as evidence in the claim.

(e) At the request of any party or on his or her own motion, an adjudication officer may impose sanctions on any party or his or her representative who fails to timely disclose medical information in compliance with this section.

(1) Sanctions must be appropriate to the circumstances and may only be imposed after giving the party an opportunity to demonstrate good cause why

disclosure was not made and sanctions are not warranted. In determining an appropriate sanction, the adjudication officer must consider—

(i) Whether the sanction should be mitigated because the party was not represented by an attorney when the information should have been disclosed; and

(ii) Whether the party should not be sanctioned because the failure to disclose was attributable solely to the party's attorney.

(2) Sanctions may include, but are not limited to—

(i) Drawing an adverse inference against the non-disclosing party on the facts relevant to the disclosure;

(ii) Limiting the non-disclosing party's claims, defenses or right to introduce evidence;

(iii) Dismissing the claim proceeding if the non-disclosing party is the claimant and no payments prior to final adjudication have been made to the claimant unless the Director agrees to the dismissal in writing (*see* § 725.465(d));

(iv) Rendering a default decision against the non-disclosing party;

(v) Disqualifying the non-disclosing party's attorney from further participation in the claim proceedings; and

(vi) Relieving a claimant who files a subsequent claim from the impact of § 725.309(c)(6) if the non-disclosed evidence predates the denial of the prior claim and the non-disclosing party is the operator.

(3) Sanctions must not include—

(i) Fines or

(ii) Imprisonment.

(4) Sanctions imposed by a district director are subject to review by an administrative law judge in accordance with the provisions of this part.

(f) This rule applies to—

(1) All claims filed after May 26, 2016;

(2) Pending claims not yet adjudicated by an administrative law judge, except that medical information received prior to May 26, 2016 and not previously disclosed must be provided to the other parties within 60 days of May 26, 2016; and

(3) Pending claims already adjudicated by an administrative law judge where—

(i) The administrative law judge reopens the record for receipt of additional evidence in response to a timely reconsideration motion (*see* § 725.479(b)) or after remand by the Benefits Review Board or a reviewing court; or

(ii) A party requests modification of the award or denial of benefits (*see* § 725.310(a)).

(The Office of Management and Budget has approved the information collection contained in this section and assigned control number 1240–0054 with an expiration date of May 31, 2019.)

[81 FR 24480, Apr. 26, 2016, as amended at 81 FR 31854, May 20, 2016]

§ 725.414 Development of evidence.

(a) *Medical evidence.* (1) For purposes of this section, a medical report is a physician's written assessment of the miner's respiratory or pulmonary condition. A medical report may be prepared by a physician who examined the miner and/or reviewed the available admissible evidence. Supplemental medical reports prepared by the same physician must be considered part of the physician's original medical report. A physician's written assessment of a single objective test, such as a chest X-ray or a pulmonary function test, is not a medical report for purposes of this section.

(2)(i) The claimant is entitled to submit, in support of his affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section.

(ii) The claimant is entitled to submit, in rebuttal of the case presented by the party opposing entitlement, no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by the designated responsible operator or the

fund, as appropriate, under paragraph (a)(3)(i) or (a)(3)(iii) of this section and by the Director pursuant to § 725.406. In any case in which the party opposing entitlement has submitted the results of other testing pursuant to § 718.107, the claimant is entitled to submit one physician's assessment of each piece of such evidence in rebuttal. In addition, where the responsible operator or fund has submitted rebuttal evidence under paragraph (a)(3)(ii) or (a)(3)(iii) of this section with respect to medical testing submitted by the claimant, the claimant is entitled to submit an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing. Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the claimant, the claimant is entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.

(3)(i) The responsible operator designated pursuant to § 725.410 is entitled to obtain and submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section. In obtaining such evidence, the responsible operator may not require the miner to travel more than 100 miles from his or her place of residence, or the distance traveled by the miner in obtaining the complete pulmonary evaluation provided by § 725.406 of this part, whichever is greater, unless a trip of greater distance is authorized in writing by the district director. If a miner unreasonably refuses—

(A) To provide the Office or the designated responsible operator with a complete statement of his or her medical history and/or to authorize access to his or her medical records, or

(B) To submit to an evaluation or test requested by the district director or the designated responsible operator, the miner's claim may be denied by reason of abandonment. (*See* § 725.409 of this part).

(ii) The responsible operator is entitled to submit, in rebuttal of the case presented by the claimant, no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by the claimant under paragraph (a)(2)(i) of this section and by the Director pursuant to § 725.406. In any case in which the claimant has submitted the results of other testing pursuant to § 718.107, the responsible operator is entitled to submit one physician's assessment of each piece of such evidence in rebuttal. In addition, where the claimant has submitted rebuttal evidence under paragraph (a)(2)(ii) of this section, the responsible operator is entitled to submit an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing. Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the responsible operator, the responsible operator is entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.

(iii) In a case in which the district director has not identified any potentially liable operators, or has dismissed all potentially liable operators under § 725.410(a)(3), or has identified a liable operator that ceases to defend the claim on grounds of an inability to provide for payment of continuing benefits, the district director is entitled to exercise the rights of a responsible operator under this section, except that the evidence obtained in connection with the complete pulmonary evaluation performed pursuant to § 725.406 must be considered evidence obtained and submitted by the Director, OWCP, for purposes of paragraph (a)(3)(i) of this section. In a case involving a dispute concerning medical benefits under

§ 725.708 of this part, the district director is entitled to develop medical evidence to determine whether the medical bill is compensable under the standard set forth in § 725.701 of this part.

(4) Notwithstanding the limitations in paragraphs (a)(2) and (a)(3) of this section, any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence.

(5) A copy of any documentary evidence submitted by a party must be served on all other parties to the claim. If the claimant is not represented by an attorney, the district director must mail a copy of all documentary evidence submitted by the claimant to all other parties to the claim. Following the development and submission of affirmative medical evidence, the parties may submit rebuttal evidence in accordance with the schedule issued by the district director.

(b) *Evidence pertaining to liability.* (1) Except as provided by § 725.408(b)(2), the designated responsible operator may submit evidence to demonstrate that it is not the potentially liable operator that most recently employed the claimant.

(2) Any other party may submit evidence regarding the liability of the designated responsible operator or any other operator.

(3) A copy of any documentary evidence submitted under this paragraph must be mailed to all other parties to the claim. Following the submission of affirmative evidence, the parties may submit rebuttal evidence in accordance with the schedule issued by the district director.

(c) *Testimony.* A physician who prepared a medical report admitted under this section may testify with respect to the claim at any formal hearing conducted in accordance with subpart F of this part, or by deposition. If a party has submitted fewer than two medical reports as part of that party's affirmative case under this section, a physician who did not prepare a medical report may testify in lieu of such a medical report. The testimony of such a physician will be considered a medical report for purposes of the limitations provided by this section. A party may offer the testimony of no more than two physicians under the provisions of this section unless the adjudication officer finds good cause under paragraph (b)(1) of § 725.456 of this part. In accordance with the schedule issued by the district director, all parties must notify the district director of the name and current address of any potential witness whose testimony pertains to the liability of a potentially liable operator or the designated responsible operator. Absent such notice, the testimony of a witness relevant to the liability of a potentially liable operator or the designated responsible operator will not be admitted in any hearing conducted with respect to the claim unless the administrative law judge finds that the lack of notice should be excused due to extraordinary circumstances.

(d) Except to the extent permitted by §§ 725.456 and 725.310(b), the limitations set forth in this section apply to all proceedings conducted with respect to a claim, and no documentary evidence pertaining to liability may be admitted in any further proceeding conducted with respect to a claim unless it is submitted to the district director in accordance with this section.

[65 FR 80054, Dec. 20, 2000, as amended at 81 FR 24480, Apr. 26, 2016]

§ 725.415 Action by the district director after development of evidence.

(a) At the end of the period permitted under § 725.410(b) for the submission of evidence, the district director shall review the claim on the basis of all evidence submitted in accordance with § 725.414.

(b) After review of all evidence submitted, the district director may issue another schedule for the submission of additional evidence pursuant to § 725.410, identifying another potentially liable operator as the responsible operator liable for the payment of benefits. In such a case, the district director shall not permit the development or submission of any additional medical evidence until after he has made a final determination of the identity of the responsible operator liable for the payment of benefits. If the operator

who is finally determined to be the responsible operator has not had the opportunity to submit medical evidence pursuant to § 725.410, the district director shall allow the designated responsible operator and the claimant not less than 60 days within which to submit evidence relevant to the claimant's eligibility for benefits. The designated responsible operator may elect to adopt any medical evidence previously submitted by another operator as its own evidence, subject to the limitations of § 725.414. The district director may also schedule a conference in accordance with § 725.416, issue a proposed decision and order in accordance with § 725.418, or take such other action as the district director considers appropriate.

§ 725.416 Conferences.

(a) At the conclusion of the period permitted by § 725.410(b) of this part for the submission of evidence, the district director may conduct an informal conference in any claim where it appears that such conference will assist in the voluntary resolution of any issue raised with respect to the claim. The conference proceedings shall not be stenographically reported and sworn testimony shall not be taken. Any conference conducted pursuant to this paragraph shall be held no later than 90 days after the conclusion of the period permitted by § 725.410(b) of this part for the submission of evidence, unless one of the parties requests that the time period be extended for good cause shown. If the district director is unable to hold the conference within the time period permitted by this paragraph, he shall proceed to issue a proposed decision and order under § 725.418 of this part.

(b) The district director shall notify the parties of a definite time and place for the conference. The district director shall advise the parties that they have a right to representation at the conference, by an attorney or a lay representative, and that no conference shall take place unless the parties are represented. A coal mine operator which is self-insured, or which is covered by a policy of insurance for the claim for which a conference is scheduled, shall be deemed to be represented. The notification shall set forth the specific reasons why the district director believes that a conference will assist in the voluntary resolution of any issue raised with respect to the claim. No sanction may be imposed under paragraph (c) of this section unless the record contains a notification that meets the requirements of this section. The district director may in his or her discretion, or on the motion of any party, cancel a conference or allow any or all of the parties to participate by telephone.

(c) The unexcused failure of any party to appear at an informal conference shall be grounds for the imposition of sanctions. If the claimant fails to appear, the district director may take such steps as are authorized by § 725.409(b)(2) to deny the claim by reason of abandonment. If the responsible operator fails to appear, it shall be deemed to have waived its right to contest its potential liability for an award of benefits and, in the discretion of the district director, its right to contest any issue related to the claimant's eligibility.

(d) Any representative of an operator, of an operator's insurance carrier, or of a claimant, authorized to represent such party in accordance with paragraph (b), shall be deemed to have sufficient authority to stipulate facts or issues or agree to a final disposition of the claim.

(e) Procedures to be followed at a conference shall be within the discretion of the district director.

§ 725.417 Action at the conclusion of conference.

(a) At the conclusion of a conference, the district director shall prepare a stipulation of contested and uncontested issues which shall be signed by the parties and the district director. If a hearing is conducted with respect to the claim, this stipulation shall be submitted to the Office of Administrative Law Judges and placed in the claim record.

(b) In appropriate cases, the district director may permit a reasonable time for the submission of additional evidence following a conference, provided that such evidence does not exceed the limits set forth in § 725.414. The district

director may also notify additional operators of their potential liability pursuant to §725.407, or issue another schedule for the submission of additional evidence pursuant to §725.410, designating another potentially liable operator as the responsible operator liable for the payment of benefits, in order to allow that operator an opportunity to submit evidence relevant to its liability for benefits as well as the claimant's eligibility for benefits.

(c) Within 20 days after the termination of all conference proceedings, the district director shall prepare and send to the parties a proposed decision and order pursuant to §725.418 of this part.

§ 725.418 Proposed decision and order.

(a) Within 20 days after the termination of all informal conference proceedings, or, if no informal conference is held, at the conclusion of the period permitted by §725.410(b) for the submission of evidence, the district director will issue a proposed decision and order. A proposed decision and order is a document, issued by the district director after the evidentiary development of the claim is completed and all contested issues, if any, are joined, which purports to resolve a claim on the basis of the evidence submitted to or obtained by the district director. A proposed decision and order will be considered a final adjudication of a claim only as provided in §725.419. A proposed decision and order may be issued by the district director at any time during the adjudication of any claim if:

(1) Issuance is authorized or required by this part;

(2) The district director determines that its issuance will expedite the adjudication of the claim; or

(3) The district director determines that the claimant is a survivor who is entitled to benefits under 30 U.S.C. 932(l). In such cases, the district director may designate the responsible operator in the proposed decision and order regardless of whether the requirements of paragraph (d) of this section have been met. Any operator identified as liable for benefits under this paragraph may challenge the finding of liability by timely requesting revision of the proposed decision and order and specifically indicating disagreement with that finding. *See* 20 CFR 725.419(a) and (b). In such cases, the district director must allow all parties 30 days within which to submit liability evidence. At the end of this period, the district director must issue a new proposed decision and order.

(b) A proposed decision and order must contain findings of fact and conclusions of law. It must be served on all parties to the claim by certified mail.

(c) The proposed decision and order must contain a notice of the right of any interested party to request a formal hearing before the Office of Administrative Law Judges. If the proposed decision and order is a denial of benefits, and the claimant has previously filed a request for a hearing, the proposed decision and order must notify the claimant that the case will be referred for a hearing pursuant to the previous request unless the claimant notifies the district director that he no longer desires a hearing. If the proposed decision and order is an award of benefits, and the designated responsible operator has previously filed a request for a hearing, the proposed decision and order must notify the operator that the case will be referred for a hearing pursuant to the previous request unless the operator notifies the district director that it no longer desires a hearing.

(d) The proposed decision and order must reflect the district director's final designation of the responsible operator liable for the payment of benefits. Except as provided in paragraph (a)(3) of this section, no operator may be finally designated as the responsible operator unless it has received notification of its potential liability pursuant to §725.407, and the opportunity to submit additional evidence pursuant to §725.410. The district director must dismiss, as parties to the claim, all other potentially liable operators that received notification pursuant to §725.407 and that were not previously dismissed pursuant to §725.410(a)(3).

[78 FR 59118, Sept. 25, 2013]

§ 725.419 Response to proposed decision and order.

(a) Within 30 days after the date of issuance of a proposed decision and order, any party may, in writing, request a revision of the proposed decision and order or a hearing. If a hearing is requested, the district director shall refer the claim to the Office of Administrative Law Judges (see § 725.421).

(b) Any response made by a party to a proposed decision and order shall specify the findings and conclusions with which the responding party disagrees, and shall be served on the district director and all other parties to the claim.

(c) If a timely request for revision of a proposed decision and order is made, the district director may amend the proposed decision and order, as circumstances require, and serve the revised proposed decision and order on all parties or take such other action as is appropriate. If a revised proposed decision and order is issued, each party to the claim shall have 30 days from the date of issuance of that revised proposed decision and order within which to request a hearing.

(d) If no response to a proposed decision and order is sent to the district director within the period described in paragraph (a) of this section, or if no response to a revised proposed decision and order is sent to the district director within the period described in paragraph (c) of this section, the proposed decision and order shall become a final decision and order, which is effective upon the expiration of the applicable 30-day period. Once a proposed decision and order or revised proposed decision and order becomes final and effective, all rights to further proceedings with respect to the claim shall be considered waived, except as provided in § 725.310.

§ 725.420 Initial determinations.

(a) Section 9501(d)(1)(A)(1) of the Internal Revenue Code (26 U.S.C.) provides that the Black Lung Disability Trust Fund shall begin the payment of benefits on behalf of an operator in any case in which the operator liable for such payments has not commenced payment of such benefits within 30 days after the date of an initial determination of eligibility by the Secretary. For claims filed on or after January 1, 1982, the payment of such interim benefits from the fund is limited to benefits accruing after the date of such initial determination.

(b) Except as provided in § 725.415, after the district director has determined that a claimant is eligible for benefits, on the basis of all evidence submitted by a claimant and operator, and has determined that a hearing will be necessary to resolve the claim, the district director shall in writing so inform the parties and direct the operator to begin the payment of benefits to the claimant in accordance with § 725.522. The date on which this writing is sent to the parties shall be considered the date of initial determination of the claim.

(c) If a notified operator refuses to commence payment of a claim within 30 days from the date on which an initial determination is made under this section, benefits shall be paid by the fund to the claimant in accordance with § 725.522, and the operator shall be liable to the fund, if such operator is determined liable for the claim, for all benefits paid by the fund on behalf of such operator, and, in addition, such penalties and interest as are appropriate.

§ 725.421 Referral of a claim to the Office of Administrative Law Judges.

(a) In any claim for which a formal hearing is requested or ordered, and with respect to which the district director has completed evidentiary development and adjudication without having resolved all contested issues, the district director shall refer the claim to the Office of Administrative Law Judges for a hearing.

(b) In any case referred to the Office of Administrative Law Judges under this section, the district director shall transmit to that office the following documents, which shall be placed in the record at the hearing subject to the objection of any party:

(1) Copies of the claim form or forms;

(2) Any statement, document, or pleading submitted by a party to the claim;

(3) A copy of the notification to an operator of its possible liability for the

claim, and any schedule for the submission of additional evidence issued pursuant to §725.410 designating a potentially liable operator as the responsible operator;

(4) All medical evidence submitted to the district director under this part by the claimant and the potentially liable operator designated as the responsible operator in the proposed decision and order issued pursuant to §725.418, or the fund, as appropriate, subject to the limitations of §725.414 of this part; this evidence shall include the results of any medical examination or test conducted pursuant to §725.406, and all evidence relevant to the liability of the responsible operator submitted to the district director under this part;

(5) Any written stipulation of law or fact or stipulation of contested and uncontested issues entered into by the parties;

(6) Any pertinent forms submitted to the district director;

(7) The statement by the district director of contested and uncontested issues in the claim; and

(8) The district director's initial determination of eligibility or other documents necessary to establish the right of the fund to reimbursement, if appropriate. Copies of the transmittal notice shall also be sent to all parties to the claim by regular mail.

(c) A party may at any time request and obtain from the district director copies of documents transmitted to the Office of Administrative Law Judges under paragraph (b) of this section. If the party has previously been provided with such documents, additional copies may be sent to the party upon the payment of a copying fee to be determined by the district director.

§725.422 Legal assistance.

The Secretary or his or her designee may, upon request, provide a claimant with legal assistance in processing a claim under the Act. Such assistance may be made available to a claimant in the discretion of the Solicitor of Labor or his or her designee at any time prior to or during the time in which the claim is being adjudicated and shall be furnished without charge to the claimant. Representation of a claimant in adjudicatory proceedings shall not be provided by the Department of Labor unless it is determined by the Solicitor of Labor that such representation is in the best interests of the black lung benefits program. In no event shall representation be provided to a claimant in a claim with respect to which the claimant's interests are adverse to those of the Secretary of Labor or the fund.

§725.423 Extensions of time.

Except for the 30-day time limit set forth in §725.419, any of the time periods set forth in this subpart may be extended, for good cause shown, by filing a request for an extension with the district director prior to the expiration of the time period.

Subpart F—Hearings

§725.450 Right to a hearing.

Any party to a claim (see §725.360) shall have a right to a hearing concerning any contested issue of fact or law unresolved by the district director. There shall be no right to a hearing until the processing and adjudication of the claim by the district director has been completed. There shall be no right to a hearing in a claim with respect to which a determination of the claim made by the district director has become final and effective in accordance with this part.

§725.451 Request for hearing.

After the completion of proceedings before the district director, or as is otherwise indicated in this part, any party may in writing request a hearing on any contested issue of fact or law (see §725.419). A district director may on his or her own initiative refer a case for hearing. If a hearing is requested, or if a district director determines that a hearing is necessary to the resolution of any issue, the claim shall be referred to the Chief Administrative Law Judge for a hearing under §725.421.

§725.452 Type of hearing; parties.

(a) A hearing held under this part shall be conducted by an administrative law judge designated by the Chief Administrative Law Judge. Except as otherwise provided by this part, all

hearings shall be conducted in accordance with the provisions of 5 U.S.C. 554 *et seq*.

(b) All parties to a claim shall be permitted to participate fully at a hearing held in connection with such claim.

(c) A full evidentiary hearing need not be conducted if a party moves for summary judgment and the administrative law judge determines that there is no genuine issue as to any material fact and that the moving party is entitled to the relief requested as a matter of law. All parties shall be entitled to respond to the motion for summary judgment prior to decision thereon.

(d) If the administrative law judge believes that an oral hearing is not necessary (for any reason other than on motion for summary judgment), the judge shall notify the parties by written order and allow at least 30 days for the parties to respond. The administrative law judge shall hold the oral hearing if any party makes a timely request in response to the order.

§ 725.453 Notice of hearing.

All parties shall be given at least 30 days written notice of the date and place of a hearing and the issues to be resolved at the hearing. Such notice shall be sent to each party or representative by certified mail.

§ 725.454 Time and place of hearing; transfer of cases.

(a) The Chief Administrative Law Judge shall assign a definite time and place for a formal hearing, and shall, where possible, schedule the hearing to be held at a place within 75 miles of the claimant's residence unless an alternate location is requested by the claimant.

(b) If the claimant's residence is not in any State, the Chief Administrative Law Judge may, in his or her discretion, schedule the hearing in the country of the claimant's residence.

(c) The Chief Administrative Law Judge or the administrative law judge assigned the case may in his or her discretion direct that a hearing with respect to a claim shall begin at one location and then later be reconvened at another date and place.

(d) The Chief Administrative Law Judge or administrative law judge assigned the case may change the time and place for a hearing, either on his or her own motion or for good cause shown by a party. The administrative law judge may adjourn or postpone the hearing for good cause shown, at any time prior to the mailing to the parties of the decision in the case. Unless otherwise agreed, at least 10 days notice shall be given to the parties of any change in the time or place of hearing.

(e) The Chief Administrative Law Judge may for good cause shown transfer a case from one administrative law judge to another.

§ 725.455 Hearing procedures; generally.

(a) *General*. The purpose of any hearing conducted under this subpart shall be to resolve contested issues of fact or law. Except as provided in § 725.421(b)(8), any findings or determinations made with respect to a claim by a district director shall not be considered by the administrative law judge.

(b) *Evidence*. The administrative law judge shall at the hearing inquire fully into all matters at issue, and shall not be bound by common law or statutory rules of evidence, or by technical or formal rules of procedure, except as provided by 5 U.S.C. 554 and this subpart. The administrative law judge shall receive into evidence the testimony of the witnesses and parties, the evidence submitted to the Office of Administrative Law Judges by the district director under § 725.421, and such additional evidence as may be submitted in accordance with the provisions of this subpart. The administrative law judge may entertain the objections of any party to the evidence submitted under this section.

(c) *Procedure*. The conduct of the hearing and the order in which allegations and evidence shall be presented shall be within the discretion of the administrative law judge and shall afford the parties an opportunity for a fair hearing.

(d) *Oral argument and written allegations*. The parties, upon request, may be allowed a reasonable time for the presentation of oral argument at the hearing. Briefs or other written statements or allegations as to facts or law

may be filed by any party with the permission of the administrative law judge. Copies of any brief or other written statement shall be filed with the administrative law judge and served on all parties by the submitting party.

§ 725.456 Introduction of documentary evidence.

(a) All documents transmitted to the Office of Administrative Law Judges under § 725.421 shall be placed into evidence by the administrative law judge, subject to objection by any party.

(b)(1) Documentary evidence pertaining to the liability of a potentially liable operator and/or the identification of a responsible operator which was not submitted to the district director shall not be admitted into the hearing record in the absence of extraordinary circumstances. Medical evidence in excess of the limitations contained in § 725.414 shall not be admitted into the hearing record in the absence of good cause.

(2) Subject to the limitations in paragraph (b)(1) of this section, any other documentary material, including medical reports, which was not submitted to the district director, may be received in evidence subject to the objection of any party, if such evidence is sent to all other parties at least 20 days before a hearing is held in connection with the claim.

(3) Documentary evidence, which is not exchanged with the parties in accordance with this paragraph, may be admitted at the hearing with the written consent of the parties or on the record at the hearing, or upon a showing of good cause why such evidence was not exchanged in accordance with this paragraph. If documentary evidence is not exchanged in accordance with paragraph (b)(2) of this section and the parties do not waive the 20-day requirement or good cause is not shown, the administrative law judge shall either exclude the late evidence from the record or remand the claim to the district director for consideration of such evidence.

(4) A medical report which is not made available to the parties in accordance with paragraph (b)(2) of this section shall not be admitted into evidence in any case unless the hearing record is kept open for at least 30 days after the hearing to permit the parties to take such action as each considers appropriate in response to such evidence. If, in the opinion of the administrative law judge, evidence is withheld from the parties for the purpose of delaying the adjudication of the claim, the administrative law judge may exclude such evidence from the hearing record and close the record at the conclusion of the hearing.

(c) Subject to paragraph (b) of this section, documentary evidence which the district director excludes from the record, and the objections to such evidence, may be submitted by the parties to the administrative law judge, who shall independently determine whether the evidence shall be admitted.

(1) If the evidence is admitted, the administrative law judge may, in his or her discretion, remand the claim to the district director for further consideration.

(2) If the evidence is admitted, the administrative law judge shall afford the opposing party or parties the opportunity to develop such additional documentary evidence as is necessary to protect the right of cross-examination.

(d) All medical records and reports submitted by any party shall be considered by the administrative law judge in accordance with the quality standards contained in part 718 of this subchapter.

(e) If the administrative law judge concludes that the complete pulmonary evaluation provided pursuant to § 725.406, or any part thereof, fails to comply with the applicable quality standards, or fails to address the relevant conditions of entitlement (see § 725.202(d)(2)(i) through (iv)) in a manner which permits resolution of the claim, the administrative law judge shall, in his or her discretion, remand the claim to the district director with instructions to develop only such additional evidence as is required, or allow the parties a reasonable time to obtain and submit such evidence, before the termination of the hearing.

§ 725.457 Witnesses.

(a) Witnesses at the hearing shall testify under oath or affirmation. The administrative law judge and the parties may question witnesses with respect to any matters relevant and material to any contested issue. Any party who intends to present the testimony of an expert witness at a hearing, including any physician, regardless of whether the physician has previously prepared a medical report, shall so notify all other parties to the claim at least 10 days before the hearing. The failure to give notice of the appearance of an expert witness in accordance with this paragraph, unless notice is waived by all parties, shall preclude the presentation of testimony by such expert witness.

(b) No person shall be required to appear as a witness in any proceeding before an administrative law judge at a place more than 100 miles from his or her place of residence, unless the lawful mileage and witness fee for 1 day's attendance is paid in advance of the hearing date.

(c) No person shall be permitted to testify as a witness at the hearing, or pursuant to deposition or interrogatory under § 725.458, unless that person meets the requirements of § 725.414(c).

(1) In the case of a witness offering testimony relevant to the liability of the responsible operator, in the absence of extraordinary circumstances, the witness must have been identified as a potential hearing witness while the claim was pending before the district director.

(2) In the case of a physician offering testimony relevant to the physical condition of the miner, such physician must have prepared a medical report. Alternatively, in the absence of a showing of good cause under § 725.456(b)(1) of this part, a physician may offer testimony relevant to the physical condition of the miner only to the extent that the party offering the physician's testimony has submitted fewer medical reports than permitted by § 725.414. Such physician's opinion shall be considered a medical report subject to the limitations of § 725.414.

(d) A physician whose testimony is permitted under this section may testify as to any other medical evidence of record, but shall not be permitted to testify as to any medical evidence relevant to the miner's condition that is not admissible.

§ 725.458 Depositions; interrogatories.

The testimony of any witness or party may be taken by deposition or interrogatory according to the rules of practice of the Federal district court for the judicial district in which the case is pending (or of the U.S. District Court for the District of Columbia if the case is pending in the District or outside the United States), except that at least 30 days prior notice of any deposition shall be given to all parties unless such notice is waived. No post-hearing deposition or interrogatory shall be permitted unless authorized by the administrative law judge upon the motion of a party to the claim. The testimony of any physician which is taken by deposition shall be subject to the limitations on the scope of the testimony contained in § 725.457(d).

§ 725.459 Witness fees.

(a) A witness testifying at a hearing before an administrative law judge, or whose deposition is taken, shall receive the same fees and mileage as witnesses in courts of the United States. If the witness is an expert, he or she shall be entitled to an expert witness fee. Except as provided in paragraphs (b) and (c) of this section, such fees shall be paid by the proponent of the witness.

(b) If the witness' proponent does not intend to call the witness to appear at a hearing or deposition, any other party may subpoena the witness for cross-examination. The administrative law judge (ALJ) shall authorize the least intrusive and expensive means of cross-examination as the ALJ deems appropriate and necessary to the full and true disclosure of the facts. If such witness is required to attend the hearing, give a deposition or respond to interrogatories for cross-examination purposes, the proponent of the witness shall pay the witness' fee. The fund shall remain liable for any costs associated with the cross-examination of the physician who performed the complete pulmonary evaluation pursuant to § 725.406.

(c) If a claimant is determined entitled to benefits, there may be assessed

as costs against a responsible operator, if any, or the fund, fees and mileage for necessary witnesses attending the hearing at the request of the claimant. Both the necessity for the witness and the reasonableness of the fees of any expert witness shall be approved by the administrative law judge. The amounts awarded against a responsible operator or the fund as attorney's fees, or costs, fees and mileage for witnesses, shall not in any respect affect or diminish benefits payable under the Act.

[65 FR 80054, Dec. 20, 2000, as amended at 68 FR 69935, Dec. 15, 2003]

§ 725.460 Consolidated hearings.

When two or more hearings are to be held, and the same or substantially similar evidence is relevant and material to the matters at issue at each such hearing, the Chief Administrative Law Judge may, upon motion by any party or on his or her own motion, order that a consolidated hearing be conducted. Where consolidated hearings are held, a single record of the proceedings shall be made and the evidence introduced in one claim may be considered as introduced in the others, and a separate or joint decision shall be made, as appropriate.

§ 725.461 Waiver of right to appear and present evidence.

(a) If all parties waive their right to appear before the administrative law judge, it shall not be necessary for the administrative law judge to give notice of, or conduct, an oral hearing. A waiver of the right to appear shall be made in writing and filed with the Chief Administrative Law Judge or the administrative law judge assigned to hear the case. Such waiver may be withdrawn by a party for good cause shown at any time prior to the mailing of the decision in the claim. Even though all of the parties have filed a waiver of the right to appear, the administrative law judge may, nevertheless, after giving notice of the time and place, conduct a hearing if he or she believes that the personal appearance and testimony of the party or parties would assist in ascertaining the facts in issue in the claim. Where a waiver has been filed by all parties, and they do not appear before the administrative law judge personally or by representative, the administrative law judge shall make a record of the relevant documentary evidence submitted in accordance with this part and any further written stipulations of the parties. Such documents and stipulations shall be considered the evidence of record in the case and the decision shall be based upon such evidence.

(b) Except as provided in § 725.456(a), the unexcused failure of any party to attend a hearing shall constitute a waiver of such party's right to present evidence at the hearing, and may result in a dismissal of the claim (see § 725.465).

§ 725.462 Withdrawal of controversion of issues set for formal hearing; effect.

A party may, on the record, withdraw his or her controversion of any or all issues set for hearing. If a party withdraws his or her controversion of all issues, the administrative law judge shall remand the case to the district director for the issuance of an appropriate order.

§ 725.463 Issues to be resolved at hearing; new issues.

(a) Except as otherwise provided in this section, the hearing shall be confined to those contested issues which have been identified by the district director (see § 725.421) or any other issue raised in writing before the district director.

(b) An administrative law judge may consider a new issue only if such issue was not reasonably ascertainable by the parties at the time the claim was before the district director. Such new issue may be raised upon application of any party, or upon an administrative law judge's own motion, with notice to all parties, at any time after a claim has been transmitted by the district director to the Office of Administrative Law Judges and prior to decision by an administrative law judge. If a new issue is raised, the administrative law judge may, in his or her discretion, either remand the case to the district director with instructions for further proceedings, hear and resolve the new issue, or refuse to consider such new issue.

(c) If a new issue is to be considered by the administrative law judge, a party may, upon request, be granted an appropriate continuance.

§ 725.464 Record of hearing.

All hearings shall be open to the public and shall be mechanically or stenographically reported. All evidence upon which the administrative law judge relies for decision shall be contained in the transcript of testimony, either directly or by appropriate reference. All medical reports, exhibits, and any other pertinent document or record, either in whole or in material part, introduced as evidence, shall be marked for identification and incorporated into the record.

§ 725.465 Dismissals for cause.

(a) The administrative law judge may, at the request of any party, or on his or her own motion, dismiss a claim:

(1) Upon the failure of the claimant or his or her representative to attend a hearing without good cause;

(2) Upon the failure of the claimant to comply with a lawful order of the administrative law judge; or

(3) Where there has been a prior final adjudication of the claim or defense to the claim under the provisions of this subchapter and no new evidence is submitted (except as provided in part 727 of this subchapter; see § 725.4(d)).

(b) A party who is not a proper party to the claim (see § 725.360) shall be dismissed by the administrative law judge. The administrative law judge shall not dismiss the operator designated as the responsible operator by the district director, except upon the motion or written agreement of the Director.

(c) In any case where a dismissal of a claim, defense, or party is sought, the administrative law judge shall issue an order to show cause why the dismissal should not be granted and afford all parties a reasonable time to respond to such order. After the time for response has expired, the administrative law judge shall take such action as is appropriate to rule on the dismissal, which may include an order dismissing the claim, defense or party.

(d) No claim shall be dismissed in a case with respect to which payments prior to final adjudication have been made to the claimant in accordance with § 725.522, except upon the motion or written agreement of the Director.

§ 725.466 Order of dismissal.

(a) An order dismissing a claim shall be served on the parties in accordance with § 725.478. The dismissal of a claim shall have the same effect as a decision and order disposing of the claim on its merits, except as provided in paragraph (b) of this section. Such order shall advise the parties of their right to request review by the Benefits Review Board.

(b) Where the Chief Administrative Law Judge or the presiding administrative law judge issues a decision and order dismissing the claim after a show cause proceeding, the district director shall terminate any payments being made to the claimant under § 725.522, and the order of dismissal shall, if appropriate, order the claimant to reimburse the fund for all benefits paid to the claimant.

§ 725.475 Termination of hearings.

Hearings are officially terminated when all the evidence has been received, witnesses heard, pleadings and briefs submitted to the administrative law judge, and the transcript of the proceedings has been printed and delivered to the administrative law judge.

§ 725.476 Issuance of decision and order.

Within 20 days after the official termination of the hearing (see § 725.475), the administrative law judge shall issue a decision and order with respect to the claim making an award to the claimant, rejecting the claim, or taking such other action as is appropriate.

§ 725.477 Form and contents of decision and order.

(a) Orders adjudicating claims for benefits shall be designated by the term ''decision and order'' or ''supplemental decision and order'' as appropriate, followed by a descriptive phrase designating the particular type of order, such as ''award of benefits,'' ''rejection of claim,'' ''suspension of benefits,'' ''modification of award.''

(b) A decision and order shall contain a statement of the basis of the order, findings of fact, conclusions of law, and an award, rejection or other appropriate paragraph containing the action of the administrative law judge, his or her signature and the date of issuance. A decision and order shall be based upon the record made before the administrative law judge.

[65 FR 80054, Dec. 20, 2000, as amended at 72 FR 4205, Jan. 30, 2007]

§ 725.478 Filing and service of decision and order.

On the date of issuance of a decision and order under § 725.477, the administrative law judge shall serve the decision and order on all parties to the claim by certified mail. On the same date, the original record of the claim shall be sent to the DCMWC in Washington, D.C. Upon receipt by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

§ 725.479 Finality of decisions and orders.

(a) A decision and order shall become effective when filed in the office of the district director (see § 725.478), and unless proceedings for suspension or setting aside of such order are instituted within 30 days of such filing, the order shall become final at the expiration of the 30th day after such filing (see § 725.481).

(b) Any party may, within 30 days after the filing of a decision and order under § 725.478, request a reconsideration of such decision and order by the administrative law judge. The procedures to be followed in the reconsideration of a decision and order shall be determined by the administrative law judge.

(c) The time for appeal to the Benefits Review Board shall be suspended during the consideration of a request for reconsideration. After the administrative law judge has issued and filed a denial of the request for reconsideration, or a revised decision and order in accordance with this part, any dissatisfied party shall have 30 days within which to institute proceedings to set aside the decision and order on reconsideration.

(d) Regardless of any defect in service, actual receipt of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.

§ 725.480 Modification of decisions and orders.

A party who is dissatisfied with a decision and order which has become final in accordance with § 725.479 may request a modification of the decision and order if the conditions set forth in § 725.310 are met.

§ 725.481 Right to appeal to the Benefits Review Board.

Any party dissatisfied with a decision and order issued by an administrative law judge may, before the decision and order becomes final (see § 725.479), appeal the decision and order to the Benefits Review Board. A notice of appeal shall be filed with the Board. Proceedings before the Board shall be conducted in accordance with part 802 of this title.

§ 725.482 Judicial review.

(a) Any person adversely affected or aggrieved by a final order of the Benefits Review Board may obtain a review of that order in the U.S. court of appeals for the circuit in which the injury occurred by filing in such court within 60 days following the issuance of such Board order a written petition praying that the order be modified or set aside. The payment of the amounts required by an award shall not be stayed pending final decision in any such proceeding unless ordered by the court. No stay shall be issued unless the court finds that irreparable injury would otherwise ensue to an operator or carrier.

(b) The Director, Office of Workers' Compensation Program, as designee of the Secretary of Labor responsible for the administration and enforcement of the Act, shall be considered the proper party to appear and present argument on behalf of the Secretary of Labor in all review proceedings conducted pursuant to this part and the Act, either as petitioner or respondent.

§ 725.483 Costs in proceedings brought without reasonable grounds.

If a United States court having jurisdiction of proceedings regarding any claim or final decision and order, determines that the proceedings have been instituted or continued before such court without reasonable ground, the costs of such proceedings shall be assessed against the party who has so instituted or continued such proceedings.

Subpart G—Responsible Coal Mine Operators

§ 725.490 Statutory provisions and scope.

(a) One of the major purposes of the black lung benefits amendments of 1977 was to provide a more effective means of transferring the responsibility for the payment of benefits from the Federal government to the coal industry with respect to claims filed under this part. In furtherance of this goal, a Black Lung Disability Trust Fund financed by the coal industry was established by the Black Lung Benefits Revenue Act of 1977. The primary purpose of the Fund is to pay benefits with respect to all claims in which the last coal mine employment of the miner on whose account the claim was filed occurred before January 1, 1970. With respect to most claims in which the miner's last coal mine employment occurred after January 1, 1970, individual coal mine operators will be liable for the payment of benefits. The 1981 amendments to the Act relieved individual coal mine operators from the liability for payment of certain special claims involving coal mine employment on or after January 1, 1970, where the claim was previously denied and subsequently approved under section 435 of the Act. See § 725.496 for a detailed description of these special claims. Where no such operator exists or the operator determined to be liable is in default in any case, the fund shall pay the benefits due and seek reimbursement as is appropriate. See also § 725.420 for the fund's role in the payment of interim benefits in certain contested cases. In addition, the Black Lung Benefits Reform Act of 1977 amended certain provisions affecting the scope of coverage under the Act and describing the effects of particular corporate transactions on the liability of operators.

(b) The provisions of this subpart define the term ''operator'' and prescribe the manner in which the identity of an operator which may be liable for the payment of benefits—referred to herein as a ''responsible operator''—will be determined.

§ 725.491 Operator defined.

(a) For purposes of this part, the term ''operator'' shall include:

(1) Any owner, lessee, or other person who operates, controls, or supervises a coal mine, or any independent contractor performing services or construction at such mine; or

(2) Any other person who:

(i) Employs an individual in the transportation of coal or in coal mine construction in or around a coal mine, to the extent such individual was exposed to coal mine dust as a result of such employment (see § 725.202);

(ii) In accordance with the provisions of § 725.492, may be considered a successor operator; or

(iii) Paid wages or a salary, or provided other benefits, to an individual in exchange for work as a miner (see § 725.202).

(b) The terms ''owner,'' ''lessee,'' and ''person'' shall include any individual, partnership, association, corporation, firm, subsidiary of a corporation, or other organization, as appropriate, except that an officer of a corporation shall not be considered an ''operator'' for purposes of this part. Following the issuance of an order awarding benefits against a corporation that has not secured its liability for benefits in accordance with section 423 of the Act and § 726.4, such order may be enforced against the president, secretary, or treasurer of the corporation in accordance with subpart I of this part.

(c) The term ''independent contractor'' shall include any person who contracts to perform services. Such contractor's status as an operator shall not be contingent upon the amount or percentage of its work or business related to activities in or around a mine, nor upon the number or percentage of

its employees engaged in such activities.

(d) For the purposes of determining whether a person is or was an operator that may be found liable for the payment of benefits under this part, there shall be a rebuttable presumption that during the course of an individual's employment with such employer, such individual was regularly and continuously exposed to coal mine dust during the course of employment. The presumption may be rebutted by a showing that the employee was not exposed to coal mine dust for significant periods during such employment.

(e) The operation, control, or supervision referred to in paragraph (a)(1) of this section may be exercised directly or indirectly. Thus, for example, where a coal mine is leased, and the lease empowers the lessor to make decisions with respect to the terms and conditions under which coal is to be extracted or prepared, such as, but not limited to, the manner of extraction or preparation or the amount of coal to be produced, the lessor may be considered an operator. Similarly, any parent entity or other controlling business entity may be considered an operator for purposes of this part, regardless of the nature of its business activities.

(f) Neither the United States, nor any State, nor any instrumentality or agency of the United States or any State, shall be considered an operator.

§ 725.492 Successor operator defined.

(a) Any person who, on or after January 1, 1970, acquired a mine or mines, or substantially all of the assets thereof, from a prior operator, or acquired the coal mining business of such prior operator, or substantially all of the assets thereof, shall be considered a ''successor operator'' with respect to any miners previously employed by such prior operator.

(b) The following transactions shall also be deemed to create successor operator liability:

(1) If an operator ceases to exist by reason of a reorganization which involves a change in identity, form, or place of business or organization, however effected;

(2) If an operator ceases to exist by reason of a liquidation into a parent or successor corporation; or

(3) If an operator ceases to exist by reason of a sale of substantially all its assets, or as a result of merger, consolidation, or division.

(c) In any case in which a transaction specified in paragraph (b), or substantially similar to a transaction specified in paragraph (b), took place, the resulting entity shall be considered a ''successor operator'' with respect to any miners previously employed by such prior operator.

(d) This section shall not be construed to relieve a prior operator of any liability if such prior operator meets the conditions set forth in § 725.494. If the prior operator does not meet the conditions set forth in § 725.494, the following provisions shall apply:

(1) In any case in which a prior operator transferred a mine or mines, or substantially all of the assets thereof, to a successor operator, or sold its coal mining business or substantially all of the assets thereof, to a successor operator, and then ceased to exist within the terms of paragraph (b), the successor operator as identified in paragraph (a) shall be primarily liable for the payment of benefits to any miners previously employed by such prior operator.

(2) In any case in which a prior operator transferred mines, or substantially all of the assets thereof, to more than one successor operator, the successor operator that most recently acquired a mine or mines or assets from the prior operator shall be primarily liable for the payment of benefits to any miners previously employed by such prior operator.

(3) In any case in which a mine or mines, or substantially all the assets thereof, have been transferred more than once, the successor operator that most recently acquired such mine or mines or assets shall be primarily liable for the payment of benefits to any miners previously employed by the original prior operator. If the most recent successor operator does not meet the criteria for a potentially liable operator set forth in § 725.494, the next

most recent successor operator shall be liable.

(e) An ''acquisition,'' for purposes of this section, shall include any transaction by which title to the mine or mines, or substantially all of the assets thereof, or the right to extract or prepare coal at such mine or mines, becomes vested in a person other than the prior operator.

§ 725.493 Employment relationship defined.

(a)(1) In determining the identity of a responsible operator under this part, the terms ''employ'' and ''employment'' shall be construed as broadly as possible, and shall include any relationship under which an operator retains the right to direct, control, or supervise the work performed by a miner, or any other relationship under which an operator derives a benefit from the work performed by a miner. Any individuals who participate with one or more persons in the mining of coal, such as owners, proprietors, partners, and joint venturers, whether they are compensated by wages, salaries, piece rates, shares, profits, or by any other means, shall be deemed employees. It is the specific intention of this paragraph to disregard any financial arrangement or business entity devised by the actual owners or operators of a coal mine or coal mine-related enterprise to avoid the payment of benefits to miners who, based upon the economic reality of their relationship to this enterprise, are, in fact, employees of the enterprise.

(2) The payment of wages or salary shall be prima facie evidence of the right to direct, control, or supervise an individual's work. The Department intends that where the operator who paid a miner's wages or salary meets the criteria for a potentially liable operator set forth in § 725.494, that operator shall be primarily liable for the payment of any benefits due the miner as a result of such employment. The absence of such payment, however, will not negate the existence of an employment relationship. Thus, the Department also intends that where the person who paid a miner's wages may not be considered a potentially liable operator, any other operator who retained the right to direct, control or supervise the work performed by the miner, or who benefitted from such work, may be considered a potentially liable operator.

(b) This paragraph contains examples of relationships that shall be considered employment relationships for purposes of this part. The list is not intended to be exclusive.

(1) In any case in which an operator may be considered a successor operator, as determined in accordance with § 725.492, any employment with a prior operator shall also be deemed to be employment with the successor operator. In a case in which the miner was not independently employed by the successor operator, the prior operator shall remain primarily liable for the payment of any benefits based on the miner's employment with the prior operator. In a case in which the miner was independently employed by the successor operator after the transaction giving rise to successor operator liability, the successor operator shall be primarily liable for the payment of any benefits.

(2) In any case in which the operator which directed, controlled or supervised the miner is no longer in business and such operator was a subsidiary of a parent company, a member of a joint venture, a partner in a partnership, or was substantially owned or controlled by another business entity, such parent entity or other member of a joint venture or partner or controlling business entity may be considered the employer of any employees of such operator.

(3) In any claim in which the operator which directed, controlled or supervised the miner is a lessee, the lessee shall be considered primarily liable for the claim. The liability of the lessor may be established only after it has been determined that the lessee is unable to provide for the payment of benefits to a successful claimant. In any case involving the liability of a lessor for a claim arising out of employment with a lessee, any determination of lessor liability shall be made on the basis of the facts present in the case in accordance with the following considerations:

(i) Where a coal mine is leased, and the lease empowers the lessor to make

decisions with respect to the terms and conditions under which coal is to be extracted or prepared, such as, but not limited to, the manner of extraction or preparation or the amount of coal to be produced, the lessor shall be considered the employer of any employees of the lessee.

(ii) Where a coal mine is leased to a self-employed operator, the lessor shall be considered the employer of such self-employed operator and its employees if the lease or agreement is executed or renewed after August 18, 1978 and such lease or agreement does not require the lessee to guarantee the payment of benefits which may be required under this part and part 726 of this subchapter.

(iii) Where a lessor previously operated a coal mine, it may be considered an operator with respect to employees of any lessee of such mine, particularly where the leasing arrangement was executed or renewed after August 18, 1978 and does not require the lessee to secure benefits provided by the Act.

(4) A self-employed operator, depending upon the facts of the case, may be considered an employee of any other operator, person, or business entity which substantially controls, supervises, or is financially responsible for the activities of the self-employed operator.

§ 725.494 Potentially liable operators.

An operator may be considered a ''potentially liable operator'' with respect to a claim for benefits under this part if each of the following conditions is met:

(a) The miner's disability or death arose at least in part out of employment in or around a mine or other facility during a period when the mine or facility was operated by such operator, or by a person with respect to which the operator may be considered a successor operator. For purposes of this section, there shall be a rebuttable presumption that the miner's disability or death arose in whole or in part out of his or her employment with such operator. Unless this presumption is rebutted, the responsible operator shall be liable to pay benefits to the claimant on account of the disability or death of the miner in accordance with this part. A miner's pneumoconiosis, or disability or death therefrom, shall be considered to have arisen in whole or in part out of work in or around a mine if such work caused, contributed to or aggravated the progression or advancement of a miner's loss of ability to perform his or her regular coal mine employment or comparable employment.

(b) The operator, or any person with respect to which the operator may be considered a successor operator, was an operator for any period after June 30, 1973.

(c) The miner was employed by the operator, or any person with respect to which the operator may be considered a successor operator, for a cumulative period of not less than one year (§ 725.101(a)(32)).

(d) The miner's employment with the operator, or any person with respect to which the operator may be considered a successor operator, included at least one working day (§ 725.101(a)(32)) after December 31, 1969.

(e) The operator is capable of assuming its liability for the payment of continuing benefits under this part. An operator will be deemed capable of assuming its liability for a claim if one of the following three conditions is met:

(1) The operator obtained a policy or contract of insurance under section 423 of the Act and part 726 of this subchapter that covers the claim, except that such policy shall not be considered sufficient to establish the operator's capability of assuming liability if the insurance company has been declared insolvent and its obligations for the claim are not otherwise guaranteed;

(2) The operator qualified as a self-insurer under section 423 of the Act and part 726 of this subchapter during the period in which the miner was last employed by the operator, provided that the operator still qualifies as a self-insurer or the security given by the operator pursuant to § 726.104(b) is sufficient to secure the payment of benefits in the event the claim is awarded; or

(3) The operator possesses sufficient assets to secure the payment of benefits in the event the claim is awarded in accordance with § 725.606.

§ 725.495 Criteria for determining a responsible operator.

(a)(1) The operator responsible for the payment of benefits in a claim adjudicated under this part (the ''responsible operator'') shall be the potentially liable operator, as determined in accordance with § 725.494, that most recently employed the miner.

(2) If more than one potentially liable operator may be deemed to have employed the miner most recently, then the liability for any benefits payable as a result of such employment shall be assigned as follows:

(i) First, to the potentially liable operator that directed, controlled, or supervised the miner;

(ii) Second, to any potentially liable operator that may be considered a successor operator with respect to miners employed by the operator identified in paragraph (a)(2)(i) of this section; and

(iii) Third, to any other potentially liable operator which may be deemed to have been the miner's most recent employer pursuant to § 725.493.

(3) If the operator that most recently employed the miner may not be considered a potentially liable operator, as determined in accordance with § 725.494, the responsible operator shall be the potentially liable operator that next most recently employed the miner. Any potentially liable operator that employed the miner for at least one day after December 31, 1969 may be deemed the responsible operator if no more recent employer may be considered a potentially liable operator.

(4) If the miner's most recent employment by an operator ended while the operator was authorized to self-insure its liability under part 726 of this title, and that operator no longer possesses sufficient assets to secure the payment of benefits, the provisions of paragraph (a)(3) shall be inapplicable with respect to any operator that employed the miner only before he was employed by such self-insured operator. If no operator that employed the miner after his employment with the self-insured operator meets the conditions of § 725.494, the claim of the miner or his survivor shall be the responsibility of the Black Lung Disability Trust Fund.

(b) Except as provided in this section and § 725.408(a)(3), with respect to the adjudication of the identity of a responsible operator, the Director shall bear the burden of proving that the responsible operator initially found liable for the payment of benefits pursuant to § 725.410 (the ''designated responsible operator'') is a potentially liable operator. It shall be presumed, in the absence of evidence to the contrary, that the designated responsible operator is capable of assuming liability for the payment of benefits in accordance with § 725.494(e).

(c) The designated responsible operator shall bear the burden of proving either:

(1) That it does not possess sufficient assets to secure the payment of benefits in accordance with § 725.606; or

(2) That it is not the potentially liable operator that most recently employed the miner. Such proof must include evidence that the miner was employed as a miner after he or she stopped working for the designated responsible operator and that the person by whom he or she was employed is a potentially liable operator within the meaning of § 725.494. In order to establish that a more recent employer is a potentially liable operator, the designated responsible operator must demonstrate that the more recent employer possesses sufficient assets to secure the payment of benefits in accordance with § 725.606. The designated responsible operator may satisfy its burden by presenting evidence that the owner, if the more recent employer is a sole proprietorship; the partners, if the more recent employer is a partnership; or the president, secretary, and treasurer, if the more recent employer is a corporation that failed to secure the payment of benefits pursuant to part 726 of this subchapter, possess assets sufficient to secure the payment of benefits, provided such assets may be reached in a proceeding brought under subpart I of this part.

(d) In any case referred to the Office of Administrative Law Judges pursuant to § 725.421 in which the operator finally designated as responsible pursuant to § 725.418(d) is not the operator that most recently employed the

miner, the record shall contain a statement from the district director explaining the reasons for such designation. If the reasons include the most recent employer's failure to meet the conditions of §725.494(e), the record shall also contain a statement that the Office has searched the files it maintains pursuant to part 726, and that the Office has no record of insurance coverage for that employer, or of authorization to self-insure, that meets the conditions of §725.494(e)(1) or (e)(2). Such a statement shall be prima facie evidence that the most recent employer is not financially capable of assuming its liability for a claim. In the absence of such a statement, it shall be presumed that the most recent employer is financially capable of assuming its liability for a claim.

§725.496 Special claims transferred to the fund.

(a) The 1981 amendments to the Act amended section 422 of the Act and transferred liability for payment of certain special claims from operators and carriers to the fund. These provisions apply to claims which were denied before March 1, 1978, and which have been or will be approved in accordance with section 435 of the Act.

(b) Section 402(i) of the Act defines three classes of denied claims subject to the transfer provisions:

(1) Claims filed with and denied by the Social Security Administration before March 1, 1978;

(2) Claims filed with the Department of Labor in which the claimant was notified by the Department of an administrative or informal denial before March 1, 1977, and in which the claimant did not within one year of such notification either:

(i) Request a hearing; or

(ii) Present additional evidence; or

(iii) Indicate an intention to present additional evidence; or

(iv) Request a modification or reconsideration of the denial on the ground of a change in conditions or because of a mistake in a determination of fact;

(3) Claims filed with the Department of Labor and denied under the law in effect prior to the enactment of the Black Lung Benefits Reform Act of 1977, that is, before March 1, 1978, following a formal hearing before an administrative law judge or administrative review before the Benefits Review Board or review before a United States Court of Appeals.

(c) Where more than one claim was filed with the Social Security Administration and/or the Department of Labor prior to March 1, 1978, by or on behalf of a miner or a surviving dependent of a miner, unless such claims were required to be merged by the agency's regulations, the procedural history of each such claim must be considered separately to determine whether the claim is subject to the transfer of liability provisions.

(d) For a claim filed with and denied by the Social Security Administration prior to March 1, 1978, to come within the transfer provisions, such claim must have been or must be approved under the provisions of section 435 of the Act. No claim filed with and denied by the Social Security Administration is subject to the transfer of liability provisions unless a request was made by or on behalf of the claimant for review of such denied claim under section 435. Such review must have been requested by the filing of a valid election card or other equivalent document with the Social Security Administration in accordance with section 435(a) and its implementing regulations at 20 CFR 410.700 through 410.707.

(e) Where a claim filed with the Department of Labor prior to March 1, 1977, was subjected to repeated administrative or informal denials, the last such denial issued during the pendency of the claim determines whether the claim is subject to the transfer of liability provisions.

(f) Where a miner's claim comes within the transfer of liability provisions of the 1981 amendments the fund is also liable for the payment of any benefits to which the miner's dependent survivors are entitled after the miner's death. However, if the survivor's entitlement was established on a separate claim not subject to the transfer of liability provisions prior to approval of the miner's claim under section 435, the party responsible for the payment of such survivors' benefits shall not be relieved of that responsibility because the miner's claim was

ultimately approved and found subject to the transfer of liability provisions.

§ 725.497 Procedures in special claims transferred to the fund.

(a) *General.* It is the purpose of this section to define procedures to expedite the handling and disposition of claims affected by the benefit liability transfer provisions of Section 205 of the Black Lung Benefits Amendments of 1981.

(b) *Action by the Department.* The OWCP shall, in accordance with the criteria contained in § 725.496, review each claim which is or may be affected by the provisions of Section 205 of the Black Lung Benefits Amendments of 1981. Any party to a claim, adjudication officer, or adjudicative body may request that such a review be conducted and that the record be supplemented with any additional documentation necessary for an informed consideration of the transferability of the claim. Where the issue of the transferability of the claim can not be resolved by agreement of the parties and the evidence of record is not sufficient for a resolution of the issue, the hearing record may be reopened or the case remanded for the development of the additional evidence concerning the procedural history of the claim necessary to such resolution. Such determinations shall be made on an expedited basis.

(c) *Dismissal of operators.* If it is determined that a coal mine operator or insurance carrier which previously participated in the consideration or adjudication of any claim, may no longer be found liable for the payment of benefits to the claimant by reason of section 205 of the Black Lung Benefits Amendments of 1981, such operator or carrier shall be promptly dismissed as a party to the claim. The dismissal of an operator or carrier shall be concluded at the earliest possible time and in no event shall an operator or carrier participate as a necessary party in any claim for which only the fund may be liable.

(d) *Procedure following dismissal of an operator.* After it has been determined that an operator or carrier must be dismissed as a party in any claim in accordance with this section, the Director shall take such action as is authorized by the Act to bring about the proper and expeditious resolution of the claim in light of all relevant medical and other evidence. Action to be taken in this regard by the Director may include, but is not limited to, the assignment of the claim to the Black Lung Disability Trust Fund for the payment of benefits, the reimbursement of benefits previously paid by an operator or carrier if appropriate, the defense of the claim on behalf of the fund, or proceedings authorized by § 725.310.

(e) Any claimant whose claim has been subsequently denied in a modification proceeding will be entitled to expedited review of the modification decision. Where a formal hearing was previously held, the claimant may waive his right to a further hearing and ask that a decision be made on the record of the prior hearing, as supplemented by any additional documentary evidence which the parties wish to introduce and briefs of the parties, if desired. In any case in which the claimant waives his right to a second hearing, a decision and order must be issued within 30 days of the date upon which the parties agree the record has been completed.

Subpart H—Payment of Benefits

GENERAL PROVISIONS

§ 725.501 Payment provisions generally.

The provisions of this subpart govern the payment of benefits to claimants whose claims are approved for payment under section 415 and part C of title IV of the Act or approved after review under section 435 of the Act and part 727 of this subchapter (see § 725.4(d)).

§ 725.502 When benefit payments are due; manner of payment.

(a)(1) Except with respect to benefits paid by the fund pursuant to an initial determination issued in accordance with § 725.418 (see § 725.522), benefits under the Act shall be paid when they become due. Benefits shall be considered due after the issuance of an effective order requiring the payment of

benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate court. An effective order shall remain in effect unless it is vacated by an administrative law judge on reconsideration, or, upon review under section 21 of the LHWCA, by the Benefits Review Board or an appropriate court, or is superseded by an effective order issued pursuant to §725.310.

(2) A proposed order issued by a district director pursuant to §725.418 becomes effective at the expiration of the thirtieth day thereafter if no party timely requests revision of the proposed decision and order or a hearing (see §725.419). An order issued by an administrative law judge becomes effective when it is filed in the office of the district director (see §725.479). An order issued by the Benefits Review Board shall become effective when it is issued. An order issued by a court shall become effective in accordance with the rules of the court.

(b)(1) While an effective order requiring the payment of benefits remains in effect, monthly benefits, at the rates set forth in §725.520, shall be due on the fifteenth day of the month following the month for which the benefits are payable. For example, benefits payable for the month of January shall be due on the fifteenth day of February.

(2) Within 30 days after the issuance of an effective order requiring the payment of benefits, the district director shall compute the amount of benefits payable for periods prior to the effective date of the order, in addition to any interest payable for such periods (see §725.608), and shall so notify the parties. Any computation made by the district director under this paragraph shall strictly observe the terms of the order. Benefits and interest payable for such periods shall be due on the thirtieth day following issuance of the district director's computation. A copy of the current table of applicable interest rates shall be attached to the computation.

(c) Benefits are payable for monthly periods and shall be paid directly to an eligible claimant or his or her representative payee (see §725.510) beginning with the month during which eligibility begins. Benefit payments shall terminate with the month before the month during which eligibility terminates. If a claimant dies in the first month during which all requirements for eligibility are met, benefits shall be paid for that month.

§725.503 Date from which benefits are payable.

(a) In accordance with the provisions of section 6(a) of the Longshore Act as incorporated by section 422(a) of the Act, and except as provided in §725.504, the provisions of this section shall be applicable in determining the date from which benefits are payable to an eligible claimant for any claim filed after March 31, 1980. Except as provided in paragraph (d) of this section, the date from which benefits are payable for any claim approved under part 727 shall be determined in accordance with §727.302 (see §725.4(d)).

(b) *Miner's claim.* Benefits are payable to a miner who is entitled beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. Where the evidence does not establish the month of onset, benefits shall be payable to such miner beginning with the month during which the claim was filed. In the case of a miner who filed a claim before January 1, 1982, benefits shall be payable to the miner's eligible survivor (if any) beginning with the month in which the miner died.

(c) *Survivor's claim.* Benefits are payable to a survivor who is entitled beginning with the month of the miner's death, or January 1, 1974, whichever is later.

(d) If a claim is awarded pursuant to section 22 of the Longshore Act and §725.310, then the date from which benefits are payable shall be determined as follows:

(1) *Mistake in fact.* The provisions of paragraphs (b) or (c) of this section, as

applicable, shall govern the determination of the date from which benefits are payable.

(2) *Change in conditions.* Benefits are payable to a miner beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment, provided that no benefits shall be payable for any month prior to the effective date of the most recent denial of the claim by a district director or administrative law judge. Where the evidence does not establish the month of onset, benefits shall be payable to such miner from the month in which the claimant requested modification.

(e) In the case of a claim filed between July 1, 1973, and December 31, 1973, benefits shall be payable as provided by this section, except to the extent prohibited by §727.303 (see §725.4(d)).

(f) No benefits shall be payable with respect to a claim filed after December 31, 1973 (a part C claim), for any period of eligibility occurring before January 1, 1974.

(g) Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant.

§725.504 Payments to a claimant employed as a miner.

(a) In the case of a claimant who is employed as a miner (see §725.202) at the time of a final determination of such miner's eligibility for benefits, no benefits shall be payable unless:

(1) The miner's eligibility is established under section 411(c)(3) of the Act; or

(2) the miner terminates his or her coal mine employment within 1 year from the date of the final determination of the claim.

(b) If the eligibility of a working miner is established under section 411(c)(3) of the Act, benefits shall be payable as is otherwise provided in this part. If eligibility cannot be established under section 411(c)(3), and the miner continues to be employed as a miner in any capacity for a period of less than 1 year after a final determination of the claim, benefits shall be payable beginning with the month during which the miner ends his or her coal mine employment. If the miner's employment continues for more than 1 year after a final determination of eligibility, such determination shall be considered a denial of benefits on the basis of the miner's continued employment, and the miner may seek benefits only as provided in §725.310, if applicable, or by filing a new claim under this part. The provisions of Subparts E and F of this part shall be applicable to claims considered under this section as is appropriate.

(c) In any case where the miner returns to coal mine or comparable and gainful work, the payments to such miner shall be suspended and no benefits shall be payable (except as provided in section 411(c)(3) of the Act) for the period during which the miner continues to work. If the miner again terminates employment, the district director may require the miner to submit to further medical examination before authorizing the payment of benefits.

§725.505 Payees.

Benefits may be paid, as appropriate, to a beneficiary, to a qualified dependent, or to a representative authorized under this subpart to receive payments on behalf of such beneficiary or dependent.

§725.506 Payment on behalf of another; "legal guardian" defined.

Benefits are paid only to the beneficiary, his or her representative payee (see §725.510) or his or her legal guardian. As used in this section, ''legal guardian'' means an individual who has been appointed by a court of competent jurisdiction or otherwise appointed pursuant to law to assume control of and responsibility for the care of the beneficiary, the management of his or her estate, or both.

§725.507 Guardian for minor or incompetent.

An adjudication officer may require that a legal guardian or representative be appointed to receive benefit payments payable to any person who is mentally incompetent or a minor and to exercise the powers granted to, or to perform the duties otherwise required of such person under the Act.

§ 725.510 Representative payee.

(a) If the district director determines that the best interests of a beneficiary are served thereby, the district director may certify the payment of such beneficiary's benefits to a representative payee.

(b) Before any amount shall be certified for payment to any representative payee for or on behalf of a beneficiary, such representative payee shall submit to the district director such evidence as may be required of his or her relationship to, or his or her responsibility for the care of, the beneficiary on whose behalf payment is to be made, or of his or her authority to receive such a payment. The district director may, at any time thereafter, require evidence of the continued existence of such relationship, responsibility, or authority. If a person requesting representative payee status fails to submit the required evidence within a reasonable period of time after it is requested, no further payments shall be certified to him or her on behalf of the beneficiary unless the required evidence is thereafter submitted.

(c) All benefit payments made to a representative payee shall be available only for the use and benefit of the beneficiary, as defined in § 725.511.

§ 725.511 Use and benefit defined.

(a) Payments certified to a representative payee shall be considered as having been applied for the use and benefit of the beneficiary when they are used for the beneficiary's current maintenance—*i.e.*, to replace current income lost because of the disability of the beneficiary. Where a beneficiary is receiving care in an institution, current maintenance shall include the customary charges made by the institution and charges made for the current and foreseeable needs of the beneficiary which are not met by the institution.

(b) Payments certified to a representative payee which are not needed for the current maintenance of the beneficiary, except as they may be used under § 725.512, shall be conserved or invested on the beneficiary's behalf. Preferred investments are U.S. savings bonds which shall be purchased in accordance with applicable regulations of the U.S. Treasury Department (31 CFR part 315). Surplus funds may also be invested in accordance with the rules applicable to investment of trust estates by trustees. For example, surplus funds may be deposited in an interest or dividend bearing account in a bank or trust company or in a savings and loan association if the account is either federally insured or is otherwise insured in accordance with State law requirements. Surplus funds deposited in an interest or dividend bearing account in a bank or trust company or in a savings and loan association must be in a form of account which clearly shows that the representative payee has only a fiduciary, and not a personal, interest in the funds. The preferred forms of such accounts are as follows:

Name of beneficiary _____

by (Name of representative payee) representative payee,

or (Name of beneficiary)

by (Name of representative payee) trustee,

U.S. savings bonds purchased with surplus funds by a representative payee for an incapacitated adult beneficiary should be registered as follows: (Name of beneficiary) (Social Security No.), for whom (Name of payee) is representative payee for black lung benefits.

§ 725.512 Support of legally dependent spouse, child, or parent.

If current maintenance needs of a beneficiary are being reasonably met, a relative or other person to whom payments are certified as representative payee on behalf of the beneficiary may use part of the payments so certified for the support of the legally dependent spouse, a legally dependent child, or a legally dependent parent of the beneficiary.

§ 725.513 Accountability; transfer.

(a) The district director may require a representative payee to submit periodic reports including a full accounting of the use of all benefit payments certified to a representative payee. If a requested report or accounting is not submitted within the time allowed, the district director shall terminate the certification of the representative payee and thereafter payments shall be

made directly to the beneficiary. A certification which is terminated under this section may be reinstated for good cause, provided that all required reports are supplied to the district director.

(b) A representative payee who has conserved or invested funds from payments under this part shall, upon the direction of the district director, transfer any such funds (including interest) to a successor payee appointed by the district director or, at the option of the district director, shall transfer such funds to the Office for recertification to a successor payee or the beneficiary.

§ 725.514 Certification to dependent of augmentation portion of benefit.

(a) If the basic benefit of a miner or of a surviving spouse is augmented because of one or more dependents, and it appears to the district director that the best interests of such dependent would be served thereby, or that the augmented benefit is not being used for the use and benefit (as defined in this subpart) of the augmentee, the district director may certify payment of the amount of such augmentation (to the extent attributable to such dependent) to such dependent directly, or to a legal guardian or a representative payee for the use and benefit of such dependent.

(b) Any request to the district director to certify separate payment of the amount of an augmentation in accordance with paragraph (a) of this section shall be in writing on such form and in accordance with such instructions as are prescribed by the Office.

(c) The district director shall specify the terms and conditions of any certification authorized under this section and may terminate any such certification where appropriate.

(d) Any payment made under this section, if otherwise valid under the Act, is a complete settlement and satisfaction of all claims, rights, and interests in and to such payment, except that such payment shall not be construed to abridge the rights of any party to recoup any overpayment made.

§ 725.515 Assignment and exemption from claims of creditors.

(a) Except as provided by the Act and this part, no assignment, release, or commutation of benefits due or payable under this part by a responsible operator shall be valid, and all benefits shall be exempt from claims of creditors and from levy, execution, and attachment or other remedy or recovery or collection of a debt, which exemption may not be waived.

(b) Notwithstanding any other provision of law, benefits due from, or payable by, the Black Lung Disability Trust Fund under the Act and this part to a claimant shall be subject to legal process brought for the enforcement against the claimant of his or her legal obligations to provide child support or make alimony payments to the same extent as if the fund was a private person.

Benefit Rates

§ 725.520 Computation of benefits.

(a) *Basic rate.* The amount of benefits payable to a beneficiary for a month is determined, in the first instance, by computing the ''basic rate.'' The basic rate is equal to 37½ percent of the monthly pay rate for Federal employees in GS–2, step 1. That rate for a month is determined by:

(1) Ascertaining the lowest annual rate of pay (step 1) for Grade GS–2 of the General Schedule applicable to such month (see 5 U.S.C. 5332);

(2) Ascertaining the monthly rate thereof by dividing the amount determined in paragraph (a)(1) of this section by 12; and

(3) Ascertaining the basic rate under the Act by multiplying the amount determined in paragraph (a)(2) of this section by 0.375 (that is, by 37½ percent).

(b) *Basic benefit.* When a miner or surviving spouse is entitled to benefits for a month for which he or she has no dependents who qualify under this part and when a surviving child of a miner or spouse, or a parent, brother, or sister of a miner, is entitled to benefits for a month for which he or she is the only beneficiary entitled to benefits, the amount of benefits to which such beneficiary is entitled is equal to the basic rate as computed in accordance

with this section (raised, if not a multiple of 10 cents, to the next high multiple of 10 cents). This amount is referred to as the ''basic benefit.''

(c) *Augmented benefit.* (1) When a miner or surviving spouse is entitled to benefits for a month for which he or she has one or more dependents who qualify under this part, the amount of benefits to which such miner or surviving spouse is entitled is increased. This increase is referred to as an ''augmentation.''

(2) The benefits of a miner or surviving spouse are augmented to take account of a particular dependent beginning with the first month in which such dependent satisfies the conditions set forth in this part, and continues to be augmented through the month before the month in which such dependent ceases to satisfy the conditions set forth in this part, except in the case of a child who qualifies as a dependent because he or she is a student. In the latter case, such benefits continue to be augmented through the month before the first month during no part of which he or she qualifies as a student.

(3) The basic rate is augmented by 50 percent for one such dependent, 75 percent for two such dependents, and 100 percent for three or more such dependents.

(d) *Survivor benefits.* As used in this section, ''survivor'' means a surviving child of a miner or surviving spouse, or a surviving parent, brother, or sister of a miner, who establishes entitlement to benefits under this part.

(e) *Computation and rounding.* (1) Any computation prescribed by this section is made to the third decimal place.

(2) Monthly benefits are payable in multiples of 10 cents. Therefore, a monthly payment of amounts derived under paragraph (c)(3) of this section which is not a multiple of 10 cents is increased to the next higher multiple of 10 cents.

(3) Since a fraction of a cent is not a multiple of 10 cents, such an amount which contains a fraction in the third decimal place is raised to the next higher multiple of 10 cents.

(f) *Eligibility based on the coal mine employment of more than one miner.* Where an individual, for any month, is entitled (and/or qualifies as a dependent for purposes of augmentation of benefits) based on the disability or death due to pneumoconiosis arising out of the coal mine employment of more than one miner, the benefit payable to or on behalf of such individual shall be at a rate equal to the highest rate of benefits for which entitlement is established by reason of eligibility as a beneficiary, or by reason of his or her qualification as a dependent for augmentation of benefit purposes.

§ 725.521 Commutation of payments; lump sum awards.

(a) Whenever the district director determines that it is in the interest of justice, the liability for benefits or any part thereof as determined by a final adjudication, may, with the approval of the Director, be discharged by the payment of a lump sum equal to the present value of future benefit payments commuted, computed at 4 percent true discount compounded annually.

(b) Applications for commutation of future payments of benefits shall be made to the district director in the manner prescribed by the district director. If the district director determines that an award of a lump sum payment of such benefits would be in the interest of justice, he or she shall refer such application, together with the reasons in support of such determination, to the Director for consideration.

(c) The Director shall, in his or her discretion, grant or deny the application for commutation of payments. Such decision may be appealed to the Benefits Review Board.

(d) The computation of all commutations of such benefits shall be made by the OWCP. For this purpose the file shall contain the date of birth of the person on whose behalf commutation is sought, as well as the date upon which such commutation shall be effective.

(e) For purposes of determining the amount of any lump sum award, the probability of the death of the disabled miner and/or other persons entitled to benefits before the expiration of the period during which he or she is entitled to benefits, shall be determined in accordance with the most current United

States Life Tables, as developed by the Department of Health, Education, and Welfare, and the probability of the remarriage of a surviving spouse shall be determined in accordance with the remarriage tables of the Dutch Royal Insurance Institution. The probability of the happening of any other contingency affecting the amount or duration of the compensation shall be disregarded.

(f) In the event that an operator or carrier is adjudicated liable for the payment of benefits, such operator or carrier shall be notified of and given an opportunity to participate in the proceedings to determine whether a lump sum award shall be made. Such operator or carrier shall, in the event a lump sum award is made, tender full and prompt payment of such award to the claimant as though such award were a final payment of monthly benefits. Except as provided in paragraph (g) of this section, such lump sum award shall forever discharge such operator or carrier from its responsibility to make monthly benefit payments under the Act to the person who has requested such lump-sum award. In the event that an operator or carrier is adjudicated liable for the payment of benefits, such operator or carrier shall not be liable for any portion of a commuted or lump sum award predicated upon benefits due any claimant prior to January 1, 1974.

(g) In the event a lump-sum award is approved under this section, such award shall not operate to discharge an operator carrier, or the fund from any responsibility imposed by the Act for the payment of medical benefits to an eligible miner.

§ 725.522 Payments prior to final adjudication.

(a) If an operator or carrier fails or refuses to commence the payment of benefits within 30 days of issuance of an initial determination of eligibility by the district director (see § 725.420), or fails or refuses to commence the payment of any benefits due pursuant to an effective order by a district director, administrative law judge, Benefits Review Board, or court, the fund shall commence the payment of such benefits and shall continue such payments as appropriate. In the event that the fund undertakes the payment of benefits on behalf of an operator or carrier, the provisions of §§ 725.601 through 725.609 shall be applicable to such operator or carrier.

(b) If benefit payments are commenced prior to the final adjudication of the claim and it is later determined by an administrative law judge, the Board, or court that the claimant was ineligible to receive such payments, such payments shall be considered overpayments pursuant to § 725.540 and may be recovered in accordance with the provisions of this subpart.

Special Provisions for Operator Payments

§ 725.530 Operator payments; generally.

(a) Benefits payable by an operator or carrier pursuant to an effective order issued by a district director, administrative law judge, Benefits Review Board, or court, or by an operator that has agreed that it is liable for the payment of benefits to a claimant, shall be paid by the operator or carrier immediately when they become due (see § 725.502(b)). An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within 10 days of the date they become due is entitled to additional compensation equal to twenty percent of those benefits (see § 725.607). Arrangements for the payment of medical costs shall be made by such operator or carrier in accordance with the provisions of subpart J of this part.

(b) Benefit payments made by an operator or carrier shall be made directly to the person entitled thereto or a representative payee if authorized by the district director. The payment of a claimant's attorney's fee, if any is awarded, shall be made directly to such attorney. Reimbursement of the fund, including interest, shall be paid directly to the Secretary on behalf of the fund.

§ 725.531 Receipt for payment.

Any individual receiving benefits under the Act in his or her own right, or as a representative payee, or as the duly appointed agent for the estate of a deceased beneficiary, shall execute receipts for benefits paid by any operator which shall be produced by such operator for inspection whenever the district director requires. A canceled check shall be considered adequate receipt of payment for purposes of this section. No operator or carrier shall be required to retain receipts for payments made for more than 5 years after the date on which such receipt was executed.

§ 725.532 Suspension, reduction, or termination of payments.

(a) No suspension, reduction, or termination in the payment of benefits is permitted unless authorized by the district director, administrative law judge, Board, or court. No suspension, reduction, or termination shall be authorized except upon the occurrence of an event which terminates a claimant's eligibility for benefits (see subpart B of this part) or as is otherwise provided in subpart C of this part, §§ 725.306 and 725.310, or this subpart (see also §§ 725.533 through 725.546).

(b) Any unauthorized suspension in the payment of benefits by an operator or carrier shall be treated as provided in subpart I.

(c) Unless suspension, reduction, or termination of benefits payments is required by an administrative law judge, the Benefits Review Board or a court, the district director, after receiving notification of the occurrence of an event that would require the suspension, reduction, or termination of benefits, shall follow the procedures for the determination of claims set forth in subparts E and F.

INCREASES AND REDUCTIONS OF BENEFITS

§ 725.533 Modification of benefits amounts; general.

(a) Under certain circumstances, the amount of monthly benefits as computed in § 725.520 or lump-sum award (§ 725.521) shall be modified to determine the amount actually to be paid to a beneficiary. With respect to any benefits payable for all periods of eligibility after January 1, 1974, a reduction of the amount of benefits payable shall be required on account of:

(1) Any compensation or benefits received under any State workers' compensation law because of death or partial or total disability due to pneumoconiosis; or

(2) Any compensation or benefits received under or pursuant to any Federal law including part B of title IV of the Act because of death or partial or total disability due to pneumoconiosis; or

(3) In the case of benefits to a parent, brother, or sister as a result of a claim filed at any time or benefits payable on a miner's claim which was filed on or after January 1, 1982, the excess earnings from wages and from net earnings from self-employment (see § 410.530 of this title) of such parent, brother, sister, or miner, respectively; or

(4) The fact that a claim for benefits from an additional beneficiary is filed, or that such claim is effective for a payment during the month of filing, or a dependent qualifies under this part for an augmentation portion of a benefit of a miner or widow for a period in which another dependent has previously qualified for an augmentation.

(b) An adjustment in a beneficiary's monthly benefit may be required because an overpayment or underpayment has been made to such beneficiary (see §§ 725.540–725.546).

(c) A suspension of a beneficiary's monthly benefits may be required when the Office has information indicating that reductions on account of excess earnings may reasonably be expected.

(d) Monthly benefit rates are payable in multiples of 10 cents. Any monthly benefit rate which, after the applicable computations, augmentations, and reductions is not a multiple of 10 cents, is increased to the next higher multiple of 10 cents. Since a fraction of a cent is not a multiple of 10 cents, a benefit rate which contains such a fraction in the third decimal is raised to the next higher multiple of 10 cents.

(e) Any individual entitled to a benefit, who is aware of any circumstances which could affect entitlement to benefits, eligibility for payment, or the

amount of benefits, or result in the termination, suspension, or reduction of benefits, shall promptly report these circumstances to the Office. The Office may at any time require an individual receiving, or claiming entitlement to, benefits, either on his or her own behalf or on behalf of another, to submit a written statement giving pertinent information bearing upon the issue of whether or not an event has occurred which would cause such benefit to be terminated, or which would subject such benefit to reductions or suspension under the provisions of the Act. The failure of an individual to submit any such report or statement, properly executed, to the Office shall subject such benefit to reductions, suspension, or termination as the case may be.

§ 725.534 Reduction of State benefits.

No benefits under section 415 of part B of title IV of the Act shall be payable to the residents of a State which, after December 31, 1969, reduces the benefits payable to persons eligible to receive benefits under section 415 of the Act under State laws applicable to its general work force with regard to workers' compensation (including compensation for occupational disease), unemployment compensation, or disability insurance benefits which are funded in whole or in part out of employer contributions.

§ 725.535 Reductions; receipt of State or Federal benefit.

(a) As used in this section the term ''State or Federal benefit'' means a payment to an individual on account of total or partial disability or death due to pneumoconiosis only under State or Federal laws relating to workers' compensation. With respect to a claim for which benefits are payable for any month between July 1 and December 31, 1973, ''State benefit'' means a payment to a beneficiary made on account of disability or death due to pneumoconiosis under State laws relating to workers' compensation (including compensation for occupational disease), unemployment compensation, or disability insurance.

(b) Benefit payments to a beneficiary for any month are reduced (but not below zero) by an amount equal to any payments of State or Federal benefits received by such beneficiary for such month.

(c) Where a State or Federal benefit is paid periodically but not monthly, or in a lump sum as a commutation of or a substitution for periodic benefits, the reduction under this section is made at such time or times and in such amounts as the Office determines will approximate as nearly as practicable the reduction required under paragraph (b) of this section. In making such a determination, a weekly State or Federal benefit is multiplied by 4⅓ and a biweekly benefit is multiplied by 2⅙ to ascertain the monthly equivalent for reduction purposes.

(d) Amounts paid or incurred or to be incurred by the individual for medical, legal, or related expenses in connection with this claim for State or Federal benefits (defined in paragraph (a) of this section) are excluded in computing the reduction under paragraph (b) of this section, to the extent that they are consistent with State or Federal Law. Such medical, legal, or related expenses may be evidenced by the State or Federal benefit awards, compromise agreement, or court order in the State or Federal benefit proceedings, or by such other evidence as the Office may require. Such other evidence may consist of:

(1) A detailed statement by the individual's attorney, physician, or the employer's insurance carrier; or

(2) Bills, receipts, or canceled checks; or

(3) Other evidence indicating the amount of such expenses; or

(4) Any combination of the foregoing evidence from which the amount of such expenses may be determinable. Such expenses shall not be excluded unless established by evidence as required by the Office.

§ 725.536 Reductions; excess earnings.

In the case of a surviving parent, brother, or sister, whose claim was filed at any time, or of a miner whose claim was filed on or after January 1, 1982, benefit payments are reduced as appropriate by an amount equal to the deduction which would be made with respect to excess earnings under the provisions of sections 203 (b), (f), (g),

(h), (j), and (l) of the Social Security Act (42 U.S.C. 403 (b), (f), (g), (h), (j), and (l)), as if such benefit payments were benefits payable under section 202 of the Social Security Act (42 U.S.C. 402) (see §§ 404.428 through 404.456 of this title).

§ 725.537 Reductions; retroactive effect of an additional claim for benefits.

Except as provided in § 725.212(b), beginning with the month in which a person other than a miner files a claim and becomes entitled to benefits, the benefits of other persons entitled to benefits with respect to the same miner, are adjusted downward, if necessary, so that no more than the permissible amount of benefits (the maximum amount for the number of beneficiaries involved) will be paid.

§ 725.538 Reductions; effect of augmentation of benefits based on subsequent qualification of individual.

(a) Ordinarily, a written request that the benefits of a miner or surviving spouse be augmented on account of a qualified dependent is made as part of the claim for benefits. However, it may also be made thereafter.

(b) In the latter case, beginning with the month in which such a request is filed on account of a particular dependent and in which such dependent qualifies for augmentation purposes under this part, the augmented benefits attributable to other qualified dependents (with respect to the same miner or surviving spouse), if any, are adjusted downward, if necessary, so that the permissible amount of augmented benefits (the maximum amount for the number of dependents involved) will not be exceeded.

(c) Where, based on the entitlement to benefits of a miner or surviving spouse, a dependent would have qualified for augmentation purposes for a prior month of such miner's or surviving spouse's entitlement had such request been filed in such prior month, such request is effective for such prior month. For any month before the month of filing such request, however, otherwise correct benefits previously certified by the Office may not be changed. Rather the amount of the augmented benefit attributable to the dependent filing such request in the later month is reduced for each month of the retroactive period to the extent that may be necessary. This means that for each month of the retroactive period, the amount payable to the dependent filing the later augmentation request is the difference, if any, between:

(1) The total amount of augmented benefits certified for payment for other dependents for that month, and

(2) The permissible amount of augmented benefits (the maximum amount for the number of dependents involved) payable for the month for all dependents, including the dependent filing later.

§ 725.539 More than one reduction event.

If a reduction for receipt of State or Federal benefits and a reduction on account of excess earnings are chargeable to the same month, the benefit for such month is first reduced (but not below zero) by the amount of the State or Federal benefits, and the remainder of the benefit for such month, if any, is then reduced (but not below zero) by the amount of excess earnings chargeable to such month.

OVERPAYMENTS; UNDERPAYMENTS

§ 725.540 Overpayments.

(a) *General.* As used in this subpart, the term ''overpayment'' includes:

(1) Payment where no amount is payable under this part;

(2) Payment in excess of the amount payable under this part;

(3) A payment under this part which has not been reduced by the amounts required by the Act (see § 725.533);

(4) A payment under this part made to a resident of a State whose residents are not entitled to benefits (see §§ 725.402 and 725.403);

(5) Payment resulting from failure to terminate benefits to an individual no longer entitled thereto;

(6) Duplicate benefits paid to a claimant on account of concurrent eligibility under this part and parts 410 or 727 (see § 725.4(d)) of this title or as provided in § 725.309.

(b) *Overpaid beneficiary is living.* If the beneficiary to whom an overpayment

was made is living at the time of a determination of such overpayment, is entitled to benefits at the time of the overpayment, or at any time thereafter becomes so entitled, no benefit for any month is payable to such individual, except as provided in paragraph (c) of this section, until an amount equal to the amount of the overpayment has been withheld or refunded.

(c) *Adjustment by withholding part of a monthly benefit.* Adjustment under paragraph (b) of this section may be effected by withholding a part of the monthly benefit payable to a beneficiary where it is determined that:

(1) Withholding the full amount each month would deprive the beneficiary of income required for ordinary and necessary living expenses;

(2) The overpayment was not caused by the beneficiary's intentionally false statement or representation, or willful concealment of, or deliberate failure to furnish, material information; and

(3) Recoupment can be effected in an amount of not less than $ 10 a month and at a rate which would not unreasonably extend the period of adjustment.

(d) *Overpaid beneficiary dies before adjustment.* If an overpaid beneficiary dies before adjustment is completed under the provisions of paragraph (b) of this section, recovery of the overpayment shall be effected through repayment by the estate of the deceased overpaid beneficiary, or by withholding of amounts due the estate of such deceased beneficiary, or both.

§ 725.541 Notice of waiver of adjustment or recovery of overpayment.

Whenever a determination is made that more than the correct amount of payment has been made, notice of the provisions of section 204(b) of the Social Security Act regarding waiver of adjustment or recovery shall be sent to the overpaid individual, to any other individual against whom adjustment or recovery of the overpayment is to be effected, and to any operator or carrier which may be liable to such overpaid individual.

§ 725.542 When waiver of adjustment or recovery may be applied.

There shall be no adjustment or recovery of an overpayment in any case where an incorrect payment has been made with respect to an individual:

(a) Who is without fault, and where

(b) Adjustment or recovery would either:

(1) Defeat the purpose of title IV of the Act, or

(2) Be against equity and good conscience.

§ 725.543 Standards for waiver of adjustment or recovery.

The standards for determining the applicability of the criteria listed in § 725.542 shall be the same as those applied by the Social Security Administration under §§ 404.506 through 404.512 of this title.

§ 725.544 Collection and compromise of claims for overpayment.

(a) *General effect of 31 U.S.C. 3711.* In accordance with 31 U.S.C. 3711 and applicable regulations, claims by the Office against an individual for recovery of an overpayment under this part not exceeding the sum of $100,000, exclusive of interest, may be compromised, or collection suspended or terminated, where such individual or his or her estate does not have the present or prospective ability to pay the full amount of the claim within a reasonable time (see paragraph (c) of this section), or the cost of collection is likely to exceed the amount of recovery (see paragraph (d) of this section), except as provided under paragraph (b) of this section.

(b) *When there will be no compromise, suspension, or termination of collection of a claim for overpayment.* (1) In any case where the overpaid individual is alive, a claim for overpayment will not be compromised, nor will there be suspension or termination of collection of the claim by the Office, if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such individual or on the part of any other party having any interest in the claim.

(2) In any case where the overpaid individual is deceased:

(i) A claim for overpayment in excess of $ 5,000 will not be compromised, nor will there be suspension or termination of collection of the claim by the Office if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such deceased individual; and

(ii) A claim for overpayment, regardless of the amount, will not be compromised, nor will there be suspension or termination of collection of the claim by the Office if there is an indication that any person other than the deceased overpaid individual had a part in the fraudulent action which resulted in the overpayment.

(c) *Inability to pay claim for recovery of overpayment.* In determining whether the overpaid individual is unable to pay a claim for recovery of an overpayment under this part, the Office shall consider the individual's age, health, present and potential income (including inheritance prospects), assets (e.g., real property, savings account), possible concealment or improper transfer of assets, and assets or income of such individual which may be available in enforced collection proceedings. The Office will also consider exemptions available to such individual under the pertinent State or Federal law in such proceedings. In the event the overpaid individual is deceased, the Office shall consider the available assets of the estate, taking into account any liens or superior claims against the estate.

(d) *Cost of collection or litigative probabilities.* Where the probable costs of recovering an overpayment under this part would not justify enforced collection proceedings for the full amount of the claim, or where there is doubt concerning the Office's ability to establish its claim as well as the time which it will take to effect such collection, a compromise or settlement for less than the full amount may be considered.

(e) *Amount of compromise.* The amount to be accepted in compromise of a claim for overpayment under this part shall bear a reasonable relationship to the amount which can be recovered by enforced collection proceedings, giving due consideration to the exemption available to the overpaid individual under State or Federal law and the time which collection will take.

(f) *Payment.* Payment of the amount the Office has agreed to accept as a compromise in full settlement of a claim for recovery of an overpayment under this part shall be made within the time and in the manner set by the Office. A claim for the overpayment shall not be considered compromised or settled until the full payment of the compromised amount has been made within the time and manner set by the Office. Failure of the overpaid individual or his or her estate to make such payment as provided shall result in reinstatement of the full amount of the overpayment less any amounts paid prior to such default.

§ 725.545 Underpayments.

(a) *General.* As used in this subpart, the term ''underpayment'' includes a payment in an amount less than the amount of the benefit due for such month, and nonpayment where some amount of such benefits is payable.

(b) *Underpaid individual is living.* If an individual to whom an underpayment was made is living, the deficit represented by such underpayment shall be paid to such individual either in a single payment (if he or she is not entitled to a monthly benefit or if a single payment is requested by the claimant in writing) or by increasing one or more monthly benefit payments to which such individual becomes entitled.

(c) *Underpaid individual dies before adjustment of underpayment.* If an individual to whom an underpayment was made dies before receiving payment of the deficit or negotiating the check or checks representing payment of the deficit, such payment shall be distributed to the living person (or persons) in the highest order of priority as follows:

(1) The deceased individual's surviving spouse who was either:

(i) Living in the same household with the deceased individual at the time of such individual's death; or

(ii) In the case of a deceased miner, entitled for the month of death to black lung benefits as his or her surviving spouse or surviving divorced spouse.

(2) In the case of a deceased miner or spouse his or her child entitled to benefits as the surviving child of such

miner or surviving spouse for the month in which such miner or spouse died (if more than one such child, in equal shares to each such child).

(3) In the case of a deceased miner, his parent entitled to benefits as the surviving parent of such miner for the month in which such miner died (if more than one such parent, in equal shares to each such parent).

(4) The surviving spouse of the deceased individual who does not qualify under paragraph (c)(1) of this section.

(5) The child or children of the deceased individual who do not qualify under paragraph (c)(2) of this section (if more than one such child, in equal shares to each such child).

(6) The parent or parents of the deceased individual who do not qualify under paragraph (c)(3) of this section (if more than one such parent, in equal shares to each such parent).

(7) The legal representative of the estate of the deceased individual as defined in paragraph (e) of this section.

(d) *Deceased beneficiary.* In the event that a person, who is otherwise qualified to receive payments as the result of a deficit caused by an underpayment under the provisions of paragraph (c) of this section, dies before receiving payment or before negotiating the check or checks representing such payment, his or her share of the underpayment shall be divided among the remaining living person(s) in the same order or priority. In the event that there is (are) no other such person(s), the underpayment shall be paid to the living person(s) in the next lower order of priority under paragraph (c) of this section.

(e) *Definition of legal representative.* The term ''legal representative,'' for the purpose of qualifying for receipt of an underpayment, generally means the executor or the administrator of the estate of the deceased beneficiary. However, it may also include an individual, institution or organization acting on behalf of an unadministered estate, provided the person can give the Office good acquittance (as defined in paragraph (f) of this section). The following persons may qualify as legal representative for purposes of this section, provided they can give the Office good acquittance:

(1) A person who qualifies under a State's ''small estate'' statute; or

(2) A person resident in a foreign country who under the laws and customs of that country, has the right to receive assets of the estate; or

(3) A public administrator; or

(4) A person who has the authority under applicable law to collect the assets of the estate of the deceased beneficiary.

(f) *Definition of ''good acquittance.''* A person is considered to give the Office ''good acquittance'' when payment to that person will release the Office from further liability for such payment.

§ 725.546 Relation to provisions for reductions or increases.

The amount of an overpayment or an underpayment is the difference between the amount to which the beneficiary was actually entitled and the amount paid. Overpayment and underpayment simultaneously outstanding against the same beneficiary shall first be adjusted against one another before adjustment pursuant to the other provisions of this subpart.

§ 725.547 Applicability of overpayment and underpayment provisions to operator or carrier.

(a) The provisions of this subpart relating to overpayments and underpayments shall be applicable to overpayments and underpayments made by responsible operators or their insurance carriers, as appropriate.

(b) No operator or carrier may recover, or make an adjustment of, an overpayment without prior application to, and approval by, the Office which shall exercise full supervisory authority over the recovery or adjustment of all overpayments.

§ 725.548 Procedures applicable to overpayments and underpayments.

(a) In any case involving either overpayments or underpayments, the Office may take any necessary action, and district directors may issue appropriate orders to protect the rights of the parties.

(b) Disputes arising out of orders so issued shall be resolved by the procedures set out in subpart F of this part.

Subpart I—Enforcement of Liability; Reports

§ 725.601 Enforcement generally.

(a) The Act, together with certain incorporated provisions from the Longshoremen's and Harbor Workers' Compensation Act, contains a number of provisions which subject an operator or other employer, claimants and others to penalties for failure to comply with certain provisions of the Act, or failure to commence and continue prompt periodic payments to a beneficiary.

(b) It is the policy and intent of the Department to vigorously enforce the provisions of this part through the use of the remedies provided by the Act. Accordingly, if an operator refuses to pay benefits with respect to a claim for which the operator has been adjudicated liable, the Director may invoke and execute the lien on the property of the operator as described in §725.603. Enforcement of this lien must be pursued in an appropriate U.S. district court. If the Director determines that the remedy provided by §725.603 may not be sufficient to guarantee the continued compliance with the terms of an award or awards against the operator, the Director may in addition seek an injunction in the U.S. district court to prohibit future noncompliance by the operator and such other relief as the court considers appropriate (*see* §725.604). If an operator unlawfully suspends or terminates the payment of benefits to a claimant, the district director may declare the award in default and proceed in accordance with §725.605. In all cases payments of additional compensation (*see* §725.607) and interest (*see* §725.608) will be sought by the Director or awarded by the district director.

(c) In certain instances the remedies provided by the Act are concurrent; that is, more than one remedy might be appropriate in any given case. In such a case, the Director may select the remedy or remedies appropriate for the enforcement action. In making this selection, the Director shall consider the best interests of the claimant as well as those of the fund.

[65 FR 80054, Dec. 20, 2000, as amended at 81 FR 24481, Apr. 26, 2016]

§ 725.602 Reimbursement of the fund.

(a) In any case in which the fund has paid benefits, including medical benefits, on behalf of an operator or other employer which is determined liable therefore, or liable for a part thereof, such operator or other employer shall simultaneously with the first payment of benefits made to the beneficiary, reimburse the fund (with interest) for the full amount of all benefit payments made by the fund with respect to the claim.

(b) In any case where benefit payments have been made by the fund, the fund shall be subrogated to the rights of the beneficiary. The Secretary of Labor may, as appropriate, exercise such subrogation rights.

§ 725.603 Payments by the fund on behalf of an operator; liens.

(a) If an amount is paid out of the fund to an individual entitled to benefits under this part or part 727 of this subchapter (see §725.4(d)) on behalf of an operator or other employer which is or was required to pay or secure the payment of all or a portion of such amount (see §725.522), the operator or other employer shall be liable to the United States for repayment to the fund of the amount of benefits properly attributable to such operator or other employer.

(b) If an operator or other employer liable to the fund refuses to pay, after demand, the amount of such liability, there shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belonging to such operator or other employer. The lien arises on the date on which such liability is finally determined, and continues until it is satisfied or becomes unenforceable by reason of lapse of time.

(c)(1) Except as otherwise provided under this section, the priority of the lien shall be determined in the same manner as under section 6323 of the Internal Revenue Code (26 U.S.C.).

(2) In the case of a bankruptcy or insolvency proceeding, the lien imposed under this section shall be treated in the same manner as a lien for taxes due and owing to the United States for purposes of the Bankruptcy Act or section

3466 of the Revised Statutes (31 U.S.C. 191).

(3) For purposes of applying section 6323(a) of the Internal Revenue Code (26 U.S.C.) to determine the priority between the lien imposed under this section and the Federal tax lien, each lien shall be treated as a judgment lien arising as of the time notice of such lien is filed.

(4) For purposes of the section, notice of the lien imposed hereunder shall be filed in the same manner as under section 6323(f) (disregarding paragraph (4) thereof) and (g) of the Internal Revenue Code (26 U.S.C.).

(5) In any case where there has been a refusal or neglect to pay the liability imposed under this section, the Secretary of Labor may bring a civil action in a district court of the United States to enforce the lien of the United States under this section with respect to such liability or to subject any property, of whatever nature, of the operator, or in which it has any right, title, or interest, to the payment of such liability.

(6) The liability imposed by this paragraph may be collected at a proceeding in court if the proceeding is commenced within 6 years after the date upon which the liability was finally determined, or prior to the expiration of any period for collection agreed upon in writing by the operator and the United States before the expiration of such 6-year period. This period of limitation shall be suspended for any period during which the assets of the operator are in the custody or control of any court of the United States, or of any State, or the District of Columbia, and for 6 months thereafter, and for any period during which the operator is outside the United States if such period of absence is for a continuous period of at least 6 months.

§ 725.604 Enforcement of final awards.

Notwithstanding the provisions of § 725.603, if an operator or other employer or its officers or agents fails to comply with an order awarding benefits that has become final, any beneficiary of such award or the district director may apply for the enforcement of the order to the Federal district court for the judicial district in which the injury occurred (or to the U.S. District Court for the District of Columbia if the injury occurred in the District). If the court determines that the order was made and served in accordance with law, and that such operator or other employer or its officers or agents have failed to comply therewith, the court shall enforce obedience to the order by writ of injunction or by other proper process, mandatory or otherwise, to enjoin upon such operator or other employer and its officers or agents compliance with the order.

§ 725.605 Defaults.

(a) Except as is otherwise provided in this part, no suspension, termination or other failure to pay benefits awarded to a claimant is permitted. If an employer found liable for the payment of such benefits fails to make such payments within 30 days after any date on which such benefits are due and payable, the person to whom such benefits are payable may, within one year after such default, make application to the district director for a supplementary order declaring the amount of the default.

(b) If after investigation, notice and hearing as provided in subparts E and F of this part, a default is found, the district director or the administrative law judge, if a hearing is requested, shall issue a supplementary order declaring the amount of the default, if any. In cases where a lump-sum award has been made, if the payment in default is an installment, the district director or administrative law judge, may, in his or her discretion, declare the whole of the award as the amount in default. The applicant may file a certified copy of such supplementary order with the clerk of the Federal district court for the judicial district in which the operator has its principal place of business or maintains an office or for the judicial district in which the injury occurred. In case such principal place of business or office is in the District of Columbia, a copy of such supplementary order may be filed with the clerk of the U.S. District Court for the District of Columbia. Such supplementary order shall be final and the court shall, upon the filing of the copy,

enter judgment for the amount declared in default by the supplementary order if such supplementary order is in accordance with law. Review of the judgment may be had as in civil suits for damages at common law. Final proceedings to execute the judgment may be had by writ of execution in the form used by the court in suits at common law in actions of assumpsit. No fee shall be required for filing the supplementary order nor for entry of judgment thereon, and the applicant shall not be liable for costs in a proceeding for review of the judgment unless the court shall otherwise direct. The court shall modify such judgment to conform to any later benefits order upon presentation of a certified copy thereof to the court.

(c) In cases where judgment cannot be satisfied by reason of the employer's insolvency or other circumstances precluding payment, the district director shall make payment from the fund, and in addition, provide any necessary medical, surgical, and other treatment required by subpart J of this part. A defaulting employer shall be liable to the fund for payment of the amounts paid by the fund under this section; and for the purpose of enforcing this liability, the fund shall be subrogated to all the rights of the person receiving such payments or benefits.

§ 725.606 Security for the payment of benefits.

(a) Following the issuance of an effective order by a district director (see § 725.418), administrative law judge (see § 725.479), Benefits Review Board, or court that requires the payment of benefits by an operator that has failed to secure the payment of benefits in accordance with section 423 of the Act and § 726.4 of this subchapter, or by a coal mine construction or transportation employer, the Director may request that the operator secure the payment of all benefits ultimately payable on the claim. Such operator or other employer shall thereafter immediately secure the payment of benefits in accordance with the provisions of this section, and provide proof of such security to the Director. Such security may take the form of an indemnity bond, a deposit of cash or negotiable securities in compliance with §§ 726.106(c) and 726.107 of this subchapter, or any other form acceptable to the Director.

(b) The amount of security initially required by this section shall be determined as follows:

(1) In a case involving an operator subject to section 423 of the Act and § 726.4 of this subchapter, the amount of the security shall not be less than $175,000, and may be a higher amount as determined by the Director, taking into account the life expectancies of the claimant and any dependents using the most recent life expectancy tables published by the Social Security Administration; or

(2) In a case involving a coal mine construction or transportation employer, the amount of the security shall be determined by the Director, taking into account the life expectancies of the claimant and any dependents using the most recent life expectancy tables published by the Social Security Administration.

(c) If the operator or other employer fails to provide proof of such security to the Director within 30 days of its receipt of the Director's request to secure the payment of benefits issued under paragraph (a) of this section, the appropriate adjudication officer shall issue an order requiring the operator or other employer to make a deposit of negotiable securities with a Federal Reserve Bank in the amount required by paragraph (b). Such securities shall comply with the requirements of §§ 726.106(c) and 726.107 of this subchapter. In a case in which the effective order was issued by a district director, the district director shall be considered the appropriate adjudication officer. In any other case, the administrative law judge who issued the most recent decision in the case, or such other administrative law judge as the Chief Administrative Law Judge shall designate, shall be considered the appropriate adjudication officer, and shall issue an order under this paragraph on motion of the Director. The administrative law judge shall have jurisdiction to issue an order under this paragraph notwithstanding the pendency of an appeal of the award of benefits with the Benefits Review Board or court.

(d) An order issued under this section shall be considered effective when issued. Disputes regarding such orders shall be resolved in accordance with subpart F of this part.

(e) Notwithstanding any further review of the order in accordance with subpart F of this part, if an operator or other employer subject to an order issued under this section fails to comply with such order, the appropriate adjudication officer shall certify such non-compliance to the appropriate United States district court in accordance with § 725.351(c).

(f) Security posted in accordance with this section may be used to make payment of benefits that become due with respect to the claim in accordance with § 725.502. In the event that either the order awarding compensation or the order issued under this section is vacated or reversed, the operator or other employer may apply to the appropriate adjudication officer for an order authorizing the return of any amounts deposited with a Federal Reserve Bank and not yet disbursed, and such application shall be granted. If at any time the Director determines that additional security is required beyond that initially required by paragraph (b) of this section, he may request the operator or other employer to increase the amount. Such request shall be treated as if it were issued under paragraph (a) of this section.

(g) If a coal mine construction or transportation employer fails to comply with an order issued under paragraph (c), and such employer is a corporation, the provisions of § 725.609 shall be applicable to the president, secretary, and treasurer of such employer.

§ 725.607 Payments of additional compensation.

(a) If any benefits payable under the terms of an award by a district director (§ 725.419(d)), a decision and order filed and served by an administrative law judge (§ 725.478), or a decision filed by the Board or a U.S. court of appeals, are not paid by an operator or other employer ordered to make such payments within 10 days after such payments become due, there will be added to such unpaid benefits an amount equal to 20 percent thereof, which must be paid to the claimant at the same time as, but in addition to, such benefits, unless review of the order making such award is sought as provided in section 21 of the LHWCA and an order staying payments has been issued.

(b) If, on account of an operator's or other employer's failure to pay benefits as provided in paragraph (a) of this section, benefit payments are made by the fund, the eligible claimant will nevertheless be entitled to receive such additional compensation to which he or she may be eligible under paragraph (a), with respect to all amounts paid by the fund on behalf of such operator or other employer.

(c) The fund may not be held liable for payments of additional compensation under any circumstances.

[81 FR 24482, Apr. 26, 2016]

§ 725.608 Interest.

(a)(1) In any case in which an operator fails to pay benefits that are due (§ 725.502), the beneficiary shall also be entitled to simple annual interest, computed from the date on which the benefits were due. The interest shall be computed through the date on which the operator paid the benefits, except that the beneficiary shall not be entitled to interest for any period following the date on which the beneficiary received payment of any benefits from the fund pursuant to § 725.522.

(2) In any case in which an operator is liable for the payment of retroactive benefits, the beneficiary shall also be entitled to simple annual interest on such benefits, computed from 30 days after the date of the first determination that such an award should be made. The first determination that such an award should be made may be a district director's initial determination of entitlement, an award made by an administrative law judge or a decision by the Board or a court, whichever is the first such determination of entitlement made upon the claim.

(3) In any case in which an operator is liable for the payment of additional compensation (§ 725.607), the beneficiary shall also be entitled to simple annual interest computed from the date upon which the beneficiary's right to additional compensation first arose.

(4) In any case in which an operator is liable for the payment of medical benefits, the beneficiary or medical provider to whom such benefits are owed shall also be entitled to simple annual interest, computed from the date upon which the services were rendered, or from 30 days after the date of the first determination that the miner is generally entitled to medical benefits, whichever is later. The first determination that the miner is generally entitled to medical benefits may be a district director's initial determination of entitlement, an award made by an administrative law judge or a decision by the Board or a court, whichever is the first such determination of general entitlement made upon the claim. The interest shall be computed through the date on which the operator paid the benefits, except that the beneficiary or medical provider shall not be entitled to interest for any period following the date on which the beneficiary or medical provider received payment of any benefits from the fund pursuant to §725.522 or subpart I of this part.

(b) If an operator or other employer fails or refuses to pay any or all benefits due pursuant to an award of benefits or an initial determination of eligibility made by the district director and the fund undertakes such payments, such operator or other employer shall be liable to the fund for simple annual interest on all payments made by the fund for which such operator is determined liable, computed from the first date on which such benefits are paid by the fund, in addition to such operator's liability to the fund, as is otherwise provided in this part. Interest payments owed pursuant to this paragraph shall be paid directly to the fund.

(c) In any case in which an operator is liable for the payment of an attorney's fee pursuant to §725.367, and the attorney's fee is payable because the award of benefits has become final, the attorney shall also be entitled to simple annual interest, computed from the date on which the attorney's fee was awarded. The interest shall be computed through the date on which the operator paid the attorney's fee.

(d) The rates of interest applicable to paragraphs (a), (b), and (c) of this section shall be computed as follows:

(1) For all amounts outstanding prior to January 1, 1982, the rate shall be 6% simple annual interest;

(2) For all amounts outstanding for any period during calendar year 1982, the rate shall be 15% simple annual interest; and

(3) For all amounts outstanding during any period after calendar year 1982, the rate shall be simple annual interest at the rate established by section 6621 of the Internal Revenue Code (26 U.S.C.) which is in effect for such period.

(e) The fund shall not be liable for the payment of interest under any circumstances, other than the payment of interest on advances from the United States Treasury as provided by section 9501(c) of the Internal Revenue Code (26 U.S.C.).

§725.609 Enforcement against other persons.

In any case in which an award of benefits creates obligations on the part of an operator or insurer that may be enforced under the provisions of this subpart, such obligations may also be enforced, in the discretion of the Secretary or district director, as follows:

(a) In a case in which the operator is a sole proprietorship or partnership, against any person who owned, or was a partner in, such operator during any period commencing on or after the date on which the miner was last employed by the operator;

(b) In a case in which the operator is a corporation that failed to secure its liability for benefits in accordance with section 423 of the Act and §726.4, and the operator has not secured its liability for the claim in accordance with §725.606, against any person who served as the president, secretary, or treasurer of such corporation during any period commencing on or after the date on which the miner was last employed by the operator;

(c) In a case in which the operator is no longer capable of assuming its liability for the payment of benefits (§725.494(e)), against any operator which became a successor operator with respect to the liable operator (§725.492) after the date on which the claim was filed, beginning with the most recent such successor operator;

(d) In a case in which the operator is no longer capable of assuming its liability for the payment of benefits (§ 725.494(e)), and such operator was a subsidiary of a parent company or a product of a joint venture, or was substantially owned or controlled by another business entity, against such parent entity, any member of such joint venture, or such controlling business entity; or

(e) Against any other person who has assumed or succeeded to the obligations of the operator or insurer by operation of any state or federal law, or by any other means.

§ 725.620 Failure to secure benefits; other penalties.

(a) If an operator fails to discharge its insurance obligations under the Act, the provisions of subpart D of part 726 of this subchapter shall apply.

(b) Any employer who knowingly transfers, sells, encumbers, assigns, or in any manner disposes of, conceals, secrets, or destroys any property belonging to such employer, after one of its employees has been injured within the purview of the Act, and with intent to avoid the payment of benefits under the Act to such miner or his or her dependents, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than $1,000, or by imprisonment for not more than one year, or by both. In any case where such employer is a corporation, the president, secretary, and treasurer thereof shall be also severally liable for such penalty or imprisonment as well as jointly liable with such corporation for such fine.

(c) No agreement by a miner to pay any portion of a premium paid to a carrier by such miner's employer or to contribute to a benefit fund or department maintained by such employer for the purpose of providing benefits or medical services and supplies as required by this part shall be valid; and any employer who makes a deduction for such purpose from the pay of a miner entitled to benefits under the Act shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not more than $1,000.

(d) No agreement by a miner to waive his or her right to benefits under the Act and the provisions of this part shall be valid.

(e) This section shall not affect any other liability of the employer under this part.

§ 725.621 Reports.

(a) Upon making the first payment of benefits and upon suspension, reduction, or increase of payments, the operator or other employer responsible for making payments shall immediately notify the district director of the action taken, in accordance with a form prescribed by the Office.

(b) Within 16 days after final payment of benefits has been made by an employer, such employer shall so notify the district director, in accordance with a form prescribed by the Office, stating that such final payment, has been made, the total amount of benefits paid, the name of the beneficiary, and such other information as the Office deems pertinent.

(c) The Director may from time to time prescribe such additional reports to be made by operators, other employers, or carriers as the Director may consider necessary for the efficient administration of the Act.

(d) Any employer who fails or refuses to file any report required of such employer under this section, and has penalties assessed for such failure or refusal after January 15, 2025, shall be subject to a civil penalty not to exceed $1,826 for each failure or refusal, which penalty shall be determined in accordance with the procedures set forth in subpart D of part 726 of this subchapter, as appropriate.

(e) No request for information or response to such request shall be considered a report for purposes of this section or the Act, unless it is so designated by the Director or by this section.

[65 FR 80054, Dec. 20, 2000, as amended at 81 FR 43449, July 1, 2016; 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2297, Jan. 15, 2020; 86 FR 2968, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2215, Jan. 13, 2023; 89 FR 1814, Jan. 11, 2024; 90 FR 1859, Jan. 10, 2025]

Subpart J—Medical Benefits and Vocational Rehabilitation

SOURCE: 83 FR 27695, June 14, 2018, unless otherwise noted.

§ 725.701 What medical benefits are available?

(a) A miner who is determined to be eligible for benefits under this part or part 727 of this subchapter (*see* § 725.4(d)) is entitled to medical benefits as set forth in this subpart as of the date of his or her claim, but in no event before January 1, 1974. Medical benefits may not be provided to the survivor or dependent of a miner under this part.

(b) A responsible operator, or where there is none, the fund, must furnish a miner entitled to benefits under this part with such medical services and treatments (including professional medical services and medical equipment, prescription drugs, outpatient medical services, inpatient medical services, and any other medical service, treatment or supply) for such periods as the nature of the miner's pneumoconiosis and disability requires.

(c) The medical benefits referred to in paragraphs (a) and (b) of this section include palliative measures useful only to prevent pain or discomfort associated with the miner's pneumoconiosis or attendant disability.

(d) An operator or the fund must also pay the miner's reasonable cost of travel necessary for medical treatment (to be determined in accordance with prevailing United States government mileage rates) and the reasonable documented cost to the miner or medical provider incurred in communicating with the operator, carrier, or OWCP on matters connected with medical benefits.

(e)(1) If a miner receives a medical service or treatment, as described in this section, for any pulmonary disorder, there will be a rebuttable presumption that the disorder is caused or aggravated by the miner's pneumoconiosis.

(2) The party liable for the payment of benefits may rebut the presumption by producing credible evidence that the medical service or treatment provided was for a pulmonary disorder apart from those previously associated with the miner's disability, or was beyond that necessary to effectively treat a covered disorder, or was not for a pulmonary disorder at all.

(3) An operator or the fund, however, cannot rely on evidence that the miner does not have pneumoconiosis or is not totally disabled by pneumoconiosis arising out of coal mine employment to defeat a request for coverage of any medical service or treatment under this subpart.

(4) In determining whether the treatment is compensable, the opinion of the miner's treating physician may be entitled to controlling weight pursuant to § 718.104(d) of this subchapter.

(5) A finding that a medical service or treatment is not covered under this subpart will not otherwise affect the miner's entitlement to benefits.

§ 725.702 Who is considered a physician?

The term ''physician'' includes only doctors of medicine (MD) and doctors of osteopathy (DO) within the scope of their practices as defined by State law. No treatment or medical services performed by any other practitioner of the healing arts is authorized by this part, unless such treatment or service is authorized and supervised both by a physician as defined in this section and by OWCP.

§ 725.703 How is treatment authorized?

(a) Upon notification to a miner of such miner's entitlement to benefits, OWCP must provide the miner with a list of authorized treating physicians and medical facilities in the area of the miner's residence. The miner may select a physician from this list or may select another physician with approval of OWCP. Where emergency services are necessary and appropriate, authorization by OWCP is not required.

(b) OWCP may, on its own initiative, or at the request of a responsible operator, order a change of physicians or facilities, but only where it has been determined that the change is desirable or necessary in the best interest of the miner. The miner may change physicians or facilities subject to the approval of OWCP.

(c) If adequate treatment cannot be obtained in the area of the claimant's residence, OWCP may authorize the use of physicians or medical facilities outside such area as well as reimbursement for travel expenses and overnight accommodations.

§ 725.704 How are arrangements for medical care made?

(a) *Operator liability*. If an operator has been determined liable for the payment of benefits to a miner, OWCP will notify the operator or its insurance carrier of the names, addresses, and telephone numbers of the authorized providers of medical benefits chosen by an entitled miner, and require the operator or carrier to:

(1) Notify the miner and the providers chosen that the operator or carrier will be responsible for the cost of medical services provided to the miner on account of the miner's total disability due to pneumoconiosis;

(2) Designate a person or persons with decision-making authority with whom OWCP, the miner and authorized providers may communicate on matters involving medical benefits provided under this subpart and notify OWCP, the miner and providers of this designation;

(3) Make arrangements for the direct reimbursement of providers for their services.

(b) *Fund liability*. If there is no operator found liable for the payment of benefits, OWCP will make necessary arrangements to provide medical care to the miner, notify the miner and providers selected of the liability of the fund, designate a person or persons with whom the miner or provider may communicate on matters relating to medical care, and make arrangements for the direct reimbursement of the medical provider.

§ 725.705 Is prior authorization for medical services required?

(a) Except as provided in paragraph (b) of this section, medical services from an authorized provider which are payable under § 725.701 do not require prior approval of OWCP or the responsible operator.

(b) Except where emergency treatment is required, prior approval of OWCP or the responsible operator must be obtained before any hospitalization or surgery, or before ordering medical equipment where the purchase price exceeds $300. A request for approval of non-emergency hospitalization or surgery must be acted upon expeditiously, and approval or disapproval will be given by telephone if a written response cannot be given within 7 days following the request. No employee of the Department of Labor, other than a district director or the Chief, Medical Audit and Operations Section, DCMWC, is authorized to approve a request for hospitalization or surgery by telephone.

§ 725.706 What reports must a medical provider give to OWCP?

(a) Within 30 days following the first medical or surgical treatment provided under § 725.701, the provider must furnish to OWCP and the responsible operator or its insurance carrier, if any, a report of such treatment.

(b) In order to permit continuing supervision of the medical care provided to the miner with respect to the necessity, character and sufficiency of any medical care furnished or to be furnished, the provider, operator or carrier must submit such reports in addition to those required by paragraph (a) of this section as OWCP may from time to time require. Within the discretion of OWCP, payment may be refused to any medical provider who fails to submit any report required by this section.

§ 725.707 At what rate will fees for medical services and treatments be paid?

(a) All fees charged by providers for any medical service, treatment, drug or equipment authorized under this subpart will be paid at no more than the rate prevailing for the service, treatment, drug or equipment in the community in which the provider is located.

(b) When medical benefits are paid by the fund at OWCP's direction, either on an interim basis or because there is no liable operator, the prevailing community rate for various types of service will be determined as provided in §§ 725.708–725.711.

(c) The provisions of §§ 725.708–725.711 do not apply to charges for medical services or treatments furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

(d) If the provisions of §§ 725.708–725.711 cannot be used to determine the prevailing community rate for a particular service or treatment or for a particular provider, OWCP may determine the prevailing community rate by reliance on other federal or state payment formulas or on other evidence, as appropriate.

(e) OWCP must review the payment formulas described in §§ 725.708–725.711 at least once a year, and may adjust, revise or replace any payment formula or its components when necessary or appropriate to ensure miners' access to care or for other reasons.

(f) Except as otherwise provided in this subpart, the provisions of §§ 725.707–725.711 apply to all medical services and treatments rendered after August 31, 2018.

§ 725.708 How are payments for professional medical services and medical equipment determined?

(a)(1) OWCP pays for professional medical services based on a fee schedule derived from the schedule maintained by the Centers for Medicare & Medicaid Services (CMS) for the payment of such services under the Medicare program (42 CFR part 414). The schedule OWCP utilizes consists of: An assignment of Relative Value Units (RVU) to procedures identified by Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code, which represents the work (relative time and intensity of the service), the practice expense and the malpractice expense, as compared to other procedures of the same general class; an assignment of Geographic Practice Cost Index (GPCI) values, which represent the relative work, practice expense and malpractice expense relative to other localities throughout the country; and a monetary value assignment (conversion factor) for one unit of value for each coded service.

(2) The maximum payment for professional medical services identified by a HCPCS/CPT code is calculated by multiplying the RVU values for the service by the GPCI values for such service in that area and multiplying the sum of these values by the conversion factor to arrive at a dollar amount assigned to one unit in that category of service.

(3) OWCP utilizes the RVUs published, and updated or revised from time to time, by CMS for all services for which CMS has made assignments. Where there are no RVUs assigned, OWCP may develop and assign any RVUs that OWCP considers appropriate. OWCP utilizes the GPCI for the locality as defined by CMS and as updated or revised by CMS from time to time. OWCP will devise conversion factors for professional medical services using OWCP's processing experience and internal data.

(b) Where a professional medical service is not covered by the fee schedule described in paragraph (a) of this section, OWCP may pay for the service based on other fee schedules or pricing formulas utilized by OWCP for professional medical services.

(c) Paragraphs (a) and (b) of this section apply to professional medical services rendered after April 26, 2020.

(d) OWCP pays for medical equipment identified by a HCPCS/CPT code based on fee schedules or other pricing formulas utilized by OWCP for such equipment.

[83 FR 27695, June 14, 2018, as amended at 84 FR 64198, Nov. 21, 2019]

§ 725.709 How are payments for prescription drugs determined?

(a)(1) OWCP pays for drugs prescribed by physicians by multiplying a percentage of the average wholesale price, or other baseline price as specified by OWCP, of the medication by the quantity or amount provided, plus a dispensing fee.

(2) All prescription medications identified by National Drug Code are assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers, or another baseline price designated by OWCP.

(3) OWCP may establish the dispensing fee.

(b) If the pricing formula described in paragraph (a) of this section is inapplicable, OWCP may make payment based on other pricing formulas utilized by OWCP for prescription medications.

(c) OWCP may, in its discretion, contract for or require the use of specific providers for certain medications. OWCP also may require the use of generic equivalents of prescribed medications where they are available.

§ 725.710 How are payments for outpatient medical services determined?

(a)(1) Except as provided in paragraphs (b) and (c) of this section, OWCP pays for outpatient medical services according to Ambulatory Payment Classifications (APCs) derived from the Outpatient Prospective Payment System (OPPS) devised by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program (42 CFR part 419).

(2) For outpatient medical services paid under the OPPS, such services are assigned according to the APC prescribed by CMS for that service. Each payment is derived by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor to arrive at a national unadjusted payment rate for the APC. The labor portion of the national unadjusted payment rate is further adjusted by the hospital wage index for the area where payment is being made. Additional adjustments are also made as required or needed.

(b) If a compensable service cannot be assigned or paid at the prevailing community rate under the OPPS or occurs at a facility excluded from the Medicare OPPS, OWCP may pay for the service based on fee schedules or other pricing formulas utilized by OWCP for outpatient services.

(c) This section does not apply to services provided by ambulatory surgical centers.

(d) This section applies to outpatient medical services rendered after April 26, 2020.

[83 FR 27695, June 14, 2018, as amended at 84 FR 64198, Nov. 21, 2019]

§ 725.711 How are payments for inpatient medical services determined?

(a)(1) OWCP pays for inpatient medical services according to predetermined rates derived from the Medicare Inpatient Prospective Payment System (IPPS) used by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program (42 CFR part 412).

(2) Inpatient hospital discharges are classified into diagnosis-related groups (DRGs). Each DRG groups together clinically similar conditions that require comparable amounts of inpatient resources. For each DRG, an appropriate weighting factor is assigned that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(3) For each hospital discharge classified within a DRG, a payment amount for that discharge is determined by using the national weighting factor determined for that DRG, national standardized adjustments, and other factors which may vary by hospital, such as an adjustment for area wage levels. OWCP may also use other price adjustment factors as appropriate based on its processing experience and internal data.

(b) If an inpatient service cannot be classified by DRG, occurs at a facility excluded from the Medicare IPPS, or otherwise cannot be paid at the prevailing community rate under the pricing formula described in paragraph (a) of this section, OWCP may pay for the service based on fee schedules or other pricing formulas utilized by OWCP for inpatient services.

§ 725.712 When and how are fees reduced?

(a) A provider's designation of the code used to identify a billed service or treatment will be accepted if the code is consistent with the medical and other evidence, and the provider will be paid no more than the maximum allowable fee for that service or treatment. If the code is not consistent with the medical evidence or where no code is supplied, the bill will be returned to the provider for correction and resubmission or denied.

(b) If the charge submitted for a service or treatment supplied to a miner exceeds the maximum amount determined to be reasonable under this subpart, OWCP must pay the amount allowed by §§ 725.707–725.711 for that service and notify the provider in writing that payment was reduced for that service in accordance with those provisions.

(c) A provider or other party who disagrees with a fee determination may seek review of that determination as provided in this subpart (*see* § 725.718).

§ 725.713 If a fee is reduced, may a provider bill the claimant for the balance?

Where a provider submits a bill to OWCP and OWCP has reduced the provider's fee, the miner is not responsible for any additional payment for services or treatments covered under this subpart. Thus, a provider whose fee for service is partially paid by OWCP as a result of the application of the provisions of §§ 725.707–725.711 or otherwise in accordance with this subpart may not request reimbursement from the miner for additional amounts.

§ 725.714 How do providers enroll with OWCP for authorizations and billing?

(a) All non-pharmacy providers seeking payment from the fund must enroll with OWCP or its designated bill processing agent to have access to the automated authorization system and to submit medical bills to OWCP.

(b) To enroll, the non-pharmacy provider must complete and submit a Form OWCP–1168 to the appropriate location noted on that form. By completing and submitting this form, providers certify that they satisfy all applicable Federal and State licensure and regulatory requirements that apply to their specific provider or supplier type.

(c) The non-pharmacy provider must maintain documentary evidence indicating that it satisfies those requirements.

(d) The non-pharmacy provider must also notify OWCP immediately if any information provided to OWCP in the enrollment process changes.

(e) All pharmacy providers must obtain a National Council for Prescription Drug Programs number. Upon obtaining such number, they are automatically enrolled in OWCP's pharmacy billing system.

(f) After enrollment, a provider must submit all medical bills to OWCP through its bill processing portal or to the OWCP address specified for such purpose and must include the Provider Number/ID obtained through enrollment, or its National Provider Number (NPI) or any other identifying numbers required by OWCP.

§ 725.715 How do providers submit medical bills?

(a) A provider must itemize charges on Form OWCP–1500 or CMS–1500 (for professional services, equipment or drugs dispensed in the office), Form OWCP–04 or UB–04 (for hospitals), an electronic or paper-based bill that includes required data elements (for pharmacies) or other form as designated by OWCP, and submit the form promptly to OWCP.

(b) The provider must identify each medical service performed using the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC) number, or the Revenue Center Code (RCC), as appropriate to the type of service. OWCP has discretion to determine which of these codes may be utilized in the billing process. OWCP also has the authority to create and supply codes for specific services or treatments. These OWCP-created codes will be issued to providers by OWCP as appropriate and may only be used as authorized by OWCP. A provider may not use an OWCP-created code for other types of medical examinations, services or treatments.

(1) For professional medical services, the provider must list each diagnosed condition in order of priority and furnish the corresponding diagnostic code using the ''International Classification of Disease, 10th Edition, Clinical Modification'' (ICD–10–CM), or as revised.

(2) For prescription drugs or supplies, the provider must include the NDC assigned to the product, and such other information as OWCP may require.

(3) For outpatient medical services, the provider must use HCPCS codes and other coding schemes in accordance with the Outpatient Prospective Payment System.

(4) For inpatient medical services, the provider must include admission and discharge summaries and an itemized statement of the charges.

(c)(1) By submitting a bill or accepting payment, the provider signifies that the service for which reimbursement is sought was performed as described, necessary, appropriate, and properly billed in accordance with accepted industry standards. For example, accepted industry standards preclude upcoding billed services for extended medical appointments when the miner actually had a brief routine appointment, or charging for the services of a professional when a paraprofessional or aide performed the service; industry standards prohibit unbundling services to charge separately for services that should be billed as a single charge.

(2) The provider agrees to comply with all regulations set forth in this subpart concerning the provision of medical services or treatments and/or the process for seeking reimbursement for medical services and treatments, including the limitation imposed on the amount to be paid.

§ 725.716 How should a miner prepare and submit requests for reimbursement for covered medical expenses and transportation costs?

(a) If a miner has paid bills for a medical service or treatment covered under § 725.701 and seeks reimbursement for those expenses, he or she may submit a request for reimbursement on Form OWCP–915, together with an itemized bill. The reimbursement request must be accompanied by evidence that the provider received payment for the service from the miner and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a copy of the miner's canceled check (both front and back) or a copy of the miner's credit card receipt.

(b) OWCP may waive the requirements of paragraph (a) of this section if extensive delays in the filing or the adjudication of a claim make it unusually difficult for the miner to obtain the required information.

(c) Reimbursements for covered medical services paid by a miner generally will be no greater than the maximum allowable charge for such service as determined under §§ 725.707–725.711.

(d) A miner will be only partially reimbursed for a covered medical service if the amount he or she paid to a provider for the service exceeds the maximum charge allowable. If this happens, OWCP will advise the miner of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the miner, or credit to the miner's account, the amount he or she paid which exceeds the maximum allowable charge.

(e) If the provider does not refund to the miner or credit to his or her account the amount of money paid in excess of the charge allowed by OWCP, the miner should submit documentation to OWCP of the attempt to obtain such refund or credit. OWCP may make reasonable reimbursement to the miner after reviewing the facts and circumstances of the case.

(f) If a miner has paid transportation costs or other incidental expenses related to covered medical services under this part, the miner may submit a request for reimbursement on Form OWCP–957 or OWCP–915, together with proof of payment.

§ 725.717 What are the time limitations for requesting payment or reimbursement for covered medical services or treatments?

OWCP will pay providers and reimburse miners promptly for all bills received on an approved form and in a timely manner. However, absent good cause, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the end of the calendar year in which the miner's eligibility for benefits is finally adjudicated, whichever is

later. A provider may not request reimbursement from a miner for a bill denied by OWCP due to late submission of the bill by the provider.

§ 725.718 How are disputes concerning medical benefits resolved?

(a) If a dispute develops concerning medical services or treatments or their payment under this part, OWCP must attempt to informally resolve the dispute. OWCP may, on its own initiative or at the request of the responsible operator or its insurance carrier, order the claimant to submit to an examination by a physician selected by OWCP.

(b) If a dispute cannot be resolved informally, OWCP will refer the case to the Office of Administrative Law Judges for a hearing in accordance with this part. Any such hearing concerning authorization of medical services or treatments must be scheduled at the earliest possible time and must take precedence over all other hearing requests except for other requests under this section and as provided by §727.405 of this subchapter (*see* §725.4(d)). During the pendency of such adjudication, OWCP may order the payment of medical benefits prior to final adjudication under the same conditions applicable to benefits awarded under §725.522.

(c) In the development or adjudication of a dispute over medical benefits, the adjudication officer is authorized to take whatever action may be necessary to protect the health of a totally disabled miner.

(d) Any interested medical provider may, if appropriate, be made a party to a dispute under this subpart.

§ 725.719 What is the objective of vocational rehabilitation?

The objective of vocational rehabilitation is the return of a miner who is totally disabled by pneumoconiosis to gainful employment commensurate with such miner's physical impairment. This objective may be achieved through a program of re-evaluation and redirection of the miner's abilities, or retraining in another occupation, and selective job placement assistance.

§ 725.720 How does a miner request vocational rehabilitation assistance?

Each miner who has been determined entitled to receive benefits under part C of title IV of the Act must be informed by OWCP of the availability and advisability of vocational rehabilitation services. If such miner chooses to avail himself or herself of vocational rehabilitation, his or her request will be processed and referred by OWCP vocational rehabilitation advisors pursuant to the provisions of §§702.501 through 702.508 of this chapter as is appropriate.

PART 726—BLACK LUNG BENEFITS; REQUIREMENTS FOR COAL MINE OPERATOR'S INSURANCE

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SOURCE: 65 FR 80097, Dec. 20, 2000, unless otherwise noted.

Subpart A—General

§ 726.1 Statutory insurance requirements for coal mine operators.

Section 423 of title IV of the Federal Coal Mine Health and Safety Act as amended (hereinafter the Act) requires each coal mine operator who is operating or has operated a coal mine in a State which is not included in the list published by the Secretary (see part 722 of this subchapter) to secure the payment of benefits for which he may be found liable under section 422 of the Act and the provisions of this subchapter by either:

(a) Qualifying as a self-insurer, or

(b) By subscribing to and maintaining in force a commercial insurance contract (including a policy or contract procured from a State agency).

§ 726.2 Purpose and scope of this part.

(a) This part provides rules directing and controlling the circumstances under which a coal mine operator shall fulfill his insurance obligations under the Act.

(b) This Subpart A sets forth the scope and purpose of this part and generally describes the statutory framework within which this part is operative.

(c) Subpart B of this part sets forth the criteria a coal mine operator must meet in order to qualify as a self-insurer.

(d) Subpart C of this part sets forth the rules and regulations of the Secretary governing contracts of insurance entered into by coal mine operators and commercial insurance sources for the payment of black lung benefits under part C of the Act.

(e) Subpart D of this part sets forth the rules governing the imposition of civil money penalties on coal mine operators that fail to secure their liability under the Act.

§ 726.3 Relationship of this part to other parts in this subchapter.

(a) This part 726 implements and effectuates responsibilities for the payment of black lung benefits placed upon coal mine operators by sections 415 and 422 of the Act and the regulations of the Secretary in this subchapter, particularly those set forth in part 725 of this subchapter. All definitions, usages, procedures, and other rules affecting the responsibilities of coal mine operators prescribed in part 725 of this subchapter are hereby made applicable, as appropriate, to this part 726.

(b) If the provisions of this part appear to conflict with any provision of any other part in this subchapter, the apparently conflicting provisions should be read harmoniously to the fullest extent possible. If a harmonious interpretation is not possible, the provisions of this part should be applied to govern the responsibilities and obligations of coal mine operators to secure the payment of black lung benefits as prescribed by the Act. The provisions of this part do not apply to matters falling outside the scope of this part.

§ 726.4 Who must obtain insurance coverage.

(a) Section 423 of part C of title IV of the Act requires each operator of a coal mine or former operator in any State which does meet the requirements prescribed by the Secretary pursuant to section 411 of part C of title IV of the Act to self-insure or obtain a policy or contract of insurance to guarantee the payment of benefits for which such operator may be adjudicated liable under section 422 of the Act. In enacting sections 422 and 423 of the Act Congress has unambiguously expressed its intent that coal mine operators bear the cost of providing the benefits established by part C of title IV of the Act. Section 3 of the Act defines an ''operator'' as any owner, lessee, or other person who operates, controls, or supervises a coal mine.

(b) Section 422(i) of the Act clearly recognizes that any individual or business entity who is or was a coal mine operator may be found liable for the payment of pneumoconiosis benefits after December 31, 1973. Within this framework it is clear that the Secretary has wide latitude for determining which operator shall be liable for the payment of part C benefits. Comprehensive standards have been promulgated in subpart G of part 725 of this subchapter for the purpose of guiding the Secretary in making such determination. It must be noted that pursuant to these standards any parent or subsidiary corporation, any individual or corporate partner, or partnership, any lessee or lessor of a coal mine, any joint venture or participant in a joint venture, any transferee or transferor of a corporation or other business entity, any former, current, or future operator or any other form of business entity which has had or will have a substantial and reasonably direct interest in the operation of a coal mine may be determined liable for the payment of pneumoconiosis benefits after December 31, 1973. The failure of any such business entity to self-insure or obtain a policy or contract of insurance shall in no way relieve such business entity of its obligation to pay pneumoconiosis benefits in respect of any case in which such business entity's responsibility for such payments has been properly adjudicated. Any business entity described in this section shall take appropriate steps to insure that any liability imposed by part C of the Act on such business entity shall be dischargeable.

§ 726.5 Effective date of insurance coverage.

Pursuant to section 422(c) of part C of title IV of the Act, no coal mine operator shall be responsible for the payment of any benefits whatsoever for any period prior to January 1, 1974. However, coal mine operators shall be liable as of January 1, 1974, for the payment of benefits in respect of claims which were filed under section 415 of part B of title IV of the Act after July 1, 1973. Section 415(a)(3) requires the Secretary to notify any operator who may be liable for the payment of benefits under part C of title IV beginning on January 1, 1974, of the pendency of a section 415 claim. Section 415(a)(5) declares that any operator who has been notified of the pendency of a section 415 claim shall be bound by the determination of the Secretary as to such

operator's liability and as to the claimant's entitlement to benefits as if the claim were filed under part C of title IV of the Act and section 422 thereof had been applicable to such operator. Therefore, even though no benefit payments shall be required of an operator prior to January 1, 1974, the liability for these payments may be finally adjudicated at any time after July 1, 1973. Neither the failure of an operator to exercise his right to participate in the adjudication of such a claim nor the failure of an operator to obtain insurance coverage in respect of claims filed after June 30, 1973, but before January 1, 1974, shall excuse such operator from his liability for the payment of benefits to such claimants under part C of title IV of the Act.

§ 726.6 The Office of Workers' Compensation Programs.

The Office of Workers' Compensation Programs (hereinafter the Office or OWCP) is that division of the U.S. Department of Labor which has been empowered by the Secretary of Labor to carry out his or her functions under section 415 and part C of title IV of the Act. As noted throughout this part 726 the Office shall perform a number of functions with respect to the regulation of both the self-insurance and commercial insurance programs. All correspondence with or submissions to the Office should be addressed as follows: Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, U.S. Department of Labor, Washington, DC 20210.

[77 FR 37286, June 21, 2012]

§ 726.7 Forms, submission of information.

Any information required by this part 726 to be submitted to the Office of Workmen's Compensation Programs or any other office or official of the Department of Labor, shall be submitted on such forms or in such manner as the Secretary deems appropriate and has authorized from time to time for such purposes.

§ 726.8 Definitions.

In addition to the definitions provided in part 725 of this subchapter, the following definitions apply to this part:

(a) *Director* means the Director, Office of Workers' Compensation Programs, and includes any official of the Office of Workers' Compensation Programs authorized by the Director to perform any of the functions of the Director under this part and part 725 of this subchapter.

(b) *Person* includes any individual, partnership, corporation, association, business trust, legal representative, or organized group of persons.

(c) *Secretary* means the Secretary of Labor or such other official as the Secretary shall designate to carry out any responsibility under this part.

(d) The terms *employ* and *employment* shall be construed as broadly as possible, and shall include any relationship under which an operator retains the right to direct, control, or supervise the work performed by a miner, or any other relationship under which an operator derives a benefit from the work performed by a miner. Any individuals who participate with one or more persons in the mining of coal, such as owners, proprietors, partners, and joint venturers, whether they are compensated by wages, salaries, piece rates, shares, profits, or by any other means, shall be deemed employees. It is the specific intention of this paragraph to disregard any financial arrangement or business entity devised by the actual owners or operators of a coal mine or coal mine-related enterprise to avoid the payment of benefits to miners who, based upon the economic reality of their relationship to this enterprise, are, in fact, employees of the enterprise.

Subpart B—Authorization of Self-Insurers

SOURCE: 89 FR 100318, Dec. 12, 2024, unless otherwise noted.

§ 726.101 Who may be authorized to self-insure.

(a) Pursuant to section 423 of part C of title IV of the Act, authorization to self-insure against liability incurred by coal mine operators on account of the total disability or death of miners due to pneumoconiosis may be granted or denied in the discretion of the Secretary. The provisions of this subpart

describe the minimum requirements established by the Secretary for determining whether any particular coal mine operator may be authorized as a self-insurer.

(b) The minimum requirements which must be met by any operator seeking authorization to self-insure are as follows:

(1) The operator must demonstrate the administrative capacity to fully service such claims as may be filed against it; and,

(2) Such operator must obtain security, in a form approved by OWCP (see §726.104) and in an amount to be determined by OWCP (see §726.105).

(c) No application will be approved until OWCP receives security in the amount and in the form determined by OWCP. If the applicant is seeking authorization to self-insure for the first time, it is not authorized to self-insure while its application is under review.

(d) No operator whose application for authorization to self-insure or to renew authorization to self-insure is denied may reapply until 12 months after a final decision denying such application.

§726.102 Application for authority to become a self-insurer; how filed; information to be submitted.

(a) *How filed.* An application for authorization to self-insure or to renew authorization to self-insure must be submitted electronically in the manner prescribed by OWCP. Such application must be signed by the applicant and if the applicant is not an individual, by the principal officer of the applicant duly authorized to make such application.

(b) *Information to be submitted.* Each application for authority to self-insure or to renew authorization to self-insure must contain the following:

(1) Any application forms required by OWCP.

(2) An actuarial report using OWCP-mandated actuarial assumptions, unless the applicant has submitted such a report within the preceding 3 years. The operator may submit an additional actuarial report using alternate assumptions with an explanation of why it believes the alternative assumptions are appropriate.

(3) A statement of the employer's payroll report for each of the preceding 3 years.

(4) A statement of the average number of employees engaged in employment within the purview of the Act for each of the preceding 3 years.

(5) A list of the mine or mines to be covered by any particular self-insurance agreement. Each such mine or mines listed must be described by name and reference must be made to the Mine Identification Number assigned such mine by the Mine Safety and Health Administration, U.S. Department of Labor.

(6) A statement demonstrating the applicant's administrative capacity to provide or procure adequate servicing for a claim including both medical and dollar claims.

(7) In addition to the information required in paragraphs (b)(1) through (6) of this section, OWCP may in its discretion, require the applicant to submit such further information or such evidence as OWCP may deem necessary.

(c) *Who may file.* An application for authorization to self-insure (including an application to renew authority to self-insure) may be filed by any parent or subsidiary corporation, partner or partnership, party to a joint venture or joint venture, individual, or other business entity which may be determined liable for the payment of black lung benefits under part C of title IV of the Act, regardless of whether such applicant is directly engaged in the business of mining coal. However, in each case for which authorization to self-insure is granted, the agreement and undertaking filed pursuant to §726.110 and the security deposit must be respectively filed by and deposited in the name of the applicant only.

§726.103 Application for authority to self-insure; effect of regulations contained in this part.

As appropriate, each of the regulations, interpretations, and requirements contained in this part, including those described in subpart C of this part, are binding upon each applicant under this subpart, and the applicant's consent to be bound by all requirements of the regulations in this part

are deemed to be included in and a part of the application, as fully as though written therein.

§ 726.104 Action by OWCP upon application of operator.

(a) Within 30 days after determining that an applicant's application for authorization to self-insure or to renew authorization to self-insure is complete, OWCP will review and consider all relevant information submitted in the application and issue a written determination either denying the application or determining the amount of security which must be given by the applicant to guarantee the payment of benefits and the discharge of all other obligations which may be required of such applicant under the Act. OWCP may extend the 30-day deadline if it determines that additional evidence is needed or that the applicant's evidence is not in compliance with OWCP's requirements in this subpart.

(b) The applicant will thereafter be notified that they may give security in the amount fixed by OWCP (see § 726.105):

(1) In the form of an indemnity bond with sureties satisfactory to OWCP;

(2) By a deposit of negotiable securities with a Federal Reserve Bank in compliance with §§ 726.106(c) and 726.107;

(3) In the form of a letter of credit issued by a financial institution satisfactory to OWCP (except that a letter of credit is not sufficient by itself to satisfy a self- insurer's obligations under this part); or

(4) In the form of a trust pursuant to section 501(c)(21) of the Internal Revenue Code (26 U.S.C. 501(c)(21)) established prior to December 12, 2024. Operators using such trusts must submit quarterly financial statements to OWCP documenting the value of the trust every ninety days, beginning with ninety days from the date on which OWCP's authorization or reauthorization of the operator's self-insurance becomes effective under paragraphs (d) and (e) of this section.

(c) Operators that are required to submit an initial or increased security deposit may do so in quarterly increments over the course of one year. Such operators must deposit at least 25 percent of the newly required security amount within thirty days of OWCP issuing the notification provided in paragraphs (d) and (e) of this section, followed by at least 50 percent of their required security within four months, at least 75 percent within eight months, and 100 percent within one year. If an operator fails to timely submit any one of these security installments, OWCP will revoke its self-insurance authorization and the operator will be subject to the civil penalty provisions in subpart D of this part.

(d) If the applicant is receiving authorization to self-insure for the first time, OWCP will notify the applicant that:

(1) Its authorization to self-insure is contingent upon submitting the required security and completed agreement and undertaking; and

(2) The applicant's authorization to self-insure is effective for 12 months from the date such security (either the full amount or first quarterly installment under paragraph (c) of this section) and completed agreement and undertaking are received by OWCP.

(e) If OWCP renews the applicant's authorization to self-insure, OWCP will notify the applicant that:

(1) If there are no changes in the required security amount, the applicant's authorization to self-insure is granted and effective for 12 months from the date the applicant's completed agreement and undertaking is received by OWCP; or

(2) If changes are needed to the existing security amount, the applicant's authorization to self-insure is not granted until the applicant has submitted the required security (either the full amount or first quarterly installment under paragraph (c) of this section) and signed agreement and undertaking. The applicant's authorization to self-insure will be effective for 12 months from the date such updated security and completed agreement and undertaking are received by OWCP.

(f) Any applicant who cannot meet the security deposit requirements imposed by OWCP in this subpart should proceed to obtain a commercial policy or contract of insurance and submit proof of such coverage within 30 days after OWCP issues notification to the

applicant of its decision. Any applicant for authorization to self-insure whose application has been denied or who believes that the security deposit requirements imposed by OWCP in this subpart are excessive may appeal such determination in the manner set forth in § 726.116.

§ 726.105 Fixing the amount of security.

Any operator approved to self-insure must submit security equal to 100 percent of the actuarially estimated liabilities (all present and future liabilities), as determined by OWCP based on the actuarial report or reports submitted with the operator's application or on file with OWCP, other information submitted with the operator's application, and any other materials or information that OWCP deems relevant.

§ 726.106 Type of security.

(a) OWCP will determine the type or types of security which an applicant must or may procure. An operator may not provide any form of security other than those provided for in § 726.104(b).

(b) In the event the indemnity bond option is selected, the bond must be in such form and contain such provisions as OWCP prescribes: *Provided* that only corporations may act as sureties on such indemnity bonds. In each case in which the surety on any such bond is a surety company, such company must be one approved by the U.S. Treasury Department under the laws of the United States and the applicable rules and regulations governing bonding companies (see Department of Treasury's Circular–570).

(c) If the form of negotiable securities is selected, the operator must deposit the amount fixed by OWCP in any negotiable securities acceptable as security for the deposit of public moneys of the United States under regulations issued by the Secretary of the Treasury in 31 CFR part 225. The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 726.107 How negotiable securities are handled.

(a) Deposits of securities provided for by the regulations in this part must be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by OWCP, or the Treasurer of the United States, and must be held in the name of the Department of Labor.

(b) If the self-insurer defaults on its obligations under the Act, OWCP has the power, in its discretion, to:

(1) Collect the interest as it may become due;

(2) Sell any or all of the securities; and

(3) Apply the collected interest or proceeds from the sale of securities to the payment of any benefits for which the self-insurer may be liable.

(c) If a self-insurer with deposits of securities has neither defaulted nor appealed from a determination made by OWCP under § 726.104, OWCP may allow the self-insurer to collect interest on the security deposit.

§ 726.108 Withdrawal of securities.

(a) Withdrawal of any form of security (indemnity bonds, negotiable securities, and/or letters of credit) is prohibited except upon express written authorization by OWCP.

(b) If a self-insurer wishes to withdraw securities, it must submit a written request, and must submit either an updated actuarial report using OWCP-mandated actuarial assumptions to support why the existing security levels are no longer applicable or replacement securities in the amount and form approved by OWCP. If OWCP approves the operator's request to withdraw and replace its securities, the operator must provide the replacement securities before it withdraws its existing securities.

§ 726.109 Increase in the amount of security.

(a) OWCP may, at its discretion, increase the amount of security a self-insurer is required to post whenever it determines that the amount of security on deposit is insufficient to secure 100 percent of the self-insurer's liability

for payment of benefits and medical expenses under the Act. OWCP will provide a written explanation for the increase.

(b) OWCP will not require an operator to post greater than 100 percent of its estimated liabilities, based on the information prompting the increase in security.

§ 726.110 Filing of agreement and undertaking.

(a) In addition to the requirement that adequate security be procured as set forth in this subpart, the applicant for the authorization to self-insure must, as a condition precedent to receiving such authorization, execute and file with OWCP an agreement and undertaking in a form prescribed and provided by OWCP in which the applicant must agree:

(1) To pay when due, as required by the Act, all benefits payable on account of total disability or death of any of its employee-miners;

(2) To furnish medical, surgical, hospital, and other attendance, treatment, and care as required by the Act;

(3) To provide security in a form approved by OWCP (see § 726.104) and in an amount established by OWCP (see § 726.105); and

(4) To authorize OWCP to sell any negotiable securities so deposited or any part thereof, and to pay from the proceeds thereof such benefits, medical, and other expenses and any accrued penalties imposed by law as OWCP may find to be due and payable.

(b) When an applicant has provided the requisite security, it must submit to OWCP a completed agreement and undertaking, together with satisfactory proof that its obligations and liabilities under the Act have been secured.

(c) Any operator authorized to self-insure must notify OWCP of any changes to its business structure, including the purchase, sale, or lease of any coal mining operations, that could affect the operator's liability for benefits under the Act. The operator must provide such notification to OWCP within 30 days of such change. In all events, however, an operator's liability following a change or sale is governed by 20 CFR 725.490 through 725.497.

(d) OWCP may, at its discretion, require an operator to provide any information that may affect the operator's liability for benefits under the Act.

§ 726.111 Notice of authorization to self-insure.

Upon receipt of a completed agreement and undertaking and satisfactory proof that adequate security has been provided, OWCP will notify an applicant for authorization to self-insure in writing that it is authorized to self-insure to meet the obligations imposed upon such operator by section 415 and part C of title IV of the Act. OWCP will also notify the applicant of the date on which its authorization is effective, the date on which such authorization will expire, and the date by which the applicant must apply to renew such authorization if the applicant intends to continue self-insuring its liabilities under the Act.

§ 726.112 Reports required of self-insurer; examination of accounts of self-insurer.

(a) Each operator who has been authorized to self-insure under this part must submit to OWCP reports containing such information as OWCP may from time to time require or prescribe.

(b) Whenever it deems it to be necessary, OWCP may inspect or examine the books of account, records, and other papers of a self-insurer for the purpose of verifying any financial statement submitted to OWCP by the self-insurer or verifying any information furnished to OWCP in any report required by this section, or any other section of this part, and such self-insurer must permit OWCP or its duly authorized representative to make such an inspection or examination as OWCP may require. In lieu of this requirement OWCP may in its discretion accept an adequate report of a certified public accountant.

(c) Failure to submit or make available any report or information requested by OWCP from an authorized self-insurer pursuant to this section may, in appropriate circumstances, result in a revocation of the authorization to self-insure.

§ 726.113 Disclosure of confidential information.

Any financial information or records, or other information relating to the business of an authorized self-insurer or applicant for the authorization of self-insurance obtained by OWCP is exempt from public disclosure to the extent provided in 5 U.S.C. 552(b) and the applicable regulations of the Department of Labor in 29 CFR part 70.

§ 726.114 Authorization and reauthorization timeframes.

(a) No initial or renewed authorization to self-insure may be granted for a period in excess of 12 months unless OWCP determines that extenuating circumstances exist to allow an extension.

(b) If an applicant is seeking to renew its authority to self-insure, the applicant must file its application no later than 90 days before its existing authorization period ends.

(c) Each operator authorized to self-insure under this part must apply for reauthorization for any period during which it engages in the operation of a coal mine and for additional periods after it ceases operating a coal mine. Upon application by the operator, accompanied by proof that the security it has posted is sufficient to secure all benefits potentially payable to miners formerly employed by the operator, OWCP will issue a certification that the operator is exempt from the coal mine operator insurance requirements of this part based on its prior operation of a coal mine. The civil money penalty provisions of subpart D of this part will be applicable to any operator that fails to apply for reauthorization in accordance with the provisions of this section.

§ 726.115 Revocation of authorization to self-insure.

OWCP may suspend or revoke the authorization of any self-insurer for good cause, including but not limited to:

(a) Failure by a self-insurer to comply with any provision or requirement of law or of the regulations in this part, or with any lawful order or request made by OWCP;

(b) The failure or insolvency of the surety on its indemnity bond, if such bond is used as security, or any other financial institution holding any form of security provided by an operator; or

(c) Impairment of financial responsibility of such self-insurer.

§ 726.116 Appeal process.

(a) *How to appeal.* Any applicant that wishes to appeal DCMWC's determination on an application must submit a written appeal to the Director of OWCP in the form and manner prescribed by OWCP within 30 days of DCMWC issuing such determination. This deadline may not be extended.

(b) *What to submit.* Within 30 days after filing a written appeal, the applicant must submit any briefing on which it intends to rely, including any arguments that DCMWC's initial determination was erroneous. The applicant is not entitled to submit any further evidence at this time; all evidence must be submitted to DCMWC with the initial application. OWCP may, at its discretion, extend this deadline at the applicant's request for up to 30 days upon a showing of good cause. No more than two extensions will be granted.

(c) *Conferences.* (1) The applicant may request an informal conference to present its position. Such request must be made in writing when the applicant submits briefing in support of its appeal.

(2) If the applicant requests a conference, the Director of OWCP will hold one with the applicant's representatives and the Department's Office of the Solicitor.

(3) If the applicant does not request a conference, OWCP may either decide the appeal on the record or, at its discretion, schedule a conference on its own initiative.

(4) The conference will be limited to the issues identified in the applicant's written materials.

(d) *OWCP's review.* OWCP will review the previous determination and issue a final agency decision.

(1) The Director of OWCP will review the initial decision, evidence of record, and arguments submitted on appeal. The applicant may not submit new evidence to the Director of OWCP.

(2) The Director of OWCP will have 60 days from receipt of the appeal to take

up the appeal and issue a final agency decision.

(3) If the Director of OWCP issues a final agency decision denying self- insurance, any existing self-insurance authorization of the applicant will end. The applicant will have 30 days from the issuance of the final agency decision to obtain and submit proof of commercial insurance or begin facing civil penalties for failure to secure benefits.

Subpart C—Insurance Contracts

§ 726.201 Insurance contracts—generally.

Each operator of a coal mine who has not obtained authorization as a self-insurer shall purchase a policy or enter into a contract with a commercial insurance carrier or State agency. Pursuant to authority contained in sections 422(a) and 423(b) and (c) of part C of title IV of the Act, this subpart describes a number of provisions which are required to be incorporated in a policy or contract of insurance obtained by a coal mine operator for the purpose of meeting the responsibility imposed upon such operator by the Act in respect of the total disability or death of miners due to pneumoconiosis.

§ 726.202 Who may underwrite an operator's liability.

Each coal mine operator who is not authorized to self-insure shall insure and keep insured the payment of benefits as required by the Act with any stock company or mutual company or association, or with any other person, or fund, including any State fund while such company, association, person, or fund is authorized under the law of any State to insure workmen's compensation.

§ 726.203 Federal Coal Mine Health and Safety Act endorsement.

(a) The following form of endorsement shall be attached and applicable to the standard workmen's compensation and employer's liability policy prepared by the National Council on Compensation Insurance affording coverage under the Federal Coal Mine Health and Safety Act of 1969, as amended:

It is agreed that: (1) With respect to operations in a State designated in item 3 of the declarations, the unqualified term ''workmen's compensation law'' includes part C of title IV of the Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. section 931–936, and any laws amendatory thereto, or supplementary thereto, which may be or become effective while this policy is in force, and definition (a) of Insuring Agreement III is amended accordingly; (2) with respect to such insurance as is afforded by this endorsement, (a) the States, if any, named below, shall be deemed to be designated in item 3 of the declaration; (b) Insuring Agreement IV(2) is amended to read ''by disease caused or aggravated by exposure of which the last day of the last exposure, in the employment of the insured, to conditions causing the disease occurs during the policy period, or occurred prior to (effective date) and claim based on such disease is first filed against the insured during the policy period.''

(b) The term ''effective date'' as used in paragraph (a) of this section shall be construed to mean the effective date of the first policy or contract of insurance procured by an operator for purposes of meeting the obligations imposed on such operator by section 423 of part C of title IV of the Act.

(c) The Act contains a number of provisions and imposes a number of requirements on operators which differ in varying degrees from traditional workmen's compensation concepts. To avoid unnecessary administrative delays and expense which might be occasioned by the drafting of an entirely new standard workmen's compensation policy specially tailored to the Act, the Office has determined that the existing standard workmen's compensation policy subject to the endorsement provisions contained in paragraph (a) of this section shall be acceptable for purposes of writing commercial insurance coverage under the Act. However, to avoid undue disputes over the meaning of certain policy provisions and in accordance with the authority contained in section 423(b)(3) of the Act, the Office has determined that the following requirements shall be applicable to all commercial insurance policies obtained by an operator for the purpose of insuring any liability incurred pursuant to the Act:

(1) *Operator liability.* (i) Section 415 and part C of title IV of the Act provide coverage for total disability or

death due to pneumoconiosis to all claimants who meet the eligibility requirements imposed by the Act. Section 422 of the Act and the regulations duly promulgated thereunder (part 725 of this subchapter) set forth the conditions under which a coal mine operator may be adjudicated liable for the payment of benefits to an eligible claimant for any period subsequent to December 31, 1973.

(ii) Section 422(c) of the Act prescribes that except as provided in 422(i) (see paragraph (c)(2) of this section) an operator may be adjudicated liable for the payment of benefits in any case if the total disability or death due to pneumoconiosis upon which the claim is predicated arose at least in part out of employment in a mine in any period during which it was operated by such operator. The Act does not require that such employment which contributed to or caused the total disability or death due to pneumoconiosis occur subsequent to any particular date in time. The Secretary in establishing a formula for determining the operator liable for the payment of benefits (see subpart D of part 725 of this subchapter) in respect of any particular claim, must therefore, within the framework and intent of title IV of the Act find in appropriate cases that an operator is liable for the payment of benefits for some period after December 31, 1973, even though the employment upon which an operator's liability is based occurred prior to July 1, 1973, or prior to the effective date of the Act or the effective date of any amendments thereto, or prior to the effective date of any policy or contract of insurance obtained by such operator. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these requirements in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(2) *Successor liability*. Section 422(i) of part C of title IV of the Act requires that a coal mine operator who after December 30, 1969, acquired his mine or substantially all of the assets thereof from a person who was an operator of such mine on or after December 30, 1969, shall be liable for and shall secure the payment of benefits which would have been payable by the prior operator with respect to miners previously employed in such mine if the acquisition had not occurred and the prior operator had continued to operate such mine. In the case of an operator who is determined liable for the payment of benefits under section 422(i) of the Act and part 725 of this subchapter, such liability shall accrue to such operator regardless of the fact that the miner on whose total disability or death the claim is predicated was never employed by such operator in any capacity. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate this requirement in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(3) *Medical eligibility*. Pursuant to section 422(h) of part C of title IV of the Act and the regulations described therein (see subpart D of part 410 of this title) benefits shall be paid to eligible claimants on account of total disability or death due to pneumoconiosis and in cases where the miner on whose death a claim is predicated was totally disabled by pneumoconiosis at the time of his death regardless of the cause of such death. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these requirements in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(4) *Payment of benefits, rates*. Section 422(c) of the Act by incorporating section 412(a) of the Act requires the payment of benefits at a rate equal to 50 per centum of the minimum monthly payment to which a Federal employee in grade GS–2, who is totally disabled is entitled at the time of payment under Chapter 81 of title 5, United States Code. These benefits are augmented on account of eligible dependents as appropriate (see section 412(a) of part B of title IV of the Act). Since the dollar amount of benefits payable to any beneficiary is required to be computed at the time of payment such amounts may be expected to increase from time to time as changes in the

GS–2 grade are enacted into law. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act, the requirement that the payment of benefits to eligible beneficiaries shall be made in such dollar amounts as are prescribed by section 412(a) of the Act computed at the time of payment.

(5) *Compromise and waiver of benefits.* Section 422(a) of part C of title IV of the Act by incorporating sections 15(b) and 16 of the Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 915(b) and 916) prohibits the compromise and/or waiver of claims for benefits filed or benefits payable under section 415 and part C of title IV of the Act. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these prohibitions in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(6) *Additional requirements.* In addition to the requirements described in paragraph (c)(1) through (5) of this section, the endorsement provisions contained in paragraph (a) of this section shall, to the fullest extent possible, be construed to bring any policy or contract of insurance entered into by an operator for the purpose of insuring such operator's liability under part C of title IV of the Act into conformity with the legal requirements placed upon such operator by section 415 and part C of title IV of the Act and parts 720 and 725 of this subchapter.

(d) Nothing in this section shall relieve any operator or carrier of the duty to comply with any State workmen's compensation law, except insofar as such State law is in conflict with the provisions of this section.

§ 726.204 Statutory policy provisions.

Pursuant to section 423(b) of part C of title IV of the Act each policy or contract of insurance obtained to comply with the requirements of section 423(a) of the Act must contain or shall be construed to contain—

(a) A provision to pay benefits required under section 422 of the Act, notwithstanding the provisions of the State workmen's compensation law which may provide for lesser payments; and,

(b) A provision that insolvency or bankruptcy of the operator or discharge therein (or both) shall not relieve the carrier from liability for such payments.

§ 726.205 Other forms of endorsement and policies.

Forms of endorsement or policies other than that described in § 726.203 may be entered into by operators to insure their liability under the Act. However, any form of endorsement or policy which materially alters or attempts to materially alter an operator's liability for the payment of any benefits under the Act shall be deemed insufficient to discharge such operator's duties and responsibilities as prescribed in part C of title IV of the Act. In any event, the failure of an operator to obtain an adequate policy or contract of insurance shall not affect such operator's liability for the payment of any benefits for which he is determined liable.

§ 726.206 Terms of policies.

A policy or contract of insurance shall be issued for the term of 1 year from the date that it becomes effective, but if such insurance be not needed except for a particular contract or operation, the term of the policy may be limited to the period of such contract or operation.

§ 726.207 Discharge by the carrier of obligations and duties of operator.

Every obligation and duty in respect of payment of benefits, the providing of medical and other treatment and care, the payment or furnishing of any other benefit required by the Act and in respect of the carrying out of the administrative procedure required or imposed by the Act or the regulations in this part or part 725 of this subchapter upon an operator shall be discharged and carried out by the carrier as appropriate. Notice to or knowledge of an operator of the occurrence of total disability or death due to pneumoconiosis

shall be notice to or knowledge of such carrier. Jurisdiction of the operator by a district director, administrative law judge, the Office, or appropriate appellate authority under the Act shall be jurisdiction of such carrier. Any requirement under any benefits order, finding, or decision shall be binding upon such carrier in the same manner and to the same extent as upon the operator.

REPORTS BY CARRIER

§ 726.208 Report by carrier of issuance of policy or endorsement.

Each carrier shall report to the Office each policy and endorsement issued, canceled, or renewed by it to an operator. The report shall be made in such manner and on such form as the Office may require.

§ 726.209 Report; by whom sent.

The report of issuance, cancellation, or renewal of a policy and endorsement provided for in § 726.208 shall be sent by the home office of the carrier, except that any carrier may authorize its agency or agencies to make such reports to the Office.

§ 726.210 Agreement to be bound by report.

Every carrier seeking to write insurance under the provisions of the Act shall be deemed to have agreed that the acceptance by the Office of a report of the issuance or renewal of a policy of insurance, as provided for by § 726.208 shall bind the carrier to full liability for the obligations under the Act of the operator named in said report. It shall be no defense to this agreement that the carrier failed or delayed to issue, cancel, or renew the policy to the operator covered by this report.

§ 726.211 Name of one employer only shall be given in each report.

A separate report of the issuance or renewal of a policy and endorsement, provided for by § 726.208, shall be made for each operator covered by a policy. If a policy is issued or renewed insuring more than one operator, a separate report for each operator so covered shall be sent to the Office with the name of only one operator on each such report.

§ 726.212 Notice of cancellation.

Cancellation of a contract or policy of insurance issued under authority of the Act shall not become effective otherwise than as provided by 33 U.S.C. 936(b); and notice of a proposed cancellation shall be given to the Office and to the operator in accordance with the provisions of 33 U.S.C. 912(c), 30 days before such cancellation is intended to be effective (see section 422(a) of part C of title IV of the Act).

§ 726.213 Reports by carriers concerning the payment of benefits.

Pursuant to 33 U.S.C. 914(c) as incorporated by section 422(a) of part C of title IV of the Act and § 726.207 each carrier issuing a policy or contract of insurance under the Act shall upon making the first payment of benefits and upon the suspension of any payment in any case, immediately notify the Office in accordance with a form prescribed by the Office that payment of benefit has begun or has been suspended as the case may be. In addition, each such carrier shall at the request of the Office submit to the Office such additional information concerning policies or contracts of insurance issued to guarantee the payment of benefits under the Act and any benefits paid thereunder, as the Office may from time to time require to carry out its responsibilities under the Act.

Subpart D—Civil Money Penalties

§ 726.300 Purpose and scope.

Any operator which is required to secure the payment of benefits under section 423 of the Act and § 726.4 and which fails to secure such benefits, shall be subject to a civil penalty of not more than $1,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended, for each day during which such failure occurs. If the operator is a corporation, the president, secretary, and treasurer of the operator shall also be severally liable for the penalty based on the operator's failure to secure the payment of benefits. This subpart defines those terms necessary for administration of the civil money penalty provisions, describes the criteria for determining the

amount of penalty to be assessed, and sets forth applicable procedures for the assessment and contest of penalties.

[81 FR 43449, July 1, 2016]

§ 726.301 Definitions.

In addition to the definitions provided in part 725 of this subchapter and § 726.8, the following definitions apply to this subpart:

(a) *Division Director* means the Director, Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, or such other official authorized by the Division Director to perform any of the functions of the Division Director under this subpart.

(b) *President, secretary, or treasurer* means the officers of a corporation as designated pursuant to the laws and regulations of the state in which the corporation is incorporated or, if that state does not require the designation of such officers, the employees of a company who are performing the work usually performed by such officers in the state in which the corporation's principal place of business is located.

(c) *Principal* means any person who has an ownership interest in an operator that is not a corporation, and shall include, but is not limited to, partners, sole proprietors, and any other person who exercises control over the operation of a coal mine.

[65 FR 80097, Dec. 20, 2000, as amended at 77 FR 37287, June 21, 2012]

§ 726.302 Determination of penalty.

(a) The following method shall be used for determining the amount of any penalty assessed under this subpart.

(b) The penalty shall be determined by multiplying the daily base penalty amount or amounts, determined in accordance with the formula set forth in this section, by the number of days in the period during which the operator is subject to the security requirements of section 423 of the Act and § 726.4, and fails to secure its obligations under the Act. The period during which an operator is subject to liability for a penalty for failure to secure its obligations shall be deemed to commence on the first day on which the operator met the definition of the term ''operator'' as set forth in § 725.101 of this subchapter. The period shall be deemed to continue even where the operator has ceased coal mining and any related activity, unless the operator secured its liability for all previous periods through a policy or policies of insurance obtained in accordance with subpart C of this part or has obtained a certification of exemption in accordance with the provisions of § 726.114.

(c)(1) A daily base penalty amount shall be determined for all periods up to and including the 10th day after the operator's receipt of the notification sent by the Director pursuant to § 726.303, during which the operator failed to secure its obligations under section 423 of the Act and § 726.4.

(2)(i) The daily base penalty amount shall be determined based on the number of persons employed in coal mine employment by the operator, or engaged in coal mine employment on behalf of the operator, on each day of the period defined by this section.

For penalties assessed after January 15, 2025, the daily base penalty amount shall be computed as follows:

TABLE 1 TO PARAGRAPH (c)(2)(i)

Employees	Penalty (per day)
Less than 25	$179
25–50	355
51–100	534
More than 100	710

(ii) For any period after the operator has ceased coal mining and any related activity, the daily penalty amount shall be computed based on the largest number of persons employed in coal mine employment by the operator, or engaged in coal mine employment on behalf of the operator, on any day while the operator was engaged in coal mining or any related activity. For purposes of this section, it shall be presumed, in the absence of evidence to the contrary, that any person employed by an operator is employed in coal mine employment.

(3) In any case in which the operator had prior notice of the applicability of the Black Lung Benefits Act to its operations, the daily base penalty amounts set forth in paragraph (c)(2)(i)

of this section shall be doubled. Prior notice may be inferred where the operator, or an entity in which the operator or any of its principals had an ownership interest, or an entity in which the operator's president, secretary, or treasurer were employed:

(i) Previously complied with section 423 of the Act and § 726.4;

(ii) Was notified of its obligation to comply with section 423 of the Act and § 726.4; or

(iii) Was notified of its potential liability for a claim filed under the Black Lung Benefits Act pursuant to § 725.407 of this subchapter.

(4) Commencing with the 11th day after the operator's receipt of the notification sent by the Director pursuant to § 726.303, for penalties assessed after January 15, 2025, the daily base penalty amounts set forth in paragraph (c)(2)(i) shall be increased by $179.

(5) In any case in which the operator, or any of its principals, or an entity in which the operator's president, secretary, or treasurer were employed, has been the subject of a previous penalty assessment under this part, for penalties assessed after January 15, 2025, the daily base penalty amounts shall be increased by $534.

(6) The maximum daily base penalty amount applicable to any violation of § 726.4 for which penalties are assessed after January 15, 2025, shall be $3,650.

(d) The penalty shall be subject to reduction for any period during which the operator had a reasonable belief that it was not required to comply with section 423 of the Act and § 726.4 or a reasonable belief that it had obtained insurance coverage to comply with section 423 of the Act and § 726.4. A notice of contest filed in accordance with § 726.307 shall not be sufficient to establish a reasonable belief that the operator was not required to comply with the Act and regulations.

[65 FR 80097, Dec. 20, 2000, as amended at 81 FR 43449, July 1, 2016; 82 FR 5381, Jan. 18, 2017; 83 FR 12, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2297, Jan. 15, 2020; 86 FR, Jan. 15, 2021; 87 FR 2333, Jan. 14, 2022; 88 FR 2215, Jan. 13, 2023; 89 FR 1815, Jan. 11, 2024; 90 FR 1859, Jan. 10, 2025]

§ 726.303 Notification; investigation.

(a) If the Director determines that an operator has violated the provisions of section 423 of the Act and § 726.4, he or she shall notify the operator of its violation and request that the operator immediately secure the payment of benefits. Such notice shall be sent by certified mail.

(b) The Director shall also direct the operator to supply information relevant to the assessment of a penalty. Such information, which shall be supplied within 30 days of the Director's request, may include:

(1) The date on which the operator commenced its operation of a coal mine;

(2) The number of persons employed by the operator since it began operating a coal mine and the dates of their employment; and

(3) The identity and last known address:

(i) In the case of a corporation, of all persons who served as president, secretary, and treasurer of the operator since it began operating a coal mine; or

(ii) In the case of an operator which is not incorporated, of all persons who were principals of the operator since it began operating a coal mine;

(c) In conducting any investigation of an operator under this subpart, the Division Director shall have all of the powers of a district director, as set forth at § 725.351(a) of this subchapter. For purposes of § 725.351(c), the Division Director shall be considered to sit in the District of Columbia.

§ 726.304 Notice of initial assessment.

(a) After an operator receives notification under § 726.303 and fails to secure its obligations for the period defined in § 726.302(b), and following the completion of any investigation, the Director may issue a notice of initial penalty assessment in accordance with the criteria set forth in § 726.302.

(b)(1) A copy of such notice shall be sent by certified mail to the operator. If the operator is a corporation, a copy shall also be sent by certified mail to each of the persons who served as president, secretary, or treasurer of the operator during any period in which the operator was in violation of section 423 of the Act and § 726.4.

(2) Where service by certified mail is not accepted by any person, the notice shall be deemed received by that person on the date of attempted delivery. Where service is not accepted, the Director may exercise discretion to serve the notice by regular mail.

§ 726.305 Contents of notice.

The notice required by § 726.304 shall:

(a) Identify the operator against whom the penalty is assessed, as well as the name of any other person severally liable for such penalty;

(b) Set forth the determination of the Director as to the amount of the penalty and the reason or reasons therefor;

(c) Set forth the right of each person identified in paragraph (a) of this section to contest the notice and request a hearing before the Office of Administrative Law Judges;

(d) Set forth the method for each person identified in paragraph (a) to contest the notice and request a hearing before the Office of Administrative Law Judges; and

(e) Inform any affected person that in the absence of a timely contest and request for hearing received within 30 days of the date of receipt of the notice, the Director's assessment will become final and unappealable as to that person.

§ 726.306 Finality of administrative assessment.

Except as provided in § 726.307(c), if any person identified as potentially liable for the assessment does not, within 30 days after receipt of notice, contest the assessment, the Director's assessment shall be deemed final as to that person, and collection and recovery of the penalty may be instituted pursuant to § 726.320.

§ 726.307 Form of notice of contest and request for hearing.

(a) Any person desiring to contest the Director's notice of initial assessment shall request an administrative hearing pursuant to this part. The notice of contest shall be made in writing to the Director, Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, United States Department of Labor. The notice of contest must be received no later than 30 days after the date of receipt of the notice issued under § 726.304. No additional time shall be added where service of the notice is made by mail.

(b) The notice of contest shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) State the specific issues to be contested. In particular, the person must indicate his agreement or disagreement with:

(i) The Director's determination that the person against whom the penalty is assessed is an operator subject to the requirements of section 423 of the Act and § 726.4, or is the president, secretary, or treasurer of an operator, if the operator is a corporation.

(ii) The Director's determination that the operator violated section 423 of the Act and § 726.4 for the time period in question; and

(iii) The Director's determination of the amount of penalty owed;

(4) Be signed by the person making the request or an authorized representative of such person; and

(5) Include the address at which such person or authorized representative desires to receive further communications relating thereto.

(c) A notice of contest filed by the operator shall be deemed a notice of contest on behalf of all other persons to the Director's determinations that the operator is subject to section 423 of the Act and § 726.4 and that the operator violated those provisions for the time period in question, and to the Director's determination of the amount of penalty owed. An operator may not contest the Director's determination that a person against whom the penalty is assessed is the president, secretary, or treasurer of the operator.

(d) Failure to specifically identify an issue as contested pursuant to paragraph (b)(3) of this section shall be deemed a waiver of the right to contest that issue.

[65 FR 80097, Dec. 20, 2000, as amended at 77 FR 37287, June 21, 2012]

§ 726.308 Service and computation of time.

(a) Service of documents under this subpart while the matter is before OWCP shall be made by delivery to the

person, an officer of a corporation, or attorney of record, or by mailing the document to the last known address of the person, officer, or attorney. If service is made by mail, it shall be considered complete upon mailing. Unless otherwise provided in this subpart, service need not be made by certified mail. If service is made by delivery, it shall be considered complete upon actual receipt by the person, officer, or attorney; upon leaving it at the person's, officer's, or attorney's office with a clerk or person in charge; upon leaving it at a conspicuous place in the office if no one is in charge; or by leaving it at the person's or attorney's residence.

(b) Service made after a complaint is filed under § 726.309 must be made in accordance with 29 CFR part 18, as appropriate. When proceedings are initiated for review by the Administrative Review Board under § 726.314, service must be made in accordance with 29 CFR part 26, as appropriate.

(c) The time allowed a party to file any response under this subpart shall be computed beginning with the day following the action requiring a response, and shall include the last day of the period, unless it is a Saturday, Sunday, or federally-observed holiday, *see* § 725.311 of Part 725 of this subchapter, in which case the time period shall include the next business day.

[65 FR 80097, Dec. 20, 2000, as amended at 86 FR 1779, Jan. 11, 2021]

§ 726.309 Referral to the Office of Administrative Law Judges.

(a) Upon receipt of a timely notice of contest filed in accordance with § 726.307, the Director, by the Associate Solicitor for Black Lung Benefits or the Regional Solicitor for the Region in which the violation occurred, may file a complaint with the Office of Administrative Law Judges. The Director may, in the complaint, reduce the total penalty amount requested. A copy of the notice of initial assessment issued by the Director and all notices of contest filed in accordance with § 726.307 shall be attached. A notice of contest shall be given the effect of an answer to the complaint for purposes of the administrative proceeding, subject to any amendment that may be permitted under this subpart and 29 CFR part 18.

(b) A copy of the complaint and attachments thereto shall be served by counsel for the Director on the person who filed the notice of contest.

(c) The Director, by counsel, may withdraw a complaint filed under this section at any time prior to the date upon which the decision of the Department becomes final by filing a motion with the Office of Administrative Law Judges or the Secretary, as appropriate. If the Director makes such a motion prior to the date on which an administrative law judge renders a decision in accordance § 726.313, the dismissal shall be without prejudice to further assessment against the operator for the period in question.

§ 726.310 Appointment of Administrative Law Judge and notification of hearing date.

Upon receipt from the Director of a complaint filed pursuant to § 726.309, the Chief Administrative Law Judge shall appoint an Administrative Law Judge to hear the case. The Administrative Law Judge shall notify all interested parties of the time and place of the hearing.

§ 726.311 Evidence.

(a) Except as specifically provided in this subpart, and to the extent they do not conflict with the provisions of this subpart, the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges established by the Secretary at 29 CFR part 18 shall apply to administrative proceedings under this subpart.

(b) Notwithstanding 29 CFR 18.1101(b)(2), subpart B of the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges shall apply to administrative proceedings under this part, except that documents contained in Department of Labor files and offered on behalf of the Director shall be admissible in proceedings under this subpart without regard to their compliance with the Rules of Practice and Procedure.

§ 726.312 Burdens of proof.

(a) The Director shall bear the burden of proving the existence of a violation, and the time period for which the violation occurred. To prove a violation, the Director must establish:

(1) That the person against whom the penalty is assessed is an operator, or is the president, secretary, or treasurer of an operator, if such operator is a corporation.

(2) That the operator violated section 423 of the Act and § 726.4. The filing of a complaint shall be considered *prima facie* evidence that the Director has searched the records maintained by OWCP and has determined that the operator was not authorized to self-insure its liability under the Act for the time period in question, and that no insurance carrier reported coverage of the operator for the time period in question.

(b) The Director need not produce further evidence in support of his burden of proof with respect to the issues set forth in paragraph (a) if no party contested them pursuant to § 726.307(b)(3).

(c) The Director shall bear the burden of proving the size of the operator as required by § 726.302, except that if the Director has requested the operator to supply information with respect to its size under § 726.303 and the operator has not fully complied with that request, it shall be presumed that the operator has more than 100 employees engaged in coal mine employment. The person or persons liable for the assessment shall thereafter bear the burden of proving the actual number of employees engaged in coal mine employment.

(d) The Director shall bear the burden of proving the operator's receipt of the notification required by § 726.303, the operator's prior notice of the applicability of the Black Lung Benefits Act to its operations, and the existence of any previous assessment against the operator, the operator's principals, or the operator's officers.

(e) The person or persons liable for an assessment shall bear the burden of proving the applicability of the mitigating factors listed in § 726.302(d).

§ 726.313 Decision and order of Administrative Law Judge.

(a) The Administrative Law Judge shall render a decision on the issues referred by the Director.

(b) The decision of the Administrative Law Judge shall be limited to determining, where such issues are properly before him or her:

(1) Whether the operator has violated section 423 of the Act and § 726.4;

(2) Whether other persons identified by the Director as potentially severally liable for the penalty were the president, treasurer, or secretary of the corporation during the time period in question; and

(3) The appropriateness of the penalty assessed by the Director in light of the factors set forth in § 726.302. The Administrative Law Judge shall not render determinations on the legality of a regulatory provision or the constitutionality of a statutory provision.

(c) The decision of the Administrative Law Judge shall include a statement of findings and conclusions, with reasons and bases therefor, upon each material issue presented on the record. The decision shall also include an appropriate order which may affirm, reverse, or modify, in whole or in part, the determination of the Director.

(d) The Administrative Law Judge shall serve copies of the decision on each of the parties by certified mail.

(e) The decision of the Administrative Law Judge shall be deemed to have been issued on the date that it is rendered, and shall constitute the final order of the Secretary unless there is a request for reconsideration by the Administrative Law Judge pursuant to paragraph (f) of this section or a petition for review filed pursuant to § 726.314.

(f) Any party may request that the Administrative Law Judge reconsider his or her decision by filing a motion within 30 days of the date upon which the decision of the Administrative Law Judge is issued. A timely motion for reconsideration shall suspend the running of the time for any party to file a petition for review pursuant to § 726.314.

(g) Following issuance of the decision and order, the Chief Administrative Law Judge shall promptly forward the

complete hearing record to the Director.

§ 726.314 Review by the Administrative Review Board.

(a) The Director or any party aggrieved by a decision of the Administrative Law Judge may petition the Administrative Review Board (Board) for review of the decision by filing a petition within 30 days of the date on which the decision was issued. Any other party may file a cross-petition for review within 15 days of its receipt of a petition for review or within 30 days of the date on which the decision was issued, whichever is later. Copies of any petition or cross-petition shall be served on all parties and on the Chief Administrative Law Judge.

(b) A petition filed by one party shall not affect the finality of the decision with respect to other parties.

(c) If any party files a timely motion for reconsideration, any petition for review, whether filed prior to or subsequent to the filing of the timely motion for reconsideration, shall be dismissed without prejudice as premature. The 30-day time limit for filing a petition for review by any party shall commence upon issuance of a decision on reconsideration.

[65 FR 80097, Dec. 20, 2000, as amended at 86 FR 1779, Jan. 11, 2021]

§ 726.315 Contents.

Any petition or cross-petition for review shall:

(a) Be dated;

(b) Be typewritten or legibly written;

(c) State the specific reason or reasons why the party petitioning for review believes the Administrative Law Judge's decision is in error;

(d) Be signed by the party filing the petition or an authorized representative of such party; and

(e) Attach copies of the Administrative Law Judge's decision and any other documents admitted into the record by the Administrative Law Judge which would assist the Secretary in determining whether review is warranted.

§ 726.316 Filing and service.

(a) *Filing.* All documents submitted to the Administrative Review Board (Board) shall be filed in accordance with 29 CFR part 26.

(b) *Computation of time for delivery by mail.* Documents are not deemed filed with the Board until actually received by the Board either on or before the due date. No additional time shall be added where service of a document requiring action within a prescribed time was made by mail.

(c) *Manner and proof of service.* A copy of each document filed with the Board shall be served upon all other parties involved in the proceeding in accordance with 29 CFR part 26.

[86 FR 1779, Jan. 11, 2021]

§ 726.317 Discretionary review.

(a) Following receipt of a timely petition for review, the Administrative Review Board (Board) shall determine whether the decision warrants review, and shall send a notice of such determination to the parties and the Chief Administrative Law Judge. If the Board declines to review the decision, the Administrative Law Judge's decision shall be considered the final decision of the agency. The Board's determination to review a decision by an Administrative Law Judge under this subpart is solely within the discretion of the Board.

(b) The Board's notice shall specify:

(1) The issue or issues to be reviewed; and

(2) The schedule for submitting arguments, in the form of briefs or such other pleadings as the Board deems appropriate.

(c) Upon receipt of the Board notice, the Director shall forward the record to the Board.

[86 FR 1779, Jan. 11, 2021]

§ 726.318 Decision of the Administrative Review Board.

The Administrative Review Board's (Board) review shall be based upon the hearing record. The findings of fact in the decision under review shall be conclusive if supported by substantial evidence in the record as a whole. The Board's review of conclusions of law shall be de novo. Upon review of the decision, the Board may affirm, reverse, modify, or vacate the decision, and may remand the case to the Office of

Administrative Law Judges for further proceedings. The Board's decision shall be served upon all parties and the Chief Administrative Law Judge in accordance with 29 CFR part 26.

[86 FR 1780, Jan. 11, 2021]

§ 726.319 Retention of official record.

The official record of every completed administrative hearing held pursuant to this part shall be maintained and filed under the custody and control of the Director.

§ 726.320 Collection and recovery of penalty.

(a) When the determination of the amount of any civil money penalty provided for in this part becomes final, in accordance with the administrative assessment thereof, or pursuant to the decision and order of an Administrative Law Judge, or following the decision of the Secretary, the amount of the penalty as thus determined is immediately due and payable to the U.S. Department of Labor on behalf of the Black Lung Disability Trust Fund. The person against whom such penalty has been assessed or imposed shall promptly remit the amount thereof, as finally determined, to the Secretary by certified check or by money order, made payable to the order of U.S. Department of Labor, Black Lung Program. Such remittance shall be delivered or mailed to the Director.

(b) If such remittance is not received within 30 days after it becomes due and payable, it may be recovered in a civil action brought by the Secretary in any court of competent jurisdiction, in which litigation the Secretary shall be represented by the Solicitor of Labor.

PARTS 727–799 [RESERVED]

CHAPTER VII—BENEFITS REVIEW BOARD, DEPARTMENT OF LABOR

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PART 800 [RESERVED]

PART 801—ESTABLISHMENT AND OPERATION OF THE BOARD

INTRODUCTORY

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AUTHORITY: 5 U.S.C. 301; 30 U.S.C. 901 *et seq.*; 33 U.S.C. 901 *et seq.*; Reorganization Plan No. 6 of 1950, 15 FR 3174; Secretary of Labor's Order 38–72, 38 FR 90, January 3, 1973.

SOURCE: 52 FR 27290, July 20, 1987, unless otherwise noted.

INTRODUCTORY

§ 801.1 Purpose and scope of this part.

This part 801 describes the establishment and the organizational structure of the Benefits Review Board of the Department of Labor, sets forth the general rules applicable to operation of the Board, and defines terms used in this chapter.

§ 801.2 Definitions and use of terms.

(a) For purposes of this chapter, except where the content clearly indicates otherwise, the following definitions apply:

(1) *Acts* means the several Acts listed in §§ 801.102 and 802.101 of this chapter, as amended and extended, unless otherwise specified.

(2) *Board* means the Benefits Review Board established by section 21 of the LHWCA (33 U.S.C. 921) as described in § 801.101, and as provided in this part and Secretary of Labor's Order No. 38–72 (38 FR 90). Mention in these regulations of the ''permanent Board'' refers to the five permanent Board members only.

(3) *Chairman* or *Chairman of the Board* means Chairman of the Benefits Review Board. The Chairman of the Board is officially entitled Chief Administrative Appeals Judge.

(4) *Secretary* means the Secretary of Labor.

(5) *Department* means the Department of Labor.

(6) *Judge* means an administrative law judge appointed as provided in 5 U.S.C. 3105 and subpart B of 5 CFR part 930, who is qualified to preside at hearings under 5 U.S.C. 557 and is empowered by the Secretary to conduct formal hearings whenever necessary in respect of any claim for benefits or compensation arising under the Acts.

(7) *Chief Administrative Law Judge* means the Chief Administrative Law Judge of the Department of Labor.

(8) *Director* means the Director of the Office of Workers' Compensation Programs of the Department of Labor (hereinafter OWCP).

(9) *Deputy commissioner* means a person appointed as provided in sections 39 and 40 of the LHWCA or his designee, authorized by the Director to make decisions and orders in respect to claims arising under the Acts.

(10) *Party* or *Party in Interest* means the Secretary or his designee and any person or business entity directly affected by the decision or order from which an appeal to the Board is taken.

(11) *Day* means calendar day.

(12) *Member* means a member of the Benefits Review Board. Unless specifically stated otherwise, the word ''member'' shall apply to permanent, temporary and interim members. Permanent Board members are officially entitled Administrative Appeals Judges. Temporary and interim Board members are designated as Acting Administrative Appeals Judges.

(b) The definitions contained in this part shall not be considered to derogate from the definitions of terms in the respective Acts.

(c) The definitions pertaining to the Acts contained in the several parts of chapter VI of this title 20 shall be applicable to this chapter as is appropriate.

[52 FR 27290, July 20, 1987, as amended at 52 FR 28640, July 31, 1987]

§ 801.3 Applicability of this part to 20 CFR part 802.

Part 802 of title 20, Code of Federal Regulations, contains the rules of practice and procedure of the Board. This part 801, including the definitions and usages contained in § 801.2, is applicable to part 802 of this chapter as appropriate.

ESTABLISHMENT AND AUTHORITY OF THE BOARD

§ 801.101 Establishment.

By Pub. L. 92–576, 82 Stat. 1251, in an amendment made to section 21 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 921), there was established effective November 26, 1972, a Benefits Review Board, which is composed of members appointed by the Secretary of Labor.

§ 801.102 Review authority.

(a) The Board is authorized, as provided in 33 U.S.C. 921(b), as amended, to hear and determine appeals raising a substantial question of law or fact taken by any party in interest from decisions or orders with respect to claims for compensation or benefits arising under the following Acts, as amended and extended:

(1) The Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 901 *et seq.;*

(2) The Defense Base Act (DBA), 42 U.S.C. 1651 *et seq.;*

(3) The District of Columbia Workmen's Compensation Act (DCWCA), 36 D.C. Code 501 *et seq.* (1973);

(4) The Outer Continental Shelf Lands Act (OCSLA), 43 U.S.C. 1331 *et seq.;*

(5) The Nonappropriated Fund Instrumentalities Act (NFIA), 5 U.S.C. 8171 *et seq.;*

(6) Title IV, section 415 and part C of the Federal Mine Safety and Health Act of 1977, Public Law 95–164, 91 Stat. 1290 (formerly the Federal Coal Mine Health and Safety Act, hereinafter, FCMHSA, of 1969) as amended by the Black Lung Benefits Reform Act of 1977, Public Law 92–239, 92 Stat. 95, the Black Lung Benefits Revenue Act of 1977, Public Law 95–227, 92 Stat. 11, and the Black Lung Benefits Amendments of 1981, Public Law 97–119, 95 Stat. 1643 (30 U.S.C. 901 *et seq.*).

§ 801.103 Organizational placement.

As prescribed by the statute, the functions of the Benefits Review Board are quasi-judicial in nature and involve review of decisions made in the course of the administration of the above statutes by the Employment Standards Administration in the Department of Labor. It is accordingly found appropriate for organizational purposes to place the Board in the Office of the Deputy Secretary and it is hereby established in that Office, which shall be responsible for providing necessary funds, personnel, supplies, equipment, and records services for the Board.

§ 801.104 Operational rules.

The Deputy Secretary of Labor may promulgate such rules and regulations as may be necessary or appropriate for effective operation of the Benefits Review Board as an independent quasi-judicial body in accordance with the provisions of the statute.

MEMBERS OF THE BOARD

§ 801.201 Composition of the Board.

(a) The Board shall be composed of five permanent members appointed by the Secretary from among individuals who are especially qualified to serve thereon. Each permanent member shall serve an indefinite term subject to the discretion of the Secretary.

(b) The member designated by the Secretary as Chairman of the Board shall serve as chief administrative officer of the Board and shall have the authority, as delegated by the Secretary, to exercise all administrative functions necessary to operate the Board.

(c) The four remaining members shall be the associate members of the Board.

(d) Upon application of the Chairman of the Board, the Secretary may designate up to four Department of Labor administrative law judges to serve as temporary Board members in addition to the five permanent Board members. Up to four such temporary members may serve at any one time. The term of any temporary Board member shall not exceed 1 year from date of appointment.

§ 801.202 Interim appointments.

(a) *Acting Chairman.* In the event that the Chairman of the Board is temporarily disabled or unavailable to perform his or her duties as prescribed in this chapter VII, he or she shall designate a permanent member to serve as Acting Chairman until such time as the Secretary designates an Acting Chairman. In the event that the Chairman is physically unable to make such designation, the next senior permanent member shall serve as Acting Chairman until such time as the Secretary of Labor designates an Acting Chairman.

(b) *Interim members.* In the event that a permanent member of the Board is temporarily unable to carry out his or her responsibilities because of disqualification, illness, or for any other reason, the Secretary of Labor may, in his or her discretion, appoint a qualified individual to serve in the place of such permanent member for the duration of that permanent member's inability to serve.

§ 801.203 Disqualification of Board Members.

(a) During the period in which the Chairman or the other members serve on the Board, they shall be subject to the Department's regulations governing ethics and conduct set forth at 20 CFR part 0.

(b) Notice of any objection which a party may have to any Board member who will participate in the proceeding shall be made by such party at the earliest opportunity. The Board member shall consider such objection and shall, in his or her discretion, either proceed with the case or withdraw.

ACTION BY THE BOARD

§ 801.301 Quorum and votes of the permanent Board; panels within the Board.

(a) For the purpose of carrying out its functions under the Acts, whenever action is taken by the entire permanent Board sitting en banc, three permanent members of the Board shall constitute a quorum, and official action of the permanent Board can be taken only on the concurring vote of at least three permanent members.

(b) The Board may delegate any or all of its powers except en banc review to panels of three members. Each panel shall consist of at least two permanent members. Two members of the panel shall constitute a quorum and official panel action can be taken only on the concurring vote of two members of the panel.

(c) A panel decision shall stand unless vacated or modified by the concurring vote of at least three permanent members sitting en banc.

(d) En banc action is not available in cases arising under the District of Columbia Workmen's Compensation Act.

§ 801.302 Procedural rules.

Procedural rules for performance by the Board of its review functions and for insuring an adequate record for any judicial review of its orders, and such amendments to the rules as may be necessary from time to time, shall be promulgated by the Deputy Secretary. Such rules shall incorporate and implement the procedural requirements of section 21(b) of the Longshore and Harbor Workers' Compensation Act.

§ 801.303 Location of Board's proceedings.

The Board shall hold its proceedings at 200 Constitution Avenue, NW., Room N–5101, Washington, DC 20210, unless for good cause the Board orders that proceedings in a particular matter be held in another location.

[62 FR 10666, Mar. 7, 1997]

§ 801.304 Business hours.

The office of the Clerk of the Board at Washington, DC shall be open from 8:30 a.m.-5:00 p.m. on all days, except

Saturdays, Sundays, and legal holidays, for the purpose of receiving notices of appeal, petitions for review, other pleadings, motions, and other papers.

REPRESENTATION

§ 801.401 Representation before the Board.

On any issues requiring representation of the Secretary, the Director, Office of Workers' Compensation Programs, a deputy commissioner, or an administrative law judge before the Board, such representation shall be provided by attorneys designated by the Solicitor of Labor. Representation of all other persons before the Board shall be as provided by the rules of practice and procedure promulgated under § 801.302 (see part 802 of this chapter).

§ 801.402 Representation of Board in court proceedings.

Except in proceedings in the Supreme Court of the United States, any representation of the Benefits Review Board in court proceedings shall be by attorneys designated by the Solicitor of Labor.

PART 802—RULES OF PRACTICE AND PROCEDURE

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AUTHORITY: 5 U.S.C. 301; 30 U.S.C. 901 *et seq.;* 33 U.S.C. 901 *et seq.;* Reorganization Plan No. 6 of 1950, 15 FR 3174; Secretary of Labor's Order 03–2006, 71 FR 4219, January 25, 2006.

SOURCE: 52 FR 27292, July 20, 1987, unless otherwise noted.

Subpart A—General Provisions

INTRODUCTORY

§ 802.101 Purpose and scope of this part.

(a) The purpose of part 802 is to establish the rules of practice and procedure governing the operation of the Benefits Review Board.

(b) Except as otherwise provided, the rules promulgated in this part apply to all appeals taken by any party from decisions or orders with respect to claims for compensation or benefits under the following Acts:

(1) The Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 901 *et seq.;*

(2) The Defense Base Act (DBA), 42 U.S.C. 1651 *et seq.;*

(3) The District of Columbia Workmen's Compensation Act (DCWCA), 36 D.C. Code 501 *et seq.* (1973);

(4) The Outer Continental Shelf Lands Act (OCSLA), 43 U.S.C. 1331 *et seq.;*

(5) The Nonappropriated Fund Instrumentalities Act (NFIA), 5 U.S.C. 8171 *et seq.;*

(6) Title IV, section 415 and part C of the Federal Mine Safety and Health Act of 1977, Public Law 95–164, 91 Stat. 1290 (formerly the FCMHSA of 1969), as amended by the Black Lung Benefits Reform Act of 1977, Public Law 95–239, 92 Stat. 95, the Black Lung Benefits Revenue Act of 1977, Public Law 95–229, 92 Stat. 11, and the Black Lung Benefits Amendments of 1981, Public Law 97–119, 95 Stat. 1643 (30 U.S.C. 901 *et seq.*).

§ 802.102 Applicability of part 801 of this chapter.

Part 801 of this chapter VII sets forth rules of general applicability covering the composition, authority, and operation of the Benefits Review Board and definitions applicable to this chapter. The provisions of part 801 of this chapter are fully applicable to this part 802.

§ 802.103 Powers of the Board.

(a) *Conduct of proceedings.* Pursuant to section 27(a) of the LHWCA, the Board shall have power to preserve and enforce order during any proceedings for determination or adjudication of entitlement to compensation or benefits or for liability for payment thereof, and to do all things in accordance with law which may be necessary to enable the Board to effectively discharge its duties.

(b) *Contumacy.* Pursuant to section 27(b) of the LHWCA, if any person in proceedings before the Board disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the same, the Board shall certify the facts to the Federal district court having jurisdiction in the place in which it is sitting (or to the U.S. District Court for the District of Columbia if it is sitting in the District) which shall thereupon in a summary manner hear the evidence as to the acts complained of, and if the evidence so warrants, punish such person in the same manner and to the same extent as for a contempt committed before the court, or commit such person upon the same conditions as if the doing of the forbidden act had occurred with reference to the process or in the presence of the court.

§ 802.104 Consolidation; severance.

(a) Cases may, in the sole discretion of the Board, be consolidated for purposes of an appeal upon the motion of any party or upon the Board's own motion where there exist common parties, common questions of law or fact or both, or in such other circumstances as justice and the administration of the Acts require.

(b) Upon its own motion, or upon motion of any party, the Board may, for good cause, order any proceeding severed with respect to some or all issues or parties.

§ 802.105 Stay of payment pending appeal.

(a) As provided in section 14(f) of the LHWCA and sections 415 and 422 of the Black Lung Benefits Act, the payment of the amounts required by an award of compensation or benefits shall not be stayed or in any way delayed beyond ten days after it becomes due pending final decision in any proceeding before the Board unless so ordered by the

Board. No stay shall be issued unless irreparable injury would otherwise ensue to the employer, coal mine operator or insurance carrier. Any order of the Board permitting any stay shall contain a specific finding, based upon evidence submitted to the Board and identified by reference thereto, that irreparable injury would result to such employer, operator or insurance carrier, and specify the nature and extent of the injury.

(b) When circumstances require, the Board, in its discretion, may issue a temporary order not to exceed 30 days granting a motion for stay of payment prior to the expiration of the ten-day period allowed for filing responses to motions pursuant to §802.219(e). Following receipt of a response to the motion or expiration of the response time provided in §802.219(e), the Board will issue a subsequent order ruling on the motion for stay of payment.

[52 FR 27292, July 20, 1987, as amended at 53 FR 16519, May 9, 1988]

Subpart B—Prereview Procedures

COMMENCING APPEAL: PARTIES

§802.201 Who may file an appeal.

(a) *A party.* (1) Any party or party-in-interest adversely affected or aggrieved by a decision or order issued pursuant to one of the Acts over which the Board has appellate jurisdiction may appeal a decision or order of an administrative law judge or deputy commissioner to the Board by filing a notice of appeal pursuant to this subpart. (See §802.205(b) and (c) for exceptions to this general rule.) A party who files a notice of appeal shall be deemed the petitioner. The Director, OWCP, when acting as a representative of the Special Fund established under the Longshore and Harbor Workers' Compensation Act or the Black Lung Disability Trust Fund established by the Black Lung Benefits Act, or, when appealing a decision or order which affects the administration of one of the Acts, shall be considered a party adversely affected.

(2) When a decision or order is favorable to a party (*i.e.*, the prevailing party), the prevailing party may file a cross-appeal pursuant to §802.205(b) to challenge any adverse findings of fact or conclusions of law in the same proceeding.

(b) *Representative parties.* In the event that a party has not attained the age of 18, is not mentally competent, or is physically unable to file and pursue or defend an appeal, the Board may permit any legally appointed guardian, committee, or other appropriate representative to file and pursue or defend the appeal, or it may in its discretion appoint such representative for purposes of the appeal. The Board may require any legally appointed representative to submit evidence of that person's authority.

§802.202 Appearances by attorneys and other authorized persons; denial or authority to appear.

(a) *Appearances.* Any party or intervenor or any representative duly authorized pursuant to §802.201(b) may appear before and/or submit written argument to the Board by attorney or any other person, including any representative of an employee organization, duly authorized pursuant to paragraph (d)(2) of this section.

(b) Any individual petitioner or respondent or his duly authorized representative pursuant to §802.201(b) or an officer of any corporate party or a member of any partnership or joint venture which is a party may participate in the appeal on his or her own behalf, or on behalf of such business entity.

(c) For each instance in which appearance before the Board is made by an attorney or duly authorized person other than the party or his legal guardian, committee, or representative, there shall be filed with the Board a notice of appearance. Any attorney or other duly authorized person of record who intends to withdraw from representation shall file prior written notice of intent to withdraw from representation of a party or of substitution of counsel or other representative.

(d) *Qualifications*—(1) *Attorneys.* An attorney at law who is admitted to practice before the Federal courts or before the highest court of any State, the District of Columbia, or any territory or commonwealth of the United States, may practice before the Board

unless he or she has been disqualified from representing claimants under the Act pursuant to 33 U.S.C. 931(b)(2)(C), or unless authority to appear has been denied pursuant to § 802.202(e)(1) and (3). An attorney's own representation that he or she is in good standing before any of such courts shall be sufficient proof thereof, unless otherwise ordered by the Board.

(2) *Persons not attorneys.* Any person who is not an attorney at law may be admitted to appear in a representative capacity unless he or she has been disqualified from representing claimants under the Act pursuant to 33 U.S.C. 931(b)(2)(C). An application by a person not an attorney at law for admission to appear in a proceeding shall be submitted in writing to the Board at the time such person's appearance is entered. The application shall state such person's name, address, telephone number, general education, any special training or experience in claims representation, and such person's relationship, if any, to the party being represented. The Board may, at any time, make further inquiry as to the qualification or ability of such person to render assistance. In the event of a failure to make application for admission to appear, the Board shall issue an order to show cause why admission to appear should not be denied. Admission to appear in a particular case shall not be deemed a blanket authorization to appear in other cases.

(e) *Denial of authority to appear*—(1) *Attorneys.* The Board may deny the privilege of appearing to any attorney, within applicable statutory constraints, e.g., 5 U.S.C. 555, who has been disbarred or suspended from the practice of law; who has surrendered his or her license while under investigation or under threat of disciplinary action; or who, after notice of an opportunity for hearing in the matter is found by the Board to have engaged in any conduct which would result in the loss of his or her license. No provision hereof shall apply to any attorney who appears on his or her own behalf.

(2) *Persons not attorneys.* The Board may deny the privilege of appearing to any person who, in the Board's judgment, lacks sufficient qualification or ability to render assistance. No provision hereof shall apply to any person who appears on his or her own behalf.

(3) Denial of authority to appear may be considered, after notice of and opportunity for a hearing, by the panel (constituted pursuant to § 801.301) which is assigned to decide the appeal in which the attorney or other person has entered an appearance. If such proceeding reveals facts suggesting that one of the circumstances described in 33 U.S.C. 931(b)(2)(C) exists, the Board shall refer that information to the Director, OWCP, for further proceedings pursuant to 33 U.S.C. 931(b)(2)(C) and 907(j). An attorney or other person may appeal a panel's decision to deny authority to appear to the entire permanent Board sitting en banc.

[52 FR 27292, July 20, 1987, as amended at 53 FR 16519, May 9, 1988]

§ 802.203 Fees for services.

(a) No fee for services rendered on behalf of a claimant in the successful pursuit or successful defense of an appeal shall be valid unless approved pursuant to 33 U.S.C. 928, as amended.

(b) All fees for services rendered in the successful pursuit or successful defense of an appeal on behalf of a claimant shall be subject to the provisions and prohibitions contained in 33 U.S.C. 928, as amended.

(c) Within 60 days of the issuance of a decision or non-interlocutory order by the Board, counsel or, where appropriate, representative for any claimant who has prevailed on appeal before the Board may file an application with the Board for a fee. Where the Board remands the case and the administrative law judge on remand issues an award, a fee petition may be filed within 60 days of the decision on remand. In the event that a claimant who was unsuccessful before the Board prevails on appeal to the court of appeals, his or her representative may within 60 days of issuance of the court's judgment file a fee application with the Board for services performed before the Board.

(d) A fee application shall include only time spent on services performed while the appeal was pending before the Board and shall be complete in all respects, containing all of the following specific information:

(1) A complete statement of the extent and character of the necessary work done;

(2) The professional status of each person for whom a fee is claimed who performed services on behalf of the claimant (if such professional status is other than attorney, a definition of the professional status of such individual must be included in the fee petition, including a statment of that individual's professional training, education and experience) and a statement that the attorney was a member in good standing of a state bar at the time the services were performed;

(3) The number of hours, in ¼ hour increments, devoted by each person who performed services on behalf of the claimant and the dates on which such services were performed in each category of work;

(4) The normal billing rate for each person who performed services on behalf of the claimant. The rate awarded by the Board shall be based on what is reasonable and customary in the area where the services were rendered for a person of that particular professional status.

(e) Any fee approved shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the complexity of the legal issues involved, the amount of benefits awarded, and, when the fee is to be assessed against the claimant, shall also take into account the financial circumstances of the claimant. A fee shall not necessarily be computed by multiplying time devoted to work by an hourly rate.

(f) No contract pertaining to the amount of a fee shall be recognized.

(g) A fee application shall be served on all other parties and accompanied by a certificate of service. The Board will not take action on the fee application until such service is effected. Any party may respond to the application within 10 days of receipt of the application. The response shall be filed with the Board and served on all other parties.

NOTICE OF APPEAL

§ 802.204 [Reserved]

§ 802.205 Time for filing.

(a) A notice of appeal, other than a cross-appeal, must be filed within 30 days from the date upon which a decision or order has been filed in the Office of the Deputy Commissioner pursuant to section 19(e) of the LHWCA or in such other office as may be established in the future (see §§ 702.349 and 725.478 of this title).

(b) If a timely notice of appeal is filed by a party, any other party may initiate a cross-appeal by filing a notice of appeal within 14 days of the date on which the first notice of appeal was filed, or within the time prescribed by paragraph (a) of this section, whichever period last expires. In the event that such other party was not properly served with the first notice of appeal, such party may initiate a cross-appeal by filing a notice of appeal within 14 days of the date that service is effected.

(c) Failure to file within the period specified in paragraph (a) or (b) of this section (whichever is applicable) shall foreclose all rights to review by the Board with respect to the case or matter in question. Any untimely appeal will be summarily dismissed by the Board for lack of jurisdiction.

§ 802.206 Effect of motion for reconsideration on time for appeal.

(a) A timely motion for reconsideration of a decision or order of an administrative law judge or deputy commissioner shall suspend the running of the time for filing a notice of appeal.

(b)(1) In a case involving a claim filed under the Longshore and Harbor Workers' Compensation Act or its extensions (see § 802.101(b)(1)–(5)), a timely motion for reconsideration for purposes of paragraph (a) of this section is one which is filed not later than 10 days from the date the decision or order was filed in the Office of the Deputy Commissioner.

(2) In a case involving a claim filed under title IV of the Federal Mine Safety and Health Act, as amended (see § 802.101(b)(6)), a timely motion for reconsideration for purposes of paragraph

(a) of this section is one which is filed not later than 30 days from the date the decision or order was served on all parties by the administrative law judge and considered filed in the Office of the Deputy Commissioner (see §§ 725.478 and 725.479(b), (c) of this title).

(c) If the motion for reconsideration is sent by mail and the fixing of the date of delivery as the date of filing would result in a loss or impairment of reconsideration rights, it will be considered to have been filed as of the date of mailing. The date appearing on the U.S. Postal Service postmark (when available and legible) shall be prima facie evidence of the date of mailing. If there is no such postmark or it is not legible, other evidence such as, but not limited to, certified mail receipts, certificates of service and affidavits may also be used to establish the mailing date.

(d) If a motion for reconsideration is granted, the full time for filing an appeal commences on the date the subsequent decision or order on reconsideration is filed as provided in § 802.205.

(e) If a motion for reconsideration is denied, the full time for filing an appeal commences on the date the order denying reconsideration is filed as provided in § 802.205.

(f) If a timely motion for reconsideration of a decision or order of an administrative law judge or deputy commissioner is filed, any appeal to the Board, whether filed prior to or subsequent to the filing of the timely motion for reconsideration, shall be dismissed without prejudice as premature. Following decision by the administrative law judge or deputy commissioner pursuant to either paragraph (d) or (e) of this section, a new notice of appeal shall be filed with the Clerk of the Board by any party who wishes to appeal. During the pendency of an appeal to the Board, any party having knowledge that a motion for reconsideration of a decision or order of an administrative law judge or deputy commissioner has been filed shall notify the Board of such filing.

§ 802.207 [Reserved]

§ 802.208 Contents of notice of appeal.

(a) A notice of appeal shall contain the following information:

(1) The full name and address of the pettioner;

(2) The full name of the injured, disabled, or deceased employee;

(3) The full names and addresses of all other parties, including, among others, beneficiaries, employers, coal mine operators, and insurance carriers where appropriate;

(4) The case file number which appears on the decision or order of the administrative law judge;

(5) The claimant's OWCP file number;

(6) The date of filing of the decision or order being appealed;

(7) Whether a motion for reconsideration of the decision or order of the administrative law judge has been filed by any party, the date such motion was filed, and whether the administrative law judge has acted on such motion for reconsideration (see § 802.206);

(8) The name and address of the attorney or other person, if any, who is representing the petitioner.

(b) Paragraph (a) of this section notwithstanding, any written communication which reasonably permits identification of the decision from which an appeal is sought and the parties affected or aggrieved thereby, shall be sufficient notice for purposes of § 802.205.

(c) In the event that identification of the case is not possible from the information submitted, the Clerk of the Board shall so notify the petitioner and shall give the petitioner a reasonable time to produce sufficient information to permit identification of the case. For purposes of § 802.205, the notice shall be deemed to have been filed as of the date the insufficient information was received.

§ 802.209 Transmittal of record to the Board.

Upon receipt of a copy of the notice of appeal or upon request of the Board, the deputy commissioner or other office having custody of such record shall immediately forward to the Clerk of the Board the official record of the

case, which record includes the transcript or transcripts of all formal proceedings with exhibits, all decisions and orders rendered in the case.

INITIAL PROCESSING

§ 802.210 Acknowledgment of notice of appeal.

Upon receipt by the Board of a notice of appeal, the Clerk of the Board shall as expeditiously as possible notify the petitioner and all other parties and the Solicitor of Labor, in writing, that a notice of appeal has been filed.

§ 802.211 Petition for review.

(a) Within 30 days after the receipt of an acknowledgment of a notice of appeal issued pursuant to § 802.210, the petitioner shall submit a petition for review to the Board which petition lists the specific issues to be considered on appeal.

(b) Each petition for review shall be accompanied by a supporting brief, memorandum of law or other statement which: Specifically states the issues to be considered by the Board; presents, with appropriate headings, an argument with respect to each issue presented with references to transcripts, pieces of evidence and other parts of the record to which the petitioner wishes the Board to refer; a short conclusion stating the precise result the petitioner seeks on each issue and any authorities upon which the petition relies to support such proposed result. The Longshore Desk Book and Black Lung Desk Book are not intended as final legal authorities and should not be cited or relied upon as such.

(c) Copies of the petition for review and accompanying documents must be served upon all parties and the Solicitor of Labor.

(d) Failure to submit a petition for review and brief within the 30-day period or to comply with any part of this section may, in the discretion of the Board, cause the appeal to be deemed abandoned (see § 802.402).

(e) When a party appears pro se the Board may, in its discretion, waive formal compliance with the requirements of this section and may, depending upon the particular circumstances, prescribe an alternate method of furnishing such information as may be necessary for the Board to decide the merits of any such appeal.

§ 802.212 Response to petition for review.

(a) Within 30 days after the receipt of a petition for review, each party upon whom it was served may submit to the Board a brief, memorandum, or other statement in response to it.

(b) Arguments in response briefs shall be limited to those which respond to arguments raised in petitioner's brief and to those in support of the decision below. Other arguments will not be considered by the Board (see § 802.205(b)).

§ 802.213 Reply briefs.

(a) Within 20 days after the receipt of a brief, memorandum, or statement submitted in response to the petition for review pursuant to § 802.212, any party upon whom it was served may file a brief, memorandum, or other statement in reply to it.

(b) Arguments in reply briefs shall be limited to those which reply to arguments made in the response brief. Any other arguments in a reply brief will not be considered by the Board.

§ 802.214 Intervention.

(a) If a person or legal entity shows in a written petition to intervene that his, her, or its rights are affected by any proceeding before the Board, the Board may permit that person or legal entity to intervene in the proceeding and to participate within limits prescribed by the Board.

(b) The petition to intervene shall state precisely:

(1) The rights affected, and

(2) The nature of any argument the person or legal entity intends to make.

§ 802.215 Additional briefs.

Additional briefs may be filed or ordered in the discretion of the Board and shall be submitted within time limits specified by the Board.

§ 802.216 [Reserved]

§ 802.217 Waiver of time limitations for filing.

(a) The time periods specified for submitting papers described in this part, except that for submitting a notice of appeal, may be enlarged for a reasonable period when in the judgment of the Board an enlargement is warranted.

(b) Any request for an enlargement of time pursuant to this section shall be directed to the Clerk of the Board and must be received by the Clerk on or prior to the date on which the paper is due.

(c) Any request for an enlargement of time pursuant to this section shall be submitted in writing in the form of a motion, shall specify the reasons for the request, and shall specify the date to which an enlargement of time is requested.

(d) Absent exceptional circumstances, no more than one enlargement of time shall be granted to each party.

(e) Absent a timely request for an enlargement of time pursuant to this section and the Board's granting that request, any paper submitted to the Board outside the applicable time period specified in this part shall be accompanied by a separate motion stating the reasons therefor and requesting that the Board accept the paper although filed out of time.

(f) When a paper filed out of time is accepted by the Board, the time for filing a response shall begin to run from the date of a party's receipt of the Board's order disposing of the motion referred to in paragraph (e) of this section.

§ 802.218 Failure to file papers; order to show cause.

(a) Failure to file any paper when due pursuant to this part, may, in the discretion of the Board, constitute a waiver of the right to further participation in the proceedings.

(b) When a petition for review and brief has not been submitted to the Board within the time limitation prescribed by § 802.211, or within an enlarged time limitation granted pursuant to § 802.217, the petitioner shall be ordered to show cause to the Board why his or her appeal should not be dismissed pursuant to § 802.402.

§ 802.219 Motions to the Board; orders.

(a) An application to the Board for an order shall be by motion in writing. A motion shall state with particularity the grounds therefor and shall set forth the relief or order sought.

(b) A motion shall be a separate document and shall not be incorporated in the text of any other paper filed with the Board, except for a statement in support of the motion. If this paragraph is not complied with, the Board will not consider and dispose of the motion.

(c) If there is no objection to a motion in whole or in part by another party to the case, the absence of an objection shall be stated on the motion.

(d) The rules governing the filing and service of documents in §§ 802.222 and 802.223 apply to all motions.

(e) Within 10 days of the receipt of a copy of a motion, a party may file a written response with the Board.

(f) As expeditiously as possible following receipt of a response to a motion or expiration of the response time provided in paragraph (e) of this section, the Board shall issue a dispositive order.

(g) *Orders granted by Clerk.* The Clerk of the Board may enter orders on behalf of the Board in procedural matters, including but not limited to:

(1) First motions for extensions of time for filing briefs and any papers other than notices of appeal or cross-appeal;

(2) Motions for voluntary dismissals of appeals;

(3) Orders to show cause why appeals should not be dismissed for failure to timely file a petition for review and brief (see § 802.218(b)); and

(4) Unopposed motions which are ordinarily granted as of course, except that the Clerk may, in his or her discretion, refer such motions for disposition to a motions panel as provided by paragraph (h) of this section.

(h) *All other motions.* All other motions will be referred for disposition to a panel of three members constituted pursuant to § 801.301. Any member may request that any motion be considered

by the entire permanent Board en banc except as provided in § 801.301(d).

(i) *Reconsideration of orders.* Any party adversely effected by any interlocutory order issued under paragraph (g) or (h) may file a motion to reconsider, vacate or modify the order within 10 days from its filing, stating the grounds for such request. Any motion for reconsideration, vacation or modification of an interlocutory order shall be referred to a three-member panel that may include any member who previously acted on the matter. Suggestions for en banc reconsideration of interlocutory orders shall not be accepted. Reconsideration of all other orders will be treated under § 802.407 of this part.

[52 FR 27292, July 20, 1987, as amended at 89 FR 8536, Feb. 8, 2024]

§ 802.220 Party not represented by an attorney; informal procedure.

A party to an appeal who is not represented by an attorney shall comply with the procedural requirements contained in this part, except as otherwise specifically provided in § 802.211(e). In its discretion, the Board may prescribe additional informal procedures to be followed by such party.

§ 802.221 Computation of time.

(a) In computing any period of time prescribed or allowed by these rules, by direction of the Board, or by any applicable statute which does not provide otherwise, the day from which the designated period of time begins to run must not be included. The last day of the period so computed must be included, unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday.

(b) For nonelectronic documents, the time period computed under paragraph (a) of this section will be deemed complied with if—

(1) When sent by mail, the envelope containing the document is postmarked by the U.S. Postal Service within the time period allowed. If there is no such postmark, or it is not legible, other evidence such as, but not limited to, certified mail receipts, certificates of service, and affidavits, may be used to establish the mailing date.

(2) When sent by commercial carrier, the receipt or tracking information demonstrates that the paper was delivered to the carrier within the time period allowed.

(c) For electronic filings made through the Board's case management system, paragraph (a) of this section will be deemed to be met if the document is electronically filed within the time period allowed. A document is deemed filed as of the date and time the Board's electronic case management system records its receipt, even if transmitted outside of the Board's business hours set forth in § 801.304 of this chapter. To be considered timely, an e-filed pleading must be filed by 11:59:59 p.m. Eastern Time on the due date.

(d) A waiver of the time limitations for filing a paper, other than a notice of appeal, may be requested by proper motion filed in accordance with §§ 802.217 and 802.219.

[89 FR 8536, Feb. 8, 2024]

§ 802.222 Filing notice of appeal, pleadings, and other correspondence.

This section prescribes rules and procedures by which parties and representatives to proceedings before the Board file pleadings (including notices of appeal, petitions for review and briefs, response briefs, additional briefs, and motions), exhibits, and other documents including routine correspondence.

(a) *Requirements for all pleadings.* All pleadings filed with the Board must—

(1) Include a caption and title.

(2) Include a certificate of service containing—

(i) The date and manner of service;

(ii) The names of persons served; and

(iii) Their mail or electronic mail addresses or the addresses of the places of delivery, as appropriate for the manner of service.

(3) Include a signature of the party (or their attorney or lay representative) and date of signature. Pleadings filed by an attorney, lay representative or self-represented party via the Board's case management system will be deemed to be signed by that person.

(4) Conform to standard letter dimensions (8.5 x 11 inches).

(b) *Redacted filings and exhibits.* Any person who files a pleading, exhibit, or other document that contains an individual's social security number, taxpayer-identification number, or birth date; the name of an individual known to be a minor; or a financial-account number, must redact all such information, except the last four digits of the social security number and taxpayer-identification number; the year of the individual's birth; the minor's initials; and the last four digits of the financial-account number.

(c) *Nonelectronic filings.* All nonelectronic pleadings filed with the Board must be secured at the top. For each pleading filed with the Board, the original and two legible copies must be submitted. Nonelectronic filings must be sent to the U.S. Department of Labor, Benefits Review Board, ATTN: Office of the Clerk of the Appellate Boards (OCAB), 200 Constitution Ave. NW, Washington, DC 20210–0001, or otherwise presented to the Clerk.

(d) *Electronic filings.* (1) Except as provided in paragraph (d)(2) of this section, beginning on March 11, 2024, attorneys and lay representatives must be registered with the Board's electronic case management system and file all pleadings, exhibits, and other documents with the Board through this system (e-file). All e-filed documents must be in Portable Document Format (PDF). The Board prefers that pleadings be filed in text-searchable PDF format. Paper copies are not required unless requested by the Board.

(2) Attorneys and lay representatives may request an exemption (pursuant to § 802.219) for good cause shown. Such a request must include a detailed explanation why e-filing or acceptance of e-service should not be required.

(3) Self-represented parties may file pleadings, exhibits, and other documents in electronic or nonelectronic form in accordance with paragraph (c) or (d) of this section.

(4) A document filed electronically is a written paper for purposes of this Part.

(5) A person who is adversely affected by a technical failure in connection with filing or receipt of an electronic document may seek appropriate relief from the Board under § 802.219. If a technical malfunction or other issue prevents access to the Board's case management system for a protracted period, the Board by special order may provide appropriate relief pending restoration of electronic access.

(e) *Special rules for notices of appeal.* (1) Except as otherwise provided in this section, a notice of appeal is considered to have been filed only as of the date it is received by the office of the Clerk of the Board.

(2) A notice of appeal submitted to any other agency or subdivision of the Department of Labor or of the U.S. Government or any state government, and subsequently received by the office of the Clerk of the Board, will be considered filed with the Clerk of the Board as of the date it was received by the other governmental unit if the Board finds in its discretion that it is in the interest of justice to do so.

(3) If the notice of appeal is sent by mail or commercial carrier and the fixing of the date of delivery as the date of filing would result in a loss or impairment of appeal rights, it will be considered to have been filed as of the date of mailing or the date of delivery to the commercial carrier.

(i) For notices sent by mail, the date appearing on the U.S. Postal Service postmark (when available and legible) will be prima facie evidence of the date of mailing. If there is no such postmark or it is not legible, other evidence such as, but not limited to, certified mail receipts, certificates of service, and affidavits, may be used to establish the mailing date.

(ii) For notices sent by commercial carrier, the date of delivery to the carrier may be demonstrated by the carrier's receipt or tracking information.

(4) If the notice of appeal is electronically filed through the Board's case management system, it is considered received by the office of the Clerk of the Board as of the date and time recorded by the system under § 802.221(c).

[89 FR 8536, Feb. 8, 2024]

§ 802.223 Service requirements.

This section prescribes rules and procedures for serving pleadings (including notices of appeal, petitions for review, and response briefs, additional briefs, and motions), exhibits, and other documents including routine correspondence on other parties and representatives.

(a) A copy of any document filed with the Board must be served on each party and the Solicitor of Labor by the party filing the document.

(b) *Manner of service.* (1) Nonelectronic service may be completed by:

(i) Personal delivery;

(ii) Mail; or

(iii) Commercial delivery.

(2) Electronic service may be completed by:

(i) Electronic mail, if consented to in writing by the person served; or

(ii) Sending it to a user registered with the Board's electronic case management system by filing via this system. A person who registers to use the Board's case management system is deemed to have consented to accept service through the system.

(c) *When service is effected.* (1) Service by personal delivery is effected on the date the document is delivered to the recipient.

(2) Service by mail or commercial carrier is effected on mailing or delivery to the carrier.

(3) Service by electronic means is effected on sending.

(d) *Date of receipt for electronic documents.* Unless the party making service is notified that the document was not received by the party served—

(1) A document filed via the Board's case management system is considered received by registered users on the date it is sent by the system; and

(2) A document served via electronic mail is considered received by the recipient on the date it is sent.

[89 FR 8537, Feb. 8, 2024]

Subpart C—Procedure for Review

ACTION BY THE BOARD

§ 802.301 Scope of review.

(a) The Benefits Review Board is not empowered to engage in a *de novo* proceeding or unrestricted review of a case brought before it. The Board is authorized to review the findings of fact and conclusions of law on which the decision or order appealed from was based. Such findings of fact and conclusions of law may be set aside only if they are not, in the judgment of the Board, supported by substantial evidence in the record considered as a whole or in accordance with law.

(b) Parties shall not submit new evidence to the Board. Any evidence submitted by a party which is not part of the record developed at the hearing before the administrative law judge will be returned without being considered by the Board.

(c) Any party who considers new evidence necessary to the adjudication of the claim may apply for modification pursuant to section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 922. A party who files a petition for modification shall promptly notify the Board of such filing. Upon receipt of such notification, the Board shall dismiss the case without prejudice. Should the petition for modification be declined, the petitioner may file a request for reinstatement of his or her appeal with the Board within 30 days of the date the petition is declined. Should the petition for modification be accepted, any party adversely affected by the decision or order granting or denying modification may file a new appeal with the Board within 30 days of the date the decision or order on modification is filed.

[52 FR 27292, July 20, 1987, as amended at 53 FR 16519, May 9, 1988]

§ 802.302 Docketing of appeals.

(a) *Maintenance of dockets.* A docket of all proceedings shall be maintained by the Board. Each proceeding shall be assigned a number in chronological order upon the date on which a notice of appeal is received. Correspondence or further applications in connection with any pending case shall refer to the docket number of that case.

(b) *Inspection of docket; publication of decision.* The docket of the Board shall be open to public inspection. The Board shall publish its decisions in a form

which is readily available for inspection, and shall allow the public to inspect its decisions at the permanent location of the Board.

ORAL ARGUMENT BEFORE THE BOARD

§ 802.303 Decision; no oral argument.

(a) In the event that no oral argument is ordered pursuant to § 802.306, the Board shall proceed to review the record of the case as expeditiously as possible after all briefs, supporting statements, and other pertinent documents have been received.

(b) Each case shall be considered in the order in which it becomes ready for decision, regardless of docket number, although for good cause shown, upon the filing of a motion to expedite by a party, the Board may advance the order in which a particular case is to be considered.

(c) The Board may advance an appeal on the docket on its own motion if the interests of justice would be served by so doing.

§ 802.304 Purpose of oral argument.

Oral argument may be held by the Board in any case:

(a) When there is a novel issue not previously considered by the Board; or

(b) When in the interests of justice oral argument will serve to assist the Board in carrying out the intent of any of the Acts; or

(c) To resolve conflicting decisions by administrative law judges on a substantial question of law.

§ 802.305 Request for oral argument.

(a) During the pendency of an appeal, but not later than the expiration of 20 days from the date of receipt of the response brief provided by § 802.212, any party may request oral argument. The Board on its own motion may order oral argument at any time.

(b) A request for oral argument shall be submitted in the form of a motion, specifying the issues to be argued and justifying the need for oral argument (see § 802.219).

(c) The party requesting oral argument shall set forth in the motion suggested dates and alternate cities convenient to the parties when and where they would be available for oral argument.

§ 802.306 Action on request for oral argument.

As expeditiously as possible after the date upon which a request for oral argument is received, the Board shall determine whether the request shall be granted or denied.

§ 802.307 Notice of oral argument.

(a) In cases where a request for oral argument has been approved or where oral argument has been ordered, the Board shall give all parties a minimum of 30 days' notice, in writing, by mail, of the scope of argument and of the time when, and place where, oral argument will be held.

(b) Once oral argument has been scheduled by the Board, continuances shall not be granted except for good cause shown by a party, such as in cases of extreme hardship or where attendance of a party or his or her representative is mandated at a previously scheduled judicial proceeding. Unless the ground for the request arises thereafter, requests for continuances must be received by the Board at least 15 days before the scheduled date of oral argument, must be served upon the other parties and must specify good cause why the requesting party cannot be available for oral argument.

(c) The Board may cancel or reschedule oral argument on its own motion at any time.

§ 802.308 Conduct of oral argument.

(a) Oral argument shall be held in Washington, DC, unless the Board orders otherwise, and shall be conducted at a time reasonably convenient to the parties. For good cause shown, the presiding judge of the panel may, in his or her discretion, postpone an oral argument to a more convenient time.

(b) The proceedings shall be conducted under the supervision of the Chairman or, if the Chairman is not on the panel, the senior judge, who shall regulate all procedural matters arising during the course of the argument.

(c) Within the discretion of the Board, oral argument shall be open to the public and may be presented by any

party, representative, or duly authorized attorney. Presentation of oral argument may be denied by the Board to a party who has not significantly participated in the appeal prior to oral argument.

(d) The Board shall determine the scope of any oral argument presented and shall so inform the parties in its notice scheduling oral argument pursuant to § 802.307.

(e) The Board in its discretion shall determine the amount of time allotted to each party for argument and rebuttal.

§ 802.309 Absence of parties.

The unexcused absence of a party or his or her authorized representative at the time and place set for argument shall not be the occasion for delay of the proceeding. In such event, argument on behalf of other parties may be heard and the case shall be regarded as submitted on the record by the absent party. The presiding judge may, with the consent of the parties present, cancel the oral argument and treat the appeal as submitted on the written record.

Subpart D—Completion of Board Review

DISMISSALS

§ 802.401 Dismissal by application of party.

(a) At any time prior to the issuance of a decision by the Board, the petitioner may move that the appeal be dismissed. If granted, such motion for dismissal shall be granted with prejudice to the petitioner.

(b) At any time prior to the issuance of a decision by the Board, any party or representative may move that the appeal be dismissed.

§ 802.402 Dismissal by abandonment.

(a) Upon motion by any party or representative or upon the Board's own motion, an appeal may be dismissed upon its abandonment by the party or parties who filed the appeal. Within the discretion of the Board, a party may be deemed to have abandoned an appeal if neither the party nor his representative participates significantly in the review proceedings.

(b) An appeal may be dismissed on the death of a party only if the record affirmatively shows that there is no person who wishes to continue the action and whose rights may be prejudiced by dismissal.

DECISION OF THE BOARD

§ 802.403 Issuance of decisions; service.

(a) The Board shall issue written decisions as expeditiously as possible after the completion of review proceedings before the Board. The transmittal of the decision of the Board shall indicate the availability of judicial review of the decision under section 21(c) of the LHWCA when appropriate.

(b) The original of the decision shall be filed with the Clerk of the Board. A copy of the Board's decision shall be sent by certified mail or otherwise presented to all parties to the appeal and the Director. The record on appeal, together with a transcript of any oral proceedings, any briefs or other papers filed with the Board, and a copy of the decision shall be returned to the appropriate deputy commissioner for filing.

(c) Proof of service of Board decisions shall be certified by the Clerk of the Board or by another employee in the office of the Clerk of the Board who is authorized to certify proof of service.

§ 802.404 Scope and content of Board decisions.

(a) In its decision the Board shall affirm, modify, vacate or reverse the decision or order appealed from, and may remand the case for action or proceedings consistent with the decision of the Board. The consent of the parties shall not be a prerequisite to a remand ordered by the Board.

(b) In appropriate cases, such as where the issues raised on appeal have been thoroughly discussed and disposed of in prior cases by the Board or the courts, or where the findings of fact and conclusions of law are both correct and adequately discussed, the Board in its discretion may issue a brief, summary decision in writing, disposing of the appeal.

(c) In cases which cannot be disposed of as in paragraph (b) of this section, a full, written decision discussing the issues and applicable law shall be issued.

§ 802.405 Remand.

(a) *By the Board.* Where a case is remanded, such additional proceedings shall be initiated and such other action shall be taken as is directed by the Board.

(b) *By a court.* Where a case has been remanded by a court, the Board may proceed in accordance with the court's mandate to issue a decision or it may in turn remand the case to an administrative law judge or deputy commissioner with instructions to take such action as is ordered by the court and any additional necessary action.

§ 802.406 Finality of Board decisions.

A decision rendered by the Board pursuant to this subpart shall become final 60 days after the issuance of such decision unless a written petition for review praying that the order be modified or set aside, pursuant to section 21(c) of the LHWCA, is filed in the appropriate U.S. court of appeals prior to the expiration of the 60-day period herein described, or unless a timely request for reconsideration by the Board has been filed as provided in § 802.407. If a timely request for reconsideration has been filed, the 60-day period for filing such petition for review will run from the issuance of the Board's decision on reconsideration.

RECONSIDERATION

§ 802.407 Reconsideration of Board decisions.

(a) Any party-in-interest may, within 30 days from the filing of a decision or non-interlocutory order by a panel or the Board pursuant to § 802.403(b), request reconsideration of such decision by those members who rendered the decision. The panel of members who heard and decided the appeal will rule on the motion for reconsideration. If any member of the original panel is unavailable, the Chariman shall designate a new panel member.

(b) Except as provided in § 801.301(d), a party may, within 30 days from the filing of a decision or non-interlocutory order by a panel of the Board pursuant to § 802.403(b), suggest the appropriateness of reconsideration by the permanent members sitting en banc. Such suggestion, however, must accompany a motion for reconsideration directed to the panel which rendered the decision. The suggestion for reconsideration en banc must be clearly marked as such.

(c) Except as provided in § 801.301(d), even where no party has suggested reconsideration en banc, any permanent member may petition the permanent Board for reconsideration en banc of a panel decision.

(d) Reconsideration en banc shall be granted upon the affirmative vote of the majority of permanent members of the Board. A panel decision shall stand unless vacated or modified by the concurring vote of at least three permanent members.

§ 802.408 Notice of request for reconsideration.

(a) In the event that a party requests reconsideration of a decision or order, he or she shall do so in writing, in the form of a motion, stating the supporting rationale for the request, and include any material pertinent to the request.

(b) The request shall be sent by mail, or otherwise presented, to the Clerk of the Board. Copies shall be served on all other parties.

§ 802.409 Grant or denial of request.

All requests for reconsideration shall be reviewed by the Board and shall be granted or denied in the discretion of the Board.

JUDICIAL REVIEW

§ 802.410 Judicial review of Board decisions.

(a) Within 60 days after a decision by the Board has been filed pursuant to § 802.403(b), any party adversely affected or aggrieved by such decision may file a petition for review with the appropriate U.S. Court of Appeals pursuant to section 21(c) of the LHWCA.

(b) The Director, OWCP, as designee of the Secretary of Labor responsible

for the administration and enforcement of the statutes listed in §802.101, shall be deemed to be the proper party on behalf of the Secretary of Labor in all review proceedings conducted pursuant to section 21(c) of the LHWCA.

§ 802.411 Certification of record for judicial review.

The record of a case including the record of proceedings before the Board shall be transmitted to the appropriate court pursuant to the rules of such court.

PARTS 803–899 [RESERVED]

CHAPTER VIII—JOINT BOARD FOR THE ENROLLMENT OF ACTUARIES

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PART 900—STATEMENT OF ORGANIZATION

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900.1 Basis.
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900.3 Composition.
900.4 Meetings.
900.5 Staff.
900.6 Offices.
900.7 Delegations of authority.

AUTHORITY: Sec. 3041–2, Pub. L. 93–406, 88 Stat. 829, 1002 (29 U.S.C. 1241–2).

SOURCE: 40 FR 18776, Apr. 30, 1975, unless otherwise noted.

§ 900.1 Basis.

This statement is issued by the Joint Board for the Enrollment of Actuaries (the Joint Board) pursuant to the requirement of section 552 of title 5 of the United States Code that every agency shall publish in the FEDERAL REGISTER a description of its central and field organization.

§ 900.2 Establishment.

The Joint Board has been established by the Secretary of Labor and the Secretary of the Treasury pursuant to section 3041 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1241). Bylaws of the Board have been issued by the two Secretaries.[1]

§ 900.3 Composition.

Pursuant to the Bylaws, the Joint Board consists of three members appointed by the Secretary of the Treasury and two members appointed by the Secretary of Labor. The Board elects a Chairman and a Secretary from among the Department of the Treasury and the Department of Labor members. The Pension Benefit Guaranty Corporation may designate a non-voting representative to sit with, and participate in, the discussions of the Board. All decisions of the Board are made by simple majority vote.

[81 FR 8833, Feb. 23, 2016]

§ 900.4 Meetings.

The Joint Board meets on the call of the Chairman at such times as are necessary in order to consider matters requiring action. Minutes are kept of each meeting by the Secretary.

§ 900.5 Staff.

(a) The Executive Director advises and assists the Joint Board directly in carrying out its responsibilities under the Act and performs such other functions as the Board may delegate to him.

(b) Members of the staffs of the Departments of the Treasury and of Labor, by arrangement with the Joint Board, perform such services as may be appropriate in assisting the Board in the discharge of its responsibilities.

§ 900.6 Offices.

The Joint Board does not maintain offices separate from those of the Departments of the Treasury and Labor. Its post office address is Joint Board for the Enrollment of Actuaries, c/o Department of the Treasury, Washington, D.C. 20220.

§ 900.7 Delegations of authority.

As occasion warrants, the Joint Board may delegate functions to the Chairman or the Executive Director, including the authority to receive applications and to give notice of actions. Any such delegation of authority is conferred by resolution of the Board.

PART 901—REGULATIONS GOVERNING THE PERFORMANCE OF ACTUARIAL SERVICES UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec.
901.0 Scope.

Subpart A—Definitions and Eligibility To Perform Actuarial Services

901.1 Definitions.
901.2 Eligibility to perform actuarial services.

Subpart B—Enrollment of Actuaries

901.10 Application for enrollment.
901.11 Enrollment procedures.
901.12 Eligibility for enrollment.

[1] Copy filed with the Office of the Federal Register. Copies may also be obtained from the Executive Director of the Board.

Subpart C—Standards of Performance for Enrolled Actuaries

901.20 Standards of performance of actuarial services.

Subpart D—Suspension or Termination of Enrollment

901.30 Authority to suspend or terminate enrollment.
901.31 Grounds for suspension or termination of enrollment.
901.32 Receipt of information concerning enrolled actuaries.
901.33 Initiation of proceeding.
901.34 Conferences.
901.35 Contents of complaint.
901.36 Service of complaint and other papers.
901.37 Answer.
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901.40 Proof; variance; amendment of pleadings.
901.41 Motions and requests.
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901.49 Decision of the Administrative Law Judge.
901.50 Appeal to the Joint Board.
901.51 Decision of the Joint Board.
901.52 Effect of suspension, termination or resignation of enrollment; surrender of enrollment certificate.
901.53 Notice of suspension, termination or resignation of enrollment.
901.54 Petition for reinstatement.

Subpart E—General Provisions

901.70 Records.
901.71 Special orders.
901.72 Additional rules.

AUTHORITY: Sec. 3042, subtitle C, title 3, Employee Retirement Income Security Act of 1974. (88 Stat. 1002, 29 U.S.C. 1241, 1242), unless otherwise noted.

SOURCE: 42 FR 39200, Aug. 3, 1977, unless otherwise noted.

§ 901.0 Scope.

This part contains rules governing the performance of actuarial services under the Employee Retirement Income Security Act of 1974, hereinafter also referred to as ERISA. Subpart A of this part sets forth definitions and eligibility to perform actuarial services; subpart B of this part sets forth rules governing the enrollment of actuaries; subpart C of this part sets forth standards of performance to which enrolled actuaries must adhere; subpart D sets forth rules applicable to suspension and termination of enrollment; and subpart E of this part sets forth general provisions.

[42 FR 39200, Aug. 3, 1977, as amended at 76 FR 17769, Mar. 31, 2011]

Subpart A—Definitions and Eligibility To Perform Actuarial Services

§ 901.1 Definitions.

As used in this part, the term:

(a) *Actuarial experience* means the performance of, or the direct supervision of, services involving the application of principles of probability and compound interest to determine the present value of payments to be made upon the fulfillment of certain specified conditions or the occurrence of certain specified events.

(b) *Responsible actuarial experience* means actuarial experience:

(1) Involving participation in making determinations that the methods and assumptions adopted in the procedures followed in actuarial services are appropriate in the light of all pertinent circumstances, and

(2) Demonstrating a thorough understanding of the principles and alternatives involved in such actuarial services.

(c) *Month of responsible actuarial experience* means a month during which the actuary spent a substantial amount of time in responsible actuarial experience.

(d) *Responsible pension actuarial experience* means responsible actuarial experience involving valuations of the liabilities of pension plans, wherein the performance of such valuations requires the application of principles of life contingencies and compound interest in the determination, under one or more standard actuarial cost methods, of such of the following as may be appropriate in the particular case:

(1) Normal cost.

(2) Accrued liability.

(3) Payment required to amortize a liability or other amount over a period of time.

(4) Actuarial gain or loss.

(e) *Month of responsible pension actuarial experience* means a month during which the actuary spent a substantial amount of time in responsible pension actuarial experience.

(f) *Applicant* means an individual who has filed an application to become an enrolled actuary.

(g) *Enrolled actuary* means an individual who has satisfied the standards and qualifications as set forth in this part and who has been approved by the Joint Board for the Enrollment of Actuaries (the Joint Board), or its designee, to perform actuarial services required under ERISA or regulations thereunder.

(h) *Actuarial services* means performance of actuarial valuations and preparation of any actuarial reports.

(i) *Certified responsible actuarial experience* means responsible actuarial experience of an individual that has been certified in writing by the individual's supervisor.

(j) *Certified responsible pension actuarial experience* means responsible pension actuarial experience of an individual that has been certified in writing by the individual's supervisor if the supervisor is an enrolled actuary. If the individual's supervisor is not an enrolled actuary, the pension actuarial experience must be certified in writing by both the supervisor and an enrolled actuary with knowledge of the individual's pension actuarial experience.

(k) *Enrollment cycle* means the three-year period from January 1, 2011, to December 31, 2013, and every three-year period thereafter.

[42 FR 39200, Aug. 3, 1977, as amended at 76 FR 17769, Mar. 31, 2011]

§ 901.2 Eligibility to perform actuarial services.

(a) *Enrolled actuary.* Subject to the standards of performance set forth in subpart C of this part, any individual who is an enrolled actuary as defined in § 901.1(g) may perform actuarial services required under ERISA or regulations thereunder. Where a corporation, partnership, or other entity is engaged to provide actuarial services, such services may be provided on its behalf only by an enrolled actuary who is an employee, partner or consultant.

(b) *Government officers and employees.* No officer or employee of the United States in the executive, legislative, or judicial branch of the Government, or in any agency of the United States, including the District of Columbia, may perform actuarial services required under ERISA or regulations thereunder if such services would be in violation of 18 U.S.C. 205. No Member of Congress or Resident Commissioner (elect or serving) may perform such actuarial services if such services would be in violation of 18 U.S.C. 203 or 205.

(c) *Former government officers and employees*—(1) *Personal and substantial participation in the performance of actuarial services.* No former officer or employee of the executive branch of the United States Government, of any independent agency of the United States, or of the District of Columbia, shall perform actuarial services required under ERISA or regulations thereunder or aid or assist in the performance of such actuarial services, in regard to particular matters, involving a specific party or parties, in which the individual participated personally and substantially as such officer or employee.

(2) *Official responsibility.* No former officer or employee of the executive branch of the United States Government, of any independent agency of the United States, or of the District of Columbia, shall, within 1 year after his employment has ceased, perform actuarial services required under ERISA or regulations thereunder in regard to any particular matter involving a specific party or parties which was under the individual's official responsibility as an officer or employee of the Government at any time within a period of 1 year prior to the termination of such responsibility.

Subpart B—Enrollment of Actuaries

§ 901.10 Application for enrollment.

(a) *Form.* As a requirement for enrollment, an applicant shall file with the Executive Director of the Joint Board a properly executed application on a form or forms specified by the Joint

Board, and shall agree to comply with these regulations and any other guidance as required by the Joint Board. A reasonable non-refundable fee may be charged for each application for enrollment filed.

(b) *Additional information.* The Joint Board or Executive Director, as a condition to consideration of an application for enrollment, may require the applicant to file additional information and to submit to written or oral examination under oath or otherwise.

(c) *Denial of application.* If the Joint Board proposes to deny an application for enrollment, the Executive Director shall notify the applicant in writing of the proposed denial and the reasons therefor, of his rights to request reconsideration, of the address to which such request should be made and the date by which such request must be made. The applicant may, within 30 days from the date of the written proposed denial, file a written request for reconsideration therefrom, together with his reasons in support thereof, to the Joint Board. The Joint Board may afford an applicant the opportunity to make a personal appearance before the Joint Board. A decision on the request for reconsideration shall be rendered by the Joint Board as soon as practicable. In the absence of a request for reconsideration within the aforesaid 30 days, the proposed denial shall, without further proceeding, constitute a final decision of denial by the Joint Board.

[42 FR 39200, Aug. 3, 1977, as amended at 76 FR 17769, Mar. 31, 2011]

§ 901.11 Enrollment procedures.

(a) *Enrollment.* The Joint Board shall enroll each applicant it determines has met the requirements of these regulations, and any other guidance as required by the Joint Board, and shall so notify the applicant. Subject to the provisions of subpart D of this part, an individual must renew his or her enrollment in the manner described in paragraph (d) of this section.

(b) *Enrollment certificate.* The Joint Board (or its designee) shall issue a certificate of enrollment to each actuary who is duly enrolled under this part.

(c) *Rosters*—(1) *Maintenance of rosters.* The Executive Director shall maintain rosters of—

(i) All actuaries who are duly enrolled under this part;

(ii) All individuals whose enrollment has been suspended or terminated; and

(iii) All individuals who are in inactive status.

(2) *Publication of rosters.* The Executive Director may publish any or all of the rosters, including display on the Joint Board's Web site, to the extent permitted by law.

(d) *Renewal of enrollment.* To maintain active enrollment to perform actuarial services under ERISA, each enrolled actuary is required to have his/her enrollment renewed as set forth herein.

(1) Each enrolled actuary must file an application for renewal of enrollment on the prescribed form no earlier than October 1, 2010, and no later than March 1, 2011, and no earlier than October 1 and no later than March 1 of every third year thereafter. If March 1 is a Saturday, Sunday, or holiday, the due date shall be the next day that is not a Saturday, Sunday, or holiday.

(2) The effective date of renewal of enrollment for an individual who files a complete renewal application within the time period described in paragraph (d)(1) of this section is the April 1 immediately following the date of application. The effective date of renewal of enrollment for an individual who files a complete renewal application after the due date described in paragraph (d)(1) of this section is the later of the April 1 immediately following the due date of application and the date of the notice of renewal.

(3) Forms required for renewal may be obtained from the Executive Director.

(4) A reasonable non-refundable fee may be charged for each application for renewal of enrollment filed.

(e) *Condition for renewal: Continuing professional education.* To qualify for renewal of enrollment, an enrolled actuary must certify, on the form prescribed by the Executive Director, that he/she has completed the applicable minimum number of hours of continuing professional education credit

required by this paragraph (e) and satisfied the recordkeeping requirements of paragraph (j) of this section.

(1) *Transition rule for renewal of enrollment effective April 1, 2011.* (i) A minimum of 36 hours of continuing professional education credit must be completed between January 1, 2008 and December 31, 2010. Of the 36 hours, at least 18 must consist of core subject matter; the remainder may be non-core subject matter.

(ii) An individual who received initial enrollment in 2008 must complete 24 hours of continuing professional education by December 31, 2010. An individual who received initial enrollment in 2009 must complete 12 hours of continuing professional education by December 31, 2010. In either case, at least one-half of the applicable hours must consist of core subject matter; the remainder may consist of non-core subject matter. For purposes of this paragraph (e)(1)(ii), credit will be awarded for continuing professional education completed after January 1 of the year in which initial enrollment was received.

(iii) An individual who receives initial enrollment during 2010 is exempt from the continuing professional education requirements during 2010, but must file a timely application for renewal during the time period described in paragraph (d)(1) of this section.

(2) *For renewal of enrollment effective April 1, 2014, and every third year thereafter.* (i) A minimum of 36 hours of continuing professional education credit must be completed between January 1, 2011 and December 31, 2013, and between January 1 and December 31 for each three-year period subsequent thereto.

(ii) An individual who receives initial enrollment during the first or second year of an enrollment cycle must satisfy the following requirements by the end of the enrollment cycle: Those enrolled during the first year of an enrollment cycle must complete 24 hours of continuing education; those enrolled during the second year of an enrollment cycle must complete 12 hours of continuing education. At least one-half of the applicable hours must be comprised of core subject matter; the remainder may be comprised of non-core subject matter. For purposes of this paragraph (e)(2)(ii), credit will be awarded for continuing professional education completed after January 1 of the year in which initial enrollment was received.

(iii) An individual who receives initial enrollment during the third year of an enrollment cycle is exempt from the continuing education requirements until the next enrollment cycle, but must file a timely application for renewal.

(iv) For an individual who was initially enrolled before January 1, 2008 (and who has therefore completed at least one full enrollment cycle as of January 1, 2011), at least 12 hours of the 36 hours of continuing professional education required for each enrollment cycle must consist of core subject matter; the remainder may consist of non-core subject matter.

(v) For an individual who was initially enrolled on or after January 1, 2008, at least 18 hours of his or her 36 hours of continuing professional education required for the first full enrollment cycle must consist of core subject matter. Thereafter, for such individuals, for each subsequent enrollment cycle at least 12 hours of the 36 hours must consist of core subject matter. In each instance, the remainder may consist of non-core subject matter.

(vi) When core subject matter hours are required (including when an individual seeks to return to active status from inactive status), an individual must complete a minimum of two hours of continuing professional education credit relating to ethical standards, regardless of the total number of core hours required.

(f) *Qualifying continuing professional education*—(1) *In general.* To qualify for continuing professional education credit an enrolled actuary must complete his/her hours of continuing professional education credit under a qualifying program, within the meaning of paragraph (f)(2) of this section, consisting of core and/or non-core subject matter. In addition, a portion of the continuing professional education credit may be earned under the provisions of paragraph (g) of this section. In any event, no less than ⅓ of the total hours of continuing professional education credit required for an enrollment cycle

must be obtained by participation in a formal program or programs, within the meaning of paragraph (f)(2)(ii)(A) of this section.

(i) Core subject matter is program content and knowledge that is integral and necessary to the satisfactory performance of pension actuarial services and actuarial certifications under ERISA and the Internal Revenue Code. Such core subject matter includes the characteristics of actuarial cost methods under ERISA, actuarial assumptions, minimum funding standards, titles I, II, and IV of ERISA, requirements with respect to the valuation of plan assets, requirements for qualification of pension plans, maximum deductible contributions, tax treatment of distributions from qualified pension plans, excise taxes related to the funding of qualified pension plans and standards of performance (including ethical standards) for actuarial services. Core subject matter includes all materials included on the syllabi of any of the pension actuarial examinations offered by the Joint Board during the current enrollment cycle and the enrollment cycle immediately preceding the current enrollment cycle.

(ii) Non-core subject matter is program content designed to enhance the knowledge of an enrolled actuary in matters related to the performance of pension actuarial services. Examples include economics, computer programming, pension accounting, investment and finance, risk theory, communication skills, and business and general tax law.

(iii) The Joint Board may publish other topics or approve other topics which may be included in a qualifying program as core or non-core subject matter.

(iv) The same course of study cannot be used more than once within a given 36-month period to satisfy the continuing professional education requirements of these regulations. A program or session bearing the same or a similar title to a previous one may be used to satisfy the requirements of these regulations if the major content of the program or session differs substantively from the previous one.

(2) *Qualifying program*—(i) *In general.* A qualifying program is a course of learning that—

(A) Is conducted by a qualifying sponsor, within the meaning of paragraph (f)(3) of this section, who identifies the program as a qualifying program;

(B) Is developed by individual(s) qualified in the subject matter;

(C) Covers current subject matter;

(D) Includes written outlines or textbooks;

(E) Is taught by instructors, discussion leaders, and speakers qualified with respect to the course content;

(F) Includes means for evaluation by the Joint Board of technical content and presentation;

(G) Provides a certificate of completion, within the meaning of paragraph (f)(3)(iv) of this section, to each person who successfully completed the program; and

(H) Provides a certificate of instruction, within the meaning of paragraph (f)(3)(v) of this section, to each person who served an instructor, discussion leader, or speaker.

(ii) *Formal programs*—(A) *Participants.* Formal programs are programs that meet all of the requirements of this paragraph (f)(2)(ii) and paragraph (f)(2)(i) of this section. Whether a program qualifies as a formal program is determined on a participant-by-participant basis. A qualifying program qualifies as a formal program with respect to a participant if the participant simultaneously participates in the program in the same physical location with at least two other participants engaged in substantive pension service, and the participants have the opportunity to interact with another individual qualified with respect to the course content who serves as an instructor, whether or not the instructor is in the same physical location. Groups of three or more participants who are in the same physical location may participate in a formal program in person or via the Internet, videoconferencing, or teleconferencing. If the qualifying program is pre-recorded, to qualify as a formal program, there must be a qualified individual who serves as the instructor and is

available to answer questions immediately following the pre-recorded program.

(B) *Instructor*. A qualifying program is a formal program with respect to the instructor only if the program is a formal program under paragraph (f)(2)(ii)(A) of this section with respect to at least three participants and the instructor is in the physical presence of at least three other individuals engaged in substantive pension service.

(3) *Qualifying sponsors*—(i) *In general*. Qualifying sponsors are organizations recognized by the Executive Director whose programs offer opportunities for continuing professional education in subject matter within the scope of this section.

(ii) *Recognition by the Executive Director*. An organization requesting qualifying sponsor status shall file a sponsor agreement request with the Executive Director and furnish information in support of such request as deemed necessary for approval by the Executive Director. Such information shall include sufficient information to establish that all programs designated as qualifying programs offered by the qualifying sponsor will satisfy the requirements of paragraph (f)(2) of this section. Recognition as a qualifying sponsor by the Executive Director shall be effective when approved, unless the Executive Director provides that it shall be effective on a different date, and shall terminate at the end of the sponsor enrollment cycle. The Executive Director may publish the names of such sponsors on a periodic basis.

(iii) *Sponsor enrollment cycle*—(A) *Transition sponsor enrollment cycle*. The transition sponsor enrollment cycle is the period beginning on January 1, 2008 and ending December 31, 2011.

(B) *Subsequent sponsor enrollment cycles*. After the transition sponsor enrollment cycle, the sponsor enrollment cycle means the three-year period from January 1, 2012, to December 31, 2014, and every three-year period thereafter.

(iv) *Certificates of completion*. Upon verification of successful completion of a qualifying program, the program's qualifying sponsor shall furnish each individual who successfully completed the qualifying program with a certificate listing the following information:

(A) The name of the participant.

(B) The name of the qualifying sponsor.

(C) The title, location, and speaker(s) of each session attended.

(D) The dates of the program.

(E) The total credit hours earned, the total core and non-core credit hours earned, and how many of those hours relate to ethics.

(F) Whether or not the program is a formal program with respect to the participant.

(v) *Certificates of instruction*. The program's qualifying sponsor shall furnish to each instructor, discussion leader, or speaker, a certificate listing the following information:

(A) The name of the instructor, discussion leader, or speaker.

(B) The name of the qualifying sponsor.

(C) The title and location of the program.

(D) The dates of the program.

(E) The total credit hours earned and the total core and non-core credit hours earned for the program, and how many of those hours relate to ethics.

(F) Whether or not the program is a formal program with respect to the instructor.

(g) *Alternative means for completion of credit hours*—(1) *In general*. In addition to credit hours completed under paragraph (f) of this section, an enrolled actuary may be awarded continuing professional education credit under the provisions of this paragraph (g).

(2) *Serving as an instructor, discussion leader or speaker*. (i) Four credit hours (that is, 200 minutes) of continuing professional education credit will be awarded for each 50 minutes completed as an instructor, discussion leader, or speaker at a qualifying program which meets the continuing professional education requirements of paragraph (f) of this section. If the qualifying program is a formal program with respect to the instructor, only the time spent during the actual program is counted toward satisfaction of the formal program requirement.

(ii) The credit for instruction and preparation may not exceed 50 percent of the continuing professional education requirement for an enrollment cycle.

(iii) Presentation of the same material as an instructor, discussion leader, or speaker more than one time in any 36-month period will not qualify for continuing professional education credit. A program will not be considered to consist of the same material if a substantial portion of the content has been revised to reflect changes in the law or practices relative to the performance of pension actuarial service.

(iv) Credit as an instructor, discussion leader, or speaker will not be awarded to panelists, moderators, or others who are not required to prepare substantive subject matter for their portion of the program. However, such individuals may be awarded credit for attendance, provided the other provisions of this section are met.

(v) The nature of the subject matter will determine if credit will be of a core or non-core nature.

(3) *Credit for publications.* (i) Continuing professional education credit will be awarded for the creation of peer-reviewed materials for publication or distribution with respect to matters directly related to the continuing professional education requirements of this section. Credit will be awarded to the author, co-author, or a person listed as a major contributor.

(ii) One hour of credit will be allowed for each hour of preparation time of the material. It will be the responsibility of the person claiming the credit to maintain records to verify preparation time.

(iii) Publication or distribution may utilize any available technology for the dissemination of written, visual or auditory materials.

(iv) The materials must be available on reasonable terms for acquisition and use by all enrolled actuaries.

(v) The credit for the creation of materials may not exceed 25 percent of the continuing professional education requirement of any enrollment cycle.

(vi) The nature of the subject matter will determine if credit will be of a core or non-core nature.

(vii) Publication of the same material more than one time will not qualify for continuing professional education credit. A publication will not be considered to consist of the same material if a substantial portion has been revised to reflect changes in the law or practices relative to the performance of pension actuarial service.

(4) *Service on Joint Board advisory committee(s).* Continuing professional education credit may be awarded by the Joint Board for service on (any of) its advisory committee(s), to the extent that the Joint Board considers warranted by the service rendered.

(5) *Preparation of Joint Board examinations.* Continuing professional education credit may be awarded by the Joint Board for participation in drafting questions for use on Joint Board examinations or in pretesting its examinations, to the extent the Joint Board determines suitable. Such credit may not exceed 50 percent of the continuing professional education requirement for the applicable enrollment cycle.

(6) *Examinations sponsored by professional organizations or societies.* Individuals may earn continuing professional education credit for achieving a passing grade on proctored examinations sponsored by a professional organization or society recognized by the Joint Board. Such credit is limited to the number of hours scheduled for each examination and may be applied only as non-core credit provided the content of the examination is core or non-core. No credit may be earned for hours attributable to any content that is neither core nor non-core.

(7) *Joint Board pension examination.* Individuals may establish eligibility for renewal of enrollment for any enrollment cycle by—

(i) Achieving a passing score on the Joint Board pension examination, as described in §901.12(d)(1)(i), administered under this part during the applicable enrollment cycle; and

(ii) Completing a minimum of 12 hours of qualifying continuing professional education by attending formal program(s) during the same applicable enrollment cycle. This option of satisfying the continuing professional education requirements is not available to those who receive initial enrollment during the enrollment cycle.

(h) *Measurement of continuing education course work.* (1) All continuing education programs will be measured in terms of credit hours. The shortest

recognized program will be one credit hour.

(2) A credit hour is 50 minutes of continuous participation in a program. Each session in a program must be at least one full credit hour, *i.e.*, 50 minutes. For example, a single-session program lasting 100 minutes will count as two credit hours, and a program comprised of three 75 minute sessions (225 minutes) constitutes four credit hours. However, at the end of an enrollment cycle, an individual may total the number of minutes of sessions of at least one credit hour in duration attended during the cycle and divide by fifty. For example, attending three 75 minute segments at two separate programs will accord an individual nine credit hours (450 minutes divided by 50) toward fulfilling the minimum number of continuing professional education hours. It will not be permissible to merge non-core hours with core hours.

(i) [Reserved]

(j) *Recordkeeping requirements*—(1) *Qualifying sponsors.* A qualifying sponsor must maintain records to verify that each program it sponsors is a qualifying program within the meaning of paragraph (f)(2) of this section, including the certificates of completion, certificates of instruction, and outlines and course material. In the case of programs of more than one session, records must be maintained to verify each session of the program that is completed by each participant. Records required to be maintained under this paragraph must be retained by the qualifying sponsor for a period of six years following the end of the sponsor enrollment cycle in which the program is held.

(2) *Enrolled actuaries*—(i) *Qualifying program credits as a participant.* To receive continuing professional education credit for completion of hours of continuing professional education under paragraph (f) of this section, an enrolled actuary must retain all certificates of completion evidencing completion of such hours for the three-year period following the end of the enrollment cycle in which the credits are earned.

(ii) *Qualifying program credits as an instructor, discussion leader, or speaker.* To receive continuing professional education credit for completion of hours earned under paragraph (g)(2) of this section, an enrolled actuary must retain all certificates of instruction evidencing completion of such hours for the three-year period following the end of the enrollment cycle in which the credits are earned.

(iii) *Credit for publications.* To receive continuing professional education credit for a publication under paragraph (g)(3) of this section, the following information must be maintained by the enrolled actuary for the three-year period following the end of the enrollment cycle in which the credits are earned:

(A) The name of the publisher.

(B) The title and author of the publication.

(C) A copy of the publication.

(D) The date of the publication.

(E) The total credit hours earned, and the total core and non-core credit hours earned, and how many of those hours relate to ethics.

(iv) *Other credits.* To receive continuing professional education credit for hours earned under paragraphs (g)(4) through (g)(7) of this section, an enrolled actuary must retain sufficient documentation to establish completion of such hours for the three-year period following the end of the enrollment cycle in which the credits are earned.

(k) *Waivers.* (1) Waiver from the continuing professional education requirements for a given period may be granted by the Executive Director only under extraordinary circumstances, and upon submission of sufficient evidence that every effort was made throughout the enrollment cycle to participate in one or more qualifying programs that would have satisfied the continuing professional education requirements.

(2) A request for waiver must be accompanied by appropriate documentation. The individual will be required to furnish any additional documentation or explanation deemed necessary by the Executive Director.

(3) The individual will be notified by the Executive Director of the disposition of the request for waiver. If the waiver is not approved, and the individual does not otherwise satisfy the

continuing professional education requirements within the allotted time, the individual will be placed on the roster of inactive enrolled individuals.

(4) Individuals seeking to rely on a waiver of the continuing professional education requirements must receive the waiver from the Executive Director before filing an application for renewal of enrollment.

(l) *Failure to comply*. (1) Compliance by an individual with the requirements of this part shall be determined by the Executive Director. An individual who applies for renewal of enrollment but who fails to meet the requirements of eligibility for renewal will be notified by the Executive Director at his/her last known address by first class mail. The notice will state the basis for the non-compliance and will provide the individual an opportunity to furnish in writing, within 60 days of the date of the notice, information relating to the matter. Such information will be considered by the Executive Director in making a final determination as to eligibility for renewal of enrollment.

(2) The Executive Director may require any individual, by first class mail sent to his/her mailing address of record with the Joint Board, to provide copies of any records required to be maintained under this section. The Executive Director may disallow any continuing professional education hours claimed if the individual concerned fails to comply with such requirements.

(3) An individual whose application for renewal is not approved may seek review of the matter by the Joint Board. A request for review and the reasons in support of the request must be filed with the Joint Board within 30 days of the date of the notice of failure to comply.

(4) *Inactive status*—(i) *Automatic placement on the inactive roster*. To remain on the roster of active enrolled actuaries, an enrolled actuary must submit a timely application for renewal showing satisfaction of the requirements for reenrollment, including completion of the required continuing professional education hours, within the appropriate time frame. The Executive Director will move an enrolled actuary who does not submit such an application for reenrollment from the roster of enrolled actuaries to the roster of inactive enrolled actuaries as of April 1 following the March 1 due date for the application. However, if an enrolled actuary completes the required number of continuing professional education hours after the close of the enrollment cycle, submits an application for reenrollment, and is informed by the Executive Director before April 1st that the enrollment has been renewed, then the Executive Director will not move such individual to the roster of inactive enrolled actuaries at that time.

(ii) *Placement on the inactive roster after notice and right to respond*. The Executive Director will move an enrolled actuary who does not submit a timely application of renewal that shows timely completion of the required continuing professional education to the inactive roster only after giving the enrolled actuary 60 days to respond as described in paragraph (l)(1) of this section.

(iii) *Length on time on inactive roster*. An individual may remain on the roster of inactive enrolled actuaries for a period up to three enrollment cycles from the date renewal would have been effective.

(iv) *Consequence of being on the inactive roster*. An individual in inactive status will be ineligible to perform pension actuarial services as an enrolled actuary under ERISA and the Internal Revenue Code. During such time in inactive status or at any other time an individual is ineligible to perform pension actuarial services as an enrolled actuary, the individual shall not in any manner, directly or indirectly, indicate he or she is so enrolled, or use the term ''enrolled actuary,'' the designation ''E.A.,'' or other form of reference to eligibility to perform pension actuarial services as an enrolled actuary.

(v) *Returning to active status*. An individual placed in inactive status may return to active status by filing an application for renewal of enrollment (with the appropriate fee) and providing evidence of the completion of all required continuing professional education hours and of satisfaction of any applicable requirements for qualifying experience under paragraph (l)(7) of

this section. If an application for return to active status is approved, the individual will be eligible to perform services as an enrolled actuary effective with the date the notice of approval is mailed to that individual by the Executive Director.

(5) *Time for return to active enrollment.* (i) An individual placed in inactive status must file an application for return to active enrollment, and satisfy the requirements for return to active enrollment as set forth in this section, within three enrollment cycles of being placed in inactive status. Otherwise, the name of such individual will be removed from the inactive enrollment roster and his/her enrollment will terminate.

(ii) For purposes of paragraph (l)(5)(i) of this section, an individual who is in inactive or retired status as of April 1, 2010, will be deemed to have been placed in inactive status on April 1, 2010.

(6) An individual in inactive status may satisfy the requirements for return to active enrollment at any time during his/her period of inactive enrollment. If only completion of the continuing professional education requirement is necessary, the application for return to active enrollment may be filed immediately upon such completion. If qualifying experience is also required, the application for return to active enrollment may not be filed until the completion of both the continuing professional education and qualifying experience requirements set forth in this subsection. Continuing professional education credits applied to meet the requirements for reenrollment under this paragraph (l)(6) may not be used to satisfy the requirements of the enrollment cycle in which the individual has been placed back on the active roster.

(7) *Continuing professional education requirements for return to active enrollment from inactive status.* (i) During the first inactive enrollment cycle; 36 hours of qualifying continuing professional education as set forth in paragraph (e)(2) of this section, without regard to paragraph (e)(2)(ii) or (e)(2)(iii) of this section, must be completed. Any hours of continuing professional education credit earned during the immediately prior enrollment cycle may be applied in satisfying this requirement.

(ii) During the second inactive enrollment cycle; four-thirds of the qualifying continuing professional education requirements as set forth in paragraph (e)(2) of this section (that is, 48 hours), without regard to paragraph (e)(2)(ii) or (e)(2)(iii) of this section, plus eighteen months of certified responsible pension actuarial experience, must be completed since the start of the first inactive enrollment cycle. Any hours of continuing professional education credit earned during the first inactive enrollment cycle may be applied in satisfying this requirement.

(iii) During the third inactive enrollment cycle: Five-thirds of the qualifying continuing professional education requirements as set forth in paragraph (e)(2) of this section, (that is, 60 hours), without regard to paragraph (e)(2)(ii) or (e)(2)(iii) of this section plus eighteen months of certified responsible pension actuarial experience, must be completed since the start of the second inactive enrollment cycle. Any hours of continuing professional education credit earned during the second inactive enrollment cycle may be applied in satisfying this requirement. No hours earned during the first inactive enrollment cycle may be applied in satisfying this requirement.

(8) An individual in inactive status remains subject to the jurisdiction of the Joint Board and/or the Department of the Treasury with respect to disciplinary matters.

(9) An individual who has certified in good faith that he/she has satisfied the continuing professional education requirements of this section will not be considered to be in non-compliance with such requirements on the basis of a program he/she has attended later being found inadequate or not in compliance with the requirements for continuing professional education. Such individual will be granted renewal, but the Executive Director may require such individual to remedy the resulting shortfall by earning replacement credit during the cycle in which renewal was granted or within a reasonable time period as determined by the Executive Director. For example, if six of the credit hours claimed were disallowed,

the individual may be required to present 42 credit hours instead of the minimum 36 credit hours to qualify for renewal related to the next cycle.

(m) *Renewal while under suspension or disbarment.* An individual who is ineligible to perform actuarial services and/or to practice before the Internal Revenue Service by virtue of disciplinary action is required to meet the requirements for renewal of enrollment during the period of such ineligibility.

(n) *Verification.* The Executive Director or his/her designee may request and review the continuing professional education records of an enrolled actuary, including programs attended, in a manner deemed appropriate to determine compliance with the requirements and standards for the renewal of enrollment as provided in this section. The Executive Director may also request and review the records of any qualifying sponsor in a manner deemed appropriate to determine compliance with the requirements of paragraphs (f)(3) and (j)(1) of this section.

(o) *Examples.* The following examples illustrate the application of the rules of paragraph (l)(7) of this section and the effective date of an enrolled actuary's renewal:

Example 1. Individual E, who was initially enrolled before January 1, 2008, completes 12 hours of core continuing professional education credit and 24 hours of non-core continuing professional education credit between January 1, 2011, and December 31, 2013. E files a complete application for reenrollment on February 28, 2014. E's reenrollment is effective as of April 1, 2014.

Example 2. Individual F, who was initially enrolled before January 1, 2008, also completes 12 hours of core continuing professional education credit and 24 hours of noncore continuing professional education credit between January 1, 2011, and December 31, 2013. However, F does not file an application for reenrollment until March 20, 2014. The Joint Board notifies F that it has granted F's application on June 25, 2014. Accordingly, effective April 1, 2014, F is placed on the roster of inactive enrolled actuaries. F returns to active status as of June 25, 2014. F is ineligible to perform pension actuarial services as an enrolled actuary under ERISA and the Internal Revenue Code from April 1 through June 24, 2014.

Example 3. Individual G, who was initially enrolled before January 1, 2008, completes only 8 hours of core continuing professional education credit and 24 hours of non-core continuing professional education credit between January 1, 2011, and December 31, 2013. G completes another 6 hours of core continuing professional education on January 15, 2014, and files an application for return to active status on January 20, 2014. G's application shows the timely completion of 32 hours of continuing professional education plus the additional 4 hours of continuing professional education earned after the end of the enrollment cycle. The Joint Board notifies G that it has granted the application on April 20, 2014. Accordingly, effective April 1, 2014, G is placed on the roster of inactive enrolled actuaries. G returns to active status as of April 20, 2014. G is ineligible to perform pension actuarial services as an enrolled actuary under ERISA and the Internal Revenue Code from April 1 through April 19, 2014. Of the 6 hours of continuing professional education earned by G on January 15, 2014, only 2 hours may be applied to the enrollment cycle that ends December 31, 2016.

Example 4. (i) Individual H, who was initially enrolled before January 1, 2008, completes 5 hours of core continuing professional education credit and 10 hours of non-core continuing professional education credit between January 1, 2011, and December 31, 2013. Accordingly, effective April 1, 2014, H is placed on the roster of inactive enrolled actuaries and is ineligible to perform pension actuarial services as an enrolled actuary under ERISA and the Internal Revenue Code.

(ii) H completes 7 hours of core continuing professional education credit and 14 hours of noncore continuing professional education credit between January 1, 2014, and May 24, 2016. Because H has completed 12 hours of core continuing professional education and 24 hours of non-core continuing professional education during the last active enrollment period and the initial period when on inactive status, H has satisfied the requirements for reenrollment during the first inactive cycle. Accordingly, H may file an application for return to active enrollment on May 24, 2016. If this application is approved, H will be eligible to perform pension actuarial services as an enrolled actuary under ERISA and the Internal Revenue Code, effective with the date of such approval.

(iii) Because H used the 21 hours of continuing professional education credit earned after January 1, 2014, for return from inactive status, H may not apply any of these 21 hours of core and non-core continuing professional education credits towards the requirements for renewed enrollment effective April 1, 2017. Accordingly, H must complete an additional 36 hours of continuing professional education (12 core and 24 non-core) prior to December 31, 2016, to be eligible for renewed enrollment effective April 1, 2017.

Example 5. (i) The facts are the same as in *Example 4* except H completes 2 hours of core continuing professional education credit and

8 hours of non-core continuing professional education credit between January 1, 2014, and December 31, 2016. Thus, because H did not fulfill the requirements for return to active status during his first inactive cycle, H must satisfy the requirements of paragraph (l)(7)(ii) of this section in order to return to active status.

(ii) Accordingly, in order to be eligible to file an application for return to active status on or before December 31, 2019, H must complete an additional 38 hours of continuing professional education credit (of which at least 14 hours must consist of core subject matter) between January 1, 2017, and December 31, 2019, and have 18 months of certified responsible pension actuarial experience during the period beginning on January 1, 2014.

(iii) Note that the 5 hours of core continuing professional education credit and the 10 hours of non-core continuing professional education credit that H completes between January 1, 2011, and December 31, 2013, are not counted toward H's return to active status and are also not taken into account toward the additional hours of continuing professional education credit that H must complete between January 1, 2017, and December 31, 2019, in order to apply for renewal of enrollment effective April 1, 2020.

Example 6. (i) The facts are the same as in *Example 4* except H completes 2 hours of core continuing professional education credit and 8 hours of non-core continuing professional education credit between January 1, 2014, and December 31, 2016, and 12 hours of core continuing professional education credit and 24 hours of non-core continuing professional education credit between January 1, 2017, and December 31, 2019. Thus, because H did not fulfill the requirements for return to active status during his first or second inactive cycles, H must satisfy the requirements of paragraph (l)(7)(iii) of this section in order to return to active status.

(ii) Accordingly, in order to be eligible to file an application for return to active status on or before December 31, 2022, H must complete an additional 24 hours of continuing professional education credit (of which, at least 8 hours must consist of core subject matter) between January 1, 2020 and December 31, 2022, and have at least 18 months of certified responsible pension actuarial experience during the period beginning on January 1, 2017.

(iii) Note that the total of 15 hours of continuing professional education credit that H completes between January 1, 2011, and December 31, 2013, as well as the 10 hours of continuing professional education credit between January 1, 2014, and December 31, 2016, are not counted toward H's return to active status and are not taken into account toward the additional hours of continuing professional education credit that H must complete between January 1, 2020, and December 31, 2022, in order to be eligible to file an application for renewal of enrollment active status effective April 1, 2023.

Example 7. (i) Individual J, who was initially enrolled July 1, 2012, completes 1 hour of core continuing professional education credit and 2 hours of non-core continuing professional education credit between January 1, 2012, and December 31, 2013. Accordingly, effective April 1, 2014, J is placed on the roster of inactive enrolled actuaries and is ineligible to perform pension actuarial services as an enrolled actuary under ERISA and the Internal Revenue Code.

(ii) J completes 5 hours of core continuing professional education credit and 4 hours of non-core continuing professional education credit between January 1, 2014, and October 6, 2014. Because J did not complete the required 12 hours of continuing professional education (of which at least 6 hours must consist of core subject matter) during J's initial enrollment cycle, J is not eligible to file an application for a return to active enrollment on October 6, 2014, notwithstanding the fact that had J completed such hours between January 1, 2012, and December 31, 2013, J would have satisfied the requirements for renewed enrollment effective April 1, 2014.

(iii) Accordingly, J must complete an additional 24 hours of continuing professional education (of which at least 12 hours must consist of core subject matter) during his/her first inactive enrollment cycle before applying for renewal of enrollment.

Example 8. The facts are the same as in *Example 7* except that J completes 17 hours of core continuing professional education credit and 16 hours of non-core continuing professional education credit between January 1, 2014, and February 12, 2015. Accordingly, because as of February 12, 2015, J satisfied the continuing professional education requirements as set forth in paragraph (e)(2) of this section without regard to paragraph (e)(2)(ii) thereof, J may file an application for return to active enrollment status on February 12, 2015.

(p) With the exception of paragraphs (e)(1) and (f)(3)(iii) of this section, this section applies to the enrollment cycle beginning January 1, 2011, and all subsequent enrollment cycles.

[42 FR 39200, Aug. 3, 1977, as amended at 53 FR 34484, Sept. 7, 1988; 76 FR 17769, Mar. 31, 2011; 76 FR 81363, Dec. 28, 2011]

§ 901.12 Eligibility for enrollment.

(a) *In general.* An individual applying to be an enrolled actuary must fulfill

the experience requirement of paragraph (b) of this section, the basic actuarial knowledge requirement of paragraph (c) of this section, and the pension actuarial knowledge requirement of paragraph (d) of this section.

(b) *Qualifying experience.* Within the 10-year period immediately preceding the date of application, the applicant shall have completed either—

(1) A minimum of 36 months of certified responsible pension actuarial experience; or

(2) A minimum of 60 months of certified responsible actuarial experience, including at least 18 months of certified responsible pension actuarial experience.

(c) *Basic actuarial knowledge.* The applicant shall demonstrate knowledge of basic actuarial mathematics and methodology by one of the following:

(1) *Joint Board basic examination.* Successful completion, to a score satisfactory to the Joint Board, of an examination, prescribed by the Joint Board, in basic actuarial mathematics and methodology including compound interest, principles of life contingencies, commutation functions, multiple-decrement functions, and joint life annuities.

(2) *Organization basic examinations.* Successful completion, to a score satisfactory to the Joint Board, of one or more proctored examinations which are given by an actuarial organization and which the Joint Board has determined cover substantially the same subject areas, have at least a comparable level of difficulty, and require at least the same competence as the Joint Board basic examination referred to in paragraph (c)(1) of this section.

(3) *Qualifying formal education.* Receipt of a bachelor's or higher degree from an accredited college or university after the satisfactory completion of a course of study:

(i) In which the major area of concentration was actuarial mathematics, or

(ii) Which included at least as many semester hours or quarter hours each in mathematics, statistics, actuarial mathematics and other subjects as the Board determines represent equivalence to paragraph (c)(3)(i) of this section.

(d) *Pension actuarial knowledge.* (1) The applicant shall demonstrate pension actuarial knowledge by one of the following:

(i) *Joint Board pension examination.* Successful completion, within the 10-year period immediately preceding the date of the application, to a score satisfactory to the Joint Board, of an examination prescribed by the Joint Board in actuarial mathematics and methodology relating to pension plans, including the provisions of ERISA relating to the minimum funding requirements and allocation of assets on plan termination.

(ii) *Organization pension examinations.* Successful completion, within the 10-year period immediately preceding the date of the application, to a score satisfactory to the Joint Board, of one or more proctored examinations which are given by an actuarial organization and which the Joint Board has determined cover substantially the same subject areas, have at least a comparable level of difficulty, and require at least the same competence as the Joint Board pension examination referred to in paragraph (d)(1)(i) of this section.

(2) For purposes of this section, the date of successful completion of an examination is generally the date a candidate sits for the examination, provided that the candidate receives a passing grade on that examination. However, an applicant who sat for an examination prior to the effective date of these regulations will be deemed to have sat for such examination on the effective date.

(e) *Form; fee.* An applicant who wishes to take an examination administered by the Joint Board under paragraph (c)(1) or (d)(1) of this section shall file an application on a form prescribed by the Joint Board. Such application shall be accompanied by payment in the amount set forth on the application form. The amount represents a fee charged to each applicant for examination and is designed to cover the costs for the administration of the examination. The fee shall be retained whether or not the applicant successfully completes the examination or is enrolled.

(f) *Denial of enrollment.* An applicant may be denied enrollment if:

(1) The Joint Board finds that the applicant, during the 15-year period immediately preceding the date of application and on or after the applicant's eighteenth birthday has engaged in disreputable conduct. The term disreputable conduct includes, but is not limited to:

(i) An adjudication, decision, or determination by a court of law, a duly constituted licensing or accreditation authority (other than the Joint Board), or by any federal or state agency, board, commission, hearing examiner, administrative law judge, or other official administrative authority, that the applicant has engaged in conduct evidencing fraud, dishonesty or breach of trust.

(ii) Giving false or misleading information, or participating in any way in the giving of false or misleading information, to the Department of the Treasury or the Department of Labor or the Pension Benefit Guaranty Corporation or any officer or employee thereof in connection with any matter pending or likely to be pending before them, knowing such information to be false or misleading.

(iii) Willfully failing to make a Federal tax return in violation of the revenue laws of the United States, or evading, attempting to evade, or participating in any way in evading or attempting to evade any federal tax or payment thereof, knowingly counseling or suggesting to a client or prospective client an illegal plan to evade federal taxes or payment thereof, or concealing assets of himself or another to evade federal taxes or payment thereof.

(iv) Directly or indirectly attempting to influence, or offering or agreeing to attempt to influence, the official action of any officer or employee of the Department of the Treasury or the Department of Labor or the Pension Benefit Guaranty Corporation by the use of threats, false accusations, duress or coercion, by the offer of any special inducement or promise of advantage or by the bestowing of any gift, favor, or thing of value.

(v) Disbarment or suspension from practice as an actuary, attorney, certified public accountant, public accountant, or an enrolled agent by any duly constituted authority of any state, possession, territory, Commonwealth, the District of Columbia, by any Federal Court of record, or by the Department of the Treasury.

(vi) Contemptuous conduct in connection with matters before the Department of the Treasury, or the Department of Labor, or the Pension Benefit Guaranty Corporation including the use of abusive language, making false accusations and statements knowing them to be false, or circulating or publishing malicious or libelous matter.

(2) The applicant has been convicted of any of the offenses referred to in section 411 of ERISA.

(3) The applicant has submitted false or misleading information on an application for enrollment to perform actuarial services or in any oral or written information submitted in connection therewith or in any report presenting actuarial information to any person, knowing the same to be false or misleading.

(Sec. 3042, subtitle C, title 3, Employee Retirement Income Security Act of 1974 (88 Stat. 1002, 29 U.S.C. 1241, 1242), and the Act of August 31, 1951, ch. 376, title V, section 501, 65 Stat. 290, 31 U.S.C. 483a)

[44 FR 11751, Mar. 2, 1979, as amended at 44 FR 68458, Nov. 29, 1979. Redesignated and amended at 76 FR 17774, Mar. 31, 2011]

Subpart C—Standards of Performance for Enrolled Actuaries

§ 901.20 Standards of performance of actuarial services.

In the discharge of duties required by ERISA of enrolled actuaries with respect to any plan to which the Act applies:

(a) *In general.* An enrolled actuary shall undertake an actuarial assignment only when qualified to do so.

(b) *Professional duty.* (1) An enrolled actuary shall perform actuarial services only in a manner that is fully in accordance with all of the duties and requirements for such persons under applicable law and consistent with relevant generally accepted standards for professional responsibility and ethics.

(2) An enrolled actuary shall not perform actuarial services for any person

or organization which he/she believes, or has reasonable grounds to believe, may utilize his/her services in a fraudulent manner or in a manner inconsistent with law.

(c) *Advice or explanations.* An enrolled actuary shall provide to the plan administrator upon appropriate request, supplemental advice or explanation relative to any report signed or certified by such enrolled actuary.

(d) *Conflicts of interest.* (1) Except as provided in paragraph (d)(2) of this section, an enrolled actuary shall not perform actuarial services for a client if the representation involves a conflict of interest. A conflict of interest exists if—

(i) The representation of one client will be directly adverse to another client; or

(ii) There is a significant risk that the representation of one or more clients will be materially limited by the enrolled actuary's responsibilities to another client, a former client, or by a personal interest of the enrolled actuary.

(2) Notwithstanding the existence of a conflict of interest under paragraph (d)(1) of this section, the enrolled actuary may represent a client if—

(i) The enrolled actuary reasonably believes that he or she will be able to provide competent and diligent representation to each affected client;

(ii) The representation is not prohibited by law; and

(iii) Each affected client waives the conflict of interest and gives informed consent at the time the existence of the conflict of interest is known by the enrolled actuary.

(e) *Assumptions, calculations and recommendations.* (1) The enrolled actuary shall exercise due care, skill, prudence and diligence when performing actuarial services under ERISA and the Internal Revenue Code. In particular, in the course of preparing a report or certificate stating actuarial costs or liabilities, the enrolled actuary shall ensure that—

(i) Except as mandated by law, the actuarial assumptions are reasonable individually and in combination, and the actuarial cost method and the actuarial method of valuation of assets are appropriate;

(ii) The calculations are accurately carried out and properly documented; and

(iii) The report, any recommendations, and any supplemental advice or explanation relative to the report reflect the results of the calculations.

(2) An enrolled actuary shall include in any report or certificate stating actuarial costs or liabilities, a statement or reference describing or clearly identifying the data, any material inadequacies therein and the implications thereof, and the actuarial methods and assumptions employed.

(f) *Due diligence.* (1) An enrolled actuary must exercise due diligence—

(i) In preparing or assisting in the preparation of, approving, and filing tax returns, documents, affidavits, and other papers relating to the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, or any other applicable Federal or State entity;

(ii) In determining the correctness of oral or written representations made by the enrolled actuary to the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, or any other applicable Federal or State entity; and

(iii) In determining the correctness of oral or written representations made by the enrolled actuary to clients.

(2) An enrolled actuary advising a client to take a position on any document to be filed with the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, or any other applicable Federal or State entity (or preparing or signing such a return or document) generally may rely in good faith without verification upon information furnished by the client. The enrolled actuary may not, however, ignore the implications of information furnished to, or actually known by, the enrolled actuary, and must make reasonable inquiries if the information as furnished appears to be incorrect, inconsistent with an important fact or another factual assumption, or incomplete.

(g) *Solicitations regarding actuarial services.* An enrolled actuary may not in any way use or participate in the use of any form of public communication or private solicitation related to

the performance of actuarial services containing a false, fraudulent, or coercive statement or claim, or a misleading or deceptive statement or claim. An enrolled actuary may not make, directly or indirectly, an uninvited written or oral solicitation of employment related to actuarial services if the solicitation violates Federal or State law, nor may such person employ, accept employment in partnership form, corporate form, or any other form, or share fees with, any individual or entity who so solicits. Any lawful solicitation related to the performance of actuarial services made by or on behalf of an enrolled actuary must clearly identify the solicitation as such and, if applicable, identify the source of the information used in choosing the recipient.

(h) *Prompt disposition of pending matters.* An enrolled actuary may not unreasonably delay the prompt disposition of any matter before the Internal Revenue Service, the Department of Labor, the Pension Benefit Guaranty Corporation, or any other applicable Federal or State entity.

(i) [Reserved]

(j) *Return of client's records.* (1) In general, an enrolled actuary must, at the request of a client, promptly return any and all records of the client that are necessary for the client to comply with his or her legal obligations. The enrolled actuary may retain copies of the records returned to a client. The existence of a dispute over fees generally does not relieve the enrolled actuary of his or her responsibility under this section. Nevertheless, if applicable State law allows or permits the retention of a client's records by an enrolled actuary in the case of a dispute over fees for services rendered, the enrolled actuary need only return those records that must be attached to the client's required forms under ERISA and the Internal Revenue Code. The enrolled actuary, however, must provide the client with reasonable access to review and copy any additional records of the client retained by the enrolled actuary under State law that are necessary for the client to comply with his or her obligations under ERISA and the Internal Revenue Code.

(2) For purposes of this section, records of the client include all documents or written or electronic materials provided to the enrolled actuary, or obtained by the enrolled actuary in the course of the enrolled actuary's representation of the client, that preexisted the retention of the enrolled actuary by the client. The term ''records of the client'' also includes materials that were prepared by the client or a third party (not including an employee or agent of the enrolled actuary) at any time and provided to the enrolled actuary with respect to the subject matter of the representation. The term ''records of the client'' also includes any return, claim for refund, schedule, affidavit, appraisal or any other document prepared by the enrolled actuary, or his or her employee or agent, that was presented to the client with respect to a prior representation if such document is necessary for the taxpayer to comply with his or her current obligations under ERISA and the Internal Revenue Code. The term ''records of the client'' does not include any return, claim for refund, schedule, affidavit, appraisal or any other document prepared by the enrolled actuary or the enrolled actuary's firm, employees or agents if the enrolled actuary is withholding such document pending the client's performance of its contractual obligation to pay fees with respect to such document.

(k) *Notification.* An enrolled actuary shall provide written notification of the non-filing of any actuarial document he/she has signed upon discovery of the non-filing. Such notification shall be made to the office of the Internal Revenue Service, the Department of Labor, or the Pension Benefit Guaranty Corporation where such document should have been filed.

(l) The rules of this section apply to all actuarial services and related acts performed on or after May 2, 2011.

[40 FR 18776, Apr. 30, 1975, as amended at 43 FR 39757, Sept. 7, 1978; 76 FR 17775, Mar. 31, 2011]

Subpart D—Suspension or Termination of Enrollment

AUTHORITY: Sec. 3042(b), ERISA, 29 U.S.C. 1242(b).

SOURCE: 43 FR 39757, Sept. 7, 1978, unless otherwise noted.

§ 901.30 Authority to suspend or terminate enrollment.

Under section 3042(b) of ERISA the Joint Board may, after notice and opportunity for a hearing, suspend or terminate the enrollment of an enrolled actuary if the Joint Board finds that such enrolled actuary

(a) Has failed to discharge his/her duties under ERISA, or

(b) Does not satisfy the requirements for enrollment in effect at the time of his/her enrollment.

§ 901.31 Grounds for suspension or termination of enrollment.

(a) *Failure to satisfy requirements for enrollment.* The enrollment of an actuary may be terminated if it is found that the actuary did not satisfy the eligibility requirements set forth in § 901.11 or § 901.12.

(b) *Failure to discharge duties.* The enrollment of an actuary may be suspended or terminated if it is found that the actuary, following enrollment, failed to discharge his/her duties under ERISA. Such duties include those set forth in § 901.20.

(c) *Disreputable conduct.* The enrollment of an actuary may be suspended or terminated if it is found that the actuary has, at any time after he/she applied for enrollment, engaged in any conduct set forth in § 901.12(f) or other conduct evidencing fraud, dishonesty, or breach of trust. Such other conduct includes, but is not limited to, the following:

(1) Conviction of any criminal offense under the laws of the United States (including section 411 of ERISA, 29 U.S.C. 1111), any State thereof, the District of Columbia, or any territory or possession of the United States, which evidences fraud, dishonesty, or breach of trust.

(2) Knowingly filing false or altered documents, affidavits, financial statements or other papers on matters relating to employee benefit plans or actuarial services.

(3) Knowingly making false or misleading representations, either orally or in writing, on matters relating to employee benefit plans or actuarial services, or knowingly failing to disclose information relative to such matters.

(4) The use of false or misleading representations with intent to deceive a client or prospective client, or of intimations that the actuary is able to obtain special consideration or action from an officer or employee of any agency or court authorized to determine the validity of pension plans under ERISA.

(5) Willful violation of any of the regulations contained in this part.

[43 FR 39757, Sept. 7, 1978, as amended at 76 FR 17776, Mar. 31, 2011]

§ 901.32 Receipt of information concerning enrolled actuaries.

If an officer or employee of the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, or a member of the Joint Board has reason to believe that an enrolled actuary has violated any provision of this part, or if any such officer, employee or member receives information to that effect, he/she may make a written report thereof, which report or a copy thereof shall be forwarded to the Executive Director. If any other person has information of any such violation, he/she may make a report thereof to the Executive Director.

[43 FR 39757, Sept. 7, 1978, as amended at 76 FR 17776, Mar. 31, 2011]

§ 901.33 Initiation of proceeding.

Whenever the Executive Director has reason to believe that an enrolled actuary has violated any provision of the laws or regulations governing enrollment, such individual may be reprimanded or a proceeding may be initiated for the suspension or termination of such individual's enrollment. A reprimand as used in this paragraph is a

statement informing the enrolled actuary that, in the opinion of the Executive Director, his/her conduct is in violation of the regulations and admonishing the enrolled actuary that repetition of the conduct occasioning the reprimand may result in the institution of a proceeding for the suspension or termination of the actuary's enrollment. A proceeding for suspension or termination of enrollment shall be initiated by a complaint naming the respondent actuary, signed by the Executive Director and filed in the Executive Director's office. Except in cases where the nature of the proceeding or the public interest does not permit, a proceeding will not be initiated under this section until the facts which may warrant such a proceeding have been called to the attention of the actuary in writing and he/she has been given an opportunity to respond to the allegations of misconduct.

§ 901.34 Conferences.

(a) *In general.* The Executive Director may confer with an enrolled actuary concerning allegations of his/her misconduct whether or not a proceeding for suspension or termination has been initiated against him/her. If the conference results in agreement as to certain facts or other matters in connection with such a proceeding, such agreement may be entered in the record at the request of the actuary or the Executive Director.

(b) *Voluntary suspension or termination of enrollment.* An enrolled actuary, in order to avoid the initiation or conclusion of a suspension or termination proceeding, may offer his/her consent to suspension or termination of enrollment or may offer his/her resignation. The Executive Director may accept the offered resignation or may suspend or terminate enrollment in accordance with the consent offered.

§ 901.35 Contents of complaint.

(a) *Charges.* A complaint initiating a suspension or termination proceeding shall describe the allegations which are the basis for the proceeding, and fairly inform the respondent of the charges against him/her.

(b) *Answer.* In the complaint, or in a separate paper attached to the complaint, notice shall be given of the place at, and time within which the respondent shall file an answer, which time shall not be less than 15 days from the date of service of the complaint. Notice shall be given that a decision by default may be rendered against the respondent if an answer is not filed as required.

§ 901.36 Service of complaint and other papers.

(a) *Complaint.* The complaint or a copy thereof may be served upon the respondent by certified mail, or first-class mail as hereinafter provided, by delivering it to the respondent, or the respondent's attorney or agent of record either in person or by leaving it at the office or place of business of the respondent, the attorney or agent, or in any other manner which may have been agreed to in writing by the respondent. Where the service is by certified mail, the return post office receipt signed by or on behalf of the respondent shall be proof of service. If the certified matter is not claimed or accepted by the respondent and is returned undelivered, complete service may be made upon the respondent by mailing the complaint to him/her by first-class mail, addressed to the respondent at the last address known to the Executive Director. If service is made upon the respondent or his/her attorney or agent in person or by leaving the complaint at the office or place of business of the respondent, attorney, or agent, the verified return by the person making service, setting forth the manner of service, shall be proof of such service.

(b) *Service of papers other than complaint.* Any paper other than the complaint may be served upon the respondent as provided in paragraph (a) of this section or by mailing the paper by first-class mail to the respondent at the last address known to the Executive Director or by mailing the paper by first-class mail to the respondent's attorney or agent. Such mailing shall constitute complete service. Notices may also be served upon the respondent or his/her attorney or agent by telegraph.

(c) *Filing of papers.* Whenever the filing of a paper is required or permitted

in connection with a suspension or termination proceeding, and the place of filing is not specified by this subpart or by rule or order of the Administrative Law Judge, the paper shall be filed with the Executive Director of the Joint Board for the Enrollment of Actuaries, Treasury Department, Washington, D.C. 20220. All papers shall be filed in duplicate.

§ 901.37 Answer.

(a) *Filing.* The respondent's answer shall be filed in writing within the time specified in the complaint or notice of initiation of the proceeding, unless, on application, the time is extended by the Executive Director or the Administrative Law Judge. The answer shall be filed in duplicate with the Executive Director.

(b) *Contents.* The answer shall contain a statement of facts which constitute the grounds of defense and it shall specifically admit or deny each allegation set forth in the complaint, except that the respondent shall not deny a material allegation in the complaint which he/she knows to be true, or state that he/she is without sufficient information to form a belief when in fact the respondent possesses such information. The respondent may also state affirmatively special matters of defense.

(c) *Failure to deny or answer allegations in the complaint.* Every allegation in the complaint which is not denied in the answer shall be deemed to be admitted and may be considered as proven, and no further evidence in respect of such allegation need be adduced at a hearing. Failure to file an answer within the time prescribed in the notice to the respondent, except as the time for answer is extended by the Executive Director or the Administrative Law Judge, shall constitute an admission of the allegations of the complaint and a waiver of hearing, and the Administrative Law Judge may make a decision by default, without a hearing or further procedure.

§ 901.38 Supplemental charges.

If it appears to the Executive Director that the respondent in his/her answer falsely and in bad faith denies a material allegation of fact in the complaint or states that the respondent has no knowledge sufficient to form a belief when he/she in fact possesses such knowledge, or if it appears that the respondent has knowingly introduced false testimony during proceedings for suspension or termination of his/her enrollment, the Executive Director may file supplemental charges against the respondent. Such supplemental charges may be tried with other charges in the case, provided the respondent is given due notice thereof and is afforded an opportunity to prepare a defense thereto.

§ 901.39 Reply to answer.

No reply to the respondent's answer shall be required, but the Executive Director may file a reply at his/her discretion or at the request of the Administrative Law Judge.

§ 901.40 Proof; variance; amendment of pleadings.

In the case of a variance between the allegations in a pleading and the evidence adduced in support of the pleading, the Administrative Law Judge may order or authorize amendment of the pleading to conform to the evidence, provided that the party who would otherwise be prejudiced by the amendment is given reasonable opportunity to meet the allegations of the pleading as amended. The Administrative Law Judge shall make findings on any issue presented by the pleadings as so amended.

§ 901.41 Motions and requests.

Motions and requests may be filed with the Executive Director or with the Administrative Law Judge.

§ 901.42 Representation.

A respondent or proposed respondent may appear at conference or hearing in person or may be represented by counsel or other representative. The Executive Director may be represented by an attorney or other employee of the Treasury Department.

§ 901.43 Administrative Law Judge.

(a) *Appointment.* An administrative law judge, appointed as provided by section 11 of the Administrative Procedure Act, 60 Stat. 244 (5 U.S.C. 3105),

shall conduct proceedings upon complaints for the suspension or termination of enrolled actuaries.

(b) *Powers of Administrative Law Judge.* Among other powers, the Administrative Law Judge shall have authority, in connection with any suspension or termination proceeding of an enrolled actuary, to do the following:

(1) Administer oaths and affirmations;

(2) Make rulings upon motions and requests, which may not be appealed before the close of a hearing except at the discretion of the Administrative Law Judge;

(3) Determine the time and place of hearing and regulate its course of conduct;

(4) Adopt rules of procedure and modify the same as required for the orderly disposition of proceedings;

(5) Rule upon offers of proof, receive relevant evidence, and examine witnesses;

(6) Take or authorize the taking of depositions;

(7) Receive and consider oral or written argument on facts or law;

(8) Hold or provide for the holding of conferences for the settlement or simplification of the issues by consent of the parties;

(9) Perform such acts and take such measures as are necessary or appropriate to the efficient conduct of any proceeding; and

(10) Make initial decisions.

§ 901.44 Hearings.

(a) *In general.* The Administrative Law Judge shall preside at the hearing on a complaint for the suspension or termination of an enrolled actuary. Hearings shall be stenographically recorded and transcribed and the testimony of witnesses shall be taken under oath or affirmation. Hearings will be conducted pursuant to section 7 of the Administrative Procedure Act, 60 Stat. 241 (5 U.S.C. 556).

(b) *Failure to appear.* If either party to the proceeding fails to appear at the hearing, after due notice thereof has been sent to the parties, the Administrative Law Judge may make a decision against the absent party by default.

§ 901.45 Evidence.

(a) *In general.* The rules of evidence prevailing in courts of law and equity are not controlling in hearings on complaints for the suspension or the termination of the enrollment of enrolled actuaries. However, the Administrative Law Judge shall exclude evidence which is irrelevant, immaterial, or unduly repetitious.

(b) *Depositions.* The deposition of any witness taken pursuant to § 901.46 may be admitted.

(c) *Proof of documents.* Official documents, records, and papers of the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, the Joint Board for the Enrollment of Actuaries or the Office of the Executive Director of the Joint Board for the Enrollment of Actuaries shall be admissible into evidence without the production of an officer or employee to authenticate them. Any such documents, records, and papers may be evidenced by a copy attested to or identified by an officer or employee of the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, the Joint Board for the Enrollment of Actuaries, or the Office of the Executive Director of the Joint Board for the Enrollment of Actuaries, as the case may be.

(d) *Exhibits.* If any document, record, or other paper is introduced into evidence as an exhibit, the Administrative Law Judge may authorize the withdrawal of the exhibit subject to any conditions which he/she deems proper.

(e) *Objections.* Objections to evidence shall state the grounds relied upon, and the record shall not include argument thereon, except as ordered by the Administrative Law Judge. Rulings on such objections shall be part of the record. No exception to the ruling is necessary to preserve the rights of the parties.

§ 901.46 Depositions.

Depositions for use at a hearing may, with the written approval of the Administrative Law Judge, be taken by either the Executive Director or the respondent or their duly authorized representatives. Depositions may be taken upon oral or written interrogatories,

upon not less than 10 days written notice to the other party, before any officer duly authorized to administer an oath for general purposes or before an officer or employee of the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, or the Joint Board who is authorized to administer an oath. Such notice shall state the names of the witnesses and the time and place where the depositions are to be taken. The requirement of 10 days notice may be waived by the parties in writing, and depositions may then be taken from the persons and at the times and places mutually agreed upon by the parties. When a deposition is taken upon written interrogatories, any cross-examination shall be upon written interrogatories. Copies of such written interrogatories shall be served upon the other party with the notice, and the copies of any written cross-interrogatories shall be mailed or delivered to the opposing party at least five days before the date of taking the depositions, unless the parties mutually agree otherwise. A party upon whose behalf a deposition is taken must file it with the Administrative Law Judge and serve one copy upon the opposing party. Expenses in the reporting of depositions shall be borne by the party at whose instance the deposition is taken.

§ 901.47 Transcript.

In cases where the hearing is stenographically reported by a Government contract reporter, copies of the transcript may be obtained from the reporter at rates not to exceed the maximum rates fixed by contract between the Government and the reporter. Where the hearing is stenographically reported by a regular employee of the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, or the Joint Board, a copy thereof will be supplied to the respondent either without charge or upon the payment of a reasonable fee. Copies of exhibits introduced at the hearing or at the taking of depositions will be supplied to parties upon the payment of a reasonable fee (31 U.S.C. 9701).

[43 FR 39757, Sept. 7, 1978, as amended at 76 FR 17776, Mar. 31, 2011]

§ 901.48 Proposed findings and conclusions.

Except in cases where the respondent has failed to answer the complaint or where a party has failed to appear at the hearing, the Administrative Law Judge, before making his/her decision, shall give the parties a reasonable opportunity to submit proposed findings and conclusions and supporting reasons therefor.

§ 901.49 Decision of the Administrative Law Judge.

As soon as practicable after the conclusion of a hearing and the receipt of any proposed findings and conclusions timely submitted by the parties, the Administrative Law Judge shall make the initial decision in the case. The decision should be based solely upon the pleading, the testimony and exhibits received in evidence at the hearing or specifically authorized to be subsequently submitted under the applicable laws and regulations. The decision shall include (a) a statement of findings and conclusions, as well as the reasons or basis therefor, upon all the material issues of fact or law presented on the record, and (b) an order of suspension, termination or reprimand or an order of dismissal of the complaint. The Administrative Law Judge shall file the decision with the Executive Director and shall transmit a copy thereof to the respondent or his/her attorney or agent of record. In the absence of an appeal to the Joint Board or review of the decision upon motion of the Joint Board, the decision of the Administrative Law Judge shall without further proceedings become the decision of the Joint Board 30 days from the date of the Administrative Law Judge's decision.

§ 901.50 Appeal to the Joint Board.

Within 30 days from the date of the Administrative Law Judge's decision, either party may appeal to the Joint Board for the Enrollment of Actuaries. The appeal shall be filed with the Executive Director in duplicate and shall

include exceptions to the decision of the Administrative Law Judge and supporting reasons for such exceptions. If an appeal is filed by the Executive Director, a copy thereof shall be transmitted to the respondent. Within 30 days after receipt of an appeal or copy thereof, the other party may file a reply brief in duplicate with the Executive Director. If the reply brief is filed by the Executive Director, a copy of it shall be transmitted to the respondent. Upon the filing of an appeal and a reply brief, if any, the Executive Director shall transmit the entire record to the joint board.

§ 901.51 Decision of the Joint Board.

On appeal from or review of the initial decision of the Administrative Law Judge, the Joint Board for the Enrollment of Actuaries will make the final decision. In making its decision the Joint Board will review the record of such portions thereof as may be cited by the parties to permit limiting of the issues. A copy of the Joint Board's decision shall be transmitted to the respondent by the Executive Director.

§ 901.52 Effect of suspension, termination or resignation of enrollment; surrender of enrollment certificate.

If the respondent's enrollment is suspended, the respondent shall not thereafter be permitted to perform actuarial services under ERISA during the period of suspension. If the respondent's enrollment is terminated, the respondent shall not thereafter be permitted to perform actuarial serv- ices under ERISA unless and until authorized to do so by the Executive Director pursuant to § 901.54. The respondent shall surrender his/her enrollment certificate to the Executive Director for cancellation in the case of a termination or resignation of enrollment or for retention during a period of suspension.

§ 901.53 Notice of suspension, termination or resignation of enrollment.

Upon the resignation or the issuance of a final order suspending or terminating the enrollment of an actuary, the Executive Director shall give notice thereof to appropriate officers and employees of the Department of the Treasury, the Department of Labor, the Pension Benefit Guaranty Corporation, and to other interested departments and agencies of the Federal Government.

§ 901.54 Petition for reinstatement.

Any individual whose enrollment has been terminated may petition the Executive Director for reinstatement after the expiration of five years following such termination. Reinstatement may not be granted unless the Executive Director, with the approval of the Joint Board, is satisfied that the petitioner is not likely to conduct himself/herself thereafter contrary to the regulations in this part, and that granting such reinstatement would not be contrary to the public interest.

Subpart E—General Provisions

AUTHORITY: Sec. 3042(b), ERISA, 29 U.S.C. 1242(b).

SOURCE: 43 FR 39761, Sept. 7, 1978, unless otherwise noted.

§ 901.70 Records.

(a) *Availability*. There are made available for public inspection at the Office of the Executive Director of the Joint Board for the Enrollment of Actuaries a roster of all persons enrolled to perform actuarial services under ERISA and a roster of all persons whose enrollments to perform such services have been suspended or terminated. Other records may be disclosed upon specific request, in accordance with the applicable disclosure and privacy statutes.

(b) *Disciplinary procedures*. A request by an enrolled actuary that a hearing in a disciplinary proceeding concerning him/her be public, and that the record thereof be made available for inspection by interested persons may be granted if written agreement is reached in advance to protect from disclosure tax information which is confidential, in accordance with applicable statutes and regulations.

§ 901.71 Special orders.

The Joint Board reserves the power to issue such special orders as it may deem proper in any case within the purview of this part.

§ 901.72 Additional rules.

The Joint Board may, in notice or other guidance of general applicability, provide additional rules regarding the enrollment of actuaries.

[76 FR 17776, Mar. 31, 2011]

PART 902—RULES REGARDING AVAILABILITY OF INFORMATION

Sec.
902.1 Scope.
902.2 Definitions.
902.3 Published information.
902.4 Access to records.
902.5 Appeal.

AUTHORITY: Sec. 3042, subtitle C, title 3, Employee Retirement Income Security Act of 1974 (88 Stat. 1002, 29 U.S.C. 1241, 1242).

SOURCE: 42 FR 39204, Aug. 3, 1977, unless otherwise noted.

§ 902.1 Scope.

This part is issued by the Joint Board for the Enrollment of Actuaries (the ''Joint Board'') pursuant to the requirements of section 552 of title 5 of the United States Code, including the requirements that every Federal agency shall publish in the FEDERAL REGISTER, for the guidance of the public, descriptions of the established places at which, the officers from whom, and the methods whereby, the public may obtain information, make submittals or requests, or obtain decisions.

§ 902.2 Definitions.

(a) *Records of the Joint Board.* For purposes of this part, the term ''records of the Joint Board'' means rules, statements, opinions, orders, memoranda, letters, reports, accounts, and other papers containing information in the possession of the Joint Board that constitute part of the Joint Board's official files.

(b) *Unusual Circumstances.* For purposes of this part, ''unusual circumstances'' means, but only to the extent reasonably necessary for the proper processing of the particular request:

(1) The need to search for and collect the requested records from other establishments that are separate from the Joint Board's office processing the request;

(2) The need to search for, collect, and appropriately examine a voluminous amount of separate and distinct records which are demanded in a single request; or

(3) The need for consultation, which shall be conducted with all practicable speed, with another agency having a substantial interest in the determination of the request.

§ 902.3 Published information.

(a) *Federal Register.* Pursuant to sections 552 and 553 of title 5 of the United States Code, and subject to the provisions of § 902.5, the Joint Board publishes in the FEDERAL REGISTER for the guidance of the public, in addition to this part, descriptions of its organization and procedures, substantive rules of general applicability, and, as may from time to time be appropriate, statements of general policy, and interpretations of general applicability.

(b) *Other published information.* From time to time, the Joint Board issues statements to the press relating to its operations.

(c) *Obtaining printed information.* If not available through the Government Printing Office, printed information released by the Joint Board may be obtained without cost from the Executive Director of the Joint Board (''Executive Director'').

§ 902.4 Access to records.

(a) *General rule.* All records of the Joint Board, including information set forth in section 552(a)(2) of title 5 of the United States Code, are made available to any person, upon request, for inspection and copying in accordance with the provisions of this section and subject to the limitations stated in section 552(b) of title 5 of the United States Code. Records falling within such limitations may nevertheless be made available in accordance with this section to the extent consistent, in the judgment of the Chairman of the Joint Board (''Chairman''), with the effective performance of the Joint Board's statutory responsibilities and with the avoidance of injury to a public or private interest intended to be protected by such limitations.

(b) *Obtaining access to records.* Records of the Joint Board subject to

this section are available by appointment for public inspection or copying during regular business hours on regular business days at the office of the Executive Director. Every request for access to such records, other than published records described in §902.3, shall be signed and submitted in writing to the Executive Director, Joint Board for the Enrollment of Actuaries, c/o Department of the Treasury, Washington, DC 20220, shall state the name and address of the person requesting such access, and shall describe such records in a manner reasonably sufficient to permit their identification without undue difficulty.

(c) *Fees.* A fee at the rate of $5.00 per hour or fraction thereof or the time required to locate such records, plus ten cents per standard page for any copying thereof, shall be paid by any person requesting records other than published records described in §902.3. In addition, the cost of postage and any packaging and special handling shall be paid by the requester. Documents shall be provided without charge or at a reduced charge where the Chairman determines that waiver or reduction of the fee is in the public interest because furnishing the information can be considered as primarily benefiting the general public.

(d) *Actions on requests.* The Executive Director shall, within ten days (excepting Saturdays, Sundays and legal public holidays) from receipt of request, determine whether to comply with such request for records and shall immediately notify in writing the person making such request of such determination and the reason therefor, and of the right of such person to appeal any adverse determination, as provided in §902.5. In unusual circumstances, the time limit for the determination may be extended by written notice to the person making such request setting forth the reasons for such extension and the date on which the determination is expected to be dispatched. No such notice shall specify a date that will result in an extension of more than ten working days.

§902.5 Appeal.

(a) Any person denied access to records requested under §902.4, may within thirty days after notification of such denial, file a signed written appeal to the Joint Board. The appeal shall provide the name and address of the appellant, the identification of the records denied, and the dates of the original request and its denial.

(b) The Joint Board shall act upon any such appeal within twenty days (excepting Saturdays, Sundays and legal public holidays) of its receipt, unless for unusual circumstances the time for such action is deferred, subject to §902.4(b), for not more than ten days. If action upon any such appeal is so deferred, the Joint Board shall notify the requester of the reasons for such deferral and the date on which the final reply is expected to be dispatched. If it is determined that the appeal from the initial denial shall be denied (in whole or in part), the requester shall be notified in writing of the denial, of the reasons therefor, of the fact the Joint Board is responsible for the denial, and of the provisions of section 552(a)(4) of title 5 of the United States Code for judicial review of the determination.

(c) Any extension or extensions of time under §§902.4(d) and 902.5(b) shall not cumulatively total more than ten days (excepting Saturdays, Sundays and legal public holidays). If an extension is invoked in connection with an initial determination under §902.4(d), any unused days of such extension may be invoked in connection with the determination on appeal under §902.5(a), by written notice from the Joint Board.

PART 903—ACCESS TO RECORDS

Subpart A—Records Pertaining to Individuals

Sec.

903.1 Purpose and scope of regulations.
903.2 Definitions.
903.3 Procedures for notification with respect to records regarding individuals.
903.4 Procedures for access to records and accountings of disclosures from records, regarding individuals.
903.5 Procedures for amendment of records regarding individual—format, agency review and appeal from initial adverse agency determination.
903.6 Fees.
903.7 Guardianship.
903.8 Exemptions.

AUTHORITY: 5 U.S.C. 552a.

SOURCE: 41 FR 1493, Jan. 8, 1976, unless otherwise noted.

Subpart A—Records Pertaining to Individuals

§ 903.1 Purpose and scope of regulations.

The regulations in this subpart are issued to implement the provisions of the Privacy Act of 1974 (5 U.S.C. 552a). The regulations relate to all records maintained by the Joint Board for the Enrollment of Actuaries (Joint Board) which are identifiable by individual name or identifier and all systems of such records which are retrievable by name or other identifier. They do not relate to personnel records of Government employees, which are under the jurisdiction of the Civil Service Commission, and, thus, subject to regulations issued by such Commission. The regulations set forth the procedures by which individuals may request notification of whether the Joint Board maintains or has disclosed a record pertaining to them or may seek access to such records maintained in any nonexempt system of records, request amendment of such records, and appeal any initial adverse determination with respect to any such request.

§ 903.2 Definitions.

(a) The term *agency* includes any executive department, military department, Government corporation, Government controlled corporation, or other establishment in the executive branch of the Government (including the Executive Office of the President), or any independent regulatory agency (see 5 U.S.C. 552(e));

(b) The term *individual* means a citizen of the United States or an alien lawfully admitted for permanent residence;

(c) The term *maintain* includes maintain, use, collect or disseminate;

(d) The term *record* means any item, collection, or grouping of information about an individual that is maintained by the Joint Board, including, but not limited to, his education, financial transactions, medical history, and criminal or employment history and that contains his name, or the identifying number, symbol, or other identifying particular assigned to the individual such as a finger or voice print or a photograph;

(e) The term *system of records* means a group of any records under the control of the Joint Board from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual;

(f) The term *routine use* means, with respect to the disclosure of a record, the use of such record for a purpose which is compatible with the purpose for which it was collected.

§ 903.3 Procedures for notification with respect to records regarding individuals.

(a) *Procedures for notification.* The systems of records maintained by the Joint Board are listed annually as required by the Privacy Act of 1974. Any individual, who wishes to know whether a system of records contains a record regarding him, may write to the Executive Director, Joint Board for the Enrollment of Actuaries, c/o U.S. Department of the Treasury, Washington, DC 20220. Requests may also be delivered personally to the Executive Director, Joint Board for the Enrollment of Actuaries, 2401 E Street, NW., suite 1537, Washington, D.C. between the hours of 9 a.m. and 5 p.m. on workdays. Any such inquiry will be acknowledged in writing within 10 days (excluding Saturdays, Sundays and legal public holidays) of receipt of the request.

(b) *Requests.* A request for notification of whether a record exists shall:

(1) Be made in writing and signed by the person making the request, who must be the individual about whom the record is maintained, or his duly authorized representative (see § 903.7);

(2) State that it is made pursuant to the Privacy Act, 5 U.S.C. 552a, or the regulations contained in this part;

(3) Furnish the name of the system of records with respect to which notification is sought, as specified in the systems notices published in the FEDERAL REGISTER, Volume 40, No. 167;

(4) Mark ''Privacy Act Request'' on the request and on the envelope in which the request is contained;

(5) Be addressed as specified in paragraph (a) of this section, unless personally delivered; and

(6) Meet the requirements set forth in paragraph (c) of this section.

(c) *Verification of identity.* Notification of the existence of records in certain systems maintained by the Joint Board will not be made unless the individual requester's identity is verified. Where applicable, requirements for verification of identity are specified in the notices of systems published in the FEDERAL REGISTER, Volume 40, No. 167.

(d) *Date of receipt of request.* A request for notification with respect to records shall be considered to have been received on the date on which the requirements of paragraphs (a), (b) and (c) of this section have been satisfied. Requests for notification shall be stamped with the date of receipt by the Office of the Executive Director.

(e) *Exemptions.* The procedures prescribed under paragraphs (a), (b) and (c) of this section shall not apply to: (1) Systems of records exempted pursuant to 5 U.S.C. 552a(k); (2) information compiled in reasonable anticipation of a civil action or proceeding (see 5 U.S.C. 552a(d) (5); or (3) information regarding an individual which is contained in, and inseparable from, another individual's record.

(f) *Notification of determination*—(1) *In general.* The Executive Director shall, except as otherwise provided in this paragraph, notify an individual requester as to whether or not a system of records contains a record regarding such individual. Such notification shall be made within 30 days (excluding Saturdays, Sundays and legal public holidays) after the date of receipt of the request, as determined in accordance with paragraph (d) of this section. If it is not possible to respond within 30 days, the Executive Director will inform the requester, stating the reasons for the delay (e.g., volume of records involved, need to consult other agencies, or the difficulty of the legal issues involved) and when a response will be dispatched.

(2) *Denial of request.* When it is determined that a request for notification with respect to records will be denied (whether in whole or in part or subject to conditions or exceptions), the person making the request shall be so notified by mail in accordance with paragraph (f)(1) of this section. The letter of notification shall set forth the name and title or position of the responsible official.

(3) *Records exempt in whole or in part.* (i) When an individual requests notification with respect to records concerning himself which have been compiled in reasonable anticipation of a civil action or proceeding either in a court or before an administrative tribunal, the Executive Director will neither confirm nor deny the existence of the record but shall advise the individual only that no record with respect to the existence of which he is entitled to be notified pursuant to the Privacy Act of 1974 has been identified.

(ii) Requests for records which have been exempted from the requirement of notification pursuant to 5 U.S.C. 552a(k)(2) shall be responded to in the manner provided in paragraph (f)(3)(i) of this section.

§ 903.4 Procedures for access to records and accountings of disclosures from records, regarding individuals.

(a) *Access.* The Executive Director of the Joint Board shall, upon request by any individual to gain access to a record regarding him which is contained in a system of records maintained by the Joint Board, or to an accounting of a disclosure from such record made pursuant to 5 U.S.C. 552a(c)(1), permit that individual, and, upon his/her request, a person he/she chooses to accompany him/her, to review the record or any such accounting and have a copy made of all or any portion thereof in a form comprehensible to the individual, except that the Executive Director may require the individual to furnish a written statement authorizing discussion of that individual's record in the accompanying person's presence. Such request may be addressed to the Executive Director, Joint Board for the Enrollment of Actuaries, c/o U.S. Department of the Treasury, Washington, DC 20220. Requests may also be delivered personally to the Executive Director, Joint Board for the Enrollment of Actuaries, 2401 E Street, NW., suite 1537, Washington,

DC, between the hours of 9 a.m. and 5 p.m. on workdays. Any such inquiry will be acknowledged in writing within 10 days (excluding Saturdays, Sundays and legal public holidays) of receipt of the request (see paragraph (e) of this section).

(b) *Requests.* A request for access to records or accountings of disclosure from records, shall:

(1) Be signed in writing by the person making the request, who must be the individual about whom the record is maintained, or his duly authorized representative (see § 903.7);

(2) State that it is made pursuant to the Privacy Act, 5 U.S.C. 552a, or the regulations contained in this part;

(3) Furnish the name of the system of records to which access is sought, or the name of the system for a disclosure from which an accounting is sought, as specified in the systems notices published in the FEDERAL REGISTER, Volume 40, No. 167;

(4) Mark ''Privacy Act Request'' on the request and on the envelope in which the request is contained;

(5) Be addressed as specified in paragraph (a) of this section, unless personally delivered;

(6) State whether the requester wishes to inspect the records and/or accountings of disclosures therefrom, or desires to have a copy made and furnished without inspecting them;

(7) State, if the requester desires to have a copy made, the requester's agreement to pay the fees for duplication as ultimately determined in accordance with § 903.6; and

(8) Meet the requirements set forth in paragraph (c) of this section.

(c) *Verification of identity.* Access to records contained in certain systems maintained by the Joint Board and/or accountings of disclosures from such records, will not be granted unless the individual requester's identity is verified. Where applicable, requirements for verification of identity are specified in the notices of systems published in the FEDERAL REGISTER, Volume 40, No. 167.

(d) *Exemptions.* The procedures specified in paragraphs (a), (b) and (c) of this section shall not apply to: (1) Systems of records exempted pursuant to 5 U.S.C. 552a(k); (2) information compiled in reasonable anticipation of a civil action or proceeding (see 5 U.S.C. 552a(d)(5)); or (3) information regarding an individual which is contained in, and inseparable from, another individual's record.

(e) *Date of receipt of request.* A request for access to records and/or accountings shall be considered to have been received on the date on which the requirements of paragraphs (a), (b) and (c) of this section have been satisfied. Requests for access, and any separate agreement to pay, shall be stamped with the date of receipt by the Office of the Executive Director. The latest of such stamped dates will be deemed to be the date of receipt of the request.

(f) *Notification of determination*—(1) *In general.* Notification of determinations as to whether to grant access to records and/or accountings requested will be made by the Executive Director of the Joint Board. The notification of the determination shall be made within 30 days (excluding Saturdays, Sundays and legal public holidays) after the date of receipt of the request, as determined in accordance with paragraph (g) of this section. If it is not possible to respond within 30 days, the Executive Director will inform the requester, stating the reason(s) for the delay (e.g., volume of records requested, need to consult other agencies, or the difficulty of the legal issues involved) and when a response will be dispatched (See 5 U.S.C. 552a (d) and (f)).

(2) *Granting of access.* (i) When it has been determined that the request for access will be granted—(A) and a copy requested; such copy in a form comprehensible to him shall be furnished promptly, together with a statement of the applicable fees for duplication as set forth elsewhere in these regulations (See § 903.6); and (B) and the right to inspect has been requested, the requester shall be promptly notified in writing of the determination, and when and where the requested records and/or accountings may be inspected.

(ii) An individual seeking to inspect records concerning himself and/or accountings of disclosure from such records may be accompanied by another individual of his own choosing. The individual seeking access shall be

required to sign the required form indicating that the Joint Board is authorized to discuss the contents of the subject record in the accompanying person's presence. If, after making the inspection, the individual making the request desires a copy of all or portion of the requested records, such copy in a form comprehensible to him shall be furnished upon payment of the applicable fees for duplication as prescribed by § 903.6. Fees shall not be charged where they would amount, in the aggregate, to less than $53.00. (See 5 U.S.C. 552a (d) and (f):

(3) *Denial of request.* (i) When it is determined that the request for access to records will be denied (whether in whole or in part or subject to conditions or exceptions), the person making the request shall be so notified by mail in accordance with paragraph (f)(1) of this section. The letter of notification shall contain a statement of the reasons for not granting the request as made, set forth the name and title or position of the responsible official and advise the individual making the request of the right to file suit in accordance with 5 U.S.C. 552a(g)(1)(B).

(ii) When it is determined that a request for access to accountings will be denied, the person making the request shall be so notified by mail in accordance with paragraph (f)(1)(4)(iii) of this section.

(4) *Records exempt in whole or in part.* (i) When an individual requests records concerning himself which have been compiled in reasonable anticipation of a civil action or proceeding either in a court or before an administrative tribunal, the Executive Director will neither confirm nor deny the existence of the record but shall advise the individual only that no record available to him pursuant to the Privacy Act of 1974 has been identified.

(ii) Requests for records which have been exempted from disclosure pursuant to 5 U.S.C. 552a(k)(2) shall be responded to in the manner provided in paragraph (f)(4)(i) of this section unless a review of the information indicates that the information has been used or is being used to deny the individual any right, privilege or benefit for which he is eligible or to which he would otherwise be entitled under Federal law. In that event, the individual shall be advised of the existence of the information but such information as would identify a confidential source shall be extracted or summarized in a manner which protects the source to the maximum degree possible and the summary extract shall be provided to the requesting individual.

(iii) When an individual requests access to accountings of disclosure from records concerning himself which have been compiled in reasonable anticipation of a civil action or proceeding, either in a court or before an administrative tribunal, or which have been exempted from disclosure pursuant to 5 U.S.C. 552a(k)(2), the Executive Director will neither confirm nor deny the existence of the record or accountings of disclosure therefrom, but shall advise the individual that no accounting available to him pursuant to the Privacy Act of 1974 has been identified.

§ 903.5 Procedures for amendment of records regarding individual—format, agency review and appeal from initial adverse agency determination.

(a) *In general.* Subject to the application of exemptions promulgated by the Joint Board, in accordance with 5 U.S.C. 552a(k), the Executive Director shall, in conformance with 5 U.S.C. 552a(d)(2), permit an individual to request amendment of a record pertaining to him. Any such request shall be addressed to the Executive Director, Joint Board for the Enrollment of Actuaries, U.S. Department of the Treasury, Washington, DC 20220 or delivered personally to the Executive Director, Joint Board for the Enrollment of Actuaries, 2401 E Street, NW., suite 1537, Washington, DC. Any request for amendment of records or any appeal from the initial denial of a request which does not fully comply with the requirements of this section will not be deemed subject to the time constraints of paragraph (e) of this section, unless and until amended so as to comply. However, the Executive Director shall forthwith advise the requester in what respect the request or appeal is deficient so that it may be resubmitted or amended. (See 5 U.S.C. 552a (d) and (f)).

(b) *Form of request to amend records.* In order to be subject to the provisions of

this section, a request to amend records shall:

(1) Be made in writing and signed by the person making the request, who must be the individual about whom the record is maintained, or his duly authorized representative. (See § 903.7);

(2) State that it is made pursuant to the Privacy Act, 5 U.S.C. 552a or these regulations;

(3) Mark ''Privacy Act Amendment Request'' on the request and on the envelope; and

(4) Reasonably describe the records which the individual desires to have amended, including, to the best of the requester's knowledge, dates of letters requesting access to such records previously and dates of letters in which notification concerning access was made, if any, and the individual's documentation justifying the correction. (See 5 U.S.C. 552a (d) and (f)).

(c) *Date of receipt of request.* A request for amendment of records pertaining to an individual shall be deemed to have been received for purposes of this subpart when the requirements of paragraphs (a) and (b) of this section have been satisfied. The Office of the Executive Director shall stamp the date of receipt of the request thereon. (See 5 U.S.C. 552a (d) and (f)).

(d) *Review of requests to amend records.* The Executive Director shall:

(1) Not later than 10 days (excluding Saturdays, Sundays, and legal public holidays) after the date of receipt of such request, acknowledge in writing such receipt; and

(2) Promptly, either—(i) make any correction of any portion of a record which the individual believes and the Executive Director agrees is not accurate, relevant, timely, or complete; or (ii) inform the individual of the refusal to amend the record in accordance with his request, the reason for the refusal, and that he may request that the Joint Board review such refusal. (See 5 U.S.C. 552a (d) and (f)).

(e) *Administrative appeal*—(1) *Ingeneral.* The Joint Board shall permit individuals to request a review of initial decisions made under paragraph (d) of this section when an individual disagrees with a refusal to amend his record. (See 5 U.S.C. 552a(d), and (g)(1)).

(2) *Form of request for administrative review of refusal to amend record.* At any time within 35 days after the date of the notification of the initial decision described in paragraph (d)(2)(ii) of this section, the requester may submit a request for review of such refusal to the official specified in the notification of the initial decision. The appeal shall:

(i) Be made in writing stating any arguments in support thereof and be signed by the person to whom the record pertains, or his duly authorized representative (See § 903.7);

(ii) Within 35 days of the date of the initial decision: (A) Be addressed and mailed to the Joint Board for the Enrollment of Actuaries, c/o U.S. Department of the Treasury, Washington, DC 20220; or (B) be personally delivered to the Executive Director, Joint Board for the Enrollment of Actuaries, 2401 E Street NW., suite 1537, Washington, DC on workdays between the hours of 9 a.m. and 5 p.m.;

(iii) Have clearly marked on the appeal and on the envelope, ''Privacy Act Amendment Appeal'';

(iv) Reasonably describe the records requested to be amended; and

(v) Specify the date of the initial request to amend records, and the date of the letter giving notification that the request was denied. (See 5 U.S.C. 552a (d) and (f)).

(3) *Date of Receipt.* Appeals shall be promptly stamped with the date of their receipt by the Office of the Executive Director and such stamped date will be deemed to be the date of receipt for all purposes of this section. The receipt of the appeal shall be acknowledged within 10 days from the date of receipt (unless the determination on appeal is dispatched in 10 days, in which case, no acknowledgment is required) by the Joint Board and the requester is advised of the date of receipt established by the foregoing and when a response is due in accordance with this paragraph. (See 5 U.S.C. 552a (d) and (f)).

(4) *Review of administrative appeals from denial of requests to amend records.* The Joint Board shall complete the review and notify the requester of the final agency decision within 30 days (exclusive of Saturdays, Sundays and legal public holidays) after the date of

receipt of such appeal, unless it extends the time for good cause shown. If such final agency decision is to refuse to amend the record, in whole or in part, the requester shall also be advised of his right; (i) to file a concise ''Statement of Disagreement'' setting forth the reasons for his disagreement with the decision which shall be filed within 35 days of the date of the notification of the final agency decision and (ii) to seek judicial review of the final agency decision under 5 U.S.C. 552a(g)(1)(A). (See 5 U.S.C. 552a (d), (f) and (g)(1)).

(5) *Notation on record and distribution of statements of disagreement.* (i) The Executive Director is responsible, in any disclosure containing information about which an individual has filed a ''Statement of Disagreement,'' occurring after the filing of the statement under paragraph (e)(4) of this section, for clearly noting any portion of the record which is disputed and providing copies of the statement and, if deemed appropriate, a concise statement of the Joint Board's reasons for not making the amendments requested, to persons or other agencies to whom the disputed record has been disclosed. (See 5 U.S.C. 552a(d)(4)).

(ii) In addition, when a ''Statement of Disagreement'' is filed regarding information previously disclosed to a person or other agency and when, for such disclosure, an accounting was made pursuant to 5 U.S.C. 552(c)(1). then the Executive Director shall provide such person or other agency with the following:

(A) Copy of the ''Statement of Disagreement'';

(B) Copy of the portion of the previously disclosed in dispute clearly noted as disputed and;

(C) If deemed approprirate, a concise statement of the Joint Board's reasons for not making requested amendments.

(f) *Records not subject to correction.* The following records are not subject to correction or amendment by individuals:

(1) Transcripts or written statements made under oath;

(2) Transcripts of Grand Jury proceedings, judicial or quasi-judicial proceedings which form the official record of those proceedings;

(3) Pre-sentence reports comprising the property of the courts but maintained in agency files;

(4) Records pertaining to the determination, the collection and the payment of federal taxes; and

(5) Records duly exempted from correction by notice published in the FEDERAL REGISTER.

[41 FR 1493, Jan. 8, 1976, as amended at 45 FR 84994, Dec. 24, 1980]

§ 903.6 Fees.

Charges for copies of records made pursuant to part 903 of this chapter will be at the rate of $0.10 per copy. For records not susceptible to photocopying, e.g., over-size materials, photographs, etc., the amount charged will be the actual cost of copying. Only one copy of each record requested will be provided. No charge will be made unless the charge as computed above would exceed $3 for each request or related series of requests. If a fee in excess of $25 is required, the requester will be notified that the fee must be tendered before the records will be copied.

§ 903.7 Guardianship.

The guardian of a person judicially determined to be incompetent shall, in addition to establishing the identity of the person he represents, establish his own guardianship by furnishing a copy of a court order establishing the guardianship and may thereafter act on behalf of such individual. (See 5 U.S.C. 552a(h)).

§ 903.8 Exemptions.

(a) *Names of systems:* JBEA–2, Enrolled Actuary Disciplinary Records; and JBEA–4, Enrolled Actuary Enrollment Records.

(b) *Provisions from which exempted:* These systems contain records described in section (k)(2) of the Privacy Act of 1974, 5 U.S.C. 552a(k)(2). Exemptions are claimed for such records only where appropriate from the following provisions: sections (c)(3); (d); (e)(1); (e)(4)(G), (e)(4)(H), and (e)(4)(I); and (f) of 5 U.S.C. 552a.

(c) *Reasons for claimed exemptions:* (1) The Privacy Act of 1974 creates several methods by which individuals may learn of and obtain records containing

information on such individuals and consisting of investigatory material compiled for law enforcement purposes. These methods are as follows: Subsection (c)(3) allows individuals to discover if other agencies are investigating such individuals; subsections (d)(1), (e)(4)(H) and (f)(2), (3) and (5) establish the ability of individuals to gain access to investigatory material compiled on such individuals; subsections (d)(2), (3) and (4), (e)(4)(H) and (f)(4) presuppose access and enable individuals to contest the contents of investigatory material compiled on these individuals; and subsections (e)(4)(G) and (f)(1) allow individuals to determine whether or not they are under investigation. Because these subsections are variations upon the individual's ability to ascertain whether his civil or criminal misconduct has been discovered, these subsections have been grouped together for purposes of this notice.

(2)(i) The Joint Board believes that imposition of the requirements of subsection (c)(3), which requires that accountings of disclosures be made available to individuals, would impair the ability of the Joint Board and other investigative entities to conduct investigations of alleged or suspected violations of the regulations governing the performance of actuarial services with respect to plans to which the Employee Retirement Income Security Act (ERISA) applies, and of civil or criminal laws. Making the accountings of disclosures available to individuals enables such individuals to identify entities investigating them and thereby to determine the nature of the violations of which they are suspected. With such knowledge, individuals would be able to alter their illegal activities, destroy or alter evidence of such activities and seriously impair the successful completion of investigations. For these reasons, the Joint Board claims exemption from the requirements of subsection (c)(3) of the Act.

(ii) With respect to subsections (d)(1), (e)(4)(H), and (f)(2), (3) and (5), the Joint Board believes that access to investigatory material would prevent the successful completion of investigations. Individuals who gain access to investigatory material involving them discover the nature and extent of the violations of regulations, and of civil and criminal laws, of which they are suspected. By gaining access, such individuals also learn the facts developed during investigations. Knowledge of these matters enables these individuals to destroy or alter evidence which would otherwise have been used against them. In addition, knowledge of the facts and suspected violations gives individuals, who are committing ongoing violations, or who are about to commit violations of regulations, or of civil or criminal laws, the opportunity to temporarily postpone the commission of the violations or to effectively disguise the commission of these violations. Material compiled on investigated individuals reveals investigative techniques and procedures, disclosure of which enables such individuals to structure their illegal activities so as to escape detection. Further, such material may contain, or by its very nature reveal, the identity of confidential sources. When the identities of confidential sources are revealed, they may be subjected to various forms of reprisal. If confidential sources of information are subjected to actual reprisals or fear thereof, they may become reluctant to provide information necessary to identify or prove the guilt of persons who violate regulations, or civil or criminal laws. Further, the protections afforded by the above-referenced subsections are unnecessary because the Joint Board may not deny enrollment or suspend or terminate the enrollment of an individual to perform actuarial services until it has provided such individual with due process safeguards. For these reasons, the Joint Board claims exemptions from the requirements of subsections (d)(1), (e)(4)(H), and (f)(2), (3), and (5) of the Act.

(iii) With respect to subsections (d)(2), (3) and (4), (e)(4)(H), and (f)(4), the Joint Board believes that the imposition of these requirements, which presuppose access and provide for amending records, would impair the ability to conduct investigations and would be unnecessary for the same reasons stated in the preceding subsection (2)(ii). These reasons herein are incorporated by reference. Therefore, the Joint

Board claims exemptions from the requirements of subsections (d)(2), (3), and (4), (e)(4)(H), and (f)(4).

(iv) With respect to subsections (e)(4)(G) and (f)(1), the Joint Board believes that informing individuals that they are the subjects of a particular system or systems of records would impair the ability of the Joint Board and its agents to successfully complete investigations of suspected or alleged violators of the regulations governing the performance of actuarial services with respect to plans to which ERISA applies. Individuals who learn that they are suspected of violating said regulations are given the opportunity to destroy or alter evidence needed to prove the alleged violations. Such individuals may also be able to impair investigations by temporarily suspending or restructuring the activities which place them in violation of said regulations. Further, as noted in the preceding subsection (2)(ii) and incorporated by reference herein, the procedural requirements imposed on the Joint Board by ERISA make the protections afforded by subsections (e)(4)(G) and (f)(1) unnecessary. For these reasons, the Joint Board claims exemptions from the requirements of subsections (e)(4)(G) and (f)(1).

(v) Subsection (e)(1) of the Privacy Act of 1974 requires that the Joint Board maintain in its records only information that is relevant and necessary to accomplish a purpose of the Office required to be accomplished by statute or by executive order of the President. The Joint Board believes that imposition of said requirement would seriously impair its ability, and the abilities of its agents and other investigative entities to effectively investigate suspected or alleged violations of regulations and of civil or criminal laws. The Joint Board does not initiate inquires into individuals' conduct unless it receives information evidencing violation by such individuals of the regulations governing performance of actuarial services with respect to plans to which ERISA applies. Sources of such information may be unfamiliar with the Joint Board's interpretations of said regulations and, therefore, may not always provide only relevant and necessary information. Therefore, it may often be impossible to determine whether or not information is relevant and necessary. For these reasons, the Joint Board claims exemption from the requirements of subsection (e)(1).

(vi) Subsection (e)(4)(I) of the Privacy Act of 1974 requires the publication of the categories of sources of records in each system of records. The Joint Board believes that imposition of said requirement would seriously impair its ability to obtain information from such sources for the following reasons. Revealing such categories of sources could disclose investigative techniques and procedures and could cause sources to decline to provide information because of fear of reprisal, or fear of breaches of promises of confidentiality. For these reasons, the Joint Board claims exemption from the requirements of subsection (e)(4)(I).

[41 FR 1493, Jan. 8, 1976, as amended at 75 FR 81455, Dec. 28, 2010]

PARTS 904–999 [RESERVED]

CHAPTER IX—OFFICE OF THE ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING SERVICE, DEPARTMENT OF LABOR

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PART 1000 [RESERVED]

PART 1001—SERVICES FOR VETERANS

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AUTHORITY: 29 U.S.C. 49k; 38 U.S.C. chapters 41 and 42.

Subpart A—Purpose and Definitions

§ 1001.100 Purpose and scope of subpart.

(a) This subpart contains the Department of Labor's regulations for implementing 38 U.S.C. 2001–2012, chapters 41 and 42, which require the Secretary of Labor to provide eligible veterans and eligible persons the maximum of employment and training opportunities, with priority given to the needs of disabled veterans and veterans of the Vietnam era, through the public employment service system established pursuant to the Wagner-Peyser Act, as amended.

(b) This subpart describes the roles and responsibilities of the Assistant Secretary for Veterans' Employment and Training (ASVET) and the staff of the Veterans' Employment and Training Service (VETS).

(c) This subpart describes the performance standards for determining compliance of State agencies in carrying out the provisions of 38 U.S.C., chapters 41 and 42 with respect to:

(1) Providing services to eligible veterans and eligible persons to enhance their employment prospects,

(2) Priority referral of special disabled veterans and veterans of the Vietnam era to job openings listed by

Federal contractors pursuant to 38 U.S.C. 2012(a), and

(3) Reporting of services provided to eligible veterans and eligible persons pursuant to 38 U.S.C. 2007(c) and 2012(c).

(d) Performance standards are contained in this part at §§1001.140–1001.142 on the conduct of the Disabled Veterans Outreach Program (DVOP) in accordance with 38 U.S.C. 2003A.

[49 FR 12919, Mar. 30, 1984. Redesignated and amended at 54 FR 39353, Sept. 26, 1989]

§1001.101 Definitions of terms used in subpart.

Assistant Secretary for Veterans' Employment and Training (ASVET) shall mean the official of the Department of Labor as described in §1001.110 of this part.

Assistant State Director for Veterans' Employment and Training Service (ASDVETS) shall mean a Federal employee who is designated as an assistant to a State Director for Veterans' Employment and Training Service (SDVETS).

Disabled Veteran shall mean a veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Veterans Administration and whos not classified as a Special Disabled Veteran.

Eligible person shall mean:

(1) The spouse of any person who died of a service-connected disability; or

(2) The spouse of any member of the armed forces serving on active duty who at the time of application for assistance under this subpart, is listed, pursuant to 37 U.S.C. 556 and the regulations issued thereunder, by the Secretary concerned, in one or more of the following categories and has been so listed for a total of more than 90 days: (i) Missing in action, (ii) captured in line of duty by a hostile force, or (iii) forcibly detained or interned in line of duty by a foreign government or power; or

(3) The spouse of any person who has a total disability permanent in nature resulting from a service-connected disability or the spouse of a veteran who died while a disability so evaluated was in existence.

Eligible veteran shall mean a person who (1) served on active duty for a period of more than 180 days and was discharged or released therefrom with other than a dishonorable discharge, or (2) was discharged or released from active duty because of a service-connected disability.

Local Veterans' Employment Representative (LVER) shall mean a member of the State agency staff designated and assigned by the State agency administrator to serve veterans and eligible persons pursuant to this subpart.

Regional Director for Veterans' Employment and Training Service (RDVETS) is the representative of the ASVET on the staff of the Veterans' Employment and Training Service (VETS) at the regional level; supervises all other VETS staff within the region to which assigned; and shall report to, be responsible to, and be under the administrative direction of the ASVET.

Service Delivery Point (SDP) shall mean a designated local employment service office which serves an area that may also contain extended service locations.

Special disabled veteran shall mean (1) a veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Veterans Administration for a disability rated at 30 percent or more, or (2) a person who was discharged or released from active duty because of a service-connected disability.

State agency means the State governmental unit designated pursuant to section 4 of the Wagner-Peyser Act, as amended, to cooperate with the United States Employment Service in the operation of the public employment service system.

State Director for Veterans' Employment and Training Service (SDVETS) is the representative of ASVET on the staff of the Veterans' Employment and Training Service (VETS) at the State level.

United States Employment Service (USES) shall mean the component of the Employment and Training Administration of the Department of Labor, established under the Wagner-Peyser

Act, as amended, to maintain and coordinate a national system of public employment service agencies.

Veteran of the Vietnam era shall mean an eligible veteran who (1) served on active duty for a period of more than 180 days, any part of which occurred during the Vietnam era (August 5, 1964, through May 7, 1975) and was discharged or released therefrom with other than a dishonorable discharge; or (2) was discharged or released from active duty for a service-connected disability if any part of such active duty was performed during the Vietnam era.

Veterans' Employment and Training Service (VETS) shall mean the organizational component of the Department of Labor administered by the Assistant Secretary of Labor for Veterans' Employment and Training established to promulgate and administer policies and regulations to provide eligible veterans and eligible persons the maximum of employment and training opportunities according to 38 U.S.C. 2002.

[49 FR 12919, Mar. 30, 1984. Redesignated and amended at 54 FR 39353, Sept. 26, 1989]

Subpart B—Federal Responsibilities

§ 1001.110 Role of the Assistant Secretary for Veterans' Employment and Training (ASVET).

(a) As the principal veterans' advisor to the Secretary of Labor, the ASVET shall formulate, promulgate, and administer policies, regulations, grant procedures, grant agreements and administrative guidelines and administer them through the Veterans' Employment and Training Service (VETS) so as to provide eligible veterans and eligible persons the maximum of employment and training opportunities, with priority given to the needs of disabled veterans and veterans of the Vietnam era, through existing programs, coordination, and merger of programs and implementation of new programs.

(b) ASVET shall oversee activities carried out by State agencies pursuant to 38 U.S.C., chapters 41 and 42.

(c) ASVET shall ensure that appropriate records and reports are maintained by State agencies within their management information systems to fulfill their obligations under this subpart.

[49 FR 12919, Mar. 30, 1984. Redesignated at 54 FR 39353, Sept. 26, 1989]

Subpart C—Standards of Performance Governing State Agency Services to Veterans and Eligible Persons

SOURCE: 49 FR 12919, Mar. 30, 1984, unless otherwise noted. Redesignated at 54 FR 39353, Sept. 26, 1989.

§ 1001.120 Standards of performance governing State agency services.

(a) To the extent required by 38 U.S.C. 2002 and other applicable law, each State agency shall assure that all of its SDPs, using LVERs and other staff, shall provide maximum employment and training opportunities to eligible veterans and eligible persons with priority given to disabled veterans and veterans of the Vietnam-era, by giving them preference over non-veterans in the provision of employment and training services available at the SDP involved. Services are those activities or efforts including but not limited to registration, counseling, referral to supportive services, job development, etc., which are directed to help applicants find jobs or training. When making referrals from the group of applicants meeting the specific eligibility criteria for a particular program, State agencies shall observe the priority order to referral in paragraph (b).

(b) In making referrals of qualified applicants to job openings and training opportunities, to provide maximum employment and training opportunities under 38 U.S.C., SDPs shall observe the following order of priority:

(1) Special disabled veterans;

(2) Veterans of the Vietnam era;

(3) Disabled veterans other than special disabled veterans;

(4) All other veterans and eligible persons; and

(5) Nonveterans.

§ 1001.121 Performance standard on facilities and support for Veterans' Employment and Training Service (VETS) staff.

Each State agency shall provide adequate and appropriate facilities and administrative support such as office space, furniture, telephone, equipment, and supplies to VETS staff.

§ 1001.122 Reporting and budget requirements.

(a) State agencies shall provide RDVETS, SDVETS, and ASDVETS with access to regular and special internal State agency reports which relate in whole or in part with services to veterans and/or eligible persons.

(b) Each State agency shall make reports and prepare budgets pursuant to instructions issued by the ASVET and in such format as the ASVET shall prescribe.

§ 1001.123 Performance standards governing the assignment and role of Local Veterans' Employment Representatives (LVERs).

(a) To carry out the requirements of 38 U.S.C. 2004, at least one member of each State agency staff, preferably an eligible veteran, shall be designated and assigned by each State agency administrator as a full-time or part-time LVER in each SDP in accordance with terms/requirements of a grant agreement approved by the ASVET. The ASVET intends to use the following criteria in establishing the terms and requirements of grant agreements:

(1) At least one full-time LVER shall be assigned in each SDP which has had 1,000 new or renewed applications from veterans and eligible persons during the most recent twelve-month report period unless a waiver based on demonstrated lack of need is granted by the ASVET, and

(2) At least one part-time LVER whose time shall be devoted to veterans' services in proportion to the full-time criteria shall be assigned to each SDP not meeting the criteria for full-time LVERs in paragraph (a)(1) of this section.

(b) Additional full-time or part-time LVERs may be assigned based on a determination of need by the State agency administrator and in accordance with terms/requirements of a grant agreement approved by the ASVET.

(c) Each LVER shall perform, at the SDP level, the duties prescribed at 38 U.S.C. 2003(c) required by 38 U.S.C. 2004.

[49 FR 12919, Mar. 30, 1984. Redesignated and amended at 54 FR 39353, Sept. 26, 1989]

§ 1001.124 Standards of performance governing State agency cooperation and coordination with other agencies and organizations.

(a) Each State agency shall establish cooperative working relationships through written agreements with the Veterans Administration (VA) offices serving the State to maximize the use of VA employment and training programs for veterans and eligible persons.

(b) All programs and activities governed by this subpart will be coordinated to the maximum extent feasible with other programs and activities under 38 U.S.C., the Wagner-Peyser Act, the Job Training Partnership Act, and other employment and training programs at the State and local level.

(c) Such relationships or agreements may be described in the Governor's Coordination and Special Services Plan prepared according to section 121(b) of the Job Training Partnership Act (Pub. L. 97–300).

§ 1001.125 Standards of performance governing complaints of veterans and eligible persons.

Each SDP shall display information on the various complaint systems to advise veterans and eligible persons about procedures for filing employment service, Federal contractor, equal opportunity, and other complaints.

Subpart D—State Employment Service Agency Compliance

§ 1001.130 Determination of compliance.

(a) The ASVET shall have authority for applying the requirements and remedial actions necessary to implement 20 CFR part 658, subpart H. In the event of such application, references in 20 CFR part 658, subpart H, to ''ETA'' shall read instead ''OASVET''; references to ''Regional Administrator''

shall read instead ''RDVETS''; and references to ''JS regulations'' shall include this part.

(b) The ASVET shall establish appropriate program and management measurement and appraisal mechanisms to ensure that the standards of performance set forth in §§1001.120–1001.125 of this part are met. Specific performance standards designed to measure State agency services provided to veterans and eligible persons required by §1001.120(a) of this part will be developed administratively through negotiations between State agency administrators and SDVETS and numerical values of the standards will be published as public notices in the FEDERAL REGISTER. A full report of those State agencies in noncompliance with the standards of performance and their corrective action plans shall be incorporated into the Secretary's annual report to the Congress cited at §1001.131 of this part.

(c) Every effort should be made by the State agency administrator and the SDVETS to resolve all issues informally before proceeding with the formal process.

(d) If it is determined by the ASVET that certain State agencies are not complying with the performance standards at §§1001.120–1001.125 of this part, such State agencies shall be required to provide documentary evidence to the ASVET that their failure is based on good cause. If good cause is not shown, the ASVET, pursuant to subpart H of 20 CFR part 658, shall formally designate the State agency as out of compliance, shall require it to submit a corrective action plan for the following program year, and may take other action against the State agency pursuant to subpart H of 20 CFR part 658.

[49 FR 12919, Mar. 30, 1984. Redesignated and amended at 54 FR 39353, Sept. 26, 1989]

§ 1001.131 Secretary's annual report to Congress.

The Secretary shall report, after the end of each program year, on the success of the Department and State agencies in carrying out the provisions of this part.

[49 FR 12919, Mar. 30, 1984. Redesignated at 54 FR 39353, Sept. 26, 1989, and amended at 54 FR 39354, Sept. 26, 1989]

Subpart E—Standards of Performance Governing the Disabled Veterans Outreach Program (DVOP)

SOURCE: 49 FR 12919, Mar. 30, 1984, unless otherwise noted. Redesignated at 54 FR 39353, Sept. 26, 1989.

§ 1001.140 Administration of DVOP.

(a) The ASVET shall negotiate and enter into grant agreements within each State to carry out the requirements of 38 U.S.C. 2003A for support of a Disabled Veterans Outreach Program (DVOP) to meet the employment needs of veterans, especially disabled veterans of the Vietnam era.

(b) The ASVET shall be responsible forthe supervision and monitoring of the DVOP program, including monitoring of the appointment of DVOP specialists.

(c) DVOP specialists shall be in addition to and shall not supplant local veterans' employment representatives assigned under §1001.123 of this part.

[49 FR 12919, Mar. 30, 1984. Redesignated at 54 FR 39353, Sept. 26, 1989, and amended at 54 FR 39354, Sept. 26, 1989]

§ 1001.141 Functions of DVOP staff.

Each DVOP specialist shall carry out the duties and functions for providing services to eligible veterans according to provisions of 38 U.S.C. 2003A (b) and (c).

§ 1001.142 Stationing of DVOP staff.

DVOP specialists shall be stationed at various locations in accordance with 38 U.S.C. 2003A(b)(2).

Subpart F—Formula for the Allocation of Grant Funds to State Agencies

SOURCE: 70 FR 28406, May 17, 2005, unless otherwise noted.

§ 1001.150 Method of calculating State basic grant awards.

(a) In determining the amount of funds available to each State, the ratio of the number of veterans seeking employment in the State to the number of veterans seeking employment in all States will be used.

(b) The number of veterans seeking employment will be determined based on the number of veterans in the civilian labor force and the number of unemployed persons. The civilian labor force data will be obtained from the Current Population Survey (CPS) and the unemployment data will be obtained from the Local Area Unemployment Statistics (LAUS), both of which are compiled by the Department of Labor's Bureau of Labor Statistics.

(c) Each State's basic grant allocation will be determined by dividing the number of unemployed persons in each State by the number of unemployed persons across all States (LAUS for the individual States / LAUS for all States) and by dividing the number of veterans in the civilian labor force in each State by the number of veterans in the civilian labor force across all States (CPS for the individual States / CPS for all States). The result of these two ratios will be averaged and converted to a percentage of veterans seeking employment in the State compared to the percentage of veterans seeking employment in all States. Three-year averages of the CPS and LAUS data will be used in calculating the funding formula to stabilize the effect of annual fluctuations in the data in order to avoid undue fluctuations in the annual basic grant amounts allocated to States.

(d) State Plans are prepared in response to estimated basic grant allocation amounts prepared by the Department of Labor, based upon a projection of the appropriation. Variations from Department of Labor projections will be treated as follows:

(1) If the actual appropriation varies from the projection, the Secretary will make every reasonable effort to avoid recalculating the estimated basic grant allocation amounts, in order to maintain the delivery of services to veterans and to minimize the administrative workload required to recalculate grant allocations and to revise State Plans. Therefore upon enactment and allotment of an appropriated amount, it is the Department's intent to proceed by awarding the estimated basic grant allocation amounts to State agencies, unless the difference between the projection and the appropriation creates a compelling reason to do otherwise.

(2) If the actual appropriation exceeds the projection, the Secretary will determine whether the appropriation and the projection is large enough to warrant recalculating the State basic grant amounts. In such case, state basic grant amounts will be recalculated in accordance with paragraphs (a) through (c) of this section. If it is determined that no compelling reason to recalculate exists, the increased amount available for basic grants will be retained as undistributed funds. These undistributed basic grant funds will be retained separately from the funds retained for TAP workload and other exigencies, as established by §1001.151(a). The intent will be to award these undistributed basic grant funds to States as basic grant supplements, in response to circumstances arising during the applicable fiscal year.

(3) If the actual appropriation falls below the projection, the Secretary will determine whether the lower appropriation creates a compelling reason to recalculate the State basic grant amounts. If it is determined that not recalculating the State basic grant amounts would jeopardize the availability of sufficient funding for TAP workload and other exigencies, a compelling reason to recalculate would exist. In that case, the State basic grant amounts will be recalculated under paragraphs (a) through (c) of this section in response to the reduced appropriation, to the extent required to assure that sufficient funding is available for TAP workload and other exigencies.

§ 1001.151 Other funding criteria.

(a) Up to four percent of the total amount available for allocation will be available for distribution based on Transition Assistance Program (TAP) workload and other exigencies.

(b) Funding for TAP workshops will be allocated on a per workshop basis.

Funding to the States will be provided pursuant to the approved State Plan.

(c) Funds for exigent circumstances, such as unusually high levels of unemployment, surges in the demand for transitioning services, including the need for TAP workshops, will be allocated based on need.

§ 1001.152 Hold-harmless criteria and minimum funding level.

(a) A hold-harmless rate of 90 percent of the prior year's funding level will be applied after the funding formula phase-in period is completed (beginning fiscal year 2006 and subsequent years).

(b) A hold-harmless rate of 80 percent of the prior year's funding level will be applied for fiscal year 2005.

(c) A minimum funding level is established to ensure that in any year, no State will receive less than 0.28 percent (.0028) of the previous year's total funding for all States.

(d) If the appropriation for a given fiscal year does not provide sufficient funds to comply with the hold-harmless provision, the Department will:

(1) Update, as appropriate, the States' estimates of TAP workload and reserve sufficient funds for that purpose from the total amount available for allocation to the States. Beyond TAP workload, no funds will be reserved for exigent circumstances because the shortfall in the appropriation will be the primary exigent circumstance to be addressed.

(2) Apply proportionally the remaining balance available for basic grant allocations to the States for that fiscal year. The proportion will be calculated by dividing the remaining balance available for allocation by the total estimated State basic grant allocations for that fiscal year. The proportion resulting from that calculation will be applied to each State's estimated basic grant allocation to calculate the amount to be awarded.

Subpart G—Purpose and Definitions

SOURCE: 78 FR 15290, Mar. 11, 2013, unless otherwise noted.

§ 1001.160 What is the purpose and scope of this part?

(a) The purpose of this part is to fulfill the requirement of 38 U.S.C. 4102A(c)(3)(B) to establish a uniform national threshold entered employment rate (UNTEER) achieved for veterans and eligible persons by the State employment service delivery systems. We will use the UNTEER as part of the review process for determining whether a State's program year EER is deficient and a Corrective Action Plan (CAP) is required of that State employment service delivery system.

(b) This part is applicable to all State agencies that are recipients of Wagner-Peyser State Grants, and/or Jobs for Veterans State Grants.

§ 1001.161 What definitions apply to this part?

Department means the United States Department of Labor, including its agencies and organizational units and their representatives.

Eligible person, as defined at 38 U.S.C. 4101(5), means:

(1) The spouse of any person who died of a service-connected disability;

(2) The spouse of any member of the Armed Forces serving on active duty who, at the time of application for assistance under this chapter, is listed, pursuant to 37 U.S.C. 556 and regulations issued thereunder by the Secretary concerned, in one or more of the following categories and has been so listed for a total of more than ninety days:

(i) Missing in action,

(ii) Captured in line of duty by a hostile force, or

(iii) Forcibly detained or interned in line of duty by a foreign government or power; or

(3) The spouse of any person who has a total disability permanent in nature resulting from a service-connected disability or the spouse of a veteran who died while a disability so evaluated was in existence.

Employment service delivery system, as defined at 38 U.S.C. 4101(7), means a service delivery system at which or through which labor exchange services, including employment, training, and placement services, are offered in accordance with the Wagner-Peyser Act.

Jobs for Veterans Act (JVA) means Public Law 107–288, 116 Stat. 2033 (2002), codified at 38 U.S.C. chapters 41 and 42.

Jobs for Veterans State Grant (JVSG) means an award of Federal financial assistance by the Department to a State for the purposes of the Disabled Veterans' Outreach Program or the Local Veterans' Employment Representative Program.

Program year is the period from July 1 of a year through June 30 of the following year and is numbered according to the calendar year in which it begins.

§ 1001.162 How does the Department define veteran for purposes of this subpart?

The Department applies two definitions of veteran for the purposes of this subpart and has established two stages for the implementation of these definitions.

(a) The first stage of implementation begins with application of this subpart G to the first program year following May 10, 2013. As of that date, veteran is defined as it is in 38 U.S.C. 4211(4), as a person who:

(1) Served on active duty for a period of more than 180 days and was discharged or released therefrom with other than a dishonorable discharge;

(2) Was discharged or released from active duty because of a service-connected disability;

(3) As a member of a reserve component under an order to active duty pursuant to 10 U.S.C. 12301(a), (d), or (g), 12302, or 12304, served on active duty during a period of war or in a campaign or expedition for which a campaign badge is authorized and was discharged or released from such duty with other than a dishonorable discharge; or

(4) Was discharged or released from active duty by reason of a sole survivorship discharge (as that term is defined in 10 U.S.C.1174(i)).

(b) The second stage of implementation begins with the first day of the program year that begins two years after the first day of the program year that State grantees begin collecting and maintaining data as required by 20 CFR 1010.330(c). As of that date, veteran will be defined as it is in 20 CFR 1010.110:

(1) A person who served in the active military, naval, or air service, and who was discharged or released there from under conditions other than dishonorable, as specified in 38 U.S.C. 101(2).

(2) Active service includes full-time Federal service in the National Guard or a Reserve component, other than full-time duty for training purposes.

(c) During the second stage of implementation, any veteran who meets the definition specified in paragraph (a) of this section will be considered to meet the definition specified in paragraph (b) of this section.

(d) We will notify State grantees when they are required to begin implementing 20 CFR 1010.330(c).

§ 1001.163 What is the national entered employment rate (EER) and what is a State's program year EER for purposes of this part?

(a) For purposes of this part, we use the EER for veterans and eligible persons. This is the EER as applied to veterans (as defined in § 1001.162) and eligible persons (as defined in § 1001.161) who are participants in State employment service delivery systems.

(b) The EER for veterans and eligible persons measures the number of the participants described in paragraph (a) of this section who are employed after exiting an employment service delivery system compared to the total number of those participants who exited. We will issue policy guidance to establish the method of calculating the EER.

(c) The national EER for veterans and eligible persons is the EER achieved by the national State employment service delivery system for those veterans and eligible persons who are participants in all of the State employment service delivery systems for the program year under review. The national EER resulting from this calculation is expressed as a percentage that is rounded to the nearest tenth of a percent.

(d) A State's program year EER is the EER for veterans and eligible persons (as calculated in paragraph (b) of this section) achieved by a single State's employment service delivery system for those veterans and eligible persons who are included in the EER measure for that State's employment

service delivery system for the program year under review. The program year EER resulting from this calculation is expressed as a percentage that is rounded to the nearest tenth of a percent.

§ 1001.164 What is the uniform national threshold EER, and how will it be calculated?

(a) The uniform national threshold EER for a program year is equal to 90 percent of the national EER for veterans and eligible persons (as defined in § 1001.163(c)).

(b) The uniform national threshold EER resulting from this calculation is expressed as a percentage that is rounded to the nearest tenth of a percent.

§ 1001.165 When will the uniform national threshold EER be published?

When practicable, the Veterans' Employment and Training Service (VETS) will publish the uniform national threshold EER for a given program year by the end of December of the calendar year in which that program year ends.

§ 1001.166 How will the uniform national threshold EER be used to evaluate whether a State will be required to submit a Corrective Action Plan (CAP)?

(a) *Comparison.* Each State's program year EER will be compared to the uniform national threshold EER for that program year. State agencies that do not achieve a program year EER that equals or exceeds the uniform national threshold EER (90 percent of the national EER) for the year under review will be subject to a review by VETS, with input from the Employment and Training Administration (ETA), to determine whether the program year EER is deficient.

(b) *Review.* For each State whose program year EER is subject to review to determine deficiency, the review will consider the degree of difference between the State's program year EER and the uniform national threshold EER for that program year, as well as the annual unemployment data for the State as compiled by the Bureau of Labor Statistics.

(1) The review also may consider other relevant measures of prevailing economic conditions and regional economic conditions, as well as other measures of the performance of workforce programs and/or any information the State may submit.

(2) The review will include consultation with VETS and ETA field staff about findings from their on-site reviews and desk audits of State agency implementation of policies and procedures for services to veterans and also may include consultation with staff affiliated with other agencies of the Department, as appropriate.

(c) *Requirement of a CAP.* After review, a State whose program year EER is determined not to be deficient will be notified that a CAP will not be required; a State whose program year EER is determined to be deficient will be required to submit a CAP to improve the State's performance in assisting veterans to meet their employment needs as a condition of receiving its next-due JVSG.

(1) Any State whose program year EER has been determined to be deficient will be notified by March 31 of the year following the calendar year in which the program year under review ended.

(2) For any State that is required to submit a CAP, VETS will provide technical assistance (TA), with input from ETA, on the development of the CAP. The CAP must be submitted to the Grant Officer's Technical Representative by June 30 of the year following the calendar year in which the program year under review ended.

(3) We will review the CAP submitted by the State and determine, with input from ETA, whether to approve it or to provide additional TA to the State.

(i) If we approve the CAP, the State must expeditiously implement it.

(ii) If we do not approve the CAP, we will take such steps as are necessary to implement corrective actions to improve the State's EER for veterans and eligible persons.

(4) If a State fails to take the actions we impose under paragraph (c)(3)(ii) of this section, the Assistant Secretary for Veterans' Employment and Training may take any actions available to remedy non-compliance under 20 CFR

1001.130(a) (referring to the compliance measures discussed in 20 CFR part 658, subpart H).

§ 1001.167 In addition to the procedures specified in this part, will the Department be conducting any other monitoring of compliance regarding services to veterans?

Yes. We will continue to monitor compliance with the regulations on veterans' priority of service at 20 CFR 1010.240(b) jointly with the ETA. If a State's program year EER is determined to be deficient for a given program year, that deficiency would constitute information to be considered in monitoring priority of service, since failure to fully implement priority of service could be one of the contributors to a deficient program year EER.

PART 1002—REGULATIONS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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APPENDIX TO PART 1002—NOTICE OF YOUR RIGHTS UNDER USERRA

AUTHORITY: Section 4331(a) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), 38 U.S.C. 4331(a) (Pub. L. 103–353, 108 Stat. 3150).

SOURCE: 70 FR 75292, Dec. 19, 2005, unless otherwise noted.

Subpart A—Introduction to the Regulations Under the Uniformed Services Employment and Reemployment Rights Act of 1994

GENERAL PROVISIONS

§ 1002.1 What is the purpose of this part?

This part implements the Uniformed Services Employment and Reemployment Rights Act of 1994 (''USERRA'' or ''the Act''). 38 U.S.C. 4301–4334. USERRA is a law that establishes certain rights and benefits for employees, and duties for employers. USERRA affects employment, reemployment, and retention in employment, when employees serve or have served in the uniformed services. There are five subparts to these regulations. Subpart A gives an introduction to the USERRA regulations. Subpart B describes USERRA's anti-discrimination and anti-retaliation provisions. Subpart C explains the steps that must be taken by a uniformed service member who wants to return to his or her previous civilian employment. Subpart D describes the rights, benefits, and obligations of persons absent from employment due to service in the uniformed services, including rights and obligations related to health plan coverage. Subpart E describes the rights, benefits, and obligations of the returning veteran or service member. Subpart F explains the role of the Department of Labor in enforcing and giving assistance under USERRA. These regulations implement USERRA as it applies to States, local governments, and private employers. Separate regulations published by the Federal Office of Personnel Management implement USERRA for Federal executive agency employers and employees.

§ 1002.2 Is USERRA a new law?

USERRA is the latest in a series of laws protecting veterans' employment and reemployment rights going back to the Selective Training and Service Act of 1940. USERRA's immediate predecessor was commonly referred to as the Veterans' Reemployment Rights Act (VRRA), which was enacted as section 404 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974. In enacting USERRA, Congress emphasized USERRA's continuity with the VRRA and its intention to clarify and strengthen that law. Congress also emphasized that Federal laws protecting veterans' employment and reemployment rights for the past fifty years had been successful and that the large body of case law that had developed under those statutes remained in full force and effect, to the extent it is consistent with USERRA. USERRA authorized the Department of Labor to publish regulations implementing the Act for State, local government, and private employers. USERRA also authorized the Office of Personnel Management to issue regulations implementing the Act for Federal executive agencies (other than some Federal intelligence agencies). USERRA established a separate program for employees of some Federal intelligence agencies.

§ 1002.3 When did USERRA become effective?

USERRA became law on October 13, 1994. USERRA's reemployment provisions apply to members of the uniformed services seeking civilian reemployment on or after December 12, 1994. USERRA's anti-discrimination and anti-retaliation provisions became effective on October 13, 1994.

§ 1002.4 What is the role of the Secretary of Labor under USERRA?

(a) USERRA charges the Secretary of Labor (through the Veterans' Employment and Training Service) with providing assistance to any person with respect to the employment and reemployment rights and benefits to which such person is entitled under the Act. More information about the Secretary's role in providing this assistance is contained in Subpart F.

(b) USERRA also authorizes the Secretary of Labor to issue regulations implementing the Act with respect to States, local governments, and private employers. These regulations are issued under this authority.

(c) The Secretary of Labor delegated authority to the Assistant Secretary

for Veterans' Employment and Training for administering the veterans' reemployment rights program by Secretary's Order 1–83 (February 3, 1983) and for carrying out the functions and authority vested in the Secretary pursuant to USERRA by memorandum of April 22, 2002 (67 FR 31827).

§ 1002.5 What definitions apply to USERRA?

(a) *Attorney General* means the Attorney General of the United States or any person designated by the Attorney General to carry out a responsibility of the Attorney General under USERRA.

(b) *Benefit, benefit of employment, or rights and benefits* means any advantage, profit, privilege, gain, status, account, or interest (other than wages or salary for work performed) that accrues to the employee because of an employment contract, employment agreement, or employer policy, plan, or practice. The term includes rights and benefits under a pension plan, health plan, or employee stock ownership plan, insurance coverage and awards, bonuses, severance pay, supplemental unemployment benefits, vacations, and the opportunity to select work hours or the location of employment.

(c) *Employee* means any person employed by an employer. The term also includes any person who is a citizen, national or permanent resident alien of the United States who is employed in a workplace in a foreign country by an employer that is an entity incorporated or organized in the United States, or that is controlled by an entity organized in the United States. ''Employee'' includes the former employees of an employer.

(d)(1) *Employer*, except as provided in paragraphs (d)(2) and (3) of this section, means any person, institution, organization, or other entity that pays salary or wages for work performed, or that has control over employment opportunities, including—

(i) A person, institution, organization, or other entity to whom the employer has delegated the performance of employment-related responsibilities, except in the case that such entity has been delegated functions that are purely ministerial in nature, such as maintenance of personnel files or the preparation of forms for submission to a government agency;

(ii) The Federal Government;

(iii) A State;

(iv) Any successor in interest to a person, institution, organization, or other entity referred to in this definition; and,

(v) A person, institution, organization, or other entity that has denied initial employment in violation of 38 U.S.C. 4311, USERRA's anti-discrimination and anti-retaliation provisions.

(2) In the case of a National Guard technician employed under 32 U.S.C. 709, the term ''employer'' means the adjutant general of the State in which the technician is employed.

(3) An employee pension benefit plan as described in section 3(2) of the Employee Retirement Income Security Act of 1974 (ERISA)(29 U.S.C. 1002(2)) is considered an employer for an individual that it does not actually employ only with respect to the obligation to provide pension benefits.

(e) *Health plan* means an insurance policy, insurance contract, medical or hospital service agreement, membership or subscription contract, or other arrangement under which health services for individuals are provided or the expenses of such services are paid.

(f) *National Disaster Medical System (NDMS)* is an agency within the Federal Emergency Management Agency, Department of Homeland Security, established by the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Public Law 107–188. The NDMS provides medical-related assistance to respond to the needs of victims of public health emergencies. Participants in the NDMS are volunteers who serve as intermittent Federal employees when activated. For purposes of USERRA coverage only, these persons are treated as members of the uniformed services when they are activated to provide assistance in response to a public health emergency or to be present for a short period of time when there is a risk of a public health emergency, or when they are participating in authorized training. See 42 U.S.C. 300hh–11(e).

(g) *Notice*, when the employee is required to give advance notice of service, means any written or verbal notification of an obligation or intention to perform service in the uniformed services provided to an employer by the employee who will perform such service, or by the uniformed service in which the service is to be performed.

(h) *Qualified*, with respect to an employment position, means having the ability to perform the essential tasks of the position.

(i) *Reasonable efforts*, in the case of actions required of an employer, means actions, including training provided by an employer that do not place an undue hardship on the employer.

(j) *Secretary* means the Secretary of Labor or any person designated by the Secretary of Labor to carry out an activity under USERRA and these regulations, unless a different office is expressly indicated in the regulation.

(k) *Seniority* means longevity in employment together with any benefits of employment that accrue with, or are determined by, longevity in employment.

(l) *Service in the uniformed services* means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority. Service in the uniformed services includes active duty, active and inactive duty for training, National Guard duty under Federal statute, and a period for which a person is absent from a position of employment for an examination to determine the fitness of the person to perform such duty. The term also includes a period for which a person is absent from employment to perform funeral honors duty as authorized by law (10 U.S.C. 12503 or 32 U.S.C. 115). The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. 107–188, provides that service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System (NDMS) or as a participant in an authorized training program is deemed ''service in the uniformed services.'' 42 U.S.C. 300hh–11(e)(3).

(m) *State* means each of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Virgin Islands, and other territories of the United States (including the agencies and political subdivisions thereof); however, for purposes of enforcement of rights under 38 U.S.C. 4323, a political subdivision of a State is a private employer.

(n) *Undue hardship*, in the case of actions taken by an employer, means an action requiring significant difficulty or expense, when considered in light of—

(1) The nature and cost of the action needed under USERRA and these regulations;

(2) The overall financial resources of the facility or facilities involved in the provision of the action; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such action upon the operation of the facility;

(3) The overall financial resources of the employer; the overall size of the business of an employer with respect to the number of its employees; the number, type, and location of its facilities; and,

(4) The type of operation or operations of the employer, including the composition, structure, and functions of the work force of such employer; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the employer.

(o) *Uniformed services* means the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in time of war or national emergency. For purposes of USERRA coverage only, service as an intermittent disaster response appointee of the NDMS when federally activated or attending authorized training in support of their Federal mission is deemed ''service in the uniformed services,'' although such appointee is not a member of the ''uniformed services'' as defined by USERRA.

§ 1002.6 What types of service in the uniformed services are covered by USERRA?

USERRA's definition of ''service in the uniformed services'' covers all categories of military training and service, including duty performed on a voluntary or involuntary basis, in time of peace or war. Although most often understood as applying to National Guard and reserve military personnel, USERRA also applies to persons serving in the active components of the Armed Forces. Certain types of service specified in 42 U.S.C. 300hh-11 by members of the National Disaster Medical System are covered by USERRA.

§ 1002.7 How does USERRA relate to other laws, public and private contracts, and employer practices?

(a) USERRA establishes a floor, not a ceiling, for the employment and reemployment rights and benefits of those it protects. In other words, an employer may provide greater rights and benefits than USERRA requires, but no employer can refuse to provide any right or benefit guaranteed by USERRA.

(b) USERRA supersedes any State law (including any local law or ordinance), contract, agreement, policy, plan, practice, or other matter that reduces, limits, or eliminates in any manner any right or benefit provided by USERRA, including the establishment of additional prerequisites to the exercise of any USERRA right or the receipt of any USERRA benefit. For example, an employment contract that determines seniority based only on actual days of work in the place of employment would be superseded by USERRA, which requires that seniority credit be given for periods of absence from work due to service in the uniformed services.

(c) USERRA does not supersede, nullify or diminish any Federal or State law (including any local law or ordinance), contract, agreement, policy, plan, practice, or other matter that establishes an employment right or benefit that is more beneficial than, or is in addition to, a right or benefit provided under the Act. For example, although USERRA does not require an employer to pay an employee for time away from work performing service, an employer policy, plan, or practice that provides such a benefit is permissible under USERRA.

(d) If an employer provides a benefit that exceeds USERRA's requirements in one area, it cannot reduce or limit other rights or benefits provided by USERRA. For example, even though USERRA does not require it, an employer may provide a fixed number of days of paid military leave per year to employees who are members of the National Guard or Reserve. The fact that it provides such a benefit, however, does not permit an employer to refuse to provide an unpaid leave of absence to an employee to perform service in the uniformed services in excess of the number of days of paid military leave.

Subpart B—Anti-Discrimination and Anti-Retaliation

PROTECTION FROM EMPLOYER DISCRIMINATION AND RETALIATION

§ 1002.18 What status or activity is protected from employer discrimination by USERRA?

An employer must not deny initial employment, reemployment, retention in employment, promotion, or any benefit of employment to an individual on the basis of his or her membership, application for membership, performance of service, application for service, or obligation for service in the uniformed services.

§ 1002.19 What activity is protected from employer retaliation by USERRA?

An employer must not retaliate against an individual by taking any adverse employment action against him or her because the individual has taken an action to enforce a protection afforded any person under USERRA; testified or otherwise made a statement in or in connection with a proceeding under USERRA; assisted or participated in a USERRA investigation: or, exercised a right provided for by USERRA.

§ 1002.20 Does USERRA protect an individual who does not actually perform service in the uniformed services?

Yes. Employers are prohibited from taking actions against an individual for any of the activities protected by the Act, whether or not he or she has performed service in the uniformed services.

§ 1002.21 Do the Act's prohibitions against discrimination and retaliation apply to all employment positions?

The prohibitions against discrimination and retaliation apply to all covered employers (including hiring halls and potential employers, see sections 1002.36 and .38) and employment positions, including those that are for a brief, nonrecurrent period, and for which there is no reasonable expectation that the employment position will continue indefinitely or for a significant period. However, USERRA's reemployment rights and benefits do not apply to such brief, nonrecurrent positions of employment.

§ 1002.22 Who has the burden of proving discrimination or retaliation in violation of USERRA?

The individual has the burden of proving that a status or activity protected by USERRA was one of the reasons that the employer took action against him or her, in order to establish that the action was discrimination or retaliation in violation of USERRA. If the individual succeeds in proving that the status or activity protected by USERRA was one of the reasons the employer took action against him or her, the employer has the burden to prove the affirmative defense that it would have taken the action anyway.

§ 1002.23 What must the individual show to carry the burden of proving that the employer discriminated or retaliated against him or her?

(a) In order to prove that the employer discriminated or retaliated against the individual, he or she must first show that the employer's action was motivated by one or more of the following:

(1) Membership or application for membership in a uniformed service;

(2) Performance of service, application for service, or obligation for service in a uniformed service;

(3) Action taken to enforce a protection afforded any person under USERRA;

(4) Testimony or statement made in or in connection with a USERRA proceeding;

(5) Assistance or participation in a USERRA investigation; or,

(6) Exercise of a right provided for by USERRA.

(b) If the individual proves that the employer's action was based on one of the prohibited motives listed in paragraph (a) of this section, the employer has the burden to prove the affirmative defense that the action would have been taken anyway absent the USERRA-protected status or activity.

Subpart C—Eligibility For Reemployment

GENERAL ELIGIBILITY REQUIREMENTS FOR REEMPLOYMENT

§ 1002.32 What criteria must the employee meet to be eligible under USERRA for reemployment after service in the uniformed services?

(a) In general, if the employee has been absent from a position of civilian employment by reason of service in the uniformed services, he or she will be eligible for reemployment under USERRA by meeting the following criteria:

(1) The employer had advance notice of the employee's service;

(2) The employee has five years or less of cumulative service in the uniformed services in his or her employment relationship with a particular employer;

(3) The employee timely returns to work or applies for reemployment; and,

(4) The employee has not been separated from service with a disqualifying discharge or under other than honorable conditions.

(b) These general eligibility requirements have important qualifications and exceptions, which are described in detail in §§ 1002.73 through 1002.138. If the employee meets these eligibility criteria, then he or she is eligible for

reemployment unless the employer establishes one of the defenses described in §1002.139. The employment position to which the employee is entitled is described in §§1002.191 through 1002.199.

§1002.33 Does the employee have to prove that the employer discriminated against him or her in order to be eligible for reemployment?

No. The employee is not required to prove that the employer discriminated against him or her because of the employee's uniformed service in order to be eligible for reemployment.

COVERAGE OF EMPLOYERS AND POSITIONS

§1002.34 Which employers are covered by USERRA?

(a) USERRA applies to all public and private employers in the United States, regardless of size. For example, an employer with only one employee is covered for purposes of the Act.

(b) USERRA applies to foreign employers doing business in the United States. A foreign employer that has a physical location or branch in the United States (including U.S. territories and possessions) must comply with USERRA for any of its employees who are employed in the United States.

(c) An American company operating either directly or through an entity under its control in a foreign country must also comply with USERRA for all its foreign operations, unless compliance would violate the law of the foreign country in which the workplace is located.

§1002.35 Is a successor in interest an employer covered by USERRA?

USERRA's definition of ''employer'' includes a successor in interest. In general, an employer is a successor in interest where there is a substantial continuity in operations, facilities, and workforce from the former employer. The determination whether an employer is a successor in interest must be made on a case-by-case basis using a multi-factor test that considers the following:

(a) Whether there has been a substantial continuity of business operations from the former to the current employer;

(b) Whether the current employer uses the same or similar facilities, machinery, equipment, and methods of production;

(c) Whether there has been a substantial continuity of employees;

(d) Whether there is a similarity of jobs and working conditions;

(e) Whether there is a similarity of supervisors or managers; and,

(f) Whether there is a similarity of products or services.

§1002.36 Can an employer be liable as a successor in interest if it was unaware that an employee may claim reemployment rights when the employer acquired the business?

Yes. In order to be a successor in interest, it is not necessary for an employer to have notice of a potential reemployment claim at the time of merger, acquisition, or other form of succession.

§1002.37 Can one employee be employed in one job by more than one employer?

Yes. Under USERRA, an employer includes not only the person or entity that pays an employee's salary or wages, but also includes a person or entity that has control over his or her employment opportunities, including a person or entity to whom an employer has delegated the performance of employment-related responsibilities. For example, if the employee is a security guard hired by a security company and he or she is assigned to a work site, the employee may report both to the security company and to the site owner. In such an instance, both employers share responsibility for compliance with USERRA. If the security company declines to assign the employee to a job because of a uniformed service obligation (for example, National Guard duties), then the security company could be in violation of the reemployment requirements and the anti-discrimination provisions of USERRA. Similarly, if the employer at the work site causes the employee's removal from the job position because of his or her uniformed service obligations, then the work site employer could be in violation of the reemployment requirements and the anti-discrimination provisions of USERRA.

§ 1002.38 Can a hiring hall be an employer?

Yes. In certain occupations (for example, longshoreman, stagehand, construction worker), the employee may frequently work for many different employers. A hiring hall operated by a union or an employer association typically assigns the employee to the jobs. In these industries, it may not be unusual for the employee to work his or her entire career in a series of short-term job assignments. The definition of ''employer'' includes a person, institution, organization, or other entity to which the employer has delegated the performance of employment-related responsibilities. A hiring hall therefore is considered the employee's employer if the hiring and job assignment functions have been delegated by an employer to the hiring hall. As the employer, a hiring hall has reemployment responsibilities to its employees. USERRA's anti-discrimination and anti-retaliation provisions also apply to the hiring hall.

§ 1002.39 Are States (and their political subdivisions), the District of Columbia, the Commonwealth of Puerto Rico, and United States territories, considered employers?

Yes. States and their political subdivisions, such as counties, parishes, cities, towns, villages, and school districts, are considered employers under USERRA. The District of Columbia, the Commonwealth of Puerto Rico, Guam, the Virgin Islands, and territories of the United States, are also considered employers under the Act.

§ 1002.40 Does USERRA protect against discrimination in initial hiring decisions?

Yes. The Act's definition of employer includes a person, institution, organization, or other entity that has denied initial employment to an individual in violation of USERRA's anti-discrimination provisions. An employer need not actually employ an individual to be his or her ''employer'' under the Act, if it has denied initial employment on the basis of the individual's membership, application for membership, performance of service, application for service, or obligation for service in the uniformed services. Similarly, the employer would be liable if it denied initial employment on the basis of the individual's action taken to enforce a protection afforded to any person under USERRA, his or her testimony or statement in connection with any USERRA proceeding, assistance or other participation in a USERRA investigation, or the exercise of any other right provided by the Act. For example, if the individual has been denied initial employment because of his or her obligations as a member of the National Guard or Reserves, the company or entity denying employment is an employer for purposes of USERRA. Similarly, if an entity withdraws an offer of employment because the individual is called upon to fulfill an obligation in the uniformed services, the entity withdrawing the employment offer is an employer for purposes of USERRA.

§ 1002.41 Does an employee have rights under USERRA even though he or she holds a temporary, part-time, probationary, or seasonal employment position?

USERRA rights are not diminished because an employee holds a temporary, part-time, probationary, or seasonal employment position. However, an employer is not required to reemploy an employee if the employment he or she left to serve in the uniformed services was for a brief, nonrecurrent period and there is no reasonable expectation that the employment would have continued indefinitely or for a significant period. The employer bears the burden of proving this affirmative defense.

§ 1002.42 What rights does an employee have under USERRA if he or she is on layoff, on strike, or on a leave of absence?

(a) If an employee is laid off with recall rights, on strike, or on a leave of absence, he or she is an employee for purposes of USERRA. If the employee is on layoff and begins service in the uniformed services, or is laid off while performing service, he or she may be entitled to reemployment on return if the employer would have recalled the employee to employment during the period of service. Similar principles

apply if the employee is on strike or on a leave of absence from work when he or she begins a period of service in the uniformed services.

(b) If the employee is sent a recall notice during a period of service in the uniformed services and cannot resume the position of employment because of the service, he or she still remains an employee for purposes of the Act. Therefore, if the employee is otherwise eligible, he or she is entitled to reemployment following the conclusion of the period of service even if he or she did not respond to the recall notice.

(c) If the employee is laid off before or during service in the uniformed services, and the employer would not have recalled him or her during that period of service, the employee is not entitled to reemployment following the period of service simply because he or she is a covered employee. Reemployment rights under USERRA cannot put the employee in a better position than if he or she had remained in the civilian employment position.

§ 1002.43 Does an individual have rights under USERRA even if he or she is an executive, managerial, or professional employee?

Yes. USERRA applies to all employees. There is no exclusion for executive, managerial, or professional employees.

§ 1002.44 Does USERRA cover an independent contractor?

(a) No. USERRA does not provide protections for an independent contractor.

(b) In deciding whether an individual is an independent contractor, the following factors need to be considered:

(1) The extent of the employer's right to control the manner in which the individual's work is to be performed;

(2) The opportunity for profit or loss that depends upon the individual's managerial skill;

(3) Any investment in equipment or materials required for the individual's tasks, or his or her employment of helpers;

(4) Whether the service the individual performs requires a special skill;

(5) The degree of permanence of the individual's working relationship; and,

(6) Whether the service the individual performs is an integral part of the employer's business.

(c) No single one of these factors is controlling, but all are relevant to determining whether an individual is an employee or an independent contractor.

Coverage of Service in the Uniformed Services

§ 1002.54 Are all military fitness examinations considered "service in the uniformed services?"

Yes. USERRA's definition of ''service in the uniformed services'' includes a period for which an employee is absent from a position of employment for the purpose of an examination to determine his or her fitness to perform duty in the uniformed services. Military fitness examinations can address more than physical or medical fitness, and include evaluations for mental, educational, and other types of fitness. Any examination to determine an employee's fitness for service is covered, whether it is an initial or recurring examination. For example, a periodic medical examination required of a Reserve component member to determine fitness for continued service is covered.

§ 1002.55 Is all funeral honors duty considered "service in the uniformed services?"

(a) USERRA's definition of ''service in the uniformed services'' includes a period for which an employee is absent from employment for the purpose of performing authorized funeral honors duty under 10 U.S.C. 12503 (members of Reserve ordered to perform funeral honors duty) or 32 U.S.C. 115 (Member of Air or Army National Guard ordered to perform funeral honors duty).

(b) Funeral honors duty performed by persons who are not members of the uniformed services, such as members of veterans' service organizations, is not ''service in the uniformed services.''

§ 1002.56 What types of service in the National Disaster Medical System are considered "service in the uniformed services?"

Under a provision of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, 42

U.S.C. 300hh 11(e)(3), ''service in the uniformed services'' includes service performed as an intermittent disaster-response appointee upon activation of the National Disaster Medical System or participation in an authorized training program, even if the individual is not a member of the uniformed services.

§ 1002.57 Is all service as a member of the National Guard considered "service in the uniformed services?"

The National Guard has a dual status. It is a Reserve component of the Army, or, in the case of the Air National Guard, of the Air Force. Simultaneously, it is a State military force subject to call-up by the State Governor for duty not subject to Federal control, such as emergency duty in cases of floods or riots. National Guard members may perform service under either Federal or State authority, but only Federal National Guard service is covered by USERRA.

(a) National Guard service under Federal authority is protected by USERRA. Service under Federal authority includes active duty performed under Title 10 of the United States Code. Service under Federal authority also includes duty under Title 32 of the United States Code, such as active duty for training, inactive duty training, or full-time National Guard duty.

(b) National Guard service under authority of State law is not protected by USERRA. However, many States have laws protecting the civilian job rights of National Guard members who serve under State orders. Enforcement of those State laws is not covered by USERRA or these regulations.

§ 1002.58 Is service in the commissioned corps of the Public Health Service considered "service in the uniformed services?"

Yes. Service in the commissioned corps of the Public Health Service (PHS) is ''service in the uniformed services'' under USERRA.

§ 1002.59 Are there any circumstances in which special categories of persons are considered to perform "service in the uniformed services?"

Yes. In time of war or national emergency the President has authority to designate any category of persons as a ''uniformed service'' for purposes of USERRA. If the President exercises this authority, service as a member of that category of persons would be ''service in the uniformed services'' under USERRA.

§ 1002.60 Does USERRA cover an individual attending a military service academy?

Yes. Attending a military service academy is considered uniformed service for purposes of USERRA. There are four service academies: The United States Military Academy (West Point, New York), the United States Naval Academy (Annapolis, Maryland), the United States Air Force Academy (Colorado Springs, Colorado), and the United States Coast Guard Academy (New London, Connecticut).

§ 1002.61 Does USERRA cover a member of the Reserve Officers Training Corps?

Yes, under certain conditions.

(a) Membership in the Reserve Officers Training Corps (ROTC) or the Junior ROTC is not ''service in the uniformed services.'' However, some Reserve and National Guard enlisted members use a college ROTC program as a means of qualifying for commissioned officer status. National Guard and Reserve members in an ROTC program may at times, while participating in that program, be receiving active duty and inactive duty training service credit with their unit. In these cases, participating in ROTC training sessions is considered ''service in the uniformed services,'' and qualifies a person for protection under USERRA's reemployment and anti-discrimination provisions.

(b) Typically, an individual in a College ROTC program enters into an agreement with a particular military service that obligates such individual to either complete the ROTC program and accept a commission or, in case he or she does not successfully complete the ROTC program, to serve as an enlisted member. Although an individual does not qualify for reemployment protection, except as specified in (a) above, he or she is protected under

USERRA's anti-discrimination provisions because, as a result of the agreement, he or she has applied to become a member of the uniformed services and has incurred an obligation to perform future service.

§ 1002.62 Does USERRA cover a member of the Commissioned Corps of the National Oceanic and Atmospheric Administration, the Civil Air Patrol, or the Coast Guard Auxiliary?

No. Although the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA) is a ''uniformed service'' for some purposes, it is not included in USERRA's definition of this term. Service in the Civil Air Patrol and the Coast Guard Auxiliary similarly is not considered ''service in the uniformed services'' for purposes of USERRA. Consequently, service performed in the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA), the Civil Air Patrol, and the Coast Guard Auxiliary is not protected by USERRA.

Absence From a Position of Employment Necessitated by Reason of Service in the Uniformed Services

§ 1002.73 Does service in the uniformed services have to be an employee's sole reason for leaving an employment position in order to have USERRA reemployment rights?

No. If absence from a position of employment is necessitated by service in the uniformed services, and the employee otherwise meets the Act's eligibility requirements, he or she has reemployment rights under USERRA, even if the employee uses the absence for other purposes as well. An employee is not required to leave the employment position for the sole purpose of performing service in the uniformed services. For example, if the employee is required to report to an out of State location for military training and he or she spends off-duty time during that assignment moonlighting as a security guard or visiting relatives who live in that State, the employee will not lose reemployment rights simply because he or she used some of the time away from the job to do something other than attend the military training. Also, if an employee receives advance notification of a mobilization order, and leaves his or her employment position in order to prepare for duty, but the mobilization is cancelled, the employee will not lose any reemployment rights.

§ 1002.74 Must the employee begin service in the uniformed services immediately after leaving his or her employment position in order to have USERRA reemployment rights?

No. At a minimum, an employee must have enough time after leaving the employment position to travel safely to the uniformed service site and arrive fit to perform the service. Depending on the specific circumstances, including the duration of service, the amount of notice received, and the location of the service, additional time to rest, or to arrange affairs and report to duty, may be necessitated by reason of service in the uniformed services. The following examples help to explain the issue of the period of time between leaving civilian employment and beginning of service in the uniformed services:

(a) If the employee performs a full overnight shift for the civilian employer and travels directly from the work site to perform a full day of uniformed service, the employee would not be considered fit to perform the uniformed service. An absence from that work shift is necessitated so that the employee can report for uniformed service fit for duty.

(b) If the employee is ordered to perform an extended period of service in the uniformed services, he or she may require a reasonable period of time off from the civilian job to put his or her personal affairs in order, before beginning the service. Taking such time off is also necessitated by the uniformed service.

(c) If the employee leaves a position of employment in order to enlist or otherwise perform service in the uniformed services and, through no fault of his or her own, the beginning date of the service is delayed, this delay does not terminate any reemployment rights.

REQUIREMENT OF NOTICE

§ 1002.85 Must the employee give advance notice to the employer of his or her service in the uniformed services?

(a) Yes. The employee, or an appropriate officer of the uniformed service in which his or her service is to be performed, must notify the employer that the employee intends to leave the employment position to perform service in the uniformed services, with certain exceptions described below. In cases in which an employee is employed by more than one employer, the employee, or an appropriate office of the uniformed service in which his or her service is to be performed, must notify each employer that the employee intends to leave the employment position to perform service in the uniformed services, with certain exceptions described below.

(b) The Department of Defense USERRA regulations at 32 CFR 104.3 provide that an ''appropriate officer'' can give notice on the employee's behalf. An ''appropriate officer'' is a commissioned, warrant, or non-commissioned officer authorized to give such notice by the military service concerned.

(c) The employee's notice to the employer may be either verbal or written. The notice may be informal and does not need to follow any particular format.

(d) Although USERRA does not specify how far in advance notice must be given to the employer, an employee should provide notice as far in advance as is reasonable under the circumstances. In regulations promulgated by the Department of Defense under USERRA, 32 CFR 104.6(a)(2)(i)(B), the Defense Department ''strongly recommends that advance notice to civilian employers be provided at least 30 days prior to departure for uniformed service when it is feasible to do so.''

§ 1002.86 When is the employee excused from giving advance notice of service in the uniformed services?

The employee is required to give advance notice of pending service unless giving such notice is prevented by military necessity, or is otherwise impossible or unreasonable under all the circumstances.

(a) Only a designated authority can make a determination of ''military necessity,'' and such a determination is not subject to judicial review. Guidelines for defining ''military necessity'' appear in regulations issued by the Department of Defense at 32 CFR 104.3. In general, these regulations cover situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. In certain cases, the Secretary of Homeland Security, in consultation with the Secretary of Defense, can make a determination that giving of notice by intermittent disaster-response appointees of the National Disaster Medical System is precluded by ''military necessity.'' See 42 U.S.C. 300hh–11(e)(3)(B).

(b) It may be impossible or unreasonable to give advance notice under certain circumstances. Such circumstances may include the unavailability of the employee's employer or the employer's representative, or a requirement that the employee report for uniformed service in an extremely short period of time.

§ 1002.87 Is the employee required to get permission from his or her employer before leaving to perform service in the uniformed services?

No. The employee is not required to ask for or get his or her employer's permission to leave to perform service in the uniformed services. The employee is only required to give the employer notice of pending service.

§ 1002.88 Is the employee required to tell his or her civilian employer that he or she intends to seek reemployment after completing uniformed service before the employee leaves to perform service in the uniformed services?

No. When the employee leaves the employment position to begin a period of service, he or she is not required to tell the civilian employer that he or she intends to seek reemployment after completing uniformed service. Even if the employee tells the employer before entering or completing uniformed service that he or she does not intend to

seek reemployment after completing the uniformed service, the employee does not forfeit the right to reemployment after completing service. The employee is not required to decide in advance of leaving the civilian employment position whether he or she will seek reemployment after completing uniformed service.

PERIOD OF SERVICE

§ 1002.99 Is there a limit on the total amount of service in the uniformed services that an employee may perform and still retain reemployment rights with the employer?

Yes. In general, the employee may perform service in the uniformed services for a cumulative period of up to five (5) years and retain reemployment rights with the employer. The exceptions to this rule are described below.

§ 1002.100 Does the five-year service limit include all absences from an employment position that are related to service in the uniformed services?

No. The five-year period includes only the time the employee spends actually performing service in the uniformed services. A period of absence from employment before or after performing service in the uniformed services does not count against the five-year limit. For example, after the employee completes a period of service in the uniformed services, he or she is provided a certain amount of time, depending upon the length of service, to report back to work or submit an application for reemployment. The period between completing the uniformed service and reporting back to work or seeking reemployment does not count against the five-year limit.

§ 1002.101 Does the five-year service limit include periods of service that the employee performed when he or she worked for a previous employer?

No. An employee is entitled to a leave of absence for uniformed service for up to five years with each employer for whom he or she works. When the employee takes a position with a new employer, the five-year period begins again regardless of how much service he or she performed while working in any previous employment relationship. If an employee is employed by more than one employer, a separate five-year period runs as to each employer independently, even if those employers share or co-determine the employee's terms and conditions of employment.

§ 1002.102 Does the five-year service limit include periods of service that the employee performed before USERRA was enacted?

It depends. USERRA provides reemployment rights to which an employee may become entitled beginning on or after December 12, 1994, but any uniformed service performed before December 12, 1994, that was counted against the service limitations of the previous law (the Veterans Reemployment Rights Act), also counts against USERRA's five-year limit.

§ 1002.103 Are there any types of service in the uniformed services that an employee can perform that do not count against USERRA's five-year service limit?

(a) USERRA creates the following exceptions to the five-year limit on service in the uniformed services:

(1) Service that is required beyond five years to complete an initial period of obligated service. Some military specialties require an individual to serve more than five years because of the amount of time or expense involved in training. If the employee works in one of those specialties, he or she has reemployment rights when the initial period of obligated service is completed;

(2) If the employee was unable to obtain orders releasing him or her from service in the uniformed services before the expiration of the five-year period, and the inability was not the employee's fault;

(3)(i) Service performed to fulfill periodic National Guard and Reserve training requirements as prescribed by 10 U.S.C. 10147 and 32 U.S.C. 502(a) and 503; and,

(ii) Service performed to fulfill additional training requirements determined and certified by a proper military authority as necessary for the employee's professional development, or

to complete skill training or retraining;

(4) Service performed in a uniformed service if he or she was ordered to or retained on active duty under:

(i) 10 U.S.C. 688 (involuntary active duty by a military retiree);

(ii) 10 U.S.C. 12301(a) (involuntary active duty in wartime);

(iii) 10 U.S.C. 12301(g) (retention on active duty while in captive status);

(iv) 10 U.S.C. 12302 (involuntary active duty during a national emergency for up to 24 months);

(v) 10 U.S.C. 12304 (involuntary active duty for an operational mission for up to 270 days);

(vi) 10 U.S.C. 12305 (involuntary retention on active duty of a critical person during time of crisis or other specific conditions);

(vii) 14 U.S.C. 331 (involuntary active duty by retired Coast Guard officer);

(viii) 14 U.S.C. 332 (voluntary active duty by retired Coast Guard officer);

(ix) 14 U.S.C. 359 (involuntary active duty by retired Coast Guard enlisted member);

(x) 14 U.S.C. 360 (voluntary active duty by retired Coast Guard enlisted member);

(xi) 14 U.S.C. 367 (involuntary retention of Coast Guard enlisted member on active duty); and

(xii) 14 U.S.C. 712 (involuntary active duty by Coast Guard Reserve member for natural or man-made disasters).

(5) Service performed in a uniformed service if the employee was ordered to or retained on active duty (other than for training) under any provision of law because of a war or national emergency declared by the President or the Congress, as determined by the Secretary concerned;

(6) Service performed in a uniformed service if the employee was ordered to active duty (other than for training) in support of an operational mission for which personnel have been ordered to active duty under 10 U.S.C. 12304, as determined by a proper military authority;

(7) Service performed in a uniformed service if the employee was ordered to active duty in support of a critical mission or requirement of the uniformed services as determined by the Secretary concerned; and,

(8) Service performed as a member of the National Guard if the employee was called to respond to an invasion, danger of invasion, rebellion, danger of rebellion, insurrection, or the inability of the President with regular forces to execute the laws of the United States.

(b) Service performed to mitigate economic harm where the employee's employer is in violation of its employment or reemployment obligations to him or her.

§ 1002.104 Is the employee required to accommodate his or her employer's needs as to the timing, frequency or duration of service?

No. The employee is not required to accommodate his or her employer's interests or concerns regarding the timing, frequency, or duration of uniformed service. The employer cannot refuse to reemploy the employee because it believes that the timing, frequency or duration of the service is unreasonable. However, the employer is permitted to bring its concerns over the timing, frequency, or duration of the employee's service to the attention of the appropriate military authority. Regulations issued by the Department of Defense at 32 CFR 104.4 direct military authorities to provide assistance to an employer in addressing these types of employment issues. The military authorities are required to consider requests from employers of National Guard and Reserve members to adjust scheduled absences from civilian employment to perform service.

APPLICATION FOR REEMPLOYMENT

§ 1002.115 Is the employee required to report to or submit a timely application for reemployment to his or her pre-service employer upon completing the period of service in the uniformed services?

Yes. Upon completing service in the uniformed services, the employee must notify the pre-service employer of his or her intent to return to the employment position by either reporting to work or submitting a timely application for reemployment. Whether the employee is required to report to work or submit a timely application for reemployment depends upon the length of service, as follows:

(a) *Period of service less than 31 days or for a period of any length for the purpose of a fitness examination.* If the period of service in the uniformed services was less than 31 days, or the employee was absent from a position of employment for a period of any length for the purpose of an examination to determine his or her fitness to perform service, the employee must report back to the employer not later than the beginning of the first full regularly-scheduled work period on the first full calendar day following the completion of the period of service, and the expiration of eight hours after a period allowing for safe transportation from the place of that service to the employee's residence. For example, if the employee completes a period of service and travel home, arriving at ten o'clock in the evening, he or she cannot be required to report to the employer until the beginning of the next full regularly-scheduled work period that begins at least eight hours after arriving home, *i.e.*, no earlier than six o'clock the next morning. If it is impossible or unreasonable for the employee to report within such time period through no fault of his or her own, he or she must report to the employer as soon as possible after the expiration of the eight-hour period.

(b) *Period of service more than 30 days but less than 181 days.* If the employee's period of service in the uniformed services was for more than 30 days but less than 181 days, he or she must submit an application for reemployment (written or verbal) with the employer not later than 14 days after completing service. If it is impossible or unreasonable for the employee to apply within 14 days through no fault of his or her own, he or she must submit the application not later than the next full calendar day after it becomes possible to do so.

(c) *Period of service more than 180 days.* If the employee's period of service in the uniformed services was for more than 180 days, he or she must submit an application for reemployment (written or verbal) not later than 90 days after completing service.

§ 1002.116 Is the time period for reporting back to an employer extended if the employee is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service?

Yes. If the employee is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service, he or she must report to or submit an application for reemployment to the employer at the end of the period necessary for recovering from the illness or injury. This period may not exceed two years from the date of the completion of service, except that it must be extended by the minimum time necessary to accommodate circumstances beyond the employee's control that make reporting within the period impossible or unreasonable. This period for recuperation and recovery extends the time period for reporting to or submitting an application for reemployment to the employer, and is not applicable following reemployment.

§ 1002.117 Are there any consequences if the employee fails to report for or submit a timely application for reemployment?

(a) If the employee fails to timely report for or apply for reemployment, he or she does not automatically forfeit entitlement to USERRA's reemployment and other rights and benefits. Rather, the employee becomes subject to the conduct rules, established policy, and general practices of the employer pertaining to an absence from scheduled work.

(b) If reporting or submitting an employment application to the employer is impossible or unreasonable through no fault of the employee, he or she may report to the employer as soon as possible (in the case of a period of service less than 31 days) or submit an application for reemployment to the employer by the next full calendar day after it becomes possible to do so (in the case of a period of service from 31 to 180 days), and the employee will be considered to have timely reported or applied for reemployment.

§ 1002.118 Is an application for reemployment required to be in any particular form?

An application for reemployment need not follow any particular format. The employee may apply orally or in writing. The application should indicate that the employee is a former employee returning from service in the uniformed services and that he or she seeks reemployment with the pre-service employer. The employee is permitted but not required to identify a particular reemployment position in which he or she is interested.

§ 1002.119 To whom must the employee submit the application for reemployment?

The application must be submitted to the pre-service employer or to an agent or representative of the employer who has apparent responsibility for receiving employment applications. Depending upon the circumstances, such a person could be a personnel or human resources officer, or a first-line supervisor. If there has been a change in ownership of the employer, the application should be submitted to the employer's successor-in-interest.

§ 1002.120 If the employee seeks or obtains employment with an employer other than the pre-service employer before the end of the period within which a reemployment application must be filed, will that jeopardize reemployment rights with the pre-service employer?

No. The employee has reemployment rights with the pre-service employer provided that he or she makes a timely reemployment application to that employer. The employee may seek or obtain employment with an employer other than the pre-service employer during the period of time within which a reemployment application must be made, without giving up reemployment rights with the pre-service employer. However, such alternative employment during the application period should not be of a type that would constitute cause for the employer to discipline or terminate the employee following reemployment. For instance, if the employer forbids employees from working concurrently for a direct competitor during employment, violation of such a policy may constitute cause for discipline or even termination.

§ 1002.121 Is the employee required to submit documentation to the employer in connection with the application for reemployment?

Yes, if the period of service exceeded 30 days and if requested by the employer to do so. If the employee submits an application for reemployment after a period of service of more than 30 days, he or she must, upon the request of the employer, provide documentation to establish that:

(a) The reemployment application is timely;

(b) The employee has not exceeded the five-year limit on the duration of service (subject to the exceptions listed at § 1002.103); and,

(c) The employee's separation or dismissal from service was not disqualifying.

§ 1002.122 Is the employer required to reemploy the employee if documentation establishing the employee's eligibility does not exist or is not readily available?

Yes. The employer is not permitted to delay or deny reemployment by demanding documentation that does not exist or is not readily available. The employee is not liable for administrative delays in the issuance of military documentation. If the employee is reemployed after an absence from employment for more than 90 days, the employer may require that he or she submit the documentation establishing entitlement to reemployment before treating the employee as not having had a break in service for pension purposes. If the documentation is received after reemployment and it shows that the employee is not entitled to reemployment, the employer may terminate employment and any rights or benefits that the employee may have been granted.

§ 1002.123 What documents satisfy the requirement that the employee establish eligibility for reemployment after a period of service of more than thirty days?

(a) Documents that satisfy the requirements of USERRA include the following:

(1) DD (Department of Defense) 214 Certificate of Release or Discharge from Active Duty;

(2) Copy of duty orders prepared by the facility where the orders were fulfilled carrying an endorsement indicating completion of the described service;

(3) Letter from the commanding officer of a Personnel Support Activity or someone of comparable authority;

(4) Certificate of completion from military training school;

(5) Discharge certificate showing character of service; and,

(6) Copy of extracts from payroll documents showing periods of service;

(7) Letter from National Disaster Medical System (NDMS) Team Leader or Administrative Officer verifying dates and times of NDMS training or Federal activation.

(b) The types of documents that are necessary to establish eligibility for reemployment will vary from case to case. Not all of these documents are available or necessary in every instance to establish reemployment eligibility.

CHARACTER OF SERVICE

§ 1002.134 What type of discharge or separation from service is required for an employee to be entitled to reemployment under USERRA?

USERRA does not require any particular form of discharge or separation from service. However, even if the employee is otherwise eligible for reemployment, he or she will be disqualified if the characterization of service falls within one of four categories. USERRA requires that the employee not have received one of these types of discharge.

§ 1002.135 What types of discharge or separation from uniformed service will make the employee ineligible for reemployment under USERRA?

Reemployment rights are terminated if the employee is:

(a) Separated from uniformed service with a dishonorable or bad conduct discharge;

(b) Separated from uniformed service under other than honorable conditions, as characterized by regulations of the uniformed service;

(c) A commissioned officer dismissed as permitted under 10 U.S.C. 1161(a) by sentence of a general court-martial; in commutation of a sentence of a general court-martial; or, in time of war, by order of the President; or,

(d) A commissioned officer dropped from the rolls under 10 U.S.C. 1161(b) due to absence without authority for at least three months; separation by reason of a sentence to confinement adjudged by a court-martial; or, a sentence to confinement in a Federal or State penitentiary or correctional institution.

§ 1002.136 Who determines the characterization of service?

The branch of service in which the employee performs the tour of duty determines the characterization of service.

§ 1002.137 If the employee receives a disqualifying discharge or release from uniformed service and it is later upgraded, will reemployment rights be restored?

Yes. A military review board has the authority to prospectively or retroactively upgrade a disqualifying discharge or release. A retroactive upgrade would restore reemployment rights providing the employee otherwise meets the Act's eligibility criteria.

§ 1002.138 If the employee receives a retroactive upgrade in the characterization of service, will that entitle him or her to claim back wages and benefits lost as of the date of separation from service?

No. A retroactive upgrade allows the employee to obtain reinstatement with the former employer, provided the employee otherwise meets the Act's eligibility criteria. Back pay and other benefits such as pension plan credits attributable to the time period between discharge and the retroactive upgrade are not required to be restored by the employer in this situation.

EMPLOYER STATUTORY DEFENSES

§ 1002.139 Are there any circumstances in which the pre-service employer is excused from its obligation to reemploy the employee following a period of uniformed service? What statutory defenses are available to the employer in an action or proceeding for reemployment benefits?

(a) Even if the employee is otherwise eligible for reemployment benefits, the employer is not required to reemploy him or her if the employer establishes that its circumstances have so changed as to make reemployment impossible or unreasonable. For example, an employer may be excused from reemploying the employee where there has been an intervening reduction in force that would have included that employee. The employer may not, however, refuse to reemploy the employee on the basis that another employee was hired to fill the reemployment position during the employee's absence, even if reemployment might require the termination of that replacement employee;

(b) Even if the employee is otherwise eligible for reemployment benefits, the employer is not required to reemploy him or her if it establishes that assisting the employee in becoming qualified for reemployment would impose an undue hardship, as defined in §1002.5(n) and discussed in §1002.198, on the employer; or,

(c) Even if the employee is otherwise eligible for reemployment benefits, the employer is not required to reemploy him or her if it establishes that the employment position vacated by the employee in order to perform service in the uniformed services was for a brief, nonrecurrent period and there was no reasonable expectation that the employment would continue indefinitely or for a significant period.

(d) The employer defenses included in this section are affirmative ones, and the employer carries the burden to prove by a preponderance of the evidence that any one or more of these defenses is applicable.

Subpart D—Rights, Benefits, and Obligations of Persons Absent from Employment Due to Service in the Uniformed Services

FURLOUGH AND LEAVE OF ABSENCE

§ 1002.149 What is the employee's status with his or her civilian employer while performing service in the uniformed services?

During a period of service in the uniformed services, the employee is deemed to be on furlough or leave of absence from the civilian employer. In this status, the employee is entitled to the non-seniority rights and benefits generally provided by the employer to other employees with similar seniority, status, and pay that are on furlough or leave of absence. Entitlement to these non-seniority rights and benefits is not dependent on how the employer characterizes the employee's status during a period of service. For example, if the employer characterizes the employee as ''terminated'' during the period of uniformed service, this characterization cannot be used to avoid USERRA's requirement that the employee be deemed on furlough or leave of absence, and therefore entitled to the non-seniority rights and benefits generally provided to employees on furlough or leave of absence.

§ 1002.150 Which non-seniority rights and benefits is the employee entitled to during a period of service?

(a) The non-seniority rights and benefits to which an employee is entitled during a period of service are those that the employer provides to similarly situated employees by an employment contract, agreement, policy, practice, or plan in effect at the employee's workplace. These rights and benefits include those in effect at the beginning of the employee's employment and those established after employment began. They also include those rights and benefits that become effective during the employee's period of service and that are provided to similarly situated employees on furlough or leave of absence.

(b) If the non-seniority benefits to which employees on furlough or leave

of absence are entitled vary according to the type of leave, the employee must be given the most favorable treatment accorded to any comparable form of leave when he or she performs service in the uniformed services. In order to determine whether any two types of leave are comparable, the duration of the leave may be the most significant factor to compare. For instance, a two-day funeral leave will not be ''comparable'' to an extended leave for service in the uniformed service. In addition to comparing the duration of the absences, other factors such as the purpose of the leave and the ability of the employee to choose when to take the leave should also be considered.

(c) As a general matter, accrual of vacation leave is considered to be a non-seniority benefit that must be provided by an employer to an employee on a military leave of absence only if the employer provides that benefit to similarly situated employees on comparable leaves of absence.

§ 1002.151 If the employer provides full or partial pay to the employee while he or she is on military leave, is the employer required to also provide the non-seniority rights and benefits ordinarily granted to similarly situated employees on furlough or leave of absence?

Yes. If the employer provides additional benefits such as full or partial pay when the employee performs service, the employer is not excused from providing other rights and benefits to which the employee is entitled under the Act.

§ 1002.152 If employment is interrupted by a period of service in the uniformed services, are there any circumstances under which the employee is not entitled to the non-seniority rights and benefits ordinarily granted to similarly situated employees on furlough or leave of absence?

If employment is interrupted by a period of service in the uniformed services and the employee knowingly provides written notice of intent not to return to the position of employment after service in the uniformed services, he or she is not entitled to those non-seniority rights and benefits. The employee's written notice does not waive entitlement to any other rights to which he or she is entitled under the Act, including the right to reemployment after service.

§ 1002.153 If employment is interrupted by a period of service in the uniformed services, is the employee permitted upon request to use accrued vacation, annual or similar leave with pay during the service? Can the employer require the employee to use accrued leave during a period of service?

(a) If employment is interrupted by a period of service, the employee must be permitted upon request to use any accrued vacation, annual, or similar leave with pay during the period of service, in order to continue his or her civilian pay. However, the employee is not entitled to use sick leave that accrued with the civilian employer during a period of service in the uniformed services, unless the employer allows employees to use sick leave for any reason, or allows other similarly situated employees on comparable furlough or leave of absence to use accrued paid sick leave. Sick leave is usually not comparable to annual or vacation leave; it is generally intended to provide income when the employee or a family member is ill and the employee is unable to work.

(b) The employer may not require the employee to use accrued vacation, annual, or similar leave during a period of service in the uniformed services.

HEALTH PLAN COVERAGE

§ 1002.163 What types of health plans are covered by USERRA?

(a) USERRA defines a health plan to include an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or arrangement under which the employee's health services are provided or the expenses of those services are paid.

(b) USERRA covers group health plans as defined in the Employee Retirement Income Security Act of 1974 (ERISA) at 29 U.S.C. 1191b(a). USERRA applies to group health plans that are subject to ERISA, and plans that are not subject to ERISA, such as those

sponsored by State or local governments or religious organizations for their employees.

(c) USERRA covers multiemployer plans maintained pursuant to one or more collective bargaining agreements between employers and employee organizations. USERRA applies to multiemployer plans as they are defined in ERISA at 29 U.S.C. 1002(37). USERRA contains provisions that apply specifically to multiemployer plans in certain situations.

§ 1002.164 What health plan coverage must the employer provide for the employee under USERRA?

If the employee has coverage under a health plan in connection with his or her employment, the plan must permit the employee to elect to continue the coverage for a certain period of time as described below:

(a) When the employee is performing service in the uniformed services, he or she is entitled to continuing coverage for himself or herself (and dependents if the plan offers dependent coverage) under a health plan provided in connection with the employment. The plan must allow the employee to elect to continue coverage for a period of time that is the lesser of:

(1) The 24-month period beginning on the date on which the employee's absence for the purpose of performing service begins; or,

(2) The period beginning on the date on which the employee's absence for the purpose of performing service begins, and ending on the date on which he or she fails to return from service or apply for a position of employment as provided under sections 1002.115–123 of these regulations.

(b) USERRA does not require the employer to establish a health plan if there is no health plan coverage in connection with the employment, or, where there is a plan, to provide any particular type of coverage.

(c) USERRA does not require the employer to permit the employee to initiate new health plan coverage at the beginning of a period of service if he or she did not previously have such coverage.

§ 1002.165 How does the employee elect continuing health plan coverage?

USERRA does not specify requirements for electing continuing coverage. Health plan administrators may develop reasonable requirements addressing how continuing coverage may be elected, consistent with the terms of the plan and the Act's exceptions to the requirement that the employee give advance notice of service in the uniformed services. For example, the employee cannot be precluded from electing continuing health plan coverage under circumstances where it is impossible or unreasonable for him or her to make a timely election of coverage.

§ 1002.166 How much must the employee pay in order to continue health plan coverage?

(a) If the employee performs service in the uniformed service for fewer than 31 days, he or she cannot be required to pay more than the regular employee share, if any, for health plan coverage.

(b) If the employee performs service in the uniformed service for 31 or more days, he or she may be required to pay no more than 102% of the full premium under the plan, which represents the employer's share plus the employee's share, plus 2% for administrative costs.

(c) USERRA does not specify requirements for methods of paying for continuing coverage. Health plan administrators may develop reasonable procedures for payment, consistent with the terms of the plan.

§ 1002.167 What actions may a plan administrator take if the employee does not elect or pay for continuing coverage in a timely manner?

The actions a plan administrator may take regarding the provision or cancellation of an employee's continuing coverage depend on whether the employee is excused from the requirement to give advance notice, whether the plan has established reasonable rules for election of continuation coverage, and whether the plan has established reasonable rules for the payment for continuation coverage.

(a) *No notice of service and no election of continuation coverage:* If an employer

provides employment-based health coverage to an employee who leaves employment for uniformed service without giving advance notice of service, the plan administrator may cancel the employee's health plan coverage upon the employee's departure from employment for uniformed service. However, in cases in which an employee's failure to give advance notice of service was excused under the statute because it was impossible, unreasonable, or precluded by military necessity, the plan administrator must reinstate the employee's health coverage retroactively upon his or her election to continue coverage and payment of all unpaid amounts due, and the employee must incur no administrative reinstatement costs. In order to qualify for an exception to the requirement of timely election of continuing health care, an employee must first be excused from giving notice of service under the statute.

(b) *Notice of service but no election of continuing coverage:* Plan administrators may develop reasonable requirements addressing how continuing coverage may be elected. Where health plans are also covered under the Consolidated Omnibus Budget Reconciliation Act of 1985, 26 U.S.C. 4980B (COBRA), it may be reasonable for a health plan administrator to adopt COBRA-compliant rules regarding election of continuing coverage, as long as those rules do not conflict with any provision of USERRA or this rule. If an employer provides employment-based health coverage to an employee who leaves employment for uniformed service for a period of service in excess of 30 days after having given advance notice of service but without making an election regarding continuing coverage, the plan administrator may cancel the employee's health plan coverage upon the employee's departure from employment for uniformed service, but must reinstate coverage without the imposition of administrative reinstatement costs under the following conditions:

(1) Plan administrators who have developed reasonable rules regarding the period within which an employee may elect continuing coverage must permit retroactive reinstatement of uninterrupted coverage to the date of departure if the employee elects continuing coverage and pays all unpaid amounts due within the periods established by the plan;

(2) In cases in which plan administrators have not developed rules regarding the period within which an employee may elect continuing coverage, the plan must permit retroactive reinstatement of uninterrupted coverage to the date of departure upon the employee's election and payment of all unpaid amounts at any time during the period established in section 1002.164(a).

(c) *Election of continuation coverage without timely payment:* Health plan administrators may adopt reasonable rules allowing cancellation of coverage if timely payment is not made. Where health plans are covered under COBRA, it may be reasonable for a health plan administrator to adopt COBRA-compliant rules regarding payment for continuing coverage, as long as those rules do not conflict with any provision of USERRA or this rule.

§ 1002.168 If the employee's coverage was terminated at the beginning of or during service, does his or her coverage have to be reinstated upon reemployment?

(a) If health plan coverage for the employee or a dependent was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment, if an exclusion or waiting period would not have been imposed had coverage not been terminated by reason of such service.

(b) USERRA permits a health plan to impose an exclusion or waiting period as to illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The determination that the employee's illness or injury was incurred in, or aggravated during, the performance of service may only be made by the Secretary of Veterans Affairs or his or her representative. Other coverage, for injuries or illnesses that

are not service-related (or for the employee's dependents, if he or she has dependent coverage), must be reinstated subject to paragraph (a) of this section.

§ 1002.169 Can the employee elect to delay reinstatement of health plan coverage until a date after the date he or she is reemployed?

USERRA requires the employer to reinstate health plan coverage upon request at reemployment. USERRA permits but does not require the employer to allow the employee to delay reinstatement of health plan coverage until a date that is later than the date of reemployment.

§ 1002.170 In a multiemployer health plan, how is liability allocated for employer contributions and benefits arising under USERRA's health plan provisions?

Liability under a multiemployer plan for employer contributions and benefits in connection with USERRA's health plan provisions must be allocated either as the plan sponsor provides, or, if the sponsor does not provide, to the employee's last employer before his or her service. If the last employer is no longer functional, liability for continuing coverage is allocated to the health plan.

§ 1002.171 How does the continuation of health plan benefits apply to a multiemployer plan that provides health plan coverage through a health benefits account system?

(a) Some employees receive health plan benefits provided pursuant to a multiemployer plan that utilizes a health benefits account system in which an employee accumulates prospective health benefit eligibility, also commonly referred to as ''dollar bank,'' ''credit bank,'' and ''hour bank'' plans. In such cases, where an employee with a positive health benefits account balance elects to continue the coverage, the employee may further elect either option below:

(1) The employee may expend his or her health account balance during an absence from employment due to service in the uniformed services in lieu of paying for the continuation of coverage as set out in §1002.166. If an employee's health account balance becomes depleted during the applicable period provided for in §1002.164(a), the employee must be permitted, at his or her option, to continue coverage pursuant to §1002.166. Upon reemployment, the plan must provide for immediate reinstatement of the employee as required by §1002.168, but may require the employee to pay the cost of the coverage until the employee earns the credits necessary to sustain continued coverage in the plan.

(2) The employee may pay for continuation coverage as set out in §1002.166, in order to maintain intact his or her account balance as of the beginning date of the absence from employment due to service in the uniformed services. This option permits the employee to resume usage of the account balance upon reemployment.

(b) Employers or plan administrators providing such plans should counsel employees of their options set out in this subsection.

Subpart E—Reemployment Rights and Benefits

PROMPT REEMPLOYMENT

§ 1002.180 When is an employee entitled to be reemployed by his or her civilian employer?

The employer must promptly reemploy the employee when he or she returns from a period of service if the employee meets the Act's eligibility criteria as described in Subpart C of these regulations.

§ 1002.181 How is "prompt reemployment" defined?

''Prompt reemployment'' means as soon as practicable under the circumstances of each case. Absent unusual circumstances, reemployment must occur within two weeks of the employee's application for reemployment. For example, prompt reinstatement after a weekend National Guard duty generally means the next regularly scheduled working day. On the other hand, prompt reinstatement following several years of active duty may require more time, because the employer may have to reassign or give notice to another employee who occupied the returning employee's position.

REEMPLOYMENT POSITION

§ 1002.191 What position is the employee entitled to upon reemployment?

As a general rule, the employee is entitled to reemployment in the job position that he or she would have attained with reasonable certainty if not for the absence due to uniformed service. This position is known as the escalator position. The principle behind the escalator position is that, if not for the period of uniformed service, the employee could have been promoted (or, alternatively, demoted, transferred, or laid off) due to intervening events. The escalator principle requires that the employee be reemployed in a position that reflects with reasonable certainty the pay, benefits, seniority, and other job perquisites, that he or she would have attained if not for the period of service. Depending upon the specific circumstances, the employer may have the option, or be required, to reemploy the employee in a position other than the escalator position.

§ 1002.192 How is the specific reemployment position determined?

In all cases, the starting point for determining the proper reemployment position is the escalator position, which is the job position that the employee would have attained if his or her continuous employment had not been interrupted due to uniformed service. Once this position is determined, the employer may have to consider several factors before determining the appropriate reemployment position in any particular case. Such factors may include the employee's length of service, qualifications, and disability, if any. The reemployment position may be either the escalator position; the preservice position; a position comparable to the escalator or pre-service position; or, the nearest approximation to one of these positions.

§ 1002.193 Does the reemployment position include elements such as seniority, status, and rate of pay?

(a) Yes. The reemployment position includes the seniority, status, and rate of pay that an employee would ordinarily have attained in that position given his or her job history, including prospects for future earnings and advancement. The employer must determine the seniority rights, status, and rate of pay as though the employee had been continuously employed during the period of service. The seniority rights, status, and pay of an employment position include those established (or changed) by a collective bargaining agreement, employer policy, or employment practice. The sources of seniority rights, status, and pay include agreements, policies, and practices in effect at the beginning of the employee's service, and any changes that may have occurred during the period of service. In particular, the employee's status in the reemployment position could include opportunities for advancement, general working conditions, job location, shift assignment, rank, responsibility, and geographical location.

(b) If an opportunity for promotion, or eligibility for promotion, that the employee missed during service is based on a skills test or examination, then the employer should give him or her a reasonable amount of time to adjust to the employment position and then give a skills test or examination. No fixed amount of time for permitting adjustment to reemployment will be deemed reasonable in all cases. However, in determining a reasonable amount of time to permit an employee to adjust to reemployment before scheduling a makeup test or examination, an employer may take into account a variety of factors, including but not limited to the length of time the returning employee was absent from work, the level of difficulty of the test itself, the typical time necessary to prepare or study for the test, the duties and responsibilities of the reemployment position and the promotional position, and the nature and responsibilities of the service member while serving in the uniformed service. If the employee is successful on the makeup exam and, based on the results of that exam, there is a reasonable certainty that he or she would have been promoted, or made eligible for promotion, during the time that the employee served in the uniformed service, then

the promotion or eligibility for promotion must be made effective as of the date it would have occurred had employment not been interrupted by uniformed service.

§ 1002.194 Can the application of the escalator principle result in adverse consequences when the employee is reemployed?

Yes. The Act does not prohibit lawful adverse job consequences that result from the employee's restoration on the seniority ladder. Depending on the circumstances, the escalator principle may cause an employee to be reemployed in a higher or lower position, laid off, or even terminated. For example, if an employee's seniority or job classification would have resulted in the employee being laid off during the period of service, and the layoff continued after the date of reemployment, reemployment would reinstate the employee to layoff status. Similarly, the status of the reemployment position requires the employer to assess what would have happened to such factors as the employee's opportunities for advancement, working conditions, job location, shift assignment, rank, responsibility, and geographical location, if he or she had remained continuously employed. The reemployment position may involve transfer to another shift or location, more or less strenuous working conditions, or changed opportunities for advancement, depending upon the application of the escalator principle.

§ 1002.195 What other factors can determine the reemployment position?

Once the employee's escalator position is determined, other factors may allow, or require, the employer to reemploy the employee in a position other than the escalator position. These factors, which are explained in §§ 1002.196 through 1002.199, are:

(a) The length of the employee's most recent period of uniformed service;

(b) The employee's qualifications; and,

(c) Whether the employee has a disability incurred or aggravated during uniformed service.

§ 1002.196 What is the employee's reemployment position if the period of service was less than 91 days?

Following a period of service in the uniformed services of less than 91 days, the employee must be reemployed according to the following priority:

(a) The employee must be reemployed in the escalator position. He or she must be qualified to perform the duties of this position. The employer must make reasonable efforts to help the employee become qualified to perform the duties of this position.

(b) If the employee is not qualified to perform the duties of the escalator position after reasonable efforts by the employer, the employee must be reemployed in the position in which he or she was employed on the date that the period of service began. The employee must be qualified to perform the duties of this position. The employer must make reasonable efforts to help the employee become qualified to perform the duties of this position.

(c) If the employee is not qualified to perform the duties of the escalator position or the pre-service position, after reasonable efforts by the employer, he or she must be reemployed in any other position that is the nearest approximation first to the escalator position and then to the pre-service position. The employee must be qualified to perform the duties of this position. The employer must make reasonable efforts to help the employee become qualified to perform the duties of this position.

§ 1002.197 What is the reemployment position if the employee's period of service in the uniformed services was more than 90 days?

Following a period of service of more than 90 days, the employee must be reemployed according to the following priority:

(a) The employee must be reemployed in the escalator position or a position of like seniority, status, and pay. He or she must be qualified to perform the duties of this position. The employer must make reasonable efforts to help the employee become qualified to perform the duties of this position.

(b) If the employee is not qualified to perform the duties of the escalator position or a like position after reasonable efforts by the employer, the employee must be reemployed in the position in which he or she was employed on the date that the period of service began or in a position of like seniority, status, and pay. The employee must be qualified to perform the duties of this position. The employer must make reasonable efforts to help the employee become qualified to perform the duties of this position.

(c) If the employee is not qualified to perform the duties of the escalator position, the pre-service position, or a like position, after reasonable efforts by the employer, he or she must be reemployed in any other position that is the nearest approximation first to the escalator position and then to the pre-service position. The employee must be qualified to perform the duties of this position. The employer must make reasonable efforts to help the employee become qualified to perform the duties of this position.

§ 1002.198 What efforts must the employer make to help the employee become qualified for the reemployment position?

The employee must be qualified for the reemployment position. The employer must make reasonable efforts to help the employee become qualified to perform the duties of this position. The employer is not required to reemploy the employee on his or her return from service if he or she cannot, after reasonable efforts by the employer, qualify for the appropriate reemployment position.

(a)(1) ''Qualified'' means that the employee has the ability to perform the essential tasks of the position. The employee's inability to perform one or more non-essential tasks of a position does not make him or her unqualified.

(2) Whether a task is essential depends on several factors, and these factors include but are not limited to:

(i) The employer's judgment as to which functions are essential;

(ii) Written job descriptions developed before the hiring process begins;

(iii) The amount of time on the job spent performing the function;

(iv) The consequences of not requiring the individual to perform the function;

(v) The terms of a collective bargaining agreement;

(vi) The work experience of past incumbents in the job; and/or

(vii) The current work experience of incumbents in similar jobs.

(b) Only after the employer makes reasonable efforts, as defined in §1002.5(i), may it determine that the employee is not qualified for the reemployment position. These reasonable efforts must be made at no cost to the employee.

§ 1002.199 What priority must the employer follow if two or more returning employees are entitled to reemployment in the same position?

If two or more employees are entitled to reemployment in the same position and more than one employee has reported or applied for employment in that position, the employee who first left the position for uniformed service has the first priority on reemployment in that position. The remaining employee (or employees) is entitled to be reemployed in a position similar to that in which the employee would have been reemployed according to the rules that normally determine a reemployment position, as set out in §§1002.196 and 1002.197.

Seniority Rights and Benefits

§ 1002.210 What seniority rights does an employee have when reemployed following a period of uniformed service?

The employee is entitled to the seniority and seniority-based rights and benefits that he or she had on the date the uniformed service began, plus any seniority and seniority-based rights and benefits that the employee would have attained if he or she had remained continuously employed. In determining entitlement to seniority and seniority-based rights and benefits, the period of absence from employment due to or necessitated by uniformed service is not considered a break in employment. The rights and benefits protected by USERRA upon reemployment include those provided by the employer and those required by statute. For example,

under USERRA, a reemployed service member would be eligible for leave under the Family and Medical Leave Act of 1993, 29 U.S.C. 2601–2654 (FMLA), if the number of months and the number of hours of work for which the service member was employed by the civilian employer, together with the number of months and the number of hours of work for which the service member would have been employed by the civilian employer during the period of uniformed service, meet FMLA's eligibility requirements. In the event that a service member is denied FMLA leave for failing to satisfy the FMLA's hours of work requirement due to absence from employment necessitated by uniformed service, the service member may have a cause of action under USERRA but not under the FMLA.

§ 1002.211 Does USERRA require the employer to use a seniority system?

No. USERRA does not require the employer to adopt a formal seniority system. USERRA defines seniority as longevity in employment together with any employment benefits that accrue with, or are determined by, longevity in employment. In the absence of a formal seniority system, such as one established through collective bargaining, USERRA looks to the custom and practice in the place of employment to determine the employee's entitlement to any employment benefits that accrue with, or are determined by, longevity in employment.

§ 1002.212 How does a person know whether a particular right or benefit is a seniority-based right or benefit?

A seniority-based right or benefit is one that accrues with, or is determined by, longevity in employment. Generally, whether a right or benefit is seniority-based depends on three factors:

(a) Whether the right or benefit is a reward for length of service rather than a form of short-term compensation for work performed;

(b) Whether it is reasonably certain that the employee would have received the right or benefit if he or she had remained continuously employed during the period of service; and,

(c) Whether it is the employer's actual custom or practice to provide or withhold the right or benefit as a reward for length of service. Provisions of an employment contract or policies in the employee handbook are not controlling if the employer's actual custom or practice is different from what is written in the contract or handbook.

§ 1002.213 How can the employee demonstrate a reasonable certainty that he or she would have received the seniority right or benefit if he or she had remained continuously employed during the period of service?

A reasonable certainty is a high probability that the employee would have received the seniority or seniority-based right or benefit if he or she had been continuously employed. The employee does not have to establish that he or she would have received the benefit as an absolute certainty. The employee can demonstrate a reasonable certainty that he or she would have received the seniority right or benefit by showing that other employees with seniority similar to that which the employee would have had if he or she had remained continuously employed received the right or benefit. The employer cannot withhold the right or benefit based on an assumption that a series of unlikely events could have prevented the employee from gaining the right or benefit.

DISABLED EMPLOYEES

§ 1002.225 Is the employee entitled to any specific reemployment benefits if he or she has a disability that was incurred in, or aggravated during, the period of service?

Yes. A disabled service member is entitled, to the same extent as any other individual, to the escalator position he or she would have attained but for uniformed service. If the employee has a disability incurred in, or aggravated during, the period of service in the uniformed services, the employer must make reasonable efforts to accommodate that disability and to help the employee become qualified to perform the duties of his or her reemployment position. If the employee is not qualified

for reemployment in the escalator position because of a disability after reasonable efforts by the employer to accommodate the disability and to help the employee to become qualified, the employee must be reemployed in a position according to the following priority. The employer must make reasonable efforts to accommodate the employee's disability and to help him or her to become qualified to perform the duties of one of these positions:

(a) A position that is equivalent in seniority, status, and pay to the escalator position; or,

(b) A position that is the nearest approximation to the equivalent position, consistent with the circumstances of the employee's case, in terms of seniority, status, and pay. A position that is the nearest approximation to the equivalent position may be a higher or lower position, depending on the circumstances.

§ 1002.226 If the employee has a disability that was incurred in, or aggravated during, the period of service, what efforts must the employer make to help him or her become qualified for the reemployment position?

(a) USERRA requires that the employee be qualified for the reemployment position regardless of any disability. The employer must make reasonable efforts to help the employee to become qualified to perform the duties of this position. The employer is not required to reemploy the employee on his or her return from service if he or she cannot, after reasonable efforts by the employer, qualify for the appropriate reemployment position.

(b) ''Qualified'' has the same meaning here as in § 1002.198.

RATE OF PAY

§ 1002.236 How is the employee's rate of pay determined when he or she returns from a period of service?

The employee's rate of pay is determined by applying the same escalator principles that are used to determine the reemployment position, as follows:

(a) If the employee is reemployed in the escalator position, the employer must compensate him or her at the rate of pay associated with the escalator position. The rate of pay must be determined by taking into account any pay increases, differentials, step increases, merit increases, or periodic increases that the employee would have attained with reasonable certainty had he or she remained continuously employed during the period of service. In addition, when considering whether merit or performance increases would have been attained with reasonable certainty, an employer may examine the returning employee's own work history, his or her history of merit increases, and the work and pay history of employees in the same or similar position. For example, if the employee missed a merit pay increase while performing service, but qualified for previous merit pay increases, then the rate of pay should include the merit pay increase that was missed. If the merit pay increase that the employee missed during service is based on a skills test or examination, then the employer should give the employee a reasonable amount of time to adjust to the reemployment position and then give him or her the skills test or examination. No fixed amount of time for permitting adjustment to reemployment will be deemed reasonable in all cases. However, in determining a reasonable amount of time to permit an employee to adjust to reemployment before scheduling a makeup test or examination, an employer may take into account a variety of factors, including but not limited to the length of time the returning employee was absent from work, the level of difficulty of the test itself, the typical time necessary to prepare or study for the test, the duties and responsibilities of the reemployment position and the promotional position, and the nature and responsibilities of the service member while serving in the uniformed service. The escalator principle also applies in the event a pay reduction occurred in the reemployment position during the period of service. Any pay adjustment must be made effective as of the date it would have occurred had the employee's employment not been interrupted by uniformed service.

(b) If the employee is reemployed in the pre-service position or another position, the employer must compensate

him or her at the rate of pay associated with the position in which he or she is reemployed. As with the escalator position, the rate of pay must be determined by taking into account any pay increases, differentials, step increases, merit increases, or periodic increases that the employee would have attained with reasonable certainty had he or she remained continuously employed during the period of service.

PROTECTION AGAINST DISCHARGE

§ 1002.247 Does USERRA provide the employee with protection against discharge?

Yes. If the employee's most recent period of service in the uniformed services was more than 30 days, he or she must not be discharged except for cause—

(a) For 180 days after the employee's date of reemployment if his or her most recent period of uniformed service was more than 30 days but less than 181 days; or,

(b) For one year after the date of reemployment if the employee's most recent period of uniformed service was more than 180 days.

§ 1002.248 What constitutes cause for discharge under USERRA?

The employee may be discharged for cause based either on conduct or, in some circumstances, because of the application of other legitimate nondiscriminatory reasons.

(a) In a discharge action based on conduct, the employer bears the burden of proving that it is reasonable to discharge the employee for the conduct in question, and that he or she had notice, which was express or can be fairly implied, that the conduct would constitute cause for discharge.

(b) If, based on the application of other legitimate nondiscriminatory reasons, the employee's job position is eliminated, or the employee is placed on layoff status, either of these situations would constitute cause for purposes of USERRA. The employer bears the burden of proving that the employee's job would have been eliminated or that he or she would have been laid off.

PENSION PLAN BENEFITS

§ 1002.259 How does USERRA protect an employee's pension benefits?

On reemployment, the employee is treated as not having a break in service with the employer or employers maintaining a pension plan, for purposes of participation, vesting and accrual of benefits, by reason of the period of absence from employment due to or necessitated by service in the uniformed services.

(a) Depending on the length of the employee's period of service, he or she is entitled to take from one to ninety days following service before reporting back to work or applying for reemployment (See §1002.115). This period of time must be treated as continuous service with the employer for purposes of determining participation, vesting and accrual of pension benefits under the plan.

(b) If the employee is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, service, he or she is entitled to report to or submit an application for reemployment at the end of the time period necessary for him or her to recover from the illness or injury. This period, which may not exceed two years from the date the employee completed service, except in circumstances beyond his or her control, must be treated as continuous service with the employer for purposes of determining the participation, vesting and accrual of pension benefits under the plan.

§ 1002.260 What pension benefit plans are covered under USERRA?

(a) The Employee Retirement Income Security Act of 1974 (ERISA) defines an employee pension benefit plan as a plan that provides retirement income to employees, or defers employee income to a period extending to or beyond the termination of employment. Any such plan maintained by the employer or employers is covered under USERRA. USERRA also covers certain pension plans not covered by ERISA, such as those sponsored by a State, government entity, or church for its employees.

(b) USERRA does not cover pension benefits under the Federal Thrift Savings Plan; those benefits are covered under 5 U.S.C. 8432b.

§ 1002.261 Who is responsible for funding any plan obligation to provide the employee with pension benefits?

With the exception of multiemployer plans, which have separate rules discussed below, the employer is liable to the pension benefit plan to fund any obligation of the plan to provide benefits that are attributable to the employee's period of service. In the case of a defined contribution plan, once the employee is reemployed, the employer must allocate the amount of its make-up contribution for the employee, if any; his or her make-up employee contributions, if any; and his or her elective deferrals, if any; in the same manner and to the same extent that it allocates the amounts for other employees during the period of service. In the case of a defined benefit plan, the employee's accrued benefit will be increased for the period of service once he or she is reemployed and, if applicable, has repaid any amounts previously paid to him or her from the plan and made any employee contributions that may be required to be made under the plan.

§ 1002.262 When is the employer required to make the plan contribution that is attributable to the employee's period of uniformed service?

(a) The employer is not required to make its contribution until the employee is reemployed. For employer contributions to a plan in which the employee is not required or permitted to contribute, the employer must make the contribution attributable to the employee's period of service no later than ninety days after the date of reemployment, or when plan contributions are normally due for the year in which the service in the uniformed services was performed, whichever is later. If it is impossible or unreasonable for the employer to make the contribution within this time period, the employer must make the contribution as soon as practicable.

(b) If the employee is enrolled in a contributory plan he or she is allowed (but not required) to make up his or her missed contributions or elective deferrals. These makeup contributions or elective deferrals must be made during a time period starting with the date of reemployment and continuing for up to three times the length of the employee's immediate past period of uniformed service, with the repayment period not to exceed five years. Make-up contributions or elective deferrals may only be made during this period and while the employee is employed with the post-service employer.

(c) If the employee's plan is contributory and he or she does not make up his or her contributions or elective deferrals, he or she will not receive the employer match or the accrued benefit attributable to his or her contribution because the employer is required to make contributions that are contingent on or attributable to the employee's contributions or elective deferrals only to the extent that the employee makes up his or her payments to the plan. Any employer contributions that are contingent on or attributable to the employee's make-up contributions or elective deferrals must be made according to the plan's requirements for employer matching contributions.

(d) The employee is not required to make up the full amount of employee contributions or elective deferrals that he or she missed making during the period of service. If the employee does not make up all of the missed contributions or elective deferrals, his or her pension may be less than if he or she had done so.

(e) Any vested accrued benefit in the pension plan that the employee was entitled to prior to the period of uniformed service remains intact whether or not he or she chooses to be reemployed under the Act after leaving the uniformed service.

(f) An adjustment will be made to the amount of employee contributions or elective deferrals the employee will be able to make to the pension plan for any employee contributions or elective deferrals he or she actually made to the plan during the period of service.

§ 1002.263 Does the employee pay interest when he or she makes up missed contributions or elective deferrals?

No. The employee is not required or permitted to make up a missed contribution in an amount that exceeds the amount he or she would have been permitted or required to contribute had he or she remained continuously employed during the period of service.

§ 1002.264 Is the employee allowed to repay a previous distribution from a pension benefits plan upon being reemployed?

Yes, provided the plan is a defined benefit plan. If the employee received a distribution of all or part of the accrued benefit from a defined benefit plan in connection with his or her service in the uniformed services before he or she became reemployed, he or she must be allowed to repay the withdrawn amounts when he or she is reemployed. The amount the employee must repay includes any interest that would have accrued had the monies not been withdrawn. The employee must be allowed to repay these amounts during a time period starting with the date of reemployment and continuing for up to three times the length of the employee's immediate past period of uniformed service, with the repayment period not to exceed five years (or such longer time as may be agreed to between the employer and the employee), provided the employee is employed with the post-service employer during this period.

§ 1002.265 If the employee is reemployed with his or her pre-service employer, is the employee's pension benefit the same as if he or she had remained continuously employed?

The amount of the employee's pension benefit depends on the type of pension plan.

(a) In a non-contributory defined benefit plan, where the amount of the pension benefit is determined according to a specific formula, the employee's benefit will be the same as though he or she had remained continuously employed during the period of service.

(b) In a contributory defined benefit plan, the employee will need to make up contributions in order to have the same benefit as if he or she had remained continuously employed during the period of service.

(c) In a defined contribution plan, the benefit may not be the same as if the employee had remained continuously employed, even though the employee and the employer make up any contributions or elective deferrals attributable to the period of service, because the employee is not entitled to forfeitures and earnings or required to experience losses that accrued during the period or periods of service.

§ 1002.266 What are the obligations of a multiemployer pension benefit plan under USERRA?

A multiemployer pension benefit plan is one to which more than one employer is required to contribute, and which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer. The Act uses ERISA's definition of a multiemployer plan. In addition to the provisions of USERRA that apply to all pension benefit plans, there are provisions that apply specifically to multiemployer plans, as follows:

(a) The last employer that employed the employee before the period of service is responsible for making the employer contribution to the multiemployer plan, if the plan sponsor does not provide otherwise. If the last employer is no longer functional, the plan must nevertheless provide coverage to the employee.

(b) An employer that contributes to a multiemployer plan and that reemploys the employee pursuant to USERRA must provide written notice of reemployment to the plan administrator within 30 days after the date of reemployment. The returning service member should notify the reemploying employer that he or she has been reemployed pursuant to USERRA. The 30-day period within which the reemploying employer must provide written notice to the multiemployer plan pursuant to this subsection does not begin until the employer has knowledge that the employee was reemployed pursuant to USERRA.

(c) The employee is entitled to the same employer contribution whether

he or she is reemployed by the pre-service employer or by a different employer contributing to the same multi-employer plan, provided that the pre-service employer and the post-service employer share a common means or practice of hiring the employee, such as common participation in a union hiring hall.

§ 1002.267 How is compensation during the period of service calculated in order to determine the employee's pension benefits, if benefits are based on compensation?

In many pension benefit plans, the employee's compensation determines the amount of his or her contribution or the retirement benefit to which he or she is entitled.

(a) Where the employee's rate of compensation must be calculated to determine pension entitlement, the calculation must be made using the rate of pay that the employee would have received but for the period of uniformed service.

(b)(1) Where the rate of pay the employee would have received is not reasonably certain, such as where compensation is based on commissions earned, the average rate of compensation during the 12-month period prior to the period of uniformed service must be used.

(2) Where the rate of pay the employee would have received is not reasonably certain and he or she was employed for less than 12 months prior to the period of uniformed service, the average rate of compensation must be derived from this shorter period of employment that preceded service.

Subpart F—Compliance Assistance, Enforcement and Remedies

Compliance Assistance

§ 1002.277 What assistance does the Department of Labor provide to employees and employers concerning employment, reemployment, or other rights and benefits under USERRA?

The Secretary, through the Veterans' Employment and Training Service (VETS), provides assistance to any person or entity with respect to employment and reemployment rights and benefits under USERRA. This assistance includes a wide range of compliance assistance outreach activities, such as responding to inquiries; conducting USERRA briefings and Webcasts; issuing news releases; and, maintaining the elaws USERRA Advisor (located at *http://www.dol.gov/elaws/userra.htm*), the e-VETS Resource Advisor and other web-based materials (located at *http://www.dol.gov/vets*), which are designed to increase awareness of the Act among affected persons, the media, and the general public. In providing such assistance, VETS may request the assistance of other Federal and State agencies, and utilize the assistance of volunteers.

Investigation and Referral

§ 1002.288 How does an individual file a USERRA complaint?

If an individual is claiming entitlement to employment rights or benefits or reemployment rights or benefits and alleges that an employer has failed or refused, or is about to fail or refuse, to comply with the Act, the individual may file a complaint with VETS or initiate a private legal action in a court of law (*see* § 1002.303). A complaint may be filed with VETS either in writing, using VETS Form 1010, or electronically, using VETS Form e1010 (instructions and the forms can be accessed at *http://www.dol.gov/elaws/vets/userra/1010.asp*). A complaint must include the name and address of the employer, a summary of the basis for the complaint, and a request for relief.

§ 1002.289 How will VETS investigate a USERRA complaint?

(a) In carrying out any investigation, VETS has, at all reasonable times, reasonable access to and the right to interview persons with information relevant to the investigation. VETS also has reasonable access to, for purposes of examination, the right to copy and receive any documents of any person or employer that VETS considers relevant to the investigation.

(b) VETS may require by subpoena the attendance and testimony of witnesses and the production of documents relating to any matter under investigation. In case of disobedience of or resistance to the subpoena, the Attorney General may, at VETS' request, apply to any district court of the United States in whose jurisdiction such disobedience or resistance occurs for an order enforcing the subpoena. The district courts of the United States have jurisdiction to order compliance with the subpoena, and to punish failure to obey a subpoena as a contempt of court. This paragraph does not authorize VETS to seek issuance of a subpoena to the legislative or judicial branches of the United States.

§ 1002.290 Does VETS have the authority to order compliance with USERRA?

No. If VETS determines as a result of an investigation that the complaint is meritorious, VETS attempts to resolve the complaint by making reasonable efforts to ensure that any persons or entities named in the complaint comply with the Act.

If VETS' efforts do not resolve the complaint, VETS notifies the person who submitted the complaint of:

(a) The results of the investigation; and,

(b) The person's right to proceed under the enforcement of rights provisions in 38 U.S.C. 4323 (against a State or private employer), or 38 U.S.C. 4324 (against a Federal executive agency or the Office of Personnel Management (OPM)).

§ 1002.291 What actions may an individual take if the complaint is not resolved by VETS?

If an individual receives a notification from VETS of an unsuccessful effort to resolve his or her complaint relating to a State or private employer, the individual may request that VETS refer the complaint to the Attorney General.

§ 1002.292 What can the Attorney General do about the complaint?

(a) If the Attorney General is reasonably satisfied that an individual's complaint is meritorious, meaning that he or she is entitled to the rights or benefits sought, the Attorney General may appear on his or her behalf and act as the individual's attorney, and initiate a legal action to obtain appropriate relief.

(b) If the Attorney General determines that the individual's complaint does not have merit, the Attorney General may decline to represent him or her.

Enforcement of Rights and Benefits Against a State or Private Employer

§ 1002.303 Is an individual required to file his or her complaint with VETS?

No. The individual may initiate a private action for relief against a State or private employer if he or she decides not to apply to VETS for assistance.

§ 1002.304 If an individual files a complaint with VETS and VETS' efforts do not resolve the complaint, can the individual pursue the claim on his or her own?

Yes. If VETS notifies an individual that it is unable to resolve the complaint, the individual may pursue the claim on his or her own. The individual may choose to be represented by private counsel whether or not the Attorney General decides to represent him or her as to the complaint.

§ 1002.305 What court has jurisdiction in an action against a State or private employer?

(a) If an action is brought against a State or private employer by the Attorney General, the district courts of the United States have jurisdiction over the action. If the action is brought against a State by the Attorney General, it must be brought in the name of the United States as the plaintiff in the action.

(b) If an action is brought against a State by a person, the action may be brought in a State court of competent jurisdiction according to the laws of the State.

(c) If an action is brought against a private employer or a political subdivision of a State by a person, the district courts of the United States have jurisdiction over the action.

(d) An action brought against a State Adjutant General, as an employer of a civilian National Guard technician, is considered an action against a State for purposes of determining which court has jurisdiction.

§ 1002.306 Is a National Guard civilian technician considered a State or Federal employee for purposes of USERRA?

A National Guard civilian technician is considered a State employee for USERRA purposes, although he or she is considered a Federal employee for most other purposes.

§ 1002.307 What is the proper venue in an action against a State or private employer?

(a) If an action is brought by the Attorney General against a State, the action may proceed in the United States district court for any district in which the State exercises any authority or carries out any function.

(b) If an action is brought against a private employer, or a political subdivision of a State, the action may proceed in the United States district court for any district in which the employer maintains a place of business.

§ 1002.308 Who has legal standing to bring an action under USERRA?

An action may be brought only by the United States or by the person, or representative of a person, claiming rights or benefits under the Act. An employer, prospective employer or other similar entity may not bring an action under the Act.

§ 1002.309 Who is a necessary party in an action under USERRA?

In an action under USERRA only an employer or a potential employer, as the case may be, is a necessary party respondent. In some circumstances, such as where terms in a collective bargaining agreement need to be interpreted, the court may allow an interested party to intervene in the action.

§ 1002.310 How are fees and court costs charged or taxed in an action under USERRA?

No fees or court costs may be charged or taxed against an individual if he or she is claiming rights under the Act. If the individual obtains private counsel for any action or proceeding to enforce a provision of the Act, and prevails, the court may award reasonable attorney fees, expert witness fees, and other litigation expenses.

§ 1002.311 Is there a statute of limitations in an action under USERRA?

USERRA does not have a statute of limitations, and it expressly precludes the application of any State statute of limitations. At least one court, however, has held that the four-year general Federal statute of limitations, 28 U.S.C. 1658, applies to actions under USERRA. *Rogers* v. *City of San Antonio,* 2003 WL 1566502 (W.D. Texas), *reversed on other grounds,* 392 F.3d 758 (5th Cir. 2004). But see *Akhdary* v. *City of Chattanooga,* 2002 WL 32060140 (E.D. Tenn.). In addition, if an individual unreasonably delays asserting his or her rights, and that unreasonable delay causes prejudice to the employer, the courts have recognized the availability of the equitable doctrine of *laches* to bar a claim under USERRA. Accordingly, individuals asserting rights under USERRA should determine whether the issue of the applicability of the Federal statute of limitations has been resolved and, in any event, act promptly to preserve their rights under USERRA.

§ 1002.312 What remedies may be awarded for a violation of USERRA?

In any action or proceeding the court may award relief as follows:

(a) The court may require the employer to comply with the provisions of the Act;

(b) The court may require the employer to compensate the individual for any loss of wages or benefits suffered by reason of the employer's failure to comply with the Act;

(c) The court may require the employer to pay the individual an amount equal to the amount of lost wages and benefits as liquidated damages, if the court determines that the employer's failure to comply with the Act was willful. A violation shall be considered to be willful if the employer either knew or showed reckless disregard for

whether its conduct was prohibited by the Act.

(d) Any wages, benefits, or liquidated damages awarded under paragraphs (b) and (c) of this section are in addition to, and must not diminish, any of the other rights and benefits provided by USERRA (such as, for example, the right to be employed or reemployed by the employer).

§ 1002.313 Are there special damages provisions that apply to actions initiated in the name of the United States?

Yes. In an action brought in the name of the United States, for which the relief includes compensation for lost wages, benefits, or liquidated damages, the compensation must be held in a special deposit account and must be paid, on order of the Attorney General, directly to the person. If the compensation is not paid to the individual because of the Federal Government's inability to do so within a period of three years, the compensation must be converted into the Treasury of the United States as miscellaneous receipts.

§ 1002.314 May a court use its equity powers in an action or proceeding under the Act?

Yes. A court may use its full equity powers, including the issuance of temporary or permanent injunctions, temporary restraining orders, and contempt orders, to vindicate the rights or benefits guaranteed under the Act.

APPENDIX TO PART 1002—NOTICE OF YOUR RIGHTS UNDER USERRA

Pursuant to 38 U.S.C. 4334(a), each employer shall provide to persons entitled to rights and benefits under USERRA a notice of the rights, benefits, and obligations of such persons and such employers under USERRA. The requirement for the provision of notice under this section may be met by posting the following notice where employers customarily place notices for employees. Posting one of the original notices published in 70 FR 75316 (Dec. 19, 2005) will also satisfy this requirement. The following text is provided by the Secretary of Labor to employers pursuant to 38 U.S.C. 4334(b).

TEXT FOR USE BY ALL EMPLOYERS

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

• Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

• The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1–866–4–USA–DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

• If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

• You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.* Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1–866–487–2365.

[73 FR 63632, Oct. 27, 2008]

PART 1010—APPLICATION OF PRIORITY OF SERVICE FOR COVERED PERSONS

Subpart A—Purpose and Definitions

Sec.

1010.100 What is the purpose and scope of this part?
1010.110 What definitions apply to this part?

Subpart B—Understanding Priority of Service

1010.200 What is priority of service?
1010.210 In which Department job training programs do covered persons receive priority of service?
1010.220 How are recipients required to implement priority of service?
1010.230 In addition to the responsibilities of all recipients, do States and political subdivisions of States have any particular responsibilities in implementing priority of service?
1010.240 Will the Department be monitoring for compliance with priority of service?
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Subpart C—Applying Priority of Service

1010.300 What processes are to be implemented to identify covered persons?
1010.310 How will priority of service be applied?
1010.320 Will recipients be required to collect information and report on priority of service?
1010.330 What are the responsibilities of recipients to collect and maintain data on covered and non-covered persons?

AUTHORITY: Pub. L. 109–461 (Dec. 22, 2006), section 605 [38 U.S.C. 4215 Note]; 38 U.S.C. 4215.

SOURCE: 73 FR 78142, Dec. 19, 2008, unless otherwise noted.

Subpart A—Purpose and Definitions

§ 1010.100 What is the purpose and scope of this part?

(a) Part 1010 contains the Department regulations implementing priority of service for covered persons. Priority of service for covered persons is authorized by section 2(a)(1) of JVA (38 U.S.C. 4215). These regulations fulfill section 605 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. 109–461 (Dec. 22, 2006), which requires the Department to implement priority of service via regulation.

(b) As provided in §1010.210, this part applies to all qualified job training programs.

§ 1010.110 What definitions apply to this part?

The following definitions apply to this part:

Covered person as defined in section 2(a) of the JVA (38 U.S.C. 4215(a)) means a veteran or eligible spouse.

Department or DOL means the United States Department of Labor, including its agencies and organizational units and their representatives.

Eligible spouse as defined in section 2(a) of the JVA (38 U.S.C. 4215(a)) means the spouse of any of the following:

(1) Any veteran who died of a service-connected disability;

(2) Any member of the Armed Forces serving on active duty who, at the time of application for the priority, is listed in one or more of the following categories and has been so listed for a total of more than 90 days:

(i) Missing in action;

(ii) Captured in line of duty by a hostile force; or

(iii) Forcibly detained or interned in line of duty by a foreign government or power;

(3) Any veteran who has a total disability resulting from a service-connected disability, as evaluated by the Department of Veterans Affairs;

(4) Any veteran who died while a disability, as indicated in paragraph (3) of this section, was in existence.

Grant means an award of Federal financial assistance by the Department of Labor to an eligible recipient.

Jobs for Veterans Act (JVA) means Public Law 107–288 (2002). Section 2(a) of the JVA, codified at 38 U.S.C. 4215(a), provides priority of service for covered persons.

Non-covered person means any individual who meets neither the definition of ''veteran,'' as defined in this section, nor the definition of ''eligible spouse'' as defined in this section.

Qualified job training program means any program or service for workforce preparation, development, or delivery that is directly funded, in whole or in part, by the Department of Labor.

Recipient means an entity to which federal financial assistance, in whole or in part, is awarded directly from the Department or through a sub-award for any qualified job training program.

Secretary means the Secretary of the Department of Labor.

Veteran means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable, as specified in 38 U.S.C. 101(2). Active service includes full-time duty in the National Guard or a Reserve component, other than full-time duty for training purposes.

Subpart B—Understanding Priority of Service

§ 1010.200 What is priority of service?

(a) As defined in section 2(a) of the JVA (38 U.S.C. 4215(a)) ''priority of service'' means, with respect to any qualified job training program, that a covered person shall be given priority over a non-covered person for the receipt of employment, training, and placement services provided under that program, notwithstanding any other provision of the law.

(b) Priority in the context of providing priority of service to veterans and other covered persons in qualified job training programs covered by this regulation means the right to take precedence over non-covered persons in obtaining services. Depending on the type of service or resource being provided, taking precedence may mean:

(1) The covered person receives access to the service or resource earlier in time than the non-covered person; or

(2) If the service or resource is limited, the covered person receives access to the service or resource instead of or before the non-covered person.

§ 1010.210 In which Department job training programs do covered persons receive priority of service?

(a) Priority of service applies to every qualified job training program funded, in whole or in part, by the Department, including:

(1) Any such program or service that uses technology to assist individuals to access workforce development programs (such as job and training opportunities, labor market information, career assessment tools, and related support services); and

(2) Any such program or service under the public employment service system, One-Stop Career Centers, the Workforce Investment Act of 1998, a demonstration or other temporary program; any workforce development program targeted to specific groups; and those programs implemented by States or local service providers based on Federal block grants administered by the Department.

(b) The implementation of priority of service does not change the intended

function of a program or service. Covered persons must meet all statutory eligibility and program requirements for participation in order to receive priority for a program or service.

§ 1010.220 How are recipients required to implement priority of service?

(a) An agreement to implement priority of service, as described in these regulations and in any departmental guidance, is a condition for receipt of all Department job training program funds.

(b) All recipients are required to ensure that priority of service is applied by all sub-recipients of Department funds. All program activities, including those obtained through requests for proposals, solicitations for grant awards, sub-grants, contracts, sub-contracts, and (where feasible) memoranda of understanding or other service provision agreements, issued or executed by qualified job training program operators, must be administered in compliance with priority of service.

§ 1010.230 In addition to the responsibilities of all recipients, do States and political subdivisions of States have any particular responsibilities in implementing priority of service?

(a) Pursuant to their responsibility under the Workforce Investment Act of 1998, States are required to address priority of service in their comprehensive strategic plan for the State's workforce investment system. Specifically, States must develop policies for the delivery of priority of service by the State Workforce Agency or Agencies, Local Workforce Investment Boards, and One-Stop Career Centers for all qualified job training programs delivered through the State's workforce system. The policy or policies must require that processes are in place to ensure that covered persons are identified at the point of entry and given an opportunity to take full advantage of priority of service. These processes shall be undertaken to ensure that covered persons are aware of:

(1) Their entitlement to priority of service;

(2) The full array of employment, training, and placement services available under priority of service; and

(3) Any applicable eligibility requirements for those programs and/or services.

(b) The State's policy or policies must require Local Workforce Investment Boards to develop and include in their strategic local plan, policies implementing priority of service for the local One-Stop Career Centers and for service delivery by local workforce preparation and training providers. These policies must establish processes to ensure that covered persons are identified at the point of entry so that covered persons are able to take full advantage of priority of service. These processes shall ensure that covered persons are aware of:

(1) Their entitlement to priority of service;

(2) The full array of employment, training, and placement services available under priority of service; and

(3) Any applicable eligibility requirements for those programs and/or services.

§ 1010.240 Will the Department be monitoring for compliance with priority of service?

(a) The Department will monitor recipients of funds for qualified job training programs to ensure that covered persons are made aware of and afforded priority of service.

(b) Monitoring priority of service will be performed jointly between the Veterans' Employment and Training Service (VETS) and the DOL agency responsible for the program's administration and oversight.

(c) A recipient's failure to provide priority of service to covered persons will be handled in accordance with the program's established compliance review processes. In addition to the remedies available under the program's compliance review processes, a recipient may be required to submit a corrective action plan to correct such failure.

§ 1010.250 Can priority of service be waived?

No, priority of service cannot be waived.

Subpart C—Applying Priority of Service

§ 1010.300 What processes are to be implemented to identify covered persons?

(a) Recipients of funds for qualified job training programs must implement processes to identify covered persons who physically access service delivery points or who access virtual service delivery programs or Web sites in order to provide covered persons with timely and useful information on priority of service at the point of entry. Point of entry may include reception through a One-Stop Career Center established pursuant to the Workforce Investment Act of 1998, as part of an application process for a specific program, or through any other method by which covered persons express an interest in receiving services, either in-person or virtually.

(b)(1) The processes for identifying covered persons at the point of entry must be designed to:

(i) Permit the individual to make known his or her covered person status; and

(ii) Permit those qualified job training programs specified in §1010.330(a)(2) to initiate data collection for covered entrants.

(2) The processes for identifying covered persons are not required to verify the status of an individual as a veteran or eligible spouse at the point of entry unless they immediately undergo eligibility determination and enrollment in a program.

(c) The processes for identifying covered persons must ensure that:

(1) Covered persons are identified at the point of entry to allow covered persons to take full advantage of priority of service; and

(2) Covered persons are to be made aware of:

(i) Their entitlement to priority of service;

(ii) The full array of employment, training, and placement services available under priority of service; and

(iii) Any applicable eligibility requirements for those programs and/or services.

§ 1010.310 How will priority of service be applied?

(a) Recipients of funds for qualified job training programs must implement processes in accordance with §1010.300 to identify covered persons at the point of entry, whether in person or virtual, so the covered person can be notified of their eligibility for priority of service. Since qualified job training programs may offer various types of services including staff-assisted services as well as self-services or informational activities, recipients also must ensure that priority of service is implemented throughout the full array of services provided to covered persons by the qualified job training program.

(b) Three categories of qualified job training programs affect the application of priority of service: universal access, discretionary targeting and statutory targeting. To obtain priority, a covered person must meet the statutory eligibility requirement(s) applicable to the specific program from which services are sought. For those programs that also have discretionary or statutory priorities or preferences pursuant to a Federal statute or regulation, recipients must coordinate providing priority of service with applying those other priorities, as prescribed in paragraphs (b)(2) and (b)(3) of this section.

(1) *Universal access programs* operate or deliver services to the public as a whole; they do not target specific groups. These programs are required to provide priority of service to covered persons.

(2) *Discretionary targeting programs* focus on a particular group, or make efforts to provide a certain level of service to such a group, but do not specifically mandate that the favored group be served before other eligible individuals. Whether these provisions are found in a Federal statute or regulation, priority of service will apply. Covered persons must receive the highest priority for the program or service, and non-covered persons within the discretionary targeting will receive priority over non-covered persons outside the discretionary targeting.

(3) *Statutory targeting programs* are programs derived from a Federal statutory mandate that requires a priority

or preference for a particular group of individuals or requires spending a certain portion of program funds on a particular group of persons receiving services. These are mandatory priorities. Recipients must determine each individual's covered person status and apply priority of service as described below:

(i) Covered persons who meet the mandatory priorities or spending requirement or limitation must receive the highest priority for the program or service;

(ii) Non-covered persons within the program's mandatory priority or spending requirement or limitation, must receive priority for the program or service over covered persons outside the program-specific mandatory priority or spending requirement or limitation; and,

(iii) Covered persons outside the program-specific mandatory priority or spending requirement or limitation must receive priority for the program or service over non-covered persons outside the program-specific mandatory priority or spending requirement or limitation.

§ 1010.320 Will recipients be required to collect information and report on priority of service?

Yes. Every recipient of funds for qualified job training programs must collect such information, maintain such records, and submit reports containing such information and in such formats as the Secretary may require related to the provision of priority of service.

§ 1010.330 What are the responsibilities of recipients to collect and maintain data on covered and non-covered persons?

(a) *General requirements.* Recipients must collect information in accordance with instructions issued by the Department.

(1) Recipients must collect two broad categories of information:

(i) For the qualified job training programs specified in paragraph (a)(2) of this section, information must be collected on covered persons from the point of entry, as defined in § 1010.300(a), and as provided in paragraph (b) of this section; and,

(ii) For all qualified job training programs, including the programs specified in paragraph (a)(2) of this section, information must be collected on covered and non-covered persons who receive services, as prescribed by the respective qualified job training programs, as provided in paragraph (c) of this section.

(2) For purposes of paragraph (a)(1) of this section, qualified job training programs that served, at the national level, 1,000 or more veterans per year for the three most recent years of program operations (currently the Wagner-Peyser, WIA Adult, WIA Dislocated Worker, WIA National Emergency Grant, and Senior Community Service Employment Programs) must collect information and report on covered entrants. The Trade Adjustment Assistance Program must collect information and report on covered entrants on the effective date of the next information collection requirement applicable to that program, whether that is for a renewal of an existing approved information collection or for approval of a new information collection.

(3) For purposes of this section, covered persons at the point of entry are referred to as ''covered entrants.'' This group includes two further subgroups: veterans and eligible spouses as defined in § 1010.110.

(b) *Collection and maintenance of data on covered entrants.* In accordance with instructions issued by the Department, recipients of assistance for the programs specified in paragraph (a)(2) of this section must collect and report individual record data for all covered entrants from the point of entry.

(c) *Collection and maintenance of data on covered and non-covered persons who receive services.* In accordance with instructions issued for individual qualified job training programs, all recipients must collect and maintain data on covered and non-covered persons who receive services, including individual record data for those programs that require establishment and submission of individual records for persons receiving services.

(1) The information to be collected shall include, but is not limited to:

(i) The covered and non-covered person status of all persons receiving services;

(ii) The types of services provided to covered and non-covered persons;

(iii) The dates that services were received by covered and non-covered persons; and;

(iv) The employment outcomes experienced by covered and non-covered persons receiving services.

(2)(i) Except as provided in paragraph (c)(2)(ii) of this section, for persons receiving services, recipients must apply the definitions set forth in §1010.110 to distinguish covered from non-covered persons receiving services and, within covered persons, to distinguish veterans from eligible spouses.

(ii) Until qualified job training programs adopt the definitions for covered and non-covered persons set forth at §1010.110 through the publication of requirements pursuant to the Paperwork Reduction Act, recipients must collect data on the services provided to and the outcomes experienced by veterans (however defined) and non-veterans receiving services in accord with regulations, policies and currently approved information collections.

(d) All information must be stored and managed in a manner that ensures confidentiality.

PART 1011—HIRE VETS MEDALLION PROGRAM

Subpart A—General Provisions

Sec.

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SOURCE: 82 FR 52203, Nov. 13, 2017, unless otherwise noted.

Subpart A—General Provisions

§1011.000 What is the HIRE Vets Medallion Program?

The HIRE Vets Medallion Program is a voluntary employer recognition program administered by the Department of Labor's Veterans' Employment and Training Service. Through the HIRE

Vets Medallion Program, the Department of Labor solicits voluntary applications from employers for the HIRE Vets Medallion Award. The purpose of this award is to recognize efforts by applicants to recruit, employ, and retain veterans and to provide services supporting the veteran community.

§ 1011.005 What definitions apply to this part?

Active Duty in the United States National Guard or Reserve means active duty as defined in 10 U.S.C. 101(d)(1).

Dedicated human resources professional means either a full-time professional or the equivalent of a full-time professional dedicated exclusively to supporting the hiring, training, and retention of veteran employees. Two half-time professionals, for example, are equivalent to one full-time professional.

Employee means any individual for whom the employer furnishes an IRS Form W–2, excluding temporary workers.

Employer means any person, institution, organization, or other entity that pays salary or wages for work performed or that has control over employee opportunities, except for the Federal Government or any State or foreign government. For the purposes of this regulation, VETS will recognize employers based on the Employer Identification Number, as described in 26 CFR 301.7701–12, used to furnish an IRS Form W–2 to an employee. However, in the case of an agent designated pursuant to 26 CFR 31.3504–1, a payor designated pursuant to 26 CFR 31.3504–2, or a Certified Professional Employer Organization recognized pursuant to 26 U.S.C. 7705, the employer shall be the common law employer, client, or customer, respectively, instead of the entity that furnishes the IRS Form W–2.

Human Resources Veterans' Initiative means an initiative through which an employer provides support for hiring, training, and retention of veteran employees.

Post-secondary education means post-secondary level education or training courses that would be acceptable for credit toward at least one of the following: associate's or bachelor's degree or higher, any other recognized post-secondary credential, or an apprenticeship.

Salary means an employee's base pay.

Temporary worker means any worker hired with the intention that the worker be retained for less than 1 year and who is actually retained for less than 1 year.

Veteran has the meaning given such term under 38 U.S.C. 101.

VETS means the Veterans' Employment and Training Service of the Department of Labor.

§ 1011.010 Who is eligible to apply for a HIRE Vets Medallion Award?

All employers who employ at least one employee are eligible to apply for a HIRE Vets Medallion Award. To qualify for a HIRE Vets Medallion Award, an employer must satisfy all application requirements.

§ 1011.015 What are the different types of the HIRE Vets Medallion Awards?

(a) There are three different categories of the HIRE Vets Medallion Award:

(1) *Large Employer Awards* for employers with 500 or more employees.

(2) *Medium Employer Awards* for employers with more than 50 but fewer than 500 employees.

(3) *Small Employer Awards* for employers with 50 or fewer employees.

(4) *Timing*. The correct category of award is determined by the employer's number of employees as of December 31 of the year prior to the year in which the employer applies for an award.

(b) Within each award category, there are two levels of award:

(1) A Gold Award; and

(2) A Platinum Award.

Subpart B—Award Criteria

§ 1011.100 What are the criteria for the large employer HIRE Vets Medallion Award?

(a) *Gold Award*. To qualify for a large employer gold HIRE Vets Medallion Award, an employer must satisfy all of the following criteria:

(1) The employer is a large employer as specified in § 1011.015 of this part;

(2) The employer is not found ineligible under § 1011.120 of this part;

(3) Veterans constitute not less than 7 percent of all employees hired by such employer during the prior calendar year;

(4) The employer has retained not less than 75 percent of the veteran employees hired during the calendar year preceding the preceding calendar year for a period of at least 12 months from the date on which the employees were hired;

(5) The employer has established an employee veteran organization or resource group to assist new veteran employees with integration, including coaching and mentoring; and

(6) The employer has established programs to enhance the leadership skills of veteran employees during their employment.

(b) *Platinum Award.* To qualify for a large employer platinum HIRE Vets Medallion Award, an employer must satisfy all of the following criteria:

(1) The employer is a large employer as specified in §1011.015 of this part;

(2) The employer is not found ineligible under §1011.120 of this part;

(3) Veterans constitute not less than 10 percent of all employees hired by such employer during the prior calendar year;

(4) The employer has retained not less than 85 percent of the veteran employees hired during the calendar year preceding the preceding calendar year for a period of at least 12 months from the date on which the employees were hired;

(5) The employer has established an employee veteran organization or resource group to assist new veteran employees with integration, including coaching and mentoring;

(6) The employer has established programs to enhance the leadership skills of veteran employees during their employment;

(7) The employer employs a dedicated human resources professional as defined in §1011.005 of this part to support hiring, training, and retention of veteran employees;

(8) The employer provides each of its employees serving on active duty in the United States National Guard or Reserve with compensation sufficient, in combination with the employee's active duty pay, to achieve a combined level of income commensurate with the employee's salary prior to undertaking active duty; and

(9) The employer has a tuition assistance program to support veteran employees' attendance in post-secondary education during the term of their employment.

§1011.105 What are the criteria for the medium employer HIRE Vets Medallion Award?

(a) *Gold Award.* To qualify for a medium employer gold HIRE Vets Medallion Award, an employer must satisfy all of the following criteria:

(1) The employer is a medium employer per §1011.015 of this part;

(2) The employer is not found ineligible under §1011.120 of this part;

(3) The employer has achieved at least one of the following:

(i) Veterans constitute not less than 7 percent of all employees hired by such employer during the prior calendar year; or

(ii) The employer has achieved both of the following:

(A) The employer has retained not less than 75 percent of the veteran employees hired during the calendar year preceding the preceding calendar year for a period of at least 12 months from the date on which the employees were hired; and

(B) On December 31 of the year prior to the year in which the employer applies for the HIRE Vets Medallion Award, at least 7 percent of the employer's employees were veterans; and

(4) The employer has at least one of the following forms of integration assistance:

(i) The employer has established an employee veteran organization or resource group to assist new veteran employees with integration, including coaching and mentoring; or

(ii) The employer has established programs to enhance the leadership skills of veteran employees during their employment.

(b) *Platinum Award.* To qualify for a medium employer platinum HIRE Vets Medallion Award, an employer must satisfy all of the following criteria:

(1) The employer is a medium employer as specified in §1011.015 of this part;

(2) The employer is not found ineligible under § 1011.120 of this part;

(3) The employer has achieved at least one of the following:

(i) Veterans constitute not less than 10 percent of all employees hired by such employer during the prior calendar year; or

(ii) The employer has achieved both of the following:

(A) The employer has retained not less than 85 percent of the veteran employees hired during the calendar year preceding the preceding calendar year for a period of at least 12 months from the date on which the employees were hired; and

(B) On December 31 of the year prior to the year in which the employer applies for the HIRE Vets Medallion Award, at least 10 percent of the employer's employees were veterans;

(4) The employer has the following forms of integration assistance:

(i) The employer has established an employee veteran organization or resource group to assist new veteran employees with integration, including coaching and mentoring; and

(ii) The employer has established programs to enhance the leadership skills of veteran employees during their employment; and

(5) The employer has at least one of the following additional forms of integration assistance:

(i) The employer has established a human resources veterans' initiative;

(ii) The employer provides each of its employees serving on active duty in the United States National Guard or Reserve with compensation sufficient, in combination with the employee's active duty pay, to achieve a combined level of income commensurate with the employee's salary prior to undertaking active duty; or

(iii) The employer has a tuition assistance program to support veteran employees' attendance in post-secondary education during the term of their employment.

§ 1011.110 What are the criteria for the small employer HIRE Vets Medallion Award?

(a) *Gold Award.* To qualify for a small employer gold HIRE Vets Medallion Award, an employer must satisfy all of the following criteria:

(1) The employer is a small employer as specified in § 1011.015 of this part;

(2) The employer is not found ineligible under § 1011.120 of this part; and

(3) The employer has achieved at least one of the following:

(i) Veterans constitute not less than 7 percent of all employees hired by such employer during the prior calendar year; or

(ii) The employer has achieved both of the following:

(A) The employer has retained not less than 75 percent of the veteran employees hired during the calendar year preceding the preceding calendar year for a period of at least 12 months from the date on which the employees were hired; and

(B) On December 31 of the year prior to the year in which the employer applies for the HIRE Vets Medallion Award, at least 7 percent of the employer's employees were veterans.

(b) *Platinum Award.* To qualify for a small employer platinum HIRE Vets Medallion Award, an employer must satisfy all of the following criteria:

(1) The employer is a small employer as specified in § 1011.015 of this part;

(2) The employer is not found ineligible under § 1011.120 of this part;

(3) The employer has achieved at least one of the following:

(i) Veterans constitute not less than 10 percent of all employees hired by such employer during the prior calendar year; or

(ii) The employer has achieved both of the following:

(A) The employer has retained not less than 85 percent of the veteran employees hired during the calendar year preceding the preceding calendar year for a period of at least 12 months from the date on which the employees were hired; and

(B) On December 31 of the year prior to the year in which the employer applies for the HIRE Vets Medallion Award, at least 10 percent of the employer's employees were veterans; and

(4) The employer has at least two of the following forms of integration assistance:

(i) The employer has established an employee veteran organization or resource group to assist new veteran employees with integration, including coaching and mentoring;

(ii) The employer has established programs to enhance the leadership skills of veteran employees during their employment;

(iii) The employer has established a human resources veterans' initiative;

(iv) The employer provides each of its employees serving on active duty in the United States National Guard or Reserve with compensation sufficient, in combination with the employee's active duty pay, to achieve a combined level of income commensurate with the employee's salary prior to undertaking active duty;

(v) The employer has a tuition assistance program to support veteran employees' attendance in post-secondary education during the term of their employment.

§ 1011.115 Is there an exemption for certain large employers from the dedicated human resources professional criterion for the large employer platinum HIRE Vets Medallion Award?

Yes. Large employers who employ 5,000 or fewer employees need not have a dedicated human resources professional to support the hiring and retention of veteran employees. A large employer with 5,000 or fewer employees can satisfy the criterion at §1011.100(b)(7) by employing at least one human resources professional whose regular work duties include supporting the hiring, training, and retention of veteran employees.

§ 1011.120 Under what circumstances will VETS find an employer ineligible to receive a HIRE Vets Medallion Award for a violation of labor law?

(a) Any employer with an adverse labor law decision, stipulated agreement, contract debarment, or contract termination, as defined in paragraphs (b) through (e) of this section, pursuant to either of the following labor laws, as amended, will not be eligible to receive an award:

(1) Uniformed Services Employment and Reemployment Rights Act (USERRA); or

(2) Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA);

(b) For purposes of this section, an adverse labor law decision means any of the following, issued in the calendar year prior to year in which applications are solicited or the calendar year in which applications are solicited up until the issuance of the award, in which a violation of any of the laws in paragraph (a) of this section is found:

(1) A civil or criminal judgment;

(2) A final administrative merits determination of an administrative adjudicative board or commission; or

(3) A decision of an administrative law judge or other administrative judge that is not appealed and that becomes the final agency action.

(c) For purposes of this section, a stipulated agreement means any agreement (including a settlement agreement, conciliation agreement, consent decree, or other similar document) to which the employer is a party, entered into in the calendar year prior to the year in which applications are solicited or the calendar year in which applications are solicited up until the issuance of the award, that contains an admission that the employer violated either of the laws cited in paragraph (a) of this section.

(d) For purposes of this section, a contract debarment means any order or voluntary agreement, pursuant to the laws listed in paragraph (a) of this section, that debars the employer from receiving any future Federal contract. Employers shall be ineligible for an award for the duration of time that the contract debarment is in effect.

(e) For purposes of this section, a contract termination means any order or voluntary agreement, pursuant to the laws listed in paragraph (a) of this section, that terminates an existing Federal contract prior to its completion. Employers shall be ineligible for the award if this termination occurred in the calendar year prior to the year in which applications are solicited or the calendar year in which applications are solicited up until the issuance of the award.

(f) VETS may delay issuing an award to an employer if, at the time the award is to be issued, VETS has credible information that a significant violation of one of the laws in paragraph (a) of this section may have occurred that could lead to an employer being disqualified pursuant to any of paragraphs (b) through (e) of this section.

Subpart C—Application Process

§ 1011.200 How will VETS administer the HIRE Vets Medallion Award process?

The Secretary of Labor will annually—

(a) Solicit and accept voluntary applications from employers in order to consider whether those employers should receive a HIRE Vets Medallion Award;

(b) Review applications received in each calendar year;

(c) Notify such recipients of their awards; and

(d) At a time to coincide with the annual commemoration of Veterans Day—

(1) Announce the names of such recipients;

(2) Recognize such recipients through publication in the FEDERAL REGISTER; and

(3) Issue to each such recipient—

(i) A HIRE Vets Medallion Award; and

(ii) A certificate stating that such employer is entitled to display such HIRE Vets Medallion Award.

§ 1011.205 What is the timing of the HIRE Vets Medallion Award process?

VETS will review all timely applications that fall under any cap established in § 1011.305 of this part to determine whether an employer should receive a HIRE Vets Medallion Award, and, if so, of what level.

(a) *Performance period*—except as otherwise noted in § 1011.120 of this part, only the employer's actions taken prior to December 31 of the calendar year prior to the calendar year in which applications are solicited will be considered in reviewing the award.

(b) *Solicitation period*—VETS will solicit applications not later than January 31 of each calendar year for the HIRE Vets Medallion Award to be awarded in November of that calendar year.

(c) *End of acceptance period*—VETS will stop accepting applications on April 30 of each calendar year for the awards to be awarded in November of that calendar year.

(d) *Review period*—VETS will finish reviewing applications not later than August 31 of each calendar year for the awards to be awarded in November of that calendar year.

(e) *Selection of recipients*—VETS will select the employers to receive HIRE Vets Medallion Awards not later than September 30 of each calendar year for the awards to be awarded in November of that calendar year.

(f) *Notice of awards and denials*—VETS will notify employers who will receive HIRE Vets Medallion Awards not later than October 11 of each calendar year for the awards to be awarded in November of that calendar year. VETS will also notify applicants who will not be receiving an award at that time.

§ 1011.210 How often can an employer receive the HIRE Vets Medallion Award?

Per section 2(d) of the HIRE Vets Act, an employer who receives a HIRE Vets Medallion Award for 1 calendar year is not eligible to receive a HIRE Vets Medallion Award for the subsequent calendar year.

§ 1011.215 How will the employer complete the application for the HIRE Vets Medallion Award?

(a) VETS will require all applicants to provide information to establish their eligibility for the HIRE Vets Medallion Award.

(b) VETS may request additional information in support of the application for the HIRE Vets Medallion Award.

(c) The chief executive officer, the chief human resources officer, or an equivalent official of each employer applicant must attest under penalty of perjury that the information the employer has submitted in its application is accurate.

(d) Interested employers can access the application form via the HIRE Vets

Web site accessible from *https://www.hirevets.gov/*.

(e) Applicants will complete the application form and submit it electronically.

(f) Applicants who need a reasonable accommodation in accessing the application form, submitting the application form, or submitting the application fee may contact VETS at (202) 693–4700 or TTY (877) 889–5627 (these are not toll-free numbers).

(g) Should the information provided on the application be deemed incomplete, VETS will attempt to contact the applicant. The applicant must respond with the additional information necessary to complete the application form within 5 business days or VETS will deny the application.

§ 1011.220 How will VETS verify a HIRE Vets Medallion Award application?

VETS will verify all information provided by an employer in its application to the extent that such information is relevant in determining whether or not such employer meets the criteria to receive a HIRE Vets Medallion Award or in determining the appropriate level of HIRE Vets Medallion Award for that employer to receive. VETS will verify this information by reviewing all information provided as part of the application.

§ 1011.225 Under what circumstances will VETS conduct further review of an application?

If at any time VETS becomes aware of facts that indicate that the information provided by an employer in its application was incorrect or that the employer does not satisfy the requirements at § 1011.120, VETS may conduct further review of the application. As part of that review, VETS may request information and/or documentation to confirm the accuracy of the information provided by the employer in its application or to confirm that the employer is not ineligible under § 1011.120. Depending on the result of the review, VETS may either deny or revoke the award. If VETS initiates such review prior to issuing the award, VETS will not be required to meet the timeline requirements in this part.

§ 1011.230 Under what circumstances can VETS deny or revoke an award?

(a) *Denial of award.* VETS may deny an award for any of the following reasons:

(1) The applicant fails to provide information and/or documentation as requested under § 1011.225 of this part;

(2) VETS determines that the chief executive officer, the chief human resources officer, or an equivalent official of the applicant falsely attested that the information on the application was true;

(3) The employer is ineligible to receive an award pursuant to § 1011.120 of this part; or

(4) The application does not satisfy all application requirements.

(b) *Revocation of award.* Once the HIRE Vets Medallion Award has been awarded, VETS may revoke the recipient's award for the following reasons:

(1) The HIRE Vets Medallion Award recipient fails to provide information and/or documentation as requested under § 1011.225 of this part;

(2) VETS determines that the chief executive officer, the chief human resources officer, or an equivalent official of the recipient falsely attested that the information on the application was true;

(3) The employer was ineligible to receive an award pursuant to § 1011.120 of this part; or

(4) The employer violated the display restrictions at § 1011.405 of this part.

(c) If VETS decides to deny or revoke an award, it will provide the employer with notice of the decision. An employer may request reconsideration of VETS' decision to deny or revoke an award pursuant to § 1011.500 of this part.

Subpart D—Fees and Caps

§ 1011.300 What are the application fees for the HIRE Vets Medallion Award?

(a) The Act requires the Secretary of Labor to establish a fee sufficient to cover the costs associated with carrying out the HIRE Vets Medallion Program.

(b) Table 1 to § 1011.300 sets forth the fees an employer must pay to apply for

the HIRE Vets Medallion Award. VETS will adjust the fees periodically according to the Implicit Price Deflator for Gross Domestic Product published by the U.S. Department of Commerce and notify potential applicants of the adjusted fees.

(1) If a significant adjustment is needed to arrive at a new fee for any reason other than inflation, then a proposed rule containing the new fees will be published in the FEDERAL REGISTER for comment.

(2) VETS will round the fee to the nearest dollar.

TABLE 1 TO § 1011.300

Application Fees	
Small Employer Fee	$90.00
Medium Employer Fee	190.00
Large Employer Fee	495.00

(c) All applicants must submit the appropriate application processing fee for each application submitted. This fee is based on the fees provided in table 1 to § 1011.300. Payment of this fee must be made electronically through the U.S. Treasury *pay.gov* system or an equivalent.

(d) Once a fee is paid, it is nonrefundable, even if the employer withdraws the application or does not receive a HIRE Vets Medallion Award.

§ 1011.305 May VETS set a limit on how many applications will be accepted in a year?

Yes, VETS may set a limit on how many applications will be accepted in any given year.

Subpart E—Design and Display

§ 1011.400 What does a successful applicant receive?

(a) The award will be in the form of a certificate and will state the year for which it was awarded.

(b) VETS will also provide a digital image of the medallion for recipients to use, including as part of an advertisement, solicitation, business activity, or product.

§ 1011.405 What are the restrictions on display and use of the HIRE Vets Medallion Award?

It is unlawful for any employer to publicly display a HIRE Vets Medallion Award, in connection with, or as a part of, any advertisement, solicitation, business activity, or product—

(a) For the purpose of conveying, or in a manner reasonably calculated to convey, a false impression that the employer received the award through the HIRE Vets Medallion Program, if such employer did not receive such award through the HIRE Vets Medallion Program; or

(b) For the purpose of conveying, or in a manner reasonably calculated to convey, a false impression that the employer received the award through the HIRE Vets Medallion Program for a year for which such employer did not receive such award.

Subpart F—Requests for Reconsideration

§ 1011.500 What is the process to request reconsideration of a denial or revocation?

(a) An applicant may file a request for reconsideration of VETS' decision to deny or revoke a HIRE Vets Medallion Award or of VETS' decision as to the level of award by mailing a request for reconsideration to the following address no later than 15 business days after the date of VETS' notice of its decision. Requests for reconsideration must be sent to: HIRE Vets Medallion Program, DOL VETS, 200 Constitution Ave. NW., Room S1325, Washington, DC 20210.

(b) Requests for reconsideration pursuant to paragraph (a) of this section must contain the following:

(1) The employer name and identification number;

(2) The reason for the request; and

(3) An explanation, accompanied by any necessary documentation to support that explanation, of why VETS' decision was incorrect.

(c) VETS may request from the employer filing such request any additional evidence or explanation it finds necessary for reconsideration.

(d) Within 30 business days after the later of the receipt of the request or

the receipt of any additional evidence or explanation requested, VETS will issue a determination about whether to grant or deny the request.

(e) No additional Department of Labor review is available.

Subpart G—Record Retention

§ 1011.600 What are the record retention requirements for the HIRE Vets Medallion Award?

Applicants must retain a record of all information used to support an application for the HIRE Vets Medallion Award for 2 years from the date of application.

PARTS 1012–1099 [RESERVED]

FINDING AIDS

A list of CFR titles, subtitles, chapters, subchapters and parts and an alphabetical list of agencies publishing in the CFR are included in the CFR Index and Finding Aids volume to the Code of Federal Regulations which is published separately and revised annually.

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For changes to this volume of the CFR prior to this listing, consult the annual edition of the monthly List of CFR Sections Affected (LSA). The LSA is available at *www.govinfo.gov*. For changes to this volume of the CFR prior to 2001, see the ''List of CFR Sections Affected, 1949–1963, 1964–1972, 1973–1985, and 1986–2000'' published in 11 separate volumes. The ''List of CFR Sections Affected 1986–2000'' is available at *www.govinfo.gov*.

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658.411 (a)(2)(i), (ii), (3), (b)(1) introductory text, (i), (ii)(A), (B), (D), (E), (c), (d)(1) introductory text, (i), (ii)(A) through (D), (iii), (iv), (3) introductory text, (4), the (5)(i) introductory text, (ii), (iii)(G), and (6) revised; (a)(4) amended; (b)(1)(ii)(F) added 82731
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702.271 (a)(2) amended 1858
725.621 (d) amended 1859
726.302 (c)(2)(i) introductory text and (4) through (6) amended; (c)(2)(i) Table 1 revised 1859